



The Advocate

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Calendar of Events

Events relating to helping children are available at: www.tennessee.gov/tccy/webcalen.pdf.

TCCY

For more information on the Tennessee Commission on Children and Youth and its programs, check out the website at: www.tennessee.gov/tccy.

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Adolescents and Substance Abuse

Youth use of alcohol and other drugs has been associated with unintentional injuries, physical fights, academic and occupational problems, and illegal behavior. Child Trends found 80 percent of adolescents have tried alcohol and 50 percent other drugs by their senior year in high school.

Much evidence suggests age of first substance use correlates to substance abuse; however, the relationship between early use and genetic and environmental factors is complicated, especially in the case of alcohol use. Parental use and family disruption are also related to youth substance abuse, as is peer influence.

Many researchers found, however, that conduct disorders and behavior problems are the strongest predictors of alcohol abuse. In males, who have a higher risk of substance abuse, these behaviors may be associated with depression. A study released in May 2008 linked adolescent drug use to depression. The study also found this self medication increased the incidence of more serious mental disorders and suicide.

The 2008 report from the White House Office of National Drug Control Policy (ONDCP) found 2 million teens felt depressed at some point during the past year. The depressed teens were more than twice as likely as non-depressed teens to have used marijuana during the year. Depressed teens were also almost twice as likely to have used illicit drugs or to abuse or become dependent on marijuana (2008).

A community response to adolescent drug use includes instituting a simple and standardized screening tool by health care providers and others (see CRAFFT tool on page 2) and increasing availability of treatment. A community response also needs to include early prevention efforts and treatment of children with risk factors. 

Alcohol and Drug Risk and Protective Factors

Source: Importance of Protective Factors Preventing Substance Abuse by Teens, 2008

Risk factors include:

- ★ **Community** factors, including availability of drugs, extreme economic deprivation;
- ★ **Family** factors, including history of substance abuse, conflict, favorable parental attitudes toward and/or involvement with substance abuse;
- ★ **School** factors, including academic failure beginning in late elementary school, lack of commitment to school;
- ★ **Individual or Peer** factors, including early and persistent antisocial behavior, friends who are substance users/abusers, early initiation of substance abuse

Risks of Teen Alcohol Use: Teens Who Drink Are

- 9.4 times more likely to drink and drive.
- 8.5 times more likely to have a serious problem with other drugs.
- 5.5 times more likely to be arrested.
- 2.25 times more likely to smoke.
- 1.5 times more likely to have a C+ average or lower and likely to miss twice as much school.
- 1.5 times more likely to require hospital emergency room care.

Sources: National Survey on Drug Use & Health & George Washington U.

Protective factors include:

- ★ **Individual characteristics**, including high intelligence, resilient temperament (adapts well to stress), competencies and skills, which contribute to a sense of competence and build self-esteem. (Parents should be verbally supportive with praise and compliments and give children tasks and responsibilities so they can develop their own skills and competencies, feel good about themselves and recognize their abilities to become successful, suggests the director of Pathways Treatment Center in Virginia.)
- ★ **Social factors**: Prosocial opportunities (responsibilities at home, participation in activities, such as sports, music, theater, art, faith-based organizations; reinforcement for prosocial involvement from influential adults; healthy relationships with adults, including parents, caregivers, teachers, coaches, pastors and others; healthy beliefs and clear standards for behavior (clearly understood and enforced rules about the use of alcohol and drugs in the home and parental role models). (See also Search Institute Developmental Assets list: <http://www.search-institute.org/assets/40AssetsList.pdf>). 

The CRAFFT Screening Tool

- C** Have you ever ridden in a **car** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
- A** Do you ever use alcohol or drugs while you are by yourself or **alone**?
- F** Do you ever **forget** things you did while using alcohol or drugs?
- F** Do your **family or friends** ever tell you that you should cut down on your drinking or drug use?
- T** Have you ever gotten into **trouble** while you were using alcohol or drugs?

Source: Archives of Pediatrics and Adolescent Medicine, 2002

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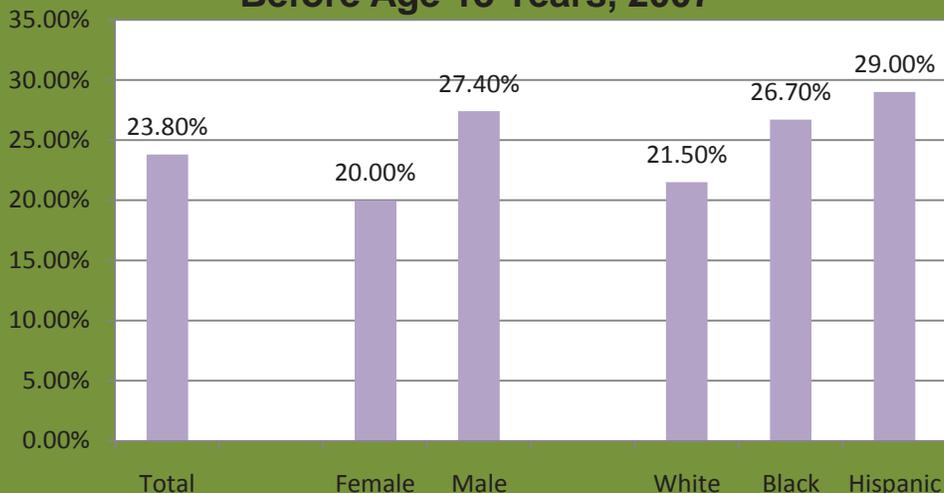
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Percentage of U.S. High School Students Who Drank* Alcohol for the First Time Before Age 13 Years, 2007



*More than a few sips; Source: CDC Morbidity & Mortality Report Weekly

2007 Youth Risk Behavior Survey-Tennessee

Percentage of students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol.	8.5
Percentage of students who rode one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol.	24.2
Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.	26.8
Percentage of students who had at least one drink of alcohol on one or more days during their life.	69.9
Percentage of students who had their first drink of alcohol other than a few sips before age 13 years.	22.3
Percentage of students who had at least one drink of alcohol on one or more of the past 30 days.	36.7
Percentage of students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days.	21.7
Among students who reported current alcohol use, the percentage who usually got the alcohol they drank by buying it in a store such as a liquor store, convenience store, supermarket, discount store, or gas station during the past 30 days.	4.6
Percentage of students who had at least one drink of alcohol on school property on one or more of the past 30 days.	4.1
Percentage of students who used marijuana one or more times during their life.	38.1
Percentage of students who tried marijuana for the first time before age 13 years.	10.6
Percentage of students who used marijuana one or more times during the past 30 days.	19.4
Percentage of students who used any form of cocaine, including powder, crack, or freebase, one or more times during their life.	6.6

What Works for Youth

Last September Substance Abuse and Mental Health Services Administration (SAMHSA) released information on adolescent substance abuse from its national survey of drug use. The report indicated drug use in this age group had dropped. Adolescents between ages 12 and 17 who said they had used a drug in the past month dropped to 9.8 percent in 2006 from 11.6 percent in 2002. This included drops in marijuana use, especially in adolescent males. At the same time the agency celebrated successes in substance abuse recovery.

Successful adolescent substance abuse components were listed in a Child Trends report issued in May 2008. The research organization maintains a database of evaluations of intervention strategies used by programs for children and youth. The report pulled together information from experimentally evaluated programs that targeted adolescent and youth substance use. The Child Trends report found the factors listed below were effective for both substance abuse prevention and cessation programs.

- ★ Programs with a variety of approaches (multiple components) generally work. These include using schools, family, community, social events and media campaigns.
- ★ Addressing all forms of drug use (including tobacco and alcohol use) together generally work, especially for prevention.
- ★ Teaching the health risks and consequences of substance use contributes to the success of cessation programs.
- ★ Tailoring programs to specific populations, grouped by developmental age, gender, ethnicity, etc., is generally successful in both prevention and cessation.
- ★ A combination of peer-led intervention with trained adult facilitators or teachers is successful.
- ★ Emphasizing drug resistance and reinforcing anti-drug attitudes appear to work in preventing substance abuse.
- ★ Both substance abuse treatment and prevention programs work to help adolescents.

The Advocate is published by the Tennessee Commission on Children and Youth as an information forum on children's issues. The Tennessee Commission on Children and Youth, an independent state agency, serves as an advocacy agency and information resource for planning and coordination of policies, programs, and services on behalf of the state's children and youth. The 26-member Commission, appointed by the governor, works with other agencies and with regional councils on children and youth in each development district to collect information and solve problems in children's services. To receive *The Advocate*, sign up on the website at www.state.tn.us/tccy/listserv.html or contact Fay L. Delk, Publications Editor, Tennessee Commission on Children and Youth, 710 James Robertson Parkway, 9th Floor, Nashville, TN 37243-0800. Phone: (615) 741-2633. Fax: (615) 741-5956. E-mail: fay.delk@state.tn.us.



The report cited a lack of stringent evaluations. Many programs have not been studied, and few studies involve randomly assigned comparison groups. The report suggested areas in which more research is needed:

- ★ Optimal length of time to attain long-term results is important (and relevant to effective use of funding) but has not been studied well.
- ★ Multi-component programs work, but it is not clear which of the components is most effective.
- ★ It is unclear which factors best contribute to lasting success after the intervention has ended.
- ★ Pathways and transitions from initial use to abuse and how to intervene and block these paths have not been studied.

In a time of budget cuts and serious challenges, research on what works is even more important. 📖

Tennessee Strategic Prevention Framework State Incentive Grant (SPF-SIG)

Source: Tennessee Department of Mental Health and Developmental Disabilities

Tennessee has received an incentive grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) infrastructure grant program. As an infrastructure grant, its purpose is to help states build a solid foundation for delivering and sustaining effective substance abuse prevention strategies.

Funding for the grant began in federal fiscal year 2005 and will end in 2009. It is based on a framework with the following goals:

- ★ Prevent the onset and reduce the progression of substance abuse, including:
 - ◆ Childhood and underage drinking,
 - ◆ Youth and young adult alcohol use/abuse;
 - ◆ Marijuana use/abuse;
 - ◆ Cocaine/crack use/abuse;
 - ◆ Methamphetamine use/abuse;
 - ◆ Decrease risk factors/increase protective factors.
- ★ Reduce substance abuse-related problems in communities;
- ★ Build prevention capacity and infrastructure at the State and community levels:
 - ◆ Structures and formal linkages;
 - ◆ Resources;
 - ◆ Champion roles;
 - ◆ Policies and procedures.



The grant's framework is based on a community-based risk and protective factors approach, with a series of steps:

- Step 1. Conduct a statewide needs assessment.
- Step 2. Build state and community prevention system capacity.
- Step 3. Develop a comprehensive, statewide strategic plan.
- Step 4. Implement evidence-based programs and infrastructure development activities.
- Step 5. Monitor progress, evaluate effectiveness, sustain effective programs and make adjustments with those who fail.

Community Anti-Drug Coalitions Across Tennessee (CADCAT) provides services to the more than 35 counties with anti-drug coalitions, helping local communities come together to prevent substance abuse and improve their services. The organization holds training sessions and shares information about resources. To find a local anti-drug coalition, go to <http://www.cadcat.org/public/calendar3.html> on the agency's website.

A Prevention Intervention Logic Model is used to assure a connection between the goals, changes required to reach the goals, the efforts to reach them and the ways of measuring success.

The Tennessee grant has an advisory committee. TCCY is represented on the committee by its executive director and its KIDS COUNT director. Other members include representatives of other state agencies, law enforcement, non-profit treatment programs, drug enforcement and education. ❏

Tennessee Treatment Programs

Source: Tennessee Department of Mental Health and Developmental Disabilities

Tennessee has consolidated its funding authority for alcohol and drug treatment services in the Department of Mental Health and Developmental Disabilities. The Division of Alcohol and Drug Abuse Services has a vision: A future where Tennessee is substance abuse free and our children are safe. The department plans, develops, administers and evaluates a statewide system of services for the treatment of people whose use of alcohol and/or other drugs has resulted in patterns of abuse or addiction.

Tennessee Access to Recovery. Tennessee was one of 14 governments out of 60 states, territories and tribal organizations to receive three year SAMHSA funding totaling \$17.8 million. The program, which began serving Tennesseans in April 2005, provided treatment services (90 days of treatment) for eligible methamphetamine users and recovery support and relapse prevention services for adults recovering from abuse or addiction to any substance. In the program's first two years, more than 9,700 people were served by 111 providers. Although the grant ended in August 2007, the planning and implementation of the project began a system of collaboration between a variety of providers and organizations.

Alcohol and Drug Abuse Treatment (ADAT) Program. The state funds treatment programs for low-income people charged with DUI and ordered to undergo alcohol and drug assessment and treatment. This program, which has been funded at \$4.5 million for FY 2007-08, is completing its 10th year. An evaluation of the program released in 2004 found 96 percent of participants completed treatment, and, at six months, more than 60 percent of ADAT clients, reported being abstinent, working full time and living with family members again.

Other Prevention Division services for young people are Intensive Focus Programs for youth through age 17, Tennessee Teen Institute, to help youth develop programs in their communities; the Faith Initiative, to elicit churches to help target services to pre-adolescent children living in inner-city single-parent families; and a program to educate deaf and hard of hearing youth. The division also provides a clearing house for alcohol and drug information. 

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Community Factors and Substance Abuse

Community factors contribute to substance use. Availability of drugs, population density, income level, neighborhood attachment and social disorganization are frequently recognized factors.

The most obvious community factor is availability. The youth who had someone try to sell them a drug are 10 times more likely to use it than those who had not been offered, based on a study of the 2002 National Survey On Drug Use and Health (NSDUH). Drugs were viewed as more easily obtained in urban areas but so is treatment. Only 9 percent of rural residents live within one mile of a treatment facility compared to 49 percent of urban residents. Generally, the rate of substance abuse is higher in urban areas, but specific drugs are a bigger problem for rural youth, who are twice as likely as urban youth to abuse alcohol.

Urban communities are viewed as having more social disorganization, but smaller communities are less likely to have planned activities, which have been found to be a protective factor against drug use. Income level interacts with other factors. Youth from lower income families are less likely to participate in youth activities and more likely to live in communities with social disorganization.

Community investment in activity and training programs for youth and mentoring programs can help address community causes of substance abuse. 

The Tennessee Adolescent Coordination of Treatment (T-ACT)

Source: Governor's Office of Children's Care Coordination (GOCCC)

The Tennessee Adolescent Coordination of Treatment (T-ACT) grant is an infrastructure grant provided to Tennessee for three years by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The vision is that Tennessee adolescents will have access to a coordinated continuum of effective services from prevention of substance use to substance abuse recovery.



The mission of the T-ACT project is to coordinate and promote effective services related to prevention, screening, treatment and recovery to adolescents with substance use/abuse problems.

The Governor's Office of Children's Care Coordination (GOCCC) is currently engaged in coordinating a number of activities intended to assure quality prevention and treatment services for youth in Tennessee who use or are at risk of substance abuse, including co-occurring disorders. The Department of Mental Health and Developmental Disabilities and the Department of Children's Services have primary responsibilities for publicly funded mental health, substance abuse and child welfare services. TennCare is a major source of funding for the public system. The Department of Education funds a variety of prevention programs through Title IV Part A, the Safe and Drug-Free Schools program. These departments have a common interest in assuring the most effective, efficient, evidence-based service system viable within the limits of the available resources.

In conjunction with the GOCCC, these departments are collaborating on plans to achieve greater integration of community based treatment and prevention services and expansion of resources within and across sectors. The principal goal of the collaborative is to form recommendations to align financial resources and administrative practices that will result in quality services to more Tennessee youth.¶¶

National Institute on Drug Abuse Principles of Effective Treatment

1. No single treatment is appropriate for all individuals.
2. **Treatment needs to be readily available.**
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change risky behaviors.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.**¶¶

Tennessee Improves on KIDS COUNT Data Book Ranking

The Tennessee Commission on Children and Youth helped the Annie E. Casey Foundation's KIDS COUNT program unveil the *2008 National Data Book*. TCCY held a press conference with representatives of the Department of Children's Services and the Department of Health at the Tennessee State Capitol.

Tennessee ranks 42nd in the nation in the book, with improved outcomes for older children, but faces challenges in the care of the very youngest. The report showed Tennessee improved on six of 10 indicators of child well-being.

The 2008 essay discusses youth who are involved in juvenile justice systems and highlights effective strategies for improving outcomes, including a continuum of community-based services, performance-based standards in juvenile facilities, detention reform, and the Casey Foundation's Juvenile Detention Alternatives Initiative. Increased opportunities for positive youth development and reduction of unnecessary and inappropriate detention and incarceration are also effective.

The KIDS COUNT National Data Book is available on the Internet at www.kidscount.org/datacenter/databook.jsp. Book details are on pages 9 and 10. 

Resources

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Tennessee

Percent Change Over Time

BETTER
ZERO
WORSE

Key Indicators

Percent low-birthweight babies
2000-2005

Infant mortality rate
(deaths per 1,000 live births)
2000-2005

Child death rate
(deaths per 100,000 children ages 1-14)
2000-2005

Teen death rate
(deaths per 100,000 teens ages 15-19)
2000-2005

Teen birth rate
(births per 1,000 females ages 15-19)
2000-2005

Percent of teens who are
high school dropouts
(ages 16-19)
2000-2006

Percent of teens not attending
school and not working
(ages 16-19)
2000-2006

Percent of children living in
families where no parent has
full-time, year-round employment
2000-2006

Percent of children in poverty
(income below \$20,444 for a family of
two adults and two children in 2006)
2000-2006

Percent of children
in single-parent families
2000-2006

Trend Data

STATE NATIONAL

2000 9.2 7.6
2005 9.5 8.2

2000 9.1 6.9
2005 8.9 6.9

2000 28 22
2005 24 20

2000 90 67
2005 79 65

2000 59 48
2005 55 40

2000 11 11
2006 6 7

2000 11 9
2006 9 8

2000 32 32
2006 36 33

2000 20 17
2006 23 18

2000 33 31
2006 35 32

National Rank

National Rank is based on
most recent available data

[43]

[45]

[34]

[34]

[45]

[15]

[36]

[40]

[41]

[40]

Patterned bars indicate national change. Solid bars indicate state change.

Background Information

Demographic Data

	NUMBER	PERCENT
Number of Children: 2006		
Total children under age 18	1,442,593	24%
Total youth ages 10-17	655,800	45%

Race and Hispanic Origin of Youth (ages 10-17): 2006

	NUMBER	PERCENT
White*	471,689	72%
Black/African American*	142,067	22%
American Indian/Alaskan Native*	1,692	less than 0.5%
Asian and Pacific Islander*	8,061	1%

More than one race*

	9,800	1%
Hispanic/Latino	22,491	3%

Children in Immigrant Families: 2006

	STATE	NATIONAL
Percent of children in immigrant families	7%	22%

* Non-Hispanic/Latino

Find the most recent data available at accf.org/kidscount/datacenter. Definitions and Data Sources can be found on page 000, or visit accf.org/kidscount for detailed information.

Education

	STATE	NATIONAL	STATE	NATIONAL
4th grade students who scored at or above proficient reading level: 2007	27%	32%	26%	29%
4th grade students who scored at or above proficient math level: 2007	29%	39%	23%	31%

8th grade students who scored at or above proficient reading level: 2007

8th grade students who scored at or above proficient math level: 2007

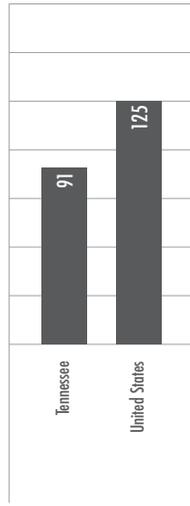
Economics

	STATE	NATIONAL
Median income of families with children: 2006	\$44,800	\$54,500
Children in extreme poverty (income below 50% of poverty level): 2006	11%	8%
Children in low-income families (income below 200% of poverty level): 2006	46%	40%
Children in low-income families that spend more than 30% of their income on housing: 2006	59%	66%

Juvenile Justice**

	STATE	NATIONAL
Estimated daily count of detained and committed youth in custody: 2006	1,419	

Rate of detained and committed youth in custody (per 100,000 youth ages 10-15): 2006



Child Health

	STATE	NATIONAL
Percent of children without health insurance: 2005	8%	11%
Number of children without health insurance: 2005	118,000	8,144,000
Percent of children with special health care needs: 2005-2006	16%	14%

Ratio of rates of youth of color to white* youth in custody: 2006

	3:1	3:1
--	-----	-----

Percent of youth in custody for non-violent offenses: 2006

	64%	66%
--	-----	-----

Juvenile violent crime arrest rate (arrests per 100,000 youth ages 10-17): 2005

	276	283
--	-----	-----

**Age range varies by state unless otherwise noted.