Alcohol and Substance Use Among Adolescents in Foster Care in Washington State:

Results From The 1998-1999 Adolescent Foster Care Survey

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EXECUTIVE SUMMARY

Risk: This report shows that adolescents in foster care are more likely than adolescents living with their parents to be at high risk for substance abuse in ***some*** dimensions. These dimensions include:

- their birth parents' substance abuse (page 18),
- their own age at first use (page 14),
- transitions and mobility (page 18),
- early occurrences of antisocial behavior (page 18), and
- personal attitudes favorable to drug use (page 18).

Lifetime Use: Also, when compared with youth living with their own parents, foster care adolescents are much more likely to have used almost any substance one can name at least once in their lives. The magnitude of the difference varies by substance: differences in alcohol and marijuana use are less pronounced than differences in other drugs (pages 8 and 9).

Past year Use: However, when use of substances during the year just before the interview is examined, a different pattern emerges. In "use of alcohol or any other drug" the two groups are almost identical. With some substances – notably alcohol, powder cocaine and other opiates – the foster care adolescents are actually a little less likely to use than the adolescents living with their own families (pages 10 and 11).

DSM-III-R Disorder and Need for Treatment: As the time frame shifts to the six months prior to the interview, adolescents in foster care are about 50% more likely than those living in their parents homes to have a current substance abuse disorder (10% to 6%) or current need for treatment (12% to 8%) (page 25).

Thirty-Day Use: During the month just prior to the interview ("past thirty day use"), substance use among fostered youth continues to decline relative to substance use among youth living with their parents. Foster care adolescent use drops **below** that of household in combined use (use of alcohol or any other drug), alcohol use, and other opiate use (page 12-13). And "heavy" use of marijuana, alcohol and all drugs combined is much lower among adolescents in foster homes than among adolescents in their parents' homes (page 14).

What has caused these changes in usage pattern? This report cannot provide definitive answers, but it can suggest some areas for further investigation. At least two areas of social services differ among these youth: the provision of foster care itself, and the increased use of formal alcohol and other drug treatment.

Effects of Foster Care: One hypothesis is that foster care itself is providing protection for these youth, repairing damage and buffering them against the risks that remain.

Children in foster care have been damaged and abused in their birth families, and have often been exposed to alcohol and other drugs in those families. Their lifetime use and age at first use, then, reflects those high-risk environments.

When these children enter their foster families, however, their lives change. Foster parents are selected for and trained in parenting and family management. They do not drink or use drugs to excess. Kids come first with them. They have expectations about the behavior of their foster children that do not include drug use.

This hypothesis is supported by the findings about risk factors connected to "families" (except for birth parent substance use, these questions generally refer to the family the youth lives with now). Foster youth scores on family attachment, family attitudes toward anti-social behavior, and family management practices are very similar to those of youth living with their own parents (page 18). This suggests that the foster youth are getting good parenting from their foster families, in areas which research has shown to affect substance use.

Effects of Treatment Penetration: A second set of changes that are part of foster care leads to another, complementary hypothesis. Foster care brings into play greater attention to the health care, mental health and alcohol and other drug treatment needs of the adolescents. They are more likely to be screened for treatment, and they become "priority populations" for state-funded services. Therefore, the second hypothesis is that the change in substance use among foster care adolescents is the result of the increases in alcohol and other drug treatment.

Among those who need treatment, there are indeed differences between adolescents in foster care and those living with their parents in treatment rates and the use of self-help groups (page 26).

- Among adolescents in foster care, almost half (46 percent) of those who needed treatment reported receiving either formal treatment or help from a doctor, teacher, counselor, or pastor. Among adolescents living with their parents, only one out of three (32 percent) received such assistance.
- Adolescents in foster care were twice as likely as those living with their parents (22% vs. 11%) to report participating in a self-help group.

These differences could certainly explain why foster youth substance use has gone down relative to youth in their parents' homes.

Washington State needs to expand adolescent treatment capacity. Targeting the remaining half of the foster youth who need treatment is important. It is also important to provide more treatment capacity for adolescents living with their parents, who are not getting the treatment they need. Treatment is working – for those few who are lucky enough to get it.

CHAPTER ONE
Overview of Adolescent Foster Care Survey

Project Goals

Between May 2000 and September 2000, 231 Washington State adolescents living in foster homes were interviewed by telephone. The interviews were conducted on behalf of the Washington State Department of Social and Health Services by trained interviewers from Washington State University's Social and Economic Services Research Center. The study was funded by Contract Number 270-96-0016 from the federal Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration.

The primary goals of the Washington State Adolescent Foster Care Survey were to:

- Provide estimates of the rates of alcohol and other drug use, abuse and dependence (based on the Diagnostic Interview Survey for Children, which assesses DSM-III psychiatric diagnoses), and need for treatment. The following drugs were included:

    - Alcohol
    - Heroin
    - Hallucinogens
    - Marijuana
    - Anabolic Steroids
    - Sedatives
    - Cocaine, including Crack
    - Inhalants
    - Amphetamines (including Meth)
    - Prescription Pain Medications
    - Tranquilizers

- Describe the risk factors for drug use experienced by these adolescents.

- Compare the risk factors, drug use, abuse, need for treatment and treatment use for adolescents in foster care to adolescents living in their parents' homes. Data on the adolescents living in their parents' homes came from the Washington State Adolescent Household Survey, which used the same survey instrument and contractor.

Sampling Method and Design

The population for the Adolescent Foster Care Survey included all Washington State households that had an adolescent foster child between the ages of 12 and 17 in January of 2000. DSHS staff drew a sample of those young people, and attempted to contact a parent or guardian to obtain permission to interview the child. Once the guardian gave permission, the foster home was telephoned and the adolescent was contacted for permission.

To help provide confidentiality for the adolescent respondent, interviewers were instructed to make an appointment for an interview at a later time. The adolescent respondent was able to choose a time and place which allowed them to answer questions without the parent or guardian's knowledge of the adolescent's answers. In some instances, the eligible adolescent was more comfortable calling the Social and Economic Research Center's toll-free number and completing the survey at that time.

Finding the Parents, Guardians and Foster Children

Finding the adolescents in foster care and obtaining permission to interview them was a complex process that needed redesign several times in the field.

Automated records proved unreliable in locating parents and guardians of the children and indeed in defining the status of the children. Sometimes this occurred because the case managers were behind in recording case closures. But even when the on-line case management system had correct information entered by the case managers, the history file on youth in care (which was what this project was using) was not updating properly.

It was much better to go to the caseworkers to locate the children and the guardians, and the project eventually hired two people to work with the caseworkers to obtain that information. That process took several months. Partly because of the time lags between drawing the sample and either locating or not locating the parent or guardian, when some of the youth were reached many of them were no longer eligible to be interviewed.

An additional sample of foster care records was drawn, this time moving directly to the caseworkers for information. Even in that sample, by the time field staff attempted to contact the foster families, a number of the youth could not be reached for interview or were ineligible because their status had changed.

In retrospect, it would have been better to limit the original design to young people who have been in foster care for at least three months. Most (but not all) of the respondents reached had been in foster care that long. This would have simplified many of the contact processes, and decreased the number of youth who were "ineligible" by the time they were reached. That process would have conserved staff time and resources, permitted a larger sample, and perhaps led to better response rates.

Response Rates

There were two phases of the study where response and cooperation rates are important. Phase One was the parent/guardian permission process. In that phase, the total cooperation rate (the rate at which parents and guardians agreed to their adolescent's participation in the survey) among parents and guardians reached was 70%. The CASRO adjusted completion rate for this phase was 66%. This means that 66% of the parents/guardians whose children were still estimated to be eligible foster children were reached and they agreed to permit their children to be surveyed.

Several factors helped to increase cooperation rates during this consent process. Once the problems with the automated system were clear, project staff and Children's Administration caseworkers worked hard to identify the appropriate parent or guardian. DSHS staff made a minimum of ten call attempts that were varied as to time of day and week, used refusal conversion attempts, and translated the survey into Spanish.

Phase Two was the telephone survey itself. Here the cooperation rate was even higher among the adolescents ever reached --79%. The CASRO adjusted completion rate for this phase was 72%, meaning that 72% of the estimated eligible foster care adolescents whose parents and guardians gave permission were reached in the survey.

Several factors helped increase completion and cooperation rates during the telephone survey. These included: a minimum of ten call attempts, varied as to time of day and week; two days of interview training and ongoing monitoring of interview performance; refusal conversion, and translations into Spanish. The survey instrument was translated and back-translated into Spanish so that Spanish speaking adolescents or parents could be interviewed in their own language.

However, response rates can suffer at either point in this process – in the parent and guardian consent process, and in the survey itself. Combining these two processes results in an adjusted response rate of 48%. That means that 48% of the estimated eligible adolescents from the original sample were interviewed.

We had hoped to achieve a 55 to 60 percent adjusted response rate for this survey. Achieving that would have been possible only if everything had gone very well in the consent phase, given the fact that the adolescent and parent live in separate households and must be contacted separately. We had underestimated and certainly under funded the difficulties we would face in finding and getting consent from the parents and guardians of adolescents in foster care.

The complete calculations that define the foster care survey response rates are shown in Appendix One.

Sample Characteristics

Table 1 compares the characteristics of survey respondents and the population of adolescents aged 12 through 17 in foster care. The table indicates that respondents are more likely to be female (55 percent versus 48 percent of the population) and less likely to be at the young end of the age spectrum (10 percent were age 12 at the time of the interview, compared to 16 percent of the population of foster care adolescents). The weighting procedure described below mitigates potential biases arising from age and gender differences between respondents and the foster care population.

Table 1: Comparison of the Demographic Characteristics of Respondents and the Population of Adolescents aged 12-17 in Foster Care

Characteristics	Number of Respondents	Youth in Foster Care[1]
Sex		
• Female	126	1,338
• Male	105	1,474
Age when Interviewed		
• 12	24	446
• 13	43	461
• 14	47	430
• 15	43	539
• 16	40	500
• 17	34	436
Total:	231	2,812

Analysis Methods

To facilitate comparisons with statewide findings from the adolescent household survey, observations were weighted so that the number of responses in each age/sex combination weighted up to the statewide population of youth in that age/sex combination. This was done so that differences in the age/sex distribution of youth responding to the foster care and household surveys would not affect the comparisons between the two groups of adolescents. Future analyses may be weighted to the age/sex proportions of the foster care population. All analyses were carried out in SAS.

Topics Covered in the Survey

The following topics were covered in the survey. The instrument was exactly the same as the one used in the Washington State Adolescent Household Survey, and is included in Appendix B.

[1] As of July 2001.

- Alcohol or other drug use (past 30 days, 6 months, lifetime)
- Alcohol or other drug abuse and dependence diagnoses, based on the Diagnostic and Statistical Manual, Version III-R (DSM-III-R) of the American Psychiatric Association. Diagnostic questions were drawn from the Diagnostic Interview Schedule for Children – the DIS-C.
- Substance abuse treatment history
- Perceived barriers to substance abuse treatment
- Disability status
- Mental health status
- Demographic information about the adolescent
- Household income, size and poverty status
- Insurance status of the adolescent
- Risk and protective factors which could influence adolescent drug use, including:
    - Transition and Mobility
    - Perceived Laws and Norms Favorable to Drug Use
    - Perceived Availability of Alcohol, Tobacco, Other Drugs, and Firearms
    - Family Management Practices
    - Parental Attitudes about Antisocial Behavior
    - Family Attachment
    - Family History of Drug or Alcohol Use
    - Academic Success or Failure
    - Commitment to School
    - Antisocial Behavior History
    - Personal Attitudes about alcohol or other drug use
    - Friend's use of alcohol or other drugs

Topics Covered in this Report

This report analyzes the rates of risk, substance use, substance use disorder, need for treatment and use of alcohol and other drug treatment between two groups of adolescents. Both groups are composed of adolescents between the ages of twelve through seventeen. The focus of this report is placed upon youth living in foster homes; the comparison group is youth living in the homes of their birth or adoptive parents.

CHAPTER TWO

Drug Use Findings, and Comparisons Between Adolescents in Foster Care and Adolescents Living with Their Own Parents

Substance Use Rates

This chapter explores the use of various substances for different time periods. Tables are presented detailing use during the adolescent's lifetime, the past year, and the past thirty days. For the past thirty day measures, "heavy" use of alcohol, marijuana, and all drugs combined are examined.

Most risk factors are reported in chapter three. However, one key risk factor -- the average age at which the adolescent first used alcohol, marijuana, and all drugs combined is reported in this chapter.

Comparison Groups

For comparison purposes, most tables include data from both the Adolescent Foster Care Survey and similar data from a survey of over 1200 adolescents living with their parents (the Adolescent Household Survey)[2].

The household survey data is weighted to represent the entire population of Washington State adolescents aged 12 through 17 living in households. The foster care survey is weighted to represent the same age/sex distribution of adolescents, so that it matches the household survey. This weighting scheme permits the discussion of differences in substance use, disorder, need for treatment, and risk factors that control for differences in age/sex composition of the two groups.

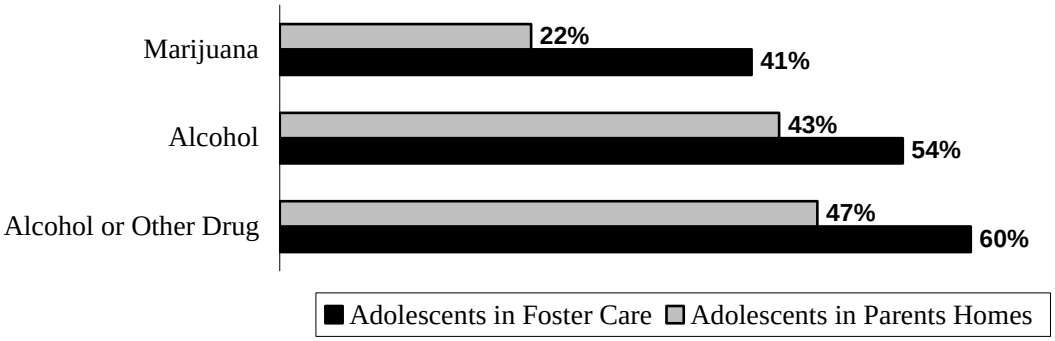
Both surveys used the same instrument and methodology. However, the sample sizes are different across the two groups, and that affects reported significance levels in some cases. There were 231 completed interviews with adolescents in foster care. There were 1,259 completed interviews with adolescents living in their parents' homes.

[2] Kohlenberg E, D Nordlund, B Triechler, J Kabel, A Lowin, M K Landry 2001. *Alcohol and Substance use Among Adolescents in Washington State: Results from the 1998-1999 Adolescent Household Survey*. Report Number 4.35 (Washington State Department of Social and Health Services, Research and Data Analysis Division: Olympia Washington).

Lifetime Use

This section examines lifetime use of alcohol and other drugs by adolescents in Washington State. "Lifetime Use" means that during the course of questioning, the adolescent reported that they have used each specific drug at least once during their life. "All drugs" include alcoholic drinks (at least one drink, not a sip or taste), marijuana, stimulants, crack cocaine, powder cocaine, hallucinogens, sedatives, tranquilizers, heroin, other opiates, and inhalants.

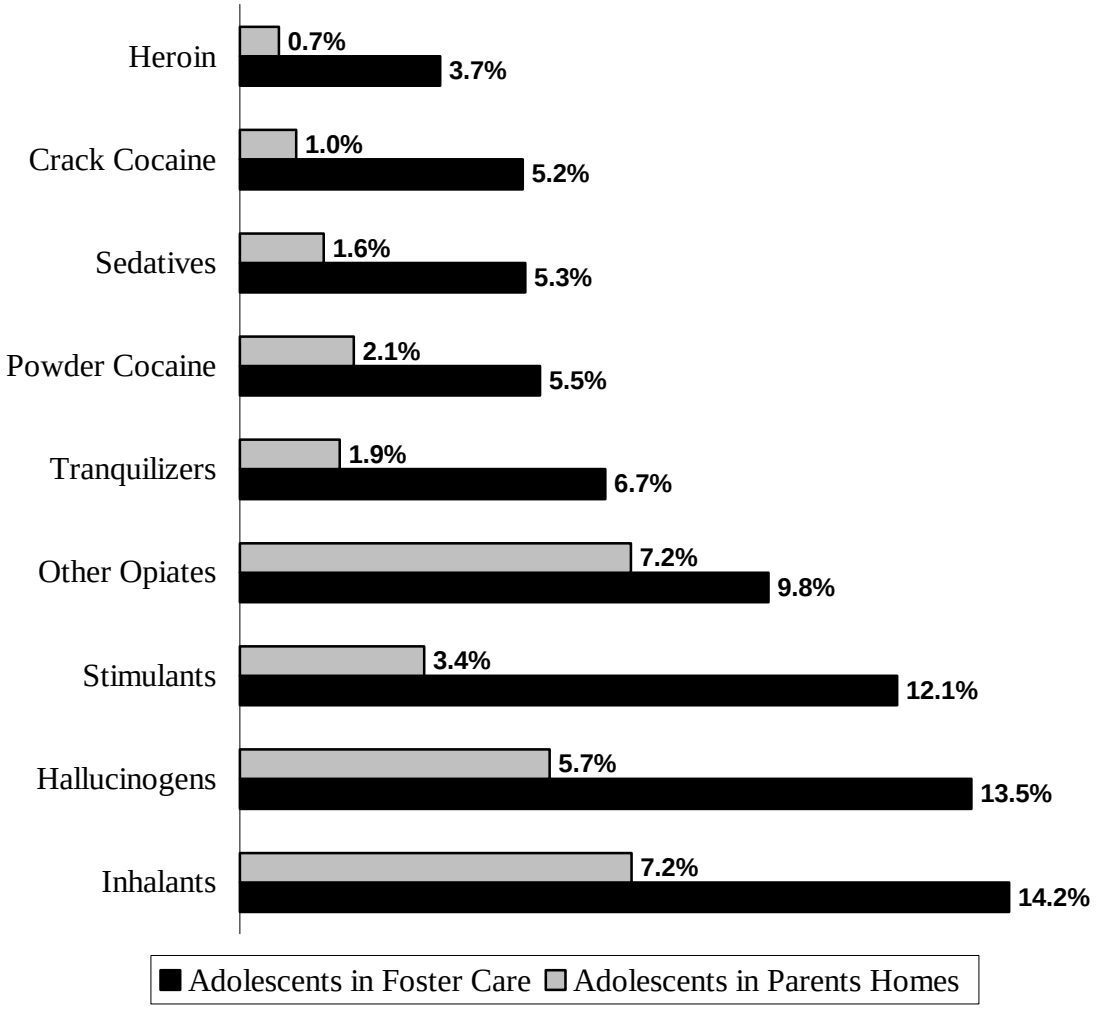
Figure 1: Percent Lifetime Use of All Drugs, Alcohol, and Marijuana



As Figure 1 above shows, adolescents in foster care are more likely to have used alcohol and other drugs at least once in their lives than are adolescents living in their parents' households. The difference between the two groups is more pronounced in the case of marijuana than alcohol: adolescents in foster care are almost twice as likely to have "ever used" marijuana than adolescents living with their parents.

Figure 2 below compares adolescent use of drugs other than alcohol or marijuana. It is quite clear from this figure that adolescents in foster care are ***much*** more likely than adolescents living with their parents to have experimented at least once in their lifetimes with illegal drugs such as hallucinogens, stimulants, inhalants, cocaine, or heroin.

Figure 2: Percent Using Drugs Other Than Alcohol or Marijuana in Lifetime



Past Year Use

This section examines substance use during the past year among adolescents in Washington State.

Generally, in lifetime substance use, youth living in foster care are quite different than youth living with their parents. When we look at past year use, differences between the two groups decrease.

As Figure 3 below shows, alcohol use in past year by adolescents in foster care drops slightly below the rate for adolescents living with their parents. Foster care youth are still more likely to smoke marijuana than children living with their parents, but the magnitude of the difference between the groups is diminishing. And the rate of past year use of any substance is almost identical between the two groups.

Figure 3: Percent Using any Substance, Alcohol and Marijuana During the Past Twelve Months

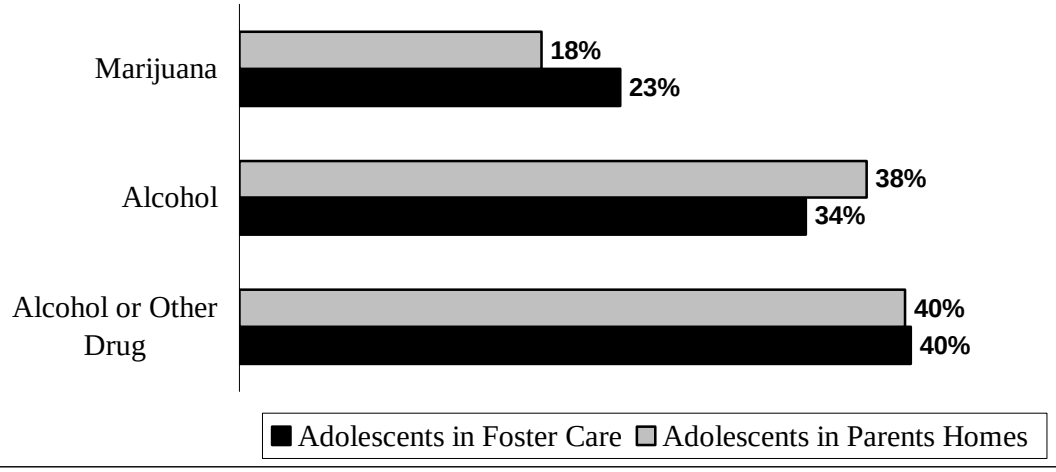
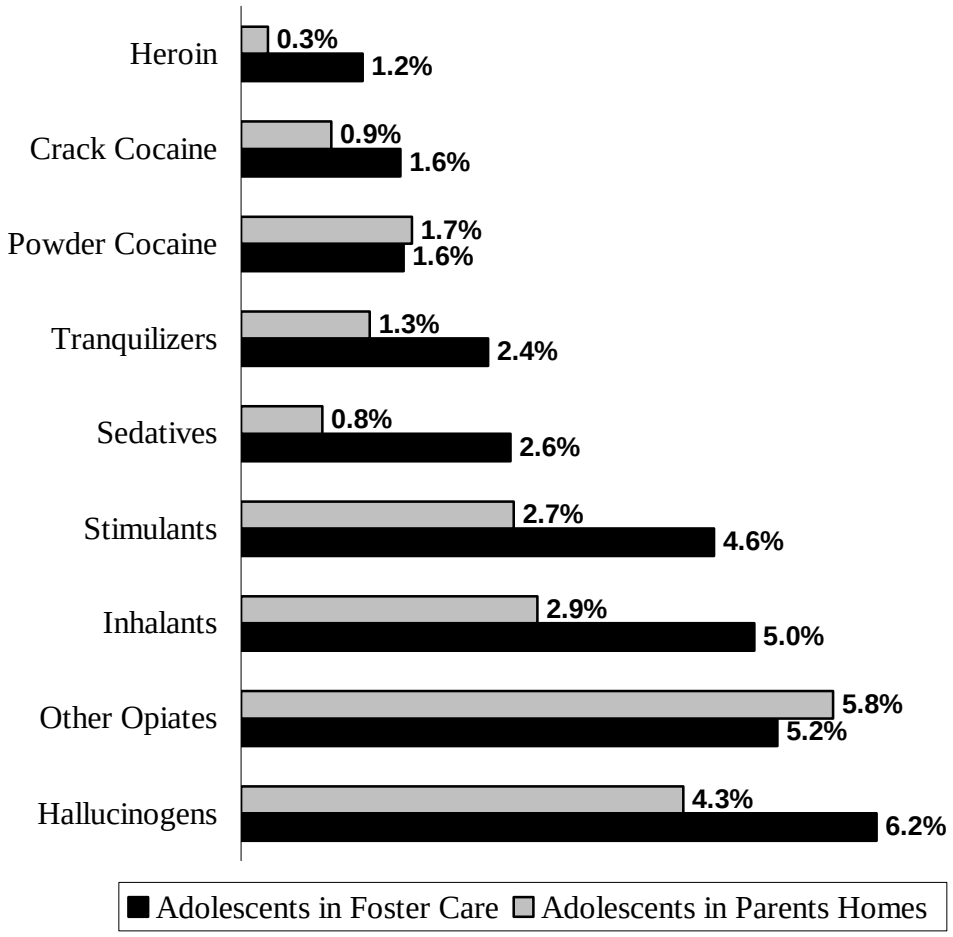


Figure 4 below also shows diminishing differences between the two groups of adolescents. However, it is clear that adolescents in foster care are still much more likely than adolescents living with their own parents to have used "hard" drugs during the past twelve months. For a few drugs (other opiates and powder cocaine), past year usage among adolescents living with their parents is a little higher than past year usage among adolescents in foster care.

Figure 4: Percent Using Drugs Other Than Alcohol or Marijuana in Past Twelve Months

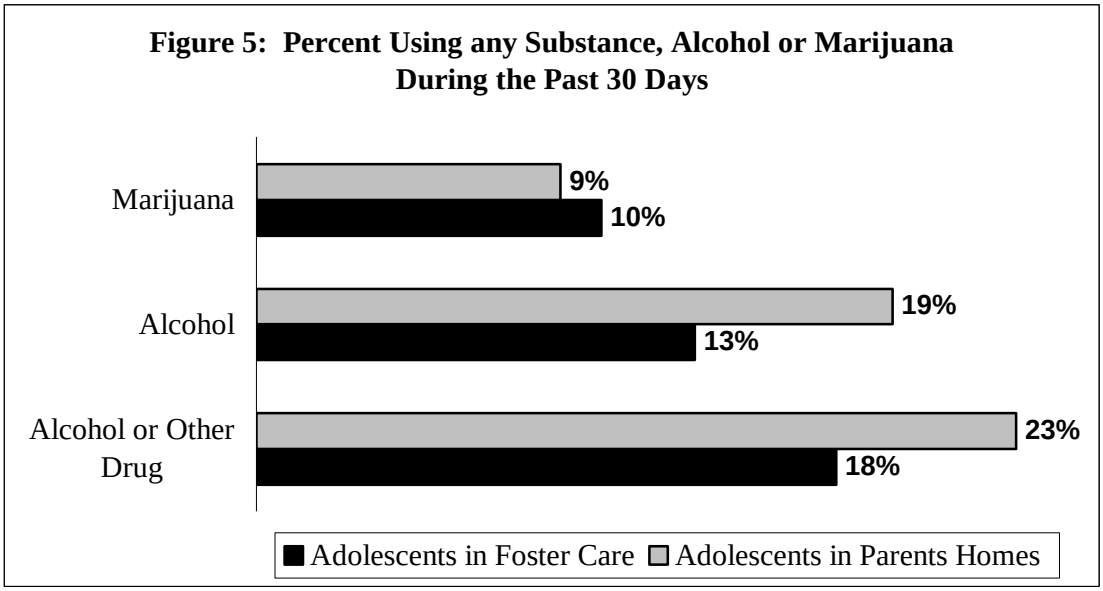


Past 30-Day Use

This section focuses on use of alcohol and other drugs during the month prior to the interview. All of the adolescents were in their foster homes at that time. The pattern of diminishing differences between groups as the time span involved is shorter and closer to the interview continues.

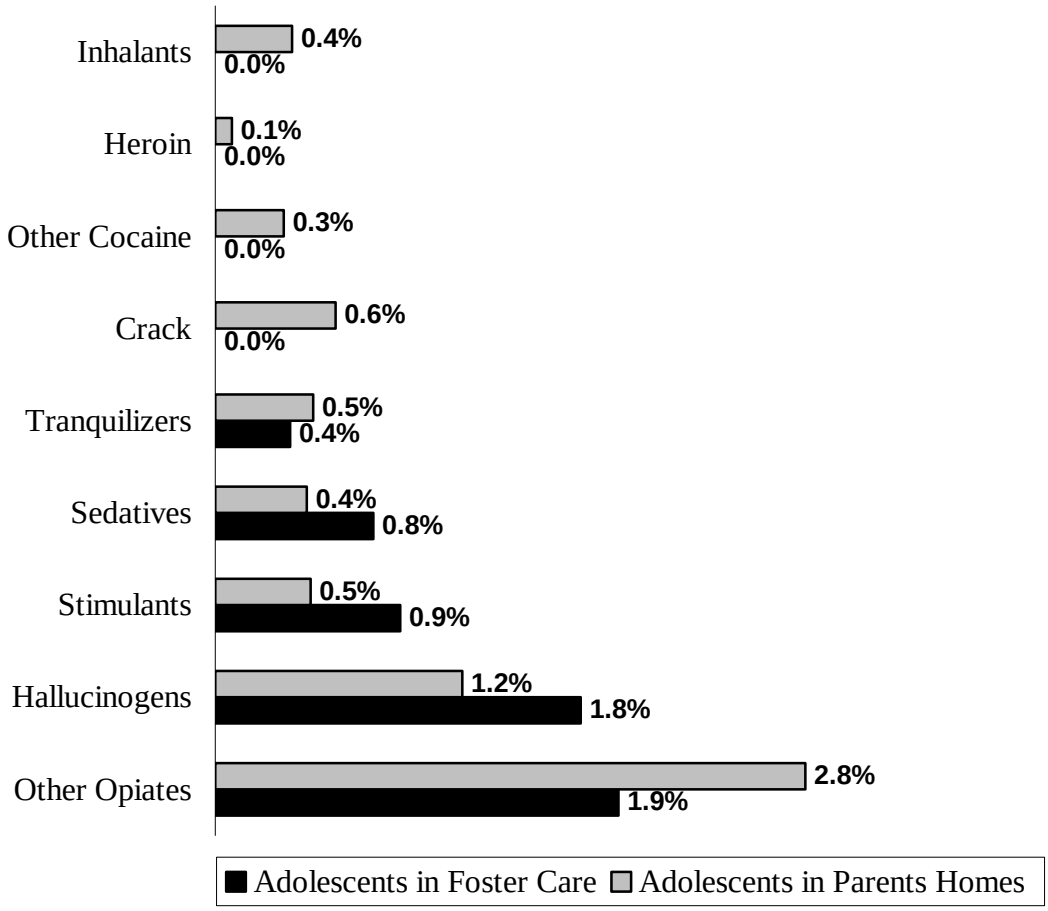
As Figure 5 below shows, alcohol usage during the past 30 days is much ***lower*** among adolescents in foster homes than that of adolescents in their parents' homes. Differences between the groups in the rate of marijuana use disappear.

Figure 5: Percent Using any Substance, Alcohol or Marijuana During the Past 30 Days



As Figure 6 below shows, thirty day usage rates demonstrate diminished differences between the two groups of adolescents in use of drugs other than alcohol or marijuana. Some of these differences may be due to the small foster care sample: 231 youth is a small group to detect use of relatively infrequently used drugs. But the directions are consistent with the more commonly used drugs, alcohol and marijuana.

Figure 6: Percent Using Drugs Other Than Alcohol or Marijuana During the Past 30 Days

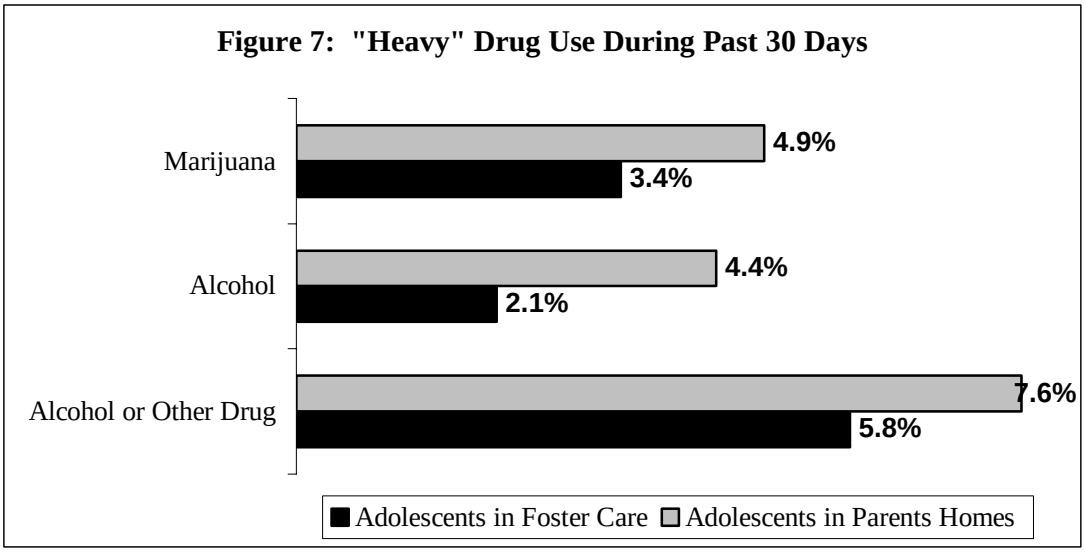


Heavy Use

Adolescent "heavy" use is examined in Figure 7 below. "Heavy" use is defined here as using alcohol or another illegal drug six or more times in the prior 30 days.

We see a now familiar pattern: heavy drug use during the past thirty days is clearly ***much*** higher among the youth living with their parents than those living with foster families.

Figure 7: "Heavy" Drug Use During Past 30 Days



Age at First Use

The age at which adolescents first use a substance is a risk factor for substance abuse later in life. The youth in foster care used substances earlier than did those living with their parents. For Washington adolescents:

First drink of alcohol

- For those living with foster families, the average age of first drink is at 11.5 years.
- For those living with their parents, the average age of the first drink is 13 years.

First use of marijuana

- For those living with foster families, the average age of first marijuana use is 12.2 years.
- For those living with their parents, the average age of first marijuana use is 13.6 years.

Discussion

The findings discussed in this chapter reveal interesting patterns in the substance use of youth living in foster homes.

First, when compared with youth living with their own parents, foster care adolescents are much more likely to have used almost any substance one can name at least once in their lives. The magnitude of the difference varies by substance: differences in alcohol and marijuana use are less pronounced than differences in other drugs.

However, when we look at use of substances during the year just before the interview, a different pattern begins to emerge. In "use of alcohol or any other drug" the two groups are almost identical. With some substances – notably alcohol, powder cocaine and other opiates – the foster care adolescents are actually a little less likely to use than the adolescents living with their own families.

The month just prior to the interview ("past thirty day use") continues these changes. Foster care adolescent use drops below that of adolescents living with their own families in combined use (use of alcohol or any other drug), alcohol use, and other opiate use. The remaining differences were not as pronounced. And "heavy" use of marijuana, alcohol and all drugs combined is much lower among adolescents in foster homes than among adolescents in their parents' homes.

CHAPTER THREE

Risk Factors and Adolescent Alcohol and Drug Use

Significant research has been recently pulled together on the relationship between community, school, family and personal risk factors and alcohol or illegal drug use by adolescents. Risk factors may be described as characteristics of the community in which adolescents live, the family with whom they live, the friends and associates with whom they spend time, their attitudes about education and their future, and personal attitudes about factors such as violence or drug and alcohol use.

The adolescent foster care and household surveys collected information on the following risk factors. The "risk factor" items and scales were developed by David Hawkins and Richard Catalano at the University of Washington, and are shown in Section G (Appendix 2).

- Transition and Mobility
- Laws and Norms Favorable to Drug Use
- Perceived Availability of Alcohol, Tobacco, Other Drugs, and Firearms
- Family Management
- Parental Attitudes about Antisocial Behavior
- Family Attachment
- Family History of Drug or Alcohol Use
- Academic Success or Failure
- Commitment to School
- Antisocial Behavior
- Personal Attitudes about Drug or Alcohol Use
- Friends Use of Alcohol or Drugs

Risk Factor Comparisons

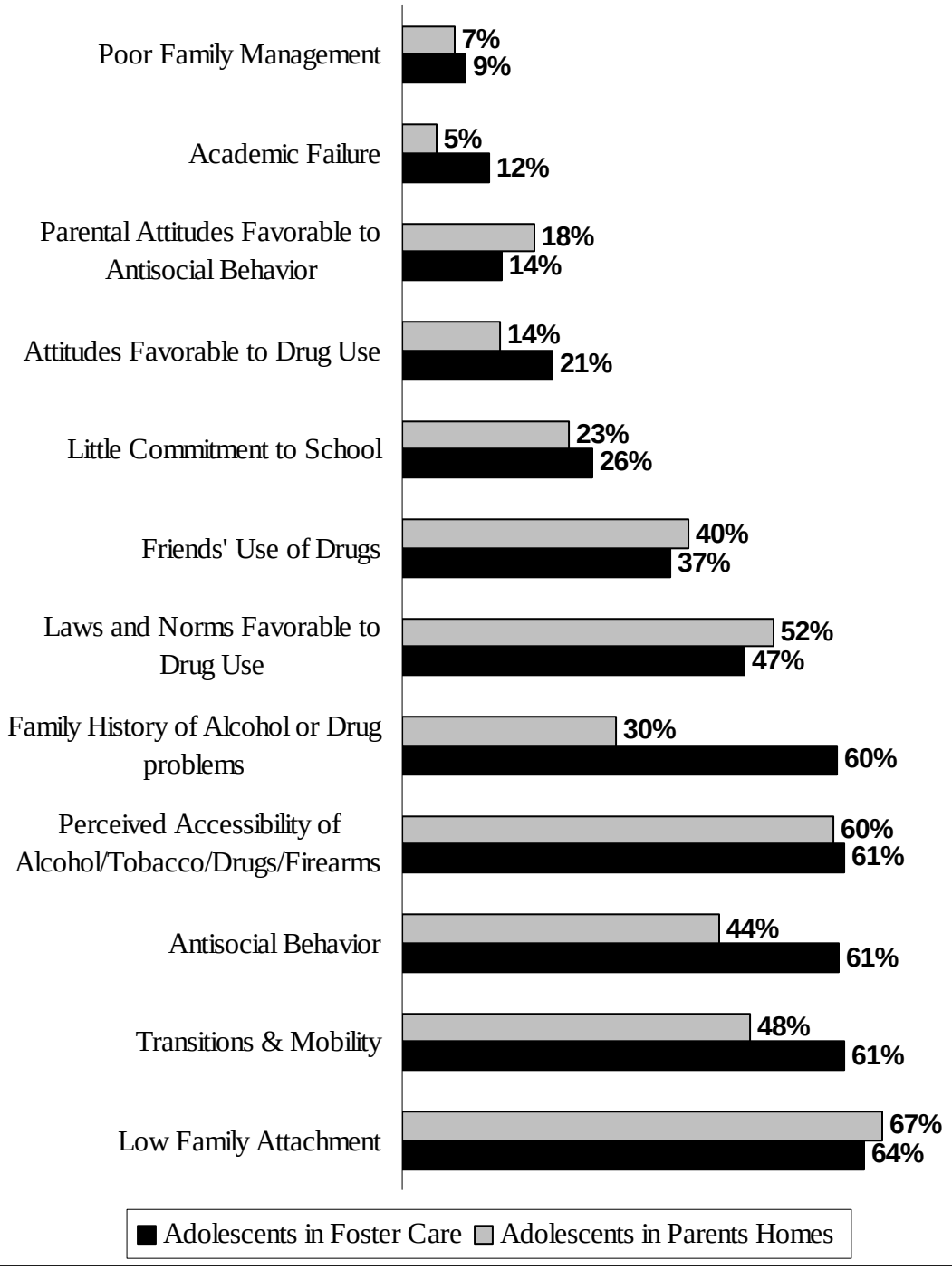
Figure 8 below shows the percentage of adolescents in foster care who have "high" scores on each risk factor. As a comparison, the percent of adolescents in households who have "high" risk factor scores is also reported in that table.

Risk factors do not vary between groups as much as one might expect. A few risk factors – academic failure, parents who abuse drugs or alcohol, early occurrences of antisocial behavior, and personal attitudes favorable to drug use – are notably higher among adolescents in foster care as compared to adolescents living with their parents.

High levels of most of the other risk factors – such as perceived access to alcohol, drugs and firearms – are similar between adolescents living in foster families and those living with their parents. This includes some individual and peer variables such as personal

attitudes and "friends who use." Again, this may reflect the fact that foster families offer "lower-risk" environments and encourage "healthy" attitudes and friendships.

Figure 8: Percent with High Risk Scores on each Risk Factor



Effects of Risk Factors on Substance Use

Figure 9 below shows the two-way relationships between risk factors and 30 day alcohol use for both groups of adolescents.

- For both groups, alcohol use is not much affected by parental attitudes towards drug use and other problem behavior, by social norms about drug use, or (oddly) by their own attitudes towards drinking and drug use.
- For adolescents in foster homes, transitions and mobility, family management practices and academic success have an impact – but these risk factors do not significantly affect alcohol use among youth living with their parents.
- On the other hand, family attachment makes a difference to youth living with their parents but not to foster youth (perhaps the whole concept of family attachment makes less sense in their circumstances).
- Availability, commitment to school, antisocial behavior and friend's use has a significant impact of alcohol use for both groups.

Figure 9: Bivariate Relationship Between Risk Factors and Past Month Alcohol Use

	Adolescents with Own Parents			Adolescents with Foster Parents		
Risk Factor	**Low Risk**	**High Risk**	**Stat Sig?**	**Low Risk**	**High Risk**	**Stat Sig?**
Transition and Mobility	8%	14%	No	7%	17%	Yes
Laws and Norms Favorable to Drug Use	10%	14%	No	10%	17%	No
Perceived Availability of Alcohol, Tobacco, Other Drugs, and Firearms	1%	19%	Yes	2%	21%	Yes
Family Management	10%	29%	No	12%	35%	Yes
Parental Attitudes about Antisocial Behavior	10%	22%	No	12%	22%	No
Family Attachment	5%	15%	Yes	12%	14%	No
Family History of Drug or Alcohol Use	9%	14%	No	9%	17%	No
Academic Success or Failure	13%	7%	No	15%	4%	Yes
Commitment to School	8%	22%	Yes	10%	28%	Yes
Antisocial Behavior	2%	18%	Yes	5%	19%	Yes
Personal Attitudes about Drug or Alcohol Use	13%	9%	No	13%	14%	No
Friends Use of Alcohol or Drugs	7%	20%	Yes	3%	31%	Yes

Figure 10 below shows the two-way relationships between risk factors and 30 day marijuana use for adolescents in foster care and those living with their parents.

- All the risk factors except transitions and mobility have a significant impact on the marijuana use of adolescents who live with their parents.
- For adolescents in foster homes, transitions and mobility *do* matter.
- For foster care adolescents, social norms, parental attitudes towards use and family history do not quite reach statistical significance as impacts on marijuana use. And, remarkably, their own attitudes towards use make very little difference to their use.
- Availability, family management, family attachment, commitment to school, academic success, antisocial behavior and friend's use has a significant impact of alcohol use for both groups of adolescents.

Figure 10: Bivariate Relationships Between Risk Factors and Past Month Marijuana Use

	Adolescents with Own Parents			Adolescents with Foster Parents		
Risk Factor	**Low Risk**	**High Risk**	**Stat Sig?**	**Low Risk**	**High Risk**	**Stat Sig?**
Transition and Mobility	10%	11%	No	4%	14%	Yes
Laws and Norms Favorable to Drug Use	7%	14%	Yes	7%	14%	No
Perceived Availability of Alcohol, Tobacco, Other Drugs, and Firearms	1%	16%	Yes	0%	17%	Yes
Family Management	9%	24%	Yes	9%	30%	Yes
Parental Attitudes about Antisocial Behavior	8%	21%	Yes	10%	17%	No
Family Attachment	4%	14%	Yes	5%	13%	Yes
Family History of Drug or Alcohol Use	6%	19%	Yes	7%	13%	No
Academic Success or Failure	10%	27%	Yes	12%	3%	Yes
Commitment to School	7%	22%	Yes	7%	19%	Yes
Antisocial Behavior	2%	19%	Yes	2%	16%	Yes
Personal Attitudes about Drug or Alcohol Use	8%	25%	Yes	11%	9%	No
Friends Use of Alcohol or Drugs	3%	21%	Yes	4%	21%	Yes

Figure 11 below shows the impact of each risk factor upon "current need for treatment." This diagnostic variable is described in more detail in Chapter 5. An adolescent needing treatment is either dependent or abusing according to DSM-III-R, reporting that they need treatment and using, recently had treatment and using, or using at a very high level.

- All the risk factors except transitions and mobility and personal attitudes toward drug use have a significant impact on current need for treatment for adolescents who live with their parents.
- For adolescents in foster homes, the only risk factors that seem to make a significant difference are availability, family attachment, commitment to school, antisocial behavior, and friends who use. All other relationships, while often in the expected directions, were weak. (The sample size is small here)

Figure 11: Bivariate Relationship Between Risk Factors and Current Need for Treatment

	Adolescents with Own Parents			Adolescents with Foster Parents		
Risk Factor	**Low Risk**	**High Risk**	**Stat Sig?**	**Low Risk**	**High Risk**	**Stat Sig?**
Transition and Mobility	8%	8%	No	8%	14%	No
Laws and Norms Favorable to Drug Use	4%	11%	Yes	10%	14%	No
Perceived Availability of Alcohol, Tobacco, Other Drugs, and Firearms	0%	13%	Yes	1%	19%	Yes
Family Management	6%	26%	Yes	10%	29%	No
Parental Attitudes about Antisocial Behavior	6%	14%	Yes	10%	22%	No
Family Attachment	2%	11%	Yes	5%	15%	Yes
Family History of Drug or Alcohol Use	5%	15%	Yes	9%	14%	No
Academic Success or Failure	6%	33%	Yes	13%	7%	No
Commitment to School	4%	19%	Yes	8%	22%	Yes
Antisocial Behavior	1%	17%	Yes	2%	18%	Yes
Personal Attitudes about Drug or Alcohol Use	7%	12%	No	13%	9%	No
Friends Use of Alcohol or Drugs	2%	16%	Yes	7%	20%	Yes

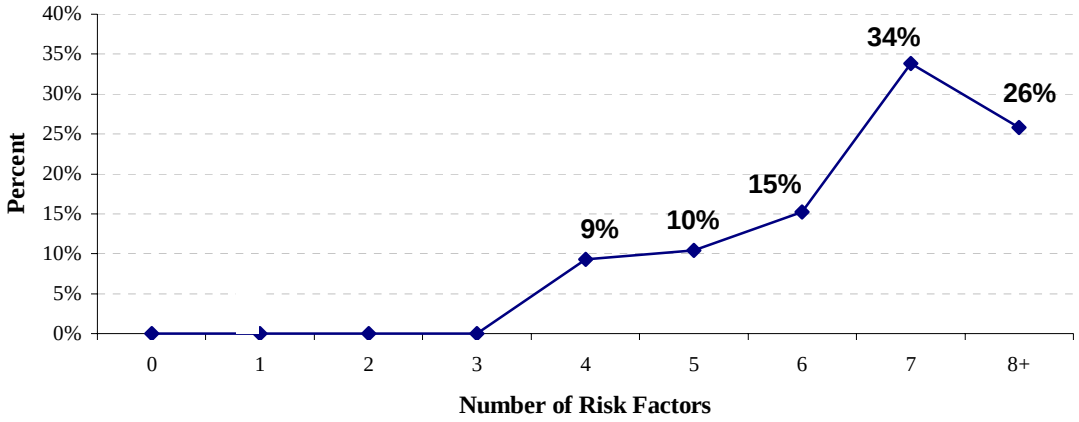
Effect of Multiple Risk Factors

Research shows that risk factors have a cumulative effect on substance use: the greater the number of risk factors affecting an adolescent, the more likely that adolescent is to evidence problem substance use. This is true for adolescents in foster care as well.

There are very few foster teens who do not have some high risk factors. There are only 5 youth in this sample with no high risk factors, 14 with one high risk factor, and 13 with two high risk factors. Each other point on the "number of risk factors scale" has between 24 and 41 youth.

Figure 12 below shows that as the number of risk factors increase, the proportion of adolescents living in foster care who currently need treatment increases also.

Figure 12: Percent with Current Need for Treatment by Number of Risk Factors Among Youth in Foster Care



CHAPTER FOUR
Alcohol/Drug Disorders, Need for and Use of Treatment

The survey instrument used in both adolescent surveys incorporated items from the Diagnostic Schedule for Children (DIS-C); a survey tool designed to assess psychiatric disorders in general population surveys. The DIS-C scales used here are based on the Diagnostic and Statistical Manual of the American Psychiatric Association, Version III-Revised (DSM-III R).

The table below shows the conceptual criteria ("symptoms") used in assessing substance abuse disorder.

DSM III R Diagnostic Criteria for Abuse and Dependence
• Substance often taken in larger amounts over a longer period than the individual intended. • Marked tolerance or markedly diminished effect with continued use of same amount. • Persistent desire or one or more unsuccessful attempts to cut down or control substance use. • Substance often taken to relieve or avoid withdrawal symptoms. • A great deal of time is spent in activities necessary to get the substance, taking the substance, or recovering from its effects. • Important social, occupational, or recreational activities given up or reduced because of substance use. • Frequent intoxication or withdrawal when expected to fulfill major role obligations or when use is physically hazardous. • Continued use despite knowledge of having persistent or recurrent social, psychological, or physical problems. • Individual is faced with characteristic withdrawal symptoms.

Definition of Six Month Abuse

An adolescent is diagnosed with "Six Month Abuse" if:

- They do not have a DSM-III-R diagnosis of substance dependence; AND
- They have ever continued substance use despite having recurrent social, occupational, psychological, or physical problems exacerbated by it OR used repeatedly in situations where use is physically hazardous; AND
- They have at least one of the above symptoms that lasted a month or more or occurred repeatedly over a longer period.

Definition of Six Month Dependence

An adolescent is diagnosed with "Six Month Dependence" if:

- They have ever had three or more of the above symptoms, AND
- At least two of those symptoms lasted a month or more or occurred repeatedly over a longer period.

Definition of Current Need for Alcohol/Drug Treatment

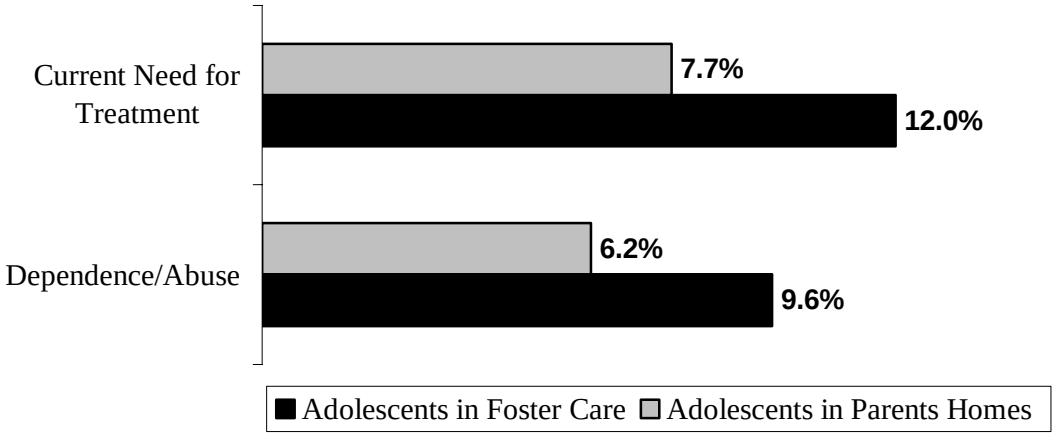
Adolescents are defined as "needing treatment" if they:

- Meet DSM III-R criteria for being dependent on or abusing alcohol or other drugs during the past six months; OR
- Said they needed alcohol/drug treatment, AND
  - Used drugs or alcohol frequently and in large amounts OR;
  - Had received treatment and were still using.

Prevalence Rates for Alcohol/Drug Disorder and Need for Treatment

Figure 13 below shows the percent of adolescents in each living situation who meet DSM-III-R criteria for alcohol or drug disorder (either dependence or abuse), or who are defined as "needing treatment." All the symptoms and other questions which define need measures refer to the six months prior to the interview. It is clear from Figure 13 that adolescents in foster care were about fifty percent more likely to need treatment during the six months prior to the interview than were adolescents living with their parents.

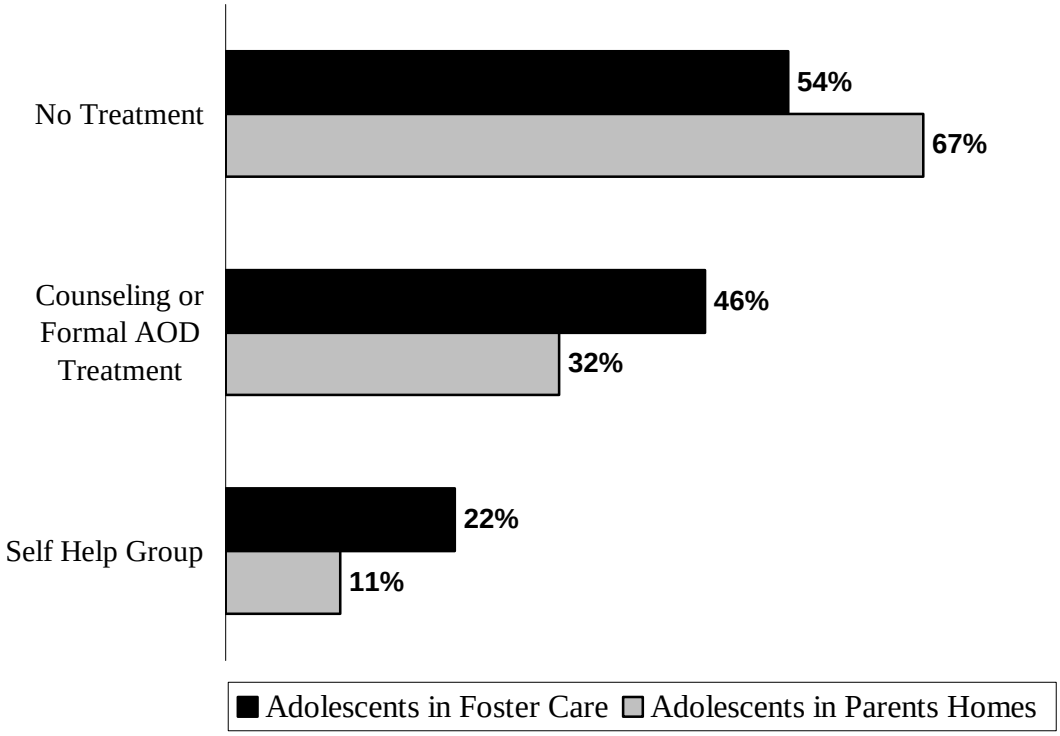
Figure 13: Six Month Prevalence of DSM-III-R Dependence and Abuse Disorders, and Current Need for Treatment



Getting Treatment to those in Need

The key question is, did those who needed alcohol and other drug treatment receive it, and were there differential rates of treatment between adolescents in foster care and those living with their parents? Figure 14 below displays different modes[3] of treatment use during the past year among those defined as having a current need for treatment, based on self-reported data.[4]

Figure 14: Percent Receiving Various Forms of Treatment for Alcohol or Other Drug Problems



No help, support or treatment: The most striking finding is related to the proportions that needed treatment and got none:

- More than half (54%) of adolescents living in foster homes who needed treatment reported receiving no treatment at all, and two out of three (67%) adolescents living in their parents' homes who needed treatment reported getting no treatment.

[3] If an adolescent both attended a self-help group (e.g., Alcoholics Anonymous or Narcotics Anonymous) and received counseling or formal AOD treatment, they are counted in each category.

[4] A related study (Kohlenberg et al, 2001, *Alcohol and Substance Use Among Adolescents in Washington State: Results from the 1998-99 Adolescent Household Survey*, Report Number 4.35, Washington State Department of Social and Health Services, Research and Data Analysis Division: Olympia Washington), reports a formal AOD 12-month treatment penetration rate of 21% for adolescents living in households who are estimated to be eligible for state-funded treatment. That penetration rate calculation uses data from the TARGET information system, as opposed to the self-reported treatment data used here.

Counseling*[5] *or formal licensed treatment: Another striking finding relates to the receipt of counseling or formal licensed treatment.

- Almost half (46%) of adolescents living in foster homes who needed treatment reported receiving counseling or formal licensed treatment, compared to only one in three (32%) adolescents living in their parents' homes.

Self-help groups:

- Adolescents living in foster homes who needed treatment were much more likely to report participating in a self-help group (22% vs. 11% of adolescents residing in households).
- All foster care adolescents who reported participating in self-help groups also reported receiving counseling or formal licensed treatment. This was also true of almost all adolescents living with their parents who reported participating in self-help groups.

Discussion

The findings on treatment need and use are dramatic. They show that adolescents in foster care are, as expected, more likely than those living with their parents to need treatment.

However, they also show that youth in foster care are **much** more likely to have received help for their substance abuse problems through all available modes – counseling or formal treatment and self-help groups. These facts may explain much of the differential rates of substance use in the more recent past – particularly the past month and past six months – between the groups; that is, they may explain why foster youth substance use has gone down relative to youth in their parents homes.

It is also clear that improvements are still needed for those children who are charges of the state. Among the foster children, less than one in two who needed treatment received any help at all.

[5] Counseling includes help from a doctor, teacher, counselor, or pastor.

CHAPTER FIVE
The Meaning of These Findings

Review of the Findings

Information presented in this report shows that adolescents in foster care are more likely than adolescents living with their parents to be at high risk for substance abuse in ***some*** dimensions. These dimensions include:

- their birth parents' substance abuse,
- their own age at first use,
- transitions and mobility,
- early occurrences of antisocial behavior, and
- personal attitudes favorable to drug use.

Also, when compared with youth living with their own parents, foster care adolescents are much more likely to have used almost any substance one can name at least once in their lives. The magnitude of the difference varies by substance: differences in alcohol and marijuana use are less pronounced than differences in other drugs.

However, when use of substances during the year just before the interview is examined, a different pattern emerges. In "use of alcohol or any other drug" the two groups are almost identical. With some substances – notably alcohol, powder cocaine and other opiates – the foster care adolescents are actually a little less likely to use than the adolescents living with their own families.

As the time frame shifts to the six months prior to the interview, adolescents in foster care are much more likely than those living in their parents' homes to have a current substance abuse disorder or current need for treatment. The definition of need for treatment includes people who have received past year treatment (since they are presumed to need follow-up care).

During the month just prior to the interview ("past thirty day use"), substance use among fostered youth continues to decline relative to substance use among youth living with their parents. Foster care adolescent use drops **below** that of household in combined use (use of alcohol or any other drug), alcohol use, and other opiate use. And "heavy" use of marijuana, alcohol and all drugs combined is much lower among adolescents in foster homes than among adolescents in their parents' homes.

Discussion and Interpretation

What has caused these changes in usage pattern? This report cannot provide definitive answers, but it can suggest some areas for further investigation.

At least two areas of social services differ among these youth: the provision of foster care itself, and the increased use of formal alcohol and other drug treatment.

One hypothesis is that foster care itself is providing protection for these youth, repairing damage and buffering them against the risks that remain. Children in foster care have been damaged and abused in their birth families, and have often been exposed to alcohol and other drugs in those families. Their lifetime use and age at first use, then, reflects those high-risk environments.

When these children enter their foster families, however, their lives change. Foster parents are selected for and trained in parenting and family management. They do not drink or use drugs to excess. Kids come first with them. They have expectations about the behavior of their foster children that do not include drug use!

This hypothesis is supported by the findings about risk factors connected to "families" (except for birth parent substance use, these questions generally refer to the family the youth lives with now). Foster youth scores on family attachment, family attitudes toward anti-social behavior, and family management practices are very similar to those of youth living with their own parents. This suggests that the foster youth are getting good parenting from their foster families, in areas which research has shown to affect substance use.

Another change that is part of foster care leads to another, complementary hypothesis. Foster care brings into play greater attention to the health care, mental health and alcohol and other drug treatment needs of the adolescents. They are more likely to be screened for treatment, and they become "priority populations" for state-funded services.

Therefore, the second hypothesis is that that the change in substance use among foster care adolescents is the result of the increases in alcohol and other drug treatment.

There are indeed differences in treatment rates (for those who needed treatment) across these two groups.

- Almost half the youth in foster care who needed treatment received it. Among youth living with their parents, only one third received any treatment at all.

These differences in treatment rates could certainly explain the pattern of past month and past year use which have been detailed in this report. However, the impact of foster care itself on the risk factors is also important. Sorting out the overlapping contribution of foster care from the increased access to treatment resources which goes along with foster care is beyond the scope of this report.

Further research is needed to explore these differences. More importantly, however, more substance abuse treatment is needed, both for foster youth and for youth living with their parents!

APPENDIX ONE: Cooperation and Response Rate Calculations

Response During Consent Process	
CON Consent (P/LG)	554
DEN Denial of Consent (P/LG)	232
URP Unable to Reach - P/LG	135
IEC-Ineligible determined during P/LG consent process	
Adolescent no longer in Foster Care	196
Over 18	17
Out-of-State	13
(IEC) Total Ineligible during F/LG Consent process	226
Wrong Numbers during consent process	*565*
Total Contacts/Attempts	*1712*
Cooperation Rate (consent): CON/(CON+DEN)	70%
IURP Eligibility Rate of the URP = URP/(URP+IEC*IURP)	37%
Adjusted (CASRO) Completion Rate: CON/(CON+DEN+URP*IURP)	66%

Response During Survey Process	
(CM) Completed Interviews	231
(PC) Partially Completed Interviews	7
(REF) Refusals to do Survey - Adolescent	62
(UI) Unable to Interview-foster HH	19
(URY) Unable to Reach - Adolescent	37
Subtotal 1	*356*
Ineligible determined during Survey with Foster Parent	
R no longer in care	26
R has run away	4
R is in Jail/Detention/Halfway House	4
R is not registered w/ Tribal Agency	3
(IES) Total Ineligible during Survey	*37*
Non-Working During Interview	
Wrong Number - R	17
Wrong Number - R has moved	50
Disconnected	18
Blocked Call	26
(NW) Non-working Subtotal	*111*
(ED) Electronic Device	4
(O) Other	4
Cooperation Rate Among Youth Contacted: (CM+PC)/(CM+PC+REF)	79%
Adjusted Completion Rate for Fielded Survey (CM+PC)/(CM+PC+REF*ER+UI*EU+URY)	72%
(EU) Eligibility of UI, UD: (CM+PC)/(CM+PC+IES+ED+O)	84%
(ER) Eligibility of REF: (REF)/(REF+IE_S)	63%
(EDEN)-Eligibility Rate Kids when P/LG Denied Consent =DEN/(DEN+IEC)	51%

Response Rates During Survey and Consent Processes Combined	
Adjusted CASRO Completion Rate for Surveys and Consent Process Combined	
(CM+PC)/(CM+PC+DEN*EDEN+REF*ER+UI*EU+URP*EURP+URY)	48%

APPENDIX TWO:

HOUSEHOLD SURVEY FOR ADOLESCENTS

Final Version 4

Substance Abuse Prevalence Project

Research and Data Analysis Division
Department of Social and Health Services
Olympia, Washington 98504-5204

February 1, 1994
Modified July, 1998

A copy of this survey may be obtained at:

http://www1.dshs.wa.gov/pdf/ms/rda/research/4/35/adolescentsurvey.pdf

or by contacting

Washington State Alcohol/Drug Clearinghouse at
1-800-662-9111 (within Washington State) or
206-725-9696 (within Seattle or outside Washington State),
by e-mail at clearinghouse@adhl.org or by writing them at
5335 Fifth Place South
Seattle, Washington 98108-0243

CSAT
Center for Substance Abuse Treatment

Substance Abuse and Mental Health Services Administration
SAMHSA

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

Research and Data Analysis Division
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