ALCOHOL, TOBACCO AND DRUG USE BY PREGNANT WOMEN IN INDIANA

A Study for the Indiana State Department of Health

September 25, 2006

Indiana University School of Medicine
Department of Family Medicine
Bowen Research Center

Terrell W. Zollinger, DrPH
Robert M. Saywell, PhD, MPH
Komal Kochhar, MBBS, MHA
Michael Przybylski, PhD
Corie Galloway, BS

TABLE OF CONTENTS

ACKNOWLEDGEMENTS……..3

EXECUTIVE SUMMARY……...5

CHAPTER 1: INTRODUCTION…….9

CHAPTER 2: SCREENING, RECRUITMENT AND RETENTION FOR ALCOHOL, TOBACCO, AND OTHER DRUG TREATMENT...……14

CHAPTER 3: PREVALENCE OF ALCOHOL, TOBACCO, AND OTHER DRUG USE AMONG PREGNANT WOMEN AND WOMEN OF CHILDBEARING AGE IN INDIANA …….……..23

CHAPTER 4: AVAILABLE TREATMENT SERVICES IN INDIANA FOR ALCOHOL, TOBACCO, AND OTHER DRUG USERS ……..…….……85

CHAPTER 5: ATTITUDES, KNOWLEDGE AND BARRIERS PREVENTING ACCESS TO TREATMENT BY ALCOHOL, TOBACCO, AND OTHER DRUG USERS ……87

CHAPTER 6: SUMMARY OF ISSUES IDENTIFIED AND SUGGESTED ACTIONS……...114

REFERENCES……...121

APPENDIX A-1: FOCUS GROUP SCRIPT……...128

APPENDIX A-2: FOCUS GROUP FEEDBACK……...131

APPENDIX B-1: TREATMENT PROVIDER SCRIPT……144

APPENDIX B-2: TREATMENT PROVIDER FEEDBACK……146

APPENDIX C-1: PRIMARY CARE PROVIDER SCRIPT/SURVEY……164

APPENDIX C-2: PRIMARY CARE PROVIDER RESPONSES……166

APPENDIX D: ALCOHOL, TOBACCO, AND OTHER DRUG TREATMENT PROGRAMS IN OTHER STATES……180

APPENDIX E: RESOURCE INVENTORY……...186

ACKNOWLEDGEMENTS

Advisory Committee Members:

Jonell Allen, RNC, MSN, CNS (Perinatal Clinical Nurse Specialist, Community Health Network)
Jan Petty Arnold, MS (State Director, Program Services, March of Dimes Indiana Chapter)
George Brenner, LCSW, LMFT, CADACI (Director of Addiction Services, Community Health Network)
Larry Humbert (Director, Indiana Access, Indiana Perinatal Network)
Nancy Jewell, BA, BS, MPA (President/CEO, Indiana Minority Health Coalition)
Debra Kirkpatrick, MD (Obstetrician, Wishard Hospital)
Joanne Martin, DrPH (Director, Maternity Outreach and Mobilization Program)
Randy Miller (Executive Director, Drug Free Marion County)
James J. Nocon, M.D., J.D. (Associate Professor, Dept. of Ob/Gyn, Director, Prenatal Recovery Program)
Karla Sneegas (Executive Director, Indiana Tobacco Prevention and Cessation)
Randy Stevens, MD (Family Physician, and Addictions Specialist, Terre Haute)
Robert Teclaw, DVM, PhD (Director and State Epidemiologist, Indiana State Department of Health)
John Viernes (Deputy Director, Division of Mental Health and Addictions)
Deanna Willis, MD (Assistant Professor of Family Medicine, Indiana University School of Medicine)

Prenatal Substance Use Prevention Program Directors:

Vickie Alexander
Jeane Bock
Joni Clark
Nancy Cripe
Marlene Cron
Priscilla Engle
Fairy Geiling
Courtney Grant
Pam Hudson
Kristen Kirby
Deborah Kovach
Robyn Pugh-Dunlap
Darla Reinbrecht
Julie Sellers
Linda Simers
Debbie Stevens
Ginny Yoder
Morgan Younger

Indiana State Department of Health Staff:
Judith Ganser, MD, MPH (Medical Director, Maternal and Children's Special Health Care)
Carolyn Waller, PhD (State PSUPP Director, Public Health Administrator)
Epidemiology Resource Center Staff

Indiana Tobacco Prevention and Cessation:
Miranda Spitznagle (Director, Program Evaluation)

The Focus Groups, Key Informant Interviews and the Primary Care Provider Survey would not have been possible without the assistance and guidance provided by many people including:

The 51 Focus Group Participants from Anderson, Greencastle, Lafayette, Muncie and Terre Haute -- the authors are indebted to these anonymous individuals who participated in the focus group sessions who responded to our request to provide their opinions.

The 11 Treatment Provider Key Informant Interviewees:
Dean Babcock LCSW, ACSW (Director of Administrative Services, Midtown CMHC)
Sarah V. Childers, BS, CHES (Tobacco Treatment Program Coordinator, HealthNet, Inc.)
Diana L. Edwards, MS, CADAC IV, ICRC/ADC, LCSW (Recovery Associates, Inc.)
Linda Hoolehan, BSN, RN (Executive Director, Recovery Associates, Inc.)
Stephanie Kapp, BA (Clinical Research Coordinator, Midtown Addiction Research Center)
Amy Martin, MS (Parent/Child Educator, Indianapolis Healthy Start)
Dave McIntyre, CADAC III (Cummins Behavioral Health Systems, Inc.)
Beth Morlock, BA (Director of Resident Services, Hope Rescue Mission)
Tiombe Plair, MSW (Medical Social Worker, II Care/ObGyn, Wishard Hospital)
Gary Robinson, LMHC, CADAC IV (Program Director, YWCA of St. Joseph County)
Edwin Ross, MS, CADAC IV (Director of Hamilton Addictions)

The 14 Primary Care Provider Interviewees and Survey Responders:
Paul Daluga, MD (Director of Residency Program, Union Hospital)
Gene Epplin, MD (Associated Physicians & Surgeons Clinic, Inc.)
Tamara A. McNally, RN, MS, CNM (Director, Midwifery of Michiana, St. Joseph Regional Medical Ctr.)
James J. Nocon, M.D., J.D. (Associate Professor, Dept. of Ob/Gyn, Director, Prenatal Recovery Program)
Joyce M. Slater, CNM, MSN (Director, Pregnancy Plus Nurse-Midwifery Services)
Donna Sweets, DO (St. Mary's Medical Center)
Grace Walker, MD (Union Hospital)
7 Residents (Residency Program, Union Hospital)

EXECUTIVE SUMMARY

Use of alcohol, tobacco and other drugs (ATOD) among pregnant women is one of the leading preventable causes of birth defects, including mental retardation, neurodevelopment disorders and other poor birth outcomes in the United States. Despite the concern over the consequences of prenatal exposure to ATOD, substance use by pregnant women remains a frequently missed diagnosis and only about 5 to 10 percent of pregnant women in need of substance use treatment services receive professional help for their problems. The purpose of this project was to collect information that will lead to a better understanding of the magnitude of the ATOD use problem in Indiana; the perceived and real barriers that prevent pregnant women that use ATOD from getting the treatment needed, and the strategies that could be undertaken to improve the access to treatment services. To accomplish this purpose, this project collected information from many sources including a review of peer-reviewed literature, government reports and documents, Internet searches, focus groups and key informant interviews, as well as from many secondary data sources, both nationally and in Indiana.

Screening is defined as the presumptive identification of a disease or defect in which tests, examinations, or other procedures can be applied rapidly and accurately. Screening pregnant patients for ATOD use is considered an essential part of good prenatal care practice. A direct outcome of screening women for ATOD use is a reduction of use during pregnancy, followed by healthier birth outcomes and fewer pregnancy and delivery complications. The ideal screening test should be concise, easily administered and scored, inexpensive to administer, and be highly sensitive and specific. Thirteen of the most commonly used ATOD screening tests used in prenatal care settings are presented in Chapter 2 along with their advantages and disadvantages.

One of the most difficult challenges of ATOD treatment is identifying women using ATOD and drawing them into care. Active recruitment and outreach efforts are needed to help women overcome self-imposed and external barriers and enter substance use treatment programs. Several substance-related factors, including type of substance, level of use and history of use, play important roles in women's enrollment in and completion of substance use treatment.

The prevalence of ATOD use among women of child bearing age and pregnant women in Indiana is similar to the patterns seen in the U.S. as a whole, as shown in Chapter 3 of this report. Smoking has been declining but is still the most commonly used of the three types of substances in Indiana. Analysis of the birth certificate data 1990 - 2004, smoking during pregnancy declined by 32% from 26.7 to 18.1%. During that same time period there was a 45% decline in the nationwide rate. That means that the smoking rate in Indiana is now 77% higher than the national rate. The birth certificate data appears to underestimate the actual prevalence, since it is self reported use. It is estimated that the prevalence of smoking is 20 percent for pregnant women in Indiana. Alcohol use is less prevalent among pregnant women in Indiana and is estimated to be 10 percent and the rate of drug use is slightly lower at about 5-6 percent. The smoking rate for pregnant Hoosiers is higher than the national average, while the rates for alcohol and drug use during pregnancy in Indiana are slightly lower than for the U.S. Particular concerns in the

trend analysis are the steep increase in alcohol use during pregnancy noted for Indiana and the U.S. in the past five years and the increase in the number of pregnant women who are using multiple substances.

ATOD treatment programs exist in all states. In Indiana, most counties have treatment programs for at least one of the three types of substances. However, many of these programs are not accessible to pregnant women especially if they have other children and/or need inpatient care. An inventory of the ATOD treatment programs in Indiana, listed by county, is included in Chapter 4 of the report, along with the type of services provided and the contact information for the program.

To obtain personal opinions, perspectives and experiences of pregnant women using substances, 51 women who met these criteria participated in 5 focus groups around the state. To supplement the perspectives of the pregnant women using substances, 11 treatment providers and 14 primary care providers were interviewed. The results are shown in Chapter 5 of this report. The barriers to treatment cited by these individuals mirror those identified in published literature: lack of transportation and child care, financial barriers, fear and distrust of the health care and treatment providers, lack of motivation and lack of awareness of available ATOD services. A major common theme was that ATOD information has generally been negative in its approach. Much of the information distributed is about the harmful effects of ATOD use on the fetus with less emphasis being on the post-partum child or on the mother herself. There was a strong belief often stated by the three groups that more supportive messages need to be presented to the public and the women using ATOD. In addition, there were concerns about lack of knowledge about the health effects of specific substance use by the general public and in particular pregnant women, lack of awareness of treatment services by primary care providers, inconsistent screening by primary care providers, and fragmented or non-existing treatment services. All cited a need for expansion of existing programs or adding new programs in areas where none currently exist. Of special need are residential treatment programs that welcome pregnant women as well as new mothers and their children.

A synthesis of the information gathered from pregnant women, treatment and primary care providers (focus groups and key informant interviews), the secondary data analysis, and the review of alcohol, tobacco and other drugs literature identified ATOD treatment issues in six major areas, as shown in Chapter 6 of this report:

1. The exact magnitude of the alcohol, tobacco and other drug problem is not known. Indiana lacks valid and timely data on alcohol, tobacco and drug use during pregnancy

- Develop a system to collect ATOD information more objectively
- Obtain larger sample sizes to provide county level ATOD prevalence
- Provide more valid and timely prevalence data on ATOD use

2. Presence of social stigma, fear of the system, and lack of positive messaging discourages utilization of prenatal and alcohol, tobacco and other drug treatment services

- Refocus the ATOD message to be more positive and supportive
- Make the public more aware of the biomedical aspects of addiction
- Emphasize the importance of primary care providers (PCPs) treating women using ATOD with dignity and respect
- Ensure patient confidentiality and trust
- Establish policies to emphasize positive support (not purely punitive) for ATOD treatment.

3. Challenges exist in the screening, brief intervention, and treatment referral for women using ATOD

- Emphasize that screening, brief intervention and treatment referral is important for all women of child bearing age using ATOD
- Reinforce the role PCPs play as part of a team assisting ATOD patients to quit
- Encourage providers to better understand the complexities of their patients' lives
- Provide PCPs with evidence-based practice guidelines from ACOG, CDC and other respected organizations for rapid, effective screening questions, brief intervention, follow up, and referral of women using ATOD
- Provide those treating women using ATOD with guidelines to ensure most effective treatment
- Develop an integrated approach to ease the transition from primary care to more specialized treatment if referral is necessary
- Encourage collaboration between PCPs and ATOD treatment providers
- Publicize availability of ATOD treatment programs to providers
- Develop and publicize standard measures of success of ATOD treatment programs to providers
- Publicize, support and expand existing referral and telephonic counseling services
- Expand medical and health professional education regarding the health impact of ATOD use
- Train hospital and birthing facility personnel to screen, test, and refer women using ATOD

4. There is a lack of knowledge and understanding on the part of the public and employers as well as pregnant women about the health effects and economic impact of ATOD use and the availability of treatment services in the community

- Educate the <u>public</u> about the relative health impacts due to using specific substances during pregnancy
- Inform <u>pregnant women</u> about the effects of using specific substances
- Inform <u>pregnant women, employers and the public</u> about the harm caused by secondhand smoke exposure
- Motivate women to seek treatment through a statewide education campaign

- Promote availability of ATOD treatment programs to the public
- Publicize measures of success of ATOD treatment programs to the public

5. Obstacles exist that hamper access to ATOD treatment for pregnant women.

- Improve efforts to address access barriers to ATOD treatment
- Offer ATOD treatment programs that are affordable
- Provide services tailored to meet the basic physical, social and economic needs of pregnant women, e.g., childcare, transportation.

6. A lack of adequate availability and funding for ATOD treatment services exists throughout Indiana

- Develop a funding plan to address the needs of pregnant women using ATOD
- Ensure that policies enable those with greatest needs to obtain the services
- Establish residential treatment programs that are available throughout Indiana
- Expand the Prenatal Substance Use Prevention Program (PSUPP)
- Develop more intensive outpatient ATOD rehabilitation programs
- Promote tobacco free environments for ATOD treatment
- Expand existing or develop a statewide ATOD telephonic counseling services

To deal with the problem of ATOD use among pregnant women effectively, the State of Indiana will need to devote more resources to provide the services needed by this population. The state and local policy makers should recognize that investment in ATOD-related prevention and treatment services will result in reduced burdens on the health care system and law enforcement agencies.

Reducing ATOD use among pregnant women is a very complex issue and will require the efforts of multiple agencies, providers and other partners. In addition to the substance use problem, many pregnant women also have other basic physical and social needs. These basic needs must be addressed to allow these women to then focus on addressing their ATOD use and improving their health behaviors.

The suggestions from the advisory committee listed in this report provide a foundation upon which an effective action plan can be developed for the State of Indiana to address the issues surrounding ATOD use among pregnant women. It will be essential to establish a state task force which includes state and local policy makers; administrators from public health, mental health and addiction, child welfare, health, education, employment security, criminal justice, and advocacy agencies; representatives from program funding organizations; primary care and ATOD treatment providers; as well as women who used ATOD during pregnancy, to work in unison to remedy these problems. This task force will need to address the prioritization of the above issues and develop a state implementation plan to improve early intervention and treatment for pregnant women using ATOD.

CHAPTER 1: INTRODUCTION

Use of alcohol, tobacco and other drugs (ATOD) among pregnant women is among the leading preventable causes of birth defects, mental retardation, neurodevelopmental disorders and other poor birth outcomes in the United States.[1, 79, 80] The use of harmful substances, including any form of tobacco, alcohol, illegal drugs or abuse of prescription drugs during pregnancy are known to have serious physiological and emotional health consequences for the mother and the fetus. [2, 3] Despite the concern over the consequences of prenatal exposure to ATOD, substance use by pregnant women remains a frequently missed diagnosis and only about 5 to 10 percent of pregnant women in need of substance use services receive professional treatment for their problems. [4, 5]

IMPACT OF SUBSTANCE USE DURING PREGNANCY

Alcohol: Prenatal exposure to alcohol is the leading preventable cause of mental retardation in the United States. It may lead to serious complications for newborns, including the three parameters of Fetal Alcohol Syndrome (FAS): facial malformation, intra-uterine growth retardation, and central nervous system dysfunction (mental retardation). [4, 6, 7, 8, 9] FAS is characterized by specific facial abnormalities and significant impairments in neurodevelopment and physical growth. Fetal Alcohol Spectrum Disorder (FASD) occurs in approximately 1 per 1000 live births, outranking Downs Syndrome (1/800) and autism (1/1000) in prevalence. [10] Nationally, the total costs of alcohol misuse and abuse are estimated at more than $667 billion yearly, including $2.8 billion attributable to FAS alone. [11] In February 2005, the US Surgeon General issued an updated opinion on Alcohol Use and Pregnancy. The advisory recommended that pregnant women should not drink alcohol, that a pregnant woman who had already consumed during her pregnancy should stop drinking to minimize further risk, and that a woman who is considering pregnancy should also abstain from alcohol. In July 2004, Centers for Disease Control and Prevention (CDC) released a report containing diagnostic criteria for FAS, as well as recommendations for prevention of alcohol-exposed pregnancies. [12] One of the major health objectives for *Healthy People 2010* is to reduce maternal use of alcohol during pregnancy to 6 percent. [13, 14, 81]Numerous reasons have been cited for under recognition of FAS in infants, including inadequate knowledge of the mother's prenatal drinking patterns and the examining physicians' lack of comfort and experience with the disorder.[12]

Smoking: Prenatal smoking has been associated with increased relative risk of spontaneous abortion, placenta previa, abruptio placenta, bleeding during pregnancy, preterm delivery and intra uterine growth retardation. [7, 82] Women who smoke during pregnancy face a 1.6 times greater risk for ectopic pregnancy, 3.4 times greater risk for miscarriage, and a 1.4 times greater risk for stillbirth, compared with nonsmokers. Also, an increased risk for premature rupture of membranes, placenta abruptio and placenta previa is incurred by these expectant mothers. [15]

Drugs: Prenatal exposure to marijuana has been associated with intra-uterine growth retardation and premature birth. Cocaine use during pregnancy has also been related to intra-uterine growth retardation, altered neonatal behavior, and major

congenital anomalies. Opiate exposure in utero may result in impaired growth, small head size, and extreme behavior withdrawal. [4] Nationally, drug abuse costs are estimated at more than $144 billion a year, including $503 million associated with healthcare costs, for drug exposed newborns. Experts at National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA) confirm that addiction is not primarily a moral weakness, as it has been viewed in the past, but a "brain disease" that should be included in a review of systems just like any other biologic disease process. [11, 83]

ACCESS TO ALCOHOL, TOBACCO AND OTHER DRUG TREATMENT

Pregnancy has been described as a window of opportunity increasing the woman's motivation to seek health care services. Yet, few women enter substance use treatment programs during pregnancy. Of those who do, many enter late in their pregnancy (i.e., in the 3rd trimester) after many critical fetal development phases have already occurred. Thus, identification of extrinsic barriers to treatment is vital and may aid help-seeking behavior, including early-in-pregnancy enrollment in substance use treatment and obtaining essential prenatal care. [2]

Many pregnant women identified as ATOD users do not have access to appropriate services due to the scarcity of substance treatment programs that will admit pregnant women. In addition, lack of adequate financial resources prevent women from accessing care since many treatment programs will not accept publicly insured patients or limit the number of treatment visits that will be reimbursed. Pregnant women who are substance users often have special needs that must be met to allow them to enter treatment, such as the need for child care, mental health care, housing services, and transportation services. [4] Historically, pregnant women who are substance users have faced tremendous difficulty obtaining treatment. Many programs have refused to accept pregnant women or have been unable to provide important services they need, such as prenatal care, parenting skills instruction, child care and transportation. [16] Thus, to be successful, treatment programs must coordinate the services of various agencies in order to meet the complex needs of pregnant women using ATOD.

Some states have also attempted to criminalize prenatal drug use or treat it as grounds for terminating parental rights, while others have placed a priority on making drug treatment more readily available to pregnant women. [16] When states enact the laws that make the use of illegal substances in pregnancy a felony, health care providers are placed in the weak position of being the patient's adversary. For example, South Carolina enacted a law that makes the use of an illegal or illicit substance during pregnancy a Class D felony. As a result of this law two issues became quite clear. They were noted in a United States Supreme Court decision, Ferguson v. City of Charleston. First, 40 out of 41 women who were arrested as a result of postpartum drug testing for cocaine were African-American. In contrast, the white women who tested positive for heroin or methamphetamine were more likely to be referred to social services. The second issue in the Ferguson case involved a point of law. The court held that if the drug test was obtained without the patient's consent, the patient cannot be subject to criminal prosecution because it constitutes an unlawful search under the Fourth Amendment.

However, if a health care provider obtained informed consent for urine drug screening, the patient could be held liable for criminal sanction and the provider may become the patient's adversary. If the provider obtained the drug test without the patient's consent, then the patient was not subject to any kind of legal penalty. Although her independence was compromised, the provider remained the patient's advocate. Such laws create a potential adversarial situation between the patients and health care providers, which could drive patients away from prenatal care. [17, 84]

Patients who disclose behaviors that are stigmatized by society may be harmed if they feel that their trust is met with condemnation, disrespect or is compromised. Criticism and shaming statements actually increase resistance and hinder positive change. In addition, women will be less likely to reveal their unhealthy behaviors and consequently not receive the support and assistance they need to change those behaviors. Effective intervention requires that universal screening questions and procedures, brief intervention, and referral to treatment are conducted with full protection of confidentiality. Although it is always appropriate for a health care provider to negotiate with a patient about her willingness to accept a medical recommendation, respect for autonomy includes respect for her refusal to be screened or to submit specimens for lab tests. Both ethical and legal perspectives require that the best interest of the child be served which requires both, protecting children and assisting their mothers, to be healthy so as to provide the most favorable situation for growth and development. Threats and imprisonments have been proven to be ineffective in reducing alcohol or drug use among pregnant women and removing children from the home may only subject them to additional risks in the foster care system. Hence, providing ATOD treatment is both more effective and less expensive than the more restrictive policies and results in an estimated mean net savings of $4,644 in medical expenses per mother/infant pair. Also, it has been noted that women who have custody of their children complete treatment at a higher rate than those who do not. Putting women in jail, where drugs may be available but treatment is not, jeopardizes the health of the women and that of their existing and future children. Referral to ATOD treatment, when combined with training in parenting skills, is the medically and ethically appropriate professional action. Parenting skills programs, assistance with employment and housing issues, and access to substance use treatment have also been shown to be successful support mechanisms for families of affected children. [11]

Thus, legal, social, attitudinal, operational and logistical barriers often come together to prevent open communication between providers and patients, resulting in a very low rate of screening or intervention for substance use in the prenatal care setting. [5] Therefore, enrollment in and compliance with, ATOD treatment for this population is very crucial. [8]

PROJECT PURPOSE

The use of alcohol, tobacco or other drugs during pregnancy is harmful to the mother and the fetus and there is strong agreement that the best strategy to reduce the consequences of ATOD use during pregnancy is to focus on preventing women of childbearing age from using these substances. However, the focus of this report is not on prevention, but on how to better meet the medical and substance use treatment needs of pregnant women and women of childbearing age who are already using ATOD.

The purpose of this project was to gain a better understanding of:

- The magnitude of the ATOD use problem in Indiana;
- The perceived and real barriers that prevent pregnant women using ATOD from getting the treatment they need to change their behavior to allow for a better health outcome for the mother and her baby;
- The strategies that could be undertaken to improve the availability of treatment services for this population; and,
- The ultimate dilemma faced by the women, their providers, the health care system and the entire community when these components are NOT understood or effectively addressed.

PROJECT METHODS

To accomplish this purpose, this project collected information from many sources including a review of peer-reviewed literature, government reports and documents, Internet searches, focus groups and key informant interviews, as well as from many secondary data sources both nationally and in Indiana. Early in the development of the project an Advisory Committee was assembled to guide the process and development of the report. This group was asked to provide input throughout the project, but specifically to help identify individuals to participate in the focus groups and key informant interviews, review the information to be collected in the primary data collection effort, help identify other sources of secondary data that might be of value, help identify the treatment services available, and, most importantly to help with the formation of the study recommendations.

All of the information gathered for this project was synthesized to provide:

- A summary of ATOD screening techniques and treatment recruitment and retention issues [Chapter 2];
- Estimates of ATOD utilization among pregnant women and women of child-bearing age in the U.S and Indiana [Chapter 3];
- An inventory of ATOD treatment services in Indiana [Chapter 4];

- A listing of the perceived or real barriers to ATOD treatment services for pregnant women in Indiana [Chapter 5]; and,

- A summary of issues and suggested solutions related to accessing ATOD prevention and treatment by pregnant women and women of child-bearing age in Indiana [Chapter 6].

All substance "use" during pregnancy is an "abuse." Since any use of alcohol, tobacco or other drugs during pregnancy is harmful to the mother and the fetus, throughout this report the term "substance use" was generally utilized rather than the terms "substance abuse" or "addiction."

CHAPTER 2: SCREENING, RECRUITMENT AND RETENTION FOR ALCOHOL, TOBACCO, AND OTHER DRUG TREATMENT

Given that there is no established safe level of alcohol, tobacco and other drug (ATOD) use for pregnant women, official guidelines have been issued by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). The Office of the Surgeon General and the Department of Health and Human Services are advising all women who are pregnant or who might become pregnant to abstain from ATOD use. [12, 85, 86, 87] Clinicians are encouraged to integrate ATOD screening and treatment into their routine assessment procedures for women of child bearing age (pregnant and non pregnant) and to provide advice and counseling based on the screening results.

- First, reliable and consistent screening for prenatal ATOD use with a validated instrument set in a patient's information form may provide valuable information to the clinician.

- Second, a diagnostic interview about ATOD use appears to result in reduced subsequent consumption. This screening and assessment may be the most economical approach to the identification and management of pregnancy risk caused by ATOD use.

- Third, techniques to increase management of social situations are needed, as they appear to be the most "risky" for prenatal ATOD consumption.

- Fourth, treatment for women using ATOD should include a "detailed and caring confrontation and advocacy-oriented support" focus.

- Lastly, motivational interviewing has shown positive results for the pregnant women who use ATOD.

A recent study recommended a shift in approach from cognitive behavioral therapy to motivational empowerment therapy (MET), where treatment strategies are matched to the patient's awareness and readiness to change. [17] The stages of change model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy. The stages of change are pre-contemplation, contemplation, preparation, action, and relapse. Pre-contemplation is when the woman is not considering any change and may present as resistant, reluctant, resigned or rationalizing. During the contemplation stage, the woman is starting to think about changing her behavior but is not yet ready to commit to a change. She can think of positive reasons to change but is also aware of the negative sides of change. In the preparation stage the woman's ambivalence is shifting toward committing to change her behavior. Although her reluctance to change is lessening, it is still present and may increase when she is challenged by those around her, triggered by the environment, or is under other types of stress which she has handled by using ATOD in the past. During the

action stage the woman has stopped using ATOD. A relapse may occur when the woman returns to using ATOD; the incidence of relapse for women using ATOD is high. [17, 18, 88]

Another helpful approach when abstinence is not possible is the "Harm Reduction Strategy", where any reduction in ATOD use is praised. This strategy includes evaluation and referral for underlying problems; encouraging the woman to keep track of her substance use; decreasing her substance use; and avoiding "friends" who use ATOD. [18]

ALCOHOL, TOBACCO AND OTHER DRUG SCREENING

Screening is the presumptive identification of an unrecognized disease or defect where tests, examinations, or other procedures can be applied rapidly and accurately. Screening tests sort out persons who may be in an early stage of a disease from those who probably do not have the disease. Thus, screening is the first step in a process that may or may not lead to a diagnosis of disease and is not intended to be diagnostic. If a screening test result is positive, a diagnostic work up should follow and treatment should be initiated after a disease state is diagnosed. Hence, the purpose of screening is to identify persons with a disease who can benefit from early intervention and treatment. [19]

The American Medical Association endorses universal ATOD use screening for pregnant women. Universal screening means that every patient is asked about ATOD use at the first prenatal visit and at least once thereafter, per trimester. This type of screening offers providers with the opportunity to discuss the risks of alcohol, drug use, smoking, prescription drug use, and other at-risk behaviors with their patients. Patients are more likely to acknowledge use of alcohol and nicotine than illegal substances. When included into the initial obstetrical history, screening tests identify women using ATOD and promote early intervention and treatment, thereby reducing health risks for the pregnancy and the child. This investment in prevention and treatment is the best way to reduce the burden of ATOD use on public programs. Thus, the practice of universal screening increases the possibility of identifying women who are substance users and allows for the earliest possible interventions or referral to specialized treatment. [17]

Asking the screening questions takes only about 30 seconds for most patients who do not have a substance use problem and 5-10 minutes for the 10-15 percent of patients who do. This small investment actually saves time by answering questions that might come up later and by reducing care time for a patient in whom obstetrical complications can be prevented through early identification and reduction or elimination of this risk factor. [18]

A positive alcohol screen however, does not necessarily indicate an alcoholism diagnosis; rather, it may signal to a physician or other healthcare provider the need to discuss the pregnancy risks from drinking with their patients. Routine use of formal screening questionnaires in clinical practices may also reduce the stigmatization of asking patients about alcohol use and result in a more accurate and consistent evaluation. [20]

Research indicates that a direct outcome of screening women for alcohol use is that women will reduce their alcohol consumption during pregnancy. The immediate

benefit is a dramatic reduction in fetal alcohol spectrum disorders (FASD), including the most debilitating form, fetal alcohol syndrome (FAS), as well as a modest reduction in premature births. Alcohol related screening for pregnant women has a very high probability of being cost effective by reducing the need for neonatal intensive care services. This is true even with very low abstinence rates because of extremely high cost of premature births and low birth weight newborns. [21]

In the case of alcohol consumption during pregnancy, the mother and the fetus need to be screened for two disorders: maternal alcohol dependence and fetal alcohol exposure. [19] Abstinence during pregnancy is the recommendation of both the AAP and ACOG. There is no universally accepted "safe level" of prenatal alcohol use. In general, expectant fathers or partners are not routinely screened for health problems or behaviors that could impact the pregnant woman's health habits. [14]

Tobacco screening and follow up should be classified as "essential" for all pregnant women in all healthcare settings. The immediate benefit is a reduction of tobacco use for the duration of pregnancy. Other benefits include a reduction in the percentage of women delivering low birth weight infants who are at a high risk of requiring neonatal intensive care services and a reduction in infant mortality. [21]

The benefits of reducing illegal drug use and prescription drug abuse during pregnancy are the elimination of maternal, fetal and infant complications. All pregnant women should be asked about their use of drugs and advised to abstain by their prenatal care providers. Women who report using drugs during pregnancy need follow up appointments, supplementary case management, and counseling to receive optimal medical care. [21] Marijuana metabolites may be detected in the mother's urine for up to 14 days after repeated use, but evidence of cocaine, opiates, amphetamines, and barbiturates is present in the urine only for 2-4 days after use. Due to the significance of a positive drug screen for the patient, the rights of patients to autonomy and privacy may have important implications for screening of asymptomatic persons. If confidentiality is not ensured, test results may affect a patient's employment, insurance coverage, and personal relationships. [22]

Recommended screening and referral protocols may be perceived as punitive measures when they are connected with legally mandated testing or reporting, or both. Such measures jeopardize the relationship of trust between the health care provider and the patient and possibly conflict with the provider's therapeutic responsibility. Also, if pregnant women become reluctant to seek medical care because of fear of being reported for alcohol or illegal drug use, these strategies could actually increase the health risks to the woman and her unborn child, rather than reduce the consequences of substance use. [11]

The ideal screening test should be concise, easily administered and scored, inexpensive to administer, and be highly sensitive and specific. [23] Examples of commonly used screening tools are listed below:

TWEAK [9, 11, 12, 17, 18, 19, 20, 24, 25, 26, 27]

T- tolerance
W- worried about drinking
E- eye opener or morning drinking
A- amnesia or blackouts
K (C)- need to cut down

Advantages: specifically designed for prenatal settings; reliable and valid tool; more sensitive than the T-ACE.
Disadvantages: not adaptable for drug consumption; for heavy or late stage drinkers only; less specific than the T-ACE.

T-ACE [9, 11, 12, 17, 18, 19, 20, 24, 25, 26, 27]

T- tolerance
A- ever annoyed by someone criticizing your drinking
C- the need to cut down
E- eye opener or morning drinking

Advantages: specifically designed for prenatal settings; well validated with pregnant population; offers the best balance of sensitivity and specificity; reliable and valid tool; more sensitive to risk drinking than CAGE; T-ACE proved to be superior to both MAST and CAGE in identifying pregnancy risk drinking.
Disadvantages: does not identify light or moderate drinkers nor illicit drug users; less sensitive than TWEAK.

CAGE [11, 12, 18, 19, 20, 24, 25, 26, 28]

C- cut down
A- annoyed by criticism
G- guilty about drinking
E- eye opener

Advantages: easy to administer; well established validity; good validity and specificity.
Disadvantages: assesses lifetime rather than current alcohol related problems; identifies heavy drinkers only; more effective in screening men; less sensitive and specific than T-ACE and TWEAK.

MAST [20, 25, 26, 28]

M- Michigan
A- alcohol
S- screening
T- test

Advantage: rapid and effective screening for lifetime alcohol related problems and alcoholism; specifically designed for screening pregnant women.
Disadvantage: does not identify heavy drinkers.

AUDIT [12, 18, 19, 20, 26, 28]

A- alcohol
U- use
D- disorders
I- identification
T- test

Advantages: can distinguish light from heavy drinkers; validated cross-culturally (so it is useful for identifying alcohol problems among ethnic minority groups); early identification of harmful drinking.
Disadvantage: not designed for pregnant populations.

NET [19, 24]

N- normal drinkers
E- eye opener
T- tolerance

Advantages: specifically designed for pregnant women; high specificity.
Disadvantages: low sensitivity; for heavy or late stage drinkers only.

TLFB calendar [19]

T- time
L- line
F- follow
B- back

Advantages: high level of reliability and validity; determines the amount and timing of alcohol use; takes approximately 10 minutes to administer during the 1st prenatal visit, and about 3 to 5 minutes at each subsequent visit; meets the criteria for screening both mother and fetus; can lead to early detection and treatment.

4 P's [12, 17, 18, 19, 24, 26]

Parental drug use
Partner drug use
Personal drug use
Pregnancy drug use

Advantages: includes partner consumption; easy to administer and score.
Disadvantage: low specificity.

Modified 5 P's [12, 24, 26, 27, 28]

Parental drug use
Partner drug use
Peer drug use
Personal drug use
Pregnancy drug use

Advantages: takes less than a minute; highly sensitive; is easily integrated into the initial prenatal visit and used for follow-up screening through pregnancy; identifies heavy drinkers, tobacco and drug users as well.
Disadvantage: potential lack of specificity.

Two-item screen [17]

Current alcohol or drug problems can be detected in patients asking them 2 questions:

Q 1. "In the last year, have you ever drunk or used drugs more than you meant to?"
Q 2. "Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?"

Advantages: very easy screening tool; can be easily integrated into the patient interview; patients tend to be more candid.

Urine testing: [17, 22]

A specimen of the mother's urine is analyzed by a laboratory for metabolites of alcohol or drugs (toxicology). Urine tests are used (with or without consent) to identify women who are substance users. Most patients consent to urine drug testing if they understand that it is a routine part of prenatal care. If a patient admits to substance use and agrees to prenatal care, then she should be tested at every prenatal visit. In addition, it is required that she be informed that a positive urine or meconium test in the newborn will trigger a Child Protective Service (CPS) intervention.

Advantages: sensitive and specific for recent drug use
Disadvantages: does not distinguish occasional use from drug abuse or dependence; testing without informed consent may violate patient autonomy; the predictive value of positive test results may be low in populations with a low prevalence of drug use; patients may be discriminated against if confidentiality of results is not ensured.

With the exception of THC, almost all other substances are excreted within 72 hours and most active drug users can avoid detection by abstaining for 1-3 days. Thus, a negative test does not rule out substance use. Given that most studies indicate that 15-20 percent of patients use alcohol or drugs during pregnancy, it follows that urine testing can reveal 50-70 percent of users on any specific visit. Thus repeated urine testing will eventually reveal the majority of common substance use.

Meconium testing of the newborn [5]

A specimen of the baby's first bowel movement (meconium) is analyzed by a laboratory for metabolites of alcohol or drugs (toxicology).

Advantages: more sensitive and accurate than urine testing; can detect second trimester exposure to drugs.
Disadvantages: available for only two days after birth.

Hair analysis [5]

A specimen of the mother's scalp hair is analyzed by a laboratory for drug residue.

Advantages: widely used; reflects exposure to drugs during the last trimester of pregnancy, hence, it is diagnostic of maternal substance use.

5 A's Brief Intervention [18, 32, 39]

Ask: Ask about tobacco use
Advise: Advise patients to quit
Assess: Assess patient's willingness to make a quit attempt
Assist: Assist patients in their quit attempt
Arrange: Arrange follow-up contact within the first week after the quit date

Advantages: easy to administer, objective and unbiased.

ALCOHOL, TOBACCO AND OTHER DRUG TREATMENT RECRUITMENT AND RETENTION

One of the most difficult aspects of ATOD treatment is identifying women using ATOD and drawing them into care. Active recruitment and outreach efforts are needed to help women overcome self-imposed barriers and enter substance use treatment programs. Non-traditional outreach methods using former users and addicts, aggressive outreach techniques, and immediate response may be effective in reducing pre-admission hurdles. Moreover, women using ATOD frequently lack knowledge regarding treatment service availability, and the means by which to access that service. Also, women using ATOD with lower levels of self-esteem and higher levels of emotional distress have more difficulty participating in ATOD treatment and are more pessimistic about the prospect of making positive changes in their lives. [29]

Research suggests that several substance-related factors play important roles in women's enrollment in and completion of substance use treatment. The *type* of substance used appears to be important. For example, women who use alcohol have been shown to be more likely to complete treatment compared to women who use illegal drugs such as heroin, amphetamines, and tranquilizers. Women's *levels* of substance use are also related to the entry into and continuation of treatment, with heavy users being more likely to enter and complete treatment. Lastly, the *past experience* of substance use treatment

also appears to influence the current treatment participation with those with a longer history of use more likely to enter and complete treatment. [4]

Individuals with substance use problems are more likely to enroll in treatment if they have participated in such programs in the past. Also, women enrolled in substance use treatment for the first time have been found to be more likely to complete treatment compared to women who have been enrolled in treatment more than once. In general, it appears that the women with the most severe substance use problems accepted the treatment services. However, many high-risk women declined enrollment in the substance use treatment services. [4] Prior treatment of the patient and her partner were also important factors in predicting pregnant women enrollment into substance use treatment. Lastly, women using ATOD who live with partners who also use substances, are less likely to seek treatment compared with women using ATOD who live with partners who are substance-free. [8]

White women are generally more likely than African American women to enter into and complete treatment. This may be, at least in part, because white women often experience fewer barriers to substance use treatment than do women of other racial groups. There is a positive association between income level and utilization of substance use services. Women who accept treatment are more likely to be single and have a significantly greater number of children. Older women are more likely to enter treatment programs and to successfully complete them, compared to younger women. This may be because older women have potentially longer histories of substance use, and more time and opportunity to seek treatment. Also, women who accept treatment are more likely to have experienced physical and/or sexual abuse, by their past or current partner, during pregnancy. Additionally, women who accept treatment tend to suffer from more severe dependency problems and may be in greater need of professional help, compared to women who decline treatment. Thus, women who accept treatment are more likely to report the continuation of substance use during pregnancy, while women who decline treatment are more capable of quitting or decreasing their level of substance use "on their own" without the aid of professional treatment. [4]

Implementing services such as case management, child care, supportive housing and residential treatment for women and their children, has shown to increase retention among pregnant women. [30] Other treatment modalities involve congratulating patients that quit, encouraging continued abstinence and motivating quit attempts, resulting in much higher quit rates. [31] In addition, cognitive behavioral interventions, recovery support groups, contingency management, giving patient tangible incentives (handing out vouchers in response to drug free urines), matrix model (16 weeks of cognitive behavioral therapy groups, family education groups, social support groups, individual counseling combined with weekly drug and alcohol testing) and MOM (Moms Off Meth) are also some of the successful approaches. [27] WIC is the special supplemental food program for Women Infants and Children where workers have the potential to discuss alcohol, drug, and cigarette use issues with many low income women. [9]

Recruitment and retention of drug using pregnant women poses additional challenges. Drug users are frequently enrolled in residential treatment programs, often as

part of a court order to drug offenses and not because the health care provider referred the patient to ATOD treatment. Patients entering residential programs experience lower rates of drug use, imprisonment, and unemployment than drug users who do not enroll. [22] Among pregnant and parenting women, intrinsic motivation and degree of treatment readiness has been correlated with retention and relapse. [2]

A 2001 study of 24 residential ATOD treatment programs across the country found that the primary source of treatment referral for pregnant and post-partum women was child protective services (CPS) agencies, followed by substance use treatment providers, and the criminal justice system (CJS). It appears that CJS is the most effective in identifying and encouraging pregnant women to seek treatment. The pregnant women required by CPS to obtain treatment were much more likely to "fail" the treatment. These women are placed under more intense scrutiny, which in turn could be perceived as additional pressure, making treatment and recovery more difficult. [31]

The desire to avoid imprisonment may be responsible for higher enrollment rates among women with more severe legal problems. Although some studies suggest that legal pressure may be associated with enrollment in drug treatment, this should not be construed to mean that threats of legal action against an expectant mother will bring her into treatment willingly. On the contrary, coercive legal policies that are designed to protect the fetus but which pit the rights of mother and unborn child against one another can weaken the trust and result in reduced contact with prenatal care. Failure to receive prenatal care is an especially unfavorable outcome for this population because, even in the absence of maternal abstinence, good prenatal care improves pregnancy outcome. [33]

CHAPTER 3: PREVALENCE OF ALCOHOL, TOBACCO, AND OTHER DRUG USE AMONG PREGNANT WOMEN AND WOMEN OF CHILDBEARING AGE IN INDIANA

This chapter focuses on the prevalence of alcohol, tobacco and other drug (ATOD) use by pregnant women and women of childbearing age nationally and in Indiana. It should be understood that there is currently no definitive source for ATOD prevalence in the U.S. or Indiana. Most of the data sources rely on self-reported substance use, which is known to not only be inaccurate, but underestimates the true use as well. Other data sources focus on specific sub-populations of women whose substance use may not mirror the substance use of women in the general population. Consequently, prevalence estimates of ATOD use during pregnancy vary considerably from data source to data source.

The first section of this chapter summarizes the estimates of ATOD use published in the literature. The second section presents the prevalence estimates of substance use from existing data sources nationally and in Indiana. These data are the best estimates of prevalence currently available. The third section describes the data sources used for this project and their limitations. Finally, a summary of prevalence estimates from all of the sources is shown in the fourth section.

PREVALENCE OF RISK FACTORS AND ATOD USE REPORTED IN PUBLISHED LITERATURE

In the United States, approximately 15-19 percent of women use alcohol, 14-20 percent smoke cigarettes and 5 percent use one or more illegal drugs during pregnancy. [8]

Alcohol: Risk factors for maternal alcohol use include Non-Hispanic white women who are more than 30 years of age, single, college educated, and employed. Physical abuse, sexual abuse and being a current smoker were also identified as risk factors for maternal alcohol use. [6, 7, 9, 13] Women who are heavy drinkers, defined as more than 5 drinks per occasion on 5 or more days in the past 30 days, are characteristic of 5.3 percent of 18-24 year olds and 3.4 percent of women aged 25 years or older. The prevalence rate for binge drinking, defined as having 5 or more drinks on any one occasion, among women age 18-44 years was 12.4 to 16.2 percent (Indiana range: 5.4%-21.6%). [17] A higher percentage (10%) of women engage in binge drinking in the first trimester. [10]

Tobacco: In Indiana, 18.5 percent pregnant women smoke (2004, ISDH provisional data) compared to 10.7 percent pregnant women who smoke in the U.S. (2004, ISDH provisional data). Indiana ranks as the 7th worst state in the U.S. for smoking. [34] Prevalence of smoking is higher among pregnant women who are American Indian, Non-Hispanic white, 18-24 years old, unmarried, and drinkers. In addition, pregnant women with low levels of education and income have higher smoking prevalence. [7, 35, 36, 37, 38] One of the *Healthy People 2010* goals is to help the nation achieve no more than 1 percent prevalence of smoking during pregnancy. [32, 81] Pregnant

women who quit smoking had different demographic profiles compared to those who continued to smoke during pregnancy. Those pregnant smokers who quit smoking more often completed high school and were more often married. Pregnant smokers who quit were less dependent on nicotine, started smoking regularly at a later age, and more often had a non-smoking partner. Women who were least likely to quit tended to smoke more heavily than those who quit. [39] About 30 percent of female smokers quit on their own upon learning they were pregnant. The rest need intervention and support to help them quit. Smoking cessation rates improved when women were systematically screened and offered treatment. Women who stopped smoking before pregnancy or during the first three months reduced their risk of having a low birth weight baby compared to women who never smoked. [15] Women with low intentions to quit smoking were less confident in their ability to quit smoking, less likely to have private health insurance, and less convinced that smoking harms the unborn child. Additionally, those who continued to smoke during pregnancy smoked more cigarettes per day, had fewer years of education, and were more likely to have friends and family members who smoke. These variables, associated with low intentions to quit smoking early in prenatal care, reflected smoking beliefs, substance use, demographic, characteristics and the social environment. [40]

Information collected about pre-pregnancy smoking status and about the smoking status of other household members would provide information essential to effective counseling. Patients of family physicians who were asked about their tobacco use or counseled about quitting were more likely to be satisfied with their physicians. [41] Given the social stigma attached to smoking during pregnancy, telephone quit lines may be particularly attractive to pregnant women seeking confidential cessation services. [3] Cigarette smoking is a strong predictor of illicit drug use. [42] Women who have reported smoking at least half-pack of cigarettes a day during pregnancy were 10 times more likely to be using illicit substances. [4] Pregnant women who continued to smoke were 8 times more likely to drink alcohol during their pregnancy than non-smokers. [7, 35, 36, 37]

Other Drugs: Six sets of factors that influence substance use during pregnancy include [1]:

- Demographic factors, such as, immigrant status, race/ethnicity, age;
- Socio economic background, such as income, education;
- Psychosocial resources, especially family and non-family social support;
- Paternal behaviors, such as, domestic violence, substance use history;
- Maternal stress, especially related to whether the pregnancy was wanted; and,
- Health history, including previous drug use.

Drug use is more prevalent among unmarried, unemployed women with less than a high school education, and previous physical abuse. Such women have a family history of alcohol or drug problems, history of childhood sexual abuse, depressive symptoms, partner involvement in alcohol and/or drug use, homelessness, transience, and inadequate social support. [22, 31, 42] Many have histories of abusive or violent relationships with men. [29] Regardless of marital status, a woman's substance use during pregnancy is highly correlated with her partner's substance use and the degree of emotional support he provided. Hence, attention should be given to intervention efforts that include women's

partners. Women at risk for prenatal substance use tend to have partners with a history of substance use, an unwanted pregnancy, and previous participation in alcohol or drug treatment programs. These are women who typically have not received early prenatal care. [1] Problems specific to many women who are substance users include low self-esteem and late entry into recovery which is often prompted by the criminal justice system (CJS) or child protective service (CPS) agencies. [29]

Women who use crack and other forms of cocaine account for the largest group of pregnancies at risk from illicit drugs. Methadone maintenance is the usual treatment for pregnant women addicted to opiates: withdrawal during pregnancy is dangerous, and the regular contact required for methadone treatment may encourage women to receive regular prenatal care. Methadone can be safely withdrawn after delivery but it prolongs withdrawal in the infant. Pregnant women who use drugs should be advised of the importance of regular prenatal care and be referred for treatment, where available. [22] Methamphetamine use is rapidly increasing in Indiana, particularly in Evansville, Terre Haute and other southwestern rural areas. Data from 4,337 newborn meconium screens conducted on women who met the Meconium Screening Program (MSP) criteria in Indiana during 2004 revealed that about 20 percent were positive overall: marijuana (10.5%), cocaine (7.2%), opiates (3.5%) and methamphetamines (0.9%). [17]

It is important for clinicians to be aware of the difficulties faced by pregnant women using ATOD, to help them develop motivation and skills to engage their partners and support systems, in their attempts to stop substance use. The association of social support with spontaneous alcohol abstinence suggests that the frequent contacts women have with health professionals during pregnancy may provide valuable opportunities to discuss both alcohol and tobacco use, and to encourage and educate the women about needed health behavior changes. Clinicians are an important source of social support. Public health messages encouraging women to stop alcohol and tobacco use during pregnancy and to maintain cessation of tobacco after birth, need to be framed and communicated in such a way that it is sensitive and relevant, in order to maximize the health benefits to the women and their children. [38]

PREVALENCE ESTIMATES FROM EXISTING DATA SOURCES

For this section of the report, the authors examined many sources of existing data both nationally and in Indiana. Those sources selected for use in this report were judged to be the most valid and reliable, based their use of well established, scientifically sound procedures to collect the data. Where similar data were available from multiple sources, data that was collected on randomly selected individuals were chosen over data collected from less representative samples, to ensure that the prevalence estimates were as valid as possible.

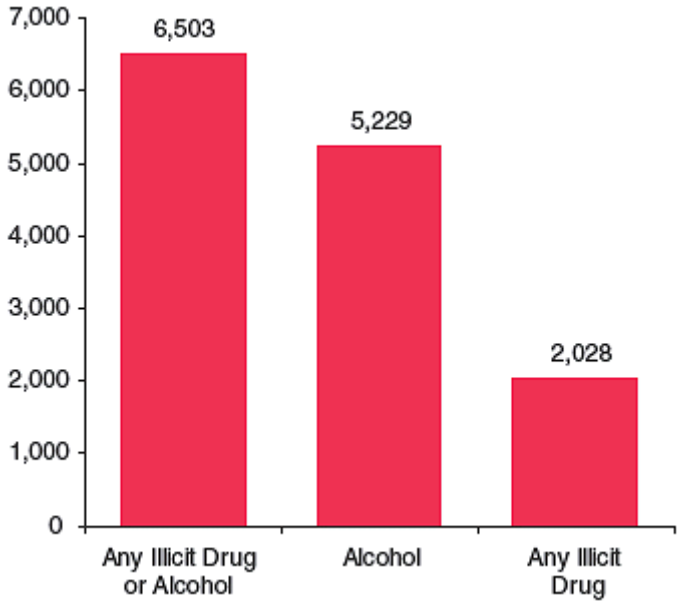
A. Alcohol Use Prevalence Estimates

1. Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) Report

Figures 3.A.1.1 to 3.A.1.6 and Tables 3.A.1.1 and 3.A.1.3 are from two special reports by SAMHSA based on the 2003 and 2004 National Survey on Drug Use and Health (NSDUH): "Substance Abuse and Dependence among Women" (August 5, 2005) [43] and "Pregnancy and Substance Use" (January 2, 2004).[44] Both reports present data on the use, abuse, or dependency on alcohol and other drugs. The report on pregnant women also covers tobacco use. Some of the figures shown in this section include data on combined drug and alcohol use as well as for alcohol use only.

NSDUH defines ***dependence on or abuse of illicit drugs or alcohol*** using criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), including symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home during the past year. The following four figures (3.A.1.1 to 3.A.1.4) are therefore not directly comparable with other data in this report that report the ***use*** of alcohol or illicit drugs.

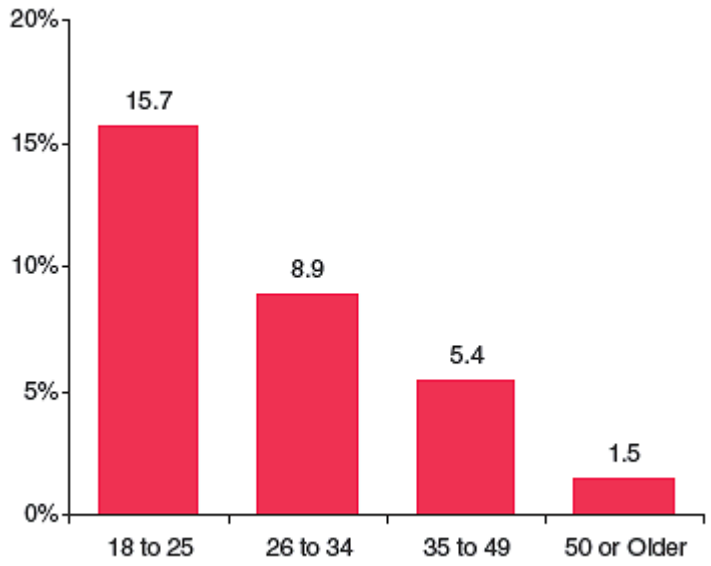
Figure 3.A.1.1 NSDUH: Estimated Numbers (in Thousands) of Women Aged 18 or Older in the United States Who Abused or Were Dependent on Alcohol or Any Illicit Drug in the Past Year: 2003 [43]



- Nationally, over 6.5 million adult women are estimated to abuse or be dependent on alcohol or any illicit drug. (Figure 3.A.1.1)

- Over twice as many adult women are estimated to abuse or be dependent on alcohol alone compared to illicit drugs alone. (Figure 3.A.1.1)

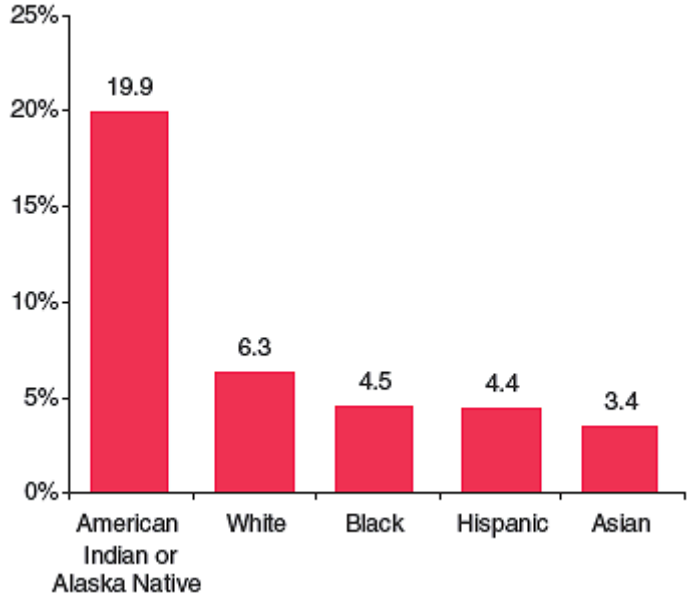
Figure 3.A.1.2 NSDUH: Percentages of Past Year Abuse of or Dependence on Alcohol or Any Illicit Drug among Women Aged 18 or Older, by Age Group: 2003 [43]



- In 2003, an estimated 5.9 percent of ***women aged 18 or older*** met criteria for abuse of or dependence on alcohol or an illicit drug in the past year (SAMHSA Report)

- Younger adult women were much more likely to abuse or be dependent of alcohol or any illicit drug. (Figure 3.A.1.2)

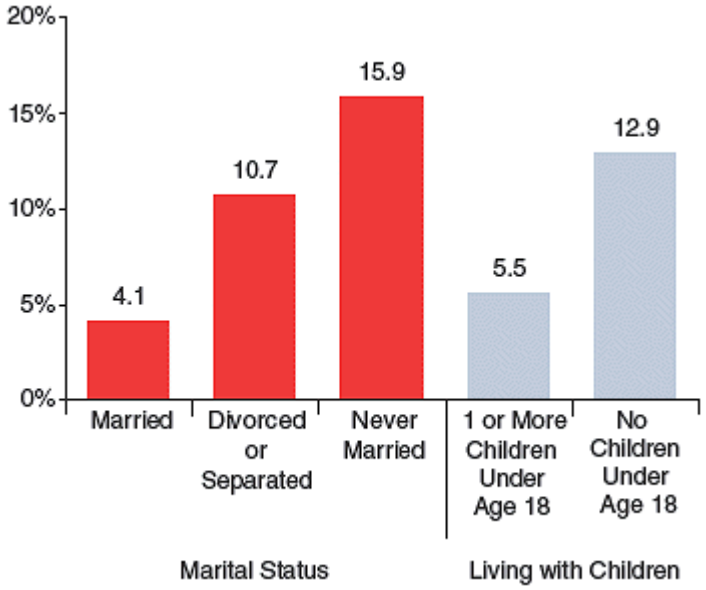
Figure 3.A.1.3 NSDUH: Percentages of Past Year Abuse of or Dependence on Any Illicit Drug or Alcohol among Women Aged 18 or Older, by Race/Ethnicity: 2003 [43]



- Nationally, American Indian or Alaska Native adult women had about a 3 fold higher rate of abuse of or dependence on alcohol or any illicit drug than women in other racial or ethnic groups. (Figure 3.A.1.3)

- Among White, Black, Hispanic and Asian adult women, the rates of abuse of or dependence on alcohol or any illicit drug were similar. (Figure 3.A.1.3)

Figure 3.A.1.4 NSDUH: Percentages of Past Year Abuse of or Dependence on Any Illicit Drug or Alcohol among Women Aged 18 to 49, by Marital Status and Living with or without Children: 2003 [43]



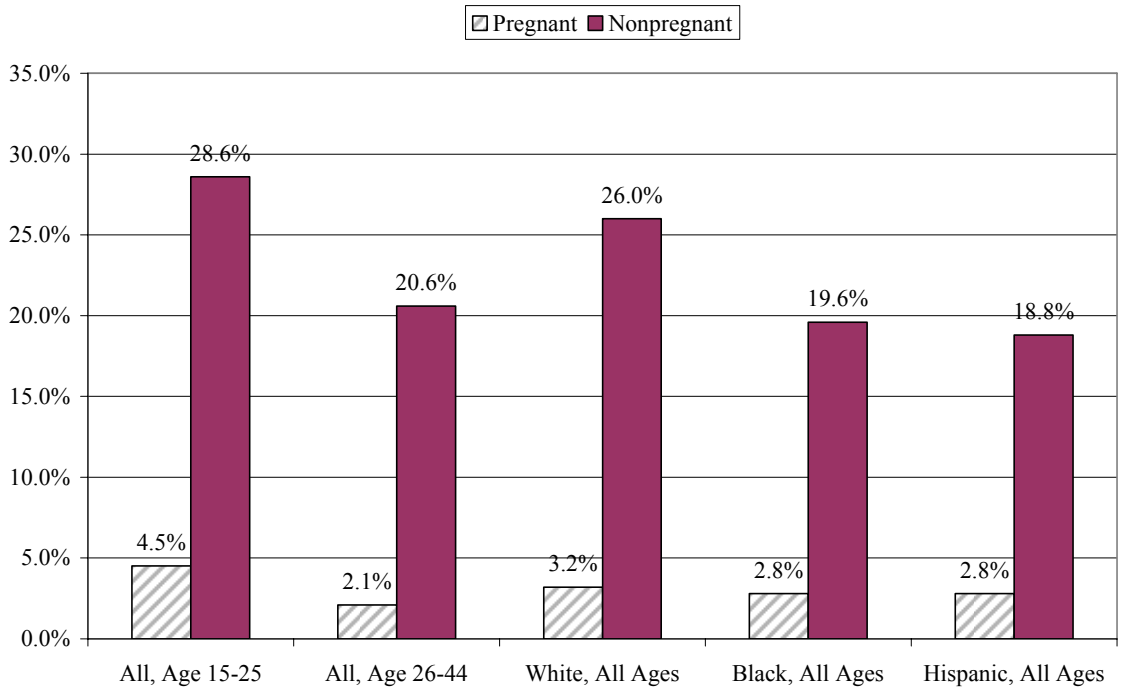
- In 2003, among women aged 18 to 49, never married women had a nearly 4 times higher rate of substance (alcohol or illicit drug) abuse or dependence than married women. (Figure 3.A.1.4)

- The rate for divorced or separated women was about two and a half times higher than for married women. (Figure 3.A.1.4)

- The rate for women with children was one half the rate for women without children. (Figure 3.A.1.4)

Figures 3.A.1.5 and 3.A.1.6 are from the SAMHSA report "Pregnancy and Substance Use" (January 2, 2004). They relate to *use* of substances rather than *abuse and dependence* used in figures 3.A.1.1. to 3.A.1.4.

Figure 3.A.1.5 NSDUH: Percentages of Past Month Binge Drinking among Women Aged 15 to 44, by Pregnancy Status, Age, and Race/Ethnicity: 2002 [44]

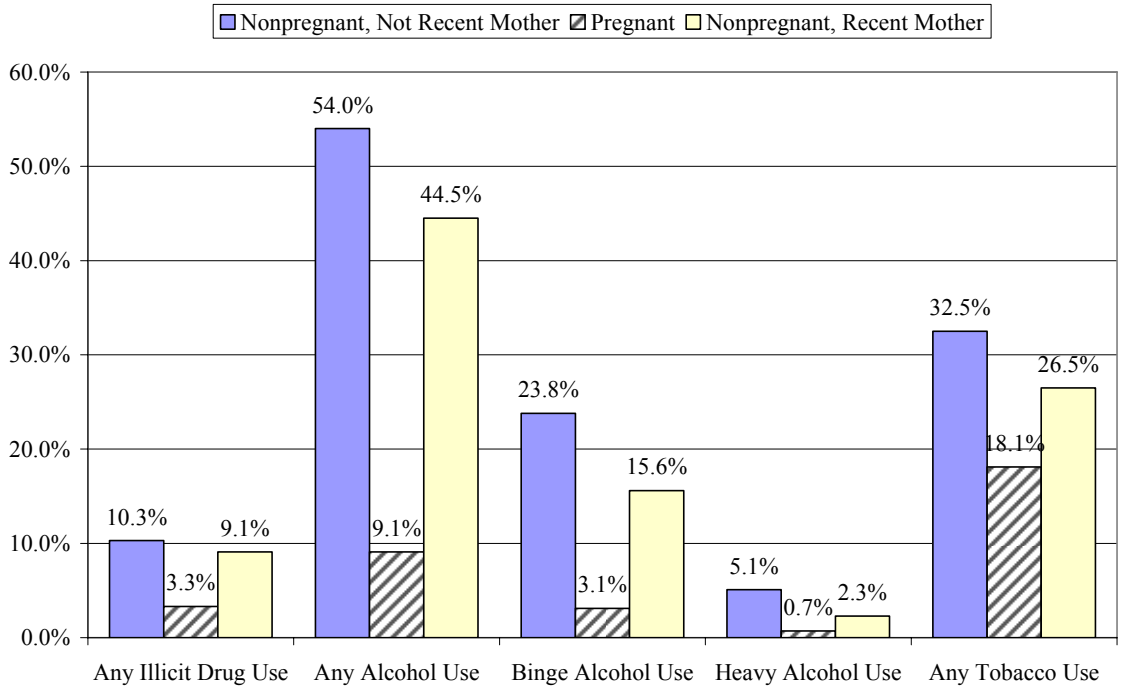


- In general, pregnant women were much less likely to binge drink and drink alcohol heavily than non-pregnant women. (Figure 3.A.1.5)

- The rate of past month binge alcohol use among pregnant women aged 15 to 25 (4.5%) was more than twice the rate reported by pregnant women aged 26 to 44 (2.1%). (Figure 3.A.1.5)

- For all of the racial/ethnic groups (White, Black, and Hispanic) women who were pregnant had much lower rates of past month binge drinking than non-pregnant women. (Figure 3.A.1.5)

Figure 3.A.1.6 NSDUH: Percentages of Women Aged 15 to 44 Reporting Past Month Substance Use, by Pregnancy and Recent Motherhood Status: 2002 [44]



- In 2002, nationally, among ***pregnant women*** aged 15 to 44 nearly 20 percent (18.1%) used tobacco, nearly 10 percent (9.1%) used alcohol and only a small percent (3.3%) used illicit drugs in the previous month. (Figure 3.A.1.6)

- In 2002, ***pregnant women aged 15 to 25*** were more likely to use illicit drugs, binge drink, and smoke cigarettes in the past month than ***pregnant women aged 26 to 44.*** (SAMHSA Report)

- Routinely, ATOD use rebounds for new mothers following a significant decrease during pregnancy. The largest decline during pregnancy and the largest recidivism was seen in alcohol use rates. (Figure 3.A.1.6)

More recent national data from the NSUDH was also available for women of childbearing ages by pregnancy status. The following three tables (3.A.1.1 to 3.A.1.3) give alcohol use, binge drinking, and heavy alcohol use by demographic characteristics for the nation as a whole.

Table 3.A.1.1 NSDUH: Alcohol Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	51.3	51.1	9.8	11.2	53.0	52.8
AGE						
15-17	28.5	28.4	14.5	14.9	28.7	28.5
18-25	55.7	55.9	10.5	10.6	58.7	58.7
26-44	53.0	52.6	8.9	11.3	54.6	54.3
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	53.7	53.5	10.1	11.2	55.3	55.3
White	57.8	58.2	10.8	11.8	59.6	60.2
Black or African American	41.0	39.5	6.4	9.6	42.2	40.6
American Indian or Alaska Native	49.8	49.5	*	*	51.7	50.6
Native Hawaiian or Other Pacific Islander	40.9	*	*	*	42.1	*
Asian	34.9	31.8	*	*	36.0	33.3
Two or More Races	53.3	57.4	*	*	55.6	59.2
Hispanic or Latino	37.9	37.6	8.6	11.0	39.6	39.0
TRIMESTER[2]						
First	N/A	N/A	19.6	22.2	N/A	N/A
Second	N/A	N/A	6.1	7.0	N/A	N/A
Third	N/A	N/A	4.7	4.9	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

Table 3.A.1.2 NSDUH: Binge Alcohol Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	22.4	22.5	4.1	4.5	23.2	23.3
AGE						
15-17	16.6	17.3	7.0	8.8	16.7	17.3
18-25	31.7	32.0	4.8	5.1	33.5	33.7
26-44	19.7	19.4	3.3	3.8	20.3	20.1
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	23.3	23.3	4.4	4.7	24.0	24.1
White	25.3	25.5	4.0	4.1	26.1	26.4
Black or African American	18.3	17.2	3.0	5.7	18.7	17.5
American Indian or Alaska Native	34.3	37.7	*	*	35.1	38.3
Native Hawaiian or Other Pacific Islander	*	15.3	*	*	*	15.4
Asian	9.0	9.1	*	*	9.1	9.3
Two or More Races	23.7	26.6	*	*	24.7	27.4
Hispanic or Latino	17.8	18.1	2.9	3.7	18.6	18.8
TRIMESTER[2]						
First	N/A	N/A	10.9	10.6	N/A	N/A
Second	N/A	N/A	1.4	1.9	N/A	N/A
Third	N/A	N/A	0.7	1.1	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

Table 3.A.1.3 NSDUH: Heavy Alcohol Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	5.1	5.3	0.7	0.5	5.3	5.6
AGE						
15-17	3.6	3.9	0.1	*	3.7	3.9
18-25	8.8	8.9	0.7	0.7	9.3	9.4
26-44	3.9	4.1	0.6	0.3	4.1	4.3
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	5.6	5.9	0.8	0.6	5.8	6.1
White	6.4[a]	6.8	0.8	0.6	6.7[a]	7.1
Black or African American	2.9	2.7	0.5	*	2.9	2.9
American Indian or Alaska Native	6.8	8.2	*	*	7.0	8.3
Native Hawaiian or Other Pacific Islander	6.2	4.1	*	*	6.1	3.9
Asian	2.2	1.9	*	*	2.3	2.0
Two or More Races	5.4	5.8	*	*	5.6	6.0
Hispanic or Latino	2.4	2.3	0.2	0.2	2.5	2.4
TRIMESTER[2]						
First	N/A	N/A	1.6	1.6	N/A	N/A
Second	N/A	N/A	*	*	N/A	N/A
Third	N/A	N/A	0.1	0.1	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
NOTE: Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on each of 5 or more days in the past 30 days.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

Alcohol use during pregnancy (Table 3.A.1.1):

- Alcohol use among 15-17 year olds (14.5%) was higher than for those ages 18 to 25 (10.6%) and those ages 26 to 44 (11.3%); 15-17 year old women were less likely to curtail their drinking when they become pregnant, compared to the older women.

- Alcohol use in the past month was far less for pregnant women (11.2% in 2003-2004) than for non-pregnant women (52.8%).

- Overall, Hispanic women were less likely to drink alcohol (37.6% vs. 53.5%), but during pregnancy, there was little difference in the drinking rates by race/ethnicity (9.6% to 11.8%).

- There was over a three fold decrease in the rate of alcohol use during the first trimester (22.2%) to the second trimester (7.0%); the rate was cut in half again by the third trimester (4.9%).

Binge Alcohol use during pregnancy (Table 3.A.1.2):

- Binge drinking among 15-17 year olds (7.0%) was higher than for those ages 18 to 25 (4.8%) and those ages 26 to 44 (3.3%).

- Binge drinking in the past month was far less for pregnant women (4.5% in 2003-2004) than for non-pregnant women (23.3%).

- Overall, Hispanic women were less likely to have episodes of binge drinking (18.1% vs. 23.3%), but during pregnancy, there was little difference in the binge drinking rates by race/ethnicity (3.7% to 5.7%).

- There was over a five fold decrease in the rate of binge drinking during the first trimester (10.6%) to the second trimester (1.9%); the rate was cut in half again by the third trimester (1.1%).

Heavy alcohol use (5+ drinks on 5+ days in the past month) during pregnancy (Table 3.A.1.3):

- Heavy alcohol use in the past month was far less for pregnant women (0.5% in 2003-2004) than for non-pregnant women (5.6%).

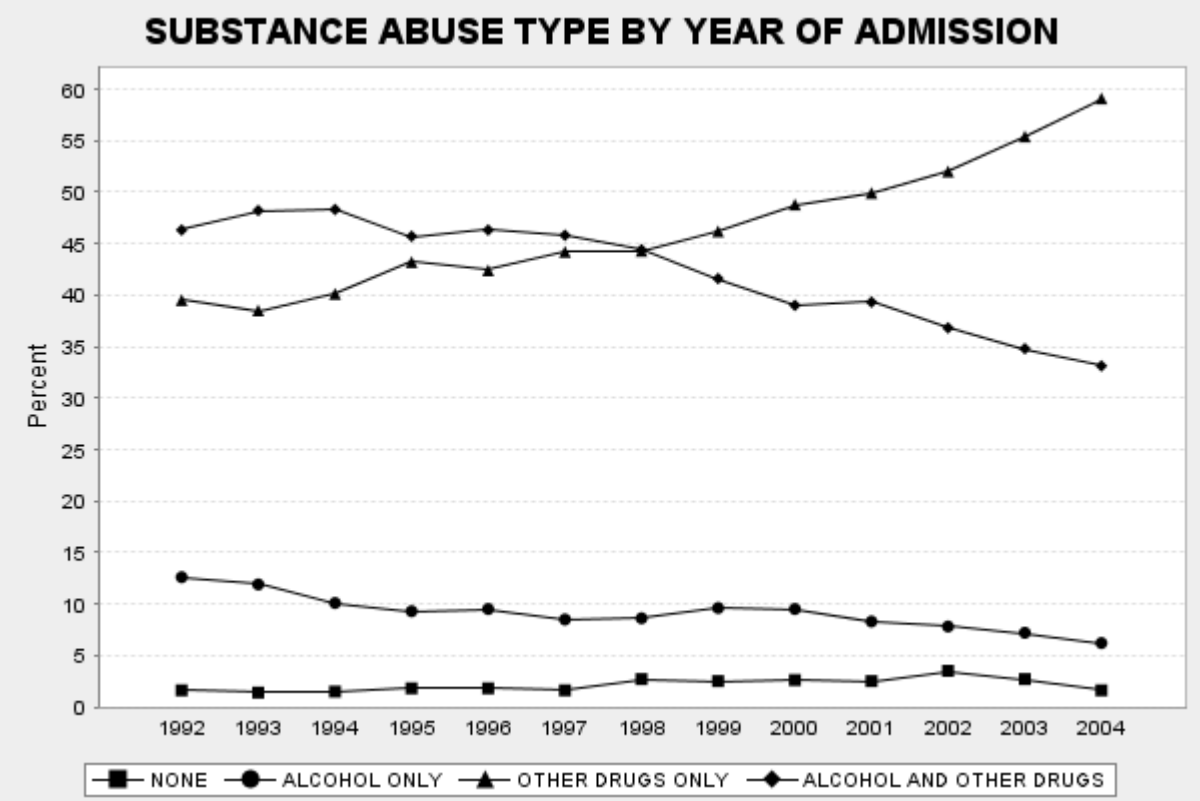
- Overall, Hispanic women were less likely to be heavy drinkers (2.3% vs. 5.9%), but during pregnancy, there was little difference in the heavy drinking rates by race/ethnicity (0.2% to 0.8%).

- There was over a 16 fold decrease in the rate of heavy alcohol use during the first trimester (1.6%) to the third trimester (0.1%).

2. Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment Episode Data Set (TEDS)

This dataset contains information about people receiving substance use treatment in SAMHSA supported treatment centers.

Figure 3.A.2.1 TEDS: U.S. Pregnant Women Ages 15-44 (reported numbers have been shown in the table below) [46]



Number reported in TEDS (total U.S.)

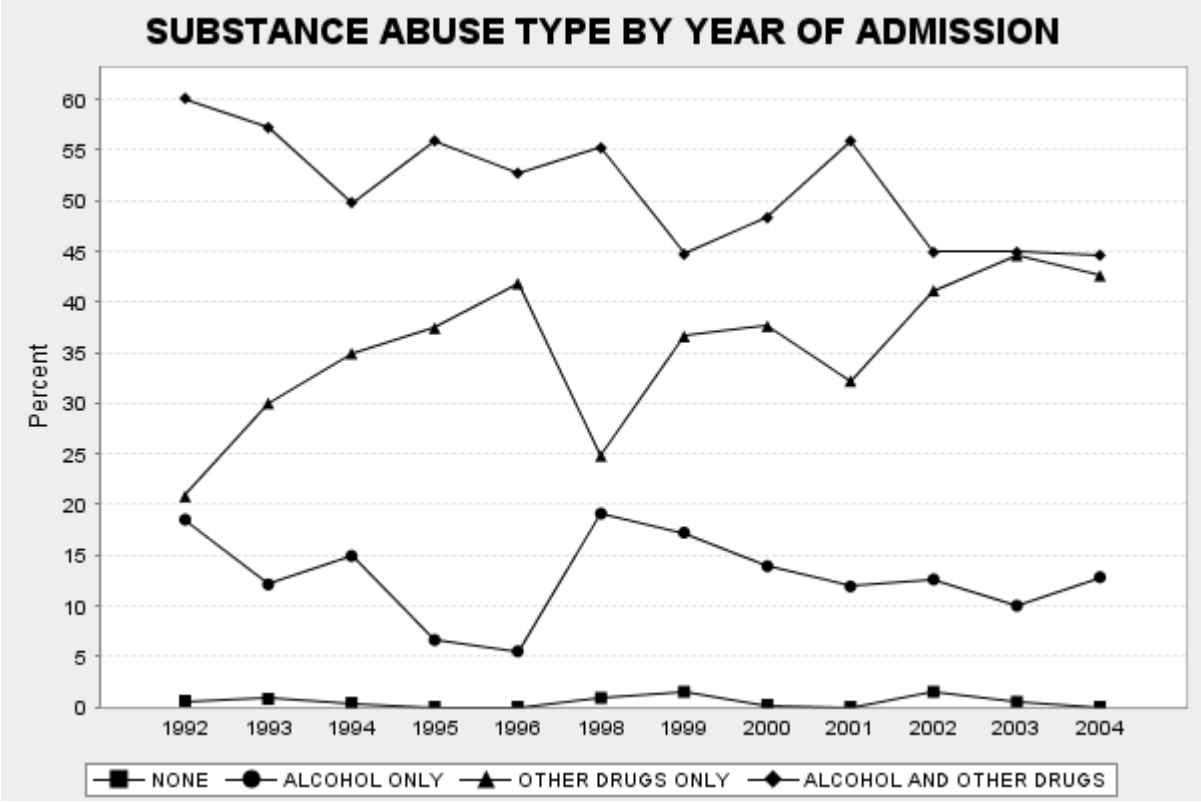
1992	1993	1994	1995	1996	1998	1999	2000	2001	2002	2003	2004
16,147	*17,121*	*17,729*	*17,642*	*16,863*	*17,120*	*16,875*	*16,782*	*17,397*	*17,574*	*18,783*	*19,431*

- Nationally, the percentage of pregnant women being treated for alcohol use only has declined slightly over the reporting period. (Figure 3.A.2.1)

- The percent of pregnant women being treated for alcohol and other drugs together has declined during the reporting period. (Figure 3.A.2.1)

- There has been an increase in the percent of pregnant women being treated for other drugs only from 1992 to 2004, and currently is the largest segment of pregnant women in treatment. (Figure 3.A.2.1)

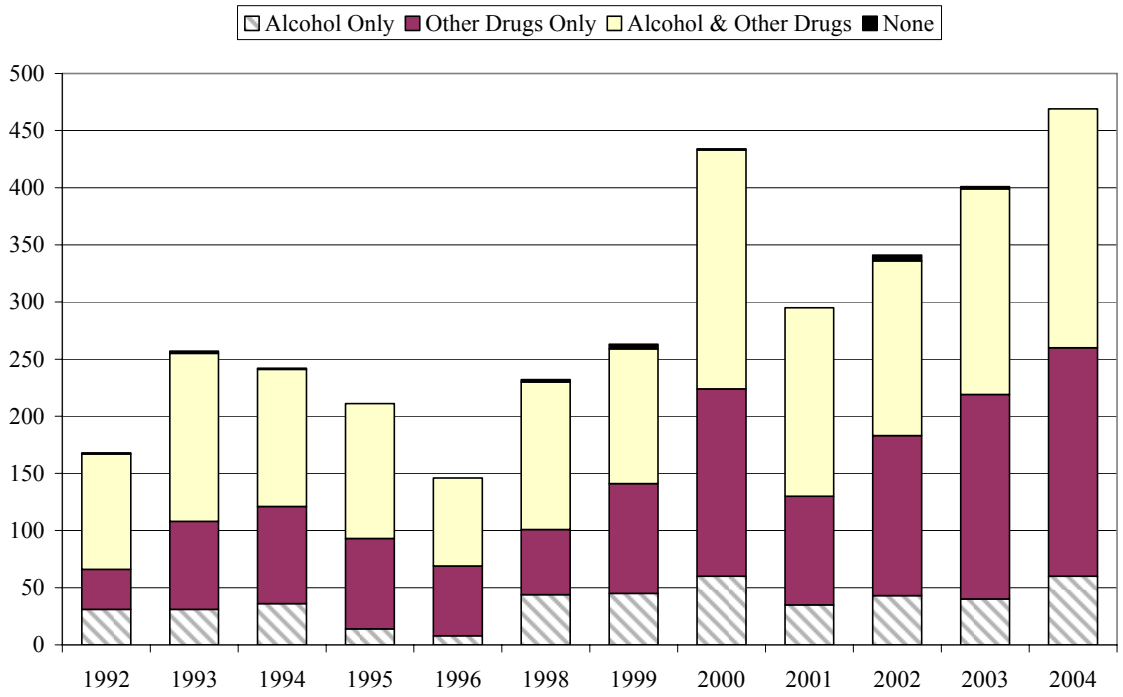
Figure 3.A.2.2 TEDS: Indiana Pregnant Women Ages 15-44 (reported numbers shown below figure) [46]



Number reported in TEDS (Indiana)

1992	1993	1994	1995	1996	1998	1999	2000	2001	2002	2003	2004
168	*257*	*241*	*211*	*146*	*230*	*262*	*433*	*295*	*341*	*401*	*469*

Figure 3.A.2.3 TEDS: Number of Indiana Women Pregnant at Admission to Treatment [46]



- In Indiana, the number of pregnant women receiving treatment in SAMHSA supported treatment centers has increased over the reporting period and has been much more rapid than the national pattern. (Figure 3.A.2.2, Figure 3.A.2.3)

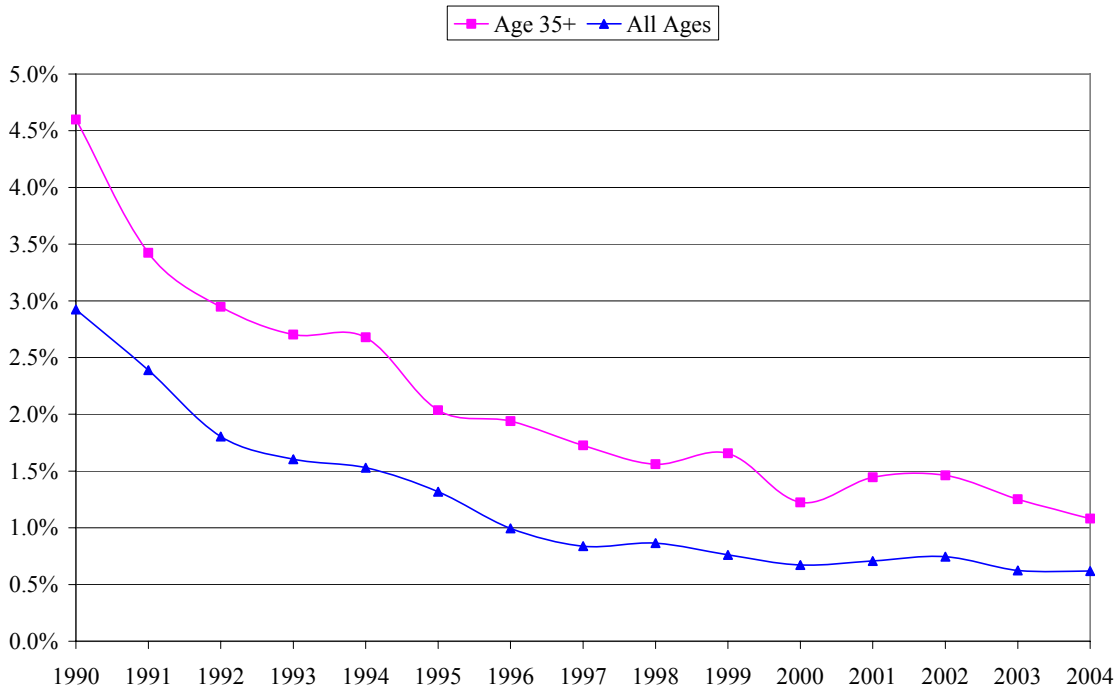
- The percentage of pregnant women being treated for alcohol use only has not changed much over the reporting period. (Figure 3.A.2.2, Figure 3.A.2.3)

- The percent of pregnant women being treated for alcohol and other drugs together has declined during the reporting period. (Figure 3.A.2.2, Figure 3.A.2.3)

- There has been an increase in the percent of pregnant women being treated for other drugs only from 1992 to 2004. (Figure 3.A.2.2, Figure 3.A.2.3)

3. Indiana State Department of Health (ISDH), Birth Certificate Data Reports

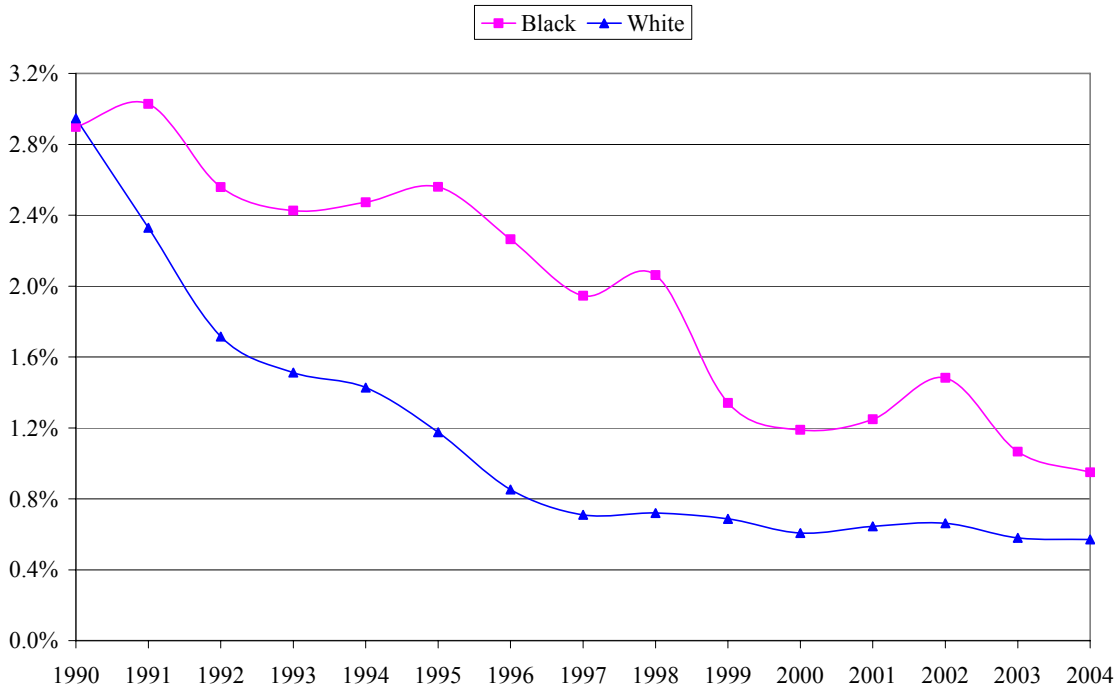
Figure 3.A.3.1 ISDH: Alcohol Use from Indiana Birth Certificates [47]



- The overall trend is consistently downward from 1990 to 2004. "Used" alcohol was down from about 3 percent in 1990 to less than 1 percent in 2004. (Figure 3.A.3.1)

- Young mothers (less than 20 years old) reported less alcohol use during the reporting period. The trends and levels are similar for the 18-19 and 15-17 year old groups. The trend in "used" was from nearly 1.5% in 1990 to less than 0.4% in 2004. (Birth Certificate Data)

Figure 3.A.3.2 ISDH: Alcohol Use from Indiana Birth Certificates by Race [47]

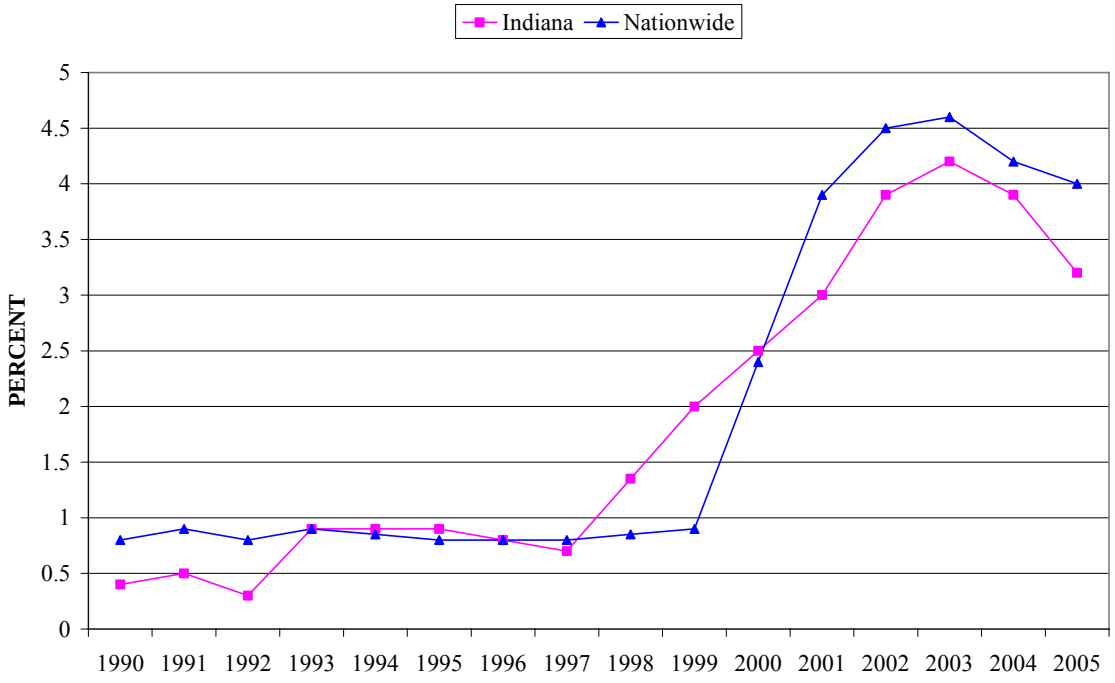


- Black mothers were more likely to report alcohol use than white mothers in every year from 1991 through 2004. (Figure 3.A.3.2)

- In 1990, the percent who used alcohol was about 3 percent for both racial groups, but a downward trend in use of alcohol began earlier for white mothers. By 2004 the gap had greatly narrowed, but black mothers still reported a higher rate of alcohol use (0.9% vs. 0.6%). (Figure 3.A.3.2)

4. Centers for Disease Control Prevention(CDC) and Indiana State Department of Health (ISDH), Behavioral Risk Factor Surveillance System (BRFSS) Reports

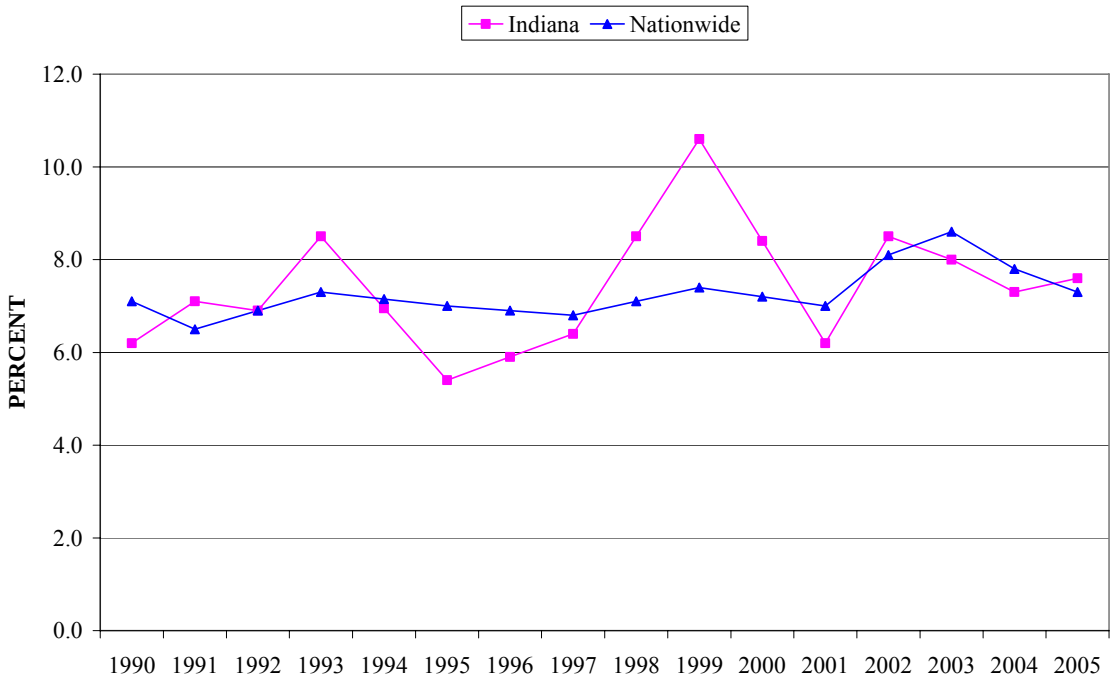
Figure 3.A.4.1 BRFSS: Chronic Alcohol Drinking among Adult Females [48]



- Chronic drinking (average of 1+ drink per day in the last month) increased greatly from 1997 to 2003 among females in Indiana as well as the nation as a whole (to over 4% of the population). There has been a slight decrease from 2003 to 2005, but levels remain historically high. (Figure 3.A.4.1)

- Chronic drinking in Indiana has been about one half a percentage point below the national level since 2002. (Figure 3.A.4.1)

Figure 3.A.4.2 BRFSS: Binge Alcohol Drinking among Adult Females [48]

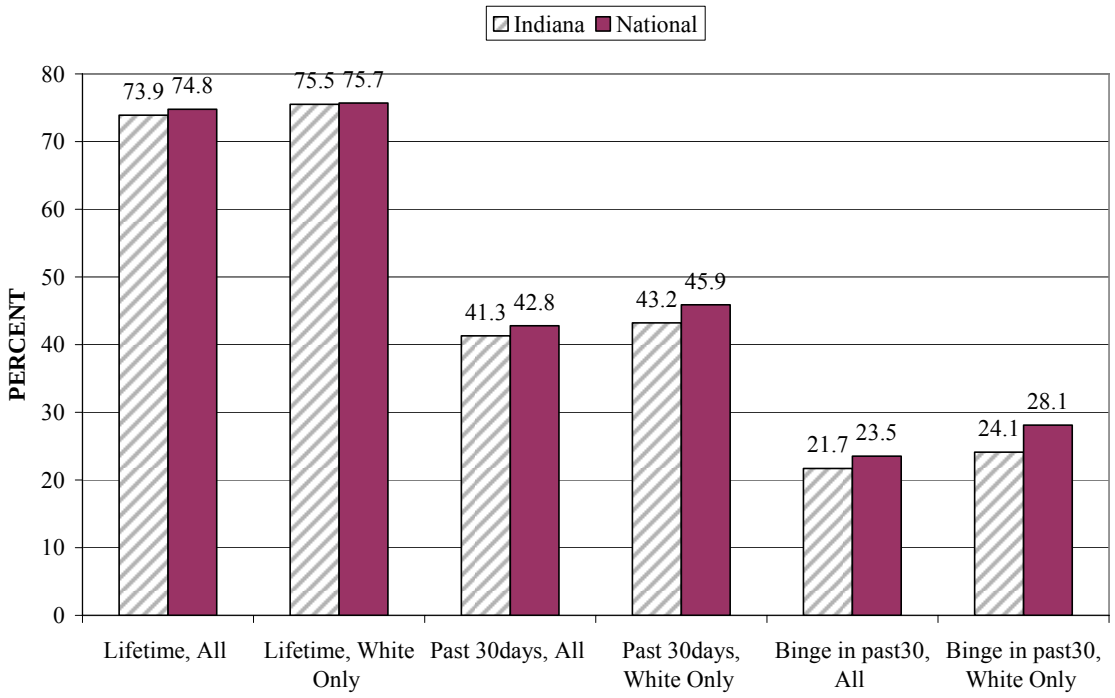


- Nationally, binge drinking (5+ drinks on 1+ days in the last month) was stable at about 7% through 2001. It rose to 8.5% in 2003 and decline to about 7.5% in 2005. (Figure 3.A.4.2)

- Binge drinking in Indiana has followed the national trend since 2001. Deviations from the national rate are noted (both above and below) before from 1990 to 2001. (Figure 3.A.4.2)

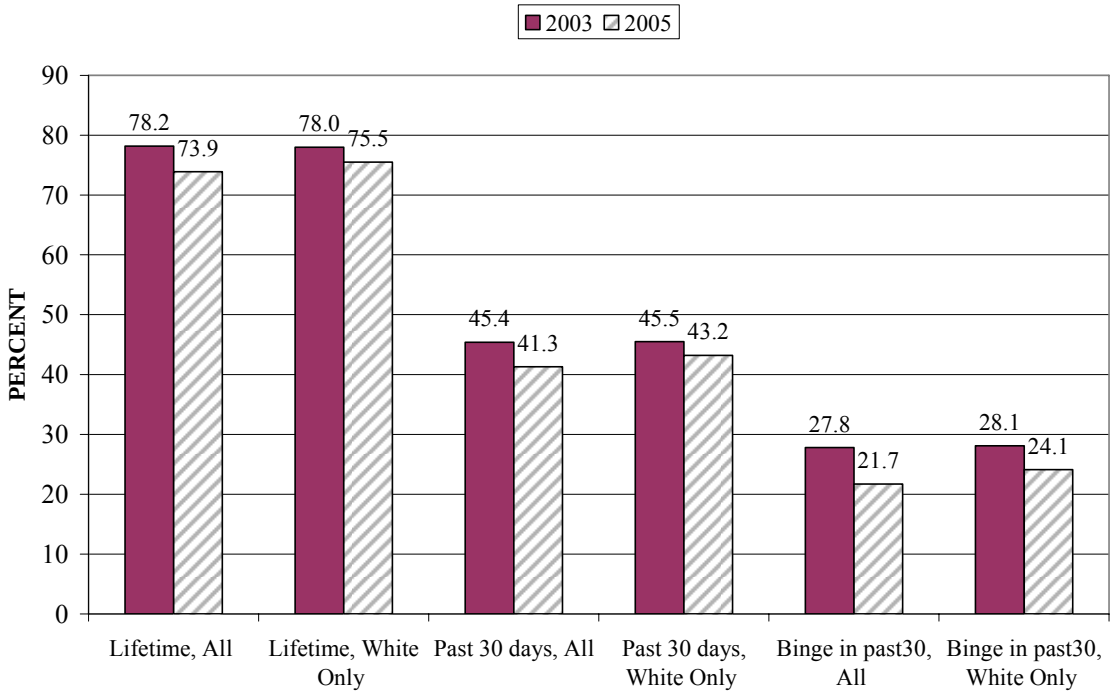
5. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Youth Risk Behavioral Surveillance System (YRBSS) Reports

Figure 3.A.5.1 YRBSS: Alcohol Use by Females, Grades 9 to 12, in 2005 [49]



- Indiana's prevalence of all three classifications of alcohol use (lifetime, current, and binge) was similar or slightly lower than the national prevalence in 2005. (Figure 3.A.5.1)

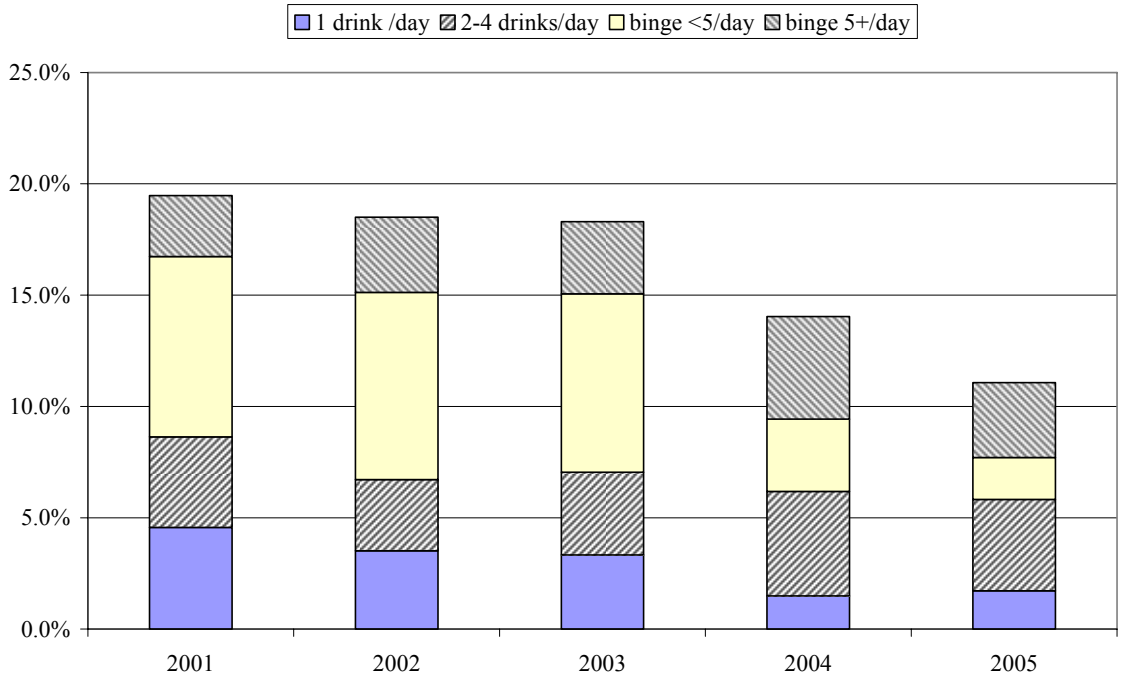
Figure 3.A.5.2 YRBSS: Alcohol Use by Females, Grades 9 to 12, in Indiana [49]



- All classifications of alcohol use (lifetime, current, and binge) by young women in Indiana decreased from 2003 to 2005. (Figure 3.A.5.2)

6. Indiana State Department of Health (ISDH), Indiana Prenatal Substance Use Prevention Program (PSUPP) Reports

Figure 3.A.6.1 PSUPP: Alcohol Use among those Screened [50]



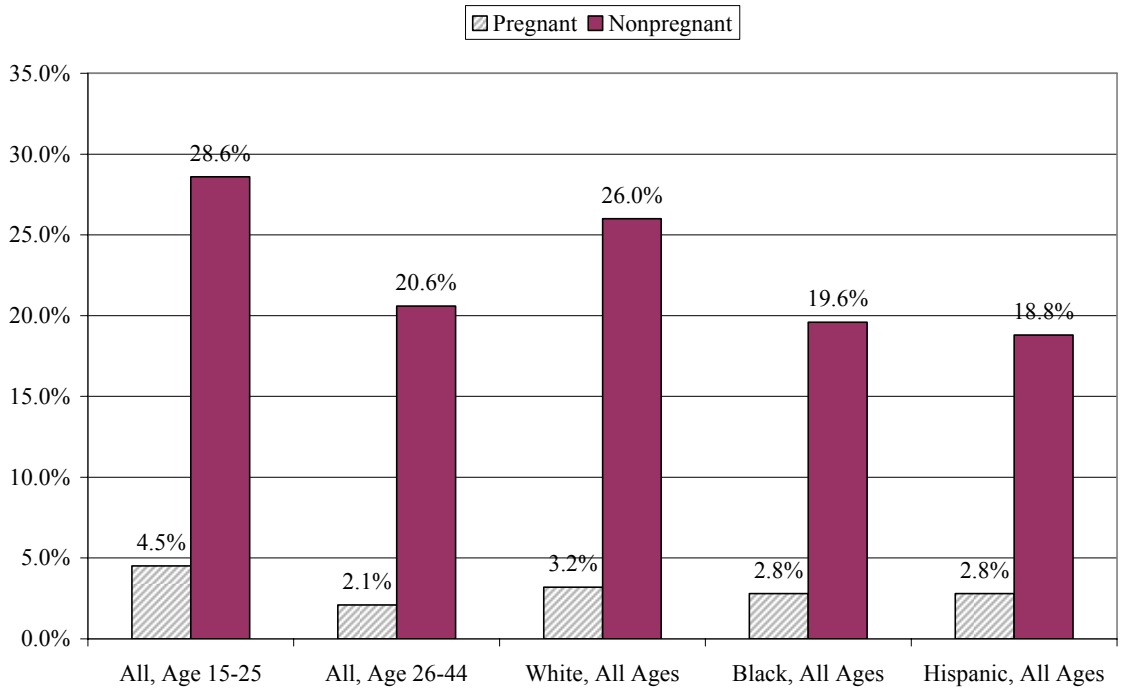
- Reported alcohol use has declined since 2001, but much of the decline has been at the lowest level (1/day) and in the category "binge drinking <5 per day". (Figure 3.A.6.1)

B. Tobacco Use Prevalence Estimates

1. Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health Report (NSDUH)

The following discussion of the prevalence of cigarette use by pregnant and non-pregnant women is from the SAMHSA report "Pregnancy and Substance Use" (January 2, 2004) previously cited in section 3.A of this report.

Figure 3.B.1.1 NSDUH: Percentages of Past Month Cigarette Use among Women Aged 15 to 44, by Pregnancy Status, Age, and Race/Ethnicity: 2002 [44]



- The rate of past month cigarette smoking among non-pregnant women (31%) was considerably higher than the rate among pregnant women (19%). (SAMHSA report)

- Pregnant women aged 15 to 25 were more than twice as likely to have smoked cigarettes in the past month as pregnant women aged 26 to 44. (Figure 3.B.1.1)

- Women ages 26 to 44 were more likely to stop smoking when they become pregnant (30.0% to 10.2%) compared to women 15 to 25 (33.2% to 26.2%). (Figure 3.B.1.1)

- White women were less likely to stop smoking when they become pregnant (36.0% to 24.1%) compared to Black women (25.3% to 7.3%) and Hispanic women (18.8% to 6.0%). (Figure 3.B.1.1)

Table 3.B.1.1 NSDUH: Cigarette Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	30.2[a]	29.5	18.0	18.0	30.7[a]	30.0
AGE						
15-17	20.9[a]	19.8	25.9	26.0	20.7[a]	19.6
18-25	36.7	35.9	27.8	28.0	37.2[a]	36.3
26-44	29.1	28.4	10.8	11.7	29.8	29.1
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	32.3[a]	31.5	21.0	20.4	32.7[a]	31.9
White	35.2	34.5	25.0	23.6	35.6	34.9
Black or African American	24.2	24.2	9.3	13.6	24.7	24.6
American Indian or Alaska Native	49.2	49.9	*	*	52.0	51.8
Native Hawaiian or Other Pacific Islander	36.5	*	*	*	36.7	*
Asian	12.2[b]	8.5	*	*	12.8[b]	8.9
Two or More Races	38.4	42.2	*	*	38.6	42.6
Hispanic or Latino	18.7	18.7	6.8	8.0	19.3	19.2
TRIMESTER[2]						
First	N/A	N/A	22.0	22.7	N/A	N/A
Second	N/A	N/A	15.5	13.4	N/A	N/A
Third	N/A	N/A	17.3	18.0	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

More recent national data from the NSUDH is also available for women of childbearing ages by pregnancy status. These data are shown in Table 3.B.1.1 giving cigarette use in the past month by demographic characteristics for the nation as a whole.

- Nationally, the cigarette smoking rate for pregnant women was 18.0 percent in 2003-2004 compared to 30.0 percent for non-pregnant women. (Table 3.B.1.1)

- Women aged 15 to 17 were more likely to smoke if they were pregnant (26.0%) than if they were not pregnant (19.6%). (Table 3.B.1.1)

- Women aged 18 to 25 were less likely to smoke if they were pregnant (28.0%) than if they were not pregnant (36.3%). (Table 3.B.1.1)

- Women aged 26 to 44 were less likely to smoke if they were pregnant (11.7%) than if they were not pregnant (29.1%). (Table 3.B.1.1)

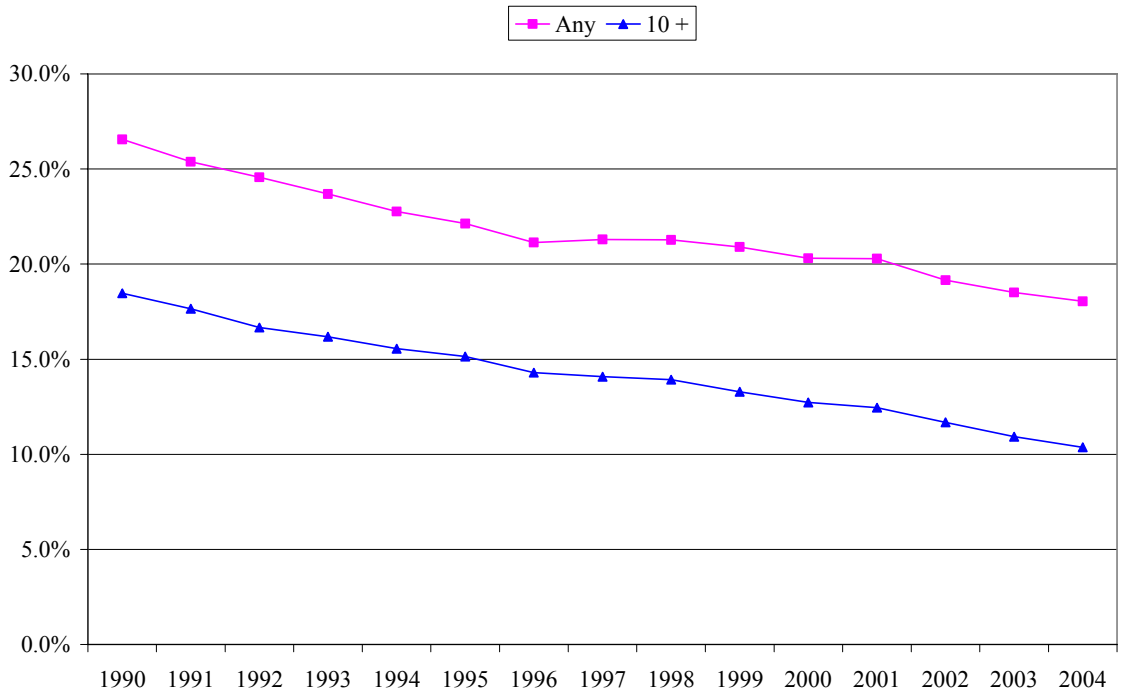
- Younger women were much less likely to curtail smoking while pregnant. In fact, those aged 15-17 were MORE likely to smoke if pregnant than if non-pregnant. (Table 3.B.1.1)

- There was little difference among the racial/ethnic groups in the amount of reduction in smoking from those who were not pregnant to those who were pregnant. The reduction was about 35-45 percent for each of the groups. (Table 3.B.1.1)

- Smoking rates in the first trimester was 22.7 percent compared to 13.4 percent in the second trimester and 18.0 percent in the third trimester. (Table 3.B.1.1)

2. Indiana State Department of Health (ISDH), Birth Certificate Data Reports

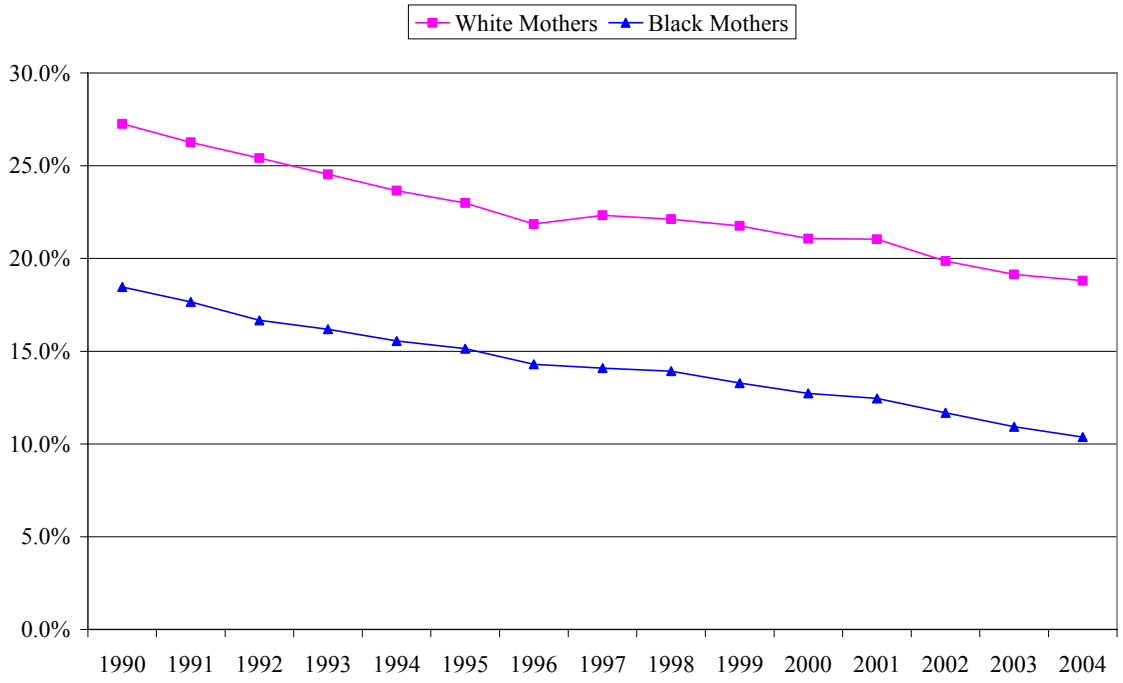
Figure 3.B.2.1 ISDH: Smoking from Birth Certificate Data: Percent Reporting the Amount per Week [47]



- In Indiana, smoking (one or more cigarettes per week) during pregnancy has consistently declined over time from about 27 percent in 1990 to about 18 percent in 2004. (Figure 3.B.2.1)

- Smoking ten or more cigarettes per day during pregnancy has consistently declined over time from about 18 percent in 1990 to about 10 percent in 2004. (Figure 3.B.2.1)

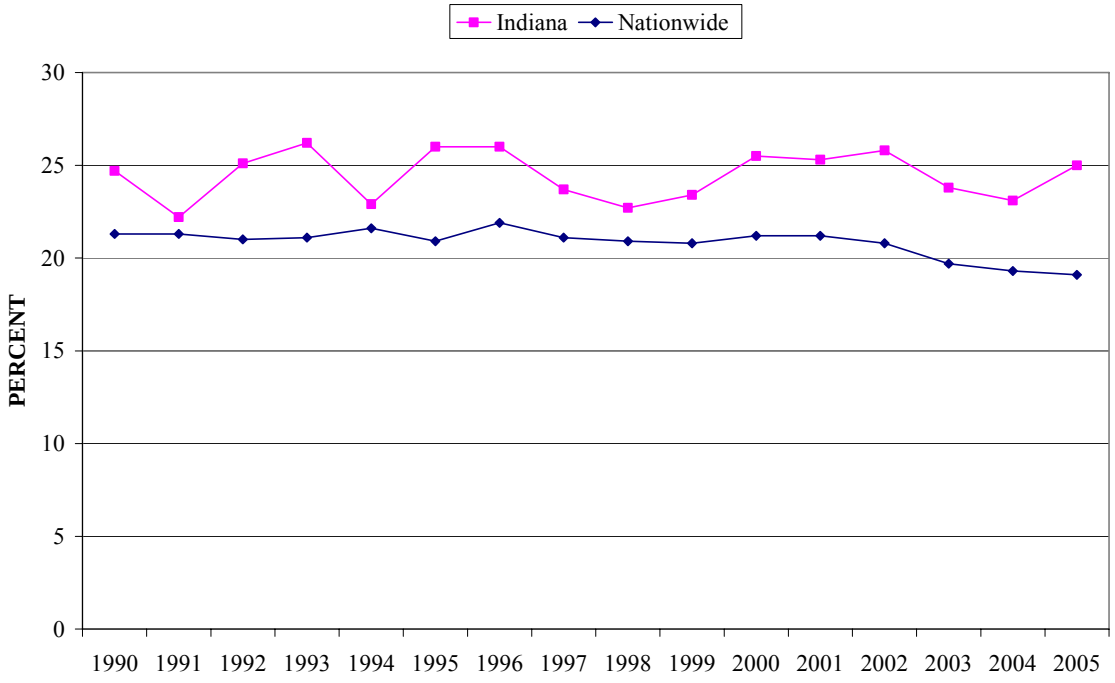
Figure 3.B.2.2 ISDH: Smoking from Birth Certificate Data: One or More Cigarettes Per Week, by Race [47]



- Smoking by Black pregnant women has been reported to be 8 to 9 percentage points below the smoking rate for White pregnant women from 1990 to 2004; smoking rates have declined for both groups. (Figure 3.B.2.2)

3. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Behavioral Risk Factor Surveillance System (BRFSS) Reports

Figure 3.B.3.1 BRFSS: Current Smokers: Adult Females [48]

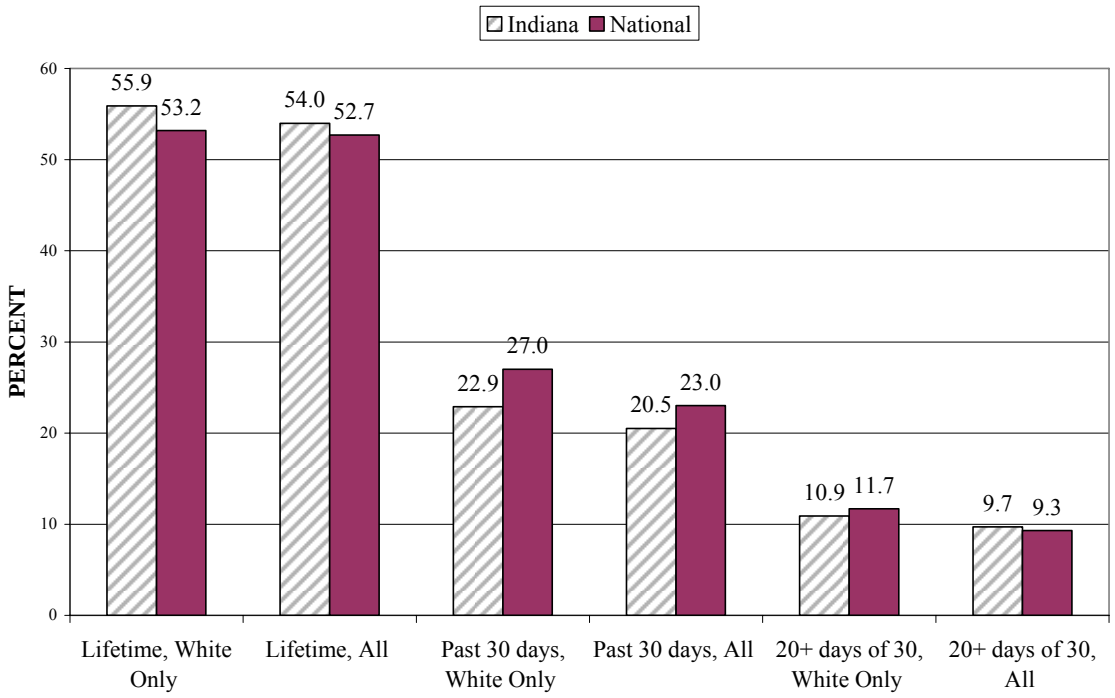


- A greater proportion of Indiana women smoke compared to women nationally over the time period from 1990 to 2005. (Figure 3.B.3.1)

- Indiana smoking prevalence is diverging further from the national rate since 1998. (Figure 3.B.3.1)

4. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Youth Risk Behavioral Surveillance System (YRBSS) Reports

Figure 3.B.4.1 YRBSS: Cigarette Smoking among Females, Grades 9 to 12, 2005 [49]

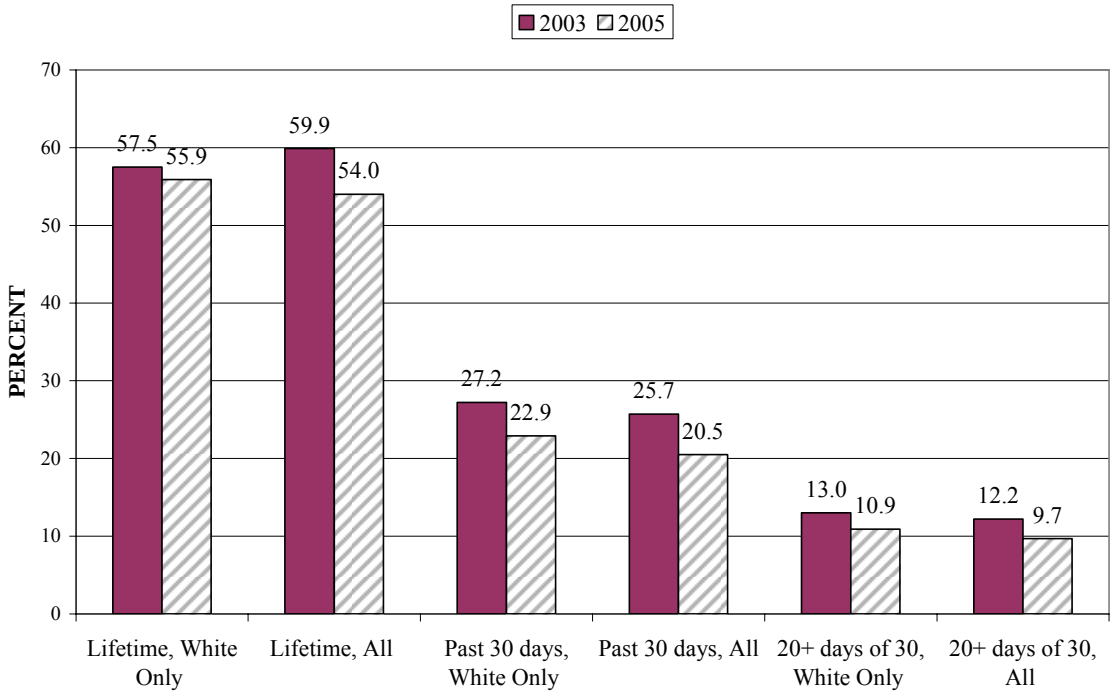


- Indiana's prevalence of lifetime smoking for females in grades 9 to 12 was higher than the national prevalence in 2005. (Figure 3.B.4.1)

- The smoking rate in the past 30 days was lower for Indiana women in grades 9 to 12 during 2005. (Figure 3.B.4.1)

- The rate of smoking on 20 or more of the past 30 days was lower for young (grades 9-12) white women in Indiana during 2005, but higher for all young women. (Figure 3.B.4.1)

Figure 3.B.4.2 YRBSS: Cigarette Smoking among Females, Grades 9 to 12, in Indiana [49]

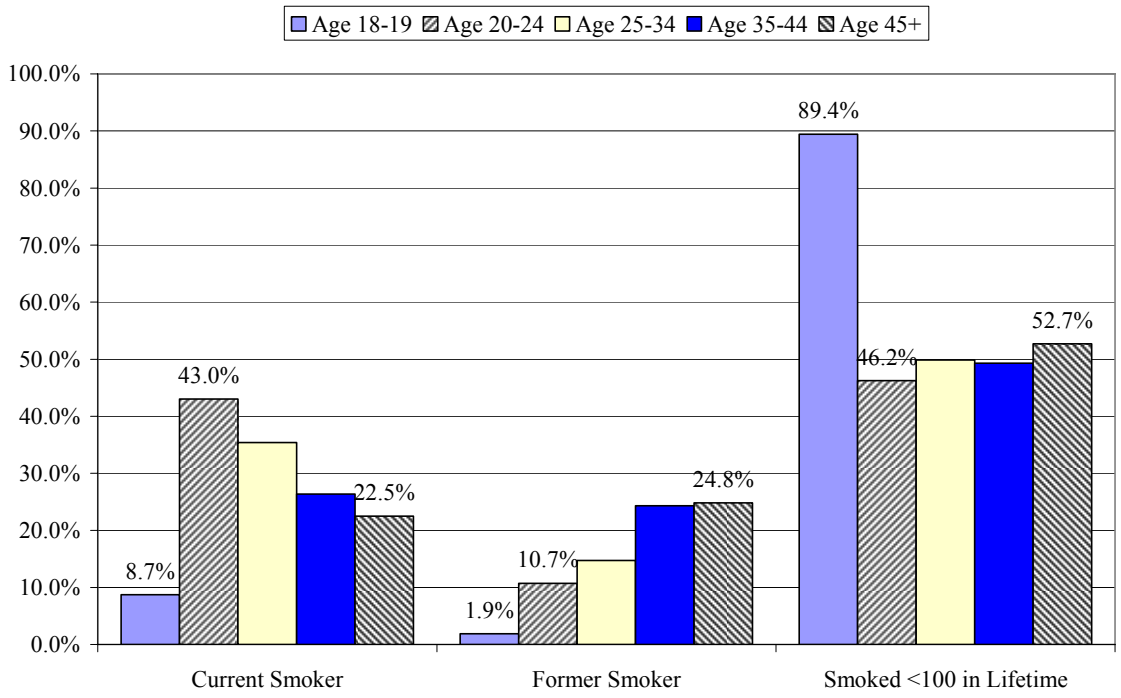


- Cigarette smoking among young (grades 9-12) women in Indiana declined from 2003 to 2005 for all levels of use. (Figure 3.B.4.2)

- White young women consistently smoked more than the all young women group. (Figure 3.B.4.2)

5. Indiana Tobacco Prevention and Cessation (ITPC), Indiana Adult Tobacco Survey (IATS) Reports

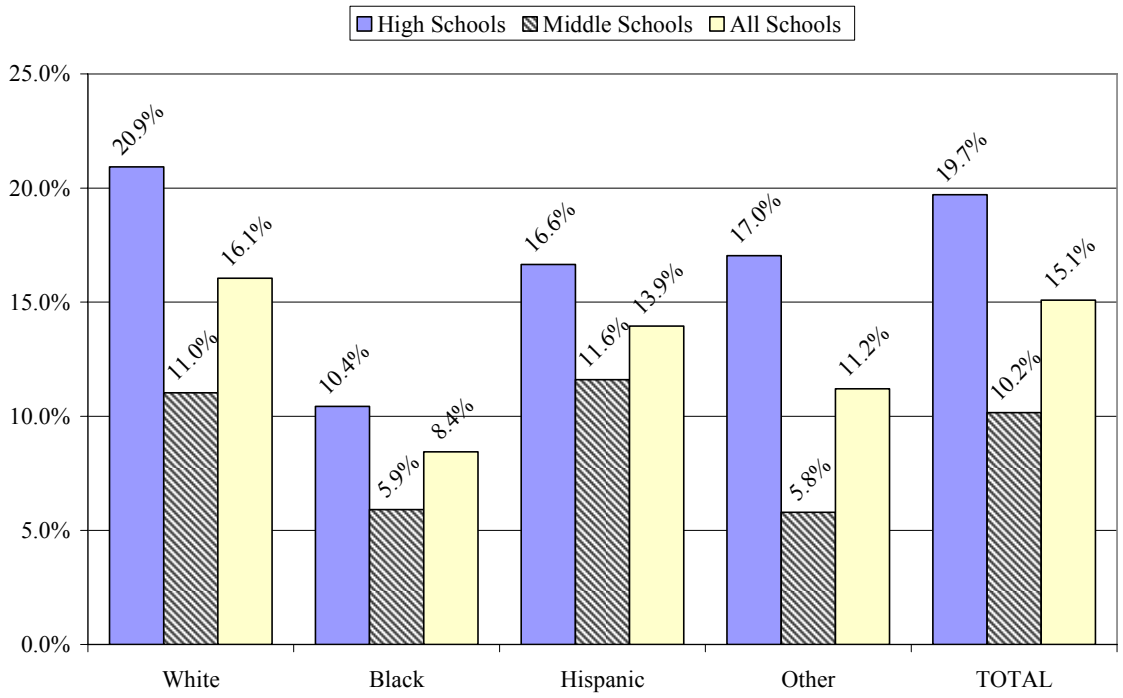
Figure 3.B.5.1: Smoking for Females by Age 2002 [51]



- Few of the 18 to 19 year old women (8.7%) were classified current smokers, while 43.0 percent of the 20 to 24 year old women are currently smoking. (Figure 3.B.5.1)

6. Indiana Tobacco Prevention and Cessation (ITPC), Indiana Youth Tobacco Survey (IYTS) Reports

Figure 3.B.6.1: Current Smoking among Females by School Level and Race 2002 [52]



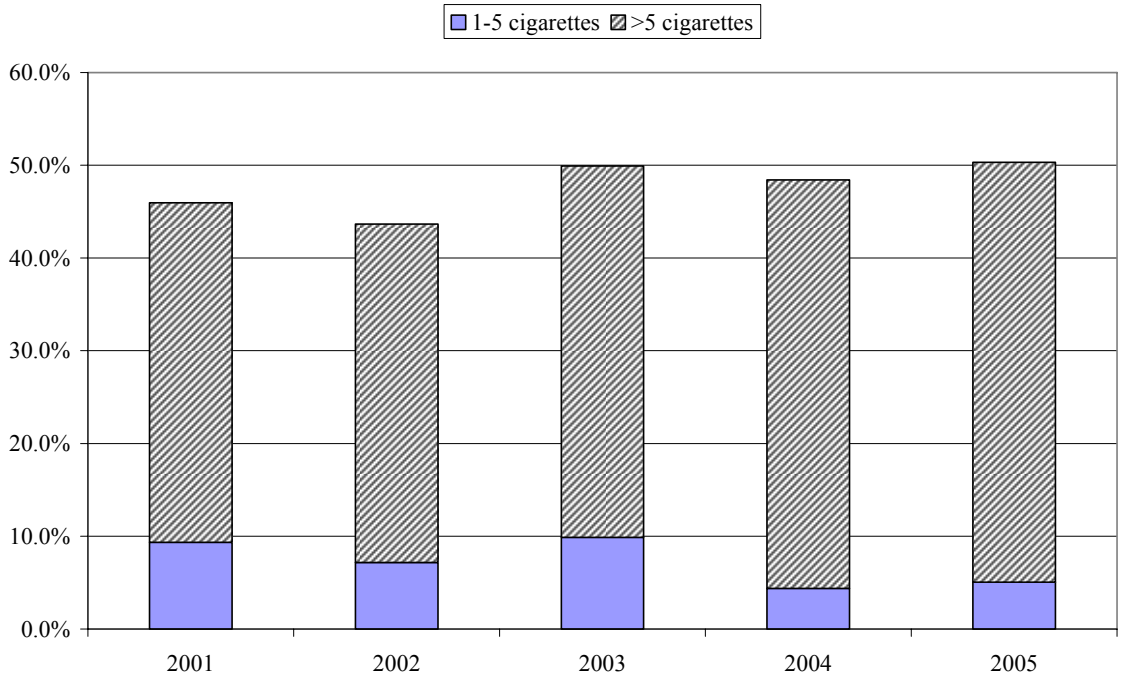
- Young women's current smoking prevalence is 10.2% in middle schools and 19.7% in high schools. (IYTS Survey)

- Hispanic young women have the highest prevalence in middle schools (11.6%) and white females have the highest smoking rates in high schools (20.9%). (Figure 3.B.6.1)

- Black young women have the lowest prevalence in high schools (10.4%) and are virtually tied for the lowest prevalence in middle school (5.9%). (Figure 3.B.6.1)

7. Indiana State Department of Health (ISDH), Indiana Prenatal Substance Use Prevention Program (PSUPP) Reports

Figure 3.B.7.1 PSUPP: Smoking among Women Screened [50]



- The overall smoking rate among pregnant women screened by PSUPP increased slightly from 2001 (46%) to 2005 (50%). (Figure 3.B.7.1)

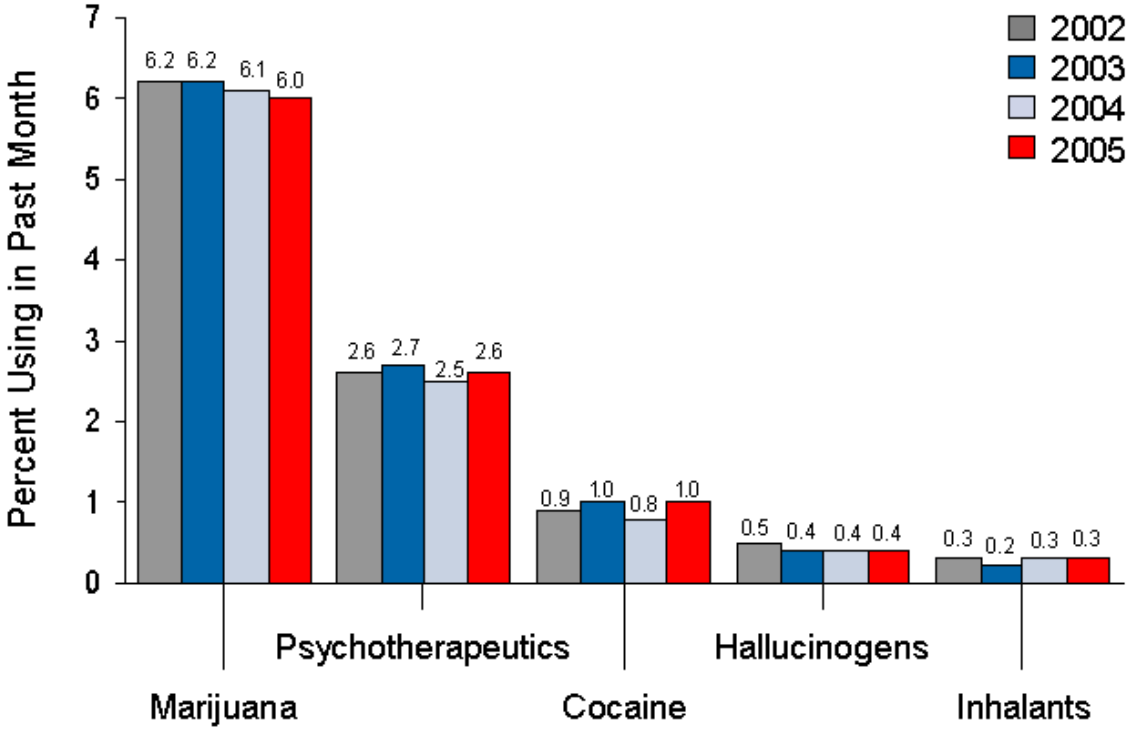
- The rate of lighter smoking (less than 5 per day) was down from nearly 10% in 2001 to about 4% in 2005. (Figure 3.B.7.1)

C. Drug Use Prevalence Estimates

1. Substance Abuse and Mental Health Services Agency (SAMHSA) National Survey on Drug Use and Health (NSDUH) Report

The tables and figures in section 3.A.1 cover both alcohol and other drugs and are not reproduced here. The following two figures present trends in drug use among the entire adult U.S. population from 1999 to 2005 (trend data from this source is available back to 1979 although comparability is problematic at several points, particularly in 2001-2002). Going from 1994 to 1999, trend data shows no substantial differences in prevalence.

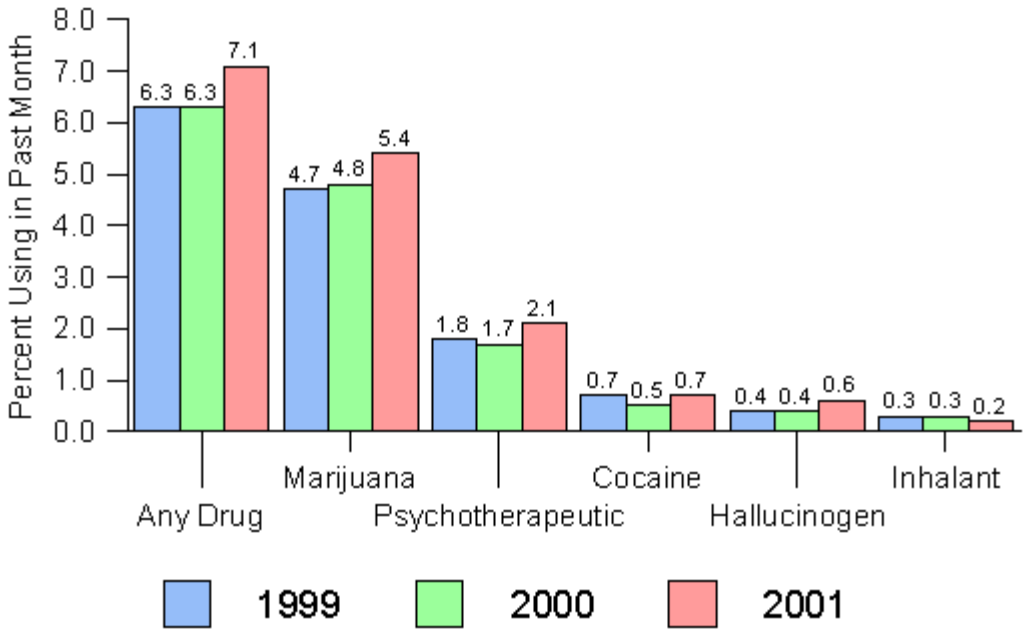
Figure 3.C.1.1 NSDUH: Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2005 [45]



[+] Difference between estimate and the 2005 estimate is statistically significant at the .05 level.

- From 2002-2005 in the entire adult population, prevalence of drug use of all types has not changed. (Figure 3.C.1.1)

Figure 3.C.1.2 NSDUH: Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 1999-2001 [53]



These prevalence 1999-2001 rates are NOT directly comparable to the rates from 2002 – 2005 above. As of 2002 the SAMHSA national survey was substantially changed and renamed. One very important change was the institution of a $30 incentive payment to survey respondents, which could result in a difference in the type of person who would respond to the survey.

- During the period 1999-2001 prevalence increased slightly in the US adult population, especially from 2000-2001. (Figure 3.C.1.2)

- SAMHSA estimates of long term trends show little change in drug use between 1994 and 1998. Before 1994 there had been declines in several types of drugs going back to the 1970's. (SAMHSA Report)

Recent national data from the NSUDH is also available for women of childbearing ages by pregnancy status. The following three tables give types of illicit drug use in the last month and drug use by demographic characteristics (both for all illicit drugs and for marijuana) for the nation as a whole.

Table 3.C.1.1 NSDUH: Types of Illicit Drug Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Drug	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
ILLICIT DRUG[2]	10.2	10.0	4.3	4.6	10.4	10.2
Marijuana and Hashish	7.4	7.3	3.5	3.6	7.6	7.5
Cocaine	1.0	1.0	0.3	0.3	1.0	1.0
Crack	0.2	0.2	0.0	*	0.2	0.2
Heroin	0.1	0.1	0.0	0.1	0.1	0.1
Hallucinogens	0.6[b]	0.5	0.3	0.2	0.6[b]	0.5
LSD	0.1	0.0	0.0	0.1	0.1	0.0
PCP	0.0	0.0	0.1	0.1	0.0	0.0
Ecstasy	0.4[b]	0.3	0.1	0.1	0.4[b]	0.3
Inhalants	0.2	0.2	0.0	0.1	0.2	0.2
Nonmedical Use of Psychotherapeutics[3]	3.8	3.8	1.2	1.4	3.9	3.9
Pain Relievers	2.6	2.7	0.9	1.2	2.7	2.8
OxyContin®	--	0.2	--	0.1	--	0.2
Tranquilizers	1.1	1.1	0.2	0.1	1.2	1.1
Stimulants	0.8	0.8	0.3	0.3	0.8	0.9
Methamphetamine	0.3	0.4	0	0.1	0.3	0.4
Sedatives	0.2	0.2	0.1	0.1	0.2	0.2
ILLICIT DRUG OTHER THAN MARIJUANA[2]	4.8	4.7	1.4	1.6	4.9	4.8

*Low precision; no estimate reported.
-- Not available.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens,
3 Non-medical use of prescription-type pain relievers, tranquilizers, stimulants, or sedatives; does not include over-the-counter drugs.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

Table 3.C.1.2 NSDUH: Illicit Drug Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	10.2	10.0	4.3	4.6	10.4	10.2
AGE						
15-17	16.5	16.1	12.8	16.0	16.5	16.0
18-25	16.4	16.0	7.5	7.8	16.9	16.4
26-44	6.8	6.7	1.6	2.1	7.0	6.9
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	10.8	10.6	4.7	4.5	11.0	10.8
White	11.4	11.1	4.4	4.2	11.6	11.4
Black or African American	9.5	9.4	8.0	7.8	9.4	9.4
American Indian or Alaska Native	15.4	17.8	*	*	16.3	18.6
Native Hawaiian or Other Pacific Islander	12.6	*	*	*	12.8	*
Asian	4.3	3.5	*	*	4.4	3.6
Two or More Races	15.4[a]	20.3	*	*	15.9[a]	20.8
Hispanic or Latino	7.2	6.9	3.0	5.0	7.4	7.0
TRIMESTER[2]						
First	N/A	N/A	7.7	8.0	N/A	N/A
Second	N/A	N/A	3.2	3.8	N/A	N/A
Third	N/A	N/A	2.3	2.4	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

Table 3.C.1.3 NSDUH: Marijuana Use in the Past Month among Females Aged 15 to 44, by Pregnancy Status and Demographic Characteristics: Percentages, Annual Averages Based on 2002-2003 and 2003-2004 [45]

Demographic Characteristic	Total[1]		PREGNANCY STATUS			
			Pregnant		Not Pregnant	
	2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
TOTAL	7.4	7.3	3.5	3.6	7.6	7.5
AGE						
15-17	12.0	11.9	9.5	12.1	12.0	11.9
18-25	13.3[b]	12.5	6.3	6.1	13.7[b]	12.9
26-44	4.4	4.5	1.2	1.7	4.5	4.7
HISPANIC ORIGIN AND RACE						
Not Hispanic or Latino	8.0	7.9	3.9	3.6	8.1	8.0
White	8.5	8.3	3.7	3.5	8.6	8.5
Black or African American	7.2	7.3	6.2	5.3	7.1	7.3
American Indian or Alaska Native	11.3	14.1	*	*	12.0	14.7
Native Hawaiian or Other Pacific Islander	5.2	5.5	*	*	5.4	5.6
Asian	2.5	2.2	*	*	2.6	2.2
Two or More Races	11.0	12.8	*	*	11.2	12.9
Hispanic or Latino	4.3	4.2	2.2	3.7	4.5	4.2
TRIMESTER[2]						
First	N/A	N/A	6.1	5.6	N/A	N/A
Second	N/A	N/A	2.5	3.2	N/A	N/A
Third	N/A	N/A	2.1	2.2	N/A	N/A

*Low precision; no estimate reported.
N/A: Not applicable.
a Difference between estimate and 2003-2004 estimate is statistically significant at the 0.05 level.
b Difference between estimate and 2003-2004 estimate is statistically significant at the 0.01 level.
1 Estimates in the Total column are for all females aged 15 to 44, including those with unknown pregnancy status.
2 Pregnant females aged 15 to 44 not reporting trimester were excluded.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

- Overall illicit drug use in the past month was 4.6 percent for pregnant women and 10.2 percent for non-pregnant women. The highest prevalence was for Marijuana and Hashish (3.6% for pregnant women and 7.5% for non-pregnant women) and for Non-medical Use of Psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) (1.4% for pregnant women and 3.9% for non-pregnant women). (Table 3.C.1.1)

- Women aged 15-25 were much more likely to use illicit drugs (about 16%) compared to women aged 26-44 (6.7%). (Table 3.C.1.2)

- Among women ages 15 to17, there was no difference in the illicit drug use for those who were pregnant and women who were not pregnant (16.0%). However, among women in the 18 to 25 age group and in the 26 to 44 age group the illicit drug use was much lower in the pregnant group compared to the non-pregnant group. (Table 3.C.1.2)

- Black or African American women were almost twice as likely to use illicit drugs compared to White women when pregnant. However, Black or African American women were less likely to use drugs when not pregnant. (Table 3.C.1.2)

- During the first trimester, 8.0 percent of the women used illicit drugs, compared to 3.8 percent in the second trimester and 2.4 percent in the third trimester. (Table 3.C.1.2)

- Women ages 15 to 25 were much more likely to use marijuana (about 12%) compared to women aged 26-44 (4.5%). (Table 3.C.1.3)

- Among women ages 15 to 17, there was no difference in the marijuana use for those who were pregnant and women who were not pregnant (12.0%). However, among women in the 18 to 25 age group and in the 26 to 44 age group the illicit drug use was much lower in the pregnant group compared to the non-pregnant group. (Table 3.C.1.3)

- Black or African American women were more likely to use marijuana compared to White women when pregnant. However, Black or African American women were less likely to use drugs when not pregnant. (Table 3.C.1.3)

- During the first trimester, 5.6 percent of the women used marijuana, compared to 3.2 percent in the second trimester and 2.2 percent in the third trimester. (Table 3.C.1.3)

2. Substance Abuse and Mental Health Services Agency (SAMHSA), Treatment Episode Data Set (TEDS) [46]

The figures in section 3.A.2 presented data for drug use as well as alcohol use.

- Nationally, there has been an increase in the percent of pregnant women being treated for other drugs only from 1992 to 2004, and currently is the largest segment of pregnant women in treatment. (Figure 3.A.2.1)

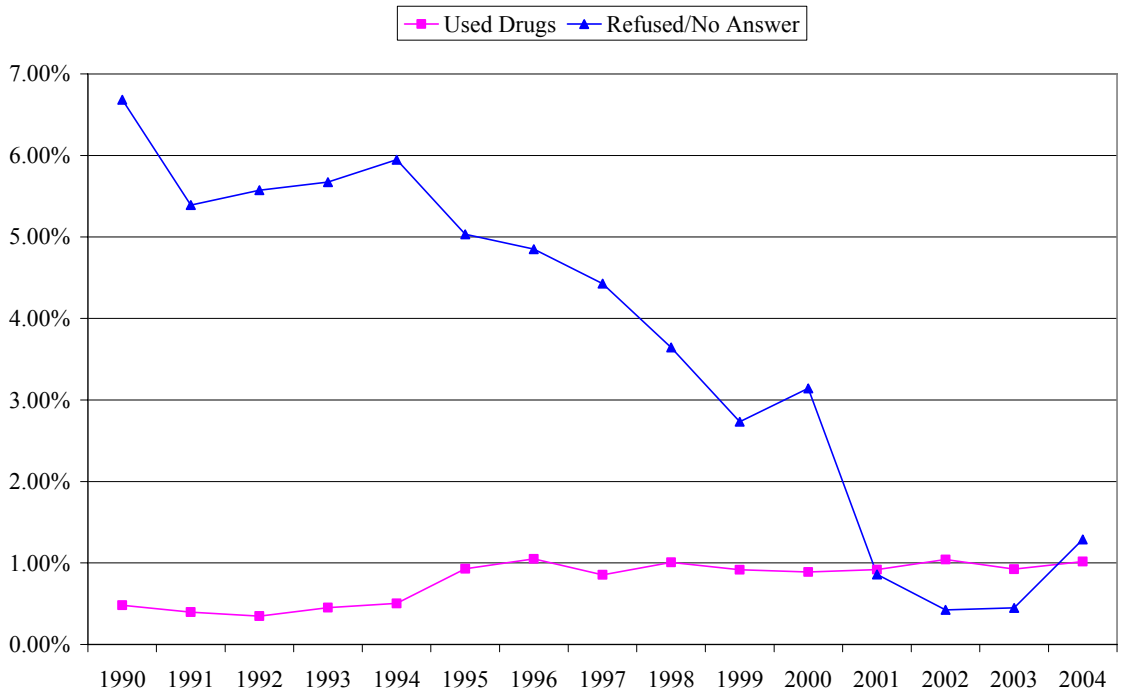
- The percent of pregnant women being treated for alcohol and other drugs together has declined during the reporting period. (Figure 3.A.2.1)

- In Indiana, there has been an increase in the percent of pregnant women being treated for other drugs only from 1992 to 2004. (Figure 3.A.2.2, Figure 3.A.2.3)

- The percent of pregnant women being treated for alcohol and other drugs together has declined during the reporting period. (Figure 3.A.2.2, Figure 3.A.2.3)

3. Indiana State Department of Health (ISDH), Birth Certificate Data Reports

Figure 3.C.3.1 ISDH: Drug Use from Birth Certificate Data: Percent Reporting Any Use During Pregnancy [47]



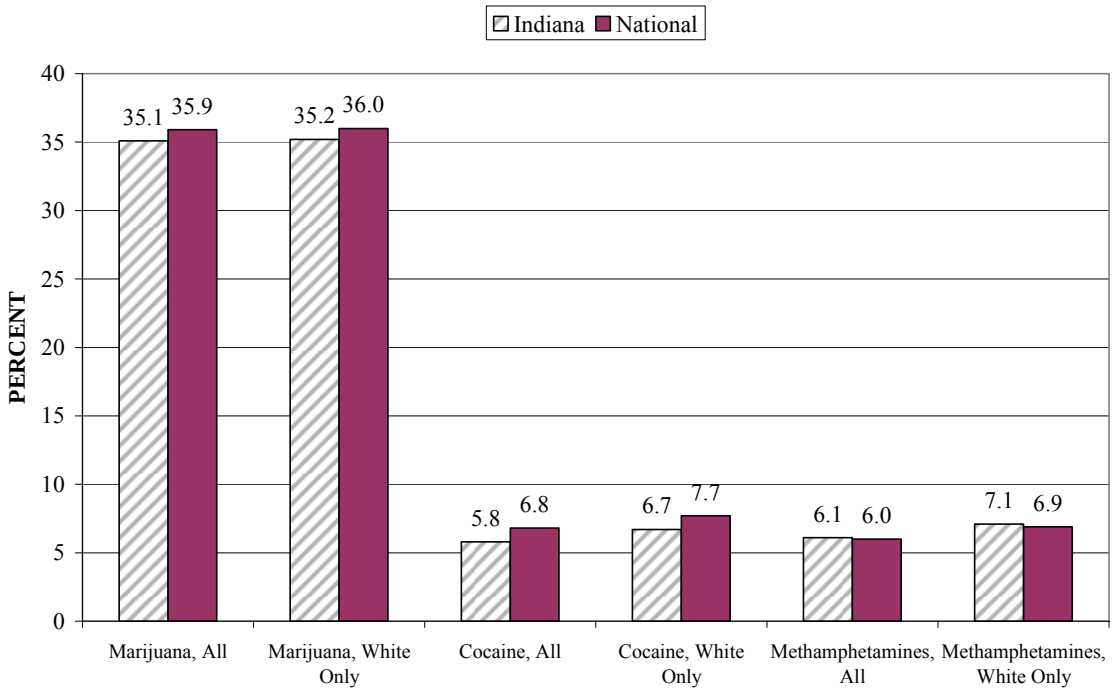
- The birth certificate data indicates that the rate of drug use during all of pregnancy was 1 percent or less from 1990 to 2004. (Figure 3.C.3.1)

- This compares to national drug use rates of 4.6 percent during the last month of pregnancy as reported by NSDUH for 2003-2004. (Table 3.C.1.1)

- Indiana mothers in the 1990s refused or neglected to answer the drug use question (3% to 6%). After 2000, that rate dropped to 1 percent or lower. This may be partly due to changes in data collection. (Figure 3.C.3.1)

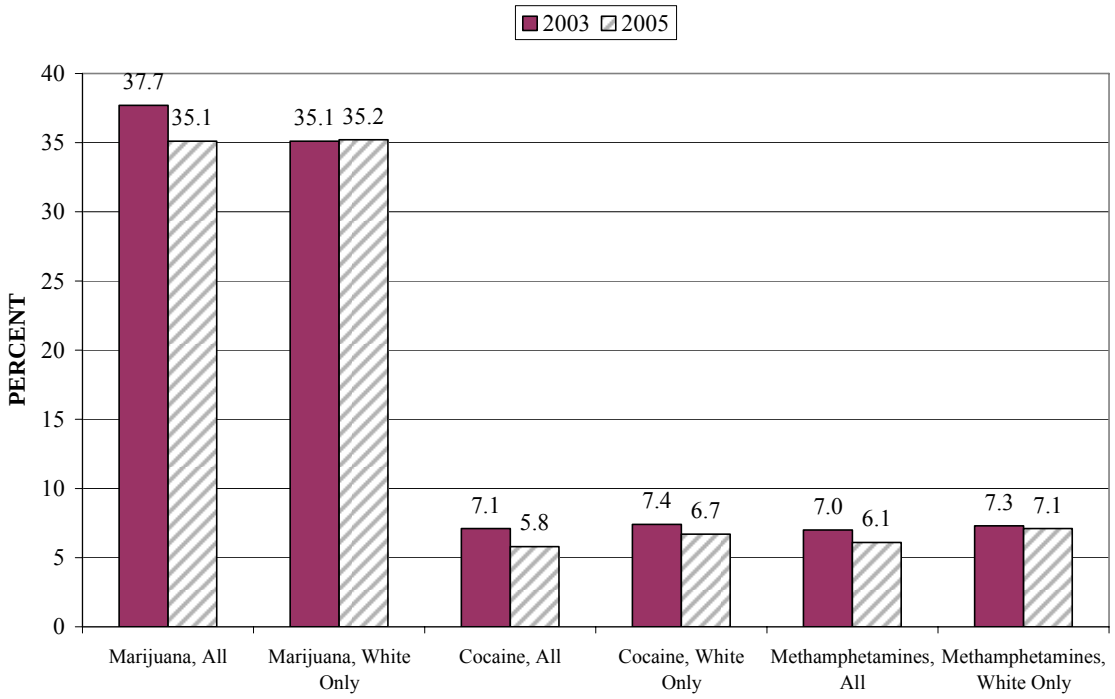
4. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Youth Risk Behavioral Surveillance System (YRBSS) Reports

Figure 3.C.4.1 YRBSS: Drug Use among Females, Grades 9 to 12, 2005 [49]



- In Indiana, the prevalence of marijuana and coke/crack use among females in grades 9 to 12 is lower than the national prevalence. (Figure 3.C.4.1)
- Methamphetamine use is about the same in Indiana as in the nation. (Figure 3.C.4.1)

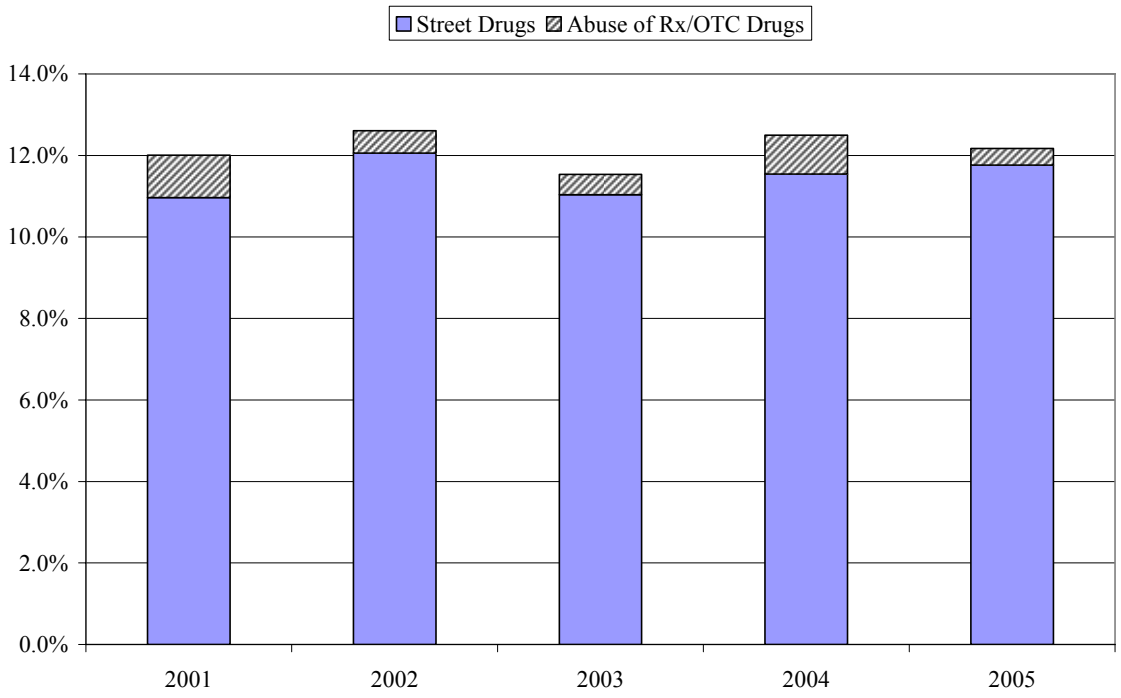
Figure 3.C.4.2 YRBSS: Drug Use among Females, Grades 9 to 12, Indiana [49]



- Marijuana, cocaine, and methamphetamine use all declined among Indiana women in grades 9 to 12 from 2003 to 2005. (Figure 3.C.4.2)

5. Indiana State Department of Health (ISDH), Indiana Prenatal Substance Use Prevention Program (PSUPP) Reports

Figure 3.C.5.1 PSUPP: Street Drug Use among Individuals Screened [50]



- About 12 percent of pregnant women screened by PSUPP in Indiana used street drugs or abused prescription or over the counter medications. (Figure 3.C.5.1)

- Drug use by women screened by PSUPP in Indiana was over twice the rate of illicit drug use among pregnant women nationwide (4.6%). This difference could be explained by differences in the populations represented by the two estimates. The women screened by PSUPP are low income and are at higher risk than the general population of pregnant women. (Table 3.C.1.2)

6. Indiana State Department of Health (ISDH), Meconium Screening Program (MSP) Reports

Table 3.C.6.1 Indiana Meconium Screen Data Summary [54]

Year	Percent Positive	Percent of Positives					Referrals as a Percent of Positives	
		Marijuana	Cocaine	Opiates	Amphetamines	CPS	First Steps	Treatment
2004	21.2%	52.4%	35.8%	17.5%	4.5%	76.7%	25.4%	13.5%
2003	19.3%	50.2%	34.2%	19.4%	3.7%	66.4%	27.3%	15.1%
2002	21.7%	53.6%	38.8%	16.5%	2.1%	missing	missing	missing
2001	18.5%	54.6%	37.1%	18.9%	0.5%	missing	missing	missing
2000	17.0%	58.4%	41.1%	8.2%	0.3%	38.3%	18.3%	23.7%
1999	19.9%	53.7%	43.3%	7.8%	0.4%	40.3%	26.0%	18.2%
Year	Number Positive	Number of Positives					Number of Referrals	
		Marijuana	Cocaine	Opiates	Amphetamines	CPS	First Steps	Treatment
2004	871	456	312	152	39	668	221	118
2003	655	329	224	127	24	435	179	99
2002	750	402	291	124	16			
2001	665	363	247	126	3			
2000	389	227	160	32	1	149	71	92
1999	231	124	100	18	1	93	60	42

- About 20 percent of the pregnant women screened (871 in 2004) tested positive for drugs over the six-year period from 1999 to 2004. The prevalence of drug use is expected to be higher in this group than among all women since the Meconium Screening Program focuses on women who are at high risk of using drugs. (Table 3.C.6.1)

- Marijuana was present in about 50 percent of the screens (456 in 2004), and was relatively stable over the period. (Table 3.C.6.1)

- Cocaine was present in about 40 percent (312 in 2004), and has been decreasing. (Table 3.C.6.1)

- Opiates were present in about 15 percent (152 in 2004), and their use has been increasing, particularly from 2000 to 2001. (Table 3.C.6.1)

- Amphetamines were present in about 2 percent of the screens (39 in 2004), and have increased from 0.4 percent in 1999 to 4.5 percent in 2004. (Table 3.C.6.1)

- During 2004, 76.7 percent of the women who tested positive (668 in 2004) were referred to Child Protective Services (CPS), 25.4 percent of infants were referred to the local FSSA First Steps Early Intervention programs (221 in 2004), and 13.5 percent were referred to treatment programs (118 in 2004). (Table 3.C.6.1)

- The proportion of positive screens referred to CPS has nearly doubled from 40.3 percent in 1999 to 76.7 percent in 2004; First Steps Early Intervention referrals were stable (26.0% to 25.4%); and treatment referrals decreased from 18.2 percent to 13.5 percent. (Table 3.C.6.1)

7. Indiana Family and Social Services Administration (FSSA), Division of Mental Health and Addictions (DMHA), Indiana Demand and Needs Assessment Studies: Alcohol and Other Drugs Report

Table 3.C.7.1 Projected Estimates of Drug Use Based on Meconium Screen Findings in the 1995 Study [55]

		Any Drug	THC	Cocaine	Opiates	Amphetamine	PCP
	Rate Positive->	6.30%	4.46%	1.15%	0.77%	0.31%	0.08%
Total Births	Year	Implied Total Positive	Implied THC Positive	Implied Cocaine Positive	Implied Opiates Positive	Implied Amphetamine Positive	Implied PCP Positive
82,918	1995	5,224	3,694	955	637	255	64
83,157	1996	5,239	3,705	958	639	255	64
83,385	1997	5,253	3,715	961	640	256	64
85,055	1998	5,358	3,789	980	653	261	65
85,489	1999	5,386	3,809	985	657	263	66
87,697	2000	5,525	3,907	1,010	674	269	67
86,122	2001	5,426	3,837	992	662	265	66
84,839	2002	5,345	3,780	977	652	261	65
86,382	2003	5,442	3,848	995	664	265	66
87,125	2004	5,489	3,881	1,004	669	268	67

- It is estimated that nearly 5,500 women would have tested positive for one or more of the drugs at time of delivery, had meconium screening been performed on all births in 2004. (Table 3.C.7.1)

- If the same percentage of positive cases were to be referred for follow up as was found in the MSP, about 4,200 women would have been referred to CPS, 1,400 would have been referred to First Steps Early Intervention programs, and 750 would have been referred to treatment statewide in 2004. (Table 3.C.7.1)

- Marijuana would be present in about 70 percent of the screens (3,881 births). (Table 3.C.7.1)

- Cocaine would be present in about 18 percent (1,004 births). (Table 3.C.7.1)

- Opiates would be present in about 12 percent (669 births). (Table 3.C.7.1)

- Amphetamines would be present in about 5 percent of the screens (268 births). (Table 3.C.7.1)

- Phencyclidine (PCP) would be present in about 1 percent of the screens (67 births). (Table 3.C.7.1)

- Total births have increased 5.1 percent from 1995 (the year of the study) to 2004. (Table 3.C.7.1)

- The positive rate for any drugs (6.3% at time of birth) is much greater than the national rate for pregnant women (4.6% in the last month) from the 2003-2004 NSDUH data. (Table 3.C.1.2)

EXISTING DATA SOURCES USED IN THIS REPORT

A. Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH) Report[56]

Description:

The National Survey on Drug Use and Health (NSDUH) is the primary source of statistical information on the use of illegal drugs by the U.S. population. Conducted by the Federal Government since 1971, the survey collects data by administering questionnaires to a representative sample of the population. Since 1999, the NSDUH interview has been carried out using computer-assisted interviewing (CAI). Most of the questions are administered with audio computer-assisted self-interviewing (ACASI). ACASI is designed to provide the respondent with a highly private and confidential means of responding to questions to increase the level of honest reporting of illicit drug use and other sensitive behaviors. Less sensitive items are administered by interviewers using computer-assisted personal interviewing (CAPI). The 2005 NSDUH employed a State-based design with an independent, multistage area probability sample within each State and the District of Columbia. The design over-sampled youths and young adults, so that each State's sample was approximately equally distributed among three age groups: 12 to 17 years, 18 to 25 years, and 26 years or older.

Nationally, 134,055 addresses were screened for the 2005 survey, and 68,308 completed interviews were obtained.

NSDUH obtains information on nine different categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants; and the non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives. In addition, the survey assesses tobacco and alcohol use.

For more information about NSDUH, visit SAMHSA's website: http://www.oas.samhsa.gov/nsduh.htm [56]

Limitations:

- The NSDUH does not currently administer sufficient interviews to allow sub-state estimates of behavior prevalence with confidence. Thus, behavior estimates are available at the state level only. Consequently, this data source is not useful to estimate prevalence at the county level or to assess the impact of county level interventions.
- All of the behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

B. Substance Abuse and Mental Health Services Agency (SAMHSA), Treatment Episode Data Set (TEDS) [57]

Description:

The Treatment Episode Data Set (TEDS) file contains millions of records of admissions to treatment facilities supported by SAMHSA for the time period 1992 to 2004. Data elements include client demographics (including pregnancy status at time of admission), geographic location of treatment site, referral sources, prior abuse treatment, substances abused, and insurance type.

To access the data set, visit the following website: http://webapp.icpsr.umich.edu/cocoon/SAMHDA-SERIES/00056.xml [57]

Limitations:

- TEDS is a measure of drug and alcohol use treatment demand only. It cannot be used to provide prevalence of use estimates.
- TEDS does not allow sub-state estimates of drug and alcohol use treatment demand with confidence. Thus, treatment demand estimates are available at the state level only.

C. Indiana State Department of Health (ISDH), Birth Certificate Data Reports [58]

Description:

The Indiana State Department of Health (ISDH), through provisions in Indiana Code 16-37-1, administers "...a system of vital statistics for Indiana." Birth records in the ISDH Vital Records office begin with October 1907. The ISDH Vital Records Division compiles data from original birth certificates filed with the ISDH and from transcripts of original certificates for Indiana residents giving birth in other states. The Data Analysis Team of the Epidemiology Resource Center compiles these data and produces standard statistical reports.

The recent Indiana birth certificate data were based on the 11th revision of the U.S. Standard Certificate of Live Birth (released in 1989 and periodically revised), as specified by the National Center for Health Statistics. In 1996, ISDH, Vital Records Division implemented an electronic birth certificate system to improve the accuracy and reduce the lag time in filing birth certificates.

The item used to record substance use by the mother on the 11th revision had multiple parts:

40.
a. Did Mother Smoke Cigarettes During Pregnancy? (No/Yes/Unknown)
b. If yes, Number Smoked Per Day? (5 or less/6-9/10-19/20-29/30+)
c. Alcohol Use During Pregnancy? (No/Yes/Unknown)
d. Average No. Drinks Per Week (_____)
e. Other Chemical Abuse? (No/Yes/Unknown)

This information was generally gathered by the birth facility staff through an interview with the mother.

In 2003, the National Center for Health Statistics released the 12th revision of the U.S. Standard Certificate of Live Birth and Indiana will begin using this revision with births occurring on or after January 1, 2007. With the new revision, only cigarette use during pregnancy will be recorded. The questions about alcohol and other chemicals (drugs) use during pregnancy will no longer be included. The wording of the item used to record the use of cigarettes during pregnancy changed significantly with the new revision:

> 37. Cigarette Smoking Before And During Pregnancy
> For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

To accompany the newly revised birth certificate, the National Center for Health Statistics provided a worksheet that the birth facility staff could use to interview the mother, or to create a questionnaire that the mother could complete, to collect the data needed for the birth certificate. The Vital Records Division at the ISDH has adopted the worksheet and will require that Indiana birth facilities use it to collect the data needed for the birth certificate. The wording of the item on the worksheet to record the use of cigarettes during pregnancy mirrors the item on the birth certificate, but is asked in the form of a question to the mother:

> 14. How many cigarettes OR packs of cigarettes did you smoke on an average day during each of the following time periods? If you NEVER smoked, enter zero for each time period. (The response options are identical)

To access the Indiana Natality reports, visit the ISDH website: http://www.in.gov/isdh/dataandstats/natality/index.htm [58]

Limitations:

- All of the behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy. Of particular concern were the data about alcohol and drug use, which were believed to have very poor validity and reliability. This was a major consideration in the decision to stop collecting information about those behaviors with the 12th revision of the U.S. Standard Birth Certificate.
- In spite of the poor quality of the alcohol and drug use data, these elements have been used to monitor trends of substance use among pregnant women in

the past. With the implementation of the new revision, it will not be possible to continue the trend analysis.

- Some recoding of the cigarette use data will be necessary to compare birth certificate data before and after the implementation of the new version.
- There is some lag time from the date of birth and the availability of the birth certificate data and the posting of natality reports on the ISDH websites; however, this seems to be improving.

D. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Behavioral Risk Factor Surveillance System (BRFSS) Reports [59, 60]

Description:

According to the Centers for Disease Control Prevention (CDC), scientific research in the 1980s indicated that individual behaviors affect premature morbidity and mortality. In 1984, the CDC established the Behavioral Risk Factor Surveillance System (BRFSS) and developed a standard survey instrument and protocol so that results would be comparable among states. The BRFSS examines health risks of adults, many of which are behavioral in nature. This survey collects annual state-level data on modifiable risk factors associated with premature death and disability. The BRFSS does not collect information on all diseases each year. The BRFSS is administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC, and is an ongoing data collection program. By 1994, all states were participating in the BRFSS. The BRFSS is an annual, random-digit dial telephone survey of non-institutional adults age 18 years and older. All behaviors are self-reported.

For more information about the Indiana BRFSS results, visit the ISDH website at http://www.in.gov/isdh/dataandstats/brfss/2004/index %20page.htm.[59]

Additional information about the BRFSS and national statistics can be found at the CDC website at http://apps.nccd.cdc.gov/brfss/index.asp.[60]

Limitations:

- The Indiana BRFSS does not currently administer sufficient interviews to allow sub-state estimates of behavior prevalence with confidence. Thus, behavior estimates are available at the state level only. Consequently, this data source is not useful to estimate prevalence at the county level or to assess the impact of county level interventions.
- Few of the individuals surveyed for the Indiana BRFSS are pregnant. Consequently, annual estimates of the prevalence of ATOD use in this group cannot be made with confidence.
- The BRFSS instrument does not contain items to estimate drug use prevalence.
- All of the behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

E. Centers for Disease Control Prevention (CDC) and Indiana State Department of Health (ISDH), Youth Risk Behavioral Surveillance System (YRBSS) Reports [61, 62]

Description:

The Youth Risk Behavior Surveillance System (YRBSS) was established in 1990 to monitor priority health-risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among youth and adults in the United States. The YRBSS comprises a series of biennial national, state, and local school surveys. These surveys poll representative samples of students in grades 9 through 12. The CDC conducts the national survey and departments of health, education, and local districts conduct the state and local surveys.

In addition to periodic surveys of special populations, the YRBSS incorporates the Youth Risk Behavior Survey (YRBS) as a regular part of this biennial national survey effort. The YRBS monitors health risks and behaviors in six categories, which are related to the leading causes of mortality and morbidity among both youth and adults. Data are collected every other year on behaviors that contribute to physical activity, nutrition, tobacco use, alcohol and other drug use, violence and injuries, and sexual behavior.

For more information about the 2005 and the 2003 Indiana Youth Risk Behavior Survey results, visit the ISDH website at www.in.gov/isdh/dataandstats/yrbs.[61]

Additional information about the YRBS and national statistics can be found at the CDC website at www.cdc.gov/HealthyYouth/yrbs.[62]

Limitations:

- The Indiana YRBS does not currently administer this survey in a manner that would allow sub-state estimates of behavior prevalence with confidence. Thus, youth behavior estimates are available at the state level only. Consequently, this data source is not useful to estimate youth prevalence at the county level or to assess the impact of county level interventions.
- The YRBS instrument does not ask if the individual is currently pregnant, so no estimates of behavior for pregnant youth are possible from this data source.
- All of the behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

F. Indiana Tobacco Prevention and Cessation (ITPC), Indiana Adult Tobacco Survey (IATS) Reports [63]

Description:

The Indiana Adult Tobacco Survey (IATS) has been conducted two times, first in 2002, then again in 2004. It is scheduled to be administered again in 2006. Both surveys were conducted for the Indiana Tobacco Prevention and Cessation (ITPC) agency. IATS is a random telephone survey of approximately 2000 Hoosiers age 18 and older. The IATS uses a standard set of questions and follows the protocol specified by CDC to enable the results in Indiana to be comparable to findings from similar surveys in other

states. In addition to assessing tobacco use behaviors, the survey measures knowledge of the health consequences of tobacco use and exposure to secondhand smoke, attitudes toward tobacco use and tobacco control policies, experiences with quit attempts and success, and awareness of community based cessation resources.

For more information about IATS, visit the Indiana Tobacco Prevention and Cessation website for research and evaluation: http://www.in.gov/itpc/ [63]

Limitations:

- The IATS does not currently administer sufficient interviews to allow county level estimates of behavior prevalence with confidence. Thus, behavior estimates are available at the state level only. Consequently, this data source is not useful to estimate prevalence at the county level or to assess the impact of county level interventions.
- The IATS instrument does not ask if the individual is currently pregnant, so no estimates of behavior for pregnant youth are possible from this data source.
- The IATS instrument does not contain items to estimate alcohol use or drug use prevalence.
- The tobacco use behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

G. Indiana Tobacco Prevention and Cessation (ITPC), Indiana Youth Tobacco Survey (IYTS) Reports [63]

Description:

The Indiana Youth Tobacco Survey (IYTS) has been conducted three times, starting in 2000, then in 2002 and it was last conducted in 2004 to over 5,000 middle school and high school students in Indiana. It is scheduled to be administered again in 2006. The 2000 survey was conducted by Smoke Free Indiana; the more recent surveys were conducted for the Indiana Tobacco Prevention and Cessation agency. The survey self-administered in a random sample of Indiana schools. The IYTS used a standard set of questions and followed the protocol specified by CDC to enable the results in Indiana to be comparable to findings from similar surveys in other states. In addition to assessing tobacco use behaviors, the survey exposure to secondhand smoke, access to tobacco products, experiences with attempts to start using tobacco, and awareness of pro-tobacco media messages and cessation resources.

For more information about IYTS, visit the Indiana Tobacco Prevention and Cessation website for research and evaluation: http://www.in.gov/itpc/ [63]

Limitations:

- The IYTS does not currently administer this survey in a manner that would allow sub-state estimates of behavior prevalence with confidence. Thus, youth behavior estimates are available at the state level only. Consequently, this data

source is not useful to estimate youth prevalence at the county level or to assess the impact of county level interventions.

- The IYTS instrument does not contain items to estimate alcohol use or drug use prevalence.
- The IYTS instrument does not ask if the individual is currently pregnant, so no estimates of behavior for pregnant youth are possible from this data source.
- The tobacco use behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

H. Indiana State Department of Health (ISDH), Indiana Prenatal Substance Use Prevention Program (PSUPP) Reports [64]

Description:

The goal of the Indiana Prenatal Substance Use Prevention Program (PSUPP) is to prevent birth defects, low birth weight deliveries, premature births, and other problems associated with prenatal substance use. The program focuses attention on pregnant and non-pregnant women who are substance users, health care providers, and the general public. Potential clients are women attending Maternal and Child Health Clinics and similar prenatal care clinics in the Indiana counties where the program operates. The program staff gathers data about those screened as well as those who participate in the program. During FY 2006, about 4,000 pregnant women were screened for substance use with over one-half determined to be at high-risk for poor birth outcome based on their use of tobacco, alcohol or drugs during pregnancy.

For more information about the PSUPP, visit the ISDH website: http://www.in.gov/isdh/programs/mch/Programs/psupp.htm [64]

Limitations:

- Pregnant women screened for PSUPP are not a random sample of the population. They have a higher prevalence of substance use than the general population since users of the prenatal care clinics are more often lower income and clinic providers refer such patients to the program.
- All of the behaviors are self-reported and subject to the acknowledged validity limitations resulting from asking individuals about their behaviors that are known to be unhealthy.

I. Indiana State Department of Health (ISDH), Meconium Screening Program (MSP) Reports [65]

Description:

As required by Indiana PL-291/2001, the meconium from certain infants is tested to identify drug afflicted infants for referral to appropriate intervention and protection programs. The criteria for determining which infants are required to be tested include:

A. Birth weight less than 2500 grams AND the head circumference is smaller than the 10th percentile for the infant's gestational age (without another medical explanation);

OR

B. When any two of the following conditions exist:
- History of current or past drug use by the mother,
- Unexpected abruptio placentae,
- No or inconsistent prenatal care, and,
- Infant shows signs/symptoms suggestive of drug effects.

In addition, health care providers can refer specific patients for the screening specifically, even if the above criteria are not met.

The meconium is tested for four classes of drugs:
- Amphetamines, including methamphetamine,
- Marijuana,
- Cocaine, and,
- Opiates, including heroine, morphine, codeine and hydrocodone

For more information about the Meconium Screening Program, visit the ISDH website: http://www.in.gov/isdh/programs/nbs/MeconiumScrSitemap.htm [65]

Limitations:
- Pregnant women screened for drug use through this program are not a random sample of the population. They have a higher prevalence of substance use than the general population since they must meet the criteria known to be related to drug use to be in this screening program.
- Only drug prevalence is obtained.

J. Indiana Family and Social Services Administration (FSSA), Division of Mental Health and Addictions (DMHA), Indiana Demand and Needs Assessment Studies: Alcohol and Other Drugs Report [55]

Description:

This set of studies, conducted in 1994, 1995, and 1996, was designed to provide information on the need for drug and alcohol treatment in the general population and specific high risk populations. One of the studies focus on estimating prevalence of drug and alcohol use among pregnant women in Indiana's rural, semi-rural, and metropolitan areas. This study involved collecting and analyzing meconium and urine specimens from a random sample of infants and mothers in these three geographical areas. The result provided the best estimates of drug use during pregnancy in Indiana, since the prevalence was not self reported.

Limitations:

- The data are now at least 10 years old and significant shifts have undoubtedly occurred, particularly related to methamphetamine use. Thus, those estimates may not accurately portray drug use prevalence today.
- Tobacco use was not included in the study.
- Due to the rapid half-life of alcohol metabolites in specimens, the alcohol prevalence estimates in the study were not reliable.

SUMMARY OF PREVALENCE ESTIMATES

The following tables summarize the prevalence estimates for alcohol, tobacco and drug use during pregnancy and for all women of childbearing age. Below each table is a bullet point that presents the best estimates of current substance use prevalence during pregnancy considering all of the data sources used for this project.

Table 3.D.1 Summary of Alcohol Prevalence Rates for Indiana Women [45, 47, 48, 49]

					Age	Age	Age	Pregnant
Data Source	Figure / Table	Prevalence Concept	Year(s) *	Area	18+	Childbearing Years	Grades 9-12	Childbearing Years
Birth Certificate	Figure 3.A.3.1	Use during pregnancy	1992 - 2004	Indiana				0.6%
NSDUH	Table 3.A.1.1	past 30 days	2003-2004	**national**		52.8%		11.2%
NSDUH	Table 3.A.1.2	binge***	2003-2004	**national**		23.3%		4.5%
NSDUH	Table 3.A.1.3	heavy****	2003-2004	**national**		5.6%		0.5%
BRFSS	none	past 30 days	2005	Indiana	42.9%			
BRFSS	Figure 3.A.4.1	chronic**	1990 - 2005	Indiana	3.2%			
BRFSS	Figure 3.A.4.2	binge***	1990 - 2005	Indiana	7.7%			
YRBSS	Figure 3.A.5.1	lifetime	2005	Indiana			73.9%	
YRBSS	Figure 3.A.5.1	past 30 days	2005	Indiana			41.3%	
YRBSS	Figure 3.A.5.1	binge ***	2005	Indiana			21.7%	
*	rate for latest year when multiple years are shown							
**	average 1+ drink per day in the last month							
***	5+ drinks on 1+ days in the past month							
****	5+ drinks on 5+ days in the past month							

- The Indiana birth certificate data indicates that the prevalence of alcohol use during pregnancy is 0.6 percent (2004); however, the National estimate of alcohol use during pregnancy is much higher (11.2% in 2004). Based on comparisons of alcohol use in the non-pregnant populations of Indiana and the U.S., it is expected that the prevalence of alcohol use during pregnancy in Indiana should be closer to 10 percent, since alcohol use among Indiana women is lower than in the U.S. Thus, alcohol use based on birth certificate data likely greatly underestimates the true prevalence of alcohol use during pregnancy in Indiana.

Table 3.D.2 Summary of Tobacco Prevalence Rates for Indiana Women [45, 47, 48, 49, 51, 52]

					Age	Age	Age	Pregnant
Data Source	Figure / Table	Prevalence Concept	Year(s) *	Area	18+	Childbearing Years	Grades 9-12	Childbearing Years
Birth Certificate	Figure 3.B.2.1	Use during pregnancy	1992 – 2004	Indiana				18.5%
NSDUH	Table 3.B.1.1	past 30 days	2003-2004	**national**		30.0%		18.0%
BRFSS	Figure 3.B.3.1	past 30 days	1990 – 2005	Indiana	25.0%			
YRBSS	Figure 3.B.4.1	lifetime	2005	Indiana			54.0%	
YRBSS	Figure 3.B.4.1	past 30 days	2005	Indiana			20.5%	
YRBSS	Figure 3.B.4.1	>20of30 days	2005	Indiana			9.7%	
ITPC ATS	Figure 3.B.5.1	past 30 days	2002	Indiana		30.0%		
ITPC ATS	none	past 30 days	2002	Indiana	26.5%			
ITPC YTS	Figure 3.B.6.1	past 30 days	2002	Indiana			19.7%	
*	rate for latest year when multiple years are shown							

- The Indiana birth certificate data indicates that the prevalence of tobacco use during pregnancy is 18.5 percent (2004), which is similar to the National estimate of tobacco use during pregnancy (18.0% in 2004). Based on comparisons of tobacco use in the non-pregnant populations of Indiana and the U.S., it is expected that the prevalence of tobacco use during pregnancy in Indiana should be higher than the U.S. rate, since the smoking rate in Indiana is higher than in the U.S. In addition, it is generally believed that self reported tobacco use underestimates the actual tobacco use prevalence. Thus, it is estimated that the actual tobacco use prevalence during pregnancy in Indiana is 20 percent.

Table 3.D.3 Summary of Drug Prevalence Rates for Indiana Women [45, 47, 49]

						Age	Age	Age	Pregnant
Data Source	Figure / Table	Substance	Prevalence Concept	Year(s) *	Area	18+	Childbearing Years	Grades 9-12	Childbearing Years
Birth Certificate	Figure 3.C.3.1	any drugs	use during pregnancy	1992 - 2004	Indiana				1.0%
NSDUH	Table 3.C.1.1	any drugs	past 30 days	2003-2004	**national**		10.2%		4.6%
NSDUH	Table 3.C.1.1	marijuana	past 30 days	2003-2004	**national**		7.5%		3.6%
NSDUH	Table 3.C.1.1	cocaine	past 30 days	2003-2004	**national**		1.0%		0.3%
NSDUH	Table 3.C.1.1	meth.	past 30 days	2003-2004	**national**		0.4%		0.1%
YRBSS	Figure 3.C.4.1	marijuana	lifetime	2005	Indiana			35.1%	
YRBSS	Figure 3.C.4.1	cocaine	lifetime	2005	Indiana			5.8%	
YRBSS	Figure 3.C.4.1	meth.	lifetime	2005	Indiana			6.1%	
Meconium Screen	Figure 3.C.7.1	any drugs	current	projected to 2004 from 1995	Indiana				6.3%
Meconium Screen	Figure 3.C.7.1	marijuana	current		Indiana				4.5%
Meconium Screen	Figure 3.C.7.1	cocaine	current		Indiana				1.2%
Meconium Screen	Figure 3.C.7.1	meth.	current		Indiana				0.3%
*	rate for latest year when multiple years are shown								

- The Indiana birth certificate data indicates that the prevalence of drug use during pregnancy is 1.0 percent (2004); however, the National estimate of drug use during pregnancy is higher (4.6% nationally in 2004). Based on the national data and the projections from the 1994 Indiana study projections (6.3% drug use prevalence), it is expected that the prevalence of drug use during pregnancy in Indiana should be closer to 5 to 6 percent. Thus, drug use based on birth certificate data likely greatly underestimates the true prevalence of drug use during pregnancy in Indiana.

CHAPTER 4: AVAILABLE TREATMENT SERVICES IN INDIANA FOR ALCOHOL, TOBACCO, AND OTHER DRUG USERS

Alcohol, tobacco and other drug (ATOD) treatment programs and services exist in all states. A few that are referenced in the literature are shown in Appendix E. This chapter focuses on only those ATOD treatment programs and services that the authors were able to identify in Indiana after an extensive search. There very well could be other programs that were not identified that should be included in a more comprehensive list. As detailed in the text that follows, a great deal of effort was expended to locate the Indiana programs – much more effort than a typical health care provider or substance user would be willing or able to devote to a search. Consequently, lack of awareness of existing treatment programs on the part of the authors likely reflects a lack of awareness of those same programs on the part of those individuals who need to know about those resources.

The presence of a treatment program on the Indiana resource inventory list does not indicate an endorsement on the part of the authors. Rarely were evaluation data available; thus, the success rates of the programs were unknown. Finally, the ability of the program to accept new clients or patients was also not available for most programs.

The resource inventory consists of a list of the identified ATOD treatment services and programs located in Indiana, as shown in Appendix E. It comprises of an alphabetical listing of ATOD treatment resources by county in Indiana. Within each county, the ATOD treatment facilities are listed alphabetically, along with the facility's address, telephone number, and the specific ATOD services provided. The resource inventory was compiled by using various Internet search engines that provided information regarding ATOD services available in Indiana. After identifying available treatment facilities, each facility was contacted to confirm the correct name, address, telephone number, and the ATOD services that are provided.

The following sources were used to identify the ATOD treatment resources in Indiana:

- Smokefree Indiana website http://www.smokefreeindiana.org/Upload/Files/countyclasses7.19.06.pdf, which is a complete list of the smoking cessation classes available in Indiana's 92 counties, was first used.

- Indiana Tobacco Quitline is also available by calling 1-800-QUIT-NOW. This comprehensive program includes a personalized quit plan and a proactive telephone-based treatment.

- Indiana Tobacco Prevention and Cessation (ITPC) website is http://www.in.gov/itpc/, which has a complete listing of all local tobacco control coalitions, the most updated tobacco use related data, and their contact information.

- MedlinePlus, a service of the U.S. National Library of Medicine and the National Institutes of Health, was used to locate substance use treatment facilities in Indiana's 92 counties. The website address is http://apps.nlm.nih.gov/medlineplus/local/indiana/list_location.cfm?areaid=13&service_id=32&service_type=term&invokedby=services.

- The Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Treatment Facility Locator was used, which is located at http://dasis3.samhsa.gov/PrxInput.aspx?STATE=Indiana. At this website a facility list search was again completed based on each of Indiana's counties. The SAMHSA's Center for Substance Abuse Treatment also operates the following toll-free referral hotlines, 1-800-662-HELP, 1-800-662-9832 (Espanol), and 1-800-228-0427 (TDD), for individuals in search of additional information.

- The Indiana Addictions Issues Coalition (IAIC) also has a website, http://recoveryindiana.org/modules.php?op=modload&name=Web_Links&file=index&req=viewlink&cid=1, which lists Indiana treatment facilities by county.

- Another website used was http://alcoholism.about.com/od/tx_in/, which lists Indiana treatment centers for Anderson, Bloomington, Elkhart, Evansville, Fort Wayne, Gary, Indianapolis, Jeffersonville, Merrillville, Plymouth, Richmond, South Bend, Terre Haute, and Valparaiso.

- At http://www.treatment-centers.net/rehab-centers/INDIANA treatment centers in the state of Indiana were listed by city; therefore, each city was entered into the GOOGLE search engine to determine which county the city was located in. Once the proper county was determined, each treatment facility could then be entered into the resource inventory. The next database used, http://www.imcpl.org/cgi-bin/irntop.pl, is provided by the Indianapolis Marion County Public Library (MCPL) and the Information Referral Network (IRN). This database provides information regarding health and human services for Marion County and its seven adjacent counties.

- Other websites that were used to produce the resource inventory include the following: http://www.ciamethwatch.com/help.html, http://www.drugfreemarioncounty.org/TreatmentDirectory/tabid/174/Default.aspx, and http://www.drugfreecouncil.org/pdf/jcrlist.pdf.

- To complete the resource inventory, Alcoholics Anonymous (AA), Cocaine Anonymous (CA), and Narcotics Anonymous (NA) support groups were included. However, due to confidentiality, limited information was available regarding the location of the support group meetings. The information that was available and was included in the resource inventory was found at http://www.aa.org/US_CTROffice/in.html, http://www.caindiana.org, and http://www.naindiana.org.

CHAPTER 5: ATTITUDES, KNOWLEDGE AND BARRIERS PREVENTING ACCESS TO TREATMENT BY ALCOHOL, TOBACCO, AND OTHER DRUG USERS

It is not possible to accurately capture and relate the intensity of the true emotion, the enormity of the concerns and the needs expressed at the focus group meetings by the women who were willing to share with us, their problems and experiences with alcohol, tobacco and other drugs (ATOD) use. Words can not even begin to reflect the difficulties they face(d) and what might be needed to improve their life, and just as important, the lives of their children. We hope that their message comes through and that their voices are heard. Treatment of ATOD use is a major challenge for them, their families, their providers, and their communities.

BARRIERS IDENTIFIED IN THE PEER-REVIEWED LITERATURE

Literature suggests that socio-demographic factors such as race/ethnicity, level of education achieved, marital status, having previous children, fear of losing custody of their child, shame, depression, denial, fear that their partners will abuse them and/or leave them if they seek treatment services, existence of waiting lists for treatment slots, a lack of child care, and a lack of transportation have all been identified as barriers for pregnant women to locate, enter and complete ATOD treatment. Other factors, such as single parenthood, lack of social support, financial limitations, legal problems, poor health status, social and psychological problems, poor housing, inadequate income, lack of education, and emotional difficulties have a negative effect on an individual's ability to enter treatment. For drug dependent persons, identified extrinsic barriers include negative societal attitudes; myths about drug dependency; program restrictions; the stigma of substance use especially for pregnant women and new mothers; high levels of family and spousal resistance to treatment; enduring physical, sexual and emotional abuse; negative attitudes of healthcare providers; and punitive public policies. [2, 9, 29, 33]

Policies that attempt to stop maternal drug use through detection and punishment include surveillance-oriented drug testing, arrest, prosecution, imprisonment, and temporary or permanent loss of child custody. However, studies have shown that threats and warnings can be de-motivating as they instill distrust in the health care system and therapeutic uncertainty that could destroy the alliances with helping professionals. [2]

Health care providers' reluctance to screen pregnant women for substance use and abuse arises from a number of factors, including their concerns and misconceptions about the liability and risks associated with treating pregnant women who are substance users, a lack of knowledge about substance use and referral options, and a lack of confidence in the effectiveness of treatment interventions. [23] These knowledge gaps are combined with the state laws designed to criminalize drug use during pregnancy, women's fears that they might lose custody of their children, and the social stigma experienced by women who abuse alcohol or use illicit drugs. Furthermore, communicating with patients about sensitive ATOD issues takes time, requires skills, and is poorly reimbursed by procedure-oriented insurance coverage. [11]

Pregnant women using ATOD who have not participated in drug treatment programs in the past may also fear the unknown and may be afraid of what the treatment actually entails. They might fear that seeking help would cause them to be labeled as a drug user and then shunned by friends and/or family members, causing them to leave medical and/or drug treatment early or to forego it entirely. In contrast, women with previous drug treatment experience however, know what the treatment entails and would therefore be less fearful of returning to treatment. They realize that it might be necessary to build new drug-free social relationships that could only be achieved through successful completion of a drug treatment program. Additionally, a woman whose partner has been in substance use treatment is more likely to comply with treatment than a woman whose partner has never been in treatment. If a partner is familiar with what is required for successful completion of a substance use treatment program, then the partner may be more supportive of the woman's efforts to remain substance-free than someone who is either using or who is unaware of the difficulties faced in attempting to break free from the addiction. [8]

In contrast, higher alcohol use has been associated with increased compliance to treatment in women. [8] However, heavily drinking women from lower socioeconomic strata may not enter prenatal care until after the first trimester due to fear of forced treatment, involuntary commitment, and criminal sanctions. Other barriers that prevent these women from obtaining prenatal care early are a lack of insurance, an inability to pay for out-of-pocket expenses, and not having a regular source for health care services. [9] As a result, many women fail to enter the healthcare system for prenatal care and simply appear at the hospital when they are about to deliver.

METHODS USED TO IDENTIFY BARRIERS THROUGH FOCUS GROUPS AND KEY INFORMANT INTERVIEWS

To complement the barrier information derived from the review of the peer-reviewed literature, focus groups and key informant interviews were conducted in Indiana to provide a better understanding of the ATOD treatment access problems for Hoosiers. Obtaining information from three separate groups, each associated differently with the use and/or treatment of ATOD resulted in many similar opinions. The three groups consisted of:

- Women who were or had been pregnant and used ATOD in Indiana,
- Individuals who were active ATOD treatment providers, and,
- Primary care providers (PCPs), which included family physicians, obstetricians, nurse midwives and clinical nurse practitioners.

Three different instruments were used to gather information from these three groups of individuals. Formal focus groups were conducted with 51 pregnant women or new mothers with a history of substance use at 5 Prenatal Substance Use Prevention Program (PSUPP) sites in Indiana. In addition, personal interviews were conducted with 11 treatment providers who were selected for their experience in treating women using

ATOD; two PCPs were interviewed; and, another 12 PCPs participated in a key informant-style survey. The focus groups and key informant interview scripts can be found in Appendices A-1 and B-1 and the PCP key informant-style survey instrument is located in Appendix C-1. The responses from the focus groups, key informant interviews and primary care providers, are included in Appendices A-2, B-2 and C-2, respectively.

I. The information obtained from the ATOD Focus Groups was reviewed and placed into seven categories for presentation in the report. The numbers following each category refer to the item question on the script/survey.

a. User Knowledge, Attitudes and Awareness [FG #1-3]
b. Treatment Provider and PCP Behavior and Knowledge [FG #4-5]
c. Obstacles and Barriers to Accessing Care [FG #6-7]
d. Treatment Center Availability [FG #8-10]
e. Public Awareness and the Stigma of ATOD Use [FG #1-11]
f. Other Attitudes and Opinions [FG #1-11]
g. Focus Group Participant Suggestions [FG #11]

II. For the ATOD Treatment Provider (TP) Key Informants, the information was placed into six categories:

a. ATOD Treatment Provider Practice Profile [TP # 1-4]
b. ATOD User Knowledge and Awareness [TP #5]
c. ATOD Treatment Provider Behavior and Knowledge [TP # 6]
d. Obstacles and Barriers to Accessing ATOD Treatment [TP #7]
e. ATOD Treatment Center Availability [TP# 8-9]
f. ATOD Treatment Provider Suggestions [TP #10]

III. The results from the Primary Care Provider Interviews/ Surveys were placed into six categories:

a. PCP Practice Profile [PCP #1]
b. ATOD User Knowledge and Awareness [PCP #2]
c. PCP Behavior and Knowledge [PCP #3-8]
d. Obstacles and Barriers to Accessing ATOD Treatment [PCP #9]
e. ATOD Treatment Center Availability [PCP #10-12]
f. PCP Suggestions [PCP #13]

For each of the above categories, several major themes were extracted based on the results by the report authors, to highlight and summarize the overall statements made by the groups. The data have been edited to permit anonymity, with the exception that cities or counties are listed, when the comment refers to the need for additional treatment facilities. It should also be noted that the statements are not presented verbatim from the tape recordings, but are based on the notes taken and edited for grammar and clarity while still reflecting the major themes provided by the participants. The tape recordings of the focus groups were available to fill in missing information or to clarify a point. The recommendations and suggestions made by the participants are listed under each section.

COMMON THEME FROM ALL FOCUS GROUPS AND PROVIDERS

One suggestion that was repeated at all focus groups, most key informant interviews and in many of the PCP surveys was that ATOD information has generally been negative in its approach. Much of this information is about the harmful effects of ATOD use on the fetus with less emphasis being on the post-partum child or on the mother herself. There was a strong belief often stated by the three groups that more supportive messages need to be presented to the public, the women using ATOD, the ATOD treatment providers and the PCPs.

The most relevant statements are presented below:

ALL WE EVER HEAR IS NEGATIVE—NOTHING IS EVER POSITIVE.

WE NEED TO FRAME MESSAGES WITH LESS GUILT—BE MORE POSITIVE.

I HAVE HEARD THINGS FROM MY PATIENTS LIKE "I WAS REALLY DISCOURAGED AT FIRST WITH ALL THE NEGATIVE STUFF".

AT THE RIGHT TIME, THE RIGHT MESSAGE WILL WORK IF YOU TALK TO THEM DIRECTLY.

THERE NEEDS TO BE MORE POSITIVE MESSAGING—"WE CAN HELP YOU QUIT AND YOU CAN DO IT". I HAVE NEVER SEEN THIS TYPE OF MESSAGE AND IT REALLY WOULD BE GOOD TO USE THIS APPROACH.

WE NEED TO PROVIDE MORE POSITIVE MESSAGES. FOR EXAMPLE, A FORMER ATOD USER MIGHT "I HAD A SUBSTANCE PROBLEM AND PSUPP WORKS. THE PROGRAM STAFF CAN HELP YOU".

The positive messages should at minimum, bring to the ATOD user the message that: **WE [THE TREATMENT PROVIDER/FACILITY] ARE HERE TO HELP YOU AND WE HAVE BEEN SUCCESSFUL WITH OTHERS. IF YOU WANT HELP WITH YOUR SUBSTANCE USE PROBLEM, WE WANT AND CAN HELP YOU.**

PHYSICIANS AND TREATMENT PROVIDERS NEED TO BE MORE POSITIVE, SUPPORTIVE AND EMPOWER THEIR PATIENTS BY SAYING "YOU ARE DOING A GOOD JOB AT TRYING TO GET BETTER; THE TREATMENT YOU ARE RECEIVING REALLY DOES WORK; AND, YOU ARE A REAL GOOD PERSON FOR GETTING THE HELP YOU NEED."

When examining the individual statements listed below (and in the appendices), clearly negative rather than positive approaches and attitudes tend to be the main theme of the messages given. The statements indicate that multiple approaches need to be taken to eliminate the many barriers and obstacles that prevent women from accessing needed ATOD treatment. The overall conclusion is that addressing the stigma and the concentration on negative advertising may represent the most difficult challenge for policy makers to address and rectify.

I. FOCUS GROUP RESULTS

I.A. USER KNOWLEDGE, ATTITUDES AND AWARENESS [FG #1-3]

Perceived Prevalence:

The majority of the focus group participants reported that they felt that most pregnant women smoke. When asked about pregnant women who use alcohol or drugs, the most common belief was fewer women drank and even fewer used drugs while pregnant. Many felt that the women who used drugs before pregnancy stopped when they found out they were pregnant. [Focus Group #1]

Impact of ATOD on Mother and Fetus:

The focus group participants reported many health effects related to ATOD use, including asthma and other respiratory problems, birth defects, Downs Syndrome, cystic fibrosis, miscarriage, low birth weight, and premature delivery. [Focus Group #2a]

Impact of ATOD on the Baby Post-Partum:

The focus group participants listed several health problems that could be caused by the mother using alcohol, tobacco and drugs after the baby is born, including sudden infant death syndrome, asthma and respiratory conditions, fetal alcohol syndrome, drug withdrawal symptoms, ear infections and learning disabilities. The groups also clearly understood the possible effects from secondhand smoke. [Focus Group #2b]

Women Aware of the Health Effects:

Most of the focus group participants felt that most women in the community know the general harmful health effects of ATOD use during pregnancy; however, they believed that most women do not know the specific details of harm caused by each type of substance. Further, it is clear that they were not aware of the concept of greater likelihood or increased risk of harm relative to different types and amounts of ATOD use. It was also a common belief that they may be aware of the risk but that they really believed that these problems will not happen to them. The rationale seemed to be that they know many people who have used alcohol, tobacco and other drugs and have had normal babies. Also, they know the potential for harm to themselves or their baby but felt that they cannot do anything about it—the addiction is so powerful. Given the environment around them-they believed that they just could not stop using the substance. [Focus Group #3]

Information Needed:

The majority of the focus group participants felt that there was a need for more positive information, but there was also the underlying feeling that many women would not read or pay attention to the information. However, they agreed that more information about the harmful effects of specific substance use needs to be made public. A major point that was made was that the messages need to be aimed at all women of child bearing age and not just pregnant women. Some felt that more information was needed about the effects of second-hand smoke (SHS) as many women tend not to believe that SHS is a real health risk. [Focus Group #3b]

How to Best Provide the Information:

The focus group participants were in agreement that radio and television messages, followed by pamphlets and brochures distributed in physician offices, would be the most effective means to distribute information. The common theme of positive/supportive messaging was raised at all the focus groups; it was felt that the issue of the positive or supportive message was more important than the way it is distributed. [Focus Group #3c]

KEY STATEMENTS:

MANY WOMEN SAY THAT NO, THEY DO NOT USE DRUGS, BUT DO USE MARIJUANA—THEY DO NOT CONSIDER MARIJUANA A DRUG.

I BELIEVE THAT NO ONE WANTS TO USE ATOD DURING PREGNANCY BUT THEY CAN NOT ALWAYS SAY NO. MANY ADDICTS DO NOT EVEN KNOW THAT THEY HAVE A PROBLEM. THEY USE IN ORDER TO HAVE FRIENDS TO HANG OUT WITH. THEIR PARTNER SAYS 'IT'S NOT FAIR, MY GIRLFRIEND DOES NOT WANT TO GET HIGH WITH ME' WHICH GIVES US A REAL GUILT TRIP. WHAT NEEDS TO HAPPEN IS THAT I NEED TO HANG OUT WITH RESPECTFUL PEOPLE.

ABUSING PRESCRIPTION DRUGS IS AS COMMON AS OR MAYBE EVEN MORE COMMON THAN STREET DRUG USE.

NOT ONLY AIM SUBSTANCE ABUSE INFORMATION AT PREGNANT WOMEN BUT AIM THE MESSAGES AT ALL WOMEN OF CHILD BEARING AGE.

YES, THEY KNOW ABOUT THE HARMFUL EFFECTS OF ATODS AND THEY CARE BUT GIVEN THE SITUATION AROUND THEM (NO HOUSE AND NO MONEY) THEY CANNOT GET OUT OF THE PROBLEM.

I BELIEVE THAT THE PROBLEMS OCCUR TO THEIR BABY AND NOT TO MINE.

WE NEED MORE INFORMATION ON WHERE TO GO FOR TREATMENT BUT ALL WE EVER HEAR IS THAT "THERE IS NO PLACE TO GO".

WOMEN DO NOT BELIEVE THAT DRUGS WILL HURT THEIR BABY AND THAT THE CHILD PROTECTION SERVICES THREAT WILL NOT SEEM REAL UNTIL IT HAPPENS. THEY WILL CONTINUE TO USE EVEN IF THEY KNOW THEY WILL LOSE THEIR BABY, BUT CANNOT QUIT---IT [DRUGS] IS VERY POWERFUL.

WOMEN UNDERSTAND ALCOHOL AND CIGARETTES BUT NOT THE DRUG IMPACT.

THEY NEED TO BE TOLD THAT IT'S OKAY TO TRY AND STOP GRADUALLY AND NOT JUST BEING TOLD "NOT TO USE AT ALL". PROVIDE PRAISE FOR SOME REDUCTION.

THERE NEEDS TO BE MORE POSITIVE MESSAGING—"WE CAN HELP YOU QUIT AND YOU CAN DO IT. I HAVE NEVER SEEN THIS TYPE OF MESSAGE AND IT REALLY WOULD BE GOOD TO USE THIS APPROACH.

I HAVE HAD ALL THE INFORMATION IN THE WORLD ABOUT DRUGS AND THE EFFECTS ON MY BABY AND HAVE HAD ALL THE GUILT I CAN HANDLE, BUT THAT DID NOT STOP ME FROM USING METH. HELP ME TO QUIT PLEASE!

TELL ME WHERE I CAN GO FOR HELP-THERE IS NO PLACE TO GO.

THERE IS SO MUCH CONDEMNATION—DRUG ADDICTION IS A DISEASE AND WE NEED HELP.

PHYSICIANS NEED TO TALK MORE ABOUT ADDICTION AND THEY NEED TO KNOW THAT THERE IS A GREAT DEAL OF PERSONAL ANXIETY IN OUR TELLING THEM.

I.B. TREATMENT PROVIDER AND PCP BEHAVIOR and KNOWLEDGE [FG #4-5]

Concern about Use of Small Amounts of ATOD

The focus group participants felt strongly that we should worry about women who use small amounts of alcohol, tobacco and drugs based on the fact that people can start with small amounts and gradually increases to a point where they are using larger and more unsafe amounts. Most felt that there is no safe level of ATOD use. [Focus Group #4]

Provider Communication about Your ATOD Use:

The focus group participants reported that a provider had asked most of them about their ATOD use, most during an initial clinic visit. However, many felt that women are afraid to tell their doctor because the consequences are so high. Some of the women reported that the provider took time to talk with them about the harmful effects of ATOD use while pregnant but others had just advised them to quit for their benefit and the baby's. The majority of the participants reported that they feel comfortable talking about ATOD use with their provider and several commented they had no problem "volunteering" their ATOD experience with their provider. Some felt that more information was needed from their PCPs about the effects of secondhand smoke exposure. [Focus Group #5]

KEY STATEMENTS:

DOCTORS NEED TO TELL ME HOW TO STOP, NOT WHAT WILL HAPPEN IF I DON'T.

IT IS NOT HARD (to talk about my ATOD use) IF THE PHYSICIAN LISTENS AND DOES NOT JUDGE ME.

ONE CAN ACCOMPLISH A LOT WITHOUT BEING RIDICULED OR BELITTLED.

GREAT IF THEY WORK WITH YOU TO SET A GOAL.

I HAVE THREE KIDS AT HOME AND AM STILL USING DRUGS. IF I AM FOUND TO BE NOT CAPABLE OF TAKING CARE OF THEM, I WILL LOSE MY KIDS SO I WILL NOT TELL THE PROVIDER ABOUT MY ADDICTION. WHAT IS THE SOLUTION? I KNOW ALL THE RISKS AND THEY ARE HORRIBLE. MY SON IS 10 AND I DO NOT HAVE CUSTODY OF HIM BUT HE DOES HAVE ALL HIS FINGERS AND TOES. IF I AM ARRESTED AND CONVICTED OF A FELONY, I WILL NOT RECEIVE ANY MEDICAID, HOUSING ASSISTANCE, STUDENT LOANS OR A GOOD JOB. SO, ONCE IN THE SYSTEM, YOU HAVE TO LIE TO MAKE IT—YOU NEVER GET HELP AND END UP SELLING DRUGS TO SURVIVE. IT IS A WICKED, VICIOUS SYSTEM. WE LACK GOOD TREATMENT CARE FOR WOMEN AND WE NEED A MAN TO TAKE CARE OF US. IT'S INSANE REALLY—WHATEVER IS DONE FOR OR TO US, LEADS TO MORE DRUGS.

I.C. OBSTACLES AND BARRIERS TO ACCESSING CARE [FG #6-7]

How to Encourage Women Using ATOD to Seek Treatment:

The time used responding to this question consumed almost one-half of the time allocated for the sessions. The focus group participants were generally in agreement that there were several major categories of obstacles and barriers that impeded their access to ATOD treatment services. This listing of barriers is not arrayed by frequency or by level of importance, but only reflects that the item was raised as being a potential problem. The barriers included:

- Lack of Motivation and Desire to Quit; Needs to Want Help
- Lack of a Positive Based Program—show me how to quit, not just scare me
- Financial Barriers ---unable to afford the ATOD treatment
- Lack of Child Care
- Employment Problems
- Getting a Bad Person label-stigma
- The belief that ATOD is not a problem
- Lack of Family Support and Encouragement for me to quit
- Lack of Knowledge about Treatment Center Location
- Scared of child protection services (CPS) and losing my baby

KEY STATEMENTS:

FOR INDIVIDUALS THAT WORK, BUT STILL DO NOT HAVE ENOUGH TO PROVIDE FOR THEIR CHILDREN, MEDICAID STILL DOES NOT COME THROUGH. YOU HAVE TO BE DIRT POOR.

IF YOU ARE LIVING IN POVERTY, YOU CANNOT GET YOURSELF BETTER BECAUSE YOU WILL LOSE YOUR MEDICAID BENEFITS.

I HAD TO QUIT MY MCDONALDS 8-5 JOB TO CARE FOR MY BABY AS IT IS HARD TO MAKE APPOINTMENTS WITH THE DOCTOR AT OTHER TIMES BECAUSE THEIR CLINIC HOURS ARE 9-5.

ALL CLINICS NEED A PSUPP TYPE PROGRAM THAT DOES NOT JUST TELL YOU "DON'T QUIT" BUT OFFERS HELP. DO NOT JUST SCARE ME AND SAY MY "KID WILL BE STILLBORN".

PREGNANT WOMEN CANNOT GET HIRED---IT'S LIKE A DISEASE.

IT IS NOT WORTH WORKING ONLY TO PAY FOR CHILDCARE.

PEOPLE NEED HELP BUT DO NOT KNOW WHERE TO GO.

MORE SEEING AND DOING AND NOT JUST BEING TOLD TO STOP.

THERE IS A BAD PERSON SYNDROME—I AM A BAD MOTHER IF I USE ATOD.

I.D. TREATMENT CENTER AVAILABILITY [FG #8-10]

Awareness of ATOD Treatment Facilities:

Basically, with the exception of the focus group participants who were clients in the PSUPP program, very few knew of any places where pregnant women could go to receive treatment for ATOD use. [Focus Group #8]

Need for Treatment Services:

The majority of the focus group participants definitely felt there was a need for ATOD treatment services in their community/county. [Focus Group #9]

PCP Awareness of ATOD Treatment Services:

The common perception among the focus group participants was that primary care providers in general, do not know about the availability of ATOD treatment services in the community. [Focus Group #10]

KEY STATEMENTS:

THERE ARE NO IN-PATIENT SERVICES AVAILABLE FOR DRUG ADDICTS WHICH REALLY COMPLICATES THINGS. WE REALLY NEED TO BE ABLE TO GET OFF THE STREET.

THE PROBLEM WITH NARCOTICS ANONYMOUS MEETINGS (NA) IS THAT THE ROOM IS FILLED WITH FRIENDS THAT ARE STILL DOING DRUGS AND I REALLY NEED TO GET AWAY FROM THEM. BUT THEY ARE IN NA AND ARE STILL USING—WE NEED INDIVIDUAL TREATMENT.

I.E. PUBLIC AWARENESS AND THE STIGMA OF ATOD USE [FG #1-11]

The message from the focus group participants was very clear and strong – the public needs to be more aware of and better understand the problems associated with ATOD use. The shame and blame stigma is wrong and does not help the individual succeed in her attempt to quit substance use. As noted in the overall theme message, more supportive messages from the treatment providers, such as “I can help you” and society’s recognition that “I suffer from a disorder” would be of great benefit. There is a need for more residential facilities and especially those that house both the mother and the child. Families need to be involved in the treatment process so that the ATOD user can succeed in her effort to quit and can ultimately function better as a family unit.

KEY STATEMENTS:

THERE HAS TO BE MORE FACILITIES BASED AROUND THE MOTHER AND THE CHILD. MANY OF US ARE SINGLE PARENTS AND DO NOT WANT TO GIVE UP OUR BABY.

I BELIEVE THAT THE WHOLE FAMILY NEEDS TREATMENT—THE MOTHER AND THE CHILDREN. WE NEED TO LEARN HOW TO DEAL WITH OUR FRIENDS COMING BY WITH DRUGS—HOW CAN WE REACT? WE NEED MORE FACILITIES THAT FOCUS ON THE FAMILY UNIT.

NUMBER ONE RECOMMENDATION---MORE RESIDENTIAL FACILITIES ARE NEEDED THAT INCLUDE THE FAMILY (MOTHERS AND BABIES AND OTHER CHILDREN).

THERE WOULD BE NO NEED CHILD PROTECTION SERVICES (CPS) AND FOSTER HOMES IF WE HAD IP RESIDENTIAL FACILITIES AVAILABLE—WE COULD KEEP THE BABY WITH US WHILE WE GET CLEAN.

I.F. OTHER ATTITUDES AND OPINIONS [FG #1-11]

The bottom line is that treatment does work. The pregnant woman using ATOD most likely wants to get better for her child's benefit, but is facing a myriad of social and individual problems that prevent her from getting "clean". A strong message that was often repeated was that criminalizing pregnant women who use ATOD does not solve the problem but on the contrary, may keep women from seeking prenatal care for fear of detection. A felony charge will prevent or hamper women from furthering their education, securing better housing, having good nutrition, and obtaining adequate medical care.

KEY STATEMENTS:

TREATMENT DOES WORK.

REDUCE THE ANXIETY AND FEAR LEVEL OF LOSING MY CHILD—TELL ME HOW TO GET BETTER.

PHYSICIANS DO NOT KNOW WHAT TO DO WITH ATOD USERS NOR WHERE TO SEND US.

PHYSICIANS NEED TO KNOW THE IMPORTANCE OF THE INITIAL VISIT AND THEY SHOULD NOT PUNISH YOU BUT GIVE YOU OPTIONS.

MORE TREATMENT PROVIDERS SHOULD USE OUR PEERS (OTHER CLEAN USERS) FOR COUNSELING—IT IS A CHALLENGE TO FIND THE RIGHT PEOPLE BUT IT WOULD BE GOOD.

TOBACCO DOES NOT DO AS MUCH HARM TO THE BABYAS METHAMPHETIMINE.

REHABILITATION IS PART OF RECOVERY AND THERE WILL BE MANY RELAPSES.

PLEASE HELP ME BEFORE I GET PREGNANT, NOT AFTER.

SOME USERS GET PREGNANT TO GET MOTIVATION TO TRY AND STOP USING. I SAID I WOULD QUIT IF I GOT PREGNANT BUT IT ONLY GOT WORSE.

DEVELOP A BUDDY SYSTEM TREE TO PROVIDE SUPPORT FOR THOSE TRYING TO CUT DOWN.

INCREASE ADVERTISING AND MARKETING ABOUT THE POSITIVE SIDE OF TREATMENT---IT CAN AND DOES WORK.

EDUCATE THE TREATMENT PROVIDERS—THEY HAVE TO BE HERE AND WALK IN MY SHOES TO KNOW WHAT I DID. I CANNOT UNDERSTAND WHAT I DID. IT MAKES NO SENSE TO ME.

I.G. FOCUS GROUP PARTICIPANT SUGGESTIONS [FG #11]

The women using ATOD, treatment providers and primary care providers need to:

- Know what ATOD treatment services are available in each community
- Have an understanding of the success rate for each treatment program
- Make pregnant mothers more aware of the harmful effects of secondhand smoke

Primary care providers need to:

- Play a key role in assisting the efforts of their ATOD patients to quit by giving them advice and encouragement
- Do more screening for ATOD use
- Communicate more with women using ATOD and ask the appropriate questions on each visit
- Refer their more complex patients using ATOD for specialized treatment

The State of Indiana needs to:

- Encourage the establishment of in-patient, comprehensive residential ATOD treatment facilities that have services available to both women and their children
- Develop a telephone hot line especially for smoking, alcohol and drug relapsers

Individual stigmas to be addressed in attempts to reduce their impact include:

- Guilt
- Shame
- Blame
- Judgmental
- Afraid of criminalization or loss of child---do not access pre-natal care
- Lack of trust—fear of the system

Barriers and obstacles to accessing ATOD services need to be addressed to eliminate their impact on accessing ATOD services:

- Lack of transportation
- Lack of child care
- Lack of knowledge of availability
- Limited financial means to obtain care
- Mistrust of the Child Protection Service (CPS)
- Mistrust of healthcare and treatment providers

Increase the availability of ATOD treatment facilities

- Clinics and treatment service providers should provide services both during the day and during evening hours
- More residential, family-based facilities are needed in Indiana

II. TREATMENT PROVIDER KEY INFORMANT RESULTS

II.A. ATOD TREATMENT PROVIDER PRACTICE PROFILE [TP #1-4]

Estimated Volume of Women Using ATOD by Substance:

For the most part, the ATOD treatment providers interviewed do not see many pregnant users of alcohol and one person noted that "it is less than the 1990's and part of this may be due to the increased awareness of fetal alcohol syndrome". On the other hand, they report that a much higher proportion (some where between 50% and 95% of their patients) use tobacco while pregnant. Just about all of the ATOD treatment providers treat pregnant women who are using drugs, with the majority using illegal substances. However, some report that they are experiencing a shift from illegal drug use to abuse of prescription drugs. [Treatment Provider # 1]

Percent Referrals from Primary Care Providers (PCPs):

Few of the ATOD treatment providers reported that they receive referrals from PCPs outside of their agency or institution; most of their patient referrals come from physicians within their healthcare system. Few of their ATOD patients are self-referred but many are court ordered to seek treatment. [Treatment Provider # 2]

Perceived Success Rate of Women Using ATOD:

As expected, the treatment providers have different definitions of success and most stated that while total abstinence was the most desirous goal, cutting back was also seen as a positive step for the patient. Some of the treatment providers were able to cite a quantitative success rate, others were not. It was generally felt that it would be a good idea to better publicize their success, as not having this publicity may be a reason why the public is not aware of their program. [Treatment Provider # 3]

PCP Awareness of my ATOD Treatment Practice:

There appears to be a general perception among the treatment providers that primary care providers are not well aware of the services provided by the program and some treatment providers feel that PCPs are also not familiar with ATOD treatments. [Treatment Provider # 4]

KEY STATEMENTS:

SOME, BUT IT IS LESS FREQUENT NOW THAN IN THE 1990'S AS THE CAUSE AND RISK OF FETAL ALCOHOL SYNDROME IS BETTER KNOWN NOW. ALCOHOL USE AMONG PREGNANT WOMEN IS NOT AS BAD AS IT USED TO BE.

TOBACCO USE IS MOST COMMON OF THE THREE. ABOUT 75 PERCENT USE TOBACCO—IT IS A HUGE PROBLEM.

THE MAJORITY OF PREGNANT WOMEN USE TOBACCO, BUT WE DO NOT DEAL WITH TOBACCO-WE DEAL WITH ALCOHOL AND OTHER DRUGS.

METHAMPHETAMINE IS REALLY A HUGE PROBLEM AS IS MARIJUANA WHERE THEY USE EVERY DAY OF THE WEEK. THE CLIENTS SAY THAT MARIJUANA IS HARMLESS AS

THERE IS NO RESEARCH ON FETUS DAMAGE FROM RECREATIONAL USE. MANY USERS ARE TRYING NOT TO USE AS MUCH AND TRY TO CUT BACK.

MOST OF THE PATIENTS ARE OUR SYSTEM PATIENTS; FEW COME FROM OUTSIDE THE SYSTEM.

ABOUT ONE-THIRD OF OUR CLIENTS ARE SELF-REFERRED WITH MANY OF OUR INDIGENT, CHRONIC POPULATION HAVING BEEN IN TREATMENT BEFORE, SO THEY KNOW US. THEY BECOME AWARE OF US THROUGH WORD-OF-MOUTH AND BY LOOKING IN THE PHONE BOOK. ONE-HALF COME FROM THE COURT SYSTEM. TYPICALLY, AN ATTORNEY WILL ADVISE THEM TO START TREATMENT BEFORE THEY APPEAR IN COURT FOR A DUI OR POSSESSION CHARGE.

THE MAJORITY ARE FROM THE COURT SYSTEM—ABOUT 75 TO 80 PERCENT AND THE MAJORITY OF THESE ARE ORDERED INTO TREATMENT/. ABOUT 15 PERCENT ARE LAWYER REFERRED TO DEMONSTRATE BEFORE THEIR COURT APPEARANCE THAT THEY ARE IN TREATMENT.

ONE MUST REMEMBER WHEN MEASURING SUCCESS, THAT THERE ARE MULTIPLE AGENDAS AT WORK WITH THE ADDICTED PATIENT.

OUR PRIMARY FOCUS IS INTOXICATION AND OUR GOAL IS TO HELP THE PATIENT ACHIEVE A DRUG FREE LIFE STYLE. MOST OF OUR CLIENTS USE MORE THAN 1 SUBSTANCE AND BASICALLY HAVE A "LOVE AFFAIR" WITH INTOXICATION.

THE CRITICAL QUESTION IS HOW DOES ONE DEFINE SUCCESS? WE SAY THAT THE "MAJORITY" OF OUR PATIENTS MAKE PROGRESS WHILE IN TREATMENT. THAT IS, THEY USE LESS, ARE MORE AWARE OF THE CONSEQUENCES OF USING, AND ARE FUNCTIONING BETTER OVERALL. WE ALSO TRACK THEIR EMPLOYMENT AND EDUCATION PROGRESS AND WHETHER THEY COMPLETE THE TREATMENT. IF THEY USE ONLY ONCE OR TWICE IN 8 WEEKS, WE FEEL THAT IS A SUCCESS. IF THEY ARE USING CRACK EVERYDAY AND COME INTO TREATMENT AND ARE CLEAN IN 8 MONTHS THAT IS SUCCESS, EVEN IF THEY HAVE SLIPPED IN TO A RELAPSE AND NEED TO GET BACK INTO TREATMENT. OUR POLICY GOAL IS ABSTINENCE.

WE HAVE BEEN VERY SUCCESSFUL IN GETTING OUR TOBACCO USERS TO CUT DOWN AND HAVE BEEN VERY SUCCESSFUL WITH OUR QUIT RATES. WE DO A QUIT RATE FOLLOW UP STUDY WITH OUR CLIENTS AT 1, 3 AND 6 MONTHS POST-PARTUM. OUR PRE-NATAL AND MEDICAL CLIENTS HAVE A 30 PERCENT QUIT RATE; THE CUT DOWN RATE IS MUCH LARGER. WE BELIEVE THAT CUTTING DOWN IS ALSO IMPORTANT AND POSITIVE AS THE CLIENT IS SUBJECT TO LESS TOXINS AND 3-5 CIGARETTES IS BETTER THAN 1-2 PACKS PER DAY.

SUCCESS IS HARD TO MEASURE. IS IT YOU HAVE EMPLOYMENT, AN APARTMENT AND ARE EATING REGULARLY BUT ARE NOT COMPLETELY CLEAN? IT IS REALLY A STEP WISE PROBLEM. I BELIEVE THAT SUCCESS IS REDUCING HARM BY REDUCING USE. WE HAVE QUITE A FEW SUCCESSES (75%).

FOR DRUGS, WE HAVE A 70-75 PERCENT SUCCESS RATE. WE DEFINE SUCCESS AS CONTINUED ABSTINENCE FOR A YEAR. IF A PERSON RELAPSES, IT IS NOT CONSIDERED A SUCCESS. WE BASE IT ON THEIR SELF-REPORT.

ALCOHOL USE IS LEGAL BUT A PERSON WHO ABUSES IS STILL AN ADDICT. OUR GOAL IS TOTAL ABSTINENCE.

FOR OUR PREGNANT ADDICTS, THE RELAPSE TIME IS SHORTER AND THERE ARE FEWER RELAPSES IN THE NON-PREGNANT POPULATION. WE WANT TOTAL ABSTINENCE FOR THE PREGNANT WOMEN.

IN MY OPINION, PCPS ARE UNCOMFORTABLE APPROACHING THEIR PATIENTS WITH QUESTIONS ABOUT THEIR ATOD USE. THEY KNOW LITTLE ABOUT SUBSTANCE ABUSE AND LACK THE KNOWLEDGE OF HOW TO TREAT IT. THEY DO GENERALLY DO NOT HAVE A SOCIAL WORKER ON STAFF THUS MAY NOT KNOW WHERE TO REFER THEIR PATIENT FOR HELP.

I BELIEVE THAT THEY KNOW ABOUT CLASSES FOR TOBACCO CESSATION BUT THEY DO NOT KNOW ABOUT TREATMENT SERVICES FOR ALCOHOL AND DRUG SUBSTANCE USE.

THERE IS A GENERAL LACK OF AWARENESS OF ATOD TREATMENT SERVICES IN THE COMMUNITY AND COMPOUNDING THIS IS THE FACT THAT PHYSICIANS ARE NOT FAMILIAR WITH ADDICTION TREATMENTS.

THEY [REFERRALS] DO NOT COME VIA A PCP REFERRAL AS HAVING A REGULAR SOURCE OF CARE IS NOT REALITY TO THEM; THEY WILL USE THE HOSPITAL EMERGENCY ROOM FOR THEIR PRIMARY CARE.

II.B. ATOD USER KNOWLEDGE AND AWARENESS [TP #5]

Women Aware of the Health Effects and Need for a Better Job Informing Them:

The ATOD treatment providers felt that the ATOD user is generally aware of the harmful effects of substance use while pregnant but may not have a good grasp of the specific effect. The problem seems to be that they also tend to believe that "it will not happen to me" as "I know many people who were using and have had normal babies". The majority of the treatment providers believe that we need to do a better job informing pregnant women of the hazards of ATOD use while pregnant. [Treatment Provider # 5 and 5a]

Information Needed:

All of the ATOD treatment providers interviewed felt strongly that more information was needed. Most replied that the messages need to be more positive—"here is our program and we have the ability to help you with your substance use". They felt that the treatment providers need to show evidence of their ability to help people quit their ATOD use. Users need to know that help is available and it works. [Treatment Provider # 5b]

How to Best Provide the Information:

Answers from the treatment providers varied considerably, which may indicate that there is no best way to provide ATOD information. [Treatment Provider # 5c]

KEY STATEMENTS:

IT'S NOT IGNORANCE, ITS AMBIVALENCE.

WE NEED TO FRAME MESSAGES WITH LESS GUILT—BE MORE POSITIVE.

WOMEN MUST KNOW ABOUT THE EFFECTS OF DRUG USE BEFORE BECOMING PREGNANT.

THEY KNOW THAT ATOD USE IS NOT GOOD BUT THEY DO NOT KNOW THE SPECIFICS.

RATHER THAN THREATEN THEM WITH JAIL TIME AND MALFORMED BABIES, TREATMENT PROVIDERS NEED TO BE MORE POSITIVE AND TRUTHFUL.

THIS IS A GREAT QUESTION. I BELIEVE THAT THE MAJORITY OF PREGNANT WOMEN KNOW THAT ATOD USE IS NOT HEALTHY BUT THEY DO NOT KNOW THE SPECIFICS OF THE AFFECT OF THE SUBSTANCE ON THEM OR ON THE BABY.

FOR TOBACCO, THEY DO KNOW BUT THEY DO NOT REALLY THINK THAT THE INFORMATION IS VALID. THEY SMOKED WITH THEIR OTHER TWO CHILDREN AND THEY HAVE HAD NO NEGATIVE SYMPTOMS SO THEY DO NOT BELIEVE THE DANGERS ARE REAL. THEY ARE AWARE OF MOST OF THE PROBLEMS BUT NOT ALL OF THEM.

YES, BUT THEY HEAR CONFLICTING STORIES FROM PEOPLE ON THE STREET OR FROM THEIR RELATIVES OR MY FRIEND SMOKES POT AND HER BABY WAS FINE.

HEALTHCARE PROVIDERS SHOULD ASK THE QUESTION 'ARE YOU THINKING ABOUT QUITTING?' AND THEN SHOULD FOLLOW UP WITH "ARE YOU READY TO QUIT?"

YES, I THINK THAT THEY KNOW MORE TODAY THAN EVER BEFORE. THEY WOULD HAVE TO LIVE IN AN ISOLATED BOX NOT TO KNOW THE EFFECTS OF ATOD ON THE BABY AND THE MOTHER.

WE NEED TO COUNTER THE STATEMENT "I AM HEALTHY AND STRONG AND MY MOM SMOKED" OR "ASTHMA IS NO BIG DEAL".

OUR MESSAGES NEED TO BE MORE POSITIVE—I.E., HERE IS OUR PROGRAM AND WE HAVE THE ABILITY TO HELP YOU WITH YOUR ADDICTION. WE NEED MAKE THE MESSAGE CLEAR AND SIMPLE AND INFORM THEM OF THE AVAILABILITY OF SUCCESSFUL PROGRAMS AND HOW SMOKING AFFECTS THE BABY DIRECTLY.

WE NEED TO INSTILL NON-STIGMATIZING HOPE WITH OUR OUT-REACH PROGRAMS. THERE IS LOTS OF GUILT AND SHAME IN OUR PATIENTS. WE NEED TO PUBLICIZE THAT RESOURCES ARE AVAILABLE TO HELP THEM CHANGE THEIR LIFE. WE CAN PROVIDE A POSITIVE THING IN YOUR R LIFE. IF YOU DO NOT HAVE MONEY BUT WANT TO GET BETTER, HERE IS WHERE YOU CAN GO, BUT YOU MUST BE WILLING TO TAKE THE FIRST STEP.

WHAT ARE THE CONSEQUENCES OF EACH DRUG AND WHAT HARM WILL IT CAUSE IN BOTH THE MOTHER AND THE BABY.

WE NEED TO PROVIDE PROOF THAT WE ARE GETTING BETTER IN HELPING PEOPLE QUIT ATOD USE.

WHAT IS THE LIKELIHOOD OF POST-NATAL DAMAGE AFTER THE BABY IS BORN ESPECIALLY DURING BEAST FEEDING AND NURTURING.

HOW CAN WE, THE TREATMENT PROVIDERS, HELP YOU TO QUIT. WE NEED TO BECOME MORE ENGAGED IN DISTRIBUTING BETTER PR MATERIALS.

ANY PUBLIC EDUCATION SHOULD STAY AWAY FROM BLAME, SHAME, MORALIZING, JUDGING AND CONCENTRATE ON 'WE CAN HELP YOU GET BETTER. THE EDUCATIONAL MATERIAL NEED TO GO WITH BIO-MEDICAL INFORMATION, NOT SHAME BASED FINGER-POINTING.

YES, WE NEED TO NOT ONLY INFORM THEM OF THE VALUE OF PREVENTION (ABSTINENCE BEFORE BECOMING PREGNANT) BUT WHERE THEY CAN GO IF THEY HAVE STEPPED OVER THE LINE AND STARTED USING OR RESUMING DRUGS WHILE PREGNANT.

PROGRAM ADMINISTRATORS AND TREATMENT PROVIDERS NEED TO BETTER PUBLICIZE THEIR SUCCESS RATES (IF THEY ARE ACCURATE).

THERE REALLY IS NO BEST WAY AS COMMUNICATIONS IS MULTI PRONGED: TELEVISION, RADIO, EMERGENCY DEPARTMENT MATERIALS, AND HEALTH CLINIC BROCHURES. IN ADDITION, IT WOULD BE BENEFICIAL TO PASS OUT MATERIALS IN BEAUTY SALONS AND IN PHYSICIAN OFFICES. IT IS AMAZING BUT PEOPLE DO SEE BILLBOARDS. THE POINT IS THAT THE BROADER—THE BETTER.

FOR LOW INCOME PATIENTS, CHANGES ARE NEEDED IN THE WAY THE INFORMATION IS DELIVERED. I GENERALLY USE THREE APPROACHES FOR EACH PATIENT: I PROVIDE A VISUAL PICTURE; I VERBALLY TELL THEM ABOUT THE AFFECT; AND, I PROVIDE A STORY ABOUT MY EXPERIENCES WITH HIGH-RISK MOTHERS AND THE OUTCOMES OF THEIR SUBSTANCE USE.

WHEN DELIVERING THE MESSAGES, IT IS BEST TO USE A PERSON WHO HAS HAD A SUBSTANCE EXPERIENCE. USE A USER TO HELP EDUCATE AND TRY TO FIND A PERSON WHO CAN BE THOUGHT OF AS A DEMOGRAPHIC PEER (AGE, RACE, AND EXPERIENCE).

THE TRICK IS HOW TO GET IT OUT AND NOT JUST WHAT TO GET OUT. THERE IS A DANGER WITH BILL BOARDS AS IT CAN ADD TO THE DENIAL PROCESS, WHICH IS A NORMAL PROTECTIVE DEFENSE---"IT'S NOT ME". BILLBOARDS ARE NOT FOR ME AT 5 CIGARETTES PER DAY BUT FOR PEOPLE WHO SMOKE 2-3 PACKS PER DAY.

THE BEST TIME IS WHEN THEY ARE ARRESTED—THEY ARE IN A LEGAL HOLD AND WE CAN GET THEIR ATTENTION. I DO NOT LIKE THE FELONY ROUTE BUT IT DOES GET THEIR ATTENTION.

IT NEEDS TO BE MULTI-DIMENSIONAL:

- **CHILD PROTECTION SERVICES ANNOUNCEMENTS**
- **FOOD STAMPS**
- **CLINICS**
- **COUNCIL ON DOMESTIC ABUSE PAMPHLETS**
- **PROVIDERS**
- **TELEVISION**
- **BILLBOARDS—PLANT A SEED AND THEN PROVIDE MORE SPECIFIC INFORMATION**
- **WIC OFFICES**

THE MAIN MESSAGE HAS BEEN TO STOP FOR YOUR BABY'S HEALTH—IT MIGHT BE BETTER TO ALSO FOCUS ON THE WOMEN'S HEALTH I.E., BEAUTIFUL SKIN, ETC. IF YOU SMOKE, YOUR SKIN WILL WRINKLE. APPEAL TO A PERSON WANTING TO MAINTAIN THEIR BEAUTY.

II.C. ATOD TREATMENT PROVIDER BEHAVIOR AND KNOWLEDGE [TP #6]

Concern about Use of Small Amounts of ATOD:

Most ATOD treatment providers felt that we should be concerned about ALL levels of ATOD use because we do not know the "safe use" levels and that small or low use can lead to greater use over time. [Treatment Provider # 6]

KEY STATEMENTS:

YES, RESEARCH SAYS THAT WE DO NOT KNOW WHAT A SAFE LEVEL IS.

ANY ATOD USE IS AN ADDICTION.

YES CERTAINLY, LESS POISON MEANS A LESSER PROBLEM.

WE WORRY ABOUT THOSE PATIENTS WHO HAVE STOPPED AND NEED TO MAKE SURE THAT THEY STAY OFF ATODS.

WE NEED TO BE AWARE OF THE FACT THAT THERE IS A DOSE RESPONSE. PEOPLE NEED TO BE TOLD THAT REDUCING USE WILL REDUCE THE RISKS; THERE IS STILL A HIGHER RISK IF YOU ARE AN INFREQUENT SMOKER, COMPARED TO NOT SMOKING AT ALL.

II.D. OBSTACLES & BARRIERS TO ACCESSING ATOD TREATMENT [TP #7]

Barriers that Should be Removed to Permit Better Access:

The ATOD treatment providers were able to identify many obstacles and barriers to services. The list mirrors the obstacles raised by the focus groups and provide further evidence that these barriers are indeed present in Indiana. [Treatment Provider # 7]

The most common barriers mentioned were:

- Stigma
- Women do not realize they need help
- Access to treatment programs
  - Geographic-distance from home
  - Insufficient numbers of services available in the community
  - Lack of insurance coverage for these services
  - Patient does not know that the treatment program exists-lack of knowledge
  - Program is not available in their community
  - Transportation-both lack of public and personal transportation
  - Child care is not available at the clinic
  - Appointments are only available during the week day-no evening hours
  - Medicaid enrollment barriers
- Lack of communication

  - Patients are not asked by their providers if they use ATOD
  - Patients will not volunteer that they use ATOD
  - Perceived differences in communication between various socio-economic groups and providers:
  - Urban/Rural
  - Rich/Poor
  - Black/White

- Cost of services

- Fear of the system- lack of trust regarding confidentiality and the need to be able to access without fear of reprisal

- Need more life-skills training

- Minimum support at home

- Women using ATOD also have other social problems:
  - Lack of employment
  - Lack of decent housing—no place to live
  - Legal problems
  - Living in an abusive/domestic violence relationship
  - Unhealthy/non-supportive relationships
  - Lack of child care
  - Financial worries-low income
  - Lack of transportation
  - Lack of regular medical care
  - Treatment centers are not always family friendly
  - No in-patient or residential treatment centers available for ATOD across Indiana

KEY STATEMENTS:

THE STIGMA OF DRUG USE DURING PREGNANCY MAY PREVENT WOMEN FROM GETTING TREATMENT. PEOPLE TEND TO ASSUME THAT YOU ARE A BAD MOTHER BECAUSE YOU ARE USING DRUGS AND MANY FEEL THAT PREGNANT WOMEN WHO ARE ADDICTED ARE 'CRIMINALS'. THE CURRENT THOUGHT IS THAT IF I ADMIT TO USE, I WILL LOSE CUSTODY OF MY CHILD. THE PUNISHMENT IS WORSE THAN THE GAIN FROM COMING IN FOR TREATMENT.

THERE ARE BAD ATTITUDES TOWARD PREGNANT WOMEN WHO ABUSE SUBSTANCES—STIGMA AND BAD MOTHER LABELING. SOCIETY HAS MORE UNDERSTANDING NOW THAN IT DID YEARS AGO. THE STIGMA IS MUCH WORSE FOR PREGNANT WOMEN THAN FOR NON-PREGNANT WOMEN.

AVAILABLE APPOINTMENT TIMES—WORKING 8-5 AND CLINICS ARE OPEN 8-5

ONCE A PATIENT HAS ACCESS, THEY NEED SPOUSAL/FAMILY SUPPORT TO BE SUCCESSFUL. IF THEIR PARTNER USES ATOD, IT WILL BE HARD TO SAY "NO". THERE IS THE PROBLEM WITH SECOND HAND SMOKE ALSO.

IT IS A MYTH THAT "DRUGS ARE NOT THAT BAD".

THEY NEED TO BE ABLE TO SEEK TREATMENT WITHOUT LEGAL IMPLICATIONS OR FEARS.

SOCIETY AND CLIENT ATTITUDINAL BARRIERS

- **GUILT**
- **BLAMING**
- **CONDEMNATION**
- **DISTRUST**
- **JUDGMENT**

STIGMATIZATION-PREGNANT WOMEN USING DRUGS ARE SUBJECT TO MUCH SHAME AND GUILT FEELINGS AND FEEL "TOTALLY WORTHLESS". WE WILL AVOID A FELONY RAP BY RUNNING AWAY.

SMOKING EXPERIENCE AND HISTORY IS ASKED VERBALLY AT THE INITIAL PRE-NATAL VISIT AND IS IN THE MEDICAL RECORD AND WE NEED TO ASK THE SMOKING QUESTION AT EVERY ENCOUNTER BUT WE ARE NOT ASKING AT OTHER TIMES.

THEY CAN NEVER BE CERTAIN THAT THEY WILL NOT BE ARRESTED—THE QUESTION IS: IS THIS REALLY A CRIME?

WHAT IS THE TRUE LAW-WHAT ARE THE STRICT CONFIDENTIALITY RULES AND HOW DO THEY IMPACT ON THE DECISION TO SEEK CARE—IS THERE TRUE CONFIDENTIALITY?

THE MOST IMPORTANT IS THE INDIVIDUAL'S LACK OF LIFE SKILLS, E.G., HOW TO KEEP A HOUSE OR APARTMENT CLEAN, HOW TO DIAPER A CHILD, HOW TO COOK A MEAL, ETC.

IF PATIENTS ASK FOR HELP, BE ABLE TO RESPOND.

WE NEED TO UNDERSTAND THE DIFFERENCE BETWEEN ADDICTION AND USE OF DRUGS. THE LIGHT USER KNOWS THE HEALTH EFFECTS AND WILL QUIT; THE HEAVY USERS WILL CONTINUE AS IT IS VERY DIFFICULT TO QUIT WITHOUT HELP.

ADDICTION IS A BIO-MEDICAL PHENOMENON.

II.E. ATOD TREATMENT CENTER AVAILABILITY [TP #8-9]

Aware of Other ATOD Treatment Facilities:

The ATOD treatment providers were able, for the most part, to name other treatment facilities in their community and many use the Rainbow Book to determine the location of treatment resources. [Treatment Provider # 8]

Need for Additional ATOD Treatment Facilities:

The overall consensus among the ATOD treatment providers was that more treatment facilities and services are needed across the state. Some questioned the need for

more tobacco cessation programs saying that classes are pretty much available everywhere. [Treatment Provider # 9]

KEY STATEMENTS:

WE NEED RESIDENTIAL TREATMENT CENTERS LOCATED IN NEIGHBORHOODS THAT ARE SUPPORTIVE OF THE EFFORT. I WOULD PREFER TO HAVE ONE ON MERIDIAN STREET (INDIANAPOLIS) AND NOT HIDDEN AWAY SOMEWHERE. MOVING THE JULIAN CENTER TO MERIDIAN WAS A GREAT IDEA AS IT "SAYS" THERE IS NO SHAME (REFERRING TO THE STIGMA OF DOMESTIC ABUSE)—AND REFLECTS AN "OUT OF THE CLOSET" WAY OF THINKING. BUT IT IS HARD TO FIND AN AREA THAT WOULD WANT THESE (ADDICTED) PATIENTS.

MOST PATIENTS HAVE MULTIPLE ATOD ISSUES SO WE NEED AN OVERALL PROGRAM FOR ABUSE—NICOTINE, ALCOHOL AND DRUGS. COCAINE VERSUS ALCOHOL DETOXIFICATION – THE TREATMENTS ARE DIFFERENT AND THERE IS NO MAGIC MEDICATION FOR COCAINE ADDICTION. THERE ARE MAJOR DIFFERENCES BETWEEN METHAMPHETAMINE ADDICTION AND ALCOHOL AS THERE ARE COGNITIVE DEFICITS WITH METHAMPHETAMINE AS THE METHAMPHETAMINE PATIENT MAY NOT REMEMBER ONE SESSION TO ANOTHER. THEY WILL MISS APPOINTMENTS AND IT IS NOT THAT THEY DO NOT CARE BUT THEY FORGET THE APPOINTMENT HAS BEEN SCHEDULED. WE NEED TO TAILOR THE METHAMPHETAMINE TREATMENT TO EACH PATIENT.

WE NEED PREVENTION PROGRAMS AT AN EARLY AGE—WE CAN STOP USE WITH PREVENTION.

WE KNOW THE OP SERVICES BUT THERE ARE NO INPATIENT SERVICES AVAILABLE.

II.F. ATOD TREATMENT PROVIDER SUGGESTIONS [TP #10]

The ATOD treatment provider suggestions can be categorized the following six groups:

Social Stigma and Fear of the System:

Reduce the social stigma against ATOD use by increased public education about substance use and take actions to eliminate fear of using the system, by maintaining patient confidentiality and trust.

KEY STATEMENTS:

PEOPLE NEED TO BE AWARE THAT THERE IS NO PUNISHMENT IF YOU SEEK TREATMENT. IT MIGHT BE ADVISABLE TO PUT SIGNS IN WAL-MARTS AND OTHER PUBLIC AREAS THAT SAY "CALL THIS 800 NUMBER IF YOU WANT TO GET OFF ATOD AND WE GUARANTEE NO PROBLEMS WITH THE POLICE".

MOST IMPORTANTLY, ADDRESS THE STIGMA AND STOP THINKING ABOUT CRIMINALIZING -- THE ANSWER IS NOT TO THREATEN THEM WITH JAIL TIME. IT IS VERY EASY TO JUMP TO THE CONCLUSION THAT JAIL TIME WILL WORK AS A DETERRENT BUT THIS IS VERY COUNTER PRODUCTIVE. THEY NEED TO SEEK HELP AND NOT GO TO JAIL. THESE ARE CROSS PURPOSES. STOP THE JAIL TALK.

FELONS ARE NOT ELIGIBLE FOR SECTION 8 HOUSING, STUDENT EDUCATION LOANS, FOOD STAMPS, AND THEY HAVE ADDED PROBLEMS TRYING TO GET A JOB—TAKE ALL THAT AWAY AND WHAT IS LEFT FOR THE "CLEAN ADDICT".

WE TEND TO GET ANGRY ABOUT PREGNANT WOMEN USING DRUGS BUT NOT WHEN WE ARE TALKING ABOUT PREGNANT WOMEN USING ALCOHOL OR TOBACCO. THERE IS GOOD DATA LINKING HARM TO A FETUS FROM ALCOHOL AND TOBACCO USE BUT THERE IS NOT AS STRONG A RELATIONSHIP WITH DRUGS. SO, WE WANT TO PUT DRUG USERS IN JAIL, NOT THOSE WHO USE ALCOHOL OR TOBACCO.

Lack of Child Care and Transportation:

Not having child care available at the treatment centers and the patient not having public or private transportation to access the treatment center are major problems that need to be addressed.

KEY STATEMENT:

CHILD CARE AND TRANSPORTATION—PROVIDE CHILD CARE AT THE CLINIC FOR THOSE MOMS WHO HAVE NO CHILD CARE AVAILABLE WHILE THEY ARE IN TREATMENT.

Lack of Inpatient or Residential Treatment Centers:

There is a need for family oriented, residential centers devoted to the treatment of women using ATOD.

KEY STATEMENT:

MORE IN-PATIENT OR RESIDENTIAL CENTERS TIED TO A TREATMENT PROGRAM, DESIGNED FOR THEM—THE PREGNANT USER. WE CAN GET SUPPORT FROM OTHER USERS WHO ARE PREGNANT.

Lack of Positive Messages:

The ATOD prevention message that is provided to users needs to be more positive by saying that "we understand your problem and can help you quit". We have been successful and want to help you. More evidence of ATOD quit-success rates needs to be disseminated to the user and to the public. Women need to know that help is available.

KEY STATEMENTS:

CHANGE THE MESSAGE FROM NEGATIVE TO POSITIVE—THIS WOULD BE A BETTER APPROACH. MAKE THE MESSAGE SAY: "WE CAN HELP YOU AND THERE ARE SERVICES AVAILABLE HERE IN THE COMMUNITY". NO ONE RESPONDS TO NEGATIVE CRITICISM, SO OFFER THE REALITIES AND HOPE THAT THE TREATMENT WILL WORK FOR THEM.

THE STATE SHOULD LOOK AT THE COSTS OF TREATMENT OPTIONS. IT COSTS ABOUT $35,000 TO INCARCERATE A FELON BUT ONLY $5,000 FOR 6-8 WEEKS OF RESIDENTIAL TREATMENT. AND THE INPATIENT TREATMENT WORKS—THE JAIL TIME DOES NOT SOLVE THE ADDICTION PROBLEM.

INFORM THE COMMUNITY OF THE AVAILABILITY OF SUCCESSFUL TREATMENT PROGRAMS.

MOST IMPORTANTLY, WE NEED TO BE MORE POSITIVE IN OUR DEALINGS WITH ATOD USERS—THE STIGMA OF ADDICTION IS POWERFUL AND DOES NOT HELP IN THE TREATMENT PROCESS. WE NEED TO SAY—"WE CAN HELP YOU WITHOUT THE FEAR OF BEING PUNISHED OR HARMED".

Lack of User and Provider Awareness of ATOD Treatment Service Availability:

Increase provider and user knowledge of successful treatments and the availability of services for women using ATOD.

KEY STATEMENTS:

MUCH LIES WITH THE PROVIDER:

- **THEY NEED TO BE WELL INFORMED ON THE AVAILABILITY AND QUALITY OF LOCAL TREATMENT PROGRAMS**
- **THEY NEED TO KNOW HOW SUCCESSFUL THE TREATMENT PROGRAMS HAVE BEEN**
- **THEY NEED TO BE ENCOURAGED TO ASK THEIR PATIENTS ABOUT THEIR SUBSTANCE USE.**
- **TEACH PCPS TO BETTER SCREEN AND REFER THEIR PATIENTS.**

Other Suggestions:

THE STATE SHOULD CONDUCT A COST STUDY TO COMPARE THE COSTS OF INCARCERATION, THE COST OF FOSTER CARE, AND THE COST OF PROVIDING MEDICAL CARE VIA THE EMERGENCY DEPARTMENT WITH THE COSTS OF PROVIDING FAMILY ORIENTED IP ADDICTION SERVICES FOR PREGNANT WOMEN.

ATOD IN PREGNANT WOMEN IS A HUGE CONCERN, BUT YOU GET WHAT YOU PAY FOR. WE NEED TO PUT MORE MONEY AND RESOURCES WHERE THE PRIORITIES ARE. THE ATOD USERS ARE A VULNERABLE, UNDER-SERVED POPULATION. IT COMES DOWN TO EXPANDING SERVICES. IN REALITY, THERE IS NO MONEY FOR CHILD CARE. THEY STRUGGLE TO MAKE IT TO TREATMENT.

PREVENTION IS THE NUMBER 1 PRIORITY.

MORE INFORMATION NEEDS TO BE DISTRIBUTED: EDUCATION OF STUDENTS AND PHYSICIANS IS THE MOST VITAL PIECE TO BEST PREVENT ATOD USE, BUT ARE THE MOST DIFFICULT TO ARRANGE.

WORK WITH THE SCHOOLS AND IN PARTICULAR THE JUNIOR HIGH SCHOOLS.

WHATEVER WE ARE DOING WITH ATOD TREATMENT SERVICES, IT IS NOT WORKING WELL.

III. PRIMARY CARE PROVIDER INTERVIEW/SURVEY RESULTS

III.A. PCP PRACTICE PROFILE [PCP #1]

Estimated Volume of Women Using ATOD by Substance:

Most of the PCPs reported that few (≈15%) of their pregnant patients use alcohol; more use tobacco (≈30-50%); while few use drugs (≈15%). [Primary Care Provider # 1]

KEY STATEMENTS:

WE HAVE LOTS OF TOBACCO USERS BUT THE TREND IS POSITIVE. THERE ARE MORE SMOKERS NOW WHO SMOKE 5-6 CIGARETTES PER DAY AND ONLY A FEW THAT SMOKE A PACK OR MORE PER DAY. PART OF THIS DECLINE MAY BE DUE TO THE INCREASED COSTS OF TOBACCO. THEY ALSO FEEL OPEN AND MORE HONEST ABOUT THEIR SMOKING USE; I AM LESS REASSURED WITH THEIR REPORTS OF ALCOHOL OR DRUG USE.

THE MAJORITY OF THE DRUG USERS I SEE ARE USING MARIJUANA. COCAINE USE IS LOW (ABOUT 15-20 PER YEAR) BUT COME TO THINK ABOUT IT, I HAVE SEEN 5 COCAINE USERS IN THE PAST FEW DAYS. I HAVE NOT SEEN ANY METHAMPHETAMINE USERS. I SEE ABOUT 3-4 PRESCRIPTION DRUG ABUSERS PER YEAR AND SEND THEM TO PSYCHIATRY FOR TREATMENT.

III.B. ATOD USER KNOWLEDGE AND AWARENESS [PCP #2]

Awareness of the Health Effects and Need for a Better Job Informing Pregnant Women:

The majority of primary care providers believe that women are somewhat aware of the harm caused by ATOD use during pregnancy and agree that there is a need for a better job informing them of the potential harm from specific substances, such as secondhand smoke. [Primary Care Provider #2 and 2a]

Information Needed:

Most agree that women need to be told the effects of ATOD on the baby and on the mother from using specific substances, but many felt that they need to be informed that help is available and that they can be successful in quitting if they ask for help. [Primary Care Provider #2b]

How Best Provide the Information:

The primary care providers provided several suggestions for best providing information to their patients including: mass advertising with radio and television public service announcements, billboards and brochures and handouts provided to people at their clinics or other areas. Key themes included: be honest with the person, have face-to-face conversations, and provide positive messages, such as, “we can help you with your substance use”. [Primary Care Provider #2c]

KEY STATEMENTS:

MOST PATIENTS HAVE THE INFORMATION, BUT DON’T LISTEN AND ARE UNWILLING TO CHANGE.

YES, THERE IS A SUBLIMINAL MESSAGE AT WORK HERE AND IT IS BASED ON THE STIGMA AND SHAME ASSOCIATED WITH ALCOHOL OR DRUGS THAT DO BAD THINGS TO THE MOTHER AND HER BABY. THEREFORE, SHE IS A BAD PERSON FOR USING. INSTEAD, WE NEED TO SEND A DIFFERENT MESSAGE- A MORE POSITIVE ONE THAT ENCOURAGES HER TO SAY "I HAVE A DISORDER AND I CAN GET CLEAN. I CAN START WITH A REDUCTION IN MY USE, NOT TOTAL ABSTINENCE AND CAN SUCCEED WITH HELP. I CAN HAVE A HEALTHIER BABY, MORE MONEY, A BETTER JOB, AND A NICER APARTMENT.

YES, FOR EXAMPLE, I GET TOLD THAT "FRIENDS I KNOW SMOKED DURING THEIR PREGNANCY AND THEIR BABY WEIGHED 8 POUNDS".

THE QUESTION TO ASK EACH PATIENT IS "HOW CAN WE EMPOWER YOU TO GET CLEAN".

WE NEED TO PROVIDE MORE POSITIVE MESSAGES. FOR EXAMPLE, "YOU HAVE A SUBSTANCE PROBLEM AND PSUPP WORKS. THE PROGRAM STAFF CAN HELP YOU".

I HAVE HEARD THINGS FROM MY PATIENTS LIKE "I WAS REALLY DISCOURAGED WITH ALL THE NEGATIVE STUFF".

THEY NEED TO BE PROVIDED WITH THE STATISTICS, FOR EXAMPLE, THE INCIDENCE OF SIDS AND THE PREVALENCE OF WOMEN WHO SMOKE AND CLEARLY BE TOLD THE RELATIONSHIP OF SIDS PREVALENCE TO SMOKING. WOMEN NEED TO BETTER UNDERSTAND THE CONCEPT OF ATOD USE AND THE LIKELIHOOD OF HARM TO THEM OR THEIR BABY. THEY NEED TO UNDERSTAND THAT THE LIKELIHOOD OF HARM INCREASES WITH MORE USE.

THEY DO NOT KNOW THE DANGERS OF SECONDHAND SMOKE OR THE RISK OF SUDDEN INFANT DEATH SYNDROME.

MEDIA/POSTERS DO NOT WORK AND REINFORCES THE NEGATIVELY OF SHAME—IF YOU SMOKE, YOUR BABY SMOKES. WE NEED TO REDO THE MESSAGES TO SAY THAT SMOKING IS BAD FOR YOU AND THE BABY AND THAT MANY PEOPLE HAVE STOPPED SUCCESSFULLY. THE MESSAGE FROM PHYSICIANS AND TREATMENT PROVIDERS NEEDS TO BE THAT TREATMENT WORKS.

POSITIVE MESSAGES SHOULD BE DISTRIBUTED BOTH THROUGH PUBLIC MEDIA AND PRIVATELY DURING PRENATAL CLINIC VISITS

INFORMATION SHOULD BE OFFERED ON A ONE-ON-ONE BASIS WITH A SOCIAL WORKER. THERE IS TOO MUCH PRINTED INFORMATION THAT IS HANDED OUT AND NEVER READ. THE ONE-ON-ONE TALK SHOULD BE DONE IN THE OFFICE DURING A REGULAR APPOINTMENT. WE NEED TO DO IT WHEN THE PATIENT IS HERE IN THE OFFICE. IT IS NOT AS EFFECTIVE TO HAVE THEM RETURN TO TALK ABOUT THEIR SUBSTANCE USE. TELEVISION IS A SECOND CHOICE.

III.C. PCP BEHAVIOR & KNOWLEDGE [PCP #3-8]

Concern about Use of Small Amounts of ATOD:

The majority of PCPs definitely felt that we should be concerned with a little substance use while pregnant. [Primary Care Provider #3]

Routinely Screen for ATOD Use:

The majority of PCPs do screen their pregnant patients for ATOD use with most of them using verbal questions. [Primary Care Provider #4]

What To Do with a Patient with a Positive Screening Result:

Most of the PCPs counsel their ATOD patients and explain the consequences of their continued use. The typical answer was that I warn them of the risk and encourage them to stop. [Primary Care Provider #5]

Comfort Level in Counseling Women Using ATOD:

Only about one-half of the PCPs responded that they were comfortable giving counseling to their ATOD patients. [Primary Care Provider #6]

How Often Refer to an ATOD Treatment Specialist:

About one-half of the PCPs refer their ATOD patients to specialized treatment. [Primary Care Provider #7]

Who Do You Refer to:

Most the PCPs who refer to specialists listed psychologists or counselors most frequently. [Primary Care Provider #8]

III.D. OBSTACLES AND BARRIERS TO ACCESSING ATOD TREATMENT [PCP #9]

Barriers Faced by Pregnant Women in Accessing ATOD Treatment:

Not surprisingly, the PCPs generally reported barriers similar to the ones the treatment providers and women using ATOD reported during the Key Informant Interviews and the Focus Groups. [Primary Care Provider #9]

Barriers listed were:

- Lack of personal resources:
  - Transportation
  - Finances
  - Employment problems
  - Low levels of education
  - Distance to treatment provider

- Lack of willingness/motivation to change

- Lack of family support

- Stigma attached to ATOD use

- Failure to appreciate the extent of potential damage to the baby or the mother

- Fear of losing the baby

KEY STATEMENT:

DRUG AND ALCOHOL USERS FACE THE SAME BARRIERS.

III.E. ATOD TREATMENT CENTER AVAILABILITY [PCP #10-12]

Perceived Success Rate of Women Using ATOD:

Most of the primary care providers felt that they were successful in getting their patients to stop their ATOD use during their pregnancy. [Primary Care Provider #10]

Aware of ATOD Treatment Facilities:

Most of the primary care providers felt that they were not aware of the ATOD services that are available in their community. [Primary Care Provider #11]

Need for Additional ATOD Treatment Facilities:

Most primary care providers felt that there was a need for more ATOD services in their community. [Primary Care Provider #12]

III.F. PCP SUGGESTIONS [PCP #13]

The ATOD treatment provider suggestions can be categorized into three groups:

Need for More Positive ATOD Messages:

The ATOD use prevention messages need to be more positive by informing users that help is available and accessible.

KEY STATEMENTS:

PHYSICIANS AND TREATMENT PROVIDERS NEED TO BE MORE POSITIVE, SUPPORTIVE AND EMPOWER THEIR PATIENTS BY SAYING "YOU ARE DOING A GOOD JOB AT TRYING TO GET BETTER; THE TREATMENT YOU ARE RECEIVING REALLY DOES WORK; AND, YOU ARE A REAL GOOD PERSON FOR GETTING THE HELP YOU NEED."

INCREASE THE AWARENESS LEVEL OF THE PUBLIC IN GENERAL TO BAD EFFECTS OF ATOD ON THEIR HEALTH AND IN THE DEVELOPING BABIES SPECIFICALLY.

WE NEED TO FOCUS ON THE INDIVIDUAL AND THAT THEY NEED TO GET OFF ATOD FOR THEMSELVES (AS WELL AS FOR THEIR BABY). WE NEED TO TELL THEM THAT THEY CAN KEEP THEIR GOOD LOOKS. THEY NEED TO BE TOLD THAT SMOKING AFFECTS THEIR FACE AND SKIN AND THEY CAN AVOID THE DRY SKIN AND WRINKLES THAT COME WITH THEIR SMOKING. ALSO, THAT SMOKING LEADS TO EARLY MENOPAUSE AND A DRY VAGINA.

BE MORE POSITIVE WITH OUR MESSAGES.

Need for Individual Life-style Changes:

There needs to be more attention placed on motivating the ATOD user to change her life-style to encourage a successful cessation.

KEY STATEMENTS:

TRULY, A LIFE STYLE CHANGE IS NEEDED.

PROVIDE MORE EDUCATION ON HOW TO COPE WITH THEIR PROBLEMS.
HAVE PEOPLE WHO HAVE EXPERIENCED THE SAME PROBLEMS WITH ADDICTION TALK AND MOTIVATE THEM TO SHOW PREGNANT USERS THAT THEY CAN SUCCEED AND QUIT.

MOTIVATE THEM ON THE EFFECTS ON THE BABY. SEE WHAT CAN HURT THE BABY. PUT THE BABY FIRST.

ADDRESS THE LACK OF MOTIVATION, BUT UNDERSTAND THE STRENGTH OF THE ADDICTION.

REMOVE THE SOCIAL STIGMA AND UNDERSTAND THAT IT IS DIFFICULT TO BREAK AWAY FROM THEIR PEER GROUP. THESE WOMEN OFTEN HAVE A LACK OF STRENGTH TO BREAK AWAY FROM THEIR ADDICTIVE BEHAVIOR.

Provider Knowledge and Awareness:

PCPs need to devote more time to be certain that their pregnant patients using ATOD completely understand the potential risk and harmful effects from using substances during pregnancy. PCPs need to increase their screening of suspected ATOD patients. PCPs and treatment providers both need to be more positive with their preventive messages.

KEY STATEMENTS:

MOST PCPS CAN NOT/DO NOT SCREEN OR DETECT OR REFER ATOD PATIENTS FOR TREATMENT.

ONCE THE RISKS ARE DISCOVERED BY THE PCP, GIVE THE PATIENT THE OPTION OF BEING REFERRED TO A SPECIALIST FOR TREATMENT.

THE BELIEF THAT "IT CAN NOT HAPPEN TO ME" IS COMMON, SO TELLING THEM ABOUT "REAL WOMEN'S" EXPERIENCES WOULD HELP.

THE BIGGEST RESISTANCE IS WITH THE PRIVATE PRACTICE PHYSICIANS WHO DO NOT SCREEN OR REFER PATIENTS FOR ATOD TREATMENT.

PROVIDING FREE, EASILY ACCESSIBLE CARE.

CHAPTER 6: SUMMARY OF ISSUES IDENTIFIED AND SUGGESTED ACTIONS

The use of alcohol, tobacco or other drugs (ATOD) during pregnancy is harmful to the mother and the fetus and there is agreement that the best strategy to reduce the consequences of ATOD use during pregnancy is to focus on preventing women of childbearing age from using these substances. However, the focus of this report is on how to better meet the medical and substance use treatment needs of pregnant women and women of childbearing age who are already using ATOD.

This chapter represents a synthesis of the information and data gathered from pregnant women, treatment and primary care providers (focus groups and key informant interviews), the secondary data analysis, and the review of alcohol, tobacco and other drugs literature to better understand the health and treatment needs of pregnant women who are using alcohol, tobacco and/or drugs in Indiana. The issues identified have been grouped into six categories and suggested actions to address each issue are listed. The categories are not distinct and are inter-related; thus, the actions suggested for one issue may also help address another issue.

The data available indicates that Indiana has a major problem with prevalence of ATOD use during pregnancy and there appears to be a gap between the number of individuals who NEED (prevalence) ATOD treatment services and the DEMAND (treatment utilization) for ATOD treatment services. There are numerous reasons for this gap. Among them is a lack of available services in local communities. Insufficient data were available to quantify the gap in Indiana and to identify specific communities where additional services may be needed. However, a common theme voiced in the focus groups and interviews was that there is a critical need for expanding the existing services for pregnant women or adding services where none exist in Indiana communities.

It is clear from the information gathered that pregnant women who use ATOD are often facing a myriad of serious problems in their lives in addition to their substance use, such as a lack of housing, low or no income, low levels of education, lack of employment, poor interpersonal relationships with family and friends, and engagement in other risky behaviors. To effectively treat the substance use problem, the family, providers, and the community need to also provide the support these women need to overcome these other serious problems.

It should also be stressed that substance use is a biomedical problem and not a character flaw. "Experts at the National Institute on Alcohol Abuse and Alcoholism and National Institute on Drug Abuse confirm that addiction is not primarily a moral weakness, as it has been viewed in the past, but a 'brain disease' that should be included in a review of symptoms just like any other biologic disease process. A medical diagnosis of addiction requires medical intervention in the same manner that a diagnosis of diabetes requires nutritional counseling or therapeutic agents or both." [11, 83]

In addition, primary care providers (PCPs) and treatment providers also face obstacles of their own in providing ATOD treatment to their patients. Time constraints, mandatory reporting laws, lack of standard screening and treatment guidelines, and lack of treatment resources impede their ability to adequately screen, treat and refer these individuals. Some of these problems may be beyond the ability of the primary care and treatment providers to modify.

CATEGORIES OF ISSUES:

1. The exact magnitude of the alcohol, tobacco and other drug problem is not known. Indiana lacks valid and timely data on alcohol, tobacco and drug use during pregnancy.

- Develop a data collection system, in conjunction with other data collection efforts to obtain ATOD use information more objectively (less reliance on self reported behaviors) on a representative sample of pregnant women to better understand the magnitude of this problem in Indiana and to provide benchmarks for surveillance over time.

- Obtain sufficient data (larger sample sizes) to provide ATOD prevalence and other important measures at the county level to assist policy makers in assessing local program needs and evaluate the progress made as a result of ongoing interventions.

- Provide more valid and timely prevalence data on ATOD use on an ongoing basis to healthcare providers, local and state public officials, the criminal justice system staff, social workers and the general public so that they may be better informed and thus, better able to address the obstacles confronting women using ATOD in Indiana.

2. Presence of social stigma, fear of the system, and lack of positive messaging discourages utilization of prenatal and alcohol, tobacco and other drug treatment services

- Refocus the ATOD prevention and treatment message to users to be more positive, non-judgmental, and supportive. For example, the message should say essentially that, "We understand your problem and we can help you quit. We have been successful helping others and we want to help you, too."

    - This positive message should be part of the mass media efforts as well as part of the message given by providers to pregnant women using ATOD to reduce feelings of guilt and shame on the part of the women.

    - The messages should be encouraging and should reduce the hopelessness resulting from repeated failures by saying, "Don't give up. We know it is difficult to stop but please continue to work on it."

  - Help women and their providers understand that addiction is a chronic, relapsing medical condition that needs continuing care.

  - Use motivational empowerment therapy (MET) to expand the positive messages by saying, "Not only do we want to help YOU, but we want to help you become a better mother."

- Increase the public's understanding of the biomedical aspects of substance use and addiction to reduce the social stigma attached to ATOD use during pregnancy.

  - The education efforts should also address cultural and family beliefs about ATOD use that may be incorrect.

  - An objective of the educational messages should be for society to become more supportive and less judgmental of women using ATOD.

  - Emphasize the importance of being substance free prior to becoming pregnant.

- Emphasize the importance of the PCP treating their patients using ATOD with dignity and respect in order to form a more therapeutic and supportive alliance. A non-judgmental and non-threatening approach should be used in order to prompt women to seek help and remain in treatment.

- Ensure patient confidentiality and trust to eliminate fear of using the prenatal care and ATOD treatment systems. Evidence indicates that pregnant women using ATOD often do not obtain adequate prenatal care for fear of reprisal from the legal system, including losing custody of their child.

- Establish policies to emphasize support for ATOD treatment rather than projecting a purely punitive approach to ATOD use. For example, do not make it a felony to use drugs during pregnancy. Passage of this criminal law will increase the fear of using the prenatal care and ATOD treatment system and discourage the appropriate use of these services.

3. Challenges exist in the screening, brief intervention, and treatment referral for women using ATOD

- Emphasize that ATOD screening, brief intervention and referral to treatment is important for all women of child bearing age, not just for those who are pregnant.

- Reinforce the key role that PCPs play as part of a team (treatment providers, social workers, school nurses and counselors, nurses, and peer educators) assisting patients using ATOD to quit by giving them appropriate brief

interventions, support and encouragement, and referral to specialized treatment when necessary.

  - PCPs need to be certain that the pregnant patients using ATOD completely understand the potential risk and harmful effects from using substances during pregnancy.

- Encourage PCPs and treatment providers to assume a "learner's stance" with their patients to obtain a better understanding of the complexities of the patients' lives, their cultural practices, influences of their social environment and peers, in order to provide more comprehensive advice and support. To be most effective, interventions need be tailored to the individual's situation.

- Provide PCPs with the best practice guidelines, [for example, assessing stage of readiness to change, using the 5 A's (Ask, Advise, Assess, Assist, and Arrange)], and encouraging the use of rapid, effective screening, intervention, follow up, and referral of their patients using ATOD.

  - Develop and adopt consistent statewide verbal prenatal and postpartum screening and testing protocols that adequately identify women and newborns in need of ATOD treatment services.

  - Make verbal screening for substance use throughout pregnancy, as well as counseling and drug use treatment, a consistent component of prenatal care.

  - Include provider education regarding the special characteristics of and therapeutic approaches necessary for certain populations using ATOD, such as: patients with dual diagnoses, women entering prenatal care late, patients with developmental disabilities, and adolescents.

- Provide best practice guidelines to treatment providers to ensure that pregnant women using ATOD receive high quality substance use treatment.

- Develop a more integrated approach for care of women who are using ATOD so there is a seamless transition between primary care and treatment as they move from the initial screening to the delivery of more specialized treatment services.

- Encourage greater collaboration and communication between PCPs and ATOD treatment providers to permit easier entry into treatment directly from prenatal care and other primary care settings.

- Publicize the availability of ATOD treatment services to inform PCPs and other medical providers of their existence in their communities.

- Develop standard measures of success and publicize the success rates of ATOD treatment programs to enable providers to select referrals more appropriately for their complex patients using ATOD who need specialized treatment.

- Publicize, support and expand telephonic counseling services (hotlines) to which primary care and treatment providers can refer their patients using ATOD.

- Emphasize and expand education in medical schools, nursing schools, residency programs, social science programs, allied health professions programs, and continuing medical education regarding the medical impact of substance use on the mother, fetus, and newborn, as well as ATOD screening and treatment best practices during pregnancy.

- Allocate resources to provide ongoing training of hospital and birthing facility personnel in ways to screen, test, and refer women to needed ATOD treatment services.

4. There is a lack of knowledge and understanding on the part of the public and employers as well as pregnant women about the health effects and economic impact of ATOD use and the availability of treatment services in the community.

- Educate the public, as well as the pregnant women using ATOD, about the concept of relative likelihood of the health and economic impacts due to using different substances during pregnancy. For example, the community does not understand that ATOD use during pregnancy does not always cause health problems for the baby, but does increase the risk of harm; that the risk of harm becomes greater with increased use; and that the risks are different depending on what substance is used and when substances are used during the pregnancy.

- Inform pregnant women about the effects of using specific substances on their health and well-being as well as on the health of their babies.

- Inform pregnant women, employers, and the public about the harm caused by secondhand smoke exposure on their health and well-being as well as on the health of their babies.

    - Develop policies that will result in more employers offering smoke free workplaces.

- Focus more attention on motivating women to seek treatment by implementing a statewide education campaign that encourages women to seek care for their substance use. Another aim of the public education effort would be to create a more supportive community.

- Promote ATOD treatment programs and better publicize their services to inform pregnant women and the general public about the ATOD treatment services that are available in their community.

- Publicize the success of ATOD treatment programs to enable women using ATOD to select the most appropriate program to meet their needs, which will also reinforce the positive message that effective help is available.

5. Obstacles exist that hamper access to ATOD treatment for pregnant women.

- Improve efforts to address common barriers to treatment access. This includes a lack of transportation and child care as well as having the clinics open during evenings and weekends in addition to normal day hours.

    - Of particular concern are the obstacles that pregnant women face while receiving publicly funded services because they are often the ones who are at highest risk. Examples include complex registration procedures and access only during usual business hours.

- Offer ATOD treatment programs that are affordable. For example, resources should be available on a sliding scale for low income patients.

- Provide a comprehensive range of services tailored to meet the basic physical, social and economic needs of pregnant women using ATOD, such as housing, employment, life-skills and mental health services, education and job skills, social support, prenatal classes, parenting and family functioning classes, as well as the ATOD treatment they need. Education and assistance will help women using ATOD to cope with their other life problems that are often barriers to seeking and obtaining ATOD treatment.

6. A lack of adequate availability and funding for ATOD treatment services exists throughout Indiana.

- Develop a funding plan that identifies new funding sources as well as explores existing Indiana sources to address the needs of pregnant women who use ATOD. This should be part of a State Plan to address ATOD use among pregnant women.

- Examine and modify existing funding and reimbursement policies to insure that those with the greatest needs, specifically pregnant women who are using ATOD, have access to medical and ATOD treatment services.

- Establish residential treatment programs that are geographically available throughout the State of Indiana. ATOD treatment residential programs for pregnant women and new mothers should be family centered and allow women and children to stay together while addiction treatment is being administered.

- Expand the Prenatal Substance Use Prevention Program (PSUPP) intervention to private providers and other clinics providing maternal and child health services in Indiana to make sure this valuable resource is available to a larger proportion of the population who needs these services.

- Develop more intensive outpatient ATOD rehabilitation programs specifically geared to pregnant women to better meet the unique needs of these individuals.

- Promote and assist treatment facilities to implement 100 percent tobacco free campus (buildings and grounds) policies.

- Expand and promote statewide telephonic counseling services to support pregnant women using ATOD to help them quit and prevent relapse. Where possible, telemedicine technology could be used. For example, the infrastructure for the Indiana Tobacco Quitline is in place, but needs funding to continue. This or another telephonic counseling service is needed to provide support for pregnant women who use alcohol and other drugs.

FUTURE DIRECTION

To deal with the problem of ATOD use among pregnant women effectively, this report suggests that the State of Indiana will need to devote more resources to provide the services needed by this population and provide more funding to the organizations and programs committed to this cause. The state and local policy makers should recognize that investment in ATOD-related prevention and treatment services will result in reduced burdens on the health care system and law enforcement agencies.

As this report indicates, reducing ATOD use among pregnant women is a very complex issue and will require the efforts of multiple agencies, providers and other partners. In addition to the substance use problem, many pregnant women also have other basic physical and social needs such as a lack of an adequate and safe housing environment, a lack of employment, a lack of education, poor parenting and life skills, and a lack of a healthy support network. These basic needs must be addressed to allow these women to then focus on addressing their ATOD use and improving their health behaviors.

The suggestions listed in this report provide a foundation upon which an effective action plan can be developed for the State of Indiana to address the issues surrounding ATOD use among pregnant women. It will be essential to establish a state task force which includes state and local policy makers; administrators from public health, mental health and addiction, child welfare, health, education, employment security, criminal justice, and advocacy agencies; representatives from program funding organizations; primary care and ATOD treatment providers; as well as women who used ATOD during pregnancy, to work in unison to remedy these problems. This task force will need to address the prioritization of the above issues and develop a state implementation plan to improve early intervention and treatment for pregnant women using ATOD.

REFERENCES

1. Perreira, K., & Cortes, K. (2006). Race/ethnicity and nativity differences in alcohol and tobacco use during pregnancy. *American Journal of Public Health*, 96, 1629, 1636.

2. Jessup, M. (2003). Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *Journal of Drug Issues*.

3. Haviland, L., Thornton, A., Carothers, C., Hund, L., Allen, J., Kastens, B., et al. (2004). Giving infants a great start: Launching a national smoking cessation program for pregnant women. *Nicotine & Tobacco Research*, 6, S181-S188.

4. Messer, K. (1996). Characteristics associated with pregnant women's utilization of substance abuse treatment services. *American Journal of Drug and Alcohol Abuse*.

5. Bar-Oz, B., Klein, J., Karaskov, T., & Koren, G. (2003). Comparison of meconium and neonatal hair analysis for detection of gestational exposure to drugs of abuse. *Disease in Childhood Fetal and Neonatal Edition*, 88.

6. Haynes, G., Dunnagan, T., & Christopher, S. (2003). Determinants of alcohol use in pregnant women at risk for alcohol consumption. *Neurotoxicology and Teratology*, 25, 659-666.

7. Stotts, A., Shipley, S., Schmitz, J., Sayre, S., & Grabowski, J. (2003). Tobacco, alcohol, and caffeine use in a low-income, pregnant population. *Journal of Obstetrics and Gynecology*, 23, 247-251.

8. Clark, K., Dee, D., Bale, P., & Martin, S. (2001). Treatment compliance among prenatal care patients with substance abuse problems. The *American Journal of Drug and Alcohol Abuse*, 27, 121-136.

9. Hankin, J., McCaul, M., & Heussner, J. (2000). Pregnant, alcohol-abusing women. *Alcoholism: Clinical and Experimental Research*, 24, 1276-1286.

10. Emerald Consulting, LLC. (2006, June). *Indiana Fetal Alcohol Spectrum Disorder Strategic Plan*. Indianapolis, IN.

11. American College of Obstetricians and Gynecologists. (2004). At-risk drinking and illicit drug use: Ethical issues in obstetric and gynecologic practice. *American Journal of Obstetrics and Gynecology*, 103, 1021-1031.

12. Floyd, R., O'Connor, M., Sokol, R., Bertrand, J., & Cordero, J. (2005). Recognition and prevention of fetal alcohol syndrome. *American Journal of Obstetrics and Gynecology*, 106, 1059-1064.

13. Leonardson, G. & Loudenburg, R. (2003). Risk factors for alcohol use during pregnancy in a multistate area. *Neurotoxicology and Teratology*, 25, 651-658.

14. Chang, G., McNamara, T., Orav, J., Koby, D., Lavigne, A., Kudman, B., et al. (2005). Brief intervention for prenatal alcohol use: A randomized trial. *American Journal of Obstetrics and Gynecology*, 105, 991-998.

15. Johnson, B. (2006, Spring). Indiana: Adverse outcomes of smoking during pregnancy. *Perinatal Perspectives*, 10, 3.

16. Dailard, C., & Nash, E. (n.d.). State responses to substance abuse among pregnant women.

17. Nocon, J. (2006). Substance use disorders and pregnancy & Indiana perinatal consensus: a statement.

18. Washington State Department of Health. (2002). *Substance abuse during pregnancy: Guidelines for screening*. Olympia, WA.

19. Savage, C., Wray, J., Ritchey, N., Sommers, M., Dyehouse, J., & Fulmer, M. (2003). Current screening instruments related to alcohol consumption in pregnancy and a proposed alternative method. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32, 437-446.

20. Chang, G. (n.d.) *Alcohol-screening instruments for pregnant women*. Boston, MA: Harvard Medical School, Department of Psychiatry.

21. Substance Abuse and Mental Health Services Administration. (2004). *Clinical preventive services in substance abuse and mental health update: From science to services*. 31-52.

22. Columbia Medical University. (n.d.). *Counseling to prevent tobacco use*. Retrieved September 1, 2006, from http://cpmcnet.columbia.edu/texts/gcps/gcps0064.html

23. Chasnoff, I., Neuman, K., Thornton, C., & Callaghan, A. (2001). Screening for substance use in pregnancy: A practical approach for the primary care physician. *American Journal of Obstetrics and Gynecology*, 184, 752-758.

24. Chasnoff, I., McGourty, R., Bailey, G., Hutchins, E., Lightfoot, S., Pawson, L., et al. (2005). The 4 P's Plus screen for substance use in pregnancy: Clinical application and outcomes. *Journal of Perinatalogy*, 25, 368-374.

25. Diekman, S., Floyd, L., Decoufle, P., Schulkin, J., Ebrahim, S., & Sokol, R. (2000). A survey of obstetrician-gynecologists on their patients' alcohol use during pregnancy. *American Journal of Obstetrics and Gynecology*, 95, 756-763.

26. Not a Single Drop. (2006). *Tools for screening and diagnosis*. Retrieved July 26, 2006, from http://www.notasingledrop.org/main.asp?id=2616

27. Frazier, H. (n.d.). Prenatal methamphetamine abuse in Indiana.

28. Substance Abuse and Mental Health Services Administration. (2006). *Screening*. Retrieved July 20, 2006, from http://pathwayscourses.samhsa.gov/vawp/vawp_fs_screening.html

29. Coletti, S. (n.d.). Service providers and treatment access issues. 237-243.

30. Melvin, C., Dolan-Mullen, P., Windsor, R., Whiteside H., & Goldenberg, R. (2000). Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tobacco Control*, 9, 80-84.

31. Hohman, M., Shillington, A., & Baxter, H. (2003). A comparison of pregnant women presenting for alcohol and other drug treatment by CPS status. *Child Abuse & Neglect*, 27, 303-317.

32. Orleans, T., Melvin, C., Marx, J., & Maibach, E., Vose, K. (2004). National action plan to reduce smoking during pregnancy: The national partnership to help pregnant smokers quit. *Nicotine & Tobacco Research*, 6, S269-S277.

33. Haller, D. (2003). Factors influencing treatment enrollment by pregnant substance abusers. *American Journal of Drug and Alcohol Abuse*.

34. Southwestern Indiana Regional Perinatal Advisory Board. (2006). *Smoking and Pregnancy*. Retrieved July 20, 2006, from http://www.healthforbabies.org/pro/smoking.html

35. Messecar, D. (2001). Smoking cessation interventions for pregnant women to prevent low birth weight: What does the evidence show? *Journal of the American Academy of Nurse Practitioners*, 13, 171-177.

36. Yu, S., Park, C., & Schwalberg, R. (2002). Factors associated with smoking cessation among U.S. pregnant women. *Maternal and Child Health Journal*, 6, 89-97.

37. Adams, J. (n.d.). *Statement of the public affairs committee of the teratology society on the importance of smoking cessation during pregnancy*. University of Massachusetts Boston, Department of Psychology.

38. Ockene, J., Ma, Y., Zapka, J., Pbert,L., Goins, K., & Stoddard, A. (2002). Spontaneous cessation of smoking and alcohol use among low-income pregnant women. *American Journal of Preventive Medicine*, 23, 150-159.

39. Wakschlag, L., Pickett, K., Middlecamp, M., Walton, L., Tenzer, P., & Leventhal, B. (2003). Pregnant smokers who quit, pregnant smokers who don't: does history of problem behavior make a difference? *Social Science & Medicine*, 56, 2449-2460.

40. Ershoff, D., Solomon, L., & Dolan-Mullen, P. (2000). Predictors of intentions to stop smoking early in prenatal care. *Tobacco Control*, 9, 41-45.

41. Klerman, L. & Spivey, C. (2003). Smoking-related activities in prenatal care programs. *American Journal of Preventive Medicine*, 25, 129-135.

42. Hutchins, E. & Dipietro, J. (1997). Psychosocial risk factors associated with cocaine use during pregnancy: A case-control study. *American Journal of Obstetrics and Gynecology*, 90, 142-147.

43. Substance Abuse and Mental Health Services Administration. (August 2005). *Substance abuse and dependence among women.*

44. Substance Abuse and Mental Health Services Administration. (January 2004). *Pregnancy and substance use.*

45. Substance Abuse and Mental Health Services Administration. (2005). *National Survey on Drug Use and Health.*

46. Substance Abuse and Mental Health Services Administration. *Treatment Epsiode Data Set.*

47. Indiana State Department of Health. *Birth Certificate Data.* Compiled by Data Analysis Group, Epidemiology Resource Center.

48. Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Reports.* Retrieved July 26, 2006, from http://apps.nccd.cdc.gov/brfss/index.asp

49. Centers for Disease Control and Prevention. *Youth Risk Behavioral Surveillance System.* Retrieved July 26, 2006, from http://apps.nccd.cdc.gov/yrbss/index.asp

50. Indiana State Department of Health. (2001-2005). *Indiana Prenatal Substance Use Prevention Program Annual Reports.* Compiled by Indiana University Bowen Research Center.

51. Indiana Tobacco Prevention and Cessation. (2002). *Indiana Adult Tobacco Survey Reports.* Compiled by Indiana University Bowen Research Center.

52. Indiana Tobacco Prevention and Cessation. (2002). *Indiana Youth Tobacco Survey Reports.* Compiled by Indiana University Bowen Research Center.

53. Substance Abuse and Mental Health Services Administration. (2002). *Annual Report.*

54. Indiana State Department of Health. *Meconium Screening Program Reports*.

55. Indiana Family and Social Services Administration, Division of Mental Health and Addictions. (1997). *Indiana Demand and Needs Assessment Studies: Alcohol and Other Drugs Report*.

56. Substance Abuse and Mental Health Services Administration. Retrieved on July 2006, from http://www.oas.samhsa.gov/nsduh.htm

57. Substance Abuse and Mental Health Services Administration. *Treatment Epsiode Data Set.* Retrieved on July 2006, from http://webapp.icpsr.umich.edu/cocoon/SAMHDA-SERIES/00056.xml

58. Indiana State Department of Health. *Birth Certificate Data.* Retrieved July 26, 2006, from http://www.state.in.us/isdh/dataandstats/natality/index.htm

59. Indiana State Department of Health. *Behavioral Risk Factor Surveillance System Reports.* Retrieved July 2006, from http://www.in.gov/isdh/dataandstats/brfss/2004/index%20page.htm

60. Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Reports.* Retrieved July 2006, from http://apps.nccd.cdc.gov/brfss/index.asp

61. Indiana State Department of Health. *Youth Risk Behavioral Surveillance System.* Retrieved July 2006, from http://www.in.gov/isdh/dataandstats/brfss/2004/index%20page.htm

62. Centers for Disease Control and Prevention. *Youth Risk Behavioral Surveillance System.* Retrieved July 2006, from http://apps.nccd.cdc.gov/brfss/index.asp

63. Indiana Tobacco Prevention and Cessation. (2002). *Indiana Adult and Youth Tobacco Survey Reports.* Retrieved July 2006, from http://www.in.gov/itpc

64. Indiana State Department of Health. (2001-2005). *Indiana Prenatal Substance Use Prevention Program Annual Reports.* Retrieved July 2006, from http://www.in.gov/isdh/programs/mch/Programs/psupp.htm

65. Indiana State Department of Health. *Meconium Screening Program Reports*. Retrieved July 2006, from http://www.in.gov/isdh/programs/nbs/MeconiumScrSitemap.htm

66. Whiteside-Mansell, L., Crone, C., & Conners, N. (1999). The development and evaluation of an alcohol and drug prevention and treatment program for women and children: The AR-CARES program. *Journal of Substance Abuse Treatment*, 16, 165-275.

67. Barker, D., Orleans, T., Halpin, H., & Barry, M. (2003). So near, yet so far: Tobacco dependence treatment for pregnant women. *Nicotine & Tobacco Research*, 6, S259-S267.

68. Olds, D. (1999). *The prenatal and early childhood nurse home visitation program*. Retrieved July 25, 2006, from http://www.strengtheningfamilies.org/html/programs_1999/12_PECNHVP.html

69. Center for Substance Abuse Prevention. (2003). *Baby S.A.F.E. (Substance abuse free environment, Hawaii)*. Retrieved July 26, 2006, from http://casat.unr.edu/bestpratices/view.php?program=8.

70. Murphy, J. (n.d.). *Background information/moms off meth group*. Retrieved August 3 2006, from http://www.momsoffmeth.com/about.htm

71. Dixon-Gray, L. (2003). *Oregon smoke free mothers and babies project*. Retrieved July 27, 2006, from http://ncth.confex.com/ncth/2003/techprogram/paper_8329.htm

72. Smoke-Free Families. (2005). *Maine Prenatal Collaborative*. Retrieved July 27, 2006, from http://www.smokefreefamilies.org/mini/maine.asp

73. Kennedy, C., Finkelstein, N., Hutchins, E., & Mahoney, J. (2004). Improving screening for alcohol use during pregnancy: The Massachusetts ASAP program. *Maternal and Child Health Journal*, 8, 137-147.

74. Hennepin County Community Health Department. (2002). *Healthy babies: The provider's role in fetal alcohol syndrome prevention*.

75. Join Together. (2002). *Trenton improves health outcomes for pregnant women*. Retrieved July 26, 2006, from http://www.jointogether.org/news/headlines/communitystories/2002/trenton-improves-health-for.html

76. Leuthard, J., & Carlson, S. (2003). *Smoke-free beginnings*. Retrieved July 27, 2006, from http://ncth.confex.com/ncth/2003/techprogram/paper_8329.htm

77. Washington State Division of Alcohol and Substance Abuse. (2005). *Pregnant and parenting women (PPW) with chemical dependency issues.*

78. Guttmacher Institute. (2006). *Substance abuse during pregnancy*. Retrieved July 12, 2006, from http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf

79. Centers for Disease Control and Prevention. (1999). Prenatal *smoking data book*. Retrieved September 20, 2006, from http://www.cdc.gov/reproductivehealth/PrenatalSmkbk/index.htm

80. Centers for Disease Control and Prevention. (2002). Alcohol Use Among Women of Childbearing Age, United States, 1991-1999. *Morbidity and Mortality Weekly Report*, 51, 273-276. Retrieved September 20, 2006, from, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5113a2.htm

81. U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Objectives for improving Health*, Part B, Volume 2. Retrieved September 20, 2006, from http://www.healthypeople.gov/document/HTML/Volume2/16MICH.htm#_Toc494699667

82. U.S. Department of Health and Human Services. (1990). *The health benefits of smoking cessation: A report of the Surgeon General.* Washington DC Public Health Service, U.S. Government Printing Office. Retrieved September 20, 2006, from http://www.hsca.com/membersonly/USDHHSlink.htm

83. National Institute on Drug Abuse. (2005). *The brain and addiction*. Retrieved September 20, 2006, from http://teens.drugabuse.gov/drnida/drnida_brain2.asp

84. U.S. Supreme Court Multimedia. (2005). *Ferguson v. City of Charleston*. Retrieved September 20, 2006, from http://www.oyez.org/oyez/resource/case/1276/

85. U.S. Department of Health and Human Services. (2005). *U.S. Surgeon General releases advisory on alcohol use in pregnancy*. Retrieved September 20, 2006, from http://www.hhs.gov/surgeongeneral/pressreleases/sg02222005.html

86. American Academy of Pediatrics (5th ed.). (2002). *Guidelines for perinatal care*. Elk Grove Village, IL.

87. U.S. Department of Health and Human Services. (2005). *Dietary guidelines for Americans*. Retrieved September 20, 2006, from http://www.health.gov/dietaryguidelines/dga2005/document/html/chapter9.htm

88. Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *The American Psychologist*, 47, 1102-14.

Appendix A-1: ATOD Needs Assessment Study
Focus Group Script

Hello, my name is _____ from Indiana University. We are working with the Indiana State Department of Health to find ways to help pregnant women get the medical services they need during pregnancy.

Let me start by telling you about the project and what we are trying to do. We know that the number of women who smoke, drink and use drugs during pregnancy is a problem in Indiana. We are talking to other groups of women like this one to ask for their opinions and to hear about their experiences. We expect that all together we will be talking to about 60 to70 women. We are also talking to doctors and others who provide treatment for pregnant women. Our project will help identify where more services are needed in the community to help women stop using tobacco, alcohol and drugs while pregnant.

We invited you to participate in this focus group because we value your perspectives and opinions. You may also know women who were smoking, drinking or using drugs during their pregnancy and can tell us about the problems they had in getting help.

Since this is a project that the University is involved in, we would like for you to sign a consent form. The form tells you about the project, the benefits to you for being in the study and who to contact if you have further questions about this study. Your participation is voluntary and if you decide not to participate in the discussion, it will not affect the services you are now receiving. We will keep your comments confidential.

We would like to tape record the session to make sure the notes we take are complete and accurate. In some cases, we will use the tape recording to quote a truly significant comment but again, no names will be released in the report and no names will be connected to any of the text.

Does anyone have questions?

Pass out consent forms, obtain their signatures and pick them up.

Focus Group Script for Women

1. When you think about pregnant women here in _____, how many do you think smoke?

1a. How many of them drink?
1b. How many use drugs?

2. If a woman used alcohol, tobacco or drugs when she was pregnant, what kind of health problems do you think the unborn baby or mother could have?

2a. What about after the baby is born?

3. Do you think that women who use alcohol, tobacco or drugs during pregnancy generally know what the health effects might be?

3a. Is there a need to do a better job informing pregnant women?
3b. What information do you think is needed?

4. Do you think we should worry about those women who use just a little alcohol, tobacco or drugs during pregnancy?

4a. Alcohol?
4b. Tobacco?
4c. Drugs?

5. What do you think would be a "safe" level of use?

5a. Alcohol?
5b. Tobacco?
5c. Drugs?

6. Do you know any users of alcohol, tobacco or drugs who tried to get treatment to help them stop?

6a. If yes → What problems did they have getting the help they wanted/needed?

[i] Did you or other users you know have any problems that kept you from going to an alcohol treatment center?
[ii] Did you or other users that you know have any problems that kept you from getting treatment for tobacco?
[iii] Did you or other users you know have any problems that kept you from getting treatment for drug use?

7. Has a doctor asked you about smoking, drinking or using drugs during your pregnancy?

7a. If yes, tell me what he or she asked.
7b. Did they talk to you about the health problems the baby or you could have if you smoked, drank alcohol or used drugs?
7c. How comfortable would you be in talking about this with your doctor?

8. If you do not know anyone who has had problems getting help, can you think about the barriers or obstacles pregnant women might have getting treatment?

8a. (For each barrier or problem, ask how often it might occur and how much of a barrier is it?

8b. What are some possible ways to eliminate these barriers to treatment?

9. Aside from PSUPP, do you know if there are other places a pregnant women could go to get help to stop their use of alcohol, tobacco or drugs?

9a. Alcohol?
9b. Tobacco?
9c. Drugs?

10. What would it take to encourage users to seek treatment while they are pregnant?

10a. What about after the baby is born?

11. Is there a need for additional treatment services in your community?

11a. If yes → What type of treatment is needed?
11b. If yes → Where would you recommend that the treatment services be located?

12. What other advice do you have for the State Department of Health as they try to provide more help for pregnant women?

Closing Statement

We're sorry we are out of time. This has been a valuable discussion and we'll make sure your comments are included in our report. Our plan is to provide this report to local and state level policy makers who are trying to make sure everyone's health needs are being met as much as possible. Thank you very much for your valuable input.

Appendix A-2: ATOD Focus Group Feedback

1. When you think about pregnant women here in _____, how many do you think smoke?

- 95%
- Lots
- Everyone I know
- One-half
- One-half
- Very common
- About one-half of them
- Probably around half of them
- Over one-half
- 80%
- 90%
- Lots
- Most, over half

1a. How many of them drink?

- Rare
- Only have seen one of my pregnant friends drink
- Not as many as those who smoke
- I have never seen a pregnant women drinking
- I am too young to drink
- Rare/unusual
- Less than the number that smoke—usually they quit when they find out they are pregnant
- If they do not know they are pregnant, probably a lot drink—maybe one-half
- Once they find out they are pregnant, probably 10 percent drink
- Do not know
- I hope that it's rare
- I am a small user-occasionally a beer
- Few
- 25%
- 50%
- 50-75%
- 50%
- A lot of women do, especially in Muncie

1b. How many use drugs?

- I have not seen any
- 60-70%
- 85%
- 90%
- Extremely low
- I cannot tell as my friends do not talk about it

- I know of two who use drugs but most keep this use under wraps and do not tell their friends
- I personally have not seen any one nor know anyone who uses drugs
- I did drugs before I was pregnant but then quit as soon as I found out I was having a baby
- It is more common in Terre Haute or Brazil than here in Greencastle, especially methadone users
- I have three pregnant friends and they are pretty strict about not using ATOD
- Those who are pregnant and using drugs are not thinking straight—they are not thinking of their baby's welfare
- Many users cannot stop just because they are pregnant—they still feel that they need a high to make it through the day
- I have friends who stop using pot when they became pregnant
- Most OD users do not admit that they use thus do not even enter the system
- I am really unsure
- Maybe 5 percent but they usually do not quit when they find out they are pregnant
- A lot, and especially weed, marijuana, prescription drugs, cocaine, and methamphetamine
- I know a person whose son was taken away by Child Protection Services (CPS) and it is hard to get him back
- Very big street use in Muncie—crack is very popular
- I have lived in Indianapolis and have seen more drug use here in Muncie than in Indy
- Many women say that no, they do not use drugs, but do use marijuana—it is not considered a drug
- Abusing prescription drugs is as common or maybe even more common than Street drug use

2. If a woman used alcohol, tobacco or drugs <u>when she was pregnant</u>, what kinds of health problems do you think the unborn baby or mother could have?

- Asthma
- Respiratory Problems
- Heroin causes birth defects
- Brain problems
- Disabilities—both learning and physical
- Low Birth Weights
- 2 fingers or other abnormalities
- Low Birth Weight
- Miscarriages
- Asthma
- Cystic Fibrosis
- Pre-mature delivery
- Fetal Alcohol Syndrome
- Downs Syndrome
- Cancer

- Still born infant
- Jaundice
- Baby is addicted
- In Owen County, LBW is a goal as it is thought to lead to easy delivery so the mothers want to have a LBW baby so are not afraid to use ATOD
- Smaller and probably cough more
- Low birth weights
- Premature delivery (early baby)
- Sicker baby
- More ear infections
- Low birth weight
- Asthma
- Low birth weight
- Sudden Infant Death Syndrome
- Deformities
- Asthma
- Unhealthy immune systems
- Brian damage

2a. If a woman uses ATOD <u>after the baby is born</u>, what kind of health problems do you think the baby could have?

- Behavioral problems – but these problems are not only caused by drug use
- Asthma
- Bronchitis
- Smokers Cough
- The baby smells bad—not very pleasant
- More asthma
- The babies usually smell bad
- Alcohol withdrawal
- Alcohol use can cause Downs Syndrome
- If breast feeding—the same problems as when pregnant
- Second Hand Smoke
- Asthma
- Respiratory
- Ear infections
- Breast feeding problems—do not use ATOD and breast feed
- Second Hand Smoke problems
- In my home, there is no smoking allowed or in my car. My mom does not smoke in front of the baby and my husband has to smoke in the garage or outside
- Asthma
- Mess up the baby's lungs
- Asthma
- Baby is not fully developed
- Sudden Infant Death syndrome
- Not taking care of the child—not watching the child

- Welfare takes the baby away from me
- Nervous child
- Learning disabilities

3. Do you think that women who use alcohol, tobacco or drugs during pregnancy generally know what the health effects might be?

- Yes, they know it's bad or wrong
- Yes, they know and they care but given the situation around them (no house and no money) they cannot get out of the problem.
- I believe that no one wants to use ATOD during pregnancy but they can not always say no. Many addicts do not even know that they have a problem. They use in order to have friends to hang out with. Their partner says 'it's not fair, my girlfriend does not want to get high with me' which gives us a real guilt trip. What needs to happen is that I need to hang out with respectful people.
- They may not know all, but know it's bad
- Yes, it is hard not to be aware, but they do not believe it all
- Many know but feel that others have used and have not had any problems
- Probably not
- They know but do not care
- Usually, but they just do not care
- Yes, they know but may not know the full effects
- The message may go in one ear and out the other
- Women do not believe that drugs will hurt their baby and the CPS threat will not seem real until it happens. They will continue to use even if they know they will lose their baby, but cannot quit---it [drugs] is very powerful

3a. Is there a need to do a better job informing pregnant women of these health effects?

- Give out information to pregnant women but it really depends on the women if she listens AND wants to change
- Some will listen and toss the information into the trash
- No, it really will not make a difference
- We need more information on where to go for treatment BUT all we ever hear is that "there is no place to go"
- They have to want to get better—getting more information is not too helpful unless they want to know
- Many will use drugs because you tell them not to
- More information would be helpful BUT many will not listen to it
- Why spend more money—it's turning a blind eye to information
- Message for tobacco-→need for visual things
- Yes, but physicians are afraid to discuss as they feel hopeless and have no history of success
- All of us know about the bad effects—something is wrong with a person who does not know.
- Yes, women might not smoke if they know more about what could happen to their baby
- Yes and especially about the affects after the baby is born

- Yes, more facts about the damage after the baby is born
- Yes, more information is needed for both pregnant women and those of child bearing age
- There are no IP services available for drug addicts which really complicates things. We really need to be able to get off the street.
- Not only aim substance abuse information at pregnant women but at all women of child bearing age

3b.What information do you think is needed?

- Heroin addiction—can not quit even though they know of the problems it causes with the unborn baby AND we have the technology to do something
- At the right time, the right message will work if you talk to them directly
- The ads where a head turns into a fish are NOT REAL so talk to me directly
- Information targeted to pregnant women
- Unsure
- Yes, they need to know what can happen to their baby
- Women do not believe that drugs will hurt their baby and the CPS threat will not seem real until it happens. They will continue to use even if they know they will lose their baby, but cannot quit---it is very powerful
- More about Second Hand Smoke
- Where to go to get help—but we know that you can get prosecuted if you get help
- More in-dept detail about what can happen—this is what will happen
- Women understand alcohol and cigarettes but not drug impact
- They need something that they can see, and not just verbal information
- They need to be told that it's okay to try and stop gradually and not just being told "NOT TO USE AT ALL". Provide praise for some reduction
- There needs to be more positive messaging—"We can help you quit and you can do it". I have never seen this type of message and it really would be good to use this approach
- Tell me where I can go for help-there is no place to go
- There is so much condemnation—drug addiction is a disease and we need help
- We need more and better facilities in all areas
- Give us some hope
- We need personal and social awareness
- Treatment with respect
- We should not get in trouble for getting treatment—you must keep our care confidential
- You need to push PSUPP as a viable, positive program that works.
- People do not know where to go in Muncie—we need more information

3c. How should this information be given?

- Television
- Radio
- Billboards
- Physician's offices

- Physicians need to talk more about addiction and they need to know that there is a great deal of personal anxiety in our telling them
- Television and radio is not effective
- Posters and brochures should be available in Emergency Departments
- All we ever hear is negative—nothing is ever positive
- I have been banned from every OB office in town due to my prescription drug abuse (morphine and oxycondone) so I came to the clinic here after hearing about it from friends

4. Do you think we should worry about those women who use just a little alcohol, tobacco or drugs during pregnancy?

- Drugs and Alcohol are not the same as cigarettes. Drugs are an addiction like methadone, crack and heroin, alcohol use leads to fetal alcohol syndrome but cigarettes do not have as extreme affect on the child as alcohol or drugs.
- Yes indeed, as they can slip and end up using more
- Yes, they can slip up
- Yes, a little can become a lot

Alcohol?

- Yes, there is no safe level for alcohol use
- Depends on what you are drinking—crown and coke is bad compared to a small glass of wine or wine cooler. Wine/wine cooler is okay to drink small amounts
- Yet one can progress from wine cooler to beer to vodka so it gets addictive as you use
- When pregnant, one can not run around like we used to
- I had some Boone Farm Red—just a little taste but I could not take more than a taste
- I gave up alcohol when my I became pregnant when my daughter and daughter was born and have been too busy since then to drink
- Do not use at all
- Can still be bad for the baby
- Yes
- Yes, there is no safe amount. My grandmother died of acute alcoholism and I do not drink at all now.
- Yes

Tobacco?

- I am trying to cut back
- No safe level of smoking
- I quit cold turkey—a pack a day to none
- I quit smoking for my second baby and the birth weights increased from 7 pounds 1 ounce to 8 pounds 3 ounces
- Yes, even a little bit can be harmful
- Need more information of the long term affects of alcohol
- Need more on risk levels between cutting back and stopping—what do the likelihood levels really mean
- Need to counter-act the belief "my mom had 3 kids with no problems and she smoked two packs per day"

- A little tobacco use is not harmful
- Yes
- No amount is safe
- Probably will not hurt the baby
- Yes
- Yes, a little tobacco is not good for the baby, but we need to let them quit slowly if needed. One or two cigarettes per day is better than 20,
- The long term effects are unknown
- Yes, next to drugs, cigarettes are the most difficult to quit

Drugs?

- NO!
- People get the idea to use drugs from the movies
- I had a friend on drugs who delivered at 20 weeks and the baby was only 4 pounds 5 ounces
- There needs to be a message that abnormal children are not only caused by drug
- or alcohol use –we need to keep things in perspective
- Do not use any, at all
- Yes
- Yes, they are really bad for the baby
- Yes, a little is bad for the baby. There is still the chance that one hit will hurt the baby. A little bit is NOT SAFE.
- Yes, certainly

5. Has a doctor or nurse practitioner asked you about smoking, drinking or using drugs during your pregnancy? If yes, tell me what he or she asked.

- Yes, on a questionnaire I completed when I entered the office they asked about my tobacco, alcohol or drug use experiences
- Yes they did at Pregnancy Plus
- Yes, he straight out asked me
- Yes, it's part of the OB history—ATOD prior and now using
- Providers who treat low income patients do not talk to you
- During my first pregnancy, I was asked about my ATOD use and had a few comments from the physician. During pregnancies 2 and 3, he said "You are a grown woman and I cannot tell you what to do. You will do whatever you want to do" and gave me no information on the harmful affects of ATOD
- In the WIC program, I have to urinate in a cup and am told that it is for iron and also for drug/alcohol detection in my system. There is nothing done to detect smoking
- Yes, but he only asked if I was smoking and how much I was smoking
- Some users will lie, especially if drinking, but we are honest for the most part
- Yes, my doctor asked me if I was a smoker. WIC people asked me if I was a smoker. Also, I filled out a questionnaire about smoking at WIC
- Yes, all patients at the Community Heath Center are asked about their ATOD use
- Yes, but women are afraid to tell their doctor because the consequences are so high AND because they are in denial

- I have three kids at home and am still using drugs. If I am found to be not capable of taking care of them, I will lose my kids so I will not tell the provider about my addiction. What is the solution? I know all the risks and they are horrible. My son is 10 and I do not have custody of him but he does have all his fingers and toes. If I am arrested and convicted of a felony, I will not receive any Medicaid, housing assistance, student loans or a good job. So, once in the system, you have to lie to make it—you never get help and end up selling drugs to survive. It is a wicked, vicious system. We lack good treatment care for women and we need a man to take care of us. It's insane really—whatever is done for or to us, leads to more drugs.
- I have had all the information in the world about drugs and the effects on my baby and have had all the guilt I can handle, but that did not stop me from using methamphetamine. Help me please?

5a. Did they talk to you about the health problems the baby or you could have if you smoked, drank alcohol or used drugs?

- Yes, most do at this site
- Yes, WIC did but not my doctor
- No, not at the initial visit but by the NP at the second visit
- They gave me pamphlets on how to stop using substances
- I was scared to admit using as they will take my baby
- Most women feel more comfortable talking about smoking and drinking
- Yes, but more do not
- Yes, but doctors need to tell me how to stop, not what will happen if I don't

5b. How comfortable would you be in talking about this with your doctor?

- It is not hard if the physician listens and does not judge me
- One can accomplish a lot without being ridiculed or belittled
- Great if they work with you to set a goal
- Religion and shame have a lot to do with how comfortable you are
- I am more comfortable with certain doctors than with others
- I would be more comfortable telling my physician that I smoke than telling him that I use drugs or alcohol
- If he talked with me first and asked, I would have talked more to him. I asked and wanted to hear about the risks and dangers of alcohol and drug use during my pregnancy
- It really depends more on whether it is a physician who I am familiar with versus a new doctor that I am seeing for the first time. I am just now getting care from a new OB and do not know his/her reaction to my use. I feel safer with an older physician
- I do not know if I would be comfortable or not
- Yes, but doctors need to tell me how to stop, not what will happen if I don't
- Very comfortable
- He showed me pictures of a bad birth outcome from drug abuse
- Very comfortable
- Several participants commented they had no problem "volunteering" their ATOD experience with their provider

- Most providers do not take the time to talk about the health effects of ATOD use.

6. What would it take to encourage users to seek treatment while they are pregnant?

- The woman needs to want to stop
- They need to know what will happen to them and their baby from ATOD use
- There needs to be more advertisements saying where one can go for help in the community and what can happen if I use ATOD while pregnant
- People need help but do not know where to go
- Physician/Nurse practitioner should play a larger role in getting us to stop
- More seeing and doing and not just being told to stop
- Commercials between shows are a waste of time, we switch channels when the commercials come on
- Probably if they know what could happen to their baby, they will want to quit
- Make it easier for them to quit
- Do not take my newborn away from me while I am in treatment---who are the foster parents anyway and how good are they? Put us both together in treatment.
- I feel safe when speaking with my providers and know that some things have to be reported.
- Who wants to be under the microscope—nothing is really confidential and I fear losing my child. I only used my first name on your consent form to protect myself.
- There is much concern with TRUST in the system. They think that we are terrorists so I am scared.

7. What problems do pregnant women have in getting treatment to help them stop using ATOD

- They were ashamed or embarrassed
- They were not motivated
- All clinics need a PSUPP type program that does not just tell you "don't quit" but offers help. Do not just scare me and say my "kid will be still born"
- Provider communication is a major problem; doctors are threatening to their patients
- Many patients are Medicaid enrolled and it is hard for them to find services. Many cannot get rehabilitation services and cannot wait for an inpatient unit to be available and cannot afford services
- Many providers do not accept Medicaid and it is hard to get on the list of those who will accept us. Many need treatment now but the provider will only accept them after they are certified. The providers need to take a chance on payment and not make people wait for care
- For individuals that work, but still do not have enough to provide for their children, Medicaid still does not come through. You have to be dirt poor.
- If you are living in poverty, you cannot get yourself better because you will lose your Medicaid benefits
- You sign in at the registration desk, hand over a $200 check at the ER desk just to see a physician
- The pregnant user has to WANT the help

- Child care is a problem for I have other kids at home
- I had to quit my McDonalds 8-5 job to care for my baby as it is hard to make appointments with the doctor at other times because their clinic hours are 9-5.
- Pregnant women cannot get hired---it's like a disease.
- It is not worth working only to pay for childcare
- Many users do not know that the services are there—a real lack of awareness
- Many ATOD users are scared to try and get help quitting
- There is a bad person syndrome—I am a bad mother if I use ATOD
- Users need support from others in the family
- Mental health services need to be more accessible\
- Users like to be independent so treatment providers need to recognize this characteristic
- Transportation is a problem—not just not having a car, but not having extra gas money
- Child care is a problem—do not want to leave their baby with just anyone—need day care at the clinics
- Financial pressures—not enough money to get treatment
- They may not have a car
- They may be working and cannot leave
- They may not be able to get an appointment
- Probably they just do not want to quit—no motivation or unsure how to quit
- Have the doctor tell them that they really have to quit for their baby's health
- A lack of awareness of where to get help
- A fear that their baby will be taken away from them
- If not on Medicaid, where can they afford to go
- Some women feel that they do not need treatment services and that since they will not be found out—it is no big deal
- Many women feel that ATOD is not a health problem
- There is a huge lack of support from family and friends. I quit smoking and my husband still smokes. Support is SPARSE
- The programs cost money and I do not have enough to pay for all the treatment
- Transportation is a problem for many but I can take the bus here
- Day care is a problem—what can I do with my older child at home—there is no day care at the clinic
- People need to know that services are available for more than pregnant women
- Transportation
- Self-attitudes – I feel guilty and ashamed of my addiction
- I am scared and fear the CPS. In Indiana, CPS is very strict and it scares me. I was so scared that I did not go for pre-natal care treatment. Who can I really trust?
- Child care—who is safe to care for my child? I fear for my child.
- Funding-financial problems
- I do not know where to go-there is no advertising saying what is available and how good are they in helping me

- You should not put women into a male therapy group as we have different problems and issues. This is also the case for smoking cessation classes.
- As far as male or female counselors, it makes no difference to me but it would be good to include people who have had some experience with substance use. They can tell their success stories and provide us some support and could be part of a mentoring process.

8. Aside from PSUPP, do you know if there are other places a pregnant women could go to get help to stop their use of alcohol, tobacco or drugs?

- Not in Terre Haute
- Not in Delaware County

Alcohol?

- NO
- NO
- AA but is there one in Greencastle
- NO
- NO
- AA in Muncie

Tobacco?

- NO
- The hospital offers tobacco cessation classes
- The hospital has classes
- NO
- There are some tobacco cessation classes in Delaware County—3 or 4 places share counselors each 3-4 times per year.

Drugs?

- NO
- NO
- Maybe their doctor but they may not want to admit to using drugs
- NO
- NO
- The problem with NA meetings is that the room is filled with friends that are still doing drugs and I really need to get away from them. But they are in NA and are still using—we need individual treatment

9. Is there a need for additional treatment services in your community?

- Yes, Anderson is not a big income city so we need more options for the low income pregnant woman—more less costly options.
- In Greencastle, we need more classes for drugs and alcohol; they should be provided at the hospital
- Yes, in Lafayette and especially for low income drug users
- The closest inpatient treatment center is in Fort Wayne or South Bend
- Yes

If yes → What type of treatment is needed and where would you recommend that the treatment services be located?

- By one of the hospitals

- Put a treatment center in a Wal-Mart Store or near the Mall for we all know where the Wal-Mart store is located.
- Need AA type classes at the hospital or clinic
- Nearer to West Lafayette
- On a bus line
- South side of Lafayette
- Near the Wal-Mart Mall on 350
- If I see it, I will more likely use it

10. Do MD's know of ATOD treatment services for pregnant women?

- NO
- Provider would refer to Mental Health clinic
- Most do not care about our problems
- Medicaid pending—most do not take these patients
- Not about tobacco cessation
- Not aware of Narcotics Anonymous
- For alcohol, AA is not much help unless the person really wants to quit
- Physicians do not know about PSUPP
- NO

11. During our discussion, we talked abut a lot of recommendations. Of all the recommendations we talked about which ones do you think are the most important for the ISDH to deal with.

- Locate at a Wal-Mart Mall
- Physicians need to know the importance of the initial visit and they should not punish you, but give you options.
- They need to care about us and not just the money
- Establish a hot line for smoking, alcohol and drug relapsers
- Develop a buddy system tree to provide support for those trying to cut down
- Nothing really
- Get more information out
- Provide new facilities for Inpatient treatment
- The Lafayette CHC PSUPP clinic is operating near full capacity
- Use a health educator to increase publicity and expand services
- Increase advertising and marketing about the positive side of treatment---it can and does work
- Provide services both during day and evening hours
- Provide child care at the clinics
- Get churches involved—increase community service participation
- We do not take kids away for tobacco or alcohol use as they are more acceptable
- In this society it's better to be addicted to tobacco or alcohol than crack or cocaine because tobacco and alcohol are legal
- Tobacco does not do as much harm as methamphetamine
- Let us know that there is help out there
- Rehabilitation is part of recovery and there will be many relapses
- I am scared to death I will lose my baby to Child Protective Services

- Educate the treatment providers—they have to be here and walk in my shoes to know what I did. I cannot understand what I did. It makes no sense to me.
- There has to be more facilities based around the mother AND the child. Many of us are single parents and do not want to give up our baby.
- I believe that the whole family needs treatment—the mother and the children. We need to learn how to deal with our friends coming by with drugs—how can we react? We need more facilities that focus on the family unit.
- More treatment providers should use our peers (other clean users) for counseling—it is a challenge to find the right people but it would be good
- Number 1 recommendation---more residential facilities that include the family (mothers and babies and other children)
- Other children in the family need to be involved in the treatment process
- We need to have education and improvements in our life skills, job skills and parenting skills.
- There is too much on TV about how to make methamphetamine.
- Please help me before I get pregnant, not after.
- Be more positive with the information you provide us
- Physicians do not know what to do with ATOD users nor where to send us
- Some users get pregnant to try and get motivation to try and stop using. I would quit if I got pregnant but it only got worse
- The physicians need to know that I need help but often, they do not know where to send me for help
- We need a place to go for treatment services
- Reduce the anxiety and fear level of losing my child—tell me how to get better
- Users need to get into the treatment/physician system, immediately after deciding that they are ready to make the change. There is no point in making me wait a few weeks to enter the system.
- If they (the providers) do not care, I don't either.
- Our area needs a "drop-in" clinic
- We need a residential IP facility and not an Emergency Department that is available 24 X 7.
- The family needs to be involved in the treatment
- There would be no need for CPS and Foster homes if we had IP Residential facilities available—we could keep the baby with us while we get clean
- We have other issues such as employment, income, and education and we could receive personal help improving our job and life skills while in a residential center.
- A residential center should also provide OP care and continuing care after delivery.

Appendix B-1: ATOD Needs Assessment Study
Treatment Provider Key Informant Script

Hello, my name is _____ from Indiana University. We are working with the Indiana State Department of Health to find ways to help pregnant women get the medical services they need during pregnancy.

Let me start by telling you about the project and what we are trying to do. We know that the number of women who smoke, drink and use drugs during pregnancy is a problem in Indiana. We are talking to other substance abuse treatment providers to ask for their opinions and to hear about their experiences with their pregnant patients who use alcohol, tobacco or other drugs. We expect that all together we will be talking to 10 substance abuse treatment providers. We are also talking to women who have been pregnant and to primary care physicians as part of this project. A major part of the study will use existing data about, alcohol, tobacco and other drug use in Indiana. Our project will help identify where more services are needed in the community to help women stop these harmful items.

We invited you to participate in this focus group because we value your perspectives and opinions. You may also know women who were, drinking, smoking or using drugs during their pregnancy and can tell us about the problems they may have experienced in getting help.

Your participation is voluntary and if you decide not to participate in the discussion, it will not affect you in any way. We will keep your comments confidential. As with all the participating key informants, we would like to list your name in the acknowledgement section of the final report. However, this is not mandatory.

We would like to tape record the interview session to make sure the notes we take are complete and accurate. In some cases, we will use the tape recording to quote a truly significant comment but again, no names will be connected to any of the individual text.

Do you have any questions before we begin?

Key Informant Script for Treatment Providers

1. How often do you treat pregnant patients/clients, who are using:

    1a. Alcohol?
    1b. Tobacco?
    1c. Drugs?

2. Do you receive referrals from PCP's of pregnant women who use ATOD?

    2a. If yes, what percent come from PCP referrals?
    2b. What percent are self referred?

3. How successful have the ATOD cessation treatments been with your pregnant patients?

4. Do you think that the PCPs in this community are aware that you provide substance abuse treatment and would accept referrals?

5. Do you think that women who use alcohol, tobacco or drugs during pregnancy generally know what the health effects might be?

5a. Is there a need to do a better job informing pregnant women?
5b. What information do you think is needed?
5c. How should this information be given to women?

6. Do you think we should worry about those women who use just a little alcohol, tobacco or drugs during pregnancy?

7. What barriers would we need to remove to encourage more pregnant women using ATOD to seek treatment?

8. Are you aware of other available ATOD treatment services in this community?

9. Is there a need for additional treatment services in your community? If yes, what type and where are they needed?

10. During our discussion, we talked about a lot of recommendations. Of all of the recommendations we talked about, which one or ones do you think are the most important ones to deal with?

Closing Statement

We're sorry we are out of time. This has been a valuable discussion and we'll make sure your comments are included in our report. Our plan is to provide this report to local and state level policy makers who are trying to make sure everyone's health needs are being met as much as possible. Thank you very much for your valuable input.

Appendix B-2: ATOD Treatment Provider Key Informant Feedback

1. How often do you treat pregnant patients/clients, who are using?

1a. Alcohol?

- 5%
- 5% but many who use drugs also use alcohol.
- Very few report that they use alcohol.
- Few
- Some, but it is less frequent now than in the 1990's as the cause and risk of fetal alcohol syndrome is better known now. Alcohol use among pregnant women is not as bad as it used to be.
- The majority are not using alcohol while pregnant, but have used some alcohol before knowing they were pregnant.
- About 20%.
- Not an issue—a very small percent.
- Not very high—about 5%.

1b. Tobacco?

- At least 75%.
- 95%
- About 50%.
- Big—a much higher majority.
- 30-40% before pregnant; 20-30% use while pregnant.
- We do not do on-site tobacco cessation counseling, so refer out our patients who smoke to external treatment providers. The majority of our clients continue to smoke while pregnant.
- Most common of the three. About 75% use tobacco—it is a huge problem.
- The majority of pregnant women use tobacco, but we do not deal with tobacco-we deal with alcohol and other drugs.
- About 65%.

1c. Drugs?

- 15% Prescription.
- 30% OD.
- Very few with positive cocaine or marijuana.
- No methamphetamine users.
- Street drugs 100%--all my clients; of those about 5% were also prescription drug abusers.
- No prescription drug abusers.
- We are noticing a shift from illegal to prescription drugs.
- Most predominant—cocaine and marijuana.
- Only a few and they want help.
- Very few abuse prescription drugs.
- For street drugs, there is a clear pattern among our pregnant clients. They tend to reduce or even stop their illegal drug use after learning they are pregnant. Most of them have a history of drug use.

- Methamphetamine is really a huge problem as is marijuana where they use every day of the week. The clients say that marijuana is harmless as there is no research on fetus damage from recreational use. Many users are trying not to use as much and try to cut back.
- The majority do not use drugs while pregnant. The majority of the drug users have methamphetamine as the drug of choice, especially before they know they are pregnant. There is also some abuse of prescription drugs and particularly with anxiety drugs. Most of our clients use several different substances.
- About 20%--mostly use street drug or a mix of street drugs and prescription drugs

2. Do you receive referrals of pregnant women ATOD users from PCPs?

2a. If yes, what percent come from PCP referrals?

- 5%
- Most come from within the Wishard System.
- Patients need proof of insurance and medical records to be seen here.
- At least one-half come from referrals. We do outreach. One of our staff members is at the Wishard system looking for high risk ATOD patients we can treat. About 30 percent of our patients are from the court system and are in danger of losing custody of their child.
- Most of the patients are our system patients; few come from outside the system.
- A few.
- Disturbingly, very few (around 15%).
- PCP referrals are an exception to the rule as they are not aware of the available programs.
- Only a few, not many although I get some from the Terre Haute PSUPP director.
- We do not get any from PCPs; our clients come from within the system.

2b. What percent are self referred?

- Very few.
- None-PCPs are not interested in our program.
- The majority of our patients are from within the network.
- Our services are free to anyone so we do get a few self-referred clients.
- We do not get any referrals from PCPs but would accept them if they ask
- Probably less than 10 percent are self-referred. Most are coerced into addiction treatment. All our ATOD patients are asked if they are pregnant as they are our highest priority.
- The only self-referral patients are for our smoking cessation classes.
- About one-third of our clients are self-referred with many of our indigent, chronic population having been in treatment before, so they know us. They become aware of us through word-of-mouth and by looking in the phone book. One-half come from the court system. Typically, an attorney will advise them to start treatment before they appear in court for a DUI or possession charge.

- Most of our clients are below the poverty level and the majority has no income at intake.
- They do not come via a PCP referral as having a regular source of care is not reality to them; they will use the hospital emergency room for their primary care.
- Every once in a while, we get a self-referral but it is usually the spouse of one of our male ATOD clients.
- The majority are from the court system—about 75 to 80 percent and the majority of these are ordered into treatment. About 15 percent are lawyer referred to demonstrate before their court appearance that they are in treatment.
- Very few and it is difficult to keep them in treatment if their families are not supportive.
- We get the majority of our clients from the courts and probation office.
- A little—less than 15%.
- 85% are court ordered with the majority being mandated.

3. How successful have the ATOD cessation treatments been with your pregnant patients?

- For our Breathe Free Smoking Program, we have a 60-70% decrease or cessation rate if the patient is fully involved in the program.
- For alcohol, we do not have any information on our successes, as all data is self disclosed and not reliable.
- For ODs, we have an 86% success rate for those who do not use by delivery but we do not have any data on post-partum utilization of ATOD.
- If we help a patient connected with Project Home, we generally achieve an 88% success rate (women who are not using Alcohol or Drugs at the time of birth).
- I specialize in tobacco cessation and of those who complete the classes, one-half quit and the remainder cut-down.
- We have been very successful in getting our tobacco users to cut down and have been very successful with our quit rates. We do a quit rate follow up study with our clients at 1, 3 and 6 months post-partum. Our pre-natal and medical clients have a 30% quit rate; the cut down rate is much larger. We believe that cutting down is also important and positive, as the client is subject to less toxins and 3-5 cigarettes is better than 1-2 packs per day.
- The patient who cuts down on tobacco use is successful also. They may have several other children at home and a few minutes outside with a cigarette may be the only peace they get during the day. A little is better than a lot.
- The critical question is how does one define success? We say that the "majority" of our patients make progress while in treatment. That is, they use less, are more aware of the consequences of using, and are functioning better, overall. We also track their employment and education progress and whether they complete the treatment. If they use only once or twice in 8 weeks, we feel that is a success. If they are using crack everyday and

come into treatment and are clean in 8 months that is success, even if they have slipped in to a relapse and need to get back into treatment. Our policy goal is ABSTINENCE.

- If you look at a one-year follow-up, we may not appear successful. Yet, should success be a "Yes" or "No" response or measured on a continuum ranging from "Never uses again" to "Chronic relapse". Most of our patients are in the middle and may have 2 or 3 relapses per year, but they are into treatment so that should be thought of as a success on the continuum.
- One must remember when measuring success, that there are multiple agendas at work with the addicted patient.
- Success is hard to measure. Is it that you have employment, an apartment and are eating regularly but are not completely clean? It is really a step-wise problem. I believe that success is reducing harm by reducing use. We have quite a few (75%) successes.
- People need to be aware that there is no punishment if you seek treatment. It might be advisable to put things in Wal-Marts and other public areas that say "call this 800 number for help with quitting".
- Our primary focus is intoxication and our goal is to help the patient achieve a drug free life style. Most of our clients use more than 1 substance and basically have a "love affair" with intoxication.
- In terms of success, the majority of clients stop their ATOD use and wait until they are not pregnant to resume their use. I believe that that they want to get into treatment.
- We need to better publicize our outcomes—we do not do any pubic relations now and that may be why people in the community are unaware of our existence.
- For drugs, we have a 70-75 percent success rate. We define success as continued abstinence for a year. If a person relapses, it is not considered a success. We base it on their self-report.
- Alcohol use is legal but a person who abuses is still an addict. Our goal is total abstinence.
- For our pregnant addicts, the relapse time is shorter and there are fewer relapses in the non-pregnant population. We want total abstinence for the pregnant women.
- That is hard to say but I do know that pregnant ATOD clients are more successful than the general addicts. Once clean, the pregnant women go back to their motherly instincts and have greater success than non-pregnant women
- Abstinence is our true goal for they rarely cut down in the long run—so abstinence is our only goal and it's helpful to aim for it—no using at all.

4. Do you think that the PCPs in your community are aware that you provide substance abuse treatment and would accept referrals?

- In my opinion, PCPs are uncomfortable approaching their patients with questions about their ATOD use. They know little about substance abuse and lack the knowledge of how to treat it. They generally do not have a

social worker on staff thus, may not know where to refer their patient for help.

- I hope that they think about this program but I am not sure.
- Some are and some are not-→ Somewhat.
- I hope so.
- PCPs do not want to deal with the issue, so do not ask.
- They need to be more aware of the ATOD treatment services available in their community.
- We get referrals for methadone patients as our #1 referral.
- Yes, most OB-GYN physicians know of our services because they are within the system.
- Most hospitals and clinics receive flyers about our services and we do a 'dog and pony' show to present what we do. We need to keep doing this or we will be forgotten.
- I believe that they know about classes for tobacco cessation but they do not know about treatment services for alcohol and drug substance use.
- Few refer to the Women's Journey program in South Bend.
- A huge proportion of our clients do not have a regular PCP.
- A huge proportion of our clients have no insurance or Medicaid so go to the hospital emergency room for treatment.
- Many PCPs have a lack of awareness of our program.
- No, they are not aware of ATOD services in our community.
- We get most of out referrals from attorneys; none from PCPs.
- For eligibility to our community housing program, the client can be addicted to drugs but can not have a major mental illness, [i.e. bi-polar] as medical and psychiatric monitoring is outside our domain.
- While we do have levels of care, we are not a lock-down facility. Clients pay their own room and board and learn how to take control of their life.
- There is a general lack of awareness of ATOD treatment services in the community and compounding this is the fact that physicians are not familiar with addiction treatments.
- Yes, and I would accept more.
- The community is small enough so they are all aware of the services available. We do an awareness campaign for the physicians in the community. They do know about our successes.
- PCPs are not good at substance screening. They tend to be very gullible and believe the addicts story. The problem is that addicts lie.

5. Do you think that women in the community who use alcohol, tobacco or drugs during pregnancy generally know what the health effects might be?

- Most know especially if they are not in their first pregnancy.
- They believe that the benefits are greater than the costs when using.
- Believe that the problems occur to their baby and not to me.
- They know that ATOD use is not good but they do not know the specifics.
- First pregnancy Mom needs education as the information from their friends is often not reliable or true.

- Yes, but they hear conflicting stories from people on the street or from their relatives or my friend smokes pot and her baby was fine.
- I worry more about crack, heroin, methamphetamine and alcohol than I do about cigarettes. What are the long term effects?
- Many believe that the effects of cocaine are not as bad as those from cigarettes. They have heard that cigarettes affect the placenta but have heard nothing bad about the affects of cocaine so it must be okay to use cocaine, but not cigarettes. They do not know the affects of cocaine on the fetus, so it must be okay.
- No, they do not.
- Yes, they know as there have been many health campaigns in the area. While they may not need more information, a media campaign can only help and not hurt.
- This is a great question. I believe that the majority of pregnant women know that ATOD use is not healthy but they do not know the specifics of the affect of the substance on them or on the baby.
- During pre-natal care appointments.
- Television.
- Radio.
- From physicians and other providers.
- Information must be distributed both before and while pregnant. We need to aim at all women of child bearing age.
- It is not a matter of IGNORANCE; it is more a problem of AMBIVALENCE.
- There is a hierarchy of needs. We are basically a Domestic Violence Shelter. Where does a homeless person who is abused (in fear of her life) go for f=help. Her family has disowned her and her partner says he is sorry; she is facing very serious survival issues. Smoking is bad but her stress level makes her tobacco use understandable. Tobacco is the coping skill that she uses to make it through the day.
- For tobacco, they do know BUT they do not really think that the information is valid. They smoked with their other two children and they have had no negative symptoms so they do not believe the dangers are real. They are aware of most of the problems but not all of them.
- Definitely not.
- Some are and some are not.
- Start ATOD prevention education before they are pregnant.
- Yes, I think that they know more today than ever before. They would have to live in an isolated box not to know the effects of ATOD on the baby and the mother.
- They have high levels of knowledge.

5a. Is there a need to do a better job informing pregnant women?

- Yes
- Yes, it is an on-going process.
- Yes

- Yes
- Yes
- Definitely
- Yes
- Yes, even though you had no problems with pregnancy number 1, pregnancy number 2 may have some problems.
- We need to counter the statement "I am healthy and strong and my mom smoked" or "Asthma is no big deal".

5b. What information do you think is needed?

- More information on the side effects to the mom and the baby (post-partum).
- More information on the long-term effects of marijuana.
- The dynamics of the women in our program are that they are young with multiple children and have a need for socialization. It's not just a need for rehabilitation but for help in how to get a job, how to be more responsible, how to better parent a child—all kinds of educational needs. In addition to alcohol or drug-related problems, there is a need to meet instant gratification and not the long-term effects of their use. It is hard for the women to understand how and why a change is needed. Scare tactics do not work as the understanding is not there. The information is overwhelming and hard to believe. Say all that you like, but we are not getting through with these tactics.
- Our messages need to be more positive—i.e., here is our program and we have the ability to help you with your addiction. We need make the message clear and simple and inform them of the availability of successful programs and how smoking affects the baby directly.
- We need to instill non-stigmatizing hope with our out-reach programs. There is lots of guilt and shame in our patients. We need to publicize that resources are available to help them change their life. We can provide a positive thing in your life. If you do not have money but want to get better, here is where you can go, but you must be willing to take the first step.
- What are the consequences of each drug and what harm will it cause in both the mother and the baby.
- Smoking affects the baby.
- Women feel very guilty about using substances. They are more likely to tell the truth when in focus group sessions than when in a one-on-one session. They tend to connect with each other and are more comfortable.
- We need to frame messages with less guilt—be more positive.
- Providers do not tell their patients about tobacco cessation programs and that they can use medication to help them quit smoking. We are a free program and can provide free medication to help them quit.
- We need to provide proof that we are getting better in helping people quit ATOD use.
- We need to focus on specific issues in addition to effects on the fetus--like what is the effect of substance use on your job? Methamphetamine and

cocaine are very devastating on your whole life and not just the unborn child.

- What is the likelihood of post-natal damage after the baby is born especially during breast feeding and nurturing?
- How can we, the treatment providers, help you to quit? We need to become more engaged in distributing better PR materials?
- Any public education should stay away from blame, shame, moralizing, judging and concentrate on 'we can help you get better. The educational material need to go with bio-medical information, not shame based finger-pointing.
- How drugs affect the fetus?
- How one can fall into addiction while recreational using?
- Women must know about the effects of drug use BEFORE becoming pregnant.
- Yes, we need to not only inform them of the value of prevention (abstinence before becoming pregnant) but where they can go if they have stepped over the line and started using or resuming drugs while pregnant.
- Program administrators and treatment providers need to better publicize their success rates (if they are accurate).
- Rather than threaten us with jail time and malformed babies, treatment providers need to be more positive and truthful.

5c. How should this information be given to women?

- For low income patients, changes are needed in the way the information is delivered. I generally use three approaches for each patient: I provide a visual picture; I verbally tell them about the effect; and, I provide a story about my experiences with high-risk mothers and the outcomes of their substance use.
- When delivering the messages, it is best to use a person who has had a substance experience. Use a user to help educate and try to find a person who can be thought of as a demographic peer (age, race, experience).
- I do not know of any role models that could be used. Many watch Oprah and Jerry Springer but they may not always have respect for them. Possibly, someone could be used in the music industry.
- The trick is how to get it out and not just what to get out. There is a danger with bill boards as it can add to the denial process, which is a normal protective defense---"it's not me". Billboards are not for me at 5 cigarettes per day but for people who smoke 2-3 packs per day.
- Medicine is helpful for tobacco cessation. Smoking harming the baby is a given. The major problem is in early delivery and low birth weights and the consequences of early delivery. We know of the harm but what are the effects in the long term.
- The best time is when they are arrested—they are in a legal hold and we can get their attention. I do not like the felony route but it does get their attention.

- Drinking is harmful in pregnancy, e.g., fetal alcohol syndrome, retardation, etc. and we all agree and understand that alcohol use is harmful. However, we need to know more and publicize the effects in the long term.
- Television would be good.
- Student prevention is the best resource—even if we are pregnant a week. Same with tobacco and alcohol—get to us earlier.
- Healthcare providers should ask the question 'Are you thinking about quitting?' and then should follow up with 'are you ready to quit?'
- A telephone help line can help those who have signed up for treatment. Nurses and other staff can be used to help the client by providing more information and support on how to quit.
- There really is no best way as communications is multi pronged: television, radio, emergency department materials, and health clinic brochures. In addition, it would be beneficial to pass out materials in beauty salons and in physician offices. It is amazing but people do see billboards. The point is that the broader—the better.
- It needs to be multi-dimensional
    - Child Protection Services announcements
    - Food Stamps
    - Clinics
    - Council on Domestic Abuse pamphlets
    - Providers
    - Television
    - Billboards—plant a seed and then provide more specific information
    - WIC offices.
- Information should be provided to Junior High School groups because kids are the most vulnerable and at risk. I believe that information should be given even before Junior High school as younger kids are also at risk—we maybe do not want to believe it, but it's true.
- Family Planning counseling is very much needed. Perhaps the ISDH and ISDE need to get together to discuss the problems even though it will be a challenge. Addicts experience a loss of control in their life and multiple babies do not help the situation. I am 21 and have 4 kids at home.
- Brochures, Messages and Posters should be displayed in:
    - Community Centers
    - Treatment Program clinics
    - Parish nursing facilities
    - Physician offices
    - YMCA/YWCA
    - Television.
- The state should do more—we as a non-profit organization cannot afford to do marketing and information distribution.
- We need to stimulate verbal communication between the provider and the patient.

    - It's a marketing issue—who and where are the treatment providers.
  - For teenagers and Medicaid patients, use the television.
  - The main message has been to stop for your baby's health—it might be better to also focus on the women's health i.e., beautiful skin, etc. If you smoke, your skin will wrinkle. Appeal to a person wanting to maintain their beauty.

6. Do you think that we should worry about those women who use just a little alcohol, tobacco or drugs during pregnancy?

- Yes, research says that we do not know what a safe level is.
- Any ATOD use is an addiction.
- We worry about those patients who have stopped and need to make sure that they "stay off" ATODs.
- We need to focus on ANY use and not just an addiction. Many patients will reply, "Addiction does not apply to me, I only drink once in a while". We are not concerned with just alcoholics as no one thinks of themselves as an addict or an alcoholic.
- Yes, give a clear message—DO NOT SMOKE. If we allow a little bit of smoking while pregnant, it may increase after the birth and the baby is then endangered from the SHS.
- Yes, do not stop with a cut-back; we do not know how much is bad for the baby—alcohol and drugs.
- Cutting down in tobacco use is not a failure to us OR to them, but never say it is okay to cut down, as it is worth the time to get them to give up smoking completely.
- Of course absolutely, because any alcohol use is dangerous to the baby.
- Definitely so—there is no safe amount of ATOD. Abstinence is the only way.
- Yes, certainly for tobacco. A little tobacco is still harmful and while 3-5 cigarettes per day is better than 1-2 packs per day, it is still ingesting chemicals.
- Yes indeed, and praise those who do cut back.
- The long-term damage from methamphetamine is not known, so stay away from it.
- Alcohol—yes, literature says that ANY alcohol can injure the patient.
- Yes certainly, less poison means a lesser problem.
- We are never really sure of the level of use among the addicts—they all lie and we have to be concerned with how deep they lie. What is the desirable level of use and what is their correct use?
- The safe level is a tougher question. I want to say no but the body is a resilient with little harm from low exposure.
- We need to be aware of the fact that there is a dose response. People need to be told that reducing use will reduce the risks; there is still a higher risk if you are an infrequent smoker, compared to not smoking at all.
- Tobacco also can affect people who are being treated for other medical diagnoses.

7. What barriers would we need to remove to encourage more pregnant ATOD users to seek treatment?

- Stigma.
- Access to Programs and it is not only poor, African-American and inner-city residents.
    - Geographic
    - Insufficient numbers of services available
    - Lack of insurance
    - Patient does not know that the treatment program exists-lack of knowledge
    - Program is not available in their community
    - Transportation
    - Child care is not available at the clinic.
- Lack of Communication
    - Patients are not asked if they use ATOD
    - Patients will not volunteer that they use ATOD
    - Differences between:
        - Urban/Rural
        - Rich/Poor
        - Black/White.
- Lack of Available Child Care.
- Available Appointment times—working 8-5 and clinics are open 8-5
- Once a patient has access, they need spousal/family support to be successful. If their partner uses ATOD, it will be hard to say "No". There is the problem with Second Hand Smoke also.
- It is a myth that "Drugs are not that bad".
- They can never be certain that they will not be arrested—the question is: is this really a crime?
- Transportation.
- Child care is a big problem.
- Cost of the services—our tobacco cessation program is free.
- Access—offer scheduling at evening and possibly weekends.
- Make the services available when the women needs them—limit the waiting time for an appointment.
- Knowledge of where the treatment providers are located.
- Little support at home—"he will quit after I am successful".
- They need to realize I need family support [and social] support.
- Many do not come to us because they are not screened and detected.
- They need to be able to seek treatment without legal implications or fears.
- What is the true law-what are the STRICT confidentiality rules and how do they impact on the decision to seek care—is there true confidentiality?
- The most important is the individual's lack of life skills, e.g., how to keep a house or apartment clean, how to diaper a child, how to cook a meal, etc.
- There are several that come to mind:
    - Lack of employment

  - Lack of decent housing-no place to live
  - Legal problems
  - Living in an abusive/domestic violence relationship
  - Unhealthy, unsupportive relationships
  - Lack of child care
  - Financial worries-low income
  - Lack of transportation
  - Treatment centers are not always family friendly
  - We do not have adequate IP or residential services available for ATOD.
- Patients are scared to get care for ATOD-they fear the system.
- We need to improve the ability to get folks into care within 72 hours—delays cause problems.
- If patients ask for help, be able to respond.
- Let them know that if they tell you they have an ATOD problem, we can help you other than just saying 'do not do it anymore'.
- The stigma of drug use during pregnancy may prevent women from getting treatment. People tend to assume that you are a bad mother because you are using drugs and many feel that pregnant women who are addicted are 'criminals'. The current thought is that if I admit to use, I will lose custody of my child. The punishment is worse than the gain from coming in for treatment.
- We need to understand the difference between addiction and use of drugs. The light user knows the health effects and will quit; the heavy users will continue as it is very difficult to quit without help.
- Medicaid enrollment barriers.
- We need more case management in the addictions field that allow for us to walk through the system in a systematic way, not haphazardly.
- Many miss their early pre-natal appointments due to late enrollment in Medicaid
- Many do not know how to apply to the Medicaid program.
- Transportation.
- Stable housing.
- Lack of a residential treatment center.
- Is there a need for female counselors with pregnant substance users—not absolutely important as each case is individualized? My preference is to have women counselors, but it is not crucial.
- Staff do not ask if they smoke so they do not learn about the clinic or the programs to help them quit.
- 75% of my clients have transportation problems limiting their access to services.
- Child care.
- No funding for IP residential women's addiction treatment services.
- Bad attitudes toward pregnant women who abuse substances—STIGMA and BAD mother labeling. Society has more understanding now than it did

years ago. The stigma is much worse for pregnant women than for non pregnant women.

- Smoking experience and history is asked verbally at the initial pre-natal visit and is in the medical record. We need to ask the smoking question at every encounter BUT we are not asking at other times.
- Lots of medical staff smoke so they set a bad example or do not think that it is important to ask the patient.
- Everything in healthcare happens so fast that things get lost in the shuffle or in the crowd. Time with the patient is too short.
- Transportation.
- Child care.
- Women-only groups are needed—difficult for pregnant women to be in a gender-mixed group.
- Medical Care.
- Financial
- Society and Client Attitudinal barriers
    - Guilt
    - Blaming
    - Condemnation
    - Distrust
    - Judgment.
- Lack of Availability of Services.
- We know what the ATOD best practices are but we do not use them.
- There is not enough capacity in the IP residential ATOD treatment centers.
- Shame.
- Fear of losing my child.
- Insensitive male providers who do not know the needs of females. Males can help female pregnant patients but they need more education on the needs of females.
- A treatment provider does not need to have personal addiction experience to be effective. A physician does not have to have heart disease to treat the heart or have had cancer to treat cancer, but they need to better understand female issues.
- Addiction is a bio-medical phenomenon.
- The major barriers are:
    - Transportation
    - Child care
    - Financial.
- Being a substance user, I can say from experience that I am not in a supportive environment and many of us are in an abusive situation.
- Stigmatization-Pregnant women using drugs are subject to much shame and guilt feelings and feel “TOTALLY WORTHLESS”. We will avoid a felony rap by running away.

- Physicians need to make more referrals and need to do more ATOD screening. There seems to be hesitancy on the provider's part to find out if we are using.
- Make treatment available across all socio-economic levels.
    - I believe most clients under 200% poverty get state subsidies.
- Transportation- we do have a good bus system—many clients use the lack of transportation as an excuse for missing an appointment.
- Child care is a serious issue.
- As far as Treatment Provider- we do gender specific counseling, which I believe is very important. I believe that many clients are male manipulators.
- It might be beneficial to have a treatment provider balance where some "clean" individuals are brought in to discuss the issues with the on-going clients. We need to be sure that they are in recovery so as to avoid any transference.
- Every counselor DOES NOT need to have been pregnant or a user.

8. Are you aware of other available treatment services in this community?

One person listed 8 facilities:

- Methodist
- Fairbanks
- Valley Vista
- Project Home
- Harbor Light
- MCHD
- Latino Institute
- Wishard
- We use the Rainbow Book or the Help Line to find services for our patients, as needed.
- Para Treatment in Franklin.
- Gallahue
- PCPs are not aware of the services available. There is a need to go back and remind them with a periodic distribution of information. PCPs have no institutional memory so we have to remind them by staying in their face.
- Pregnant Home
- Dr. Nocon at Wishard Hospital.
- Methodist Hospital
- Alcoholics Anonymous
- Narcotics Anonymous
- Physicians really do not know
- We know the OP services but there are no IP services available.
- Yes, we do know about tobacco cessation assistance—there are many classes in the community.
- Fellowship House is a residential female unit and they will take pregnant women but they do not want them, given the extra "baggage" [liability and responsibility].

- Because of a decrease in funding, the availability of IP residential units has declined
- Hamilton Center—residential for men only.
- Community Mental Health Center
- None that I know for tobacco cessation, but I believe that there is a "Quit Now" program and an 800 phone line to call for help.

9. Is there a need for additional treatment services in your community?

- Not for tobacco programs as there are sufficient numbers—Classes are available somewhere every day in Indianapolis.

9a. If yes, what type and where are they needed?

TYPE:

- Yes, absolutely.
- For alcohol and drugs, we need more
    - Partial hospitalization units
    - Project Home programs that meet OP 2-3 times per week
    - Stabilization/Detoxification programs
    - Transitional Housing
- We need residential treatment centers located in neighborhoods that are supportive of the effort. I would prefer to have one on Meridian Street (Indianapolis) and not hidden away somewhere. Moving the Julian Center to Meridian was a great idea as it "says" there is no shame (referring to the stigma of domestic abuse)—and reflects an "out of the closet" way of thinking. But it is hard to find an area that would want these (addicted) patients.
- Most patients have multiple ATOD issues so we need an overall program for abuse—nicotine, alcohol and drugs. Cocaine versus alcohol detoxification – the treatments are different and there is no magic medication for cocaine addiction. There are major differences between methamphetamine addiction and alcohol as there are cognitive deficits with methamphetamine as the methamphetamine patient may not remember one session to another. They will miss appointments and it is not that they do not care but they forget the appointment has been scheduled. We need to tailor the methamphetamine treatment to each patient.
- My gut feeling is yes.
- Yes, residential.
- Yes, we need fully comprehensive, case managed facilities.
- Sure, we need to expand the Women's Journey type programs where IP residential treatment services are available for women and children.
- Obviously, we have a huge waiting list for services at our facility and there are many others who are not even on the list.
- Definitely and more residential treatment centers because they are multi-dimensional and provide:
    - Medical care services
    - Mental health services
    - Dental care (especially important for methamphetamine mouth
    - Parenting skills

- Employment
- Educational
- Absolutely, we need more services in Marion County. My smoking cessation program is at full capacity now.

WHERE:

- Multiple places
- People relate to where they are – North, South, East, and West sides of Indianapolis.
- Put where the substance is.
- One stop shopping.
- In the east-central part of Marion County—an area of high economic need
- Need more alcohol treatment services for pregnant women in Terre Haute.
- There are 3-4 treatment groups in the area but they do not focus on pregnant females.
- Tobacco cessation—definitely need more services.
- Yes in the Terre Haute area.
- We need IP treatment programs for men and women (hospitalization, detoxification, medications) then into community housing for a continuity of care system.
- We need prevention programs at an early age—we can stop use with prevention.

10. During our discussion, we talked about a lot of recommendations. Of all the recommendations we talked about, which one or ones do you think are the most important ones to deal with?

- People need to be aware that there is no punishment if you seek treatment. It might be advisable to put things in Wal-Marts and other public areas that say "call this 800 number if you want to get off ATOD and we guarantee no problems with the police.
- Child care and transportation—provide child care at the clinic for those moms who have no home care available while they are in treatment.
- Individuals need to learn to take responsibility for their actions and the services should not be totally free. If one charges $1, the effort may be more as the money is coming out of my pocket.
- Most importantly, address the stigma and stop thinking about criminalizing -- the answer is not to threaten them with jail time. It is very easy to jump to the conclusion that jail time will work as a deterrent but this is very counter-productive. They need to seek help and not go to jail. These are cross purposes. STOP THE JAIL TALK
- Felons are not eligible for Section 8 housing, student education loans, food stamps, and they have added problems trying to get a job—take all that away and what is left for the "clean addict".
- More IP residential centers tied to a treatment program, designed for them—the pregnant user. We can get support from other users who are pregnant.

    - Change the message from negative to positive—this would be a better approach. Make the message to reflect the message: We can help you and there are services available here in the community. No one responds to negative criticism so offer the realities and hope that maybe the treatment will work for me.
    - Dissemination of information into the community. OBs here do a good job referring within our system. I worry about the women in the community who are pregnant and not getting treatment.
    - Prevention is the number 1 priority.
    - We tend to get angry about pregnant women using drugs but not when we are talking about pregnant women using alcohol. There is good data linking harm to a fetus from alcohol use but not as strong a relationship. So, we want to put drug users in jail, not those who use alcohol or tobacco.
- The public needs to know more about the problem of addiction during pregnancy.
- Much lies with the provider:
    - They need to be well informed on the availability and quality of local treatment programs
    - They need to know how successful the treatment programs have been
    - They need to be encouraged to ask their patients about their substance use.
- We cannot PUNISH addiction out of ANYONE.
- The state should look at the Women's Journey program in South Bend as a model program that provides residential inpatient rehabilitation and provides housing for the woman and her children.
- The State should conduct a cost study to compare the costs of incarceration, the cost of foster care, and the cost of providing medical care via the emergency department WITH the costs of providing family oriented IP addiction services for pregnant women.
- ATOD in pregnant women is a huge concern, but you get what you pay for. We need to put more money and resources where the priorities are. The ATOD users are a vulnerable, under-served population. It comes down to expanding services. In reality, there is no money for child care. They struggle to make it to treatment.
- A chemical dependency program today is a money loser. We all agree that they are important programs and that they are successful, but we have no money to operate the programs.
- ATOD programs are viable but people cannot get help at a site where there is no child care available and we should not be "forced" into a men's program. Our issues are different than those for the men.
- The state should look at the costs of treatment options. It costs about $35,000 to incarcerate a felon but only $5,000 for 6-8 weeks of residential treatment. And the IP treatment works—the jail time does not solve the addiction problem.
- Whatever we are doing with ATOD treatment services, it is not working well.
- The number one priority is to provide more information to the public about the damage that ATOD can create with the baby <u>and</u> what services or resources are available in the community.

- We need more specific high profile public awareness of where the treatment centers are and what they can do for the addicted client.
- We need more inpatient residential facilities in the community that accept pregnant ATOD substance users.
- More information needs to be distributed: Education of students and physicians is the most vital piece to best prevent ATOD use but are the most difficult to arrange.
    - Work with the schools and in particular the Junior High Schools
    - Teach PCPs to better screen and refer their patients
    - Inform the community of the availability of successful treatment programs
- At our facility, we do have capacity in the OP program but our residential unit is at full capacity (12 female beds) with 8-12 people on the waiting list at all times.
- We cannot allow children into this program—it is just not possible. But this itself causes problems:
    - What do I do with my kids?
    - How do I pay the room and board?
    - How can you help me ensure I will have a home to go back to?
    - How can you help me retain or get a new job when I am done with treatment?
- The mother cannot pay both rent AND room and board at the residential center.
- Offer treatment for pregnant women and their children. Offer them a place to stay to remove them from the on-going substance use cycle where they can truly focus on the other needs also, like nutrition and medical care. These are often avoided in other treatment programs.
- A community based drop-in clinic might work to engage them when they are desperate.
- Tobacco support groups for pregnant women.
- People want and need more one on one individualized treatment.
- Most clients are aware of AA and NA.
- Transportation is a major problem.
- We need more provider education so that physicians will become more proactive in screening and referring their ATOD patients. In addition, the, the physician can serve as an important supporter of the patient.
- We need better access—more awareness and more expanded services.
- More and stronger home support –this need should be part of the public message.
- Most importantly, we need to be more positive in our dealings with ATOD users—the stigma of addiction is powerful and does not help in the treatment process. We need to say—"We can help you without the fear of being punished or harmed".
- We need to distribute more information on the harmful effects of substance use.

Appendix C-1: ATOD Needs Assessment Study
Primary Care Provider (PCP) Questionnaire

Introduction:

We are working with the Indiana State Department of Health to find ways to help pregnant women get the medical services they need during pregnancy. As you probably know, the number of women who smoke, drink and use drugs during pregnancy is a significant health problem in Indiana. We are gathering information from other primary care providers about their opinions and their experiences with pregnant patients who use tobacco, alcohol or other drugs. As part of this project, we are also holding focus groups with women who have been pregnant and to substance abuse/ATOD treatment counselors. A major part of the study will use existing data about, alcohol, tobacco and other drug use in Indiana. Our project will help identify barriers to receiving services and where more services are needed in the community to help women stop using these harmful items.

We sent this questionnaire to you because we value your perspectives and opinions. Your participation is voluntary, but your input is very important to us. We will keep your comments confidential. As with all the participating key informants, we would like to list your name in the acknowledgement section of the final report. However, this is not mandatory.

Key Informant Script for PCP's

1. When you think about your pregnant patients, what percent (approximately) do you think use
   - 1a. Alcohol? _____%
   - 1b. Tobacco? _____%
   - 1c. Drugs _____%

2. Do you think that women who use alcohol, tobacco or drugs during pregnancy generally know what the negative health effects might be?
   - 2a. Is there a need to do a better job informing pregnant women about the health effects of substance use?
   - 2b. What information do you think needs to be disseminated?
   - 2c. How would be the best way to get that information out to pregnant women?

3. Do you think we should worry about those women who use just a little alcohol, tobacco or drugs during pregnancy?
   - 3a. Alcohol?
   - 3b. Tobacco?
   - 3c. Drugs?

4. Do you routinely screen pregnant patients for their use of alcohol, tobacco or other drugs (ATOD)?
    If yes, how do you screen for:
    4a. Alcohol?
    4b. Tobacco?
    4c. Other Drugs?

5. What do you do if you find a patient who is positive for
    5a. Alcohol?
    5b. Tobacco?
    5c. Other Drugs?

6. How comfortable are you giving counseling help to women who use ATOD?

7. How often do refer your patients who use ATOD for more specialized treatment?

8. When you refer, to whom do you refer pregnant patients who are using
    8a. Alcohol?
    8b. Tobacco?
    8c. Other Drugs?

9. What barriers do you think pregnant women have getting ATOD treatment in their community?
    In general?
    9a. for Alcohol?
    9b. for Tobacco?
    9c. for Other Drugs?

10. Have your patients who use ATOD been successful in stopping their substance use during their pregnancy?

11. How aware do you think you are about the ATOD treatment services that are available in your community?

12. Is there a need for additional ATOD treatment services in your community?
    If yes, what type and where?

13. Of all of the recommendations you can think of to improve ATOD services for pregnant women, which one(s) do you think are the most important to deal with?

Thank you:

Thank you very much for your valuable input. We will make sure your comments are included in our report. Our plan is to provide this report to local and state level policy makers who are trying to make sure everyone's health needs are being met as much as possible.

Appendix C-2: ATOD Primary Care Provider Feedback

1. When you think about your pregnant patients, what percent (approximately) do you think use?

1a. Alcohol?

- Most are found during an initial intake and are patients who drank before they knew they were pregnant, but quit after learning they were pregnant. It is really a very small percentage as I can only recall 2 alcohol abusers this past year.
- 10%
- 0% - I don't accept patients who won't quit when pregnant
- 15%
- 50%
- 10%
- 10%
- 0%
- 5%
- 5%
- 25%
- 5%
- 15%
- 4% binge drinking

1b. Tobacco?

- We have lots of tobacco users but the trend is positive. There are more smokers now who smoke 5-6 cigarettes per day and only a few that smoke a pack or more per day. Part of this decline may be due to the increased costs of tobacco. They also feel open and more honest about their smoking use; I am less reassured with their reports of alcohol or drug use.
- 30%
- 0% - I don't accept patients who won't quit when pregnant
- 25%
- 25%
- 15%
- 40%
- 10%
- 40%
- 30%
- 50%
- 25%
- 60-70% and people rarely quit
- 20% easily

1c. Drugs?

- The majority of the drug users I see are using marijuana. Cocaine use is low (about 15-20 per year) but come to think about it, I have seen 5 cocaine users in the past few days. I have not seen any methamphetamine users. I see about 3-4 prescription drug abusers per year and send them to psychiatry for treatment**.**
- 20%
- 0% - I don't accept patients who won't quit when pregnant
- 10%
- 5%
- 5%
- 10%
- 0%
- 5%
- 30%
- 10%
- 10-20% illegal drugs (mostly marijuana)
- 25% abuse prescription drugs (xanax, vicodin etc; it is an increasing problem here
- 15% illegal drugs

2. Do you think that women who use alcohol, tobacco or drugs during pregnancy generally know what the negative health effects might be?

- I do not know but we tell them anyway.
- Yes
- Most do
- Yes
- No- maybe they know it is generally bad, but do not know why
- Yes
- Yes, I warn them explicitly
- Yes, I am absolutely convinced they know the effects of ATOD
- The problem is Ambivalence, not Ignorance
- Yes
- Yes, for the most part. I always educate and a few quit, especially tobacco
- Yes
- They want to give up but they are using substances to avoid withdrawal problems
- Yes
- They know it could hurt someone else's baby, but they think their own use is minimal and will not hurt their baby
- Yes, I am sure that they do
- All patients see the PSUPP coordinator and the MCH Clinic. They ask about their alcohol, tobacco and drug use and talk to them about the harmful effects

  2a. Is there a need to do a better job informing pregnant women about the health effects of substance use?

  - Yes, there is a need.

- Most patients have the information, but don't listen and are unwilling to change.
- Sure
- No
- Yes
- Yes, there is a subliminal message at work here and it is based on the stigma and shame associated with alcohol or drugs that do this bad thing to the mother and her baby. Therefore, she is a bad person for using. Instead, we need to send a different message- a more positive one that encourages her to say "I have a disorder and I can get clean. I can start with a reduction in my use, not total abstinence and can succeed with help. I can have a healthier baby, more money, a better job, and a nicer apartment.
- Yes
- Yes
- Yes
- Of course
- Yes, inform them <u>before</u> conception
- Yes
- Yes
- Yes, for example, I get told that "friends I know smoked during their pregnancy and their baby weighed 8 pounds".

2b. What information do you think needs to be disseminated?

- Pictures of babies who have been abused by drugs
- Attention Deficit Disorder
- It is easier to quit smoking and I have information for you to help you quit
- With cocaine, I do not feel as competent here discussing the complications of the pregnancy
- We need to tell them not what drugs do, but that treatment works. You can get clean and it is not that difficult.
- That they are not immune to the adverse effects
- Effects on baby, pregnancy and mother
- The specific consequences should be clearly shown via audio-visual presentation
- The exact congenital anomalies and complications (e.g. abruptio placenta that can arise)
- Smoking[pre term birth weight, abruption placenta]; alcohol [fetal alcohol syndrome]; methamphetamine [you will lose your child]
- Pamphlets or side effects of drugs
- Effect of alcohol, tobacco & street drugs on pregnancy
- Mostly tobacco effects- short term & long term
- Everything: tobacco, ethanol, drugs, weight management, folic acid
- Harmful effects, more education

- Compliance rates are a good measure. Patients in a treatment program have higher compliance, more pre-natal visits and significantly more negative toxicology screens compared to those not in treatment.
- The question to ask each patient is "How can we empower you to get clean".
- That each patient should be honest about their drug & alcohol use
- Our clinic is the only one in town with a substance use prevention program. Our physicians stress the health effects and that they better cut down. They do not provide a specific lecture on 'what happens to the baby'.
- Honestly, they do know overall, but not the specific problems ATOD may cause.
- They do not know the dangers of second hand smoke or the risk of sudden infant death syndrome.
- They need to be provided with the statistics, for example, the incidence of SIDS and the prevalence of women who smoke and clearly be told the relationship of SIDS prevalence to smoking. Women need to better understand the concept of ATOD use and the likelihood of harm to them or their baby. They need to understand that the likelihood of harm increases with more use.
- We need to provide more positive messages. For example, I had a substance problem and PSUPP works. The program staff CAN help you.
- I have heard things from my patients that 'I was really discouraged with all the negative stuff'.

2c. What would be the best way to get that information out to pregnant women?

- Information should be offered on a one-on-one basis with a social worker. There is too much printed information that is handed out and never read. The one-on-one talk should be done in the office during a regular appointment. We need to do it when the patient is here in the office. It is not as effective to have them return to talk about their substance use. Television is a second choice.
- TV commercials? They often just throw away the pamphlets we give them
- I counsel, schools, churches
- Audio visual & media ads, "shock advertisements" showing abruption, fetal alcohol syndrome, and death due to drug abuse
- Face to face conversation/counseling by their primary care provider that they trust
- At initial OB visit
- Media/posters do not work and reinforces the negativity of shame—if you smoke, your baby smokes. We need to redo the messages to say that smoking is bad for you and the baby and that many people have stopped successfully. The message from physicians and treatment providers needs to be that TREATMENT WORKS.

- Both through public media & privately during prenatal clinic visits
- Posters, handouts, educational lecture
- Billboards, TV ads
- Middle & high schools, TV information commercials- make it glitzy
- Family doctor, counseling
- Make it safe for patient to be honest
- We need to provide more positive messages. For example, I had a substance problem and PSUPP works. The program staff CAN help you.
- I have heard things from my patients like 'I was really discouraged with all the negative stuff'.
- Medical students are reluctant or resist asking their pregnant patients about their ATOD use. Most are afraid that asking the question will make them angry. And they do not know how to screen and do not know what to do if the screen is positive. They do not think that they can do anything.
- We need to give PCPs the:
    - Simple tools to detect and screen ATOD use
    - Means to intervene—support, empower and advise
    - Option to refer to addiction specialists
- Students and PCPs should learn how to screen, i.e., how to use the CAGE tool. They know about them but do not use them. Screening tools need to be integrated into the medical school curriculum in each year.

3. Do you think we should worry about those women who use just <u>a little</u> alcohol, tobacco or drugs during pregnancy?

3a. Alcohol?

- I do not worry about a glass of wine per week.
- Studies have not shown exactly what levels of ethanol affect baby
- Yes
- Yes
- Yes
- We are not sure how much alcohol leads to fetal alcohol syndrome so it's best to use no alcohol during pregnancy
- Yes
- Yes
- Yes- if they admit to a little, probably means they are using more
- Yes
- Research supports – do not drink at all. A beer every so often is okay depending on your lifestyle. One glass of wine with a meal is okay but if my partner is an alcoholic, it may increase over time.
- Yes
- Yes

3b. Tobacco?

- Yes, I do worry about smoking as there is no benefit from any use. I tell them it is better to quit right now, for later, you will realize the benefit to stopping and why wait.
- Any smoking is detrimental

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes- if they admit to a little, probably means they are using more
- Yes
- Yes
- Yes
- Yes, but we need to concentrate on the pack per day smoker more than the 3-4 cigarettes per day smoker.

3c. Drugs?

- With drugs, even a little is too much, even marijuana.
- Most patients don't feel that marijuana is harmful. We have a hard time convincing patients of risks.
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes- if they admit to a little, probably means they are using more
- Yes
- Yes, the question to ask each patient is "How can we empower you to get clean".
- Yes, you need to stop totally
- I believe that low doses are okay, for example, I closely monitor my back patients who are taking vicodin and there are some patients who are getting relief from morning sickness using pot.

4. Do you routinely screen pregnant patients for their use of alcohol, tobacco or other drugs (ATOD)?

- Yes, I screen the patient verbally. If I get a 'yes' response, I review and screen at every appointment. I want substance use down to zero.
- Yes
- Yes
- No
- Yes
- Yes
- Yes
- Yes
- Yes, I only see patients who have had a positive toxicology screen
- No
- No, it is up and down. When they enroll in the program, some sign and some do not that it is okay to randomly do drug screening.

If yes, how do you screen for:

- I do not have a screening tool but play it by ear.
- We screen with both written and verbal questions with history taking at the beginning of the pregnancy, If they have a positive drug screen, we address the problems with the use. For smoking, we ask every time, but not for drugs.
- We screen with a urine test if we believe that they are at risk, but not everyone—they may be offended.

4a. Alcohol?

- Direct questions from nurse & doctor
- Ask
- History
- In history (prenatal)
- Questions every visit
- I ask them, on highly suspect patients (e.g. patients who have history of substance abuse) I do a urine toxicology screen

4b. Tobacco?

- Direct questions from nurse & doctor
- Ask
- History
- In prenatal history
- Questions every visit
- I ask them, on highly suspect patients (e.g. patients who have history of substance abuse) I do a urine toxicology screen

4c. Other Drugs?

- Urine drug screen at first visit; every patient
- Ask
- History
- Toxic screen for symptomatic patient & through prenatal history
- Questions every visit
- I ask them, on highly suspect patients (e.g. patients who have history of substance abuse) I do a urine toxicology screen

5. What do you do if you find a patient who is positive for?

5a. Alcohol?

- Discuss stopping and methods we can use to help stop using these. Also discuss what options SMMC or organizations have available
- To PSUPP counselor
- Counseling
- Explain possible consequences of these drugs to them and their unborn baby and advise them to stop
- Counsel
- I warn them of the risks and encourage them to stop
- Emphasize effect of alcohol & refer to alcohol cessation counseling
- Advise against it and explain risks and consequences of use
- Long discussion, encourage cessation, refer to mental health
- Counsel

- We have hardly any, so I do not know

5b. Tobacco?

- Discuss stopping and methods we can use to help stop using these. Also discuss what options SMMC or organizations have available
- To PSUPP counselor
- Counseling
- Explain possible consequences of these drugs to them and their unborn baby and advise them to stop
- Counsel
- I warn them of the risks and encourage them to stop
- Emphasize effect of tobacco & discourage, also offer cessation counseling
- Advise against it and explain risks and consequences of use
- Long discussion, encourage cessation, refer to mental health
- Counsel
- If smoking, all patients see the PSUPP coordinator. One problem is that our PSUPP counselor is only part-time, so we sometimes have a problem having her see the patients when they first start getting care.

5c. Other Drugs?

- Discuss stopping and methods we can use to help stop using these. Also discuss what options SMMC or organizations have available
- To PSUPP counselor
- Counseling
- I warn them of the risks and encourage them to stop
- Explain possible consequences of these drugs to them and their unborn baby and advise them to stop
- Counsel
- Emphasize effect of the drug used & discourage it, also refer to counseling for cessation
- Advise against it and explain risks and consequences of use
- Long discussion, encourage cessation, refer to mental health
- Counsel

6. How comfortable are you giving counseling help to substance users yourself?

- I am comfortable
- Very
- Moderate
- Not very comfortable beyond warning them of the medical complications related to substances
- Very
- Moderate
- Not very comfortable
- Somewhat
- I am quite good at it
- 75%
- Very comfortable

- Not as comfortable as I could be
- I do tell them about some clinical effects

7. How often do refer your patients who use ATOD for more specialized treatment?

- Dependent upon need and willingness to work
- None yet as we have PSUPP
- Almost every time
- About ¼ of the time
- Always refer patients who are ready to go for counseling
- Haven't
- Rarely
- ~ 3-5 a year
- 25%- usually for drugs or buprenorphine
- Seldom, I refer to CPS
- I use consultants for my patients with co-morbid psychiatric conditions for example, my bi-polar patients. Also, I seek consultation for diabetics, recovering alcoholics or HIV positive or hepatitis positive patients.

8. When you refer, to whom do you refer pregnant patients who are using?

8a. Alcohol?

- Dependent upon patients' resources
- PSUPP
- Psychologist
- Behavioral scientist (i.e. counselor, psychologist, etc.)
- Psychologist
- Only if the patient needs detox for 3 days—If no detox is needed, I recommend counseling and AA
- Alcohol cessation counselor
- Community mental health center, 2) psychologist
- PSUPP

8b. Tobacco?

- Dependent upon patients' resources
- PSUPP
- Smoking cessation counselor
- Behavioral scientist (i.e. counselor, psychologist, etc.)
- Psychologist
- Tobacco cessation counselor
- Community mental health center, 2) psychologist

8c. Other Drugs?

- Dependent upon patients' resources
- PSUPP
- Psychologist
- Behavioral scientist (i.e. counselor, psychologist, etc.)
- Psychologist
- Drug cessation counselor
- Community mental health center, 2) psychologist

- PSUPP

9. What barriers do you think pregnant women have getting ATOD treatment in their community?

In general?

- Transportation
- Communications problems between provider and patient
- Child care
- Lack of resources
- Lack of support from others in the family and especially if they are also users
- Social pressure at parties—where others are using alcohol or drugs—believe that it is not a problem for "me'
- Drug and alcohol users all have the same barriers
- Lack of coherence in drug users—hard to communicate
- Admitting that their behaviors need to change
- Stigma attached to use
- Fear their baby will be taken away or protective services will become involved
- Transportation
- Unwillingness to change
- No support in peer group
- Transportation-Medicaid will pay for pre-natal transportation
- Upheaval in their lives
    - Housing
    - Partner has left me
    - Employment
- Stress
- Lack of support—all in the family smoke
- Lack of child care
- Education
- Employment
- Financial
- Lack of motivation – the strength of the addiction
- Gender of the counselor does not matter BUT patients relate better to a female
    - People in the same situation
- Finances
- Lack of will
- Social stigma, difficult to break away from their peer group, lack of strength to break away from their addictive behavior
- Distance to care
- Access
- Failure to really appreciate the bad effect of ATOD to the mother & the pregnancy
- Financial barrier: when they have to pay, some find this a problem
- Lack of information and help
- It is always money & insurance/Medicaid coverage

- Do not wish to quit
- Social taboo (drugs)
- Shame
- Finances
- Fear of having baby taken away
- Denial
- Stigma of the label
- Not wanting to quit/seek help

9a. for Alcohol?

- Minimalization- patient thinks she does not drink that much
- Transportation-Medicaid will pay for pre-natal transportation
- Upheaval in their lives
    - Housing
    - Partner has left me
    - Employment
- Stress
- Lack of support—all in the family smoke
- Lack of child care
- Education
- Employment
- Financial
- Lack of motivation – the strength of the addiction
- Gender of the counselor does not matter BUT patients relate better to a female
    - People in the same situation

9b. for Tobacco?

- Most don't want to
- Transportation-Medicaid will pay for pre-natal transportation
- Upheaval in their lives
    - Housing
    - Partner has left me
    - Employment
- Counseling and hypnosis
- Stress
- Lack of support—all in the family smoke
- Lack of child care
- Education
- Employment
- Financial
- Lack of motivation – the strength of the addiction
- Gender of the counselor does not matter BUT patients relate better to a female
    - People in the same situation

9c. for Other Drugs?

- Fear of having baby taken away
- Transportation-Medicaid will pay for pre-natal transportation

- Upheaval in their lives
  - Housing
  - Partner has left me
  - Employment
- Stress
- Lack of support—all in the family smoke
- Lack of child care
- Education
- Employment
- Financial
- Lack of motivation – the strength of the addiction
- Gender of the counselor does not matter BUT patients relate better to a female
  - People in the same situation

10. Have your patients who use ATOD been successful in stopping their substance use during their pregnancy?

- Some successes
- Yes
- Mostly not
- Really (very) pretty successful—most of our patients quit or cutback and we consider either outcome successful
- Yes
- Many have—over 2/3rds of smokers and ½ of drug users
- Some have been successful
- Yes (patients are motivated when pregnant), except cigarette smokers- these ladies won't/can't quit. They do try to decrease.
- Yes

11. How aware do you think you are about the ATOD treatment services that are available in this community?

- Pretty aware as I have been in the community over 12 years and I have a good social worker in the office
- PCPs in our hospital are all aware of the availability of services. We have a good social worker in the hospital and all the MDs know her and would get help for their patients.
- I feel I am aware of most of them
- Very little as we have PSUPP close
- Moderate
- Not very aware
- Not much aware
- Somewhat aware
- Aware to a good extent, but I could be better
- Don't know about them
- Aware. Getting patients to go is a challenge.
- Not
- Probably 50%

- Not as aware as I should be but I use the county resource guide and it is pretty good.

12. Is there a need for additional ATOD treatment services in your community?

- South Bend--Want to say yes, but we could not support them, as the problem is not that bad.
- Drug use during pregnancy is our biggest issue. I do not know if IP treatment services are available at the Madison Center.
- Evansville --No
- Terre Haute --Yes
- Terre Haute --Yes
- Terre Haute -- Don't know
- Terre Haute -- I don't know
- Terre Haute -- Yes
- Terre Haute -- I'm sure, but don't really know
- Terre Haute -- Yes
- Terre Haute -- Yes
- Terre Haute – Yes
- Anderson – Yes
- Indianapolis – Absolutely we need more facilities

If yes, what type and where?

- Local small group easily available with child care and reward for attending and compliance
- Special clinics for pregnant females with addictions, preferably covered by insurance/state sponsored
- Should be easily accessible & free
- More available, easier access. It is hard to get an appointment at the community mental health center (TH).
- Alcohol, pot, & methamphetamine support groups, counseling, & safe houses
- End the punitive nature of treatment
- I wish we could use more tobacco patches—they are safe at low dosages
- Our ATOD treatment needs to address more than just getting off drugs. The patients need more life skills education.
- Treatment is a golden opportunity—pregnant women really want to get healthy.
- Treatment DOES WORK.

13. Of all of the recommendations you can think of to improve ATOD services for pregnant women, which one or ones do you think are the most important ones to deal with?

- There is a need for a circuit rider—a drug counselor—so that we could schedule our drug user patients to see her on the days she is available here. If we have counselors in the office on selected days, it would be more efficient.
- First we must convince them of the <u>need</u> to change behaviors, <u>MOTIVATION</u>
- Peer group influences
- Media input about specific worst consequences of ATOD

- Taking time to get patient to understand implications of their actions and patients help them see the need to fight their addiction
- Providing free, easily accessible care.
- Most PCPs cannot/do not screen or detect or refer ATOD patients for treatment
- Once the risks are discovered by the PCP, give the patient the option of being referred to a specialist for treatment
- Physicians and treatment providers need to be more positive, supportive and empower their patients by saying "You are doing a good job at tying to get better; the treatment you are receiving really does work; and, you are a real good person for getting the help you need."
- Increasing the awareness level of the public in general to bad effects of ATOD on their health & in the developing babies specifically
- Staffing & money, not enough personnel & no money to pay for it
- Prescription drugs are discouraging for us with patients being treated for back pain, etc and they say that they cannot get through the day without the medication. They call us for a prescription. We need better ways to help them cope. They have lost their coping skills. We need to get the message out that even with the discomfort of pregnancy, we can help them cope and get away from drugs.
- We need to focus on the individual and that they need to get off ATOD for themselves (as well as for their baby). We need to tell them that they can keep their good looks. They need to be told that smoking affects their face and skin and they can avoid the dry skin and wrinkles that come with their smoking. Also, that smoking leads to early menopause and a dry vagina.
- Truly, a life style change is needed.
    - Be more positive with our messages
    - Provide more education on how to cope with their problems
    - Have people who have experienced the same problems with addiction talk and motivate them to show that they can succeed and quit.
- Motivate them on the effects on the baby. See what can hurt the baby. Put the baby first.
- It can not happen to me is common, so telling them about "real women experiences would help".
- My goal is met if I can get one-half of my patients that are using identified with a simple screen and get them into a treatment/recovery program.
- ATOD recovery is a continuing task. Phase 1 is getting the patient into see the health care providers and counselors in the mental health system and have them continue with the treatment. Phase 2 is to have them participate in self-help group sessions with peers helping and supporting each other in positive ways.
- The biggest resistance is with the private practice physicians who do not screen or refer patients for ATOD treatment
- One in 10 dependency or addicted patients are from families with generations of ATOD history
- Three or four of 10 health workers have been "wounded" by an addict. We have all been affected by addiction, even our legislators. It needs to come out that it is hard to work with addicts.

Appendix D: Programs In Other States

ARKANSAS

AR-CARES Program (Arkansas Center for Addictions Research, Education, and Services) [66]

Provides residential and outpatient substance abuse prevention and treatment services to low income pregnant and parenting women and their children. By the end of the project, AR-CARES was advocating more community based and in-home services.

Initial phase plan: 4-5 hour treatment day

- Assistance in locating child care in the community
- Alcohol and drug use assessment
- Education and treatment
- Mental health assessment and referral
- Life skills assessment and development
- Group and individual counseling
- 12-step recovery
- Self esteem building
- Relapse prevention
- Parenting education and support
- Health services (prenatal care, delivery services, postpartum and interconceptional care, child health services)
- Health education

Follow-up Phase Plan: 7-8 hour treatment day

- On-site residential support
- Licensed early intervention services
- On-site licensed child care
- Infant and toddler
- Entrepreneurial skills/vocational education
- Community 12-step meeting attendance
- Off-site residential support
- Employment skills and counseling
- Licensed mental health services
- On-site evening outpatient treatment services
- Transportation
- Tobacco free environment

CALIFORNIA:

San Diego Partnership for Smoke Free Families [67]

COLORADO

The Prenatal and Early Childhood Nurse Home Visitation Program [68]

This is a well –tested model that improves the health and social functioning of low- income first time mothers and their babies. Nurse home visitors develop a supportive relationship with the mother and family which emphasize education, mutual goal setting, and the development of the parents' own problem- solving skills and sense of self- efficacy. Beginning in pregnancy, the nurses help women to improve their health behaviors related to substance abuse(smoking, drugs alcohol) and nutrition, significant risk factors for pre- term delivery, low birth weight, and infant neuron- developmental impairment. Nurses work to improve environmental contexts by enhancing informal support and by linking families with needed health and services.

Using developmentally established protocols, nurses visit families as follows: (a) weekly during the first month following enrollment, (b) every other week throughout the remainder of the woman's pregnancy, (c) weekly for the first six weeks postpartum, (d) every other week thereafter through the child's 21st month and (e) then monthly until the child reaches age two.

Visit protocols focus on five domains of functioning: personal health, environmental health, maternal role, maternal life course development, and family and friend support.

HAWAII

Baby S.A.F.E. (Substance Abuse Free Environment) [69]

- Combines prevention, intervention and administration components
- Aimed at well being of women using ATOD, rather than punishment
- Creation of extensive networks through which clients can be reached

IOWA:

Moms Off Meth (MOM) [70]

Started in 1999, based solely on the idea that women were experts on their lives and together they could find solutions to the many barriers they face on a daily basis. The power of the group relies solely on the support, encouragement and passion women bring to the room every week, and not so much on the information that is given to them.

- ATOD Services
- No cost, open entry and open end
- Court advocacy
- Some childcare available

MAINE:

Maine Prenatal Collaborative [71, 72]

This program is using a group learning process among provider practices to raise clinician self- efficacy , promote a team approach, and use patient self- management tools.

MASSACHUSSETS

ASAP Program (Alcohol Screening and Assessment in Pregnancy) [73]

Methodology:

- engagement of site staff;
- staff training;
- self administered questionnaire (5 P's screening tool);
- a brief intervention protocol (5 A's) ;
- unique office protocols (clinical decision tree);
- identification of treatment and referral resources;
- ongoing technical assistance and consultation

MINNESOTA[74]

- Adopt system- wide alcohol screening and intervention protocols.
- Expand awareness of the effects of alcohol use in pregnancy.
- Conduct research to improve detection and intervention capability.
- Re-conceptualize the treatment model for pregnant women
- Improve surveillance and monitoring capability.
- Systems change is needed to standardize state- of –the science protocol for the identification, intervention, or referral of child bearing age women who drink.
- Alcohol screening and counseling at visits for annual examinations; preconception consultation; pregnancy testing and prenatal care; the establishment of an office-based intervention system including referral methods; and active case management
- Provider training on alcohol screening and clinic-based treatment at-risk drinking in women will be needed in many clinics.

Mother Baby Chemical Health program

The Mother Baby Chemical Health program is operated by Health Partners for its members. The program offers an opportunity for specially trained nurses to complete a chemical assessment, make referrals to treatment, and provide extensive education and active case management for substance using pregnant women. The level of intervention is tailored to the patient's level of risk and often includes assistance coordinating basic needs such as food and housing, referring to community resources, and communicating with the baby's health care provider.

Circle of women program

Circle of women is an advocacy program funded by Minnesota Department of Human Services and operated separately through the University of Minnesota and the Minneapolis Indian Health Board. (Circle of Women is also offered at the Leech Lake Indian Reservation.) The Circle of Women program at the University of Minnesota Department of Pediatrics matches each substance-abusing pregnant and parenting woman with an advocate who follows her for three years and offers individualized programming including prenatal support, doula services, chemical health support groups(transportation, meals, and child care provided, parenting classes, case management with treatment centers, home visits, and emotional support).

NEW JERSEY:
Trenton's Demand Treatment! Partnership [75]

Goals:

- To increase screening in Trenton's four prenatal clinics and to raise awareness of the barriers among pregnant women.
- To increase screening and the number of referrals for assessments and treatment placements in the community
- Link pregnant women to home-visiting nurses
- Transitional housing facility for the women ands their children
- To improve birth outcomes and access to health acre
- Promote effective parenting skills and practices
- Enhance the quality of child care
- Strengthen leadership capacity in child health issues

OKLAHOMA:
Oklahoma Smoke Free Beginnings [71, 76]

Ranked 3rd highest state in the percentage of women who smoke
Implementing the 5A's intervention model

This program is adapting an academic detailing model by assigning Physician Enhancement assistants to train providers on-site and develop new office systems.

OREGON:
Oregon Smoke Free Mothers and Babies [71]

A collaborative partnership including: public health maternal and child health nurses/maternity case managers (MCM's); prenatal care providers (PNCP's); and the Oregon Quit Line through outreach and raining , standardized documentation procedures, and a fax referral system.

- Focus on system change
- Behavior of MCM's and PNCP's
- Use the 5A's intervention
- Intervention is focused on low-income pregnant women via Medicaid.

WASHINGTON:
Division of Alcohol and Substance Abuse (DASA) [77]

- Offers chemical dependency treatment for women and children
- Intervention on a pregnant chemically dependent woman, which may prevent a drug or alcohol exposed baby
- Intervention on a chemically dependent woman may prevent an unintended pregnancy, which could lead to a baby that is drug or alcohol exposed.

- Priority access into outpatient and residential chemical dependency treatment services
- Resources regarding Fetal Alcohol Spectrum Disorders (FASD)

Programs include:

- PPW Residential Chemical Dependency Programs
- Therapeutic Childcare
- Chemical Using Pregnant (CUP) Detoxification
- Outpatient chemical dependency treatment services
- PPW Housing Support Services Program
- Crisis Nurseries
- Parent Child Assistance Program (PCAP)
- Safe Babies Safe Moms
- Parent Trust
- Fetal Alcohol Spectrum Diagnostic and Prevention Network (FASDPN)
- Fetal Alcohol Syndrome Family Resource Institute (FAS*FRI)
- Fetal Alcohol Syndrome Interagency Workgroup (FASIAWG)

STATE POLICIES ON SUBSTANCE ABUSE DURING PREGNANCY

STATE	SUBSTANCE ABUSE DURING PREGNANCY CONSIDERED:		WHEN ABUSE SUSPECTED, STATE REQUIRES:		DRUG TREATMENT FOR PREGNANT WOMEN	
	Child Abuse	Grounds for Civil Commitment	Reporting	Testing	Targeted Program Created	Pregnant Women Given Priority Access in General Programs
Alaska			X			
Arizona			X			X
Arkansas	X				X	
California					X	
Colorado	X				X	
Connecticut					X	
Florida	X				X	
Georgia						X
Illinois	X		X		X	
Indiana	X					
Iowa	X		X	X		
Kansas						X
Kentucky				X	X	
Louisiana	X		X		X	
Maryland	X				X	
Massachusetts			X			
Michigan			X			
Minnesota	X	X	X	X	X	
Missouri					X	X[Ω]
Nebraska					X[†]	
Nevada	X					
New York					X	
North Carolina					X	
North Dakota			X	X		
Ohio					X	
Oklahoma			X			X
Oregon					X[‡]	
Pennsylvania					X	
Rhode Island	X		X			
South Carolina	X[*]					
South Dakota	X	X				
Texas	X					X
Utah			X			
Virginia	X			X	X	
Washington					X	
Wisconsin	X	X				X
TOTAL	**16**	**3**	**12**	**5**	**19**	**7**

* The South Carolina Supreme Court held that a viable fetus is a "person" under the state's criminal child-endangerment statute and that "maternal acts endangering or likely to endanger the life, comfort, or health of a viable fetus" constitute criminal child abuse.

† Applies only to women and newborns eligible for Medicaid.

‡ Establishes requirements for health care providers to encourage and facilitate drug counseling.

Ω Priority applies to pregnant women referred for treatment.

Note. From "Substance Abuse During Pregnancy," by Guttmacher Institute, 2006, *State Policies in Brief*, Copyright 2006 by the Guttmacher Institute [78]

Appendix E: Resource Inventory

County	Facility	Location	ATOD	Telephone Number
Adams				
	Adams County Memorial Hospital	1100 Mercer Ave., Decatur, IN 46733	ATOD	260-724-2145 *3892
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Anti-Tobacco Coalition of Adams County	313 W. Jefferson, Decatur, IN 46733	T	260-274-5368
	Behavioral Health Resource Center- Decatur	805 High St., Decatur, IN 46733	A, OD	260-724-2145
	Behavioral Health Resource Center- Berne	1521 W. Main St., Berne, IN 46711	A, OD	260-724-2145
	Midwest Addiction Psychiatric and Psychological Services	1620 Morningstar Blvd., Decatur, IN 46733	A, OD	260-471-0632
	Park Center, Inc.	809 High Street, Decatur, IN 46733	A, OD	260-724-9669
Allen				
	Addictive Behaviors Counseling Center	3464 Stellhorn Rd., Fort Wayne, IN 46815	A, OD	260-485-2230
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Fort Wayne Area Intergroup	2118 Inwood Drive, Fort Wayne, IN 46815	A	260-471-6262
	Bowen Center	2100 Goshen Road, Fort Wayne, IN 46808	A, OD	260-471-3500

	Brown and Associates Consulting	2324 Lake Avenue, Fort Wayne, IN 46805	A, OD	260-422-2930
	Caring About People Inc	1417 North Anthony Boulevard, Fort Wayne, IN 46805	A, OD	800-932-4213
	Center for Behavioral Health	1414 Wells Street, Fort Wayne, IN 46808	OD	260-420-6010
	Center for Solutions	2722 Fairfield Avenue, Fort Wayne, IN 46808	A, OD	260-456-8616
	Charis House	533 W. Washington Blvd., Fort Wayne, IN 46802	A, OD	260-426-8123
	Cocaine Anonymous	Box 12741, Fort Wayne, IN 46864	OD	260-460-4739
	Counseling Services and Consulting LLC	4660 West Jefferson Boulevard Suite 200, Fort Wayne, IN 46804	A, OD	260-432-9916
	Family and Children's Services, Inc.	2712 S. Calhoun Street, Fort Wayne, IN 46807	A, OD	260-744-4326
	Hope House I	1115 Garden Street, Fort Wayne, IN 46802	A, OD	260-424-2471
	Martha's Place	1129 Garden Street, Fort Wayne, IN 46802	A, OD	260-424-3711
	Midwest Addiction Phychiatric and Psychological Services	3010 East State Boulevard Door A, Fort Wayne, IN 46805	A, OD	260-471-0632
	Narcotics Anonymous- North East Area (Fort Wayne)		OD	260-460-4626
	Pancner Psychiatric Association	2805 Fairfield Ave., Fort Wayne, IN 46807	A, OD	260-456-4880
	Park Center, Inc	909 E. State Boulevard, Fort Wayne, IN 46805	A, OD	260-481-2700
	Parkview Behavioral Health	1720 Beacon Street, Fort Wayne, IN 46805	ATOD	260-373-7500
	Peace Counseling Inc	515 West Wayne Street, Fort Wayne, IN 46802	A, OD	260-424-8861
	Prenatal Substance Use Prevention Program	1717 S. Calhoun, Fort Wayne, IN 46802	ATOD	260-458-2641 *3668
	Smoke Buster's Support Group	7950 W. Jefferson Blvd., Fort Wayne, IN 46804	T	260-435-7094

	St. Joseph Health System-Chemical Dependence	700 Broadway, Fort Wayne, IN 46802	A, OD	260-425-3606
	Tobacco Free Allen County	7950 W. Jefferson Blvd., Fort Wayne, IN 46804	T	260-435-7094
	Transitions	2440 Bowser Avenue, Fort Wayne, IN 46803	A, OD	260-744-9201
	United Hispanic Americans, Inc	2424 Fairfield, Fort Wayne, IN 46835	T	260-456-5000
	Washington House Treatment Center	2720 Culbertson Street, Fort Wayne, IN 46802	A, OD	260-432-8684
	Wise Choices Inc	205 East Washington Center Road, Fort Wayne, IN 46825	A, OD	260-482-2586
Bartholomew				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Columbus Regional Hospital - Healthy Communities	2400 E.17th St., Columbus, IN 47201	T	812-379-4441
	ACCESS Counseling DBA	522 7th St., Columbus, IN 47201	A, OD	812-378-4357
	Making New Choices	716 3rd St., Columbus, IN 47201	A, OD	812-372-2496
	Narcotics Anonymous- South Central Area (Columbus)		OD	
	Quinco Behavioral Health Systems	720 N. Marr Rd., Columbus, IN 47201	A, OD	812-379-2341
	Steps of Addiction Recovery, LLC	1601 Orinoco Avenue, Columbus, IN 47201	A, OD	812-378-2660
Benton				
	Tobacco Prevention & Cessation Coalition	5465 N. 600 E., Fowler, IN 47944	T	219-261-2871
Blackford				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Blackford Community Hospital	St. Rd. 3 North, Hartford City, IN 47348	T	765-331-2117
	Narcotics Anonymous- Mid-State Area		OD	765-683-2022
Boone				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	BehaviorCorp	602 Ransdell Road, Lebanon, IN 46052	A, OD	765-482-7100
	Boone County Cancer Society	127 W. Main St., Rm 309, Lebanon, IN 46052	T	765-482-2043
	Cocaine Anonymous		OD	317-767-1300
	Family Service of Central Indiana Inc	327 N. Lebanon Street, Suite 103, Indianapolis, IN 46052	A, OD	765-482-6396
	Meridian Health Group of Lebanon	129 Lakeshore Dr., Lebanon, IN 46052	A, OD	765-483-8150
	Narcotics Anonymous- Central Area (Lebanon)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Zionsville)		OD	317-875-5459
	Tobacco Free Boone County	116 W. Washington St., Lebanon, IN 46052	T	765-482-3942 *8311
Brown				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Brown County Health Department	201 Locust Lane, Nashville, IN 47448	T	812-988-2255
	Brown County High School	235 S. School House Ln., Nashville, IN 47448	T	812-988-6606

	Quinco Consulting Center	Jefferson and Mound Streets, Nashville, IN 47448	A, OD	812-988-2258
Carroll				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Carroll County Health Department	101 W. Main St., Delphi, IN 46923	T	765-564-3420
Cass				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Four County Counseling Center	1015 Michigan Avenue, Logansport, IN 46947	A, OD	574-722-5151
	Narcotics Anonymous- Cross Roads Area (Logansport)		OD	765-456-5905
	Smoke Free Cass County	1015 Michigan Ave., Logansport, IN 46947	T	574-753-5109 *36
Clark				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bliss House	214 E. Maple Street, Jeffersonville, IN 47131	A, OD	812-282-0063
	Clark County Tobacco Prevention & Cessation Coalition	1220 Missouri Avenue, Jeffersonville, IN 47130	T	812-283-2649
	Clark Memorial Hospital - Behavioral Health Services	1220 Missouri Avenue, Jeffersonville, IN 47130	A, OD	812-283-2811
	CRC Health - Southern Indiana Treatment Center, Inc.	1713 E 10th Street, Jeffersonville, IN 47130	A, OD	866-762-3766
	Life Improvement Counseling Center	418 Watt St., Jeffersonville, IN 47130	A, OD	812-288-8030
	LifeSpring Mental Health Services	1415 Mitchell Avenue, Jeffersonville, IN 47130	A, OD	812-280-6606

	LifeSpring Mental Health Services	460 Spring Street, Jeffersonville, IN 47130	ATOD	812-280-2080
	Prenatal Substance Use Prevention Program	1101 Spring St., Suite 2, Jeffersonville, IN 47130	ATOD	812-288-1470
	Southern Indiana Treatment Center	1713 East 10th Street, Jeffersonville, IN 47130	OD	812-283-4844
	Stop Smoking Successfully	1319 Missouri Ave., Jeffersonville, IN 47130	T	812-283-2649
	Turning Point Center	1060 Sharon Drive, Jeffersonville, IN 47130	A, OD	812-283-7116
	Wellstone Regional Hospital	2700 Vissing Park Road, Jeffersonville, IN 47130	A, OD	812-284-8000
Clay				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Clay City Center for Family Medicine	315 Lankford St., Clay City, IN 47841	T	812-939-2126
	Clay County Health Department	1214 E. National Ave., Suite B110, Brazil, IN 47834	T	812-448-9019
	Hamilton Center, Inc	1211 E. National Avenue, Brazil, IN 47834	A, OD	812-448-8801
	Narcotics Anonymous- Wabash Valley Area (Brazil)		OD	877-888-4130
	Quit Smart Program	1206 E. National Ave., Brazil, IN 47834	T	812-442-2671
	Union Hospital Health Group/Maple Center	1801 N. 6th St., Suite 600, Terre Haute, IN 47804	T	812-235-4867
Clinton				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Howard Regional Health System Community Counseling Center	250 Alhambra Ave., Frankfort, IN 46041	A, OD	765-659-4771

	St. Vincent Frankfort Hospital	1300 S. Jackson St., Frankfort, IN 46041	T	765-656-3000
Crawford				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Patoka Family Health Care Clinic	307 S. Indiana Ave., English, IN 47118	T	812-238-2924
	Southern Hills Counseling Center, Inc	523 N. Main Street, English, IN 47118	A, OD	812-338-2756
Daviess				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Daviess Community Hospital	1314 E. Walnut St., Washington, IN 47501	T	812-254-2760 *532
	Samaritan Center Substance Abuse Program	2007 State Street, Washington, IN 47501	A, OD	812-254-1558
DeKalb				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Drug Free DeKalb County	101 N. Main St., Suite A, Auburn, IN 46706	T	260-920-2572
	Northeastern Center	1800 Wesley Road, Auburn, IN 46706	A, OD	260-925-2453
Dearborn				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Community Mental Health Center	285 Bielby Road, Lawrenceburg, IN 47025	A, OD	812-537-1924
	Community Mental Health Center	28208 State Road 1, Suite 101, West Harrison, IN 47060	A, OD	812-576-1600
	Community Mental Health Center	427 Eads Pkwy Dearborn Plaza, Lawrenceburg, IN 47025	A, OD	812-537-7375

	Community Mental Health Center	283 Bielby Road, Lawrenceburg, IN 47025	A, OD	812-537-1924
	CRC Health - East Indiana Treatment Center, Inc.	816 Rudolph Way, Lawrenceburg, IN 47025	OD	866-762-3766
	Prenatal Substance Use Prevention Program	202 N. Gaslight Dr., Versailles, IN 47042	ATOD	812-689-6363
	Prevention and Cessation of Tobacco (PACT)	P.O. Box 3581, Lawrenceburg, IN 47025	T	812-537-5065
Decatur				
	Adapt Program	208 W. Main Street, Suite 2, Greensburg, IN 47240	A, OD	812-662-7171
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Southeastern Indiana Intergroup	P.O. Box 502, Greensburg, IN 47240	A	812-663-0821
	Decatur County Memorial Hospital	720 N. Lincoln, Greensburg, IN 47240	T	812-663-1328
Delaware				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Muncie Tri-District 85, 87, 89 Intergroup	P.O. Box 2072, Muncie, IN 47307	A	765-284-2515
	Cancer Services of Delaware County	401 W. Jackson St., Muncie, IN 47305	T	765-284-9063
	Delaware County Health Department	100 W. Main St., Muncie, IN 47305	T	765-747-7721
	Meridian	240 N. Tillotson Ave., Muncie, IN 47304	A, OD	765-288-1928
	Muncie Living Life Clean	125 N. High St., Muncie, IN 47305	A, OD	765-287-0071

	Narcotics Anonymous- Mid-State Area (Muncie)		OD	765-683-2022
	Prenatal Substance Use Prevention Program	3715 S. Madison St., Muncie, IN 47302	ATOD	765-286-7000
Dubois				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Dubois County Tobacco Prevention Coalition	1900 Medical Arts Dr., Huntingburg, IN 47542	T	812-683-6441
	Memorial Hospital & Health Care Center	800 W. 9th St., Jasper, IN 47546	T	812-481-8425
	Prenatal Substance Use Prevention Program	607 3rd St., Jasper, IN 47456	ATOD	812-482-2233
	Southern Hills Counseling Center, Inc	480 Eversman Drive, Jasper, IN 47547	A, OD	812-482-3020
	Tri-Cap Teen Wellness Center	607 3rd Ave., Jasper, IN 47456	T	812-482-2233
Elkhart				
	Addiction Recovery Centers	120 South Main Street, Elkhart, IN 46516	A, OD	574-293-1086
	Addiction Recovery Centers	114 N. Main St., Goshen, IN 46526	A, OD	574-533-6154
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Central Service Office	949A Middlebury St., Elkhart, IN 46516	A	574-295-8188
	Bowen Center	23426 US 33 East, Elkhart, IN 46517	A, OD	574-875-8482
	Center for Problem Resolution Inc	211 South 5th Street, Elkhart, IN 46516	A, OD	574-294-7447
	Center for Problem Resolution Inc	117 W. Washington St., Goshen, IN 46526	A, OD	574-533-0664

	Danen Counseling Services	109 E. Clinton St., Suite 17, Goshen, IN 46528	A, OD	574-537-9868
	Elkhart General Hospital	600 E. Blvd., Elkhart, IN 46514	T	574-294-2621
	Heart City Health Center	236 Simpson Ave., Elkhart, IN 46516	T	574-293-0052
	Life Treatment Centers	1332 W. Indiana Avenue, Elkhart, IN 46516	A, OD	574-389-8080
	Madison Center	56218 Parkway Ave., Elkhart, IN 46516	A, OD	574-523-3750
	Oaklawn Psychiatric Center Inc	2600 Oakland Avenue, Elkhart, IN 46517	A, OD	574-533-1234
	Oaklawn Psychiatric Center Inc	330 Lakeview Drive, Goshen, IN 46528	A, OD	574-533-1234
	Oaklawn Psychiatric Center Inc	101 Marilyn Avenue, Goshen, IN 46526	A, OD	574-533-1234
	On Site Health Solutions LLC	11724 Oakland Ln., Granger, IN 46530	T	574-243-5108
	Narcotics Anonymous- North Central Area (Elkhart)		OD	574-674-1685
	Narcotics Anonymous- North Central Area (Goshen)		OD	574-674-1685
	Prenatal Substance Use Prevention Program	1400 Hudson St., Elkhart, IN 46516	ATOD	574-522-0104
	Reaching Out Counseling LLC	1400 West Indiana Avenue, Elkhart IN 46516	A, OD	574-522-4323
	Recovery Journey Inc	2851 East Bristol Street Suite B, Elkhart, IN 46514	A, OD	574-264-5840
	Tobacco Control of Elkhart County	608 Oakland Ave., Elkhart, IN 46516	T	574-523-2114
Fayette				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Creative Counseling	1956 Ohio Ave., Connersville, IN 47331	T	765-827-5610
	Dunn Mental Health Center Inc	390 E. Erie St., Connersville, IN 47331	A, OD	765-983-8000

	Fayette County Health Department	111 W. 4th St., Rm 109, Connersville, IN 47331	T	765-825-4013
	Fayette Memorial Hospital	1941 Virginia Ave., Connersville, IN 47331	ATOD	765-827-7789
	Jack Hopkins	1100 Spartan Dr., Connersville, IN 47331	T	765-825-1151
	Rocksolid Ministrien Petra Project	1024 E. Main St., Richmond, IN 47374	T	765-962-5099
Floyd				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Family Health Center of Floyd County	1000 E. Spring St., New Albany, IN 47150	T	812-283-2308
	Floyd County Tobacco Prevention & Cessation Coalition	4212 Aberdeen Ct., New Albany, IN 47150	T	812-944-4822
	Floyd Memorial Hospital	1850 State St., New Albany, IN 47150	T	812-948-6730
	Our Place	P.O. Box 8, Mt. St. Francis, IN 47146	ATOD	800-276-9773
Fountain				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bartlett Counseling Services LLC	101 N. Main St., Veedersburg, IN 47987	A, OD	765-294-3100 *3
	Community Action Program, Inc.	418 Washington St., Covington, IN 47932	T	765-793-4881
	Wabash Valley Hospital Inc	101 Suzie Ln., Attica, IN 47918	A, OD	765-762-6187
Franklin				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Community Mental Health Center	Hwy. 101 and Cooley Road, Brookville, IN 47012	A, OD	765-647-4173
	Creative Counseling	1965 Ohio Ave., Connersville, IN 47331	T	765-827-5610

	Prenatal Substance Use Prevention Program	202 N. Gaslight Dr., Versailles, IN 47042	ATOD	812-689-6363
Fulton				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Four County Counseling Center	401 E. 8th St., Rochester, IN 46975	A, OD	574-223-8565
	Fulton County Wellness Center	529 Main St., Rochester, IN 46975	T	574-223-3657
	Smoke Free Fulton County/Fulton County Health Dept.	125 E. 9th St., Rochester, IN 46975	T	574-224-5152
Gibson				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Gibson County Regional Services	310 S. Fifth Avenue, Princeton, IN 47670	A, OD	812-385-5275
	Tobacco Prevention & Cessation	614 SE Third St., Evansville, IN 47713	T	812-476-1471
Grant				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Marion Area Intergroup	P.O. Box 1401, Marion, IN 46952	A	765-677-7535
	Cocaine Anonymous		OD	317-767-1300
	Cornerstone Behavioral Health Center	505 N Wabash Avenue, Marion, IN 46952	A, OD	765-662-3971
	Grant County Tobacco Prevention Coalition	401 S. Adams St., Marion, IN 46953	T	765-517-2170
	Great Beginnings of Marion General Hospital	1251 Kem Rd., Station A, Marion, IN 46952	ATOD	765-662-41077

	Marion General Hospital	441 N. Wabash Ave., Marion, IN 46952	T	765-662-4701
	Narcotics Anonymous- Mid-State Area (Fairmount)		OD	765-683-2022
	Narcotics Anonymous- Mid-State Area (Gas City)		OD	765-683-2022
	Narcotics Anonymous- Mid-State Area (Marion)		OD	765-683-2022
	Narcotics Anonymous- Mid-State Area (Van Buren)		OD	765-683-2022
	Prenatal Substance Use Prevention Program	321 E. 2nd St., Marion, IN 46952	ATOD	765-664-5772
	VA Northern Indiana Health Care Systems- Marion	1700 E 38th St., Bldg 172, 1D, Marion, IN 46953-4589	A, OD	765-674-3321
Greene				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Greene County Tobacco Prevention & Cessation	31 W. Main St., Bloomfield, IN 47424	T	812-384-4538
	Hamilton Center, Inc.	431 E. Main Street, P.O. Box 69, Bloomfield, IN 47424	A, OD	812-384-9452
	Narcotics Anonymous- Limestone Area		OD	812-331-9767
Hamilton				
	Adventist Community Services	15250 N. Meridian St., Carmel, IN 46032	T	317-844-6201
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	

	American Lung Association of Indiana	13400 N. Meridian St., Suite. 650, Carmel, IN 46032	T	317-583-7604
	BehaviorCorp	697 Pro-Med Lane, Carmel, IN 46032	A, OD	317-574-1254
	BehaviorCorp	957 ProMed Lane, Carmel, IN 46032	ATOD	317-574-0055
	BehaviorCorp	54 N. 9th Street, Suite 200, Noblesville, IN 46060	A, OD	317-773-6864
	Center for Mental Health	1969 Conner Street, Noblesville, IN 46060	A, OD	317-776-3730
	Community Addiction Services, Inc.	942 N. 10th Street, Noblesville, IN 46060	A, OD	317-776-3478
	Family Service of Central Indiana Inc.	942 N. 10th Street, Noblesville, IN 46060	A, OD	317-773-6273
	Hamilton County Health Department	1 Hamilton County Sq., Suite. 30, Noblesville, IN 46060	T	317-776-8500
	Hamilton County Tobacco Control Coalition	11006 Broadway, Indianapolis, IN 46280	T	317-844-9324
	Indiana Recovery Partners	107 S. 8th St., Noblesville, IN 46060	A, OD	317-7700108
	Midwest Counseling Associates Inc	120 W. Jackson St., Cicero, IN 46034	A, OD	317-545-8490
	Narcotics Anonymous- Central Area (Carmel)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Noblesville)		OD	317-875-5459
	Prevail, Inc.	1100 S. 9th Street, Suite 100, Noblesville, IN 46060	A, OD	317-773-6942
	Proactive Resources Berg Counseling Services Inc	128 West Carmel Drive, Carmel, IN 46032	A, OD	317-844-5742
	Riverview Hospital	395 Westfield Rd., Noblesville, IN 46060	T	317-776-7484

Hancock				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Family Service of Central Indiana Inc.	98 E. North Street, Greenfield, IN 46140	A, OD	317-462-3733
	Gallahue Mental Health Services	145 W Green Meadows Dr., Greenfield, IN 46140-4001	A, OD	317-462-1481
	Hancock Counseling	180 W. Muskegon Dr., Greenfield, IN 46140	T	317-468-4506
	Hancock Regional Hospital	801 N. State, Greenfield, IN 46140	T	317-468-4506
	Narcotics Anonymous- Central Area (Greenfield)		OD	317-875-5459
Harrison				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Harrison County Hospital Foundation	245 Atwood St., Corydon, IN 47112	T	812-738-8708
Hendricks				
	Advantage Counseling and Fitness Services	1005 E. Main St., Suite A, Plainfield, IN 46168	A, OD	317-839-7323
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alpha Resources Counseling Services, Inc	188 N. State Road 267, Suite 110, Avon, IN 46123	A, OD	317-272-5340
	American Health Network	5250 E. US 36, Avon, IN 46123	T	317-745-5403
	Clarian West Medical Center	1111 N. Ronald Reagan Parkway, Avon, IN 46123	T	317-217-3477
	Cummins Behavioral Health	6655 E. U.S. 36, Avon, IN 46123	A, OD	317-272-3330

	Systems			
	Hamilton Center, Inc.	900 Southfield Drive, Plainfield, IN 46168	A, OD	317-837-9719
	Hendricks Regional Health	1000 E. Main St., Danville, IN 46122	T	317-745-3553
	Hendricks County Coalition for Tobacco Intervention & Prevention		T	317-828-9248
	Narcotics Anonymous- Central Area (Avon)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Danville)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Plainfield)		OD	317-875-5459
	Penrod Counseling Center	192 N. S.R. 267, Suite 300, Avon, IN 46123	A, OD	317-272-5247
	Proactive Resources	515 N. Green St., Suite 300, Brownsburg, IN 46112	A, OD	317-844-5742
Henry				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Christian Counseling and Addiction Services Inc	423 S. 11th St., New Castle, IN 47362	A, OD	765-533-3573
	Henry County Memorial Hospital	1000 N. 16th St., New Castle, IN 47362	T	765-521-1174
	Meridian	930 N. 14th St., New Castle, IN 47362	A, OD	765-521-2450
	Narcotics Anonymous- Mid-State Area (New Castle)		OD	765-683-2022
Howard				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	

	Cocaine Anonymous		OD	317-767-1300
	Howard Regional Health System	3500 S. Lafountain St., Kokomo, IN 46902	T	765-453-8571
	Narcotics Anonymous- Cross Roads Area (Kokomo)		OD	765-456-5905
	St. Joseph Hospital	1907 W. Sycamore, Kokomo, IN 46901	T	765-456-5941
Huntington				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Evergreen Meadows Inc	1401 Evergreen Rd., Huntington, IN 46750	A, OD	260-356-5735
	Otis R. Bowen Center for Human Services, Inc.	2860 Northpark Ave., Huntington, IN 46750	T	260-356-2875
	Parkview Huntington Hospital	2001 Stults Rd., Huntington, IN 46750	T	260-355-3038
Jackson				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Jackson County Health Department	801 W. Second St., Seymour, IN 47274	T	812-522-6474
	Narcotics Anonymous- South Central Area (Seymour)		OD	
	Schneck Medical Center	411 W. Tipton, Seymour, IN 47265	T	812-346-6310
	Polarity Counseling	210 1/2 W. 2nd St., Seymour, IN 47274	A, OD	812-523-6221
	Quinco Consulting	1443 Corporate Way, Seymour, IN 47274	A, OD	812-522-4341
Jasper				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Ryan and Ryan Consulting	125 S. McKinley Ave., Rensselaer, IN 47978	T	219-866-3331

	Wabash Valley Outpatient Clinic	131 W. Drexel Pkwy., Rensselaer, IN 47978	A, OD	219-866-4194
Jay				
	Jay County Hospital	500 W. Votaw, Portland, IN 47371	T	260-726-1925
	Meridian	931 W. Water St., Portland, IN 47371	A, OD	260-726-9348
Jefferson				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Quinco Consulting	3008 N. Bevcher St., Madison, IN 47250	A, OD	812-265-1918
	Steps of Addiction Recovery, LLC	51 1/2 N. Pike St., Vernon, IN 47282	A, OD	812-352-8284
	Tobacco Prevention & Cessation of Jefferson & Switzerland Counties	P.O. Box 447 One King's Daughters' Dr., Madison, IN 47250	T	812-265-0598
Jennings				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Narcotics Anonymous- South Central Area (North Vernon)		OD	
	Prenatal Substance Use Prevention Program	202 N. Gaslight Dr., Versailles, IN 47042	ATOD	812-689-6363
	Quinco Consulting	1260 E. Buckeye St., North Vernon, IN 47265	A, OD	812-346-4468
	WIC Building	945 Veterans Dr., North Vernon, IN 47265	T	812-346-2515
Johnson				
	Adult and Child	86 Drake Road, Franklin, IN 46131-0435	A, OD	877-882-5122
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Cummins Behavioral Health Systems	540 Tracy Road, New Whiteland, IN 46184	A, OD	317-535-0513

	Indy Interventions - Addiction Recovery	500 S. Polk Street, Suite 6, Greenwood, IN 46143	A, OD	317-885-8296
	DBA Brumbaugh and Associates	200 E. Jefferson St., Franklin, IN 46131	A, OD	317-736-7282
	Narcotics Anonymous- Central Area (Greenwood)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Franklin)		OD	317-875-5459
	Nonviolent Alternatives	695 Industrial Dr., Franklin, IN 46131	A, OD	317-346-7299
	Partnership for a Healthier Johnson County	1125 W. Jefferson St., Suite V, P.O. Box 549, Franklin, IN 46131	T	317-346-3728
	Reach for Youth	3500 N. Morton, Franklin, IN 46131	A, OD	317-738-5433
	Tara Treatment Center	6231 S. U.S. 31, Franklin, IN 46131	A, OD	812-526-2611
	Tara Treatment Center	77 W. Monroe St., Franklin, IN 46131	A, OD	812-526-2611
	Tara Treatment Center	7919 S. 100 E., Nineveh, IN 46164	A, OD	812-526-2611
	Valle Vista	898 E. Main St., Greenwood, IN 46143	A, OD	317-887-1348
Knox				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Intervention and Addiction Services	121 Buntin St., Vincennes, IN 47591	A, OD	812-885-2700
	Knox County Tobacco Coalition	520 S. 7th St., Vincennes, IN 47591	T	812-885-3215
	Southwest Indiana Regional Youth Village	2290 S. Theobald Lane, Vincennes, IN 47591	A, OD	812-886-3000
Kosciusko				
	Addiction Recovery Centers Inc	2176 N. Biomet Dr., Suite 3, Warsaw, IN 46582	A, OD	574-269-6444

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bowen Center	901 S. Huntington Street, Syracuse, IN 46567	A, OD	574-457-4400
	Bowen Center	850 N. Harrison Street, Warsaw, IN 46580	A, OD	800-342-5653
	Narcotics Anonymous- North Central Area (Warsaw)		OD	574-674-1685
	Smoke Free Fulton County/Fulton County Health Department	125 E. 9th St., Rochester, IN 46975	T	574-224-5152
LaPorte				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	LaPorte Hospital	1203 Washington St., LaPorte, IN 46350	T	219-326-2474
	Madison Center	3714 S. Franklin ST., Michigan City, IN 46360	A, OD	219-879-8539
	Narcotics Anonymous- North West Area (Michigan City)		OD	877-548-4223
	Narcotics Anonymous- North Central Area (Laporte)		OD	574-674-1685
	Prenantal Substance Use Prevention Program	7451 W. Johnson Rd., Michigan City, IN 46360	ATOD	219-874-0007
	St. Anthony Memorial	301 W. Homer St., Michigan City, IN 46360	T	219-929-5826
	Stress Center of LaPorte Hospital	1007 Lincoln Way, LaPorte, IN 46350	A, OD	219-326-2420
	Swanson Center Counseling Services	1230 State Road 2, La Porte, IN 46350	A, OD	219-362-2145
	Swanson Center Counseling Services	450 St. John Road, Suite 501, Michigan City, IN 46360	A, OD	219-879-4621
Lagrange				
	Addiction Recovery Centers Inc	400 Union St., Lagrange, IN 46761	A, OD	260-463-2999

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Narcotics Anonymous- North Central Area (LaGrange)		OD	574-674-1685
	Northeastern Center	2155 North State Road 9, Lagrange, IN 46761	A, OD	260-463-7144
	Tobacco-Free LaGrange County	229 River Run Ct., Columbia City, IN 46725	T	260-336-9349
Lake				
	Addiction and Behavioral Counseling	7805 Taft Street, Merrillville IN 46410	A, OD	219-756-3791
	Addiction and Family Care Inc.	3440 169th St., Hammond, IN 46323	A, OD	219-844-7152
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Calumet Area Intergroup	7202 Indianapolis Blvd., Hammond, IN 46324	A	219-844-6695
	Anglican Social Services of Northwest Indiana	8555 Grand Boulevard, Merrillville IN 46410	A, OD	219-942-3476
	Awakenings LLC	7853 Taft Street, Merrillville IN 46410	A, OD	219-374-4990
	Awakenings LLC	10800 W 133rd Ave., Cedar Lake, IN 46303	A, OD	219-374-4990
	Bibleway Church of God's Word Inspire Program	220 E. 49th Ave., Gary, IN 46408	T	219-884-8730
	Center for Addictive Services	600 Grant St., Gary, IN 46402	A, OD	219-886-4220
	Century Program - Adolescents	1409 E. 84th Place, Merrillville, IN 46410	A, OD	219-794-2000
	Discovery House Inc	4195 South Cleveland Street, Gary, IN 46408	OD	219-985-8144
	Edgewater Systems for Balanced Living	1100 W. Sixth Avenue, Gary, IN 46402	A, OD	219-885-4264
	First Attending Urgent Care	1217 US Highway 41 P.O. Box 265, Schererville, IN 46375	T	219-322-6767

	Fresh Start Counseling Services	7108 Calumet Ave., Hammond, IN 46324	ATOD	219-933-7990
	Fresh Start Counseling Services	100 W 78th Ave., Merrillville, IN 46410	ATOD	219-933-7990
	Gary Community Health Foundation, Inc.	1021 W. 5th Ave., Gary, IN 46402	T	219-883-7848
	Healthy East Chicago, Inc.	100 W. Chicago Ave., East Chicago, IN 46312	T	219-397-6863
	Integrative Counseling Services	2331 45th St., Highland, IN 46322	A, OD	219-922-0735
	Narcotics Anonymous- South Shore Area (Merrillville)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Hammond)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Munster)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Crown Point)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Griffith)		OD	219-793-6262
	Narcotics Anonymous- North West Area (Gary)		OD	877-548-4223
	Narcotics Anonymous- North West Area (East Chicago)		OD	877-548-4223
	Prenatal Substance Use Prevention Program	3814 Grant St., Suite B, Gary, IN 46408	ATOD	219-887-3570
	Semoran Treatment Center	8060 Melton Road, Gary, IN 46403	OD	219-938-4651
	Sisters of St. Francis Health Services Inc	24 Joliet St., Dyer, IN 46311	A, OD	219-865-2141 *45008

	Southlake Center for Mental Health	1348 S. Lake Park Avenue, Hobart, IN 46342	A, OD	219-942-4040
	Southlake Center for Mental Health	8555 Taft Street, Merrillville, IN 46410	A, OD	219-769-4005
	Southlake Center for Mental Health	290-A E. 90th Drive, Merrillville, IN 46410	A, OD	219-736-9115
	Southlake Center for Mental Health	2001 U.S. 41, Schererville, IN 46375	A, OD	219-322-6622
	St. Catherine Hospital - Behavorial Health Services	4321 Fir Street, East Chicago, IN 46312	A, OD	219-392-7466
	St. Mary Medical Center	1500 S. Lake Park Ave., Hobart, IN 46342	T	219-947-6487
	Tri-City Comprehensive Community Mental Health Center	2600 Highway Avenue, Highland, IN 46322	A, OD	219-972-0131
	Tri-City Comprehensive Community Mental Health Center	3903 Indianapolis Boulevard, East Chicago, IN 46312	A, OD	219-392-6001
	Tri-City Comprehensive Community Mental Health Center	100 W. Chicago Avenue, East Chicago, IN 46312	A, OD	219-392-6061
Lawrence				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Center for Behavioral Health	1315 Hillcrest Drive, Bedford, IN 47421	A, OD	812-279-3591
	Dunn Community Health & Wellness Center	2415 Mitchell Rd., Bedford, IN 47421	T	812-279-6222
	Lois J Rifner, PhD	1702 C Street, Bedford, IN 47421	A, OD	812-279-8651
	Narcotics Anonymous- South Central Area (Bedford)		OD	
Madison				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Madison County Intergroup	P.O.Box 326, Anderson, IN 46015	A	765-644-3212
	Anderson Center	2210 Jackson St., Anderson, IN 46016	A, OD	765-646-8106
	Center for Mental Health	2020 Brown Street, Anderson, IN 46015	A, OD	765-649-8161
	Center for Mental Health	10731 State Road 13, Elwood, IN 46036	A, OD	765-552-5009
	Community Hospital Anderson	1515 N. Madison Ave., Anderson, IN 46011	T	765-298-1653
	Community Hospitals of Indiana Inc - Crestview Center	2201 Hillcrest Drive, Anderson, IN 46012	A, OD	765-649-1961
	House of Hope of Madison County	902 High Street, Anderson IN 46012	A, OD	765-644-7086
	Midwest Counseling Associates Inc	1721 Willams Way, Anderson, IN 46011	A, OD	765-644-2667
	Minority-Based Tobacco Cessation	1547 Ohio Ave., Anderson, IN 46016	T	765-641-0255
	Minority Health Coalition of Madison County	903 S. Madison Ave., Anderson, IN 46016	T	765-641-8075
	Narcotics Anonymous- Mid-State Area (Anderson)		OD	765-683-2022
	Prenatal Substance Use Prevention Program	1515 N. Madison Street, Anderson, IN 46011	ATOD	765-298-1701
	Sowers of Seeds Counseling Inc.	517 W 11th St., Anderson, IN 46016-1227	A, OD	765-649-3453
	St. Johns Anderson Center	2210 Jackson Street, Anderson IN 46016	A, OD	765-646-8444
	St. John's Health System	2015 Jackson St., Anderson, IN 46016	T	765-608-2663
	St. Vincent Mercy Hospital	1331 South A St., Elwood, IN 46036	T	765-552-4816
Marion				

	Addiction Resource Network of Indiana, Inc.	233 McCrea Street, Suite 200, Indianapolis, IN 46225	A, OD	317-955-2764
	Adult and Child	8320 Madison Avenue, Indianapolis, IN 46227 -6090	A, OD	877-882-5122
	Agape Counseling and Human Services	5162 East Stop 11 Road Suite 1, Indianapolis IN 46237	A, OD	317-889-7520
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous-Indianapolis Intergroup Inc.	136 E. Market Street, Suite 1030, Indianapolis, IN 46204	A	317-632-7864
	Alpha Resources Counseling Center	2511 E. 46th St., Suite C-3, Indianapolis, IN46205	A, OD	317-899-2010
	Alpha Resources Counseling Center	5317 E. 16th Street, Suite 8, Indianapolis, IN 46218	A, OD	317-353-8494
	Alpha Resources Counseling Center	3901 W. 30th Street, Suite B, Indianapolis, IN 46222	A, OD	317-293-9874
	Alpha Resources Counseling Center	539 Turtle Creek South Drive, Suite 38, Indianapolis, IN 46227	A, OD	317-784-3985
	Alpha Resources Counseling Center	6531 W. Washington Street, Indianapolis, IN 46241	A, OD	317-243-3806
	Alpha Resources Counseling Center	3757 N. Post Road, Indianapolis, IN 46226	A, OD	317-899-2010
	Amani Treatment Center	1050 E. 86th St., Suite C-3, Indianapolis, IN 46240	A, OD	317-581-0600
	American Cancer Society	6030 W. 62nd St., Indianapolis, IN 46278	T	317-347-6670
	American Lung Association	9445 Delegates Row, Indianapolis, IN 46240	T	317-539-3900 *226

	Beacon House	2456 N. Bolton Ave., Indianapolis, IN 46218	A, OD	317-375-0326
	BehaviorCorp	2506 Willowbrook Parkway, Suite 300, Indianapolis, IN 46205	A, OD	317-257-3903
	BehaviorCorp	5525 Georgetown Road, Suite E, Indianapolis, IN 46254	A, OD	317-328-5800
	Bethlehem House	130 E. 30th St., Indianapolis, IN 46205	A, OD	317-920-1519
	Center for Behavioral Change	5356 Hillside Avenue Suite 1, Indianapolis IN 46220	A, OD	317-257-0490
	Choices Counseling	3512 Rockville Road, Suite 152-D, Indianapolis IN 46222	A, OD	317-244-9391
	Citizens Health Center	1650 N. College Ave., Indianapolis, IN 46202	T	317-924-6351
	Clarian Behavioral Health	I-65 at 21st St., P.O. Box 1367, Indianapolis, IN 46206	A, OD	317-962-0651
	Clarian Tobacco Control Center	I-65 at 21st St., P.O. Box 1367, Indianapolis, IN 46206	T	317-962-9663
	Cocaine Anonymous	Box 20689, Indianapolis, IN 46220	OD	317-767-1300
	Community Addiction Services, Inc.	3561 English Avenue, Indianapolis, IN 46201	A, OD	317-356-7214
	Community Addiction Services, Inc.	1040 E. New York Street, Indianapolis, IN 46202	A, OD	317-633-8240
	Community Addiction Services of Indiana	1125 Brookside Ave., Suite. I, Indianapolis, IN 46202	A, OD	317-536-7100
	Community Counseling Center	3515 E. Washington Street, Indianapolis, IN 46202	A, OD	317-633-8240
	Community Counseling Center	2416 E. 55th Place, Indianapolis, IN 46220	A, OD	317-423-8654
	Community Counseling Center	3901 S. East Street, Indianapolis, IN 46227	A, OD	317-423-8654

	Community Counseling Center	2709 W. 16th Street, Suite A, Indianapolis, IN 46222	A, OD	317-423-8654
	Community Counseling Center	4955 W. Washington Street, Indianapolis, IN 46241	A, OD	317-423-8654
	CorVasc MDs	8433 Harcourt Rd., Indianapolis, IN 46260	T	317-583-7604
	CRC Health - Indianapolis Treatment Center, Inc.	2626 E 46th Street, Suite J, Indianapolis, IN 46205	A, OD	866-762-3766
	Cummins Behavioral Health Systems	2345 S. Lynhurst Drive, Suite 205, Indianapolis, IN 46241	A, OD	317-247-8900
	Cummins Behavioral Health Systems	1005 S. Meridian Street, Lebanon, IN 46205	A, OD	765-482-7421
	Dove Recovery House for Women	14 N. Highland Avenue, Indianapolis, IN 46202	A, OD	317-964-0451
	Esther's Place Inc	1810 E. 62nd St., Suite 8, Indianapolis, IN 46220	A, OD	317-466-0657
	Fairbanks	8102 Clearvista Parkway, Indianapolis, IN 46256-4698	ATOD	317-849-8222
	Fallcreek Counseling Services	3500 Lafayette Road Suite 302, Indianapolis, IN 46222	A, OD	317-291-6360
	Fallcreek Counseling Services	2525 N Shadeland Ave., Indianapolis, IN 46219-1787	A, OD	317-375-1901
	Family Service of Central Indiana, Inc.	615 N. Alabama Street, Suite 320, Indianapolis, IN 46204	A, OD	317-634-6341
	Freedom From Smoking	3145 E. Thompson Rd., Indianapolis, IN 46227	T	317-782-7999
	Gallahue Mental Health Services	8404 Siear Terrace, Suite 208, Indianapolis, IN 46227	A, OD	317-887-7050

	Gallahue Mental Health Services	5470 E. 16th St., Suite A21, Indianapolis, IN 46219	A, OD	317-355-5394
	Gallahue Mental Health Services	6950 Hillsdale Ct., Indianapolis, IN 46250	A, OD	317-621-7600
	Greater Indianapolis Council on Alcoholism & Drug Dependence	2511 E. 46th St., Suite A-1, Indianapolis, IN 46205	A, OD	317-542-7128
	Hamilton Center	2160 N. Illinois St., Indianapolis, IN 46205	A, OD	317-937-3700
	Hamilton Center	602 High School Rd., Indianapolis, IN 46214	A, OD	317-484-5380
	HealthNet	3401 E. Raymond St., Indianapolis, IN 46203	T	317-781-4869
	Health Recovery Centers of Indiana	2305 N. Meridian St., Indianapolis, IN 46208	A, OD	317-925-4508
	Horizon House	1033 E. Washington Street, Indianapolis, IN 46202	A, OD	317-423-8909
	Indiana Latino Institute	445 N. Pennsylvania St., Suite 800, Indianapolis, IN 46204	A, T	317-472-1055
	Indianapolis Counseling Center	2511 East 46th Street Building T-6, Indianapolis IN 46205	A, OD	317-549-0333
	Indianapolis Treatment Center Inc	2626 East 46th Street Suite J, Indianapolis IN 46205	OD	317-475-9066
	Indianapolis Urban League	777 Indiana Ave., Indianapolis, IN 46202	A, OD	317-693-7603
	Life Alternatives	8686 Madison Ave., Suite J, Indianapolis, IN 46227	A, OD	317-887-3290
	Lighthouse Mission	520 E. Market St., Indianapolis, IN 46204	A, OD	317-955-7957
	Marion County Health Department	3838 N. Rural St., Indianapolis, IN 46205	T	317-221-2084
	Martin University	2171 Station St., Indianapolis, IN 46218	T	317-917-3353
	Methodist Hospital Behavioral Care Center	1701 North Senate Blvd. Building C Floor 3, Indianapolis, IN 46206	A, OD	317-962-2622
	Midtown Mental Health Center	1001 W. 10th Street, Indianapolis, IN 46202	A, OD	317-630-7791

	Midtown Mental Health Center	1700 N. Illinois St., Indianapolis, IN 46204	A, OD	317-630-7791
	Midtown Mental Health Center	832 N. Meridian ST., Indianapolis, IN 46204	OD	317-686-5634
	Midwest Counseling Associates Inc	5321 Cheviot Place, Indianapolis, IN 46226	A, OD	317-545-8490
	Minority Health Coalition of Marion County	2804 E. 55th Place, Suite R, Indianapolis, IN 46220	T	317-257-9700
	Mosaic Recovery Inc	2554 S. Madison Ave., Indianapolis, IN 46225	A, OD	317-788-6560
	Narcotics Anonymous- Central Area (Camby)		OD	317-875-5459
	Narcotics Anonymous- Central Area (Indianapolis)		OD	317-875-5459
	Nicotine Anonymous	4180 N College, Indianapolis, IN 46218	T	317-351-9336
	Pathway Family Center	6408 Castleplace Drive, Indianapolis, IN 46250	A, OD	317-585-6953
	Pathway to Recovery	2135 N. Alabama St., Indianapolis, IN 46202	A, OD	317-926-8557
	Penrod Counseling Center	3410 N. High School Road, Suite A, Indianapolis, IN 46224	A, OD	317-297-4516
	Phoenix Treatment Centers LLC	3901 S. East Street, Indianapolis, IN 46227	A, OD	317-788-4136
	Potter and Clay Ministries	P.O. Box 14182, Indianapolis, IN 46201	A, OD	317-257-2222
	Prenatal Substance Use Prevention Program	2868 Pennsylvania, Indianapolis, IN 46208	ATOD	317-221-8953
	Reach for Youth	3505 N. Washington Boulevard, Indianapolis, IN 46205	ATOD	317-738-5433
	Reach for Youth	5401 Shelby Street, Indianapolis, IN 46227	A, OD	317-788-4451
	Road to Freedom	6190 E. 38th St., Indianapolis, IN	A, OD	317-568-0683
	Roudebush VA Medical Center	1481 W. 10th St., Indianapolis, IN 46202	ATOD	317-554-0000

	Saint Florian Center	2511 E. 46th St., Suite P-1, Indianapolis, IN 46205	T	317-545-6580
	Salvation Army Adult Rehabilitation Center	711 E. Washington Street, Indianapolis, IN 46202	A, OD	317-638-6585
	Salvation Army Harbor Light Center	2400 N. Tibbs Avenue, Indianapolis, IN 46222	A, OD	317-972-1450
	Salvation Army Indiana Division	3100 N. Meridian Street, Indianapolis, IN 46208	A, OD	317-937-7000
	Second Chance Ministries, Inc.	401 N. Delaware, Indianapolis, IN 46204	A, OD	317-955-7957
	Seeds of Hope	1425 S. Mickley Ave., Indianapolis, IN 46241	A, OD	317-244-0203
	St. Francis Hospital	650 East Southport Road Suite C, Indianapolis IN 46227	ATOD	317-783-8383
	St. Francis Hospital	1600 Albany St., Beech Grove, IN 46107	A, OD	317-783-8477
	St. Vincent Stress Center	8401 Harcourt Road, Indianapolis, IN 46260	A, OD	317-338-4600
	Shalom Health Center	2301 N. Park Ave., Indianapolis, IN 46205	T	317-924-4978
	Springtime Counseling Center	6515 East 82nd Street Suite 102, Indianapolis, IN 46250	A, OD	317-849-0599
	Universal Behavioral Services	3590 N. Meridian St., Indianapolis, IN 46208	A, OD	317-684-0442
	Valle Vista	8902 N. Meridian St., Suite. 240, Indianapolis, IN 46260	A, OD	800-943-8759
	Volunteers of America	927 N. Pennsylvania Street, Indianapolis, IN 46204	A, OD	317-686-5808
	Westside Clinic	5610 Crawfordsville Rd., Suite 2201, Indianapolis, IN 46224	A, OD	317-244-2243
	Wheeler Mission Ministries	245 N. Delaware Street, Indianapolis, IN 46204	A, OD	317-635-3575

	White River Psychology	303 N. Alabama Street, Suite 390, Indianapolis, IN 46204	A, OD	317-684-7171
	Wishard Health Services	1001 W. 10th St., Indianapolis, IN 46202	T	317-630-7653
	Wishard II Care Substance Abuse Clinic (prenatal)	1002 Wishard Blvd., Indianapolis, IN 46202	A, OD	317-692-2365
	Women in Need Growing Strong	P.O. Box 441383, Indianapolis, IN 46244	A, OD	317-251-7575
Marshall				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bowen Center	990 Illinois Street, Plymouth, IN 46563	A, OD	574-936-9646
	Brighter Tomorrows Inc.	310 North Michigan Street Suite 208, Plymouth IN 46563	A, OD	574-935-9449
	Community Hospital of Bremen	411 S. Whitlock, Bremen, IN 46506	T	574-546-2211
	Eric Foster Inc	322 West Jefferson Street, Plymouth, IN 46563	A, OD	574-936-3377
	Madison Center Plymouth	209 East Jefferson Street, Plymouth IN 46563	A, OD	574-935-3770
	Michiana Behavioral Health Center	1800 North Oak Road, Plymouth IN 46563	A, OD	574-936-3784
	Saint Joseph Regional Medical Center	234 S. Chapin St., Suite 2, South Bend, IN 46601	T	574-239-5298
	Women's Care Center	224 N. Michigan St., Plymouth, IN 46563	T	574-936-5141
Martin				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
Miami				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	

	Four County Counseling Center	655 E. Main St., Peru, IN 46970	ATOD	574-722-1515 *281
	Miami County Tobacco Awareness Group	P.O.Box 1084, Peru, IN 46970	T	765-472-4450
	Narcotics Anonymous- Cross Roads Area (Peru)		OD	765-456-5905
Monroe				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Amethyst Addiction Services	645 N. Walnut Street, Bloomington, IN 47404	A, OD	812-336-3570
	Amethyst Addiction Services	322 West 2nd Street, Bloomington IN 47401	A, OD	812-336-2666
	Bloomington Hospital	2920 McIntire Dr., Suite 165, Bloomington, IN 47403	T	812-353-5811
	Bloomington Meadows Hospital	3600 North Prow Road, Bloomington IN 47404	A, OD	812-331-8000
	Center for Behavioral Health	645 S. Rogers Street, Bloomington, IN 47403	A, OD	812-339-1691
	Elizabeth York and Associates	120 West 7th Street, Suite 312, Bloomington, IN 47404	A, OD	812-330-1477
	Indiana University Health Center	600 N. Jordan, Bloomington, IN 47405	T	812-855-8230
	MLS Health Services, Inc.	430 S. Dunn St. #318, Bloomington, IN 47401	T	812-287-0055
	Monroe County Health Department	119 W. 7th St., Bloomington, IN 47404	T	812-349-2150
	Narcotics Anonymous- Limestone Area (Bloomington)		OD	812-331-9767
	Sunrise Counseling Centers	830 West 17th Street, Bloomington IN 47404	A, OD	812-330-8183
Montgomery				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	

	Cummins Behavioral Health Systems	701 Englewood Drive, Crawfordsville, IN 47933	A, OD	765-361-9767
	Hope Counseling Services	1984 Indianapolis Rd., Crawfordsville, IN 47933	ATOD	765-364-0380
	Montgomery County AHEAD Coalition	116 N. Green St., Crawfordsville, IN 47933	T	765-364-7870 *103
	Narcotics Anonymous- Central Area (Crawfordsville)		OD	317-875-5459
	Wabash Valley Hospital Inc	1480 Darlington Ave., Crawfordsville, IN 47933	A, OD	765-362-2852
Morgan				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Center for Behavioral Health	1175 Southview Drive, Martinsville, IN 46151	A, OD	765-342-6616
	Center for Behavioral Health	11370 N. State Road 67, Mooresville, IN 46158	A, OD	317-834-8187
	Eastview Christian Church	2745 Old Morgantown Rd., Martinsville, IN 46151	ATOD	765-342-0391
	Family Service of Central Indiana Inc.	465 S. Main Street, Suite 106, Martinsville, IN 46151	A, OD	765-342-0202
	Freedom From Smoking	1201 Hadley Rd., Mooresville, IN 46158	T	317-831-9333
	Martinsville High School	1360 E. Gray St., Martinsville, IN 46151	T	765-342-5571 *4222
	Morgan County Health Department	180 S. Main St., Suite 252, Martinsville, IN 46151	T	765-342-6621
	Not On Tobacco (N.O.T)	550 N. Indiana St., Mooresville, IN 46158		
	South Point Psychological Group	1201 Hadley Rd., Mooresville, IN 46158	A, OD	317-834-5756

Newton				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
Noble				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bowen Center	101 E. Park Drive, Albion, IN 46701	A, OD	260-636-6884
	Northeastern Center	1930 E. Dowling Street, Kendallville, IN 46755	A, OD	260-347-4400
	Northeastern Center	150 Lincoln Way South, Ligonier, IN 46767	A, OD	260-894-7179
	Tobacco-Free Noble County	100 E. Main St., Albion, IN 46701	T	260-636-3365
	Wise Choices Inc	126 S. Main St., Kendallville, IN 46755	A, OD	260-482-2586
Ohio				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Community Mental Health Center	315 Industrial Access Road, P.O. Box 167, Rising Sun, IN 47040	A, OD	812-438-2711
	Prenatal Substance Use Prevention Program	202 N. Gaslight Dr., Versailles, IN 47042	ATOD	812-689-6363
Orange				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bloomington Hospital of Orange County	642 W. Hospital Rd., Paoli, IN 47454	T	812-723-7474
	Southern Hills Counseling Center, Inc.	488 W. Hospital Road, Paoli, IN 47454	A, OD	812-723-4301
Owen				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Center for Behavioral Health	R.R. 5, Box 296, Spencer, IN 47460	A, OD	812-829-4871
	Hamilton Center, Inc.	909 W. Hillside Avenue, P.O. Box 595, Spencer, IN 47460	A, OD	812-829-0037
	Owen County Family YMCA	1111 Hwy. 46 West, Spencer, IN 47460	T	812-828-9622
	Prenatal Substance Use Prevention Program	911 Hillside Ave., Spencer, IN 47460	ATOD	812-829-0303
Parke				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Hamilton Center, Inc.	215 N. Jefferson Street, P.O. Box 123, Rockville, IN 47872	A, OD	765-569-2031
	Parke County Partners	109 S. Jefferson, Rockville, IN 47872	T	765-569-4008
Perry				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Cannelton City Schools	125 S. 6th St., Cannelton, IN 47520	T	812-547-3296
	Healthy Families Perry County	302 Main St., Tell City, IN 47586	T	812-547-3435
	Perry Central Community Schools	18677 Old State Rd. 37, Leopold, IN 47551	T	812-843-4122
	Perry County Memorial Hospital	1 Hospital Rd., Tell City, IN 47586	T	812-547-0125
	Southern Hills Counseling Center, Inc.	1443 Ninth Street, Tell City, IN 47586	A, OD	812-547-7905
	Tell City School Corporation	837 12th St., Tell City, IN 47586	T	812-547-3131
Pike				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Pike County Tobacco Coalition	801 Main St., Petersburg, IN 47567	T	812-582-0442
	Samaritan Center	400 Main St., Petersburg, IN 47567	A, OD	812-886-6800
Porter				
	Addiction and Behavioral Counseling Services	54 South Valparaiso Street, Valparaiso IN 46383	A, OD	219-477-4646
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alice's Halfway House for Women	606 Brown Street, Valparaiso, IN 46384	A, OD	219-462-7600
	Care Counseling Services	793-2 Juniper Road, Valparaiso, IN 46385	A, OD	219-759-6760
	CHOICES Counseling Center	607 E. Lincoln Way, Valparaiso, IN 46383	T	
	Christian Service Center	791 Juniper Street, Valparaiso IN 46385	A, OD	219-762-0021
	Fresh Start Counseling	1552 West Lincolnway, Valparaiso, IN 46385	ATOD	219-548-9400
	Joseph Corporation- DBA Care Counseling Services	793-2 Juniper Rd., Valparaiso, IN 46385	A, OD	219-759-6760
	LaPorte Hospital	1203 Washington St., LaPorte, IN 46350	T	219-326-2474
	Moraine House, Inc.	353 W. Lincolnway, Valparaiso, IN 46383	A, OD	219-464-9983
	Narcotics Anonymous- South Shore Area (South Haven)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Portage)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Wheeler)		OD	219-793-6262
	Narcotics Anonymous- South Shore Area (Valparaiso)		OD	219-793-6262

	Narcotics Anonymous- South Shore Area (Chesterton)		OD	219-793-6262
	Porter Memorial Hospital	814 LaPorte St., Valparaiso, IN 46383	A, T	219-263-4671
	Porter-Starke Services, Inc.	3349 Willowcreek Road, Portage, IN 46368	ATOD	219-762-9557
	Porter-Starke Services, Inc.	701 Wall Street, Valparaiso, IN 46383	ATOD	219-531-3681
	Tobacco Prevention & Cessation Coalition for Porter County	836 LaPorte Ave., Valparaiso, IN 46383	T	219-464-5480
Posey				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Posey County Regional Services	100 Vista Drive, Mount Vernon, IN 47620	A, OD	812-838-6558
	Steps of Addiction Recovery, LLC	51 1/2 N. Pike Street, Vernon, IN 47282	A, OD	812-378-2660
	Tobacco Prevention & Cessation	614 SE Third St., Evansville, IN 47713	T	812-476-1471
Pulaski				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Four County Counseling Center	118 N. Sally Dr., Winamac, IN 46996	A, OD	574-946-4233
	Pulaski Memorial Hospital	616 E. 13th St., Winamac, IN 46996	T	574-946-6017
Putnam				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Cummins Behavioral Health Systems	308 Medic Way, Greencastle, IN 46135	A, OD	765-653-2669
	Hamilton Center, Inc.	239 Hillsdale Avenue, Greencastle, IN 46135	A, OD	765-653-1024
	Narcotics Anonymous- Wabash Valley Area (Greencastle)		OD	877-888-4130

	Prenatal Substance Use Prevention Program	141 Martinsville St., Greencastle, IN 46135	ATOD	765-653-1841
	Putnam County Tobacco Prevention & Cessation	1542 S. Bloomington St., Greencastle, IN 46135	T	765-655-2697
Randolph				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Dunn Mental Health Center	132 & 135 N. Main Street, Winchester, IN 47394	A, OD	888-983-8000
	Meridian	2 ONCO Sq., Winchester, IN 47394	A, OD	765-584-7820
	Randolph County Health Department	325 S. Oak St., Suite 202, Winchester, IN 47394	T	765-584-1155
	St. Vincent Randolph Hospital	409 Greenville Ave., Winchester, IN 47394	T	765-584-0745
	Winchester Living Life Clean	120 W. 3rd St., Winchester, IN 47394	A, OD	765-546-0116
Ripley				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Community Mental Health Center	215 E. George Street, Batesville, IN 47006	A, OD	812-934-3245
	Community Mental Health Center	240 W. Craven Street, Osgood, IN 47037	A, OD	812-689-4281
	Ripley County Tobacco Prevention & Cessation	102 W. 1st North St., Suite 106, Versailles, IN 47042	T	812-689-5751
	Margaret Mary Coummunity Hospital	321 Mitchell Ave., Batesville, IN 47006	T	812-933-5115
	Narcotics Anonymous- South Central Area (Versailles)		OD	
	Prenatal Substance Use Prevention Program	202 N. Gaslight Drive, P.O. Box 766, Versailles, IN 47042	ATOD	812-689-6363

Rush				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Dunn Mental Health Center	201 Harcourt Way, Suites B&C, Rushville, IN 46173	A, OD	888-983-8000
	Rush County Substance Abuse Services	246 N. Main St., Rushville, IN 46173	A, OD	765-938-1749 *1
	Rush Memorial Hospital	1300 North Main St., Rushville, IN 46173	T	765-932-7472
Scott				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	LifeSpring Mental Health Services	75 N. 1st St., Scottsburg, IN 47170	A, OD	812-752-2837
	Prenatal Substance Use Prevention Program	1101 Spring St., Suite 2, Jeffersonville, IN 47130	ATOD	812-288-1470
	YMCA	805 Community Way, Scottsburg, IN 47170	T	812-752-7239
Shelby				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Family Services and Prevention Programs	2535 Parkway Dr., Suite. 1, Shelbyville, IN 46176	A, OD	317-398-0955
	Gallahue Mental Health Services	7 E. Hendricks St., Shelbyville, IN 46176	A, OD	317-392-2564
	Major Hospital	150 W. Washington St., Shelbyville, IN 46176	T	317-421-5689
	Narcotics Anonymous- Central Area (Shelbyville)		OD	317-875-5459
	Recovery Counseling Services	24 1/2 W. Polk St., Shelbyville, IN 46176	A, OD	317-421-0845

Spencer				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Perry County Memorial Hospital	1 Hospital Rd., Tell City, IN 47586	T	812-547-0125
	Prenatal Substance Use Prevention Program	818 Madison, Rockport, IN 47635	ATOD	812-649-4410
	Southern Hills Counseling Center, Inc.	24 S. Washington St., Dale, IN 47523	A, OD	812-482-3020
	Southern Hills Counseling Center, Inc.	107 N. 2nd Street, Rockport, IN 47635	A, OD	812-649-9168
	Spencer County Tobacco Prevention & Cessation Coalition	1140 31st St., Tell City, IN 47586	T	812-547-2299
St. Joseph				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Michiana Central Service Office	814 E. Jefferson Boulevard, South Bend, IN 46617	A	574-234-7007
	American Cancer Society	601 W. Edison Rd., Mishawaka, IN 46545	T	574-257-9789
	Childrens Campus Inc	1411 Lincolnway West, Mishawaka, IN 46544	A, OD	574-259-5666 *266
	Crossroads Counseling	711 E. Colfax Avenue, Suite 229, South Bend, IN 46617	A, OD	574-233-4183
	Dockside Services, Inc.	2606 S. Michigan St., South Bend, IN 46614	A, OD	574-288-2792
	Family and Childrens Center	105 East Jefferson Blvd., Suite 700, South Bend, IN 46601	A, OD	574-232-2255
	Healthy Communities Initiative	401 E Colfax Ave. #310, South Bend, IN 46617	T	574-239-8585

	Joseph Regional Medical Center	234 South Chapin St., Suite 2, South Bend, IN 46601	T	574-239-5298
	Life Treatment Centers	1402 S. Michigan Street, South Bend, IN 46613	A, OD	574-233-5433
	Life Treatment Centers	130 S. Taylor St., South Bend, IN 46601	A, OD	574-233-5433
	Madison Center - Quiet Care	533 N. Niles Avenue, South Bend, IN 46617	A, OD	574-283-1751
	Madison Center - New Passages	813 S. Michigan Street, South Bend, IN 46601	A, OD	574-282-8712
	Madison Center	403 E.Madison St., South Bend, IN 46617	A, OD	574-234-0061
	Memorial Health Discovery Center	100 Navarre Place Suite 6670, South Bend, IN 46601	T	574-647-6880
	Michiana Addiction Recovery Centers	103 West Wayne St., Suite 304, South Bend, IN 46601	A, OD	574-233-5920
	Narcotics Anonymous- North Central Area (South Bend)		OD	574-674-1685
	Narcotics Anonymous- North Central Area (Mishawaka)		OD	574-674-1685
	Nowak and Associates PC	300 N. Michigan St., South Bend, IN 46601	A, OD	574-234-3338
	Prenatal Substance Use Prevention Program	818 E. Jefferson Blvd., South Bend, IN 46617	ATOD	574-234-6024
	Wellspring Counseling and Learning Center	207 S. Michigan St., Lakeville, IN 46536	A, OD	574-784-2700
	Victory Clinic Services II	4005 Western Ave., South Bend, IN 46619	OD	574-233-1524
	YWCA	1102 S. Fellows St., South Bend, IN 46601	A, OD	574-233-9491
Starke				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Narcotics Anonymous- North Central Area (Knox)		OD	574-674-1685
	North Judson-San Pierre Middle School	950 Campbell Dr., North Judson, IN 46366	T	574-896-2167
	Porter-Starke Services	1003 Edgewood Dr., Knox, IN 46534	ATOD	219-476-4643
	Tobacco Free Starke County	52 W. Lake St., Knox, IN 46534	T	574-772-3353
Steuben				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Tri-State Intergroup	Box 583, Angola, IN 46703	A	866-608-3793
	Cameron Memorial Community Hospital	416 E. Maumee St., Angola, IN 46703	ATOD	260-665-2141
	Narcotics Anonymous- North East Area (Angola)		OD	260-460-4626
	Northeastern Center	200 Hoosier Drive, Suite E, Angola, IN 46703	A, OD	260-665-9494
Sullivan				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	C.H.A.N.C.E.S…for Indiana Youth	444 S. 6th St., Terre Haute, IN 47807	T	812-238-5190
	Hamilton Center, Inc.	2134 Mary Sherman Drive, Sullivan, IN 47882	A, OD	812-268-6376
	Milburn's Pharmacy	13 W. Jackson, Sullivan, IN 47882	T	812-268-4737
Switzerland				

	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Community Mental Health Center	205 W. Main Street, Vevay, IN 47043	A, OD	812-427-2737
	Prenatal Substance Use Prevention Program	202 Gaslight Dr., Versailles, IN 47042	ATOD	812-689-6363
	Tobacco Prevention & Cessation of Jefferson and Switzerland Counties	P.O. Box 447 One King's Daughters' Dr., Madison, IN 47250	T	812-265-0598
Tippecanoe				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Lafayette Area Intergroup	P.O. Box 6228, Lafayette, IN 47903	A	765-742-1666
	Alpine Clinic	1415 Salem Street, Lafayette, IN 47905	A, OD	765-446-9394
	Alpine Clinic	3660 Rome Drive, Lafayette, IN 47905	A, OD	765-446-9394
	Alpine Clinic	500 W. Navajo Street, West Lafayette, IN 47906	A, OD	765-446-9394
	Alpine Clinic	3678 Rome Drive, Suite 1, Lafayette, IN 47905	A, OD	765-446-9394
	Arnett Health Plans	415 N. 26th St., Suite 101, Lafayette, IN 47904	T	765-448-7453
	Cocaine Anonymous		OD	317-767-1300
	Community and Family Resource Center/Centro Hispano	330 Fountain St., Lafayette, IN 47905	T	765-742-5046
	Cummins Behavioral Health Systems	427 N. 6th Street, Lafayette, IN 47901	A, OD	765-420-0938
	Family Services, Inc.	731 Main St., Lafayette, IN 47905	T	765-423-5361
	Home with Hope Inc	1001 Ferry St., Lafayette, IN 47901	A, OD	765-742-2321

	Kathryn Weil Center for Educ. Dept. of Greater Lafayette Health Services	2400 South St., Lafayette, IN 47904	T	765-449-5133
	Narcotics Anonymous- Cross Roads Area (Lafayette)		OD	765-456-5905
	Narcotics Anonymous- Cross Roads Area (Monitor)		OD	765-456-5905
	Nursing Center for Family Health	502 N. University St., West Lafayette, IN 47907	T	765-494-6341
	Prenatal Substance Use Prevention Program	1716 Hartford Street, Lafayette, IN 47904	ATOD	765-429-2703
	Purdue University WorkLife Programs	1402 West State St., PWF, West Lafayette, IN 47907	T	765-496-6334
	Tobacco Free Partnership of Tippecanoe County	502 N. University St., Rm 250, West Lafayette, IN 47907	T	765-494-4012
	Wabash Valley Hospital Inc	610 Main St., Lafayette, IN 47905	A, OD	765-423-2638
	Wabash Valley Hospital Inc	2900 N. River Rd., West Lafayette, IN 47906	A, OD	765-463-2555 *268
Tipton				
	Tipton County Tobacco Prevention	1000 South Main St., Tipton, IN 46072	T	765-675-8741
Union				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Rocksolid Ministrien Petra Project	1024 E. Main St., Richmond, IN 47374	T	765-962-5099
	Tobacco Prevention Treatment & Recovery Center	305 N. Main St., Liberty, IN 47353	T	
Vanderburgh				

	ADAPT Counseling Services	715 North 1st Avenue Suite 44, Evansville IN 47710	A, OD	812-421-9900
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous-Southwestern Indiana Central Office	123 NW 4th St., Evansville, IN 47708	A	812-464-2219
	Amethyst Addiction Services	501 John Street, Suite 7, Evansville, IN 47713	A, OD	812-401-3415
	Cocaine Anonymous		OD	317-767-1300
	CRC Health - Evansville Treatment Center, Inc.	1510 W Franklin Street, Evansville, IN 47710	OD	866-762-3766
	Deaconess Cross Pointe Center LLC	7200 E. Indiana Street, Evansville, IN 47715	A, OD	812-476-7200
	Deaconess Family Practice Clinic	515 Read St., Evansville, IN 47710	T	812-450-6044
	Foundations Education and Counseling Services	105 NW 4th Street, Evansville IN 47708	A, OD	812-426-2074
	Lillian Moulton Center	1 N. Barker Avenue, Evansville, IN 47712	A, OD	812-423-4418
	Mulberry Center, Inc.	414 S.E. Fourth Street, Evansville, IN 47713	A, OD	812-423-4700
	New Visions SA Counseling Service	312 NW Martin Luther King Jr Blvd., Suite 108, Evansville, IN 47708	A, OD	812-422-6812
	Prenatal Substance Use Prevention Program	727 John Street, Evansville, IN 47713	ATOD	812-428-5871
	Southwestern Indiana Mental Health Center, Inc.	60 S. Stockwell Road, Evansville, IN 47714	A, OD	812-476-5437
	Southwestern Indiana Mental Health Center, Inc.	415 Mulberry Street, Evansville, IN 47713	A, OD	812-436-4232
	Smokefree Communities	1605 John St., Evansville, IN 47714	T	812-467-0728

	Stepping Stone	30 S. Stockwell Road, Evansville, IN 47714	A, OD	812-473-3144
	Vanderburgh County Minority Health Coalition	906 Main St., Evansville, IN 47708	T	812-423-5452
Vermillion				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Hamilton Center, Inc.	510 S. Main Street, P.O. Box 306, Clinton, IN 47842	A, OD	765-832-2436
	Narcotics Anonymous- Wabash Valley Area (Clinton)		OD	877-888-4130
	Vermillion County Health Department		T	812-208-5708
	Vermillion County Tobacco Prevention Coalition	P.O. Box 14, Newport, IN 47966	T	812-208-5708
Vigo				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Wabash Valley Intergroup	1435 Lafayette Avenue, Terre Haute, IN 47805	A	812-234-0827
	C.H.A.N.C.E.S…for Indiana Youth	444 S. 6th St., Terre Haute, IN 47807	ATOD	812-238-5190
	Cocaine Anonymous		OD	317-767-1300
	Cummins Behavioral Health Systems	4600 Springhill Junction, Terre Haute, IN 47802	A, OD	812-242-2244
	Hamilton Center, Inc. - Addiction Services	66 Wabash Court, Terre Haute, IN 47804	A, OD	812-231-8171

	Hamilton Center Child and Adolscent Services	500 8th Avenue, Terre Haute, IN 47804	A, OD	812-231-8376
	Light House Mission Ministries, Inc.	1450 Wabash Avenue, Terre Haute, IN 47807	A, OD	812-232-7001
	Maternal Health Clinic	1801 N. 6th St., Suite 200, Terre Haute, IN 47804	T	812-238-7301
	Narcotics Anonymous- Wabash Valley Area (Terre Haute)		OD	877-888-4130
	Prenatal Substance Use Prevention Program	1801 N. Sixth St., Suite 200, Terre Haute, IN 47804	ATOD	812-238-7301
	Recovery Associates, Inc.	2911 ljams Drive, Terre Haute, IN 47802	A, OD	812-232-5272
	Recovery Associates, Inc.	605 Ohio, Suite 204, Terre Haute, IN 47807	A, OD	812-234-9911
	Union Hospital Health Group/Maple Center	1801 N. 6th St., Suite 600, Terre Haute, IN 47804	T	812-235-4867
	Vigo County Health Department	147 Oak St., Terre Haute, IN 47807	T	812-462-3437
	YMCA of Terre Haute	951 Dresser Dr., Terre Haute, IN 47807	T	812-232-3358
Wabash				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bowen Center	255 N. Miami Street, P.O. Box 548, Wabash, IN 46992	A, OD	260-563-8446
	Health Education LLC	4887 E. 900 S., Lafontaine, IN 46940	T	765-981-4322
Warren				
	Coummunity Action Program, Inc.	418 Washington St., Covington, IN 47932	T	765-793-4881
Warrick				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	

	Prenatal Substance Use Prevention Program	499 W. State Road 62, Boonville, IN 47601	ATOD	812-897-5918
	Smokefree Communities	1605 John St., Evansville, IN 47714	T	812-467-0728
	Warrick County Regional Services	315 S. Third Street, Boonville, IN 47601	A, OD	812-897-4776
Washington				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	LifeSpring Mental Health Services	1321 Jackson St., Salem, IN 47167	A, OD	812-883-3095
	Washington County Memorial Hospital	911 N. Shelby St., Salem, IN 47167	ATOD	812-883-5881
Wayne				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Alcoholics Anonymous- Richmond Indiana Answering Service	Richmond, IN 47385	A	765-965-1800
	CRC Health - Richmond Treatment Center, Inc.	4265 South A Street, Richmond, IN 47374	A, OD	866-762-3766
	Dunn Mental Health Center	831 Dillon Drive, Richmond, IN 47374	A, OD	888-983-8000
	Meridian	1528 NW 5th St., Richmond, IN 47374	A, OD	765-983-2220
	Narcotics Anonymous- Central Area (Richmond)		OD	317-875-5459
	Reid Hospital and Health Care Services	1401 Chester Boulevard, Richmond, IN 47374	ATOD	765-983-3150
	Richmond State Hospital	498 NW 18th Street, Richmond IN 47374	A, OD	765-966-0511 *4647
	Richmond Treatment Center	4265 South A Street, Richmond IN 47374	OD	765-962-8843

	Rocksolid Ministrien Petra Project	1024 E. Main St., Richmond, IN 47374	T	765-962-5099
Wells				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Caring About People Inc	113 West Market Street, Bluffton, IN 46714	A, OD	260-424-5814
	Caylor-Nickel Foundation	311 S. Scott St., Bluffton, IN 46714	T	260-824-5019
	Park Center, Inc.	1115 S. Main Street, Bluffton, IN 46714	A, OD	260-824-1071
	Narcotics Anonymous- North East Area (Bluffton)		OD	260-460-4626
White				
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Narcotics Anonymous- Cross Roads Area (Monticello)		OD	765-456-5905
	Wabash Valley Hospital Inc	207 N. Bluff St., Monticello, IN 47960	A, OD	574-583-9350
	White County Tobacco Prevention Coalition	110 N. Main St., Monticello, IN 47960	T	574-583-9864
Whitley				
	Addictions Recovery Centers Inc	232 West Van Buren St., Columbia City, IN 46725	A, OD	574-533-6154
	Alcoholics Anonymous	http://www.indyaa.org/MEETINGS/Indiana%20Contacts%20by%20county.htm	A	
	Bowen Center	119 W. Market Street, Columbia City, IN 46725	A, OD	260-248-8176
	Whitley County Tobacco-Free	111 N. Main St., South Whitley, IN 46787	T	260-723-5911