

INCARCERATED WOMEN AND DRUG ABUSE: AN INTERNATIONAL PERSPECTIVE

Judith Grant
University of Ontario Institute of Technology

Abstract

The climate of domestic drug policy in the United States as it pertains to both women and men at the beginning of the 21st century is the criminalization mode of regulation—a mode that is based on the model of addiction as a crime and one that is used to prohibit the use of currently illegal drugs. In Canada, drug policy is based mainly on the harm reduction model, a policy or program directed towards decreasing the adverse health, social, and economic consequences of drug abuse without requiring abstinence from such use. As a response to the problem of drug abuse, the United States national drug policies have emphasized punishment over treatment and, as argued in this paper, have had a disproportionate impact on women. Using a comparative analysis between these two societies, this paper considers the ramifications of these two regulatory modes through women's perspectives. This paper seeks an answer to the question: "Using an international perspective (i.e., Canada and the United States), is American drug policy directed toward women who abuse drugs a miscarriage of justice?"

Incarcerated Women and Drug Abuse: An International Perspective

The criminalization mode of regulation—a mode that is based on the model of addiction as a crime is the domestic drug policy in the United States. Such a mode of regulation entails tough enforcement, and is the centerpiece of American drug policy in terms of rhetoric, budget, and substance (Boyum & Reuter, 2005). Drug policy in Canada is based mainly on a harm reduction model that operates with the assumption that some people who engage in high-risk behaviors are unwilling or unable to abstain. Rather than having abstinence goals set for them, clients in such programs take part in a goal-setting process, an approach that has been shown to correlate consistently with retention and success (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992). Using a comparative analysis between these two societies, this paper considers the ramifications of these two regulatory modes through women's perspectives, thus combining my two interests, drug policies and women who are addicted to drugs.

I begin with an overview of the problem and significance of women's drug abuse in both the United States and Canada. I then continue with a discussion of the two modalities as they relate to women's experiences: the criminalization model and the harm reduction model. I conclude by arguing in opposition to the criminalization model

Direct correspondence to Judith.Grant@uoit.edu

© 2007 published here by permission

The Journal of the Institute of Justice & International Studies Vol 7

as, in my view, such a mode of regulation is more harmful to women and, therefore, results in a miscarriage of justice¹ (Wellisch, Anglin, & Prendergast, 1994; Women's Prison Association, 2004).

The Problem and Significance of Women's Addiction in the United States and Canada

Substance abuse continues to afflict both Canadian and American society to a great extent (Substance Abuse and Mental Health Services Administration (SAMHSA), 2000; Adrian & Kellner, 1996), resulting in serious consequences for those afflicted and for their families (Abbott, 1995). For example, in the United States, approximately 41.6% of women ages 12 or older reported using an illicit drug at some point in their lives (SAMHSA, 2006). Among pregnant women aged 15 to 44, 4% reported using illicit drugs while pregnant (SAMHSA, 2004). Approximately 38% of female high school students reported using marijuana (Centers for Disease Control (CDC), 2004), and of the 22,000 persons who died of drug-induced causes in 2001, 34% were female (CDC, 2004). In terms of alcohol use among American women, 77.6% of women age 12 and older reported ever using alcohol, while 60% reported past year use and 45.1% reported using alcohol in the past month (SAMHSA, 1999).

In the United States, of the 670,000 individuals admitted to emergency departments for drug related health problems, some 308,000 were women. This represents a 22% increase from 1995 (SAMHSA, 2004). Women also accounted for 30% of the nationwide admissions to all forms of drug treatment during 2002 (SAMHSA, 2004). Additional data show that more than half of treatment admissions for sedatives in 2002 involved women (SAMHSA, 2004). About 30% of the approximately 40,000 new HIV infections occur among women (CDC, 2001). In 1992, women accounted for an estimated 14% of adults and adolescents living with AIDS in the 50 states and the District of Columbia (CDC, 1998). By the end of 2005, this proportion had grown to 23% (CDC, 2005). Overall, the direct and indirect costs of drug abuse totaled more than \$294 billion (U.S. dollars) in the United States in 2001 (Office of National Drug Control Policy (ONDCP), 2001).

Substance abuse among Canadian women continues to be a serious issue as well (Adrian & Kellner, 1996). In the 1994 *Canada's Alcohol and Other Drugs Survey* (Statistics Canada, 1996), 10% of men and 4.9% of women reported using cannabis in the past year while in the 2004 *Canadian Addiction Survey*, this increased to 18.2% of men and 10.2% of women. (Adlaf, Begin & Sawka, 2005). In a 2002 *Canadian Community Epidemiology Network on Drug Use* (CCENDU) national report, the percentage of female drinkers increased in Canada, most pronouncedly among 20- to 24-year-olds. Since the 1970s, studies have found that Canadian women drinkers consume less alcohol and drink less frequently than men who drink. For example, in 2004 more women (74.2%) than men (53.4%) reported drinking no more than one or two standard drinks on a single occasion in the past year. However, alcohol is the most common substance used by women and its use has been on the rise over the past decade (Adlaf et al., 2005). Among Canadian women who were pregnant, 17–25% reported drinking alcohol during pregnancy. A larger proportion of women than men (23% versus 17%) report using at least one mood-altering prescription drug; although, in the general population, women are half as likely as men to be current users of cannabis or any other illegal drug. Women are less likely than men to report

legal problems but are more likely to report harm to home life as a result of their substance abuse (Dell & Garabedian, 2003).

In Canada, of the 18,124 cumulative AIDS cases in adults, 7.9% occur among women. The proportion of AIDS cases among women (relative to all reported AIDS cases in adults for which gender and age are known) has increased over time from 5.6% before 1992 to 8.3% in 1995 and peaked at 16.4% in 1999. In 2001, the proportion of AIDS cases among women remained at 16% (Center for Infectious Disease Prevention and Control, 2003). From 1996 to 2001, injection drug use as a risk factor for HIV decreased substantially for females (from 51% in 1996 to 32% in 2001) and remained relatively stable for males (from 29% in 1996 to 22% in 2001) (Health Canada, 2002a). Needle-exchange and harm-reduction programs in Canada report significant use by women: for example, women comprise 35% of the approximately 6000 registrants of the Vancouver Needle Exchange and were represented in the same proportion in the cohort of injection drug users involved in the Vancouver Injection Drug Use Study (VIDUS). Approximately 20% of injection drug users recruited in Montreal for an observational study of risk behaviors and HIV infection were women (Bruneau, Lamothe, Franco, Lachance, Desy, & Soto, 1997).

A report entitled, *The Costs of Substance Abuse in Canada 2002*, funded by the Canadian Center for Substance Abuse (Rehm, Baliunas, Brochu, Fischer, Gnam, Patra, Popova, Sarnocinska-Hart, & Taylor, 2006) and more than 10 other Canadian institutions, investigated the impact of substance abuse on Canadian society. It estimated the effects of tobacco, alcohol and illegal drugs in terms of death, illness and economic costs in 2002. The study revealed that substance abuse places a significant burden on the Canadian economy. It has both a direct impact on health care and criminal justice costs, and an indirect toll on productivity resulting from disability and premature death. Although the study did not use a gender breakdown, it did show that the total annual cost of substance abuse in Canada is \$39.8 billion (CAD dollars) (based on 2002 data)—a cost of \$1,267 to each Canadian. The study reveals that: legal substances (tobacco and alcohol) account for almost 80% of the total cost of substance abuse (79.3%); illegal drugs make up the remaining 20.7%; tobacco leads the way with a cost of \$17 billion (42.7%); alcohol accounts for \$14.6 billion (36.6%); and, illegal drugs account for \$8.2 billion (20.7%) (Rehm et al., 2006).

The cost of substance abuse among both women and men is high in both personal and social terms for both the United States and Canada in the 21st century: totaling more than \$294 billion (U.S. dollars) in the United States versus the cost in Canada of \$39.8 billion (CAD dollars). Obviously, the costs are radically different between the two societies despite the disproportion in population (302 million in the United States versus 33 million in Canada). The public's belief in an ever-growing drug problem has fuelled the prohibitionist reaction to drug use and the user in the United States. Such a view assumes that illicit drug use is a morally corrupt behavior; therefore the control of such immoral behavior is necessary, requiring a strong law-enforcement apparatus and a drug policy that declares war on drugs and heavily punishes drug users (Cheung, 2000).

Canada's drug policy is based mainly on the harm reduction model and its public health principles which do not require abstinence from drug use. Such a model has proven to be cost-effective in dealing with drug abuse. For example, it increases social and financial efficiency by interrupting the transmission of infectious disease at a lower cost, rather than waiting to treat complications of advanced illness at a much higher cost (Drucker, 2006). Not only do harm reduction measures save human life

and improve its quality by allowing drug users to remain integrated in society, but they also economically benefit communities (see Lurie & Drucker, 1997; Holtgrave, Pinkerton, Jones, Lurie & Vlahov, 1998; Laufner, 2001).

However, how women who are addicts are treated is vastly different between these two societies, and how they are dealt with is dependent on the current modality. The next discussion centers on these two modalities as they relate to women's experiences: the criminalization model and the harm reduction model. Highlighted in this overview is how women are impacted through these two approaches.

The Criminalization Model

Criminalization refers to the fact that all existing laws prohibiting currently illegal drugs are enforced. Individuals caught possessing or trafficking drugs are charged, given criminal records, fined and/or incarcerated (Haden, 2002). As Boyum and Reuter (2005) argue, the number of drug offenders in the United States under incarceration has grown tenfold since 1980, but there is strikingly little evidence that increased punishment has significantly reduced drug use. The war on drugs is now used to describe laws, policies and practices that prohibit and harshly punish the use, possession, and/or sale of drugs deemed illegal or controlled. This drug war costs a great deal to fight—over \$12 billion in 2004 alone—and has led to no measurable decline in illegal drug use. In 1959, as today, drug addiction was treated as a crime. Addicts could not seek and obtain treatment, and were subjected to police harassment, arrest and incarceration. These punitive attitudes toward drug use and abuse have intensified over the last half-century, leading to the drastic increase in the number of women (as well as men) caught in the net of the war on drugs (Lapidus, Luthra, Verma, Small, Allard & Levingston, 2007).

Nationally in the United States, there are now more than eight times as many women incarcerated in state and federal prisons and local jails as there were in 1980, increasing in number from 12,300 in 1980 to 182,271 by 2002. Between 1986 and 1999, the number of women incarcerated in state facilities for drug related offenses increased by 888%, surpassing the rate of growth in the number of men imprisoned for similar crimes. When all forms of correctional supervision—probation, parole, jail, and state federal prison—are considered, more than one million women are now behind bars or under the control of the criminal justice system (Bloom, Johnson & Belzer, 2003), comprising 7% of the United States prison population (Owen, 2006). More than 71% of all female arrests are for drug-related offenses. Moreover, there was a 96% increase in female drug arrests between 1985 and 1996, far exceeding the 55% increase in male arrests during this same period (Federal Bureau of Investigation (FBI), 1998).

Obviously, although men still outnumber women in prison for drug offenses, the gap seems to be closing. For example, women convicted for drug offenses increased by 40% outpacing those of men. Between 1980 and mid-2003, the number of women in state and federal prisons has risen nearly eightfold—from 12,000 to almost 98,000 (Harrison, Allen & Beck, 2005), showing a rise of 108% compared to male prisoners—77% (Owen, 2006). In addition, almost one million women are on probation or parole (Bureau of Justice Statistics (BJS), 2004). The chance of a woman going to prison in her lifetime in 2001 was 1.8% compared to .3% in 1974, a six fold increase (BJS, 2004).

Women are significantly disadvantaged while in prison. For example, sexual abuse is a major issue. Exacerbating the problem, around 70% of guards in women's correctional facilities are men. These guards are responsible for monitoring women prisoners at all times and in all places, including showers and bathrooms. This partially accounts for high numbers of rape, sexual assault, extortion, and groping during body searches (Amnesty International, 1999).

The imbalance of power between inmates and guards involves the use of direct physical force and indirect force based on the prisoners' total dependency on officers for basic necessities and the guards' ability to withhold privileges. Some women are coerced into sex for favors such as extra food or personal hygiene products, or to avoid punishment (Amnesty International, 2007). Sexual violence or the threat of violence is widespread throughout prisons, but relatively few studies have been able to document its precise prevalence. This is understandable as due to fear of reprisal from perpetrators, a code of silence among inmates, personal embarrassment, and lack of trust in staff, victims are often reluctant to report incidents to correctional authorities (Beck & Hughes, 2005).

However, the Bureau of Justice Statistics (BJS) completed a recent study (Beck & Hughes, 2005) showing that among victims of abusive sexual contacts, women were over-represented compared with the general inmate population. Females comprised 46% of victims of abusive sexual contacts in state prisons, and 28% of the victims in local jails. This is the first-ever national survey of administrative records on sexual violence in adult and juvenile correctional facilities. Although data are limited to incidents reported to correctional authorities during 2004, the survey provides an understanding of how administrators respond to such violence (Beck & Hughes, 2005). Ironically, what is considered a crime outside of prisons is effectively ignored by the system, or at worst condoned as a reality of prisoner life. Guards use physical assaults, threats of stopping visitations by children and other family members, and sentence extensions in order to retaliate against and deter women from reporting abuse (Amnesty International, 1999).

About 20% of children of incarcerated mothers end up living with their fathers, about 60% live with grandmothers, and about 10–15% are put into foster care (Amnesty International, 1999). Incarcerated women can lose their children. The Adoption and Safe Families Act of 1997 eliminates parental rights to a child who has been in foster care for 15 out of the previous 22 months in the United States. The vast majority of incarcerated women will therefore lose their children if they have to put them in foster care (Taifa, 2002). Obviously, incarceration imposes many adverse effects on the mother-child bond, along with development of children born to female offenders. It is important to acknowledge that the separation of the child from the mother can be a traumatic event for many children of all ages if their mother is sentenced to incarceration. This is due to the fact that women were more likely to have been primary caretakers of their children prior to incarceration, thus their absence can place unique strains on their families. The trauma associated with the separation can impose emotional, psychological, and physical problems for these children (Bloom, 1993; Goff, 1999). Bloom (1993) argues that children of incarcerated women often struggle in school, with interpersonal relationships, and are at a far greater risk for delinquent behavior and future incarceration than children whose mothers are not incarcerated.

Many former prisoners in the U.S. are also denied public support and services, increasing the chance that they will return to prison. Anyone convicted of a drug-

related felony is prohibited from receiving cash and food stamps or living in public housing. This makes it difficult for women convicted of drug felonies to support themselves and their children (Allard, 2002).

Women drug offenders are disproportionately represented in the criminal justice system, resulting in longer mandatory sentences normally reserved for serious and violent crimes (Owen, 2006). Women are seemingly disadvantaged more by the system than are men. For example, women in state prisons in 2003 were more likely than men to be incarcerated for a drug offense (29% vs. 19%) or property offense (30% vs. 20%); in 1997, 65% of women in state prisons were parents of minor children, compared to 55% of men; approximately 37% of women and 28% of men in prison had monthly incomes of less than \$600 prior to their arrest; nearly a quarter of women in state prisons have a history of mental illness; nationally 3.6% of women in state and federal prisons were HIV positive in 2000, compared to 2% of men; and more than half of the women in state prisons have been abused, 47% physically abused and 39% sexually abused (with many being survivors of both types of abuse) (BJS, 2000). Many authors argue that this results in a gendered effect of the imprisonment binge (Bloom et al., 1994; Bush-Baskette, 1999; Mauer, Potler & Wolf, 1999; Owen, 1999; Women's Prison Association, 2004).

This section has provided an overview of the criminalization of substance abuse among women in the United States. The following discussion centers on the use of the harm reduction model in Canada and how Canadian women who are incarcerated are affected.

The Harm Reduction Model

Harm reduction is defined as: "a policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use" (Riley & O'Hare, 2000, p. 1). Further, harm reduction is a non-judgmental response that meets users "where they are" with regard to their substance use rather than imposing a moralistic judgment on their behaviors. As such, the approach includes a broad continuum of responses, from those that promote safer substance use, to those that promote abstinence (Thomas, 2005). Harm reduction is a term that refers to a specific set of approaches and corresponding policies that underlie those approaches to reduce risks for people who use drugs and/or engage in behaviors that put them at risk. Increasingly harm reduction is deemed to be a realistic, pragmatic, humane and successful approach to addressing drug problems of individuals and communities. Harm reduction programs operate with the assumption that some people who engage in high-risk behaviors are unwilling or unable to abstain (Thomas, 2005).

Although harm reduction is new in North America, it is not new to other parts of the world. Amsterdam has had needle exchanges in operation since the early 1980s and methadone programs have been available since the 1970s. The police in both Germany and the Netherlands focus enforcement efforts toward harm reduction. Many cities in Australia, United Kingdom, Switzerland, Germany and the Netherlands have facilities known as injection rooms with Switzerland opening its first injection room in the late 1980s (Stimson, 2007).

At the conceptual level harm reduction maintains a value-neutral and humanistic view of drug use and the user, focuses on problems rather than on use per se, neither insists on nor objects to abstinence and acknowledges the active role of the user in

harm reduction programs. At the practical level the aim of harm reduction is to reduce the more immediate harmful consequences of drug abuse through pragmatic, realistic and low-threshold programs. At the policy level harm reduction generates a patchwork quilt of middle-range policy measures that match a wide spectrum of patterns of drug abuse and problems and can sometimes be accommodated by the existing larger drug policy framework. Examples of the more widely known harm reduction strategies are needle exchange programs, methadone maintenance programs, outreach programs for high-risk populations, law-enforcement cooperation, prescription of heroin and other drugs, tolerance zones where users can inject drugs in a hygienic environment, alcohol programs such as server intervention and tobacco programs ranging from control of smoking in public places to the use of nicotine gum and patches (Stimson, 2007).

In 1987, the Canadian government adopted harm reduction as the framework for Canada's National Drug Strategy (Riley & O'Hare, 2000). The framework of the harm reduction model incorporates four pillars as it tries to balance public order and public health: prevention, treatment, enforcement and harm reduction (MacPherson, 2001). The approach responds to those who need treatment for addiction, while clearly stressing that public disorder, including the open drug scene, must be stopped.

The main objective of harm reduction is to mitigate the potential dangers and health risks associated with the behaviors themselves. Another objective of harm reduction is to reduce harm associated with, or caused by the legal circumstances under which the behaviors are carried out (such as the prohibition of a substance or act, which causes people to take certain behaviors "underground" into an environment where the risk of harm or exploitation is increased).

Harm reductionists contend that no one should be denied services, such as healthcare and social security, merely because they take certain risks or exhibit certain behaviors that are generally disapproved of by society as a whole, or its laws. Further, harm reduction seeks to take a social justice stance in response to behaviors such as the use of illicit drugs, as opposed to criminalizing and prosecuting these behaviors. Often, harm reduction advocates view the prohibition of drugs as discriminatory, ineffective and counter-productive. Among other arguments, they point out that the burden placed on the public health system and society as a whole from cannabis use and other illegal drugs are relatively low (MacPherson, 2001).

Coupled with the harm reduction model is the safe injection room which is a legally sanctioned, supervised facility designed to reduce the health and public order problems associated with illegal injection drug use. The first and only safe injection site in North America opened in Vancouver, British Columbia, Canada, in September 2003, called *Insite*. Safe injection rooms provide sterile injection equipment, information about drugs and health care, treatment referrals, and access to medical staff. Some offer counseling, hygienic and other services of use to itinerant and impoverished individuals. Evaluations of safe injection rooms generally find them successful in reducing injection-related risks and harms, including vein damage, overdose and transmission of disease. They also appear to be successful in reducing public order problems associated with illicit drug use, including improper syringe disposal and publicly visible illegal drug use (MacPherson, 2001).

Another project currently underway in Canada is the heroin maintenance project in Vancouver, British Columbia, called the NAOMI (North American Opiate Medication Initiative) Project. Some 100+ long-term heroin addicts who have not been helped by available treatment options are taking part in the NAOMI trials. The program enrolled

its first participants in February 2005 in Vancouver, and in June 2005 in Montréal. The intent is to eventually enroll 470 participants (NAOMI, 2005).

Although some access to harm reduction strategies has been promoted in general society in Canada, a divide between what is available and what is advocated continues to exist within the prison system (Rehman, Gahagan, Dicenso, & Dias, 2004). So how are Canadian women who are drug offenders affected by all this?

In 2006 in Canada, there were 909 federal women offenders, either incarcerated or on conditional release: 44% (401) were incarcerated while 56% (508) were on conditional release (Correctional Service of Canada (CSC), 2006). As of 2001, the majority of drug offenders were men (94.1%), while there were 342 (5.9%) cases of a woman offender for whom a drug offense was listed (Motiuk & Vuong, 2002).

The Prison for Women (P4W), in Kingston, Ontario, housed all women offenders far from their home communities and in a maximum-security environment since its opening in 1934. However, it was an institution that had a violent culture that was perpetuated by correctional officers (Marron, 1996). Eventually, the Honorable Louise Arbour, a justice on the Supreme Court of Canada, conducted an inquiry into wrongdoing in the prison, notably gangs of men brutally strip searching women in segregation (Faith, 1999). As a result, the recommendations from *Creating Choices*, the 1990 report of the Task Force on Federally Sentenced Women, resulted in the closure of the P4W and the opening of five regional institutions and one healing lodge across Canada: the Okimaw Ohci Healing Lodge, Maple Creek, Saskatchewan; Nova Institution for Women, Truro, Nova Scotia; Joliette Institution, Joliette, Quebec; Grand Valley Institution for Women, Kitchener, Ontario; Edmonton Institution for Women, Edmonton, Alberta; and the Fraser Valley Institution for Women, Abbotsford, British Columbia (CSC, 1990).

In theory, Canada's prison strategy requires a "correction plan" that is individually developed for each woman entering prison. Components of the plan include education, addiction and medical treatment, parenting classes, and three months of training in nontraditional jobs. In addition, all inmates are given intensive psychological testing and spend several hours a week in anger-management, behavior-modification, cognitive-therapy and domestic-violence-prevention programs (CSC, 1990).

Yet, such programs for Canadian women offenders are not without critics. The original plan for women's prisons was for them to be caring, empowering and supportive facilities in which punishment would no longer be the guiding principle (Faith, 2004). Faith (2004) argues that the CSC had adopted a progressive and decarcerative rhetoric but since that time has regressed to its former ways: "the correctional practices of the CSC remain conservative and punitive" (p. 281). Faith (2004) states that "abuses continue: illegal strip searches, lack of legal counsel, inappropriate classification, segregations, and the transfer of women to men's prisons" (p. 281). The argument can be made that the CSC "in practice traveled full circle in reentrenching correctionalism in the women's system" (Faith, 2004, p. 286).

Further, harm reduction is listed as a "theoretical influence" in CSC's recent effort to modernize programs for substance-using female prisoners in Canada (CSC, 2002). The main argument against promoting harm reduction measures for substance abusers within the criminal justice system is that it would send the "wrong message" and make substance use more socially acceptable. In spite of this challenge, harm reduction policies and programs have found their way into some criminal justice settings in Canada.

For example, in recent years the CSC has attempted to respond to the special needs of women offenders. The *Aboriginal Offender Substance Abuse Program* (AOSAP) is currently being implemented as a pilot project as well as the *Women Offender Substance Abuse Program* (WOSAP) which was implemented in June 2003; every women's institution offers the WOSAP to women who are assessed as having a moderate to high need for substance abuse intervention (CSC, 2007). The *Methadone Maintenance Treatment Program* is available for offenders who meet the program criteria, and Intensive Support Units are in place for offenders who are committed to living a drug-free lifestyle while incarcerated (Health Canada, 2002b).

Discussion

As I have attempted to show in this paper substance abuse among women is a major health, legal, economic, and social issue in both Canada and the United States (Adrian & Kellner, 1996; Campbell, 2000; Goode, 1999). Such abuse among women has serious implications both for society and for women struggling with their addictions. This paper has provided some insights into the experiences of women who are incarcerated in both the American and Canadian penal systems. For example, Canada's drug enforcement policy, without mandatory minimum sentences or a national war on drugs, means that Canada has a lower incarceration rate for women than the United States. Without as many drug arrests, Canada's crime rate is much lower than America's. And, obviously, with less crime comes less cost to the government charged with arresting, housing, and feeding women inmates, plus fewer ex-convicts in the general population.

Many critics argue that the failures of the war on drugs should lead the United States to adopt more humanistic approaches such as harm reduction efforts that involve treatment and education (McShane & Williams, 2006), perhaps similar to what Canada provides. Riley and O'Hare (2000) argue that the objective standpoint offered by the harm reduction model is helpful in getting beyond the rhetoric of the war on drugs since harm reduction focuses on objective (and non-judgmental) information about drugs and their effects. The harm reduction model also helps to reduce the conflict between the drug user and the community, as it tries to erase the boundaries between these two groups, and by providing the drug user the opportunity to be more a part of the community. The emphasis on getting many different members of the community involved helps to give drug users the feeling that they are helping to solve a serious problem, which benefits them and the community. The argument can be made that problems caused by drug abuse cannot be separated from the physical, social and policy environment in which they occur. Policies that are intended to reduce drug related harms are most effective in supportive environments. Without adequate education and treatment, it is not possible to decrease the cost of the war on drugs.

Overall, several authors argue that the lack of gender-specific services in the United States remains a serious defect in the rehabilitation and treatment field (Owen, 2004; McShane & Williams, 2006; Wellisch et al., 1994). The vast majority of imprisoned women have a need for substance abuse services, but a relatively small percentage receives any treatment while incarcerated (Owen, 1999) due to cost and the limited number of spaces in subsidized programs. Available treatment is often not adequate to meet the manifold needs of this population (Peugh & Belenko, 1999).

Canada could also do much more for women incarcerated for drug abuse: as Faith (2004) argues the original plan for women's prisons was for them to be caring,

empowering and supportive facilities in which punishment would no longer be the guiding principle. This has not been the case. Even though the CSC has attempted to put more programs in place only the future will tell if this agency will remain conservative and punitive (Faith, 2004) in its approach.

Conclusion

The purpose of this paper was to outline the differences between Canada and the United States in how they treat incarcerated women drug offenders, and to argue that the American approach is more detrimental to women, thus constituting what I view as a miscarriage of justice. My aim in this paper was to seek an answer to the question: "Using an international perspective (i.e., Canada and the United States), is American drug policy directed toward women who abuse drugs a miscarriage of justice?" As Hardin (2000) notes, no issue has had more impact on the criminal justice system (in the United States) in the past two decades than the national drug policy. The war on drugs that was declared in the early 1980s has been a primary contributor to the enormous growth of the prison system in the United States, and since that time has affected all aspects of the criminal justice system. As a response to the problem of drug abuse, national drug policies have emphasized punishment over treatment and have had a disproportionate impact on low-income communities, minorities, and women.

Critics from both nations have argued that changes need to be made in each country's drug policies and dialogues will undoubtedly continue. The claim can be made that overall there are no ideal drug policies, just more humane and less harmful ones. With that idea in mind, I argue that Canada's approach to drug abuse as a health problem and not a criminal one seems to be the least harmful. In Canada, the disease of addiction is not treated as a criminal justice issue, but as a public health problem. Harm reduction principles and strategies are designed to minimize the destructive consequences of illicit drug use and other behaviors that may pose serious health risks. Individuals are able to receive treatment in a somewhat safe and respectful environment and, oftentimes, they can do this in a climate in which they are valued and treated with dignity. Perhaps, in doing so, programs that impact women who are incarcerated for drug abuse in Canada can and will make a difference in their lives. Perhaps, too, women who are affected by the drug problem will be able to reclaim their humanity and their rights in a more humane fashion, and will not experience what I term in the American system, a miscarriage of justice, an act that is unfair and/or improper.

Endnote

¹ A miscarriage of justice is a wrongful conviction. It means that an innocent person has been erroneously convicted of a crime that he or she did not commit. In many instances, this results in long and difficult years of incarceration (Bellemare & Finlayson, 2004). In this paper, I define the term "miscarriage of justice" to describe a legal act that appears to be clearly mistaken, unfair, and/or improper.

References

- Abbot, A. A. (1995). Substance abuse and the feminist perspective. In N. Van Den Bergh (Ed.). *Feminist practice in the 21st century* (pp. 258–278). Washington, DC: National Association of Social Workers Press.
- Adlaf, E.M., P. Begin, & E. Sawka (Eds.). (2005). *Canadian addiction survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report*. Ottawa, Canada: Canadian Center on Substance Abuse.
- Adrian, M. & Kellner, F. (1996). The need for a woman-centered approach to substance abuse issues. In M. Adrian, C. Lundy, & M. Eliany (Eds.). *Women's Use of Alcohol, Tobacco and Other Drugs in Canada* (pp. vi–xiii). Toronto, Ontario: Addiction Research Foundation.
- Allard, P. (2002). *Life sentences: Denying welfare benefits to women convicted of drug offenses*. Washington, DC: The Sentencing Project.
- Amnesty International. (2007). *Stop violence against women: Women in prison: A fact sheet*. Retrieved July 25, 2007 from: <http://www.amnestyuse.org/women/womeninprison.html>.
- Amnesty International. (1999). *Not part of my sentence: Violation of the human rights of women in custody: Sexual abuse and women in prison*. Retrieved January 4, 2007 from: <http://web.amnesty.org/library/Index/ENGAMR510191999?open&of=ENG-360>.
- Beck, A. J. & Hughes, T.A. (2005). Sexual violence reported by correctional authorities, 2004. *Prison rape elimination act of 2003*. U.S. Department of Justice. Office of Justice Programs, July, NCJ 210333.
- Bellemare, D. A. & Finlayson, R. (2004). *Report on the Prevention of Miscarriages of Justice*. Department of Justice, Ottawa, Canada: FPT Heads of Prosecutions Committee.
- Bloom, B. (1993). Incarcerated mothers and their children: Maintaining family ties. In American Correctional Association (Ed.), *Female Offenders: Meeting Needs of a Neglected Population* (pp. 60-68). Laurel, MD: American Correctional Association.
- Bloom, B., Johnson, J. & Belzer, E. (2003). Effective management of female offenders. *American Jails*. September/October: 29-33.
- Bloom, B., Lind, M.C. & Owen, B. (1994). *Women in California Prisons: Hidden Victims of the War on Drugs*. San Francisco, CA: The Center on Juvenile and Criminal Justice.
- Boyum, D. & Reuter, P. (2005). *Are We Losing the War on Drugs? An Analytic Assessment of U.S. Drug Policy*. Washington, D.C.: American Enterprise Institute for Public Policy Research.
- Bruneau J., Lamothe, F., Franco, E., Lachance, N., Desy, M. & Soto, J. (1997). High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: Results of a cohort study. *American Journal of Epidemiology*, 146(12): 994 –1002.
- Bureau of Justice Statistics (BJS). (2004). *Prevalence of Imprisonment in the U.S. Population, 1974 – 2001*. Retrieved January 4, 2007 from: <http://www.ojp.usdoj.gov/bjs/pub/ascii/piusp01.txt>.
- Bureau of Justice Statistics . (2000). *Women Offenders*. Retrieved January 4, 2007 from: <http://www.ojp.usdoj.gov/bjs/pub/pdf/wo.pdf>.

- Bush-Baskette, S. (1999). The war on drugs as a war on black women. In S. Miller (Ed.). *Crime Control*. (pp. 113-139). Thousand Oaks, CA: Sage Publications.
- Campbell, N. (2000). *Gender, Drug Policy, and Social Justice: Using Women*. New York: Routledge.
- Center for Disease Control and Prevention (CDC). (2005). *HIV/AIDS Surveillance Report, 2005*. Atlanta, GA: United States Department of Health and Human Services, Vol. 17, 1-46. Retrieved January 4, 2007 <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/default>.
- Center for Disease Control and Prevention (CDC). (2004). *Youth Risk Behavior Surveillance—United States, 2003*. Atlanta, GA: United States Department of Health and Human Services. Retrieved January 7, 2007 <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm>.
- Center for Disease Control and Prevention (CDC). (2001). *HIV and AIDS – United States, 1981–2001*. Atlanta, GA: United States Department of Health and Human Services. Retrieved January 7, 2007 from: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2001report/default>.
- Center for Disease Control and Prevention (CDC). (1998). *HIV/AIDS Surveillance Report*. Atlanta, GA: United States Department of Health and Human Services, 10(2): 1-43. Retrieved January 7, 2007 from: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/pdf/hasr1002.pdf>.
- Center for Infectious Disease Prevention and Control. (2003). Ottawa, Canada: Public Health Agency of Canada.
- Cheung, Y. W. (2000). Substance abuse and developments in harm reduction. *CMAJ*, 162(12).
- Correctional Service of Canada (CSC). (2007). *Women Offender Substance Abuse Programming*. Retrieved July 28, 2007 from: http://www.csc-scc.gc.ca/text/prgrm/fsw/pro02-2_e.shtml.
- Correctional Service of Canada (CSC). (2006). *Profile of Women Offenders*. Retrieved December 28, 2006 from: http://www.csc-scc.gc.ca/text/prgrm/fsw/wos24/profile_women_e.shtml.
- Correctional Service of Canada (CSC). (2002). *Manual for the High Intensity Substance Abuse Program (HISAP)*. Ottawa, Canada: Reintegration Programs Division.
- Correctional Service of Canada (CSC). (1990). *Creating Choices: Report of the Task Force on Federally Sentenced Women*. Ottawa, Canada: Correctional Service of Canada.
- Dell, C. A. & Garabedian, K. (2003). *Canadian Community Epidemiology Network on Drug Use (CCENDU): 2002 National Report*. Ottawa, Canada: Canadian Center on Substance Abuse.
- Drucker, E. (2006). Insite: Canada's landmark safe injecting program at risk. *Harm Reduction Journal*, 3: 24. Retrieved July 26, 2007 from: <http://www.harmreductionjournal.com/content/3/1/24>.
- Faith, K. (2004). Progressive rhetoric, regressive politics: Canadian prisons for women. In B. R. Price & N. J. Skoloff (eds.). *The Criminal Justice System and Women: Offenders, Prisoners, Victims and Workers* (3rd Ed.). pp. 281-288. John Jay College of New York: McGraw Hill.

- Faith, K. (1999). Transformative justice versus re-entrenched correctionalism: The Canadian experience. In S. Cook & S. Davies (Eds.), *Harsh Punishment: International Experiences of Women's Imprisonment*. pp. 99-122. Boston: Northeastern.
- Federal Bureau of Investigation (FBI). (1998). *1997 Uniform Crime Report*. Washington, DC: U. S. Department of Justice.
- Goff, C. (1999). *Corrections in Canada*. Cincinnati, OH: Anderson Publishing Co.
- Goode, E. (1999). *Drugs in American Society* (5th Ed.). Boston: McGraw-Hill.
- Haden, M. (2002). Illicit IV drugs: A public health approach. *Canadian Journal of Public Health*, 93(6).
- Hardin, C. (2000). *How Adjudication Affects One's Life Chances; Personal Costs and Societal Consequences of Being a Convicted Felon*. Retrieved January 4, 2007 from: <http://www.pubadm/fsu.edu/paga/actionreports/f00Hardin.pdf>.
- Harrison, P., Allen, M.J. & Beck, J. (2005). *Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 2004*. Washington, DC: U. S. Department of Justice.
- Health Canada. (2002a). *HIV and AIDS in Canada. Surveillance Report to December 31, 2001*. Ottawa, Canada : Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Center for Infectious Disease Prevention and Control.
- Health Canada. (2002b). *Best Practices: Methadone Maintenance Treatment*. Retrieved July 28, 2007 from: http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/methadone-bp-mp/index_e.html.
- Holtgrave, D.R., Pinkerton, S.D., Jones, T.S., Lurie, P. & Vlahov, D. (1998). Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18(1): 133-138.
- Lapidus, L., Luthra, N., Verma, A., Small, D., Allard, P. & Levingston, K. (2007). *Caught in the Net: The Impact of Drug Policies on Women and Families*. Retrieved July 25, 2007 from: www.fairlaws4families.org.
- Laufer F. (2001). Cost-effectiveness of syringe exchange as a HIV prevention strategy. *Journal of Acquired Immune Deficiency Syndromes*, 28(3): 273-278.
- Lurie P. & Drucker, E. (1997). An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA. *Lancet*, 349: 604-608.
- MacPherson, D. (2001). *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*. Vancouver, BC: City of Vancouver.
- Marron, K. (1996). *The Slammer: The Crisis in Canada's Prison System*. Toronto: Doubleday.
- Mauer, M., Potler, C. & Wolf, R. (1999). *Gender and Justice: Women, Drugs and Sentencing Policy*. Washington, D.C.: The Sentencing Project.
- McShane, M. & Williams III, F. (2006). Women drug offenders. In A. V. Merlo & J. M. Pollock (eds.). *Women, Law, and Social Control*. (2nd Ed.) (pp. 212-226). Boston, MA: McGraw Hill.
- Motiuk, L. & Vuong, B. (2002). *Homicide, Sex, Robbery and Drug Offenders in Federal Corrections: An End-of-2001 Review*. Ottawa, Canada: Correctional Service of Canada Research Branch.

- North American Opiate Medication Initiative (NAOMI). (2005). *Backgrounder*. Retrieved July 28, 2007 from: http://www.naomistudy.ca/pdfs/naomi_background.pdf.
- Office of National Drug Control Policy (ONDCP). (2001). *The Escalating Costs of Drug Abuse in the US, 1992–2002*. Washington, D.C.: Executive Office of the President.
- Owen, B. (2006). The context of women's imprisonment. In A. V. Merlo & J. M. Pollock (eds.). *Women, law, and social control* (2nd Ed.). (pp. 251- 270). Boston, MA: McGraw Hill.
- Owen, B. (2004). Women and imprisonment in the United States. In B. R. Price & N. J. Skoloff (eds.). *The criminal justice system and women: Offenders, prisoners, victims and workers* (3rd Ed.) (pp. 195-206). John Jay College of New York: McGraw Hill.
- Owen, B. (1999). Women and imprisonment in the United States: The gendered consequences of the U. S. imprisonment binge. In S. Cook & S. Davis (eds.). *Harsh punishments: International experiences of women's imprisonment* (pp. 81-98). Boston: Northeastern University Press.
- Peugh, J. & Belenko, S. (1999). Substance-involved women inmates: Challenges to providing effective treatment. *The Prison Journal*, 79: 23-44.
- Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., Popova, S., Sarnocinska-Hart, A. & Taylor, B. in collaboration with E. Adlaf, M. Recel, & E. Single. (2006). *The costs of substance abuse in Canada 2002*. Ottawa, Canada: Canadian Center for Substance Abuse (CCSA).
- Rehman, L., Gahagan, J., Dicenso, A.M. & Dias, G. (2004). Harm reduction and women in the Canadian national prison system: Policy or practice? *Women & Health*, 40(4): 57-73.
- Riley, D. & O'Hare, P. (2000). Harm reduction: History, definition and practice. In J. Inciardi & L. Harrison. (Eds.). *Harm reduction: National and international perspectives*, (pp.1-26). Thousand Oaks, CA: Sage Publications.
- Sobell, M. B., Sobell, L., Bogardis, J., Leo, G.I. & Skinner, W. (1992). Problem drinkers' perception of whether treatment goals should be self-selected or therapist-selected. *Behavior Therapy*, 23: 43-52.
- Statistics Canada. (1996). *Canada's alcohol and other drugs survey*. Ottawa, Canada: Statistics Canada (Canadian Center for Health Information).
- Stimson, G. (2007). Harm reduction—Coming of age: A local movement with global impact. *International Journal of Drug Policy*, 18(2): 67-69.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). *Results from the 2005 national household survey on drug use and health: Detailed tables*. Rockville, MD: SAMHSA. Retrieved January 7, 2007 from: <http://www.whitehousedrugpolicy.gov/drugfact/women/index.html>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2004). *Results from the 2003 national household survey on drug use and health: Detailed tables*. Rockville, MD: SAMHSA. Retrieved January 7, 2007 from: <http://www.oas.samhsa.gov/NSDUH/2k4NSDUH/2k4results/2k4results.htm>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2000). *Results from the 1999 national household survey on drug abuse*. Rockville, MD.: SAMHSA. Retrieved January 7, 2007 from: http://www.icpsr.umich.edu/SAMHDA/survey-inst/NHSDA_12.pdf.

- Substance Abuse and Mental Health Services Administration (SAMHSA). (1999). *Summary of findings from the 1998 national household survey on drug abuse*. DHHS Publication No. (SMA) 99-3328. Rockville, MD: SAMHSA. Retrieved January 7, 2007 from: <http://www.oas.samhsa.gov/NHSDA/98SummHtml/TOC.htm>.
- Taifa, N. (2002). *Roadblocked re-entry: The prison after imprisonment*. Retrieved January 4, 2007 from: <http://www.opensocietypolicycenter.org/pdf/roadblocked.pdf>.
- Thomas, G. (2005). *Harm reduction policies and programs for persons involved in the criminal justice system*. Ottawa, Canada: Canadian Center on Substance Abuse.
- Wellisch, J., Anglin, M.D. & Prendergast, M. (1994). Treatment strategies for drug-abusing women offenders. In J. Inciardi (Ed.). *Drug treatment and the criminal justice system* (pp. 5-25). Thousand Oaks, CA: Sage Publications.
- Women's Prison Association. (2004). *Focus on women and justice: Trends in arrest and sentencing*. Retrieved January 4, 2007 from: www.wpaonline.org.