Scott.A.Milkey

From: Hammond, John
Sent: Tuesday, June 13, 2017 8:52 AM
To: Huntsinger, Douglas;McClelland, Jim
Cc: Jankowski, Jane
Subject: Interesting piece on Vivitrol

https://www.nytimes.com/2017/06/11/health/vivitrol-drug-opioid-addiction.html?_r=0

John R. Hammond IV

Senior Operations Director
Office of Governor Eric J. Holcomb
Office: 317-234-4743 | Cell: 317-[redacted]
Follow Governor Eric Holcomb on Twitter, Facebook, & Instagram

Scott.A.Milkey

From: McClelland, Jim
Sent: Monday, June 12, 2017 11:11 AM
To: Jankowski, Jane;dhuntsinger@gov.in.gov;Evans, Daniel;Adams, Jerome;Walthall, Jennifer;George, Tim;Jackson, Sharon
Subject: FW: Here is the link to the online story

Read this. It will air this afternoon on All Things Considered.

From: Krauss, John L [mailto:jkrauss@iupui.edu]
Sent: Monday, June 12, 2017 10:40 AM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Subject: Here is the link to the online story

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http://www.npr.org/sections/health-shots/2017/04/13/523774660/a-drugmaker-tries-to-cash-in-on-the-opioid-epidemic-one-state-law-at-a-time?live=1

From: McClelland, Jim [mailto:JMcClelland@gov.in.gov]
Sent: Monday, June 12, 2017 9:43 AM
To: Krauss, John L <jkrauss@iupui.edu>
Subject: RE: Important WFYI story on NPR Monday

Thanks, John.
Jim

From: Krauss, John L [mailto:jkrauss@iupui.edu]
Sent: Monday, June 12, 2017 9:37 AM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Subject: Important WFYI story on NPR Monday
Importance: High

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Jim:

Heads up – FYI.

John

Subject: Important WFYI story on NPR Monday
Importance: High

Good evening,

On Monday, June 12, 2017, NPR is expected to air an investigative story detailing the ways in which the drug company Alkermes has pushed for legislation that will benefit its drug Vivitrol (a medication used to treat opioid addiction), and make it harder to access other treatments. The story was reported by WFYI's Jake Harper through a collaboration between NPR and Side Effects Public Media. At this point, NPR is planning to launch the on-line version of the story Monday morning and will run Jake's feature story in the afternoon during *All Things Considered*.

One portion of the story discusses the tactics used by Alkermes and, in particular, it mentions the work of an Indianapolis-based lobbyist who helped craft legislation that creates barriers for addicts whose doctors advise they use one of Vivitrol's competitors. The lobbyist's publicist and lawyer have preemptively expressed concerns to WFYI and NPR about the way they feared their client would be portrayed. We are confident that Jake, Carmel and the editors at NPR have done a thorough, professional job of fact-checking and vetting the story, and as an organization, WFYI stands behind it. If you have any questions or concerns of any kind about this story, please reach out to Andy Klotz.

msp

Matt Shafer Powell
Chief Content Officer
WFYI Public Media
1630 N. Meridian St.
Indianapolis, IN 46202
mpowell@wfyi.org
317-614-0420



Scott.A.Milkey

From: Jim McClelland <jmcclelland@[redacted]>
Sent: Monday, June 12, 2017 9:44 AM
To: Jankowski, Jane;Huntsinger, Douglas;dfevans@iuhealth.org
Subject: NYTimes: Seizing on Opioid Crisis, a Drug Maker Lobbies Hard for Its Product

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https://www.nytimes.com/2017/06/11/health/vivitrol-drug-opioid-addiction.html?smprod=nytcore-ipad&smid=nytcore-ipad-share

Despite limited evidence to prove its drug works, the maker of Vivitrol has used political connections and marketing to push for its use for opioid addiction.

Sent from my iPad

Scott.A.Milkey

From: McClelland, Jim
Sent: Monday, June 12, 2017 9:43 AM
To: Jankowski, Jane;dhuntsinger@gov.in.gov;Evans, Daniel
Subject: FW: Important WFYI story on NPR Monday

FYI. There's another piece on Alkermes in today's NYT. I'll forward the link.

From: Krauss, John L [mailto:jkrauss@iupui.edu]
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msp

Matt Shafer Powell
Chief Content Officer
WFYI Public Media

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Indianapolis, IN 46202
mpowell@wfyi.org
317-614-0420



Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Monday, June 12, 2017 9:15 AM
To: McClelland, Jim
Cc: Linda Grove-Paul
Subject: Re: Opioid summit

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Thanks Jim!

Linda will work with you on all the details.

Thanks again,

Steve

Stephen C McCaffrey, JD
Sent from my iPhone

On Jun 12, 2017, at 7:51 AM, McClelland, Jim <JMcClelland@gov.IN.gov> wrote:

I would be glad to do this. Let me know the time you would like for me to speak, and I'll put it on my calendar.

Thanks for the invitation.

Jim

Jim McClelland
Executive Director for Drug Prevention, Treatment, and Enforcement
State of Indiana

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Sunday, June 11, 2017 5:33 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Cc: Linda Grove-Paul <linda.grove-paul@centerstone.org>
Subject: Fwd: Opioid summit

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Hi Jim—

I would like to introduce you via email to Linda Grove-Paul, who is with Centerstone and for this purpose, the Program Chair for the Monroe County Opioid Summit. The Summit is planned for September 28 and a few details from Linda are listed below.

She is soliciting national speakers and I suggested that you would be a great choice for the Luncheon or a Plenary Session.

Let us know whether you would be interested and available to speak.

Thanks Jim,

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<image001.png>

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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Begin forwarded message:

From: Linda Grove-Paul <lindagrovepaul[redacted]
Subject: Fwd: Opioid summit
Date: June 11, 2017 at 5:04:29 PM EDT
To: Steve McCaffrey <smccaffrey@mhai.net>

Here is a description of what we are planning to put together overall. I would see him as a speaker we would want to plug in maybe at lunch or the beginning of the day after we have the plenary. The date is September 28. We would be glad to have him anytime that is convenient. I am working with Diana Williams to see if we can get a couple of powerful national speakers.

South Central Opioid and Prescription Drug Summit

Monroe County Government hosts the inaugural South CentralOpioid, Rx Drugs, and Heroin Abuse Summit. The opioid epidemic kills more people than guns and automobiles. In Monroe County, Indiana, we are losing family members, friends, employees, and employers to overdose and opioid addiction while our foster care system, mental health system, and justice system are unable to meet the demands of our community. Monroe County Government wants to provide information, opportunities to hear what other communities are doing successfully, leadership opportunities, and advocacy training to the next generation.

Mission Statement

The South Central Opioid, Prescription Drug, and Heroin Abuse Summit brings together community members, caring professionals, and stakeholders to educate each other, examine innovative ideas, and to collaborate on evidence-based solutions to the ever increasing opioid, heroin, and prescription drug use problems in our communities. This epidemic has fiscal, medical, legal, spiritual, and generational consequences for those who struggle with addiction and their loved ones. There is no institution that is free from this problem – we must take a proactive approach to help our communities reduce the costs of abuse of these substances and this summit will provide us with the tools to better tackle this problem together.

Goals of the Summit

The summit will bring together community members, caring professionals, and stakeholders to EDUCATE each other, examine INNOVATIVE idea, and to COLLABORATE on compassionate solutions to the ever-increasing opiate, heroin, and prescription drug use problems in our communities.

Who Should Attend

- Concerned Citizens
- Employers
- Healthcare Professionals
- Mental Health Providers
- Community Leaders
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- Law Enforcement
- Community Corrections
- Addiction Specialists
- Survivors

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- Mental Health Providers
- Community Leaders
- Educators
- Law Enforcement
- Community Corrections
- Addiction Specialists
- Survivors

From: Deborah McMahan <Deborah.McMahan@co.allen.in.us>
Sent: Tuesday, June 6, 2017 10:03 AM
To: Hulvershorn, Leslie Ann; amy lahood (amylahood@[redacted]); Charles Clark; connie kerrigan (Connie.Kerrigan@parkview.com); Dan Roth; Greg Eigner (geigner@fwmep.edu)
Cc: mhaaff@thelutheranfoundation.org (mhaaff@thelutheranfoundation.org); Tom Allman; shawn.fingerle@parkview.com; Megan Fisher (Megan.fisher@bowencenter.org); Kelley, Kristen (Kristen.Kelley@atg.in.gov); Jennifer Miller; MacKie, Palmer J. (pmackie@iu.edu); Fox, Trent (ISDH) (TreFox@isdh.IN.gov); Kevin Howell (lucinatreatmentcenter@[redacted]); Dan Heath; Wendy Davis; Charles Pratt; Frances Gull; Mathew McAllister (Mathew.McAllister@parkview.com) (Mathew.McAllister@parkview.com); sarah giaguinta (segiaquinta@[redacted]); Michelle Sybesma; Paul Wilson; McClelland, Jim; Cory McConnell
Subject: meeting of the minds

All,

Hope you are enjoying this beautiful weather!

I would like to propose a telephone conference to discuss the current situation with privacy issues around addiction and mental health. Here is what I am hoping will happen in the next year or so (with your leadership):

We need a health information exchange that allows medical, pharmacy, mental health, judiciary to participate in true collaboration in developing and implementing and maintaining an integrated treatment plan. The partitioned care is not working currently and we need to remove federal and state restrictions that prohibit real time exchange of information that is critical to addressing all aspects of the addiction issue. With this level of functional collaboration and integrated care I believe we will see much more functional outcomes than the present model allows.

I have heard different opinions from all of you regarding the current regulations surrounding privacy. I think we need to discuss openly and come to some conclusion as to the current state and the specific changes we want to make at the federal level if we are to go on and develop the integrated health exchange.

What are your thoughts and are you willing to participate?

Scott.A.Milkey

From: McClelland, Jim
Sent: Monday, June 05, 2017 8:16 AM
To: dhuntsinger@gov.in.gov
Subject: FW: Social Finance and IN OMB Follow-Up
Attachments: Social Finance_PFS and the Opioid Crisis_vSent.pdf; CT Family Stability Project_Fact Sheet.pdf

Here's the paper I promised to send you.

From: Jeff Shumway [mailto:jshumway@socialfinance.org]
Sent: Tuesday, May 23, 2017 5:30 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Cc: Jake Edwards <jedwards@socialfinance.org>
Subject: Fwd: Social Finance and IN OMB Follow-Up

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Jim-

Wanted you to see this. I hope this helps grease the skids with the State!

Let us know next steps. We are excited to explore any of these models in Indiana.

Jeff
---------- Forwarded message ----------
From: **Jake Edwards** <jedwards@socialfinance.org>
Date: Tue, May 23, 2017 at 9:38 AM
Subject: Social Finance and IN OMB Follow-Up
To: mvincent@gov.in.gov
Cc: Jeff Shumway <jshumway@socialfinance.org>

Micah,

Hope this finds you well! Thank you for taking the time to meet with Jeff and me while we were in Indianapolis—we're always grateful to speak with government folks who share an appreciation for wonkier side of our work.

I wanted to pass along a few documents as follow-up from our conversation, as follows:

1. ***Intersection of Pay for Success and Opioid Crisis***. Overview materials on the pervasive impact of the opioid challenge, and the potential to use PFS as a tool to combat the crisis
2. ***CT Family Stability PFS Project Fact Sheet.***

Please feel free to share these materials with Darshan, and let us know if there's any additional information we can pass along!

We look forward to continuing to explore opportunities to align our work.

Best,
Jake

--
Jake Edwards
Associate Director, Social Finance
(617) 939-9900 x40
Social Finance | 10 Milk Street | Suite 1010 | Boston, MA 02108
Mobilizing capital to drive social progress
www.socialfinance.org

--
Jeff Shumway
Vice President of Advisory Services, Social Finance
1161 Mission St, San Francisco, CA 94103

Social Finance, Inc.
Mobilizing Investment Capital To Drive Social Progress
www.socialfinance.org

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Connecticut Family Stability Pay for Success Project

FACT SHEET

Ensuring Family Stability is a priority for Governor Dannel Malloy, Department of Children and Families Commissioner Joette Katz, and the State of Connecticut. The Connecticut Family Stability Pay for Success Project is an innovative strategy to better serve families struggling with substance use by expanding an intensive, in-home treatment program to families presently involved with the Department of Children and Families.



PROJECT OVERVIEW

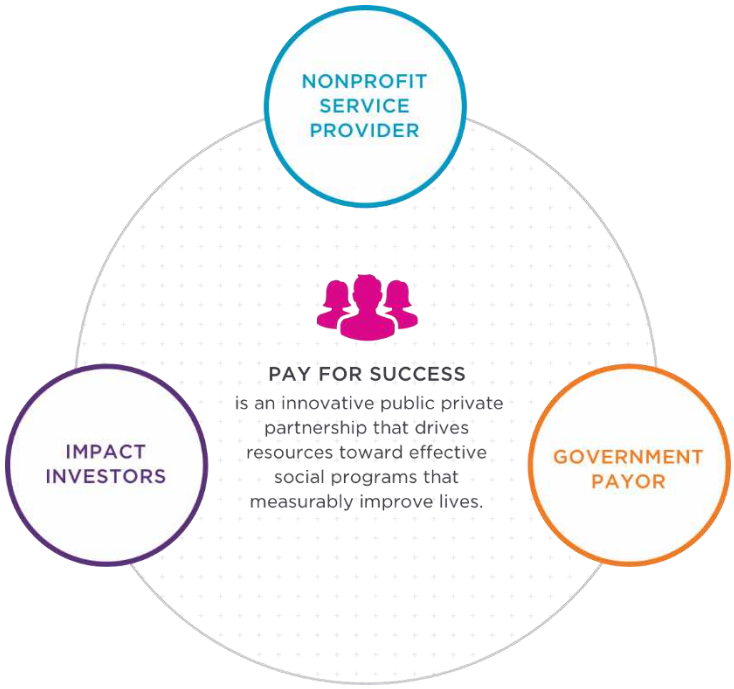
The Connecticut Department of Children and Families (DCF), Family-Based Recovery Services at the Yale Child Study Center, and Social Finance are **launching a Pay for Success (PFS) project to promote family stability and reduce parental substance use for DCF-involved families throughout Connecticut.**

The project will leverage $11.2m of philanthropic and private capital to scale **Family-Based Recovery (FBR) to serve approximately 500 families throughout Connecticut over four and a half years.** Once a family enrolls with FBR, they receive services focused on understanding and responding to the child's developmental needs and treating substance use for an average of six months.

- **Substance use is a pervasive challenge for families involved with DCF and it has persistent consequences for the State of Connecticut.** DCF spends more than $600 million each year to address child abuse and neglect. In 2013, more than 50 percent of all cases investigated by DCF had an indication of parental substance use (18,118 out of 36,131). In addition, the Centers for Disease Control estimates that the lifetime cost associated with one incident of child maltreatment is more than $210,000 in healthcare, child welfare, criminal justice, and special education costs and productivity losses.
- **The Connecticut Family Stability Pay for Success Project will pair families in need with a treatment team that provides regular visits to the client's home to promote positive parent-child interactions, increase parental awareness and understanding of child development, and help parents maintain their recovery.** The PFS project will serve families across Connecticut that struggle with a substance use problem, are working with DCF, and have children up to the age of 6 years old. These families will receive FBR's proven, intensive, in-home treatment that focuses on parent-child attachment and substance use recovery.
- **FBR has a track record of success both in reducing involvement with DCF and in keeping families together through intensive support**. FBR has demonstrated statistically significant reductions in both the rate at which children were removed from the home and the rate of re-referrals to DCF compared to treatment as usual.

PAY FOR SUCCESS OVERVIEW

Pay for Success (PFS) projects, also called Social Impact Bonds, combine nonprofit expertise, private sector funding, and rigorous evaluation to transform the way government and society respond to chronic social problems.



- **PFS is a public-private partnership which funds effective social services through a performance-based contract.** Many high-impact service providers do not have access to the funds they need to scale-up their services due to limited budgets. In addition, government support for social programs is not always tied to results.
- **PFS helps address these challenges by engaging private funders to cover the upfront costs of expanding high impact programs and by establishing performance goals that allow government, funders, and project partners to measure outcomes and track success over the long term.** If, following an independent evaluation, the program achieves predetermined outcomes that benefit society and generate value for government, then government repays the original investment. However, if the project does not achieve its target results, government pays nothing.
- **In the Connecticut Family Stability Pay for Success Project, Connecticut will repay funders only if FBR demonstrably produces positive outcomes and benefits for the State.** Specifically, the project will measure the impact on four outcomes: 1) prevented out-of-home placements; 2) prevented re-referrals to DCF; 3) reduction in substance use; and 4) successful FBR enrollment.
- Existing PFS projects in the United States have addressed job training and employment, reducing recidivism, juvenile justice, homelessness, and early childhood education. The Connecticut Family Stability Pay for Success Project is the first PFS project in Connecticut.

PROJECT PARTNERS

Connecticut Department of Children and Families

The Department of Children and Families (DCF) has a consolidated statutory mandate which includes child welfare, juvenile justice, children's behavioral health and prevention. DCF's mission is to work together with families and communities to keep children healthy, safe, smart and strong. Since 2011, under Commissioner Joette Katz's leadership, key reforms have included: maintaining and reunifying children with families; increasing placements with relatives or non-relative families with whom children have strong bonds; reducing the use of group or "congregate" settings which are not normative environments for children; and increasing community based services for families to keep more children at home when possible. As a result of these reforms, one of DCF's prioritized areas of need relates to parent and caregiver substance use, including community-based treatment services and in-home support, which will be widely expanded to communities in need of these services as a result of the Family Stability Pay for Success Project.

Family-Based Recovery, Yale Child Study Center

Family-Based Recovery (FBR) is an in-home parent-child attachment and substance use treatment program for mothers and fathers who are actively parenting a child younger than 36 months. The program aims to eliminate substance use among parents, prevent the risk of child neglect and disruption of primary relationships, and promote healthy child development. To qualify for FBR services, caregiver(s) demonstrate the need for substance use treatment by producing a positive toxicology screen or by self-report of use within 45 days of referral to the program. The mission of FBR is for children to be raised in substance-free, safe and stable homes with their parent(s). Community-based behavioral health providers deliver FBR within local communities, and FBR Services, operating within the Yale Child Study Center, oversees the implementation and delivery of FBR throughout Connecticut.

FBR Implementing Agents, Community Health Centers

In addition to Yale Child Study Center, FBR teams will be managed at three different local community health centers: United Child and Family Services, Community Mental Health Affiliates, and Community Health Resources. All three organizations were selected based on their track record of implementing FBR and their fit with project goals.

Social Finance

Social Finance is a 501(c)(3) nonprofit organization dedicated to mobilizing capital to drive social progress. Social Finance is committed to using PFS to tackle complex social challenges, facilitate greater access to services for vulnerable populations, and direct capital to evidence-based social services – all with the goal of measurably improving the lives of people most in need. Social Finance was one of the first organizations in the United States dedicated to providing PFS intermediary services. Social Finance has successfully designed and implemented all aspects of PFS projects, including: program design, evaluation structure, economic and financial modeling, and contract development. Social Finance's sister organization Social Finance UK pioneered the first Social Impact Bond in the world in 2010.

UConn Health

UConn Health is the independent evaluation entity responsible for implementing an outcome evaluation to measure the impact of the FBR programs. The UConn Health team is led by Dr. Jane Ungemack in collaboration with Dr. Kathryn Parr from the School of Social Work. The Project will be evaluated via Randomized Controlled Trial, the gold standard for a rigorous evaluation.

Harvard Kennedy School Government Performance Lab

The Harvard Kennedy School Government Performance Lab (GPL) conducts research on how governments can improve the results they achieve for their citizens. An important part of the GPL research model involves providing pro bono technical assistance to state and local governments on projects related to Pay for Success contracts and other outcomes-based procurement strategies. Formerly the Social Impact Bond Technical Assistance Lab (SIB Lab), the GPL has been at the forefront of the Pay for Success movement since 2012 and has advised 8 out of the 12 PFS projects launched in the United States to date. The GPL has been working with Connecticut since 2013, and has provided assistance to DCF through all stages of the project, including policy area selection, project design, procurement, data analysis strategy, and contract negotiations.

Jones Day

Jones Day is a law firm with more than 2,400 lawyers on five continents that is relentlessly focused on client service. Jones Day is serving as legal counsel to Social Finance in the Connecticut Family Stability Pay for Success project.

Project Funders

BNP Paribas

BNP Paribas is a leading bank in Europe with an international reach. It has a presence in 75 countries, with more than 189,000 employees, including more than 146,000 in Europe. The Group has key positions in its three main activities: Domestic Markets and International Financial Services (whose retail-banking networks and financial services are covered by Retail Banking & Services) and Corporate & Institutional Banking, which serves two client franchises: corporate clients and institutional investors. The Group helps all its clients (individuals, community associations, entrepreneurs, SMEs, corporate and institutional clients) to realise their projects through solutions spanning financing, investment, savings and protection insurance. In Europe, the Group has four domestic markets (Belgium, France, Italy and Luxembourg) and BNP Paribas Personal Finance is the leader in consumer lending. BNP Paribas is rolling out its integrated retail-banking model in Mediterranean countries, in Turkey, in Eastern Europe and a large network in the western part of the United States. In its Corporate & Institutional Banking and International Financial Services activities, BNP Paribas also enjoys top positions in Europe, a strong presence in the Americas as well as a solid and fast-growing business in Asia-Pacific.

QBE Insurance Group Limited

QBE Insurance Group, headquartered in Sydney, is one of the world's leading general insurance and reinsurance companies, employing around 14,500 people across 37 countries. QBE's strategic vision is to be the insurer that builds the strongest partnerships with customers. This helped to inspire QBE's activities in impact investment through Premiums4Good. Premiums4Good is a new initiative from QBE, using everyday insurance spending to grow awareness of impact investments by directing a percentage of everyday insurance premiums into investments with an additional social or environmental impact. By providing an institutional investor lens, QBE is helping to shape and develop the market.

Reinvestment Fund

Reinvestment Fund is a catalyst for change in low-income communities. We integrate data, policy and strategic investments to improve the quality of life in low-income neighborhoods. Using analytical and financial tools, we bring high-quality grocery stores, affordable housing, schools and health centers to the communities that need better access—creating anchors that attract investment over the long term and help families lead healthier, more productive lives. Learn more at reinvestment.com.

Doris Duke Charitable Foundation

The mission of the Doris Duke Charitable Foundation is to improve the quality of people's lives through grants supporting the performing arts, environmental conservation, medical research and child well-being, and through preservation of the cultural and environmental legacy of Doris Duke's properties.

Laura and John Arnold Foundation

LJAF is a private foundation that is working to address our nation's most pressing and persistent challenges using evidence-based, multi-disciplinary approaches. Its investments are currently focused on criminal justice, education, evidence-based policy and innovation, public accountability, and research integrity. LJAF has offices in Houston, New York City, and Washington, D.C.

Nonprofit Finance Fund

Nonprofit Finance Fund® (NFF®) unlocks the potential of mission-driven organizations through tailored investments, strategic advice and accessible insights. Founded in 1980, NFF helps organizations connect money to mission effectively, and supports innovations such as growth capital campaigns, cross-sector economic recovery initiatives and impact investing. A leading community development financial institution (CDFI) with over $250 million in assets under management, NFF has provided $620 million in financing and access to additional capital in support of over $2.3 billion in projects for thousands of organizations nationwide.

Additional support from two Family Foundations

SOCIAL FINANCE

USING PAY FOR SUCCESS TO COMBAT THE OPIOID CRISIS

MAY 2017

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10 Milk Street, Suite 1010, Boston, MA 02108

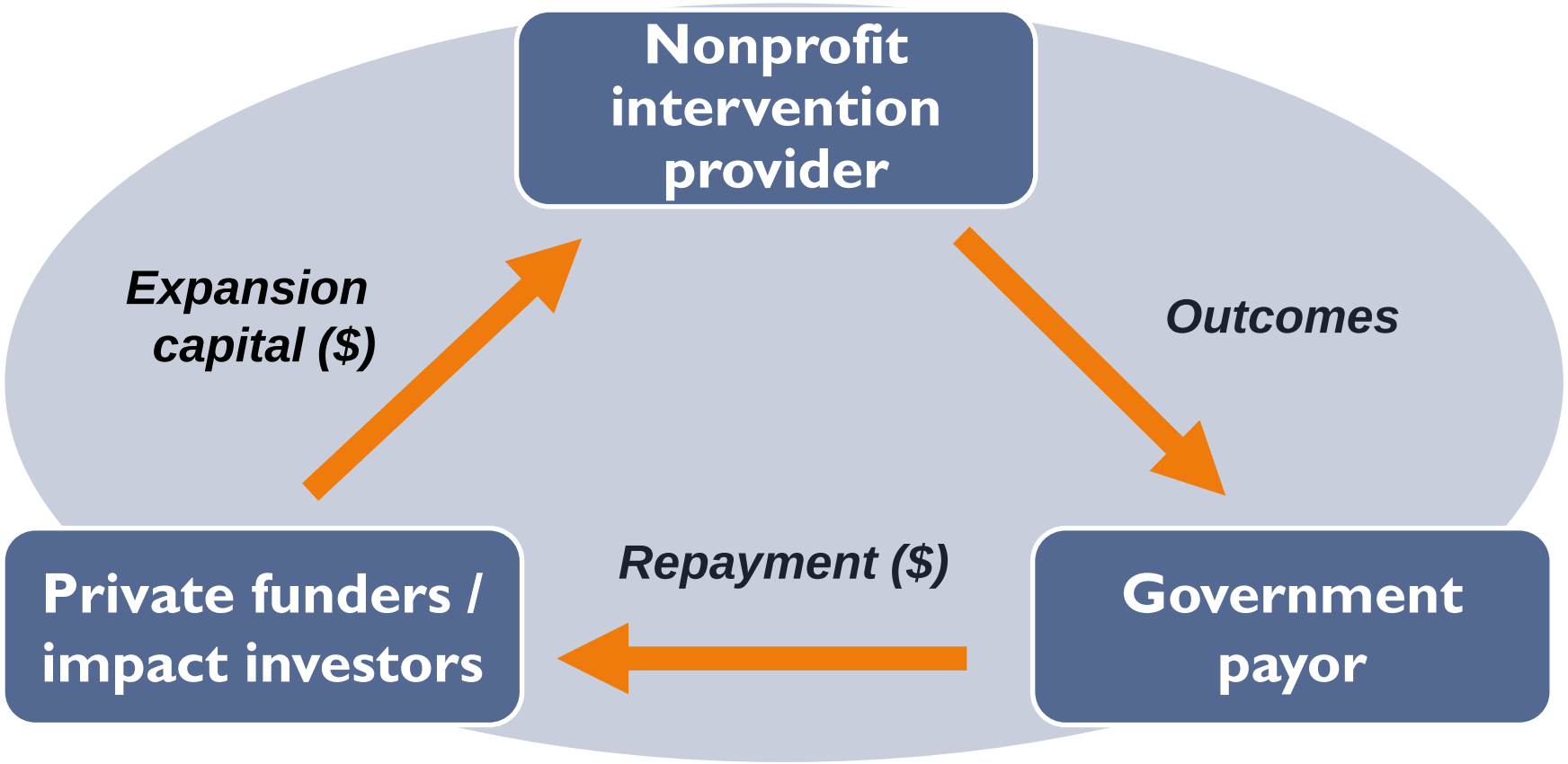
CONTENTS

1. Using Pay for Success to Combat the Opioid Crisis
2. **Spotlight:** CT Family Stability PFS Project
3. Appendix

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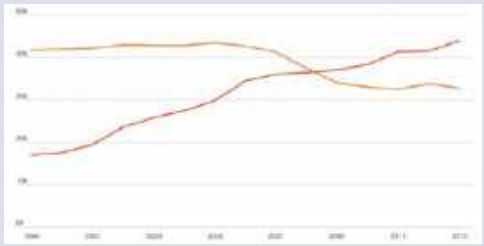
WHAT IS PAY FOR SUCCESS?



Pay for Success is about **measurably improving** the lives of **people most in need** by driving government resources toward **more effective programs**

USING PAY FOR SUCCESS TO COMBAT THE OPIOID CRISIS

The opioid crisis is expanding and pervasive



Drug overdose is the leading cause of injury death killing more people than car crashes

In 2013, 43,982 people died from drug overdoses; 32,719 died in car crashes

---

There are strong interventions available…

*E.g. medication-assisted treatment (MAT) is a broad term for **evidence-based interventions** that combine **counseling or behavioral therapy** with **medication to treat substance use disorders***

One promising example is Office-Based Opioid Treatment with Buprenorphine (OBOT-B)—a program with a track record of success in Massachusetts

---

…but scale of treatment and access to recovery supports are insufficient

*Expanded access to **office-based treatment programs** and increased **number of waivered practitioners** can address the scale of unmet need*

Access to recovery supports** for individuals that complete treatment **can sustain recovery** and **abstinence outcomes

* Pay for success can be a tool to **identify the most effective treatments** and **leverage private capital to address an unmet need for services**

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THE OPIOID CRISIS, AS PART OF BROADER SUBSTANCE USE ISSUE, INTERSECTS WITH COMPLEX SOCIAL CHALLENGES

	Criminal Justice	*Child Welfare*	*Housing and Homelessness*
Problem	Criminal offenders have rates of substance use and dependence that **are more than four times that of the general population.** More than 50% of inmates meet the criteria for drug use or dependence[1]	Across the country, parental substance use was identified as **a reason for removal in more than 30% of all child welfare cases**[2] In the State of Connecticut, this figure is in excess of 50%[3]	According to HUD 2016 Continuum of Care Homeless Report, **approximately 20% of homeless individuals** in the US **have a chronic substance use issue.**[4] This figure is likely underestimated, and increases significantly among high-acuity homeless populations
Potential Solutions	1. Expand **access to drug courts** to divert substance-involved detainees from incarceration 2. Expand **access to MAT in correctional settings** 3. Implement processes to ensure individuals **are enrolled in Medicaid upon release** so they can receive community-based treatment	1. Programs that deliver **in-home substance use treatments and parenting therapy** to reduce out-of-home placements and promote parental abstinence *Example: Family-Based Recovery, a program developed at the Yale Child Study Center, is serving families throughout the state of Connecticut that are impacted by parental substance use*	1. Permanent Supportive Housing is an evidence-based program that combines **subsidized housing with supportive services,** including **substance use and mental health services** • Supportive service providers can partner with certified community health centers to connect PSH participants to MAT

1. Expand access to MAT in a primary care (i.e. BMC OBOT-B model) or community-based setting. Make resources available to ease MAT training and certification for primary care physicians and incent full caseloads among certified physicians.

1. Belenko, Steven et al, "Treating Substance Use Disorders in the Criminal Justice System," *Curr Psychiatry Rep,* November 2013
2. Data provided by the national Adoption and Foster Care Analysis and Reporting System (AFCARS), as reported in the "Is U.S. Opioid Crisis Straining State Child Welfare Systems?" *YouthToday* 30 September 2016
3. Placement Data for Connecticut, *Center for State Child Welfare Data at Chapin Hall Center for Children,* August 2014
4. HUD 2016 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations Report

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AN OPIOID-FOCUSED PAY FOR SUCCESS PROJECT CAN…

1. *Provide **operating capital to expand evidence-based or innovative treatments** to address an unmet need…*
2. *Make **investments in technical assistance capacities**, such as data collection and quality assurance resources for model developers…*
3. *Measure treatment progress and performance **across outcomes that are meaningful to beneficiaries and government partners**…*
4. *Convene and foster **coordination** between **key public and private stakeholders across healthcare, criminal justice, and housing domains**…*
5. *Develop an **on-ramp for sustainable government funding streams**, should outcomes be achieved…*

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CONTENTS

1. Using Pay for Success to Combat the Opioid Crisis

2. **Spotlight:** CT Family Stability PFS Project

3. Appendix

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EXECUTIVE SUMMARY

Social Finance has launched a Pay for Success Project with the Connecticut Department of Children and Families (DCF)

- The Connecticut Family Stability Pay for Success Project will provide **Family Based Recovery (FBR)** to more than **500 vulnerable families** involved with the Connecticut Department of Children and Families (DCF)
- Pay for Success Projects are **public-private partnerships** where funders provide **upfront capital to scale prevention-focused interventions**
- **Government re-pays** the upfront investment plus a modest return only if the interventions **produce measurable results**
- The Project will **promote family stability and reduce out-of-home placements for children throughout Connecticut**

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THE FAMILY STABILITY CHALLENGE IN CONNECTICUT

A significant problem…

- **Substance Use as a Cause:** In 2013, more than 50% of all cases investigated by the CT Department of Children and Families had an indication of parental substance use (18,118 out of 36,131)[1]
- **Disproportionate Share of Out-of-Home Placements (OOHPs):** Connecticut data indicates that from 2000 to 2013, children age 0 to 1 comprised more than 21% of the total OOHPs[2] (6,722 out of 29,404); children age 1 to 5 made up an additional 32% (9,374 total)[1]
- **Experience Long Durations in Placements:** Over five years, children aged 0 – 5 in CT, with both a caregiver substance use indication and an OOHP, spend an average of 838 days in placement[3]

…with long-term consequences for the State of Connecticut

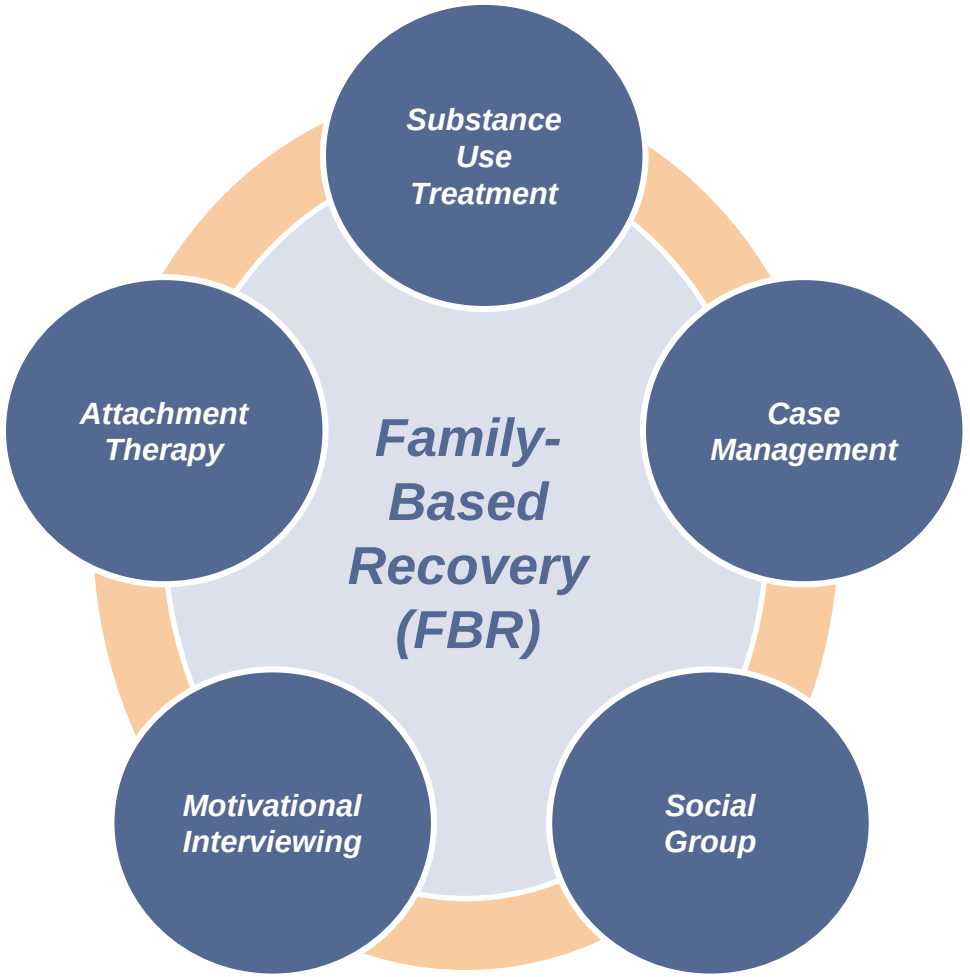
- **Continued Involvement with the Child Welfare System:** Over five years, children aged 0 – 5, with a DCF-reported parental indication of substance use, experience an average of 3.8 re-referrals to the agency[3]
- **High Cost of Child Maltreatment:** The Centers for Disease Control estimates that the lifetime cost associated with one incident of Child Maltreatment is more than $210,000 in healthcare, child welfare, criminal justice, and special education costs and productivity losses[4]
- **High Cost to the State of Connecticut:** The Department of Children and Families spends more than $601 million each year to address child abuse and neglect[5]

1. Placement Data for Connecticut, *Center for State Child Welfare Data at Chapin Hall Center for Children,* August 2014
2. "OOHP" refers to an Out of Home Placement; defined as a removal of a child from a caregiver's residence
3. Based on 4,489 CT DCF Cases in 2010; Analysis conducted by Harvard Social Impact Bond Technical Assistance Lab
4. Based on nationwide analysis of child welfare systems: Brown, Derek et al, "The economic burden of child maltreatment in the United States and implications for prevention," *Child Abuse and Neglect*, 2012
5. "Federal, State, and Local Spending to Address Child Abuse and Neglect in SFY2012," *Child Trends, Casey Family Programs, Annie E. Casey Foundation*, September 2014

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INTERVENTION: FAMILY-BASED RECOVERY (FBR)

FBR combines several evidence-based practices for strengthening families and treating substance use disorders



Intervention Details

- FBR was developed by clinicians at the **Yale Child Study Center** in 2006
- FBR is an **intensive, in-home parent-child attachment program** for families with young children at risk for: abuse and or neglect, poor development outcomes, and/or removal, due to parental substance use
- Families received **three home visits per week** (with a toxicology screen at each visit) for **an average of six months.**
- FBR uses **Reinforcement-Based Treatment** (RBT), an evidence-based substance use program originating from Johns Hopkins University
- FBR uses **Coordinated Intervention for Women and Infants (CIWI) theory**, attachment-based parent-child treatment developed at the
- An independent evaluation of FBR found the program **significantly reduced out-of-home placement and DCF re-referral rates**[1]

1. Josephine Hawke and Karen Steinberg, "Family-Based Recovery: Evaluation of Child Permanency Outcomes," *University of Connecticut Health Center, Department of Psychiatry,* October 2012

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PROJECT OVERVIEW

A collaboration among Connecticut, Social Finance Inc., and the Yale Child Study Center

Project Overview

- **Intervention:** Family-Based Recovery (developed at the Yale Child Study Center)
- **Outcomes:** 1) Child Removals from the Home; 2) Re-Referrals to DCF, 3) Caregiver Substance Dependence, and 4) Enrollment
- **Scale:** Expand service delivery ~**500 families over four years with children aged 0 - 6**
- **Geography:** New teams assigned **Region 2** (New Haven and Milford), **Region 3** (Willimantic, Middletown, Norwich), and **Region 5** (Waterbury, Torrington, and Danbury)
- **Innovation:** Expanded programming for **children aged 3 - 6** (current program serves aged 0 to 3)
- **Measurement**: **Randomized Controlled Trial** conducted by an **Independent Evaluator** at UCONN Health Center
- **Outcomes Payor:** The Connecticut Department of Children and Families (DCF)
- **Outcomes Schedule:** Five outcomes payments, beginning month 21, annually thereafter
- **Size:** ~$11.2 MM from lenders; capital drawn semi-annually over four years

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CONTENTS

1. Using Pay for Success to Combat the Opioid Crisis

2. **Spotlight:** CT Family Stability PFS Project

3. Appendix

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SPOTLIGHT ON A PROMISING MODEL: BMC OBOT-B PROGRAM

Pay for Success could be a tool to build on the early success of an office-based, nurse-care treatment model in Massachusetts

- Nurse Care Managers serve as **primary contact between patients and physicians**, allowing physicians to take on a larger patient load while still providing high quality care
- Within 3 years of implementation, the **number of waivered physicians** in community health centers (CHCs) increased from 24 to 114, representing a **375% increase**[1]
  - 2/3 of patients in OBOT-B **remain in care for more than 12 months**, with steady increases in treatment duration over time, demonstrating the efficacy and maturation of treatment
- Integration of the nurse care manager model into existing primary care facilities **expands access** and allows patients to receive treatment for opioid dependence in the same way they would other **chronic diseases**
- The program was piloted successfully at BMC and was then implemented at Massachusetts CHCs to further expand access
  - More than **8,000 patients have received treatment through OBOT B** in Massachusetts, and BMC's program is the largest primary care practice in the state, currently serving approximately **500 patients with opioid dependence at any given time**
- **BMC provides training and technical support to participating CHCs**, including quarterly trainings, consultations, and site visits

1. Colleen Labelle et al, "Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model," *Journal of Substance Use Treatment,* 17 June 2015.

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OPIOID TREATMENT MEDICATIONS

Common types of Medicaid-Assisted Treatment

Medication Name	Type	FDA Approval	Treatment and Access	Use
Methadone	Synthetic Slow-Acting Opioid Agonist, Schedule II	1947	• Reduces drug cravings during recovery, but can have some of the same side effects as heroin • Can only be dispensed by a SAMHSA-certified opioid treatment program that has been registered as a narcotic treatment program by the DEA—clients need to show up every day to get the medication	Adjustable once-a-day dose
Buprenorphine	Partial Opioid Agonist, Schedule III	2002	• Reduces withdrawal systems and cravings • Office-based use limited to physicians who complete special training, receive SAMHSA and DEA waiver approvals (Waiver allows for prescription to 100 patients) • Typically more expensive than Methadone	Adjustable-dose tablet or monthly injection
Naltrexone	Opioid Antagonist	1984 (oral), 2010 (injectable-No generic available)	• Blocks the effects of opiates for 24-30 hours (oral) or up to 30 days (extended-release)—will also block pain relief effects • Can be prescribed by a licensed health care professional	Oral or Injected (once monthly if Vivitrol)
Naloxone or Nalorphine	Antidote/ Opioid Antagonist	1971, 2015 (Narcan nasal spray)	• Used to treat a narcotic overdose in an emergency situation • Policy innovations involve increased availability to friends and family (without a prescription) as a lifesaving device	Injected into a muscle or into a vein through an IV, or via nasal spray
Buprenorphine -Naloxone	Partial Opioid Agonist/Antagonist, Schedule III	2002	• Combination medication available with same limitations as Buprenorphine, but reduces the risk of addiction or misuse due to the presence of naloxone	Typically in sublingual tablet form

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FOUR APPROACHES TO ADDRESSING THE OPIOID CRISIS

Addressing the opioid crisis requires a full spectrum of interventions; from prevention to enforcement

Most relevant for Pay for Success

Prevention:

Increasing awareness to better educate the public of the inherent risks involved in using heroin and prescription opioids, and taking advantage of technological advances available to deter the abuse of prescription drugs and prevent addiction

Expanding Access:

Treatment:

Recognizing the critical need for expanded and improved insurance coverage, and enhancing access to all forms of effective treatment in order to help individuals return to stable and productive lives

Recovery:

Providing the proper supports, such as safe environments, stable employment, and opportunities to participate in diversion programs that avoid incarceration in order to facilitate successful recoveries from addiction

Enforcement:

Implementing criminal justice reforms that give law enforcement the necessary tools to disrupt the supply of heroin and stop the diversion of opiate prescription medications within the state.

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OUTCOMES

Adherence to medication-assisted treatment produces positive outcomes across several issue areas

 **Engagement Outcomes**	• Access to MAT (i.e. did the individual get the treatment) • Completion of recommended treatment • Continuity of treatment
 **Health Outcomes**	• Opioid abstinence (urinalysis testing) • Overdose avoidance • Reduction in ED visits • Reduction in hospitalizations • Reduction in Hepatitis C and HIV infections (comorbidities)
 **Criminal Justice Outcomes**	• Avoidance of arrests • Avoidance of incarcerations • Avoidance of jail bed days
 **Stability Outcomes**	• Employment attainment • Employment continuity • Family functionality and stability

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Scott.A.Milkey

From: Kidwell, Jenny <jenny.kidwell@courts.IN.gov>
Sent: Friday, June 02, 2017 1:41 PM
To: Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Carter, Robert (Rob);Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: Justice Reinvestment Advisory Council Meeting - Friday, June 9, 2017 @ 9:30 a.m.-11:30 a.m.
Attachments: Justice Reinvestment Advisory Council agenda 6-9-17.docx

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

The next meeting of the Justice Reinvestment Advisory Council will be held on Friday, June 9, 2017, at the **Indiana Government South, Conference Room A**, Indianapolis, Indiana. Attached, you will find the proposed agenda.

The meeting will be held from 9:30 a.m. to 11:30 a.m. Please use the highlighted link below to advise us of your attendance. Thank you.

Register now for 6/9/2017 Meeting

Jenny Kidwell
Indiana Office of Court Services
30 S. Meridian Street, Suite 900
Indianapolis, IN 46204
317-232-1313

Justice Reinvestment Advisory Council

June 9, 2017

9:30 a.m.-11:30 a.m.

Agenda

1. Welcome and introductions
2. Approval of Minutes of the April 7, 2017 meeting
3. DOC Population report
4. Update from DOC—Grant status
5. Grant audit discussion: scope; preparation/education
6. Update from DMHA
7. Summer study committee discussion; proposed legislation
8. Other Business
9. Next meeting—July?

Scott.A.Milkey

From: Kidwell, Jenny <jenny.kidwell@courts.IN.gov>
Sent: Thursday, May 18, 2017 11:48 AM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Carter, Robert (Rob);Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: JRAC meeting on 5/19/17 Canceled

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Confirming the previously scheduled Justice Reinvestment Advisory Council meeting on Friday, May 19, 2017 has been **canceled**. The next meeting is scheduled for June 9th. Location and time will be sent soon.

Jenny Kidwell
Indiana Office of Court Services
30 S. Meridian Street, Suite 900
Indianapolis, IN 46204
317-232-1313

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Tuesday, May 16, 2017 3:10 PM
To: McClelland, Jim
Subject: Re: INARMS

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Ok thanks.

Just let me know.

Steve
Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On May 16, 2017, at 2:06 PM, McClelland, Jim <JMcClelland@gov.IN.gov> wrote:

Steve, I'm waiting for confirmation on the date of another September event where I've agreed to be the speaker. When I have that confirmation I'll let you know if I can do the INARMS event.

Thanks for the invitation.

Jim

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Sunday, May 14, 2017 6:37 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Subject: Re: INARMS

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Jim—

I gave you the wrong date below, sorry. It is September 12/13 at the Marriott East.

lmk

Thanks

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<image001.png>

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On May 14, 2017, at 6:24 PM, Stephen C McCaffrey <smccaffrey@mhai.net> wrote:

Hi Jim—

I enjoyed your presentation at the Council meeting last week.

I don't know if you are familiar with the INARMs conference, but it is a statewide addictions conference initiated by DMHA and now organized by MHAI. This year it will be held on September 26th and 27th at the Marriott East Conference Center.

This is typically a crowd of 300+ of addiction/mental health providers, professionals, and people in recovery with national speakers. I think it would be an audience/event that you might want to speak to, if you are available.

Let me know if you are interested/available.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<unknown.png>

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1431 North Delaware Street
Indianapolis, Indiana, 46202

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Scott.A.Milkey

From: McClelland, Jim
Sent: Tuesday, May 16, 2017 2:07 PM
To: Stephen C McCaffrey
Subject: RE: INARMS

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Subject: Re: INARMS

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<unknown.png>

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Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Sunday, May 14, 2017 6:37 PM
To: McClelland, Jim
Subject: Re: INARMS

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Jim—

I gave you the wrong date below, sorry. It is September 12/13 at the Marriott East.

lmk

Thanks

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On May 14, 2017, at 6:24 PM, Stephen C McCaffrey <smccaffrey@mhai.net> wrote:

Hi Jim—

I enjoyed your presentation at the Council meeting last week.

I don't know if you are familiar with the INARMs conference, but it is a statewide addictions conference initiated by DMHA and now organized by MHAI. This year it will be held on September 26th and 27th at the Marriott East Conference Center.

This is typically a crowd of 300+ of addiction/mental health providers, professionals, and people in recovery with national speakers. I think it would be an audience/event that you might want to speak to, if you are available.

Let me know if you are interested/available.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<unknown.png>

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Sunday, May 14, 2017 6:25 PM
To: McClelland, Jim
Subject: INARMS

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Hi Jim—

I enjoyed your presentation at the Council meeting last week.

I don't know if you are familiar with the INARMs conference, but it is a statewide addictions conference initiated by DMHA and now organized by MHAI. This year it will be held on September 26th and 27th at the Marriott East Conference Center.

This is typically a crowd of 300+ of addiction/mental health providers, professionals, and people in recovery with national speakers. I think it would be an audience/event that you might want to speak to, if you are available.

Let me know if you are interested/available.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
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smccaffrey@mhai.net

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Scott.A.Milkey

From: Moore, Kevin B
Sent: Wednesday, May 10, 2017 5:00 PM
To: McClelland, Jim;Huntsinger, Douglas;Walthall, Jennifer
Subject: FW: 2016 Epi Report and Drug Facts
Attachments: Substance Abuse Trends in Indiana - A 10-Year Perspective.pdf

Here is a new report from the IU Center for Health Policy. While the data is not necessarily new, the policy recommendations are good ones that support the strategic plan of the Commission.

Kevin

From: Greene, Marion S [mailto:msgreene@iu.edu]
Sent: Friday, May 05, 2017 11:53 AM
To: Hubbard, Leone <Leone.Hubbard@fssa.IN.gov>
Cc: McCaffrey, Steve <smccaffrey@mhai.net>; Moore, Kevin B <Kevin.Moore@fssa.IN.gov>
Subject: RE: 2016 Epi Report and Drug Facts

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Leone,

In addition to the Epi Report, we also published an issue brief on 10-year trends of substance abuse in Indiana. Feel free to share with MHAPAC members.

Thanks,
Marion

Marion S. Greene, MPH, PhD(c)
Public Health Research Analyst
Center for Health Policy
IU Richard M. Fairbanks School of Public Health at IUPUI
1050 Wishard Blvd. / RG 5143
Indianapolis, IN 46202
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http://www.healthpolicy.iupui.edu/
http://pbhealth.iupui.edu/

From: Greene, Marion S
Sent: Friday, May 5, 2017 11:30 AM
To: Adams, Elizabeth Alice <adamsela@iupui.edu>; Ailes, Dennis <Dennis.Ailes@fssa.in.gov>; Anderson, Kathleen <kathleen@indiana.edu>; Balio, Casey <cbalio@umail.iu.edu>; Bozell, David <David.Bozell@fssa.in.gov>; Carrico, Sonya <scarrico@cji.in.gov>; Dotson, Kayley <KDotson@isdh.IN.gov>; Ecklor, Bethany <Bethany.Ecklor@fssa.IN.gov>; Fernandes, Taya <Taya.Fernandes@atg.in.gov>; Garner, Aaron <agarner@idoc.in.gov>; Garret, Mandy <agarrett@pla.in.gov>; Greene, Marion S <msgreene@iu.edu>; Gries, Julie <Julie.Gries@fssa.in.gov>; Hemze-Mills, Leah <leah.hemze-mills@dcs.in.gov>; Keen, Mark <MKeen1@doe.in.gov>; Kenny, Rachel <RKenny@isdh.IN.gov>; Kooreman, Harold Edward <hkoorema@iu.edu>; Landis, Winnie <'winpharm@[redacted]'>; Mangrum, Vera <Vera.Mangrum@fssa.IN.gov>; Manlove, Kim <kmanlove@mhai.net>; Mcclendon, Michaelangelo <michaelangelo.mcclendon@fssa.in.gov>; Meade, Magan <MMeade@isdh.IN.gov>; Milroy, Lauren M

<LMilroy@isdh.IN.gov>; Olcott, Courtney Owyn <coolcott@indiana.edu>; Omenka, Ogbonnaya Isaac <oomenka@iupui.edu>; Pontones, Pam <ppontones@isdh.IN.gov>; Ross, Michael <Michael.Ross@fssa.IN.gov>; Rupp, Katelin <KaRupp@isdh.IN.gov>; Samanic, Claudine <CSamanic@isdh.IN.gov>; Seitz-De-Martinez, Barbara Joan <seitzb@indiana.edu>; Shue, Christian B., D.O. (IU Health) <cbshue@IUHealth.org>; Smith, Lynn S <Lynn.Smith@fssa.in.gov>; Steiner, Kerry <KSteiner@inaiac.in.gov>; Strittmatter, Matt <MPStrittmatter@atc.IN.gov>; Toles, Mike <MToles@isp.IN.gov>; Trout, Vickie <Vickie.Trout@fssa.IN.gov>; Watson, Dennis P <dpwatson@iu.edu>
Cc: Kevin Moore <Kevin.Moore@fssa.IN.gov>; Blackmon, Sirrilla (Sirrilla.Blackmon@fssa.IN.gov) <Sirrilla.Blackmon@fssa.IN.gov>; Cook, Terry E <Terry.Cook@fssa.IN.gov>; Hubbard, Leone <Leone.Hubbard@fssa.in.gov>
Subject: 2016 Epi Report and Drug Facts

Dear SEOW,

The 2016 Epi Report and the drug fact sheets are final and can be shared. Thank you for your support.

Sincerely,
Marion

Marion S. Greene, MPH, PhD(c)
Public Health Research Analyst
Center for Health Policy
IU Richard M. Fairbanks School of Public Health at IUPUI
1050 Wishard Blvd. / RG 5143
Indianapolis, IN 46202
(317) 278-3247
msgreene@iu.edu
http://www.healthpolicy.iupui.edu/
http://pbhealth.iupui.edu/

From: Greene, Marion S
Sent: Thursday, April 27, 2017 5:26 PM
To: Kevin Moore <Kevin.Moore@fssa.IN.gov>; Blackmon, Sirrilla (Sirrilla.Blackmon@fssa.IN.gov) <Sirrilla.Blackmon@fssa.IN.gov>; Cook, Terry E <Terry.Cook@fssa.IN.gov>; Adams, Elizabeth Alice <adamsela@iupui.edu>; Ailes, Dennis <Dennis.Ailes@fssa.in.gov>; Anderson, Kathleen <kathleen@indiana.edu>; Balio, Casey <cbalio@umail.iu.edu>; Bozell, David <David.Bozell@fssa.in.gov>; Carrico, Sonya <scarrico@cji.in.gov>; Dotson, Kayley <KDotson@isdh.IN.gov>; Ecklor, Bethany <Bethany.Ecklor@fssa.IN.gov>; Fernandes, Taya <Taya.Fernandes@atg.in.gov>; Garner, Aaron <agarner@idoc.in.gov>; Garret, Mandy <agarrett@pla.in.gov>; Greene, Marion S <msgreene@iu.edu>; Gries, Julie <Julie.Gries@fssa.in.gov>; Hemze-Mills, Leah <leah.hemze-mills@dcs.in.gov>; Keen, Mark <MKeen1@doe.in.gov>; Kenny, Rachel <RKenny@isdh.IN.gov>; Kooreman, Harold Edward <hkoorema@iu.edu>; Landis, Winnie <'winpharm@[redacted]'>; Mangrum, Vera <Vera.Mangrum@fssa.IN.gov>; Manlove, Kim <kmanlove@mhai.net>; Mcclendon, Michaelangelo <michaelangelo.mcclendon@fssa.in.gov>; Meade, Magan <MMeade@isdh.IN.gov>; Milroy, Lauren M <LMilroy@isdh.IN.gov>; Olcott, Courtney Owyn <coolcott@indiana.edu>; Omenka, Ogbonnaya Isaac <oomenka@iupui.edu>; Pontones, Pam <ppontones@isdh.IN.gov>; Ross, Michael <Michael.Ross@fssa.IN.gov>; Rupp, Katelin <KaRupp@isdh.IN.gov>; Samanic, Claudine <CSamanic@isdh.IN.gov>; Seitz-De-Martinez, Barbara Joan <seitzb@indiana.edu>; Shue, Christian B., D.O. (IU Health) <cbshue@IUHealth.org>; Smith, Lynn S <Lynn.Smith@fssa.in.gov>; Steiner, Kerry <KSteiner@inaiac.in.gov>; Strittmatter, Matt <MPStrittmatter@atc.IN.gov>; Toles, Mike <MToles@isp.IN.gov>; Trout, Vickie <Vickie.Trout@fssa.IN.gov>; Watson, Dennis P <dpwatson@iu.edu>
Subject: 2016 Epi Report (embargoed until 5/3)

Dear SEOW,

The 2016 Epidemiological Profile is completed (see attachment). Our website is currently under construction, but you can also access the document at 72786gG8qg7 (password is [redacted].

Thank you for all the feedback on the draft chapters. Your comments and suggestions have been incorporated in the final version. Please review the document one last time and let me know by May 3rd if you have any reservations. Unless I hear from you to the contrary, we will officially release the report on May 3rd.

I want to thank you for all your support.

Sincerely,
Marion

Marion S. Greene, MPH, PhD(c)
Public Health Research Analyst
Center for Health Policy
IU Richard M. Fairbanks School of Public Health at IUPUI
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IUPUI
CENTER FOR HEALTH POLICY
RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH
Indiana University–Purdue University Indianapolis

Substance Abuse Trends in Indiana: A 10-Year Perspective

Substance use is a significant public health problem in the United States. National statistics show that in 2015, over 139 million U.S. residents ages 12 and older reported drinking alcohol in the past month and nearly half of them (67 million) engaged in binge drinking; 64 million Americans consumed tobacco products, predominantly cigarettes; and 27 million Americans used some type of illicit drug, including nonmedical use of prescription drugs [1]. Nationally, consumption of some substances (e.g., tobacco, alcohol, and cocaine) decreased over the past 10 years, while use of other drugs (e.g., marijuana, heroin, and prescription pain relievers) has become increasingly more prevalent [1]. Substance use in Indiana has mirrored national trends to some extent; however, the state also has its own unique set of challenges. Indiana counted 1,245 fatal drug overdoses in 2015, representing an age-adjusted mortality rate of 19.5 deaths per 100,000 Hoosiers, placing the state 17th in the nation for drug overdose fatalities [2]. Furthermore, Indiana ranks among the states with the highest rates of tobacco use [3]. Tobacco use among expectant mothers is of particular concern, as nearly 15% of Hoosier women smoke during pregnancy [4].

Excessive use of alcohol and drugs has been linked to increased morbidity and mortality from cardiovascular conditions; injuries and motor vehicle crashes; sexually transmitted and blood-borne illnesses, including HIV/AIDS and hepatitis B and C, resulting from risky sexual behaviors and/or injection drug use; pregnancy complications and neonatal abstinence syndrome (NAS); and drug overdoses [5, 6]. Additionally, substance use can lead to harmful social and legal consequences, such as family disruptions, financial problems, lost productivity, failure in school or at work, domestic violence, child abuse, and crime [5]. The National Institute of Drug Abuse (NIDA) estimates that the total cost of substance abuse in the nation, including costs related to lost productivity, health, and crime, exceed $700 billion annually [7].

Most Commonly Abused Substances

The mind-altering substances most frequently abused include alcohol, tobacco (nicotine), marijuana, opioids (prescription pain relievers and heroin), cocaine, and methamphetamine.

SUMMARY

Over the past 10 years

- Alcohol and tobacco continue to be the most widely used substances.
- Indiana's high smoking prevalence, particularly among expectant mothers, led the state to identify tobacco as one of its substance abuse prevention priorities.
- The opioid epidemic involving both prescription pain relievers and heroin has impacted Indiana tremendously, leading to significant increases in addiction treatment admissions and overdose deaths attributable to these drugs.
- The economic impact of substance abuse is considerable. In Indiana, the estimated annual costs attributable to tobacco use were approximately $6.8 billion; alcohol consumption exceeded $4.4 billion; and overdose deaths accrued to $1.4 billion.
- Policy recommendations to address substance abuse include
  - o Expanding access to treatment, especially MAT programs
  - o Incorporating a recovery-based framework
  - o Promoting the use of naloxone
  - o Preventing transmission of HIV and hepatitis C among injection drug users
  - o Implementing effective youth prevention programs
  - o Monitoring substance abuse in the state

Alcohol is the most commonly used and abused substance throughout the United States and excessive consumption can affect the health and wellbeing of those using it [8]. Alcohol is a central nervous system depressant and can impact an individual in as little as 10 minutes. In small amounts, alcohol is typically not a health concern, but regular and excessive consumption can have immediate and long-term effects. Short-term effects of alcohol include mood changes, impaired coordination, and slurred speech. In large amounts, alcohol consumption can cause breathing problems, coma, or death [8]. Regular consumption for long periods of time can impact liver, pancreas, and heart health as well as increase the risk for certain types of cancer [9]. In addition to affecting users, alcohol can also affect those around them through violence, alcohol-related driving accidents, and risks to an unborn infant [8]. The effects of alcohol may vary depending on the individual's age, family history of alcohol use, and the frequency of consumption [8].

Tobacco comes in a variety of forms and can be smoked, chewed, or sniffed. Though cigarettes continue to be the most widely used tobacco product in the nation, electronic cigarettes (e-cigarettes) have become more and more popular, especially among youth. Tobacco contains nicotine, a highly addictive substance that causes the body to release epinephrine (adrenaline). Epinephrine has a stimulating effect on the central nervous system, raising blood pressure, respiration, and heart rate. Smoking has long-lasting extensive health impacts, often leading to lung disease, including chronic bronchitis, emphysema, and lung cancer, but has also been linked to several types of cancer. Individuals who smoke are at an increased risk for heart disease, which can lead to heart attack and stroke. [10]. In the United States, tobacco is responsible for more than 480,000 preventable deaths annually [11]. People exposed to secondhand smoke, i.e., the smoke produced from lit tobacco products and exhaled by a smoker, are at increased risk for lung cancer, heart disease, and respiratory infections as well. A particularly vulnerable population is infants born to women who smoked during pregnancy. Smoking during pregnancy increases the risk of stillbirth as well as pre-term delivery and low neonatal birth weight, both of which can adversely affect a child's health later in life [12].

Marijuana is derived from the Cannabis sativa plant. Its main psychoactive compound is delta-9-tetrahydrocannabinol (THC) [13]. Marijuana can be inhaled or ingested, frequently causing the user to experience an altered state of mind, distorted sense of time, mood changes, impaired body movement, hallucinations, paranoia, and impaired memory shortly after consumption. Long-term impacts of marijuana use include breathing problems, poorer physical and mental health, and among individuals who regularly used marijuana in their teenage years, decreases in IQ in early adulthood [13]. Some studies suggest a connection between marijuana use and depression and anxiety in teens [14-16], though results are mixed [17, 18]. As of 2016, 28 states have legalized marijuana for medical use [19] and eight for recreational use [20]. With the increasing public support for marijuana, it has become the most widely used illicit substance in the country with 22.2 million current users [1].

Prescription opioids (pain relievers) are pharmaceutical drugs that are typically prescribed by a healthcare professional to treat acute or chronic pain conditions. Opioids bind to specific opioid receptors in the body, generating pain relief and often, especially in higher doses, a feeling of euphoria [21]. Due to the addictive nature of these drugs, prescription opioids are frequently misused. The majority of individuals using prescription opioids for nonmedical purposes receive them from a friend or relative [22]. Prescription pain relievers have similar characteristics and effects as heroin and there is evidence that any opioid use is a risk factor for future heroin use; though only a subset of those misusing prescription drugs follow this course [23]. Substance use disorders related to prescription opioids affected 1.9 million Americans age 12 and over in 2014 [1].

Heroin is a highly addictive semi-synthetic opioid made from the resin of the opium poppy. The drug can be injected, inhaled, or smoked. Once heroin enters the brain, it is converted into morphine, which rapidly binds to opioid receptors, leading to euphoria [24]. Because both heroin and prescription pain relievers are opioid-based substances, they share many chemical properties and physical effects. While some research shows that prescription drug users may be at higher risk of future heroin use, only a subset of those having used prescription drugs progress to heroin [23]. Heroin use may result in a variety of serious health conditions. Repeated or chronic use can lead to addiction, increased risk for infectious diseases including HIV/AIDS and hepatitis C, and drug overdoses. Maternal heroin use during pregnancy may cause low birth weight in babies and can lead to NAS [24]. The recent national increase in heroin use has been attributed, at least in part, to heroin becoming increasingly available at a low cost [23]. According to the CDC, the level of use of prescription and non-prescription opioids across the country has reached epidemic proportions.

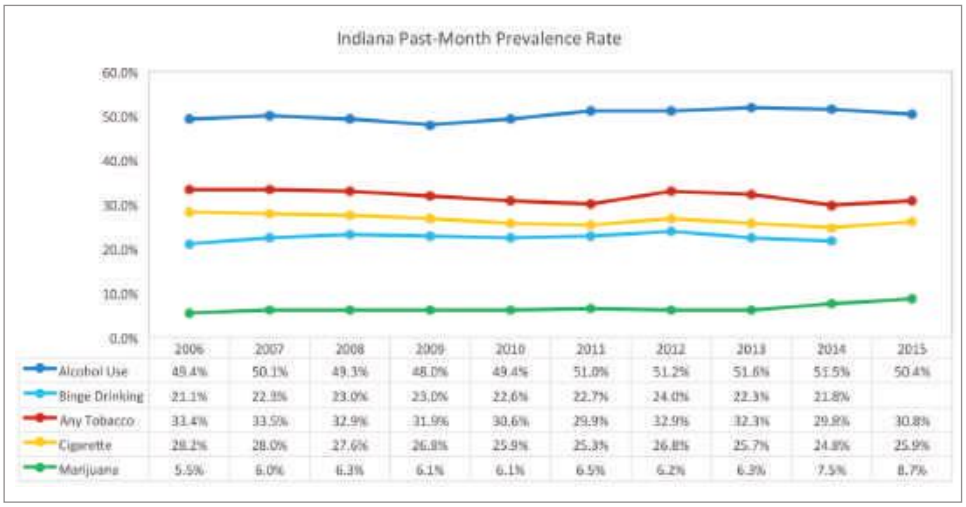
Cocaine is a highly addictive stimulant derived from the South American coca plant and is generally snorted or injected. Crack is a form of cocaine made by crystallizing cocaine. Crack gets its name from the crackling sounds which result when crystals are heated, allowing their vapors to be inhaled [25]. When consumed, cocaine causes the brain to release dopamine, a neurotransmitter responsible for pleasure and movement. Over time, cocaine affects the brain's ability to recycle dopamine, requiring increasingly higher doses of the drug to achieve the same effect, leading to a dangerous cycle of addiction. Although injecting cocaine heightens one's risk of contracting HIV and hepatitis C through needle sharing, using cocaine through any route of administration increases one's likelihood of engaging in high-risk sexual behaviors, which are also linked to the transmission of both diseases [25].

Methamphetamine (meth) is a synthetic stimulant that can be smoked, snorted, or dissolved and injected [26]. Like cocaine, methamphetamine causes the brain to release dopamine creating a sense of pleasure after consumption. The use of methamphetamine can also lead users to experience paranoia, delusions, and hallucinations. Long-term use may result in emotional and cognitive problems, extreme weight loss, dental problems ("meth mouth"), and skin sores. When injected, methamphetamine use increases the individual's risk for HIV and hepatitis B and C through needle-sharing; however, the use of meth by any method may heighten the probability for acquiring such infectious diseases [26]. While a pharmaceutical form of methamphetamine is available by prescription, meth is usually manufactured illegally in clandestine labs. In 2014, Indiana reported the most clandestine meth lab seizures in the country. Of the 9,338 clandestine labs seized in the United States, 16% (1,471 incidents) occurred in Indiana [27]. However, the number of lab seizures in Indiana has dropped since then to 943 in 2016 [28].

10-Year Trends in Substance Use in Indiana

In the following section, we present findings on the use and abuse of specific substances over a 10-year time span for Indiana and the nation. The first part examines substance use within the general population; i.e., prevalence rate estimates based on findings from the National Survey on Drug Use and Health (NSDUH) [29]. The second part discusses drug use within the substance abuse treatment population. It reflects the 10-year trends of primary drugs (or drugs of choice) reported at the time of treatment admission; based on information from the Treatment Episode Data System (TEDS) [30].

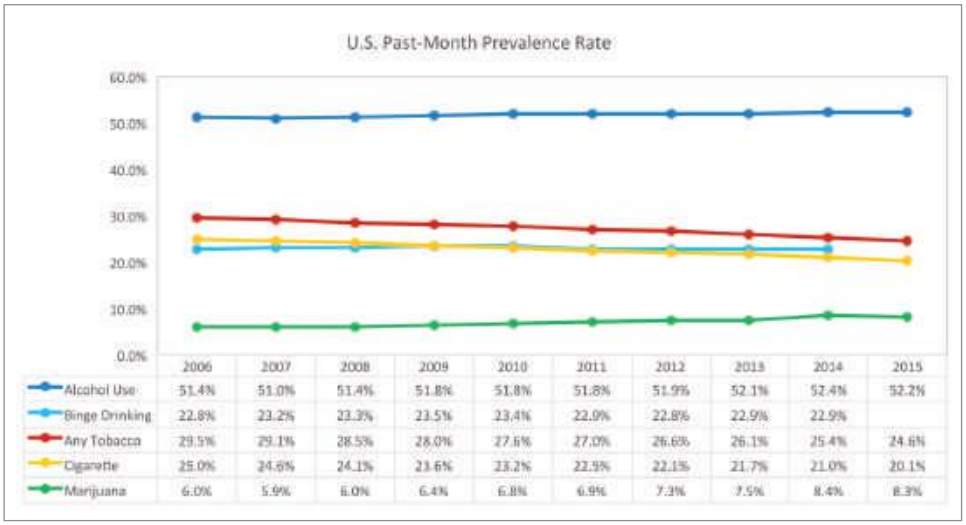
Figure 1A. Percentage of Indiana residents ages 12 and older engaging in past-month use of alcohol, tobacco, and marijuana (NSDUH, 2006-2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Alcohol Use	49.4%	50.1%	49.3%	48.0%	49.4%	51.0%	51.2%	51.6%	51.5%	50.4%
Binge Drinking	21.1%	22.3%	23.0%	23.0%	22.6%	22.7%	24.0%	22.3%	21.8%	
Any Tobacco	33.4%	33.5%	32.9%	31.9%	30.6%	29.9%	32.9%	32.3%	29.8%	30.8%
Cigarette	28.2%	28.0%	27.6%	26.8%	25.9%	25.3%	26.8%	25.7%	24.8%	25.9%
Marijuana	5.5%	6.0%	6.3%	6.1%	6.1%	6.5%	6.2%	6.3%	7.5%	8.7%

Note: In 2015, SAMHSA modified the definition of binge drinking for women from "having five or more drinks on one occasion" to "having four or more drinks." As a result of these modifications, 2015 data on binge drinking cannot be compared to NSDUH estimates from previous years.
Source: SAMHSA, 2017

Figure 1B. Percentage of U.S. residents ages 12 and older engaging in past-month use of alcohol, tobacco, and marijuana (NSDUH, 2006-2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Alcohol Use	51.4%	51.0%	51.4%	51.8%	51.8%	51.8%	51.9%	52.1%	52.4%	52.2%
Binge Drinking	22.8%	23.2%	23.3%	23.5%	23.4%	22.9%	22.8%	22.9%	22.9%	
Any Tobacco	29.5%	29.1%	28.5%	28.0%	27.6%	27.0%	26.6%	26.1%	25.4%	24.6%
Cigarette	25.0%	24.6%	24.1%	23.6%	23.2%	22.5%	22.1%	21.7%	21.0%	20.1%
Marijuana	6.0%	5.9%	6.0%	6.4%	6.8%	6.9%	7.3%	7.5%	8.4%	8.3%

Note: In 2015, SAMHSA modified the definition of binge drinking for women from "having five or more drinks on one occasion" to "having four or more drinks." As a result of these modifications, 2015 data on binge drinking cannot be compared to NSDUH estimates from previous years.
Source: SAMHSA, 2017

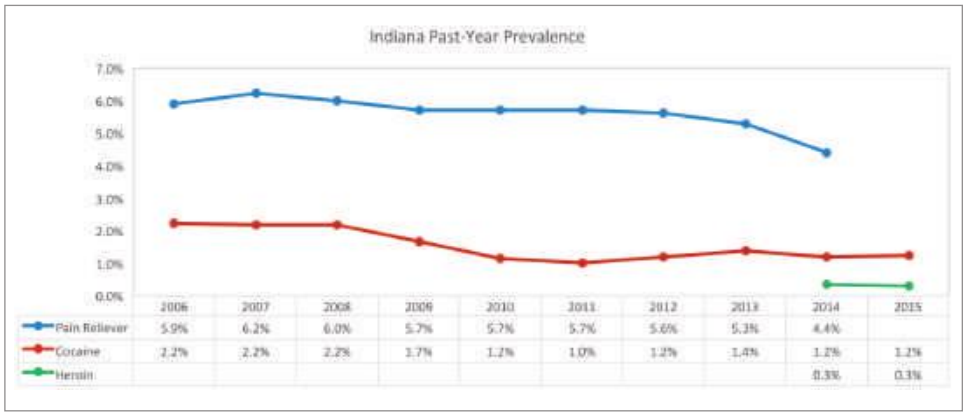
Substance Use in the General Population (NSDUH)

Alcohol was the most widely used substance in Indiana. About half of all Hoosiers ages 12 and older drank alcohol in the past month and almost one-fourth engaged in binge drinking. Tobacco consumption was also high. Nearly one-third of Indiana residents reported using tobacco (primarily cigarettes) in the past month. Among illicit drugs, marijuana was the drug most commonly used (see Figure 1A) [29].

Over the past 10 years, prevalence rates were similar in Indiana and the United States for most substances, including past-month use of alcohol and marijuana as well as binge drinking. However, Indiana exhibited higher rates of tobacco use (see Figures 1A and 1B) [29]. Indiana's high smoking prevalence, particularly among expectant mothers [4], led the state to identify tobacco as one of its substance abuse prevention priorities [31].

For substances that are less commonly used in the general population, NSDUH provides state-level estimates of past-year use. This includes past-year prevalence rates for cocaine, prescription pain reliever (opioid analgesic), and, since 2014, heroin abuse (state-level prevalence data for methamphetamine are currently not available). Among these three drug categories, prescription pain relievers were the most frequently abused, followed by cocaine, and heroin respectively (see Figures 2A and 2B). Indiana and U.S. rates were similar. [29].

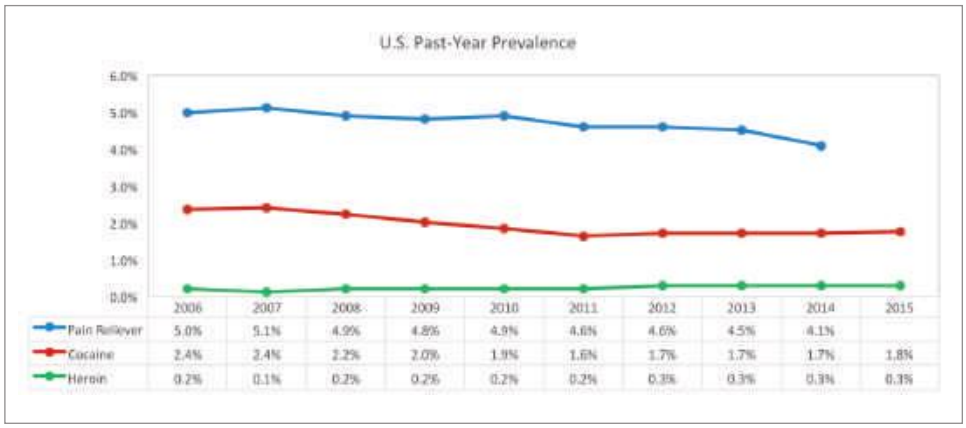
Figure 2A. Percentage of Indiana residents ages 12 and older engaging in past-year use of cocaine, prescription pain relievers, and heroin (NSDUH, 2006-2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Pain Reliever	5.9%	6.2%	6.0%	5.7%	5.7%	5.7%	5.6%	5.3%	4.4%	
Cocaine	2.2%	2.2%	2.2%	1.7%	1.2%	1.0%	1.2%	1.4%	1.2%	1.2%
Heroin									0.3%	0.3%

Note: In 2015, SAMHSA completely revised the prescription drug module for pain relievers. As a result of these modifications, 2015 data on prescription pain reliever misuse cannot be compared to NSDUH estimates from previous years. Also, state-level estimates for heroin use did not become available until 2014.
Source: SAMHSA, 2017

Figure 2B. Percentage of U.S. residents ages 12 and older engaging in past-year use of cocaine, prescription pain relievers, and heroin (NSDUH, 2006-2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Pain Reliever	5.0%	5.1%	4.9%	4.8%	4.9%	4.6%	4.6%	4.5%	4.1%	
Cocaine	2.4%	2.4%	2.2%	2.0%	1.9%	1.6%	1.7%	1.7%	1.7%	1.8%
Heroin	0.2%	0.1%	0.2%	0.2%	0.2%	0.2%	0.3%	0.3%	0.3%	0.3%

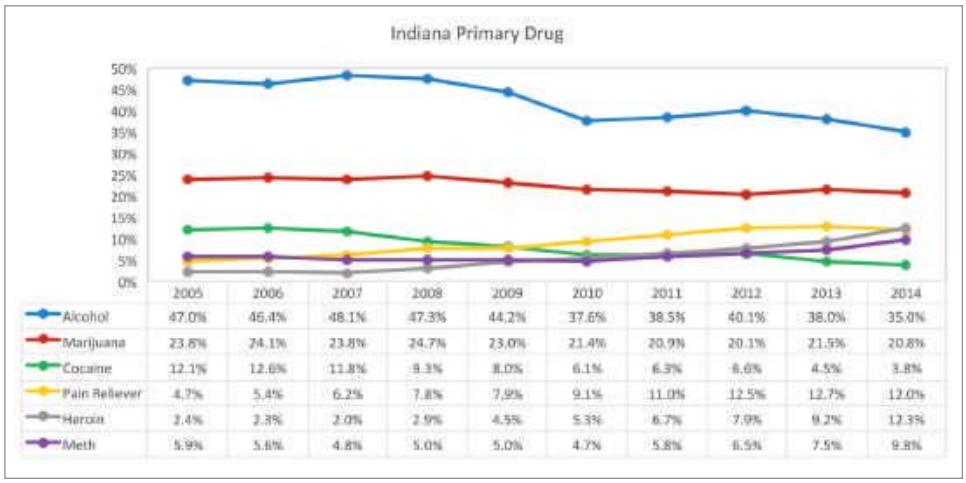
Note: In 2015, SAMHSA completely revised the prescription drug module for pain relievers. As a result of these modifications, 2015 data on prescription pain reliever misuse cannot be compared to NSDUH estimates from previous years.
Source: SAMHSA, 2017

Substance Use in the Treatment Population (TEDS)

Both nationally and in Indiana, alcohol has historically been the most widely used substance and the primary reason for people to seek treatment. A review of TEDS data from 2005 through 2014 shows that in Indiana, alcohol and marijuana were the most frequently reported substances, making up the bulk of treatment admissions. The same trend held true for the rest of the nation until 2012, when heroin replaced marijuana as the second most commonly reported drug of choice.

Among Indiana treatment admissions, the popularity of other drugs also shifted from 2005 through 2014. Use of cocaine, initially the third most frequently reported drug of choice in the state, decreased from 12 percent to under 4 percent. At the same time, treatment admissions for heroin, prescription pain reliever, and meth abuse rose substantially, reflecting 413%, 155%, and 66% increases respectively since 2005. Although heroin use was significantly lower among Indiana's treatment admissions compared to the rest of the nation, the state has experienced a steep rise in the proportion of treatment episodes reporting heroin use. Importantly, polysubstance use (i.e. the use of two or more drugs) was reported in over half of all treatment admissions. For trend information on the primary drugs reported at treatment admission from 2005 through 2014, see Figures 3A (Indiana) and 3B (United States) [30].

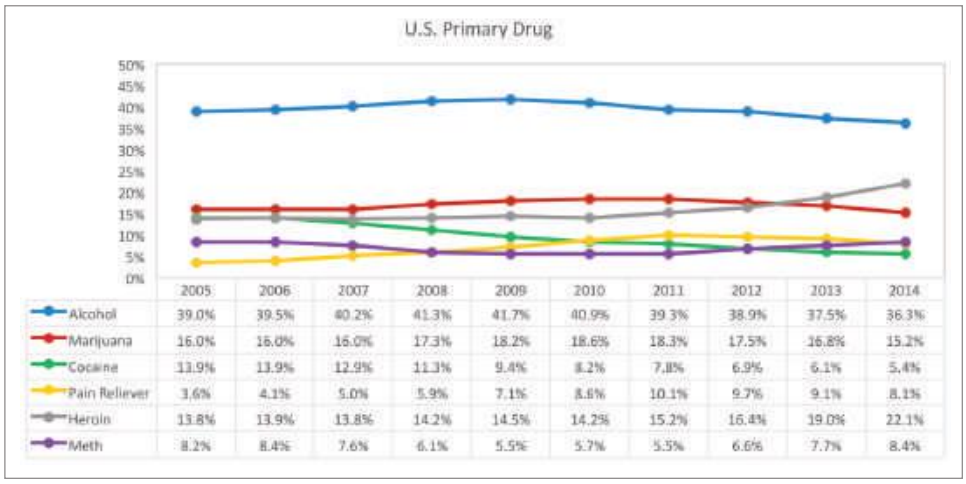
Figure 3A. Indiana Percentage of Treatment Episodes by Primary Substance Reported at Admission (TEDS, 2005-2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Alcohol	47.0%	46.4%	48.1%	47.3%	44.2%	37.6%	38.5%	40.1%	38.0%	35.0%
Marijuana	23.8%	24.1%	23.8%	24.7%	23.0%	21.4%	20.9%	20.1%	21.5%	20.8%
Cocaine	12.1%	12.6%	11.8%	9.3%	8.0%	6.1%	6.3%	6.6%	4.5%	3.8%
Pain Reliever	4.7%	5.4%	6.2%	7.8%	7.9%	9.1%	11.0%	12.5%	12.7%	12.0%
Heroin	2.4%	2.3%	2.0%	2.9%	4.5%	5.3%	6.7%	7.9%	9.2%	12.3%
Meth	5.9%	5.6%	4.8%	5.0%	5.0%	4.7%	5.8%	6.5%	7.5%	9.8%

Source: SAMHSA, 2014

Figure 3B. U.S. Percentage of Treatment Episodes by Primary Substance Reported at Admission (TEDS, 2005-2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Alcohol	39.0%	39.5%	40.2%	41.3%	41.7%	40.9%	39.3%	38.9%	37.5%	36.3%
Marijuana	16.0%	16.0%	16.0%	17.3%	18.2%	18.6%	18.3%	17.5%	16.8%	15.2%
Cocaine	13.9%	13.9%	12.9%	11.3%	9.4%	8.2%	7.8%	6.9%	6.1%	5.4%
Pain Reliever	3.6%	4.1%	5.0%	5.9%	7.1%	8.6%	10.1%	9.7%	9.1%	8.1%
Heroin	13.8%	13.9%	13.8%	14.2%	14.5%	14.2%	15.2%	16.4%	19.0%	22.1%
Meth	8.2%	8.4%	7.6%	6.1%	5.5%	5.7%	5.5%	6.6%	7.7%	8.4%

Source: SAMHSA, 2014

Costs Attributable to Substance Use in Indiana

The burden of substance abuse is considerable, having a significant economic and social impact on the state. Estimates from 2010, the most recent year for which data were available, indicated that the costs of alcohol use in Indiana exceeded $4.4 billion [32]. Furthermore, a more recent report estimated that in Indiana tobacco use resulted in approximately $6.8 billion dollars spent in 2014, in the form of health care costs, tax burdens, and lost productivity [33]. In the same year, the costs attributable to drug overdose deaths were estimated at over $1.4 billion [34]. Also, according to a state-by-state analysis published in 2015, opioid abuse is costing the state over $650 million in health care costs [35].

In addition to its economic burden, substance abuse has significant societal implications, including:

1. *Overdose deaths*

   In 2015, there were 1,236 overdose deaths in Indiana, more than double the fatalities that occurred in 2005 (609 deaths) [36].

2. *Children exposed to meth labs*

   In 2016, there were 153 Indiana children removed from homes that contained a meth lab [28].

3. *Drug arrests*

   In 2014, close to 23,000 arrests were made in Indiana for the possession or sale of drugs, in addition to nearly 28,000 arrests for DUI and public intoxication [37].

4. *Alcohol-related motor vehicle accidents*

   In 2015, a total of 8,642 alcohol-related motor vehicle accidents took place in Indiana, which resulted in 152 fatalities [38].

The economic and societal costs of substance abuse in Indiana support the need for further research and policy initiatives targeting prevention and treatment for the consequences of alcohol, tobacco, and other drug use.

Risk and Protective Factors for Substance Abuse

Most substance use occurs in early adulthood; therefore, addressing risk and protective factors present in early life and adolescence can influence future rates of substance abuse [39]. Risk factors for substance use include drug availability, neighborhood characteristics, weak family relationships, family substance use, peer use, and mental health problems [39-43]. The strongest predictive risk factor for substance use among youth was peer substance use [42, 43]. Conversely, protective factors are those that mediate or moderate substance use. Strong family relationships, neighborhood economic viability, low childhood stress, restrictive laws, and excise taxes can all lower the likelihood of substance use even in the face of risk factors [39, 42, 43]. Addressing these risk and protective factors would require tackling many larger population concerns, but would likely result in benefits to society beyond those associated with decreased substance use. Because of the longitudinal nature of risk and protective factors, the effect of interventions to reduce risk factors and enhance protective factors may not be immediate and ongoing intervention and monitoring will be necessary to achieve maximum effectiveness [43].

Co-Occurring Mental Health and Substance Use Disorders

Frequently called co-occurring disorder (COD) or dual diagnosis, mental health and substance use disorders often occur together; i.e., people who have a mental health disorder are more likely to abuse alcohol and/or illicit drugs and persons with a substance use disorder are more likely to suffer from mental health conditions [44]. In 2015, an estimated 3.3% of Americans experienced both some type of mental illness and a substance use disorder; the prevalence rate for COD was highest among young adults ages 18 to 25 [45].

Because mental health disorders are a risk factor for substance use and vice versa, it is critical that we understand, monitor, and address the relationship between these two conditions. Integrated treatment for co-occurring disorders allows providers to address both disorders together, saving time and resources and often creating better outcomes than treatment for each disorder individually [44]. Current efforts to address COD include improving care coordination between primary care and mental health professionals, improving access to services, and supporting vulnerable populations such as those in the criminal justice system, individuals experiencing homelessness, and veterans and their families [44].

Thoughts for Policymakers

Due to the numerous and often severe consequences linked to alcohol, tobacco, and other drugs, it is crucial that the state continues and expands its efforts to prevent substance abuse and provide adequate access to treatment. Indiana currently has various policies and programs in place that are designed to reduce the prevalence and incidence of drug consumption, monitor patterns of abuse throughout the state, and provide evidence-based programs to treat substance use disorders and related health consequences. However, to keep abreast of this ongoing issue, additional policies, strategies, and funding could prove beneficial in lessening the economic and social burden to the state. To address this, our recommendations include:

1. **Expand access to substance abuse treatment services, including medication-assisted treatment programs**

   Adequate access to evidence-based treatment is crucial for clients suffering from addictions. Medication-assisted Treatment (MAT) incorporating methadone, buprenorphine, or naltrexone in combination with counseling has been shown effective in treating opioid use disorders [46, 47] and reducing mortality, relapse, and costs compared to drug-free treatment or no treatment [48]. Indiana currently has 14 accredited Opioid Treatment Programs (OTPs) [49] and 321 physicians who are licensed to provide buprenorphine to treat opioid addiction [50]. However, a 2015 study found significant gaps between the nation's need for MAT and its capacity to provide such services [51]. Indiana ranked as one of the worst states in terms of high need and low MAT capacity. Although OTPs and MAT programs have increased over the past 10 years, they have not grown proportionally with the rise in opioid use and dependence [51].

   Action steps to expand access to treatment could include:

   - Encourage, train, and mentor eligible health care professionals (physicians, nurse practitioners, and physician assistants) to provide office-based MAT.

   - Increase the number of OTPs and/or allow methadone maintenance in community mental health centers to make it more accessible to patients, especially in rural areas.

2. Incorporate a recovery-based framework

The recovery-oriented systems of care (ROSC) framework is a relatively new effort supported by SAMHSA. ROSC uses a chronic-care approach rather than an acute-care model for the treatment of substance use disorders. Treatment is tailored to individual needs and includes traditional SUD care in addition to more comprehensive services such as employment training, housing assistance, and childcare support. [52]. Several states, including Arizona and Connecticut, have adopted state-wide ROSC models. While many of the individual ROSC components have been shown effective in addressing addictions, comprehensive studies evaluating the full ROSC model are not yet widely available [53].

Action steps to incorporate a recovery-based framework could include:

- Support a strong peer recovery workforce and allow Medicaid billing for peer services.
- Increase funding for supportive services like job training, child care, case management, family-inclusive services, and services for vulnerable and underserved populations (e.g., LGBT, adolescents, veterans, and those who have been incarcerated).
- Explore the use of regular post-discharge follow-ups for people who leave treatment programs, especially those from vulnerable and underserved populations.
- Advocate for elimination of punitive policies that terminate services for people who relapse.

3. Educate, train, and promote the use of naloxone among first- and lay-responders

Naloxone is an opioid antagonist that is used to reverse the effects of an opioid overdose [54]. Naloxone training programs have been found effective in improving individuals' ability to accurately identify and address opioid overdoses [55-57] and reducing opioid-related overdose deaths [58]. Current legislation and state efforts allow healthcare professionals, emergency responders, and more recently, family members or friends of an individual at risk of an opioid overdose to access and administer the medication when necessary without legal implications [59, 60], although the person revived can still face criminal charges.

Action steps to promote the use of naloxone could include:

- Train a broad range of social service and public health workers to educate and promote the use of naloxone.
- Provide funds for social service and public health departments to purchase and distribute naloxone kits.
- Advocate for elimination of punitive policies where individuals revived from an overdose face criminal charges.

4. Prevent the transmission of HIV and hepatitis C in injection drug users

Systematic reviews evaluating syringe exchange programs have generally found compelling evidence that these programs are effective in reducing transmission of HIV and hepatitis C [61-64]. In light of the HIV epidemic in southern Indiana, the state passed legislation allowing counties who have declared a public health emergency from HIV or hepatitis C related to injection drug use to operate syringe exchange programs [65]. At present, Indiana has eight syringe exchange programs. However, this number may rise as the House passed a bill on January 31, 2017, allowing counties to establish syringe exchanges outside of public health emergencies. The bill is currently before the Senate.

Action steps to prevent the transmission of HIV and hepatitis C could include:

- Support laws that allow the establishment of syringe exchange programs prior to counties experiencing a public health emergency.
- Encourage syringe exchange programs to be "one-stop-shops;" e.g., educating clients on how to prevent the transmission of HIV and hepatitis C; connecting clients to treatment, if they choose; and promoting the use of naloxone.
- Advocate to decriminalize the possession of syringes.

5. Implement effective youth prevention programs

Most substance use occurs in young or emerging adulthood; however, effective prevention initiatives early in life can influence future outcomes. A recent comprehensive review of adolescent substance use prevention efforts found that school-based interventions were the most effective across substances while the effect of family-centered interventions varied by substance [66].

Many evidence-based curricula exist, but school adoption and effective implementation of such curricula is lacking [67-70]. Recent teacher or substance use prevention instructor training and use of interactive teaching strategies may help improve the effectiveness of evidence-based programs. Selecting and encouraging personality-specific, interactive, evidence-based curricula as well as school participation in programs such as Drug-Free Communities Support Program and Safe Schools/Healthy Students may be useful tools for preventing youth substance use in Indiana.

Action steps for effective youth prevention could include:

- Allocate prevention funding to favor evidence- and school-based programming, especially programs that support positive peer relationships and social competence/social influence approaches.

- Encourage schools to offer evidence-based family programming (e.g., Strengthening Families) to supplement classroom programs.

6. Monitor substance abuse and consequences

State-level tracking systems that collect information on indicators of substance abuse are essential tools for monitoring the opioid epidemic and other drug-related issues in Indiana. One of these information systems is INSPECT, Indiana's prescription drug monitoring program. Evidence suggests that prescription drug monitoring programs are effective in tracking prescribing and dispensing patterns of controlled substances [71] and reducing the rate increase of opioid use and misuse [72]. Surveillance and/or advisory bodies with access to a wide variety of relevant data across agencies and organizations are vital in compiling, analyzing, and interpreting the information.

Action steps for monitoring substance abuse could include:

- Allow linkage of INSPECT to other databases such as electronic health records.

- Encourage the consistent and accurate collection of data statewide, especially at sub-state (e.g., county) levels, across agencies and organizations

- Advocate for additional funding for statewide surveys to be administered in a manner that allows for county-level estimates

- Require coroners to report when a drug overdose caused or contributed to a death and have a comprehensive drug panel performed to indicate on the death certificate the specific drug(s) involved.

- Set up an early warning system for the state, similar to SAMHSA's now defunct Drug Abuse Warning Network (DAWN) to track emergency department visits caused by drug abuse in order to identify the drugs being abused, determine patterns and changing/emerging trends in specific areas of the state.

- Require complete reporting of alcohol- and drug-related arrests by law enforcement and develop a unified reporting system across all law enforcement agencies.

Conclusion

Over the past 10 years, alcohol and tobacco have been the most widely used substances in Indiana. Marijuana, though still illegal in Indiana, has gained much more public acceptance due to the changing landscape of state marijuana laws. As of 2016, more than half of all U.S. states have legalized marijuana for medical and/or recreational purposes. The opioid epidemic involving both prescription pain relievers and heroin has impacted Indiana tremendously, with substantial increases in substance abuse treatment admissions and overdose deaths attributable to these drugs.

Indiana has established many efforts to prevent and reduce substance abuse in the state, but these programs and policies should continue to be evaluated and revised as trends in substance use change.

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Sent: Wednesday, May 10, 2017 1:39 PM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Carter, Robert (Rob);Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: JRAC Meeting - May 19th Update

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

As you may remember, we tentatively scheduled a JRAC meeting for noon on May 19, 2017; however, it turns out that we have members that are unable to attend that day. Unless I hear by Friday that someone has an urgent agenda item for us to consider on May 19th, I would like to cancel that meeting. I will get back with you next week about our next meeting date. And, if there is a compelling reason to meet, I will notify you all as soon as I know that. Thank you for your flexibility. Jane

Jane A. Seigel
Executive Director
Indiana Office of Court Services
30 S. Meridian Street, Suites 500 & 900
Indianapolis, IN 46204
317-232-1313

Scott.A.Milkey

From: Carrico, Sonya
Sent: Monday, May 08, 2017 12:07 PM
To: Jackson, Sharon;McClelland, Jim;Huntsinger, Douglas
Subject: FW: 2016 Epi Report and Drug Facts
Attachments: 2016 Drug Facts.pdf; 2016 Epi Report.pdf

Good afternoon,
The 2016 State Epi reported was released Friday. I'm sending it in the event you have not yet received it.

Thank you,

Sonya R. Carrico, BSW
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101 West Washington Street, Suite 1170
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scarrico@cji.in.gov

From: Greene, Marion S [mailto:msgreene@iu.edu]
Sent: Friday, May 05, 2017 11:30 AM
To: Adams, Elizabeth Alice <adamsela@iupui.edu>; Ailes, Dennis B <Dennis.Ailes@fssa.IN.gov>; Anderson, Kathleen <kathleen@indiana.edu>; Balio, Casey <cbalio@umail.iu.edu>; Bozell, David D <David.Bozell@fssa.in.gov>; Carrico, Sonya <scarrico@cji.IN.gov>; Dotson, Kayley <KDotson@isdh.IN.gov>; Ecklor, Bethany D <Bethany.Ecklor@fssa.IN.gov>; Fernandes, Taya <Taya.Fernandes@atg.in.gov>; Garner, Aaron <AGarner@idoc.IN.gov>; Garrett, Amanda <AGarrett@pla.IN.gov>; Greene, Marion S <msgreene@iu.edu>; Gries, Julie A <Julie.Gries@fssa.IN.gov>; Hemze-Mills, Leah <Leah.Hemze-Mills@dcs.IN.gov>; Keen, Mark F <MKeen1@doe.in.gov>; Kenny, Rachel <RKenny@isdh.IN.gov>; Kooreman, Harold Edward <hkoorema@iu.edu>; Landis, Winnie <'winpharm@[redacted]'>; Mangrum, Vera <Vera.Mangrum@fssa.IN.gov>; Manlove, Kim <kmanlove@mhai.net>; Mcclendon, Michaelangelo <Michaelangelo.Mcclendon@fssa.IN.gov>; Meade, Magan L <MMeade@isdh.IN.gov>; Milroy, Lauren M <LMilroy@isdh.IN.gov>; Olcott, Courtney Owyn <coolcott@indiana.edu>; Omenka, Ogbonnaya Isaac <oomenka@iupui.edu>; Pontones, Pamela <ppontones@isdh.IN.gov>; Ross, Michael <Michael.Ross@fssa.IN.gov>; Rupp, Katelin <KaRupp@isdh.IN.gov>; Samanic, Claudine <CSamanic@isdh.IN.gov>; Seitz de Martinez, Barbara <seitzb@indiana.edu>; Shue, Christian B., D.O. (IU Health) <cbshue@IUHealth.org>; Smith, Lynn S <Lynn.Smith@fssa.in.gov>; Steiner, Kerry <KSteiner@inaiac.in.gov>; Strittmatter, Matt P <MPStrittmatter@atc.IN.gov>; Toles, Mike <MToles@isp.IN.gov>; Trout, Vickie <Vickie.Trout@fssa.IN.gov>; Watson, Dennis P <dpwatson@iu.edu>
Cc: Moore, Kevin B <Kevin.Moore@fssa.IN.gov>; Blackmon, Sirrilla <Sirrilla.Blackmon@fssa.IN.gov>; Cook, Terry E <Terry.Cook@fssa.IN.gov>; Hubbard, Leone <Leone.Hubbard@fssa.IN.gov>
Subject: 2016 Epi Report and Drug Facts

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Dear SEOW,

The 2016 Epi Report and the drug fact sheets are final and can be shared. Thank you for your support.

Sincerely,

Marion

Marion S. Greene, MPH, PhD(c)
Public Health Research Analyst
Center for Health Policy
IU Richard M. Fairbanks School of Public Health at IUPUI
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From: Greene, Marion S
Sent: Thursday, April 27, 2017 5:26 PM
To: Kevin Moore <Kevin.Moore@fssa.IN.gov>; Blackmon, Sirrilla (Sirrilla.Blackmon@fssa.IN.gov) <Sirrilla.Blackmon@fssa.IN.gov>; Cook, Terry E <Terry.Cook@fssa.IN.gov>; Adams, Elizabeth Alice <adamsela@iupui.edu>; Ailes, Dennis <Dennis.Ailes@fssa.in.gov>; Anderson, Kathleen <kathleen@indiana.edu>; Balio, Casey <cbalio@umail.iu.edu>; Bozell, David <David.Bozell@fssa.in.gov>; Carrico, Sonya <scarrico@cji.in.gov>; Dotson, Kayley <KDotson@isdh.IN.gov>; Ecklor, Bethany <Bethany.Ecklor@fssa.IN.gov>; Fernandes, Taya <Taya.Fernandes@atg.in.gov>; Garner, Aaron <agarner@idoc.in.gov>; Garret, Mandy <agarrett@pla.in.gov>; Greene, Marion S <msgreene@iu.edu>; Gries, Julie <Julie.Gries@fssa.in.gov>; Hemze-Mills, Leah <leah.hemze-mills@dcs.in.gov>; Keen, Mark <MKeen1@doe.in.gov>; Kenny, Rachel <RKenny@isdh.IN.gov>; Kooreman, Harold Edward <hkoorema@iu.edu>; Landis, Winnie <'winpharm@[redacted]>; Mangrum, Vera <Vera.Mangrum@fssa.IN.gov>; Manlove, Kim <kmanlove@mhai.net>; Mcclendon, Michaelangelo <michaelangelo.mcclendon@fssa.in.gov>; Meade, Magan <MMeade@isdh.IN.gov>; Milroy, Lauren M <LMilroy@isdh.IN.gov>; Olcott, Courtney Owyn <coolcott@indiana.edu>; Omenka, Ogbonnaya Isaac <oomenka@iupui.edu>; Pontones, Pam <ppontones@isdh.IN.gov>; Ross, Michael <Michael.Ross@fssa.IN.gov>; Rupp, Katelin <KaRupp@isdh.IN.gov>; Samanic, Claudine <CSamanic@isdh.IN.gov>; Seitz-De-Martinez, Barbara Joan <seitzb@indiana.edu>; Shue, Christian B., D.O. (IU Health) <cbshue@IUHealth.org>; Smith, Lynn S <Lynn.Smith@fssa.in.gov>; Steiner, Kerry <KSteiner@inaiac.in.gov>; Strittmatter, Matt <MPStrittmatter@atc.IN.gov>; Toles, Mike <MToles@isp.IN.gov>; Trout, Vickie <Vickie.Trout@fssa.IN.gov>; Watson, Dennis P <dpwatson@iu.edu>
Subject: 2016 Epi Report (embargoed until 5/3)

Dear SEOW,

The 2016 Epidemiological Profile is completed (see attachment). Our website is currently under construction, but you can also access the document at 72786gG8qg7 (password is [redacted]).

Thank you for all the feedback on the draft chapters. Your comments and suggestions have been incorporated in the final version. Please review the document one last time and let me know by May 3rd if you have any reservations. Unless I hear from you to the contrary, we will officially release the report on May 3rd.

I want to thank you for all your support.

Sincerely,
Marion

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INDIANA SPF

May 2017

For questions and additional information, please contact:

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Prepared for:
Indiana Family and Social Services Administration
Division of Mental Health and Addiction

Prepared by:
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Substance Abuse in Indiana

A quick summary on alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, nonmedical prescription drugs, and polysubstance use in Indiana

Introduction

In 2005, the State Epidemiology and Outcomes Workgroup (SEOW) was established as part of the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework State Incentive Grant (SPF SIG) Program to collect and analyze epidemiological data and facilitate data-based decision-making regarding substance abuse prevention across Indiana. Though the grant funding has ended, the Division of Mental Health and Addiction continues to support the work of the SEOW.

As of this date, the Indiana SEOW has published 11 annual comprehensive state epidemiological profiles on substance use. This issue brief provides a concise but comprehensive overview of alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, nonmedical prescription drug, and polysubstance use in Indiana. For a more detailed analysis, refer to *The Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile, 2016*.

OUR VISION

Healthy, safe, and drug-free environments
that nurture and assist all Indiana citizens to thrive.

OUR MISSION

To reduce substance use and abuse
across the lifespan of Indiana citizens.

IUPUI | CENTER FOR HEALTH POLICY
RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH
Indiana University–Purdue University Indianapolis



ALCOHOL

Prevalence

- Alcohol is the most frequently used drug in Indiana and the United States.
- Among Hoosiers ages 12 and older, 50.4% drank alcohol in the past month.[1]
- Young adults ages 18 to 25 had the highest rates of alcohol use in Indiana: 59.7% reported current alcohol use.[1]
- Rates for heavy drinking were slightly lower in Indiana than in the United States (IN: 5.3%; U.S.: 5.9%), although this difference was not statically significant.[2]
- Among Indiana college students, 62.7% reported current (past-month) use of alcohol.[3]

Youth Consumption—Underage Drinking

- Among Hoosiers 12 to 20 years old, 21.0% reported current alcohol use.[1]
- 10.6% of Indiana youth ages 12 to 17 drank alcohol in the past month.[1]
- 30.5% of Indiana high school students (grades 9 through 12) used alcohol in the past month, and 17.4% engaged in binge drinking.[4]
- 13.2% of 8th graders, 22.9% of 10th graders, and 34.6% of 12th graders consumed alcohol in the past 30 days in Indiana.[5]



Impact: Health

- An estimated 5.9% of Hoosiers had an alcohol use disorder in the past year; the highest rate was found among 18- to 25-year-olds (12.5%).[1]
- Most admissions to substance abuse treatment were due to alcohol; more than one-third of treatment admissions among Hoosiers (35.0%) were for alcohol dependence (U.S.: 36.3%).[6]
- Alcohol abuse in the treatment population differed by race: 34.1% of whites, 39.0% of blacks, and 37.9% of other races indicated alcohol dependence.[6]
- From 2000 through 2015, a total of 6,571 Hoosiers died from alcohol-induced causes.7 The age-adjusted alcohol-attributable mortality rate in 2015 was 9.4 per 100,000 Indiana residents.[7]

Impact: Criminal Justice

- In 2015, a total of 8,642 alcohol-related collisions occurred in Indiana; 152 of these were fatal.[8]
- In 2014, Indiana arrest rates per 1,000 population were 3.2 for driving under the influence (20,810 arrests), 1.1 for public intoxication (7,107arrests), and 1.2 for liquor law violations (8,245 arrests).[9]

TOBACCO

Prevalence

- Just under one-third of Hoosiers ages 12 and older used a tobacco product in the past month (30.8%). This was significantly higher than the U.S. rate of 24.6%.[1]
- The highest tobacco use rate in the state was among 18- to 25-year-olds (42.7%).[1]
- One-fourth (25.9%) of Hoosiers ages 12 and older smoked cigarettes in the past month. This was statistically higher than the U.S. smoking rate of 20.1%.[1]
- The highest rate for current cigarette use in the state was among 18- to 25-year-olds (35.1%).[1]
- Indiana's adult smoking prevalence (20.6%) is the 12th highest in the nation. It is also significantly higher than the U.S. median of 17.5%.[2]
- 14.7% of Hoosiers ages 18 and older use cigarettes every day.[2]
- Smoking prevalence was generally higher among younger individuals and persons with less educational attainment and lower income levels.[2]
- Among Indiana college students, 13.0% reported current use of cigarettes.[3]

Youth Consumption

- Among 12- to 17-year-olds in Indiana, 9.1% reported current use of a tobacco product, and 6.7% indicated that they currently smoke cigarettes.[1]
- 2.9% of middle school students and 12.0% of high school students in Indiana smoked cigarettes in the past month.[10]
- The use of e-cigarettes is on the rise. Past-month prevalence increased significantly from 2012 to 2014 for students in middle school (from 1.3% to 5.2%) and high school (from 3.9% to 15.6%).[10]
- White high school students had significantly higher smoking rates than black students (12.1% and 7.1%, respectively).[4]

Impact: Health

- An estimated 11,100 Hoosiers die annually from smoking-attributable causes.[11]
- On average, smoking reduces adult life expectancy by at least 10 years.[11]
- Tobacco causes serious health consequences, including heart disease, cancer, and respiratory illnesses.[11]
- The average annual age-adjusted smoking-attributable mortality rate per 100,000 population was higher among Hoosiers (323.3) than the U.S. median (288.1).[12]
- Secondhand smoke is also detrimental to health and can cause many illnesses, especially in children.[13]



MARIJUANA

Prevalence

- Marijuana is the most commonly used illicit substance in Indiana and the nation.[1]
- Among Hoosiers ages 12 and older, 8.7% used marijuana in the past month, and 13.9% used it in the past year; U.S. rates were comparable.[1]
- Highest rate of current use was among 18- to 25-year-olds (20.7%).[1]
- Among Indiana college students, 19.6% reported current marijuana use.[3]



Youth Consumption

- 6.0% of Indiana youth ages 12 to 17 used marijuana for the first time during the past year, and 8.1% currently use marijuana.[1]
- 16.4% of Indiana high school students currently use marijuana.[4]
- In Indiana, 6.6% of 8th grade students, 13.7% of 10th grade students, and 20.3% of 12th grade students currently use marijuana.[5]

Impact: Health

- Harmful effects include respiratory illnesses, a weakened immune system, and an increased risk of heart attack and cancer.[14]
- In 20.8% of Indiana treatment admissions, marijuana dependence was reported at treatment admission, a significantly higher percentage compared to the nation's 15.2%.[6]
- Marijuana users in treatment were more likely to be male, black, and under 18 years old.[6]

Impact: Criminal Justice

- In 2014, Indiana had more than 10,000 arrests for possession and 1,903 arrests for sale/manufacture of marijuana, representing arrest rates of 1.6 and 0.3 per 1,000 population, respectively.[9]

COCAINE

Prevalence

- Among Hoosiers ages 12 and older, 1.2% used cocaine in the past year.[1]
- Highest rate of past-year use in Indiana was among 18- to 25-year-olds (3.9%).[1]
- Among Indiana college students, 1.9% reported past-month cocaine use.[3]

Youth Consumption

- 0.5% of Indiana youth ages 12 to 17 used cocaine in the past year.[1]
- 4.0% of Indiana high school students have used a form of cocaine at least once in their life.[4]
- 1.4% of 12th grade students in Indiana reported current cocaine or crack use use.[5]



Impact: Health

- Cocaine use can lead to cardiovascular problems, respiratory difficulties, neurological effects, and gastrointestinal complications. Users may even suffer sudden death with first-time use.[15]
- Babies born to mothers who abuse cocaine during pregnancy are often prematurely delivered, have low birth weight and smaller head circumference, and are shorter in length.[15]
- Substance abuse treatment admissions in which cocaine use was reported decreased significantly in Indiana from 25.5% in 2000 to 10.9% in 2014 with dependence in 3.8% of treatment episodes.[6]
- Cocaine users in treatment were more likely to be female, black, and 35 years or older.[6]

Impact: Criminal Justice

- In 2014, Indiana had 1,649 arrests for possession of cocaine/opiates and more than 1,500 for sale/manufacture of the substance, representing arrest rates of 0.2 and 0.2 per 1,000 population, respectively.[9]

HEROIN

Prevalence

- Among Hoosiers age 12 and older, an estimated 0.3% used heroin in the past month (U.S.: 0.3%).[1]
- Among Indiana college students, 0.2% had used heroin in the past month.[3]

Youth Consumption

- 2.4% of Indiana high school students have used heroin at least once in their life.[4]
- Among 12th grade students in Indiana, 0.5% used heroin in the past 30 days.[5]

Impact: Health

- Heroin abuse can cause fatal overdose, spontaneous abortion, collapsed veins, and if injected, the contraction of infectious diseases such as HIV/AIDS and hepatitis B and C.[16]
- In 2014, 15.9% of Indiana treatment admissions reported heroin use, which is significantly less than the U.S. percentage of 25.8%. Heroin use in the treatment population has been rising consistently in the past years; however, Indiana's increase has been steeper compared to the nation's.[6]
- Among Indiana's substance abuse treatment population, women, whites, and individuals under the age of 35 had the highest rates of heroin use. Furthermore, the percentage of youth less than 18 years old in the treatment population seeking treatment for heroin saw a sharp increase from 1.1% in 2010 to 11.5% in 2012, but then decreased significantly and remained low at 1.7% in 2014.[6]
- At the end of 2015, a total of 11,698 Hoosiers were living with HIV or AIDS. Among the 543 newly diagnosed HIV cases in 2015, 32% were transmitted via injection drug use.[17]
- Over the past 10 years there has been a steady increase in overdose deaths with heroin identified as a contributing factor, rising from 7 deaths in 2005 to 239 deaths in 2015.[18]

Impact: Criminal Justice

- In 2014, Indiana had 1,649 arrests for possession of cocaine/opiates and more than 1,500 for sale/manufacture of the substance, representing arrest rates of 0.2 and 0.2 per 1,000 population, respectively.[9]



METHAMPHETAMINE (METH)

Prevalence

- No state estimates for methamphetamine use are available for the general population; however, in 2015, U.S. lifetime use among individuals ages 12 and over was an estimated 5.4%, past-year use 0.6%, and past-month use 0.3%.[1]
- Among Indiana college students, 0.2% reported current (past-month) use of meth.[3]

Youth Consumption

- The rates of Indiana high school students reporting having tried meth at least once in their life has steadily declined from 8.2% in 2003 to 2.9% in 2015.[4]
- In 2016, 0.1% of 8th grade students, 0.3% of 10th grade students, and 0.7% of 12th grade students reported past-month meth use in Indiana.[5]



Impact: Health

- Health consequences of meth use include cardiovascular problems; stroke; brain, liver, and kidney damage; severe tooth decay ("meth mouth"); increased risk of STD/HIV transmission and hepatitis; mental illness; and death.[18]
- The percentage of treatment episodes with meth use reported has increased significantly from 10.9% in 2005 (U.S.: 11.8%) to 15.9% in 2014 (U.S.: 13.5%).[6]
- Meth users in treatment were primarily female, white, and between 25 and 44 years of age.[6]

Impact: Criminal Justice

- The number of clandestine meth labs seized and arrests made at these labs by the Indiana State Police decreased from an all-time high in 2013 (1,721 lab seizures and 1,507 arrests) to 943 lab seizures and 622 arrests in 2016.[19]
- After exceeding 440 in 2013, the number of children taken from meth lab homes has decreased in subsequent years to 153 in 2016.[19]
- In 2014, there were 1,895 arrests for synthetic drug possession (including meth) and 909 for sale, corresponding to arrest rates of 0.3 and 0.1 per 1,000 population respectively.[9]

PRESCRIPTION DRUG ABUSE

Prevalence

- The three most commonly abused types of prescription medicine are pain relievers (opioids), central nervous system depressants (sedatives, tranquilizers, hypnotics), and stimulants (used to treat attention deficit disorders, narcolepsy, and weight loss).[20]
- Over 11 million prescription drugs (controlled substances) were dispensed in Indiana in 2016. Of these, more than half were opioids.[21]
- Past-year prevalence for nonmedical pain reliever use in Indiana residents ages 12 and older was 4.4% in 2014; young Hoosiers ages 18 to 25 had the highest rate (9.5%).[1]
- Among Indiana college students, prescription stimulants were the most commonly reported prescription drug, with 5.2% of students reporting misuse in the past month. Past-month prevalence of prescription painkiller and sedative misuse were 2.3% and 2.2% respectively.[3]

Youth Consumption

- 4.9% of young Hoosiers ages 12 to 17 misused pain relievers in the past year.[1]
- In Indiana, 1.8% of 8th grade students, 3.7% of 10th grade students, and 5.8% of 12th grade students indicated current misuse of prescription drugs.[5]

Impact: Health

- Prescription drug misuse was reported in 28.5% of substance use treatment admissions in Indiana; dependence was indicated in 14.4% (U.S.: 20.2% and 9.8% respectively).[6]
- Pain reliever misuse was the leading category of prescription drug misuse reported at treatment admissions in 2014 (22.8%) followed by sedatives/tranquilizers (8.1%).[6]
- Prescription drug abusers in treatment were primarily female and white.[6]

Impact: Criminal Justice

- In Indiana, 2,805 arrests were made in 2014 for possession of barbiturates (sedatives) and Benzedrine (a stimulant); 1,495 arrests were made for sale/manufacture of these substances. Indiana's arrest rate of 0.4 per 1,000 population for possession was significantly lower than the national rate (0.8 per 1,000 population); however, arrest rates for sale/manufacture were the same (0.2 per 1,000 population).[9]

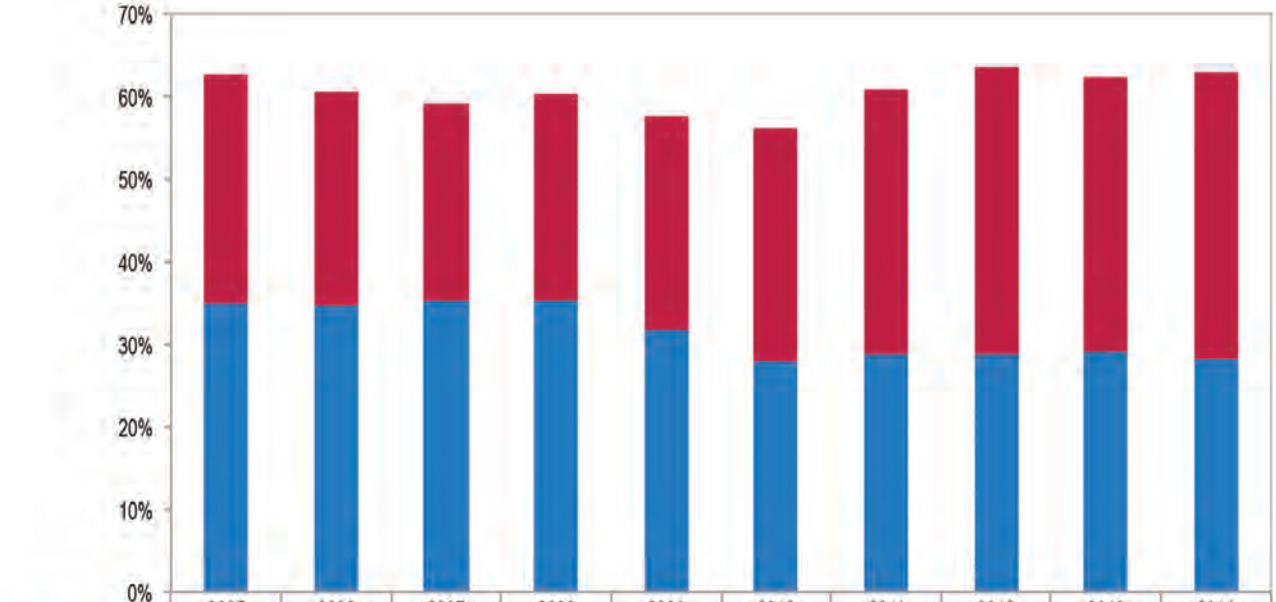


POLYSUBSTANCE ABUSE

Prevalence

- Polysubstance abuse is a serious pattern of drug use that involves the consumption of two or more drugs at a time.
- Among the Indiana treatment population, 62.8% reported use of two or more drugs; the percentage was statistically significantly higher in Indiana compared to the nation (54.3%).[6]
- The percentage of treatment admissions with polysubstance abuse has remained relatively stable in Indiana since 2005. (For the percentages of Indiana treatment admissions with reported use of two substances and three substances, see Figure 1).[6]
- Much of the substance use in Indiana involves using two or more substances, most frequently alcohol together with another drug.[6]
- Alcohol and marijuana were the substances most commonly reported at treatment admission. The most common drug clusters identified in Indiana were (a) alcohol and marijuana; (b) alcohol, marijuana, and some other drug; and (c) marijuana and some other drug.[6]

Figure 1. Percentage of Indiana Treatment Episodes with Reported Use of Two Substances and Three Substances (Treatment Episode Data Set, 2005-2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
3 Drugs Reported	27.5%	25.9%	23.9%	25.0%	25.9%	28.4%	32.2%	34.8%	33.2%	34.5%
2 Drugs Reported	35.0%	34.6%	35.3%	35.4%	31.8%	27.8%	28.7%	28.7%	29.1%	28.3%

Source: SAMHSA, 2014

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21 Indiana Professional Licensing Agency. (2017). *Controlled substances dispensed in Indiana (INSPECT 2013 – 2016).* Information received January 9, 2017, from Amanda Garrett, Director of Operations, INSPECT, Indiana Professional Licensing Agency.

About Substance Abuse in Indiana

This issue brief provides a concise overview of alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, non-medical prescription drug abuse, and polysubstance abuse in Indiana.

For detailed analysis of substance abuse in Indiana, see *The Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile, 2016*, a comprehensive epidemiologic profile created by the Indiana University Center for Health Policy for the State Epidemiology and Outcomes Workgroup (SEOW).

Funding for these reports was provided by the Indiana Family and Social Services Administration/Division of Mental Health and Addiction (DMHA) through the Substance Abuse Prevention and Treatment (SAPT) Block Grant CFDA 93.959 from the Substance Abuse and Mental Health Services Administration (SAMHSA).

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17-H03

MARIJUANA COCAINE PRESCRIPTION DRUGS

The Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile 2016

Indiana State Epidemiological Outcomes Workgroup

Richard M. Fairbanks School of Public Health

Indiana University

Center for Health Policy

IUPUI

TOBACCO HEROIN METHAMPHETAMINE ALCOHOL

THE CONSUMPTION AND CONSEQUENCES OF ALCOHOL, TOBACCO, AND DRUGS IN INDIANA: A STATE EPIDEMIOLOGICAL PROFILE 2016

Developed by the Indiana State Epidemiological Outcomes Workgroup, 2016

Our Vision

Healthy, safe, and drug-free environments that nurture and assist all Indiana citizens to thrive.

Our Mission

To reduce substance use and abuse across the lifespan of Indiana citizens.

Published by the Center for Health Policy,
Indiana University Richard M. Fairbanks School of Public Health,
Indiana University-Purdue University Indianapolis (IUPUI)

This document, written for state policymakers and community leaders, presents data and analyses to support the development of a framework for advancing the mission of the Indiana Substance Abuse Prevention System.

This document and the efforts described herein were funded by the Indiana Family and Social Services Administration/Division of Mental Health and Addiction through the Substance Abuse Prevention and Treatment Block Grant CFDA 93.959 from the Substance Abuse and Mental Health Services Administration.

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This document is available via the World Wide Web and can be accessed and downloaded from the Center for Health Policy Web site (www.healthpolicy.iupui.edu).

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The mission of the Center for Health Policy (CHP) is to conduct research on critical health-related issues and translate data into evidence-based policy recommendations to improve community health. The CHP faculty and staff collaborate with public and private partners to conduct quality data-driven program evaluation and applied research analysis on relevant public health issues. The Center serves as a bridge between academic health researchers and federal, state, and local government as well as healthcare and community organizations.

TABLE OF CONTENTS

Introduction 1

1. Data Highlights 3

2. Methods 15

3. Alcohol Use in Indiana: Consumption Patterns and Consequences 25

4. Tobacco Use in Indiana: Consumption Patterns and Consequences 51

5. Marijuana Use in Indiana: Consumption Patterns and Consequences 75

6. Cocaine Use in Indiana: Consumption Patterns and Consequences 93

7. Heroin Use in Indiana: Consumption Patterns and Consequences 107

8. Methamphetamine Use in Indiana: Consumption Patterns and Consequences 119

9. Prescription Drug Abuse in Indiana: Consumption Patterns and Consequences 139

10. Polysubstance Abuse 161

11. Mental Health 179

12. Indicators of Substance Abuse 191

APPENDIX I. Data Sources Recommended by the State Epidemiological Outcomes Workgroup (SEOW) 209

APPENDIX II. Substance Use Indicators At-A-Glance 211

Introduction

In July 2005, Indiana's Office of the Governor received a grant from the U.S. Department of Health and Human Services' Center for Substance Abuse Prevention (CSAP) as part of CSAP's Strategic Prevention Framework State Incentive Grant (SPF SIG) program. The SPF SIG program represented a continuation of ongoing CSAP initiatives encouraging states to engage in data-based decision-making in the area of substance abuse prevention planning and grant making.

This grant was made on the heels of an earlier CSAP State Incentive Grant (SIG), which laid much of the groundwork for this new initiative. A great deal of work was completed under the first SIG to assess substance abuse prevention services and develop a strategic framework to guide policymaking in this area for the 21st century. The final report summarizing the outcomes of this work, entitled *Imagine Indiana Together: The Framework to Advance the Indiana Substance Abuse Prevention System*, was prepared by the Governor's Advisory Panel within the Division of Mental Health and Addiction (DMHA), Indiana Family and Social Services Administration. This report is available from DMHA and the Indiana Prevention Resource Center at Indiana University Bloomington.

As a requirement of the SPF SIG initiative, the State established a State Epidemiology and Outcomes Workgroup (SEOW) to facilitate data-based decision-making regarding substance abuse prevention programming through the collection, analysis, and reporting of available epidemiological data. After the end of the Indiana SPF SIG in 2010, the State decided to continue supporting the work of the SEOW as part of its long-term efforts to improve substance abuse prevention policy.

This report represents the 11th official *State Epidemiological Profile* completed by the SEOW. As in past years, we have updated the core set of analyses to reflect the most recent data available. In order to make the report most useful for state and local policymakers and service providers, we present detailed information and descriptive analyses regarding the patterns and consequences of substance use both for the state and, whenever possible, each of Indiana's 92 counties. The opioid epidemic still remains a significant public health concern. The costs attributable to the abuse of and addiction to prescription pain relievers and heroin are staggering both economically and in terms of human suffering,

As with our prior reports, our primary aim in preparing this annual document is to provide a useful reference tool for policymakers, communities, and professionals involved in substance abuse prevention and mental health promotion. We realize not everyone has the time or energy to review the contents in detail. For this reason, we again are offering drug fact sheets with summaries on each of the major substances. This report, as well as earlier versions and these supplemental resources, are available on the Center for Health Policy website (www.healthpolicy.iupui.edu). The website also has links to a series of issue briefs on critical topics related to drug abuse that are developed each year as part of the SEOW's work.

We appreciate your interest and leadership in addressing the problem of substance abuse in Indiana, and, as always, we welcome your feedback on this report and our work.

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1 Data Highlights

ALCOHOL

Alcohol is the most frequently used drug in both Indiana and the United States. Over half of the population 12 years and older reported current (past month) use (IN: 50.4%; U.S.: 52.2%) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).[1]

More than one-fifth of Hoosiers (21.8%) engaged in binge drinking in the past month (U.S.: 22.9%). The highest rate was found among 18- to 25-year-olds (IN: 39.5%; U.S.: 37.8%) (SAMHSA, 2017).

An estimated 62.7% of Indiana college students currently drink alcohol and 35.7% engage in binge drinking (King & Jun, 2016).[2]

Youth Consumption—Underage Drinking

In Indiana, 10.1% of 12- to 17-year-old youths reported that they had consumed alcohol in the past 30 days (U.S.: 10.6%) (SAMHSA, 2017).

An estimated 30.5% of high school students (grades 9 through 12) reported current use of alcohol (U.S.: 32.8%), and 17.4% admitted to binge drinking in the past month (U.S.: 17.7%). Indiana and the nation were similar on both measures (Centers for Disease Control and Prevention [CDC], 2017b).

Alcohol Abuse and Dependence

The population-based rates for alcohol abuse and/or dependence were similar in Indiana (5.9%) and the nation (6.1%). The most affected age group encompassed 18- to 25-year-olds (IN: 12.5%; U.S.: 11.6%). The percentages of individuals ages 12 and older needing but not receiving treatment for alcohol use in the past year were also comparable (IN: 6.4%; U.S.: 6.2%) (SAMHSA, 2017).

According to substance abuse treatment data, alcohol was responsible for the largest percentage of admissions to treatment facilities in 2014. The percentage of treatment admissions in which alcohol dependence was indicated was comparable in Indiana (35.0%) and the nation (36.3%) (SAMHSA, 2014).

Morbidity and Mortality

Between 2000 and 2015, a total of 6,571 Hoosiers died from alcohol-induced causes. In 2015, Indiana's age-adjusted mortality rate for alcohol-attributable deaths was 9.4 per 100,000 population (U.S.: 9.1 per 100,000 population) (CDC, 2017b).

Motor Vehicle Crashes

In Indiana, the number of alcohol-related collisions decreased from 13,911 in 2003 to 8,642 in 2015. Also, the number of fatalities in crashes attributable to alcohol declined from 242 to 152 during those same years. The 2015 overall annual rate for alcohol-related collisions in Indiana was 1.3 per 1,000 population (Indiana State Police [ISP], 2016).

Legal Consequences

In 2014, nearly 21,000 arrests were made in Indiana for driving under the influence (DUI), along with over 7,000 arrests for public intoxication, and more than 8,000 arrests for liquor law violations. The arrest rates for these offenses were 3.2 for DUI (U.S.: 3.0), 1.1 for public intoxication (U.S.: 1.0), and 1.2 for liquor law violations (U.S.: 0.9)—all rates per 1,000 population (Federal Bureau of Investigation [FBI], 2014).

TOBACCO

Cigarette smoking remains the leading cause of preventable death in the United States, accounting for approximately one of every five deaths (U.S. Department of Health and Human Services [USDHHS], 2014). In Indiana, nearly one-third of the population ages 12 years and older (30.8%) reported using a tobacco product in the past month (U.S.: 24.6%). The age group with the highest rate of use was 18- to 25-year-olds (IN: 42.7%; U.S.: 34.0%). Most tobacco consumption involved cigarettes. Indiana's past-month smoking prevalence among individuals ages 12 years and older was 25.9% (U.S.:

[1]NSDUH estimates on binge drinking are based on 2014 survey results, because of a change in the definition of binge drinking. For more information, see Chapter 2, "Methods."
[2]Twenty Indiana colleges participated in the survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

20.1%). Again, the highest rate was found among 18- to 25-year-olds (IN: 35.1%; U.S.: 27.5%) (SAMHSA, 2017).

In 2015, adult (18 years and older) smoking prevalence in Indiana (20.6%) was the 12th highest in the nation and greater than the U.S. median rate (17.5%). Smoking prevalence was inversely associated with education and income level: High rates of use were found among individuals with less than a high school education and people whose household income was below $15,000 (CDC, 2017a).

Among Indiana college students, 13.0% reported currently smoking cigarettes and 10.4% are using electronic vapor products / e-cigarettes (King & Jun, 2016).

Youth Consumption

Over 9% of Indiana youth ages 12 to 17 currently use a tobacco product (U.S.: 6.5%), mostly cigarettes (IN: 6.7%; U.S.: 4.5%) (SAMHSA, 2017).

Past-month cigarette use decreased significantly from 2004 through 2014 among Indiana students: from 7.8% to 2.9% for middle school students, and from 21.3% to 12.0% for high school students. Unfortunately, current use of e-cigarettes is on the rise and increased significantly from 2012 to 2014 in both middle school students (from 1.3% to 5.2%) and high school students (from 3.9% to 15.6%) (Indiana State Department of Health, Tobacco Prevention and Cessation Commission [ISDH/TPCC], 2015).

Morbidity and Mortality

Tobacco causes serious health consequences, including lung cancer, respiratory illness, and heart disease. An estimated 11,100 Hoosiers die annually from smoking-attributable causes (USDHHS, 2014).

The age-adjusted annual tobacco-attributable mortality rate (per 100,000 population) was higher among Hoosiers (323.3) than the U.S. median (288.1) (CDC, 2009).

MARIJUANA

Marijuana is the most commonly used illicit substance. Nearly 14% of Indiana residents ages 12 and older reported past-year use (U.S.: 13.4%), and 8.7% reported past-month use (U.S.: 8.3%). Highest rates were found among 18- to 25-year-old Hoosiers (past-year: 33.6%; past-month: 20.7%); national rates were similar (SAMHSA, 2017).

Table 1.1 Adult Smoking Prevalence in Indiana, by Education and Income Levels (Behavioral Risk Factor Surveillance System, 2015)

	Smoking Prevalence (95% CI)
Education	
Less than high school	36.5% (29.9–43.1)
High school or GED	24.6% (21.7–27.5)
Some post-high school	19.2% (16.3–22.1)
College graduate	6.5% (5.0–8.0)
Income	
Less than $15,000	35.4% (28.9–41.8)
$15,000–$24,999	30.6% (25.8–5.3)
$25,000–$34,999	22.8% (17.5–28.1)
$35,000–$49,999	21.0% (16.3–25.7)
$50,000 and above	11.7% (9.6–13.8)
$50,000 and above	13.2% (11.7-14.7)

Note: CI = confidence interval
Source: CDC, 2017a

Marijuana use was also prevalent among Indiana college students, as 19.6% of students reported current use (King & Jun, 2016).

Youth Consumption

Among Indiana youth ages 12 to 17, an estimated 6.0% had used marijuana for the first time during the past year (U.S.: 7.2%). Patterns of current use among young people in that age group were similar in Indiana and the nation (IN: 8.1%; U.S.: 7.2%) (SAMHSA, 2017).

Significantly fewer Indiana high school students reported using marijuana in the past month than did students in the U.S. (IN: 16.4%; U.S.: 21.7). Black students (23.2%) were more likely to report current use than white students (14.9%) (CDC, 2017c).

Table 1.2 depicts current marijuana use among Indiana and U.S. 8th, 10th, and 12th grade students throughout the past decade (Gassman et al., 2016; Inter-university Consortium for Political and Social Research [ICPSR], 2016).

Table 1.2 Percentage of Indiana and U.S. 8th, 10th, and 12th Grade Students Reporting Current Marijuana Use, by Grade (Indiana Youth Survey and Monitoring the Future Survey, 2007–2016)

Grade	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Indiana 8th Grade	8.3%	7.1%	7.8%	8.9%	8.3%	8.0%	7.1%	6.8%	7.1%	6.6%
U.S. 8th Grade	5.7%	5.8%	6.5%	8.0%	7.2%	6.5%	7.0%	6.5%	6.5%	6.5%
Indiana 10th Grade	14.4%	13.5%	14.6%	16.8%	16.4%	15.4%	13.7%	13.6%	14.0%	13.7%
U.S. 10th Grade	14.2%	13.8%	15.9%	16.7%	17.6%	17.0%	18.0%	16.6%	14.8%	14.8%
Indiana 12th Grade	15.8%	16.2%	16.7%	19.2%	19.8%	17.8%	17.6%	17.6%	18.8%	20.3%
U.S. 12th Grade	18.8%	19.4%	20.6%	21.4%	22.6%	22.9%	22.7%	21.2%	21.3%	21.3%

Source: Gassman, et al., 2016; ICPSR, 2016

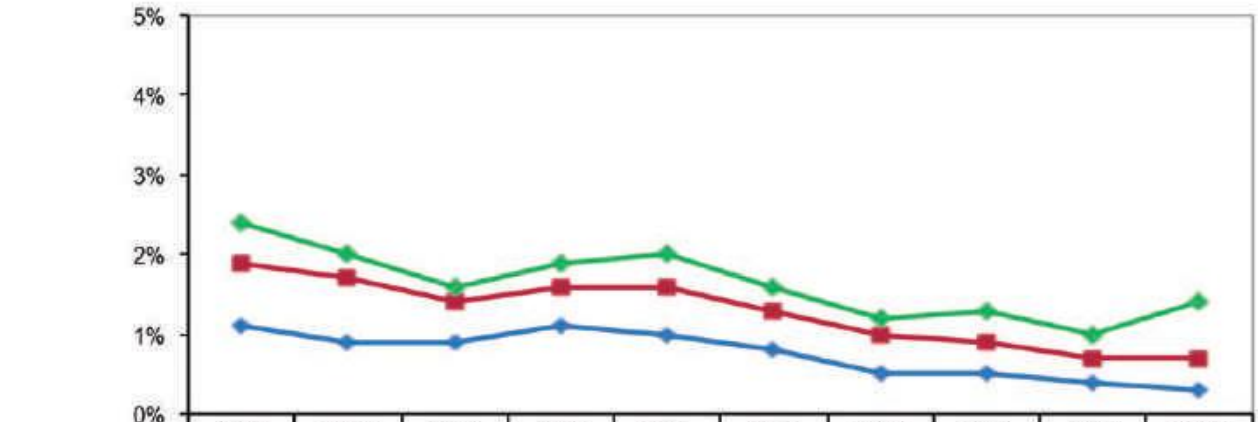
Marijuana Abuse and Dependence

In 2014, nearly one-half (48.3%) of Indiana residents in substance abuse treatment reported marijuana use at admission; the percentage was significantly higher in Indiana than the rest of the nation (35.6%). In Indiana's treatment population, marijuana use was most likely to be reported by males (52.5%), blacks (58.4%), and individuals under the age of 18 (90.3%). Just over one-fifth of Hoosiers in treatment (20.8%) reported marijuana dependence,[3] a percentage significantly higher than the nation's (15.2%). Again, males (23.7%), blacks (37.2%), and individuals under the age of 18 (74.4%) had statistically higher percentages (SAMHSA, 2014).

Legal Consequences

In 2014, the Indiana arrest rate for marijuana possession was 1.6 per 1,000 population (U.S.: 1.6); the Indiana arrest rate for marijuana sale/manufacture was 0.2 per 1,000 population (U.S.: 0.2) (FBI, 2014).

Figure 1.1 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Current Cocaine/Crack Use (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th Grade	1.1%	0.9%	0.9%	1.1%	1.0%	0.8%	0.5%	0.5%	0.4%	0.3%
10th Grade	1.9%	1.7%	1.4%	1.6%	1.6%	1.3%	1.0%	0.9%	0.7%	0.7%
12th Grade	2.4%	2.0%	1.6%	1.9%	2.0%	1.6%	1.2%	1.3%	1.0%	1.4%

Source: Gassman et al., 2016

[3]We defined marijuana dependence as "individuals in substance abuse treatment listing marijuana as their primary substance at admission."

COCAINE

Population-based estimates on past-year cocaine use were similar between Indiana and the nation (IN: 1.2%; U.S.: 1.8%). Young adults from ages 18 to 25 displayed the highest rates (IN: 3.9%; U.S.: 5.0%) (SAMHSA, 2017).

Nearly 2% of Indiana college students reported current cocaine use (King & Jun, 2016).

Youth Consumption

The rates for past-year cocaine use among 12- to 17-year-olds were similar in Indiana (0.5%) and the United States (0.6%) (SAMHSA, 2017).

Among Indiana high school students, 4.0% reported having used cocaine at least once in their lifetime (U.S.: 5.2%); male students (5.2%) were more likely than female students (2.7%) to report lifetime cocaine use (CDC, 2017c).

From 2007 through 2016, rates for current cocaine/crack use among 8th, 10th, and 12th grade students in Indiana declined over the years (see Figure 1.1). However, due to lack of detail in the publicly available data sets, statistical significance of the results could not be determined (Gassman et al., 2016).

Cocaine Abuse and Dependence

In 2014, 10.9% of Indiana's treatment episodes involved cocaine use; this figure was significantly lower than the U.S. percentage (18.0%). Similarly, cocaine was reported as the primary drug of abuse in 3.8% of Indiana treatment episodes, which was significantly lower than the U.S. percentage of 5.4%. Significant differences within Indiana's treatment population were seen by gender, race, and age group (see Table 1.3) (SAMHSA, 2014).

Indiana law enforcement made nearly 1,600 arrests for possession and over 1,500 arrests for sale/manufacture of opiates and cocaine in 2014, representing arrest rates of 0.2 per 1,000 population for both possession (U.S.: 0.7) and sale/manufacture (U.S.: 0.2) of opiates and cocaine (U.S.: 0.2)) (FBI, 2014).[4]

Table 1.3 Percentage of Treatment Episodes with Cocaine Use and Dependence Reported at Treatment Admission in Indiana (Treatment Episode Data Set, 2014)

		Cocaine Use	Cocaine Dependence
Gender	Male	10.0%	3.3%
	Female	12.3%	4.5%
Race	White	8.8%	2.2%
	Black	23.5%	13.5%
	Other	12.2%	3.7%
Age Group	Under 18	1.8%	0.2%
	18-24	4.8%	1.2%
	25-34	9.5%	2.5%
	35-44	15.1%	5.9%
	45-54	19.7%	8.4%
	55 and over	15.7%	6.8%
Total		10.9%	3.8%

Source: SAMHSA, 2014

HEROIN

According to 2015 NSDUH estimates, 0.3% of Indiana residents ages 12 and older used heroin in the past year (U.S.: 0.3%) (SAMHSA, 2017).

Among Indiana college students, 0.2% reported past month use of heroin (U.S.: 0.2%) (King & Jun, 2016).

Youth Consumption

Lifetime heroin use among high school students has been similar in Indiana and the nation (IN: 2.4%; U.S.: 2.1%). No significant differences were detected by gender, race, or grade level in Indiana (CDC, 2017b).

In 2015, past-month heroin use among Indiana 12th grade students was 0.5% (U.S.: 0.2%) (Gassman et al., 2016; ICPSR, 2016).

Heroin Abuse and Dependence

In 2014, heroin use was reported in 15.9% of Indiana treatment episodes (U.S.: 25.8%), and heroin dependence[5] was reported in 12.3% of Indiana treatment episodes (U.S.: 22.1%). While Indiana's percentages were significantly lower than the nation's, it should be noted that both heroin use and dependence have increased significantly in Indiana's treatment population since 2001. Significant differences were seen by gender (more women reported use), race (whites had higher percentages), and age group (adults ages 18 to 34 were mostly affected) (SAMHSA, 2014).

[4]The Uniform Crime Reporting Program data set combines arrests for cocaine and opiates; arrest information is not available for cocaine or opiates alone.
[5]We defined heroin dependence as "individuals in substance abuse treatment listing heroin as their primary substance at admission."

Morbidity and Mortality

A potential consequence of injected heroin use is contraction of HIV and/or hepatitis (B or C) from contaminated needles. In 2015, 621 new HIV infections and 78 new AIDS cases were reported in Indiana. As of December 31, 2015, a total of 11,698 individuals were living in Indiana with HIV disease[6] (ISDH, 2016).

The estimated annual rate of AIDS diagnoses in Indiana adults and adolescents was 4.9 per 100,000 population in 2014 (U.S.: 7.8) (The Kaiser Family Foundation, 2015). Indiana's age-adjusted HIV/AIDS mortality rate for 2014 was 1.2 per 100,000 population (95% CI: 1.0–1.5), which was significantly lower than the U.S. rate of 2.0 per 100,000 population (95% CI: 1.9–2.0) (CDC, 2016).[7]

The hepatitis B virus (HBV) and hepatitis C virus (HCV) are usually transmitted via unprotected sex and among injection drug users. The incidence rates per 100,000 population for acute hepatitis in Indiana were 1.9 for HBV (U.S.: 0.9) and 1.8 for HCV (U.S.: 0.7) in 2013. Indiana's HCV incidence rate was significantly greater than the national rate and has seen a steady increase since 2010 (CDC, 2016). The age-adjusted mortality rate (per 100,000 population) attributable to hepatitis B and hepatitis C (acute and chronic) was 1.2 in Indiana, significantly lower than the national rate (U.S.: 2.0) (CDC, 2016).

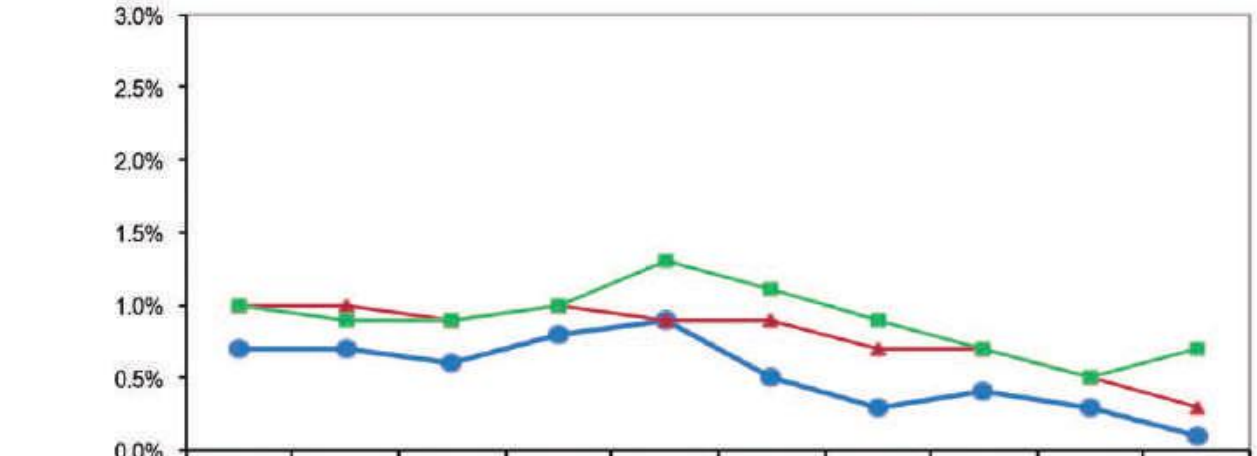
Legal Consequences

Indiana law enforcement made nearly 1,600 arrests for possession and over 1,500 arrests for sale/manufacture of opiates and cocaine in 2014, representing arrest rates of 0.2 per 1,000 population for both possession and sale/manufacture of opiates and cocaine. Indiana's arrest rates were lower for cocaine/opiate possession but comparable to the nation's for sale/manufacture (U.S.: 0.7 and 0.2 per 1,000 population, respectively) (FBI, 2014).[8]

METHAMPHETAMINE (METH)

Of Americans 12 years and older, 5.4% have used methamphetamine at least once in their lifetime; 0.6% used it in the past year; and 0.3% reported past-month use. Americans ages 18 to 25 had the highest past-year use (0.6%) (SAMHSA, 2017). There are currently no state-level NSDUH estimates for methamphetamine use available.

Figure 1.2 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Monthly Methamphetamine Use (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th Grade	0.7%	0.7%	0.6%	0.8%	0.9%	0.5%	0.3%	0.4%	0.3%	0.1%
10th Grade	1.0%	1.0%	0.9%	1.0%	0.9%	0.9%	0.7%	0.7%	0.5%	0.3%
12th Grade	1.0%	0.9%	0.9%	1.0%	1.3%	1.1%	0.9%	0.7%	0.5%	0.7%

Source: Gassman et al., 2016

[6]HIV disease includes both HIV infections and AIDS cases.
[7]Mortality rates for HIV/AIDS are based on ICD-10 codes B20-B24 (Human immunodeficiency virus [HIV] disease).
[8]The Uniform Crime Reporting Program data set combines arrests for cocaine and opiates; arrest information is not available for cocaine or opiates alone.

In 2016, an estimated 0.2% of Indiana college students had used meth in the past month (U.S.: <0.05%) (King & Jun, 2016).

Youth Consumption Patterns

Lifetime prevalence of methamphetamine use among high school students was similar in Indiana and the nation (IN: 2.9%; U.S.: 3.0%). In Indiana, no significant rate differences were found by gender, race, or grade level (CDC, 2017b).

Monthly meth prevalence among 8th, 10th, and 12th grade students in Indiana is depicted in Figure 1.2 (Gassman et al., 2016).

Methamphetamine Abuse and Dependence

Between 2005 and 2014, the percentage of treatment admissions in Indiana with reported meth use and dependence[9] increased significantly; rising from 10.9% to 15.9% for use and from 5.9% to 9.8% for dependence. Significant differences were observed by gender (more women reported using meth), race (whites had the highest percentage of use), and age group (primarily 25- to 44-year-olds were affected).

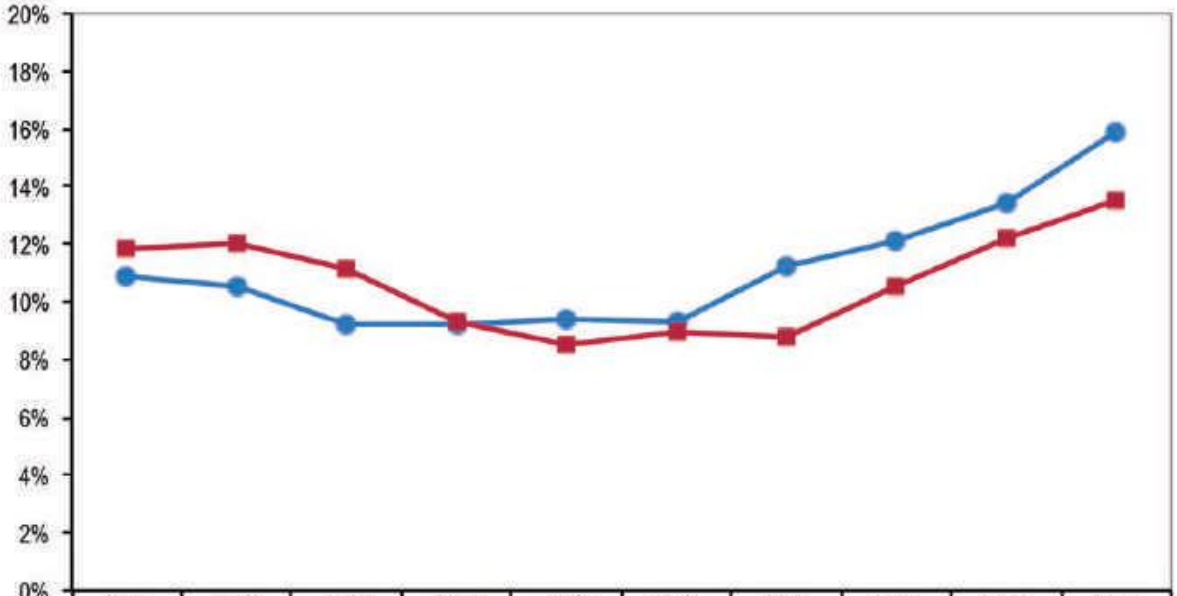
In the early- to mid-2000s, meth use in Indiana's treatment population was lower than or similar to that found in the rest of the nation. However, since 2009, Indiana's percentage surpassed the U.S. percentage (see Figure 1.3) (SAMHSA, 2014).

Legal Consequences

The Indiana State Police (ISP) seized 943 clandestine methamphetamine labs and made 622 meth lab arrests in 2016; these figures represent a decrease in both lab seizures and arrests from their peak in 2013 (ISP, 2017).

In Indiana, nearly 1,900 arrests were made for possession and just over 900 arrests for the sale/manufacture of synthetic drugs[10] in 2014; this represents annual arrest rates of 0.3 (U.S.: 0.2) and 0.1 (U.S.: 0.1), per 1,000 population, respectively (FBI, 2014).

Figure 1.3 Percentage of Treatment Episodes with Methamphetamine Use Reported at Treatment Admission in Indiana and U.S. (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	10.9%	10.5%	9.2%	9.2%	9.4%	9.3%	11.2%	12.1%	13.4%	15.9%
U.S.	11.8%	12.0%	11.1%	9.3%	8.5%	8.9%	8.8%	10.5%	12.2%	13.5%

Source: SAMHSA, 2014

[9]We defined methamphetamine dependence as "individuals in substance abuse treatment listing methamphetamine as their primary substance at admission."
[10]The Uniform Crime Reporting Program collects arrest information on synthetic drugs. The category includes methamphetamine, methadone, and Demerol.

PRESCRIPTION DRUG ABUSE

In 2016, more than 11 million controlled prescription drugs were dispensed in Indiana, most of which were opioids[11] (6.4 million) (Indiana Professional Licensing Agency [IPLA], 2017).

In 2014, an estimated 4.4% of Indiana residents ages 12 and older reported nonmedical use of pain relievers in the past year. Indiana's prevalence rate was similar to the nation's (4.1%). Young adults ages 18 to 25 had the highest rate (IN: 9.5%; U.S.: 8.3%) (SAMHSA, 2017).[12]

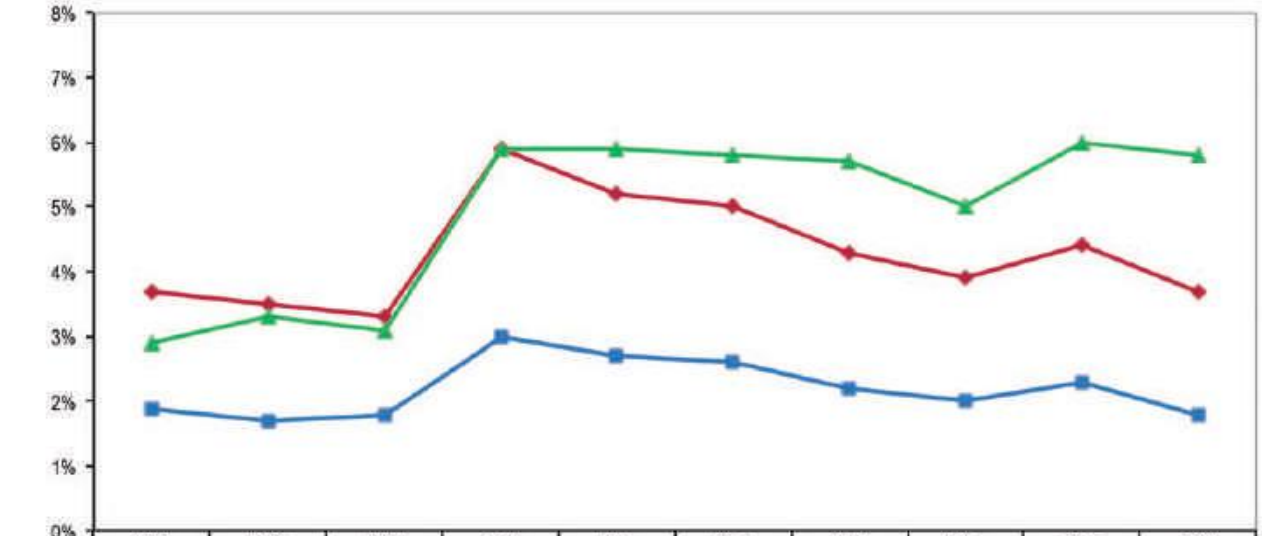
The Indiana College Substance Use Survey includes questions assessing a student's current (past month) use of various prescription medications for which he or she did not have a doctor's prescription. In 2016, 5.2% of college students misused prescription stimulants, 2.3% misused prescription painkillers, and 2.2% misused sedatives (King & Jun, 2016).

Youth Consumption

In 2014, nearly 5% of Hoosiers ages 12 to 17 used prescription pain medications for nonmedical purposes in the past year; Indiana's percentage was statistically similar to the nation's (4.6%) (SAMHSA, 2017).

For Indiana prevalence rates of current nonmedical use of prescription drugs[13] among 8th, 10th, and 12th grade students, see Figure 1.4.

Figure 1.4 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Current Nonmedical Use of Prescription Drugs (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th	1.9%	1.7%	1.8%	3.0%	2.7%	2.6%	2.2%	2.0%	2.3%	1.8%
10th	3.7%	3.5%	3.3%	5.9%	5.2%	5.0%	4.3%	3.9%	4.4%	3.7%
12th	2.9%	3.3%	3.1%	5.9%	5.9%	5.8%	5.7%	5.0%	6.0%	5.8%

Source: Gassman et al., 2016

[11]IOpioids include pain relievers, such as oxycodone and hydrocodone.
[12]NSDUH estimates for nonmedical use of prescription pain relievers are based on 2014 survey results, because of a change in methodology pertaining to prescription drug misuse. For more information, see Chapter 2, "Methods."
[13]Includes Ritalin, Oxycontin, and Xanax

Table 1.6 Percentage of Treatment Episodes with Prescription Drug Abuse and Dependence Reported at Treatment Admission in Indiana, by Drug Category, Gender, Race, and Age Group (Treatment Episode Data Set, 2014)

		All Prescription Drugs		Pain Relievers		Sedatives/ Tranquilizers		Stimulants	
		Misuse	Dependence	Misuse	Dependence	Misuse	Dependence	Misuse	Dependence
Gender	Male	23.6%	10.8%	18.6%	9.0%	6.6%	1.4%	1.3%	0.3%
	Female	36.3%	20.1%	29.5%	16.8%	10.6%	2.7%	1.7%	0.6%
Race	White	32.1%	16.4%	25.7%	13.6%	9.2%	2.3%	1.7%	0.5%
	Black	7.4%	3.3%	5.8%	2.8%	2.0%	0.5%	0.4%	0.1%
	Other	25.0%	11.5%	20.2%	10.4%	6.4%	0.7%	1.3%	0.4%
Ethnicity	Hispanic	16.4%	7.1%	13.3%	6.1%	4.2%	0.7%	1.0%	0.3%
	Non-Hispanic	29.0%	14.8%	23.2%	12.3%	8.3%	2.0%	1.5%	0.4%
Age Group	Under 18	14.4%	3.8%	8.4%	2.5%	5.2%	1.1%	1.9%	0.3%
	18-24	27.9%	11.2%	20.9%	8.8%	9.0%	2.0%	1.5%	0.4%
	25-34	36.5%	19.2%	30.0%	16.3%	9.8%	2.4%	1.9%	0.6%
	35-44	28.3%	15.7%	23.0%	13.3%	8.1%	1.9%	1.5%	0.5%
	45-54	17.0%	9.7%	14.4%	8.4%	4.5%	1.1%	0.4%	0.2%
	55+	14.9%	9.2%	11.9%	7.6%	4.8%	1.4%	0.7%	0.2%

Source: SAMHSA, 2014

Prescription Drug Abuse and Dependence

Prescription drug abuse has increased significantly in Indiana's substance abuse treatment population, rising from 14.5% in 2005 (U.S.: 11.0%) to 28.5% in 2014 (U.S.: 20.2%). The increase was primarily due to pain relievers. Compared to the nation, Indiana's percentages were significantly higher for overall prescription drugs, as well as each individual prescription drug category other than stimulants. In Indiana, significant differences were seen by gender, race, and age group. For detailed information on prescription drug abuse and dependence[14] in Indiana's treatment population, see Table 1.4 (SAMHSA, 2014).

Legal Consequences

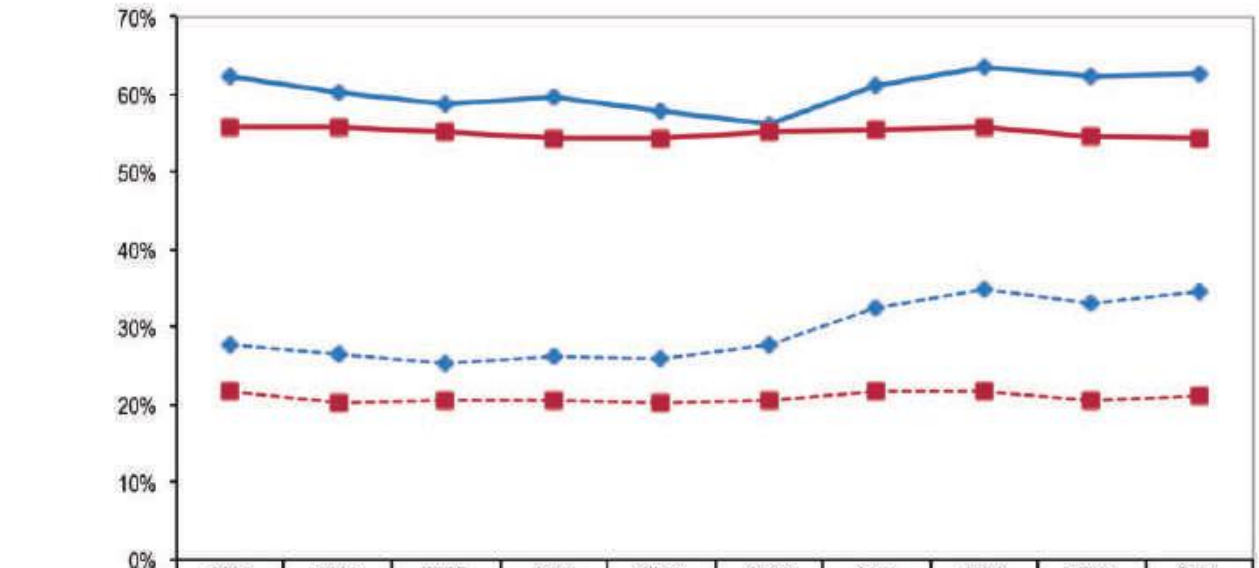
In 2014, law enforcement made over 2,800 arrests for possession and nearly 1,500 arrests for sale/manufacture of "other drugs" in Indiana. This represents arrest rates of 0.4 and 0.2 per 1,000 population, respectively. U.S. rates were significantly higher for possession (0.9) but the same for sale/manufacture (0.2) (FBI, 2014).

POLYSUBSTANCE ABUSE

Polysubstance abuse is a particularly serious pattern of drug use that involves consumption of two or more substances. A review of data from 2005 through 2014 revealed that over half of the individuals in substance abuse treatment reported using at least two drugs at the time of admission, and Indiana's rates were significantly higher than the nation's (see Figure 1.5). Furthermore, in one-third of Indiana treatment episodes, use of three or more substances was reported; Indiana's percentage increased significantly from 27.7% in 2005 to 34.5% in 2014 (see Figure 1.5). The percentages of polysubstance abuse were slightly higher for females, whites, and adults under the age of 35 (SAMHSA, 2014).

[14]We defined prescription drug dependence as "individuals in substance abuse treatment listing prescription drugs as their primary substance at admission."

Figure 1.5 Percentage of Indiana and U.S. Treatment Episodes with Polysubstance Abuse (Using at Least Two Substances; Using at Least Three Substances) Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana 2+	62.4%	60.4%	58.8%	59.8%	57.8%	56.2%	61.1%	63.5%	62.3%	62.8%
U.S. 2+	55.7%	55.9%	55.2%	54.4%	54.4%	55.1%	55.5%	55.9%	54.7%	54.4%
Indiana 3+	27.7%	26.6%	25.3%	26.3%	26.0%	27.8%	32.6%	34.8%	33.2%	34.5%
U.S. 3+	21.7%	20.2%	20.6%	20.5%	20.1%	20.4%	21.6%	21.7%	20.4%	21.0%

Notes: The percentage of treatment episodes with three or more substances is a subgroup of (i.e., included in) the percentage of treatment episodes with two or more substances.
Source: SAMHSA, 2014

Cluster Analysis

We conducted a cluster analysis of 2014 Indiana TEDS data to determine the combinations of drugs currently used by polysubstance abusers within the state. Alcohol and marijuana were most widely indicated in polysubstance abuse. The drug clusters most frequently reported at substance abuse treatment admission in Indiana were (a) alcohol and marijuana, (b) alcohol, marijuana, and a drug in the "other drug" category, and (c) marijuana and a drug in the "other drug" category (SAMHSA, 2014).

MENTAL HEALTH

Mental illness is associated with a number of other chronic diseases, as well as tobacco and substance use, and higher rates of suicide. The current prevalence of mental illness (MI) is higher in Indiana (20.6%) than in the United States (18.0%) (SAMHSA, 2017). However, rates of lifetime depression for Hoosiers were similar to those for the nation (IN: 20.5%; U.S.: 19.0%) (CDC, 2017a). Within Indiana, having a history of depression was most likely among females and individuals who identified as multiracial (CDC, 2017a).

Individuals with mental health or substance use disorders do not always receive treatment. Of Hoosiers with a mental health disorder, 41.8% received treatment (U.S.: 44.7%) while only 15.2% of those with an illicit substance use disorder (U.S.: 11.7%) and just 4.3% of those with an alcohol use disorder received care (U.S.: 4.6%) (SAMHSA, 2017).

Based on information from the Data Assessment Registry Mental Health and Addiction (DARMHA), about two-thirds (64.1%) of the treatment population were diagnosed with serious mental illness (SMI) and one-third (34.9%) had a substance use disorder (SUD); furthermore, 22% of clients were diagnosed with both a

co-occurring mental illness and substance use disorder. For details of the treatment population, see Table 1.5 (Indiana Division of Mental Health and Addiction, 2015).

Finally, the percentage of attempted suicides among high school students were similar in Indiana (9.9%) and the broader United States (8.6%), and suicide deaths in Indiana have increased gradually since 2003 (CDC, 2017b).

Table 1.5 Demographic Characteristics of Clients by Serious Mental Illness (SMI), Substance Use Disorder (SUD), and Co-occurring Disorder (COD) Diagnosis, in Indiana (DARMHA, 2015)

		SMI	SUD	COD
Gender	Male	55.9% (55.6-56.2)	38.7% (38.3-39.0)	22.5% (22.2-22.8)
	Female	77.2% (71.9-72.6)	31.2% (30.8-31.5)	21.4% (21.1-21.7)
Race	White	65.2% (64.9-65.4)	35.7% (35.4-36.0)	22.3% (22.1-22.6)
	Black	62.4% (61.8-63.1)	34.5% (33.8-35.1)	23.4% (22.8-23.9)
	Other	58.7% (58.0-59.5)	29.7% (29.0-30.3)	17.1% (16.5-17.7)
Ethnicity	Hispanic	61.7% (61.0-62.5)	29.9% (29.2-30.7)	19.7% (19.0-20.3)
	Non-Hispanic	64.4% (64.1-64.6)	35.4% (35.2-35.7)	22.2% (22.0-22.4)
Age Group	Under 18	44.9% (44.5-45.4)	14.5% (14.2-14.8)	12.2% (11.9-12.4)
	18-24	63.8% (63.1-64.6)	49.4% (48.7-50.2)	24.6% (23.9-25.2)
	25-34	65.6% (65.0-66.2)	55.7% (55.1-56.3)	29.0% (28.5-29.6)
	35-44	74.4% (73.9-75.0)	47.4% (46.8-48.1)	25.7% (28.2-29.3)
	45-54	82.5% (81.9-82.9)	41.2% (40.6-41.9)	29.0% (28.3-29.6)
	55-64	87.2% (86.6-87.8)	32.5% (31.7-33.3)	24.5% (23.7-25.2)
	65+	91.1% (90.1-91.9)	18.0% (16.8-19.2)	14.8% (13.7-16.0)
Total		**64.1% (63.9-64.4)**	**34.9% (34.7-35.1)**	**22.0% (21.8-22.2)**

Source: Indiana Division of Mental Health and Addiction, 2016

INDICATORS OF SUBSTANCE ABUSE

To measure and compare the severity of substance abuse among Indiana counties, we identified county-level consumption and consequence data for individual drug categories, including alcohol, marijuana, cocaine and heroin, methamphetamine, and prescription drugs. We then ranked Indiana counties on the selected indicators, using a highest-need/highest-contributor model; i.e., counties received a priority score based on their need for intervention (measured by the rate[15] at which an indicator occurred) and their overall *contribution* to the problem (measured by the frequency with which an indicator occurred).

We then calculated an *overall substance abuse priority score* to assess severity of consumption and consequences of alcohol and other drugs within each county. This score was computed by averaging the priority scores from each drug category. The top 10 percent of counties, i.e., those with the highest overall scores and most severe problems, are listed in Table 1.8.

Table 1.8 Counties with Total Priority Scores in the Top 10 Percent

Top 10 Percent	Overall Priority Score
Delaware	204
Vanderburgh	203
Madison	195
Lake	176
Monroe	174
Allen	167
Cass	160
Howard	159
Clark	155
Kosciusko	148

Note: Overall substance abuse priority scores ranged from 12 to 204, with higher scores indicating a more severe problem.
Source: Indiana Family and Social Services Administration, 2016; FBI, 2014; ISP, 2016, 2017; Indiana Professional Licensing Agency, 2017

[15]The rate was calculated by taking the frequency of an event (e.g., number of arrests), dividing it by the specified population (e.g., county population), and multiplying the result by 1,000. This represents the rate per 1,000 population.

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2 Methods

This report describes the consumption and consequences of alcohol, tobacco, and other drugs in Indiana residents. We analyzed patterns among Indiana's overall adult, and youth population, and compared them to patterns found among the U.S. population. Based on discussions with the State Epidemiology and Outcomes Workgroup (SEOW), we have reviewed consumption and consequences data for the following drugs: alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, and prescription medications. Additionally, we examined the occurrence of polysubstance abuse (i.e., the use of two or more drugs) as well as indicators of mental health in Indiana. Furthermore, we rank-ordered Indiana counties on the severity of their substance abuse problems, based on data sources available to us.

Our research team completed statistical analyses on publicly available local and national data sets using Statistical Package for the Social Sciences (SPSS) and Statistical Analysis System (SAS) software. For surveys that do not have publicly available data sets, we conducted statistical analyses using online analysis software and/or analysis tables provided by the agencies that conducted the data collection. Whenever possible, we made statistical comparisons across gender, racial/ethnic, and age groups for both drug-consumption behaviors and drug-use consequences. For all comparisons, a *P* value of .05 or less, or the 95 percent Confidence Interval (CI) was used to determine statistical significance.[1]

Prevalence rates and other statistics may be presented somewhat differently across all chapters, depending on the data sources that provided the information.

We used two guidelines to determine potential priorities. The first guideline was statistical significance. Statistical significance is a mathematical concept used to determine whether differences between groups are true or due to chance. Significance in this context does not necessarily mean "meaningful" and does not convey practical or clinical importance. Specific drug consumption and consequence patterns that place Indiana statistically significantly higher than the United States were used as markers for areas that could potentially benefit from intervention.

The second guideline was clinical or substantive significance; i.e., consumption behaviors or drug-use consequences that are trending toward a higher frequency within a particular group of Hoosiers, such as specific gender, race/ethnicity, or age.

DATA SOURCES

The data for these analyses were gathered from various publicly available federal, state, and local-level surveys and data sets. In order to compare Indiana with the nation as a whole and to determine trends in drug use and drug-related consequences over time, we selected, whenever possible, surveys and data sources that had at least two years' worth of data available. In all cases, the most recent findings were included.

All of the data sources have important strengths and weaknesses, which were factored into the interpretations of the findings. In general, trends evident in multiple sources based on probability samples (rather than on nonrandom samples) were given more weight in the interpretation process. The following sections briefly describe the surveys and data sources used to complete these reports. An overview of these sources is also provided in the SEOW data sources list, beginning on page 22 at the end of this chapter.

Alcohol-Related Disease Impact (ARDI) Database

The Centers for Disease Control and Prevention's (CDC) ARDI software generates estimates of alcohol-related deaths and years of potential life lost (YPLL) due to alcohol consumption. To do this, ARDI either calculates estimates or uses predetermined estimates of alcohol-attributable fractions (AAFs)—that is, the proportion of deaths from various causes that are due to alcohol. These AAFs are then multiplied by the number of deaths caused by a specific condition (e.g., liver cancer) to obtain the number of alcohol-attributable deaths. Reports can be generated based on national or state-level data.

[1]Throughout the chapters, we use the terms "significant," "significantly different," or "statistically different" to report on a statistically significant difference between groups.

Automated Reporting Information Exchange System (ARIES) and Fatality Analysis Reporting System (FARS)

The Indiana State Police's ARIES is a central repository for all vehicle collisions reported in the state of Indiana, with and without alcohol involvement. Information on fatal accidents contained in the system is submitted to FARS. FARS is a national database of fatal motor vehicle accidents, which was developed by the National Highway Traffic Safety Administration's National Center for Statistics and Analysis in 1975. Comparisons between Indiana and the nation should be interpreted with caution as data submissions to the FARS database are done on a voluntary basis and may not include all fatal motor vehicle accidents within a state or the nation.

Behavioral Risk Factor Surveillance System (BRFSS) Survey

The CDC conducts the BRFSS annually with the assistance of health departments in all 50 states and the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. BRFSS asks respondents ages 18 and older questions about health-related behaviors, including alcohol consumption and tobacco use. BRFSS results are available at the national and state levels as well as for selected metropolitan/micropolitan areas. BRFSS data allow for statistical comparisons across gender, age, race/ethnicity, educational attainment, and income level.

The BRFSS has traditionally used random-digit-dial telephone sampling of households with landline telephones. However, the increasing percentage of households abandoning their landline telephones for cell phones has significantly eroded the population coverage provided by landline-based surveys to 70% of the U.S. household population. To meet challenges for increasing non-coverage and decreasing response rates due to cell-phone-only households, BRFSS has expanded its traditional methodology to a dual frame survey of landline and cell phone numbers and has introduced a new weighting method called iterative proportional fitting, or raking.

Even though the State Epidemiological Profile continues to provide information on present and past BRFSS prevalence rates for alcohol and tobacco use, it would not be appropriate to directly compare estimates prior to 2011 with later estimates, due to different data adjustment methods and different sampling frames.

Data Assessment Registry for Mental Health and Addiction (DARMHA)

The Data Assessment Registry for Mental Health and Addiction (DARMHA) is an administrative database operated by Indiana's Division of Mental Health and Addiction (DMHA). The registry collects information on the entire Hoosier Assurance Plan (HAP) consumer population served by DMHA-contracted substance abuse and mental health providers. The registry was developed to support the use of information about the strengths and needs of clients to help make treatment decisions, monitor progress, and improve quality.

Hospital Discharge Data

The Indiana State Department of Health (ISDH) collects information on inpatients discharged from hospitals in Indiana. The data are publicly available in aggregate format and include information on hospitals, principal diagnoses and procedures, length of stay, total charges, etc. Additionally, ISDH provides reports (on request) on statewide outpatient visits, i.e., information contained in the State Emergency Department Dataset. Both datasets can be queried on diagnoses related to alcohol or drug use.

Indiana Adult Tobacco Survey (IN ATS)

The Indiana Adult Tobacco Survey (IN ATS), a survey by the Indiana Tobacco Prevention and Cessation Agency (ITPC), collects information on tobacco use among Hoosiers ages 18 and older. The survey uses a random-sampling design; African-American and Hispanic adults as well as residents in more rural regions of the state are oversampled. Data are available by gender, race/ethnicity, age group, income level, educational attainment, Indiana region, health insurance type, and number of children in household.

Indiana College Substance Use Survey

The Indiana College Substance Use Survey was developed in 2009 by the Indiana Collegiate Action Network (ICAN) and the Indiana Prevention Resource Center (IPRC), with input from Indiana institutions of higher education and the Indiana State Epidemiology and Outcomes Workgroup. The instrument was designed to assess prevalence of alcohol, tobacco and other drug use; consequences of use; alcohol availability; and student

perceptions of peer behaviors among Indiana college students. Information is available by gender, age category (under 21 vs. 21 or over), and type of institution (private vs. public). All two- and four-year colleges in Indiana are invited to participate in the survey. Results are based on nonrandom sampling and are not representative of all college students in Indiana. In 2016, 20 colleges participated in the survey, resulting in 9,898 usable responses.

Indiana Meth Lab Statistics and National Clandestine Laboratory Seizure System (NCLSS)

The Indiana State Police (ISP), Meth Suppression Section, collects data on clandestine meth lab seizures in the state, including number of meth labs seized, number of arrests made during lab seizures, and the number of children located at/rescued from meth labs. The information is then submitted to NCLSS, a database maintained by the U.S. Drug Enforcement Administration and the El Paso Intelligence Center. State and county-level information can be requested from the Indiana State Police.

Indiana Mortality Data and National Vital Statistics System (NVSS)

NVSS is a CDC-maintained data system that provides information on mortality rates by cause of death as coded in the World Health Organization's International Classification of Diseases, 10th Edition (ICD-10). Health departments in the 50 states, the District of Columbia, and U.S. territories provide CDC with data on deaths throughout the country. Using the query system on CDC's website (CDC WONDER), researchers can compute mortality rates for deaths due to diseases and events associated with alcohol, tobacco, and other drug use (e.g., cirrhosis, lung cancer, heart disease, suicide, homicide, etc.) at the national, state, and county level. The system also allows for comparisons across gender, age, and racial groups. Indiana mortality data can also be requested directly from the Indiana State Department of Health.

Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT)

INSPECT is the state's prescription drug monitoring program. The secure database collects basic demographic information on the patient, the type of controlled substance prescribed, the prescribing practitioner, and the dispensing pharmacy. Each time a controlled substance is dispensed, the dispenser (e.g., pharmacy, physician, etc.) is required to submit the information to INSPECT. The program was designed to help address problems of prescription drug abuse and diversion in Indiana. By compiling controlled substance information into an online database, INSPECT performs two critical functions: (1) maintaining a warehouse of patient information to assist healthcare professionals in making treatment decisions; and (2) providing an important investigative tool for law enforcement to help prevent the possible diversion of controlled substances.

Indiana Youth Survey (INYS)

The Indiana Youth Survey is an annual school-based assessment conducted by the Indiana Prevention Resource Center (IPRC) and funded through the Indiana Family and Social Services Administration/Division of Mental Health and Addiction. The survey is designed to monitor patterns of alcohol, tobacco, and other drug use; gambling behaviors; as well as risk and protective factors among Indiana middle and high school students, grades 6 through 12. Young people who complete the questionnaire are asked to report on their monthly use (use of drug at least once in the 30 days prior to the survey) of a wide range of substances.

In 2016, the INYS adopted two sampling approaches: (1) a probability sampling technique that generates a state-wide representative sample to provide statewide prevalence rates and risk and protective factors and (2) a convenience sampling technique that provides communities with local prevalence rates and risk and protective factors for needs assessment, planning and evaluation of substance abuse prevention programs, etc. For the random sample, which is conducted every other year, the target population contains all currently-operating public schools in Indiana. Only students in grades 6th, 8th, 10th, and 12th are surveyed. Monetary incentives are provided to the participating schools. In 2016, a total of 254 schools were selected, of which 113 schools participated in the survey and a total of 24,761 students were included in the data analyses. For the convenience sample, all public and private schools serving grades 6th through 12th are invited to participate in the survey every year. Schools that partake in the convenience samples do not

receive financial incentives. The benefits of participation include the ability to add up to 15 locally relevant questions and receiving a school corporation summary report prepared free-of-charge. More than 100,000 students have participated in the survey every year since 2005.

Indiana Youth Tobacco Survey (IYTS)

The CDC developed the National Youth Tobacco Survey as a way to estimate the current use of tobacco products among middle school and high school students in the United States. Student respondents are asked to describe their lifetime, annual, and current use of cigarettes and other tobacco products. The Indiana State Department of Health's Tobacco Prevention and Cessation Commission oversees Indiana's version of the survey, which includes CDC core and recommended questions, as well as state-specific items. IYTS is conducted every other year (even years); findings allow comparisons across gender, race/ethnicity, and grade levels.

Monitoring the Future (MTF) Survey

MTF is a national survey conducted annually by the National Institute on Drug Abuse in order to track changes in the drug consumption patterns of 8th, 10th, and 12th grade students throughout the United States. Respondents report on their lifetime, annual, and monthly use of a wide variety of substances, including alcohol, tobacco, heroin, cocaine, marijuana, methamphetamine, etc. Results from MTF are released annually and data sets are publicly available. Respondents are sampled randomly from schools throughout the country; data are not available at the state level.

National Survey on Drug Use and Health (NSDUH)

NSDUH is a national survey funded by SAMHSA and designed to monitor patterns and track changes in substance use for U.S. residents 12 years of age and older. The survey asks respondents to report on consumption patterns of substances including alcohol, tobacco, marijuana, cocaine, and other illicit drugs, as well as on the nonmedical (recreational) use of prescription medication. Additionally, NSDUH asks respondents whether they received treatment for drug abuse or drug dependence during the past (prior) year. The survey also includes several modules of questions that focus on mental health issues.

Prevalence rates for substance use and specific mental health indicators are provided for the nation and each state. Raw data files from NSDUH surveys are publicly available; however, they do not allow for comparisons among states because NSDUH eliminates state identifiers in the process of preparing public-use data files. Tables with prevalence numbers and rates are prepared by SAMHSA's Center for Behavioral Health Statistics and Quality and can be accessed online. Data reports are available since 1994. There is usually a two-year delay from the time of data collection to its availability.

In 2015, several changes were made to the NSDUH questionnaire and data collection process, causing some estimates not to be comparable with estimates from previous years. Items affected by these changes included binge drinking and prescription drug misuse. As part of the redesign, the definition of binge drinking for women was lowered from five or more drinks on one occasion to four or more drinks (for men, it remained at five or more drinks). Regarding prescription drug misuse, the modifications were substantial and included changing the definition of prescription drug misuse; revising the list of pertinent prescription drugs to exclude those that have been discontinued or are no longer legally available in the U.S.; adding questions that assess both appropriate use and misuse of prescription medication; and adding items that ask individuals to describe the ways they misuse prescription drugs and the motives driving their misuse. Due to these revisions, 2015 estimates cannot be compared to earlier years, nor can SAMHSA provide state-level estimates on these indicators, as state-level estimates require the use of two years' worth of data. SAMHSA will provide state-level estimates for binge drinking and prescription drug use starting with the 2017 NSDUH.

Treatment Episode Data Set (TEDS)

TEDS is a national database maintained by SAMHSA that records information about individuals entering treatment for substance abuse and/or dependence. State mental health departments submit data to TEDS on an annual basis. The information reported in TEDS includes age, race, ethnicity, gender, and other demographic characteristics, as well as information on the use of various substances. The data represent admissions rather than individuals, thus individuals may be admitted to treatment more than once in a given year. TEDS data become publicly available approximately two years after

the information is gathered. The format of the TEDS data allows for comparisons between Indiana and the United States by gender, race, and age groups.

County-level TEDS data for Indiana are available from the Indiana Family and Social Services Administration. While TEDS data can provide some information on drug use and abuse patterns both nationally and at the state level, the population on which the data are based may not be representative of all individuals in drug and alcohol treatment. For Indiana, TEDS data are limited to information on individuals entering substance abuse treatment who are 200% below the federal poverty level and receive state-funded treatment.

Uniform Crime Reporting Program (UCR)

UCR is a national database maintained by the FBI that records the number of arrests for various offenses, including property crimes, violent crimes, and drug-related crimes throughout the United States. Law enforcement agencies in the 50 states and the District of Columbia submit UCR data annually. Data are reported for each state and each county. UCR data sets are publicly available; however, there is a two-year lag from the time data are collected until they are published. The format of the UCR data sets allows for comparisons of arrests between Indiana and the entire United States, and for comparisons between juveniles and adults. Since the data are presented in an aggregate format, demographic variables such as gender, age, or race/ethnicity are not available.

While UCR data include information about drug possession and drug manufacturing arrests, the involvement of drugs or alcohol in the commission of other crimes such as rape, burglary, robbery, etc., is not recorded. Additionally, since states are not required to submit crime information to the FBI, the level of reporting varies considerably. Because of these variations, the FBI uses statistical algorithms to estimate arrests for counties in which reporting is less than 100 percent. In Indiana, typically about 60% of counties, on average, submit information to the FBI. Indiana has a rather low reporting rate, so UCR results should be interpreted with caution; however, completeness of reporting has been improving over the past years (see Table 2.1, page 26, for coverage indicator by county).

Youth Risk Behavior Surveillance System (YRBSS)

The YRBSS is a national survey of health-related behaviors among students in grades 9 through 12. The CDC conducts the survey biannually with the cooperation of state health departments throughout the nation. Student respondents are asked to describe whether they have engaged in numerous behaviors that could pose a danger to their health, including the use of alcohol, tobacco, and other drugs. CDC's online database allows comparisons between Indiana and the United States on gender, race/ethnicity, and grade level. Data for the YRBSS are available every other year (odd years), with a one-year lag between the end of data collection and the publication of results. Though YRBSS data for some states are available from 1991, Indiana started participating in data collection in 2003. Availability of state-level results is dependent upon sufficient participation to achieve an adequate response rate to weight the data.

CONSIDERATIONS

This report relies primarily on the data sources just discussed. These are either 1) publicly available sources that our researchers could access and analyze for this year's state epidemiological report or 2) agency data sources that were provided specifically to the SEOW. Because of the nature of the available data, there are significant limitations to the interpretations presented:

- Consistent comparisons across data sources are not always possible due to the nature of the survey questions asked and information gathered.
- Inconsistencies may occur within classifications of demographic characteristics (e.g., age ranges, racial categories, grade levels).
- Timeframes may be inconsistent for comparisons across substances and data sources (e.g., some data have longer gaps than others before they are made publicly available).
- State-level prevalence rates presented in national surveys are often estimated using statistical algorithms.
- Due to the reporting requirements for national databases, the data may not be representative of the actual population of either the state or the nation.

In future editions of this report, we will expand the data analysis as additional data sources are made available to the SEOW data analysis team.

SEOW DATA SOURCES LIST

Following is a list of the data sources used in this report, presented in a format for comparison.

Alcohol-Related Disease Impact (ARDI) Database

Description: ARDI provides state and national estimates on alcohol-related deaths and years of potential life lost (YPLL) based on alcohol-attributable fractions.
Sponsoring Organization/Source: Centers for Disease Control and Prevention (CDC)
Geographic Level: National and state levels
Availability: The database can be accessed at http://nccd.cdc.gov/DPH_ARDI/default/default.aspx .
Trend: 2006–2010 (all estimates are based on data averages from 2006 through 2010)
Strengths/Weaknesses: ARDI may underestimate the actual number of alcohol-related deaths and years of potential life lost.

Automated Reporting Information Exchange System (ARIES) and Fatality Analysis Reporting System (FARS)

Description: ARIES contains data on vehicle crashes with and without alcohol involvement; data on fatal crashes are submitted to FARS.
Sponsoring Organization/Source: Indiana State Police (ISP); U.S. Department of Transportation / National Highway Traffic Safety Administration (NHTSA)
Geographic Level: National, state, and county levels
Availability: Data are available from the NHTSA at http://www-fars.nhtsa.dot.gov/ and upon request from the Indiana State Police.
Trend: 1994–2015
Strengths/Weaknesses: The data are in aggregate format; comparisons by demographic variables such as age, gender, and race/ethnicity are not possible.

Behavioral Risk Factor Surveillance System (BRFSS) Survey

Description: BRFSS is an annual state health survey that monitors risk behaviors, including alcohol and tobacco consumption, related to chronic diseases, injuries, and death.
Sponsoring Organization/Source: Centers for Disease Control and Prevention (CDC); Indiana State Department of Health (ISDH)
Geographic Level: National and state
Availability: National and state data are available from the CDC at http://www.cdc.gov/brfss/brfssprevalence .
Trend: 1995–2015
Strengths/Weaknesses: CDC consistently works to test and improve BRFSS methodology in an effort to make findings result in more valid and reliable data for public health surveillance. Due to substantial changes in methodology starting with the 2011 survey, comparison of current estimates with estimates from previous years would not be appropriate.

Data Assessment Registry for Mental Health and Addiction (DARMHA)

Description: DARMHA is an administrative database that collects information on Indiana's consumer population served by DMHA-contracted substance abuse and mental health providers.
Sponsoring Organization/Source: Indiana Division of Mental Health and Addiction (DMHA)
Geographic Level: State and county levels
Trend: 2015
Availability: Memorandum of Understanding (MOU) between SEOW and DMHA.
Strengths/Weaknesses: Administrative data collected by behavioral health providers and submitted to DMHA.

Hospital Discharge Data

Description: Hospital discharge data are publicly available in aggregate format. Dataset can be queried by primary diagnosis (ICD-9 codes), e.g., alcohol- and drug-induced diseases.
Sponsoring Organization/Source: Indiana State Department of Health (ISDH)
Geographic Level: Indiana
Availability: Annual data are available at http://www.in.gov/isdh/20624.htm .
Trend: 1999–2015
Strengths/Weaknesses: The data are in aggregate format; comparisons by demographic variables such as age, gender, and race/ethnicity are not possible.

Indiana Adult Tobacco Survey (IN ATS)

Description: This survey measures tobacco use among Indiana adults, and includes items on tobacco use, cessation, secondhand smoke, and awareness.
Sponsoring Organization/Source: Indiana State Department of Health's Tobacco Prevention and Cessation Committee

Geographic Level: Indiana
Availability: Datasets can be requested from ITPC; reports are available at http://www.in.gov/isdh/tpc/2343.htm .
Trend: 2002, 2006–2015
Strengths/Weaknesses: IN ATS uses a random-sample design, making findings representative of all Hoosier adults. Oversampling of African-American and Hispanic adults, as well as residents in more rural regions, provides more robust estimates for these population groups.

Indiana College Substance Use Survey

Description: The survey measures the prevalence of alcohol, tobacco and other drug use; consequences of use; alcohol availability; and student perceptions of peer behaviors among Indiana college students.
Sponsoring Organization/Source: Indiana Collegiate Action Network (ICAN); Indiana Prevention Resource Center (IPRC)
Geographic Level: Indiana
Availability: Annual data are available at http://www.drugs.indiana.edu/indiana-college-survey/substance-use-survey.
Trend: 2009–2016
Strengths/Weaknesses: The survey utilizes a nonrandom sampling design; results, therefore, are not representative of all college students in Indiana.

Indiana Meth Lab Statistics and National Clandestine Laboratory Seizure System (NCLSS)

Description: The Indiana State Police (ISP), Meth Suppression Section, collects meth lab incidence data and submits the information to NCLSS, a national database. Data include: Number of meth labs seized, number of arrests made during lab seizures, and the number of children located at/rescued from meth labs.
Sponsoring Organization/Source: Indiana State Police (ISP), Meth Suppression Section; Drug Enforcement Administration (DEA), El Paso Intelligence Center (EPIC)
Geographic Level: National, state, and county
Availability: Indiana data from ISP are available on request; national data can be accessed at http://www.dea.gov/resource-center/meth-lab-maps.shtml .
Trend: 1995–2016
Strengths/Weaknesses: The data include all meth incidents, including labs, "dumpsites," or "chemical and glassware" seizures.

Indiana Mortality Data and National Vital Statistics System (NVSS)

Description: NVSS contains mortality data from all U.S. states; the online database can be queried on number of deaths and death rates from alcohol- and drug-related causes. Indiana data can also be directly requested from the Indiana State Department of Health (ISDH).
Sponsoring Organization/Source: Indiana State Department of Health (ISDH); CDC's National Center for Health Statistics
Geographic Level: National, state, and county levels
Availability: National mortality data can be accessed by underlying cause of death (ICD-10 codes) from CDC at http://wonder.cdc.gov/mortSQL.html; state data are available on request from the Indiana State Department of Health.
Trend: 1999–2014 (online from CDC); Indiana data for other years are available on request from ISDH.
Strengths/Weaknesses: The strengths of the NVSS include availability of multiple years of data and the relatively large number of American Indian, Alaska Native, and other Native American respondents. However, a primary weakness of the data are the quality of the race/ethnicity information, particularly for the American Indian/Alaska Native category, as data quality checks of the racial/ethnic distribution of the deceased in this category are lower than the distribution represented in Census estimates.

Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT)

Description: INSPECT is Indiana's prescription drug monitoring program; the online database collects information each time a controlled substance is dispensed.
Sponsoring Organization/Source: Indiana Professional Licensing Agency (IPLA)
Geographic Level: Indiana and counties (zip codes)
Availability: Eligible users (such as health care providers) may register for a secured account at www.in.gov/INSPECT .
Trend: 2010–2016
Strengths/Weaknesses: Data collection is statewide, and licensed dispensers (e.g., pharmacies, physicians) are required to submit information each time a controlled substance is dispensed.

Indiana Youth Survey (INYS)

Description: The Indiana Prevention Resource Center (IPRC) manages the Indiana Youth Survey. The survey is administered to students (6th through 12th graders) annually in a number of schools throughout the state.
Sponsoring Organization/Source: Indiana Prevention Resource Center (IPRC); Indiana Family and Social Services Administration (FSSA)/Indiana Division of Mental Health and Addiction (DMHA)
Geographic Level: State and regions
Availability: Reports with data tables are available at http://inys.indiana.edu/survey-results .
Trend: 1993–2016
Strengths/Weaknesses: School-specific survey results are valuable to participating schools and provide statewide prevalence estimates. Due to changes made to the survey, data cannot be compared to findings from previous years (prior to 2015).

Indiana Youth Tobacco Survey (IYTS) and National Youth Tobacco Survey (NYTS)

Description: IYTS is Indiana's adapted version of CDC's NYTS. The surveys collect data from students in grades 6 through 12 on all types of tobacco use, exposure to secondhand smoke, and access to tobacco.
Sponsoring Organization/Source: Indiana Tobacco Prevention and Cessation Agency (ITPC); Centers for Disease Control and Prevention (CDC)
Geographic Level: National and state
Availability: Data are available on request from ITPC, and annual reports can be accessed at http://www.in.gov/isdh/tpc/2343.htm . National data are available at http://www.cdc.gov/tobacco/data_statistics/surveys/NYTS/ .
Trend: 2000 through 2013 (NYTS) / 2000 through 2014 (IYTS)
Strengths/Weaknesses: The IYTS provides detailed statewide information regarding youth knowledge, attitudes, and behaviors. However, county-level data are not available.

Monitoring the Future (MTF) Survey

Description: MTF is an ongoing study of youth behaviors, attitudes, and values about substance use. Approximately 50,000 students in 8th, 10th, and 12th grades are surveyed annually. Follow-up surveys are distributed to a sample of each graduating class for a number of years after initial participation.
Sponsoring Organization/Source: National Institute on Drug Abuse (NIDA)
Geographic Level: National
Availability: Data tables are available at http://www.monitoringthefuture.org/data/data.html.
Trend: 1991–2015
Strengths/Weaknesses: A limitation of the survey design is that the target population does not include students who drop out of high school before graduation.

National Survey on Drug Use and Health (NSDUH)

Description: NSDUH provides national and state-level estimates on the use of alcohol, tobacco, and illicit drugs (including nonmedical prescription drug use), as well as mental health indicators in the general population ages 12 and older.
Sponsoring Organization/Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
Geographic Level: National and state; some sub-state data are available using small-area estimation techniques.
Availability: National and state data tables are available at the NSDUH website at http://www.samhsa.gov/data/population-data-nsduh .
Trend: State estimates are available for 1999–2015.
Strengths/Weaknesses: State-level data do not allow for comparisons by gender or race/ethnicity.

Treatment Episodes Data Set (TEDS)

Description: TEDS provides information on demographic and substance abuse characteristics of individuals in alcohol and drug abuse treatment. Data are collected by treatment episode. A treatment episode is defined as the period from the beginning of treatment services (admission) to termination of services.
Sponsoring Organization/Source: Substance Abuse and Mental Health Services Administration (SAMHSA); Indiana Family and Social Services Administration (FSSA)/Division of Mental Health and Addiction (DMHA)
Geographic Level: National and state; county-level data available from FSSA upon special request
Availability: National and state TEDS data were acquired from SAMHSA's Drug & Alcohol Services Information System at http://wwwdasis.samhsa.gov/dasis2/teds.htm .
Trend: 1999–2014 national and state TEDS data; county-level data reported for 2016

Strengths/Weaknesses: In Indiana, these data are not representative of the state as a whole, as only individuals who are at or below the 200% poverty level are eligible for treatment at state-registered facilities.

Uniform Crime Reporting Program (UCR): County-Level Detailed Arrest and Offense Data

Description: The UCR program provides a nationwide view of crime based on the submission of statistics by local law enforcement agencies throughout the country.
Sponsoring Organization/Source: United States Department of Justice/Federal Bureau of Investigation (FBI)
Geographic Level: National, state, and county
Availability: Data can be downloaded from the National Archive of Criminal Justice Data website (http://www.icpsr.umich.edu/icpsrweb/content/NACJD/guides/ucr.html).
Trend: 1994–2014
Strengths/Weaknesses: Reporting of UCR data by jurisdictions across the state is often less than 100%, in which case statistical algorithms are employed to estimate arrest numbers. See Table 2.1 on page 26 for coverage indicator by Indiana county.

Youth Risk Behavior Surveillance System (YRBSS)

Description: This biannual national survey monitors health risks and behaviors among youth in grades 9 through 12.
Sponsoring Organization/Source: Centers for Disease Control and Prevention (CDC); Indiana State Department of Health (ISDH)
Geographic Level: National, state
Availability: National and state-level data are downloadable from selected published tables on the CDC website at http://nccd.cdc.gov/YouthOnline/App/Default.aspx .
Trend: For the nation, the survey tracks every other year from 1991 through 2015; Indiana data are available for 2003 through 2015 (though due to a low response rate, no Indiana estimates are available for 2013).
Strengths/Weaknesses: At the state level, data by ethnicity (Hispanic) might not be available for some variables.

Table 2.1 Coverage Indicator for the 2014 Uniform Crime Reporting Data, by County (in Percent)

County	Coverage Indicator
Adams	38.8%
Allen	89.5%
Bartholomew	96.5%
Benton	0.0%
Blackford	100.0%
Boone	48.6%
Brown	100.0%
Carroll	0.0%
Cass	95.6%
Clark	99.4%
Clay	0.0%
Clinton	100.0%
Crawford	100.0%
Daviess	100.0%
Dearborn	17.6%
Decatur	44.7%
DeKalb	50.3%
Delaware	100.0%
Dubois	42.1%
Elkhart	100.0%
Fayette	0.0%
Floyd	95.9%
Fountain	0.0%
Franklin	100.0%
Fulton	70.2%
Gibson	67.3%
Grant	100.0%
Greene	86.0%
Hamilton	68.6%
Hancock	94.7%
Harrison	97.3%
Hendricks	100.0%
Henry	64.1%
Howard	98.7%
Huntington	42.8%
Jackson	71.1%
Jasper	17.6%
Jay	89.0%
Jefferson	0.0%
Jennings	84.2%
Johnson	98.8%
Knox	44.9%
Kosciusko	100.0%
LaGrange	100.0%
Lake	69.2%
LaPorte	62.2%
Lawrence	90.6%
Madison	98.1%

County	Coverage Indicator
Marion	94.9%
Marshall	31.1%
Martin	18.4%
Miami	100.0%
Monroe	99.6%
Montgomery	100.0%
Morgan	15.7%
Newton	58.3%
Noble	95.2%
Ohio	0.0%
Orange	0.0%
Owen	0.0%
Parke	25.0%
Perry	37.2%
Pike	20.3%
Porter	95.7%
Posey	87.6%
Pulaski	0.0%
Putnam	0.0%
Randolph	31.1%
Ripley	0.0%
Rush	27.3%
Saint Joseph	99.8%
Scott	50.7%
Shelby	100.0%
Spencer	0.0%
Starke	84.3%
Steuben	97.9%
Sullivan	46.7%
Switzerland	0.0%
Tippecanoe	98.8%
Tipton	65.9%
Union	0.0%
Vanderburgh	100.0%
Vermillion	27.6%
Vigo	97.9%
Wabash	67.6%
Warren	0.0%
Warrick	100.0%
Washington	0.0%
Wayne	43.8%
Wells	57.2%
White	85.4%
Whitley	31.7%

Note: The Coverage Indicator represents the proportion of county data that is not imputed for a given year. The indicator ranges from 0.0% (indicating that all data in the county are based on estimates) to 100.0% (indicating complete reporting; no computation).
Source: Federal Bureau of Investigation (FBI), 2014

3 Alcohol Use in Indiana: Consumption Patterns and Consequences

ALCOHOL CONSUMPTION

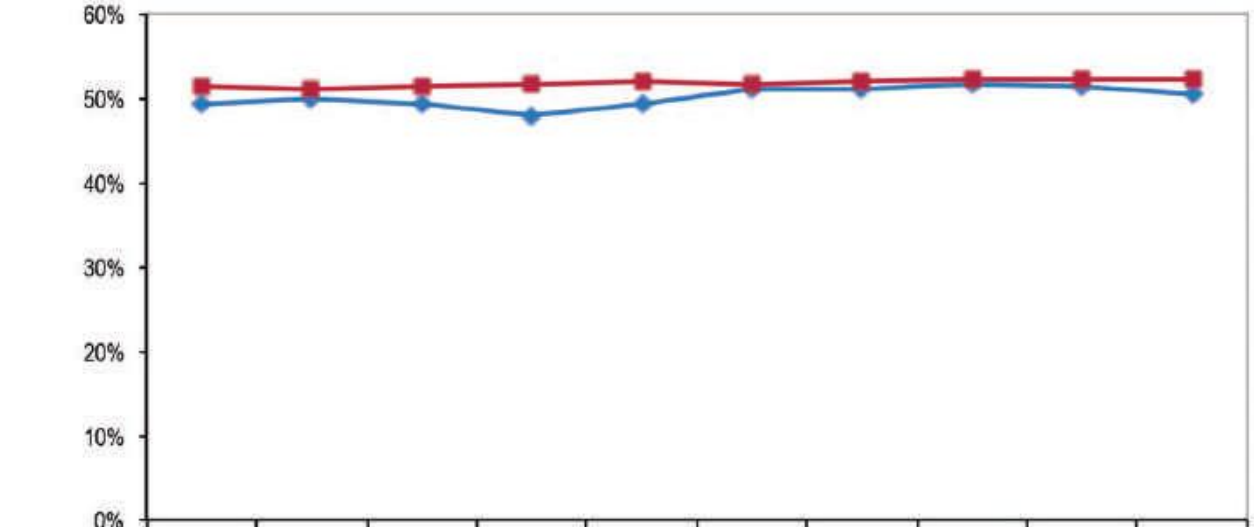
General Consumption Patterns

Alcohol is the most frequently used substance in both Indiana and the United States. In 2011, 11.2 million gallons of ethanol (the intoxicating agent in alcoholic beverages) were estimated to have been consumed in Indiana; this included, by volume, 119 million gallons of beer, 11.4 million gallons of wine, and 10.2 million gallons of spirits. The estimated annual per capita consumption of ethanol for the population 14 years and older was 2.0 gallons in Indiana and 2.3 gallons in the nation (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2016).

In 2016, a total of 11,691 permits for sale of alcoholic beverages were on file in Indiana, representing a rate of 1.8 licenses per 1,000 Hoosiers. Most licenses were in Marion (1,704) and Lake (894) Counties (Alcohol and Tobacco Commission, 2016).

Based on 2014–2015 averages calculated from the National Survey on Drug Use and Health (NSDUH), the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 50.4% (95% Confidence Interval [CI]: 47.7–53.2) of Indiana residents 12 years of age or older had used alcohol during the past month; Indiana's prevalence rate for current alcohol use[1] was similar to the U.S. rate of 52.2% (95% CI: 51.7–52.6) (see Figure 3.1) (SAMHSA, 2017).

Figure 3.1 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Current Alcohol Use (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	49.4%	50.1%	49.3%	48.0%	49.4%	51.0%	51.2%	51.6%	51.5%	50.4%
U.S.	51.4%	51.0%	51.4%	51.8%	51.8%	51.8%	51.9%	52.1%	52.4%	52.2%

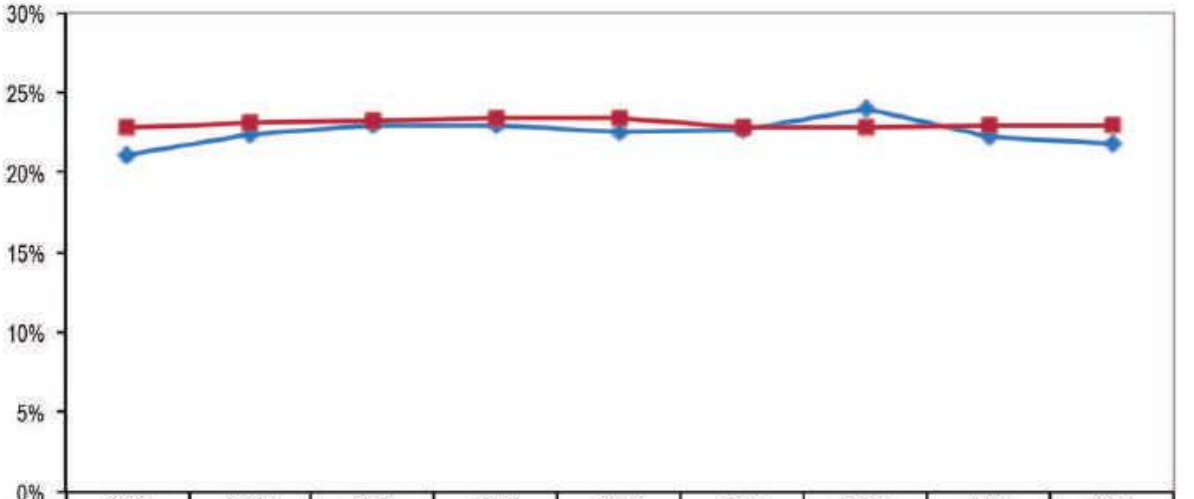
Source: SAMHSA, 2017

[1] Current alcohol use is defined as having used alcohol in the past 30 days or past month.

In 2015, SAMHSA redesigned the questions on the NSDUH pertaining to binge and heavy drinking. The definition of binge drinking for women was lowered from five or more drinks on one occasion to four or more drinks. As a result of these modifications, 2015 national data on binge alcohol use cannot be compared to NSDUH estimates from previous years. For the same reason, state-level data for binge alcohol use are currently not available as these estimates rely on pooled averages from two years' worth of data. State-level estimates will once again be available for the 2016 NSDUH (Center for Behavioral Health Statistics and Quality, 2016). Because of the NSDUH redesign, the current report relies upon data from the 2014 NSDUH for estimates of binge drinking, but provides 2015 estimates for all other alcohol-related patterns.

In previous years, NSDUH defined binge drinking as consumption of five or more alcoholic beverages on the same occasion (i.e., within a couple of hours of each other) on at least one day in the past month. In 2014, 21.8% of the Indiana population 12 years of age or older reported binge drinking (95% CI: 19.6–24.0), similar to that of the national average of 22.9% (95% CI: 22.5–23.3) (see Figure 3.2) (SAMHSA, 2017).

Figure 3.2 Percentage of Indiana and U.S. Population (12 years and older) Reporting Current Binge Drinking (National Survey on Drug Use and Health, 2006–2014)



	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	21.1%	22.3%	23.0%	23.0%	22.6%	22.7%	24.0%	22.3%	21.8%
U.S.	22.8%	23.2%	23.3%	23.5%	23.4%	22.9%	22.8%	22.9%	22.9%

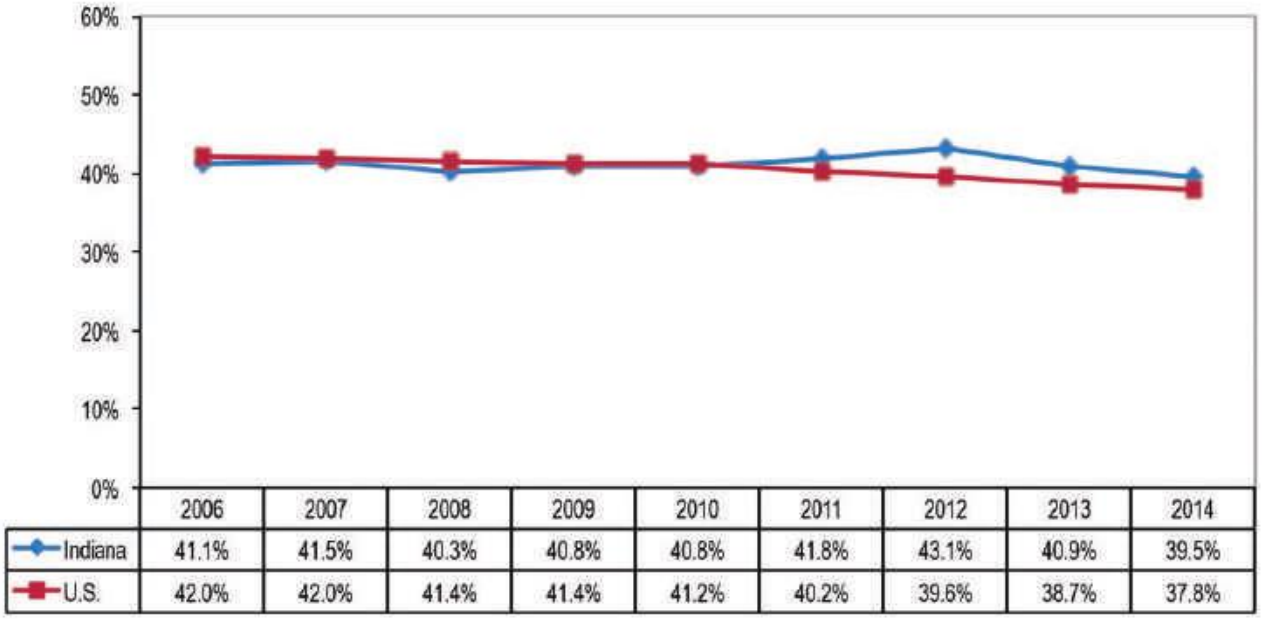
Note: Due to a change in the NSDUH question pertaining to binge drinking, no state-level estimates are currently available for 2015.
Source: SAMHSA, 2017

Adult Alcohol Consumption Patterns

According to 2014–2015 NSDUH results, 59.7% of Hoosiers (95% CI: 55.8–63.5) between the ages of 18 and 25 reported current alcohol use; the U.S. rate was similar at 59.0% (95% CI: 58.2–59.8). Past-month alcohol consumption was also similar among Indiana and U.S. adults 26 years and older with rates of 54.3% (95% CI: 50.5–58.1) and 56.2%, respectively (95% CI: 55.6–56.8) (SAMHSA, 2017).

Binge drinking was particularly widespread among young adults. The highest prevalence rate was found among 18- to 25year-olds, with the Indiana rate (39.5%; 95% CI: 35.7–43.3) and U.S. rate (37.8%; 95% CI: 37.1–38.6) being similar (see Figure 3.3). Among adults, binge drinking rates decreased with age; 21.0% (95% CI: 18.2–24.1) of Hoosiers ages 26 years and older reported having consumed five or more drinks on the same occasion during the last 30 days (U.S.: 22.2%, 95% CI: 21.7–22.7) (SAMHSA, 2017).

Figure 3.3 Percentage of Indiana and U.S. 18- to 25-Year-Olds Reporting Binge Drinking in the Past 30 Days (National Survey on Drug Use and Health, 2006–2014)



	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	41.1%	41.5%	40.3%	40.8%	40.8%	41.8%	43.1%	40.9%	39.5%
U.S.	42.0%	42.0%	41.4%	41.4%	41.2%	40.2%	39.6%	38.7%	37.8%

Note: Due to a change in the NSDUH question pertaining to binge drinking, no state-level estimates are currently available for 2015.
Source: SAMHSA, 2017

Table 3.1 Percentage of Indiana Adults Having Used Alcohol in the Past 30 Days, by Gender, Race/Ethnicity, and Age Group (Behavioral Risk Factor Surveillance System, 2015)

		Indiana % (95% CI)
Gender	Male	56.3% (53.4–59.1)
	Female	42.9% (40.3–45.4)
Race/Ethnicity	White	50.1% (48.1–52.1)
	Black	47.1% (39.2–55.0)
	Hispanic	48.6% (38.9–58.3)
Age Group	18-24	54.1% (46.9–61.3)
	25-34	57.7% (52.1–63.3)
	35-44	58.3% (53.2–63.4)
	45-54	51.2% (46.9–55.4)
	55-64	48.1% (44.6–51.5)
	65+	31.2% (28.7–33.7)
Total		**49.4% (47.5–51.3)**

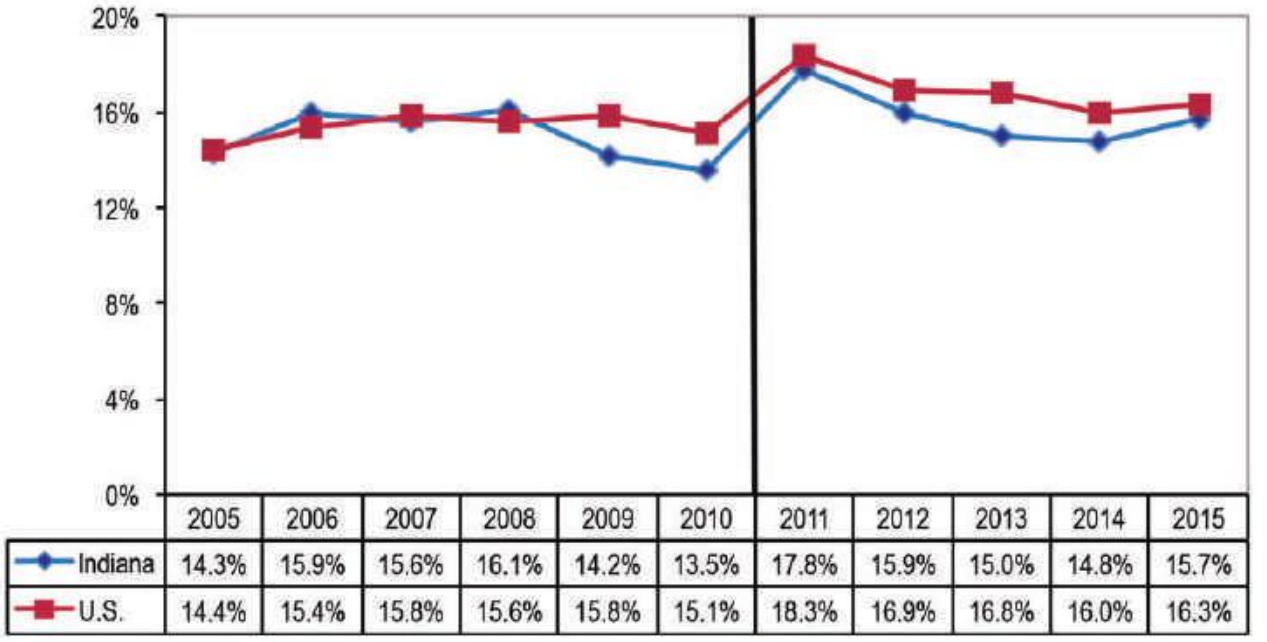
Source: CDC, 2017a

Based on findings from the 2015 Behavioral Risk Factor Surveillance System (BRFSS), adult prevalence rates for current alcohol use were 49.4% (95% CI: 47.5–51.3) for Indiana and 54.0% for the nation. In Indiana, rates were higher among males and among younger age groups (see Table 3.1) (Centers for Disease Control and Prevention [CDC], 2017a).

The BRFSS defines binge drinking as "males having five or more drinks on one occasion and females having four or more drinks on one occasion." The overall prevalence rate for adult binge drinking in Indiana (15.7%, 95% CI: 14.2–17.2) was similar to the U.S. median rate (16.3%) in 2015.

Statewide, binge alcohol use was significantly higher in males and more prevalent in younger individuals (see Table 3.2). Trends in binge drinking are shown in Figure 3.4. However, due to changes the CDC made to the BRFSS, survey data from 2011 and onward should not be compared to results from earlier years, though the data are provided here as a reference point. For more detailed information, see Chapter 2, "Methods."

Figure 3.4 Percentage of Indiana and U.S. Adults Reporting Binge Drinking in the Past 30 Days (Behavioral Risk Factor Surveillance System, 2005–2015)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	14.3%	15.9%	15.6%	16.1%	14.2%	13.5%	17.8%	15.9%	15.0%	14.8%	15.7%
U.S.	14.4%	15.4%	15.8%	15.6%	15.8%	15.1%	18.3%	16.9%	16.8%	16.0%	16.3%

Note: Beginning in 2011, prevalence rates should not be compared to earlier years due to changes in methodology.
Source: CDC, 2017a

Table 3.2 Percentage of Indiana Residents Who Engaged in Binge Drinking in the Past 30 Days, by Gender, Race/Ethnicity, and Age Group (Behavioral Risk Factor Surveillance System, 2015)

		Indiana % (95% CI)
Gender	Male	22.0% (19.5–24.5)
	Female	9.8% (8.1–11.5)
Race/Ethnicity	White	15.5% (13.9–17.1)
	Black	14.5% (8.8–20.1)
	Hispanic	21.5% (13.0–30.1)
Age Group	18-24	28.7% (22.3–35.0)
	25-34	21.8% (17.1–26.5)
	35-44	20.9% (16.7–25.0)
	45-54	14.0% (11.0–16.9)
	55-64	9.8% (7.7–12.0)
	65+	4.0% (2.9–5.1)
Total		**15.7% (14.2–17.2)**

Source: CDC, 2017a

Youth Alcohol Consumption Patterns/ Underage Drinking

According to the Youth Risk Behavior Surveillance System (YRBSS), during 2015, 30.5% (95% CI: 26.3–35.2) of high school students in Indiana had consumed at least one alcoholic drink in the past 30 days. No significant differences in alcohol consumption were observed by gender or race/ethnicity; however, rates varied by grade level, with 9th grade students reporting the lowest rate. Indiana's past-month alcohol prevalence among high school students was similar to the nation's rate (32.8%: 95% CI: 30.4–35.2) (CDC, 2017c).

In 2015, 17.4% (95% CI: 14.0–21.5) of high school students in Indiana said they had had five or more alcoholic drinks within a couple of hours at least once in the past month. This was statistically similar to the U.S. rate (17.7%; 95% CI: 15.8–19.8). Indiana's binge alcohol consumption among high school students decreased significantly from 28.9% in 2003 to 17.4% in 2015 (CDC, 2017c).

According to 2015 NSDUH estimates, 10.6% (95% CI: 8.22–12.3) of young people ages 12 to 17 consumed

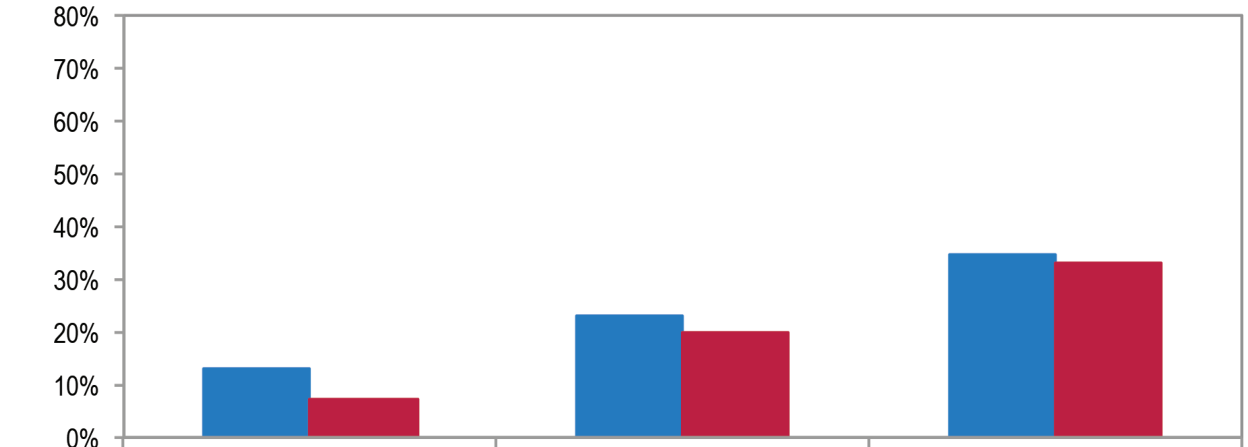
alcohol in the past 30 days in Indiana; the rate was the same on the national level (10.6%; 95% CI: 10.2–11.0; SAMHSA, 2017). In 2014, 6.3% (95% CI: 5.0–7.9) of Indiana youths in this age group engaged in binge drinking in the past month; the state's prevalence among 12- to 17-year-olds was similar to the nation's (6.2%; 95% CI: 5.9–6.5) (SAMHSA, 2017).

NSDUH also provides underage drinking prevalence estimates among 12- to 20-year-olds. In 2015, Indiana's rate for current use (21.0%; 95% CI: 18.6–23.6) was similar to that of the U.S. (21.6%; 95% CI: 21.0–22.2) (SAMHSA, 2017). Binge drinking rates in 2014 for 12- to 20-year-olds in Indiana (14.1%; 95% CI: 12.1–16.3) and the U.S. (14.0%; 95% CI: 13.5–14.5) were similar (SAMHSA, 2017).

In 2016, over one-third (34.6%) of Indiana 12th grade students reported using alcohol at least once during the past 30 days (Gassman et al., 2016). Overall, alcohol consumption patterns seemed to progress with age; i.e., 8th grade students showed lower prevalence rates than 10th and 12th grade students. For more detailed data on monthly alcohol use among Indiana and U.S. 8th, 10th, and 12th grade students, see Figure 3.5; for trend information (from 2005 through 2016) on monthly alcohol use among high school seniors, see Figure 3.6. For monthly and binge use by Indiana region and grade for 2016, see Appendix 3A, page 39.

The Indiana Prevention Resource Center (IPRC) developed the Indiana College Substance Use Survey to measure alcohol and other drug usage, attitudes, and perceptions among college students at two- and four-year institutions. According to 2016 results, which were based on 20 participating colleges, 62.7% of respondents reported past-month alcohol use; past-month consumption rates were significantly lower for underage students (52.0%) than for those ages 21 and older (74.0%). Similarly, past-month binge drinking prevalence (overall 35.7%) was significantly lower for underage students (31.4%) than for those ages 21 and older (40.2%) (King & Jun, 2016).[2]

Figure 3.5 Percentage of Indiana and U.S. 8th, 10th, and 12th Grade Students Reporting Monthly Alcohol Use (Indiana Youth Survey and Monitoring the Future Survey, 2016)

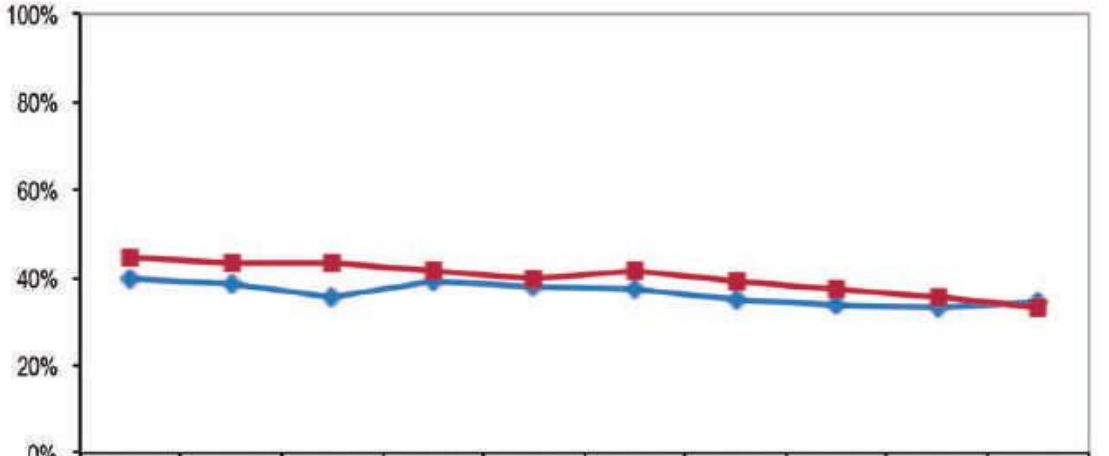


	8th Grade Monthly	10th Grade Monthly	12th Grade Monthly
Indiana	13.2%	22.9%	34.6%
U.S.	7.3%	19.9%	33.2%

Source: Gassman, et al., 2016; Inter-university Consortium for Political and Social Research, University of Michigan, 2016

[2]Twenty Indiana colleges participated in the 2016 survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

Figure 3.6 Percentage of Indiana and U.S. High School Seniors (12th Grade) Reporting Monthly Alcohol Use (Indiana Youth Survey and Monitoring the Future Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
IN Monthly Use	39.7%	38.4%	35.7%	39.4%	37.8%	37.6%	34.9%	33.9%	33.2%	34.6%
U.S. Monthly Use	44.4%	43.1%	43.5%	41.2%	40.0%	41.5%	39.2%	37.4%	35.3%	33.2%

Source: Gassman, et al., 2016; Inter-university Consortium for Political and Social Research, University of Michigan, 2016

CONSEQUENCES

Alcohol use is a major factor in homicides, suicides, violent crimes, and motor vehicle crashes. Heavy alcohol use can lead to serious patterns of abuse and/or dependence and is associated with other health compromising behaviors, such as cigarette smoking, illicit drug use, and risky sexual behaviors. Chronic alcohol use can lead to the development of cirrhosis and other serious liver diseases (CDC, 2016).

Alcohol Abuse and Dependence

Based on 2014–2015 NSDUH averages, the estimated prevalence for alcohol abuse and/or dependence[3] in the past year among those ages 12 and older was 5.9% (95% CI: 5.0–7.0) in Indiana, which was similar to the national estimate (6.1%; 95% CI: 6.0–6.3). Since at least 2006, Indiana's alcohol abuse/dependence prevalence rates have been similar to U.S. rates (see Figure 3.7). Of all age groups, adults ages 18 to 25 reported the highest prevalence rates both in Indiana and nationally across all years reviewed. Additionally, an estimated 6.4% (95% CI: 5.4–7.5) of those ages 12 and older were in need of but did not receive treatment for alcohol use in Indiana (U.S.: 6.2%; 95% CI: 6.0–6.4) (SAMHSA, 2017).

According to the Treatment Episode Data Set (TEDS), alcohol plays a major role in admissions to substance abuse treatment. In over half (53.3%) of Indiana treatment episodes in 2014, alcohol use was reported (U.S.: 51.9%), and in more than one-third (35.0%), alcohol dependence[4] was indicated (U.S.: 36.3%) (see Figure 3.8) (SAMHSA, 2014).

Factors significantly associated with alcohol abuse and dependence in Indiana included gender, race/ethnicity, and age:

Gender—A higher percentage of males (39.6%) in substance abuse treatment listed alcohol as their primary substance, compared to 27.6% of females.

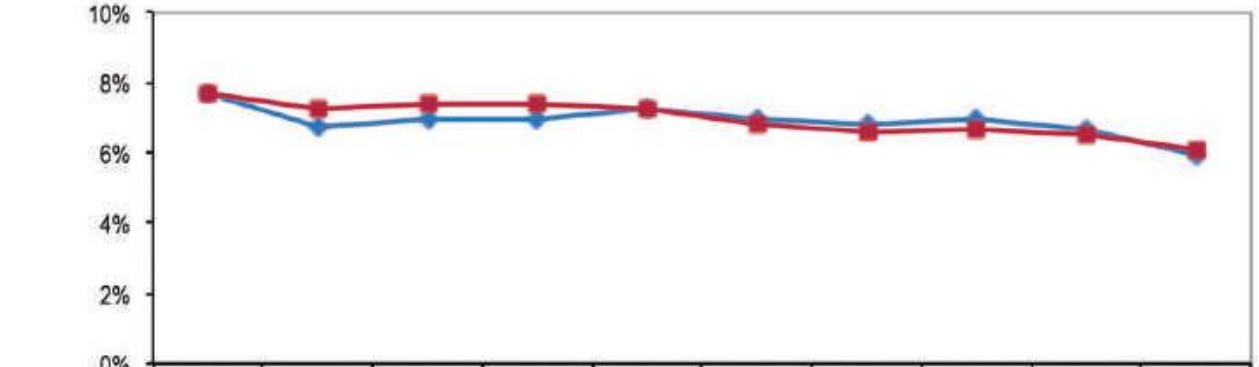
Race/ethnicity—Over one-third of whites (34.1%) reported alcohol as their primary substance; this percentage was below that for blacks (39.0%) and other races (37.9%). With regard to ethnicity, a significantly higher percentage of Hispanics (48.0%) reported alcohol dependence than non-Hispanics (34.6%).

[3]The NSDUH uses the terms "dependence" and "abuse" based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
[4]We defined alcohol dependence as "individuals in substance abuse treatment listing alcohol as their primary substance at admission."

Age—In the treatment population, the percentage of Hoosiers with alcohol dependence increased with age; clients under the age of 18 had the lowest percentage (14.3%) and those ages 55 and older had the highest percentage (65.4%).

Table 3.3 depicts the percentage of Indiana residents, categorized by gender, race, ethnicity, and age group, in treatment for alcohol abuse and dependence. See Appendix 3B, page 40, for county-level treatment data.

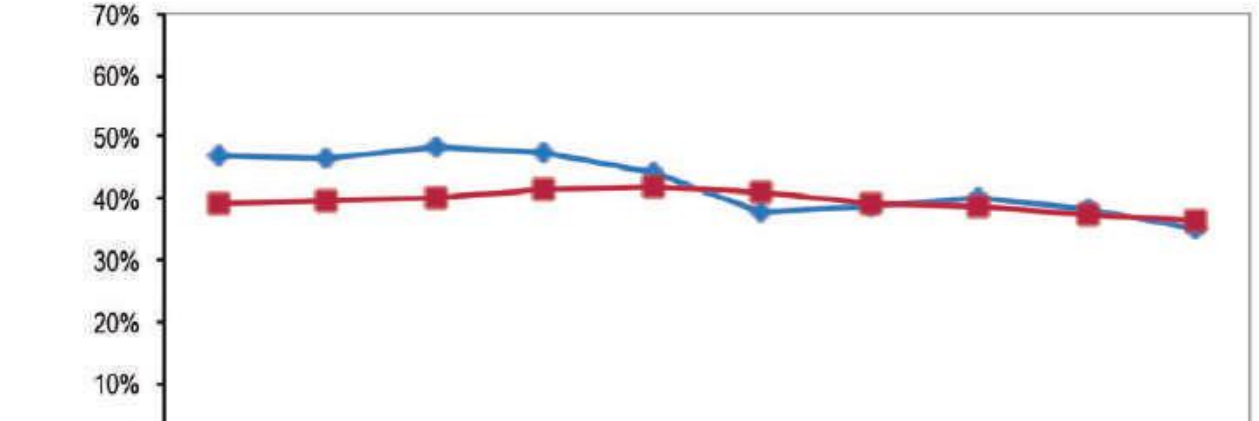
Figure 3.7 Percentage of Indiana and U.S. Population Ages 12 and Older with Alcohol Abuse and/or Dependence (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	7.7%	6.7%	6.9%	7.0%	7.2%	6.9%	6.8%	7.0%	6.7%	5.9%
U.S.	7.7%	7.2%	7.4%	7.4%	7.3%	6.8%	6.6%	6.7%	6.5%	6.1%

Source: SAMHSA, 2017

Figure 3.8 Percentage of Treatment Episodes in Indiana and the United States with Alcohol Dependence Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	47.0%	46.4%	48.1%	47.3%	44.2%	37.6%	38.5%	40.1%	38.0%	35.0%
U.S.	39.0%	39.5%	40.2%	41.3%	41.7%	40.9%	39.3%	38.9%	37.5%	36.3%

Source: SAMHSA, 2014

Table 3.3 Percentage of Treatment Episodes in Indiana with Alcohol Dependence Reported at Treatment Admission, by Gender, Race, Ethnicity, and Age Group (Treatment Episode Data Set, 2014)

		Alcohol Dependence
Gender	Male	39.6%
	Female	27.6%
Race	White	34.1%
	Black	39.0%
	Other	37.9%
Ethnicity	Hispanic	48.0%
	Non-Hispanic	34.6%
Age Group	Under 18	14.3%
	18-24	25.8%
	25-34	27.5%
	35-44	40.6%
	45-54	57.5%
	55+	65.4%
Total		**35.0%**

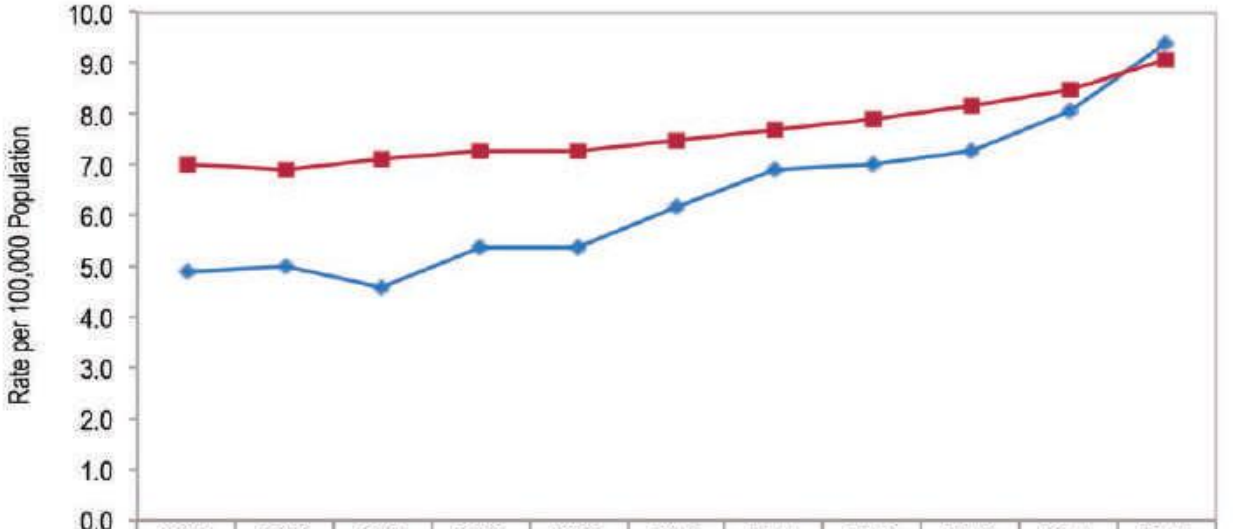
Source: SAMHSA, 2014

Alcohol-Related Morbidity and Mortality

Hospital discharge records show that in 2015, a total of 1,389 hospitalized patients were treated in Indiana for an alcohol-attributable primary diagnosis, representing one percent (0.7%) of all hospital discharges in the state (Indiana State Department of Health [ISDH], 2016).[5]

From 2000 through 2015, a total of 6,571 Hoosiers died from alcohol-induced causes (ISDH, 2017).[6] The age-adjusted mortality rate for alcohol-attributable deaths has climbed gradually throughout this time period in Indiana and the United States. Indiana's age-adjusted rate was 9.4 per 100,000 (95% CI: 8.7–10.1) in 2015, which was similar to the U.S. rate of 9.1 per 100,000 population (95% CI: 9.0–9.2) (see Figure 3.9) (CDC, 2017b).

Figure 3.9 Age-Adjusted Alcohol-attributable Mortality Rates per 100,000 Population in Indiana and the United States (CDC WONDER, 2005–2015)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	4.9	5.0	4.6	5.4	5.4	6.2	6.9	7.0	7.3	8.1	9.4
U.S.	7.0	6.9	7.1	7.3	7.3	7.5	7.7	7.9	8.2	8.5	9.1

Source: CDC, 2017b

[5]For our analysis, we only included primary diagnoses that were 100% attributable to alcohol, as listed in CDC's Alcohol-Related Disease Impact (ARDI) database. These included ICD-10 codes E24.4 (Alcohol-induced pseudo-Cushing's syndrome), F10 (Mental and behavioral disorders due to use of alcohol), G31.2 (Degeneration of nervous system due to alcohol), G62.1 (Alcoholic polyneuropathy), G72.1 (Alcoholic myopathy), I42.6 (Alcoholic cardiomyopathy), K29.2 (Alcoholic gastritis), K70 (Alcoholic liver disease), K86.0 (Alcohol-induced chronic pancreatitis), R78.0 (Finding of alcohol in blood), X45 (Accidental poisoning by and exposure to alcohol), X65 (Intentional self-poisoning by and exposure to alcohol), Y15 (Poisoning by and exposure to alcohol, undetermined cause) (Centers for Disease Control and Prevention, 2006-2010).

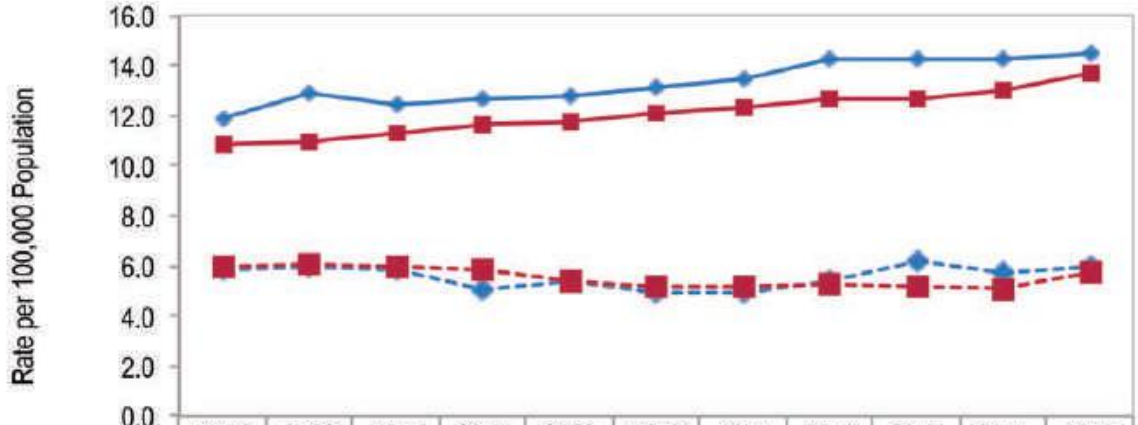
[6]Alcohol-induced causes of death include the following ICD-10 codes: E24.4, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K86.0, R78.0, X45, X65, Y15.

Though alcohol use is not associated with every suicide and homicide, these violent acts often involve individuals who have been drinking. According to CDC's Alcohol-Related Disease Impact (ARDI) database, 23% of suicides and 47% of homicides can be attributed to alcohol consumption (CDC, 2006–2010). (Appendix 3C, page 41, lists conditions that can be attributed to alcohol, along with their alcohol-attributable percentages.) For this reason, intentional self-harm (suicide)[7] and assault (homicide)[8] rates may provide additional information on alcohol's impact in a community.

From 2000 through 2015, a total of 13,114 Hoosiers died by suicide. Applying ARDI's estimate of 23%, this means that during these 16 years, a total of 3,016 suicide deaths were attributable to alcohol. Indiana's age-adjusted mortality rate for suicide was 14.5 per 100,000 population (95% CI: 13.5–15.3) in 2015, a rate statistically higher than the U.S. rate of 13.7 per 100,000 population (95% CI: 13.2–13.4) (see Figure 3.10). Rates were more than four times higher for males (23.8 per 100,000 population; 95% CI: 22.1–25.5) than for females (5.5 per 100,000 population; 95% CI: 4.7–6.3), and three times higher for whites (15.6 per 100,000 population; 95% CI: 14.5–16.6) than for blacks (5.0 per 100,000 population; 95% CI: 5.3–9.7) in Indiana (CDC, 2017b).

From 2000 through 2015, a total of 5,776 homicides were committed in Indiana. Applying ARDI's estimate of 47%, this means that 2,715 homicide deaths were attributable to alcohol during that time period. Indiana's age-adjusted homicide death rate was 6.0 per 100,000 population (95% CI: 5.4–6.6) in 2015, which was statistically similar to the U.S. rate of 5.7 per 100,000 population (95% CI: 5.6–5.7) (see Figure 3.10). In 2015, rates were three times higher for Indiana males (9.3 per 100,000 population; 95% CI: 8.2–10.3) than for females (2.8 per 100,000 population; 95% CI: 2.2–3.4), and almost 10 times higher for blacks (29.7 per 100,000 population; 95% CI: 25.6–33.8) than for whites (3.1 per 100,000 population; 95% CI: 2.6–3.5) (CDC, 2017b).

Figure 3.10 Age-Adjusted Mortality Rates per 100,000 Population for Intentional Self-Harm (Suicide) and Assault (Homicide), Indiana and the United States (CDC WONDER, 2005–2015)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Suicide Indiana	11.9	12.9	12.4	12.6	12.8	13.1	13.5	14.3	14.2	14.3	14.5
Suicide U.S.	10.8	10.9	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13.0	13.7
Homicide Indiana	5.8	5.9	5.8	5.1	5.4	4.9	4.9	5.4	6.2	5.7	6.0
Homicide U.S.	6.0	6.1	6.0	5.8	5.4	5.2	5.2	5.3	5.2	5.1	5.7

Source: CDC, 2017b

[7]Intentional self-harm (suicide) includes ICD-10 codes X60–X84.
[8]Assault (homicide) includes ICD-10 codes X85–Y09.

Alcohol consumption during pregnancy is another major concern since fetal alcohol spectrum disorders (FASD) are a direct result of prenatal exposure to alcohol. FASD is not a clinical diagnosis, but an umbrella term used to describe a range of disorders such as fetal alcohol syndrome, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects. Possible physical effects include brain damage; facial anomalies; growth deficiencies; defects of heart, kidney, and liver; vision and hearing problems; skeletal defects; and dental abnormalities. In the United States, the prevalence of fetal alcohol spectrum disorders is 10.0 per 1,000 live births (SAMHSA, Fetal Alcohol Spectrum Disorders Center for Excellence, 2007).

The Indiana Birth Defects and Problems Registry collects information on birth defects and birth problems for all children in Indiana from birth to 3 years old (5 years old for autism and fetal alcohol syndrome). State law requires doctors, hospitals, and other healthcare providers to submit a report to the registry at ISDH when a child is born with a birth defect. From 2008 through 2012, 116 children were born with fetal alcohol syndrome,[9] the most severe form of FASD, in Indiana (ISDH, 2008–2012).

Alcohol-Related Motor Vehicle Accidents

According to the Fatality Analysis Reporting System (FARS), a total of 746 fatal crashes occurred in Indiana in 2014, of which 192 (or 27%) were alcohol-related (U.S.: 9,068 alcohol-related crashes; 30%) (National Highway Traffic Safety Administration, 2014). Even though most fatal collisions happened in the afternoon between 3:00 and 5:59 p.m., the highest percentage of crashes attributable to alcohol-impaired driving[10] occurred at nighttime, especially between midnight and early morning hours (see Table 3.4).

Data from the Automated Reporting Information Exchange System (ARIES), part of the Indiana State Police's Vehicle Crash Records System, showed a decrease in alcohol-related collisions from 13,911 in 2003 to 8,642 in 2015. This represents a 38% drop. The number of fatal crashes with alcohol involvement also decreased, from 242 to 152, representing a 37% drop. (For a detailed listing of alcohol-related collisions and fatalities in Indiana by county for 2015, see Appendix 3D, pages 41-43). The overall rate for alcohol-related collisions in Indiana in 2015 was 1.3 per 1,000 population (Indiana State Police, 2016.

[9]The ICD-9 code for fetal alcohol syndrome is 760.71.
[10]Alcohol-impaired driving means that at least one driver or motorcycle rider had a blood alcohol content (BAC) of .08 or higher.

Table 3.4 Number of Fatal Crashes and Percent Alcohol-Related in Indiana, by Time of Day and Crash Type (Fatality Analysis Reporting System, 2014)

	Single Vehicle			Multiple Vehicle			All Crashes		
Time of Crash	Number	Alcohol-impaired Driving	Percent Alcohol-impaired Driving	Number	Alcohol-impaired Driving	Percent Alcohol-impaired Driving	Number	Alcohol-impaired Driving	Percent Alcohol-impaired Driving
Midnight to 2:59 a.m.	49	28	57%	17	7	41%	66	35	53%
3 a.m. to 5:59 a.m.	46	24	53%	16	6	36%	62	30	49%
6 a.m. to 8:59 a.m.	33	4	12%	39	3	8%	72	7	10%
9 a.m. to 11:59 a.m.	33	5	15%	40	3	8%	73	8	11%
Noon to 2:59 p.m.	33	7	21%	55	4	7%	88	11	12%
3 p.m. to 5:59 p.m.	53	16	30%	75	12	16%	128	28	22%
6 p.m. to 8:59 p.m.	61	18	30%	51	13	25%	112	31	28%
9 p.m. to 11:59 p.m.	75	28	38%	29	14	47%	104	42	40%
Total	**383**	**130**	**34%**	**322**	**61**	**19%**	**705**	**192**	**27%**

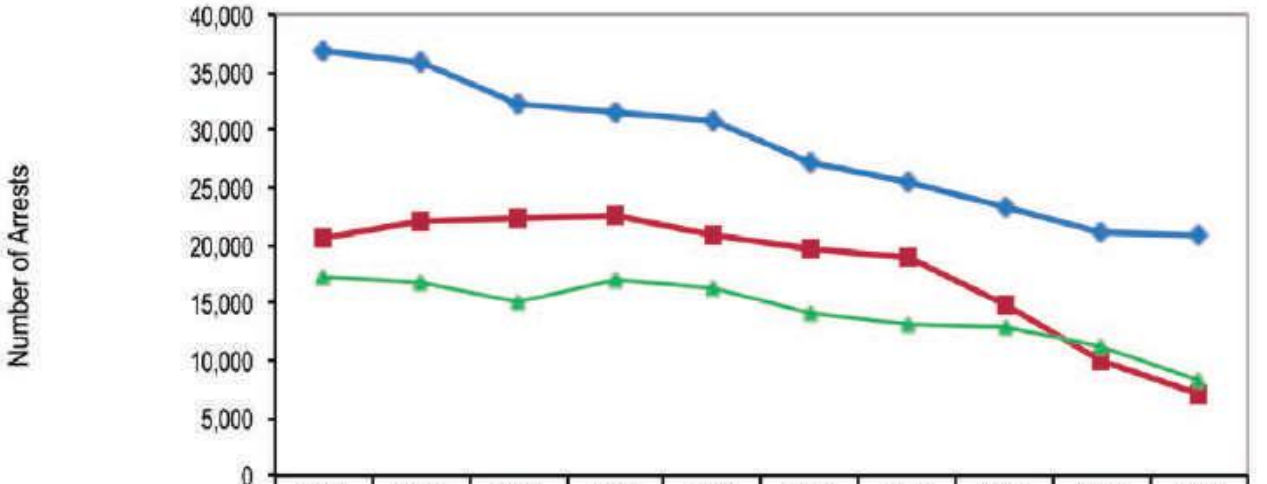
Note: National Highway Traffic Safety Administration estimates alcohol involvement when alcohol test results are unknown.
Source: National Highway Traffic Safety Administration, 2014

Alcohol-Related Crimes

Using the Uniform Crime Reporting Program (UCR) dataset, we compared alcohol-related offenses, including arrests for driving under the influence (DUI; commonly known as "drunk driving"), public intoxication ("public drunkenness"), and liquor law violations (i.e., violations of alcohol-related policies by the alcohol retail industry, including selling/furnishing alcohol to minors, minimum age of employee selling/serving alcohol, etc.), between Indiana and the United States (Federal Bureau of Investigation [FBI], 2014). In 2014, a total of 20,810 DUI arrests were made in Indiana. The arrest rate was statistically significantly higher for Hoosiers, at 3.2 per 1,000 population (95% CI: 3.1–3.3), compared to U.S. residents, at 3.0 per 1,000 population (95% CI: 3.0–3.0). Close to 7,100 Hoosiers were arrested for public intoxication; the arrest rate in Indiana of 1.1 per 1,000 population (95% CI: 1.0–1.2), was the same as the national rate. Additionally, almost 8,250 arrests occurred for liquor law violations in Indiana, representing an arrest rate of 1.2 per 1,000 population (95% CI: 1.1–1.3), which was significantly higher than the U.S. rate of 0.9 per 1,000 population (95% CI: 0.9–0.9) (see Figures 3.11–3.14).

Arrests for alcohol-related crimes varied among Indiana counties. These county differences are presented in Maps 3.1 through 3.3 (pages 46-48) and Appendix 3E (pages 44-45).

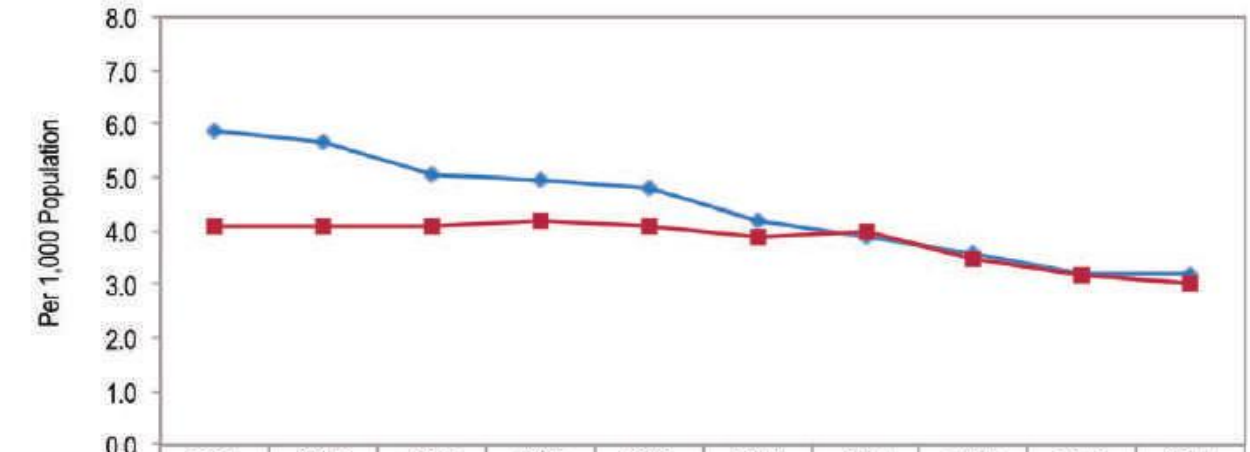
Figure 3.11 Number of Arrests for Driving Under the Influence (DUI), Public Intoxication, and Liquor Law Violations in Indiana (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
DUI	36,772	35,884	32,232	31,447	30,819	27,112	25,410	23,350	21,160	20,810
Public Intoxication	20,701	21,987	22,229	22,545	20,936	19,617	18,975	14,787	9,897	7,107
Liquor Law Violations	17,119	16,659	15,066	16,950	16,183	14,027	13,042	12,866	11,292	8,245

Source: FBI, 2014

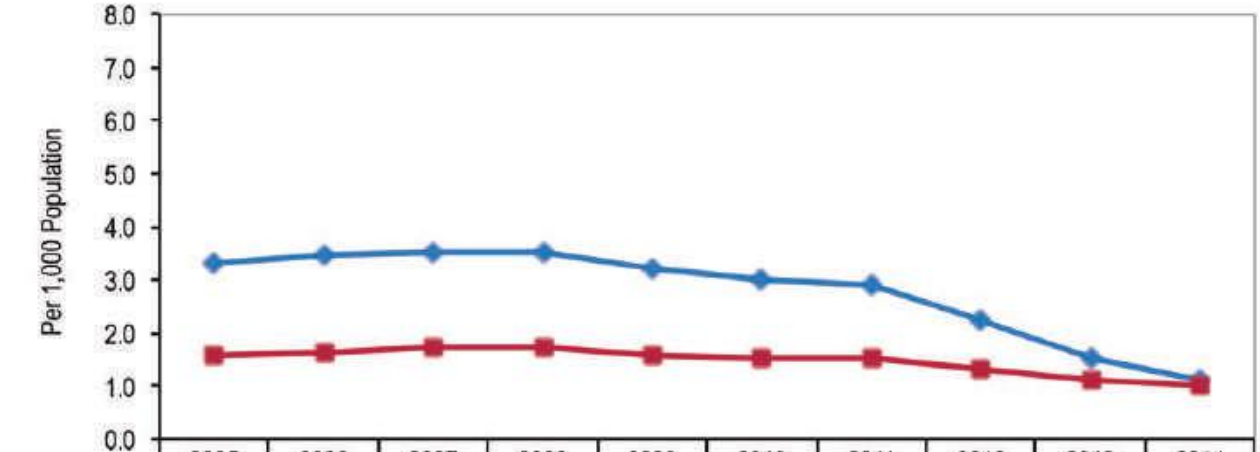
Figure 3.12 Arrest Rates, per 1,000 Population, for Driving Under the Influence (DUI) in Indiana and the United States (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	5.9	5.7	5.1	4.9	4.8	4.2	3.9	3.6	3.2	3.2
U.S.	4.1	4.1	4.1	4.2	4.1	3.9	4.0	3.5	3.2	3.0

Source: FBI, 2014

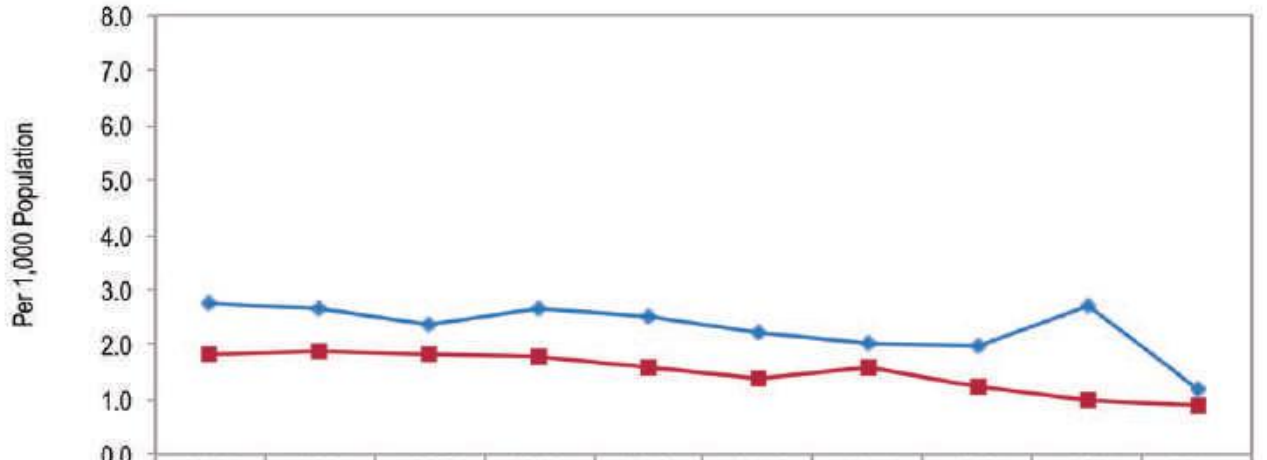
Figure 3.13 Arrest Rates, per 1,000 Population, for Public Intoxication in Indiana and the United States (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	3.3	3.5	3.5	3.5	3.2	3.0	2.9	2.3	1.5	1.1
U.S.	1.6	1.6	1.7	1.7	1.6	1.5	1.5	1.3	1.1	1.0

Source: FBI, 2014

Figure 3.14 Arrest Rates, per 1,000 Population, for Liquor Law Violation in Indiana and the United States (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	2.7	2.6	2.4	2.7	2.5	2.2	2.0	2.0	2.7	1.2
U.S.	1.8	1.9	1.8	1.8	1.6	1.4	1.6	1.2	1.0	0.9

Source: FBI, 2014

APPENDIX 3A

Percentage of Indiana Students Reporting Monthly and Binge Alcohol Use, by Region and Grade (Indiana Youth Survey, 2016)

		Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
6th Grade	Monthly	3.6	4.1	3.7	4.7	1.8*	3.3	4.0	3.1	4.6*
	Binge	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7th Grade	Monthly	7.4	9.5*	10.2*	5.8	5.6*	5.5*	7.4	6.5	8.5
	Binge	2.6	3.7*	4.3*	2.6	0.9*	2.1	2.4	2.2	2.9
8th Grade	Monthly	13.2	15.2*	14.8*	10.7	11.2*	11.3*	14.0	12.6	13.6
	Binge	5.0	5.8	6.4*	4.6	3.6*	4.5	4.7	4.7	5.0
9th Grade	Monthly	18.2	19.4	17.6	18.6	15.8	15.3*	18.6	21.2*	18.1
	Binge	7.8	8.3	7.8	6.1	5.9*	6.5*	7.0	9.3*	9.1*
10th Grade	Monthly	22.9	26.3*	25.7*	21.8	23.2	18.5*	22.6	23.0	22.4
	Binge	9.8	12.1*	10.4	5.1*	10.4	7.3*	9.6	10.8	9.1
11th Grade	Monthly	26.9	30.0*	24.7	22.8	27.0	27.6	23.5*	27.0	27.8
	Binge	12.2	13.6	10.6	7.8*	11.9	11.8	9.6*	14.1*	13.7
12th Grade	Monthly	34.6	36.2	34.1	31.1	37.1	30.2*	30.0*	35.7	38.5*
	Binge	17.5	18.7	16.7	13.2	19.0	15.0*	13.7*	19.1	19.5*

Notes: * Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).
Beginning in 2015, the Indiana Youth Survey stopped asking 6th grade students about binge drinking.
Source: Gassman et al., 2016

APPENDIX 3B

Number of Treatment Episodes with Alcohol Use and Dependence Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Alcohol Use		Alcohol Dependence	
County	**Total**	**Number**	**%**	**Number**	**%**
Adams	295	165	55.9%	100	33.9%
Allen	1,618	1,077	66.6%	655	40.5%
Bartholomew	581	201	34.6%	123	21.2%
Benton	50	39	78.0%	23	46.0%
Blackford	82	31	37.8%	17	20.7%
Boone	187	68	36.4%	55	29.4%
Brown	83	42	50.6%	25	30.1%
Carroll	84	54	64.3%	33	39.3%
Cass	253	177	70.0%	105	41.5%
Clark	313	82	26.2%	73	23.3%
Clay	181	93	51.4%	65	35.9%
Clinton	227	109	48.0%	68	30.0%
Crawford	45	22	48.9%	14	31.1%
Daviess	169	71	42.0%	51	30.2%
Dearborn	449	229	51.0%	149	33.2%
Decatur	212	122	57.5%	76	35.8%
DeKalb	242	176	72.7%	106	43.8%
Delaware	1,138	462	40.6%	345	30.3%
Dubois	280	221	78.9%	151	53.9%
Elkhart	654	349	53.4%	245	37.5%
Fayette	234	82	35.0%	51	21.8%
Floyd	117	34	29.1%	33	28.2%
Fountain	48	16	33.3%	7	14.6%
Franklin	166	76	45.8%	47	28.3%
Fulton	143	97	67.8%	52	36.4%
Gibson	295	177	60.0%	125	42.4%
Grant	436	265	60.8%	163	37.4%
Greene	204	85	41.7%	53	26.0%
Hamilton	893	550	61.6%	384	43.0%
Hancock	193	90	46.6%	65	33.7%
Harrison	31	11	35.5%	9	29.0%
Hendricks	351	133	37.9%	100	28.5%
Henry	330	119	36.1%	78	23.6%
Howard	610	276	45.2%	182	29.8%
Huntington	147	67	45.6%	35	23.8%
Jackson	298	111	37.2%	61	20.5%
Jasper	105	49	46.7%	29	27.6%
Jay	188	86	45.7%	51	27.1%
Jefferson	366	155	42.3%	1,065	29.0%
Jennings	223	100	44.8%	63	28.3%
Johnson	275	136	49.5%	81	29.5%
Knox	298	146	49.0%	99	33.2%
Kosciusko	381	235	61.7%	140	36.7%
LaGrange	186	127	68.3%	66	35.5%
Lake	2,339	1,348	57.6%	965	41.3%
LaPorte	377	208	55.2%	145	38.5%
Lawrence	485	193	39.8%	114	23.5%
Madison	1,278	589	46.1%	366	28.6%
Marion	3,645	1,540	42.2%	1,002	27.5%
Marshall	205	104	50.7%	62	30.2%
Martin	62	28	45.2%	108	29.0%
Miami	272	163	59.9%	96	35.3%
Monroe	1,180	620	52.5%	427	36.2%
Montgomery	374	153	40.9%	100	26.7%
Morgan	482	177	36.7%	119	24.7%
Newton	33	15	45.5%	13	39.4%
Noble	307	178	58.0%	94	30.6%
Ohio	40	24	60.0%	17	42.5%
Orange	160	89	55.6%	52	32.5%
Owen	199	95	47.7%	58	29.1%
Parke	67	42	62.7%	27	40.3%
Perry	102	65	63.7%	39	38.2%
Pike	53	28	52.8%	26	49.1%
Porter	410	160	39.0%	101	24.6%
Posey	170	116	68.2%	75	44.1%
Pulaski	109	57	52.3%	32	29.4%
Putnam	215	86	40.0%	57	26.5%
Randolph	170	77	45.3%	50	29.4%
Ripley	184	103	56.0%	66	35.9%
Rush	138	62	44.9%	30	21.7%
Saint Joseph	1,231	620	50.4%	434	35.3%
Scott	165	42	25.5%	26	15.8%
Shelby	168	73	43.5%	50	29.8%
Spencer	144	89	61.8%	49	34.0%
Starke	193	48	24.9%	33	17.1%
Steuben	298	211	70.8%	131	44.0%
Sullivan	78	44	56.4%	25	32.1%
Switzerland	63	28	44.4%	18	28.6%
Tippecanoe	404	219	54.2%	130	32.2%
Tipton	70	32	45.7%	17	24.3%
Union	22	8	36.4%	7	31.8%
Vanderburgh	1,319	722	54.7%	439	33.3%
Vermillion	123	50	40.7%	31	25.2%
Vigo	803	392	48.8%	244	30.4%
Wabash	225	129	57.3%	83	36.9%
Warren	9	6	66.7%	<5	N/A
Warrick	267	159	59.6%	94	35.2%
Washington	63	18	28.6%	9	14.3%
Wayne	438	192	43.8%	108	24.7%
Wells	128	70	54.7%	33	25.8%
White	110	57	51.8%	29	26.4%
Whitley	105	73	69.5%	40	38.1%
Indiana	**33,170**	**16,629**	**50.1%**	**10,753**	**32.4%**

Notes: We defined alcohol dependence as “individuals in substance abuse treatment listing alcohol as their primary substance at admission.”
We calculated the percentages by dividing the number of reported alcohol use/dependence by the number of treatment episodes.
Information on treatment episodes <5 was suppressed due to confidentiality constraints.
Source: Indiana Family and Social Services Administration, 2016

APPENDIX 3C

Conditions that are Directly Attributable to Alcohol in Indiana (Alcohol-Related Disease Impact, Based on Averages from 2006–2010)

Condition	Percentage Directly Attributable to Alcohol
Alcohol abuse/dependence	100%
Alcohol cardiomyopathy	100%
Alcohol polyneuropathy	100%
Alcohol-induced chronic pancreatitis	100%
Alcoholic gastritis	100%
Alcoholic liver disease	100%
Alcoholic myopathy	100%
Alcoholic psychosis	100%
Degeneration of nervous system due to alcohol	100%
Fetal alcohol syndrome/Fetus and newborn affected by maternal alcohol use	100%
Alcohol poisoning	100%
Excessive blood alcohol level	100%
Suicide by and exposure to alcohol	100%

Condition	Percentage Directly Attributable to Alcohol
Chronic pancreatitis	84%
Gastroesophageal hemorrhage	47%
Homicide	47%
Fire Injuries	42%
Hypothermia	42%
Esophageal varices	40%
Liver cirrhosis, unspecified	40%
Portal hypertension	40%
Drowning	34%
Fall injuries	32%
Poisoning (not alcohol)	29%
Acute pancreatitis	24%
Suicide	23%

Source: Centers for Disease Control and Prevention, 2006–2010

APPENDIX 3D

Number and Rate (per 1,000) of All and Fatal Alcohol-Related Collisions in Indiana, by County (Automated Reporting Information Exchange System, 2015)

	All Collisions			Fatal Collisions		
County	Total Collisions	Alcohol-related Collisions	Alcohol-related Collision Rate	Total Fatal Collision	Alcohol-related Fatal Collisions	Alcohol-related Fatal Collision Rate
Adams	762	31	0.89	5	1	0.03
Allen	13,776	624	1.69	27	11	0.03
Bartholomew	2,220	72	0.89	18	3	0.04
Benton	166	9	1.04	1	0	0.00
Blackford	299	14	1.14	1	0	0.00
Boone	1,931	48	0.76	12	2	0.03
Brown	517	33	2.20	2	0	0.00
Carroll	489	22	1.11	3	1	0.05
Cass	1,143	50	1.32	3	1	0.03
Clark	5,012	154	1.33	15	1	0.01
Clay	773	35	1.32	7	1	0.04
Clinton	1,127	67	2.05	7	3	0.09
Crawford	335	11	1.05	5	1	0.10
Daviess	312	32	0.97	7	1	0.03
Dearborn	1,840	76	1.54	7	3	0.06
Decatur	917	33	1.24	0	0	0.00
DeKalb	1,333	47	1.10	7	0	0.00
Delaware	4,260	191	1.63	10	2	0.02
Dubois	1,650	90	2.12	5	1	0.02
Elkhart	7,379	239	1.17	31	7	0.03
Fayette	500	33	1.41	2	0	0.00
Floyd	2,794	110	1.43	8	2	0.03
Fountain	428	16	0.96	1	0	0.00

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APPENDIX 3D *(Continued from previous page)*

	All Collisions			Fatal Collisions		
County	**Total Collisions**	**Alcohol-related Collisions**	**Alcohol-related Collision Rate**	**Total Fatal Collision**	**Alcohol-related Fatal Collisions**	**Alcohol-related Fatal Collision Rate**
Franklin	500	30	1.31	2	0	0.00
Fulton	627	20	0.98	3	0	0.00
Gibson	1,189	56	1.66	12	3	0.09
Grant	2,404	53	0.78	7	0	0.00
Greene	953	36	1.11	2	1	0.03
Hamilton	8,093	291	0.94	12	2	0.01
Hancock	1,700	57	0.79	6	2	0.03
Harrison	1,300	43	1.09	10	1	0.03
Hendricks	4,456	159	1.01	11	1	0.01
Henry	1,103	46	0.94	7	2	0.04
Howard	2,602	100	1.21	12	3	0.04
Huntington	1,209	47	1.28	7	2	0.05
Jackson	1,723	63	1.43	7	0	0.00
Jasper	1,294	45	1.34	6	2	0.06
Jay	703	20	0.95	6	2	0.09
Jefferson	1,031	53	1.63	4	0	0.00
Jennings	825	28	1.00	3	0	0.00
Johnson	3,560	143	0.96	9	1	0.01
Knox	930	53	1.40	3	0	0.00
Kosciusko	2,611	95	1.21	8	2	0.03
LaGrange	981	38	0.98	6	0	0.00
Lake	16,750	741	1.52	56	11	0.02
LaPorte	3,818	203	1.83	10	4	0.04
Lawrence	1,589	67	1.47	3	0	0.00
Madison	3,979	180	1.39	15	2	0.02
Marion	34,278	1,202	1.28	88	13	0.01
Marshall	1,636	73	1.56	3	1	0.02
Martin	148	5	0.49	3	0	0.00
Miami	1,094	48	1.34	8	1	0.03
Monroe	4,315	205	1.42	7	1	0.01
Montgomery	1,147	43	1.12	5	2	0.05
Morgan	1,809	74	1.06	13	6	0.09
Newton	423	24	1.71	3	1	0.07
Noble	1,502	78	1.63	5	0	0.00
Ohio	164	6	1.01	1	0	0.00
Orange	625	28	1.43	3	0	0.00
Owen	637	33	1.58	7	2	0.10
Parke	533	32	1.89	3	1	0.06
Perry	481	33	1.71	4	2	0.10
Pike	221	19	1.51	5	0	0.00
Porter	5,240	258	1.54	20	6	0.04
Posey	659	39	1.53	4	1	0.04
Pulaski	431	21	1.63	1	0	0.00
Putnam	983	47	1.25	8	3	0.08
Randolph	549	22	0.87	8	1	0.04
Ripley	860	36	1.25	1	0	0.00
Rush	352	15	0.90	3	1	0.06
Saint Joseph	8,806	303	1.13	12	4	0.01
Scott	640	23	0.97	1	0	0.00
Shelby	1,247	40	0.90	8	0	0.00

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APPENDIX 3D *(Continued from previous page)*

County	All Collisions			Fatal Collisions		
	Total Collisions	Alcohol-related Collisions	Alcohol-related Collision Rate	Total Fatal Collision	Alcohol-related Fatal Collisions	Alcohol-related Fatal Collision Rate
Spencer	682	37	1.79	7	0	0.00
Starke	667	32	1.39	3	1	0.04
Steuben	1,510	54	1.57	5	2	0.06
Sullivan	472	29	1.39	6	1	0.05
Switzerland	175	7	0.67	2	0	0.00
Tippecanoe	7,481	261	1.40	15	4	0.02
Tipton	373	17	1.11	2	1	0.07
Union	118	5	0.70	2	0	0.00
Vanderburgh	7,347	272	1.50	15	3	0.02
Vermillion	379	25	1.59	4	1	0.06
Vigo	3,749	149	1.38	11	1	0.01
Wabash	984	36	1.12	12	3	0.09
Warren	227	9	1.09	2	0	0.00
Warrick	1,560	51	0.82	4	0	0.00
Washington	733	27	0.97	5	1	0.04
Wayne	2,605	111	1.66	7	1	0.01
Wells	761	28	1.00	3	2	0.07
White	921	43	1.77	12	3	0.12
Whitley	895	38	1.14	4	0	0.00
Indiana	**216,312**	**8,642**	**1.31**	**756**	**152**	**0.02**

Note: Rates based on numbers lower than 20 are unreliable.
Source: Indiana State Police, 2015

APPENDIX 3E

Number and Rate, per 1,000 Population, of Arrests for Driving Under the Influence (DUI), Public Intoxication, and Liquor Law Violations in Indiana, by County (Uniform Crime Reporting Program, 2014)

County	Number of Arrests for DUI	DUI Arrest Rate	Number of Arrests for Public Intoxication	Public Intoxication Arrest Rate	Number of Arrests for Liquor Law Violations	Liquor Law Violation Arrest Rate
Adams	77	2.2	5	0.1	35	1.0
Allen	1,231	3.4	429	1.2	161	0.4
Bartholomew	402	5.0	75	0.9	105	1.3
Benton	27	3.1	5	0.6	11	1.3
Blackford	39	3.2	7	0.6	6	0.5
Boone	225	3.7	29	0.5	86	1.4
Brown	26	1.7	0	0.0	9	0.6
Carroll	61	3.0	8	0.4	23	1.1
Cass	203	5.3	140	3.6	131	3.4
Clark	620	5.5	168	1.5	109	1.0
Clay	86	3.2	16	0.6	37	1.4
Clinton	78	2.4	7	0.2	74	2.3
Crawford	45	4.2	7	0.7	9	0.8
Daviess	122	3.7	14	0.4	54	1.7
Dearborn	171	3.4	26	0.5	53	1.1
Decatur	47	1.8	3	0.1	107	4.1
DeKalb	144	3.4	19	0.4	52	1.2
Delaware	559	4.8	293	2.5	200	1.7
Dubois	127	3.0	11	0.3	64	1.5
Elkhart	678	3.4	80	0.4	192	1.0
Fayette	81	3.4	24	1.0	45	1.9
Floyd	196	2.6	105	1.4	58	0.8
Fountain	53	3.2	12	0.7	26	1.5
Franklin	2	0.1	0	0.0	29	1.4
Fulton	49	2.4	17	0.8	19	0.9
Gibson	138	4.1	18	0.5	60	1.8
Grant	125	1.8	57	0.8	71	1.0
Greene	47	1.4	10	0.3	13	0.4
Hamilton	903	3.0	130	0.4	455	1.5
Hancock	205	2.7	18	0.2	68	0.9
Harrison	42	1.1	8	0.2	23	0.6
Hendricks	344	2.2	19	0.1	150	1.0
Henry	127	2.6	39	0.8	103	2.1
Howard	238	2.9	109	1.3	61	0.7
Huntington	130	3.5	11	0.3	43	1.2
Jackson	157	3.6	70	1.6	61	1.4
Jasper	108	3.2	10	0.3	31	0.9
Jay	92	4.3	29	1.3	26	1.2
Jefferson	106	3.3	24	0.7	52	1.6
Jennings	39	1.4	9	0.3	90	3.2
Johnson	419	2.8	42	0.3	278	1.9
Knox	93	2.5	34	0.9	57	1.5
Kosciusko	538	6.9	38	0.5	87	1.1
LaGrange	99	2.6	11	0.3	178	4.7
Lake	2,262	4.6	925	1.9	673	1.4
LaPorte	577	5.2	180	1.6	207	1.9
Lawrence	97	2.1	10	0.2	103	2.2
Madison	377	2.9	113	0.9	136	1.0

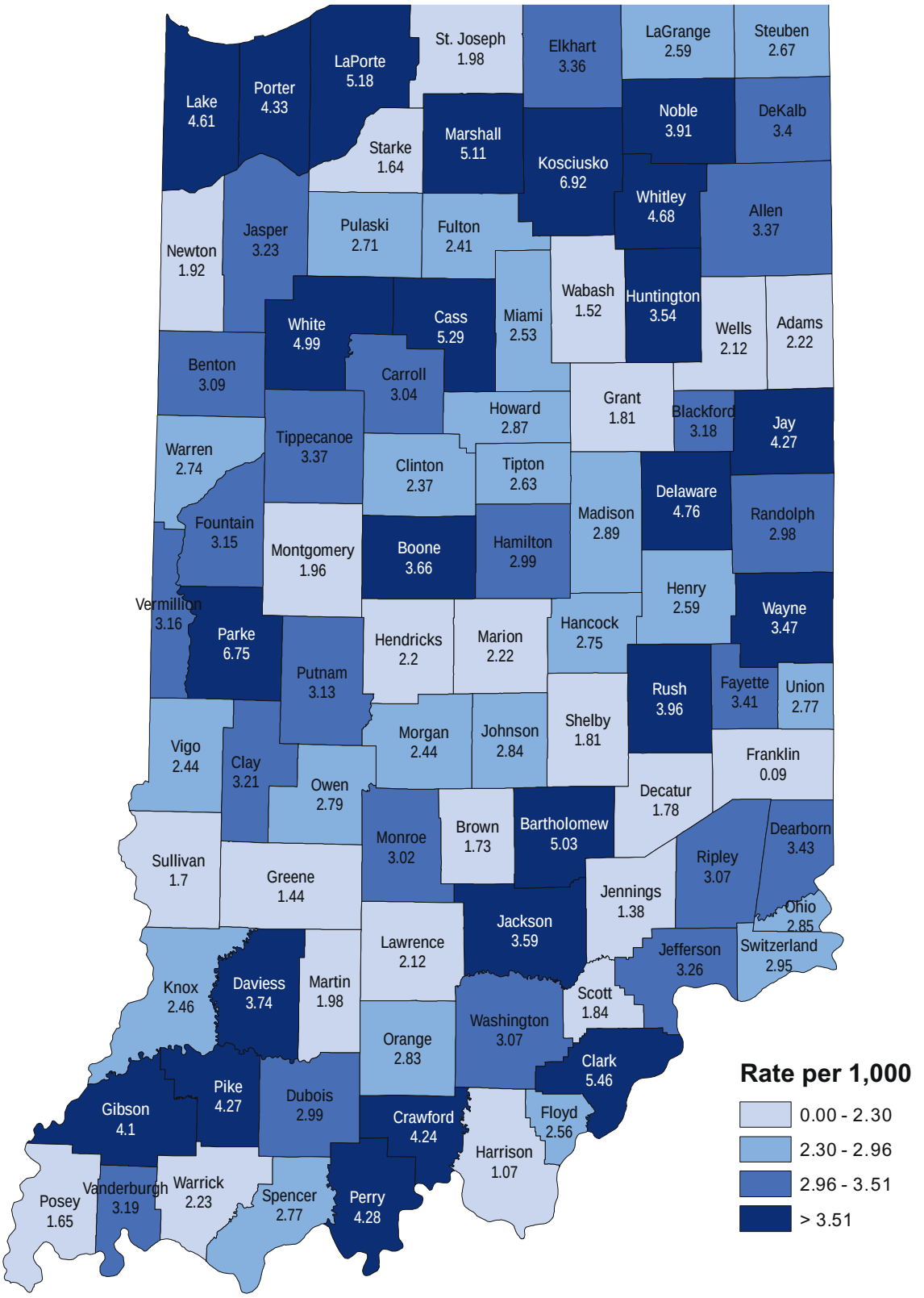
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APPENDIX 3E *(Continued from previous page)*

County	Number of Arrests for DUI	DUI Arrest Rate	Number of Arrests for Public Intoxication	Public Intoxication Arrest Rate	Number of Arrests for Liquor Law Violations	Liquor Law Violation Arrest Rate
Marion	2,073	2.2	1,756	1.9	559	0.6
Marshall	241	5.1	32	0.7	70	1.5
Martin	20	2.0	8	0.8	9	0.9
Miami	91	2.5	29	0.8	22	0.6
Monroe	431	3.0	267	1.9	639	4.5
Montgomery	75	2.0	12	0.3	21	0.5
Morgan	171	2.4	37	0.5	111	1.6
Newton	27	1.9	9	0.6	10	0.7
Noble	186	3.9	13	0.3	53	1.1
Ohio	17	2.8	1	0.2	5	0.8
Orange	56	2.8	4	0.2	21	1.1
Owen	59	2.8	3	0.1	19	0.9
Parke	116	6.7	8	0.5	24	1.4
Perry	84	4.3	17	0.9	46	2.3
Pike	54	4.3	32	2.5	8	0.6
Porter	724	4.3	112	0.7	360	2.2
Posey	42	1.7	23	0.9	11	0.4
Pulaski	35	2.7	3	0.2	14	1.1
Putnam	117	3.1	21	0.6	50	1.3
Randolph	76	3.0	15	0.6	30	1.2
Ripley	92	3.1	15	0.5	42	1.4
Rush	67	4.0	2	0.1	48	2.8
Saint Joseph	528	2.0	49	0.2	177	0.7
Scott	44	1.8	45	1.9	34	1.4
Shelby	81	1.8	14	0.3	69	1.5
Spencer	58	2.8	4	0.2	23	1.1
Starke	38	1.6	17	0.7	23	1.0
Steuben	92	2.7	13	0.4	43	1.2
Sullivan	36	1.7	9	0.4	17	0.8
Switzerland	31	2.9	2	0.2	11	1.0
Tippecanoe	613	3.4	381	2.1	223	1.2
Tipton	41	2.6	11	0.7	7	0.4
Union	20	2.8	1	0.1	6	0.8
Vanderburgh	581	3.2	401	2.2	123	0.7
Vermillion	50	3.2	5	0.3	13	0.8
Vigo	265	2.4	169	1.6	243	2.2
Wabash	49	1.5	23	0.7	37	1.1
Warren	23	2.7	2	0.2	9	1.1
Warrick	137	2.2	19	0.3	34	0.6
Washington	85	3.1	14	0.5	35	1.3
Wayne	235	3.5	71	1.0	112	1.7
Wells	59	2.1	6	0.2	20	0.7
White	122	5.0	11	0.5	43	1.8
Whitley	156	4.7	7	0.2	50	1.5
Indiana	**20,810**	**3.2**	**7,107**	**1.1**	**8,245**	**1.2**

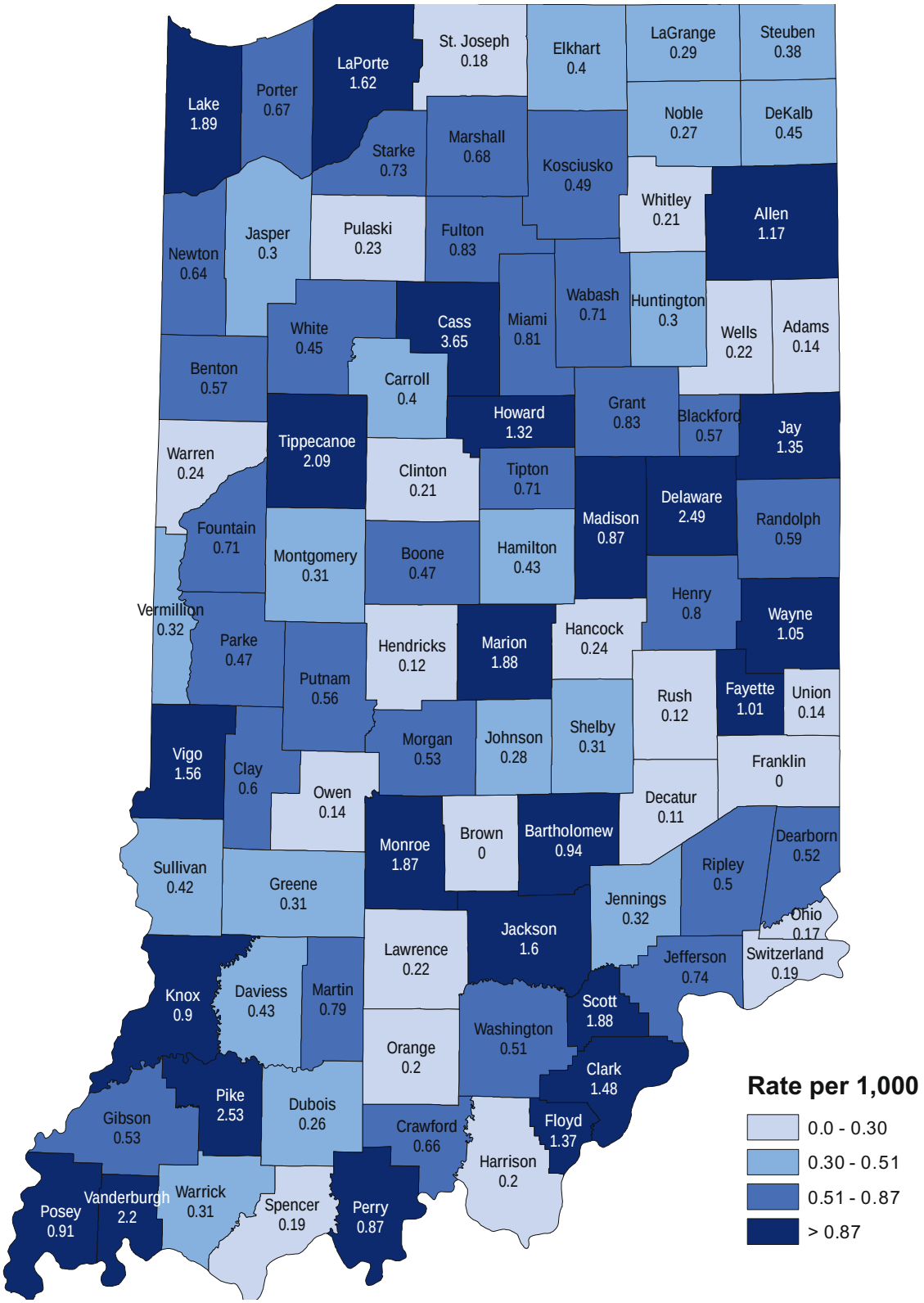
Note: Rates based on numbers lower than 20 are unreliable.
Source: FBI, 2014

Map 3.1 DUI Arrest Rates in Indiana, by County (Uniform Crime Reporting Program, 2014)



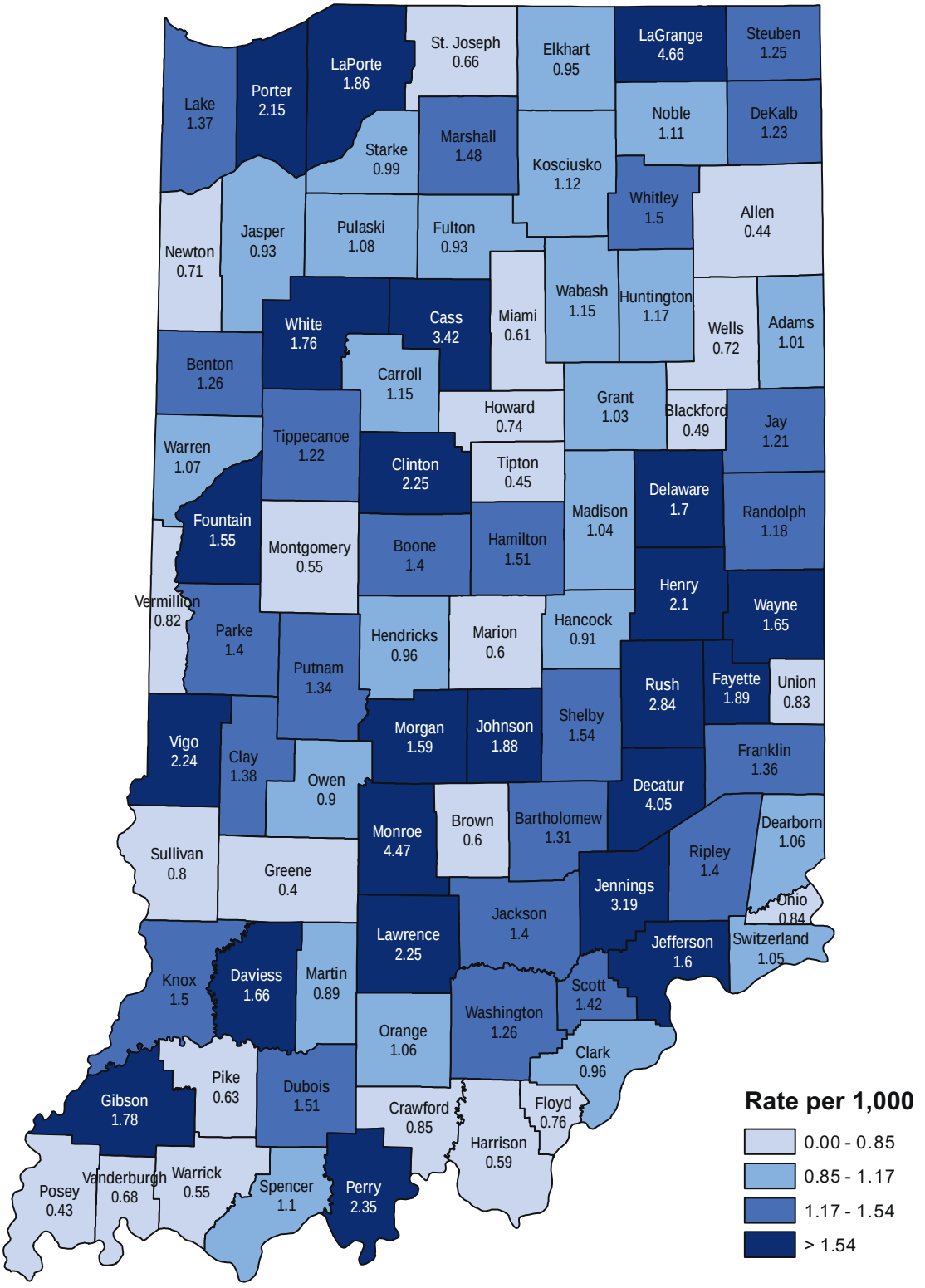
Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 3E (pages 44-45) for additional information.
Source: FBI, 2014

Map 3.2 Public Intoxication Arrest Rates per 1,000 in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 3E (pages 44-45) for additional information.
Source: FBI, 2014

Map 3.3 Liquor Law Violation Arrest Rates Per 1,000 in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 3E (pages 44-45) for additional information.
Source: FBI, 2014

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4 Tobacco Use in Indiana: Consumption Patterns and Consequences

TOBACCO CONSUMPTION

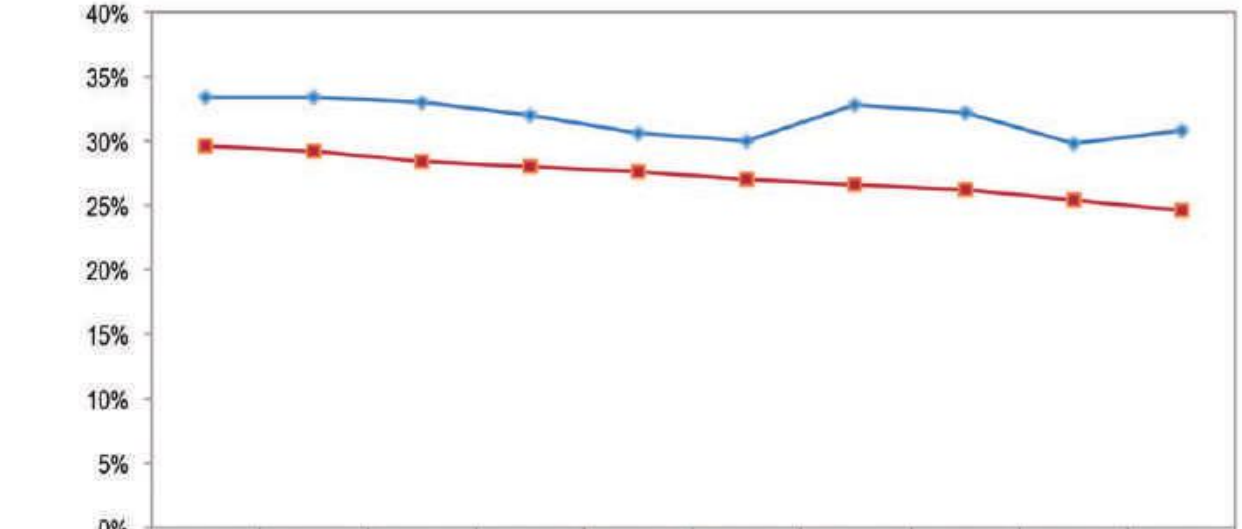
In the United States, one of every five deaths is related to cigarette smoking, making it the leading cause of preventable disease and death (U.S. Department of Health and Human Services [USDHHS], 2014). The adverse effects of tobacco on population health have been well-researched. In Indiana, more than 11,100 adults die every year from their own smoking, and 333,000 live with a tobacco-related disease (USDHHS, 2014). Furthermore, 151,000 (approximately 1 in 10) Indiana youth now under the age of 18 will prematurely die from a smoking-related illness (USDHHS, 2014). Also, over 1,300 adults, children, and infants died in 2014 as a result of exposure to secondhand smoke (Lewis & Zollinger, 2014). Indiana incurs close to $3 billion annually in health care costs directly caused by smoking, including nearly $590 million that is absorbed by Medicaid (Campaign for Tobacco-Free Kids, 2017b).

Though self-reported cigarette smoking has been on the decline, electronic vapor products, including e-cigarettes, have surged in popularity in recent years (Marynak et al., 2017). While e-cigarettes have been promoted as less dangerous than cigarettes, they have not been approved as safe by the U.S. Food and Drug Administration (FDA) and health effects of exposure to aerosol from e-cigarettes are currently unknown (Indiana State Department of Health, Tobacco Prevention and Cessation Commission [ISDH/TPCC], 2015a).

General Consumption Patterns

Estimates from the 2015 National Survey on Drug Use and Health (NSDUH) showed that 30.8% (95% Confidence Interval [CI]: 28.4–33.4) of Indiana residents 12 years and older used a tobacco product in the past month, which was significantly higher than the U.S. rate (24.6%; 24.2–25.0). Tobacco products include cigarettes, smokeless tobacco, cigars, and pipe tobacco. Indiana's rate has remained relatively stable for at least the past 10 years, from 2006 through 2015 (see Figure 4.1) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

Figure 4.1 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Any Tobacco Use in the Past Month (National Survey on Drug Use and Health, 2006–2015)

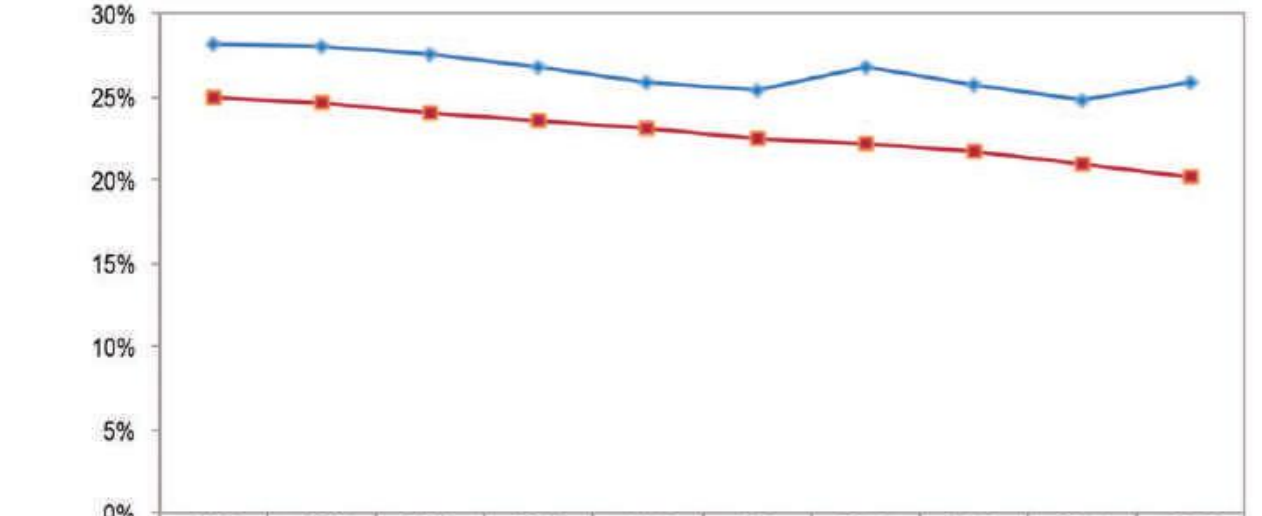


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	33.4%	33.5%	32.9%	31.9%	30.6%	29.9%	32.9%	32.3%	29.8%	30.8%
U.S.	29.5%	29.1%	28.5%	28.0%	27.6%	27.0%	26.6%	26.1%	25.4%	24.6%

Source: SAMHSA, 2017

The majority of tobacco consumers smoked cigarettes. In 2015, 25.9% (95% CI: 23.7–28.2) of Hoosiers ages 12 years and older reported past-month use of cigarettes, which was significantly higher than the U.S. rate (20.1%; 95% CI: 19.7–20.5). Indiana's smoking prevalence remained relatively stable from 2006 (28.2%; 95% CI: 25.7–30.8) to 2015 (25.9%; 95% CI: 23.7–28.2) (see Figure 4.2).

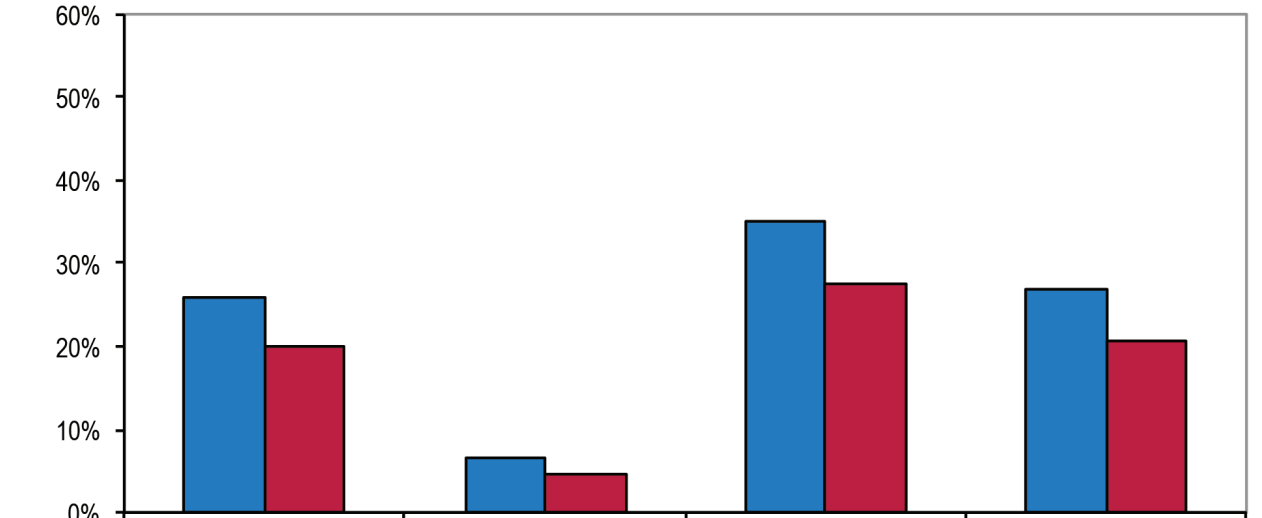
Figure 4.2 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Cigarette Use in the Past Month (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	28.2%	28.0%	27.6%	26.8%	25.9%	25.3%	26.8%	25.7%	24.8%	25.9%
U.S.	25.0%	24.6%	24.1%	23.6%	23.2%	22.5%	22.1%	21.7%	21.0%	20.1%

Source: SAMHSA, 2017

Figure 4.3 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Cigarette Use in the Past Month (National Survey on Drug Use and Health, 2015)



	Total	12-17	18-25	26 and older
Indiana	25.9%	6.7%	35.1%	26.8%
U.S.	20.1%	4.5%	27.5%	20.7%

Source: SAMHSA, 2017

In addition to smoking rates, cigarette consumption is an indicator of smoking behavior. Cigarette consumption decreased from 113.9 packs sold per capita in State Fiscal Year (SFY) 2001 to 63.7 packs sold per capita in SFY 2016 (ISDH/TPCC, 2016).

Adult Consumption Patterns

The highest rate of tobacco use occurred among 18- to 25-year-olds. An estimated 42.7% of Hoosiers in this age group (95% CI: 39.0–46.4) reported currently, i.e., within the past 30 days, using a tobacco product, which was significantly higher than the national rate (34.0%; 95% CI: 33.3–34.8). The 30-day prevalence rate for cigarette smoking among 18- to 25-year-olds was 35.1% (95% CI: 31.2–39.3) in Indiana (U.S.: 27.5%; 95% CI: 26.8–28.3) (see Figure 4.3).

Also, 31.6% (95% CI: 28.7–34.6) of Hoosiers ages 26 and older, used a tobacco product, and 26.8% (95% CI: 24.1–29.6) smoked cigarettes in the past month. U.S. rates were significantly lower for both tobacco use (25.1%; 95% CI: 24.7–25.6) and cigarette smoking (20.7%; 95% CI: 20.3–21.2) (SAMHSA, 2017).

The Behavioral Risk Factor Surveillance System (BRFSS) focuses on behaviors and conditions that are linked with leading causes of death. According to 2015 findings, the prevalence rate for adult smoking in Indiana was 20.6% (95% CI: 18.9–22.2). Moreover, 14.7% (95% CI: 13.2–16.2) of Hoosiers used cigarettes every day. Indiana's smoking prevalence rates were higher than national median rates: 17.5% of U.S. residents smoked in the past month and 11.9% reported smoking every day (Centers for Disease Control and Prevention [CDC], 2017a). Statistically significant differences in smoking prevalence were observed by age, educational attainment, and income, but not by gender or race (see Table 4.1):

- Younger adults displayed higher smoking rates than older adults.
- Educational attainment was inversely associated with prevalence rate, i.e., individuals who achieved higher levels of education had lower smoking rates.
- Income level was inversely associated with prevalence rate, i.e., individuals with higher income levels had lower smoking rates.

Table 4.1 Adult Smoking Prevalence in Indiana, by Gender, Race/Ethnicity, Age Group, Educational Attainment, and Income Level (Behavioral Risk Factor Surveillance System, 2015)

		Indiana (95% CI)
Gender	Male	21.9% (19.4 – 24.3)
	Female	19.3% (17.0 – 21.6)
Race / Ethnicity	White	20.9% (19.0 – 22.7)
	Black	21.6% (15.7 – 27.5)
	Hispanic	11.3% (5.5 – 17.1)
Age Group	18-24	24.4% (17.8 – 31.0)
	25-34	23.0% (18.0 – 28.0)
	35-44	21.0% (16.8 – 25.1)
	45-54	26.5% (22.7 – 30.3)
	55-64	19.7% (16.8 – 22.5)
	65+	10.9% (9.1 – 12.7)
Education	Less than High School	36.5% (29.9 – 43.1)
	High School or GED	24.6% (21.7 – 27.5)
	Some post-High School	19.2% (16.3 – 22.1)
	College Graduate	6.5% (5.0 – 8.0)
Income	Less than $15,000	35.4% (28.9 – 41.8)
	$15,000 – $24,999	30.6% (25.8 – 5.3)
	$25,000 – $34,999	22.8% (17.5 – 28.1)
	$35,000 – $49,999	21.0% (16.3 – 25.7)
	$50,000 and above	11.7% (9.6 – 13.8)
Total		20.6% (18.9 – 22.2)

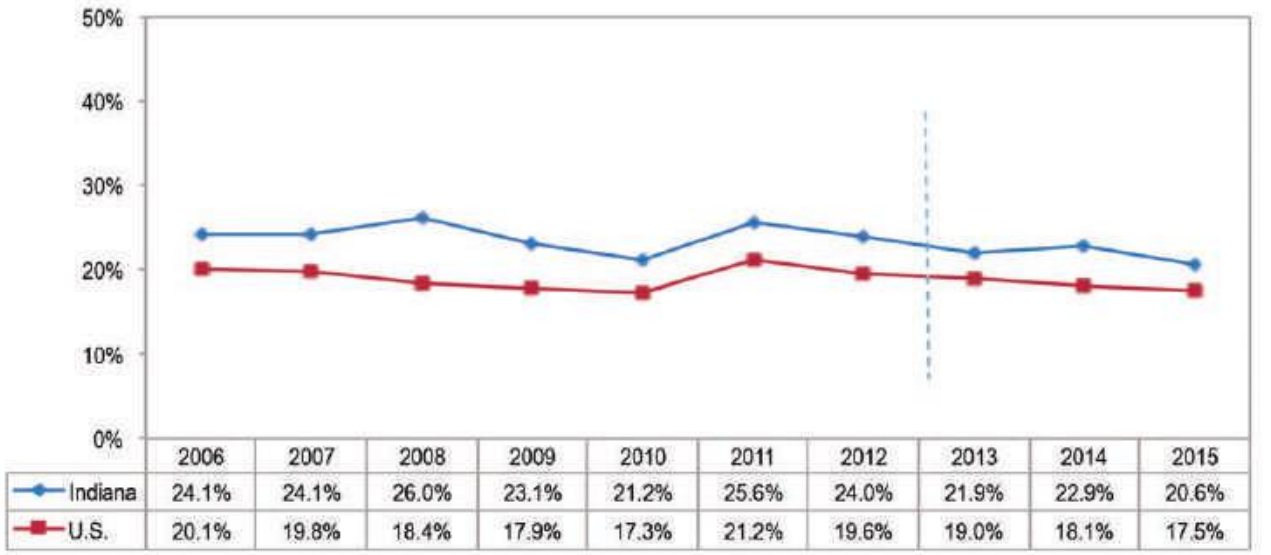
Source: CDC, 2017a

Adult smoking prevalence in Indiana has been above the U.S. level for at least the past ten years (see Figure 4.4). Adult smoking prevalence, as shown in Figure 4.4, has been trending downward since 2011 (due to changes in BRFSS methodology, findings starting in 2011 should not be compared to results from previous years; for more detailed information, see Chapter 2 "Methods").

The 2015 Indiana Adult Tobacco Survey (IATS) estimated the overall smoking prevalence among Indiana adults at 14.7%. Approximately 16.4% of adults in Indiana reported ever trying an e-cigarette. Both current cigarette smokers (68.0%) and former smokers (14.8%) were significantly more likely to have used e-cigarettes in their lifetime than never smokers (4.0%). However, there were increases in usage of e-cigarettes since 2013 by current (49.2%), former (9.8%), and never smokers (3.6%) (Brown, Raines, & Stedman, 2015).

The Indiana College Substance Use Survey includes questions on the use of various tobacco products. The 2016 survey, which was based on 20 participating colleges and universities, showed that cigarettes were still the most commonly used tobacco product, with 13.0% of Indiana college students reporting current (past-month) use (U.S.: 11.3%). Results for the different types of tobacco by demographic characteristics can be found in Table 4.2 (King & Jun, 2016).[1]

Figure 4.4 Percentage of Indiana and U.S. Population (18 Years and Older) Reporting Current Cigarette Use (Behavioral Risk Factor Surveillance System, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	24.1%	24.1%	26.0%	23.1%	21.2%	25.6%	24.0%	21.9%	22.9%	20.6%
U.S.	20.1%	19.8%	18.4%	17.9%	17.3%	21.2%	19.6%	19.0%	18.1%	17.5%

Note: Prevalence rates, starting with 2011, should not be compared to previous years due to changes in methodology.
Source: CDC, 2017a

Table 4.2 Rates of Past-Month (Current) Tobacco Use by Indiana College Students, by Type of Product and by Overall Use, Gender, Age Group, and Type of Institution (Indiana College Substance Use Survey, 2016)

	Indiana (Total)	Male	Female	Under 21	21 or Over
Cigarettes	13.0	17.2	10.5	10.5	15.6*
Cigars	8.0	14.3	4.2*	8.6	7.3*
Chewing/smokeless tobacco	4.3	10.2	0.8*	3.8	4.8*
Smoking tobacco with hookah/water pipe	7.8	9.7	6.6*	7.6	8.0
Electronic vapor products	10.4	14.6	7.9	11.4	9.4*

Note: *$P < 0.05$
Source: King & Jun, 2016

[1]Twenty Indiana colleges participated in the 2016 survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

Youth Consumption Patterns

The use of tobacco products has wide-ranging consequences for adolescents and young adults. Factors associated with youth tobacco use include low socioeconomic status; use and approval of tobacco use by peers or siblings; smoking by parents or guardians; accessibility, availability and price of tobacco products; a perception that tobacco use is normative; lack of parental support or involvement; low levels of academic achievement; lack of skills to resist influences to tobacco use; lower self-image or self-esteem; belief in functional benefits of tobacco use; and lack of self-efficacy to refuse offers of tobacco (CDC, 2016b).

Based on results from the 2015 NSDUH, 9.1% (95% CI: 7.3–11.2) of Hoosiers ages 12 to 17 used a tobacco product in the past month (U.S.: 6.5%; 95% CI: 6.2–6.8). Most tobacco use was attributable to cigarette smoking; i.e., 6.7% (95% CI: 5.3–8.5) of young Hoosiers smoked cigarettes (U.S.: 4.5%; 95% CI: 4.3–4.8) (SAMHSA, 2017).

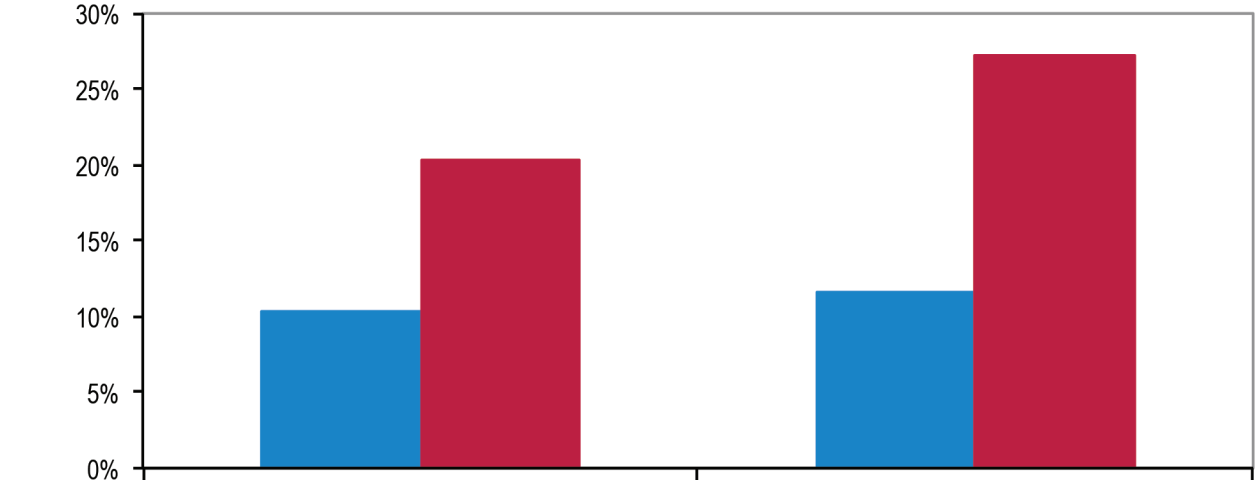
The Youth Risk Behavior Surveillance System (YRBSS) monitors health-risk behaviors such as tobacco, alcohol, and other drug use, which contribute to death and disability among youths in schools nationwide. According to 2015 YRBSS findings, almost one-third of high school students currently use a tobacco product, primarily electronic vapor products (see Table 4.3). In Indiana, rates of current cigarette use decreased significantly from 25.6% (95% CI: (23.2–28.2) in 2003 to 11.2% (95% CI: 8.3–14.8) in 2015; however, electronic vapor products have gained popularity with nearly one-fourth of high school students (23.9%; 95% CI: 20.6–27.7) reporting current use (CDC, 2017b). For more information, see Figures 4.5 through 4.7.

Table 4.3 Current Use of Tobacco Products in Indiana and U.S. High School Students (9th–12th grade), (Youth Risk Behavior Surveillance System, 2015)

	Indiana (95% CI)	U.S. (95% CI)
Any Tobacco Use	32.4% (27.3–38.0)	31.4% (29.1–33.8)
Electronic Vapor Products	23.9% (20.6–27.7)	24.1% (22.1–26.2)
Smoke Cigarettes	11.2% (8.3–14.8)	10.8% (9.4–12.4)
Smoke Cigars	11.4% (9.1–14.3)	10.3% (9.0–11.8)
Smokeless Tobacco	9.4% (5.9–14.7)	7.3% (6.1–8.6)

Source: CDC, 2017b

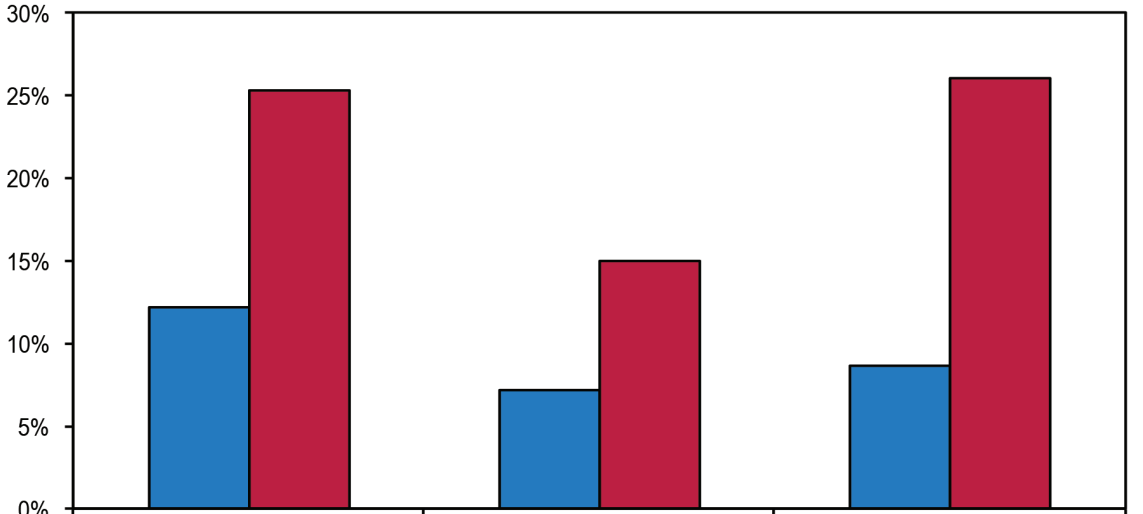
Figure 4.5 Rates of Current Use of Cigarettes and Electronic Vapor Products in Indiana High School Students (9th–12th Grade), by Gender (Youth Risk Behavior Surveillance System, 2015)



	Female	Male
Cigarettes	10.4%	11.7%
Electronic Vapor	20.3%	27.2%

Source: CDC, 2017b

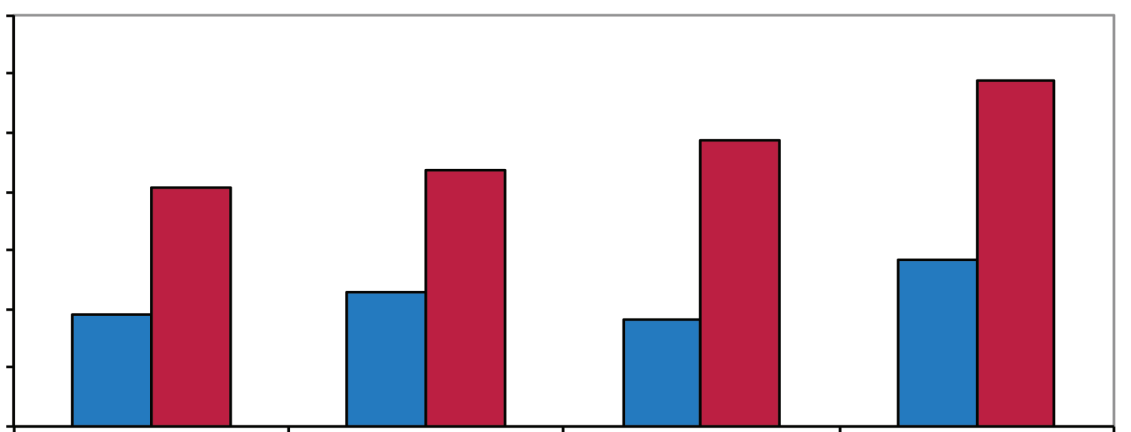
Figure 4.6 Rates of Current Use of Cigarettes and Electronic Vapor Products in Indiana High School Students (9th–12th Grade), by Race/Ethnicity (Youth Risk Behavior Surveillance System, 2015)



	White	Black	Hispanic
Cigarettes	12.1%	7.1%	8.6%
Electronic Vapor	25.3%	14.9%	26.0%

Source: CDC, 2017b

Figure 4.7 Rates of Current Use of Cigarettes and Electronic Vapor Products in Indiana High School Students (9th–12th Grade), by Grade (Youth Risk Behavior Surveillance System, 2015)

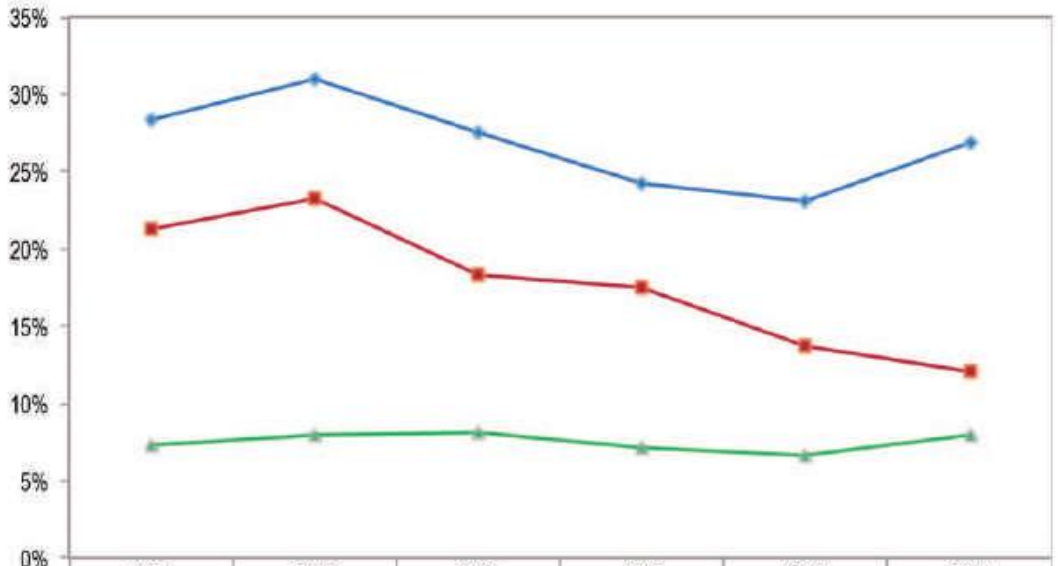


	9th Grade	10th Grade	11th Grade	12th Grade
Cigarettes	9.6%	11.5%	9.1%	14.2%
Electronic Vapor	20.4%	21.8%	24.3%	29.4%

Source: CDC, 2017b

The Indiana Youth Tobacco Survey (IYTS) is a statewide school-based survey of middle school (grades 6 through 8) and high school (grades 9 through 12) students that captures information on various tobacco-related issues, such as tobacco use, smoking cessation, tobacco-related attitudes and beliefs, social influences on tobacco use, and secondhand smoke exposure. According to IYTS results, cigarette and overall tobacco use declined significantly in Indiana from 2004 to 2014; however, consumption of smokeless tobacco products remained stable (see Figures 4.8 and 4.9) (ISDH/TPCC, 2015b).

Figure 4.8 Tobacco Use Among Indiana High School Students (9th–12th Grade) (Indiana Youth Tobacco Survey, 2004–2014)



	2004	2006	2008	2010	2012	2014
Tobacco Use	28.3%	31.0%	27.5%	24.2%	23.0%	26.9%
Cigarette Use	21.3%	23.2%	18.3%	17.5%	13.7%	12.0%
Smokeless Tobacco Use	7.3%	7.9%	8.2%	7.2%	6.6%	8.0%

Note: Due to the emergence of new tobacco products in recent years and corresponding changes to the survey instrument, the definition of "any tobacco use" has changed over time. Between 2004 and 2010, "any tobacco use" included cigarettes, cigars, smokeless tobacco, pipe, or bidis. In 2012 and 2014, "any tobacco use" included cigarettes, cigars, smokeless tobacco, bidis, pipe, hookah, snus, dissolvable tobacco, and e-cigarettes.
Source: ISDH/TPCC, 2015c

Based on 2014 IYTS results, a total of 4.8% of middle school students (95% CI: 3.5–6.0) and 20.5% of high school students (95% CI: 15.4–25.6) used any tobacco product[2] in the past month. Among middle school students, 2.9% (95% CI: 1.9–3.8) and among high school students, 12.0% (95% CI: 8.6–15.4) reported smoking cigarettes in the past month (ISDH/TPCC, 2015b).

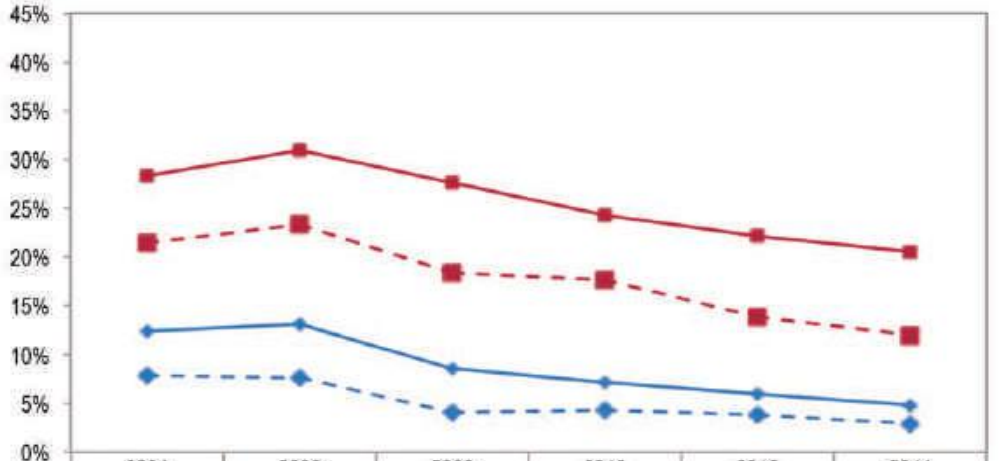
Appendix 4A (pages 63-66) shows the percentages, including 95% confidence intervals, of Indiana middle and high school students who reported current use of various tobacco products, grouped by gender, race/ethnicity, and grade, from 2004 through 2014.

The Indiana Youth Survey, conducted annually of students in Grades 6 to 12, assesses students' substance use, mental health, gambling, and risk and protective factors that can affect their success. Findings from the 2016 survey showed that tobacco use increased as students progressed in school, i.e., higher smoking rates occurred among 12th grade students than 8th-graders, both for cigarettes and electronic vapor products (such as e-cigarettes, vaping pens, and e-hookahs.) (see Figure 4.10) (Gassman et al., 2016). See Appendix 4B (page 67) for Indiana students' 2016 monthly cigarette and e-cigarette use by region and grade.

Comparisons between Indiana and the United States on 30-day prevalence of cigarette use among 12th grade students imply that (a) Hoosier students have had higher rates throughout the years, and (b) rates have been declining for both groups (see Figure 4.11). However, these results need to be interpreted with caution, as statistical significance could not be determined due to the lack of detail provided in the publicly available data set.

In 2014, 5.2% of middle school students and 15.6% of high school students in Indiana reported current use of e-cigarettes. Among Indiana youth who currently smoke cigarettes, 63.7% of middle school students and 65.9% of high school students also reported currently using e-cigarettes (ISDH/TPCC, 2015b).

Figure 4.9 Percentage of Indiana Middle School and High School Students Reporting Current Tobacco and Cigarette Use (Indiana Youth Tobacco Survey, 2004–2014)

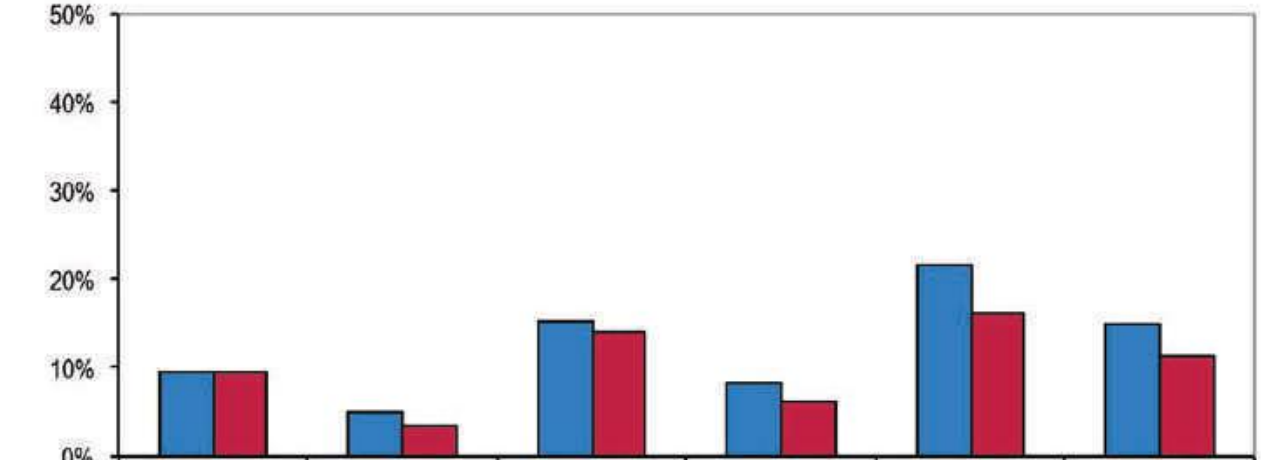


	2004	2006	2008	2010	2012	2014
Current MS Tobacco Use	12.4%	13.0%	8.5%	7.1%	5.9%	4.8%
Current HS Tobacco Use	28.3%	31.0%	27.5%	24.2%	22.0%	20.5%
Current MS Cigarettes Use	7.8%	7.7%	4.1%	4.4%	3.7%	2.9%
Current HS Cigarettes Use	21.3%	23.2%	18.3%	17.5%	13.7%	12.0%

Source: ISDH/TPCC, 2015b

[2]This included use of cigarettes, cigars, smokeless tobacco (chewing tobacco, snuff, or dip), pipe, bidis, or kreteks.

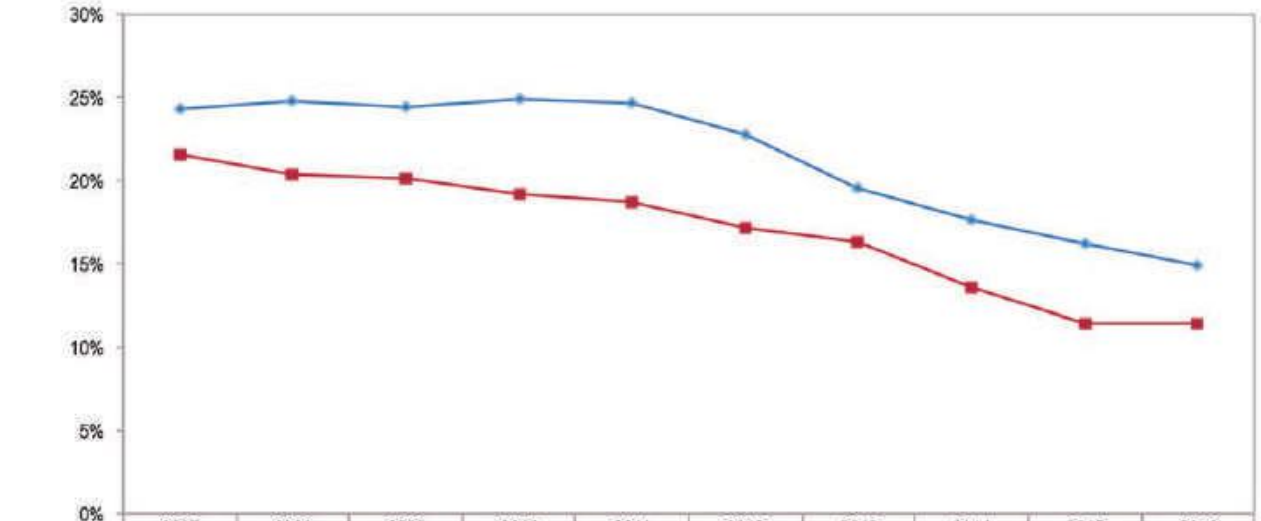
Figure 4.10 Monthly Cigarette and E-Cigarette Use Among 8th, 10th, and 12th Grade Students, Indiana and the United States (Indiana Youth Survey and Monitoring the Future Survey, 2016)



	8th Grade E-Cigs	8th Grade Cigarettes	10th Grade E-Cigs	10th Grade Cigarettes	12th Grade E-Cigs	12th Grade Cigarettes
Indiana	9.4%	5.1%	15.4%	8.4%	21.6%	14.9%
U.S.	9.5%	3.6%	14.0%	6.3%	16.2%	11.4%

Source: Gassman et al., 2016; Inter-university Consortium for Political and Social Research, 2016

Figure 4.11 Past-Month Smoking Prevalence for 12th Grade Students in Indiana and the United States (Indiana Youth Survey: 2007–2016; and Monitoring the Future Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Indiana	24.3%	24.8%	24.4%	24.9%	24.6%	22.8%	19.5%	17.6%	16.2%	14.9%
U.S.	21.6%	20.4%	20.1%	19.2%	18.7%	17.1%	16.3%	13.6%	11.4%	11.4%

Source: Gassman et al., 2016; Inter-university Consortium for Political and Social Research, 2016

CONSEQUENCES

Health Consequences

As the second major cause of death in the world, tobacco is responsible for approximately 6 million deaths every year, including about 600,000 deaths from exposure to second-hand smoke (World Health Organization, 2015). In the United States, cigarette smoking is the single most preventable cause of disease and death, causing more deaths annually than acquired immune deficiency syndrome (AIDS), alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined (USDHHS, 2014).

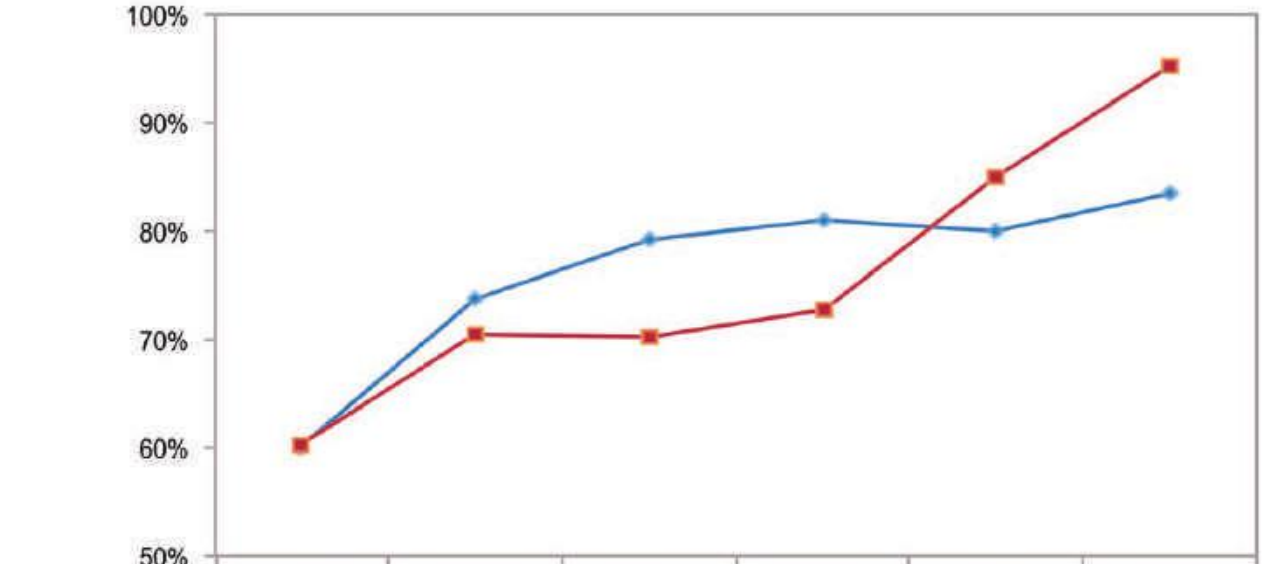
In the United States, tobacco use is responsible for more than 480,000 deaths per year among adults age 35 and older. In addition, 16 million adults are suffering from smoking-related conditions. On average, smoking reduces adult life expectancy by a minimum of 10 years. Smoking is the leading risk-factor for lung cancer, which is the foremost cause of cancer-related deaths for both males and females (Siegel, Miller, & Jemal, 2015).

Smoking affects respiratory health and is related to chronic coughing and wheezing among adults. Smokers are more likely than nonsmokers to have upper and lower respiratory tract infections. Generally, lung function deteriorates more quickly in smokers than in nonsmokers. Smoking contributes significantly to the number of deaths from lung cancer, heart disease, chronic lung diseases, and other illnesses (USDHHS, 2014). Adverse outcomes of smoking also include cancers of the oral cavity, pharynx, larynx, esophagus, bladder, stomach, cervix, kidney, and pancreas. Furthermore, smoking has been linked to liver, colorectal, prostate, and breast cancers, and can also result in acute myeloid leukemia (USDHHS, 2014). For smoking-attributable cancers, the risk generally increases with the number of cigarettes smoked and the number of years of smoking, and usually decreases after the smoker quits completely. The leading cause of cancer deaths is lung cancer, and cigarette smoking causes most cases. However, any tobacco use can be detrimental. Smokeless tobacco has been shown to cause oral cancers and may also be a risk factor for cardiovascular disease (CDC, 2016a). Other specific health-related outcomes include age-related macular degeneration, dental disease, diabetes, autoimmune disease, rheumatoid arthritis, systemic lupus erythematosus, and inflammatory bowel disease (USDHHS, 2014).

Smoking may harm men's and women's reproductive health, and the effects can be seen in fetuses, infants, and children. Smoking can affect men's sperm and lead to reduced fertility and increased risk for birth defects and miscarriage.

Women who smoke have an increased risk for infertility and ectopic pregnancies. Smoking during pregnancy results in health problems for both mothers and babies. These include increased risk of spontaneous abortions, pregnancy complications (e.g., placenta previa, placental abruption, and premature rupture of membranes before labor begins), premature delivery, low-birth-weight infants, stillbirth, and sudden infant death syndrome (SIDS). Mothers who smoke during pregnancy reduce their babies' lung function (CDC, 2016a). In Indiana, the percentage of births to mothers who smoked during pregnancy declined from 18.5% in 2007 to 14.3% in 2015; a higher percentage of white mothers (15.6%) smoked during pregnancy than black mothers (11.1%) (ISDH/Epidemiology Resource Center, 2016). The Indiana State Department of Health, Tobacco Prevention and Cessation provides county-level information on various smoking-related outcomes. For a detailed list, see Appendix 4C, pages 68-71.

Figure 4.12 Percentage of Smoke-free Homes and Workplaces in Indiana (Adult Tobacco Survey, 2002–2015)



	2002	2006	2007	2008	2013	2015
Homes	60.1%	73.8%	79.3%	81.1%	80.0%	83.4%
Workplaces	60.3%	70.4%	70.3%	72.8%	85.0%	95.3%

Source: Brown et al., 2015

Secondhand smoke: Secondhand smoke (sometimes called environmental tobacco smoke) has serious health consequences. An estimated 58 million nonsmoking Americans continue to be exposed to secondhand smoke in homes, vehicles, workplaces, and public places. Exposure to tobacco smoke can cause heart disease and lung cancer even in nonsmoking adults, increasing the risk by 25% to 30% for heart disease and by 20% to 30% for lung cancer. Children, in particular, are heavily impacted by secondhand smoke. Exposure increases their chance of developing significant lung conditions, especially asthma and bronchitis. Also, secondhand smoke can cause SIDS, acute respiratory infections, ear problems, and more frequent and severe asthma attacks in children. In the United States, secondhand smoke is responsible for nearly 34,000 deaths due to heart disease, more than 8,000 deaths from stroke, and over 7,300 lung cancer deaths each year among nonsmoking adults (USDHHS, 2014). An estimated 1,337 Hoosiers die each year from secondhand smoke (Lewis & Zollinger, 2014).

In Indiana, the percentage of smoke-free homes has increased from 60.1% in 2002 to 83.4% in 2015. However, among smokers, only 40.8% do not allow smoking in their homes. The percentage of smoke-free workplaces[3] rose from 60.3% to 95.3% during that time period (see Figure 4.12). Although Indiana is making progress, it is lagging behind the rest of the nation terms of *comprehensive* coverage from secondhand smoke exposure (comprehensive coverage includes workplaces, restaurants, and bars). With the addition of the statewide smoke-free air law in 2012, all Indiana residents are covered in most workplaces and restaurants, but exempts bars, clubs, and gaming facilities. As of March 2017, a total of 21 communities[4] in Indiana have passed comprehensive smoke-free air ordinances which cover all workplaces, including bars, to ensure that all workers are protected from secondhand smoke. These 21 comprehensive ordinances cover approximately 31% of all residents in Indiana. (ISDH/TPCC, 2017).

[3]This measure refers to the prevalence of workers reporting a 100% smoke-free workplace (Adult Tobacco Survey).
[4]These include Delaware Co., Hancock Co., Monroe Co., Vanderburgh Co., Vigo Co., Bloomington, Columbus, Cumberland, Elkhart, Fort Wayne, Franklin, Greencastle, Indianapolis, Lawrence, Plainfield, South Bend, Terre Haute, West Lafayette, and Zionsville.

E-cigarettes: The health effects of exposure to aerosol from e-cigarettes are currently unknown; however, research shows that the aerosol releases measurable amounts of carcinogens and other toxins into the air, including nicotine, formaldehyde, and acetaldehyde. In addition, e-cigarette aerosol has been found to contain a high concentration of ultra-fine particles. Exposure to fine and ultra-fine particles may exacerbate respiratory conditions and constrict arteries (ISDH/TPCC, 2014).

In 2016 the U.S. Surgeon General issued a report highlighting concerns related to e-cigarette use among youth and young adults (USDHHS, 2016). Key findings of the report are as follows:

- E-cigarette use among youth and young adults has become a public health concern.
- E-cigarettes are not the most commonly used tobacco product among youth, and use of e-cigarettes is strongly associated with use of other tobacco products.
- The use of products containing nicotine pose danger to youth, pregnant women, and fetuses. The use of products containing nicotine among youth, including e-cigarettes, is unsafe.
- E-cigarette aerosol is not harmless. It can contain harmful and potentially harmful constituents.
- E-cigarettes are marketed by promoting flavors and using a variety of media channels and approaches that have been used in the past to market tobacco to youth and young adults.

Economic Consequences

In 2014, the annual U.S. tobacco industry marketing expenditures were approximately $9.1 billion, including Indiana's share of $284.5 million. The state's total tobacco marketing expenditures declined after peaking at $475.4 million in 2003 (Campaign for Tobacco-Free Kids, 2016; Federal Trade Commission, 2016).

The federal excise tax is $1.01 per pack of cigarettes. The average state cigarette excise tax is $1.69 per pack, but varies from 17 cents in Missouri to $4.35 in New York; Indiana's tobacco excise tax rate is 99.5 cents per pack (Campaign for Tobacco-Free Kids, 2017a).

Cigarette smoking is estimated to be responsible for greater than $300 billion in annual health-related economic losses in the United States ($170 billion in direct medical costs and approximately $156 billion in lost productivity) (CDC, 2016a). In Indiana, $2.93 billion dollars of health-related costs in 2009 were smoking-attributable expenditures (SAE). Most of these costs accrued through hospital care ($1.57 billion) and prescription drugs ($525 million); the SAE estimate also included ambulatory care ($405 million), nursing home care ($283 million), and other health-related costs ($147 million) (CDC, 2016a). The combination of increased medical costs, higher insurance rates, added maintenance expenses, lower productivity, and higher rates of absenteeism due to smoking adds financial strain to U.S. businesses every year.

APPENDIX 4A - Part 1

Percentage of Indiana Middle School and High School Respondents Who Currently Use Any Tobacco Product, by Gender, Race/Ethnicity, and School Grade (Indiana Youth Tobacco Survey, 2004–2014)

	2004		2006		2008		2010		2012		2014	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
MIDDLE SCHOOL												
Gender												
Male	10.8	(8.8–12.8)	13.2	(10.3–16.1)	9.9	(7.3–12.5)	9.3	(7.0–11.6)	6.9	(5.1–8.8)	9.8	(7.5–12.0)
Female	14.0	(10.8–17.2)	12.7	(10.2–15.2)	7.1	(5.2–9)	4.5	(2.9–6.1)	6.4	(4.5–8.4)	6.3	(4.3–8.4)
Race/Ethnicity												
White	11.8	(9.2–14.4)	11.9	(9.1–14.7)	7.7	(5.5–9.9)	6.4	(5.0–7.8)	6.2	(4.4–8.0)	7.4	(5.1–9.8)
Black	13.8	(9.1–18.5)	17.4	(12.9–21.9)	10.6	(7.6–13.6)	9.0	(4.8–13.2)	5.9	(3.7–8.1)	9.8	(4.9–14.6)
Hispanic	13.6	(8.2–19.0)	12.5	(8.5–16.5)	11.5	(8.7–14.3)	12.2	(8.5–15.9)	9.3	(5.4–13.3)	11.3	(6.3–16.3)
Grade												
6	8.6	(4.7–12.5)	6.2	(4.3–8.1)	2.7	(1.2–4.2)	2.1	(0.6–3.6)	2.7	(1.2–4.1)	5.0	(2.3–7.6)
7	11.0	(8.4–13.6)	10.9	(8.9–12.9)	8.2	(6.0–10.4)	5.3	(3.6–7.0)	5.7	(3.8–7.5)	7.9	(5.4–10.5)
8	16.8	(12.6–21.0)	21.3	(16.3–26.3)	14.6	(10.9–18.3)	11.8	(7.6–16.0)	11.9	(8.6–15.2)	11.5	(7.9–15.2)
Total	**12.4**	**(10.2–14.6)**	**13.0**	**(10.6–15.4)**	**8.5**	**(6.6–10.4)**	**7.1**	**(5.7–8.5)**	**6.7**	**(5.2–8.3)**	**8.2**	**(6.4–10.0)**
HIGH SCHOOL												
Gender												
Male	33.0	(29.8–36.2)	35.0	(30.3–39.7)	31.2	(28.6–33.8)	28.6	(24.9–32.3)	28.3	(24.6–32.0)	30.4	(24.5–36.3)
Female	23.2	(20.8–25.6)	26.8	(22.0–31.6)	23.7	(20.9–26.5)	19.3	(16.6–22.0)	17.3	(13.6–21.1)	23.0	(19.1–27.0)
Race/Ethnicity												
White	28.5	(25.8–31.2)	31.9	(27.0–36.8)	28.4	(26.1–30.7)	24.5	(21.9–27.1)	23.6	(20.5–26.8)	28.4	(23.1–33.8)
Black	22.8	(18.5–27.1)	22.8	(16.9–28.7)	20.4	(16.6–24.2)	16.2	(12.4–20.0)	17.6	(11.0–24.2)	18.5	(14.3–22.6)
Hispanic	32.2	(25.4–39)	29.1	(23.1–35.1)	28.9	(24.5–33.3)	27.5	(22.7–32.3)	24.1	(18.4–29.7)	22.9	(16.2–29.7)
Grade												
9	24.4	(21.8–27.0)	23.8	(20.1–27.5)	19.2	(15.9–22.5)	17.9	(14.8–21.0)	15.2	(10.8–19.6)	20.5	(17.0–23.9)
10	24.7	(21.6–27.8)	30.2	(24.4–36.0)	25.6	(21.5–29.7)	20.9	(17.2–24.6)	19.2	(16.7–21.8)	21.3	(15.6–26.9)
11	31.0	(26.1–35.9)	35.0	(29.7–40.3)	33.2	(28.1–38.3)	28.7	(25.1–32.3)	27.3	(21.0–33.6)	27.3	(22.7–32.0)
12	34.3	(28.3–40.3)	37.2	(30.2–44.2)	34.3	(28.8–39.8)	29.4	(24.2–34.6)	31.1	(25.9–36.4)	38.9	(28.2–49.7)
Total	**28.3**	**(25.9–30.7)**	**31.0**	**(26.8–35.2)**	**27.5**	**(25.5–29.5)**	**24.2**	**(21.9–26.5)**	**23.0**	**(20.2–25.8)**	**26.9**	**(22.2–31.6)**

Note: *Due to the emergence of new tobacco products in recent years and corresponding changes to the survey instrument, the definition of “any tobacco use” has changed over time. Between 2004 and 2010, “any tobacco use” included cigarettes, cigars, smokeless tobacco, pipe, or bidis. In 2012 and 2014, “any tobacco use” included cigarettes, cigars, smokeless tobacco, bidis, pipe, hookah, snus, dissolvable tobacco, and e-cigarettes.
Source: ISDH/TPCC, 2015b

APPENDIX 4A - Part 2

Percentage of Indiana Middle School and High School Respondents Who Currently Use Cigarettes, by Gender, Race/Ethnicity, and School Grade (Indiana Youth Tobacco Survey, 2004–2014)

	2004		2006		2008		2010		2012		2014	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
MIDDLE SCHOOL												
Gender												
Male	5.7	(3.7–7.6)	7.1	(5.2–9.1)	4.5	(2.9–6.0)	5.2	(3.7–6.8)	3.6	(2.5–4.7)	2.9	(1.8–3.9)
Female	10.1	(7.5–12.6)	8.3	(6.2–10.5)	3.7	(2.4–4.9)	3.5	(1.9–5.1)	3.9	(2.8–5.0)	2.8	(1.6–4.0)
Race/Ethnicity												
White	8.2	(5.6–10.7)	7.4	(5.5–9.4)	7.0	(4.8–9.1)	4.1	(2.9–5.3)	3.5	(2.5–4.5)	2.8	(1.7–3.9)
Black	6.2	(2.9–9.6)	7.8	(4.5–11.1)	2.9	(1.3–4.4)	4.7*	(1.8–7.5)	1.9*	(0.0-4.0)	2.2*	(0.1–4.3)
Hispanic	7.6*	(2.9–12.3)	8.4	(5.3–11.5)	4.2	(2.5–6.0)	8.8	(5.6–12.0)	6.2	(3.2–9.2)	3.9*	(1.2–6.6)
Grade												
6	4.9*	(0.6–9.2)	2.9	(1.7–4.1)	1.3*	(0.3–2.2)	1.5*	(0.1–2.9)	1.1*	(0.2–2.0)	1.0*	(0.0–2.3)
7	8.2	(6.2–10.2)	5.4	(3.8–7.0)	4.1	(2.6–5.7)	2.6	(1.1–4.0)	3.2	(1.7–4.7)	3.4	(1.6–5.1)
8	10.2	(7.1–13.3)	14.6	(10.8–18.5)	6.9	(4.6–9.3)	8.1	(5.3–10.9)	7.0	(4.8–9.2)	4.3	(2.4–6.2)
Total	**7.8**	**(5.9–9.7)**	**7.7**	**(5.9–9.6)**	**4.1**	**(2.9–5.3)**	**4.4**	**(3.3–5.5)**	**3.7**	**(2.7–4.7)**	**2.9**	**(1.9–3.8)**
HIGH SCHOOL												
Gender												
Male	22.8	(20.1–25.6)	23.6	(20.0–27.1)	19.0	(16.0–21.9)	18.8	(15.6–21.9)	14.8	(12.2-17.4)	12.5	(9.1-15.9)
Female	19.4	(17.1–21.8)	22.7	(18.0–27.4)	17.5	(15.1–20.0)	15.8	(13.1–18.5)	12.7	(9.4-16.0)	11.3	(7.8-14.7)
Race/Ethnicity												
White	22.1	(19.4–24.9)	24.8	(20.6–28.9)	21.1	(17.6–24.6)	18.2	(15.4–20.9)	14.5	(11.8–17.2)	13.0	(9.2–16.7)
Black	12.6	(8.9–16.3)	12.5	(8.3–16.8)	12.7	(9.4–16.0)	9.2	(6.2–12.2)	8.6	(4.5–12.7)	5.3	(2.7–7.9)
Hispanic	22.6	(17.3–27.9)	19.9	(14.6–25.1)	15.5	(12.4–18.5)	21.0	(15.6–26.4)	14.1	(9.1–19.1)	8.5*	(2.8–14.2)
Grade												
9	18.5	(15.5–21.5)	16.4	(13.5–19.4)	11.5	(8.5–14.5)	13.2	(10.8–15.5)	10.0	(6.4–13.6)	9.0	(6.6–11.4)
10	19.1	(16.6–21.6)	22.5	(18.1–27.0)	16.9	(13.4–20.3)	14.1	(10.5–17.6)	11.5	(8.8–14.2)	8.9	(4.4–13.3)
11	22.9	(18.4–27.3)	27.5	(22.1–32.9)	23.4	(18.2–28.6)	21.2	(17.4–24.9)	18.2	(13.5–22.9)	11.0	(7.8–14.1)
12	25.6	(20.4–30.8)	28.1	(20.6–35.7)	22.7	(18.5–26.9)	21.5	(16.4–26.6)	15.6	(11.1–20.1)	19.1	(11.9–26.3)
Total	**21.3**	**(19.1–23.5)**	**23.2**	**(19.5–26.8)**	**18.3**	**(16.0–20.5)**	**17.5**	**(15.1–19.9)**	**13.7**	**(11.3–16.1)**	**12.0**	**(8.6–15.4)**

Note: *Indicates data are statistically unstable because the relative standard error is >30%. These estimates should be interpreted with caution.
Source: ISDH/TPCC, 2015b

APPENDIX 4A - Part 3

Percentage of Indiana Middle School and High School Respondents Who Currently Use Smokeless Tobacco, by Gender, Race/Ethnicity, and School Grade (Indiana Youth Tobacco Survey, 2004–2014)

	2004		2006		2008		2010		2012		2014	
	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
MIDDLE SCHOOL												
Gender												
Male	3.1	(1.5–4.7)	5.2	(3.1–7.3)	4.3	(2.7–5.9)	4.2	(2.6–5.8)	2.1	(1.0–3.2)	2.7	(1.7–3.7)
Female	1.1*	(0.3–2.0)	2.0	(1.1–2.8)	2.2	(1.0–3.4)	0.7*	(0.2–1.1)	0.8*	(0.2–1.4	0.9*	(0.2–1.5)
Race/Ethnicity												
White	2.3	(1.2–3.4)	3.4	(1.9–4.9)	4.1	(2.0–6.2)	2.4	(1.4–3.3)	1.6	(0.9–2.3)	1.7	(1.0–2.3)
Black	3.0*	(0.7–5.3)	3.9*	(1.4–6.3)	2.8	(1.3–4.3)	1.9*	(0.2–3.6)	0.0	(0.0–0.0)	1.0*	(0.0–2.3)
Hispanic	0.6*	(0.0–1.4)	2.7*	(0.8–4.6)	2.7	(1.1–4.2)	2.9*	(0.3–5.5)	1.7*	(0.3–3.1)	3.0*	(0.0–6.1)
Grade												
6	1.9*	(0.2–3.5)	1.5*	(0.6–2.3)	0.9*	(0.1–1.8)	0.5*	(0.0–1.3)	0.7*	(0.0–1.4)	1.1*	(0.2–2.1)
7	1.6*	(0.6–2.6)	3.2	(1.8–4.5)	2.9	(1.6–4.1)	1.7	(0.7–2.7)	1.2*	(0.1–2.3)	1.8	(0.9–2.8)
8	2.6	(1.1–4.1)	6.1	(2.9–9.3)	6.1	(3.4–8.8)	4.5	(2.3–6.8)	2.6	(1.1–4.1)	2.4	(1.2–3.5)
Total	2.2	(1.2–3.1)	3.6	(2.4–4.9)	3.3	(2.0–4.6)	2.5	(1.7–3.4)	1.5	(0.9–2.1)	1.8	(1.2–2.4)
HIGH SCHOOL												
Gender												
Male	11.8	(9.4–14.1)	14.1	(10.1–18.1)	13.9	(10.5–17.2)	11.8	(9.7–13.9)	11.2	(8.7–13.7)	13.6	(7.8–19.4)
Female	2.5	(1.6–3.3)	1.6	(0.7–2.5)	2.4	(1.5–3.4)	2.3	(1.3–3.3)	1.8	(0.9–2.7)	2.0	(1.1–2.9)
Race/Ethnicity												
White	7.8	(6.2–9.5)	8.9	(6.3–11.4)	10.3	(7.3–13.3)	7.5	(6.1–9.0)	7.3	(5.8–8.8)	9.4	(5.5–13.3)
Black	2.6*	(1.0–4.1)	2.5*	(0.9–4.0)	5.7	(3.1–8.3)	1.4*	(0.0–2.9)	2.2*	(0.3–4.1)	0.9*	(0.0–1.8)
Hispanic	7.6	(4.3–11.0)	7.1	(3.3–10.9)	4.5	(2.5–6.6)	10.2	(6.5–13.9)	6.0	(2.8–9.2)	2.7*	(0.6–4.7)
Grade												
9	6.2	(5.0–7.5)	6.9	(4.3–9.4)	4.6	(3.2–6.0)	3.7	(1.8–5.7)	5.7	(2.9–8.5)	7.3	(4.2–10.3)
10	7.3	(5.3–9.4)	7.0	(3.5–10.5)	8.5	(5.6–11.4)	7.9	(5.5–10.3)	5.9	(3.9–7.9)	4.2*	(1.2–7.1)
11	7.8	(5.0–10.6)	7.3	(3.6–11.1)	10.9	(5.9–15.9)	9.1	(6.9–11.4)	8.2	(5.1–11.3)	6.5	(4.5–8.4)
12	8.0	(5.5–10.5)	10.9	(6.9–14.9)	9.4	(6.5–12.4)	8.1	(4.7–11.6)	6.7	(3.5–9.9)	14.0	(7.0–21.0)
Total	7.3	(5.9–8.8)	7.9	(5.7–10.1)	8.2	(6.1–10.2)	7.2	(5.9–8.6)	6.6	(5.3–7.9)	8.0	(4.6–11.3)

Note: *Indicates data are statistically unstable because the relative standard error is >30%. These estimates should be interpreted with caution.

Source: ISDH/TPCC, 2015b

APPENDIX 4A - Part 4

Percentage of Indiana Middle and High School Respondents Who Currently Use E-cigarettes,** by Gender, Race/Ethnicity, and School Grade (Indiana Youth Tobacco Survey, 2012-2014)

	2012		2014	
	%	(95% CI)	%	(95% CI)
MIDDLE SCHOOL				
Gender				
Male	1.1	(0.4–1.9)	5.8	(4.2–7.4)
Female	1.5	(0.6–2.5)	4.2	(2.6–5.9)
Race/Ethnicity				
White	1.5	(0.8–2.3)	4.4	(2.7–6.1)
Black	0.2*	(0.0–0.5)	7.0	(2.7–11.3)
Hispanic	0.9*	(0.0–2.0)	7.4	(3.9–10.8)
Grade				
6	0.5*	(0.0–1.2)	2.4*	(0.5–4.4)
7	0.8*	(0.3–1.4)	4.9	(2.2–7.6)
8	2.7	(1.1–4.3)	8.0	(5.1–10.9)
Total	**1.3**	**(0.7–2.0)**	**5.2**	**(3.8–6.6)**
HIGH SCHOOL				
Gender				
Male	5.2	(3.6–6.8)	17.3	(13.4–21.2)
Female	2.6	(1.4–3.7)	13.6	(10.8–16.4)
Race/Ethnicity				
White	4.4	(3.4–5.3)	16.5	(13.2–19.9)
Black	1.1	(0.0–2.4)	10.0	(7.3–12.7)
Hispanic	4.5	(2.1–6.9)	13.5	(8.1–18.8)
Grade				
9	2.4	(1.3–3.6)	10.7	(7.7–13.6)
10	3.6	(2.5–4.8)	12.2	(8.7–15.8)
11	4.4	(2.7–6.2)	15.6	(11.7–19.5)
12	5.2	(3.5–6.8)	24.1	(16.4–31.8)
Total	**3.9**	**(3.0–4.7)**	**15.6**	**(12.5–18.6)**

Notes: *Indicates data are statistically unstable because the relative standard error is >30%. These estimates should be interpreted with caution.

**In 2012, current e-cigarette use was assessed by the question, “In the past 30 days, which of the following [tobacco] products have you used on at least one day?” and was the 8th response option available. In 2014, current e-cigarette use was assessed using the question, “During the past 30 days, on how many days did you use electronic cigarettes?” Students who reported using e-cigarettes on one or more of the past 30 days were considered current e-cigarette users.

Source: ISDH/TPCC, 2015b

APPENDIX 4B - Part 1

Percentage of Indiana Students Reporting Monthly Cigarette Use, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
6th Grade	1.3	1.0	1.9*	0.7	0.6	0.9	2.1*	0.9*	2.1*
7th Grade	2.8	1.9	4.2*	3.4	2.4	2.4	3.8*	2.1	3.6*
8th Grade	5.1	4.3	5.0	5.7	3.9	4.8	5.6	4.5	6.8*
9th Grade	7.3	6.7	6.4	7.4	6.9	5.1	9.0*	8.1	10.1*
10th Grade	8.4	7.8	7.5	10.7	10.4*	6.1	10.5*	10.1*	9.1
11th Grade	11.4	10.8	11.4	11.3	10.6	8.6	12.0	13.7*	14.1*
12th Grade	14.9	13.5	13.6	21.4*	14.5	12.2	15.9	16.6	17.5*

Note: * Indicates a local rate that is significantly different from the overall state rate (P < 0.05).

Source: Gassman et al., 2016

APPENDIX 4B - Part 2

Percentage of Indiana Students Reporting Monthly E-Cigarette Use, by Region and Grade (Indiana Youth Survey, 2015)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
6th Grade	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7th Grade	4.9	5.9	6.3*	3.4	2.9	4.2	5.9	4.0	5.6
8th Grade	9.4	11.1*	10.5	7.4	5.8	9.9	8.9	9.0	9.0
9th Grade	13.7	14.7	13.1	13.9	11.4	11.9	14.5	15.9*	13.0
10th Grade	15.4	16.6	15.0	13.3	16.3	12.7	16.5	17.8*	14.8
11th Grade	18.8	18.9	15.0	16.4	17.5	19.2	18.3	21.3*	20.1
12th Grade	21.6	21.1	19.3	20.8	20.7	20.7	22.2	22.2	23.9*

Note: * Indicates a local rate that is significantly different from the overall state rate (P < 0.05).

The Indiana Youth Survey did not ask 6th grade students about e-cigarette use.

Source: Gassman et al., 2016

APPENDIX 4C - Part 1

Adult Smoking Prevalence and Chronic Disease Outcomes, by County

County	Estimated Adult Smoking Rate	Estimated Number of Adult Smokers	Asthma ER Visits Age-Adjusted Rate per 10,000 (2015)	Lung Cancer Average Mortality Rate per 100,000 (2010-2014)	COPD Average Age-adjusted Mortality Rate per 100,000 (2011-2015)	Major CVD Average Age-adjusted Mortality Rate per 100,000 (2011-2015)
Adams	19%	4,586	21.9	32.8	40.0	226.3
Allen	23%	58,785	45.0	43.9	52.5	225.1
Bartholomew	21%	12,084	40.5	58.4	62.9	237.2
Benton	Unreliable	Unreliable	26.8	77.8	42.3	254.9
Blackford	25%	2,431	43.3	56.6	64.2	244.7
Boone	15%	6,302	24.4	52.7	58.5	262.4
Brown	20%	2,419	Unstable Rate	51.8	50.1	209.3
Carroll	25%	3,765	24.2	51.4	46.3	207.4
Cass	Unreliable	Unreliable	43.6	65.9	62.4	238.2
Clark	24%	20,165	25.6	65.4	63.7	265.8
Clay	21%	4,299	35.9	58.3	61.5	282.0
Clinton	27%	6,598	40.8	57.5	60.4	280.8
Crawford	Unreliable	Unreliable	24.6	78.3	47.3	261.9
Daviess	16%	3,626	47.2	52.9	55.5	260.1
Dearborn	19%	7,234	25.5	61.7	51.4	236.3
Decatur	14%	2,639	49.2	51.7	49.0	266.1
DeKalb	28%	8,743	26.0	58.6	56.5	264.2
Delaware	24%	22,894	45.0	56.6	74.9	254.1
Dubois	14%	4,474	5.6	40.6	32.7	247.5
Elkhart	21%	29,096	44.5	46.8	49.1	243.6
Fayette	32%	5,937	27.5	69.9	71.4	271.4
Floyd	18%	9,941	27.1	54	58.8	264.4
Fountain	27%	3,534	60.9	60.2	70.1	253.8
Franklin	26%	4,472	12.4	52.7	48.1	224.1
Fulton	17%	2,652	35.0	67.1	67.8	301.7
Gibson	14%	3,465	47.4	46.7	55.5	245.7
Grant	32%	17,456	59.1	62.1	68.2	250.2
Greene	32%	7,985	24.8	65.3	63.8	260.9
Hamilton	12%	22,373	19.5	35.2	36.2	173.6
Hancock	23%	11,913	29.0	58.1	46.3	216.3
Harrison	20%	5,883	23.0	70.3	56.3	231.4
Hendricks	14%	14,652	15.3	50.5	53.0	207.0
Henry	28%	10,856	46.1	60.1	55.9	256.9
Howard	24%	15,194	57.3	52.8	61.6	274.4
Huntington	29%	8,154	40.0	49.2	61.1	268.5
Jackson	20%	6,278	67.9	69.3	68.2	250.1
Jasper	22%	5,532	34.1	66.6	51.6	274.2
Jay	20%	3,195	54.2	52	62.8	271.4
Jefferson	33%	8,393	31.0	65.4	73.0	307.9
Jennings	30%	6,357	55.6	66.8	76.3	279.5
Johnson	23%	23,956	39.0	51.3	72.4	242.9
Knox	22%	6,563	43.6	56.4	65.6	300.4
Kosciusko	27%	15,760	28.7	52.7	61.3	229.5
LaGrange	23%	5,489	27.4	40.3	48.1	262.0
Lake	26%	94,794	69.9	50.9	44.5	251.8
LaPorte	28%	23,963	52.5	58.1	56.4	272.6
Lawrence	30%	10,713	50.5	67.9	56.6	294.6
Madison	28%	28,069	87.0	69.3	66.7	248.9
Marion	25%	169,834	83.4	62.4	63.9	247.0
Marshall	23%	7,976	25.9	50.6	59.0	209.1
Martin	23%	1,821	Unstable Rate	59.8	54.7	247.7
Miami	30%	8,657	45.0	60.5	45.9	324.5
Monroe	20%	22,673	22.9	48.1	43.5	185.7
Montgomery	19%	5,468	51.3	52.7	65.1	265.2
Morgan	24%	12,453	41.6	63.8	77.5	269.8
Newton	Unreliable	Unreliable	31.1	70.3	65.1	254.2

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APPENDIX 4C - Part 1

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County	Estimated Adult Smoking Rate	Estimated Number of Adult Smokers	Asthma ER Visits Age-Adjusted Rate per 10,000 (2015)	Lung Cancer Average Mortality Rate per 100,000 (2010-2014)	COPD Average Age-adjusted Mortality Rate per 100,000 (2011-2015)	Major CVD Average Age-adjusted Mortality Rate per 100,000 (2011-2015)
Noble	23%	7,833	32.8	53.5	77.8	235.8
Ohio	Unreliable	Unreliable	Unstable Rate	83.8	49.4	210.9
Orange	Unreliable	Unreliable	52.8	61.8	69.5	263.4
Owen	Unreliable	Unreliable	32.8	60.4	60.1	276.9
Parke	31%	4,224	32.3	61.8	50.5	272.6
Perry	Unreliable	Unreliable	73.8	69.8	43.9	245.8
Pike	Unreliable	Unreliable	Unstable Rate	55	50.0	240.4
Porter	19%	23,493	44.0	51.2	43.3	213.6
Posey	Unreliable	Unreliable	20.7	45.6	52.9	222.5
Pulaski	Unreliable	Unreliable	29.4	58.5	64.0	311.9
Putnam	33%	9,932	25.1	72.6	46.7	245.4
Randolph	18%	3,503	47.7	59.2	53.5	238.4
Ripley	27%	5,749	39.0	58.7	48.4	245.4
Rush	Unreliable	Unreliable	83.1	62.6	82.8	275.1
Scott	28%	5,090	51.9	79.9	78.2	281.7
Shelby	25%	8,531	51.6	54.3	49.1	252.5
Spencer	18%	2,914	22.5	46.1	50.5	204.4
St. Joseph	23%	45,517	50.6	51.3	50.2	237.1
Starke	31%	5,515	51.8	78.5	67.2	342.0
Steuben	21%	5,495	40.7	53.9	40.2	238.6
Sullivan	25%	4,138	46.8	68.5	57.5	284.7
Switzerland	Unreliable	Unreliable	Unstable Rate	73	75.6	277.8
Tippecanoe	20%	26,981	38.0	45.1	45.9	228.3
Tipton	Unreliable	Unreliable	40.4	42.9	40.2	246.0
Union	Unreliable	Unreliable	Suppressed	43.4	64.7	268.9
Vanderburgh	22%	31,432	54.9	54.1	59.3	237.3
Vermillion	Unreliable	Unreliable	48.7	74.3	72.5	392.8
Vigo	26%	22,343	44.9	62	66.9	284.8
Wabash	18%	4,679	27.4	46.6	59.3	230.9
Warren	Unreliable	Unreliable	47.3	50.4	64.1	172.3
Warrick	14%	6,278	30.1	45.4	47.5	189.9
Washington	23%	4,835	44.3	69.9	70.7	292.8
Wayne	28%	14,704	41.9	63.5	62.3	263.1
Wells	21%	4,362	28.0	41.2	51.5	206.2
White	21%	3,934	53.8	54.6	65.3	228.7
Whitley	22%	5,597	35.1	51.1	53.6	226.1
Indiana	**20.6%**	**1,004,354**	**47.4**	**55.1**	**56.2**	**243.9**

Notes:

1) County-level adult smoking prevalence estimates were calculated using combined landline and cell phone BRFSS data from 2011–2015. The statewide landline and cell phone weight was used to calculate county-level estimates. County estimates are suppressed when the relative standard error is greater than 30%, when the half-width of the 95% confidence interval is greater than 10 percentage points, or when there were fewer than 50 respondents in the county.
2) Statewide adult smoking prevalence is from the 2015 Behavioral Risk Factor Surveillance system and is not comparable to county-level estimates.
3) Estimated number of adult smokers is calculated by multiplying the estimated county or state smoking prevalence by the county or state adult population total from the 2010 U.S. Census.
4) Data source for asthma emergency department visits: Indiana State Department of Health, Asthma Program. 2015 Indiana County Age-Adjusted Emergency Department and Hospitalization Rates (http://www.in.gov/isdh/files/2015%20County%20ED%20and%20Hosp%20aa%20Rates.pdf)
5) Data source for lung cancer mortality: Indiana State Cancer Registry Report Generator (http://www.in.gov/isdh/24360.htm)
6) Data source for other chronic disease data: Centers for Disease Control and Prevention. Wide-ranging Online Data for Epidemiologic Research (WONDER).

Source: ISDH/TPCC, 2015c

APPENDIX 4C - Part 2

County	Percentage of Live Births to Mothers who Smoked during Pregnancy (2015	Estimated cost of smoking-affected births	Estimated number of people living with tobacco-related illnesses	Annual deaths due to tobacco	Annual deaths due to Secondhand Smoke (SHS)	Economic burden of SHS
Adams	8.0	$71,920	1,617	54	7	$11.5 Million
Allen	9.8	$701,353	17,715	591	73	$118.7 Million
Bartholomew	16.2	$241,116	3,923	131	16	$25.7 Million
Benton	24.3	$35,309	449	15	2	$3 Million
Blackford	25.6	$42,065	673	22	3	$4.3 Million
Boone	10.0	$104,973	2,781	93	12	$18.9 Million
Brown	21.7	$35,362	824	27	3	$5.1 Million
Carroll	21.0	$55,610	1,038	35	4	$6.7 Million
Cass	17.8	$119,653	1,972	66	8	$13 Million
Clark	13.2	$266,554	5,746	192	23	$36.8 Million
Clay	22.8	$107,130	1,397	47	6	$9 Million
Clinton	17.2	$108,613	1,665	55	7	$11.1 Million
Crawford	26.3	$42,144	561	19	2	$3.6 Million
Daviess	13.1	$92,329	1,539	51	7	$10.6 Million
Dearborn	21.1	$153,584	2,563	85	10	$16.7 Million
Decatur	23.6	$112,812	1,310	44	5	$8.6 Million
DeKalb	20.8	$149,706	2,123	71	9	$14.1 Million
Delaware	22.8	$367,833	6,427	214	24	$39.3 Million
Dubois	11.2	$86,999	2,132	71	9	$14 Million
Elkhart	10.6	$458,906	9,657	322	41	$66 Million
Fayette	27.8	$93,626	1,261	42	5	$8.1 Million
Floyd	15.2	$187,632	3,869	129	15	$24.9 Million
Fountain	21.5	$58,394	892	30	4	$5.8 Million
Franklin	18.6	$57,085	1,165	39	5	$7.7 Million
Fulton	23.1	$81,561	1,070	36	4	$7 Million
Gibson	17.3	$91,154	1,732	58	7	$11.2 Million
Grant	36.1	$371,110	3,749	125	14	$23.4 Million
Greene	24.0	$109,835	1,727	58	7	$11.1 Million
Hamilton	2.0	$105,978	13,089	436	57	$91.7 Million
Hancock	10.1	$113,018	3,529	118	14	$23.4 Million
Harrison	20.6	$126,446	2,053	68	8	$13.1 Million
Hendricks	7.6	$181,749	7,208	240	30	$48.6 Million
Henry	21.2	$137,038	2,624	87	10	$16.5 Million
Howard	22.6	$300,156	4,314	144	17	$27.6 Million
Huntington	17.5	$103,140	1,935	64	8	$12.4 Million
Jackson	17.7	$138,451	2,183	73	9	$14.2 Million
Jasper	21.5	$111,533	1,700	57	7	$11.2 Million
Jay	18.3	$76,045	1,066	36	4	$7.1 Million
Jefferson	31.3	$157,695	1,714	57	7	$10.8 Million
Jennings	27.1	$115,558	1,434	48	6	$9.5 Million
Johnson	13.7	$350,325	7,018	234	29	$46.6 Million
Knox	25.8	$151,007	2,066	69	8	$12.8 Million
Kosciusko	13.4	$186,885	3,930	131	16	$25.8 Million
LaGrange	6.9	$70,558	1,661	55	8	$12.4 Million
Lake	9.1	$730,346	25,185	839	102	$165.7 Million
LaPorte	22.8	$414,896	5,880	196	23	$37.2 Million
Lawrence	30.4	$205,178	2,408	80	10	$15.4 Million
Madison	22.1	$453,178	6,915	231	27	$44 Million
Marion	10.9	$2,136,254	46,232	1,541	186	$301.8 Million
Marshall	16.4	$135,409	2,350	78	10	$15.7 Million
Martin	20.0	$35,308	536	18	2	$3.5 Million

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APPENDIX 4C - Part 2

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County	Percentage of Live Births to Mothers who Smoked during Pregnancy (2015	Estimated cost of smoking-affected births	Estimated number of people living with tobacco-related illnesses	Annual deaths due to tobacco	Annual deaths due to Secondhand Smoke (SHS)	Economic burden of SHS
Miami	19.3	$98,023	1,947	65	8	$12.3 Million
Monroe	14.9	$273,769	7,889	263	28	$46.1 Million
Montgomery	21.6	$138,744	1,980	66	8	$12.7 Million
Morgan	25.8	$271,882	3,522	117	14	$23 Million
Newton	26.9	$62,467	749	25	3	$4.8 Million
Noble	18.5	$164,304	2,369	79	10	$15.9 Million
Ohio	14.8	$10,853	330	11	1	$2 Million
Orange	27.5	$89,628	1,021	34	4	$6.6 Million
Owen	30.3	$93,816	1,131	38	4	$7.2 Million
Parke	14.9	$46,134	931	31	4	$5.8 Million
Perry	24.7	$78,825	1,038	35	4	$6.5 Million
Pike	23.4	$43,535	681	23	3	$4.3 Million
Porter	9.6	$223,451	8,498	283	34	$54.9 Million
Posey	15.4	$59,603	1,350	45	5	$8.7 Million
Pulaski	23.7	$43,449	697	23	3	$4.5 Million
Putnam	20.2	$99,302	2,047	68	8	$12.7 Million
Randolph	19.6	$80,117	1,352	45	5	$8.7 Million
Ripley	22.5	$98,998	1,450	48	6	$9.6 Million
Rush	19.1	$48,763	894	30	4	$5.8 Million
Scott	28.0	$114,072	1,255	42	5	$8.1 Million
Shelby	21.4	$143,853	2,294	76	9	$14.8 Million
Spencer	14.7	$38,129	1,085	36	4	$7 Million
St. Joseph	11.4	$538,746	13,734	458	55	$89.2 Million
Starke	29.7	$106,075	1,207	40	5	$7.8 Million
Steuben	27.2	$153,660	1,800	60	7	$11.4 Million
Sullivan	18.9	$52,872	1,153	38	4	$7.2 Million
Switzerland	28.6	$48,937	539	18	2	$3.5 Million
Tippecanoe	11.4	$369,691	9,361	312	36	$57.7 Million
Tipton	12.5	$24,444	836	28	3	$5.3 Million
Union	26.1	$24,456	385	13	2	$2.5 Million
Vanderburgh	17.4	$525,041	9,549	318	37	$60 Million
Vermillion	27.2	$62,425	852	28	3	$5.4 Million
Vigo	20.1	$350,751	5,792	193	22	$36 Million
Wabash	22.5	$103,276	1,737	58	7	$11 Million
Warren	21.5	$23,066	445	15	2	$2.8 Million
Warrick	9.5	$88,114	3,023	101	12	$19.9 Million
Washington	17.2	$77,547	1,444	48	6	$9.4 Million
Wayne	22.1	$236,493	3,622	121	14	$23 Million
Wells	16.8	$77,341	1,416	47	6	$9.2 Million
White	23.1	$95,050	1,276	43	5	$8.2 Million
Whitley	18.6	$100,530	1,715	57	7	$11.1 Million
Indiana	**14.3**	**$16,315,012**	**333,000**	**11,100**	**1,337**	

Notes:

1) Data source for smoking during pregnancy rates: Indiana State Department of Health. Indiana Natality Report, State and County Data 2014. Published December 2015.
2) Costs of smoking-affected births are calculated by multiplying the estimated number of smoking-affected births by $1,358 (the estimated cost per smoking-affected birth as calculated by Miller et al., 2001).
3) County-level estimates of the number of people living with a tobacco-related illness, deaths due to tobacco, deaths due to secondhand smoke, and economic burden of secondhand smoke represent the county's pro-rata share of tobacco-related illnesses based on the county's 2010 adult population.
4) The economic burden of secondhand smoke includes medical costs and premature death.

Source: ISDH/TPCC, 2015c

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5

Marijuana Use in Indiana: Consumption Patterns and Consequences

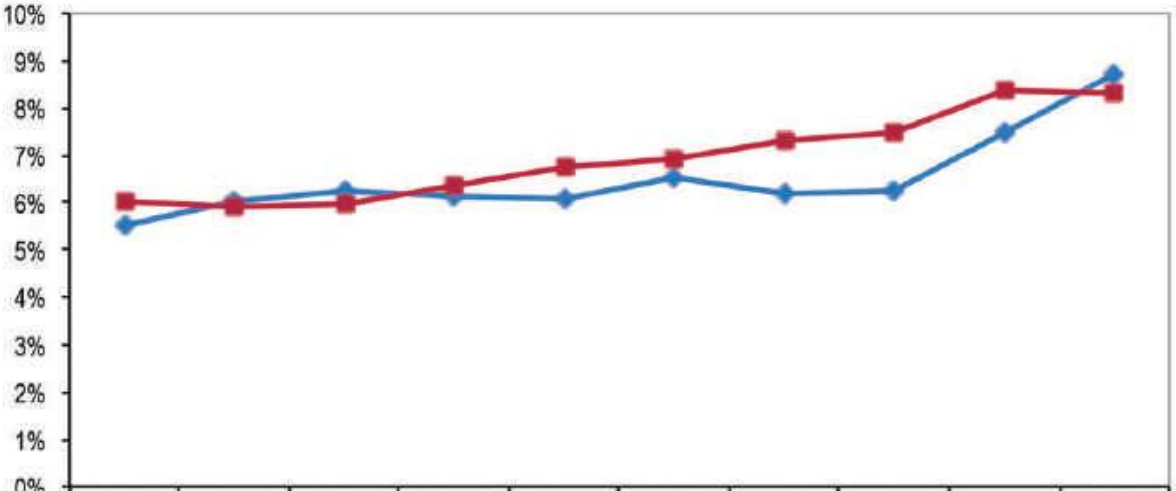
MARIJUANA CONSUMPTION

Marijuana is a product of the hemp plant, known as Cannabis sativa. Found in the dried leaves, stems, seeds, and flowers, delta-9-tetrahydrocannabinol (THC) is the primary psychoactive (mind-altering) chemical. The drug can be consumed in different ways: by smoking "joints" or "blunts" (hand-rolled cigarettes or cigars filled only with cannabis, not tobacco) and hookah (water pipes), mixing into foods, or brewing as tea (Hall & Solowij, 1998; National Institute on Drug Abuse [NIDA], 2016a). Recent studies show an increase in edible consumption of marijuana, especially in states that allow medical use of marijuana (NIDA, 2016a).

General Consumption Patterns

Marijuana is the most commonly used illicit drug in the United States (Azofeifa et al., 2016). According to the 2015 National Survey on Drug Use and Health (NSDUH), an estimated 8.7% (95% Confidence Interval [CI]: 7.4–10.2) of Indiana residents ages 12 and older reported current (past-month) marijuana use (U.S.: 8.3%; 95% CI: 8.1–8.6); past-year use was estimated at 13.9% (95% CI: 12.3–15.7; U.S.: 13.4%; 95% CI: 13.1–13.7) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). For 10-year trend data on past-month marijuana use, see Figure 5.1.

Figure 5.1 Percentage of Indiana and U.S. Population (Ages 12 and Older) Reporting Current Marijuana Use (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	5.5%	6.0%	6.3%	6.1%	6.1%	6.5%	6.2%	6.3%	7.5%	8.7%
U.S.	6.0%	5.9%	6.0%	6.4%	6.8%	6.9%	7.3%	7.5%	8.4%	8.3%

Source: SAMHSA, 2017

Adult Consumption Patterns

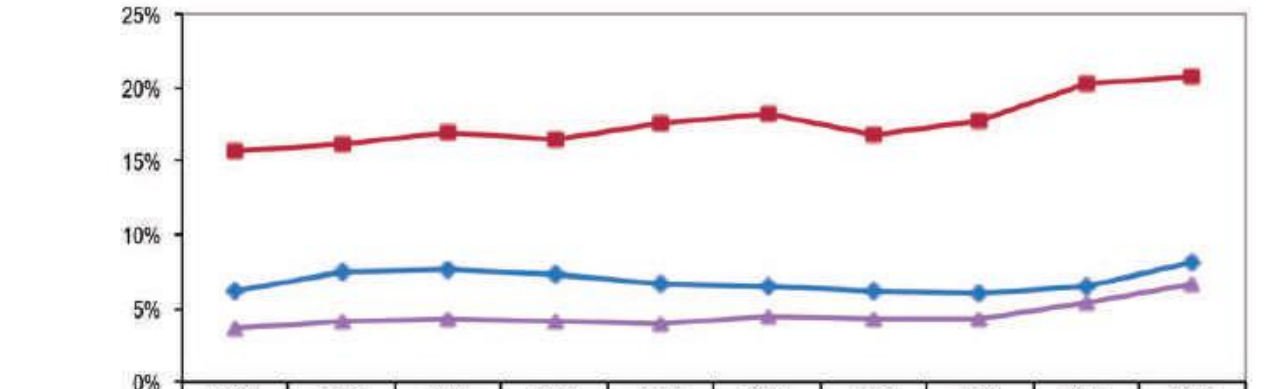
In the past decade, patterns of adult marijuana use in Indiana and the United States were similar. According to the 2015 NSDUH report, the highest prevalence was among individuals aged 18 to 25, with 20.7% (95% CI: 17.8–24.0) of Hoosiers in this age group reporting current marijuana use (U.S.: 19.7%; 95% CI: 19.1–20.3) and 33.6% (95% CI: 30.1–37.2) reporting past-year use (U.S.: 32.1; 95% CI: 31.4–32.8) (SAMHSA, 2017).

Prevalence rates were significantly lower in adults ages 26 and older, with 6.7% (95% CI: 5.4–8.3) of Hoosiers in that age group reporting past-month marijuana use (U.S.: 6.6%; 95% CI: 6.3–6.8) and 10.4% (95% CI: 8.7–12.4) reporting use in the past year (U.S.: 10.3%; 95% CI: 9.9–10.6) (SAMSHA, 2017). See Figure 5.2 for current marijuana use rates by age group in Indiana.

An estimated 9.0% (95% CI: 7.3–11.0) of Hoosiers ages 18 to 25 initiated marijuana, i.e., used marijuana for the first time, in the past year (U.S.: 7.9%; 95% CI: 7.5–8.3), as did 0.3% (95% CI: 0.2–0.5) of individuals 26 years and older (U.S.: 0.3%; 95% CI: 0.3–0.4) (SAMHSA, 2017).

Marijuana use was also prevalent among college students. Results from the 2016 Indiana College Substance Use Survey, based on twenty participating colleges and universities, showed that 19.6% of Indiana college students reported current marijuana use (U.S.: 21.1%). Users were more likely to be male and under the age of 21 (King & Jun, 2016).[1]

Figure 5.2 Percentage of Indiana Residents Reporting Current Marijuana Use, by Age Group (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
12-17	6.2%	7.4%	7.6%	7.2%	6.7%	6.5%	6.2%	6.0%	6.5%	8.1%
18-25	15.6%	16.2%	16.9%	16.5%	17.5%	18.2%	16.8%	17.7%	20.3%	20.7%
26 and older	3.6%	4.1%	4.3%	4.2%	4.1%	4.4%	4.3%	4.3%	5.4%	6.7%

Source: SAMHSA, 2017

[1]Twenty Indiana colleges participated in the survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

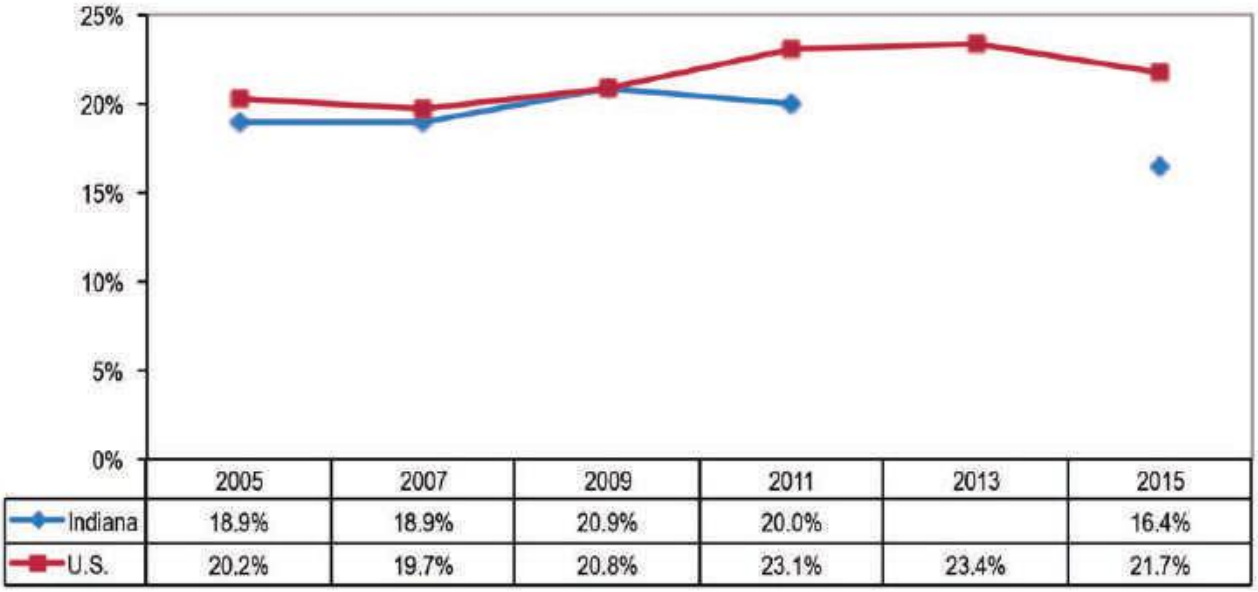
Youth Consumption Patterns

Age of first use is an important risk factor in the subsequent progression to substance abuse and dependence (King & Chassin, 2007). Adolescents who used marijuana by the age of 17 were found to be at greater risk of using other drugs and developing alcohol and drug abuse/dependence (Lynskey et al., 2003).

According to 2015 NSDUH findings, 12.1% (95% CI: 10.1–14.5) of 12- to 17-year-olds in Indiana reported using marijuana in the past year (U.S.: 13.5%; 95% CI: 13.1–13.9) and 8.1% (95% CI: 6.4-10.1) in the past month (U.S.: 7.2%; 95% CI: 6.9-7-6). Initiation, or first-time use, was reported in 6.0% (95% CI: 5.0-7.1) of Indiana youth in that age group (U.S.: 5.4%; 95% CI: 5.2–5.7) (SAMHSA, 2017). For past-month marijuana prevalence rates by age group in Indiana, see Figure 5.2.

The 2015 Youth Risk Behavior Surveillance System (YRBSS) estimated that 16.4% (95% CI: 14.1–18.9) of Indiana high school students (grades 9 through 12) used marijuana in the past month; a percentage significantly lower than the national rate of 21.7% (95% CI: 19.3–24.2). Use was more likely to occur in higher grade levels and in black or Hispanic students (Centers for Disease Control and Prevention [CDC], 2017). For more detailed information, see Table 5.1 and Figure 5.3.

Figure 5.3 Percentage of Indiana and U.S. High School Students Currently Using Marijuana (Youth Risk Behavior Surveillance System, 2005–2015)



	2005	2007	2009	2011	2013	2015
Indiana	18.9%	18.9%	20.9%	20.0%		16.4%
U.S.	20.2%	19.7%	20.8%	23.1%	23.4%	21.7%

Note: 2013 estimates for Indiana are not available.
Source: CDC, 2017

In 2015, 6.2% (95% CI: 5.3–7.4) of Indiana students reported having tried marijuana before the age of 13; that figure was comparable to the national rate (7.5%; 95% CI: 6.5–8.7) (CDC, 2017). For more detailed information, see Table 5.2.

Data from the Indiana Youth Survey (Gassman et al., 2016), and the Monitoring the Future (MTF) survey (Inter-university Consortium for Political and Social Research (ICPSR), 2016) show that marijuana use among 8th, 10th, and 12th grade students increased with grade level/age. Prevalence rates for current marijuana use in Indiana and the nation were similar; however, due to lack of detail in the publicly available dataset, statistical significance could not be determined. For current marijuana use trends among 8th, 10th, and 12th grade students from 2007 through 2016, see Figure 5.4; for monthly marijuana use by Indiana region and grade level for 2016, see Appendix 5A, page 85.

Table 5.1 Percentage of Indiana and U.S. High School Students Reporting Current (Past Month) Marijuana Use, by Grade, Gender, and Race/Ethnicity (Youth Risk Behavior Surveillance System, 2015)

		Indiana Prevalence Rate (95% CI)	U.S. Prevalence Rate (95% CI)
Grade	9th	13.7% (10.4–17.9)	15.2% (16.8–23.5)
	10th	16.8% (12.5–22.2)	20.0% (24.0–30.4)
	11th	17.0% (13.2–21.7)	24.8% (22.3–27.5)
	12th	18.4% (14.1–23.7)	27.6% (23.8–31.6)
Gender	Male	16.4% (13.8–19.4)	23.2% (20.4–26.3)
	Female	15.9% (12.7–19.7)	20.1% (17.6–22.9)
Race/Ethnicity	Black	23.2% (17.1–30.7)	28.9% (26.3–31.6)
	White	14.9% (12.4–17.8)	20.4% (17.8–23.3)
	Hispanic	18.1% (13.6–23.6)	27.6% (24.6–30.7)
Total		**16.4% (14.1–18.9)**	**21.7% (19.3–24.2)**

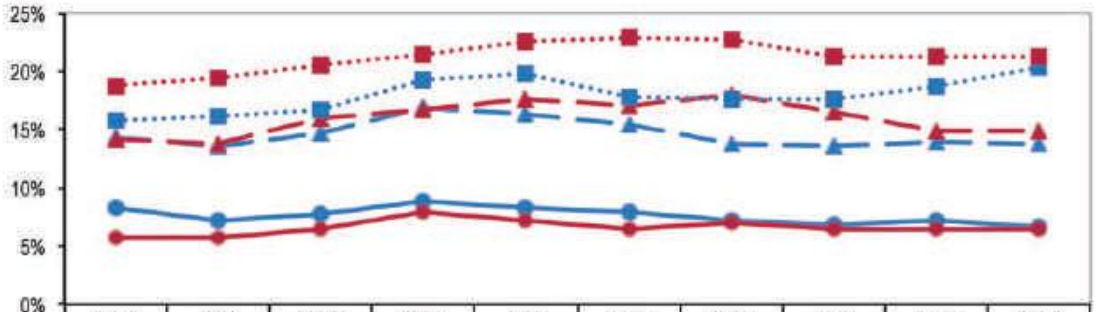
Source: CDC, 2017

Table 5.2 Percentage of Indiana and U.S. High School Students Reporting Marijuana Initiation Before Age 13, by Grade, Gender, and Race/Ethnicity (Youth Risk Behavior Surveillance System, 2015)

		Indiana Prevalence Rate (95% CI)	U.S. Prevalence Rate (95% CI)
Grade	9th	10.2% (7.6–13.4)	8.5% (7.1–10.1)
	10th	6.2% (4.4–8.8)	8.3% (6.5–10.5)
	11th	4.9% (3.1–7.6)	6.7% (5.3–8.4)
	12th	3.6% (2.1–6.1)	6.1% (4.9–7.5)
Gender	Male	6.9% (5.8–8.2)	9.2% (7.7–11.0)
	Female	5.2% (3.5–7.7)	5.6% (4.6–6.9)
Race/Ethnicity	Black	6.7% (4.0–11.2)	13% (9.6–17.5)
	White	5.4% (4.1–7.2)	6.7% (5.2–8.7)
	Hispanic	10.1% (6.9–14.5)	13.6% (11.7–15.7)
Total		**6.2% (5.3–7.4)**	**7.5% (6.5–8.7)**

Source: CDC, 2017

Figure 5.4 Percentage of Indiana and U.S. 8th, 10th, and 12th Grade Students Reporting Current Marijuana Use (Indiana Youth Survey and Monitoring the Future Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Indiana 8th Grade	8.3%	7.1%	7.8%	8.9%	8.3%	8.0%	7.1%	6.8%	7.1%	6.6%
U.S. 8th Grade	5.7%	5.8%	6.5%	8.0%	7.2%	6.5%	7.0%	6.5%	6.5%	6.5%
Indiana 10th Grade	14.4%	13.5%	14.6%	16.8%	16.4%	15.4%	13.7%	13.6%	14.0%	13.7%
U.S. 10th Grade	14.2%	13.8%	15.9%	16.7%	17.6%	17.0%	18.0%	16.6%	14.8%	14.8%
Indiana 12th Grade	15.8%	16.2%	16.7%	19.2%	19.8%	17.8%	17.6%	17.6%	18.8%	20.3%
U.S. 12th Grade	18.8%	19.4%	20.6%	21.4%	22.6%	22.9%	22.7%	21.2%	21.3%	21.3%

Source: Gassman et al., 2016; ICPSR, 2016

CONSEQUENCES OF MARIJUANA USE

Health-Related Consequences

The use of marijuana can result in adverse physical, mental, emotional, and behavioral changes. Short-term effects include memory impairment and learning problems, distorted perception, difficulty thinking and solving problems, loss of coordination, and increased heart rate. Long-term use has been linked to respiratory illnesses and an increased risk of heart attack and cancer (Crean, Crane, & Mason, 2011; Volkow, Baler, Compton, & Weiss, 2014). Furthermore, prolonged marijuana use can lead to mental health problems such as depression, anxiety, suicidal thoughts, and personality disturbances (Patton et al., 2002; Caspi et al., 2005).

Babies born to women who used marijuana during their pregnancy may be at an increased risk for neurobehavioral problems, potentially exhibiting difficulties with attention, memory, and problem solving (NIDA, 2016a).

Marijuana Dependence

The Treatment Episode Data Set (TEDS) collects information from clients being admitted to substance abuse treatment. The data show that from 2005 through 2014, Indiana exhibited a significantly higher percentage of treatment episodes reporting marijuana use and dependence[2] compared to the rest of the United States. From 2005 through 2014, roughly one-half of Indiana treatment admissions reported marijuana use (see Figure 5.5) and about one-fifth indicated marijuana dependence (see Figure 5.6) (SAMHSA, 2014).

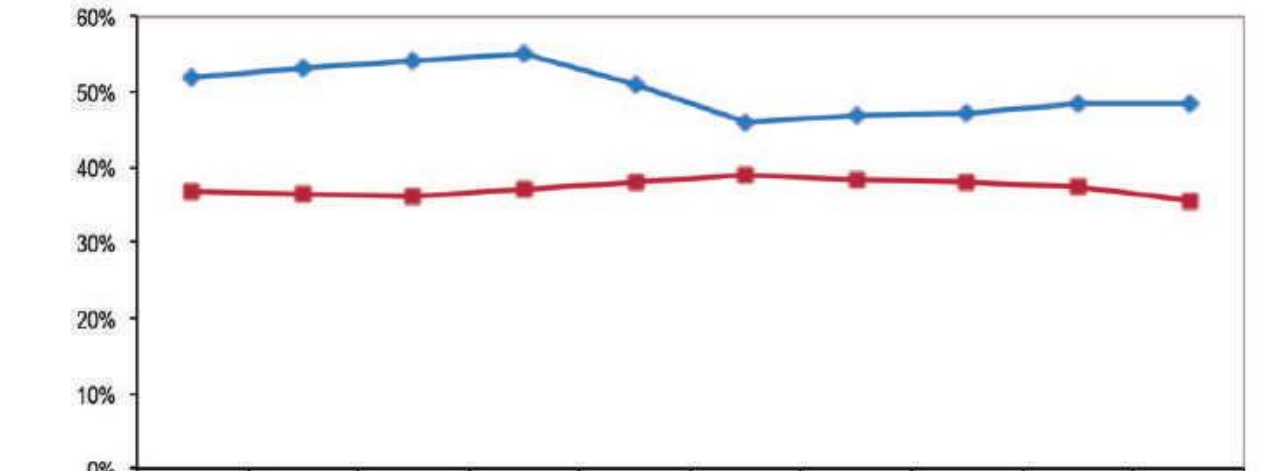
Statistically significant differences in marijuana use among Indiana's treatment population were observed by gender, race, and age, as follows:

- Across the years, the percentage of males reporting marijuana use and dependence was higher than the percentage of females (see Figures 5.7 and 5.8).
- The percentage of blacks who report marijuana use and dependence was higher compared to Whites and other races (see Figures 5.9 and 5.10).
- Marijuana use and dependence in the treatment population decreased by age; i.e., the highest percentage was found among adolescents under the age of 18 and the lowest among older adults ages 55 and above (see Figures 5.11 and 5.12).

For county-level information on marijuana use and dependence, see Appendix 5B, page 86 (Indiana Family and Social Services Administration, 2016).

[2]We defined marijuana dependence as "individuals in substance abuse treatment listing marijuana as their primary substance at admission."

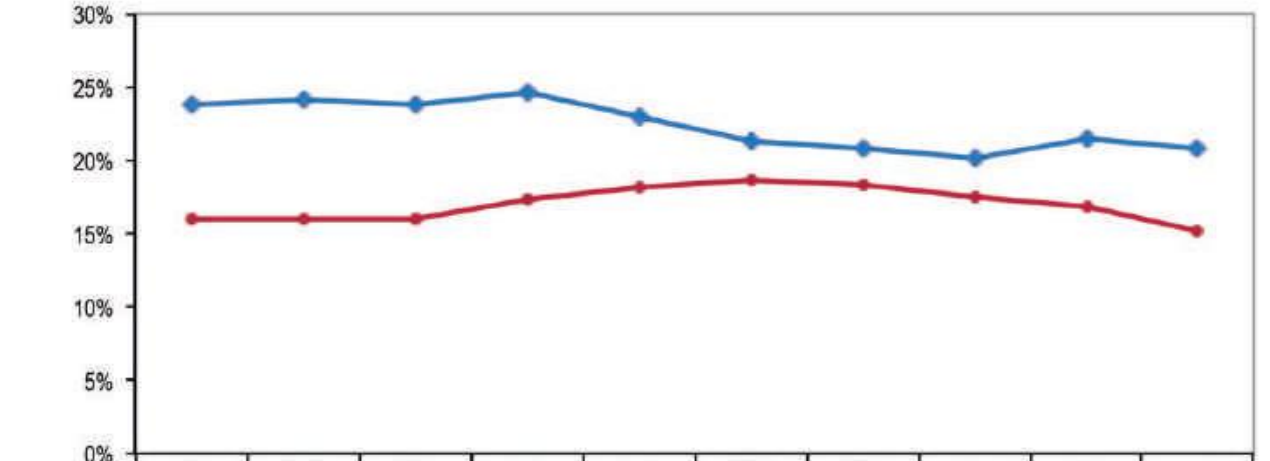
Figure 5.5 Percentage of Indiana and U.S. Treatment Episodes with Marijuana Use Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	52.0%	53.1%	54.0%	55.0%	51.0%	46.0%	46.9%	47.2%	48.3%	48.3%
U.S.	36.6%	36.4%	36.0%	37.1%	38.0%	39.0%	38.2%	38.0%	37.3%	35.6%

Source: SAMHSA, 2014

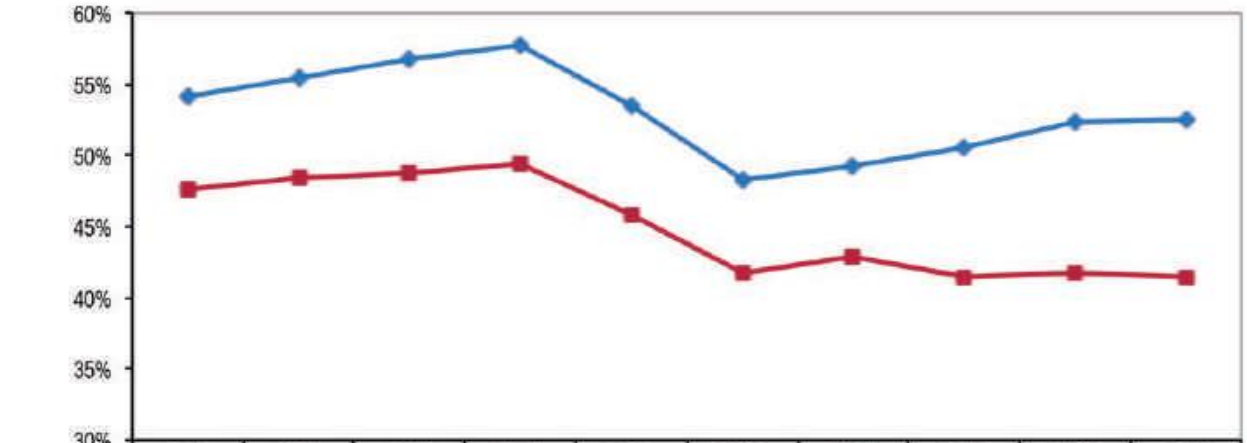
Figure 5.6 Percentage of Indiana and U.S. Treatment Episodes with Marijuana Dependence Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	23.8%	24.1%	23.8%	24.7%	23.0%	21.4%	20.9%	20.1%	21.5%	20.8%
U.S.	16.0%	16.0%	16.0%	17.3%	18.2%	18.6%	18.3%	17.5%	16.8%	15.2%

Source: SAMHSA, 2014

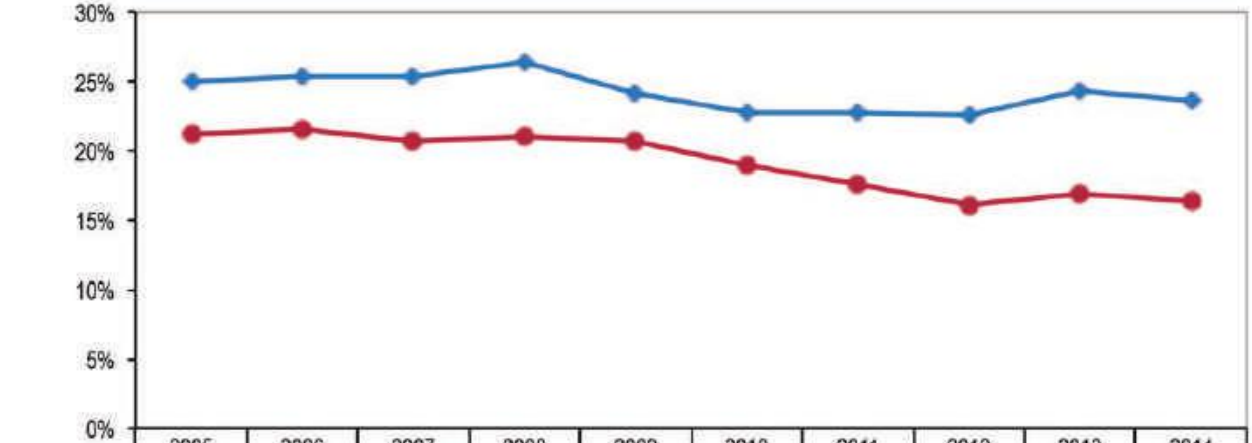
Figure 5.7 Percentage of Indiana Treatment Episodes with Marijuana Use Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	54.1%	55.5%	56.7%	57.7%	53.5%	48.3%	49.2%	50.6%	52.4%	52.5%
Female	47.7%	48.4%	48.7%	49.5%	45.9%	41.8%	42.9%	41.5%	41.7%	41.5%

Source: SAMHSA, 2014

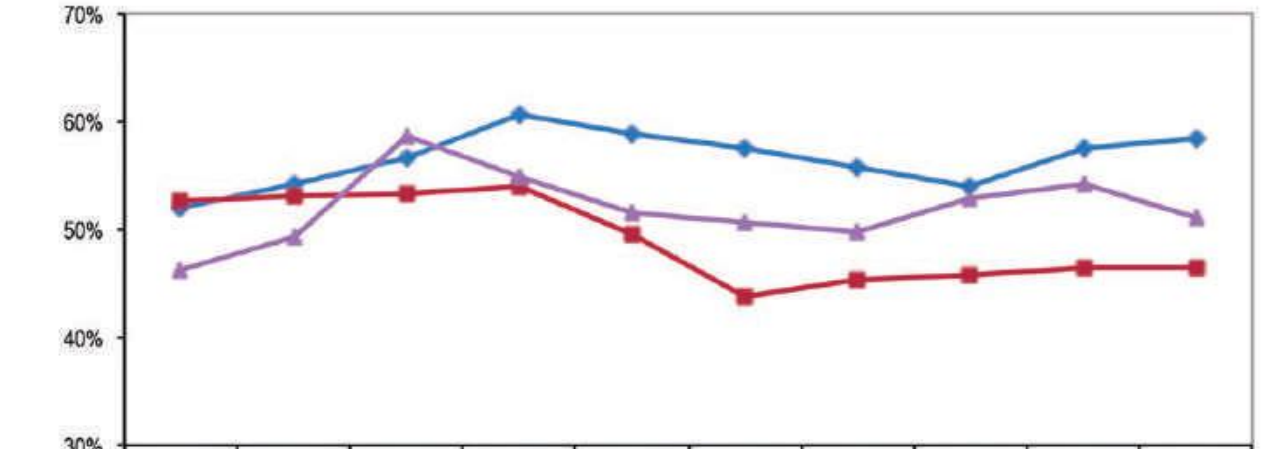
Figure 5.8 Percentage of Indiana Treatment Episodes with Marijuana Dependence Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	25.0%	25.4%	25.4%	26.4%	24.2%	22.8%	22.7%	22.5%	24.4%	23.7%
Female	21.2%	21.6%	20.6%	21.1%	20.6%	19.0%	17.6%	16.1%	16.8%	16.3%

Source: SAMHSA, 2014

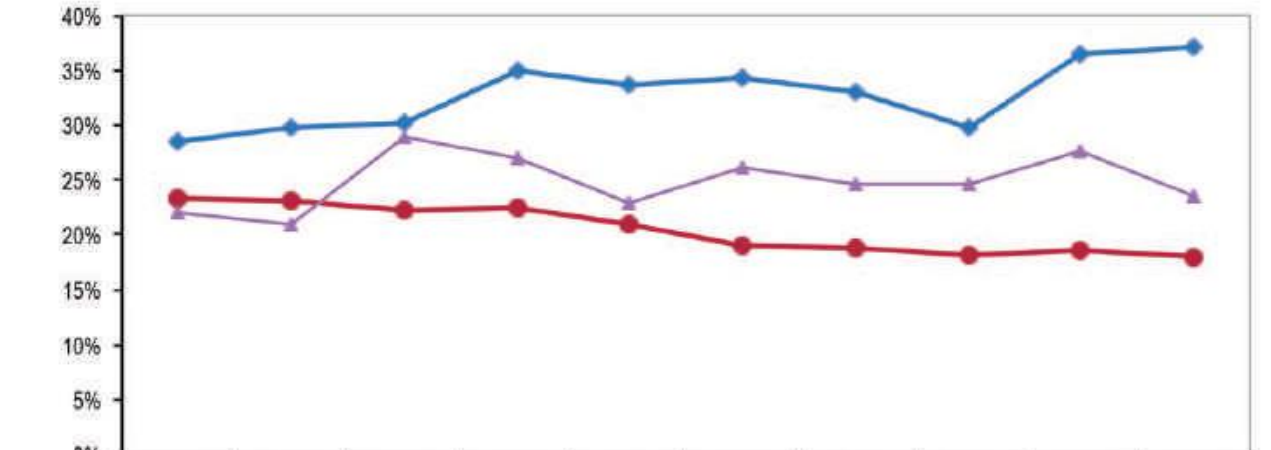
Figure 5.9 Percentage of Indiana Treatment Episodes with Marijuana Use Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	52.0%	54.2%	56.6%	60.6%	58.8%	57.6%	55.8%	54.0%	57.6%	58.4%
White	52.7%	53.2%	53.3%	53.9%	49.6%	43.8%	45.4%	45.7%	46.4%	46.4%
Other	46.2%	49.4%	58.6%	54.9%	51.5%	50.7%	49.7%	52.9%	54.2%	51.2%

Source: SAMHSA, 2014

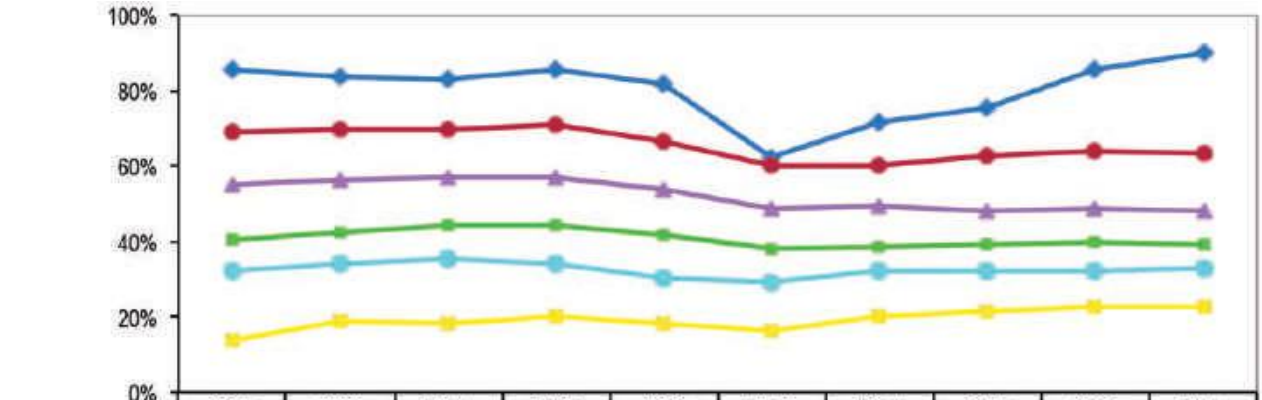
Figure 5.10 Percentage of Indiana Treatment Episodes with Marijuana Dependence Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	28.4%	29.8%	30.2%	35.0%	33.7%	34.4%	32.9%	29.8%	36.4%	37.2%
White	23.3%	23.1%	22.2%	22.4%	20.9%	18.9%	18.7%	18.1%	18.5%	18.0%
Other	22.1%	20.9%	28.8%	27.0%	22.9%	26.0%	24.7%	24.6%	27.7%	23.5%

Source: SAMHSA, 2014

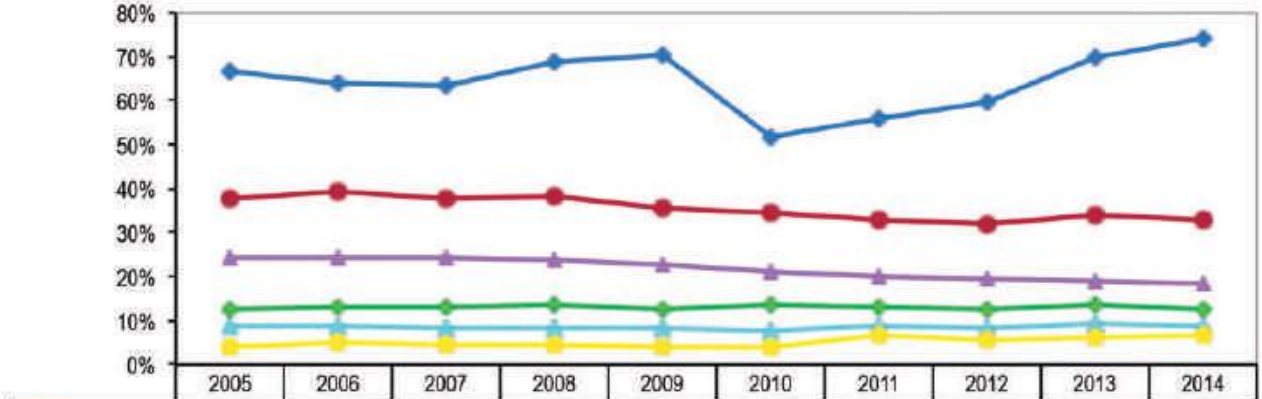
Figure 5.11 Percentage of Indiana Treatment Episodes with Marijuana Use Reported at Treatment Admission, by Age Group (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
under 18	85.9%	83.8%	83.3%	85.8%	82.0%	62.4%	71.9%	75.6%	85.8%	90.3%
18 to 24	68.9%	70.0%	69.7%	70.7%	66.3%	60.1%	60.4%	62.7%	64.2%	63.1%
25 to 34	55.2%	56.2%	57.0%	57.3%	53.9%	48.9%	49.1%	48.0%	48.5%	48.4%
35 to 44	40.8%	42.4%	44.0%	44.0%	41.5%	38.2%	38.9%	39.2%	39.6%	39.5%
45 to 54	32.1%	34.1%	35.1%	34.2%	30.3%	29.3%	32.2%	32.1%	32.2%	32.8%
55 and over	13.5%	19.2%	18.3%	20.0%	18.3%	16.5%	20.1%	21.3%	22.5%	22.7%

Source: SAMHSA, 2014

Figure 5.12 Percentage of Indiana Treatment Episodes with Marijuana Dependence Reported at Treatment Admission, by Age Group (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
under 18	66.4%	64.1%	63.3%	68.8%	70.3%	51.8%	56.2%	59.7%	69.6%	74.4%
18 to 24	37.9%	39.3%	37.6%	38.4%	35.7%	34.3%	33.0%	32.0%	34.0%	32.7%
25 to 34	24.4%	24.4%	24.3%	23.7%	22.8%	20.9%	20.2%	19.3%	19.1%	18.2%
35 to 44	12.5%	13.2%	13.0%	13.7%	12.6%	13.6%	13.1%	12.3%	13.5%	12.5%
45 to 54	8.7%	8.7%	8.5%	8.0%	8.0%	7.6%	8.7%	8.0%	9.4%	8.9%
55 and over	4.2%	5.2%	4.5%	4.5%	3.9%	4.0%	6.6%	5.8%	6.2%	6.4%

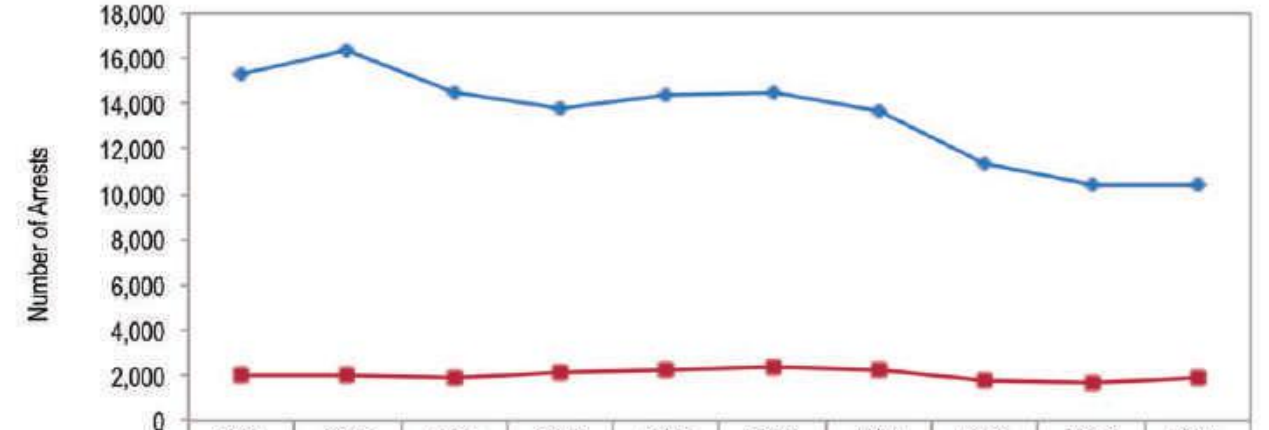
Source: SAMHSA, 2014

Criminal Consequences

The Uniform Crime Reporting (UCR) program collects drug violation arrest data nationwide. According to 2014 results, more than 10,000 arrests for possession of marijuana were made in Indiana, representing an arrest rate of 1.6 (95% CI: 1.6–1.6) per 1,000 population; the U.S. rate was the same. Additionally, more than 1,900 Hoosiers were arrested for selling marijuana; reflecting an arrest rate of 0.2 per 1,000 population (95% CI: 0.2–0.2); again, the U.S. rate was the same (see Figures 5.13 and 5.14) (Federal Bureau of Investigation [FBI], 2014).

Maps 5.1 and 5.2 (pages 89 and 90) and Appendix 5C (pages 87-88) depict the distribution of arrests for possession and sale/manufacture of marijuana by county.

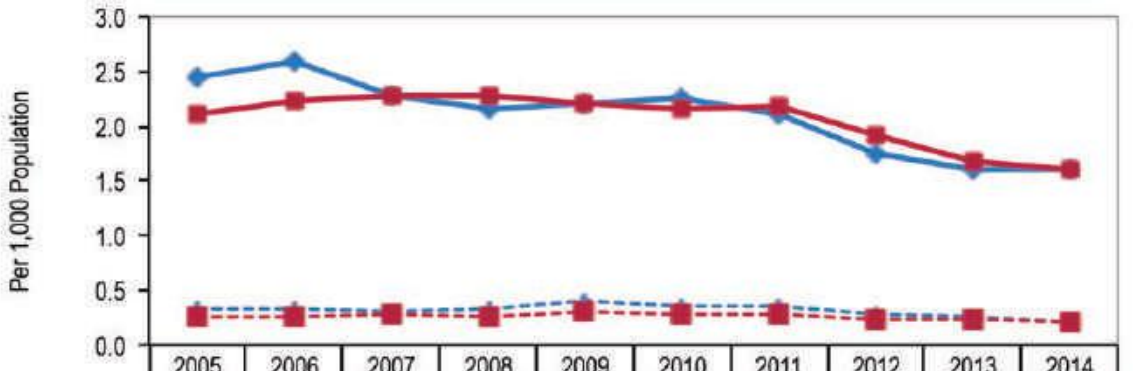
Figure 5.13 Number of Indiana Arrests for Marijuana Possession and Sale/Manufacture (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Possession	15,358	16,373	14,493	13,797	14,432	14,552	13,702	11,385	10,474	10,392
Sales	2,053	2,082	1,904	2,106	2,297	2,324	2,241	1,839	1,695	1,903

Source: FBI, 2014

Figure 5.14 Indiana and U.S. Arrest Rates for Marijuana Possession and Sale/Manufacture per 1,000 Population (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana Possession	2.4	2.6	2.3	2.2	2.2	2.2	2.1	1.7	1.6	1.6
U.S. Possession	2.1	2.2	2.3	2.3	2.2	2.2	2.2	1.9	1.7	1.6
Indiana Sales	0.3	0.3	0.3	0.3	0.4	0.4	0.3	0.3	0.3	0.2
U.S. Sales	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2

Source: FBI, 2014

APPENDIX 5A

Percentage of Indiana Students Reporting Monthly Marijuana Use, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
6th Grade	1.0	0.9	1.0	1.2	0.2	1.5*	1.3	0.5	0.8
7th Grade	2.8	3.1	4.4*	3.7	1.5	1.9	5.3*	2.0	2.4
8th Grade	6.6	8.4*	8.5*	4.6	3.5	7.7*	8.9*	3.8	5.4
9th Grade	10.0	11.8*	9.8	5.5	6.8	9.3	13.8*	8.5	8.5
10th Grade	13.7	16.1*	17.0*	9.3	13.8	12.7	16.8*	9.5	10.9
11th Grade	16.2	20.8*	16.5	13.4	13.3	16.3	17.9	13.8	12.5
12th Grade	20.3	24.5*	21.5	15.9	21.6	19.9	21.9	14.3	18.8

Note: * Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).

Source: Gassman et al., 2016

APPENDIX 5B

Number of Treatment Episodes with Marijuana Use and Dependence Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Marijuana Use		Marijuana Dependence	
County	**Total**	**Number**	**%**	**Number**	**%**
Adams	295	173	58.6%	79	26.8%
Allen	1,618	980	60.6%	416	25.7%
Bartholomew	581	291	50.1%	87	15.0%
Benton	50	32	64.0%	11	22.0%
Blackford	82	44	53.7%	13	15.9%
Boone	187	75	40.1%	47	25.1%
Brown	83	38	45.8%	12	14.5%
Carroll	84	43	51.2%	8	9.5%
Cass	253	132	52.2%	46	18.2%
Clark	313	65	20.8%	40	12.8%
Clay	181	80	44.2%	35	19.3%
Clinton	227	108	47.6%	47	20.7%
Crawford	45	22	48.9%	6	13.3%
Daviess	169	62	36.7%	35	20.7%
Dearborn	449	225	50.1%	61	13.6%
Decatur	212	117	55.2%	46	21.7%
DeKalb	242	144	59.5%	45	18.6%
Delaware	1,138	459	40.3%	195	17.1%
Dubois	280	162	57.9%	69	24.6%
Elkhart	654	321	49.1%	185	28.3%
Fayette	234	85	36.3%	31	13.2%
Floyd	117	15	12.8%	8	6.8%
Fountain	48	23	47.9%	6	12.5%
Franklin	166	75	45.2%	20	12.0%
Fulton	143	87	60.8%	31	21.7%
Gibson	295	138	46.8%	64	21.7%
Grant	436	257	58.9%	70	16.1%
Greene	204	86	42.2%	41	20.1%
Hamilton	893	424	47.5%	239	26.8%
Hancock	193	100	51.8%	53	27.5%
Harrison	31	<5	N/A	<5	N/A
Hendricks	351	146	41.6%	77	21.9%
Henry	330	111	33.6%	51	15.5%
Howard	610	249	40.8%	67	11.0%
Huntington	147	84	57.1%	39	26.5%
Jackson	298	147	49.3%	53	17.8%
Jasper	105	56	53.3%	13	12.4%
Jay	188	114	60.6%	35	18.6%
Jefferson	366	178	48.6%	55	15.0%
Jennings	223	106	47.5%	37	16.6%
Johnson	275	133	48.4%	57	20.7%
Knox	298	125	41.9%	49	16.4%
Kosciusko	381	238	62.5%	78	20.5%
LaGrange	186	111	59.7%	44	23.7%
Lake	2,339	929	39.7%	473	20.2%
LaPorte	377	136	36.1%	43	11.4%
Lawrence	485	235	48.5%	84	17.3%
Madison	1,278	700	54.8%	380	29.7%
Marion	3,645	1,626	44.6%	806	22.1%
Marshall	205	106	51.7%	58	28.3%
Martin	62	35	56.5%	16	25.8%
Miami	272	150	55.1%	43	15.8%
Monroe	1,180	559	47.4%	196	16.6%
Montgomery	374	216	57.8%	98	26.2%
Morgan	482	217	45.0%	93	19.3%
Newton	33	20	60.6%	<5	N/A
Noble	307	208	67.8%	84	27.4%
Ohio	40	17	42.5%	7	17.5%
Orange	160	82	51.3%	39	24.4%
Owen	199	94	47.2%	41	20.6%
Parke	67	28	41.8%	14	20.9%
Perry	102	63	61.8%	32	31.4%
Pike	53	22	41.5%	10	18.9%
Porter	410	166	40.5%	70	17.1%
Posey	170	84	49.4%	33	19.4%
Pulaski	109	47	43.1%	16	14.7%
Putnam	215	105	48.8%	60	27.9%
Randolph	170	88	51.8%	39	22.9%
Ripley	184	92	50.0%	32	17.4%
Rush	138	87	63.0%	35	25.4%
Saint Joseph	1,231	565	45.9%	302	24.5%
Scott	165	40	24.2%	9	5.5%
Shelby	168	91	54.2%	38	22.6%
Spencer	144	76	52.8%	38	26.4%
Starke	193	78	40.4%	15	7.8%
Steuben	298	154	51.7%	80	26.8%
Sullivan	78	37	47.4%	12	15.4%
Switzerland	63	28	44.4%	11	17.5%
Tippecanoe	404	231	57.2%	91	22.5%
Tipton	70	38	54.3%	21	30.0%
Union	22	10	45.5%	<5	N/A
Vanderburgh	1,319	727	55.1%	320	24.3%
Vermillion	123	55	44.7%	27	22.0%
Vigo	803	432	53.8%	220	27.4%
Wabash	225	135	60.0%	37	16.4%
Warren	9	5	55.6%	<5	N/A
Warrick	267	143	53.6%	45	16.9%
Washington	63	18	28.6%	7	11.1%
Wayne	438	195	44.5%	71	16.2%
Wells	128	86	67.2%	40	31.3%
White	110	47	42.7%	11	10.0%
Whitley	105	59	56.2%	22	21.0%
County Info Missing	27	7	25.9%	<5	N/A
Indiana	**33,170**	**16,034**	**48.3%**	**6,927**	**20.9%**

Note: We defined marijuana dependence as “individuals in substance abuse treatment listing marijuana as their primary substance at admission.”

We calculated the percentages by dividing the number of reported marijuana use/dependence by the number of treatment episodes.

Information on treatment episodes <5 was suppressed due to confidentiality constraints.

Source: Indiana Family and Social Services Administration, 2016

APPENDIX 5C

Number and Rate, per 1,000 Population, of Arrests for Marijuana Possession and Sale/Manufacture in Indiana, by County (Uniform Crime Reporting Program, 2014)

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Adams	31	0.9	9	0.3
Allen	567	1.6	42	0.1
Bartholomew	156	2.0	6	0.1
Benton	13	1.5	3	0.3
Blackford	23	1.9	2	0.2
Boone	125	2.0	9	0.1
Brown	14	0.9	3	0.2
Carroll	26	1.3	6	0.3
Cass	119	3.1	44	1.1
Clark	368	3.2	39	0.3
Clay	43	1.6	8	0.3
Clinton	66	2.0	9	0.3
Crawford	6	0.6	8	0.8
Daviess	69	2.1	2	0.1
Dearborn	78	1.6	14	0.3
Decatur	71	2.7	7	0.3
DeKalb	66	1.6	19	0.4
Delaware	255	2.2	4	0.0
Dubois	57	1.3	16	0.4
Elkhart	343	1.7	19	0.1
Fayette	46	1.9	9	0.4
Floyd	90	1.2	11	0.1
Fountain	27	1.6	6	0.4
Franklin	5	0.2	30	1.4
Fulton	22	1.1	6	0.3
Gibson	54	1.6	6	0.2
Grant	109	1.6	5	0.1
Greene	14	0.4	5	0.2
Hamilton	621	2.1	45	0.1
Hancock	83	1.1	29	0.4
Harrison	10	0.3	9	0.2
Hendricks	169	1.1	51	0.3
Henry	90	1.8	10	0.2
Howard	127	1.5	19	0.2
Huntington	40	1.1	15	0.4
Jackson	139	3.2	12	0.3
Jasper	31	0.9	14	0.4
Jay	47	2.2	3	0.1
Jefferson	58	1.8	12	0.4
Jennings	31	1.1	6	0.2
Johnson	411	2.8	31	0.2
Knox	59	1.6	13	0.3
Kosciusko	126	1.6	23	0.3
LaGrange	21	0.5	5	0.1
Lake	1,025	2.1	356	0.7
LaPorte	206	1.9	54	0.5
Lawrence	83	1.8	14	0.3
Madison	246	1.9	48	0.4
Marion	301	0.3	38	0.0

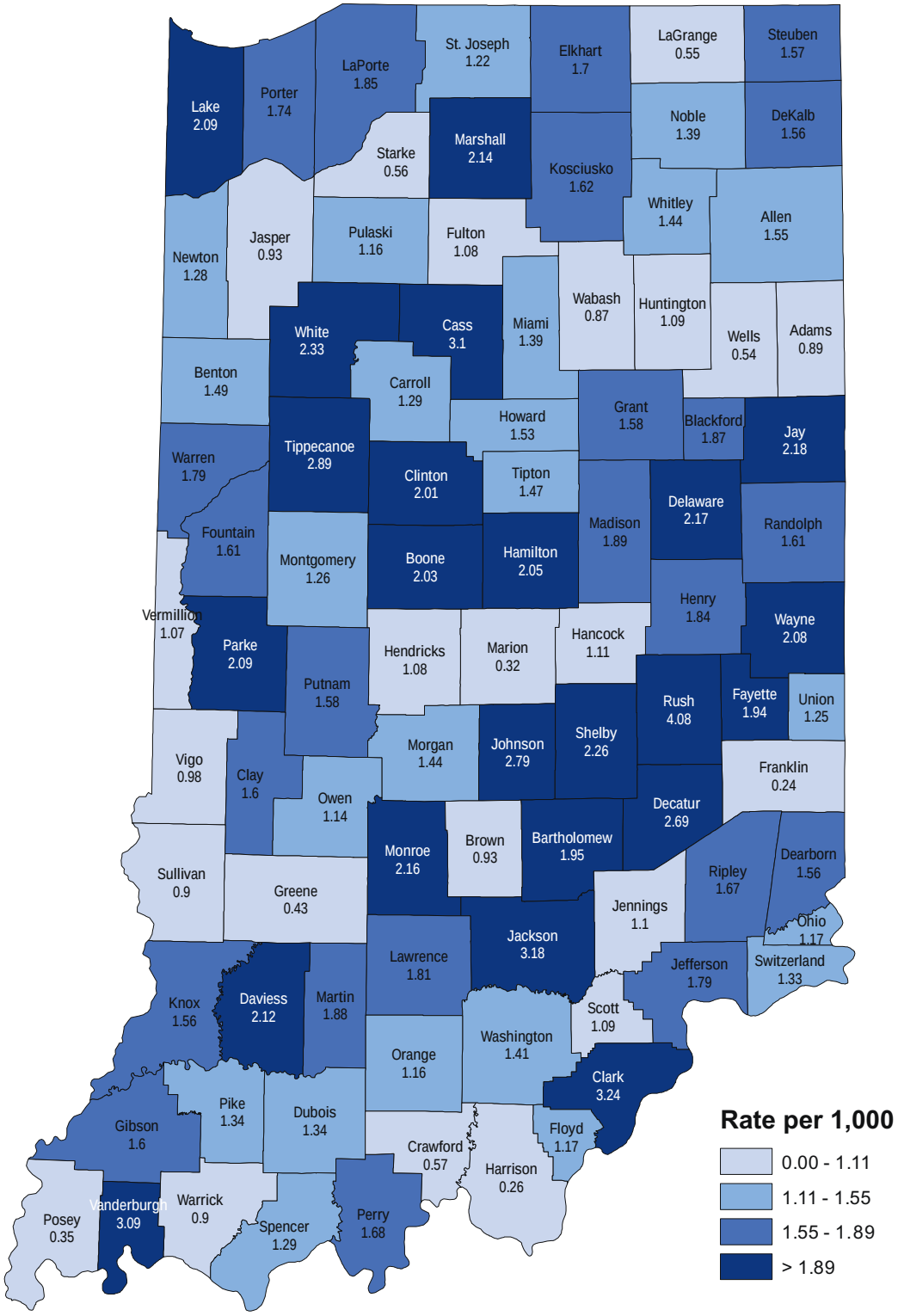
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APPENDIX 5C *(Continued from previous page)*

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Marshall	101	2.1	25	0.5
Martin	19	1.9	1	0.1
Miami	50	1.4	45	1.2
Monroe	308	2.2	23	0.2
Montgomery	48	1.3	11	0.3
Morgan	101	1.4	66	0.9
Newton	18	1.3	0	0.0
Noble	66	1.4	4	0.1
Ohio	7	1.2	1	0.2
Orange	23	1.2	9	0.5
Owen	24	1.1	4	0.2
Parke	36	2.1	8	0.5
Perry	33	1.7	6	0.3
Pike	17	1.3	58	4.6
Porter	291	1.7	26	0.2
Posey	9	0.4	5	0.2
Pulaski	15	1.2	4	0.3
Putnam	59	1.6	10	0.3
Randolph	41	1.6	6	0.2
Ripley	50	1.7	18	0.6
Rush	69	4.1	9	0.5
Saint Joseph	325	1.2	72	0.3
Scott	26	1.1	4	0.2
Shelby	101	2.3	24	0.5
Spencer	27	1.3	7	0.3
Starke	13	0.6	9	0.4
Steuben	54	1.6	3	0.1
Sullivan	19	0.9	2	0.1
Switzerland	14	1.3	4	0.4
Tippecanoe	526	2.9	43	0.2
Tipton	23	1.5	6	0.4
Union	9	1.2	2	0.3
Vanderburgh	562	3.1	104	0.6
Vermillion	17	1.1	15	0.9
Vigo	106	1.0	38	0.4
Wabash	28	0.9	9	0.3
Warren	15	1.8	3	0.4
Warrick	55	0.9	11	0.2
Washington	39	1.4	8	0.3
Wayne	141	2.1	27	0.4
Wells	15	0.5	3	0.1
White	57	2.3	1	0.0
Whitley	48	1.4	15	0.5
Indiana	**10,392**	**1.6**	**1,903**	**0.3**

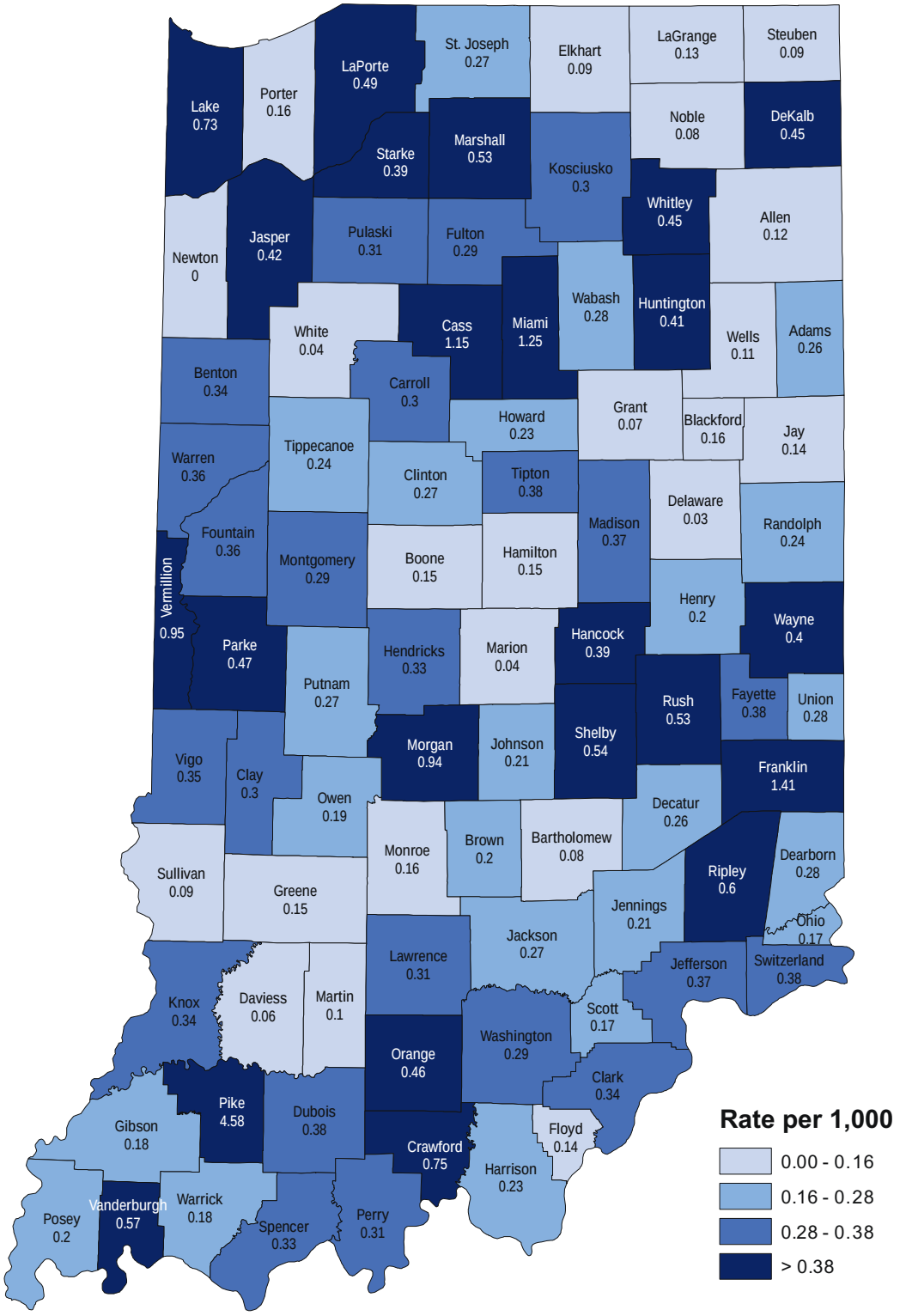
* Rates based on arrest numbers lower than 20 are unreliable.
Source: FBI, 2014

Map 5.1 Marijuana Possession Arrest Rates in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 5C (pages 89-90) for additional information.
Source: FBI, 2014

Map 5.2 Marijuana Sale/Manufacture Arrest Rates in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 5C (pages 89-90) for additional information.
Source: FBI, 2014

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6 Cocaine Use in Indiana: Consumption Patterns and Consequences

COCAINE CONSUMPTION

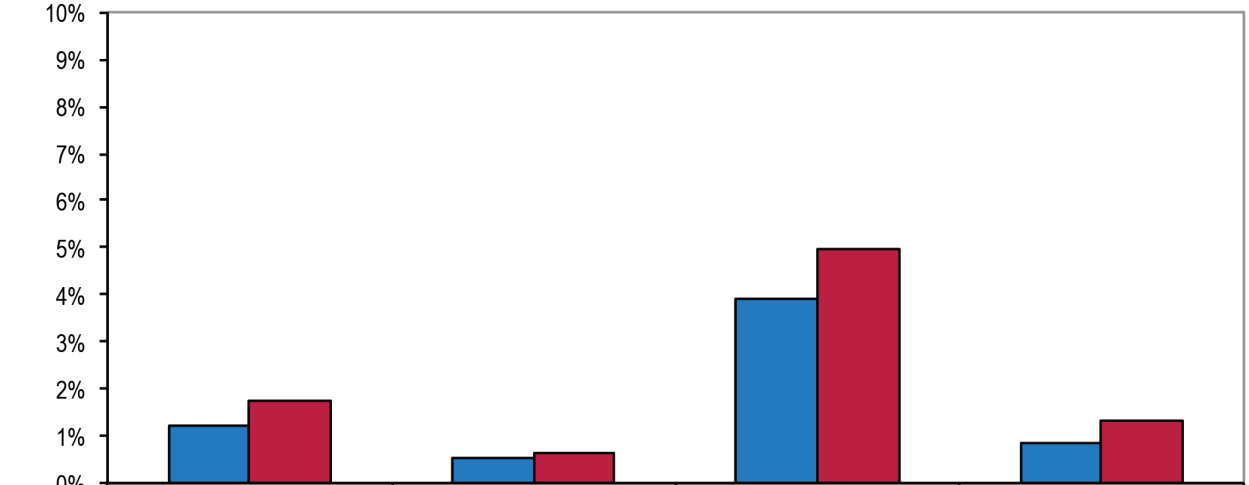
Cocaine is a highly addictive stimulant made from the leaves of the coca plant. Use of the drug results in an increase in levels of dopamine, the neurotransmitter responsible for motivation and reward. Due to the short duration of the desired effects, individuals who use cocaine will often increase the dose or take the drug repeatedly in order to boost the duration and intensity of the high. Cocaine can be snorted, smoked, or injected. When snorted, cocaine powder is inhaled through the nose where it is absorbed into the bloodstream through the nasal tissues, resulting in a high that may last 15 to 30 minutes. When injected, a needle is used to release the drug directly into the bloodstream. Smoking involves inhaling cocaine vapor or smoke into the lungs where absorption into the bloodstream results in a high that may last 5 to 10 minutes (National Institute on Drug Abuse [NIDA], 2016a, 2016b).

Crack is a popular form of cocaine in which the drug is processed into a rock crystal (often called "freebase cocaine") and then heated to produce vapors. These vapors are then inhaled. The name "crack" refers to the crackling sound made when the rock is heated (NIDA, 2016a, 2016b).

General Consumption Patterns

The National Survey on Drug Use and Health (NSDUH) provides national and state-level estimates of alcohol, tobacco, and other drug use. According to 2015 data, 1.2% (95% Confidence Interval [CI]: 0.9–1.8) of Indiana residents ages 12 and older reported having used cocaine in the past year (U.S.: 1.8%; 95% CI: 1.7–1.9) (see Figure 6.1) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

Figure 6.1 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Cocaine Use in the Past Year, by Age Group (National Survey on Drug Use and Health, 2015)

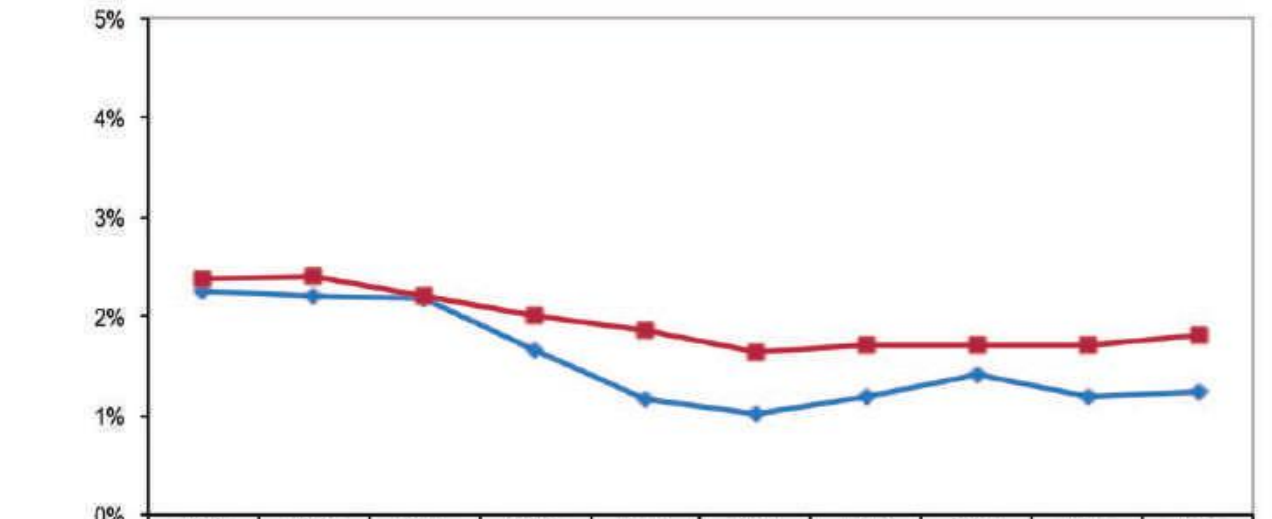


	Total	12-17	18-25	26 and older
Indiana	1.2%	0.5%	3.9%	0.9%
U.S.	1.8%	0.6%	5.0%	1.4%

Source: SAMHSA, 2017

NSDUH data from 2006 through 2015 show that past-year cocaine use in Indiana has slightly decreased over the past ten years, mirroring national rates (see Figure 6.2).

Figure 6.2 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Cocaine Use in the Past Year (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	2.2%	2.2%	2.2%	1.7%	1.2%	1.0%	1.2%	1.4%	1.2%	1.2%
U.S.	2.4%	2.4%	2.2%	2.0%	1.9%	1.6%	1.7%	1.7%	1.7%	1.8%

Source: SAMHSA, 2017

Adult Consumption Patterns

According to 2015 NSDUH estimates, the prevalence rate for cocaine use in Indiana was highest among 18- to 25-year-olds with 3.9% (95% CI: 2.8–5.5) of Hoosiers in that age group reporting past-year use. Adults ages 26 and older had a significantly lower rate (0.9%; 95% CI: 0.5–1.4) (see Figure 6.1) (SAMHSA, 2017).

The Indiana College Substance Use Survey provides estimates of alcohol, tobacco, and other drug use among Indiana college students. According to findings from the 2016 survey, which were based on 20 participating colleges and universities, 6.8% of Indiana college students reported having used cocaine at least once in their life, most of whom (65.4%) initiated use after starting college. Within Indiana, 1.9% of college students used cocaine in the past month (U.S.: 1.5%). Males reported significantly higher rates of current use (3.0%) than females (1.5%). Students over age 21 reported slightly higher rates of current use (2.1%) compared to students under age 21 (1.7%); however, this difference was statistically not significant (King & Jun, 2016).[1]

[1]Twenty colleges participated in the 2016 survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

Table 6.1 Percentage of Indiana and U.S. High School Students (Grades 9 through 12) Reporting Lifetime Cocaine Use, by Gender, Race/Ethnicity, and Grade (Youth Risk Behavior Surveillance System, 2015)

		Indiana (95% CI)	U.S. (95% CI)
Gender	Male	5.2% (3.4–7.9)	6.3% (5.1–7.9)
	Female	2.7% (1.7–4.2)	3.8% (3.1–4.6)
Race/Ethnicity	White	3.6% (2.3–5.6)	4.1% (3.3–5.2)
	Black	3.7% (1.2–10.7)	3.8% (2.5–6.0)
	Hispanic	7.9% (4.2–14.1)	8.0% (6.6–9.7)
Grade	9	3.5% (1.6–7.2)	3.4% (2.6–4.5)
	10	4.7% (3.4–6.5)	5.1% (3.8–6.8)
	11	4.7% (2.6–8.6)	5.0% (3.9–6.5)
	12	3.4% (1.8–6.3)	7.2% (5.6–9.1)
Total		4.0% (2.9–5.7)	5.2% (4.3–6.2)

Source: CDC, 2017

Youth Consumption Patterns

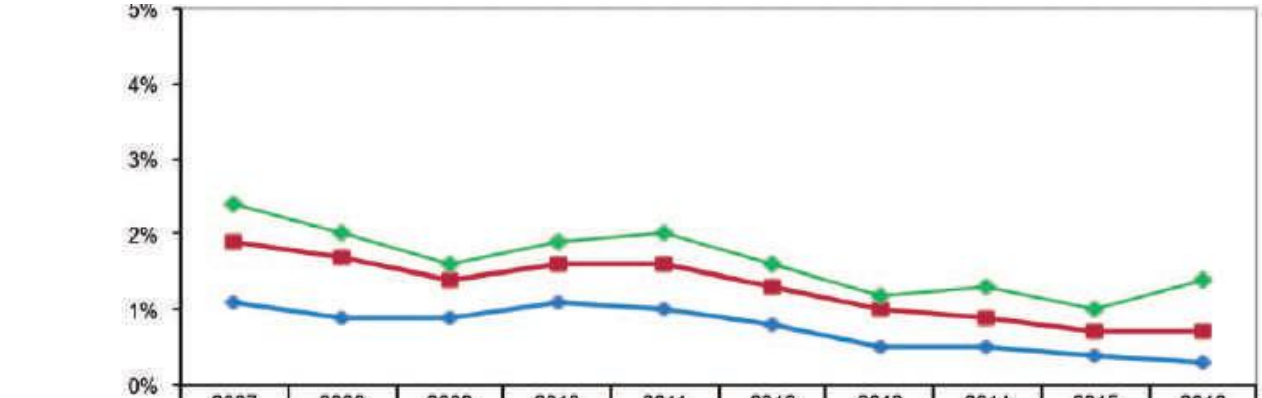
Findings from the 2015 NSDUH survey show that 0.5% (95% CI: 0.3–0.9) of 12- to 17-year-old Hoosiers used cocaine in the past year (see Figure 6.1). The national rate for this age group was similar (0.64%; 95% CI: 0.54–0.77) (SAMHSA, 2017).

According to the 2015 Youth Risk Behavior Surveillance System (YRBSS), 4.0% (95% CI: 2.9–5.7) of Indiana high school students (grades 9-12) reported that they had used a form of cocaine at least once in their life. National rates for lifetime use were similar, at 5.2% (95% CI: 4.3–6.2). The difference in Indiana prevalence rates by gender, race/ethnicity, or grade level was not statistically significant (see Table 6.1) (Centers for Disease Control and Prevention [CDC], 2017).

Overall prevalence of lifetime cocaine use among Indiana's high school students decreased from 7.9% (95% CI: 6.5–9.5) in 2003 to 4.0% (95% CI: 2.9–5.7) in 2016 (CDC, 2017).

According to the annual Indiana Youth Survey, rates of current cocaine and crack use among Indiana 8th, 10th, and 12th grade students have been on a downward trend since 2007, although there was a statistically significant increase in use rates among 12th graders from 2015 to 2016 (see Figure 6.3) (Gassman et al., 2016). For 2016 data on current cocaine and crack use among students in grades 7 through 12, by Indiana region, see Appendix 6A, page 99.

Figure 6.3 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Current Cocaine/Crack Use (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th Grade	1.1%	0.9%	0.9%	1.1%	1.0%	0.8%	0.5%	0.5%	0.4%	0.3%
10th Grade	1.9%	1.7%	1.4%	1.6%	1.6%	1.3%	1.0%	0.9%	0.7%	0.7%
12th Grade	2.4%	2.0%	1.6%	1.9%	2.0%	1.6%	1.2%	1.3%	1.0%	1.4%

Source: Gassman, et al., 2016

CONSEQUENCES

Health Consequences

The effects of cocaine appear almost immediately after its use and tend to wear off within less than an hour. Cocaine's effects depend on the amount taken and its route of administration. Taken in small amounts, cocaine can make the user feel euphoric, energetic, talkative, and mentally alert; it might also decrease the need for food and sleep temporarily. Large amounts of the drug can intensify the euphoria, but may lead to bizarre, erratic, and even violent behavior. The route of a drug's administration affects its rate of absorption. Faster absorption of cocaine produces a more intense high, but is also shorter in duration. Cocaine use can lead to severe medical complications, including cardiovascular problems, respiratory difficulties, neurological effects, gastrointestinal complications, and may be fatal (NIDA, 2016b).

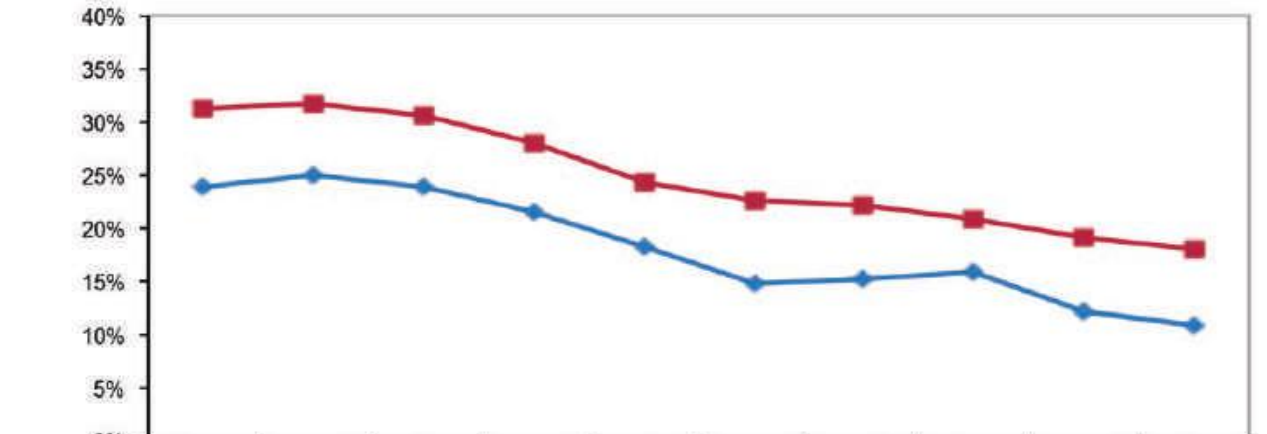
In addition, the effects of cocaine can extend beyond the user. Using cocaine during pregnancy may result in premature delivery, low birthweight, or neonatal abstinence syndrome (NIDA, 2016a). Additionally, users who inject cocaine intravenously are at higher risk for acquiring and/or transmitting HIV/AIDS and hepatitis C (HCV), if needles or other injection equipment are shared. Furthermore, use of cocaine can impair the immune system and cell function which usually results in more severe and advanced progression of HIV and HCV. However, even cocaine users who do not inject drugs are

Table 6.2 Percentage of Indiana Treatment Episodes with Cocaine Use Reported at Treatment Admission, by Gender, Race, and Age Group (Treatment Episode Data Set, 2014)

		Cocaine Use	Cocaine Dependence
Gender	Male	10.0%	3.3%
	Female	12.3%	4.5%
Race	White	8.8%	2.2%
	Black	23.5%	13.5%
	Other	12.2%	3.7%
Age Group	Under 18	1.8%	0.2%
	18-24	4.8%	1.2%
	25-34	9.5%	2.5%
	35-44	15.1%	5.9%
	45-54	19.7%	8.4%
	55 and over	15.7%	6.8%
Total		**10.9%**	**3.8%**

Source: SAMHSA, 2014

Figure 6.4 Percentage of Indiana and U.S. Treatment Episodes with Cocaine Use Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	23.8%	25.0%	23.9%	21.4%	18.3%	14.8%	15.2%	15.8%	12.2%	10.9%
U.S.	31.2%	31.7%	30.5%	27.9%	24.3%	22.6%	22.1%	20.8%	19.0%	18.0%

Source: SAMHSA, 2014

at an increased risk of contracting HIV, because they are more likely to engage in sexual risk behaviors related to HIV-transmission (NIDA, 2016b).

Cocaine Abuse and Dependence

According to findings from the 2014 Treatment Episode Data Set (TEDS), cocaine use was reported in 10.9% of treatment episodes in Indiana (U.S.: 18.0%) and dependence[2] in 3.8% (U.S.: 5.4%). Treatment admissions with reported cocaine use or dependence have been on a downward trend in Indiana and the United States at least for the past 10 years (see Figures 6.4 and 6.5) (SAMHSA, 2014).

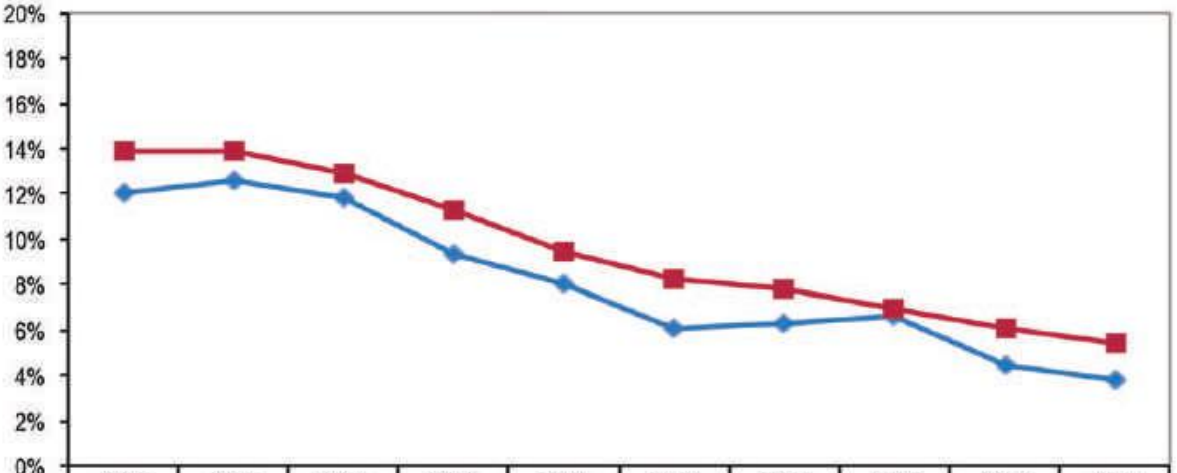
Gender, race, and age differences were associated with cocaine use and dependence in Indiana ($P < 0.001$). Generally, more women than men, more blacks than whites or other races, and more adults ages 35 and older reported use or dependence of the drug (see Table 6.2). (For county-level information on cocaine use, see Appendix 6B, page 100.)

Legal and Criminal Consequences

Possession or sale/manufacturing of cocaine can result in legal consequences. The Uniform Crime Reporting (UCR) Program provides the number of arrests for offenses regarding cocaine and opiates combined. In 2014, there were over 1,600 arrests for the possession of cocaine and opiates and 1,556 arrests for the sale/manufacturing of these drugs (see Figure 6.6). This translates to an arrest rate for possession of 0.2 per 1,000 (95% CI: 0.2–0.2) in Indiana compared to the national arrest rate for possession of 0.7 (95% CI: 0.7–0.7) (see Figure 6.7). While the national rate for possession was higher than Indiana's, arrest rates for sale/manufacture of cocaine and opiates were the same at 0.2 per 1,000 (Federal Bureau of Investigation (FBI), 2014).

The number and rates of arrests for both possession and sale/manufacture of cocaine and opiates steadily decreased from 2006 to 2012 and have remained relatively stable both nationally and in Indiana (see Figures 6.6 and 6.7). Maps 6.1 and 6.2 (pages 103-104) and Appendix 6C (pages 101-102) show Indiana's cocaine/opiates possession and sale/manufacture arrests by county for 2014.

Figure 6.5 Percentage of Indiana and U.S. Treatment Episodes with Cocaine Dependence Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)

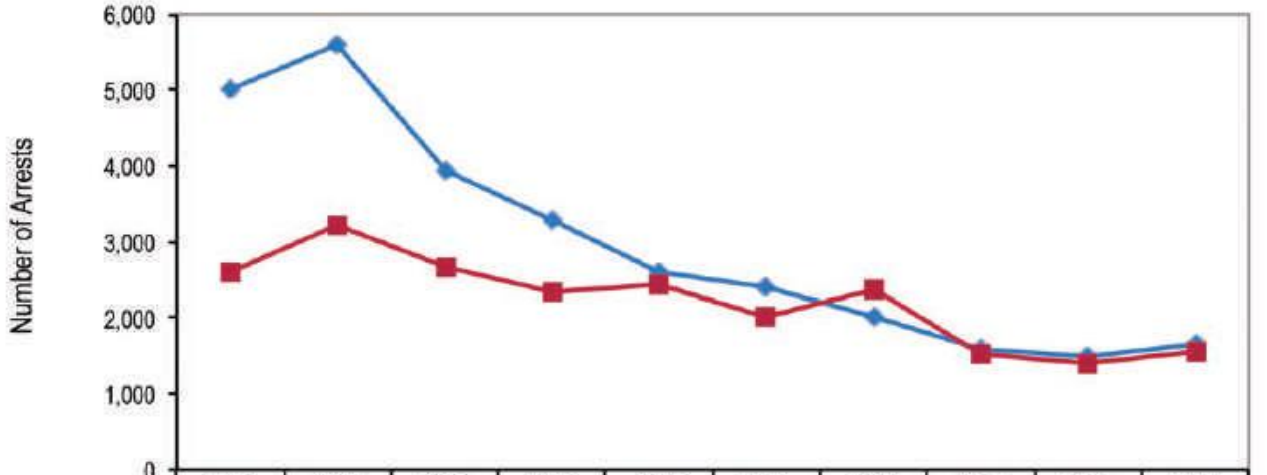


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	12.1%	12.6%	11.8%	9.3%	8.0%	6.1%	6.3%	6.6%	4.5%	3.8%
U.S.	13.9%	13.9%	12.9%	11.3%	9.4%	8.2%	7.8%	6.9%	6.1%	5.4%

Source: SAMHSA, 2014

[2]We defined cocaine dependence as "individuals in substance abuse treatment listing cocaine as their primary substance at admission."

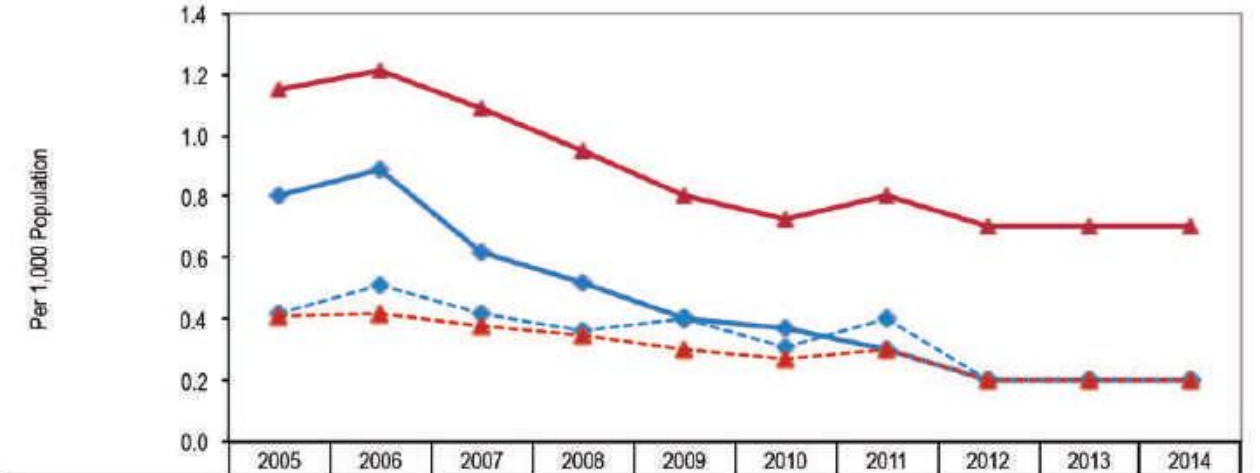
Figure 6.6 Number of Arrests for Cocaine and Opiates Possession and Sale/Manufacture in Indiana (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Possession	5,020	5,608	3,937	3,301	2,617	2,397	2,004	1,599	1,488	1,649
Sale	2,617	3,227	2,668	2,336	2,425	2,028	2,368	1,510	1,406	1,556

Source: FBI, 2014

Figure 6.7 Indiana and U.S. Arrest Rates, per 1,000 Population, for Cocaine and Opiates Possession and Sale/ Manufacture (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
IN Possession	0.8	0.9	0.6	0.5	0.4	0.4	0.3	0.2	0.2	0.2
U.S. Possession	1.2	1.2	1.1	1.0	0.8	0.7	0.8	0.7	0.7	0.7
IN Sale	0.4	0.5	0.4	0.4	0.4	0.3	0.4	0.2	0.2	0.2
U.S. Sale	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.2	0.2	0.2

Source: FBI, 2014

APPENDIX 6A

Percentage of Indiana Students Reporting Monthly Crack/Cocaine Use, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
7th Grade	0.2	0.2	0.4*	0.0	0.2	0.2	0.0	0.1	0.3
8th Grade	0.3	0.3	0.4	0.4	0.3	0.3	0.2	0.2	0.3
9th Grade	0.4	0.5	0.5	0.0	0.2	0.4	0.7	0.3	0.4
10th Grade	0.7	0.7	0.9	0.0	1.5*	0.5	0.9	0.3*	0.3*
11th Grade	0.9	1.6*	0.9	0.8	0.5	1.0	1.0	0.4*	0.4*
12th Grade	1.4	1.4*	2.5*	0.0	1.5	1.4	2.1*	0.6*	0.7*

Notes: * Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).
Beginning in 2015, the Indiana Youth Survey combined crack/cocaine use into a single category and stopped asking 6th grade students about crack/cocaine use; also, lifetime prevalence is no longer available by region.
Source: Gassman et al., 2016

APPENDIX 6B

Number of Treatment Episodes with Cocaine Use and Dependence Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Cocaine Use		Cocaine Dependence	
County	**Total**	**Number**	**%**	**Number**	**%**
Adams	295	32	10.8%	<5	N/A
Allen	1,618	359	22.2%	118	7.3%
Bartholomew	581	32	5.5%	6	1.0%
Benton	50	8	16.0%	<5	N/A
Blackford	82	<5	N/A	<5	N/A
Boone	187	<5	N/A	<5	N/A
Brown	83	6	7.2%	<5	N/A
Carroll	84	<5	N/A	<5	N/A
Cass	253	17	6.7%	<5	N/A
Clark	313	24	7.7%	17	5.4%
Clay	181	<5	N/A	<5	N/A
Clinton	227	19	8.4%	<5	N/A
Crawford	45	<5	N/A	<5	N/A
Daviess	169	<5	N/A	<5	N/A
Dearborn	449	45	10.0%	5	1.1%
Decatur	212	9	4.2%	<5	N/A
DeKalb	242	10	4.1%	<5	N/A
Delaware	1,138	134	11.8%	39	3.4%
Dubois	280	5	1.8%	<5	N/A
Elkhart	654	78	11.9%	35	5.4%
Fayette	234	15	6.4%	6	2.6%
Floyd	117	<5	N/A	<5	N/A
Fountain	48	6	12.5%	<5	N/A
Franklin	166	6	3.6%	<5	N/A
Fulton	143	10	7.0%	<5	N/A
Gibson	295	5	1.7%	<5	N/A
Grant	436	39	8.9%	10	2.3%
Greene	204	<5	N/A	<5	N/A
Hamilton	893	68	7.6%	22	2.5%
Hancock	193	18	9.3%	5	2.6%
Harrison	31	<5	N/A	<5	N/A
Hendricks	351	17	4.8%	5	1.4%
Henry	330	30	9.1%	5	1.5%
Howard	610	87	14.3%	29	4.8%
Huntington	147	8	5.4%	<5	N/A
Jackson	298	10	3.4%	<5	N/A
Jasper	105	11	10.5%	<5	N/A
Jay	188	17	9.0%	<5	N/A
Jefferson	366	22	6.0%	5	1.4%
Jennings	223	12	5.4%	<5	N/A
Johnson	275	17	6.2%	<5	N/A
Knox	298	<5	N/A	<5	N/A
Kosciusko	381	32	8.4%	<5	N/A
LaGrange	186	10	5.4%	<5	N/A
Lake	2,339	439	18.8%	185	7.9%
LaPorte	377	59	15.6%	12	3.2%
Lawrence	485	16	3.3%	5	1.0%
Madison	1,278	122	9.5%	37	2.9%
Marion	3,645	651	17.9%	236	6.5%
Marshall	205	11	5.4%	<5	N/A
Martin	62	<5	N/A	<5	N/A
Miami	272	9	3.3%	<5	N/A
Monroe	1,180	88	7.5%	26	2.2%
Montgomery	374	33	8.8%	5	1.3%
Morgan	482	20	4.1%	<5	N/A
Newton	33	5	15.2%	<5	N/A
Noble	307	20	6.5%	<5	N/A
Ohio	40	<5	N/A	<5	N/A
Orange	160	7	4.4%	<5	N/A
Owen	199	5	2.5%	<5	N/A
Parke	67	<5	N/A	<5	N/A
Perry	102	7	6.9%	<5	N/A
Pike	53	<5	N/A	<5	N/A
Porter	410	54	13.2%	21	5.1%
Posey	170	<5	N/A	<5	N/A
Pulaski	109	6	5.5%	<5	N/A
Putnam	215	<5	N/A	<5	N/A
Randolph	170	15	8.8%	<5	N/A
Ripley	184	14	7.6%	<5	N/A
Rush	138	14	10.1%	<5	N/A
Saint Joseph	1,231	324	26.3%	155	12.6%
Scott	165	<5	N/A	<5	N/A
Shelby	168	19	11.3%	<5	N/A
Spencer	144	<5	N/A	<5	N/A
Starke	193	10	5.2%	<5	N/A
Steuben	298	15	5.0%	<5	N/A
Sullivan	78	<5	N/A	<5	N/A
Switzerland	63	<5	N/A	<5	N/A
Tippecanoe	404	21	5.2%	<5	N/A
Tipton	70	6	8.6%	<5	N/A
Union	22	<5	N/A	<5	N/A
Vanderburgh	1,319	75	5.7%	28	2.1%
Vermillion	123	<5	N/A	<5	N/A
Vigo	803	21	2.6%	5	0.6%
Wabash	225	9	4.0%	<5	N/A
Warren	9	<5	N/A	<5	N/A
Warrick	267	7	2.6%	<5	N/A
Washington	63	<5	N/A	<5	N/A
Wayne	438	107	24.4%	25	5.7%
Wells	128	16	12.5%	<5	N/A
White	110	<5	N/A	<5	N/A
Whitley	105	8	7.6%	<5	N/A
County Info Missing	27	<5	N/A	<5	N/A
Indiana	**33,170**	**3,509**	**10.6%**	**1,126**	**3.4%**

Notes: We defined cocaine dependence as “individuals in substance abuse treatment listing cocaine as their primary substance at admission.”
We calculated the percentages by dividing the number of reported cocaine use/dependence by the number of treatment episodes.
Information on treatment episodes <5 was suppressed due to confidentiality constraints.
Source: Indiana Family and Social Services Administration, 2016

APPENDIX 6C

Number and Rate, per 1,000 Population, of Arrests for Cocaine/Opiates Possession and Sale/Manufacture in Indiana, by County (Uniform Crime Reporting Program, 2014)

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Adams	4	0.1	4	0.1
Allen	97	0.3	48	0.1
Bartholomew	16	0.2	7	0.1
Benton	2	0.2	2	0.2
Blackford	2	0.2	4	0.3
Boone	14	0.2	9	0.1
Brown	4	0.3	0	0.0
Carroll	4	0.2	5	0.2
Cass	9	0.2	57	1.5
Clark	196	1.7	78	0.7
Clay	6	0.2	7	0.3
Clinton	16	0.5	6	0.2
Crawford	0	0.0	0	0.0
Daviess	16	0.5	29	0.9
Dearborn	12	0.2	13	0.3
Decatur	8	0.3	3	0.1
DeKalb	11	0.3	6	0.1
Delaware	35	0.3	113	1.0
Dubois	8	0.2	4	0.1
Elkhart	23	0.1	25	0.1
Fayette	8	0.3	8	0.3
Floyd	8	0.1	18	0.2
Fountain	4	0.2	4	0.2
Franklin	3	0.1	0	0.0
Fulton	5	0.2	4	0.2
Gibson	5	0.1	6	0.2
Grant	47	0.7	1	0.0
Greene	1	0.0	5	0.2
Hamilton	67	0.2	94	0.3
Hancock	23	0.3	1	0.0
Harrison	1	0.0	1	0.0
Hendricks	47	0.3	14	0.1
Henry	16	0.3	7	0.1
Howard	80	1.0	55	0.7
Huntington	6	0.2	4	0.1
Jackson	17	0.4	33	0.8
Jasper	6	0.2	8	0.2
Jay	10	0.5	15	0.7
Jefferson	9	0.3	9	0.3
Jennings	16	0.6	12	0.4
Johnson	48	0.3	42	0.3
Knox	9	0.2	7	0.2
Kosciusko	29	0.4	21	0.3
LaGrange	5	0.1	16	0.4
Lake	126	0.3	181	0.4
LaPorte	31	0.3	93	0.8
Lawrence	12	0.3	3	0.1
Madison	29	0.2	36	0.3
Marion	44	0.0	28	0.0

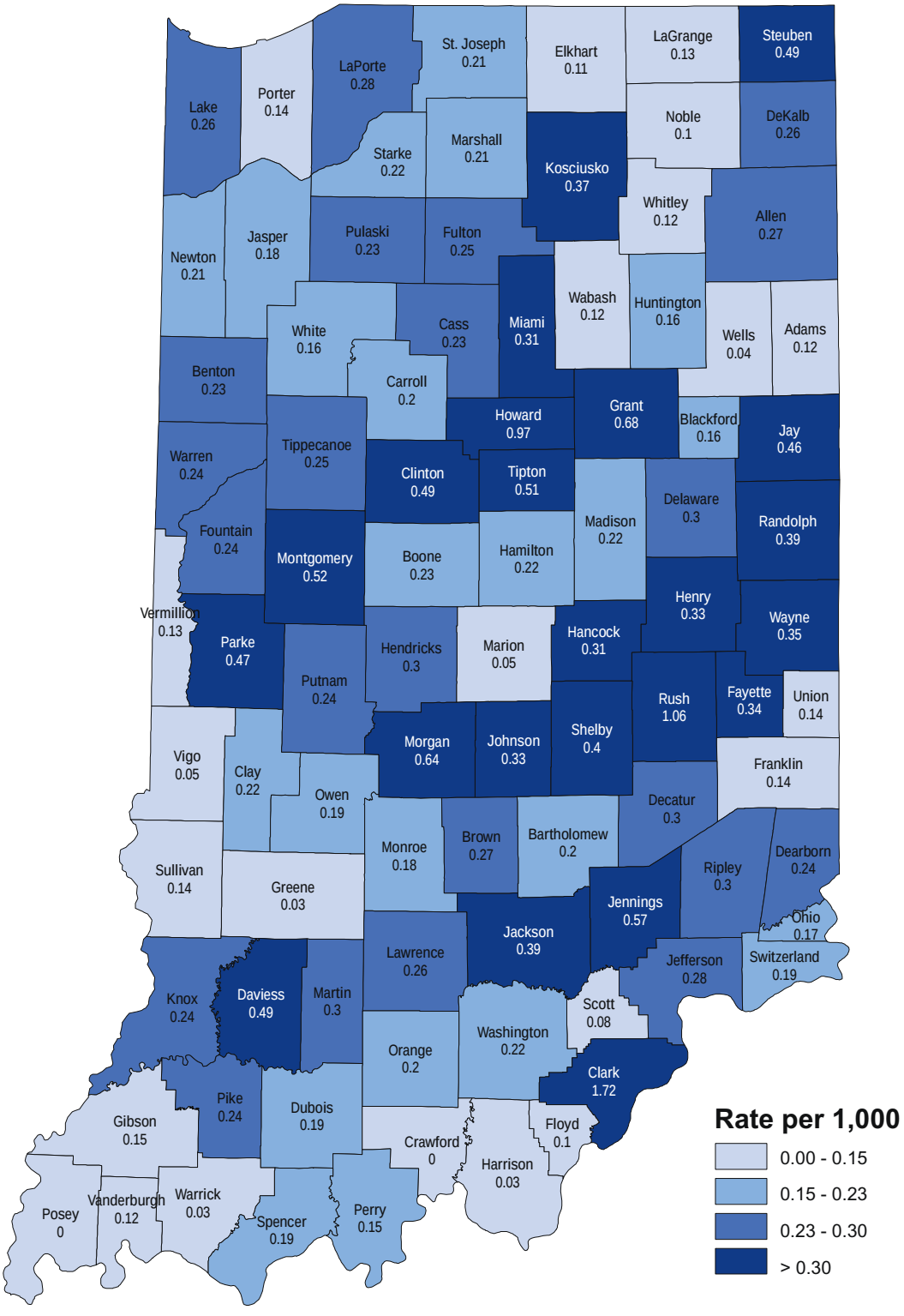
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APPENDIX 6C *(Continued from previous page)*

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Marshall	10	0.2	12	0.3
Martin	3	0.3	1	0.1
Miami	11	0.3	36	1.0
Monroe	26	0.2	23	0.2
Montgomery	20	0.5	2	0.1
Morgan	45	0.6	39	0.6
Newton	3	0.2	2	0.1
Noble	5	0.1	19	0.4
Ohio	1	0.2	1	0.2
Orange	4	0.2	4	0.2
Owen	4	0.2	4	0.2
Parke	8	0.5	0	0.0
Perry	3	0.2	4	0.2
Pike	3	0.2	1	0.1
Porter	24	0.1	10	0.1
Posey	0	0.0	0	0.0
Pulaski	3	0.2	3	0.2
Putnam	9	0.2	9	0.2
Randolph	10	0.4	7	0.3
Ripley	9	0.3	9	0.3
Rush	18	1.1	4	0.2
Saint Joseph	55	0.2	30	0.1
Scott	2	0.1	2	0.1
Shelby	18	0.4	5	0.1
Spencer	4	0.2	4	0.2
Starke	5	0.2	3	0.1
Steuben	17	0.5	1	0.0
Sullivan	3	0.1	2	0.1
Switzerland	2	0.2	2	0.2
Tippecanoe	45	0.2	90	0.5
Tipton	8	0.5	1	0.1
Union	1	0.1	1	0.1
Vanderburgh	21	0.1	29	0.2
Vermillion	2	0.1	2	0.1
Vigo	5	0.0	6	0.1
Wabash	4	0.1	4	0.1
Warren	2	0.2	2	0.2
Warrick	2	0.0	1	0.0
Washington	6	0.2	7	0.3
Wayne	24	0.4	20	0.3
Wells	1	0.0	2	0.1
White	4	0.2	0	0.0
Whitley	4	0.1	6	0.2
Indiana	**1,649**	**0.2**	**1,556**	**0.2**

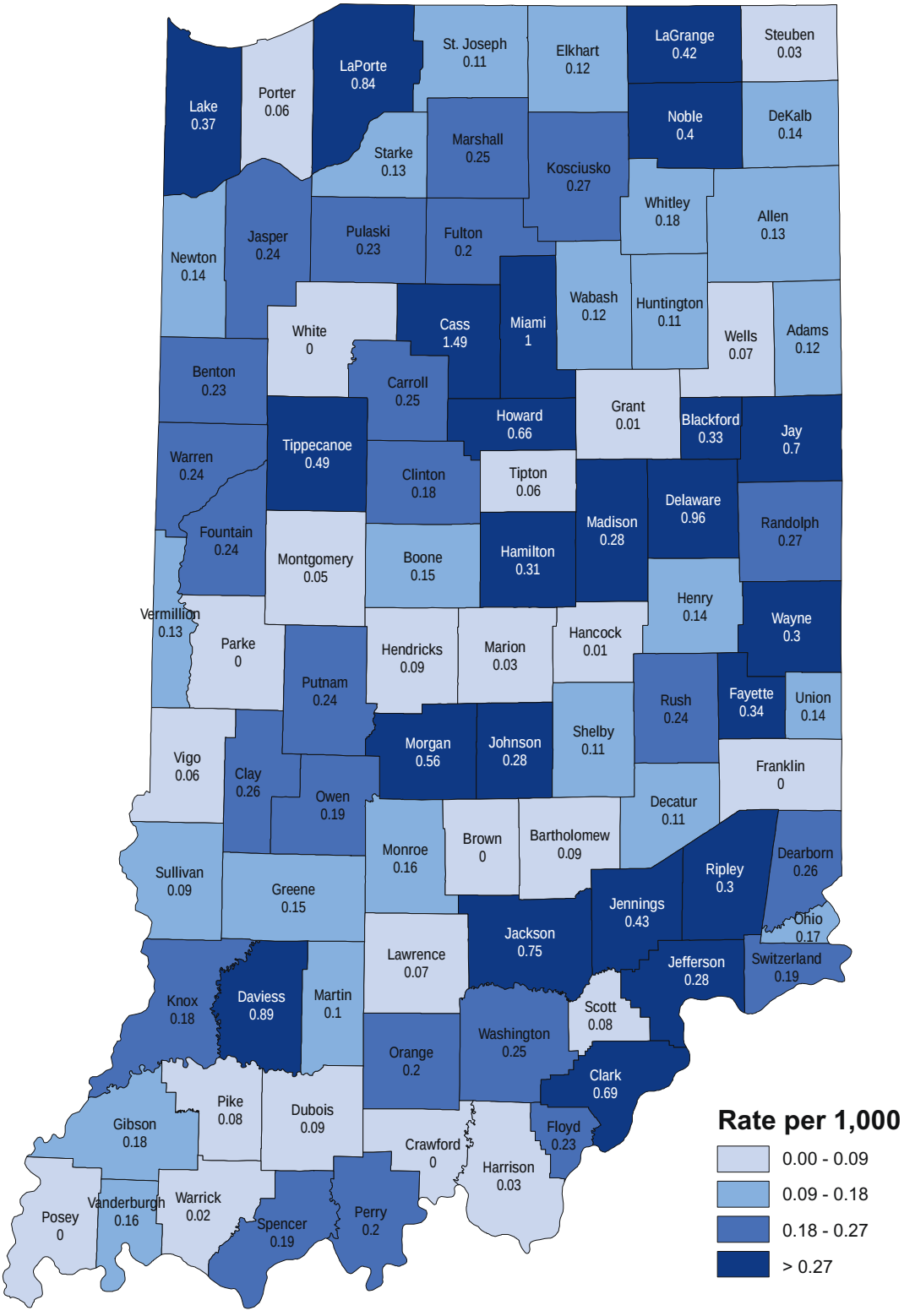
Note: Rates based on arrest numbers lower than 20 are unreliable.
Source: FBI, 2014

Map 6.1 Cocaine/Opiate Possession Arrest Rates in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 6C (pages 101-102) for additional information.
Source: FBI, 2014

Map 6.2 Cocaine/Opiate Sales Arrest Rates in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 6C (pages 101-102) for additional information.
Source: FBI, 2014

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7 Heroin Use in Indiana: Consumption Patterns and Consequences

HEROIN CONSUMPTION

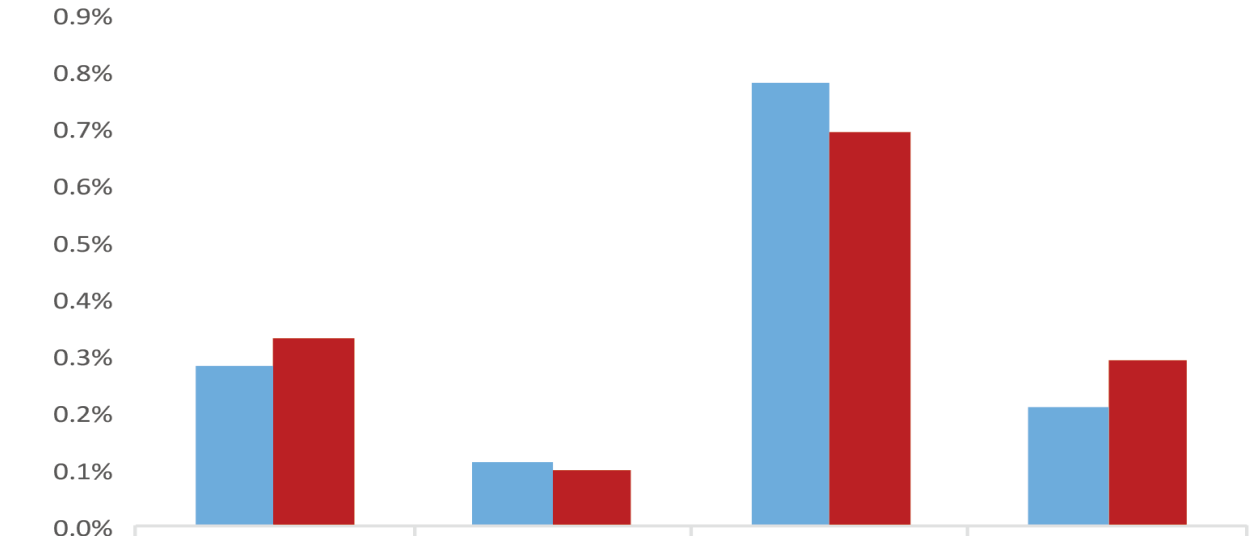
Heroin is a highly addictive opioid. It is derived from morphine, a naturally occurring substance extracted from the Asian opium poppy plant. Heroin can be injected, smoked, or snorted. When heroin enters the brain, it binds rapidly to opioid receptors, especially those involved in feelings of pleasure and pain. People who use heroin frequently experience an initial feeling of euphoria followed by a state of alternating wakefulness and drowsiness. The intensity of the euphoria, or "rush," depends on how much drug is taken and how rapidly it binds to the opioid receptors. It is estimated that about 23% of people who have used the drug become dependent; for those who use heroin over and over again, addiction is more likely. (National Institute on Drug Abuse [NIDA], 2014a, 2017a, 2017b).

General Consumption Patterns

Although heroin use in the general U.S. population is uncommon (an estimated 0.3%), the percentage of Americans using the drug is higher than it was 10 years ago (Lipari and Hughes, 2015). Heroin has also become a major concern in Indiana. Its rise in use, as evidenced by the increase in heroin overdose fatalities, has led to several efforts by state agencies and organizations to identify and develop sources of Indiana-specific data and surveillance (Indiana State Department of Health [ISDH], 2017).

According to findings from the 2015 National Survey on Drug Use and Health (NSDUH), 1.9% of Americans ages 12 and older had tried heroin at least once in their lifetime, 0.3% had used heroin in the past year, and 0.1% in the past month. Similarly, 0.3% (95% Confidence Interval [CI]: 0.1–0.5) of Hoosiers ages 12 and older reported using heroin in the past year (see Figure 7.1) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

Figure 7.1 Percentage of Indiana and U.S. Population (12 years and older) Reporting Past-Year Heroin Use, by Age Group (National Survey on Drug Use and Health, 2015)



	Total	12-17	18-25	26 and older
Indiana	0.3%	0.1%	0.8%	0.2%
U.S.	0.3%	0.1%	0.7%	0.3%

Source: SAMHSA, 2017

Adult Consumption Patterns

The Indiana College Substance Use Survey[1] provides estimates of alcohol, tobacco, and other drug use among Indiana college students. According to 2016 results, which are based on 20 participating colleges and universities, 1.0% of Indiana college students reported ever having used heroin. Of students who reported using heroin at least once in their lifetime, 64.4% first used heroin prior to starting college. Only a small percentage of college students reported using heroin in the past month (IN: 0.2%; U.S.: 0.05); male college students in Indiana had higher rates of past-month-use (0.3%) than female college students (less than 0.1%; P < .05). No significant differences were detected by age group (under 21 vs. 21 or over) (King & Jun, 2016).

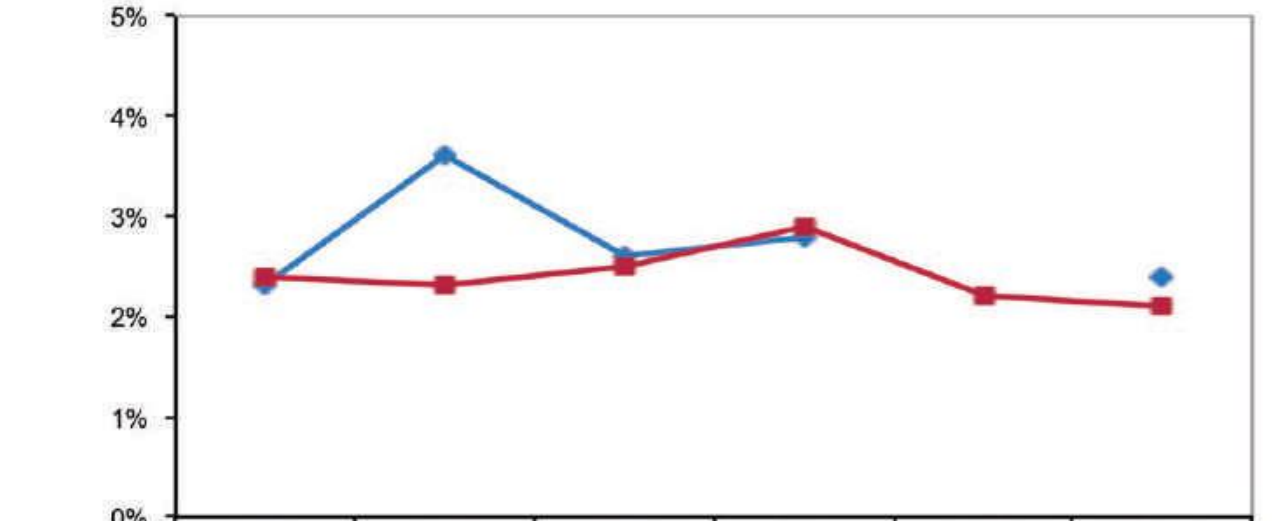
Youth Consumption Patterns

In 2015, 2.4% (95% CI: 1.3–4.4) of high school students (grades 9 through 12) in Indiana reported having tried heroin at least once in their life, according to the 2015 Youth Risk Behavior Surveillance System (YRBSS). Indiana's rate was similar to the national rate of 2.1% (95% CI: 1.5–2.8) (see Figure 7.2). No statistical differences by gender, race, or grade level were observed in 2015. Prevalence of lifetime heroin use has remained relatively stable among both Indiana and national high school students from 2005 through 2015 (Centers for Disease Control and Prevention [CDC], 2017b).

As noted previously, a common route of administration for heroin is by needle injection. According to the 2015 YRBSS, the percentage of high school students who used a needle to inject any illegal drug into their body one or more times during their lifetime was statistically similar in Indiana (2.2%; 95% CI: 1.1–4.3) and the nation (1.8%; 95% CI: 1.3–2.3) (CDC, 2017b).

Based on results from the 2016 Indiana Youth Survey, past-month heroin use among 7th through 12th grade students ranged from 0.1% to 0.5% (see Figure 7.3). Heroin use among Indiana 12th graders peaked in 2011 at 1.2%, but is now at 0.5% (see Figure 7.4). Within Indiana, rates of past-month heroin use among 7th and 9th grade students decreased from 2015 to 2016 (P < .05) (Gassman et al., 2016). For monthly heroin use rates in Indiana by region and grade level, see Appendix 7A, page 116.

Figure 7.2 Percentage of Indiana and U.S. High School Students (Grades 9 through 12) Who Have Used Heroin at Least Once During their Lifetime (Youth Risk Behavior Surveillance System, 2005–2015)

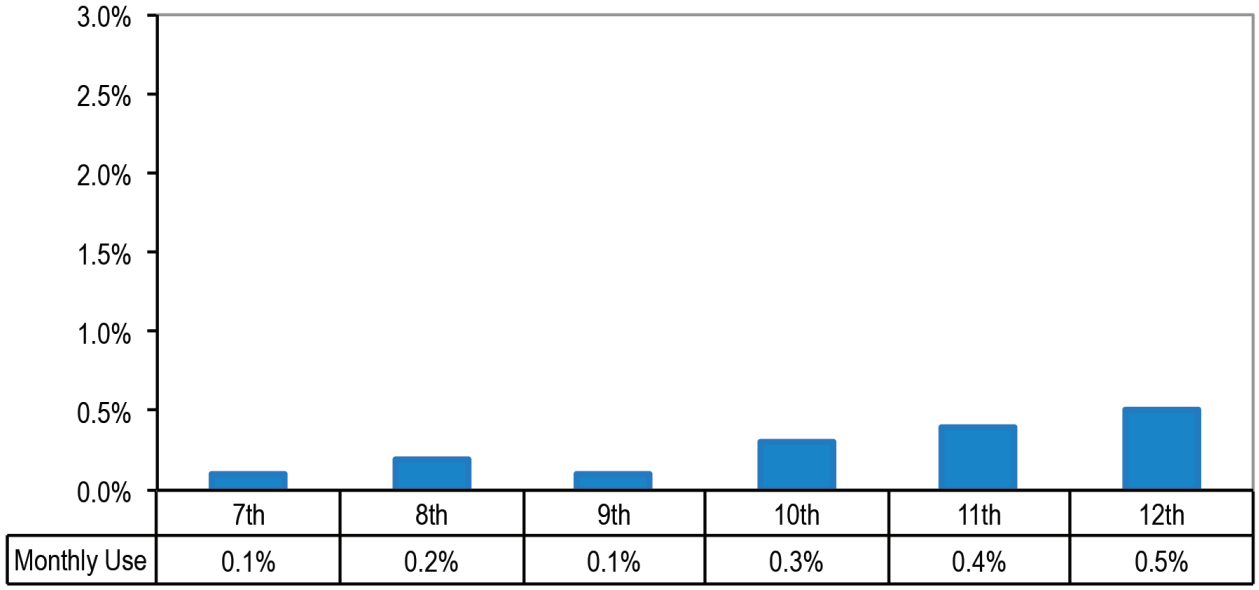


	2005	2007	2009	2011	2013	2015
Indiana	2.3%	3.6%	2.6%	2.8%		2.4%
U.S.	2.4%	2.3%	2.5%	2.9%	2.2%	2.1%

Note: 2013 estimates for Indiana are not available.
Source: CDC, 2017b

[1]Twenty Indiana colleges participated in the survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

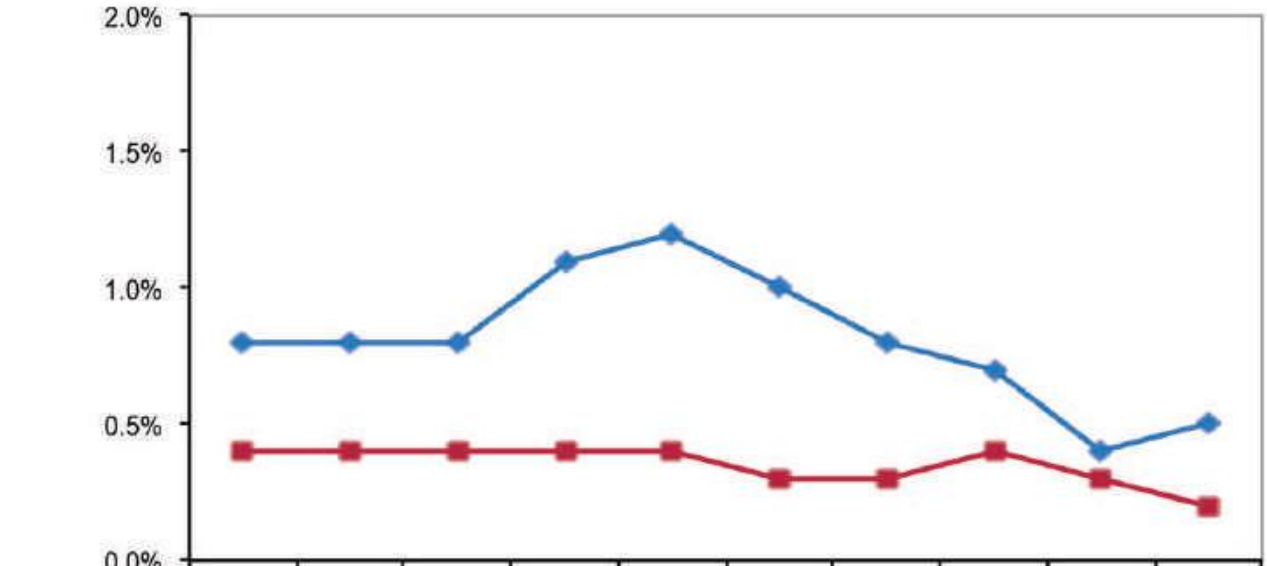
Figure 7.3 Percentage of Indiana 7th through 12th Grade Students Reporting Monthly Heroin Use (Indiana Youth Survey, 2016)



	7th	8th	9th	10th	11th	12th
Monthly Use	0.1%	0.2%	0.1%	0.3%	0.4%	0.5%

Source: Gassman et al., 2016

Figure 7.4 Percentage of Indiana and U.S. 12th Grade Students Reporting Monthly Heroin Use (Indiana Youth Survey and Monitoring the Future Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Indiana	0.8%	0.8%	0.8%	1.1%	1.2%	1.0%	0.8%	0.7%	0.4%	0.5%
U.S.	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.4%	0.3%	0.2%

Source: Gassman, et al., 2016

CONSEQUENCES

Heroin use may result in a variety of serious health conditions. Short-term or immediate effects include euphoria; warm flushing of the skin; dry mouth; and a heavy feeling in the extremities, which may be accompanied by nausea, vomiting, and severe itching. The initial effects are followed by drowsiness, clouded thinking, and slowed breathing and heart rate. Long-term or repeated use can lead to addiction, a chronic relapsing disease beyond physical dependence that is characterized by uncontrollable drug-seeking. Furthermore, heroin use has been linked to fatal drug overdoses, infectious diseases like HIV/AIDS and hepatitis C, and pregnancy complications such as infants at risk for low birthweight and neonatal abstinence syndrome (NIDA, 2017a, 2017b).

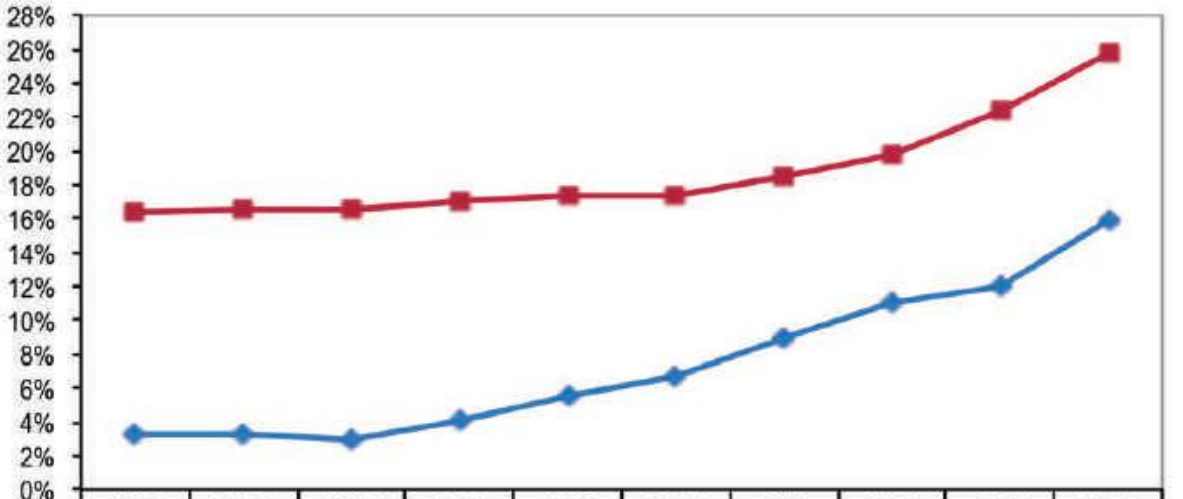
Because street heroin often contains toxic additives that do not easily dissolve, blood vessels leading to the heart, lungs, liver, kidneys, or brain can become clogged. Clogs of this nature can lead to infection or death of small patches of cells in vital organs (NIDA, 2014a).

Heroin Dependence

Data from the Treatment Episode Data Set (TEDS) spanning 2005 through 2014 show that the percentage of treatment episodes in which heroin use was reported at admission was significantly lower in Indiana than the United States ($P < 0.001$); however, reported use of heroin increased both within Indiana and nationally. In 2014, heroin use was reported in 15.9% of Indiana treatment admissions (U.S.: 25.8%), a nearly 400% increase from 3.3% reported in 2005 (see Figure 7.5) (SAMHSA, 2014).

Similarly, the percentage of drug treatment admissions for heroin dependence[2] has consistently been lower in Indiana than the rest of the nation ($P < 0.001$). However, heroin dependence in Indiana has increased

Figure 7.5 Percentage of Indiana and U.S. Treatment Episodes with Heroin Use Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)

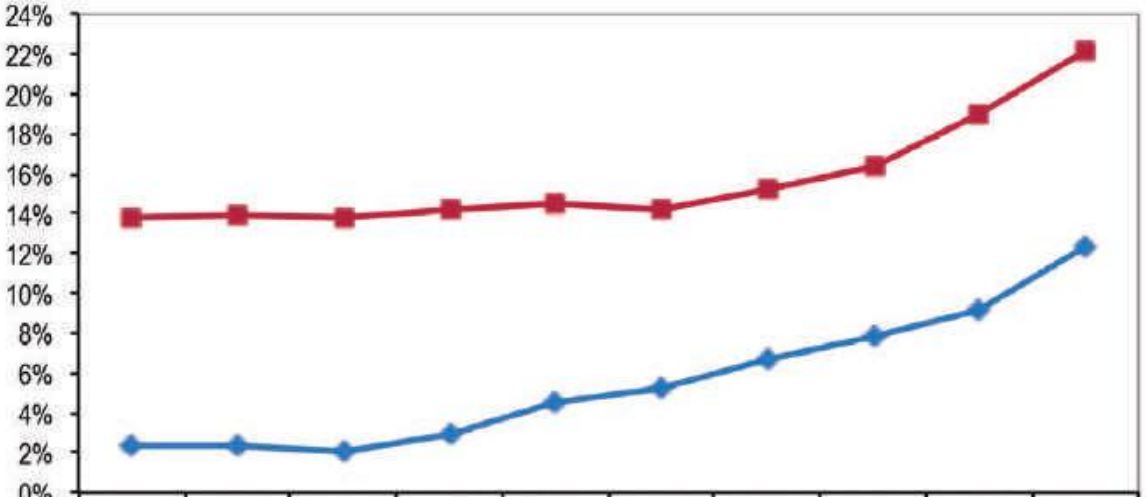


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	3.3%	3.2%	2.9%	4.1%	5.5%	6.6%	9.0%	11.1%	12.0%	15.9%
U.S.	16.4%	16.6%	16.5%	17.0%	17.3%	17.4%	18.5%	19.8%	22.4%	25.8%

Source: SAMHSA, 2014

[2]We defined heroin dependence as "individuals in substance abuse treatment listing heroin as their primary substance at admission."

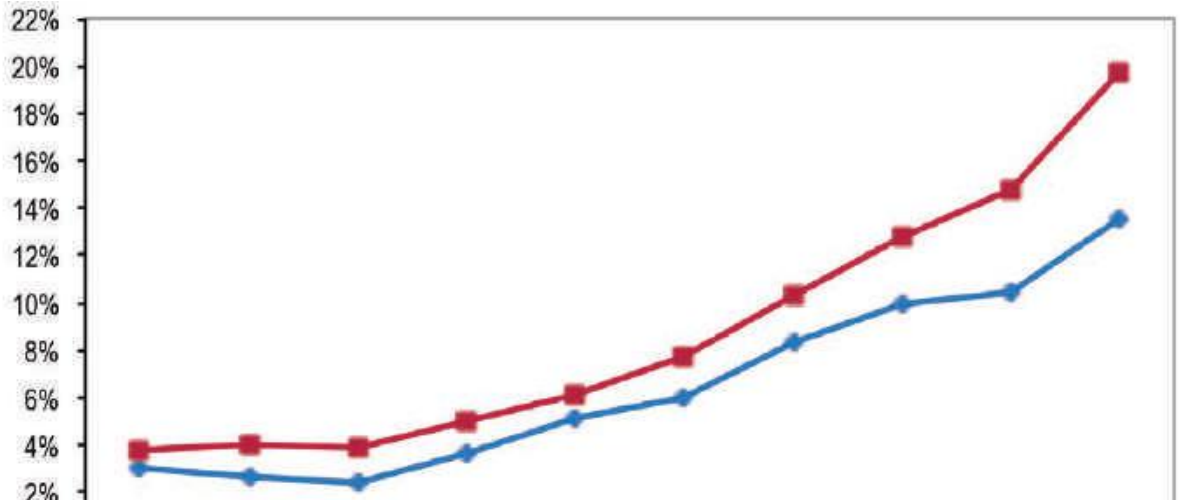
Figure 7.6 Percentage of Indiana and U.S. Treatment Episodes with Heroin Dependence Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	2.4%	2.3%	2.0%	2.9%	4.5%	5.3%	6.7%	7.9%	9.2%	12.3%
U.S.	13.8%	13.9%	13.8%	14.2%	14.5%	14.2%	15.2%	16.4%	19.0%	22.1%

Source: SAMHSA, 2014

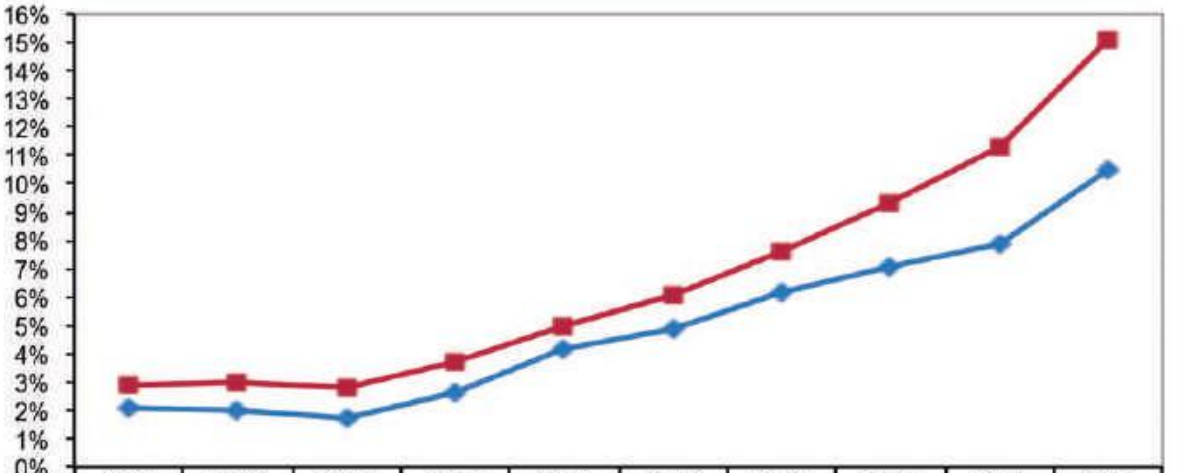
Figure 7.7 Percentage of Indiana Treatment Episodes with Heroin Use Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	3.0%	2.7%	2.4%	3.6%	5.1%	6.0%	8.3%	10.0%	10.4%	13.6%
Female	3.8%	4.0%	3.9%	5.0%	6.1%	7.7%	10.3%	12.8%	14.8%	19.7%

Source: SAMHSA, 2014

Figure 7.8 Percentage of Indiana Treatment Episodes with Heroin Dependence Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	2.1%	2.0%	1.7%	2.6%	4.2%	4.9%	6.2%	7.1%	7.9%	10.5%
Female	2.9%	3.0%	2.8%	3.7%	5.0%	6.1%	7.6%	9.3%	11.3%	15.1%

Source: SAMHSA, 2014

considerably, from 2.4% in 2005 to 12.3% in 2014 (see Figure 7.6). For county-level information on heroin use and dependence, see Appendix 7B, page 117.

Within Indiana's treatment population, reported heroin use and dependence differed significantly by gender, race, and age group:

- **Gender**—Reported heroin use and dependence increased among both males and females, but has consistently been higher in females ($P < .001$) (see Figures 7.7 and 7.8).
- **Race**—Since 2010, whites had the highest percentage of heroin use and dependence compared to all other races. While reported heroin use and dependence among blacks has remained relatively stable over the years, it has been steadily increasing among whites and other races (see Figures 7.9 and 7.10).
- **Age**—Since 2011, heroin use and dependence within Indiana's treatment population has been highest among adults ages 18 to 34. Use among minors under the age of 18 peaked in 2012 but has dropped since then to 1.7% for use and 1.1% for dependence (see Figures 7.11 and 7.12) (SAMHSA, 2014).

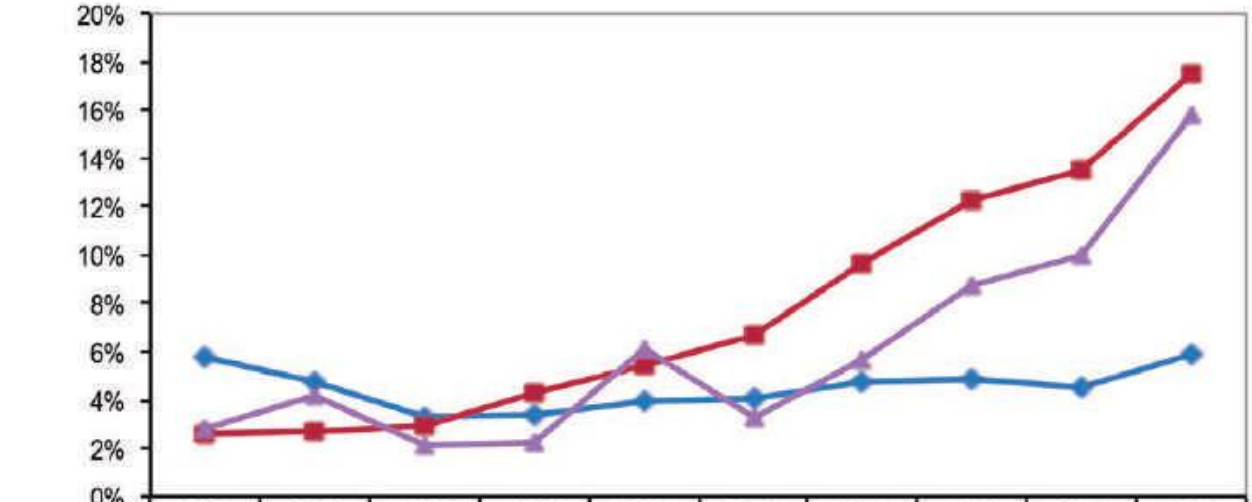
Overdose Mortality

In high doses, heroin, as well as all other opioids, can cause respiratory depression and death (NIDA, 2017a). The number of fatal overdoses where heroin was a contributing factor dramatically increased in Indiana from 7 deaths in 2004 to 239 deaths in 2015, a nearly 18-fold increase (see Figure 7.13) (ISDH, 2017).

HIV/AIDS

Heroin use, especially when injected, is a significant risk factor for contracting human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) due to the common practice of needle-sharing among injection drug users. However, heroin use in any form is associated with risk behaviors related to HIV/AIDS transmission (NIDA, 2012). As of December 31, 2015, 11,698 individuals in Indiana were living with HIV or AIDS, 621 of which were newly reported cases (ISDH, 2016a). Of the new cases of HIV in 2016 in Indiana, 32% were related to injection drug use. In February of 2015, ISDH announced a spreading outbreak of HIV in southeastern Indiana tied to needle sharing among intravenous drug users (ISDH, 2015). Originally, 26 cases were confirmed within a two-month time period; by December of 2015 the number grew to 184 confirmed cases of HIV and by May of 2016 the number was up to 191 confirmed HIV cases (ISDH, 2016b). Due to this outbreak, the public health emergency declaration for Scott County has been extended until May 24, 2017, which will allow for continued syringe exchange programs in the area. As a state, Indiana's age-adjusted HIV/AIDS mortality rate for 2014 was 1.2 per 100,000

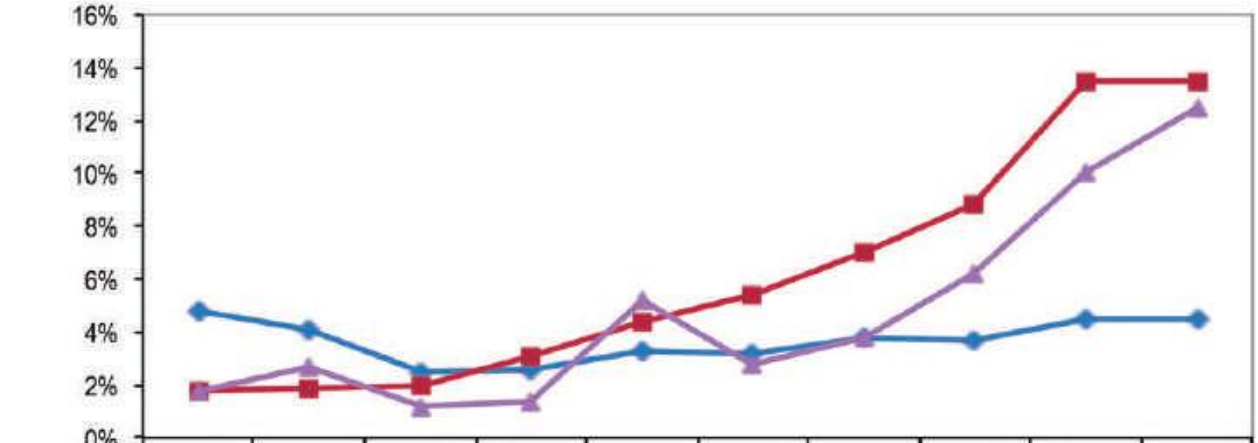
Figure 7.9 Percentage of Indiana Treatment Episodes with Heroin Use Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	5.8%	4.8%	3.3%	3.4%	3.9%	4.1%	4.7%	4.9%	4.5%	5.9%
White	2.6%	2.7%	2.9%	4.3%	5.4%	6.7%	9.6%	12.3%	13.5%	17.5%
Other	2.8%	4.2%	2.1%	2.2%	6.1%	3.3%	5.7%	8.7%	10.0%	15.8%

Source: SAMHSA, 2014

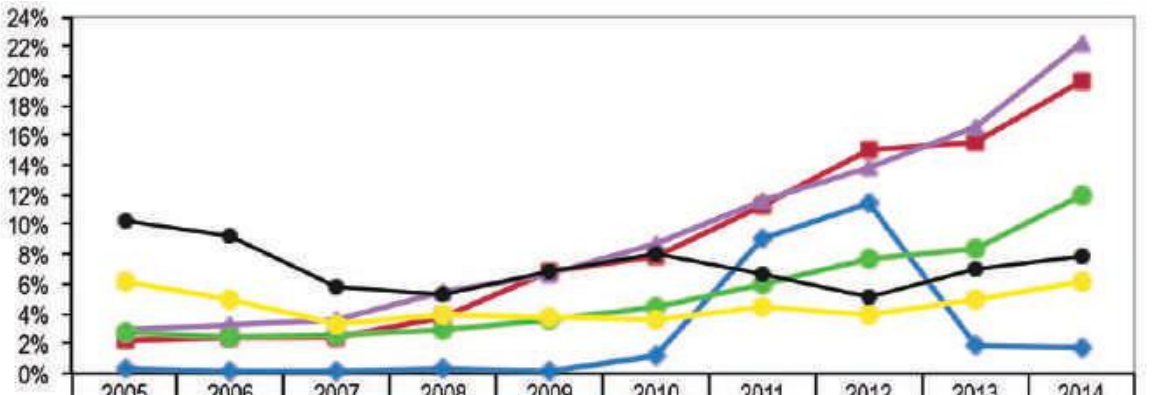
Figure 7.10 Percentage of Indiana Treatment Episodes with Heroin Dependence Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	4.8%	4.1%	2.5%	2.6%	3.3%	3.2%	3.8%	3.7%	4.5%	5%
White	1.8%	1.9%	2.0%	3.1%	4.4%	5.4%	7.0%	8.8%	13.5%	14%
Other	1.8%	2.7%	1.2%	1.4%	5.2%	2.8%	3.8%	6.2%	10.0%	13%

Source: SAMHSA, 2014

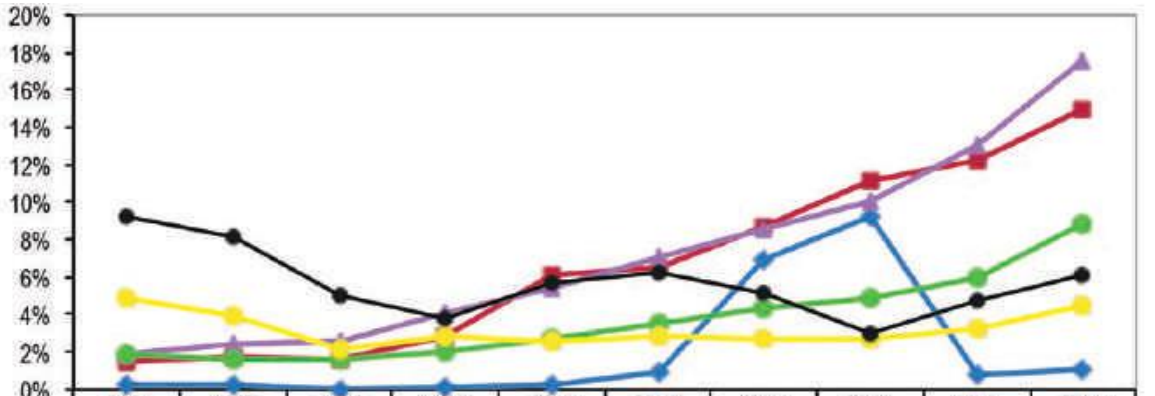
Figure 7.11 Percentage of Indiana Treatment Episodes with Heroin Use Reported at Treatment Admission, by Age Group (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Under 18	0.3%	0.2%	0.1%	0.4%	0.2%	1.1%	9.1%	11.5%	1.8%	1.7%
18 to 24	2.2%	2.4%	2.3%	3.8%	6.9%	7.8%	11.2%	15.1%	15.6%	19.7%
25 to 34	2.9%	3.2%	3.6%	5.5%	6.6%	8.7%	11.6%	13.9%	16.6%	22.2%
35 to 44	2.8%	2.4%	2.5%	2.9%	3.6%	4.4%	5.9%	7.7%	8.4%	11.9%
45 to 54	6.2%	5.0%	3.3%	3.9%	3.7%	3.6%	4.5%	3.9%	4.9%	6.2%
55 and over	10.2%	9.3%	5.8%	5.2%	6.9%	8.0%	6.6%	5.1%	7.0%	7.8%

Source: SAMHSA, 2014

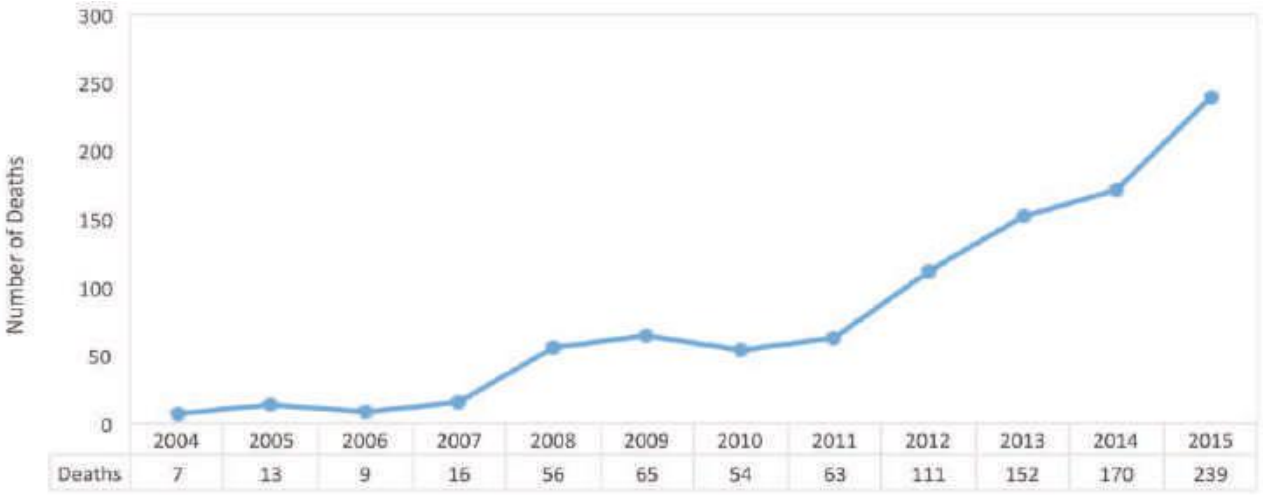
Figure 7.12 Percentage of Indiana Treatment Episodes with Heroin Dependence Reported at Treatment Admission, by Age Group (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Under 18	0.2%	0.2%	0.0%	0.1%	0.2%	0.9%	6.9%	9.3%	0.8%	1.1%
18 to 24	1.5%	1.7%	1.6%	2.8%	6.1%	6.5%	8.7%	11.2%	12.2%	14.9%
25 to 34	1.9%	2.4%	2.6%	4.0%	5.4%	7.0%	8.6%	10.1%	13.0%	17.5%
35 to 44	1.9%	1.6%	1.6%	2.0%	2.7%	3.5%	4.3%	4.9%	6.0%	8.9%
45 to 54	4.9%	3.9%	2.1%	2.9%	2.6%	2.8%	2.7%	2.7%	3.3%	4.5%
55 and over	9.3%	8.1%	5.0%	3.8%	5.7%	6.2%	5.2%	3.0%	4.8%	6.1%

Source: SAMHSA, 2014

Figure 7.13 Number of Overdose Deaths in Indiana with Heroin as a Contributing Factor (Overdose Mortality, 2004–2015)



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Deaths	7	13	9	16	56	65	54	63	111	152	170	239

Source: ISDH, 2017

population (95% CI: 1.0–1.5), which was significantly lower than the U.S. rate of 2.0 per 100,000 population (95% CI: 1.9–2.0) (CDC, 2016).[3]

Hepatitis

Hepatitis is a liver disease that is caused by viral infection. The most common types are hepatitis A, B, and C. The hepatitis B virus (HBV) and hepatitis C virus (HCV) are transmitted when blood of an infected person enters the body of a person who is not infected and are commonly associated with injection drug use (IDU). IDU is a major risk factor for both acquiring and transmitting HBV and HCV (CDC, 2014). It is estimated that each injection drug user infected with HCV is likely to infect 20 other people, extending the risk of infection far beyond the individual using the drug (NIDA, 2014b). Furthermore, an estimated 50% to 80% of injection drug users become infected with these viruses within five years after initiating IDU (CDC, 2014).

In 2014, there were 123 cases of hepatitis B and 5,289 cases of hepatitis C[4] in Indiana (ISDH, 2016a). In 2014, 126 acute cases of hepatitis B and 122 acute cases of hepatitis C occurred in Indiana, representing rates of 1.9 for HBV (U.S.: 0.9) and 1.8 for HCV (U.S.: 0.7), per 100,000 population (CDC, 2016). The HIV outbreak beginning in 2015 in southeastern Indiana has also been connected to the spread of HCV (ISDH, 2016b).

The 2014 age-adjusted mortality rate attributable to HBV and HCV[5] was 1.2 per 100,000 population (95% CI: 1.0–1.5) in Indiana, which was significantly lower than the national rate of 2.0 per 100,000 population (95% CI: 2.0–2.1) (CDC, 2016).

Legal Consequences

The Uniform Crime Reporting (UCR) Program collects information on arrests for possession and sale/manufacture of opiates and cocaine combined; data on either drug category individually are currently not available (all figures, tables, and maps summarizing UCR arrest data for cocaine and opiates are presented in Chapter 6 Cocaine). According to the 2014 data, there were over 1,600 arrests in Indiana for possession of cocaine or opiates, including heroin, and 1,556 arrests for the sale/manufacturing of these drugs. This translates to an arrest rate for possession of 0.2 per 1,000 (95% CI: 0.2–0.2) in Indiana compared to the national arrest rate for possession of 0.7 (95% CI: 0.7–0.7) (see Figure 6.7). While the national rate for possession was higher than Indiana's, arrest rates for sale/manufacture of cocaine and opiates were the same at 0.2 per 1,000 (Federal Bureau of Investigation [FBI], 2014). For trend information and comparisons with the United States, refer to Chapter 6, Cocaine, starting on page 97; for county-level data, see Maps 6.1 and 6.2 (pages 103 and 104) and Appendix 6C (pages 101-102).

[3]Mortality rates for HIV/AIDS are based on ICD-10 codes B20-B24 (Human immunodeficiency virus [HIV] disease).
[4]This included all suspected, probable, and confirmed Hepatitis C cases based on case investigations.
[5]Mortality rates for hepatitis B and C infections are based on the following ICD-10 codes: B16 (Acute hepatitis B), B17.0 (Acute delta-[super]infection of hepatitis B carrier), B17.1 (Acute hepatitis C), B18.0 (Chronic viral hepatitis B with delta-agent), B18.1 (Chronic viral hepatitis B without delta-agent), B18.2 (Chronic viral hepatitis C).

APPENDIX 7A

Percentage of Indiana Students Reporting Monthly Heroin Use in Indiana, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
7th Grade	0.1	0.2	0.3*	0.3	0.0	0.1	0.0	0.1	0.0
8th Grade	0.2	0.2	0.2	0.7	0.2	0.2	0.1	0.2	0.2
9th Grade	0.1	0.3	0.0	0.0	0.0	0.3	0.1	0.1	0.1
10th Grade	0.3	0.2	0.3	0.0	1.3*	0.3	0.2	0.0	0.1
11th Grade	0.4	0.5	0.5	0.2	0.1	0.6	0.3	0.3	0.3
12th Grade	0.5	0.5	0.7	0.0	0.6	0.4	1.1*	0.3	0.1

Notes: * Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).
Beginning in 2015, the Indiana Youth Survey stopped asking 6th grade students about heroin use.
Source: Gassman et al., 2016

APPENDIX 7B

Number and Percentage of Treatment Episodes with Heroin Use and Dependence Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Heroin Use		Heroin Dependence	
County	Total	Number	%	Number	%
Adams	295	63	21.4%	47	15.9%
Allen	1,618	206	12.7%	153	9.5%
Bartholomew	581	124	21.3%	76	13.1%
Benton	50	<5	N/A	<5	N/A
Blackford	82	34	41.5%	32	39.0%
Boone	187	42	22.5%	35	18.7%
Brown	83	20	24.1%	13	15.7%
Carroll	84	11	13.1%	8	9.5%
Cass	253	43	17.0%	32	12.6%
Clark	313	55	17.6%	48	15.3%
Clay	181	10	5.5%	8	4.4%
Clinton	227	45	19.8%	36	15.9%
Crawford	45	6	13.3%	<5	N/A
Daviess	169	<5	N/A	<5	N/A
Dearborn	449	150	33.4%	109	24.3%
Decatur	212	24	11.3%	13	6.1%
DeKalb	242	12	5.0%	<5	N/A
Delaware	1,138	267	23.5%	197	17.3%
Dubois	280	11	3.9%	<5	N/A
Elkhart	654	55	8.4%	44	6.7%
Fayette	234	93	39.7%	72	30.8%
Floyd	117	24	20.5%	24	20.5%
Fountain	48	13	27.1%	7	14.6%
Franklin	166	54	32.5%	39	23.5%
Fulton	143	11	7.7%	6	4.2%
Gibson	295	<5	N/A	<5	N/A
Grant	436	80	18.3%	68	15.6%
Greene	204	33	16.2%	24	11.8%
Hamilton	893	169	18.9%	135	15.1%
Hancock	193	33	17.1%	28	14.5%
Harrison	31	10	32.3%	10	32.3%
Hendricks	351	92	26.2%	78	22.2%
Henry	330	51	15.5%	29	8.8%
Howard	610	204	33.4%	161	26.4%
Huntington	147	24	16.3%	13	8.8%
Jackson	298	45	15.1%	24	8.1%
Jasper	105	39	37.1%	30	28.6%
Jay	188	81	43.1%	70	37.2%
Jefferson	366	50	13.7%	25	6.8%
Jennings	223	45	20.2%	29	13.0%
Johnson	275	70	25.5%	63	22.9%
Knox	298	8	2.7%	<5	N/A
Kosciusko	381	50	13.1%	35	9.2%
LaGrange	186	<5	N/A	<5	N/A
Lake	2,339	551	23.6%	496	21.2%
LaPorte	377	121	32.1%	107	28.4%
Lawrence	485	67	13.8%	45	9.3%

	Treatment Episodes	Heroin Use		Heroin Dependence	
County	Total	Number	%	Number	%
Madison	1,278	173	13.5%	110	8.6%
Marion	3,645	924	25.3%	807	22.1%
Marshall	205	33	16.1%	27	13.2%
Martin	62	<5	N/A	<5	N/A
Miami	272	46	16.9%	32	11.8%
Monroe	1,180	261	22.1%	165	14.0%
Montgomery	374	91	24.3%	62	16.6%
Morgan	482	117	24.3%	84	17.4%
Newton	33	15	45.5%	10	30.3%
Noble	307	6	2.0%	<5	N/A
Ohio	40	7	17.5%	5	12.5%
Orange	160	11	6.9%	8	5.0%
Owen	199	25	12.6%	12	6.0%
Parke	67	6	9.0%	<5	N/A
Perry	102	<5	N/A	<5	N/A
Pike	53	<5	N/A	<5	N/S
Porter	410	153	37.3%	133	32.4%
Posey	170	5	2.9%	5	2.9%
Pulaski	109	12	11.0%	9	8.3%
Putnam	215	15	7.0%	7	3.3%
Randolph	170	53	31.2%	47	27.6%
Ripley	184	53	28.8%	45	24.5%
Rush	138	25	18.1%	10	7.2%
Saint Joseph	1,231	221	18.0%	187	15.2%
Scott	165	20	12.1%	17	10.3%
Shelby	168	41	24.4%	32	19.0%
Spencer	144	<5	N/A	<5	N/A
Starke	193	66	34.2%	55	28.5%
Steuben	298	<5	N/A	<5	N/A
Sullivan	78	<5	N/A	<5	N/A
Switzerland	63	11	17.5%	10	15.9%
Tippecanoe	404	85	21.0%	62	15.3%
Tipton	70	9	12.9%	<5	N/A
Union	22	9	40.9%	5	22.7%
Vanderburgh	1,319	57	4.3%	37	2.8%
Vermillion	123	13	10.6%	7	5.7%
Vigo	803	41	5.1%	31	3.9%
Wabash	225	53	23.6%	33	14.7%
Warren	9	<5	N/A	<5	N/A
Warrick	267	12	4.5%	<5	N/A
Washington	63	19	30.2%	18	28.6%
Wayne	438	192	43.8%	145	33.1%
Wells	128	28	21.9%	20	15.6%
White	110	11	10.0%	<5	N/A
Whitley	105	9	8.6%	5	4.8%
County Info Missing	27	9	33.3%	8	29.6%
Indiana	33,170	6,159	18.6%	4,765	14.4%

Note: We defined heroin dependence as “individuals in substance abuse treatment listing heroin as their primary substance at admission.”
We calculated the percentages by dividing the number of reported heroin use/dependence by the number of treatment episodes.
Information on treatment episodes <5 was suppressed due to confidentiality constraints.
Source: Indiana Family and Social Services Administration, 2016

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8 Methamphetamine Use in Indiana: Consumption Patterns and Consequences

METHAMPHETAMINE CONSUMPTION

Methamphetamine (meth) is a potent and highly addictive stimulant. Also known as "crystal" or "ice," it is a derivative of amphetamine. Similar to its parent compound amphetamine, meth affects the central nervous system, but its effects are more pronounced and longer-lasting. It can be injected, snorted, smoked, or ingested orally. Methamphetamine users feel a short, intense euphoria or "rush" when the drug is initially administered, followed by an extended high that can last up to 12 hours because of the drug's long half-life (Halkitis, Parsons, & Stirrat, 2001; Centers for Disease Control and Prevention [CDC], 2007). The immediate effects of methamphetamine include increased physical activity, wakefulness, and decreased appetite (National Institute on Drug Abuse [NIDA], 2014). The intensity of meth stimulation depends on the mode of use: Oral ingestion or snorting produces a longer-lasting, but less intense effect, while the effect from smoking or injecting intravenously is brief, but more intense (Homer et al., 2008).

General Consumption Patterns

Methamphetamine use in the general population is fairly low, so no state-level prevalence estimates currently exist. However, the National Survey on Drug Use and Health (NSDUH) measures lifetime, past year, and past month (current) use of methamphetamine in the United States. Based on 2015 NSDUH findings, 5.4% of Americans ages 12 and older used meth at least once in their lifetime, 0.6% used it in the past year, and 0.3% in the past-month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).

Adult Consumption Patterns

According to national estimates from the 2015 NSDUH, past-year meth use was reported in 0.9% of Americans ages 18 to 25 and in 0.6% of adults ages 26 and older; past-month meth use was estimated at 0.4% in both age groups (SAMHSA, 2017).

The Indiana College Substance Use Survey provides estimates of alcohol, tobacco, and other drug use among Indiana college students. According to 2016 survey results, which were based on 20 participating colleges and universities, 0.2% of Indiana college students reported using meth in the past month (U.S.: < 0.05%). Use of meth seemed higher among male college students (0.4%) compared to their female counterparts (0.1%); however, the difference was not statistically significant (King & Jun, 2016).[1]

[1]Twenty Indiana colleges participated in the 2016 survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

Youth Consumption Patterns

According to the 2015 Youth Risk Behavior Surveillance System (YRBSS), 2.9% (95% Confidence Interval [CI]: 1.5–5.4) of Indiana high school students reported having used meth once or more in their lifetimes; the national rate was similar (3.0%; 95% CI: 2.4–3.8). Indiana's lifetime prevalence rate dropped significantly from 8.2% in 2003 to 2.9% in 2015 (see Figure 8.1). Rate differences by gender, race, and grade level were not significant in Indiana (see Table 8.1) (CDC, 2017).

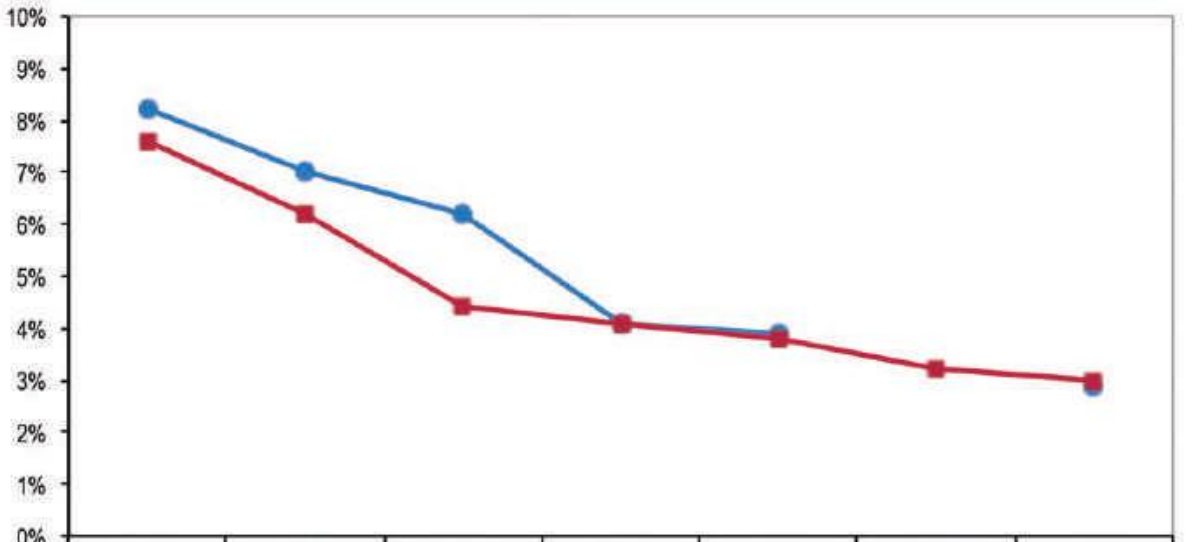
According to the Indiana Youth Survey (INYS), current (past month) rates of meth use among 8th, 10th, and 12th grade students seemed to have decreased from 2005 to 2016, though statistical significance could not be tested (see Figure 8.2). For monthly meth use in Indiana, by region and grade, see Appendix 8A, page 130.

Table 8.1 Percentage of Indiana and U.S. High School Students Reporting Lifetime Methamphetamine Use, by Gender, Race/Ethnicity, and Grade (Youth Risk Behavior Surveillance System, 2015)

		Indiana Prevalence % (95% CI)	U.S. Prevalence % (95% CI)
Gender	Male	4.1% (2.0–8.2)	3.6% (2.6–4.9)
	Female	1.4% (0.8–2.6)	2.3% (1.7–3.0)
Race/Ethnicity	Black	3.7% (1.2–10.7)	2.8% (1.5–5.1)
	White	2.4% (1.1–5.3)	2.1% (1.5–2.8)
	Hispanic	3.2% (1.4–7.0)	4.4% (3.3–5.9)
Grade	9th	3.5% (1.6–7.8)	2.0% (1.5–2.7)
	10th	2.3% (1.4–3.8)	3.3% (2.3–4.9)
	11th	3.7% (1.5–8.9)	2.8% (1.9–4.0)
	12th	1.6% (0.4–6.6)	3.8% (2.7–5.3)
Total		**2.9% (1.5-5.4)**	**3.0% (2.4-3.8)**

Source: CDC, 2017

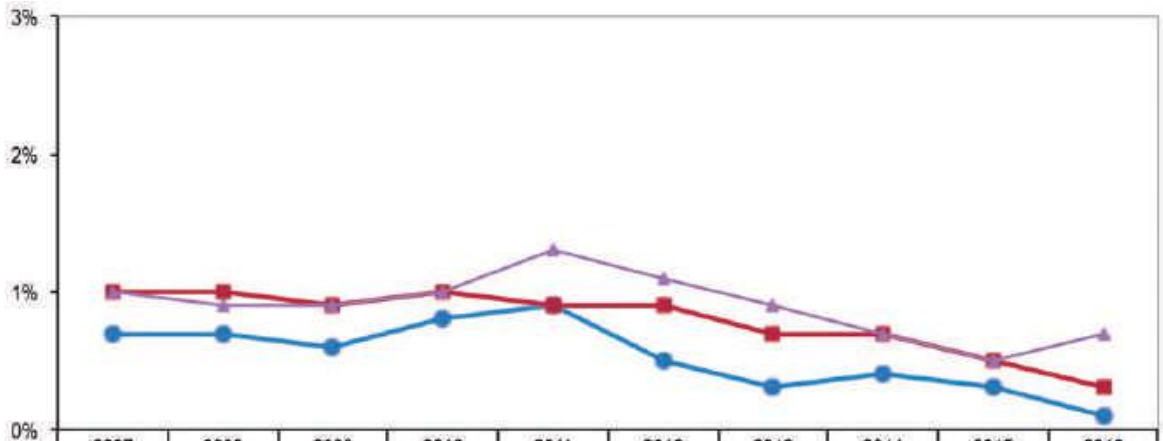
Figure 8.1 Percentage of Indiana and U.S. High School Students (9th–12th Grade) Reporting Lifetime Methamphetamine Use (Youth Risk Behavior Surveillance System, 2003–2015)



	2003	2005	2007	2009	2011	2013	2015
Indiana	8.2%	7.0%	6.2%	4.1%	3.9%		2.9%
U.S.	7.6%	6.2%	4.4%	4.1%	3.8%	3.2%	3.0%

Note: 2013 YRBSS data are not available for Indiana due to insufficient response rate.
Source: CDC, 2017

Figure 8.2 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Current (Past Month) Methamphetamine Use, by Grade (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th Grade	0.7%	0.7%	0.6%	0.8%	0.9%	0.5%	0.3%	0.4%	0.3%	0.1%
10th Grade	1.0%	1.0%	0.9%	1.0%	0.9%	0.9%	0.7%	0.7%	0.5%	0.3%
12th Grade	1.0%	0.9%	0.9%	1.0%	1.3%	1.1%	0.9%	0.7%	0.5%	0.7%

Source: Gassman et al., 2016

CONSEQUENCES

Health-Related Consequences

Methamphetamine use has both short- and long-term health consequences. Short-term effects include increased wakefulness, physical activity, decreased appetite, cardiac problems, and hyperthermia (elevated body temperature). Chronic meth use causes physiological changes such as impaired memory, mood alterations, and diminished motor coordination. Additional long-term effects include insomnia, violent behavior, hallucinations, confusion, weight loss, stroke, and psychiatric problems (NIDA, 2014). Certain psychiatric conditions, such as paranoid psychosis, can result from both short- and long-term use, and may persist for a long period even after meth use has ceased. Also, clinical observations show a link between meth use and long-lasting brain injury (Ernst, Chang, Leonido-Yee, & Speck, 2000). Other health consequences of prolonged meth use include cardiovascular collapse; brain, liver, and kidney damage; severe tooth decay (or "meth mouth"); hepatitis; extreme weight loss; mental illness; increased risk of unsafe sex and risky sexual behaviors; increased risk of STD/HIV transmission (especially associated with injection drug use); unwanted pregnancy; and death (NIDA, 2014).

Meth labs and parental addiction pose serious risks to children, including chemical contamination; fires and explosions; physical, emotional, and sexual abuse; and abuse-related deaths (Messina, Marinelli-Casey, West, & Rawson, 2007; Petit & Curtis, 1999). Children living in meth labs may be exposed to highly toxic fumes created by meth production or the secondhand smoke of adults using the drug. Also, these children face a high risk of accidental ingestion of chemicals used for meth production, which may be fatal (Perez, Arsura, & Strategos, 1999). Low-level exposure to some of the meth ingredients may lead to headache, nausea, dizziness, and fatigue. Exposure to high levels of these chemicals can produce lung irritation, coughing, chest pain, dizziness, chemical burns (to the skin, eyes, mouth, and nose), damage to the brain, and even death (Office of Justice Programs, 2003; Irvine & Chin, 1997).

Meth Abuse and Dependence

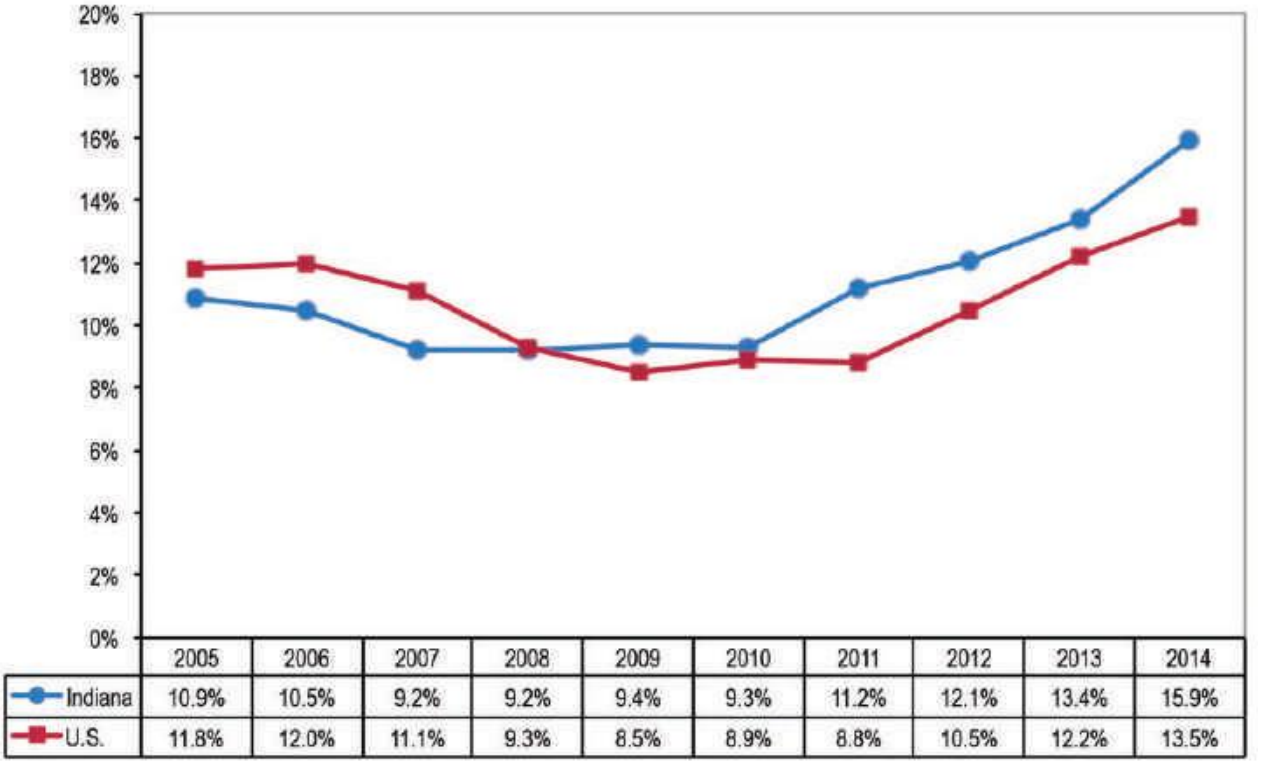
The Treatment Episode Data Set (TEDS) includes information gathered from patients at the time of substance abuse treatment admission (SAMHSA, 2014). Indiana TEDS data show an increase in the percentage of patients reporting meth use and dependence[2] at admission (see Figures 8.3 and 8.4).

In Indiana, statistically significant differences in meth use and dependence were observed by gender, race, and age group, as follows ($P < 0.001$):

- **Gender**—The percentage of female clients who reported meth use or dependence was significantly higher compared to their male counterparts (see Figures 8.5 and 8.6).
- **Race**—Meth use and dependence was highest among whites and lowest among blacks (see Figures 8.7 and 8.8).
- **Age**—Adults ages 25 to 44 reported the highest percentage of meth use and dependence (see Figures 8.9 and 8.10) (SAMHSA, 2014).

For county-level treatment data, see Appendix 8B, page 131.

Figure 8.3 Percentage of Treatment Episodes with Meth Use Reported at Treatment Admission in Indiana and the United States (Treatment Episode Data Set, 2005–2014)

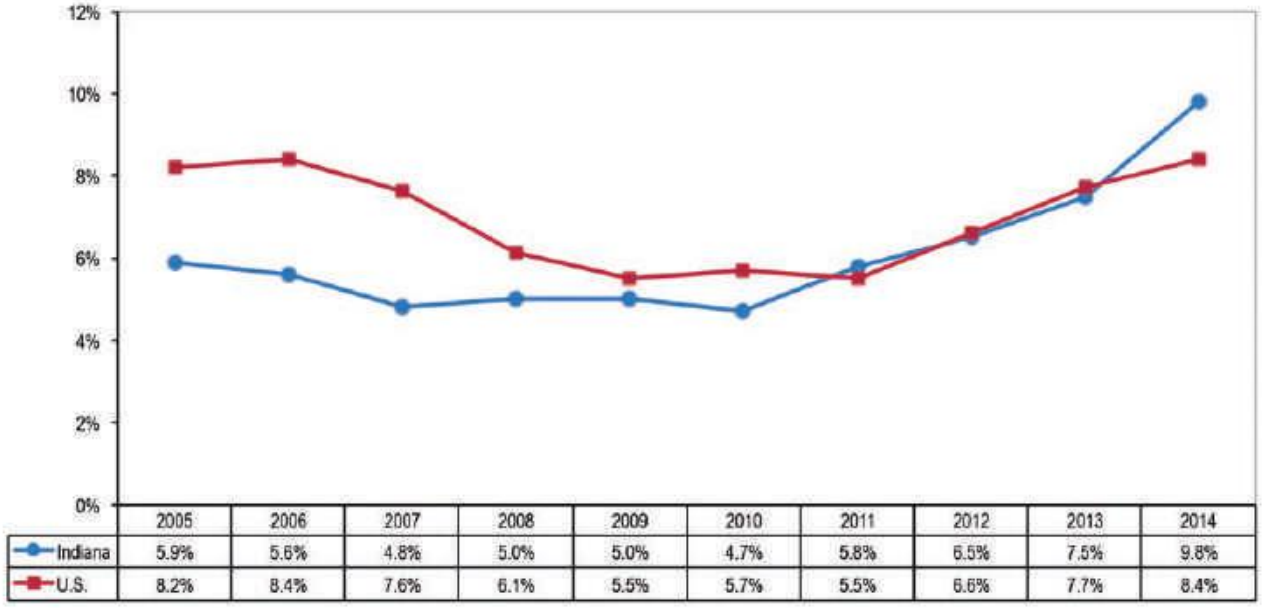


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	10.9%	10.5%	9.2%	9.2%	9.4%	9.3%	11.2%	12.1%	13.4%	15.9%
U.S.	11.8%	12.0%	11.1%	9.3%	8.5%	8.9%	8.8%	10.5%	12.2%	13.5%

Source: SAMHSA, 2014

[2]We defined methamphetamine dependence as "individuals in substance abuse treatment listing methamphetamine as their primary substance at admission."

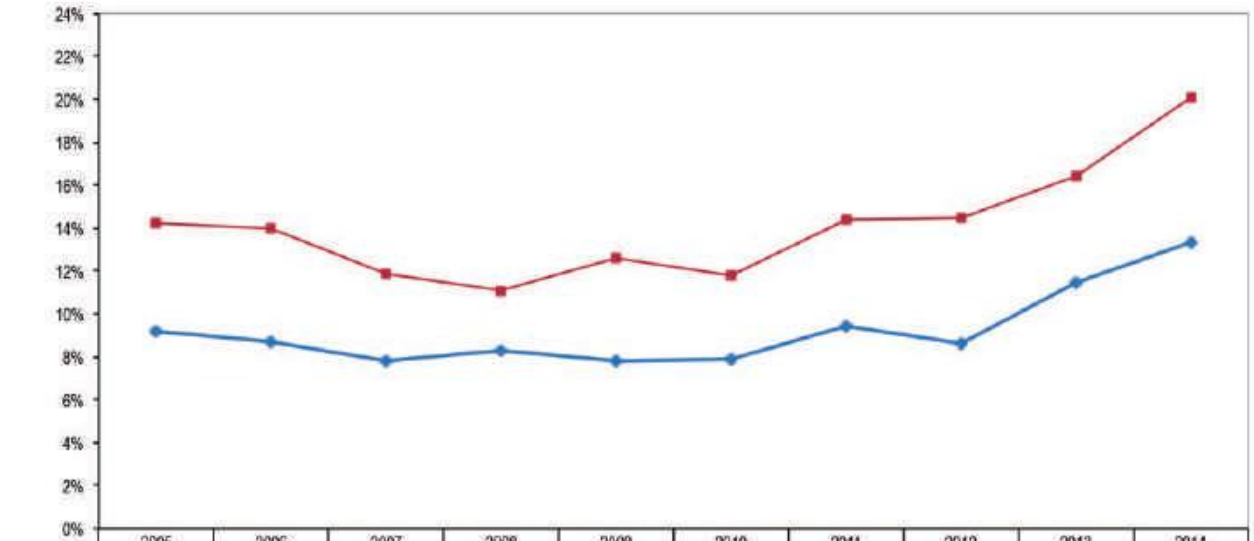
Figure 8.4 Percentage of Treatment Episodes with Meth Dependence Reported at Treatment Admission in Indiana and the United States (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	5.9%	5.6%	4.8%	5.0%	5.0%	4.7%	5.8%	6.5%	7.5%	9.8%
U.S.	8.2%	8.4%	7.6%	6.1%	5.5%	5.7%	5.5%	6.6%	7.7%	8.4%

Source: SAMHSA, 2014

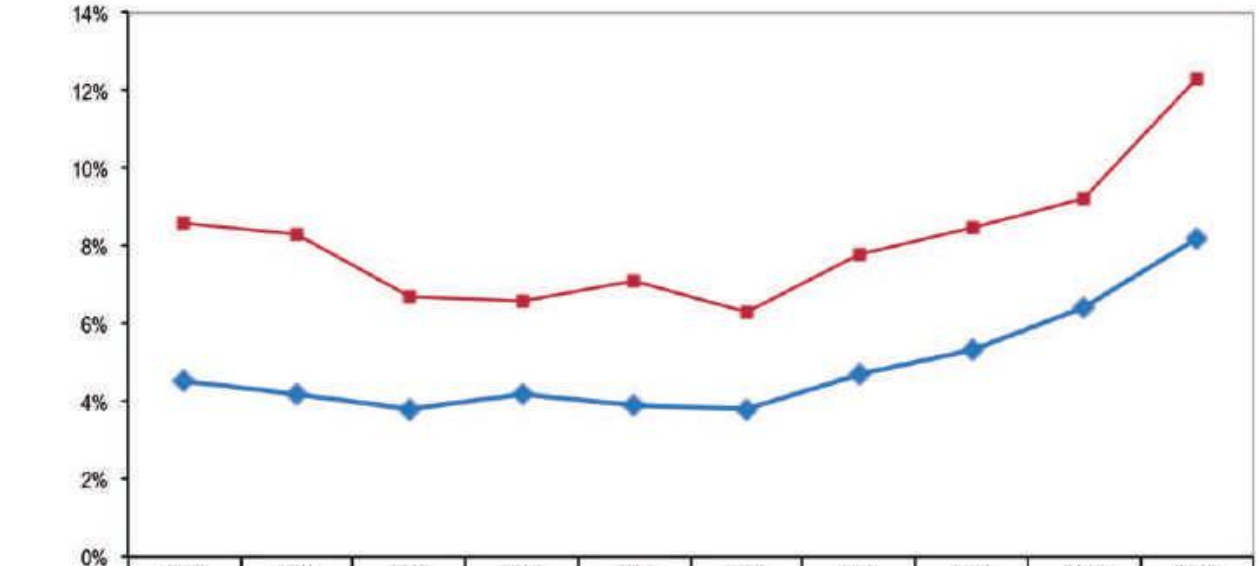
Figure 8.5 Percentage of Treatment Episodes with Meth Use Reported at Treatment Admission in Indiana, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	9.2%	8.7%	7.8%	8.3%	7.8%	7.9%	9.4%	8.6%	11.5%	13.3%
Female	14.2%	14.0%	11.9%	11.1%	12.6%	11.8%	14.4%	14.5%	16.4%	20.1%

Source: SAMHSA, 2014

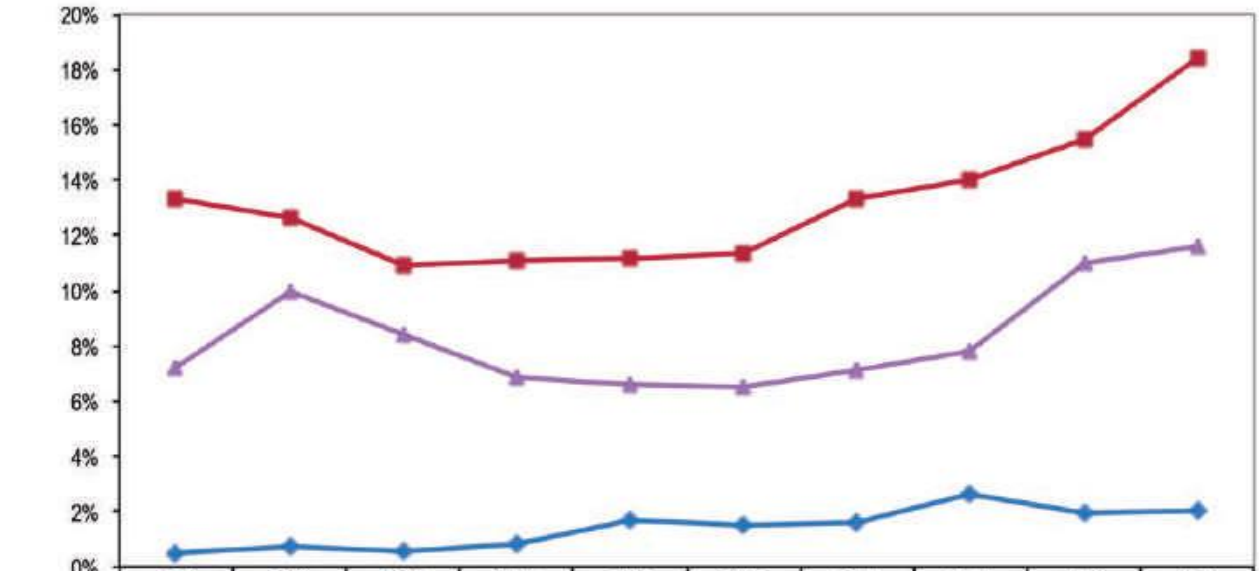
Figure 8.6 Percentage of Treatment Episodes with Meth Dependence Reported at Treatment Admission in Indiana, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	4.5%	4.2%	3.8%	4.2%	3.9%	3.8%	4.7%	5.3%	6.4%	8.2%
Female	8.6%	8.3%	6.7%	6.6%	7.1%	6.3%	7.8%	8.5%	9.2%	12.3%

Source: SAMHSA, 2014

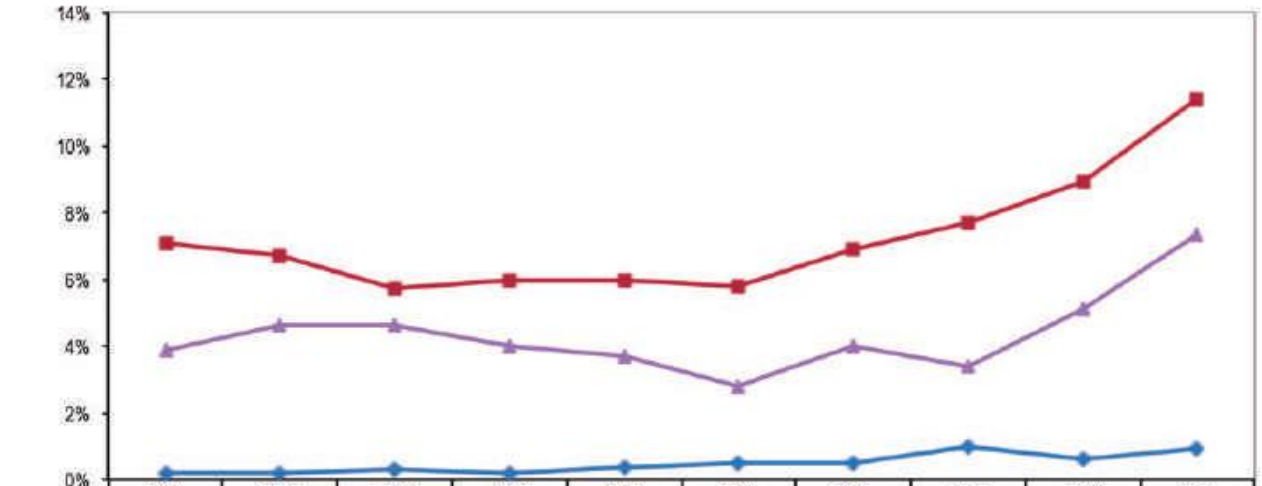
Figure 8.7 Percentage of Treatment Episodes with Meth Use Reported at Treatment Admission in Indiana, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	0.5%	0.7%	0.6%	0.8%	1.7%	1.5%	1.6%	2.6%	1.9%	2.0%
White	13.3%	12.6%	10.9%	11.1%	11.2%	11.3%	13.3%	14.0%	15.5%	18.4%
Other	7.2%	10.0%	8.4%	6.9%	6.6%	6.5%	7.1%	7.8%	11.0%	11.6%

Source: SAMHSA, 2014

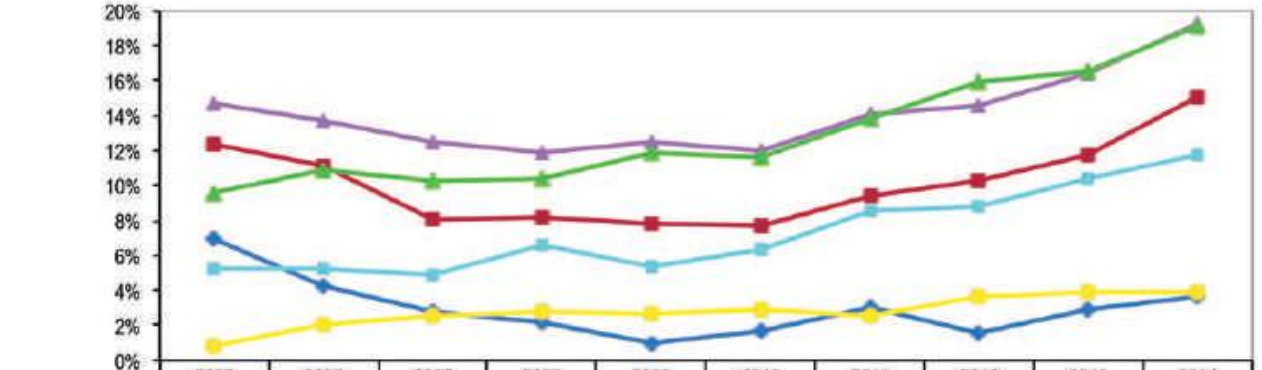
Figure 8.8 Percentage of Treatment Episodes with Meth Dependence Reported at Treatment Admission in Indiana, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	0.2%	0.2%	0.3%	0.2%	0.4%	0.5%	0.5%	1.0%	0.6%	0.9%
White	7.1%	6.7%	5.7%	6.0%	6.0%	5.8%	6.9%	7.7%	8.9%	11.4%
Other	3.9%	4.6%	4.6%	4.0%	3.7%	2.8%	4.0%	3.4%	5.1%	7.3%

Source: SAMHSA, 2014

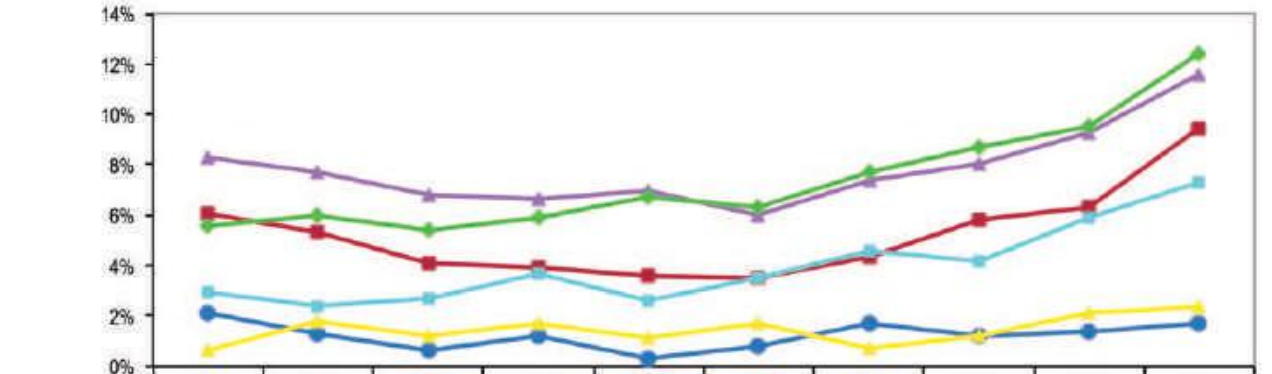
Figure 8.9 Percentage of Treatment Episodes with Meth Use Reported at Treatment Admission in Indiana, by Age Group (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Under 18	7.0%	4.3%	2.8%	2.2%	1.0%	1.7%	3.1%	1.6%	2.9%	3.7%
18 to 24	12.4%	11.1%	8.1%	8.2%	7.8%	7.7%	9.4%	10.3%	11.8%	15.1%
25 to 34	14.7%	13.7%	12.5%	11.9%	12.5%	12.0%	14.1%	14.6%	16.4%	19.2%
35 to 44	9.6%	10.9%	10.3%	10.4%	11.9%	11.6%	13.8%	15.9%	16.5%	19.1%
45 to 54	5.3%	5.3%	4.9%	6.6%	5.4%	6.4%	8.6%	8.8%	10.4%	11.8%
55 and over	0.8%	2.1%	2.5%	2.8%	2.7%	2.9%	2.5%	3.7%	3.9%	3.9%

Source: SAMHSA, 2014

Figure 8.10 Percentage of Treatment Episodes with Meth Dependence Reported at Treatment Admission in Indiana, by Age Group (Treatment Episode Data Set, 2005–2014)



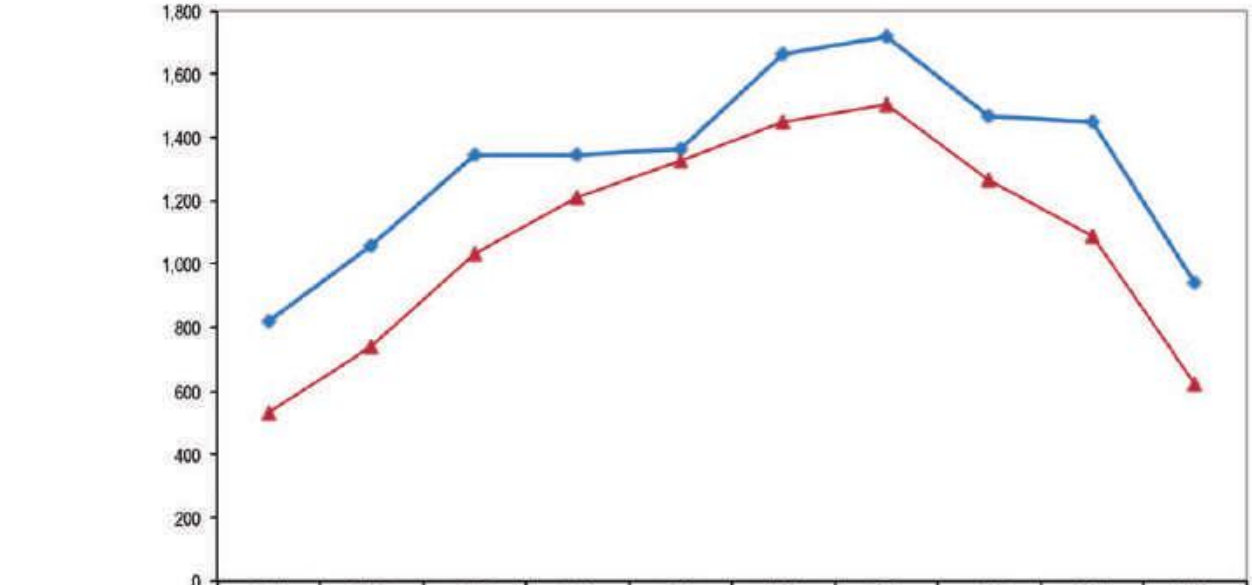
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Under 18	2.1%	1.3%	0.6%	1.2%	0.3%	0.8%	1.7%	1.2%	1.4%	1.7%
18 to 24	6.1%	5.3%	4.1%	3.9%	3.6%	3.5%	4.3%	5.8%	6.3%	9.4%
25 to 34	8.3%	7.7%	6.8%	6.6%	7.0%	6.0%	7.4%	8.0%	9.3%	11.6%
35 to 44	5.6%	6.0%	5.4%	5.9%	6.7%	6.3%	7.7%	8.7%	9.5%	12.4%
45 to 54	2.9%	2.4%	2.7%	3.7%	2.6%	3.5%	4.6%	4.2%	5.9%	7.3%
55 and over	0.6%	1.8%	1.2%	1.7%	1.1%	1.7%	0.7%	1.2%	2.1%	2.4%

Source: SAMHSA, 2014

Criminal Consequences

The Indiana State Police (ISP) seized 943 clandestine methamphetamine labs, and made 622 meth lab arrests in the state between January 1 and December 31, 2016. These numbers represent a remarkable decline in both lab seizures and arrests from the previous year (see Figure 8.11) (ISP, 2017). However, not all seizures involved the "traditional" clandestine lab. A popular technique for meth production is the one-pot or "shake and bake" method, which entails combining all the ingredients in one container (often a 2-liter or 20-ounce plastic soda bottle) and shaking. This can be done almost anywhere, even in a moving vehicle, and waste disposal is often along roadsides, in discarded plastic bottles (Blostein et al., 2009; Greene, Williams, & Wright, 2010). The number of meth labs seized by ISP included all meth incidents, such as labs, "dump sites," and "chemical and glassware" seizures. In 2016, a total of 862 seized labs (91% of all meth labs seized by ISP), were using the one-pot method, which was a major increase from 2010 (493 seizures, or 37%) (ISP, 2017). Map 8.1 (page 134) shows the number of meth labs seized by ISP in each county in 2016.

Figure 8.11 Number of Clandestine Methamphetamine Labs Seized and Number of Arrests Made at Methamphetamine Labs by the Indiana State Police (Indiana Meth Lab Statistics, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of Lab Seizures	820	1,059	1,343	1,346	1,363	1,663	1,721	1,466	1,452	943
Number of Arrests	534	739	1,031	1,212	1,328	1,448	1,507	1,263	1,087	622

Source: ISP, 2017

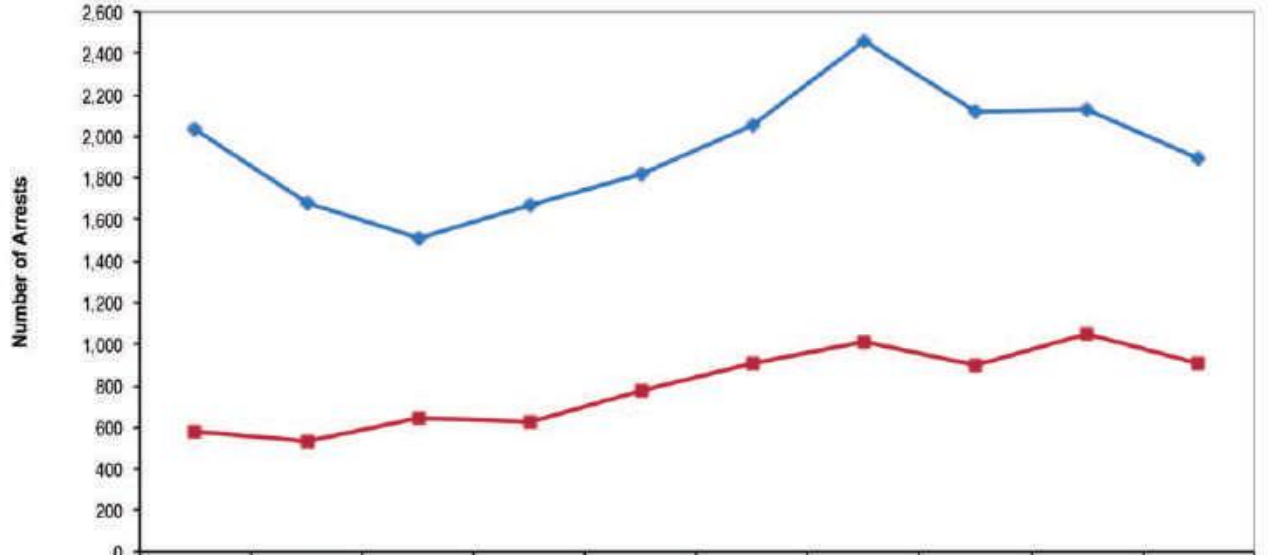
Methamphetamine is classified as a synthetic stimulant. The Uniform Crime Reporting (UCR) Program collects information on crimes associated with synthetic drug possession and sale/manufacture, defining "synthetic" to include a number of drugs in addition to methamphetamine, such as Demerol and methadone. According to 2014 results, 1,895 Hoosiers were arrested for possession of synthetic drugs, which represents an arrest rate of 0.3 (95% CI: 0.3–0.3) per 1,000 population; the U.S. rate was 0.2 (95% CI: 0.2–0.2). Additionally, 909 arrests were made in Indiana for the sale and manufacture of synthetic drugs. Indiana and U.S. arrest rates were the same, 0.1 (95% CI: 0.1–0.1) per 1,000 population (see Figures 8.12 and 8.13) (Federal Bureau of Investigation (FBI), 2014).

Maps 8.2 and 8.3 (pages 135 and 136), and Appendix 8C (pages 132–133) show arrest data for synthetic drug possession and sale/manufacture by county. Caution should be exercised when interpreting these data due to variations in reporting procedures and a lack of data to identify meth-specific arrests. In Indiana, reporting by county and local law enforcement jurisdictions is sometimes incomplete; therefore, a portion of these data is based on estimates. (For more details, see the discussion of UCR data in Chapter 2, "Methods.")

Social Consequences

In addition to the health-related and criminal consequences, meth use and abuse can have serious social impacts, affecting children and families in ways similar to other forms of substance abuse, such as contributing to increased interpersonal conflicts, violence, financial problems, and poor parenting (Sommers, Baskin, & Baskin-Sommers, 2006). Other social impacts of meth use include incarceration of parents and placement of children in protective custody. According to ISP data, the number of children who were taken from meth lab homes in Indiana peaked in 2013 (440 children), but dropped to 153 in 2016. (see Figure 8.14) (ISP, 2017).

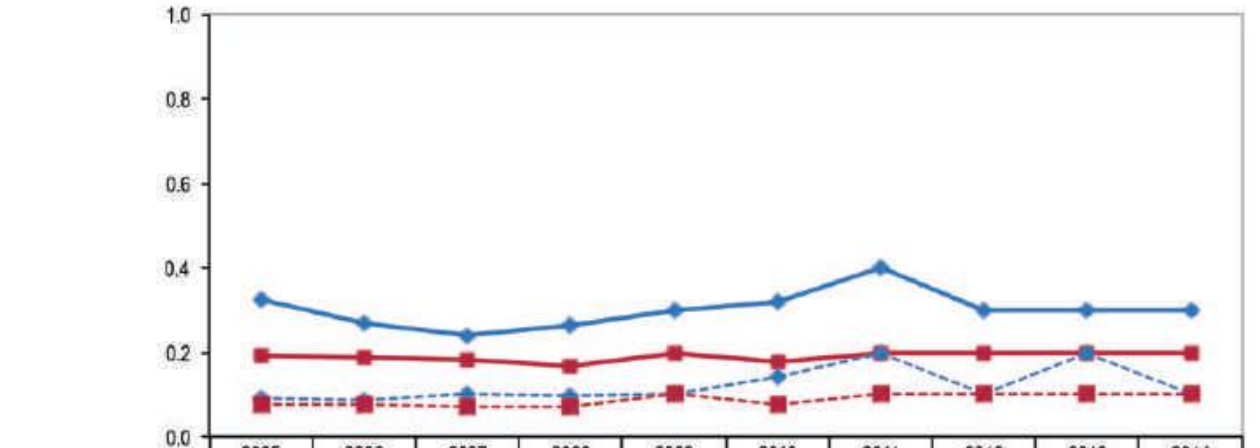
Figure 8.12 Number of Arrests for Synthetic Drug Possession and Sale/Manufacture in Indiana (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Possession	2,034	1,683	1,511	1,671	1,824	2,058	2,458	2,122	2,131	1,895
Sale	581	529	649	628	777	908	1,008	896	1,047	909

Source: FBI, 2014

Figure 8.13 Arrest Rates for Synthetic Drug Possession and Sale/Manufacture per 1,000 Population, Indiana and United States (Uniform Crime Reporting Program, 2005–2014)

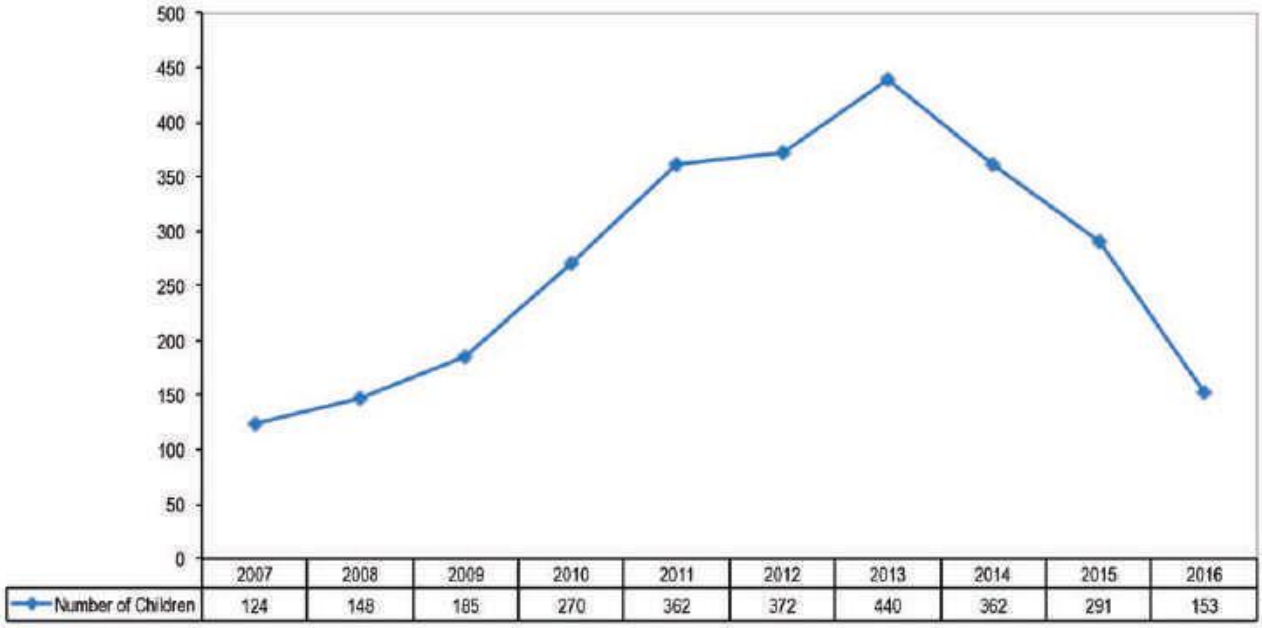


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
IN Possession	0.3	0.3	0.2	0.3	0.3	0.3	0.4	0.3	0.3	0.3
U.S. Possession	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
IN Sale	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.1
U.S. Sale	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1

Source: FBI, 2014

In addition to the health-related and criminal consequences, meth use and abuse can have serious social impacts on children and families in ways similar to other forms of substance abuse. These include contributing to increased interpersonal conflicts, violence, financial problems, and poor parenting (Sommers, Baskin, & Baskin-Sommers, 2006). Other social effects of meth use include incarceration of parents and placement of children in protective custody. According to ISP data, the number of children who were taken from meth lab homes in Indiana peaked in 2013 (440 children), but dropped to 153 in 2016. (see Figure 8.14) (ISP, 2017).

Figure 8.14 Number of Indiana Children Taken by the Indiana State Police from Methamphetamine Lab Homes (Indiana Meth Lab Statistics, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of Children	124	148	185	270	362	372	440	362	291	153

Source: ISP, 2017

APPENDIX 8A

Percentage of Indiana Students Reporting Monthly Methamphetamine Use, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
7th Grade	0.1	0.2	0.2	0.0	0.0	0.1	0.1	0.1	0.1
8th Grade	0.1	0.2	0.1	0.0	0.2	0.2	0.3	0.1	0.1
9th Grade	0.2	0.3	0.1	0.0	0.1	0.4	0.3	0.2	0.2
10th Grade	0.3	0.3	0.4	0.0	0.2	0.5	0.5	0.2	0.3
11th Grade	0.5	0.7	0.5	0.4	0.2	0.5	0.5	0.4	0.4
12th Grade	0.7	0.5	0.7	0.0	0.7	0.5	2.2*	0.6	0.6

Notes: * Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).
Beginning in 2015, the Indiana Youth Survey stopped asking 6th grade students about methamphetamine use.
Source: Gassman et al., 2016

APPENDIX 8B

Number of Treatment Episodes with Methamphetamine Use and Dependence Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Meth Use		Meth Dependence	
County	**Total**	**Number**	**%**	**Number**	**%**
Adams	295	44	14.9%	20	6.8%
Allen	1,618	137	8.5%	66	4.1%
Bartholomew	581	309	53.2%	203	34.9%
Benton	50	<5	N/A	<5	N/A
Blackford	82	8	9.8%	<5	N/A
Boone	187	22	11.8%	14	7.5%
Brown	83	27	32.5%	13	15.7%
Carroll	84	23	27.4%	15	17.9%
Cass	253	54	21.3%	21	8.3%
Clark	313	31	9.9%	20	6.4%
Clay	181	62	34.3%	37	20.4%
Clinton	227	34	15.0%	13	5.7%
Crawford	45	20	44.4%	10	22.2%
Daviess	169	64	37.9%	50	29.6%
Dearborn	449	17	3.8%	9	2.0%
Decatur	212	86	40.6%	49	23.1%
DeKalb	242	85	35.1%	50	20.7%
Delaware	1,138	200	17.6%	98	8.6%
Dubois	280	59	21.1%	18	6.4%
Elkhart	654	128	19.6%	77	11.8%
Fayette	234	35	15.0%	13	5.6%
Floyd	117	13	11.1%	9	7.7%
Fountain	48	17	35.4%	11	22.9%
Franklin	166	32	19.3%	17	10.2%
Fulton	143	34	23.8%	12	8.4%
Gibson	295	104	35.3%	72	24.4%
Grant	436	20	4.6%	10	2.3%
Greene	204	59	28.9%	27	13.2%
Hamilton	893	34	3.8%	12	1.3%
Hancock	193	16	8.3%	8	4.1%
Harrison	31	<5	N/A	<5	N/A
Hendricks	351	60	17.1%	35	10.0%
Henry	330	42	12.7%	19	5.8%
Howard	610	117	19.2%	47	7.7%
Huntington	147	27	18.4%	13	8.8%
Jackson	298	139	46.6%	99	33.2%
Jasper	105	28	26.7%	14	13.3%
Jay	188	32	17.0%	17	9.0%
Jefferson	366	126	34.4%	82	22.4%
Jennings	223	114	51.1%	62	27.8%
Johnson	275	44	16.0%	30	10.9%
Knox	298	109	36.6%	75	25.2%
Kosciusko	381	115	30.2%	67	17.6%
LaGrange	186	84	45.2%	50	26.9%
Lake	2,339	21	0.9%	6	0.3%
LaPorte	377	9	2.4%	5	1.3%
Lawrence	485	179	36.9%	103	21.2%
Madison	1,278	178	13.9%	83	6.5%
Marion	3,645	296	8.1%	135	3.7%
Marshall	205	48	23.4%	17	8.3%
Martin	62	24	38.7%	14	22.6%
Miami	272	74	27.2%	31	11.4%
Monroe	1,180	298	25.3%	159	13.5%
Montgomery	374	86	23.0%	39	10.4%
Morgan	482	180	37.3%	111	23.0%
Newton	33	6	18.2%	<5	N/A
Noble	307	152	49.5%	91	29.6%
Ohio	40	<5	N/A	<5	N/A
Orange	160	51	31.9%	22	13.8%
Owen	199	75	37.7%	44	22.1%
Parke	67	20	29.9%	10	14.9%
Perry	102	32	31.4%	15	14.7%
Pike	53	16	30.2%	11	20.8%
Porter	410	<5	N/A	<5	N/A
Posey	170	64	37.6%	34	20.0%
Pulaski	109	19	17.4%	6	5.5%
Putnam	215	88	40.9%	36	16.7%
Randolph	170	25	14.7%	11	6.5%
Ripley	184	31	16.8%	12	6.5%
Rush	138	49	35.5%	31	22.5%
Saint Joseph	1,231	109	8.9%	59	4.8%
Scott	165	45	27.3%	25	15.2%
Shelby	168	46	27.4%	20	11.9%
Spencer	144	60	41.7%	34	23.6%
Starke	193	56	29.0%	26	13.5%
Steuben	298	79	26.5%	46	15.4%
Sullivan	78	24	30.8%	10	12.8%
Switzerland	63	10	15.9%	5	7.9%
Tippecanoe	404	91	22.5%	47	11.6%
Tipton	70	9	12.9%	8	11.4%
Union	22	<5	N/A	<5	N/A
Vanderburgh	1,319	482	36.5%	267	20.2%
Vermillion	123	53	43.1%	33	26.8%
Vigo	803	328	40.8%	192	23.9%
Wabash	225	53	23.6%	29	12.9%
Warren	9	<5	N/A	<5	N/A
Warrick	267	113	42.3%	72	27.0%
Washington	63	11	17.5%	<5	N/A
Wayne	438	24	5.5%	10	2.3%
Wells	128	24	18.8%	8	6.3%
White	110	33	30.0%	10	9.1%
Whitley	105	33	31.4%	18	17.1%
County Info Missing	27	<5	N/A	<5	N/A
Indiana	**33,170**	**6,533**	**19.7%**	**3,543**	**10.7%**

Notes: We defined methamphetamine dependence as “individuals in substance abuse treatment listing methamphetamine as their primary substance at admission.”
We calculated the percentages by dividing the number of reported methamphetamine use/dependence by the number of treatment episodes.
Information on treatment episodes <5 was suppressed due to confidentiality constraints.
Source: Indiana Family and Social Services Administration, 2016

APPENDIX 8C

Number and Rate, per 1,000 Population, of Arrests for Synthetic Drug Possession and Sale/Manufacture in Indiana, by County (Uniform Crime Reporting Program, 2014)

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Adams	8	0.2	5	0.1
Allen	106	0.3	14	0.0
Bartholomew	52	0.7	31	0.4
Benton	2	0.2	1	0.1
Blackford	33	2.7	10	0.8
Boone	10	0.2	5	0.1
Brown	6	0.4	2	0.1
Carroll	4	0.2	3	0.1
Cass	1	0.0	14	0.4
Clark	111	1.0	30	0.3
Clay	8	0.3	4	0.1
Clinton	9	0.3	2	0.1
Crawford	4	0.4	0	0.0
Daviess	15	0.5	14	0.4
Dearborn	10	0.2	6	0.1
Decatur	7	0.3	8	0.3
DeKalb	26	0.6	40	0.9
Delaware	91	0.8	9	0.1
Dubois	13	0.3	6	0.1
Elkhart	29	0.1	26	0.1
Fayette	9	0.4	4	0.2
Floyd	9	0.1	13	0.2
Fountain	6	0.4	3	0.2
Franklin	1	0.0	0	0.0
Fulton	3	0.1	2	0.1
Gibson	10	0.3	17	0.5
Grant	1	0.0	1	0.0
Greene	5	0.2	0	0.0
Hamilton	88	0.3	18	0.1
Hancock	8	0.1	16	0.2
Harrison	6	0.2	10	0.3
Hendricks	16	0.1	10	0.1
Henry	20	0.4	14	0.3
Howard	11	0.1	5	0.1
Huntington	7	0.2	14	0.4
Jackson	21	0.5	4	0.1
Jasper	5	0.1	6	0.2
Jay	32	1.5	14	0.7
Jefferson	12	0.4	6	0.2
Jennings	0	0.0	7	0.2
Johnson	18	0.1	11	0.1
Knox	10	0.3	7	0.2
Kosciusko	42	0.5	47	0.6
LaGrange	14	0.4	0	0.0
Lake	62	0.1	19	0.0
LaPorte	25	0.2	3	0.0
Lawrence	40	0.9	3	0.1
Madison	71	0.5	16	0.1
Marion	56	0.1	10	0.0

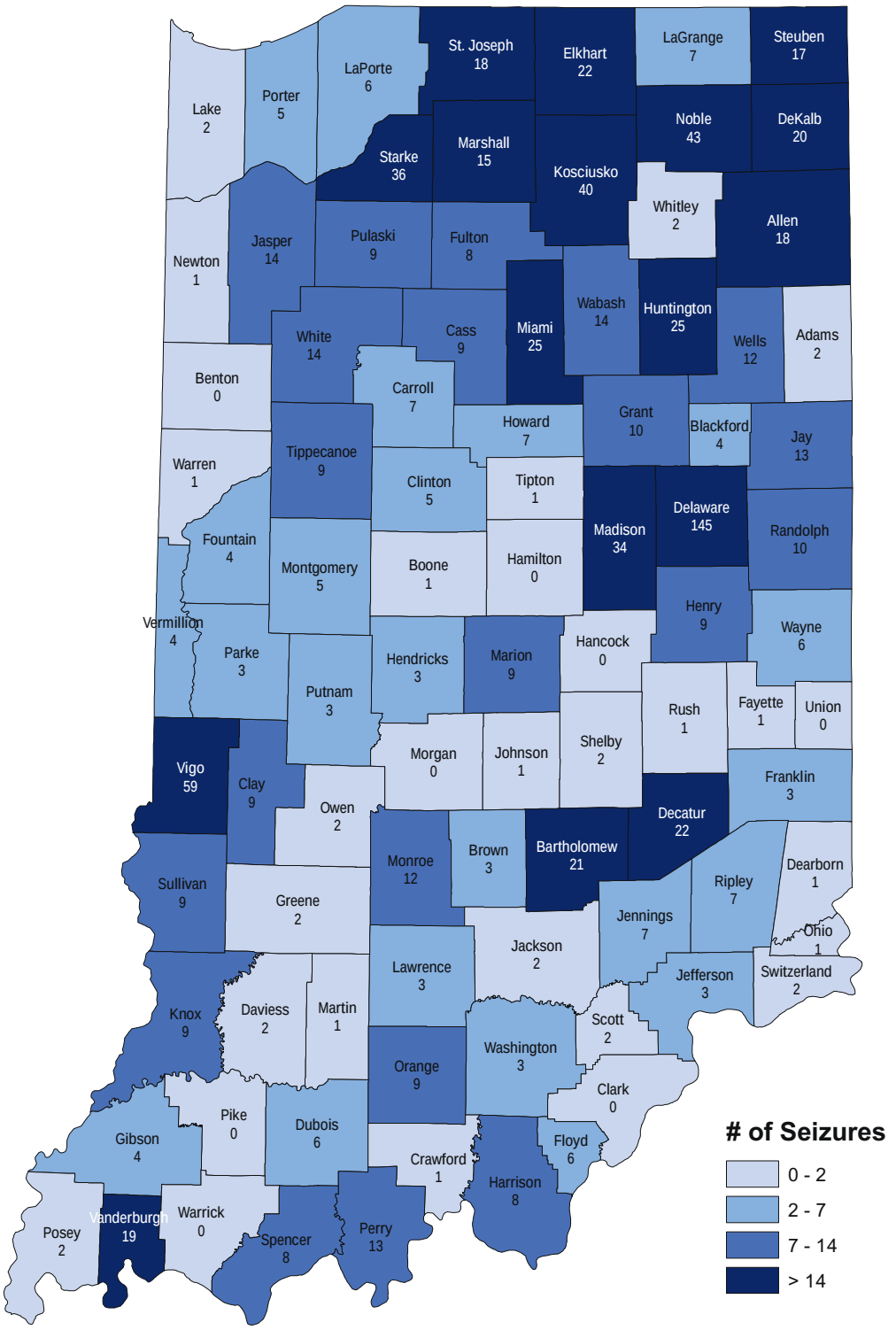
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APPENDIX 8C *(Continued from previous page)*

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Marshall	29	0.6	13	0.3
Martin	3	0.3	0	0.0
Miami	6	0.2	2	0.1
Monroe	30	0.2	1	0.0
Montgomery	2	0.1	0	0.0
Morgan	15	0.2	6	0.1
Newton	9	0.6	3	0.2
Noble	21	0.4	25	0.5
Ohio	1	0.2	1	0.2
Orange	7	0.4	4	0.2
Owen	4	0.2	3	0.1
Parke	32	1.9	12	0.7
Perry	17	0.9	7	0.4
Pike	1	0.1	0	0.0
Porter	3	0.0	1	0.0
Posey	3	0.1	10	0.4
Pulaski	4	0.3	3	0.2
Putnam	10	0.3	5	0.1
Randolph	13	0.5	6	0.2
Ripley	10	0.3	7	0.2
Rush	4	0.2	6	0.4
Saint Joseph	53	0.2	4	0.0
Scott	30	1.3	11	0.5
Shelby	25	0.6	5	0.1
Spencer	7	0.3	4	0.2
Starke	4	0.2	2	0.1
Steuben	2	0.1	21	0.6
Sullivan	2	0.1	1	0.0
Switzerland	4	0.4	2	0.2
Tippecanoe	82	0.5	15	0.1
Tipton	12	0.8	19	1.2
Union	1	0.1	1	0.1
Vanderburgh	127	0.7	97	0.5
Vermillion	4	0.3	1	0.1
Vigo	22	0.2	37	0.3
Wabash	4	0.1	3	0.1
Warren	3	0.4	2	0.2
Warrick	45	0.7	44	0.7
Washington	8	0.3	4	0.1
Wayne	17	0.3	6	0.1
Wells	0	0.0	0	0.0
White	53	2.2	2	0.1
Whitley	13	0.4	3	0.1
Indiana	**1,895**	**0.3**	**909**	**0.1**

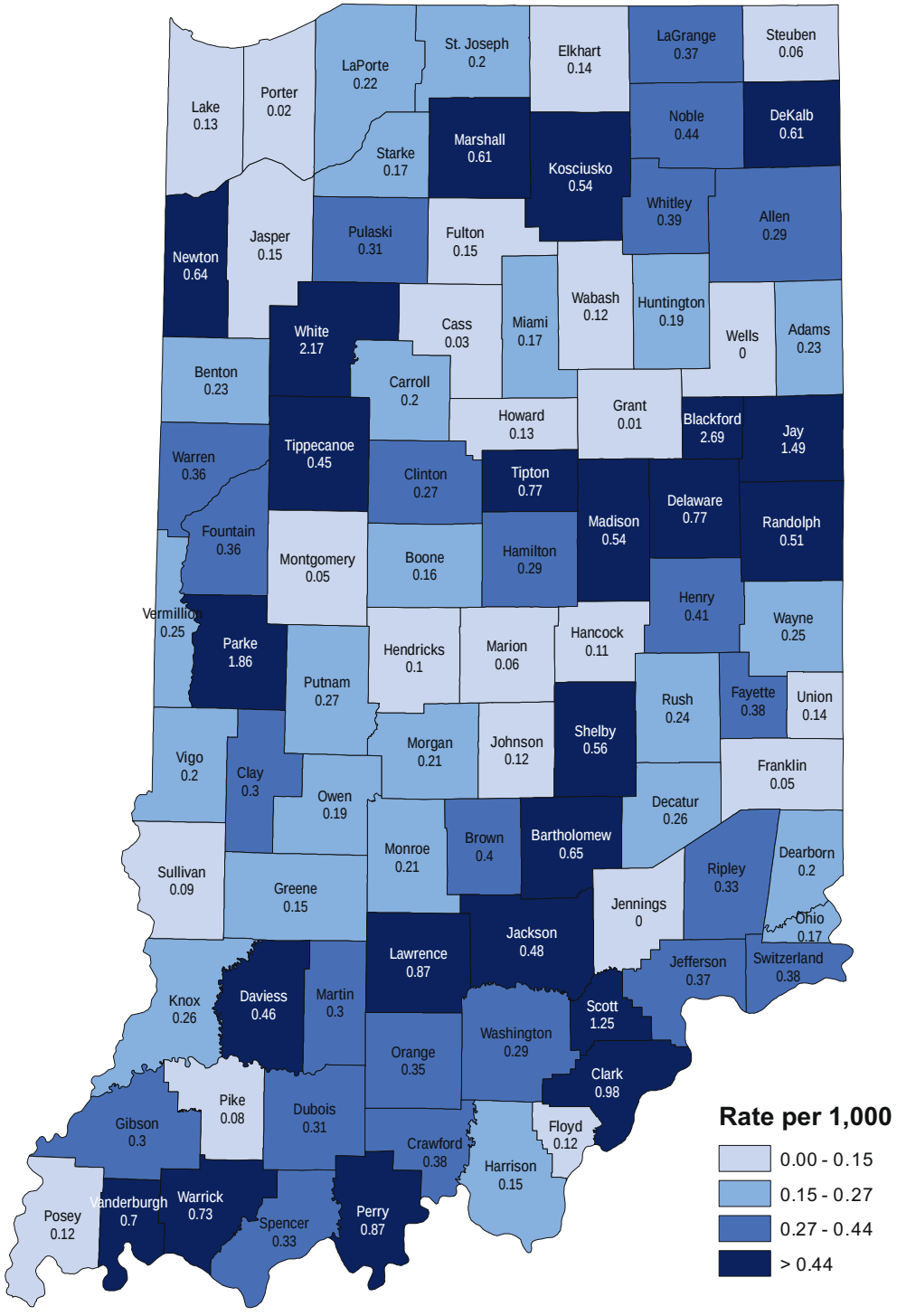
Note: Rates based on arrest numbers lower than 20 are unreliable.
Source: FBI, 2014

Map 8.1 Number of Clandestine Methamphetamine Labs Seized by the Indiana State Police (ISP), by County (Indiana Meth Lab Statistics, 2016)



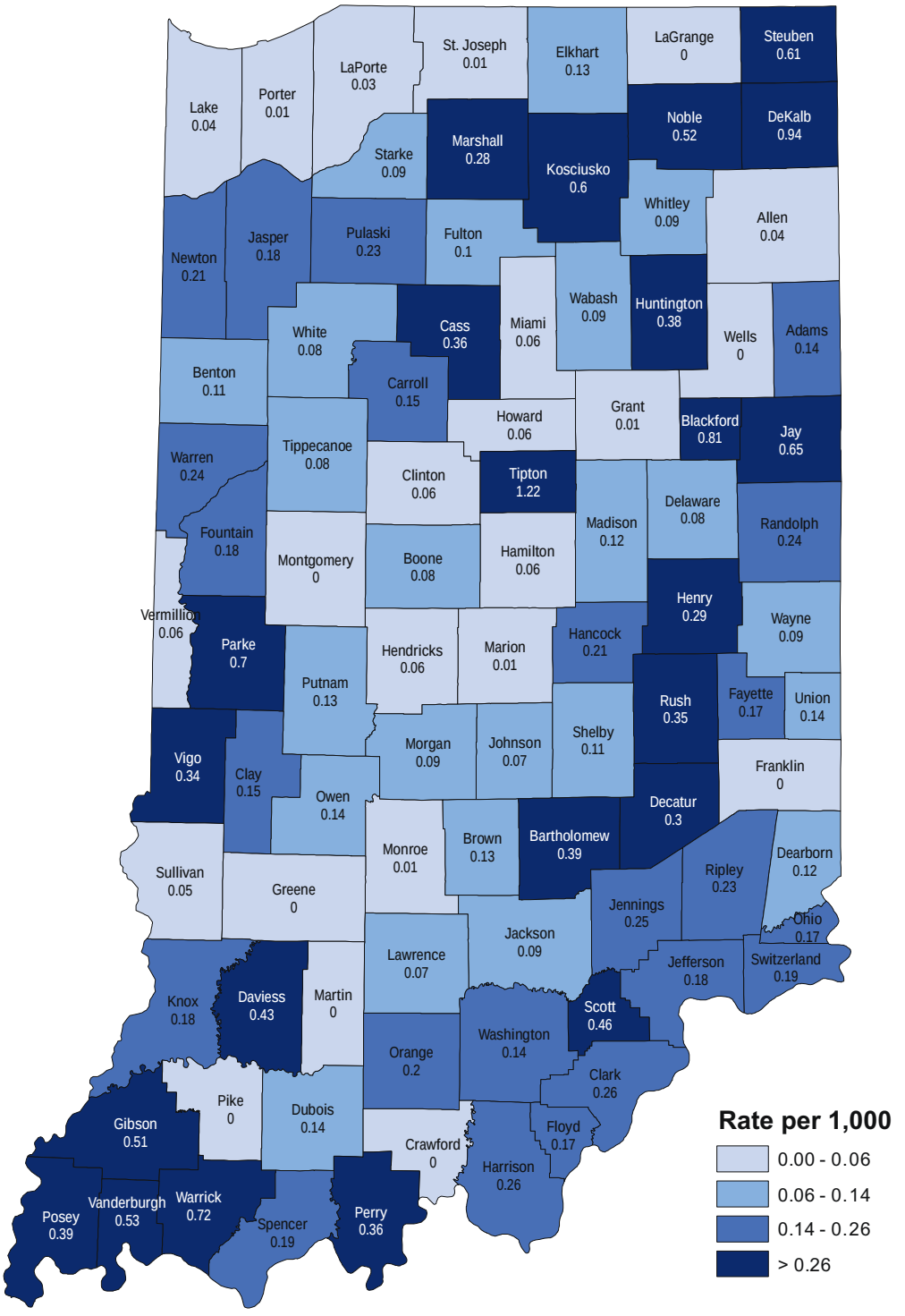
Source: ISP, 2017

Map 8.2 Arrest Rates for Synthetic Drug Possession, per 1,000 Population, in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 8C (pages 132–133) for additional information.
Source: FBI, 2014

Map 8.3 Arrest Rates for Synthetic Drug Sale/Manufacture, per 1,000 Population, in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 8C (pages 132–133) for additional information.
Source: FBI, 2014

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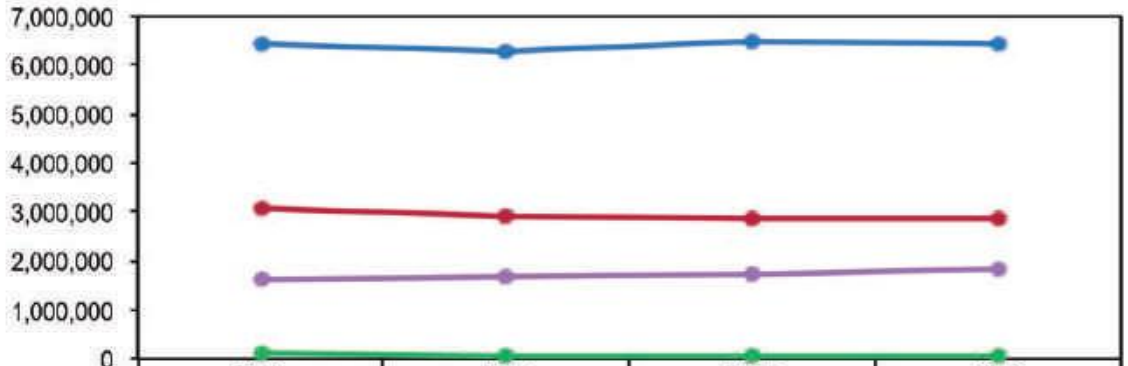
9 Prescription Drug Abuse in Indiana: Consumption Patterns and Consequences

Abuse of prescription drugs[1] is a serious and growing public health problem in the United States. According to the National Survey on Drug Use and Health (NSDUH), in 2015, 18.9 million Americans (7.1%) ages 12 years and older reported misuse[2] of prescription-type psychotherapeutics in the past 12 months. This included pain relievers, sedatives, tranquilizers, and stimulants (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). The National Institute on Drug Abuse (NIDA) lists the three most commonly abused types of prescription medicine as:

- *Opioids*, which are primarily prescribed to treat pain—examples include oxycodone (e.g., OxyContin®, Percocet®), hydrocodone (e.g., Vicodin®), codeine, and morphine;
- *Central nervous system (CNS) depressants*, such as sedatives and tranquilizers to treat sleep and anxiety disorders—examples include barbiturates (e.g., Mebaral®, Nembutal®) and benzodiazepines (e.g., Valium®, Xanax®); and
- *Stimulants,* which are often prescribed to treat narcolepsy and attention-deficit hyperactivity disorder (ADHD)—examples include dextroamphetamine (Dexedrine® and Adderall®) and methylphenidate (Ritalin® and Concerta®) (National Institute on Drug Abuse, 2014).

INSPECT is Indiana's prescription drug monitoring program, collecting information on all controlled substance (DEA Schedules II through V) dispensations within the state. In 2016, more than 11 million prescriptions for controlled substances were filled in Indiana and over half of these were opioids (see Figure 9.1) (Indiana Professional Licensing Agency [IPLA], 2017a). These results describe the legal dispensation of prescription pharmaceuticals; they infer use of the drugs but do not estimate misuse. See Appendix 9A for the number of opioid dispensations by county (page 148).

Figure 9.1 Dispensation of Prescribed Controlled Substances in Indiana (INSPECT, 2013–2016)



	2013	2014	2015	2016
Opioids	6,450,083	6,284,664	6,459,599	6,417,413
Benzodiazepnies	3,068,891	2,925,495	2,842,022	2,867,573
Stimulants	1,607,601	1,646,314	1,715,653	1,812,813
Muscle Relaxants	111,458	85,713	73,685	61,493

Source: IPLA, 2017a

[1]Throughout the report, the term "prescription drugs" refers to controlled substances (Schedules II-V) that are being prescribed by a healthcare professional. Other non-controlled prescriptions, such as blood pressure medication, cholesterol-lowering drugs, etc., are not included.

[2]The terms nonmedical use, misuse, and abuse of prescription drugs are used interchangeably throughout this report and refer to any type of use other than that prescribed by a healthcare professional.

General Consumption Patterns

In 2015, SAMHSA redesigned the questions in the NSDUH pertaining to the use and misuse of prescription drugs. The redesign included changing the definition of prescription drug misuse; revising the list of pertinent prescription drugs to exclude those that have been discontinued or are no longer legally available in the U.S.; adding questions that assess both appropriate use and misuse of prescription medication; and adding items that ask individuals to describe the ways they misuse prescription drugs and the motives driving their misuse. Due to these changes, estimates for 2015 cannot be compared to previous years of the NSDUH, nor can SAMHSA provide state-level estimates of past-year use, as these estimates require the use of two years' worth of data. SAMHSA will provide state-level estimates starting with the 2017 NSDUH (Hughes, Williams, Lipari, & Bose, 2016). In light of the NSDUH redesign, the consumption data presented in this report will continue to rely on data from the 2014 NSDUH.

The 2014 NSDUH estimated that 4.4% (95% Confidence Interval [CI]: 3.6–5.3) of Indiana residents ages 12 and older misused pain relievers in the past year (240,244 Hoosiers). Indiana's prevalence rate was similar to the nation's, at 4.1% (95% CI: 3.9–4.2) (SAMHSA, 2017). For trend information, see Figure 9.2.

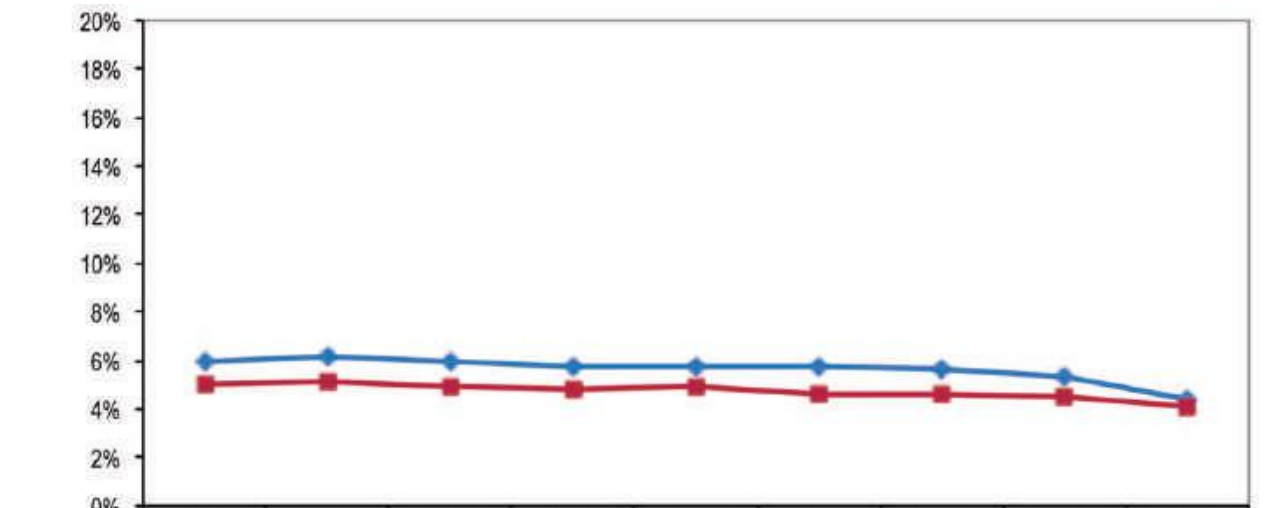
Adult Consumption Patterns

The 2014 NSDUH reports that young people ages 18 through 25 had the highest rate of prescription pain medication abuse. Indiana's past-year usage rate of 9.5% (95% CI: 7.8–11.7) was statistically similar to the nation's rate (8.3%; 95 % CI: 8.0–8.7) (see Figure 9.3).

The Indiana College Substance Use Survey[3] includes questions on the past-month use of prescription stimulants, prescription painkillers, and prescription sedatives not prescribed to the student. Findings from the 2016 survey, which were based on 20 participating colleges and universities, were as follows:

a) Misuse of prescription stimulants:
   - 5.2% of Indiana college students misused prescription stimulants in the past month.
   - Rates were significantly higher in males (7.7%) than females (3.8%).
   - No significant differences were found by age group (college students ages 21 or over compared to those under 21).

Figure 9.2 Prevalence of Past-Year Pain Reliever Use in Indiana and the United States (National Survey on Drug Use and Health, 2006 – 2014)



	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	5.9%	6.2%	6.0%	5.7%	5.7%	5.7%	5.6%	5.3%	4.4%
U.S.	5.0%	5.1%	4.9%	4.8%	4.9%	4.6%	4.6%	4.5%	4.1%

Source: SAMHSA, 2017

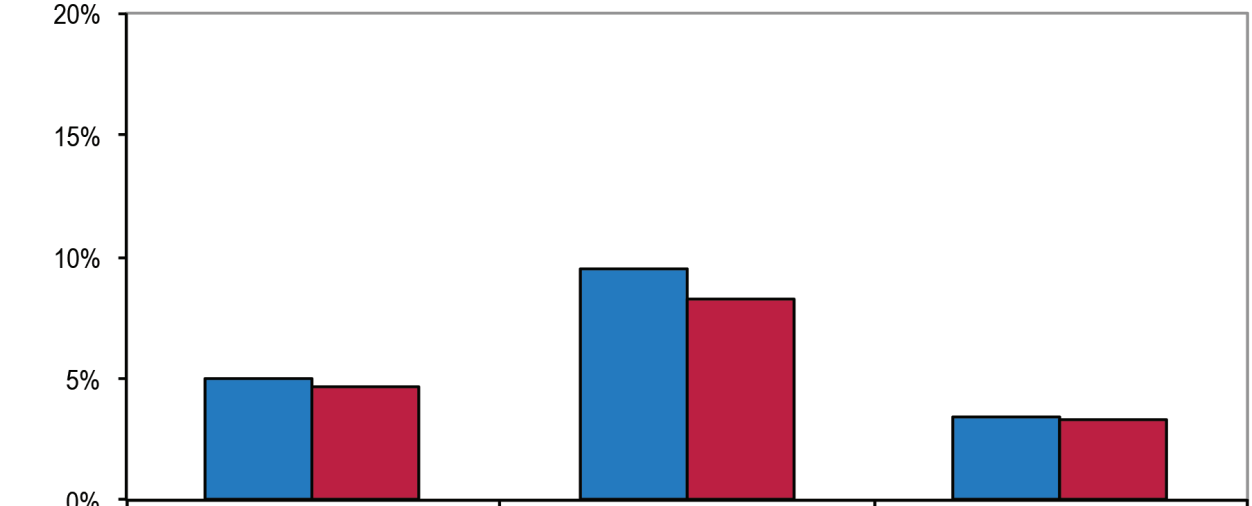
[3]Twenty colleges participated in the 2016 survey; results are based on nonrandom sampling and are not representative of all college students in Indiana.

b) Misuse of prescription painkillers:
- 2.3% of Indiana college students misused prescription painkillers in the past month.
- Rates were significantly higher in males (3.2%) than females (1.7%).
- No significant differences were found by age group (college students ages 21 or over compared to those under 21).

c) Misuse of prescription sedatives:
- 2.2% of Indiana college students misused sedatives in the past month.
- Rates were significantly higher in males (3.4%) than females (1.4%).
- No significant differences were found by age group (college students ages 21 or over compared to those under 21).

(King & Jun, 2016).

Figure 9.3 Prevalence of Past-Year Pain Reliever Use in Indiana and the United States, by Age Group (National Survey on Drug Use and Health, 2014)



	12-17	18-25	26 and older
Indiana	5.0%	9.5%	3.4%
U.S.	4.7%	8.3%	3.3%

Source: SAMHSA, 2014

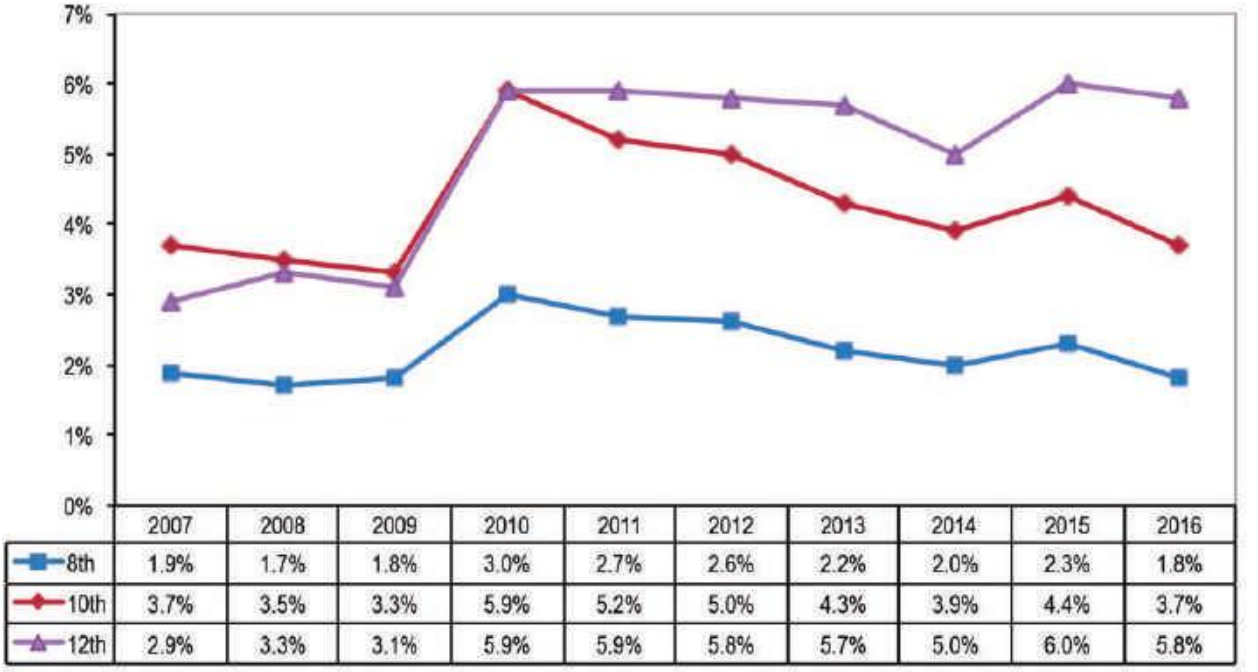
Youth Consumption Patterns

Estimates from the 2014 NSDUH suggest that 4.9% (95% CI: 3.8–6.4) of Indiana's youth ages 12 through 17 used prescription pain medications for nonmedical purposes in the past year. The national rate of prescription drug abuse by 12- to 17-year-olds was similar at 4.6% (95% CI: 4.4–5.0) (SAMHSA, 2014).

For Indiana prevalence rates of current nonmedical use of prescription drugs[4] among 8th, 10th, and 12th grade students, see Figure 9.4 (Gassman et al., 2016). For regional prevalence rates among Indiana students grades 6 through 12, see Appendix 9B, page 149.

[4]Includes Ritalin®, Oxycontin®, and Xanax®.

Figure 9.4 Percentage of Indiana 8th, 10th, and 12th Grade Students Reporting Current Nonmedical Use of Prescription Drugs (Indiana Youth Survey, 2007–2016)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
8th	1.9%	1.7%	1.8%	3.0%	2.7%	2.6%	2.2%	2.0%	2.3%	1.8%
10th	3.7%	3.5%	3.3%	5.9%	5.2%	5.0%	4.3%	3.9%	4.4%	3.7%
12th	2.9%	3.3%	3.1%	5.9%	5.9%	5.8%	5.7%	5.0%	6.0%	5.8%

Source: Gassman et al., 2016

PRESCRIPTION DRUG ABUSE CONSEQUENCES

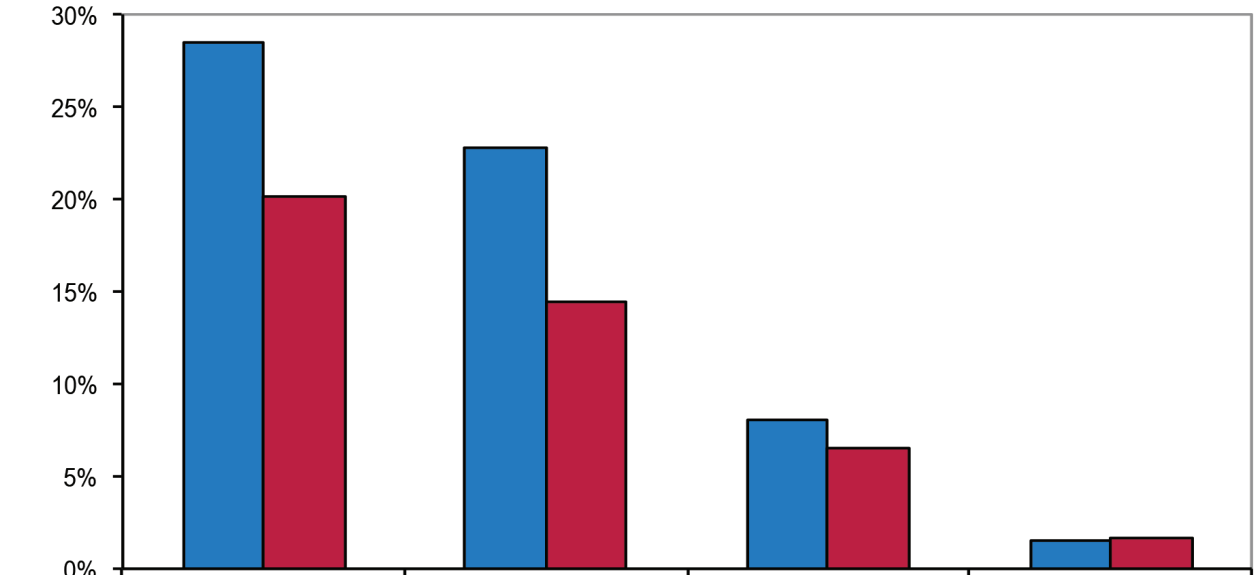
Prescription Drug Abuse and Dependence

Another method of tracking prescription drug abuse is to examine the Treatment Episode Data Set (TEDS) for individuals who report nonmedical use of pain relievers (opioids),[5] CNS depressants (sedatives and tranquilizers),[6] and stimulants[7] at the time of admission to substance abuse treatment.

In nearly 29% of Indiana treatment admissions, some type of prescription drug abuse was reported (U.S.: 20.2%) and in 14.4% of admissions, prescription drug dependence[8] was indicated (U.S.: 9.8%) in 2014. Abuse and dependence of all categories of prescription drugs, except stimulants, were significantly higher in Indiana than the United States (see Figures 9.5 and 9.6) (SAMHSA, 2014).

[5]We used TEDS variables "nonprescription methadone" and "other opiates/synthetics" to define pain reliever use (excludes heroin).
[6]We used TEDS variables "benzodiazepines," "other tranquilizers," "barbiturates," and "other sedatives/hypnotics" to define CNS depressant use.
[7]We used TEDS variables "other amphetamines" and "other stimulants" to define stimulant use.
[8]We defined prescription drug dependence as "individuals in substance abuse treatment listing prescription drugs as their primary substance at admission."

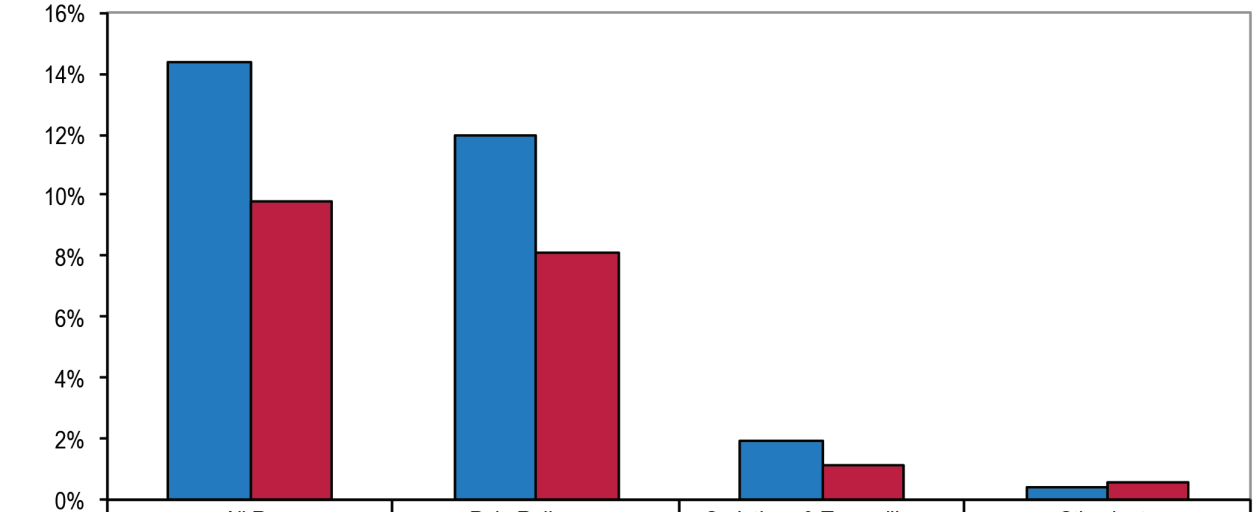
Figure 9.5 Percentage of Indiana and U.S. Treatment Episodes with Prescription Drug Misuse Reported at Treatment Admission, by Drug Category (Treatment Episode Data Set, 2014)



	All Rx	Pain Relievers	Sedatives & Tranquilizers	Stimulants
Indiana	28.5%	22.8%	8.1%	1.5%
U.S.	20.2%	14.5%	6.5%	1.6%

Source: SAMHSA, 2014

Figure 9.6 Percentage of Indiana and U.S. Treatment Episodes with Prescription Drug Dependence Reported at Treatment Admission, by Drug Category (Treatment Episode Data Set, 2014)



	All Rx	Pain Relievers	Sedatives & Tranquilizers	Stimulants
Indiana	14.4%	12.0%	1.9%	0.4%
U.S.	9.8%	8.1%	1.1%	0.6%

Source: SAMHSA, 2014

In Indiana, significant differences were seen by gender, race, ethnicity, and age group. Generally speaking, women, whites, non-Hispanics, and adults between the ages of 18 and 44 had the highest percentages of misuse and dependence across all prescription drug categories (see Table 9.1) (SAMHSA, 2014).

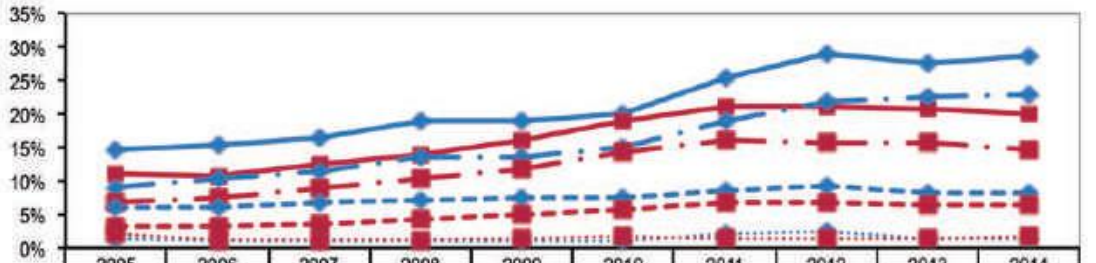
A review of TEDS data from 2005 through 2014 shows that overall, prescription drug abuse and dependence increased significantly from 2005 through 2014, mainly driven by the increase in prescription pain reliever consumption (see Figures 9.7 and 9.8). For county-level information, see Appendix 9C, pages 150-153.

Table 9.1 Percentage of Indiana Treatment Episodes with Prescription Drug Misuse and Dependence Reported at Treatment Admission, by Drug Category, Gender, Race, and Age Group (Treatment Episode Data Set, 2014)

		All Prescription Drugs		Pain Relievers		Sedatives/Tranquilizers		Stimulants	
		Misuse	Dep.	Misuse	Dep.	Misuse	Dep.	Misuse	Dep.
Gender	Male	23.6%	10.8%	18.6%	9.0%	6.6%	1.4%	1.3%	0.3%
	Female	36.3%	20.1%	29.5%	16.8%	10.6%	2.7%	1.7%	0.6%
Race	White	32.1%	16.4%	25.7%	13.6%	9.2%	2.3%	1.7%	0.5%
	Black	7.4%	3.3%	5.8%	2.8%	2.0%	0.5%	0.4%	0.1%
	Other	25.0%	11.5%	20.2%	10.4%	6.4%	0.7%	1.3%	0.4%
Ethnicity	Hispanic	16.4%	7.1%	13.3%	6.1%	4.2%	0.7%	1.0%	0.3%
	Non-Hispanic	29.0%	14.8%	23.2%	12.3%	8.3%	2.0%	1.5%	0.4%
Age Group	Under 18	14.4%	3.8%	8.4%	2.5%	5.2%	1.1%	1.9%	0.3%
	18-24	27.9%	11.2%	20.9%	8.8%	9.0%	2.0%	1.5%	0.4%
	25-34	36.5%	19.2%	30.0%	16.3%	9.8%	2.4%	1.9%	0.6%
	35-44	28.3%	15.7%	23.0%	13.3%	8.1%	1.9%	1.5%	0.5%
	45-54	17.0%	9.7%	14.4%	8.4%	4.5%	1.1%	0.4%	0.2%
	55+	14.9%	9.2%	11.9%	7.6%	4.8%	1.4%	0.7%	0.2%

Source: SAMHSA, 2014

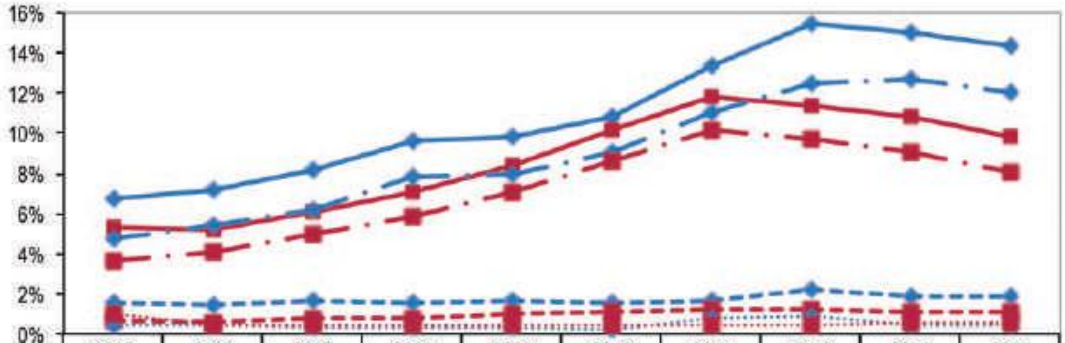
Figure 9.7 Percentage of Indiana and U.S. Treatment Episodes with Prescription Drug Misuse Reported at Treatment Admission, by Drug Category (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
IN: Rx	14.5%	15.5%	16.5%	18.9%	19.1%	20.2%	25.4%	29.1%	27.5%	28.5%
U.S.: Rx	11.0%	10.8%	12.4%	14.0%	16.2%	19.1%	21.0%	21.1%	20.9%	20.2%
IN: Pain Reliever	9.1%	10.2%	11.3%	13.7%	13.6%	15.2%	19.0%	22.0%	22.4%	22.8%
U.S.: Pain Reliever	6.8%	7.5%	8.8%	10.2%	11.9%	14.2%	16.0%	15.9%	15.6%	14.5%
IN: Sed/Tranq	6.0%	6.1%	6.6%	7.3%	7.6%	7.5%	8.4%	9.4%	8.1%	8.1%
U.S.: Sed/Tranq	3.2%	3.2%	3.7%	4.1%	4.9%	5.8%	6.6%	6.6%	6.5%	6.5%
IN: Stimulants	1.4%	1.2%	1.0%	1.0%	1.0%	1.0%	2.2%	2.6%	1.4%	1.5%
U.S.: Stimulants	2.0%	1.2%	1.2%	1.2%	1.3%	1.6%	1.5%	1.5%	1.5%	1.6%

Source: SAMHSA, 2014

Figure 9.8 Percentage of Indiana and U.S. Treatment Episodes with Prescription Drug Dependence Reported at Treatment Admission, by Drug Category (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
IN: Rx	6.7%	7.2%	8.2%	9.6%	9.8%	10.8%	13.4%	15.5%	15.0%	14.4%
U.S.: Rx	5.3%	5.2%	6.1%	7.1%	8.4%	10.2%	11.8%	11.4%	10.8%	9.8%
IN: Pain Reliever	4.7%	5.4%	6.2%	7.8%	7.9%	9.1%	11.0%	12.5%	12.7%	12.0%
U.S.: Pain Reliever	3.6%	4.1%	5.0%	5.9%	7.1%	8.6%	10.1%	9.7%	9.1%	8.1%
IN: Sed/Tranq	1.6%	1.4%	1.7%	1.6%	1.7%	1.5%	1.7%	2.2%	1.9%	1.9%
U.S.: Sed/Tranq	0.7%	0.6%	0.8%	0.8%	1.0%	1.1%	1.2%	1.2%	1.1%	1.1%
IN: Stimulants	0.4%	0.4%	0.3%	0.3%	0.3%	0.2%	0.8%	0.9%	0.5%	0.4%
U.S.: Stimulants	1.0%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%	0.6%	0.6%

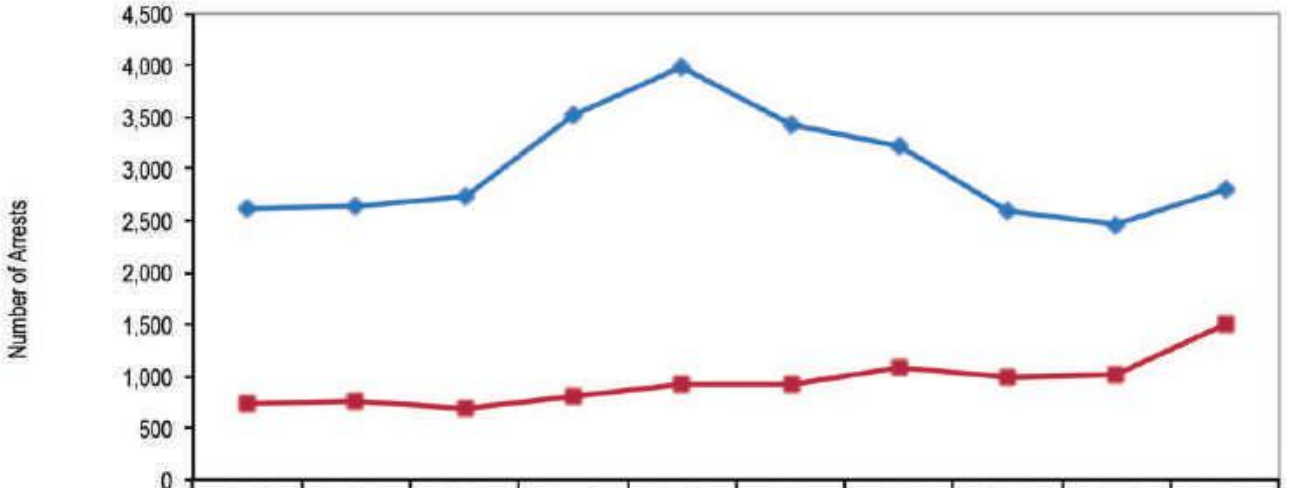
Source: SAMHSA, 2014

Criminal Consequences

Individuals illegally obtain prescription drugs through a variety of means, such as "doctor shopping" (going to a number of doctors to obtain prescriptions for a controlled pharmaceutical) or other prescription fraud; illegal online pharmacies; theft and burglary (from residences and pharmacies); and receiving/purchasing the medication from friends, family members, and dealers (Inciardi et al., 2009, 2010; McCabe & Boyd, 2005). Patients may also obtain controlled substances when physicians overprescribe, either negligently or intentionally (Manchikanti et al., 2012).

The Uniform Crime Reporting (UCR) Program collects information on criminal activities, including possession and sale/manufacture of various drugs (Federal Bureau of Investigation [FBI], 2014). The "other drugs" category in the data set refers to arrests involving barbiturates (sedatives) and Benzedrine (amphetamine/stimulant). In 2014, over 2,800 arrests were made for possession and nearly 1,500 arrests for sale/manufacture of "other drugs" in Indiana. This represents arrest rates of 0.4 (95% CI: 0.4–0.4) and 0.2 (95% CI: 0.1–0.2) per 1,000 population, respectively. The U.S. rates per 1,000 population were statistically higher for possession of "other drugs," at 0.9 per 1,000 population (95% CI: 0.9–0.9). However, the rates per 1,000 population were the same for sale/manufacture of "other drugs," at 0.2 per 1,000 population (95% CI: 0.2–0.2) (see Figures 9.9 and 9.10) (FBI, 2014). The distribution of arrest rates for possession and sale/manufacture in Indiana by county for 2014 is depicted on Maps 9.1 and 9.2, pages 156 and 157, and in Appendix 9D, pages 154-155.

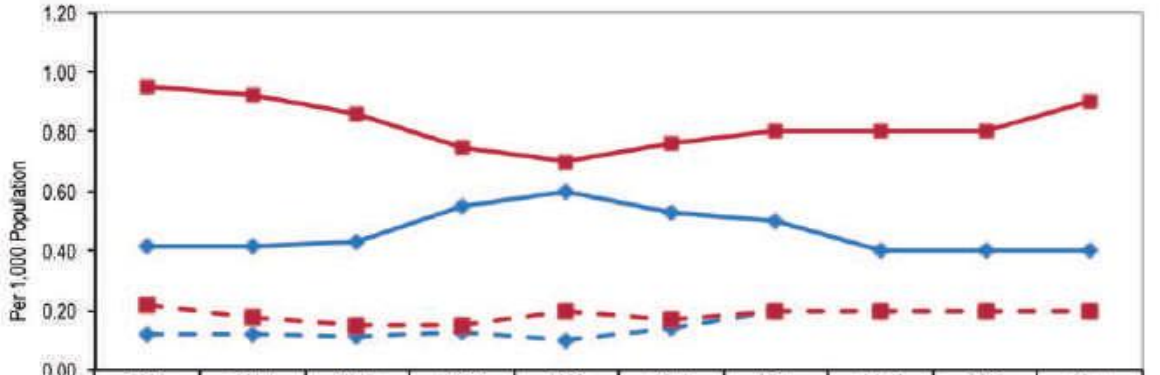
Figure 9.9 Number of Arrests for Possession and Sale/Manufacture of "Other Drugs" (Barbiturates and Benzedrine) in Indiana (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Possession	2,620	2,643	2,720	3,511	3,994	3,426	3,227	2,590	2,464	2,805
Sale	746	767	690	815	930	931	1,074	1,000	1,026	1,495

Source: FBI, 2014

Figure 9.10 Arrest Rates, per 1,000 Population, for Possession and Sale/Manufacture of "Other Drugs" (Barbiturates and Benzedrine) in Indiana and the United States (Uniform Crime Reporting Program, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
IN Possession	0.4	0.4	0.4	0.6	0.6	0.5	0.5	0.4	0.4	0.4
U.S. Possession	0.9	0.9	0.9	0.8	0.7	0.8	0.8	0.8	0.8	0.9
IN Sale	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
U.S. Sale	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2

Source: FBI, 2014

Indiana has been hit hard by pharmacy burglaries, ranking first in the nation in 2015 with 175 robberies. According to data from the Indiana Professional Licensing agency, the number of robberies decreased to 75 in 2016, reflecting 106,921 total doses of controlled substances that were stolen and a purchase value of $246,138 (see Table 9.2) (IPLA, 2017b).

Fatal Drug Overdoses

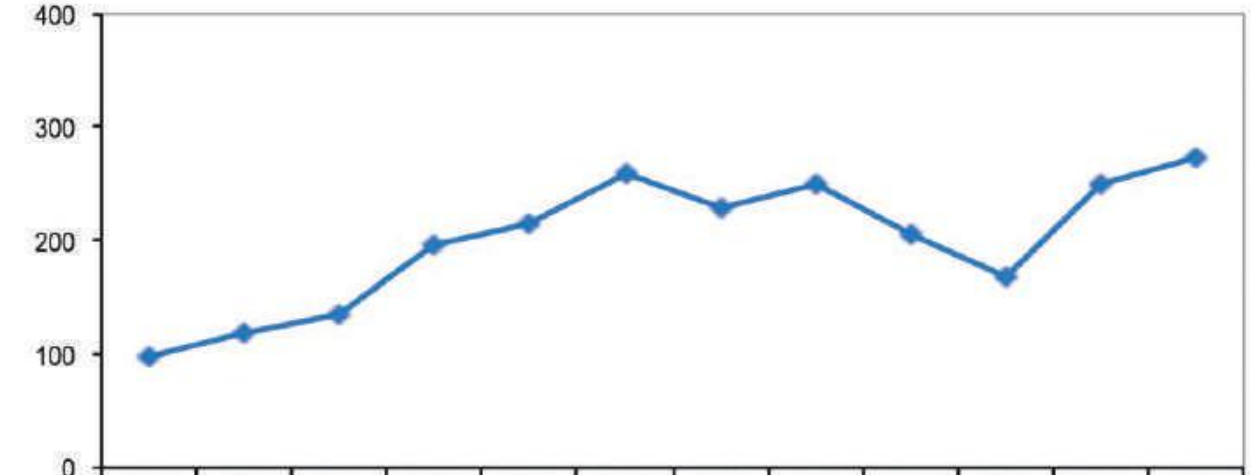
Drug poisonings (overdoses) are a serious problem in the United States. The number of overdose deaths increased from 281 in 2002 to 1,245 in 2014 (Centers for Disease Control and Prevention [CDC], 2017a).[9] The majority of overdose fatalities involve an opioid. According to the CDC, an estimated 91 Americans die every day from an opioid overdose (CDC, 2017b). The number of overdose deaths involving a prescription opioid nearly tripled in Indiana, from 98 in 2004 to 274 in 2015 (see Figure 9.11) (Indiana State Department of Health [ISDH], 2017). For drug overdose mortality rates, by county, from 2002–2015, see Map 9.3 on page 158.

Table 9.2 Pharmacy Robberies in Indiana (Summary Report 2016)

	2013	2014	2015	2016
Number of Robberies	71	80	175	75
Purchase Value of Stolen Drugs	$202,133	$293,079	$479,785	$246,138
Number of Doses Stolen				
Oxycodone	6,457	50,525	113,807	46,325
Hydrocodone	4,159	14,702	40,452	25,737
Others	1,735	10,502	29,442	34,859
Total	**12,351**	**75,729**	**183,701**	**106,921**

Source: IPLA, 2017b

Figure 9.11 Number of Drug Overdose Deaths Involving Opioid Pain Relievers in Indiana (Overdose Mortality, 2004–2015)



Source: ISDH, 2017

[9]Includes ICD-10 causes of death: X40-X44, X60-X64, X85, Y10-Y14

APPENDIX 9A

Number of Prescription Opioids Dispensed in Indiana, by County (INSPECT, 2016)

County	Opioids
Adams	23,779
Allen	283,006
Bartholomew	82,209
Benton	7,434
Blackford	22,025
Boone	50,544
Brown	8,675
Carroll	14,084
Cass	35,282
Clark	134,118
Clay	28,458
Clinton	36,976
Crawford	15,008
Daviess	29,781
Dearborn	38,450
Decatur	46,949
DeKalb	26,408
Delaware	136,125
Dubois	37,835
Elkhart	148,768
Fayette	33,489
Floyd	80,777
Fountain	20,308
Franklin	16,994
Fulton	20,139
Gibson	39,923
Grant	87,349
Greene	40,922
Hamilton	172,537
Hancock	70,528
Harrison	43,181
Hendricks	110,099
Henry	67,701
Howard	106,500
Huntington	36,965
Jackson	47,747
Jasper	39,427
Jay	16,865
Jefferson	39,940
Jennings	33,747
Johnson	142,623
Knox	54,621
Kosciusko	66,673
LaGrange	127,250
Lake	19,071
LaPorte	412,600
Lawrence	66,783
Madison	175,546
Marion	816,813
Marshall	40,900
Martin	14,732
Miami	36,458
Monroe	96,470
Montgomery	41,439
Morgan	84,222
Newton	12,078
Noble	44,787
Ohio	6,876
Orange	25,049
Owen	28,478
Parke	13,263
Perry	18,157
Pike	17,775
Porter	165,582
Posey	26,960
Pulaski	17,116
Putnam	34,676
Randolph	28,644
Ripley	31,438
Rush	18,192
Saint Joseph	38,004
Scott	44,047
Shelby	20,052
Spencer	236,701
Starke	36,620
Steuben	28,446
Sullivan	24,899
Switzerland	10,230
Tippecanoe	124,251
Tipton	15,042
Union	5,580
Vanderburgh	222,659
Vermillion	16,492
Vigo	103,911
Wabash	39,305
Warren	5,668
Warrick	60,794
Washington	29,691
Wayne	78,626
Wells	23,852
White	26,658
Whitley	33,218
Out of State	177,354
Indiana	**6,241,070**

Source: Indiana Professional Licensing Agency, 2017

APPENDIX 9B

Percentage of Indiana Students Reporting Monthly Nonmedical Prescription Drug Use, by Region and Grade (Indiana Youth Survey, 2016)

	Indiana	Northwest	North Central	Northeast	West	Central	East	Southwest	Southeast
6th Grade	1.7	2.0	1.4	0.5	1.9	1.4	1.2	1.8	2.4*
7th Grade	1.6	1.6	2.0	1.8	0.7*	1.9	1.9	1.6	1.4
8th Grade	2.2	3.0*	2.2	3.1	2.5	2.1	2.5	1.7	1.5*
9th Grade	3.1	3.6	3.3	2.8	2.6	2.8	3.4	3.0	2.5
10th Grade	3.9	5.5*	4.3	4.6	4.0	3.0*	4.9*	2.7*	2.8*
11th Grade	4.9	6.6*	6.6*	4.3	4.8	4.4	4.6	3.7*	3.7*
12th Grade	6.0	7.0	7.0	2.6	7.0	6.1	6.6	4.7*	4.9*

Notes: Includes Ritalin®, Oxycontin®, and Xanax®.

* Indicates a local rate that is significantly different from the overall state rate ($P < 0.05$).

Beginning in 2015, lifetime prevalence is no longer available by region.

Source: Gassman et al., 2016

APPENDIX 9C — PART 1

Number of Treatment Episodes with Prescription Drug (Rx) Abuse and Dependence Reported at Treatment Admission in Indiana, by County and Drug Category (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

County	Treatment Episodes Total	All Rx Abuse Number	All Rx Abuse %	All Rx Dependence Number	All Rx Dependence %	Opioid Abuse Number	Opioid Abuse %	Opioid Dependence Number	Opioid Dependence %
Adams	295	74	25.1%	25	8.5%	63	21.4%	24	8.1%
Allen	1,618	329	20.3%	136	8.4%	270	16.7%	121	7.5%
Bartholomew	581	179	30.8%	77	13.3%	150	25.8%	65	11.2%
Benton	50	13	26.0%	6	12.0%	8	16.0%	<5	8.0%
Blackford	82	38	46.3%	17	20.7%	31	37.8%	15	18.3%
Boone	187	44	23.5%	30	16.0%	41	21.9%	28	15.0%
Brown	83	17	20.5%	11	13.3%	13	15.7%	8	9.6%
Carroll	84	16	19.0%	6	7.1%	11	13.1%	5	6.0%
Cass	253	56	22.1%	23	9.1%	49	19.4%	23	9.1%
Clark	313	114	36.4%	96	30.7%	97	31.0%	83	26.5%
Clay	191	39	21.5%	13	7.2%	31	17.1%	12	6.6%
Clinton	227	57	25.1%	31	13.7%	42	18.5%	25	11.0%
Crawford	45	20	44.4%	11	24.4%	18	40.0%	10	22.2%
Daviess	169	47	27.8%	19	11.2%	32	18.9%	17	10.1%
Dearborn	449	207	46.1%	94	20.9%	184	41.0%	86	19.2%
Decatur	212	60	28.3%	25	11.8%	52	24.5%	21	9.9%
DeKalb	242	44	18.2%	14	5.8%	33	13.6%	12	5.0%
Delaware	1,138	426	37.4%	247	21.7%	366	32.2%	225	19.8%
Dubois	280	80	28.6%	33	11.8%	53	18.9%	24	8.6%
Elkhart	654	103	15.7%	54	8.3%	82	12.5%	46	7.0%
Fayette	234	121	51.7%	57	24.4%	106	45.3%	50	21.4%
Floyd	117	40	34.2%	34	29.1%	39	33.3%	34	29.1%
Fountain	48	17	35.4%	8	16.7%	17	35.4%	6	12.5%
Franklin	166	57	34.3%	23	13.9%	54	32.5%	23	13.9%
Fulton	143	33	23.1%	9	6.3%	27	18.9%	8	5.6%
Gibson	295	58	19.7%	20	6.8%	42	14.2%	13	4.4%
Grant	436	162	37.2%	77	17.7%	124	28.4%	65	14.9%
Greene	204	61	29.9%	30	14.7%	47	23.0%	23	11.3%
Hamilton	893	208	23.3%	85	9.5%	157	17.6%	77	8.6%
Hancock	193	46	23.8%	27	14.0%	31	16.1%	20	10.4%
Harrison	31	9	29.0%	7	22.6%	7	22.6%	7	22.6%
Hendricks	351	90	25.6%	50	14.2%	73	20.8%	44	12.5%
Henry	330	185	56.1%	137	41.5%	169	51.2%	120	36.4%
Howard	610	211	34.6%	85	13.9%	171	28.0%	75	12.3%
Huntington	147	66	44.9%	32	21.8%	57	38.8%	28	19.0%
Jackson	298	106	35.6%	51	17.1%	84	28.2%	42	14.1%
Jasper	105	39	37.1%	14	13.3%	34	32.4%	12	11.4%
Jay	188	54	28.7%	13	6.9%	41	21.8%	11	5.9%
Jefferson	366	174	47.5%	84	23.0%	154	42.1%	71	19.4%
Jennings	223	73	32.7%	26	11.7%	62	27.8%	21	9.4%
Johnson	275	79	28.7%	34	12.4%	67	24.4%	32	11.6%
Knox	298	105	35.2%	60	20.1%	73	24.5%	44	14.8%
Kosciusko	381	91	23.9%	27	7.1%	74	19.4%	20	5.2%
LaGrange	186	35	18.8%	10	5.4%	19	10.2%	10	5.4%
Lake	2,339	355	15.2%	170	7.3%	251	10.7%	133	5.7%
LaPorte	377	101	26.8%	61	16.2%	87	23.1%	58	15.4%
Lawrence	485	218	44.9%	108	22.3%	173	35.7%	84	17.3%
Madison	1,278	516	40.4%	284	22.2%	436	34.1%	249	19.5%
Marion	3,645	1,011	27.7%	552	15.1%	793	21.8%	497	13.6%
Marshall	205	63	30.7%	33	16.1%	53	25.9%	30	14.6%
Martin	62	18	29.0%	5	8.1%	16	25.8%	<5	N/A
Miami	272	72	26.5%	31	11.4%	62	22.8%	30	11.0%

(continued on next page)

APPENDIX 9C — PART 1 *(Continued from previous page)*

County	Treatment Episodes Total	All Rx Abuse Number	%	All Rx Dependence Number	%	Opioid Abuse Number	%	Opioid Dependence Number	%
Monroe	1,180	365	30.9%	180	15.3%	272	23.1%	147	12.5%
Montgomery	374	101	27.0%	33	8.8%	71	19.0%	26	7.0%
Morgan	482	129	26.8%	64	13.3%	96	19.9%	52	10.8%
Newton	33	8	24.2%	<5	N/A	6	18.2%	<5	N/A
Noble	307	50	16.3%	16	5.2%	33	10.7%	11	3.6%
Ohio	40	12	30.0%	7	17.5%	12	30.0%	7	17.5%
Orange	160	60	37.5%	32	20.0%	49	30.6%	29	18.1%
Owen	199	51	25.6%	28	14.1%	40	20.1%	18	9.0%
Parke	67	13	19.4%	6	9.0%	9	13.4%	5	7.5%
Perry	102	29	28.4%	8	7.8%	20	19.6%	6	5.9%
Pike	53	11	20.8%	<5	N/A	5	9.4%	<5	N/A
Porter	410	144	35.1%	75	18.3%	114	27.8%	69	16.8%
Posey	170	64	37.6%	20	11.8%	38	22.4%	10	5.9%
Pulaski	109	37	33.9%	15	13.8%	33	30.3%	15	13.8%
Putnam	215	40	18.6%	14	6.5%	29	13.5%	11	5.1%
Randolph	170	42	24.7%	17	10.0%	36	21.2%	14	8.2%
Ripley	184	55	29.9%	20	10.9%	48	26.1%	16	8.7%
Rush	138	53	38.4%	20	14.5%	46	33.3%	16	11.6%
Saint Joseph	1,231	185	15.0%	78	6.3%	132	10.7%	64	5.2%
Scott	165	109	66.1%	85	51.5%	104	63.0%	84	50.9%
Shelby	168	53	31.5%	20	11.9%	38	22.6%	16	9.5%
Spencer	144	41	28.5%	15	10.4%	28	19.4%	8	5.6%
Starke	193	103	53.4%	56	29.0%	84	43.5%	54	28.0%
Steuben	298	31	10.4%	11	3.7%	18	6.0%	8	2.7%
Sullivan	78	29	37.2%	18	23.1%	23	29.5%	15	19.2%
Switzerland	63	22	34.9%	12	19.0%	21	33.3%	12	19.0%
Tippecanoe	404	119	29.5%	39	9.7%	86	21.3%	32	7.9%
Tipton	70	27	38.6%	15	21.4%	26	37.1%	14	20.0%
Union	22	12	54.5%	6	27.3%	7	31.8%	<5	N/A
Vanderburgh	1,319	426	32.3%	205	15.5%	318	24.1%	169	12.8%
Vermillion	123	31	25.2%	19	15.4%	25	20.3%	14	11.4%
Vigo	803	139	17.3%	80	10.0%	93	11.6%	56	7.0%
Wabash	225	68	30.2%	30	13.3%	60	26.7%	26	11.6%
Warren	9	5	55.6%	<5	N/A	<5	N/A	<5	N/A
Warrick	267	87	32.6%	48	18.0%	70	26.2%	41	15.4%
Washington	63	22	34.9%	14	22.2%	16	25.4%	12	19.0%
Wayne	438	114	26.0%	53	12.1%	89	20.3%	43	9.8%
Wells	128	57	44.5%	20	15.6%	52	40.6%	19	14.8%
White	110	27	24.5%	<5	N/A	23	20.9%	<5	N/A
Whitley	105	30	28.6%	13	12.4%	21	20.0%	10	9.5%
County Info Missing	27	5	18.5%	<5	N/A	<5	N/A	<5	N/A
Indiana	**33,170**	**9,443**	**28.5%**	**4,620**	**13.9%**	**7,524**	**22.7%**	**3,961**	**11.9%**

Notes: We defined prescription drug dependence as “individuals in substance abuse treatment listing prescription drugs as their primary substance at admission.”

We calculated the percentages by dividing the number of reported prescription drug use/dependence by the number of treatment episodes.

Information on treatment episodes <5 was suppressed due to confidentiality constraints.

Source: Indiana Family and Social Services Administration, 2016

APPENDIX 9C — PART 2

County	CNS Depressant Abuse Number	CNS Depressant Abuse %	CNS Depressant Dependence Number	CNS Depressant Dependence %	Stimulant Abuse Number	Stimulant Abuse %	Stimulant Dependence Number	Stimulant Dependence %
Adams	8	2.7%	<5	N/A	5	1.7%	<5	N/A
Allen	71	4.4%	9	0.6%	24	1.5%	6	0.4%
Bartholomew	40	6.9%	8	1.4%	7	1.2%	<5	N/A
Benton	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Blackford	14	17.1%	<5	N/A	<5	N/A	<5	N/A
Boone	5	2.7%	<5	N/A	<5	N/A	<5	N/A
Brown	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Carroll	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Cass	8	3.2%	<5	N/A	7	2.8%	<5	N/A
Clark	22	7.0%	9	2.9%	6	1.9%	<5	N/A
Clay	13	7.2%	<5	N/A	<5	N/A	<5	N/A
Clinton	22	9.7%	<5	N/A	5	2.2%	<5	N/A
Crawford	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Daviess	18	10.7%	<5	N/A	<5	N/A	<5	N/A
Dearborn	39	8.7%	8	1.8%	9	2.0%	<5	N/A
Decatur	12	5.7%	<5	N/A	<5	N/A	<5	N/A
DeKalb	11	4.5%	<5	N/A	5	2.1%	<5	N/A
Delaware	93	8.2%	14	1.2%	19	1.7%	8	0.7%
Dubois	32	11.4%	7	2.5%	7	2.5%	<5	N/A
Elkhart	18	2.8%	5	0.8%	10	1.5%	<5	N/A
Fayette	24	10.3%	7	3.0%	<5	1.7%	<5	N/A
Floyd	<5	N/A	<5	N/A	<5	0.9%	<5	N/A
Fountain	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Franklin	7	4.2%	<5	N/A	<5	N/A	<5	N/A
Fulton	5	3.5%	<5	N/A	<5	N/A	<5	N/A
Gibson	17	5.8%	<5	N/A	6	2.0%	<5	N/A
Grant	53	12.2%	11	2.5%	22	5.0%	<5	N/A
Greene	11	5.4%	<5	N/A	8	3.9%	<5	N/A
Hamilton	55	6.2%	7	0.8%	12	1.3%	<5	N/A
Hancock	19	9.8%	5	2.6%	<5	N/A	<5	N/A
Harrison	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Hendricks	21	6.0%	<5	N/A	5	1.4%	<5	N/A
Henry	47	14.2%	15	4.5%	7	2.1%	<5	N/A
Howard	51	8.4%	8	1.3%	7	1.1%	<5	N/A
Huntington	12	8.2%	<5	N/A	5	3.4%	<5	N/A
Jackson	25	8.4%	7	2.3%	5	1.7%	<5	N/A
Jasper	14	13.3%	<5	N/A	<5	N/A	<5	N/A
Jay	17	9.0%	<5	N/A	<5	N/A	<5	N/A
Jefferson	38	10.4%	10	N/A	8	N/A	<5	N/A
Jennings	10	4.5%	<5	N/A	5	N/A	<5	N/A
Johnson	18	6.5%	<5	N/A	<5	N/A	<5	N/A
Knox	38	12.8%	9	3.0%	11	3.7%	7	2.3%
Kosciusko	20	5.2%	6	1.6%	10	2.6%	<5	N/A
LaGrange	5	2.7%	<5	N/A	13	7.0%	<5	N/A
Lake	125	5.3%	33	1.4%	12	0.5%	<5	N/A
LaPorte	15	4.0%	<5	N/A	5	1.3%	<5	N/A
Lawrence	67	13.8%	22	4.5%	9	1.9%	<5	N/A
Madison	163	12.8%	27	2.1%	20	1.6%	8	0.6%
Marion	301	8.3%	43	1.2%	37	1.0%	12	0.3%
Marshall	10	4.9%	<5	N/A	7	3.4%	<5	N/A
Martin	5	8.1%	<5	N/A	<5	N/A	<5	N/A
Miami	9	3.3%	<5	N/A	8	2.9%	<5	N/A
Monroe	108	9.2%	27	2.3%	24	2.0%	6	0.5%
Montgomery	27	7.2%	6	1.6%	11	N/A	<5	N/A

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APPENDIX 9C — PART 2 *(Continued from previous page)*

County	CNS Depressant Abuse Number	CNS Depressant Abuse %	CNS Depressant Dependence Number	CNS Depressant Dependence %	Stimulant Abuse Number	Stimulant Abuse %	Stimulant Dependence Number	Stimulant Dependence %
Morgan	41	8.5%	10	2.1%	6	N/A	<5	N/A
Newton	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Noble	9	2.9%	<5	N/A	13	N/A	<5	N/A
Ohio	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Orange	14	8.8%	<5	N/A	<5	N/A	<5	N/A
Owen	13	6.5%	9	4.5%	<5	N/A	<5	N/A
Parke	5	7.5%	<5	N/A	<5	N/A	<5	N/A
Perry	7	6.9%	<5	N/A	5	4.9%	<5	N/A
Pike	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Porter	38	9.3%	5	1.2%	5	1.2%	<5	N/A
Posey	21	12.4%	5	2.9%	11	6.5%	5	2.9%
Pulaski	6	5.5%	<5	N/A	<5	N/A	<5	N/A
Putnam	14	6.5%	<5	N/A	<5	N/A	<5	N/A
Randolph	10	5.9%	<5	N/A	<5	N/A	<5	N/A
Ripley	9	4.9%	<5	N/A	<5	N/A	<5	N/A
Rush	15	10.9%	<5	N/A	<5	N/A	<5	N/A
Saint Joseph	56	4.5%	6	0.5%	21	1.7%	8	0.6%
Scott	16	9.7%	<5	N/A	6	3.6%	<5	N/A
Shelby	20	11.9%	<5	N/A	<5	N/A	<5	N/A
Spencer	15	10.4%	5	3.5%	5	3.5%	<5	N/A
Starke	35	18.1%	<5	N/A	5	2.6%	<5	N/A
Steuben	7	2.3%	<5	N/A	7	2.3%	<5	N/A
Sullivan	5	N/A	<5	N/A	<5	N/A	<5	N/A
Switzerland	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Tippecanoe	35	8.7%	5	1.2%	7	1.7%	<5	N/A
Tipton	8	11.4%	<5	N/A	<5	N/A	<5	N/A
Union	7	31.8%	<5	N/A	<5	N/A	<5	N/A
Vanderburgh	171	13.0%	30	2.3%	26	2.0%	6	0.5%
Vermillion	14	11.4%	<5	N/A	<5	N/A	<5	N/A
Vigo	57	7.1%	20	2.5%	6	0.7%	<5	N/A
Wabash	10	N/A	<5	N/A	<5	N/A	<5	N/A
Warren	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Warrick	24	N/A	5	N/A	6	N/A	<5	N/A
Washington	6	N/A	<5	N/A	<5	N/A	<5	N/A
Wayne	32	N/A	9	N/A	5	N/A	<5	N/A
Wells	6	N/A	<5	N/A	<5	N/A	<5	N/A
White	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Whitley	<5	N/A	<5	N/A	8	N/A	<5	N/A
County Info Missing	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Indiana	**2,531**	**7.6%**	**503**	**1.5%**	**577**	**1.7%**	**156**	**0.5%**

Notes: We defined prescription drug dependence as “individuals in substance abuse treatment listing prescription drugs as their primary substance at admission.”

We calculated the percentages by dividing the number of reported prescription drug use/dependence by the number of treatment episodes.

Information on treatment episodes <5 was suppressed due to confidentiality constraints.

Source: Indiana Family and Social Services Administration, 2016

APPENDIX 9D

Number and Rate, per 1,000 Population, of Arrests for Possession and Sale/Manufacture of "Other Drugs" (including Barbiturates and Benzedrine) in Indiana, by County (Uniform Crime Reporting Program, 2014)

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Adams	17	0.5	11	0.3
Allen	145	0.4	76	0.2
Bartholomew	40	0.5	1	0.0
Benton	4	0.5	2	0.2
Blackford	4	0.3	1	0.1
Boone	16	0.3	8	0.1
Brown	9	0.6	0	.0
Carroll	9	0.4	6	0.3
Cass	96	2.5	125	3.3
Clark	130	1.1	23	0.2
Clay	15	0.6	7	0.3
Clinton	10	0.3	9	0.3
Crawford	5	0.5	0	0.0
Daviess	28	0.9	10	0.3
Dearborn	19	0.4	13	0.3
Decatur	75	2.8	32	1.2
DeKalb	18	0.4	20	.5
Delaware	3	0.0	32	0.3
Dubois	18	0.4	9	0.2
Elkhart	18	0.1	5	0.0
Fayette	13	0.5	13	0.5
Floyd	60	0.8	70	0.9
Fountain	12	0.7	6	0.4
Franklin	11	0.5	6	0.3
Fulton	9	0.4	26	1.3
Gibson	24	0.7	5	0.1
Grant	4	0.1	0	0.0
Greene	12	0.4	9	0.3
Hamilton	52	0.2	24	0.1
Hancock	2	0.0	3	0.0
Harrison	11	0.3	5	0.1
Hendricks	23	0.1	12	0.1
Henry	13	0.3	15	0.3
Howard	83	1.0	21	0.3
Huntington	16	0.4	9	0.2
Jackson	73	1.7	15	0.3
Jasper	11	0.3	14	0.4
Jay	6	0.3	4	0.2
Jefferson	20	0.6	11	0.3
Jennings	8	0.3	8	0.3
Johnson	65	0.4	29	0.2
Knox	21	0.6	13	0.3
Kosciusko	131	1.7	20	0.3
LaGrange	2	0.1	0	0.0
Lake	330	0.7	108	0.2
LaPorte	12	0.1	6	0.1
Lawrence	36	0.8	18	0.4
Madison	39	0.3	42	0.3
Marion	36	0.0	17	0.0

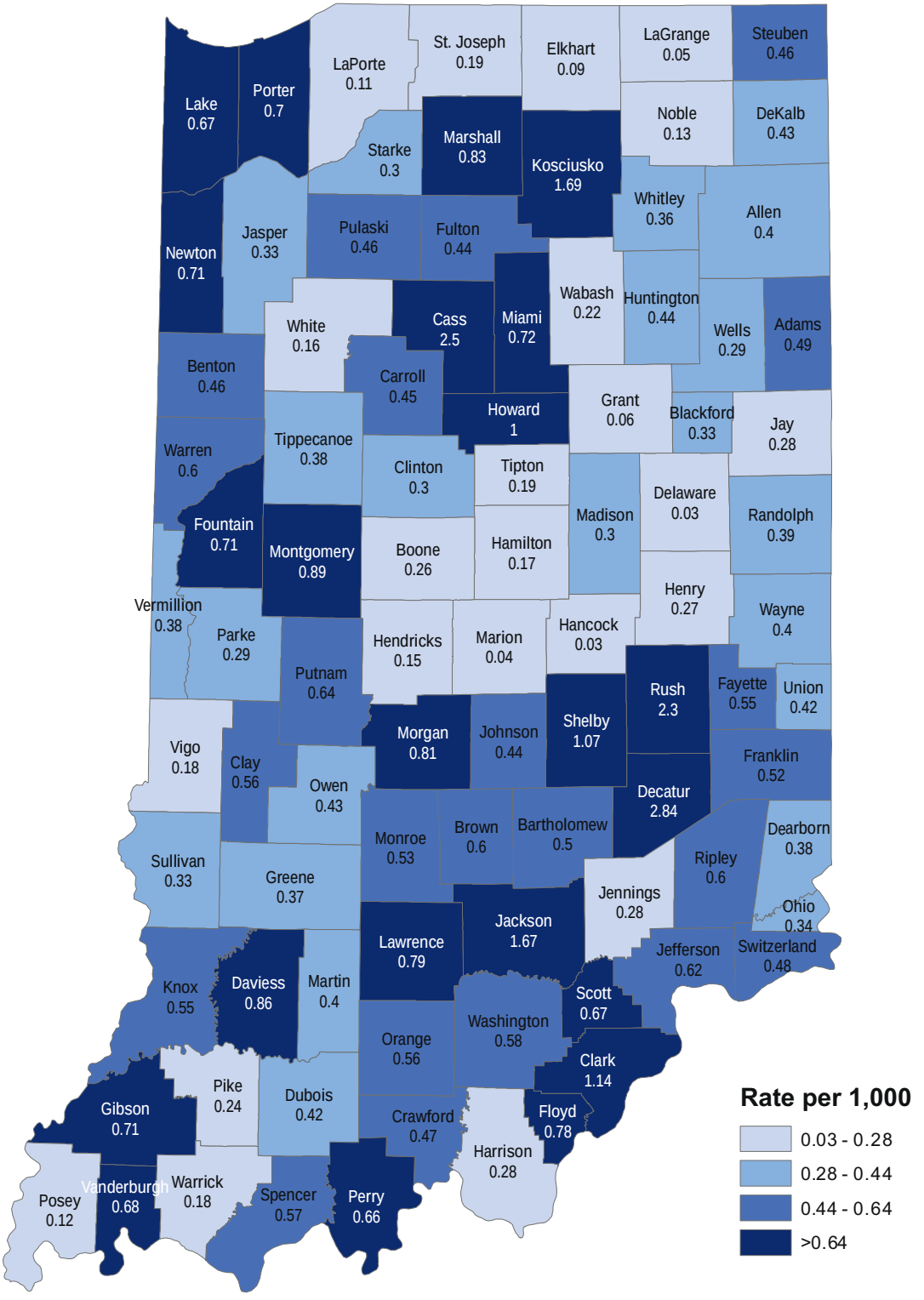
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APPENDIX 9D *(Continued from previous page)*

County	Number of Arrests for Possession	Possession Arrest Rate	Number of Arrests for Sale	Sale Arrest Rate
Marshall	39	0.8	43	0.9
Martin	4	0.4	3	0.3
Miami	26	0.7	39	1.1
Monroe	76	0.5	60	0.4
Montgomery	34	0.9	13	0.3
Morgan	57	0.8	18	0.3
Newton	10	0.7	3	0.2
Noble	6	0.1	2	0.0
Ohio	2	0.3	2	0.3
Orange	11	0.6	14	0.7
Owen	9	0.4	12	0.6
Parke	5	0.3	0	0.0
Perry	13	0.7	7	0.4
Pike	3	0.2	2	0.2
Porter	117	0.7	16	0.1
Posey	3	0.1	3	0.1
Pulaski	6	0.5	5	0.4
Putnam	24	0.6	13	0.3
Randolph	10	0.4	11	0.4
Ripley	18	0.6	17	0.6
Rush	39	2.3	13	0.8
Saint Joseph	52	0.2	27	0.1
Scott	16	0.7	8	0.3
Shelby	48	1.1	24	0.5
Spencer	12	0.6	8	0.4
Starke	7	0.3	9	0.4
Steuben	16	0.5	15	0.4
Sullivan	7	0.3	4	0.2
Switzerland	5	0.5	4	0.4
Tippecanoe	70	0.4	24	0.1
Tipton	3	0.2	0	0.0
Union	3	0.4	3	0.4
Vanderburgh	124	0.7	47	0.3
Vermillion	6	0.4	6	0.4
Vigo	20	0.2	31	0.3
Wabash	7	0.2	2	0.1
Warren	5	0.6	3	0.4
Warrick	11	0.2	29	0.5
Washington	16	0.6	10	0.4
Wayne	27	0.4	9	0.1
Wells	8	0.3	3	0.1
White	4	0.2	6	0.2
Whitley	12	0.4	8	0.2
Indiana	**2,805**	**0.4**	**1,495**	**0.2**

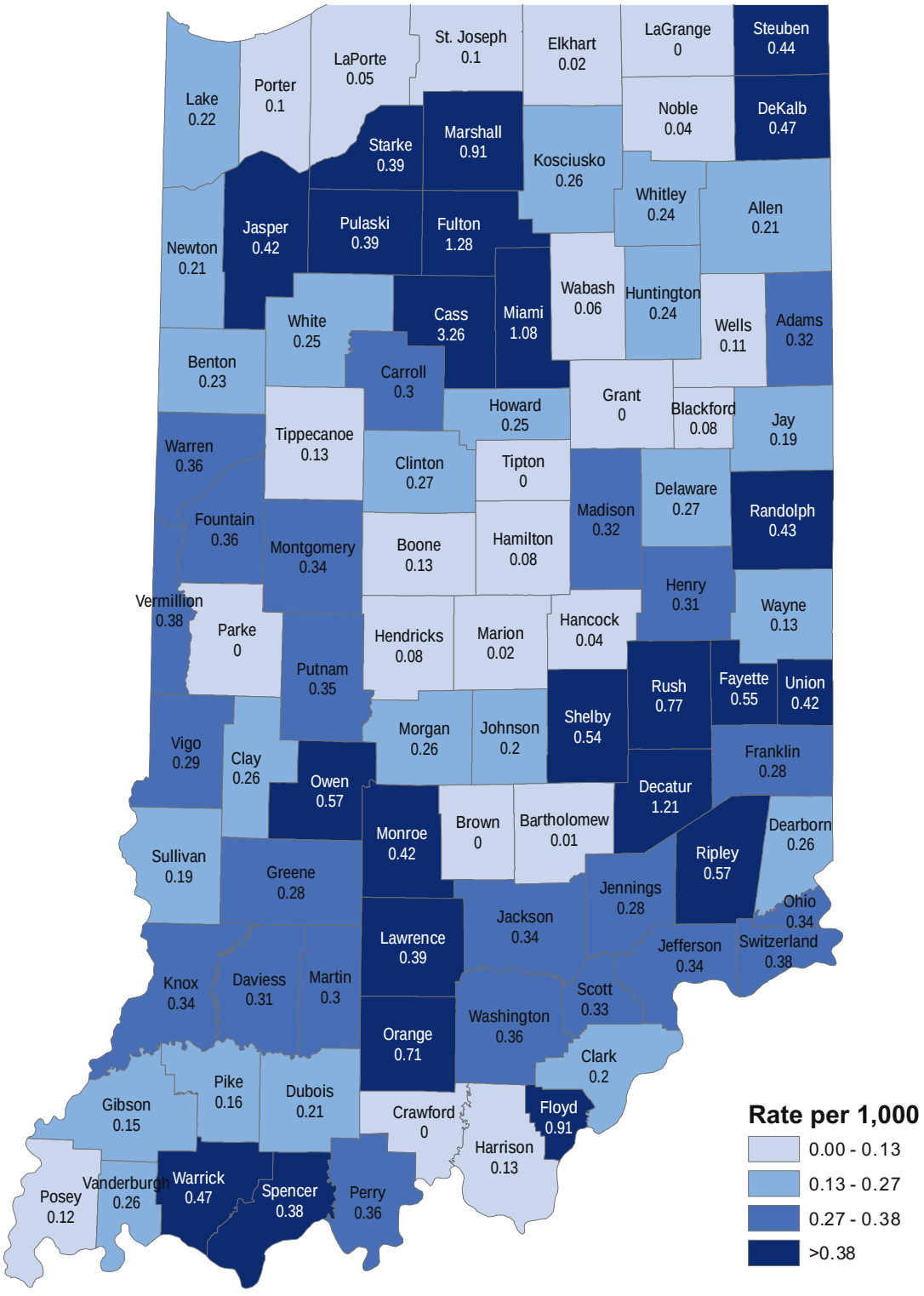
* Rates based on arrest numbers lower than 20 are unreliable.
Source: FBI, 2014

Map 9.1 Arrest Rates, per 1,000 Population, for Possession of "Other Drugs" (Barbiturates and Benzedrine) in Indiana, by County (Uniform Crime Reporting Program, 2014)



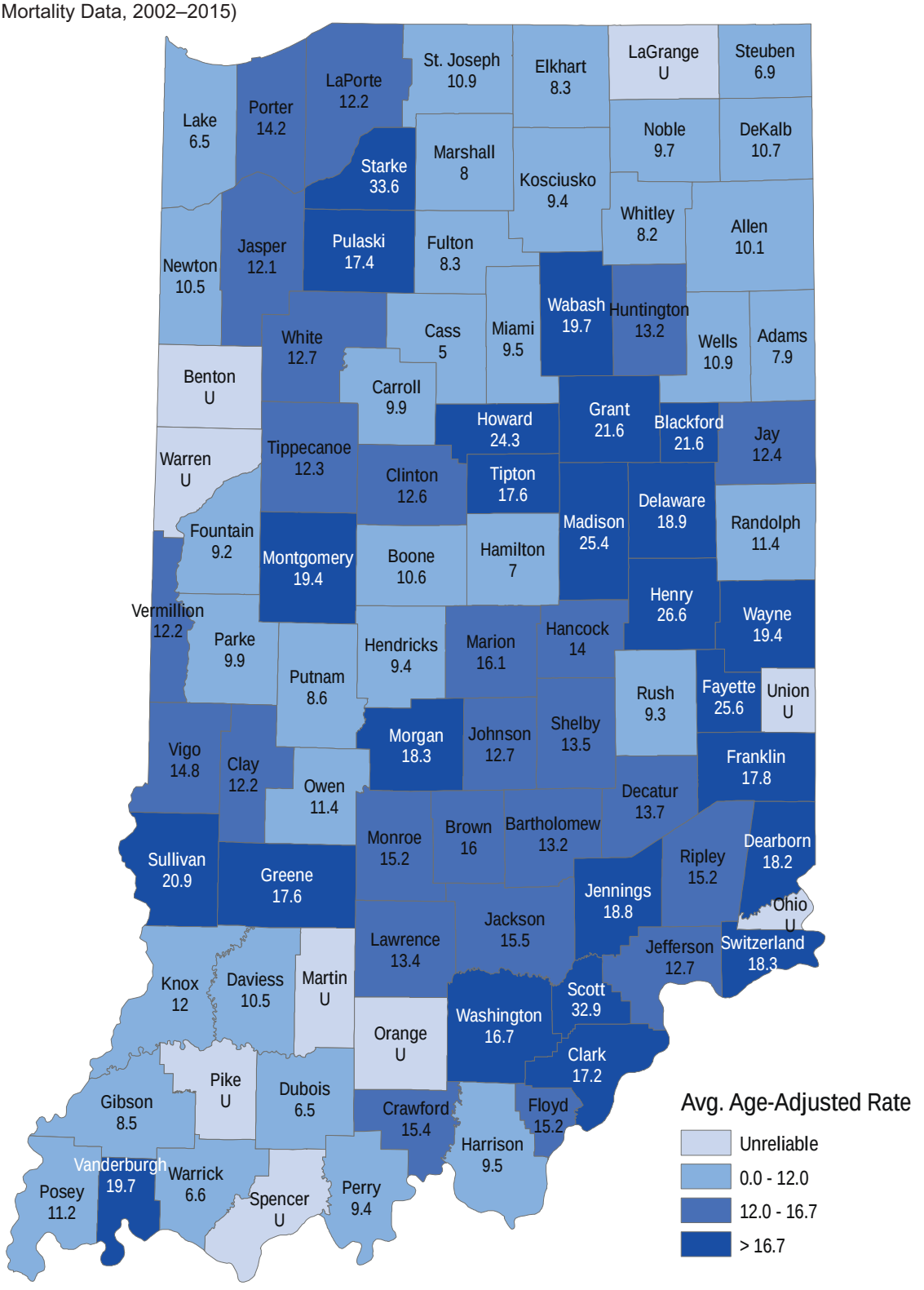
Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 9D (pages 154-155) for additional information.
Source: FBI, 2014

Map 9.2 Arrest Rates, per 1,000 Population, for Sale/Manufacture of "Other Drugs" (Barbiturates and Benzedrine) in Indiana, by County (Uniform Crime Reporting Program, 2014)



Note: Rates based on arrest numbers lower than 20 are unreliable. Please refer to Appendix 9D (pages 154-155) for additional information.
Source: FBI, 2014

Map 9.3 Average Age-Adjusted Prescription Drug Overdose Mortality Rate per 100,000 in Indiana, by County (Indiana Mortality Data, 2002–2015)



Notes: Includes ICD-10 causes of death: X40, X41, X42, X43, X44, X60, X61, X62, X63, X64, Y10, Y11, Y12, Y13, and Y14.
Rates based on number of deaths <20 are not computed, but marked unstable ("U").
Source: CDC, 2017a

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10 Polysubstance Abuse

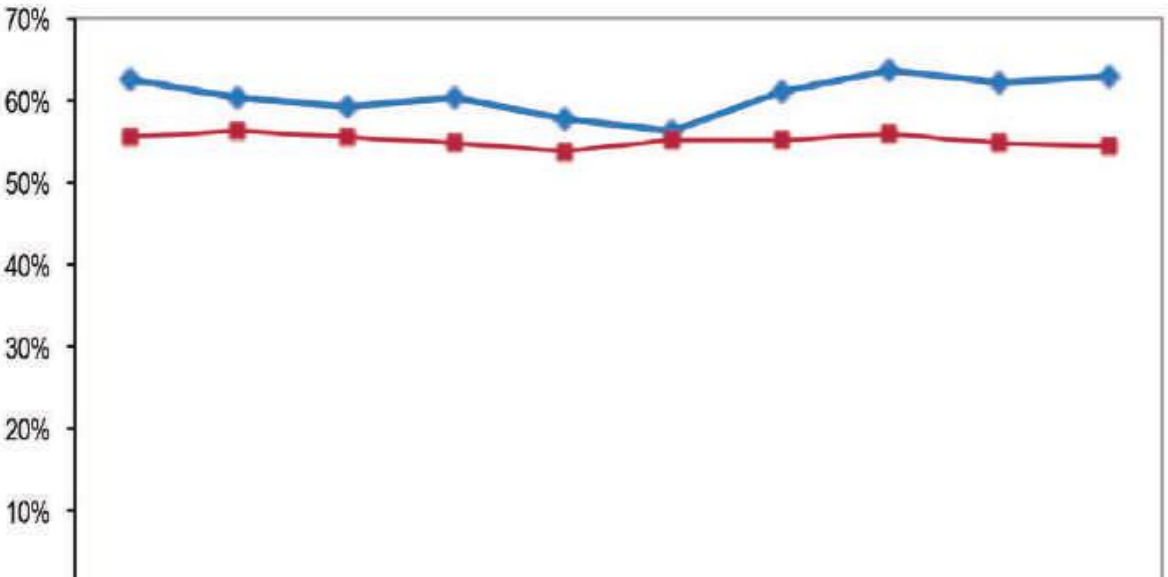
Polysubstance Abuse

Polysubstance abuse refers to substance abuse during which two or more substances are used in combination. It is a particularly serious pattern of drug abuse that appears to be generally established by late adolescence (Collins, Ellickson, & Bell, 1998).

Available data on polysubstance abuse are limited, and all information gathered for this chapter was provided by the Treatment Episode Data Set (TEDS) obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) and the Indiana Family and Social Services Administration (FSSA, 2016). For each treatment admission, the TEDS database allows the recording of a primary, secondary, and tertiary substance of abuse. The SEOW defined polysubstance abuse as any treatment admission where an individual reported using two or more substances. TEDS data for 2005 through 2014 indicate that a large proportion of the treatment population reported using at least two drugs at the time they were admitted to treatment (see Figures 10.1 and 10.2). In 2014, the percentage of polysubstance abuse reported among Indiana's treatment population was significantly higher compared to the rest of the United States (IN: 62.8%; U.S.: 54.3%; $P < .05$). Also, in 29% of Indiana treatment episodes, use of two drugs was reported; in 35%, use of three drugs was mentioned (see Figure 10.2).

County-level treatment data on individuals using two or more substances during 2016 is available in Appendix 10A, pages 170-171.

Figure 10.1 Percentage of Indiana and U.S. Treatment Episodes with Polysubstance Abuse (Use of at Least Two Substances) Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



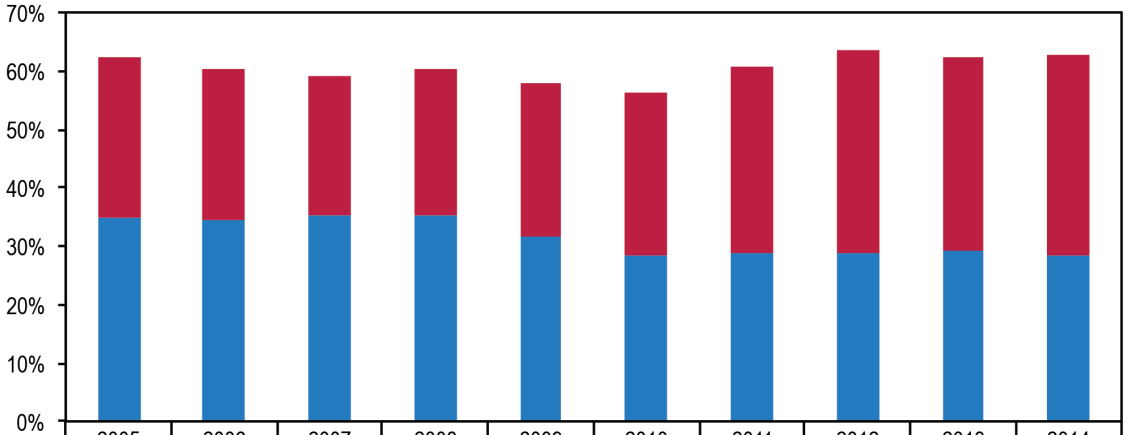
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indiana	62.5%	60.5%	59.2%	60.4%	57.7%	56.2%	60.9%	63.5%	62.3%	62.8%
U.S.	55.4%	56.1%	55.5%	54.6%	53.8%	55.1%	55.1%	55.9%	54.7%	54.3%

Source: SAMHSA, 2014

Demographic Characteristics of Polysubstance Users

Gender—From 2005 through 2014, the percentage of both males and females reporting use of two or more substances at treatment admission fluctuated between 56% and 64% (see Figure 10.3). In 2014, men were more likely to report use of two substances, while women were more likely to report use of three substances (see Figure 10.4).

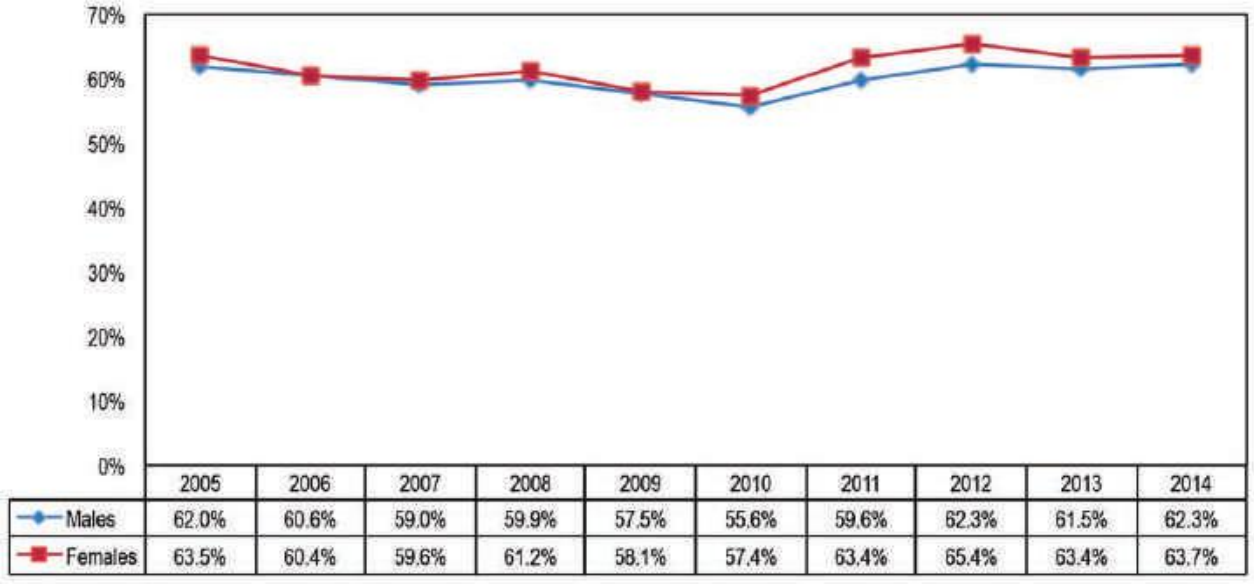
Figure 10.2 Percentage of Indiana Treatment Episodes with Use of Two and Three Substances Reported at Treatment Admission (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
3 Drugs Reported	27.5%	25.9%	23.9%	25.0%	25.9%	27.8%	32.2%	34.8%	33.2%	34.5%
2 Drugs Reported	35.0%	34.6%	35.3%	35.4%	31.8%	28.4%	28.7%	28.7%	29.1%	28.3%

Source: SAMHSA, 2014

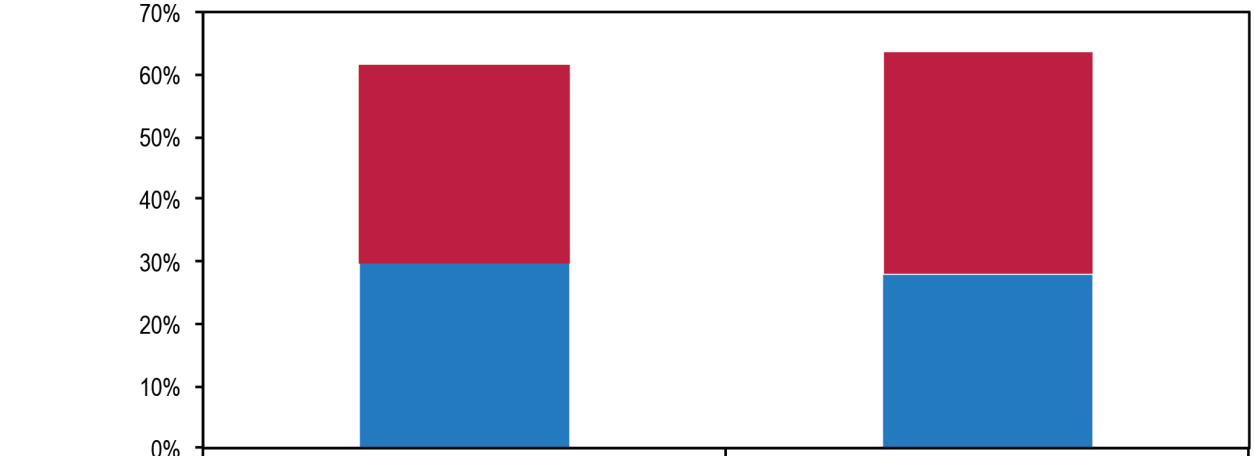
Figure 10.3 Percentage of Indiana Treatment Episodes with Polysubstance Abuse (Use of at Least Two Substances) Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Males	62.0%	60.6%	59.0%	59.9%	57.5%	55.6%	59.6%	62.3%	61.5%	62.3%
Females	63.5%	60.4%	59.6%	61.2%	58.1%	57.4%	63.4%	65.4%	63.4%	63.7%

Source: SAMHSA, 2014

Figure 10.4 Percentage of Indiana Treatment Episodes with Use of Two and Three Substances Reported at Treatment Admission, by Gender (Treatment Episode Data Set, 2014)



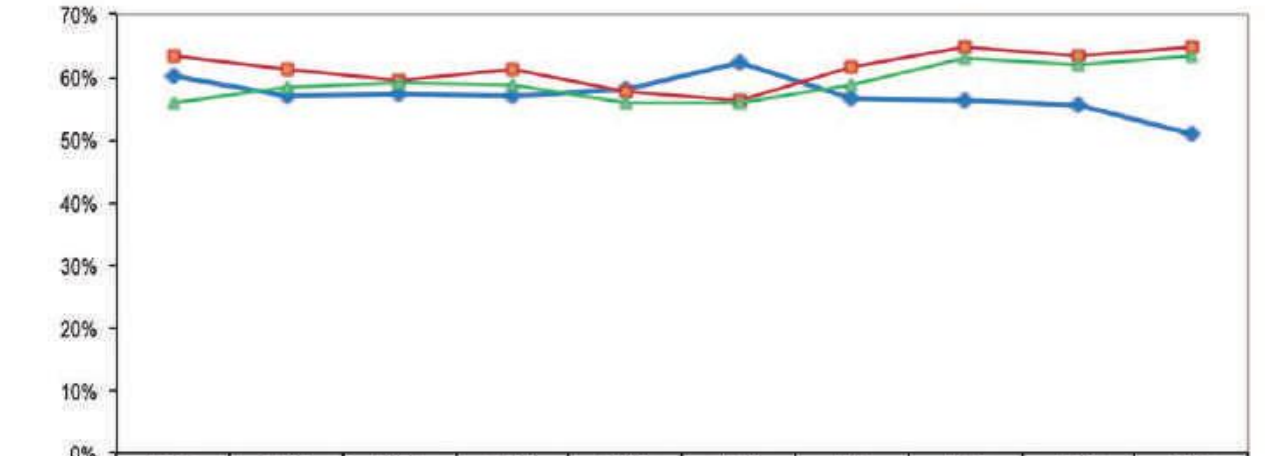
	Males	Females
3 Drugs Reported	31.7%	35.6%
2 Drugs Reported	29.8%	27.8%

Source: SAMHSA, 2014

Race—Overall, in 2014, blacks entering substance abuse treatment reported significantly less polysubstance abuse (50.9%) than did whites (64.7%) and persons of other races (63.3%) (see Figure 10.5). Blacks were more likely to report use of two substances, while whites and persons of other races were more likely to report use of three substances (see Figure 10.6).

Age—Adults 18 to 34 years of age reported the highest percentage of polysubstance abuse at treatment admission, while treatment entrants 55 years of age or older were the least likely to report the use of multiple substances (see Figures 10.7 and 10.8).

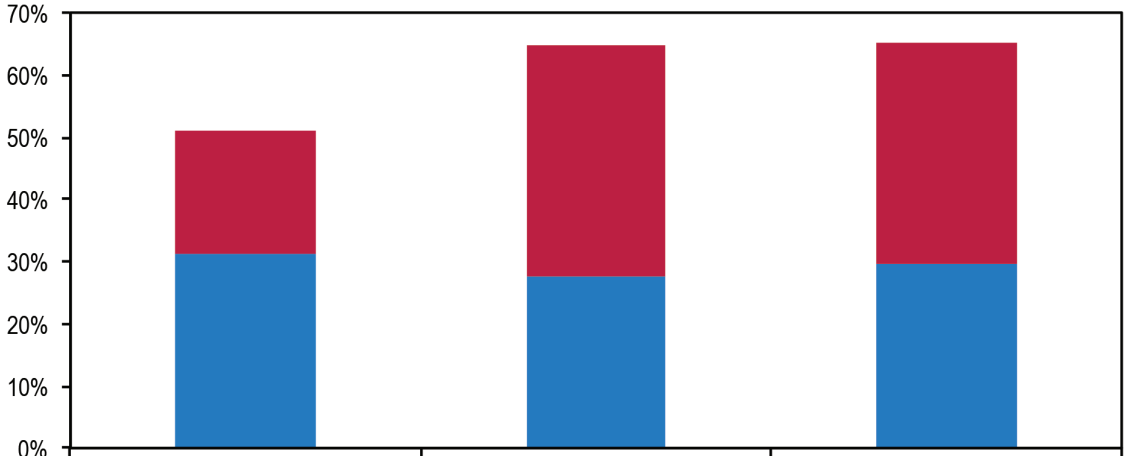
Figure 10.5 Percentage of Indiana Treatment Episodes with Polysubstance Abuse (Use of at Least Two Substances) Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Black	60.3%	56.9%	57.5%	57.1%	58.1%	62.4%	56.5%	56.2%	55.7%	50.9%
White	63.4%	61.4%	59.6%	61.2%	57.8%	56.2%	61.7%	64.9%	63.4%	64.7%
Other	56.1%	58.3%	59.3%	58.6%	55.9%	55.8%	58.9%	63.2%	61.8%	63.3%

Source: SAMHSA, 2014

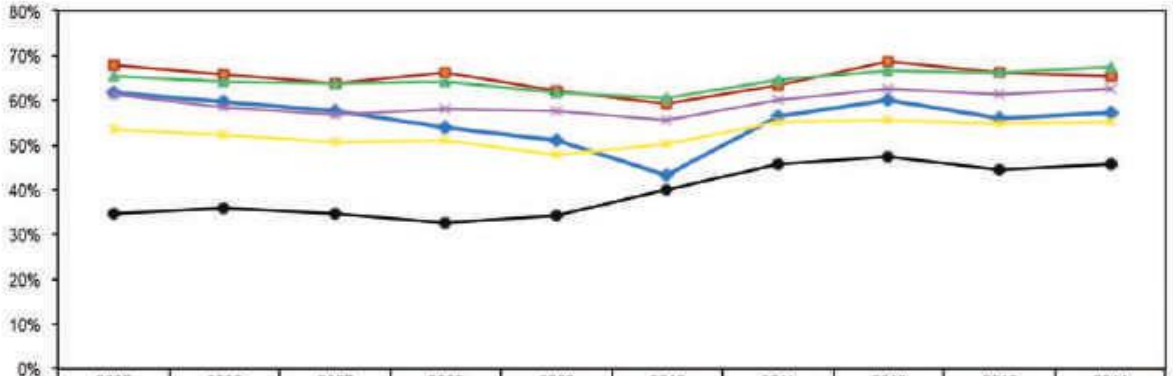
Figure 10.6 Percentage of Indiana Treatment Episodes with Use of Two and Three Substances Reported at Treatment Admission, by Race (Treatment Episode Data Set, 2014)



	Black	White	Other
3 Drugs Reported	19.6%	37.0%	35.5%
2 Drugs Reported	31.3%	27.7%	29.8%

Source: SAMHSA, 2014

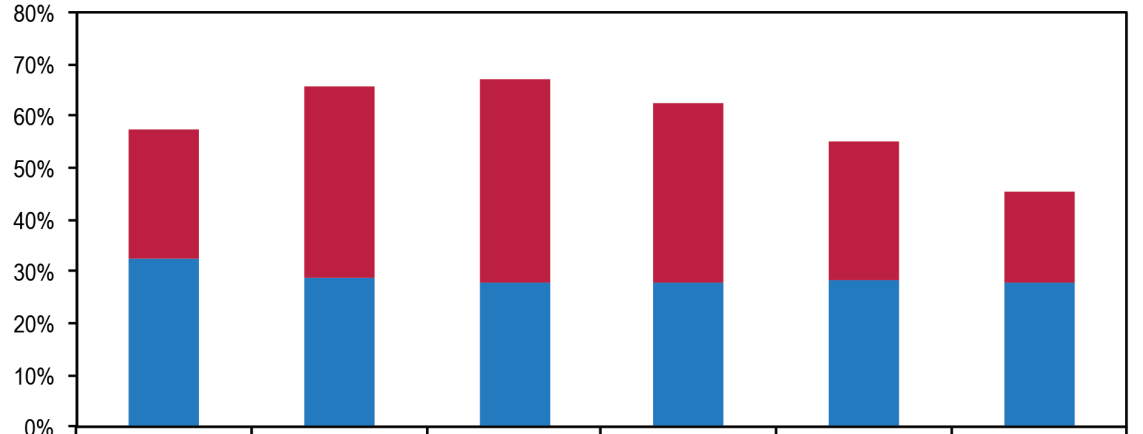
Figure 10.7 Percentage of Indiana Treatment Episodes with Polysubstance Abuse (Use of at Least Two Substances) Reported at Treatment Admission, by Age (Treatment Episode Data Set, 2005–2014)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Under 18	61.6%	59.7%	57.5%	53.8%	50.9%	43.2%	56.3%	60.1%	56.0%	57.3%
18 to 24	68.0%	65.8%	63.7%	66.1%	62.3%	59.2%	63.4%	68.5%	66.4%	65.6%
25 to 34	65.6%	64.0%	63.7%	64.2%	61.9%	60.4%	64.7%	66.5%	66.3%	67.3%
35 to 44	61.3%	58.5%	57.0%	58.2%	57.5%	55.4%	60.0%	62.4%	61.5%	62.5%
45 to 54	53.5%	52.4%	50.6%	51.0%	47.6%	50.3%	55.0%	55.6%	54.8%	55.2%
55 and Over	34.8%	36.0%	34.7%	32.4%	34.2%	39.9%	45.6%	47.3%	44.4%	45.6%

Source: SAMHSA, 2014

Figure 10.8 Percentage of Indiana Treatment Episodes with Use of Two and Three Substances Reported at Treatment Admission, by Age (Treatment Episode Data Set, 2014)



	Under 18	18 to 24	25 to 34	35 to 44	45 to 54	55 and Over
3 Drugs Reported	25.1%	36.7%	39.2%	34.8%	27.1%	17.9%
2 Drugs Reported	32.3%	28.9%	28.0%	27.7%	28.1%	27.7%

Source: SAMHSA, 2014

Polysubstance Abuse Clusters in Indiana

Statewide Analysis—Using 2016 TEDS data provided to the SEOW by FSSA's Division of Mental Health and Addiction, we conducted a cluster analysis to determine the various combinations of drugs currently used by polysubstance abusers within the state. The cluster analysis was completed in two steps following standardized methods (Hair, Anderson, Tatham, & Black, 1995).

In the first step, we performed a hierarchical cluster analysis specifying solutions with 2 to 20 clusters using Ward's method (Hair et al., 1995). Second, we used the results of the hierarchical cluster analysis to create "seed points" to serve as cluster centroids for follow-up K-Means cluster analyses, specifying 2 to 20 clusters. We selected this two-step method because it produces clusters that are more easily interpretable (Hair et al., 1995).

Then, to select the final classification solution, we compared the cubic clustering criteria (the expected value of the within sum of squares) with the face-validity of the set of drugs across the clusters (Hair et al., 1995). The results of the K-Means cluster analyses indicated that a 10-cluster solution best fit the available data.

Table 10.1, page 174, shows the image matrix for the 10-cluster solution. The image matrix represents the percentage of individuals within a cluster who used each specific drug. Using cluster 1 as an example, 100% of the individuals in this cluster used alcohol, 0% used cocaine, 54% used marijuana, 0% used heroin, and so on. A specific drug was considered part of a cluster, if at least 50% of the individuals within the cluster used the drug.

The most frequently occurring drug clusters in Indiana were clusters 4, 1, 7, and 2. Individuals in cluster 4 reported using a combination of alcohol and marijuana. Polysubstance users in cluster 1 used alcohol, marijuana, and some other drug. The individuals making up cluster 7 reported using marijuana and some other drug. Polysubstance users in cluster 2 reported using a combination of alcohol, cocaine, and marijuana. These clusters accounted for more than half of polysubstance users in the analysis (57.8%); the remaining six clusters accounted for 42.2% of polysubstance use within Indiana's treatment population (see Table 10.2)

Overall, alcohol and marijuana were the most commonly reported drugs, with alcohol appearing in 4 of the 10 clusters and marijuana appearing in 8. Opiates-synthetic drugs and heroin each appeared in two

clusters. For detailed information on all 10 clusters, see Table 10.2 (page 174).

Table 10.3 (page 175) breaks down the clusters by demographic characteristics. In terms of gender, men accounted for at least half of the individuals within 7 of the 10 clusters. Men and women were nearly equally represented in cluster 7 (alcohol/opiates-synthetics). Women comprised just over half of the individuals in clusters 5 (heroin/methamphetamine) and 7 (marijuana/opiates-synthetics).

Racially, whites composed the largest percentage of polysubstance abusers across every cluster. Blacks, however, were more strongly represented in cluster 2, the only cluster that contained cocaine, and cluster 4 (alcohol/marijuana). Whites represented close to or over 90% of the population in clusters 3, 5, 6, and 10. These four clusters included opiates-synthetics, methamphetamine, or heroin.

Approximately 60% or more of polysubstance abusers within 5 of the 10 clusters were between the ages of 18 and 34 (clusters 4, 5, 7, 8, 9). The majority of individuals in clusters 3, 6, and 10 were between the ages of 25 to 44; persons in cluster 2 were typically 35 to 54; and those in cluster 4 were primarily 18 to 44 years of age. The youngest polysubstance users, those under 18, were more often found in clusters 1 (alcohol/marijuana/other drug), 4 (alcohol/marijuana), and 8 (marijuana/benzodiazepines). Older polysubstance users, those 45 years of age and above, were most strongly represented in cluster 1 (alcohol/marijuana/other drug), 2 (alcohol/cocaine/marijuana), and 6 (alcohol/opiates-synthetics).

County-Level Analyses—We completed cluster analyses for each of Indiana's 92 counties using the 2016 county-level TEDS data set. Appendix 10B (pages 172-177) lists the results of the cluster analysis for each county. Similar to the statewide findings, the most common polysubstance clusters at the county level were composed of both alcohol and marijuana (the top-ranked cluster in 26 counties) or alcohol, marijuana, and a drug falling in the other drug category (the top-ranked cluster in 14 counties) (See Appendix 10B, pages 172-177).

Table 10.1 Image Matrix for Polysubstance Abuse Clusters (Treatment Episode Data Set, 2016)

Image Matrix	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5	Cluster 6	Cluster 7	Cluster 8	Cluster 9	Cluster 10
Drug										
Alcohol	1.00	0.74	0.13	1.00	0.04	1.00	0.00	0.00	0.29	0.00
Cocaine	0.00	1.00	0.01	0.00	0.18	0.00	0.09	0.06	0.13	0.10
Marijuana	0.54	0.50	0.62	1.00	0.16	0.00	0.53	0.90	0.90	0.67
Heroin	0.03	0.07	0.00	0.00	1.00	0.13	0.36	0.00	1.00	0.00
Methadone	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.02	0.00	0.02
Opiates-Synthetics	0.00	0.07	0.07	0.14	0.42	0.67	0.45	0.00	0.26	1.00
PCP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hallucinogens	0.00	0.01	0.02	0.01	0.01	0.01	0.01	0.10	0.00	0.00
Methamphetamine	0.00	0.13	1.00	0.20	0.58	0.34	0.00	0.35	0.00	0.42
Amphetamines	0.00	0.01	0.02	0.01	0.01	0.03	0.02	0.11	0.01	0.04
Stimulants	0.00	0.00	0.01	0.06	0.00	0.01	0.04	0.05	0.00	0.02
Benzodiazepines	0.01	0.01	0.02	0.05	0.15	0.20	0.07	0.78	0.09	0.30
Tranquilizers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.01
Barbiturates	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00
Sedatives/Hypnotics	0.00	0.00	0.01	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Inhalants	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.01	0.00	0.00
Over-the-Counter	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.01	0.00	0.00
Other Drug	1.00	0.09	0.65	0.00	0.06	0.13	1.00	0.10	0.00	0.00

Note: Each number in the image matrix represents the percentage of persons within a cluster that used each individual drug. For example, in cluster 1, 100% used alcohol, 0% used cocaine, 54% used marijuana, 3% used heroin, and so on.
Source: Indiana Family and Social Services Administration, 2016

Table 10.2 Number and Percentage of Treatment Episodes within Each Cluster in Indiana (Treatment Episode Data Set, 2016)

Cluster	Number of Treatment Episodes Within Cluster (%)
1 Alcohol, Marijuana, Other Drug	3,072 (14.0)
2 Alcohol, Cocaine, Marijuana	2,181 (9.9)
3 Marijuana, Methamphetamine, Other Drug	1,868 (8.5)
4 Alcohol, Marijuana	4,858 (22.1)
5 Heroin, Methamphetamine	2,101 (9.6)
6 Alcohol, Opiates/Synthetics	1,561 (7.1)
7 Marijuana, Other Drug	2,372 (10.8)
8 Marijuana, Benzodiazepines	443 (2.0)
9 Marijuana, Heroin	1,636 (7.4)
10 Marijuana, Opiates/Synthetics	1,871 (8.5)
Total	**21,963 (100.0)**

Source: Indiana Family and Social Services Administration, 2016

Table 10.3 Demographic Characteristics of Polysubstance Abusers within Clusters in Indiana (Treatment Episode Data Set, 2016)

	Cluster 1		Cluster 2		Cluster 3		Cluster 4		Cluster 5	
	N	%	N	%	N	%	N	%	N	%
Gender										
Male	2,151	70.0	1,337	61.3	960	51.4	3,476	71.6	979	46.6
Female	921	30.0	844	38.7	908	48.6	1,382	28.4	1,122	53.4
Race										
White	2,530	82.4	1,343	61.6	1,711	91.6	3,758	77.4	1,885	89.7
Black	299	9.7	672	30.8	31	1.7	645	13.3	63	3.0
Other	243	7.9	166	7.6	126	6.7	455	9.4	153	7.3
Ethnicity										
Non-Hispanic	2,874	93.6	1,967	90.2	1,784	95.5	4,539	93.4	1,993	94.9
Hispanic	198	6.4	214	9.8	84	4.5	319	6.6	108	5.1
Age										
Under 18	139	4.5	20	0.9	20	1.1	294	6.1	10	0.5
18-24	572	18.6	178	8.2	310	16.6	1,214	25.0	442	21.0
25-34	890	29.0	545	25.0	832	44.5	1,687	34.7	1,104	52.5
35-44	605	19.7	626	28.7	482	25.8	983	20.2	407	19.4
45-54	552	18.0	569	26.1	197	10.5	505	10.4	93	4.4
55 and Older	314	10.2	243	11.1	27	1.4	175	3.6	45	2.1

	Cluster 6		Cluster 7		Cluster 8		Cluster 9		Cluster 10	
	N	%	N	%	N	%	N	%	N	%
Gender										
Male	874	56.0	1,197	50.5	255	57.6	945	57.8	900	48.1
Female	687	44.0	1,175	49.5	188	42.4	691	42.2	971	51.9
Race										
White	1,410	90.3	2,028	85.5	385	86.9	1,444	88.3	1,673	89.4
Black	34	2.2	176	7.4	30	6.8	84	5.1	67	3.6
Other	117	7.5	168	7.1	28	6.3	108	6.6	131	7.0
Ethnicity										
Non-Hispanic	1,478	94.7	2,193	92.5	419	94.6	1,547	94.6	1,782	95.2
Hispanic	83	5.3	179	7.5	24	5.4	89	5.4	89	4.8
Age										
Under 18	7	0.4	72	3.0	18	4.1	14	0.9	33	1.8
18-24	157	10.1	534	22.5	143	32.3	439	26.8	364	19.5
25-34	627	40.2	1,018	42.9	166	37.5	817	49.9	886	47.4
35-44	429	27.5	465	19.6	88	19.9	242	14.8	392	21.0
45-54	227	14.5	193	8.1	25	5.6	84	5.1	153	8.2
50 and Older	114	7.3	90	3.8	3	0.7	40	2.4	43	2.3

Source: Indiana Family and Social Services Administration, 2016

APPENDIX 10A

Number and Percentage of Treatment Episodes with Polysubstance Abuse (Use of Two and Three Substances) Reported at Treatment Admission in Indiana, by County (Substance Abuse Population by County/Treatment Episode Data Set, 2016)

	Treatment Episodes	Use of 2 Substances		Use of 3 Substances		Polysubstance Abuse	
County	Total	Number	Percentage	Number	Percentage	Number	Percentage
Adams	295	92	31.2%	129	43.7%	221	74.9%
Allen	1,618	547	33.8%	650	40.2%	1197	74.0%
Bartholomew	581	172	29.6%	238	41.0%	410	70.6%
Benton	50	16	32.0%	28	56.0%	44	88.0%
Blackford	82	27	32.9%	35	42.7%	62	75.6%
Boone	187	38	20.3%	26	13.9%	64	34.2%
Brown	83	29	34.9%	30	36.1%	59	71.1%
Carroll	84	30	35.7%	39	46.4%	69	82.1%
Cass	253	67	26.5%	155	61.3%	222	87.7%
Clark	313	30	9.6%	35	11.2%	65	20.8%
Clay	181	60	33.1%	77	42.5%	137	75.7%
Clinton	227	85	37.4%	81	35.7%	166	73.1%
Crawford	45	8	17.8%	22	48.9%	30	66.7%
Daviess	169	39	23.1%	46	27.2%	85	50.3%
Dearborn	449	109	24.3%	268	59.7%	377	84.0%
Decatur	212	62	29.2%	80	37.7%	142	67.0%
DeKalb	242	60	24.8%	129	53.3%	189	78.1%
Delaware	1,138	355	31.2%	285	25.0%	640	56.2%
DuBois	280	72	25.7%	124	44.3%	196	70.0%
Elkhart	654	179	27.4%	135	20.6%	314	48.0%
Fayette	234	62	26.5%	83	35.5%	145	62.0%
Floyd	117	12	10.3%	9	7.7%	21	17.9%
Fountain	48	9	18.8%	29	60.4%	38	79.2%
Franklin	166	51	30.7%	75	45.2%	126	75.9%
Fulton	143	36	25.2%	91	63.6%	127	88.8%
Gibson	295	93	31.5%	99	33.6%	192	65.1%
Grant	436	119	27.3%	236	54.1%	355	81.4%
Greene	204	66	32.4%	68	33.3%	134	65.7%
Hamilton	893	252	28.2%	198	22.2%	450	50.4%
Hancock	193	59	30.6%	40	20.7%	99	51.3%
Harrison	31	<5	n/a	<5	n/a	7	22.6%
Hendricks	351	108	30.8%	106	30.2%	214	61.0%
Henry	330	114	34.5%	102	30.9%	216	65.5%
Howard	610	172	28.2%	301	49.3%	473	77.5%
Huntington	147	36	24.5%	92	62.6%	128	87.1%
Jackson	298	77	25.8%	108	36.2%	185	62.1%
Jasper	105	26	24.8%	61	58.1%	87	82.9%
Jay	188	51	27.1%	90	47.9%	141	75.0%
Jefferson	366	97	26.5%	153	41.8%	250	68.3%
Jennings	223	70	31.4%	95	42.6%	165	74.0%
Johnson	275	92	33.5%	77	28.0%	169	61.5%
Knox	298	71	23.8%	90	30.2%	161	54.0%
Kosciusko	381	84	22.0%	241	63.3%	325	85.3%
LaGrange	186	34	18.3%	122	65.6%	156	83.9%
Lake	2,339	703	30.1%	521	22.3%	1,224	52.3%
LaPorte	377	106	28.1%	97	25.7%	203	53.8%

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APPENDIX 10A *(Continued from previous page)*

	Treatment Episodes	Use of 2 Substances		Use of 3 Substances		Polysubstance Abuse	
County	**Total**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Lawrence	485	133	27.4%	215	44.3%	348	71.8%
Madison	1,278	372	29.1%	406	31.8%	778	60.9%
Marion	3,645	1055	28.9%	1214	33.3%	2,269	62.2%
Marshall	205	64	31.2%	103	50.2%	167	81.5%
Martin	62	16	25.8%	30	48.4%	46	74.2%
Miami	272	63	23.2%	163	59.9%	226	83.1%
Monroe	1,180	352	29.8%	425	36.0%	777	65.8%
Montgomery	374	104	27.8%	177	47.3%	281	75.1%
Morgan	482	185	38.4%	152	31.5%	337	69.9%
Newton	33	9	27.3%	18	54.5%	27	81.8%
Noble	307	78	25.4%	172	56.0%	250	81.4%
Ohio	40	13	32.5%	16	40.0%	29	72.5%
Orange	160	47	29.4%	62	38.8%	109	68.1%
Owen	199	59	29.6%	68	34.2%	127	63.8%
Parke	67	19	28.4%	29	43.3%	48	71.6%
Perry	102	31	30.4%	41	40.2%	72	70.6%
Pike	53	17	32.1%	9	17.0%	26	49.1%
Porter	410	120	29.3%	135	32.9%	255	62.2%
Posey	170	42	24.7%	84	49.4%	126	74.1%
Pulaski	109	33	30.3%	56	51.4%	89	81.7%
Putnam	215	63	29.3%	81	37.7%	144	67.0%
Randolph	170	36	21.2%	61	35.9%	97	57.1%
Ripley	184	55	29.9%	81	44.0%	136	73.9%
Rush	138	37	26.8%	82	59.4%	119	86.2%
Saint Joseph	1,231	389	31.6%	272	22.1%	661	53.7%
Scott	165	39	23.6%	54	32.7%	93	56.4%
Shelby	168	42	25.0%	73	43.5%	115	68.5%
Spencer	144	34	23.6%	63	43.8%	97	67.4%
Starke	193	51	26.4%	109	56.5%	160	82.9%
Steuben	298	98	32.9%	113	37.9%	211	70.8%
Sullivan	78	23	29.5%	33	42.3%	56	71.8%
Switzerland	63	22	34.9%	25	39.7%	47	74.6%
Tippecanoe	404	120	29.7%	225	55.7%	345	85.4%
Tipton	70	22	31.4%	24	34.3%	46	65.7%
Union	22	<5	n/a	14	63.6%	18	81.8%
Vanderburgh	1,319	344	26.1%	652	49.4%	996	75.5%
Vermillion	123	34	27.6%	62	50.4%	96	78.0%
Vigo	803	267	33.3%	329	41.0%	596	74.2%
Wabash	225	48	21.3%	158	70.2%	206	91.6%
Warren	9	<5	n/a	6	66.7%	8	88.9%
Warrick	267	47	17.6%	141	52.8%	188	70.4%
Washington	63	7	11.1%	19	30.2%	26	41.3%
Wayne	438	122	27.9%	198	45.2%	320	73.1%
Wells	128	31	24.2%	79	61.7%	110	85.9%
White	110	37	33.6%	56	50.9%	93	84.5%
Whitley	105	22	21.0%	76	72.4%	98	93.3%
Missing County Data	27	8	29.6%	6	22.2%	14	51.9%
Indiana	**33,170**	**9,496**		**12,467**		**21,963**	

Note: The category “Polysubstance Abuse” is an aggregate of “Use of 2 Substances” and “Use of 3 Substances.” We calculated the percentages by dividing the number of reported polysubstance abuse by the number of treatment episodes. Information on treatment episodes <5 was suppressed due to confidentiality constraints.
Source: Indiana Family and Social Services Administration, 2016

APPENDIX 10B

Combination of Drugs Used Among Polysubstance Abusers in Substance Abuse Treatment, by County (Based on Cluster Analysis of Substance Abuse Population by County/Treatment Episode Data Set, 2016)

County	Cluster #	Cluster Composition	N	%
Adams				
	1	Alcohol/Marijuana	61	27.6%
	2	Alcohol/Marijuana/Other Drug	48	21.7%
	5	Alcohol/Cocaine/ Marijuana	25	11.3%
	7	Marijuana/Heroin	24	10.9%
	4	Heroin/Opiates-Synthetics	23	10.4%
	6	Marijuana/ Methamphetamine	21	9.5%
	3	Marijuana/Opiates-Synthetics/Other Drug	19	8.6%
		Total	221	
Allen				
	2	Alcohol/Marijuana	354	29.6%
	4	Alcohol/Cocaine/ Marijuana	212	17.7%
	1	Alcohol/Marijuana/Other Drug	184	15.4%
	6	Cocaine/Marijuana	173	14.5%
	3	Heroin/Opiates-Synthetics	144	12.0%
	5	Alcohol/Marijuana/ Opiates-Synthetics	130	10.9%
		Total	1,197	
Bartholomew				
	1	Marijuana/ Methamphetamine	161	39.3%
	2	Alcohol/Marijuana	130	31.7%
	3	Heroin/ Methamphetamine	119	29.0%
		Total	410	
Benton				
	2	Alcohol/Marijuana/Other Drug	14	31.8%
	1	Alcohol/Marijuana	12	27.3%
	4	Alcohol/Other Drug	10	22.7%
	3	Alcohol/Marijuana/ Opiates-Synthetics	8	18.2%
		Total	44	
Blackford				
	2	Marijuana/Heroin/ Opiates-Synthetics	24	38.7%
	1	Alcohol/Marijuana	20	32.3%
	3	Alcohol/Marijuana/ Opiates-Synthetics	18	29.0%
		Total	62	
Boone				
	3	Heroin/Opiates-Synthetics	27	42.2%
	1	Alcohol/Marijuana	21	32.8%
	2	Marijuana/ Methamphetamine	16	25.0%
		Total	64	
Brown				
	1	Marijuana/Heroin/ Methamphetamine	30	50.8%
	2	Alcohol/Marijuana	29	49.2%
		Total	59	
Carroll				
	1	Alcohol/Other Drug	25	36.2%
	2	Marijuana/ Methamphetamine/Other Drug	23	33.3%
	2	Alcohol/Marijuana	21	30.4%
		Total	69	

County	Cluster #	Cluster Composition	N	%
Cass				
	2	Alcohol/Other Drug	76	34.2%
	1	Alcohol/Marijuana/Other Drug	59	26.6%
	3	Alcohol/Marijuana	50	22.5%
	4	Alcohol/Opiates-Synthetics	37	16.7%
		Total	222	
Clark				
	1	Methamphetamine	22	33.8%
	2	Alcohol/Marijuana	15	23.1%
	4	Heroin/Opiates-Synthetics	15	23.1%
	3	Marijuana/Opiates-Synthetics	13	20.0%
		Total	65	
Clay				
	1	Alcohol/Marijuana/Other Drug	50	36.5%
	3	Opiates-Synthetics/ Methamphetamine/Other Drug	45	32.8%
	2	Marijuana/ Methamphetamine/Other Drug	42	30.7%
		Total	137	
Clinton				
	5*	Alcohol/Marijuana/ Heroin*	21	12.7%
	6	Marijuana/Other Drug	21	12.7%
	8	Marijuana/Heroin/ Opiates-Synthetics	20	12.0%
	1	Alcohol/Marijuana	38	10.7%
	4	Alcohol/Opiates-Synthetics	15	9.0%
	7	Opiates-Synthetics/ Other Drug	15	9.0%
	3	Heroin/Other Drug	12	7.2%
	2	Alcohol/Other Drug	24	3.4%
		Total	166	
Crawford				
		Insufficient data for analysis		
Daviess				
	1	Marijuana/ Methamphetamine	47	55.3%
	2	Alcohol/Other Drug	38	44.7%
		Total	85	
Dearborn				
	1	Alcohol/Marijuana/Other Drug	79	21.0%
	7	Alcohol/Other Drug	66	17.5%
	4	Marijuana/Heroin/ Opiates-Synthetics	48	12.7%
	2	Alcohol/Marijuana/ Opiates-Synthetics	43	11.4%
	3	Marijuana/Heroin/Other Drug	41	10.9%
	6	Heroin/Opiates-Synthetics/Other Drug	38	10.1%
	5	Marijuana/Heroin	35	9.3%
	8	Opiates-Synthetics/ Benzodiazepines	27	7.2%
		Total	377	

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APPENDIX 10B *(continued from previous page)*

County	Cluster #	Cluster Composition	N	%
Decatur				
	3	Marijuana/ Methamphetamine	58	40.8%
	2	Opiates-Synthetics/ Methamphetamine	44	31.0%
	1	Alcohol/Marijuana	40	28.2%
		Total	142	
DeKalb				
	3	Marijuana/Other Drug	52	52.5%
	2	Alcohol/Marijuana/ Methamphetamine	49	25.9%
	1	Alcohol/Marijuana	47	24.9%
	4	Marijuana/ Methamphetamine	41	21.7%
		Total	189	
Delaware				
	2	Alcohol/Marijuana	111	17.3%
	4	Marijuana/Opiates-Synthetics	98	15.3%
	6	Heroin/Opiates-Synthetics/ Methamphetamine	86	13.4%
	7	Alcohol/Opiates-Synthetics	61	9.5%
	5	Marijuana/ Methamphetamine	60	9.4%
	1	Alcohol/Cocaine	58	9.1%
	3	Marijuana/Heroin	57	8.9%
	8	Cocaine/Marijuana	56	8.8%
	9	Opiates-Synthetics/ Benzodiazepines	53	8.3%
		Total	640	
Dubois				
	2	Alcohol/Marijuana/ Methamphetamine	37	18.9%
	1	Alcohol/Marijuana/Other Drug	33	16.8%
	3	Alcohol/Opiates-Synthetics/ Methamphetamine/ Benzodiazepines	33	16.8%
	4	Alcohol/Marijuana	64	32.7%
	5	Alcohol/Marijuana/ Opiates-Synthetics	29	14.8%
		Total	196	
Elkhart				
	2	Alcohol/Marijuana	85	27.1%
	5	Marijuana/ Methamphetamine	65	20.7%
	3	Marijuana/Opiates-Synthetics	62	19.7%
	1	Alcohol/Cocaine/ Marijuana	58	18.5%
	4	Marijuana/Other Drug	44	14.0%
		Total	314	
Fayette				
	1	Heroin/Opiates-Synthetics	55	37.9%
	2	Marijuana/Heroin/ Opiates-Synthetics	50	34.5%
	3	Alcohol/Marijuana	40	27.6%
		Total	145	
Floyd				
	2	Heroin/Opiates-Synthetics	11	52.4%
	1	Alcohol/Marijuana/Other Drug	10	47.6%
		Total	21	

County	Cluster #	Cluster Composition	N	%
Fountain				
	2	Alcohol/Marijuana/Other Drug	12	31.6%
	3	Marijuana/Heroin/ Methamphetamine	11	28.9%
	4	Marijuana/ Opiates-Synthetics/ Methamphetamine	8	21.1%
	1	Opiates-Synthetics/ Other Drug	7	18.4%
		Total	38	
Franklin				
	2	Alcohol/Marijuana/Other Drug	47	36.5%
	3	Marijuana/Heroin/ Opiates-Synthetics	46	36.5%
	1	Marijuana/ Methamphetamine/Other Drug	33	26.2%
		Total	126	
Fulton				
	4	Marijuana/ Opiates-Synthetics/ Methamphetamine/Other Drug	34	26.8%
	3	Alcohol/Marijuana	33	26.0%
	2	Alcohol/Marijuana/Other Drug	32	25.2%
	1	Alcohol/Other Drug	28	22.0%
		Total	127	
Gibson				
	1	Alcohol/Marijuana/Other Drug	96	50.0%
	2	Marijuana/ Methamphetamine	96	50.0%
		Total	192	
Grant				
	4	Alcohol/Marijuana	66	18.6%
	1	Alcohol/Marijuana/Other Drug	63	17.7%
	2	Alcohol/Other Drug	52	14.6%
	6	Marijuana/Heroin	52	14.6%
	7	Marijuana/ Opiates-Synthetics/ Benzodiazepines	43	12.1%
	5	Alcohol/Marijuana/ Opiates-Synthetics	41	11.5%
	3	Marijuana/Other Drug	38	10.7%
		Total	355	
Greene				
	1	Alcohol/Other Drug	32	23.9%
	3	Alcohol/Marijuana	30	22.4%
	2	Heroin/Opiates-Synthetics	28	20.9%
	4	Marijuana/ Methamphetamine/Other Drug	26	19.4%
	5	Alcohol/Marijuana/ Methamphetamine	18	13.4%
		Total	134	
Hamilton				
	1	Alcohol/Marijuana	142	31.6%
	3	Alcohol/Marijuana/ Opiates-Synthetics	68	15.1%
	2	Alcohol/Cocaine/ Marijuana	51	11.3%
	4	Marijuana/Heroin	51	11.3%

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APPENDIX 10B *(continued from previous page)*

County	Cluster #	Cluster Composition	N	%
	5	Heroin/Opiates-Synthetics	39	8.7%
	7	Alcohol/Marijuana/Benzodiazepines	39	8.7%
	8	Alcohol/Marijuana/Other Drug	31	6.9%
	6	Marijuana/Methamphetamine	29	6.4%
		Total	450	
Hancock				
	1	Alcohol/Marijuana	39	39.4%
	2	Cocaine/Marijuana/Heroin	22	22.2%
	3*	Opiates-Synthetics	21	21.2%
	4	Marijuana/Methamphetamine	17	17.2%
		Total	99	
Harrison				
		Insufficient data for analysis		
Hendricks				
	2	Alcohol/Marijuana/Other Drug	75	35.0%
	3	Marijuana/Methamphetamine	38	17.8%
	4	Heroin/Other Drug	38	17.8%
	1	Heroin/Opiates-Synthetics	37	17.3%
	5	Alcohol/Other Drug	26	12.1%
		Total	214	
Henry				
	2	Opiates-Synthetics/Other Drug	49	22.7%
	4	Heroin/Opiates-Synthetics	49	22.7%
	3	Marijuana/Opiates-Synthetics	45	20.8%
	1	Opiates-Synthetics/Benzodiazepines	39	18.1%
	5	Alcohol/Marijuana	34	15.7%
		Total	216	
Howard				
	2	Alcohol/Marijuana	82	17.3%
	1	Heroin/Other Drug	75	15.9%
	5	Heroin/Methamphetamine	74	15.6%
	3	Alcohol/Marijuana/Other Drug	68	14.4%
	6	Alcohol/Cocaine	63	13.3%
	7	Heroin/Opiates-Synthetics	59	12.5%
	4	Opiates-Synthetics/Other Drug	52	11.0%
		Total	473	
Huntington				
	2	Marijuana/Opiates-Synthetics/Other Drug	42	32.8%
	3	Alcohol/Other Drug	33	25.8%
	1	Alcohol/Marijuana/Opiates-Synthetics	32	25.0%
	4	Heroin/Opiates-Synthetics/Methamphetamine	21	16.4%
		Total	128	
Jackson				
	1	Opiates-Synthetics/Methamphetamine	62	33.5%
	3	Marijuana/Methamphetamine	62	33.5%
	2	Alcohol/Marijuana	61	33.0%
		Total	185	

County	Cluster #	Cluster Composition	N	%
Jasper				
	2	Alcohol/Marijuana	31	35.6%
	1	Marijuana/Opiates-Synthetics	29	33.3%
	3	Marijuana/Methamphetamine	27	31.0%
		Total	87	
Jay				
	2	Marijuana/Heroin	42	29.8%
	3	Alcohol/Marijuana	34	24.1%
	4	Heroin/Opiates-Synthetics	25	17.7%
	1	Marijuana/Methamphetamine	23	16.3%
	5	Alcohol/Marijuana/Other-Drug	17	12.1%
		Total	141	
Jefferson				
	1	Marijuana/Opiates-Synthetics	98	39.2%
	3	Opiates-Synthetics/Methamphetamine	85	34.0%
	2	Alcohol/Marijuana	67	26.8%
		Total	250	
Jennings				
	2	Marijuana/Methamphetamine	53	32.1%
	3	Heroin/Methamphetamine	39	23.6%
	4	Alcohol/Methamphetamine	39	23.6%
	1	Alcohol/Marijuana	34	20.6%
		Total	165	
Johnson				
	3	Alcohol/Marijuana	73	43.2%
	1	Heroin/Opiates-Synthetics	42	24.9%
	4	Marijuana/Methamphetamine	31	18.3%
	2	Heroin/Opiates-Synthetics/Other Drug	23	13.6%
		Total	169	
Knox				
	1	Alcohol/Marijuana/Methamphetamine	49	30.4%
	2	Marijuana/Methamphetamine	40	24.8%
	4	Opiates-Synthetics/Methamphetamine	25	15.5%
	5	Alcohol/Other Drug	24	14.9%
	3	Marijuana/Opiates-Synthetics	23	14.3%
		Total	161	
Kosciusko				22.3%
	1	Alcohol/Marijuana	78	24.0%
	5	Marijuana/Opiates-Synthetics	66	20.3%
	2	Alcohol/Marijuana/Other Drug	59	18.2%
	3	Alcohol/Other Drug	46	14.2%
	4	Marijuana/Methamphetamine/Other Drug	38	11.7%
	6	Heroin/Methamphetamine	38	11.7%
		Total	325	
LaGrange				
	3	Alcohol/Marijuana/Other Drug	59	37.8%
	1	Alcohol/Marijuana/Methamphetamine	50	32.1%

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APPENDIX 10B *(continued from previous page)*

County	Cluster #	Cluster Composition	N	%
	2	Marijuana/ Methamphetamine/Other Drug	47	30.1%
		Total	156	
Lake				
	1	Alcohol/Marijuana	307	25.1%
	4	Alcohol/Marijuana/Other Drug	261	21.3%
	3	Cocaine/Marijuana/ Heroin	247	20.2%
	5	Alcohol/Cocaine	234	19.1%
	2	Heroin/Opiates-Synthetics	175	14.3%
		Total	1,224	
La Porte				
	2	Alcohol/Marijuana	99	48.8%
	3	Heroin/Opiates-Synthetics	59	29.1%
	1	Marijuana/Heroin	45	22.2%
		Total	203	
Lawrence				
	2	Opiates-Synthetics/ Methamphetamine	140	40.2%
	1	Alcohol/Marijuana	115	33.0%
	3	Marijuana/ Methamphetamine	93	26.7%
		Total	348	
Madison				
	5	Alcohol/Marijuana	199	25.6%
	6	Opiates-Synthetics/ Methamphetamine	133	17.1%
	7	Alcohol/Opiates-Synthetics	127	16.3%
	3	Marijuana/Opiates-Synthetics	115	14.8%
	1	Alcohol/Cocaine/ Marijuana	90	11.6%
	4	Marijuana/ Opiates-Synthetics/ Benzodiazepines	65	8.4%
	2	Marijuana/Other Drug	49	6.3%
		Total	778	
Marion				
	4	Alcohol/Marijuana	434	19.1%
	1	Opiates-Synthetics/ Other Drug	390	17.2%
	2	Marijuana/Other Drug	316	13.9%
	7	Alcohol/Marijuana	308	13.6%
	8	Marijuana/Heroin/ Opiates-Synthetics	251	11.1%
	5	Alcohol/Cocaine/ Marijuana	207	9.1%
	3	Heroin/Benzodiazepines	188	8.3%
	6	Heroin/ Methamphetamine	175	7.7%
		Total	2,269	
Marshall				
	2	Alcohol/Other Drug	48	35.0%
	1	Marijuana/Other Drug	44	32.1%
	3	Heroin/Opiates-Synthetics/Other Drug	34	24.8%
	4	Alcohol/Marijuana	11	8.0%
		Total	137	
Martin				
	3	Alcohol/Other Drug	19	41.3%
	1	Marijuana/ Methamphetamine/Other Drug	18	39.1%
	2	Alcohol/Opiates-Synthetics/ Benzodiazepines	9	19.6%
		Total	46	
Miami				
	3	Marijuana/Other Drug	85	37.6%
	1	Alcohol/Marijuana/Other Drug	81	35.8%
	2	Alcohol/Marijuana	60	26.5%
		Total	226	
Monroe				
	2	Alcohol/Marijuana/Other Drug	221	28.4%
	7	Marijuana/Heroin/ Methamphetamine	99	12.7%
	3	Alcohol/Other Drug	90	11.6%
	5	Marijuana/Opiates-Synthetics	83	10.7%
	4	Heroin/Opiates-Synthetics/ Methamphetamine	75	9.7%
	6	Alcohol/Opiates-Synthetics	73	9.4%
	8*	Heroin/Benzodiazepines	70	9.0%
	1	Alcohol/Cocaine/ Marijuana	66	8.5%
		Total	777	
Montgomery				
	1	Alcohol/Marijuana/Other Drug	83	29.5%
	3	Marijuana/ Methamphetamine	73	26.0%
	4*	Opiates-Synthetics/ Various Other Drugs	65	23.1%
	2	Marijuana/Other Drug	60	21.4%
		Total	281	
Morgan				
	1	Heroin/ Methamphetamine	106	31.5%
	2	Marijuana/ Methamphetamine	86	25.5%
	4	Alcohol/Marijuana	80	23.7%
	3	Alcohol/Marijuana/Other Drug	65	19.3%
		Total	337	
Newton				
	1	Alcohol/Marijuana	12	44.4%
	3	Marijuana/Heroin	9	33.3%
	2	Heroin/ Methamphetamine	6	22.2%
		Total	27	
Noble				
	1	Alcohol/Marijuana	101	40.4%
	3	Marijuana/ Methamphetamine	90	36.0%
	2	Alcohol/Other Drug	59	23.6%
		Total	250	
Ohio				
	1	Alcohol/Other Drug	16	55.2%
	2	Alcohol/Marijuana	7	24.1%
	3	Heroin/Opiates-Synthetics/Other Drug	6	20.7%
		Total	29	
Orange				
	3	Marijuana/Opiates-Synthetics	40	36.7%
	2	Alcohol/Marijuana	36	33.0%

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APPENDIX 10B *(continued from previous page)*

County	Cluster #	Cluster Composition	N	%
	1	Alcohol/Marijuana/ Methamphetamine	33	30.3%
		Total	109	
Owen				
	4	Alcohol/Other Drug	33	26.0%
	3	Marijuana/ Methamphetamine	30	23.6%
	2	Alcohol/Marijuana	25	19.7%
	5	Heroin/Opiates-Synthetics	20	15.7%
	1	Alcohol/Marijuana/ Methamphetamine	19	15.0%
		Total	127	
Parke				
	2	Alcohol/Other Drug	14	29.2%
	4	Methamphetamine/Other Drug	13	27.1%
	3	Marijuana/Other Drug	12	25.0%
	1	Alcohol/Marijuana	9	18.8%
		Total	48	
Perry				
	2	Alcohol/Marijuana	42	58.3%
	1	Marijuana/ Methamphetamine	30	41.7%
		Total	72	
Pike				
		Insufficient Cases for Analysis		
Porter				
	2	Marijuana/Heroin	140	54.9%
	1	Alcohol/Marijuana	115	45.1%
		Total	255	
Posey				
	3	Alcohol/Marijuana	62	49.2%
	2	Alcohol/ Methamphetamine	36	28.6%
	1	Alcohol/Marijuana/Other Drug	28	22.2%
		Total	126	
Pulaski				
	1	Alcohol/Marijuana/Other Drug	32	36.0%
	2	Alcohol/Other Drug	25	28.1%
	3	Marijuana/Opiates-Synthetics/Other Drug	16	18.0%
	4	Alcohol/Opiates-Synthetics	16	18.0%
		Total	89	
Putnam				
	1	Marijuana/Other Drug	81	56.3%
	2	Alcohol/Marijuana/Other Drug	63	43.8%
		Total	144	
Randolph				
	2	Marijuana/Heroin	49	50.5%
	1	Alcohol/Marijuana	48	49.5%
		Total	97	
Ripley				
	1	Alcohol/Marijuana	79	58.1%
	2	Marijuana/Heroin	57	41.9%
		Total	136	
Rush				
	2	Marijuana/Opiates-Synthetics	45	37.8%
	3	Alcohol/Marijuana	38	31.9%
	1	Marijuana/Other Drug	36	30.3%
		Total	119	

County	Cluster #	Cluster Composition	N	%
St. Joseph				
	1	Alcohol/Marijuana	131	19.8%
	2	Alcohol/Cocaine	100	15.1%
	3	Heroin/Opiates-Synthetics	61	9.2%
	4	Marijuana/ Methamphetamine	41	6.2%
	5	Alcohol/Other Drug	69	10.4%
	6	Cocaine/Marijuana	43	6.5%
	7	Alcohol/Cocaine/ Marijuana	73	11.0%
	8	Heroin/ Methamphetamine	48	7.3%
	9	Marijuana/Heroin	72	10.9%
	10	Marijuana/ Benzodiazepines	23	3.5%
		Total	661	
Scott				
	1	Marijuana/Opiates-Synthetics	55	59.1%
	2	Opiates-Synthetics/ Methamphetamine	38	40.9%
		Total	93	
Shelby				
	2	Marijuana/ Methamphetamine	79	68.7%
	1	Heroin/Opiates-Synthetics	36	31.3%
		Total	115	
Spencer				
	1	Alcohol/Marijuana	39	40.2%
	2	Alcohol/Marijuana/ Methamphetamine	31	32.0%
	3	Marijuana/ Methamphetamine	27	27.8%
		Total	97	
Starke				
	1	Marijuana/Other Drug	62	38.8%
	3*	Heroin/Various Other Drugs	55	34.4%
	2	Opiates-Synthetics/ Other Drug	43	26.9%
		Total	160	
Steuben				
	1	Alcohol/Marijuana	86	40.8%
	2	Marijuana/ Methamphetamine	63	29.9%
	3	Alcohol/Other Drug	62	29.4%
		Total	211	
Sullivan				
	3	Alcohol/Other Drug	34	60.7%
	1	Marijuana/Opiates-Synthetics	11	19.6%
	2	Marijuana/Other Drug	11	19.6%
		Total	56	
Switzerland				
	2	Alcohol/Other Drug	29	61.7%
	1	Marijuana/Opiates-Synthetics	18	38.3%
		Total	47	
Tippecanoe				
	4	Alcohol/Marijuana	87	25.2%
	2	Marijuana/Other Drug	81	23.5%
	5	Alcohol/Other Drug	70	20.3%
	1	Alcohol/Marijuana/Other Drug	56	16.2%
	3	Marijuana/Heroin	51	14.8%
		Total	345	

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APPENDIX 10B *(continued from previous page)*

County	Cluster #	Cluster Composition	N	%
Tipton				
	2	Alcohol/Marijuana	24	52.2%
	1	Marijuana/Opiates-Synthetics	12	26.1%
	3	Opiates-Synthetics/ Benzodiazepines	10	21.7%
		Total	46	
Union				
		Insufficient Cases for Analysis		
Vanderburgh				
	5	Marijuana/ Methamphetamine	220	22.1%
	2	Alcohol/Other Drug	198	19.9%
	6	Alcohol/Marijuana	176	17.7%
	1	Alcohol/ Methamphetamine	151	15.2%
	4	Marijuana/Opiates-Synthetics/	137	13.8%
	3	Opiates-Synthetics/ Methamphetamine	114	11.4%
		Total	996	
Vermillion				
	4	Opiates-Synthetics/ Methamphetamine/ Benzodiazepines	20	20.8%
	3	Marijuana/ Methamphetamine/Other Drug	30	20.0%
	2	Alcohol/Marijuana/Other Drug	18	18.8%
	1	Alcohol/Other Drug	17	17.7%
	5	Alcohol/Marijuana/ Methamphetamine	11	11.5%
		Total	96	
Vigo				
	2	Alcohol/Other Drug	161	27.0%
	1	Alcohol/Marijuana/Other Drug	125	21.0%
	3	Marijuana/ Methamphetamine/Other Drug	117	19.6%
	4	Alcohol/Marijuana/ Methamphetamine	103	17.3%
	5*	Opiates-Synthetics/ Methamphetamine	90	15.1%
		Total	596	
Wabash				
	1	Alcohol/Marijuana	71	34.5%
	4	Marijuana/Heroin/ Methamphetamine	53	25.7%
	3	Marijuana/Other Drug	42	20.4%
	2	Alcohol/Other Drug	40	19.4%
		Total	206	
Warren				
		Insufficient cases for analysis		
Warrick				
	4	Alcohol/Marijuana	50	26.6%
	2	Marijuana/ Methamphetamine	39	20.7%
	3	Alcohol/Opiates-Synthetics	37	19.7%
	1	Alcohol/Marijuana/ Methamphetamine	32	17.0%
	5	Marijuana/Opiates-Synthetics	30	16.0%
		Total	188	
Wayne				
	1	Alcohol/Marijuana	75	23.4%
	2	Cocaine/Heroin	60	18.8%
	4	Marijuana/Opiates-Synthetics	58	18.1%
	5	Marijuana/Heroin	54	16.9%
	3	Heroin/Other Drug	47	14.7%
	6	Heroin/ Methamphetamine	26	8.1%
		Total	320	
Wells				
	1	Alcohol/Marijuana	58	52.7%
	2	Marijuana/Opiates-Synthetics	52	47.3%
		Total	110	
White				
	1	Alcohol/Other Drug	51	54.8%
	2	Marijuana/ Methamphetamine/Other Drug	42	45.2%
		Total	93	
Whitley				
	2	Alcohol/Other Drug	32	32.7%
	1	Alcohol/Marijuana	26	26.5%
	3	Alcohol/Marijuana/Other Drug	20	20.4%
	4	Marijuana/Other Drug	20	20.4%
		Total	98	

Note: Results from the county-level cluster analysis differ from the state-level findings.
*Due to the small sample size and/or the nature of the data, this cluster was composed of one drug where at least 50% of individuals reported using it but where the second and/or third drug used could not be determined.
Source: Indiana Family and Social Services Administration, 2016

REFERENCES, CHAPTER 10

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11 Mental Health in Indiana

According to the U.S. Centers for Disease Control and Prevention (CDC, 2011), approximately 25% of U.S. adults currently have a mental illness, and about 50% will develop a mental illness during their lifetime. Mental illness is associated with a number of other chronic diseases, as well as tobacco use, substance abuse, and higher rates of suicide. It is also a significant barrier to accessing healthcare. Additionally, seven to ten million U.S. adults are living with both a diagnosable mental illness and substance use disorder in any given year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2002). The National Survey on Drug Use and Health (NSDUH) report stated that of the 19.6 million adults with a past-year substance use disorder, 8.1 million (41.2%) also suffered from mental illness, while only 15.8% of adults without a past-year substance use disorder had a mental illness diagnosis in the past year (SAMHSA, 2017). Individuals diagnosed with both mental health and substance use disorders tend to have more complex problems, often resulting in a more chronic and persistent course of illness, poorer response to treatment, and higher rates of substance abuse relapse (Bradizza, Stasiewicz, & Paas, 2006; Davidson & White, 2007; Kessler, 2004).

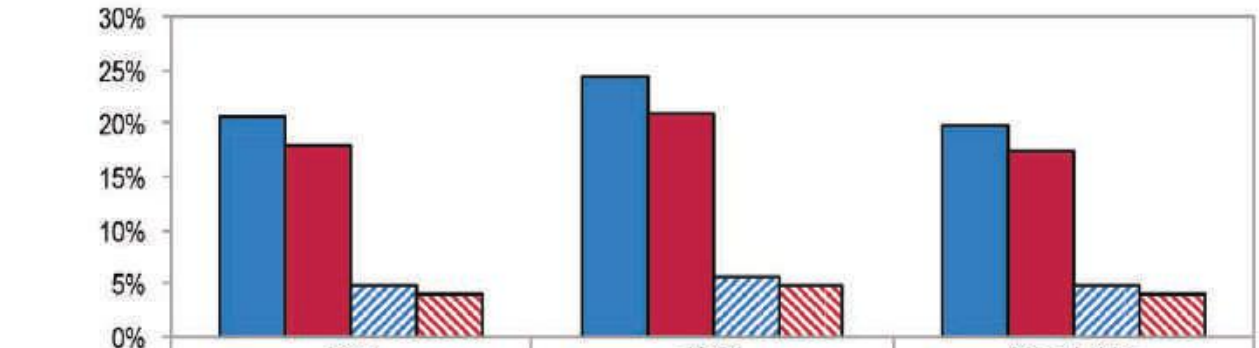
For this chapter, we compiled available state-level data on indicators related to mental health. Definitions of specific terms used in this chapter can be found in Appendix 11A, pages 187-188.

PREVALENCE OF PSYCHOLOGICAL DISTRESS IN INDIANA

General Prevalence

In 2015, a total of 20.6% Indiana adults reported having any mental illness (AMI) in the past year (95% CI [Confidence Interval]: 18.5–22.8); the U.S. rate of 18.0% (95% CI: 17.7–18.4) was statistically significantly lower. Indiana's past-year prevalence rate for serious mental illness (SMI) was similar to the nation's (IN: 4.8%, 95% CI: 3.9–5.9; U.S.:4.1%, 95% CI: 3.9–4.2). For AMI and SMI prevalence rates by age group, see Figure 11.1 (SAMHSA, 2017).

Figure 11.1 Percentage of Indiana and U.S. Population (18 Years and Older) Reporting Any Mental Illness (AMI) or Serious Mental Illness (SMI) in the Past Year, by Age Group (National Survey on Drug Use and Health, 2015)



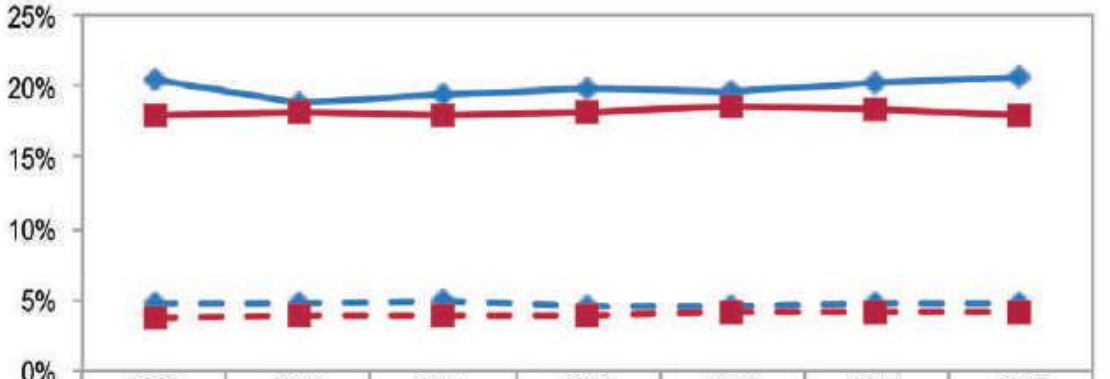
	Total	18-25	26 and older
Indiana AMI	20.6%	24.3%	19.9%
U.S. AMI	18.0%	20.9%	17.5%
Indiana SMI	4.8%	5.7%	4.7%
U.S. SMI	4.1%	4.9%	3.9%

Source: SAMHSA, 2017

For adults ages 18 and older, past-year prevalence of AMI or SMI remained fairly stable from 2009 to 2015 in Indiana and the nation (see Figure 11.2) (SAMHSA, 2017).

In 2015, 7.9% of Indiana adults (95% CI: 6.7–9.3) reported having had at least one major depressive episode (MDE) in the past year (U.S.: 6.6%, 95% CI: 6.4–6.9). For rates by age group, see Figure 11.3 (SAMHSA, 2017).

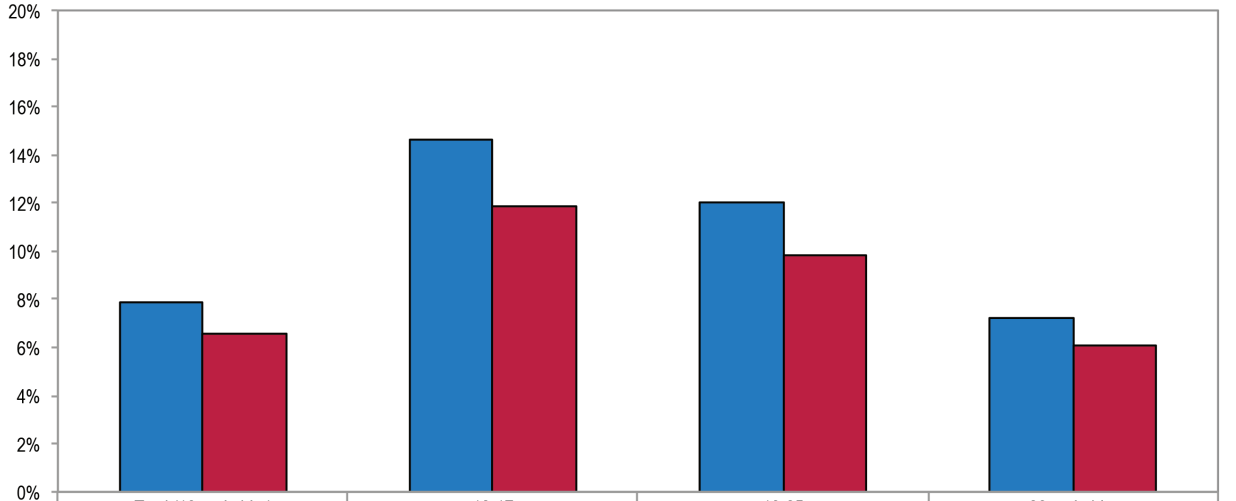
Figure 11.2 Percentage of Indiana and U.S. Population (18 Years and Older) Reporting Any Mental Illness (AMI) or Serious Mental Illness (SMI) in the Past Year (National Survey on Drug Use and Health, 2009–2015)



	2009	2010	2011	2012	2013	2014	2015
Indiana AMI	20.4%	18.8%	19.5%	19.9%	19.6%	20.3%	20.6%
U.S. AMI	17.9%	18.1%	17.9%	18.2%	18.5%	18.3%	18.0%
Indiana SMI	4.7%	4.8%	4.9%	4.5%	4.5%	4.8%	4.8%
U.S. SMI	3.7%	3.9%	4.0%	4.0%	4.1%	4.2%	4.1%

Source: SAMHSA, 2017

Figure 11.3 Percentage of Indiana and U.S. Population (12 Years and Older) Reporting at Least One Major Depressive Episode in the Past Year, by Age Group (National Survey on Drug Use and Health, 2015)



	Total (18 and older)	12-17	18-25	26 and older
Indiana	7.9%	14.6%	12.0%	7.2%
U.S.	6.6%	11.9%	9.8%	6.1%

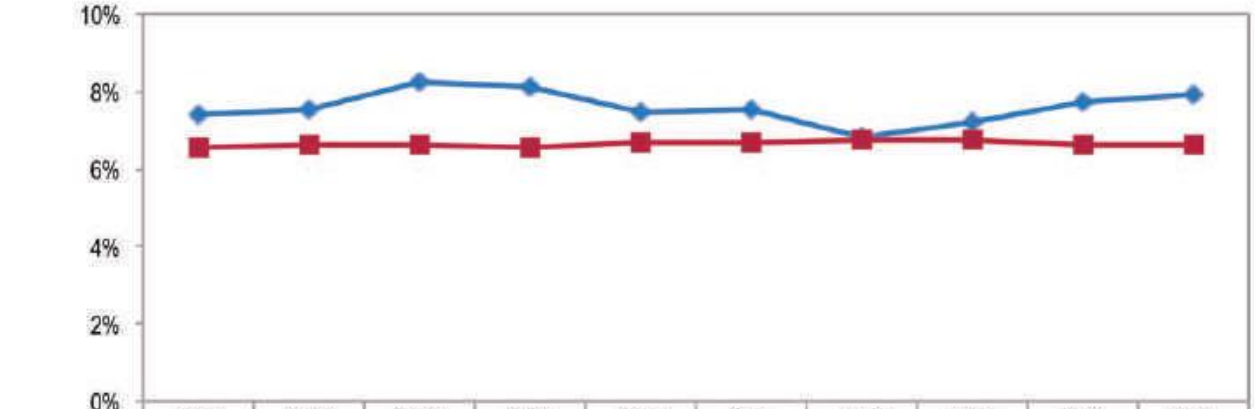
Note: There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths ages 12 to 17 were not combined with data from persons ages 18 or older to produce the total MDE estimate.

Source: SAMHSA, 2017

The percentage of adults with a major depressive episode did not change significantly from 2006 to 2015 (see Figure 11.4) (SAMHSA, 2017).

According to the 2015 Behavioral Risk Factor Surveillance System (BRFSS), 20.5% of adults in Indiana reported ever being told that they had depression (U.S.: 19.0%). Within Indiana, history of depression was greatest among females, individuals who identified as multiracial, and individuals 18-24 years old (see Table 11.1) (CDC, 2017a).

Figure 11.4 Percentage of Indiana and U.S. Population (18 Years and Older) Reporting at Least One Major Depressive Episode in the Past Year (National Survey on Drug Use and Health, 2006–2015)



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	7.4%	7.6%	8.2%	8.1%	7.5%	7.6%	6.8%	7.2%	7.7%	7.9%
U.S.	6.5%	6.6%	6.6%	6.5%	6.7%	6.7%	6.7%	6.8%	6.6%	6.6%

Source: SAMHSA, 2017

Table 11.1 Percentage of Indiana and U.S. Population (18 Years and Older) Reporting a History of Depression (Behavioral Risk Factor Surveillance System, 2015)

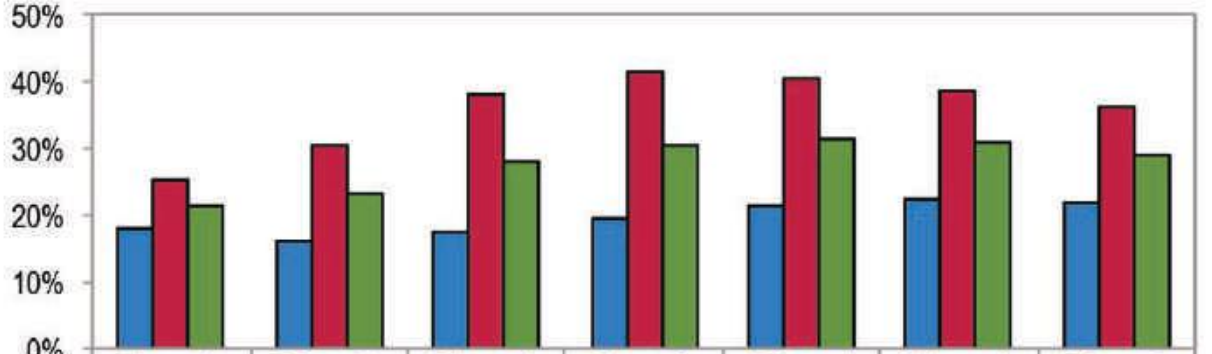
		Indiana (95% CI)	U.S.
Gender	Male	14.7% (12.7–16.7)	13.6%
	Female	25.9% (23.6–28.3)	20.1%
Race/Ethnicity	White	21.2% (19.5–22.9)	15.3%
	Black	15.0% (9.4–20.7)	18.9%
	Hispanic	15.9% (7.6–24.1)	15.0%
	Other	N/A	31.4%
	Multiracial	33.7% (18.7–48.6)	15.6%
Age Group	18-24	29.3% (22.5–36.1)	19.6%
	25-34	17.4% (13.3–21.6)	20.0%
	35-44	16.9% (13.0–20.9)	21.6%
	45-54	21.5% (18.3–24.7)	21.8%
	55-64	23.9% (21.1–26.8)	14.8%
	65+	15.8% (13.8–17.8)	18.7%
Total		**20.5% (18.9–22.0)**	

Source: CDC, 2017a

Youth Prevalence

Results from the Indiana Youth Survey show that more than one-fifth of students in grades 6 through 12 reported feeling sad or hopeless in 2016. The data suggest higher rates for female students (see Figure 11.5). However, due to the nature of the publicly available data, statistical significance of differences could not be determined (Gassman et al., 2016).

Figure 11.5 Percentage of Indiana Students (Grades 6 through 12) Reporting Feeling Sad or Hopeless (Indiana Youth Survey, 2016)



	6th grade	7th grade	8th grade	9th grade	10th grade	11th grade	12th grade
Males	18.0%	16.1%	17.7%	19.5%	21.1%	22.3%	21.6%
Females	25.0%	30.2%	38.1%	41.2%	40.6%	38.3%	36.1%
Total	21.5%	23.1%	28.0%	30.5%	31.2%	30.7%	29.1%

Source: Gassman et al., 2016

Table 11.2 Percentage of Indiana and U.S. High School Students (Grades 9 through 12) Reporting Feeling Sad or Hopeless (Youth Risk Behavior Surveillance System, 2015)

		Indiana (95% CI)	U.S. (95% CI)
Gender	Male	19.8 (17.5–22.3)	20.3 (18.9–21.8)
	Female	39.2 (33.6–45.0)	39.8 (36.5–43.2)
Race/Ethnicity	White	28.4 (25.8–31.1)	28.6 (25.8–31.5)
	Black	31.2 (22.2–41.8)	25.2 (21.7–29.1)
	Hispanic	36.8 (27.8–46.8)	35.3 (32.3–38.4)
Grade	9th	26.9 (23.0–31.2)	28.4 (25.9–31.0)
	10th	33.3 (27.8–39.3)	29.8 (26.6–33.1)
	11th	31.8 (25.7–38.7)	31.4 (28.3–34.8)
	12th	26.0 (21.6–30.8)	30.0 (27.5–32.6
Total		**29.4% (27.0–31.9)**	**29.9% (27.0–31.9)**

Source: CDC, 2017c

Based on the 2015 Youth Risk Behavior Surveillance System (YRBSS), the percentage of high school students who reported "stopping some of their normal activities during the past year due to feeling sad or hopeless almost every day for two weeks" did not differ significantly between Indiana and the nation (IN: 29.4%; U.S.: 29.9%). For rates by gender, race/ethnicity, and grade level, see Table 11.2 (CDC, 2017c).

Physically and verbally threatening behaviors, most often in the form of bullying, have been linked to a number of mental health problems in youth, primarily depression and anxiety (CDC, 2017c). The YRBSS collects information on some of these indicators. According to 2015 findings:

- 6.6% of Indiana high school students (95% CI: 4.8–9.0) reported being threatened or injured on school property at least once with a weapon (U.S.: 6.0%, 95% CI: 5.2–6.8);
- 18.1% of Indiana high school students (95% CI: 15.0–21.6) reported being in a physical fight at least once (U.S.: 22.6%, 95% CI: 20.9–24.4);
- 15.7% of Indiana high school students (95% CI: 14.0–17.7) reported being electronically bullied (U.S.:15.5%, 95% CI: 14.5–16.6); and
- 18.7% of Indiana high school students (95% CI: 16.1–21.5) reported being bullied on school property (U.S.: 20.2, 95% CI: 18.8–21.7) (CDC, 2017c).

CONSEQUENCES

Treatment

The 2015 NSDUH indicated that among U.S. adults ages 18 or older who had a mental illness, 8.8 million reported a perceived unmet need for treatment. The most commonly cited reason for not receiving mental health services was an inability to afford the costs of care (43.6%). Additionally, 8.1 million adults had a co-occurring mental illness and substance use disorder. Out of those with co-occurring disorders (CODs), 48.0% received either mental health care or substance use treatment, and 6.8% received both mental health care and specialty substance abuse treatment (Park-Lee, Lipari, & Hedden, 2016).

Findings from the SAMHSA Uniform Reporting System showed that the Indiana Division of Mental Health and Addiction (DMHA) served 133,387 Hoosiers in 2015, nearly all of which (132,685) were treated in community settings rather than state hospitals (1,154) with 452 individuals receiving treatment in both settings. The client population was predominately white (76.9%) and slightly more than half were female (52.9%) (SAMHSA, 2016). For more detailed client information, see Table 11.3.

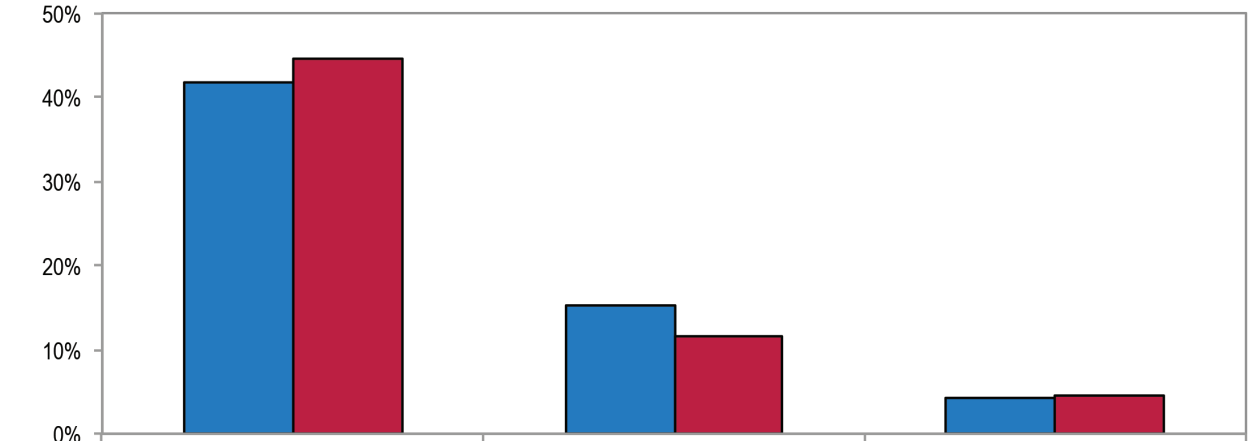
In 2013, the most recent year for which state-level estimates are available, the percentage of adults with a mental illness or with an alcohol use disorder who received any form of treatment was similar in Indiana and the U.S. (SAMHSA, 2015a, 2015b, 2017). In terms of persons with an illicit substance use disorder, a significantly larger percentage of persons received treatment in Indiana (15.2%; 95% CI: 15.0–15.4) compared to the U.S. (11.7%; 95% CI: 11.6–11.7) (SAMHSA, 2017) (see Figure 11.6).

Table 11.3 Characteristics of Adults with SMI and Children with Serious Emotional Disturbance (SED) Served by the Indiana Division of Mental Health and Addiction (Uniform Reporting System, 2015)

Gender	Male	47.1%
	Female	52.9%
Race	White	76.9%
	Black	14.5%
	Other/Unknown	8.6%
Ethnicity	Hispanic	6.0%
Age	0–17	40.0%
	18–64	57.0%
	65 and over	3.0%
Employment status (adults)	Employed	22.3%
	Unemployed	20.7%
	Not in labor force	57.0%
Medicaid funding status	Medicaid only	67.6%
	Both Medicaid and other funds	14.2%
	Non-Medicaid	18.2%
Total clients served		**133,387 (100.0%)**

Source: SAMHSA, 2016

Figure 11.6 Percentage of Indiana and U.S. Adults Who Received Any Mental Health Treatment, Any Illicit Substance Abuse Treatment, and Any Alcohol Abuse Treatment (National Survey on Drug Use and Health, 2013, 2015)



	Any Mental Health Treatment	Any Illicit Substance Abuse Treatment	Any Alcohol Abuse Treatment
Indiana	41.8%	15.2%	4.3%
U.S.	44.7%	11.7%	4.6%

Source: SAMHSA, 2015a, 2015b, 2017
Note: Data on mental health treatment utilization is based on the 2013 NSDUH as more current data are not yet available. Data on alcohol and substance abuse treatment are based on the 2015 NSDUH.

Co-occurring Mental Illness and Substance Use

Tobacco use is a significant problem in individuals with behavioral health conditions (Indiana State Department of Health, Tobacco Prevention and Cessation Commission, 2016); nearly 40% of all cigarettes in the United States are being smoked by individuals with mental illness and/or substance use disorders (SAMHSA, 2013). In Indiana, the smoking prevalence was considerably higher in adults with a mental illness (38.8%) compared to those without the condition (24.4%) (CDC, 2013b).

Based on information from the Data Assessment Registry Mental Health and Addiction (DARMHA), we find that in the treatment population, there was a significantly higher percentage of SMI (64.1%) than Substance Use Disorder (SUD) (34.9%), which, in turn, was significantly higher than the percentage of those with Co-Occurring Disorder (COD) (22.0%). This pattern was also found when looking at the DARMHA population by gender, race/ethnicity, and age group.

Males had a lower percentage of SMI (55.9%) but a higher percentage of SUD (38.7%) compared to females (SMI: 77.2%, SUD: 31.2%); COD did not differ significantly by gender. Similar to the previous year, race/ethnicity seemed to have little effect on diagnosis; most differences were not statistically significant. Age, however, was clearly associated with diagnosis.

The percentage of those with SMI significantly increased with age, from 44.9% for those under 18 to 91.1% for those 65 and older. SUD was lowest for those under 18 (14.5%) and highest for those 25-34 (55.7%) years of age, but then decreased significantly with age. COD was lowest for those under 18 (12.2%) and highest in both those 25-34 (29%) and 45-54 (29%) (see Table 11.4) (Indiana Division of Mental Health and Addiction, 2016). The patterns identified within the treatment population in 2015 are very similar to the patterns in the previous year.

Table 11.4 Demographic Characteristics of Clients by Serious Mental Illness (SMI), Substance Use Disorder (SUD), and Co-occurring Disorder (COD) Diagnosis (DARMHA, 2015)

		SMI	SUD	COD
Gender	Male	55.9% (55.6-56.2)	38.7% (38.3-39.0)	22.5% (22.2-22.8)
	Female	77.2% (71.9-72.6)	31.2% (30.8-31.5)	21.4% (21.1-21.7)
Race	White	65.2% (64.9-65.4)	35.7% (35.4-36.0)	22.3% (22.1-22.6)
	Black	62.4% (61.8-63.1)	34.5% (33.8-35.1)	23.4% (22.8-23.9)
	Other	58.7% (58.0-59.5)	29.7% (29.0-30.3)	17.1% (16.5-17.7)
Ethnicity	Hispanic	61.7% (61.0-62.5)	29.9% (29.2-30.7)	19.7% (19.0-20.3)
	Non-Hispanic	64.4% (64.1-64.6)	35.4% (35.2-35.7)	22.2% (22.0-22.4)
Age Group	Under 18	44.9% (44.5-45.4)	14.5% (14.2-14.8)	12.2% (11.9-12.4)
	18-24	63.8% (63.1-64.6)	49.4% (48.7-50.2)	24.6% (23.9-25.2)
	25-34	65.6% (65.0-66.2)	55.7% (55.1-56.3)	29.0% (28.5-29.6)
	35-44	74.4% (73.9-75.0)	47.4% (46.8-48.1)	25.7% (28.2-29.3)
	45-54	82.5% (81.9-82.9)	41.2% (40.6-41.9)	29.0% (28.3-29.6)
	55-64	87.2% (86.6-87.8)	32.5% (31.7-33.3)	24.5% (23.7-25.2)
	65+	91.1% (90.1-91.9)	18.0% (16.8-19.2)	14.8% (13.7-16.0)
Total		**64.1% (63.9-64.4)**	**34.9% (34.7-35.1)**	**22.0% (21.8-22.2)**

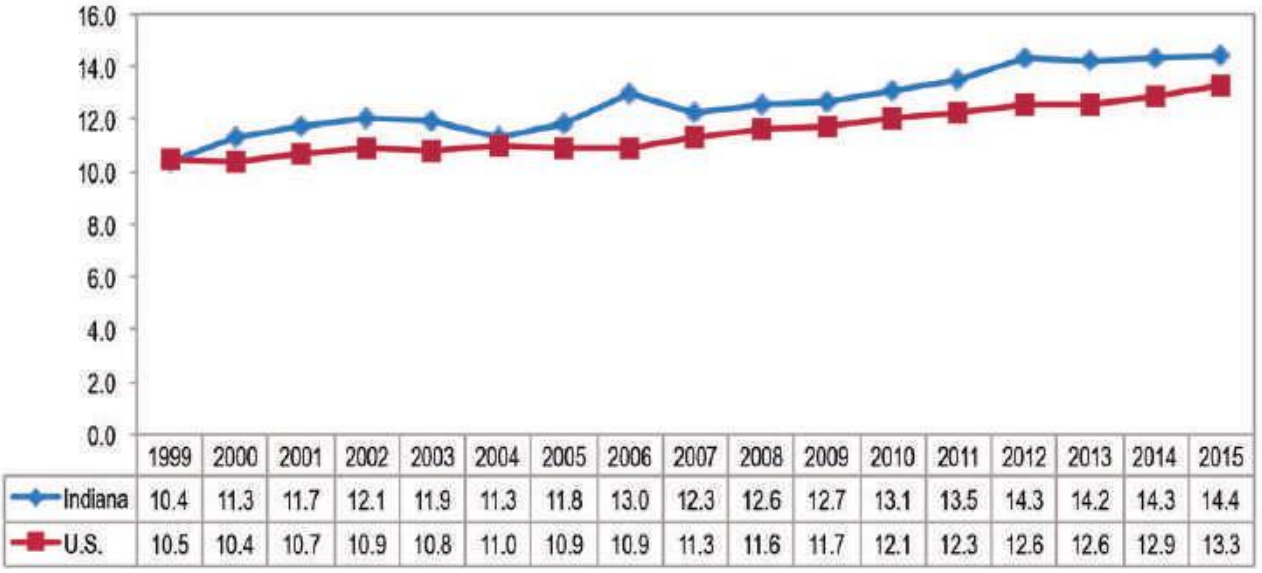
Source: Indiana Division of Mental Health and Addiction, 2015

Suicide Ideation, Attempt, and Completion

Suicide is a public health issue that is often associated with mental illness and substance abuse (CDC, 2013a; Lipari, Hughes, & Williams, 2016). Prior to actually making a suicide attempt, individuals may often spend significant amounts of time thinking about and planning how they might kill themselves. Among adults, those 18 to 25 years old are more likely than other age groups to contemplate suicide. Nationally, 7.4% (95% CI: 7.1–7.8) of adults between 18 and 25 years of age reported serious thoughts of suicide in the past year with a similar percent of Hoosiers in that age group reporting such thoughts (8.2%; 95% CI: 6.7–10.2) (Lipari, Hughes, & Williams, 2016). When compared to other states, Indiana ranked 10th in the percent of 18- to 25-year-olds who endorsed serious thoughts of suicide in the past year (Lipari, Hughes, & Williams, 2016).

Based on estimates from the 2015 YRBSS, nearly one in ten high school students attempted suicide in the past year. The overall percentages were similar in Indiana (9.9%) and the U.S. (8.6%). For prevalence rates by gender, race/ethnicity, and grade level, see Table 11.5 (CDC, 2017c).

Figure 11.7 Age-Adjusted Suicide Mortality Rate per 100,000 Population in Indiana and the United States (CDC WONDER, 1999–2015)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	10.4	11.3	11.7	12.1	11.9	11.3	11.8	13.0	12.3	12.6	12.7	13.1	13.5	14.3	14.2	14.3	14.4
U.S.	10.5	10.4	10.7	10.9	10.8	11.0	10.9	10.9	11.3	11.6	11.7	12.1	12.3	12.6	12.6	12.9	13.3

Source: CDC, 2017b

Within Indiana, suicide is one of the top 10 leading causes of death for persons between the ages of 10 and 64 (National Center for Health Statistics, 2017). Although younger individuals are more likely to think about suicide, suicide deaths most frequently occur in adults between the ages of 45 and 54 (CDC, 2017b). Suicide mortality rates both nationally and in Indiana have increased significantly from 1999 to 2015 (see Figure 11.7) and were highest among whites and males (see Table 11.6) (CDC, 2017b). County-level suicide rates from 2002–2015 are presented in Map 11.1, page 186.

Table 11.5 Percentage of Indiana and U.S. High School Students (Grades 9 through 12) Reporting Attempting Suicide in the Past Year (Youth Risk Behavior Surveillance System, 2015)

		Indiana (95% CI)	U.S. (95% CI)
Gender	Male	8.7 (6.0–12.5)	5.5 (4.7–6.4)
	Female	10.9 (8.3–14.1)	11.6 (9.7–13.7)
Race/Ethnicity	White	8.7 (6.5–11.5)	6.8 (5.5–8.4)
	Black	14.5 (8.8–23.1)	8.9 (6.7–11.9)
	Hispanic	15.5 (8.9–25.8	11.3 (9.9–13.0)
Grade	9th	12.8 (7.7–12.7)	9.9 (8.5–11.5)
	10th	11.4 (8.6–14.9)	9.4 (7.6–11.6)
	11th	10.0 (6.4–15.2)	8.0 (6.8–9.5)
	12th	5.0 (2.7–9.0)	6.2 (4.9–7.9)
Total		**9.9 (7.7–12.7)**	**8.6 (7.6–9.6)**

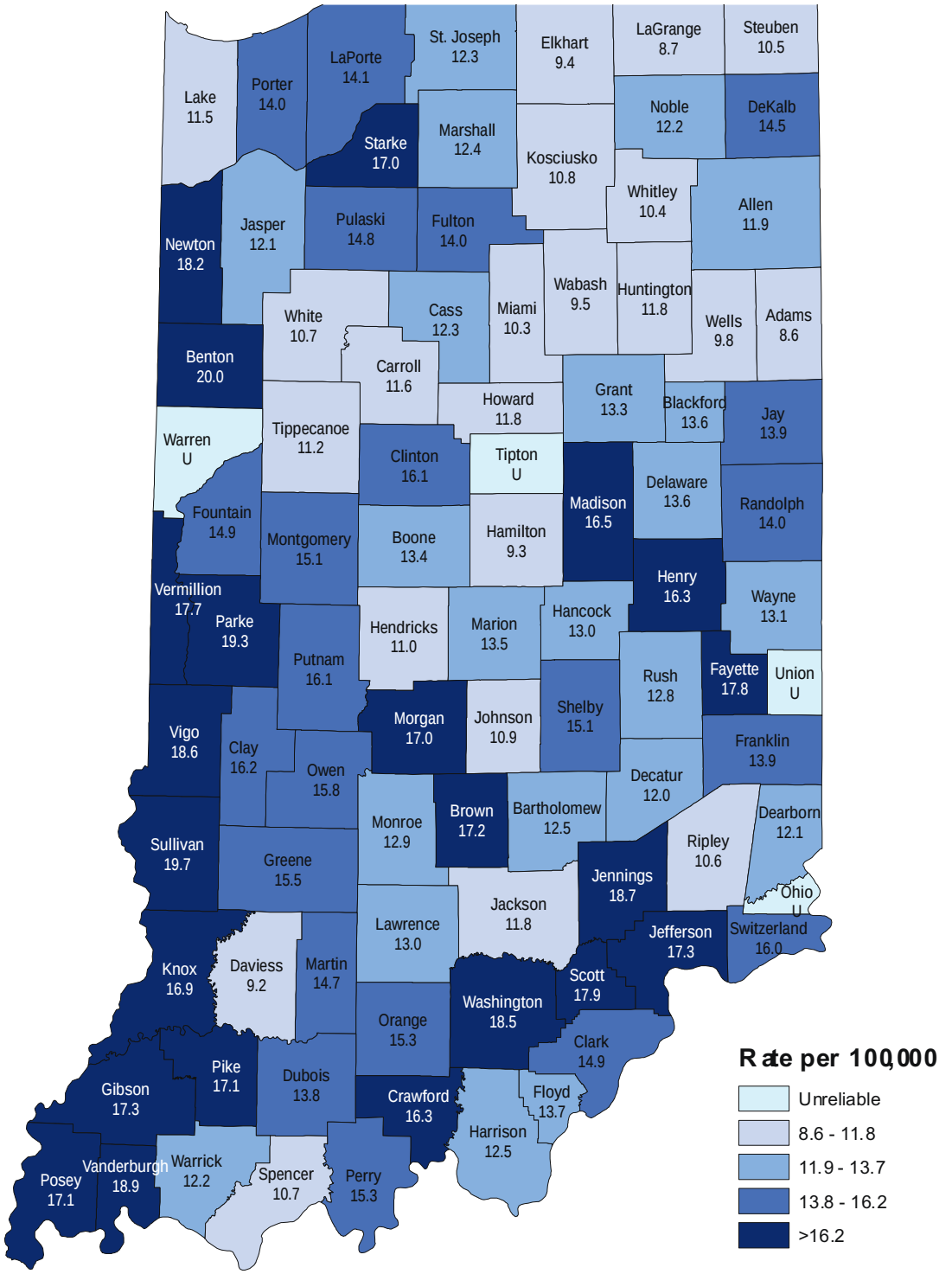
Source: CDC, 2017c

Table 11.6 Age-Adjusted Suicide Mortality Rate per 100,000 Population in Indiana and the United States (CDC WONDER, 2015)

		Indiana (95% CI)	U.S. (95% CI)
Gender	Male	23.8% (22.1-25.5)	21.1% (20.8-21.3)
	Female	5.5% (4.7 - 6.3)	6.0% (5.9-6.29)
Race/Ethnicity	White Non-Hispanic	16.0% (14.9-17.1)	17.0% (16.8-17.2)
	Black Non-Hispanic	7.5% (5.5-10.0)	5.5% (5.6-6.0)
	Hispanic	9.9% (6.5-14.5)	6.2% (6.0 – 6.4)
Total		**14.3 (13.3 - 15.2)**	**12.9% (12.8-13.0)**

Source: CDC, 2017b

Map 11.1 Average Age-Adjusted Suicide Rate in Indiana, by County (Indiana Mortality Data, 2002–2015)



Note: Rates based on numbers of death <20 are not computed, but marked as unreliable (“U”).
Source: CDC, 2017b

Appendix 11A
Definitions and Explanations

Any Mental Illness (AMI): "AMI among adults aged 18 or older is defined as currently or at any time in the past 12 months having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)" (SAMHSA, 2017).

Serious Mental Illness (SMI): "SAMHSA defined SMI as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet the criteria specified within DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" (SAMHSA, 2017).

Major Depressive Episode (MDE): "MDE, as defined in NSDUH, is based on the definition of MDE in the DSM-IV (APA, 1994) and is measured for the lifetime and past year periods. Lifetime MDE is defined as having at least five or more of nine symptoms of depression in the same 2-week period in a person's lifetime, in which at least one of the symptoms was a depressed mood or loss of interest or pleasure in daily activities. Respondents who had MDE in their lifetime were defined as having past year MDE if they had a period of depression lasting 2 weeks or longer in the past 12 months while also having some of the other symptoms of MDE. It should be noted that, unlike the DSM-IV criteria for MDE, no exclusions were made in NSDUH for depressive symptoms caused by medical illness, bereavement, or substance use disorders" (SAMHSA, 2017).

Depression: "Has a doctor, nurse, or other health professional EVER told you that you had...a depressive disorder, including depression, major depression, dysthymia, or minor depression?" (CDC, 2017a).

Feeling Sad or Hopeless:

a) "Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)" (CDC, 2017c).
b) "During the past 12 months, did you ever feel so sad or hopeless almost every day for 2 weeks or more in a row that you stopped doing some usual activities?" (Gassman et al., 2016).

Mental Health Treatment: "Mental health treatment is using prescription medication or receiving outpatient or inpatient care for problems with emotions, nerves, or mental health. Respondents were asked not to include treatment for alcohol or drug use. Respondents with unknown treatment information were excluded" (SAMHSA, 2017).

Perceived Unmet Need for Mental Health Treatment: "Perceived unmet need for mental health treatment is defined as reporting at least one occurrence in the past 12 months of feeling the need for mental health treatment or counseling but not receiving it. This definition of unmet need does not preclude respondents from having received mental health treatment in the past 12 months. Respondents with unmet need may have eventually gotten mental health treatment or counseling, or they may have received mental health treatment but perceived the need for additional treatment that they did not receive" (SAMHSA, 2017).

Substance Abuse Treatment: "Substance abuse treatment is treatment to reduce or stop alcohol or illicit drug use or for medical problems associated with alcohol or illicit drug use. It includes treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006" (SAMHSA, 2017).

Unmet Need for Substance Abuse Treatment: "Unmet need for substance abuse treatment is defined as a need for treatment that was not received. Respondents were classified as needing treatment for an alcohol or illicit drug problem if they met at least one of three criteria

during the past year: (1) dependent on alcohol or illicit drugs, (2) abused alcohol or illicit drugs, or (3) received treatment for alcohol or illicit drug use at a specialty facility (i.e., alcohol and drug rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Adults are defined as people aged 18 or older" (SAMHSA, 2017).

Outpatient Services: "Outpatient services are treatment from a (1) private therapist, psychologist, psychiatrist, social worker, or counselor; (2) mental health clinic or center; (3) partial day hospital or day treatment program; or (4) in-home therapist, counselor, or family preservation worker…Mental health services include treatment for emotional or behavioral problems not caused by alcohol or drug use. Respondents with unknown receipt of mental health service information were excluded. Respondents could indicate multiple service sources; thus, these responsive categories are not mutually exclusive" (SAMHSA, 2017).

Inpatient Services: "An inpatient service is a stay of overnight or longer in a hospital or other facility for mental health problems…Mental health services include treatment for emotional or behavioral problems not caused by alcohol or drug use. Respondents with unknown receipt of mental health service information were excluded. Respondents could indicate multiple service sources; thus, these responsive categories are not mutually exclusive" (SAMHSA, 2017).

Nonspecialty Services: "Includes use of mental health services provided by a pediatrician or other family doctor…Mental health services include treatment for emotional or behavioral problems not caused by alcohol or drug use. Respondents with unknown receipt of mental health service information were excluded. Respondents could indicate multiple service sources; thus, these responsive categories are not mutually exclusive" (SAMHSA, 2017).

Suicide Attempts: "Attempted suicide one or more times during the 12 months before the survey" (CDC, 2017c).

Suicide Deaths: Suicide (intentional self-harm) deaths include ICD-10 codes X60-X84 (CDC, 2013a).

REFERENCES, CHAPTER 11

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12 Indicators of Substance Abuse

INDIANA COMMUNITIES AT RISK

To measure and compare the severity of substance abuse among Indiana counties, we identified county-level consumption and consequence data for individual drug categories, including alcohol, marijuana, cocaine and heroin, methamphetamine, and prescription drugs. We then ranked Indiana counties on the selected indicators, using a highest-need/highest-contributor model. Counties received a priority score based on their need for intervention (measured by the rate[1] at which an indicator occurred) and their overall *contribution* to the problem (measured by the frequency with which an indicator occurred).

For each indicator, counties were given three points if they were in the top 10 percent (90th percentile), two points if they were in the top 11 to 25 percent (75th percentile), one point if they were in the top 26 to 50 percent (50th percentile), and zero points if they fell below the 50th percentile. The points were then added up, averaged over the number of indicators, and multiplied by 100; this created a priority score for each drug category. Higher scores equated to larger burdens of substance abuse. For each substance, the top 10 percent of counties, i.e., those most severely affected, were determined.

We then calculated an *overall substance abuse priority score* to assess severity of consumption and consequences of alcohol and other drugs within each county. This score was computed by averaging the priority scores from each drug category. The top 10 percent of counties, i.e., those with the highest overall scores and most severe problems, are listed in Table 12.6.

The selection of substance abuse indicators was limited to datasets with de-identified county-level information, such as the

- 2016 Treatment Episode Data Set (TEDS) (Indiana Family and Social Services Administration [FSSA], 2016),[2]
- 2014 Uniform Crime Reporting (UCR) Program (Federal Bureau of Investigation [FBI], 2014),[3]
- 2015 Indiana Automated Reporting Information Exchange System (ARIES) (Indiana State Police [ISP], 2016),
- 2016 Methamphetamine Lab Statistics (Indiana State Police, 2017), and
- 2016 INSPECT data (Indiana Professional Licensing Agency [IPLA], 2017).

[1]The rate was calculated by taking the frequency of an event (e.g., number of arrests), dividing it by the specified population (e.g., county population), and multiplying the result by 1,000. This represents the rate per 1,000 population.
[2]Indiana TEDS data are limited to individuals entering substance abuse treatment who are 200% below the federal poverty level and receive state-funded treatment; therefore, data are not representative of the entire substance abuse treatment population.
[3]States are not required to submit crime information to the FBI, and level of reporting varies by county. The FBI uses statistical algorithms to estimate arrests for counties in which reporting is less than 100%. In Indiana, an average of about 60% of counties report the number of arrests, so the rest are estimated (see Table 2.1, page 26, for level of coverage by county).

INDICATORS OF ABUSE

Alcohol Indicators

Counties were assessed and ranked according to the following 10 indicators for alcohol abuse:

- number and rate of alcohol-related crashes
- number and rate of arrests for driving under the influence (DUI)
- number and rate of arrests for public intoxication
- number and rate of arrests for liquor law violations
- number and rate of substance abuse treatment episodes with reported alcohol use

The counties that scored in the top 10 percent based on these 10 alcohol indicators are shown in Table 12.1. For a complete listing of counties by all alcohol abuse indicators, see Appendix 12A, pages 195-197.

Table 12.1 Counties with Alcohol Priority Scores in the Top 10 Percent

Top 10 Percent	Alcohol Priority Score
Delaware	230
Monroe	230
Lake	220
LaPorte	220
Allen	200
Cass	200
Tippecanoe	200
Vanderburgh	200
Marion	190
Porter	190

Note: Alcohol priority scores ranged from 0 to 230, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014; ISP, 2016

Marijuana Indicators

Following the methodology of the highest-need/highest-contributor model, we computed priority scores for marijuana abuse for each county. We examined communities based on the following six indicators for marijuana abuse:

- number and rate of arrests for possession of marijuana
- number and rate of arrests for sale/manufacture of marijuana
- number and rate of substance abuse treatment episodes with reported marijuana use

Table 12.2 lists the counties that ranked in the top 10 percent for marijuana abuse. For a complete listing of counties by all marijuana indicators, see Appendix 12B, pages 198-199.

Table 12.2 Counties with Marijuana Priority Scores in the Top 10 Percent

Top 10 Percent	Marijuana Priority Score
Vanderburgh	267
Lake	233
Madison	217
Cass	200
Hamilton	183
Monroe	167
Morgan	167
Rush	167
Tippecanoe	167
Wayne	167

Note: Marijuana priority scores ranged from 0 to 267, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014

Cocaine and Heroin Indicators

Since the UCR data do not provide cocaine- or heroin-specific information, we used aggregated arrests for cocaine and opiates. In order to stay consistent with our methodology, we included both treatment admissions with reported use of cocaine and heroin. Our analysis is based on the following eight indicators:

- number and rate of arrests for possession of cocaine and opiates
- number and rate of arrests for sale/manufacture of cocaine and opiates
- number and rate of substance abuse treatment episodes with reported cocaine use
- number and rate of substance abuse treatment episodes with reported heroin use

Table 12.3 displays the counties with cocaine-heroin priority scores in the top 10 percent. For a complete listing of counties by cocaine and heroin abuse indicators, see Appendix 12C, pages 200-201.

Table 12.3 Counties with Cocaine and Heroin Priority Scores in the Top 10 Percent

Top 10 Percent	Cocaine-Heroin Priority Score
Howard	300
Delaware	263
Wayne	250
Lake	225
Madison	213
Allen	200
LaPorte	200
Clark	188
Jay	188
Dearborn	175
Fayette	175
Monroe	175
Montgomery	175
Morgan	175
Saint Joseph	175

Note: Cocaine-heroin priority scores ranged from 0 to 300, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014

Methamphetamine (Meth) Indicators

We computed meth priority scores based on eight indicators:

- number and rate of arrests for possession of synthetic drugs
- number and rate of arrests for sale/manufacture of synthetic drugs
- number and rate of substance abuse treatment episodes with reported meth use
- number and rate of clandestine meth lab seizures

The UCR program does not collect meth-specific information, but includes arrests for possession and sale/manufacture of synthetic drugs, encompassing methamphetamine. For the top 10 percent of counties with the highest meth priority scores, see Table 12.4. A complete listing of all counties by methamphetamine indicators can be found in Appendix 12D, pages 202-203.

Table 12.4 Counties with Methamphetamine Priority Scores in the Top 10 Percent

Top 10 Percent	Meth Priority Score
Vanderburgh	238
Bartholomew	225
Kosciusko	225
Noble	225
Delaware	213
DeKalb	200
Jay	200
Vigo	200
Madison	715
Perry	163
Warrick	163

Note: Methamphetamine priority scores ranged from 0 to 238, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014; ISP, 2016

Prescription Drug (Rx) Indicators

Prescription drug abuse refers to the nonmedical use of any prescription-type pharmaceutical, including opioids (pain relievers), depressants of the central nervous system (sedatives, hypnotics, and tranquilizers), and stimulants. We selected the following prescription drug indicators for our analysis:

- number and rate of arrests for possession of "other drugs" (barbiturates and Benzedrine)[4]
- number and rate of arrests for sale/manufacture of "other drugs" (barbiturates and Benzedrine)
- number and rate of treatment episodes with nonmedical prescription drug use reported
- number and rate of prescription opioids (pain relievers) dispensed

Table 12.5 lists the counties in the top 10 percent for prescription drug abuse. For a complete listing of counties by prescription drug abuse indicators, see Appendix 12E, pages 204-205.

Table 12.5 Counties with Prescription Drug (Rx) Priority Scores in the Top 10 Percent

Top 10 Percent	Rx Priority Score
Decatur	225
Howard	213
Lawrence	213
Madison	213
Vanderburgh	213
Monroe	200
Clark	163
Delaware	163
Floyd	163
Allen	163
Cass	150
Jackson	150
Jefferson	150
Marshall	150
Rush	150
Scott	150

Note: Prescription drug priority scores ranged from 0 to 225, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014; IPLA. 2017

SEVERITY OF BURDEN – OVERALL RANKING OF COUNTIES

To measure the overall burden of substance abuse on Indiana communities, we averaged the priority scores across all five drug categories and ranked counties by severity of alcohol and drug problems. The top 10 percent of counties are displayed in Table 12.6. A complete listing of all counties by overall priority score can be found in Appendix 12F, page 206.

Table 12.6 Counties with Total Priority Scores in the Top 10 Percent

Top 10 Percent	Total Priority Score
Delaware	204
Vanderburgh	203
Madison	195
Lake	176
Monroe	174
Allen	167
Cass	160
Howard	159
Clark	155
Kosciusko	148

Note: Overall substance abuse priority scores ranged from 12 to 204, with higher scores indicating a more severe problem.
Source: FSSA, 2016; FBI, 2014; ISP, 2015, 2016; IPLA, 2017

[4]Barbiturates (central nervous system depressants) and Benzedrine (amphetamine/stimulant) are types of prescription drugs that are frequently used nonmedically or for recreational purposes.

APPENDIX 12A

Alcohol Abuse Indicators and Priority Scores by County, With Rank, All Rates per 1,000 Population (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016; and Automated Reporting Information Exchange System, 2015)

County	DUI Arrests		Public Intoxication Arrests		Liquor Law Violation Arrests		Alcohol Use Reported at Treatment Admission		Alcohol-Related Collisions		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Adams	77	2.22	5	*0.14	35	1.01	165	4.72	31	0.89	40	
Allen	1,231	3.37	429	1.17	161	0.44	1,077	2.92	624	1.69	200	Top 10
Bartholomew	402	5.03	75	0.94	105	1.31	201	2.48	72	0.89	150	Top 25
Benton	27	3.09	5	*0.57	11	*1.26	39	4.49	9	*1.04	50	
Blackford	39	3.18	7	*0.57	6	*0.49	31	2.52	14	*1.14	20	
Boone	225	3.66	29	0.47	86	1.40	68	1.07	48	0.76	80	Top 50
Brown	26	1.73	0	*0.00	9	*0.60	42	2.80	33	2.20	40	
Carroll	61	3.04	8	*0.40	23	1.15	54	2.72	22	1.11	10	
Cass	203	5.29	140	3.65	131	3.42	177	4.66	50	1.32	200	Top 10
Clark	620	5.46	168	1.48	109	0.96	82	0.71	154	1.33	150	Top 25
Clay	86	3.21	16	*0.60	37	1.38	93	3.51	35	1.32	50	
Clinton	78	2.37	7	*0.21	74	2.25	109	3.34	67	2.05	100	Top 50
Crawford	45	4.24	7	*0.66	9	*0.85	22	2.10	11	*1.05	30	
Daviess	122	3.74	14	*0.43	54	1.66	71	2.16	32	0.97	60	
Dearborn	171	3.43	26	0.52	53	1.06	229	4.63	76	1.54	130	Top 25
Decatur	47	1.78	3	*0.11	107	4.05	122	4.60	33	1.24	90	Top 50
DeKalb	144	3.40	19	*0.45	52	1.23	176	4.13	47	1.10	90	Top 50
Delaware	559	4.76	293	2.49	200	1.70	462	3.95	191	1.63	230	Top 10
Dubois	127	2.99	11	*0.26	64	1.51	221	5.20	90	2.12	140	Top 25
Elkhart	678	3.36	80	0.40	192	0.95	349	1.72	239	1.17	130	Top 25
Fayette	81	3.41	24	1.01	45	1.89	82	3.50	33	1.41	80	Top 50
Floyd	196	2.56	105	1.37	58	0.76	34	0.44	110	1.43	90	Top 50
Fountain	53	3.15	12	*0.71	26	1.55	16	*0.96	16	*0.96	40	
Franklin	2	*0.09	0	*0.00	29	1.36	76	3.32	30	1.31	30	
Fulton	49	2.41	17	*0.83	19	*0.93	97	4.77	20	0.98	50	
Gibson	138	4.10	18	*0.53	60	1.78	177	5.24	56	1.66	150	Top 25
Grant	125	1.81	57	0.83	71	1.03	265	3.90	53	0.78	90	Top 50
Greene	47	1.44	10	*0.31	13	*0.40	85	2.62	36	1.11	0	
Hamilton	903	2.99	130	0.43	455	1.51	550	1.78	291	0.94	160	Top 25
Hancock	205	2.75	18	*0.24	68	0.91	90	1.24	57	0.79	40	
Harrison	42	1.07	8	*0.20	23	0.59	11	*0.28	43	1.09	10	
Hendricks	344	2.20	19	*0.12	150	0.96	133	0.84	159	1.01	80	Top 50
Henry	127	2.59	39	0.80	103	2.10	119	2.43	46	0.94	80	Top 50
Howard	238	2.87	109	1.32	61	0.74	276	3.34	100	1.21	120	Top 25
Huntington	130	3.54	11	*0.30	43	1.17	67	1.83	47	1.28	60	
Jackson	157	3.59	70	1.60	61	1.40	111	2.52	63	1.43	120	Top 25
Jasper	108	3.23	10	*0.30	31	0.93	49	1.46	45	1.34	40	
Jay	92	4.27	29	1.35	26	1.21	86	4.07	20	0.95	80	Top 50
Jefferson	106	3.26	24	0.74	52	1.60	155	4.78	53	1.63	140	Top 25
Jennings	39	1.38	9	*0.32	90	3.19	100	3.58	28	1.00	60	
Johnson	419	2.84	42	0.28	278	1.88	136	0.91	143	0.96	110	Top 50

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APPENDIX 12A *(Continued from previous page)*

County	DUI Arrests		Public Intoxication Arrests		Liquor Law Violation Arrests		Alcohol Use Reported at Treatment Admission		Alcohol-Related Collisions		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Knox	93	2.46	34	0.90	57	1.50	146	3.85	53	1.40	90	Top 50
Kosciusko	538	6.92	38	0.49	87	1.12	235	2.99	95	1.21	120	Top 25
LaGrange	99	2.59	11	*0.29	178	4.66	127	3.27	38	0.98	80	Top 50
Lake	2,262	4.61	925	1.89	673	1.37	1,348	2.76	741	1.52	220	Top 10
LaPorte	577	5.18	180	1.62	207	1.86	208	1.88	203	1.83	220	Top 10
Lawrence	97	2.12	10	*0.22	103	2.25	193	4.24	67	1.47	110	Top 50
Madison	377	2.89	113	0.87	136	1.04	589	4.54	180	1.39	160	Top 25
Marion	2,073	2.22	1,756	1.88	559	0.60	1,540	1.64	1,202	1.28	190	Top 10
Marshall	241	5.11	32	0.68	70	1.48	104	2.22	73	1.56	130	Top 25
Martin	20	1.98	8	*0.79	9	*0.89	28	2.74	5	*0.49	10	
Miami	91	2.53	29	0.81	22	0.61	163	4.55	48	1.34	70	
Monroe	431	3.02	267	1.87	639	4.47	620	4.28	205	1.42	230	Top 10
Montgomery	75	1.96	12	*0.31	21	0.55	153	4.00	43	1.12	30	
Morgan	171	2.44	37	0.53	111	1.59	177	2.54	74	1.06	90	Top 50
Newton	27	1.92	9	*0.64	10	*0.71	15	*1.07	24	1.71	40	
Noble	186	3.91	13	*0.27	53	1.11	178	3.73	78	1.63	110	Top 50
Ohio	17	*2.85	1	*0.17	5	*0.84	24	4.04	6	*1.01	20	
Orange	56	2.83	4	*0.20	21	1.06	89	4.54	28	1.43	30	
Owen	59	2.79	3	*0.14	19	*0.90	95	4.55	33	1.58	40	
Parke	116	6.75	8	*0.47	24	1.40	42	2.49	32	1.89	80	Top 50
Perry	84	4.28	17	*0.87	46	2.35	65	3.36	33	1.71	120	Top 25
Pike	54	4.27	32	2.53	8	*0.63	28	2.22	19	*1.51	70	
Porter	724	4.33	112	0.67	360	2.15	160	0.95	258	1.54	190	Top 10
Posey	42	1.65	23	0.91	11	*0.43	116	4.55	39	1.53	80	Top 50
Pulaski	35	2.71	3	*0.23	14	*1.08	57	4.42	21	1.63	40	
Putnam	117	3.13	21	0.56	50	1.34	86	2.29	47	1.25	70	
Randolph	76	2.98	15	*0.59	30	1.18	77	3.06	22	0.87	40	
Ripley	92	3.07	15	*0.50	42	1.40	103	3.59	36	1.25	40	
Rush	67	3.96	2	*0.12	48	2.84	62	3.72	15	*0.90	60	
Saint Joseph	528	1.98	49	0.18	177	0.66	620	2.31	303	1.13	120	Top 25
Scott	44	1.84	45	1.88	34	1.42	42	1.77	23	0.97	60	
Shelby	81	1.81	14	*0.31	69	1.54	73	1.64	40	0.90	20	
Spencer	58	2.77	4	*0.19	23	1.10	89	4.30	37	1.79	50	
Starke	38	1.64	17	*0.73	23	0.99	48	2.09	32	1.39	30	
Steuben	92	2.67	13	*0.38	43	1.25	211	6.14	54	1.57	90	Top 50
Sullivan	36	1.70	9	*0.42	17	*0.80	44	2.10	29	1.39	10	
Switzerland	31	2.95	2	*0.19	11	*1.05	28	2.66	7	*0.67	0	
Tippecanoe	613	3.37	381	2.09	223	1.22	219	1.18	261	1.40	200	Top 10
Tipton	41	2.63	11	*0.71	7	*0.45	32	2.10	17	*1.11	10	
Union	20	2.77	1	*0.14	6	*0.83	8	*1.11	5	*0.70	0	
Vanderburgh	581	3.19	401	2.20	123	0.68	722	3.97	272	1.50	200	Top 10

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APPENDIX 12A *(Continued from previous page)*

County	DUI Arrests		Public Intoxication Arrests		Liquor Law Violation Arrests		Alcohol Use Reported at Treatment Admission		Alcohol-Related Collisions		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Vermillion	50	3.16	5	*0.32	13	*0.82	50	3.19	25	1.59	40	
Vigo	265	2.44	169	1.56	243	2.24	392	3.63	149	1.38	180	Top 25
Wabash	49	1.52	23	0.71	37	1.15	129	4.01	36	1.12	50	
Warren	23	2.74	2	*0.24	9	*1.07	6	*0.73	9	*1.09	0	
Warrick	137	2.23	19	0.31	34	0.55	159	2.57	51	0.82	40	
Washington	85	3.07	14	0.51	35	1.26	18	*0.65	27	0.97	30	
Wayne	235	3.47	71	1.05	112	1.65	192	2.87	111	1.66	180	Top 25
Wells	59	2.12	6	*0.22	20	0.72	70	2.50	28	1.00	0	
White	122	4.99	11	*0.45	43	1.76	57	2.35	43	1.77	100	Top 50
Whitley	156	4.68	7	*0.21	50	1.50	73	2.19	38	1.14	50	
Indiana	**20,810**	**3.15**	**7,107**	**1.08**	**8,245**	**1.25**	**16,615**	**2.52**	**8,642**	**1.31**		

* Rates that are based on numbers lower than 20 are unreliable.
Notes: Due to confidentiality concerns, health data (such as treatment data) with numbers less than five are not specified, but marked <5.
The alcohol priority score was based on 10 indicators and ranged from 0 to 230. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016; ISP, 2015

APPENDIX 12B

Marijuana Abuse Indicators and Priority Scores by County, With Rank, All Rates per 1,000 Population (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016)

County	Marijuana Possession Arrests		Marijuana Sale Arrests		Marijuana Use Reported At Treatment Admission		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate		
Adams	31	0.89	9	*0.26	173	4.95	83	Top 50
Allen	567	1.55	42	0.12	980	2.66	133	Top 25
Bartholomew	156	1.95	6	*0.08	291	3.59	117	Top 50
Benton	13	*1.49	3	*0.34	32	3.69	33	
Blackford	23	1.87	2	*0.16	44	3.58	33	
Boone	125	2.03	9	*0.15	75	1.18	83	Top 50
Brown	14	*0.93	3	*0.20	38	2.54	0	
Carroll	26	1.29	6	*0.30	43	2.17	17	
Cass	119	3.10	44	1.15	132	3.48	200	Top 10
Clark	368	3.24	39	0.34	65	0.56	150	Top 25
Clay	43	1.60	8	*0.30	80	3.02	50	
Clinton	66	2.01	9	*0.27	108	3.31	100	Top 50
Crawford	6	*0.57	8	*0.75	22	2.10	50	
Daviess	69	2.12	2	*0.06	62	1.88	50	
Dearborn	78	1.56	14	*0.28	225	4.55	150	Top 25
Decatur	71	2.69	7	*0.26	117	4.41	117	Top 50
DeKalb	66	1.56	19	*0.45	144	3.38	117	Top 50
Delaware	255	2.17	4	*0.03	459	3.93	150	Top 25
Dubois	57	1.34	16	*0.38	162	3.82	100	Top 50
Elkhart	343	1.70	19	*0.09	321	1.58	117	Top 50
Fayette	46	1.94	9	*0.38	85	3.63	83	Top 50
Floyd	90	1.17	11	*0.14	15	*0.20	33	
Fountain	27	1.61	6	*0.36	23	1.39	33	
Franklin	5	*0.24	30	1.41	75	3.28	100	Top 50
Fulton	22	1.08	6	*0.29	87	4.28	50	
Gibson	54	1.60	6	*0.18	138	4.09	83	Top 50
Grant	109	1.58	5	*0.07	257	3.78	83	Top 50
Greene	14	*0.43	5	*0.15	86	2.65	0	
Hamilton	621	2.05	45	0.15	424	1.37	183	Top 10
Hancock	83	1.11	29	0.39	100	1.38	83	Top 50
Harrison	10	*0.26	9	*0.23	<5	N/A	17	
Hendricks	169	1.08	51	0.33	146	0.92	117	Top 50
Henry	90	1.84	10	*0.20	111	2.27	67	
Howard	127	1.53	19	*0.23	249	3.02	100	Top 50
Huntington	40	1.09	15	*0.41	84	2.29	50	
Jackson	139	3.18	12	*0.27	147	3.34	133	Top 25
Jasper	31	0.93	14	*0.42	56	1.67	50	
Jay	47	2.18	3	*0.14	114	5.40	100	Top 50
Jefferson	58	1.79	12	*0.37	178	5.49	150	Top 25
Jennings	31	1.10	6	*0.21	106	3.80	50	
Johnson	411	2.79	31	0.21	133	0.89	150	Top 25
Knox	59	1.56	13	*0.34	125	3.30	100	Top 50
Kosciusko	126	1.62	23	0.30	238	3.03	133	Top 25
LaGrange	21	0.55	5	*0.13	111	2.86	17	
Lake	1,025	2.09	356	0.73	929	1.90	233	Top 10
LaPorte	206	1.85	54	0.49	136	1.23	150	Top 25
Lawrence	83	1.81	14	*0.31	235	5.17	150	Top 25
Madison	246	1.89	48	0.37	700	5.40	217	Top 10
Marion	301	0.32	38	0.04	1,626	1.73	117	Top 50
Marshall	101	2.14	25	0.53	106	2.26	133	Top 25
Martin	19	*1.88	1	*0.10	35	3.42	33	
Miami	50	1.39	45	1.25	150	4.18	150	Top 25
Monroe	308	2.16	23	0.16	559	3.86	167	Top 10
Montgomery	48	1.26	11	*0.29	216	5.65	117	Top 50
Morgan	101	1.44	66	0.94	217	3.12	167	Top 10
Newton	18	*1.28	0	*0.00	20	*1.43	0	

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APPENDIX 12B *(Continued from previous page)*

County	Marijuana Possession Arrests		Marijuana Sale Arrests		Marijuana Use Reported At Treatment Admission		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate		
Noble	66	1.39	4	*0.08	208	4.36	83	Top 50
Ohio	7	*1.17	1	*0.17	17	*2.86	0	
Orange	23	1.16	9	*0.46	82	4.18	83	Top 50
Owen	24	1.14	4	*0.19	94	4.50	50	
Parke	36	2.09	8	*0.47	28	1.66	67	
Perry	33	1.68	6	*0.31	63	3.26	50	
Pike	17	*1.34	58	4.58	22	1.75	100	Top 50
Porter	291	1.74	26	0.16	166	0.99	100	Top 50
Posey	9	*0.35	5	*0.20	84	3.29	17	
Pulaski	15	*1.16	4	*0.31	47	3.65	33	
Putnam	59	1.58	10	*0.27	105	2.79	67	
Randolph	41	1.61	6	*0.24	88	3.50	33	
Ripley	50	1.67	18	*0.60	92	3.21	100	Top 50
Rush	69	4.08	9	*0.53	87	5.22	167	Top 10
Saint Joseph	325	1.22	72	0.27	565	2.10	150	Top 25
Scott	26	1.09	4	*0.17	40	1.68	0	
Shelby	101	2.26	24	0.54	91	2.05	117	Top 50
Spencer	27	1.29	7	*0.33	76	3.67	33	
Starke	13	*0.56	9	*0.39	78	3.40	67	
Steuben	54	1.57	3	*0.09	154	4.48	83	Top 50
Sullivan	19	*0.90	2	*0.09	37	1.77	0	
Switzerland	14	*1.33	4	*0.38	28	2.66	17	
Tippecanoe	526	2.89	43	0.24	231	1.24	167	Top 10
Tipton	23	1.47	6	*0.38	38	2.49	17	
Union	9	*1.25	2	*0.28	10	*1.39	17	
Vanderburgh	562	3.09	104	0.57	727	4.00	267	Top 10
Vermillion	17	*1.07	15	*0.95	55	3.50	83	Top 50
Vigo	106	0.98	38	0.35	432	4.00	150	Top 25
Wabash	28	0.87	9	*0.28	135	4.20	83	Top 50
Warren	15	*1.79	3	*0.36	5	*0.60	33	
Warrick	55	0.90	11	*0.18	143	2.31	50	
Washington	39	1.41	8	*0.29	18	*0.65	17	
Wayne	141	2.08	27	0.40	195	2.91	167	Top 10
Wells	15	*0.54	3	*0.11	86	3.08	17	
White	57	2.33	1	*0.04	47	1.93	67	
Whitley	48	1.44	15	*0.45	59	1.77	50	Top 50
Indiana	**10,392**	**1.58**	**1,903**	**0.29**	**16,027**	**2.43**		

* Rates that are based on numbers lower than 20 are unreliable.
Notes: Due to confidentiality concerns, health data (such as treatment data) with numbers less than five are not specified, but marked <5.
The marijuana priority score was based on six indicators and ranged from 0 to 267. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016

APPENDIX 12C

Cocaine and Heroin Abuse Indicators and Priority Scores by County, With Rank, All Rates per 1,000 Population (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016)

County	Cocaine-Heroin Possession Arrests		Cocaine-Heroin Sale Arrests		Cocaine Use Reported at Treatment Admission		Heroin Use Reported at Treatment Admission		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Adams	4	*0.12	4	*0.12	32	0.91	63	1.80	100	Top 50
Allen	97	0.27	48	0.13	359	0.97	206	0.56	200	Top 10
Bartholomew	16	*0.20	7	*0.09	32	0.39	124	1.53	113	Top 50
Benton	2	*0.23	2	*0.23	8	*0.92	<5	N/A	63	
Blackford	2	*0.16	4	*0.33	<5	N/A	34	2.76	75	Top 50
Boone	14	*0.23	9	*0.15	<5	N/A	42	0.66	50	
Brown	4	*0.27	0	*0.00	6	*0.40	20	1.34	50	
Carroll	4	*0.20	5	*0.25	<5	N/A	11	*0.55	13	
Cass	9	*0.23	57	1.49	17	*0.45	43	1.13	150	Top 25
Clark	196	1.72	78	0.69	24	0.21	55	0.48	188	Top 10
Clay	6	*0.22	7	*0.26	<5	N/A	10	*0.38	25	
Clinton	16	*0.49	6	*0.18	19	*0.58	45	1.38	150	Top 25
Crawford	0	*0.00	0	*0.00	<5	N/A	6	*0.57	0	
Daviess	16	*0.49	29	0.89	<5	N/A	<5	N/A	113	Top 50
Dearborn	12	*0.24	13	*0.26	45	0.91	150	3.03	175	Top 10
Decatur	8	*0.30	3	*0.11	9	*0.34	24	0.90	63	
DeKalb	11	*0.26	6	*0.14	10	*0.23	12	*0.28	50	
Delaware	35	0.30	113	0.96	134	1.15	267	2.28	263	Top 10
Dubois	8	*0.19	4	*0.09	5	*0.12	11	*0.26	13	
Elkhart	23	0.11	25	0.12	78	0.38	55	0.27	100	Top 50
Fayette	8	*0.34	8	*0.34	15	*0.64	93	3.97	175	Top 10
Floyd	8	*0.10	18	*0.23	<5	N/A	24	0.31	38	
Fountain	4	*0.24	4	*0.24	6	*0.36	13	*0.78	38	
Franklin	3	*0.14	0	*0.00	6	*0.26	54	2.36	50	
Fulton	5	*0.25	4	*0.20	10	*0.49	11	*0.54	50	
Gibson	5	*0.15	6	*0.18	5	*0.15	<5	N/A	25	
Grant	47	0.68	1	*0.01	39	0.57	80	1.18	163	Top 25
Greene	1	*0.03	5	*0.15	<5	N/A	33	1.02	25	
Hamilton	67	0.22	94	0.31	68	0.22	169	0.55	150	Top 25
Hancock	23	0.31	1	*0.01	18	*0.25	33	0.46	75	Top 50
Harrison	1	*0.03	1	*0.03	<5	N/A	10	*0.25	0	
Hendricks	47	0.30	14	*0.09	17	*0.11	92	0.58	113	Top 50
Henry	16	*0.33	7	*0.14	30	0.61	51	1.04	125	Top 50
Howard	80	0.97	55	0.66	87	1.05	204	2.47	300	Top 10
Huntington	6	*0.16	4	*0.11	8	*0.22	24	0.66	0	
Jackson	17	*0.39	33	0.75	10	*0.23	45	1.02	138	Top 50
Jasper	6	*0.18	8	*0.24	11	*0.33	39	1.17	75	Top 50
Jay	10	*0.46	15	*0.70	17	*0.80	81	3.84	188	Top 10
Jefferson	9	*0.28	9	*0.28	22	0.68	50	1.54	150	Top 25
Jennings	16	*0.57	12	*0.43	12	*0.43	45	1.61	150	Top 25
Johnson	48	0.33	42	0.28	17	*0.11	70	0.47	150	Top 25
Knox	9	*0.24	7	*0.18	<5	N/A	8	*0.21	50	
Kosciusko	29	0.37	21	0.27	32	0.41	50	0.64	138	Top 50
LaGrange	5	*0.13	16	*0.42	10	*0.26	<5	N/A	50	
Lake	126	0.26	181	0.37	439	0.90	551	1.13	225	Top 10
LaPorte	31	0.28	93	0.84	59	0.53	121	1.09	200	Top 10
Lawrence	12	*0.26	3	*0.07	16	*0.35	67	1.47	100	Top 50
Madison	29	0.22	36	0.28	122	0.94	173	1.33	213	Top 10
Marion	44	0.05	28	0.03	651	0.69	924	0.98	163	Top 25
Marshall	10	*0.21	12	*0.25	11	*0.23	33	0.70	63	
Martin	3	*0.30	1	*0.10	<5	N/A	<5	N/A	25	
Miami	11	*0.31	36	1.00	9	*0.25	46	1.28	125	Top 50

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APPENDIX 12C *(Continued from previous page)*

County	Cocaine-Heroin Possession Arrests		Cocaine-Heroin Sale Arrests		Cocaine Use Reported at Treatment Admission		Heroin Use Reported at Treatment Admission		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Monroe	26	0.18	23	0.16	88	0.61	261	1.80	175	Top 10
Montgomery	20	0.52	2	*0.05	33	0.86	91	2.38	175	Top 10
Morgan	45	0.64	39	0.56	20	0.29	117	1.68	175	Top 10
Newton	3	*0.21	2	*0.14	5	*0.36	15	*1.07	25	
Noble	5	*0.10	19	*0.40	20	0.42	6	*0.13	75	Top 50
Ohio	1	*0.17	1	*0.17	<5	N/A	7	*1.18	25	
Orange	4	*0.20	4	*0.20	7	*0.36	11	*0.56	25	
Owen	4	*0.19	4	*0.19	5	*0.24	25	1.20	25	
Parke	8	*0.47	0	*0.00	<5	N/A	6	*0.36	38	
Perry	3	*0.15	4	*0.20	7	*0.36	<5	N/A	25	
Pike	3	*0.24	1	*0.08	<5	N/A	<5	N/A	13	
Porter	24	0.14	10	*0.06	54	0.32	153	0.91	100	Top 50
Posey	0	*0.00	0	*0.00	<5	N/A	5	*0.20	0	
Pulaski	3	*0.23	3	*0.23	6	*0.47	12	*0.93	50	
Putnam	9	*0.24	9	*0.24	<5	N/A	15	*0.40	50	
Randolph	10	*0.39	7	*0.27	15	*0.60	53	2.11	138	Top 50
Ripley	9	*0.30	9	*0.30	14	*0.49	53	1.85	138	Top 50
Rush	18	*1.06	4	*0.24	14	*0.84	25	1.50	125	Top 50
Saint Joseph	55	0.21	30	0.11	324	1.21	221	0.82	175	Top 10
Scott	2	*0.08	2	*0.08	<5	N/A	20	0.84	13	
Shelby	18	*0.40	5	*0.11	19	*0.43	41	0.92	88	Top 50
Spencer	4	*0.19	4	*0.19	<5	N/A	<5	N/A	13	
Starke	5	*0.22	3	*0.13	10	*0.44	66	2.87	75	Top 50
Steuben	17	*0.49	1	*0.03	15	*0.44	<5	N/A	75	Top 50
Sullivan	3	*0.14	2	*0.09	<5	N/A	<5	N/A	0	
Switzerland	2	*0.19	2	*0.19	<5	N/A	11	*1.05	38	
Tippecanoe	45	0.25	90	0.49	21	0.11	85	0.46	138	Top 50
Tipton	8	*0.51	1	*0.06	6	*0.39	9	*0.59	63	
Union	1	*0.14	1	*0.14	<5	N/A	9	*1.25	13	
Vanderburgh	21	0.12	29	0.16	75	0.41	57	0.31	100	Top 50
Vermillion	2	*0.13	2	*0.13	<5	N/A	13	*0.83	13	
Vigo	5	*0.05	6	*0.06	21	0.19	41	0.38	38	
Wabash	4	*0.12	4	*0.12	9	*0.28	53	1.65	38	
Warren	2	*0.24	2	*0.24	<5	N/A	<5	N/A	25	
Warrick	2	*0.03	1	*0.02	7	*0.11	12	*0.19	0	
Washington	6	*0.22	7	*0.25	<5	N/A	19	*0.68	25	
Wayne	24	0.35	20	0.30	107	1.60	192	2.87	250	Top 10
Wells	1	*0.04	2	*0.07	16	*0.57	28	1.00	50	
White	4	*0.16	0	*0.00	<5	N/A	11	*0.45	0	
Whitley	4	*0.12	6	*0.18	8	*0.24	9	*0.27	25	
Indiana	**1,649**	**0.25**	**1,556**	**0.24**	**3,506**	**0.54**	**6,150**	**0.94**		

* Rates that are based on numbers lower than 20 are unreliable.
Notes: Due to confidentiality concerns, health data (such as treatment data) with numbers less than five are not specified, but marked <5. The cocaine-heroin priority score was based on eight indicators and ranged from 0 to 300. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016

APPENDIX 12D

Methamphetamine (Meth) Abuse Indicators and Priority Scores by County, With Rank, All Rates per 1,000 Population (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016; Methamphetamine Lab Statistics, 2016)

County	Synthetic Possession Arrests		Synthetic Sale Arrests		Meth Use Reported at Treatment Admission		Meth Lab Seizures		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Adams	8	*0.23	5	*0.14	44	1.26	2	*0.06	13	
Allen	106	0.29	14	*0.04	137	0.37	49	0.13	150	Top 25
Bartholomew	52	0.65	31	0.39	309	3.81	21	0.26	225	Top 10
Benton	2	*0.23	1	*0.11	<5	N/A	0	*0.00	0	
Blackford	33	2.69	10	*0.81	8	*0.65	4	*0.33	125	Top 25
Boone	10	0.16	5	*0.08	22	0.35	1	*0.02	13	
Brown	6	*0.40	2	*0.13	27	1.80	3	*0.20	38	
Carroll	4	*0.20	3	*0.15	23	1.16	7	*0.35	50	
Cass	1	*0.03	14	*0.36	54	1.42	9	*0.24	100	Top 50
Clark	111	0.98	30	0.26	31	0.27	0	*0.00	125	Top 25
Clay	8	*0.30	4	*0.15	62	2.34	9	*0.34	88	Top 50
Clinton	9	*0.27	2	*0.06	34	1.04	5	*0.15	25	
Crawford	4	*0.38	0	*0.00	20	*1.91	1	*0.10	25	
Daviess	15	*0.46	14	*0.43	64	1.94	2	*0.06	113	Top 50
Dearborn	10	*0.20	6	*0.12	17	*0.34	1	*0.02	25	
Decatur	7	*0.26	8	*0.30	86	3.24	22	0.83	150	Top 25
DeKalb	26	0.61	40	0.94	85	2.00	20	*0.47	200	Top 10
Delaware	91	0.77	9	*0.08	200	1.71	145	1.24	213	Top 10
Dubois	13	*0.31	6	*0.14	59	1.39	6	*0.14	100	Top 50
Elkhart	29	0.14	26	0.13	128	0.63	22	0.11	113	Top 50
Fayette	9	*0.38	4	*0.17	35	1.49	1	*0.04	38	
Floyd	9	*0.12	13	*0.17	13	*0.17	6	*0.08	38	
Fountain	6	*0.36	3	*0.18	17	*1.02	4	*0.24	38	
Franklin	1	*0.05	0	*0.00	32	1.40	3	*0.13	25	
Fulton	3	*0.15	2	*0.10	34	1.67	8	*0.39	63	
Gibson	10	*0.30	17	*0.51	104	3.08	4	*0.12	125	Top 25
Grant	1	*0.01	1	*0.01	20	*0.29	10	*0.15	25	
Greene	5	*0.15	0	*0.00	59	1.82	2	*0.06	25	
Hamilton	88	0.29	18	*0.06	34	0.11	0	*0.00	75	Top 50
Hancock	8	*0.11	16	*0.21	16	*0.22	0	*0.00	38	
Harrison	6	*0.15	10	*0.26	<5	N/A	8	*0.20	50	
Hendricks	16	*0.10	10	*0.06	60	0.38	3	*0.02	38	
Henry	20	0.41	14	*0.29	42	0.86	9	*0.18	100	Top 50
Howard	11	*0.13	5	*0.06	117	1.42	7	*0.08	63	
Huntington	7	*0.19	14	*0.38	27	0.74	25	0.68	125	Top 25
Jackson	21	0.48	4	*0.09	139	3.15	2	*0.05	100	Top 50
Jasper	5	*0.15	6	*0.18	28	0.84	14	*0.42	75	Top 50
Jay	32	1.49	14	*0.65	32	1.52	13	*0.62	200	Top 10
Jefferson	12	*0.37	6	*0.18	126	3.89	3	*0.09	113	Top 50
Jennings	0	*0.00	7	*0.25	114	4.09	7	*0.25	113	Top 50
Johnson	18	*0.12	11	*0.07	44	0.29	1	*0.01	25	
Knox	10	*0.26	7	*0.18	109	2.87	9	*0.24	113	Top 50
Kosciusko	42	0.54	47	0.60	115	1.46	40	0.51	225	Top 10
LaGrange	14	*0.37	0	*0.00	84	2.16	7	*0.18	75	Top 50
Lake	62	0.13	19	*0.04	21	0.04	2	*0.00	63	
LaPorte	25	0.22	3	*0.03	9	*0.08	6	*0.05	25	
Lawrence	40	0.87	3	*0.07	179	3.93	3	*0.07	138	Top 25
Madison	71	0.54	16	*0.12	178	1.37	34	0.26	175	Top 10
Marion	56	0.06	10	*0.01	296	0.32	9	*0.01	100	Top 50
Marshall	29	0.61	13	*0.28	48	1.02	15	*0.32	138	Top 25

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APPENDIX 12D *(Continued from previous page)*

County	Synthetic Possession Arrests		Synthetic Sale Arrests		Meth Use Reported at Treatment Admission		Meth Lab Seizures		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Martin	3	*0.30	0	*0.00	24	2.35	1	*0.10	38	
Miami	6	*0.17	2	*0.06	74	2.06	25	0.70	100	Top 50
Monroe	30	0.21	1	*0.01	298	2.06	12	*0.08	100	Top 50
Montgomery	2	*0.05	0	*0.00	86	2.25	5	*0.13	38	
Morgan	15	*0.21	6	*0.09	180	2.58	0	*0.00	88	Top 50
Newton	9	*0.64	3	*0.21	6	*0.43	1	*0.07	38	
Noble	21	0.44	25	0.52	152	3.18	43	0.90	225	Top 10
Ohio	1	*0.17	1	*0.17	<5	N/A	1	*0.17	25	
Orange	7	*0.35	4	*0.20	51	2.60	9	*0.46	100	Top 50
Owen	4	*0.19	3	*0.14	75	3.59	2	*0.10	63	
Parke	32	1.86	12	*0.70	20	1.18	3	*0.18	125	Top 25
Perry	17	*0.87	7	*0.36	32	1.65	13	*0.67	163	Top 10
Pike	1	*0.08	0	*0.00	16	*1.27	0	*0.00	0	
Porter	3	*0.02	1	*0.01	<5	N/A	5	*0.03	0	
Posey	3	*0.12	10	*0.39	64	2.51	2	*0.08	75	Top 50
Pulaski	4	*0.31	3	*0.23	19	*1.47	9	*0.70	88	Top 50
Putnam	10	*0.27	5	*0.13	88	2.34	3	*0.08	75	Top 50
Randolph	13	*0.51	6	*0.24	25	0.99	10	*0.40	100	Top 50
Ripley	10	*0.33	7	*0.23	31	1.08	7	*0.24	75	Top 50
Rush	4	*0.24	6	*0.35	49	2.94	1	*0.06	75	Top 50
Saint Joseph	53	0.20	4	*0.01	109	0.41	18	*0.07	75	Top 50
Scott	30	1.25	11	*0.46	45	1.90	2	*0.08	125	Top 25
Shelby	25	0.56	5	*0.11	46	1.03	2	*0.04	50	
Spencer	7	*0.33	4	*0.19	60	2.90	8	*0.39	100	Top 50
Starke	4	*0.17	2	*0.09	56	2.44	36	1.57	113	Top 50
Steuben	2	*0.06	21	0.61	79	2.30	17	*0.49	150	Top 25
Sullivan	2	*0.09	1	*0.05	24	1.15	9	*0.43	38	
Switzerland	4	*0.38	2	*0.19	10	*0.95	2	*0.19	38	
Tippecanoe	82	0.45	15	*0.08	91	0.49	9	*0.05	125	Top 25
Tipton	12	*0.77	19	*1.22	9	*0.59	1	*0.07	113	Top 50
Union	1	*0.14	1	*0.14	<5	N/A	0	*0.00	13	
Vanderburgh	127	0.70	97	0.53	482	2.65	23	0.13	238	Top 10
Vermillion	4	*0.25	1	*0.06	53	3.38	4	*0.25	63	
Vigo	22	0.20	37	0.34	328	3.04	64	0.59	200	Top 10
Wabash	4	*0.12	3	*0.09	53	1.65	14	*0.44	75	Top 50
Warren	3	*0.36	2	*0.24	<5	N/A	1	*0.12	25	
Warrick	45	0.73	44	0.72	113	1.83	0	*0.00	163	Top 10
Washington	8	*0.29	4	*0.14	11	*0.40	3	*0.11	25	
Wayne	17	*0.25	6	*0.09	24	0.36	6	*0.09	38	
Wells	0	*0.00	0	*0.00	24	0.86	12	*0.43	50	
White	53	2.17	2	*0.08	33	1.36	14	*0.58	113	Top 50
Whitley	13	*0.39	3	*0.09	33	0.99	2	*0.06	25	
Indiana	**1,895**	**0.29**	**909**	**0.14**	**6,530**	**0.99**	**983**	**0.15**		

* Rates that are based on numbers lower than 20 are unreliable.
Notes: Due to confidentiality concerns, health data (such as treatment data) with numbers less than five are not specified, but marked <5. The methamphetamine priority score was based on eight indicators and ranged from 0 to 238. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016; ISP, 2016

APPENDIX 12E

Prescription Drug (Rx) Abuse Indicators and Priority Scores by County, With Rank, Rates per 1,000 Population (except rate for prescription opioids dispensed is per capita) (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016; INSPECT Data, 2016)

County	"Other" Drug Possession Arrests		"Other" Drug Sale Arrests		Rx Drug Abuse Reported at Treatment Admission		Controlled Substances Dispensed		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate (per capita)		
Adams	17	*0.49	11	*0.32	74	2.12	23,779	0.68	75	Top 50
Allen	145	0.40	76	0.21	329	0.89	283,006	0.77	150	Top 10
Bartholomew	40	0.50	1	*0.01	179	2.21	82,209	1.01	100	Top 50
Benton	4	*0.46	2	*0.23	13	*1.50	7,434	0.86	13	
Blackford	4	*0.33	1	*0.08	38	3.09	22,025	1.79	63	
Boone	16	*0.26	8	*0.13	44	0.69	50,544	0.80	25	
Brown	9	*0.60	0	*0.00	17	*1.14	8,675	0.58	13	
Carroll	9	*0.45	6	*0.30	16	*0.81	14,084	0.71	25	
Cass	96	2.50	125	3.26	56	1.47	35,282	0.93	150	Top 10
Clark	130	1.14	23	0.20	114	0.99	134,118	1.16	163	Top 10
Clay	15	*0.56	7	*0.26	39	1.47	28,458	1.07	38	
Clinton	10	*0.30	9	*0.27	57	1.75	36,976	1.13	50	
Crawford	5	*0.47	0	*0.00	20	*1.91	15,008	1.43	50	
Daviess	28	0.86	10	*0.31	47	1.43	29,781	0.91	63	
Dearborn	19	0.38	13	*0.26	207	4.19	38,450	0.78	100	Top 50
Decatur	75	2.84	32	1.21	60	2.26	46,949	1.77	225	Top 10
DeKalb	18	0.43	20	0.47	44	1.03	26,408	0.62	63	
Delaware	3	*0.03	32	0.27	426	3.65	136,125	1.16	163	Top 10
Dubois	18	*0.42	9	*0.21	80	1.88	37,835	0.89	50	
Elkhart	18	*0.09	5	*0.02	103	0.51	148,768	0.73	63	
Fayette	13	*0.55	13	*0.55	121	5.16	33,489	1.43	138	Top 25
Floyd	60	0.78	70	0.91	40	0.52	80,777	1.05	163	Top 10
Fountain	12	*0.71	6	*0.36	17	*1.02	20,308	1.22	63	
Franklin	11	*0.52	6	*0.28	57	2.49	16,994	0.74	50	
Fulton	9	*0.44	26	1.28	33	1.62	20,139	0.99	75	Top 50
Gibson	24	0.71	5	*0.15	58	1.72	39,923	1.18	88	Top 50
Grant	4	*0.06	0	*0.00	162	2.38	87,349	1.28	88	Top 50
Greene	12	*0.37	9	*0.28	61	1.88	40,922	1.26	75	Top 50
Hamilton	52	0.17	24	0.08	208	0.67	172,537	0.56	125	Top 50
Hancock	2	*0.03	3	*0.04	46	0.63	70,528	0.97	13	
Harrison	11	*0.28	5	*0.13	9	*0.23	43,181	1.09	25	
Hendricks	23	0.15	12	*0.08	90	0.57	110,099	0.70	63	
Henry	13	*0.27	15	*0.31	185	3.78	67,701	1.38	125	Top 50
Howard	83	1.00	21	0.25	211	2.56	106,500	1.29	213	Top 10
Huntington	16	*0.44	9	*0.24	66	1.80	36,965	1.01	50	
Jackson	73	1.67	15	*0.34	106	2.41	47,747	1.08	150	Top 10
Jasper	11	*0.33	14	*0.42	39	1.17	39,427	1.18	63	
Jay	6	*0.28	4	*0.19	54	2.56	16,865	0.80	25	
Jefferson	20	*0.62	11	*0.34	174	5.37	39,940	1.23	150	Top 10
Jennings	8	*0.28	8	*0.28	73	2.62	33,747	1.21	63	
Johnson	65	0.44	29	0.20	79	0.53	142,623	0.95	100	Top 50
Knox	21	0.55	13	*0.34	105	2.77	54,621	1.44	138	Top 25
Kosciusko	131	1.69	20	0.26	91	1.16	66,673	0.85	125	Top 50
LaGrange	2	*0.05	0	*0.00	35	0.90	127,250	3.28	63	
Lake	330	0.67	108	0.22	355	0.73	19,071	0.04	138	Top 25
LaPorte	12	*0.11	6	*0.05	101	0.91	412,600	3.72	88	Top 50
Lawrence	36	0.79	18	*0.39	218	4.79	66,783	1.47	213	Top 10
Madison	39	0.30	42	0.32	516	3.98	175,546	1.35	213	Top 10
Marion	36	0.04	17	*0.02	1,011	1.08	816,813	0.87	113	Top 50
Marshall	39	0.83	43	0.91	63	1.34	40,900	0.87	150	Top 10

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APPENDIX 12E *(Continued from previous page)*

County	"Other" Drug Possession Arrests		"Other" Drug Sale Arrests		Rx Drug Abuse Reported at Treatment Admission		Controlled Substances Dispensed		Priority Score	Rank
	Number	Rate	Number	Rate	Number	Rate	Number	Rate (per capita)		
Martin	4	*0.40	3	*0.30	18	*1.76	14,732	1.44	63	
Miami	26	0.72	39	1.08	72	2.01	36,458	1.02	138	Top 25
Monroe	76	0.53	60	0.42	365	2.52	96,470	0.67	200	Top 10
Montgomery	34	0.89	13	*0.34	101	2.64	41,439	1.08	138	Top 25
Morgan	57	0.81	18	*0.26	129	1.85	84,222	1.21	138	Top 25
Newton	10	*0.71	3	*0.21	8	*0.57	12,078	0.86	25	
Noble	6	*0.13	2	*0.04	50	1.05	44,787	0.94	13	
Ohio	2	*0.34	2	*0.34	12	*2.02	6,876	1.16	38	
Orange	11	*0.56	14	*0.71	60	3.06	25,049	1.28	125	Top 50
Owen	9	*0.43	12	*0.57	51	2.44	28,478	1.36	100	Top 50
Parke	5	*0.29	0	*0.00	13	*0.77	13,263	0.78	0	
Perry	13	*0.66	7	*0.36	29	1.50	18,157	0.94	38	
Pike	3	*0.24	2	*0.16	11	*0.87	17,775	1.41	25	
Porter	117	0.70	16	*0.10	144	0.86	165,582	0.99	138	Top 25
Posey	3	*0.12	3	*0.12	64	2.51	26,960	1.06	50	
Pulaski	6	*0.46	5	*0.39	37	2.87	17,116	1.33	88	Top 50
Putnam	24	0.64	13	*0.35	40	1.06	34,676	0.92	50	
Randolph	10	*0.39	11	*0.43	42	1.67	28,644	1.14	50	
Ripley	18	*0.60	17	*0.57	55	1.92	31,438	1.10	100	Top 50
Rush	39	2.30	13	*0.77	53	3.18	18,192	1.09	150	Top 10
Saint Joseph	52	0.19	27	0.10	185	0.69	38,004	0.14	88	Top 50
Scott	16	*0.67	8	*0.33	109	4.59	44,047	1.86	150	Top 10
Shelby	48	1.07	24	0.54	53	1.19	20,052	0.45	113	Top 50
Spencer	12	*0.57	8	*0.38	41	1.98	236,701	11.43	125	Top 50
Starke	7	*0.30	9	*0.39	103	4.49	36,620	1.60	113	Top 50
Steuben	16	*0.46	15	*0.44	31	0.90	28,446	0.83	63	
Sullivan	7	*0.33	4	*0.19	29	1.39	24,899	1.19	13	
Switzerland	5	*0.48	4	*0.38	22	2.09	10,230	0.97	50	
Tippecanoe	70	0.38	24	0.13	119	0.64	124,251	0.67	100	Top 50
Tipton	3	*0.19	0	*0.00	27	1.77	15,042	0.99	13	
Union	3	*0.42	3	*0.42	12	1.67	5,580	0.78	25	
Vanderburgh	124	0.68	47	0.26	426	2.34	222,659	1.22	213	Top 10
Vermillion	6	*0.38	6	*0.38	31	1.98	16,492	1.05	50	
Vigo	20	0.18	31	0.29	139	1.29	103,911	0.96	100	Top 50
Wabash	7	*0.22	2	*0.06	68	2.12	39,305	1.22	63	
Warren	5	*0.60	3	*0.36	5	*0.60	5,668	0.69	25	
Warrick	11	*0.18	29	0.47	87	1.41	60,794	0.98	75	Top 50
Washington	16	*0.58	10	*0.36	22	0.79	29,691	1.07	63	
Wayne	27	0.40	9	*0.13	114	1.70	78,626	1.17	88	Top 50
Wells	8	*0.29	3	*0.11	57	2.04	23,852	0.85	13	
White	4	*0.16	6	*0.25	27	1.11	26,658	1.10	13	
Whitley	12	*0.36	8	*0.24	30	0.90	33,218	0.99	0	
Indiana	**2,805**	**0.43**	**1,495**	**0.23**	**9,438**	**1.43**	**6,241,070**	**0.95**		

* Rates that are based on numbers lower than 20 are unreliable.
Notes: Due to confidentiality concerns, health data (such as treatment data) with numbers less than five, are not specified but marked <5. The prescription drug priority score was based on eight indicators and ranged from 0 to 225. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016; IPLA, 2017

APPENDIX 12F

Total Priority Scores by County, Ranked in Descending Order (Uniform Crime Reporting Program, 2014; Treatment Episode Data Set, 2016; Indiana Automated Reporting Information Exchange System, 2015; Methamphetamine Lab Statistics, 2016; INSPECT data, 2016)

County	Total Priority Score	Rank
Delaware	204	Top 10
Vanderburgh	203	Top 10
Madison	195	Top 10
Lake	176	Top 10
Monroe	174	Top 10
Allen	167	Top 10
Cass	160	Top 10
Howard	159	Top 10
Clark	155	Top 10
Kosciusko	148	Top 10
Tippecanoe	146	Top 25
Wayne	144	Top 25
Lawrence	142	Top 25
Bartholomew	141	Top 25
Jefferson	141	Top 25
Hamilton	139	Top 25
LaPorte	137	Top 25
Marion	136	Top 25
Vigo	134	Top 25
Morgan	131	Top 25
Decatur	129	Top 25
Jackson	128	Top 25
Marshall	123	Top 25
Saint Joseph	122	Top 50
Jay	119	Top 50
Miami	117	Top 50
Dearborn	116	Top 50
Rush	115	Top 50
Johnson	107	Top 50
Porter	106	Top 50
Elkhart	104	Top 50
DeKalb	104	Top 50
Fayette	103	Top 50
Noble	101	Top 50
Montgomery	99	Top 50
Henry	99	Top 50
Knox	98	Top 50
Gibson	94	Top 50
Steuben	92	Top 50
Ripley	91	Top 50
Grant	90	Top 50
Jennings	87	Top 50
Clinton	85	Top 50
Hendricks	82	Top 50
Dubois	81	Top 50
Daviess	80	Top 50

County	Total Priority Score	Rank
Starke	79	Top 50
Perry	79	Top 50
Shelby	77	Bottom 50
Orange	73	Bottom 50
Floyd	72	Bottom 50
Randolph	72	Bottom 50
Scott	70	Bottom 50
Warrick	66	Bottom 50
Spencer	64	Bottom 50
Blackford	63	Bottom 50
Putnam	62	Bottom 50
Adams	62	Bottom 50
Parke	62	Bottom 50
Wabash	62	Bottom 50
Jasper	61	Bottom 50
Pulaski	60	Bottom 50
White	58	Bottom 50
Fulton	58	Bottom 50
Huntington	57	Bottom 50
LaGrange	57	Bottom 50
Owen	56	Bottom 50
Franklin	51	Bottom 50
Boone	50	Bottom 50
Clay	50	Bottom 50
Hancock	50	Bottom 50
Vermillion	50	Bottom 50
Posey	44	Bottom 50
Tipton	43	Bottom 50
Fountain	42	Bottom 50
Pike	42	Bottom 50
Martin	34	Bottom 50
Washington	32	Bottom 50
Benton	32	Bottom 50
Crawford	31	Bottom 50
Whitley	30	Bottom 50
Switzerland	28	Bottom 50
Brown	28	Bottom 50
Wells	26	Bottom 50
Newton	26	Bottom 50
Greene	25	Bottom 50
Carroll	23	Bottom 50
Warren	22	Bottom 50
Ohio	22	Bottom 50
Harrison	20	Bottom 50
Union	13	Bottom 50
Sullivan	12	Bottom 50

Note: Total priority scores ranged from 12 to 204. Higher priority scores indicate a more severe problem.
Source: FBI, 2014; FSSA, 2016; ISP, 2015, 2016; IPLA, 2017

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APPENDIX I: Data Sources Recommended by the State Epidemiology and Outcomes Work Group (SEOW)

Data Set	Source	Years	How to Access	Coverage	Target
Alcohol-Related Disease Impact (ARDI) Database	CDC	Based on averages 2006-2010	http://nccd.cdc.gov/DPH_ARDI/default/default.aspx	U.S. and states	General population
Automated Reporting Information Exchange System (ARIES)	ISP	Annual Most recent 2015	On request from ISP	Indiana and counties	Vehicle collisions in general population
Behavioral Risk Factor Surveillance System (BRFSS)	CDC	Annual 1995-2015	http://www.cdc.gov/brfss/brfssprevalence/index.html	U.S. and states	Adults 18 and older
Data Assessment Registry Mental Health and Addiction (DARMHA) System	DMHA	Annual Most recent 2015	On request from DMHA	Indiana	Substance abuse & mental health treatment population eligible for public services (200% FPL)
Fatality Analysis Reporting System (FARS)	NHTSA	Annual 1994-2014	http://www-fars.nhtsa.dot.gov/	U.S., states, and counties	General population
Hospital Discharge Database	ISDH	Annual 1999-2015	http://www.in.gov/isdh/20624.htm	Indiana and counties	General population
Indiana Adult Tobacco Survey (IATS)	ISDH/TPCC	Bi-annual 2002-2015	On request from ISDH	Indiana	Adults
Indiana College Substance Use Survey	ICAN/IPRC	Annual 2009-2016	http://www.drugs.indiana.edu/indiana-college-survey/substance-use-survey	Indiana	College students
Indiana Clandestine Meth Lab Seizures	ISP	Annual 1995-2016	On request from ISP	Indiana and counties	General population
Indiana Youth Survey	IPRC	Annual 1993-2016	http://inys.indiana.edu/survey-results	Indiana and regions	6th – 12th grade students in Indiana
Indiana Youth Tobacco Survey (IYTS)	ISDH/TPCC	Bi-annual 2000-2014	On request from ISDH	Indiana	6th – 12th grade students in Indiana

Continued on Next Page

APPENDIX I (continued)

Data Set	Source	Years	How to Access	Coverage	Target
Monitoring the Future (MTF) Survey	NIDA	Annual 1999-2016	http://www.monitoringthefuture.org/data/data.html	U.S.	8th, 10th, and 12th grade students
Mortality data (e.g., alcohol-, smoking-, and drug-related mortality)	ISDH	Annual Most recent 2015	On request from ISDH	Indiana and counties	General population
	CDC	Annual 1999-2015	http://wonder.cdc.gov/mortSQL.html	U.S., states, and counties	General population
National Survey on Drug Use and Health (NSDUH)	SAMHSA	Annual 1994-2015	http://www.samhsa.gov/data/population-data-nsduh	U.S., states, and some sub-state estimates	Population 12 years and older
Population Estimates	U.S. Census Bureau	Annual	http://www.census.gov/	U.S., states, and counties	General population
Treatment Episode Data Set (TEDS)	SAMHSA	Annual 1992-2014	http://wwwdasis.samhsa.gov/dasis2/teds.htm	U.S. and states; for county-level data contact Indiana DMHA	Substance abuse treatment population eligible for public services (200% FPL)
	DMHA	Annual 2016			
Uniform Crime Reporting Program (UCR)	FBI/NACJD	Annual 1994-2014	http://www.icpsr.umich.edu/icpsrweb/content/NACJD/guides/ucr.html	U.S., states, and counties	Arrests within general population
Uniform Reporting System (URS) – Mental Health National Outcomes Measures	SAMHSA	Annual Most recent 2015	http://www.samhsa.gov/data/reports-by-geography?tid=633&map=1	U.S. and states	Treatment population eligible for public services (200% FPL)
Youth Risk Behavior Surveillance System (YRBSS)	CDC	Bi-annual Indiana: 2003-2015	http://nccd.cdc.gov/YouthOnline/App/Default.aspx	U.S. and states	High school students

Abbreviations used: ARIES = Automated Reporting Information Exchange System; CDC = Centers for Disease Control and Prevention; DMHA = Division of Mental Health & Addiction; FBI = Federal Bureau of Investigation; ICAN = Indiana Collegiate Action Network; IPRC = Indiana Prevention Resource Center; ISDH = Indiana State Department of Health; ISP = Indiana State Police; NACJD = National Archive of Criminal Justice Data; NHTSA = National Highway Traffic Safety Administration; NIDA = National Institute on Drug Abuse; SAMHSA = Substance Abuse and Mental Health Services Administration; TPCC = Tobacco Prevention & Cessation Commission.

APPENDIX II: SUBSTANCE USE INDICATORS AT-A-GLANCE

SUBSTANCE	USE OR CONSEQUENCE	TARGET POPULATION	DATASET
Alcohol	Past-month use Past-month binge drinking (methodology change; no 2015 data) Alcohol dependence in the past year Alcohol use disorder in the past year	General population ages 12+	NSDUH
	Past-month alcohol use Past-month binge drinking Past-month heavy drinking Past-month chronic drinking	Adults ages 18+	BRFSS
	Lifetime use First time use Past-month use Past-month binge drinking Source of alcohol Largest number of drinks	Grades 9-12	YRBSS
	Past-month use Past-month binge drinking Mean age of first use	Grades 6-12	Indiana Youth Survey
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for DUI Public intoxication Liquor law violation	General population	UCR
	Alcohol-related crashes Alcohol-related fatal crashes	General population	ARIES
	Alcohol-attributable deaths Alcohol-attributable fractions Years of potential life lost due to excessive alcohol use	General population	ARDI
	Alcohol-induced deaths	General population	ISDH
Tobacco	Past-month use of Tobacco product Cigarettes	General population ages 12+	NSDUH
	Past-month smoking Past-month smokeless tobacco Four-level smoking status	Adults ages 18+	BRFSS
	Past-month use of Tobacco Cigarettes E-cigarettes Smokeless tobacco	Middle and high school students	IYTS

Continued on Next Page

APPENDIX II (continued)

SUBSTANCE	USE OR CONSEQUENCE	TARGET POPULATION	DATASET
Tobacco (cont.)	Lifetime and past-month use of cigarettes First use of cigarettes Frequent use of cigarettes Smoked more than 10 cigarettes Daily use of cigarettes Sources of cigarettes Smoking cessation Past-month use of Any tobacco Cigars Smokeless tobacco Electronic vapor products	Grades 9-12	YRBSS
	Past-month use Cigarettes Smokeless tobacco Cigars Pipe Electronic vapor products Mean age of first use	Grades 6-12	INYS
	Percentage of smoke-free homes and work places	General population	IATS
Marijuana	Past-month use First use	General population ages 12+	NSDUH
	Lifetime use Marijuana Synthetic marijuana Past-month marijuana use First use of marijuana	Grades 9-12	YRBSS
	Past-month use Marijuana Synthetic marijuana Mean age of first use	Grades 6-12	INYS
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for Possession of marijuana Sale of marijuana	General population	UCR

Continued on Next Page

APPENDIX II (continued)

SUBSTANCE	USE OR CONSEQUENCE	TARGET POPULATION	DATASET
Cocaine	Past-year use	General population ages 12+	NSDUH
	Lifetime use	Grades 9-12	YRBSS
	Past-month use of cocaine/crack Mean age of first use	Grades 6-12	INYS
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for Possession of cocaine/opiates Sale of cocaine/opiates	General population	UCR
Heroin	Past-year use	General population ages 12+	NSDUH
	Lifetime use of heroin Used a needle to inject any illegal drug at least once during their lifetime	Grades 9-12	YRBSS
	Past-month use Mean age of first use	Grades 6-12	INYS
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for Possession of cocaine/opiates Sale of cocaine/opiates	General population	UCR
Methamphetamine	Lifetime use	Grades 9-12	YRBSS
	Past-month use Mean age of first use	Grades 6-12	INYS
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for Possession of synthetic drugs Sale of synthetic drugs	General population	UCR
	Clandestine meth lab seizures Children identified/rescued in lab homes Arrests made during lab seizures	General population	ISP Meth Lab Seizures

Continued on Next Page

APPENDIX II (continued)

SUBSTANCE	USE OR CONSEQUENCE	TARGET POPULATION	DATASET
Prescription Drugs	Past-year nonmedical use of pain relievers (methodology change; no 2015 data)	General population ages 12+	NSDUH
	Past-month use of prescription drugs Mean age of first use	Grades 6-12	INYS
	Past-year dispensation of controlled substances	General population	INSPECT
	Use reported at treatment admission Primary use (dependence) reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS
	Arrests for Possession of 'other drugs' Sale of 'other drugs'	General population	UCR
	Poisoning/overdose deaths (Rx-related mortality)	General population	ISDH
Polysubstance Abuse	Use of 2+ substances reported at treatment admission	Treatment population at or below 200% FPL, in state-sponsored programs	TEDS

Abbreviations used: ARDI = Alcohol-Related Disease Impact database; ARIES = Automated Reporting Information Exchange System; BRFSS = Behavioral Risk Factor Surveillance System; IATS = Indiana Adult Tobacco Survey; INSPECT = Indiana Scheduled Prescription Drug Electronic Collection and Tracking system; INYS = Indiana Youth Survey; ISDH = Indiana State Department of Health; ISP = Indiana State Police; IYTS = Indiana Youth Tobacco Survey; NSDUH = National Survey on Drug Use and Health; SAMMEC = Smoking-Attributable Mortality, Morbidity, and Economic Costs; TEDS = Treatment Episode Data Set; UCR = Uniform Crime Reporting program; YRBSS = Youth Risk Behavior Surveillance System.

Additional information on these datasets, including how to access them, can be found in Chapter 2 and Appendix I.

MARIJUANA COCAINE PRESCRIPTION DRUGS

The Consumption and Consequences of Alcohol, Tobacco, and Drugs in Indiana: A State Epidemiological Profile 2016

Indiana State Epidemiological Outcomes Workgroup

The Indiana State Epidemiological Outcomes Workgroup (SEOW) was established in April 2006 to review epidemiological data on the patterns and consequences of substance use and abuse in Indiana and to make recommendations to the State of Indiana regarding priorities for prevention funding for the following year. The priorities were developed based on a systematic analysis of available data, the results of which are detailed in this report.

RICHARD M. FAIRBANKS
SCHOOL OF PUBLIC HEALTH
INDIANA UNIVERSITY
Center for Health Policy
IUPUI

TOBACCO HEROIN METHAMPHETAMINE ALCOHOL

Our Vision

"Healthy, safe, and drug-free environments that nurture and assist all Indiana citizens to thrive."

Our Mission

"To reduce substance use and abuse across the lifespan of Indiana citizens."

17-H01

Scott.A.Milkey

From: Huntsinger, Douglas
Sent: Thursday, May 04, 2017 4:38 PM
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> That would be great. Thank you.
>
> On another note, we were in a meeting yesterday and the diversion of suboxone in prisons came up. Since the strips are often diverted is there a plan to move to the pill version? Is that even a possibility?
>
> Douglas Huntsinger
> Office of the Governor
> (317) 232-1080
>
> ---
>
> **From:** Spoolstra, Stephanie L
> **Sent:** Thursday, May 4, 2017 11:14 AM
> **To:** Huntsinger, Douglas <DHuntsinger@gov.IN.gov>
> **Subject:** FW: NGA Opioid Learning Lab Kick-Off Meeting -- Updates
>
> Let me know how you want to proceed. I recall that John Hammond had expressed some interest meeting again as a group to prepare for the trip. I would be glad to take a stab at the PowerPoint if that is your desire.
>
> Thanks,
>
> **Stephanie L. Spoolstra, LCSW**
> Executive Director, Addiction Recovery Services

Indiana Department of Correction
302 W. Washington, W341
Indianapolis, IN 46204
sspoolstra1@idoc.in.gov
317-233-9588 (o)
317-[redacted] (c)

From: Becker, Melinda [mailto:mbecker@nga.org]
Sent: Thursday, May 04, 2017 8:01 AM
To: Huntsinger, Douglas <DHuntsinger@gov.IN.gov>; Spoolstra, Stephanie L <SSpoolstra1@idoc.IN.gov>; Hammond, John <JHammond2@gov.IN.gov>; Lanham, Julie (COA) <jlanham@idoc.in.gov>; Boarman, Angela <Angela.Boarman@fssa.IN.gov>; Hufford, Christopher D <CHufford20@idoc.IN.gov>
Subject: NGA Opioid Learning Lab Kick-Off Meeting -- Updates

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Doug, Stephanie, John, Julie, Angela and Christopher –

I hope this note finds you well. As we get closer to the learning lab kick-off meeting in Boston on June 5-6, I wanted to reach out with a few quick updates and reminders.

Brief Presentation
Attached is a PowerPoint template that we're asking each state team to use in developing a brief presentation for the meeting. Each team will designate a representative to present their slides in one of the opening sessions, as a means of introduction to the other state teams and Massachusetts participants. We would appreciate if you could send us your completed slides by **Friday, May 19th**.

All State Prep Call
We will be hosting a call on **Wednesday, May 17th at 3:30 pm ET** to walk through the meeting agenda and the strategic action plan template, which will guide each team's efforts following the meeting in Boston. This is also a great opportunity to raise any questions you have about the meeting or the learning lab project more generally. A calendar invitation will be forthcoming.

Travel Reminder
If you haven't yet registered or booked travel for the meeting in Boston, please do so as soon as possible via the meeting website below to ensure the NGA meeting rate. Hotel reservations can be made through the link on the registration site or by calling the hotel at 617-426-2000 and asking for the National Governors Association (NGA) Expanding Opioid Treatment meeting rate. Air or train travel arrangements must be made through our travel agent. Please call Innovative Travel at 877-309-4322 to book your ticket, and reference meeting code 0260002066 MH-03.

Learning Lab Kick-Off Meeting Website

Please feel free to reach out with any questions.

Thanks,
Melinda

Melinda Becker
Senior Policy Analyst, Health Division
NGA Center for Best Practices
202-624-5336 | mbecker@nga.org

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Scott.A.Milkey

From: Matt Brooks <mbrooks@indianacouncil.org>
Sent: Thursday, May 04, 2017 9:48 AM
To: Watson, William;Angel, Natalie B;'Dan Peck (dpeck@swansoncenter.org)';Landis, Larry (PDC);'Stephanie Yager';'Richie Adderley (radderle@hamiltoncenter.org)';'m.w.kempf@[redacted]';'Michael Gray (Michael.Gray@aspireindiana.org)';Burden, Matthew;Cozad, Sara;'tina.skeel@aspireindiana.org';'Nichelle Washington (nwashington@hamiltoncenter.org)';'Linda Grove-Paul (linda.grove-paul@centerstone.org)';McCaffrey, Steve;'David Bottorff';'eowens@hamiltoncenter.org';'Barbara Moser';'Celeste Jackson (CJackson@voain.org)';Moore, Kevin B;'Bridget Bascom (Bridget.Bascom@cmhcinc.org)';'Susan Jo Thomas';'DEB HODSON';'bwilson@indianasheriffs.org';Seigel, Jane;Benjamin Bennett;Spoolstra, Stephanie L;Scism, Joshua R;Braun, Deborah L;'DONALD B. LOUGH';'Linda Grove-Paul';'jholloway@aspin.org';'Beth Overmyer';Boarman, Angela;'Beth Barchet (BarchetB@southwestern.org)';Denise DeLong;Casper, Kristin;Lanham, Julie (COA);Levenhagen, Mark;Bauer, Jenny;'TONY BREWER';'Jerry Landers (Jerry.Landers@aspireindiana.org)';'Katy Adams - Southwestern Behavioral Healthcare, Inc. (adamsk@southwestern.org)';'Marci Toler';Ferguson, Jon;Chaudhary, Jay;Evers, Rayshad;Eickmeier, Amy;'trusa.grosso@aspireindiana.org';'susan.cantin@aspireindiana.org';'Finnegan priest, Caitlin F.';'CJ Davis';'breanna.jackson@bowencenter.org';Blackmon, Sirrilla;'Lori.Phillips-Steele@csh.org';Mccord, Brandy L;'Megan Maxwell-Ranjbar';McClelland, Jim;McCord, Brandy (Wexford);Buhner, Rebecca B
Subject: Additional Materials2.0
Attachments: Recovery Works Coverage Map 5-4-17.pdf; Recovery Works Update 5-4-17.pdf

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Dear Committee Members:

DMHA just sent me additional materials for today's meeting.

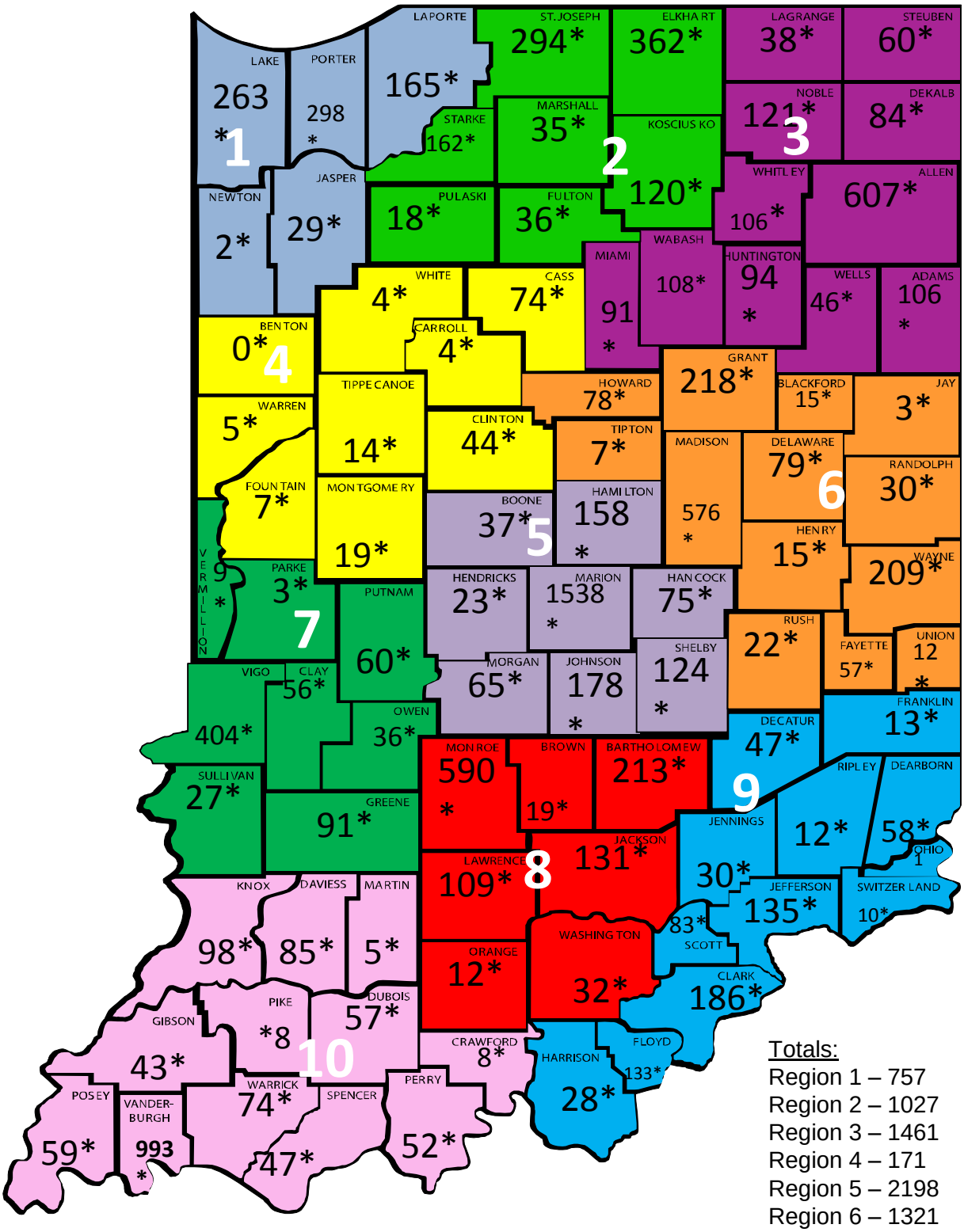
Matthew G. Brooks, MA
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Recovery Works: Clients Enrolled



Numbers as of 4.3.17.
ICCMHC- Mtg on 5.4.17 ONLY.
NOT for distribution.

Totals:

Region 1 – 757
Region 2 – 1027
Region 3 – 1461
Region 4 – 171
Region 5 – 2198
Region 6 – 1321
Region 7 – 686
Region 8 – 1106
Region 9 – 736
Region 10 – 1469

Recovery Works

INDIANA'S FORENSIC TREATMENT PROGRAM

Recovery Works by the Numbers:



SFY 2016 Total: 3,178 SFY 2017 YTD Total: 9,210 (last reported 8,059)

Total Enrolled: **12,301** (last reported 11,237) (#s are as of 5.3.17)



SYF 2016 Total: $1,209,190 SFY 2017 YTD: **$10,464,690** (last reported $9,063,628)

Total: **$11,673,881** (last reported $10,272,819) (#s are as of 5.3.17) * April is missing MRO match dollars

Top 5 Services by the Dollars:

1. Medication
2. Substance Use Disorder Counseling-Group
3. Skills Training and Development – Individual
4. Transportation
5. Housing

Top 5 Services by the Clients:

1. Case Management
2. Substance Use Disorder Counseling-Group
3. Drug Screens
4. Skills Training and Development – Individual
5. Mental Health Counseling – Individual

Top 5 Counties:

1. Marion
2. Vanderburgh
3. Monroe
4. Madison
5. Allen

Updates and Opportunities:

- Providers
  - 75 Designated Recovery Works Agencies; 60 Agencies actively enrolling clients
- Jail ReEntry Pilot Program
  - Finalizing site visits
  - Beginning to collect monthly reports. (Will share information next month.)
- Forensic Peer Support Services
  - Received 8 applications
  - Currently reviewing proposals. Will award by May 15th.
- Vouchers
  - Currently, we have **$16,734,387** in vouchers. This means our providers predict they will provide services that total that amount within the next 30-60 days.
  - When calculating total Recovery Works funds spent, in order to determine remaining funds available, we must add the dollars encumbered within vouchers to the dollars expended for services.

    Example:
    (Total Expended) **$11,673,881 +** (Total in Vouchers) **$16,734,387**
    = (prediction of total Recovery Works dollars expended within the next 30-60 days) **$28,408,268**
  - Providers are claiming roughly 44% of vouched services. This would be equivalent to $7,363,130

Resources:

- Email address: Recovery.Works@fssa.in.gov
- Website: www.RecoveryWorks.fssa.IN.gov

Scott.A.Milkey

From: Matt Brooks <mbrooks@indianacouncil.org>
Sent: Thursday, May 04, 2017 9:43 AM
To: Watson, William;Angel, Natalie B;Dan Peck (dpeck@swansoncenter.org);Landis, Larry (PDC);'Stephanie Yager';'Richie Adderley (radderle@hamiltoncenter.org)';'m.w.kempf@[redacted];'Michael Gray (Michael.Gray@aspireindiana.org)';Burden, Matthew;Cozad, Sara;tina.skeel@aspireindiana.org;'Nichelle Washington (nwashington@hamiltoncenter.org)';'Linda Grove-Paul (linda.grove-paul@centerstone.org)';McCaffrey, Steve;'David Bottorff';eowens@hamiltoncenter.org;'Barbara Moser';Celeste Jackson (CJackson@voain.org);Moore, Kevin B;Bridget Bascom (Bridget.Bascom@cmhcinc.org);'Susan Jo Thomas';DEB HODSON;'bwilson@indianasheriffs.org';Seigel, Jane;Benjamin Bennett;Spoolstra, Stephanie L;Scism, Joshua R;Braun, Deborah L;DONALD B. LOUGH;Linda Grove-Paul;jholloway@aspin.org;Beth Overmyer;Boarman, Angela;Beth Barchet (BarchetB@southwestern.org);Denise DeLong;Casper, Kristin;Lanham, Julie (COA);Levenhagen, Mark;Bauer, Jenny;TONY BREWER;Jerry Landers (Jerry.Landers@aspireindiana.org);'Katy Adams - Southwestern Behavioral Healthcare, Inc. (adamsk@southwestern.org)';Marci Toler;Ferguson, Jon;Chaudhary, Jay;Evers, Rayshad;Eickmeier, Amy;'trusa.grosso@aspireindiana.org';susan.cantin@aspireindiana.org;Finnegan priest, Caitlin F.;CJ Davis;'breanna.jackson@bowencenter.org';Blackmon, Sirrilla;Lori.Phillips-Steele@csh.org;Mccord, Brandy L;Megan Maxwell-Ranjbar;McClelland, Jim;McCord, Brandy (Wexford);Buhner, Rebecca B
Subject: Additional Materials for Today's Meeting
Attachments: Community Correction Work Programs.pdf; Mental Health Addictions and Criminal Justice Legislative Update 5-4-17.pdf; DOC Work Release.pdf

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Dear Committee Member:

Please see attached additional materials for today’s meeting.

Matt

Matthew G. Brooks, MA
President & Chief Executive Officer
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IC 11-12-5

Chapter 5. County Jails: Work; Temporary Release

IC 11-12-5-1

Inmates; clean and orderly quarters; general maintenance work

Sec. 1. (a) A person confined in a county jail may be required to keep his own living quarters clean and orderly.

(b) A person confined in a county jail upon conviction of a crime may be required to perform general maintenance work and assist in providing other services essential to the administration of the facility or program. As used in this subsection, "general maintenance work" does not include construction, remodeling, or repair of the facility.

As added by Acts 1979, P.L.120, SEC.5. Amended by P.L.72-1992, SEC.2; P.L.1-1993, SEC.67.

IC 11-12-5-2

Temporary release from custody; purpose; eligibility

Sec. 2. (a) The county sheriff may establish a program whereby persons who have been committed to the county jail upon conviction of a crime or adjudication of contempt may be temporarily released from custody to work, attend an academic or vocational training institution or program, or obtain medical, psychiatric, or psychological treatment, including treatment for drug addiction or alcoholism.

(b) A person is eligible for temporary release under this section unless:

(1) the sentencing or committing court disapproves the person's release; or

(2) the person has been convicted of a sex offense under IC 35-42-4 or IC 35-46-1-3.

(c) "Work" under this section includes assignment to a work party formed to perform any work the sheriff determines to be of benefit to the community.

(d) Persons on work parties formed under this section may be required to wear distinctive jail uniforms.

As added by Acts 1979, P.L.120, SEC.5. Amended by P.L.144-1995, SEC.2; P.L.264-1999, SEC.2.

IC 11-12-5-3

Earnings of person employed under this chapter; distribution; use of remaining amount; waiver of collection of room and board

Sec. 3. (a) Any earnings of a person employed under this chapter, less payroll deductions required by law and court ordered deductions for satisfaction of a judgment against that person, shall be collected by the county sheriff, probation department, county office of the division of family resources, or other agency designated by the sentencing or committing court. Unless otherwise ordered by the court, the remaining earnings shall be distributed in the following

order:

(1) To pay state and federal income taxes and Social Security deductions not otherwise withheld.

(2) To pay the cost of membership in an employee organization.

(3) Not less than fifteen percent (15%) of the person's gross earnings, if that amount of the gross is available after the above deductions, to be given to that person or retained for the person, with accrued interest, until the person's release or discharge.

(4) To pay for the person's room and board provided by the county.

(5) To pay transportation costs to and from work, and other work related incidental expenses.

(6) To pay court ordered costs, fines, or restitution.

(b) After the amounts prescribed in subsection (a) are deducted, the remaining amount may be used to:

(1) when directed by the person or ordered by the court, pay for the support of the person's dependents (if the person's dependents are receiving welfare assistance, the appropriate county office of the division of family resources or welfare department in another state shall be notified of such disbursements); and

(2) with the consent of the person, pay to the person's victims or others any unpaid obligations of that person.

(c) Any remaining amount shall be given to the person or retained for the person according to subsection (a)(3).

(d) The collection of room and board under subsection (a)(4) may be waived.

As added by Acts 1979, P.L.120, SEC.5. Amended by P.L.2-1992, SEC.115; P.L.4-1993, SEC.16; P.L.5-1993, SEC.29; P.L.146-2008, SEC.373; P.L.44-2009, SEC.8.

IC 11-12-5-4

Application of IC 11-12-5-2 and IC 11-12-5-3

Sec. 4. Sections 2 and 3 of this chapter do not apply to a person serving a term of imprisonment under IC 35-38-2-2.3(c).

As added by Acts 1979, P.L.120, SEC.5. Amended by P.L.5-1988, SEC.62; P.L.1-1991, SEC.99.

IC 11-12-5-5

Health care copayments

Sec. 5. (a) This section does not apply to a person confined to a county jail who:

(1) maintains a policy of insurance from a private company covering:

(A) medical care;

(B) dental care;

(C) eye care; or

(D) any other health care related service; or

(2) is willing to pay for the person's own medical care.

(b) Except as provided in subsection (c), a person confined to a county jail may be required to make a copayment in an amount of not more than fifteen dollars ($15) for each provision of any of the following services:

(1) Medical care.

(2) Dental care.

(3) Eye care.

(4) Any other health care related service.

(c) A person confined to a county jail is not required to make the copayment under subsection (b) if:

(1) the person does not have funds in the person's commissary account or trust account at the time the service is provided;

(2) the person does not have funds in the person's commissary account or trust account within sixty (60) days after the service is provided;

(3) the service is provided in an emergency;

(4) the service is provided as a result of an injury received in the county jail; or

(5) the service is provided at the request of the sheriff or jail administrator.

(d) Money collected must be deposited into the county medical care for inmates fund.

(e) Rules for the implementation of this section must be approved by the county legislative body.

As added by P.L.72-1994, SEC.1. Amended by P.L.143-1995, SEC.2; P.L.102-2002, SEC.1.

IC 11-12-5-5.5

County reimbursement for health care services provided to person subject to lawful detention

Sec. 5.5. (a) As used in this section, "charge description master" means a listing of the amount charged by a hospital for each service, item, and procedure:

(1) provided by the hospital; and

(2) for which a separate charge exists.

(b) As used in this section, "health care services" includes health care items and procedures.

(c) As used in this section, "lawful detention" means the following:

(1) Arrest.

(2) Custody following surrender in lieu of arrest.

(3) Detention in a penal facility.

(4) Detention for extradition or deportation.

(5) Custody for purposes incident to any of the above, including transportation, medical diagnosis or treatment, court appearances, work, or recreation.

The term does not include supervision of a person on probation or

parole or constraint incidental to release with or without bail.

(d) This section:

(1) does not apply in the case of a person who is subject to lawful detention by a county sheriff and is:

(A) covered under private health coverage for health care services; or

(B) willing to pay for the person's own health care services;

(2) does not apply to an inmate receiving inpatient services under IC 36-2-13-19; and

(3) does not affect copayments required under section 5 of this chapter.

(e) Except as provided in subsections (f) and (g), a county that is responsible for payment for health care services provided to a person who is subject to lawful detention by the county's sheriff shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) another health care provider;

for the cost of a health care service at the federal Medicare reimbursement rate for the health care service provided plus four percent (4%).

(f) Except as provided in subsection (g), if there is no federal Medicare reimbursement rate for a health care service described in subsection (e), the county shall do the following:

(1) If the health care service is provided by a hospital, the county shall reimburse the hospital an amount equal to sixty-five percent (65%) of the amount charged by the hospital according to the hospital's charge description master.

(2) If the health care service is provided by a physician or another health care provider, the county shall reimburse the physician or health care provider an amount equal to sixty-five percent (65%) of the amount charged by the physician or health care provider.

(g) A county described in subsection (e) or (f) may reimburse a health care provider described in subsection (e)(1), (e)(2), or (e)(3) at a lower reimbursement rate than the rate required by subsection (e) or (f) if the county enters into an agreement with a health care provider described in subsection (e)(1), (e)(2), or (e)(3) to reimburse the health care provider for a health care service at the lower reimbursement rate.

As added by P.L.80-2009, SEC.1. Amended by P.L.205-2011, SEC.1; P.L.185-2015, SEC.6.

IC 11-12-5-6

Medical care expenses

Sec. 6. (a) As used in this section, "medical care expenses" refers to expenses relating to the following services provided to a county jail inmate:

(1) Medical care.
(2) Dental care.
(3) Eye care.
(4) Any other health care related service.

(b) The medical care expenses of a person committed to a county jail by another county are the responsibility of the committing county.

(c) The medical care expenses of a person committed to a county jail by the department of correction are the responsibility of the department of correction.

As added by P.L.141-1999, SEC.1.

IC 11-12-5-7

Reimbursement of inmate medical care expenses

Sec. 7. (a) As used in this section, "medical care expenses" refers to expenses relating to the following services provided to a county jail inmate:

(1) Medical care.
(2) Dental care.
(3) Eye care.
(4) Any other health care related service.

(b) Notwithstanding section 6 of this chapter and subject to subsection (c), as a term of a sentence, a court may order a county jail inmate to reimburse a county for all or a portion of medical care expenses incurred by the county in providing medical care to the inmate.

(c) A county jail inmate may not be required to reimburse a county for medical care expenses under this section if:

(1) all the charges for which the inmate was detained in the county jail are dismissed; or
(2) the inmate is acquitted of all charges for which the inmate was detained in the county jail.

(d) In determining the amount of reimbursement that an inmate may be required to pay under subsection (b), the court shall consider the inmate's ability to pay.

(e) If a court orders a county jail inmate to reimburse a county for medical care expenses under subsection (b), the amount of the medical care expenses shall be reduced by the amount of any copayment the inmate was required to make for the medical care expenses under IC 11-10-3-5 or section 5 of this chapter.

(f) Subject to subsection (c), if a county incurs medical care expenses in providing medical care to an inmate and the medical care expenses are not reimbursed, the county shall attempt to determine the amount, if any, of the medical care expenses that may be paid:

(1) by a policy of insurance that is maintained by the inmate and that covers medical care, dental care, eye care, or any other health care related service; or
(2) by Medicaid.

As added by P.L.213-2005, SEC.2. Amended by P.L.205-2013, SEC.171.

IC 11-12-5-8

Return of unused medications, medical devices, or medical supplies

Sec. 8. (a) This section applies to the return of:

(1) unused medications that meet the requirements of IC 25-26-13-25(k)(1) through IC 25-26-13-25(k)(6); and

(2) unused medical devices or medical supplies that are used for prescription drug therapy and that meet the requirements of IC 25-26-13-25(l).

(b) The county sheriff:

(1) shall return medication that belonged to a Medicaid recipient; and

(2) may return other unused medication;

to the pharmacy that dispensed the medication if the unused medication meets the requirements of IC 25-26-13-25(k)(1) through IC 25-26-13-25(k)(6).

(c) The county sheriff may return unused medical devices or medical supplies that are used for prescription drug therapy and that meet the requirements of IC 25-26-13-25(l) to a pharmacy or pharmacist.

(d) A pharmacist or pharmacy that enters into an agreement with the county sheriff to accept the return of:

(1) unused medications that meet the requirements of IC 25-26-13-25(k)(1) through IC 25-26-13-25(k)(6); or

(2) unused medical devices or medical supplies that are used for prescription drug therapy and that meet the requirements of IC 25-26-13-25(l);

may negotiate with the county sheriff a fee for processing the returns.
As added by P.L.174-2011, SEC.2. Amended by P.L.159-2012, SEC.2.

IC 11-12-5-9

Assistance in applying for Medicaid before release or discharge; timing of assistance; contract with outside entity

Sec. 9. (a) This section is effective beginning September 1, 2015.

(b) For an offender who is incarcerated for less than thirty (30) days, a sheriff, in consultation with the county executive or a person designated by the county executive, may:

(1) assist an offender in applying for Medicaid; and

(2) act as the offender's Medicaid authorized representative as described in IC 11-10-3-7;

so that the offender might be eligible for coverage when the offender is subsequently released from the county jail.

(c) Before discharge or release from a county jail of an offender incarcerated for at least thirty (30) days, the sheriff, in consultation with the county executive or a person designated by the county

executive in the county in which the incarcerated person is located shall assist the offender in applying for Medicaid, if eligible, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the offender might be eligible for coverage when the offender is subsequently released from the county jail.

(d) The sheriff shall provide the assistance described in subsection (c) in sufficient time to ensure that the offender will be able to receive coverage at the time the offender is released from the county jail.

(e) A county executive may contract with any entity that complies with IC 27-19-2-12, including a hospital or outreach eligibility worker, to assist with Medicaid applications under this section. A county executive may develop intergovernmental agreements with other counties to provide both authorized representative and health navigator services required under this section. Upon a determination that an incarcerated individual qualifies for Medicaid coverage, the office of the secretary of family and social services, division of family resources, shall authorize and then immediately suspend Medicaid coverage for those inmates not requiring immediate medical attention.

As added by P.L.185-2015, SEC.7.

IC 11-12-5-10

Assistance in securing treatment for mental illness or addictive disorder; timing of assistance; outside entity assistance

Sec. 10. (a) This section is effective beginning September 1, 2015.

(b) The sheriff, in consultation with the county executive or a person designated by the county executive, shall assist an offender who has a mental illness or addictive disorder in securing treatment for the mental illness or for substance abuse addiction, as the authorized representative as described in IC 11-10-3-7 or as a health navigator under the requirements of IC 27-19-2-12, so that the offender might be eligible for treatment when the offender is subsequently released from the county jail or required to receive inpatient psychiatric services while incarcerated to the extent authorized under federal law.

(c) The sheriff shall provide the assistance described in subsection (b) in sufficient time to ensure that the offender will be able to receive treatment at the time the committed offender is released from the county jail.

(d) A sheriff shall use a community mental health center (as defined in IC 12-7-2-38) or a provider certified or licensed by the division of mental health and addiction, including a hospital or outreach eligibility worker, to assist with securing treatment for a mental illness or addictive disorder through the Medicaid program under this section.

As added by P.L.185-2015, SEC.8.

IC 11-10-8

Chapter 8. Minimum Security Release Program for Criminal Offenders and Offender Earnings

IC 11-10-8-1

Application of chapter

Sec. 1. This chapter applies only to criminal offenders.

As added by Acts 1979, P.L.120, SEC.3.

IC 11-10-8-2

Establishment of programs; violent crime offenders

Sec. 2. (a) Except as provided in subsection (b), the department shall establish a minimum security release program in which eligible committed offenders may be temporarily released from custody to:

(1) work;

(2) conduct a business or other self-employed occupation, including housekeeping or attending to family needs;

(3) attend an academic or vocational training institution or program;

(4) obtain medical, psychiatric, or psychological treatment, including treatment for drug addiction or alcoholism; or

(5) accomplish other purposes consistent with programs of the department.

(b) An offender convicted of:

(1) a violent crime (as defined in IC 5-2-6.1-8); or

(2) a sex offense under IC 35-42-4 or IC 35-46-1-3;

is not eligible to participate in a minimum security assignment that constitutes an assignment of the offender to a program requiring weekly reporting to a designated official.

As added by Acts 1979, P.L.120, SEC.3. Amended by P.L.136-1989, SEC.2; P.L.2-1992, SEC.110; P.L.47-1993, SEC.5; P.L.144-1995, SEC.1.

IC 11-10-8-3

Assignment to program; requirements

Sec. 3. (a) Before an offender may be assigned to a minimum security release program:

(1) the offender must be assigned to a minimum security classification in accord with IC 35-38-3 (any change in the degree of security, from minimum to a higher degree, whether the change occurs before or after assignment to a release program, renders the offender ineligible for participation in the release program, and the department shall take appropriate action for the offender's immediate removal from the release program and reassignment to a facility or program consistent with the offender's degree of security assignment); and

(2) the department must find that:

(A) the offender is likely to respond affirmatively to the

program;

(B) it is reasonably unlikely that the offender will commit another crime while assigned to the program; and

(C) the offender demonstrates reading and writing skills that meet minimum literacy standards:

(i) developed by the department; and

(ii) established under rules adopted by the department under IC 4-22-2.

(b) The minimum literacy standards adopted by the department under subsection (a)(2)(C) must provide that an offender is exempt from those standards if the department determines that:

(1) the offender is unable to meet the minimum literacy standards as a result of a disability; or

(2) the length of the offender's sentence prevents the offender from achieving the minimum literacy standards before the expiration of the offender's sentence.

As added by Acts 1979, P.L.120, SEC.3. Amended by P.L.150-1987, SEC.1; P.L.23-1993, SEC.34; P.L.1-2005, SEC.124; P.L.1-2007, SEC.101.

IC 11-10-8-4

Contracts for confinement of offenders

Sec. 4. The department may enter into contracts with appropriate city, county, state, or federal authorities for the confinement of, and provision of other correctional services to, offenders; and the city, county, and state authorities may enter into such contracts. If the department determines that an offender participating in a minimum security release program does not require the security of a public detention facility, it may contract with other public or private agencies for his custody and care.

As added by Acts 1979, P.L.120, SEC.3.

IC 11-10-8-5

Directives; establishment

Sec. 5. (a) The department shall establish directives governing:

(1) eligibility and selection of prospective employers for participation in the work release program;

(2) eligibility and selection of institutions and programs for participation in the study release program;

(3) eligibility and selection of hospitals, clinics, or other agencies or individuals for participation in the medical release program;

(4) the procedure by which an offender may apply for participation in a minimum security release program;

(5) custody of an offender during the time he is not actively engaged in the activity to which he is assigned;

(6) conduct of an offender participating in a minimum security release program, including sanctions for violation of rules of

conduct;

(7) accounting procedures for the disposition of a participating offender's earnings;

(8) an offender's voluntary or involuntary removal from a minimum security release program;

(9) departmental assistance in obtaining medical treatment or suitable employment, academic, or vocational training in the programs authorized by this chapter; and

(10) any additional matters concerning the general administration of programs authorized by this chapter.

(b) For purposes of IC 4-22-2, the term "directive" as used in this section relates solely to internal policy and procedure not having the force of law.

As added by Acts 1979, P.L.120, SEC.3.

IC 11-10-8-6

Earnings of offender; distribution

Sec. 6. (a) The earnings of an offender employed in a work release program under this chapter, less payroll deductions required by law and court ordered deductions for satisfaction of a judgment against the offender, shall be surrendered to the department or its designated representative. The remaining earnings shall be distributed in the following order:

(1) State and federal income taxes and Social Security deductions not otherwise withheld.

(2) The cost of membership in an employee organization.

(3) Ten percent (10%) of the offender's gross earnings, to be deposited in the violent crime victims compensation fund established by IC 5-2-6.1-40.

(4) Not less than fifteen percent (15%) of the offender's gross earnings, if that amount of the gross is available after the above deductions, to be given to the offender or retained by the department. If retained by the department, the amount, with accrued interest, must be returned to the offender not later than at the time of the offender's release on parole or discharge.

(5) The expense of room and board, as fixed by the department and the budget agency, in facilities operated by the department, or, if the offender is housed in a facility not operated by the department, the amount paid by the department to the operator of the facility or other appropriate authority for room and board and other incidentals as established by agreement between the department and the appropriate authority.

(6) Transportation cost to and from work, and other work related incidental expenses.

(7) Court ordered costs or fines imposed as a result of conviction of an offense under Indiana law, unless the costs or fines are being paid through other means.

(8) If an offender is eligible for an offender reentry

administrative account under IC 11-10-15, at least ten percent (10%) and not more than twenty percent (20%) of the offender's gross earnings, to be deposited in the offender's reentry administrative account.

(b) After the amounts prescribed in subsection (a) are deducted, the department may, out of the remaining amount:

(1) when directed by the offender or ordered by the court, pay for the support of the offender's dependents (if the offender's dependents are receiving welfare assistance, the appropriate county office of the division of family resources or welfare department in another state shall be notified of these disbursements); and

(2) with the consent of the offender, pay to the offender's victims or others any unpaid obligations of the offender.

(c) Any remaining amount shall be given to the offender or retained by the department in accord with subsection (a)(4).

(d) The department may, when special circumstances warrant or for just cause, waive the collection of room and board charges by or on behalf of a facility operated by the department or, if the offender is housed in a facility not operated by the department, authorize payment of room and board charges from other available funds.

As added by Acts 1979, P.L.120, SEC.3. Amended by P.L.2-1992, SEC.111; P.L.4-1993, SEC.14; P.L.5-1993, SEC.27; P.L.47-1993, SEC.6; P.L.1-1994, SEC.44; P.L.146-2008, SEC.370; P.L.44-2009, SEC.6; P.L.104-2009, SEC.3.

IC 11-10-8-6.5

Work release—study release subsistence special revenue fund

Sec. 6.5. (a) There is created the work release-study release subsistence special revenue fund to be used for:

(1) construction of new work release or study release facilities;

(2) maintenance of work release or study release facilities;

(3) general operating costs of the work release or study release programs, including offender services;

(4) providing programs or services established under IC 11-13-8; or

(5) the matching of federal funds for use in the work release or study release programs.

(b) Money collected under section 6(a)(5) of this chapter shall be deposited in the fund not later than the fifteenth day of the month following the month in which it was received.

(c) Earnings on the money deposited in the fund shall be deposited in the fund.

(d) The commissioner shall submit a proposed budget for expenditure of the money in the fund to the state budget agency for approval in accord with IC 4-12-1.

(e) If the fund is abolished, its contents revert to the state general fund.

(f) Money in the fund is continuously appropriated for the purposes provided under this article.

As added by Acts 1980, P.L.88, SEC.2. Amended by P.L.240-1991(ss2), SEC.55.

IC 11-10-8-7

Supervision over conditions of employment

Sec. 7. The department of labor shall exercise the same supervision over conditions of employment for offenders under this chapter as the department of labor does over conditions of employment for persons who are not committed.

As added by Acts 1979, P.L.120, SEC.3. Amended by P.L.37-1985, SEC.3.

IC 11-10-8-8

Status of offender while going to or from employment

Sec. 8. An offender employed under this chapter by an employer other than the department is not an agent, employee, or involuntary servant of the department while working or going to or from the employment.

As added by Acts 1979, P.L.120, SEC.3.

IC 11-10-8-9

Notice to victim before assignment of offender to work release program

Sec. 9. Before the department may assign an offender to a work release program, the department must notify any victim of the offender's crime of the right to submit a written statement to:

(1) a sentencing court in accordance with IC 11-10-11.5-4.5, if the offender is under consideration for assignment to a community transition program; and

(2) the department, if the offender is under consideration for assignment to any other work release program.

If the name or address of a victim of the offender's crime changes after the offender is sentenced for the offense, and the offender's sentence may result in the offender's assignment to the work release program, the victim is responsible for notifying the department of the name or address change.

As added by P.L.90-2000, SEC.2.

INDIANA COUNCIL of Community Mental Health Centers, Inc.

Legislative Impacting Mental Health, Addictions, and Criminal Justice

Report created on May 3, 2017

HB1001 **STATE BIENNIAL BUDGET** (BROWN T) Appropriates money for capital expenditures, the operation of the state, K-12 and higher education, the delivery of Medicaid and other services, and various other distributions and purposes.

Current Status: 4/27/2017 - Signed by the Governor

HB1006 **MENTAL HEALTH MATTERS** (KIRCHHOFER C) Requires the secretary of family and social services to provide that residences for residential care and supported housing for chronic addiction that receive reimbursement when used as a recovery residence to be certified and meet standards determined by the division of mental health addiction through administrative rules. Adds, subject to the approval of the Indiana commission to combat drug abuse (commission), an individual who is: (1) less than 18 years of age; and (2) a defendant whose case is either waived from juvenile court to adult court or directly filed in adult court; to the individuals who may be eligible for mental health and addiction forensic treatment services. Provides that a child welfare program may be established for the purpose of providing child welfare substance abuse treatment services for families and children who have an open child welfare or delinquency case with the juvenile court. Requires that information and training concerning child welfare substance abuse treatment services be provided to certain judges, department of child services employees, and public defenders. Includes neonatal abstinence syndrome as a factor for a child to be determined a child in need of services. Urges the legislative council to assign to the interim study committee on corrections and criminal code the topic of extending mental health and addiction forensic treatment services to individuals in the criminal justice system: (1) who: (A) are charged with a misdemeanor offense; or (B) have a prior misdemeanor conviction; and (2) who have been placed in or are eligible for placement in a pretrial services program, a community corrections program, a prosecuting attorney's diversion program, or jail. (The introduced version of this bill was prepared by the interim study committee on public health, behavioral health, and human services).

Current Status: 4/28/2017 - Signed by the Governor

HB1010 **COMMITMENT TO THE DOC FOR A LEVEL 6 FELONY** (STEUERWALD G) Amends the law limiting the circumstances under which a person convicted of a Level 6 felony can be committed to the department of correction (DOC). Provides that a person convicted of a Level 6 felony can be committed to the DOC if: (1) the commitment is

due to the revocation of the person's sentence for violating probation, parole, or community corrections and the revocation of the person's sentence is due to a new criminal offense; or (2) the person is convicted of a Level 6 felony and the sentence for that felony is ordered to be served consecutively to the sentence for another felony.

Current Status: 3/29/2017 - Signed by the Governor

HB1218 **JUVENILE JUSTICE** (MCNAMARA W) Adds additional members to a community corrections advisory board. Allows an application for a state grant for a community corrections program for juveniles to be made to the department of correction division of youth services. Provides that a child who was: (1) the victim of human trafficking; and (2) adjudicated a delinquent child for an act performed while a victim of human trafficking and the delinquent act was a result of human trafficking; is entitled to have the adjudication expunged. Specifies that expunged electronic records must be stored in a secure data base. Permits the department of correction to award funding to a court appointed forensic advocate program. Provides that a person who was: (1) the victim of human trafficking; and (2) convicted of a nonviolent offense committed while the person was being trafficked; is entitled to have the person's conviction vacated if certain conditions are met. Provides that prostitution is a criminal offense only if committed by a person who is at least 18 years of age. Defines "juvenile prostitution". Provides that a person less than 18 years of age who is engaged in juvenile prostitution is considered a victim of juvenile prostitution and human or sexual trafficking. Adds juvenile prostitution to offenses involving prostitution in human trafficking crimes and the crimes of visiting a common nuisance and promoting prostitution. Makes technical corrections.

Current Status: 4/20/2017 - Signed by the Governor

HB1335 **STATE INSTITUTIONS** (KIRCHHOFER C) Includes the Neurodiagnostic Institute and Advanced Treatment Center as a state institution. Allows for the instruction of medical students at all state institutions. (Current law allows for instruction of medical students only at Larue D. Carter Memorial Hospital.) Authorizes the director of the division of mental health and addiction to contract for the management and clinical operation of any state institution, including contracting with an entity for services. (Current law allows for only Larue D. Carter Memorial Hospital.)

Current Status: 3/29/2017 - Signed by the Governor

HB1337 **TELEMEDICINE MATTERS** (KIRCHHOFER C) Requires the office of Medicaid policy and planning (office) to reimburse a Medicaid provider, determined by the office to be eligible, for covered telemedicine services. Prohibits the office from setting any distance restrictions under Medicaid on telehealth services and telemedicine services. Adds podiatrist to the definition of "prescriber" for purposes of telemedicine services. Requires a telemedicine services prescriber to contact the

patient's primary care provider if the telemedicine services prescriber has provided care to the patient at least two consecutive times through the use of telemedicine services. Removes a limitation on prescribing controlled substances except for opioids through the use of telemedicine if: (1) the prescriber maintains a controlled substance registration; (2) the prescriber meets federal requirements concerning the prescribing of the controlled substance; (3) the patient has been examined in person by a licensed Indiana health care provider that has established a treatment plan to assist the prescriber in the diagnosis of the patient; (4) the prescriber has reviewed and approved the treatment plan and is prescribing for the patient pursuant to the treatment plan; and (5) the prescriber complies with the requirements of the INSPECT program. Allows for the prescribing of an opioid using telemedicine services if the opioid being prescribed is a partial agonist being prescribed to treat or manage an opioid dependence.

Current Status: 4/24/2017 - Signed by the Governor

HB1349 **REHABILITATION PROGRESS AND RECIDIVISM REPORTING** (STEUERWALD G) Provides that any entity in receipt of funds: (1) recommended by the justice reinvestment advisory council; and (2) appropriated by the department of correction; must provide certain statistics related to recidivism, rehabilitation, supervision, and treatment. Defines certain terms. Urges the legislative council to assign to a study committee the topic of the implementation of HEA 1006-2014. Makes conforming amendments.

Current Status: 4/24/2017 - Signed by the Governor

HB1391 **SOCIAL WORKER LICENSES** (FRIZZELL D) Creates a bachelor's degree social worker license. Provides an exception from the social work and clinical social work license requirements for providers who are contracted by the department of child services and meet certain requirements. Provides that individuals who pursue a social work license with a bachelor's degree may apply under existing requirements and use clinical social work experience hours until July 1, 2019. Allows individuals who: (1) have at least two years of experience; (2) meet certain requirements; and (3) apply before July 1, 2018; to be granted a bachelor's degree social worker license without taking an examination. Provides that any supervised clinical social work experience hours that an applicant for licensure as a clinical social worker accumulates do not expire and may be used by the applicant to satisfy the supervised clinical social work experience requirements. Requires the behavioral health and human services licensing board to issue a license to a bachelor's degree social worker, social worker, or clinical social worker who: (1) has a valid license or certificate to practice from another state or jurisdiction; (2) has passed an examination substantially equivalent to the license examination; (3) does not have a pending disciplinary proceeding in another state; and (4) pays a fee.

Current Status: 4/26/2017 - Signed by the Governor

HB1406 **CRIMINAL OFFENSES** (WASHBURNE T) Provides that a person who knowingly or intentionally manufactures or finances the manufacture of methamphetamine commits manufacturing methamphetamine, a Level 4 felony. Specifies circumstances under which the crime is a Level 3 or Level 2 felony. Provides that the crime of strangulation includes application of pressure to a victim's torso, and increases the penalty to a Level 5 felony if it is knowingly committed against a pregnant woman. Provides that a person commits controlled substances criminal mischief if the person damages property while manufacturing or dealing in a controlled substance. (Under current law, the statute applies only to certain controlled substances.) Creates an enhancement to obstruction of justice if a person interferes with a witness during the investigation or pendency of a domestic violence or child abuse case. Increases the penalty for receiving stolen auto parts if the person has a prior conviction for this offense or for auto theft. Defines "drug related felony", and requires the division of state court administration to report certain drug related felonies to the National Precursor Log Exchange (NPLEx) so that NPLEx can generate a stop sale alert to prevent individuals with drug related felonies from purchasing ephedrine or pseudoephedrine. Provides that the offense of possession of a precursor by a methamphetamine offender (which prohibits the possession of pseudoephedrine or ephedrine without a prescription by persons convicted of certain offenses) applies to a person who has been convicted of a drug related felony. Makes cemetery mischief: (1) a Class A misdemeanor if the pecuniary loss is less than $750; (2) a Level 6 felony if the pecuniary loss is at least $750 but less than $50,000; and (3) a Level 5 felony if the pecuniary loss is at least $50,000. Increases the penalty for contributing to the delinquency of a minor: (1) to a felony of the same level as the delinquent act committed by the child, if the child commits an act that would be a felony if committed by an adult; and (2) to a felony one level higher than the level that the delinquent act would be if committed by an adult, with the exception of murder or a Level 1 felony, if the person who commits the offense is at least 21 years of age, the child is less than 16 years of age, and the child commits a delinquent act that would be a misdemeanor or felony if committed by an adult. Establishes sentence enhancements applicable if a certain quantity of heroin is sold within a 90 day period. Makes dealing in heroin as a Level 2 or Level 3 felony non-suspendible if the person has a prior felony conviction.

Current Status: 4/28/2017 - Signed by the Governor

HB1438 **SYRINGE EXCHANGE PROGRAMS** (KIRCHHOFER C) Allows a county or municipality to approve the operation of a syringe exchange program (program). Allows a program to be renewed for not longer than two years. Requires a program to keep a sufficient quantity of an overdose intervention drug in stock to administer when needed. Requires the state health commissioner to receive written notice when a program is renewed, expired, or terminated or if the qualified entity operating the

program changes. Extends the law concerning programs until July 1, 2021. (Current law expires July 1, 2019.)

Current Status: 4/26/2017 - Signed by the Governor

HB1439 **FSSA MATTERS** (KIRCHHOFER C) Allows a Medicaid recipient who is incarcerated to have the recipient's Medicaid suspended for up to two years instead of one year before terminating the recipient's Medicaid eligibility. Defines "comprehensive risk contract" and "managed care organization" for purposes of Medicaid. Specifies that if a provision of Indiana insurance law conflicts with the administration of a law applying to a managed care organization with respect to the managed care organization's Medicaid responsibilities, the law applying to the managed care organization with respect to the Medicaid responsibilities is controlling. Changes language in the Medicaid law to reflect the existence of more than one risk based managed care program. Removes obsolete references to "primary care case management". Removes references to "insurer", "insurance", and "health maintenance organization" in the law concerning the healthy Indiana plan (plan) to reflect the sole use of managed care organizations to provide coverage under the plan. Allows the secretary of the office of family and social services (office) to determine the amount, based on the individual's annual household income per year, that an individual must continue to contribute to the individual's health care account in order to participate in the plan. Provides that the amount determined by the office based on an individual's annual income must be budget neutral to the state as determined by the state budget agency. Requires that the federal government approve the contribution amount determined by the secretary. Makes conforming amendments. Makes a technical correction to a federal Code citation.

Current Status: 4/24/2017 - Signed by the Governor

HB1540 **PHARMACIES AND PHARMACISTS** (DAVISSON S) Allows the state health commissioner or a designated public health authority who is a licensed prescriber to issue a statewide standing order, prescription, or protocol that allows a pharmacist to administer or dispense a smoking cessation product. Requires that the standing order, prescription, or protocol be posted on the Internet web site of the board of pharmacy (board). Allows: (1) more than four members of the same political party; and (2) individuals who are full-time members or professors at a school of pharmacy; to serve on the board. Allows the board to adopt emergency rules concerning pharmacies that perform compounding. Removes the requirement that a pharmacy permit and pharmacist's license be prominently displayed at the pharmacy. Removes the requirement that a prescriber be notified when there is a change in the quantity filled of certain prescriptions. Adds the following immunizations to the list of immunizations that pharmacists may administer if certain conditions are met: (1) Measles, mumps, and rubella. (2) Varicella. (3) Hepatitis A. (4) Hepatitis B. (5) Haemophilus influenzae type b (Hib). Allows a

pharmacist to administer pneumonia immunizations to individuals who are at least 50 years of age. Requires a pharmacist to comply with the public health emergency consent requirements for immunizations administered during a public health emergency. Authorizes a pharmacist to administer immunizations under a standing order, prescription, or protocol of the state health commissioner. Defines "patient care", "remote dispensing facilities" and "telepharmacy" for purposes of the laws concerning remote dispensing facilities. Establishes a registration for pharmacy remote dispensing facilities and sets forth requirements for the registration. Makes various changes to the laws concerning drug regimens and the use of protocols. Requires that a health insurance policy and a health maintenance organization contract that provide coverage for prescription medications must provide for synchronized refill schedule coordination for prescription medications for chronic conditions. Provides that the taking of a controlled substance from: (1) a pharmacist acting in an official capacity; or (2) a pharmacy; is robbery, a Level 4 felony. Provides that: (1) the use of a deadly weapon; or (2) causing bodily injury to any person other than the defendant; during the robbery of: (A) a pharmacist acting in an official capacity; or (B) a pharmacy; is a Level 2 felony. Provides that causing serious bodily injury to any person other than the defendant during a robbery of: (1) a pharmacist acting in an official capacity; or (2) a pharmacy; is a Level 1 felony.

Current Status: 4/26/2017 - Signed by the Governor

HB1541 **ADDICTION TREATMENT TEAMS** (DAVISSON S) Adds a definition of "medication assisted treatment". Specifies: (1) providers that must be included as part of; and (2) services that must be provided by; an addiction treatment team. Establishes reimbursement for addiction treatment teams from health and addiction forensic treatment services grants. Allows addiction treatment teams to provide services in temporary locations and mobile units in specified conditions.

Current Status: 4/26/2017 - Signed by the Governor

SB51 **IMMUNIZATIONS** (GROOMS R) Allows the state health commissioner or a designated public health authority who is a licensed prescriber to issue a statewide standing order, prescription, or protocol that allows a pharmacist to administer or dispense certain immunizations. Allows immunization data to be released to an entity for outreach and education purposes to increase immunization rates if certain conditions are met. Requires that the standing order, prescription, or protocol be posted on the Internet web site of the board of pharmacy. Adds the following immunizations to the list of immunizations that pharmacists may administer if certain conditions are met: (1) Measles, mumps, and rubella. (2) Varicella. (3) Hepatitis A. (4) Hepatitis B. (5) Haemophilus influenzae type b (Hib). Allows a pharmacist to immunize an individual who is at least 50 years of age for pneumonia under a physician's protocol. Requires a pharmacist to comply with the public health emergency consent requirements for immunizations administered during a public

health emergency. Authorizes a pharmacist to administer immunizations under a standing order, prescription, or protocol of the state health commissioner.

Current Status: 4/21/2017 - Signed by the Governor

SB55 **DRUG OR ALCOHOL SCREENING TESTS** (BRAY R) Expands the definition of "drug or alcohol screening test" for purposes of the criminal law governing forgery, fraud, and other deceptions to include testing that is ordered by a court as part of a civil action.

Current Status: 4/13/2017 - Signed by the Governor

SB59 **PROFESSIONAL LICENSING** (HEAD R) Requires the behavioral health and human services licensing board to issue a license to a social worker, clinical social worker, marriage and family therapist, mental health counselor, licensed addiction counselor, licensed clinical addiction counselor, addiction counselor associate, or clinical addiction counselor associate who: (1) has a valid license or certificate to practice from another state or jurisdiction; (2) has passed an examination substantially equivalent to the level for which licensure is being requested; (3) does not have a pending disciplinary proceeding in another state; and (4) pays a fee. Establishes requirements to obtain a license as an addiction counselor associate or clinical addiction counselor associate. Allows for an out-of-state individual seeking reciprocity for licensing in Indiana for psychology to receive a temporary license.

Current Status: 4/28/2017 - Signed by the Governor

SB151 **INFORMATION IN INSPECT PRESCRIPTION DRUG DATA BASE** (MERRITT J) Requires the ephedrine, pseudoephedrine, and controlled substance prescription monitoring program to include an entry for a dispenser to indicate, when applicable, if a patient has entered into a pain management contract with a designated practitioner. Allows the management performance hub and the state epidemiologist to obtain information from the INSPECT program. Requires that the information provided to the management performance hub not include personally identifying information. Requires the professional licensing agency (agency) to establish a workgroup consisting of emergency medical technicians, registered nurses, paramedics, pharmacists, physicians, law enforcement officers and physician assistants for the purpose of evaluating the cost and feasability of cataloging: (1) each administration of an overdose intervention drug by an emergency medical services provider; and (2) data related to certain controlled substance investigations by law enforcement; in the INSPECT data base. Requires the agency to provide: (1) statutory recommendations; and (2) a written report; to the legislative council not later than December 1, 2017.

Current Status: 4/25/2017 - Signed by the Governor

SB154 **ASSET LIMITATION FOR SNAP ELIGIBILITY** (MERRITT J) Requires the division of family resources to: (1) beginning January 1, 2018, implement within the federal Supplemental Nutritional Assistance Program (SNAP) an expanded eligibility category and specifies a countable asset limitation for resources of $5,000 in determining an individual's SNAP eligibility; and (2) notify the United States Department of Agriculture of the implementation of expanded categorical eligibility under SNAP. Specifies certain resources that may not be counted as an asset for purposes of SNAP eligibility. Requires the division of family resources to submit a report to the legislative council concerning the projected total amounts that individuals receiving SNAP benefits would be required to repay over the period beginning January 1, 2018, and ending December 31, 2019, due to positive errors.

Current Status: 4/27/2017 - Signed by the Governor

SB156 **DRUG AND ALCOHOL TREATMENT REPORTING** (MERRITT J) Adds additional reporting requirements for opioid treatment programs. Requires the office of the secretary of family and social services, with the assistance of the state department of health and the department of administration, to report to the legislative council a comprehensive plan to increase the number of inpatient and residential beds used for detoxification, treatment, and rehabilitation, including the: (1) number of hospital beds currently available in Indiana; (2) location and physical description of state owned buildings that are currently available, or expected to be available before July 1, 2018, for conversion and use; and (3) feasibility of using currently unused hospital and health care facility beds; for drug and alcohol detoxification, treatment, and rehabilitation.

Current Status: 4/25/2017 - Signed by the Governor

SB226 **PRESCRIBING AND DISPENSING OF OPIOIDS** (MERRITT J) Limits the amount of an opioid prescription a prescriber may issue for: (1) an adult who is being prescribed an opioid for the first time; and (2) a child; unless the prescription is for the treatment of specified conditions or circumstances. Requires documentation in the use of certain exemptions. Requires a prescriber to issue a prescription for an opioid in a lesser amount if requested by specified individuals and to document the request. Requires a pharmacist, upon the request of a specified individual, to partially fill the opioid prescription in compliance with federal law. Requires the pharmacist to document that the opioid prescription was partially filled. Requires the medical licensing board, in consultation with specified persons, to adopt emergency rules and rules concerning conditions that will be exempt from the prescription limitations.

Current Status: 4/26/2017 - Signed by the Governor

SB231 **CRISIS INTERVENTION TEAMS** (CRIDER M) Provides that in conjunction with the Indiana commission (commission) to combat drug abuse and the division of mental

health and addiction, the law enforcement training board may establish the technical assistance center. Provides that the commission may make grants to the law enforcement training board to carry out the purposes of the technical assistance center. Transfers the administration of the technical assistance center for crisis intervention teams from the Indiana criminal justice institute to the Indiana law enforcement training board. Makes a technical correction.

Current Status: 4/21/2017 - Signed by the Governor

SB242 **INDIANA HOUSING FIRST PROGRAM** (MERRITT J) Establishes the Indiana housing first program (program) to provide housing and support services for eligible persons that have: (1) a serious and persistent mental illness; (2) a chronic chemical addiction; or (3) serious and persistent mental illness with a co-occurring chronic chemical addiction. Requires the housing and community development authority (authority) to administer the program. Requires the authority to establish, not later than January 1, 2018, policies and procedures to implement and administer the program. Provides that the policies and procedures must ensure the program does the following along with other requirements: (1) Includes partnerships with private and public entities to provide support services and a continuum of care for program participants. (2) Provide for program rental assistance for use in dedicated supportive housing units and in existing market units in the community. (3) Include a plan for the: (A) initial leasing of; and (B) management of rental assistance for; supportive housing developed under the program. Provides that in establishing the required policies and procedures, the authority may collaborate with or seek guidance from: (1) other appropriate state agencies; (2) officials in other states or municipalities that have implemented housing first programs; and (3) other specified public or private entities. Establishes the Indiana housing first account within the state general fund to provide funds to provide housing and support services to eligible persons under the program. Allows the authority to adopt rules to establish the policies and procedures to implement and administer the program. Provides that the Indiana commission to combat drug abuse may award grants to the authority for the purposes of the program.

Current Status: 4/21/2017 - Signed by the Governor

SB243 **SUBSTANCE ABUSE PROGRAMS** (CRIDER M) Subject to the approval of the Indiana commission to combat drug abuse (commission), establishes the physician medication assisted treatment training reimbursement pilot program (pilot program) to reimburse qualified physicians who undergo certain medication assisted treatment training, for the purpose of increasing the number of physicians in Indiana allowed under the federal Drug Addiction Treatment Act of 2000 to prescribe certain controlled substances to treat opioid dependency in settings other than an opioid treatment program. Establishes requirements for participation in the pilot program. Subject to the approval of the commission, establishes the maternal

neonatal opioid addiction project (project) within the division of mental health and addiction (division). Allows the division to implement the project and award one grant to a health care system application that meets specified requirements for participation in the project.

Current Status: 4/25/2017 - Signed by the Governor

SB279 **POST-EXPOSURE PROPHYLAXIS REIMBURSEMENT** (LANANE T) Changes the definition of "additional forensic services" to include HIV prophylactic medication, and removes discretionary reimbursement for the service.

Current Status: 4/21/2017 - Signed by the Governor

SB322 **DNA FOR FELONY ARRESTEES** (HOUCHIN E) Requires every person arrested for a felony after December 31, 2017, to submit a DNA sample, and specifies that the sample may be obtained only by buccal swab. Provides that the DNA sample may not be shipped for DNA identification unless the arrestee was arrested pursuant to a felony arrest warrant or a court has found probable cause for the felony arrest. Provides for removal of a DNA sample from the data base if: (1) the person is acquitted of all felony charges or the charges are converted to misdemeanors; (2) all felony charges against the person are dismissed; or (3) no felony charges are filed against the person within 365 days. Requires the officer who obtains a DNA sample from a person to inform the person of the right to DNA removal and to provide the person with instructions and a form that may be used for DNA removal. Provides that a person who knowingly or intentionally disseminates, receives, or otherwise uses information in the DNA data base for a purpose other than authorized by law commits a Level 6 felony. Increases the DNA sample processing fee from $2 to $3. Amends distribution percentages to hold harmless all funds and to provide an additional amount to the DNA processing fund. Specifies that the discovery of DNA evidence tending to show previously unknown crimes committed by a person on bail may lead to revocation of bail or an increase in the amount of bail.

Current Status: 4/21/2017 - Signed by the Governor

SB392 **EMERGENCY MEDICATION** (STOOPS M) Defines "emergency medication" as epinephrine, albuterol, or naloxone. Allows a school or school corporation to: (1) fill a prescription for an emergency medication; and (2) store the emergency medication. (Current law allows a school to fill a prescription for auto-injectable epinephrine and store the auto-injectable epinephrine.) Defines "emergency stock medication" as emergency medication to which both the following apply: (1) The prescription of the emergency medication is filled by a school or school corporation. (2) The emergency medication is stored at a school. Provides that injectable epinephrine filled by certain entities must have an expiration date of not less than 12 months from the date that the pharmacy dispenses the injectable epinephrine. Makes conforming changes regarding: (1) administering emergency stock

medication; (2) prescribing and dispensing emergency medication; and (3) certain immunity from liability concerning the administration of emergency stock medication. Defines "school" and "school nurse". Requires the department of education (department) to develop guidance materials concerning emergency medication and post a copy of the materials on the department's Internet web site. Requires a school nurse or school employee to make a report if an emergency stock medication is administered and submit the report in an electronic format to the department.

Current Status: 4/21/2017 - Signed by the Governor

SB408 **INSPECT PROGRAM** (HOUCHIN E) Adds a definition of the Indiana board of pharmacy (board) for purposes of the INSPECT program. Requires the board to report, before December 1, 2017, to the legislative council concerning grants or funding received and applied for by the state for integration of the INSPECT program data base with electronic health records. Urges the legislative council to assign to the appropriate study committee the topic of potential improvements to the INSPECT program.

Current Status: 4/27/2017 - Signed by the Governor

SB446 **RESIDENTIAL SUBSTANCE ABUSE TREATMENT** (MERRITT J) Establishes, subject to the approval of the Indiana commission to combat drug abuse (commission), an opioid addiction recovery pilot program (program) to assist pregnant women and women with newborns, with an opioid addiction by providing treatment in a residential care facility and home visitation services following discharge from the residential care facility. Provides that the program is administered by the department of health. Provides that the program shall include three facilities and that medication assisted treatment may be used when appropriate.

Current Status: 4/25/2017 - Signed by the Governor

SB447 **CHILD SERVICES** (MERRITT J) Requires child abuse and neglect training for school employees. Allows the department of child services (department) to share costs incurred in maintaining the new hire directory in accordance with federal law with the department of workforce development. Adds a definition of "concurrent planning". Adds a definition of "nonwaivable offense" and makes conforming changes. Allows the department to pay the criminal background check fee in certain adoption cases. Prohibits the department from charging a fee for state tax offsets. Amends provisions concerning restricted driving licenses. Provides that the department may not grant a variance or waiver of a rule to an applicant for a: (1) child care institution; (2) foster family home; (3) group home; or (4) child placing agency; license if the applicant has been convicted of certain felonies. Requires that a criminal history check be conducted on all members of the household of an applicant for a foster family home license. (Current law requires a criminal history

check of household members 14 years of age or older.) Amends provisions governing sharing of jurisdiction between: (1) a court that has jurisdiction over a child in a marriage dissolution or paternity action; and (2) another court hearing a delinquency or child in need of services proceeding regarding the child. Permits a juvenile court to authorize drug and alcohol testing of a child under certain circumstances. Requires an individual who is required to make a report of abuse or neglect in the individual's capacity as a member of the staff of a hospital licensed under IC 16-21-2 to first notify the individual in charge of the hospital or the designated agent of the individual in charge of the hospital. Prohibits a public or nonpublic school, school corporation, facility, or agency from establishing a policy restricting an employee's duty to report suspected child abuse or neglect. Adds a written report as a means to report suspected child abuse or neglect. Amends a requirement that the department must notify the United States Department of Defense Family Advocacy Program (Program) regarding a substantiated investigation of abuse or neglect of a child of an active duty military member, to provide that the department must notify the Program upon request. Provides that a child: (1) who lives in the same household as another child who is a child in need of services because the other child is a victim of specified offenses; and (2) regarding whom a caseworker makes specified determinations; is a child in need of services. Provides that a child who: (1) is born with: (A) neonatal abstinence syndrome; or (B) a controlled substance, legend drug, or metabolite of a controlled substance or legend drug in the child's body, including in the child's blood, urine, umbilical cord tissue, or meconium; and (2) needs care, treatment, or rehabilitation the child is not receiving or unlikely to receive without court intervention; is a child in need of services, and establishes a rebuttable presumption that the conditions regarding the child's care, treatment, or rehabilitation are met if evidence exists that the child's mother used a controlled substance or a legend drug during pregnancy. Provides that a child in need of services may be placed in a residence at which a person who has been convicted of battery (rather than battery only as a felony, as provided in current law) resides, if the person's commission of the offense is not relevant to the person's ability to care for the child and the placement is in the best interests of the child. Makes optional (rather than required, as under current law) certain recommendations in a petition seeking participation of a parent, guardian, or custodian in a program of care, treatment, or rehabilitation of a child. Permits out-of-home placement of a child in a facility located outside Indiana only if there is not an equivalent facility (rather than a comparable facility, under current law) located in Indiana. Provides that a court may order a parent, guardian, or custodian of a child to participate in a mental health or addiction treatment program if the parent, guardian, or custodian will be participating in a program of care, treatment, or rehabilitation of the child. Prohibits filing by a child placing agency of a petition for voluntary termination of parental rights unless the petition is in furtherance of an adoption or other permanency plan. Requires a law enforcement agency to forward a missing child report to the department. Requires the department to complete a

written report within 24 hours of receiving a report of a missing child. Requires the department to provide information concerning certain missing children to the National Center for Missing and Exploited Children. Provides that the consent of an agency or local office: (1) with lawful custody of a child whose adoption is being sought; and (2) who is served with a notice of adoption concerning the child; is not subject to being irrevocably implied. Provides immunity for a person who leaves an infant with a person who is an emergency medical services provider.

Current Status: 4/26/2017 - Signed by the Governor

SB497 **MEDICAID ELIGIBILITY OF FORMER FOSTER CHILDREN** (GROOMS R) Sets forth Medicaid eligibility for individuals who: (1) are at least 18 years of age or emancipated; and (2) are less than 26 years of age. Requires the department of child services (department), in cooperation with the office of Medicaid policy and planning (office), to enroll individuals, who received foster care in Indiana and are turning 18 years of age, in the Medicaid program as part of the individuals' transitional services plan. Prohibits the office from requiring the individual to submit eligibility information after enrolling in the Medicaid program during the individual's Medicaid eligibility as a former foster child. Requires the department to provide information concerning the individual's Medicaid enrollment to the individual.

Current Status: 4/21/2017 - Signed by the Governor

SB499 **OPIOID ADDICTION** (RAATZ J) Provides that, after approval of the Indiana commission to combat drug abuse (commission), the division of mental health and addiction (division) shall establish a three year opioid treatment pilot program (pilot program) for opioid abuse disorder in Tippecanoe, Marion, and Wayne counties. Establishes the criteria for the program. Requires the division to collect data and issue a report to the legislative council on the pilot program. Specifies that certain persons: (1) charged with or convicted of a drug offense; and (2) who received an overdose intervention drug for an acute opioid overdose; are entitled to priority admission in a forensic diversion program, a pretrial diversion program, or another program, including a drug court program, offering treatment for persons with addictive disorders.

Current Status: 4/21/2017 - Signed by the Governor

SB510 **SUBSTANCE ABUSE PILOT PROGRAM** (MERRITT J) Provides that Allen County may enter into an agreement with an entity to administer a substance abuse pilot program after approval of the Indiana commission to combat drug abuse (commission). Specifies that the entity that agrees to administer the pilot program: (1) may not expend state grants unless the administrator has raised at least $1 of local funds for every $1 of state funds before July 1, 2018; and (2) may not expend money granted to the administrator for the pilot program for a state fiscal year

unless the administrator expends at least $1 of local funds for every $1 of state funds expended.

Current Status: 4/25/2017 - Signed by the Governor

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Saturday, April 29, 2017 12:21 PM
To: McClelland, Jim
Subject: Re: 20th Annual Mental Health Symposium

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Jim--

You are always invited to MHA events !

Please let me know if I can be of service to you in any way.

Thanks!

Stephen C McCaffrey, JD
Sent from my iPhone

On Apr 29, 2017, at 8:37 AM, McClelland, Jim <JMcClelland@gov.IN.gov> wrote:

Steve, thank you for the invitation. Because of a speaking engagement I have that day in the southern part of the state, I will not be able to attend the MHA symposium. I do appreciate your thinking of me, though.

Many thanks!

Jim

Sent using OWA for iPad

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Thanks

Steve

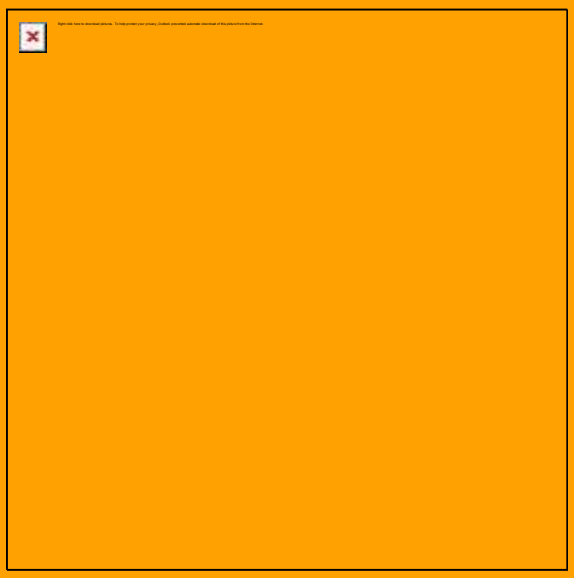
Stephen C. McCaffrey, JD
President & Chief Executive Officer

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Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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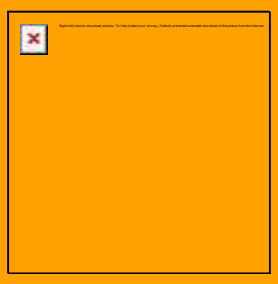
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- **Opioid Panel Discussion**
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- **Jim Ryser, History & Music**

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Mental Health America of Indiana
An Affiliate of Mental Health America

INDIANA UNIVERSITY
DEPARTMENT OF PSYCHIATRY
School of Medicine

The 20th Annual

Mental Health and Addiction Symposium

in partnership with Indiana University School of Medicine Department of Psychiatry

June 1st, 2017
Crowne Plaza at Union Station
9 am - 4pm



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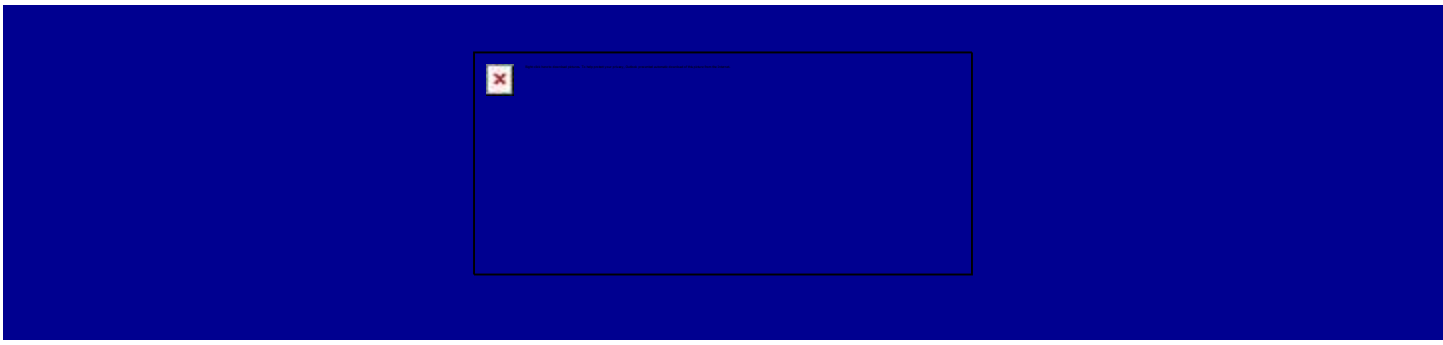
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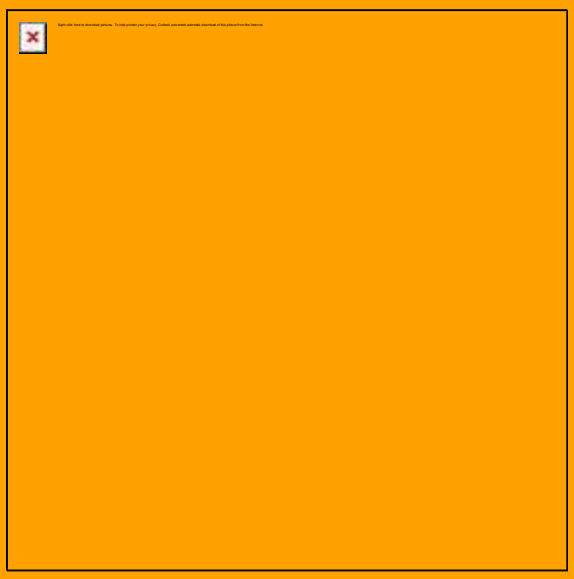


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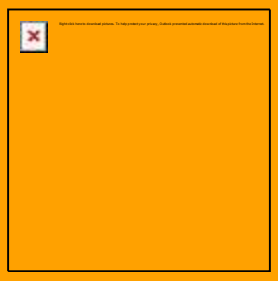
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Sent by mhai@mhai.net

Scott.A.Milkey

From: Seigel, Jane <jane.seigel@courts.IN.gov>
Sent: Thursday, March 30, 2017 7:43 AM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Forkner, Justin;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: Justice Reinvestment Advisory Council Meeting - April 7, 2017
Attachments: January 2017 JRAC minutes.docx

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Attached, you will find the minutes from the January 12, 2017 meeting. The next meeting of the Justice Reinvestment Advisory Council will be held from Noon to 3:00 p.m. (EST) on **April 7, 2017**, in the 30 South Meridian Street Building. (Meeting Room is 803 located on the 8th floor.) Since this meeting is immediately following the morning EBDM meeting, lunch will be provided. Please use the link below to advise us of your attendance.

RSVP for April 7th Meeting

Thank you again for your time.

Jane Seigel
Executive Director
Indiana Office of Court Services

Justice Reinvestment Advisory Council
Meeting Minutes
January 12, 2017

The Justice Reinvestment Advisory Council met at the Indiana Office of Court Services at 30 South Meridian Street in Indianapolis, Indiana on January 12, 2017. The Advisory Council met 1:00 p.m. - 3:00 p.m.

1. **Members present.** The following members of the Justice Reinvestment Advisory Council were present: Larry Landis, Executive Director of the Indiana Public Defender Commission; David Powell, Executive Director of the Indiana Prosecuting Attorneys Council; Kevin Moore, Director of the Division of Mental Health and Addiction; Julie Lanham, proxy for the Commissioner of the Indiana Department of Correction; David Murtaugh, Executive Director of the Indiana Criminal Justice Institute; Bill Watson, President of the Indiana Association of Community Corrections Act Counties; Linda Brady, President of the Probation Officer's Professional Association of Indiana; and Jane Seigel, Executive Director of the Indiana Office of Court Services and Council Chair.

2. **Guests present.** The following guests also attended the meeting: Deb Braun and Jim Basinger from the Indiana Department of Correction; Chris Cunningham and Lynn Wininger from the Indiana Association of Community Corrections Act Counties; Dr. Jennifer Walthall and Gus Habig from the Family and Social Service Administration; Sara Cozad the Division of Mental Health and Addiction; Steve McCaffrey from Mental Health America of Indiana; Rep. Greg Steuerwald and Trent Glass from the Indiana House of Representatives; Mary Willis from the Office of Judicial Administration; Lisa Thompson and Dave Williams from Trial Court Technology; and Matt Brooks from the Indiana Council of Community Mental Health Centers.

3. **Staff assistance.** Jennifer Bauer, Mary Kay Hudson, and Michelle Goodman provided staff assistance to the Advisory Council.

4. **Approval of minutes.** The minutes from the November 18, 2016 meeting were unanimously approved.

5. **DOC Population Report.** Jane Seigel reported that the January 2017 DOC population report was distributed by email prior to the meeting. The Advisory Council members discussed the confusing nature of the information on Level 6 offenders and requested a clarification from the DOC research division. The Advisory Council members also requested that the DOC report include more data on monthly admissions and discharges.

DRAFT

6. **Update from DOC.** Deb Braun reported that the grant applications for FY 18 community supervision funding are due by January 31, 2017. She distributed a timeline for distribution of grant money and stated that DOC will send recommendations to JRAC in April. Ms. Braun also stated that she notified current grant recipients in December about proposed changes to data points collected by DOC and the requirement for all grant recipients to submit weekly population snapshots.

7. **Update from DMHA on Recovery Works.** Jane Seigel introduced new FSSA Secretary Dr. Jennifer Walthall and thanked her for attending the JRAC meeting. Dr. Walthall stated that there are exciting things happening at FSSA and DMHA in 2017.

   Kevin Moore reported that his testimony before the House Courts and Criminal Code Committee went well. He also reported that there is new federal money available for opioid addiction treatment.

   Sara Cozad Angie distributed a handout and reported that the Recovery Works program has enrolled 8,295 individuals as of today's date and expended a total of $5.54 million. The top 5 services by payment are consistently medication (which includes Vivitrol injections), group substance use counseling, skills training, housing and transportation. The top 5 services by client are case management, group substance use, drug screens, skills, and mental health counseling. Ms. Cozad also reported that there are now 53 active providers, and more are expected to come on board after the Indiana Professional Licensing Agency sent out a notice about Recovery Works to all licensed counselors. DMHA released an RFP to support 10 certified forensic peer support services specialists in drug courts. The positions will be similar to the VJO model used by the Department of Veterans Affairs. Ms. Cozad further reported that DMHA is working with Steve McCaffrey and Mental Health America Indiana to increase supportive housing and recovery residences. They will use NARR guidelines to establish certified recovery housing. Ms. Cozad also stated that the surveys have been sent out and she asked the Advisory Council members to remind their stakeholders to respond. Dr. Brad Ray from Indiana University is conducting the survey and evaluation for Recovery Works and just received the first batch of data from year 1 of the program.

   The Advisory Council members discussed getting county specific data to Rep. Steuerwald as soon as possible and trying to coordinate data with DOC. The Advisory Council also discussed the issue of Recovery Works services not being available for juveniles waived to adult court/direct filed to adult court. Rep. Steuerwald stated that he would sponsor an amendment to fix this gap in treatment services. David Powell made a motion to propose a legislative amendment on Recovery Works eligibility for juveniles in adult court on direct

DRAFT

file/waiver. Dave Murtaugh seconded the motion and the motion passed unanimously.

8. **Legislative Update.** Jane Seigel reported that several JRAC members testified before the House Courts and Criminal Code Committee meeting on January 11th. The members who testified were Jane Seigel, Larry Landis, Linda Brady, Bill Watson, and Kevin Moore. Ms. Seigel stated that committee chair Rep. Washburne invited them to present information on JRAC, EBDM, local collaboration, and addictions treatment. Rep. Steuerwald, a sitting member of the House Courts and Criminal Code Committee, stated that the testimony was well-received by the members of the committee and the work of JRAC is greatly appreciated. He also stated that bills supported by JRAC will greatly benefit from JRAC support and committee testimony. The Advisory Council members discussed a bill that would require the addition of juvenile justice members to community corrections advisory boards.

9. **Data Update.** Lisa Thompson reported that Mary Willis reached out to courts that were not complying with the rule on completion of abstracts and all judges were reminded of the abstract rule in a recent weekly message from the Supreme Court. According to Ms. Thompson, there is now a 91% compliance rate for all felony convictions and 100% compliance for felons sentenced to DOC. She said the non-compliance affected DOC jail reimbursements to counties. Jane Seigel stated that the issue will continue to be an agenda item for future JRAC meetings.

   Michelle Goodman reported that the Office of Court Services is working with the University of Cincinnati on validation of the IRAS and IYAS risk assessment tools. She plans to invite JRAC and EBDM members to a meeting with UC on the work being done.

   Jane Seigel reported that the transactional control number (also known as TCN) can be reported on the abstract of judgment form, but it is not a required data field. She stated that the Office of Court Services has been discussing this and will propose that the TCN be mandatory on all abstracts. The number is important because it links charging information with disposition information.

   Lisa Thompson also reported on the SRS case management system. She stated that the SRS has been a 2.5 year project that Trial Court Technology did for Marion County. The system is used by Marion County's probation department, community corrections agency, and problem solving courts. She also stated that the SRS has a dual interface with Odyssey and INcite.

10. **Other Business.** Mary Kay Hudson reported that the Bureau of Justice Assistance published a grant opportunity for pretrial reform and data collection.

DRAFT

She stated that the time is right for Indiana to apply for grant assistance in light of the EBDM initiative. The Office of Court Services will be that applicant agency and will need letters of support from JRAC and EBDM. The due date for the grant application is February 7. Larry Landis made a motion for JRAC to support the IOCS grant application. The motion was seconded by Dave Murtaugh and approved unanimously by the Advisory Council members.

Linda Brady reported that many chief probation officers have contacted her with concern about decreasing probation user fee funds. She asked JRAC to consider the issue at a future meeting.

11. **Next meetings.** The next meeting of the Advisory Council is scheduled for February 24 at 10 a.m. at the Indiana Office of Court Services.

Respectfully submitted,

Jennifer Bauer
Staff Attorney
Indiana Office of Court Services

DRAFT

Scott.A.Milkey

From: Karns, Allison
Sent: Monday, March 27, 2017 3:52 PM
To: 'Rebekah Gorrell'
Cc: McCaffrey, Steve
Subject: RE: Hoosier Idol

Hi, Rebekah & Steve! Thank you so much for the invitation. Unfortunately, I am unable to make it.

From: Rebekah Gorrell [mailto:rgorrell@mhai.net]
Sent: Monday, March 27, 2017 10:00 AM
To: Karns, Allison <AKarns@gov.IN.gov>
Cc: McCaffrey, Steve <smccaffrey@mhai.net>
Subject: Hoosier Idol

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Hello Allison,

We are inviting the Governor's Office to attend our premiere fundraising event **Hoosier Idol** on April 11, 2017 at the Indiana Roof Ballroom, with our compliments. This event features members of the Indiana General Assembly showcasing their hidden talents to compete for the title of **2017 Hoosier Idol**.

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If your office would like to attend the event, we are extending a complimentary table for 8. Please contact Rebekah Gorrell at rgorrell@mhai.net or (317) 638-3501 x 1228 with any questions or to RSVP. **Please RSVP by April 3, 2017.**

Scott.A.Milkey

From: Rebekah Gorrell <rgorrell@mhai.net>
Sent: Monday, March 27, 2017 2:40 PM
To: McClelland, Jim
Subject: Re: Hoosier Idol

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Thank you Jim,

Maybe next year!

Sincerely,

Rebekah Gorrell
Executive Assistant to the President

1431 N. Delaware Street
Indianapolis, IN 46202
317-638-3501x1228



> On Mar 27, 2017, at 2:38 PM, McClelland, Jim <JMcClelland@gov.IN.gov> wrote:
>
> Rebekah,
>
> Thanks so much for the invitation. Unfortunately, I will not be able to attend. I do appreciate the opportunity, though, and I hope the event is very successful!
>
> Best regards.
>
> Jim
>
> Jim McClelland
> Executive Director for Drug Prevention, Treatment, and Enforcement
> State of Indiana
>
> ---
>
> **From:** Rebekah Gorrell [mailto:rgorrell@mhai.net]
> **Sent:** Monday, March 27, 2017 11:51 AM
> **To:** McClelland, Jim <JMcClelland@gov.IN.gov>
> **Cc:** McCaffrey, Steve <smccaffrey@mhai.net>
> **Subject:** Hoosier Idol

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Scott.A.Milkey

From: McClelland, Jim
Sent: Monday, March 27, 2017 2:39 PM
To: Rebekah Gorrell
Cc: McCaffrey, Steve
Subject: RE: Hoosier Idol

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Jim

Jim McClelland
Executive Director for Drug Prevention, Treatment, and Enforcement
State of Indiana

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Sent: Monday, March 27, 2017 11:51 AM
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Scott.A.Milkey

From: Rebekah Gorrell <rgorrell@mhai.net>
Sent: Monday, March 27, 2017 11:51 AM
To: McClelland, Jim
Cc: McCaffrey, Steve
Subject: Hoosier Idol
Attachments: 2nd Revised Idol Flyer 2017 copy.pdf; ATT00001.htm; image001.png; ATT00002.htm

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Note: Date Change from April 18th to April 11, 2017!







MENTAL HEALTH AMERICA OF INDIANA PRESENTS...

HOOSIER IDOL 2017



Hoosier Idol 2017 Indiana Roof Ballroom,
April 11, 2017 at 6 p.m.

Join MHAI, Brian Bosma, Phil Terry, Roger Harvey, and our panel of Celebrity Judges on April 11, 2017 as members of the Indiana General Assembly showcase their hidden talents to compete for the title of the 2017 "Hoosier Idol". Reception and Silent Auction starts at 6, followed by dinner and the show!

Contact Rebekah Gorrell for more info at rgorrell@mhai.net or 317-638-3501x1228 or visit hoosieridol.org!

Scott.A.Milkey

From: Rebekah Gorrell <rgorrell@mhai.net>
Sent: Monday, March 27, 2017 10:00 AM
To: Karns, Allison
Cc: McCaffrey, Steve
Subject: Hoosier Idol
Attachments: 2nd Revised Idol Flyer 2017 copy.pdf; ATT00001.htm; image001.png; ATT00002.htm

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Contact Rebekah Gorrell for more info at rgorrell@mhai.net or 317-638-3501x1228 or visit hoosieridol.org!

Scott.A.Milkey

From: McClelland, Jim
Sent: Thursday, March 16, 2017 12:15 PM
To: Zachary Eckert;McCaffrey, Steve
Cc: Gilson, Katie
Subject: RE: Senator Raatz- meeting

Next week will be fine for me. Please work with Katie Gilson to find a time that will work for all of us.
Thanks.
Jim

From: Zachary Eckert [mailto:Zachary.Eckert@iga.in.gov]
Sent: Thursday, March 16, 2017 11:47 AM
To: McClelland, Jim <JMcClelland@gov.IN.gov>; McCaffrey, Steve <smccaffrey@mhai.net>
Subject: Senator Raatz- meeting

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Gentlemen:

Senator Raatz would like to have a meeting with you two in the near future if possible to discuss SB 499. Please let me know if you have any availability this afternoon to meet or any availability for next week.

Thanks,
Zachary Eckert
Indiana Senate Legislative Assistant
Senator Dennis Kruse
Senator Jeff Raatz
Phone: (317) 233-0930
Email: Zachary.Eckert@iga.in.gov

Scott.A.Milkey

From: Zachary Eckert <Zachary.Eckert@iga.in.gov>
Sent: Thursday, March 16, 2017 11:47 AM
To: McClelland, Jim;McCaffrey, Steve
Subject: Senator Raatz- meeting

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Thanks,
Zachary Eckert
Indiana Senate Legislative Assistant
Senator Dennis Kruse
Senator Jeff Raatz
Phone: (317) 233-0930
Email: Zachary.Eckert@iga.in.gov

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Tuesday, March 14, 2017 3:35 PM
To: McClelland, Jim
Subject: Re: Hoosier Idol 2017

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Jim—

Ok, thanks—I think we are both in an upcoming meeting on cigarettes.
I look forward to seeing you then.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On Mar 14, 2017, at 3:06 PM, McClelland, Jim <JMcClelland@gov.IN.gov> wrote:

Thanks for the invitation, Steve. While I appreciate the opportunity, I've checked with Dan, and neither of us will be able to attend.

Thanks.

Jim

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Saturday, March 11, 2017 12:07 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Cc: Rebekah Gorrell <rgorrell@mhai.net>
Subject: Hoosier Idol 2017

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Let me know if either of you would like to attend and I will make the appropriate arrangements.

Thanks

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<image001.png>

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

<image002.jpg>

<image004.jpg>

March 11, 2017

Dear Stephen McCaffrey

<image003.jpg>

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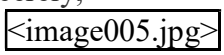
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Sincerely,



Stephen C. McCaffrey, JD
President and CEO





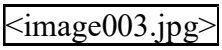
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Indianapolis, IN 46202
(317) 638-3501

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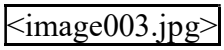
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Indiana, 1431 N. Delaware St., Indianapolis, IN 46202



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Scott.A.Milkey

From: McClelland, Jim
Sent: Tuesday, March 14, 2017 3:07 PM
To: Stephen C McCaffrey
Subject: RE: Hoosier Idol 2017

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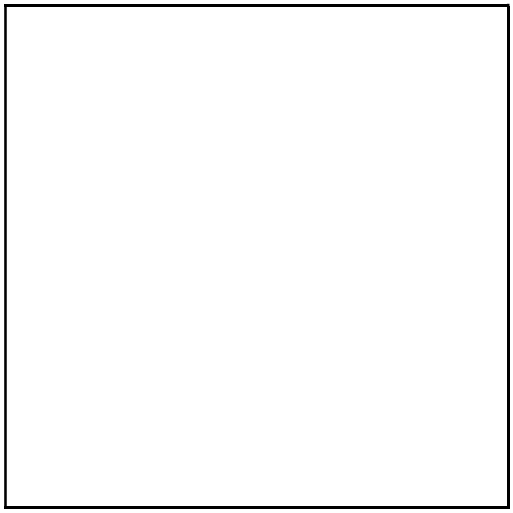
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1431 North Delaware Street
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317.638.3501 x1222
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March 11, 2017

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President and CEO

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Sent by mhai@mhai.net

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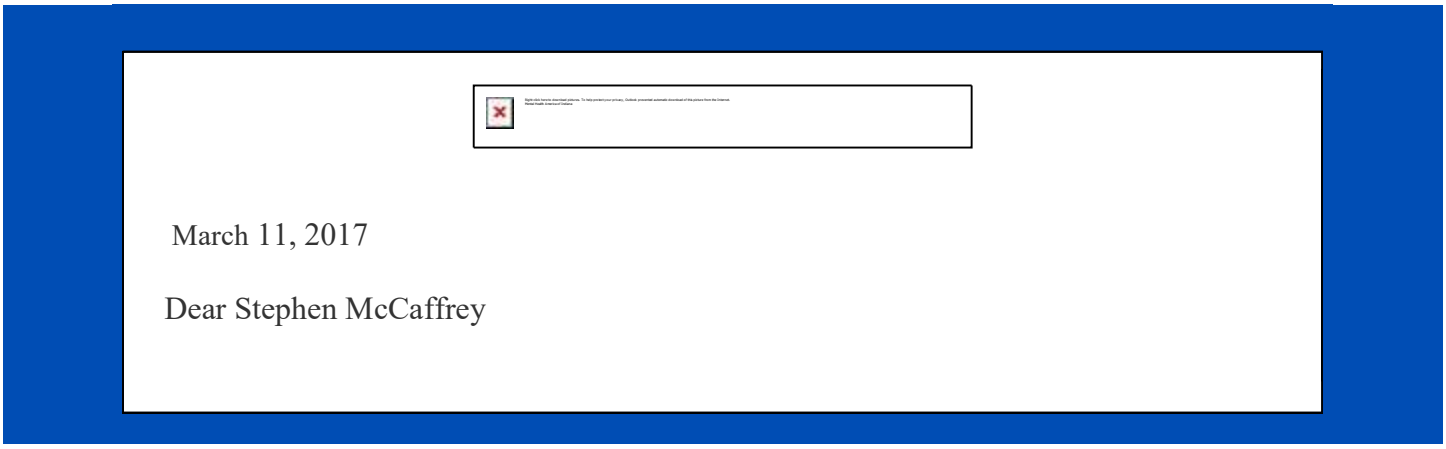
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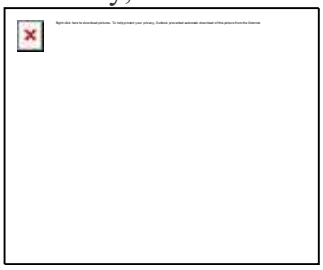
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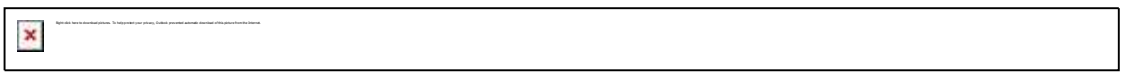
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Scott.A.Milkey

From: McClelland, Jim
Sent: Thursday, March 09, 2017 3:41 PM
To: Huntsinger, Doug
Subject: FW: Heroin Epidemic/Offer to Help

Please add Kim to our list of those who want to help.

From: Love, Kim
Sent: Thursday, March 9, 2017 2:28 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Subject: Heroin Epidemic/Offer to Help

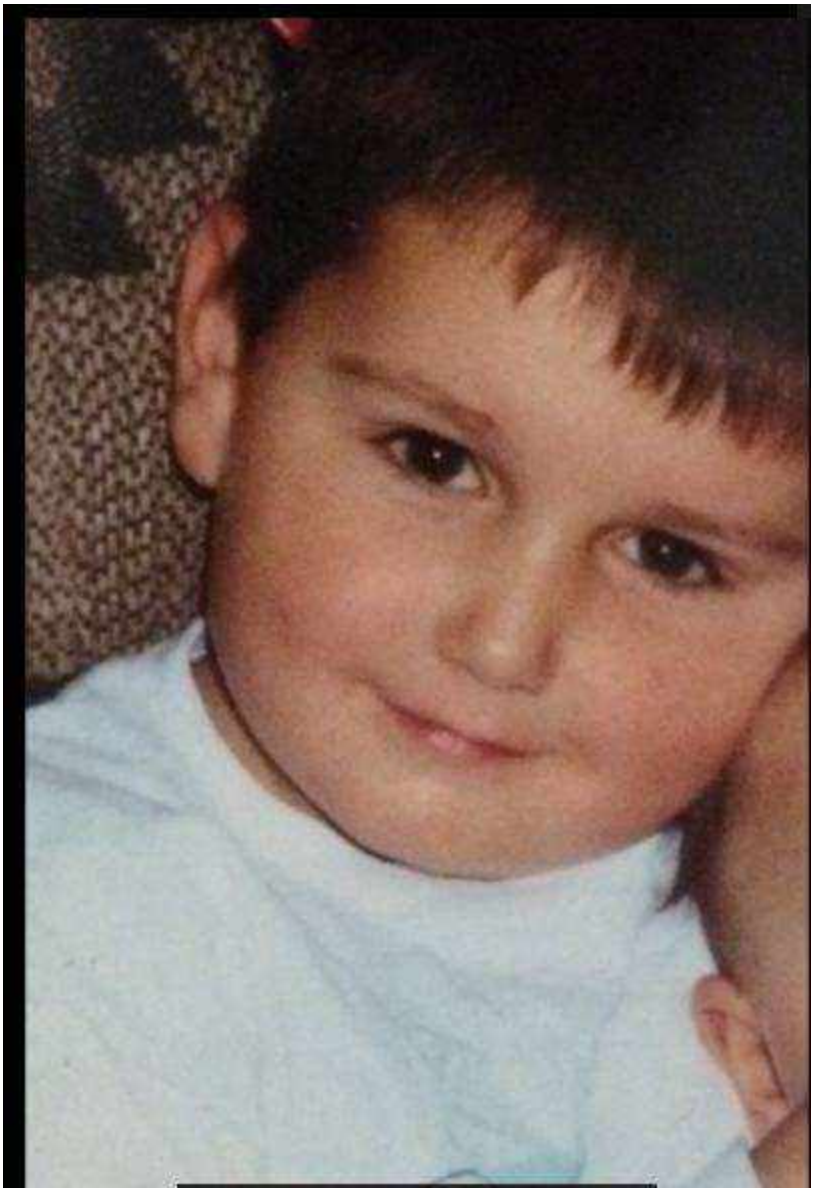
Dear Mr. McLeland,
I am a Mother and State employee with a child who is a recovering "heroin addict". Please know that we are a normal family where there was never any partying or drug use in our family. Would you please consider involving me in your meetings to help save lives regarding the heroin epidemic across our state? I have so much to offer in regards to rehab services (pros and cons) and the drugs that help an addict that aren't readily available (vivitrol) in our state etc. or are not even mentioned.

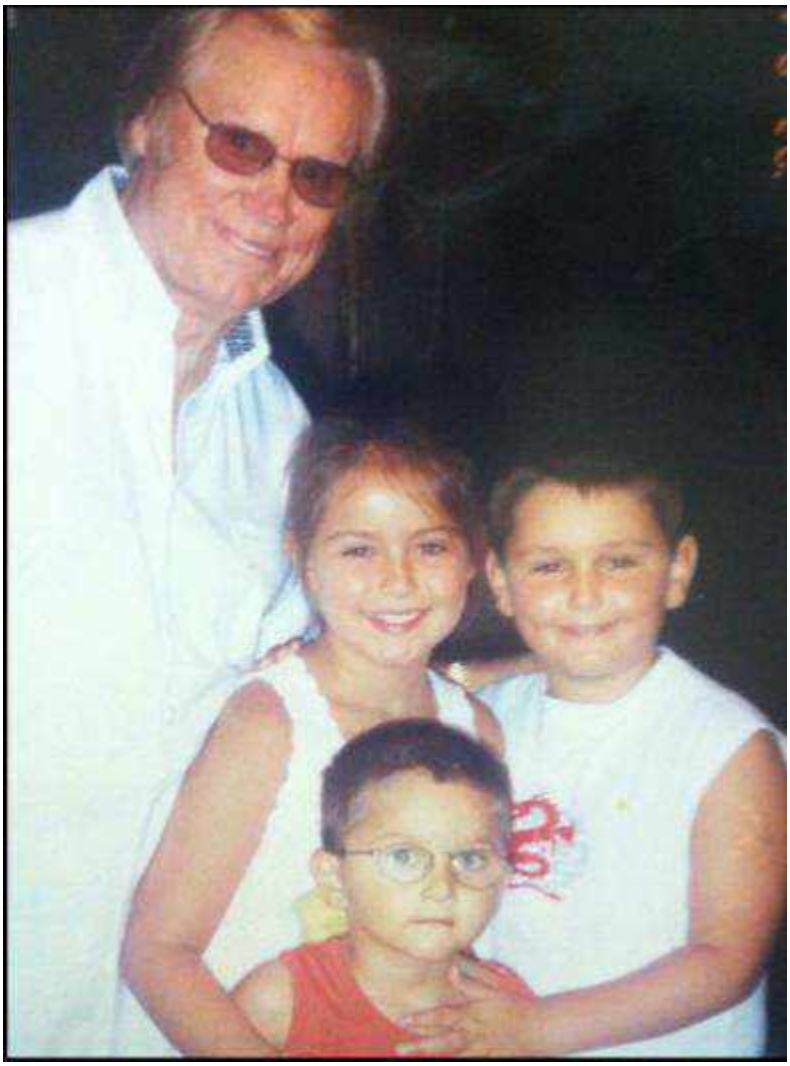
I hope to hear from you and hope we can help fight this epidemic that is tearing our families apart.

Sincerely,

Kim Love
317-[redacted]
klove@iot.in.gov

This is my son Garrett – This is Garrett with his brother and Cousin at a show at the Little Nashville Opry that his Dad and I were singing at with George Jones





Scott.A.Milkey

From: McClelland, Jim
Sent: Thursday, March 09, 2017 3:41 PM
To: dhuntsinger@gov.in.gov
Subject: FW: Heroin Epidemic/Offer to Help

Please add Kim to our list of those who want to help.

From: Love, Kim
Sent: Thursday, March 9, 2017 2:28 PM
To: McClelland, Jim <JMcClelland@gov.IN.gov>
Subject: Heroin Epidemic/Offer to Help

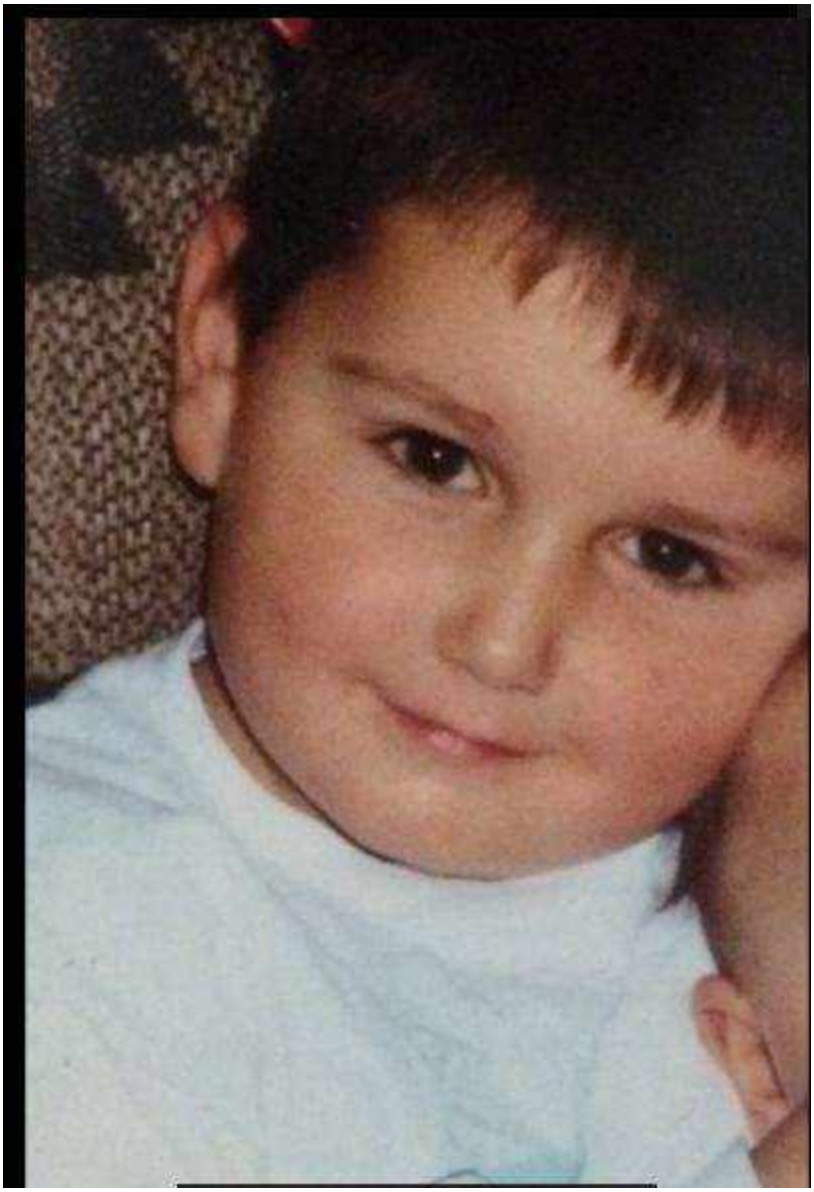
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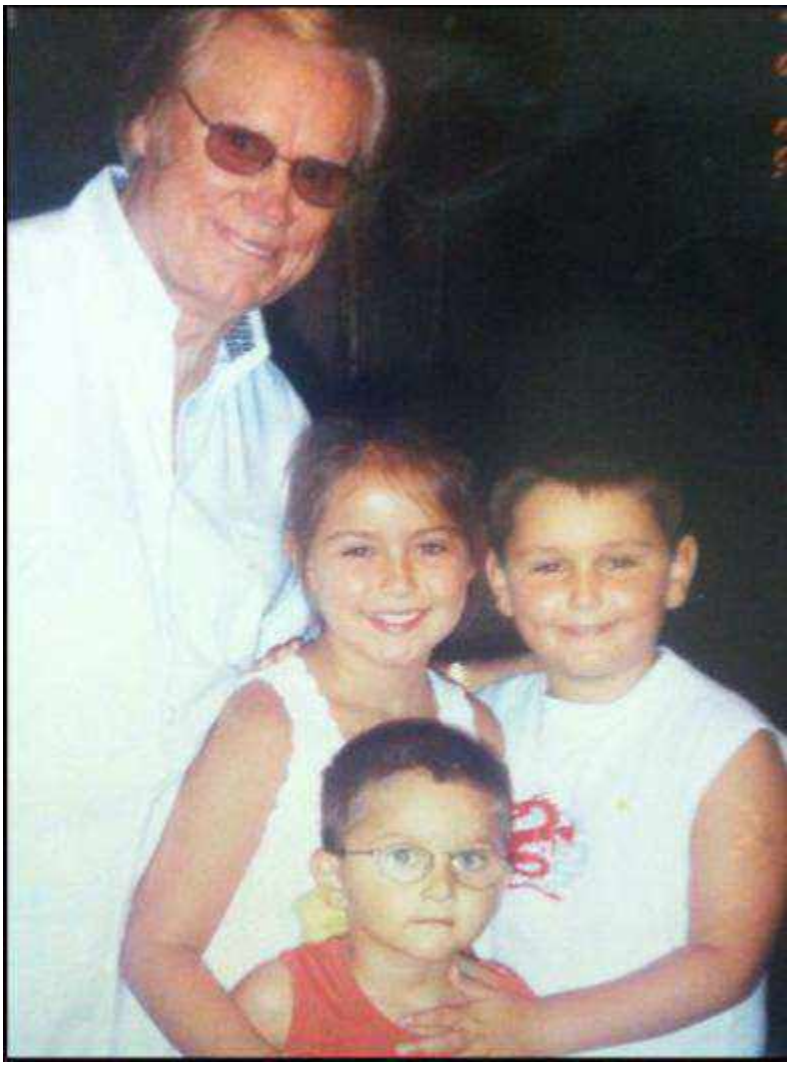
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Sincerely,

Kim Love
317-[redacted]
klove@iot.in.gov

This is my son Garrett – This is Garrett with his brother and Cousin at a show at the Little Nashville Opry that his Dad and I were singing at with George Jones





Scott.A.Milkey

From:	Hudson, MK <mk.hudson@courts.IN.gov>
Sent:	Thursday, March 09, 2017 3:06 PM
To:	Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Mason, Derrick;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;Luttrull, James;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Hammond, John;vbecker@elkhartpa.com;Jerry Torr
Subject:	Indiana EBDM Policy Team Meeting Materials - March 10, 2017 - 9:00 am - 12:00 pm - Indiana Government Center South - Conference Room 18
Attachments:	Final Draft Wisconsin Pretrial Pilot Protocol-03-03-17.pdf; March 10 2017 Agenda.docx; February 3 2017 Meeting Record.docx; Local Site Reports Feb 2017.pdf; indiana iras 2017 final.pdf

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Dear state EBDM team members:

- A reminder that the state EBDM team is scheduled to meeting tomorrow, **March 10** from **9:00 am – 12:00 pm** at the **Indiana Government Center South Conference Room 18.** The address is 302 West Washington Street. Enclosed is a link to the conference center map. http://www.in.gov/idoa/images/Map_Conference_Centers_in_Indiana_Government_Center_South_(rev11).pdf

- Attached is a meeting agenda and additional materials. We will have copies on site. If you prefer to print them in advance of the meeting, please note that the Wisconsin Pretrial Protocol and the Local Site Reports documents are large.

- Work group chairs: Please be prepared to give a brief report on your work group's activities and have available any information you would like the state team to review or consider.

- I received the email below from Rachelle at Mimi's office. She is asking us to send her 1 or 2 of our state team's major accomplishments that will be shared with NIC. Before our meeting tomorrow, please take a moment to consider what the Indiana Policy Team should highlight. This will be a discussion item on our agenda ☺

  EBDM Site Coordinators,

  NIC has a time sensitive request for information from the EBDM sites. Can you please respond to this email with: **1 or 2 accomplishments or something your policy team is very proud of** that you would like shared with the NIC executives next week? This may include policy or practice changes or any other notable accomplishments that your policy team has made since the start

of Phase V. Short bullet points are preferred. If you have data to share that supports or is relevant to the highlighted accomplishment, we would love to collect that as well. Any information you can provide by this **Friday, March 10 at noon Eastern** is much appreciated. We will be sharing any information collected with NIC on Friday afternoon.

Please let me know if you have any questions. I look forward to seeing you tomorrow!

Mary Kay Hudson, LSW, Deputy Director
Indiana Office of Court Services, Office of Judicial Administration
Indiana Supreme Court
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
(317) 234-0106 desk

Indiana EBDM Policy Team Meeting Record
February 3, 2017 9:00 am – 12:00 pm
Indiana Office of Court Services

1. Welcome and Introductions

Justice David called the meeting to order at approximately 9:00 am. Persons in attendance were:

- Chris Cunningham, Grant County Community Corrections
- Christine Kerl, Marion Superior Court Probation Department
- Madonna Wagoner, Hamilton County Probation Department
- Connie Smith, Indiana Prosecuting Attorneys Council
- Vicki Becker, Elkhart County Prosecuting Attorney
- David Powell, Indiana Prosecuting Attorneys Council
- Jim Luttrull, Grant County Prosecuting Attorney
- Judge Surbeck, Allen Superior Court, Criminal Division
- Larry Landis, Indiana Public Defender Council
- Kristen Casper, Indiana Public Defender Council
- Steve Creason, Office of the Indiana Attorney General
- Dan Miller, Indiana Prosecuting Attorneys Council
- David Murtaugh, Indiana Criminal Justice Institute
- Dave Williams, Trial Court Technology
- Mary Kay Hudson, Indiana Office of Court Services
- Angie Hensley, Indiana Office of Court Services
- Jenny Bauer, Indiana Office of Court Services
- Michelle Goodman, Indiana Office of Court Services
- Kathryn Dolan, Office of Community Education and Outreach, OJA
- Ashley Rozier, Indiana Office of Court Services
- Sara Cozad, Division of Mental Health and Addiction
- Jane Seigel, Indiana Office of Court Services
- Julie Lanham, Indiana Department of Correction
- John Hammond, Office of the Governor
- Lisa Thompson, Trial Court Technology
- Mary Willis, Office of Judicial Administration
- Trent Glass, Indiana House of Representatives
- Chad Lewis, Jefferson County Prosecuting Attorney
- Charles Miller, Indiana Parole Board
- Cindy McCoy, Grant Correctional Services

Linda Brady, Monroe County Probation Department and Mimi Carter, Center for Effective Public Policy, participated by conference call.

2. Indiana Risk Assessment Validation Work Group Meeting

Michelle Goodman reported that Dr. Latessa will present on the IRAS/IYAS validation study project design on March 2, 2017, 2:00 pm – 4:00 pm (location TBD). Michelle encouraged state team members to attend. Dr. Latessa will be available to answer questions about the study and the use of risk assessments generally. Several members agreed to attend or send staff to the meeting. Michelle Goodman will develop a list of topics that Dr. Latessa will cover during the presentation and send that out to the state team. Justice David asked state team members to send Michelle additional items for Dr. Latessa to address by February 17.

3. Change Target Work Group Updates – Work Group Chairs

- Data – Lisa Thompson reported that the data work group reviewed the dates on the work plan and that the work group identified MPH as the data hub. Lisa reported that she and Dave Murtaugh met with MPH the week before and MPH is coming on as a partner. Lisa identified a need to develop an interagency data sharing agreement. Lisa reported that Trial Court Technology continues to work with ISP to get TCNs on all abstracts except in circumstances when a defendant is not available for fingerprinting. State team members discussed how the TCN collection will be improved and how this information will improve criminal history information.

- Mental Health - Sara Cozad reported the work group met on January and stated they added Sonya Carrico from ICJI and Marianne Halbert from NAMI to the work group. Mary Kay Hudson noted that the work group revised its work plan and will focus on the two primary goals of decreasing in the number of persons with SMI who enter the CJ system through the expansion of crisis intervention teams and increasing access to treatment generally. Sara reported that Open Beds has a platform to provide treatment providers access to a database in which they can select and refer to services (inpatient and outpatient) based on availability. The state team discussed generating state maps of facilities, providers, and beds, that are DMHA funded and not DMHA funded to provide more information to stakeholders to find out how to access care. Sara reported that the work group needs to develop a process to collect baseline treatment information for persons who are justice involved. State team members discussed the amount of time it takes persons to access treatment services as a barrier, and Sara stated she would look in to the possibility of being able to collect data on wait times for services.

She will let the state team know if she needs any assistance from the team in obtaining permission to ask providers to report this information. Sara reported that they have hired additional Recovery Works staff and the regions 4, 7, and 9 are still struggling with access to Recovery Works providers. Julie Lanham suggested that community corrections could use grants to fund the licensed clinicians not funded by Recovery Works. Sara report that the Indiana Professional Licensing Agency sent out letters to all LAC/LCACs to recruit additional Recovery Works providers. Because of that effort, five new providers signed on. Sara reported that many licensed individuals are already working at Recovery Works providers.

- Professional Development - Jane Seigel reported the work group identified a need to determine the knowledge, skills, and abilities we want all EBDM stakeholders to possess and that the work group is responsible for ensuring that stakeholders are trained, coached, and audited. The work group will address this on parallel tracks, with the initial goal to strengthen the pilot sites and the secondary goal to educate the rest of the state. Angie Hensley is developing a matrix of the trainings available for all the criminal justice stakeholder groups. Jane reported the work group is planning evidence based practice summit. The work group will solicit feedback from the pilot sites for the summit agenda. State team members agreed that it is important for the local stakeholder groups to get together and that the summit should target the different groups. State team members discussed the possibility of having DOC and DMHA/Recovery Works provide some funding to support the summit.

- Risk Reduction Strategies – Mary Kay Hudson reported that the risk reduction strategies work group updated its work plan timeline and narrowed the pilot project decision points to prosecutor diversion, plea negotiations, sentencing, and community supervision. The work group's goal is to identify two EBDM counties willing to participate in a pilot project in these areas. The work group is drafting proposed protocols for each of these decision points that may become the basis for a future pilot.

- Behavior Responses – Jenny Bauer reported that work group discussed joining with the risk reduction strategies to include behavior responses as part of the two-county pilot (as a component of the diversion and community supervision decision points). Jenny reported that the work group could use a modified version of the incentives and sanctions developed by Dr. Smith. Jenny reported that the work group's biggest concern is getting baseline data to study outcomes and to work with the professional development work group on training staff. Chris Cunningham commented on how much behavioral responses is dependent on the culture of the county.

- Pretrial – Mary Kay Hudson reported that the work group added the pretrial stakeholder work groups to its work plan and that work group member will conduct sites visits to each of the pilot sites. Jenny Bauer reported that she updated the release and response matrices based upon feedback from the pretrial work group. Mimi Carter suggested adding possible responses to the response matrix. Jenny and Dan Miller will work with Mimi to add these to the response matrix.

4. Discussion: February 10, 2017 Kickoff Meeting Agenda

Members discussed the format of the meeting agenda in depth, including that some team members were assigned to briefly present on one or more pretrial expectations topics. Members were provided a list of the registrants to date.

5. Next Meeting Dates

- June 23, 2017 9:00 am – 12:00 pm
- July 14, 2017 9:00 am – 12:00 pm
- August 23, 2017 9:00 am – 12:00 pm

(All meetings will be held at the Indiana Office of Court Services unless otherwise noted on the Outlook meeting invitation.)

6. Other Business

State team members voted in support of the Indiana Office of Court Services to submit an application under the Bureau of Justice Assistance Justice Reinvestment Initiative solicitation. IOCS will apply for defense counsel services in the pilot sites, project coordinators, evaluation services and local implementation activities. The application is due February 7.

7. Adjourn

Justice David adjourned the meeting at approximately 12:00 pm

DRAFT



Wisconsin Evidence-Based Decision Making (EBDM) Initiative Pretrial Pilot Protocol

FINAL DRAFT: 03/03/2017

Table of Contents

Introduction..... 1
Chapter 1: Recent Advances in Pretrial Justice Policy and Practice..... 2
Research Summary..... 2
A More Detailed Look at the Research..... 2
Chapter 2: Expectations of Wisconsin EBDM Pretrial Pilot Sites..... 7
Tab 1: Pretrial Definitions..... 12
Tab 2: Baseline Data Collection Protocol..... 16
Tab 3: The PSA Protocol..... 20
Tab 4: Wisconsin Pretrial Decision Making Framework..... 36
Tab 5: Policy and Procedure: Verification of Defendant Information..... 37
Tab 6: Universal Screening Quality Assurance Protocol..... 39
Tab 7: Milwaukee County Pretrial Risk Assessment Report..... 41
Tab 8: Pretrial Interview and Release of Information Consent Form..... 42
Tab 9: Memorandum of Understanding Regarding Pretrial Protections..... 43
Tab 10: Wisconsin Pretrial Decision Making Framework..... 45
Tab 11: Behavior Response Decision Making Process Guidelines..... 46
Tab 12: Pretrial Behavior Response Matrix..... 49
Tab 13: Critical Incident Review Protocol..... 50
Appendix 1: Calculating Potential Pretrial Screening Costs..... 53
Appendix 2: Calculating Potential Pretrial Supervision Costs..... 55
Appendix 3: References..... 57

Introduction

Wisconsin's State Criminal Justice Coordinating Council (CJCC) has partnered with the National Institute of Corrections' Evidence-Based Decision Making (EBDM) initiative to implement state and local criminal justice system improvement efforts. Working collaboratively with the State CJCC for the current phase, Phase VI, of EBDM implementation are eight local teams: Chippewa County, Eau Claire County, La Crosse County, Marathon County, Milwaukee County, Outagamie County, Rock County, and Waukesha County.

One of the goals identified by Wisconsin's state and local EBDM teams through EBDM's Phase V strategic planning efforts was to develop evidence-based pretrial release and supervision decisions and processes that continued to emphasize the importance of public safety. In order to advance this goal, Wisconsin's teams are partnering in the development of local pretrial pilot programs. The focus of these programs is to explore moving from a charge- and money-based system of release and detention to a risk-informed system, using less or no money when that money interferes with or undermines the lawful purposes of pretrial release and detention or public safety.

The purpose of this Pretrial Justice Protocol is to provide consistent, evidence-based policies and procedures for use by the local pretrial pilot sites in their program development.

Chapter 1: Recent Advances in Pretrial Justice Policy and Practice[1]

Research Summary

The decision to release or detain a defendant during the pretrial phase of a criminal case has both short- and long-term consequences for defendants, the justice system, and the general public. The decision has become the focus of a national pretrial reform movement aimed at aligning pretrial practices with legal and evidence-based practices. Risk is an inherent part of both "bail" (release) and "no bail" (detention); therefore, research around risk assessment and mitigation is a critical component of that movement.

As one of many fundamental topics underlying the study of pretrial release and detention, pretrial research is inextricably tied to another fundamental topic: the law. Social science research in particular, including research on risk, is especially important because it tells us what works to achieve our pretrial goals, which the law limits to only three: (1) maximizing the release of pretrial defendants (recognizing the presumption of innocence and the harmful effects of pretrial detention); (2) maximizing public safety; and (3) maximizing court appearance. The limited nature of these goals, coupled with other legal principles such as presumption of innocence, equal protection, excessive bail, and due process of law, means that post-conviction research cannot easily be applied to the pretrial phase, and that pretrial research, no matter how convincing, might need to be discarded if the intervention does not advance a proper purpose or does not otherwise follow fundamental legal principles.

Social science research surrounding the pretrial phase of a criminal case is somewhat sparse compared to post-conviction research, but that is changing. Important new studies using large and generalizable populations with sophisticated statistical methodology are helping guide jurisdictions toward assessing and mitigating pretrial risk while, in most cases, more faithfully following the law.

A More Detailed Look at the Research

Research and practice in the field of pretrial release and detention is inextricably linked to the law through the notion of implementing "legal and evidence-based practices" rather than simply "evidence-based practices" (VanNostrand, 2007). Following that notion, research and practice have evolved and been molded through history and the law to study and attempt to achieve three underlying goals: (1) maximize the release of pretrial defendants (recognizing the presumption of innocence and the harmful effects of pretrial detention); (2) maximize public safety; and (3) maximize court appearance (Schnacke, 2014a).[2]

---

[1] This research review is extracted with permission from *Risk Reduction Research Review*, prepared by David Robinson and Natalie Jones, of Orbis Partners Inc., in collaboration with The Carey Group (© 2015 The Carey Group).

[2] These three goals follow from a study of the history, the law, empirical studies, and rationales articulated by pretrial researchers, and national best-practice standards on pretrial release and detention (Schnacke, 2014b).

ASSESSING RISK: Until fairly recently, justice system practitioners have tried to achieve these goals by using subjective notions of risk or by using a defendant's most serious charge as a proxy for risk. This is a less than ideal method of assessing the risk to public safety and court appearance and may lead to releasing and detaining defendants without regard to actual risk of misconduct as well as using ineffective strategies to mitigate risk for those who are released (Milgram, Holsinger, VanNostrand, & Alsdorf, 2015).

According to the research, making pretrial release and detention decisions without actuarial assessment guidance can have harmful effects on both defendants and the general public. Releasing extremely high risk defendants without assessment or matched supervision can be a threat to public safety. At the same time, recent research has also demonstrated that detaining low and moderate risk defendants in jail for even short periods of time (i.e., 2–3 days) can increase their risk for misconduct both short- and long-term (Lowenkamp, VanNostrand, & Holsinger, 2013a). The same phenomenon does not necessarily hold true for high risk defendants, however, thus providing additional evidence of an acute need to accurately assess the risk level of defendants.

In addition to the numerous social costs of unnecessary pretrial detention articulated by the United States Supreme Court, such as the loss of a job or the inability to prepare one's own defense (*Barker v. Wingo*, 1972), recent research has shown that—all other things being equal—defendants detained pretrial are more likely to be convicted and to receive longer sentences than defendants who are not detained (Lowenkamp, VanNostrand, & Holsinger, 2013b; Oleson, Lowenkamp, Wooldredge, VanNostrand, & Cadigan, 2014). Finally, the absence of pretrial risk assessment can lead to decisions that violate the "risk principle," which suggests that fewer or no resources should be expended on lower risk persons and more resources on higher risk persons. The risk principle is well established in the post-conviction arena, and has been determined to have equal relevance to pretrial release and detention decisions (Milgram et al., 2015; VanNostrand & Keebler, 2009).

Fortunately, there has been a recent increase in research around the development of objective tools designed to help jurisdictions identify the likelihood of pretrial misconduct (risk of rearrest and failure to appear for court during the pretrial phase of the case). Use of these tools is widely considered to be an evidence-based practice, and often is a critical prerequisite to adopting other best practices in the pretrial field (Pretrial Justice Institute, 2015). Use of empirically based risk assessment tools to inform pretrial release determinations, and ensuring that pretrial detention occurs in a "carefully limited" way (*United States v. Salerno*, 1987), are considered legal and evidence-based practices. To be clear, pretrial assessment tools are not designed to replace professional discretion but rather to enhance pretrial decision making by coupling professional judgment and objective assessment, which research has shown produces the best assessment results (Milgram et al., 2015; Pretrial Justice Institute,

2015). Notwithstanding the above, bias in the criminal justice system is of significant concern, and care should be taken to prevent its occurrence. The appropriate use of well-validated risk and needs assessment tools can help reduce bias and disparities in justice system decision making.

Based on variations in population, data collection, and other variables, empirically derived pretrial assessment tools differ among the jurisdictions that use them. In 2009, VanNostrand and Keebler (2009) identified nine statistically significant and policy-relevant predictors of pretrial outcomes in the federal system to guide decision makers in the release and detention process in the federal courts. Two years later, Mamalian (2011) examined studies undertaken in the previous decade and summarized the six most common pretrial risk factors identified by those studies. Despite their commonalities, she advised caution in extrapolating those factors due to their nuanced differences. That same year, Bechtel, Lowenkamp, and Holsinger (2011) completed a comprehensive meta-analysis to examine numerous risk factors and to identify which factors were statistically associated with pretrial failure. Most recently, the Pretrial Justice Institute (2015) listed 17 risk factors variously linked to six widely used assessment tools; interestingly, no single factor was included in all six tools.
The differences among various assessment tools (including the weighting of the predictive factors themselves), nuances in meaning behind predictive factors, and even operational or legal cultural differences means that certain elements that are predictive in one jurisdiction may not be predictive in another. Accordingly, no single list is definitive, and jurisdictions must recognize the necessity of validating any proposed set of predictive factors to their local populations. Nevertheless, many of the factors found in the various tools are similar and tend to fall into two groups: (1) static (unchanging factors typically pertaining to justice system history or involvement, such as history of failure to appear (FTA) or prior convictions); and (2) dynamic (changing factors typically pertaining to community stability, such as employment or residence; VanNostrand & Lowenkamp, 2013).

Of these two groups, static factors are emerging as the strongest predictors of pretrial misconduct (Bechtel et al., 2011; VanNostrand & Lowenkamp, 2013), although some researchers have argued that dynamic factors and the defendant interviews needed to ascertain them may have independent value. Nevertheless, some speculate that the combination of the acute need for research-based pretrial assessment and budgetary considerations means that an assessment instrument using only static factors that does not take a defendant interview to complete is likely to become a growing practice.
In 2013, researchers funded by the Laura and John Arnold Foundation created such a tool, named the Public Safety Assessment (PSA). It uses nine static factors (which are weighted and tested to be race- and gender-neutral) to accurately predict the risk that a defendant will commit any new crime, commit a violent crime, or fail to appear for court (Laura and John Arnold Foundation, 2013; VanNostrand & Lowenkamp, 2013). The PSA was created using a large (over 1 million) defendant population, making the tool initially generalizable to all states. It is currently being tested in multiple American jurisdictions.

RISK MITIGATION: In addition to pretrial risk assessment, another step toward the development of a fair, rational, and transparent pretrial process is to match pretrial interventions (conditions of release or detention) to risk, often called "risk mitigation."[3] Unfortunately, in this area there is significantly less research. While the research suggests that pretrial supervision generally can help achieve better court appearance or public safety rates (Goldkamp & White, 2006; Lowenkamp & VanNostrand, 2013), and has shown that placing conditions on lower risk persons can actually increase their overall risk both pretrial and post-conviction (Lowenkamp & Latessa, 2004; VanNostrand & Keebler, 2009), the research concerning the efficacy of *particular* variations of general supervision or *particular* techniques reflecting specific conditions or interventions (such as drug testing or electronic monitoring) is limited, inconclusive, or has shown no effect on pretrial misbehavior (VanNostrand, Rose, & Weibrecht, 2011). The exception to this appears to be court date notification; a growing number of studies show the effectiveness of court date reminders in significantly increasing appearance rates (Crozier, 2000; Herian & Bornstein, 2010; Schnacke, Jones, & Wilderman, 2012; Siddiqi, 1999).

RELEASE TYPES: Perhaps due to the historical tie between money and release, there have been studies surrounding so-called "release types," which are forms of release that are "typed" by how each form uses the monetary condition (e.g., as a personal recognizance bond or a cash bond). Unfortunately, most of these studies have been discredited for various reasons, often due to their unintentionally improper use of government statistics (Bechtel et al., 2012). A recent study, however, showed that jurisdictions could release significantly more defendants on unsecured bond (that is, with money only promised in the event of failure to appear for court) versus secured bonds (with money actually paid up front as a precondition of release) without experiencing differences in court appearance or public safety rates (Jones, 2013).

The shift from secured to unsecured bonds may result in an increased number of defendants being placed on pretrial supervision and being charged supervision and monitoring fees. Research has shown that, like bail and bond fees, these fees often have a disproportional impact on the poor (Diller, 2010). Relying on fees to fund operations "goes against best practices recommended by the American Bar Association, the National Center for State courts, and other justice experts" (Diller, 2010, p. 9) and has led to calls for pretrial agencies to eliminate the charging of pretrial supervision or monitoring fees.

RELEASE AND DETENTION GUIDELINES: There has been growing interest across the country in using a release and detention "guideline," "matrix," or "praxis." These

[3] Risk assessment might lead to paths for defendants other than detention or traditional release with conditions, such as placement in specialty courts or pretrial diversion programs. Even though they may involve overlapping concepts, these alternatives have their own literatures that should be studied in addition to the information summarized here.

decision making support tools combine risk assessment and, in some instances, charge categories (or other factors) with agreed-upon release and/or supervision strategies, typically manifested in a grid format to help judicial officers make better pretrial release and detention decisions (VanNostrand et al., 2011). Overall, the creation of these documents at the jurisdictional level encourages justice system leaders to explore matters pertaining to detention and release, including their level of tolerance for certain types of risk when weighted against the effects of detention, and facilitates consensus building around release and detention guidelines, as well as responses to pretrial misconduct. A recent study analyzing decisions made under such guidelines in Virginia showed that proper training and use of guidelines positively affected pretrial officer recommendations, judicial decisions, and differential use of supervision (Danner, VanNostrand, & Spruance, 2015).

Without a doubt, the field of pretrial justice will benefit from more research concerning risk assessment and mitigation, release and detention guidelines, and other important issues related to pretrial justice. Nevertheless, the existing research provides foundational information upon which jurisdictions can make meaningful improvements that follow legal and evidence-based practices designed to reduce risk and harm.

Chapter 2: Expectations of Wisconsin EBDM Pretrial Pilot Sites

Purpose

The purpose of the pilot project is to provide an opportunity to develop a model of pretrial release that can be tested and evaluated to determine the effectiveness, to potentially lead to replication in other counties. The premise is that pretrial reform is necessary and intended to improve public safety by following legal and evidence-based practices in pretrial release and detention. Ultimately in the current generation of pretrial reform, that goal has been interpreted by a variety of jurisdictions and public and private entities to mean moving from a charge-and-money-based system of release and detention to a risk-informed system, using less or no money when that money interferes with or undermines the lawful purposes of pretrial release and detention or public safety.[4, 5]

Laying the Foundation

1. Pilot projects will be conducted within the context of the EBDM Framework, guided by a collaborative team ("the team," "collaborative teams," "pretrial pilot sites") process.
2. The following stakeholder groups should be members of the collaborative EBDM Policy Team or Criminal Justice Coordinating Council and should have decision making authority (as the principal or designee):
    a. law enforcement officials
    b. pretrial officials
    c. victim service providers
    d. district attorney/prosecutors
    e. defense attorneys
    f. jail administrators

[4] See, e.g., *Conference of Chief Justices Resolution 3: Endorsing the Conference of State Court Administrators Policy Paper on Evidence-Based Pretrial Release* (2013), found at http://www.pretrial.org/wp-content/uploads/2013/05/CCJ-Resolution-on-Pretrial.pdf; National Association of Counties' *The American County Platform and Resolutions 2016-2017* ("Corrections"), found at http://www.naco.org/sites/default/files/documents/2016-2017%20American%20County%20Platform.pdf; National Sheriff's Association's *Resolution 2012-6* concerning pretrial services agencies (2012), found at http://www.sheriffs.org/sites/default/files/uploads/documents/2012resolutions/2012-6%20Pretrial%20Services.pdf. Moving from charge to risk and dealing with money bail can be, by far, the most important yet complex part of a larger effort to provide "pretrial justice," which involves the proper administration of laws through fair and effective pretrial policies and practices for "the host of decisions that occur, from arrest up to the point at which the case is concluded or disposed of" (see the definition of "pretrial justice," from *Transcript: Justice Matters – Interview with Tim Murray Regarding Pre-Trial Justice and the Crucial Role Reentry Programs Play in the Justice System*, in Pretrial Justice Institute's glossary of terms, found at http://www.pretrial.org/glossary-terms/). This definition of pretrial justice broadens the concept beyond merely the bail, or release/detention decision, to all decisions made during the pretrial phase of a criminal case. The benefits of following legal and evidence-based decision making can apply equally to those decisions. These concepts, in addition to other defining elements of this generation of bail reform, are included in the National Institute of Corrections' comprehensive report *Fundamentals of Bail: A Resource Guide for Pretrial Practitioners and a Framework for American Pretrial Reform* (2014), found at http://static.nicic.gov/UserShared/2014-11-05_final_bail_fundamentals_september_8,_2014.pdf.

[5] See Wisconsin's State Criminal Justice Coordinating Council's position paper *EBDM Position Paper: Value of Evidence-Based Decision Making*, found at https://www.cjcc.doj.wi.gov.

g. court administrators
h. judicial/court commissioners
i. CJCC coordinator
j. judges (all criminal court judges are strongly encouraged to actively participate)
k. probation/parole/community corrections officials
l. city/county managers/administrators/board members
m. health and social service providers
n. community representatives

3. The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot.
4. The team will work collaboratively with their local counterparts, with the state team, and with their assigned technical assistance (TA) provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.
5. Collaborative teams are encouraged to discuss and agree upon a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:
    a. Wisconsin's pretrial justice system should strive to maximize public safety and court appearance while maximizing pretrial release.
    b. Wisconsin's pretrial justice system should support the overall Wisconsin EBDM effort by utilizing data and research, as well as professional judgment based on comprehensive case-specific information, to:
        i. promote fairness and equal treatment: A pretrial justice system that is fair is not based on ability to pay but instead is based on the equal assessment of objective factors relevant to public safety and court appearance.
        ii. increase public safety, reduce harm, and improve quality of life: A pretrial justice system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention
        iii. use resources effectively: A pretrial justice system that uses resources effectively reserves expensive jail resources for those who pose a danger to public safety or are unlikely to appear in court and utilizes non-detention-based interventions (e.g., mental health/substance abuse services, court reminder system, pretrial services) for those who can be safely managed in the community

6. The team will actively participate in the cross-site effort to utilize common definitions[6] and to collect and analyze data in order to establish baseline[7] information about pre-pilot pretrial practices and their impact, and the impact of the pilot projects. The data collection will be informed by existing research and data collection guidelines.[8]

Pretrial Justice Components

7. Pretrial pilot sites will operate a risk-informed pretrial justice system that incorporates a validated pretrial risk assessment tool.
    a. Pretrial pilot sites, ideally, will assess all individuals (in or out of custody) who are subject to bail for a criminal offense.
    b. Pretrial pilot sites will, at a minimum, assess all individuals *booked into jail* and subject to bail for a criminal offense.
    c. All pilot sites will use the Public Safety Assessment (PSA) risk assessment tool.[9, 10]
    d. Pilot sites may use additional screening or assessment tools, as appropriate (i.e., supplemental tools to assess substance abuse, mental health; a secondary risk assessment tool).
    e. Assessment tools that are race, gender, and socioeconomically neutral should be utilized.
8. Pretrial pilot sites are encouraged to discuss and consider their policies around release and supervision determination to encourage the development of consistent practices. A model matrix has been developed in a collaborative effort between the state team and local pilot sites.[11]
9. Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), document the verification sources, and transparently report whether data has been verified.[12]
10. Pretrial pilot sites should identify means other than user fees to support the costs of pretrial supervision and monitoring.

[6] See Tab 1 for terms and definitions.
[7] See Tab 2 for the baseline data collection protocol.
[8] See the National Institute of Corrections' document *Measuring What Matters: Outcome and Performance Measures for the Pretrial Services Field* (2011), found at https://www.pretrial.org/download/performance-measures/Measuring%20What%20Matters.pdf.
[9] See Tab 3 for the PSA protocol.
[10] The use of the Public Safety Assessment (PSA) as the primary risk assessment tool for the pilots and a potential train-the-trainer model is currently under consideration by the Laura and John Arnold Foundation.
[11] See Tab 4 for a model release and supervision matrix.
[12] See Tab 5 for a model verification protocol.

11. Pretrial pilot sites will comply with standards established by the National Association of Pretrial Services Agencies (NAPSA).[13]
12. Assessors will be trained and will demonstrate competency[14] in the administration and scoring of the pretrial risk assessment tool, as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic "refresher training."[15]
13. Pretrial pilot sites will develop and implement a local quality assurance protocol to ensure the integrity of the administration, scoring, and use of the risk assessment tool(s). The EBDM State Policy Team has developed a model that can be tailored to meet local pilot sites' needs and resource capacity.[16] Teams will be expected to report on their quality assurance policies and findings.
14. Pretrial pilot sites will utilize a pretrial risk assessment report based on a common set of required fields. The fields have been defined and a model report has been developed by the EBDM State Policy Team, with input from representatives from the pilot sites.[17] Initially, the fields may be collected in a "paper and pencil" format; ultimately, the fields and associated form will be automated to enable local and cross-site data collection and analysis.
15. Pretrial pilot sites will implement practices to ensure data is managed securely and confidentially and, if conducting an interview, will obtain informed consent from participants regarding the collection of individual-level data. The EBDM State Policy Team has developed a model consent form.[18]
16. Pretrial pilot sites may consider establishing an MOU between prosecution and defense that limits the use of pretrial information. The EBDM State Policy Team has developed a model MOU.[19]
17. Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, texts, robo-calls, etc.) will be locally determined.
18. Pretrial pilot sites will develop and implement a process for the ongoing review of the status of detained pretrial defendants,[20] the purpose of which is to identify defendants who remain in detention past the point at which release was expected to have occurred. The process should be used to determine if the status or circumstances of a defendant have changed, warranting review of whether they should continue to be detained.

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[13] See the National Association of Pretrial Services Agencies' *Standards on Pretrial* Release (3rd edition): https://www.pretrial.org/download/performance-measures/napsa%20standards%202004.pdf. Note that this document, from 2004, is currently under revision.

[14] Or similar process for efficacy in administration and scoring.

[15] Pilot sites are encouraged to consider seeking professional pretrial certification through NAPSA.

[16] See Tab 6 for a model quality assurance protocol.

[17] See Tab 7 for a model pretrial risk assessment report.

[18] See Tab 8 for a pretrial interview and release of information consent form.

[19] See Tab 9 for a model MOU.

[20] According to "Standard 3.6: Responsibility for ongoing review of the status of detained defendants" in the National Association of Pretrial Services Agencies' *Standards on Pretrial Release* (Third Edition; 2004): "The pretrial services agency or program should review the status of detained defendants on an ongoing basis to determine if there are changes in eligibility for release options or other circumstances that might enable the conditional release of the defendants. The program or agency should take such actions as may be necessary to provide the court with needed information and to facilitate the release of defendants under appropriate conditions." (See https://www.pretrial.org/download/performance-measures/napsa%20standards%202004.pdf.)

19. Pretrial pilot sites will work toward validating the pretrial risk assessment tool locally and will collect the data necessary to support the validation effort.
20. Pretrial pilot sites will develop and implement a risk-informed differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team has developed a model that can be tailored to meet local pilot sites' needs and resource capacity.[21]
21. Pretrial pilot sites will develop and implement a structured method to respond to pretrial conduct that includes both rewards for positive or prosocial activities and sanctions for misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team has developed a model behavior management policy and pretrial behavior response matrix that can be tailored to meet local pilot sites' needs and resource capacity.[22, 23]
22. Pretrial pilot sites will establish a speedy,[24] meaningful first appearance during which all parties (court, prosecution, defense) are present and pretrial assessment information is reviewed, a decision regarding release and level of supervision is made, and other resolution options may be considered (e.g. eligibility for diversion or treatment court, etc.).
23. Pretrial pilot sites will work collaboratively with their in-state partners to educate colleagues and the broader community on the goals and values of Wisconsin's pretrial justice system.
24. Pretrial pilot sites will have a critical incident review to debrief on the processes and practices following during such incidents, with the goal of understanding and preventing similar outcomes in the future. The EBDM State Policy Team has developed a guide to assist local teams in the development of their protocols.[25]

[21] See Tab 10 for a model release and supervision matrix.
[22] See Tab 11 for a model behavior management policy.
[23] See Tab 12 for a model pretrial behavior response matrix.
[24] Wisconsin statute 970.01 requires within 48 hours (see https://docs.legis.wisconsin.gov/statutes/statutes/970/01). Research suggests that even short periods of confinement can have harmful effects on low and moderate risk defendants (Lowenkamp et al., 2013a).
[25] See Tab 13 for a model critical incident review protocol.

Pretrial Definitions

Term	Definition	Notes on Measurement	Reviewer
Adherence rate	The frequency with which the court follows risk assessment results when determining pretrial release or detention and conditions.	By risk level	DA/PD/ COURTS
Appearance bond	A secured or unsecured bond that can be issued to defendants charged with a misdemeanor. The judge may require the execution of an appearance bond with sufficient solvent sureties, or the deposit of cash in lieu of sureties (Wisc. Statute 969.02(2)).		DA/PD/ COURTS
Average daily population	Count of inmates in a facility on each day for a given time period divided by the number of days in that time period.		DOC
Bail	Monetary conditions of release (Wis. Statute 969.001). An amount of money set by the court which is required to be obligated and secured as provided by law for the release of a person in custody so that the person will appear before the court in which the person's appearance may be required and that the person will comply with such conditions as are set forth in the bail bond (WI Statute 967.02 (3)).		DA/PD/ COURTS
Bail/bond hearing	A court hearing where a judicial officer reviews the bail/bond and determines if the bail/bond or conditions should be changed.	asks for the terms/conditions of bail to be reviewed.	DA/PD/ COURTS
Concurrence rate	The percentage of defendants whose supervision level or detention status corresponds with their assessed risk of pretrial misconduct.	By risk level	DA/PD/ COURTS
Court appearance rate	The percentage of defendants on pretrial release who make all scheduled court appearances.	Measured by failures to appear (FTA) out of total scheduled court appearances	DA/PD/ COURTS
Defendant	Any party who has been formally charged with violating a criminal statute.		DA/PD/ COURTS
Failure to appear	A nonappearance at a known scheduled court date for which the court issued or stayed a bench warrant for the defendant.	As defined by the *MCPRAI-R Scoring Guide*	DA/PD/ COURTS
Forfeiture of bail	If the conditions of bond are not complied with, the court having jurisdiction over the defendant in the criminal action shall enter an order declaring the bail to be forfeited. This order may be set aside upon such conditions as the court imposes if it appears that justice does not require the enforcement of the forfeiture (WI Stat. 969.13(1) and (2)).	CCAP code CBF=Cash Bond Forfeited	DA/PD/ COURTS
Initial appearance	A hearing where a person appears before a judicial officer and is informed of the charges, the potential penalties, right to counsel, and related aspects of the criminal proceedings. The judicial officer shall also admit the defendant to bail in accordance with ch. 969. (Adapted from Wisc. Statute 970.01 and 970.02.)		DA/PD/ COURTS
New criminal offense	The formal filing of a criminal case for charges having an offense date after the filing date of the cases for which the defendant is on pretrial release.		

Pretrial Definitions

Term	Definition	Notes on Measurement	Reviewer
Personal recognizance (PR) bond	Release on unsecured appearance bond in specified monetary amount with or without other conditions. A PR bond is an obligation of record, entered into before a court or duly authorized magistrate, whereby the party bound acknowledges (recognizes) that they owe a personal debt to the state. A recognizance bond is subject to a "defeasance"; that is, the obligation will be avoided if the person bound does some particular act, such as appearing in court on a particular day.		DA/PD/ COURTS
Preliminary hearing	A hearing before a court for the purpose of determining if there is probable cause to believe that the defendant has committed a felony.		DA/PD/ COURTS
Pretrial average length of stay	The sum of days from date of jail entry to date of release for each pretrial detainee divided by the total number of released pretrial detainees during a specified time period.	By risk level	DA/PD/ COURTS/DOC
Pretrial caseload ratio	The number of supervised defendants divided by the numbers of pretrial case managers.		DA/PD/ COURTS
Pretrial compliance rate	The percentage of released defendants who 1) are not revoked for technical violations of release conditions; 2) appear for all scheduled court appearances; and 3) are not charged with a new criminal offense during the pretrial phase.	By risk level	DA/PD/ COURTS
Pretrial detention	The holding of a defendant in jail during the pretrial phase on criminal charges either because release was denied or because the established bail bond could not be posted.		DA/PD/ COURTS
Pretrial detention hearing	A hearing before a court for the purpose of determining if the continued detention of the defendant is justified (Wisc. Stat. 969.035).		DA/PD/ COURTS
Pretrial detention rate	The proportion of pretrial defendants who are detained throughout pretrial case processing. OR The percentage of pretrial defendants who are detained during the pretrial phase.	By risk level	DA/PD/ COURTS
Pretrial phase	The phase of a criminal defendant's case starting at arrest and ending at sentencing or acceptance of deferred prosecution agreements (DPAs) per statute.		DA/PD/ COURTS
Pretrial release	When a defendant is free from jail during the pretrial phase.	By risk level	DA/PD/ COURTS
Pretrial release conditions	The terms under which a person is released from jail prior to trial. The conditions should be reasonable and designed to enssure his or her appearance in court, protect members of the community from serious bodily harm, or prevent the intimidation of witnesses. (Adapted from Wisc. Stat. 969.01(1).) See Wisc. Stat. 969.01(4) for factors to consider when determining pretrial release conditions.		DA/PD/ COURTS/ DOC

Pretrial Definitions

Term	Definition	Notes on Measurement	Reviewer
Pretrial release rate	The percentage of pretrial defendants eligible for release who secure release.	By risk level	DA/PD/ COURTS
Pretrial risk assessment	A validated tool that measures a person's likelihood for failure to appear in court or to engage in new criminal activity during pretrial release.		DA/PD/ COURTS/DOC
Pretrial risk level	The measure of a person's risk of failing to appear in court or committing a new criminal offense during the pretrial phase, based on a validated pretrial risk assessment tool.		DA/PD/ COURTS
Pretrial safety rate	The percentage of defendants who are not charged with a new criminal offense during the pretrial phase.	By risk level	DA/PD/ COURTS
Pretrial services	A program that conducts pretrial risk assessments and supervises persons who are released from custody, helping to ensure they comply with release conditions, appear for scheduled court appearances during the pretrial period, and do not endanger community safety. OR Generally, any organization or entity created ideally to perform the three primary pretrial agency or program functions of: (1) collecting and analyzing defendant information for use by the court in assessing risk; (2) making recommendations to the court concerning bail bond conditions of release to address risk; and (3) monitoring and supervising defendants who are released from secure custody during the pretrial phase of their cases in order to manage their risk.		DA/PD/ COURTS/DOC
Pretrial supervision	The act of managing, directing, or overseeing a defendant who has been released from secure custody during the pretrial phase of a criminal case, ideally to reasonably ensure both court appearance and public safety and to provide oversight for compliance with all conditions of a bail bond.		DA/PD/ COURTS
Preventive detention	The pretrial detention of a person without bail for community safety reasons, based on a validated pretrial risk assessment.		DA/PD/ COURTS
Recidivism	Refers broadly to reoffending, with the most common measurements including rearrest, reconviction, and/or reincarceration. Recidivism rates measure the frequency with which individuals re-engage with the criminal justice system within a defined time period.		DA/PD/ COURTS
Release without bail	When a defendant is released from custody without posting a cash bail and promises to return to court when required.		DA/PD/ COURTS
Risk assessment tool	A validated tool that predicts the likelihood of certain behaviors, such as reoffending or failing to appear in court, that is developed through statistical analysis using data on the criminal justice population.	Risk assessment tools should also be validated on the local population.	DA/PD/ COURTS

Pretrial Definitions

Term	Definition	Notes on Measurement	Reviewer
Signature bond	An undertaking either secured or unsecured entered into by a person in custody by which the person binds himself or herself to comply with such conditions as are set forth therein (WI Statute 967.02 (4)).		DA/PD/ COURTS
Time on pretrial supervision	The time between the pretrial program's assumption of supervision and the resolution of the case or the removal of supervision conditions by a judicial officer.	Defendant's first contact date with pretrial program to case disposition or issue of new release or detention requirements, in days	DA/PD/ COURTS
Universal screening	A program intended to assess the pretrial risk and need level of all individuals entering the criminal justice system, often conducted at the jail. Universal screening can help identify individuals eligible for release by statute or based on local program eligibility criteria. Screening includes any combination of a pretrial interview, application of a validated risk assessment instrument, or measurement against other established criteria for release recommendation or program placement.		DA/PD/ COURTS
Validation of risk assessment tools	Empirical evidence demonstrating the accuracy of a risk assessment tool that predicts the risk of engaging in new criminal behavior or failing to appear for court. OR A scientific approach to ensuring that a risk assessment measures what it is intended to measure and that assessment scores are statistically related to performance data.	Validation should occur on a local population.	LE/DA/PD/ COURTS

Baseline Data Collection Protocol

I. GOALS AND ASSUMPTIONS

Goals

The project goal is to help Wisconsin EBDM Pretrial pilot sites determine:

1. the size and composition of their prospective pretrial populations[1]; and
2. baseline data on pretrial misconduct (defined as FTA and new criminal behavior while on pretrial release) prior to implementation of the pretrial pilot project.[2]

Assumptions

All sites will:

1. use the Milwaukee County Pretrial Risk Assessment Instrument-Revised (MCPRAI-R) to assess defendant level of risk;
2. adopt a single definition source for data: the most recent *MCPRAI-R Scoring Guide*;
3. collect and validate data on cases filed during a specified data collection period;
4. record project data in automated form;
5. follow a verification protocol to determine the accuracy of the data collected; and
6. follow similar procedures for collecting baseline data on pretrial success (defined as court appearance and absence of new criminal conduct during the pretrial release period).

II. DATA COLLECTION FOR DETERMINING PRETRIAL POPULATION RISK LEVEL

Population Cohort and Data Definitions

1. The sample population will include defendants charged with misdemeanor, felony, and criminal traffic offense cases (as defined in the *MCPRAI-R Scoring Guide*) whose cases were filed during the data collection period.
2. Charges and charge types will be those described in Appendices C and D of the *MCPRAI-R Scoring Guide*.
3. Data subjects will include “in-custody defendants” (those not securing release prior to the initial appearance) and “out-of-custody” defendants (those released prior to initial appearance).
4. Collected data will include those needed to complete the MCPRAI-R.

[1] Based upon use of the MCPRAI-R, as described in Section II, “Date Collection for Determining Pretrial Population Risk Level.”

[2] Based upon CCAP data, as described in Section III, “Data Collection for Determining Pretrial Success Rate.”

a. These include all data noted in the *MCPRAI-R Scoring Guide*, particularly data outlined in Appendices A and B, and other identified information needed for completion of the MCPRAI-R.

Data Collection Time Period

1. The data collection sample should be large and representative enough to represent one year of case filings. The following should be considered:
   a. The sample should be 250 cases, or 5% of the county's yearly filings of criminal cases.
   b. The sample should consider variations in total case filings that may occur throughout the year (or month); for example, higher rates of arrests and case filings occurring during "busier" times or differences in the types of cases (e.g., violent, property, or drug crimes) spiking or dropping during specific times.
   c. If no significant variations exist, sites should conduct a 60-day data collection protocol.
   d. Ideally, all pilot sites will use the same 60-day period.
   e. Ideally, all cases filed during the 60-day period will be included in the data collection.
   f. If including all cases in the 60-day period is untenable, cases will be randomly selected during the study period.
      i. If cases are randomly selected, sites will institute an alternating day collection scheme, for example, Monday, Wednesday, and Friday on odd weeks and Tuesday and Thursday on even weeks.
2. If variance exists, sites will develop an appropriate case weighting scheme to balance the number and type of cases to fit case types and numbers across the course of a calendar year.

Data Collection Instrument

1. Sites will record data in an electronic form and in a standard format. Standard electronic data formats will help ensure proper validation of project data and facilitate analysis across sites.
   a. DOJ will provide a standard data collection tool.

Data Validation

1. A designated senior subject matter expert (SME) will be identified.
2. The SME will ensure that the data set contains a sufficient number of cases.
3. The SME will ensure that data collectors have the necessary skills to properly collect and record the data.
4. The SME will validate the data in two stages:
   a. Stage One involves an initial quality data review for obvious errors for correction and for discrepancies in the initial data collection period (defined as the first two weeks of data collection).
      a. The SME will randomly select MCPRAI-R assessments completed by each data collector to verify scoring.

   b. The SME will inspect all automated data entry and flag and correct obvious discrepancies in data.
   c. The SME will catalogue identified errors and discrepancies from "a" and "b" above, for type and frequency of noted errors and data corrected in the official data set.
   d. The SME will provide individualized or group retraining of data collectors, as needed.
   e. The SME will monitor data accuracy going forward to ensure the accuracy of data collection.
2. b. Stage Two involves a validation of 5% of the data sample on all collected data once the data collection period has ended.
   a. The Stage Two goal is a 95% or better accuracy rate for the entire sample.
   b. The SME will randomly select no less than 10% of the data pool collected by the data collection team.
   c. The SME will use all original source data to verify the accuracy of the data.
   d. All noted discrepancies will be catalogued.

III. DATA COLLECTION FOR DETERMINING PRETRIAL SUCCESS RATE

Data Collection Time Period and Cohort

1. The data collection period will be calendar year 2016.
2. The study cohort will include all pretrial defendants whose pretrial status began during the study period.

Data Definitions and Sources; Determining Baseline FTA Rate

1. Appearance rate is measured by failures to appear (FTA).
   a. As defined by the *MCPRAI-R Scoring Guide*, "FTA" is a nonappearance at a known scheduled court date for which the court issued or stayed a bench warrant for the defendant.
2. The Wisconsin Circuit Court Access Consolidated Court Automation Program (CCAP) will be the valid source for FTA data.
3. Data collectors will designate FTAs as follows:
   a. voluntary defendant surrenders, for defendants who return voluntarily following an FTA. (these FTAs may be assumed as those that could be prevented with court notification of pretrial monitoring or supervision);
   b. system-resolved FTAs resolved by arrest on new offenses or via bench warrant; and
   c. absconder status for FTAs not resolved at the end of the data collection period.
4. DOJ will provide a data collection tool that is formatted to record each FTA resolution.

Determining Baseline Pretrial Misconduct (or "Safety") Rate

1. "Pretrial safety rate" is defined as the percentage of defendants who are not charged with a criminal offense during the pretrial phase.
    a. As defined by the *MCPRAI-R Scoring Guide*, "rearrest" is a new filed case involving one of the offenses listed in Appendices C and D.
2. The CCAP will be the accepted source of rearrest data. This includes verification of charge offense and filing dates.
3. As noted in the *MCPRAI-R Scoring Guide*, rearrests will not include:
    a. cases of defendants detained pretrial with new charges filed against them while awaiting trial;
    b. cases of released defendants who are arrested for a charge with an alleged offense date that is prior to the filing date in the original case; and
    c. defendants charged with "stand-alone" bail jumping charges only.
4. DOJ will provide a data collection tool that is formatted to record each FTA resolution.

The PSA Protocol

The Public Safety Assessment (PSA) is a pretrial risk assessment that uses nine risk factors to assess the risk of new criminal activity (NCA), including new violent criminal activity (NVCA) and failure to appear (FTA) pending case disposition.[1] The assessment is intended to assess the risk of NCA, NVCA, and FTA for defendants who have been arrested in the community and are awaiting the disposition of their cases. The PSA is not intended to be used for defendants who are charged with an offense while already incarcerated (e.g., an inmate assaults a corrections officer or another inmate).

All pretrial risk factors are identified based on the defendant's adult criminal history; juvenile records are not considered when completing the assessment. In addition, criminal history and failure to appear factors relate only to traffic and criminal charges that carry a potential penalty of incarceration (jail or prison)—in other words, those charges for which the statute allows for a sentence of incarceration upon conviction.

The following offers guidelines for scoring the assessment.

RISK FACTORS

1. AGE AT CURRENT ARREST

Document the defendant's age in years at the time of the current arrest. If there was not an arrest or the arrest date is unknown, use the defendant's age at the time the PSA is completed. Based on the defendant's age at current arrest, answer whether the defendant was 20 years old or younger, 21 or 22 years old, or 23 years old or older.

2. CURRENT VIOLENT OFFENSE

Generally, offenses are considered violent when a person causes or attempts to cause physical injury to another person. The most common violent offenses include the following: murder; homicide; manslaughter; kidnapping; abduction; robbery; carjacking; assault involving physical injury, including domestic assault (misdemeanor or felony); and person-to-person sex offenses (e.g., rape, sexual assault/battery, indecent liberties with child, forcible sodomy). A charge of attempt (e.g., attempted murder, attempted rape), being an accessory before the fact, solicitation, and conspiracy to commit any of these offenses is considered a violent offense. Threats, harassment, and the like are not considered violent offenses. See the appendix for applicable WI Criminal Code offenses that are considered violent for the purpose of risk assessment. If any of the current offenses for which you are scoring the assessment are violent, answer yes to these risk factors.

[1] According to the Laura and John Arnold Foundation (n.d.), "The PSA does not consider factors that could be discriminatory such as race, gender, level of education, socioeconomic status, and neighborhood." Research on the use of the PSA in the state of Kentucky supports the finding that the tool is both race and gender neutral.

2a. CURRENT VIOLENT OFFENSE & 20 YEARS OLD OR YOUNGER

If one or more of the current offenses is violent as defined in risk factor 2 above AND the defendant was 20 years old or younger at the time of the arrest defined in risk factor 1 above, answer yes to this risk factor.

3. PENDING CHARGE AT THE TIME OF THE OFFENSE

"Pending" refers to any charge that has a future pre-disposition court date, or has not been disposed of due to the defendant's failure to appear, or that is in some form of deferred status (e.g., deferred prosecution, diversion, first offender, withheld finding, held in abeyance). Charges include any criminal or traffic offense that carries a potential penalty of incarceration (jail or prison). The pending charge must have been pending at the time of the alleged offense for the current case, which is an indication that the defendant was on some form of pretrial release when the current offense allegedly occurred. If the current arrest is for a failure to appear for a pre-disposition court appearance, the underlying charge for the failure to appear is counted as a pending charge. If the defendant had a pending criminal or traffic charge that carried a potential penalty of incarceration (jail or prison) at the time the current offense allegedly occurred, answer yes to this risk factor.

4. PRIOR MISDEMEANOR CONVICTION

A misdemeanor includes any criminal or traffic offense defined by statute as a misdemeanor that carries a potential penalty of incarceration (jail or prison). A conviction includes any guilty plea or finding of guilt. A charge that is in some form of deferred status (e.g., deferred prosecution, diversion, first offender, withheld finding, held in abeyance) is not considered a conviction. If the defendant has pled guilty or been found guilty as an adult of one or more criminal or traffic misdemeanor offenses that carries a potential penalty of incarceration, answer yes to this risk factor.

Do NOT count the following as convictions:

- if the offense is reduced to a forfeiture
- if the defendant was found not guilty due to mental disease or defect
- any case that was expunged.

5. PRIOR FELONY CONVICTION

A felony includes any criminal or traffic offense defined by statute as a felony. A conviction includes any guilty plea or finding of guilt. A charge that is in some form of deferred status (e.g., deferred prosecution, diversion, first offender, withheld finding, held in abeyance) is not considered a conviction. If the defendant has pled guilty or been found guilty as an adult of one or more criminal or traffic felony offenses, answer yes to this risk factor.

Do NOT count the following as convictions:

- if the offense is reduced to a forfeiture
- if the defendant was found not guilty due to mental disease or defect
- any case that was expunged.

5a. PRIOR CONVICTION

If the defendant has a prior misdemeanor conviction as defined in risk factor 4 above or the defendant has a prior felony conviction defined in risk factor 5 above, answer yes to this risk factor.

6. PRIOR VIOLENT CONVICTION

Generally, offenses are considered violent when a person causes or attempts to cause physical injury to another person. The most common violent offenses include the following: murder; homicide; manslaughter; kidnapping; abduction; robbery; carjacking; assault involving physical injury, including domestic assault (misdemeanor or felony) and person-to-person sex offenses (e.g., rape, sexual assault/battery, indecent liberties with child, forcible sodomy). A charge of attempt (e.g., attempted murder, attempted rape), being an accessory before the fact, solicitation, and conspiracy to commit any of these offenses is considered a violent offense. Threats, harassment, and the like are not considered violent offenses. See the appendix for applicable WI Criminal Code offenses that are considered violent for the purpose of risk assessment.

Examine the defendant's adult criminal history and determine the total number of violent charges that resulted in a conviction. A conviction includes any guilty plea or finding of guilt. A charge that is in some form of deferred status (e.g., deferred prosecution, diversion, first offender, withheld finding, held in abeyance) is not considered a conviction. Based on the total number of violent convictions, answer whether the defendant had none, 1, 2, or 3 or more prior violent convictions.

Do NOT count the following as convictions:

- if the offense is reduced to a forfeiture
- if the defendant was found not guilty due to mental disease or defect
- any case that was expunged.

7. PRIOR FAILURE TO APPEAR PRETRIAL IN PAST 2 YEARS

A failure to appear includes any pre-disposition court appearance for which the defendant failed to appear and a bench warrant or capias for arrest was issued. The court appearance

must be for a pending (pre-disposition) criminal or traffic offense that carries a potential penalty of incarceration (jail or prison). Post-disposition court appearances such as hearings for non-payment/failure to pay, violations of supervision, and violations of other court-ordered obligations are not counted. A failure to appear for a single court appearance is counted once regardless of the number of charges or warrants issued related to the single court appearance.

A failure to appear is not counted if there is confirmation that the defendant was in custody (jail or prison) when the failure to appear occurred. Examine the defendant's adult criminal history and determine the total number of times in the past 2 years the defendant failed to appear in court for a pre-disposition court appearance and a warrant for arrest was issued. The two-year timeframe includes the two-year period prior to the date of the current arrest. If there was not an arrest or the arrest date is unknown, the two-year timeframe includes the two-year period prior to the PSA completion date. Based on the total number of prior failures to appear in the past two years, answer whether the defendant had none, 1, or 2 or more prior failures to appear.

Count the following as a failure to appear:

- if the defendant misses an out-of-custody initial appearance, fails to appear, and an arrest warrant is issued
- if the defendant is hospitalized
- if the defendant misses court but the warrant is stayed, or if the warrant is stayed for another court appearance and they miss this appearance
- if a warrant is issued due to non-appearance but the defendant appears later that day.

8. PRIOR FAILURE TO APPEAR PRETRIAL OLDER THAN 2 YEARS

A failure to appear includes any pre-disposition court appearance for which the defendant failed to appear and a bench warrant or capias for arrest was issued. The court appearance must be for a pending (pre-disposition) criminal or traffic offense that carries a potential penalty of incarceration (jail or prison). Post-disposition court appearances such as hearings for non-payment/failure to pay, violations of supervision, and violations of other court-ordered obligations are not counted. A failure to appear for a single court appearance is counted once regardless of the number of charges or warrants issued related to the single court appearance.

A failure to appear is not counted if there is confirmation that the defendant was in custody (jail or prison) when the failure to appear occurred. Examine the defendant's adult criminal history and determine if the defendant failed to appear for court for a pre-disposition court appearance and a warrant for arrest was issued more than 2 years from the time of the current arrest. If there was not an arrest or the arrest date is unknown, use the PSA completion date to determine if the failure to appear for court occurred more than 2 years from the time of the PSA completion date. If the defendant failed to appear for court and a warrant was issued for

arrest more than 2 years from the time of arrest or PSA completion date, answer yes to this risk factor.

Count the following as a failure to appear:

- if the defendant misses an out-of-custody initial appearance, fails to appear, and an arrest warrant is issued
- if the defendant is hospitalized
- if the defendant misses court but the warrant is stayed, or if the warrant is stayed for another court appearance and they miss this appearance
- if a warrant is issued due to non-appearance but the defendant appears later that day

9. PRIOR SENTENCE TO INCARCERATION

A sentence to incarceration includes any sentence to jail or prison of 14 days or more, imposed by a judge at the time of sentencing or re-sentencing (e.g., supervision violation hearing, revocation of suspended sentence). A sentence of 14 days or more is included only if it is imposed as a single sentence and not a combination of multiple lesser sentences. Incarceration in lieu of payment of fines or costs, suspended sentences, and sanctions imposed by non-judges (e.g., probation officers) are not considered sentences to incarceration. If the defendant previously received a sentence of incarceration to jail or prison of 14 days or more as a single sentence imposed by a judge, answer yes to this risk factor.

In terms of further guidelines:

- If a defendant is sentenced to incarceration but receives a “time served” disposition, count this as a prior sentence to incarceration.
- If the judge gives the discretion of jail time to a probation officer, do not count this as a sentence to incarceration.
- If the judge stays a sentence and places the defendant on probation, do not count this as a sentence to incarceration; however, if the defendant’s probation is revoked, do count this as a sentence to incarceration.
- If someone is sentenced to electronic monitoring/home detention, do not count this as a prior sentence to incarceration.

OUTCOME MEASURES

According to the PSA, there are two primary pretrial outcome measures for defendants released pending case disposition: success and failure. There are two primary types of pretrial failure: failure to appear and new criminal activity. In addition, the PSA measures whether the

new criminal activity is violent. Generally, defendants who do not experience either type of pretrial failure are considered successful. Descriptions of the primary types of pretrial failure are provided below.

1. FAILURE TO APPEAR (FTA)

"Failure to appear" is defined as any missed court appearance while on release pending case disposition for the current case for which a bench warrant or capias for arrest was issued. A failure to appear is not counted if there is confirmation that the defendant was in custody (jail or prison) when the failure to appear occurred.

Count the following as a failure to appear:

- if the defendant misses an out-of-custody initial appearance, fails to appear, and an arrest warrant is issued
- if the defendant is hospitalized
- if the defendant misses court but the warrant is stayed, or if the warrant is stayed for another court appearance and they miss this appearance
- if a warrant is issued due to non-appearance but the defendant appears later that day.

2. NEW CRIMINAL ACTIVITY (NCA)

"New criminal activity" is defined as an arrest for a criminal or traffic offense that carries a potential penalty of incarceration (jail or prison) that allegedly occurred while on release pending disposition for the current case.

Note: Count any arrest for new criminal activity as NCA (i.e., it does not have to be a filed case in CCAP).

2a. NEW VIOLENT CRIMINAL ACTIVITY (NVCA)

"New violent criminal activity" is defined as an arrest for a violent offense that allegedly occurred while on release pending case disposition for the current case. Generally, offenses are considered violent when a person causes or attempts to cause physical injury to another person. The most common violent offenses include the following: murder; homicide; manslaughter; kidnapping; abduction; robbery; carjacking; assault involving physical injury, including domestic assault (misdemeanor or felony); and person-to-person sex offenses (e.g., rape, sexual assault/battery, indecent liberties with child, forcible sodomy). A charge of attempt (e.g., attempted murder, attempted rape), being an accessory before the fact, solicitation, and conspiracy to commit any of these offenses is considered a violent offense. Threats, harassment, and the like are not considered violent offenses. See the appendix for applicable WI Criminal Code offenses that are considered violent for the purpose of risk assessment.

Appendix: Wisconsin Criminal Code PSA Violent Offenses

This document identifies the State of Wisconsin Criminal Code offenses that meet the definition of a violent offense for the purpose of administering the Public Safety Assessment. According to the PSA, offenses are considered violent when a person causes or attempts to cause physical injury to another person.

WISCONSIN CRIMINAL CODE PSA VIOLENT OFFENSES

Chapter 940	Crimes Against Life and Bodily Security
940.01	First-degree intentional homicide
940.02	First-degree reckless homicide
940.03	Felony murder
940.05	Second-degree intentional homicide
940.06.	Second-degree reckless homicide
940.07	Homicide resulting from negligent control of vicious animal
940.08	Homicide by negligent handling of dangerous weapons, explosives or fire
940.09	Homicide by intoxicated use of vehicle or firearm
940.1	Homicide by negligent operation of vehicle
940.19	Battery; substantial battery; aggravated battery
940.195	Battery to an unborn child; substantial battery to an unborn child; aggravated battery to an unborn child
940.2	Battery: special circumstance
940.201	Battery or threat to witnesses
940.203	Battery or threat to judge
940.205	Battery or threat to department of revenue employee

940.207	Battery or threat to department of safety and professional services or department of workforce development employee
940.208	Battery to certain employees of counties, cities, villages, or towns
940.21	Mayhem
940.22 (2)	Sexual exploitation by therapist; duty to report
940.225	Sexual assault
940.235	Strangulation and suffocation
940.285	Abuse of individuals at risk
940.29	Abuse of residents of penal facilities
940.295	Abuse and neglect of patients and residents
940.3	False imprisonment
940.302	Human trafficking
940.305	Taking hostages
940.31	Kidnapping
940.32	Stalking
940.43 (1, 2, 3)	Intimidation of witnesses; felony
940.45 (1, 2, 3)	Intimidation of victims; felony
Chapter 941	**Crimes Against Public Health and Safety**
941.2 (2a), (3a1)	Endangering safety by use of a dangerous weapon
941.26 (2f), (2g), (4b), (4d), (4e)	Machine guns and other weapons; use in certain cases; penalty

941.32	Administering dangerous or stupefying drug
941.325	Placing foreign objects in edibles
941.327	Tampering with household products
941.38 (2)	Criminal gang member solicitation of a child
Chapter 943	**Crimes Against Property**
943.10 (2d)	Burglary
943.23 (1g)	Operating vehicle without owner's consent
943.32	Robbery
943.87	Robbery of a financial institution
Chapter 946	**Crimes Against Government and Its Administration**
946.01.	Treason
946.03.	Sedition
946.41 (2r), (2t)	Resisting or obstructing an officer
946.43	Assaults by prisoners
Chapter 947	**Crimes Against Public Peace, Order and Other Interests**
947.013 (1m)(a)	Harassment
Chapter 948	**Crimes Against Children**
948.02.	Sexual assault of a child
948.025	Engaging in repeat acts of sexual assault of the same child
948.03	Physical abuse of a child

948.05	Sexual exploitation of a child
948.051	Trafficking of a child
948.06	Incest with a child
948.07	Child enticement
948.075	Use of a computer to facilitate a child sex crime
948.08	Soliciting a child for prostitution
948.085	Sexual assault of a child placed in substitute care
948.09	Sexual intercourse with a child age 16 or older
948.095	Sexual assault of a student by a school instructional staff person
948.3	Abduction of another's child; constructive custody
948.51 (2)	Hazing

Applying the Scores to the Decision Making Framework (DMF)

Once the PSA is completed, apply the scores to the Wisconsin Decision Making Framework (DMF). The DMF uses the scores obtained from the PSA and plots the individual onto the DMF graph using the application of FTA and NCA scores. The intersection of scores determines the category into which a person falls on the grid. Judicial officers use the DMF to determine the release and/or supervision conditions that might be applicable to mitigate an individual's risk while out on release during the pretrial period.

Below is the Wisconsin DMF and corresponding instructions for the application of the DMF.

Wisconsin Pretrial Decision Making Framework
Version 3 (10/26/2016)

	NCA 1	NCA 2	NCA 3	NCA 4	NCA 5	NCA 6
FTA 1	Level 1 & ROR	Level 1 & ROR				
FTA 2	Level 1 & ROR	Level 1 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	
FTA 3		Level 2 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Level 5 & Financial
FTA 4		Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Misd. - Level 5 & ROR Fel. - Level 5 & Financial	Level 5 & Financial
FTA 5		Level 3 & ROR	Level 3 & ROR	Misd. - Level 4 & ROR Fel. - Level 5 & ROR	Level 5 & Financial	Level 5 & Financial
FTA 6				Level 5 & Financial	Level 5 & Financial	Level 5 & Financial

	Level 1	Level 2	Level 3 (Standard)	Level 4 (Enhanced)	Level 5 (Intensive)	Level 5 (Intensive)
Bail	ROR	ROR	ROR	ROR	ROR	Cash
TOT	No	No	Yes	Yes	Yes	Yes
Face-to-Face Contact	No	No	1x/month	Every other week	Weekly	Weekly
Alternative Contact	No	1x/month	1x/month	Every other week	No	No
Supervised Conditions	No	No	As authorized	As authorized	As authorized	As authorized
Court Date Reminder	No	Yes	Yes	Yes	Yes	Yes
Criminal History/CJIS	No	Yes	Yes	Yes	Yes	Yes

Authorized Conditions

Condition	Authorized
Drug Testing	Defendant Level 3 or greater supervision on the DMF **AND** Scores 3 or greater on UNCOPE **AND** has a history of illegal drug use/abuse
Portable Breathalyzer	Defendant Level 3 or greater supervision according to DMF **AND** Scores 3 or greater on UNCOPE **AND** (has a history of problematic alcohol use/abuse **OR** current alcohol abuse) **OR** charged with an OWI case **AND** qualifies for supervision
Absolute Sobriety	Defendant has UNCOPE of 3 or greater and a history of alcohol abuse or current alcohol abuse **OR** Police report and/or criminal complaint indicate the defendant was intoxicated at time of arrest **OR** charged with an OWI case and qualifies for supervision
GPS Monitoring	Defendant charged with a felony non-OWI offense, is subject to DMF Step 2 **OR** scored Level 5 Supervision *and* charged with a violent offense **OR** Concern for victim safety

Scoring Rules Review

The following scoring instructions should be followed:

1. OLD CCAP RECORDS
    a. If the client has old cases in CCAP without a statute description, look them up (e.g., using Google or charges page).
    b. If a client has one or more cases in CCAP that cannot be accessed and that might impact the score—for example, if a client has only old, converted cases—run a WI NCIC search (0072) along with the other NCIC searches. Count the convictions

and record if they are violent via Google search, but don't access any sentencing information.

c. If you complete this type of search, include the results in your NCIC case notes. For example, you might record that that the NCIC check, including a search for WI records, is complete.

2. ARREST WARRANTS
    a. Count arrest warrants as FTAs if there is a notation of a failed missed intake court appearance.
    b. If the DA's office files the case and just issues a warrant (without scheduling an IA date), do not count this.
3. FTA CHANGES
    a. If a client appears late, count it as an FTA.
    b. Count both stayed warrants and issued warrants.
4. ABSOLUTE SOBRIETY
    a. A client does not need to be eligible for Level 3 or greater to qualify for Absolute Sobriety.
    b. Any OWI charge (or charge that indicates any type of intoxication) should automatically receive Absolute Sobriety.
    c. If a client has an UNCOPE score of 3+ and a history of alcohol abuse, they would qualify for Absolute Sobriety.
5. DRUG TESTING
    a. Needs to be Level 3 or greater
    b. Also needs an UNCOPE score of 3+ and a history of drug use
6. PBTs
    a. Needs to be Level 3 or greater.
    b. For OWIs, UNCOPE does not matter as long as the client qualifies for supervision (Level 3+).
    c. Non-OWIs qualify if they are Level 3+, UNCOPE 3+, or have a history of alcohol abuse.
7. GPS
    a. Charged with a Step 2 offense, OR
    b. Scored into Level 5 supervision AND charged with a violent felony offense, OR
    c. Concern for victim safety

    Please note: "Scored into Level 5" means that the FTA/NCA scores put the person in Level 5 and the person was not "bumped" to Level 5 by a Step 4 charge.

8. SCRAM
    a. Needs to be OWI case and Level 3 or greater and have one of the following:
        i. UNCOPE of 3+
        ii. Charged with OWI 3rd or greater
        iii. Currently on release for an OWI at the time of the alleged new OWI

9. COMMENTS ON DECLINES/UNABLES
    a. After recommendations are set, comment on anything that is typically required for a completed interview report.
        i. Examples of comments you could make: any holds, aliases, open cases
        ii. Exception: Interview-related comments
10. STEPS 2 AND 4:
    a. Check the charges and manually bump the DMF recommendation.
    b. If qualify for both steps 2 and 4, can check both boxes.

Verification

While the PSA does not require an interview to complete the risk assessment process, JusticePoint believes that an interview is important as information obtained during the interview process is used to determine additional programming within the criminal justice system.

One process that is important after the completion of an interview is verifying the information gathered in the interview. Every effort must be made to obtain accurate collateral contact information from the defendant. (For more information about verification policies and procedures, see Tab 5.) While verification of assessment items is always the goal, there are times when the assessment must be calculated, reported, and relied upon without aspects of the defendant's responses being verified through outside sources.

Much like with other interview-based assessments, verification aids in the acquisition of valid information; however, verification itself is not weighted or otherwise incorporated into the calculation of the final risk score. In other words, assessments do not need to be verified in order for the risk evaluation to be scored.

Comments Section

When conducting the defendant interview, the pretrial investigator may learn information that may be helpful to stakeholders during the bail hearing. This information should be included in the Comments section of the risk evaluation report. Any information learned regarding a defendant's mental health status or other medical concerns should be provided to stakeholders while maintaining the confidentiality of the defendant's mental health or medical status. In addition, should a defendant decline to complete the risk evaluation process, the Comments section can be used to communicate this information to the bail setting authorities.

The following is a *non-exhaustive* list of information that may be relevant to the judicial officer, defense attorney, or assistant district attorney at the bail hearing and, therefore, may be included in the Comments section:

Mental Health Concerns

- Defendants who present as actively psychotic, manic, or are currently experiencing active auditory or visual hallucinations
- Defendants who report having been diagnosed with a severe or persistent mental illness or cognitive impairment and are currently experiencing symptoms of their mental illness or cognitive impairment
- Defendants who are diagnosed with a severe and persistent mental illness but who report that they are not under the care of a treating physician or receiving medication
- Defendants who report that they are struggling to maintain their mental health stability but who may be receiving medication and have a treating physician
- Defendants who are unable to respond or participate in the assessment process due to their mental illness or a cognitive impairment

Invalid Address

- Defendants who provide an address that appears to be invalid based on USPS.com and Google or Bing Maps

GPS Eligibility

- Defendants who meet the eligibility criteria for GPS monitoring but whose ability to comply with GPS requirements is compromised due to an uncontrolled severe and persistent mental illness or AODA issue

72 Hour No Contact/Temporary Housing

- An alternative housing plan for defendants who may not be able to return to their residence due to the nature of their current charges or an indication of a defendant's willingness or lack of willingness or plan to reside at a shelter

Maximum Release Date/Good Time Release Date

- The maximum release or good time release date, for defendants who are serving prison time*

  ***NOTE**: Pretrial investigators do not currently have a reliable method by which to check Wisconsin (or other state) DOC records to determine exact maximum release dates. Information relayed to the court regarding maximum release dates will therefore be a "self-report' from the defendant.

Felony Bench Warrant

- The case number, charge(s), and assigned court, for defendants who have a felony bench warrant at the time the pretrial investigation is taking place

Out of Jurisdiction Warrants

- The jurisdiction, type of warrant (if known), and case number (where applicable), for defendants who have a warrant in another jurisdiction. This information can be gathered through a review of the CJIS system and, as applicable, the CCAP system.

Other Holds

- *Any* known holds that are not covered by other parts of this guide (e.g., ICE holds, municipal holds, VOP holds, etc.)
- One exception: It is not necessary to comment on a captain's hold or a medical hold as they do not delay a defendant's release.

Open Cases

- The county and case number, for defendants who have open cases that are not receiving a praxis recommendation

Recording Information in the Comments Section

The information provided in the Comments section should be clear and concise and should reflect the issues that the investigator deems relevant to the bail decision. Any verification or attempt at verification of information appearing in the Comments section should be noted in the Comments section. The investigator should clearly document in the case notes section of the Wisconsin Pretrial Information System the reason for including the comment in the risk report. The notes should be sufficiently detailed so that other stuff speaking at the bail hearing will understand the reason for the comment.

Comment Examples

Mental Health Concerns

Example 1: Mr. Doe reports that he has been diagnosed with a severe and persistent mental health issue. He reports that he is currently experiencing active symptoms associated with his mental health issue. Mr. Doe reports that he is not currently under the care of a treating physician for his mental health issue.

Example 2: Mr. Doe reports that he has been diagnosed with a severe and persistent mental health issue. He reports that he is experiencing symptoms associated with his mental health issue. Mr. Doe reports that he is currently receiving treatment for his mental health issue and is supported through a case management program in the community.

Example 3: Justice Point/WCS was unable to complete the risk assessment with Mr. Doe due to his mental health concerns at this time.

Felony Bench Warrant
Example: Mr. Smith currently has an open felony bench warrant for Kenosha County case number 2012CF002033.

Open Case(s)
Example 1: Mr. Smith has the following open cases: Milwaukee County case 2012CF003023 and Ozaukee County case 2013CM002654.

72 Hour No Contact/Temporary Housing
Example 1: Should Mr. Smith be unable to return to the above address due to his current charges, he plans to reside at 821 W. State Street, Milwaukee, WI, 53233. This info has/not been verified.

Example 2: Should Mr. Smith be unable to return to the above address due to his current charges, he plans to reside at a shelter/is willing to reside at a shelter."

Example 3: Should Mr. Smith be unable to return to the above address due to his current charges, Mr. Smith plans to live with his sister, Ms. Smith, at an unknown address off of N. 60th and W. Mill Road.

Wisconsin Pretrial Decision Making Framework
Version 3 (10/26/2016)

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FTA 2	Level 1 & ROR	Level 1 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	
FTA 3		Level 2 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Level 5 & Financial
FTA 4		Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Misd. - Level 5 & ROR Fel. - Level 5 & Financial	Level 5 & Financial
FTA 5		Level 3 & ROR	Level 3 & ROR	Misd. - Level 4 & ROR Fel. - Level 5 & ROR	Level 5 & Financial	Level 5 & Financial
FTA 6				Level 5 & Financial	Level 5 & Financial	Level 5 & Financial

	Level 1	Level 2	Level 3 (Standard)	Level 4 (Enhanced)	Level 5 (Intensive)	Level 5 (Intensive)
Bail	ROR	ROR	ROR	ROR	ROR	Cash
TOT	No	No	Yes	Yes	Yes	Yes
FacetoFace Contact	No	No	1x/month	Every other week	Weekly	Weekly
Alternative Contact	No	1x/month	1x/month	Every other week	No	No
Supervised Conditions	No	No	As authorized	As authorized	As authorized	As authorized
Court Date Reminder	No	Yes	Yes	Yes	Yes	Yes
Criminal History/CJIS	No	Yes	Yes	Yes	Yes	Yes

Authorized Conditions

Condition	Authorized
Drug Testing	Defendant Level 3 or greater supervision on the DMF **AND** Scores 3 or greater on UNCOPE **AND** has a history of illegal drug use/abuse
Portable Breathalyzer	Defendant Level 3 or greater supervision according to DMF **AND** Scores 3 or greater on UNCOPE **AND** (has a history of problematic alcohol use/abuse **OR** current alcohol abuse) **OR** charged with an OWI case **AND** qualifies for supervision
Absolute Sobriety	Defendant has UNCOPE of 3 or greater and a history of alcohol abuse or current alcohol abuse **OR** Police report and/or criminal complaint indicate the defendant was intoxicated at time of arrest **OR** charged with an OWI case and qualifies for supervision
GPS Monitoring	Defendant charged with a felony non-OWI offense, is subject to DMF Step 2 **OR** scored Level 5 Supervision *and* charged with a violent offense **OR** Concern for victim safety
SCRAM	Defendant charged with an OWI offense and qualifies for Level 3 Supervision according to the DMF **AND** if any 1 of the following is true: Scores 3 or higher on UNCOPE **OR** Currently on pretrial release for an OWI at time of alleged new OWI **OR** Charged with 3rd or greater OWI. If defendant does not qualify for supervision, private pay SCRAM is an option depending upon program capacity.

Policy and Procedure: Verification of Defendant Information

1. **Policy Statement**
   The purpose of this policy is to outline expectations for verification of defendant interview and criminal history information collected during the pretrial screening process.

2. **Reasons for Policy**
   Information used to assess risk of pretrial misconduct and to contact defendants after release relies upon the accuracy of the information provided by the defendant during the interview and collected during the criminal history check. If the information provided by the defendant is inaccurate or the criminal history information collected is incorrect, the risk assessment may be invalid.

3. **Procedures**
   a. At the conclusion of the interview, the pretrial investigator will ask the defendant to provide the names of at least three personal references, their relationship to the defendant, and the telephone number where they can be reached.
   b. The pretrial investigator must advise the defendant that the purpose of obtaining reference information is to verify information collected during the pretrial screening process.
   c. The pretrial investigator will contact references as soon as is reasonably possible after the interview, before a defendant has time to contact the references and coach them on responses.
   d. The pretrial investigator shall seek to verify the following defendant information:

- address	- length of time at current address
- date of birth	- length of time in the city/county
- employment/means of support	- MH/AODA history
- family status	- primary caregiver status
- out-of-state criminal history (if no access to NCIC)	

   d. Ideally, information will be verified by the source closest to the question being verified (e.g., from the high school the defendant attends, from the defendant's employer, etc.). When these sources are unavailable, verification through the defendant's family or friends is appropriate.
   e. When contacting references, the pretrial investigator must identify himself/herself and explain the reason for the call (e.g., verifying residence).
   f. The pretrial investigator must not discuss specific facts of the case. If necessary, he/she can release the defendant's current location, court date, and court time.
   g. If the pretrial investigator is contacting a defendant's employer to verify information, he/she must not release any information unless the defendant grants Pretrial Services specific permission to do so. Every attempt shall be made not to jeopardize a defendant's employment.
   h. When verifying information, the pretrial investigator should always ask open-ended questions. For example, if a defendant reports working full time as a cook, the

investigator should ask the collateral contact, “Is Mr. X employed? Where?” The investigator should not attempt to verify with leading questions such as “Mr. X reported that he works as a cook at McBurger’s. Is that true?” By asking open-ended questions, the investigator will have the best chance of ensuring that the answer received from the collateral contact is accurate and not a product of the leading question.

i. The pretrial investigator must also access available electronic information systems such as CCAP, jail information system, the sheriff’s CJIS system, Vinelink, NCIC, the Forward Health Portal (for Title 19 eligibility—an indicator of disability benefits), and/or local pretrial information systems to verify defendant information.

j. If the defendant’s background has not been sufficiently verified, or there are major discrepancies between information provided by the defendant and the reference(s), attempt to re-interview the defendant. If this cannot be done prior to arraignment, note the discrepancies on the court report.

k. Record all verification in the Wisconsin Pretrial Information System under the “Verification” tab. The verification information entered will appear on the risk evaluation report that is available to the bail setting authority, defense attorney, and assistant district attorney. The following information will be entered for each verification source provided by the defendant: first name, last name, relationship to defendant, telephone number(s), indication of whether attempt to contact that source was made, and result of the attempt.

4. **Resources**

National Association of Pretrial Services Agencies. (2004). *Standards on pretrial release: Standard 3.3(d)* (3rd ed.). Retrieved from https://www.pretrial.org/download/performance-measures/napsa%20standards%202004.pdf

Pretrial Justice Institute. (n.d.) *Pretrial services program implementation: A starter kit.* Retrieved from https://www.pretrial.org/download/pji-reports/Pretrial%20Services%20Starter%20Kit%20-%20PJI%202010.pdf

Universal Screening Quality Assurance Protocol

PURPOSE

To ensure the provision of the highest possible level of quality universal screening risk investigation, verification, and reporting services to the courts, attorneys, and defendants of the Wisconsin criminal justice system.

MANNER OF ACCOMPLISHMENT

Quality assurance (QA) checks of all pretrial investigators in the following areas of performance:

1. Interviewing
2. Investigation
3. Reporting
4. Data Entry
5. Public Safety Assessment (PSA) Scoring
6. Decision Making Framework (DMF) Application.

PROCEDURE

The following procedure shall be used for conducting QA checks:

Interviewing
Staff will be observed conducting a full pretrial interview at least one time per quarter by a shift supervisor, program coordinator, or program director. Staff will be assessed on their interviewing technique, mastery of the investigation report, interaction with the client, and ability to obtain needed information from the client. Feedback will be given verbally to the pretrial investigator, and a record of any areas in need of improvement will be documented in the pretrial investigator's personnel file. Where needed, additional training will be provided to ensure the pretrial investigator meets or exceeds agency expectations of performance.

PSA QA Process
All supervisors and veteran staff members trained in the PSA QA process will complete full QAs on the following PSA reports:
1. Every PSA that goes to In Custody Intake Court for a bail/release decision
2. Every PSA that has a case in warrant status
3. Every PSA completed for an OWI offense
4. Every PSA completed for staff members in training status.

When conducting a QA check, the following should be reviewed: CJIS; CCAP; NCIC; investigation report; PSA report, including scoring and subsequent DMF application; and all universal screening pages applicable to the Wisconsin Pretrial Information System.

Feedback from these QA checks will be provided via email or, when deemed appropriate, verbally to the pretrial investigator. Ongoing or consistent problems will be recorded in writing and documented in the pretrial investigator's personnel file. Where needed, additional training will be provided to ensure the pretrial investigator meets or exceeds agency expectations of performance.

PSA Scoring and DMF Application Knowledge

At least one time per calendar year, the shift supervisor and program coordinator shall conduct written and verbal testing of each pretrial investigator's knowledge of the PSA and DMF. Staff will be asked questions about the overall risk tool, the manner and nuances of collecting data for each risk factor, the research behind the risk tool, the risk principle, and the application of the risk score to the DMF.

Feedback from this testing will be provided verbally to the pretrial investigator. Ongoing or consistent problems will be recorded in writing and documented in the pretrial investigator's personnel file. Where needed, additional training will be provided to ensure the pretrial investigator meets or exceeds agency expectations of performance.

Wisconsin Pretrial Risk Assessment Report

PSA Assessment Date: 05/27/2016 Prepared By: _____

Identifying Information:

Defendant name Date of Birth: Phone #
Gender Race Ethnicity
Address: Address Verified

Arrest Date: 04/10/2016

Charge	Description	Charge Severity	Charge Type	Step2	Step4
None					
941.20(1)(C)	INTENTIONALLY POINT FIREARM AT PERSON	Misd. A	Summary Arrest	No	Yes

Risk Information & Recommendation:

Risk indicator Scores: FTA = 1 NCA = 1 NVCA = No
DMF Supervision Level and Bail Type: Level 2 & Personal Recognizance Bond

	NCA 1	NCA 2	NCA 3	NCA 4	NCA 5	NCA 6
FTA 1						
FTA 2						
FTA 3						
FTA 4						
FTA 5						
FTA 6						

Drug Testing	Breathalyzer	Absolute Sobriety	SCRAM	GPS
No	No	No	No	No

Risk Factors:

1. Age at current arrest: 23 or Older
2. Current violent offense: No
2a. Current violent offense and 20 years old or younger: No
3. Pending charge at the time of the offense: No
4. Prior misdemeanor conviction: No
5. Prior felony conviction: No
5a. Prior conviction: No
6. Prior violent conviction: 0
7. Prior failure to appear in the past 2 years: 0
8. Prior failure to appear older than 2 years: No
9. Prior sentence to incarceration: No

NCIC Check Impacted PSA Score: No

Additional Information:

Early Intervention Eligibility: ☐ Diversion Eligibility ☐ Further Assessment Needed
Additional Considerations: ☐ DOC Supervision ☐ Pretrial Supervision
Dosage Probation: No

Memo:

Defendant Identifying Information

Case Number (once filed)

DMF Steps

PSA Scores

Supervision Recommendation

PSA Score

If the interview is declined or unable it will be noted here.

Authorized Conditions

Risk Factors

Prior Violent Conviction & Prior Failure to Appear in the past 2 years are the actual number of prior violent convictions or FTAs in the past 2 years.

NCIC checks are completed for all defendants. The risk factors can max out, so it is possible to have criminal history outside of Wisconsin and not have the NCIC check impact the risk score.

Early Intervention Eligibility

Additional Comments/Information

Pretrial Interview and Release of Information Consent Form

I, _____,

Print Name (First, Middle, Last)

understand that I am being requested to give information about myself to Wisconsin Pretrial Services. I also understand the following:

1. The pretrial representative will be conducting an interview collecting information concerning my prior criminal history, residence, family, employment, substance abuse, and health status. I understand that participation in the interview is voluntary.
2. I understand that if I participate in the interview, the information collected by the pretrial representative will be used by the court to determine my pretrial release status (bail and conditions).
3. I will not be asked anything about my charge(s) nor will I discuss my arrest and charge(s).
4. I will be asked to provide contact information for people who can verify the information I provide.
5. I understand that the information I provide will be verified and that any false information I give may delay final decisions about my release status.
6. Information provided in this interview will be provided to the legal counsel representing me and the assistant district attorney in court.

I have read the above form, or had it read to me, and consent to the pretrial interview and the release of information outlined above. I understand that this is not a waiver of my medical and mental health privacy rights.

_____ _____

Defendant's Signature Date

_____ _____

Pretrial Representative Date

DECLINED INTERVIEW

_____ _____

Defendant's Signature Date

Memorandum of Understanding Regarding Pretrial Protections

Purpose

_____ is participating in a pilot project to develop a model of pretrial release that can be tested and evaluated to determine its effectiveness, potentially leading to replication in other counties. The goal of this pilot is to move from a charge- and money-based system of release and detention to a risk-informed system, using less or no money when that money interferes with or undermines the lawful purposes of pretrial release and detention or public safety. The purpose of this memorandum of understanding is to define the objectives, responsibilities, and procedural guidelines regarding pretrial protections of individuals participating in the pretrial risk assessment process.

Background

_____ is participating in a national initiative supported by the U.S. Department of Justice, National Institute of Corrections, to improve the functioning of the criminal justice system. The goal of the effort is to achieve more successful outcomes with individuals involved in criminal justice and to improve public safety. In _____, this involves the utilization of evidence-based decision making (EBDM) at each criminal justice decision point.

As part of this effort, county employees are administering validated pretrial risk assessments (PRAs) to individuals booked into the _____ Jail in order to identify those who should be released from the jail pending future court appearances. These tools are in use in many jurisdictions throughout the country and are based in research. A pretrial risk assessment is an important component of a robust, evidence-based pretrial program and is an actuarial tool designed to measure individuals' risk to public safety and likelihood of appearance in court. Moving forward, we want to ensure that accurate and thorough information is being gathered to validate statistical measures for _____'s population.

The pretrial assessment being utilized in _____ looks at recorded information (i.e., past criminal history) and requires individuals to respond by self-reporting potentially incriminating information in order to qualify for the pretrial release program.

Agreement

The parties agree that no responses to the pretrial risk assessments will be used to prosecute individuals who participate in the assessments. Individuals should be informed that their answers on the PRA cannot be used to prosecute them.

Information supplied by a defendant to a representative of the pretrial services agency during their initial interview or subsequent contacts, or information obtained by the pretrial services agency as a result of the interview or subsequent contacts, shall be deemed confidential and

shall not be subject to subpoena or to disclosure without the written consent of the individual. Further, information in regard to the originating offense that is potentially incriminating that is supplied by a defendant to a representative of _____ during their placement in the pretrial justice program shall be deemed confidential and shall not be subject to subpoena or to disclosure without the written consent of the individual.

Exceptions: The court may admit such statements:

1. in a pretrial proceeding regarding release involving the arrestee; or
2. in any proceeding in which another statement made in preparing an authorized evidence-based risk assessment tool has been introduced, if in fairness the statements ought to be considered together.

Terms of Agreement, Modifications, and Termination

This agreement is effective when signed by all parties (members of the _____ Criminal Justice Coordinating Council). Any individual agency or organization wishing to amend, modify, or terminate this agreement will notify _____. The request will be reviewed and approved by the _____.

In witness thereof, the parties have caused their duly authorized representatives to execute this agreement.

_____			_____		
Name	Title	Date	Name	Title	Date
_____			_____		
Name	Title	Date	Name	Title	Date
_____			_____		
Name	Title	Date	Name	Title	Date
_____			_____		
Name	Title	Date	Name	Title	Date
_____			_____		
Name	Title	Date	Name	Title	Date

Wisconsin Pretrial Decision Making Framework
Version 3 (10/26/2016)

	NCA 1	NCA 2	NCA 3	NCA 4	NCA 5	NCA 6
FTA 1	Level 1 & ROR	Level 1 & ROR				
FTA 2	Level 1 & ROR	Level 1 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	
FTA 3		Level 2 & ROR	Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Level 5 & Financial
FTA 4		Level 2 & ROR	Level 3 & ROR	Level 4 & ROR	Misd. - Level 5 & ROR Fel. - Level 5 & Financial	Level 5 & Financial
FTA 5		Level 3 & ROR	Level 3 & ROR	Misd. - Level 4 & ROR Fel. - Level 5 & ROR	Level 5 & Financial	Level 5 & Financial
FTA 6				Level 5 & Financial	Level 5 & Financial	Level 5 & Financial

	Level 1	Level 2	Level 3 (Standard)	Level 4 (Enhanced)	Level 5 (Intensive)	Level 5 (Intensive)
Bail	ROR	ROR	ROR	ROR	ROR	Cash
TOT	No	No	Yes	Yes	Yes	Yes
FacetoFace Contact	No	No	1x/month	Every other week	Weekly	Weekly
Alternative Contact	No	1x/month	1x/month	Every other week	No	No
Supervised Conditions	No	No	As authorized	As authorized	As authorized	As authorized
Court Date Reminder	No	Yes	Yes	Yes	Yes	Yes
Criminal History/CJIS	No	Yes	Yes	Yes	Yes	Yes

Authorized Conditions

Condition	Authorized
Drug Testing	Defendant Level 3 or greater supervision on the DMF **AND** Scores 3 or greater on UNCOPE **AND** has a history of illegal drug use/abuse
Portable Breathalyzer	Defendant Level 3 or greater supervision according to DMF **AND** Scores 3 or greater on UNCOPE **AND** (has a history of problematic alcohol use/abuse **OR** current alcohol abuse) **OR** charged with an OWI case **AND** qualifies for supervision
Absolute Sobriety	Defendant has UNCOPE of 3 or greater and a history of alcohol abuse or current alcohol abuse **OR** Police report and/or criminal complaint indicate the defendant was intoxicated at time of arrest **OR** charged with an OWI case and qualifies for supervision
GPS Monitoring	Defendant charged with a felony non-OWI offense, is subject to DMF Step 2 **OR** scored Level 5 Supervision *and* charged with a violent offense **OR** Concern for victim safety
SCRAM	Defendant charged with an OWI offense and qualifies for Level 3 Supervision according to the DMF **AND** if any 1 of the following is true: Scores 3 or higher on UNCOPE **OR** Currently on pretrial release for an OWI at time of alleged new OWI **OR** Charged with 3rd or greater OWI. If defendant does not qualify for supervision, private pay SCRAM is an option depending upon program capacity.

Behavior Response Decision Making Process Guidelines

Background

This document provides criminal justice system professionals with an overview of the purposes, philosophies, and values that have been established to consistently and appropriately respond to the behavior of defendants and offenders, hereafter referred to as "justice-involved individuals," in the county's criminal justice system.

Purpose

The purpose of this document is to provide decision makers with consistent, objective criteria that guide responses to the behavior of justice-involved individuals. It was developed in recognition of the fact that heretofore programs, services, interventions, and decision makers throughout the justice system have responded to behavior based upon varying philosophies and understandings of how best to encourage and reinforce prosocial behavior. These guidelines seek to align the philosophies, policies, and decision making practices among decision makers and across the justice system with contemporary research findings.

Key Definitions

- ***Prosocial behavior*** is defined as behavior that comports with society's prosocial norms. Prosocial behaviors span a range of actions, from those that may be considered minor (e.g., speaking respectfully, arriving for scheduled appointments on time) to those that may be considered meritorious (e.g., remaining clean and sober for a significant period of time, obtaining a GED or job promotion, etc.). For some individuals, adherence to prosocial norms is common and takes little effort; for others, such behaviors do not come as easily. Regardless of the complexity of the behavior, research demonstrates that reinforcement of prosocial behavior is a powerful motivator and, in fact, may have a more significant influence on future behavior than negative reinforcers (Molm, 1988; Wodahl, Garland, Culhane, & McCarty, 2011). To maximize their effectiveness, responses to prosocial behavior should follow evidence-based principles, as described later in this document.

- ***Noncompliant behavior*** is defined as behavior that does not conform to expectations, rules, or laws. Like prosocial behaviors, noncompliant behavior encompasses a wide spectrum of actions, from very significant (e.g., commission of an act of violence) to important but not as critical (e.g., inappropriate dress in formal settings). Noncompliant behavior is also relative; a non-serious infraction committed by an individual who is largely prosocial and at low risk for future criminal behavior in all likelihood will evoke a different response than would a similar infraction from an individual with a lengthy pattern of such behavior or one who is assessed to be at high risk for future criminal behavior. Further, research demonstrates that responses to noncompliant behavior are most effective when they follow certain principles, as described later in this document.

- ***Criminogenic needs*** are the risk factors demonstrated by research to be correlated with criminal conduct. "Static" risk factors are those conditions correlated with future criminal behavior that cannot be changed (e.g., age at first arrest), whereas "dynamic" risk factors are those conditions that are changeable (e.g., use of substances). Research demonstrates that effectively addressing dynamic risk factors among moderate and high risk offenders can reduce the likelihood of recidivism; thus, dynamic risk factors should be the target of behavioral interventions (Andrews, 2007).

The Goal of the Justice System

Although the interventions available for justice-involved individuals span a continuum of criminal justice decision points and thus may serve different populations or seek somewhat different outcomes, justice system leaders strive to ultimately have a positive influence on the behavior of those who are served, regardless of their justice system status. To this end, the county's EBDM policy team seeks to work collaboratively to ensure a fair, efficient, and effective justice system that enhances public safety and quality of life in our community.

The Principles that Guide Responses to Behavior

Noncompliant behavior among justice-involved individuals is sometimes more the rule than the exception due to the challenges individuals face regarding substance abuse, mental health, physical health, job skills, education, prior criminal involvement, unstable housing, and lack of prosocial connections. Nonetheless, research demonstrates that when certain principles guide responses to these behaviors, increases in prosocial behaviors and compliance levels are most likely to occur. For this reason, Milwaukee County has adopted these principles to guide responses to the behaviors of justice-involved individuals.

In order to maximize the effectiveness of the behavior response process, responses to prosocial and noncompliant behavior will be:

- transparent (Paternoster, Brame, Bachman, & Sherman, 1997);
- consistent (Paternoster et al., 1997);
- fair;
- proportional (Martin & Van Dine, 2008; Quirk, Seldon, & Smith, 2010; Taxman, Soule, & Gelb, 1999);
- swift (Hawken & Kleiman, 2009; Paternoster, 2010);
- parsimonious (for noncompliant behavior, the least intrusive intervention, consistent with risk and severity, will be utilized; Quirk et al., 2010);
- restorative;
- rehabilitative;
- effective;
- accountable; and
- legitimate and credible.

Behavioral responses will be formulated in such a way as to maximize effectiveness, holding individuals accountable for their actions while using interventions that are most likely to achieve long-term behavior change (Andrews, 2007; Andrews et al., 1990). Victim and

community safety (i.e., consideration of the safety of the victim and general public) will be of paramount importance in the formulation of all responses.

Key Policies

Although the County's behavior response system encompasses a variety of interventions as described above, justice system leaders nonetheless seek to implement consistent policies and practices throughout the system. To that end, the following policies have been established and will be consistently applied across the justice system's decision points:

1. We will respond to all behaviors, both prosocial and noncompliant.
2. We will document the behavior of justice-involved individuals and our responses to these behaviors. Doing so reinforces our commitment to transparency (Paternoster et al., 1997) and allows us to collect data to support the evaluation of the effectiveness of our responses.
3. We will intentionally recognize and reward prosocial behavior (Marlowe, n.d.).
4. In the case of noncompliant behavior, program staff will make personal contact with individuals within 72 business hours of the notification of the noncompliance. In those instances where additional information is required, responses will be determined and applied within 7 business days.
5. We will reserve the use of court, prosecution, defense, and jail resources for individuals who pose a public safety risk and for those individuals in need of risk control/stabilization conditions that cannot otherwise be achieved through the program/intervention.
6. When responding to noncompliant behavior, program staff will have discretion to select the response(s) most appropriate under the individual's circumstances within specific "presumptive response ranges." Multiple responses may be selected if deemed essential to achieving the desired behavior change, provided the principle of parsimony is also applied.
7. In the case of multiple noncompliant behaviors that occur within a single incident, these behaviors will be addressed in their totality. The presumptive response range will be determined based upon the most significant behavior.
8. If a staff member determines that a response in the presumptive range is not appropriate, the staff member will document both the factors that influence the recommendation. In such cases, both "stabilizing" and "destabilizing" factors (as defined later in this document) will be documented, in order to ensure that the totality of the circumstances are considered.
9. Responses outside of the presumptive response range must be approved by staff members' immediate supervisors. Immediate supervisors can approve a response one level above or below the presumptive range.
10. While exceptions to the presumptive response range can and should be expected, in order to preserve the integrity of the structured decision making tools, they should not exceed 15% of the cases.[1] These rates will be monitored on an ongoing basis.

[1] General guidance in the field suggests that over/underrides that exceed approximately 15% of the cases run the risk of eroding the utility of the decision making tool.

Pretrial Behavior Response Matrix

Violation Definitions		
Low Severity	**Moderate Severity**	**High Severity**
Definition: Involves violations that show a lapse in judgment but do not cause harm to the justice-involved individual or others.	Definition: Violations that appear to show a disregard for court orders and pretrial supervision but do not cause harm or potential harm to others.	Definition: Violations that appear to show a willful and/or repeated disregard for court orders and pretrial supervision, and/or violations that cause or present a risk of harm to the justice-involved individual and/or others.
Late to scheduled office contact without acceptable excuse	Failure to respond to call or communication from PTS within 24 hours	Any new criminal charge
Insufficient UA/diluted UA/refusal to follow UA collection protocol	Failure to report a new arrest	Missed scheduled face contact
Disruptive behavior in PTS office	Missed scheduled alternate contact	Missed court date (FTA)
GPS low severity violations (see list)	GPS moderate severity violations (see list)	GPS high severity violations (see list)
SCRAM minor severity violations (see list)	SCRAM moderate severity violations (see list)	SCRAM high severity violations (see list)
Failure to report police contact	Failure to comply with verification	Tamper/attempt tamper–UA
Failure to report after court	Missed UA/PBT, refusal to submit UA/PBT, positive drug test/PBT	Violation of no contact/stay away order
Failure to report address/phone number change	Repeated* low severity violations	Failure to complete a violations response
		Repeated* moderate severity violations
*Repeated = More than two events within the period of supervision		

Response Levels			
Supervision Level	**Low Severity Violation**	**Mod. Severity Violation**	**High Severity Violation**
Level 3 (Standard)	Low Response	Low–Mod. Response	Mod.–High Response
Level 4 (Enhanced)	Low–Mod. Response	Mod.–High Response	High Response
Level 5 (Intensive)	Low–Mod. Response	Mod.–High Response	High Response

Response Definitions	
Low Response	Verbal warning, review release conditions with defendant, consult with attorney, consult with family/support, role clarification, use of disapproval
Moderate Response	Meet with attorney and defendant (staffing), reflective writing assignment, increase frequency of substance testing, increase PBT/UA testing frequency, refer for AODA assessment, refer for mental health services, increase supervision level, consult with AODA/MH treatment provider, Event worksheet, Risk Mitigation Plan
High Response	Notify court, ADA, defense attorney; request additional bail conditions (SCRAM, GPS, curfew, drug testing, treatment); request bail hearing; return to custody; Court Appearance Plan; Thinking Model

SCRAM/GPS-Specific Violations		
Violation Severity	**GPS**	**SCRAM**
Low	First low battery event	Low battery event
Moderate	Inclusion zone violation, failure to respond to order-in by case manager, subsequent low battery event	Failure to download; loss, damage, or destruction of equipment; failure to respond to order-in by case manager
High	Failure to cooperate/show for install, exclusion zone violation, confirmed tamper	Failure to cooperate/show for install, loss of contact, confirmed tamper, confirmed drinking event

Critical Incident Review Protocol

Introduction

Criminal justice professionals are, by the very nature of their work, in the risk management business. No amount of research, experience, or foresight can consistently and without failure anticipate how others will behave in the future. The occurrence of unexpected, unfortunate, and sometimes tragic events should be planned for. Doing so will equip decision makers to rationally approach these occurences in order to understand them, manage their consequences, and, importantly, learn from them.

Purpose

The purpose of the critical incident review protocol is to plan, in advance, for the occurrence of such events. This protocol is drawn from experiences and writings from a variety of emergency management fields. The protocol is designed to encourage discussion and consensus among collaborative teams about the process they will use to identify and address critical incidents.

Steps to Take; Agreements to Make

Policy teams are encouraged to work through the questions below to develop their critical incident review protocol. Agreements should be documented thoroughly and, ideally, signed by team members.

1. What will constitute a “critical incident”? Possible discussion items:
    a. Who determines an incident to be a critical one?
    b. What is the expected or required timing of the critical incident review?
    c. Must a negative outcome occur for the incident to be identified as critical? If so, what type of negative outcome?
    d. Who can call for a critical incident review?

2. What are the purposes of the critical incident review? Possible discusion items:
    a. To debrief the facts of an incident and identify what went right and should be repeated in the future
    b. To debrief the facts of an incident and determine if actions can be taken to prevent such occurrences in the future
    c. To debrief the facts of an incident and determine what the next steps are relative to the current incident
    d. To debrief the facts of an incident and form a strategy for communicating with one or more audiences about the incident

3. Who is on the Critical Incident Review Team? Possible discussion items:
    a. Are there permanent members who will consistently participate?

   b. Are there situations when ad hoc members might be included? If so, what types of persons (e.g., those with specialized knowledge of procedures, those involved in the incident)? Is their participation different from permanent members' participation in terms of opportunity for input or decision making?

4. Are there key roles that will be assigned to members of the review team? If so, what qualities are important for the person filling them to possess? Who will assume these roles? Possible discussion items:
   a. Chairperson
   b. Co-chair
   c. Spokesperson
   d. Facilitator
   e. Recorder
   f. Other

5. Are the meetings open or closed?

6. Are there principles and ground rules the review team should agree to follow? Possible discussion items:
   a. Agreements around confidentiality
   b. Focus is forward-looking, on understanding and improving policies and practices
   c. Recognition that humans make errors
   d. Most people seek to succeed, but decisions are sometimes made under stressed conditions, without appropriate tools or with incomplete information
   e. Recognition that even when everything is done right, things can go wrong
   f. Recognition that when everything was not done right, learning and improvement are possible
   g. Prohibitions against finger-pointing and blaming

7. Should an MOU (or similar document) be developed to codify the purposes and processes of the review team?

8. Is it helpful to have a structured agenda that is routinely followed, to organize and manage the conversation and ensure key topics are consistently addressed? Possible discussion items:
   a. Purpose of the meeting: Remind the group that the purpose of the critical incident review is constructive analysis and problem solving. Set the tone for the conversation. Revisit the ground rules. Define the length of the meeting and the outcome the meeting will produce.
   b. Recap the event: Describe the facts associated with the critical incident, including key steps and processes that led up to the incident and followed the incident. Identify information gaps that still exist. The description should be devoid of opinions and assumptions.

c. Debrief the event: First discuss what went right. Be specific. Next discuss what went wrong. Be specific (and be mindful of the ground rules). Identify any signs that were missed that might have helped to anticipate the incident and its outcome. Consider whether established systems failed or are lacking and, if so, in what ways.
d. Improve processes: Discuss specific strategies to prevent or ameliorate similar incidents in the future. What needs to be put into place? Who is responsible for leading the effort and what is the expected timeline? Develop a specific action plan.
e. Managing the outcome: Discuss what needs to be done to address any harm caused by the incident or its aftermath. What harms have been done? In what ways can these harms be addressed most effectively? Who will carry out these strategies and what is the expected timeline? Develop a specific action plan.
f. Communication: Discuss how the team will handle communication about the incident going forward with, as applicable: (1) the affected parties; (2) internal agency staff, with identification of which agencies in particular; (3) the broader professional community; (4) the media; and (5) the broader public. Develop a specific action plan that identifies the goal of the communication with each group; the information or messages to be communicated, which should be consistent with the team's local message triangle and broader communication strategy; who will lead the effort; and the expected timeline.

9. How will review team decisions be documented? Possible discussion items:
    a. Create a template for the criticial incident report that will be routinely followed. Describe the problem; record in objective terms what worked and what didn't. Include an action plan template that is routinely used to record planned next steps.
    b. Consider who will receive copies of the report, or parts of it.

Calculating Potential Pretrial Screening Costs

This document is provided to help teams calculate their resource needs for pretrial assessment.

STAFFING

Data Needed

1. *Jail*: Daily, the average number of persons booked into the jail on any one of the following:
   - summary felony, misdemeanor, or criminal traffic offense
   - felony, misdemeanor, or criminal traffic warrant return
   - felony, misdemeanor, or criminal traffic bench warrant return

   It is ideal to obtain the above data by shift to aid in determining peak volume booking periods and the most efficient and effective deployment of available staff.

2. *Assessment*: Amount of time it takes to complete one risk assessment, verify information, and prepare a risk assessment report.

   Staffing Calculation
   # of bookings per day × # of hours per assessment = # of screening hours per day
   # of screening hours per day ÷ 8 hour shift = # of FTE positions needed
   # of FTE positions needed × 1.7 shift relief factor = # of FTEs needed

   Example Calculations

   1. *Booking Data by Shift Not Available*
      15 bookings per day × 1.25 hours per assessment = 18.75 screening hours per day
      18.75 screening hours per day ÷ 8 hour shift = 2.34 FTEs needed
      2.34 FTEs × 1.7 shift relief factor = 3.98 (4) FTEs needed

      NOTE: The shift relief factor is used to account for staff vacation, sick time, and personal time off.

   2. *Booking Data by Shift Available*
      1st Shift
      10 bookings per day × 1.25 hours per assessment = 12.5 screening hours per day
      12.5 screening hours ÷ 8 hour shift = 1.56 FTE positions needed
      1.56 FTE positions × 1.7 shift relief factor = 2.66 FTE positions needed

      2nd Shift
      24 bookings per day × 1.25 hours per assessment = 30 screening hours per day
      30 screening hours per day ÷ 8 hour shift = 3.75 FTEs needed
      3.75 FTE positions × 1.7 shift relief factor = 6.38 FTEs needed

      3rd Shift
      32 bookings per day × 1.25 hours per assessment = 40 screening hours per day
      40 screening hours per day ÷ 8 hour shift = 5 FTE positions needed
      5 FTE positions needed × 1.7 shift relief factor = 8.5 FTE positions needed

      Total FTE positions needed per day = 17.54 (17.5)

SUPPLIES & OPERATING

In addition to staffing costs, below is a sample budget based on example calculation #1 above that includes potential supplies and operating costs often associated with a pretrial screening program. This sample budget is based on a jurisdiction contracting with a private agency for services.

	FTE	Annual Salary	Total Salary	FICA	Health	Life	Total
Program Director/Supervisor	1	$48,000	$48,000	$3,672	$11,000	$30	$62,702
Pretrial Screeners	4	$35,000	$140,000	$10,710	$44,000	$120	$194,830
Subtotal Staffing	**5**		**$188,000**	**$14,382**	**$55,000**	**$150**	**$257,532**
Worker's Compensation ($.29/$100 of wages)							$545
Office Supplies ($50 per position per month)							$3,000
Telephone							$1,000
Postage							$150
Equipment (computers, phones, desks, chairs)							$15,000
Equipment Rental (copier, toner)							$2,000
Printing							$1,500
Staff Training/Development (NAPSA)							$7,500
Professional Fees (NAPSA certification, membership)							$500
Subtotal Supplies & Operating							**$31,195**
Administrative Fees: 12% (assumes private vendor)							**$34,647**
Total Expenses							**$323,374**

Calculating Potential Pretrial Supervision Costs

This document is provided to help teams calculate their resource needs for pretrial assessment.

STAFFING

Assumptions

- Estimated daily supervision census of 200 defendants (based on baseline jail screening data)
- 3 levels of supervision: standard, enhanced, and intensive
  - Standard supervision consists of 1x per month face-to-face contact, 1x per month alternative contact (phone, text, email), court reminders, and criminal history checks for new arrests/charges.
  - Enhanced supervision consists of face-to-face contact every other week, alternative contact every other week, court reminders, and criminal history checks for new arrests/charges.
  - Intensive supervision consists of weekly face-to-face contact, court reminders, and criminal history checks for new arrests/charges.

- Caseload Percentage Breakdowns (based on baseline jail screening data)

Standard	51%
Enhanced	36%
Intensive	13%

- Maximum Caseloads & Case Weights
  - Standard supervision: 90 defendants Case weight: 1.0
  - Enhanced supervision: 68 defendants Case weight: 1.33
  - Intensive supervision: 45 defendants Case weight: 2.0

Calculations

- Anticipated Caseload by Supervision Level
  (Total caseload) × (Caseload % breakdown) = (Anticipated caseload by supervision level)
  200 × .51 = 102 standard
  200 × .36 = 72 enhanced
  200 × .13 = 26 intensive

- Weighted Caseload by Supervision Level
  (Anticipated caseload by supervision level) × (Case weight)
  Standard = 102 × 1.0 = 102
  Enhanced = 72 × 1.33 = 96
  Intensive = 26 × 2.0 = 52

- Total Weighted Caseload
  (Weighted standard supervision) + (Weighted enhanced supervision) + (Weighted intensive supervision)
  102 + 96 + 52 = 250

- Supervision Staff Required
  (Total weighted caseload) ÷ 90 = (# of supervision staff needed)
  250 ÷ 90 = 2.77 (round up to 3)

SUPPLIES & OPERATING

In addition to staffing costs, below is a sample budget based on the staffing plan above that includes potential supplies and operating costs often associated with a pretrial supervision program. This sample budget is based on a jurisdiction contracting with a private agency for services.

	FTE	Annual Salary	Total Salary	FICA	Health	Life	Total
Supervisor/Team Lead	1	$40,000	$40,000	$3,060	$11,000	$30	$54,090
Pretrial Supervision Staff	3	$35,000	$105,000	$8,033	$33,000	$90	$146,123
Subtotal Staffing	**4**		**$145,000**	**$11,093**	**$44,000**	**$120**	**$200,213**
Worker's Compensation ($.29/$100 of wages)							$421
Office Supplies ($100 per position per month)							$4,800
Telephone							$2,880
Postage							$300
Equipment (computers, phones, desks, chairs)							$12,000
Equipment Rental (copier, toner)							$1,500
Printing							$2,000
Staff Training/Development (NAPSA)							$6,000
Professional Fees (NAPSA certification, membership)							$400
Subtotal Supplies & Operating							**$30,301**
Administrative Fees: 12% (assumes private vendor)							**$27,662**
Total Expenses							**$258,176**

OTHER BUDGET CONSIDERATIONS

- Case management/data collection software or systems
- Costs for office space
- Additional costs for other supportive services such as transportation (bus tickets), GPS monitoring for highest risk defendants, SCRAM monitoring, and drug/breathalyzer testing.

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EXPECTATION DISCUSSIONS MASTER WORKSHEET

For Submission at Conclusion of Workshop

Team Name: Hamilton County

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	Hamilton County started our pretrial pilot on June 1, 2016 as part of a change target in our local EBDM process
Questions about this component	
Implementation challenges with this component	The resources required to implement this program to full capacity requires a full-time Director and six full-time screening analysts with a cost of approximately $600,000 annually.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 2: The following stakeholders will be invited to become members of the local collaborative team: **a. Law Enforcement Officials** **b. Pretrial Officials** **c. Victim Service Providers** **d. Prosecutors** **e. Defense Attorneys** **f. Jail Administrators** **g. Court Administrators** **h. Judges (all criminal court judges are strongly encouraged to actively participate)** **i. Probation/Parole/Community Corrections Officials** **j. City/County Managers/Commissioners/County Councils** **k. Behavioral Health and Human Service Representatives** **l. Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.** **In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)**	
Team's assessment of progress regarding this component	Individuals from each of these areas have been invited to be part of the team
Questions about this component	
Implementation challenges with this component	Representation at meetings has been well received from the above list of stakeholders.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	A subcommittee from the pretrial pilot group meets weekly to collaborate. There is representation from court administration, judges, prosecutors, defense bar, community corrections, jail and probation.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	Meeting weekly has given us the opportunity to discuss successes, concerns, ideas etc. Having representation from all these areas facilitates decisions making.
Needs for assistance around this component	
Team's next steps regarding this component	Continue meeting weekly

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	The team meets regularly with our assigned TA. Our Chief Probation Officer and Court Administrator are part of the EBDM State Policy Team.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Continue working with state partners

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	We had discussions early on with local law enforcement and the local defense bar about the pretrial program. Our Court Administrator has had discussions with County Commissioners, County Council and local media about our efforts.
Questions about this component	
Implementation challenges with this component	Buy in from some stakeholders but this is a process
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	With the hiring of a Director of Pretrial Services, additional discussions are planned with local stakeholders

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:

a. **Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release**

b. **Indiana's pretrial system should:**

i. **Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance**

ii. **Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention**

iii. **Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information**

iv. **Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community**

Team's assessment of progress regarding this component	Our team as discussed and agreed upon the "3 M's" and that has been documented.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Drafting a mission and vision for the program.

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	We have not completed any work on this expectation as to date.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Develop written protocol

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	A review of our current bond schedule was completed in 2016. Hamilton County operates with a single bond schedule.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	Our team has been using the IRAS-PAT and Proxy since the pilot project began in 2016.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Our team will continue to research additional supplemental assessment tools that could assist with decision making. Policies regarding the use of these assessments is in progress.

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	Our team has been using NCIC record checks, New World, BMV, Odyssey, Incite and Doxpop to verify the accuracy of information obtained.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	Screeners are certified in the administration of the IRAS-PAT. We have a certified IRAS trainer within our county that provides ongoing training as needed.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	This is an area that needs to be formalized.
Questions about this component	
Implementation challenges with this component	Community Corrections and Probation have collaborated on completing the screenings for the past 10 months. Supervisors from the probation department have reviewed select files for accuracy.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	A formalized procedure will be drafted regarding an ongoing QA process.

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	Our team has had discussions with IUPUI researchers assigned to this state project. We currently keep an excel spreadsheet with local data.
Questions about this component	
Implementation challenges with this component	Local jails do not use the same system to record data so this has been a challenge for IUPUI researchers.
Successes to share with other teams regarding this component	
Needs for assistance around this component	A state wide data reporting system is needed for all counties to utilize.
Team's next steps regarding this component	

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	Our county implemented a Pretrial Summary Report in 2016 that is utilized.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	Our subcommittee worked together to develop a summary report that was beneficial for all stakeholders.
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	This was completed in 2016. We use a system called Anytrax that pulls information from Odyssey. An initial email is sent then 7 days prior to a defendant's court date an automated call is generated then 2 days prior to the defendant's court date a text message is sent.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	Our team is currently discussing this process.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Anticipate that we will begin this process in April with new screening analysts.

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	Our team has developed a supervision matrix.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	This is an area that we still need to address.
Questions about this component	
Implementation challenges with this component	Currently our local probation department is providing the supervision for those on PTR in addition to regular probation caseloads.
Successes to share with other teams regarding this component	
Needs for assistance around this component	Plan to work with our TA on a violations matrix
Team's next steps regarding this component	Start working on a violations matrix

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	We implemented this process in 2016. Defense Counsel are present at all initial hearings along with prosecutor.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	Need to create infrastructure to make these meaningful
Team's next steps regarding this component	

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	Currently the subcommittee discusses any critical incidents at the weekly meeting.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Need to define locally a critical incident Develop a formal procedure for reviewing critical incidents

EXPECTATION DISCUSSIONS MASTER WORKSHEET

For Submission at Conclusion of Workshop

Team Name: _____Hendricks County_____

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	Expectation # 19: Develop written protocol, i.e. pretrial system map
Questions about this component	
Implementation challenges with this component	Our challenge is to educate colleagues and broader community, e.g. all judges D01: Pleased w/level of participation by State; some judges continue to lack buy-in Loren: More optimistic D04: Can we implement this across all courts via LR?
Successes to share with other teams regarding this component	
Needs for assistance around this component	4 week criminal case filing rotation: Week 1: Assess and release, if allowable (D04) Week 2: Assess and release, if allowable (D05) Week 3: Assess and release, if allowable (C01) Week 4: Assess but do not release, even if allowable (D02)
Team's next steps regarding this component	Our policy team should assume that some judges may not be receptive to following the pretrial release/differential supervision matrix by July 1, 2017. As a result, we should develop a criminal case filing rotation that still allows 3 courts to participate and generate data while accommodating D02. D02 will serve as our control.

Expectation 2: The following stakeholders will be invited to become members of the local collaborative team:

a. **Law Enforcement Officials**
b. **Pretrial Officials**
c. **Victim Service Providers**
d. **Prosecutors**
e. **Defense Attorneys**
f. **Jail Administrators**
g. **Court Administrators**
h. **Judges (all criminal court judges are strongly encouraged to actively participate)**
i. **Probation/Parole/Community Corrections Officials**
j. **City/County Managers/Commissioners/County Councils**
k. **Behavioral Health and Human Service Representatives**
l. **Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.**

In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)

Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:

a. **Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release**

b. **Indiana's pretrial system should:**

   i. **Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance**

   ii. **Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention**

   iii. **Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information**

   iv. **Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community**

Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	Assessments will never, ever replace professional judgment Assessments are a tool to inform one's decision Ask for Mark Carey's PP In a study, 70% of POs incorrectly determined a defendant's risk level w/o using a risk assessment tool. 91% of POs correctly determined a defendant's risk level using a risk assessment tool. Assessments do not get it right all the time – it's about probability! Manage expectations! Assessments increase the odds for success. Professional judgment + use of actuarial tool = best predictor. There is no controversy around this! If you depart from the assessment, depart sparingly and with good reason Forthcoming: An Indiana resource guide that describes supplemental tools useful at the pretrial decision point to determine serious and persistent mental illness and substance abuse needs. This resource guide will include costs of the supplemental tools FTA = result of hearing is commenced and concluded. There is an FTA event that may be added to the case. The judges need to agree upon what is an FTA? The FTA is a dated event, i.e. this event may be added multiple times to the same case
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	

Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	

Team's next steps regarding this component	

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	We can develop a simple reporting form that lists the I-PAT and supplemental risk assessment scores pending the release of the State's common pretrial assessment form Since jailers are ineligible for IRAS-PAT training, Barto Co. trained their jailers on using the Hawaii Proxy Tool 24-7. If arrestees are released, they are directed to report the following day for an IRAS-PAT "Look-back" – we want a process to tickle judges about defendants who remain in custody past the point of expected release. We need to make a procedural decision about how these cases will be revisited Court reminder – Anytrax (this interfaces w/Odyssey) Look-back – weekly report from the Jail re: days held. Later, this report will include a risk-level column as well. The common pretrial assessment form with the defendant's risk level should be distributed to Jail in addition to hearing officer, prosecutor, and defense attorney If a defendant is not assessed within 8 hrs. of book-in, then the Hamilton Co. bond schedule kicks in and a defendant may post a cash bond without an assessment. On a weekend, the bond schedule kicks in immediately, b/c pretrial assessment officers only work M-F at this time
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this	

component	
Team's next steps regarding this component	

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	What is the role of defense counsel at the IH? Review risk assessment results w/defendant Under Indiana law, right to counsel attaches upon arrest, not upon first appearance No distinction b/w CMs and felonies – right to counsel attaches to both Ideally, the defense counsel should be encouraged to meet with his/her client in advance of IH in order to review charges. In model counties, defense counsel also explains pretrial assessment and assesses for indigency What is a limited appearance? Is this defined under the PR Rules?
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	Will our team respond publicly? Who will serve as our spokesperson? A collective response is best, i.e. no team member is hung out to dry State team is developing a critical incident response template
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

EXPECTATION DISCUSSIONS MASTER WORKSHEET

For Submission at Conclusion of Workshop

Team Name: Jefferson County Pretrial

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	We have a team formed and have been meeting on a regular basis for about 2 years
Questions about this component	
Implementation challenges with this component	Getting people to come to meetings; getting people to volunteer to do work; not having everybody at the table doing the work;
Successes to share with other teams regarding this component	Have meetings at a good time with food
Needs for assistance around this component	
Team's next steps regarding this component	Schedule/verify meeting dates for the rest of the year.

Expectation 2: The following stakeholders will be invited to become members of the local collaborative team:

a. **Law Enforcement Officials**
b. **Pretrial Officials**
c. **Victim Service Providers**
d. **Prosecutors**
e. **Defense Attorneys**
f. **Jail Administrators**
g. **Court Administrators**
h. **Judges (all criminal court judges are strongly encouraged to actively participate)**
i. **Probation/Parole/Community Corrections Officials**
j. **City/County Managers/Commissioners/County Councils**
k. **Behavioral Health and Human Service Representatives**
l. **Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.**

In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)

Team's assessment of progress regarding this component	Most of these team members have been at the table
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	inviting a member of the county council to come to meetings; inviting a person from a community based organization come

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	The team has been working together for the last year for implementation.
Questions about this component	
Implementation challenges with this component	Getting people hired in the needed positions
Successes to share with other teams regarding this component	About 2 months before implementation, the pretrial team really seemed to click – we met about every other week and got procedures mapped out, calendars coordinated, questions answered and completed a lot of education to court staff and jail staff.
Needs for assistance around this component	
Team's next steps regarding this component	We will need to get regularly scheduled meetings on our calendars for continued review of the project; the team is working on figuring out where pretrial falls structurally within the criminal justice system. The team has talked about developing a court services model to unify all those who provide supervision services for the Court.

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	The pretrial team put on a training for local criminal justice agencies to educate them on the pretrial project and invited Tara Bo Bair from Kentucky State Pretrial Services to speak. Members of Indiana Office of Court Services and the State team along with Justice David also came to show support and answer questions.
Needs for assistance around this component	
Team's next steps regarding this component	The team needs to develop a Communications strategy to education and inform the community of this project

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	Some pd's are reluctant in having defendants interviewed pretrial; they are talking to our 2 current pretrial PD's; concerned about having all the data together at once (criminal history); doing initials only 2 days per week; education with court staff with pretrial process and coordination; jail staff
Successes to share with other teams regarding this component	Court is getting paperwork on-time
Needs for assistance around this component	Need access to criminal history at the initial hearing; need to get an approved account for NCIC; data concerns with; contact IPAC to try to identify the accuracy of the system
Team's next steps regarding this component	Susan will contact State Police/Dispatch to determine what the next steps are for obtaining criminal history through NCIC

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:

a. **Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release**

b. **Indiana's pretrial system should:**

   i. **Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance**

   ii. **Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention**

   iii. **Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information**

   iv. **Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community**

Team's assessment of progress regarding this component	The team has a policy and procedures manual completed except for where pretrial falls structurally.
Questions about this component	Are there other counties that have this completed? Is the state going to provide standards much like probation and problem solving courts?
Implementation challenges with this component	
Successes to share with other teams regarding this component	The manual has all of the key points listed above
Needs for assistance around this component	Any help on a template for this would be helpful
Team's next steps regarding this component	Review the manual frequently to ensure it is updated and correct

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	See above
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	Review processes to see what happens to bond when we get to the initial hearing; looking at release conditions based upon what the release matrix states; not all team members agree that the pretrial coordinator should have release decisions
Successes to share with other teams regarding this component	The judges, prosecutor and defense attorneys did all get together and revised the bond schedules
Needs for assistance around this component	
Team's next steps regarding this component	Develop release procedures for the pretrial coordinator; rely less on bond when making release decisions; gathering data around release and concurrence rate

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	Policy and procedures have been developed on this expectation
Questions about this component	
Implementation challenges with this component	During the initial hearing – we are litigating what the risk is and it is challenging the risk assessment itself
Successes to share with other teams regarding this component	
Needs for assistance around this component	The Prosecutor's office and the PD receiving training on the IRAS- PT; having the state come down to do a training on the risk assessment
Team's next steps regarding this component	Develop a training plan/schedule for defense and prosecutors

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	Procedures have been developed to implement this expectation
Questions about this component	
Implementation challenges with this component	The pretrial assessors don't always have all of the criminal history by the time they do the assessment and the assessment score may need to be changed with this new information
Successes to share with other teams regarding this component	
Needs for assistance around this component	The Pretrial assessors need access to NCIC;
Team's next steps regarding this component	Updating the pretrial form to indicate whether or not the information has been verified

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	The pretrial assessors are all certified in the IRAS=PAT and will be recertified as directed
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	The pretrial department follows the same quality assurance standards as the Community Corrections department; direct observations will be made quarterly to ensure the assessments are being done correctly
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	IDOC has recently funding a new EBDM Pretrial Data Specialists. This new staff person will be able to collect and analyze all data required in addition to the data wanted by the team
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	In June 2016, baseline measures were collected for the current FTA rate and the re-offense rate. We can use this information to measure progress in the future.
Needs for assistance around this component	
Team's next steps regarding this component	The team will need to collect baseline measures as outlined in our work plan

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	A current pretrial form is used in both courts. Once the state comes out with a unified form, we will begin using it.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	Having the form in INCite
Team's next steps regarding this component	

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	Emails are out with the texting company; there are problems with the way the data is pulled and submitted
Questions about this component	
Implementation challenges with this component	Data – inputing the data into a system; getting that information into the reminder system data; getting the reminder system company to contact us back; Shelby will be getting with Susan to collect data; adding cell phone provider to the intake form; court staff have not been too receptive of this expectation
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Contact the texting company and start putting some deadlines on implementation

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	Scheduling a set time as to when to review the court cases; let the judge know when somebody has been in there a long time whether or not that is what he wants.
Successes to share with other teams regarding this component	
Needs for assistance around this component	What happens after the people who have been and identified as could be released; probation/cc violations and what are the procedures on this; look at number of days a person has been in jail
Team's next steps regarding this component	To develop procedure on this expectation and incorporate it into our workplan

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	The pretrial team has developed policy around this expectation.
Questions about this component	
Implementation challenges with this component	The defendants are not always being released according to the recommendation on the pretrial report
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Collecting data on concurrence rate

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	The pretrial team has a pretrial violation matrix developed to respond to violations
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Gathering data around these this expectation to measure its effectiveness

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	This needs to be worked on in Circuit Court as hearings are being done at different times than scheduled and the pretrial assessors are not being notified
Successes to share with other teams regarding this component	The Courts have rearranged calendars to have scheduled initial hearings at times when the prosecutor and defense can be there along with being later in the day so the pretrial assessors have time to get the reports to the Court and attorneys
Needs for assistance around this component	
Team's next steps regarding this component	Getting a definite initial hearing time on the court's calendar.

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	We have not worked on this expectation (working on a plan where if something tragic happens on pretrial release, how that incident is handled) the team should collectively respond to these situations
Questions about this component	
Implementation challenges with this component	Discussing delicate subjects
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	This expectation needs to be discussed with the pretrial team and implemented into the work plan

EXPECTATION DISCUSSIONS MASTER WORKSHEET

For Submission at Conclusion of Workshop

Team Name: Monroe County

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	Our initial team has been identified though we are lacking a few people representative of the list on the expectations. We are meeting monthly on the 4th Wednesday of the month for two hours at a time.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	Our first meeting was held in January 2017.
Needs for assistance around this component	
Team's next steps regarding this component	We will continue to meet each month.

Expectation 2: The following stakeholders will be invited to become members of the local collaborative team:

a. **Law Enforcement Officials**
b. **Pretrial Officials**
c. **Victim Service Providers**
d. **Prosecutors**
e. **Defense Attorneys**
f. **Jail Administrators**
g. **Court Administrators**
h. **Judges (all criminal court judges are strongly encouraged to actively participate)**
i. **Probation/Parole/Community Corrections Officials**
j. **City/County Managers/Commissioners/County Councils**
k. **Behavioral Health and Human Service Representatives**
l. **Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.**

In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)

Team's assessment of progress regarding this component	We had a large number of people participate in our first meeting.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We identified a member of the County Council and a member from Bloomington Police Department to invite to future meetings.

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	We will be meeting monthly and we are committed to an open and honest discussion to move the project forward.
Questions about this component	
Implementation challenges with this component	Ensuring that everyone provides input into the process and feels like they have a voice in the process.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We will continue to meet monthly.

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	Meetings are set for the year that include the technical assistance providers every other month with telephone and email consultation as needed. We also have members from the state team on our local team.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We will continue to meet with the teams.

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	We have educated, in part, the members of the team locally, but we need additional education in many other areas.
Questions about this component	
Implementation challenges with this component	Identifying the groups that need more education and ensuring the same message is being communicated.
Successes to share with other teams regarding this component	A presentation was made at the local Bench-Bar Conference in February. A separate presentation was made to a small group of attendees at the Monroe County Citizen's academy in March.
Needs for assistance around this component	
Team's next steps regarding this component	We will identify other groups (Prosecutor's Office, Public Defenders, Jail staff, County Council, law enforcement, etc.) to make presentations. Over the long term, we will have directed presentations in the community.

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:

a. **Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release**

b. **Indiana's pretrial system should:**

   i. **Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance**

   ii. **Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention**

   iii. **Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information**

   iv. **Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community**

Team's assessment of progress regarding this component	We are in the very initial stages of this through discussion at our first local team meeting.
Questions about this component	
Implementation challenges with this component	Possibly creating agreement among all the team members. It was apparent after the first stakeholder meeting that all members are at different places in the pretrial process and we need to solidify a common agenda.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We believe the technical assistance will be instrumental in this area to help us identify our guiding principles.
Team's next steps regarding this component	We will continue discussion in local team meetings with the technical assistance is present.

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	Proposed policies and procedures have been written by probation regarding the assessment and community supervision of individuals.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	As the team identifies changes and encompasses additional parts to the process; add to the proposed policies to expand and make them more global for all the players in the process.

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	Monroe County has a single bond schedule.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Review the bond schedule to see if agreement can be made to create less reliance on money.

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	We are currently using the IRAS-PAT. However, we are not using other tools yet. It is administered by probation prior to the Initial hearing.
Questions about this component	
Implementation challenges with this component	If we add supplemental assessments it may be difficult to implement in the limited time we have prior to initial hearing. If we add supplemental assessments we would need to know how much weight to give the outcome vs the IRAS-PAT.
Successes to share with other teams regarding this component	
Needs for assistance around this component	Information about other tools and how they can be implemented.
Team's next steps regarding this component	Looking at other tools (PROXY, violence assessment, OWI, etc.) and may be adding more information to our recommendation form (additional criminal history, etc.).

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	We conduct/obtain records checks on everyone pretrial to help verify the information gathered for the IRAS. We also help verify the information gathered for the IRAS. We also check other case management systems for additional information and attempt to verify other items as needed (employment, etc.).
Questions about this component	
Implementation challenges with this component	Time constraints to complete all of the information prior to initial hearing.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Investigate the use of jail paper records in additional to other methods.

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	All IRAS-PAT assessors are certified and are have just been recertified.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	If any new assessments are introduced, all staff will be certified to administer the assessments in accordance with the guidelines of the assessment.

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	Monroe County has an IRAS trainer on staff who conducts booster sessions for certified administrators of the tool. The trainer also provides additional help as needed.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We need to establish consistent periodic quality improvement practices to assess the inter-rater reliability of the tools. We are also willing to participate in any project that involves norming and validating the tools at the state and/or local level.

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	Monroe County is collecting data on the pretrial project and we are ready to submit the first quarter data to the researchers. We have experienced difficulty in obtaining historical data due to the data being kept in multiple databases and the limited ability to run queries from each database which could ultimately require that the data be gathered by hand.
Questions about this component	
Implementation challenges with this component	Historical data is maintained in two databases and methods for extraction may be difficult and time consuming.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like to receive guidance on other data elements which are critical and informative on our process and ultimate success. We would also like to receive guidance on methods for analyzing the data.
Team's next steps regarding this component	We will speak with Dr. Ray regarding his abilty to obtain the Appris jail data for the historical data comparison. We will continue to work with local partners to obtain the needed historical data if Dr. Ray is not successful. We will continue to identify additional data elements to collect and inform on our project.

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	We are currently using a recommendation form to inform the Court and our courtroom partners prior to the initial hearing regarding the defendant's risk and other important information requested by the Court in making an informed decision.
Questions about this component	
Implementation challenges with this component	Different stakeholders want different details on the recommendation form. If we entertain all the requests the report would become multiple pages in length. We all need to agree on what is essential information.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We will participate and cooperate with the State in developing a standard tool/form that can be used across the State.

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	Monroe County sends voice calls two days prior to the hearing and a text one day prior to the hearing to remind defendants of their hearings.
Questions about this component	
Implementation challenges with this component	We have experienced challenges in reminding defendants of their hearing when they do not possess a phone. Also, Odyssey and probation's case management system do not interface with each other regarding hearing information thus all court events are manually entered into the probation case management system so that automatic reminders can be implemented. Unfortunately, changes to hearing dates and times are not always recognized and changed in the probation case management system so some defendants are receiving calls in error.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	We will work with Court Technology to create a method to pull information from Odyssey that can be digitally updated into probation's case management system daily to ensure calls are made appropriately.

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	Aside from a bail review hearing which occurs three days after the initial hearing, we do not have a formal look-back process. We need to evaluate whether bail reviews have a purpose and what is different about defendants at the time of the bail review than at the time of the initial hearing.
Questions about this component	
Implementation challenges with this component	Time constraints of adding another hearing in the pretrial process.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like to learn about other jurisdictions and how they are completing this process.
Team's next steps regarding this component	Investigate ways to identify defendants and information needed to initiate a look-back process as well as criteria for setting hearings, etc.

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	Monroe County currently uses a matrix regarding the development of recommendations for release which includes differential supervision levels based upon the risk of the defendants and the instant offense.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like to receive more guidance regarding the use of the instant offense in the matrix and the weight given to the offense.
Team's next steps regarding this component	We will work with the State to help develop the model for use and then examine the State's tool and modify our own, if needed. We will also continue to collect data regarding success and failure rates and reexamine our matrix and make changes based on the data, if necessary.

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	Monroe County currently uses a matrix to aid in responding to violations and pretrial misconduct. We have the ability to respond to technical violations administratively. Notices of Noncompliance that are filed with the Court seem to pend until the case is resolved. We need to evaluate what the result of the NNC should be.
Questions about this component	
Implementation challenges with this component	Our currentl matrix for violation responses does not currently take into account the risk of the defendant. Some of our current supervision levels have too many technical conditions for pre-trial defendants (as opposed to post-conviction clients), which could result unnecessary technical violations of supervision.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like to know how other pilot counties are responding to violations and what violations their Court requires them to report through a formal violation notice.
Team's next steps regarding this component	We will discuss our conditions of supervision and make modifications as necessary. Additionally, we will review the State's matrix and make modifications of our local matrix as necessary.

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	All parties are present at the first appearance with the defendant. The defendant has access to defense counsel for questions and to be represented during the initial hearing.
Questions about this component	
Implementation challenges with this component	Currently, felony cases are provided with a hearing to establish probable cause before their initial hearing. This has presented challenges regarding when bail is addressed during the first appearance for the defendants. We are also experiencing many instances of a cash bond requirement remaining on some defendants after recommendations are being made for community supervision.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like more information on the defense counsel's role and expected participation during the initial hearing. Typically, they are not appointed to represent the defendant as no determination of financial inability to pay has been determined.
Team's next steps regarding this component	We would like to examine the need for probable cause hearings. We will also examine the prevalence and reasons for the requirement of cash bonds after community supervision is being ordered if the defendant posts the bond. Additionally, we want to continue to explore the most effective and meaningful participation of the public defender during the initial appearance.

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	We do not currently have a process in place.
Questions about this component	
Implementation challenges with this component	We may have challenges regarding agreement among the local team regarding a communication plan after critical incidents.
Successes to share with other teams regarding this component	
Needs for assistance around this component	We would like to receive information on a model process to follow that we could employ locally.
Team's next steps regarding this component	We will investigate a process and develop local procedures to implement.

Team Worksheet for Expectation Discussions
FOR NOTETAKING

St. Joseph County

Name: Sharon McBride

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	*Noted that Judge Hurley stated that SJC team have addressed Expectations 1-4
Questions about this component	How do we get Public Defenders engaged and to be a part of the collaboration?
Implementation challenges with this component	Getting the defense attorneys and other agencies to buy-in to the efforts. Must continue to reach out and encourage participation and promote its viability.
Successes to share with other teams regarding this component	We have addressed #1-4 and have identified other stakeholders.
Needs for assistance around this component	
Team's next steps regarding this component	Contact Public Defenders

Expectation 2: The following stakeholders will be invited to become members of the local collaborative team: **a. Law Enforcement Officials** **b. Pretrial Officials** **c. Victim Service Providers** **d. Prosecutors** **e. Defense Attorneys** **f. Jail Administrators** **g. Court Administrators** **h. Judges (all criminal court judges are strongly encouraged to actively participate)** **i. Probation/Parole/Community Corrections Officials** **j. City/County Managers/Commissioners/County Councils** **k. Behavioral Health and Human Service Representatives** **l. Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.** **In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)**	
Team's assessment of progress regarding this component	Continue to meet regularly and discuss goals and strategies with stakeholders
Questions about this component	
Implementation challenges with this component	Buy-in with stakeholders
Successes to share with other teams regarding this component	Most outreach efforts have been successful and meetings have taken place
Needs for assistance around this component	
Team's next steps regarding this component	Continue to reach out and have open communication, input and feedback

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	Have identified that criminal history and jail information is requested by judicial and prosecutors office in order to provide additional information
Questions about this component	What specific information to gather and by whom?
Implementation challenges with this component	Information sharing; universal access
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team:

a. Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release

b. Indiana's pretrial system should:

i. Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance

ii. Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention

iii. Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information

iv. Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community

Team's assessment of progress regarding this component	
Questions about this component	Ken's concern is public safety; Pre-Trial Assessment Tool does not include criminal history; Julies identified that some type of jail assessment is needed for mod-high risk
Implementation challenges with this component	Review/revise bond schedule; agreeing on definition of public safety; community buy-in
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	1. Define public safety (danger to community); 2. Work on providing criminal history; 3. Review bond schedule; 4. Develop mapping; 5. Develop release matrix; 6. Court notification

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	Infancy stage with developing policies and procedures
Questions about this component	
Implementation challenges with this component	Quality assurance protocols
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Roadmap; release matrix and bond schedule

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	In process of revisiting and reviewing bond schedule
Questions about this component	High risk clients and public safety
Implementation challenges with this component	Common definition of public safety and danger to community
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Bond schedule, court notification and defining risk

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	
Questions about this component	Engage and encourage public defenders to attend initial assessment within 24-48 hours; validity and reliability of risk assessment; providing jail data classification and criminal history information Can we get a criminal history printout included with the PAT?
Implementation challenges with this component	Buy in from public defenders; staffing for assessments; interpretation of risk; costs
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	PAT within 24-48 hours; meet with public defenders; provide criminal history; determine additional assessment tools, such as substance abuse, mental health, DV, and sex offenders; evaluate pros and cons

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	Independent data tracking and measuring outcomes
Questions about this component	Uniformity of data and info sharing
Implementation challenges with this component	Centralized system
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	Community Corrections and Probation staff are in compliance with assessment certifications
Questions about this component	Staffing and administering assessments
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Implement assessment evaluations and recommendations

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	
Questions about this component	Define definitions and goals (who, what, target dates)
Implementation challenges with this component	Data collection must be centralized and universal
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	Community Corrections and Probation utilize universal assessment tool that is validated. Already available on INcite
Questions about this component	Information sharing with other agencies
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Work on additional assessment resources

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e.g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	In process
Questions about this component	
Implementation challenges with this component	Interphase systems; accuracy of info as dates changes frequently
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Select and implement notification system

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	
Questions about this component	Ways to develop (review and track) jail system; how will probation and community correction identify clients to "step down" in level of supervision? When does client have to go before Court to modify?
Implementation challenges with this component	Track the current process; universal data
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Discuss levels of exclusion for change in supervision level decisions

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	In process. Based on Courts and Prosecutor
Questions about this component	Dependent upon the need (eg. DV-GPS; Electronic Monitoring; ROR; Bond; Probation)
Implementation challenges with this component	Level of supervision determination
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity .	
Team's assessment of progress regarding this component	In process
Questions about this component	Court order with specifics; level of supervision contingent based on probation and community corrections sanctions
Implementation challenges with this component	Identify violations and outline appropriate response
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	In development
Questions about this component	Staff with public defenders at initial hearing; PAT timely to court; prosecutors info; staffing point person
Implementation challenges with this component	**Need to find a workable procedure with the public defender present. Need buy in from the office of the public defender.**
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Send copy of PAT to prosecutor, court and public defender

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	
Questions about this component	Ask what could have been done differently. Rationally, how to relay to community/public about suicide, mental health, DV clients
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

EXPECTATION DISCUSSIONS MASTER WORKSHEET

For Submission at Conclusion of Workshop

Team Name: Tipton

Expectation Discussion 1

Expectation 1: Guided by a collaborative team process, Indiana pretrial pilot sites will develop and implement pretrial pilot projects within the context of the National Institute of Corrections Evidence Based Decision Making (EBDM) Framework.	
Team's assessment of progress regarding this component	The team has made considerable progress. Beginning October 1, 2016, Tipton County adopted a Release Schedule that does not use money bond. Policies and procedures have been written. The Jail has been given release authority. Everyone arrested is to complete an IRAS-PAT. Based on offense and risk a supervision level is determined. Procedures for response for violations and successes have been established. Public Defenders are available at each court appearance.
Questions about this component	None
Implementation challenges with this component	Challenges include the change in perception regarding money bonds. The use of City Courts that are not courts of record and will close in the next few years but currently are holding low level defendants for monetary fine.
Successes to share with other teams regarding this component	Training and education of team members, law enforcement officers, and correctional officers. Team effectiveness Use of release schedule
Needs for assistance around this component	Model for meaningful first appearance
Team's next steps regarding this component	Look at current data, review procedures, enhance QA, detailed analysis of framework.

Expectation 2: **The following stakeholders will be invited to become members of the local collaborative team:** a. **Law Enforcement Officials** b. **Pretrial Officials** c. **Victim Service Providers** d. **Prosecutors** e. **Defense Attorneys** f. **Jail Administrators** g. **Court Administrators** h. **Judges (all criminal court judges are strongly encouraged to actively participate)** i. **Probation/Parole/Community Corrections Officials** j. **City/County Managers/Commissioners/County Councils** k. **Behavioral Health and Human Service Representatives** l. **Local teams are encouraged to invite faith based organizations, and/or other key community stakeholders.** **In selecting stakeholder representation and collaborative team members, each team should ensure the representation is also diverse in nature (e.g. minority representation, gender diversity, etc.)**	
Team's assessment of progress regarding this component	The team has been functioning for two years. The self-assessment is that we are a highly functioning team. We have grown considerably over this time span and are confident that we can meet the expectations of the pretrial work.
Questions about this component	What changes should be made to the team composition?
Implementation challenges with this component	Educating new members on the research, data, history, team goals, ground rules, etc. Building trust, cohesion, and buy in to the greater good of the system.
Successes to share with other teams regarding this component	Our team's success in following the EBDM framework in phase V. We have commitment, we follow ground rules, we developed trust, we have common mission and goals.
Needs for assistance around this component	We would like to have additional team building for growth and integration of the new members perhaps through the Colors or the Kantor or some other team training.
Team's next steps regarding this component	Adding Deputy Prosecutor Matthew Quigley, an elected official, and Elizabeth Avery Director of Four County Counseling Center. Effectively orienting them.

Expectation 3: The team will work together collaboratively on all aspects of the development and implementation of the pretrial pilot project.	
Team's assessment of progress regarding this component	The policy team has had input and given approval for all policies and procedures for the project. The Work Group meets to review areas of concern, trouble shoot, and make recommendations to the team.
Questions about this component	None
Implementation challenges with this component	None
Successes to share with other teams regarding this component	Decisions are made by consensus. Team members are encouraged to express concerns and debate the merits of all options.
Needs for assistance around this component	None
Team's next steps regarding this component	Continued growth of the collaboration. Considering doing the Kantor with the team.

Expectation 4: The team will work collaboratively with their local counterparts, the EBDM State Policy Team, and their assigned technical assistance provider(s) in the development, implementation, and enhancement of their pretrial pilot projects.	
Team's assessment of progress regarding this component	Team members are involved in committees led by the State team involving other local teams such as Team Coordinators, Pretrial Work Group, and discipline specific groups. The team has a strong relationship and commitment with our TA provider.
Questions about this component	
Implementation challenges with this component	The team members are trying to discern the amount of time that should be committed to these work groups given the commitment toward collaboration balanced with the time necessary to participate.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 18: Pretrial pilot sites will work collaboratively with their state partners to educate colleagues and the broader community on the goals and values of Indiana's pretrial justice system.	
Team's assessment of progress regarding this component	Team members have attended meetings, conferences, and workshops to present the elements of an effective pretrial program.
Questions about this component	
Implementation challenges with this component	Coordination of participation in presentations and the consistent message given
Successes to share with other teams regarding this component	Four team members have presented to a least six different groups in the past year, and have provided materials and advice by phone as well.
Needs for assistance around this component	Development of a communications plan including policy when a request for assistance is made.
Team's next steps regarding this component	To develop a more detailed communications plan

Expectation 5: The team is encouraged to discuss, agree upon, and document a set of principles to guide their pretrial work. The following guiding principles have been developed by the EBDM State Policy Team: **a. Indiana's pretrial system should strive to achieve the "3 M's": (i) Maximize public safety, (ii) Maximize court appearance, (iii) Maximize pretrial release** **b. Indiana's pretrial system should:** **i. Be fair; a pretrial system that is fair is not based on ability to pay, but instead is based on the assessment of objective factors relevant to public safety and court appearance** **ii. Reduce harm; a pretrial system that reduces harm protects the public from those who pose a danger to the community, while reducing the detention of those whose risk to public safety may actually be increased as a result of pretrial detention** **iii. Be informed; a pretrial system that is informed is guided by social science research along with comprehensive case-specific information** **iv. Be parsimonious; a pretrial system that is parsimonious reserves expensive jail resources for those who pose a danger to public safety and utilizes non-detention based interventions (e.g., mental health/substance abuse services, pretrial supervision) for those who can be safely managed in the community**	
Team's assessment of progress regarding this component	The team has taken the State teams principles
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	The team has participated in multiple training sessions that espouse the principles of pretrial work.
Needs for assistance around this component	
Team's next steps regarding this component	To determine how these principles should be memorialized.

Expectation 19: Each of the pilot sites will develop a written protocol to document adherence to these principles.	
Team's assessment of progress regarding this component	The team has approved policies and procedures but has not developed a quality assurance plan.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	Input from TA will be useful in this process
Team's next steps regarding this component	Developing the quality assurance plan including checklists and reporting.

Expectation 7: Pretrial pilot sites are encouraged to review their bond schedule(s) and agree upon a single bond schedule for use within the county. When developing local bond schedules, sites should be mindful that the purpose of bond is to ensure appearance, not to collect fines, costs, and fees.	
Team's assessment of progress regarding this component	Our release schedule is set and we have been using it since October 1st. It is the only schedule for the County. It does not include money.
Questions about this component	
Implementation challenges with this component	It is a challenge to have a release schedule that does not use money given that we do not have preventative detention in Indiana.
Successes to share with other teams regarding this component	Success rates have been high. During our first quarter under this schedule we had 86 arrests and only 1 FTA and 4 new arrests while on release.
Needs for assistance around this component	
Team's next steps regarding this component	Data review and analysis

Expectation Discussion 2

Expectation 8: Pretrial pilot sites will operate a risk-informed pretrial system. All pilot sites will use the Indiana Risk Assessment System – Pretrial Assessment Tool (IRAS-PAT). Pilot sites may use additional assessment tools and information as they determine appropriate (e.g., criminal history, supplemental tools to assess violence, substance abuse and mental health assessment information, a secondary risk assessment tool). Sites must establish a policy and procedure that identifies when the assessment is administered and who or what agency administers the assessment.	
Team's assessment of progress regarding this component	The team has a policy regarding assessment. The PROXY is done at the jail and all arrestees are given an IRAS-PAT.
Questions about this component	Can defense attorneys be in the assessment interview? What if any secondary assessments should be used and when? What should be given to the court and parties regarding assessments?
Implementation challenges with this component	24/7 response for assessment for release at the jail.
Successes to share with other teams regarding this component	The data from the first quarter of operation show success in release, conduct, and appearance.
Needs for assistance around this component	
Team's next steps regarding this component	Develop policy regarding secondary assessments. Revisit policy regarding information shared from assessment. Norm the PROXY

Expectation 9: Pretrial pilot sites will develop and implement processes to verify the accuracy of the information obtained to score the risk assessment (e.g., NCIC records check, collateral contacts, etc.), to document the verification sources, and to report whether data has been verified.	
Team's assessment of progress regarding this component	The team feels that the self-report information is more accurate than the records due to poor data entry on the reports. NCIC records are run and contacts are made with other county's courts for verification of information regarding criminal history.
Questions about this component	
Implementation challenges with this component	Running the NCIC
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Consider an agreement that the Prosecutor will offer the NCIC at initial hearing instead of waiting for a motion for discovery.

Expectation 10: Assessors will be credentialed in the administration and scoring of the IRAS-PAT as well as any other tools used to assess pretrial risk. Assessors will also participate in periodic training and recertification activities pursuant to the Indiana Risk Assessment Policy.	
Team's assessment of progress regarding this component	The Correctional Officers attended a two hour training regarding administration of the PROXY. The Pretrial officers administering the IRAS-PAT are certified and will be recertified. Also, interrater reliability is ensured by bi-annually assessing together.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	This policy needs to be put into the pretrial written quality assurance policies. A policy needs to be developed for retraining of jail staff on the PROXY.

Expectation 11: Pretrial pilot sites will develop and implement a local quality assurance protocol to assure the integrity of the administration, scoring, and use of the risk assessment tool(s).	
Team's assessment of progress regarding this component	The Correctional Officers attended a two hour training regarding administration of the PROXY. The Pretrial officers administering the IRAS-PAT are certified and will be recertified. Also, interrater reliability is ensured by bi-annually assessing together.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	This policy needs to be put into the pretrial written quality assurance policies. A policy needs to be developed for retraining of jail staff on the PROXY.

Expectation Discussion 3

Expectation 6: The team will participate in the cross-site efforts to collect and analyze data in order to establish baseline information about pre-pilot pretrial practices and their impact and the impact of the pilot projects.	
Team's assessment of progress regarding this component	A year of baseline data from the jail was sent to the contract evaluators.
Questions about this component	
Implementation challenges with this component	The jail software was developed by an individual who has since retired. We found him and paid him to write a program to pull the needed data for the baseline submission. This may not be reasonable for continued reporting. However, the jail will have a new system in June.
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Implementation of the new jail software

Expectation 12: Pretrial pilot sites will utilize a common pretrial assessment report form. This form will be developed by the EBDM State Policy Team, with input from representatives from the pilot sites. Initially the form will be developed in "paper and pencil" format. Ultimately the form will be developed in INcite to enable local and cross-site data collection and analysis.	
Team's assessment of progress regarding this component	
Questions about this component	Input current IRAS-PAT into Incite
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	Await form and policy from State

Expectation Discussion 4

Expectation 13: Pretrial pilot sites will develop and implement a court reminder system. The method used (e,g., phone calls, robo-calls, etc.) will be locally determined.	
Team's assessment of progress regarding this component	The team has been using a court reminder system. At booking the defendant completes a form asking if they prefer text, voice, or email reminder and requesting the appropriate contact information. A court staff member then sends the appropriate reminder 48 hours prior to the hearing.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	Only one FTA since implemented. Court staff cross checks information with pretrial staff weekly.
Needs for assistance around this component	
Team's next steps regarding this component	

Expectation 14: Pretrial pilot sites will develop and implement a "look-back" process to identify defendants who remain in detention past the point at which release was expected to have occurred.	
Team's assessment of progress regarding this component	Defendants are generally not held with money bond so a look back for failure to meet a money bond is rarely necessary. However, there are holds for probation or release violations that may require a second look. This is usually instigated by the defense attorney and involves additional conditions of release such a home detention.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	
Team's next steps regarding this component	The team will develop a written policy for the second look process Should policy establish that release should be addressed at every pretrial conference?

Expectation Discussion 5

Expectation 15: Pretrial pilot sites will develop and implement a differential supervision approach for those defendants on pretrial release. The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	A system of differentiated supervision has been established. It is based on risk and seriousness of offense. It involves phone and face to face contacts. There are standard conditions of release and additional conditions may be imposed, but are rare.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	Defendants have been successful under the supervision given
Needs for assistance around this component	
Team's next steps regarding this component	Reporting, quality assurance, and data analysis

Expectation 16: Pretrial pilot sites will develop and implement a structured method to respond to pretrial misconduct (i.e., rule infractions, FTA, new arrests). The EBDM State Policy Team will develop a model that can be tailored to meet local pilot sites' needs and resource capacity.	
Team's assessment of progress regarding this component	The policies address behavior response by the pretrial agency
Questions about this component	
Implementation challenges with this component	The two City Courts that are not courts of record. It has been challenging to address those on supervision with fail to comply.
Successes to share with other teams regarding this component	
Needs for assistance around this component	Response to City Court and low level offenses by low risk defendants.... Diversion programming.
Team's next steps regarding this component	Addressing City Courts with policies for supervision and consistent behavior responses. Also policy needs revisited for reporting and court response

Expectation Discussion 6

Expectation 17: For arrestees who remain in custody, pretrial pilot sites will establish a speedy, meaningful first appearance during which all parties (court, prosecution, defense counsel) are present and the pretrial report is reviewed.	
Team's assessment of progress regarding this component	The team has received funding to ensure representation by the public defenders at first appearance.
Questions about this component	How do we make the first appearance meaningful? How can the PDs be more effective at the first appearance?
Implementation challenges with this component	Information prior to first appearance
Successes to share with other teams regarding this component	We have provided representation at first appearance so that defendants can ask questions
Needs for assistance around this component	Assistance in making the first appearance more meaningful
Team's next steps regarding this component	The team will address how the first appearance can be more meaningful and how more information can be provided. The coordinator will work on an agreement with the Prosecutor to provide the III, to consider a 5th amendment consent form at assessment, to obtain a report form from Monroe County.

Expectation 20: Each of the pilot sites will establish a process for reviewing critical incidents (as defined by the pilot site) to determine any need to adjust local pretrial release policies and procedures.	
Team's assessment of progress regarding this component	We do not have a critical incident protocol.
Questions about this component	
Implementation challenges with this component	
Successes to share with other teams regarding this component	
Needs for assistance around this component	Guidance and example would be appreciated
Team's next steps regarding this component	To create a rough draft through facilitated discussion of the team

The Reliability and Validity of the IRAS: Current State & Upcoming Evaluation

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University of Cincinnati

How Did We Get Here?

The Need for a Statewide Risk Assessment System

- Engine that drives effective supervision & interventions
  - Common "risk" language across the state & across criminal justice actors – based on Indiana data
  - Structured & uniformed process for meeting the principles of effective intervention – Risk, Need, Responsivity
  - Help guide decision-making & help determine appropriate level of intervention
  - Ability to assess behavior change
  - Can enhance public safety

Development of the IRAS

- Review of theoretically-relevant factors
  - Original data collection tools included over 100 items found in research to be related to recidivism
- Sample of offenders included both felons and misdemeanants from various points in CJ system
  - N = 1,380
  - We did not collect data on the PAT
  - Follow-up period = approximately 12 months
  - Recidivism was based on FBI data

Development of the IRAS

- Items kept for inclusion on each IRAS instrument were found to be significant predictors of recidivism
- Items that were not significant predictors of recidivism were not included

Development of the IRAS:
What was *not* Predictive of Recidivism?

- Current offense
- Misdemeanant arrests or convictions
- Previously convicted of the same offense
- Problems in any life areas due to *alcohol* use
- Whether current crime was violent/non-violent (including DV)
- Whether person has a child under age of 18
- Type of MH disorder
- Whether offender complies with medication requirements
- Whether offender feels MH problems disrupts their ability to work, parent, or causes undue stress
- Whether offender has been physically or sexually abused

Development of the IRAS

Several instruments spanning the criminal justice system:

1. **Pretrial (PAT)**
2. **Community Supervision Screening Tool (CSST)**
3. **Community Supervision (CST)**
4. **Prison Intake (PIT)**
5. **Supplemental Reentry (SRT)**
6. **Static Tool (ST)**

NOTE: ORAS includes the MAT for misdemeanants and the RT for inmates serving 4 years or more.

PAT

- Used at time of arrest/jail to make bail, release, & formal supervision decisions
- Helps determine offenders' likelihood of failing to appear in court & risk to reoffend (new arrest) during pre-trial period
- Items cover three general areas:
  1. Criminal History (3 items)
  2. Employment & Residential Stability (2 items)
  3. Substance Abuse (2 items)

CST

- Used at time of disposition & to develop individualized case plans
- Helps determine likelihood for a new offense while on community supervision
- Domains covered on the tool:

1. Criminal History (6 items)
2. Education, Employment & Financial Situation (6 items)
3. Family & Social Support (5 items)
4. Neighborhood Problems (2 items)
5. Substance Use (5 items)
6. Peer Associations (4 items)
7. Criminal Attitudes & Behavioral Problems (7 items)

PIT

- Used to make decisions at intake into prison & to develop individualized case plans
- Helps determine likelihood for a new offense while in prison

1. Criminal History (7 items)
2. School Behavior & Employment (6 items)
3. Family & Social Support (5 items)
4. Substance Abuse & Mental Health (5 items)
5. Criminal Lifestyle (7 items)

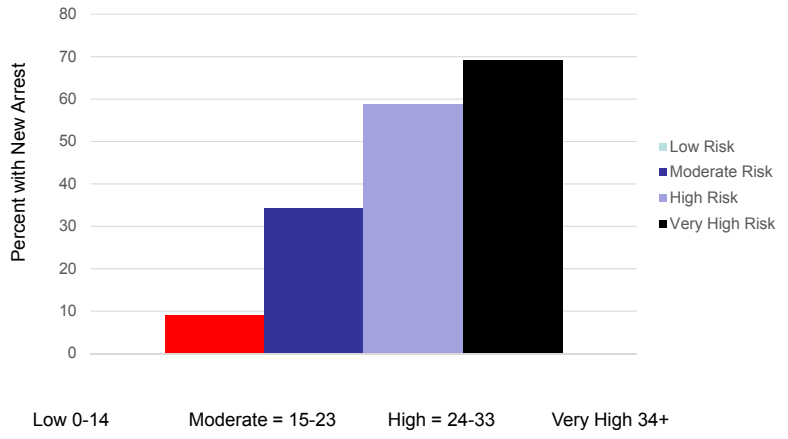
SRT

- Used at time of release from prison & to develop individualized case plans
- Helps determine likelihood for a new offense when the person is reentering the community after prison
  1. Criminal History (8 items)
  2. Education, Employment, & Social Support (7 items)
  3. Substance Abuse & Mental Health (4 items)
  4. Criminal Attitudes & Behavioral Patterns (12 items)

ST

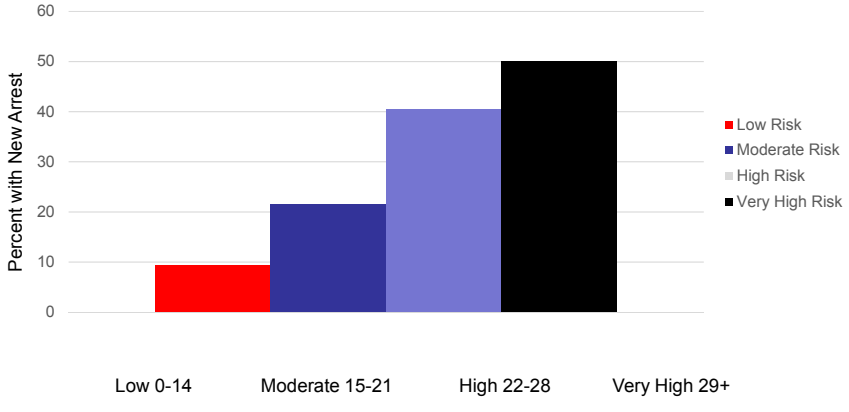
- Used with clients who are not available for a face-to-face interview due to medical &/or psychiatric conditions or have absconded & a risk level must be established
- Helps determine likelihood for a new offense solely on static factors
  1. Age at time of Assessment (1 item)
  2. Criminal History (7 items)

Males: Risk Level by Recidivism for IRAS-CST Sample



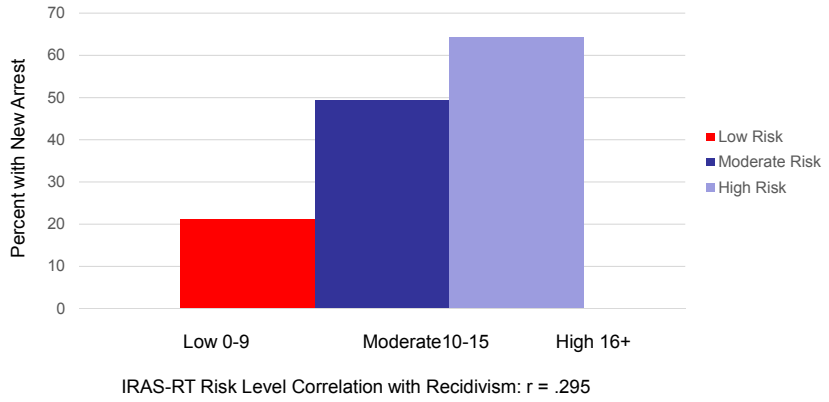
IRAS-CST Risk Level Correlation with Recidivism: r = .373

Females: Risk Level by Recidivism for IRAS-CST Sample



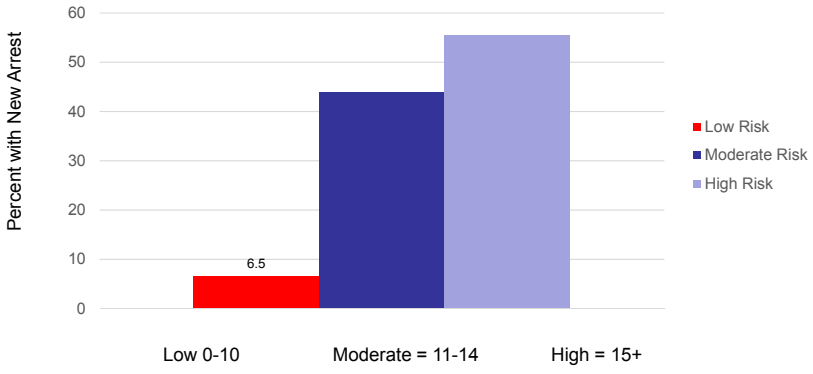
IRAS-CST Risk Level Correlation with Recidivism: r = .300

Males: Risk Level by Recidivism for IRAS-RT Sample



IRAS-RT Risk Level Correlation with Recidivism: r = .295

Females: Risk Level by Recidivism for IRAS-RT Sample



IRAS-RT Risk Level Correlation with Recidivism: r = .442

Validity & Reliability of the IRAS

Two Important Concepts:

1. Validity: means the tool is measuring what you think it is measuring
2. Reliability: Different types but most relevant to offender assessment is inter-rater reliability: Are staff consistent in scoring?

What can a Validity & Reliability Study tell us?

- How well the tool is predicting outcomes
- If the domains are predictive
- If specific indicators are predictive
- If there is a good separation in risk levels
- If the tool is predictive for sub-groups (i.e. certain types of offenders)
- If there are items that appear to be bias
- Norming values across sub-groups
- If there is inter-rater reliability (consistency & agreement) among assessors, and if not which items are problematic
- Internal reliability - whether a set of items are accurately measuring a specified construct (e.g. risk of reoffending)
- If cut off scores need to be adjusted
- If re-assessments are predictive of changes in recidivism

What a Validity and Reliability Study Cannot tell us:

- If the tool is being conducted properly
- If there is bias in how the tool is being administered
- If other items should be added to the tool (unless data is available)
- If the tool is being used to assist in determining interventions
- If treatment programs are successful at reducing recidivism

Importance of Reliability & Fidelity

- There are a lot of advantages to new generation risk assessments, but they can also pose some challenges
- Requires specialized knowledge of the dynamic items contained within the tool and how to gauge and score them
- Can also require more skills in collecting information (i.e. interviewing, more sources of information, longer process, etc.)

Maintaining Validity through Fidelity

- Not just about the tools or the programs you have, but *how* you use them
- A variety of factors can affect the success of IRAS efforts
  - Staff training and experience
  - Perceptions of using actuarial-based assessment instruments
  - Quality assurance processes

IRAS in other States

- Besides Indiana & Ohio, the IRAS is used in several other states:
  - Alabama
  - Arkansas
  - Colorado
  - Connecticut
  - Guam
  - Massachusetts
  - Montana
  - Nevada
  - New Hampshire
  - Texas
  - Vermont
- Also has been implemented in more than 30 counties & local agencies

Validation Studies Completed, in Progress, or Up-coming

- Texas
- Massachusetts
- Ohio (in-progress)
- Connecticut (up-coming)
- Vermont (up-coming)
- Colorado (up-coming)

Overview of the Texas Validation Study

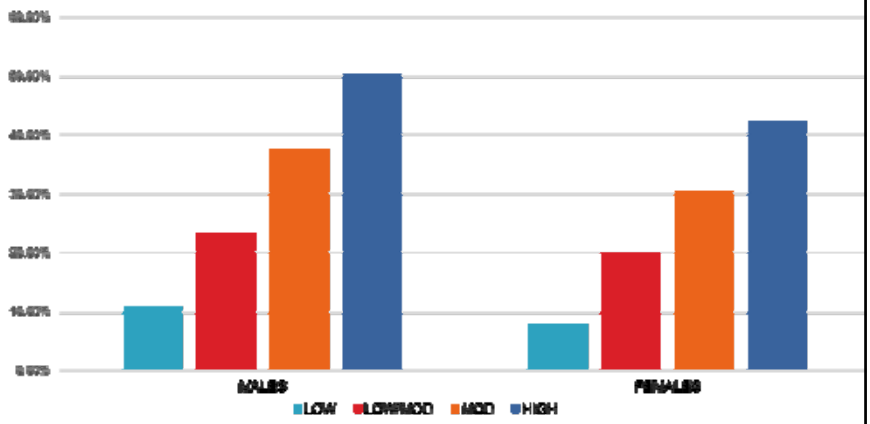
- Follow-up averaged 18 months
- Outcome included any failure (new arrests; violations; revocations)

Validation of the TRAS

- Study included over 5,800
  - 1,913 small counties
  - 1,398 medium
  - 2,170 large
- Race:
  - Caucasian/Non-Hispanic 41.5%
  - Black/Non-Hispanic 19.0%
  - Hispanic 37.9%
  - Other 1.4%
- Gender:
  - Male 70%
  - Female 30%

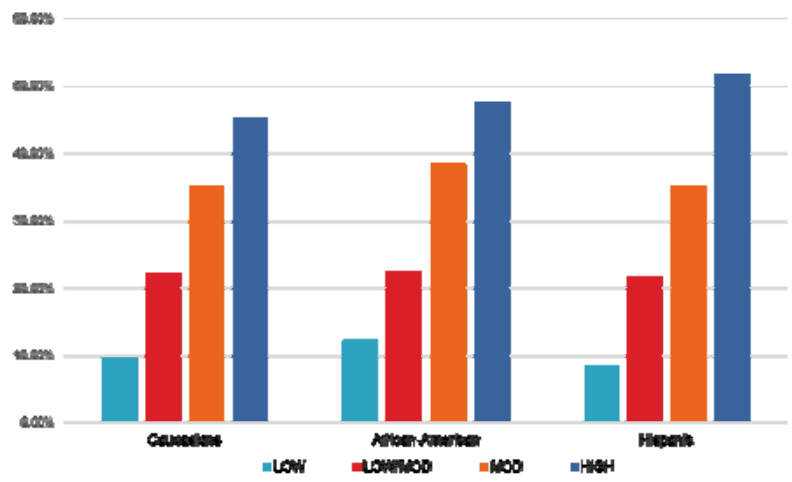
Lovins, B. K., and May. T. (2016). The Texas Risk Assessment System: Revalidating the ORAS for Texas Community Supervision.

TRAS Risk Levels by Gender



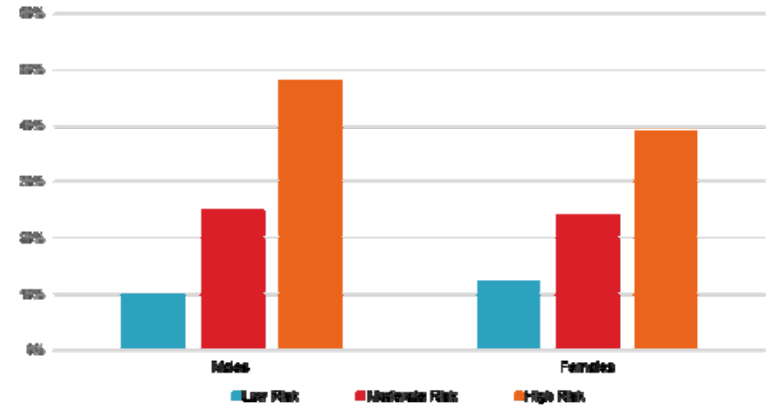
Males = p ≤ .001; r = .288; AUC = .674; Females p ≤ .001; r = .263; AUC = .676

TRAS Risk Levels by Race

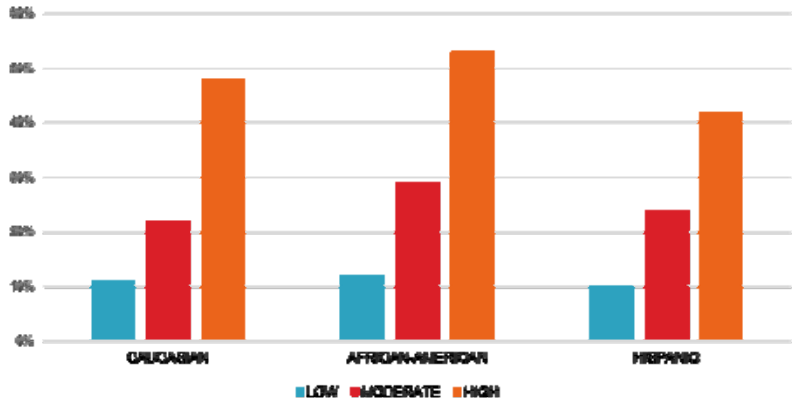


Caucasian: p ≤ .0001, r = .270, AUC = .670; African-American: p ≤ .0001, r = .257, AUC = .652; Hispanic: p ≤ .0001; r = .314; AUC = .693;

Recidivism Rates for the Misdemeanor Tool by Gender

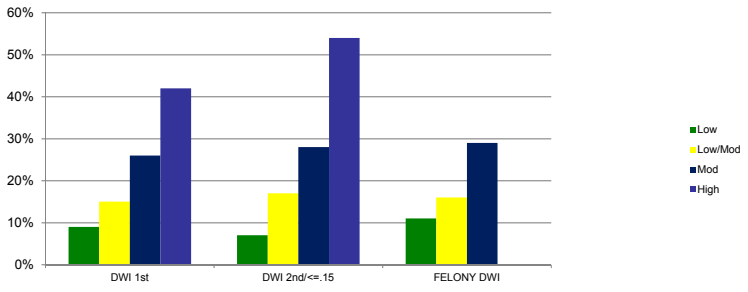


Recidivism Rates for Misdemeanor Tool by Race



Caucasian ≤ .0001, r = .290, AUC = .679; AA ≤ .0001, r = .331 AUC = .693; Hispanic ≤ .0001, r = .265, AUC = .665

Using the TRAS for DWI



Results from the Massachusetts Study

- Included both inter-rater reliability and validity

Methods

- Sample:
  - CST N = 10,548
- Follow-Up = 14-months from assessment date
- Outcomes included new arraignments and new convictions
- Reliability – 120 POs scored 5 vignettes
  - Consistency in scoring individual items
  - Agreement in risk categories

Results: Inter-Rater Reliability

Items, Average Domain Scores, & Total Score

Average % Agreement across Domain Scores & Average Total Risk Score

Domain	% Agreement
1.0 Criminal History	82.2
2.0 Education, Employment, & Financial Situation	86.2
3.0 Family & Social Support	80.0
4.0 Neighborhood Problems	86.7
5.0 Substance Use	85.7
6.0 Peer Associations	72.8
7.0 Criminal Attitudes & Behavioral Patterns	63.5
Average Across All Items	79.6

Results: Inter-Rater Reliability

Items, Average Domain Scores, & Total Score

- Rates of agreement across officers on individual items varied considerably
  - Agreement 80% or greater = 17 items
  - Agreement less than 80% = 18 items

Problematic Items Percent Agreement	
Item/Domain	% Agreement
1.0 Criminal History	
1.2 Number Of Prior Adult Felony Convictions	64.4
1.6 Community Supervision Ever Been Revoked for Technical Violation	78.0
2.0 Education, Employment, & Financial Situation	
2.3 Employed At The Time Of Arrest	76.2
3.0 Family & Social Support	
3.3 Emotional Or Personal Support Available From Family Or Others	70.6
3.4 Level of Satisfaction With Current Level Of Support From Family/Others	74.8
3.5 Stability Of Residence	77.3
4.0 Neighborhood Problems	
4.2 Drugs Readily Available In Neighborhood	77.7
5.0 Substance Use	
5.4 Drug Use Caused Problems	69.3
5.5 Drug Use Caused Problems with Employment	77.4
6.0 Peer Associations	
6.1 Criminal Friends	63.0
6.2 Contact with Past Criminal Peers	63.6
6.4 Criminal Activities	66.2
7.0 Criminal Attitudes & Behavioral Patterns	
7.1 Criminal Attitudes	60.3
7.2 Express Concern about Others	48.5
7.3 Feels Lack of Control Over Events	61.5
7.4 Sees No Problem In Telling Lies	75.0
7.5 Engages In Risk Taking Behavior	40.7
7.6 Walks Away From A Fight	68.7

Results: Inter-Rater Reliability

Overall Risk Level

Inter-Rater Agreement by Risk Level for Each Vignette (N =120)

	Male Vignettes					
	Toby Krane		Richard Sampson		Alfredo Diaz	
Risk Level	N	%	N	%	N	%
Low-Risk	0	0.0	0	0.0	0	0.0
Moderate-Risk	2	1.7	1	0.8	87	72.5
High-Risk	107	89.2	3	2.5	31	25.8
Very High-Risk	11	9.2	116	96.7	1	0.8

	Female Vignettes			
	Jane Smith		Brandi Jones	
Risk Level	N	%	N	%
Low-Risk	0	0.0	0	0.0
Moderate/Low-Risk	0	0.0	15	12.5
Moderate-Risk	61	50.8	97	80.8
High-Risk	59	49.2	8	6.7

Results: Inter-Rater Reliability
Overall Risk Level

- Agreement varied across each vignette
  - Between 97% & 81% agreement on three vignettes
  - Less than 80% agreement on two vignettes
- Total risk scores varied across risk scales considerably
  - More than one or two points between raters' scores on two vignettes

Massachusetts Results: The Predictive Validity of the CST

CST Assessment Distribution of Overall Sample & Subgroups by Risk Level

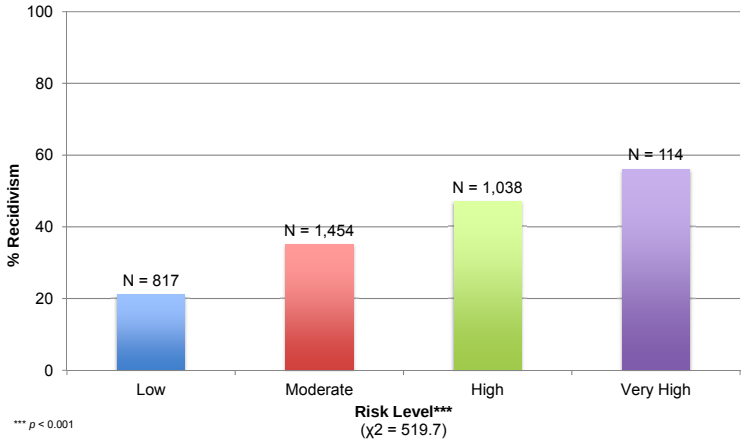
Risk Level	Overall (N = 10,548)		Male (N = 9,166)		Female (N = 1,382)		White (N = 6,667)		Non-White (N = 3,747)	
	N	%	N	%	N	%	N	%	N	%
Low-Risk	3,960	37.5	3,402	37.1	557	40.3	2,704	40.6	1,177	31.4
Moderate-Risk	4,158	39.4	3,716	40.6	442	32.0	2,603	39.0	1,516	40.5
High-Risk	2,226	21.1	1,906	20.8	320	23.1	1,256	18.8	956	25.5
Very High-Risk	204	1.9	141	1.5	63	4.6	104	1.6	98	2.6

Recidivism Rates (% of failures) by Risk Level for the Overall Sample

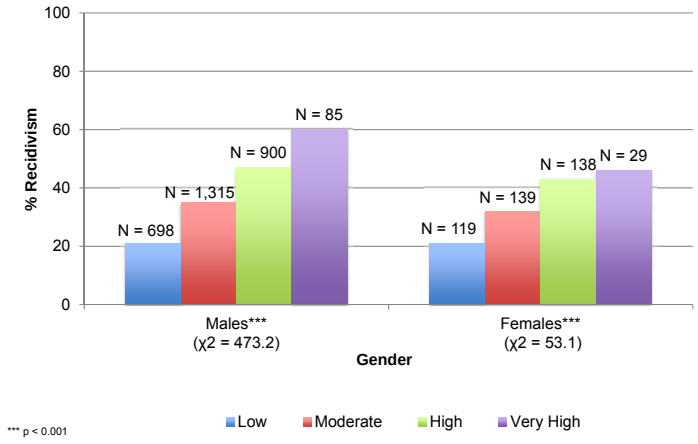
Risk Level	New Arraignment		New Conviction	
	N	%	N	%
Low-Risk (N = 3,960)	817	20.6	346	8.7
Moderate-Risk (N = 4,158)	1,454	35.0	701	16.9
High-Risk (N = 2,226)	1,038	46.6	581	26.1
Very High-Risk (N = 204)	114	55.9	62	30.4
Failure rates across all levels of risk (N = 10,548)	3,423	32.5	1,690	16.0
	$\chi^2 = 519.7^{***}$		$\chi^2 = 357.7^{***}$	

*** $p < 0.001$

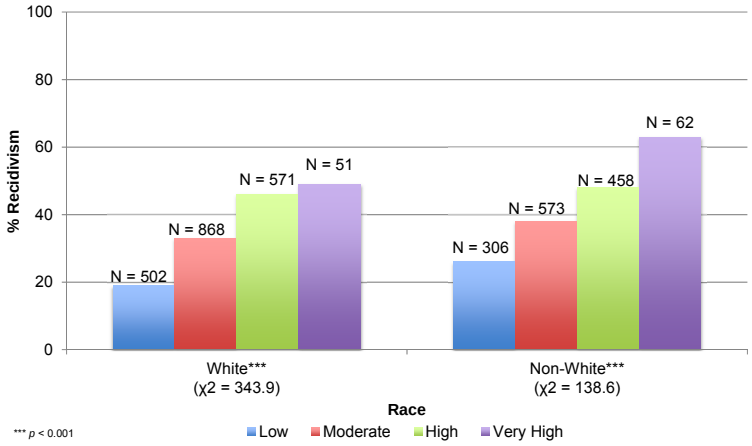
New Arraignment Rates by Risk Level for Overall Sample



New Arraignment Rates by Risk Level & Gender for ORAS-CST Sample



New Arraignment Rates by Risk Level & Race for ORAS-CST Sample



Correlations for CST Assessment Total Score & Recidivism

	New Arraignment	New Conviction
Overall (N = 5,274)	0.25***	0.21***
Males (N = 4,583)	0.25***	0.21***
Females (N = 691)	0.20***	0.18***
Whites (N = 3,336)	0.25***	0.21***
Non-Whites (N = 1,865)	0.22***	0.20***

Where are We Going?

Upcoming Evaluation

- Indiana Office of Court Services (IOCS) contracted with UCCI to evaluate the reliability & validity of all IRAS & IYAS instruments used by the IOCS. Goals of the study will be to evaluate
  1. Inter-rater reliability (IRR);
  2. Internal reliability;
  3. Predictive validity; &
  4. Internal reliability & predictive validity for different subgroups

The Study Will Tell Us…

- Inter-rater reliability: Consistency & agreement among raters
- Internal reliability: Whether a set of items are accurately measuring a specified construct (e.g. risk of reoffending)
- Predictive validity of the tool: Whether the tool is measuring what it is supposed to be measuring (e.g., recidivism)
- Validity of specific items: whether indicators are predictive
- *If inter-rater reliability is poor, validity can be affected*

Methods: Inter-Rater Reliability

- Each participant will review & score a series of IRAS/IYAS vignettes to allow them to score the same cases
- Data related to officers' demographic characteristics and work experience will also be collected

Methods: Inter-Rater Reliability

- Statistical Analyses will examine participant's agreement on:
  - Individual item scores
  - Domain scores
  - Total risk score
  - Overall risk level

Methods: Validity

- Random sample of assessments from will be drawn from each tool. Number of IRAS completed:
  - PAT 44,942
  - CCST 194,611
  - CST 430,955
  - PIT 70,601
  - SRT 44,342
  - Static 892
- Various types of data will be needed:
  - Offender
  - Assessment
  - Recidivism

Outcome Measures

- Recidivism: can be defined in multiple ways (i.e. re-arrest, conviction, TV, incarceration or some combination)
- If data are available it can also include looking at:
  - Type of crime
  - Revocations
  - Severity of Crime
- For Pretrial FTA and Arrests are best

Arrest

- Will capture most new offenses and is the broad measure, however:
  - Data not always reliable
  - Can include petty crimes/traffic
  - Not always guilty
  - Tells us nothing about seriousness

Conviction

- Guilt established and tends to be more reliable, however:
  - Plea bargaining can effect attempts at measuring seriousness
  - Can include petty crimes/traffic
  - Tells us nothing about seriousness

Incarceration

- Narrowest measure
  - Can include technical violations
  - Most reliable (at least prison)
  - Does not capture all new criminal behavior

Technical Violations

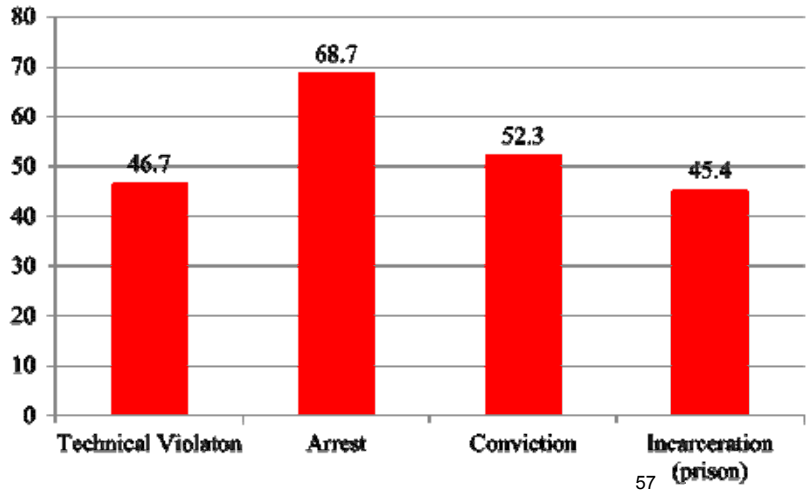
Useful for probation or parole, however:

- Not all TVs are “criminal”
- Have to be under supervision
- If not included how do you count someone revoked on a TV and sent to prison?

Follow-up of Offenders

- Length of follow-up and definition of recidivism will effect outcome rates
  - Arrest will have highest rates
  - Incarceration the lowest (but could change if TV revocations are included)

Failure Rate by Definition

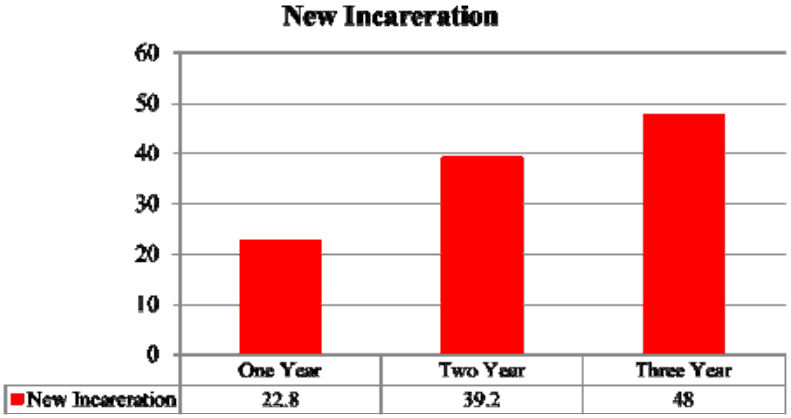


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As a general rule, the majority of failures will occur within three years

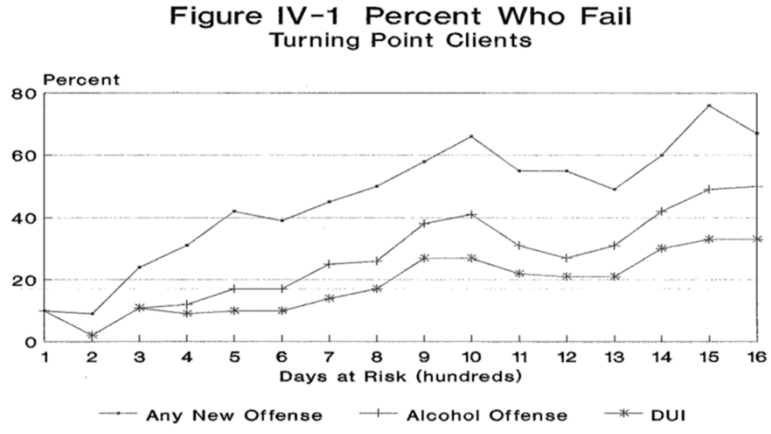
- About 40% first year
- About 60% by year three
- About 85% by year five
- Exceptions: sex offenders and drunk drivers

Recidivism rates for Cohort of Youth Released from Ohio Department of Youth Services*



*The number of youth returned to DYS or DRC within one, two or three years of release from a DYS institution.

Example from longer term follow-up of Habitual Drunk Drivers



Rates will also vary Based on Risk of Population Served

- For example, prison will have greater proportion of high risk offenders, rates will also vary by gender
- Have to be careful about comparing recidivism rates without knowing risk level of population

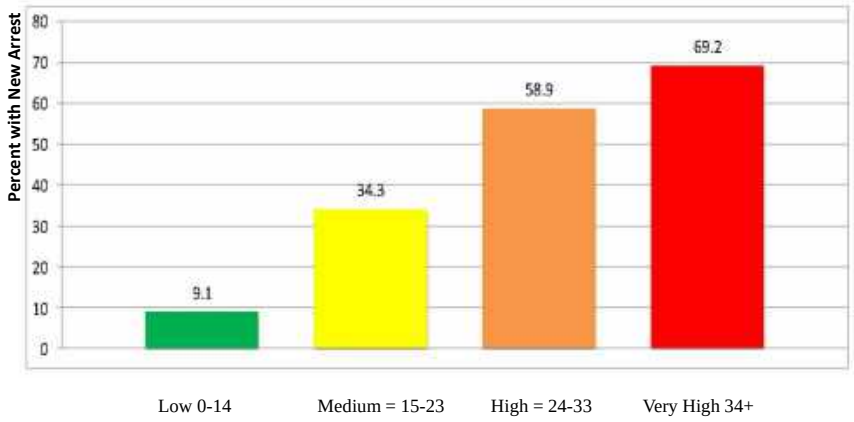
The Distribution of Risk Levels in a Community Supervision Sample

Level	Female %	Male %
Low Risk	25	15
Medium Risk	40	40
High Risk	35	45

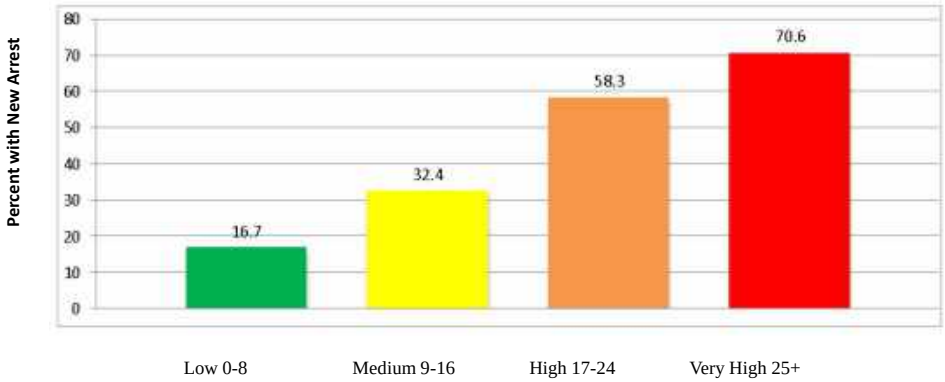
The Distribution of Risk Levels in a Prison Intake Sample

Level	Female %	Male %
Low Risk	42	9
Medium Risk	39	42
High Risk	19	49

Risk Level by Recidivism for a Community Supervision Sample



Risk Level by Recidivism for a Prison Sample



Internal & External Factors can Affect Recidivism Rates

- Internal – changes in policies, i.e. probation department may increase drug testing which can lead to higher failure rates
- External – Local police may focus on specific types of crime such as drug sweeps

Reliability of Data

- Official data is most reliable but does not account for all criminal behavior and in the case of arrests may be dependent on local police to enter information in a timely fashion

Seriousness

- Big difference between public intoxication and armed robbery, but difficult to distinguish seriousness in recidivism data
- Perhaps eliminate some minor offenses
- Seriousness indicators can include misdemeanor or felony, type of offense, or seriousness based on statute

Methods: Validity
Offender Data

Variable	*Description*
Offender ID #/Unique ID #	Offender's unique identification number
Date of Birth	Offender's date of birth
Sex	Offender's biological sex
Race	Offender's race
Ethnicity	Whether offender is of Hispanic descent
County	County responsible for offender's supervision
Sex Offender	Whether offender is considered a sex offender
Other Types of Offenders	Examples would be DWI or DV
Conviction Date	Date of conviction
Disposition Type	Type of disposition (e.g., probation, prison)
Release Date	Date of release from probation or prison

Methods: Validity
Assessment Data

Variable	*Description*
Offender ID #/Unique ID #	Offender's unique identification number
Assessment Type	Type of assessment (e.g., PAT, CST, PIT, RT, SRT)
Item Scores	Scores for each item on the IRAS/IYAS
Domain Sub-Scores	Total sub-scores for each IRAS/IYAS domain
Total Score	IRAS/IYAS total score
Overall Risk Level	Overall IRAS/IYAS risk level (e.g., low, moderate, high)
Override Risk Level	Overall risk level if overridden
Assessment Date	Date IRAS/IYAS was completed
Assessment Time	Whether assessment was an initial assessment or re-assessment

Methods: Validity
Recidivism Data

Variable	*Description*
Offender ID #/Unique ID #	The offender's unique identification number
Arrest Date	Date of new arrest, if applicable
Conviction Date	Date of new conviction, if applicable
Type	Violent, drug, property, sex, etc.
Violation Date	Date of new probation/technical violation, if applicable
Failure to Appear Date	Date of failure to appear
Pre-Trial Arrest Date	Date of arrest during time defendant was on pre-trial
Offense Level	Whether the offense is a felony or misdemeanor

Methods: Validity by Subgroups

- As long as we have data, we can examine reliability & validity of the tools by different subgroups
  - Gender
  - Race
  - OWI
  - DV
  - Violent

Determining whether Other Factors are Predictive

- Additional factors can be examined in the current study but data has to be available electronically
- If data is not available, new items can be added to the database for future validation efforts

IRAS Validation Study Summary

- We have large sample for all IRAS tools except the Static Tool which means we can look a subgroups
- Type of outcome measures will depend on availability of data
- If there are sufficient reassessments we can examine effects of changes in scores on outcomes
- Measuring seriousness (e.g., violence will depend on availability of data)
- Examining other factors not included in the tools will depend on availability of data
- Assessment of inter-rater reliability requires participation of POs

Results from the Study

- Results from IRR study will be used to examine reliability amongst staff across the state
  - Inconsistencies & discrepancies in scoring will help to identify areas where additional training & booster sessions may be needed

Results from the Study

- Validation results will be used to determine whether
  - Individual items &/or full domains on tools should be removed
  - How well the tools work for subgroups
  - If specific outcomes can be predicted (i.e. violence)
  - New cut-off scores should be developed
  - Enhancements to case management & supervision processes are needed

Results from the Study

- Final report will be written detailing findings from the study
- Recommendations will be provided outlining steps for IOCS to aid in maintaining reliability & validity of tools
- Results will be presented to IOCS upon completion of the study

Pretrial Assessment

- There are a number of assessment tools available and most find similar predictors

The Most Common Items in Pretrial Assessment Tools

- Prior FTAs
- Prior Convictions
- Present Charge a Felony
- Being Employed
- History of Drug Use
- Having a Pending Case

Pretrial Assessment Some Methodological and Practical Issues in Developing

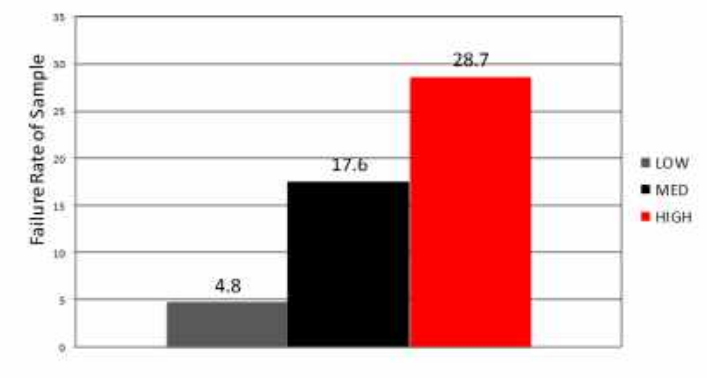
All the problems normally associated with developing assessment tools plus:

- Quality and availability of data
- Skewed sample – many high risk/serious defendants are not granted pretrial release
- Two outcomes: FTA and New Arrests
- Generally we are concerned about outcomes during the pretrial release period: result is short follow-up and low base rates of failure
- Legal status limits type of information that can be gathered
- Time constraints for assessment

IRAS- PAT

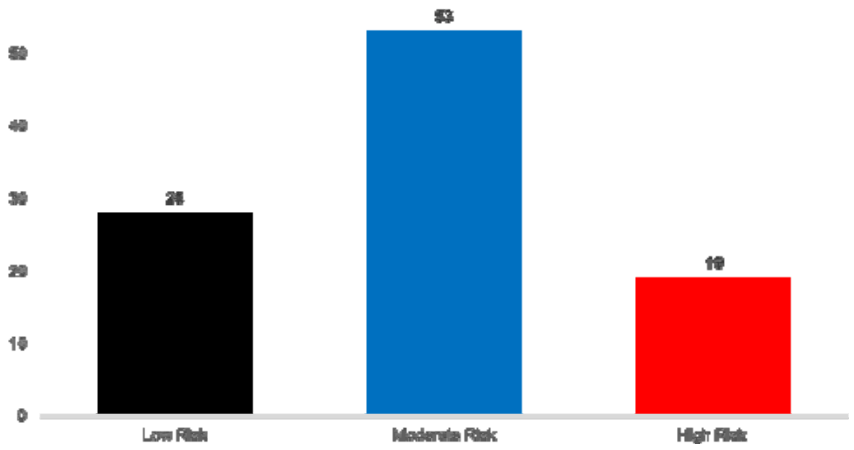
- Like most it is short
- Non-proprietary
- Minimal Training

Cutoffs: Any Violation



Differences in Recidivism Rates for each Risk Level
(n=452)

Percentage in Each Risk Category



Research on the Effects of Supervised Pretrial Intervention is still Evolving but some Findings Include:

- Research has found that when lower risk defendants were released to conditions that included alternatives to detention, they were *more* likely to experience pretrial failure. These defendants were, in effect, over-supervised given their risk level.
- Use of quantitative or mixed quantitative-qualitative risk assessments lowers a defendant's likelihood of pretrial misconduct
- Ability to impose sanctions and reports to courts is associated with less pretrial misconduct
- The more ways a pretrial program has to follow-up an FTA, the lower the likelihood of a defendant's pretrial misconduct
- Use of targeted mental health screening lowers a defendant's likelihood of pretrial misconduct
- Supervising mentally ill defendants lowers the likelihood of a defendant's re-arrest

Levin, D. (2007) *Examining the Efficacy of Pretrial Release Conditions, Sanctions and Screening with the State Court Processing Statistics Data Series*. Paper Prepared for the Presentation at the Annual Meeting of the American Society of Criminology, Atlanta, GA.

Remember

- The IRAS is designed to identify general need areas and probability of failure – low risk sometimes fail and high risk sometimes make it
- To better understand level of care needed, specialized assessments may be used
  - Substance abuse → SASSI
  - Attitudes & values → Criminal Thinking Scale
  - Needs & Strengths → CANS/ANSA
  - Domestic Violence → ODARA

Responses to Other Questions:

- Statutory Changes and the IRAS?
  - Some changes should not effect predictive power of tool (i.e. limits on revocation) but others, such as changing some offenses from felonies to misdemeanants might. This is an empirical question.
- How can a tool that is used to predict to a group be used and applied to an individual?
  - No process (actuarial or clinical) can predict what an individual will do in the future but we can assign probabilities - remember, we are not saying that John Doe will fail – we are saying that given his risk factors he is in a group with an X chance of failing and these are the areas that seem to related to that risk.

Questions

- Scored low but not consistent with experience?
  - Double check that you scored it properly
  - Use professional judgement and override if you don't believe the tool is capturing the risk of the individual
- Why are some items not important when experience tells us otherwise?

  Items can be non significant for a number of reasons
  - No variation in responses
  - No substantive difference between groups (i.e. failed/not failed)
  - Some items captured in other items (i.e. prior conviction for same crime is captured in prior conviction)
  - Very rare event

Questions

- Why is the scoring set up the way it is?
  - The results from the data analysis determined the cut points.
  - For some items once they a certain number it didn't matter (i.e. prior convictions didn't matter if they had 3 or 10).
- Has anyone researched "risk" that distinguishes specific acts (i.e. violence, intimidating witnesses, B&E, etc.)?
  - Some tend to be rare events so difficult to predict
  - Some work on violence being done but again most risk assessment tools predict a general outcome
  - Even certain types of offender commit range of acts (i.e. about 50% of sex offenders get new conviction for non-sex offense.

How we identified each item in the tools

We reviewed each item collected and examined the responses based on failure (new arrest and revocation):

	Recidivism Rates
Arrest under 17 yrs of age	
No arrest	22.7%
Arrest for Misdemeanor	41.1%
Arrest for Felony	49.8%
Alcohol—problems caused	
Never	28.4%
Ever	28.4%
In the past year	25.3%
Average Recidivism for group	27.8%

Determining an Item on a Risk Assessment Instrument

	No	% Reoffended
Evidence of Alcohol abuse		
Never	72.8%	27.2%
Last 12 months	73.1%	26.9%
Over 12 months	70.2%	29.8%

No significant difference in reoffending between those with no alcohol problem, alcohol problem in last 12 months, and over 12 months

	No	Yes Reoffended
Evidence of Drug Abuse		
Never	77.7%	22.3%
Last 12 months	68.5%	31.5%
Over 12 months	64.0%	36.0%

Significant differences between those who have no drug abuse history, last 12 months, and more than 12 months

Questions

- White collar criminals tend to score low. Has there been any research?
  - That is because most are low and no there is not a lot of research at least in terms of risk assessment. A doctoral student at UC is looking at Federal data for her dissertation and hopes to identify risk factors.
- Seriousness of the crime isn't a predictor?
  - Was not found to be significant and rarely is
- No place to note lying to assessor?
  - Indication of criminal thinking – remember you are assessing risk, if you think they are deceptive in an area score as risk factor
- Why isn't AKA include?
  - Studies have included it but relatively few have real aliases and does not predictive
- No recent FTAs because confined to DOC
  - Again, if there was a pattern then override

Questions?

INDIANA EBDM POLICY TEAM
Meeting Agenda
March 10, 2017 9:00 am – 12:00 pm
Indiana Government Center South Conference Center, Conference Room 18

I. Welcome and Introductions

II. Discussion – NIC Request for Information: State Team Accomplishments

III. Work Group Updates

- Pretrial – Larry Landis and Mary Kay Hudson
  - February 10, 2017, State and Local Team Workshop Debriefing
  - Review of Local Team Workshop Reports
  - Indiana Pretrial Executives Training Proposed Dates:
    - Week of May 8 and August 14, 2017
  - Pretrial Pilot Research Update
  - March 2, 2017, IRAS/IYAS Validation Meeting Debriefing
  - Risk assessment access and confidentiality issues
  - Wisconsin Pretrial Protocol
- Professional Development – Jane Seigel and Julie Lanham
- Data – Dave Murtaugh and Lisa Thompson
- Mental Health – Sara Cozad
- Risk Reduction Strategies – Dan Miller and Mary Kay Hudson
- Behavioral Responses – Jenny Bauer and Chris Cunningham

IV. Other Business / Open Discussion

V. Adjourn

Next Meeting Date: April 7, 2017 9:00 am – 12:00 pm
Indiana Office of Court Services
30. S. Meridian Street, 9th Floor, Indianapolis

Scott.A.Milkey

From: McClelland, Jim
Sent: Wednesday, March 08, 2017 1:10 PM
To: Huntsinger, Doug
Subject: FW: Addiction Resources
Attachments: Surgeon General's Addiction Report Glossary.pdf; Surgeon General's Addiction Report, Neurobiology Chapter.pdf; Opioids Glossary.docx

You might find these useful.

Opioid Epidemic Abbreviations Glossary:

- ASAM: American Society of Addiction Medicine
- CARA (2016): Comprehensive Addiction and Recovery Act
  - Federal; Funding available through SAMHSA grant. DMHA's application for Indiana's $10.9 million share is due on February 17, 2017.
- CBT: Cognitive Behavioral Therapy
- CMHC: Community Mental Health Center
- COWS: Clinical Opiate Withdrawal Scale
  - Measurement of someone's detoxification symptoms
- DATA 2000: Drug Addiction Treatment Act of 2000
  - Creates an 8-hour training program to allow non-specialist providers to apply to the DEA for a waiver to prescribe buprenorphine medication-assisted treatment
- DMHA: Division of Mental Health and Addiction
  - Indiana's Single State Agency for SAMHSA purposes, housed in FSSA
- FQHC: Federally Qualified Health Centers
  - Qualify for enhanced Medicare/Medicaid reimbursement based on service of an underserved area or population, etc.
- ICCDA: Indiana Commission to Combat Drug Abuse
  - New commission taking over for the Governor's Drug Task Force
- INSPECT: Indiana Scheduled Prescription Electronic Collection and Tracking
  - Indiana's prescription drug monitoring program (PDMP)
- MAT: Medication-Assisted Treatment
  - Opioid addiction treatment using methadone, buprenorphine products, or extended-release naltrexone (Vivitrol)
- MME: Morphine Milligram Equivalent
  - A measure of the level of morphine a prescription translates to
- NARR: National Alliance for Recovery Residences
  - A nonprofit recovery community organization that sets standards for recovery residences
- NAS: Neonatal Abstinence Syndrome
  - Disorder characterized by a newborn withdrawing from a drug in their mother's system during their gestation
- NFP: Nurse Family Partnership
  - An evidence-based community health program focused on first time pregnant moms. The mother is partnered with a registered nurse and receives ongoing home visits from the first trimester through the child's second birthday
- NIDA: National Institute on Drug Abuse
- NIH: National Institutes of Health

- OBT: Office-Based Treatment (pronounced o-bot)
    - A place to receive medication-assisted treatment (not methadone) in a provider's regular office.
- OTP: Opioid Treatment Program
    - Typically a methadone clinic
- PDMP: Prescription Drug Monitoring Program
    - A state database tracking an individual's prescription drug use
- PDO: Prescription Drug Overdose
- PHSA: Public Health Service Act
- ROSC: Recovery Oriented Systems of Care
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SBIRT: Screening, Brief Intervention, Referral to Treatment
- SSA: Single State Agencies
- SUD: Substance Use Disorder

Medication-Assisted Treatment Drugs:

- Methadone: an opioid agonist administered at an OTP. Affects receptors the same way that heroin does. Stays in the body for a long time.
- Buprenorphine (Byoo-pre-norff-een): a partial agonist that produces a high that is cut off at a certain point. Takes less time to detox from than methadone.
    - Subutex
    - Suboxone
- (Extended-Release) Naltrexone: an antagonist that blocks the receptors, preventing someone from getting high. Must be administered after detoxification to avoid precipitated withdrawal
    - Vivitrol: the brand-name monthly injection of extended-release naltrexone
- Naloxone: an antagonist used to reverse the effects of an opioid medication. Used in overdoses
    - Narcan: the brand-name for naloxone that many people are familiar with

Assistive Technology users should contact **Jinhee Lee**, Jinhee.lee@samhsa.hhs.gov, 240-276-0545.

GLOSSARY OF TERMS

Term	Definition
12-Step Program	A group providing mutual support and fellowship for people recovering from addictive behaviors. The first 12-step program was Alcoholics Anonymous (AA), founded in 1935; an array of 12-step groups following a similar model have since emerged and are the most widely used mutual aid groups and steps for maintaining recovery recovery from alcohol and drug use disorders. It is not a form of treatment, and it is not to be confused with the treatment modality called Twelve-Step Facilitation.
Abstinence	Not using alcohol or drugs.
Addiction	The most severe form of *substance use disorder*, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
Agonist	A chemical substance that binds to and activates certain receptors on cells, causing a biological response. Fentanyl and methadone are examples of opioid receptor agonists.
Antagonist	A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone is an example of an opioid receptor antagonist.
Binge Drinking	For men, drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.
Case Management	A coordinated approach to delivering health care, substance use disorder treatment, mental health care, and social services. This approach links clients with appropriate services to address specific needs and goals.
Clinical Decision Support	A system that provides health care professionals, staff, patients, or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care.
Clinical Trial	Any research study that prospectively assigns human participants or groups of participants to one or more health-related interventions to evaluate the effects on health outcomes.
Compulsivity	Repetitive behaviors in the face of adverse consequences, as well as repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.

Term	Definition
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Cost-Benefit Study	A study that determines the economic worth of an intervention by quantifying its costs in monetary terms and comparing them with the benefits, also expressed in monetary terms. Total benefits divided by total costs is called a cost-benefit ratio. If the ratio is greater than 1, the benefits outweigh the costs.
Cost-Effectiveness Study	A comparative analysis of two or more interventions against their health and economic outcomes. These outcomes could be lives saved, illnesses prevented, or years of life gained.
Dependence	A state in which an organism only functions normally in the presence of a substance, experiencing physical disturbance when the substance is removed. A person can be dependent on a substance without being addicted, but dependence sometimes leads to addiction
Dissemination	The active distribution of evidence-based interventions (EBIs) to specific audiences, with the goal of increasing their adoption.
Drug Diversion	A medical and legal concept involving the transfer of any legally prescribed controlled substance from the person for whom it was prescribed to another person for any illicit use.
Fidelity	The extent to which an intervention is delivered as it was designed and intended to be delivered.
Gender	The social, cultural, or community designations of masculinity or femininity.
Health Care System	The World Health Organization defines a health care system as (1) all the activities whose primary purpose is to promote, restore, and/or maintain health, and (2) the people, institutions, and resources, arranged together in accordance with established policies, to improve the health of the population they serve. The health care system is made up of diverse health care organizations ranging from primary care, specialty substance use disorder treatment (including residential and outpatient settings), mental health care, infectious disease clinics, school clinics, community health centers, hospitals, emergency departments, and others.
Health Disparities	Preventable differences in the burden of disease or opportunities to achieve optimal health that are experienced by socially disadvantaged populations, defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation.
Heavy Drinking	Defined by the Centers for Disease Control and Prevention (CDC) as consuming 8 or more drinks per week for women, and 15 or more drinks per week for men, and by the Substance Abuse and Mental Health Services Administration (SAMHSA), for research purposes, as binge drinking on 5 or more days in the past 30 days.
Implementation	A specified set of activities designed to put policies and programs into practice.
Impulsivity	Inability to resist urges, deficits in delaying gratification, and unreflective decision-making. Impulsivity is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long-term goals.
Inpatient Treatment	Intensive, 24-hour-a-day services delivered in a hospital setting.
Integration	The systematic coordination of general and behavioral health care. Integrating services for primary care, mental health, and substance use use-related problems together produces the best outcomes and provides the most effective approach for supporting whole-person health and wellness.

Term	Definition
Intervention	A professionally delivered program, service, or policy designed to prevent substance misuse (prevention intervention) or treat a substance use disorder (treatment intervention).
Learning Health Care System	As described by the IOM, a learning health care system is "designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care."
Longitudinal Study	A type of study in which data on a particular group of people are gathered repeatedly over a period of years or even decades.
Meaningful Use	Using certified EHR technology to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination and population and public health; and maintain privacy and security of patient health information.
Negative Reinforcement	The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.
Net Economic Benefit	The value of total benefits minus total costs.
Neurobiology	The study of the anatomy, function, and diseases of the brain and nervous system.
Opioid Treatment Program (OTP)	SAMHSA-certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have opioid use disorders. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.
Pharmacokinetics	What the body does to a drug after it has been taken, including how rapidly the drug is absorbed, broken down, and processed by the body.
Positive Reinforcement	The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.
Prescription Drug Misuse	Use of a drug in any way a doctor did not direct an individual to use it.
Prevalence	The proportion of a population who have (or had) a specific characteristic—for example, an illness, condition, behavior, or risk factor— in a given time period.
Protective Factors	Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.
Public Health System	Defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction" and includes state and local public health agencies, public safety agencies, health care providers, human service and charity organizations, recreation and arts-related organizations, economic and philanthropic organizations, education and youth development organizations, and education and youth development organizations.
Quality-Adjusted Life Year (QALY)	A measure of the burden of disease used in economic evaluations of the value of health care interventions that accounts for both the years of life lived and the quality of life experienced during those years, relative to quality associated with perfect health.
Randomized Controlled Trial (RCT)	A clinical trial of an intervention in which people are randomly assigned either to a group receiving the intervention being studied or to a *control group* receiving a standard intervention, a placebo (a medicine with no therapeutic effect), or no intervention. At the end of the study, the results from the different groups are compared.

Term	Definition
Recovery	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic substance use disorders can, with help, overcome their substance use disorder and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery". Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.
Relapse	The return to alcohol or drug use after a significant period of abstinence.
Remission	A medical term meaning that major disease symptoms are eliminated or diminished below a pre-determined, harmful level.
Residential Treatment	Intensive, 24-hour a day services delivered in settings other than a hospital.
Risk Factors	Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems associated with use.
Sex	The biological and physiological characteristics that define human beings as female or male.
Standard Drink	Based on the 2015-2020 Dietary Guidelines for Americans, a standard drink is defined as 12 fl. oz. of regular beer, 8-9 fl. oz. of malt liquor, 5 fl. oz. of table wine, or 1.5 fl. oz. of 80-proof distilled spirits. All of these drinks contain 14 grams (0.6 ounces) of pure alcohol.
Substance	A psychoactive compound with the potential to cause health and social problems, including substance use disorders (and their most severe manifestation, addiction).
Substance Misuse	The use of any substance in a manner, situation, amount or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute as misuse (e.g., under-age drinking, injection drug use).
Substance Misuse Problems or Consequences	Any health or social problem that results from substance misuse. Substance misuse problems or consequences may affect the substance user or those around them, and they may be acute (e.g., an argument or fight, a motor vehicle crash, an overdose) or chronic (e.g., a long-term substance-related medical, family, or employment problem, or chronic medical condition, such as various cancers, heart disease, and liver disease). These problems may occur at any age and are more likely to occur with greater frequency of substance misuse.
Substance Use	The use—even one time—of any substance.
Substance Use Disorders	A medical illness caused by repeated misuse of a substance or substances. According to the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), substance use disorders are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Note: Severe substance use disorders are commonly called *addictions*.
Substance Use Disorder Treatment	A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability.
Telehealth	The use of digital technologies such as electronic health records, mobile applications, telemedicine, and web-based tools to support the delivery of health care, health-related education, or other health-related services and functions.
Telemedicine	Two-way, real-time interactive communication between a patient and a physician or other health care professional at a distant site. Telemedicine is a subcategory of *telehealth*.

Term	Definition
Tolerance	Alteration of the body's responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.
Withdrawal	A set of symptoms that are experienced when discontinuing use of a substance to which a person has become dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.
Wrap-Around Services	Wrap -around services are non-clinical services that facilitate patient engagement and retention in treatment as well as their ongoing recovery. This can include services to address patient needs related to transportation, employment, childcare, housing, legal and financial problems, among others.

LIST OF ABBREVIATIONS

Abbreviation	Definition
AA	Alcoholics Anonymous
ACC	Accountable Care Community
ACO	Accountable Care Organization
AIDS	Acquired Immune Deficiency Syndrome
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Content
BASICS	Brief Alcohol Screening and Intervention for College Students
BNST	Bed Nucleus of the Stria Terminalis
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
CADCA	Community Anti-Drug Coalitions of America
CARA	Comprehensive Addiction and Recovery Act
CARPS	Computerized Alcohol-Related Problems Survey
CBT	Cognitive Behavioral Therapy
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CeA	Central Nucleus of the Amygdala
CHIP	Children's Health Insurance Program
CIDI	Composite International Diagnostic Interview
CMCA	Communities Mobilizing for Change on Alcohol
CMS	Centers for Medicare & Medicaid Services
CRF	Corticotropin-Releasing Factor
CSA	Controlled Substances Act
CTC	Communities That Care
DEA	Drug Enforcement Administration

Abbreviation	Definition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DUI	Driving Under the Influence
DS	Dorsal Striatum
EBI	Evidence-Based Interventions
EHR	Electronic Health Record
FASD	Fetal Alcohol Spectrum Disorder
FBT	Family Behavior Therapy
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
GABA	Gamma-Aminobutyric Acid
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICCPUD	Interagency Coordinating Committee on the Prevention of Underage Drinking
IOM	Institute of Medicine, now known as the Health and Medicine Division of the National Academies of Science, Engineering, and Medicine
LGBT	Lesbian, Gay, Bisexual, and Transgender
LST	Life Skills Training
MADD	Mothers Against Drunk Driving
MET	Motivational Enhancement Therapy
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
MLDA	Minimum Legal Drinking Age
MRI	Magnetic Resonance Imaging
NA	Narcotics Anonymous
NAc	Nucleus Accumbens
NASPER	National All Schedules Prescription Electronic Reporting Act
NFP	Nurse-Family Partnership Program
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
OTP	Opioid Treatment Program
PDMP	Prescription Drug Monitoring Program
PET	Positron Emission Tomography
PFC	Prefrontal Cortex
PRISM	Psychiatric Research Interview for Substance and Mental Disorders
PROSPER	PROmoting School-community-university Partnerships to Enhance Resilience

Abbreviation	Definition
PTSD	Post-Traumatic Stress Disorder
QALY	Quality-Adjusted Life Year
RHC	Raising Healthy Children
RMC	Recovery Management Check-up
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFP	Strengthening Families Program
SIM	State Innovation Models
SPA	State Plan Amendment
THC	Δ^9-tetrahydrocannabinol
USPSTF	U.S. Preventive Services Task Force
VTA	Ventral Tegmental Area

CHAPTER 2.
THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION

Chapter 2 Preview

A substantial body of research has accumulated over several decades and transformed our understanding of substance use and its effects on the brain. This knowledge has opened the door to new ways of thinking about prevention and treatment of substance use disorders.

This chapter describes the neurobiological framework underlying substance use and why some people transition from using or misusing alcohol or drugs to a substance use disorder—including its most severe form, addiction. The chapter explains how these substances produce changes in brain structure and function that promote and sustain addiction and contribute to relapse. The chapter also addresses similarities and differences in how the various classes of addictive substances affect the brain and behavior and provides a brief overview of key factors that influence risk for substance use disorders.

An Evolving Understanding of Substance Use Disorders

Scientific breakthroughs have revolutionized the understanding of substance use disorders. For example, severe substance use disorders, commonly called *addictions*, were once viewed largely as a moral failing or character flaw, but are now understood to be chronic illnesses characterized by clinically significant impairments in health, social function, and voluntary control over substance use.[3] Although the mechanisms may be different, addiction has many features in common with disorders such as diabetes, asthma, and hypertension. All of these disorders are chronic, subject to relapse, and influenced by genetic, developmental, behavioral, social, and environmental factors. In all of these disorders, affected individuals may have difficulty in complying with the prescribed treatment.[4]

This evolving understanding of substance use disorders as medical conditions has had important implications for prevention and treatment. Research demonstrating that addiction is driven by changes in the brain has helped to reduce the negative attitudes associated with substance use disorders and provided support for integrating treatment for substance use disorders into mainstream health care. Moreover, research on the basic neurobiology of addiction has already resulted in several effective

KEY FINDINGS*

- Well-supported scientific evidence shows that addiction to alcohol or drugs is a chronic brain disease that has potential for recurrence and recovery.
- Well-supported evidence suggests that the addiction process involves a three-stage cycle: binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation. This cycle becomes more severe as a person continues substance use and as it produces dramatic changes in brain function that reduce a person's ability to control his or her substance use.
- Well-supported scientific evidence shows that disruptions in three areas of the brain are particularly important in the onset, development, and maintenance of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex. These disruptions: (1) enable substance-associated cues to trigger substance seeking (i.e., they increase incentive salience); (2) reduce sensitivity of brain systems involved in the experience of pleasure or reward, and heighten activation of brain stress systems; and (3) reduce functioning of brain executive control systems, which are involved in the ability to make decisions and regulate one's actions, emotions, and impulses.
- Supported scientific evidence shows that these changes in the brain persist long after substance use stops. It is not yet known how much these changes may be reversed or how long that process may take.
- Well-supported scientific evidence shows that adolescence is a critical "at-risk period" for substance use and addiction. All addictive drugs, including alcohol and marijuana, have especially harmful effects on the adolescent brain, which is still undergoing significant development.

* Well-supported: when evidence is derived from multiple rigorous human and nonhuman studies; Supported: when evidence is derived from rigorous but fewer human and nonhuman studies.

medications for the treatment of alcohol, opioid, and nicotine use disorders, and clinical trials are ongoing to test other potential new treatments.[5]

All addictive substances have powerful effects on the brain. These effects account for the euphoric or intensely pleasurable feelings that people experience during their initial use of alcohol or other substances, and these feelings motivate people to use those substances again and again, despite the risks for significant harms.

FOR MORE ON THIS TOPIC

See the section on *"Factors that Increase Risk for Substance Use, Misuse, and Addiction"* later in this chapter.

As individuals continue to misuse alcohol or other substances, progressive changes, called *neuroadaptations*, occur in the structure and function of the brain. These neuroadaptations compromise brain function and also drive the transition from controlled, occasional substance use to chronic misuse, which can be difficult to control. Moreover, these brain changes endure long after an individual stops using substances. They may produce continued, periodic craving for the substance that can lead to relapse: More than 60 percent of people treated for a substance use disorder experience relapse within the first year after they are discharged from treatment,[4,6] and a person can remain at increased risk of relapse for many years.[7,8]

However, addiction is not an inevitable consequence of substance use. Whether an individual ever uses alcohol or another substance, and whether that initial use progresses to a substance use disorder of any severity, depends on a number of factors. These include: a person's genetic makeup and other individual

biological factors; the age when use begins; psychological factors related to a person's unique history and personality; and environmental factors, such as the availability of drugs, family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support.[9] Some of these factors increase risk for substance use, misuse, and use disorders, whereas other factors provide buffers against those risks. Nonetheless, specific combinations of factors can drive the emergence and continuation of substance misuse and the progression to a disorder or an addiction.

FOR MORE ON THIS TOPIC

See Chapter 3 - *Prevention Programs and Policies.*

Conducting Research on the Neurobiology of Substance Use, Misuse, and Addiction

Until recently, much of our knowledge about the neurobiology of substance use, misuse, and addiction came from the study of laboratory animals. Although no animal model fully reflects the human experience, animal studies let researchers investigate addiction under highly controlled conditions that may not be possible or ethical to replicate in humans. These types of studies have greatly helped to answer questions about how particular genes, developmental processes, and environmental factors, such as stressors, affect substance-taking behavior.

KEY TERMS

Neurobiology. The study of the anatomy, function, and diseases of the brain and nervous system.

Neurobiology studies in animals have historically focused on what happens in the brain right after taking an addictive substance (this is called the acute impact), but research has shifted to the study of how ongoing, long-term (or chronic) substance use changes the brain. One of the main goals of this research is to understand at the most basic level the mechanisms through which substance use alters brain structure and function and drives the transition from occasional use to misuse, addiction, and relapse.[10]

A growing body of substance use research conducted with humans is complementing the work in animals. For example, human studies have benefited greatly from the use of brain-imaging technologies, such as magnetic resonance imaging (MRI) and positron emission tomography (PET) scans. These technologies allow researchers to "see" inside the living human brain so that they can investigate and characterize the biochemical, functional, and structural changes in the brain that result from alcohol and drug use. The technologies also allow them to understand how differences in brain structure and function may contribute to substance use, misuse, and addiction.

Animal and human studies build on and inform each other, and in combination provide a more complete picture of the neurobiology of addiction. The rest of this chapter weaves together the most compelling data from both types of studies to describe a neurobiological framework for addiction.

A Basic Primer on the Human Brain

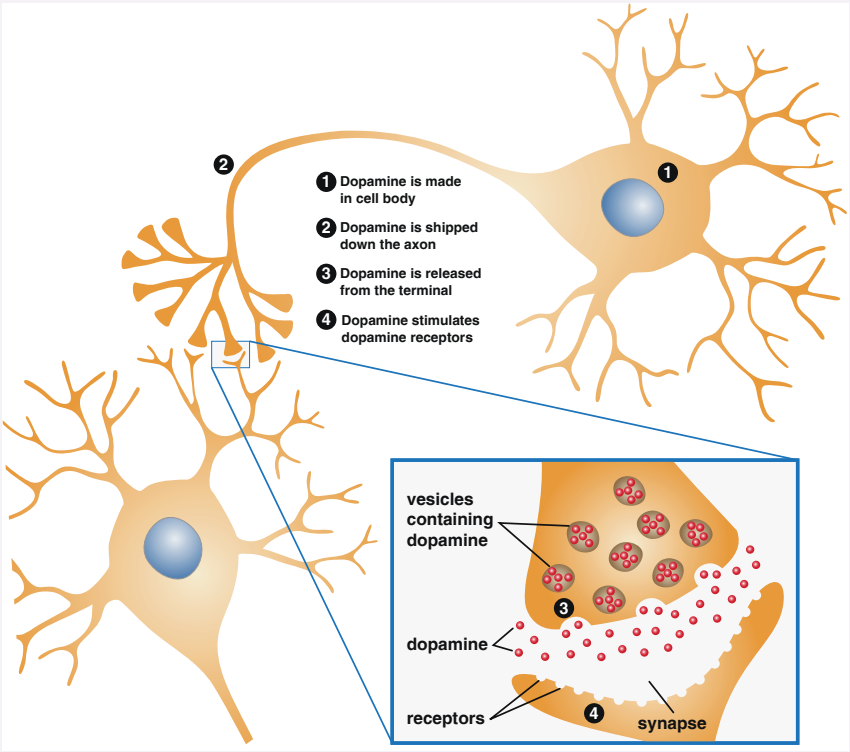
To understand how addictive substances affect the brain, it is important to first understand the basic biology of healthy brain function. The brain is an amazingly complex organ that is constantly at work. Within the brain, a mix of chemical and electrical processes controls the body's most basic functions, like breathing and digestion. These processes also control how people react to the multitudes of sounds, smells, and other sensory stimuli around them, and they organize and direct individuals' highest thinking and emotive powers so that they can interact with other people, carry out daily activities, and make complex decisions.

The brain is made of an estimated 86 billion nerve cells—called neurons—as well as other cell types. Each neuron has a cell body, an axon, and dendrites (Figure 2.1). The cell body and its nucleus control the neuron's activities. The axon extends out from the cell body and transmits messages to other neurons. Dendrites branch out from the cell body and receive messages from the axons of other neurons.

Neurons communicate with one another through chemical messengers called neurotransmitters. The neurotransmitters cross a tiny gap, or synapse, between neurons and attach to receptors on the receiving neuron. Some neurotransmitters are inhibitory—they make it less likely that the receiving neuron will carry out some action. Others are excitatory, meaning that they stimulate neuronal function, priming it to send signals to other neurons.

Neurons are organized in clusters that perform specific functions (described as networks or circuits). For example, some networks are involved with thinking, learning, emotions, and memory. Other networks communicate with muscles, stimulating them into action. Still others receive and interpret stimuli from the sensory organs, such as the eyes and ears, or the skin. The addiction cycle disrupts the normal functions of some of these neuronal networks.

Figure 2.1: A Neuron and its Parts

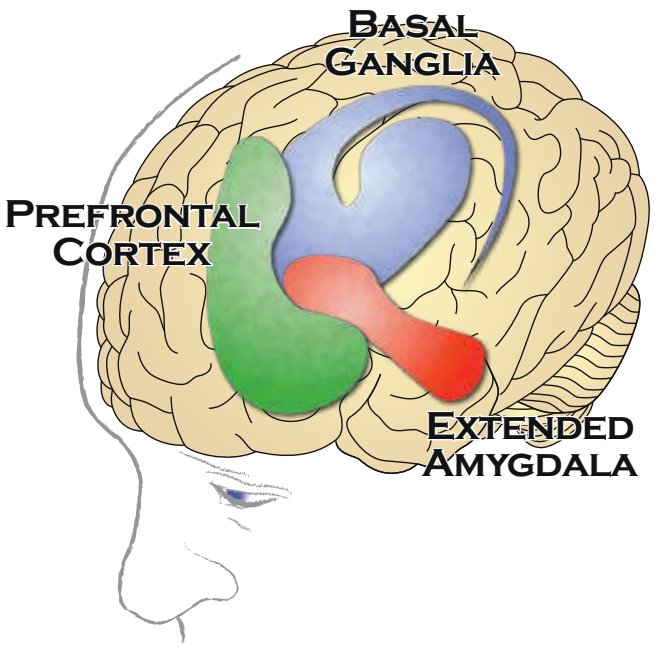


The Primary Brain Regions Involved in Substance Use Disorders

The brain has many regions that are interconnected with one another, forming dynamic networks that are responsible for specific functions, such as attention, self-regulation, perception, language, reward, emotion, and movement, along with many other functions. This chapter focuses on three regions that are the key components of networks that are intimately involved in the development and persistence of substance use disorders: the **basal ganglia**, the **extended amygdala**, and the **prefrontal cortex** (Figure 2.2). The basal ganglia control the rewarding, or pleasurable, effects of substance use and are also responsible for the formation of habitual substance taking. The extended amygdala is involved in stress and the feelings of unease, anxiety, and irritability that typically accompany substance withdrawal. The prefrontal cortex is involved in executive function (i.e., the ability to organize thoughts and activities, prioritize tasks, manage time, and make decisions), including exerting control over substance taking.

These brain areas and their associated networks are not solely involved in substance use disorders. Indeed, these systems are broadly integrated and serve many critical roles in helping humans and other animals survive. For example, when people engage in certain activities, such as consuming food or having sex, chemicals within the basal ganglia produce feelings of pleasure. This reward motivates individuals to continue to engage in these activities, thereby ensuring the survival of the species. Likewise, in the face of danger, activation of the brain's stress systems within the extended amygdala drives "fight or flight" responses. These responses, too, are critical for survival. As described in more detail below, these and other survival systems are "hijacked" by addictive substances.

Figure 2.2: Areas of the Human Brain that Are Especially Important in Addiction



The Basal Ganglia

The basal ganglia are a group of structures located deep within the brain that play an important role in keeping body movements smooth and coordinated. They are also involved in learning routine behaviors and forming habits. Two sub-regions of the basal ganglia are particularly important in substance use disorders:

- The nucleus accumbens, which is involved in motivation and the experience of reward, and
- The dorsal striatum, which is involved in forming habits and other routine behaviors.[11]

The Extended Amygdala

The extended amygdala and its sub-regions, located beneath the basal ganglia, regulate the brain's reactions to stress-including behavioral responses like "fight or flight" and negative emotions like unease, anxiety, and irritability. This region also interacts with the hypothalamus, an area of the brain that controls activity of multiple hormone-producing glands, such as the pituitary gland at the base of the brain and the adrenal glands at the top of each kidney. These glands, in turn, control reactions to stress and regulate many other bodily processes.[12]

The Prefrontal Cortex

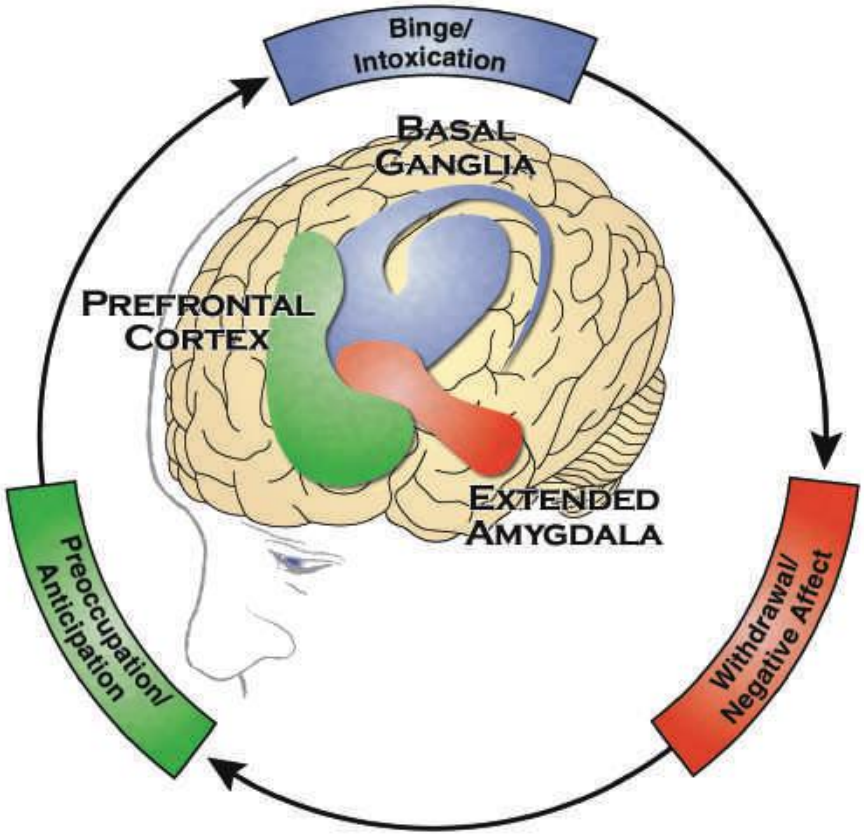
The prefrontal cortex is located at the very front of the brain, over the eyes, and is responsible for complex cognitive processes described as "executive function." Executive function is the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's actions, emotions, and impulses.[13]

The Addiction Cycle

Addiction can be described as a repeating cycle with three stages. Each stage is particularly associated with one of the brain regions described above—basal ganglia, extended amygdala, and prefrontal cortex (**Figure 2.3**).[10] This three-stage model draws on decades of human and animal research and provides a useful way to understand the symptoms of addiction, how it can be prevented and treated, and how people can recover from it.[14] The three stages of addiction are:

- **Binge/Intoxication**, the stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects;
- **Withdrawal/Negative Affect**, the stage at which an individual experiences a negative emotional state in the absence of the substance; and
- **Preoccupation/Anticipation**, the stage at which one seeks substances again after a period of abstinence.

Figure 2.3: The Three Stages of the Addiction Cycle and the Brain Regions Associated with Them



The three stages are linked to and feed on each other, but they also involve different brain regions, circuits (or networks), and neurotransmitters and result in specific kinds of changes in the brain. A person may go through this three-stage cycle over the course of weeks or months or progress through it several times in a day. There may be variation in how people progress through the cycle and the intensity with which they experience each of the stages. Nonetheless, the addiction cycle tends to intensify over time, leading to greater physical and psychological harm.[10]

The following sections describe each of the stages in more detail. But first, it is necessary to explain four behaviors that are central to the addiction cycle: impulsivity, positive reinforcement, negative reinforcement, and compulsivity.

For many people, initial substance use involves an element of impulsivity, or acting without foresight or regard for the consequences. For example, an adolescent may impulsively take a first drink, smoke a cigarette, begin experimenting with marijuana, or succumb to peer pressure to try a party drug. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again.

Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings negatively reinforces

substance use, increasing the likelihood that the person will use again. Importantly, positive and negative reinforcement need not be driven solely by the effects of the drugs. Many other environmental and social stimuli can reinforce a behavior. For example, the approval of peers positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides relief from social isolation, substance use behavior could be negatively reinforced.

The positively reinforcing effects of substances tend to diminish with repeated use. This is called tolerance and may lead to use of the substance in greater amounts and/or more frequently in an attempt to experience the initial level of reinforcement. Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression, or feel physically ill. This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms.

As use becomes an ingrained behavior, impulsivity shifts to compulsivity, and the primary drivers of repeated substance use shift from positive reinforcement (feeling pleasure) to negative reinforcement (feeling relief), as the person seeks to stop the negative feelings and physical illness that accompany withdrawal.[15] Eventually, the person begins taking the substance not to get "high," but rather to escape the "low" feelings to which, ironically, chronic drug use has contributed. Compulsive substance seeking is a key characteristic of addiction, as is the loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after attempting to abstain from or reduce use.

KEY TERMS

Impulsivity. An inability to resist urges, deficits in delaying gratification, and unreflective decision-making. It is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long-term goals.[1]

Positive reinforcement. The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

Negative reinforcement. The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.

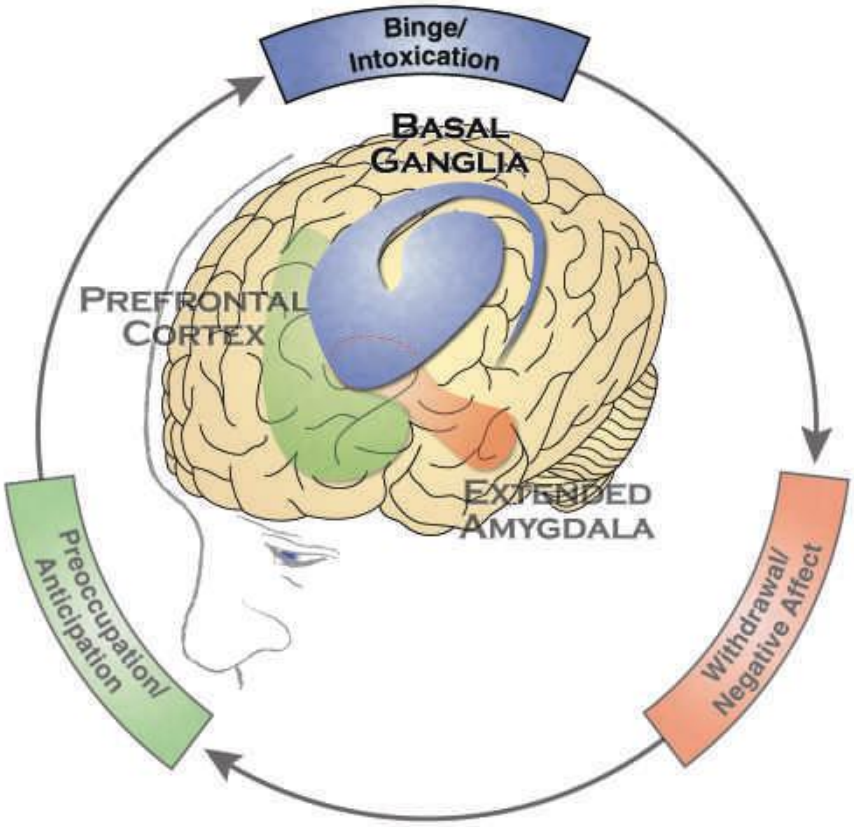
Compulsivity. Repetitive behaviors in the face of adverse consequences, and repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.[1]

The following sections provide more detail about each of the three stages—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—and the neurobiological processes underlying them.

Binge/Intoxication Stage: Basal Ganglia

The binge/intoxication stage of the addiction cycle is the stage at which an individual consumes the substance of choice. This stage heavily involves the basal ganglia (Figure 2.4) and its two key brain sub-regions, the nucleus accumbens and the dorsal striatum. In this stage, substances affect the brain in several ways.

Figure 2.4: The Binge/Intoxication Stage and the Basal Ganglia



Addictive Substances "Hijack" Brain Reward Systems

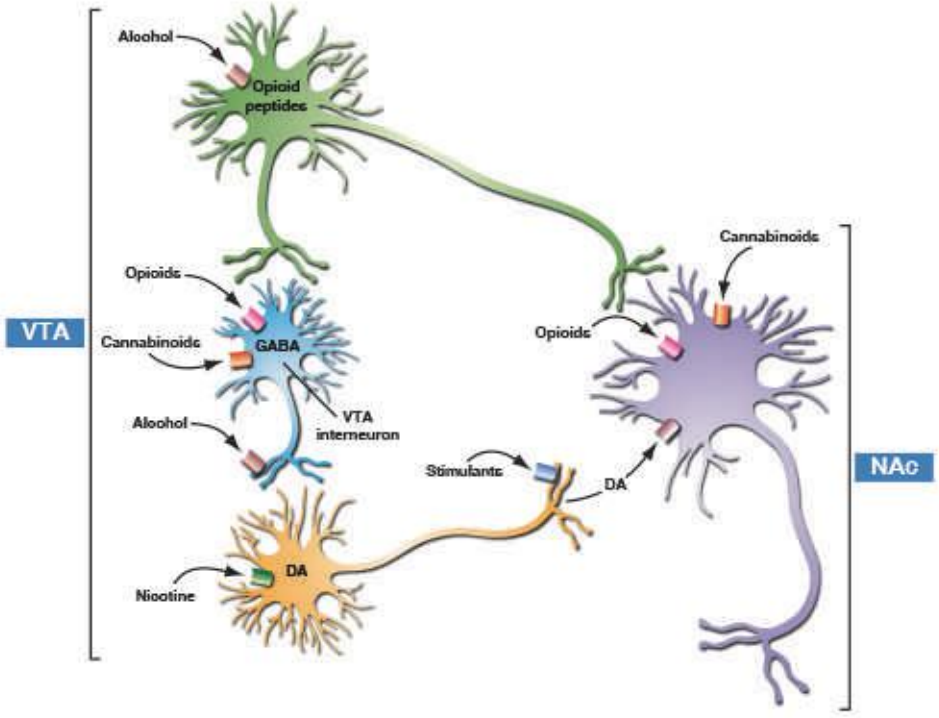
All addictive substances produce feelings of pleasure. These "rewarding effects" positively reinforce their use and increase the likelihood of repeated use. The rewarding effects of substances involve activity in the nucleus accumbens, including activation of the brain's dopamine and opioid signaling system. Many studies have shown that neurons that release dopamine are activated, either directly or indirectly, by all addictive substances, but particularly by stimulants such as cocaine, amphetamines, and nicotine (Figure 2.5).[16] In addition, the brain's opioid system, which includes naturally occurring opioid molecules (i.e., endorphins, enkephalins, and dynorphins) and three types of opioid receptors (i.e., mu, delta, and kappa), plays a key role in mediating the rewarding effects of other addictive substances, including opioids and alcohol. Activation of the opioid system by these substances stimulates the nucleus accumbens directly or indirectly through the dopamine system. Brain imaging studies in humans show activation of dopamine and opioid neurotransmitters during alcohol and other substance use (including nicotine).[10,17] Other studies show that antagonists, or inhibitors, of dopamine and opioid receptors can block drug and alcohol seeking in both animals and humans.[14,18,19]

KEY TERMS

Antagonist. A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone is an example of an opioid receptor antagonist.

Cannabinoids such as delta-9-tetrahydrocannabinol (THC), the primary psychoactive component of marijuana, target the brain's internal or endogenous cannabinoid system. This system also contributes to reward by affecting the function of dopamine neurons and the release of dopamine in the nucleus accumbens.

Figure 2.5: Actions of Addictive Substances on the Brain



Notes: Figure 2.5 is a simplified schematic of converging acute rewarding actions of addictive substances on the nucleus accumbens (NAc). Dopamine neurons that originate in the ventral tegmental area (VTA) project to the NAc. Opioid peptides act both in the VTA and NAc. Despite diverse initial actions, addictive substances produce some common effects on the VTA and NAc. Stimulants directly increase dopamine (DA) transmission in the NAc. Opioids, alcohol, and inhalants (e.g., the solvent toluene) do the same indirectly. Alcohol also activates the release of opioid peptides. Heroin and prescribed opioid pain relievers directly activate opioid peptide receptors. Nicotine activates dopamine neurons in the VTA. Cannabinoids may act in the VTA to activate dopamine neurons but also act on NAc neurons themselves.

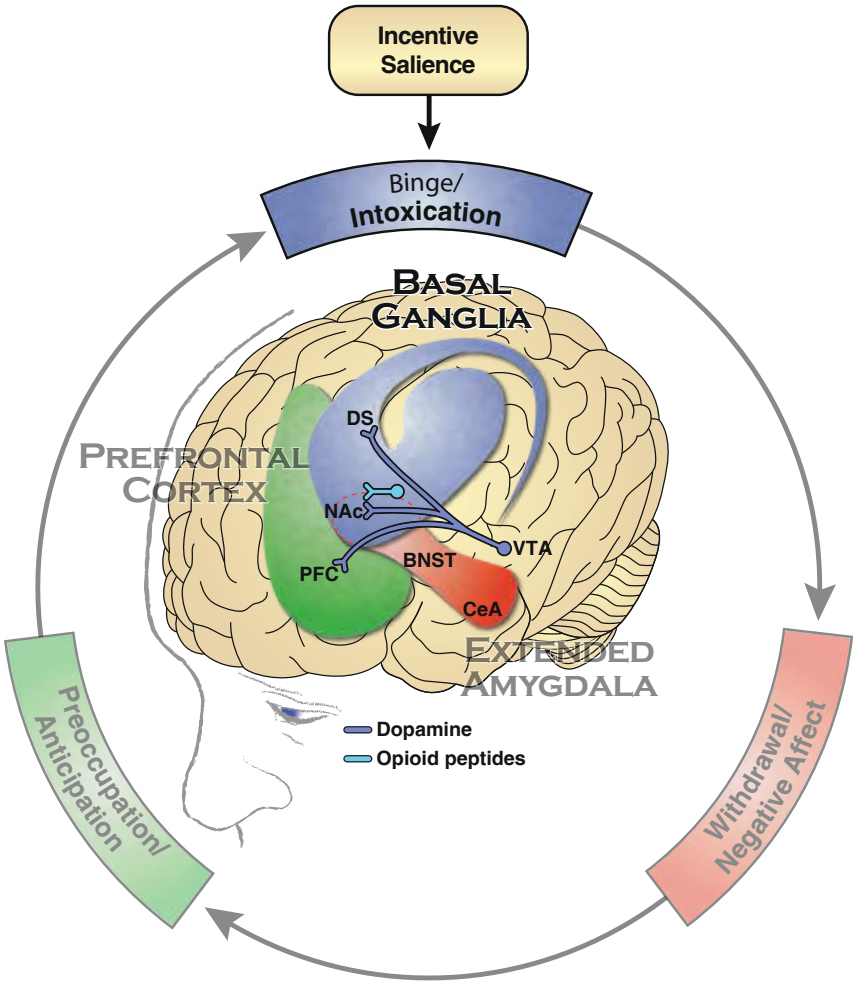
Source: Modified with permission from Nestler, (2005).[16]

Stimuli Associated with Addictive Substances Can Trigger Substance Use

Activation of the brain's reward system by alcohol and drugs not only generates the pleasurable feelings associated with those substances, it also ultimately triggers changes in the way a person responds to stimuli associated with the use of those substances. A person learns to associate the stimuli present while using a substance—including people, places, drug paraphernalia, and even internal states, such as mood—with the substance's rewarding effects. Over time, these stimuli can activate the dopamine system on their own and trigger powerful urges to take the substance. These "wanting" urges are called incentive salience and they can persist even after the rewarding effects of the substance have diminished. As a result, exposure to people, places, or things previously associated with substance use can serve as "triggers" or cues that promote substance seeking and taking, even in people who are in recovery.

Figure 2.6 shows the major neurotransmitter systems involved in the binge/intoxication stage of addiction. In this stage, the neurons in the basal ganglia contribute to the rewarding effects of addictive substances and to incentive salience through the release of dopamine and the brain's natural opioids.

Figure 2.6: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Binge/Intoxication Stage of Addiction



Notes: Blue represents the basal ganglia involved in the Binge/Intoxication stage. Red represents the extended amygdala involved in the Negative Affect/Withdrawal stage. Green represents the prefrontal cortex involved in the Preoccupation/Anticipation stage.

Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

Early studies in animals demonstrated how incentive salience works. For example, after researchers repeatedly gave an animal a stimulant drug (e.g., cocaine) along with a previously neutral stimulus, such as a light or a sound, they found that the neutral stimulus by itself caused the animal to engage in drug-seeking behavior, and it also resulted in dopamine release that had previously occurred only in response to the drug.[20] Even more compelling results were seen when scientists recorded the electrical activity of dopamine-transmitting neurons in animals that had been exposed multiple times to a neutral (non-

drug) stimulus followed by a drug. At first, the neurons responded only when they were exposed to the drug. However, over time, the neurons stopped firing in response to the drug and instead fired when they were exposed to the neutral stimulus associated with it. This means that the animals associated the stimulus with the substance and, in anticipation of getting the substance, their brains began releasing dopamine, resulting in a strong motivation to seek the drug.[21,22] Imaging studies in humans have shown similar results. For example, dopamine is released in the brains of people addicted to cocaine when they are exposed to cues they have come to associate with cocaine.[23,24] This effect occurs even though cocaine itself causes less dopamine to be released in these individuals compared to those who are not addicted to cocaine (an effect also seen with other substances).[25]

Together, these studies indicate that stimuli associated with addictive drugs can, by themselves, produce drug-like effects on the brain and trigger drug use. These findings help to explain why individuals with substance use disorders who are trying to maintain abstinence are at increased risk of relapse if they continue to have contact with the people they previously used drugs with or the places where they used drugs.

Substances Stimulate Areas of the Brain Involved in Habit Formation

A second sub-region of the basal ganglia, the dorsal striatum, is involved in another critical component of the binge/intoxication stage: habit formation. The release of dopamine (along with activation of brain opioid systems) and release of glutamate (an excitatory neurotransmitter) can eventually trigger changes in the dorsal striatum.[2,26] These changes strengthen substance-seeking and substance-taking habits as addiction progresses, ultimately contributing to compulsive use.

In Summary: The Binge/Intoxication Stage and the Basal Ganglia

The "reward circuitry" of the basal ganglia (i.e., the nucleus accumbens), along with dopamine and naturally occurring opioids, play a key role in the rewarding effects of alcohol and other substances and the ability of stimuli, or cues, associated with that substance use to trigger craving, substance seeking, and use.

As alcohol or substance use progresses, repeated activation of the "habit circuitry" of the basal ganglia (i.e., the dorsal striatum) contributes to the compulsive substance seeking and taking that are associated with addiction.

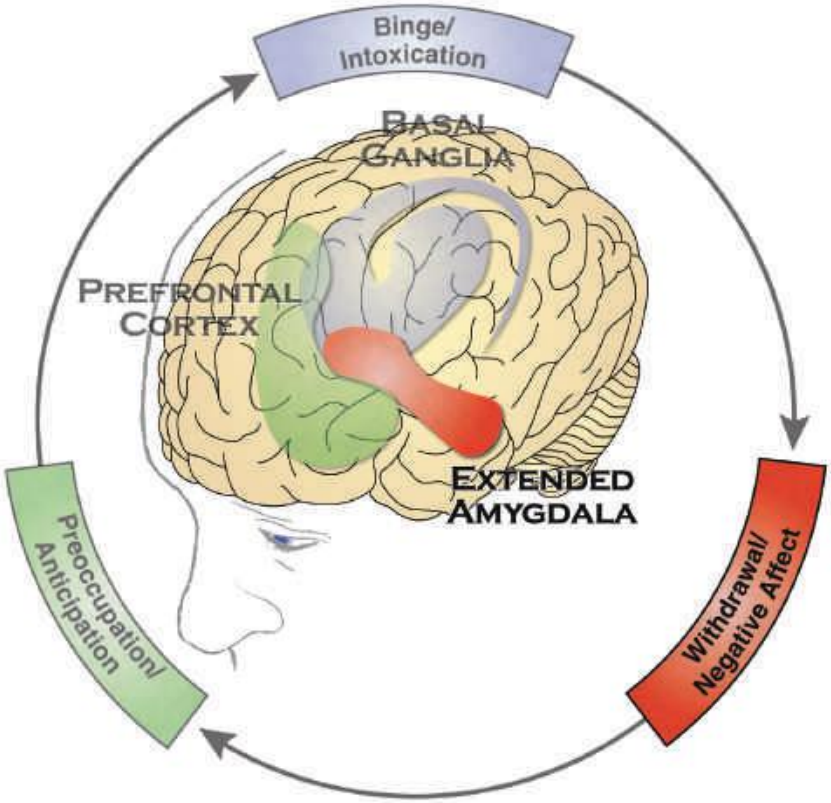
The involvement of these reward and habit neurocircuits helps explain the intense desire for the substance (craving) and the compulsive substance seeking that occurs when actively or previously addicted individuals are exposed to alcohol and/or drug cues in their surroundings.

Withdrawal/Negative Affect Stage: Extended Amygdala

The withdrawal/negative affect stage of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, which include negative emotions and, sometimes, symptoms of physical illness, when they stop taking the substance. Symptoms of withdrawal may occur with all

addictive substances, including marijuana, though they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry of the basal ganglia[14] and activation of the brain's stress systems in the extended amygdala (Figure 2.7).

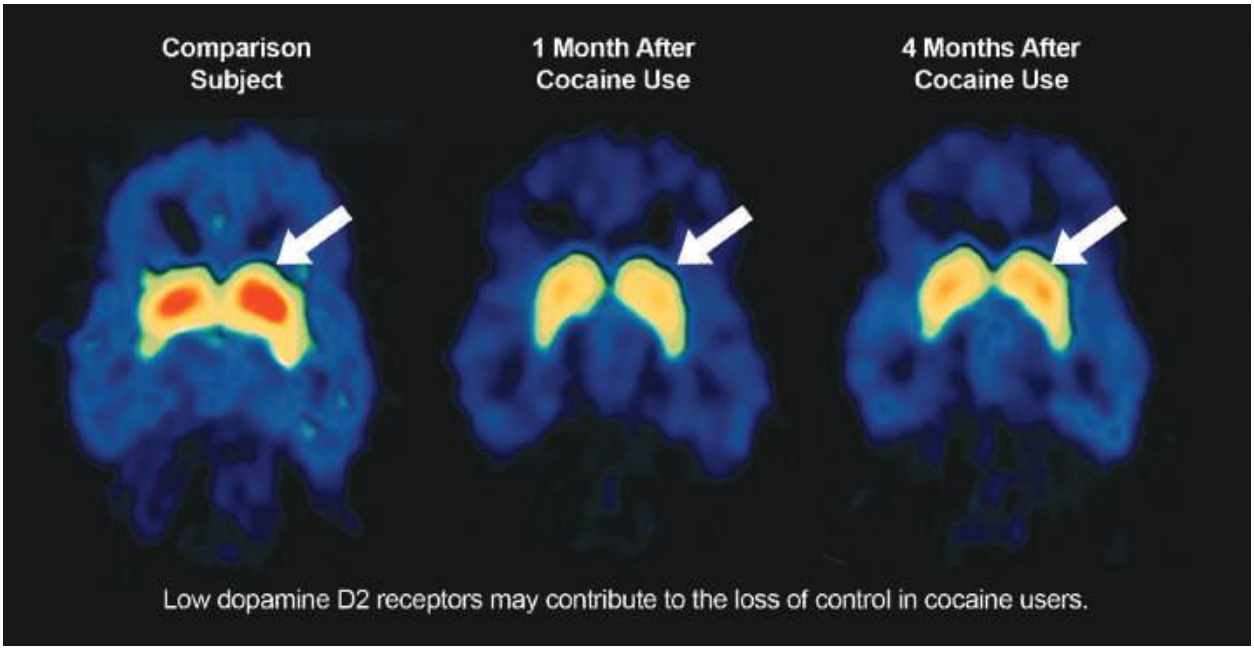
Figure 2.7: The Withdrawal/Negative Affect Stage and the Extended Amygdala



When used over the long-term, all substances of abuse cause dysfunction in the brain's dopamine reward system.[27] For example, brain imaging studies in humans with addiction have consistently shown long-lasting decreases in a particular type of dopamine receptor, the D2 receptor, compared with non-addicted individuals (Figure 2.8).[25,28] Decreases in the activity of the dopamine system have been observed during withdrawal from stimulants, opioids, nicotine, and alcohol. Other studies also show that when an addicted person is given a stimulant, it causes a smaller release of dopamine than when the same dose is given to a person who is not addicted.

These findings suggest that people addicted to substances experience an overall reduction in the sensitivity of the brain's reward system (especially the brain circuits involving dopamine), both to addictive substances and also to natural reinforcers, such as food and sex. This is because natural reinforcers also depend upon the same reward system and circuits. This impairment explains why those who develop a substance use disorder often do not derive the same level of satisfaction or pleasure from once-pleasurable activities. This general loss of reward sensitivity may also account for the compulsive escalation of substance use as addicted individuals attempt to regain the pleasurable feelings the reward system once provided.[15]

Figure 2.8: Time-Related Decrease in Dopamine Released in the Brain of a Cocaine User



Notes: These fMRI images compare the brain of an individual with a history of cocaine use disorder (middle and right) to the brain of an individual without a history of cocaine use (left). The person who has had a cocaine use disorder has lower levels of the D2 dopamine receptor (depicted in red) in the striatum one month (middle) and four months (right) after stopping cocaine use compared to the non-user. The level of dopamine receptors in the brain of the cocaine user are higher at the 4-month mark (right), but have not returned to the levels observed in the non-user (left).

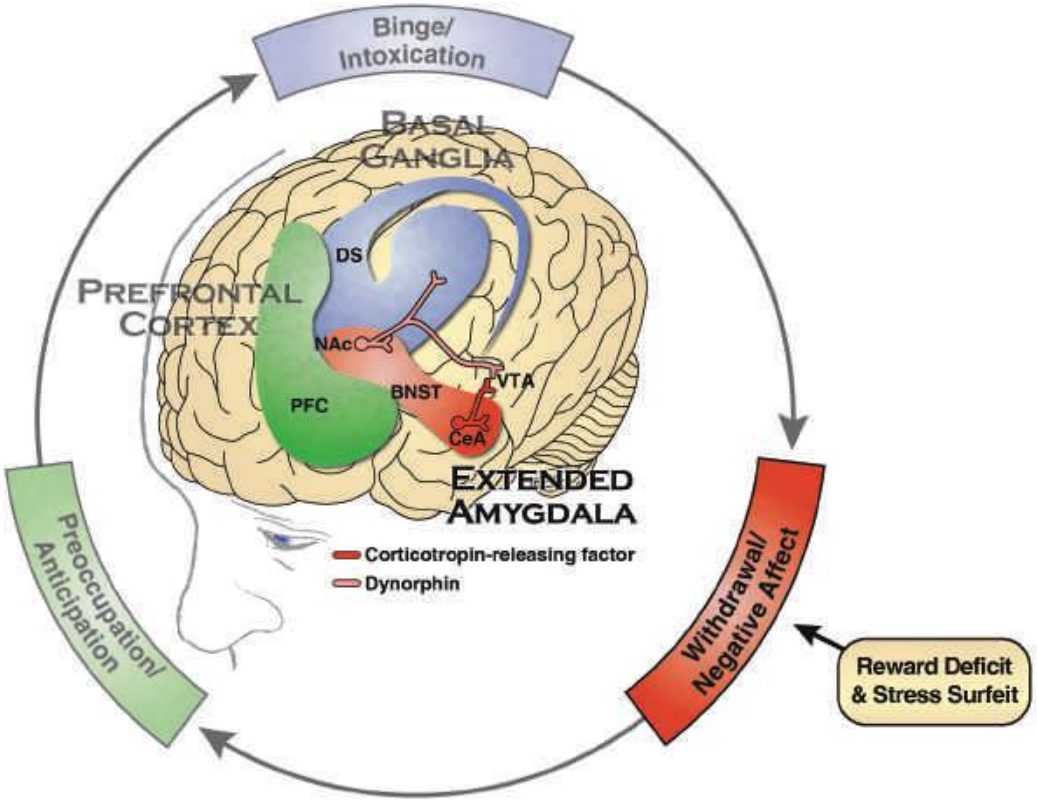
Source: Modified with permission from Volkow et al., (1993).[29]

At the same time, a second process occurs during the withdrawal stage: activation of stress neurotransmitters in the extended amygdala. These stress neurotransmitters include corticotropin-releasing factor (CRF), norepinephrine, and dynorphin (**Figure 2.9**).[30]

Studies suggest that these neurotransmitters play a key role in the negative feelings associated with withdrawal and in stress-triggered substance use. In animal and human studies, when researchers use special chemicals called antagonists to block activation of the stress neurotransmitter systems, it has the effect of reducing substance intake in response to withdrawal and stress. For example, blocking the activation of stress receptors in the brain reduced alcohol consumption in both alcohol-dependent rats and humans with an alcohol use disorder.[31] Thus, it may be that an additional motivation for drug and alcohol seeking among individuals with substance use disorders is to suppress overactive brain stress systems that produce negative emotions or feelings. Recent research also suggests that neuroadaptations in the endogenous cannabinoid system within the extended amygdala contribute to increased stress reactivity and negative emotional states in addiction.[32]

The desire to remove the negative feelings that accompany withdrawal can be a strong motivator of continued substance use. As noted previously, this motivation is strengthened through negative reinforcement, because taking the substance relieves the negative feelings associated with withdrawal, at least temporarily. Of course, this process is a vicious cycle: Taking drugs or alcohol to lessen the symptoms of withdrawal that occur during a period of abstinence actually causes those symptoms to be even worse the next time a person stops taking the substance, making it even harder to maintain abstinence.

Figure 2.9: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Withdrawal/Negative Affect Stage of Addiction



Notes: Not shown is the neurotransmitter norepinephrine which is also activated in the extended amygdala during withdrawal.

Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

In Summary: The Withdrawal/Negative Affect Stage and the Extended Amygdala

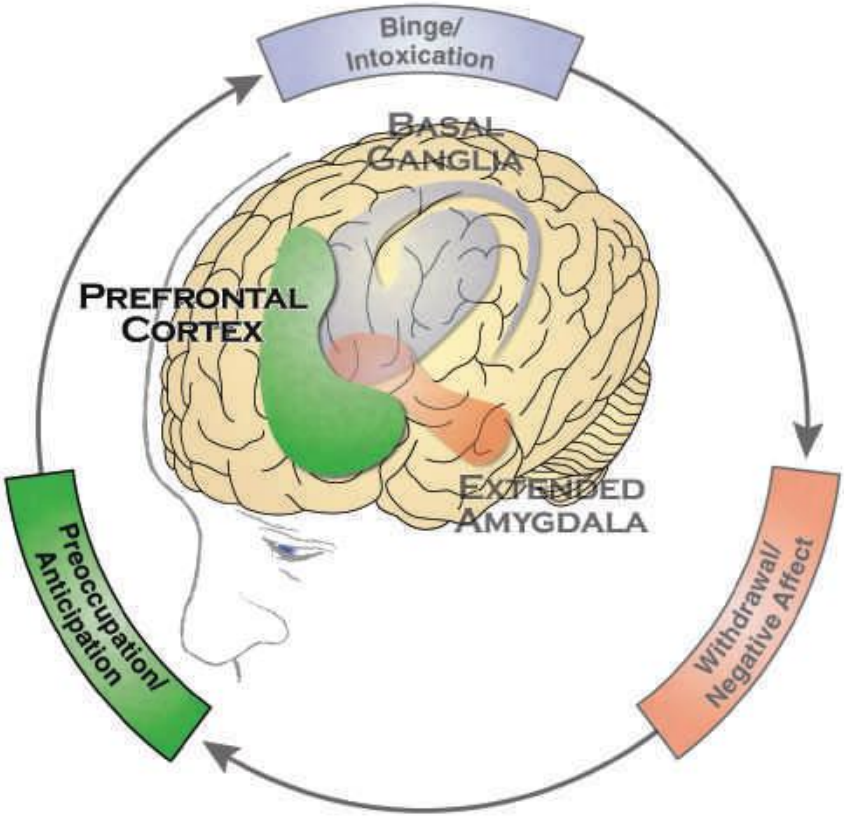
This stage of addiction involves a decrease in the function of the brain reward systems and an activation of stress neurotransmitters, such as CRF and dynorphin, in the extended amygdala. Together, these phenomena provide a powerful neurochemical basis for the negative emotional state associated with withdrawal. The drive to alleviate these negative feelings negatively reinforces alcohol or drug use and drives compulsive substance taking.

Preoccupation/Anticipation Stage: Prefrontal Cortex

The preoccupation/anticipation stage of the addiction cycle is the stage in which a person may begin to seek substances again after a period of abstinence. In people with severe substance use disorders, that period of abstinence may be quite short (hours). In this stage, an addicted person becomes preoccupied with using substances again. This is commonly called "craving." Craving has been difficult to measure in human studies and often does not directly link with relapse.

This stage of addiction involves the brain's prefrontal cortex (Figure 2.10) the region that controls executive function: the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's own actions, emotions, and impulses. Executive function is essential for a person to make appropriate choices about whether or not to use a substance and to override often strong urges to use, especially when the person experiences triggers, such as stimuli associated with that substance (e.g., being at a party where alcohol is served or where people are smoking) or stressful experiences.

Figure 2.10: The Preoccupation/Anticipation Stage and the Prefrontal Cortex

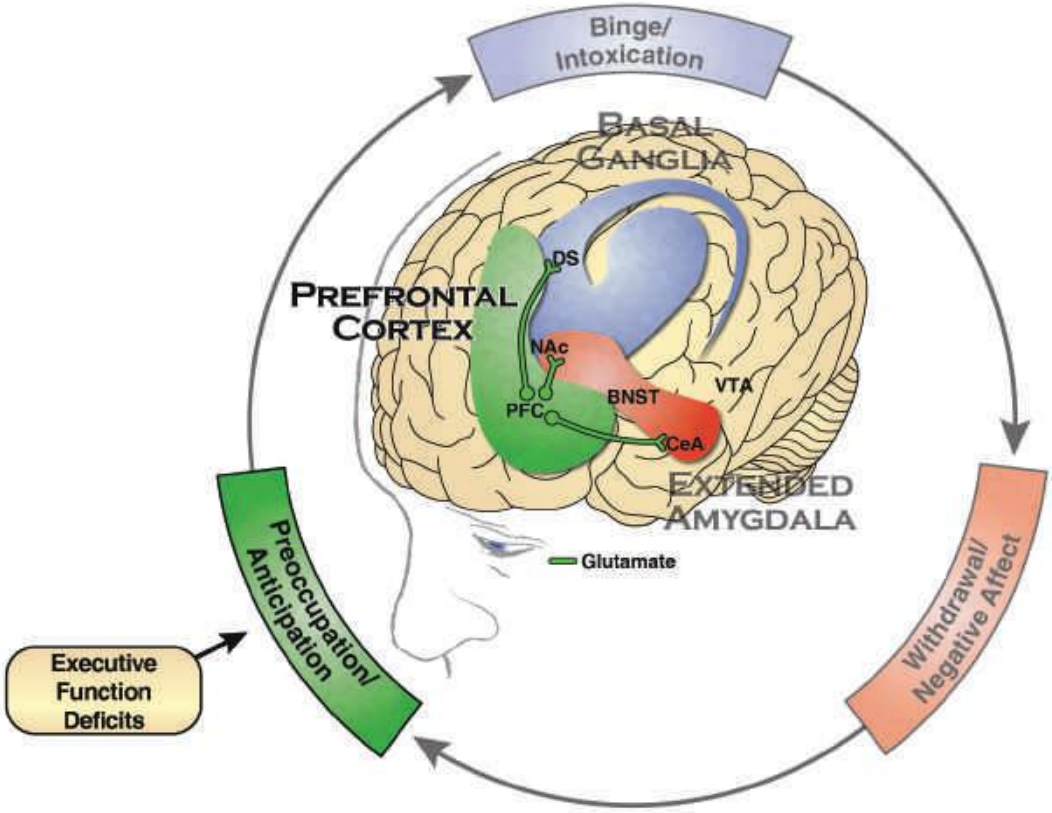


To help explain how the prefrontal cortex is involved in addiction, some scientists divide the functions of this brain region into a "Go system" and an opposing "Stop system."[33] The Go system helps people make decisions, particularly those that require significant attention and those involved with planning. People also engage the Go system when they begin behaviors that help them achieve goals. Indeed, research shows that when substance-seeking behavior is triggered by substance-associated environmental cues (incentive salience), activity in the Go circuits of the prefrontal cortex increases dramatically. This increased activity stimulates the nucleus accumbens to release glutamate, the main excitatory neurotransmitter in the brain. This release, in turn, promotes incentive salience, which creates a powerful urge to use the substance in the presence of drug-associated cues.

The Go system also engages habit-response systems in the dorsal striatum, and it contributes to the impulsivity associated with substance seeking. Habitual responding can occur automatically and subconsciously, meaning a person may not even be aware that they are engaging in such behaviors. The

neurons in the Go circuits of the prefrontal cortex stimulate the habit systems of the dorsal striatum through connections that use glutamate (Figure 2.11).

Figure 2.11: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Preoccupation/Anticipation Stage of Addiction



Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

The Stop system inhibits the activity of the Go system. Especially relevant to its role in addiction, this system controls the dorsal striatum and the nucleus accumbens, the areas of the basal ganglia that are involved in the binge/intoxication stage of addiction. Specifically, the Stop system controls habit responses driven by the dorsal striatum, and scientists think that it plays a role in reducing the ability of substance-associated stimuli to trigger relapse—in other words, it inhibits incentive salience.[34]

The Stop system also controls the brain's stress and emotional systems, and plays an important role in relapse triggered by stressful life events or circumstances. Stress-induced relapse is driven by activation of neurotransmitters such as CRF, dynorphin, and norepinephrine in the extended amygdala. As described above, these neurotransmitters are activated during prolonged abstinence during the withdrawal/negative affect stage of addiction. More recent work in animals also implicates disruptions in the brain's cannabinoid system, which also regulates the stress systems in the extended amygdala, in relapse. Studies show that lower activity in the Stop component of the prefrontal cortex is associated with increased activity of stress circuitry involving the extended amygdala, and this increased activity drives substance-taking behavior and relapse.[37]

Brain imaging studies in people with addiction show disruptions in the function of both the Go and Stop circuits.[35-37] For example, people with alcohol, cocaine, or opioid use disorders show impairments in executive function, including disruption of decision-making and behavioral inhibition. These executive function deficits parallel changes in the prefrontal cortex and suggest decreased activity in the Stop system and greater reactivity of the Go system in response to substance-related stimuli.

Indeed, a smaller volume of the prefrontal cortex in abstinent, previously addicted individuals predicts a shorter time to relapse.[38] Studies also show that diminished prefrontal cortex control over the extended amygdala is particularly prominent in humans with post-traumatic stress disorder (PTSD), a condition that is frequently accompanied by drug and alcohol use disorders.[39] These findings bolster support for the role of the prefrontal cortex-extended amygdala circuit in stress-induced relapse, and suggest that strengthening prefrontal cortex circuits could aid substance use disorder treatment.

In Summary: The Preoccupation/Anticipation Stage and the Prefrontal Cortex

This stage of the addiction cycle is characterized by a disruption of executive function caused by a compromised prefrontal cortex. The activity of the neurotransmitter glutamate is increased, which drives substance use habits associated with craving, and disrupts how dopamine influences the frontal cortex.[2] The over-activation of the Go system in the prefrontal cortex promotes habit-like substance seeking, and the under-activation of the Stop system of the prefrontal cortex promotes impulsive and compulsive substance seeking.

To recap, addiction involves a three-stage cycle—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—that worsens over time and involves dramatic changes in the brain reward, stress, and executive function systems. Progression through this cycle involves three major regions of the brain: the basal ganglia, the extended amygdala, and the prefrontal cortex, as well as multiple neurotransmitter systems (**Figure 2.12**). The power of addictive substances to produce positive feelings and relieve negative feelings fuels the development of compulsive use of substances. The combination of increased incentive salience (binge/intoxication stage), decreased reward sensitivity and increased stress sensitivity (withdrawal/negative affect stage), and compromised executive function (preoccupation/anticipation stage) provides an often overwhelming drive for substance seeking that can be unrelenting.

Different Classes of Substances Affect the Brain and Behavior in Different Ways

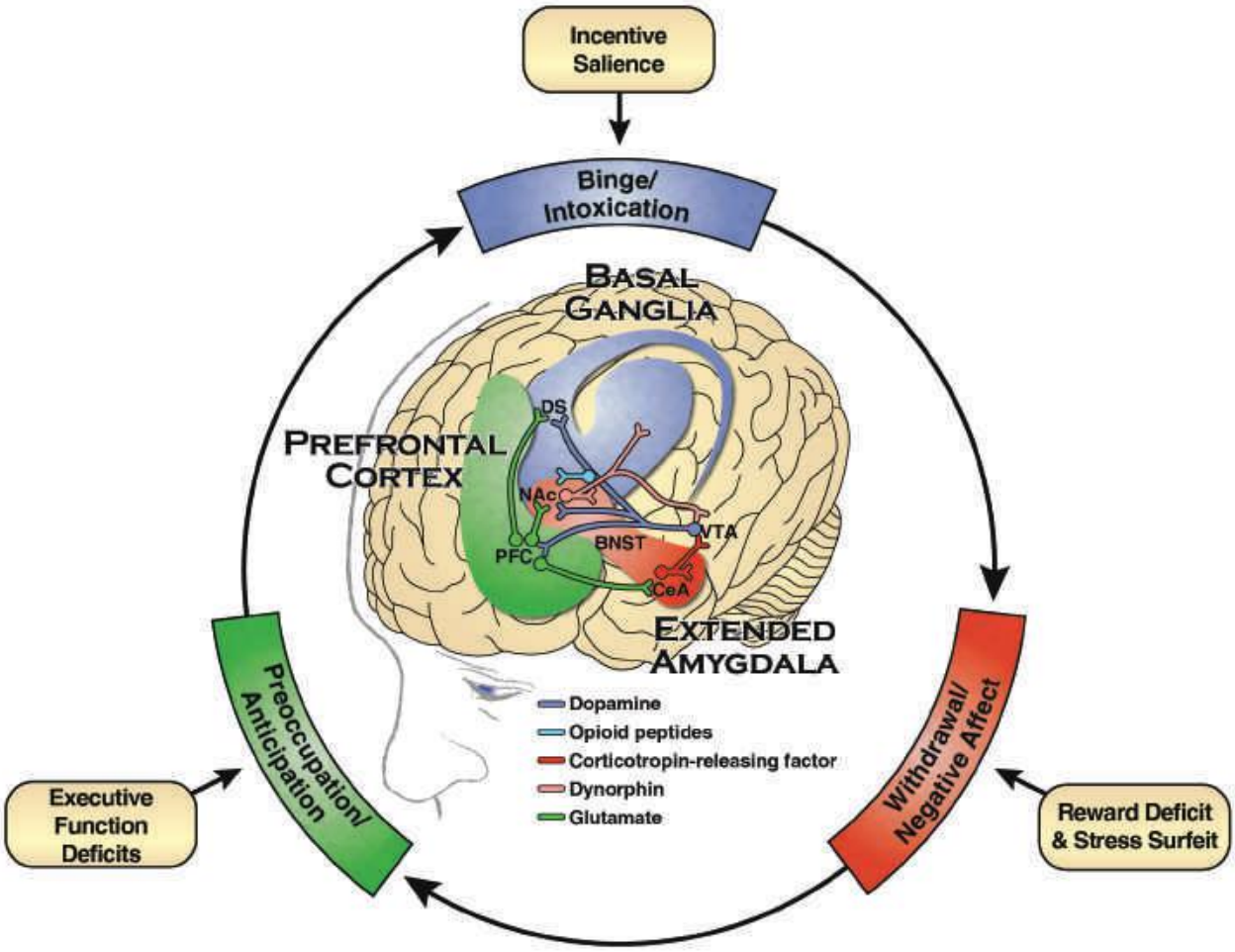
Although the three stages of addiction generally apply to all addictive substances, different substances affect the brain and behavior in different ways during each stage of the addiction cycle. Differences in the pharmacokinetics of various substances determine the duration of their effects on the body and partly account for the differences in their patterns of use. For example, nicotine has a short half-life, which means smokers need to smoke often to maintain the effect. In contrast, THC, the primary psychoactive compound in marijuana, has a much longer half-life. As a result, marijuana smokers do not typically smoke

as frequently as tobacco smokers.[40] Typical patterns of use are described below for the major classes of addictive substances. However, people often use these substances in combination.[41] Additional research is needed to understand how using more than one substance affects the brain and the development and progression of addiction, as well as how use of one substance affects the use of others.

KEY TERMS

Pharmacokinetics. What the body does to a drug after it has been taken, including how rapidly the drug is absorbed, broken down, and processed by the body.

Figure 2.12: The Primary Brain Regions and Neurotransmitter Systems Involved in Each of the Three Stages of the Addiction Cycle



Opioids

Opioids attach to opioid receptors in the brain, which leads to a release of dopamine in the nucleus accumbens, causing euphoria (the high), drowsiness, and slowed breathing, as well as reduced pain signaling (which is why they are frequently prescribed as pain relievers). Opioid addiction typically involves a pattern of: (1) intense intoxication, (2) the development of tolerance, (3) escalation in use, and (4) withdrawal signs that include profound negative emotions and physical symptoms, such as

bodily discomfort, pain, sweating, and intestinal distress and, in the most severe cases, seizures. As use progresses, the opioid must be taken to avoid the severe negative effects that occur during withdrawal. With repeated exposure to opioids, stimuli associated with the pleasant effects of the substances (e.g., places, persons, moods, and paraphernalia) and with the negative mental and physical effects of withdrawal can trigger intense craving or preoccupation with use.

Alcohol

When alcohol is consumed it interacts with several neurotransmitter systems in the brain, including the inhibitory neurotransmitter GABA, glutamate, and others that produce euphoria as well as the sedating, motor impairing, and anxiety-reducing effects of alcohol intoxication. Alcohol addiction often involves a similar pattern as opioid addiction, often characterized by periods of binge or heavy drinking followed by withdrawal. As with opioids, addiction to alcohol is characterized by intense craving that is often driven by negative emotional states, positive emotional states, and stimuli that have been associated with drinking, as well as a severe emotional and physical withdrawal syndrome. Many people with severe alcohol use disorder engage in patterns of binge drinking followed by withdrawal for extended periods of time. Extreme patterns of use may evolve into an opioid-like use pattern in which alcohol must be available at all times to avoid the negative consequences of withdrawal.

KEY TERMS

Binge drinking. For men, drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.

Stimulants

Stimulants increase the amount of dopamine in the reward circuit (causing the euphoric high) either by directly stimulating the release of dopamine or by temporarily inhibiting the removal of dopamine from synapses, the gaps between neurons. These drugs also boost dopamine levels in brain regions responsible for attention and focus on tasks (which is why stimulants like methylphenidate [Ritalin®] or dextroamphetamine [Adderall®] are often prescribed for people with attention deficit hyperactivity disorder). Stimulants also cause the release of norepinephrine, a neurotransmitter that affects autonomic functions like heart rate, causing a user to feel energized.

Addiction to stimulants, such as cocaine and amphetamines (including methamphetamine), typically follows a pattern that emphasizes the binge/intoxication stage. A person will take the stimulant repeatedly during a concentrated period of time lasting for hours or days (these episodes are called binges). The binge is often followed by a crash, characterized by negative emotions, fatigue, and inactivity. Intense craving then follows, which is driven by environmental cues associated with the availability of the substance, as well as by a person's internal state, such as their emotions or mood.

Marijuana (Cannabis)

Like other drugs, marijuana (also called cannabis) leads to increased dopamine in the basal ganglia, producing the pleasurable high. It also interacts with a wide variety of other systems and circuits in the brain that contain receptors for the body's natural cannabinoid neurotransmitters. Effects can be different from user to user, but often include distortions in motor coordination and time perception. Cannabis addiction follows a pattern similar to opioids. This pattern involves a significant binge/

intoxication stage characterized by episodes of using the substance to the point of intoxication. Over time, individuals begin to use the substance throughout the day and show chronic intoxication during waking hours. Withdrawal is characterized by negative emotions, irritability, and sleep disturbances.[40] Although the craving associated with cannabis[42] has been less studied than for other substances, it is most likely linked to both environmental and internal states, similar to those of other addictive substances.[43,44]

Synthetic Drugs

Different classes of chemically synthesized (hence the term synthetic) drugs have been developed, each used in different ways and having different effects in the brain. Synthetic cathinones, more commonly known as "bath salts," target the release of dopamine in a similar manner as the stimulant drugs described above. To a lesser extent, they also activate the serotonin neurotransmitter system, which can affect perception. Synthetic cannabinoids, sometimes referred to as "K2", "Spice", or "herbal incense," somewhat mimic the effects of marijuana but are often much more powerful. Drugs such as MDMA (ecstasy) and lysergic acid diethylamide (LSD) also act on the serotonin neurotransmitter system to produce changes in perception. Fentanyl is a synthetic opioid medication that is used for severe pain management and is considerably more potent than heroin. Prescription fentanyl, as well as illicitly manufactured fentanyl and related synthetic opioids, are often mixed with heroin but are also increasingly used alone or sold on the street as counterfeit pills made to look like prescription opioids or sedatives.

Factors that Increase Risk for Substance Use, Misuse, and Addiction

Not all people use substances, and even among those who use them, not all are equally likely to become addicted. Many factors influence the development of substance use disorders, including developmental, environmental, social, and genetic factors, as well as co-occurring mental disorders. Other factors protect people from developing a substance use disorder or addiction. The relative influence of these risk and protective factors varies across individuals and the lifespan. The following sections discuss some of these factors.

Early Life Experiences

FOR MORE ON THIS TOPIC

See Chapter 1 - *Introduction and Overview* and Chapter 3 - *Prevention Programs and Policies.*

The experiences a person has early in childhood and in adolescence can set the stage for future substance use and, sometimes, escalation to a substance use disorder or addiction. Early life stressors can include physical, emotional, and sexual abuse; neglect; household instability (such as parental substance use and conflict, mental illness, or incarceration of household members);[45] and poverty.[46] Research suggests that the stress caused by these risk factors may act on the same stress circuits in the brain as addictive substances, which may explain why they increase addiction risk.[47]

Adolescence is a critical period in the vulnerability to substance use and use disorders, because a hallmark of this developmental period is risk taking and experimentation, which for some young people includes trying alcohol, marijuana, or other drugs. In addition, the brain undergoes significant changes during this life stage, making it particularly vulnerable to substance exposure.[48] Importantly,

the frontal cortex—a region in the front part of the brain that includes the prefrontal cortex—does not fully develop until the early to mid-20s, and research shows that heavy drinking and drug use during adolescence affects development of this critical area of the brain.[49]

About three quarters (74 percent) of 18- to 30-year-olds admitted to treatment programs began using substances at the age of 17 or younger.[50] Individuals who start using substances during adolescence often experience more chronic and intensive use, and they are at greater risk of developing a substance use disorder compared with those who begin use at an older age. In other words, the earlier the exposure, the greater the risk.[51]

Not all adolescents who experiment with alcohol, cigarettes, or other substances go on to develop a substance use disorder, but research suggests that those who do progress to more harmful use may have pre-existing differences in their brains. For example, a brain imaging study of adolescents revealed that the volume of the frontal cortex was smaller in youth who transitioned from no or minimal drinking to heavy drinking over the course of adolescence than it was in youth who did not drink during adolescence.[49] Additional research can shed light on how these differences contribute to the progression from use to a disorder, as well as how changes caused by substance use affect brain function and behavior and whether they can be reversed.

Genetic and Molecular Factors

Genetic factors are thought to account for 40 to 70 percent of individual differences in risk for addiction.[52,53] Although multiple genes are likely involved in the development of addiction, only a few specific gene variants have been identified that either predispose to or protect against addiction. Some of these variants have been associated with the metabolism of alcohol and nicotine, while others involve receptors and other proteins associated with key neurotransmitters and molecules involved in all parts of the addiction cycle.[54] Genes involved in strengthening the connections between neurons and in forming drug memories have also been associated with addiction risk.[55,56] Like other chronic health conditions, substance use disorders are influenced by the complex interplay between a person's genes and environment. Additional research on the mechanisms underlying gene by environment interactions is expected to provide insight into how substance use disorders develop and how they can be prevented and treated.

Use of Multiple Substances and Co-occurring Mental Health Conditions

Many individuals with a substance use disorder also have a mental disorder,[57,58] and some have multiple substance use disorders. For example, according to the 2015 *National Survey on Drug Use and Health* (NSDUH), of the 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and 41.2 percent also had a mental illness.[59] Particularly striking is the 3- to 4-fold higher rate of tobacco smoking among patients with schizophrenia and the high prevalence of co-existing alcohol use disorder in those meeting criteria for PTSD. It is estimated that 30-60 percent of patients seeking treatment for

alcohol use disorder meet criteria for PTSD,[60,61] and approximately one third of individuals who have experienced PTSD have also experienced alcohol dependence at some point in their lives.[60]

The reasons why substance use disorders and mental disorders often occur together are not clear, and establishing the relationships between these conditions is difficult. Still, three possible explanations deserve attention. One reason for the overlap may be that having a mental disorder increases vulnerability to substance use disorders because certain substances may, at least temporarily, be able to reduce mental disorder symptoms and thus are particularly negatively reinforcing in these individuals. Second, substance use disorders may increase vulnerability for mental disorders,[62-64] meaning that the use of certain substances might trigger a mental disorder that otherwise would have not occurred. For example, research suggests that alcohol use increases risk for PTSD by altering the brain's ability to recover from traumatic experiences.[65,66] Similarly, the use of marijuana, particularly marijuana with a high THC content, might contribute to schizophrenia in those who have specific genetic vulnerabilities.[67] Third, it is also possible that both substance use disorders and mental disorders are caused by shared, overlapping factors, such as particular genes, neurobiological deficits, and exposure to traumatic or stressful life experiences. As these possibilities are not mutually exclusive, the relationship between substance use disorders and mental disorders may result from a combination of these processes.

Regardless of which one might influence the development of the other, mental and substance use disorders have overlapping symptoms, making diagnosis and treatment planning particularly difficult. For example, people who use methamphetamine for a long time may experience paranoia, hallucinations, and delusions that may be mistaken for symptoms of schizophrenia. And, the psychological symptoms that accompany withdrawal, such as depression and anxiety, may be mistaken as simply part of withdrawal instead of an underlying mood disorder that requires independent treatment in its own right. Given the prevalence of co-occurring substance use and mental disorders, it is critical to continue to advance research on the genetic, neurobiological, and environmental factors that contribute to co-occurring disorders and to develop interventions to prevent and treat them.

Biological Factors Contributing to Population-based Differences in Substance Misuse and Substance Use Disorders

Differences Based on Sex

Some groups of people are also more vulnerable to substance misuse and substance use disorders. For example, men tend to drink more than women and they are at higher risk for alcohol use disorder, although the gender differences in alcohol use are declining.[68] Men are also more likely to have other substance use disorders.[69] However, clinical reports suggest that women who use cocaine, opioids, or alcohol progress from initial use to a disorder at a faster rate than do men (called "telescoping").[70-72] Compared with men, women also exhibit greater symptoms of withdrawal from some drugs, such as nicotine. They also report worse negative affects during withdrawal and have higher levels of the stress hormone cortisol.[73]

Sex differences in reaction to addictive substances are not particular to humans. Female rats, in general, learn to self-administer drugs and alcohol more rapidly, escalate their drug taking more quickly, show greater symptoms of withdrawal, and are more likely to resume drug seeking in response to drugs, drug-related cues, or stressors. The one exception is that female rats show less withdrawal symptoms related to alcohol use.[74] Researchers are investigating the neurobiological bases for these differences.

Differences Based on Race and Ethnicity

Research on the neurobiological factors contributing to differential rates of substance use and substance use disorders in particular racial and ethnic groups is much more limited. A study using functional magnetic resonance imaging (fMRI) found that African American smokers showed greater activation of the prefrontal cortex upon exposure to smoking-related cues than did White smokers, an effect that may partly contribute to the lower smoking-cessation success rates observed among African Americans.[75]

Alcohol research with racial and ethnic groups has shown that approximately 36 percent of East Asians carry a gene variant that alters the rate at which members of that racial group metabolize alcohol, causing a buildup of acetaldehyde, a toxic byproduct of alcohol metabolism that produces symptoms such as flushing, nausea, and rapid heartbeat. Although these effects may protect some individuals of East Asian descent from alcohol use disorder, those who drink despite the effects are at increased risk for esophageal[76] and head and neck cancers.[77] Another study found that even low levels of alcohol consumption by Japanese Americans may result in adverse effects on the brain, a finding that may be related to the differences in alcohol metabolism described above.[78] Additional research will help to clarify the interactions between race, ethnicity, and the neuroadaptations that underlie substance misuse and addiction. This work may inform the development of more precise preventive and treatment interventions.

Recommendations for Research

Decades of research demonstrate that chronic substance misuse leads to profound disruptions of brain circuits involved in the experience of pleasure or reward, habit formation, stress, and decision-making. This work has paved the way for the development of a variety of therapies that effectively help people reduce or abstain from alcohol and drug misuse and regain control over their lives. In spite of this progress, our understanding of how substance use affects the brain and behavior is far from complete. Four research areas are specifically emphasized in the text below.

Effects of Substance Use on Brain Circuits and Functions

Continued research is necessary to more thoroughly explain how substance use affects the brain at the molecular, cellular, and circuit levels. Such research has the potential to identify common neurobiological mechanisms underlying substance use disorders, as well as other related mental disorders. This research is expected to reveal new neurobiological targets, leading to new medications and non-pharmacological treatments—such as transcranial magnetic stimulation or vaccines—for the treatment of substance use disorders. A better understanding of the neurobiological mechanisms underlying substance use disorders could also help to inform behavioral interventions. Therefore, basic research that further elucidates the neurobiological framework of substance use disorders and

co-occurring mental disorders, as well as research leading to the development of new medications and other therapeutics to treat the underlying neurobiological mechanisms of substance use disorders should be accelerated.

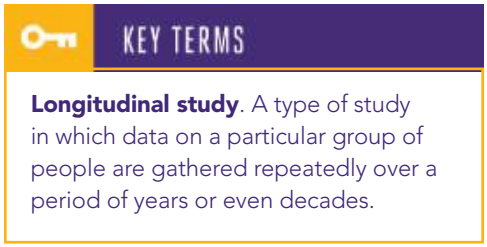
As with other diseases, individuals vary in the development and progression of substance use disorders. Not only are some people more likely to use and misuse substances than are others and to progress from initial use to addiction differently, individuals also differ in their vulnerability to relapse and in how they respond to treatments. For example, some people with substance use disorders are particularly vulnerable to stress-induced relapse, but others may be more likely to resume substance use after being exposed to drug-related cues. Developing a thorough understanding of how neurobiological differences account for variation among individuals and groups will guide the development of more effective, personalized prevention and treatment interventions. Additionally, determining how neurobiological factors contribute to differences in substance misuse and addiction between women and men and among racial and ethnic groups is critical.

Continued advances in neuroscience research will further enhance our understanding of substance use disorders and accelerate the development of new interventions. Data gathered through the National Institutes of Health's Adolescent Brain Cognitive Development study, the largest long-term study of cognitive and brain development in children across the United States, is expected to yield unprecedented information about how substance use affects adolescent brain development. The Human Connectome Project and the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative are poised to spur an explosion of knowledge about the structure and function of brain circuits and how the brain affects behavior. Technologies that can alter the activity of dysfunctional circuits are being explored as possible treatments. Moreover, continued advances in genomics, along with President Obama's Precision Medicine Initiative, a national effort to better understand how individual variability in genes, environment, and lifestyle contribute to disease, are expected to bring us closer to developing individually-tailored preventive and treatment interventions for substance-related conditions.

Neurobiological Effects of Recovery

Little is known about the factors that facilitate or inhibit long-term recovery from substance use disorders or how the brain changes over the course of recovery. Developing a better understanding of the recovery process, and the neurobiological mechanisms that enable people to maintain changes in their substance use behavior and promote resilience to relapse, will inform the development of additional effective treatment and recovery support interventions. Therefore, an investigation of the neurobiological processes that underlie recovery and contribute to improvements in social, educational, and professional functioning is necessary.

Adolescence, Brain Change, and Vulnerability to Substance Use Disorders



Although young people are particularly vulnerable to the adverse effects of substance use, not all adolescents who experiment with alcohol or drugs go on to develop a substance use disorder. Prospective, longitudinal studies are needed to investigate whether pre-existing neurobiological factors contribute to adolescent substance use and the development of substance use disorders, how adolescent substance use affects brain structure and function, and whether the changes in brain structure and function that accompany chronic substance use can recover over time. Studies that follow groups of adolescents over time to learn about the developing human brain should be conducted. These studies should investigate how pre-existing neurobiological factors contribute to substance use, misuse, and addiction, and how adolescent substance use affects brain function and behavior.

Neurobiological Effects of Polysubstance Use and Emerging Drug Products

Patterns of alcohol and drug use change over time. New drugs or drug combinations, delivery systems, and routes of administration emerge, and with them new questions for public health. For example, concern is growing that increasing use of marijuana extracts with extremely high amounts of THC could lead to higher rates of addiction among marijuana users. Concerns also are emerging about how new products about which little is known, such as synthetic cannabinoids and synthetic cathinones, affect the brain. Additional research is needed to better understand how such products - as well as emerging addictive substances - affect brain function and behavior, and contribute to addiction.

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Scott.A.Milkey

From: McClelland, Jim
Sent: Wednesday, March 08, 2017 1:10 PM
To: dhuntsinger@gov.in.gov
Subject: FW: Addiction Resources
Attachments: Surgeon General's Addiction Report Glossary.pdf; Surgeon General's Addiction Report, Neurobiology Chapter.pdf; Opioids Glossary.docx

You might find these useful.

Opioid Epidemic Abbreviations Glossary:

- ASAM: American Society of Addiction Medicine
- CARA (2016): Comprehensive Addiction and Recovery Act
  - Federal; Funding available through SAMHSA grant. DMHA's application for Indiana's $10.9 million share is due on February 17, 2017.
- CBT: Cognitive Behavioral Therapy
- CMHC: Community Mental Health Center
- COWS: Clinical Opiate Withdrawal Scale
  - Measurement of someone's detoxification symptoms
- DATA 2000: Drug Addiction Treatment Act of 2000
  - Creates an 8-hour training program to allow non-specialist providers to apply to the DEA for a waiver to prescribe buprenorphine medication-assisted treatment
- DMHA: Division of Mental Health and Addiction
  - Indiana's Single State Agency for SAMHSA purposes, housed in FSSA
- FQHC: Federally Qualified Health Centers
  - Qualify for enhanced Medicare/Medicaid reimbursement based on service of an underserved area or population, etc.
- ICCDA: Indiana Commission to Combat Drug Abuse
  - New commission taking over for the Governor's Drug Task Force
- INSPECT: Indiana Scheduled Prescription Electronic Collection and Tracking
  - Indiana's prescription drug monitoring program (PDMP)
- MAT: Medication-Assisted Treatment
  - Opioid addiction treatment using methadone, buprenorphine products, or extended-release naltrexone (Vivitrol)
- MME: Morphine Milligram Equivalent
  - A measure of the level of morphine a prescription translates to
- NARR: National Alliance for Recovery Residences
  - A nonprofit recovery community organization that sets standards for recovery residences
- NAS: Neonatal Abstinence Syndrome
  - Disorder characterized by a newborn withdrawing from a drug in their mother's system during their gestation
- NFP: Nurse Family Partnership
  - An evidence-based community health program focused on first time pregnant moms. The mother is partnered with a registered nurse and receives ongoing home visits from the first trimester through the child's second birthday
- NIDA: National Institute on Drug Abuse
- NIH: National Institutes of Health

- OBT: Office-Based Treatment (pronounced o-bot)
    - A place to receive medication-assisted treatment (not methadone) in a provider's regular office.
- OTP: Opioid Treatment Program
    - Typically a methadone clinic
- PDMP: Prescription Drug Monitoring Program
    - A state database tracking an individual's prescription drug use
- PDO: Prescription Drug Overdose
- PHSA: Public Health Service Act
- ROSC: Recovery Oriented Systems of Care
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SBIRT: Screening, Brief Intervention, Referral to Treatment
- SSA: Single State Agencies
- SUD: Substance Use Disorder

Medication-Assisted Treatment Drugs:

- Methadone: an opioid agonist administered at an OTP. Affects receptors the same way that heroin does. Stays in the body for a long time.
- Buprenorphine (Byoo-pre-norff-een): a partial agonist that produces a high that is cut off at a certain point. Takes less time to detox from than methadone.
    - Subutex
    - Suboxone
- (Extended-Release) Naltrexone: an antagonist that blocks the receptors, preventing someone from getting high. Must be administered after detoxification to avoid precipitated withdrawal
    - Vivitrol: the brand-name monthly injection of extended-release naltrexone
- Naloxone: an antagonist used to reverse the effects of an opioid medication. Used in overdoses
    - Narcan: the brand-name for naloxone that many people are familiar with

Assistive Technology users should contact **Jinhee Lee**, Jinhee.lee@samhsa.hhs.gov, 240-276-0545.

GLOSSARY OF TERMS

Term	Definition
12-Step Program	A group providing mutual support and fellowship for people recovering from addictive behaviors. The first 12-step program was Alcoholics Anonymous (AA), founded in 1935; an array of 12-step groups following a similar model have since emerged and are the most widely used mutual aid groups and steps for maintaining recovery recovery from alcohol and drug use disorders. It is not a form of treatment, and it is not to be confused with the treatment modality called Twelve-Step Facilitation.
Abstinence	Not using alcohol or drugs.
Addiction	The most severe form of *substance use disorder*, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
Agonist	A chemical substance that binds to and activates certain receptors on cells, causing a biological response. Fentanyl and methadone are examples of opioid receptor agonists.
Antagonist	A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone is an example of an opioid receptor antagonist.
Binge Drinking	For men, drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.
Case Management	A coordinated approach to delivering health care, substance use disorder treatment, mental health care, and social services. This approach links clients with appropriate services to address specific needs and goals.
Clinical Decision Support	A system that provides health care professionals, staff, patients, or other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care.
Clinical Trial	Any research study that prospectively assigns human participants or groups of participants to one or more health-related interventions to evaluate the effects on health outcomes.
Compulsivity	Repetitive behaviors in the face of adverse consequences, as well as repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.

Term	Definition
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Cost-Benefit Study	A study that determines the economic worth of an intervention by quantifying its costs in monetary terms and comparing them with the benefits, also expressed in monetary terms. Total benefits divided by total costs is called a cost-benefit ratio. If the ratio is greater than 1, the benefits outweigh the costs.
Cost-Effectiveness Study	A comparative analysis of two or more interventions against their health and economic outcomes. These outcomes could be lives saved, illnesses prevented, or years of life gained.
Dependence	A state in which an organism only functions normally in the presence of a substance, experiencing physical disturbance when the substance is removed. A person can be dependent on a substance without being addicted, but dependence sometimes leads to addiction
Dissemination	The active distribution of evidence-based interventions (EBIs) to specific audiences, with the goal of increasing their adoption.
Drug Diversion	A medical and legal concept involving the transfer of any legally prescribed controlled substance from the person for whom it was prescribed to another person for any illicit use.
Fidelity	The extent to which an intervention is delivered as it was designed and intended to be delivered.
Gender	The social, cultural, or community designations of masculinity or femininity.
Health Care System	The World Health Organization defines a health care system as (1) all the activities whose primary purpose is to promote, restore, and/or maintain health, and (2) the people, institutions, and resources, arranged together in accordance with established policies, to improve the health of the population they serve. The health care system is made up of diverse health care organizations ranging from primary care, specialty substance use disorder treatment (including residential and outpatient settings), mental health care, infectious disease clinics, school clinics, community health centers, hospitals, emergency departments, and others.
Health Disparities	Preventable differences in the burden of disease or opportunities to achieve optimal health that are experienced by socially disadvantaged populations, defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation.
Heavy Drinking	Defined by the Centers for Disease Control and Prevention (CDC) as consuming 8 or more drinks per week for women, and 15 or more drinks per week for men, and by the Substance Abuse and Mental Health Services Administration (SAMHSA), for research purposes, as binge drinking on 5 or more days in the past 30 days.
Implementation	A specified set of activities designed to put policies and programs into practice.
Impulsivity	Inability to resist urges, deficits in delaying gratification, and unreflective decision-making. Impulsivity is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long-term goals.
Inpatient Treatment	Intensive, 24-hour-a-day services delivered in a hospital setting.
Integration	The systematic coordination of general and behavioral health care. Integrating services for primary care, mental health, and substance use use-related problems together produces the best outcomes and provides the most effective approach for supporting whole-person health and wellness.

Term	Definition
Intervention	A professionally delivered program, service, or policy designed to prevent substance misuse (prevention intervention) or treat a substance use disorder (treatment intervention).
Learning Health Care System	As described by the IOM, a learning health care system is "designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care."
Longitudinal Study	A type of study in which data on a particular group of people are gathered repeatedly over a period of years or even decades.
Meaningful Use	Using certified EHR technology to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination and population and public health; and maintain privacy and security of patient health information.
Negative Reinforcement	The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.
Net Economic Benefit	The value of total benefits minus total costs.
Neurobiology	The study of the anatomy, function, and diseases of the brain and nervous system.
Opioid Treatment Program (OTP)	SAMHSA-certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have opioid use disorders. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.
Pharmacokinetics	What the body does to a drug after it has been taken, including how rapidly the drug is absorbed, broken down, and processed by the body.
Positive Reinforcement	The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.
Prescription Drug Misuse	Use of a drug in any way a doctor did not direct an individual to use it.
Prevalence	The proportion of a population who have (or had) a specific characteristic—for example, an illness, condition, behavior, or risk factor— in a given time period.
Protective Factors	Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.
Public Health System	Defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction" and includes state and local public health agencies, public safety agencies, health care providers, human service and charity organizations, recreation and arts-related organizations, economic and philanthropic organizations, education and youth development organizations, and education and youth development organizations.
Quality-Adjusted Life Year (QALY)	A measure of the burden of disease used in economic evaluations of the value of health care interventions that accounts for both the years of life lived and the quality of life experienced during those years, relative to quality associated with perfect health.
Randomized Controlled Trial (RCT)	A clinical trial of an intervention in which people are randomly assigned either to a group receiving the intervention being studied or to a *control group* receiving a standard intervention, a placebo (a medicine with no therapeutic effect), or no intervention. At the end of the study, the results from the different groups are compared.

Term	Definition
Recovery	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic substance use disorders can, with help, overcome their substance use disorder and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery". Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.
Relapse	The return to alcohol or drug use after a significant period of abstinence.
Remission	A medical term meaning that major disease symptoms are eliminated or diminished below a pre-determined, harmful level.
Residential Treatment	Intensive, 24-hour a day services delivered in settings other than a hospital.
Risk Factors	Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems associated with use.
Sex	The biological and physiological characteristics that define human beings as female or male.
Standard Drink	Based on the 2015-2020 Dietary Guidelines for Americans, a standard drink is defined as 12 fl. oz. of regular beer, 8-9 fl. oz. of malt liquor, 5 fl. oz. of table wine, or 1.5 fl. oz. of 80-proof distilled spirits. All of these drinks contain 14 grams (0.6 ounces) of pure alcohol.
Substance	A psychoactive compound with the potential to cause health and social problems, including substance use disorders (and their most severe manifestation, addiction).
Substance Misuse	The use of any substance in a manner, situation, amount or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute as misuse (e.g., under-age drinking, injection drug use).
Substance Misuse Problems or Consequences	Any health or social problem that results from substance misuse. Substance misuse problems or consequences may affect the substance user or those around them, and they may be acute (e.g., an argument or fight, a motor vehicle crash, an overdose) or chronic (e.g., a long-term substance-related medical, family, or employment problem, or chronic medical condition, such as various cancers, heart disease, and liver disease). These problems may occur at any age and are more likely to occur with greater frequency of substance misuse.
Substance Use	The use—even one time—of any substance.
Substance Use Disorders	A medical illness caused by repeated misuse of a substance or substances. According to the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), substance use disorders are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Note: Severe substance use disorders are commonly called *addictions*.
Substance Use Disorder Treatment	A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability.
Telehealth	The use of digital technologies such as electronic health records, mobile applications, telemedicine, and web-based tools to support the delivery of health care, health-related education, or other health-related services and functions.
Telemedicine	Two-way, real-time interactive communication between a patient and a physician or other health care professional at a distant site. Telemedicine is a subcategory of *telehealth*.

Term	Definition
Tolerance	Alteration of the body's responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.
Withdrawal	A set of symptoms that are experienced when discontinuing use of a substance to which a person has become dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.
Wrap-Around Services	Wrap -around services are non-clinical services that facilitate patient engagement and retention in treatment as well as their ongoing recovery. This can include services to address patient needs related to transportation, employment, childcare, housing, legal and financial problems, among others.

LIST OF ABBREVIATIONS

Abbreviation	Definition
AA	Alcoholics Anonymous
ACC	Accountable Care Community
ACO	Accountable Care Organization
AIDS	Acquired Immune Deficiency Syndrome
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Content
BASICS	Brief Alcohol Screening and Intervention for College Students
BNST	Bed Nucleus of the Stria Terminalis
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
CADCA	Community Anti-Drug Coalitions of America
CARA	Comprehensive Addiction and Recovery Act
CARPS	Computerized Alcohol-Related Problems Survey
CBT	Cognitive Behavioral Therapy
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CeA	Central Nucleus of the Amygdala
CHIP	Children's Health Insurance Program
CIDI	Composite International Diagnostic Interview
CMCA	Communities Mobilizing for Change on Alcohol
CMS	Centers for Medicare & Medicaid Services
CRF	Corticotropin-Releasing Factor
CSA	Controlled Substances Act
CTC	Communities That Care
DEA	Drug Enforcement Administration

Abbreviation	Definition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DUI	Driving Under the Influence
DS	Dorsal Striatum
EBI	Evidence-Based Interventions
EHR	Electronic Health Record
FASD	Fetal Alcohol Spectrum Disorder
FBT	Family Behavior Therapy
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
GABA	Gamma-Aminobutyric Acid
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICCPUD	Interagency Coordinating Committee on the Prevention of Underage Drinking
IOM	Institute of Medicine, now known as the Health and Medicine Division of the National Academies of Science, Engineering, and Medicine
LGBT	Lesbian, Gay, Bisexual, and Transgender
LST	Life Skills Training
MADD	Mothers Against Drunk Driving
MET	Motivational Enhancement Therapy
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
MLDA	Minimum Legal Drinking Age
MRI	Magnetic Resonance Imaging
NA	Narcotics Anonymous
NAc	Nucleus Accumbens
NASPER	National All Schedules Prescription Electronic Reporting Act
NFP	Nurse-Family Partnership Program
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
OTP	Opioid Treatment Program
PDMP	Prescription Drug Monitoring Program
PET	Positron Emission Tomography
PFC	Prefrontal Cortex
PRISM	Psychiatric Research Interview for Substance and Mental Disorders
PROSPER	PROmoting School-community-university Partnerships to Enhance Resilience

Abbreviation	Definition
PTSD	Post-Traumatic Stress Disorder
QALY	Quality-Adjusted Life Year
RHC	Raising Healthy Children
RMC	Recovery Management Check-up
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFP	Strengthening Families Program
SIM	State Innovation Models
SPA	State Plan Amendment
THC	Δ^9-tetrahydrocannabinol
USPSTF	U.S. Preventive Services Task Force
VTA	Ventral Tegmental Area

CHAPTER 2.
THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION

Chapter 2 Preview

A substantial body of research has accumulated over several decades and transformed our understanding of substance use and its effects on the brain. This knowledge has opened the door to new ways of thinking about prevention and treatment of substance use disorders.

This chapter describes the neurobiological framework underlying substance use and why some people transition from using or misusing alcohol or drugs to a substance use disorder—including its most severe form, addiction. The chapter explains how these substances produce changes in brain structure and function that promote and sustain addiction and contribute to relapse. The chapter also addresses similarities and differences in how the various classes of addictive substances affect the brain and behavior and provides a brief overview of key factors that influence risk for substance use disorders.

An Evolving Understanding of Substance Use Disorders

Scientific breakthroughs have revolutionized the understanding of substance use disorders. For example, severe substance use disorders, commonly called *addictions*, were once viewed largely as a moral failing or character flaw, but are now understood to be chronic illnesses characterized by clinically significant impairments in health, social function, and voluntary control over substance use.[3] Although the mechanisms may be different, addiction has many features in common with disorders such as diabetes, asthma, and hypertension. All of these disorders are chronic, subject to relapse, and influenced by genetic, developmental, behavioral, social, and environmental factors. In all of these disorders, affected individuals may have difficulty in complying with the prescribed treatment.[4]

This evolving understanding of substance use disorders as medical conditions has had important implications for prevention and treatment. Research demonstrating that addiction is driven by changes in the brain has helped to reduce the negative attitudes associated with substance use disorders and provided support for integrating treatment for substance use disorders into mainstream health care. Moreover, research on the basic neurobiology of addiction has already resulted in several effective

KEY FINDINGS*

- Well-supported scientific evidence shows that addiction to alcohol or drugs is a chronic brain disease that has potential for recurrence and recovery.
- Well-supported evidence suggests that the addiction process involves a three-stage cycle: binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation. This cycle becomes more severe as a person continues substance use and as it produces dramatic changes in brain function that reduce a person's ability to control his or her substance use.
- Well-supported scientific evidence shows that disruptions in three areas of the brain are particularly important in the onset, development, and maintenance of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex. These disruptions: (1) enable substance-associated cues to trigger substance seeking (i.e., they increase incentive salience); (2) reduce sensitivity of brain systems involved in the experience of pleasure or reward, and heighten activation of brain stress systems; and (3) reduce functioning of brain executive control systems, which are involved in the ability to make decisions and regulate one's actions, emotions, and impulses.
- Supported scientific evidence shows that these changes in the brain persist long after substance use stops. It is not yet known how much these changes may be reversed or how long that process may take.
- Well-supported scientific evidence shows that adolescence is a critical "at-risk period" for substance use and addiction. All addictive drugs, including alcohol and marijuana, have especially harmful effects on the adolescent brain, which is still undergoing significant development.

* Well-supported: when evidence is derived from multiple rigorous human and nonhuman studies; Supported: when evidence is derived from rigorous but fewer human and nonhuman studies.

medications for the treatment of alcohol, opioid, and nicotine use disorders, and clinical trials are ongoing to test other potential new treatments.[5]

All addictive substances have powerful effects on the brain. These effects account for the euphoric or intensely pleasurable feelings that people experience during their initial use of alcohol or other substances, and these feelings motivate people to use those substances again and again, despite the risks for significant harms.

FOR MORE ON THIS TOPIC

See the section on *"Factors that Increase Risk for Substance Use, Misuse, and Addiction"* later in this chapter.

As individuals continue to misuse alcohol or other substances, progressive changes, called *neuroadaptations*, occur in the structure and function of the brain. These neuroadaptations compromise brain function and also drive the transition from controlled, occasional substance use to chronic misuse, which can be difficult to control. Moreover, these brain changes endure long after an individual stops using substances. They may produce continued, periodic craving for the substance that can lead to relapse: More than 60 percent of people treated for a substance use disorder experience relapse within the first year after they are discharged from treatment,[4,6] and a person can remain at increased risk of relapse for many years.[7,8]

However, addiction is not an inevitable consequence of substance use. Whether an individual ever uses alcohol or another substance, and whether that initial use progresses to a substance use disorder of any severity, depends on a number of factors. These include: a person's genetic makeup and other individual

biological factors; the age when use begins; psychological factors related to a person's unique history and personality; and environmental factors, such as the availability of drugs, family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support.[9] Some of these factors increase risk for substance use, misuse, and use disorders, whereas other factors provide buffers against those risks. Nonetheless, specific combinations of factors can drive the emergence and continuation of substance misuse and the progression to a disorder or an addiction.

FOR MORE ON THIS TOPIC

See Chapter 3 - *Prevention Programs and Policies.*

Conducting Research on the Neurobiology of Substance Use, Misuse, and Addiction

Until recently, much of our knowledge about the neurobiology of substance use, misuse, and addiction came from the study of laboratory animals. Although no animal model fully reflects the human experience, animal studies let researchers investigate addiction under highly controlled conditions that may not be possible or ethical to replicate in humans. These types of studies have greatly helped to answer questions about how particular genes, developmental processes, and environmental factors, such as stressors, affect substance-taking behavior.

KEY TERMS

Neurobiology. The study of the anatomy, function, and diseases of the brain and nervous system.

Neurobiology studies in animals have historically focused on what happens in the brain right after taking an addictive substance (this is called the acute impact), but research has shifted to the study of how ongoing, long-term (or chronic) substance use changes the brain. One of the main goals of this research is to understand at the most basic level the mechanisms through which substance use alters brain structure and function and drives the transition from occasional use to misuse, addiction, and relapse.[10]

A growing body of substance use research conducted with humans is complementing the work in animals. For example, human studies have benefited greatly from the use of brain-imaging technologies, such as magnetic resonance imaging (MRI) and positron emission tomography (PET) scans. These technologies allow researchers to "see" inside the living human brain so that they can investigate and characterize the biochemical, functional, and structural changes in the brain that result from alcohol and drug use. The technologies also allow them to understand how differences in brain structure and function may contribute to substance use, misuse, and addiction.

Animal and human studies build on and inform each other, and in combination provide a more complete picture of the neurobiology of addiction. The rest of this chapter weaves together the most compelling data from both types of studies to describe a neurobiological framework for addiction.

A Basic Primer on the Human Brain

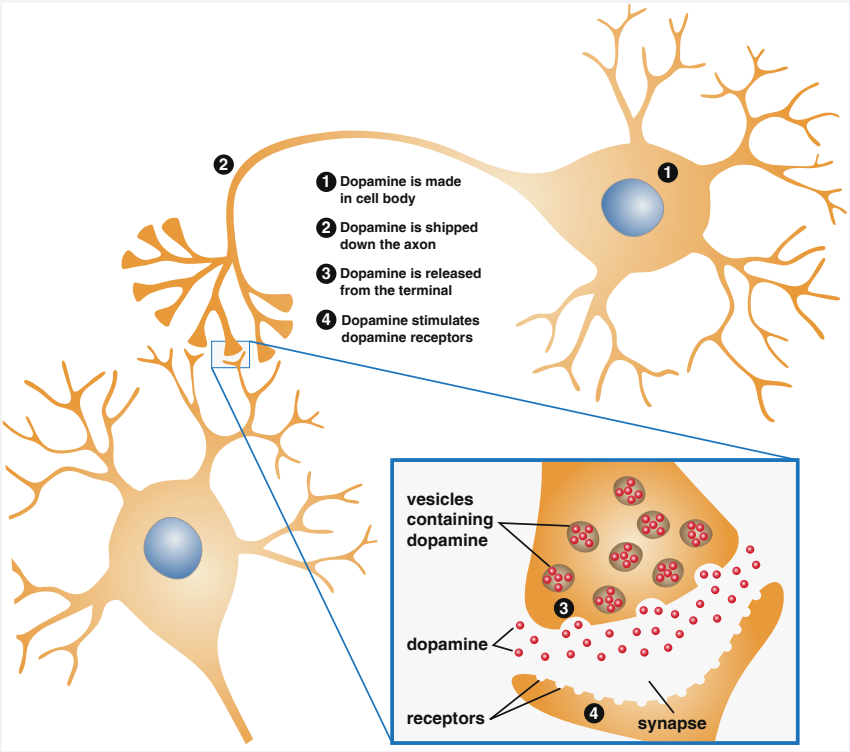
To understand how addictive substances affect the brain, it is important to first understand the basic biology of healthy brain function. The brain is an amazingly complex organ that is constantly at work. Within the brain, a mix of chemical and electrical processes controls the body's most basic functions, like breathing and digestion. These processes also control how people react to the multitudes of sounds, smells, and other sensory stimuli around them, and they organize and direct individuals' highest thinking and emotive powers so that they can interact with other people, carry out daily activities, and make complex decisions.

The brain is made of an estimated 86 billion nerve cells—called neurons—as well as other cell types. Each neuron has a cell body, an axon, and dendrites (Figure 2.1). The cell body and its nucleus control the neuron's activities. The axon extends out from the cell body and transmits messages to other neurons. Dendrites branch out from the cell body and receive messages from the axons of other neurons.

Neurons communicate with one another through chemical messengers called neurotransmitters. The neurotransmitters cross a tiny gap, or synapse, between neurons and attach to receptors on the receiving neuron. Some neurotransmitters are inhibitory—they make it less likely that the receiving neuron will carry out some action. Others are excitatory, meaning that they stimulate neuronal function, priming it to send signals to other neurons.

Neurons are organized in clusters that perform specific functions (described as networks or circuits). For example, some networks are involved with thinking, learning, emotions, and memory. Other networks communicate with muscles, stimulating them into action. Still others receive and interpret stimuli from the sensory organs, such as the eyes and ears, or the skin. The addiction cycle disrupts the normal functions of some of these neuronal networks.

Figure 2.1: A Neuron and its Parts

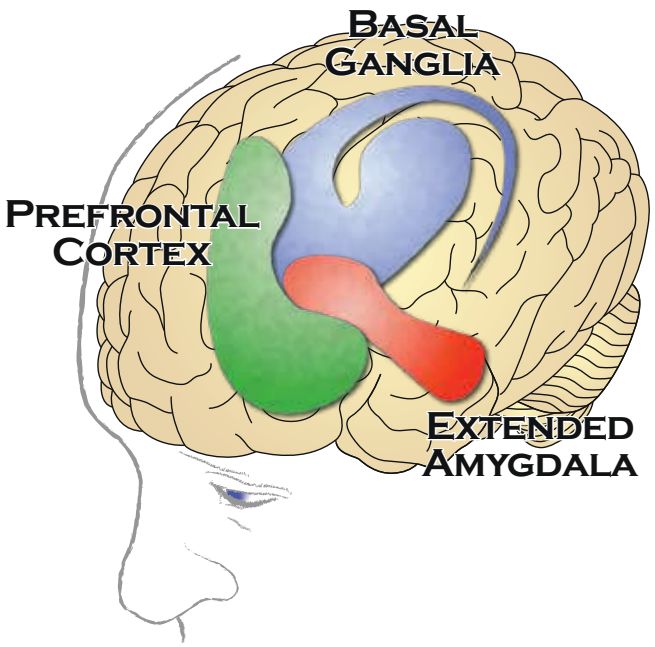


The Primary Brain Regions Involved in Substance Use Disorders

The brain has many regions that are interconnected with one another, forming dynamic networks that are responsible for specific functions, such as attention, self-regulation, perception, language, reward, emotion, and movement, along with many other functions. This chapter focuses on three regions that are the key components of networks that are intimately involved in the development and persistence of substance use disorders: the **basal ganglia**, the **extended amygdala**, and the **prefrontal cortex** (Figure 2.2). The basal ganglia control the rewarding, or pleasurable, effects of substance use and are also responsible for the formation of habitual substance taking. The extended amygdala is involved in stress and the feelings of unease, anxiety, and irritability that typically accompany substance withdrawal. The prefrontal cortex is involved in executive function (i.e., the ability to organize thoughts and activities, prioritize tasks, manage time, and make decisions), including exerting control over substance taking.

These brain areas and their associated networks are not solely involved in substance use disorders. Indeed, these systems are broadly integrated and serve many critical roles in helping humans and other animals survive. For example, when people engage in certain activities, such as consuming food or having sex, chemicals within the basal ganglia produce feelings of pleasure. This reward motivates individuals to continue to engage in these activities, thereby ensuring the survival of the species. Likewise, in the face of danger, activation of the brain's stress systems within the extended amygdala drives "fight or flight" responses. These responses, too, are critical for survival. As described in more detail below, these and other survival systems are "hijacked" by addictive substances.

Figure 2.2: Areas of the Human Brain that Are Especially Important in Addiction



The Basal Ganglia

The basal ganglia are a group of structures located deep within the brain that play an important role in keeping body movements smooth and coordinated. They are also involved in learning routine behaviors and forming habits. Two sub-regions of the basal ganglia are particularly important in substance use disorders:

- The nucleus accumbens, which is involved in motivation and the experience of reward, and
- The dorsal striatum, which is involved in forming habits and other routine behaviors.[11]

The Extended Amygdala

The extended amygdala and its sub-regions, located beneath the basal ganglia, regulate the brain's reactions to stress-including behavioral responses like "fight or flight" and negative emotions like unease, anxiety, and irritability. This region also interacts with the hypothalamus, an area of the brain that controls activity of multiple hormone-producing glands, such as the pituitary gland at the base of the brain and the adrenal glands at the top of each kidney. These glands, in turn, control reactions to stress and regulate many other bodily processes.[12]

The Prefrontal Cortex

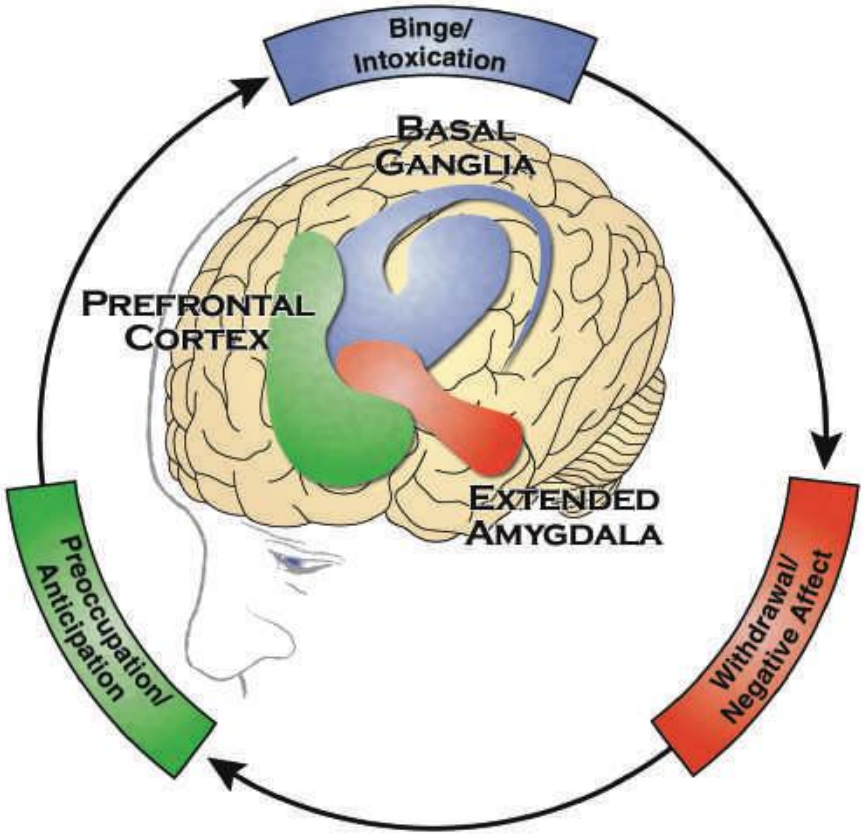
The prefrontal cortex is located at the very front of the brain, over the eyes, and is responsible for complex cognitive processes described as "executive function." Executive function is the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's actions, emotions, and impulses.[13]

The Addiction Cycle

Addiction can be described as a repeating cycle with three stages. Each stage is particularly associated with one of the brain regions described above—basal ganglia, extended amygdala, and prefrontal cortex (**Figure 2.3**).[10] This three-stage model draws on decades of human and animal research and provides a useful way to understand the symptoms of addiction, how it can be prevented and treated, and how people can recover from it.[14] The three stages of addiction are:

- **Binge/Intoxication**, the stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects;
- **Withdrawal/Negative Affect**, the stage at which an individual experiences a negative emotional state in the absence of the substance; and
- **Preoccupation/Anticipation**, the stage at which one seeks substances again after a period of abstinence.

Figure 2.3: The Three Stages of the Addiction Cycle and the Brain Regions Associated with Them



The three stages are linked to and feed on each other, but they also involve different brain regions, circuits (or networks), and neurotransmitters and result in specific kinds of changes in the brain. A person may go through this three-stage cycle over the course of weeks or months or progress through it several times in a day. There may be variation in how people progress through the cycle and the intensity with which they experience each of the stages. Nonetheless, the addiction cycle tends to intensify over time, leading to greater physical and psychological harm.[10]

The following sections describe each of the stages in more detail. But first, it is necessary to explain four behaviors that are central to the addiction cycle: impulsivity, positive reinforcement, negative reinforcement, and compulsivity.

For many people, initial substance use involves an element of impulsivity, or acting without foresight or regard for the consequences. For example, an adolescent may impulsively take a first drink, smoke a cigarette, begin experimenting with marijuana, or succumb to peer pressure to try a party drug. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again.

Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings negatively reinforces

substance use, increasing the likelihood that the person will use again. Importantly, positive and negative reinforcement need not be driven solely by the effects of the drugs. Many other environmental and social stimuli can reinforce a behavior. For example, the approval of peers positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides relief from social isolation, substance use behavior could be negatively reinforced.

The positively reinforcing effects of substances tend to diminish with repeated use. This is called tolerance and may lead to use of the substance in greater amounts and/or more frequently in an attempt to experience the initial level of reinforcement. Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression, or feel physically ill. This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms.

As use becomes an ingrained behavior, impulsivity shifts to compulsivity, and the primary drivers of repeated substance use shift from positive reinforcement (feeling pleasure) to negative reinforcement (feeling relief), as the person seeks to stop the negative feelings and physical illness that accompany withdrawal.[15] Eventually, the person begins taking the substance not to get "high," but rather to escape the "low" feelings to which, ironically, chronic drug use has contributed. Compulsive substance seeking is a key characteristic of addiction, as is the loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after attempting to abstain from or reduce use.

KEY TERMS

Impulsivity. An inability to resist urges, deficits in delaying gratification, and unreflective decision-making. It is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long-term goals.[1]

Positive reinforcement. The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

Negative reinforcement. The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.

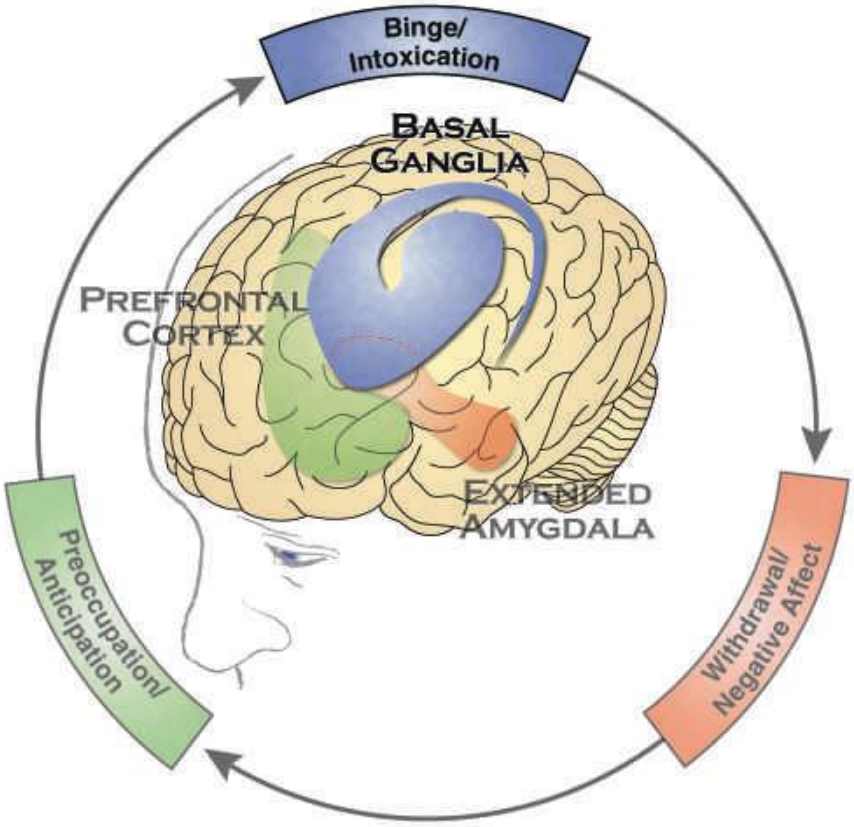
Compulsivity. Repetitive behaviors in the face of adverse consequences, and repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.[1]

The following sections provide more detail about each of the three stages—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—and the neurobiological processes underlying them.

Binge/Intoxication Stage: Basal Ganglia

The binge/intoxication stage of the addiction cycle is the stage at which an individual consumes the substance of choice. This stage heavily involves the basal ganglia (Figure 2.4) and its two key brain sub-regions, the nucleus accumbens and the dorsal striatum. In this stage, substances affect the brain in several ways.

Figure 2.4: The Binge/Intoxication Stage and the Basal Ganglia



Addictive Substances "Hijack" Brain Reward Systems

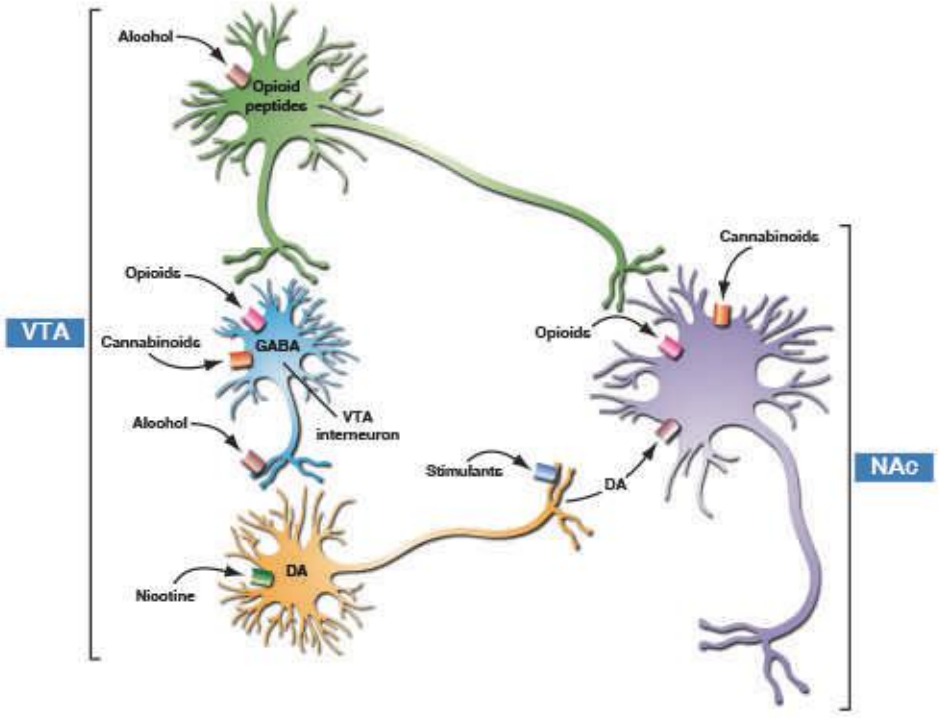
All addictive substances produce feelings of pleasure. These "rewarding effects" positively reinforce their use and increase the likelihood of repeated use. The rewarding effects of substances involve activity in the nucleus accumbens, including activation of the brain's dopamine and opioid signaling system. Many studies have shown that neurons that release dopamine are activated, either directly or indirectly, by all addictive substances, but particularly by stimulants such as cocaine, amphetamines, and nicotine (Figure 2.5).[16] In addition, the brain's opioid system, which includes naturally occurring opioid molecules (i.e., endorphins, enkephalins, and dynorphins) and three types of opioid receptors (i.e., mu, delta, and kappa), plays a key role in mediating the rewarding effects of other addictive substances, including opioids and alcohol. Activation of the opioid system by these substances stimulates the nucleus accumbens directly or indirectly through the dopamine system. Brain imaging studies in humans show activation of dopamine and opioid neurotransmitters during alcohol and other substance use (including nicotine).[10,17] Other studies show that antagonists, or inhibitors, of dopamine and opioid receptors can block drug and alcohol seeking in both animals and humans.[14,18,19]

KEY TERMS

Antagonist. A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone is an example of an opioid receptor antagonist.

Cannabinoids such as delta-9-tetrahydrocannabinol (THC), the primary psychoactive component of marijuana, target the brain's internal or endogenous cannabinoid system. This system also contributes to reward by affecting the function of dopamine neurons and the release of dopamine in the nucleus accumbens.

Figure 2.5: Actions of Addictive Substances on the Brain



Notes: Figure 2.5 is a simplified schematic of converging acute rewarding actions of addictive substances on the nucleus accumbens (NAc). Dopamine neurons that originate in the ventral tegmental area (VTA) project to the NAc. Opioid peptides act both in the VTA and NAc. Despite diverse initial actions, addictive substances produce some common effects on the VTA and NAc. Stimulants directly increase dopamine (DA) transmission in the NAc. Opioids, alcohol, and inhalants (e.g., the solvent toluene) do the same indirectly. Alcohol also activates the release of opioid peptides. Heroin and prescribed opioid pain relievers directly activate opioid peptide receptors. Nicotine activates dopamine neurons in the VTA. Cannabinoids may act in the VTA to activate dopamine neurons but also act on NAc neurons themselves.

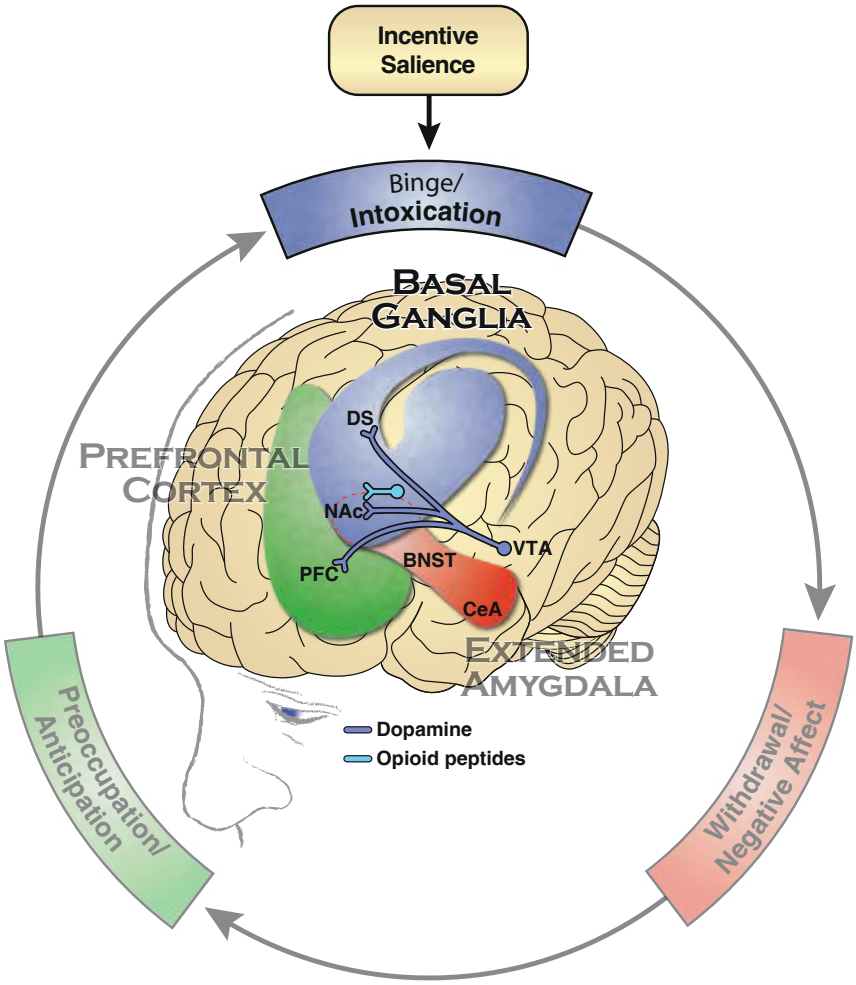
Source: Modified with permission from Nestler, (2005).[16]

Stimuli Associated with Addictive Substances Can Trigger Substance Use

Activation of the brain's reward system by alcohol and drugs not only generates the pleasurable feelings associated with those substances, it also ultimately triggers changes in the way a person responds to stimuli associated with the use of those substances. A person learns to associate the stimuli present while using a substance—including people, places, drug paraphernalia, and even internal states, such as mood—with the substance's rewarding effects. Over time, these stimuli can activate the dopamine system on their own and trigger powerful urges to take the substance. These "wanting" urges are called incentive salience and they can persist even after the rewarding effects of the substance have diminished. As a result, exposure to people, places, or things previously associated with substance use can serve as "triggers" or cues that promote substance seeking and taking, even in people who are in recovery.

Figure 2.6 shows the major neurotransmitter systems involved in the binge/intoxication stage of addiction. In this stage, the neurons in the basal ganglia contribute to the rewarding effects of addictive substances and to incentive salience through the release of dopamine and the brain's natural opioids.

Figure 2.6: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Binge/Intoxication Stage of Addiction



Notes: Blue represents the basal ganglia involved in the Binge/Intoxication stage. Red represents the extended amygdala involved in the Negative Affect/Withdrawal stage. Green represents the prefrontal cortex involved in the Preoccupation/Anticipation stage.

Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

Early studies in animals demonstrated how incentive salience works. For example, after researchers repeatedly gave an animal a stimulant drug (e.g., cocaine) along with a previously neutral stimulus, such as a light or a sound, they found that the neutral stimulus by itself caused the animal to engage in drug-seeking behavior, and it also resulted in dopamine release that had previously occurred only in response to the drug.[20] Even more compelling results were seen when scientists recorded the electrical activity of dopamine-transmitting neurons in animals that had been exposed multiple times to a neutral (non-

drug) stimulus followed by a drug. At first, the neurons responded only when they were exposed to the drug. However, over time, the neurons stopped firing in response to the drug and instead fired when they were exposed to the neutral stimulus associated with it. This means that the animals associated the stimulus with the substance and, in anticipation of getting the substance, their brains began releasing dopamine, resulting in a strong motivation to seek the drug.[21,22] Imaging studies in humans have shown similar results. For example, dopamine is released in the brains of people addicted to cocaine when they are exposed to cues they have come to associate with cocaine.[23,24] This effect occurs even though cocaine itself causes less dopamine to be released in these individuals compared to those who are not addicted to cocaine (an effect also seen with other substances).[25]

Together, these studies indicate that stimuli associated with addictive drugs can, by themselves, produce drug-like effects on the brain and trigger drug use. These findings help to explain why individuals with substance use disorders who are trying to maintain abstinence are at increased risk of relapse if they continue to have contact with the people they previously used drugs with or the places where they used drugs.

Substances Stimulate Areas of the Brain Involved in Habit Formation

A second sub-region of the basal ganglia, the dorsal striatum, is involved in another critical component of the binge/intoxication stage: habit formation. The release of dopamine (along with activation of brain opioid systems) and release of glutamate (an excitatory neurotransmitter) can eventually trigger changes in the dorsal striatum.[2,26] These changes strengthen substance-seeking and substance-taking habits as addiction progresses, ultimately contributing to compulsive use.

In Summary: The Binge/Intoxication Stage and the Basal Ganglia

The "reward circuitry" of the basal ganglia (i.e., the nucleus accumbens), along with dopamine and naturally occurring opioids, play a key role in the rewarding effects of alcohol and other substances and the ability of stimuli, or cues, associated with that substance use to trigger craving, substance seeking, and use.

As alcohol or substance use progresses, repeated activation of the "habit circuitry" of the basal ganglia (i.e., the dorsal striatum) contributes to the compulsive substance seeking and taking that are associated with addiction.

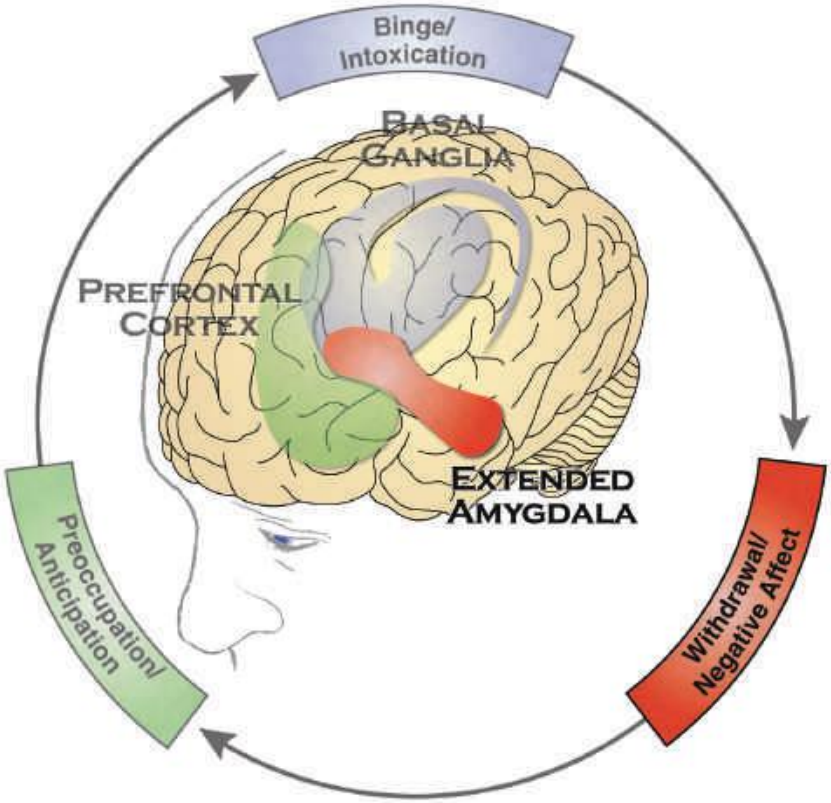
The involvement of these reward and habit neurocircuits helps explain the intense desire for the substance (craving) and the compulsive substance seeking that occurs when actively or previously addicted individuals are exposed to alcohol and/or drug cues in their surroundings.

Withdrawal/Negative Affect Stage: Extended Amygdala

The withdrawal/negative affect stage of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, which include negative emotions and, sometimes, symptoms of physical illness, when they stop taking the substance. Symptoms of withdrawal may occur with all

addictive substances, including marijuana, though they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry of the basal ganglia[14] and activation of the brain's stress systems in the extended amygdala (Figure 2.7).

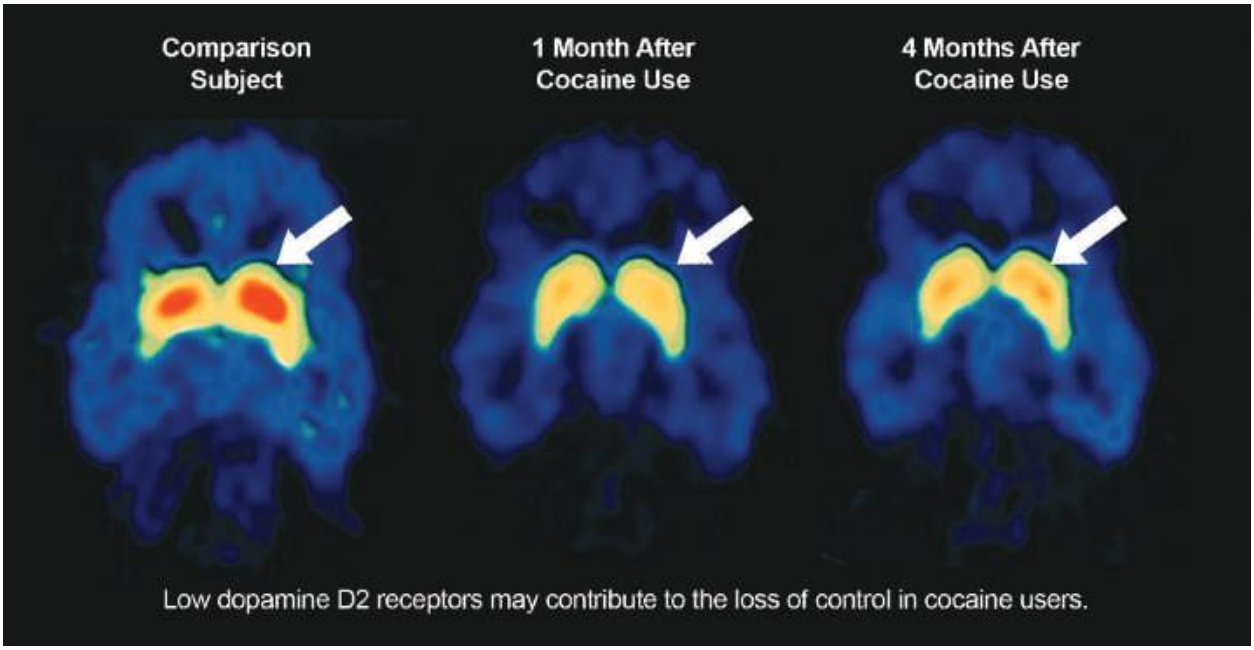
Figure 2.7: The Withdrawal/Negative Affect Stage and the Extended Amygdala



When used over the long-term, all substances of abuse cause dysfunction in the brain's dopamine reward system.[27] For example, brain imaging studies in humans with addiction have consistently shown long-lasting decreases in a particular type of dopamine receptor, the D2 receptor, compared with non-addicted individuals (Figure 2.8).[25,28] Decreases in the activity of the dopamine system have been observed during withdrawal from stimulants, opioids, nicotine, and alcohol. Other studies also show that when an addicted person is given a stimulant, it causes a smaller release of dopamine than when the same dose is given to a person who is not addicted.

These findings suggest that people addicted to substances experience an overall reduction in the sensitivity of the brain's reward system (especially the brain circuits involving dopamine), both to addictive substances and also to natural reinforcers, such as food and sex. This is because natural reinforcers also depend upon the same reward system and circuits. This impairment explains why those who develop a substance use disorder often do not derive the same level of satisfaction or pleasure from once-pleasurable activities. This general loss of reward sensitivity may also account for the compulsive escalation of substance use as addicted individuals attempt to regain the pleasurable feelings the reward system once provided.[15]

Figure 2.8: Time-Related Decrease in Dopamine Released in the Brain of a Cocaine User



Notes: These fMRI images compare the brain of an individual with a history of cocaine use disorder (middle and right) to the brain of an individual without a history of cocaine use (left). The person who has had a cocaine use disorder has lower levels of the D2 dopamine receptor (depicted in red) in the striatum one month (middle) and four months (right) after stopping cocaine use compared to the non-user. The level of dopamine receptors in the brain of the cocaine user are higher at the 4-month mark (right), but have not returned to the levels observed in the non-user (left).

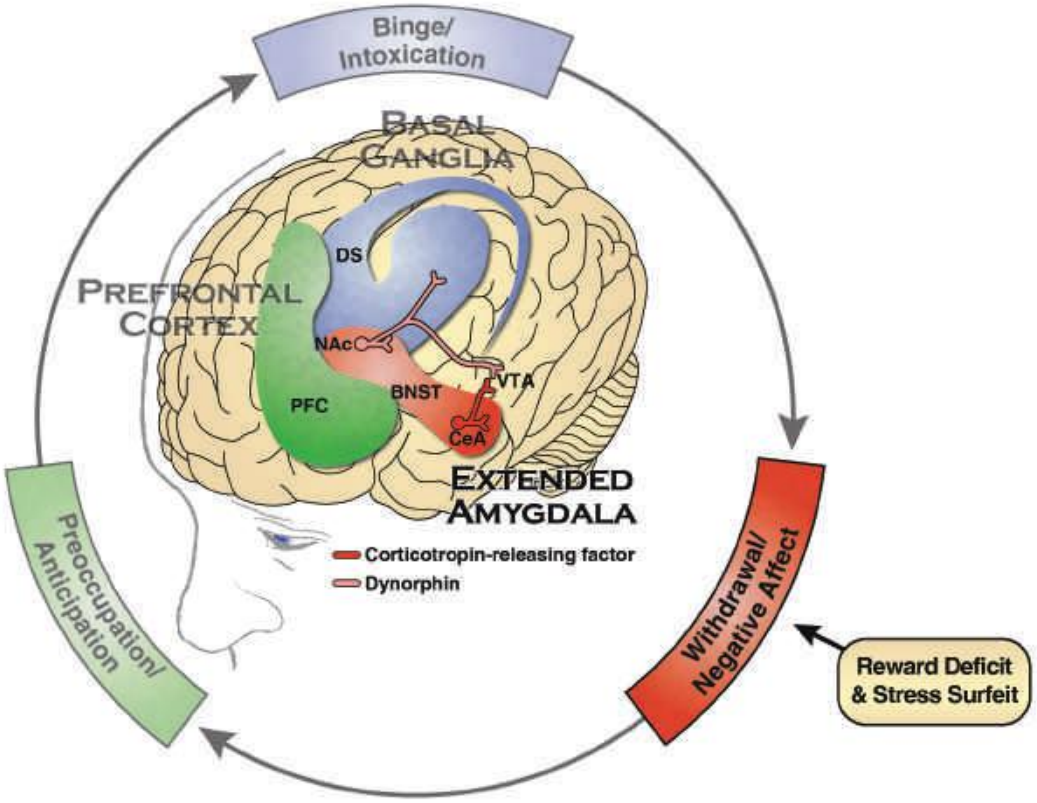
Source: Modified with permission from Volkow et al., (1993).[29]

At the same time, a second process occurs during the withdrawal stage: activation of stress neurotransmitters in the extended amygdala. These stress neurotransmitters include corticotropin-releasing factor (CRF), norepinephrine, and dynorphin (**Figure 2.9**).[30]

Studies suggest that these neurotransmitters play a key role in the negative feelings associated with withdrawal and in stress-triggered substance use. In animal and human studies, when researchers use special chemicals called antagonists to block activation of the stress neurotransmitter systems, it has the effect of reducing substance intake in response to withdrawal and stress. For example, blocking the activation of stress receptors in the brain reduced alcohol consumption in both alcohol-dependent rats and humans with an alcohol use disorder.[31] Thus, it may be that an additional motivation for drug and alcohol seeking among individuals with substance use disorders is to suppress overactive brain stress systems that produce negative emotions or feelings. Recent research also suggests that neuroadaptations in the endogenous cannabinoid system within the extended amygdala contribute to increased stress reactivity and negative emotional states in addiction.[32]

The desire to remove the negative feelings that accompany withdrawal can be a strong motivator of continued substance use. As noted previously, this motivation is strengthened through negative reinforcement, because taking the substance relieves the negative feelings associated with withdrawal, at least temporarily. Of course, this process is a vicious cycle: Taking drugs or alcohol to lessen the symptoms of withdrawal that occur during a period of abstinence actually causes those symptoms to be even worse the next time a person stops taking the substance, making it even harder to maintain abstinence.

Figure 2.9: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Withdrawal/Negative Affect Stage of Addiction



Notes: Not shown is the neurotransmitter norepinephrine which is also activated in the extended amygdala during withdrawal.

Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

In Summary: The Withdrawal/Negative Affect Stage and the Extended Amygdala

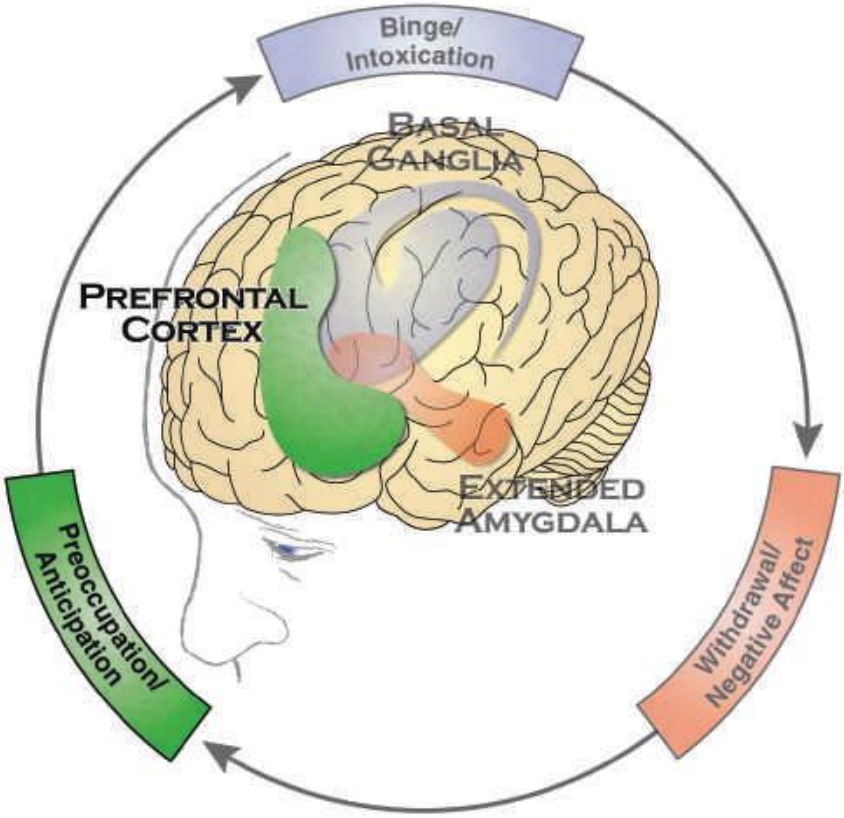
This stage of addiction involves a decrease in the function of the brain reward systems and an activation of stress neurotransmitters, such as CRF and dynorphin, in the extended amygdala. Together, these phenomena provide a powerful neurochemical basis for the negative emotional state associated with withdrawal. The drive to alleviate these negative feelings negatively reinforces alcohol or drug use and drives compulsive substance taking.

Preoccupation/Anticipation Stage: Prefrontal Cortex

The preoccupation/anticipation stage of the addiction cycle is the stage in which a person may begin to seek substances again after a period of abstinence. In people with severe substance use disorders, that period of abstinence may be quite short (hours). In this stage, an addicted person becomes preoccupied with using substances again. This is commonly called "craving." Craving has been difficult to measure in human studies and often does not directly link with relapse.

This stage of addiction involves the brain's prefrontal cortex (Figure 2.10) the region that controls executive function: the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's own actions, emotions, and impulses. Executive function is essential for a person to make appropriate choices about whether or not to use a substance and to override often strong urges to use, especially when the person experiences triggers, such as stimuli associated with that substance (e.g., being at a party where alcohol is served or where people are smoking) or stressful experiences.

Figure 2.10: The Preoccupation/Anticipation Stage and the Prefrontal Cortex

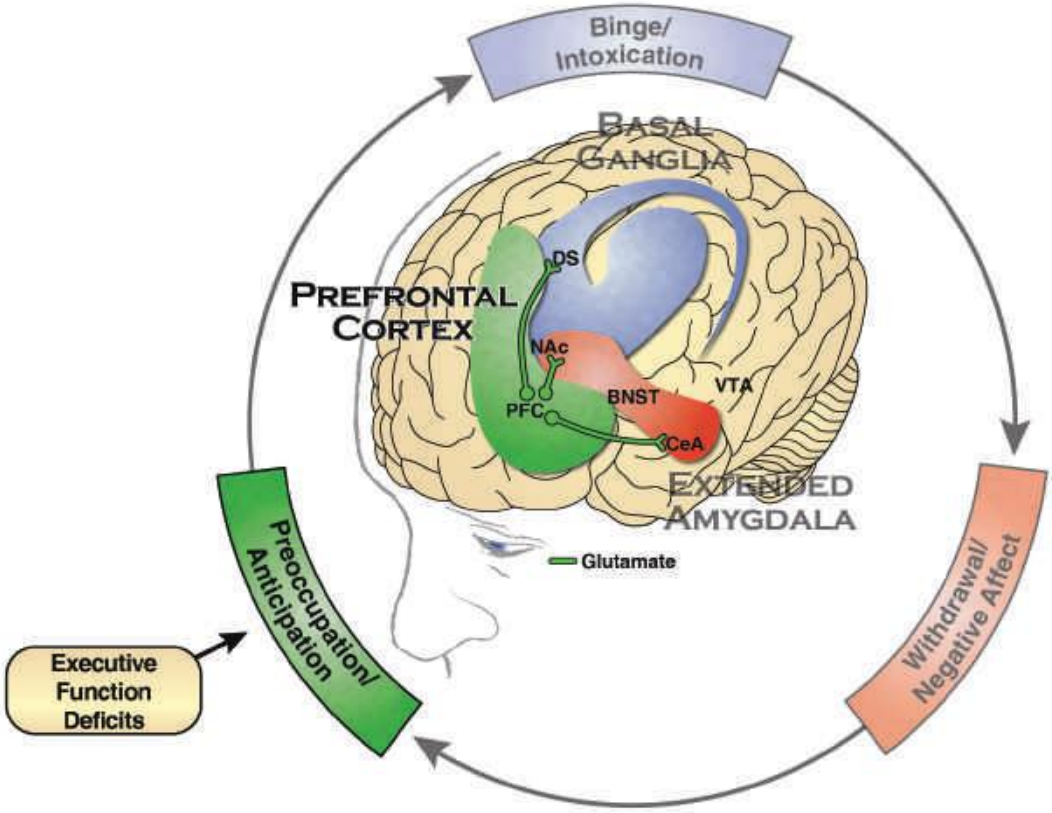


To help explain how the prefrontal cortex is involved in addiction, some scientists divide the functions of this brain region into a "Go system" and an opposing "Stop system."[33] The Go system helps people make decisions, particularly those that require significant attention and those involved with planning. People also engage the Go system when they begin behaviors that help them achieve goals. Indeed, research shows that when substance-seeking behavior is triggered by substance-associated environmental cues (incentive salience), activity in the Go circuits of the prefrontal cortex increases dramatically. This increased activity stimulates the nucleus accumbens to release glutamate, the main excitatory neurotransmitter in the brain. This release, in turn, promotes incentive salience, which creates a powerful urge to use the substance in the presence of drug-associated cues.

The Go system also engages habit-response systems in the dorsal striatum, and it contributes to the impulsivity associated with substance seeking. Habitual responding can occur automatically and subconsciously, meaning a person may not even be aware that they are engaging in such behaviors. The

neurons in the Go circuits of the prefrontal cortex stimulate the habit systems of the dorsal striatum through connections that use glutamate (Figure 2.11).

Figure 2.11: Major Neurotransmitter Systems Implicated in the Neuroadaptations Associated with the Preoccupation/Anticipation Stage of Addiction



Abbreviations: PFC - prefrontal cortex, DS - dorsal striatum, NAc - nucleus accumbens, BNST - bed nucleus of the stria terminalis, CeA - central nucleus of the amygdala, VTA - ventral tegmental area.

Source: Modified with permission from Koob & Volkow, (2010).[14]

The Stop system inhibits the activity of the Go system. Especially relevant to its role in addiction, this system controls the dorsal striatum and the nucleus accumbens, the areas of the basal ganglia that are involved in the binge/intoxication stage of addiction. Specifically, the Stop system controls habit responses driven by the dorsal striatum, and scientists think that it plays a role in reducing the ability of substance-associated stimuli to trigger relapse—in other words, it inhibits incentive salience.[34]

The Stop system also controls the brain's stress and emotional systems, and plays an important role in relapse triggered by stressful life events or circumstances. Stress-induced relapse is driven by activation of neurotransmitters such as CRF, dynorphin, and norepinephrine in the extended amygdala. As described above, these neurotransmitters are activated during prolonged abstinence during the withdrawal/negative affect stage of addiction. More recent work in animals also implicates disruptions in the brain's cannabinoid system, which also regulates the stress systems in the extended amygdala, in relapse. Studies show that lower activity in the Stop component of the prefrontal cortex is associated with increased activity of stress circuitry involving the extended amygdala, and this increased activity drives substance-taking behavior and relapse.[37]

Brain imaging studies in people with addiction show disruptions in the function of both the Go and Stop circuits.[35-37] For example, people with alcohol, cocaine, or opioid use disorders show impairments in executive function, including disruption of decision-making and behavioral inhibition. These executive function deficits parallel changes in the prefrontal cortex and suggest decreased activity in the Stop system and greater reactivity of the Go system in response to substance-related stimuli.

Indeed, a smaller volume of the prefrontal cortex in abstinent, previously addicted individuals predicts a shorter time to relapse.[38] Studies also show that diminished prefrontal cortex control over the extended amygdala is particularly prominent in humans with post-traumatic stress disorder (PTSD), a condition that is frequently accompanied by drug and alcohol use disorders.[39] These findings bolster support for the role of the prefrontal cortex-extended amygdala circuit in stress-induced relapse, and suggest that strengthening prefrontal cortex circuits could aid substance use disorder treatment.

In Summary: The Preoccupation/Anticipation Stage and the Prefrontal Cortex

This stage of the addiction cycle is characterized by a disruption of executive function caused by a compromised prefrontal cortex. The activity of the neurotransmitter glutamate is increased, which drives substance use habits associated with craving, and disrupts how dopamine influences the frontal cortex.[2] The over-activation of the Go system in the prefrontal cortex promotes habit-like substance seeking, and the under-activation of the Stop system of the prefrontal cortex promotes impulsive and compulsive substance seeking.

To recap, addiction involves a three-stage cycle—binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation—that worsens over time and involves dramatic changes in the brain reward, stress, and executive function systems. Progression through this cycle involves three major regions of the brain: the basal ganglia, the extended amygdala, and the prefrontal cortex, as well as multiple neurotransmitter systems (**Figure 2.12**). The power of addictive substances to produce positive feelings and relieve negative feelings fuels the development of compulsive use of substances. The combination of increased incentive salience (binge/intoxication stage), decreased reward sensitivity and increased stress sensitivity (withdrawal/negative affect stage), and compromised executive function (preoccupation/anticipation stage) provides an often overwhelming drive for substance seeking that can be unrelenting.

Different Classes of Substances Affect the Brain and Behavior in Different Ways

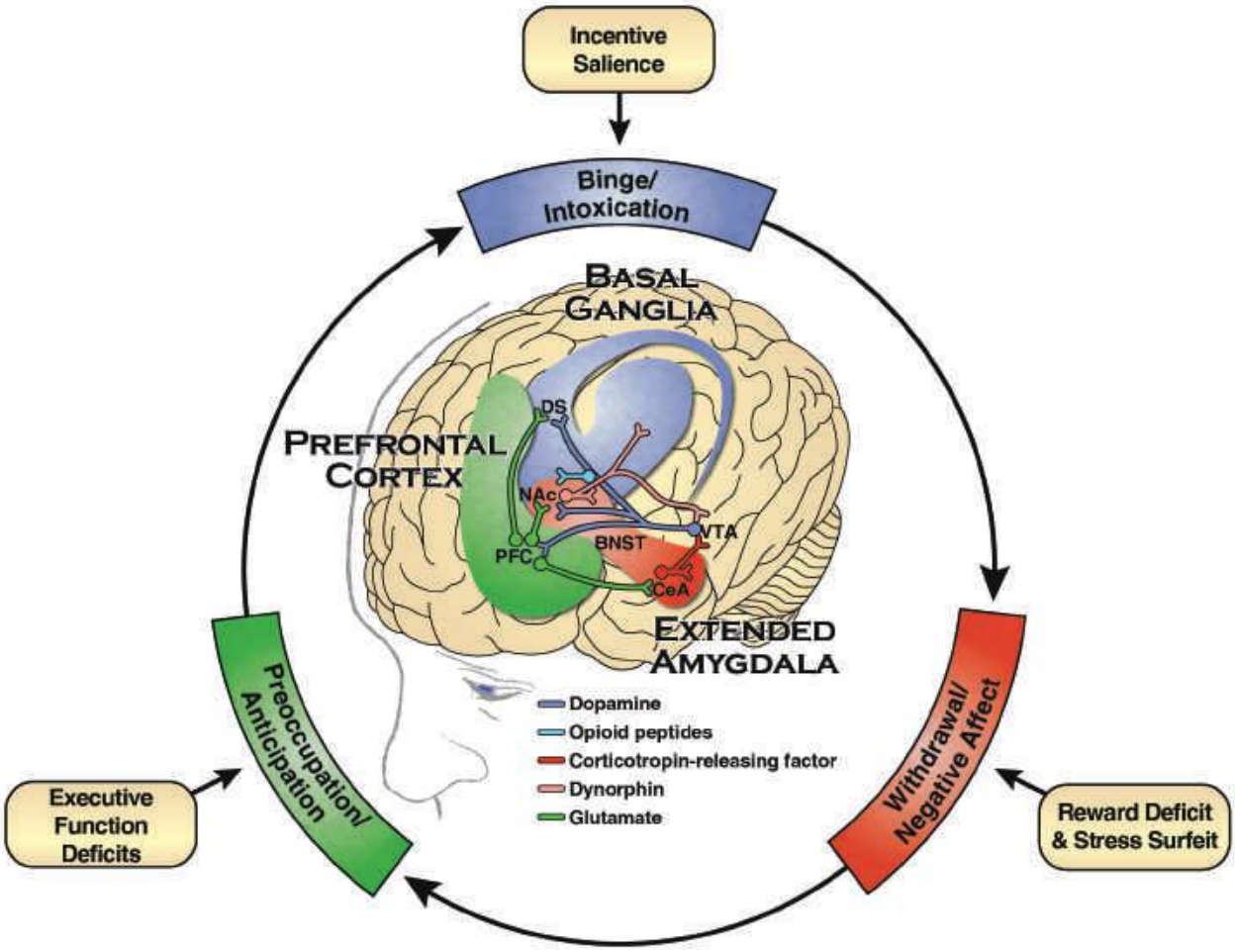
Although the three stages of addiction generally apply to all addictive substances, different substances affect the brain and behavior in different ways during each stage of the addiction cycle. Differences in the pharmacokinetics of various substances determine the duration of their effects on the body and partly account for the differences in their patterns of use. For example, nicotine has a short half-life, which means smokers need to smoke often to maintain the effect. In contrast, THC, the primary psychoactive compound in marijuana, has a much longer half-life. As a result, marijuana smokers do not typically smoke

as frequently as tobacco smokers.[40] Typical patterns of use are described below for the major classes of addictive substances. However, people often use these substances in combination.[41] Additional research is needed to understand how using more than one substance affects the brain and the development and progression of addiction, as well as how use of one substance affects the use of others.

KEY TERMS

Pharmacokinetics. What the body does to a drug after it has been taken, including how rapidly the drug is absorbed, broken down, and processed by the body.

Figure 2.12: The Primary Brain Regions and Neurotransmitter Systems Involved in Each of the Three Stages of the Addiction Cycle



Opioids

Opioids attach to opioid receptors in the brain, which leads to a release of dopamine in the nucleus accumbens, causing euphoria (the high), drowsiness, and slowed breathing, as well as reduced pain signaling (which is why they are frequently prescribed as pain relievers). Opioid addiction typically involves a pattern of: (1) intense intoxication, (2) the development of tolerance, (3) escalation in use, and (4) withdrawal signs that include profound negative emotions and physical symptoms, such as

bodily discomfort, pain, sweating, and intestinal distress and, in the most severe cases, seizures. As use progresses, the opioid must be taken to avoid the severe negative effects that occur during withdrawal. With repeated exposure to opioids, stimuli associated with the pleasant effects of the substances (e.g., places, persons, moods, and paraphernalia) and with the negative mental and physical effects of withdrawal can trigger intense craving or preoccupation with use.

Alcohol

When alcohol is consumed it interacts with several neurotransmitter systems in the brain, including the inhibitory neurotransmitter GABA, glutamate, and others that produce euphoria as well as the sedating, motor impairing, and anxiety-reducing effects of alcohol intoxication. Alcohol addiction often involves a similar pattern as opioid addiction, often characterized by periods of binge or heavy drinking followed by withdrawal. As with opioids, addiction to alcohol is characterized by intense craving that is often driven by negative emotional states, positive emotional states, and stimuli that have been associated with drinking, as well as a severe emotional and physical withdrawal syndrome. Many people with severe alcohol use disorder engage in patterns of binge drinking followed by withdrawal for extended periods of time. Extreme patterns of use may evolve into an opioid-like use pattern in which alcohol must be available at all times to avoid the negative consequences of withdrawal.

KEY TERMS

Binge drinking. For men, drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days.

Stimulants

Stimulants increase the amount of dopamine in the reward circuit (causing the euphoric high) either by directly stimulating the release of dopamine or by temporarily inhibiting the removal of dopamine from synapses, the gaps between neurons. These drugs also boost dopamine levels in brain regions responsible for attention and focus on tasks (which is why stimulants like methylphenidate [Ritalin®] or dextroamphetamine [Adderall®] are often prescribed for people with attention deficit hyperactivity disorder). Stimulants also cause the release of norepinephrine, a neurotransmitter that affects autonomic functions like heart rate, causing a user to feel energized.

Addiction to stimulants, such as cocaine and amphetamines (including methamphetamine), typically follows a pattern that emphasizes the binge/intoxication stage. A person will take the stimulant repeatedly during a concentrated period of time lasting for hours or days (these episodes are called binges). The binge is often followed by a crash, characterized by negative emotions, fatigue, and inactivity. Intense craving then follows, which is driven by environmental cues associated with the availability of the substance, as well as by a person's internal state, such as their emotions or mood.

Marijuana (Cannabis)

Like other drugs, marijuana (also called cannabis) leads to increased dopamine in the basal ganglia, producing the pleasurable high. It also interacts with a wide variety of other systems and circuits in the brain that contain receptors for the body's natural cannabinoid neurotransmitters. Effects can be different from user to user, but often include distortions in motor coordination and time perception. Cannabis addiction follows a pattern similar to opioids. This pattern involves a significant binge/

intoxication stage characterized by episodes of using the substance to the point of intoxication. Over time, individuals begin to use the substance throughout the day and show chronic intoxication during waking hours. Withdrawal is characterized by negative emotions, irritability, and sleep disturbances.[40] Although the craving associated with cannabis[42] has been less studied than for other substances, it is most likely linked to both environmental and internal states, similar to those of other addictive substances.[43,44]

Synthetic Drugs

Different classes of chemically synthesized (hence the term synthetic) drugs have been developed, each used in different ways and having different effects in the brain. Synthetic cathinones, more commonly known as "bath salts," target the release of dopamine in a similar manner as the stimulant drugs described above. To a lesser extent, they also activate the serotonin neurotransmitter system, which can affect perception. Synthetic cannabinoids, sometimes referred to as "K2", "Spice", or "herbal incense," somewhat mimic the effects of marijuana but are often much more powerful. Drugs such as MDMA (ecstasy) and lysergic acid diethylamide (LSD) also act on the serotonin neurotransmitter system to produce changes in perception. Fentanyl is a synthetic opioid medication that is used for severe pain management and is considerably more potent than heroin. Prescription fentanyl, as well as illicitly manufactured fentanyl and related synthetic opioids, are often mixed with heroin but are also increasingly used alone or sold on the street as counterfeit pills made to look like prescription opioids or sedatives.

Factors that Increase Risk for Substance Use, Misuse, and Addiction

Not all people use substances, and even among those who use them, not all are equally likely to become addicted. Many factors influence the development of substance use disorders, including developmental, environmental, social, and genetic factors, as well as co-occurring mental disorders. Other factors protect people from developing a substance use disorder or addiction. The relative influence of these risk and protective factors varies across individuals and the lifespan. The following sections discuss some of these factors.

Early Life Experiences

FOR MORE ON THIS TOPIC

See Chapter 1 - *Introduction and Overview* and Chapter 3 - *Prevention Programs and Policies.*

The experiences a person has early in childhood and in adolescence can set the stage for future substance use and, sometimes, escalation to a substance use disorder or addiction. Early life stressors can include physical, emotional, and sexual abuse; neglect; household instability (such as parental substance use and conflict, mental illness, or incarceration of household members);[45] and poverty.[46] Research suggests that the stress caused by these risk factors may act on the same stress circuits in the brain as addictive substances, which may explain why they increase addiction risk.[47]

Adolescence is a critical period in the vulnerability to substance use and use disorders, because a hallmark of this developmental period is risk taking and experimentation, which for some young people includes trying alcohol, marijuana, or other drugs. In addition, the brain undergoes significant changes during this life stage, making it particularly vulnerable to substance exposure.[48] Importantly,

the frontal cortex—a region in the front part of the brain that includes the prefrontal cortex—does not fully develop until the early to mid-20s, and research shows that heavy drinking and drug use during adolescence affects development of this critical area of the brain.[49]

About three quarters (74 percent) of 18- to 30-year-olds admitted to treatment programs began using substances at the age of 17 or younger.[50] Individuals who start using substances during adolescence often experience more chronic and intensive use, and they are at greater risk of developing a substance use disorder compared with those who begin use at an older age. In other words, the earlier the exposure, the greater the risk.[51]

Not all adolescents who experiment with alcohol, cigarettes, or other substances go on to develop a substance use disorder, but research suggests that those who do progress to more harmful use may have pre-existing differences in their brains. For example, a brain imaging study of adolescents revealed that the volume of the frontal cortex was smaller in youth who transitioned from no or minimal drinking to heavy drinking over the course of adolescence than it was in youth who did not drink during adolescence.[49] Additional research can shed light on how these differences contribute to the progression from use to a disorder, as well as how changes caused by substance use affect brain function and behavior and whether they can be reversed.

Genetic and Molecular Factors

Genetic factors are thought to account for 40 to 70 percent of individual differences in risk for addiction.[52,53] Although multiple genes are likely involved in the development of addiction, only a few specific gene variants have been identified that either predispose to or protect against addiction. Some of these variants have been associated with the metabolism of alcohol and nicotine, while others involve receptors and other proteins associated with key neurotransmitters and molecules involved in all parts of the addiction cycle.[54] Genes involved in strengthening the connections between neurons and in forming drug memories have also been associated with addiction risk.[55,56] Like other chronic health conditions, substance use disorders are influenced by the complex interplay between a person's genes and environment. Additional research on the mechanisms underlying gene by environment interactions is expected to provide insight into how substance use disorders develop and how they can be prevented and treated.

Use of Multiple Substances and Co-occurring Mental Health Conditions

Many individuals with a substance use disorder also have a mental disorder,[57,58] and some have multiple substance use disorders. For example, according to the 2015 *National Survey on Drug Use and Health* (NSDUH), of the 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and 41.2 percent also had a mental illness.[59] Particularly striking is the 3- to 4-fold higher rate of tobacco smoking among patients with schizophrenia and the high prevalence of co-existing alcohol use disorder in those meeting criteria for PTSD. It is estimated that 30-60 percent of patients seeking treatment for

alcohol use disorder meet criteria for PTSD,[60,61] and approximately one third of individuals who have experienced PTSD have also experienced alcohol dependence at some point in their lives.[60]

The reasons why substance use disorders and mental disorders often occur together are not clear, and establishing the relationships between these conditions is difficult. Still, three possible explanations deserve attention. One reason for the overlap may be that having a mental disorder increases vulnerability to substance use disorders because certain substances may, at least temporarily, be able to reduce mental disorder symptoms and thus are particularly negatively reinforcing in these individuals. Second, substance use disorders may increase vulnerability for mental disorders,[62-64] meaning that the use of certain substances might trigger a mental disorder that otherwise would have not occurred. For example, research suggests that alcohol use increases risk for PTSD by altering the brain's ability to recover from traumatic experiences.[65,66] Similarly, the use of marijuana, particularly marijuana with a high THC content, might contribute to schizophrenia in those who have specific genetic vulnerabilities.[67] Third, it is also possible that both substance use disorders and mental disorders are caused by shared, overlapping factors, such as particular genes, neurobiological deficits, and exposure to traumatic or stressful life experiences. As these possibilities are not mutually exclusive, the relationship between substance use disorders and mental disorders may result from a combination of these processes.

Regardless of which one might influence the development of the other, mental and substance use disorders have overlapping symptoms, making diagnosis and treatment planning particularly difficult. For example, people who use methamphetamine for a long time may experience paranoia, hallucinations, and delusions that may be mistaken for symptoms of schizophrenia. And, the psychological symptoms that accompany withdrawal, such as depression and anxiety, may be mistaken as simply part of withdrawal instead of an underlying mood disorder that requires independent treatment in its own right. Given the prevalence of co-occurring substance use and mental disorders, it is critical to continue to advance research on the genetic, neurobiological, and environmental factors that contribute to co-occurring disorders and to develop interventions to prevent and treat them.

Biological Factors Contributing to Population-based Differences in Substance Misuse and Substance Use Disorders

Differences Based on Sex

Some groups of people are also more vulnerable to substance misuse and substance use disorders. For example, men tend to drink more than women and they are at higher risk for alcohol use disorder, although the gender differences in alcohol use are declining.[68] Men are also more likely to have other substance use disorders.[69] However, clinical reports suggest that women who use cocaine, opioids, or alcohol progress from initial use to a disorder at a faster rate than do men (called "telescoping").[70-72] Compared with men, women also exhibit greater symptoms of withdrawal from some drugs, such as nicotine. They also report worse negative affects during withdrawal and have higher levels of the stress hormone cortisol.[73]

Sex differences in reaction to addictive substances are not particular to humans. Female rats, in general, learn to self-administer drugs and alcohol more rapidly, escalate their drug taking more quickly, show greater symptoms of withdrawal, and are more likely to resume drug seeking in response to drugs, drug-related cues, or stressors. The one exception is that female rats show less withdrawal symptoms related to alcohol use.[74] Researchers are investigating the neurobiological bases for these differences.

Differences Based on Race and Ethnicity

Research on the neurobiological factors contributing to differential rates of substance use and substance use disorders in particular racial and ethnic groups is much more limited. A study using functional magnetic resonance imaging (fMRI) found that African American smokers showed greater activation of the prefrontal cortex upon exposure to smoking-related cues than did White smokers, an effect that may partly contribute to the lower smoking-cessation success rates observed among African Americans.[75]

Alcohol research with racial and ethnic groups has shown that approximately 36 percent of East Asians carry a gene variant that alters the rate at which members of that racial group metabolize alcohol, causing a buildup of acetaldehyde, a toxic byproduct of alcohol metabolism that produces symptoms such as flushing, nausea, and rapid heartbeat. Although these effects may protect some individuals of East Asian descent from alcohol use disorder, those who drink despite the effects are at increased risk for esophageal[76] and head and neck cancers.[77] Another study found that even low levels of alcohol consumption by Japanese Americans may result in adverse effects on the brain, a finding that may be related to the differences in alcohol metabolism described above.[78] Additional research will help to clarify the interactions between race, ethnicity, and the neuroadaptations that underlie substance misuse and addiction. This work may inform the development of more precise preventive and treatment interventions.

Recommendations for Research

Decades of research demonstrate that chronic substance misuse leads to profound disruptions of brain circuits involved in the experience of pleasure or reward, habit formation, stress, and decision-making. This work has paved the way for the development of a variety of therapies that effectively help people reduce or abstain from alcohol and drug misuse and regain control over their lives. In spite of this progress, our understanding of how substance use affects the brain and behavior is far from complete. Four research areas are specifically emphasized in the text below.

Effects of Substance Use on Brain Circuits and Functions

Continued research is necessary to more thoroughly explain how substance use affects the brain at the molecular, cellular, and circuit levels. Such research has the potential to identify common neurobiological mechanisms underlying substance use disorders, as well as other related mental disorders. This research is expected to reveal new neurobiological targets, leading to new medications and non-pharmacological treatments—such as transcranial magnetic stimulation or vaccines—for the treatment of substance use disorders. A better understanding of the neurobiological mechanisms underlying substance use disorders could also help to inform behavioral interventions. Therefore, basic research that further elucidates the neurobiological framework of substance use disorders and

co-occurring mental disorders, as well as research leading to the development of new medications and other therapeutics to treat the underlying neurobiological mechanisms of substance use disorders should be accelerated.

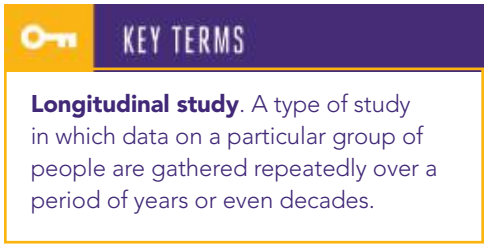
As with other diseases, individuals vary in the development and progression of substance use disorders. Not only are some people more likely to use and misuse substances than are others and to progress from initial use to addiction differently, individuals also differ in their vulnerability to relapse and in how they respond to treatments. For example, some people with substance use disorders are particularly vulnerable to stress-induced relapse, but others may be more likely to resume substance use after being exposed to drug-related cues. Developing a thorough understanding of how neurobiological differences account for variation among individuals and groups will guide the development of more effective, personalized prevention and treatment interventions. Additionally, determining how neurobiological factors contribute to differences in substance misuse and addiction between women and men and among racial and ethnic groups is critical.

Continued advances in neuroscience research will further enhance our understanding of substance use disorders and accelerate the development of new interventions. Data gathered through the National Institutes of Health's Adolescent Brain Cognitive Development study, the largest long-term study of cognitive and brain development in children across the United States, is expected to yield unprecedented information about how substance use affects adolescent brain development. The Human Connectome Project and the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative are poised to spur an explosion of knowledge about the structure and function of brain circuits and how the brain affects behavior. Technologies that can alter the activity of dysfunctional circuits are being explored as possible treatments. Moreover, continued advances in genomics, along with President Obama's Precision Medicine Initiative, a national effort to better understand how individual variability in genes, environment, and lifestyle contribute to disease, are expected to bring us closer to developing individually-tailored preventive and treatment interventions for substance-related conditions.

Neurobiological Effects of Recovery

Little is known about the factors that facilitate or inhibit long-term recovery from substance use disorders or how the brain changes over the course of recovery. Developing a better understanding of the recovery process, and the neurobiological mechanisms that enable people to maintain changes in their substance use behavior and promote resilience to relapse, will inform the development of additional effective treatment and recovery support interventions. Therefore, an investigation of the neurobiological processes that underlie recovery and contribute to improvements in social, educational, and professional functioning is necessary.

Adolescence, Brain Change, and Vulnerability to Substance Use Disorders



Although young people are particularly vulnerable to the adverse effects of substance use, not all adolescents who experiment with alcohol or drugs go on to develop a substance use disorder. Prospective, longitudinal studies are needed to investigate whether pre-existing neurobiological factors contribute to adolescent substance use and the development of substance use disorders, how adolescent substance use affects brain structure and function, and whether the changes in brain structure and function that accompany chronic substance use can recover over time. Studies that follow groups of adolescents over time to learn about the developing human brain should be conducted. These studies should investigate how pre-existing neurobiological factors contribute to substance use, misuse, and addiction, and how adolescent substance use affects brain function and behavior.

Neurobiological Effects of Polysubstance Use and Emerging Drug Products

Patterns of alcohol and drug use change over time. New drugs or drug combinations, delivery systems, and routes of administration emerge, and with them new questions for public health. For example, concern is growing that increasing use of marijuana extracts with extremely high amounts of THC could lead to higher rates of addiction among marijuana users. Concerns also are emerging about how new products about which little is known, such as synthetic cannabinoids and synthetic cathinones, affect the brain. Additional research is needed to better understand how such products - as well as emerging addictive substances - affect brain function and behavior, and contribute to addiction.

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Scott.A.Milkey

From: Lanham, Julie (COA)
Sent: Thursday, February 23, 2017 10:33 AM
To: Hudson, Mary Kay
Cc: Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Mason, Derrick;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;Luttrull, James;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Hammond, John;vbecker@elkhartpa.com;Jerry Torr
Subject: Re: Indiana EBDM Policy Team Meeting - PLEASE NOTE MEETING LOCATION CHANGE

I won't be there

Sent from my iPhone

> On Feb 22, 2017, at 3:54 PM, Hudson, MK <mk.hudson@courts.IN.gov> wrote:
>
> **** This is an EXTERNAL email. Exercise caution. DO NOT open
> attachments or click links from unknown senders or unexpected email.
> **** _____ A reminder that the Indiana EBDM Policy Team is scheduled to meet on Friday, March 10, from 9 am – 12 pm.
>
> The meeting will be held at the Indiana Government Center South Conference Center, Conference Room 18. I will forward meeting materials next week.
>
> Because we are in a location different from our usual meeting space, please note:
>
> 1. With the legislature in session, parking in the state parking facilities may be limited. For a conference center map and nearby parking options, please visit http://www.in.gov/idoa/2375.htm
> 2. Because we are in the government center, we are limited in the adjustments that can be made in the room set up. So we are sure to have seating for all, please respond to this invitation regarding your attendance by March 3, 2017.
> 3. We will not have conference call capabilities for this meeting.
>
> Please let me know if you have any questions. Thank you!
>
>
> Mary Kay Hudson, LSW, Deputy Director
> Indiana Office of Court Services, Office of Judicial Administration
> Indiana Supreme Court
> 30 South Meridian Street, Suite 900
> Indianapolis, IN 46204
> (317) 234-0106 desk

>
>
> <meeting.ics>

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Monday, February 20, 2017 11:47 AM
To: Karns, Allison
Subject: Re: Meeting today with Governor Holcomb
Attachments: image001.png

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Hi Allison--

There are various levels of sponsorship, but we have a government rate of $25/ (which is the cost of the dinner) that we are waiving.

Let me know if you need anything else.

Thx

Steve

Stephen C McCaffrey, JD
Sent from my iPhone

On Feb 20, 2017, at 11:18 AM, Karns, Allison <AKarns@gov.IN.gov> wrote:

Thanks, Steve. For purposes of reviewing the ethics rules – can you please let us know if there is a registration fee that MHA is waiving/paying?

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Monday, February 20, 2017 7:57 AM
To: Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov>
Cc: Karns, Allison <AKarns@gov.IN.gov>; Lopez, Danny <DaLopez@gov.IN.gov>; Gilson, Katie <KGilson@gov.IN.gov>
Subject: Re: Meeting today with Governor Holcomb

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Btw, on a lighter topic, the Hoosier Idol event date has been changed from April 18th to April 11 due to the change in the legislative calendar.

Of course the Governor, Janet, and the office staff are all invited to attend with our compliments.

Just let me know.

Thanks!

Steve

Stephen C. McCaffrey, JD

President & Chief Executive Officer



Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On Feb 20, 2017, at 7:20 AM, Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov> wrote:

Steve:

I just received word from Governor Holcomb that he will be out of the office until 1:30 p.m. today. He asked that I reschedule your meeting for later this afternoon. I am holding 3 p.m. on his schedule. Please let me know if this time works for Navigant.

Regards,

Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Karns, Allison
Sent: Monday, February 20, 2017 10:55 AM
To: McCaffrey, Steve
Subject: RE: Meeting today with Governor Holcomb

Thanks, Steve. For purposes of reviewing the ethics rules – can you please let us know if there is a registration fee that MHA is waiving/paying?

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Monday, February 20, 2017 7:57 AM
To: Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov>
Cc: Karns, Allison <AKarns@gov.IN.gov>; Lopez, Danny <DaLopez@gov.IN.gov>; Gilson, Katie <KGilson@gov.IN.gov>
Subject: Re: Meeting today with Governor Holcomb

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Just let me know.

Thanks!

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

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On Feb 20, 2017, at 7:20 AM, Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov> wrote:

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Regards,

Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Ban, Margaret R (Maggie) (GOV)
Sent: Monday, February 20, 2017 8:06 AM
To: McCaffrey, Steve
Cc: Karns, Allison;Lopez, Danny;Gilson, Katie
Subject: RE: Meeting today with Governor Holcomb

Thank you.

Maggie

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Monday, February 20, 2017 7:43 AM
To: Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov>
Cc: Karns, Allison <AKarns@gov.IN.gov>; Lopez, Danny <DaLopez@gov.IN.gov>; Gilson, Katie <KGilson@gov.IN.gov>
Subject: Re: Meeting today with Governor Holcomb

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Maggie—

That will work.

Thank you for working us in.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

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Regards,

Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Monday, February 20, 2017 7:57 AM
To: Ban, Margaret R (Maggie) (GOV)
Cc: Karns, Allison;Lopez, Danny;Gilson, Katie
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Btw, on a lighter topic, the Hoosier Idol event date has been changed from April 18th to April 11 due to the change in the legislative calendar.

Of course the Governor, Janet, and the office staff are all invited to attend with our compliments.

Just let me know.

Thanks!

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

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On Feb 20, 2017, at 7:20 AM, Ban, Margaret R (Maggie) (GOV) <MaBan@gov.IN.gov> wrote:

Steve:

I just received word from Governor Holcomb that he will be out of the office until 1:30 p.m. today. He asked that I reschedule your meeting for later this afternoon. I am holding 3 p.m. on his schedule. Please let me know if this time works for Navigant.

Regards,

Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Monday, February 20, 2017 7:43 AM
To: Ban, Margaret R (Maggie) (GOV)
Cc: Karns, Allison;Lopez, Danny;Gilson, Katie
Subject: Re: Meeting today with Governor Holcomb

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Maggie—

That will work.

Thank you for working us in.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

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Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Ban, Margaret R (Maggie) (GOV)
Sent: Monday, February 20, 2017 7:21 AM
To: McCaffrey, Steve
Cc: Karns, Allison;Lopez, Danny;Gilson, Katie
Subject: Meeting today with Governor Holcomb

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Regards,

Maggie Ban
Executive Assistant
Office of Governor Eric Holcomb

Scott.A.Milkey

From: Goodman, Michelle <michelle.goodman@courts.IN.gov>
Sent: Tuesday, February 14, 2017 8:44 AM
To: Powell, David N;Landis, Larry (llandis@i[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;Luttrull, James;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Jerry Torr;Rachelle Ramirez;Hammond, John;Mason, Derrick
Cc: Hudson, Mary Kay;McGriff, Paul;Melissa Stephenson;Ralph Watson;dellaswincher@[redacted];Vicki Becker
Subject: EBDM - Risk Assessment Validation Workgroup information
Attachments: Validation workgroup March 2 topics for discussion.docx

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Hello:

At the last EBDM meeting we invited anyone interested to participate in the Risk Assessment Validation Workgroup. Our first meeting will be Thursday, March 2nd from 2-4 p.m. at 30 South Meridian Street, Indianapolis, Room 804. Dr. Edward Latessa with the University of Cincinnati has agreed to join us for this discussion. Attached for your review and comment is a list of topics for discussion at this meeting. If you have any additional questions or topics you would like included, please email them to me by Sunday, Feb. 19th so we can include them as we prepare for this meeting.

I'll also be sending out a separate calendar invite so you can more easily add this to your schedule. If you have any questions or need something additional, please feel free to email me.

Thank you,

Michelle C. Goodman
Staff Attorney
Indiana Office of Court Services
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
Telephone: (317) 232-1313
Fax: (317) 233-3367
Email Address: michelle.goodman@courts.in.gov

Risk Assessment Validation Workgroup
Topics for March 2, 2016 meeting

- Overview of what a validation study does and does not tell us
- Aside from Indiana and Ohio, what other states use IRAS and have other validation studies been done on their populations?
- Overview of the process for conducting a validation study
    - Methodology used - pros and cons
    - Sample sizes needed
    - Types of data needed
    - How to measure for recidivism
- Are these tools race and gender neutral? How is that researched?
- Can we have other sub-populations studied (i.e. OWI offenders, violence)? If so, what type of information is needed?
- Can we have other items researched? And if so, what type of information is needed?
- Tools don't address all aspects of criminal history or specific on current offense. How can this still be useful?
- When your research has found something not to be predictive, what does that mean in this context? How can you explain this when our experience tells us to the contrary (i.e. prior conviction for same crime, whether crime was violent or not, etc.)?
- Since our criminal code reform, how can we study items on the tools to see if there are amendments needed due to statutory conditions (i.e. item measuring revocations and the new statutory limits on what cases can go back to DOC).
- How do we control for quality or other items that impact overall validity during the validation study?
- Once we get the results from the validation studies, how do we
    - Decide what items to amend, keep, discard, or add?
    - Decide what cut point adjustment should be made to determine low, moderate, high categories
- How can tools that predict group behavior be used and applied to individuals?
- Seeing scores of low, but not consistent with common sense and experience. How can this be?

DRAFT

Scott.A.Milkey

From: Kidwell, Jenny <jenny.kidwell@courts.IN.gov>
Sent: Monday, February 13, 2017 2:22 PM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Forkner, Justin;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hill, John;Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Barrett, Tami;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Cc: Utley, Katelyn
Subject: Justice Reinvestment Advisory Council Meeting Canceled 2/24/17

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

The February 24, 2017 meeting of the Justice Reinvestment Advisory Council meeting **has been canceled**. The meeting had been set to discuss legislative issues and after conferring with other members, it was decided to cancel the meeting. The next meeting, will be held on April 7th at the Indiana Office of Court Services, 30 South Meridian Street from Noon-3:00 p.m. This meeting will be held immediately following the EBDM morning meeting and lunch will be provided.

Jenny Kidwell
Indiana Office of Court Services
30 S. Meridian Street, Suite 900
Indianapolis, IN 46204
Phone: 317-232-1313
Fax: 317-233-3367
jenny.kidwell@courts.in.gov

Scott.A.Milkey

From: Karns, Allison
Sent: Wednesday, February 08, 2017 9:34 AM
To: McCaffrey, Steve
Subject: RE: Meeting

Thanks, Steve!

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Wednesday, February 8, 2017 7:40 AM
To: Karns, Allison <AKarns@gov.IN.gov>
Subject: Re: Meeting

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Thanks for all of your help Allison!

Btw on a fun note, Hoosier Idol is April 18 and of course the Governor and all staff are invited complimentary.

If the Governor has a hidden talent that he would like to display, I would of course be happy to accommodate him 🖷.

Stephen C McCaffrey, JD
Sent from my iPhone

On Feb 7, 2017, at 8:23 PM, Karns, Allison <AKarns@gov.IN.gov> wrote:

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> Navigant is a national firm that operates in 45 other states and pretty much does it all—risk assessment, program design, implementation, monitoring and evaluation. While traditionally strong in the public health care system, they are moving more into the behavioral healthcare space.

You don't need to do any prep for the meeting—my hope is it might open doors to future collaborations that might be of benefit.

Hope that helps.

Steve

Stephen C. McCaffrey, JD
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<unknown.png>

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From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Monday, February 6, 2017 3:36 PM
To: Karns, Allison <AKarns@gov.IN.gov>
Subject: Re: Meeting

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Hi Allison--

February the 20th at 11am works.

I will let you know who will be in the meeting as soon as I know for sure, but I do know they will be flying in to meet with the Governor

Thanks so much for putting this together.

Steve

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From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
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Subject: Re: Meeting

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Thanks much!

Stephen C. McCaffrey, JD
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On Feb 5, 2017, at 2:05 PM, Karns, Allison <AKarns@gov.IN.gov> wrote:

Hi, Steve,

Good to hear from you! I will submit the request and be in touch. In the meantime, please do not hesitate to reach out to me if you need anything!

Thanks,
Allison

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Sunday, February 5, 2017 1:41 PM
To: Karns, Allison <AKarns@gov.IN.gov>
Subject: Meeting

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Scott.A.Milkey

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Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Tuesday, February 07, 2017 8:13 PM
To: Karns, Allison
Subject: Re: Meeting

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Thanks Allison—

The attendees will be myself, Dave Mosley, and Catherine Sreckovich.

Dave and Catherine manage Government Health Solutions for Navigant. They are a trusted resource for many political leaders in DC and across the nation—including a number of Governors. In light of the transition, they would like to offer to be of service to the Governor.

Navigant is a national firm that operates in 45 other states and pretty much does it all—risk assessment, program design, implementation, monitoring and evaluation. While traditionally strong in the public health care system, they are moving more into the behavioral healthcare space.

You don't need to do any prep for the meeting—my hope is it might open doors to future collaborations that might be of benefit.

Hope that helps.

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

Mental Health America of Indiana
1431 North Delaware Street
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On Feb 6, 2017, at 9:33 PM, Karns, Allison <AKarns@gov.IN.gov> wrote:

We calendared you for 2/20 at 11am. Can you please let us know who will be in attendance, any background we need, and what the meeting is about? Thanks, Steve!

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Monday, February 6, 2017 3:36 PM
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<image001.png>

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Thanks,
Allison

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Sunday, February 5, 2017 1:41 PM
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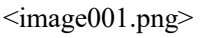
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Scott.A.Milkey

From: Karns, Allison
Sent: Monday, February 06, 2017 11:40 AM
To: McCaffrey, Steve
Subject: Re: Meeting

Thanks

Sent from my iPhone

On Feb 6, 2017, at 11:35 AM, Stephen C McCaffrey <smccaffrey@mhai.net> wrote:

> **** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****
>
> Let me check with Dave and get back to you asap.
>
> Thanks!
>
> Steve
> Stephen C. McCaffrey, JD
> *President & Chief Executive Officer*
>
> <unknown.png>
>
> Mental Health America of Indiana
> 1431 North Delaware Street
> Indianapolis, Indiana, 46202
> 317.638.3501 x1222
> smccaffrey@mhai.net
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Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
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To: Karns, Allison
Subject: Re: Meeting

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Let me check with Dave and get back to you asap.

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I would appreciate it if you would let me know how best to proceed to set-up a time for Dave and the Governor to get together.

Thanks

Steve

Stephen C. McCaffrey, JD
President & Chief Executive Officer

<image001.png>

Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, Indiana, 46202
317.638.3501 x1222
smccaffrey@mhai.net

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution of or copying of this information is strictly prohibited. Erroneous transmission or receipt of this information contained herein shall not constitute a waiver of any applicable privilege. If you have received this message by error, please notify us immediately and destroy the related message.

Scott.A.Milkey

From: Karns, Allison
Sent: Sunday, February 05, 2017 2:05 PM
To: McCaffrey, Steve
Subject: RE: Meeting

Hi, Steve,

Good to hear from you! I will submit the request and be in touch. In the meantime, please do not hesitate to reach out to me if you need anything!

Thanks,
Allison

From: Stephen C McCaffrey [mailto:smccaffrey@mhai.net]
Sent: Sunday, February 5, 2017 1:41 PM
To: Karns, Allison <AKarns@gov.IN.gov>
Subject: Meeting

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Hi Allison—

I have been doing some work with Navigant—a national government health solutions firm. Dave Mosley manages Navigant's Government Healthcare Solutions and met the Governor at a RGA meeting in Orlando after the election. There was interest in setting up a meeting to discuss opportunities for a potential collaboration.

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Sent: Sunday, February 05, 2017 1:41 PM
To: Karns, Allison
Subject: Meeting

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Scott.A.Milkey

From: Stephen P. Luce <sluce@indianasheriffs.org>
Sent: Wednesday, February 01, 2017 2:52 PM
To: Hudson, Mary Kay;Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;'Mason, Derrick';'Creason, Steve';Light, Matt (matt.light@atg.in.gov);'Steuerwald, Greg';'Glass, Trent';Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;'Goodman, Michelle';'Hensley, Angie';'Thompson, Lisa';'Chad Lewis';dbottorff@indianacounties.org;David, Steven H;'Knox, Sandy';Karns, Allison;'Madeline Carter';'Surbeck, John F';Dolan, Kathryn;Smith, Connie S;'Rozier, Ashley';Landis, Larry (PDC);'Willis, Mary';'Williams, Dave';Mason, Derrick;'Mains, Diane';'Jeff Yoder';Avery, Karen;'Ray, Brad';Casper, Kristin;'Boswell, Diane';Freese, Robert;tharper@co.monroe.in.us;'Kerl, Christine';'Luttrull, James';'McMahon, Mike';'Meyer, Stephen';'Miller, Mike';Pate, Mike;'Stephen Dillon';'Torr, Jerry';'Wagoner, Madonna';'Young, Michael';Miller, Charles F;'Jerry Torr';'Rachelle Ramirez';Hammond, John
Subject: RE: Indiana EDBM Phase VI Kickoff Meeting - DRAFT agenda

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Mary Kay, right now I will have the following Sheriffs in attendance :

Sheriff Mark Bowen- Hamilton County
Sheriff Brett Clark- Hendricks County

Stephen P. Luce (ret.)
Executive Director
Indiana Sheriffs' Association
147 E. Maryland Street
Indianapolis, In. 46204-3608
317-356-3633 Office
1-800-622-4779 Indiana Only
317-356-3996 Fax
812-[redacted] Cell

CONFIDENTIAL - PROTECTED COMMUNICATION!!

This message is confidential, intended only for the named recipient(s) and may contain information that is privileged, attorney work product, law enforcement sensitive information, intelligence or other information exempt from disclosure under applicable laws. If you are not the intended recipient(s), you are notified that the dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, or are not the name recipient(s), please notify the sender at either the e-mail address or telephone number above and delete this e-mail from your computer. Receipt by anyone other than

the named recipient(s) is not a waiver of any applicable privilege under federal or state law.

From: Hudson, MK [mailto:mk.hudson@courts.IN.gov]
Sent: Wednesday, February 01, 2017 11:34 AM
To: Powell, David; Landis, Larry; candacebacker@[redacted]; Miller, Daniel R; Cozad, Sara; McCaffrey, Steve; Moore, Kevin; andrew@sagamoreinstitute.org; Mason, Derrick; Creason, Steve; Matt.Light@atg.in.gov; Steuerwald, Greg; Glass, Trent; Brady, Linda; Murtaugh, David; Seigel, Jane; Lanham, Julie; Spitzer, Mark E.; Cunningham, Chris; McCoy, Cindy; diekhofm@bloomington.in.gov; Bauer, Jennifer; Goodman, Michelle; Hensley, Angie; Thompson, Lisa; Chad Lewis; dbottorff@indianacounties.org; David, Steven; Knox, Sandy; Luce, Steve; Karns, Allison; Madeline Carter; Surbeck, John F; Dolan, Kathryn; Smith, Connie S; Rozier, Ashley; Landis, Larry (PDC); Willis, Mary; Williams, Dave; Derrick Mason; Mains, Diane; Jeff Yoder; Karen Avery; Ray, Brad; kcasper@pdc.in.gov; Boswell, Diane; Freese, Robert; Harper, Teresa; Kerl, Christine; Luttrull, James; McMahon, Mike; Meyer, Stephen; Miller, Mike; Pate, Robert Michael; Stephen Dillon; Torr, Jerry; Wagoner, Madonna; Young, Michael; ChMiller1@idoc.IN.gov; Jerry Torr; Rachelle Ramirez; JHammond2@gov.IN.gov
Subject: Indiana EDBM Phase VI Kickoff Meeting - DRAFT agenda

Good morning!

Please find attached the latest DRAFT agenda for our **EBDM Phase VI kickoff meeting** scheduled for February 10 at the Crowne Plaza.

The agenda consists primarily of discussions surrounding the "Indiana EBDM Pretrial Expectations" document developed by the state team. In order to encourage interaction between the local sites and the state team, Mimi recommends that we assign state team members to each discussion. So, some of you will see your name included on the agenda as proposed team members assigned to that topic- please review it carefully ☺ We will discuss the nature of the state team members involvement in those discussions at our state EBDM team meeting this Friday. Mimi will join us via conference call.

Please let me know if you have any questions!

Mary Kay Hudson, LSW, Deputy Director
Indiana Office of Court Services, Office of Judicial Administration
Indiana Supreme Court
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
(317) 234-0106 desk

Scott.A.Milkey

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Sent: Wednesday, February 01, 2017 11:34 AM
To: Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Mason, Derrick;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;Luttrull, James;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Jerry Torr;Rachelle Ramirez;Hammond, John
Subject: Indiana EDBM Phase VI Kickoff Meeting - DRAFT agenda
Attachments: IN EBDM Phase VI Pretrial Justice Workshop AGENDA 01.31.17.docx

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Mary Kay Hudson, LSW, Deputy Director
Indiana Office of Court Services, Office of Judicial Administration
Indiana Supreme Court
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
(317) 234-0106 desk

Indiana EBDM Phase VI Pretrial Justice Workshop

Friday, February 10, 2017

DRAFT AGENDA – 01.31.17

Background

Indiana's Phase VI EBDM efforts focus in large part (although not entirely) on pretrial justice. The EBDM State Team—and its local partners—seeks to collaboratively establish a high functioning pretrial justice system in each of ten pilot sites and draw on the lessons from the pilots in considering expansion to other localities in the future. In an effort to establish a framework to guide the pilot sites in the establishment of their local pretrial systems, the Indiana EBDM State Team has identified a set of expectations for each pilot site.

Workshop Goals

The purpose of this workshop is to bring together the State Team and all of the local pilots to discuss key aspects of the pretrial pilot "expectations," identify and work through barriers to implementation, and generally ensure that all teams and stakeholders are working collaboratively and in unison.

More specifically, the workshop agenda focuses on the exploration of selected areas of work identified in the expectations document and provides teams with an opportunity to engage in dialogue regarding each key area. The workshop will also serve as a forum for participants to meet with other members of their discipline to exchange challenges and solutions around implementation of research-informed pretrial practices. Finally, the workshop will conclude with a discussion of a strategy for moving the pretrial work forward in a manner that ensures ongoing communication and coordination across teams.

Agenda

9:00 - 9:20 Welcome; Opening Remarks

The Honorable Steven H. David, Justice, Indiana Supreme Court, and Chair of the Indiana EBDM Policy Team

David Powell, Executive Director, Indiana Prosecuting Attorneys Council, and Vice-Chair of the Indiana EBDM Policy Team

Lori Eville, Correctional Program Specialist, National Institute of Corrections, and Program Manager for the EBDM Initiative

DRAFT

9:20 - 9:50 The Elements of a High Functioning Legal and Evidence-Based Pretrial Justice System

The National Institute of Corrections, in partnership with the National Association of Pretrial Services Agencies, has outlined a set of fundamental elements necessary for achieving a high functioning legal and evidence-based pretrial justice system. These elements informed the EBDM State Policy Team's development of the set of expectations for pretrial pilot sites. Each element will be reviewed briefly during this session to ensure a common understanding among all participants of legal and evidence-based pretrial practices.

Introduction by Jane Siegel, Executive Director, Indiana Office of Court Services

Lori Eville

9:50-9:55 Expectations of Indiana's Pretrial Pilot Sites: Introduction

The goals and format of the day's sessions on the pretrial pilot site "expectations" discussions will be described, followed by presentations from EBDM State Team members and other content experts on the expectations and related best practices. Throughout the day, participants will be given various opportunities for discussion—within their teams and with other state and local team members—to surface and explore questions and implementation barriers, and exchange information about approaches used across the pilot sites.

Madeline (Mimi) Carter, Principal, Center for Effective Public Policy, and Project Director for the EBDM Initiative

9:55 – 10:25 Expectations Discussion 1

During this session, the following expectations of pretrial pilot sites will be addressed:

- Expectation 1: Pilots conducted within context of EBDM
- Expectation 2: Establish local collaborative teams
- Expectation 3: Teams develop and implement pilots collaboratively
- Expectation 4: Teams work with state and local partners
- Expectation 18: Educate colleagues and broader community
- Expectation 5: Principles to guide the work
- Expectation 19: Develop written protocol
- Expectation 7: Teams review bond schedules

David Powell

Larry Landis, Executive Director, Indiana Public Defender Council

10:25 – 10:40 Break

DRAFT

10:40 – 12:00 Expectations Discussion 2

During this session, the following expectations of pretrial pilot sites will be addressed:

- Expectation 8: Use risk assessments
- Expectation 9: Verify risk assessment data
- Expectation 10: Assessors will be credentialed
- Expectation 11: Local quality assurance around risk assessment

Mark Carey, President, The Carey Group

Dr. Brad Ray, Assistant Professor, School of Public and Environmental Affairs, Indiana University-Purdue University Indianapolis

12:00 - 12:15 Prepare for Working Lunch

12:15 - 1:30 Working Lunch: Stakeholder Discussion Groups

Participants will meet over lunch with colleagues within their discipline to discuss concerns, challenges, and solutions related to pretrial justice practices.

1:30 – 2:00 Expectations Discussion 3

During this session, the following expectations of pretrial pilot sites will be addressed:

- Expectation 6: Teams participate in evaluation project
- Expectation 12: Use common pretrial assessment report form

Mary Kay Hudson, Deputy Director, Indiana Office of Court Services, Office of Judicial Administration

Cindy McCoy, Director, Grant County Correctional Services

2:00 – 2:30 Expectations Discussion 4

During this session, the following expectations of pretrial pilot sites will be addressed:

- Expectation 13: Court reminder system
- Expectation 14: Look back process

Chris Cunningham, Director, Grant County Community Corrections and Past President, Indiana Association of Community Corrections Grant Act Counties

Judge John F. Surbeck, Jr., Allen County Superior Court

2:30 – 2:45 Break

2:45 – 3:15 Expectations Discussion 5

During this session, the following expectations of pretrial pilot sites will be addressed:

DRAFT

- Expectation 15: Differential supervision approach
- Expectation 16: Behavior responses

Linda Brady, President, Probation Officers Professional Association of Indiana

3:15 – 3:45 Expectations Discussion 6

During this session, the following expectations of pretrial pilot sites will be addressed:

- Expectation 17: Speedy, meaningful first appearance
- Expectation 20: Critical incident protocol

David Powell

Larry Landis

3:45 – 4:15 Team-Based Action Planning; Moving Forward Collaboratively

During this session, participants will have an opportunity to engage in some action planning with their team members, and EBDM State Team members will address any outstanding questions from participants and discuss next steps for continued information sharing and collaboration among the pretrial pilot sites and within each discipline group.

EBDM State Team Representatives

4:15 Adjourn

DRAFT

Scott.A.Milkey

From: Chris Cunningham <ccunningham@grantcounty.net>
Sent: Monday, January 30, 2017 10:11 AM
To: Hudson, Mary Kay;Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Mason, Derrick;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;James Luttrull;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Jerry Torr
Subject: RE: Indiana EBDM Policy Team Meeting Reminder - February 3, 2017 - 9 am - 12 pm

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MK,
I will be there.
TFAYD!
Chris

From: Hudson, MK [mailto:mk.hudson@courts.IN.gov]
Sent: Monday, January 30, 2017 10:07 AM
To: Powell, David; Landis, Larry; candacebacker@[redacted]; Miller, Daniel R; Cozad, Sara; McCaffrey, Steve; Moore, Kevin; andrew@sagamoreinstitute.org; Mason, Derrick; Creason, Steve; Matt.Light@atg.in.gov; Steuerwald, Greg; Glass, Trent; Brady, Linda; Murtaugh, David; Seigel, Jane; Lanham, Julie; Mark Spitzer; Chris Cunningham; Cindy Mccoy; diekhofm@bloomington.in.gov; Bauer, Jennifer; Goodman, Michelle; Hensley, Angie; Thompson, Lisa; Chad Lewis; dbottorff@indianacounties.org; David, Steven; Knox, Sandy; Luce, Steve; Karns, Allison; Madeline Carter; Surbeck, John F; Dolan, Kathryn; Smith, Connie S; Rozier, Ashley; Landis, Larry (PDC); Willis, Mary; Williams, Dave; Derrick Mason; Mains, Diane; Jeff Yoder; Karen Avery; Ray, Brad; kcasper@pdc.in.gov; Boswell, Diane; Freese, Robert; Harper, Teresa; Kerl, Christine; James Luttrull; McMahon, Mike; Meyer, Stephen; Miller, Mike; Pate, Robert Michael; Stephen Dillon; Torr, Jerry; Wagoner, Madonna; Young, Michael; ChMiller1@idoc.IN.gov; Jerry Torr
Subject: Indiana EBDM Policy Team Meeting Reminder - February 3, 2017 - 9 am - 12 pm

A reminder that the Indiana EBDM Policy Team is scheduled to meeting this **Friday, February 3 from 9 am – 12 pm at the Indiana Office of Court Services, 8th floor conference center.**

Items for the agenda include reports from the change target work group meetings held last week and a discussion of the February 10 meeting agenda. **Work group chairs:** Please be prepared to do a 10-15 minute report out on your work group discussions and future activities. If you have any items you would like to add to the agenda, please let me know.

If you have not done do, please let me know whether or not you plan to attend. Thank you !

Mary Kay

-----Original Appointment-----
From: Hudson, MK
Sent: Wednesday, November 23, 2016 12:59 PM
To: Hudson, MK; dpowell@ipac.in.gov; 'Larry Landis'; candacebacker@[redacted]; Miller, Daniel R; Cozad, Sara; McCaffrey, Steve; Kevin.Moore@fssa.IN.gov; andrew@sagamoreinstitute.org; Mason, Derrick; Creason, Steve; Matt.Light@atg.in.gov; Steuerwald, Greg; Glass, Trent; Brady, Linda; David Murtaugh (dmurtaugh@cji.in.gov); Seigel, Jane; Lanham, Julie; Spitzer, Mark E.; Chris Cunningham; Cindy McCoy; diekhofm@bloomington.in.gov; Bauer, Jennifer; Goodman, Michelle; Hensley, Angie; Thompson, Lisa; Chad Lewis; dbottorff@indianacounties.org; David, Steven; Knox, Sandy; sluce@indianasheriffs.org; Karns, Allison; John Hill (jhill@gov.in.gov); Mimi Carter; Surbeck, John F; Dolan, Kathryn; Smith, Connie S; Rozier, Ashley; Landis, Larry (PDC); Willis, Mary; Williams, Dave; Derrick.mason@pdcom.in.gov; Mains, Diane; Jeff Yoder; Karen Avery; Ray, Brad; kcasper@pdc.in.gov; Boswell, Diane; Freese, Robert; Harper, Teresa; Kerl, Christine; Luttrull, James; McMahon, Mike; Meyer, Stephen; Miller, Mike; Pate, Robert Michael; Stephen Dillon; Torr, Jerry; Wagoner, Madonna; Young, Michael; ChMiller1@idoc.IN.gov
Cc: Jerry Torr
Subject: Indiana EBDM Policy Team Meeting
When: Friday, February 03, 2017 9:00 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Indiana Office of Court Services - 30 South Meridian Street - 8th floor

Please note the meeting will be held on the 8th floor in the conference center.

Scott.A.Milkey

From: Hudson, MK <mk.hudson@courts.IN.gov>
Sent: Monday, January 30, 2017 10:07 AM
To: Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Mason, Derrick;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Thompson, Lisa;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Landis, Larry (PDC);Willis, Mary;Williams, Dave;Mason, Derrick;Mains, Diane;Jeff Yoder;Avery, Karen;Ray, Brad;Casper, Kristin;Boswell, Diane;Freese, Robert;tharper@co.monroe.in.us;Kerl, Christine;Luttrull, James;McMahon, Mike;Meyer, Stephen;Miller, Mike;Pate, Mike;Stephen Dillon;Torr, Jerry;Wagoner, Madonna;Young, Michael;Miller, Charles F;Jerry Torr
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Where: Indiana Office of Court Services - 30 South Meridian Street - 8th floor

Please note the meeting will be held on the 8th floor in the conference center.

Scott.A.Milkey

From: Stephen C McCaffrey <smccaffrey@mhai.net>
Sent: Wednesday, January 25, 2017 10:11 PM
To: McClelland, Jim
Subject: Addiction Treatment Teams
Attachments: Addiction Treatment Teams concept.docx; ATT00001.htm; HB1541.01.INTR.pdf; ATT00002.htm

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Addiction Treatment Teams (ATT)

Addiction Treatment Teams shall be developed to provide comprehensive treatment for opioid addiction and other substance use disorders in response to the workforce shortage. The goal of an Addiction Treatment Team is to move a patient with a substance use disorder to abstinence or the lowest appropriate maintenance dose, as well as to educational services, vocational training, and employment.

The Addiction Treatment Team shall consist of a:

1) Nurse Practitioner or Physician Assistant,
2) Licensed Clinical Addiction Counselor or other masters level licensed therapist certified in addiction treatment by a credentialing body endorsed by the Division of Mental Health and Addiction; and
3) Recovery Coach certified by a credentialing body endorsed by the Division of Mental Health and Addiction;

The Addiction Treatment Team shall enter into a Memorandum of Understanding for purposes of referral with a:

1) Pharmacy, and
2) Mental health provider that treats patients with substance use disorder.

The Addiction Treatment Teams shall provide addiction treatment services with a goal of abstinence or the lowest appropriate maintenance dose, which shall include, when appropriate:

1) Addiction counseling,
2) Detoxification, and
3) Medication assisted treatment, including a federal Food and Drug Administration approved long acting, nonaddictive medication for the treatment of opioid or alcohol dependence.

OMPP and DMHA shall develop a funding mechanism utilizing a bundled rate sufficient to encourage the development and proliferation of Addiction Treatment Teams.

Private or community funding may provide additional financial resources to the Addiction Treatment Team. Private funding may be an option, but not a requirement, as some communities may not have the community or private resources but have a high priority substance abuse problem.

The Addiction Treatment Teams shall supplement treatment infrastructure shortages in a permanent location, temporary location or as a mobile unit. Priority should be given to the Addiction Treatment Teams in:

(1) geographically high-risk areas,

(2) underserved areas,

(3) areas with high incidence of Neonatal Abstinence Syndrome and accompanying DCS out-of -home placement through CHINS

(4) areas with high forensic treatment needs and services provided through Recovery Works or Community Corrections.

HOUSE BILL No. 1541

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-1.4; IC 12-15-47.

Synopsis: Addiction treatment teams and Medicaid. Establishes Medicaid reimbursement for addiction treatment teams. Specifies providers and services that must be included as part of an addiction treatment team. Allows addiction treatment teams to provide services in temporary locations and mobile units in specified conditions.

Effective: July 1, 2017.

Davisson, Ziemke, Shackleford

January 18, 2017, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 120th General Assembly (2017)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2016 Regular Session of the General Assembly.

HOUSE BILL No. 1541

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-1.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: **Sec. 1.4. "Addiction treatment team", for purposes of IC 12-15-47, has the meaning set forth in IC 12-15-47-1.**

SECTION 2. IC 12-15-47 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]:

Chapter 47. Addiction Treatment Teams

Sec. 1. As used in this chapter, "addiction treatment team" means a group of providers consisting of at least:

(1) either:

(A) an advanced practice nurse licensed under IC 25-23 with prescriptive authority to prescribe a legend drug; or

(B) a physician assistant licensed under IC 25-27.5;

(2) either:

(A) a licensed clinical addiction counselor licensed under IC 25-23.6-10.5; or

(B) another master's level licensed therapist certified by the division of mental health and addiction; and

(3) a recovery coach certified by a credentialing body endorsed by the division of mental health and addiction;

that provides comprehensive treatment for addiction and substance use disorders in a manner that moves a patient with an addiction or substance use disorder to abstinence or the lowest appropriate maintenance dose and provides educational services and vocational training that lead to employment.

Sec. 2. An addiction treatment team shall provide addiction treatment services with a goal of patient abstinence. An addiction treatment team shall provide the following services, when appropriate:

(1) Addiction counseling.

(2) Detoxification.

(3) Medication assisted treatment, including a long acting, nonaddictive medication that:

(A) has been approved by the federal Food and Drug Administration; and

(B) is used for the treatment of opioid or alcohol dependence.

Sec. 3. When considered necessary, an addiction treatment team shall enter into a memorandum of understanding with the following:

(1) A pharmacy licensed under IC 25-26, for purposes of accessing medication assisted treatment drugs.

(2) A mental health provider that treats patients with substance use disorders, for the purpose of providing comprehensive treatment for a patient.

Sec. 4. (a) The office shall reimburse for the use of addiction treatment teams under the Medicaid program, including the healthy Indiana plan.

(b) The office, in consultation with the division of mental health and addiction, shall develop a reimbursement system for addiction treatment teams that reimburses at a bundled rate that is sufficient to encourage the development and use of addiction treatment teams.

(c) The office may use private grants, gifts, and donations to provide additional incentive payments to addiction treatment teams for providing services in high risk areas with a substance abuse epidemic.

Sec. 5. An addiction treatment team may supplement treatment

infrastructure shortages by providing services in a mobile unit or temporary location, including in the following locations:

(1) Geographically high risk areas for substance use disorders.

(2) Medically underserved areas.

(3) Areas with a high incidence of neonatal abstinence syndrome.

(4) Areas with high forensic treatment services needs under IC 12-23-19.

Scott.A.Milkey

From: Linda Brady <lbrady@co.monroe.in.us>
Sent: Tuesday, January 24, 2017 10:13 AM
To: Hudson, Mary Kay;Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Long, Chad;Thompson, Lisa;Williams, Dave;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Hill, John;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Willis, Mary;Casper, Kristin;Ray, Brad;Avery, Karen;Miller, Charles F;Sapp, Dona Rae;Thelin, Rachel;backbren90@[redacted];Mason, Derrick
Subject: RE: Phase VI Kickoff Meeting DRAFT Agenda - For Your Review and Comment

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Dear Policy Team:

The one part of the Agenda that I suggest be reconsidered is the self-assessment portion in the morning.

Our own team has never met as a team…yet.

I know that we are new to the EBDM process, but for our team, basically we have not started. There is nothing really to rate team-wise.

Couldn't the self-assessment be done in the home counties rather than when we are all together as a state group?

Our team was hoping that we would hear from other Indiana teams…what their experiences have been, what lessons they have learned, what is and is not working well, etc.

Thanks,

Linda

From: Hudson, MK [mailto:mk.hudson@courts.IN.gov]
Sent: Friday, January 20, 2017 3:14 PM
To: Powell, David; Landis, Larry; candacebacker@[redacted]; Miller, Daniel R; Cozad, Sara; McCaffrey, Steve; Moore, Kevin; andrew@sagamoreinstitute.org; Creason, Steve; Matt.Light@atg.in.gov; Steuerwald, Greg; Glass, Trent; Linda Brady; Murtaugh, David; Seigel, Jane; Lanham, Julie; Spitzer, Mark E.; Cunningham, Chris; McCoy, Cindy; diekhofm@bloomington.in.gov; Bauer, Jennifer; Goodman, Michelle; Hensley, Angie; Long, Chad; Thompson, Lisa; Williams, Dave; Chad Lewis; dbottorff@indianacounties.org; David, Steven; Knox, Sandy; Luce, Steve; Karns, Allison; Hill, John; Madeline Carter; Surbeck, John F; Dolan, Kathryn; Smith, Connie S; Rozier, Ashley; Willis, Mary; kcasper@pdc.in.gov; Ray, Brad; Karen Avery; Miller, Charles F; Sapp, Dona Rae; Thelin, Rachel E; backbren90@[redacted]; Derrick Mason
Subject: Phase VI Kickoff Meeting DRAFT Agenda - For Your Review and Comment

Dear Indiana EBDM Policy Team Members-

Please find attached for your review and comment a DRAFT agenda for our February 10, 2017, Phase VI EBDM Kickoff Meeting. There are two versions of the same agenda – one contains notes on the rationale/objective for the session, the other a clean copy. Please review the agenda and provide comments/suggestions to me on the content by **close of business Wednesday, January 25, 2017**. Because this is a draft and subject to change, please do not distribute it outside of the state team.

Justice David and Dave Powell- Mimi suggested that you provide some brief opening remarks as chair and vice chair of the state team. Please let me know if you are willing to take on this task ☺

Also attached is a spreadsheet with the names of persons registered to date- the numbers are still on the rise. We are up to 71, which includes the state team members who have registered. If you have not yet registered, please visit https://ijc.wufoo.com/forms/ebdm-phase-vi-kickoff-workshop/

Have a great weekend!

Mary Kay Hudson, Deputy Director
Indiana Office of Court Services, Office of Judicial Administration
Indiana Supreme Court
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
(317) 234-0106 desk

Scott.A.Milkey

From: Larry Landis <llandis@[redacted]>
Sent: Monday, January 23, 2017 5:02 PM
To: Hudson, Mary Kay;Powell, David N;candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;'Creason, Steve';Light, Matt (matt.light@atg.in.gov);'Steuerwald, Greg';'Glass, Trent';Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;'Goodman, Michelle';'Hensley, Angie';'Long, Chad';'Thompson, Lisa';'Williams, Dave';'Chad Lewis';dbottorff@indianacounties.org;David, Steven H;'Knox, Sandy';'Luce, Steve';Karns, Allison;'Hill, John';'Madeline Carter';'Surbeck, John F';Dolan, Kathryn;Smith, Connie S;'Rozier, Ashley';'Willis, Mary';Casper, Kristin;'Ray, Brad';Avery, Karen;Miller, Charles F;'Sapp, Dona Rae';Thelin, Rachel;backbren90@[redacted];Mason, Derrick
Subject: Whether a pretrial release proceeding is a critical stage
Attachments: Pretrial Counsel Brief 7.pdf

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Attached is a short article on the issue I have raised several times in our discussions about pretrial release: whether a pretrial release proceeding is a critical stage under which defendants must have counsel according *to Rothgery v. Gillespie County*?

To the best of my knowledge, there is no Indiana case law squarely on point on this issue. If is determined that the pretrial release proceeding is a critical stage, then the presence of counsel who is prepared to be an advocate for the accused at the initial hearing is constitutionally required. If it is not required, there is still the policy issue of whether it should be recommended or required as a best practice.

I understand that because of the indigent defense delivery system in many counties, it will be difficult to provide counsel at the initial hearing who is prepared to be an advocate for the accused. I believe that is not a good justification for the denial of access to counsel at a proceeding to determine whether a person should be released pretrial. Other states do it. We can too, if there is the will to do it.

Larry A. Landis
Executive Director
Indiana Public Defender Council
309 W. Washington St., Rm 401
Indianapolis, IN 46204
(317)232-2321
llandis@pdc.in.gov

Access to Counsel at Pretrial Release Proceedings

Pretrial Justice Brief 7* November 2016

The *Rothgery* case

The legal basis for a defendant's right to counsel at the pretrial stage is rooted in the Supreme Court case *Rothgery v. Gillespie County*.[1] In this decision, the Court held that a defendant's right to counsel "attaches" at his first appearance before a judge or magistrate.[2] Attachment occurs, the Court said, when there has been a commitment made to prosecute the defendant on specific criminal charges.[3] Once attachment has occurred, the defendant is guaranteed the presence of counsel at "any critical stage" in the proceedings that follow. The Court defines a critical stage as one in which there are "trial-like confrontations" between the defendant and the state. [4] Therefore, under *Rothgery*, counsel is not required to be present at the point at which attachment occurs, only those "critical stages" following that attachment. The *Rothgery* decision left open whether a proceeding at which the decision is made to release or detain a defendant pending trial qualifies as one of these critical stages at which counsel must be present.

Rothgery recognized in 2008 that 34 states appoint pretrial counsel for defendants "before, at, or just after initial appearance."[5] Today, states adopt different interpretations of *Rothgery*'s attachment and critical stage requirements. At least six states have considered whether a pretrial release proceeding is a critical stage under which defendants must have counsel according to *Rothgery*.

States with a Guarantee of Counsel

Three states have interpreted *Rothgery* to require counsel to be present at a defendant's pretrial release decision.[6] In each of these states, the court found that the appointment and therefore attachment of the right to counsel occurs before the defendant's pretrial release decision is made, and the point at which that decision is made is a critical stage at which counsel must be present.

In *DeWolfe v. Richmond*, the Court of Appeals of Maryland held that "an indigent defendant is entitled to state-furnished counsel at an initial hearing."[7] The Maryland court found that counsel is necessary because a release determination could result in continued incarceration for a defendant and therefore a potential loss of his liberty.[8] In *Gonzalez v. Commissioner of Corrections*, the Supreme Court of Connecticut used a similar reasoning, finding that effective counsel is essential for a defendant in these pretrial release decisions because the decision involves the restraining of a defendant's liberty.[9] Through *Hurrell-Harring v. State*, the New York Court of Appeals ruled that defendants must be provided counsel at

*This Brief was prepared by Sara Sapia of the National Center for State Courts' Pretrial Justice Center for Courts (www.ncsc.org/pjcc). The Pretrial Justice Center provides information and tools, offers education and technical assistance, facilitates cross-state learning and collaboration, and promotes the use of evidence-based pretrial practices for courts across the country. It works closely with the Conference of Chief Justices, the Conference of State Court Administrators, and other national court organizations to implement pretrial justice reform. The Center is supported by the Public Welfare Foundation (PWF). Points of view or opinions expressed in this Brief are those of the author and do not necessarily represent the official position of the NCSC or PWF.

bail hearings because of the inherent liberty interest in these types of proceedings.[10]

States with no Guarantee of Counsel

Three states have interpreted *Rothgery* to not require counsel to be present at a defendant's pretrial release decision. Instead, the right to counsel attaches at or just after that decision is made. Under this reasoning, the pretrial release decision cannot be considered a critical stage at which a defendant is guaranteed counsel because a critical stage must necessarily follow the point at which counsel attaches.

In *People v. Rojas-Ruiz*, the Appellate Court of Illinois held "that the defendant's Sixth Amendment right to counsel did not attach until…he appeared in court for the first time."[11] Similarly in *Ex parte Cooper*, the Alabama Supreme Court cited *Rothgery* and found that the defendant's initial appearance in court was the point at which adversarial judicial proceedings began, requiring a defendant to have the assistance of counsel at all critical stages following, but not including, that point at which a pretrial release decision was made.[12] In *People v. Hurt*, the Court of Appeals of Michigan also emphasized the difference between the point at which counsel attaches and the critical stages that follow, finding that "whether the right to counsel has attached is distinct from whether a defendant has been denied his right to counsel at a critical stage in the proceeding."[13]

Advocates for Pretrial Counsel

The distinction between the attachment of counsel and the critical stages following that attachment remains unclear. This was a topic at the National Symposium on Pretrial Justice in Washington, DC in 2011.[14] At this symposium, advocates for the presence of counsel at pretrial appearances, such as the DC Pretrial Services Agency, suggested that the presence of counsel assists the court in accurately assessing a defendant's risk and thereby decreases the number of people who are unnecessarily detained in jail during the pretrial stage. Symposium participants thereby recommended the "presence of a defense counsel at the initial appearance who is prepared to make representations on the defendant's behalf for the court's pretrial release decision." In addition, the Bureau of Justice Assistance's Smart Pretrial program lists "provid[ing] access to effective defense counsel at the earliest hearing that could result in pretrial detention" as one of its elements for the implementation of "safe, fair, and effective pretrial procedures" nationwide.[15] A wide variety of research further supports that representation for defendants at this pretrial stage results in courts giving defendants individual consideration and making more efficient and accurate release decisions.[16]

Concern about Pretrial Counsel

Those who are concerned about this type of pretrial reform argue that providing counsel to such a large number of defendants on a daily basis would be very expensive and would stretch the already limited public defender system too thin. And while state budgets continue to shrink, adding more work for already overwhelmed attorneys may prove to be impractical.[17]

Further Research

The National Council of State Legislatures compiled state constitutional provisions and state procedural rules that provide guidance on how the right to counsel is implemented.[18] This compilation is a resource for anyone who wants to further explore the different constitutional and legislative approaches states take in establishing the right to counsel at pretrial release proceedings.

Endnotes

[1] This decision applies only to the appointment of counsel in federal courts. This brief discusses how states have used *Rothgery* to interpret the appointment of counsel in their own jurisdictions.
[2] *Rothgery v. Gillespie County*, 554 U.S. 191, 199 (2008).
[3] *Rothgery*, 554 U.S. at 211.
[4] *Rothgery*, 554 U.S. at 212.
[5] *Rothgery*, 554 U.S. at 203-204.
[6] The point at which a defendant's pretrial release decision is made varies among states. Some states make this decision at a defendant's initial appearance before the court, while others make this decision at a defendant's arraignment or have specific pretrial release proceedings, such as bail or bond hearings, in place.
[7] *DeWolfe v. Richmond*, 434 Md. 444, 464 (Md. Ct. App. 2013).
[8] *DeWolfe*, 434 Md. At 461.
[9] *Gonzalez v. Comm'r of Corr.*, 308 Conn. 463 (2013).
[10] *Hurrell-Harring v. State of New York*, 15 N.Y.3d 8, 20-21 (2010).
[11] *People v. Rojas-Ruiz*, 2016 Ill. App. Unpub. LEXIS 951 at 40 (2016).
[12] *Ex parte Cooper*, 43 So. 3d 547, 549-50 (Ala. 2009).
[13] *People v. Hurt*, 2013 Mich. App. LEXIS 836 at 12-13 (2013).
[14] https://www.pretrial.org/download/infostop/NSPJ%20Report%202011.pdf
[15] https://www.bja.gov/funding/PretrialTTA16.pdf
[16] http://www.americanbar.org/content/dam/aba/publications/criminal_justice_magazine/v31/cjspring2016_BUNIN.authcheckdam.pdf
[17] https://www.washingtonpost.com/opinions/our-public-defender-system-isnt-just-broken--its-unconstitutional/2015/09/03/aadf2b6c-519b-11e5-9812-92d5948a40f8_story.html
[18] http://www.ncsl.org/research/civil-and-criminal-justice/pretrial-right-to-counsel.aspx

Scott.A.Milkey

From: Hudson, MK <mk.hudson@courts.IN.gov>
Sent: Wednesday, January 18, 2017 11:52 AM
To: Powell, David N;Landis, Larry (llandis@[redacted]);candacebacker@[redacted];Miller, Daniel R;Cozad, Sara;McCaffrey, Steve;Moore, Kevin B;andrew@sagamoreinstitute.org;Creason, Steve;Light, Matt (matt.light@atg.in.gov);Steuerwald, Greg;Glass, Trent;Brady, Linda;Murtaugh, David;Seigel, Jane;Lanham, Julie (COA);Spitzer, Mark;Cunningham, Chris;McCoy, Cindy;diekhofm@bloomington.in.gov;Bauer, Jenny;Goodman, Michelle;Hensley, Angie;Long, Chad;Thompson, Lisa;Williams, Dave;Chad Lewis;dbottorff@indianacounties.org;David, Steven H;Knox, Sandy;Luce, Steve;Karns, Allison;Madeline Carter;Surbeck, John F;Dolan, Kathryn;Smith, Connie S;Rozier, Ashley;Willis, Mary;Casper, Kristin;Ray, Brad;Avery, Karen;backbren90@[redacted];Miller, Charles F;Thelin, Rachel;Sapp, Dona Rae;'Lori Eville';DonnaReback@FlintSpringsAssociates.com;bney@cepp.com;Rachelle Ramirez;Landis, Larry (llandis@[redacted]);Mason, Derrick
Cc: Mains, Diane;Hensley, Angie
Subject: Indiana EBDM Phase VI Kick-Off Meeting - Please Register!

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Dear Indiana EBDM Policy Team Members:

Good morning! Please find enclosed a link to register for the Indiana EBDM Phase VI Kick-Off Meeting scheduled for **February 10, 2017, at the Crowne Plaza Hotel**. I know that a number of you have RSVPd to my Outlook invitation, but we are asking attendees to also register via this link. Our seating, materials, meals, and possibly portions of the agenda will be based upon who is in attendance. If you plan to attend, please complete the registration form by **Friday, January 27, 2017.**
https://ijc.wufoo.com/forms/ebdm-phase-vi-kickoff-workshop/

The purpose of this meeting is to bring together state team and the local pretrial pilot sites to discuss key aspects of the pretrial pilot "expectations," identify and work through barriers to implementation, and generally to ensure that all teams and stakeholders are working collaboratively and in unison. The workshop agenda will focus on selected areas of the work identified in the pretrial pilot expectations document and provide each team with an opportunity to assess their level of progress in key areas. The workshop will also serve as a forum for participants to meet with other members of their discipline to exchange challenges and solutions around implementation of research-informed pretrial practices. Finally, the workshop will conclude with a discussion for moving the pretrial work forward in a manner that ensures ongoing communication and coordination across teams.

Mimi and her team are finalizing a draft agenda for our review. I will distribute a draft agenda for the team's review and comment this week. Please let me know if you have any questions ☺

Mary Kay Hudson, Deputy Director
Indiana Office of Court Services, Office of Judicial Administration
Indiana Supreme Court
30 South Meridian Street, Suite 900
Indianapolis, IN 46204
(317) 234-0106 desk

Scott.A.Milkey

From: Kidwell, Jenny <jenny.kidwell@courts.IN.gov>
Sent: Monday, January 09, 2017 4:31 PM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Forkner, Justin;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hill, John (GOV);Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: FW: IDOC January 2017 Population Report
Attachments: HEA 1006_One Page Summary January 2017.pdf; Indiana Department of Correction January 2017 Total Population Summary.pdf

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

FYI

From: Koester, Randy [mailto:RKoester@idoc.IN.gov]
Sent: Monday, January 9, 2017 2:24 PM
Subject: IDOC January 2017 Population Report

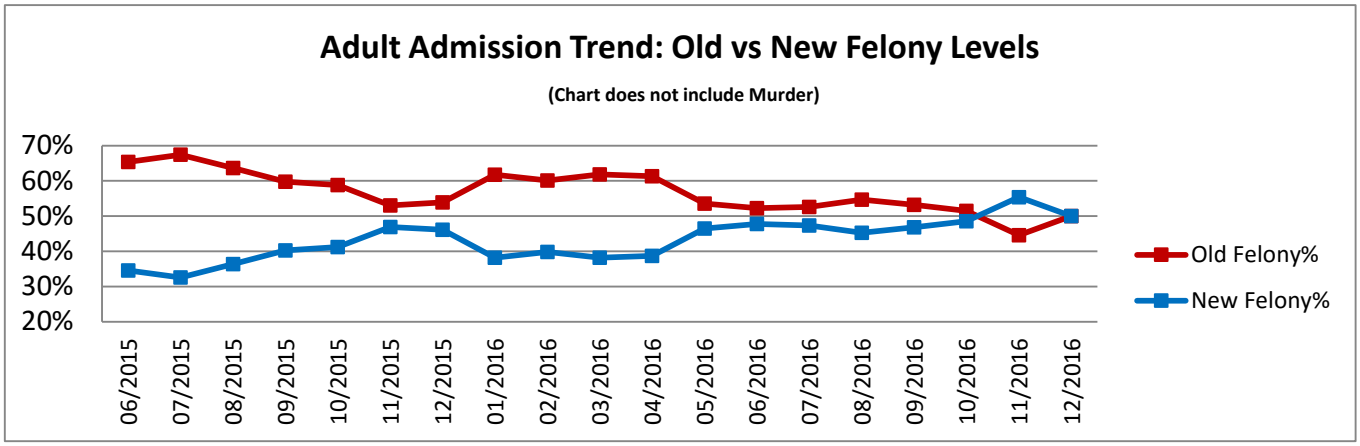
Greetings,

Members of the State Budget Committee and Justice Reinvestment Advisory Council –

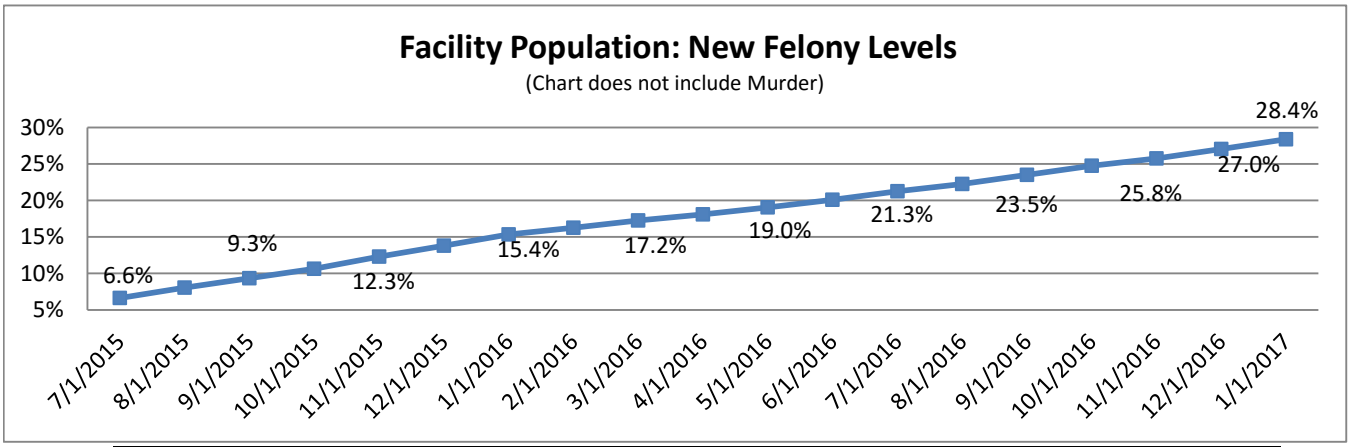
Per HEA1006-2015, the Department of Correction is required to submit to you the attached population report. Please let us know if you have any questions.

RPK

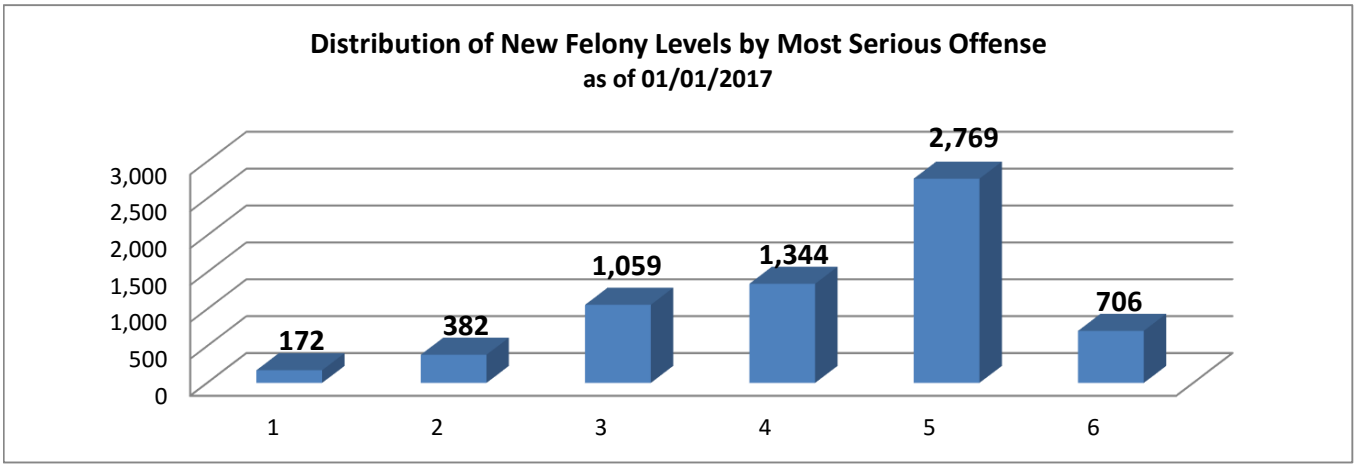
INDIANA DEPARTMENT OF CORRECTION
HEA 1006: Summary Report for January 2017



Month	Old	New	Murder	Total	Old Felony%	New Felony%
11/2016	375	466	8	841	44.6%	55.4%
12/2016	433	433	7	873	50.0%	50.0%



Date	Old	New	Murder	Total	Old Felony%	New Felony%
12/1/2016	16,597	6,153	2,466	25,216	73.0%	27.0%
1/1/2017	16,225	6,432	2,468	25,125	71.6%	28.4%



December Admissions:
5 Missing Sentencing Data/ HO

Comparisons include grouping
Old A-D Offenses Vs. New 1-6 Offenses

Total Population:
18 Missing Data or HO Offenses

Indiana Department of Correction

January 2017

Offender Population Report

Prepared for the Justice Reinvestment Advisory Council
and State Budget Committee

TABLE OF CONTENTS

DOC Monthly Admissions - Adult Offenders 1

Current Adult Offenders, by County of Commit 4

Population Trend Graphs 6

DOC Adult Offenders – Facility Breakdowns, 8
by highest Felony Classification

DOC Adult Offenders – Most Serious Offense, 10
Alphabetical by highest Felony Classification

DOC Adult Offenders – Most Serious Offense, Ranked 14
by highest Felony Classification

Appendix – DOC Facilities – Felony Breakdowns 18

INDIANA DEPARTMENT OF CORRECTION

for January 2017

December 2016 Admissions

by Most Serious Offense

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Resulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	2	.	2
Aggravated Battery	.	.	2	.	.	.	.	2	.	.	.	4
Aiding Inducing/Causing An Offense	.	.	.	1	.	.	.	1	.	3	.	5
Arson	.	.	2	.	.	.	.	.	1	.	.	3
Assisting A Criminal	.	.	.	2	1	.	.	.	.	.	.	3
Attempt To Commit Felony	.	1	3	.	1	2	.	2	.	2	.	11
Auto Theft, Receiving Stolen Auto Parts	.	.	.	.	2	.	.	.	.	.	4	6
Battery	.	.	2	14	.	.	1	1	.	35	2	55
Bribery	.	.	.	2	.	.	.	.	.	.	.	2
Burglary	.	2	46	23	.	.	1	.	33	23	.	128
Carjacking	.	.	3	.	.	.	.	.	.	.	.	3
Carrying Handgun Without License	.	.	.	2	.	.	.	.	.	.	.	2
Child Exploitation	.	.	.	1	.	.	.	.	.	1	.	2
Child Molesting	.	9	7	14	.	5	.	3	6	.	.	44
Child Solicitation	.	.	1	.	.	.	.	.	1	.	.	2
Conspiracy	.	4	.	1	.	.	3	.	.	4	.	12
Corrupt Business Influence	.	.	.	.	.	.	.	.	.	3	.	3
Criminal Confinement	.	.	6	2	.	.	.	5	.	2	1	16
Criminal Deviate Conduct	.	.	4	.	.	.	.	.	.	.	.	4
Criminal Recklessness	.	.	.	2	1	.	.	.	.	1	.	4
Deal Sub Represented To Be Controlled Sub	.	.	.	.	.	.	.	.	.	.	1	1
Dealing In Cocaine Or Narcotic Drug	.	9	39	1	.	.	6	3	8	11	.	77
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	.	.	.	.	.	1	.	2
Dealing In Methamphetamine	.	.	19	.	.	.	7	7	12	13	.	58
Dealing In Schedule IV Controlled Substance	.	.	1	1	.	.	.	.	.	.	.	2
Dealing In a Schedule I, II, or III Controlled Substance	.	1	9	.	.	.	.	.	.	1	.	11
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	3	.	3
Domestic Battery	.	.	.	.	4	.	.	.	.	.	2	6
Domestic Battery With Previous Battery Conviction	.	.	.	.	.	.	.	.	.	1	.	1
Driving While Intoxicated Result - Death	.	.	.	1	.	.	.	.	.	.	.	1
Escape	.	.	.	.	.	.	.	.	.	2	11	13
Fail To Stop At An Accident/Sbi/Prior	.	.	.	.	.	.	.	2	.	.	.	2
Failure To Register As A Sex Offender	.	.	.	1	.	.	.	.	.	9	2	12
Failure To Return Lawful Detention/Escape	.	.	.	1	2	.	.	.	.	.	.	3
Firearm Within 1 Mile School Property Without License	.	.	.	3	.	.	.	.	.	.	.	3
Forgery,Counterfeiting,Application Fraud	.	.	.	14	2	.	.	.	.	.	5	21

Note: 5 current admissions have missing sentencing data due to processing or safekeepers.

INDIANA DEPARTMENT OF CORRECTION

for January 2017

December 2016 Admissions

by Most Serious Offense

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Fraud	.	.	.	.	.	.	.	.	.	.	2	2
Fraud On A Financial Institution	.	.	.	3	.	.	.	.	.	3	.	6
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	14	.	14
Human Sexual Trafficking	.	.	1	.	.	.	.	.	.	.	.	1
Incest	.	.	.	1	.	.	.	.	.	.	.	1
Intimidation	.	.	.	2	1	.	.	.	.	6	1	10
Involuntary Manslaughter	.	.	.	.	.	.	.	.	.	1	.	1
Kidnapping	.	.	.	.	.	.	1	.	.	.	.	1
Maintaining Common Nuisance	.	.	.	.	2	.	.	.	.	.	.	2
Murder	7	.	.	.	.	.	.	.	.	.	.	7
Neglect Of A Dependent	.	.	1	3	1	.	.	.	.	2	.	7
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	9	4	.	.	.	.	.	.	13
OPER VEH .15 OR MORE - PRIOR CONVICTION	.	.	.	.	.	.	.	.	.	1	.	1
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	1
Obstruction Of Justice	.	.	.	.	1	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	9	.	.	.	.	.	17	.	26
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	3	1	.	5
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	8	.	.	.	.	.	2	10
Operating Vehicle-Habit Traffic Violator	.	.	.	.	2	.	.	.	.	.	1	3
Possess Of Precursors	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of A Controlled Substance	.	.	.	.	5	.	.	.	.	.	.	5
Possession Of Cocaine Or Narcotic Drug	.	.	2	5	3	.	.	2	4	6	8	30
Possession Of Methamphetamine	.	.	3	1	2	.	.	1	1	3	6	17
Possession Of Paraphernalia	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of Syringes Or Needles	.	.	.	.	2	.	.	.	.	5	2	9
Rape	.	.	2	.	.	1	.	3	.	.	.	6
Residential Entry	.	.	.	.	3	.	.	.	.	.	2	5
Resisting Law Enforcement	.	.	.	.	2	.	.	.	.	.	2	4
Robbery	.	1	22	5	.	.	3	21	.	7	.	59
Sexual Misconduct With A Minor	.	.	7	3	.	.	.	.	3	4	.	17
Stalking	.	.	.	.	.	.	.	.	.	1	.	1
Strangulation	.	.	.	.	2	.	.	.	.	.	1	3
Theft,Receiving Stolen Property	.	.	.	.	32	.	.	.	.	1	10	43
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	1	.	2

Note: 5 current admissions have missing sentencing data due to processing or safekeepers.

INDIANA DEPARTMENT OF CORRECTION

for January 2017

December 2016 Admissions

by Most Serious Offense

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Unlawful Firearm Poss By Serious Felon	.	.	10	.	.	.	.	.	15	.	.	25
Voluntary Manslaughter	.	.	.	.	.	.	4	.	.	.	.	4
	7	28	193	129	83	8	26	54	87	191	67	873

Note: 5 current admissions have missing sentencing data due to processing or safekeepers.

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by County of Commitment
for January 2017
snapshot date: 01/01/2017

County of Commit	Department of Correction	**Community Corrections Programs	Local Jail Holds		COUNTY TOTALS
			DOC Contract	Felony Level 6 Diversions	
Adams	148	107	0	0	255
Allen	1,463	740	30	93	2,326
Bartholomew	259	306	3	30	598
Benton*	19	91	0	4	114
Blackford	68	66	7	8	149
Boone	134	21	3	13	171
Brown	38	67	2	0	107
Carroll	45	101	1	7	154
Cass	179	90	3	2	274
Clark	238	156	0	3	397
Clay	58	50	6	3	117
Clinton	141	47	4	22	214
Crawford	31	235	1	0	267
Daviess	85	140	2	5	232
Dearborn	368	335	6	35	744
Decatur	119	135	1	9	264
DeKalb	126	802	1	18	947
Delaware	399	205	9	6	619
Dubois	88	385	2	4	479
Elkhart	1,552	140	29	42	1,763
Fayette	187	122	4	10	323
Floyd	206	66	3	41	316
Fountain	35	20	0	2	57
Franklin*	82	34	0	0	116
Fulton	90	146	3	8	247
Gibson	104	68	2	26	200
Grant	402	253	3	30	688
Greene	120	227	0	0	347
Hamilton	323	64	2	84	473
Hancock	142	135	2	57	336
Harrison	110	97	0	2	209
Hendricks	217	482	8	63	770
Henry	238	42	0	9	289
Howard	298	90	8	36	432
Huntington	308	87	3	54	452
Jackson	201	17	6	19	243
Jasper	71	305	0	3	379
Jay	207	22	4	17	250
Jefferson	214	295	4	15	528
Jennings	128	187	3	19	337
Johnson	318	34	7	28	387

*Counties that are not participating in Community Corrections
** Community Corrections data as of 12/27/16

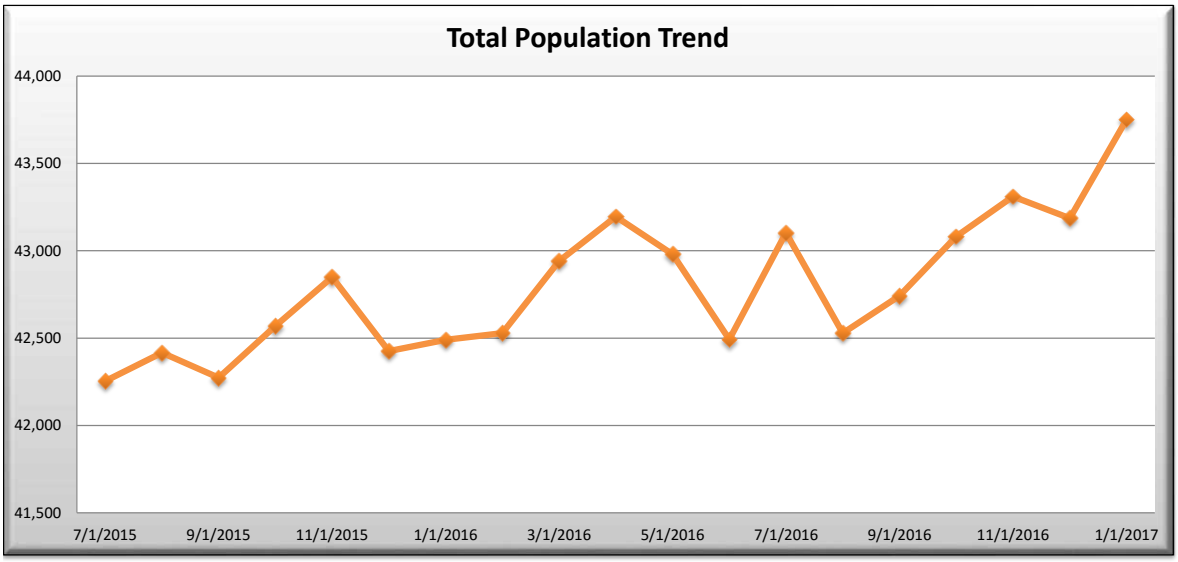
INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by County of Commitment
for January 2017
snapshot date: 01/01/2017

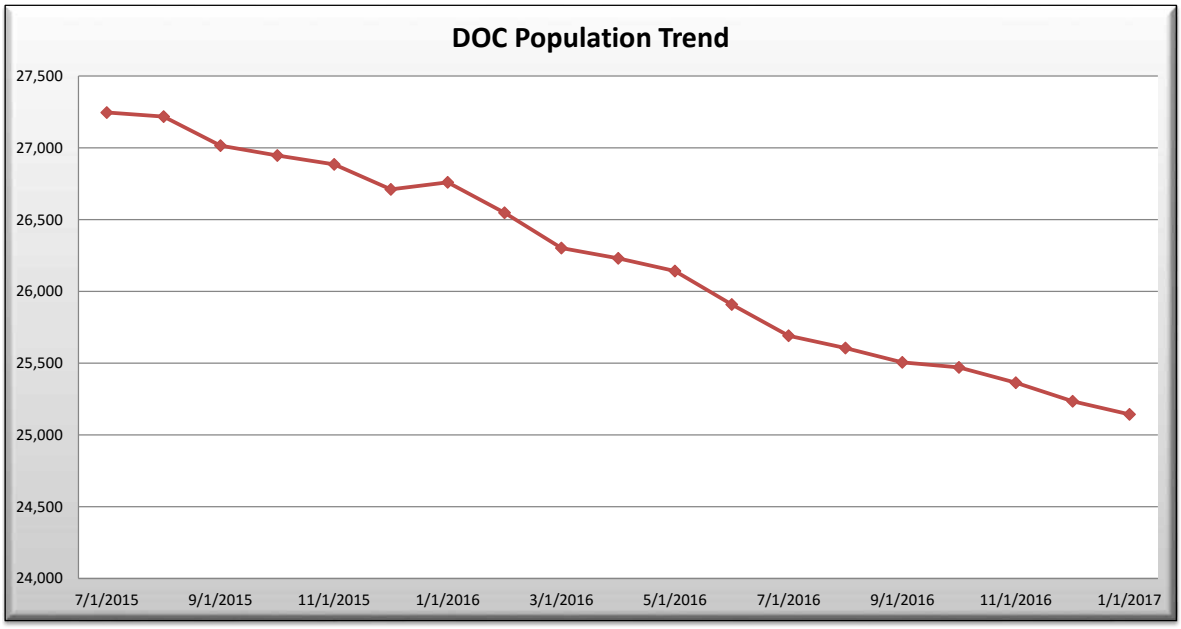
County of Commit	Department of Correction	**Community Corrections Programs	Local Jail Holds		COUNTY TOTALS
			DOC Contract	Felony Level 6 Diversions	
Knox	48	83	1	0	132
Kosciusko	220	259	4	16	499
LaGrange	62	180	0	7	249
Lake	1,148	243	21	32	1,444
LaPorte	386	322	10	4	722
Lawrence	167	2,921	6	10	3,104
Madison	1,090	60	8	19	1,177
Marion	5,284	73	18	142	5,517
Marshall	127	36	4	19	186
Martin	48	464	13	0	525
Miami	71	69	12	0	152
Monroe	318	119	2	0	439
Montgomery	175	519	0	14	708
Morgan	199	13	6	47	265
Newton*	50	135	1	5	191
Noble	124	173	2	10	309
Ohio	43	11	0	0	54
Orange	49	51	0	0	100
Owen	39	69	1	0	109
Parke	38	0	0	9	47
Perry	53	131	0	3	187
Pike	68	33	2	0	103
Porter	266	10	0	8	284
Posey	95	49	0	13	157
Pulaski	31	53	0	4	88
Putnam	86	63	7	16	172
Randolph	54	41	0	0	95
Ripley	106	111	7	31	255
Rush	80	158	0	7	245
St Joseph	1,034	96	32	70	1,232
Scott	154	234	6	8	402
Shelby	302	67	8	26	403
Spencer	32	127	1	1	161
Starke	98	24	2	9	133
Steuben	114	12	1	14	141
Sullivan	45	489	2	6	542
Switzerland	24	7	1	0	32
Tippecanoe	758	16	10	34	818
Tipton	11	414	0	0	425
Union	27	69	0	0	96
Vanderburgh	825	468	12	92	1,397
Vermillion	64	50	4	7	125
Vigo	422	22	5	0	449
Wabash	179	23	1	0	203
Warren	15	146	0	13	174
Warrick	58	72	1	3	134
Washington	117	73	2	8	200
Wayne	459	80	12	28	579
Wells	142	282	1	17	442
White	73	79	0	0	152
Whitley	92	290	5	25	412
Missing	14	0	0	0	14
TOTALS	**25,143**	**16,601**	**403**	**1,604**	**43,751**
			2,007		

*Counties that are not participating in Community Corrections
** Community Corrections data as of 12/27/16

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
Population Trend Summary
for January 2017
snapshot date: 01/01/2017

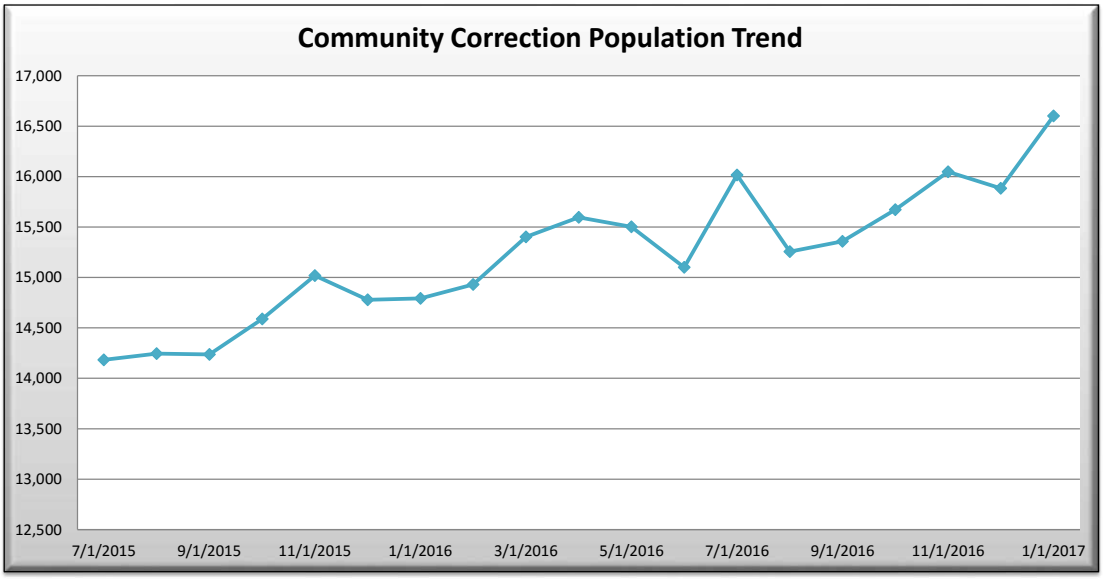
Date	DOC Adult	Community Corrections	Jail DOC Contract	Jail Felony Level 6 Diversions	Total
7/1/2016	25,691	16,016	302	1,094	43,103
8/1/2016	25,605	15,257	319	1,348	42,529
9/1/2016	25,506	15,357	361	1,518	42,742
10/3/2016	25,471	15,672	365	1,574	43,082
11/1/2016	25,364	16,047	363	1,537	43,311
12/1/2016	25,235	15,883	370	1,698	43,186
1/1/2017	25,143	16,601	403	1,604	43,751

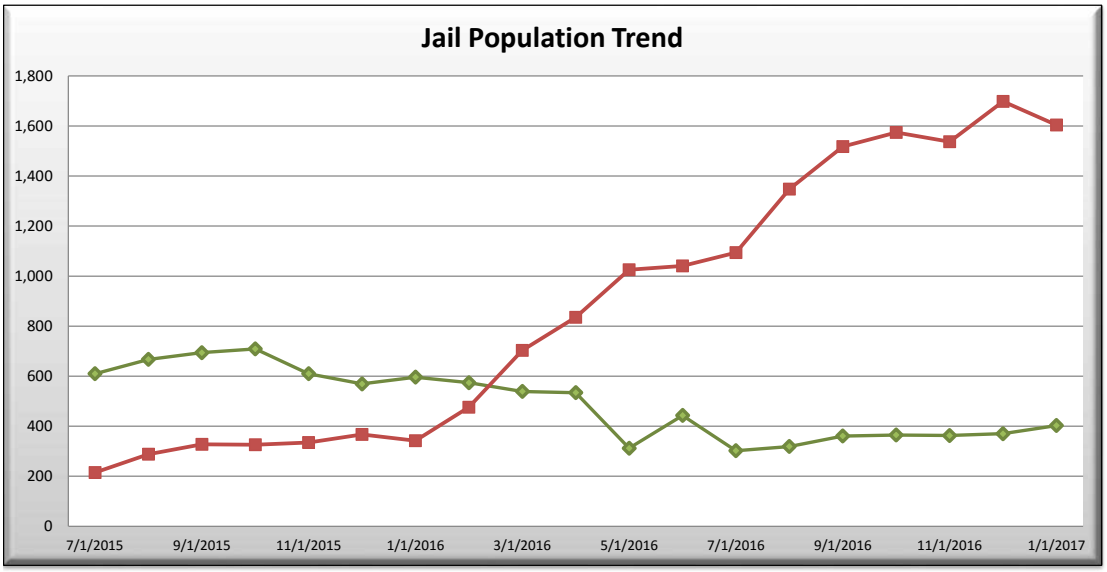




INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
Population Trend Summary
for January 2017
snapshot date: 01/01/2017

Date	DOC Adult	Community Corrections	Jail DOC Contract	Jail Felony Level 6 Diversions	Total
7/1/2016	25,691	16,016	302	1,094	43,103
8/1/2016	25,605	15,257	319	1,348	42,529
9/1/2016	25,506	15,357	361	1,518	42,742
10/3/2016	25,471	15,672	365	1,574	43,082
11/1/2016	25,364	16,047	363	1,537	43,311
12/1/2016	25,235	15,883	370	1,698	43,186
1/1/2017	25,143	16,601	403	1,604	43,751





INDIANA DEPARTMENT OF CORRECTION
by highest felony classification
for January 2017
snapshot date: 01/01/2017

Minimum Security - Adult MALE															
Facility Name	**Beds**	**Offenders**	**% Capacity**	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**HO**
Chain O'Lakes	129	123	95.3%	.	11	45	14	5	.	1	5	10	26	6	.
Edinburgh	344	304	88.4%	.	22	113	31	26	.	2	4	26	69	11	.
Miami - MCA	204	193	94.6%	7	40	64	21	8	.	.	1	9	36	7	.
New Castle - NCA	204	186	91.2%	.	4	58	20	17	.	1	2	16	62	6	.
Pendleton - IRO	220	207	94.1%	19	35	73	20	15	.	.	2	9	31	3	.
Westville - WCA	379	345	91.0%	.	13	91	35	13	.	1	3	36	124	29	.
Wabash Valley - WVA	198	147	74.2%	.	9	62	16	5	.	.	1	12	35	7	.
Indianapolis Re-Entry	420	231	55.0%	12	59	122	23	.	.	.	3	4	8	.	.
Sub-Total	**2,098**	**1,736**	**82.7%**	**38**	**193**	**628**	**180**	**89**	**0**	**5**	**21**	**122**	**391**	**69**	**0**

Re-Entry & Work Release - Adult MALE															
Facility Name	**Beds**	**Offenders**	**% Capacity**	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**HO**
Bartholomew Co. Re-Entry	8	8	100.0%	.	1	5	2	.	.	.	.	.	.	.	.
Chain O'Lakes Re-Entry	7	4	57.1%	.	1	1	.	.	.	.	.	.	2	.	.
Clark Co. Re-Entry	0	0	100.0%	.	.	.	.	.	.	.	.	.	.	.	.
Duvall Center Re-Entry	11	11	100.0%	1	1	4	4	1	.	.	.	.	.	.	.
Elkhart Co. Re-Entry	0	0	100.0%	.	.	.	.	.	.	.	.	.	.	.	.
Lake Co. Re-Entry	5	5	100.0%	.	2	3	.	.	.	.	.	.	.	.	.
South Bend Re-Entry	172	127	73.8%	3	16	60	15	6	.	.	1	5	17	4	.
VOA/Hope Hall Re-Entry	17	16	94.1%	.	2	8	.	2	.	.	.	.	4	.	.
Starke Co. PI - TC	27	27	100.0%	.	.	3	1	1	.	.	.	9	10	3	.
Sub-Total	**247**	**198**	**80.2%**	**4**	**23**	**84**	**22**	**10**	**0**	**0**	**1**	**14**	**33**	**7**	**0**

Medium Security - Adult MALE															
Facility Name	**Beds**	**Offenders**	**% Capacity**	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**HO**
Branchville	1,485	1,246	83.9%	10	48	442	122	43	.	24	94	159	243	61	.
Correctional Industrial	1,449	1,389	95.9%	96	402	578	81	15	7	55	72	32	39	12	.
Indiana State Prison ISO	385	234	60.8%	23	55	80	24	7	.	1	2	8	30	4	.
Plainfield	1,696	1,381	81.4%	37	113	504	178	63	.	13	62	119	236	56	.
Putnamville	2,510	1,966	78.3%	31	116	720	237	60	.	46	159	175	338	83	1
Heritage Trail	868	671	77.3%	2	4	183	104	50	.	8	46	60	177	36	1
Westville	2,941	2,418	82.2%	34	174	803	315	117	.	23	130	199	495	127	1
New Castle	2,431	2,401	98.8%	15	680	972	323	27	2	1	81	140	139	21	.
Sub-Total	**13,765**	**11,706**	**85.0%**	**248**	**1,592**	**4,282**	**1,384**	**382**	**9**	**171**	**646**	**892**	**1,697**	**400**	**3**

Note: 14 offenders have missing sentencing data due to processing or are safekeepers

INDIANA DEPARTMENT OF CORRECTION
by highest felony classification
for January 2017
snapshot date: 01/01/2017

Maximum Security - Adult MALE																
Miami	2,984	2,892	96.9%	182	819	1173	179	30	60	98	146	66	108	31	.
Indiana State Prison	2,067	1,938	93.8%	705	764	356	34	3	28	13	19	5	9	2	.
Pendleton	1,353	1,325	97.9%	444	533	230	36	4	18	15	15	6	13	8	0
Pendleton Treatment Unit	298	185	62.1%	46	41	59	13	2	3	1	8	2	7	1	.
ISR Secure Housing Unit	69	41	59.4%	11	9	16	3	.	.	.	.	.	1	1	.
New Castle Annex	486	422	86.8%	58	122	170	37	3	.	.	8	9	10	5	.
New Castle Mental Health	128	111	86.7%	15	33	28	9	3	.	.	3	4	9	2	.
WCU Secure Housing Unit	110	104	94.5%	14	17	44	15	2	.	.	5	.	6	1	.
Wabash Valley	1,784	1,665	93.3%	536	668	294	35	7	37	11	26	15	28	5	0
WVS Secure Housing Unit	216	162	75.0%	40	32	65	11	2	.	.	1	2	6	3	.
Sub-Total	**9,495**	**8,845**	**93.2%**	**2,051**	**3,038**	**2,435**	**372**	**56**	**146**	**138**	**231**	**109**	**197**	**59**	**0**

Intake Facility - Adult MALE															
Reception Diag. Center	695	521	75.0%	4	19	86	60	50	10	14	40	59	127	50	1
Sub-Total	**695**	**521**	**75.0%**	**4**	**19**	**86**	**60**	**50**	**10**	**14**	**40**	**59**	**127**	**50**	**1**

Minumum Security & Re-Entry - Adult FEMALE															
Facility Name	**Beds**	**Offenders**	**% Capacity**	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**HO**
Madison	662	511	77.2%	5	25	178	61	29	.	10	16	64	94	29	.
Brandon Hall Re-Entry	13	12	92.3%	.	.	1	4	4	.	.	.	1	1	1	.
Crane House	15	15	100.0%	.	.	2	2	5	.	.	.	2	3	1	.
Jefferson Co. Re-Entry	58	38	65.5%	.	4	18	5	.	.	.	.	1	8	2	.
Theodora House	4	4	100.0%	.	.	3	.	.	.	.	1	.	.	.	.
VOA/Evansville/Female	0	0	0.0%	.	.	.	.	.	.	.	.	.	.	.	.
Sub-Total	**752**	**580**	**77.1%**	**5**	**29**	**202**	**72**	**38**	**0**	**10**	**17**	**68**	**106**	**33**	**0**

Medium Security - Adult FEMALE															
Facility Name	**Beds**	**Offenders**	**% Capacity**	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**HO**
Rockville	981	879	89.6%	46	150	272	68	45	3	25	63	48	115	44	0
Sub-Total	**981**	**879**	**89.6%**	**46**	**150**	**272**	**68**	**45**	**3**	**25**	**63**	**48**	**115**	**44**	**0**

Maximum Security - Adult FEMALE															
Women's Prison	631	589	93.3%	71	86	150	60	35	4	14	33	28	80	28	.
Rockville Intake	288	89	30.9%	1	3	15	6	9	0	5	7	4	23	16	0
Sub-Total	**919**	**678**	**73.8%**	**72**	**89**	**165**	**66**	**44**	**4**	**19**	**40**	**32**	**103**	**44**	**0**

TOTAL	**28,952**	**25,143**	**86.8%**	**2,468**	**5,133**	**8,154**	**2,224**	**714**	**172**	**382**	**1,059**	**1,344**	**2,769**	**706**	**4**

Note: 14 offenders have missing sentencing data due to processing or are safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Alphabetical
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	4	1	.	.	.	.	1	11	1	.	18
Aggravated Battery	.	.	270	.	.	4	.	122	.	.	.	.	396
Aiding Inducing/Causing An Offense	.	51	91	13	.	2	6	18	20	41	.	.	242
Aiding in Manufacture of Sch II Controlled Substance	.	.	.	.	.	.	.	.	.	.	3	.	3
Arson	.	18	67	.	2	.	.	2	32	.	.	.	121
Assisting A Criminal	.	.	.	9	.	.	.	.	.	3	1	.	13
Assisting Suicide	.	.	.	1	.	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	564	164	22	6	39	8	31	12	45	3	.	894
Auto Theft, Receiving Stolen Auto Parts	.	.	.	28	16	.	.	.	.	1	51	.	96
Battery	.	25	61	215	15	.	3	22	1	419	34	.	795
Battery By Bodily Waste	.	.	.	3	3	.	.	.	.	.	.	.	6
Battery On Law Enforcement	.	.	.	.	1	.	.	.	.	.	.	.	1
Battery To A Child Causing Death	.	7	.	.	.	.	.	.	.	.	.	.	7
Bribery	.	.	.	1	.	.	.	.	.	2	.	.	3
Burglary	.	290	1,580	385	.	13	50	10	531	332	.	.	3,191
Carjacking	.	.	59	.	.	.	.	.	.	.	.	.	59
Carrying Handgun Without License	.	.	.	26	.	.	.	.	.	.	.	.	26
Causing Suicide	.	.	1	.	.	.	.	.	.	.	.	.	1
Check Deception	.	.	.	.	1	.	.	.	.	.	.	.	1
Check Fraud	.	.	.	4	2	.	.	.	.	.	1	.	7
Child Exploitation	.	.	.	12	1	.	.	.	.	10	.	.	23
Child Molesting	.	1,450	505	206	.	78	.	55	88	.	.	.	2,382
Child Seduction	.	.	.	3	2	.	.	.	.	3	.	.	8
Child Solicitation	.	.	1	10	3	.	.	.	6	22	.	.	42
Conspiracy	.	129	124	17	2	2	19	15	13	29	.	.	350
Controlled Substance Registration	.	.	.	4	3	.	.	.	.	1	1	.	9
Conversion	.	.	.	.	.	.	.	.	.	2	.	.	2
Corrupt Business Influence	.	.	.	30	.	.	.	.	.	30	.	.	60
Criminal Confinement	.	.	180	36	6	.	2	47	.	42	4	.	317
Criminal Deviate Conduct	.	142	105	.	.	.	.	.	.	.	.	.	247
Criminal Gang Activity	.	.	.	.	1	.	.	.	.	.	.	.	1
Criminal Recklessness	.	.	.	24	15	.	.	.	.	29	6	.	74
Criminal Trespass	.	.	.	.	1	.	.	.	.	.	1	.	2
Dangerous Control Of A Handgun	.	.	.	.	.	.	.	.	.	2	.	.	2
Dangerous Possession Of A Handgun	.	.	.	1	.	.	.	.	.	.	.	.	1
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	4	.	4
Deal Substance Represented To Be Controlled Substance	.	.	.	.	1	.	.	.	.	.	.	.	1
Dealing In A Schedule V Controlled Subtance	.	.	2	.	.	.	.	.	.	2	.	.	4
Dealing In Cocaine Or Narcotic Drug	.	971	1,055	2	.	.	111	80	139	218	.	.	2,576
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	13	5	.	.	.	.	12	2	.	32
Dealing In Methamphetamine	.	257	883	.	.	.	104	88	184	280	.	.	1,796
Dealing In Schedule IV Controlled Subtance	.	.	23	17	.	.	.	4	.	5	.	.	49
Dealing Possessing Look-Alike Substance	.	.	.	9	.	.	.	.	.	16	4	.	29

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Alphabetical
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Dealng In a Schedule I, II, or III Controlled Substance	.	110	520	.	.	.	9	6	14	17	2	.	678
Disarming A Law Enforcement Officer	.	.	.	5	.	.	.	1	.	7	.	.	13
Distribute Destructive Device To Minor	.	.	1	.	.	.	.	.	.	.	.	.	1
Domestic Battery	.	.	.	.	26	.	.	.	.	6	22	.	54
Driving While Intoxicated	.	.	.	.	1	.	.	.	.	.	.	.	1
Driving While Intoxicated Result - Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Dumping Controlled Substance Waste	.	.	.	.	.	.	.	.	.	.	1	.	1
Escape	.	.	.	.	.	.	.	.	3	51	51	.	105
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	11	.	.	.	.	11
Fail To Stop After Accident - Operating Vehicle Intoxicated	.	.	4	.	.	.	.	.	.	.	.	.	4
Fail To Stop At An Accident/Sbi/Prior	.	.	.	.	1	.	.	.	.	.	.	.	1
Failure Of Sex Offender To Possess Id	.	.	.	.	1	.	.	.	.	.	.	.	1
Failure To Appear	.	.	.	.	.	.	.	.	.	.	2	.	2
Failure To Register As A Sex Offender	.	.	.	39	8	.	.	.	.	115	6	.	168
Failure To Return Lawful Detention/Escape	.	.	12	39	14	.	.	.	.	.	.	.	65
Firearm Within 1 Mile School Property Without License	.	.	.	30	.	.	.	.	.	.	.	.	30
Forgery,Counterfeiting,Application Fraud	.	.	.	262	6	.	.	.	.	.	16	.	284
Fraud	.	.	.	.	10	.	.	.	.	.	7	.	17
Fraud On A Financial Institution	.	.	.	25	.	.	.	.	.	41	.	.	66
Habitual Offender	.	.	.	.	.	.	.	.	.	.	.	3	3
Habitual Offender Substance Abuse	.	.	.	.	4	.	.	.	.	.	.	1	5
Handgun Violation	.	.	.	2	.	.	.	.	.	.	.	.	2
Handgun Violation (Felony Within 15 Yrs)	.	.	.	16	.	.	.	.	.	185	.	.	201
Home Improvement Fraud Enhancement	.	.	.	4	.	.	.	.	.	.	.	.	4
Home Improvement Fraud Offenses	.	.	.	.	1	.	.	.	.	.	.	.	1
Human Sexual Trafficking	.	.	4	.	.	.	.	2	1	.	.	.	7
Identity Deception	.	.	.	1	4	.	.	.	.	.	3	.	8
Illegal Possession Of Firearm By Felon	.	.	.	1	.	.	.	.	.	.	.	.	1
Incest	.	.	24	15	.	.	.	.	2	4	.	.	45
Insurance Fraud	.	.	.	1	.	.	.	.	.	.	.	.	1
Intimidation	.	.	.	31	13	.	.	.	.	57	14	.	115
Invasion Of Privacy	.	.	.	.	3	.	.	.	.	.	4	.	7
Involuntary Manslaughter	.	.	.	3	.	.	.	.	.	.	.	.	3
Kidnapping	.	88	.	.	.	.	5	5	.	3	.	.	101
Maintaining Common Nuisance	.	.	.	.	12	.	.	.	.	.	13	.	25
Minor Passenger In Vehicle - Previous Conviction	.	.	.	1	.	.	.	.	.	.	.	.	1
Mischief	.	.	.	.	1	.	.	.	.	.	.	.	1
Murder	2,468	.	.	.	.	.	.	.	.	.	.	.	2,468
Neglect Of A Dependent	.	.	51	20	4	.	.	.	.	11	2	.	88

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Alphabetical
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	40	.	.	.	.	40
Neglect Of Dependent Resulting In Death	.	66	.	.	.	10	.	.	.	.	.	.	76
Non Support Of Dependent Child	.	.	.	91	31	.	.	.	.	4	3	.	129
OPER VEH .15 OR MORE - PRIOR CONVICTION	.	.	.	.	.	.	.	.	.	1	.	.	1
Obliterating Handgun I.D.	.	.	.	3	.	.	.	.	.	5	.	.	8
Obstruction Of Justice	.	.	.	.	2	.	.	.	.	.	5	.	7
Operate Vehicle After Suspended For Life	.	.	.	112	.	.	.	.	.	250	.	.	362
Operating Vehicle Intoxicated Resulting in Death	.	.	56	9	.	.	.	.	26	15	.	.	106
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	7	3	.	.	.	.	7	3	.	20
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	55	.	.	.	.	2	34	.	91
Operating Vehicle With Schedule I in Body - Causing Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Operating Vehicle-Habit Traffic Violator	.	.	.	3	18	.	.	.	.	.	17	.	38
Opererating Vehicle - Schedule I Or II Control Substance	.	.	.	.	3	.	.	.	.	.	.	.	3
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	8	.	.	.	.	.	.	.	8
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	26	.	26
Pointing A Firearm	.	.	.	.	1	.	.	.	.	.	.	.	1
Possess Chemical Reagents Or Precursors	.	.	.	18	.	.	.	.	.	6	.	.	24
Possess Destructive Device Or Explosive	.	1	.	.	.	.	1	.	.	.	.	.	2
Possess Methamphetamine Without Pay Tax	.	.	.	.	1	.	.	.	.	.	.	.	1
Possess Of Precursors	.	.	.	.	12	.	.	.	.	.	11	.	23
Possession Of A Controlled Substance	.	.	1	31	40	.	.	.	.	.	.	.	72
Possession Of Child Pornography	.	.	.	.	.	.	.	.	.	.	5	.	5
Possession Of Cocaine Or Narcotic Drug	.	66	95	44	30	.	.	12	25	58	49	.	379
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	5	1	.	.	6
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	18	.	.	.	.	.	.	.	18
Possession Of Methamphetamine	.	7	76	27	35	.	.	23	24	65	43	.	300
Possession Of Paraphernalia	.	.	.	.	3	.	.	.	.	.	4	.	7
Possession Of Syringes Or Needles	.	.	.	2	13	.	.	.	.	19	17	.	51
Possession Or Use Of Legend Drug	.	.	.	1	1	.	.	.	.	.	4	.	6
Prisoner Poss. Dangerous Device/Material	.	.	11	2	.	.	.	.	.	.	.	.	13
Promoting Prostitution	.	.	.	2	.	.	.	.	.	.	.	.	2
Promoting Prostitution Under Age 18	.	.	5	.	.	.	.	.	.	.	.	.	5
Prostitution	.	.	.	.	.	.	.	.	.	.	1	.	1
Public Indecency	.	.	.	.	.	.	.	.	.	.	2	.	2
Rape	.	275	152	.	.	24	.	39	.	.	.	.	490
Reckless Homicide	.	.	.	23	.	.	.	.	.	15	.	.	38
Reckless Vehicle Work Zone Causing Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Removing, Damaging, Or Altering a VIN	.	.	.	1	.	.	.	.	.	.	.	.	1

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INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Alphabetical
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Residential Entry	.	.	.	.	9	.	.	.	.	.	22	.	31
Resisting Law Enforcement	.	.	7	2	16	.	.	5	.	6	27	.	63
Robbery	.	262	1,199	149	.	.	38	421	.	171	.	.	2,240
Sale Of Unregistered Security	.	.	.	2	.	.	.	.	.	.	.	.	2
Security Fraud	.	.	1	1	.	.	.	.	.	.	.	.	2
Sexual Battery	.	.	.	1	6	.	.	.	3	.	5	.	15
Sexual Misconduct Gov Employe W/Detainee	.	.	.	1	.	.	.	.	.	.	.	.	1
Sexual Misconduct With A Minor	.	3	273	59	2	.	.	.	51	33	.	.	421
Stalking	.	.	3	12	1	.	.	.	5	21	.	.	42
Strangulation	.	.	.	.	13	.	.	.	.	.	15	.	28
Theft,Receiving Stolen Property	.	.	.	6	193	.	.	.	.	6	153	.	358
Trafficking With An Inmate	.	.	.	15	.	.	.	.	.	28	.	.	43
Unlawful Firearm Poss By Serious Felon	.	.	431	.	.	.	.	.	157	.	.	.	588
Unlawful Medical Practice	.	.	.	.	.	.	.	.	.	1	.	.	1
Unlawful Transfer of Handgun Ownership	.	.	.	.	.	.	.	.	.	1	.	.	1
Vicarious Sexual Gratification	.	.	4	2	.	.	.	.	1	.	.	.	7
Viol/Failure Of Carriers Duty To Warn	.	.	.	.	1	.	.	.	.	.	.	.	1
Violation Of Custody Order	.	.	.	.	1	.	.	.	.	.	.	.	1
Voluntary Manslaughter	.	351	49	.	.	.	26	.	.	.	.	.	426
Voyeurism	.	.	.	.	1	.	.	.	.	.	1	.	2
Welfare Fraud	.	.	.	8	2	.	.	.	.	.	.	.	10
Total	**2,468**	**5,133**	**8,154**	**2,224**	**714**	**172**	**382**	**1,059**	**1,344**	**2,769**	**706**	**4**	**25,129**

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Ranked
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Burglary	.	290	1,580	385	.	13	50	10	531	332	.	.	3,191
Dealing In Cocaine Or Narcotic Drug	.	971	1,055	2	.	.	111	80	139	218	.	.	2,576
Murder	2,468	.	.	.	.	.	.	.	.	.	.	.	2,468
Child Molesting	.	1,450	505	206	.	78	.	55	88	.	.	.	2,382
Robbery	.	262	1,199	149	.	.	38	421	.	171	.	.	2,240
Dealing In Methamphetamine	.	257	883	.	.	.	104	88	184	280	.	.	1,796
Attempt To Commit Felony	.	564	164	22	6	39	8	31	12	45	3	.	894
Battery	.	25	61	215	15	.	3	22	1	419	34	.	795
Dealng In a Schedule I, II, or III Controlled Substance	.	110	520	.	.	.	9	6	14	17	2	.	678
Unlawful Firearm Poss By Serious Felon	.	.	431	.	.	.	.	.	157	.	.	.	588
Rape	.	275	152	.	.	24	.	39	.	.	.	.	490
Voluntary Manslaughter	.	351	49	.	.	.	26	.	.	.	.	.	426
Sexual Misconduct With A Minor	.	3	273	59	2	.	.	.	51	33	.	.	421
Aggravated Battery	.	.	270	.	.	4	.	122	.	.	.	.	396
Possession Of Cocaine Or Narcotic Drug	.	66	95	44	30	.	.	12	25	58	49	.	379
Operate Vehicle After Suspended For Life	.	.	.	112	.	.	.	.	.	250	.	.	362
Theft,Receiving Stolen Property	.	.	.	6	193	.	.	.	.	6	153	.	358
Conspiracy	.	129	124	17	2	2	19	15	13	29	.	.	350
Criminal Confinement	.	.	180	36	6	.	2	47	.	42	4	.	317
Possession Of Methamphetamine	.	7	76	27	35	.	.	23	24	65	43	.	300
Forgery,Counterfeiting,Application Fraud	.	.	.	262	6	.	.	.	.	.	16	.	284
Criminal Deviate Conduct	.	142	105	.	.	.	.	.	.	.	.	.	247
Aiding Inducing/Causing An Offense	.	51	91	13	.	2	6	18	20	41	.	.	242
Handgun Violation (Felony Within 15 Yrs)	.	.	.	16	.	.	.	.	.	185	.	.	201
Failure To Register As A Sex Offender	.	.	.	39	8	.	.	.	.	115	6	.	168
Non Support Of Dependent Child	.	.	.	91	31	.	.	.	.	4	3	.	129
Arson	.	18	67	.	2	.	.	2	32	.	.	.	121
Intimidation	.	.	.	31	13	.	.	.	.	57	14	.	115
Operating Vehicle Intoxicated Resulting in Death	.	.	56	9	.	.	.	.	26	15	.	.	106
Escape	.	.	.	.	.	.	.	.	3	51	51	.	105
Kidnapping	.	88	.	.	.	.	5	5	.	3	.	.	101
Auto Theft, Receiving Stolen Auto Parts	.	.	.	28	16	.	.	.	.	1	51	.	96
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	55	.	.	.	.	2	34	.	91
Neglect Of A Dependent	.	.	51	20	4	.	.	.	.	11	2	.	88
Neglect Of Dependent Resulting In Death	.	66	.	.	.	10	.	.	.	.	.	.	76
Criminal Recklessness	.	.	.	24	15	.	.	.	.	29	6	.	74
Possession Of A Controlled Substance	.	.	1	31	40	.	.	.	.	.	.	.	72
Fraud On A Financial Institution	.	.	.	25	.	.	.	.	.	41	.	.	66
Failure To Return Lawful Detention/Escape	.	.	12	39	14	.	.	.	.	.	.	.	65
Resisting Law Enforcement	.	.	7	2	16	.	.	5	.	6	27	.	63

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Ranked
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Corrupt Business Influence	.	.	.	30	.	.	.	.	.	30	.	.	60
Carjacking	.	.	59	.	.	.	.	.	.	.	.	.	59
Domestic Battery	.	.	.	.	26	.	.	.	.	6	22	.	54
Possession Of Syringes Or Needles	.	.	.	2	13	.	.	.	.	19	17	.	51
Dealing In Schedule IV Controlled Subtance	.	.	23	17	.	.	.	4	.	5	.	.	49
Incest	.	.	24	15	.	.	.	.	2	4	.	.	45
Trafficking With An Inmate	.	.	.	15	.	.	.	.	.	28	.	.	43
Child Solicitation	.	.	1	10	3	.	.	.	6	22	.	.	42
Stalking	.	.	3	12	1	.	.	.	5	21	.	.	42
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	40	.	.	.	.	40
Operating Vehicle-Habit Traffic Violator	.	.	.	3	18	.	.	.	.	.	17	.	38
Reckless Homicide	.	.	.	23	.	.	.	.	.	15	.	.	38
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	13	5	.	.	.	.	12	2	.	32
Residential Entry	.	.	.	.	9	.	.	.	.	.	22	.	31
Firearm Within 1 Mile School Property Without License	.	.	.	30	.	.	.	.	.	.	.	.	30
Dealing Possessing Look-Alike Substance	.	.	.	9	.	.	.	.	.	16	4	.	29
Strangulation	.	.	.	.	13	.	.	.	.	.	15	.	28
Carrying Handgun Without License	.	.	.	26	.	.	.	.	.	.	.	.	26
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	26	.	26
Maintaining Common Nuisance	.	.	.	.	12	.	.	.	.	.	13	.	25
Possess Chemical Reagents Or Precursors	.	.	.	18	.	.	.	.	.	6	.	.	24
Child Exploitation	.	.	.	12	1	.	.	.	.	10	.	.	23
Possess Of Precursors	.	.	.	.	12	.	.	.	.	.	11	.	23
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	7	3	.	.	.	.	7	3	.	20
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	4	1	.	.	.	.	1	11	1	.	18
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	18	.	.	.	.	.	.	.	18
Fraud	.	.	.	.	10	.	.	.	.	.	7	.	17
Sexual Battery	.	.	.	1	6	.	.	.	3	.	5	.	15
Assisting A Criminal	.	.	.	9	.	.	.	.	.	3	1	.	13
Disarming A Law Enforcement Officer	.	.	.	5	.	.	.	1	.	7	.	.	13
Prisoner Poss. Dangerous Device/Material	.	.	11	2	.	.	.	.	.	.	.	.	13
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	11	.	.	.	.	11
Welfare Fraud	.	.	.	8	2	.	.	.	.	.	.	.	10
Controlled Substance Registration	.	.	.	4	3	.	.	.	.	1	1	.	9
Child Seduction	.	.	.	3	2	.	.	.	.	3	.	.	8
Identity Deception	.	.	.	1	4	.	.	.	.	.	3	.	8

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INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Ranked
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Obliterating Handgun I.D.	.	.	.	3	.	.	.	.	.	5	.	.	8
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	8	.	.	.	.	.	.	.	8
Battery To A Child Causing Death	.	7	.	.	.	.	.	.	.	.	.	.	7
Check Fraud	.	.	.	4	2	.	.	.	.	.	1	.	7
Human Sexual Trafficking	.	.	4	.	.	.	.	2	1	.	.	.	7
Invasion Of Privacy	.	.	.	.	3	.	.	.	.	.	4	.	7
Obstruction Of Justice	.	.	.	.	2	.	.	.	.	.	5	.	7
Possession Of Paraphernalia	.	.	.	.	3	.	.	.	.	.	4	.	7
Vicarious Sexual Gratification	.	.	4	2	.	.	.	.	1	.	.	.	7
Battery By Bodily Waste	.	.	.	3	3	.	.	.	.	.	.	.	6
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	5	1	.	.	6
Possession Or Use Of Legend Drug	.	.	.	1	1	.	.	.	.	.	4	.	6
Habitual Offender Substance Abuse	.	.	.	.	4	.	.	.	.	.	.	1	5
Possession Of Child Pornography	.	.	.	.	.	.	.	.	.	.	5	.	5
Promoting Prostitution Under Age 18	.	.	5	.	.	.	.	.	.	.	.	.	5
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	4	.	4
Dealing In A Schedule V Controlled Subtance	.	.	2	.	.	.	.	.	.	2	.	.	4
Fail To Stop After Accident - Operating Vehicle Intoxicated	.	.	4	.	.	.	.	.	.	.	.	.	4
Home Improvement Fraud Enhancement	.	.	.	4	.	.	.	.	.	.	.	.	4
Aiding in Manufacture of Sch II Controlled Substance	.	.	.	.	.	.	.	.	.	.	3	.	3
Bribery	.	.	.	1	.	.	.	.	.	2	.	.	3
Habitual Offender	.	.	.	.	.	.	.	.	.	.	.	3	3
Involuntary Manslaughter	.	.	.	3	.	.	.	.	.	.	.	.	3
Opererating Vehicle - Schedule I Or II Control Substance	.	.	.	.	3	.	.	.	.	.	.	.	3
Conversion	.	.	.	.	.	.	.	.	.	2	.	.	2
Criminal Trespass	.	.	.	.	1	.	.	.	.	.	1	.	2
Dangerous Control Of A Handgun	.	.	.	.	.	.	.	.	.	2	.	.	2
Failure To Appear	.	.	.	.	.	.	.	.	.	.	2	.	2
Handgun Violation	.	.	.	2	.	.	.	.	.	.	.	.	2
Possess Destructive Device Or Explosive	.	1	.	.	.	.	1	.	.	.	.	.	2
Promoting Prostitution	.	.	.	2	.	.	.	.	.	.	.	.	2
Public Indecency	.	.	.	.	.	.	.	.	.	.	2	.	2
Sale Of Unregistered Security	.	.	.	2	.	.	.	.	.	.	.	.	2
Security Fraud	.	.	1	1	.	.	.	.	.	.	.	.	2
Voyeurism	.	.	.	.	1	.	.	.	.	.	1	.	2
Assisting Suicide	.	.	.	1	.	.	.	.	.	.	.	.	1
Battery On Law Enforcement	.	.	.	.	1	.	.	.	.	.	.	.	1
Causing Suicide	.	.	1	.	.	.	.	.	.	.	.	.	1

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense, Ranked
for January 2017
snapshot date: 01/01/2017

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Check Deception	.	.	.	.	1	.	.	.	.	.	.	.	1
Criminal Gang Activity	.	.	.	.	1	.	.	.	.	.	.	.	1
Dangerous Possession Of A Handgun	.	.	.	1	.	.	.	.	.	.	.	.	1
Deal Substance Represented To Be Controlled Substance	.	.	.	.	1	.	.	.	.	.	.	.	1
Distribute Destructive Device To Minor	.	.	1	.	.	.	.	.	.	.	.	.	1
Driving While Intoxicated	.	.	.	.	1	.	.	.	.	.	.	.	1
Driving While Intoxicated Result - Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Dumping Controlled Substance Waste	.	.	.	.	.	.	.	.	.	.	1	.	1
Fail To Stop At An Accident/Sbi/Prior	.	.	.	.	1	.	.	.	.	.	.	.	1
Failure Of Sex Offender To Possess Id	.	.	.	.	1	.	.	.	.	.	.	.	1
Home Improvement Fraud Offenses	.	.	.	.	1	.	.	.	.	.	.	.	1
Illegal Possession Of Firearm By Felon	.	.	.	1	.	.	.	.	.	.	.	.	1
Insurance Fraud	.	.	.	1	.	.	.	.	.	.	.	.	1
Minor Passenger In Vehicle - Previous Conviction	.	.	.	1	.	.	.	.	.	.	.	.	1
Mischief	.	.	.	.	1	.	.	.	.	.	.	.	1
OPER VEH .15 OR MORE - PRIOR CONVICTION	.	.	.	.	.	.	.	.	.	1	.	.	1
Operating Vehicle With Schedule I in Body - Causing Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Pointing A Firearm	.	.	.	.	1	.	.	.	.	.	.	.	1
Possess Methamphetamine Without Pay Tax	.	.	.	.	1	.	.	.	.	.	.	.	1
Prostitution	.	.	.	.	.	.	.	.	.	.	1	.	1
Reckless Vehicle Work Zone Causing Death	.	.	.	1	.	.	.	.	.	.	.	.	1
Removing, Damaging, Or Altering a VIN	.	.	.	1	.	.	.	.	.	.	.	.	1
Sexual Misconduct Gov Employe W/Detainee	.	.	.	1	.	.	.	.	.	.	.	.	1
Unlawful Medical Practice	.	.	.	.	.	.	.	.	.	1	.	.	1
Unlawful Transfer of Handgun Ownership	.	.	.	.	.	.	.	.	.	1	.	.	1
Viol/Failure Of Carriers Duty To Warn	.	.	.	.	1	.	.	.	.	.	.	.	1
Violation Of Custody Order	.	.	.	.	1	.	.	.	.	.	.	.	1
Total	**2,468**	**5,133**	**8,154**	**2,224**	**714**	**172**	**382**	**1,059**	**1,344**	**2,769**	**706**	**4**	**25,129**

Note: 14 offenders have missing sentencing data due to processing or safekeepers

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Branchville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	1	2
Aggravated Battery	.	.	7	.	.	.	.	8	.	.	.	15
Aiding Inducing/Causing An Offense	.	.	8	1	.	.	1	2	1	3	.	16
Arson	.	.	4	.	.	.	.	.	.	.	.	4
Assisting A Criminal	.	.	.	.	.	.	.	.	.	1	.	1
Attempt To Commit Felony	.	7	10	1	.	.	1	2	2	4	.	27
Auto Theft, Receiving Stolen Auto Parts	.	.	.	.	1	.	.	.	.	.	4	5
Battery	.	.	2	18	1	.	.	2	.	34	7	64
Battery On Law Enforcement	.	.	.	.	1	.	.	.	.	.	.	1
Burglary	.	4	100	26	.	.	1	1	67	38	.	237
Carrying Handgun Without License	.	.	.	1	.	.	.	.	.	.	.	1
Child Molesting	.	2	1	.	.	.	.	.	.	.	.	3
Conspiracy	.	2	8	3	.	.	1	4	1	4	.	23
Controlled Substance Registration	.	.	.	1	.	.	.	.	.	1	.	2
Corrupt Business Influence	.	.	.	.	.	.	.	.	.	1	.	1
Criminal Confinement	.	.	3	2	.	.	.	6	.	5	1	17
Criminal Recklessness	.	.	.	2	.	.	.	.	.	2	2	6
Criminal Trespass	.	.	.	.	1	.	.	.	.	.	.	1
Dealing In Cocaine Or Narcotic Drug	.	16	75	.	.	.	6	12	16	13	.	138
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	4	.	.	.	.	.	2	.	6
Dealing In Methamphetamine	.	8	81	.	.	.	12	19	37	13	.	170
Dealing In Sched Iv Controlled Subtance	.	.	.	.	.	.	.	2	.	.	.	2
Dealing In Schedule IV Controlled Subtance	.	.	3	1	.	.	.	.	.	.	.	4
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	2	1	.	.	.	3
Dealng In a Schedule I, II, or III Controlled Substance	.	3	45	.	.	.	.	.	.	2	.	50
Disarming A Law Enforcement Officer	.	.	.	1	.	.	.	.	.	.	.	1
Domestic Battery	.	.	.	.	2	.	.	.	.	1	1	4
Escape	.	.	.	.	.	.	.	.	1	5	2	8
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	2	.	.	.	.	.	11	.	13
Failure To Return Lawful Detention/Escape	.	.	1	.	2	.	.	.	.	.	.	3
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	15	.	.	.	.	.	.	.	15
Fraud	.	.	.	.	1	.	.	.	.	.	1	2
Fraud On A Financial Institution	.	.	.	.	.	.	.	.	.	7	.	7

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Branchville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Habitual Offender Substance Abuse	.	.	.	.	1	.	.	.	.	.	.	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	21	.	21
Home Improvement Fraud Enhancement	.	.	.	1	.	.	.	.	.	.	.	1
Intimidation	.	.	.	2	1	.	.	.	.	3	2	8
Kidnapping	.	.	.	.	.	.	.	.	.	1	.	1
Maintaining Common Nuisance	.	.	.	.	.	.	.	.	.	.	2	2
Murder	10	.	.	.	.	.	.	.	.	.	.	10
Neglect Of A Dependent	.	.	2	.	.	.	.	.	.	.	.	2
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Non Support Of Dependent Child	.	.	.	8	4	.	.	.	.	.	.	12
Operate Vehicle After Suspended For Life	.	.	.	6	.	.	.	.	.	29	.	35
Operating Vehicle Intoxicated Resulting in Death	.	.	5	.	.	.	.	.	2	.	.	7
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	1	1	.	.	.	.	.	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	4	.	.	.	.	.	1	5
Operating Vehicle-Habit Traffic Violator	.	.	.	1	.	.	.	.	.	.	1	2
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	1	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	3	3
Possess Chemical Reagents Or Precursors	.	.	.	4	.	.	.	.	.	.	.	4
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	1	2
Possession Of A Controlled Substance	.	.	.	3	.	.	.	.	.	.	.	3
Possession Of Cocaine Or Narcotic Drug	.	1	7	2	4	.	.	1	3	6	5	29
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	3	.	.	.	.	.	.	3
Possession Of Methamphetamine	.	.	10	2	2	.	.	5	8	9	8	44
Possession Of Syringes Or Needles	.	.	.	.	1	.	.	.	.	2	.	3
Rape	.	1	.	.	.	.	.	.	.	.	.	1
Reckless Homicide	.	.	.	2	.	.	.	.	.	2	.	4
Reckless Vehicle Work Zone Causing Death	.	.	.	1	.	.	.	.	.	.	.	1
Resisting Law Enforcement	.	.	.	1	2	.	.	1	.	.	4	8
Robbery	.	1	42	6	.	.	.	26	.	15	.	90
Sexual Misconduct With A Minor	.	.	1	.	.	.	.	.	.	.	.	1
Stalking	.	.	.	.	.	.	.	.	.	2	.	2
Strangulation	.	.	.	.	.	.	.	.	.	.	2	2
Theft,Receiving Stolen Property	.	.	.	1	8	.	.	.	.	1	13	23
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	4	.	5
Unlawful Firearm Poss By Serious Felon	.	.	25	.	.	.	.	.	21	.	.	46
Viol/Failure Of Carriers Duty To Warn	.	.	.	.	1	.	.	.	.	.	.	1
Voluntary Manslaughter	.	3	2	.	.	.	.	.	.	.	.	5
Welfare Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Total	**10**	**48**	**442**	**122**	**43**	**.**	**24**	**94**	**159**	**243**	**61**	**1,246**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Correctional Industrial Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	1	.	.	.	.	.	.	.	.	1
Aggravated Battery	.	.	32	.	.	1	.	14	.	.	.	47
Aiding Inducing/Causing An Offense	.	6	6	.	.	.	.	.	.	.	.	12
Arson	.	4	6	.	.	.	.	.	1	.	.	11
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	33	13	.	.	1	1	2	.	1	1	52
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	1	.	.	.	.	.	1	3
Battery	.	1	10	10	.	.	.	.	.	8	2	31
Burglary	.	27	146	15	.	1	13	2	17	1	.	222
Carjacking	.	.	8	.	.	.	.	.	.	.	.	8
Child Molesting	.	53	7	2	.	1	.	4	2	.	.	69
Conspiracy	.	21	10	.	.	.	2	1	.	.	.	34
Criminal Confinement	.	.	22	.	.	.	1	5	.	.	.	28
Criminal Deviate Conduct	.	3	2	.	.	.	.	.	.	.	.	5
Criminal Gang Activity	.	.	.	.	1	.	.	.	.	.	.	1
Criminal Recklessness	.	.	.	1	1	.	.	.	.	.	.	2
Dangerous Control Of A Handgun	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Cocaine Or Narcotic Drug	.	129	65	.	.	.	18	4	2	2	.	220
Dealing In Methamphetamine	.	42	44	.	.	.	15	2	1	2	.	106
Dealing In Sched Iv Controlled Subtance	.	.	.	.	.	.	.	1	.	.	.	1
Dealing In Schedule IV Controlled Subtance	.	.	2	.	.	.	.	.	.	.	.	2
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	.	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	10	24	.	.	.	.	.	.	.	.	34
Disarming A Law Enforcement Officer	.	.	.	1	.	.	.	1	.	.	.	2
Domestic Battery	.	.	.	.	1	.	.	.	.	.	1	2
Escape	.	.	.	.	.	.	.	.	.	1	1	2
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	2	.	.	.	2
Failure To Register As A Sex Offender	.	.	.	3	.	.	.	.	.	1	.	4
Failure To Return Lawful Detention/Escape	.	.	1	3	.	.	.	.	.	.	.	4
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	13	.	.	.	.	.	.	1	14
Fraud	.	.	.	.	1	.	.	.	.	.	.	1
Habitual Offender Substance Abuse	.	.	.	.	1	.	.	.	.	.	.	1

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Correctional Industrial Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Handgun Violation (Felony Within 15 Yrs)	.	.	.	1	.	.	.	.	.	6	.	7
Home Improvement Fraud Enhancement	.	.	.	1	.	.	.	.	.	.	.	1
Human Sexual Trafficking	.	.	1	.	.	.	.	.	.	.	.	1
Incest	.	.	1	.	.	.	.	.	.	.	.	1
Intimidation	.	.	.	3	.	.	.	.	.	4	.	7
Kidnapping	.	9	.	.	.	.	.	.	.	.	.	9
Murder	96	.	.	.	.	.	.	.	.	.	.	96
Neglect Of A Dependent	.	.	2	.	.	.	.	.	.	.	.	2
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	2	.	.	.	2
Neglect Of Dependent Resulting In Death	.	2	.	.	.	2	.	.	.	.	.	4
Non Support Of Dependent Child	.	.	.	1	.	.	.	.	.	.	.	1
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	1
Operate Vehicle After Suspended For Life	.	.	.	5	.	.	.	.	.	4	.	9
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	1	.	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Possess Destructive Device Or Explosive	.	1	.	.	.	.	.	.	.	.	.	1
Possess Of Precursors	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of A Controlled Substance	.	.	1	1	1	.	.	.	.	.	.	3
Possession Of Cocaine Or Narcotic Drug	.	3	7	.	1	.	.	.	2	.	.	13
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	.	3	2	.	.	.	2	2	.	.	9
Possession Of Syringes Or Needles	.	.	.	.	.	.	.	.	.	.	1	1
Prisoner Poss. Dangerous Device/Material	.	.	1	.	.	.	.	.	.	.	.	1
Rape	.	2	6	.	.	1	.	.	.	.	.	9
Reckless Homicide	.	.	.	2	.	.	.	.	.	.	.	2
Resisting Law Enforcement	.	.	.	.	.	.	.	1	.	.	.	1
Robbery	.	24	109	11	.	.	2	29	.	4	.	179
Security Fraud	.	.	1	.	.	.	.	.	.	.	.	1
Sexual Misconduct With A Minor	.	.	8	.	.	.	.	.	1	.	.	9
Stalking	.	.	.	.	.	.	.	.	.	1	.	1
Strangulation	.	.	.	.	1	.	.	.	.	.	1	2
Theft,Receiving Stolen Property	.	.	.	1	5	.	.	.	.	.	1	7
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	2	.	3

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Correctional Industrial Facility												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Unlawful Firearm Poss By Serious Felon	.	.	35	.	.	.	.	.	3	.	.	**38**
Voluntary Manslaughter	.	32	3	.	.	.	3	.	.	.	.	**38**
Total	**96**	**402**	**578**	**81**	**15**	**7**	**55**	**72**	**32**	**39**	**12**	**1,389**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Chain O'Lakes Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Aiding Inducing/Causing An Offense	.	.	.	.	.	.	.	1	.	.	.	1
Attempt To Commit Felony	.	.	2	.	.	.	.	1	.	1	.	4
Battery	.	.	.	.	.	.	.	.	.	1	.	1
Burglary	.	.	7	4	.	.	.	.	6	8	.	25
Corrupt Business Influence	.	.	.	.	.	.	.	.	.	1	.	1
Criminal Trespass	.	.	.	.	.	.	.	.	.	.	1	1
Dealing In Cocaine Or Narcotic Drug	.	9	4	.	.	.	.	.	2	1	.	16
Dealing In Methamphetamine	.	1	18	.	.	.	1	1	1	7	.	29
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	1	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	1	2	.	.	.	.	.	.	.	.	3
Firearm Within 1 Mile School Property Without License	.	.	.	2	.	.	.	.	.	.	.	2
Forgery,Counterfeiting,Application Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Intimidation	.	.	.	.	1	.	.	.	.	.	.	1
Neglect Of A Dependent	.	.	.	.	.	.	.	.	.	1	.	1
Non Support Of Dependent Child	.	.	.	1	.	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	3	.	.	.	.	.	5	.	8
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	.	1	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	1	.	.	.	.	.	2	3
Possession Of A Controlled Substance	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Cocaine Or Narcotic Drug	.	1	.	.	.	.	.	.	.	.	.	1
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	.	1	1	.	.	.	.	.	1	1	4
Possession Of Paraphernalia	.	.	.	.	.	.	.	.	.	.	1	1
Robbery	.	.	8	1	.	.	.	2	.	.	.	11
Theft,Receiving Stolen Property	.	.	.	1	1	.	.	.	.	.	1	3
Unlawful Firearm Poss By Serious Felon	.	.	3	.	.	.	.	.	1	.	.	4
Total	**.**	**12**	**46**	**14**	**5**	**.**	**1**	**5**	**10**	**28**	**6**	**127**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Edinburgh Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	1
Aiding Inducing/Causing An Offense	.	.	4	1	.	.	.	.	.	.	.	5
Arson	.	.	1	.	.	.	.	.	1	.	.	2
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	1	1	.	.	.	.	1	1	1	.	5
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	.	.	.	.	.	.	1	2
Battery	.	.	.	.	1	.	.	.	.	3	.	4
Bribery	.	.	.	.	.	.	.	.	.	1	.	1
Burglary	.	1	20	9	.	.	.	.	13	17	.	60
Conspiracy	.	1	3	.	.	.	1	.	.	.	.	5
Corrupt Business Influence	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Cocaine Or Narcotic Drug	.	14	18	.	.	.	1	1	6	6	.	46
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Dealing In Methamphetamine	.	3	32	.	.	.	.	1	4	5	.	45
Dealing In Schedule IV Controlled Subtance	.	.	1	.	.	.	.	.	.	.	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	1	14	.	.	.	.	.	.	.	1	16
Forgery,Counterfeiting,Application Fraud	.	.	.	5	1	.	.	.	.	.	.	6
Fraud On A Financial Institution	.	.	.	.	.	.	.	.	.	2	.	2
Habitual Offender Substance Abuse	.	.	.	.	1	.	.	.	.	.	.	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	9	.	9
Insurance Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Intimidation	.	.	.	.	1	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	3	6	.	.	.	.	.	.	9
Operate Vehicle After Suspended For Life	.	.	.	4	.	.	.	.	.	9	.	13
Operating Vehicle Intoxicated Resulting in Death	.	.	6	.	.	.	.	.	.	1	.	7
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	2	.	.	.	.	.	2	4
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	1	2
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of A Controlled Substance	.	.	.	1	.	.	.	.	.	.	.	1
Possession Of Cocaine Or Narcotic Drug	.	.	1	.	1	.	.	.	.	1	.	3
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	1	2	1	.	.	.	.	1	3	1	9
Possession Of Syringes Or Needles	.	.	.	.	.	.	.	.	.	3	1	4

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Edinburgh Correctional Facility												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Possession Or Use Of Legend Drug	.	.	.	.	.	.	.	.	.	.	1	**1**
Residential Entry	.	.	.	.	.	.	.	.	.	.	1	**1**
Resisting Law Enforcement	.	.	.	.	1	.	.	.	.	.	1	**2**
Robbery	.	.	5	4	.	.	.	1	.	5	.	**15**
Theft,Receiving Stolen Property	.	.	.	.	8	.	.	.	.	1	1	**10**
Unlawful Firearm Poss By Serious Felon	.	.	5	.	.	.	.	.	.	.	.	**5**
Total	**.**	**22**	**113**	**31**	**26**	**.**	**2**	**4**	**26**	**69**	**11**	**304**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Heritage Trail Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	.	1
Aggravated Battery	.	.	2	.	.	.	.	2	.	.	.	.	4
Aiding Inducing/Causing An Offense	.	.	1	.	.	.	.	1	2	1	.	.	5
Arson	.	.	.	.	.	.	.	.	1	.	.	.	1
Assisting A Criminal	.	.	.	.	.	.	.	.	.	1	.	.	1
Attempt To Commit Felony	.	.	2	2	.	.	.	3	1	3	.	.	11
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	.	.	.	.	.	.	3	.	4
Battery	.	.	1	13	3	.	.	.	.	53	3	.	73
Burglary	.	.	50	19	.	.	.	.	23	21	.	.	113
Carjacking	.	.	4	.	.	.	.	.	.	.	.	.	4
Check Fraud	.	.	.	.	1	.	.	.	.	.	.	.	1
Conspiracy	.	.	1	.	.	.	.	2	.	.	.	.	3
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	2	.	.	3
Criminal Confinement	.	.	2	2	.	.	.	2	.	4	.	.	10
Criminal Recklessness	.	.	.	.	3	.	.	.	.	3	1	.	7
Dealing In Cocaine Or Narcotic Drug	.	2	40	.	.	.	5	6	8	7	.	.	68
Dealing In Methamphetamine	.	2	31	.	.	.	2	1	3	7	.	.	46
Dealing In Schedule IV Controlled Subtance	.	.	1	1	.	.	.	.	.	.	.	.	2
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	1	1	.	2
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	.	1	1	.	.	.	2
Dealng In a Schedule I, II, or III Controlled Substance	.	.	20	.	.	.	.	.	.	.	.	.	20
Disarming A Law Enforcement Officer	.	.	.	2	.	.	.	.	.	.	.	.	2
Domestic Battery	.	.	.	.	4	.	.	.	.	1	2	.	7
Escape	.	.	.	.	.	.	.	.	1	1	2	.	4
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Failure To Return Lawful Detention/Escape	.	.	.	2	1	.	.	.	.	.	.	.	3
Forgery,Counterfeiting,Application Fraud	.	.	.	14	.	.	.	.	.	.	1	.	15
Habitual Offender	.	.	.	.	.	.	.	.	.	.	.	1	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	15	.	.	15
Intimidation	.	.	.	1	.	.	.	.	.	6	1	.	8
Invasion Of Privacy	.	.	.	.	1	.	.	.	.	.	1	.	2
Murder	2	.	.	.	.	.	.	.	.	.	.	.	2
Neglect Of A Dependent	.	.	2	1	1	.	.	.	.	1	.	.	5
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	19	3	.	.	.	.	.	.	.	22

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Heritage Trail Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Obliterating Handgun I.D.	.	.	.	1	.	.	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	6	.	.	.	.	.	17	.	.	23
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	1	.	.	.	.	.	.	.	.	1
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	2	.	.	.	.	.	2	.	4
Operating Vehicle-Habit Traffic Violator	.	.	.	.	2	.	.	.	.	.	1	.	3
Opererating Vehicle - Schedule I Or II Control Substance	.	.	.	.	1	.	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	1	.	1
Possess Of Precursors	.	.	.	.	2	.	.	.	.	.	.	.	2
Possession Of A Controlled Substance	.	.	.	2	1	.	.	.	.	.	.	.	3
Possession Of Cocaine Or Narcotic Drug	.	.	4	5	4	.	.	.	1	4	3	.	21
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	1	.	.	.	1
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	.	1	1	2	.	.	.	.	5	2	.	11
Possession Of Syringes Or Needles	.	.	.	1	1	.	.	.	.	2	2	.	6
Reckless Homicide	.	.	.	1	.	.	.	.	.	2	.	.	3
Residential Entry	.	.	.	.	1	.	.	.	.	.	2	.	3
Resisting Law Enforcement	.	.	.	.	1	.	.	.	.	.	3	.	4
Robbery	.	.	13	6	.	.	1	26	.	14	.	.	60
Stalking	.	.	.	1	.	.	.	.	.	3	.	.	4
Strangulation	.	.	.	.	1	.	.	.	.	.	1	.	2
Theft,Receiving Stolen Property	.	.	.	.	14	.	.	.	.	.	4	.	18
Trafficking With An Inmate	.	.	.	.	.	.	.	.	.	1	.	.	1
Unlawful Firearm Poss By Serious Felon	.	.	8	.	.	.	.	.	18	.	.	.	26
Unlawful Transfer of Handgun Ownership	.	.	.	.	.	.	.	.	.	1	.	.	1
Welfare Fraud	.	.	.	1	.	.	.	.	.	.	.	.	1
Total	**2**	**4**	**183**	**104**	**50**	**.**	**8**	**46**	**60**	**177**	**36**	**1**	**671**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Indianapolis Re-Entry Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Aggravated Battery	.	.	3	.	.	.	.	.	.	.	.	3
Aiding Inducing/Causing An Offense	.	1	1	.	.	.	.	.	.	.	.	2
Arson	.	1	.	.	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	6	3	.	.	.	.	.	.	1	.	10
Battery	.	.	2	2	.	.	.	.	.	.	.	4
Burglary	.	4	15	6	.	.	.	.	3	2	.	30
Conspiracy	.	3	3	.	.	.	.	.	.	1	.	7
Criminal Confinement	.	.	1	.	.	.	.	.	.	.	.	1
Criminal Recklessness	.	.	.	1	.	.	.	.	.	.	.	1
Dealing In Cocaine Or Narcotic Drug	.	22	20	.	.	.	.	1	.	.	.	43
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	.	.	.	.	.	.	.	1
Dealing In Methamphetamine	.	3	19	.	.	.	.	1	.	2	.	25
Dealng In a Schedule I, II, or III Controlled Substance	.	2	19	.	.	.	.	.	.	.	.	21
Driving While Intoxicated Result - Death	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	3	.	.	.	.	.	.	.	3
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	1	.	1
Home Improvement Fraud Enhancement	.	.	.	1	.	.	.	.	.	.	.	1
Murder	12	.	.	.	.	.	.	.	.	.	.	12
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	1	.	.	.	.	.	1	.	2
Operating Vehicle Intoxicated Resulting in Death	.	.	3	1	.	.	.	.	.	.	.	4
Possession Of Cocaine Or Narcotic Drug	.	1	.	1	.	.	.	.	.	.	.	2
Possession Of Methamphetamine	.	.	3	.	.	.	.	.	.	.	.	3
Reckless Homicide	.	.	.	1	.	.	.	.	.	.	.	1
Robbery	.	4	19	3	.	.	.	1	.	.	.	27
Theft,Receiving Stolen Property	.	.	.	1	.	.	.	.	.	.	.	1
Unlawful Firearm Poss By Serious Felon	.	.	9	.	.	.	.	.	1	.	.	10
Voluntary Manslaughter	.	11	2	.	.	.	.	.	.	.	.	13
Total	**12**	**59**	**122**	**23**	**.**	**.**	**.**	**3**	**4**	**8**	**.**	**231**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Indiana State Prison

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	1
Aggravated Battery	.	.	21	.	.	.	.	4	.	.	.	25
Aiding Inducing/Causing An Offense	.	4	8	2	.	.	.	.	.	.	.	14
Arson	.	1	1	.	.	.	.	.	1	.	.	3
Attempt To Commit Felony	.	100	15	.	.	8	1	.	.	.	.	124
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	.	.	.	.	.	.	.	1
Battery	.	7	4	9	1	.	.	.	.	9	2	32
Burglary	.	50	82	10	.	3	5	.	2	6	.	158
Carjacking	.	.	1	.	.	.	.	.	.	.	.	1
Check Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Child Molesting	.	227	16	1	.	11	.	1	1	.	.	257
Conspiracy	.	15	3	.	.	.	.	1	.	.	.	19
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	1	.	2
Criminal Confinement	.	.	18	.	.	.	.	.	.	1	.	19
Criminal Deviate Conduct	.	27	5	.	.	.	.	.	.	.	.	32
Criminal Recklessness	.	.	.	1	1	.	.	.	.	.	.	2
Dealing In Cocaine Or Narcotic Drug	.	136	48	.	.	.	5	2	3	3	.	197
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	.	.	.	.	.	.	.	1
Dealing In Methamphetamine	.	23	17	.	.	.	1	.	2	2	.	45
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	.	.	1	.	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	6	15	.	.	.	.	.	.	.	.	21
Domestic Battery	.	.	.	.	.	.	.	.	.	.	1	1
Escape	.	.	.	.	.	.	.	.	.	1	.	1
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	2	.	.	.	.	.	.	.	2
Failure To Return Lawful Detention/Escape	.	.	2	2	.	.	.	.	.	.	.	4
Forgery,Counterfeiting,Application Fraud	.	.	.	7	.	.	.	.	.	.	.	7
Fraud On A Financial Institution	.	.	.	1	.	.	.	.	.	1	.	2
Human Sexual Trafficking	.	.	1	.	.	.	.	.	.	.	.	1
Incest	.	.	1	.	.	.	.	.	.	.	.	1
Intimidation	.	.	.	2	.	.	.	.	.	.	.	2
Kidnapping	.	19	.	.	.	.	.	.	.	.	.	19
Murder	728	.	.	.	.	.	.	.	.	.	.	728

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Indiana State Prison

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Neglect Of A Dependent	.	.	4	.	.	.	.	.	.	.	1	5
Neglect Of Dependent Resulting In Death	.	10	.	.	.	2	.	.	.	.	.	12
Non Support Of Dependent Child	.	.	.	.	1	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	4	.	.	.	.	.	7	.	11
Operating Vehicle Intoxicated Resulting in Death	.	.	3	.	.	.	.	.	.	.	.	3
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of A Controlled Substance	.	.	.	1	2	.	.	.	.	.	.	3
Possession Of Cocaine Or Narcotic Drug	.	12	2	2	.	.	.	.	.	.	.	16
Possession Of Methamphetamine	.	.	1	1	.	.	.	.	.	.	.	2
Possession Of Paraphernalia	.	.	.	.	.	.	.	.	.	.	1	1
Prisoner Poss. Dangerous Device/Material	.	.	3	.	.	.	.	.	.	.	.	3
Rape	.	66	10	.	.	4	.	2	.	.	.	82
Reckless Homicide	.	.	.	1	.	.	.	.	.	.	.	1
Resisting Law Enforcement	.	.	3	.	1	.	.	1	.	.	.	5
Robbery	.	44	107	8	.	.	1	9	.	5	.	174
Sexual Misconduct With A Minor	.	1	9	.	.	.	.	.	.	.	.	10
Stalking	.	.	.	.	.	.	.	.	.	2	.	2
Theft,Receiving Stolen Property	.	.	.	.	3	.	.	.	.	.	.	3
Unlawful Firearm Poss By Serious Felon	.	.	29	.	.	.	.	.	3	.	.	32
Voluntary Manslaughter	.	71	7	.	.	.	1	.	.	.	.	79
Total	**728**	**819**	**436**	**58**	**10**	**28**	**14**	**21**	**13**	**39**	**6**	**2,172**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Indiana Women's Prison												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	1	.	.	.	.	.	1	.	**2**
Aggravated Battery	.	.	3	.	.	.	.	6	.	.	.	**9**
Aiding Inducing/Causing An Offense	.	5	3	1	.	.	.	1	.	.	.	**10**
Arson	.	1	4	.	.	.	.	.	3	.	.	**8**
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	**1**
Attempt To Commit Felony	.	13	1	.	2	.	.	.	.	1	.	**17**
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	.	.	.	.	.	.	2	**3**
Battery	.	2	2	2	2	.	.	1	.	23	1	**33**
Battery By Bodily Waste	.	.	.	.	1	.	.	.	.	.	.	**1**
Battery To A Child Causing Death	.	1	.	.	.	.	.	.	.	.	.	**1**
Burglary	.	2	18	2	.	.	.	.	12	8	.	**42**
Child Molesting	.	.	2	.	.	.	.	.	1	.	.	**3**
Conspiracy	.	4	4	.	.	.	2	1	.	2	.	**13**
Controlled Substance Registration	.	.	.	2	.	.	.	.	.	.	1	**3**
Corrupt Business Influence	.	.	.	2	.	.	.	.	.	.	.	**2**
Criminal Confinement	.	.	2	1	.	.	.	.	.	1	.	**4**
Criminal Recklessness	.	.	.	1	.	.	.	.	.	2	.	**3**
Dealing In Cocaine Or Narcotic Drug	.	11	22	.	.	.	4	.	6	7	.	**50**
Dealing In Methamphetamine	.	16	21	.	.	.	3	4	4	12	.	**60**
Dealing In Schedule IV Controlled Subtance	.	.	2	3	.	.	.	.	.	.	.	**5**
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	.	.	**1**
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	1	.	1	.	.	**2**
Dealng In a Schedule I, II, or III Controlled Substance	.	7	26	.	.	.	.	.	.	2	.	**35**
Domestic Battery	.	.	.	.	1	.	.	.	.	.	1	**2**
Escape	.	.	.	.	.	.	.	.	.	2	1	**3**
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	**1**
Failure To Return Lawful Detention/Escape	.	.	.	1	.	.	.	.	.	.	.	**1**
Forgery,Counterfeiting,Application Fraud	.	.	.	18	.	.	.	.	.	.	1	**19**
Fraud	.	.	.	.	2	.	.	.	.	.	1	**3**
Fraud On A Financial Institution	.	.	.	1	.	.	.	.	.	.	.	**1**
Handgun Violation	.	.	.	1	.	.	.	.	.	.	.	**1**
Identity Deception	.	.	.	.	2	.	.	.	.	.	.	**2**
Incest	.	.	1	.	.	.	.	.	.	.	.	**1**
Intimidation	.	.	.	.	.	.	.	.	.	4	.	**4**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Indiana Women's Prison												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Maintaining Common Nuisance	.	.	.	.	3	.	.	.	.	.	2	**5**
Murder	71	.	.	.	.	.	.	.	.	.	.	**71**
Neglect Of A Dependent	.	.	8	3	.	.	.	.	.	1	.	**12**
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	5	.	.	.	**5**
Neglect Of Dependent Resulting In Death	.	12	.	.	.	4	.	.	.	.	.	**16**
Operate Vehicle After Suspended For Life	.	.	.	2	.	.	.	.	.	1	.	**3**
Operating Vehicle Intoxicated Resulting in Death	.	.	2	1	.	.	.	.	1	1	.	**5**
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	.	.	.	.	.	.	1	.	**1**
Possess Chemical Reagents Or Precursors	.	.	.	1	.	.	.	.	.	.	.	**1**
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	.	**1**
Possession Of A Controlled Substance	.	.	.	2	3	.	.	.	.	.	.	**5**
Possession Of Cocaine Or Narcotic Drug	.	1	2	2	1	.	.	.	.	3	1	**10**
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	**1**
Possession Of Methamphetamine	.	.	4	1	5	.	.	1	.	2	2	**15**
Possession Of Paraphernalia	.	.	.	.	.	.	.	.	.	.	2	**2**
Possession Of Syringes Or Needles	.	.	.	.	.	.	.	.	.	1	.	**1**
Promoting Prostitution	.	.	.	1	.	.	.	.	.	.	.	**1**
Promoting Prostitution Under Age 18	.	.	1	.	.	.	.	.	.	.	.	**1**
Reckless Homicide	.	.	.	2	.	.	.	.	.	1	.	**3**
Resisting Law Enforcement	.	.	.	.	.	.	.	.	.	.	2	**2**
Robbery	.	4	19	2	.	.	3	13	.	3	.	**44**
Stalking	.	.	.	1	.	.	.	.	.	.	.	**1**
Theft,Receiving Stolen Property	.	.	.	.	9	.	.	.	.	.	11	**20**
Trafficking With An Inmate	.	.	.	2	.	.	.	.	.	1	.	**3**
Unlawful Firearm Poss By Serious Felon	.	.	2	.	.	.	.	.	.	.	.	**2**
Violation Of Custody Order	.	.	.	.	1	.	.	.	.	.	.	**1**
Voluntary Manslaughter	.	7	1	.	.	.	1	.	.	.	.	**9**
Welfare Fraud	.	.	.	1	1	.	.	.	.	.	.	**2**
Total	**71**	**86**	**150**	**60**	**35**	**4**	**14**	**33**	**28**	**80**	**28**	**589**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Madison Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	1	.	.	1
Aiding Inducing/Causing An Offense	.	.	6	1	.	.	.	.	1	5	.	13
Arson	.	.	.	.	1	.	.	1	1	.	.	3
Auto Theft, Receiving Stolen Auto Parts	.	.	.	.	1	.	.	.	.	.	1	2
Battery	.	.	.	.	.	.	.	.	.	5	.	5
Burglary	.	1	20	6	.	.	.	.	26	3	.	56
Conspiracy	.	4	5	2	.	.	1	1	3	3	.	19
Corrupt Business Influence	.	.	.	2	.	.	.	.	.	5	.	7
Criminal Recklessness	.	.	.	.	.	.	.	.	.	.	1	1
Dealing In Cocaine Or Narcotic Drug	.	5	39	.	.	.	6	4	9	27	.	90
Dealing In Methamphetamine	.	6	65	.	.	.	3	5	17	21	.	117
Dealing In Schedule IV Controlled Subtance	.	.	4	2	.	.	.	.	.	.	.	6
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	4	.	5
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	.	.	5	.	.	5
Dealng In a Schedule I, II, or III Controlled Substance	.	6	39	.	.	.	.	.	.	3	1	49
Domestic Battery	.	.	.	.	.	.	.	.	.	.	1	1
Forgery,Counterfeiting,Application Fraud	.	.	.	24	.	.	.	.	.	.	1	25
Fraud	.	.	.	.	1	.	.	.	.	.	1	2
Fraud On A Financial Institution	.	.	.	3	.	.	.	.	.	1	.	4
Identity Deception	.	.	.	.	.	.	.	.	.	.	1	1
Maintaining Common Nuisance	.	.	.	.	3	.	.	.	.	.	.	3
Murder	5	.	.	.	.	.	.	.	.	.	.	5
Neglect Of A Dependent	.	.	2	3	.	.	.	.	.	.	.	5
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	1	.	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	3	.	.	.	.	.	5	.	8
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	.	.	.	1
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	2	.	.	.	.	.	.	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	2	.	.	.	.	1	1	4
Operating Vehicle-Habit Traffic Violator	.	.	.	.	.	.	.	.	.	.	2	2
Possess Chemical Reagents Or Precursors	.	.	.	3	.	.	.	.	.	.	.	3
Possess Of Precursors	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of A Controlled Substance	.	.	.	2	6	.	.	.	.	.	.	8

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Madison Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Possession Of Cocaine Or Narcotic Drug	.	2	2	1	3	.	.	.	2	4	3	**17**
Possession Of Methamphetamine	.	.	5	2	2	.	.	1	.	2	2	**14**
Possession Of Syringes Or Needles	.	.	.	.	1	.	.	.	.	2	4	**7**
Possession Or Use Of Legend Drug	.	.	.	.	.	.	.	.	.	.	2	**2**
Promoting Prostitution	.	.	.	1	.	.	.	.	.	.	.	**1**
Robbery	.	1	7	2	.	.	.	4	.	4	.	**18**
Theft,Receiving Stolen Property	.	.	.	.	9	.	.	.	.	.	9	**18**
Trafficking With An Inmate	.	.	.	2	.	.	.	.	.	7	.	**9**
Unlawful Firearm Poss By Serious Felon	.	.	1	.	.	.	.	.	.	.	.	**1**
Voluntary Manslaughter	.	3	.	.	.	.	.	.	.	.	.	**3**
Welfare Fraud	.	.	.	3	.	.	.	.	.	.	.	**3**
Total	**5**	**29**	**196**	**66**	**29**	**.**	**10**	**16**	**65**	**102**	**31**	**549**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Miami Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	3	.	.	.	.	.	.	1	.	4
Aggravated Battery	.	.	76	.	.	.	.	33	.	.	.	109
Aiding Inducing/Causing An Offense	.	9	17	1	.	.	4	4	2	.	.	37
Aiding in Manufacture of Sch II Controlled Substance	.	.	.	.	.	.	.	.	.	.	1	1
Arson	.	3	10	.	.	.	.	.	3	.	.	16
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	1	2
Attempt To Commit Felony	.	95	25	4	.	17	1	5	.	1	.	148
Auto Theft, Receiving Stolen Auto Parts	.	.	.	4	.	.	.	.	.	.	1	5
Battery	.	4	16	22	1	.	.	3	.	28	2	76
Battery To A Child Causing Death	.	2	.	.	.	.	.	.	.	.	.	2
Burglary	.	56	283	50	.	1	13	.	30	13	.	446
Carjacking	.	.	13	.	.	.	.	.	.	.	.	13
Carrying Handgun Without License	.	.	.	5	.	.	.	.	.	.	.	5
Causing Suicide	.	.	1	.	.	.	.	.	.	.	.	1
Check Fraud	.	.	.	.	.	.	.	.	.	.	1	1
Child Molesting	.	103	29	4	.	32	.	5	4	.	.	177
Conspiracy	.	24	19	1	.	1	5	.	2	1	.	53
Controlled Substance Registration	.	.	.	1	.	.	.	.	.	.	.	1
Corrupt Business Influence	.	.	.	3	.	.	.	.	.	1	.	4
Criminal Confinement	.	.	35	3	1	.	.	11	.	2	.	52
Criminal Deviate Conduct	.	6	3	.	.	.	.	.	.	.	.	9
Criminal Recklessness	.	.	.	2	2	.	.	.	.	4	.	8
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	1	1
Dealing In Cocaine Or Narcotic Drug	.	280	127	.	.	.	26	4	4	11	.	452
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	.	.	.	.	.	.	.	1
Dealing In Methamphetamine	.	71	99	.	.	.	22	5	11	21	.	229
Dealing In Schedule IV Controlled Subtance	.	.	1	.	.	.	.	.	.	.	.	1
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	.	.	1
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	1	.	.	.	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	27	57	.	.	.	.	.	.	1	.	85
Domestic Battery	.	.	.	.	2	.	.	.	.	.	1	3
Dumping Controlled Substance Waste	.	.	.	.	.	.	.	.	.	.	1	1
Escape	.	.	.	.	.	.	.	.	.	4	5	9

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Miami Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Fail To Stop After Accident - Operating Vehicle Intoxicated	.	.	1	.	.	.	.	.	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	.	.	.	.	.	.	1	.	1
Failure To Return Lawful Detention/Escape	.	.	3	11	1	.	.	.	.	.	.	15
Firearm Within 1 Mile School Property Without License	.	.	.	2	.	.	.	.	.	.	.	2
Forgery,Counterfeiting,Application Fraud	.	.	.	22	.	.	.	.	.	.	.	22
Fraud On A Financial Institution	.	.	.	.	.	.	.	.	.	2	.	2
Handgun Violation (Felony Within 15 Yrs)	.	.	.	1	.	.	.	.	.	17	.	18
Identity Deception	.	.	.	.	2	.	.	.	.	.	1	3
Incest	.	.	2	.	.	.	.	.	.	.	.	2
Intimidation	.	.	.	4	1	.	.	.	.	1	.	6
Invasion Of Privacy	.	.	.	.	.	.	.	.	.	.	1	1
Kidnapping	.	9	.	.	.	.	4	1	.	.	.	14
Murder	189	.	.	.	.	.	.	.	.	.	.	189
Neglect Of A Dependent	.	.	8	1	.	.	.	.	.	.	.	9
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	6	.	.	.	6
Neglect Of Dependent Resulting In Death	.	7	.	.	.	1	.	.	.	.	.	8
Non Support Of Dependent Child	.	.	.	2	1	.	.	.	.	.	.	3
Obliterating Handgun I.D.	.	.	.	1	.	.	.	.	.	.	.	1
Obstruction Of Justice	.	.	.	.	1	.	.	.	.	.	1	2
Operate Vehicle After Suspended For Life	.	.	.	4	.	.	.	.	.	16	.	20
Operating Vehicle Intoxicated Resulting in Death	.	.	8	1	.	.	.	.	1	2	.	12
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	.	.	.	.	.	.	.	1	1
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	1	.	.	.	.	.	2	3
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	2	3
Possess Chemical Reagents Or Precursors	.	.	.	2	.	.	.	.	.	.	.	2
Possess Destructive Device Or Explosive	.	.	.	.	.	.	1	.	.	.	.	1
Possess Methamphetamine Without Pay Tax	.	.	.	.	1	.	.	.	.	.	.	1
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of A Controlled Substance	.	.	.	6	2	.	.	.	.	.	.	8
Possession Of Cocaine Or Narcotic Drug	.	20	17	7	2	.	.	1	1	2	2	52
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	2	.	.	2
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	3	10	1	2	.	.	.	1	1	2	20

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Miami Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Possession Of Syringes Or Needles	.	.	.	.	1	.	.	.	.	1	.	**2**
Prisoner Poss. Dangerous Device/Material	.	.	2	.	.	.	.	.	.	.	.	**2**
Rape	.	14	4	.	.	8	.	4	.	.	.	**30**
Reckless Homicide	.	.	.	2	.	.	.	.	.	1	.	**3**
Residential Entry	.	.	.	.	2	.	.	.	.	.	1	**3**
Resisting Law Enforcement	.	.	2	1	2	.	.	.	.	1	2	**8**
Robbery	.	50	258	25	.	.	13	65	.	8	.	**419**
Sexual Misconduct With A Minor	.	1	8	.	.	.	.	.	1	.	.	**10**
Stalking	.	.	2	3	.	.	.	.	.	1	.	**6**
Strangulation	.	.	.	.	1	.	.	.	.	.	2	**3**
Theft,Receiving Stolen Property	.	.	.	.	9	.	.	.	.	.	7	**16**
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	2	.	**3**
Unlawful Firearm Poss By Serious Felon	.	.	89	.	.	.	.	.	13	.	.	**102**
Voluntary Manslaughter	.	75	9	.	.	.	8	.	.	.	.	**92**
Total	**189**	**859**	**1,237**	**200**	**38**	**60**	**98**	**147**	**75**	**144**	**38**	**3,085**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

New Castle Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	1
Aggravated Battery	.	.	14	.	.	.	.	3	.	.	.	17
Aiding Inducing/Causing An Offense	.	1	4	.	.	.	.	.	1	3	.	9
Aiding in Manufacture of Sch II Controlled Substance	.	.	.	.	.	.	.	.	.	.	1	1
Arson	.	.	7	.	.	.	.	.	2	.	.	9
Attempt To Commit Felony	.	51	28	2	.	.	.	9	3	5	.	98
Auto Theft, Receiving Stolen Auto Parts	.	.	.	3	.	.	.	.	.	.	3	6
Battery	.	2	5	11	.	.	.	1	.	18	1	38
Burglary	.	26	98	26	.	.	1	1	19	9	.	180
Carjacking	.	.	2	.	.	.	.	.	.	.	.	2
Check Fraud	.	.	.	.	1	.	.	.	.	.	.	1
Child Exploitation	.	.	.	11	1	.	.	.	.	10	.	22
Child Molesting	.	558	400	177	.	2	.	39	75	.	.	1,251
Child Seduction	.	.	.	3	2	.	.	.	.	2	.	7
Child Solicitation	.	.	.	10	3	.	.	.	5	21	.	39
Conspiracy	.	4	8	3	.	.	.	.	.	.	.	15
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	1	.	2
Criminal Confinement	.	.	14	7	.	.	.	2	.	6	.	29
Criminal Deviate Conduct	.	44	84	.	.	.	.	.	.	.	.	128
Criminal Recklessness	.	.	.	2	.	.	.	.	.	1	.	3
Dangerous Control Of A Handgun	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Cocaine Or Narcotic Drug	.	16	29	.	.	.	.	2	5	24	.	76
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Dealing In Methamphetamine	.	3	39	.	.	.	1	1	4	16	.	64
Dealing In Sched V Controlled Substance	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Schedule IV Controlled Subtance	.	.	2	2	.	.	.	.	.	.	.	4
Dealng In a Schedule I, II, or III Controlled Substance	.	6	30	.	.	.	.	.	.	2	.	38
Disarming A Law Enforcement Officer	.	.	.	.	.	.	.	.	.	2	.	2
Distribute Destructive Device To Minor	.	.	1	.	.	.	.	.	.	.	.	1
Domestic Battery	.	.	.	.	1	.	.	.	.	.	.	1
Escape	.	.	.	.	.	.	.	.	.	1	2	3
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	8	5	.	.	.	.	22	2	37

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

New Castle Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Failure To Return Lawful Detention/Escape	.	.	.	1	2	.	.	.	.	.	.	3
Firearm Within 1 Mile School Property Without License	.	.	.	2	.	.	.	.	.	.	.	2
Forgery,Counterfeiting,Application Fraud	.	.	.	12	.	.	.	.	.	.	.	12
Fraud	.	.	.	.	1	.	.	.	.	.	.	1
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	1	.	3
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	9	.	9
Human Sexual Trafficking	.	.	.	.	.	.	.	2	1	.	.	3
Incest	.	.	18	15	.	.	.	.	1	4	.	38
Intimidation	.	.	.	3	.	.	.	.	.	1	.	4
Invasion Of Privacy	.	.	.	.	1	.	.	.	.	.	.	1
Kidnapping	.	12	.	.	.	.	.	.	.	.	.	12
Maintaining Common Nuisance	.	.	.	.	1	.	.	.	.	.	.	1
Murder	88	.	.	.	.	.	.	.	.	.	.	88
Neglect Of A Dependent	.	.	.	1	1	.	.	.	.	1	.	3
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	7	3	.	.	.	.	.	.	10
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	1
Obstruction Of Justice	.	.	.	.	.	.	.	.	.	.	1	1
Operate Vehicle After Suspended For Life	.	.	.	5	.	.	.	.	.	11	.	16
Operating Vehicle Intoxicated Resulting in Death	.	.	5	.	.	.	.	.	.	.	.	5
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	3	.	.	.	.	.	.	3
Operating Vehicle-Habit Traffic Violator	.	.	.	.	.	.	.	.	.	.	1	1
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	1	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	2	2
Possess Chemical Reagents Or Precursors	.	.	.	2	.	.	.	.	.	.	.	2
Possess Of Precursors	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of A Controlled Substance	.	.	.	2	.	.	.	.	.	.	.	2
Possession Of Child Pornography	.	.	.	.	.	.	.	.	.	.	5	5
Possession Of Cocaine Or Narcotic Drug	.	1	6	2	1	.	.	.	.	1	1	12
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	1	.	.	1
Possession Of Methamphetamine	.	.	4	.	3	.	.	.	1	1	.	9
Possession Of Syringes Or Needles	.	.	.	1	.	.	.	.	.	2	.	3
Prisoner Poss. Dangerous Device/Material	.	.	1	.	.	.	.	.	.	.	.	1

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

New Castle Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Promoting Prostitution Under Age 18	.	.	3	.	.	.	.	.	.	.	.	3
Public Indecency	.	.	.	.	.	.	.	.	.	.	2	2
Rape	.	89	113	.	.	.	.	26	.	.	.	228
Residential Entry	.	.	.	.	2	.	.	.	.	.	1	3
Robbery	.	17	74	6	.	.	.	7	.	10	.	114
Sexual Battery	.	.	.	1	6	.	.	.	3	.	5	15
Sexual Misconduct Gov Employe W/Detainee	.	.	.	1	.	.	.	.	.	.	.	1
Sexual Misconduct With A Minor	.	.	218	57	2	.	.	.	44	30	.	351
Stalking	.	.	.	.	.	.	.	.	.	1	.	1
Theft,Receiving Stolen Property	.	.	.	.	8	.	.	.	.	.	5	13
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	1	.	2
Unlawful Firearm Poss By Serious Felon	.	.	15	.	.	.	.	.	3	.	.	18
Vicarious Sexual Gratification	.	.	4	2	.	.	.	.	1	.	.	7
Voluntary Manslaughter	.	8	2	.	.	.	.	.	.	.	.	10
Voyeurism	.	.	.	.	1	.	.	.	.	.	1	2
Total	**88**	**839**	**1,228**	**389**	**50**	**2**	**2**	**94**	**169**	**220**	**34**	**3,115**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Pendleton Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	1
Aggravated Battery	.	.	19	.	.	.	.	5	.	.	.	24
Aiding Inducing/Causing An Offense	.	5	5	1	.	1	.	.	.	.	.	12
Arson	.	4	3	.	.	.	.	.	1	.	.	8
Attempt To Commit Felony	.	79	9	1	.	4	.	.	.	2	.	95
Auto Theft, Receiving Stolen Auto Parts	.	.	.	2	2	.	.	.	.	1	2	7
Battery	.	3	4	18	1	.	2	2	.	6	.	36
Battery To A Child Causing Death	.	2	.	.	.	.	.	.	.	.	.	2
Burglary	.	39	82	18	.	3	2	.	9	7	.	160
Carjacking	.	.	6	.	.	.	.	.	.	.	.	6
Check Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Child Molesting	.	211	10	3	.	9	.	1	.	.	.	234
Conspiracy	.	10	5	.	.	.	.	.	.	.	.	15
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	.	.	1
Criminal Confinement	.	.	17	1	.	.	.	2	.	3	.	23
Criminal Deviate Conduct	.	32	3	.	.	.	.	.	.	.	.	35
Criminal Recklessness	.	.	.	2	.	.	.	.	.	.	1	3
Dealing In Cocaine Or Narcotic Drug	.	84	32	.	.	.	2	1	.	3	.	122
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	.	.	.	.	.	.	2	.	2
Dealing In Methamphetamine	.	11	23	.	.	.	2	1	1	6	.	44
Dealng In a Schedule I, II, or III Controlled Substance	.	5	8	.	.	.	.	.	.	.	.	13
Escape	.	.	.	.	.	.	.	.	.	1	.	1
Failure To Register As A Sex Offender	.	.	.	.	.	.	.	.	.	1	.	1
Failure To Return Lawful Detention/Escape	.	.	.	2	.	.	.	.	.	.	.	2
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	7	.	.	.	.	.	.	.	7
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	.	.	2
Habitual Offender Substance Abuse	.	.	.	.	1	.	.	.	.	.	.	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	3	.	3
Incest	.	.	1	.	.	.	.	.	1	.	.	2
Intimidation	.	.	.	1	.	.	.	.	.	.	.	1
Involuntary Manslaughter	.	.	.	1	.	.	.	.	.	.	.	1
Kidnapping	.	12	.	.	.	.	.	.	.	.	.	12

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Pendleton Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Murder	520	.	.	.	.	.	.	.	.	.	.	520
Neglect Of A Dependent	.	.	2	1	.	.	.	.	.	.	.	3
Neglect Of Dependent Resulting In Death	.	4	.	.	.	.	.	.	.	.	.	4
Non Support Of Dependent Child	.	.	.	.	1	.	.	.	.	1	1	3
Operate Vehicle After Suspended For Life	.	.	.	1	.	.	.	.	.	8	.	9
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	1	.	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	3	.	.	.	.	.	1	4
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Possession Of Cocaine Or Narcotic Drug	.	4	1	.	3	.	.	.	.	.	2	10
Possession Of Methamphetamine	.	.	2	.	1	.	.	1	.	2	1	7
Prisoner Poss. Dangerous Device/Material	.	.	1	.	.	.	.	.	.	.	.	1
Rape	.	43	9	.	.	4	.	1	.	.	.	57
Reckless Homicide	.	.	.	1	.	.	.	.	.	.	.	1
Residential Entry	.	.	.	.	1	.	.	.	.	.	.	1
Resisting Law Enforcement	.	.	1	.	.	.	.	.	.	1	.	2
Robbery	.	34	98	6	.	.	5	11	.	4	.	158
Sexual Misconduct With A Minor	.	.	7	1	.	.	.	.	.	.	.	8
Stalking	.	.	.	.	.	.	.	.	1	.	.	1
Strangulation	.	.	.	.	.	.	.	.	.	.	1	1
Theft,Receiving Stolen Property	.	.	.	.	7	.	.	.	.	.	3	10
Unlawful Firearm Poss By Serious Felon	.	.	23	.	.	.	.	.	3	.	.	26
Voluntary Manslaughter	.	36	6	.	.	.	3	.	.	.	.	45
Total	**520**	**618**	**378**	**72**	**21**	**21**	**16**	**25**	**17**	**52**	**13**	**1,753**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Plainfield Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Aggravated Battery	.	.	12	.	.	.	.	10	.	.	.	22
Aiding Inducing/Causing An Offense	.	2	6	1	.	.	.	.	2	3	.	14
Arson	.	.	5	.	1	.	.	.	5	.	.	11
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	19	6	1	1	.	.	2	.	3	.	32
Auto Theft, Receiving Stolen Auto Parts	.	.	.	3	2	.	.	.	.	.	7	12
Battery	.	.	2	26	.	.	.	1	1	28	3	61
Battery To A Child Causing Death	.	1	.	.	.	.	.	.	.	.	.	1
Burglary	.	8	110	27	.	.	4	.	49	28	.	226
Carjacking	.	.	5	.	.	.	.	.	.	.	.	5
Carrying Handgun Without License	.	.	.	3	.	.	.	.	.	.	.	3
Check Fraud	.	.	.	1	.	.	.	.	.	.	.	1
Child Molesting	.	9	2	3	.	.	.	.	.	.	.	14
Child Solicitation	.	.	1	.	.	.	.	.	.	.	.	1
Conspiracy	.	11	9	2	.	.	.	1	1	2	.	26
Corrupt Business Influence	.	.	.	2	.	.	.	.	.	1	.	3
Criminal Confinement	.	.	8	3	1	.	.	2	.	3	.	17
Criminal Deviate Conduct	.	.	2	.	.	.	.	.	.	.	.	2
Criminal Recklessness	.	.	.	4	.	.	.	.	.	3	.	7
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	1	1
Deal Substance Represented To Be Controlled Substance	.	.	.	.	1	.	.	.	.	.	.	1
Dealing In A Schedule V Controlled Subtance	.	.	1	.	.	.	.	.	.	.	.	1
Dealing In Cocaine Or Narcotic Drug	.	40	102	.	.	.	7	5	18	15	.	187
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	2	1	.	.	.	.	2	.	5
Dealing In Methamphetamine	.	2	58	.	.	.	1	4	15	23	.	103
Dealing In Schedule IV Controlled Subtance	.	.	1	2	.	.	.	.	.	2	.	5
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	1	.	2
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	1	1	2	.	.	4
Dealng In a Schedule I, II, or III Controlled Substance	.	2	45	.	.	.	.	.	.	.	.	47
Disarming A Law Enforcement Officer	.	.	.	.	.	.	.	.	.	1	.	1
Domestic Battery	.	.	.	.	2	.	.	.	.	.	.	2
Driving While Intoxicated	.	.	.	.	1	.	.	.	.	.	.	1
Escape	.	.	.	.	.	.	.	.	.	5	4	9

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Plainfield Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Fail To Stop After Accident - Operating Vehicle Intoxicated	.	.	1	.	.	.	.	.	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	4	1	.	.	.	.	16	.	21
Failure To Return Lawful Detention/Escape	.	.	.	4	1	.	.	.	.	.	.	5
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	14	1	.	.	.	.	.	.	15
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	7	.	9
Handgun Violation (Felony Within 15 Yrs)	.	.	.	1	.	.	.	.	.	18	.	19
Home Improvement Fraud Offenses	.	.	.	.	1	.	.	.	.	.	.	1
Intimidation	.	.	.	4	2	.	.	.	.	6	3	15
Invasion Of Privacy	.	.	.	.	.	.	.	.	.	.	1	1
Kidnapping	.	2	.	.	.	.	.	1	.	.	.	3
Maintaining Common Nuisance	.	.	.	.	.	.	.	.	.	.	1	1
Murder	37	.	.	.	.	.	.	.	.	.	.	37
Neglect Of A Dependent	.	.	2	1	.	.	.	.	.	2	.	5
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	3	.	.	.	3
Non Support Of Dependent Child	.	.	.	10	1	.	.	.	.	1	.	12
Obliterating Handgun I.D.	.	.	.	1	.	.	.	.	.	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	13	.	.	.	.	.	28	.	41
Operating Vehicle Intoxicated Resulting in Death	.	.	3	.	.	.	.	.	4	.	.	7
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	.	.	.	.	.	.	2	.	2
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	7	.	.	.	.	.	4	11
Operating Vehicle With Schedule I in Body - Causing Death	.	.	.	1	.	.	.	.	.	.	.	1
Operating Vehicle-Habit Traffic Violator	.	.	.	1	3	.	.	.	.	.	3	7
Opererating Vehicle - Schedule I Or II Control Substance	.	.	.	.	2	.	.	.	.	.	.	2
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Possess Chemical Reagents Or Precursors	.	.	.	2	.	.	.	.	.	1	.	3
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of A Controlled Substance	.	.	.	2	4	.	.	.	.	.	.	6
Possession Of Cocaine Or Narcotic Drug	.	3	15	4	2	.	.	1	1	5	6	37
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	.	1	.	1
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	2	.	.	.	.	.	.	2
Possession Of Methamphetamine	.	.	3	5	2	.	.	5	6	4	3	28
Possession Of Syringes Or Needles	.	.	.	.	.	.	.	.	.	.	1	1

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Plainfield Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Prisoner Poss. Dangerous Device/Material	.	.	.	1	.	.	.	.	.	.	.	1
Rape	.	1	1	.	.	.	.	.	.	.	.	2
Reckless Homicide	.	.	.	3	.	.	.	.	.	2	.	5
Resisting Law Enforcement	.	.	.	.	2	.	.	.	.	.	4	6
Robbery	.	4	69	16	.	.	.	26	.	17	.	132
Sale Of Unregistered Security	.	.	.	1	.	.	.	.	.	.	.	1
Stalking	.	.	.	3	.	.	.	.	1	2	.	6
Strangulation	.	.	.	.	2	.	.	.	.	.	2	4
Theft,Receiving Stolen Property	.	.	.	.	19	.	.	.	.	3	12	34
Trafficking With An Inmate	.	.	.	2	.	.	.	.	.	1	.	3
Unlawful Firearm Poss By Serious Felon	.	.	32	.	.	.	.	.	14	.	.	46
Voluntary Manslaughter	.	9	3	.	.	.	.	.	.	.	.	12
Total	**37**	**113**	**504**	**178**	**63**	**.**	**13**	**62**	**119**	**236**	**56**	**1,381**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Putnamville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	1	.	.	1
Aggravated Battery	.	.	18	.	.	.	.	14	.	.	.	.	32
Aiding Inducing/Causing An Offense	.	1	4	1	.	.	1	.	2	2	.	.	11
Arson	.	1	8	.	.	.	.	.	5	.	.	.	14
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	.	1
Assisting Suicide	.	.	.	1	.	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	24	8	4	1	.	1	3	.	5	1	.	47
Auto Theft, Receiving Stolen Auto Parts	.	.	.	8	2	.	.	.	.	.	9	.	19
Battery	.	.	3	21	.	.	.	3	.	67	4	.	98
Battery By Bodily Waste	.	.	.	1	1	.	.	.	.	.	.	.	2
Bribery	.	.	.	.	.	.	.	.	.	1	.	.	1
Burglary	.	12	172	52	.	.	4	4	90	44	.	.	378
Carjacking	.	.	5	.	.	.	.	.	.	.	.	.	5
Carrying Handgun Without License	.	.	.	5	.	.	.	.	.	.	.	.	5
Check Fraud	.	.	.	1	.	.	.	.	.	.	.	.	1
Child Molesting	.	3	5	3	.	.	.	.	.	.	.	.	11
Child Seduction	.	.	.	.	.	.	.	.	.	1	.	.	1
Conspiracy	.	5	13	2	.	.	2	.	.	3	.	.	25
Conversion	.	.	.	.	.	.	.	.	.	2	.	.	2
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	6	.	.	7
Criminal Confinement	.	.	20	4	1	.	.	9	.	6	.	.	40
Criminal Recklessness	.	.	.	2	.	.	.	.	.	6	.	.	8
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Cocaine Or Narcotic Drug	.	32	135	.	.	.	14	10	16	14	.	.	221
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	1	.	.	.	.	3	1	.	6
Dealing In Methamphetamine	.	4	86	.	.	.	15	18	16	16	.	.	155
Dealing In Schedule IV Controlled Subtance	.	.	1	1	.	.	.	.	.	.	.	.	2
Dealing Possessing Look-Alike Substance	.	.	.	1	.	.	.	.	.	2	.	.	3
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	1	2	.	.	.	.	3
Dealng In a Schedule I, II, or III Controlled Substance	.	5	39	.	.	.	.	.	.	.	.	.	44
Disarming A Law Enforcement Officer	.	.	.	.	.	.	.	.	.	1	.	.	1
Domestic Battery	.	.	.	.	2	.	.	.	.	2	4	.	8
Escape	.	.	.	.	.	.	.	.	1	7	7	.	15
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Failure To Appear	.	.	.	.	.	.	.	.	.	.	1	.	1

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Putnamville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Failure To Register As A Sex Offender	.	.	.	7	2	.	.	.	.	24	1	.	34
Failure To Return Lawful Detention/Escape	.	.	.	5	1	.	.	.	.	.	.	.	6
Firearm Within 1 Mile School Property Without License	.	.	.	11	.	.	.	.	.	.	.	.	11
Forgery,Counterfeiting,Application Fraud	.	.	.	30	.	.	.	.	.	.	3	.	33
Fraud	.	.	.	.	.	.	.	.	.	.	1	.	1
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	5	.	.	7
Habitual Offender Substance Abuse	.	.	.	.	.	.	.	.	.	.	.	1	1
Handgun Violation	.	.	.	1	.	.	.	.	.	.	.	.	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	3	.	.	.	.	.	20	.	.	23
Identity Deception	.	.	.	1	.	.	.	.	.	.	.	.	1
Intimidation	.	.	.	4	2	.	.	.	.	7	1	.	14
Kidnapping	.	4	.	.	.	.	.	1	.	.	.	.	5
Maintaining Common Nuisance	.	.	.	.	1	.	.	.	.	.	3	.	4
Murder	31	.	.	.	.	.	.	.	.	.	.	.	31
Neglect Of A Dependent	.	.	.	1	.	.	.	.	.	1	1	.	3
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	2	.	.	.	.	2
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	9	3	.	.	.	.	1	.	.	13
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	.	1
Obstruction Of Justice	.	.	.	.	.	.	.	.	.	.	1	.	1
Operate Vehicle After Suspended For Life	.	.	.	14	.	.	.	.	.	28	.	.	42
Operating Vehicle Intoxicated Resulting in Death	.	.	2	2	.	.	.	.	3	4	.	.	11
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	1	1	.	.	.	.	2	1	.	5
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	2	.	.	.	.	.	.	.	2
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	1	.	2
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	2	.	.	.	.	.	.	.	2
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	5	.	5
Possess Chemical Reagents Or Precursors	.	.	.	1	.	.	.	.	.	1	.	.	2
Possess Of Precursors	.	.	.	.	1	.	.	.	.	.	1	.	2
Possession Of A Controlled Substance	.	.	.	1	4	.	.	.	.	.	.	.	5
Possession Of Cocaine Or Narcotic Drug	.	1	6	6	2	.	.	4	5	8	2	.	34
Possession Of Dangerous Device	.	.	.	.	.	.	.	.	1	.	.	.	1
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	2	.	.	.	.	.	.	.	2
Possession Of Methamphetamine	.	.	6	4	2	.	.	4	2	8	4	.	30
Possession Of Paraphernalia	.	.	.	.	2	.	.	.	.	.	.	.	2

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Putnamville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Possession Of Syringes Or Needles	.	.	.	.	4	.	.	.	.	1	1	.	6
Possession Or Use Of Legend Drug	.	.	.	1	.	.	.	.	.	.	.	.	1
Rape	.	1	1	.	.	.	.	.	.	.	.	.	2
Reckless Homicide	.	.	.	2	.	.	.	.	.	1	.	.	3
Residential Entry	.	.	.	.	.	.	.	.	.	.	5	.	5
Resisting Law Enforcement	.	.	.	.	2	.	.	1	.	3	.	.	6
Robbery	.	5	111	16	.	.	4	83	.	31	.	.	250
Sale Of Unregistered Security	.	.	.	1	.	.	.	.	.	.	.	.	1
Sexual Misconduct With A Minor	.	.	1	.	.	.	.	.	1	.	.	.	2
Stalking	.	.	.	3	.	.	.	.	2	1	.	.	6
Strangulation	.	.	.	.	3	.	.	.	.	.	3	.	6
Theft,Receiving Stolen Property	.	.	.	.	15	.	.	.	.	1	21	.	37
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	1	.	.	2
Unlawful Firearm Poss By Serious Felon	.	.	74	.	.	.	.	.	31	.	.	.	105
Voluntary Manslaughter	.	17	2	.	.	.	4	.	.	.	.	.	23
Total	**31**	**116**	**720**	**237**	**60**	**.**	**46**	**159**	**175**	**338**	**83**	**1**	**1,966**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Reception Diagnostic Center

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Aggravated Battery	.	.	1	.	.	.	.	3	.	.	.	.	4
Aiding Inducing/Causing An Offense	.	.	.	.	.	.	.	.	.	4	.	.	4
Aiding in Manufacture of Sch II Controlled Substance	.	.	.	.	.	.	.	.	.	.	1	.	1
Arson	.	.	1	.	.	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	1	1	.	.	1	.	1	.	1	.	.	5
Auto Theft, Receiving Stolen Auto Parts	.	.	.	1	2	.	.	.	.	.	2	.	5
Battery	.	.	.	5	.	.	.	.	.	16	1	.	22
Bribery	.	.	.	1	.	.	.	.	.	.	.	.	1
Burglary	.	3	28	9	.	1	1	.	25	13	.	.	80
Carrying Handgun Without License	.	.	.	2	.	.	.	.	.	.	.	.	2
Child Exploitation	.	.	.	1	.	.	.	.	.	.	.	.	1
Child Molesting	.	6	3	3	.	8	.	3	5	.	.	.	28
Child Solicitation	.	.	.	.	.	.	.	.	1	.	.	.	1
Conspiracy	.	1	1	1	.	.	.	.	1	2	.	.	6
Corrupt Business Influence	.	.	.	1	.	.	.	.	.	1	.	.	2
Criminal Confinement	.	.	4	1	.	.	.	2	.	2	1	.	10
Criminal Deviate Conduct	.	.	2	.	.	.	.	.	.	.	.	.	2
Criminal Recklessness	.	.	.	1	1	.	.	.	.	1	.	.	3
Deal Sub Represented To Be Controled Sub	.	.	.	.	.	.	.	.	.	.	1	.	1
Dealing In Cocaine Or Narcotic Drug	.	6	10	1	.	.	4	3	4	9	.	.	37
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	.	.	.	.	.	.	1	.	.	1
Dealing In Methamphetamine	.	.	8	.	.	.	3	3	3	9	.	.	26
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	2	.	.	2
Dealng In a Schedule I, II, or III Controlled Substance	.	.	5	.	.	.	.	.	.	.	.	.	5
Disarming A Law Enforcement Officer	.	.	.	.	.	.	.	.	.	1	.	.	1
Domestic Battery	.	.	.	.	3	.	.	.	.	.	1	.	4
Escape	.	.	.	.	.	.	.	.	.	2	5	.	7
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Failure To Appear	.	.	.	.	.	.	.	.	.	.	1	.	1
Failure To Register As A Sex Offender	.	.	.	.	.	.	.	.	.	9	.	.	9
Failure To Return Lawful Detention/Escape	.	.	.	.	2	.	.	.	.	.	.	.	2
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	7	.	.	.	.	.	.	4	.	11
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	1	.	.	3
Habitual Offender	.	.	.	.	.	.	.	.	.	.	.	1	1

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Reception Diagnostic Center

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	13	.	.	13
Intimidation	.	.	.	2	.	.	.	.	.	5	1	.	8
Kidnapping	.	.	.	.	.	.	1	.	.	.	.	.	1
Minor Passenger In Vehicle - Previous Conviction	.	.	.	1	.	.	.	.	.	.	.	.	1
Mischief	.	.	.	.	1	.	.	.	.	.	.	.	1
Murder	4	.	.	.	.	.	.	.	.	.	.	.	4
Neglect Of A Dependent	.	.	1	1	1	.	.	.	.	1	.	.	4
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Neglect Of Dependent Resulting In Death	.	1	.	.	.	.	.	.	.	.	.	.	1
Non Support Of Dependent Child	.	.	.	11	2	.	.	.	.	.	.	.	13
OPER VEH .15 OR MORE - PRIOR CONVICTION	.	.	.	.	.	.	.	.	.	1	.	.	1
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	.	1
Operate Vehicle After Suspended For Life	.	.	.	4	.	.	.	.	.	10	.	.	14
Operating Vehicle Intoxicated Resulting in Death	.	.	1	.	.	.	.	.	1	1	.	.	3
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	7	.	.	.	.	.	3	.	10
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	1	.	2
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	3	.	3
Possess Of Precursors	.	.	.	.	.	.	.	.	.	.	1	.	1
Possession Of A Controlled Substance	.	.	.	.	3	.	.	.	.	.	.	.	3
Possession Of Cocaine Or Narcotic Drug	.	.	1	2	2	.	.	.	3	5	7	.	20
Possession Of Methamphetamine	.	.	1	.	3	.	.	.	3	3	1	.	11
Possession Of Syringes Or Needles	.	.	.	.	2	.	.	.	.	2	1	.	5
Rape	.	.	1	.	.	.	.	2	.	.	.	.	3
Residential Entry	.	.	.	.	2	.	.	.	.	.	5	.	7
Resisting Law Enforcement	.	.	.	.	2	.	.	.	.	.	3	.	5
Robbery	.	1	9	2	.	.	2	21	.	7	.	.	42
Sexual Misconduct With A Minor	.	.	3	.	.	.	.	.	2	2	.	.	7
Stalking	.	.	.	.	.	.	.	.	.	1	.	.	1
Strangulation	.	.	.	.	1	.	.	.	.	.	.	.	1
Theft,Receiving Stolen Property	.	.	.	.	15	.	.	.	.	.	7	.	22
Trafficking With An Inmate	.	.	.	.	.	.	.	.	.	1	.	.	1
Unlawful Firearm Poss By Serious Felon	.	.	5	.	.	.	.	.	11	.	.	.	16
Voluntary Manslaughter	.	.	.	.	.	.	3	.	.	.	.	.	3
Total	**4**	**19**	**86**	**60**	**50**	**10**	**14**	**40**	**59**	**127**	**50**	**1**	**520**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Rockville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Aggravated Battery	.	.	6	.	.	.	.	2	.	.	.	8
Aiding Inducing/Causing An Offense	.	4	4	1	.	.	.	.	2	3	.	14
Arson	.	1	2	.	.	.	.	1	1	.	.	5
Assisting A Criminal	.	.	.	1	.	.	.	.	.	.	.	1
Attempt To Commit Felony	.	10	3	.	1	1	2	.	1	4	.	22
Auto Theft, Receiving Stolen Auto Parts	.	.	.	.	1	.	.	.	.	.	2	3
Battery	.	1	1	7	.	.	1	4	.	19	1	34
Battery By Bodily Waste	.	.	.	1	.	.	.	.	.	.	.	1
Burglary	.	3	47	3	.	1	1	1	17	9	.	82
Carjacking	.	.	2	.	.	.	.	.	.	.	.	2
Check Deception	.	.	.	.	1	.	.	.	.	.	.	1
Child Molesting	.	25	11	3	.	1	.	2	.	.	.	42
Child Solicitation	.	.	.	.	.	.	.	.	.	1	.	1
Conspiracy	.	10	10	.	.	.	2	3	1	2	.	28
Controlled Substance Registration	.	.	.	.	1	.	.	.	.	.	.	1
Corrupt Business Influence	.	.	.	4	.	.	.	.	.	1	.	5
Criminal Confinement	.	.	2	.	.	.	.	2	.	.	.	4
Criminal Deviate Conduct	.	4	1	.	.	.	.	.	.	.	.	5
Dealing In A Schedule V Controlled Subtance	.	.	1	.	.	.	.	.	.	.	.	1
Dealing In Cocaine Or Narcotic Drug	.	28	44	.	.	.	5	6	8	19	.	110
Dealing In Methamphetamine	.	21	45	.	.	.	13	11	11	21	.	122
Dealing In Schedule IV Controlled Subtance	.	.	2	2	.	.	.	.	.	3	.	7
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	1	.	1
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	2	1	2	.	.	5
Dealng In a Schedule I, II, or III Controlled Substance	.	13	46	.	.	.	.	.	.	1	.	60
Domestic Battery	.	.	.	.	1	.	.	.	.	.	1	2
Escape	.	.	.	.	.	.	.	.	.	6	7	13
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	1
Fail To Stop At An Accident/Sbi/Prior	.	.	.	.	1	.	.	.	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	1	.	.	.	.	.	2	1	4
Failure To Return Lawful Detention/Escape	.	.	.	3	2	.	.	.	.	.	.	5
Forgery,Counterfeiting,Application Fraud	.	.	.	28	2	.	.	.	.	.	1	31
Fraud	.	.	.	.	1	.	.	.	.	.	1	2

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Rockville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Fraud On A Financial Institution	.	.	.	2	.	.	.	.	.	5	.	7
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	3	.	3
Human Sexual Trafficking	.	.	2	.	.	.	.	.	.	.	.	2
Identity Deception	.	.	.	.	.	.	.	.	.	.	1	1
Intimidation	.	.	.	.	.	.	.	.	.	1	.	1
Kidnapping	.	.	.	.	.	.	.	1	.	1	.	2
Maintaining Common Nuisance	.	.	.	.	3	.	.	.	.	.	2	5
Murder	47	.	.	.	.	.	.	.	.	.	.	47
Neglect Of A Dependent	.	.	12	2	1	.	.	.	.	.	.	15
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	9	.	.	.	9
Neglect Of Dependent Resulting In Death	.	14	.	.	.	.	.	.	.	.	.	14
Non Support Of Dependent Child	.	.	.	.	.	.	.	.	.	.	1	1
Operate Vehicle After Suspended For Life	.	.	.	1	.	.	.	.	.	8	.	9
Operating Vehicle Intoxicated Resulting in Death	.	.	5	.	.	.	.	.	6	.	.	11
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	.	.	.	.	.	.	1	.	1
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	7	.	.	.	.	1	1	9
Operating Vehicle-Habit Traffic Violator	.	.	.	.	.	.	.	.	.	.	1	1
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	1	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Possess Chemical Reagents Or Precursors	.	.	.	.	.	.	.	.	.	1	.	1
Possess Of Precursors	.	.	.	.	2	.	.	.	.	.	2	4
Possession Of A Controlled Substance	.	.	.	.	4	.	.	.	.	.	.	4
Possession Of Cocaine Or Narcotic Drug	.	1	5	3	.	.	.	2	1	4	2	18
Possession Of Methamphetamine	.	1	5	1	4	.	.	4	.	3	6	24
Possession Of Syringes Or Needles	.	.	.	.	1	.	.	.	.	3	2	6
Promoting Prostitution Under Age 18	.	.	1	.	.	.	.	.	.	.	.	1
Prostitution	.	.	.	.	.	.	.	.	.	.	1	1
Rape	.	.	.	.	.	.	.	1	.	.	.	1
Reckless Homicide	.	.	.	2	.	.	.	.	.	1	.	3
Residential Entry	.	.	.	.	1	.	.	.	.	.	1	2
Resisting Law Enforcement	.	.	.	.	.	.	.	.	.	.	1	1
Robbery	.	5	17	3	.	.	2	19	.	9	.	55
Sexual Misconduct With A Minor	.	.	8	.	.	.	.	.	2	1	.	11

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Rockville Correctional Facility												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Strangulation	.	.	.	.	1	.	.	.	.	.	.	**1**
Theft,Receiving Stolen Property	.	.	.	1	18	.	.	.	.	.	24	**43**
Trafficking With An Inmate	.	.	.	3	.	.	.	.	.	3	.	**6**
Unlawful Firearm Poss By Serious Felon	.	.	2	.	.	.	.	.	.	.	.	**2**
Unlawful Medical Practice	.	.	.	.	.	.	.	.	.	1	.	**1**
Voluntary Manslaughter	.	12	3	.	.	.	2	.	.	.	.	**17**
Welfare Fraud	.	.	.	2	.	.	.	.	.	.	.	**2**
Total	**47**	**153**	**287**	**74**	**54**	**3**	**30**	**70**	**52**	**138**	**60**	**968**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

South Bend Community Re-Entry Center												
Most Serious Offense	**Murder**	**FA**	**FB**	**FC**	**FD**	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**	**Total**
Aggravated Battery	.	.	1	.	.	.	.	.	.	.	.	**1**
Attempt To Commit Felony	.	1	2	.	.	.	.	.	.	.	.	**3**
Battery	.	.	.	.	.	.	.	.	.	1	.	**1**
Burglary	.	2	9	4	.	.	.	.	2	3	.	**20**
Carrying Handgun Without License	.	.	.	1	.	.	.	.	.	.	.	**1**
Conspiracy	.	.	3	.	.	.	.	.	.	.	.	**3**
Criminal Confinement	.	.	1	.	.	.	.	.	.	.	.	**1**
Dealing In Cocaine Or Narcotic Drug	.	3	6	.	.	.	.	.	.	.	.	**9**
Dealing In Methamphetamine	.	1	22	.	.	.	.	.	3	4	.	**30**
Dealing Possessing Look-Alike Substance	.	.	.	.	.	.	.	.	.	1	.	**1**
Dealng In a Schedule I, II, or III Controlled Substance	.	1	4	.	.	.	.	.	.	1	.	**6**
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	**1**
Forgery,Counterfeiting,Application Fraud	.	.	.	2	.	.	.	.	.	.	.	**2**
Handgun Violation (Felony Within 15 Yrs)	.	.	.	.	.	.	.	.	.	1	.	**1**
Intimidation	.	.	.	.	1	.	.	.	.	1	.	**2**
Invasion Of Privacy	.	.	.	.	.	.	.	.	.	.	1	**1**
Murder	3	.	.	.	.	.	.	.	.	.	.	**3**
Neglect Of A Dependent	.	.	.	1	.	.	.	.	.	.	.	**1**
Non Support Of Dependent Child	.	.	.	1	1	.	.	.	.	.	.	**2**
Operate Vehicle After Suspended For Life	.	.	.	2	.	.	.	.	.	3	.	**5**
Operating Vehicle Intoxicated Resulting in Death	.	.	2	.	.	.	.	.	.	.	.	**2**
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	.	1	.	.	.	.	.	.	**1**
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	1	.	.	.	.	.	1	**2**
Operating Vehicle-Habit Traffic Violator	.	.	.	.	.	.	.	.	.	.	1	**1**
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	1	.	.	.	.	.	.	**1**
Possession Of A Controlled Substance	.	.	.	1	.	.	.	.	.	.	.	**1**
Possession Of Cocaine Or Narcotic Drug	.	3	1	.	1	.	.	.	.	1	.	**6**
Possession Of Methamphetamine	.	.	.	.	.	.	.	.	.	1	.	**1**
Residential Entry	.	.	.	.	.	.	.	.	.	.	1	**1**
Robbery	.	1	7	2	.	.	.	1	.	.	.	**11**
Unlawful Firearm Poss By Serious Felon	.	.	2	.	.	.	.	.	.	.	.	**2**
Voluntary Manslaughter	.	4	.	.	.	.	.	.	.	.	.	**4**
Total	**3**	**16**	**60**	**15**	**6**	**.**	**.**	**1**	**5**	**17**	**4**	**127**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Wabash Valley Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Aggravated Battery	.	.	21	.	.	3	.	6	.	.	.	30
Aiding Inducing/Causing An Offense	.	11	2	.	.	1	.	.	.	1	.	15
Arson	.	1	5	.	.	.	.	.	1	.	.	7
Attempt To Commit Felony	.	102	17	1	.	7	.	.	.	1	.	128
Auto Theft, Receiving Stolen Auto Parts	.	.	.	.	.	.	.	.	.	.	1	1
Battery	.	4	2	13	2	.	.	.	.	15	3	39
Burglary	.	41	81	13	.	3	1	.	19	10	.	168
Carjacking	.	.	9	.	.	.	.	.	.	.	.	9
Child Molesting	.	252	19	4	.	14	.	.	.	.	.	289
Conspiracy	.	8	7	2	.	1	1	.	.	.	.	19
Criminal Confinement	.	.	16	2	.	.	.	.	.	.	.	18
Criminal Deviate Conduct	.	24	2	.	.	.	.	.	.	.	.	26
Criminal Recklessness	.	.	.	3	2	.	.	.	.	1	.	6
Dealing In Cocaine Or Narcotic Drug	.	65	34	.	.	.	1	2	.	1	.	103
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	2	.	.	.	.	.	.	.	2
Dealing In Methamphetamine	.	22	45	.	.	.	4	3	3	7	.	84
Dealing In Schedule IV Controlled Subtance	.	.	1	1	.	.	.	.	.	.	.	2
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	1	.	.	.	.	1
Dealng In a Schedule I, II, or III Controlled Substance	.	6	10	.	.	.	.	.	.	1	.	17
Escape	.	.	.	.	.	.	.	.	.	4	2	6
Failure To Register As A Sex Offender	.	.	.	.	.	.	.	.	.	5	.	5
Failure To Return Lawful Detention/Escape	.	.	2	1	.	.	.	.	.	.	.	3
Firearm Within 1 Mile School Property Without License	.	.	.	1	.	.	.	.	.	.	.	1
Forgery,Counterfeiting,Application Fraud	.	.	.	2	.	.	.	.	.	.	.	2
Fraud On A Financial Institution	.	.	.	.	.	.	.	.	.	1	.	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	2	.	.	.	.	.	4	.	6
Intimidation	.	.	.	.	.	.	.	.	.	3	.	3
Invasion Of Privacy	.	.	.	.	1	.	.	.	.	.	.	1
Kidnapping	.	20	.	.	.	.	.	.	.	.	.	20
Maintaining Common Nuisance	.	.	.	.	.	.	.	.	.	.	1	1
Murder	576	.	.	.	.	.	.	.	.	.	.	576
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	4	.	.	.	4
Neglect Of Dependent Resulting In Death	.	12	.	.	.	1	.	.	.	.	.	13
Non Support Of Dependent Child	.	.	.	1	.	.	.	.	.	1	1	3
Operate Vehicle After Suspended For Life	.	.	.	3	.	.	.	.	.	6	.	9
Operating Vehicle Intoxicated Resulting in Death	.	.	5	1	.	.	.	.	1	.	.	7

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Wabash Valley Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	Total
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	1	.	.	.	.	.	.	.	1
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	1	.	.	.	.	.	1	2
Operating Vehicle-Habit Traffic Violator	.	.	.	.	1	.	.	.	.	.	1	2
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	1	1
Possess Chemical Reagents Or Precursors	.	.	.	1	.	.	.	.	.	.	.	1
Possession Of Cocaine Or Narcotic Drug	.	3	3	.	.	.	.	.	.	1	.	7
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	1	.	.	.	.	.	.	1
Possession Of Methamphetamine	.	1	2	.	.	.	.	.	.	3	.	6
Possession Of Paraphernalia	.	.	.	.	1	.	.	.	.	.	.	1
Prisoner Poss. Dangerous Device/Material	.	.	3	.	.	.	.	.	.	.	.	3
Rape	.	54	7	.	.	7	.	3	.	.	.	71
Reckless Homicide	.	.	.	1	.	.	.	.	.	.	.	1
Removing, Damaging, Or Altering a VIN	.	.	.	1	.	.	.	.	.	.	.	1
Resisting Law Enforcement	.	.	1	.	1	.	.	1	.	.	.	3
Robbery	.	47	93	5	.	.	2	9	.	3	.	159
Sexual Misconduct With A Minor	.	1	9	.	.	.	.	.	.	.	.	10
Stalking	.	.	.	.	.	.	.	.	.	1	.	1
Strangulation	.	.	.	.	.	.	.	.	.	.	1	1
Theft,Receiving Stolen Property	.	.	.	1	4	.	.	.	.	.	3	8
Unlawful Firearm Poss By Serious Felon	.	.	23	.	.	.	.	.	5	.	.	28
Voluntary Manslaughter	.	35	2	.	.	.	1	.	.	.	.	38
Total	**576**	**709**	**421**	**62**	**14**	**37**	**11**	**28**	**29**	**69**	**15**	**1,971**

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Westville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Accident Fail To Stop Reulting in Serious Injury or Death	.	.	.	.	.	.	.	.	.	2	.	.	2
Aggravated Battery	.	.	31	.	.	.	.	12	.	.	.	.	43
Aiding Inducing/Causing An Offense	.	2	12	2	.	.	.	9	7	16	.	.	48
Arson	.	1	10	.	.	.	.	.	6	.	.	.	17
Assisting A Criminal	.	.	.	2	.	.	.	.	.	1	.	.	3
Attempt To Commit Felony	.	22	18	6	.	.	1	2	4	11	1	.	65
Auto Theft, Receiving Stolen Auto Parts	.	.	.	2	4	.	.	.	.	.	12	.	18
Battery	.	.	7	38	3	.	.	5	.	85	4	.	142
Battery By Bodily Waste	.	.	.	1	1	.	.	.	.	.	.	.	2
Battery To A Child Causing Death	.	1	.	.	.	.	.	.	.	.	.	.	1
Burglary	.	11	208	85	.	.	4	1	100	92	.	.	501
Carjacking	.	.	4	.	.	.	.	.	.	.	.	.	4
Carrying Handgun Without License	.	.	.	8	.	.	.	.	.	.	.	.	8
Child Molesting	.	1	.	3	.	.	.	.	.	.	.	.	4
Conspiracy	.	6	12	1	2	.	2	1	3	7	.	.	34
Controlled Substance Registration	.	.	.	.	1	.	.	.	.	.	.	.	1
Corrupt Business Influence	.	.	.	11	.	.	.	.	.	8	.	.	19
Criminal Confinement	.	.	15	10	3	.	1	4	.	9	2	.	44
Criminal Deviate Conduct	.	2	1	.	.	.	.	.	.	.	.	.	3
Criminal Recklessness	.	.	.	2	5	.	.	.	.	6	1	.	14
Dangerous Possession Of A Handgun	.	.	.	1	.	.	.	.	.	.	.	.	1
Dealing In Cocaine Or Narcotic Drug	.	71	199	1	.	.	7	17	32	54	.	.	381
Dealing In Marijuana, Hash, or Hash Oil	.	.	.	1	1	.	.	.	.	2	1	.	5
Dealing In Methamphetamine	.	17	120	.	.	.	6	8	48	85	.	.	284
Dealing In Sched Iv Controlled Subtance	.	.	.	.	.	.	.	1	.	.	.	.	1
Dealing In Sched V Controlled Substance	.	.	.	.	.	.	.	.	.	1	.	.	1
Dealing In Schedule IV Controlled Subtance	.	.	2	2	.	.	.	.	.	.	.	.	4
Dealing Possessing Look-Alike Substance	.	.	.	3	.	.	.	.	.	3	2	.	8
Dealng A Sched I, Ii, Iii Control Subst	.	.	.	.	.	.	.	.	2	.	.	.	2
Dealng In a Schedule I, II, or III Controlled Substance	.	9	71	.	.	.	.	.	.	4	.	.	84
Disarming A Law Enforcement Officer	.	.	.	1	.	.	.	.	.	2	.	.	3
Domestic Battery	.	.	.	.	7	.	.	.	.	2	8	.	17
Escape	.	.	.	.	.	.	.	.	.	11	13	.	24
Fail To Return To Accident Resulting in Serious Injury	.	.	.	.	.	.	.	1	.	.	.	.	1
Fail To Stop After Accident - Operating Vehicle Intoxicated	.	.	2	.	.	.	.	.	.	.	.	.	2

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Westville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Failure Of Sex Offender To Possess Id	.	.	.	.	1	.	.	.	.	.	.	.	1
Failure To Register As A Sex Offender	.	.	.	12	.	.	.	.	.	23	2	.	37
Failure To Return Lawful Detention/Escape	.	.	3	4	2	.	.	.	.	.	.	.	9
Firearm Within 1 Mile School Property Without License	.	.	.	6	.	.	.	.	.	.	.	.	6
Forgery,Counterfeiting,Application Fraud	.	.	.	34	2	.	.	.	.	.	4	.	40
Fraud	.	.	.	.	2	.	.	.	.	.	2	.	4
Fraud On A Financial Institution	.	.	.	8	.	.	.	.	.	8	.	.	16
Habitual Offender	.	.	.	.	.	.	.	.	.	.	.	1	1
Handgun Violation (Felony Within 15 Yrs)	.	.	.	8	.	.	.	.	.	44	.	.	52
Home Improvement Fraud Enhancement	.	.	.	1	.	.	.	.	.	.	.	.	1
Illegal Possession Of Firearm By Felon	.	.	.	1	.	.	.	.	.	.	.	.	1
Intimidation	.	.	.	5	4	.	.	.	.	15	6	.	30
Involuntary Manslaughter	.	.	.	2	.	.	.	.	.	.	.	.	2
Kidnapping	.	1	.	.	.	.	.	1	.	1	.	.	3
Maintaining Common Nuisance	.	.	.	.	.	.	.	.	.	.	2	.	2
Murder	48	.	.	.	.	.	.	.	.	.	.	.	48
Neglect Of A Dependent	.	.	6	3	.	.	.	.	.	3	.	.	12
Neglect Of A Dependent Resulting in Serious Injury	.	.	.	.	.	.	.	6	.	.	.	.	6
Non Support Of Dependent Child	.	.	.	17	5	.	.	.	.	.	.	.	22
Obliterating Handgun I.D.	.	.	.	.	.	.	.	.	.	1	.	.	1
Obstruction Of Justice	.	.	.	.	1	.	.	.	.	.	1	.	2
Operate Vehicle After Suspended For Life	.	.	.	28	.	.	.	.	.	54	.	.	82
Operating Vehicle Intoxicated Resulting in Death	.	.	2	3	.	.	.	.	5	5	.	.	15
Operating Vehicle Intoxicated Resulting in Serious Bodily Injury	.	.	.	1	.	.	.	.	.	1	1	.	3
Operating Vehicle While Intoxicated-Previous Conviction	.	.	.	.	12	.	.	.	.	.	11	.	23
Operating Vehicle-Habit Traffic Violator	.	.	.	1	6	.	.	.	.	.	1	.	8
Opererating Vehicle While Intoxicated - Endangering Person	.	.	.	.	1	.	.	.	.	.	.	.	1
Opererating Vehicle While Intoxicated - Prior Conviction	.	.	.	.	.	.	.	.	.	.	8	.	8
Pointing A Firearm	.	.	.	.	1	.	.	.	.	.	.	.	1
Possess Chemical Reagents Or Precursors	.	.	.	1	.	.	.	.	.	3	.	.	4
Possess Of Precursors	.	.	.	.	2	.	.	.	.	.	3	.	5
Possession Of A Controlled Substance	.	.	.	7	7	.	.	.	.	.	.	.	14
Possession Of Cocaine Or Narcotic Drug	.	9	15	6	3	.	.	3	6	12	15	.	69
Possession Of Marijuana, Hash, Hash Oil	.	.	.	.	4	.	.	.	.	.	.	.	4
Possession Of Methamphetamine	.	1	12	5	7	.	.	.	.	17	10	.	52

INDIANA DEPARTMENT OF CORRECTION
ADULT OFFENDERS
by Most Serious Offense
for January 2017
snapshot date: 01/01/2017

Westville Correctional Facility

Most Serious Offense	Murder	FA	FB	FC	FD	F1	F2	F3	F4	F5	F6	HO	Total
Possession Of Syringes Or Needles	.	.	.	.	2	.	.	.	.	.	4	.	6
Possession Or Use Of Legend Drug	.	.	.	.	1	.	.	.	.	.	1	.	2
Prisoner Poss. Dangerous Device/Material	.	.	.	1	.	.	.	.	.	.	.	.	1
Rape	.	4	.	.	.	.	.	.	.	.	.	.	4
Reckless Homicide	.	.	.	3	.	.	.	.	.	5	.	.	8
Residential Entry	.	.	.	.	.	.	.	.	.	.	5	.	5
Resisting Law Enforcement	.	.	.	.	2	.	.	.	.	1	7	.	10
Robbery	.	20	133	25	.	.	3	67	.	32	.	.	280
Security Fraud	.	.	.	1	.	.	.	.	.	.	.	.	1
Sexual Misconduct With A Minor	.	.	1	1	.	.	.	.	.	.	.	.	2
Stalking	.	.	1	1	1	.	.	.	1	6	.	.	10
Strangulation	.	.	.	.	3	.	.	.	.	.	2	.	5
Theft,Receiving Stolen Property	.	.	.	.	36	.	.	.	.	.	31	.	67
Trafficking With An Inmate	.	.	.	1	.	.	.	.	.	3	.	.	4
Unlawful Firearm Poss By Serious Felon	.	.	49	.	.	.	.	.	30	.	.	.	79
Voluntary Manslaughter	.	26	7	.	.	.	.	.	.	.	.	.	33
Welfare Fraud	.	.	.	.	1	.	.	.	.	.	.	.	1
Total	**48**	**204**	**941**	**366**	**133**	**.**	**24**	**138**	**244**	**635**	**160**	**1**	**2,894**

Scott.A.Milkey

From: Karns, Allison
Sent: Friday, January 06, 2017 9:39 PM
To: Schilb, Veronica J
Subject: Re: Response Needed

Thanks

Sent from my iPhone

On Jan 6, 2017, at 9:02 PM, Schilb, Veronica J <VSchilb@gov.IN.gov> wrote:

FYI

Veronica Schilb
Criminal Justice Policy Consultant
Office of Governor Mike Pence
317-232-4566

From: Brown, James M (Jim)
Sent: Friday, January 6, 2017 6:44 PM
To: Schilb, Veronica J
Cc: Vincent, Matthew
Subject: Fwd: Response Needed

FYI

Sent from my iPhone

Begin forwarded message:

From: Amanda Constable <a.marieconstable@[redacted]>
Date: January 6, 2017 at 6:06:36 PM EST
To: James Bauerle <bgjimbauerle@[redacted]>
Cc: Mike Malast <mmalast@[redacted]>, "Bonnie & Bill Sweeney" <GOING2C@[redacted]>, Michael Sturm <michael.sturm@ngai.net>, CLINK7361@[redacted], MICHAEL HAMM <indyhambone@[redacted]>, "ejtrice@[redacted]" <ejtrice@[redacted]>, Plk1027@[redacted], Base005@[redacted], Russell Silver <russell.silver@[redacted]>, Nathan Zaugg <njzaugg@[redacted]>, "victor@saveourveterans.org" <victor@saveourveterans.org>, "Krc6247@[redacted]" <Krc6247@[redacted]>, "tom.pappas01@[redacted]" <tom.pappas01@[redacted]>, james Davis <amgsn@[redacted]>, Rick Baum <signaturewound@[redacted]>, "comdshaw@[redacted]" <comdshaw@[redacted]>, "glenn powers @va.gov" <glenn.powers@va.gov>, Christy Broady <jcbb@hrtc.net>, "president@usoindiana.org" <president@usoindiana.org>, Albert Winks <albertwinks@[redacted]>, Ron

Martin <vfw7119@[redacted]>, Don Steel <steel-don@[redacted]>, "saver@[redacted]" <saver@[redacted]>, "ekibbey@cbmc.com" <ekibbey@cbmc.com>, "diane.martinez@saveourveterans.org" <diane.martinez@saveourveterans.org>, James Robert Reardon <jrreardon@[redacted]>, "rogervandrey@[redacted]" <rogervandrey@[redacted]>, Robert Nester <robert_nester@[redacted]>, Ron Wilson <memnpap@[redacted]>, Hugh Dagley <hdagley@indlegion.org>, "Caldwell, Richard Dean NFG NG INANG (US)" <richard.d.caldwell.nfg@[redacted]>, Insurance@ngai.net, Mil Compo <mecompo@[redacted]>, Lisa Wilken <votingveteranindy@[redacted]>, "Brown, James M (Jim)" <jambrown@dva.in.gov>, Tom Jones <genjones@[redacted]>, Andy Gothreau <agothreau@[redacted]>, Saggi32@[redacted], Margaret Washburn <mwashburn688@[redacted]>, vamotor@[redacted], "Krisabertrand@[redacted]" <Krisabertrand@[redacted]>, tomhill@plannedinvest.com, "sistersoldiernetwork@[redacted]" <sistersoldiernetwork@[redacted]>, Carol Mutter <carol.mutter@[redacted]>, Scott Zigmond <szigmond@performanceservices.com>, Andrew Rutz <arutz@lawyers4veterans.com>, Dean Farr <dean.farr@[redacted]>, ddanielson@[redacted], "vlincks@kipva.org" <vlincks@kipva.org>, Richard Simers <phv@seidata.com>
Subject: Re: Fwd: Response Needed

**** This is an EXTERNAL email. Exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. ****

Thanks General,

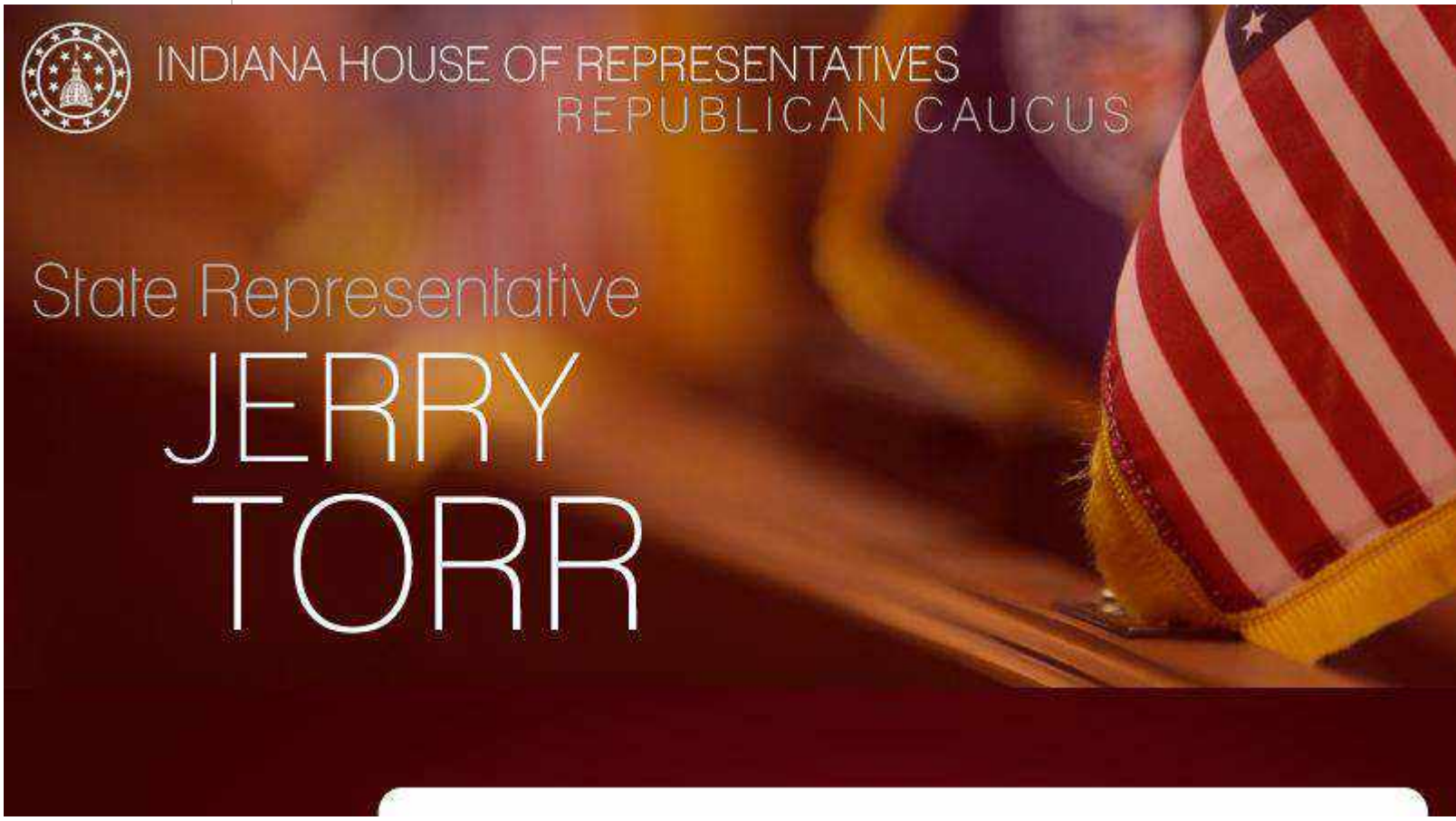
This is their annual survey they send out to everyone. I am friends with Rep. Torr and I will text him too. It's important for everyone to respond. Happy New Year.

Amanda Constable, M.A.
Director of Government Relations
The Third House, LLC

On Jan 6, 2017 5:08 PM, "James Bauerle" <bgjimbauerle@[redacted]> wrote:

> I received a request from my representative-- I request widest distribution to your organization and ask them to fill out the survey and complete the last question -- by telling legislators to fund veterans issues. You can use your own list or here are a few from the coalition's list. 1. Fund the clinical trial to treat veterans suffering TBI/PTSD/PCS with hyperbaric oxygen therapy. 2. Fund the summer study presented 21st Century Veterans Support Program which provides adequate funding and staffing for county veteran service officers. 3. Fund recruiting efforts to get service members scheduled for discharge within 6 months to come to Indiana and take jobs in Indiana.
> ---------- Forwarded message ----------
> From: **Jerry Torr** <house_republicans@subscriptions.iga.in.gov>
> Date: Fri, Jan 6, 2017 at 10:00 AM
> Subject: Response Needed
> To: bgjimbauerle@[redacted]

View as a Web page



Dear Friend,

The 2017 legislative session kicked off this week, and I would like your feedback on important issues facing Indiana.

Our state is leading the nation in many areas like job creation, cost of doing business and lower taxes with less regulation. I am committed to building on this momentum and continuing to move Indiana forward.

This session, I'll join fellow legislators in crafting the state's next two-year budget, which funds critical government services like education and infrastructure. I'll work hard to ensure Indiana continues living within its means – just as Hoosiers like you do every day.

I will also support a long-term, comprehensive and sustainable road funding plan that doesn't leave future generations with mountains of debt.

Please help me best represent you and the needs of our community by completing my online survey. Your responses will help guide me when I vote on these and other policies that come before the legislature.

Thank you for giving me the opportunity to serve you and your family, and I look forward to hearing from you.

Sincerely,



State Rep. Jerry Torr



Forward to a Friend | Unsubscribe | Privacy Policy
This email was sent to: **bgjimbauerle@gmail.com**

This email was sent by: **Indiana House Republicans**
200 W. Washington Street
Indianapolis, IN 46204

POWERED BY
Delivra

--
BG James L. Bauerle USA Ret.
10721 Lakeshore Drive East
Carmel, Indiana 46033
317-[redacted]
bgjimbauerle@[redacted]

Scott.A.Milkey

From: Schilb, Veronica J
Sent: Friday, January 06, 2017 9:02 PM
To: Karns, Allison;Creighton, Christopher
Subject: Fw: Response Needed

FYI

Veronica Schilb
Criminal Justice Policy Consultant
Office of Governor Mike Pence
317-232-4566

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Cc: Vincent, Matthew
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FYI

Sent from my iPhone

Begin forwarded message:

> **From:** Amanda Constable <a.marieconstable@[redacted]>
> **Date:** January 6, 2017 at 6:06:36 PM EST
> **To:** James Bauerle <bgjimbauerle@[redacted]>
> **Cc:** Mike Malast <mmalast@[redacted]>, "Bonnie & Bill Sweeney" <GOING2C@[redacted]>, Michael Sturm <michael.sturm@[redacted]t>, CLINK7361@[redacted], MICHAEL HAMM <indyhambone@[redacted]>, "ejtrice@[redacted]" <ejtrice@[redacted]>, Plk1027@[redacted], Base005@[redacted], Russell Silver <russell.silver@[redacted]>, Nathan Zaugg <njzaugg@[redacted]>, "victor@saveourveterans.org" <victor@saveourveterans.org>, "Krc6247@[redacted]" <Krc6247@[redacted]>, "tom.pappas01@[redacted]" <tom.pappas01@[redacted]>, james Davis <amgsn@[redacted]>, Rick Baum <signaturewound@[redacted], "comdshaw@[redacted]" <comdshaw@[redacted]>, "glenn powers @va.gov" <glenn.powers@va.gov>, Christy Broady <jcbb@[redacted]>, "president@usoindiana.org" <president@usoindiana.org>, Albert Winks <albertwinks@[redacted]>, Ron Martin <vfw7119@[redacted]>, Don Steel <steel-don@[redacted]>, "saver@[redacted]" <saver@[redacted]>, "ekibbey@[redacted]" <ekibbey@[redacted]>, "diane.martinez@saveourveterans.org" <diane.martinez@saveourveterans.org>, James Robert Reardon <jrreardon@[redacted]>, "rogervandrey@[redacted]" <rogervandrey@[redacted]>, Robert Nester <robert_nester@[redacted]>, Ron Wilson <memnpap@[redacted]>, Hugh Dagley <hdagley@indlegion.org>, "Caldwell, Richard Dean NFG NG INANG (US)" <richard.d.caldwell.nfg@[redacted]>, Insurance@ngai.net, Mil Compo <mecompo@[redacted]>, Lisa Wilken <votingveteranindy@[redacted]>, "Brown, James M (Jim)" <jambrown@dva.in.gov>, Tom Jones <genjones@[redacted]>, Andy Gothreau

<agothreau@[redacted]>, Saggi32@[redacted], Margaret Washburn <mwashburn688@[redacted]>, vamotor@[redacted], "Krisabertrand@[redacted]" <Krisabertrand@[redacted]>, tomhill@[redacted], "sistersoldiernetwork@[redacted]" <sistersoldiernetwork@[redacted]>, Carol Mutter <carol.mutter@[redacted]>, Scott Zigmond <szigmond@performanceservices.com>, Andrew Rutz <arutz@lawyers4veterans.com>, Dean Farr <dean.farr@[redacted]>, ddanielson@[redacted], "vlincks@[redacted]" <vlincks@[redacted]>, Richard Simers <phv@[redacted]>
Subject: Re: Fwd: Response Needed

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Thanks General,

This is their annual survey they send out to everyone. I am friends with Rep. Torr and I will text him too. It's important for everyone to respond. Happy New Year.

Amanda Constable, M.A.
Director of Government Relations
The Third House, LLC

On Jan 6, 2017 5:08 PM, "James Bauerle" <bgjimbauerle@[redacted]> wrote:

> I received a request from my representative-- I request widest distribution to your organization and ask them to fill out the survey and complete the last question -- by telling legislators to fund veterans issues. You can use your own list or here are a few from the coalition's list. 1. Fund the clinical trial to treat veterans suffering TBI/PTSD/PCS with hyperbaric oxygen therapy. 2. Fund the summer study presented 21st Century Veterans Support Program which provides adequate funding and staffing for county veteran service officers. 3. Fund recruiting efforts to get service members scheduled for discharge within 6 months to come to Indiana and take jobs in Indiana.
> ---------- Forwarded message ----------
> From: **Jerry Torr** <house_republicans@subscriptions.iga.in.gov>
> Date: Fri, Jan 6, 2017 at 10:00 AM
> Subject: Response Needed
> To: bgjimbauerle@[redacted]
>
> View as a Web page


INDIANA HOUSE OF REPRESENTATIVES
REPUBLICAN CAUCUS
State Representative
JERRY
TORR

Dear Friend,

The 2017 legislative session kicked off this week, and I would like your feedback on important issues facing Indiana.

Our state is leading the nation in many areas like job creation, cost of doing business and lower taxes with less regulation. I am committed to building on this momentum and continuing to move Indiana forward.

This session, I'll join fellow legislators in crafting the state's next two-year budget, which funds critical government services like education and infrastructure. I'll work hard to ensure Indiana continues living within its means – just as Hoosiers like you do every day.

I will also support a long-term, comprehensive and sustainable road funding plan that doesn't leave future generations with mountains of debt.

Please help me best represent you and the needs of our community by completing my online survey. Your responses will help guide me when I vote on these and other policies that come before the legislature.

Thank you for giving me the opportunity to serve you and your family, and I look forward to hearing from you.

Sincerely,



State Rep. Jerry Torr

District 39



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This email was sent to: **bgjimbauerle@gmail.com**

This email was sent by: **Indiana House Republicans**
200 W. Washington Street
Indianapolis, IN 46204

POWERED BY Delivra

--
BG James L. Bauerle USA Ret.
10721 Lakeshore Drive East
Carmel, Indiana 46033
317-[redacted]
bgjimbauerle@[redacted]

Scott.A.Milkey

From: Gregory Steuerwald <gsteuerwald@[redacted]>
Sent: Friday, January 06, 2017 1:32 PM
To: Kidwell, Jenny;Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Forkner, Justin;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hill, John (GOV);Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Lemmon, Bruce;Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: RE: Justice Reinvestment Advisory Council 1/12/2017

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I will do my best to attend. It's timely and important.

GREGORY E. STEUERWALD
STEUERWALD, HANNON & WITHAM, LLP

From: Kidwell, Jenny [mailto:jenny.kidwell@courts.IN.gov]
Sent: Friday, January 06, 2017 1:03 PM
To: Alderete, Hilary <halderete@sba.in.gov>; Banschbach, Kristen <KBanschbach1@sba.IN.gov>; Basinger, James <jbasinger@idoc.in.gov>; Bauer, Jennifer <jennifer.bauer@courts.IN.gov>; Boarman, Angie <Angela.Boarman@fssa.IN.gov>; Bowen, Mark <mark.bowen@hamiltoncounty.in.gov>; Brady, Linda <lbrady@co.monroe.in.us>; Braun, Deborah <DLBraun@idoc.IN.gov>; Brooks, Matthew G <mbrooks@indianacouncil.org>; Cook, Terry <Terry.Cook@fssa.IN.gov>; Cozad, Sara <sara.cozad@fssa.in.gov>; Cunningham, Chris <ccunningham@grantcounty.net>; Ferguson, Jon <jferguson1@idoc.in.gov>; Forkner, Justin <justin.forkner@courts.IN.gov>; Garner, Aaron <AGarner@idoc.IN.gov>; Glass, Trent <trent.glass@iga.in.gov>; Goodman, Michelle <michelle.goodman@courts.IN.gov>; Hill, John <jhill@gov.in.gov>; Hudson, MK <mk.hudson@courts.IN.gov>; Karns, Allison <akarns@gov.in.gov>; Kerl, Christine <christine.kerl@indy.gov>; Kidwell, Jenny <jenny.kidwell@courts.IN.gov>; Koester, Randy <RKoester@idoc.in.gov>; Landis, Larry <llandis@[redacted]; Lanham, Julie <Jlanham@IDOC.in.gov>; Lemmon, Bruce <blemmon@idoc.in.gov>; Luce, Steve <sluce@indianasheriffs.org>; McCaffrey, Steve <smccaffrey@mhai.net>; McDonald, Devon <demcdonald@cji.in.gov>; McQueen, Adam <adammcq@co.wayne.in.us>; Moore, Kevin <kevin.moore@fssa.in.gov>; Murtaugh, David <dmurtaugh@cji.in.gov>; Naylor, Chris <cnaylor1@ipac.in.gov>; Powell, David <dpowell@ipac.in.gov>; Reynolds, David <david.reynolds@iga.in.gov>; Rivera, Krista L <krista.rivera@iga.in.gov>; Ross, Josh <joross@cji.in.gov>; Seigel, Jane <jane.seigel@courts.IN.gov>; Sobecki, Ron <rsobecki@sba.in.gov>; Gregory Steuerwald <gsteuerwald@shwlawyers.com>; Thompson, Lisa <lisa.thompson@courts.in.gov>; Walthall, Dr. Jennifer <JWalthall@isdh.IN.gov>; Watson, Bill <William.Watson@VigoCounty.In.Gov>; Williams, Dave <dave.williams@courts.IN.gov>; Willis, Mary <mary.willis@courts.IN.gov>; Wilson, Bill <bwilson@indianasheriffs.org>
Subject: Justice Reinvestment Advisory Council 1/12/2017

The next meeting of the Justice Reinvestment Advisory Council will be held on January 12, 2017 from 1:00 to 3:00 p.m. We are hopeful that everyone will be able to attend the meeting in Room 9002 at the office of the Indiana Office of Court Services, 30 South Meridian Street, Suite 900.

Jane would like to know if there are any items/ideas you would like to have included on the final agenda. If so, please send them to Jane at jane.seigel@courts.in.gov as soon as possible. Thank you.

Registration January 12, 2017

Jenny Kidwell
Indiana Office of Court Services
30 S. Meridian Street, Suite 900
Indianapolis, IN 46204
Phone: 317-232-1313
Fax: 317-233-3367
jenny.kidwell@courts.in.gov

Scott.A.Milkey

From: Kidwell, Jenny <jenny.kidwell@courts.IN.gov>
Sent: Friday, January 06, 2017 1:03 PM
To: Alderete, Hilary;Banschbach, Kristen;Basinger, James;Bauer, Jenny;Boarman, Angela;Bowen, Mark J.;Brady, Linda;Braun, Deborah L;Brooks, Matthew G;Cook, Terry E;Cozad, Sara;Cunningham, Chris;Ferguson, Jon;Forkner, Justin;Garner, Aaron;Glass, Trent;Goodman, Michelle;Hill, John (GOV);Hudson, Mary Kay;Karns, Allison;Kerl, Christine;Kidwell, Jenny;Koester, Randy;Landis, Larry (llandis@[redacted]);Lanham, Julie (COA);Lemmon, Bruce;Luce, Steve;McCaffrey, Steve;Mcdonald, Devon;McQueen, Adam;Moore, Kevin B;Murtaugh, David;Naylor, Christopher W (Chris);Powell, David N;Reynolds, David;Rivera, Krista L;Ross, Joshua;Seigel, Jane;Sobecki, Ron;Steuerwald, Greg;Thompson, Lisa;Walthall, Jennifer;Watson, William;Williams, Dave;Willis, Mary;Wilson, Bill
Subject: Justice Reinvestment Advisory Council 1/12/2017

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Registration January 12, 2017

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