The PREVENTION CONNECTION
NEWSLETTER

She Works Hard for the Money

By Terry Kendrick

Everyone knows it's stressful to balance the responsibilities of work and family, but for too many women in Montana, the balance has tipped them into poverty and taken their kids along with them. Women and their children make up the majority of those living in poverty in this state. According to *State Rankings, a Statistical View of the United States*, Montana ranked first in the nation in the rate of increase of poverty and second for the percentage of children living in poverty in 2002. Low wages, geographic isolation and the lack of economic opportunities are the key factors contributing to poverty in Montana. Another factor is that the majority of Montana women still work in traditionally female-dominated jobs such as cashier, waitress, retail sales, teacher and administrative assistant. In year 2000, 68 percent of Montana working women earned less than $20,000 a year.

Nationally, women make up nearly 60 percent of the workers earning minimum or near minimum wage. According to the Coalition on Human Needs, the majority are adult women struggling to support themselves and their children on one income. Working women have the added challenge of finding safe affordable child care. Children's Defense Fund data reveals that the cost of sending a 4-year-old to child care in Montana is about the same as paying tuition for a year at a public college. Unlike those with college-age children, families with young children are typically not at their peak earning years, which means that paying for child care consumes a significant percentage of their wages.

Added to the stress of juggling work and child care is the responsibility of finding health care. As health care costs keep rising, many Montana women and children go without the preventive and curative health care they need. Montana ranks 3rd in the nation for children *not* covered by health insurance (Montana Office of Rural Health) and 83 percent of the uninsured in Montana are in working families. (CDC/NCHS Report)

Often, economic status is not something people bring on themselves. People are not in poverty because they don't want to work or don't work hard enough: Montana ranks 3rd in the nation for people holding multiple jobs.

These statistics coupled with other social indicators tell us that family life in Montana is not all it should and could be. What statistics *don't* show are the people behind the numbers: the women who work and live in our communities. They check groceries, take blood pressure, teach our children. Their children go to school, want to participate in extracurricular activities and share the dreams and desires of their peers.

The way to measure the health of a community or of a state is by measuring the health and well-being of its most vulnerable citizens. When our women and children are thriving, Montana will be thriving, too.

—This article is excerpted from Terry Kendrick's ***Montana Women's Report*** *published in December 2002. Ms. Kendrick has a B.A. in Political Science from the University of Montana and an M.A. in Organizational Leadership from Gonzaga University.*

The Montana Women's Report can be accessed online at *www.wordinc.org/cpacc/mtwomenecon 1202.pdf.*

Women and Girls

The Vicki Column

Remember: Ginger Rogers did everything Fred Astaire did, but backwards and in high heels. —Faith Whittlesey

The topic for this issue is (admittedly) broad. In our *Women & Girls* issue, we've tried to accomplish the impossible: address some of the unique challenges, programs and issues specific to half of Montana's population. Then again, maybe that's appropriate, given the current expectations of women and girls. At some level, we are expected to have it all, do it all, *be* it all . . . for girls that generally means being smart, pretty, popular, nice, athletic, thin, academic . . . and able to excel without appearing competitive. Girls carry the list into womanhood, then add to it . . . perfect mom, good breadwinner, loving wife, loyal friend, dutiful daughter, thoughtful sister . . . the list goes on. And on. Women are expected to survive and thrive in a competitive culture, yet provide the compassion, empathy and nurturing often lacking in today's busy world.

As a gender, women face a number of obstacles that men, as a group, do not. Women working full time, year round make far less than men do. To a great degree, single parent families are still headed by women, who are—by nature or nurture—the caretakers. Often they find themselves sandwiched between generations, responsible to both. Physically weaker, many fall victim to sexual and domestic violence. Women's bodies are more susceptible to the effects of drugs, alcohol and tobacco, and the effects of addiction can be more horrendous.

This is not meant to be a treatise on the difficulties of being a woman. Women and girls are very different than boys and men, and they face different challenges. That is the reality. Women, as a group, demonstrate astonishing strength, fortitude and ability. We have attempted, in this issue, to look at some of the issues disproportionately facing them, at some of the characteristics of our gender, and at some of the triumphant programs taking place in Montana. Of course we haven't been able to hit everything we'd like to, but hopefully this will provide a few of the highlights.

Vicki

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.state.mt.us/prc

Director
Vicki Turner
(406) 444-3484
vturner@state.mt.us

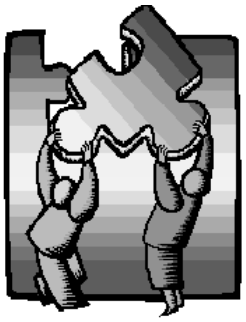
Ernie Chang
VISTA Leader
(406) 444-3925
echang@state.mt.us

Andrea Simon
VISTA Leader
(406) 444-9655
asimon@state.mt.us

Alan Rogers
PRC Technician
(406) 444-9654
arogers@state.mt.us

Add *Your* Voice

Do you have something to add to the *Prevention Connection* conversation? Here are the themes for our upcoming issues. If you have an idea for an article, please contact Sherrie Downing, Editor, at *DowningSL@bresnan.net* or 406.443.0580 or Prevention Resource Center Director, Vicki Turner at *VTurner@ state.mt.us* or 406.444.3484.



Interested in becoming a Prevention Resource Center VISTA site?

For January 2005 VISTA placements, applications are due by 5 p.m. September 10, 2004. For more information contact PRC Director Vicki Turner at vturner @state.mt.us or 406-444-3484 – or VISTA Leader Ernie Chang at echange@ state.mt.us or 406-444-3925.

Theme	*Publication Date*	*Date articles are due*
Kids Dealing with Issues Outside the Mainstream	November 2004	October 1, 2004
Co-occurring Disorders	February 2005	January 3, 2005
Marijuana and Other Drugs	May 2005	April 1, 2005
Adolescent Development	August 2005	July 1, 2005
Legal Drugs	November 2005	October 1, 2005
Indian Country	February 2006	January 1, 2006

The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@bresnan.net
www.sherriedowning.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: kdgrafix@acegroup.cc

Notes From the Edge

By Shannon Stober

I own innumerable one-ounce bottles of hand lotion. They come in a variety of scents, from *Juniper* to *Rosemary Mint*. I carry them in my purse and in my backpack, keep them at my desk and in my glove box. I have lotion within easy reach 24 hours a day. If you're thinking that this is a bit obsessive, then you don't understand that these tiny bottles are *tools*. The problem is, my hands smell. The moment I get out of bed in the morning, I start to worry that they're emitting an offensive odor, one that will be obvious to anyone who comes within 10 feet of me. In reality, I can't smell a thing. In fact, at this point, I can barely detect even strong odors. Smoking will do that to you.

The story of how I started smoking cigarettes is not exactly an after-school special. I wasn't pressured into smoking, I wasn't tied down and forced to put my lips around the filter. Quite the opposite really—I asked for one, wanted to try it. Not because I thought it made me look cool, or because it would make me skinny. I wanted to try it because I was bored and insecure, a cliché of adolescent emotions bundled up in one 14-year-old girl.

I was not an athlete. I was not a scholar or musician, writer or artist. I wasn't popular or unpopular, I just *was*. I didn't have a driving passion. Everyone around me at that point seemed to group up according to common interests. As a girl with virtually *no* interests, I had a hard time fitting in. I really wanted to be part of "a group," but lacked the confidence to try new things. I turned solitary, which protected me from criticism. Unfortunately, this approach also kept me from the growth that comes with having the confidence to take risks.

Titles such as *rebel* or *at risk youth* come to mind when I think about my first true friends. Their standards were low, so low that I not only didn't have to be good at anything, I didn't even have to *try*. All I had to do was agree with their philosophy that school, parents . . . and everything else . . . was a waste of time. I adopted the code. Anger and resentment were much easier than trying to learn something productive. My fear of failure was masked with a general disinterest in hobbies or activities so convincing that I even tricked myself, but smoking was one thing that I absolutely could *not* fail at. I smoked because I wanted to, because it defined me. It was a signal to the world of where I stood. As a terrified young girl, I was content simply with having somewhere to stand.

Girls don't begin smoking because they believe they have something better to do. Girls begin smoking because they lack identity and confidence. Communities must continue to make a significant effort to provide girls with safe, noncompetitive environments in which they can explore activities and discover their passions. Providing opportunities to allow girls to understand what makes them tick is foundational to developing character and confidence. Self-assurance and identity lead to good choices. The need to provide healthy outlets becomes critical when coupled with the lifelong penalties associated with nicotine addiction.

During the past ten years, I have found my passion and my identity. I have overcome many of the barriers that trapped me when I was younger, and yet despite many successes, I still carry the visible scar of a troubled youth – my addiction to cigarettes. Attempting to kick the habit has proven far more difficult than any emotional housekeeping I have done. I don't know what it will take for me to quit, but I hope that my story will assist those who work to keep others from starting. In the meantime, I'll continue to hold onto my one-ounce bottles of lotion.

—Shannon Stober is a Colorado native who relocated to Montana to work as an AmeriCorps VISTA. After her first year, she spent a second year serving as a PRC VISTA Leader. Shannon has recently begun working as the Training Specialist with the Governor's Office for Community Service.

Interagency Coordinating Council (ICC)

Mission: To create and sustain a coordinated and comprehensive system of prevention services in the State of Montana.

Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
(406) 444-3484
(406) 444-4435 (Fax)

Chair: ***Roland M. Mena***
Executive Director
Montana Board of Crime Control

Vice-Chair: ***Gail Gray***
Director
Department of Public Health & Human Services

Members

Bill Slaughter
Director
Department of Corrections

Wendy Keating
Commissioner
Department of Labor and Industry

Linda McCulloch
Superintendent
Office of Public Instruction

Mike McGrath
Attorney General

William Snell, Jr.
Director
InCare Network, Inc.

General John E. Pendergast
Department of Military Affairs

Dave Galt
Director
Department of Transportation

Betty Hidalgo
Chair
Montana Children's Trust Fund

Marko Lucich
Chief Juvenile Probation Officer
Judicial District 2

Sheila Stearns
Commissioner of Higher Education

Lori Ryan
Acting State Coordinator of Indian Affairs

Jean Branscum
Ex-officio Governor's Office

Queen Bees &Wannabes

A book review by Andrea Simon

Rosalind Wiseman's book delves into* Girl World *and offers tips on how to relate to and parent daughters . . . no matter where they are on the social totem pole.

Queen Bees and Wannabes: *Helping Your Daughter Survive Cliques, Gossip, Boyfriends and Other Realities of Adolescence* by Rosalind Wiseman leads the reader to a deeper understanding of what girls face with cliques. According to Wiseman, girls live in a system based on social hierarchy and are either "in" or "out." "Popular" girls are in cliques comprised of seven characters—following is a description of the queen and her court.

The Queen Bee is a charmer who has everyone under her spell. She is charismatic, beautiful and manipulative. The Queen reigns supreme over the other girls and has total control that includes the ability to weaken others' relationships in order to strengthen her own influence. Though seen as omnipotent, she loses a great deal of her sense of self because she must always maintain appearances.

The **Side Kick** is the Queen's best friend, which gives her a lot of power over the other girls. She backs up the Queen no matter what and takes on many of her mannerisms. Though she is highly regarded by the Queen, she is told what to do and how to do it. She feels popular and included and knows that she and the Queen are a force to be reckoned with. Even so, the Side Kick can lose herself in this relationship.

The Banker is almost always included and rarely the subject of fights. She is a strategic thinker who gathers information to maintain her position. When she gets the other girls to confide in her, it seems friendly, but she is waiting until the perfect time to use the information to others' detriment and her own benefit. She gains power and security from this role, but loses out when other girls stop trusting her.

The Floater is friends with several different groups and everyone likes her. This is the girl most parents want their daughters to be. The Floater is balanced, confident and nice to everyone. The Floater is less likely to sell herself short for social status and is one of the few who will stand up for herself if confronted by the Queen.

The Torn Bystander is in constant conflict. She wants to be part of the group but knows there are better ways of doing things. Finding herself in the middle of conflict, she apologizes for the Queen's behavior. The group easily controls the Torn Bystander because she has little or no sense of self. She does whatever it takes to be accepted.

The Pleaser/Wannabe/Messenger will do almost anything to be part of the group and embraced by the Queen and her Sidekick. In this case, the good news is the bad news: *most* girls are pleasers and wannabes. The Wannabe dresses like the Queen and her Side Kick, fights for them and ventures no opinions of her own. She serves the other girls and is talked about behind her back. If she tries too hard to fit in, the others simply stop including her.

The Target is the victim. She may be in the group or on the outside. This girl challenges the "norm" and is easy to pick on. Girls can become the target by confronting someone in the group. They feel helpless and isolated and have no one to back them up when the other girls become abusive. On one level she feels like she should change to fit in, on another, she feels powerless to do so.

Though there are exceptions, cliques are scary because they can control the ways young women feel about themselves. Parents need to understand where their daughters fit and to be aware of what their daughters are facing. Young women have a rough road to travel but with an understanding and supportive family, they can make it to smoother ground.

—Andrea Simon has just finished her year as a VISTA Leader for the Prevention Resource Center. Though she isn't sure where her next stop is, she plans to continue her career in public relations and marketing.

Wiseman's book, ***Queen Bees and Wannabes: Helping Your Daughter Survive Cliques, Gossip, Boyfriends and Other Realities of Adolescence*** *is geared to helping parents understand their daughters' friendships, the power of cliques and the roles of girls in context with other girls. The book provides tips on talking with teens and other down-to-earth advice.*

Resource: Queen Bees & Wannabes: Three Rivers Press. ISBN #1400047927.

Odd Girl Out

An exceptional book on the girl-to-girl (and woman-to-woman) dynamics of aggression is ***Odd Girl Out: The Hidden Culture of Aggression in Girls*** *by Rachel Simmons.* Odd Girl Out *is based on the premise that girls are socialized to be sweet –they must value relationships and are* not *free to express anger or participate in overt conflict. The result is what Simmons calls "a hidden culture of silent and indirect aggression." The author visited 30 schools and talked to 300 girls. She describes prototypical acts of aggression that include the silent treatment, note-passing, glaring, gossiping, excluding and ganging up. Simmons not only describes these destructive patterns, but offers clear strategies for dealing with them. A very insightful read. Harvest Books: ISBN #0156027348.*

Women & Poverty

By Hank Hudson, Administrator, Human & Community Services Division

Poverty is a persistent and destructive influence on the lives of many women and girls in Montana. Women earn less than men and find themselves more frequently in the role of single parent.

For many, a combination of employment and assistance is the best strategy to address poverty. For example, a single parent with two children working 20 hours a week at minimum wage will earn only $5,315 a *year*. However, if this income is supplemented by Temporary Assistance to Needy Families (TANF), the Earned Income Tax Credit, Medicaid, Food Stamps, Child Care and utility assistance, actual annual income is elevated to the range of $25,170. This temporary aid is designed to give a family some financial breathing room while the breadwinner pursues a higher-wage job.

An additional response to these issues must be the reduction, and ultimately, elimination of domestic violence. While we support education, prevention and law enforcement efforts, we must also look at programs. Efforts to increase employment and self-sufficiency must include services to address the consequences of abuse and violence. These issues must take top priority, even before moving on to other activities.

High quality child care that is supportive and respectful of the central role of the parent is one of the most effective ways of supporting low-income women. Montana is blessed with many dedicated child care providers. When a parent is confident in the quality of child care, she can focus on the road out of poverty.

We want to help ensure that every community in Montana has the tools and leaders to combat poverty. This is our priority.

The Department of Public Health and Human Services, and specifically the Human and Community Services Division, addresses the issue of women and poverty in these and other ways.

We encourage all who need these services to contact their local office of public assistance to pursue a comprehensive approach including work, assistance, training and high quality child care.

The Helping Programs

Temporary Assistance for Needy Families (TANF): TANF consists of three programs: the Job Supplement Program provides options to cash grants such as Medicaid, child care assistance or a one-time employment-related payment; the Pathways Program is a time limited monthly cash grant coupled with opportunities leading to self-sufficiency; and the Community Services Program is a cash assistance program designed for individuals who have used all their Pathways benefits, but have not yet achieved self-sufficiency.

Food Stamps: This program supplements the food budgets of low income households with coupons redeemable for groceries. Amounts reflect the actual value of coupons issued.

Medicaid Medical Assistance: Pays medical costs for TANF and SSI individuals, families and other qualified persons. Each person is counted as a "case," and is unduplicated.

Low Income Energy Assistance Program (LIEAP): Direct payment to fuel vendors for heating on behalf of low income families and seniors. The season runs from October 1 through April 30.

Day Care: There are four TANF related child care programs, all of which are designed to help TANF eligible or potentially eligible families become or remain self-sufficient. Clients must either be working or attending approved education or training, and in some cases must make a co-payment.

A Snapshot: *Montana's Social Service Programs June 2004 (except as noted)*

Program	Cases	Expenditures
TANF*	5,127 (13,562 persons served)	$1,686,741
Food Stamps	33,431 (78,427 persons served)	$6,711,659
Medicaid	84,166 claims	$41,870,854
CHIP (Children's Health Insurance Program)	10,914 children served	$1,419,329
Child Care (May 2004)	5,087 children reserved	$1,161,788
LIEAP (July 2003 – May 2004)	19,100 (45,446 persons served)	$7,477,765

*Just 928 (approximately 18 percent) of the TANF cases were unemployed parents.

Source: DPHHS statistical data; www.dphhs.state.mt.us.

Quick Facts from MTUPP

As reported by the Montana Tobacco Use Prevention Program, the Youth Risk Behavior Survey (YRBS) demonstrates that youth tobacco use fell between 2001 and 2003—from 32 percent of females students (grades 9-12) surveyed in 2001 to 24 percent in 2003. Among males, current cigarette smoking dropped from 25 percent in 2001 to 22 percent in 2003. Current cigarette smoking among high school students peaked in 1997 and then decreased significantly.

Women & Homelessness in Montana

By Jim Nolan, Chief, Intergovernmental Human Services Bureau

In April 2003, during an annual point-in-time survey, volunteers and non-profit workers identified 2,823 homeless individuals in Montana's seven largest population centers. This number included 516 homeless families comprised of 1,426 members. While this cannot be considered a census of the homeless, the composite results provide a valuable snapshot of what it means to be homeless in Montana.

The majority of homeless families were headed by women. More than one in four (27%) of the 2,823 persons identified were under age 18, and nearly all children and youth were members of homeless families. Another 27 percent were between the ages of 18–34. Among the heads of homeless families, 35 percent had not achieved the equivalent of a high school education. Most of those surveyed were *not* strangers in their communities either: approximately 60 percent had lived in the area for at least two years.

Despite the fact that the people in homeless families slightly outnumbered homeless individuals, these numbers might be low. Homeless women tend to be harder to identify than homeless men. Rather than taking advantage of emergency shelters or sleeping on the street, they often stay with friends and relatives. Many (about 27%) are working, and though most are probably eligible for such subsidies as food stamps, only about one in five is accessing them.

Women disproportionately face a number of challenges that can lead to homelessness. Poverty, particularly among single mothers, is extremely high: nearly 6 out of 10 (58.5%) single women with children under age 5 live in poverty (2000 Census). In case you're wondering, that means $12,490 annually for a mother with one child and $15,670 for a mother of two.

Many of Montana's women work for wages that do not even *reach* the poverty level. Working full time at minimum wage results in a wage of $10,712 a year. These numbers fall far short of the living wage needed to meet basic needs without public assistance, and lend some ability to deal with emergencies and to plan ahead. On a human level, the numbers boil down to the fact that there is no margin for error. A lost day of work because daycare wasn't available for a sick child can easily lead to missed rent—and subsequent homelessness.

Wage Inequity by the Numbers

According to *Homeless in Montana,* released in July, the National Center on Family Homelessness is performing comprehensive research on sheltered homeless and low-income housed families and their children. The study has yielded disturbing findings about homeless mothers and their housed, low-income counterparts.

- 31% of homeless mothers and 26% of housed low-income mothers had attempted suicide at least once, usually in adolescence.
- More than 40% of homeless and housed low-income mothers had been sexually molested as children, and by age 12, 60% had been severely physically or sexually abused.
- Nearly 1/3 reported a current chronic health condition, with high rates of asthma, anemia and ulcers, despite an average age of 27. (*familyhomelessnessorg/research_evaluation/research.html*)

Governor Judy Martz has taken one of the first steps to responding to this growing problem. By Executive Order, she formed the Montana Council on Homelessness in July, naming Hank Hudson, Administrator of the Human & Community Services Division, Chair. This Council will examine many of the issues attending homelessness, and seek solutions through policy, collaboration, protocol and potential legislation. The Council is a broad-based group that will seek input through workgroups set up around specific issues. These workgroups, including a Native American Leadership Group, will be formed in September and October.

Source: Homeless in Montana, a Report http://www.dphhs.state.mt.us/homeless_in_montana.pdf

Three factors influence homelessness. The first is structural—the interrelation of housing cost, availability and income. The second is personal vulnerability, which might include mental health, substance abuse, cognitive or physical ability. The third is social policy, which can either ameliorate or worsen the other factors.

—Martha Burt, Director
of the Social Service Research
Program of the Urban Institute

Join the new Montana Council on Homelessness Listserv! E-mail DowningSL@bresnan.net and write "Join Homeless Listserv" in the subject line.

The Intergovernmental Human Services Bureau (IHSB) sponsors the Survey on Homelessness as well as the Montana Council on Homelessness. This bureau works through several federal programs to combat poverty and homelessness in Montana. Efforts include participation in and sponsorship of the statewide Continuum of Care, a loose consortium of agencies providing services to the homeless. The IHSB also manages the food commodity program, the Low Income Energy Assistance Program and provides services through emergency shelter facilities statewide. For more information, to request a copy of the report, or to express interest in a Council Workgroup, contact Jim Nolan, Bureau Chief, at 447-1680 or jnolan@state.mt.us.

The 4 H's of Eating Disorders

By Joan Trost, Coordinator, Eating Disorder Task Force of Great Falls

Eating disorders are about substituting food or a process for authentic physical, mental, social and spiritual health.

A recent Stanford University study found that "half of 3rd – 6th grade boys wanted to lose weight, while more than half of the girls wished they were thinner." In a Cosmogirl.com poll of 6,000 readers, 88 percent reported that "they hated either some or all of the things about their bodies."

It's no wonder that 10 million Americans suffer from eating disorders: dissatisfaction and low self-esteem along with cultural pressures, genetic traits and bad eating habits put young people at risk. To understand the path to prevention we need to understand the 4 H's of eating disorders.

Home: Culture that was once passed down by story and legend is now passed down by media trying to sell something. By promoting unrealistic, even unhealthy, ideals of appearance, the media models and reinforces unhealthy patterns of food consumption. As the world shrinks, eating disorders grow. A Harvard study on the island of Fiji was conducted prior to the arrival of television. It showed *no* disordered eating. A few years after television was introduced, 75 percent of schoolgirls wanted to look more like television characters and many had developed eating disorders and dieting behaviors. The association between media's promotion of a thin standard of beauty and disordered eating is well documented. "Our culture has created an environment that exults thinness, stigmatizes fatness, encourages unregulated consumption of energy-dense foods and promotes a *quick fix* approached to weight loss."

Health: Adolescence is a time of high risk for eating disorders, when weight may be used as a tool to change feelings. *Reviving Ophelia* by Mary Pipher describes the death of self-esteem as "little girls attempting to move into the unrealistic cultural expectations of beautiful, thin and sexy." In our culture, losing weight is regarded as "good," but instead of building authentic self-esteem, weight loss is a success determined and measured by external standards. Temporary false self esteem is followed by guilt and shame, and thus begins the cycle of disordered eating.

Heredity: Studies have only begun to explore the roles that biological factors and genetics play in the development of obesity and eating disorders, but the dramatic increases in the last 20 years suggest environmental factors are primarily to blame. Genetics determine many characteristics, but do not necessarily have to determine fate.

Habits: Reserach suggests that television slows the metabolism, encourages binge eating, exposes viewers to a glut of seductive food advertisements, depresses mood and "eats" away at self-esteem.

The specific language of advertising suggests that merchandise can make people happy. Children watch 30,000 television ads annually, 95 percent of them for four food groups: soda, fast foods, candy and sugared cereal. "*Children ages 8-18 spend 6-1/2 hours each day using print media, television, videos, video games, radio, CDs, tapes and computers...*" (Preventive Medicine, 2002) The trouble is, tiny habits can create huge consequences.

Media's unhealthy love/hate relationship with food creates an atmosphere where eating disorders thrive. The National Restaurant Association estimates that by 2010, 53 percent of each food dollar will be spent on food eaten away from home. Fast foods are associated with poorer nutrition, poorer food choices, "supersized" and cheap portions. At the same time, we have become a nation of "sitters." We sit in the car, at a desk, at the computer and, finally, in front of the television.

Media can't shoulder all the blame. By challenging the culture that sets unrealistic standards and creates a culture of acceptance and diversity, we can each become agents of social change. Examine your *own* destructive attitudes about weight and look at your own habits and health issues—your children *are* watching.

—Joan Trost is founder and coordinator of the Eating Disorder Task Force of Great Falls. A program of the Mental Health Association of Great Falls, it has brought together 18 professionals from medical, mental health and nutrition backgrounds, who work to prevent and treat eating disorders through education, awareness and treatment. Joan can be reached at 406-727-7831.

Sources Cited: Preventive Medicine 34, pp. 299-309 (2002) National Restaurant Association, Pocket Facts Book

A Short Resource List

www.caprojectlean.org*, Food on the Run: Your Energy Wake Up Call, a website with simple nutrition and active solutions for teens*

www.cdc.gob/nccdphp/dnpa*, The Centers for Disease Control and Prevention (CDC) site is a resource for nutrition and activity issues*

Hunger Pains, The Modern Woman's Tragic Quest for Thinness, Mary Pipher, Ph.D.

When Dieting Becomes Dangerous, A Guide to Understanding and Treating Anorexia and Bulimia, Deborah Michel, Susan Willard

Surviving an Eating Disorder, Strategies for Family and Friends, M. Siegel, Ph.D.

— The last time something was this good, I married him. *—a recent yogurt ad*

— Respect yourself in the morning. *—a breakfast bar ad showing a very slender young woman with a huge croissant lying across her hip.*

— Nothing says lovin' like something from the oven. *—Pillsbury*

Dying to Be Thin

By Mona Sumner

"We are seeing young women in their 20's with the bones of 80 year-olds when we do do bone density testing." —Dr. Eugene Taub, Psychiatrist, Rimrock Foundation

A recent Colgate University study revealed that 42 percent of girls in the grades 1 – 3 want to be thinner; 81 percent of 10-year-olds reported being afraid of being fat. The latest findings from the *National Eating Disorder Association* indicate that of the 10 million American women and one million men with eating disorders, 40 percent are in the 15-19 year old age bracket.

The incidence of eating disorders continues to rise in our country, disproportionately affecting young women. *Bulimia* and *Anorexia* are most common, and both disorders have grave consequences for the developing bones and health of young women.

Rimrock Foundation has been treating eating disorders since 1980 in a six-bed unit staffed with a nurse case manager, social worker, therapist, dietician, and—of course—the supportive staff and resources of the Foundation. Over time, we have seen an evolution in the types of patients coming in for help. Although they come from all backgrounds, two patterns of family dysfunction seem common. The classic enmeshed family system with high expectations of the child and over-emphasis on achievement, performance and control is one. In this system, we often find a mother who is very weight conscious and who overvalues attractiveness. In some of these families, we have even found that the fear of child obesity is so strong that whole milk has never been served, even to infants and very young children. The other pattern commonly found is a disengaged, chaotic family characteristic of addiction-based family systems. Here the theme is one of the child trying to gain some measure of control—through the eating disorder—in the face of chaos and pain. Control is a central feature of eating disorders. Recently we have begun seeing young, oppositional-defiant females using their eating disorders as weapons against parents.

We live in a culture that prizes thinness and where the ideal woman is extremely thin. Girls feel pressured to fit into fashions that are attractive *only* for the very thin. The current rage to bare the midriff and expose the hips is an example of a fashion that few wear attractively unless they are very thin—with no stomach or "love handles." Most young teens have not lost the baby fat so obvious in these styles. Girls entering adolescence have a hard enough time with body image, hormonal changes and working through their developmental identity tasks without dealing with this kind of pressure.

Starting at around 14 years of age, girls are extremely vulnerable to critical messages and uncomfortable with their developing bodies. The slightest suggestion from a valued adult to "lose a few pounds" can become a compulsion to be thin.

There is no "one size fits all answer" to why our population develops eating disorders at a rate unheard of in other countries, but culture must play a significant role. Eating disorders are difficult to treat and require a highly trained, experienced multi-disciplinary staff. The inpatient stay is regarded as a stabilization period in which destructive behaviors are brought to a halt [e.g., bingeing, purging and excessive exercising] and eating is normalized. Initial weight goals are met in this period, after which the patient is stepped down to less intensive on-going care.

Managing an eating disorder is not very different than managing an addiction—both are lifetime illnesses that require daily management. In the case of eating disorders, though, *food* is the demon that must be faced daily for survival. This makes recovery from these disorders much more difficult. Food is not the underlying issue of eating disorders, but it has been externalized as the problem. It takes a considerable period of recovery before the person with an eating disorder can gain the insight necessary to eat with comfort.

—Mona L. Sumner, a Master of Arts in Counseling (M.A.C.) and a Master of Arts in Health Administration (M.H.A.), is the Chief Operations Officer/Clinical Director for Rimrock Foundation. She has spent over 30 years specializing in the treatment of addictions, and manages all aspects of the patient care programs at Rimrock. She has published numerous articles, and travels extensively giving workshops on addictions and relationship illnesses. She is a member of the American College of Addiction Treatment Administrators (ACATA) and the National Association of Addiction Treatment Providers (NAATP).

"I started when I was 8 years old. I was watching TV and on the news they said that girls around 8 start worrying about their weight. I never had a problem with it, so I thought maybe I should. So I decided that I was too big. I remember when I talked to the other girls they said they were like 80 pounds. I was like 60 pounds and happy with myself . . . I still think about it almost every day."

—A high school senior after a presentation by the Eating Disorder Task Force of Great Falls

Resources

http://www.something-fishy.org/

Resources on anorexia, bulimia and compulsive overeating, including signs and symptoms, recovery information, cultural issues and treatment finder.

http://www.bulimia.com/

Specializes in information about eating disorders including anorexia nervosa, bulimia nervosa and binge eating; also offers information on elated topics such as body image and obesity.

Violence Against Women & Girls

By Wendy Sturn

Violence against women and girls is a serious problem throughout the world. Montana is no exception. Of the 18,044 victims who received services through Montana's victim assistance programs last year, 14,218 (79%) were female. Many of the male victims were actually the children of women fleeing domestic and sexual abuse. Of those served, 12,604 (89%) were females over the age 13. The vast majority were victims of gender-motivated crime including domestic violence, sexual assault and stalking. Less than half of these crimes are reported to law enforcement. Even fewer culminate in prosecution.

Violence against women starts young in our society. Although we would like to believe that this problem is specific to adult females, a study conducted by Kaiser Permanente revealed that 40 percent of female respondents aged 14–17 reported knowing someone their age who had been hit or beaten by a boyfriend. Approximately 10 percent of teens responding to the *2003 Montana Youth Risk Behavior Survey* answered "Yes" to, *"Have you ever been physically forced to have sexual intercourse when you did not want to?"* If the toll on the human spirit is immense, the social costs are also enormous. In dollars and cents, a conservative estimate puts the annual cost of family violence between $5-$10 billion annually.

The Montana Board of Crime Control (MBCC) is committed to making Montana a safer place for women and girls. Since 1995, MBCC has awarded more than $20 million to local non-profit, tribal and state programs in support of providing direct services to crime victims and to improve the response of the criminal justice system to victims. Funding comes from the U.S. Department of Justice in the form of block grants to the states under the Victims of Crime Act and the Violence Against Women Act. These block grants have provided the opportunity to start and continue more than 60 programs statewide.

Through careful planning, training and responsible stewardship, MBCC has helped create and sustain a stable and professional network of programs, making services accessible to a majority of Montana citizens from Libby to Sidney. Examples of direct services include crisis counseling, 24-hour hotlines, emergency shelters, transportation, criminal justice, personal and legal advocacy, support groups and therapy. Most programs rely heavily on well-trained and dedicated volunteers with a few paid staff. Victim assistance programs are broken down into two major categories: non-profit victim assistance programs and public victim advocacy programs. The majority of the public victim advocacy programs are in prosecutor's offices and place a major emphasis on criminal justice advocacy. The rural nature of Montana often means that programs must function in both capacities.

The Board of Crime Control also takes a leadership role in numerous areas affecting training, policy development, legislative initiatives and program planning/development. Examples include: a pilot project to more than triple the number of victim/witness programs in Montana; planning and hosting a statewide conference for 200 professionals in the criminal justice system and non-profit arena featuring national experts in domestic violence and sexual assault; initiating legislation to eliminate fees to victims for sexual assault forensic examinations and Orders of Protection for domestic abuse victims; establishment of a Violence Against Women Committee; funding comprehensive training programs for law enforcement, judges, advocates and sexual assault nurse examiners; and helping establish Montana's domestic violence fatality review team. Many of these activities have laid the groundwork for lasting change in the justice system's response to crime victims, especially female victims. Cumulatively, these efforts will help lead Montana to a safer era for women and girls.

—Wendy Sturn is a Victim Assistance Program Manager with the Montana Board of Crime Control. She can be reached at westurn@state.mt.us *For more information on current requests for proposals or for crime data, visit* www.mbcc.state.mt.us

For more information on Violence Against Women visit:

Montana Coalition Against Domestic and Sexual Violence www.mcadsv.com

National Coalition Against Domestic Violence: www.ncadv.org

National Network to End Domestic Violence: www.nnedv.org

National Resource Center (NRC), a project of the Pennsylvania Coalition Against Domestic Violence: www.pcadv.org

Office on Violence Against Women: www.ojp.usdoj.gov/vawo

The opinions expressed herein are not necessarily those of the Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services.

The Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services attempt to provide reasonalbe accommodations for any known disability that may interefere with a person participating in this service. Alternative accessible formats of this document will be provided upon request. For more information, call AMDD at (406) 444-1202, 1-800-457-2327 or the Prevention Resource Center at (406) 444-3484.

The Friendship Center

By Holly Kaleczyk, Executive Director

Relationship violence: *It's not okay . . . <u>and</u> it's against the law!*

***Domestic violence** is a pattern of behavior used to establish power and control over another person, often through fear and intimidation, and often including the threat or use of violence. There are several forms of abuse: physical battering, sexual abuse and psychological battering. Physical attacks can range from bruising to murder. Physical abuse is often accompanied by—or culminates in—sexual violence. The abuser progressively isolates the victim from family and friends, and deprives the victim of physical and economic resources. The victim can be so intimidated that she begins to believe that she has no choice but to stay with her abuser.*

—National Coalition Against Domestic Violence
www.ncdav.org

The Friendship Center of Helena provides a safe haven at no charge for women and children who have suffered domestic violence and sexual abuse, and is the only shelter in Lewis and Clark, Jefferson and Broadwater counties. The mission is to offer refuge and the opportunity for new beginnings to women, children and other survivors of domestic violence or sexual assault.

Unfortunately, domestic abuse is *not* an uncommon problem in our area—or elsewhere. Domestic violence is the leading cause of injury to women between the ages of 15-44 in the United States—more than car accidents, muggings, and rapes combined. About one in four women is likely to be abused by a partner in her lifetime. While studies of domestic violence consistently find that battering occurs in all types of families regardless of income, profession, region, ethnicity, educational level or race, lower income victims are over-represented in calls to the police, at battered women's shelters and in social services. This is likely due to a lack of other resources.

The Friendship Center's direct service caseloads were up 28 percent in the last* half *of 2003.

Unrelenting economic hardship, skyrocketing energy costs, a methamphetamine epidemic impacting every one of our social systems and struggling social service programs make it harder than ever before for women to stay safe. Coupled with this social trend is poverty that disproportionately affects women. Poverty eliminates options, meaning that women often feel that they have no other options than to stay with dangerous, often drug dependent, abusers.

— In year 2000, Montana Board of Crime Control data reveals that statewide, 4,141 partner or family member assaults were reported to Montana law enforcement agencies, compared to 3,195 in 1999. This equates to a 29.6 percent increase in *one* year.

— A partner or family member assault was reported, on average, every 121 minutes in Montana in 2000.

For more information or for free and confidential assistance, contact the Friendship Center at 1503 Gallatin Helena, Montana 59601, 406.442.6800 or 800.248.3166

Response to a growing crisis

Shelter: In the early 1980s, the Friendship Center began serving victims of domestic violence by placing them in safe homes. Within six years, we had acquired two shelters and begun serving women and their children on site. Short-term emergency shelter allows us to support female clients for 60 days; the longer-term transitional facility allows them to stay for periods of up to 6 months. In 2003, we served 605 survivors and assisted 185 children who had witnessed domestic violence.

Outreach & advocacy: The Friendship Center has run sexual assault outreach and crime victim advocacy programs since 1995. Volunteer advocates are trained to meet with survivors at hospitals, police stations and other sites. A companion service assists victims who want to prosecute the perpetrator. Last year we served 75 women through the sexual assault program and the Friendship Center's crime victim advocate served 253 victims of violent crime.

The center also employs a children's advocate to focus on the needs of children who have witnessed family violence. The advocate works individually with children and with the family as a whole. She also works with the children in a group setting once a week.

Education is also part of the Friendship Center's roster of services. Last year alone, the coordinator of this program spoke to 2,199 students.

Extended services: In 2002, the Friendship Center received an Office of Justice Rural Victimization Grant for over $200,000. This two-year grant has allowed extension of services into the farthest corners of our service area. As a result of this grant, there are now satellite offices in Boulder and Townsend, and hope of expansion to the Lincoln/Augusta area this fall. These rural offices are crucial to assisting survivors of domestic and sexual violence in areas so remote that Helena services seem beyond their reach.

Crisis line: Residents of the tri-county service area can reach the Friendship Center through a 24-hour, crisis hotline primarily staffed by local volunteers. In the last fiscal year, these volunteers donated over 13,000 hours to the Center.

The DELTA Project

By Karen Lane & Beth Satre

In September 2002, the Centers for Disease Control and Injury Prevention (CDC) selected the Montana Coalition Against Domestic Violence (MCADSV) as one of 14 states to participate in the new *Domestic Violence Prevention Enhancement and Leadership Through Alliances (*DELTA) Program. Coalitions were selected based on their abilitiy to develop prevention initiatives, coordinate services and mobilize communities in response to domestic violence. In addition to building on existing Coordinated Community Response (CCR) efforts, the DELTA Program provides technical assistance, training, and local funding to help implement prevention programs.

Like the Greek symbol, the DELTA project is all about *change*. How that change occurs is as individual as the communities served. The project has three primary elements that make it a unique and exciting approach to the prevention of intimate partner violence (IPV.) Those elements are:

— A focus on prevention;

— A collaborative process from the start; and

— A multi-level approach, attempting to influence change at various levels of the community.

Until now, most of the focus of CCRs has been on intervention, providing for victim safety and batterer accountability. Effort has been invested in coordinating the services and responses to incidents and to the aftermath of domestic violence. This has included the judicial system, law enforcement and shelter services. DELTA adds a prevention focus to existing CCR activities. Preventing violence requires changing attitudes and beliefs about what it *means* to be male or female in our society. Boys and girls learn how to interact with one another, respect differences and resolve conflicts within a community context. Children pay close attention to the ways in which adults behave and to the messages they see in the media and video games. It's not enough to *tell* children to behave, adults must *act* in ways that are coercive, violent or disrespectful.

DELTA is a collaborative process, with domestic violence coalitions from 14 states working with the CDC to define parameters and focus. In some ways, Intimate Partner Violence (IPV) prevention is new territory. Though much more is known about the occurrence of IPV, how to stop it from occurring in the first place remains a mystery. What is clear, however, is that violence is learned.

Because IPV is so pervasive in our culture, it is necessary to take a multifaceted approach to prevention. Coordinated Community Response teams engaging in prevention need to expand to include a broad cross section of the community, and to incorporate local beliefs, attitudes, resources, and skills. Five communities will have the advantage of additional funding for this work, but others will have access to training and technical assistance as they develop the local prevention focus.

Change must be encouraged at state and national levels as well. The MCADSV has convened a statewide DELTA Advisory Council comprised of representatives who have oversight at the systems level. This Council will have the ability to review and influence revision of policies, procedures and protocols currently in place. The goal will be to identify practices that inhibit an adequate response to domestic violence or that promote conflict and violence. Council members will also serve as resources for local CCRs as they do their work. The Advisory Council membership includes agencies such as the Office of Public Instruction, Board of Crime Control, DPHHS-Child and Family Services, Office of Victim Services, and Adolescent and School Health Services. The clergy, universities, families and friends of IPV victims, Native American, Gay Lesbian Bisexual Transgender Intersex (GLBTI), healthcare providers, people with disabilities, businesses and employment services are all represented.

—Karen Lane has worked in the field of domestic violence, counseling and non-profit management for nearly 30 years. As the Montana DELTA Project Coordinator, she directs collaboration in Montana and with National DELTA partners.

—Beth Satre, formerly the MCADSV Public Policy Specialist and Media Consultant, now works as a graphic designer and publishing consultant.

Violence prevention is the responsibility of the entire community.

Some of the Myths about Battering

Myth #1: Battering is rare.
FACT: Battering is extremely common. The FBI estimates that a women is beaten every 7.4 seconds in the United States.

Myth #2: Domestic violence occurs only in poor or poorly educated families.
FACT: There is no correlation between socioeconomic class or educational attainment status and battering. Battering can happen in any "type" of family.

Myth #3: The problem is not really woman abuse; it is spouse abuse. Women are just as violent as men.
FACT: In over 95% of domestic assaults, the man is the perpetrator.

Myth #4: When there is violence in the family, all members of the family are participating in the dynamic, therefore, all must change for the violence to stop.
FACT: Only the perpetrator has the ability to stop the violence. Many women make numerous attempts to change their behavior in hopes of stopping the abuse. This does not work.

Myth #5: Batterers are mentally ill.
FACT: An extremely small percentage of batterers are mentally ill. Battering is a behavioral choice.

Source: http://www.msu.edu/~cdaadmin/myths_and_facts.htm

Montana: *(Not Quite)* Making the Grade on Women's Health

—According to the 2004 Report Card, the nation is so far from achieving the goals set forth by Healthy People 2010 that it actually receives an "unsatisfactory" grade for its efforts toward improving women's health.

The 2004 edition of *Making the Grade on Women's Health: a National and State-by-State Report Card* clearly shows that the United States (and for our purposes, Montana) is not meeting the health needs of women. The *2004 Report Card* reveals that for the bulk of indicators on the status of women's health, the nation as a whole *and* individual states are failing to meet the national goals established by the U.S. Department of Health and Human Services *Healthy People 2010* agenda.

The *2004 Report Card* evaluated 27 benchmarks and found that the nation was only meeting two: the percentage of women 40 and older who were regularly receiving mammograms and the number of dental visits. More importantly, the United States fails on nine indicators, including women's access to health insurance, the prevalence of diseases such as diabetes and death from coronary disease. According to the *2004 Report Card*, the nation is so far from achieving the goals set forth by Healthy People 2010 that it actually receives an "unsatisfactory" grade for its efforts toward improving women's health. The disparities women experience in quality of health care correlate with factors including race, ethnicity, sexual orientation and disability: it is fair to say that the problems many women face are even greater than these overall numbers might suggest.

The *2004 Report Card* findings illustrate the women's health issues that need to be addressed by local, state, and federal policymakers and health care providers. Some critical areas include:

— A troubling number of American women lack health insurance (17.7% U.S., 17.5% Montana);

— Women eligible for Medicaid are deterred from enrolling due to the complex enrollment procedures;

— 16.3% of Montanans live in "medically underserved areas" with reduced access to primary care physicians, as compared to nearly 12% nationally;

— Women's health suffers when family planning services are not available. Nationally nearly half of all pregnancies are unintended, substantially missing the national goal of 30% or fewer; and

— At least 14.6% of all Montana women live in poverty, as compared 12 percent nationally. This percentage spikes dramatically for female householders without husbands present: 41.6% of those with children under 18 and 58.5% of those with children under 5 live in poverty. (2000 Census)

For Montana, receiving an "unsatisfactory" grade from the *2004 Report Card* would be more discouraging if not for our relatively high rank. Montana is 17th in the nation. All 50 states and the District of Columbia were evaluated by the *2004 Report Card*. Shockingly, there wasn't one state that received a "satisfactory" rating and only eight earned a "satisfactory minus" grade (Minnesota, Massachusetts, Vermont, Connecticut, New Hampshire, Hawaii, Colorado, Utah).

Montana's performance for the 27 women's health status indicators shows critical successes as well as areas in desperate need of resources. Of the 27 indicators, Montana received five "satisfactory," six "satisfactory minus," five "unsatisfactory," and eleven "fail" ratings.

The data clearly shows that many of our critical efforts are preventing higher rates of disease and death. The data also reveals that the combination of certain behaviors and the reality of limited access to health care take a toll on the health and well-being of Montana women.

Although the indicators demonstrating need of improvement exceed the successes, we can take heart from the fact that the eleven "satisfactory" and "satisfactory minus" ratings are the result of hard work in the public health arena in cooperation with private health care providers and caring communities. Despite our shortfalls, as a frontier state with a shoestring budget, it is reassuring that our efforts are improving the lives of women.

Making the Grade on Women's Health: Women & Smoking.

A national state-by-state report card (2003) ranked Montana 35th in the nation with a grade of "F" on a number of indicators, including the number of all adult women who currently smoke (21.3% as compared to 20.7% nationally), the number of girls in grades 9–12 who currently smoke (31.8% as compared to 27.7% nationally) and other factors. The numbers jump dramatically among adult Native American women—to 44.8%. The report is available on-line at www.nwlc.org/pdf/Women&SmokingReportCard2003.pdf.

SOURCE: Significant portions of the narrative on page 12 and all cited facts were excerpted from *Making the Grade on Women's Health: A National and State-by-State Report Card*. National Women's Law Center and Oregon Health & Science University. 2004. The report can be viewed, downloaded or ordered on-line at *http://www.nwlc.org/details.cfm?id =1861&section=health.*

Teen Pregnancy: *Guarding Against Complacency*

—Teen pregnancy in Montana is a public health success story. Our teens are delaying their sexual activity and using contraceptives wisely, a testament to our willingness to trust and educate our youth. —Stacey Anderson, Teen Pregnancy Prevention Coordinator, DPHHS

The past 20 years have brought good news about Montana teens: teen pregnancy and birth rates have declined significantly—led by less sexual activity and better contraceptive use. As a state, we deserve to be proud of this encouraging trend, and yet Montana and its communities must remain vigilant. By maintaining and improving our efforts, it is possible to see an even greater reduction in the teen pregnancy rate.

Despite the decline, 20 percent of all Montana teenage girls get pregnant at least once before they reach 20, resulting in 1,711 teen pregnancies in 2002. Compared to other states, Montana is doing well, especially given the fact that the United States has the highest rate of teen pregnancy in the industrialized world.

Teen pregnancy prevention is a priority for the State of Montana. Reducing the rate of unintended teen pregnancy is one of the most strategic and direct means available to improve overall child well-being and to reduce persistent childhood poverty. Teen pregnancy has serious consequences for parents, the child and society in general.

For the young woman, the personal, economic and social costs of teen pregnancy are extremely high. Not only do educational and employment prospects decline significantly, young women may experience serious health risks if they become mothers too soon.

The children of young mothers more frequently exhibit low birth weights and related health problems. They often have insufficient health care and are more likely to be raised in poverty. Perhaps the most difficult social cost, though, is the effect of poor or inadequate parenting. Teen parents are typically too young to master the demands of *being* a parent. Still growing and developing themselves, teen parents are often unable to provide the kind of environment infants and very young children require for optimal development. Ultimately, the outcomes can be abuse, neglect and overall reduction in future prospects for the child.

The United States leads the fully industrialized world in teen pregnancies and birth rates by a wide margin. In fact, U.S. rates are nearly double Great Britain's, at least four times those of France and Germany, and more than ten times those of Japan.[1] Most teen mothers are unmarried; many are poor and supported by government assistance programs. It is estimated that each year, the federal government alone spends $40 billion to help families that began with a teenage birth.[2]

Looking into the future, our state and local communities must constantly renew their commitment to reduce unintended teen pregnancy by providing the support and education necessary to help young people make good decisions. While the costs to mother, child, and society are primary reasons to continue our prevention efforts, perhaps the best motivation would be gained by looking forward. Each year, Montana welcomes another generation of teenagers into its schools and communities. Prevention efforts must be constantly renewed and reinvented to address changing needs and cultural influences. What worked in the 90s may not appeal to today's young people. We must continue to build on Montana's success story by writing a new chapter with each generation.

For more information, access Trends in Montana Teen Pregnancies and Their Outcomes: 1981–2000. www.dphhs.state.mt.us/services/reports/trends_in_ teen_ pregnancies.pdf

[1] Singh, S. & Darroch, J.E. (2000). Adolescent pregnancy and child-bearing: Levels and trends in developed countries. Family Planning Perspectives, 32(1), 14-23.

[2] Flinn, S.K. & Hauser, D. (1998). *Teenage Pregnancy: The case for prevention. An analysis of recent trends and federal expenditures associated with teenage pregnancy.* Washington: Advocates for Youth.

CHIP

Among our nation's more serious problems is the large number of citizens who cannot afford medical care. Despite significant budget cuts, Montana's state government has accomplished a great deal in the past year. Last fall Governor Judy Martz allocated part of some unanticipated one-time funding to an expansion of the Children's Health Insurance Program (CHIP), which provides a very good health insurance plan to low-income children. In June 2004, the Department of Public Health and Human Services used funds achieved through good fiscal management to continue the expanded CHIP caseload. As a result, there are 1,300 more poor children with health insurance in July 2004 than there were in July of 2003. —Dan Anderson, former Administrator, Addictive & Mental Disorders Division

www.teenpregnancy.org
The National Campaign to Prevent Teen Pregnancy has performed extensive research on programs found to be effective or promising in preventing teen pregnancy.

http://www.mathematica-mpr.com/earlycare/challenges.asp
Research on affordable and accessible child care.

http://www.pregnancy-info.net/risk_factors.html
Pregnancy information for would-be mothers.

http://www.focusas.com/SingleParenting.html
A good resource for single parents.

Guiding Principles

from the Community Resouce Center

By Stephanie Iron Shooter

There is a disproportionate number of American Indian families in the systems here in Billings, from the social services to corrections and justice systems. The Community Resource Center (CRC) stopped to ask how best to address this issue. The local Family Task Force said, "*Parenting*!" loud and clear. We tried to move on with this agenda, but soon found that there weren't any best practice curriculums proven to be culturally appropriate for our population. When we sat down to brainstorm next steps, my cultural background allowed me to share my philosophy, and to help shape a protocol of respect for everyone involved.

In this light, we realized that, in order to come up with a plan, we would need to seek the advice and support of our elders as well as our stakeholders. We invited two tribal elders from each tribe in Montana, local stakeholders and urban Indian parents. The turn out was *great*! We will be moving forward with our own "Plains Indian" version of guiding principles and will choose a curriculum that best fits our Indian community here in Billings and on the reservations, if they want it.

We will be holding more Gatherings in the future, supported by a grant funded for three years. We know that the voice of our tribal elders is strong and that we can take ownership of this process and move forward to empower families. Our ultimate goal is to build trust and collaborative efforts among all of our communities.

If you have any questions please contact the Community Resource Center at 657-1732/2349 or *sironshooter@msubillings.edu/klundgren@msubillings.edu.* Stephanie Iron Shooter, Coordinator, CIP Grant.

— Stephanie Iron Shooter has been a Prevention Resource Center for three years. She has this to say about her experience:

The Principles

Though each of our great tribes is different in its customs and belief systems, there are *commonalities among the tribes:*

— the importance of community and family,

— acceptance,

— acknowledgement of past, present, and future,

— spirituality,

— respect,

— holistic health . . . and

— knowing that our children are a gift or "loan" from the Creator, not to be taken lightly.

Thank You PRC

It has been three wonderfully productive years for me as a VISTA with the Community Resource Center (CRC). I was fortunate to be able to see the birth of this awesome partnership between Montana State University Billings and the United Way of Yellowstone County. It is amazing how you see things in a different perspective when collaboration is truly working in your community. Some days I was trudging toward a light I could barely see, than other days the light would be so bright I found myself running toward it. ***Thank you Prevention Resource Center for providing me with this incredible opportunity!***

—Stephanie Iron Shooter

Alcohol & Pregnancy Don't Mix

Binge drinking among young women is on the rise, bringing with it a number of health consequences, including fetal alcohol syndrome. That's the conclusion of a report, *Alcohol and Pregnancy Don't Mix*, issued in June by the National Organization on Fetal Alcohol Syndrome. This report revealed that binge drinking in women aged 18 to 44 had increased in the United States by 13 percent between 1999 and 2002.

Henry Wechsler, director of College Alcohol Studies at the Harvard School of Public Health in Boston, called binge drinking "a national problem."

"It results in a number of negative effects ranging from automobile fatalities to fetal alcohol syndrome to all sorts of other problems," he said.

Why the overall increase? Experts aren't sure, but advertising might have something to do with it. "The general thinking is that the market has shifted to women as a very easy target," said Dr. Gopal Upadhya, medical director of Areba Casriel Institute, a substance abuse treatment facility in New York City.

For more information, go to the National Organization on Fetal Alcohol Syndrome (www.nofas.org).

Source: *health.discovery.com/news/healthscout/article.jsp?aid=519708&tid=22*

CTI: *Offering a Hand Up*

By Sheila Hogan, Executive Director, the Career Training Institute

If a community values its children, it must cherish their parents.
—John Bowlby

Poverty is the single most powerful risk factor facing families today. The issues and challenges of achieving economic self sufficiency have shifted since the 1964 War on Poverty. Education and training that lead to self–sufficiency are key elements in moving families out of poverty and reducing or preventing their need for intervention.

Poverty results from a number of interrelated factors including parental employment status and earning levels, family structure, parental education, job skills, health, divorce, desertion and chemical dependency. Families living in poverty are at increased risk for child abuse and neglect, domestic violence, chemical dependency, depression, homelessness and a multitude of health problems. The most current Census data indicates that of the 118,489 Montana families with children under the age of 18 in Montana, 19,427—or 16%—live in poverty.

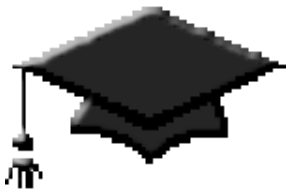
> ***The higher our self-esteem, the better equipped we are to deal with life's adversities; the more resilient we are, the more we resist pressure to succumb to despair or defeat.***
>
> ***—Nathaniel Branden***

Families living in poverty face daily struggles on several fronts: maintaining physical and mental health, keeping themselves and their children sheltered and fed, getting transportation to work and other necessary destinations, finding reliable childcare, getting and keeping a job and managing the stresses of family life. Their individual resources to meet these needs are often insufficient and even when community resources are available, accessing them takes time and persistence. It is difficult for families with so many pressing safety and survival needs to navigate a complex web of fragmented services provided by multiple community agencies. The goal then, is to provide access to services and information within a coordinated and collaborative system of community providers.

Since inception in 1983, the Career Training Institute (CTI), has recognized and supported the research suggesting that the primary factors in helping people move out of poverty are education, improved job skills and positive relationships. Over the years, CTI has provided community services and training in response to the needs of the community. Examples of programs designed to meet specific needs include nontraditional training programs for high-wage/high-demand occupations, as well as financial literacy classes. These were developed when it became evident that participants were increasingly falling victim to predatory lenders. Additional classes and programs have included computer and clerical training, business plan development, entrepreneurial training, family literacy, career counseling, occupational and work readiness, post-secondary opportunities, work experiences, on-the-job-training and job retention skills.

Services are delivered through an intensive one-to-one case management model, supportive services, classroom training, job-site training, long-term follow-up and coordination with other community service providers.

CTI is a partner agency in the Capital Area Workforce System (CAWS). CTI and the other participating CAWS agencies are invested in innovative approaches to serving the at-risk population of our communities. Integration and coordination of the services offered by several providers leads to enhanced quality of services for consumers. Integrated service delivery leads to people who are better prepared to achieve and sustain self-sufficiency.



Workforce Investment Act (WIA) Adult Program

The WIA Title IB Adult Program provides intensive training services to help individuals age 22 and older obtain employment, or obtain and retain employment that allows self-sufficiency. Services are limited to those unable to obtain other assistance for services. The WIA Adult Program has served approximately 1,800 individuals since July 2001. For more information, visit jsd.dli.state.mt.us/wia or call an adult service provider near you.

Adult Service Providers

Anaconda Workforce Center: 563-3444

Billings :

- *South Central Montana JobLINC Center: 652-3080*
- *YWCA Employment & Training Center: 252-6303*

Bozeman Career Transitions: 587-1721

Butte :

- *Workforce Center: 494-0300*
- *Career Futures, Inc.: 723-9101*

Dillon Workforce Center: 683-4259

Glasgow Workforce Center: 228-9369

Great Falls Workforce Center: 791-5800

Havre:

- *District IV HRDC: 265-6743*
- *Workforce Center: 265-5847*

Helena:

- *Adult Learning Center: 447-8876*
- *Career Training Institute: 443-0800*
- *Workforce Center: 447-3200*

Kalispell-NW Montana HRDC: 758-5426

Lewistown District VI HRDC: 538-7488

Livingston Workforce Center: 222-0520

Miles City Workforce Center: 232-8340

Miles Community College: 234-3538

Missoula Workforce Center: 542-5762

Polson Job Service: 883-5261

Wolf Point Workforce Center: 653-1720

New Day: *Investing in the Future*

By Ellen Gartner, New Day, Inc. Group Home Program Manager

Teenage girls of today increasingly experience peer pressure to get involved in destructive behaviors. They get involved in more violence, sexual experimentation, alcohol and drugs abuse, and they do so at younger ages. They are victims of emotional, physical and sexual abuse. The girls at New Day, Inc. Group Homes are learning to cope with histories that include all of this and more. New Day, Inc. provides these girls with placement in an intensive therapeutic group home setting as well as mental health day treatment program services. While at New Day, they are involved in various therapeutic activities, including horseback riding, cultural awareness activities, chemical dependency treatment services, work projects and life skills training. The effects are very positive.

I've never ridden horses, so he taught me slow to learn how to trot and I have a good time.

—New Day resident

Cultural awareness is heightened through involvement in traditional Native American rituals including talking circles, cultural drumming, the sweat lodge and traditional singing. The girls learn how to make moccasins, dream catchers and to do beading. They enjoy these activities, and in the process learn positive new ways to express themselves. Native American girls are also learning more about their cultural backgrounds and gaining positive ways to share those backgrounds with others. Many also benefit from the opportunity to spend time riding horses and learning to care for them.

I like the work projects because the CEO is cool to work with and it gives us a chance to be trusted and earn money.

—New Day resident

The girls who have had problems with drugs and/or alcohol get a chance to go through chemical dependency treatment. They complete the twelve steps of recovery and learn how to maintain sobriety after discharge. Through work projects, youth have the opportunity to earn money and learn skills. They get outside, work with their hands and do some physical labor, side-by-side with our Chief Executive Officer (CEO).

Activities promoting life skills are integrated throughout the day, helping girls learn everything from the basics of cleaning their rooms to continuing their educations, and from learning how to deal with stressful situations to anger management. This is done through a *Behavior Module Point System* that holds girls accountable for their actions, as well as through individual and group therapy sessions.

Girls at New Day are also encouraged to become involved in various community activities including community service at a home for the elderly and volunteering with the food bank. One girl expressed her thoughts about her experiences at New Day, Inc. during a speech at the Child Abuse Prevention Walk. This girl had always been shy about speaking in front of people, especially a crowd. She admitted later that she was very nervous and thought she might not be able to go through with it, but she got encouragement from her peers and the staff. She not only made her speech, she did it wonderfully. We were proud of her—and she can be proud of herself—for overcoming her fear.

There have also been girls who have been able to work through treatment programs, in the process learning to effectively deal with their issues, whether family troubles, drugs, alcohol or criminal charges. This experience has allowed each girl to go on and to have a chance at a better future. Some girls, after discharge, go to the Job Corps, where they further their educations and training. Some are able to go back to their families, and others have found new families through the therapeutic foster care system.

The girls who come to us enter with a variety of issues and troubles. They find a safe place where they can learn how to deal and cope with these issues. They do not always like the rules and do not always agree with them, but the programs make a difference in their lives. At the end of the day, they sincerely thank our staff for helping them through tough times to a new day.

SMART Girls

In response to the growing need to provide young women with the necessary skills to say no to drugs, alcohol and premature sexual activity, the Boys & Girls Clubs of America developed a curriculum, appropriately dubbed *SMART Girls*.

The goal of the *SMART Girls* Program is to promote healthy attitudes and lifestyles. To accomplish this, the program addresses health and social issues specific to adolescent female B&G Club members. *SMART Girls* is designed to reach two age groups: 8–12 and 13–17. The curricula are designed to reach girls at critical developmental stages and geared to meet them at their physiological, mental and emotional levels.

SMART Girls takes the skills, mastery and resistance training concept of the award-winning *SMART Moves* Program for youth of both genders and all ages further by providing gender- and age-specific information that helps young women develop the skills to live long and healthy lives. The specific curriculum for SMART *Girls* teaches young women to:

— understand and appreciate the physical, emotional and social changes their bodies are experiencing;

— develop positive lifelong nutritional habits based on nutritional needs specific to females;

— adopt healthy exercise routines, including a broad range of physical and leisure-time activities;

— learn how to access the healthcare delivery services in their community;

— develop and enhance important female relationships through the involvement of adult female role models/mentors (specifically mothers, grandmothers and other family members); and

— develop communication skills for building cooperative relationships by recognizing and avoiding abusive behavior.

Guidance and help at critical stages can help ensure that the transition from girl to woman is a positive one. It is crucial that sensitive and complex issues be addressed in a safe environment. *SMART Girls* promotes self-esteem and self-confidence, healthy attitudes about the body, practical life skills, opportunities to contribute to the community and positive female mentors/role models.

Most Boys & Girls Clubs also offer a similar program for boys called *Passport to Manhood*, *SMART Moves* prevention program. For more information or to find the nearest Boys & Girls Club, visit *www.bgca.org*.

GoGirlGo! Grants: *Targeting At-Risk Girls*

The Women's Sports Foundation is accepting applications for its *GoGirlsGo!* Grant and Education Program, which supports sports and physical-activity programs for girls.

GoGirlsGo! focuses on funding initiatives for girls that combine athletic instruction and programming with the delivery of educational information designed to reduce risk behaviors. The Women's Sports Foundation directs its funding to economically disadvantaged girls and/or girls from populations with high incidences of health-risk behaviors. Organizations, agencies and schools are eligible to apply, but recipients must agree to participate in the *GoGirlGo!* educational curriculum, provided free of charge by the Women's Sports Foundation.

Up to $200,000 in grants will be awarded. Funds can be used for athletic equipment, supplies, facility rental, league/tournament fees, travel, coaching, scholarships and/or program administration expenses associated with girls' sports and physical-activity programs.

The application deadline is November 30. Complete program guidelines and application instructions are available at the Women's Sports Foundation website at *www.womenssportsfoundation.org*.

Cool Links

www.bluejeanonline.com/index.html
A creative space for young women ages 14-22 to submit their writings, art work, photography, crafts and other work for online publication.

questdb.arc.nasa.gov/content_search_women.htm
Site designed to encourage more young women to pursue careers in science, math, and technology.

www.studio2b.org/
Developed by the Girl Scouts, to offer teen girls a space where they can explore who they want to be and what they want to do.

www.girlsinc.org/gc/
A web site designed to inspire girls to be "strong, smart, and bold."

www.4girls.gov/index.htm
Sponsored by the U. S. Department of Health and Human Services, this site gives girls aged 10-16 reliable, current health information with separate sections for parents and caregivers.

www.unf.edu/coh/us/indexus.htm
The website for the US Women's and Girls Health initiative.

www.daughtersandsonstowork.org/
The Ms. Foundation for Women launched Take Our Daughters and Sons To Work® in April 2003 to broaden the discussion about the competing challenges of work and family.

Girls Rock!
The Girls Empowerment Project

By Bobbi Hughes, Women's Resource Center

"At my school, it's pretty commonplace to see guys harass girls in the hallways. They think it's cool to make sexual jokes and call certain girls sexual names. I used to be one of those girls, but I don't take it anymore. I won't let it happen and I won't let it happen in front of me. The Girls Rock! Retreat helped make me more aware and helped empower me to stand up for myself and what I believe in. It inspired me to feel better about being who I am. I realized empowerment can be as simple as telling some guy I'm with that I'm feeling uncomfortable and that I want to go home. ***The Girls Rock! Retreat helped me see I can have power over what I do.****"*

–Jess, *Girls Rock!* Retreat participant

Girls participate in an activity to learn team-building and problem-solving skills at the Girls Rock! *Retreat.*

The isolation of rural living has a significant impact on youth in Northeastern Montana and can create unmet social service needs. All adolescent girls need guidance, support, encouragement and assistance to achieve their full potential and to discover their worth. Unfortunately, opportunities for girls to experience mentorship from accomplished women and to learn the significance of healthy relationships can be lacking in rural areas.

For the second year, the Women's Resource Center is providing one answer to this challenge by empowering girls in Northeastern Montana through the *Girls Rock!* Retreats. Two retreats—held in Plentywood and Fort Peck—offer girls entering grades 9-12 the opportunity to explore their talents, find resources to address their challenges and build their cultural awareness. Through workshops and activities led by women mentors, participants gain knowledge from a pro-woman perspective that can help inform their future decisions and encourage them to take on positive challenges as a woman.

The 3-day retreats provide varied activities to keep girls engaged and interested. Workshop topics include positive self image, community involvement, health and wellness, exploration of the creative self, economic opportunities and raising consciousness in political and social justice for women. Daily activities revolve around themes, such as: *EveryBODY is Beautiful, Express Yourself* and *Get Involved In Changing Your World.* All reinforce positive messages and facilitate girls' exploration and growth. A *Food Around the World* meal encourages expansion of participants' cultural awareness and understanding. This meal includes discussion of traditions, status of women and children around the world and basic conversation about the interdependence and interconnection of the global community. Every participant receives items that remind her to listen to the voice within, including a *Girls Rock!* T-shirt, a music CD with positive and empowering messages, stickers and buttons with pro-girl messages and an exploratory journal.

The mentors at the *Girls Rock!* Retreat foster an environment where girls' voices are represented and respected to help girls recognize their own worth. Retreat organizers carefully plan youth-oriented, interactive, culturally-appropriate activities to cultivate self-awareness and build self-esteem. By strengthening participants' sense of self, the Retreat aims to inspire girls to step forward as leaders who actively participate in creating positive social change.

I AM . . .

I am hoping for peace.
I am blunt, smart & funny.
I am the color "light gray."
I am proud of being forward, overcoming fear.
– Identity poem by a* Girls Rock! *participant

For more information on the Girls Rock! Retreats and other youth empowerment projects, contact the Women's Resource Center, 114 5th St. S., Glasgow, MT 59230, 406-228-8401, women@nemontel.net

—Bobbi Hughes is the Public Relations Coordinator for the Women's Resource Center in Glasgow, Montana and chairperson of the Children's Task Force for the Montana Coalition Against Domestic and Sexual Violence. She is also a former PRC VISTA.

Hill County Mentoring: *the Power of a Caring Adult*

By Anna Emrick

We all know that children need lots of love and support . . . and that the more caring, responsible, well-rounded adults are present, the more likely children will grow into caring, responsible, well-rounded adults. District IV HRDC in Havre, Montana runs a community-based mentoring program that gives children an extra adult to hang out with, model their lives after and talk to. The program pairs Havre 5th, 6th and 7th graders with responsible adults from the community. About 2/3 of those enrolled are girls.

Adult mentors are volunteers. Once trained, they spend 1-2 hours a week with their mentees. The matches have lots of fun together—talking, laughing and supporting one another. Some play sports, while others bake or make crafts, but most like to participate in a variety of activities. Although this is not a school-based mentoring program, some children ask for help with their homework.

There's no better way to build a successful adult than to give a child time.

A mentor can contribute and encourage great changes in a child's life. Through mentoring, the child may find characteristics in herself that she never knew existed. Increased self-esteem, improved school performance, self-confidence, and self-respect are a few of the outcomes of successful matches. Particularly with girls, these characteristics can be slow to develop. Many have a real need for adult guidance as they grow into the teenage years and beyond. This year alone, two cases have demonstrated how effective mentoring can be for girls.

In one case, a young girl entered the program with very low self-esteem and a poor self-image. She did not easily trust adults, even in a school setting. Comments made to her by other students were always taken as offensive, even when they were not intended to be. Soon after being matched with a mentor, this girl began showing improvement in terms of self-esteem and self-confidence. Though she still had trouble trusting her mentor, she became more comfortable each time they got together. Now, whenever I see her, she is full of life and ready to talk. She exudes self-confidence.

Another young lady enrolled this year. She had already exhausted one mentor, but remained in need of extra adult guidance. This girl's home life was relatively unsupervised, which was evident when she attended group activities. She had trouble in school, showed few manners, lied and had low self-esteem and very little self-confidence. As soon as a mentor was assigned, changes became evident. A few months after being matched, the girl's manners had improved, she became more reliable, was fabricating fewer stories and started finishing her homework. All of these improvements led to greater self-esteem. Her mentor provided her with direction *and* space to be her own person. This girl learned how to give and receive respect. The small gift of time from her mentor had a huge impact on this girl's life.

It takes a little time and effort to be a mentor, but it can have an amazing impact. Children need guidance and love as they grow, and there's no better way to build a successful adult than to ensure that a child has the time of a caring adult.

—Anna Emrick is the Mentoring Coordinator for the District IV HRDC. She is a one-year volunteer working at HRDC through the Brethren Volunteer Service. She also works in domestic abuse program at the HRDC. For more information, contact, 1-800-640-6743 or hannumd@hrdc4.havre.mt.us

Gender Specific Prevention

Alcohol and drug problems are connected with a wide range of issues impacting young women, including family violence, unwanted pregnancy, sexual assault, HIV/AIDS and other sexually transmitted diseases, and media that fosters the development of a negative body image.

- *Girls are 3 times more likely than boys to have a negative body image.*
- *Girls as young as 12 are concerned about weight control, but most are not very concerned about healthy eating.*
- *Girls with the most pathological attitudes about eating were most likely to use AOD and have more sexual experiences.*
- *Girls are 4 times more likely than boys to be physically or sexually abused and abuse history is strongly correlated with AOD use.*

Research-based alcohol and other drug (AOD) prevention strategies found to be especially effective with girls and young women include three overarching protective factors:

(1) caring relationships which convey compassion, understanding, respect, and establish basic trust;

(2) high expectations that provide challenge, motivation, positive beliefs, and send the message of "You can do it!" and

(3) opportunities for participation and contribution that give the message that youth belong and are valued in their community.

Source: preventionTactics: Prevention Strategies for Adolescent Girls & Young Women. http://www.emt.org/userfiles/Tactics_5-3.pdf

Teens-N-Crisis

By Gerri Gardner

My life was turned upside down when my angel of a girl grew into an adolescent possessed by methamphetamine. Anji was an exceptional student and a beautiful girl, with dreams of becoming a doctor. She was a loving and caring person, special to her family and to everyone who knew her. It took just 18 months for methamphetamine to master her soul and rob her of her life.

Our family suffered without a moment's peace during the months of Anji's drug use. We asked ourselves again and again what we had done wrong. How it could have happened to *our* little girl? Why we hadn't been able to stop it? We had to start with the basics—learning about meth and addiction. We couldn't understand that Anji didn't seem to realize that she was sliding toward the edge of a cliff, and she obviously couldn't stop herself. Our questions were as endless as our fear. I was in shock at first, but time and knowledge have helped me understand the horrible and magnetic force of this drug—and the torment and destruction its victims endure.

There is nothing in this life to prepare a family to lay a child to rest. The strength to go on becomes a daily struggle—it's as if a part of *you* is missing. The grief is all consuming. The sorrow was just too great for Anji's father. He took his life a few months after we lost our daughter. I began to question my value and my purpose in life. I questioned God, and didn't know how I would find the strength to go on. I spent a lot of time praying and reaching out for answers, really needing to believe that a greater good could come of this horrible tragedy.

It wasn't long before I realized that there are many, many other devastated parents whose children made the one bad choice that started them on a long slide toward the edge of a cliff. It was too late to change the outcome of my daughter's life, but I didn't want this horrible loss to be in vain. I decided to share the knowledge I had gained from my experience in the hope of saving someone else from the horror we knew all too well. From this inspiration came *Teens-N- Crisis: Community Support for At Risk Youth.*

It began as a whisper in the wind three years ago, but with the help and support of Senator Max Baucus, Governor Martz, our local law enforcement community and other state and local leaders, Teens-N-Crisis started a *Kids Speaking to Kids* Program that has reached over 20,000 young Montanans. Without any sugar coating, these kids—residents of an 18-month plus treatment program—tell it like it is. Their message is clear—the choices you make will make or break you.

A weekly support group for parents with teens in crisis offers information, support and financial aid through fundraising activities to local families whose children need treatment. We travel to other communities to educate and start support groups. Together we are making a difference one family, one life at a time.

For more information, contact Teens-N-Crisis, PO Box 213, Kalispell, Montana 59903 or Gerri Gardner at 406.837.2563.

PNA Data Bite

According to the 2002 Prevention Needs Assessment, a self-report survey instrument administered to 8,10 and 12th graders throughout Montana, 96.4% of 8th graders, 93.1% of 10th graders and 89.7% of 12th graders had never used stimulants ("amphetamines, meth, crystal, crank"). During the 30 days prior to the survey, 98.4% of 8th graders, 97.4% of 10th graders and 96.9% of 12th graders had not used stimulants.

Meth & Girls

Meth is marketed to a wide audience that varies considerably by gender, age, race and social status. Drug dealers market meth as a diet aid for adolescent girls, as an energy supplement for overworked moms, and as an escape from everyday reality for bored young adults. It is a nightmare in terms of what it does to users' health. It is not unusual for health professionals to see users in their twenties with no teeth, skin lesions and chemical burns caused by meth.

http://www.doj.state. mt.us/safety/methinmontana.asp

The Future of Prevention

By Greg Wallinger, VISTA

Montana has had a number of recent tragedies rising from young people's use of alcohol and other drugs. Substance abuse prevention is key, and we must make best use of our limited resources. Through years of scientific study, we have learned that some strategies are highly productive while others produce little effect. We know that a sustained effort is more valuable than a single event and that exaggeration and scare tactics often backfire while honesty and factual statistics can be very effective. Environmental strategies can accomplish what information dissemination alone cannot: changing a community's response to a problem is far more successful than altering individual awareness.

The newly formed Montana Prevention Network, in association with the Montana Public Health Association, the Addictive and Mental Disorders Division and the Montana Tobacco Use Prevention Program (MTUPP), decided that the time was right for a national convention on prevention right here in Montana.

The first annual *Future of Prevention Conference on Holistic Adolescent Health* was held in Billings on May 7 and 8. It was designed to bring new prevention technology to communities around the state. The 25 presenting and 50 non-presenting attendees included a wide range of people interested in the direction that prevention technology and practices are taking. Health care professionals, educators, police officers, government officials and concerned parents all came equipped with ideas and open minds, prepared to discuss how we can make prevention a more effective tool for Montana.

The conference featured speakers from around the country. Dr. Michael Klitzner, from George Washington University in Washington, D.C., kicked off the weekend with his dynamic presentation on Environmental Strategies. He challenged participants to examine their perspective on the subject in a new way. Dr. Bertha Madras from Harvard University presented the latest research on the impact of intoxicating substances on the adolescent brain. Dr. Barbara Hardy from the University of Utah examined the transformations that take place during adolescence, and how we can use that knowledge to better structure our programs.

Interspersed with these plenary presentations were four breakout sessions featuring experts in prevention from around the state. Representative Rosie Buzzas gave insight on legislative strategies. Dr. Robert Shepard discussed his internationally renowned research on the correlation between heart attacks and second-hand smoke. Cindy Thomas, with the National Center for Drug Free Sports, looked at how sports participation fits into the preventative picture of teenage health. Also of note were presentations on methamphetamine use by U.S. Attorney Bill Mercer and on the latest strategies by the Montana Tobacco Use Prevention Program (MTUPP).

Friday evening, a panel discussed the development of the Minor in Possession Law in Montana and included as guests Justice of the Peace Gregory P. Mohr from Sidney, LAC Kara Hubbard from Turning Point in Missoula, and Certified Prevention Specialist Tracy Moseman from Boyd Andrew in Helena.

The conference brought together an assortment of concerned community members in an environment alive with a multitude of new and exciting ideas about prevention. Next year, the Montana Prevention Network hopes to coordinate with other agencies involved in prevention.

If you are interested in being a part of the second annual *Future of Prevention Conference*, contact Greg Wallinger at gwallinger@state.mt.us for more information.

Don't Miss Out

Visit the Prevention Resource Center website to view some of the cutting-edge presentations from the Future of Prevention Conference: www.state.mt.us/prc/preventioncon04/prevenCon2004.htm

— *Reducing Alcohol & Drug Problems through Restructuring Community Environments by Michael Klitzner, Ph.D., Senior Associate with Klitzner & Associates, the principal Social Scientist at CDM Group, Inc., and Adjunct Assistant Professor of Psychiatry and Behavioral Sciences at the George Washington University.*

— *Changing Your Mind: Drugs in the Brain by Bertha Madras, PhD, Associate Director for Medical Education, Division on Addictions Professor of Psychobiology, Department of Psychiatry, Harvard Medical School.*

— *Adolescent Brain Development; It's Not All Raging Hormones by Barbara Hardy, PhD, Associate Director of the Utah Addiction Center, University of Utah Health Sciences Center.*

Coping with Caring

*By Sandra Hare, S*HareSolutions*

Anyone who has spent time assisting, caring and providing services for, or listening to someone struggling with acute crisis or trauma knows how draining it can be. It doesn't matter if there's a paycheck at the end of the day or not: a tremendous personal cost comes with caring for others. Over time, this cost contributes to high turnover rates, reduced production, attendance issues—or, on a personal level, depression, divorce, illness and diminished life experience.

Most of us know now it feels to be completely drained from responding to the needs of others. Typically, we refer to that as *burnout*, but what we commonly call burnout may actually be *compassion fatigue* (CF). Burnout may be caused by such things as policy changes, too much work, repetitive labor or budgeting pressures, and can usually be relieved by vacation, sabbatical or physical activity.

Compassion fatigue, on the other hand, comes from constantly giving of ourselves to assist others. The effects of CF can be felt by men and women alike, but it seems more prevalent among women. Often, women take care of others in their jobs and then go home to care for their families during the off hours, leaving little or no time for themselves. The empathy that makes women so good at their jobs and at nurturing family members also puts them at risk for compassion fatigue. At some point, reserves are simply empty.

Symptoms of compassion fatigue include sleeplessness, feeling drained, inept and helpless. Hallmarks also include avoiding people, depression and feelings of constant, low-grade stress. CF can only be relieved by taking action—learning triggers, setting healthy boundaries (personally and professionally) and practicing self-care. Over time, these actions result in more rewarding lives.

Compassion fatigue is the result of existing on a one-way street where we give and give without replenishing our own energy levels.

As long as women take care of others, they run the risk of developing compassion fatigue. Self-assessment and continued monitoring are essential in the prevention and recovery process. Because women are especially prone to this condition, first and foremost they must learn to value—and care for—themselves.

MORE COOL LINKS

www.nimh.nih.gov/publicat/depwomenknows.cfm
The National Institute of Mental Health: Depression: What Every Woman Should Know.

www.theorganizers.nb.ca/tips-superwoman.html
Tips for women who want to do everything themselves.

www.grandparenting.org/Grandparents%20Raising%20Grandchildren.htm
A page for grandparents raising grandchildren.

www.femina.com/
Provides a comprehensive, searchable directory of links to female-friendly sites.

www.cybergrrl.com/
Articles, advice and links to sites on many topics of interest to women.

www.womenssportsfoundation.org/cgi-bin/iowa/index.html
Resources related to women's participation in sports, including scholarships and internships, information about training, fitness, careers, gender equity, homophobia, disability and more.

www.4woman.gov
Provides free, reliable health information.

www.unf.edu/coh/us/indexus.htm
The website for the US Women's and Girls Health initiative.

Why Girls Use

Girls and young women use cigarettes, alcohol and other drugs for different reasons than boys do and are more vulnerable to substance abuse and addiction and its consequences, according to a report released by the National Center on Addiction and Substance Abuse (CASA): *The Formative Years—Pathways to Substance Abuse among Girls and Young Women Ages 8-22.*

Some of the gender-specific risks and consequences of smoking, drinking and drug use identified by the CASA report include:

— Girls experiencing early puberty are at higher risk of using substances sooner, more often and in greater quantities than later maturing peers.

— Girls are more likely than boys to be depressed, have eating disorders or be sexually or physically abused—all of which increase the risk for substance abuse.

— Girls using alcohol and drugs are likelier to attempt suicide.

— Girls making the transition from high school to college show the largest increases in smoking, drinking and marijuana use.

— Religion is more protective for girls than for boys.

Download the report at www.casacolumbia.org/pdshopprov/shop/item.asp?itemid=13

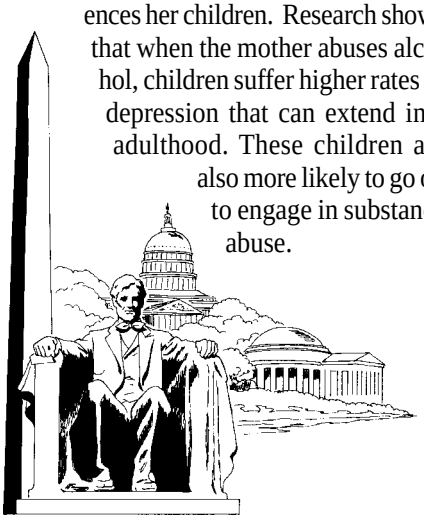
The DC Connection
Women & Alcohol: *Handle with Care*

By Theresa Racicot and Dr. Vivian W. Pinn

When it comes to the effects of alcohol use, differences between the genders are critical. While the research isn't conclusive as to why and what causes the differences, we know that women metabolize alcohol very differently than men do, and that even one or two glasses of alcohol a day are much harder on a woman's body than a man's.

Heavy alcohol use is a recognized risk factor for osteoporosis and increases the risk for breast cancer. Chronic use suppresses the immune system and the body's ability to fight infection and tumor growth. Women are also at higher risk than men of developing liver disease at *any* level of alcohol intake. Women become addicted more quickly and require less alcohol to become drunk. Furthermore, the impact of binge drinking and alcohol abuse can have far more devastating immediate effects among women. For example, in its 2002 report on college binge drinking, the National Institute on Alcohol Abuse and Alcoholism noted that anually 70,000 sexual assaults on college campuses involve alcohol. For Montana, this is a message that has special relevance. According to Behavioral Risk Factor Surveillance System (BRFSS) data for 2002, 19.8 percent of Montana women had engaged in binge drinking at least once in the past month, as compared to the national average of 17.4 percent.

A mother's drinking also influences her children. Research shows that when the mother abuses alcohol, children suffer higher rates of depression that can extend into adulthood. These children are also more likely to go on to engage in substance abuse.



Maternal alcohol use during pregnancy contributes to a range of effects in children, including hyperactivity and attention problems, learning and memory deficits, and problems with social and emotional development. The most serious consequence is Fetal Alcohol Syndrome (FAS). This disorder is entirely preventable and most tragic, leaving children to face a lifetime of neurological deficits.

According to the *Leadership to Keep Children Alcohol Free*, nearly a third of youth begin drinking before age 13. In 2002, 1.5 million youth ages 12-17 needed treatment for alcohol abuse or dependence. Forty percent of kids who began drinking before age 15 will experience alcohol abuse or dependence at some time in their lives. These statistics paint only part of the picture. After a gradual shift, the new face of underage drinking belongs to teenage girls. There are several reasons for this shift: many girls want to keep up with boys; peer pressure from girl- and boyfriends; less parental supervision; more spending money; rising rates of stress and depression; newer alcohol products that appeal to girls and women; and advertising equating alcohol use to being sexy and cool.

Girls now outnumber boys in using alcohol. National data available to the *Leadership to Keep Children Alcohol Free* shows that 38.5 percent of 9th grade girls reported drinking in the past month, as opposed to 34 percent of boys. Twenty-one percent of girls and 19 percent of boys reported binge drinking.

The advice we would offer girls and women is to advocate for your own health. Your body needs to last a lifetime: there's no return and there's no exchange, so handle with care.

—Theresa Racicot is the former First Lady of Montana and Co-chair of Leadership's Emeritus Group for the Leadership to Keep Children Alcohol Free. Dr. Vivian W. Pinn is the Associate Director for Research on Women's Health and the Director of the Office of Research on Women's Health for the National Institutes of Health.

Women, Co-Occurring Disorders and Violence

Millions of women in America suffer from co-occurring substance abuse and mental health disorders. The federal Women, Co-occurring Disorders & Violence Study has revealed that violence and abuse are very common in the lives of these women:

- *50-70% of women hospitalized for psychiatric reasons,*
- *40-60% of women receiving outpatient psychiatric services; and*
- *55-99% of women with substance abuse problems report having been physically and/or sexually abused at some point in their lives.*

Women living with mental health, substance abuse and trauma are likely to have more severe difficulties and to use services more often than women with any one of these

problems alone. Additionally, trauma symptoms rising from past violence and the absence of a safe environment are major obstacles to treatment and recovery. Appropriate treatment must be trauma-specific and trauma-informed.

More information on the lessons learned from the Women, Co-Occurring Disorders and Violence Study is available on-line at: http://www.wcdvs.com/publications/

The Last Word

By Joan Cassidy, Chemical Dependency Bureau Chief

I've spent my career working in the chemical dependency field, and over time I've observed a huge difference between treating chemically dependent men and chemically dependent women. Men can be treated with cognitive and behavioral therapies without much need to account for extraneous factors. For women, it's rarely that simple. Treating chemically dependent women means addressing a wide array of clinical and systems needs and addressing relationship issues becomes key to treatment success.

Chemically dependent women often have different agendas in therapy. Because of women's muliple roles, addiction has a greater impact on family and relationships. Women often feel that they cannot be treated without ample support. Depression is frequently a factor in women's substance use, as is a history of other abuse, isolation, lack of a social connectivity and exaggerated social stigma, grief or loss and deeply seated problems with family and children, poverty and stress.

Compounding the problem is that substance abusing women face even greater stigma than men do. Mothers who are addicted carry an immense burden of guilt and shame. It is also extremely difficult for women to move beyond the labels that detract from their ability to seek help. Loss of relationships and economic instability also weigh heavier and may cause resistance to recovery.

Chemically dependent women can be very good at disguising their addictions by assuming socially acceptable appearances. They may appear to be doing a good job of juggling career, home, family and community, but behind the appearance is a distorted sense of self and feelings of inadequacy and shame. No matter how attractive or successful the woman is, the *outside* isn't consistent with what is going on *inside*. One of the most difficult steps in recovery is helping a woman learn to nurture and accept herself, and finally to begin believing in her own worth.

One of the best messages we can give to our young women is to accept and value themselves. The message must also convey that adhering to social image may divert them from healthy lifestyles and recovery. These tools will be instrumental in helping young women avoid addiction and in helping those who are engaged in addictive behaviors to grow into healthy, vibrant women.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

Be a Copy Cat

You may make copies of articles in the Prevention Connection for noncommercial, educational use. No reprint of this document or articles contained herein should be used in a way that could be understood as an expressed or implied endorsement of a commercial product, service or company. To use this document in electronic format, permission must be sought from the Prevention Connection and the individual author. Please be sure to include acknowledgement of the author and the Prevention Connection in any reproductions. All other rights remain the property of the Prevention Connection and the author.

2,000 copies of this public document were published at an estimated cost of $2.18 per copy, for a total cost of $4,358.98, which includes $4,090.45 for production and printing and $268.53 for distribution.

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604

**PRSRT
STD RATE
U.S. Postage
Paid
Permit No. 246
Helena, MT**