Alcohol, Drug, and Tobacco Use

DEFINITION

Alcohol, drug, and tobacco use is the percentage of middle school and high school students who report using alcohol, tobacco products (including e-cigarettes), and illicit substances.

SIGNIFICANCE

The use and/or abuse of substances such as alcohol, tobacco, and other substances by youth impact the health and safety of themselves, their families, their schools, and their communities.[1,2] Rhode Island ranks among the states with the highest percentages of adolescents reporting use of alcohol and many types of illicit drugs.[3]

Key risk periods for alcohol, tobacco, and other drug abuse occur during major life transitions, including the shifts to middle school and high school, when young people experience new academic, social, and emotional challenges. Adolescents are especially vulnerable to developing substance abuse disorders because their brains are still developing; the prefrontal cortex, responsible for decision-making and risk-assessment, is not mature until the mid-20s.[4,5]

Pathways for becoming a substance user involve the relationship between risk and protective factors, which vary in their effect on different people. Risk factors are associated with increased drug use and include early aggressive behavior, poor school achievement, peer and parental substance abuse, chaotic home environment, and poverty. Protective factors lessen the risk of drug use, and include a strong parent-child bond, healthy school environment, academic competence, and attachment to their communities.[6,7] For over three decades, Hispanic and Black high school seniors in the U.S. have generally had lower rates of substance use than their White peers, but recently these differences have narrowed due to an increased use of marijuana.[8,9]

Prevention and reduction in teen substance abuse can be achieved by enacting policies that support prevention, screening, early intervention, treatment, and recovery. Policy examples include preventing underage substance use and sales to minors, improving school climate and academic achievement, enacting sentencing reform, and adequate funding for multi-sector youth development, treatment, and recovery services.[10]

In Rhode Island in 2013-2014, 3% of youth ages 12-17 needed but did not receive specialty treatment for their alcohol use problem, which is the 15th highest rate among all states. Four percent of Rhode Island youth ages 12-17, needed but did not receive any specialty treatment for their illicit drug use. Rhode Island has the sixth highest percentage among all states on this measure.[11]

Tobacco Use Among Rhode Island Youth

- **In 2017, 26% of Rhode Island high school students reported currently smoking cigarettes or cigars or using smokeless tobacco or e-cigarettes (i.e. e-cigars, e-pipes, vaping pipes/pens, e-hookahs/pens). Current use is defined as use on at least one day during the 30 days before the survey.[12]**

- **E-Cigarettes: E-cigarettes are harmful to youth. They contain, among other chemicals, nicotine which is highly addictive and can harm brain development. Some e-cigarette pods have as much or more nicotine as a pack of cigarettes.[13]**

- **E-Cigarettes: Nationally in 2018, current e-cigarette use among high school students reached 21%, higher than use of traditional tobacco cigarettes or any other tobacco product.[14] In Rhode Island in 2017, 20% of high school students reported current use of e-cigarettes and 40% reported ever using e-cigarettes.[15] Effective January 1, 2018, the General Assembly passed legislation prohibiting the use of e-cigarettes in schools.[16]**

- **Cigarettes: Cigarette use has reached record low levels among U.S. middle and high school students.[17] In 2017, 6% of Rhode Island high school students reported currently smoking cigarettes. Fifty-nine percent of Rhode Island high school students who reported current cigarette use in 2017 also reported trying to quit smoking in the past year.[18]**

- **Hookah, cigars, and smokeless tobacco: The prevalence of youth hookah, cigar, and smokeless tobacco use has declined nationally and in Rhode Island.[19] In 2017, 5% of Rhode Island high school students reported currently smoking tobacco in a hookah, 7% reported currently smoking cigars, and 5% reported current use of smokeless tobacco.[20]**

Tobacco to 21

- **The Centers for Disease Control and Prevention, the Institute of Medicine, and the American Academy of Pediatrics suggest that raising the minimum legal sale age for tobacco products to 21 may prevent or delay initiation of tobacco use by adolescents.[21,22,23] Nationally, 88% of adult cigarette users who smoke daily report starting by age 18.[24] Rhode Island's minimum sale age is 18 years. As of January 2018, seven states have set the age to 21 (HI, CA, NJ, OR, ME, MA, VA).[25,26]**

Current Substance Use, Rhode Island High School Students by Select Subgroups, 2017

	ALCOHOL USE*	E-CIGARETTE USE*	CIGARETTE USE*	MARIJUANA USE*	PRESCRIPTION DRUG MISUSE**
Female	26%	17%	5%	23%	3%
Male	20%	22%	7%	23%	4%
Black, Non-Hispanic	19%	12%	1%	27%	4%
White, Non-Hispanic	25%	23%	7%	22%	3%
All other races, Non-Hispanic	NA	16%	1%	19%	2%
Multiple races, Non-Hispanic	29%	20%	6%	38%	1%
Hispanic	20%	16%	6%	23%	4%
9th Grade	16%	17%	6%	15%	4%
10th Grade	20%	21%	5%	20%	5%
11th Grade	26%	22%	4%	26%	3%
12th Grade	33%	21%	9%	33%	2%
All Students	*23%*	*20%*	*6%*	*23%*	*4%*

Source: *2017 Rhode Island Youth Risk Behavior Survey*, Rhode Island Department of Health, Center for Health Data and Analysis. *Current use is defined as students who answered yes to using respective substances in the 30 days prior to the survey. **Prescription drug misuse is defined as those without a doctor's prescription. NA is not available due to small sample size.

◆ **Among Rhode Island high school students in 2017, 23% reported current alcohol consumption, 23% reported current marijuana use, 20% reported current use of e-cigarettes, 11% reported current binge drinking, 6% reported current cigarette use, 5% reported currently using over the counter drugs to get high, and 4% reported currently misusing prescription drugs.[27]**

◆ **In 2017, a majority of Rhode Island high school students reported that they have never smoked a cigarette (81%) or used an e-cigarette product (60%).[28]**

◆ **Cigarette excise taxes are a potential funding stream for state tobacco control programs.[29] Between SFY 2002-2018, Rhode Island cigarette tax revenue increased from $79.4 million to $143.1 million and state tobacco control funding decreased from $3 million to $388,000. Only .27% of the cigarette tax in SFY 2018 went toward tobacco control and smoking cessation programs.[30,31,32,33]**

Family and Community Exposure

◆ **Having parents or friends who use tobacco, alcohol, and other drugs, as well as living in communities where there is drug use, are risk factors for teen substance use.[34] In Rhode Island in 2017, 35% of middle school students and 33% of high school students reported living with someone who smokes cigarettes. One in six (17%) Rhode Island high school students under age 18 who used an e-cigarette during the past 30 days reported buying it in a store, despite laws prohibiting sales to minors. One in seven (14%) high school students who had ever taken a prescription drug without a doctor's prescription reported taking it from a friend or relative without their knowledge.[35]**

Exposure to Substances at Birth

◆ **Neonatal abstinence syndrome (NAS) refers to the objective and subjective signs and symptoms attributed to the cessation of prenatal exposure of substances. Neonatal opioid withdrawal syndrome, more specifically, refers to the withdrawal symptoms related to opioid exposure. Not all substance exposed newborns are diagnosed with NAS.[36]**

◆ **In Rhode Island in 2017, 113 newborns were diagnosed with NAS, at a rate of 106 per 10,000 births; almost as high as the highest rate in 2015 at 114 per 10,000 births, and double the rate of 37.2 in 2006.[37]**

◆ **Eighty-three percent of babies born with NAS in 2017 were born to white mothers, 94% were born to mothers who were covered by Medicaid, and 52% lived in the four core cities.[38]**

◆ **NAS rates will not decrease until Opiate Use Disorder rates decreases in the general population. Adequate treatment options and services for those struggling with Opiate Use Disorder are needed before and during pregnancy, at birth, and throughout parenting for the whole family.[39]**

References

[1,4,6] *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health.* (2016). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

[2] *Substance-free youth.* (2015). Washington, DC: Child Trends.

(continued on page 182)