**Substance Abuse Prevention in Rhode Island: Making the Case**

**Understanding the Problem**

Studies have shown that the annual cost of substance use disorders are nationally to be $510.8 billion in 1999 (Harwood, 2000). More specifically, Alcohol abuse cost the nation $191.6 billion. Tobacco use cost the nation $167.8 billion. Drug abuse cost the nation $151.4 billion. Substance abuse clearly is among the most costly health problems in the United States. Among national estimates of the costs of illness for 33 diseases and conditions, alcohol ranked second, tobacco ranked sixth, and drug disorders ranked seventh (National Institutes of Health [NIH], 2000). Programs designed to prevent substance use disorders can reduce these costs.

**Prevention Yields Huge Savings**

Effective substance abuse prevention can yield major economic dividends. In 2003, an estimated dollar invested in prevention can save between $2.00 to $20.00 dollars. (Grant & Dawson, 1997; Lynskey et al., 2003). Research demonstrates that illegal drug use among youth declines as the perception of risk and social disapproval increases. Effective substance abuse prevention involves:

* Reducing the availability of alcohol, tobacco and other drugs (ATOD);
* Reducing access to ATOD;
* Enforcing consequences for alcohol and other drug related offenses;
* Changing attitudes and perceptions about the dangers and acceptability of ATOD use
* Changing social norms (i.e., community perceptions regarding risk and harm) about ATOD use
* Raising awareness about the costs and consequences of ATOD misuse and abuse
* Building skills in youth, parents and communities to deal with these issues effectively.

The community coalition model utilized in RI has proven successful in reducing alcohol and other drug use and underage drinking.

**Current Prevention is Outcomes Based**

Rhode Island has chosen to align its prevention goals with those of the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention. They are:

**Goal 1:** With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

**Goal 2:** Prevent or reduce consequences of underage drinking and adult problem drinking.

**Goal 3:** Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

**Goal 4:** Reduce prescription drug misuse and abuse.

The interventions used by prevention providers in RI are not random but are based on evidence of effectiveness documented in current research. Prevention in the US is on the Risk and Protective Factor Theory developed by David Hawkins and Richard Catalano introduced in the late 1980s. Since then researchers have continued to add to the list of known risk and protective factors for substance abuse and mental health disorders. Prevention providers are required to use a continuous strategic planning framework that includes:

* *Assessing* local data to identify the substance abuse problem(s) to focus on and the risk and protective factors related to it
* Assessing and then *building c*ommunity capacity to respond to the problem
* *Planning* and then *implementing evidence-based* prevention interventions ( programs, policies and practices) directly related to the identified risk and protective factors
* *Evaluating* effectiveness of the interventions using outcome data

**Prevention Works!**

Substance use disorders are preventable. Over 20 years of research demonstrates that prevention interventions designed and tested to reduce risk and enhance protective factors can help children at every step along their developmental path, from early childhood into young adulthood. Prevention research strives to help people *across the lifespan* develop and apply the skills and resources they need to stop problem behaviors before, and after, they begin.

**The Rhode Island Problem**

**Rhode Island Ranking:**

* 2010 National Survey on Drug Use and Health (NSDUH) reported Rhode Island is in top fifth for the past month illicit drug and marijuana use.
* 2012 NISDUH data reports Rhode Island exceeds the rates in illicit drug, marijuana, alcohol and tobacco use in all populations over 12 years in past month use
* RI also exceeds the rates nationally and regionally
* Prescription drug use for past year (NSDUH 2012), Rhode Island exceeds both US and New England region among persons aged 12 or older.

**Past month use in individuals aged 12 and older**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Illicit Drug Use | Marijuana | Alcohol | Tobacco |
| US | 8.95% | 7.13% | 51.94% | 26.60% |
| New England | 9.35% | 7.72% | 57.31% | 25.62% |
| Rhode Island | 15.61% | 13.00% | 63.35% | 28.05% |

**Past year prescription drug use in individuals 12 and older**

|  |  |
| --- | --- |
|  | Prescription Drug |
| US | 4.57% |
| New England | 4.14% |
| Rhode Island | 5.23% |

So what is the concern? This last legislative session effectively ELIMINATED all state dollars allocated to prevention programming. The general revenue allocation has completely disappeared. With rates of substance abuse still high, ZERO dollars at the state level are being allocated to this issue. All funding for prevention now comes through the federal funding, whose future is unknown, putting the future of prevention in RI in jeopardy.

In addition to the transfer of funds from a state line item to federal dollars, our state services have diminished. For example, decreases in funding to the "state’s student assistance programs has resulted in drastic decreases in the number of students who receive services statewide from over 10,000 at risk youth served to just over 4,000 this year, 60% drop in just 6 years. Our task force network considered to be one of the most comprehensive in the country and a major factor in RI receiving a number of federal grants has experienced at least two significant cuts in the past 10 years.

Student assistance programs have experienced a loss of federal and state dollars resulting in regulation in reduction in services which, in turn, has resulted in drastic decreases in the number of students served. In 2008-2009, 20, 339 RI middle and high school services received assessment, early intervention and referral services for substance abuse and related problems. In 2013-2014, 4,112 students received services.

Rhode Island Substance Abuse Prevention Act (RISAPA) has experienced same kind of cuts. So what does this tells us? Despite decreases in funding and in services, our outcomes have been improving. This is because our providers are working smarter and harder! However, continued cuts---now a grave threat with the current funding situation---will effectively paralyze the system of services developed over the years

Leaving all funding to federal sources is also causing problems in our ability to seek additional federal dollars. Before this, state and local providers could leverage state funds as matching dollars for federal grant applications. This is no longer an option. For example, the federal Drug Free Communities grants have been awarded to nine RI communities. Any applicant must as a requirement provide a dollar-for-dollar local match. Since communities now have no state funds, they have no money they can use as matching dollars and so cannot apply, thus eliminating this revenue stream for RI. In fact, communities with current DFC grants may actually lose their continued funding due to this lack of a match.

***A Governor’s Council Proposal***

***The Prevention Advisory Committee requests that the Council on Behavioral Healthcare host a presentation to the legislature by Kathryn Power, Regional Administrator for SAMHSA, a Rhode Island resident and the former director of the Department of MHRH. Her charge would be to highlight the critical nature of substance use disorders in RI and to advocate for a strong financial commitment of the legislature to substance services: prevention, treatment and recovery support.***

**Rhode Island Data:**

The following data testifies to the success of recent substance abuse prevention efforts. The charts below clearly indicate that for youth in grades 9-12, our efforts to reduce past month alcohol use, binge drinking, initial first use of alcohol and marijuana, past month drinking and driving as well as tobacco use has significantly decreased and decreased more than the US as a whole. However, there is still more work to be done. Marijuana use past month is still higher than the national average. In addition, we know from research that these gains will erode unless our current prevention strategies are sustained and even increased based on the current changes in perceptions of the harm of marijuana and prescription drug use in this country.

**RI vs. US comparison on nine key Consumption Indicators for underage population (<18), 2001-2013**

| **% of Students (grades 9-12) Reporting:** | **2001** | **2009** | **2011** | **2013** |
| --- | --- | --- | --- | --- |
| **RI** | **US** | **Ratio** | **RI** | **US** | **Ratio** | **RI** | **US** | **Ratio** | **RI** | **US** | **Ratio** |
| **RI/US** | **RI/US** | **RI/US** | **RI/US** |
| **Alcohol use** |
| **Alcohol use past month** | 50.30% | 47.00% | **1.07** | 34.00% | 41.80% | **0.81** | 30.00% | 38.70% | **0.78** | 30.90% | 34.90% | **0.88** |
| **Binge drinking past month** | 30.70% | 29.90% | **1.02** | 18.70% | 24.2 % | **0.77** | 18.30% | 21.90% | **0.84** | 15.30% | 20.80% | **0.74** |
| **Initial use of alcohol before age 13** | 29.70% | 29.10% | **1.02** | 15.80% | 21.10% | **0.75** | 15.60% | 20.50% | **0.76** | 13.50% | 18.60% | **0.73** |
| **Drinking and driving past month** | 15.50% | 13.30% | **1.16** | 7.20% | 9.70% | **0.74** | 6.50% | 8.20% | **0.79** | 8.50% | 10.00% | **0.85** |
| **In car w/ driver who had been drinking (past month)** | 32.30% | 30.70% | **1.05** | 23.10% | 28.30% | **0.82** | 21.90% | 24.10% | **0.9** | 20.10% | 21.90% | **0.92** |
| **Cigarette use** |
| **Smoking cigarettes 20 + days past month** | 14.20% | 13.80% | **1.03** | 5.40% | 7.30% | **0.74** | 4.40% | 6.40% | **0.69** | 3.10% | 5.60% | **0.55** |
| **Initial use of tobacco before age 13** | 22.30% | 22.10% | **1.01** | 8.40% | 10.70% | **0.79** | 7.10% | 10.30% | **0.69** | 5.60% | 9.30% | **0.60** |
| **Marijuana use** |
| **Using marijuana past month** | 33.20% | 23.90% | **1.38** | 26.30% | 20.80% | **1.26** | 26.30% | 21.30% | **1.23** | 23.90% | 23.40% | **1.02** |
| **Initial use of marijuana before age 13** | 12.80% | 10.20% | **1.25** | 8.30% | 7.50% | **1.11** | 7.10% | 8.10% | **0.87** | 6.80% | 8.60% | **0.79** |
| **Prescription drug** |
| **Ever prescription drug misuse** | -- | -- | **--** | -- | -- | **--** | 14.10% | 20.70% | **0.68** | 13.50% | 17.80% | **0.76** |

**RI vs. Region comparison on Alcohol Consumption Indicators for underage population (<18), 2001-2013**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **USA** | **RI** | **CT** | **MA** | **ME** | **NH** | **NJ** | **NY** | **PA** | **VT** |
|  | Binge drinking (5+ drinks in one sitting) past month |
| **2001** | **29.90%** | **30.70%** | -- | 32.70% | 31.50% | -- | 32.60% | -- | -- | 29.00% |
| **2009** | **24.20%** | **🡫18.7%** | 24.20% | 24.50% | -- | 24.00% | 26.70% | 23.80% | 21.90% | 23.10% |
| **2011** | **21.90%** | **🡫18.3%** | 22.30% | 22.20% | 16.20% | 23.80% | 23.70% | 22.00% | -- | 20.90% |
| **2013** | **20.80%** | **🡫15.3%** | 20.00% | 18.90% | 14.40% | 17.30% | 23.00% | 18.40% | -- | 21.40% |
|  | Initial use of alcohol before age 13 |
| **2001** | **29.10%** | **29.70%** | -- | 27.90% | 21.70% | -- | 32.50% | -- | -- | 26.00% |
| **2009** | **21.10%** | **🡫15.8%** | 17.60% | 17.20% | 20.30% | 14.80% | 18.00% | 21.00% | 19.00% | 18.20% |
| **2011** | **20.50%** | **🡫15.6%** | 15.60% | 14.60% | 15.80% | 14.30% | 14.40% | 19.00% | -- | 14.80% |
| **2013** | **18.60%** | **🡫13.5%** | 14.90% | -- | 13.30% | 11.90% | 14.60% | -- | -- | 16.20% |
|  | Drinking and driving past month |
| **2001** | **13.30%** | **15.50%** | -- | 12.20% | 10.80% | -- | 13.00% | -- | -- | 10.10% |
| **2009** | **9.70%** | **🡫7.2%** | 8.70% | 9.00% | -- | 8.50% | 7.70% | 10.00% | 6.90% | 8.00% |
| **2011** | **8.20%** | **🡫 6.5%** | 6.90% | 6.50% | -- | 8.60% | 6.40% | 5.40% | -- | 7.10% |
| **2013** | **10.00%** | **🡫 8.5%** | 9.40% | 7.10% | 6.60% | 8.40% | 8.70% | 10.20% | -- | 10.20% |

**RI vs. Region comparison on Marijuana Consumption Indicators for underage population (<18), 2001-2013**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **USA** | RI | **CT** | **MA** | **ME** | **NH** | **NJ** | **NY** | **PA** | **VT** |
|  | **Using marijuana past month** |
| **2001** | **23.90%** | **33.20%** | -- | 30.90% | 27.20% | -- | 24.90% | -- | -- | 30.30% |
| **2009** | **20.80%** | **26.30%** | 21.80% | 27.10% | 20.50% | 25.60% | 20.30% | 20.90% | 19.30% | 24.60% |
| **2011** | **23.10%** | **26.30%** | 24.10% | 27.90% | 21.20% | 28.40% | 21.10% | 20.50% | -- | 24.40% |
| **2013** | **23.40%** | **23.90%** | 26.00% | 24.80% | 21.30% | 24.40% | 21.00% | 21.40% | -- | 25.70% |
|  | **Initial use of marijuana before age 13** |
| **2001** | **10.20%** | **12.80%** | -- | 11.90% | 12.00% | -- | 9.20% | -- | -- | 12.20% |
| **2009** | **7.50%** | **8.30%** | 5.80% | 9.00% | 9.80% | 8.40% | 4.10% | 7.70% | 5.30% | 8.70% |
| **2011** | **8.10%** | **7.10%** | 6.30% | 6.90% | 7.30% | 7.70% | 4.30% | 7.60% | -- | 6.40% |
| **2013** | **8.60%** | **6.80%** | 7.00% | 6.60% | 7.10% | 6.60% | 5.10% | 7.30% | -- | 8.40% |

**RI vs. Region comparison on Prescription Drug Consumption Indicators for underage population (<18), 2011-2013**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **USA** | RI | **CT** | **MA** | **ME** | **NH** | **NJ** | **NY** | **PA** | **VT** |
|
|  | **Ever took prescription drugs without a doctor’s prescription** |
| **2011** | **20.70%** | **14.10%** | -- | -- | 13.90% | 20.80% | 15.10% | -- | -- | -- |
| **2013** | **17.80%** | **13.50%** | -- | -- | 12.40% | 16.50% | 11.80% | -- | -- | -- |

* YRBS data comparing Rhode Island with the entire US showed an encouraging trend for declines in 30-day alcohol prevalence. **Rhode Island’s decline from 2001-2009 was greater than the average decline in the nation**. We believe prevention initiatives contributed to this reduction in prevalence. Definitive testing of such a hypothesis was precluded by the cancellation of the SALT survey. However, continuance of this trend in the 2013 YRBS data increases the plausibility.

**BHDDH Prevention System:**

**Rhode Island Substance Abuse Prevention Act (RISAPA)** – promotes comprehensive prevention programming at the community level. 35 municipal task forces, covering all of the state’s 39 cities and towns engage in local needs assessments; and planning, implementation, and evaluation of strategies, policies, and programs to produce long term reductions in substance use and abuse.

**State Epidemiological Outcomes Workgroup** (SEOW) – leads data-driven planning and decision making for the purposes of state and community level substance use and abuse, and consequences, and mental illness across the State of Rhode Island. With BHDDH administered authority, Department of Community Health at Brown University has a lead responsibility for epidemiologic analyses conducted by SEOW, and University of Rhode Island Department of Psychology provides prevention evaluation services for BHDDH. With the advent of PFS money, SEOW will continue its efforts until September 2018.

**Synar** – requires states to have in place a law prohibiting the sale or distribution of tobacco products to children under the age of 18. The program annually surveys random retail tobacco outlets statewide to determine retailer compliance with the youth access law.

**Rhode Island Student Assistance** – school based alcohol, tobacco and other drug abuse prevention/early intervention program. The SAMHSA/CSAP model program Project Success(formerly Westchester Student Assistance Program) is used. It is available in 18 middle/junior high schools and 24 high schools, representing 18 districts. 4,112 students have been served by on-site Master’s level counselors from August 2013 to July 2014.

**Rhode Island Strategic Prevention Framework Partnership for Success (PFS)** – twelve communities (Burrillville, Cranston, Cumberland, Foster, Johnston, Lincoln, Little Compton, New Shoreham, Newport, Providence, Scituate, Westerly) will enhance current underage drinking efforts with youth ages 12-17. Additional priorities will be to reduce marijuana use among youth 12-17 and assess prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden. The PFS will be administered by the RI Department of Behavioral Healthcare Developmental Disabilities and Hospitals, conducted in partnership between Brown University, University of Rhode Island, JSI/Prevention Resource Center (PRC).

**Primary Prevention Services: Reducing the Use of Marijuana and Other Drugs (MOD)** – nine communities (Woonsocket, Warren, South Kingstown, Pawtucket, Tiverton, Central Falls, Chariho, Glocester, Barrington) implement evidence based programs listed in SAMHSA’s Registry addressing all six Center for Substance Abuse Prevention (CSAP). University of Rhode Island performs process & outcome evaluations and examines that the fidelity measure are being met for evidence based programming. It collaborates with SEOW on transfer of outcomes and technology from science and research to practice at the local level. The total target population for the initiative is 6,600 students. During the two years, 3,215 students have received direct intervention with evidence-based universal curriculums.

**Rhode Island Prevention Resource Center** (RIPRC) – provides training and technical assistance resource to Rhode Island substance abuse prevention providers. The Center fosters state and local collaboration to prevent substance abuse and other risk-taking behaviors in Rhode Island.

**Enforcing Underage Drinking Laws-** the overall purpose of EUDL is to effect population level reductions in underage drinking and reduce youth access to alcohol through policy, awareness and enforcement strategies. Mothers Against Drunk Driving (MADD) convenes a Statewide Advisory Committee.

**FDA Tobacco Compliance Check Inspection Program** – enforces certain previsions of the federal smoking prevention and tobacco control. BHDDH contracted for last three years on behalf of the State with FDA to conduct compliance inspections of all retail tobacco outlets in the State of Rhode Island. Today approximately 5,000 inspections have been conducted.