A FEDERAL RESPONSE TO A HIDDEN EPIDEMIC: ALCOHOL & OTHER DRUG PROBLEMS AMONG WOMEN

A Report
from the
National Council on Alcoholism

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Supported by a grant from The Ford Foundation

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ACKNOWLEDGMENTS AND FOREWORD

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This study and report were made possible by Grant No. 865-0453 to the National Council on Alcoholism from the Ford Foundation. We express our appreciation to Shelby Miller, Program Officer, for her support and encouragement.

In many respects—both physiological and social—the effects of alcohol and other drugs are different for women than for men. Yet women's drinking and other drug usage problems may be more frequently misdiagnosed or viewed as less serious than men's. The unwillingness of many physicians, mental health professionals, police, and the courts to recognize women as alcoholics or drug addicts impedes early intervention and treatment. Reluctance to leave their children deters women from entering a rehabilitation facility. As a result, women in general are underrepresented in treatment programs everywhere. And women who are poor, who are members of minority groups, or both, are perhaps even less well represented in proportion to their needs. Often, the circumstances of their lives isolate them from social agencies that might help them.

It was in the hope of mitigating the effects of such differences that NCA undertook this study of a federal program that aims to encourage greater attention through the use of public funds to the special problems women experience with alcohol and other drugs. NCA is pleased that the Ford Foundation, in its concern to help disadvantaged groups reduce their dependency, has recognized the importance of the study.

The program that is the subject of this report operates through federal "block grants" to the 50 states, Washington, D.C. and six territorial jurisdictions. These grants regularly include funding for statewide operation of programs to combat problems with alcohol and other drugs in the general population. The program is a new, specific designation—a "set-aside" of funds for women's programs within each state's total funding for alcohol and other drug problems.

It is important to note that conclusions must be tentative because the study covered only one year of operation of the set-aside—October 1, 1984–September 30, 1985. The program should be re-examined after it has generated more experience. NCA believes, however, that this report will serve the useful purpose of indicating emerging trends and key issues for the benefit of policymakers, program directors and others concerned about the issues of women and alcohol and other drugs.

The National Council on Alcoholism was fortunate to have the expert guidance of an Advisory Committee consisting of individuals concerned about alcohol and other drug problems among women. Advisory Committee members were: Shirley Cooke, Associate Director for the Alcoholism Control Administration for the State of Maryland; Jane Delgado, Ph.D., National Executive Director for the National Coalition of Hispanic Health and Human Services Organizations; Anne Geller, M.D., Chief of the Smithers Alcoholism Center; Roberta Meyer, President and Executive Director of Roberta Meyer Communications Experiences and an NCA Board Member; Mary Morin, Executive Director of NCA Inc./Michigan; Robert Niven, M.D., Medical Director of Substance Abuse Program, Dept. of Psychiatry, Harper Hospital, immediate past Director of the National Institute on Alcohol Abuse and Alcoholism, and an NCA Board Member; and Joan Volpe, Ph.D., Director of the Alcohol and Drug Programs for Fairfax/Falls Church Community Services Board in Virginia. Anne Baxter, the Administrator of the Smithers Alcoholism Center, also assisted in the project.

We also express a special "thank you" to Katherine K. Pike for her financial assistance and overall support, interest and guidance.

NCA acknowledges with gratitude the assistance of the Ford Foundation, the Advisory Committee, and Mrs. Pike. Responsibility for the conclusions, findings and recommendations rests entirely with NCA.

NCA also thanks the respondents to the survey among State Alcohol and Drug Administrators in 45 states and three jurisdictions, persons in the eight site-visit states who generously helped with their time and insights, and numerous individuals and organizations for providing information and other assistance essential for this study.

Christine Lubinski, NCA Washington Representative, had overall supervisory responsibility for this study. Susan Galbraith, Assistant Washington Representative, performed some of the field work

and wrote several drafts of the report. Ms. Lubinski and Ms. Galbraith shouldered the bulk of the responsibility for the study throughout its course. Jo Ann Goldberg, Ph.D., a consultant to NCA, designed and administered the survey and conducted most of the field visits. Thomas Cooney assisted in final editing of the report. Jeanne Mayer was the patient and cheerful word processor for numerous drafts. George Marcelle and Lesley Lull brought this final publication to life. To all of these individuals and others who were involved, I express my admiration and appreciation.

NCA hopes that this report will raise awareness about the special problems of women, alcohol and other drugs, and will contribute to the expansion of programs to meet their needs.

Thomas V. Seessel
Executive Director
National Council on Alcoholism
August 1987

SUMMARY

Purpose of the Study

In 1984, Congress enacted Public Law 98-509, which included a provision that became known as the "five percent women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant." The set-aside provision aimed to increase services for women with alcohol and other drug problems by expanding existing prevention and treatment services and developing new programs. It required each state to devote five percent of its total ADMS block grant funds to these purposes. Set-aside funds in all states came to a grand total of $63.5 million in 1985, 1986 and 1987. The National Council on Alcoholism (NCA), an independent nonprofit organization, conducted a nationwide study in 1986 and early 1987 to learn how states responded to the set-aside mandate in its first full year of operation, October 1, 1984 through September 30, 1985 (fiscal year 1985). This report presents the results of that study. It is based on a written survey to which 45 states and three jurisdictions—Washington, D.C., Puerto Rico and the Virgin Islands—responded, and on field visits by NCA researchers to eight states chosen for their variety of geographical, economic, demographic, and administrative characteristics.

Method

For the written survey, NCA staff and consultants designed a questionnaire and mailed it to all state alcohol and drug program directors in August 1986. The survey asked how each state responded in fiscal year 1985 to the legislative mandate, what types of programs it implemented and what benefits and problems it associated with the set-aside. It also asked for demographics on the women served by block grant funds, including minority characteristics and economic status. The survey findings reported throughout this document summarize the replies of the alcohol and drug program administrators who responded.

NCA staff and a consultant conducted three or more site visits in each of eight states—Alabama, California, Maine, Michigan, Nebraska, New York, Texas and Virginia—to observe set-aside programs and interview their administrators and directors. Staff of the state alcohol and drug authorities responsible for administering set-aside funds were also interviewed. In choosing the sites to visit, the observers gave priority to programs designed to address the prevention or treatment needs of minority and low-income women.

Conclusion: The Effects of the Legislation

The NCA study shows that the women's set-aside has achieved its goal "to initiate and expand alcohol and drug abuse services for women" by bringing to life a broad range of new programs and services of prevention, education and treatment. A few states funded over 20 new programs, and all made a serious attempt to respond to the spirit of the legislation. Benefits reported by the states included increased availability of programs and services, increased awareness of the needs of women who have problems with alcohol and other drugs, and increased assessment of, and planning to meet, women's treatment needs. The states also reported some problems with the set-aside. Because it did not add any new funds and because the ADMS block grant appropriation level remained constant during the first year, the set-aside tended to reduce services for other populations as well as cost-of-living increases for other programs, and to shift resources from other priorities for which states and local authorities had planned. This effect was compounded by the fact that enactment of the federal legislation came after the states already had their planning processes in place. The legislation also increased administrative costs by adding new planning and reporting requirements.

States and jurisdictions also reported a number of factors that, if they were present, enhanced their responses to the set-aside requirements. Among these were: a commitment on the part of the state authority to the development of programs for women; a strong constituency group supportive of women's programming; and whether the state had sustained its general ADMS block grant funding level under a concurrent but unrelated change in the funding formula.

In general the set-aside has ignited a new interest and excitement in the states among treatment providers, state authorities and community-based organizations. Most importantly, the set-aside has made recovery a possibility and a reality for greater numbers of alcoholic and drug-addicted women across America and brought a new sense of hope to these women and their families.

I. INTRODUCTION

Need for the Study

A few miles from the downtown center of Omaha, Nebraska, on a commercial strip bordered by worn and sometimes abandoned storefront businesses, stands the North Omaha Alcoholism Counseling Program (NOAC). During its twelve years of operation, it has served as a haven for local residents who are struggling with alcoholism and other drug addictions. In November 1985, a new treatment program opened at NOAC: Women's Partial Care—an alcohol and drug outpatient treatment service for women. Sherita Richardson, coordinator of the program, says, "[We are trying] to put women's lives back together again. They are unemployed... [some have children] in foster care. They are on parole or probation... they are required [by the courts] to be in partial care." Joyce Harrison, program director, calls Women's Partial Care an alternative to inpatient treatment. Thirty-six women have gone through this eight-week program of group meetings and lectures. Ms. Richardson pointed out an important benefit of this program: "They're less fearful of losing their children when they come to a day program."

In Oakland, California, the drop-in program of the Orchid Women's Recovery Center is located on a busy street in the heart of the city. Women who have problems with alcohol are free to stop in. They are welcome to bring their children. According to Liz Scaags, the program director, Orchid is a self-help program. Meetings focus on the concerns of women. Staff provide support and referrals for medical, legal and social services. The program is designed to "make it as easy as possible for women to come in." Most of its clients are local Black and Hispanic women. Its staff is composed of minority women all of whom have recovered from alcoholism or addiction to other drugs. Orchid stands for Option, Recovery, Choices, Hidden, In-Between, Denial. In a residential area about seven miles from the drop-in center, the program recently opened a small recovery home that provides a supportive and drug-free environment for alcoholic women.

Women's Partial Care in Omaha and the Orchid Recovery Center in Oakland are two examples of the many programs that have resulted since 1985 from Congressional legislation that aimed to increase services for women who have alcohol and other drug problems. Public Law 98-509, the Alcohol Abuse, Drug Abuse and Mental Health Amendments of 1984, included a special nationwide "set-aside" of $63.5 million of federal block grant funds for use over the next three years to expand existing services and develop new programs for women.

Alcoholism is a chronic, progressive and potentially fatal disease characterized by tolerance and physical dependency that may be accompanied by pathological organ changes. It is one of the most serious public health problems in the United States today. An estimated 10.6 million adult Americans have one or more symptoms of the disease. Alcoholism is treatable, and its treatment saves not only lives, but money, especially in total health care costs. A study of 20 million claim records between 1980 and 1983 showed that alcoholic families used health care services and incurred costs at twice the rate of similar families with no known alcoholic members. For the average alcoholic, the cost of alcoholism treatment was estimated to be offset by reductions in other health care costs within two to three years (see Appendix A for additional information on alcohol and other drug-related problems in the U.S.).

There are no precise data on the number of women who are alcoholic; estimates range from 25 to 50 percent of the alcoholic population. In 1983, 30 percent of the members of Alcoholics Anonymous were women. But in proportion to these figures, it appears that women continue to be under-represented in most publicly-funded alcoholism treatment programs. Nationwide, they constitute less than 20 percent of all clients in such programs. Figures for women in privately owned facilities are not available.

Alcoholism and other drug addictions have been traditionally viewed as male problems. According to former first lady Betty Ford, "Alcoholism has always been a macho disease... when he comes of age, a man is supposed to learn to drink, and he can drink a lot... and still get his job done. A woman can't have a small child and be drinking." Researchers and clinicians point out that women with alcohol and other drug-related problems are stigmatized. Their problem is frequently misdiagnosed by physicians, mental health professionals, police and the courts. A 1986 study of 242 women patients in two middle class private gynecological practices in and near Boston found

that 12 percent of the women who came for routine care and 21 percent of the PMS patients satisfied a diagnosis of alcohol abuse or alcohol dependence. Sheila B. Blume, M.D., a leading expert on women and alcoholism and a member of the NCA board of directors reviewed this study and concluded that the "hidden" female alcoholics are not hidden, but in fact "easily found... in their doctors' offices."

On October 19, 1984, President Reagan signed Public Law 98-509, the Alcohol Abuse, Drug Abuse and Mental Health Amendments of 1984. This three-year legislation included a provision to address the prevention and treatment needs of alcohol and other drug-dependent women. It mandated that states spend five percent of their total block grant award for new and expanded services for women in each of the fiscal years covered by the bill. This bill was enacted by Congress and signed by the President over the opposition of individual state directors as well as of the National Association of State Alcohol and Drug Abuse Directors, and with little active support from most of the other organizations in the alcohol and drug field. The reauthorization legislation was accompanied by the passage of funding legislation for the ADMS block grant, which provided no funding increase, either inflationary or real, despite the new initiatives for women.

The NCA study reported here is the only non-governmental national study to date of the women's set-aside. Two government agencies are conducting studies, but these will be considerably more limited in scope than the NCA study. The Secretary of Health and Human Services is required under PL98-509 to render annual reports on the set-aside. These reports, however, will be dependent exclusively on state authorities' accounts of their own activities, which will vary greatly. Some states describe set-aside efforts in one general paragraph, while others offer detailed program and funding information for every women's initiative in the state.

The U.S. General Accounting Office (GAO), an arm of Congress, is examining the women's set-aside as part of a survey requested by two Congressional committees. The committees asked the GAO to look at how the states are managing programs funded by the ADMS Block Grant and whether the two associated set-asides (one for women alcoholics and drug addicts, and the other for certain mental health initiatives) were fulfilling their purposes. Since the GAO study is based on visits to nineteen service providers in eight states, it will also be limited in scope. It will be completed in August, 1987.

The NCA study reported on here will, it is hoped, be a useful contribution, both in scope and timeliness, to the analysis and planning of policymakers, state alcohol and drug authorities, local treatment providers, and all others interested in bringing adequate services to women with alcohol and other drug problems.

About NCA

The National Council on Alcoholism is the nation's independent nonprofit organization working to reduce the incidence and prevalence of alcoholism and other drug problems. NCA was founded in 1944 by Marty Mann, one of the first women to become sober in Alcoholics Anonymous. Mrs. Mann believed there was a need for a public information organization that could educate the nation about alcoholism as a treatable disease and engage in public advocacy for alcoholics. NCA has worked for over four decades to overcome ignorance and stigma associated with the disease of alcoholism; to develop efforts—such as occupational alcoholism programs—to deal with alcohol problems in the workplace; to promote extension of insurance coverage for the treatment and rehabilitation of alcoholism; and to encourage the development of high-quality, cost-effective treatment and rehabilitation programs.

Through its network of 190 state and local nonprofit affiliate councils on alcoholism, NCA disseminates information, involves community volunteer leadership, and heightens public consciousness about alcoholism and other alcohol-related problems. In addition, the councils work to improve state and local services and policies that address alcoholism and other alcohol and drug-related problems.

Since the early 1970s, NCA has led the field as an advocate for increased attention to the research, prevention and treatment needs of women with alcohol problems. Its advocacy has included Congressional testimony, many publications and, since 1984, sponsorship of National Fetal Alcohol Syndrome Awareness Week. More recently, NCA has provided training, technical assistance and written materials for the National Association of Junior Leagues "Woman to Woman" project addressing alcohol problems among women at the workplace and in colleges.

II. ABOUT THIS STUDY

The NCA study that is the subject of this report examines how states responded to the women's set-aside initiative in its first full year of operation. The study had two components: a survey to which 45 states and three jurisdictions responded, and field visits to eight states in different regions of the country with different characteristics. The five central questions of the study are: (1) How did the states respond to the set-aside? (2) Did the legislation achieve its intended effect? (3) What factors may have hindered or enhanced the effort? (4) What new services were established? and (5) Were more women served as a result of this federal mandate?

NCA mailed all state alcohol and drug program directors a survey questionnaire in August 1986 covering the period October 1, 1984, through September 30, 1985 (fiscal year 1985). The survey asked state alcohol and drug program directors to describe in writing the types of programs established in their particular states as a result of the set-aside mandate, the effects of the set-aside on other programs, and the benefits and problems associated with the initiative. While most survey questions were open-ended, one asked for facts on the demographic characteristics of women served by block grant funds. Survey findings reported throughout this document summarize the responses of the 45 state and three jurisdiction alcohol and drug program administrators. (See Appendix B for a list of respondents and Appendix C for the written questionnaire survey form.)

Researchers for the NCA study conducted three days of site visits in each of eight states—Alabama, California, Maine, Michigan, Nebraska, New York, Texas and Virginia—from September through December, 1986. The researchers personally interviewed state alcohol and drug program directors (who had also been asked to respond to the written questionnaire) using a standard set of questions (see Appendix D) designed to gain an understanding of the procedures individual states followed to put the law into effect. The respondents gave oral replies which the researchers recorded. The researchers conducted similar interviews (for standard questions, see Appendix E) with directors of some of the set-aside funded services to ascertain the types of services offered, the characteristics of clients served, and directors' perceptions of their states' responsiveness to the needs of women with alcohol and other drug-related problems. In states that had started significant numbers of set-aside programs, NCA visited both rural and urban sites, both alcohol and other drug programs, and gave priority to those trying to meet the prevention or treatment needs of minority and low-income populations.

This report identifies significant issues that emerged from the questionnaires and from discussions both with directors of state alcohol and drug agencies and with leaders of community-based services. It also presents a profile of how the states have responded so far to the federal set-aside mandate after about one year of experience.

III. LEGISLATIVE BACKGROUND OF THE WOMEN'S SET-ASIDE OF THE ADMS BLOCK GRANT

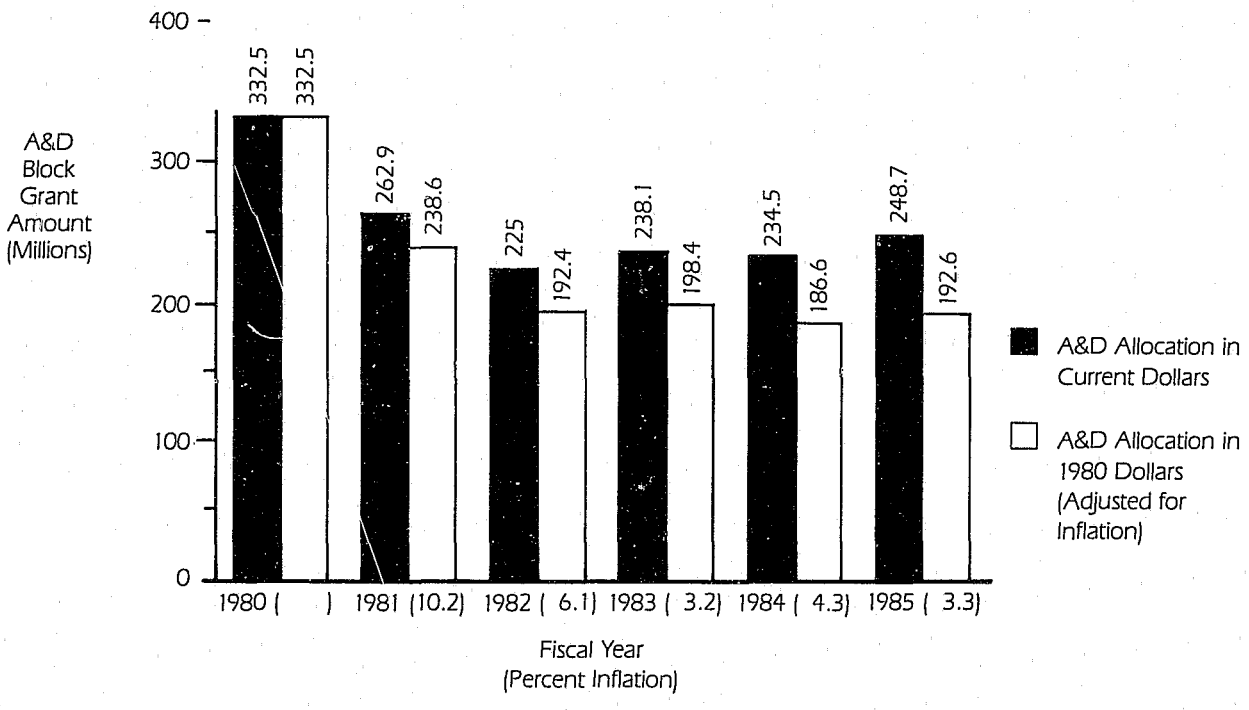
In the mid-1970s, Congress became concerned about the paucity of resources offering help to alcoholic and other drug-addicted women. In 1976, a hearing of a Congressional Subcommittee on Alcoholism and Narcotics on "Alcohol Abuse Among Women: Special Problems and Unmet Needs" stimulated some special initiatives on women. By 1980, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) had made grants for the establishment of 41 alcohol treatment programs specifically for women. NIAAA also sponsored a 1981 conference that brought together from across the nation both researchers on women and alcohol and program directors from all the newly-funded federal women's programs. This conference generated a final report entitled "Advances in Alcoholism Treatment for Women," which highlights the experiences of the conferees, whom it called "these pioneers of women's alcoholism programming." Their consensus was that the nation urgently required more service and treatment programs to address the unmet needs of women with alcohol and other drug problems.

But with the advent in 1981 of the federal block grant program to the states, federally funded, targeted efforts to reach women with alcohol and other drug problems were stalled. Federal alcohol and drug treatment funding was reduced 40 percent and combined with mental health services funding in the form of the Alcohol, Drug Abuse and Mental Health Services block grant. States were offered far-reaching discretion on how to spend these funds with few requirements mandated by the federal government.

While flexibility in planning authority has increased under the block grant system, federal allocations for alcohol and drug services within the block grant have decreased sharply. There has been a 42 percent decline in federal funding for alcohol and drug services in terms of constant 1980 dollars. Table I shows the Alcohol and Drug Block Grant allocations in current dollars and in dollars adjusted annually for ongoing inflation.

Table I

A&D Block Grant Allocations in Real & Inflation-Adjusted Dollars (1980–1985)



Source: National Association of State Alcohol & Drug Abuse Directors

Block Grants

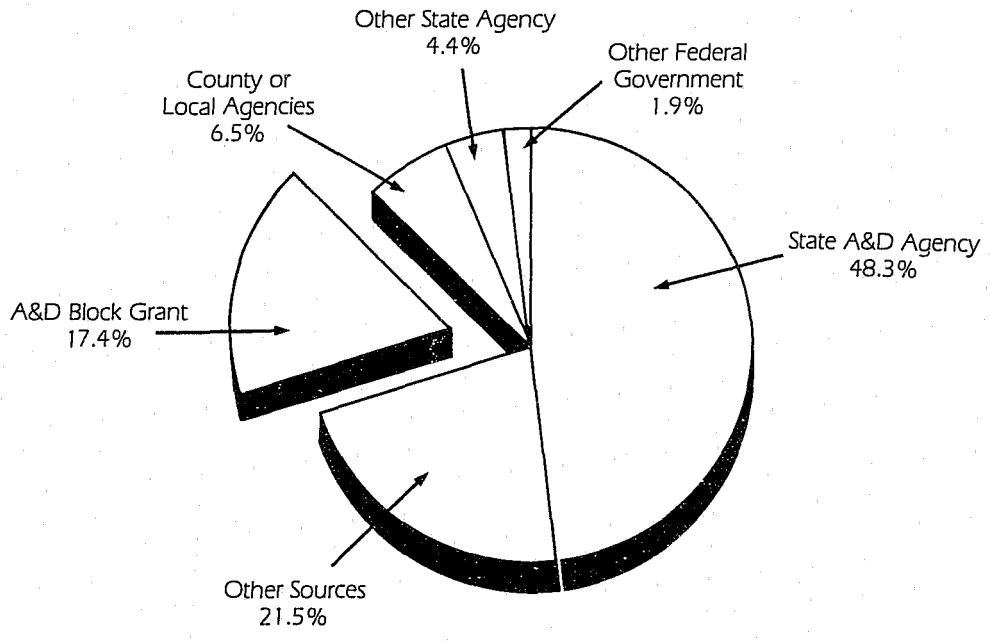
The block grant procedure was established in the Omnibus Budget Reconciliation Act (OBRA) of 1981. Before that, federal funding for a variety of domestic assistance programs, including education, health, and social services, had been administered through about 80 "categorical" programs. In the 1981 Act, Congress consolidated the 80 or so programs into nine block grants. The ADMS block grant was one of these nine. As part of the "New Federalism," block grants were intended to return programming decisions and additional fiscal responsibilities to states and localities. Thus, the federal government transferred block grant funds directly to the states with dramatically reduced requirements on how the states should spend the money and report on its use.

The ADMS block grant consolidated categorical grants previously administered by the NIAAA, the National Institute on Drug Abuse (NIDA), and the National Institute on Mental Health (NIMH). The categorical grant programs were designed to help states meet needs in alcohol and other drug addictions and in mental health, through grants for outpatient and residential treatment programs affiliated with community-based mental health centers and freestanding alcohol and drug facilities. Under the block grant system that superseded these programs, the amount of alcohol and drug funds allocated to each state is based, in part, on its level of funding for the prior categorical programs. Thus, the original pattern for each state is frozen into the block grant system.

The states' newly won self-determination brought with it a substantially increased local and state fiscal burden and significantly reduced the federal responsibility for the provision of alcohol and other drug services. Table II shows that the federal alcohol and drug block grant monies constitute only 17.4 percent of all public dollars spent on alcohol and drug services.

Table II

Major Sources of Funds Expended In Fiscal Year 1985 for Alcohol and Drug Services (Total Expenditures: $1,364,765,441)



Source: State and Alcohol Drug Abuse Profile FY 1985

Origins of the Women's Set-Aside

The transition to the block grants and the concurrent decrease in the federal commitment to alcohol and other drug efforts were major concerns for the states when Congress began to consider reauthorization of the ADMS block grant in 1984. Two Congressional committees held hearings on the reauthorization, the House Committee on Energy and Commerce and the Senate Committee on Labor and Human Resources. The scope of their hearings was broadened to include testimony about the research, prevention, and treatment needs of women.

This focus on women's needs melded with a revived desire by some members of Congress to increase federal control of the way states spent federal funds. With the switch in 1981 from categorical to block grants, Congressional control of education, health, and social service programs had virtually come to a halt except in determining funding levels. Concern about resources for alcohol- and other drug-dependent women first took the form of a Senate legislative proposal for a small, categorical funding program to finance women's prevention and treatment services and a $1 million authorization for the NIAAA and the NIDA to conduct research on women-related issues.

But the proposal met with significant resistance on the part of state alcohol and drug abuse directors opposed to any new federal dictates, and it elicited little interest on the part of most major constituency groups. Without strong field support, the categorical funding approach to an increase of services to women failed in the bill-writing process. Nevertheless, the House-Senate conference on the ADMS block grant reauthorization preserved the focus on women by including the women's set-aside in the legislation it eventually agreed upon. The set-aside reestablished a precedent for a federal response to special service needs and provided additional federal control over states' expenditures of federal funds.

A part of that legislation was Public Law 98-509, the Alcohol Abuse, Drug Abuse and Mental Health Amendments of 1984. One of these amendments—the "set-aside"—mandated that each state spend five percent of its total ADMS block grant award for new and expanded services for women in each of the next three fiscal years. As a result, the states together spent totals of $14.7 million in 1985, $23.4 million in 1986, and will spend $25.4 million in 1987, for a grand total over the three years of $63.5 million. The 1985 total is the smallest because of a subsequent reduction in the set-aside requirement from five to three percent for fiscal year 1985 because many states had already spent a portion of their previously authorized 1985 funding.

The committee reports accompanying the legislation outlined Congressional recommendations for new and expanded services for consideration by states.

These recommendations included:

- Development of separate and discrete services for female alcoholics and other drug addicts in the following components of treatment: inpatient, outpatient, halfway house and extended care;
- Development of programs that provide residential and therapeutic care for women alcoholics and other drug addicts;
- Development of programs that provide access to vocational and educational services including counseling and training for women alcoholics and other drug addicts who are returning to the labor force or entering it for the first time;
- Development of services—inpatient and outpatient—for pregnant alcoholics and other drug addicts;
- Development of incentives to create diversion programs for women alcoholics and other drug addicts in the criminal justice system;
- Development of programs to address the sub-populations of women alcoholics and other drug addicts, including victims of violence, elderly women, youth, children of alcoholics and drug addicts, single heads of households, and incarcerated women;
- Development of employee assistance programs in female-intensive industries.

The President signed P.L. 98-509 and the women's set-aside mandate it included into law in October, 1984. Although the set-aside assured that the states would make $63.5 million available over three years for new and expanded prevention and treatment efforts for women, it contained three important and potentially troublesome features. First, Congress called for new programs but provided no new funds specifically for the set-aside nor any increase in funding for the block grant as a whole. Second, the legislation required states to calculate the amount of funds for women's alcohol and drug services based on five percent of the total ADMS block grant—including mental health as well as alcohol and drug allocations. And, finally, while the legislation mandated that states expand existing services or provide new services for women, it was left to states to determine which types of services to provide.

IV. THE SPECIAL PROBLEMS OF ALCOHOLISM AND OTHER DRUG ADDICTIONS AMONG WOMEN

Within the last decade-and-a-half both the public and members of the health professions have increasingly come to see alcoholism as an illness and a major public health concern rather than a behavior problem or moral weakness. Even so, society continues to harbor misconceptions about alcohol and other drug-related illnesses among women. Their problems are often minimized by family members who are frightened and eager to protect "Mom," avoided by employers reluctant to confront female employees, and misdiagnosed by many physicians and other health professionals unwilling to label women as alcoholic or drug dependent. Often the illness is covered up in an apparent belief that it is more shameful in a woman than in a man.

There are significant ways in which the experience of alcoholism is different for women. Women more often suffer from "telescoped" alcoholism; they begin to drink a little later in life, drift into alcoholism somewhat later than men, and find their way to treatment after a shorter period of drinking and when they are physically sicker than their male counterparts. Women with drinking problems appear to be more isolated and concealed than men, and especially minority women because of racial discrimination, ethnic customs, or poverty. (See Appendix F for additional information on minority women.) Alcohol- and other drug-dependent women report a high incidence of sexual abuse, including rape and incest. According to one study, 74 percent of alcohol and other drug-dependent women in treatment reported incidents of sexual abuse.

The physiological consequences of drinking are also more severe for women than for men. Women have a greater prevalence of pancreatitis, cirrhosis, ulcers, and cardiovascular disorders. Women develop liver disease at an earlier age than men, with lower levels of alcohol consumption, and have a higher risk of dying once the liver has been injured. Alcoholic women report a high percentage of gynecological and obstetrical disorders. In one study, 78 percent of women alcoholics reported gynecological and obstetrical disorders as compared to 35 percent of a nonalcoholic control group. The risk of breast cancer is increased by 30 percent among women who consume as little as three alcoholic drinks per week compared to abstainers.

Many of these factors have special impact on minority women. Black women share in the disproportionate health effects of alcoholism on all Blacks. For example, death rates for chronic liver disease and cirrhosis, which are reliable indicators of alcoholism, are twice as high for Blacks of both sexes as for whites; Black women ages 15 to 34 have cirrhosis rates over six times those for white women. A recent study has found that the risk for Fetal Alcohol Syndrome (FAS) among Black infants is seven times greater than among white infants who receive the same prenatal alcohol exposure. Native American women ages 15 to 34 have a cirrhosis death rate 36 times that of white women. Although Hispanic groups have strong cultural sanctions against it, problem drinking by Hispanic women seems to be increasing with acculturation as well as being seriously underreported.

Women in general have difficulty getting into alcoholism treatment. Estimates of the number of women who are alcoholic range up to 50 percent of the total alcoholic population. But, according to the most recent Analysis of State Alcohol and Drug Abuse Profile Data prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), in 1985 only 19.7 percent of those entering publicly funded alcoholism treatment programs were women.

There are several reasons why women addicted to alcohol and other drugs may fail to enter treatment. They may be reluctant to reveal their problems because of the stigma or because of lack of support from family and friends. They may be inhibited by certain structural characteristics of programs, such as a preponderance of male staff and clients, inaccessible locations, inconvenient hours of program operation, or the lack of childcare. Lack of childcare has in fact been cited as one of the most significant barriers to treatment for women. In 3,500 surveys distributed in 34 cities by the National Association of Junior Leagues in 1986, treatment providers, physicians, clergy, state alcohol authorities, and law enforcement personnel identified childcare as the number one unmet need of women who require alcoholism treatment.

Treatment programs that try to eliminate such barriers have had considerable success in attracting women who need their help. Such programs reach out to women rather than wait for them to come forward. They offer a comprehensive range of services, including treatment, childcare, and

vocational and educational opportunities, and they offer help on problems that are critical for alcoholic and other drug-addicted women, including sexual and physical abuse, parental alcoholism, and eating disorders. The positive experience of these programs was an important factor leading up to establishment of the women's set-aside of the ADMS block grant.

V. THE EFFECTS OF THE SET-ASIDE LEGISLATION

The women's set-aside has brought to life a broad range of new programs and services for alcoholic and other drug-dependent women. Thirty-eight of the 45 states and 3 jurisdictions reported that compliance with the set-aside legislation produced a notable increase in the availability of alcohol and other drug prevention and treatment services for women. They funded treatment services, employee assistance programs, and prevention and education programs to reduce the incidence of FAS and mitigate its effects. They also funded clearinghouses on women's alcohol and other drug problems, technical assistance programs, and programs to train service providers. Many states, noting that the absence of childcare keeps significant numbers of women from entering treatment, funded programs with childcare components.

States also cited such benefits as greater awareness among administrators and program providers of the service needs of women, increases in assessments to evaluate the treatment needs of women, and more plans to meet these needs. The states' answers to the questionnaire included more general comments:

> "[The women's set-aside] allows for more women initiatives that had only been paper dreams before to be actualized. It acknowledges and addresses the need for specialized services for the unserved, the underserved, and/or the inappropriately served females of this state." (State Program Administrator)

> "The primary benefit has been the alleviation of the need to justify the operation of a treatment unit specific to women. There have not been any problems due to the set-aside funds. As a result we have been able to operate a single model women's program that attempts to utilize the latest innovation and strategies for treating women and evaluating them for effectiveness and appropriateness." (State Program Director)

> "The set-aside forced people to think more about women's issues and to do something about them. It was when we heard that the mandate might be coming down the pike that we conducted a needs assessment." (State Program Coordinator)

Thirty-two states reported problems in meeting the set-aside mandate. The most important was that the legislation provided no new funds for the new and expanded services it required. Among other problems these states reported were that the set-aside mandate reduced funding or services for other populations, denied cost of living adjustments to other programs, overrode other state and local planning priorities, reduced states' ability to plan, and added to administrative costs by imposing new planning and reporting requirements. State responses described other difficulties as well:

> "[This state] employs a decentralized county-based planning and services delivery system. This system relies on local elected officials to make service decisions that are matched to community needs.... Provisions such as the set-aside disrupt local decisions and can defeat local initiatives." (State Administrator)

> "[We are hampered by] lack of expertise to expand programs and lack of funds to continue programs once they are started." (State Deputy Director for Alcoholism Services)

> "In a small state the percent [of the set-aside] represents such a minimal amount of funding that meaningful outcomes to the system are not achieved." (State Administrator)

A. Types of Activities, Programs and Services Funded by the Women's Set-Aside

Most states added new programs and activities to existing services. Virginia used a portion of the set-aside funds to help a mental health center start a new outpatient group counseling program for alcohol and other drug-dependent women. In San Francisco, a multi-purpose senior center added an outreach component to identify and treat older alcoholic women. A full listing of the types of activities funded under the set-aside appears in Table III below.

Table III

Types of Activities, Programs, and Services Funded by the Women's Set-Aside

Type of Program	Number of States
Assessment and referral service	3
Case management service	3
Casefinding service	1
Clearinghouse on Women's Substance Abuse Information	2
Conference on Minority Needs and Conference for Professionals	2
Detoxification unit	2
Drug testing program	1
Education programs including education on: family issues, fetal alcohol syndrome, parenting and stress management for adolescents, girl's clubs, medical professionals, single parents and the rural community	21
Education materials development	1
Employee assistance program	2
Medical care to addicted mothers and their infants	31
Communication network for service providers	4
Outpatient counseling for physically abused, adult children of alcoholics, clients in aftercare, families of alcoholics, group sessions, impaired professionals, individuals, prisoners, FAS at risk pregnant women, intensive day treatment	17
Outreach programs	5
Intervention	9
Residential detoxification, halfway house, and halfway house with childcare	29
Student assistance program	1
Substance Abuse Council	1
Support groups	2
Task Force on Substance Abuse	1
Technical assistance program	2
Training and program development for professionals	6

Source: NCA State Survey, 1986, Appendix F

The set-aside channeled public funds into services for a predominantly low-income population that lacks access to treatment covered by third party insurers. Recognizing that economic and racial barriers often keep women from seeking treatment or undermine its positive effects, many states have made special efforts to reach low-income and minority women. Some programs use welfare departments and child protective services to identify women in need of intervention and treatment. Others develop comprehensive services that include cooperative agreements with local hospitals, legal services, vocational rehabilitation services, skills training programs and educational institutions.

Typical of set-aside programs that try to lower the economic and cultural barriers to recovery is the Cleveland area's United Labor Agency Unemployed Women Alcohol and Drug Information and Referral Project. This project has provided alcohol and other drug information and referral services to at least 500 women who have sought jobs through the Cleveland or Cuyahoga County Job Training Partnership Act (JTPA) Title III Disabled Workers Programs. Another Ohio program launched with set-aside funds is a community-based referral service for newly-released female ex-felons. When such women re-enter the community, the program staff gets in touch with them through the parole and probation offices and the city workhouse and prison social service departments, and guides them into a network of alcohol and other drug treatment services. Oregon used the set-aside to help direct services to recipients of Aid to Families With Dependent Children (AFDC), on the grounds that treating these women's alcohol problems will help protect their children as well as reduce AFDC costs.

The set-aside allowed many states to focus on the lack of childcare as one of the most serious barriers against treatment for women. Some program directors recommended that agencies providing treatment for women be required to develop adequate childcare and that accreditation bodies consider the provision of childcare as a positive factor in their assessments of programs. Many states gave priority to childcare in the use of set-aside funds. Minnesota is conducting a feasibility study to determine what childcare components should be integrated into existing treatment services. Alabama developed outpatient and day treatment programs with children's services components. The District of Columbia, in funding services for pregnant addicts, added pediatric care for their infants after birth.

B. The Decision Process

In making their decisions about the use of set-aside funds, the states consulted service providers, local community groups, state annual plans, and other sources of information. In California, the state Office of Alcohol and Drug Programs set up a Women's Alcohol Initiative Committee that helped the state to determine programming needs and funding priorities. In some states, programs and organizations competed with each other for set-aside support under the terms of a Request for Proposal promulgated by the state. To meet these terms, many local agencies conducted needs assessments and held community hearings. Survey respondents mentioned using state annual plans, state legislative committees, and alcohol and other drug committees, as well as information collected during federally mandated public hearings on state plans for programs and activities.

Table IV, The Decision Process, lists the information resources and groups utilized by 48 survey respondents in making funding decisions.

Table IV

The Decision Process

Information Resources	Number of States
Communicated with service providers	35
Communicated with local groups	33
Issued request for proposals	23
Conducted needs assessments	23
Held annual public hearings	19
Disseminated funds evenly to agencies	13
Convened A&D advisory committee	9
Consulted state annual plan	7
Convened legislative committee	6

C. Characteristics of Women Admitted to Block Grant Funded Programs

In fiscal year 1985, 215,952 women—22 percent of all clients—were admitted to block grant funded alcoholism and other drug addiction treatment programs as reported by 40 states and territories in response to the NCA survey. Over 44 percent of these female clients were in poverty, and 19 percent of them were members of minority groups.

Table V below lists the characteristics of individuals admitted to block grant funded programs in fiscal year 1985.

Table V

Characteristics of Males and Females Admitted for Treatment to Block Grant Funded Programs in Fiscal Year 1985

	MALE ALC	MALE DRUG	FEM ALC	FEM DRUG	FEM ALC MIN	FEM DRUG MIN	FEM ALC POV	FEM DRUG POV
AL	4,874	1,869	1,151	957	272	187	921	766
AK	8,590	1,047	2,816	329	1,597	60	2,273	169
AR	6,152	1,554	1,067	543	179	102	427	217
CA	103,000	NA	24,000	NA	7,000	NA	17,000	NA
CO	25,257	1,254	4,811	583	1,164	121	3,863	429
CT	4,055	3,321	1,611	1,289	130	304	822	657
DE	3,580	710	690	244	179	85	NA	NA
DC	6,378	2,581	1,217	1,105	1,120	1,006	1,086	976
GA	17,931	4,481	3,828	1,904	1,342	427	859	273
ID	3,889	919	1,003	662	138	85	140	93
IN	20,289	6,763	7,315	2,438	988	488	4,828	1,609
IA	4,146	1,059	865	405	71	41	692	324
KS	1,124	187	201	59	37	11	160	49
KY	11,400	2,450	2,739	1,360	118	43	507	252
LA	8,897	4,622	2,688	1,396	800	450	1,200	600
ME	9,772	*	2,802	*	NA	NA	1,437	*
MD A/D	4,943	2,332	1,241	450	273	272	NA	NA
MI	91,752	*	23,670	*	4,800	*	23,670	*
MN	752	337	336	148	211	95	135	61
MO	15,696	3,818	3,206	1,156	525	293	3,206	1,156
MT	3,843	966	2,588	647	388	97	NA	NA
NE	13,389	*	3,909	*	782	*	NA	NA
NV	9,453	706	2,151	395	63	52	NA	NA
NH	1,755	467	697	200	9	5	443	135
NY A/D	62,000	25,357	26,000	11,233	5,300	NA	6,900	NA
NC	23,766	5,186	4,893	2,147	1,480	533	3,914	1,288
OK	5,702	*	1,851	*	NA	NA	NA	NA
OR	24,888	3,438	6,487	1,154	762	130	1,751	535
PA	37,600	16,500	8,000	7,800	2,500	2,400	2,800	2,700
PR	8,199	4,321	361	573	NA	NA	NA	NA
RI	1,526	1,301	503	678	33	70	NA	NA
SC	16,742	3,313	3,369	1,324	NA	NA	NA	NA
SD	5,023	309	1,415	124	353	30	455	33
TX	6,191	5,388	1,25[illegible]	1,761	366	677	366	677
UT	12,216	1,251	1,741	545	335	75	NA	NA
VT	2,725	910	1,103	367	NA	NA	607	202
VI	77	61	17	19	NA	NA	NA	NA
VA	22,295	4,071	4,032	1,660	NA	NA	NA	NA
WA	37,311	4,529	8,891	2,382	NA	NA	NA	NA
WI	4,284	470	1,205	193	NA	NA	NA	NA
TOTAL	651,452	117,848	167,722	48,230	33,315	8,139	80,462	13,201

* = Drug and alcohol totals combined under alcohol
NA = Not Available

Source: NCA State Survey, 1986. These are reports from all survey respondents who provided data on clients admitted into treatment programs in their state in 1986.

Alcoholic and other drug-addicted women tend to enter treatment after experiencing great economic, physical, and social hardships. Some have lost their children and spouses. Many women need immediate and comprehensive medical attention.

Table VI shows the percentage distribution for women of the data in Table V.

Table VI

Characteristics of Females Admitted to Treatment in Block Grant Funded Programs in 1985 (Percent)

STATE	A	B	C	D	E
AL	24	19	34	80	22
AK	25	25	24	78	53
AR	17	15	26	40	18
CA	19	19	NA	71	29
CO	17	16	32	80	24
CT	28	28	28	51	15
DE	18	16	26	NA	28
DC	21	16	30	89	92
GA	20	48	30	20	31
ID	26	21	42	14	13
IN	26	26	26	66	15
IA	20	17	28	80	9
KS	17	15	24	80	19
KY	23	19	36	19	4
LA	23	23	23	44	31
ME	22	22	NA	51	NA
MD A/D	19	20	16	NA	32
MI	21	21	*	100	20
MN	31	31	31	41	63
MO	18	17	23	100	19
MT	40	40	40	NA	15
NE	23	23	*	NA	20
NV	20	19	36	NA	5
NH	29	28	30	64	2
NY A/D	30	30	31	19	14
NC	20	17	29	74	29
OK	25	25	*	NA	NA
OR	21	21	25	30	12
PA	23	18	32	35	31
PR	7	4	12	NA	NA
RI	29	25	34	NA	9
SC	19	17	29	NA	NA
SD	22	22	29	32	25
TX	21	17	25	35	35
UT	15	12	30	NA	18
VT	29	29	29	55	NA
VI	21	18	24	NA	NA
VA	18	15	29	NA	NA
WA	21	19	34	NA	NA
WI	23	22	29	NA	NA

A = Percent of all clients who are female

B = Percent of all clients with primary diagnosis of alcohol addiction who are female

C = Percent of all clients with primary diagnosis of drug addiction who are female

D = Percent of all female clients classified as poverty

E = Percent of all female clients classified as minority

* = Drug and alcohol totals combined under alcohol

NA = Not Available

D. How Women Are Referred to Treatment

Women with alcohol and other drug problems come to treatment primarily by referral through an informal network of social service providers. Some alcohol and drug programs provide problem assessment and referral services only. NCA affiliates and other community-based organizations provide hotline counseling and referrals, operating as conduits to publicly and privately funded treatment programs. In Texas, for example, the Women's Services Project (WSP), an employee assistance program, disseminates alcohol and other drug information to employees in industries whose workforces have a high proportion of women. A woman with an alcohol or other drug problem contacts WSP independently or is referred by her job supervisor. WSP staff meet with the woman, assess her problem, provide crisis intervention, and then refer her to the appropriate services.

Some programs are affiliated with larger facilities like hospitals, community service boards, and community mental health centers. Most of their referrals come from these larger facilities. For example, the Women's Day Treatment Program in Petersburg, Virginia, is a program of Virginia's District XIX Community Service Board—the primary agency with responsibility for planning and implementing alcohol, drug, and mental health services in that geographic area. This Board refers women with alcohol or other drug problems directly to the Women's Day Treatment Program.

Referrals also come through the legal system. Courts often require persons convicted of such violations as drinking while driving to undergo pre-sentencing assessments of their use of alcohol and other drugs. Sentencing then may include an alcohol or other drug education course, a program of treatment, or detention. In Michigan, judges are now required to order alcohol and other drug assessments on all those arrested for driving under the influence. As a result, the number of women admitted to treatment has increased. Currently, one third of the female clients in Michigan enter treatment through the court system.

Table VII

Treatment Program Referral Resources

STATE, CITY	TREATMENT PROGRAM NAME	SOURCE OF REFERRAL TO TREATMENT	REFERRAL TO OTHER SERVICES
AL, Anniston	Women's Set-Aside Prog.	1, 2, 3	NA
AL, Birmingham	Women's Recovery Center	1, 5, 6, 10	NA
AL, Tuscaloosa	Women's Subst. Abuse Prog.	1, 6	4, 9
CA, Oakland	Women's Recovery Center	4, 6	NA
CA, San Francisco	North of Market	4, 6, 8	NA
ME, Saco	Women in the Work Place	6, 7	5
MI, Detroit	Pregnant Addicts Prog.	3, 4, 6	NA
MI, Muskegon	Every Woman's Place	1, 3, 6	2, 4
MI, Pontiac	Inner Change	1, 4, 5, 6	NA
NE, Omaha	Women's Partial Care	1, 2, 4, 5	5
NE, Omaha	Genesis II	4, 11	9
NY, Buffalo	Casa Davita	5	3, 4
NY, NY	Women in Need	8	NA
TX, Austin	Women's Service Proj. (EAP)	6, 7	3, 5, 9
TX, Houston	Teenage Pregnancy Prog.	8	3
VA, Forest	Arise Women's Prog.	1, 2, 4, 6, 8	4
VA, Petersburg	Women's Day Treatment Prog.	1, 2, 4	4, 9
VA, Vienna	The Women's Center	3, 4, 5, 6	4, 5

Referral Agency Key:

1. Law (Courts, Probation, Parole)
2. Child Protective Services
3. Medical (Hospital, Private Physician)
4. Other Social Service Agency (ex. Welfare)
5. Alcoholics Anonymous, Narcotics Anonymous, Other Treatment Programs
6. Self or Friend Referral
7. Employer Referral
8. Referred by Other Component of Agency
9. Education, Employment Vocational Rehabilitation, Legal, Housing
10. Outreach/Publicity

NA = Not Available

Source: NCA Study Site Visits to Set-Aside Funded Programs, 1986

Many women in intensive day and residential programs reach treatment because of other legal requirements. Women with children in foster care may enter treatment as a condition for regaining custody. Those on probation or parole may enter treatment as a condition of their freedom.

Alcohol and other drug treatment services and social service programs often operate under interagency agreements requiring cooperation and referral of clients between programs and services. States use a variety of mechanisms to encourage coordination. In Nebraska, for example, social service agency representatives meet periodically to coordinate activities. In Austin, Texas, a grassroots organization called Austin Net meets monthly. Program directors learn of the activities of other regional agencies and services at these meetings. California held planning meetings to develop a set-aside funded training program on alcoholism and domestic violence. Individuals from a wide range of agencies attended these meetings to help set up training materials and a state-wide conference program. Those attending included alcoholism counselors, domestic violence workers, private psychologists and social workers, child protective service workers, welfare workers, and lawyers from the local chapter of the American Bar Association. Oregon encourages coordination through an administrative requirement that all state social service and welfare workers receive training on how to identify and refer alcoholics and other drug addicts to treatment.

Table VII lists the sources of referral for the set-aside programs that NCA visited in the eight states in which it made site visits for the study.

E. How States Used the Set-Aside: Eight Case Studies

ALABAMA

Set-aside allocation: $466,400

Program Selection Procedure: State alcohol and drug administrators met with service providers to review possible uses of set-aside funds. Both groups considered an across-the-board requirement that all block grant-funded programs increase services to women. The administrators felt, however, that this strategy would dilute the effect of the legislation. Instead, they made set-aside funds available to all alcohol and drug services and state community mental health centers through competition under a Request for Proposals (RFP) that gave priority to new treatment services.

Four treatment programs received funding through the RFP procedure. Several months after these new programs started up, directors circulated quantitative and anecdotal information on them to enable others to build upon their experiences. The state then made further funds available under a second round RFP, which generated three additional women's treatment programs.

Kinds of Programs Funded: Activities thus funded included comprehensive outpatient services with children's service components, case management services, and outreach to minority women.

* * *

A typical major program is the Women's Recovery Center of Althea House in Birmingham funded at $85,000 annually. The center provides intensive day treatment services to women, as well as childcare and parenting classes. Women attend the program for four hours each day, five days a week. Structured activities include alcohol and other drug education, stress management classes, and lectures on nutrition. There are group therapy sessions every day. Mothers with children under five are provided with on-site and inexpensive structured childcare. A child development specialist directs an academic learning center, a developmental skills program, and counseling.

CALIFORNIA

Set-Aside Allocation: $2,420,300

Program Selection: The state devoted 60 percent of the set-aside to alcohol services, with 40 percent to other drug services. The Division of Alcohol Programs, a state-level agency, managed the set-aside alcohol funds. The drug funds went directly to the 56 county drug agencies, each of which determined how it would use the money.

The Division of Alcohol Programs put half of its share of the funds into treatment programs and half into indirect services such as education, training and research. It selected programs at the state level by competition under the terms of an RFP that encouraged variety in programs and gave priority to the service needs of specific groups. County administrators viewed this procedure as problematic, possibly because it was a departure from the usual method of allocating alcohol funds through the counties.

Priorities specified in the RFP were for the development of direct services, especially for Black, Hispanic and Native American women; for development of educational and training materials specifically on Fetal Alcohol Syndrome, Fetal Alcohol Effects (FAE), and domestic violence; and for research on the indicators and prevalence of alcohol problems and alcoholism among women in California.

The State Office of Alcohol and Drug Programs commissioned a 32-member Women's Alcohol Initiative Committee to evaluate the current status of women's alcohol-related services and to make recommendations for future planning.

Kinds of Programs Funded: Twenty-four alcohol programs received grants for new and expanded services for women with children, Black, Hispanic, and Native American women, lesbians, older women, battered women, and for the general female population as well. Over half of direct service funds went to residential programs. Other programs provide prevention, counseling, outreach, intervention, and treatment services. They included awards to develop Fetal Alcohol Syndrome materials for Native American women, public service announcements for Black women in southern California, and training on alcohol and domestic violence for such service providers as social workers, child abuse caseworkers, and alcoholism counselors.

* * *

The North of Market Senior Alcohol Program is part of a multi-service senior center in San Francisco's "Tenderloin," where many older people live in apartments and single room occupancy hotels (SROs). Funded through the set-aside, North of Market is one of the few programs in the country to address specifically the needs of older women. It makes special efforts to reach isolated older women, including a brochure that says "activities are as close as your lobby, or within walking or riding distance from your residence." It holds group sessions at the Senior Sobriety Center and encourages women to take advantage of the senior center's medical and social services. It places those who need "intensive" inpatient and residential care in treatment programs in the local community. North of Market Senior Services received $63,721 for the first 18 months of operation.

MAINE

Set-Aside Amount: $186,650

Program Selection: The state complied with the set-aside by requiring most treatment programs to increase the number of women they served by five percent but did not earmark special funds with which to do so. State alcohol and drug administrators established broad guidelines within which each program would decide how to meet this requirement. Alcohol and drug administrators met with service providers to discuss reallocation plans and the different treatment needs of women. For practical reasons, the administrators exempted a few treatment programs from the requirement to serve women. For example, the detoxification unit of a street shelter was exempted because its layout did not lend itself to the creation of sleeping accommodations for women.

Kinds of Programs Funded: Typical of the responses of treatment programs was that of a community mental health center to reallocate staff time to increase education and outreach efforts for female employees in "women-intensive" industries. Other programs developed groups for alcoholic and drug dependent women in four clinics; added a bed to an already existing halfway house for alcoholic women; developed education programs on FAS and FAE; began alcohol prevention efforts with the Girl Scouts; and published a newsletter focusing on alcohol, other drugs, and women's health.

MICHIGAN
Set-Aside Amount: $797,400

Program Selection: The Michigan Office of Substance Abuse Services (OSAS) funded four new women's programs through competition under an RFP that gave priority to programs from regions with high need, strong community support, and financing from other sources. In addition, all state prevention coordinators dedicated a percentage of their time to increasing prevention activities for women.

Michigan channels funds for alcohol and drug services through 18 coordinating agencies, which contract directly with service providers. A number of set-aside proposals came from areas where regional coordinators had been encouraging OSAS to fund new women's programs.

Kinds of Programs Funded: Michigan funded four new women's initiatives—three outpatient programs and one halfway house.

* * *

One of the most comprehensive is the Women's Treatment Center of Detroit's Hutzell Hospital, a program aimed at female drug addicts and their children. Its services include inpatient detoxification, day treatment and outpatient services, and shelter for up to six months for women and children. Originally designed to serve pregnant addicts, the Center has expanded with set-aside funds to serve any woman with a drug problem. Its new outpatient program for the non-narcotic addict offers instructional sessions, "focused groups" on such topics as the recovery process and parenting, introduction to self-help groups like Narcotics Anonymous, and group therapy sessions. Treatment, which is individualized, can last for up to a year. According to program director Dee Caudel, most women who enter the program are cross-addicted with cocaine, which is now the "drug of choice." The average age of women entering the program is 26. Sixty to 70 percent are Black and all are low-income; the majority have children. According to Ms. Caudel, an important goal of the program is to "mend the parental bond" and "weaken the generational cycle" of drug addiction.

NEBRASKA
Set-Aside Amount: $134,150

Program Selection: Normally, the state channels funds to six regional boards, each of which contracts directly with local service providers, conducting its own needs assessments, allocating funds, evaluating programs, and managing relations with service providers. In the case of the set-aside, the state asked regional administrators to review and send promising proposals to the state administration which made the final funding decisions.

Set-aside funds were offered as "one-time monies" to fund programs or projects for two years, with preference to programs or projects the regional governing board might be willing to continue beyond the three years of the set-aside.

Kinds of Programs Funded: Nebraska used set-aside funds for prevention, education, treatment, and drug testing. A women's halfway house whose admissions had increased hired a psychiatrist to give supplemental treatment to clients and to train staff in managing complex cases. A Native American center added alcohol and other drug education and counseling to its services. A methadone maintenance clinic used the funds to help offset the additional costs of a recent sharp jump in admissions. An alcohol and drug program affiliated with the YWCA created new aftercare counseling groups. A community-based alcohol and drug program created a women's intensive day-treatment program.

* * *

Genesis II in Omaha is a set-aside funded aftercare program for alcoholic and other drug-addicted women that operates from the YWCA. Responding to outreach efforts beginning in September 1985, the first women entered the program in December 1985. Designed for women who have graduated from a treatment program or who have maintained sobriety for at least two years in A.A. or N.A., the program gives supportive counseling and workshops on self-esteem, parenting, assertiveness, healthy sexuality, spirituality, job-seeking skills and strategies, and self-defense. Genesis II received $36,375 of state funds in the first year of operation.

NEW YORK
Set-Aside Amount: $2,004,850

Program Selection: New York has a policy of funding only mixed-sex treatment services. State authorities indicated that they used the set-aside to support efforts directed at women that had already been planned. In drug programs such efforts included individual and group counseling; vocational counseling; workshops on assertiveness, stress, anxiety, depression, and domestic violence; parent training; and special education courses. In alcoholism programs, set-aside funds went to public education; employee assistance and other workplace intervention programs; outpatient services, including clinics and rehabilitation programs; outreach services; and community residential facilities.

* * *

Women in Need is a program that offers shelter to homeless women and their children in New York City. In early 1987, the program established a comprehensive alcoholism clinic for homeless women and their children. The clinic provides professional diagnostic and evaluation services, case management, treatment planning, individual and group counseling for the entire family, self-help groups, and alcohol and other drug education. Childcare services make it possible for homeless mothers to participate in treatment and help prevent addiction among their high-risk children. Either directly or by arrangement with other community agencies, the clinic provides vocational counseling and employment, financial counseling, preventive services, housing assistance, medical and psychological services, and referrals to inpatient detoxification and rehabilitation programs. The first year funding award for Women in Need was $206,500.

TEXAS
Set-Aside Amount: $1,072,300

Program Selection: State administrators funded alcohol and drug programs through an RFP that invited competitive proposals. In drug programs, they gave preference to new initiatives for young, poor, and minority females. On the alcohol side they tended to support expansion of existing programs. Support took the form of seed money and partial funding. In order to be eligible for state money, a program must show that it can generate enough community support to survive possible future state funding reductions.

Kinds of Programs Funded: The State Commission allocated a total of $350,000 to three agencies to expand existing residential and outpatient alcoholism treatment services and to start new ones. It gave an additional $150,000 to four agencies to increase case-finding, assessment, and referral services for women with alcohol problems and to begin new services. Four new drug prevention and five new drug treatment programs resulted. These included services for Black and Hispanic women and an employee assistance program for women labor union members.

* * *

The Teenage Pregnancy Program in Houston used set-aside funds to develop a drug prevention education curriculum for pregnant adolescents in September, 1986. It calls for twelve group meetings with a counselor at the Chicano Family Center in East Houston, and instructs 40 pregnant adolescent girls in the effects of drug use, especially inhalants (a considerable problem in this region). The girls also get training in parenting and problem solving. The University of Texas Medical Center collaborates by making follow-up evaluations of the children of the program participants.

VIRGINIA
Set-Aside Amount: $419,200

Program Selection: The Virginia Substance Abuse Service disseminated set-aside funds by inviting competitive proposals. Because it wanted to see whether intensive outpatient treatment was more effective than other modalities, the Service gave it preference in its RFP. If outpatient treatment is more effective and less costly, this knowledge may have a long-term impact on planning.

The Virginia Substance Abuse Services operates through 40 Community Services Boards, which may put forward grant requests to the state for new women's services. These Boards make programming decisions based on local needs assessments and discussions at community meetings. The Boards finance programs by drawing upon local and state monies. The state distributes funds to local boards through specific allocations as well as by selecting among competitive proposals.

Kinds of Programs Funded: *Virginia funded five new programs including several intensive day-treatment programs and a case-management program.*

* * *

The Arise Program is located in Lynchburg. It offers outreach and a full array of services for women with alcohol and other drug problems, including intervention, screening and diagnosis, day treatment, and residential services. It serves eight women in the residential program and 14 in day treatment. The main goals of Arise are to provide treatment to meet the needs of female alcoholics and drug addicts; to promote awareness and educate the community about women, alcoholism, and other drug addictions; to increase female admissions to residential and outpatient services; and to establish and mobilize other community resources to help female alcoholics and addicts. It provides specialized services for women who have been victims of sexual abuse as children or battered as adults.

Table VIII lists the characteristics of set-aside programs visited in this study and the services they provide.

Table VIII

Characteristics of Set-Aside Programs Visited in This Study: The Services They Provide

STATE, CITY	PROGRAM NAME	START DATE	NO. CLIENTS SERVED	SERVICES PROVIDED
AL, Anniston	Women's Set-Aside Prog.	Jul 85	67	8, 9
AL, Birmingham	Women's Recovery Center	Jul 85	95	6
AL, Tuscaloosa	Women's Sub. Ab. Prog.	Jul 85	70	3, 5, 10
CA, Los Angeles	LAPIS Extension	Sum 86	NA	12
CA, Oakland	Native Am. Alc. Prog.	Win 87	NA	NA
CA, Oakland	Preg. Teen Alc. Prvnt. Proj.	Dec 86	NA	5
CA, Oakland	Women's Recovery Center	Apr 86	NA	1, 10, 11
CA, Porterville	Tule River Alcohol Prog.	Fall 86	NA	12
CA, San Francisco	No. Market Str. Srvcs.	Jul 85	59	8, 10
CA, San Francisco	Women's Alcoholism Center	Jul 86	NA	12
ME, Rockland	Skyward	Aug 85	NA	5, 10
ME, Saco	Women in the Work Place	Aug 85	60	8, 10
MI, Detroit	Pregnant Addicts Prog.	Apr 86	75	4, 8
MI, Muskegon	Every Woman's Place	Apr 85	120	1, 2, 5
MI, Pontiac	Inner Change	Dec 85	139	8
NE, Omaha	Women's Partial Care	Nov 85	36	6
NE, Omaha	Genesis II	Dec 85	60	8
NY, Buffalo	Casa Davita	May 85	34	11
NY, NY	Women in Need	Jan 87	NA	4, 3, 9
TX, Austin	Women's Service Proj. (EAP)	Jan 86	300	1, 5, 7
TX, Houston	Teenage Pregnancy Prog.	Oct 86	35	5, 7
VA, Forest	Arise Women's Prog.	Jan 86	150	3, 5, 8, 10
VA, Petersburg	Women's Day Treatment Prog.	Nov 85	64	6
VA, Vienna	The Women's Center	Mar 86	57	4, 5, 6, 10

Services Provided Key:

1. Assessment & Referral
2. Casefinding
3. Case Management
4. Child Care, Assessment Treatment
5. Prevention Education
6. Intensive Day Treatment
7. Intervention
8. Outpatient Group Counseling
9. Outpatient Individual Counseling
10. Outreach
11. Residential Treatment
12. Professional Training, Curriculum Development

Source: NCA Study Site Visits to Set-Aside Funded Programs, 1986

CONCLUSIONS

As Betty Ford said, "We have a civilization that doesn't like to admit that nice women drink, a civilization in which the idea of an alcoholic woman needing special attention is still fairly new. Not only employers and uneasy husbands have turned their backs on the fact of women alcoholics, so have doctors."

Congressional passage of Public Law 98-509, the Alcohol Abuse, Drug Abuse and Mental Health Amendments of 1984, was an important step toward national recognition of the seriousness of alcoholism and other drug addictions among women and of the need for immediate and comprehensive attention.

This Report has examined how states responded to the set-aside mandate in its first full year of operation. The study asked five central questions: (1) How did the states respond to the set-aside? (2) Did the legislation achieve its intended effect? (3) What factors may have hindered or enhanced the effort? (4) What new services were established? and (5) Were more women served as a result of this federal mandate? The following answers must be regarded as provisional since they reflect only the first year of operation.

(1) How did the states respond?

States responded to the set-aside mandate in a number of ways that resulted in the establishment of a full range of prevention, education, and treatment services. Among the 45 states and three jurisdictions that responded to NCA's call for information, none failed to make a genuine attempt to respond to the spirit of the legislation. In many states (perhaps the majority) the response was comprehensive and the effects on the availability of programs and services for women, formidable. At least one state reported doubling the number of women who sought alcohol or other drug treatment in the first year of the set-aside. California funded 24 different initiatives to respond to the needs of women, and Virginia initiated a network of comprehensive outpatient treatment services for women.

(2) Did the legislation achieve its intended effect?

In addition to concrete programmatic and service gains, a substantial majority of the states reported a new awareness among administrators and providers about the needs of women with alcohol and other drug problems and, frequently, a renewed commitment to address these needs specifically and enduringly.

State accounts of the implementation process indicate that many forces influenced a given state's response to the set-aside—a complex array of federal, state and local mechanisms and funding variables. The effects of the set-aside in any state were at least in part influenced by the size of the block grant award, by whether the effect of the earlier federal formula change on the state alcohol and drug allocation had been positive or negative, the nature and extent of the state's support from its own funds for alcohol and other drug services, and the particular budgetary processes by which public alcohol and drug monies, including block grant funds, are routinely awarded to programs and services. A number of states chose to address the set-aside through a special competitive process, and while many more identifiable initiatives appeared to be generated as a result, county administrators and other officials routinely involved in program planning and implementation were generally not pleased with this departure from previous practice.

(3) What factors may have hindered or enhanced the effort?

Factors that hindered the states' responses were the provisions that no new funds would accompany the federal mandate, that the appropriation level for the ADMS block grant remained constant for the first year of the set-aside, and the fact that the legislation was enacted after states were already well along in their planning processes. Factors that enhanced the states' responses to the set-aside included commitment on the part of the state authorities to the development of programs for women, the presence of a strong constituency group supportive of women's programming (such as the California Women's Commission on Alcoholism), and, in some states, positive effects stemming from the earlier funding formula change in the ADMS block grant.

(4) What new services were established?

Initiatives funded with the set-aside ranged from primary prevention to aftercare; from prevention services for pregnant teens to treatment programs for older women; from prevention and education efforts to address Fetal Alcohol Syndrome and Fetal Alcohol Effects to comprehensive treatment services for pregnant addicts; from the establishment of employee assistance programs in industries with high proportions of female employees to the provision of therapeutic childcare services as components of both outpatient and residential treatment services. Prevention and treatment services for minority populations were frequently cited and in some cases became the priority focus for the state's set-aside compliance effort. In short, most states responded to the set-aside mandate by setting up new and expanded services for alcoholic and other drug-dependent women.

(5) Were more women served as a result of this federal mandate?

It is not possible to evaluate the success of the set-aside in terms of increases in the number of women who have been served. This study looked only at the first year of implementation and many programs had just opened their doors in the spring and summer of 1986. Furthermore, there is no uniform, national system for collecting data. This makes it impossible to look at trends in female admissions to treatment over time. Finally, states use a variety of sources to fund public treatment programs and do not necessarily break down admissions data to correspond to source of funding.

General Conclusions

Although the future of the women's set-aside and the programs it established is unclear, the climate for its continuation appears favorable. Action on reauthorization of the legislation will occur in the summer of 1987. The National Association of State Alcohol and Drug Abuse Directors, at first resistant to the set-aside, has indicated that it will not oppose continuation. Women have become organized in the states and are prepared to support its renewal. The amount available to each state under a continued five percent set-aside would be affected by two changes in the block grant under consideration by Congress. These are creation of an alcoholism and drug block grant separate from mental health funds, thus reducing the dollar amount on which the five percent is calculated, and a proposed change in the formula for allocating funds to the states and territorial jurisdictions.

The General Accounting Office (GAO), using information from its not yet completed study, highlighted the importance of the set-asides in its testimony on April 3, 1987, at a hearing on the reauthorization of the Alcohol, Drug Abuse and Mental Health Services block grant before Representative Henry Waxman's (D-CA) Subcommittee on Health and the Environment. The GAO testimony pointed out that service providers were skeptical about the future of their programs if the set-aside is ended. According to the GAO, "[Although] state officials representing 22 of our 24 cases said they would continue similar funding for these services even without the federal requirements,... service providers were less optimistic.... Only four of 19 visited believed their programs would be continued if the set-aside provisions were removed." Both the GAO testimony and the NCA study indicate that, from the perspective of the women's program directors, the future of these programs is highly tentative if the set-aside is not continued.

Nevertheless, the women's set-aside of the ADMS block grant achieved its goal "to initiate and expand alcohol and drug abuse services for women." It brought to life a variety of alcohol and other drug prevention, education, and treatment programs designed to address the needs of women. The set-aside has ignited a new interest and excitement in the states among treatment providers, state authorities, and community-based citizens' organizations. Most important, the set-aside has enhanced the possibility of recovery for greater numbers of alcoholic and drug-addicted women across America and brought a new sense of hope to these women and their loved ones.

APPENDIX A

Alcohol and Other Drug-Related Problems in the U.S.

Alcohol is the most widely available and the most destructive drug in America. Of the approximately 110 million adult drinkers in 1985, 10.6 million were alcoholics. Another 7.3 million adults experienced at least one serious consequence of alcohol use in the preceding year. For every alcoholic or problem drinker, another four people close to the drinker suffer negative effects. As many as one American in every three says an alcohol-related problem has caused trouble in his or her family.

The adverse economic impact of alcoholism and other alcohol-related problems is nearly $120 billion per year; there are almost 100,000 deaths from alcohol-related causes. Fetal Alcohol Syndrome is the third leading known cause of birth defects with accompanying mental retardation, and the only preventable one among the top three—preventable by not drinking. Brain damage by alcohol is second only to Alzheimer's disease as a known cause of mental deterioration in adults. Alcohol contributes to other chronic illnesses, including cardiac myopathy, hypertension, pneumonia, and several types of cancers. Even light drinkers have doubled their risk of hemorrhagic stroke compared to abstainers. Alcohol is a major factor in about 15 percent of all health-care expenditures and 30 to 40 percent of hospital admissions.

In the latter half of 1986, illicit drug use received enormous political and public attention which culminated in passage of the Anti-Drug Abuse Act of 1986. Problems with licit drugs, on the other hand, particularly over-the-counter and prescription drugs, are less popular targets of concern.

Data on the incidence, prevalence, and costs of drug problems (other than alcohol) are difficult to obtain due to the illegal nature of these substances. The Drug Abuse Warning Network (DAWN) data indicates that there were 3,539 drug-related deaths in 1984. The cost to society of problems with drugs other than alcohol in 1983 was at least $60 billion. This includes both indirect costs such as reduced productivity and lost employment and direct costs such as treatment and support.

Drinking and Other Drug Usage Practices Among Women

Surveys of drinking in the general population indicate that women have been more likely than men to abstain from alcohol, to drink less than men, and to report fewer drinking-related problems. Sixty percent of adult women 18 and over drink, while 40 percent are abstainers. Fifty-five percent of adult women who drink do so moderately (defined as less than 60 drinks per month) while five percent are heavy drinkers (more than 60 drinks per month).

But drinking practices among women are changing. According to Dr. Sheila Blume, "Estimates of the relative prevalence of female and male alcohol problems have varied widely over time and in relationship to populations studied, but there is little doubt that both drinking and alcohol problems in women have increased considerably since the end of World War II." This trend is reflected—and possibly strengthened—by the current heavy targeting of women in the advertising and marketing of alcoholic beverages, more today than at any time in our nation's history. According to a recent liquor industry newsletter, women are expected to spend $30 billion on alcoholic beverages in 1994, compared with $20 billion in 1984.

Regular drinking is now common among high school girls, and a sizable number drink heavily. Drinking differences between boys and girls are diminishing. The number of young female drinkers has been increasing more rapidly than the number of young male drinkers. In a 1983 survey, 31 percent of 12th grade girls had consumed at least five or more drinks at least once in the preceding two weeks. There is evidence that the higher a woman's income and education level, the more likely she is to have a drinking problem. A recent survey on patterns of addiction conducted by Ms. magazine, whose readers are predominately well-educated, found that a "disconcerting number of women in our sample appear to have symptoms of problem drinking." Ms. reported that among its readers "34.4 percent of those who drink have had memory lapses or blackouts, as compared with 23.7 percent of women drinkers nationally; 5.7 percent have drunk in the morning, compared with 2.9 percent nationally; and 10.8 percent reported that they had not been able to cut down, compared with 2.7 percent nationally."

As with alcohol, women use other drugs less frequently than men. The notable exceptions are cigarettes and medically prescribed psychoactive drugs. According to a recent Public Health Service publication, smoking by high school senior women now exceeds that of men and the same is true for young adults 18 to 25. "Because of this increase in smoking by young women, the total number of female smokers of all ages is now only about ten percent smaller than that of male smokers (28.4 versus 31.8 million)."

There is a higher incidence of medical prescription of psychotherapeutic drugs among women than among men. According to the 1986 Report of the Public Health Service Task Force on Women's Health Issues: "In 1979, the latest year for which detailed survey data on psychotherapeutic drugs are available, nearly twice as many women as men (over 18) had used psychotherapeutic drugs in the preceding year (20.2 percent versus 11.0 percent by men). Anti-anxiety agents—the minor tranquilizers—were also used nearly twice as often by women (14.1 percent versus 7.5 percent). Sedatives were used by over three times as many women as men (2.6 percent versus 0.8 percent). Over twice as many women used antidepressants in the preceding year (2.8 percent versus 1.3 percent) and 20 percent used hypnotics (sleep-inducing drugs). Anti-psychotic medication—chiefly the major tranquilizers used to treat such disorders as schizophrenia—were used by 50 percent more women (1.5 percent versus 1.0 percent)."

Women frequently engage in the high risk practice of using alcohol in combination with other drugs, particularly psychotherapeutic drugs. In a 1983 Alcoholics Anonymous Survey, 40 percent of female A.A. members reported addiction to another drug. This number increased to 64 percent for women 30 years of age and under.

APPENDIX B

Survey Respondents

All 50 state and seven jurisdiction alcohol and drug abuse agency directors were surveyed. Alcohol and drug services are under a single director in 44 states and under separate directors in six states. In the six states with discrete agencies, both the alcohol and the drug agency were surveyed separately.

Forty-five states and three jurisdictions responded to the survey. They are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland A/D, Massachusetts A/D, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey D, New York A/D, North Carolina, Ohio A/D, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, Washington, Washington, D.C., West Virginia, Wisconsin and Wyoming.

NCA expresses its appreciation to the state officials who completed this survey and furnished other assistance and information for this study.

Note: "A/D" indicates both drug and alcohol agency response.

APPENDIX C

State Survey Questionnaire
(Sent by mail and requiring written replies.)

1. Which types of women's programs do you expect ADMS block grant monies to support in your state fiscal years 1986 and 1987?

2. What has been the effect, if any, of the set-aside on funding for other programs for underserved and general populations? If there were any reductions, was the state able to fund these programs with other monies?

3. What are your impressions of the benefits and the problems of the women's set-aside? Do the advantages outweigh the disadvantages?

4. Do you recommend other, legislative or non-legislative, ways of determining the type and extent of services for women?

5. How was the community involved in the planning and implementation of the women's set-aside? (Check all that apply.)

Community advisory committee _____

Discussion with treatment providers _____

Needs assessment _____

Public hearings _____

Other (specify) _____

6. Please estimate the percent of total state A&D monies in 1984 and 1985 which were allocated, obligated, or expended for women's programs.

1984 % monies _____ 1985 % monies _____

7. Indicate the characteristics of your state's alcohol and drug population supported by ADMS block grant monies by completing this chart.

Number Males & Females Admitted to
Block Grant Funded Programs in 1985

	Alcohol	Drug
Number		
Males		
Females		
Minority Females*		
Poverty Females*		

*Please estimate minority and poverty numbers if this information is not readily available. Also, use your state's definition of poverty.

APPENDIX D

State A&D Program Administrator Questionnaire (Interview guide for site visits.)

1. Which types of women's programs did your state fund using ADMS block grant monies in fiscal year 1985? What are your plans for the two coming years?

2. How much priority does the women's set-aside have? How much priority do programs for women have in the state?

3. In what way did the state define or interpret the set-aside in order to implement it successfully?

4. What changes, if any, had to occur from existing conditions at the state and service provider levels in order to implement the set-aside? These changes might be formal (staffing, materials, budget, time, etc.) or informal (relationships or attitudes).

   What procedures did you use to implement the set-aside?
   (Examples: RFP, conference, renegotiation of prior contract.)

   What criteria did you use in deciding which programs to fund?

5. Does your state have policies or procedures to enable agencies (health, social service and law enforcement) to identify and refer low-income women to treatment programs?

6. Do you think that women are underrepresented in existing treatment programs? What is the evidence?

7. Do you think that the set-aside has affected this state's perspective about service needs for women? How about for minority, low income women?

8. Do you recommend other, legislative or non-legislative, ways of determining the type and extent of services for women?

9. In sum, what have been the benefits of the set-aside programs? What problems have been encountered? Does the good outweigh the bad?

10. What do you expect the legacy of the women's set-aside to be in your state?

APPENDIX E

Program Director Questionnaire (Interview guide for site visits.)

1. What is the (Women's set-aside funded) program name and type (Alcohol, Drug, Alcohol & Drug)?

2. What is the program category? Is this a prevention or treatment (detox, rehab, outpatient) or other type of program?

3. When did the program start admitting clients?

4. What are the age, income, and minority characteristics of the typical client population? (Youth –18, Adult 18–64, Older 64 +), (L,M,H), (W,B,H,AP,AmN). How many clients does the program serve? (Annual max, low-hi, mean.)

5. What are the services provided by the program? (Aftercare, childcare, inpatient, pregnancy, other.) What is the larger facility of which this program is a part? How does the program relate to the goals of the larger facility? Why did you seek funding for this program?

6. What are the evaluation criteria for successful treatment? Do you conduct follow up?

7. How are clients brought into the program? By referral? By outreach to the general public, low income, ethnic, or other groups? What other means are used?

8. Which components of this program are most attractive to clients? Why?

9. Which components of this program are most attractive to low income and minority clients? Why?

10. How well is the program working?

11. Do you think that there is an unmet demand for programs for women or for particular subpopulations of women (older, family, etc.)? How is this measured?

12. Do you think women are underrepresented in existing treatment programs?

13. Does the state have policies or procedures which enable agencies (health, social service and law enforcement) to identify and refer low-income women to treatment programs?

14. Do you think the set-aside has affected state practices or your perceptions and practices regarding services for women?

15. If set-aside funds are withdrawn, what do you think will be the legacy of this legislative effort?

APPENDIX F
Minority Women

Information on patterns of alcohol and other drug use among minority women is minimal and often fails to take into consideration regional, tribal, intratribal, cultural, class and sex differences in drinking and other drug-taking attitudes and behaviors. Despite this lack, some observations regarding Black, Native American and Hispanic women can be made.

Alcohol use is responsible for some of the most significant health problems among Blacks. According to the NIAAA: "alcohol problems have a major impact on Black Americans. The violent consequences of alcohol abuse have been extreme for Black Americans (especially Black males) in terms of homicides, accidents, criminal assaults, and other conflicts with the law. In addition, Black Americans suffer disproportionately from the health consequences of alcoholism including cancer, obstructive pulmonary disease, severe malnutrition, intestinal disaccharidase actions, hypertension and birth defects." The average annual age-adjusted death rates for chronic liver disease and cirrhosis, which are good indicators of alcoholism, are twice as high for Blacks as for whites. Very little is known about the prevalence and natural history of alcohol problems among Black women. Black women, like Black men, have higher abstention rates than whites but report heavier drinking and more problems associated with alcohol use when they do drink. Black women between the ages of 15 and 34 have rates of cirrhosis a little over six times the rate for white women. The risk for FAS among Black infants is seven times greater than among white infants who receive the same prenatal alcohol exposure, according to a study of 8,331 consecutive pregnancies over a 33-month period in Cleveland.

The magnitude of alcohol and other drug problems among Native Americans was underscored in Congressional consideration of the Anti-Drug Abuse Act of 1986. According to Congressional findings "alcoholism and alcohol and substance abuse is the most severe health and social problem facing Indian tribes and people today and nothing is more costly to Indian people than the consequences of alcohol and substance abuse measured in physical, mental, social and economic terms." Native Americans die from alcoholism at more than four times the age-adjusted rates for the United States population as a whole. Four of the top 10 causes of death among Native Americans are alcohol-related: injuries (18 percent of all deaths), chronic liver disease and cirrhosis (five percent), suicide (three percent) and homicide (three percent). Native Americans between the ages of 15 and 24 are more than twice as likely to commit suicide as the general population and approximately 80 percent of those suicides are alcohol-related. Native Americans between the ages of 15 and 24 are twice as likely as the general population to die in automobile accidents and 75 percent of these are alcohol related. Women account for almost half of the cirrhosis deaths among Native Americans. The cirrhosis death rate for Native American females between the ages of 15 and 34 is 36 times the rate of white females in the same age group. The high incidence of drinking among Native American women of child-bearing age makes this an extremely vulnerable group for alcohol-related complications in pregnancy and for producing children with FAS and FAE.

Hispanics—whose origins are Mexican, Puerto Rican, Cuban, Central or South American, and European—are the second largest ethnic minority group in the United States. Few studies have been conducted on alcohol problems among Hispanics and almost all of these have focused on Hispanic males. Although a greater proportion of Hispanics abstain from alcohol or are very light drinkers than in the general population, a greater proportion of those who drink, drink heavily. Drinking has been historically viewed as an activity of Hispanic males. But recently, researchers have questioned the assumption that Hispanic women have a low incidence of alcohol-related problems. A 1986 publication by the National Clearinghouse on Alcohol Information points out that a "number of researchers have found that the drinking problems of Hispanic women are seriously underreported, partly because of the strong cultural sanctions against females over-indulging. As a result, Hispanic women may be reluctant to report, even anonymously, experiencing problems with alcohol." Moreover, evidence that associates acculturation of Hispanic women in the U.S. with increases in alcohol consumption suggests that this group needs additional attention.