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NJ
WomenCount

Substance
Abuse and Its
Effect on Women



Substance Abuse and Its Effect on Women

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Introduction

With this issue of *NJ WomenCount*, the Division on Women of New Jersey's Department of Community Affairs, in collaboration with the Institute for Women's Leadership at Rutgers University, introduces the first in an innovative series of publications whose mission is to provide organizational leaders, policymakers, and the New Jersey public with up-to-date information on women in the state. The goal is to improve the status of women, encourage growth in the numbers of women in decision-making positions, and broaden women's ability to influence policy.

The Division on Women and the Institute for Women's Leadership plan to release a series of *NJ WomenCount* publications that focus on particular topics affecting women in New Jersey while identifying and examining links among leadership, policymaking, and the status of women. The intent in this collaboration is to summarize multiple perspectives rather than present an in-depth study of the subject. Those who work in the fields under study (many of whom we have consulted) are the experts. The purpose of this report is to consider topics from a leadership and gender perspective and to engage a wide audience.

To develop a distinctive research style and a consistent context, the Division on Women and the Institute for Women's Leadership have implemented a framework for researching and presenting each topic in the series. Drawn from organizational behavior research, this systems model allows us to focus on large, complex issues and enhances the ability to draw conclusions and recommend action and policy. *NJ WomenCount* reports will be organized to highlight three general categories:

- (1) New Jersey **leadership** as it relates to the topic under discussion, paying particular attention to the presence or absence of women in decision-making positions;
- (2) **Structural** or organizing entities associated with the topic (for example, a government department); and
- (3) **Support** systems available to help us understand the topic (for example, budgets, policies, or state data).

In addition to the research summarized in *NJ WomenCount*, original research will be conducted on topics of concern to New Jersey women and to examine the impact of leadership on those topics. As it becomes available, this research will be presented to the public on the websites of both the Division on Women and the Institute for Women's Leadership. The authors are confident that *NJ WomenCount* and its associated research will not only be a source of information for New Jersey women and men but will also broaden women's understanding of their peers and enhance one's ability to take action and make a difference.

This issue of *NJ WomenCount* deals with substance abuse and its effect on New Jersey women. (The next issue in the series is expected to be released in winter 2007 and will focus on the status of older New Jersey women, ages fifty-five and above.) While everyone agrees that drug addiction and substance abuse are serious problems, not enough citizens are aware of the distinctly different ways in which women and men confront these issues. Gender matters in drug addiction, but discussions about addiction often overlook gender distinctions.

Here in New Jersey, women make up one-third of admissions to treatment facilities for substance abuse, and the percentage of women among those incarcerated for drug-related offenses has increased. As long as women continue to be primarily responsible for care of their children, treatment and incarceration for drug abuse, which separate women from their dependents, pose a unique hardship. In addition, New Jersey's increasing number of female-headed households and the growing number of

children facing poverty—trends that have been illuminated in previous reports of *NJ WomenCount*—are gender-specific issues with important implications for the topic of women's drug abuse. In this document both women's connections with substance abuse are examined as well as New Jersey's progress in dealing with the issue and challenges the state still faces. At the same time, the research seeks to expand the understanding of leadership, presuming to ask if and how leadership should change.

Executive Summary

N*J WomenCount's* initial application of its research model assesses the status of women as related to substance abuse, targets analysis of substance abuse among women who are mothers, and makes specific policy recommendations. Recent restructuring of government departments and increasing state responsiveness to the issue of women and drug abuse suggest that circumstances may improve for affected women and their children. As an example, the New Jersey Child Welfare Reform Plan of 2004 asks the Division of Youth and Family Services (DYFS) to improve its workers' understanding of the interrelationship among family-risk factors such as substance abuse, mental health issues, housing problems, and domestic violence.

Prevention, education, and access to treatment services are society's best methods for eliminating the harsh toll that substance abuse takes on women and their families. But as this issue of *NJ WomenCount* will illustrate, many New Jersey women who struggle with substance abuse still do not have accessible treatment services and resources. The reasons are complex and touch on health and social matters that concern all women in New Jersey—as well as legislators, doctors, educators, treatment providers, and policymakers.

Leadership Women leaders advocate for women's issues.

Research shows that women in leadership positions advocate for women's issues and policies that affect women's lives, a fact that both female and male legislators perceive.¹ According to Susan Carroll, a leading researcher of women in politics, "women legislators have given more priority than men to legislation on health care and the welfare of families and children."²

New Jersey's low percentage of women legislators makes it vitally important to promote women's leadership in the state.

Substance abuse transcends gender, but certain issues are specific to women. As the mothers and primary caregivers of children, women face obstacles to obtaining help that men do not necessarily encounter. Women in need of treatment must plan not only for themselves but, in nearly half the reported cases, for children as well. Almost one in two women in treatment in New Jersey are mothers, and most of that number are single mothers.

Policy Recommendations Programs advocating for women leaders in New Jersey government are essential:

- It is important for New Jersey to draw women into public office at all levels. Their presence and leadership will increase awareness of policies concerning issues important to women, including substance abuse.

Structure Women who struggle with substance abuse do not have accessible services and resources.

Private community based organizations, government agencies, and other entities have been working together to end substance abuse and increase specialized services to women. Although these groups are strengthening the effectiveness of their partnerships, having enough available and accessible treatment opportunities remains a challenge for all concerned. In 2000, almost 20,000 women had unmet needs for treatment.

Half of all women admitted to New Jersey treatment facilities are mothers, most of them single mothers. Women struggling to overcome substance abuse are often faced with harsh choices; they are often without accessible treatment programs that include transportation and child care as part of a continuum of care. Many mothers fear prosecution and losing custody of their children, thus leading them further away from treatment. In 2004, forty-six of the 331 treatment facilities in the state accepted pregnant and postpartum women.

In 2003, a working conference focusing on the state of women's health in New Jersey identified four main barriers to treating substance abuse among women in the state:

- (1) need for services such as transportation and child care,
- (2) access to insurance,
- (3) need for supportive care that minimized the effects of discrimination or language barriers, and
- (4) need for a long-range philosophy and plan of prevention and treatment.

Policy Recommendations

Develop plans and policies that will close the service gap between demand and availability and increase specialized treatment modalities.

- Recent changes in child welfare policies that pertain to substance abuse evaluation and treatment are promising. The continuation of reforms directly affecting women are critical.
- Develop program standards and accountability through outcome measurements.

Develop policies regarding the treatment of substance abuse that prevent the need for disrupting families and continue to strengthen the goal of family reunification.

- Develop comprehensive policies and effective strategies designed to enhance outcomes for women with children and pregnant women seeking treatment. Focus on the co-occurring problems including domestic violence, housing needs and poverty; Design programs to provide transportation and child care.
- Develop training curriculum for substance abuse workers on the issues of domestic violence, housing needs and poverty.

Develop as an alternative to a mandatory sentencing policy, mandatory treatment and community service for nonviolent drug offenders.

Support

Substance abuse has a harsh impact on women and society.

Substance abuse is not an issue that can be understood nor defeated in isolation. It takes a toll on individual lives and on society at large. One-fourth of deaths in the United States are attributed to alcohol, tobacco, or illicit drug use. The economic costs to society are staggering; substance abuse costs the U.S. economy \$414 billion per year.³

In addition to deaths and economic implications, "more than 75 percent of domestic violence victims report that their assailant had been drinking or using illicit drugs at the time of the incident."⁴ Of actual arrests, alcohol and drugs were involved in 29 percent of domestic violence cases in 2004. Furthermore, children were present in 30 percent of those domestic violence offenses and involved in 5 percent of them.⁵

Nationally, most child welfare workers have not been trained in assessing or dealing with substance abuse.⁶ However, the New Jersey Child Welfare Reform Plan of 2004 asks the Division of Youth and Family Services (DYFS) to improve its workers' understanding of the interrelationship among family-risk factors such as substance abuse, mental health issues, housing problems, and domestic violence. Currently eight agencies funded by either a block grant women's set-aside or the DYFS initiative offer residential programs for women and their children under five years of age. In all other treatment programs, additional support is needed for the children.

Health concerns at birth and during childhood, disruptions of families, living in poverty, and exposure to domestic violence often occur with substance abuse and have a negative affect on children. According to *Innovators*, a national organization that addresses substance abuse, "children from families with substance-abusing parents are more likely to have problems with delinquency, poor school performance, and emotional difficulties than their peers from homes without substance abuse."⁷

In 2004, a reported 32,746 people in New Jersey had HIV/AIDS. Of those cases, 31 percent were exposed to the virus by drug injection and of those drug users 35 percent were female. Overall, women account for 36 percent of people in New Jersey living with HIV/AIDS.⁸

In addition, thirty-six percent of New Jersey prisoners are incarcerated for drug offenses, compared to 20 percent nationally. From 1990 to 2002 the percentage of incarcerated women in New Jersey rose by 52 percent (31 percent for men), with the top offenses being drug-related; The high rate of incarceration for drug offenses in New Jersey is primarily due to our state's mandatory minimum sentencing laws.⁹ The Justice Policy Institute reports that an estimated two-thirds of New Jersey prisoners need drug treatment and 59 percent need treatment for alcohol abuse. In 2001, there were 1359 therapeutic community beds in six different prisons, up from 329 as recently as 1998.¹⁰

Policy Recommendations

Information gathering for unanswered questions that can help target future strategies to address substance abuse and its effect on women is recommended.

- Interested community based organizations, governmental entities, and individuals suggest that the following areas and questions may provide fertile ground for ideas to develop additional study of women and substance abuse. What is being done to address substance abuse in New Jersey prisons? What happens to incarcerated pregnant women with substance abuse problems? What types of services are offered to imprisoned women with substance abuse problems? How effective are these programs? How many children are in foster care as a direct result of a parent's substance abuse? What happens to children when their mothers do not receive treatment for substance abuse? To what extent is substance abuse a consequence of negative coping strategies after a sexual assault?

Legislation

In the 2006–2007 legislative session, two bills before the New Jersey Assembly and Senate required health insurers to cover alcohol and drug treatment. Assembly Bill A-2512, sponsored by Assembly persons Gordon, Johnson, and Manzo¹¹ "revises statutory mental health coverage requirements and requires all health insurance to cover alcohol and drug addiction treatment under the same terms and conditions as for other diseases or illnesses."¹² New Jersey Senate Bill S-807, sponsored by Senators Joseph F. Vitale and Barbara Buono, revises "statutory mental health coverage requirements and requires all health insurers and the State Health Benefits Plan to cover treatment for alcoholism and other substance-use disorders under same terms and conditions as for other diseases or illnesses."¹³ This legislation helps to remove one identified significant barrier to substance abuse services for working women and mothers by increasing access to services for them through health insurance coverage.

Key Facts

1. Almost one in two women in substance abuse treatment in New Jersey are mothers; most are single mothers.
2. Overcoming substance abuse presents a significant barrier for women who are mothers: How can they care for their children while getting the treatment they need themselves?
3. In 2000, almost 20,000 women had unmet needs for treatment. Overall, one in two adults, or approximately 70,000 men and women, were not able to access services for treatment in New Jersey.
4. There are four key barriers for women in treatment:
 - a. Need for services such as transportation and child care
 - b. Access to insurance
 - c. Need for supportive care that minimizes the effects of discrimination or language barriers
 - d. Need for a long-range philosophy and plan of prevention and treatment
5. In 2003, only 12 percent of treatment centers in New Jersey accepted pregnant and postpartum women.
6. The percentage of women in New Jersey prisons rose by 52 percent in the twelve years between 1990 and 2002. The primary offenses that put women in prison were drug-related.
7. Ninety percent of incarcerated fathers report that their children live with the other parent while they are incarcerated. But only 28 percent of incarcerated mothers report that their children live with the other parent.

Research Model Methodology

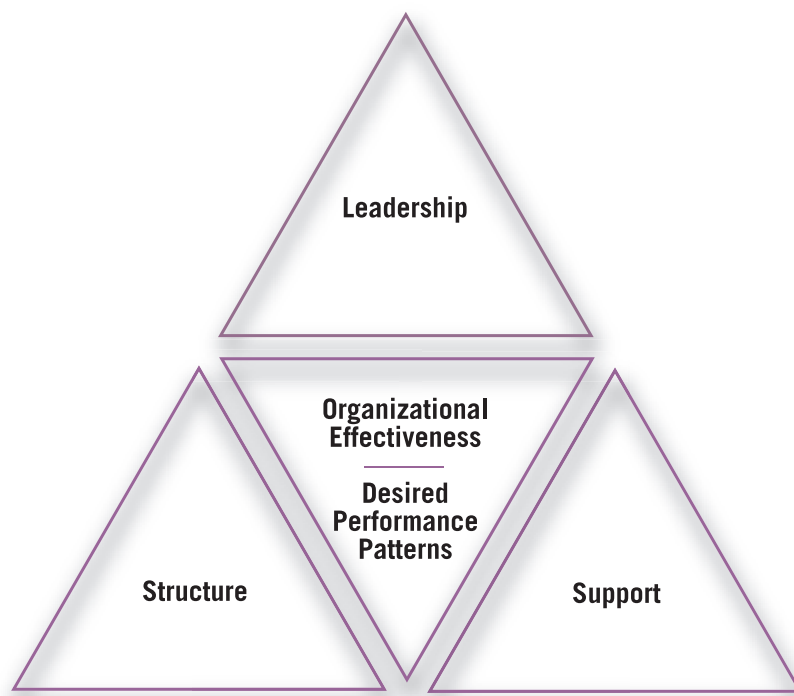
N*J WomenCount* uses a research model that leads to action and change. The model stipulates that the outcome to be achieved requires leadership, structure, and support systems to be aligned and focused on working together toward that goal. The desired outcomes of this research include the following:

- Understanding leadership as it relates to an issue
- Recognizing the issue as it relates to the quality of life for women in New Jersey
- Understanding the barriers to overcoming the issue
- Timely response to the issue
- Policy that promotes women-centered policy development
- Understanding the resources available to women

The research is organized into three categories:

1. **Leadership:** understanding leadership in New Jersey as it relates to an issue and women
2. **Structure:** examining those organizational structures currently surrounding the issue
3. **Support:** data and resources that clarify the issue and its impact on women

Using this model to integrate existing data allows us to suggest policy and action in areas where leadership, structure, and support are not aligned or are not consistent with the desired objectives.



Mainsail Associates, Inc., Princeton, NJ

Note: For more information about this model please refer to www.mainsailassociates.com

Substance Abuse and Women: An Overview

Substance abuse has a profound effect on women and their children in the state of New Jersey. Even with recent improvements, the state must continue to address the problem’s wide-reaching implications. It is not possible to understand or address these needs in isolation. Substance abuse and its effects contribute to a perpetual cycle of drug use, poverty, and domestic violence.¹⁴

The drugs people abuse range from prescription drugs, to legal substances such as alcohol and tobacco, to illegal narcotics. The National Institute on Drug Abuse lists the following commonly abused drugs:¹⁵

Acid/LSD	Marijuana
Alcohol	Methamphetamine
Club drugs	Phencyclidine/PCP
Cocaine	Prescription medications
Ecstasy/MDMA	Smoking/nicotine
Heroin	Steroids (anabolic)
Inhalants	

Overcoming substance abuse presents a significant barrier for women who are mothers: how do they care for their children while getting the treatment they need themselves? Although awareness is clearly rising (see page 20 of this report), “it is undeniable that significantly more treatment programs, especially those which provide treatment to pregnant women and children of substance abusers, must be developed and funded.”¹⁶ There are few programs in New Jersey that allow women in treatment to stay with their children, although such programs clearly provide more effective help to women and their families in comparison to those that separate women from their children.¹⁷ As Sara Kershner and Lynn Paltrow point out, “holding women responsible includes reversing the policies that pit a mother’s needs against her children’s. The needs of women, their children

and their families are not opposed, but part of a larger goal of family wellness.”¹⁸ As discussed, the new goals presented in the state’s Child Welfare Reform Plan take seriously the need for reunification of families.

When compared to New Jersey’s needs, the availability of treatment for substance abuse is inadequate.¹⁹ Fifty percent of the adults who have sought treatment for substance abuse in our state (70,000 people) have not been able to receive help due to “limited treatment capacity.”²⁰ This concern is amplified for women, who often face significantly greater obstacles than men do. As mentioned, substance abuse by women and the ability to obtain treatment is often associated with domestic violence and child care needs.²¹ In families, alcohol and drug abuse is associated with divorce, domestic violence, and child neglect and abuse. It also affects societal issues and government programs such as foster care, health care, the criminal and justice systems, violence in communities, and employment and workplace safety.²²

According to Kershner and Paltrow, the greatest and deepest concern about the impact of drug use on children comes from pregnant and parenting mothers who use drugs themselves. . . . we [need to] move away from approaches that pit women’s needs and rights against a child’s needs and rights, and move to a different approach based on a new set of questions: How do we mobilize the concern shared by pregnant and parenting mothers who use drugs towards making changes for the improvement of their own and their children’s well-being? How do we increase the options available to women and families to act upon that concern?²³

That is, what is the best way to provide necessary treatment, safeguard families, and obtain reunification without long-term separation or estrangement?

Effects of Parental Substance Abuse on Families

Parental substance abuse influences the extent to which a family functions effectively.²⁴ It may have negative effects on financial well-being and marital satisfaction. There is a greater risk of child abuse and neglect as well as violence against a partner when substance abuse is present in a family. Additionally, children with a parent who is a substance abuser have a greater risk of experiencing trouble in school as well as social isolation. Moreover, children living in these unstable environments are at a greater risk of becoming substance abusers themselves. (See the appendix for examples of potential health effects as a result of a mother’s substance abuse.)

Prisons, Substance Abuse, and Women

New Jersey not only has the highest number of people incarcerated for drug offenses in the nation, but the number is growing at a faster rate for women than for men. Between 1990 and 2002, the percentage of incarcerated females in the state rose by 52 percent; the percentage for men rose by 31 percent. Women in New Jersey represent a “fast growing segment of the prison population; they are more likely to be

incarcerated for the least violent offenses, and the costs of incarcerating them to neighborhoods, families and communities are huge.” In addition, the Justice Policy Institute reports that when a father is incarcerated, the effect on the children is different from when mothers are incarcerated, since women are much more likely to be the caregivers. Specifically, 90 percent of fathers reported that their children “reside with their other parent while they are imprisoned—but just 28 percent of mothers report this to be the case. Most women prisoners’ children are displaced—living with extended family members or friends—while they are incarcerated. At least 10 percent of the children of prisoners are placed in non-kin foster care.”²⁵

Since 1999, drug offenses have been the most common reason for incarceration among women in New Jersey state prisons (see Table 1). Among male prisoners in 2004, violent offenses were the most common reason for conviction.²⁶ “Women represent the fastest growing population of people being imprisoned for drug offenses” in both the United States as a whole and New Jersey in particular.²⁷ In 2000, New Jersey was among the top three states with the highest percentage of women imprisoned for drug violations: New York (68 percent), Washington (54 percent), and New Jersey (49 percent). The lowest percentage was Iowa (17 percent).²⁸

Table 1. Female facilities detail, New Jersey Department of Corrections statistics ²⁹

Year	Drug Offenses		Median Term	Median Mandatory Minimum Term	Median Age of Offender	Percent of Black Offenders
	Number	Percent				
2004	440	38	5 Years	4 Years	36	60
2003	480	42	5 Years	3 Years, 4 Months	35	61
2001	429	40	5 Years	3 Years, 3 Months	34	60
1991	499	44	4 Years	3 Years	32	66

According to a 2004 *Star Ledger* article, the increase in prison population is due to New Jersey's zero-tolerance drug laws. Specifically, the state maintains mandatory minimum sentencing for drug offenses. As mandatory sentencing has grown, so has the number of drug offenders in prison.³⁰ As a result, New Jersey has the highest number of "incarcerated drug offenders in the nation."³¹ In 1982, 11 percent of prisoners were serving mandatory minimums, 12 percent of them as drug offenders. Compare those figures to 2001, when 61 percent of prisoners were serving mandatory minimums, 34 percent of them as drug offenders. This is a huge increase in less than twenty years. According to Families Against Mandatory Minimums (FAMM), an organization that reports results from a poll conducted by the Eagleton Center for Public Interest Polling at Rutgers University, 80 percent of respondents support "sentences of mandatory treatment and community service for low-level non-violent drug offenders, if such sentences will reduce the amount of money New Jersey spends on corrections." Laura Sager, FAMM's national campaign director, states, "New Jersey residents are ready for the kind of sensible, cost-effective reforms that have been implemented by other states across the country. Now, judges have to send some low level offenders to costly prisons, even when they think other options would be more appropriate. It's time to give judges back the authority to fit punishment to the crime and to invest in programs that save money while better protecting public safety."³²

Both the rise of incarceration due to drug offenses and the undeniable effect of incarceration on families need New Jersey's attention. As John Hulick, public policy director for the National Council on Alcohol and Drug Dependency—New Jersey, says,

With the highest proportion of incarcerated drug offenders in the country, our prisons are filled with people who could be safely and more effectively treated elsewhere. Studies show that treatment programs

are more effective and less expensive than prisons. Rather than wasting costly prison beds on low level drug offenders, New Jersey should expand its popular drug treatment programs, and reform mandatory sentencing laws that prevent judges from determining appropriate sentences.³³

According to the Justice Policy Institute, "the cost of incarcerating New Jersey drug offenders is greater than what one third of the states spend on their entire corrections system."³⁴ In 2001, New Jersey spent an estimated \$266 million on drug offenders.

The National Institute on Drug Abuse suggests that "many drug-using women do not seek treatment because they are afraid: They fear not being able to take care of or keep their children, they fear reprisal from their spouses or boyfriends, and they fear punishment from authorities in the community. . . . Traditional drug treatment programs may not be appropriate for women because those programs may not provide these services" such as parenting training, family therapy, child care, and family planning.³⁵ Kershner and Paltrow concur: "Pregnancy and motherhood do not change either personal histories or present contexts for women's lives, they only intensify the need for support and the consequences of their drug use, while further limiting the options available."³⁶ Both the DYFS initiative and the block grant women's set-aside program are beginning to fund treatment centers in New Jersey that provide not only care for mothers who are overcoming substance abuse but also offer training in life skills.

DID YOU KNOW...

Women account for 36% of the 32,746 people living with HIV/AIDS in New Jersey. Of those women, 3 of 4 are between 20 and 49 years old and 4 of 5 are minorities.

Substance Abuse and Child Welfare Reform

In June 2004, the state’s Department of Human Services issued the report *A New Beginning: The Future of Child Welfare in New Jersey*.³⁷ The report discusses ways to transform the child welfare plan. Of particular interest to *NJ WomenCount* are the report’s suggested changes in philosophy toward female substance abusers and their families. The plan proposes a new case practice model that focuses on outcomes, not the process. It requires caseworkers to maintain a reasonable workload—that is, not to stretch their time and responsibilities to a point at which they can no longer provide adequate and effective service. Additionally it proposes changes in how caseworkers interact with families so that they can learn to recognize the uniqueness of each family.

Under the new plan specialists will be employed to investigate each case before transferring it to a permanent caseworker. The caseworker’s goal will be family reunification or a permanent placement for the child. Therefore, caseworkers will collaborate with other entities who can provide support, such as families, community representatives, and other service providers.

The report recognizes that substance abuse affects child welfare and is one cause of family disruption. Thus, the new plan empowers mothers who are substance abusers, teaching them coping skills and enhancing their ability to deal with their addiction. By suggesting that the state should offer gender-specific services such as parenting, job, and life skills for mothers, in addition to treatment for substance abuse, the report emphasizes the central importance of family reunification (see the appendix).

Relevant Data

The data on women and substance abuse in New Jersey is extensive and publicly available in the reports and websites of government agencies and research and treatment facilities (see the endnotes). In 2003, women made up 31 percent (approximately 16,000) of the 52,241 admissions into New Jersey substance abuse treatment facilities.³⁸ From 1 June 2004 through 31 May 2005, almost half of all women admitted to treatment were mothers; and of those mothers, 81 percent were single mothers (see table 2).³⁹

Almost 1 in 2 women in treatment in New Jersey are mothers; most are single mothers.

Table 2. New Jersey women admitted to treatment facilities, 1 June 2004 to 31 May 2005

Women	Number	Percent of Total
Mothers Total	7,550	47.42
Single Mothers	6,109	38.37
Not Mothers	8,370	52.58
Total Women	15,920	100

Table 3. Admissions to treatment facilities and child care responsibilities, New Jersey, 1995

Treatment Modality	Number of Admissions	Percent of Women			
		In Each Modality	By Modality	With Dependent Children	With no Dependent Children but Would Seek Custody
Inpatient Detox	4,907	29	33	44	9
Residential	1,921	30	13	29	15
Drug-Free Outpatient	4,800	32	32	48	7
Outpatient Methadone Maintenance and Detox	2,107	43	21	72	2
Total	13,735	31	99 (rounding)	51	7

It was also the case in 1995 that half of the women receiving treatment were mothers. Table 3 depicts child care responsibilities by type of treatment for 1995. As we have already stated in this report, it is not yet clear where children are placed when they are not accompanying their mothers in treatment.⁴⁰

New Jersey citizens who are working to overcome their substance abuse often have no accessible services and resources. In 2000, more

than 50 percent of those seeking treatment—men, women, and adolescents—did not receive it. It is not clear what happens to such individuals. According to New Jersey’s Division of Addiction Services, Table 4 reveals current available data.⁴¹

Substance abuse affects women in all New Jersey counties. Of people admitted to treatment, generally 30 percent of those from each county are women, ranging from a low of 24 percent in Cumberland to a high of 39 percent in Sussex (see Table 5).⁴²

The cost to American society of illegal drugs is close to \$67 billion a year. One-fourth of deaths each year in the United States are a result of alcohol, tobacco, or illegal drugs.⁴³ Drug use also influences HIV/AIDS.⁴⁴ As of June 2001, of the 18,153 men in New Jersey living with AIDS, 41.5 percent were injection drug users; of the 9,886 women in the state living with AIDS, 35.6 percent were injection drug users.

Table 4. Met and unmet demands for treatment, New Jersey, 2000

	Demanded Treatment	Received Treatment	Did Not Receive Treatment
Adults	138,450	67,070	71,380
Women	41,950	22,520	19,430
Adolescents	14,540	5,130	9,410

Table 5. Admissions to treatment facilities by county and gender, 1 January through 31 December 2003

County	Total Admissions	County of Residence, Percent of Total	Per Capita Income, 2000 (dollars)	Admissions by Gender		Percent of Admissions Who Were Female	Percent of Clients Treated in Their Own County
				Female	Male		
Atlantic	2,195	4	21,034	621	1,574	28	64
Bergen	3,280	6	33,638	960	2,319	29	73
Burlington	1,309	2	26,339	405	901	31	21
Camden	3,542	7	22,354	1,058	2,482	30	69
Cape May	925	2	24,172	266	658	29	65
Cumberland	1,416	3	17,376	340	1,076	24	45
Essex	8,940	17	24,943	3,220	5,713	36	65
Gloucester	1,503	3	22,708	415	1,087	28	36
Hudson	4,133	8	21,154	1,121	3,010	27	63
Hunterdon	725	1	36,370	243	482	34	66
Mercer	1,827	3	27,914	489	1,336	27	57
Middlesex	2,977	6	26,535	825	2,149	28	50
Monmouth	3,981	7	31,149	1,264	2,712	32	75
Morris	2,038	4	36,964	597	1,439	29	60
Ocean	3,079	6	23,054	1,012	2,063	33	39
Passaic	3,468	6	21,370	950	2,516	27	51
Salem	482	1	20,874	138	344	29	51
Somerset	1,136	2	37,970	345	789	30	62
Sussex	753	1	26,992	291	462	39	39
Union	3,838	7	26,992	1,148	2,689	30	54
Warren	810	2	25,728	283	526	35	64
Other	1,332	2					
State totals	53,908		27,006	16,472	37,395	31	57

Table 6. New Jersey resident admissions, by ethnicity, gender, primary drug, and mean age, 2001

Ethnicity by Gender		Primary Drug									
		Alcohol		Cocaine		Heroin		Marijuana		Others	
		Number Admitted	Mean Age	Number Admitted	Mean Age	Number Admitted	Mean Age	Number Admitted	Mean Age	Number Admitted	Mean Age
Black	Female	873	37.7	1,115	35.8	4,103	37.8	339	24.6	73	34.8
	Male	2,456	37	1,682	37.7	6,081	38.8	2,090	23.5	127	29.4
White	Female	2,780	37.8	707	31.5	3,978	29.9	494	22.3	567	35.6
	Male	7,842	37.6	1,462	33	7,756	31.9	1,915	21.6	782	33.2
Hispanic	Female	206	33.8	175	32.3	966	33.1	153	22.1	27	31.8
	Male	1,341	35.8	496	33.5	3,560	33.7	749	22.1	85	27.4
Other	Female	45	35	15	32.8	147	31.9	15	19.2	8	34.1
	Male	208	36	35	33.1	365	32.8	84	23.5	23	31
Total	Female	3,904	37.5	2,012	34	9,194	33.8	1,001	23	675	35.4
	Male	11,847	37.2	3,675	35.2	17,762	34.6	4,838	22.6	1,017	32.2

Men and women differ physiologically in both their reactions to addictive substances and the types of drugs they use. Women are 48 percent more likely than men to use prescription drugs that can be abused. Additionally, women tend to begin using drugs at an older age than men do. Alcohol abuse in women is most strongly predicted by family history; for men, however, the strongest predictor is socioeconomic status.⁴⁵

For both females and males, heroin abuse is the primary reason for admission to treatment. But there are differences in admissions by race. White women accounted for most female admissions for alcohol abuse (71.2 percent),

while black and Hispanic women together accounted for the majority of female admissions for both cocaine abuse (64.1 percent) and heroin abuse (55.1 percent) (see Table 6)⁴⁶

Regardless of age, heroin abuse accounted for the majority of female admissions for treatment (55 percent) in 2001. Nevertheless, women between the ages of thirty-five and forty-four accounted for 43 percent of admissions for alcohol abuse, while women age twenty and younger accounted for 51 percent of admissions for marijuana abuse. Tables 7a, 7b, and 7c provide an overview of the type of drug abused by both women and men in various age groups.⁴⁷

Table 7a. New Jersey women's admissions, by primary drug and age group, 2001

Age Group	Primary Drug										Total	
	Alcohol		Cocaine		Heroin		Marijuana		Others			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0-17	136	3.5	27	1.3	86	0.9	331	33.2	32	4.8	612	3.7
18-20	125	3.2	42	2.1	678	7.4	174	17.4	30	4.5	1,049	6.3
21-24	217	5.6	152	7.6	1,020	11.1	181	18.1	45	6.7	1,615	9.6
25-29	315	8.1	280	13.9	1,037	11.3	118	11.8	67	10	1,817	10.8
30-34	587	15.1	555	27.6	1,903	20.7	72	7.2	126	18.8	3,243	19.3
35-39	849	21.8	505	25.1	1,967	21.4	54	5.4	139	20.7	3,514	21
40-44	831	21.3	316	15.7	1,461	15.9	41	4.1	114	17	2,763	16.5
45-49	422	10.8	88	4.4	717	7.8	14	1.4	70	10.4	1,311	7.8
50-54	211	5.4	34	1.7	245	2.7	13	1.3	24	3.6	527	3.1
55-59	126	3.2	8	0.4	51	0.6	0	0	17	2.5	202	1.2
60-64	49	1.3	0	0	9	0.1	0	0	3	0.4	61	0.4
65+	32	0.8	2	0.1	7	0.1	0	0	5	0.7	46	0.3
Total	3,900	100	2,009	100	9,181	100	998	100	672	100	16,760	100

Table 7b. New Jersey men's admissions, by primary drug and age group, 2001

Age Group	Primary Drug										Total	
	Alcohol		Cocaine		Heroin		Marijuana		Others			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0-17	350	3	34	0.9	89	0.5	1,489	30.8	59	5.8	2,021	5.2
18-20	501	4.2	136	3.7	900	5.1	1,003	20.7	126	12.4	2,666	6.8
21-24	1,029	8.7	241	6.6	1,900	10.7	927	19.2	120	11.8	4,217	10.8
25-29	1,206	10.2	445	12.1	2,462	13.9	643	13.3	148	14.6	4,904	12.5
30-34	1,578	13.3	819	22.3	3,413	19.3	347	7.2	140	13.8	6,297	16.1
35-39	2,193	18.5	888	24.2	3,552	20	221	4.6	124	12.2	6,978	17.9
40-44	1,998	16.9	672	18.3	2,773	15.6	107	2.2	138	13.6	5,688	14.6
45-49	1,336	11.3	278	7.6	1,624	9.2	56	1.2	107	10.5	3,401	8.7
50-54	866	7.3	95	2.6	750	4.2	27	0.6	33	3.2	1,771	4.5
55-59	447	3.8	50	1.4	213	1.2	11	0.2	13	1.3	734	1.9
60-64	194	1.6	12	0.3	31	0.2	3	0.1	5	0.5	245	0.6
65+	136	1.1	2	0.1	21	0.1	0	0	3	0.3	162	0.4
Total	11,834	100	3,672	100	17,728	100	4,834	100	1,016	100	39,084	100

Table 7c. All New Jersey admissions, by primary drug and age group, 2001

Age Group	Primary Drug										Total	
	Alcohol		Cocaine		Heroin		Marijuana		Others			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0-17	486	3.1	61	1.1	175	0.7	1,820	31.2	91	5.4	2,633	4.7
18-20	626	4	178	3.1	1578	5.9	1,177	20.2	156	9.2	3,715	6.7
21-24	1,246	7.9	393	6.9	2,920	10.9	1,108	19	165	9.8	5,832	10.4
25-29	1,521	9.7	725	12.8	3,499	13	761	13	215	12.7	6,721	12
30-34	2,165	13.8	1,374	24.2	5,316	19.8	419	7.2	266	15.8	9,540	17.1
35-39	3,042	19.3	1,393	24.5	5,519	20.5	275	4.7	263	15.6	10,492	18.8
40-44	2,829	18	988	17.4	4,234	15.7	148	2.5	252	14.9	8,451	15.1
45-49	1,758	11.2	366	6.4	2,341	8.7	70	1.2	177	10.5	4712	8.4
50-54	1,077	6.8	129	2.3	995	3.7	40	0.7	57	3.4	2,298	4.1
55-59	573	3.6	58	1	264	1	11	0.2	30	1.8	936	1.7
60-64	243	1.5	12	0.2	40	0.1	3	0.1	8	0.5	306	0.5
65+	168	1.1	4	0.1	28	0.1	0	0	8	0.5	208	0.4
Total	15,734	100	5,681	100	26,909	100	5,832	100	1,688	100	55,844	100

Barriers to Drug Treatment Listening to Women’s Voices

A 1997 report compiled data from a survey on women welfare recipients’ opinions about self-sufficiency. A section of the report focused on women who were also dealing with substance abuse. The following key points from the report illustrate the barriers such women face:⁴⁸

- Most respondents reported that substance abuse had affected them, either their own use or the use of partners, family members, or friends.
- Respondents reported that substance-abusing welfare recipients experience discrimination, stigma, and demeaning treatment when approaching both the public welfare system and the job market.
- Most felt that women using drugs would be willing to self-identify and undergo treatment if they could be sure that they and their families would not be jeopardized.
- According to respondents, educating caseworkers about addiction and how to question welfare recipients in nonjudgmental, supportive ways is an important step in identifying those who use alcohol and other drugs.
- Respondents believed that comprehensive, supportive treatment services in which women are not separated from their children are essential to stopping substance use.
- The majority reported that treatment is necessary before employment or self-sufficiency strategies can be successfully enforced.

- Most did not want substance-abusing welfare recipients to go into the labor market because their presence might reinforce negative stereotypes and damage their chances with employers.
- Substance-abusing welfare recipients had needs similar to those of non-using recipients but were likely to encounter more obstacles on the path to self-sufficiency.

Problems Affecting the Treatment of Substance Abuse in Women

The 2003 working conference on women's health in New Jersey was sponsored by the state's Department of Health and Senior Services, its Public Health Association, and the Division of Women of the Department of Community Affairs as well as the U.S. Department of Health and Human Services' regional Office on Women's Health and the Southern New Jersey Perinatal Cooperative. Participants at the conference identified four main barriers to treating addiction among women in the state:⁴⁹

- *Enabling services.* "Transportation, short-term childcare and housing for women while [they are] undergoing rehabilitation are scarce, preventing broader participation. Little follow-up is provided to those who do enter programs."
- *Access.* "Many women lack insurance to cover costly rehabilitation or medical service, and consequently return to reliance on substances. Often women in need, and the health professionals providing care, are not aware of even those services that are available. No central directory of services and programs is available in the state. Fear of loss of confidentiality (even with new Health Insurance Portability and Accountability Act restrictions) prevents utilization of services."
- *Attitudes.* "Often addictive behavior is related to low self-esteem and lack of supportive environments. In addition,

the pressures of the culture in which the individual functions may increase these high-risk behaviors. Language barriers, racial or ethnic discrimination or attitudes of health care workers or child protective services may encourage women to avoid confronting or acknowledging their problems."

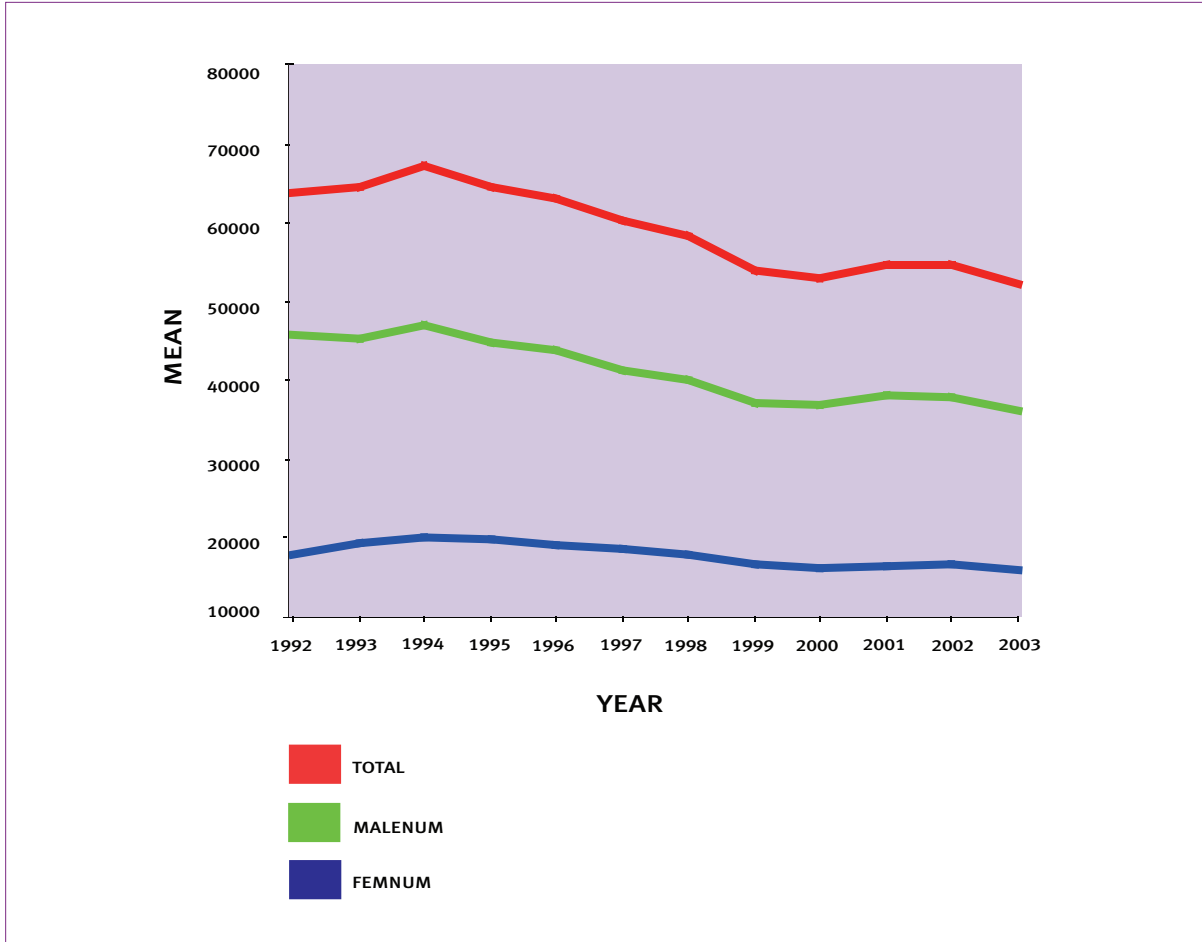
- *Philosophy and long range plans.* "The lack of an overriding philosophy or long range plan for prevention, treatment and care of addicted women has impeded the growth of funding and innovative approaches for specific programs and services. Timely data and research are needed to identify, disseminate and monitor best practices. Agencies should develop quality assurance criteria and practices."

Data Limitations

In our review of substance abuse in New Jersey, it is clear there exists unanswered questions and areas where further research would provide answers. What happens to children when their mothers are residing in treatment centers or receiving intensive outpatient therapy for substance abuse? The number of children placed in foster care as a direct result of their mother's substance abuse is currently unknown. Although the Division of Addiction Services is beginning to track the number of children who are placed with their mothers at treatment centers, that information is not yet available.

Since 1992, the number of admissions to treatment facilities in New Jersey has decreased for both men and women. Figure 1 shows not only large differences in the numbers of men and women who are admitted (men outnumber women by three to one) but also the growing downward trend between 1992 and 2003.⁵⁰ The Division of Addiction Services is currently exploring the reasons for this decrease.

Figure 1. Admissions to New Jersey treatment facilities by year and gender



Research Model Analysis

Leadership

As discussed, research shows that women in leadership roles can positively influence women’s issues and policies affecting women’s lives. Why? Despite changes in gender roles during the past several decades, women and men continue to have different responsibilities and experiences, meaning that “women are likely to examine and evaluate public policy proposals through a . . . set of lenses [different from] the lenses that men use.”⁵¹

Therefore, leadership matters when addressing women’s health care concerns, including substance abuse. For women’s health issues to receive the attention they need, women need to have a greater role in and impact on our government and medical communities; this is only beginning to occur. Furthermore, having more women involved in both political and medical leadership will broaden the traditional male model of medicine to include more studies on women.⁵²

DID YOU KNOW...

The Center for American Women in Politics conducts *Ready to Run™*, a bipartisan effort to encourage and train New Jersey women to run for political office at all levels.

In New Jersey, women lead efforts to battle substance abuse at many levels, including government, treatment centers, and communities. As Charlotte Bunch, executive director of the Center for Women’s Global Leadership at Douglass College, Rutgers

University, states, “Often women leading or seeking to lead are confined to the family or local community’s private sphere, but nonetheless they are exercising leadership. . . . Women have been resolving conflicts and finding solutions to community problems. . . . Women are always making priorities (hard choices) and stretching tight budgets.”⁵³ But New Jersey’s paucity of women legislators makes it more important than ever to encourage women to become involved in politics and the legislative process as well as other political causes that affect the women in the state.

New Jersey legislators, both women and men, have already begun speaking out about the need for more treatment facilities in the state and increased funding for them.⁵⁴

- “There are not enough treatment facilities” (Senator Loretta D. Weinberg, D-37, quoted when she was an assemblywoman)
- “We need to address a funding need for treatment” (Senator Robert W. Singer, R-30)
- “We should be ashamed of ourselves that in the largest county [Essex] in the state . . . there are 22,000 people going untreated because we can’t develop an ample public policy” (Assemblywoman Sheila Y. Oliver, D-34)
- “There’s a desperate need for substance abuse drug space, treatment and programs in this state. We are probably the worst in the nation at dealing with this problem” (Assemblyman Louis Manzo, D-31)

Women Leaders

Many women and men are working toward alleviating and improving problems associated with substance abuse in New Jersey, including the following:

- Senator Loretta D. Weinberg, sponsor of Assembly Bill No. 333
- Christine Scalise, specialist, Women's Special Programs, Office of Priority Populations, Division of Addiction Services
- Dr. Linda Jeffrey, director, Center for Addiction Studies, Rowan University
- Charlotte Blackwell, administrator, Edna Mahan Correctional Facility for Women, Hunterdon County

Division of Addiction Services and Division of Youth and Family Services Executive Committee and Steering Committee

In 2004, the Division of Addiction Services (DAS) and the Division of Youth and Family Services (DYFS) organized an executive committee and a steering committee. All participants are DAS-licensed treatment providers for DYFS women with children. Executive committee members include a small group of treatment providers who, for a number of years, have been implementing specialized programs for DYFS women and their children. The executive committee serves as advisor to the full steering council. Both executive and steering committee meetings address all issues related to the DYFS initiative, best practices, the Rutgers MOMS evaluation research project (see page 32 of this report), barriers to treatment, and training needs and costs of treatment. DAS provides technical assistance and support as needed.

Maternal and Child Health Consortium

The Maternal and Child Health Consortium, regulated by the New Jersey Department of Health and Senior Services, offers outreach, education, and enabling services for pregnant women and their families.⁵⁶ Out of this consortium the Perinatal Addictions Prevention

Project was developed to assess and screen pregnant women for substance abuse as well as offer prevention. Women drive the project. For more information about this project, see page 31 of this report.

Governor's Council on Alcoholism and Drug Abuse

The Governor's Council on Alcoholism and Drug Abuse was established in 1989 to "review and coordinate New Jersey's efforts in regards to planning and provision of treatment, prevention, research, evaluation, and education services for, and public awareness of alcoholism and drug abuse." The council has fourteen members: two are appointed by the senate president, two are appointed by the assembly speaker, and ten are appointed by the governor with senate approval. Of the ten, two are required to be recovering alcoholics; another two are required to be recovering drug abusers. The current chairman (since inception) is Joseph P. Miele, Esquire, and the executive director (since January 1998) is Mary Lou Powner. Leadership is a guiding principle: "We exercise leadership in the prevention, intervention, and treatment of substance abuse in the state."⁵⁷ The objectives of the council are to review county plans and distribute recommendations and grants accordingly, to assess funding for alcohol and drug abuse programs, and to collect necessary data from sources throughout the state.

County Alcoholism and Drug Abuse Authorities

There are twenty-one counties in New Jersey, and all either have an agency or an individual who is designated as the county alcoholism and drug abuse authority.⁵⁸ Of these officials, fifteen are women, and six are men. Each county drafts a county alcoholism and drug abuse plan and works with the local advisory committee on alcoholism and drug abuse.

Effectiveness of Leadership

While it is clear that individuals and organizations in New Jersey are committed to the task of reducing substance abuse, what level of coordination exists among these various bodies? Are they focused on a common goal? Are they aware of the hard work being done by other organizations? Is there an overriding philosophy or set of priorities that unites their efforts? These questions need further consideration. The need for more programs advocating for women leaders in our government is another important area for growth.

Structure

Many private agencies, government agencies, and other entities are working together to combat the problem of substance abuse; and, clearly, they are moving toward a stronger partnership—as evidence, for example, in the creation of the Child Welfare Reform Plan.

Division of Addiction Services

In 2004, the Division of Addiction Services moved from the Department of Health and Senior Services to the Department of Human Services. The mission of the division is to “decrease misuse or abuse of alcohol, tobacco and other drugs by New Jerseyans by supporting the development of a comprehensive network of prevention, intervention and treatment services in New Jersey.”⁵⁹ The Child Welfare Reform Plan resources provided for the expansion of specialized women’s services in 2004 and 2005. Current leaders of DAS include:

- Kevin M. Ryan, commissioner
- James W. Smith, Jr., acting director
- Christine Scalise, specialist, Women’s Special Programs

The division offers a thorough directory of definitions used in their website and discussions of substance abuse.⁶⁰

The Department of Community Affairs

The Department of Community Affairs is “a state agency created to provide administrative guidance, financial support and technical assistance to local governments, community development organizations, businesses and individuals to improve the quality of life in New Jersey.”⁶¹ Current leaders include

- Susan Bass Levin, commissioner
- Charles A. Richman, deputy commissioner
- Suzanne Winderman, chief of management and operations
- Michelle Richardson, assistant commissioner

Within the department, the Division on Women (a partner in *NJ WomenCount*) offers programs for women with problems or issues that can be complicated by substance abuse in the home, such as domestic violence, sexual assault, abuse, and job training. The Division of Housing also offers programs for families struggling with issues that may overlap with substance abuse, such as single motherhood and domestic violence, as well as programs for families moving toward self-sufficiency. The State Rental Assistance Program offers housing solutions; 17 percent of the people involved are homeless families with children, most of them women with children. The Shelter Housing Exit Program aids victims of domestic violence with children. Substance abusers living in assisted households risk losing their benefits unless they show they are participating in a substance abuse treatment program.

National Council on Alcoholism and Drug Dependency—New Jersey

The National Council on Alcoholism and Drug Dependency—New Jersey (NCADD-NJ), which also has a national presence, promotes prevention, treatment, and recovery from alcoholism and substance abuse.⁶² The council’s goal is to reduce the stigma associated with drug use and alcoholism. Additionally, it formulates public policy supporting the notion that alcoholism and drug abuse are treatable and preventable.

Treatment Providers and Agencies in New Jersey

As of 2004, there are 331 treatment facilities in New Jersey. Of that number, 46 take pregnant or postpartum women, and 108 are for women only.⁶³ As Table 8 shows, the number of facilities accepting pregnant women decreased from 2002 to 2004.

A number of treatment providers in New Jersey offer services to women and in some cases their children. As Table 9 depicts, funding is provided either through block grant women's set-aside programs or the DYFS initiative.⁶⁴

Following are three representative examples of New Jersey treatment centers for women and children and what these centers provide.

Cooper House. Located in Camden, Cooper House provides outpatient care for women seeking treatment for substance abuse.⁶⁵ They also provide on-site day care for preschool children and offer treatment priority to pregnant and parenting women.

Seabrook House. Located in Seabrook, Seabrook House provides recovery programs for adults struggling with alcoholism and drug addiction, including women with dependent children. It is currently under the leadership of Audrey Carter. According to the Seabrook House website, the average cost is \$18,400 for four days of detoxification and twenty-eight days of rehabilitation. Average health insurance plans cover one to two weeks of treatment. The program is also state-funded through the DYFS initiative's referral program.

Seabrook House features a unique program for mothers called MatriArk, a separate treatment program that provides "comprehensive substance abuse treatment to positively change the entire life pattern of addicted mothers and their children." This model program admits pregnant women, and mothers can bring along infants and children up to age twelve.

The goal of this program is to offer a "gender specific, culturally sensitive, 'women for women' program, which addresses the total woman and her family."⁶⁶ The Department of Human Services has provided \$3 million to develop and fund both the program and the facility and has also made additional funding to construct a new MatriArk facility that would expand the program's current capacity. According to Rebecca Flood, former vice president of treatment programs at Seabrook House, "for every person who accesses [substance abuse] treatment in New Jersey, there are three additional people who need treatment but can't get it. It is undeniable that more treatment programs need to be developed especially for pregnant women and children of abusers."⁶⁷

Great Expectations. Located in Somerville, Great Expectations is a residential treatment program for homeless pregnant women and adolescents between the ages of thirteen and forty. According to its website, the center is "the only licensed agency in New Jersey to provide housing and treatment for both adolescent and adult women who are pregnant and addicted to drugs and/or alcohol and who want to carry their babies to term."⁶⁸

Great Expectations receives more than twenty referrals each month from state agencies, but it can only house six women and their infants at one given time. Although clients come to the center through referrals from various New Jersey programs and departments, including the Work First New Jersey Substance Abuse Initiative, DYFS, social service agencies, hospitals, and churches, it currently does not receive state funding as part of the DYFS Initiative.

As the agency acknowledges, a limitation of the program is that women are forced to "graduate" from the program once they have given birth. To alleviate this problem, Great Expectations is seeking corporate sponsorship to expand both its services and facility.

Table 8. New Jersey treatment facilities that accept pregnant women

Year	Total Number of Facilities	Accept Pregnant or Postpartum Women	Accept Women Only	Offer Child Care	Offer Residential Bed for Clients' Children
2002	315	55	119	17	N/A
2003	322	40	120	26	10
2004	331	46	108	25	12

Table 9. Government-funded treatment providers in New Jersey by type of treatment

Type of Treatment	Name of Treatment Provider	City and County	Funding by Block Grant Women's Set-Aside	Funding by DYFS Initiative
Residential: women and children	Choices	Newark (Essex)	X	X
	Epiphany House	Asbury Park, Long Branch (Monmouth)	X	X
	Seabrook House	Seabrook (Cumberland)	X	X
	Trinitas Hospital	Elizabeth (Union)	X	
	Newark Renaissance House	Newark (Essex)	X	X
	Sunrise House	Lafayette (Sussex)	X	X
	CURA (New Beginnings Women's Services Program)	Vineland (Cumberland)		X
	Straight and Narrow	Paterson (Passaic)		X
Residential: women only	Eva's Sheltering Program	Paterson (Passaic)	X	
	Good News Home	Flemington, Hunterdon	X	
	CURA	Secaucus (Essex)	X	X
	Straight and Narrow	Paterson, Passaic, Secaucus (Essex)	X	X

continued on next page

Table 9 continued

Outpatient and intensive outpatient	Atlanticare Behavioral Health	Egg Harbor (Atlantic)	X	
	Newark Renaissance House	Newark (Essex)	X	X
	Counseling and Referral of Ocean	Brick (Ocean)	X	
	Effective Life Management	Medford (Burlington)	X	
	UMDNJ, Pediatrics	Newark (Essex)	X	
	UMDNJ, University Behavioral Healthcare	Piscataway (Essex)	X	
	180, Turning Lives Around	Hazlet (Monmouth)	X	
	Cooper Health System	Camden (Camden)	X	
	Center for Family Services	Voorhees (Camden)		X
	The Bridge Inc.	Irvington, Union		X
	Caper Counseling Services	Cape May (Cape May)		X
	Christ Hospital CMHC	Jersey City (Hudson)		X
	Catholic Charities	Asbury Park (Monmouth)		X
	Cathedral Health Services	Trenton (Mercer)		X
	Center for Behavioral Health	Plainfield (Union)		X
	Preferred Behavioral Health	Barnegat (Ocean)		X
	Reunity House	Orange (Essex)		X
	SODAT of New Jersey	Vineland (Cumberland)		X

Drug Courts

Drug courts in New Jersey take on cases of drug offenders that have not involved violence.⁶⁹ Offenders are given opportunities to enter treatment and, if possible, avoid prison sentences.⁷⁰ Drug courts have functioned successfully in both New Jersey and around the nation.⁷¹

In the late 1990s, Camden and Sussex counties began using drug courts; and by 1999, they had expanded to Mercer, Passaic, and Union counties. In 2001, legislation was passed to launch a statewide drug court system. By April 2002, drug courts had been launched in Bergen, Cumberland/Gloucester/Salem, Monmouth, Morris, and Ocean counties. Currently, establishment is pending in Atlantic/Cape May, Burlington, Hudson, Middlesex, and Somerset/Hunterdon counties.

Since the inception of drug courts in New Jersey, fifty-three drug-free babies have been born to female drug court participants; and fifty-two parents regained custody of their minor children due to participation in drug courts.⁷² It will be interesting to follow the expansion and effectiveness of this approach, especially as they relate to the lives of women and children. Given the state's high levels of incarceration, drug courts offer a practical alternative that may reduce prison costs as well as provide offenders with the needed resources.

New Jersey Drug Facts

Located as it is between New York City and Philadelphia, New Jersey is a corridor for drug transportation and use.⁷³ Heroin is the state's most significant narcotic drug problem, and marijuana is the most available and most frequently abused. Cocaine and crack are also widely available. In 2004, New Jersey ranked twenty-fifth in a national tally of states' violent crime offenses. A total of 55,814 drug violation arrests were made in 2004, up 1 percent from the previous year.⁷⁴ New Jersey has the highest rate of imprisonment due to drug offenses in the nation.⁷⁵

The Bureau of Justice Statistics (an arm of the U.S. Department of Justice's Office of Justice Programs) provides data on drug and crime facts:⁷⁶

- An estimated 1,678,192 state and local arrests were made for drug violations in the United States in 2003.
- Possession accounts for more than four-fifths of the drug-violation arrests nationally.
- As Table 10 shows, the northeast leads the nation in the number of arrests for the sale and manufacturing of drugs.

Temporary Assistance for Needy Families and Work First New Jersey

Individuals and couples with children receive welfare through a program known as Temporary Assistance for Needy Families (TANF).⁷⁷ A goal of the program is to provide parents with work skills and support so they can become self-sufficient. The assistance also allows parents to care for children in their own homes. TANF emphasizes work and the people's responsibility to support themselves and their families.

Work First New Jersey (WFNJ) is a program designed to move TANF recipients off welfare and back to work. Recipients receive a "temporary cash subsidy to bridge the gap while individuals seek and obtain self-sufficiency through bona fide unsubsidized employment." Recipients receive a lifetime maximum of sixty cumulative months of support and must complete thirty-five hours per week of work-related activities. Additional support includes "medical assistance through Medicaid; child care; transportation; housing assistance; work activity allowances; substance abuse treatment; assistance in applying for SSI [social security benefits]; assistance to past or present victims of family violence; and diversion through the EEI."⁷⁸

Table 10. Arrests for drug-abuse violations by U.S. geographic region, 2003 (in percent)

Violation	Northeast	Midwest	South	West	U.S. Total
Sale or manufacture	25.7	19.2	20.1	15.9	19.4
Heroin or cocaine	17.1	4.8	9.8	5.8	8.8
Marijuana	6.4	7.7	5.3	4.2	5.5
Synthetic or manufactured drugs	1	1.4	2.8	0.7	1.5
Other dangerous non-narcotic drugs	1.2	5.2	2.3	5.2	3.6
Possession	74.3	80.8	79.9	84.1	80.6
Heroin or cocaine	24.3	11.4	22.3	23.8	21.5
Marijuana	42.3	51.7	46.3	26.2	39.5
Synthetic or manufactured drugs	1.8	3.1	4.3	2.6	3.1
Other dangerous non-narcotic drugs	5.7	14.7	6.9	31.5	16.6
Total	100	100	100	100	100

For TANF recipients who need substance abuse treatment, the Substance Abuse Initiative (SAI) provides for referral to an SAI care coordinator and placement in a state-funded treatment program. Time spent in treatment is allocated toward an individual's work plan. "The central concept of the SAI is to place alcohol and drug treatment professionals [care coordinators] in or near New Jersey's 21 county welfare offices to assess recipients who themselves identify alcohol or drug use as a barrier to getting or keeping a job, and referring these recipients to treatment." It is important to note that "participation in an approved substance abuse treatment program that is monitored by the clinical substance abuse treatment care coordinator is considered a work activity for purposes of WFNJ."⁷⁹

Effectiveness of Structure

Although new and exciting developments are occurring in our state, we still need to expand and improve upon the effectiveness of services and treatment offered to substance abusers. Providing treatment opportunities that keep mothers with their young children, expanding our drug courts, and funding our treatment facilities are steps in the right direction. Focus and action should also be geared toward closing the gap between demand and availability; reducing mandatory sentencing for low-level, nonviolent drug offenders; and strengthening family reunification and avoiding family disruption.

Support

As awareness of substance abuse and its implications for society becomes stronger, so do support mechanisms such as legislation, budgets, available data, related policies, and publications.

Legislation

As mentioned previously in this report, two imperative bills related to substance abuse are currently pending approval in the New Jersey legislature: Assembly Bill A-2512 and Senate Bill S-807.

Currently New Jersey supports women's right to privacy and mandatory drug testing of pregnant women is not public policy. This includes child welfare laws to address prenatal exposure to drugs and laws focusing on reporting and testing requirements.⁸⁰ Furthermore, there is no state-level needle-exchange law.⁸¹ Needle-exchange programs distribute clean, safe syringes to injection-drug users and offer referrals to treatment centers and other social services. Although programs were scheduled to begin in both Atlantic City and Camden on 1 July 2005, both were stopped by a court injunction.⁸²

Budgets

The costs of treating substance abuse are substantial and difficult to calculate, as they involve not only treatment but also the effects and expenses associated with lack of treatment, crime, health care, and the salaries of state workers who deal with families.⁸³ Following are some examples of budgets.⁸⁴

- *Substance abuse treatment for DYFS/Work First mothers, pilot project, 2004: \$1,400,000 in grant aid money from the Department of Health and Senior Services*

- *Community-based substance abuse treatment and prevention (state share), 2004: \$20,900,000 from the Department of Health and Senior Services*
- *Grant to New Jersey from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (76 percent of grant money docketed as substance abuse funds), fiscal year 2004–2005: \$55,565,961 total substance abuse funds; \$47,251,367 as a block grant for prevention and treatment; \$1,075,722 as discretionary funding for prevention; \$7,238,872 as discretionary funding for treatment*

Current New Jersey Research

Perinatal Addictions Prevention Project. In an effort to support women with substance abuse, the Maternal and Child Health Consortia has developed the Perinatal Addictions Prevention Project to “shape new systems and improve existing ones so that substance-using pregnant women in this state can be identified, assessed and treated. The development of a uniform screening tool, the 4 P’s Plus, that will facilitate data collection was a critical step in this process.”⁸⁵ The tool is now being used throughout the state, and the data collected will be used in planning treatment programs for pregnant women (see Table 11).

DID YOU KNOW...

Of the 76,109 domestic violence victims in New Jersey (2004), 77% were women.

Table 11. 4 P's Plus data, June 2004

	Number	Percent
Women screened	14,254	
At risk for alcohol	1,363	9.6
At risk for cigarettes	1,935	13.6
At risk for violence	379	2.7
Presently using alcohol	164	1.2
Presently using drugs	78	0.5
Referrals indicated	685	4.8

The MOMS Project: Current Research. The Division of Addiction Services, in conjunction with the Center for Alcohol Studies at Rutgers University, is conducting a two-year study evaluating the effectiveness of state-funded treatment programs for mothers. The MOMS Project will specifically evaluate three major outcomes:

1. *Treatment outcomes.* How effective are programs in treating substance abuse as well as providing skills that help women handle other life issues such as overall health, parenting, legal concerns, and general well-being?
2. *Child outcomes.* How well is the child doing, based on the mother's report and data such as the extent to which the child stays in the house with his or her family?
3. *Cost analysis.* The study will evaluate the cost benefit of these state-funded programs.

Three populations will be considered:

1. Women with children who have been referred for treatment by DYFS
2. Women who have come in on their own and have an active DYFS case but were not directly referred by the department
3. Women who are considered at high risk for DYFS intervention—that is, mothers who are drug abusers

A total of twenty-seven treatment centers in New Jersey will participate in the study. The treatment programs fall into three categories:

1. Residential treatment
2. Partially assisted residential treatment
3. Intensive outpatient, including both drug-free intensive outpatient and methadone programs

Results of this groundbreaking study are anticipated in 2007 and will be presented to the Division of Addiction Services (which is funding the study) and disseminated to the public.

Effectiveness of Support

The adoption of laws to include substance abuse treatment as part of mental health benefits, current research assessing the effectiveness of treatment programs, and funding for treatment are all encouraging and provide a platform for improvement in our state. It is important that these programs and policies get attention and understanding from the public so that change can continue to occur. Additionally, continued and expanding research will be required as the state implements new programs and policies.

Conclusions

It is important to consider the data using the research model guiding this review: leadership, structure, and support must focus on substance abuse and work together to overcome the problems and concerns that have been highlighted. Following are aspects of each strand that are encouraging and challenging.

Leadership

Encouraging:

Many leaders in New Jersey are aware of the toll substance abuse is taking and the lack of available and affordable treatment. Many speak out about the need for change and are working toward change.

Challenging:

It is important for leaders to develop opportunities to change public policies and images concerning substance abuse. Further, it is essential to draw more women in and encourage them to seek involvement in politics and policy issues throughout New Jersey. We can encourage our leaders in this field to communicate and coordinate efforts to treat and prevent substance abuse.

Structure

Encouraging:

Many departments within the New Jersey government structure, including the Division of Addiction Services and national organizations such as NCADD-NJ, are working to develop and execute a more comprehensive program of prevention and treatment in the state. Many programs such as the DYFS initiative, WFNJ, and SAI are providing funding, care, and resources to affect not only treatment but also the overall lives of those seeking treatment.

Challenging:

More treatment centers are needed to facilitate the wellness and health of the more than 70,000 adults and 9,000 adolescents in New Jersey who are not receiving the care they need.

NJ WomenCount suggests a further construct change for New Jersey: focus on beginning appropriate services before a family is disrupted. Programs and policies that address treating a woman's needs before she is in danger of losing her children need to be defined and supported at both the state and local levels. Additional programs working toward reunification of mothers and their children are needed in situations where separation has occurred. There is also a need for a coordinating body to continue to research this topic and monitor and influence efforts.

Support

Encouraging:

Legislation such as A-2512 and S-807, which requires mental health insurance to be extended to alcohol and drug treatment, is being promoted. Comprehensive data on this topic are readily available to the public and support the need for additional resources and care. Groundbreaking research combining the resources of both government and academia (such as the MOMS Project) is being developed and executed.

Challenging:

One challenge is to develop policies that provide more care and expanded health coverage to individuals, families, and mothers in need. Continued research, best practices, and data need to be collected and monitored. Special issues surrounding women and substance abuse need to be recognized and widely understood so that legislative priorities can be established.

Resources

Finding Help

- NJ SAMS is a web-based data reporting system for substance abuse treatment providers in New Jersey. It offers training as well as reports and statistics: <http://samsdev.rutgers.edu/samstraining/mainhome.htm>
- Division of Addiction Services: <http://www.nj.us/humanservices/das>
- Center for Alcohol Studies, Rutgers University: <http://alcoholstudies.rutgers.edu>

Publications

- *Perspectives: A Journal on Addiction Research and Public Policy*, published by NCADD-NJ

Children's Substance Abuse

The National Center on Addiction and Substance Abuse at Columbia University presented a white paper in March 2005 demonstrating the clear effects of family on preventing and coping with substance abuse.⁸⁶ The report offers additional resources to educate yourself on the signs and symptoms of substance abuse and how to get professional help: <http://www.casacolumbia.org>

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Appendix

The Future of Child Welfare

The following text quotes directly from the New Jersey Department of Human Services, “A New Beginning: The Future of Child Welfare in New Jersey” (Trenton, 9 June 2004):

Current

- Approximately one-third of substantiated child abuse and neglect cases involve a substance abuse problem in at least one caregiver. These are the cases we know about. Nationally, the prevalence rates of families involved with child welfare with substance abuse is anywhere from 60–80%.
- Although the Department of Health and Senior Services’ Division of Addiction Services (DAS) provides a variety of substance abuse services, for every slot filled, there are three additional people waiting.
- The Department of Human Services (DHS) now spends approximately \$30 million in a variety of substance abuse services across several divisions.
- Yet, there are only a limited number of slots available to serve women and an even smaller proportion for women and children involved with DYFS—where the treatment model incorporates child safety outcomes, Adoption and Safe Families Act (ASFA) timeframes, parenting and reunification issues.
- DHS and DAS slots available to women with child protective or welfare issues and substance abuse currently total 1,106 per year in outpatient, intensive outpatient, and short and long-term residential services and methadone maintenance.
- DYFS District Offices do not have enough substance abuse specialists to perform assessments and case consultation. Families are wait-listed and do not receive treatment when they need it.
- Both inpatient and outpatient services for adolescents with substance abuse issues are limited. Few DYFS involved adolescents will volunteer that they have a problem with substance abuse and it rarely exists in isolation. Therefore, some programs are reluctant to provide services because, “He’s still in denial”, or “You’ll have to address her mental health issues before we deal with her substance abuse,” and [vice versa from the perspective of the mental health treatment provider]. A holistic treatment approach is needed.
- About 33% of DYFS-involved families are also active with the Temporary Assistance for Needy Families (TANF) program adopted through the Division of Family Development (DFD).

New

- DAS will move under the umbrella of DHS—yielding greater efficiency and improved coordination of substance abuse services within DHS as well as enhanced opportunities for federal reimbursement.
- DFD, DYFS and the substance abuse community have agreed to use the same assessment tools to determine the best substance abuse treatment options for families. Guidelines regarding level of care will use the American Society of Addiction Medicine (ASAM) criteria.

- All children entering foster care will be assessed for the impact of substance abuse (either their own or a parent's); medical screening (e.g., urinalysis) will be used only where indicated.
- As first step of a five year initiative, \$3 million was included in FY 04 to specifically meet the treatment, child safety, timeframes, transportation, and childcare needs of DYFS families in an additional 71 treatment slots, including both outpatient, intensive outpatient slots, long term residential beds, residentially assisted partial care, and methadone maintenance.
- At the end of three years, a total of \$28.3 million (if funding is dedicated) will have been invested to expand these coordinated and specially designed substance abuse treatment services, providing approximately 2,302 additional slots across various treatment modalities, which approaches the national estimate of a 60% prevalence rate.
- The allocation and effectiveness of these new substance abuse resources will be reviewed on an annual basis to fine-tune the expansion process to improve access and target resources to the areas of highest need.
- Substance abuse providers will participate in the Family Team process to ensure that treatment is coordinated.
- Additional certified substance abuse specialists will be contracted to work in each DYFS office to perform substance abuse assessments, treatment referrals, case consultation and training. With the expanded treatment options listed above—women will have increased access to the types of services they need when they need them.
- The Administrative Office of the Courts (AOC), DAS and DYFS will collaborate to expand the Family Drug Court model starting in Morris County. Two additional family drug courts will be established, based in a careful evaluation of this model, in the neediest communities by June 2008 at an estimated cost of \$1 million per court. All staff will be cross-trained.
- By March 2005, we will begin the process to better identify substance abuse problems in adolescents by referring the youth for assessment within 24 hours of identifying a need for substance abuse services. DAS and SYFS will work together to develop a curriculum for cross training of their agency's staff to identify needs through screening.
- Integrate adolescent substance abuse services into behavioral health services using the federal Substance Abuse and Mental Health Services Administration (SAMSHA) model to create 750 slots over five years.
- In the first year, we will expand capacity to create 125 new outpatient treatments slots and 25 new inpatient treatment beds for substance abusing teenage mothers with young children who want to keep their children with them during their substance abuse treatment, at an annualized cost of \$2.3 million beginning in July 2004. An additional \$1 million in capital funding will be requested in FY 2005 to provide the needed infrastructure to support the service expansion.
- We will develop a plan to meet the 600 remaining slots over four years and determine the appropriate number of slots for each type of treatment.
- Integrated behavioral health and substance abuse services must address the unique challenges of adolescents transitioning into adulthood, incorporate independent living skills into treatment modalities to increase the capacity to become self-sufficient, and meet child care needs of adolescent parents.

- Work with existing substance abuse providers to incorporate on-site psychiatric and psychological Medicaid eligible services into their adolescent treatment components by September 2005.
- Existing providers of behavioral health services will develop the skills needed to integrate effective substance abuse practice, intervention and treatment into their current program models. Training and consultation will be provided in conjunction with DAS.
- Create an interdisciplinary adolescent best practice task force to develop standards for working with youth involved with DYFS, JJC, the courts, DAS, and behavioral; health providers.
- DYFS, DFD through the County Boards of Social Services (BSS), and Medicaid will use an information systems' match to identify mutual clients and coordinate care at the local level.

Use proven best practices to provide substance abuse services to adolescents to identify substance abuse problems, intervene earlier and adapt services to meet the unique development needs of adolescents. DAS and DYFS will coordinate the work of the DYFS substance abuse and adolescent specialists and the community treatment provider network. Future community based intervention and prevention models will incorporate child welfare outcomes (e.g., reduction in out-of-home placements) as well as substance abuse outcomes. Activities will shift toward what we know works to decrease or prevent adolescent substance abuse. (199–22).

Effects of Pregnant Women's Substance Abuse

It is critical for a pregnant woman to get treatment for substance abuse. Not only is her life impacted, the welfare of her child is also put at risk. Currently, only one agency in New Jersey (Great Expectations in Somerville) offers methadone treatment to pregnant women. Methadone blocks the withdrawal effects of heroin.

Following are other health effects of drug use during pregnancy. Information is from "Family Matters: Substance Abuse and the American Family" (Columbia University, National Center on Addiction and Substance Abuse, March 2005).

Health Effects

- Tobacco
 - Stillbirth
 - Low birth weight
 - Sudden infant death syndrome (SIDS)
 - Cleft palate and cleft lip
 - Chronic ear infections
 - Tonsillitis
 - Asthma
 - Bronchitis
 - Pneumonia
 - Fire-related death and injuries
 - Behavior disorders during childhood and adolescence
 - Obesity and diabetes in adulthood

- Alcohol
 - Fetal alcohol spectrum disorder (FASD), fetal alcohol syndrome (FAS)
 - Small children
 - Facial anomalies
 - Central nervous system damage
 - Cardiac problems
 - Skeletal malformations
 - Visual and auditory deficits
 - Altered immunological function
 - Long-term problems in children
 - Hyperactivity and attention deficits
 - Childhood depressive symptoms
 - Memory and information processing difficulties
 - Poor problem-solving skills
 - Deficits in abstract thinking and flexibility
 - Significant weaknesses in arithmetic skills
 - Lower IQ scores
 - Problems with linguistic, perceptual, and motor development
- Marijuana
 - Similar to effects of smoking tobacco
 - Verbal and memory problem
 - Low birth weight
 - Premature delivery
 - Delivery complications
- Opiates/heroin
 - Premature delivery
 - Miscarriages
 - Low birth weight
 - After delivery
 - SIDS
 - Restlessness, disturbed sleep
 - Feeding problems
 - Vomiting, diarrhea, fever
 - Excessive crying
- Cocaine
 - Decreased oxygen and nutrition flow to fetus
 - Risk of retardation
 - Low birth weight
 - Premature delivery
 - Spontaneous abortion
 - Premature detachment

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State of New Jersey
Department of Community Affairs
Division on Women
101 South Broad
Post Office Box 801
Trenton, NJ 08625-0801

and the

Institute for Women's Leadership, Rutgers University
Ruth Dill Johnson Crockett Building
162 Ryders Lane
New Brunswick, NJ 08901

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Department of Community Affairs

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Institute for Women's Leadership

Michelle E. Richardson, Assistant Commissioner
Department of Community Affairs

Mary K. Trigg, Director
Leadership Programs and Research
Institute for Women's Leadership
Center for Women and Work

Jennie H. Hendrix, Project Director
NJ WomenCount

New Jersey Advisory Council on the Status of Women

