Concluding Remarks

Existing Need for Drug/Alcohol Treatment

There is a large gap between the self-reported need and more objectively defined need among adolescent Kentuckians for alcohol or drug treatment. When respondents were asked if they needed alcohol or drug treatment and had not received it, an estimated 757 adolescents acknowledge an unmet treatment need. When objective criteria for treatment need were used, DSM-IV-TR criteria for drug abuse or dependence, the estimated treatment need increases to 25,793 adolescents. An estimated 3,287 adolescent Kentuckians report they would have sought services if they were available.

The overall need for adolescent treatment decreased from 9.6% in the 1998 Kentucky Needs Assessment to 7.6% in 2005. Cigarette use among adolescents in Kentucky parallels national trends in the Monitoring the Future study. In the seven-year period from 1998 to 2005 cigarette use in the past 30 days in Kentucky decreased from 15.3% to 7.1%. Lifetime cigarette use also decreased, from 39.1% to 22.8% for males, and from 49.8% to 21.1% for females. These decreases may be attributed to adolescents' perception of the harm related to smoking. Approximately 94% of adolescents reported they believed that smoking one or more packs of cigarettes per day was of either moderate or great risk. Furthermore, the use of cigarettes was tied less to being "cool" than was the use of alcohol or marijuana.

Although the percentage of adolescents who used alcohol in their lifetime declined from 1998 to 2005, past year rates increased slightly for males while decreasing for female adolescents. This may be explained by the differences between males and females in their perceived risk of drinking one or two alcoholic beverages a day. The overall percentage of adolescents who have used illicit drugs also decreased from 1998 to 2005, but like alcohol, there was a slight increase in recent use for males.

A clear relationship between age and lifetime use of drugs and alcohol emerged. For many substances, almost no use was found among the youngest group of adolescents but steady increases were found in each subsequent age group. Whereas 12 to 14 year olds used cigarettes, alcohol and illicit drugs at relatively low rates (10.5%, 13.2% and 4.3%, respectively), adolescents aged 15 to 17 report substantially higher rates of using these substances (33.1%, 44.0% and 17.6%, respectively).

Consistent with other research on drug and alcohol use among adolescents, peer group substance use is a strong indicator of an adolescent's own use. Having at least one close friend who drinks alcohol puts an adolescent at 5.2 times the risk of drinking than if no close friends drink alcohol. Having at least one close friend who uses drugs puts an adolescent at 10 times the risk of using drugs compared to adolescents with no close friends who use drugs.

Also consistent with other findings is that the use of nicotine, alcohol, and marijuana can serve as a gateway to other drug use. Specifically, adolescents who smoked cigarettes

were 4.4 times more likely to drink alcohol and 14.4 times more likely to use drugs than adolescents who do not smoke. In addition, adolescent Kentuckians who drink alcohol are 14.4 times more likely to use drugs than non-drinking adolescents. Adolescents who smoke marijuana are 31.8 times more likely to use drugs other than marijuana when compared to those who do not smoke marijuana.

A strength of the Kentucky Needs Assessment Project 2005 Adolescent Household Survey is that these estimates of substance use and treatment need were developed for the state as well as for four sampling regions. These estimates indicate that substance use and treatment needs are not uniformly distributed across Kentucky. Although more populated areas generally have higher rates of adolescents who use illicit drugs, the more rural West region have the highest rates of alcohol use and substance treatment need.

References

1. American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC.

2. Wolf J, Gibson OM, Watson DD, and Leukefeld CG (1998). *Kentucky Needs Assessment Project Adolescent Household Survey Report*. University of Kentucky, Center on Drug & Alcohol Research.

3. DeLeeuw ED, and Joop JH (2004). "I am not selling anything: 29 experiments in telephone instructions." *International Journal of Public Opinion Research*, 16:4, pp. 464-473.

4. McAuliffe WE, Geller S, LaBrie R, Paletz S, and Fournier E (1998). "Are telephone surveys suitable for studying substance abuse? Cost, administration, coverage and response rate issues." *Journal of Drug Issues*, 28:2, pp. 455-483.

5. McAuliffe WE, Paletz S, Geller S, and LaBrie R (1996). *Substance abuse telephone surveys: History, feasibility, and validity.* Cambridge, MA.

6. DeLeeuw, ED (1992). *Data quality in mail, telephone, and face-to-face surveys.* Amsterdam: TT-publikaties.

7. DeLeeuw ED, and Van Der Zouwen J (1988). "Data quality in telephone and face-to-face surveys: A comparative meta-analysis." In R. M. Groves et al. (Eds.). *Telephone Survey Methodology* (pp. 283-299). New York: Wiley.

8. Rehm J, Frick U, and Bondy S (1999). "A reliability and validity analysis of an alcohol-related harm scale for surveys." *Journal of Studies on Alcohol*, 60:2, pp. 203-208

9. Ellen JM, Gurvey JE, Pasch L, Tschann J, Nanda J, and Cantania J (2002). "A randomized comparison of A-CASI and Phone Interviews to Assess STD/HIV-related risk behaviors in teens." *Society for Adolescent Medicine*, 36, pp. 26-30.

10. Slutske WS, True WR, Scherrer JF, Goldburg J, Bucholtz KK, Heath AC, et al, (1998). "Long-term reliability and validity of alcoholism diagnoses and symptoms in a large national telephone interview survey." *Alcoholism: Clinical and Experimental Research*, 22:3, pp. 553-558

11. Harrison L, and Hughes A (1997). "The validity of self-reported drug use: Improving the accuracy of survey estimates." *National Institute on Drug Abuse*, 97-4147, pp. 1-17

12. Office of Applied Studies (2003). *Results from the 2003 National Survey on Drug Use and Health: Appendix A.* Retrieved March 2, 2006 from http://oas.samhsa.gov/nhsda/2k3nsduh/appa.htm

13. Leifman H (2002). “The six-country survey of the European comparative alcohol study: Comparing patters and assessing validity.” *Contemporary Drug Problems*, 29:3, pp. 477-500

14. Johnson TP, Hougland JG, and Clayton RR (2003). “Obtaining reports of sensitive behavior: A comparison of substance use reports from telephone and face-to-face interviews.” *Social Science Quarterly*, 70:1, pp. 174-183.

15. Aquilino WS (1994). “Interview mode effects in surveys of drug and alcohol use.” *Public Opinion Quarterly*, 58, pp. 210-240.

16. Gmel G (2000). “The effect of mode of data collection and non-response on reported alcohol consumption: A split sample study in Switzerland.” *Addiction*, 95, pp. 123-134

17. Johnston LD, O’Malley PM, Bachman JG, and Schulenberg JE (2005) *Monitoring the Future national survey results on drug use, 1975-2004: Volume I, Secondary School Students*. (NIH Publication #05-5727) Bethesda, MD: National Institute on Drug Abuse

18. United States Census 2005. Data for population estimates by county.

19. Oetting ER, and Beauvais F (1986) Peer Cluster Theory: Drugs and the Adolescent. *Journal of Counseling and Development*. 65;17-22

20. Bauman KE, and Ennett ST (1996) On the importance of peer influence for adolescent drug use: commonly neglected considerations. *Addiction*. 91(2);185-198

21. Rosner B (2000). *Fundamentals of Biostatistics*. (pp. 596-609) Pacific Grove, CA: Duxbury/Thompson Learning