DRUG ABUSE PREVENTION AND TREATMENT: AN HISPANIC PERSPECTIVE

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Any analysis of this nation's drug control system shows that the primary strategy now in use is law enforcement, not prevention and treatment. As of Fiscal Year 1990, 70% of federal drug control funds were allocated to domestic and international law enforcement and other supply reduction efforts, and 30% to all prevention and treatment activities. Thus in addition to all other complicating factors, efforts to address substance abuse problems in the Hispanic community must contend with an overall lack of resources devoted to reducing the demand for illicit drugs.

Efforts to develop appropriate and effective substance abuse prevention and treatment programs for Hispanics are also severely hindered by a lack of information about the nature and extent of the problem as it affects Hispanics. Data on substance abuse among Hispanics remain incomplete; recent national data on the various Hispanic subgroups are almost non-existent. In addition, while factors correlated with substance abuse have been identified, the relative importance of various individual, family, cultural, locational, and societal factors are not well understood. Very little information is available about Hispanics in substance abuse treatment programs, and almost no national data can be found on Hispanic participation in prevention efforts.

Data on Hispanic-focused prevention and treatment services are similarly limited. The absence of information on Hispanic-focused efforts reflects two factors: inadequate evaluation and documentation of existing program models and services, and a severe lack of culturally appropriate, Hispanic-targeted programs. Due to the absence of such programs, recent increases in prevention and treatment activities have had minimal effect on the situation of Hispanics.

Because of the relative youth of the Hispanic population, the severity of its drug problems, and the high number of drug abuse risk factors faced by most Hispanics, drug abuse prevention is a particularly urgent need within the Hispanic community. The large size of the Hispanic youth population indicates a large population at risk. Hispanics are the nation's youngest major population group; more than one-third are under 18 years of age. As the nation's most heavily urbanized population, Hispanics also face a number of other risk factors such as undereducation, early exposure to drugs, and a host of problems associated with inner-city life.

There is reason to believe that most prevention programs are not effective in reaching Hispanics. Experts now agree that effective drug abuse prevention programs must be designed with an understanding of the specific prevention needs of the intended target group. Barriers of language and culture limit the impact of "mainstream" drug prevention efforts on Hispanics, and few Hispanic-targeted programs have been developed due to inadequate funding and research. Furthermore, a large portion of current prevention activity takes place within the public schools, yet high dropout rates among Hispanics preclude many

Hispanic youth from being reached by school-based initiatives, especially those that target senior high school students.

Because few Hispanic-targeted prevention and treatment programs have been tried -- and even fewer evaluated -- development of new programs has been hindered by lack of information about what works. Opportunities for developing and testing programs for Hispanics have recently been expanded, but much of this growth has been in the form of demonstration projects. Few successful programs have been implemented widely. Thus even if funding should expand significantly, it will be at least several years before a significant national body of knowledge with tested models emerges.

The close connection between intravenous (IV) drug use and HIV/AIDS among Hispanics lends added urgency to the need for drug abuse prevention programs targeting Hispanics. More than half of all AIDS cases reported among Hispanics aged 13 and older were drug related, and there is an IV drug use connection in more than 70% of all Hispanic pediatric AIDS cases. Increased attention must be given to the development and implementation of substance abuse prevention efforts targeted to Hispanics if the link between substance abuse and AID/HIV among Hispanics is to be broken.

Hispanics are overrepresented among drug treatment clients based upon their proportion of the general population. However, this is not a good indication of actual need for treatment. Drug use patterns suggest that Hispanics may actually be underrepresented based on need. Many factors create high risk for drug use among Hispanics, with the result that Hispanics almost certainly constitute a greater share of the population in need of treatment than they do of the general population.

Hispanics seeking treatment face severe overcrowding. It has been estimated that 90% of drug abusers seeking treatment are turned away due to lack of space; there are reasons to believe the situation for Hispanics is worse than for other groups. Hispanics typically receive drug treatment in the most crowded and least supervised facilities, such as methadone maintenance programs, where utilization rates are high and staff-to-client ratios low.

In addition to overcrowding, Hispanics seeking treatment encounter a lack of bilingual staff and few culturally relevant programs. Very few Hispanic-targeted treatment programs exist, and this may account for the fact that Hispanics are less likely than either Blacks or Whites to participate in drug-free treatment program. Drug-free treatment relies heavily upon counseling, group therapy, and other communication-based therapies which are of limited help to Hispanics when differences in language and culture are not taken into account. The recent increase in the use of crack and other cocaine by Hispanics makes the need for drug-free treatment programs targeted to Hispanics especially urgent, since addition to these drugs is currently treated only through drug-free programs.

Of all Hispanics, pregnant women and young children face the greatest difficulties in obtaining drug treatment. The current treatment system was designed primarily to serve adult male heroin addicts, and provides few options for women and children in need of care. Many treatment centers deny services to drug-dependent pregnant women because programs are not prepared to assume responsibility for the health of the fetus. Programs for children are also limited; less than one-third of treatment units offered youth services as of 1987.

Few Hispanics have been trained as drug abuse prevention and treatment professionals. Although the training of Hispanics in this field is essential for promoting Hispanic-targeted efforts, training programs have been largely unsuccessful in recruiting Hispanic participants.

Overall funding for prevention and treatment activities has increased in recent years, but Hispanics still do not receive their fair share of funding for research or demonstration projects. Only about 3% of recent research and demonstration grants from the National Institute on Drug Abuse (NIDA) have gone to Hispanic-focused projects, and about 9% of Office for Substance Abuse Prevention (OSAP) prevention grants. To the extent that "minority" drug abuse initiatives have been undertaken, they have rarely focused on Hispanics, although there is some evidence that attention to Hispanic concerns has recently increased.

Hispanic community-based organizations already play a critical role in addressing the drug abuse problem, and could play an even greater role if encouraged to do so through public and private policies and programs. Local family-focused Hispanic organizations know how to find and serve high-risk groups, and already carry out a variety of programs targeting the very groups that are considered at greatest risk for substance abuse. Yet few of them receive substance abuse funding.

The problem of substance abuse in Hispanic communities can be adequately addressed only through increased attention to Hispanic needs in all aspects of the drug control system. More research is needed on Hispanic substance abuse and the factors which contribute to it, with Hispanic participation in study design and implementation. National surveys need to not only oversample Hispanics, but provide subgroup data. Major emphasis needs to be placed on demonstration prevention and treatment projects, and on evaluating, disseminating, and replicating effective models. In short, Hispanics need to receive their fair share of substance abuse attention and funding.

I. INTRODUCTION

This analysis focuses on illicit substance abuse as it affects Hispanic Americans. It deals only with illegal drug abuse, and therefore excludes alcohol abuse except to the extent that it occurs in combination with the abuse of other substances.

Any attempt to address substance abuse prevention and treatment in the Hispanic community must begin with an understanding of both the need for services and the current status of prevention and treatment programs, with special emphasis on the extent to which they target, reach, and effectively serve Hispanics. However, this overview of drug prevention and treatment in the Hispanic community suffers from several major limitations.

First, although it is abundantly clear that substance abuse is a major problem in Hispanic communities throughout the country, data on the level and nature of Hispanic substance abuse remain seriously inadequate. Some major studies either do not oversample Hispanics or do not present data by race and ethnicity; no ongoing national survey provides data by Hispanic subgroup. Available information is presented in a companion paper, "The Demographics of Drug Abuse in Hispanic Communities: An Overview."[1] Moreover, while the correlates of Hispanic substance abuse have been studied, researchers are far from a definitive understanding of cause-and-effect relationships.

Second, the paucity of national data on the participation rates of Hispanics in drug abuse prevention and treatment programs and on the existence of culturally relevant programs is even more pronounced. Limited data are available on Hispanic participation in substance abuse treatment programs -- and there is almost no information about Hispanic participation in prevention programs. The lack of data on prevention and treatment programs targeting Hispanics appears to reflect partly a lack of data collection systems, especially for prevention, and partly a severe lack of Hispanic-focused prevention and treatment efforts. While some studies -- most of them local, state, or regional rather than national -- address questions of prevention and treatment effectiveness, there remains a very limited understanding of the extent to which particular modalities, environments or approaches effectively address Hispanic needs.

Several national studies on drug treatment have counted Hispanic clients, but almost none have provided data for Hispanic subgroups (Cuban, Mexican American, Puerto Rican, Central and South American, Other Hispanics), thus blurring important regional and cultural distinctions. Moreover, none of the data on Hispanics in federally funded treatment are up-to-date: after funds for drug abuse treatment were block-granted to the states beginning in 1982, federal reporting requirements became largely voluntary, with the result that detailed client information -- previously obtained through CODAP (the Client-Oriented Data Acquisition Process) -- were reported by less than one-third of the states. Fundamental changes have occurred in the patterns of drug abuse since that time, however, and findings from earlier studies may have limited applicability to today's population of drug abusers. The only major survey of drug treatment clients which includes both publicly and

privately funded treatment units is the National Drug and Alcoholism Treatment Unit Survey (NDATUS).[2] However, the most recent data are from October 30, 1987, and the survey provided no information about Hispanic participants in prevention projects. Another survey, State Resources and Services Related to Alcohol and Other Drug Abuse Problems,[3] provides data via the State Alcohol and Drug Abuse Profile (SADAP) data collection effort; however, it includes only publicly funded treatment units which receive some funds administered by the state's alcohol/drug abuse agency. SADAP indicates the total percentage of Hispanic clients entering treatment by state, but does not provide other data by race/ethnicity. In short, even the most complete national data provide limited information about drug treatment and prevention, especially with regard to the needs, participation rates, and treatment outcomes of Hispanics in specific types of programs -- and no data on Hispanic subgroups.

According to a recent report by the National Academy of Science's Institute of Medicine, two very different types of drug treatment facilities exist in the United States: "one for the poor under public sponsorship and one for those who can pay with private insurance or public funds." These two tiers of drug treatment differ "not only in their sources of financing, but also in their recency and origins, provider and facility characteristics, modalities [forms of treatment] offered, clientele served, and capacity utilized. Moreover, the public tier interacts extensively with the criminal justice system."[4] The report goes on to conclude, perhaps not surprisingly, that those who can afford private drug treatment programs receive better care overall.

Most Hispanics who require drug treatment cannot afford to pay for private care; the most severe problems of drug abuse within the Hispanic community co-exist with high rates of poverty. Thus it seems appropriate to focus on the public tier of drug treatment, and to take advantage of available information on federal funding priorities and some limited program data. Similarly, while prevention efforts are now being carried out by community groups, businesses, and other private entities, most identifiable projects which target Hispanics are at least partially publicly funded.

This focus on federally funded efforts is not meant to imply that they are necessarily of greater importance or effectiveness than state, local, or privately funded efforts; the reverse may well be true, at least for treatment, since the majority of funding comes from non-federal sources. Rather, such a focus is necessary because of the lack of any consistent body of data on state and locally funded drug programs. Some states keep data on their Hispanic clients and programs, but many do not. Even before the decentralization of federal funding for drug programs, state health departments showed great variability in the structure of their drug treatment and prevention systems. With the deregulation and block-granting of federal support, each state adopted methods of service delivery, reporting, and evaluation which reflected its own priorities; state and federal funds were often combined. Participation in data collection efforts on the part of local program operators and local government entities often became voluntary. As a result, an adequate assessment of the national commitment to drug treatment and prevention has become increasingly difficult.

Recent changes in the federal system provide some sense of possible directions in drug treatment and prevention for Hispanics. However, much of the "action" in drug treatment and prevention is still taking place on the state and local levels.

II. THE FEDERAL TREATMENT AND PREVENTION SYSTEM

The federal drug treatment and prevention system had its beginnings in the early 1900s, when federal law enforcement agencies developed strategies to combat drug use and trafficking by organized crime syndicates.[5] The first federally sponsored drug treatment programs were opened in the mid-1930s. These programs provided treatment to incarcerated drug addicts and conducted research on the nature and characteristics of addiction.[6] For 30 years, two prison hospitals, together with the enforcement efforts of various criminal justice agencies, comprised the entire federal drug control system. Few opportunities for treatment were available to the unincarcerated, and no general program for prevention existed.

In the late 1960s and early 1970s, public concern about a growing substance abuse problem led to major federal initiatives, and a medical conception of drug abuse began to compete with the dominant criminal model. The Special Action Office for Drug Abuse Prevention (SAODAP) in the Executive Office of the President provided early leadership in the development of a federal response. The view of addiction as a treatable disease prompted the funding of a network of community-based treatment centers under the administration of state and local health departments. Their appearance marked the beginning of a "mixed" approach to drug abuse which included both law enforcement and medical care.

In 1974, medically-oriented federal drug programs became the purview of the National Institute on Drug Abuse (NIDA), a newly created branch of the Department of Health, Education, and Welfare's Public Health Service. NIDA's chief responsibilities included sponsorship of research related to understanding addiction and treatment and the dissemination of information about drug abuse. As part of the newly formed Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), NIDA also administered federal grants for the funding of local drug abuse treatment and prevention programs. State and local governments were required to submit data on services provided and clients in treatment, as well as to meet certain standards of performance. Like other categorical programs, NIDA's treatment grants grew in scope and budget authority throughout the 1970s.

Effective in Fiscal Year 1982, ADAMHA's categorical programs were consolidated into one Alcohol, Drug, and Mental Health (ADM) block grant awarded directly to the states. As with other programs which were block-granted at the same time, the ADM block grant reduced both the amount of funding and the restrictions imposed on funding use. Federal expenditures fell by one-third from their peak in 1979 ($336 million) to $224 million in 1982.[7] At the same time, federally mandated data collection systems and evaluation programs disappeared almost overnight. Even where comprehensive records and

assessments were maintained, methods of data collection and reporting varied enough to prevent reliable reporting of national trends and figures or comparisons across localities.

During the 1980s, increases in drug-related crime and violence created a growing public concern which led to new legislation, increased funding, and a return to federal leadership in setting drug policy. Although the Anti-Drug-Abuse Acts of 1986 and 1988[8] focused heavily on criminal justice and other "supply reduction" efforts, they also provided for the expansion of drug treatment, prevention, and education programs. The 1986 Act also called for the establishment of an Office of Substance Abuse Prevention (OSAP) within ADAMHA, an increase in drug treatment research, and the initiation of a Drug-Free Schools and Communities program. In 1988, an Office of National Drug Control Policy (ONDCP) was created within the Executive Office of the President to coordinate federal drug programs and to create a national drug control strategy with measurable goals and objectives. The Act also created an Office of Treatment Improvement (OTI) and required that states set aside 50% of supplemental allocations for the treatment of intravenous drug users. In addition, block grant monies were targeted to communities demonstrating the greatest need for services, several national data collection studies were re-instituted, and OSAP's budget was increased, partly to support a new series of demonstrations targeting high-risk groups.

Despite these new directions, the federal drug control strategy continues to place primary emphasis on reduction of the drug supply, devoting over 70% of available resources to interdiction, prison expansion, aggressive prosecution of criminals charged with drug-related crimes, and, more recently, efforts to prevent the harvesting of drug crops in their source countries. Attempts to reduce the demand for drugs, including all treatment and prevention efforts, receive less than 30% of the federal drug budget (See Figure 1).[9] Figure 2 presents comparative federal expenditures for prevention, treatment, and criminal justice over two decades and shows the relative increases in expenditures for criminal justice activities compared to prevention and treatment in the 1980s.

ONDCP now serves as the federal government's "lead agency" in setting national drug policy. According to its most recent strategy report (January 1990), priorities for federal initiatives in the area of drug treatment and prevention include the following: increasing the availability and quality of treatment services; increasing vocational counseling, training services, and aftercare for recovering drug addicts; expanding and improving outreach and treatment services for pregnant women and babies; improving programs of data collection, service-related and biomedical research, evaluation, demonstrations, and dissemination; increasing drug prevention efforts in housing projects; mobilizing more communities against drug use by expanding the number of community-based prevention programs; and stimulating private-sector and volunteer efforts in prevention. ONDCP requested $1.75 billion for prevention and treatment Fiscal Year 1991, an increase of about 11% from FY 1990; in comparison, expenditures for criminal justice activities are slated to rise by more than 40%.[10] Current funding for federal "demand reduction" efforts is divided among 24 agencies (See Figure 3).

FIGURE 1
FEDERAL DRUG CONTROL FUNDING BY FUNCTION
BUDGET AUTHORITY IN MILLIONS OF DOLLARS

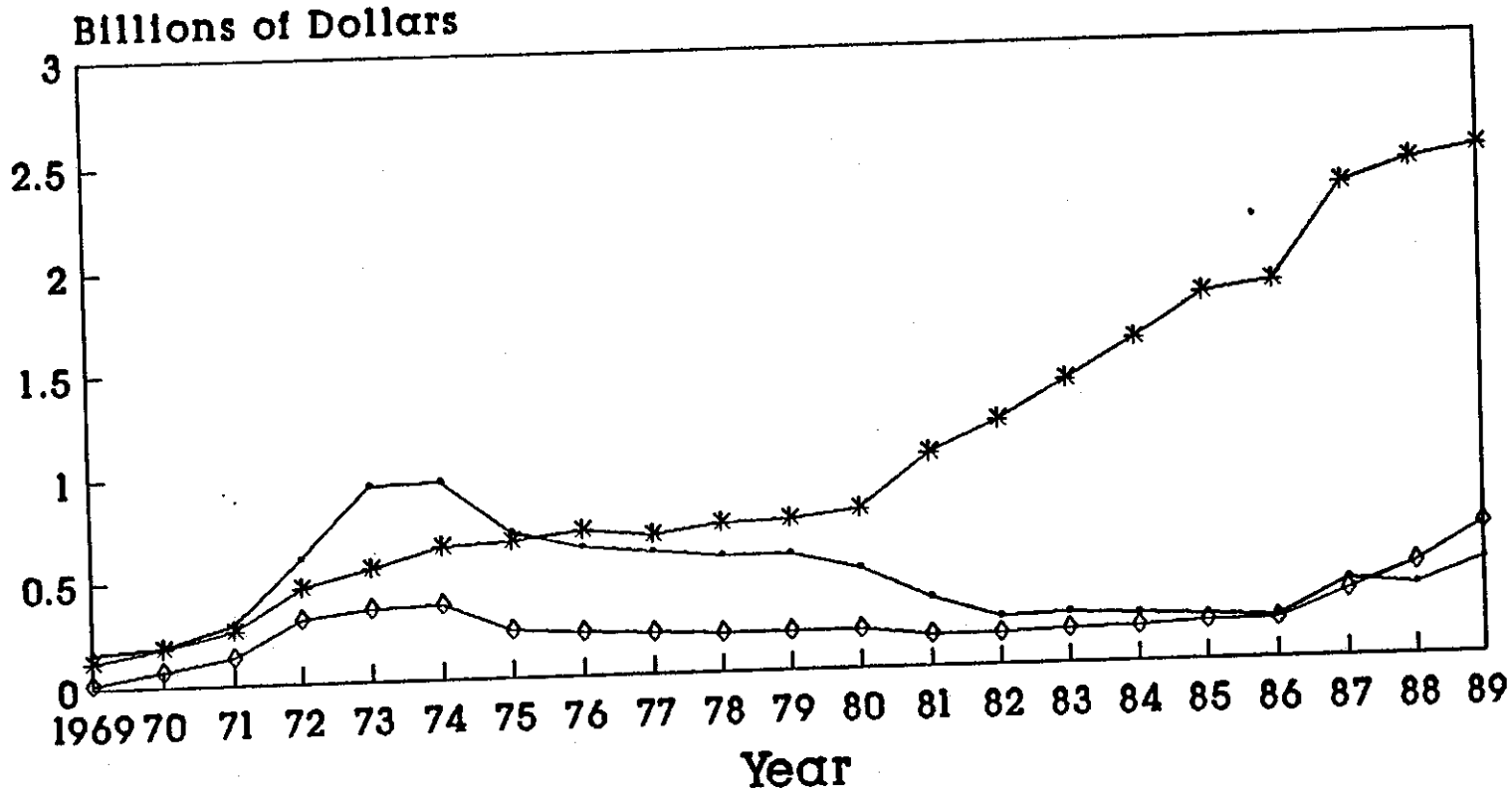
	FY 1989	FY 1990	FY 1991	FY 90-91 INCREASE $	FY 90-91 INCREASE %
Criminal Justice *	2,682	4,191	4,279	88	2
Treatment	888	1,337	1,492	155	12
Education/Community/Workplace	677	1,118	1,242	124	11
International Initiatives	304	419	690	271	65
Interdiction Efforts	1,467	2,029	2,373	344	17
Research	231	318	383	65	20
Intelligence	53	71	172	101	142
TOTAL	$6,302	$9,483	$10,631	+$1,148	+12

* The figures for Criminal Justice include the costs of Federal prison construction, which in FY 1990, totaled approximately $1 billion. Because prison construction costs do not recur in subsequent years, the true programmatic increase from 1990 to 1991 is actually $1 billion higher than the figures above would indicate. Adjusting for this, the FY 1990 to FY 1991 Criminal Justice increase equals 34 percent.

Source: National Drug Control Strategy, 1990.

FIGURE 2

FEDERAL ANTI-DRUG ABUSE EXPENDITURES 1969-89 (1987 Dollars)



Treating Drug Problems, Vol. I

FIGURE 3
NATIONAL DRUG CONTROL BUDGET
FOR TREATMENT AND PREVENTION BY AGENCY

Budget Authority ($ Millions)	1989 Actual	1990 Estimate	1991 Request
DRUG ABUSE PREVENTION			
ONDCP	1.2	4.0	5.5
Special Forfeiture Fund	0.0	0.0	0.0
ADAMHA	120.8	234.5	282.9
Centers for Disease Control	20.0	25.2	30.2
Human Development Services	30.0	29.6	29.6
Family Support Admin.	3.0	1.9	0.0
DOD	69.7	72.5	74.6
Education	354.5	539.2	593.3
HUD	4.1	49.2	75.0
Labor	38.2	70.1	83.5
Bureau of Land Management	0.1	0.3	0.3
National Park Service	0.2	0.4	0.4
Bureau of Indian Affairs	2.6	5.7	6.9
Office of Ter. & Intntl. Afrs.	0.0	0.2	0.4
ACTION	10.1	9.2	9.6
Agency for International Development	3.1	4.7	3.4
DEA	2.2	2.2	2.2
Office of Justice Programs	13.0	56.6	30.8
Federal Aviation Admin.	4.3	12.6	13.2
	677.1	1,118.1	1,241.8
DRUG ABUSE TREATMENT			
ONDCP	1.2	4.0	5.5
Special Forfeiture Fund	0.0	0.0	0.0
ADAMHA	391.7	685.6	759.7
Health Care Financing Admin.	140.0	170.0	190.0
Indian Health Service	18.7	32.8	33.0
Human Development Services	0.0	0.0	6.0
Education	21.8	23.3	24.4
DOD	12.4	11.6	11.4
Bureau of Prisons	4.1	6.0	8.0
Office of Justice Programs	34.4	95.1	104.9
Bureau of Indian Affairs	0.0	0.0	0.0
Labor	0.4	0.5	2.7
Veterans Affairs	239.8	269.2	297.7
U.S. Courts	23.3	39.2	48.5
	887.8	1,337.3	1,491.8
TOTAL DRUG CONTROL BUDGET	$6,301.6	$9,483.2	$10,630.7

Source: National Drug Control Strategy, 1990.

The lead agency for drug treatment is ADAMHA. ADAMHA controls 50% of federal funds for drug treatment, with appropriations of over $1.04 billion for Fiscal Year 1990. Within ADAMHA, *NIDA* is the key sponsor of research and demonstration programs, focusing on causes, incidence and prevalence of drug abuse and the development and testing of treatment and prevention options. *OTI* has taken over administration of the ADM block grant and also runs various treatment programs. In addition, OTI administers a number of demonstration programs and special initiatives, is collaborating with NIDA on the development of comprehensive treatment guidelines, and runs nationwide efforts to recruit and train drug treatment staff. *OSAP* supports model prevention and early intervention projects, emphasizing those which are targeted towards youth and other high-risk populations. OSAP also publishes a wide variety of drug prevention and education materials in English and Spanish, trains prevention workers through its National Training System, and operates both the National Clearinghouse on Alcohol and Drug Information (NCADI) and the Regional Alcohol and Drug Awareness Resource (RADAR) Network. Thus much of the federal funding available to or benefiting community-based organizations comes from OSAP.

The Department of Education (DOEd) receives the largest share of prevention funds, between 5% and 6% of the federal drug control budget ($539 million in FY 1990), to implement programs outlined in the Drug-Free Schools and Communities Act of 1986. Most of the funds are allocated to states and territories according to the size of their school-aged population. At least 90% of these funds must be passed through to local educational agencies, with priority to localities with the greatest number of economically and educationally disadvantaged children. Governors receive the remainder of the funds for statewide prevention initiatives. DOEd's current funding for substance abuse prevention is more than double that of OSAP, but little of this money gets to community-based organizations.

Other major providers of federal substance abuse prevention and treatment services include the Health Care Financing Administration, The Office of Justice Programs, and the Departments of Veterans Affairs, Labor and Defense. The Department of Veterans Affairs, through its Veterans Health Services and Research Administration (VA), operates drug abuse treatment programs based in the Department's network of medical centers and outpatient clinics. In 1990, the VA received $269.2 million for drug treatment -- more than any other federal agency except ADAMHA.

III. PREVENTION

A. Introduction

Because of the relative youth of the Hispanic population, the severity of its drug problems, and the high number of drug abuse risk factors faced by most Hispanics, drug abuse prevention is a particularly urgent need within the Hispanic community. Despite this, there is reason to believe that most prevention programs are not effective in reaching Hispanics. Barriers of language and culture limit the impact of "mainstream" drug prevention efforts on Hispanics, and few Hispanic-targeted programs have been developed due to inadequate funding and research. Furthermore, a large portion of current prevention activity takes place within the public schools, yet high dropout rates among Hispanics preclude many Hispanic youth from being reached by school-based initiatives, especially those that target senior high school students.

According to most measures, Hispanics are at high risk of developing drug problems, and the large size of the Hispanic youth population indicates a large population at risk. Hispanics are the nation's youngest major population group; more than one-third are under 18 years of age. Recent research indicates that initiation to drug and alcohol use typically occurs between the ages of 12 and 20, with the highest incidence of initiation among 15 year-olds. In some inner-city environments, the age of initiation is even younger; dropouts typically report having begun to use drugs before the age of 15. At the same time, it has been shown that age of first use is the variable most reliably associated with drug abuse, with those who start younger more likely to develop drug problems.[11]

Youth alone, however, is not a condition of unusual risk; other factors must be present which raise the likelihood of early initiation into drug use. For Hispanics, these factors are present in abundance.

School failure has been linked to drug problems by a number of studies.[12] Recent studies show that Hispanics remain the least educated major population in the United States, with the highest dropout rate of any major group; moreover, they drop out earlier than other youth.[13] Half of Mexican American and Puerto Rican youth leave school without a diploma, and the dropout rate for Hispanic students exceeds 70% in the inner cities of some major metropolitan areas. Increasing school segregation and disparities in school financing systems have denied Hispanics equal educational opportunities, causing the "educational gap" between Hispanics and the rest of society to grow.

Disruptive or dysfunctional families play a dual role in placing people at risk for substance abuse.[14] Not only can the trauma of these dynamics create the need for escape or relief sought by many drug users, but family disturbances erode an important support system for those at high risk. Data compiled by the Office for Substance Abuse Prevention reveal that Hispanic families experience a high incidence of family disruption in the form of divorce, parental abuse of alcohol or other drugs, or illness.[15] According to the latest Census figures,

nearly one-fourth (23.1%) of Hispanic families are headed by single females, compared to about one-sixth of non-Hispanic families.

Although the relationship between poverty and drug use is ambiguous,[16] low socioeconomic status has been correlated with the most serious forms of drug dependency.[17] Hispanics, and Hispanic children especially, are among the poorest Americans, with 26.7% of all Hispanics living in poverty. Nearly half of the Hispanic poor are 18 years of age or younger, and Hispanic female- headed households with children have the highest poverty rate of any major group (59.2%).[18]

Both the process of acculturation and the stresses which accompany that process have been linked to drug abusing behavior.[19] Studies have indicated that more acculturated Hispanics are more likely to use drugs than those who retain more traditional values, and non-U.S.-born Hispanics are less likely to use drugs than are Hispanics born in the U.S. In addition, personal and family stresses associated with acculturation, especially for refugees, may contribute to substance abuse. Intergenerational conflicts between traditional parents and their more acculturated children are frequently-cited sources of Hispanics family disruption, especially among recent immigrants and refugee families.

Some of the highest rates of drug abuse are reported in the inner cities of major metropolitan areas. Hispanics are the most urbanized major U.S. population group, and they are more likely than non-Hispanics to live in inner cities. Thus, many of Hispanics' high risk factors are connected to the conditions of inner-city life. An important factor is easy access and early exposure to illicit drugs. For example, a recent survey conducted by the Media Partnership for a Drug-Free America found that Hispanic children aged 9-12 were much more likely to say that "crack is easy to get" than Blacks or Whites.[20] Other risk factors endemic to inner-city life include chronic poverty, youth gangs in many cities, and a lack of positive role models. Moreover, while the effects of racism and discrimination exist in all communities, they are particularly pervasive in decaying inner cities, where long-term poverty and lack of opportunity may lead to a sense of hopelessness that has been described in studies of what has been called the "Hispanic underclass."

While none of these variables guarantees the emergence of drug problems, they have been shown to increase the likelihood of drug abuse.[21] Any prevention program targeted to Hispanics must begin with an understanding of these variables if it is to be appropriate and effective.

B. Approaches to Prevention

Until the 1970s, prevention activities in the United States consisted of little more than the enforcement of laws against illegal drug use. This approach to prevention was based on a perception of drug use as a marginal social problem, controllable through the threat of legal consequences. As a means of prevention, legal deterrence was primarily

passive and indirect. The nation's drug problem continued to grow in scope, however, and the inadequacy of such passive prevention soon became clear. Consequently, several direct approaches were developed to address the root causes of drug abuse.

The first direct prevention programs emphasized education about drug abuse and its consequences. These programs were based on a belief that, once properly informed of the adverse effects of illicit drugs, young people would choose not to use them. Educational programs failed to bring about significant changes in behavior, however, and new approaches were sought.

In the mid-1970s, prevention programs were developed based on the model of values clarification or "affective" education. This approach emphasized the importance of responsible decision making, enhanced self-esteem, and a firmly grounded notion of the limits of acceptable behavior. Programs of this type often featured discussion groups, peer counseling, assertiveness training, and other vehicles for gaining self-understanding and interpersonal skills. Participation in alternatives to substance abuse such as youth groups or after-school events was also encouraged. However, evaluations of these effort failed to demonstrate that affective prevention alone helped to deter drug use.[22]

Most recently, prevention programs have begun to address the broader psychological and social issues surrounding drug use as well as the developmental context in which most children are introduced to drugs. These programs, using what are often referred to as "psychosocial" approaches, incorporate many of the elements of information and affective programs, but add an emphasis on the development of peer-refusal techniques, life-coping skills, and other practical strategies for avoiding real-life pressures toward drug use. The psychosocial approach was first developed as a smoking-prevention strategy, and has yet to be thoroughly tested for effectiveness in preventing other types of drug use. Preliminary evaluations, while promising, have focused mainly on programs targeted to White, middle-class populations.[23]

As prevention programs have expanded to address social and environmental issues, attention has been drawn to the importance of broader community involvement as well. In the past, strategies for drug prevention focused on altering the knowledge, attitudes, and practices of individuals. Many prevention experts now agree that drug prevention programs must be more comprehensive. The involvement of families, schools, and communities is now considered to be essential to creating an effective prevention plan. In contrast to the passive, indirect approach of legal deterrence, comprehensive programs seek to involve all sectors of the community in active, direct prevention activities.

Widening the parameters of prevention activities is believed to have a number of benefits. First, a comprehensive approach helps to eliminate conflicting messages about the acceptability of drug abuse by establishing attitudes of intolerance towards drug use in every part of a young person's environment: at home, in school, and around the community. Second, by recognizing the importance of family, community, and peer support networks on

influencing behavior, comprehensive approaches seek to ensure that these systems serve as sources of resilience rather than risk. Finally, comprehensive approaches to drug prevention can establish a useful precedent for community-wide cooperation on other types of issues.

The main elements in a comprehensive drug prevention program are strategies targeted to individuals, families, peer groups, schools, the workplace, and the community,[24] as described below.

- **Strategies targeted to individuals** include all the approaches discussed above, plus special programs which focus on particular high-risk factors of individuals or groups of individuals. These latter efforts may include psychological counseling and academic tutoring. Many community-based education programs for Hispanic children and youth include this kind of drug abuse prevention component.

Strategies targeted to families recognize that parents are a primary influence on the behavior of their children. Research has shown that stable, caring family relationships appear to discourage drug use,[25] while problems caused by family dysfunction and parents' use of drugs can make drug problems more likely.[26] Prevention programs focused on the family include family therapy, parenting-skills workshops, and the encouragement of clear family policies against illicit drug use. Parents can also be involved in the operation of school- and community-based prevention programs. In the Hispanic community, such programs can build upon the values placed upon the family and the traditional strengths of the extended family.

Family prevention programs have the greatest impact when they involve families most at risk. These families, however, are often extremely difficult for mainstream organizations to recruit. Health clinics, social service agencies, and other community-based organizations often serve families at risk and can be indispensable in helping to locate and recruit them for prevention programs. For example, many Hispanic community-based organizations operate family-oriented programs which provide a range of services, from counseling to recreational services to education.

Strategies targeted to peer groups are another important component of comprehensive prevention programs. Research has indicated that the drug-using behavior of friends is one of the strongest predictors of drug involvement, and some studies indicate that the influence of peer pressure is a stronger on Hispanics than non-Hispanics.[27] Peer group prevention programs vary in size of target group and approach, but most rely upon the influence of role models upon peer norms. Common strategies targeted to peer groups include clubs and organizations with strict no-drug policies, peer counseling, and large-scale media campaigns. In Hispanic communities, many peer group strategies focus on the influence of youth gangs or use sports or other recreational programs to involve peer groups.

Strategies targeted to the schools include formal curriculum-based programs and less formal reinforcement of individual- and peer-focused prevention activities. Examples of the latter include developing and implementing strict alcohol and drug use prevention policies,

training teachers and faculty to recognize the signs and symptoms of drug use, and establishing student assistance programs for students with drug problems. Schools can also contribute to drug prevention by simply being more effective schools. Successful students are less likely to develop drug problems than are those who experience academic failure. In Hispanic communities, emphasis has been placed on programs which reach youth at an early age, before they have tried alcohol or illicit drugs.

Strategies targeted to employees in the workplace are among the most effective ways to reach adults with prevention messages. Some firms have established employee assistance programs which provide counseling and access to treatment to employees with drug problems. Other workplace prevention measures include drug-testing and information campaigns.

Strategies targeted to the community incorporate both special community-wide initiatives and prevention programs designed to reach those who have no access to mainstream efforts. Community-wide efforts can bring together prevention groups from all sectors for special coordinated events or may even take the form of a more permanent coalition or task force on drug prevention. Community leaders play an important role in supporting community prevention programs by placing these efforts high on the community's agenda and by allocating appropriate resources to promising activities.

Strategies targeting the community are especially effective in bringing prevention activities to those not normally reached by mainstream campaigns. Within Hispanic communities, churches and community-based organizations are excellent sources of contact for hard-to-reach groups such as youth not in school and the unemployed. Many Hispanic groups have prior experience with counseling and disease prevention programs, and these organizations can bring familiarity and credibility to efforts such as screening for drug problems, drug-and alcohol-free social events, prevention education, and treatment referral.

Comprehensive programs can be designed to incorporate all or some of the elements described above, depending on existing needs and resources. To run successfully, they often require partnerships between community-based organizations, families, schools, the private sector, and the public sector. Because comprehensive prevention programs address a wide range of factors contributing to drug use, these programs -- especially when combined with appropriate law enforcement and treatment services -- appear to provide the most promise for achieving positive, long-term results.

C. Funding Trends

After years of minimal funding, financial support for drug abuse prevention has increased significantly in recent years. Federal support for the development, implementation, and testing of new prevention models received new life in 1986 with the passage of the Drug-Free Schools and Communities Act and the establishment of the federal

Office for Substance Abuse Prevention (OSAP). Total federal funding for prevention activities grew from $180 million in FY 1985 to $680 million in FY 1989.[28] Many states have recently increased their commitment to prevention initiatives as well.

When compared to support for other areas of drug control, however, funding for prevention activities is very low. In a 1987 report to Congress, the Department of Education concluded that "there is little evidence to challenge the basic premise that prevention is the most humane and cost-effective response to alcohol and other drug related problems."[29] Yet less than 10% of all public expenditures on drug control are devoted to drug abuse prevention. In FY 1989, federal funding for interdiction efforts was twice as great as that for prevention; funding for drug-related criminal justice activities was nearly four times as great. Federal funding for prevention rose sharply from FY 1989 to FY 1990 (from $680 million to $1.1 billion), but similar gains in other areas kept support for prevention activities at around 12% of the overall budget. For 1991, the Bush administration requested an increase of 11% in prevention funding, the smallest increase requested for any drug control category.

Currently, the federal government is the major source of public funding for drug use prevention. Total federal outlays for prevention activities are expected to reach an all-time high of $1.24 billion in Fiscal Year 1991. Over half this money is passed along to the States through the Drug-Free Schools and Communities Act, the ADM block grant, the Job Training Partnership Act (JTPA) block grant, and other grant programs. Remaining funds support a variety of national drug abuse prevention activities, including research and the funding of model prevention projects.

In 1990, nearly 70% of all federal funds for drug use prevention were divided between the Department of Education (48% or $539.2 million) and ADAMHA (21% or $234.5 million):

- Department of Education funds were spent on grants to State Education Agencies (86%), national programs (11%), teacher training (2.6%), and the National Commission on Drug-Free Schools (less than 1%).

- ADAMHA funds were spent on demonstration programs (53%), research (35%), training (7%), and the prevention portion of the ADM block grant (1%). About 3% was spent on management and support.[30]

State drug and alcohol agencies provide the second largest share of public funds for drug abuse prevention. State alcohol and drug agencies do not report separately on drug abuse prevention expenditures, so exact figures are not available. It has been estimated that these agencies spend an average of five times as much on treatment than prevention, however, and an upper limit for state prevention expenditures can be arrived at by using this ratio.

Based on $1 billion dollars of total expenditures by state substance abuse agencies in 1989, up to $200 million was probably spent on substance abuse prevention. It is reasonable to assume that at least half this amount was spent on drug abuse prevention and combined alcohol/drug efforts, although the division of prevention resources varies state by state.

Growth in public-sector support for drug use prevention has served to strengthen the prevention work of privately-funded nonprofit organizations, private foundations, and businesses as well. Because of the diffuse nature of privately sponsored prevention efforts, information concerning their scope and effects is largely anecdotal; nevertheless, the contributions of private prevention programs seem to be significant, especially for underserved populations. Program, reporting, and evaluation models are particularly important. The Henry J. Kaiser Family Foundation, for example, has funded the adaptation of a prevention program assessment instrument for use within the Hispanic community.[31]

D. Prevention Services and Hispanics

Drug use prevention programs are highly diverse, ranging from grassroots parents' networks to multi-million dollar media campaigns -- but few of them target Hispanics. Although comprehensive data on prevention activities are not available, some general features of prevention programs have emerged. For instance, most programs appear to be run by schools or community groups whose main function is not drug abuse prevention. These entities offer major advantages in knowledge of the community and credibility among its members. Resources for drug abuse prevention are scarce, however, and even where funding exists, local efforts are forced to contend with a lack of appropriate program models and limited access to prevention professionals. Only a tiny percentage of prevention efforts specifically target Hispanics. There is, however, some evidence that attention to Hispanic-focused substance abuse prevention at the federal level may be increasing.

The close connection between intravenous (IV) drug use and HIV/AIDS among Hispanics lends added urgency to the need for drug abuse prevention programs targeted to Hispanics. According to the Centers for Disease Control, more than half (51.1%) of all AIDS cases reported among Hispanics aged 13 and older have been drug related. Furthermore, there is an IV drug use connection in more than 70% of all Hispanic pediatric AIDS cases.[32]

The impact on the Hispanic community of recent increases in prevention activity is not yet known, although some progress has been made in placing the needs of Hispanics on the federal prevention agenda. For example, Spanish-language prevention materials are becoming more widely available, and emphasis is being placed on the recruitment and training of Hispanic researchers and prevention professionals. However, the proportion of total research and prevention activities focusing on Hispanics remains minimal.

Hispanics continue to receive an extremely small share of grants for prevention research and other drug-related research and demonstration efforts, especially from NIDA. Thirty-one of the 947 grants which NIDA funded in Fiscal Year 1990 are for research related to Hispanic concerns. This represents 3% of all grants. Just one of NIDA's 31 FY 1990 prevention research grants specifically targets Hispanics. Nine of these grants are directly prevention-oriented and at least 13 others will yield results useful for prevention program planning. Most of the NIDA Hispanic grants are in their beginning stages.

- **OSAP appears to be giving slightly more attention to Hispanic prevention needs.** A total of 23 of 245 OSAP prevention grants awarded to date for youth at high risk went to projects which serve a primarily Hispanic population. This represents 9% of the total.

Preliminary steps have been taken in creating a support structure for Hispanic-oriented prevention research, and further improvements are projected in the future. A recent OSAP publication called for the formation of a nationally focused technical working group to address the need for better information on Hispanics. According to the proposal, the group would be charged with advising government agencies and other prevention organizations on the design of national surveys and other methods for improving data collection and research on Hispanics.[33] In addition, the 1990 National Drug Control Strategy announced that ADAMHA will establish a research center on minority drug prevention.

Despite these gains, prevention services for Hispanics remain seriously underdeveloped. Because most wide-scale prevention efforts do not begin from an understanding of the cultural and linguistic context of the Hispanic community, the ability of these programs to reach and influence Hispanics is limited; Hispanics are not likely to respond as well to "generic" prevention initiatives as they are to programs designed specifically for use within the Hispanic community. Thus, increases in mainstream prevention activities are not necessarily a gain for Hispanics.

Even where recognition of the importance of targeted prevention efforts is recognized, Hispanic initiatives tend to receive far less support proportionately than programs for other groups. Only a handful of Hispanic researchers work in the major federal agencies involved in substance abuse. To the extent that "minority" drug abuse initiatives are identified, their focus tends to be on Black concerns, though many of the same drug-related problems are shared by Hispanics. Since OSAP began awarding prevention grants targeted to youth at high risk, 62 such grants out of a total of 245 -- or 25% -- have gone to projects targeting Blacks, including 24 in the first year, compared to a cumulative total of 23 -- 9% -- to projects targeting Hispanics. Minority-oriented projects are underfunded in general, but the situation for Hispanics is especially severe.

Longstanding inattention to Hispanic concerns has left Hispanics at the early stages of prevention research, unable to take full advantage of newly available program service funding. A profound lack of reliable data on Hispanics has hindered development of

models for Hispanic-oriented drug abuse prevention, and this, in turn, has delayed the expansion of prevention activity within the Hispanic community.

There exists no single source of current, reliable data on the extent and nature of substance abuse among Hispanics. Without accurate knowledge of the target population, the development of prevention program models proceeds slowly and on a "best guess" basis. Prevention experts have repeatedly acknowledged the need for further study of non-White populations and their unique prevention needs, yet research in this area has only recently been granted priority status.[34]

The lack of epidemiological data is matched by ignorance about Hispanics' knowledge, beliefs, and attitudes towards substance abuse. Such knowledge is crucial for planning effective, appropriate prevention strategies, yet no comprehensive data have been compiled. Most existing studies of Hispanic perceptions focus on alcohol use.

According to OSAP, "Research is needed particularly to address [the needs of] Hispanic children and adolescents, a population for which knowledge of drug and alcohol abuse is especially scarce."[35] The major source of national data on drug abuse among young adults, the annual High School Senior Survey, does not present information by race or ethnic group. However, even if the Senior Survey were modified to include markers for race and ethnicity, it would remain a poor source of information on Hispanic youth. Due to high dropout rates, participation of Hispanic youth in surveys focusing on seniors is disproportionately low, and those Hispanics who do participate are probably a non-representative sample.

Knowledge of past programs is also scarce. Researchers and community groups have developed prevention programs targeted to Hispanics despite the absence of an adequate understanding of the circumstances of substance abuse within the Hispanic community. Unfortunately, few of these programs have been properly evaluated, and even fewer documented for replication. A recent review of Hispanic prevention literature cited incomplete information about results from programs targeted to Hispanics as a primary obstacle to the development of new approaches.[36]

Few Hispanics have been trained as drug abuse prevention professionals and researchers, although the training of Hispanics in these fields is essential to promoting Hispanic-targeted prevention efforts. In one NIDA-sponsored training program which focuses on the recruitment of minority drug abuse researchers, 47 pre- and post-doctoral fellows have been appointed over six years; of these, six have been Hispanics. In the current year, just one of the program's 21 fellows is Hispanic.[37]

IV. TREATMENT

A. *Introduction*

It is difficult to estimate the need for drug abuse treatment among Hispanics in the absence of reliable data about the drug-abusing population. Major complications surround any attempt to formulate an accurate estimate of the level of illicit drug use in the United States. Most data on drug use come from national studies which rely upon self-reporting. These surveys almost certainly underestimate levels of substance abuse in general, and are particularly poor sources of information on Hispanics. The National Household Survey on Drug Abuse -- the only study on nationwide prevalence of illicit drug use which reports data separately for Hispanics -- fails to count incarcerated persons and those with no fixed address, and probably undercounts other hard-to-reach populations as well. The most detailed data on drug abuse among Hispanics come from the Hispanic Health and Nutrition Examination Survey (HHANES), but these data were collected from 1982-24, are not generalizable beyond the regions which were sampled, and do not capture changes in drug use since that time, most notably the rise in use of "crack" cocaine.

National data on Hispanic treatment program clients are extremely limited; national data on treatment outcomes are almost non-existent. The only source of information on both publicly and privately funded treatment facilities and clients is NDATUS,[38] and the most recent information available date form October 30, 1987. SADAP[39] data provide information only on federally funded treatment programs. The best source of data on treatment clients in the 1970s -- including drugs of abuse and treatment experiences and outcomes -- was CODAP, which became a victim of the block-granting of drug treatment funds. As a result, much of the available information on Hispanic-focused drug treatment services and outcomes comes from sources other than national data bases.

Two factors are especially important in reviewing drug treatment services to Hispanics: the availability of treatment, and the nature of treatment services. Availability includes total treatment slots and funding, the types of clients targeted (including not only race/ethnicity but also age, sex, and nature of drug abuse), location of those slots, and costs. The nature of services includes consideration of the types of modalities, environments, and services provided, and the extent to which Hispanics are enrolled in various types of programs.

B. *Modalities of Treatment*

The major forms or "modalities" of drug treatment are detoxification, methadone maintenance, residential drug-free, and outpatient drug-free.

Detoxification is not by itself a form of treatment, but is generally the first step taken in preparing drug-dependent individuals for long-term care. During detoxification, drug use

is stopped completely, and the user passes through a period of withdrawal. Some "detox" cases require hospitalization, but most can be handled on an outpatient basis.

Nearly all treatment programs begin with detoxification, although not all persons who complete detox programs continue on with treatment. This may be because they decide to quit "cold turkey," and feel that no treatment is needed, because they relapse into drug abuse after being detoxified, or because no slots in treatment programs are available upon their release from detoxification. There are an estimated 100,000 admissions to drug detoxification programs annually;[40] at last measure (1987), Hispanics made up approximately 14% of admissions.[41]

Methadone maintenance is a form of treatment for dependence on heroin and other drugs derived from opium. Patients in methadone maintenance programs receive regular oral doses of methadone hydrochloride, a synthetic narcotic which prevents opiate withdrawal symptoms. In addition to easing the withdrawal process, methadone also blocks the effects of heroin, and so discourages clients from relapsing to heroin use while in treatment.

Proponents believe that by substituting methadone for heroin, treatment clients are able to achieve the stability and clarity necessary for participation in drug counseling and therapy, vocational training, and other social services which aid in their transition to a lifestyle free of illicit drug use. Because methadone maintenance may remove the abuser's desire to inject drugs, it can be an effective means of preventing transmission of the HIV virus which causes AIDS.[42]

However, methadone is an addictive drug, and some criticize methadone maintenance as the substitution of one narcotic for another. Furthermore, many methadone clinics have a history of poor administration and supervision. A survey by the General Accounting Office (GAO) found that in the absence of federal performance standards, "programs established their own goals, policies and practices, which varied widely."[43] The GAO survey also found that recent evaluations of methadone maintenance programs revealed serious and widespread violations of federal regulations. Methadone can become a drug of abuse, and the incidence of improper use of methadone by clients in treatment is reported to be widespread. Moreover, methadone maintenance is not a treatment option for addiction to cocaine, now the leading drug of abuse in the United States.

Currently, methadone maintenance programs are the most popular treatment modality for heroin addiction. In part, their popularity may be attributed to affordability. Because methadone programs are usually administered on an outpatient basis, they tend to be less expensive than some other modalities, costing between $3,000 to $4,500 annually.[44]

Drug-Free treatment programs work to bring about changes in the drug abuser's personality and behavior. Most drug-free programs are based upon a model which perceives drug addiction as a result of underlying psychological problems, and thus rely upon counseling as the primary method of treatment. Drug-free programs usually begin with a

period of detoxification, after which the client undergoes intensive counseling and is kept off drugs entirely. Drug-free treatment can include a variety of counseling approaches, and is administered in both residential and outpatient environments.

Residential drug-free treatment centers are generally freestanding facilities, although some are associated with hospitals and halfway houses.[45] For most clients, the cost and length of stay of residential programs is prohibitive. Intensive "therapeutic communities" (TCs) require an average stay of nine to 12 months and can cost from $1,200 to $2,500 per month. Twelve-step programs, based on the Alcoholics Anonymous model, cost about $6,000 per client. Psychiatric hospital care is by far the most expensive of the residential drug-free options; inpatient programs may cost a total of as much as $30,000 per patient.

Twelve-step programs and psychiatric drug treatment have not been the subject of much research, and the effectiveness of these programs remains undetermined. Research on therapeutic communities has been more extensive, but the diversity of these programs and their clients preclude the drawing of widely applicable conclusions. TC programs do seem to reduce drug use and associated behaviors (criminal activity, unemployment) for clients who remain in treatment for at least three months.[46] Attrition rates for TCs are typically high, however, and as many as four out of every five patients who begin treatment in a TC drop out or are expelled before the program's end.[47]

Outpatient drug-free treatment is the most popular and perhaps the least well understood modality. Programs treat a variety of drug problems, and clients may include non-dependent individuals, veterans of other treatment modalities, and clients compelled to attend drug counseling upon release from incarceration or as a condition of probation in lieu of incarceration. A standard course of treatment in an outpatient drug-free program includes one or two counseling sessions per week and lasts for six months; costs average $200 to $600 per month.

While outpatient drug-free programs are relatively inexpensive, there is considerable question about their effectiveness. Outpatient programs have been shown to have roughly the same positive results as therapeutic communities, but higher attrition rates. The best results are among clients who remain in treatment at least three months.[48]

C. *Funding Trends*

According to a recent report by the National Academy of Science's Institute of Medicine, two very different types of drug treatment facilities exist in the United States: "one for the poor under public sponsorship and one for those who can pay with private insurance or public funds." These two tiers of drug treatment differ "not only in their sources of financing, but also in their recency and origins, provider and facility characteristics, modalities offered, clientele served, and capacity utilized."[49]

The study notes that the public tier of treatment services has suffered reductions in both the intensity and breadth of its program services and the experience levels of its staff. These reductions are attributed to "a general shrinkage in public services and a more specific shift back toward the criminal approach to drug problems, rather than to patterns or trends in the severity of drug problems...".[50]

In contrast, private, for-profit programs have increased rapidly over the past decade, growing in both number and share of treatment revenues. In 1982, there were 159 private, for-profit drug treatment units. By 1987, for-profit units had increased to 730. Government-owned drug treatment facilities grew comparatively little during the same period, going from 950 units to 1,020. The most dramatic change in funding for drug treatment has not been disproportionate growth in units, however, but the rise of private payments as a total share of drug treatment funding (See Figure 4). In 1976, private sources accounted for less than 9% of payments for drug treatment; state, local and federal government funding provided the remaining 91%. In 1987, private insurance and out-of-pocket payments were up to 38.5% of total treatment funding, while government funding accounted for slightly more than half (56.7%).[51]

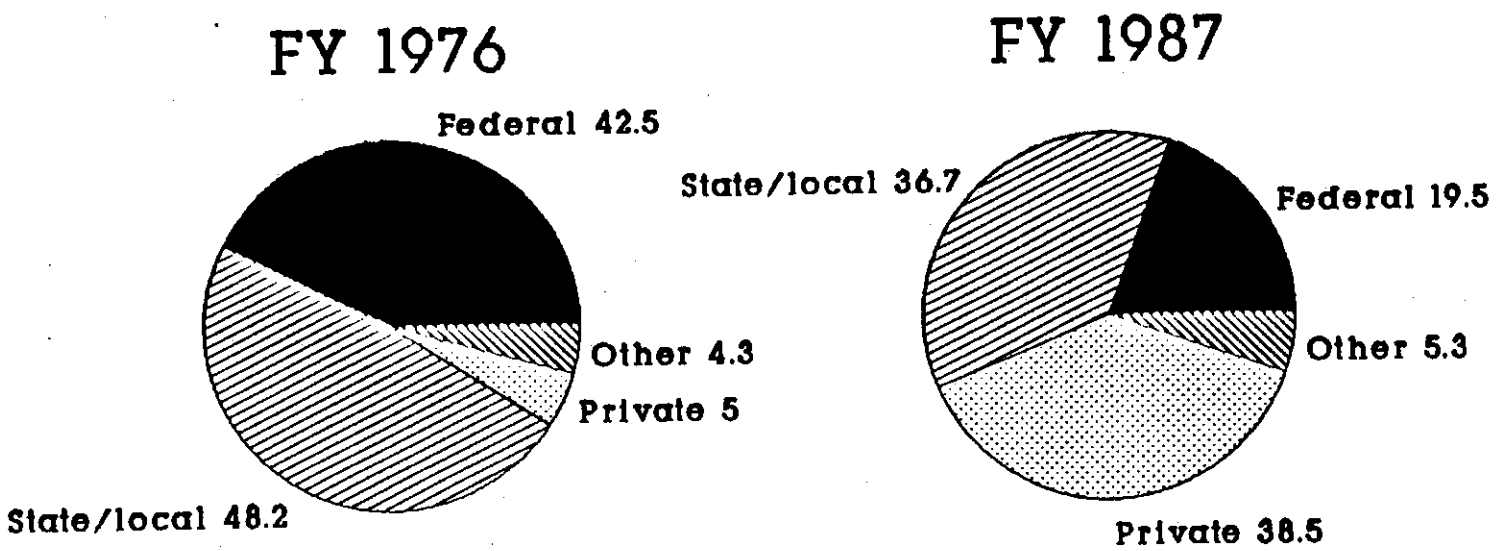
Within the public tier of drug abuse treatment, most funding is provided by state and local governments. State and local government resources provided $373 million in support for public drug abuse treatment programs in 1987. Direct contributions from federal sources totalled $157 million for that year, including $110 million in block grant monies and $47 million in categorical grants.[52]

Although funding for drug abuse treatment has recently increased, the real value of those increases have not kept pace with inflation. The Institute of Medicine study concluded that "[the nation's] drug treatment system is...notably weaker and smaller than it was in 1976 in aggregate funds and in resources per client served."[53]

D. Treatment Services and Hispanics

It is difficult to estimate the need for drug abuse treatment among Hispanics in the absence of reliable data about the drug abusing population in general. Major complications surround any attempt to formulate an accurate estimate of the level of illicit drug use in the United States. Most data on drug use come from national studies which rely upon self-reporting. These surveys almost certainly underestimate levels of substance abuse in general, and are particularly poor sources of information on Hispanics. The National Household Survey on Drug Abuse -- the only study on nationwide prevalence of illicit drug use which reports data separately for Hispanics -- fails to count incarcerated persons and those with no fixed address, and probably undercounts other hard-to-reach populations as well. The most detailed data on drug abuse among Hispanics come from the Hispanic Health and Nutrition Examination Survey (HHANES), but these data were recorded from 1982-24 and do not capture changes in drug use since then, most notably the rise in popularity of "crack" cocaine.

FUNDING SOURCES FOR DRUG TREATMENT
FY 1976 AND FY 1987



Treating Drug Problems, Vol. I

FIGURE 4

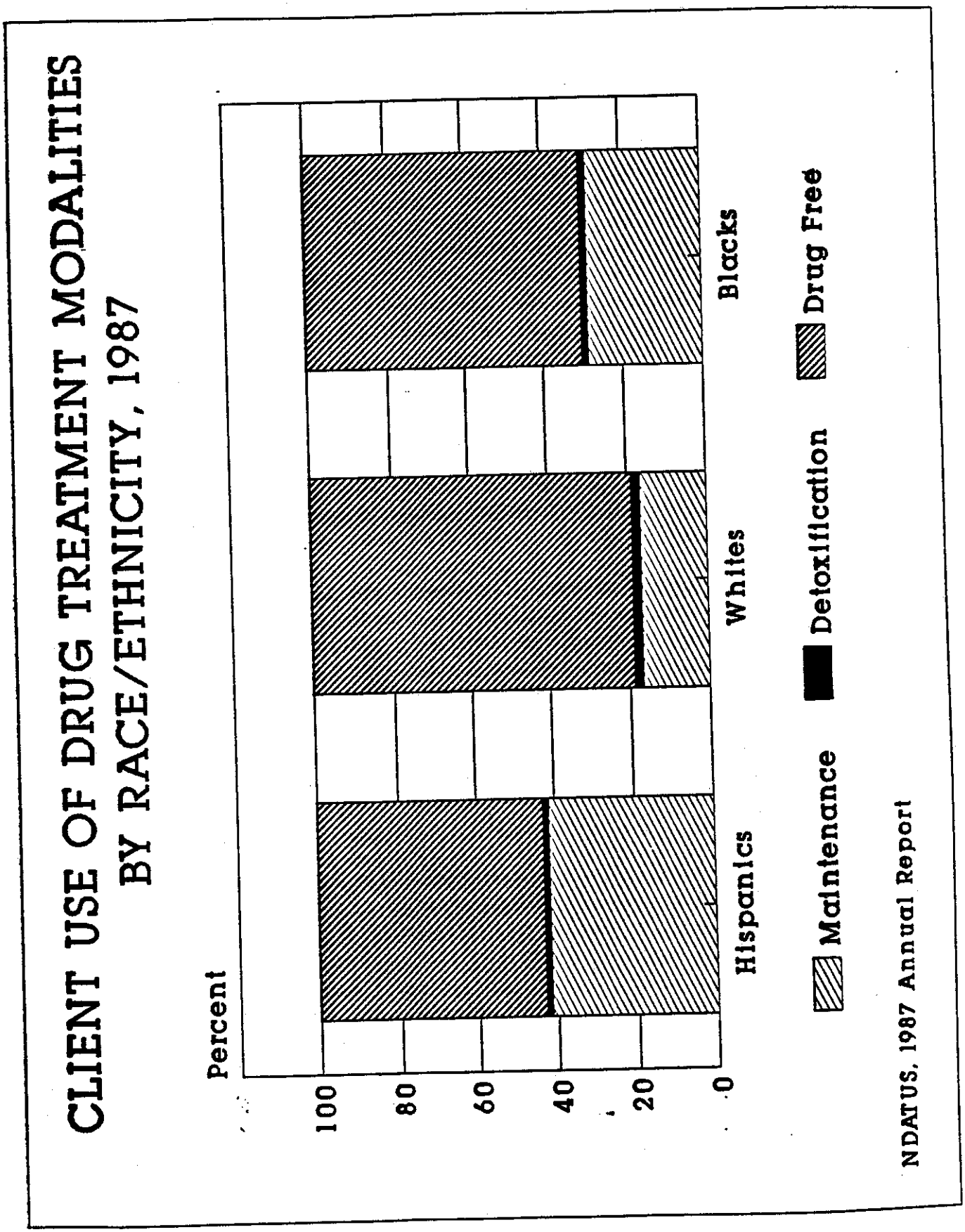
Drug abuse treatment is available to only a small fraction of those who need it. Although exact figures on the need for drug treatment are not available, the National Academy of Science recently estimated that 5.5 million Americans clearly or probably need drug treatment.[54] The 1987 NDATUS reported 260,151 clients in treatment, a little more than 5% of those in need.[55] Some experts estimate that 90% of all those seeking drug abuse treatment are turned away for lack of space.[56]

Based upon their proportion of the general population, Hispanics are overrepresented among drug abuse clients. Although the number of Hispanics needing drug treatment is unknown, information on the population of individuals who actually receive treatment is available from NDATUS. According to the 1987 NDATUS, Hispanics made up about one-sixth (15.9%) of the clients in treatment for whom race and ethnicity is known, but less than 8% of young adults in the general population.[57] National figures probably understate the proportion of Hispanics in treatment, however, due to the geographic concentration of Hispanics certain regions of the country. Data from the National Association of State Alcohol and Drug Abuse Agency Directors indicate that Hispanics are overrepresented in public drug treatment programs in seven of the nine states with the largest Hispanic populations. Overrepresentation was greatest in New Mexico (42.5% of drug treatment clients, 36.7% of the state population) and New Jersey (13.7% of drug treatment clients, 8.4% of the state population).[58]

Drug use patterns suggest that Hispanics may actually be underrepresented among drug treatment clients relative to need. Although Hispanics report lower rates of occasional drug use than non-Hispanics, Hispanics are more likely to be recent and current users of certain highly addictive drugs, especially cocaine. This suggests that while drug use among Hispanics in general may be low, the need for treatment among Hispanics who use drugs might actually be quite high. In other words, Hispanics probably constitute a greater share of the population in need of treatment than assumptions based on their share of the general population would indicate. In addition, Hispanics face a number of barriers to treatment which may well result in an *underrepresentation* of Hispanic drug treatment clients compared to the population in need.

Hispanics typically receive drug treatment in the most crowded and least supervised facilities, and are more likely than other groups to be served in methadone maintenance and other outpatient modalities, where utilization rates are high and staff-to-client ratios are low. In 1987, 41.3% of Hispanics in treatment were enrolled in methadone maintenance programs (See Figure 5). According to NDATUS, methadone maintenance programs have the lowest staff-to-client ratios of any major modality: one staff member to 40.8 clients, compared to 1:24.5 for drug-free units and 1:25.3 for detox programs. They also have the highest utilization rate (actual clients served compared to budget capacity) of any treatment modality: 89.3%, compared to 76.8% for drug-free and 55.9% for detox.

FIGURE 5


CLIENT USE OF DRUG TREATMENT MODALITIES
BY RACE/ETHNICITY, 1987
Percent
100
80
60
40
20
0
Hispanics
Whites
Blacks
Maintenance
Detoxification
Drug Free
NDATUS, 1987 Annual Report

Hispanics were much more likely than either Blacks or Whites to participate in methadone maintenance programs; 41.3% of Hispanic drug treatment clients participated in methadone maintenance programs in 1987, compared to 28.3% of Blacks and 16.6% of Whites.[59]

Hispanics were slightly less likely than Blacks and much less likely than Whites to be enrolled in drug-free treatment. According to the 1987 NDATUS, 81.2% of Whites and 69.9% of Blacks received drug-free treatment, compared to 57.0% of Hispanics.[60] Hispanics were 12.7% of all drug-free treatment clients in 1987 and 15.9% of the drug treatment client population overall. This disparity may reflect the very limited availability of Hispanic-targeted drug-free treatment programs; drug-free treatment relies heavily upon counseling, support groups, and other communication-based therapies which may present problems for Hispanics when differences in language and culture are not taken into account. Figure 6, attached, shows the race/ethnicity of drug treatment clients in single-modality units in 1987.

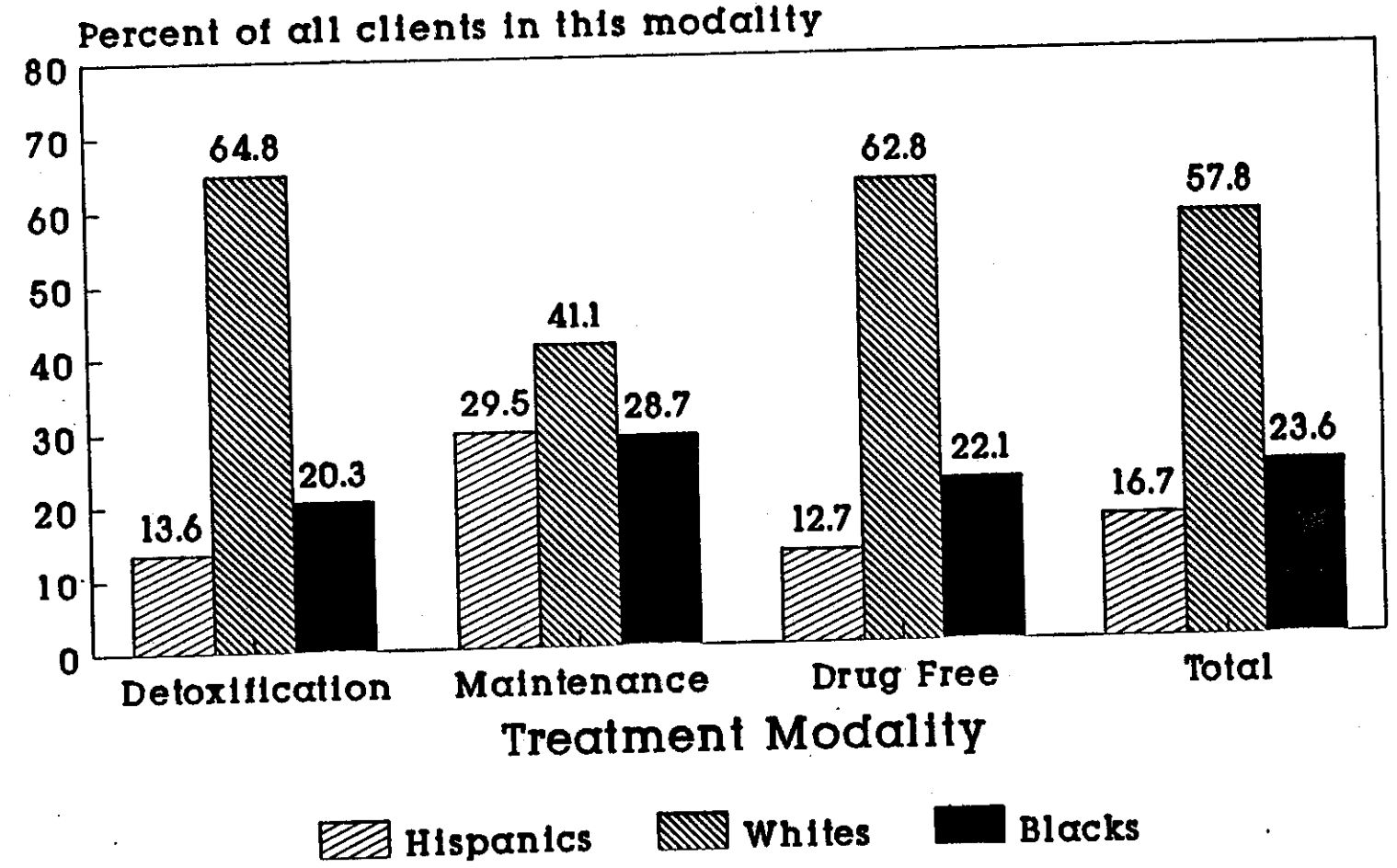
Hispanics were slightly less likely to undergo detoxification than Blacks or Whites. Relatively few drug treatment clients received detoxification alone in 1987. Hispanics had slightly lower participation rates in detoxification programs (1.7%) than either Blacks (1.8%) or Whites (2.2%).[61]

Hispanics and other groups had similar representation in various treatment environments. The environment for the large majority of Hispanics in treatment was outpatient (90.7%); 7.8% were treated in residential settings, and 1.5% on an inpatient basis (See Figure 7).[62] A somewhat higher proportion of Hispanics were treated as outpatients than either Blacks (86.6%) or Whites (88.7%). Blacks were slightly more likely to receive treatment in residential settings (10.7%) than Hispanics (7.8%) or Whites (7.6%). A very small percentage of drug treatment clients overall received care as inpatients (3%), with Whites and Blacks both more likely than Hispanics to receive treatment in this environment.[63] Figure 8, attached, shows race/ethnicity of drug treatment clients by treatment environment for 1987.

Hispanics seeking treatment face not only overcrowding, but also a lack of bilingual staff and few culturally relevant programs. Of the 5,158 drug treatment units reporting special programs in the 1987 NDATUS, only 469 (9%) had programs targeting Hispanics.[64]

Of all Hispanics, pregnant women and young children face the greatest difficulties in obtaining drug treatment. In addition to limitations set by overcrowding and low availability of Hispanic-targeted programs, Hispanic pregnant women and children face special barriers to treatment. These two groups still represent a relatively small segment of Hispanic drug abusers, but recent surveys indicate steady gains in the number of women and children with serious drug problems, especially among Puerto Ricans. The current treatment system, which was designed primarily to serve adult male heroin addicts, provides few

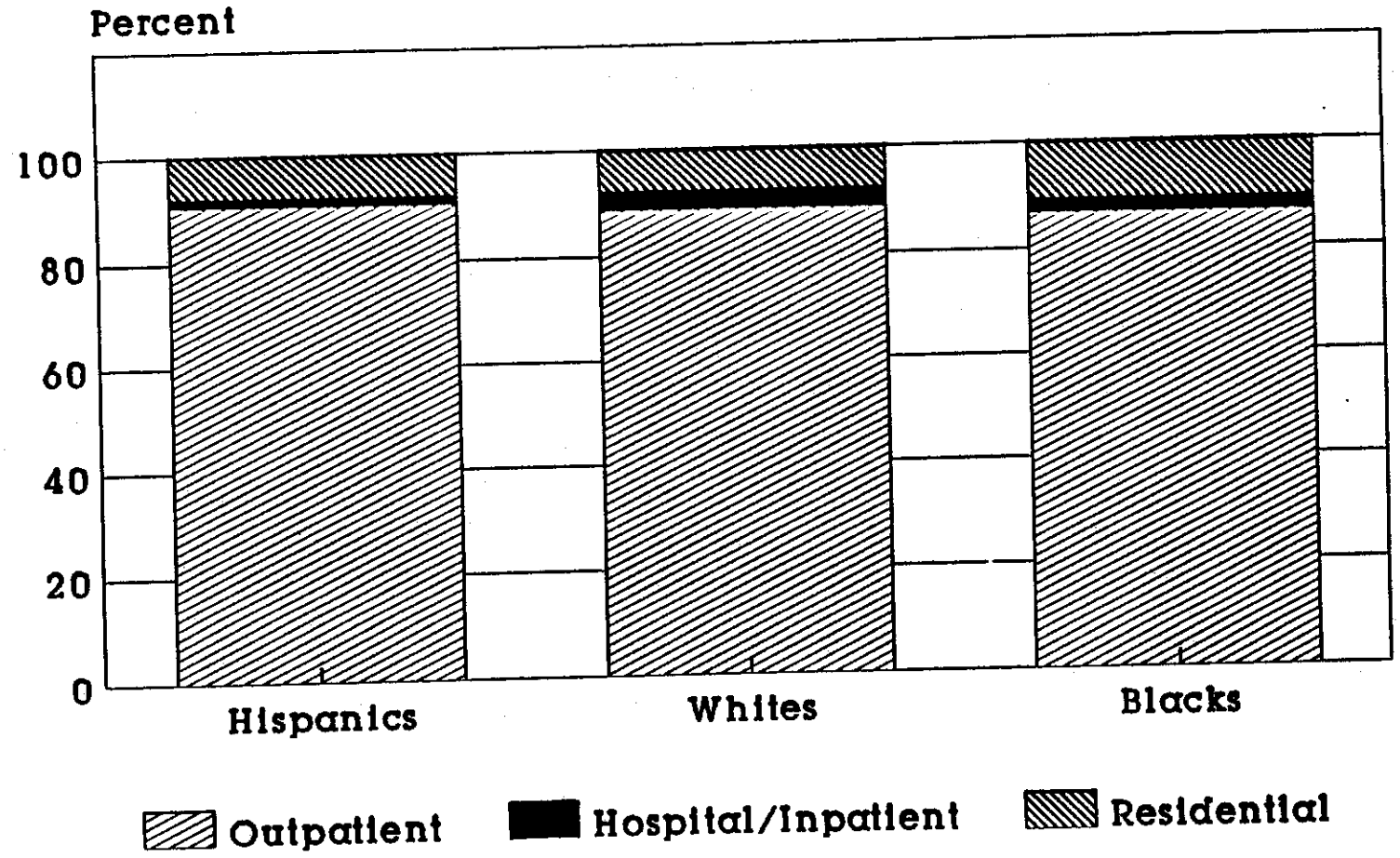
RACE/ETHNICITY OF DRUG TREATMENT CLIENTS BY MODALITY, SINGLE-MODALITY UNITS, 1987



NDATUS, 1987 Final Report

FIGURE 6

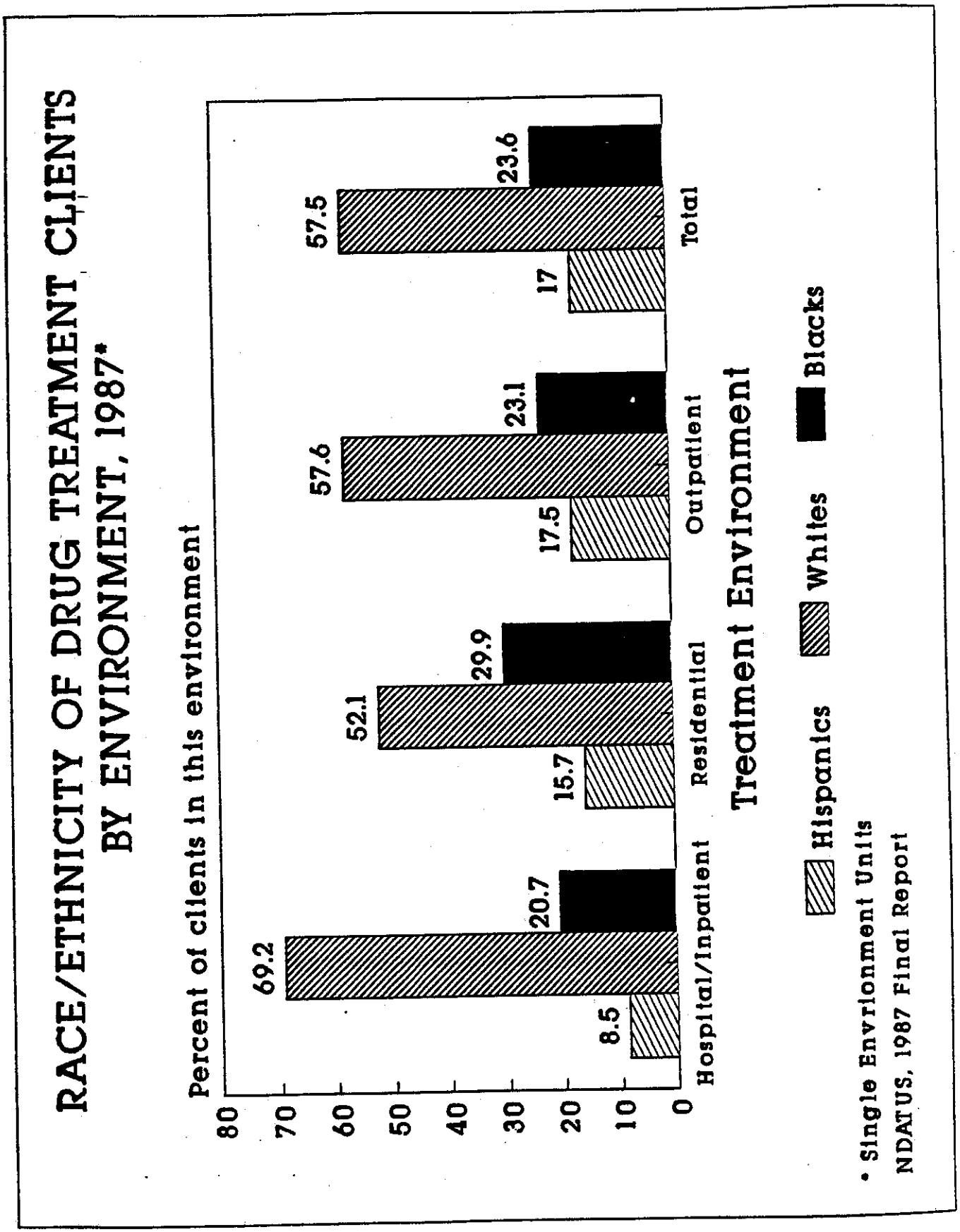
CLIENT DRUG TREATMENT ENVIRONMENTS BY RACE/ETHNICITY, 1987



NDATUS, 1987 Annual Report

FIGURE 7

FIGURE 8


RACE/ETHNICITY OF DRUG TREATMENT CLIENTS
BY ENVIRONMENT, 1987*
Percent of clients in this environment
80
70
60
50
40
30
20
10
0
69.2
20.7
8.5
52.1
29.9
15.7
57.6
23.1
17.5
57.5
23.6
17
Hospital/Inpatient
Residential
Outpatient
Total
Treatment Environment
Hispanics
Whites
Blacks
* Single Environment Units
NDATUS, 1987 Final Report

options for women and children in need of care. Many treatment centers deny services to drug-dependent pregnant women because they are not prepared to assume responsibility for the health of the fetus.[65] Programs for children are also scarce; among the treatment units surveyed by NIDA in 1987, less than one-third offered youth services.[66]

V. CONCLUSIONS

Efforts to develop appropriate and effective substance abuse prevention and treatment programs for Hispanics are severely hindered by a lack of information about the nature and extent of the problem. Data about substance abuse among Hispanics remains incomplete; recent national data on the various Hispanic subgroups are almost non-existent. While factors correlated with substance abuse have been identified, the relative importance of various individual, family, cultural, locational, and societal factors are not well understood. For example, while it is clear that poverty, crime, low levels of education, unemployment and underemployment, and residence in inner cities are closely related to substance abuse, no clear cause-and-effect relationship can be cited. Very little information is available about Hispanics in substance abuse treatment programs, and almost no national data can be found on Hispanic participation in prevention efforts. Moreover, most treatment program data focus on publicly funded and especially federally funded programs -- even though the majority of treatment services are not federally funded, and about 40% are privately funded.

Data on Hispanic-focused prevention and treatment services are similarly lacking. This reflects two factors: inadequate evaluation and documentation of existing program models and services, and a severe lack of culturally appropriate, Hispanic-targeted programs. Due to the absence of such programs, recent increases in prevention and treatment activities have had minimal effect on the situation of Hispanics.

Hispanics have not received their fair share of funding for research or demonstration projects. Only about 3% of recent NIDA research and demonstration grants have gone to Hispanic-focused projects, and about 9% of OSAP prevention grants. To the extent that "minority" drug abuse initiatives exist, they rarely focus on Hispanic concerns and needs.

Few Hispanics have been trained as drug abuse prevention and treatment professionals. Although the training of Hispanics in this field is essential for promoting Hispanic-targeted efforts, training programs have been largely unsuccessful in recruiting Hispanic participants.

Drug abuse treatment and prevention continues to receive far less attention and less funding than other approaches to drug control. Recent increases in funding for drug abuse treatment and prevention have been small compared to increases in "supply side" areas

of drug control such as criminal justice and interdiction. Over the past two decades, increases in federal funding for treatment and prevention have hardly kept pace with inflation.

Prevention efforts designed specifically for Hispanics are especially rare, despite general acknowledgment of the importance of targeting prevention programs to particular groups. Experts now agree that effective drug abuse prevention programs must be designed with an understanding of the specific prevention needs of the intended target group. However, only a very small percentage of prevention efforts specifically target Hispanics, and most of these have not been evaluated or documented for replication.

The close connection between intravenous (IV) drug use and HIV/AIDS among Hispanics lends added urgency to the need for drug abuse prevention programs targeted to Hispanics. More than half of all AIDS cases reported among Hispanics aged 13 and older have been drug related, and there is an IV drug use connection in more than 70% of all Hispanic pediatric AIDS cases. Increased attention must be given to the development and implementation of substance abuse prevention efforts targeted to Hispanics if the link between substance abuse and AIDS among Hispanics is to be broken.

Because few Hispanic-targeted prevention programs have been tried -- and even fewer evaluated -- development of new programs is hindered by a lack of information about what works. Opportunities for developing and testing prevention programs for Hispanics have recently been expanded, but much of this growth has been in the form of demonstration projects. Few successful programs have been implemented widely. Thus even if funding should expand significantly, it will be at least several years before a significant national body of knowledge with tested prevention models emerges.

Hispanics are overrepresented among drug treatment clients based upon their proportion of the general population. However, this is not a good indication of actual need for treatment. Drug use patterns suggest that Hispanics may actually be underrepresented based on need. Many factors create high risk for drug use among Hispanics, with the result that Hispanics almost certainly constitute a greater share of the population in need of treatment than they do of the general population.

Hispanics seeking treatment face severe overcrowding. It has been estimated that 90% of drug abusers seeking treatment are turned away due to lack of space; moreover, there is reason to believe the situation for Hispanics is worse than for other groups. Hispanics are more likely to receive drug treatment in the most crowded and least supervised facilities, such as methadone maintenance, where utilization rates are high and staff-to-client ratios low.

In addition to overcrowding, Hispanics seeking treatment encounter a lack of bilingual staff and few culturally relevant programs. Very few Hispanic-targeted treatment programs exist, and this may account for the fact that Hispanics are less likely than either Blacks or Whites to participate in drug-free treatment program. Drug-free treatment relies heavily upon counseling, group therapy, and other communication-based therapies

which are of limited help to Hispanics when differences in language and culture are not taken into account. Despite Hispanics' low relative participation in drug-free programs, they are still more likely to be in drug-free treatment than any other modality. Moreover, there has been a major increase in the use of crack and other cocaine by Hispanics in the past several years, and drug-free treatment is currently the only available modality for treating addiction to these drugs. Thus the need for drug-free treatment programs targeted to Hispanics is especially urgent.

Of all Hispanics, pregnant women and young children face the greatest difficulties in obtaining drug treatment. The current treatment system was designed primarily to serve adult male heroin addicts, and provides few options for women and children in need of care. Many treatment centers deny services to drug-dependent pregnant women because programs are not prepared to assume responsibility for the health of the fetus. Programs for children are also limited; less than one-third of the NDATUS treatment units offered youth services.

Hispanic community-based organizations already play a critical role in addressing the drug abuse problem, and could play an even greater role if encouraged to do so through public and private policies and programs. Local family-focused Hispanic organizations know how to find and serve high-risk groups, and already carry out a variety of programs targeting the very groups that are considered at greatest risk for substance abuse. Yet few of them receive substance abuse funding.

The problem of substance abuse in Hispanic communities can be adequately addressed only through increased attention to Hispanic needs in all aspects of the drug control system. More research is needed on Hispanic substance abuse and the factors which contribute to it, with Hispanic participation in study design and implementation. National surveys need to not only oversample Hispanics, but provide subgroup data. Major emphasis needs to be placed on demonstration prevention and treatment projects, and on evaluating, disseminating, and replicating effective models. In short, Hispanics need to receive their fair share of substance abuse attention and funding.

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