Adolescent Alcohol and Drug Use in Maine: Progress & Needs

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a report of the

Substance Abuse Services Commission

in conjunction with the

Maine Office of Substance Abuse

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Introduction

Alcohol and drug use continues to be a common rite of passage during adolescence.

By the time they graduate from high school, most teenagers will have consumed alcohol to intoxication at least once and a slight majority of students will have tried at least one illicit drug.[1] This needs to be of concern to the citizens of Maine not just because of long-term consequences like addiction, but because alcohol and drug use is a leading factor in accidents of all kinds, including motor vehicle accidents, and in all types of violence including sexual assault. It is a factor in three of the leading causes of death for adolescents in Maine: accidents, suicide, and homicide.[2]

It is time for Maine to seriously address adolescent alcohol and drug use.

We should not accept alcohol consumption as a rite of passage. We should not be relieved when we discover our children are "only" smoking marijuana, not using "real" drugs. Alcohol and drug use has taken a toll on communities across the state. It causes most crime in Maine, is a critical factor in the majority of child welfare cases, causes a large proportion of fires, automobile accidents, and adds millions of dollars to health care costs. Most alcohol and drug use begins in adolescence, so in order to ameliorate the many consequences of drug and alcohol use and abuse, we must stop use before it begins.

We must give up our complacency and heed this call to action.

Adolescent alcohol and drug use continues to be a serious problem in Maine. It will require the concerted effort of every Maine citizen to significantly reduce this problem and make life in Maine truly "the way it should be."

[1] Maine Youth Drug and Alcohol Use Survey, 2002.
[2] Center for Disease Control and Prevention, 2000.

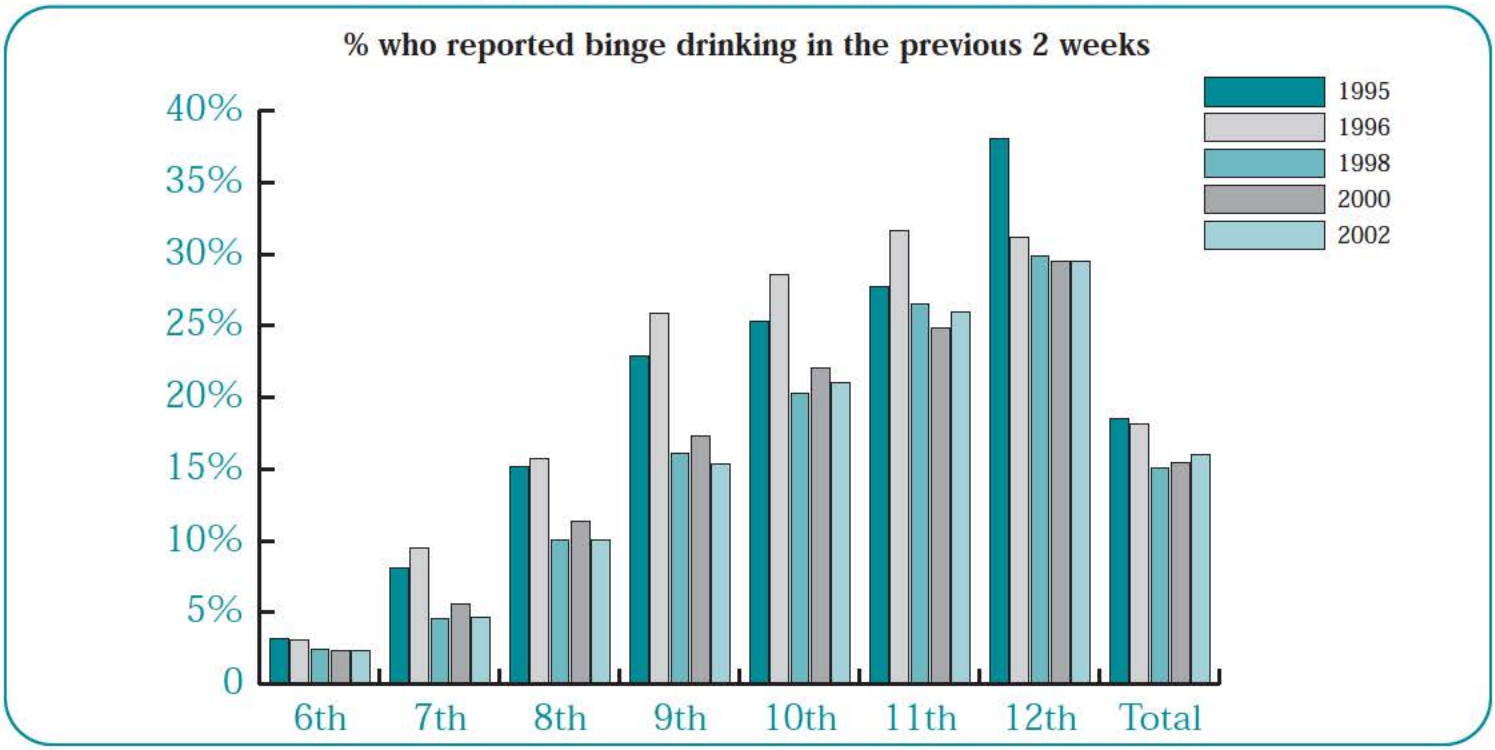
METHODS

The Substance Abuse Services Commission held three focus groups in addition to using data from the Treatment Data System, the Maine Youth Drug and Alcohol Use Survey, and various national publications. The focus groups were held in November 2002 for three different interest groups: treatment providers, prevention providers, and adolescents themselves. The adolescent focus group used teleconferencing technology to allow for youth across the state to participate. A list of all focus group participants is included in the Appendix. The concerns and solutions included in this report are a result of discussion during the focus groups with much weight given to the students' comments and concerns.

PREVALENCE

Alcohol is the most commonly used drug for both adolescents and adults. By senior year in high school 79% of students have tried it, and 49% have drunk in the past month. Nearly 1/3 of high school seniors have had more than five drinks in one sitting (defined as binge drinking) within the prior two weeks.[3] Clearly, when teenagers drink, they drink to intoxication.

MYDAUS SURVEY RESULTS: BINGE DRINKING[4]



On a positive note, alcohol consumption has decreased since 1995, particularly among 6th, 7th and 8th graders.

[3] Maine Youth Drug and Alcohol Use Survey, 2002.
[4] Binge Drinking is defined as five or more drinks in one sitting.

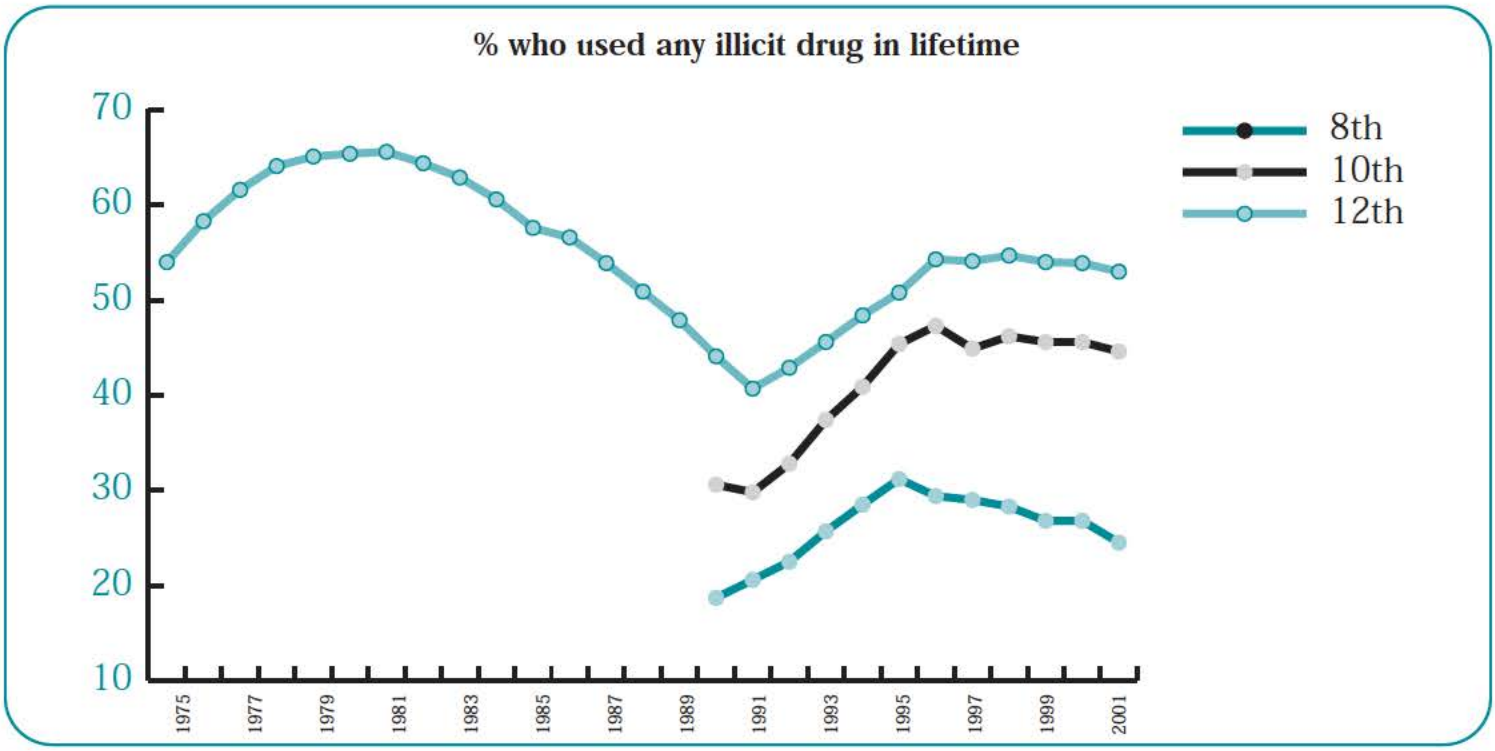
Prevalence of Lifetime Alcohol Use among the Maine Student Population in Grades 6-12: 1995-2002.[5]

	LIFETIME USE					Percentage Change	
	1995	1996	1998	2000	2002	Since 1995	Since 2000
Alcohol							
6th grade	40.5%	36.8%	23.8%	24.0%	19.7%	-51.4%	-17.9%
7th grade	60.3%	59.1%	35.1%	35.8%	30.5%	-49.4%	-14.8%
8th grade	72.4%	69.6%	52.1%	51.1%	44.9%	-38.0%	-12.1%
9th grade	78.4%	77.2%	62.9%	63.3%	57.5%	-26.7%	-9.2%
10th grade	81.3%	84.3%	70.7%	72.8%	68.4%	-15.9%	-6.0%
11th grade	82.6%	85.8%	79.4%	77.7%	75.4%	-8.7%	-3.0%
12th grade	88.8%	87.8%	84.2%	82.1%	79.2%	-10.8%	-3.5%
Total	70.7%	68.0%	57.6%	56.7%	54.6%	-22.8%	-3.7%

Over the past five years there has been an increased effort to prevent alcohol use by middle school students. This effort seems to be paying off.

While there is still a high rate of alcohol consumption by high school students, there has been a gradual reduction in both lifetime and past month use since 1995.

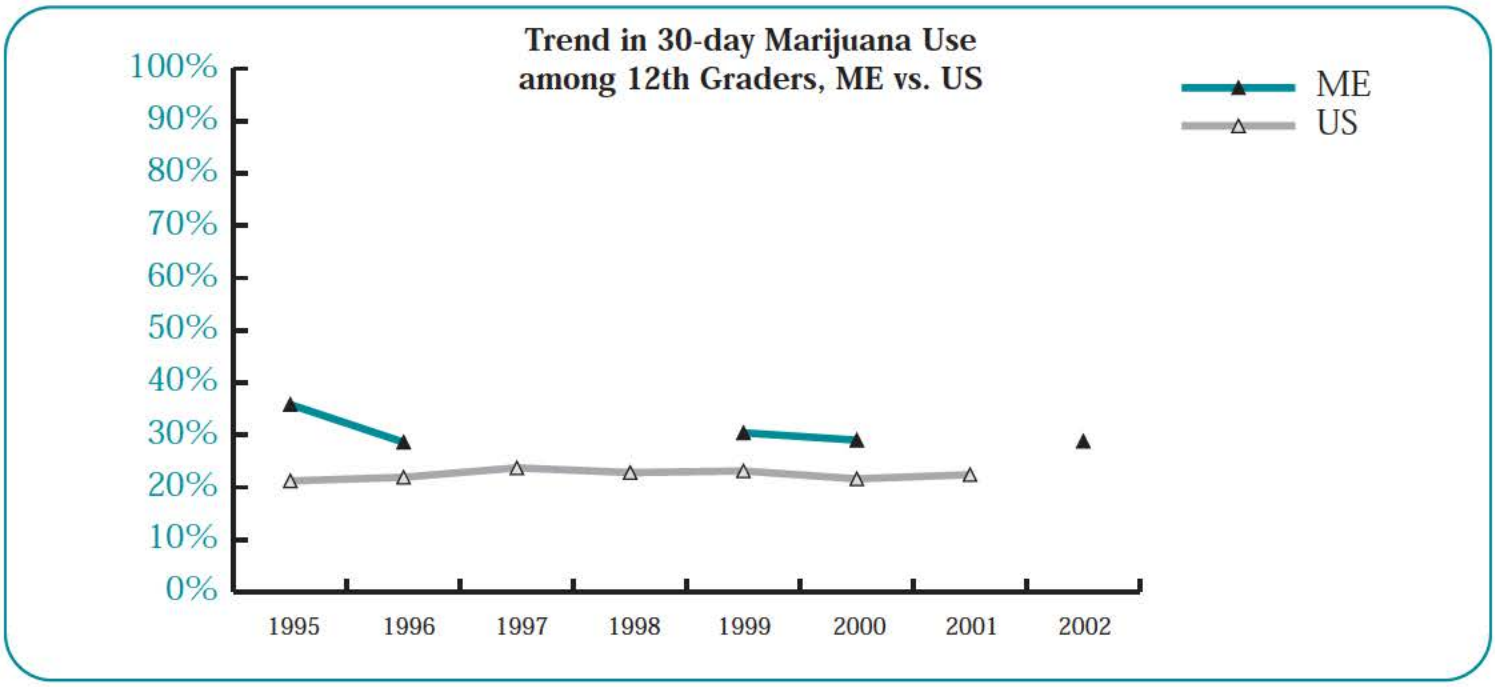
The Monitoring the Future survey is a national drug use survey that has been administered by the University of Michigan since 1975. Nationally, drug use peaked in 1981, with 65.6% of high school seniors having tried an illicit drug (usually marijuana) by the time they graduated. After a decade of strenuous effort, drug use decreased to a low of 40% in 1992. Since then, it has risen and leveled off at about 55%.



Monitoring the Future

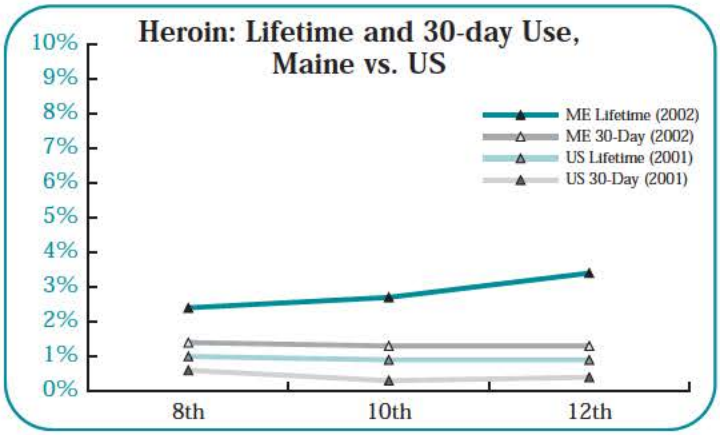
[5] Maine Youth Drug and Alcohol Use Survey, 2002.

Maine students' use in general mirrors that of the youth of the nation. However, in Maine, marijuana use is historically significantly greater, which led to our grade of D in adolescent drug use in the Fordham Institute for Innovation in Social Policy Report on the Social Health of the States in 2001.

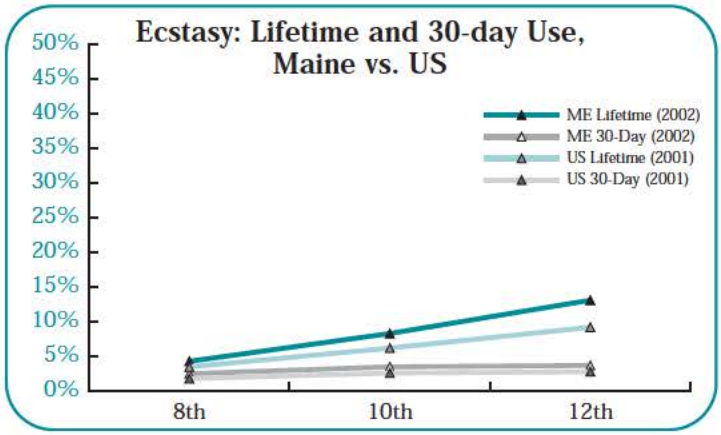


Maine Youth Drug and Alcohol Use Survey/ Monitoring the Future

Maine also seems to have a high rate of use of other illegal drugs compared to national surveys, but because the numbers are so small, it is hard to assess whether or not there is a significant difference.



Maine Youth Drug and Alcohol Survey



Maine Youth Drug and Alcohol Survey

Also, these are school surveys. It is possible that these results reflect better retention of problem students in Maine schools, rather than drug use that is higher than national averages.

What is positive for Maine compared to the nation is that Maine students appear to begin drug use later than students in the rest of the nation. Prevalence of lifetime use of most drugs is lower than national levels in eighth grade, but rises to or above national levels by twelfth grade.

Prevention

Several Maine communities can be proud to have been involved for the past seven years with national research to determine what causes substance use and abuse. Maine's participation in the Six State Consortium and the Diffusion Project, both National Institute on Drug Abuse funded grants to University of Washington researchers David Hawkins and Richard Catalano, have resulted in early adoption of the risk and protective factor model of understanding adolescent substance use and abuse. This research laid the groundwork for the current understanding of why teens use or do not use drugs and alcohol.

The research and growth in understanding of what risk factors lead to substance use and what protective factors (also known as assets) prevent teens from using has helped make enormous strides in our ability to provide effective prevention programming. Over the past ten years we have gone from offering programs that feel good to adults, but often have little effect on adolescent behavior, to having a plethora of programs that have been proven to be effective in addressing specific risk and protective factors.

Both risk and protective factors occur in four domains: peer/individual, family, school, and community. An effective statewide prevention plan must address all four domains. Good local programming assesses risk and protective factors for the community, and develops services that decrease the risks and increase the protective factors that are indicated.

Risk factors include: chaotic home environments, lack of positive role models, failure in school, poor social coping skills, affiliation with drug using peers, and perception that drug use is acceptable and common behavior.

Protective factors include: strong parental bonds with clear rules about drug use, community involvement, and community norms against drug and alcohol use.

Protective factors are a different scale from risk factors - they are not just opposites. Strong bonds with a parent figure are protective even if the home environment is chaotic, for example.

In 1997, the Maine Office of Substance Abuse adopted the Risk and Protective Factor model and began requiring that all funding be used only for prevention programs that could prove their effectiveness via changing use itself or addressing appropriate risk and protective factors. It is too soon to determine what the effect of this change in policy may be, but it is a positive step in assuring that all state funding for substance abuse prevention is spent in a productive way.

Specific Prevention Needs

Students and professionals in prevention agree that *parents need to be more aware* of the risks of substance abuse and the potential for their child to abuse alcohol or drugs. A recent parent survey completed by the Office of Substance Abuse found that only one parent out of the 500 person random sample believed that his/her teen might have been binge drinking in the past two weeks. However, in the MYDAUS survey, 30% of high school juniors and seniors reported having gotten drunk in the prior two weeks. Parents believe there is a community problem with adolescent substance abuse, but they don't believe that their child could be a participant.

Another underlying issue with parents is that they don't want to disrupt what they perceive as a positive relationship with their child by asking difficult questions or enforcing strong rules regarding substance use. Particularly with alcohol, *parents give mixed messages about the acceptability of use*. While most parents feel very strongly that a thirteen year old should never drink, many parents have more ambivalent feeling about their seventeen year olds' drinking. Some want them to learn to drink responsibly, so allow them to drink at home, some are afraid of drinking and driving so provide a "safe" place to drink, some are relieved that it is "only alcohol" and do not discipline as they would for other drugs.

Two-thirds of high school students believe that they could drink and get away with it; that their parents would either not know, or not react to their alcohol consumption. *Parents need more information* on the risks of alcohol consumption, especially binge drinking, the probability of their child consuming alcohol, and better ways of responding to adolescent drinking, both proactive and reactive. *Parents also need community support* for taking a strong stance. Some communities have formed parent groups where parents band together and guarantee that their homes will be alcohol free. This activity needs to be expanded to all Maine communities.

While parents underestimate the probability of their child abusing alcohol or drugs, *teens themselves overestimate the extent of the use among their peer group.* Many teens that do not drink or drug will describe themselves as "the only one in my whole school who doesn't use!" While it is true that by senior year in high school 79% of adolescents have used alcohol at least once, fewer than half of seniors have used in the past thirty days. All of those students are doing something on most weekends that does not involve alcohol or drugs. *Clearly, the student that does not use is not alone,* yet the perception of the norm of frequent and regular alcohol and drug use is a strong one.

The strength of this belief reaches students in middle school who also believe that most kids their age drink. Most kids in eighth grade have never drunk alcohol, so their perception is clearly distorted.

Teens need to know the real extent of their peers' use, as their misperception can lead them to make poor decisions in order to be like everyone else.

Common community held beliefs support parent's inaction and kids' assumptions that everyone uses alcohol and drugs. It is a commonly held belief that in adolescence children abandon their families for peer groups; that they live in a peer community isolated from the broader community. The mass media certainly feed this widely held belief in their portrayal of teenagers leading lives almost completely separate from adults. When they do portray parents or other adults in teenager's lives, they are either inept or cruel. Teens and parents as well as the broader community accept these stereotypes.

While it is true that teens are moving away from parents and defining themselves as separate individuals, this can be said of any stage in a child's development, whether it is the two year old who has learned to say no, or the five year old off to the first day of school, or the ten year old at her first sleepover at a friend's house.

In fact, *adolescents need parental monitoring and adult guidance* as they maneuver the many firsts on their way to independence. The reality is that while the relationship with parents is changing, it is still a critical, for many the most critical, factor in many decisions including whether to drink or drug.[6] The most commonly cited reason for teens not using is "My mother would kill me." *The family relationship is still paramount* despite the widely held belief that teens travel in packs isolated and alienated from the rest of society.

This community norm is a self-perpetuating myth. Adolescents who do not have relationships with adults, who do not have a place in the community, are at risk for substance abuse. *Communities need to promote adolescent involvement in the broader community life,* to allow them to interact with people of all ages, rather than restricting them to teen only activities where they miss out on important role models and opportunities to be role models to younger children.

Another commonly held community belief is that all teens experiment with alcohol and drugs and that it is a harmless phase of adolescent development. *The community acceptance of alcohol and drug use as a rite of passage makes it difficult for parents to enforce rules* regarding use, and they support teen' belief that everyone uses and undermine any education they may have received regarding the risks of use. People who glorify their own high school drunken escapades, who supply alcohol for adolescents, who smoke marijuana with their kids and their friends create a lax public attitude toward adolescent alcohol and drug use.

Maine needs to work at both the state level and the local level to combat these community norms that promote alcohol and drug use, and make it difficult for teens to resist or parents to insist that use is inappropriate.

Maine received $3,000,000 in federal funding last year to provide science based prevention programming. This funding will increase the reach of community coalitions to most counties in the state. However, it is short term - lasting for three years. *The state will have to find ways to continue the work begun by the coalitions* after the federal funding is gone.

Schools play a pivotal role in children's lives and should be an important part of any plan to prevent substance abuse. The perception of prevention providers and students is that schools do not spend enough classroom time or have adequate resources to address the substance abuse prevention or treatment needs of their students. Students also emphasize that what programs are offered are often not the most effective available programs. DARE is still the most frequently offered substance abuse prevention program followed by school assemblies during red ribbon week. While these programs may be reinforcing for students that do not use or intend to use drugs, and may provide other benefits to schools and students, they have been shown to be ineffective methods of reducing substance abuse when used alone.

Alcohol and drug education should be an integral part of health education from the early grades. In addition, schools should begin prevention programming from fifth or sixth grade and continue it through the high school years. There are a number of nationally recognized school based programs that have been shown to be effective at reducing teen alcohol and drug use. DARE is working to develop a more effective program, which should be available within the coming year. A list of model programs endorsed by the Center for Substance Abuse Prevention can be found at ww.modelprograms.samhsa.gov.

[6] Protecting Adolescents from Harm: Findings from the National Longitudinal Study of Adolescent Health, 1997.

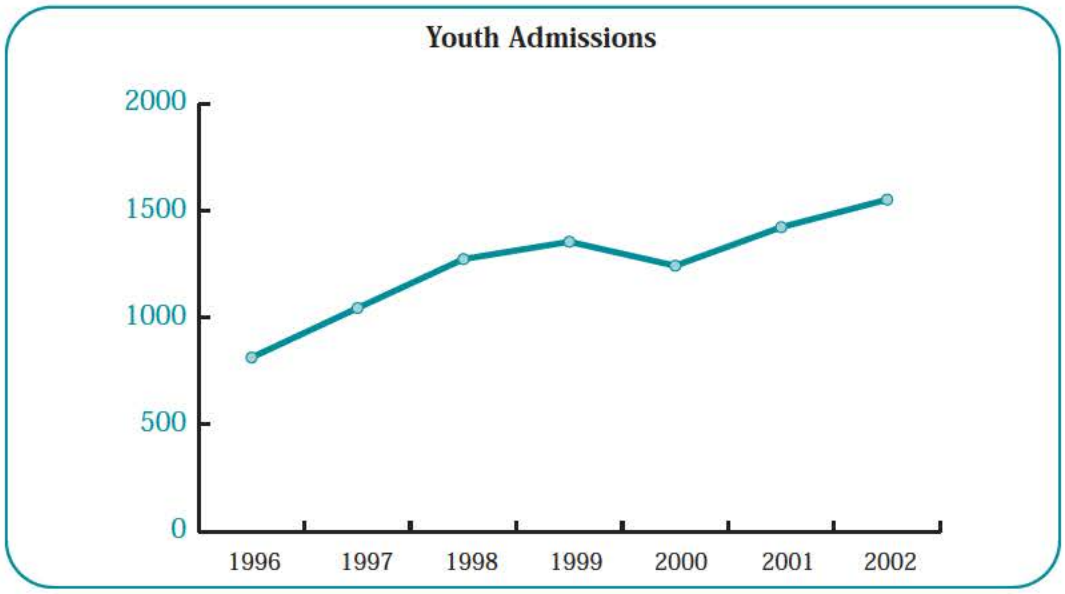
TREATMENT

Treating adolescent addiction has proven a frustrating and frequently unsuccessful endeavor. Rates of relapse are higher among adolescents and they tend to be harder to engage and motivate than adults with similar use histories.

This is primarily due to the treatment system's inability to meet adolescents' needs rather than due to any special intractability of adolescent addiction. Historically, treatment providers have used models that are effective for adults but have never been tested in children. Frequently adolescents are treated in groups with adults with whom they see themselves having little in common.

As in the field of prevention, research on effective treatment modalities for adolescents has only emerged within the past ten years. Most of the reports have been published within the past two to three years. What we are learning is not necessarily surprising, but it is important, as it will change the way we treat early onset addiction.

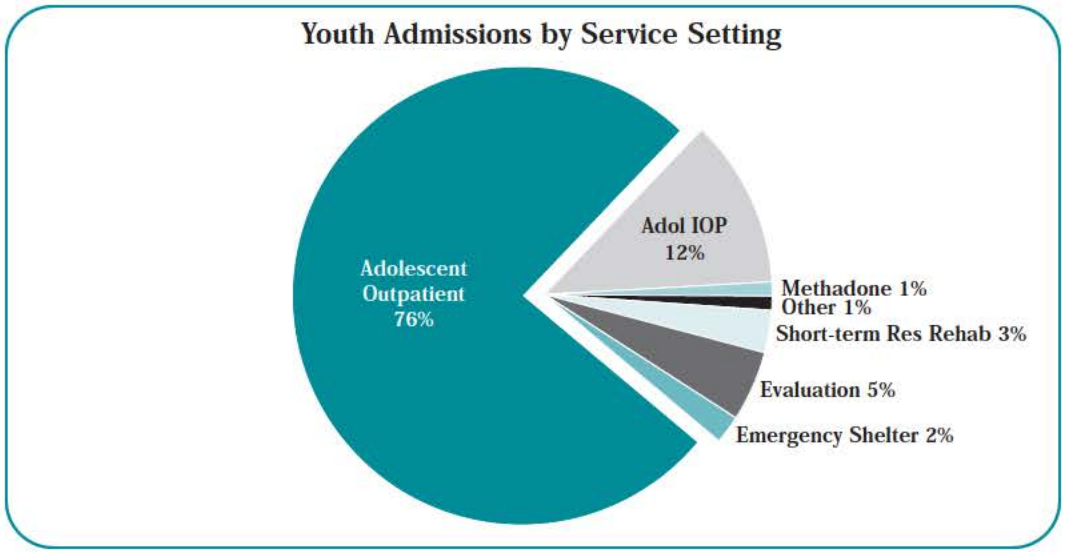
Maine has made an effort to increase access to treatment for adolescents over the course of the past seven years. Because of this concerted effort to expand access to treatment, particularly at the out-patient and intensive out-patient level, Maine is able to treat nearly twice as many adolescents in 2003 than it did in 1996.



Office of Substance Abuse Treatment Data System

While most of the nation is only able to treat 10% of the adolescents that need treatment, Maine treats 18%. This is still not adequate, but it should be pointed out that most people that need treatment do not necessarily seek it.

Most teens are able to succeed in outpatient care, and with over 50 substance abuse treatment providers that work with adolescents scattered across the state, this service is readily accessible to all but the most remote communities. The quantity of outpatient care is adequate to meet the current demand, but as stated above, the quality of adolescent specific services is questionable because most treatment providers have not been trained in adolescent development and in specific techniques that are effective with youth.



Office of Substance Abuse Treatment Data System

Maine was one of the first states to design and implement a statewide drug court system for adolescents. This type of program is effective because it uses the power of the court to ensure that teens with criminal histories attend and comply with treatment. Maine has been a national leader in its efforts to provide treatment to this population of youth.

Maine should also be commended for its efforts to provide treatment to incarcerated youth. Both Long Creek and Mountain View Youth Development Centers offer comprehensive treatment programs to youth who are assessed to need substance abuse treatment. What needs to be improved in this system is the transition from the facility to the community. Ideally, youth should have aftercare appointments arranged prior to discharge and should have met their out-patient counselor prior to discharge from the facility.

Residential treatment is a scarce commodity for Maine teens. Until 2003, it was only available for those aged 16 and older. There was only one program with 12 beds specifically for adolescents in the southern-most part of the state. Adult programs have been willing to accept adolescents on occasion. One program in Limestone will take up to three adolescents at a time. There are a couple hospital programs remaining that provide very short term treatment to adolescents, primarily those that also have a mental illness.

In spring 2003, a new program for adolescents will open in Augusta. This program was scheduled to open in fall 2002, but had difficulty staffing the program and postponed opening by six months. With the opening of this 16-bed facility, there should be adequate capacity for residential treatment, although it will be hard for families in northern Maine to visit or participate in the treatment of their child.

One of the biggest gaps in care for adolescents is detoxification. Most teens do not need detoxification, as their use history is not long or severe enough to warrant this primarily medical service. However, with the increase in opiate abuse, and the requirement by residential treatment programs that clients be fully detoxed prior to admission, there have been a number of teenagers that needed detoxification that could not gain access to it because of their age. With the exception of one residential program in Portland, detoxification is a hospital service. Over the past 15 years as insurance has reduced payment for hospitalization for addiction many hospitals have closed their detox units or reduced the number of beds available. Because the need for adolescents to detox from alcohol is almost non-existent (their length of use and physical dependence has not yet reached the level that requires hospitalization for safe detoxification) and because alcohol has always been the primary drug of abuse in Maine, most detox units stopped taking adolescents. *This has created a crisis for the adolescent opiate addict who cannot face withdrawal outside of a controlled environment.* Maine needs to add capacity to treat adolescent withdrawal within its existing system.

The most important predictor of treatment success is completion of treatment. *Adolescents are twice as likely to drop out of treatment as adults.* Only one in four teens that enter treatment in Maine will complete it. While this mirrors national trends, it reflects a sad disservice to the adolescent in need of treatment.

Treatment providers themselves say that they desperately need more training in addressing age specific issues, in adequately treating opiate abuse, and in understanding youth culture. They do not know how to motivate teenagers to continue treatment and maintain abstinence. They need help in engaging families and schools. They know that there is research on effective treatment for adolescents, but they don't know how to implement effective programs.

The state needs to make a concerted effort to train treatment providers in effective treatment for adolescents. They need training in adolescent development, in motivational interviewing with adolescents, in family therapy, and in specific techniques that are effective with adolescents. Also, it is clear from the difficulty that Phoenix House has had in finding staff that the state needs to work to draw people interested in working with teenagers into the substance abuse field. Only with training in appropriate techniques to engage and treat adolescents and by drawing more people who enjoy working with adolescents into the field can we increase treatment retention and provide the treatment that teens need in order to lead healthy lives.

Treatment providers suggest that *there should be more treatment available at school.* As schools have had to cut budgets over the past ten years, one of the first places they have cut is in school health and social services. Very few schools provide substance abuse treatment in the schools. Because of the expansion of MaineCare for children and low income families, and with the potential of insurance parity, it may be possible for these services to be offered in the schools, but reimbursed by other systems. Providers, the Office of Substance Abuse, and the Department of Education need to explore more options to get treatment into the place that youth spend most of their time.

One effort that Maine needs to continue to expand is the work to have other systems of care identify teens with substance abuse problems. Too often adolescents who are in special education due to behavioral problems, in the child welfare or criminal justice system do not get assessed for alcohol and drug use. This leads to misdiagnosis, over medication, and inappropriate placements. Maine has a system to screen all youth entering the criminal justice system for substance abuse problems, but currently only half of the youth are screened. *This screening tool needs to be used for all youth in the criminal justice system,* and the same or a similar tool *needs to be more widely used in the education and child welfare systems. Primary health care providers should also be screening for substance abuse by their adolescent patients.*

Maine is working on providing appropriate treatment for youth who have both a diagnosed mental illness and a substance abuse history. These are often the hardest kids to engage and the most difficult to treat. They show up in all of the state systems in crisis situations and have very expensive episodes of care that lead to little in gains in health care or behavioral change. Maine providers of mental health and substance abuse services are focusing training efforts on becoming able to work with these difficult to care for children, and state government is making changes to ensure that there are no artificial barriers in reimbursement, licensing or record keeping that prevent these children from receiving the excellent care they deserve.

Specific Treatment Needs

Maine needs to *increase access to detoxification services for adolescents.* This is a critical first step that is often necessary for entrance into the system, but is generally unavailable to those under eighteen years of age. This can probably be done within existing resources, but needs to be a criteria for funded detoxification programs and will require staff training.

Maine needs to make a *focused effort on educating* physicians, nurse practitioners, physician assistants, and other *health care providers on early identification and referral resources for adolescent substance abuse.* The earlier abuse is identified and treated, the less likely it is to cause further health and social problems. Questions regarding alcohol and drug use need to become part of health screening by age twelve.

The state needs to *support the treatment system* in its desire to continue to work with adolescents *by funding all levels of care:* out-patient, intensive out-patient, residential treatment (both short and long term) and detoxification. Because of their special needs, adolescent treatment can be more expensive than adult treatment, but a successful outcome saves more in the long run.

Maine needs to *continue to educate its treatment workforce* to utilize treatment methods that have been proven to be effective with adolescents. This training should include adolescent development, motivational therapy, family therapy techniques, and other therapies that have been proven to work with youth. Without this knowledge the treatment that is provided to teenagers will not help them make the changes necessary in order to live healthy lives.

Maine needs to encourage schools and the treatment system to work together to *make treatment more accessible by offering it in schools* either during or outside of school hours. Because family involvement is so important, whenever possible *family treatment should be encouraged.*

Conclusion

Maine has made considerable progress in reducing teen tobacco and alcohol use. Between 1995 and 2002 tobacco use decreased by 39% and alcohol use decreased by 20%, with a decrease of 50% at the middle school level. More children that need treatment are able to get it in Maine than in most other states in the nation. But we still have far to go.

Maine youth use marijuana and prescription drugs at an alarming rate. Parents are unaware of the extent of their own children's drinking and drugging. Adolescents under the age of 18 have difficulty accessing some levels of care including detoxification and residential treatment. Though the quantity of other types of treatment is probably adequate, much of the treatment available is not geared to adolescents unique treatment needs, resulting in a high treatment dropout rate.

FOLLOWING ARE RECOMMENDATIONS FOR NEXT STEPS FOR MAINE TO BETTER ADDRESS ADOLESCENT SUBSTANCE ABUSE:

1. Maine needs to continue its public education efforts to address the misperceptions of both parents and children regarding alcohol and drug use.

2. Maine needs to develop public education efforts to address the specific risks of abusing prescription drugs and to inform parents that dangerous drugs may be available right in their medicine cabinets.

3. Maine needs to expand efforts to enforce liquor and drug laws. Underage drinking laws in particular have had lax enforcement due to lack of resources and low perceived priority.

4. Maine needs to find a way to sustain the One ME: Stand United for Prevention effort currently funded with a federal categorical grant that will end by FY 2006.

5. Maine needs to encourage detoxification programs to accept adolescents.

6. Maine needs to train treatment providers in methods that are effective for working with adolescents and create a goal of improving treatment retention by 50% within five years.

7. Maine needs to address the issue of the lack of trained or interested workers for both prevention and treatment work.

APPENDIX

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