



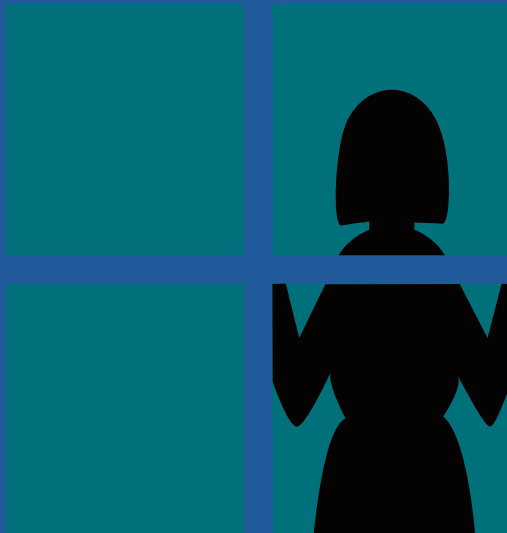
DRUG STRATEGIES 1998

Keeping Score

WOMEN AND DRUGS: LOOKING AT THE FEDERAL DRUG CONTROL BUDGET

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INTRODUCTION

Drug Strategies prepares Keeping Score annually to capture the dimensions of the nation's drug problems as well as to assess the impact of Federal drug control spending. It is intended to help Americans understand the priorities reflected in the Federal drug budget so that they can judge for themselves the effectiveness of Federal policy. Keeping Score also identifies strategies and programs that are making a difference in communities across the country.

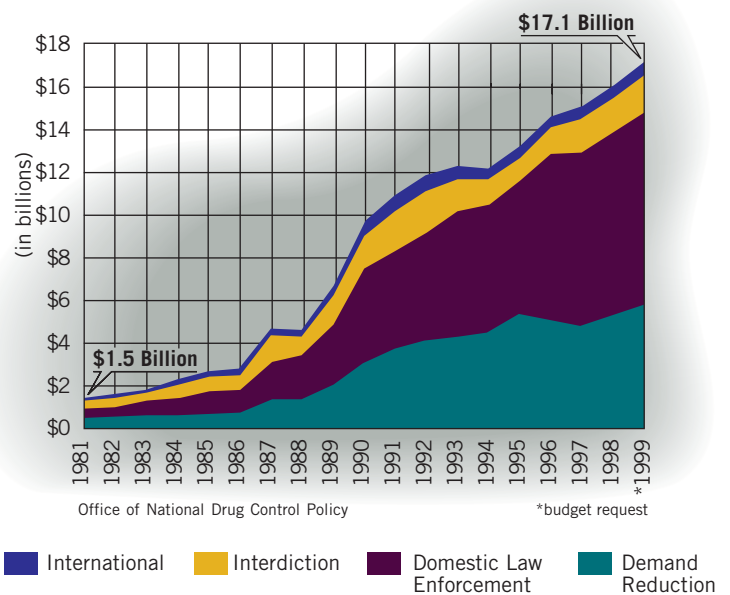
This annual review, supported by a grant from Carnegie Corporation of New York, is guided by our Board of Directors as well as a distinguished national advisory panel of experts from a wide range of disciplines, including law, medicine, criminal justice, public health and education. We are grateful for their insights and their wisdom; however, Drug Strategies is solely responsible for the content of this report.

Each year, Keeping Score examines how Federal anti-drug initiatives affect four areas that are at the heart of public concern about drugs: illicit drug use, drug-related crime, drugs in the workplace and the impact of drugs on health and health care costs. These measures provide a starting point for better public understanding of how pervasive the effects of drugs are in our society. Directly or indirectly, Americans all pay a price for this problem.

Federal drug control spending has grown ten-fold since 1981, when the total anti-drug budget was \$1.6 billion compared to \$17 billion today. Under both Republican and Democratic administrations, the need for more vigorous efforts to combat drugs has been a central theme. However, for two decades, the direction of these efforts has not changed. Enforcement, interdiction and overseas programs to cut off foreign drug supplies continue to dominate spending, accounting for two-thirds of the Federal drug budget. Although the current national drug control strategy articulates the need for much greater emphasis on demand reduction, funding priorities remain the same. In 1998, prevention, educa-

tion, treatment and research account for only one-third of the total drug budget, the same proportion as in 1991. Although occasional cocaine and marijuana use among

FEDERAL DRUG CONTROL SPENDING



adults has declined substantially during the past decade, chronic, compulsive use of both drugs is increasing. Heroin continues to grow in popularity, as does methamphetamine. All these drugs are cheaper and more readily available than ever before.

Last year, Keeping Score concentrated on children and adolescents, the group most vulnerable to drugs. Since 1991, drug use among young teens has more than doubled, and attitudes towards drug use among both teens and adults have become more accepting. The most recent National Household Survey (August 1998) reported that illicit drug use in the past year among children ages 12 to 17 increased by almost two-thirds from 1992 to 1997. If these trends continue, by the year 2002, teen drug use will reach the peak levels of the late 1970s.

Despite widespread public concern about rising teen drug use, prevention remains the lowest priority of

the Federal drug control budget. The new \$195 million anti-drug advertising campaign, launched by President Clinton in 1998 to change attitudes towards drugs, represents slightly more than one percent of total Federal anti-drug spending.

Substance abuse among women has adverse effects not only on the individuals involved but also on their children, their families and their communities, creating a host of health and social problems.

This year, Keeping Score assesses Federal drug control spending with a special focus on women. We look at alcohol, tobacco and other drug use among women from many different perspectives: public health, criminal justice, impact on children, treatment and prevention. Although the number of women and girls who use illegal drugs has risen sharply in recent years, they still represent a much smaller percentage of the nation's addicts than do men. However, if binge drinking, smoking, and abuse of prescription drugs are also considered, millions more women are affected. Several recent studies have documented this silent epidemic of alcohol and other drug abuse that afflicts an estimated 31 million American women.

Substance abuse among women has adverse effects not only on the individuals involved but also on their children, their families and their communities, creating a host of health and social problems. Pregnant women who use alcohol and other drugs risk the safe and healthy development of their unborn children. Research continues to document the effects of neonatal drug exposure, which may include increased vulnerability to drug abuse as drug-exposed infants grow to adolescence. Modern economic realities have also created unprecedented changes for women as parents, employees and commu-

nity members. In 1998, nearly 60 percent of adult women are employed, and their added responsibilities in the workplace have reduced their availability to participate in school and volunteer activities.

Women are still largely responsible for raising children. Alcohol and other drugs can exacerbate domestic violence, lead to child abuse and neglect and result in foster care placement. The General Accounting Office (GAO) estimates that substance abuse is a critical factor in at least three-quarters of the nation's 502,000 foster care cases. Millions more children are cared for by relatives under protective custody of the court because their parents—often single mothers—have serious alcohol and other drug problems.

In the past decade, arrests of girls for drug offenses have more than tripled. Women have been incarcerated in unprecedented numbers, largely for drug offenses. Many women have been implicated in drug crimes through spouses or boyfriends. They are more likely than their male counterparts to be nonviolent with no criminal history or involvement in high-level drug trafficking. The majority of women behind bars leave children under age 18 at home, according to a Department of Justice analysis of 1991 data (the most recent available). Most of their children are taken in by relatives; about 9 percent are placed in foster care. More than half of the incarcerated women are never visited by their children, often because they are imprisoned a great distance from their communities. And the children of women in prison are at increased risk for alcohol and other drug use.

Keeping Score 1998 explores the dimensions of alcohol and other drug use among women and the myriad effects this problem has on families and society. The crack cocaine epidemic that erupted in the mid-1980s riveted public attention on women addicts, largely because the drug hooked them in record numbers. Thousands of “crack babies,” born premature, underweight, and drug addicted, created new burdens on public hospitals and

outraged public opinion. Crack also destroyed many already fragile families, increased violent, erratic behavior which often led to child abuse and neglect, and turned inner-city neighborhoods into war zones. By the late 1980s, Federal drug policy began to focus on women addicts as a distinct group. Public concern about crack babies led to new prevention and treatment initiatives designed specifically for women and their children. However, as crack abuse has slowly declined in recent years, funding for women's programs has also declined.

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Yet significant problems remain. Smoking, drinking, and other drug use among adolescent girls is climbing. If current trends continue, rates of drinking among 10th grade girls will surpass rates among boys of the same age by the year 2000.

Girls are closing the gender gap, too, with regard to smoking. In 1997, one in five 8th grade girls reported smoking regularly, the same rate reported by 8th grade boys. By 12th grade, more than one in three boys and girls are regular smokers.

Marijuana use has more than doubled among young teens since 1992;

however, increases among girls have been particularly rapid. In 1992, for example, only one in seven 10th grade girls reported using marijuana in the past year, compared to one in three in 1997. Alcohol, tobacco and other drug use will follow many of these girls into adulthood, creating myriad problems for themselves, their families, their children and their communities.

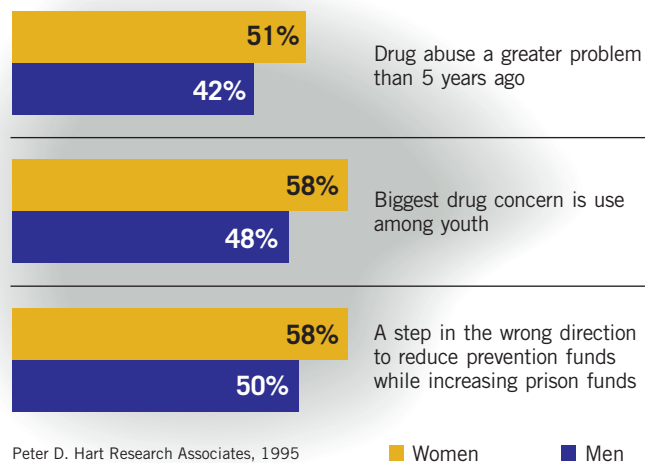
Keeping Score 1998 brings together the latest research on women and alcohol, tobacco and other drugs. We hope that this focus will help Americans understand the need to concentrate resources where they will have maximum effect in reducing substance use and abuse among girls and women. Keeping Score also highlights a number of promising programs for girls, women and their families in communities across the country. Only a few have been rigorously evaluated; when services are scarce, as they have traditionally been for women, funds for research and evaluation are rarely available. However, we believe that the experience of the past decade suggests that the programs we describe point the way for future efforts.



DRUG USE AND ATTITUDES

In a nationwide survey of American's attitudes towards drug abuse conducted in 1995 by Peter D. Hart Research Associates, women's views differed markedly from those of men. Substantially more women than men see drugs as an extremely serious problem in their communities, a problem which they believe is getting worse. They are particularly concerned about increased drug use among young people and the spread of AIDS through contaminated needles. In contrast, men express somewhat greater concern about violent and property crimes related to drugs as well as about higher health care costs from treating drug users.

DRUG PROBLEM VIEWED DIFFERENTLY BY WOMEN



Although the great majority of both men and women have confidence that treatment can reduce drug abuse, women more strongly favor putting additional funds into prevention and treatment programs. As to specific approaches to control damage due to illegal drugs, women also show greater support for needle exchange programs and testing reckless drivers for drugs.

A 1997 study of parental attitudes by the Partnership for a Drug-Free America found that mothers are more likely than fathers to talk to their children about drugs. More mothers than fathers believe that

their children can easily obtain marijuana and other drugs. Mothers are also more optimistic than fathers about their ability to reduce the drug problem.

Tracking Alcohol, Tobacco and Other Drug Use Among Women

Until quite recently, women drug users received little special focus from either researchers or public officials responsible for anti-drug programs. Twenty-five years ago, at the height of the heroin epidemic, a literature search of the topic produced very few references to women—most of them to laboratory studies involving female rats. This silence about women's drug use reflected a long history of public thinking about addiction largely in terms of men. In part, this perception was based on the lower numbers of women who sought treatment as well as the stigma attached to illicit drug use.

At the turn of the century when these drugs were legal, opiate and cocaine use was widespread among women. (Many home remedies for pain, nerves, and even dyspeptic children, included the opiate laudanum; Coca-Cola syrup relied on cocaine for its energizing qualities until 1903.) After the Harrison Narcotics Act of 1914 outlawed these drugs, women's drug use became more hidden. By the 1960s, alcohol, tranquilizers, amphetamines and other prescription drugs tended to be women's drugs of misuse. Public concern about illicit drug use and drug-related crime still concentrated on men. Prevalence estimates during that period indicated that women accounted for fewer than one in four addicts. As a result, government-funded programs which became national models for drug treatment were designed primarily for men, not women.

Even now, a decade after the emergence of the crack cocaine epidemic created millions of new addicts, many of them women, detailed information on women's drug use patterns is relatively limited. The primary sources are the National Household Survey on Drug Abuse, which interviews adolescents and adults living in households,

and the Monitoring the Future Study, which surveys junior high, high school and college students. Both surveys are conducted annually and collect extensive self-report data on alcohol, tobacco and other drug use. Although some gender breakdowns are published regularly, in-depth data are often not available without a special request and payment of a fee. Unless gender differences are specifically analyzed in published national surveys, they can easily be overlooked in the wealth of other data on drug use.

Other Federal data sources, such as the FBI's Uniform Crime Reports (UCR) and the Drug Abuse Warning Network (DAWN) also publish limited data related to women and drugs. In producing Keeping Score 1998, Drug Strategies compiled all of the data available from Federal sources, much of which has never been published before. Detailed tables are presented on pages 34-36.

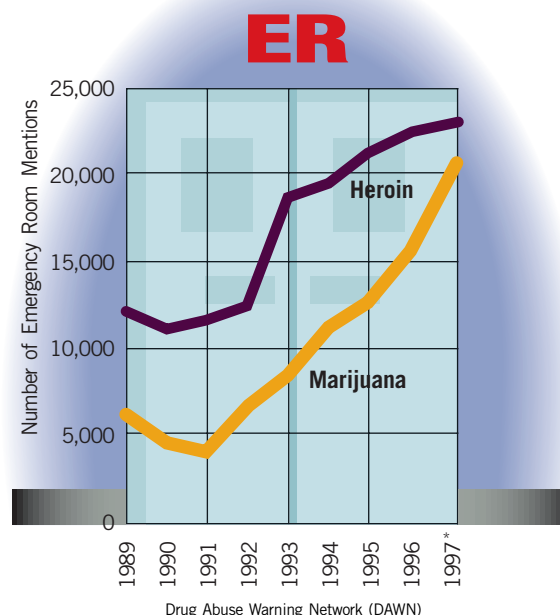
Nationwide surveys confirm that drug use is increasing among women, often more rapidly than among men. From 1992 to 1997, for example, regular (past month) use of cocaine increased slightly for women while men's cocaine use declined slightly. Nonetheless, rates of use for men were almost double those for women.

Rates of smoking and drinking among women are drawing closer to those of men. However, for binge drinking, men's rates are three times higher than women's. Smoking among men has dropped, and women are catching up. And while men still smoke more heavily, women appear to be less successful at quitting. Far more often than men, women cite stress and concerns about weight as primary reasons for smoking.

Studies in men have confirmed a genetic predisposition for alcoholism. New research on twins in Australia has found a similar genetic link in women. Women are also more vulnerable to the effects of tobacco. Lung cancer is three times more likely to develop in women than in men who smoke the same amount. At least half of

women who smoke will die of tobacco-related diseases. Racial and ethnic differences in use patterns are particularly striking among women smokers.

HEROIN AND MARIJUANA EMERGENCY ROOM VISITS INCREASING AMONG WOMEN



*Projections for full year based on ER visits reported in the first half of 1997.

Hospital emergency room visits for drug-related problems, including overdose and withdrawal, provide additional information about women's drug use patterns. The Drug Abuse Warning Network (DAWN) reports that emergency room visits by women because of drug-related problems rose 35 percent between 1990 and 1996. During that period, the number of visits related to heroin and marijuana rose more rapidly for women than for men.

Among older women, the overuse of psychoactive prescription drugs, such as tranquilizers, sedatives and anti-depressants, poses a particular threat. A recent study found that one in four women over 60 takes at least one of these drugs daily and that some of them develop serious drug problems.

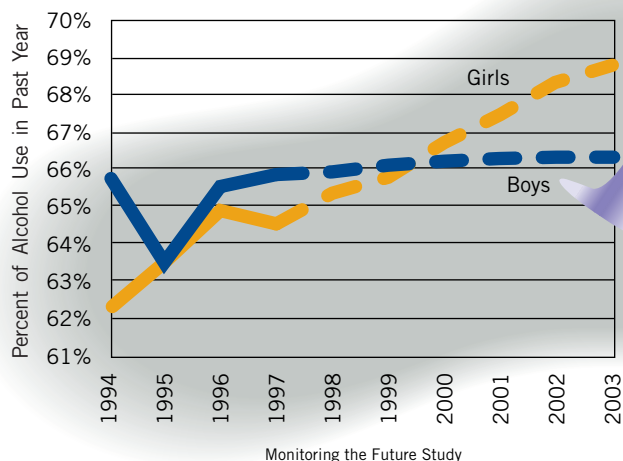
Trends Among Teenage Girls

In recent years, drugs have become an equal opportunity problem for teenagers. The Monitoring the Future Study, which surveys junior high and high school students, reports that girls are catching up with boys with regard to alcohol, tobacco and other drug use, and in some cases, already surpassing them. Young people who become involved in substance abuse often also engage in other problem behaviors, such as truancy, delinquency and early pregnancy. Effective prevention efforts promote resilience and protective factors that strengthen a teen's resistance to high risk activities.

Alcohol: The 1997 Monitoring the Future Study found that boys and girls report similar rates of drinking. Almost one half of all 8th graders acknowledge drinking in the past year, despite the fact that alcohol is illegal for minors. By 10th grade, two in three students report drinking in the past year.

Drinking rates are increasing much faster for girls than for boys. More than half of all 10th grade girls reported drinking in the past year, a 38 percent jump since 1993. If the current trend continues, by 2000, drinking rates among 10th grade girls will have surpassed those of boys.

SOON MORE 10TH GRADE GIRLS THAN BOYS WILL USE ALCOHOL



Binge drinking (defined as having five or more drinks at least once in the past two weeks) is also increasing for both boys and girls. Rates for boys still exceed those for girls; however, the gap is closing, particularly for older teens. For example, in 1997, one in four 12th grade girls reported binge drinking compared to one in five 12th grade girls in 1992—an increase of 20 percent. An even higher percentage of 12th grade girls reported having been drunk in the past month (29 percent), and this rate is climbing faster for girls than for boys.

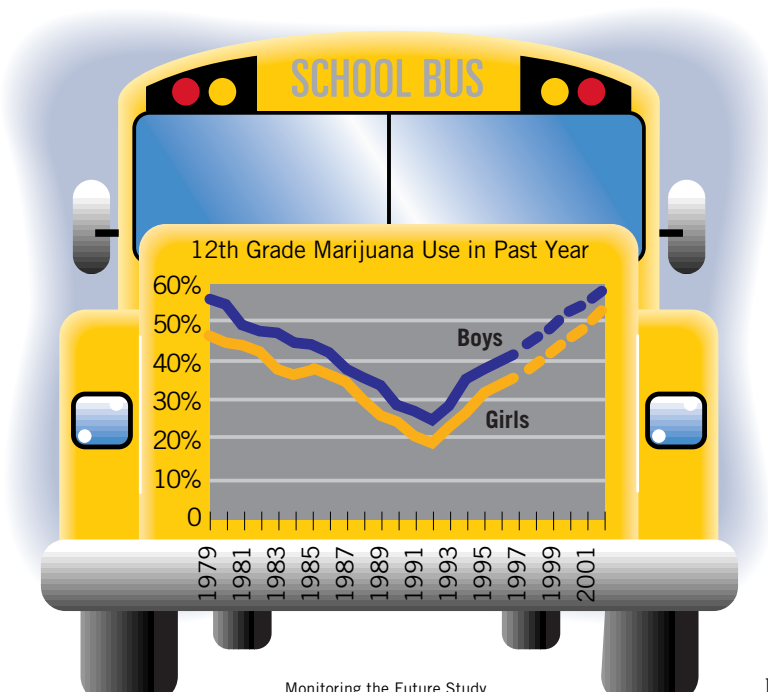
By college, women students are drinking even more heavily. The Harvard School of Public Health College Alcohol Study found that in 1997 almost 40 percent—two in five—college women reported binge drinking within two weeks prior to the survey; many binged more frequently. Men's drinking rates still surpass those of women: almost half the college men binge drink. Campus norms tend to encourage drinking, so that having five drinks in a row (the definition of binge drinking) is considered typical. This is particularly true in sorority and fraternity houses, where four in five residents report binge drinking.

The social norms that once tended to limit female drinking are apparently no longer effective constraints. This change is reflected in more accepting attitudes towards drinking. Perceptions that binge drinking carries “great risk” are falling for both boys and girls; however, the rate of decrease is much faster among girls. So, too, with regard to strong disapproval of people who binge drink: disapproval rates are falling more rapidly among girls.



Tobacco: Girls and boys report similar rates of smoking, and these rates are climbing. One in five 8th graders say they have smoked at least once in the past month. By 12th grade, almost one in four students acknowledges smoking daily. Tenth grade girls are especially vulnerable: from 1992 to 1997, regular smoking (once a month or more) among this group jumped 40

2002 MARIJUANA PROJECTIONS REACH EPIDEMIC LEVELS OF LATE 1970'S



percent. As with drinking, girls report more accepting attitudes towards smokers and lower perceptions of risk in regular smoking.

At every age, women are more likely than men to become addicted to tobacco. Smoking rates among girls vary considerably by race, with highest use among white, non-Hispanic girls and lowest among black, non-Hispanic girls.

Two major reasons why teen girls turn to smoking are concerns about weight and stress. A recent survey of more than 33,000 adolescents found that frequent

dieting increased the likelihood of smoking among girls in grades 7-12, but not among boys. Moreover, many girls identify with the images of health, slenderness, and popularity offered in cigarette advertisements. Smoking also appears to relieve stress. In the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls, two in three girls who smoked regularly said they did so because of stress. Smoking was related to depression: girls with depressive symptoms were more than twice as likely to report smoking (23 percent) than were girls with low or no symptoms (11 percent).

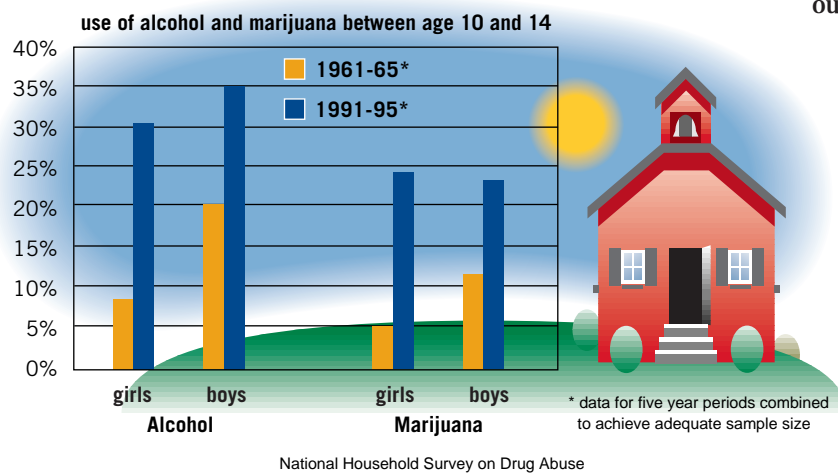
Marijuana, Cocaine and Other Drugs: Both teenage girls and boys report increases in the use of cocaine, stimulants, LSD and other illicit drugs since 1992; however, marijuana remains the dominant drug of choice among teens after alcohol and tobacco. Marijuana use has more than doubled among young teens since 1992. In 1997, one in five 8th grade girls had tried marijuana, compared to one in ten five years earlier. However, among 12th grade girls, marijuana use is increasing even faster than it is among boys. Moreover, by the year 2002, both boys' and girls' marijuana use will reach the epidemic levels of the late 1970s unless prevention efforts prove effective.

Inhalants: Inhalants—common household substances like paint thinner, dry cleaning fluid, and airplane glue—pose a particularly serious threat. Children and their parents are often not aware that inhalants can cause severe neurological damage or sudden death. In 1997, more than one in five 8th grade girls nationwide reported having tried inhalants, a 30 percent jump since 1992. Rates of use are increasing most rapidly among young girls.

Girls Are Trying Drugs at Younger Ages

In the past three decades, teens have been trying alcohol, tobacco and other drugs at increasingly younger ages. This trend, which has been especially marked among girls, has serious adverse consequences.

RATES OF EARLY USE NOW RISING FASTER THAN THIRTY YEARS AGO



The younger a child is when she begins experimenting with alcohol, tobacco and other drugs, the more likely it is that she will develop dependency in later years. Every year that drug use is prevented buys important time for personal growth and intellectual development that help children resist pressures to use. A recent study by the National Institute on Alcohol Abuse and Alcoholism reports that the younger the age of drinking onset, the greater the chance that a child will at some point in life develop alcohol problems. Adolescents who begin drinking before age 15 are four times more likely to develop alcoholism than those who begin drinking at age 21. Similar patterns are apparent with smoking. One in three girls who try cigarettes will become a regular smoker. However, if adolescents reach age 21 without smoking, it is highly unlikely that they will ever begin.

Alcohol, tobacco and other drugs can seriously harm the intellectual, social and physical development of adolescents. Progress in school can be jeopardized, both through impaired concentration and disruptive behavior. Girls who smoke put themselves at higher risk for heart disease, lung cancer and bladder cancer than non-smokers. Drinking and other drug use lower inhibitions and can lead to high-risk behavior with particularly dangerous

implications for girls and women. For

example, condom use during intercourse is

one-third less common among girls who drink more than five times a month than among girls who do not drink.

Thus, girls who drink are at increased risk for early pregnancy, HIV/AIDS, and other sexually transmitted diseases (STDs). According to a recent Harvard

School of Public Health study of alcohol and other drug use at colleges and

universities, drinking is involved in two-thirds of unsafe sexual practices and three-quarters of all date rapes.

One in three girls who try cigarettes will become a regular smoker. However, if adolescents reach age 21 without smoking, it is highly unlikely that they will ever begin.

PREVENTION PROGRAMS

Keeping Score highlights a number of prevention, treatment and criminal justice programs for girls, women and their families in communities across the country. Only a few have been rigorously evaluated; when services are scarce, as they have traditionally been for women, funds for research and evaluation are rarely available. However, based on the experience of the past decade, we believe the programs we describe point the way for future efforts.

■ ■ Nationwide. **MADD About Drunk Driving.** Three in five Americans will be involved in an alcohol-related traffic crash in their lifetime, according to the National Highway Traffic Safety Administration (NHTSA). But this startling figure will be reduced if it's up to Mother's Against Drunk Driving (MADD). Founded in 1980 by a woman whose daughter was killed by a drunk driver, MADD is dedicated to stopping drunk driving and supporting its victims. A nonprofit, grassroots organization, MADD has been instrumental in the passage of more than 2,200 anti-drunk driving laws. The group's current efforts are focused on passing a national law to lower the legal blood alcohol content limit to .08, while a long-term goal is to help NHTSA reduce alcohol-related fatalities by nearly 60 percent between 1990 and 2005. MADD administers a national hotline for drunk driving victims, regularly publishes a report on each state's effort to fight drunk driving, and organizes national public awareness campaigns, such as designated driver programs. The organization also runs youth programs that target underage drinking and impaired driving. These are just a few of MADD's many initiatives. Today MADD has more than 600 chapters and more than 3 million supporters nationwide. Financial support comes primarily from private donations, with some assistance from the U.S. Department of Transportation. For further information, call (214) 744-MADD.

■ ■ Nationwide. **Building Friendships to Fight Drugs.** As every parent of a teenager knows, friends can make or break a young person's decision to use drugs or alcohol. That's why Girls, Incorporated—a nonprofit organization dedicated to girls' well-being—created Friendly PEERsuasion. Since 1989, this innovative nationwide program has helped pre-teen and adolescent girls understand the harmful effects of drug use and negative peer pressure. At the same time, Friendly PEERsuasion helps girls build healthy friendships while developing skills in the areas of communication, leadership and stress management. An evaluation of Friendly PEERsuasion proves the program achieves results. Participants were less likely to use alcohol, tobacco and other drugs (22 percent) than nonparticipants (40 percent), and just 4 percent of participants who finished the program remained in situations where friends engaged in drug use, compared to 14 percent of nonparticipants. Friendly PEERsuasion has received funding from the Center for Substance Abuse Prevention, the Nancy Reagan Foundation, and the W.T. Grant Foundation. The program has been featured in *The Baltimore Sun*, *The Seattle Times* and *The Philadelphia Inquirer*. To learn more about this unique program for girls, call (317) 634-7546.

■ ■ Nationwide. **Empowering Girls to Resist Drugs.** Upon entering adolescence, many girls lose self-confidence, grow less physically active and perform less well in school. To counter this troubling phenomenon, which has been documented in numerous studies, the U.S. Department of Health and Human Services created Girl Power! in 1996. This national public education campaign communicates health messages that address girls' unique needs and interests, while encouraging girls aged 9-14 to make the most of their lives. Substance abuse prevention is a key emphasis. Girl Power! teaches girls from a wide range of backgrounds about the harms of alcohol, tobacco and other drugs, while helping them improve academic skills and self-confidence, excel in the arts and get involved in sports. Parents, schools, religious organizations, health providers and other adults assist in providing positive messages and health-related information. Promoted by Dominique Dawes, 1996 Olympic gymnastics gold medalist, Girl Power! is sponsored by the Substance Abuse and Mental Health Services Administration and supported by over 100 private and public partners. To learn more, call (301) 443-0373.

■ ■ Washington, DC. **Mobile Counseling for Prostitutes.** Every night, roughly 500 prostitutes work the streets of the nation's capital. Drug use runs rampant among them, and just one advocacy organization in the city addresses their needs: Helping Individual Prostitutes Survive (HIPS). Every Friday and Saturday from 10:30 p.m. until 5:00 a.m., HIPS workers travel the streets in a mobile unit, dispensing condoms, coffee, hot cocoa and on-the-spot professional counseling. In addition to referring prostitutes to drug treatment programs and other resources, HIPS provides free HIV testing (one-fourth of Washington's prostitutes are HIV-positive), a 24-hour hotline, a drop-in center, food, clothing and legal help. Each year HIPS makes contact with an estimated 3,000 prostitutes. Since the organization's creation in August 1993, HIPS has helped some 100 teenagers escape from prostitution. HIPS' support comes from a variety of sources, including churches, foundations and a 4-H grant administered by the University of the District of Columbia. A sergeant from the Metropolitan Police Department serves on HIPS' Board of Directors to ensure cooperation between the program and law enforcement. For more information, call (202) 543-5262.

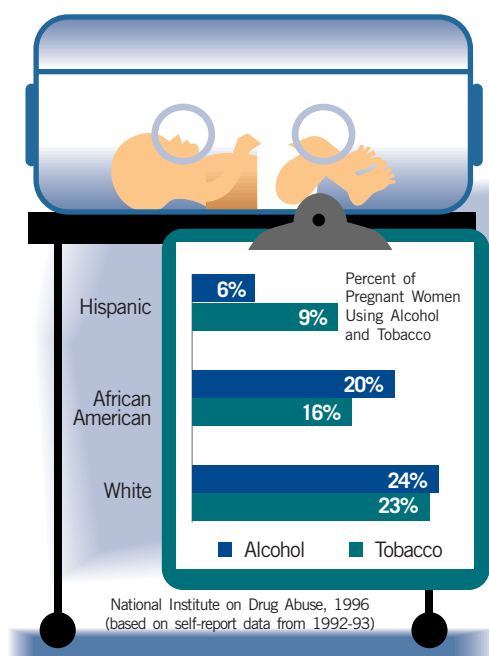
■ ■ Rural Illinois. **Drug Prevention for Pregnant Teens.** When teens visit clinics in rural Southern Illinois, there's no time for flipping through magazines in the waiting room. An innovative drug prevention program sees to it that their time is better spent. While the mothers-to-be wait to see the doctor, nurses teach them about the dangerous impacts of alcohol, tobacco and other drugs on their developing babies and their own bodies. The nurses use a curriculum that aims to reduce drug and alcohol use among pregnant teenagers and improve birth outcomes. Called the Adolescent Substance Prevention Education Network (ASPEN), the eight-module curriculum was designed in 1989 by the Shawnee/Adolescent Health Center in collaboration with Anna Rural Health, Inc. and Community Health and Emergency Service. The curriculum is clearly needed. A 1992 study of 293 pregnant teens in the Mississippi Delta region found that 24.4 percent smoke cigarettes, 20.4 percent had consumed alcohol in the previous five months, and 5.2 percent had used marijuana during the same period. Statistics like these help explain why clinics in 11 other states have purchased ASPEN's manual to help prevent drug use among their pregnant teenage patients. To learn more about ASPEN, call (618) 529-2621.

HEALTH AND WELFARE

Drug Use Among Pregnant Women

Alcohol and tobacco are the most commonly used drugs among pregnant women, according to the National Institute on Drug Abuse (NIDA). Of the approximately 4 million women who give birth every year, one in eight uses alcohol, tobacco or other drugs during the week prior to delivery. Rates of drinking and smoking are higher among pregnant white women than among pregnant black and Hispanic women.

ALCOHOL, TOBACCO USE DURING PREGNANCY MOST COMMON AMONG WHITE WOMEN



The CDC reports that drinking among pregnant women has increased dramatically in recent years: the number who consumed any alcohol climbed more than 60 percent from 1992 to 1995. At the same time, frequent drinking (at least seven drinks in one week or five on one occasion) among pregnant women grew four-fold. NIDA estimates that at least 20 percent of pregnant women smoke throughout their pregnancies.

The 1992 National Pregnancy and Health Survey found that one in 20 infants born between November 1992

and August 1993 were exposed prenatally to illicit drugs, primarily marijuana and cocaine. Many of these 222,000 babies were also exposed to tobacco and alcohol, since many women who use illegal drugs while pregnant also smoke and drink. Women substance abusers are much less likely to seek prenatal care than other pregnant women, increasing the potential risks to their unborn children.

Maternal alcohol, tobacco and other drug use can lead to devastating physical, neurological and behavioral problems for their children. The rate of infant deaths increases by 50 percent among babies whose mothers smoke during pregnancy, and the incidence of sudden infant death syndrome is at least twice as high. Respiratory infections are also more common. Smoking accounts for 20 percent of low birth weight babies.

Although the long-term impact of in utero exposure to illegal drugs, particularly cocaine, on a child's physical, mental and social well-being is as yet unknown, the short-term effects are well documented. Maternal cocaine use is linked to preterm delivery, low birth weight, neonatal seizures, and a variety of fetal physical abnormalities. It is also linked to a higher incidence of behavioral and learning disorders among preschoolers and school-age children. However, specific drug effects are often difficult to distinguish from outcomes related to other risk factors. For example, poor nutrition and lack of prenatal care are also common among cocaine and other illegal drug users, who often drink and smoke as well, all of which increase the likelihood of negative birth outcomes.

Alcohol is responsible for a high incidence of stillbirths, miscarriages and premature babies; it also damages the developing fetus. According to CDC, alcohol is the leading known preventable cause of birth defects and mental retardation. The longer a mother drinks during her pregnancy the lower the mental capacities of her infant will be. Becoming abstinent, even as late as the third trimester, can improve outcomes.

Babies born with fetal alcohol syndrome (FAS) suffer from irreversible physical and mental defects including small brains, facial abnormalities, poor coordination, short attention span and mental retardation. Children damaged to lesser degrees from alcohol exposure in utero also exhibit some of these problems. There are more than 7,000 FAS cases each year, according to the Children of Alcoholics Foundation. At least three to four times as many children are born with fetal alcohol effects. The cost of caring for infants, children, and surviving adults with FAS amounts to more than \$2 billion a year.

The toxic effects of alcohol, tobacco and other drugs on the unborn child are not limited to physical and mental damage. New research suggests that drug-exposed children are more likely to become drug users themselves. Women who smoke during pregnancy increase the likelihood that their children will smoke: this correlation is stronger for daughters than for sons. Moreover, adolescent daughters of women who smoked at least a pack a day while pregnant are seven times more likely to smoke than girls whose mothers did not smoke while pregnant.

So grave are the consequences of maternal alcohol and other drug use that some states have instituted criminal proceedings against women who use drugs during pregnancy. The large number of “crack babies” born during the crack epidemic—estimated at 200,000 to 300,000 in the late 1980s—led to criminal action in 35 states. During the past decade, more than 240 women have been criminally prosecuted for drug use during pregnancy. However, in every state except for South Carolina, appeals courts have rejected these cases as unconstitutional. In 1998, the South Carolina Supreme Court ruled that viable fetuses are protected from maternal drug use by state child abuse laws. The U.S. Supreme Court refused to block this state ruling on appeal.

Since 1992, South Carolina has prosecuted 40 women; two are serving lengthy sentences for using crack during pregnancy. State officials assert that the

threat of “doing time” is an effective deterrent to keep women from using drugs. They also note that a woman has many chances to go to treatment before she is actually prosecuted under South Carolina law. On the other hand, public health experts argue that the fear of being reported and the possibility of arrest prevent many women from seeking prenatal care or drug treatment. They also are afraid their children will be taken away by child welfare agencies.

Women substance abusers typically have multiple social, economic and health problems. Lack of accessible prenatal care compounds the damage to the unborn child. In reality, pregnant addicts often have few options other than going “cold turkey.” Drug treatment is not readily available for the majority of the nation’s drug addicts, both men and women. Comprehensive drug treatment for pregnant women, including prenatal and perinatal services, is very scarce.

Domestic Violence, Child Abuse and Neglect

Alcohol and other drug use is closely linked to domestic violence as well as sexual and physical abuse in which women are usually the victims. One in four women in America will be assaulted at some time by a domestic partner, according to the U.S. Department of Health and Human Services. More than half of all domestic violence cases nationwide involve drinking at the time of the attack. A recent study in Memphis, Tennessee, found that in 94 percent of the domestic violence calls, the assailant had used alcohol alone or in combination with cocaine, marijuana, or other drugs within six hours of the assault. About 43 percent of the victims in the Memphis study had also been using alcohol and other drugs.

Women with serious alcohol and other drug problems typically have been sexually or physically abused. Three in four women in drug treatment programs report having been assaulted by family members or partners;

incest and rape during adolescence are common experiences. Studies of crack-using mothers in New York City found that half of those who reported sexual abuse said that this abuse took place before they began using drugs.

The National Women's Study (1989) found that the severity of women's dependence on alcohol and other drugs relates directly to the numbers of violent assaults she has sustained. The greater the number of attacks, the more serious the drug problem a woman develops. This suggests that many women turn to alcohol and other drugs as a form of self-medication in very difficult circumstances. Unfortunately, no more current information is available.

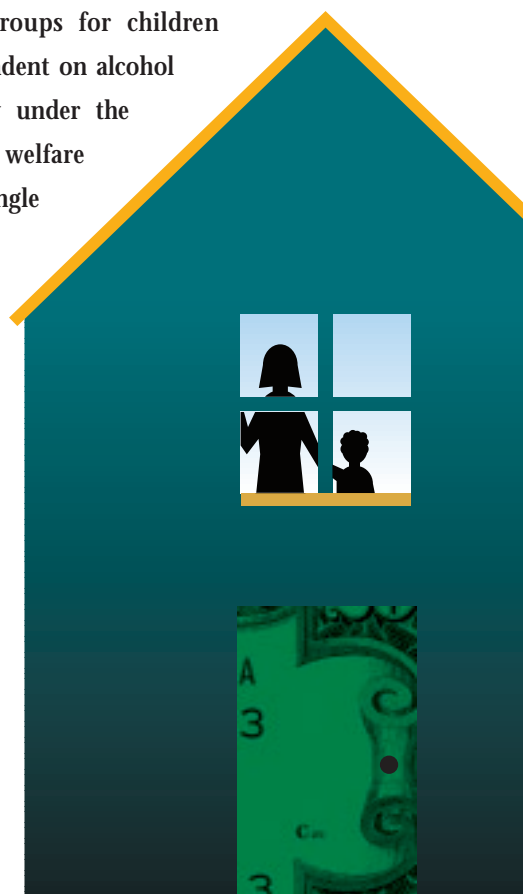
Depression and attempted suicide are common among women substance abusers. At least one in two women in drug treatment are also diagnosed with other mental disorders. For many, their depressive symptoms predated their use of alcohol and other drugs, and are often related to post-traumatic stress.

As many as 80 percent of child abuse cases are associated with alcohol and other drug use, according to the National Committee to Prevent Child Abuse. The number of child abuse and neglect cases nationwide climbed from 1.4 million in 1986, the beginning of the crack cocaine epidemic, to 2.8 million in 1993. By 1997, 502,000 children were in foster care, largely because of alcohol and other drug abuse by at least one parent. The total cost of investigations, foster care and adoption services exceeds \$5 billion annually. Foster care children from families with substance abuse problems stay in foster care for longer periods of time. They also enter foster care at younger ages than children whose families do not have substance abuse problems.

Drug testing is not yet widely used in family court: as a result, most data on the extent of substance abuse problems depend on self-reports. However, some jurisdictions are now moving to establish comprehensive drug testing in order to help determine the need for treatment. In the District of Columbia Family Court,

drug tests of families with abused and neglected children in 1995 (the most recent available data) revealed that two in three parents tested positive for cocaine, while one in seven tested positive for heroin and other opiates.

A 1998 survey by the Child Welfare League of America examined public child welfare agencies' services for pervasive substance abuse problems among the families and children they serve. Only eight of the 47 states that responded to the survey collect systematic substance abuse data on their clients; nonetheless, 80 percent of the states responding reported that parental substance abuse and poverty are the two top problems they face in their caseloads. Almost half the state agencies said they take primary responsibility for management of alcohol and other drug problems and treatment in child abuse and neglect cases. However, less than a third of the agencies said they were able to obtain treatment services for their clients. With regard to pregnant women, the agencies reported being able to find treatment help for only one in five. Very few of the agencies (4 out of 47) provide special support groups for children whose parents are dependent on alcohol and other drugs. Many under the jurisdiction of child welfare agencies are in fact single women with substance abuse problems. The severe shortage of prevention and treatment services for these women and their children—many of whom also have alcohol and other drug problems—is a major obstacle in restoring them to productive, healthy lives.



PREGNANT AND PARENTING WOMEN'S PROGRAMS

■ ■ Boston, Massachusetts. **Connecting with Women of Color.** Research shows that only a small fraction of low-income, Hispanic and black pregnant women who need substance abuse treatment receive it. Experts attribute this to a range of factors, including a lack of culturally specific substance abuse and prenatal care services and language barriers. The Mom's Project, in collaboration with Boston City Hospital, works to enhance positive birth outcomes and provide access to substance abuse treatment for women in Boston's inner city communities, where high rates of infant mortality, low birth weight, HIV/AIDS and adolescent pregnancy are common. Although substance abuse rates among pregnant women are higher in these areas than throughout the city, women rarely utilize prenatal and substance abuse treatment services. The Mom's Project reaches women through aggressive community outreach, including treatment referrals, health education, and recovery support groups; other support services such as transportation, child care, food and clothing are also provided. The program provides critical links to substance abuse treatment and other health care. The Mom's Project, originally called Programa Mamá, was first developed to reach Hispanic women in inner city Boston. For more information, call (617) 534-7411.

■ ■ Seattle, Washington. **Preventing Fetal Alcohol Syndrome.** Since 1991, the Seattle Advocacy Model has helped postpartum women protect their babies from the harmful effects of alcohol and other drugs. These women typically receive little prenatal care and may be difficult to trace after they give birth. The Seattle Advocacy Model establishes a three-year relationship between advocates and mothers beginning at delivery. The staff works with each participant through home visits. By assisting mothers with practical problems—from getting diapers to obtaining specialized medical care—advocates gradually gain their trust. The program also links women to helpful resources in the community. An evaluation of client outcomes is encouraging: 84 percent of clients have participated in treatment, and 48 percent have abstained from alcohol and other drugs for at least six months (significantly better than a control group). In addition, 97 percent of infants are receiving well-child care and are fully immunized. Initially supported by a five-year demonstration grant from the Center for Substance Abuse Prevention, the program is now funded by the state of Washington. To find out more, call (206) 543-7155.

■ ■ Baltimore, Maryland. **Acupuncture Against Addiction.** Children whose mothers are addicted to drugs often end up in foster care. But the Maternal Substance Abuse Acupuncture Program (MSAAP) in Baltimore reunites these families, using an unusual approach: intensive counseling, drug testing, parental training and acupuncture. Studies over the past 20 years indicate that acupuncture treatment can help alleviate the withdrawal symptoms associated with detoxification, and MSAAP confirms those findings. In a two-year research period, four women participating in MSAAP regained custody of 11 children, saving approximately \$88,000 in foster care costs. MSAAP also resolved four cases without foster care services, saving an additional \$100,000 per year. Client costs for the program were \$531 per month. Collaboration with local social service agencies contributes to MSAAP's success. Administered by the University of Maryland, the program was originally funded jointly by the Abell Foundation and the Open Society Institute. For more information about MSAAP, call (410) 328-6600.

■ ■ Xenia, Ohio. **Mending Broken Lives.** Desperation marks the lives of the women who find their way to the Women's Recovery Center, a four-acre facility in Southern Ohio. Many are homeless and have lost their children to foster care. Others have experienced sexual abuse, violence and drug-related crime. The Women's Recovery Center is where these broken lives begin to heal. Serving women from across Ohio, the Center treats substance abuse and other health problems. It is a welcoming place that does not turn away women who cannot pay. Those who are pregnant, HIV-positive or who use injection drugs are admitted first. Clients who give birth while in treatment may return to the Center with their babies. During their stay, the Center works to establish supportive living environments for them and when necessary places them in one of its four transitional housing units. Women stay an average of 75 days, and after they leave, a social worker follows their progress for two years. A 1997 evaluation found that two years after leaving the Center, half of the women surveyed were completely abstinent from alcohol and other drugs, and 80 percent had no new arrests. The Center receives funding from Federal, state and county governments, as well as private individuals. By the end of 1999, the Center will have room for 32 women and 12 infants. For more information, call (937) 372-4777.

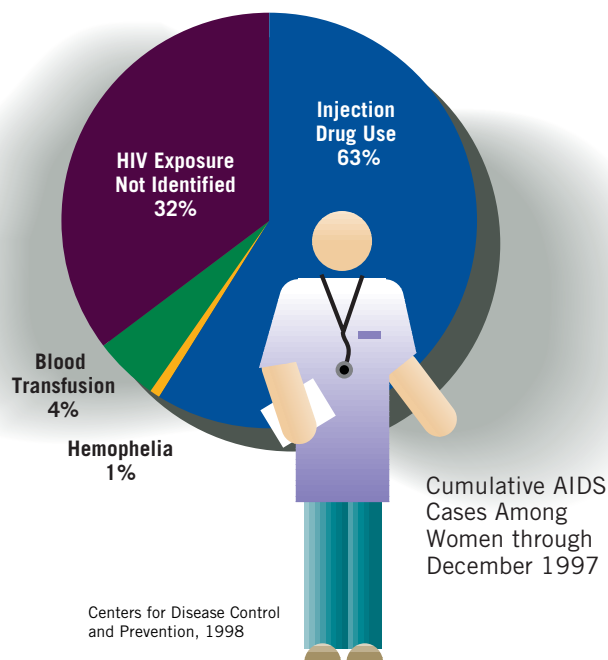
■ ■ San Francisco, California. **Where Mothers See the Light.** At the Epiphany Center for Families in Recovery, women don't have to be away from their children while recovering from substance abuse. This free outpatient drug treatment program promotes family unity by empowering women who are pregnant or who have children and helping them develop skills for a healthy life. Clients stay at the Center for an average of 18 months. Roughly half of Epiphany clients participate in STAR (Services To Accelerate Reunification), a program for addicted mothers at risk of losing their infants because of abuse or neglect. Instead of placing the children in foster homes, Child Protective Services places them in Epiphany's care so that they can be with their mothers during parenting classes and before and after treatment sessions. The Center also provides early intervention services for infants who have been exposed to drugs. As treatment progresses, clients are allowed to spend more time off-site with their children. A nurse, parenting educator and service coordinator conduct home visits for at least 12 months after family reunification. Since the Epiphany Center opened in 1991, it has served approximately 560 women, and the STAR program has reunited 73 percent of children with their mothers or relatives. According to a 1997 evaluation, parenting skills and children's behavior improve significantly during treatment. The Center receives support from the San Francisco Department of Public Health. For further information, call (415) 567-9121.

■ ■ Chicago, Illinois. **Child-Centered Treatment.** Since 1990, the Chicago Women's Treatment Center has offered a wide variety of residential and outpatient programs for women with young children, pregnant women and adolescent girls. Treatment includes individual and group therapy, vocational, parenting, social skills and literacy training, as well as medical services. In collaboration with the Chicago Board of Education, the Center offers a fully accredited pre-kindergarten with licensed teachers. Mothers work as teachers' aides, giving them a unique opportunity to contribute to their children's education. The children may remain in the pre-kindergarten for the duration of the school year even after the mother leaves treatment. The Center has the only crisis nursery in Chicago which provides care 24 hours a day to the infants and children of women undergoing medically supervised detoxification. The Center can treat 108 women and teenagers in the residential program. As a result of the Treatment Center's focus on responsible parenting, 67 drug-free babies have been born to women in treatment. The Center's focus is not only on substance abuse treatment, but also on developing child-centered treatment for families. For additional details, call (312) 850-0050.

HIV/AIDS

Women are one of the fastest growing group of new AIDS cases in the United States, largely because of drugs. In 1997, women accounted for 23 percent of AIDS cases, compared to 7 percent in 1985. Of the 98,468 women diagnosed with AIDS, two in three women contracted

INJECTION DRUG USE ACCOUNTS FOR MOST AIDS CASES AMONG WOMEN



the virus from injection drug use or sexual contact with injection drug users. In 1997, women accounted for 5,687 new drug-related AIDS cases. Healthcare costs for these new cases, not including protease inhibitors, is \$29.3 million a year. Lifetime healthcare costs for all drug-related AIDS cases in women exceeds \$6.1 billion.

Women are the fastest growing group of new HIV cases in the United States. The number of new cases among women increased 13 percent between 1993 and 1997, while decreasing 12 percent among men overall, and 17 percent among homosexual men. The increase is largely because of drugs. Among teenage girls, the num-

ber of new HIV infections is outpacing that of males the same age. Recent research reports that women infected with HIV develop AIDS more quickly than men.

In 1996, AIDS became the third leading cause of death among women of reproductive age in the United States, and the number one cause of death for black women of that age. More than half of pediatric AIDS cases are attributed to intravenous drug use by the mother or one of her sexual partners. Almost half of HIV-infected pregnant women use illicit drugs during pregnancy, primarily cocaine, and many use multiple drugs. Perinatal transmission of HIV to the fetus is nearly twice as likely among drug users than other pregnant women with HIV (27 percent vs. 16 percent). A number of factors may account for this difference. For instance, drug users may be less likely than other pregnant women to receive AZT and other HIV treatments known to reduce transmission during labor. In addition, drug users are more likely to be infected with multiple strains of the HIV virus, and are therefore harder to treat effectively.

Drug Treatment for Women and Their Children

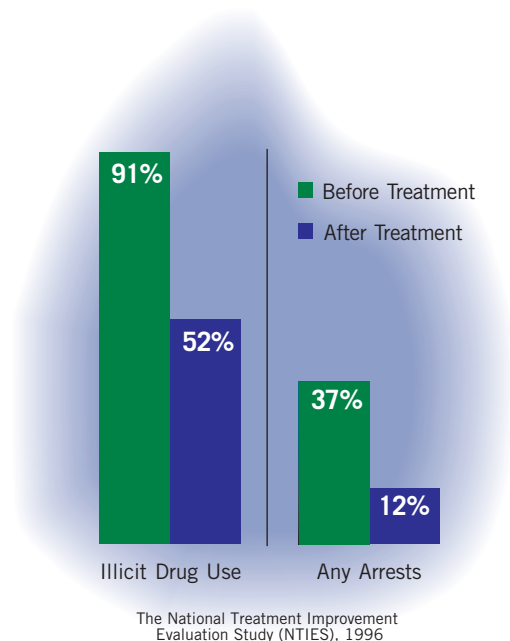
Women substance abusers account for almost one-third of the total number of people in treatment in 1996 (the most recent available data). This represents an increase since 1980, when one-quarter of all treatment clients were women. However, special services for women addicts are still very limited. The 1996 Uniform Facility Data Set found that only 6 percent of the treatment programs surveyed provided prenatal care; 4.2 percent offered perinatal care, and 11.5 percent offered child care.

A decade ago, very few programs admitted pregnant addicts, particularly for residential treatment. Although many more programs now accept pregnant addicts, child care services remain scarce. A 1993 study of outpatient

and residential programs reported that several major cities, including New York, did not provide residential treatment with child care for pregnant addicts.

The lack of specialized treatment opportunities translates into greatly increased health and social costs. According to a study in Washington State, Medicaid expenses during the first two years of life of an infant born to an untreated substance abusing woman were 1.4 times higher than those incurred for infants born to treated substance abusing women. The difference in dollar terms amounted to \$1,800 per infant. In Ohio, special treatment programs for pregnant addicts reported that

TREATMENT REDUCES DRUG USE AND ARRESTS AMONG WOMEN



1,908 drug-free babies were born from 1993-1997. The estimated cost savings was \$88.2 million with immeasurable improvements in the quality of life for the families and children involved.

The 1998 Services Research Outcomes Study, which surveyed several thousand addicts five years after their discharge from treatment, found that women respond better to treatment than men. Although rates of illicit

drug use were higher among women than among men before treatment, women reported almost twice as great a reduction as did men in the five years after treatment. The 1996 National Treatment Improvement Evaluation Study also found that women addicts showed marked improvements in the year following treatment. Among the treated group, arrests declined by two-thirds while drug use dropped by almost half.

Most drug treatment models were originally designed for male addicts. The past decade of experience suggests that certain features are particularly important in addressing women's treatment needs. Children are a central reality in the lives of most women. Unless programs provide help with children, women often cannot participate. Several treatment outcome studies have found that women who have their children with them during residential treatment are less likely to drop out and are more successful after treatment than women whose children are not with them during treatment. Moreover, having children accompany mothers in both non-residential and residential treatment provides an opportunity for women to learn more about parenting skills in a safe therapeutic setting.

Sexual and physical abuse, domestic violence and depression are widespread among women addicts; these concerns must be addressed in order to prevent relapse. Research indicates that women-only programs tend to be more effective than co-ed, primarily because women feel more able to talk openly about their experiences. Since many women entering treatment have multiple problems, programs should offer access to comprehensive services, ranging from family planning, physical and mental health care, job training, parenting and family building skills. This model departs from traditional drug treatment which concentrates almost exclusively on addressing the addictive behavior rather than the constellation of other problems that often accompany addiction in women.

SPOTLIGHT

Methadone Maintenance Treatment

Methadone maintenance, a drug treatment developed over 30 years ago, provides addicts with daily doses of a legal, synthetic narcotic (methadone) which blocks the effects of heroin. Methadone maintenance has proved effective in reducing heroin use, increasing productivity and curtailing criminal activity. In 1993, researchers at the University of Pennsylvania found that methadone treatment, when properly administered and combined with intensive counseling, reduces illicit drug use by 79 percent. Clients in methadone programs were five times less likely to become infected with HIV than addicts who were not in treatment. After extensive study, a distinguished panel of the National Academy of Sciences' Institute of Medicine recently recommended expanding methadone treatment and allowing doctors to dispense methadone directly. A 1997 review by a NIH consensus panel also called for the expansion of methadone maintenance treatment.

The National Institute on Drug Abuse reports that of the estimated 4 million drug addicts in the United States, 800,000 are addicted to heroin. There are only 115,000 methadone slots nationwide to treat this population—36,000 of them are in New York City which has an estimated 250,000 heroin addicts. In July 1998, Mayor Rudolph Giuliani proposed a new policy to eliminate methadone programs in New York City within four years, criticizing these programs as substituting one narcotic drug for another. His methadone-to-abstinence policy has met with strong objections from the scientific community. A review this year by the General Accounting Office concluded that “research provides strong evidence to support methadone maintenance as the most effective treatment for heroin addiction.” General Barry McCaffrey, Director of the White House Office of National Drug Control Policy, strongly supports expanding the availability of well-run methadone programs in both public clinics and private doctor's offices.

Views of Avram Goldstein, MD

Dr. Goldstein, a Board Member of Drug Strategies, is Professor Emeritus of Pharmacology at Stanford University, a member of the National Academy of Sciences, and an expert in the field of addiction.

Methadone Is A Medication, Not A Heroin Substitute

As a medical scientist I find it amazing that an established medical treatment can be “controversial” after 34 years. Some people, on ideological grounds, oppose all medication for the addictions. Some politicians imagine (wrongly) that they can save money by shutting down methadone clinics.

Massive scientific evidence shows that methadone, in sufficient dosage, in a well-run treatment program, allows heroin addicts to stop using heroin, to become rehabilitated, and to enter the socioeconomic mainstream.

Here I discuss the main ideologic objection to methadone—a misconception that flies in the face of what we know about the neurobiology of heroin addiction. Numerous brain chemicals send signals from one neuron to another, keeping the complex circuits in stable balance. Among these neurotransmitters are our natural endorphins, which act on special receptors in the “reward system” to produce normal feelings of satisfaction from such normal activities as eating, drinking, and sexual activity.

An addict using heroin typically injects several times a day. Each time, the endorphin receptors are flooded by this drug (actually by morphine, to which heroin is converted), and a dramatic change in

mood occurs—the heroin “high.” This lasts but a short time, to be replaced by a state of withdrawal sickness—time for another injection! These repeated spikes of heroin, swamping the endorphin receptors, drastically upset the fine-tuned regulations that keep the brain in a normal state of equilibrium.

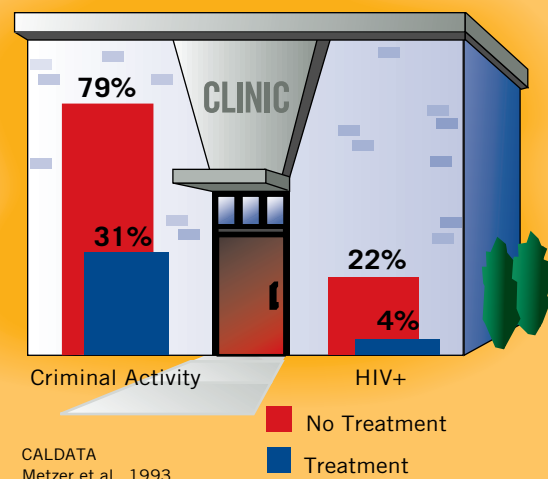
Although it is true that methadone, like heroin, occupies the endorphin receptors, the nature of the interaction is completely different. There is no methadone “high” because methadone occupies those receptors in a long-lasting stable way in contrast to the spiking pattern of intravenous heroin use. Thus, it is wrong to call methadone a heroin substitute, to say we are “just substituting another addictive opiate for heroin.” Methadone is a medication, which occupies the endorphin receptors and stabilizes the disrupted endorphin systems. Methadone is best described as an endorphin substitute, not a heroin substitute.

Can an addict under treatment with methadone ever stop taking the medication? Some can, and remain abstinent, but others relapse to heroin use. Many find it useful to continue methadone indefinitely. All physical and mental functions are normal in a methadone-maintained person. No test other than an actual methadone assay can pick out such a person. Yes, a methadone patient who abruptly stops taking methadone will suffer unpleasant withdrawal symptoms. But these are much less serious than if a diabetic stops insulin, a patient with rheumatoid arthritis stops steroids, or a patient with heart disease stops digoxin. Curiously, the pejorative term “addictive drug” is never applied to those and other instances of long-term drug therapy. In short, methadone is a safe and effective medication for a chronic relapsing disease that if untreated wreaks havoc on the addict and on

society. A special benefit is that it is taken by mouth, so intravenous drug use can cease. That means reduced risk of AIDS, hepatitis, and other serious infections spread by contaminated needles.

All this is supported by experimental and epidemiologic evidence published in the medical journals and in official government and quasi-government sources. The ultimate absurdity is the notion that stopping methadone treatment will be cost-effective. On the contrary, as addicts relapse, the costs of crime, law enforcement, and health care will inevitably escalate. Why, then, do politicians and ideologues persist in ignoring or distorting the facts?

METHADONE TREATMENT REDUCES CRIME AND HIV



FAMILY TREATMENT PROGRAMS

■ ■ Florida. **Model Services for Nearly Three Decades.** In 1970 government leaders and community members in West Central Florida mobilized to create an organization that has become a national model for substance abuse and mental health treatment and research. Known as Operation PAR, Inc., the group provides treatment, prevention and support services to people and communities affected by substance abuse, mental disorders and other problems. For drug treatment and prevention alone, Operation PAR, Inc. offers 40 programs. One of them, PAR Village, is a residential center where addicted mothers receive counseling and training in a range of areas, from parenting skills to job readiness. Many of these women have dual diagnoses, and they receive help from licensed counselors with credentials in addiction treatment, mental health and psychiatry. Daytime child care is provided during treatment, which averages nine months. Six months after completing treatment, 65 percent of participants are drug-free, 87 percent have not been arrested and 45 percent have regained custody of their children. PAR Village receives funding from the Florida Department of Children and Families, Florida Department of Corrections, and the U.S. Department of Housing and Urban Development. For more information, call (727) 570-5080.

■ ■ Littleton, Colorado. **Guiding Women Toward Self-Sufficiency.** Studies show that shouldering responsibility helps recovering substance abusers. Those with jobs are less likely to relapse than the unemployed, and women who live with their children during treatment tend to remain drug-free longer than those who do not. This evidence is the driving force behind New Directions for Families, a residential drug treatment program offered through Arapahoe House, Colorado's largest provider of alcohol and drug treatment services. Participants acquire the skills to reduce their dependence on welfare and prevent out-of-home placement for their children. Case managers conduct outreach in rural areas and reservations to attract an ethnically diverse clientele. Upon enrollment, two-thirds of the women rely on public assistance. But during the seven-month treatment program, participants must hold a job. Before discharge, each woman is required to work at least 32 hours a week for one month. The average participant is employed for three months. From April 1995 to June 1998, 105 families benefited from New Direction's drug treatment program. Preliminary findings indicate that 32 percent of the participants successfully completed the treatment requirements, and had housing and employment by the time they finished. Six months later, 70 percent of the women remained drug-free or significantly reduced their drug use. For more information on Arapahoe House or New Directions for Families, call (303) 657-3700.

■ ■ Pascua Yaqui Reservation, Arizona. **Making a PATH to Recovery.** A virtual epidemic among Native Americans, alcoholism kills those residing on reservations at nearly seven times the national alcoholism mortality rate. The Pascua Alcoholism Treatment Home (PATH), located on the Pascua Yaqui Indian reservation, is working to stem this problem, particularly among women. Using a 12-step model tailored specifically for this population, PATH's entirely female staff incorporates spiritual exploration and culturally familiar elements, such as talking circles and "sweats" for prayer and meditation. During a three-day "vision quest" in the wilderness, clients use meditation to help them envision a life free from addiction. Each client writes her life story, which forms the basis for her specialized treatment plan. After three years 50 percent of PATH clients have completed treatment. Originally funded by the Center for Substance Abuse Prevention, the program currently receives tribal support and funding through the Arizona Department of Health Service. For more information about PATH's women's programs, call (520) 883-5145. To learn more about the organization's programs for men, call (520) 883-5152.

■ ■ Greensboro, North Carolina. **Productive Prison Alternative for Mothers.** Established in the late 1970s, Summit House is an alternative correctional facility for mothers who are repeat offenders, typically convicted for drugs or drug-related property crimes. In lieu of prison, the women at Summit House participate in an 18- to 24-month residential program while retaining care of their young children. The program houses between 60 and 80 women and children. The women are responsible for paying \$90 monthly rent, maintaining their living quarters, helping with communal tasks and, most importantly, caring for their children. Because 80 percent of the women have substance abuse problems, Summit House requires all residents to complete a drug treatment program, comprised of 12-step fellowship groups, educational and vocational counseling, and aftercare services. To assist the women with childrearing, Summit House offers a number of professional services, including day care, health care, professional counseling and recreation and play therapy. The results are notable. Recidivism among participants is only 25 percent, compared to 42 percent among nonparticipants. And the cost for treating a woman at Summit House is 26 percent less than incarceration at the Correctional Institutes for Women in Raleigh. To contact Summit House, call 1-800-294-0189.

■ ■ Philadelphia, Pennsylvania. **Helping Homeless, Substance Abusing Families.** Homeless women with dependent children—the fastest-growing group of homeless in the U.S.—are up to eight times more likely to have substance abuse problems than women with housing. In 1989 Gaudenzia, a private therapeutic community, established two treatment programs to reach substance-abusing homeless women who are pregnant or have children. While many addiction services treat the homeless, Gaudenzia's programs are unique in their sole focus on homeless women. The programs, called New Image and Kindred House, provide residential and non-residential treatment in Philadelphia and surrounding communities. With support from the Philadelphia Department of Health, the programs help women build a new, healthy, peer-support network and re-establish family ties. Using a culturally sensitive approach, Gaudenzia helps women overcome addiction and social isolation while teaching them skills for employment, housing stabilization and building a supportive community. Once mothers complete residential treatment, they move to transitional housing for more individualized treatment and counseling. An outcome evaluation is currently underway. To learn more about Gaudenzia's New Image and Kindred House programs, call (212) 845-4400.

■ ■ Cleveland, Ohio. **Treating Families at Miracle Village.** A typical family living at Miracle Village in Cleveland, Ohio, consists of three children and a 29-year-old woman addicted to crack with a 15-year history of drug abuse. The family has lived in shelters or with family members or friends as a direct result of the mother's addiction. Miracle Village is a unique program which involves the entire family in residential drug treatment in an environment that fosters resilience in children. All family members participate in treatment, in educational, parenting, budgeting, and wellness classes, and in family recreational activities. The Ohio Department of Human Services maintains protective custody of the children, and women who choose to leave treatment early may not take their children. Comprehensive services continue for up to 24 months, with families moving from Miracle Village to Recovery Village after the initial treatment period. Spouses and significant others can stay in a nearby transitional housing program for the first 90 days, then join the family. Miracle Village has served 305 families with about 900 children since opening in 1992. Approximately 100 children in foster care have been reunited with their mothers. Drug-related crime in the adjacent housing project has dropped by over 45 percent since Miracle Village opened. For more information about Miracle Village, call (216) 881-2504.

SPOTLIGHT

Welfare Reform and Drug Abuse

One in five welfare recipients has an alcohol or other drug abuse problem, according to a recent study by the Legal Action Center. In contrast, the National Institute on Alcoholism and Alcohol Abuse (NIAAA) reports much lower rates of dependence, estimating that fewer than one in twelve has an alcohol or other drug problem that meets strict DSM-IV criteria. Regardless of differing estimates, experts in the field believe that substance abuse among welfare recipients is widely under-reported.

Federal welfare reform legislation adopted in 1996 (Temporary Assistance to Needy Families—TANF) has major implications for welfare recipients with substance abuse problems. Many of the affected recipients are women. Over 90 percent of the 3 million households receiving TANF funds in 1998 are headed by women. The law denies welfare benefits to anyone convicted of a drug felony since August 22, 1996, and authorizes states to drug test welfare recipients. States have wide discretion to override sections of the Federal law by passing their own regulations for Medicaid eligibility, drug testing, and the provision of cash benefits and food stamps to drug felons. In the past two years, many states have adopted stricter work requirements and shorter time limits than Congress originally envisioned in welfare reform. Publicly-funded alcohol and other drug treatment services are optional under Medicaid, and some states provide very limited services, or none at all. More than half the states have passed or plan to pass legislation to screen welfare recipients for drug problems.

The success of welfare reform will depend on providing support for mothers in a variety of areas, including substance abuse treatment. At least 400,000 of the 8 million TANF recipients require alcohol or other drug treatment. However, treatment availability is already severely limited. Many com-

plex social problems are linked to alcohol and other drug abuse, including unemployment, chronic poverty, criminal involvement, child abuse and neglect, juvenile delinquency and teen pregnancy. Without treatment, thousands of women trying to make the transition from welfare to work will face serious difficulties meeting TANF job training and employment requirements.

Without treatment, thousands of women trying to make the transition from welfare to work will face serious difficulties...

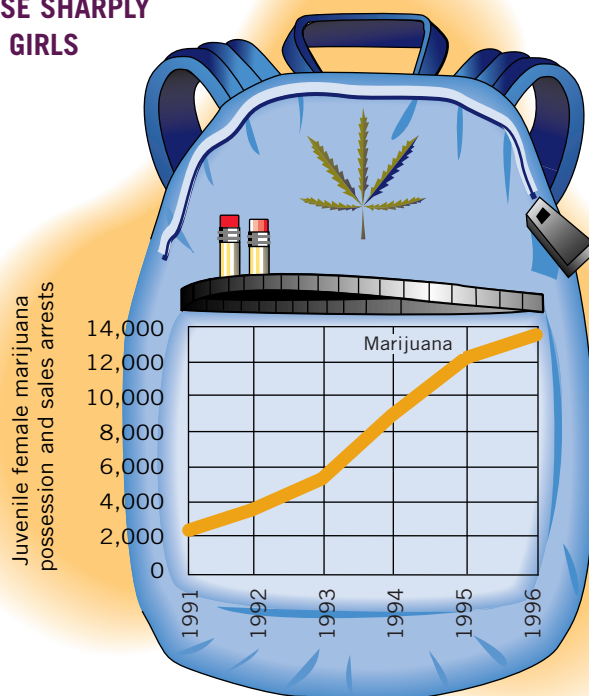
Several states are proactively dealing with this situation. In Oregon, for example, every regional welfare office is required to include plans for addressing substance abuse in their welfare-to-work programs. The Kansas welfare system (known as KanWork) is becoming a gateway to substance abuse treatment and recovery, as well as economic self-sufficiency. In a 1995 welfare-to-work program with Cessna aircraft, one-in-five KanWork participants referred to Cessna's job training program failed the company's mandatory drug screen. The experience inspired the employment preparation services to collaborate with the state's substance abuse treatment agency. The substance abuse treatment needs of welfare recipients are now integrated into Kansas's income maintenance and employment services program. Prior to the new Federal legislation, Ohio saw a 15 percent reduction in AFDC outlays for women who completed alcohol or drug treatment. Evaluations of the new welfare-to-work programs are underway in several states.

DRUGS AND CRIME

Drugs are the common denominator for women and girls in the criminal justice system. Both those who are arrested and those who are imprisoned report high rates of alcohol and other drug use, regardless of their offense. Women offenders often have multiple psychiatric problems as well as drug dependency. In Chicago, a study of pretrial female inmates in 1991-1993 found that three in four had serious alcohol and other drug problems while two in five had clinical depression, anxiety, or post-traumatic stress.

Many women inmates also have histories of sexual or physical abuse. In Federal prisons, one-fifth of women convicted of property, public order or drug offenses have such a history. The percentage of women offenders who have been physically or sexually abused is even higher among state prison inmates (56 percent of violent offenders; 37 percent of others).

MARIJUANA OFFENSES INCREASE SHARPLY AMONG GIRLS



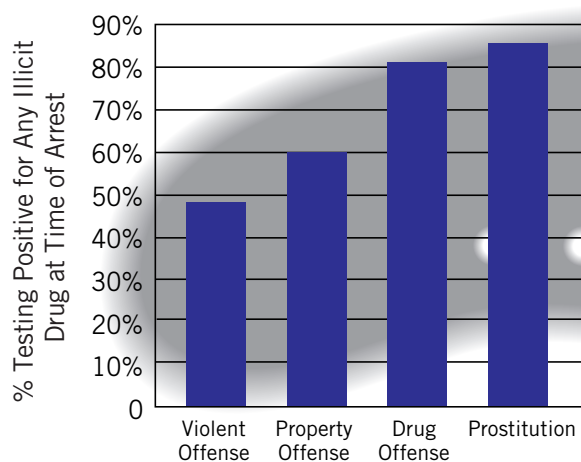
Uniform Crime Reports, FBI

Drug Arrests: Arrests of girls and women for drug offenses (sale and/or possession) climbed 42 percent from 129,895 in 1991 to 184,058 in 1996. Arrests of male drug offenders also increased during that period, although at a slower rate (36 percent). A close examination of Uniform Crime Reports data on drug offenses among women (not regularly published but obtained by Drug Strategies for this report) reveals significant patterns of arrests:

- The largest increases were in arrests for drug possession, particularly marijuana. Total female arrests for marijuana possession more than doubled from 1991 to 1996, climbing from 21,481 to 51,587. Although cocaine and opiate possession arrests in 1996 were more numerous (57,488) than those for marijuana, the rate of increase was much slower. (See detailed data tables at end of report.)
- Arrests for drug sale/manufacturing decreased slightly (from 41,604 in 1991 to 40,642 in 1996). Over half of these arrests were related to opium or cocaine.
- Drug arrests of girls have climbed dramatically. In 1996, 19,940 girls were arrested for drug offenses, compared to 6,708 in 1991. The great majority of these arrests were for possession. Marijuana possession accounted for almost two-thirds of all drug arrests of girls in 1996. Arrests for possession of heroin and/or cocaine increased 41 percent, while arrests for marijuana sales more than doubled.
- Arrests for Driving Under the Influence (DUI) rose slightly for women, while decreasing substantially for men. In 1988, women accounted for 155,473 DUI arrests, compared to 158,181 in 1996.

Drug Use Among Arrestees: Drugs are as pervasive among women as among men in the criminal justice system. From 1990 to 1997, about two-thirds of both female and male arrestees tested positive for drugs, according to the Arrestee Drug Abuse Monitoring Program. ADAM

DRUG USE PERVASIVE AMONG FEMALE ARRESTEES REGARDLESS OF OFFENSE



Arrestee Drug Abuse Monitoring Program (ADAM), 1997

(formerly known as Drug Use Forecasting) reports on arrestee drug tests in 23 cities; however, only 21 cities keep separate data for women. In 1997, Manhattan reported the highest percentage of positive tests for women—80.5 percent—compared to 37.6 percent in San Antonio, the lowest of the cities monitored.

In the great majority of the 21 ADAM cities that collect data on women, cocaine/crack was by far the most frequently reported drug. However, there were notable exceptions. In Omaha, for example, marijuana dominated the drug positives. In San Diego and San Jose, “multiple drugs” were predominant, followed closely by methamphetamine. Only in Portland and Manhattan did opiates, including heroin, account for 20 percent or more of the positive drug tests. All cities showed a substantial percentage of “multiple drugs.”

Drug Use Widespread Regardless of Offense: Most women who are arrested use illegal drugs, regardless of the crime for which they are charged. The 1997 ADAM data show that the highest percentage of women who test positive for drugs are those arrested for prostitution while drug offenses are a close second.

A U.S. Department of Justice study of state prisoners in 1991 (the latest data available) confirms

that drug abuse is widespread among women offenders.

And the rate of involvement is increasing. In 1986, fewer women inmates reported using drugs regularly before committing their offense than male inmates; however, by 1991, women surpassed men in drug use.

About one in four females (23.9 percent) said they committed their offense to get money to buy drugs, compared to 16.5 percent of male prisoners. The same study showed a different picture with regard to alcohol. Women inmates were less likely than men to have been drinking at the time of their offense.

...the highest percentage of women who test positive for drugs are those arrested for prostitution while drug offenses are a close second.

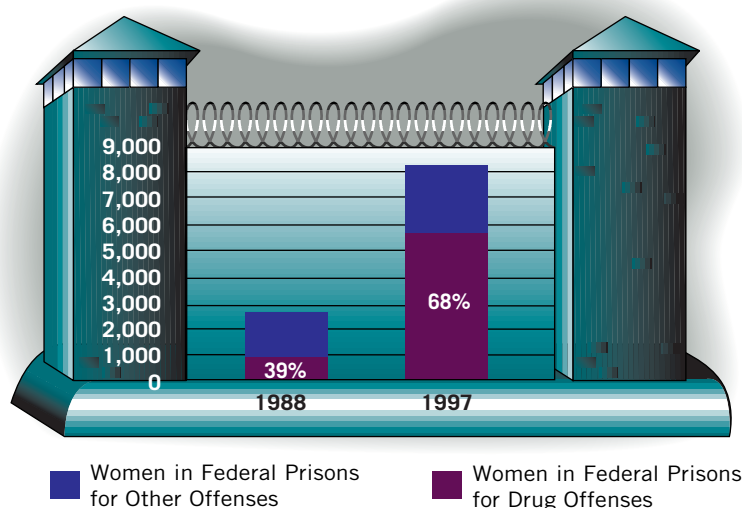
In 1997, 79,600 women were serving sentences in Federal and state prisons, six times the number incarcerated in 1980. This increase is due largely to drug offenses and to crimes which are often committed to support addiction, like theft and prostitution. In Federal prisons,



more than two-thirds of the women inmates have been incarcerated for drug offenses. Increased use of mandatory minimum sentencing laws and sentencing guidelines in Federal and state courts have contributed to these trends. Intensified enforcement efforts may also play a role in many communities.

In state prisons, one in three women inmates was serving time for drug offenses in 1991 (the most recent available data); an increase of nearly 400 percent since 1986. Women drug offenders are more likely than their male counterparts to be nonviolent with no criminal history or involvement in high-level trafficking. Many have been implicated in drug crimes through spouses or boyfriends. A 1995 study of state inmates by the

DRUG OFFENDERS ACCOUNT FOR TWO-THIRDS OF WOMEN IN FEDERAL PRISONS



Federal Bureau of Prisons

University of Maryland's Center for Substance Abuse Research (CESAR) found that 40 percent of all low-level drug offenders nationwide are women. Low-level drug offenders are more likely to have higher educational levels than other prisoners, and they are significantly less troublesome while in prison.

Many women inmates in Federal prison are serving mandatory minimum sentences, which do not allow judges to consider individual circumstances, such as pregnancy or minor children at home. Twenty years ago, nearly two-thirds of women convicted of Federal felonies were placed on probation. But in 1991, only 28 percent were given straight probation. The majority of women inmates have children under age 18.

...40 percent of all low-level drug offenders nationwide are women.

While women offenders are incarcerated, their children are cared for by relatives or placed in foster care. The Department of Justice study of state prison inmates (1991) found that one in four of these children live with their fathers, while most are cared for by grandparents or other relatives. Incarcerated mothers much prefer to have their children placed with family members, since they believe that relatives will encourage the children to visit and that they will have a better chance of getting their children back after their release. Nonetheless, more than half the mothers never received visits by their minor children, although most had telephone or mail contact.

CRIMINAL JUSTICE PROGRAMS

■ ■ Nationwide. **Mother and Child Reunions.** The number of women imprisoned for drug-related crimes is rising, and most of them have children under 18. But distance and costs often prevent these children from visiting their incarcerated mothers, and the separation can lead to anxiety and trauma for the youngsters. In November 1992, Girl Scouts USA joined forces with the Maryland Department of Corrections and a local church to develop Girl Scouts Beyond Bars, an outreach program for the daughters of female inmates. By enrolling in the program, Girl Scouts with incarcerated mothers receive transportation, organizational affiliation and emotional support—key resources for girls at risk of following in their mothers' footsteps. Girls visit their mothers inside the correctional facilities two Saturdays per month and meet with troop leaders on alternative Saturdays. They also participate in regular scouting activities, including weekly meetings and camping trips. The program, which has attracted state, local and private funding, has established 19 chapters in 15 states. In the two sites that have been evaluated, the program increased visitation rates by 31 percent. Stress and disciplinary problems among children also declined. Girl Scouts Beyond Bars has been honored with many awards, including two from the governors of Florida and Texas. To find out more, call (202) 514-6205.

■ ■ Syracuse, New York. **Training for Judges.** Few substance abuse treatment programs for women offenders meet their complex treatment needs. In recent years, innovative efforts have emerged to improve the situation through judicial education. In 1997, the National Association of Women Judges published *Judicial Considerations When Sentencing Pregnant Substance Users*. Similarly, the Center for Community Alternatives in Syracuse is designing a training curriculum to get female offenders into treatment. Funded by the U.S. Department of Justice, the Center for Community Alternatives will conduct training seminars for New York State judges, court and treatment personnel about the gender-specific needs of female offenders. The curriculum will include case studies of addicted women, following their progress from arrest through treatment. The Center will work with at least 100 judges in 1999. The project will use Crossroads (the Center's community-based drug treatment program) as a model. For more information, contact the Center for Community Alternatives at (315) 422-5638 or Crossroads at (212) 691-1911.

■ ■ California. **Cleaning Up While Doing Time.** Women behind bars in California can turn their lives around in an intensive, four- to six-month treatment program called Forever Free from Drugs and Crime. The California Department of Corrections and Department of Alcohol and Drug Programs began this program in 1991 at the California Institute for Women in Frontera. Today, women from any of the state's prisons can apply six months before their release. Forever Free participants live in a separate 240-bed housing unit and receive treatment four hours a day, five days a week. Counseling, relapse prevention, problem solving, resocialization and 12-step groups are all part of the program. Counselors also help the women with such issues as dependency, physical and sexual abuse and parenting. Upon release, the women receive after-care planning and placement in a residential or outpatient treatment program to help ensure a successful transition back into society. The program serves 320 clients a year with a dropout rate of just 7 percent. A 1996 outcome study conducted by the University of California-Los Angeles found that the longer a woman remained in Forever Free, the greater her chances of staying out of jail. The study suggested that women should be in the program for at least five months. For more information, call the California Department of Corrections' Office of Substance Abuse Programs at (916) 327-3707.

■ ■ California. **A House for Everyone.** Every day more than 600 people receive some sort of service from Walden House, a multifaceted drug treatment organization serving the San Francisco Bay area. Walden House offers services for HIV-positive women including safe housing and detoxification, residential drug treatment, group and individual therapy, nutritional counseling, and alternative healing techniques. Walden House is involved in a number of criminal justice programs, including Sister South located at the California Rehabilitation Center in Norco. The program provides substance abuse treatment to 80 women. Walden House also provides outpatient service to individuals sentenced through the Bay Area Drug Court. In 1994, more than 731 clients successfully completed treatment. For more details about Walden House or the Sister South program, call (415) 554-1100.

■ ■ Washington, DC. **Preventing Abuses Among Female Inmates.** At least half of all women in state prisons suffer from alcohol or drug abuse, and up to 88 percent are victims of domestic violence and sexual or other physical abuse. Unfortunately, female inmates are also commonly abused while inside many of these prisons. Recognizing the threat to incarcerated women, the National Women's Law Center, a nonprofit legal advocacy group, created the DC Prisoners' Legal Services Project in 1990. By empowering women with education and legal advocacy, the program helps end the cycle of drug addiction and the sexual and physical abuse of women in prison. In 1995, the DC Prisoners' Legal Services Project published a resource guide for incarcerated women, followed by a 1998 manual entitled *An End to Silence: A Women Prisoners' Handbook on Identifying and Addressing Sexual Misconduct*. The first of its kind, the handbook informs incarcerated women across the U.S. about accessible legal services and information about inappropriate sexual conduct in prisons. To date, the project has provided free legal counseling and advocacy to more than 1,500 women incarcerated by the District of Columbia Department of Corrections and the Federal Bureau of Prisons. Funding is currently being sought to continue the project. For more information, call (202) 775-0323.

■ ■ New York, New York. **Extending Hope to Imprisoned Women.** New York State has one of the largest female prison populations in the country. The majority of these women are incarcerated for drug-related, nonviolent crimes, and about 80 percent have histories of substance abuse. Through life-skills training, family reunification and transitional living, the Women's Prison Association (WPA) helps women in New York's criminal justice system transform their lives and those of their families. Of WPA's many programs, two have specifically focused on substance abuse. Until recently, the Hopper Home Alternative to Incarceration Program provided supervision and treatment services for drug-addicted women while they rebuilt connections with their children and community. Established in 1992, the program was replaced with a male-focused program in 1997. The cost of participating in Hopper Home was approximately half the cost of a jail or prison term. Ninety percent of residential clients completed the program, and nearly all of them remained drug-free. The WPA's other substance abuse program, the Sarah Powell Huntington House, continues to offer support for homeless mothers leaving incarceration. This program provides transitional housing and family reunification services, including the return of children in foster care to their mothers. To learn more about the Women's Prison Association, call (212) 674-1163.

SPOTLIGHT

Women and Drug Abuse: Court Innovations

Drug use and related crime are largely responsible for dramatic increases in the number of women in jails and prisons in recent years. Child neglect and abuse cases also involve high rates of parental alcohol and other drug abuse. Innovations in local courts throughout the country are helping to reduce drug use and recidivism.

Women's Drug Courts. Drug courts place nonviolent, drug abusing offenders into intensive court-supervised treatment instead of prison. Most of the nation's 309 drug courts treat men and women—with more than 65,000 individuals treated since 1989. In Kalamazoo, Michigan (where 84 percent of all nonviolent women offenders abuse drugs), one drug court specializes in women's treatment. The Kalamazoo Drug Court opened in 1992, and includes trauma treatment and other specialized treatment groups for female offenders. More than half of the participants complete the program, and recidivism among graduates is just 10 percent. The Brooklyn Treatment Court has a Women's Criminal Justice/Treatment Network designed to link the court with treatment and social service partners as well as conduct cross-training for program staff.

The National Association of Women Judges views drug courts as a viable alternative to prison for pregnant substance abusers. Since 1989, more than 200 drug-free babies have been born to women receiving treatment through drug courts. Reduced health care costs for these infants exceeds \$50 million. For more information, call the Drug Court Clearinghouse and Technical Assistance Project at (202) 885-2875 or the National Association for Drug Court Professionals at (703) 706-0576.

Family Drug Courts. In 1997, the Center for Substance Abuse Treatment started to develop and evaluate family drug courts for child neglect and abuse cases. The Family Drug Court Initiative can

improve access to substance abuse treatment, strengthen families, increase rates of family reunification, and improve child placement decisions. Participants are monitored through alcohol and other drug testing, frequent court appearances and court-supervised treatment. Child protective services (CPS) workers have learned to identify and refer families with substance abuse problems to the programs. In the first year, the project assembled an expert panel of judges, researchers, and representatives of the National Council of Juvenile and Family Drug Court Judges and the American Bar Association (ABA). The second year is devoted to capacity building and technical assistance to pilot evaluation sites, which include the Manhattan Family Court, the Kansas City Family Court, and the San Diego Juvenile Court. Currently, there are 16 Family Drug Courts, and another 10 being planned across the country. To learn more, contact the Family Drug Court Initiative at (202) 530-2309.

Unified Family Courts. Domestic relations, substance abuse and juvenile cases involving the same family have traditionally been heard in separate courts by different judges. Unified Family Courts aim to reduce duplication, delays and contradictory rulings related to a single family by combining traditional family and juvenile courts into one court which also provides social services to resolve family problems. The courts have jurisdiction over all family-related legal matters. In 1998, there were Unified Family Courts in 23 states, the District of Columbia and Puerto Rico. The ABA Standing Committee on Substance Abuse is working with courts in six jurisdictions to implement Unified Family Courts. In Georgia and Illinois, for example, the courts can order substance abuse counseling and rely on counselors' reports in making final determinations. In California, some counties hold family night court with staffed child care facilities in some courthouses. For details on Unified Family Courts, call the ABA at (202) 662-1785 or the ABA Steering Committee on Unmet Legal Needs of Children at (202) 662-1675.

LOOKING TO THE FUTURE

Federal Funding for Women's Programs

Funding for programs specifically designed to reduce substance abuse among women has varied in the past two decades. In 1984, Congress enacted the Alcohol Abuse, Drug Abuse and Mental Health Amendments, which included a set-aside for women. The set-aside required each state to devote 5 percent of its total block grant funding to the expansion of prevention and treatment services for women. When the crack cocaine epidemic became a dominant public concern a decade ago, women's programs became a greater priority. In 1988, the set-aside was increased to 10 percent, and states were required to emphasize funding programs for pregnant women and women with young children. Yet treatment for women was still scarce.

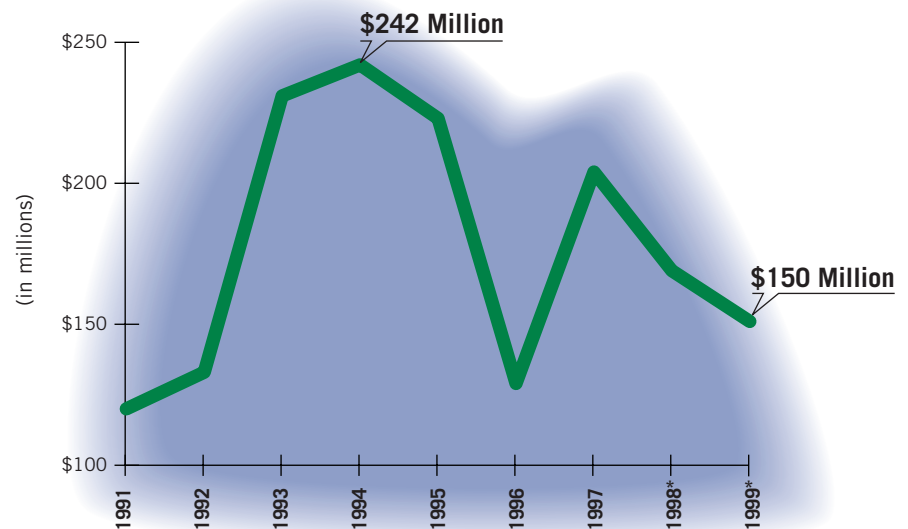
In 1991, the General Accounting Office (GAO) called for "an urgent national response" to the thousands of drug-exposed infants born each year. According to the GAO, the projected costs for medical and social services for each of these infants was \$750,000.

In 1992, Congress authorized funding for women and children's demonstration projects through the Substance Abuse and Mental Health Services Administration (SAMHSA). These included new Residential Women and Children (RWC) programs and interventions for Pregnant and Postpartum Women (PPW), for which 5 percent of SAMHSA block grant funds were reserved. Prior to this, most programs did not make a great effort to engage women in treatment, and gender-based data on treatment outcomes were relatively limited. Once SAMHSA funded a critical number of demonstration programs, studying gender-specific treatment outcomes became a real possibility. Budgets for these programs peaked in 1994 at nearly \$60 million.

Although this was a substantial increase over previous years, these funds represented less than 3 percent of SAMHSA's total budget.

Despite increasing drug abuse among women and rising numbers of women convicted of drug-related crimes, Federal funding to reduce drug problems among

SAMHSA FUNDING FOR WOMEN-SPECIFIC PROGRAMS



*Appropriated

Substance Abuse and Mental Health Services Administration (SAMHSA)

Only includes funding designated specifically for women; does not reflect funding that goes to both women and men's programs

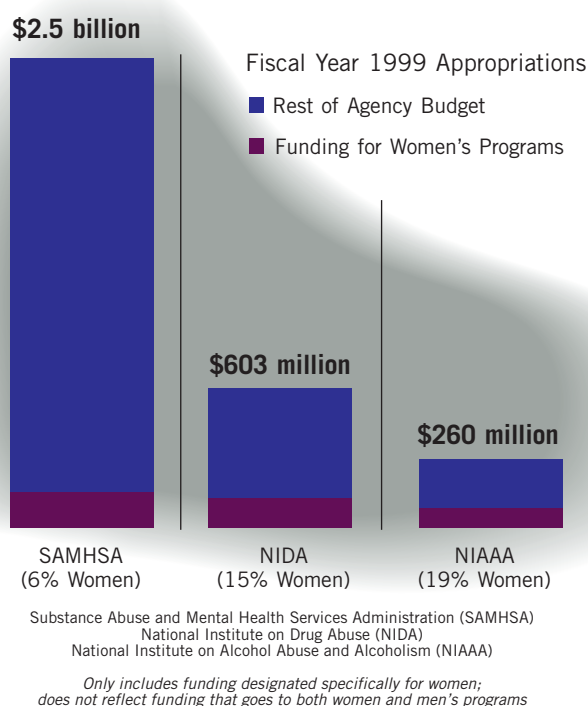
women has declined in recent years. Federal funding for treatment programs targeting pregnant and postpartum women and their children is now only 10 percent of the funding provided in 1995.

Overall SAMHSA funding designated for women has dropped by 38 percent since 1994. In 1996, SAMHSA began shifting funds from targeted treatment programs, such as RWC and PPW, to its new Knowledge Development and Application (KDA) initiative which received \$329 million in substance abuse funding in the current fiscal year (FY99). The move was a response to a Congressional requirement that SAMHSA emphasize evaluation and research in its demonstration grant

programs, rather than services for designated populations. KDA may fund some women's programs if they include rigorous evaluations that can enhance general knowledge on outcomes. However, these programs must now compete for funds with other research initiatives. About 16 percent of KDA funds (\$52 million) is allocated to women's programs.

Other Federal agencies, such as NIDA, NIAAA and the Centers for Disease Control and Prevention (CDC) have research programs designated for women. While

FUNDING FOR WOMEN-SPECIFIC PROGRAMS A SMALL PORTION OF AGENCY BUDGETS



CDC has programs related to HIV/AIDS, STDs and other communicable diseases, funds are not specifically allocated for women's initiatives. The National Cancer Institute also has no set-aside for programs targeting women smokers. Only a small percentage of the SAMHSA budget is currently directed to women's programs; however, it is important to note that states have

the option of allocating as much of their Substance Abuse Prevention and Treatment block grant funds (through SAMHSA) as they wish to women's programs. However, data on state expenditures of Federal funds for women's programs have not been compiled.

Despite the growth in the number of women arrested and imprisoned for drug crimes, the Department of Justice has few initiatives focused specifically on women. In FY 1998, Congress approved \$3.3 billion for the Office of Justice Programs (OJP), of which 8 percent was designated for programs to reduce violence against women. OJP funds correctional treatment, drug courts and other programs related to substance abuse, but none of these initiatives have set-asides for women.

Intensive Prevention Efforts Needed

The harmful effects of substance abuse often extend beyond individual life spans to impact the healthy development of future generations. In this context, the need for more effective prevention and treatment efforts is particularly urgent. Timely intervention can save lives, reduce economic costs, curtail crime and strengthen both children and families. Yet, despite the compelling data on increasing alcohol, tobacco and other drug problems among women and girls, demand reduction remains a low priority of Federal drug policy.

In 1998, two-thirds of the national drug control budget supported efforts to reduce the supplies of illicit drugs through law enforcement, interdiction and international source country programs. Only one-third went to prevention, education and treatment. These budget allocations have remained essentially unchanged since 1991, largely because Congress under both Democratic and Republican leadership continues to concentrate on supply control. The Congress in September 1998 authorized an additional \$2.6 billion for interdiction over strong Administration objections that the measure was driven

by election-year politics; \$690 million was appropriated for the current fiscal year (FY 99).

Since 1981, the Federal government has spent more than \$30 billion trying to curtail foreign drug supplies; however, drugs are cheaper and more plentiful in this country than they were a decade ago. According to the Drug Enforcement Administration, heroin now sells for less than half its 1981 street price, and heroin purity exceeds 70 percent in many cities, compared with only 7 percent in 1981. Cocaine prices have dropped by two-thirds. At the same time, consumption of heroin and cocaine has increased since 1992, while the number of “hard-core” addicts has also risen, according to Office of National Drug Control Policy figures. Teen marijuana use is climbing. If current trends continue, within three years, teen use will reach the epidemic levels of the late 1970s. As much as half of the marijuana consumed in this country comes from illegal domestic production, not foreign sources, which interdiction and source country programs do not address.

Most Americans do not realize the widespread damage that smoking, drinking and other drug use cause, even for unborn children. These threats are particularly overlooked for women, since their use rates have traditionally been significantly lower than those of men. Yet girls are rapidly catching up with boys in rates of smoking and drinking. Many will develop lifelong dependencies with devastating health and social consequences. Teens view tobacco and alcohol as less harmful than they once did. Girls are particularly vulnerable. They are more likely than boys to become addicted to tobacco and more susceptible to alcohol and tobacco related diseases. Nonetheless, the Administration’s major youth prevention initiative—an anti-drug advertising campaign projected to cost about one billion dollars over five years—does not include tobacco and alcohol. Together, both the tobacco and alcohol industries spend an estimated \$6.5 billion annually on promotion, much of it directed towards teenagers, even

though they cannot legally purchase these products. Current trends in teen smoking and drinking will not decline without intensive prevention and research efforts, as well as increased funding.

Alcohol, tobacco and other drug use during pregnancy harm not only the mother but also her unborn child. Although warning labels on tobacco and alcohol products advise that smoking and drinking during pregnancy can have adverse effects, most women are not aware of recent research findings that any use can be harmful to the fetus. Moreover, several studies suggest that children exposed to alcohol, tobacco and other drugs in utero are more likely to become drug users in adolescence. Aggressive public education campaigns will be required to inform women of the risks involved in drinking, smoking or using other drugs during pregnancy. Doctors, who are often a primary point of contact with the health care system, can play a key role in educating women about these dangers. However, most medical school curricula still give cursory attention to the implications of alcohol, tobacco and other drug use, particularly in the context of the long-term health of women and children.

Information on Women and Substance Abuse Limited

Alcohol, tobacco and other drug use patterns, health consequences and related crimes among women differ substantially from those of men. However, women are rarely a priority in Federal drug control research and policies. This oversight results in part from the lack of in-depth data on women and substance abuse. Because women still represent a relatively small portion of illicit drug users and prison inmates, trends among women addicts are often eclipsed by those of men. Moreover, much of the information on women gathered by Federal surveys and reporting systems is available only on special request. Since published data influence funding

directions as well as public perceptions of the problem, the lack of readily accessible information on women effectively excludes them from critically important policy decisions.

Expanded research in a number of key areas would generate more informed approaches to women's alcohol, tobacco and other drug problems. These areas include gender-specific risk factors for addiction and age of onset; the relationship between prostitution and drug addiction; women drug dealers supporting families; recidivism among female drug offenders; and outcomes for children of incarcerated women. Although research on pregnant addicts increased in response to the crack cocaine epidemic, this focus should be sustained even as the epidemic wanes. The long-term damage of maternal alcohol and other drug use on the fetus is only beginning to be understood.

Treatment for Women

Although significant progress has been made in the past decade in understanding the health and socioeconomic impacts of substance abuse among women, treatment is still scarce. Only a small fraction of the estimated 9 million women with serious alcohol and other drug problems are able to get treatment, unless they can afford to pay. Programs that treat pregnant addicts are even more limited, particularly those that allow women to live with their children during treatment.

Yet treatment can make an enormous difference for individual addicts, their children, and their communities. The savings in social and economic costs are also impressive. For example, the cost of incarcerating women drug offenders in Federal prisons in 1997 was \$102 million. Annual expenditures for all alcohol and other drug related foster care cases (many of whom have mothers in state and Federal prisons) reached \$1.2 billion in 1997. The lifetime health care costs for drug-related AIDS cases in women now exceeds \$6 billion.

Treatment for a mother means prevention for a child. In 1997, more than a third of pregnant drug users had young children living with them. In recent years, innovative treatment programs targeting pregnant, post-partum and parenting alcohol and other drug abusers have begun to intervene early in the lives of high risk children. These programs provide treatment as well as parent training and job readiness skills. And the results are good. Follow-up studies of women's programs funded by the Center for Substance Abuse Treatment found that two-thirds of the women were not using any drugs, including alcohol, after treatment; more than one-third of the women were employed; 86 percent of the children were living with their mothers; and less than 10 percent of the women were involved with the criminal justice system.

Treatment for a mother means prevention for a child.

Accessible treatment for women, including child care, is critically important for the success of welfare-to-work programs. Several states are currently experimenting with the concept of making treatment a requirement for continued welfare payments with the goal of improving participation in treatment and long-term employment. Unfortunately, too few programs specifically designed for women are available to meet the need.

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Alcohol, Tobacco and Other Drug Use Among Teenage Girls

8th Grade

	1991	1992	1993	1994	1995	1996	1997
Any Illicit Drug							
lifetime	17.7	20.6	22.1	24.7	27.0	29.9	27.9
annual	11.0	13.6	14.9	17.6	20.2	23.3	21.3
past month	5.4	7.1	8.1	9.6	11.9	14.1	12.3
Marijuana							
lifetime	8.3	10.3	10.8	13.7	17.2	20.5	20.2
annual	5.1	6.9	8.0	10.9	13.7	16.9	16.1
past month	2.6	3.5	4.1	6.0	8.2	10.2	8.9
Inhalants							
lifetime	16.5	16.9	19.9	19.9	22.6	22.8	22.1
annual	9.0	9.8	11.9	12.2	14.0	14.1	12.9
past month	4.7	4.9	6.0	5.8	6.6	6.6	5.8
Cocaine							
lifetime	1.8	2.2	2.1	2.9	3.4	4.0	3.2
annual	1.1	1.2	1.2	1.8	2.2	2.6	1.8
past month	0.4	0.6	0.5	0.8	1.0	1.1	0.7
Stimulants							
annual	6.9	7.9	8.8	9.3	10.3	11.3	9.6
Cigarettes							
lifetime	41.7	43.6	44.6	44.6	45.4	48.5	46.9
past month	13.1	15.9	16.3	17.9	19.0	21.1	19.5
daily	6.2	7.2	7.8	8.0	9.2	10.1	8.7
Alcohol*							
lifetime	69.5	69.2	66.8				
			44.6	54.4	52.9	53.9	53.2
annual	36.4	53.9	52.3				
			31.6	46.2	44.3	44.1	45.3
past month	23.8	25.9	26.1				
			23.7	24.7	24.0	25.8	23.9
Binge Drinking							
past 2 weeks	11.4	12.8	12.3	13.0	13.9	14.5	13.5

10th Grade

	1991	1992	1993	1994	1995	1996	1997
Any Illicit Drug							
lifetime	30.0	28.9	32.0	35.2	40.3	44.5	45.6
annual	21.1	20.1	24.0	28.0	32.5	36.3	36.8
past month	10.8	10.5	12.5	16.1	19.0	21.9	21.0
Marijuana							
lifetime	21.4	19.3	21.7	26.8	31.6	37.3	39.3
annual	15.1	13.9	16.9	21.9	26.5	31.4	32.3
past month	7.3	7.1	8.6	12.8	15.0	18.6	17.9
Inhalants							
lifetime	13.7	15.9	18.9	16.5	18.2	18.5	17.9
annual	6.6	7.5	7.7	8.6	8.9	8.9	8.2
past month	2.6	2.6	2.9	3.3	3.2	3.2	2.9
Cocaine							
lifetime	3.7	3.0	2.6	3.4	4.3	5.1	5.9
annual	2.1	1.5	1.4	2.1	2.9	3.3	4.0
past month	0.5	0.5	0.4	0.7	1.3	1.2	1.5
Stimulants							
annual	9.3	9.3	10.9	11.7	14.1	14.2	13.9
Cigarettes							
lifetime	54.8	53.0	55.7	55.0	57.2	61.3	60.3
past month	20.7	22.2	24.5	23.9	27.9	30.8	31.1
daily	12.5	12.4	14.3	13.7	16.1	18.6	18.5
Alcohol*							
lifetime	84.7	83.0	81.3				
			60.6	69.5	70.7	71.4	71.8
annual	72.9	70.9	69.6				
			46.7	62.3	63.6	64.8	64.5
past month	40.2	38.3	39.4				
			35.6	34.8	37.8	38.3	37.9
Binge Drinking							
past 2 weeks	19.5	18.6	19.3	18.7	21.5	22.3	21.7

12th Grade

	1991	1992	1993	1994	1995	1996	1997
Any Illicit Drug							
lifetime	41.6	38.2	40.0	43.1	46.1	47.3	52.2
annual	26.2	24.7	27.9	32.7	35.8	36.2	40.0
past month	14.1	12.7	15.9	18.3	20.4	21.2	23.2
Marijuana							
lifetime	32.8	28.6	31.3	33.7	37.7	40.7	46.6
annual	20.1	18.9	22.4	26.4	30.6	31.6	35.5
past month	11.2	10.2	12.6	15.1	17.2	18.2	20.3
Inhalants							
lifetime	14.3	13.1	13.9	15.0	14.6	14.2	13.9
annual	5.0	4.5	4.8	6.0	6.2	6.1	5.2
past month	1.6	1.6	1.6	1.9	2.5	2.0	1.8
Cocaine							
lifetime	6.6	5.1	4.6	4.7	4.9	5.4	7.4
annual	2.6	2.4	2.3	2.8	3.1	3.5	4.2
past month	0.9	0.9	0.9	1.1	1.3	1.4	2.4
Stimulants							
annual	7.9	6.9	8.5	9.4	8.9	8.8	10.2
Cigarettes							
lifetime	62.5	60.2	60.2	60.5	63.5	62.2	64.4
past month	27.5	26.1	28.7	29.2	32.0	32.4	35.2
daily	17.9	16.7	18.2	18.1	20.8	21.8	23.6
Alcohol*							
lifetime	88.2	87.6	87.2				
			80.1	80.2	80.1	79.4	81.5
annual	76.2	76.2	76.0				
			72.2	72.1	72.7	71.5	73.6
past month	49.0	46.8	46.7				
			43.4	45.2	47.0	46.9	48.9
Binge Drinking							
past 2 weeks	21.2	20.3	20.7	20.2	23.0	23.5	24.4
Diet Pills							
lifetime	28.1	23.2	23.3	23.7	23.9	25.5	24.5
annual	14.2	12.2	12.3	14.9	15.1	14.1	14.6
past month	5.5	5.8	4.9	6.4	5.7	5.8	7.0
Stay-Awake Pills							
lifetime	37.9	37.3	30.1	32.2	32.3	32.1	34.5
annual	22.0	20.2	17.6	20.4	20.1	18.7	21.0
past month	5.5	6.5	5.5	5.8	7.1	6.1	8.2

* Survey instrument was changed in 1993; both the old and the new versions were administered that year.

Monitoring the Future Study. National Percentages.

Drug Use Among Women

	1991	1992	1993	1994	1995	1996	1997
Any Illicit Drug							
lifetime	33.4	31.7	32.4	29.9	29.8	29.9	31.0
annual	10.9	9.0	9.6	8.4	8.7	8.0	8.4
past month	5.4	4.2	4.3	4.3	4.5	4.2	4.5
Marijuana							
lifetime	29.0	28.0	28.7	26.8	26.8	27.5	28.3
annual	7.3	6.3	6.5	5.9	6.5	6.0	6.5
past month	3.6	3.1	3.0	3.1	3.3	3.1	3.5
Cocaine							
lifetime	9.0	8.7	8.5	8.2	7.9	8.0	7.9
annual	2.0	1.7	1.3	1.1	1.2	1.3	1.4
past month	0.6	0.4	0.4	0.4	0.4	0.5	0.5
Stimulants							
lifetime	5.9	5.3	4.8	3.2	3.6	3.8	3.4
annual	1.2	0.8	0.9	0.5	0.7	0.7	0.5
past month	0.2	0.2	0.2	0.2	0.3	0.3	0.2
Tranquilizers							
lifetime	5.2	4.6	4.1	3.6	3.3	2.8	2.7
annual	1.7	1.3	1.3	1.1	0.9	1.0	0.8
past month	0.6	0.4	0.3	0.4	0.3	0.4	0.4
Cigarettes							
lifetime	68.5	65.1	66.3	67.8	66.9	66.7	66.1
annual	29.7	28.9	26.6	29.0	29.5	29.7	30.9
past month	31.1	30.0	27.3	26.0	26.8	26.7	28.2
Alcohol							
lifetime	80.6	79.0	79.8	80.3	79.2	78.8	77.5
annual	63.8	60.2	61.7	62.4	61.1	60.2	59.8
past month	45.4	41.4	43.6	47.9	45.0	43.6	45.1
Binge Drinking							
past month	8.3	7.7	7.3	8.9	8.5	8.7	8.1

National Household Survey on Drug Abuse, SAMHSA. National Percentages.

Women Arrestees Testing Positive for Drugs in Selected U.S. Cities

(Median Percentage)

	1991	1992	1993	1994	1995	1996	1997
Any Illicit Drug	64	66	68	67	66	66	67
Marijuana	11	15	17	17	18	23	24
Cocaine	47	50	46	50	48	46	45
Opiates	9	8	9	8	8	9	8
Multiple Drugs	18	20	22	21	19	21	24

Arrestee Drug Abuse Monitoring Program (ADAM),
National Institute of Justice

Arrests Among Women and Girls

(Number of Arrests in the U.S.)

		1991	1992	1993	1994	1995	1996
Drug Abuse Violations							
Total	<i>Adult</i>	123,187	141,369	141,738	160,772	175,179	164,118
	<i>Juvenile</i>	6,708	8,083	10,091	14,735	18,761	19,940
Sale/Manufacturing							
Total	<i>Adult</i>	39,482	40,444	37,597	38,035	40,049	37,498
	<i>Juvenile</i>	2,122	2,120	2,184	2,620	3,015	3,144
Opium/Cocaine	<i>Adult</i>	23,722	25,119	23,514	23,103	23,253	21,138
	<i>Juvenile</i>	1,274	1,319	1,226	1,381	1,395	1,447
Marijuana	<i>Adult</i>	6,608	7,677	6,914	6,874	7,353	7,486
	<i>Juvenile</i>	382	483	619	818	1,103	1,214
Synthetic Narcotics	<i>Adult</i>	925	999	947	1,110	1,490	1,375
	<i>Juvenile</i>	63	68	57	70	103	92
Other Drugs	<i>Adult</i>	8,227	6,649	6,222	6,948	7,953	7,499
	<i>Juvenile</i>	423	250	282	351	414	391
Possession							
Total	<i>Adult</i>	83,705	100,925	104,141	122,737	135,130	126,620
	<i>Juvenile</i>	4,586	5,963	7,907	12,115	15,746	16,796
Opium/Cocaine	<i>Adult</i>	46,203	55,706	54,482	61,482	63,371	55,424
	<i>Juvenile</i>	1,468	1,762	1,865	2,194	2,337	2,064
Marijuana	<i>Adult</i>	19,224	26,039	26,934	31,133	38,933	38,935
	<i>Juvenile</i>	2,257	3,285	4,840	8,262	11,209	12,652
Synthetic Narcotics	<i>Adult</i>	2,085	2,007	2,143	2,608	3,603	3,374
	<i>Juvenile</i>	140	135	173	240	352	328
Other Drugs	<i>Adult</i>	16,193	17,173	20,582	27,514	29,223	28,887
	<i>Juvenile</i>	721	781	1,029	1,419	1,848	1,752
Driving Under the Influence							
	<i>Adult</i>	170,188	182,523	170,219	158,734	152,763	156,056
	<i>Juvenile</i>	1,859	1,687	1,541	1,582	1,696	2,125

Uniform Crime Reports, FBI

Emergency Room Drug Mentions Among Women

	1989	1990	1991	1992	1993	1994	1995	1996
Atlanta	2,926	2,624	2,881	3,573	3,076	3,941	3,902	3,617
Baltimore	1,996	2,382	4,138	4,840	4,902	5,999	6,117	6,069
Boston	3,888	3,971	4,768	5,843	5,884	7,018	7,070	5,557
Buffalo	671	587	770	976	1,102	1,223	1,108	1,172
Chicago	6,662	6,131	6,114	7,290	7,087	8,523	9,032	9,648
Dallas	2,810	2,503	2,483	2,209	2,677	3,003	2,932	2,774
Denver	2,133	1,883	1,840	1,999	1,942	2,412	2,377	1,830
Detroit	6,304	5,204	6,191	6,745	7,607	7,037	7,382	8,005
Los Angeles	10,883	8,633	8,732	9,416	9,142	8,858	8,664	8,727
Miami	1,636	1,720	2,354	2,276	2,467	2,536	2,849	2,520
Minneapolis	2,329	2,223	2,109	2,270	2,746	2,732	2,382	2,424
New Orleans	1,755	1,748	1,716	1,823	1,502	1,722	2,205	2,154
New York	12,041	9,454	11,609	13,808	13,456	13,271	12,297	10,711
Newark	2,996	3,038	2,876	3,164	3,449	3,664	4,290	3,988
Philadelphia	8,523	7,413	6,767	8,450	8,040	7,369	7,776	8,153
Phoenix	3,110	2,901	3,484	3,539	3,478	3,582	4,024	3,541
St. Louis	2,402	2,271	2,533	2,303	2,159	2,920	2,802	3,032
San Diego	2,498	2,471	2,628	2,977	2,530	2,425	2,229	2,545
San Francisco	4,167	4,340	4,131	3,610	4,055	3,975	3,930	3,770
Seattle	2,669	2,163	2,504	3,046	3,537	4,473	3,894	3,707
Washington, DC	6,008	4,911	5,114	5,245	5,753	6,815	5,860	5,435

Drug Abuse Warning Network (DAWN)

HIV/AIDS Among Women

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
HIV*											
Total New Cases							3,870	4,837	4,195	3,983	4,362
Injection Drug User (IDU)							993	1,256	891	755	663
Sex with IDU							521	501	500	404	373
% IDU-related							39.1%	36.3%	33.2%	29.1%	23.8%
AIDS											
Total New Cases	1,690	3,296	3,626	4,890	5,730	6,255	16,824	14,081	13,764	13,820	13,105
IDU	834	1,742	1,831	2,329	2,752	2,815	7,827	5,749	5,204	4,694	4,212
Sex with IDU	303	620	733	1,062	1,239	1,321	2,833	2,032	1,921	1,911	1,475
% IDU-related	67.3%	71.7%	70.7%	69.3%	69.7%	66.1%	63.4%	55.3%	51.8%	47.8%	43.4%

* Number of new HIV cases not recorded until 1993.

HIV/AIDS Surveillance Report, Centers for Disease Control and Prevention (CDC)

SAMHSA Funding for Women (in thousands of dollars)

	1991	1992	1993	1994	1995	1996	1997	1998*	1999*
Total Agency Budget	2,843,000	1,950,756	2,038,500	2,150,000	2,200,000	1,890,000	2,180,000	2,200,000	2,300,000
Total SAMHSA Women's Budget	120,009	133,104	230,900	242,041	223,488	128,695	204,297	169,113	151,346
Percent of Agency Budget	4.2%	3.3%	11.3%	11.3%	10.2%	6.8%	9.4%	7.7%	6.1%

* Appropriated

Substance Abuse and Mental Health Services Administration

DRUG STRATEGIES

The mission of Drug Strategies is to promote more effective approaches to the nation's drug problems and to support private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement.

This project is guided by Drug Strategies' Board of Directors as well as by a distinguished panel of experts from many fields, including law, medicine, criminal justice, public health and education. We are grateful for their help and their wisdom. However, Keeping Score reflects the judgment of Drug Strategies alone, not necessarily the views of our advisors or funders.

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