

Effects of Drug and Alcohol Use on Women's and Perinatal Health

Illicit drug use among women has received increased attention as a health problem during the last three decades, particularly, but not exclusively, with regard to use during pregnancy. Nearly 50 percent of American women ages 15-44 have used illicit drugs at least once in their lifetime.¹ The peak age for use among women parallels the peak childbearing years, 15-44 years of age, which is of special concern due to the risks to the fetus. Marijuana is by far the most commonly used illicit substance by women in this age group.

Alcohol is the most frequently used substance among U.S. women. The major risk period for initiation of alcohol use is over by age 20, and almost no individuals initiate alcohol use after age 29.² Alcohol abuse and/or dependence occurs in less than 10 percent of women. Among women, reported prevalence of alcohol abuse in 1991 was highest in White women, followed by Black and Hispanic women. Prevalence rates for alcohol abuse in Asian women are low.³

Although most women who use alcohol begin their use early, use of hard drugs like cocaine and heroin or chronic excessive use of alcohol occurs later.² These findings highlight target times for focused primary prevention programs.

The tables provided illustrate the use of alcohol, marijuana, and cocaine by young men and women from 1976 to 1992, according to results from several years of the National Household Survey on Drug Abuse, administered to a sample of the population 12 years of age and over in the coterminous United States by the National Institute on Drug Abuse.⁴

Among adolescents, family/parent connectedness, perception of connectedness to school, high self-esteem, high grade point average, and religious identity have all been found to be protective against alcohol use.⁵ On the other hand, higher rates of substance use are reported for adolescents with access to substances in their homes and for adolescents who appear older than their school mates.⁵ Protective factors in adults are not known.

Use of Alcohol in the Month Before the Survey (%)⁴

Year	Female		Male	
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25
1976	29	58	36	79
1979	36	68	39	84
1982	27	61	27	75
1985	29	65	34	78
1990	24	53	25	74
1992	15	53	17	60

Use of Marijuana in the Month Before the Survey (%)⁴

Year	Female		Male	
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25
1976	11	19	14	31
1979	14	26	19	45
1982	10	19	13	36
1985	11	17	13	27
1990	4	9	6	17
1992	3	8	5	15

Use of Cocaine in the Month Before the Survey (%)⁴

Year	Female		Male	
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25
1982	1.5	4.7	1.8	9.1
1985	1.4	6.2	2.0	9.0
1988	1.4	3.0	0.9	6.0
1990	0.4	1.6	0.7	2.8
1992	0.3	0.8	0.2	2.9

Consequences of Women's Use of Drugs and Alcohol

Women who abuse alcohol and/or various illicit drugs are more likely to have poor nutrition and to experience medical problems such as elevated blood pressure, increased heart rates, and/or sexually transmitted diseases.⁶⁻⁸ They are more likely than non-users to attempt suicide.⁸ Approximately 64 percent of reported AIDS cases among women are due to either intravenous drug use or having sex with an intravenous drug user.⁷ Alcohol and/or drug abuse is also linked to incidents of sexual assault, unprotected sex, unwanted pregnancies, and domestic violence.⁹⁻¹¹

For women, the social consequences of substance abuse include increasing likelihood of incarceration,¹² homelessness, and child abuse and neglect.^{6,8} Chronic heavy alcohol use has especially deleterious consequences for the health of women because of a "telescoping effect." Women who abuse alcohol experience higher rates of liver disease and related mortality after shorter periods of use and lower amounts of drinking than men. Mortality rates for women who abuse alcohol are also high for suicide,⁸ alcohol-related accidents, circulatory diseases,¹³ and breast cancer.¹⁴ The co-occurrence of mental disorders with substance abuse has been reported in a number of studies, of which major depression, anxiety disorder, and post-traumatic stress disorder are the most common problems.^{15,16} Moreover, use of stimulants, marijuana, and opiates by women has been correlated with eating disorders, particularly bulimia.¹⁶

The use and abuse of alcohol and drugs before and during pregnancy has negative effects for both women and children. More than 5 percent of pregnant women are estimated to use illicit substances sometime during their pregnancy.¹⁷ In 1995, a higher rate of alcohol use during pregnancy was reported by women than in 1994: 16.3 percent.¹⁸ The highest reported use was in women over 30. Women who use drugs during their pregnancies are more likely to be depressed, have fewer social supports, have less stable living arrangements, and are more likely to drink alcohol and smoke.^{19,20}

Infants born to women who abuse drugs and/or alcohol during pregnancy are at increased risk for a number of deleterious effects. For example, infants born to women who use cocaine are at an increased risk of being born small.²⁰ The heavy use of alcohol by women during pregnancy has been associated with severe birth defects, such as cranio-facial abnormalities.²¹ Native Americans

consistently have the highest rates of alcohol use, with a concomitant increase in rates of fetal alcohol syndrome (FAS) relative to other ethnic groups.²² With the exception of FAS, research is inconclusive regarding the long-term consequences of maternal substance use on the health and development of children. Children of substance users, however, are much more likely to be displaced from their home than children of non-users.

Interventions

According to Gehshan (1993), the three most common sources of referral of women to substance abuse treatment are: the criminal justice system, family members, and child protective services.²³ Only 4 percent of substance abuse programs report medical professionals as the most common source of referral.²³ Less than 10 percent of medical schools provide a course on substance abuse or alcohol addiction.²⁴

Despite the increased focus on interventions for drug abuse, many pregnant women with drug problems do not receive the help they need. Reasons for not receiving treatment may include lack of awareness, poverty, lack of available services, and fear of criminal prosecution,^{25,26} which may lead addicted women to conceal their drug use from medical providers and further jeopardize pregnancy outcome.²¹ Despite increased state funding for and requirements to provide access to services for pregnant women within 24 hours of seeking care, services are still not adequate to meet the needs of pregnant and parenting women.²⁷

Screening women for substance abuse has not been very common or effective.²⁸ Providers are not adequately educated about women's substance use. Although no method of screening currently available (maternal reports or biological markers) is optimal, careful questioning of women about use by caring professionals has been shown to have good sensitivity and specificity,²⁹ and federal agencies are promoting such screening.³⁰ Moreover, with welfare reform and the increasing numbers of managed care organizations, challenges exist relating to assurance of appropriate screening and effective care for women with substance abuse problems.³¹

There are few substance abuse prevention programs for adult women and few empirical studies conducted specifically on women's needs. With regard to treatment, components that may increase the likelihood for successful outcomes in treating pregnant women are child care,

transportation, counseling, and parenting education.³² Interventions in the preconception period are very important as there is a clear link between excessive alcohol abuse in early pregnancy and fetal alcohol syndrome.²¹

Studies of interventions for women with substance abuse primarily focus on illicit drugs rather than alcohol. Questions remain about different models of treatment for women with alcohol dependence, such as family and psychosocial interventions in the community, education regarding self-esteem, assertiveness training, use of women-only groups, or skills-building and counseling interventions. Outcomes to gauge success in substance abuse treatment programs need to include variables other than abstinence from substance use. Studies have shown improvement in women's health (including increased psychological functioning and decreased psychiatric symptoms), productivity (including greater employment rates, fewer rearrests, and more appropriate utilization of public assistance), parenting ability, and the health and well-being of their children.³²⁻³⁴

Many barriers affect women's access to substance abuse treatment services. These barriers include lack of early identification by professionals, access to services that accommodate children, transportation, culturally sensitive services for minority and disadvantaged women, and safe, drug-free housing. Outreach to adult women with no children who are not pregnant nor planning pregnancy is difficult, because these women are less likely to interface with the health care system. Treatment of women for addiction is also difficult due to complex community, cultural, family, economic, and personal issues,³⁵ as well as women's fear of being reported to the justice system by health care providers.^{25,26} Negative attitudes of staff about the ability of women to recover from their addiction also are barriers.³⁶ One study noted that Black women experience additional barriers to treatment related to home responsibilities for children and adult partners, inability to pay, use of substances to cope with the stresses of social disadvantage, fear of removal of their children, stigma and shame associated with addiction, prior failures in treatment, and waiting lists for services.³⁷

A key to preventing and reducing substance abuse among women is decreasing the number of adolescent users. A few programs have been shown to be effective in decreasing marijuana use for middle to high school-aged children.⁵ Effective programs include substance abuse education (with both resistance skills and normative education) in the school health curriculum, as well as parent and community education.³⁸

Issues for Policy, Practice and Research*

Primary prevention of use of alcohol, marijuana, and hard drugs such as heroin and cocaine can be targeted for focussed programs during distinct time frames. Providers need to carefully question women in order to screen for substance abuse, and women who screen positive need to be assured treatment services (which, despite increased state funding and legislation, may still not be adequate to meet women's needs), to help them break the vicious cycle of substance abuse. Many issues remain to be addressed: several of these are mentioned in the previous pages, and several more follow.

Public education is needed to counteract the social stigma of substance abuse among women (given its chronic, relapsing, but treatable nature) and to increase awareness of the dangers of substance abuse during pregnancy.

Few substance abuse prevention and treatment programs designed to address protective and risk factors have been subjected to rigorous evaluation. Moreover, virtually no data exist on access to and use of substance abuse treatment and counseling among women in managed care organizations (where substance abuse treatment is often a "carve-out") or in the health care system in general.

Studies on the effects of substance use are needed to address specific concerns, such as assessment of whether the "telescoping" effect of alcohol use for women is also seen for other substances; the levels of alcohol intake that may positively affect the health of women while not jeopardizing fetal health; whether the effect of substance use on pregnancy outcomes is a result of the substance or the other life circumstances of women who use substances; the effects of poly-substance use; and the long term effects of substance use during pregnancy on children.

*Given the formative nature of our research on this topic, this material does not reflect an exhaustive list of potential issues of concern. Rather, the material below reflects selected preliminary ideas generated to stimulate dialogue and further study. In addition, certain issues may have been intentionally omitted from this section in favor of their incorporation in other materials prepared as part of a broader initiative to review the state of the field of perinatal and women's health.

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- 1** The Social Context of Women's Health
- 2** Women's Reproductive Health and Their Overall Well-being
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