United States Department of Agriculture Food and Nutrition Service

Substance Use Prevention

Screening, Education, and Referral Resource Guide for Local WIC Agencies

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The development of this Guide has been conducted under the overall direction of Melanie Haake, MPH, RD, Nutritionist with the Supplemental Food Programs Division, FNS, USDA.

Resource Guide Content:

Melanie Haake, MPH, RD
Nutritionist
Supplemental Food Programs Division
Food and Nutrition Service, USDA
Alexandria, VA

Grace Chang, MD, MPH
Professor
Harvard Medical School
Brigham and Women's Hospital
Boston, MA

Nancy C. Goler, MD
OB/GYN
Fremont Medical Center
Regional Medical Director
Early Start Program
Wellness Coaching Center
Clinical Director, Vallejo Call Center
Kaiser Permanente
Northern California
Vallejo, CA

Shannon Whaley, PhD
Director of Research and Evaluation
PHFE WIC
Irwindale, CA

Jonathan Winickoff, MD, MPH
Associate Professor of Pediatrics
Harvard Medical School
Boston, MA

Copy/Design:

CarrotNewYork
New York, NY

Welcome

Welcome to the ***Substance Use Prevention: Screening, Education, and Referral Resource Guide for Local WIC Agencies***.

WIC's mission is to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals. As a WIC professional, you support WIC's mission by promoting healthy lifestyles for women and their families. Due to the harmful effects of fetal and infant exposure to substances during pregnancy and breastfeeding, the possible negative impact to a woman's nutritional needs, and the increased potential for child abuse and neglect by addicted parents, preventing substance use is a vital element of promoting healthy lifestyles.

The WIC Program has a defined role in providing substance abuse–prevention information and conducting referral activities (see Provisions of the Law on page 14). WIC's substance abuse prevention and referral activities are intended to increase participants' access to information about the dangers of substance use during pregnancy and postpartum, and while breastfeeding due to potential effects of these substances on both the mother *and* the child. WIC's activities are also intended to facilitate referrals for further assessment, as appropriate. Because no one set of standard activities can meet the needs of the large variety of WIC local agencies, this Resource Guide provides a range of practical suggestions from which to select or tailor suitable elements.

For practical purposes, the process by which you identify participants who are at risk for substance use problems and offer them referrals should entail a nominal time commitment and minimal training to prepare you. Since many approaches to substance use prevention are not feasible within these constraints, this Resource Guide was designed with these constraints in mind, and provides you with:

- Background, idea starters, and resources for developing/delivering educational information, performing screening, and providing referrals with respect to substance use
- Information and additional resources to help you foster the conversation with participants about substance use, educate participants about substance use during and after pregnancy, and, as appropriate, offer referrals to them
- Statistics and information about the effects of use of specific substances by pregnant women and breastfeeding mothers/caregivers, to enable you to answer questions on these topics

Though WIC's role in preventing substance use is limited, you can play a valuable part in the process by becoming informed about and comfortable with the topic.

Using This Resource Guide

This Resource Guide includes a series of topical chapters to provide background and initial preparation for carrying out substance abuse prevention and referral activities. It is meant to assist WIC local agency staff who must decide how to integrate substance use information and referral elements into their activities without overburdening either their participants or themselves, and without reducing current efforts focused on providing nutritious supplemental foods, nutrition education, and referrals for health care and other social services.

In addition, it contains a wealth of available resources and links to access a variety of appropriate educational materials for WIC participants and training materials for WIC staff. Where applicable, you'll also find optional customizable forms intended to facilitate your education and referral activities.

In the context of WIC's focus on pregnant, postpartum, and breastfeeding women, and for the purposes of this Guide, the term "drug abuse" used in authorizing legislation is broadly interpreted. It includes *any* use of alcohol, tobacco, or other drugs that might cause harm to a developing fetus or child, including misused prescription drugs and potentially harmful over-the-counter or herbal medications. Therefore, the terms "use" and "abuse" are used interchangeably throughout the Guide.

For your convenience, the electronic version of this Guide makes use of technological functionality:

- Internal hyperlinks (shown in orange) transport you directly to more information on a particular topic within the Guide by clicking on the link. Items that are hyperlinked include:
  - Cross-referenced information (references to other sections or chapters where more detailed information can be found about a topic)
  - Forms and worksheets
  - Glossary terms (takes you to the definition of that term)
- Once you have jumped to a linked page, you will have two options located at the top right of the page:

"Back to the Previous View"
(takes you to the last page viewed)

"Back to the Beginning of the Chapter"

- If you are connected to the Internet, external links (shown in green) provide a "research shortcut" that launches specific Web sites and resources to make your background research efficient and direct.

As you read through the chapters and explore the resources and materials in the appendix section (including appendix 1: Training Materials and Resources for WIC Staff, appendix 2: Education Materials for WIC Participants, and appendix 3: Additional Links and Resources (beginning on page 85), choose the ones that work best for your WIC agency. Also for your convenience, the Resource Guide can be:

- Saved to your computer/desktop for easy use/reference. As you read through the chapters and their associated worksheets, you can resave this document to keep it updated.
- Customized by completing worksheet pages tailored to your site-specific needs.
- Printed, though keep in mind that this Resource Guide is a lengthy document. If you decide to print, be sure to select the page range you wish to print if you don't wish to print the entire Guide.

Acronyms

AA	Alcoholics Anonymous
AAP	American Academy of Pediatrics
ACDE	American Council for Drug Education/Affiliate of Phoenix House Foundation
ACoA	Adult Children of Alcoholics
ACOG	American Congress of Obstetricians and Gynecologists
ART	Active Referral to Treatment
ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
BI	Brief Intervention
BNI	Brief Negotiated Interview
CA	Cocaine Anonymous
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
DGAs	Dietary Guidelines for Americans
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAP	Employee Assistance Programs
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FDA	Food and Drug Administration
FNS	Food and Nutrition Service
FRAMES	Feedback, Responsibility, Advice, Menu, Empathy, and Self-efficacy
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
LSD	Lysergic Acid Diethylamide
MI	Motivational Interviewing
NA	Narcotics Anonymous
NAS	Neonatal Abstinence Syndrome
NCADI	National Clearinghouse for Alcohol and Drug Information
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NSAIDs	Nonsteroidal Anti-inflammatory Drugs
OB/GYN	Obstetrics/Gynecology
OTC	Over-the-Counter
PDR	Physicians' Desk Reference
PHFE	Public Health Foundation Enterprise
SAMSHA	Substance Abuse and Mental Health Services Administration
SBI	Screening and Brief Invention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SIDS	Sudden Infant Death Syndrome
USDA	United States Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

CHAPTER I

WIC's Role in Preventing Substance Abuse

This chapter reviews the Congressional mandates that address drug (substance) abuse information and referral activities in the WIC Program, and clarifies WIC's role.

- Introduction
- Provisions of the Law
- WIC Program: An Ideal Place for Education and Referrals
- Overview of Regulatory Requirements
  - Defining WIC Responsibilities

Introduction

Concern over low birth weight and infant mortality outcomes, as well as the incidence of drug addiction among pregnant women and newborn infants, prompted Congress to include drug abuse education responsibilities for the WIC Program.

Drug abuse education, as defined by Public Law 100-690, includes the provision of information concerning the dangers of drug abuse, the referral of participants suspected of drug abuse for counseling or treatment, and the distribution of drug abuse education materials. By warning women about the dangers of substance use and abuse, and referring women as appropriate, WIC contributes to the broader goal of decreasing the incidence of substance abuse among pregnant women, of perinatal addiction, and infant mortality.

WIC's role in preventing substance abuse is to provide WIC participants with education, referrals, and coordination of services. The intended effects of WIC's substance abuse prevention and referral activities are to increase participants' access to information about the dangers of substance use during pregnancy and breastfeeding, and to facilitate referrals for further assessment, as appropriate. WIC regulations at 7 CFR Section 246.4(a)(9)(i) require State agencies to describe in their annual State plan of operations, the methods that will be used to provide drug and other harmful substance abuse information.

These activities, however, are not intended to burden local staff with added requirements. Before Congress passed the Anti-Drug Abuse Act of 1988, the sponsoring legislators made it clear that the drug abuse information and referral efforts were not meant to reduce or interfere with WIC's primary and ongoing responsibilities of providing supplemental food, nutrition education, and health care referrals. Although some basic screening may be necessary to assist in fulfilling the referral mandate, WIC staff is not expected to diagnose substance use problems or to provide in-depth counseling. Rather, they are to provide substance abuse–related information and materials in the course of routine activities. Through established linkages and coordination with local resources, suspected substance users are to be referred to existing assessment agencies for professional evaluation, as appropriate. Find more information about referrals in chapter VII.

Provisions of the Law

In 1988, the U.S. Congress amended the Child Nutrition Act with the Anti-Drug Abuse Act of 1988 (PL 100-690). This Act mandated that WIC agencies implement measures to educate women participants about substance use–related problems and refer them, when possible, to appropriate prevention and treatment services. Key features and intended outcomes of the amended act are:

- Drug abuse education should be limited to the provision of information and materials to WIC participants.
- In cases of suspected drug abuse, however, WIC interviewers are permitted to make referrals to clinics, treatment programs, counselors, or other professionals.
- Drug abuse information and referrals should be available to all pregnant, postpartum, and breastfeeding women, as well as to the parents or caretakers of participating infants and children.
- In areas where English is not the prevailing first language, multilingual educational materials should be made available.
- States are required to document how they intend to coordinate their drug abuse information and referral activities with existing education, counseling, and treatment programs.

Additionally, Public Law 101-147, the Child Nutrition and WIC Reauthorization Act of 1989, enacted November 10, 1989, requires WIC local agencies to:

- Coordinate with local alcohol and drug abuse treatment services. Coordination with alcohol and drug abuse counseling was already a regulatory requirement; and
- Maintain and make available a list of local resources for substance abuse counseling and treatment.

Before Congress passed the Anti-Drug Abuse Act of 1988, the sponsoring legislators made it clear that the drug abuse information and referral efforts were not meant to reduce or interfere with WIC's primary and ongoing responsibility to provide supplemental food, nutrition education, and health care referrals.

WIC Program: An Ideal Place for Education and Referrals

Congress, in mandating that WIC agencies provide participants with drug abuse-related information and referral services, responded in part to the crises arising from increasing drug use among pregnant women.

Though there are legislative mandates to provide substance abuse information and referrals, the WIC Program offers a suitable intervention point for several reasons. First, doing so aligns with WIC's mission to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. Unlike many reproductive hazards, unnecessary risks from substance use can be eliminated – or at least reduced – if the pregnant woman avoids or moderates consumption of alcohol, tobacco, and other drugs.

Secondly, the WIC Program acknowledges that substance use is incompatible with good nutrition, as evidenced by such use being a nutrition risk criterion that would make an applicant eligible for the Program (as long as categorical and financial requirements are met). Substance use undermines WIC's efforts to help participants achieve and maintain optimal nutritional status. Tobacco, alcohol, and other drugs tend to suppress appetite, and can therefore interfere with healthy eating habits and normal weight gain during pregnancy. Additionally, drugs can deplete the pregnant woman and her fetus of nutrients needed for healthy growth.

Third, research studies indicate that women are more motivated than usual to improve their lifestyle and health habits during periods when they make the transition from one life situation or role to another[1]. Pregnancy is an especially receptive period for advising women to take good care of themselves in order to have healthy babies.[2,3] WIC participants are a natural target audience for substance use information because they are, by definition, in the life transition stage of pregnancy and new motherhood.

Overview of Regulatory Requirements

WIC's role in preventing substance abuse is to provide participants with information, referrals, and coordination of services. The intended effects of WIC's substance use prevention and referral activities are to:

- **Increase participants' access to information** about the dangers of substance use for pregnant, postpartum, and breastfeeding women; and, as appropriate,
- **Provide referrals for further assessment**.

Therefore, the role of WIC staff is to provide information, education, and referrals, as appropriate, for **alcohol, tobacco, and other substance use**. The specific regulatory requirements for these activities are described below.

Federal WIC regulations (7 CFR 246.4(a)(9)(i)) require that the State agency's nutrition education goals and action plans include a description of the methods that will be used to provide drug and other harmful substance abuse information. Additionally, the procedure manual that the State agency develops for guidance to local agencies in operating the Program must include methods for providing nutrition education to participants, which includes information on drug abuse and other harmful substances (7 CFR 246.4(a)(11)(ii)), and instructions on coordinating operations under the Program with drug and other harmful substance abuse counseling and treatment services (7 CFR 246.4(a)(11)(v)).

Federal WIC regulations (7 CFR 246.7(a)) also require local agencies to maintain and make available for distribution to all pregnant, postpartum, and breastfeeding women and to parents or caretakers of infants and children applying for and participating in the Program a list of local resources for drug/other harmful substance–abuse counseling and treatment.

With respect to screening, Federal WIC regulations (7 CFR 246.7(n)) stipulate that to the extent that a State agency determines that screening is necessary to fulfill the referral requirements, the State agency must require screening for the use of drugs and other harmful substances. When such screening is required, it shall be limited to the extent the State agency deems necessary to fulfill the referral requirement of the State plan. Additionally, it shall be integrated into the certification process as part of the medical or nutrition assessment, and be an integral part of nutrition education. Thus, the role of WIC staff may also include performing basic screening for alcohol, tobacco, and other substance use.

Defining WIC Responsibilities

It is important to note that screening (**potential WIC responsibility**) and providing information and referrals for substance abuse (**WIC responsibilities**) are very different activities relative to diagnosing substance use problems or providing in-depth counseling (***not* WIC responsibilities**). The following definitions serve to illustrate the differences between these four activities:

Screening (potential WIC responsibility): a brief procedure used to determine the probability of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. Screening determines the need for a comprehensive assessment; it does not establish definitive information about diagnosis and possible treatment needs.[4]

Referring (WIC responsibility): the process of facilitating the participant's use of available support systems and community resources to meet needs identified during screening;[5] it includes identifying and offering information on the most appropriate substance abuse services for an individual[6] who was identified during the screening process as being in need of further evaluation for potential or current substance use. *(Note: The word* referral *is used in two ways in this Guide. The definition above is in line with* formal/active referrals. *See below for additional information.)*

Diagnosing (not a WIC responsibility): the process of determining disease status through the study of symptom patterns and the factors responsible for producing them. No single screening test can diagnose substance abuse.[7]

Counseling (not a WIC responsibility): a process that facilitates patients' progress toward mutually determined treatment goals and objectives, and includes other behavioral therapies to help them modify or change behaviors.[7]

Referral activities can be accomplished in two ways: informal/passive or formal/active. Providing informal/passive referrals (see chapter VI, Providing Information) may be carried out without any screening by providing all participants with information about community resources; from the list of local substance abuse counseling and treatment services, women can secure services on their own. In contrast, providing formal/active referrals (see chapter VII, Referrals) entails contacting a community resource on the participant's behalf to arrange for substance use–related assessment services.

CHAPTER II

Patterns, Predictors, and Hazards of Maternal Substance Use

This chapter provides general introductory information about patterns and predictors of, as well as the potential dangers of and trends in, substance use during pregnancy, breastfeeding, and parenting.

- Limitations of Research About Risks
- Patterns of Substance Use Among Women of Childbearing Age
  - Prevalence and Patterns of Substance Use
  - Long-Term Trends
  - Predictors of Substance Use
- Implications for Talking with Participants
  - Statistics Do Not Predict Individual Cases
  - Tempering Caution with Compassion
  - Recommendation of Abstinence May Not Reach All Women
- Implications of Substance Use During Pregnancy
  - General Consequences of Substance Use on Pregnant and Postpartum Women
- Substance Use During Breastfeeding
  - The 2015 Dietary Guidelines for Americans Key Definitions for Alcohol
  - General Consequences of Maternal Substance Use on Breastfeeding Infants
  - Breastfeeding and the Use of Human Milk
  - Common Effects of Substances on the Breastfed Baby
- Substance Use During Parenting

Limitations of Research About Risks

Due to the nature of what is being studied, teratogenic research on the effects of various substances on the reproductive system, the fetus, and the developing child has important limitations:

- Scientists cannot ethically experiment directly on pregnant women to determine substance use–related effects.
- Animals, as alternative experimental subjects for drug safety research, are imperfect models.
- Retrospective interviews with mothers of children with birth defects may not address the right questions or obtain accurate and reliable answers, especially from substance-dependent women trying to recall events from previous pregnancies.
- Only a small number of cases are available for many studies of the effects of substance use, particularly in the cases of use of illegal drugs that are not widely used or acknowledged. Findings from early, small-scale studies may be inconsistent and are not replicable.

Medical practice in the absence of conclusive, well-controlled research must often rely on a few journal case reports of negative reactions, and is understandably conservative in the interest of protecting the fetus and the breastfed infant.

This leaves alternative methods, each with its own limitations as well. For more information on these alternative methods and their limitations, see appendix 4: Teratogenic Research: Alternatives and Their Limitations.

Patterns of Substance Use Among Women of Childbearing Age

It is possible that you may encounter some women who may be using substances while pregnant or breastfeeding. By understanding trends in substance use by women of childbearing age and the potential consequences of their substance use, you can be better equipped to provide information and answer questions that may arise. Basing the information you provide on facts rather than personal judgment or assumptions is more constructive and educational. It also may help build rapport by helping to eliminate the conveying of any personal opinions you may have.

Prevalence and Patterns of Substance Use

In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) published results of the annual National Survey on Drug Use and Health (NSDUH).[8] This survey interviewed civilian, noninstitutionalized people in the United States aged 12 years or older. Rates of illicit drug, alcohol, and tobacco use are available for subpopulations, including pregnant women aged 15 to 44. Overall, the percentage of pregnant women who reported using substances was lower than for their nonpregnant peers, except for pregnant women ages 15 to 17, who had similar rates of illicit drug use as women of the same age who were not pregnant. Pregnant women in this age group also use drugs at a higher rate than other age groups.

Specific trends identified in the study referenced on the preceding page are as follows (figures referenced in the following bullets are from this SAMHSA report):

Illicit Drug Use

- Among pregnant women aged 15 to 44, 4.4% were current illicit drug users based on data averaged across 2009 and 2010. This was lower than the rate among women in this age group who were not pregnant (10.9%). Among pregnant women aged 15 to 44, the average rate of current illicit drug use in 2009–2010 (4.4%) was not significantly different from the rate averaged across 2007–2008 (5.1%). The rate of current illicit drug use in the combined 2009–2010 data was 16.2% among pregnant women aged 15 to 17, 7.4% among pregnant women aged 18 to 25, and 1.9% among pregnant women aged 26 to 44 (figure 2.9).
- In 2010, as in prior years, the rate of current illicit drug use among persons aged 12 or older was higher for males (11.2%) than for females (6.8%). Males were more likely than females to be current users of several different illicit drugs, including marijuana (9.1% vs. 4.7%), nonmedical use of psychotherapeutic drugs (3.0% vs. 2.5%), cocaine (0.8% vs. 0.4%), and hallucinogens (0.6% vs. 0.3%). The 2010 rates for both males and females aged 12 or older were similar to those reported in 2009. In 2010, the rates of current illicit drug use were similar between males and females aged 12 to 17 (10.4% for males vs. 9.8% for females). However, males aged 12 to 17 were more likely than females aged 12 to 17 to be current marijuana users (8.3% vs. 6.4%), while females aged 12 to 17 were more likely than males aged 12 to 17 to be current nonmedical users of psychotherapeutic drugs (3.7% vs. 2.3%) and current nonmedical users of pain relievers (3.0 vs. 2.0%) (figure 2.8).
- There were no statistically significant differences in the rate of current illicit drug use between 2002 and 2010 for any of the racial/ethnic groups (figure 2.10).

Tobacco Use

- Two-year moving average rates from 2002–2003 to 2009–2010 indicate that current cigarette use among women aged 15 to 44 decreased from 30.7% to 26.7% for those who were not pregnant and from 18.0% to 16.3% for those who were pregnant, although the latter difference was not statistically significant (figure 4.5). Additional categorized findings are as follows:

Race/Ethnicity

- In 2010, the prevalence of current use of a tobacco product among persons aged 12 or older was 12.5% for Asians, 21.9% for Hispanics, 27.3% for blacks, 29.5% for whites, 32.0% for persons who reported two or more races, and 35.8% for American Indians or Alaska Natives. There were no statistically significant changes in past-month use of a tobacco product between 2009 and 2010 for any of these racial/ethnic groups.
- In 2010, current cigarette smoking among youths aged 12 to 17 and young adults aged 18 to 25 was more prevalent among whites than blacks (9.8% vs. 4.5% for youths and 39.1% vs. 26.3% for young adults).
- The current smoking rates in 2010 for Hispanics across age groups were 8.0% among youths aged 12 to 17, 27.4% among young adults aged 18 to 25, and 20.5% among those aged 26 or older. These rates were similar to smoking rates for Hispanics in 2009.
- Smoking rates across age groups held steady for Asians between 2009 and 2010. The current smoking rate for Asian youths aged 12 to 17 was 2.5% in 2009 and 3.6% in 2010. The rates for Asian young adults aged 18 to 25 and adults aged 26 or older also held steady between 2009 and 2010 (21.6% to 21.0% for young adults and 9.9 to 10.1% for adults aged 26 or older, respectively).
- The current smoking prevalence rate for American Indian or Alaska Native youths aged 12 to 17 was 14.9% in 2010. This rate was not significantly different from the rate in 2008 (18.9%) or 2009 (11.6%).

Employment

- In 2010, current cigarette smoking was more common among unemployed adults aged 18 or older than among adults who were working full time or part time (39.9% vs. 24.9% and 24.4%, respectively). Cigar smoking followed a similar pattern, with 9.4% of unemployed adults reporting past-month use, compared with 5.9% of full-time workers and 5.3% of part-time workers.
- Current use of smokeless tobacco in 2010 was higher among adults aged 18 or older who were employed full time and those who were unemployed (both at 4.6%) than among adults who were employed part time (2.6%) and those in the "other" employment category, which includes persons not in the labor force (2.2%). These rates were similar to 2009 smokeless tobacco use rates for these employment categories.

Geographic Area

- In 2010, current cigarette smoking among persons aged 12 or older was lower in the West (20.0%) than in the Northeast (22.2%), which in turn was lower than in the South (24.1%) and Midwest (24.8%). Use of smokeless tobacco was also higher in the Midwest and South (3.9% and 4.3%, respectively) than in the West (3.0%), which in turn was higher than in the Northeast (2.1%). As in 2009, the rates of tobacco use in 2010 were associated with county type among persons aged 12 or older. The rate of current cigarette use was 21.7% in large metropolitan areas, 23.5% in small metropolitan areas, and 26.0% in nonmetropolitan areas. Use of smokeless tobacco in the past month in 2010 among persons aged 12 or older was lowest in large metropolitan areas (2.3%). In small metropolitan areas, the current smokeless tobacco use rate was 4.0%; in nonmetropolitan areas, it was 6.5%.

Association with Illicit Drug and Alcohol Use

Use of illicit drugs and alcohol was more common among current cigarette smokers than among nonsmokers in 2010, as in prior years since 2002. Among persons aged 12 or older, 22.6% of past-month cigarette smokers reported current use of an illicit drug, compared with 4.9% of persons who were not current cigarette smokers. Over half (52.9%, or 1.1 million) of youths aged 12 to 17 who smoked cigarettes in the past month also used an illicit drug, compared with 6.2% of youths who did not smoke cigarettes.

Past-month alcohol use was reported by 66.2% of current cigarette smokers, compared with 47.5% of those who did not use cigarettes in the past month. The association also was found with binge drinking (43.7% of current cigarette smokers vs. 16.9% of current nonsmokers) and heavy drinking (15.8% vs. 3.9%, respectively).

Alcohol Use

- In 2010, an estimated 57.4% of males aged 12 or older were current drinkers, higher than the rate for females (46.5%). However, among youths aged 12 to 17, the percentage of males who were current drinkers (13.7%) was similar to the rate for females (13.5%). The rate among males aged 12 to 17 dropped from 15.1% in 2009. Among young adults aged 18 to 25, an estimated 57.0% of females and 65.9% of males reported current drinking in 2010. These rates were similar to those reported in 2009 (57.7% and 65.9%, respectively). Among pregnant women aged 15 to 44, an estimated 10.8% reported current alcohol use, 3.7% reported binge drinking, and 1.0% reported heavy drinking. These rates were significantly lower than the rates for nonpregnant women in the same age group (54.7%, 24.6%, and 5.4%, respectively). Binge drinking during the first trimester of pregnancy was reported by 10.1% of pregnant women aged 15 to 44. All of these estimates by pregnancy status are based on data averaged over 2009 and 2010 (figure 3.1).
- Among persons aged 12 or older, whites in 2010 were more likely than other racial/ethnic groups to report current use of alcohol (56.7%) (figure 3.2). The rates were 45.2% for persons reporting two or more races, 42.8% for blacks, 41.8% for Hispanics, 38.4% for Asians, and 36.6% for American Indians or Alaska Natives.

The authors of this survey noted that, since the survey data reflect self-reported use, some of the differences between pregnant and nonpregnant women may be due to the tendency to give socially desirable answers to survey questions. However, it is known that women who smoke and/or drink alcohol plan to stop or reduce their use if they get pregnant, and the survey results may reflect these attempts.

There is little evidence from this survey that *all* types of substance use are reduced during pregnancy. The following are current statistics and findings from the above-mentioned SAMSHA survey for use of substances other than tobacco and alcohol.

Use of Illicit Substances

Past-month Illicit Drug Use

- Pregnant Women aged 15 to 44: **4.4%**
  - Pregnant Women aged 15 to 17: **16.2%**
  - Pregnant Women aged 18 to 25: **7.4%**
  - Pregnant Women aged 26 to 44: **1.9%**
- Nonpregnant Women aged 15 to 44: **10.9%**
- Females aged 12 to 17: **9.8%**

Substances Included

- Marijuana/hashish
- Cocaine
- Heroin
- Inhalants
- Prescription-type psychotherapeutics and opiates used nonmedically

Findings on Specific Substances

- Methamphetamine has become the most common substance for which women require treatment during pregnancy, with rates mirroring that of the general population (5.2% in 2009).[9]
- There has been a sharp rise in nonmedical prescription drug use, specifically opiates. This is the second-most-prevalent illicit drug use category among youths and young adults in 2010 (marijuana is first).[8] This increase is also observed in the rise in the number of infants born with symptoms of opiate withdrawal.[10,11]
- MDMA ("Ecstasy") use is typically stopped during pregnancy, so rates in the second and third trimesters are generally very low.[12]

Long-Term Trends

Trends of substance use over time tend to vary, depending on the substance.[8] For example:

Tobacco

Overall smoking rates among women aged 15 to 44 have decreased between 2002–2003 and 2009–2010, but not among pregnant women, as follows:

- Among nonpregnant women, smoking rates declined significantly (30.7% to 26.7%).
- Among pregnant women, there was not a statistically significant decrease in smoking rates (18.0% to 16.3%).[8]

Alcohol

There has been a decline in alcohol use among women entering substance abuse treatment; that trend is most pronounced among pregnant women.[13] However, binge drinking still remains a problem and is highly associated with negative outcomes. Alcohol use trends follow.

- In both 2002 and 2010, pregnant women aged 15 to 44 reported current alcohol use and binge drinking at rates significantly lower than the rates for nonpregnant women of that age.[14]
  - Among nonpregnant women aged 15 to 44, rates of current alcohol use increased from 53.4% in 2002 to 54.7% in 2010; binge drinking increased from 23.4% to 24.6% over the same time period.[14]
  - Among pregnant women aged 15 to 44 , rates of current alcohol use increased from 9.1% in 2002 to 10.8% in 2009-2010; binge drinking increased from 3.1% to 3.7% over the same time period.

Illicit Substances

Levels of use have generally stayed the same, as follows: Among pregnant women aged 15 to 44, the percentage reporting current illicit substance use in 2009 to 2010 (4.4%) was not significantly different from the rate averaged across 2007 to 2008 (5.1%).[8]

Predictors of Substance Use

Early Substance Use

- For teenage mothers, early use (12 to 18 years of age) of tobacco or marijuana is a risk factor for continued use as a young adult.[15]

Prepregnancy Substance Use

- Alcohol use levels prior to pregnancy are a strong predictor of alcohol use during pregnancy.[16,17]
- Likewise, frequency of drug use before pregnancy is a predictor of drug use continuation during pregnancy.[17]

Demographic Characteristics

Use and substance choice vary by demographic group.

- Substance use after pregnancy is more likely for Native Americans and African Americans.[17]
- African American women and economically disadvantaged women are more likely to use illicit substances, particularly cocaine.[18]
- Caucasian women and women with higher education levels are more likely to use alcohol.[18]

Domestic Issues

Substance use is increased among women who:

- Were raised by parents who abuse substances.[18]
- Have experienced sexual abuse.[18]
- Have experienced intimate partner violence.[19]

Mental Health

- Women with a diagnosis of substance abuse or chemical dependency may have one or more mental disorders.[18]

Implications for Talking with Participants

In some cases, the limitations in research knowledge may pose a dilemma when informing pregnant women about the potential effects of substance use. The dangers certainly need to be emphasized, primarily because substance use is a risk factor in pregnancy over which most women have direct control. When discussing these issues with participants, there are a couple of points to keep in mind:

Statistics Do Not Predict Individual Cases

Although statistics indicate risk associated with substance use during pregnancy and breastfeeding, a negative outcome *may not occur* in every situation. Remember: statistics only predict the probability of an outcome, given the presence of certain factors. For this reason, the warning about risks could potentially backfire on you if a substance-using or -abusing woman – or her substance-using or -abusing friend – gives birth to an apparently healthy baby. In this instance, the pregnant woman or new mother may conclude that the experts were wrong and refuse to listen to further advice.

Therefore, information about possible negative consequences should be worded cautiously to allow for the possibility that the mother may be lucky and escape the odds this time. You can remind her that she can, of course, increase the probability of a positive outcome through adoption of recommended behaviors.

In addition, remember that women who deliver infants with birth defects have enough problems without the added burden of guilt. Some experts estimate that only a small percentage of the congenital malformations, developmental defects, and functional abnormalities found among newborns in the United States can be attributed to alcohol, drugs, or other chemicals in the environment. Other deficiencies in the newborns may result from genetic influences, abnormal deliveries, or unknown causes.

Tempering Caution with Compassion

When talking to women about the dangers of maternal substance use, be careful never to predict the outcome of a specific pregnancy. Statistical odds do not predict specific case results. Instead, remind pregnant women that they increase their chances of a positive outcome by abstaining from using substances.

Recommend abstinence from all drugs that are not medically prescribed during pregnancy and while breastfeeding, but be compassionate if warnings about the hazards of substance use are not completely and immediately heeded. All substance-using women need positive support in their efforts to quit.

Recommendations of Abstinence May Not Reach All Women

Safe limits on substance use during pregnancy and breastfeeding have not been established; indeed, many experts note that there is no safe use of a substance during pregnancy. Therefore, public health messages are quite conservative, and physicians and researchers typically advise total abstinence from all nonessential drugs and chemicals during pregnancy and breastfeeding. This is a simple message that most women who are not substance-dependent will try to follow once they understand the dangers of exposing the fetus to substances. This advice, however, may not reach all women.

Some pregnant women may have smoked cigarettes or consumed drugs such as prescription medications or alcohol during the early and vulnerable weeks of fetal development before they realized they were pregnant. Additionally, substance-dependent women need sensitive intervention and referral for further counseling and treatment to help them quit. As current models of change indicate, change itself is influenced by biological, psychological, sociological, and spiritual variables, and although the client is ultimately responsible for change, this responsibility is shared with the clinician through the development of a therapeutic partnership.[20]

Implications of Substance Use During Pregnancy

A woman's substance use during pregnancy may have physical and mental health consequences ranging from serious to mild. The extent and likelihood of these effects depend on a variety of factors.

For example, use of substances during pregnancy has been associated with adverse pregnancy outcomes, including low birth weight. This section outlines the risk factors that influence low birth weight. It also addresses the effect of *degree* and *type* of substance use on the fetus. In addition, you'll find additional information on the other potential effects of substance use by pregnant and breastfeeding women in chapter III: Specific Drugs and Their Effects.

General Consequences of Substance Use on Pregnant and Postpartum Women

Maternal substance use – both during and after pregnancy – can have consequences for both the mother *and* the child. These can affect many areas of a mother's life and can also have a long-term impact on both her and her child.

For a mother, substance use can affect four major life areas. It's important to be familiar with these as you work with WIC participants in order to have a full picture of what a woman may be experiencing. Substance use can have consequences related to:

Personal Health and Safety

Use of alcohol, tobacco, illicit substances, and other substances poses a threat to health and safety, including but not limited to:

- Increased likelihood of death by illness, accident or suicide; domestic violence; and unintended pregnancy[21,22,23,24]
- Transmission of sexually transmitted diseases, including HIV/AIDS[25,26]

Obstetrical and Prenatal Complications

Alcohol, tobacco, and other substances (and withdrawal from them) may cause constriction of uterine blood vessels, leading to:[27]

- Uteroplacental insufficiency (insufficient flow of blood to the placenta)
- Abruptio placenta (separation of the placenta from the uterus)
- Premature labor

These three complications may, in turn, increase the risk of:[27]

- Fetal loss (miscarriage)
- Premature birth
- Stillbirth

In addition, obstetrical complications, such as maternal hypertension (high blood pressure) or hemorrhage, may threaten both maternal *and* fetal health.

Legal Ramifications

Substance use during pregnancy is regarded as a form of child abuse in some U.S. states. Legal sanctions for substance use during pregnancy include termination of parental rights and mandated civil commitment of women.[28]

Societal Impacts (particularly those affecting children and families)

Children of parents/caretakers who abuse substances are at high risk for a range of physical and behavioral problems, including substance abuse problems. Substance abuse is also associated with:

- Separation and divorce
- An unstable family structure
- Involvement of Child Protective Services
- Temporary removal of children from the home
- Termination of parental rights[29]

Substance Use During Breastfeeding

An especially sensitive time is the period during which infants may breastfeed. In general, it is best for the breastfeeding mother to avoid alcohol, tobacco, and illegal drugs, since most maternally ingested substances are transmitted to human breast milk, though the concentration and potential danger to the breastfed baby is affected by interactions among a variety of factors.[30]

In their policy statement, *Breastfeeding and the Use of Human Milk*, the American Academy of Pediatrics (AAP) concludes that maternal substance abuse is not a categorical contraindication to breastfeeding. Breastfeeding in situations in which the mother is undergoing pharmacologic therapy must balance the benefits to infant and mother against the potential risk of substance exposure to the infant. "Adequately nourished narcotic-dependent mothers can be encouraged to breastfeed if they are enrolled in a supervised methadone maintenance program and have negative screening for HIV and illicit drugs."[30]

Conversely, street drugs such as PCP, cocaine, and marijuana can be detected in human milk, and their use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development, and thus is contraindicated.[30] Futhermore, the FDA has a strengethed warning on medication labels to mothers that breastfeeding is not recommended when taking medicines containing codeine or tramadol due to the risk of serious adverse reactions in breastfed infants. [66]

In addition, alcohol may blunt prolactin response to suckling, and it negatively affects infant motor development. Also, a breastfeeding woman's quantity of milk produced is reduced in 3 to 4 hours after alcohol is consumed.[31]

However, the Dietary Guidelines for Americans (DGAs)[31] recognizes that there is substantial evidence that clearly demonstrates the health benefits of breastfeeding and indicates that occasionally consuming an alcoholic drink does not warrant stopping breastfeeding. Nonetheless, the DGAs warn that breastfeeding women should be very cautious about drinking alcohol, if they choose to drink at all, and the *Scientific Report of the 2015 Dietary Guidelines Advisory Committee*[32] recommends, that for those women who choose to drink to do so only if the infant's breastfeeding behavior is well-established, consistent and predictable.

The 2015 Dietary Guidelines for Americans[31] Key Definitions for Alcohol

For women, the DGAs define:

moderate drinking	as consuming up to one drink* per day
heavy or high-risk drinking	as consuming four or more drinks* on any day or more than eight per week
binge drinking	as consuming four or more drinks* within two hours

** One alcoholic drink is the equivalent of a 12-ounce regular beer (5% alcohol), 5-ounce glass of wine (12% alcohol), or 1.5 ounces of 80-proof (40%-alcohol) distilled spirits/hard alcohol.*

(no earlier than 3 months of age). In this case, a mother may consume a single alcoholic drink if she waits at least four hours before breastfeeding. Alternatively, a woman may express breast milk before consuming the drink, and feed the expressed milk to her infant later.

In general, breastfeeding is not recommended when mothers are receiving prescription medication from the following classes of substances: amphetamines, chemotherapy agents, ergotamines, and statins,[57] or when taking medications that contain codeine or tramadol.[66] Therefore, although breastfeeding is recognized to be the optimal source of infant nutrition, and provides significant health benefits to both a mother and her infant, there are circumstances when a mother should not breastfeed when it comes to substance use.[30]

A valuable resource from the National Institutes of Health National Library of Medicine is LactMed, an online database (http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm) of drugs to which breastfeeding mothers may be exposed. Among the data included are maternal and infant levels of drugs, possible effects on breastfed infants and on lactation, and alternate drugs to consider.

General Consequences of Maternal Substance Use on Breastfeeding Infants

As noted above, most maternally ingested substances are transmitted to human breast milk, though the concentration and potential danger to the breastfed baby is affected by interactions among a variety of factors. Factors that can impact potential danger to the breastfed baby may include:

- Clinical properties of the specific drug – its solubility in fat and water and diffusion rate into milk, molecular weight, pH of the substance, duration of effectiveness, and type of intoxication produced;
- Patterns of substance use by the mother – the dosage consumed, frequency and regularity of use (which affects accumulation in the body and rate of detoxification), route of drug administration (e.g., whether the drug is smoked, inhaled, ingested, or injected), and length of time between use of the substance and the baby's feeding; and
- Characteristics of the baby – body weight and size, age and maturity of the organs that metabolize drugs, and amount of breast milk consumed in the total diet.

Some of the potential hazards of prescription and over-the-counter (OTC) drug consumption by the breastfeeding mother can be reduced if a particular medication is necessary for medical treatment and a physician recommends proper use in amounts or timing. Dosages can be scheduled to maximize the time between consumption and the next feeding.

In-depth information on specific effects of common substances used by breastfeeding mothers can be found in chapter III: Specific Drugs and Their Effects; however, in the charts on page 25 are some of the more common effects of the general classes of substances to the breastfed baby, including OTC medications.[33] Participants should be encouraged to discuss with their physicians all drugs being used, since interactions among different prescription medications, OTC preparations, and other legal and illegal substances may produce quite different effects than any one substance taken alone.

It is important to note that, just as with effects of *prenatal* exposure to various substances, researchers are still discovering the hazardous effects of these substances on the *breastfed* infant. Similar limitations exist with regard to conclusive knowledge because:

- Research findings regarding specific drugs are not always current, particularly for the newer and less widely used illegal substances;
- Reports on a sufficient number of cases to provide conclusive evidence are frequently lacking; and
- Measurement problems often exist with regard to collecting and testing adequate numbers of mild samples from different time periods and regulating or determining substance dosages levels in the breastfeeding mothers.

Breastfeeding and the Use of Human Milk

The AAP's Policy Statement *Breastfeeding and the Use of Human Milk*[30], states that, in general, breastfeeding is not recommended when mothers are receiving prescription medication from the following classes of substances:

- Amphetamines
- Chemotherapy agents
- Ergotamines
- Statins

The FDA also added a strengthened warning on medication labels to mothers that breastfeeding is not recommended when taking medicines containing **codeine** and **tramadol**. [66]

For more information on safety of specific medications, visit LactMed at National Library of Medicine/National Institutes of Health: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT.

Also see chapter III: Specific Drugs and Their Effects for information about the potential effects of individual substances on pregnancy, the fetus, the child, and breastfeeding.

Common Effects of Substances on the Breastfed Baby

Alcohol	
	• Reduced motor development • Significantly less time spent in active sleep immediately after exposure to alcohol in human milk • Reduced milk consumption

Tobacco/Nicotine	
	• Colic • Reduced duration of breastfeeding periods • Reduced breast milk production • Reduced infant weight gain • Increased incidence in infant respiratory allergy • Sudden infant death syndrome (SIDS)

Over-the-Counter (OTC)	
	• OTC medications are defined as substances that are safe and effective for use by the general public without seeking treatment by a health professional.[34] Whether OTC medications are considered safe to use while breastfeeding depends on the specific medication. As a rule of thumb, if wondering about safety of specific medications or how often to use a medication that is generally considered safe for use while breastfeeding, a breastfeeding woman should check with her health-care professional (see Selected Commonly Used Over-The-Counter Medications on page 42).

Prescription Medications	
Sedative-Hypnotics and Anxiolytic Medications	• Sedation • Poor feeding • Irritability • Insomnia
Prescription "opioids" (non-opium-based pain management drugs that have opiate-like characteristics)	• Excess sleepiness • Difficulty breastfeeding • Serious breathing problems that could result in death.[66]

Illicit Substances	
Amphetamines	• Irritability • Extreme agitation • Hallucinations • Seizures • Poor sleep patterns
Cocaine	• Intoxication • Diarrhea • Rapid heart rate • High blood pressure • Seizures • Vomiting • Choking • Agitation • Irritability • Jitteriness • Increased startle reflex • Negative effects on neurobehavioral development
Hallucinogens	• Negative effects on neurobehavioral development
Inhalants & Solvents	• No information is available.
Marijuana	• Sedation • Reduced muscle tone • Poor sucking • Delayed growth • Delayed motor development
Opiates & Synthetic Narcotics	• Irritability • Extreme agitation • Hallucinations • Seizures • Poor sleep patterns.[22]

Substance Use During Parenting

The detrimental consequences of substance use seldom start or end with fetal exposure during pregnancy or infant consumption of drug-contaminated breast milk. Substance use can impact the family and parenting in a number of ways, and may be linked with poor parenting practices, child neglect, and abuse.[35]

"Parents with substance use disorders may not be able to function effectively in a parental role. This can be due to:

- Impairments (both physical and mental) caused by alcohol or other drugs
- Domestic violence, which may be a result of substance use
- Expenditure of often limited resources on purchasing alcohol or other drugs
- Frequent arrests, incarceration, and court dates
- Time spent seeking out manufacturing or using alcohol or other drugs
- Estrangement from primary family and related support

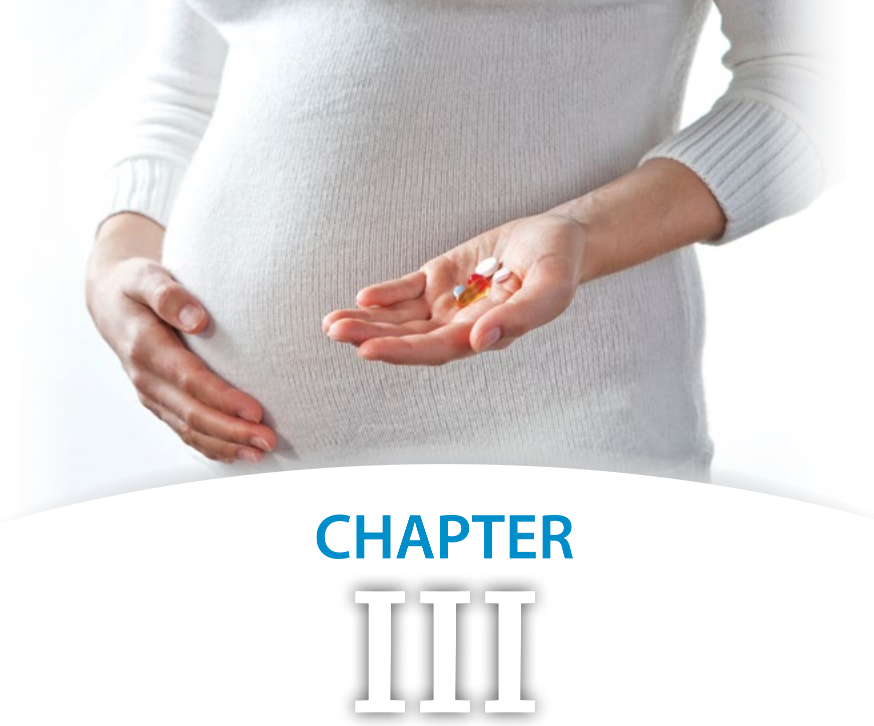
Families in which one or both parents have substance use problems, and particularly families with an addicted parent, often experience several other problems that affect parenting, including mental illness, unemployment, high stress levels, and impaired family functioning, all of which can put children at risk for maltreatment (National Center on Addiction and Substance Abuse at Columbia University, 2005). The basic needs of children, including nutrition, supervision, and nurturing, may go unmet due to parental substance use, resulting in neglect. Depending on the extent of the substance use and other circumstances (e.g., the presence of another caregiver), dysfunctional parenting can also include physical and other kinds of abuse.[36]"

Another common phenomenon seen in some families of substance abusers is known as parentification. This occurs when children assume adult roles or responsibilities that the substance-abusing parent may have given up – roles that children often are not developmentally or emotionally prepared to manage successfully. Parentification can have profound effects on children, contributing to substance use, emotional distress, and problem behaviors such as inappropriate sexual behaviors and conduct problems.

Stress, depression, anxiety, and feeling unable to confide in parents – common by-products of living with an addicted parent – may increase the likelihood that children will engage in substance use in an attempt to relieve their negative feelings.[35]

For more information on the topic of substance use during parenting, the following resources may be helpful:

- **Family Matters: Substance Abuse and the American Family, from Columbia University:** http://www.casacolumbia.org/templates/Publications_Reports.aspx#r20
- **Parental Substance Use and the Child Welfare System from U.S. Department of Health and Human Services:** https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm#2



CHAPTER III

Specific Drugs and Their Effects

This chapter contains information about specific substances, including alcohol and tobacco, and their effects on pregnancy and the child, and when used by breastfeeding women. Use of prescription and over-the-counter (OTC) medications during pregnancy is also discussed.

- Introduction
- FDA Drug Labeling Requirements
  - FDA Pregnancy Categories
- Effects of Specific Drugs
  - Physical and Psychological Manifestations of Adverse Drug Reactions
  - Alcohol
  - Amphetamines
  - Cocaine and Crack
  - Hallucinogens
  - Inhalants and Solvents
  - Marijuana
  - Opiates and Synthetic Narcotics
  - Sedative-Hypnotic and Anxiolytic Medications
  - Tobacco and Nicotine
- Selected Commonly Used Over-the-Counter (OTC) Medications

Introduction

Although the focus of this Guide is on drugs that are commonly used for nonmedical purposes and are known to endanger the fetus, many prescription and OTC medications can also pose hazards. Some prescription medications may be taken for nonmedical reasons or used in ways other than prescribed. Recipients may not use psychoactive tranquilizers, sleeping pills, or even cold remedies for the intended medical purposes.

Such medications may be purposely misused by using them too often, in larger-than-prescribed doses, or over a longer time than indicated. Some women may share doses of these medicines or experiment with different mixtures. Pregnant and breastfeeding/postnatal WIC participants may be enrolled in or referred to prenatal/postnatal care where substance use may be monitored. Staff, however, should remind pregnant and breastfeeding participants to discuss with their doctors any prescription and OTC medications they take, even if these substances have been previously prescribed for them.

FDA Drug Labeling Requirements

The Food and Drug Administration (FDA) requires that the labeling for most over-the-counter medications include a general warning statement, which advises that pregnant and breastfeeding women seek advice of a health professional before using the product.

For prescription drugs, labeling is directed at health care professionals, although it is sometimes adapted for use in consumer-directed resources, such as patient package inserts (PPI) or patient medication guides. While labeling contains a great deal of information, PPIs, and medication guides and labels are required to include narrative summaries of the risks of a drug during pregnancy and discussions of the data supporting those summaries, the best source of information remains talking to one's health care professional.

FDA previoulsy developed and used a classification system for most prescription drugs specifying the degree to which available information has ruled out risk to fetus, balanced against the drug's potential benefits to the patient. The five ratings were as outlined below:

A - Controlled studies show no risk
B - No evidence of risk in humans
C - Risk cannot be ruled out
D - Positive evidence of risk
X - Contraindicated in pregnancy

However, effective June 30, 2015, along with other new labeling requirements, FDA eliminated the pregnancy categories because they are often viewed as confusing and overly simplistic and don't effectively communicate the risk a drug may have during pregnancy and lactation and in females and males of reproductive potential. Because implementation of new labeling requirements and elimination of the classification will take time, consumers may still see the classification system letters for several years after June 30, 2015.

Information on many specific drugs can be found in the *Physicians' Desk Reference (PDR)*.[37] This information is derived from official labeling requirements mandated by FDA and supplied by the manufacturer. Patient labeling is required to accompany certain drugs, such as oral contraceptives. For other drugs, pharmacists can supply labeling information.
You can find more information about drug labeling related to pregnancy and lactation at FDA's Questions and Answers on the Pregnancy and Lactation Labeling Rule at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Labeling/ucm093311.htm.

Because of product liability concerns, labeling precautions are generally conservative. These publications also indicate usual dosages as well as contraindications (high fetal risk) and adverse reactions, interactions with other drugs, potential for abuse and dependence, and overdose precautions and methods for management.

Effects of Specific Drugs

Potential dangers to both mother and fetus of nonmedically supervised withdrawal from some drugs are emphasized. For many substances, sudden cessation after daily or more frequent use – to the extent of physical addiction or tolerance – will produce unpleasant and sometimes dangerous reaction symptoms in the user as blood levels drop rapidly. The withdrawal syndrome is usually the opposite of the normal drug effect: anxiety, insomnia, and tremulousness for the users of such "downers" as alcohol, barbiturates, or tranquilizers; irritability, nausea, chills, and diarrhea for narcotics users; and serious depression, apathy, and lethargy for the addicted users of such "uppers" as amphetamines and cocaine or crack. Withdrawal from heavy alcohol or barbiturate use can be life-threatening to the pregnant woman and to the fetus, if not medically monitored. The dangers to the fetus depend on its stage of development, the severity of the addiction and withdrawal effects, and the type of drug being stopped.

Because other levels of substance use may not be accurately reported, staff should be cautious when advising the pregnant or breastfeeding woman to cease consumption without medical supervision. Under a physician's care, the woman may be gradually tapered off the drug, may be given a substitute medication, or may be treated symptomatically with other medications while the status of the fetus is monitored. Detoxification (withdrawal) may need to be done in a hospital or residential treatment setting.

Because other levels of substance use may not be accurately reported, staff should be cautious when advising the pregnant or breastfeeding woman to cease consumption without medical supervision. Staff may encounter other drug classification systems in other research. One system groups the drugs by their usual and similar effects on the body, as shown at right.

The section that follows groups some commonly used substances into the following categories: alcohol; amphetamines; cocaine/crack; hallucinogens; inhalants and solvents; marijuana; opiates and synthetic narcotics; sedative-hypnotic and anxiolytic medication; and tobacco and nicotine. Their discussion includes some street names, appearance and usual methods of use, symptoms and hazards of use, and effects on pregnancy, the fetus, the infant, and breastfeeding.

Physical and Psychological Manifestations of Adverse Drug Reactions

Psychoactive Agent	Physical Signs and Symptoms	Psychological Signs and Symptoms
Alcohol	• Apprehensiveness/ timidiness • Dilated pupils • Respiratory depression	• Agitation • Confusion • Hallucinations
Amphetamines	• Dilated pupils • Increased blood pressure • Increased motor activity • Increased sweating • Rapid pulse	• Confusion • Delusions • Hallucinations • Hyperactivity • Paranoia
Cocaine	• Dilated pupils • Increased heart rate • Increased blood pressure • Nausea • Possible stupor	• Agitation • Confusion • Delusions • Hallucinations • Hyperactivity • Paranoia
Hallucinogens	• Dilated pupils • Increased blood pressure • Increased body temperature • Increased heart rate • Nausea • Reflex hyperactivity	• Agitation • Anxiety • Apprehension • Confusion • Delusions • Hallucinations • Hyperactivity • Paranoia • Sensory distortions
Marijuana	• Dilation of conjunctival blood vessels • Increased blood pressure • Increased heart rate • No pupilary dilation • Rapid pulse	• Anxiety • Apprehension • Confusion • Possible hallucinations • Sensory distortions
Opiates	• Apprehensiveness/ timidiness • Constricted pupils • Decrease in body temperature • Respiratory depression	• Confusion
Sedative-Hypnotics	• Apprehensiveness/ timidiness • Convulsions • Dilated pupils • Respiratory depression	• Ataxia • Confusion • Slurred speech
Solvents	• Apprehensiveness/ timidiness • Dilated pupils • Increased blood pressure • Increased heart rate • Respiratory depression	• Delusions • Hallucinations • Hyperactivity • Sensory delusions

Source: Drugs and Behavior – Cause, Effects, and Treatment.[38] *Additional information on specific drugs and their effects can be found at http://www.drugabuse.gov/drugs-abuse.*

Alcohol

(ethanol – includes beer, wine, wine coolers, liquor, and liqueurs)

Street Names

Booze, hooch, brew, juice

Symptoms of Use

Odor on breath and skin, mild flushing, talkativeness, dulling of senses, dizziness, slurred speech, intoxication, hangover

Hazards of Use

Impaired judgment, reflexes, memory, and coordination; heart and liver damage; pancreatitis, peptic ulcers; malnutrition; neurological disorders; cancers of the mouth, stomach, and bladder; alteration of menstrual cycle

Appearance and Methods of Use

Liquid, usually legally available commercial preparations but sometimes illegal, homemade preparations ("moonshine"), and products containing alcohol (e.g., vanilla) when beer, wine, or liquor are not available

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

If a mother consumes alcohol during pregnancy, it can lead to:

- Miscarriage
- Stillbirth
- Low birth weight
- Preterm delivery
- Increased incidence of fetal distress at delivery
- Impact on brain development and facial changes (e.g., short palebral fissure)
- Sudden infant death syndrome[39,40]

Did You Know:

There is no "Safe" Consumption of Alcohol During Pregnancy!

No consumption of alcohol – either in a small amount, or at a particular time during pregnancy – is free of effects on a developing fetus. That's why the National Institute on Alcohol Abuse and Alcoholism,[41] the Centers for Disease Control and Prevention, and the American Academy of Pediatrics (AAP) all recommend that all pregnant women abstain from alcohol.[42]

Child

Children who are exposed to alcohol prior to birth can experience long-term cognitive, behavioral, social, and emotional developmental consequences; together, these are called Fetal Alcohol Effects. The extent of these effects can vary depending on both the amount of alcohol that was consumed by the mother and the timing of the exposure. In general, effects on the child can include:

- Weakness
- Decrease in linear growth
- Abnormal weight gain
- Facial abnormalities

What's more, once they reach adulthood, these children have a higher likelihood of developing somatoform disorders (mental disorders with physical symptoms), substance dependence, paranoia, passive-aggressive disorder, and antisocial and other personality disorders.[43]

About FAS and FASD

Fetal alcohol syndrome (FAS) is a **developmental disorder** that occurs in children of mothers who have high blood levels of alcohol during certain stages of pregnancy.[44,45] Given the wide range of potential effects, the term FAS has been expanded to fetal alcohol spectrum disorders (FASD). This updated term better addresses the wide range of symptoms associated with prenatal alcohol exposure that might not meet the FAS criteria above.[45]

Symptoms of FAS include:

- Facial abnormalities
- Growth retardation
- Central nervous system dysfunction, such as low intelligence or microcephaly
- Other anatomical abnormalities – for example, malformed eyes and ears

Breastfeeding

The AAP and the Dietary Guidelines for Americans (DGAs) recommend that nursing mothers minimize alcohol use. Additionally, the Scientific Report of the 2015 Dietary Guidelines Advisory Committee recommends that if a nursing mother does drink alcohol, to do so only if the infant's breastfeeding behavior is well-established, consistent, and predictable (no earlier than 3 months of age). In this case, a woman may consume a single alcoholic drink if she waits at least four hours before breastfeeding to minimize its concentration in the ingested milk. Alternatively, a woman may express breast milk before consuming the drink, and feed the expressed milk to her infant later (see The 2015 Dietary Guidelines for Americans/Key Definitions for Alcohol on page 23).

Potential consequences of use of alcohol during breastfeeding can include:

For the infant:

- Reduced motor development
- Reduced milk consumption
- Significantly less time in active sleep immediately after exposure to alcohol in human milk

For the mother:

- Decreased milk let down
- Decreased maternal prolactin response to suckling

Minimizing Alcohol Consumption if Breastfeeding

The AAP cautions that ingestion of alcoholic beverages should be minimized and limited to an occasional intake.[30] In addition, the DGAs recommends that those women who choose to drink do so only if the infant's breastfeeding behavior is well-established, consistent, and predictable (no earlier than 3 months of age). In this case, a woman may:

- consume a single alcoholic drink if she waits at least four hours before breastfeeding; or
- express breast milk *before* consuming the drink, and feed the expressed milk to her infant later.

The DGAs define one drink as: 12 fl oz. of beer (5% alcohol), 5 fl oz. of wine (12% alcohol), or 1.5 fl oz. of 80-proof distilled spirits (40% alcohol). Since not alcoholic beverages contain the same alcohol content, it is important to determine how many drink equivalents are in a beverage and limit intake. Alcoholic drink equivalents of select beverages can be found in Appendix 9 of the 2015-2020 DGAs.

Information and Referral:

If a screening test reveals that a woman is at severe risk or has a dependency on alcohol, or if she meets the diagnostic criteria for substance dependence or mental illnesses as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), it is recommended that she be referred for professional treatment.[46] Quitting at any time during pregnancy is beneficial.

Amphetamines

(includes dextroamphetamine and methamphetamine)

Street Names

Speed, uppers, pep pills, bennies, dexies, meth, crystal, black beauties, crank, ice, Skippy, the smart drug, vitamin R, roses, hearts

Symptoms of Use

Excessive activity, dilated pupils, decreased appetite, dizziness, sleeplessness, mood swings, irritability, confusion

Hazards of Use

Hallucinations; paranoia; psychosis; convulsion; irregular heartbeat; risk of HIV; stroke; heart failure; if injected, risk of viral hepatitis, abscesses, and other infections

Appearance and Methods of Use

Off-white powder sold loose or in capsules, tablets, or pills; ingested, smoked, or injected

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

Methamphetamine effects may resemble those of cocaine, including neurobehavioral deficits. The longer or more intense the exposure, the greater the impact on the neonate.[47] *Prenatal* amphetamine exposure leads to a significantly elevated risk for:

- Premature delivery
- Low birth weight
- Being small for gestational age[48]

Child

- Under-arousal
- Low tone
- Poorer quality of movement
- Increased stress[49]

However, the longer-term effects may be less pronounced by age 1 and resolved by age 3.[50]

Breastfeeding

The American Academy of Pediatrics considers maternal amphetamine use to be an absolute contraindication to breastfeeding. Use by the mother can cause the following effects on the baby:

- Irritability
- Extreme agitation
- Hallucinations
- Seizures
- Poor sleep patterns

Information and Referral:

Refer for assessment. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Quitting at any time during pregnancy is beneficial.

Cocaine and Crack

(cocaine hydrochloride and freebase cocaine)

Street Names

Cocaine: C, coke, snow, girl, toot, nose candy, blow, flake

Crack: Cloud 9, rock, cokesmoke, super white (Crack cocaine is a form of the drug that has been processed to make a rock crystal, which, when heated, produces vapors that are smoked.)

Symptoms of Use

Cocaine: Dilated pupils, elevated blood pressure, runny nose, rapid breathing, sleeplessness, restlessness; at later stages of use, irritability, unpredictability, paranoia, delusions, violent behavior, occasionally psychosis

Crack: Erratic mood swings (e.g., five minutes of elation followed by agitation and depression); hoarseness; parched lips, tongue, and throat

Hazards of Use

Cocaine: Ulcerated nasal passages; headaches; sudden death from cardiac arrhythmia or respiratory arrest; if injected, viral hepatitis, AIDS, abscesses, and other infections

Crack: Rapid addiction; irregular heartbeat; high blood pressure; respiratory problems (e.g., congestion, wheezing, black phlegm, chronic cough, impairment of lungs); brain seizures; radical changes in behavior and personality (e.g., extreme depression, irritability, short temper, social withdrawal, and violent or suicidal behavior)

Appearance and Methods of Use

Cocaine: White crystalline powder; inhaled through nasal passages, injected, or, less frequently, smoked

Crack: Light-beige pellets, crystal rocks, or dirty-white powdery chunks; smoked in a water pipe and vapor-inhaled

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

The most common outcomes associated with cocaine use during pregnancy include:

- Premature birth
- Respiratory distress
- Bowel infarctions (death of bowel tissue)
- Cerebral infarctions (death of cerebral tissue)
- Reduced head circumference
- Increased risk of seizures[22,44]
- Amniotic sac rupture more than one hour before labor begins[51]
- Separation of the placenta from the uterus prior to delivery[51]
- Increased risk of spontaneous abortion[51]
- Neurological abnormalities[51]

In addition, use of crack increases the risk of premature delivery, growth retardation, and reduced head circumference.

Child

Exposure to cocaine during fetal development may lead to subtle, yet significant, deficits in some children, including deficits in some aspects of cognitive performance, information processing, and attention to tasks – abilities that are important for the realization of a child's full potential.[52]

Breastfeeding

Cocaine and crack are excreted into breast milk in significant amounts. The American Academy of Pediatrics considers maternal cocaine or crack use to be an absolute contraindication to breastfeeding. These street drugs can be detected in human milk, and their use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development, and thus are contraindicated.[53]

Some of the effects on the infant include:

- Intoxication
- Diarrhea
- Rapid heart rate
- High blood pressure
- Seizures
- Vomiting
- Choking
- Agitation
- Irritability
- Jitteriness
- Increased startle reflex
- Negative effects on neurobehavioral development

Information and Referral:

Refer for assessment. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Quitting at any time during pregnancy is beneficial.

Hallucinogens

(includes PCP, LSD, mescaline, peyote, and psilocybin)

Street Names

PCP: Loveboat, hog, killer weed, angel dust, lovely, peace pill, superpot (when combined with marijuana)

LSD: Acid

Mescaline: Mesc

Peyote: Buttons

Psilocybin: Mushrooms, magic mushrooms

Symptoms of Use

PCP: Agitation and confusion; slowed movement; impaired coordination; constricted pupils; sweating; incoherent speech; hostile, aggressive, and unpredictable behavior

Other Hallucinogens: Time and reality distortions, visual and auditory illusions, occasional panic reactions, "bad trips," flashbacks

Hazards of Use

Chronic memory and speech problems, mood disorders, psychiatric disorders, hallucinations, convulsions, death

Appearance and Methods of Use

PCP: A liquid, white powder, pill, or capsule; taken orally, inhaled, injected, or smoked in cigarettes or with marijuana

LSD: Tablets or impregnated absorbent paper that can be licked; ingested orally

Mescaline: Tablets or capsules; ingested orally

Peyote (Cactus Buttons) and Psilocybin (Mushrooms): Natural materials; chewed and swallowed or smoked

Effects on Pregnancy, the Child, and Breastfeeding:

For the mother, hallucinogenic substances produce alterations in sense perception, including visual, auditory, and sometimes olfactory hallucinations.[44]

Fetus

There are little data regarding fetal exposure to hallucinogens, although it *may* include:

- Early motor delays might be associated with prenatal exposure[54]
- Adverse effects on the developing brain and behavior
- Congenital anomalies,[55,56] such as anatomical deformities.

Child

No information is available.

Breastfeeding

The American Academy of Pediatrics considers PCP use to be a contraindication to breastfeeding. This street drug can be detected in human milk, and its use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development, and thus is contraindicated.[57]

Information and Referral:

Refer for assessment. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. PCP users should be evaluated and monitored by skilled drug treatment specialists. Quitting at any time during pregnancy is beneficial.

Inhalants and Solvents

(includes volatile solvents and propellants)

Street Names

Glue, sniff, poppers, locker room, whippets, laughing gas, tywol

Symptoms of Use

Impaired judgment, vision, or memory; lack of coordination; light-headedness and disorientation; loss of appetite; nausea; fatigue, nasal inflammation; headache; intoxication; violent behavior; poor personal hygiene; slurred speech

Hazards of Use

High risk of sudden death by heart failure or suffocation; brain, liver, lung, and kidney damage; accidental injury to self or others

Appearance and Methods of Use

Vapors found in such products as gasoline, airplane glue, paint thinner, dry-cleaning solutions, and aerosol sprays; inhaled or sniffed, often with a paper or plastic bag or rag

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

Mothers exposed to inhalants while pregnant have been found to have a higher incidence of preeclampsia (a dangerous condition that includes maternal high blood pressure and protein in the urine) and spontaneous abortion (miscarriage) than mothers not exposed to inhalants.

There is an established connection between exposure to organic solvents during pregnancy (e.g., in the mother's workplace) and greater likelihood of:

- Central nervous system defects
- Malformed oral clefts
- Renal-urinary defects
- Sacral agenesis (abnormal development of the spinal cord)
- Gastrointestinal abnormalities

Child

- Higher rates of head and facial deformities
- Smaller-than-normal head and brain development
- Low birth weight
- Developmental delays[58,59]

A recent report notes that infants born to women who have recently used inhalants may experience an alcohol-like withdrawal syndrome.[60]

Breastfeeding

No information is available.

Information and Referral:

Refer for assessment. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Chronic inhalant abusers should be evaluated and monitored by skilled drug treatment specialists. Quitting at any time during pregnancy is beneficial.

Marijuana

(cannabis, delta-9-tetrahadocannabiono)

Street Names

Pot, grass, joint, weed, reefer, dope, herb, Acapulco gold, sinsemilla (a very strong variety); hashish or hash, made from the resin of the marijuana plant, is considered stronger than most marijuana, but usually not as strong as sinsemilla

Symptoms of Use

Sweet, burnt odor, bloodshot eyes, dry mouth, increased appetite, increased heart rate, lack of interest in appearance and personal hygiene, detachment from concerns of daily life

Hazards of Use

Difficulty paying attention; impaired memory; interference with learning; impaired coordination; negative impact on heart and lungs; menstrual irregularities and decreased ovulation for women and decreased sperm production and increased abnormal sperm production for men; cancer (contains more cancer-causing agents than tobacco)

Appearance and Methods of Use

Looks like dried herbs mixed with stems and small seeds; usually smoked in a hand-rolled cigarette, but may be eaten; sometimes mixed with PCP in a product called "superpot"

Effects on Pregnancy, the Child, and Breastfeeding:

The effects of smoking marijuana during pregnancy are different than the effects of tobacco.

Fetus

Several research studies have explored the effects of a mother's use of marijuana on her unborn child. To date, there have been no findings that fetal marijuana exposure leads to major growth or physical abnormalities in the fetus,[22] although smoking marijuana while pregnant can result in:

- A one-week-shorter gestation period[61]
- Visual abnormalities for the child[61]
- Ocular hypertelorism (widely spaced eyes) and severe epicanthus (skin folds at the corners of the upper eyelids) in instances where the mother smoked more than five joints per week while pregnant[61]

Child

Despite the lack of evidence for link between maternal marijuana use with specific physical anomalies, evidence that there is an increased risk of long-term neurological and behavioral consequences[22] is building.

Older children may demonstrate subtle effects, including:

- Impairment of attention, language, and learning skills
- Problems with behavioral regulation[62]

Breastfeeding

The American Academy of Pediatrics (AAP) considers marijuana use to be a contraindication to breastfeeding, particularly with regard to the infant's long-term neurobehavioral development.[53] In the infant, it can cause:

- Sedation
- Reduced muscle tone
- Poor sucking
- Delayed growth
- Delayed motor development

According to the AAP, marijuana can be detected in human milk, and its use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development, and thus is contraindicated.[57]

Information and Referral:

Refer for assessment. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Quitting at any time during pregnancy is beneficial.

About Medical Marijuana

Although some states have passed referenda (or legislative actions) legalizing marijuana for a variety of medical conditions upon a doctor's recommendation, marijuana has been shown to have negative effects on brain development; therefore, it is recommended that pregnant and breastfeeding women not use marijuana.

Opiates and Synthetic Narcotics

(includes heroin, methadone, dilaudid, morphine, codeine, meperidine, oxycodone, hydrocodone, and other opiates)

Street Names

Heroin: Junk, smack, horse, H, boy, mud, scag, black tar, China white, brown sugar

Methadone: Meth, hillbilly heroin, oxy, OC, oxycotton, percs, happy pills, vikes

Symptoms of Use

Drowsiness, constricted pupils, watery eyes, itching, decreased sensitivity to pain, needle marks, loss of appetite

Hazards of Use

Endocarditis; coma or sudden death from overdose; rapid addiction; risk of HIV; withdrawal (flu-like symptoms of cramping, nausea, chills, sweating); if injected, viral hepatitis, abscesses, and other infections

Appearance and Methods of Use

Heroin: A white-to-brown powder or tarlike substance; injected, smoked, or inhaled

Methadone and Other Opiate-Based Medications: Pill or liquid; ingested orally or dissolved in liquid and injected

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

Heroin is an illicit drug that can be injected, smoked, or snorted. Abrupt changes in a mother's daily heroin levels can lead to **fetal abstinence syndrome**. This increases the risk of:

- Low birth weight
- Stillbirth
- Sudden infant death syndrome (SIDS)[22,63]

Prescription opioids (non-opium-based pain management drugs that have opiate-like characteristics) – such as Vicodin, Narco, Perocet, morphine – have become widely used as a drug of abuse. These medications are associated with the same risks as heroin in terms of stillbirths and SIDS, and also cause Neonatal Abstinence Syndrome (NAS) [see Child section below].

Other opiates such as methadone and buprenorphine are prescribed for the treatment of opiate addiction (methadone is the only FDA-approved drug for the treatment of opiate addiction in pregnancy). They are also associated with NAS, but help women with their cravings and with avoiding high-risk behaviors.[64]

Child

As noted above, NAS can occur in infants prenatally exposed to opiates. Withdrawal symptoms associated with NAS can include:

- Abnormally high muscle tone
- Inconsolability
- Irritability
- Sneezing and stuffiness
- Excessive sucking or poor sucking ability
- High-pitched crying
- Serious central nervous system symptoms, such as seizures[22]

Some evidence exists for long-term effects of opiate exposure, including one study that has shown abnormal development of white matter (the tissue responsible for rapid conduction of nerve impulses in the brain) in children whose mothers used opiates during pregnancy.[22,65]

Breastfeeding

In 2017, the FDA required several changes to the labels of all prescription medicines containing codeine and tramadol, one of which was strengthening the warning to mothers on medication labels that breastfeeding is not recommended when taking these medicines due to the risk of serious adverse reactions in breastfed infants, including:

- Excess sleepiness
- Difficulty breathing
- Serious breathing problems that could result in death.[66]

A breastfeeding mother should talk to her doctor about pain medicines other than codeine or tramadol.

It is important to note that the American Academy of Pediatrics states that adequately nourished narcotic-dependent mothers can be encouraged to breastfeed if they are enrolled in a supervised methadone maintenance program and have negative screening for HIV and illicit drugs.[57]

A Special Note About Opiates

As you work with WIC participants, keep in mind that screening for opiates (for example, sedative narcotics) is becoming especially important, given the recent increase in availability of prescription opiate medications. (See Fetus section above for a list of common prescription opiate and opiate-like medications.)

Specifically, there has been an increase in **Neonatal Abstinence Syndrome (NAS)**, a postnatal drug withdrawal syndrome observed in infants born to mothers who used opiates during pregnancy. This increase is attributed to the widespread availability and diversion of prescription opiate medications.[67]

Information and Referral:

Refer for assessment. Do not advise a woman who uses narcotics to stop use on her own. This step should be taken only under the supervision of a physician or treatment specialist. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Quitting at any time during pregnancy is beneficial.

Sedative-Hypnotic and Anxiolytic Medications

(includes barbiturates, benzodiazepines, and sleep medications)

Trade Names and Street Names

Trade Names: Nembutal, Seconal, Valium, Xanax, Ativan, Dolman

Street Names: Downers, barbs, ludes, pills, yellow jackets, red or blue devils, reds, red birds, yellows, tooies, candy, sleeping pills, zombie pills, tranks, A-minus

Symptoms of Use

Retardation and loss of inhibition, impaired coordination and judgment, slurred speech, confusion, dilated pupils, drowsiness, mood swings, hangover

Hazards of Use

Impaired coordination; loss of appetite; nausea; vomiting; rapid addiction; dizziness; lethargy; anxiety; emotional depression and instability; blurred vision; death from overdose

Appearance and Methods of Use

Tablets or capsules; ingested orally, but sometimes dissolved and injected

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

Benzodiazepines used during the first trimester are associated with increased fetal malformations.[44] However, although the risk of fetal abnormalities occurring due to taking benzodiazepines is considered small,[44,68] the risk has been labeled as significant. Studies on the effects of barbiturate use during pregnancy on the developing fetus have had varied results.[44,]

Child

Withdrawal symptoms associated with prenatal benzodiazepine exposure are common and have been reported as late as three months after delivery.[71] These symptoms include:

- Restlessness
- Hypertonia (excessive muscle tone, causing stiffness)
- Hyperreflexia (involuntary nervous system reactions, such as spasms, heart rate changes, or skin color changes)
- Tremor
- Apnea (suspension of breathing)
- Diarrhea
- Vomiting

Breastfeeding

Use of these substances may lead to the following effects on the infant:

- Sedation
- Poor feeding
- Irritability
- Insomnia

Information and Referral:

Refer for assessment. Do not advise women who use sedatives, hypnotics, or tranquilizers regularly to stop or reduce use on their own. This step should be taken only under the supervision of a physician or treatment specialist. It is important to encourage/support a woman to stop drug use, but stopping will require support from a professional. Quitting at any time during pregnancy is beneficial.

Tobacco and Nicotine

(includes cigarettes, cigars, pipes, snuff, and chewing tobacco)

Street Names

Butt, smoke, cigs, chaw, quid, snuff, dip, chew, snus, hookah, bidi, cigarillos

Note: **electronic cigarettes** are another delivery mechanism for nicotine; however, at the time of this writing, they have not been well studied/approved by FDA for use in pregnant or breastfeeding women.

Symptoms of Use

Characteristic smell on clothing and breath, stained teeth and fingers, nervousness when not smoking

Hazards of Use

High carbon monoxide levels; emphysema; heart disease; stroke; cancers of lung, throat, and mouth; impaired fertility; impaired wound healing such as after giving birth; cavities; pneumonia

Appearance and Methods of Use

Smoked in cigarettes, cigars, and pipes; taken orally as snuff or chewing tobacco; sniffed through the nose as dry snuff

Effects on Pregnancy, the Child, and Breastfeeding:

Fetus

Carbon monoxide and nicotine in tobacco smoke can interfere with oxygen delivery to an unborn baby. In addition, harmful compounds in tobacco smoke can become concentrated in fetal tissues.[72]

Smoking during pregnancy can lead to:

- Slower fetal growth rate
- Increased risk of premature delivery
- Increased risk of respiratory problems for newborns
- Reduction in birth weight along with an overall increased risk of low birth weight
- Increase risk of placental abruption
- Increased risk of stillbirth
- Increased risk of infant mortality[72]

Mothers who are exposed to secondhand smoke while pregnant are also more likely to have babies with lower birth weights, which makes infants weaker and increases their risk for additional health problems.[73]

Child

When considering the effects of tobacco use on children, there are two parts to the equation. One is exposure via mothers who smoke while pregnant; the other relates to second-hand smoke.

Children of Mothers Who Smoked While Pregnant

Long-term consequences can include:

- Aggressive behaviors[74]
- Sleep problems[75]
- Potential for substance use later in life[76]

Children Who Inhale Secondhand Smoke

The U.S. Surgeon General designated secondhand smoke as "harmful and hazardous to the health of the general public and particularly dangerous to children."[72] It can lead to:

- Increase in wheezing and asthma (by at least 20%)[76]
- Increased risk and severity of otitis media (ear infection)
- Increased risk of allergies
- Higher incidence and severity of pneumonia, sudden infant death syndrome (SIDS), developmental delay, sleep disturbance, dental caries, and school absenteeism

What's more, infants and children are exposed to thirdhand smoke via toxic substances that remain on surfaces in the physical environment where someone has smoked. Thirdhand smoke has been identified as containing many of the same compounds as secondhand smoke (previous page) as well as some highly toxic compounds unique to aged tobacco smoke.[78,79] Finally, children of parents who smoke are more likely to grow up to be smokers.

Breastfeeding

According to the American Academy of Pediatrics (AAP), smoking by breastfeeding mothers is not an absolute contraindication to breastfeeding, but should be strongly discouraged because it is associated with an increased incidence in infant respiratory allergy and SIDS. Smoking should not occur in the presence of the infant, so as to minimize the negative effect of secondary passive smoke inhalation. Smoking is also a risk factor for low milk supply and poor weight gain.[57]

It can cause:

- Colic
- Reduced duration of breastfeeding periods
- Reduced breast milk production
- Reduced infant weight gain
- Increased incidence in infant respiratory allergy
- SIDS

Information and Referral:

Advise women to stop smoking or chewing tobacco. Quitting at any time during pregnancy or postpartum is beneficial. Refer women who have problems quitting to smoking-cessation programs. There are free tobacco-cessation quitlines in every state (1-800-QUIT-NOW). Smoke-free texting programs are increasingly available as well; see http://smokefree.gov/smokefreetxt/.

Selected Commonly Used Over-the-Counter (OTC) Medications

OTC medications are defined as substances that are "safe and effective for use by the general public" without seeking treatment by a health professional.[80] Whether OTC medications are considered safe during pregnancy (or at certain times during the pregnancy) depends on the specific medication.

Additionally, adverse reactions in infants from maternal OTC ingestion depend largely on the amount of milk consumed by the infant, timing of breastfeeding in relation to dosing, dose of the medication, dosing interval, and duration of therapy. When taking medications, breastfeeding mothers should be instructed to take their medication after breastfeeding, at the lowest effective dose and for the shortest duration.[33]

As a rule of thumb, if wondering about safety of specific medications or how often to use a medication that is generally considered safe, pregnant and breastfeeding women should check with their health-care professional. That being noted, general information on selected OTC medications follows.

Pain Medications

- **Acetaminophen** (such as Tylenol) is considered a pain reliever of choice during pregnancy[81] as well as breastfeeding.[81]
- **Aspirin** is not recommended except for special indications during pregnancy.[82,83,84] **Aspirin** has been associated with significant negative effects on some nursing infants, and the American Academy of Pediatrics recommends giving aspirin to nursing mothers with caution.[33]
- **Nonsteroidal anti-inflammatory drugs (NSAIDs)** such as **Ibuprofen**, **ketoprofen**, and **naproxen** are not recommended for use during pregnancy;[81] they should all be avoided in the third trimester. However, Ibuprofen (Advil, Nuprin, Motrin) appears to be the safest NSAID for breastfeeding women.[81]

Cough and Cold Preparations/Decongestants, Expectorants, and Antihistamines

Decongestants, expectorants, and antihistamines have not been well studied for use in pregnant women.[81] Additionally, mothers taking cough and cold products should watch for adverse events in their breastfed infants.

Antidiarrheal Agents

- Loperamide (Imodium®) is considered the antidiarrheal agent of choice during pregnancy and breastfeeding.
- The other most commonly used antidiarrheal agents are *not* recommended for pregnant and breastfeeding women. These include:
  - Kaopectate, made from kaolin (a clay), bismuth subsalicylate, and pectin (a plant-based gel)[81]
  - Pepto-Bismol® (bismuth subsalicylate)
  - Lomotil® (atropine/diphenoxylate)[81]

Caffeine

Although caffeine is not a medication per se, it is a psychoactive substance widely used by pregnant women.[85] Consumption during pregnancy is associated with:

- Increased risk of fetal growth restriction
- Increase risk of first-trimester miscarriage if consuming more than one cup of caffeine per day

The use of caffeine in a nursing mother remains controversial. Some sources claim that up to two cups of coffee per day will have no effect on the infant. Increased intake can lead to increased wakefulness and irritability in the infant, potentially leading to loss of sleep.[33]

Women of childbearing age should be advised to reduce caffeine intake before conception *and* throughout pregnancy.

Consuming coffee, tea, and caffeinated sodas *in moderation* is fine for breastfeeding women. If a breastfeeding woman feels that her infant becomes more fussy or irritable after consuming excessive amounts of caffeine (usually more than five caffeinated beverages per day), she should consider decreasing her intake. It is important for the women to not only pay attention to the amount of tea, soda, and chocolate consumed,[86] but also to other sources, including other beverages, foods, and medications.

Although most OTC drugs have an excellent safety profile, some have unproven safety or are known to adversely affect the fetus. The safety profile of some medications may change according to the gestational age of the fetus. Because an estimated 10% or more of birth defects result from maternal drug exposure, the Food and Drug Administration (FDA) has assigned a risk category to each drug (see FDA Drug Labeling Requirements on page 28 earlier in this chapter).

CHAPTER IV

Developing Information, Education, and Referral Activities

This chapter includes the steps that local agencies may want to consider in designing and implementing substance use- and abuse-related information and referral activities and staying current in their efforts. This chapter may also be useful to those agencies who wish to reassess and redesign their current efforts to ensure that their activities meet their participants' needs.

- Reviewing WIC Clinic Resources
- Planning Your Screening, Information, and Referral Components
  - Screening Component
  - Information Component
  - Referral Component
- Developing Information Activities
- Motivations for Reducing or Stopping Substance Use
- Arranging Staff Training and Support
  - Staff Training
  - Staff Support
- Using Appropriate Educational Materials
- Using Appropriate Staff Training Materials
- Evaluating Prevention, Screening, and Education Components
- Scheduling Regular Review of Practices
- Staying Up to Date with Current Research

Reviewing WIC Clinic Resources

Consideration of facilities, timing, and choices of setting are all part of planning educational activities. Staff may find the following Q&A to be helpful as they plan to incorporate the substance use–related information and referral activities into the WIC Program.

Where in the WIC clinic can education discussions/activities be conducted?

Some printed materials, such as bulletin boards, audiovisuals, and posters, can be displayed in the waiting room. A computer kiosk could also be set up. One-on-one sessions are effective for providing information, assessing the participant's understanding of information, and conducting screenings and referrals. Additionally, rooms or cubicles where confidential screening and referral activities can be conducted are desirable.

How much time will be needed?

The staffing, participant flow, and facilities at each local agency will affect the amount of time that can be devoted to providing information to participants. Substance use information may be incorporated into participant nutrition education. Screening may be integrated into the nutritional assessment performed during the certification process.

What educational materials are needed for participants and staff? How can they be obtained?

Consider the types of materials that WIC staff and participants find most desirable and effective. Possible materials may include handouts, DVDs, questionnaires, worksheets, posters, or online sites. Appendices 1: Training Materials and Resources for WIC Staff, 2: Education Materials for WIC Participants, and 3: Additional Links and Resources (beginning on page 85) in this Guide can assist in locating materials and sites with downloads available; consider how many copies of printed materials will be required for a specified time period.

Who is most appropriate to conduct the activities?

Decide on the necessary qualifications for each person conducting a specific activity and determine who, among available staff, might be appropriate. For example, consider whether a registered dietician is desired for participation in nutrition education activities, or if a trained paraprofessional can assist in education sessions instead. Consider what training is needed and whether a community resource is available for providing this training.

In some situations, special graduate school internships, State training assistance, or training by personnel from a related social service agency may be possibilities.

Planning Your Screening, Information, and Referral Components

Once the general outlines for the screening, information, and referral activities are developed, the next step is to develop a specific implementation plan. This usually entails:

- Listing, in sequence, the tasks that need to be completed and who will be responsible for each;
- Identifying helpful information sources or needed resources;
- Noting any special considerations, such as needed approvals; and
- Specifying a time for completion.

A list of tasks for each activity might include the following, as an example:

Screening Component

1. Determine from WIC State agency guidance whether substance use screening is to be performed and, if so, what level of screening is required. Keep in mind that, if screening is performed, it must be reasonably related to the referral requirement in order to be counted as an allowable WIC cost.
2. Examine sample screening tools.
3. Select questions appropriate to program participants and revise current screening questions or incorporate new questions.
4. Train staff to conduct the basic substance use screening.
5. Pilot-test the substance use screening procedure.
6. Revise the substance use screening procedure, as necessary.
7. Evaluate the procedure at least annually.

Information Component

1. Decide what educational activities can reasonably be undertaken.
2. Select materials to supplement ongoing nutrition education sessions and meet any special needs identified among participants.
3. Identify and train staff to conduct the information activities.
4. Review any problems after the first several sessions and make necessary revisions.
5. Plan regular evaluations by both staff and participants.

Referral Component

1. Review WIC State agency guidance to determine referral protocols. If formal/active referrals are to be provided, develop procedures for carrying them out – including appropriate documentation requirements and the designation of staff to make referrals (see chapter VII).
2. Review and contact the local community counseling and treatment network for information on substance use problems in similar target populations.
3. Compile a list of local substance use–related community services. Develop a resource directory and a process for ongoing recording and filing of information for the directory.
4. Select a primary resource for referral for assessment.
5. Arrange staff training, as appropriate (see the next section for information on staff training).
6. Implement referral procedures and review after first few weeks.
7. Continue evaluation of referral efforts.

These three tasks – screening, providing information, and referrals – are discussed individually as follows: chapter V: Screening, chapter VI: Providing Information, and chapter VII: Referrals.

Developing Information Activities

In addition to thinking about the *content* of prevention messages for participants, it is also important to consider *how and when* to provide substance-related information. Existing procedures and resources largely determine what can be attempted. Even within the time and staff constraints of most local WIC agencies, however, a number of choices can be made.

Some suggestions adapted from The U.S. Department of Health and Human Services' *Healthy Mothers, Healthy Babies: A Compendium of Program Ideas for Serving Low-Income Women*[87] may help in designing informational activities. Ideas and suggestions from this compendium follow.

Do not rely only on printed posters and handouts to convey substance use/abuse prevention messages. Supplement them with personal instruction and encouragement.

The most effective methods for communicating information to low-income women, in order of effectiveness, are (1) individual face-to-face contacts, (2) classes, and (3) audiovisual materials. Although printed materials are the least effective approach as a stand-alone method of providing information, they can be used in face-to-face discussions to reinforce the information and they can serve as useful references for discussions with other family members. Audiovisual or written materials should be used as an accompaniment to personal contacts.

Make a creative use of participants' time when designing information activities.

Consider ways to make use of participants' time as they are waiting for WIC services. For example, this "time window" can provide an opportunity to participate in conversations; view DVDs, bulletin boards, or Web pages; read pamphlets; or engage in other health promotion activities.

Incorporate information about the consequences of maternal substance use with discussions about nutrition, pregnancy outcomes, and other related issues.

Educational approaches that integrate prevention messages with more general health promotion issues (e.g., how to have a healthy pregnancy, stress reduction during and after pregnancy, nutritional problems related to substance use) are more effective than approaches that focus on the single issue of substance use. Weaving the discussion into an information session about nutrition, one of WIC's core topics, may be especially successful.

Plan ways to engage participants in prevention activities. Do not wait for them to ask questions or raise issues.

Some women may be reluctant to ask questions. Although participants may be interested in prevention, they may be hesitant to seek advice or start discussions about personal problems. Participants can be involved in setting discussion agendas, evaluating the relevance of prevention information to their personal lives, or identifying issues of particular interest. This can be accomplished through a survey or evaluation form given out after nutrition education classes. A question could also be added to a Participant Nutrition Education Needs Assessment form to identify areas of interest.

Stress the importance of making personal commitments and taking immediate, realistic steps to achieve healthier goals.

For women who are drinking, using drugs, or both during pregnancy, place more emphasis on motivation for improving health (*see also:* Emotion-Based Messaging on page 63). Women may already be familiar with guidelines regarding substance use and prenatal care, but are not following recommended practices.

Providing practical information on quitting or reducing substance use is helpful. Addicted women, however, may be knowledgeable about the risks and still not stop; they need additional help, and may benefit from a formal/active referral.

Make certain that prevention information is appropriate for participants' interests and literacy levels.

Some of the available digital and printed materials about substance use may be too complicated for participants. Additionally, participants will likely not relate to situations depicted that are too distant from their life experiences. Therefore, choosing or developing materials that provide relevant and familiar examples, practical suggestions, and information in everyday language is important. Gear all written materials toward a low literacy level and provide information that is culturally relevant and sensitive as well as gender sensitive. (See appendix 3: Additional Links and Resources [under the Developing Education Materials section], appendix 5A: Sample Education Material Evaluation Form for Staff, and appendix 6: Guidelines for Developing Education Materials.)

Deliver continuous and consistent prevention messages reinforced through multiple types of media materials.

Health promotion messages that are repeated through a variety of media such as pamphlets, posters, and DVDs can help ensure that consistent messaging. Staff can convey these messages about substance use/abuse prevention to participants and incorporate similar information into various WIC services. This ensures that the prevention effort is sustained in an ongoing, continual manner, rather than a one-time-only campaign.

Make the most of participants' trust and respect for WIC staff.

WIC staff have direct contact with participants and are generally highly regarded by them. Good rapport has usually already been developed between the staff and participants. WIC staff have the opportunity to leverage this rapport when having frank discussions about substance use, broaching these difficult topics in a nonjudgmental manner.

Motivations for Reducing or Stopping Substance Use

The mere conditions of being pregnant, breastfeeding, or parenting a child may increase the motivation to stop using substances of abuse. These increased concerns of pregnant and postpartum women can provide a teachable moment – giving you an important window of opportunity during the prenatal and postnatal periods.[88]

As you work with WIC participants and seek opportunities for opening a dialogue to have meaningful conversations about substance use, it's helpful to know about typical motivations for reducing or stopping substance use. In general, these may include:

- Concerns about the health of her infants and children
- Concerns about the mother's own physical and mental health
- Concerns about the financial cost of substance use
- Pressure from family, friends, employers, the legal system, and child protection services[89]

In the case of pregnant and postpartum women in particular, the motivations for stopping substance use can be even greater than for the general population. Motivations for pregnant/postpartum women can include:

- Fear that substance use not only impacts her health, but also the health of her unborn baby or her child[90,91]
- Potential increased financial stress brought on by the addition of a child
- The wish to provide a healthy environment for the fetus/child
- A desire to not let the child to know about smoking or drug use
- Perceived substantial social pressure[92,93]

In addition, a mother's identity as a provider and/or role model to her child or children is likely to motivate her to reduce or stop substance use.[93]

Arranging Staff Training and Support

Staff Training

Effective staff training entails careful planning. It is helpful to take these aspects into consideration:

- The most appropriate level of training;
- The most appropriate target audience for each training session;
- The best-qualified available trainers to conduct the sessions; and
- The most appropriate times and places for the training.

WIC local agencies may want to provide staff training in the following areas:

- The reproductive consequences of maternal substance use;
- Provision of substance use/abuse prevention information to participants;
- The mechanics of the screening process; and
- The mechanics of the informal/passive and formal/active referral processes.

Regular staff meetings provide opportunities for continuing in-service training (e.g., by having staff share effective techniques, correct mistakes, and enhance skills). Staff can also learn from training sessions by representatives from other community services, including substance use and/or abuse prevention and treatment services, and from other published sources (see appendix 1: Training Materials and Resources for WIC Staff and appendix 3: Additional Links and Resources [under the Training Information/Programs on the Effects of Substance Use section]).

Staff Support

In local agencies where participants are heavy substance users and are difficult to reach and refer, staff may become discouraged. Staff meetings to discuss feelings, review procedures, and suggest improvements can help. Guidance from an outside expert in mental health may be useful in setting up and conducting such meetings.

Using Appropriate Educational Materials

There is a wide variety of educational materials that already exist and are available for use with WIC participants. Appendix 2: Education Materials for WIC Participants reviews a selected list of published materials from various government and other entities. When reviewing these and other materials, there are certain considerations that can help you determine which will work best for your needs.

Appendices 5A and 5B contain sample evaluation forms (for both staff and participants) that include aspects to consider when determining whether an education material is appropriate for your agency. Appendix 6: Guidelines for Developing Education Materials also provides guidelines for developing new materials.

An additional resource for developing education materials is the WIC Works Resource System; search under Nutrition Education as well as for key words, such as "health literacy," "plain language," and "assessing written materials." WIC Learning Online also serves as a resource for developing education materials through the online course and accompanying job aids.

In addition to the considerations covered in appendices 5A, 5B and 6, a few other aspects to consider when selecting materials for participant education include the following:

Self-Help Format

Research has shown that materials that guide a participant to change nearly *double* the odds of quitting smoking, compared with standard care.[94]

Electronic Materials

Computer-delivered formats have a number of advantages.[95] These include:

- Greater ease of dissemination and replication;
- Cost-effectiveness;
- Anonymity (reduced-confidentiality issues);
- Accessibility;
- Personalization.

Child-Focused

A recent study reported that educational material that highlights the negative effects of smoking on the health of a *child* in a family of smokers was more effective than material that highlighted the negative effects of smoking on *parent* smoker(s).[96]

(Also see: chapter VI: Providing Information for additional considerations.)

Using Appropriate Staff Training Materials

For those who do *not* specialize (nor are trained) in addiction treatment and do not have professional counseling credentials, it can be intimidating or challenging to perform activities related to substance abuse prevention. However, there are several resources that provide training and guidance on this topic. A number of these are listed in appendix 1: Training Materials and Resources for WIC Staff, along with information regarding how to access each of them.

Several Federal government agencies and well-respected organizations also offer Brief Intervention self-training resources that your agency can utilize (although the materials were not designed for use with pregnant or postpartum women, the tools take into account the limited time available for screening and intervention activities and, therefore, can be adapted for a WIC setting). Some examples include:

- *The American College of Surgeons Committee on Trauma Quick Guide* offers self-training resources, practice guidelines, and general information.[97]
  https://www.facs.org/~/media/files/quality%20programs/trauma/publications/sbirtguide.ashx
- The World Health Organization offers a manual entitled *Brief Intervention for Substance Use: A Manual for Use in Primary Care*[98] that can be used as a self-training tool.
  http://www.who.int/substance_abuse/activities/assist/en/
- The National Institute on Drug Abuse (NIDA) *Screening for Drug Use in General Medical Settings Resource Guide.*[99]
  https://www.drugabuse.gov/publications/resource-guide/preface
- The Substance Abuse and Mental Health Services Administration (SAMHSA) quick guide for clinicians, entitled *Brief Interventions and Brief Therapies for Substance Abuse.*[100]
  http://162.99.3.213/products/manuals/tips/pdf/TIP34.pdf.

Evaluating Prevention, Screening, and Education Components

Evaluation is an important component of any program, project, or process. It helps assess progress toward attainment of goals and objectives (compared to prior years, if applicable) and it provides information on the effectiveness of intervention methodologies and obtains suggestions for future interventions.

In evaluating substance use prevention information, screening, and referral efforts, WIC agencies can answer questions on how services are delivered, the quality of service, and the impact on program participants. Two main types of evaluation can be conducted:

- A **process or implementation evaluation**, which provides detailed information on the execution of an activity or program; or
- An **impact or outcome evaluation**, which considers the effects of an activity or program.

A **process evaluation** attempts to answer questions such as:

- Were components and procedures implemented as intended?
- How many participants received printed materials about the dangers of substance use during pregnancy, breastfeeding, and parenting?
- How many participants viewed an educational DVD?
- How do participants respond to the substance use/abuse prevention materials?
- What proportion of screenings raises the possibility of substance use?
- How many referrals for further assessment were made?
- What types of referral resources were suggested?

Impact evaluations try to answer questions such as:

- Do the substance use prevention activities increase participant knowledge about the dangers of using various substances during pregnancy and breastfeeding?
- Do the substance use prevention activities influence participants to obtain help with an alcohol, tobacco, or other drug problem?
- Do the substance use prevention activities increase the number of participants who stop smoking, drinking, or using other drugs during pregnancy?
- Do the substance use prevention activities increase the number of participants who cut down on smoking, drinking, or using other drugs during pregnancy?

A **program evaluation** can contain elements of both process and impact evaluations. Three activities that may be evaluated are:

- **Screening** of participants to determine potential or suspected substance use;
- **Provision of information** to participants on the dangers of substance use before conception, during pregnancy, and while breastfeeding; and
- **Referral of participants** who request help or whose screening results suggest the need for further assessment of their substance use and who may need additional counseling or treatment.

Relevant information to help evaluate whether or not these activities have been successfully implemented can be collected in several ways. Self-administered questionnaires, formal interviews, observations, and administrative record data extractions are all acceptable ways to obtain information. Information from a program perspective may be obtained by having staff complete checklists or questionnaires. To collect information from participants, questionnaires may suffice. For samples of instruments that may be used to collect data from WIC staff and participants, see appendix 7: Sample Data Collection Instruments.

Scheduling Regular Review of Practices

To stay current with your activities and processes, a flexible approach is recommended. At regular intervals, try to:

- Review the effectiveness of your screening, information, and referral practices;
- Discuss staff preferences for screening and referral strategies and options with others at your agency;
- Reexamine the selection of suggested screening tool options and available materials;
  - See appendix 1: Training Materials and Resources for WIC Staff and appendix 2: Education Materials for WIC Participants
  - Visit the WIC Works Resource System: https://wicworks.fns.usda.gov/
- Check out new research about effective screening and referral for substance use, including new delivery mechanisms based on changing technology;
- Update your screening and referral processes as needed.

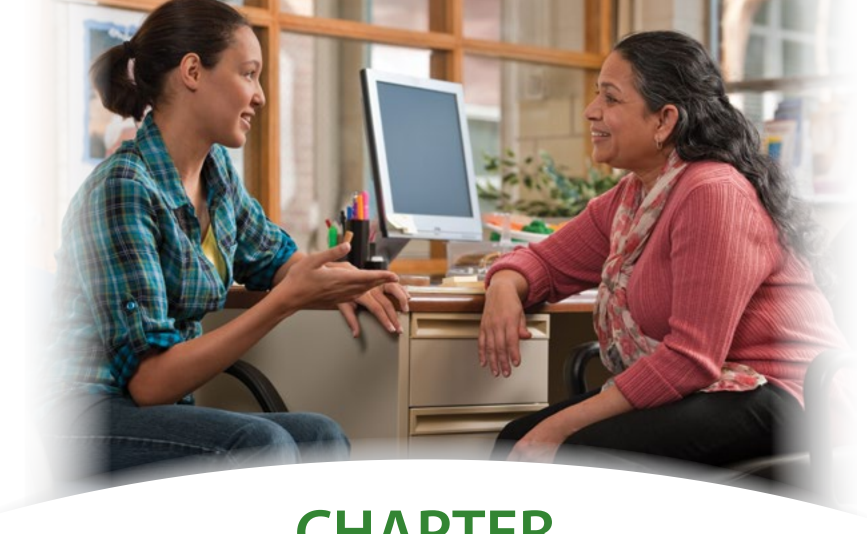
Staying Up to Date with Current Research

Research on substance use and its prevention is ongoing. Additionally, the types of substances used and the popularity of substances within demographic groups change over time. Staying informed is a good way to make sure your approach and messages are accurate and relevant to your participants.

You can stay current with changing trends and information by:

- Periodically visiting reliable online resources, such as:
  - National Institute on Drug Abuse (NIDA):
    http://www.drugabuse.gov/
    http://www.drugabuse.gov/related-topics/trends-statistics
    http://www.drugabuse.gov/nidamed-medical-health-professionals
    https://www.drugabuse.gov/publications/medical-consequences-drug-abuse/prenatal-effects
  - Substance Abuse and Mental Health Services Administration (SAMHSA):
    http://www.samhsa.gov/prevention/
  - National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism (NIAAA):
    http://www.niaaa.nih.gov/
  - Centers for Disease Control and Prevention (CDC):
    http://www.cdc.gov/alcohol/index.htm
    http://www.cdc.gov/alcohol/resources.htm
    http://www.cdc.gov/Features/FASD/
  - National Center on Addiction and Substance Abuse at Columbia University:
    http://www.centeronaddiction.org/
  - WIC Works Resource System:
    https://wicworks.fns.usda.gov/
  - Subscribing to press releases for health-related government entities, such as the U.S. Department of Health and Human Services alerts on new developments and Web resources:
    http://www.hhs.gov/about/news/index.html

- Conducting periodic searches to discover new developments. For example, you can utilize the free PubMed search engine at the U.S. National Library of Medicine/National Institutes of Health: http://www.ncbi.nlm.nih.gov/pubmed. When searching, use keywords like "substance use" or "substance use prevention" combined with "pregnancy" and/or "breastfeeding."



CHAPTER V

Screening Participants for Substance Use

This section discusses the screening of participants as a first step, to be followed by the provision of information and making referrals.

- Introduction
- Substance Use Screening
- Considerations for Conducting Screening
  - Screening and Brief Intervention When Time is Limited
  - Question Approaches for Conducting the Screening
  - Approaches for Conducting the Screening
  - Tips for Including Screening in Everyday Practice
- Screening Methods: Selecting or Developing Standard Screening Questions
  - Specific Content of Questions
  - Number of Questions Asked
  - Sample Screening Instruments
    1. T-ACE
    2. TWEAK
  - Additional Screening Tools Not Tested with Pregnant Women
    1. NIDA Quick Screen
    2. NIDA ASSIST
  - Sequence of Questions
  - Format of the Screening Tool
- Setting the Stage for the Screening Interview

Introduction

Although not specifically required, WIC local agencies are in a position to conduct basic substance use screening, particularly for eligible pregnant women, because they discuss nutritional behaviors and related health risks during certification. In fact, some State agencies consider alcohol, tobacco, and other substance use by pregnant women to be a nutritional risk criterion and already include some basic screening as part of the medical or nutritional assessment.

As previously discussed, though screening WIC participants for substance use is well within the Congressional mandates, the legislation does not require the WIC Program to screen participants for substance use; however, some very basic screening may be necessary to effectively fulfill WIC's substance use information and referral responsibilities.

Also keep in mind that some WIC agencies are co-located with other health services where participants are screened for substance use, and the results may be included on the medical record accompanying a referral to WIC. Such co-located WIC agencies would not need to screen, because they would duplicate services already provided.

Substance use screening, education, and referral activities are allowable WIC administrative and program services costs. If WIC State agencies determine that screening is necessary, however, it must be limited to the extent that it is reasonably related to WIC's substance use/abuse information and referral responsibilities. Screening, if required, must be integrated into the medical or nutritional assessment performed during a participant's certification process. WIC local agencies need to consult their State agencies to determine which screening questions are most appropriate and how these might be incorporated into the certification process.

Substance Use Screening

The term "screening" is used purposefully in this Guide instead of the term "assessment." This is because the two procedures are distinctly different.

- Screening is not intended to diagnose, but to detect warning signs of substance use and to uncover potential problems. Screening is not definitive, and should be followed by education and a referral for assessment, if appropriate.
- The assessment process is an in-depth evaluation of the extent of an individual's substance problems and should be conducted by a professional trained in substance use/abuse counseling and treatment.

The basic screening activity provided by a WIC local agency can be an important service. Screening helps focus attention on potential problems that might otherwise be overlooked. Participants whose screening results suggest that they may be at risk for continued use while pregnant or breastfeeding, or at risk for a substance use problem, should be provided with a list of resources to secure services on their own or formally/actively referred by staff for further assessment (see chapter VII: Referrals).

For information on legal issues related to screening, see appendix 8: Legal and Confidentiality Issues.

Considerations for Conducting Screening

As previously stated, screening is not required to meet the mandated referral obligations. Screening, however, can assist the local agency in identifying participants in need of follow-up information and referral(s). If screening is performed, it must be reasonably related to the referral requirements in order to be counted as an allowable WIC cost. Before selecting or developing substance use screening questions, it is suggested that WIC agencies consider when, where, how, and by whom screening will be conducted.

Health-care professionals working with high-risk pregnant women uniformly report that these patients provide the most honest and accurate answers if screening is embedded in a routine medical history or in the context of other questions about nutrition, exercise, and health habits. Including substance-related questions in the certification process for all WIC participants avoids any possibility of stigma and is less threatening.

Screening and Brief Intervention When Time is Limited

For those agencies implementing a screening process to facilitate referral requirements, it is important to choose a process that is feasible and practical for a WIC setting. Given WIC's target population, training constraints for WIC staff, and time constraints for both participants and WIC staff, Screening and Brief Intervention (SBI) is a practical approach for WIC agencies.

Using SBI with pregnant and postpartum WIC participants enables you to identify – and potentially reduce – their use of hazardous substances. Brief interventions (BI) can be given in a matter of minutes, and they require minimal follow-up. In addition, BI is designed to be provided by those who do *not* specialize (nor are trained) in addiction treatment or have professional counseling credentials.

The process includes:

1. Screening of WIC participants to **identify those at risk** for – or meeting criteria for – substance use disorders;
2. Providing **educational information**;
3. Performing a BI that includes **personalized feedback** regarding the screening results;
4. Providing **referrals** for further evaluation and/or treatment when appropriate.

WIC staff can find more information about screening and BI at http://www.cdc.gov/features/alcoholscreening/index.html and http://pubs.niaaa.nih.gov/publications/AA66/AA66.htm, and in appendix 3: Additional Links and Resources (under the Information & Tips on Screenings and Referrals section).

Question Approaches for Conducting the Screening

Screening instruments can be used by interviewers, participants (self-administered), or a combination of these two approaches. The most truthful answers may result from screening questions in a self-administered questionnaire that is completed by the WIC participant in private.[101,102]

- **Self-Administered Screening Questions:** The option of self-administration may be followed by a personal staff interview. For a Sample Health Questionnaire that was designed for use as a screening self-test, see appendix 11: Sample Health Questionnaire.
- **Screening by Interview/Observation:** Direct questioning, while observing reactions, gives the interviewer an opportunity to repeat and rephrase any items that a participant does not understand, as well as a chance to probe for more information. An interviewer can also summarize the findings immediately for clarification and engage the participant in deciding what additional and appropriate actions are necessary.

Approaches for Conducting the Screening

The staff members who conduct substance use screening during the certification process should pose questions related to substance use in a straightforward, nonthreatening, and nonjudgmental way. No indication of surprise or moral indignation should ever be displayed by staff, whatever the responses given.

The Boston University School of Public Health BNI ART Institute (BNI =Brief Negotiated Interview; ART = Active Referral to Treatment) offers a series of videos demonstrating SBIRT (Screening, Brief Intervention, and Referral to Treatment). These videos emphasize current use rather than substance use history and are not specific to pregnant or postpartum women; however, they include how to screen and pose questions related to substance use in a straightforward, nonthreatening, and nonjudgmental way. SBIRT has the potential to be a suitable model for identifying WIC participants at risk for substance use problems and delivering a brief substance use intervention or referral to treatment in prenatal clinics across the country.

Although the videos take place in a clinical setting, the approach used in them is relevant and can be adapted to the WIC Program. These informative videos can be found at: http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/. (Note: the first video listed on this site shows what not to do.)

Special staff training for substance use/abuse–related screening may be obtained from such sources as local Employee Assistance Programs (EAP), prenatal clinics, and substance treatment programs. An EAP is a service offered by many employers that provides assessment, referral, and short-term counseling to employees for mental health and substance abuse problems.

Tips for Including Screening in Everyday Practice

1. Use common areas to cue participants to think about substance use.
   a. Posters and displays
   b. Bulletin board with notices about referrals
   c. Newsletters
   d. Leaflets and education material on display
2. Include health information in participant records/files.
   a. Particular health-related needs
   b. Whether a screening (such as T-ACE questions) has taken place; if so, include score and what the score means, if applicable
3. Update the participant's record to indicate if and when a screening has occurred. For example, place a sticker on the participant's record or update the participant's electronic record by notating substance use screening on the participant's list of potential problems.
4. Implement reminder systems. These systems can be used to:
   a. Invite participants to have a screening interview;
   b. Prompt WIC staff to administer screening;
   c. Invite participants for post-screening follow-up, if needed;
   d. Remind WIC staff when next the screening may be due.

Screening Methods: Selecting or Developing Standard Screening Questions

Several methods can be used for determining participants' patterns of substance use. Some combination of the approaches discussed in this section may be appropriate. Using standard questions facilitates screening for staff and speeds up the process. To help determine which questions are most appropriate, consider the factors outlined below.

Specific Content of Questions

To determine participants' patterns of substance use, most screening instruments contain questions in the following three categories:

1. *History and duration of substance use:* covers past, recent, and current use. Questions determine which, if any, drugs the participant has ever used, how chronic her use is, and the combinations of substances usually taken together or sequentially.

   Do you ever use _________? or

   Have you used _________since becoming pregnant? or

   How old were you when you first used _________? or

   Did you use _________when you were already pregnant but before you knew *you were pregnant?*

2. *Usual frequency and patterns of use:* tell whether the participant uses a substance daily, weekly, or only on rare occasions. Questions of this nature, along with those about quantity, can identify binge or other patterns of use. Some participants, for example, typically drink until drunk, or smoke cocaine until the supply is exhausted.

   How often do you usually use _________? Ever use it more often?

3. *Usual quantity (dose) used:* is expressed in whatever terms are most standard (packs of cigarettes, bottles of beer, glasses of wine, numbers of joints).

   How much ________do you usually use per occasion? Ever use more?

Before informally suggesting referral resources for the participant to contact on her own or making a formal/active referral, staff need to know whether a participant suspected to have substance problems is already in treatment. Staff also need to know whether a pregnant participant is currently receiving prenatal care.

Number of Questions Asked

Conducting substance use screening need not be time-consuming. First, not all the questions about every drug will need to be asked of every participant. Many participants, for example, may use no drugs at all. Some participants may use only cigarettes or alcohol, or both.

Sample Screening Instruments

There are several simple instruments that are available for screening for substance use that consist of 10 or fewer questions and can be administered quickly.

1. T-ACE

T-ACE was developed in 1989, specifically for assessing alcohol use/risk drinking among pregnant women.[103] T-ACE detects all levels of drinking, including social drinking. The brief format of T-ACE makes it well suited for use in WIC clinics. T-ACE is an acronym for:

- Tolerance to alcohol;
- Being Annoyed by others' comments about drinking;
- Attempts to Cut-down;
- Having a drink first thing in the morning – Eye Opener.

T-ACE takes only one minute to administer and has been found to be a useful screening approach.

T-ACE Questions	Score
T How many drinks does it take to make you feel high (TOLERANCE)?	2 if more than two drinks
A Have people ANNOYED you by criticizing your drinking?	1 if positive
C Have you felt you ought to CUT DOWN on your drinking?	1 if positive
E Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)?	1 if positive
If a woman's total score is 2 or more, a more detailed history should be pursued.	

Robert J. Sokol, M., Susan S. Martier, MSSA, CSW, and Joel W. Ager, PhD, Department of Obstetrics-Gynecology, Wayne State University School of Medicine, 4707 St. Antoine Blvd., Detroit, MI.[103]

The Seattle Health and Pregnancy Project reported that positive answers to only two screening questions identified 80% of the pregnant women who were later assessed as problem drinkers:[103]

- Do you ever take five or more drinks on any single occasion?
- Do you have the feeling that you should decrease your alcohol use?

2. TWEAK

Like T-ACE, TWEAK assesses alcohol use, and has been evaluated for use with pregnant women.[105,106] TWEAK is a measurement of:

- alcohol Tolerance;
- the degree to which friends or family are Worried;
- drinking as an Eye-opener;
- Amnesia or blackouts while drinking;
- K for trying to cut down.

TWEAK Questions	
T: Tolerance	How many drinks can you hold?
W: Worried	Have close friends or relatives worried or complained about your drinking in the past year?
E: Eye-Opener	Do you sometimes take a drink in the morning when you get up?
A: Amnesia	Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
K (C): Cut down	Do you sometimes feel the need to cut down on your drinking?

TWEAK questions can be found online at: http://pubs.niaaa.nih.gov/publications/arh25-3/204-209.htm

Additional Screening Tools Not Tested with Pregnant Women

There are two additional screening tools that may be helpful: National Institute on Drug Abuse (NIDA) Quick Screen and ASSIST. It is important to note that NIDA Quick Screen and ASSIST have **not been evaluated for use with pregnant women,** but WIC staff may find them to offer helpful approaches or idea-starters for screening planning and adaptation.

1. NIDA Quick Screen

The NIDA Quick Screen is located online. As noted, it has not been tested among pregnant women. It consists of a single-question screening tool to assess alcohol, tobacco, and drug use. The NIDA Quick Screen screening question is: "How many times in the past year have you used an illegal substance or used a prescription medication for nonmedical reasons?"

This single-question approach has been shown as an effective method for screening.[107] (Again, this method has not been specifically tested with pregnant women.) If a participant answers "yes" to any component of the question, a longer and more comprehensive screening tool can be administered.

Time required for training and administration of this instrument is brief.[108]

NIDA Quick Screen Steps
• Introduce yourself and establish rapport • Remind participant of confidentiality • Ask participants about past substance use • If the participant answers "yes," begin the NIDA-Modified ASSIST • Determine risk level
Access the NIDA Quick Screen via: **Web site:** http://www.drugabuse.gov/nmassist/ **PDF:** http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

2. NIDA ASSIST

ASSIST is an acronym for Alcohol, Smoking, and Substance Involvement Screening Test. This Web-based interactive tool guides clinicians through a short series of screening questions and, based on the patient's responses, generates a substance involvement score that suggests the level of intervention needed.

ASSIST Approach	
The NIDA ASSIST screening tool explores the following: • Use of substances in your lifetime • Use and consequences in the past three months • Concern expressed by others • Attempts to cut down or stop usage	
Specific ASSIST Questions (Qs) cover these topics:	
Q1:	Asks about which substances have ever been used in participant's lifetime
Q2:	Asks about frequency of substance use in past three months
Q3:	Asks about frequency of experiencing strong desire to use each substance in past three months
Q4:	Asks about frequency of health, social, legal, or financial problems related to substance use in past three months
Q5:	Asks about frequency with which use of each substance has interfered with role responsibilities in past three months
Q6:	Asks if anyone else ever expressed concern about use of each substance, and, if so, how recently
Q7:	Asks whether woman has ever tried to cut down or stop use of a substance, and failed that attempt, and, if so, how recently
Q8:	Asks whether the participant has ever injected any substance and, if so, how recently
See appendix 9: NIDA Quick Screen for the NIDA Quick Screen v. 1.0 and NIDA Questions 1–8. **PDF of NIDA ASSIST Screening Tool:** http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf **Online Questions:** http://www. drugabuse.gov/nmassist/?q=qm_json&pageId=questions_1&pageName=QuickScreen&token_id=4128	

Sequence of Questions

Researchers who specialize in the development of substance use–related screening and assessment instruments recommend that questions be asked in an order that encourages accurate and honest responses.

- ***Ask about the least threatening or embarrassing drugs first, and discuss them in the context of less threatening time periods, e.g., before she knew she was pregnant.***

  Progress, for example, from over-the-counter and prescription drugs, to cigarettes, alcohol, marijuana, cocaine, and any other illegal drugs. To save time, initially ask about several drugs at once: "Have you ever tried marijuana, cocaine, crack, PCP, or heroin?"

- ***Consider asking about each drug separately, if the initial responses indicate a potentially abusive or heavy use pattern.***
  Despite the increased length of the screening process, some researchers believe that asking separately about each drug will increase the accuracy of responses. For example, for women who acknowledge that they drink alcohol, ask about beer, wine, and liquor separately, rather than just about alcohol. Similarly, for users of any illegal drugs, verify use of each specific drug category – marijuana, cocaine, crack, heroin, and so forth.

- ***Consider suggesting specific answers or ranges for both dose and frequency.***
  Start with the highest categories (e.g., four to five drinks, one to two drinks, daily, weekly, less than monthly). In fact, some clinicians suggest probing for relatively large quantities of a substance if the participant hesitates to answer. At the Cleveland Metropolitan General Hospital, pregnant patients who said they drank beer were matter-of-factly asked if they consumed one or two six-packs at a time. Respondents who did not abuse alcohol usually laughed and specified a much lower amount, and those with problems frequently agreed with an amount close to the one suggested.[109]

Format of the Screening Tool

The physical design and layout of the screening tool is important for conserving staff time. Local WIC agency staff may want to experiment with different formats and arrangements to make certain the instrument meets their needs. Legal issues, especially those related to confidentiality, should be considered when designing a screening instrument (see appendix 8: Legal and Confidentiality Issues for more information).

An example screening tool is the three-part instrument: Lifestyle Questionnaire, Lifestyle Assessment, and Assessment Response forms (see appendix 10: Sample Three-Part Screening Instrument). Developed and used by Health Start, Inc., in St. Paul, Minnesota, it demonstrates how information can be summarized, the participant's goals recorded, referral actions suggested and checked off if performed, and specific information and follow-up activities recorded. The Lifestyle Questionnaire is an example of a screening instrument that flags questions with an asterisk in order to alert staff to a response that requires attention.

Other examples of screening tools developed by various health-based organizations and agencies, each with different focus areas, include:

- WIC in Vermont Health and Nutrition Questionnaire for Pregnant Women:
  - Available for download at: http://healthvermont.gov/wic/apply.aspx (choose Prenatal Woman) or as a PDF at: http://www.healthvermont.gov/wic/documents/Prenatal_1107.pdf
  - Contains questions regarding general health, nutrition and diet, physical activity, alcohol use, tobacco use, and illicit substance use
- PHFE-WIC Program's CARE (Cease Alcohol Related Exposure) Project Nutrition Questionnaire:
  - Available at: http://www.phfewic.org/Projects/Care.aspx or as a PDF at: http://www.phfewic.org/Projects/Docs/Care/PrenatalNutritionQuestionApr10.pdf
  - Contains questions regarding general health, nutrition, physical activity, and alcohol use (does not contain questions on tobacco or illicit drug use or mental health)
- Kaiser Permanente's Prenatal Questionnaire:
  - Available at: https://mydoctor.kaiserpermanente.org/ncal/Images/Prenatal%20Questionnaire_tcm75-23290.pdf
  - Contains some questions on substance use, mental health, and social circumstances (does not contain questions on nutrition or physical activity)

Setting the Stage for the Screening Interview

As you prepare for a successful screening interview, there are some key preparations you can take. In addition, there are recommended approaches for starting the conversation in a positive, nonthreatening way. The following steps can help make WIC participants more comfortable chatting with you and also make them more likely to hear what you say and share honestly with you. Consider these techniques:

1. *Ensure that your setting demonstrates respect and is conducive to participant sharing* (see WIC Nutrition Services Standards, Clinic Environment and Customer Service).

   Seek a location that is out of the path of busy traffic at your clinic. Strive for privacy, a quiet setting, and comfortable seating set up for dialogue, not a teacher/student situation.
2. *Review confidentiality.*

   Remind participants that your conversation is private.
3. *Explain the process and why the information is being collected.*
4. *Provide assurance that truthful answers will not damage WIC eligibility.*

   Assure the woman that her access to WIC services **will not be affected** by any disclosure of substance use.
5. *Demonstrate concern for the child (in a nonjudgmental way).*

   Let the woman know that you are reaching out to her to let her know that there are steps she can take to help protect the health and safety of her unborn baby/young child.

It is helpful to inform women that there are programs that can assist her to be clean/sober during her pregnancy, and that there is research that demonstrates that if she stops using then there is less risk for a preterm birth and less risk that her baby will need to stay in the nursery or require a breathing machine. Let her know that there are community resources such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), chemical dependency programs, and free quit-smoking lines – but that you cannot help her to have the healthiest pregnancy possible if you do not know what substance she is using.

You can also inquire about how important the health and safety of her unborn baby are to her, and hear what she has to say. Then you could ask: Would you like to hear about some proven steps to help improve the health and safety of your child?

CHAPTER

Providing Information

As mandated by Public Law 100-690, WIC must provide information to participants about the dangers of substance use. In addition, Public Law 101-147 requires WIC local agencies to coordinate with alcohol and drug abuse treatment services and to maintain and make available for distribution a list of local resources for substance abuse counseling and treatment. This chapter discusses issues related to providing such information.

- **Providing List of Local Counseling and Treatment Resources**
- **Goals for Substance Use Prevention Activities**
  - Sample Goals
- **Messages with Positive Focus**
  - Accentuate the Positive and Avoid the Negative
  - Positive Substance Use Prevention Messages
  - Emotion-Based Messaging
- **Conveying Prevention Messages**
  - Methods of Conveying Substance Use–Related Information
  - Passive Dissemination
  - Guidelines for Effective Printed Materials
  - Interactive Involvement
  - Personal Instruction and Support
  - Ideas for Successful Class Topics
  - Steps for Making an Informal/Passive Referral
- **Barriers to Prevention Messages**
  - Limited Literacy Skills
  - Common Challenges Language Differences
  - Varied Ethnic and Cultural Beliefs
  - Implications of Poverty
  - Substance Use/Dependence
  - Barriers to Participants' Understanding and Accepting Prevention Messages
- **Techniques for Delivering Effective Messages**
  - Show Compassion
  - Be Accurate and Specific
  - Be Realistic and Positive
  - Use Active Listening Skills
- **Questions from Participants**
  - General Communications Skills and Avoiding Judgment
  - Having the Conversation: Tips for Effective Engagement
  - Communicating About Risk: Tips for Consideration

Providing List of Local Counseling and Treatment Resources

Public Law 101-147 requires WIC local agencies to maintain and make available for distribution a list of local resources for substance abuse counseling and treatments. Receiving such a resource list may prompt some participants to voluntarily seek out counseling or group support services. These participants might include nondependent substance users and cigarette smokers who are sufficiently motivated to assume responsibility for their own needs and make choices from the resource list of no-smoking clinics, self-help programs, or other counseling services.

Local resource information can be featured on agency bulletin boards and posters, and in individual discussion or group sessions, as well as distributed in printed handouts or flyers. Topics related to identification of these local resources are discussed in detail in chapter VII, which addresses referrals.

Goals for Substance Use Prevention Activities

Awareness of health hazards is only a first step in making behavioral improvements. For example: who in America does not realize that cigarette smoking endangers health – and yet, smoking continues. Therefore, providing accurate information is necessary, but not enough, for an effective prevention campaign. Changes must also take place in a target group's *attitudes, beliefs, and behaviors***.**

The five-stage model for effective prevention education (see appendix 12: Stages of Change Model for more information on this approach) is a refinement of these three steps, and can be helpful to local WIC agencies that may want to set goals for their substance use–related informational activities. The following list includes a goal that is appropriate to each stage.

Sample Goals

Stage 1 Provide accurate, realistic, and believable information about the dangers of maternal substance use, repeating the facts in understandable language with relevant illustrations until they are understood.

Stage 2 Inform participants about available and reliable methods and strategies to eliminate use of substance.

Stage 3 Encourage participants to assess their personal risks for potential substance use–related problems.

Stage 4 Recommend that participants develop specific and appropriate plans for stopping potentially harmful substance use and provide the facts they need to obtain assessment and help.

Stage 5 Support the participants' decisions to quit substance use.

For some participants, a clear presentation of basic information about the potential reproductive hazards of substance use may be enough to change attitudes and behaviors. Many pregnant women are already abstinent and only need reinforcement of this chosen lifestyle. Many participants are not currently abusing substances and will welcome information that can help them assure healthier pregnancies.

For other participants, a goal of total abstinence during pregnancy is not achievable because they used one or more substance before confirming their pregnancy or before receiving and understanding prevention information. Some of the women, however, may be readily persuaded to give up using these substances. They need to know that stopping use at *any* time, even late in pregnancy, can decrease risk of harm to the developing fetus and improve parenting practices.

Receiving the list of local resources for substance abuse counseling and treatment will assist some participants who need help in setting goals and changing behavior. Moreover, staff can reinforce positive change by supporting and praising participants' efforts.

Messages with Positive Focus

WIC agencies must carefully select the messages that they convey to participants about the dangers of substance use. Sensationalism and scare tactics are inappropriate, as well as demeaning. **Guilt** is nonproductive and will not motivate a pregnant woman to change nearly as effectively as **praise**. In fact, criticism and rejection may provoke anxieties that lead participants to increase their substance use.

Individuals with low self-esteem may have great difficulty mobilizing themselves for positive actions. Almost any perceived slight can be an excuse for self-destructive behavior. Extensive testing for public health messages related to substance use by pregnant women overwhelmingly supports the same approach: Keep the prevention message positive.

An early example from the Boston University School of Medicine's Fetal Alcohol Education Program[110] illustrated how negative comments can be turned into positive ones.

Accentuate the Positive and Avoid the Negative	
Positive	**Negative**
If you stop drinking now, you have a better chance of having a healthy baby.	Your drinking has already damaged your baby.
Your concern for your baby will help you be a good mother.	If you really loved your baby, you would not drink so much.
You will feel better when you are sober and so will your child.	Continued drinking will ruin your health and prevent your child from developing normally.

The prevention campaigns developed by special prenatal health-care projects for substance-dependent women and for other public health agencies and organizations provide other examples of appropriate messages that can be adapted for local use.

Positive Substance Use Prevention Messages

- Some people have days when they drink too much. If this happens to you, start the next day fresh. Return to your goal. Do not give up.
- If you are pregnant and you smoke, drink alcohol, or do drugs, get help. Your health-care provider can recommend programs to help you quit. You and your baby will be better off.
- Quitting smoking will help you feel better and provide a healthier environment for your baby.

Emotion-Based Messaging

WIC staff may find that screening and providing information can be especially effective by creating and using emotion-based messaging. Rather than just giving or reinforcing facts, this approach appeals to a mother's desire to do whatever she can to help make her child's life better. It may often include pictures or photos that evoke an emotional response from a participant.

Traditionally, health messages have often been based upon logic-based reasoning: giving facts and accurate information as the inspiration for change. However, knowing the facts does not always inspire a person to take action. It can lead to a WIC participant feeling lectured to, causing guilty feelings and lowering self-esteem. But by incorporating emotion-based messaging – in this case, appealing to concern for the health and well-being of the WIC participant's baby – WIC staff can help the mother engage with making healthful decisions for the future of her child. Emotion-based messaging can capture her attention, engage her with the benefits of taking action, and ultimately help in achieving behavior change.

As such, emotion-based messaging can help women to make personal commitments toward taking realistic steps for the health of both herself *and* her baby. It focuses on working toward behavior change by helping message recipients make decisions based on *feelings* in addition to *knowledge*. Helping her feel good about herself and her decision to do what is best for her child can be extremely motivating.

Examples of emotion-based messaging:

- When you smoke, your baby does too. YOU have the power to keep your unborn baby safe – quit smoking!
- You can help keep your baby safe by committing to an alcohol-free pregnancy.
- Be the kind of mother you want to be. Protect your baby: Ask for help if you're using drugs.

Keeping the above findings in mind, staff can weigh the advantages and disadvantages of the following methods for presenting information to participants.

> **Methods of Conveying Substance Use–Related Information**
>
> **Passive Dissemination**
> - Handouts – pamphlets, brochures, flyers
> - Bulletin boards
> - Computer kiosks
> - Posters
> - CDs, DVDs, online information
>
> **Interactive Involvement**
> - Self-instruction – quizzes or activity sheets
> - Contests
> - Interactive Web sites or apps
>
> **Personal Instruction and Support**
> - One-on-one, informal questions and interactions
> - Structured classes and groups
> - Peer support groups
> - Informal/passive referral

Passive Dissemination

Disseminating print and other materials, without active staff participation, is the least time- and staff-intensive way to provide substance-related information. Although there are considerable disadvantages to this method, it may be an effective strategy when combined with other communication techniques.

- *Printed pamphlets and brochures* are probably the most frequently used method for providing information to participants, although the least effective way to get a message across. These materials can easily be ignored and discarded. Still, handouts do have some advantages:
  - The messages conveyed are consistent, can be selected carefully for accuracy and appropriateness, and are relatively low in cost.
  - Printed materials can provide names and telephone numbers of resources for later reference. Information in pamphlets can be reviewed at leisure and shared with others. They can be chosen and used wisely to support personalized information efforts.
- *Flyers and leaflets* are effective means for announcing information about meetings, classes, and local community resources. Additionally, leaflets can reinforce themes from more personalized education.
  - For example, a written description of the range of substance effects on pregnancy and the fetus can be reviewed at home and shared with family and/or friends after the information has been explained in a group or individually.
  - Other suggested topics include the dangers of using cocaine just before delivery, how substance use can affect appetite, and the dangers of substance use at different stages of fetal development.

  Note: Printed materials that are meant for clients to take home with them (such as flyers, leaflets, printed pamphlets, and brochures) should not just be left in the waiting room. They can be inserted into voucher folders and handed to the participant, for example.

  See appendix 3: Additional Links and Resources (under the Developing Education Materials section), appendices 5A and 5B: Evaluating Education Materials, and appendix 6: Guidelines for Developing Education Materials for more detailed information to help ensure that printed materials you develop (or select from existing materials) are the most effective for your participants.
- *Bulletin boards* can be useful for posting newspaper clippings, magazine articles, or Web printouts related to drugs or pregnancy with headings to attract attention.
- *Computer kiosks* can be available to offer quick access to topical Web sites for reviewing articles and printing information.

  Often, there are articles about substance-exposed babies in the popular press (in print or online); however, success stories are preferable, as they will convey a positive message. While the text in such articles may be complicated, the pictures and headings can evoke thought-provoking discussion.
- *Posters* add an attractive, decorative touch to waiting rooms and offices. Pictures and drawings have an immediate, visual impact that can be particularly appealing if the lifestyle and real-world conditions of a specific ethnic group are accurately portrayed.
  - To enhance a poster's effectiveness, staff should incorporate its message into personal discussions with participants or ask for their comments.
  - Posters have more impact if they are changed regularly, and if not too many posters with competing messages are displayed at one time.

- *Audio/CDs, DVDs, or online material*s may be used in waiting rooms or during special classes.
  - As with printed materials and posters, the impact of this essentially passive educational approach is enhanced considerably if the messages are simultaneously reinforced by other, more personalized activities focused on drug abuse prevention.
  - For example, even a brief staff introduction to a film, pointing out its highlights, or a group discussion afterwards, makes the messages more memorable.

Guidelines for Effective Printed Materials

These techniques can help to make printed materials more appealing and accessible to low-literacy populations:

- Short Sentences
- Familiar Vocabulary
- Short Paragraphs
- Large, Heavy Type for Headings
- Ample White Space
- Bright Colors
- Active Voice
- Personal Pronouns
- Simple Pictures and Graphics
- Upper-/Lower-Case Print Mix
- Provide More DOs Than DON'Ts

For more information on developing materials, see appendix 3: Additional Links and Resources/Developing Education Materials and appendix 6: Guidelines for Developing Education Materials.

Interactive Involvement

The effectiveness of printed, graphic, and audiovisual materials is enhanced if the participant can interact with these materials.

- *Written and verbal quizzes or activity sheets* about nutritional information are already used by some WIC agencies. Staff can design similar substance-related materials.
  - Although not all participants may respond in a positive manner to questionnaires, some information is usually transmitted through this format. The challenge of quizzes and suggested activities may appeal to other participants.
  - Offering prizes for turning in the activity sheets and for correct answers often increases participation; local sponsors can reward participation (with incentives such as food coupons or other prizes).
- *Contests* can inspire participants to participate in educational activities. Staff at local WIC agencies can invent or adapt a variety of games and activities with prevention themes.
  - A Question-of-the Week contest could be held, where participants pose and answer a question about drugs and pregnancy. Stop-smoking challenges can be conducted, with prizes given for remaining smoke-free for a certain number of weeks.
  - Other suggestions for contests include a poster contest or lyrics contest (to a given tune). The questions and messages should be clear, accurate, and simple.

Personal Instruction and Support

For effective teaching and counseling, there is no substitute for personal attention. Two-way, personal exchange is a key factor in learning. Having someone who is knowledgeable and trusted explaining substance use and how it can harm an unborn child may also be useful.

- *One-on-one interaction and support*. Brief, informal comments from staff can be extremely effective. For example, a quick question to the participant about how she is doing on her no-smoking commitment is a powerful reinforcement. Overall, the staff's personalized concern about substance use patterns, far from being resented by most participants, is a motivator to take action.

  Many unstructured opportunities exist in providing WIC services when the subject of substance use during pregnancy or parenting comes up naturally. These opportunities may occur during group education sessions or a discussion following film or video presentations.

  Staff are not expected to become experts on substance abuse. Rather, staff can provide information, reinforce the simple messages already stated, and describe the referral resources available in the community to provide specialized help with substance-related problems.

- *Nutrition education classes*. Substance-related information can be integrated into scheduled nutrition education sessions. The effects of substance use on appetite and its interference with nutritional benefits are natural leads into the subject.

  If classes or groups are used to communicate prevention messages, the leaders can experiment to find the most effective approaches for reaching participants and getting specific information across. Supplemental graphics, DVDs, and handouts can make such sessions more interesting and likely to be remembered. Follow-up question-and-answer periods encourage participants to express their own concerns.

If classes are held, content should be matched to the scheduled audience. All topics will not be equally appealing to all participants. In fact, single-focus lectures on substance-related topics are not usually well attended by participants.

Ideas for Successful Class Topics

Special issues that may draw more interest include:

- How to have a healthy pregnancy;
- Healthy ways to handle stress during and after pregnancy;
- Breastfeeding;
- Handling learning disabilities and hyperactivity in young children;
- Caring for the difficult premature newborn;
- Being a single parent;
- The causes and symptoms of difficult pregnancies and deliveries;
- Nutritional problems related to substance use.

- *Peer support groups*. Another approach staff may consider is peer support groups. These may be led by pregnant volunteers who are successful role models for changing health habits. The groups can discuss common problems, enhance participants' self-esteem, and build confidence in their ability to sustain positive change.

- *Informal/passive referral*. Staff can provide an informal/passive referral without screening simply by providing all participants with the list of local substance abuse counseling and treatment resources, which Public Law 101-147 requires WIC local agencies to maintain. From the community resources list, participants can secure needed services on their own. Some limited screening, however, can assist the local agency in identifying participants most in need of referral. Page 76 in chapter VII describes techniques for identifying substance-related resources in the community.

  The general steps for providing an informal/passive referral are summarized as follows:

Steps for Making an Informal/Passive Referral

1. If the WIC State agency has established basic screening for substance use, **discuss the potential substance problem** with participant and suggest that further assessment be obtained, if appropriate.
2. **Provide participant with resources handout** and review it with her to ensure that she understands it.
3. **Conclude conversation** by encouraging participant to contact an appropriate agency for help, if needed.

In designing successful informational activities, WIC staff may wish to consider the following barriers that their participants face.

Limited Literacy Skills

WIC staff may work with participants who are at a low literacy level. If the vocabulary is not familiar or the context is not meaningful, participants may simply ignore the information. To overcome literacy-based issues, messages should be repeated frequently in many forms and through a variety of media, using concrete terms in words familiar to participants. Audiovisual materials can be especially helpful when working with WIC participants who are at low literacy levels.[111]

Regardless of the medium (audio, visual, computer-based, or print), the messages delivered should be clear and concise.

A sample form for evaluating existing materials is in appendix 5A; guidelines for developing print materials can be found in appendix 6. Additional resources can be found in appendix 3: Additional Links and Resources under the Developing Education Materials section; examples of such resources include:

- *Nutrition and the Pregnant Adolescent: A Practical Reference Guide*. Chapter 18: Communicating effectively with pregnant adolescents who have limited literacy or comprehension skills.[111] http://www.epi.umn.edu/let/pubs/img/NMPA_181-193.pdf.
- CDC guide for creating materials: http://www.cdc.gov/healthliteracy/ http://www.cdc.gov/healthliteracy/pdf/simply_put.pdf
- CMS Toolkit for Making Written Material Clear and Effective: http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit
- Plain Language Action and Information Network: http://www.plainlanguage.gov
- NIH Clear Communication: A Health Literacy Initiative: http://www.nih.gov/clearcommunication/

To further ensure that the materials you develop (or select from existing materials) for participant education are effective with and relevant to your participants, you can pilot-test the materials with your target audience for language, tone, and cultural appropriateness. See appendix 5B for a sample participant education handout evaluation form.

It is also interesting to note that, in a recent study at the University of Minnesota Center for Leadership, Education and Training in Maternal and Child Nutrition, the most highly rated method of nutrition education by individuals with limited literacy skills, including adolescents, is group activities. Groups should be kept small – four to six people at most.[112]

Common Challenges

Many participants may work or have other responsibilities, which drain their energies and limit their patience for what they consider irrelevant or unnecessary activities, information, or demands. Problems, including emotional stress, may take priority over health care during the pregnancy. For example, women may be considerably more interested in discussing issues related to *mental* health than those related to *physical* health.[110]

Additionally, if they are in early or late pregnancy, women may be physically uncomfortable and/or tired; and participants may have difficulties arranging for babysitting and for transportation so that engaging their attention for any sustained period is difficult.

To surmount common challenges, staff may need to be creative. For example, special children's activities, provided by volunteers, can be helpful to the mothers, as well as an opportunity to provide guidance in parenting. Tokens for transportation may be available through social service agencies and health clinics in some areas. WIC certification appointments and voucher pickup schedules can be arranged to take advantage of natural groupings of participants (e.g., pregnant women, breastfeeding mothers, mothers of preschoolers) so that a relevant educational topic (e.g., impact of substance use on breastfed babies) can be introduced and discussed with women who have a special interest in the subject and whose schedules are not being disrupted to accommodate an extra trip.

Language Differences

Many WIC agencies may serve participants for whom English is a second language, or who do not speak or understand English easily. These ethnic groups may include a variety of subgroups that come from many different countries and communicate in a variety of dialects. To the extent possible, and wherever a particular ethnic group makes up a substantial portion of the population served, staff from the same background are, of course, desirable.

In addition, staff or volunteers who speak the group's language may be able and willing to translate some simple written materials. It cannot be assumed, however, that participants whose native language is not English are literate in their native language either. Representatives from churches or adult education classes in English for speakers of other languages may provide some help. Key considerations follow:

- Have a native speaker translate the materials back into English. Many important concepts are lost when translated and may not be apparent to nonnative readers of that language. A native speaker should also be able to tell you if there are any culturally sensitive phrases or concepts that should be omitted or revised.[112]
- In addition to printed materials, consider developing/ translating audio and video materials for non–English speaking participants.[112]
- Remain sensitive to the potential for a participant's limited social, educational, and economic resources, and to their cultural backgrounds.[111]

Varied Ethnic and Cultural Beliefs

Less obvious cultural beliefs and practices, which are more prevalent than language barriers, influence how prevention messages are received and whether they are accepted. It is difficult to be sensitive to the variety of attitudes and behaviors found in a single cultural group, which may include partially assimilated subgroups. Although people from a given culture will tend to have experiences that are culturally patterned and similar in nature, there are variations within each cultural group due to differences in socioeconomic status, religion, age, education, location, and length of time in the United States. The following points and illustrations may be helpful.

- Racial and ethnic groups vary in their willingness to talk about private matters and disclose personal information. Participants who hesitate to discuss private matters may try to avoid direct confrontation through conversational diversions, staying away from sensitive subjects until they trust the interviewer.[111]

  Differences in both verbal and nonverbal communication exist between cultures. Where strong cultural traditions of privacy prevail, participants may misinterpret staff's attempts to express concern and ask questions. Making direct eye contact is a sign of disrespect in some cultures. In other cultures, refusing to make direct eye contact is a sign of disrespect.[113,114,115] Likewise, a nod does not always indicate agreement. Sometimes a nod simply means, "I hear what you are saying."[113] Other ethnic groups resent touching without permission, even if the touching is intended to show concern for the other person.[114]
- Traditional themes may present possibilities for developing messages that appeal to a specific cultural group. Some women may fear that staff will scorn their traditional beliefs, so staff should consider each participant's cultural beliefs.[111]
- Many urban black women feel that modifying health-related behavior during pregnancy could be interpreted as coddling or spoiling the baby. This emphasis on toughness needs to be considered in developing themes for this group.[111]
- The authority of male family members, matriarchs, and other community figures (e.g., a priest, natural healer, or pharmacist) in different cultures needs to be considered in developing prevention messages and strategies.[112]

Implications of Poverty

Living in poverty may affect participants as much as any ethnic or country-specific heritage. Specifically, the continuing struggle for money and resources often makes low-income women focus more on the present than the future. Substance use offers a powerful and immediate escape; in addition, the health and welfare of an unborn child may be less compelling than the ever-present problems of feeding, clothing, and caring for existing children. Potential birth defects and learning deficiencies may not seem important if education and formal learning are not valued and expected.[112]

To be understandable and to be well received, prevention materials should be appropriate for low-income women. For example, literature that advises abstainers under stress to relax by joining an aerobics class, attending a concert, hiring help for the home, or taking a vacation may be offensive to low-income women, and are examples of what *not* to do. Rather, text or instructions should be illustrated with relevant pictures or suggestions reflecting participants' everyday experiences.

Substance Use/Dependence

Another barrier to accepting and acting on prevention messages may be substance use itself. Individuals under the influence of a substance could deny their problems, and may even deny use. The effects of substances could impair rational understanding.

Reaching women who are substance-dependent with health information – and encouraging them to follow through on referrals – can be difficult, and frequently unsuccessful. Unfortunately, some of the women most in need of help may be unresponsive. Substance-dependent women may precipitate negative feelings by staff and consume extensive time and energy.

WIC staff may assure the participant that receipt of WIC benefits is not dependent on her willingness to pursue an informal/passive referral or to accept a formal/active referral if the local agency's policy is to bring such action on the participant's behalf, or to participate in educational activities. Providing supplemental food may, indeed, be the best that can be done for some women. Substance-dependent women need someone to advocate on their behalf and to make linkages for them. If possible, they should be referred to someone who can do this.

Barriers to Participants' Understanding and Accepting Prevention Messages

- Limited literacy skills
- Common challenges (day-to-day issues, as well as other competing priorities)
- Languages differences
- Varied ethnic and cultural beliefs
- Implications of poverty
- Substance dependence

Techniques for Delivering Effective Messages

Delivery methods/mediums that are appealing, creative, relevant, and interactive serve to engage participants as well as create opportunities for feedback.[116,117] In addition to appropriate delivery methods/mediums, certain communication techniques can help increase the effectiveness of messages. A few techniques that may enhance their effectiveness follow.

Show Compassion

Show compassion rather than exhibiting judgment of a participant or provoking guilt. The goal is to make the participant feel safe and supported. A positive, accepting attitude is compatible with being direct. There is no need to ignore or skirt issues while communicating hope and belief that the participant wants to change. Generous praise is a helpful technique. Also, staff can reinforce their spoken words with nonverbal messages of concern, such as eye contact, a soft, well-modulated tone, or a handshake, bearing in mind cultural differences in how these messages may be perceived.

Be Accurate and Specific

Provide information in simple, clear language and be ready to offer practical advice and suggestions, if asked. Accuracy is vital, and it may sometimes be necessary to get more information to answer a participant's questions. Practical advice means helping the participant to establish priorities among simple steps she can remember, accomplish, and start right away.

Be Realistic and Positive

Focus on manageable changes the participant can handle and that she suggests or agrees to try. Overly optimistic goals may, paradoxically, cause more stress and pressure to use a substance as an escape. Sudden changes in lifestyle are difficult for everyone; praise and support for what is accomplished are more effective than criticism or reminders of what hasn't been done yet.

Use Active Listening Skills

The best discussions are open-ended and nonjudgmental. They do not attempt to label the participant's behavior. They do encourage her to look at her situation honestly. Listen to understand (vs. listening only to formulate a response), and try to paraphrase the participant's questions and responses to avoid misunderstanding. Do not hesitate to ask for clarifications as necessary. It helps to use the same words and terminology as the participant. Nonjudgmental and direct questions typically enhance a pregnant woman's disclosure of substance use. WIC staff may find it helpful to practice a discussion style that is nonjudgmental, supportive and caring, direct and honest, and that offers encouragement and praise.[118]

Questions from Participants

Certain questions may come up frequently when talking with participants about substances. This section presents a number of such questions, with answers.

What about the drugstore pills and other things I take for headaches and heartburn? Should I stop using them now that I'm pregnant? What about the drugs the doctor gave me?

Discuss with your doctor any medicine you're taking even if it was prescribed for you before you became pregnant.

Tell your doctor about any pills or other medicines you're taking even if you bought them in the drugstore without a prescription. It's a good idea to bring to the doctor or nurse at the prenatal clinic any medicines you're taking. It's especially important to bring in any medicines that were given to you by another doctor or nurse before you became pregnant. Don't start using any drug, even aspirin, until you check with your doctor or clinic.

Also see: Selected Commonly Used Over-the-Counter (OTC) Medications on page 42.

Will using a little cocaine every once in a while hurt my baby?

Don't use cocaine any time while you're pregnant or breastfeeding your baby. Your baby will be healthier if you don't use cocaine, and so will you.

I've been pregnant for a long time and I've been drinking and using drugs. What difference does it make if I stop now? The damage is done.

It's never too late to stop drinking or using drugs. You'll feel better; you'll feel more like eating and you'll eat foods that are better for you and your baby; you'll sleep better and will be able to follow the doctor's directions more carefully.

When you stop using drugs and alcohol, your baby stops using, too. When you eat better and take care of yourself, you're helping your baby to grow properly.

I'd like you to talk to someone who can help you stop drinking and using drugs.

I'm having a hard time with my drinking (or drug use) and can't seem to stop. What can I do?

Before you do anything, I want you to talk to someone who can help you with your drinking (or drug use). Together, you can work out a plan for helping you and your baby.

One of my sisters used drugs when she was pregnant, and her baby is fine. What's the big deal?

Some children whose mothers used drugs seem to be okay. Other children have problems that don't show up until they're older. Then, they may have trouble learning in school and they may not be able to behave or get along with the other children.

Still other children have serious health problems because their mothers used drugs while pregnant. Some children die, some have AIDS, and some are very hard to take care of. Why take this chance? You and your baby will do better if you don't drink or use drugs.

Will a little wine or beer with meals hurt my baby?

Wine and beer both contain alcohol. There is no known amount of alcohol that is safe to drink while pregnant, so it is best to not drink while you're pregnant.

I only drink wine coolers. I can't believe they're a problem. They taste like soft drinks.

You might be surprised to learn that a typical serving of wine cooler or beer contains the same amount of alcohol as a shot of whiskey. Even though wine coolers look and taste like fruit drinks, they're not good for your baby. Don't drink wine coolers while you're pregnant or breastfeeding.

General Communications Skills and Avoiding Judgment

It's not what you say; it's how you say it

There are several skills you can hone in order to have a more natural, comfortable discussion with participants. Practice these approaches:

Reflecting	Summarize without adding judgment. *For example:* • "It sounds as if you feel…" • "So you're saying that you are [confused, scared]…"
Reframing	View/state the situation in a positive way. This is especially helpful if the conversation gets stuck. *For example:* • Rather than thinking of a participant as stubborn, think of her as committed to her beliefs.
Partnership	Establish your role as a partner in problem-solving her barriers, and listen – don't preach. This can help you lead her toward developing her own answers. *For example:* • "We'll be working together to help your baby be as healthy as possible." • "I'm here to help and provide information."
Support	Provide positive feedback on open discussion and small steps; avoid trying to provoke guilt. *For example:* • "I'll be here to work with you and answer any questions you might have."
Establish a Relationship	Take time to build upon your rapport. Be warm, friendly, and caring. *For example:* • Listen respectfully to what she says. • Be concrete and specific in your responses.
Affirmation	Make positive and nonjudgmental comments at every opportunity. Be aware that many women fear being criticized or lectured to. *For example:* • "It seems like you really care about yourself and your baby."
Privacy	Always be aware that confidentiality is of the utmost importance. *For example:* • Ask questions when you are in a one-on-one situation; never ask in front of a woman's family members or friends.

Having the Conversation: Tips for Effective Engagement

Overall, you can consider the positive potential your conversation can have. By working one-on-one with a participant throughout the screening, information, and referral processes, you will be able to:

- Educate about the health effects of substance use;
- Advise on the types of services available, how to access them, and what they offer. Leave the door open for the participant to bring up questions/issues about substance use in the future.

Starting the Dialogue

One approach for opening the dialogue is to begin by describing consequences. Using alcohol use as an example:

- Read aloud: "If you drink, your unborn baby drinks too."
- Describe potential consequences: Review the problems caused by drinking during pregnancy.
- Elicit response: Ask the woman how she feels about this information. Which of these potential problems are of most concern to her?

Handling Resistance and Common Concerns

One of the challenges in talking to WIC participants about substance use – such as smoking – is responding to their objections about stopping. If you find yourself in this position, keep these tips in mind:

- Acknowledge her concerns. Assure her that it's normal to have mixed feelings about stopping. Be ready to respond to her questions.
- Familiarize yourself with common questions in order to provide effective answers. Consider framing the conversation around the benefits of making changes (reducing or, ideally, stopping use), and highlight those most relevant to the participant.

The example below is based upon questions about smoking; adapt it according to the substance you are discussing. For this example, the benefits and realities of quitting smoking can help frame your answers. (See "Impact on Others" and "Why Quitting is Hard" under "Prepare to Quit" and "Rewards of Quitting" under "Quit Today" at http://smokefree.gov/impact-on-others.)

Question and Answer Examples

Q: *Don't some women [smoke] during pregnancy and have healthy babies?*

A: When a woman [smokes], she takes a big risk with her baby's health. The more you [smoke], the greater the chance of harm. All pregnancies are different.

Q: *You're asking me to do too many things at once. Can't I wait to quit [smoking]?*

A: I know it's hard to change long-term habits. But if you can make one change, it can encourage you to make another. The sooner you quit, the better for you and your baby. I know you can do it! Plus, people who have quit smoking have reported feeling better and having more energy when they walk, play with their kids, or do something active.

Q: *Since [smokers] have smaller babies, won't delivery be easier?*

A: A smaller baby may be easier to deliver, but it's dangerous for the baby to be small and dangerous for you, due to the risk of complications. Your baby may be too little, or be born prematurely with health problems. A smaller baby is more likely to need special care, stay in the hospital longer, or even die at birth or before age 1 than a baby born at normal weight.

Q: *Last time I quit, I felt really sad and depressed. Why did I feel this way?*

A: Those feelings are normal, because nicotine is an addictive drug that affects your brain. [Smoking] was an important part of your life that you did along with your daily activities. Remember that the symptoms, including craving, will fade with every day that you stay [smoke]-free. If you find that you are feeling very down after quitting [smoking], then you should talk about this with friends and family, and also call your doctor.

Handling Issues Outside of WIC's Scope of Practice

There may be times when a participant has concerns of a more serious nature and/or an immediate concern that can serve as a barrier to hearing substance use prevention messages, or any other type of message, for that matter. Disclosure of partner violence, inadequate housing, and food insecurity are just a few examples of such concerns. As these issues are outside WIC's scope of practice, they can be difficult issues to which to respond; however, it is important to do so in order to move the conversation forward and, if possible, facilitate getting the participant the assistance she needs.

The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings, produced by Futures Without Violence[119] (formerly known as the Family Violence Prevention Fund), is a publication that provides recommendations for addressing domestic violence situations and offers techniques and strategies for dealing with and/or acknowledging special issues that a WIC participant may bring up. Although the publication focuses primarily on physical violence, it can also aid you in addressing other sensitive issues by adapting these questions/responses to other situations (such as inadequate housing and food insecurity) that could also be a concern for participants and/or a barrier to accepting prevention messages.

For suggestions on how to manage these types of situations, see appendix 13: Handling Issues Outside WIC Staff's Scope of Practice.

Establishing Rapport/Trust

Communicating risk is an important element of having the conversation. To do this effectively, it is important that you establish rapport with the participant by:

- Being open, honest, nonjudgmental, and respectful;
- Showing empathy and caring;
- Avoiding sarcasm;
- Using a friendly tone and volume when speaking;
- Maintaining frequent eye contact.

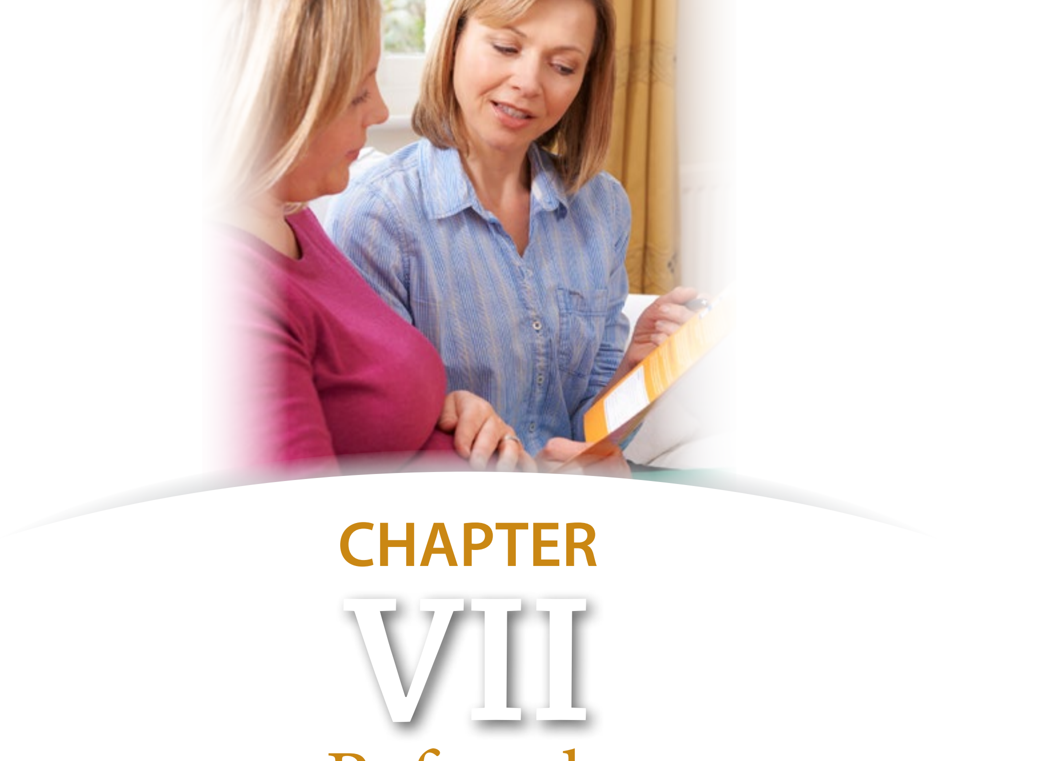
In addition, continue to remind her that you have confidence in her. Challenge her in a supportive way to take control of her own situation for the health of herself and her baby. You'll be helping to empower her and put her on the road to self-efficacy.

Communicating About Risk: Tips for Consideration

- Keep messages clear, simple, and realistic.
  - Don't overwhelm with statistics and data.
- Avoid technical language; rather, use simple language to convey technical language.

  Here are examples of simple messaging; the topic here is alcohol use during pregnancy:[120]
  - "If you drink, your unborn baby drinks too."
  - "Drinking when you are pregnant can harm your unborn baby."
  - "Some babies whose mothers drank during pregnancy:
    - Are born very small and have a hard time growing healthy and strong.
    - Have birth defects.
    - Have developmental disabilities and problems with behavior and learning."
  - "Even if they don't have such serious problems, some babies:
    - Are difficult to care for because they have trouble eating or sleeping.
    - Are very active when they are growing up and have trouble paying attention in school.
    - Are slower to learn to talk and develop language.
    - Have trouble remembering things and doing well in school.
    - Have problems with their hearing or vision."

  For more on this topic, see appendix 15: Resource for Conveying Technical Language.
- Stick to the facts:
  - Avoid humor or sensationalizing the topic.
- Don't predict the outcome of the situation/pregnancy:
  - Remember that each woman is different.
- Deliver personal, individually tailored messages.
- Stress the positive:
  - Don't give negative messaging; rather, promote the fact that making changes will have a positive effect on the baby/child.
- Help the participant assess/understand her own risk.
- Motivate risk reduction and encourage ongoing hope:
  - Support the woman with suggestions/educational materials that suggest interim steps.
  - Praise goals and achievements.
- Make a local referral:
  - Warnings without offering a next step can frustrate the participant.
  - Be sensitive to legal implications.



CHAPTER VII
Referrals

This chapter focuses on the formal/active referral of participants who may be using substances for further assessment.

- “Referral” Defined
- Goal of Formal/Active Referrals
  - Identification of Local Resources
- Understanding and Establishing Contact with the Local Network
  - Treatment Services
  - Model Treatment Settings
  - Phases of Substance Abuse Treatment
  - Phases of Smoking Cessation Treatment
  - Special Treatment Needs of Women
  - Criteria for Women’s Treatment Services
  - Availability of Treatment Resources
  - Establishing Linkages with the Treatment Service Network
  - States with Mandatory Reporting Law: Modifying Your Approach
  - Maintaining Directory of Community Resources
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  - Tips for Making Appropriate Referrals
- Selecting the Primary Resource for Assessment
- Steps in the Formal/Active Referral Process
  - Engaging the Participant
  - Selecting and Obtaining Permission to Contact a Referral Resource
  - Making an Appointment with the Referral Resource
  - Encouraging Follow-through
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  - Documenting Formal/Active Referrals and Results
  - Summary of Steps in Formal/Active Referral Process
- Treatment Programs for Substance Abuse During Pregnancy
  - Providing a Formal/Active Referral

"Referral" Defined

As discussed previously, the word "referral" is used in two ways in this Guide.

Informal/Passive Referral: An informal/passive referral can be accomplished without screening by providing a participant with a list (required by Federal WIC regulations 7 CFR 246.7[a]) of community substance abuse counseling and treatment resources so that she can secure services on her own. Some limited screening, however, can assist the local agency in identifying participants in need of referral.

Formal/Active Referral: A formal/active referral occurs when a staff member initiates contact with an assessment, counseling, treatment, legal, or any other substance use–related agency on behalf of a participant who has a substance use concern or is suspected of having a substance use problem. The formal/active referral process is consistent with the definition that substance use assessment and treatment programs most commonly use.

Though Federal WIC regulations require local agencies to maintain a list of local resources for drug and other harmful substance abuse counseling and treatment, regulations do not outline specific requirements for referral protocols. This allows State agencies flexibility in developing their protocols, and, therefore, the ability to include State agency options such as to whether to screen for substance use or whether to document referrals. Any screening activities, however, must be reasonably related to the referral requirement.

Priority Access to Treatment Facilities

Some programs in your state may make pregnant and/or postpartum women a priority for treatment services. Contact the programs in your area to learn which ones.

Confidentiality

It is important to note that WIC confidentiality regulations permit the release of WIC information for a substance referral to a public organization administering health or welfare programs serving the WIC population under the State agency's agreement with that organization. It is, therefore, legally permissible for WIC to release information a participant provides to such an organization in making a referral for counseling or treatment without first obtaining a signed release form. For more information on confidentiality, see appendix 8: Legal and Confidentiality Issues.

Goal of Formal/Active Referrals

For participants whose screening results suggest that substance use may be a problem, a formal/active referral is important. Many of these women will not have been identified previously. Prompt formal/active referral for an assessment and, based on results of the assessment of the referred entity, further treatment as indicated, has potential to benefit not only the participants themselves, but also their existing families and as yet unborn offspring. Even when such a formal/active referral is rejected, the interest demonstrated by staff may penetrate the denial that often accompanies substance dependency and signal to the participant that the problem is a matter to be taken seriously.

Identification of Local Resources

Possible sources to contact for a current listing of substance use/abuse services in a community are:

- The WIC State agency;
- The State or local health department;
- The State or Territorial Alcoholism and Drug Abuse Program Director;
- The local health and welfare council or United Way of America;
- A local council on alcoholism and drug abuse;
- Affiliates of the American Lung and Heart Associations and the American Cancer Society (for smoking cessation resources only).

The general steps for compiling resources are summarized as follows:

Steps for Compiling Local Resources

1. Collect information about available community resources.
2. Determine the suitability of available services for participants (e.g., whether pregnant women are served).
3. Compile information about services in a form useful to participants (e.g., fact sheet, pamphlet, information card).

Understanding and Establishing Contact with the Local Network

In order for referrals to be useful, it is important to learn what is available locally and understand the types of service(s) each entity provides, with the goal of identifying as many resources as possible that can provide the full continuum of care. Therefore, it is imperative to investigate, characterize, and contact your local network of substance-related resources to determine which have assessment, treatment, and counseling services appropriate for participants.

The task of establishing contact with the local network can be performed more easily if staff have some familiarity with current approaches to cessation programs for cigarette smoking and treatment and rehabilitation programs for substance dependence. In most locations, tobacco, alcohol, and other drug programs will be independent of one another, requiring contact with three relatively separate systems. Despite their organizational differences, however, some common characteristics can be described that may help one to understand how these programs function.

Treatment Services

Community services for substance use-related problems include both public and private facilities. Facilities can be for-profit or nonprofit, and include inpatient hospital programs, residential communities, outpatient clinics, and counseling services.

Additional resources include the array of self-help groups for substance users and their family members (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Al-Anon Family Groups, Adult Children of Alcoholics, Women for Sobriety), as well as local smoking cessation programs sponsored by the American Lung Association, American Cancer Society, and Seventh-Day Adventists, among others.

Counseling and treatment programs need to meet professional practice standards and be certified by the local and State agencies that govern their funding and approval to operate. The State or Territorial Alcoholism and Drug Abuse Program Director can provide specific information on this issue; local affiliates of the American Cancer Society and the American Lung Association can suggest appropriate smoking cessation programs. Each State has different program standards and staff or professional qualification requirements for public and private facilities.

The model on the following page lists these varied settings, some standard services that may be included in the different treatment modalities, the usual duration of care, and some alternative locations. Not all of these resources are available in every community and not all are suitable for women or for low-income participants. This model, however, introduces the broad range of services that may exist.

Model Treatment Settings

Setting	Standard Services	Treatment	Locations
Diagnostic and Assessment and Referral	• Medical history • Physical exam • Psychological testing • Psychosocial history • Substance use and treatment history • Personal information	• Several hours to several days • Team approach or specialists	• Central intake facility • Employee assistance programs • Private specialists
Inpatient	• Detoxification • Individual, group, and family therapy • Substance abuse education and relapse prevention	• 5–28 days	• Hospitals
Residential	• Pharmacotherapy • Individual, group, and family therapy • Substance abuse education • Vocational and educational services	• 1–12 months	• Freestanding facilities • Halfway houses • Group homes • Therapeutic communities
Outpatient	• Pharmacotherapy • Individual, group, and family therapy • Substance abuse education • Vocational, educational, and legal services	• 3–18 months • 1–8 hours • Daily to weekly	• Drug-free programs • Methadone maintenance • Anti-abuse • Other special programs
Self-help Groups	• Group discussion • Education • On-going support and relapse prevention	• Meetings: Daily to weekly, short- to long-term	• Drug-specific: alcohol, narcotics, cocaine, smoking

For the severely addicted participant, treatment experts agree that effective substance abuse rehabilitation programs, particularly for women with children, should involve family members and require at least six months to one year to complete.

Substance dependency is generally characterized as a chronic, relapsing condition, entailing a good deal of personal effort and commitment to surmount. Early termination from a program is nearly always followed by a relapse. Successful substance abuse treatment usually consists of three phases of care and progression. Women who use alcohol and other drugs, but are not severely addicted, may not need the intensive level of treatment that is described at right.

Phases of Substance Abuse Treatment

- **Concentrated detoxification** – weans the participant from the substance, often with decreasing doses of substitute medications or drugs for symptomatic relief, depending on the type of drug and the duration and severity of abuse. In pregnant women, withdrawal is gradual and closely monitored to forestall reaction symptoms in both the mother and the fetus.
- **Stabilization** – focuses on changes in lifestyle, such as reordering priorities from substance-seeking and -using activities to personal growth, education, vocational training, enhanced parenting and domestic skills, new relationships and friendships, and legal assistance. Relapse prevention is also usually offered.
- **Follow-up support and aftercare** – sustains positive changes made during the stabilization phase, usually through regular group meetings with other program alumnae.

Likewise, smoking experts generally agree that effective smoking cessation programs consist of three phases. While not all the activities in these phases are realistic for low-income women, they do provide information on what treatment strategies are currently being used.

Phases of Smoking Cessation Treatment

- **Preparation** – enhances the smoker's motivation to quit by educating her about the risks of continued smoking and the benefits of stopping. Simultaneously, builds confidence in her ability to be successful in quitting.
- **Intervention** – applies specific strategies to help smokers stop smoking by teaching the skills necessary for quitting through individual and group counseling. Encourages the use of support systems, self-rewards, relaxation, and various techniques for changing behavior and coping with withdrawal.
- **Maintenance** – helps ex-smoker maintain abstinence through training in coping strategies, social support, and the use of such substitutes for smoking as exercise and other pursuits.
  - Over 60% of women who quit smoking during pregnancy will relapse once the baby is born, so preventing recidivism (returning to smoking) is a priority.[121]

Special Treatment Needs of Women

In addition to understanding the variety and effectiveness of approaches to treatment that may exist in a community, local agencies should be familiar with the special treatment needs of women when evaluating services for them. The following criteria can be used when evaluating/comparing various services in the community and whether they are appropriate for women, specifically.

Criteria for Women's Treatment Services

- **Accessible:** The facility should be easily reachable by affordable public transportation or within walking distance.
- **Affordable:** The cost of the service should be within the means of low-income women; there should be a sliding scale for fees, and the program should accept Medicaid or other insurance reimbursements.
- **Convenient:** Hours of operation should be compatible with women's schedules.
- **Approachable:** Language and literacy barriers should not inhibit treatment, nor should a moralistic attitude discourage the attendance of patients with legal and social problems.
- **Gender-Appropriate Orientation:** Female counselors and therapy groups should be available so that sexual issues do not intrude on discussions.
- **Child-Centered Services:** Child care, as well as guidance and support in parenting efforts, should be included within the program's array of services.
- **Coordinated Services:** Access to multiple, needed services (e.g., social services, medical/prenatal care) should be facilitated by the program as far as possible. Special transportation arrangements and coordinated processing and scheduling of appointments provide encouragement for women who have responsibility for small children to pursue needed services.

Availability of Treatment Resources

Substance use/abuse treatment resources in some communities are limited. Many programs are filled to capacity, with long waiting lists for entry. Some WIC agencies may find that participants formally referred for assessment and then diagnosed as substance-dependent cannot be accommodated.

However, it is important to note that some programs make pregnant and/or postpartum women a priority for treatment services. Be sure to contact programs in your area to learn which ones offer this type of priority status.

If you are having difficulty locating a substance use specialist, remember: the primary care physician/clinic is your ally in ensuring that a WIC participant gets the diagnosis and treatment she needs. Another option for breastfeeding women is to use the baby's pediatrician as a partner. This clinician will have a long-term, established relationship with the mother and the infant.

A listing of hotlines and self-help groups that may provide temporary assistance should be maintained. Staff should be realistic with participants about the available resources. Also, staff should try to document and report any unmet needs for assessment and treatment services to their State or Territorial Alcoholism and Drug Abuse Program Director.

Establishing Linkages with the Treatment Service Network

As WIC local agencies become familiar with the substance-related treatment services in the community, they can begin to make contacts and establish linkages to 1) ensure compatibility of referral procedures within the system; 2) establish mechanisms to resolve unusual cases or other problems; 3) decide how service responsibilities will be allocated; and 4) set up arrangements for staff training and technical consultation, if appropriate.

You can foster linkages with the treatment service network in a variety of ways. You can invite staff from different substance use assessment and treatment programs to attend WIC staff meetings and present short descriptions of their services, or schedule regular brown-bag luncheon discussions or more formal half-day sessions to identify common problems with participants and attempt to find resolutions. Sharing information and experiences not only facilitates the formal/active referral process, but may also substantially improve the quality of services available to substance-dependent women.

States with Mandatory Reporting Law: Modifying Your Approach

It is important to understand your State's mandated reporting laws for reporting women who are using alcohol or drugs. In those States with mandatory reporting laws, women need to know the mandate, and then the discussion can still continue. Educational pamphlets and anonymous referral sources like AA and NA can still be given to women who do not openly admit to use, as well.

Maintaining a Directory of Community Resources

Once a list of community services is compiled, a resource directory should be developed. The directory could be a computer document such as a spreadsheet that can be easily sorted, updated, and printed; a loose-leaf notebook or Rolodex with tabs to separate different sections; or the customizable form (see appendix 14: Local Referral Directory Form) on page 131 of this Guide. Whatever format the local agency staff decides upon, the key is to set it up to facilitate updating as needed. Listings can be categorized by setting, by the drug focused on (e.g., alcohol, tobacco, cocaine/crack), or by treatment approach.

It is more efficient if information for each listing is entered in a standardized format, both for easy access and for sorting capabilities. At first, the name, address, and telephone number of the service, as well as a general description, will be adequate. If news articles or Web site information about the service appear, they can be clipped and attached until more information is gathered. Eventually, the listing can become more complete.

In large communities, local organizations may already publish service directories. To be useful, large directories probably need a cross-indexing system and some additional information about services for pregnant women. Suggestions about the types of information useful for WIC agencies follow.

Your Local Referral Directory

The directory can include:

- Name, address, and telephone number of the service
- General description of the service
- News articles/Web site printouts about the service
- Access via public transportation
- Costs/Medicaid participation
- Language(s) spoken
- Specific services
- Staffing pattern (ethnic composition of staff, ratio of males to females, number of physicians and nurses)
- Whether a program accepts pregnant women, or makes them a priority
- Contact person
- Service hours
- Eligibility criteria
- Availability of child care
- Philosophy
- Family involvement
- Comments and recommendations
- Web site addresses

Customized Referrals:

As you work with WIC participants, it is important to note that local specialists are the optimal choice for effective referral.

Your customized list of referral agencies will likely include:

- Local specialists (first choice)
- Primary care provider
- Recommendations from local ER
- Ob/Gyn's office

One method for updating and confirming the information is to encourage feedback from participants who use community services. Participants' reactions and recommendations can be noted anonymously in the resource directory and dated.

Types of Substance Use Referral Agencies

- Substance use services
  - Outpatient services
  - Medically monitored inpatient treatment
  - Medically managed inpatient treatment
- Supervised living
- Self-help groups (such as Alcoholics Anonymous)
- Referrals for family members of substance users

Tips for Making Appropriate Referrals

- Be informed about services available in your community.
- Carefully determine each participant's potential need of referral.
- If you suspect/discover substance use, match the participant with an appropriate resource (in that specific specialty area, if possible/feasible).
- Know what happens at treatment so that you can answer the participants' questions intelligently and respectfully.
- If possible, familiarize yourself with the process at local referral agencies. For example:
  - Should a participant bring a family member to the appointment?
  - What happens once the participant arrives?
  - What types of tests or evaluations might she expect?

By having an understanding of these processes, you will be better able to answer specific questions the participant may have at the time you make the referral.

Selecting the Primary Resource for Assessment

The basic screening activities that WIC agencies may conduct are not intended to diagnose substance abuse, but to uncover possible problems in order to determine which WIC participants need referral for further assessment, counseling, or treatment. Skilled substance use/abuse specialists, who will also determine the kinds of services needed if a substance problem is confirmed, should conduct the assessment.

Possible resources within a community to perform this assessment include:

- A comprehensive, community-based substance abuse diagnostic and evaluation unit;
- A prenatal care facility that also treats or refers substance-related problems;
- A public health department unit specializing in substance abuse; and
- A community mental health center with a chemical dependency component.

In selecting a resource to conduct further assessments, a site visit should be made, if possible, and information about available services should be obtained. If a site visit is not possible, someone from the facility might be willing to come to WIC and give a presentation on the program.

Steps in the Formal/Active Referral Process

To facilitate formal/active referrals, a protocol needs to be established. Often this process can begin immediately after the screening. Several steps in making a formal/active referral are discussed in the following paragraphs, and later summarized.

Engaging the Participant

Probably the most difficult part of the referral process is approaching the participant about her substance-related problems. Staff may be more resistant to this step than participants. In retrospect, most participants are appreciative that someone cared enough to approach them. Many give credit for their health to the person who recommended treatment.

All referrals should be made in private. The essential objectives are to ease discomfort, foster rapport, and open a dialogue with the participant. A good beginning is to affirm any positive behaviors noted during the screening.

- "You seem to know about nutrition and to be eating right. That's good for you and your baby."
- "I see you sought help several years ago for a drinking problem. That seems to have been a good step."

Then the problems noted in the screening can he approached, as supportively and acceptingly as possible.

- "You seem to be concerned about your drinking. I am, too. We can help you see a specialist about this problem."
- "Quitting smoking seems to be giving you some trouble. I'd like you to try a program that might help."
- "Stopping cocaine use would be good for you and your baby. I'd like a specialist to talk with you some more about this."

The discussion should be straightforward and candid. The reason the referral is indicated should be explained clearly, and the participant should be assured of confidentiality. The person making the referral should offer to involve the family or explain the reason for referral to them.

Selecting and Obtaining Permission to Contact a Referral Resource

Once a participant agrees to the idea of a formal/active referral, proceed immediately. The participant may or may not have suggestions about a resource. It is wise to involve her by asking:

- "Do you know a program or resource that might help you with this?"
- "Does one of these choices seem better for you than another?"
- "Can we make an appointment for you with the program now?"

  Smoking cessation examples:

  – "While you're here, why don't we call the national toll-free number for quitting smoking together?" (1-800-QUIT-NOW)

  – "Shall we visit the Smokefree.gov Web site together now?" (This Web site from the U.S. Department of Health and Human Services can be found at http://smokefree.gov/.)

  – "Are you familiar with SmokefreeTXT? Shall we sign you up for this texting program now?" (Information about this mobile service can be found at http://smokefree.gov/smokefreetxt/.)

It will be necessary to obtain a written release form from the participant to release information to the referral agency. This release form must comply with the WIC regulations and FNS Confidentiality policy and, when appropriate, with the HHS "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2. For more information about confidentiality and other legal issues, see appendix 8: Legal and Confidentiality Issues.

It is important that the participant be informed about the type of information that will be transmitted to the referral agency about her, and also that:

- The release simply allows WIC to contact the referral resource on her behalf and transmit certain information supplied by the applicant to the referral agency.
- Receipt of WIC benefits does not depend on her consent for substance use referral, nor does failure to sign this form in any way jeopardize program eligibility or participation.
- Signing the release does not commit her to anything. It is one way of assuring that information is kept private and given only to a designated professional with a need to know.
- She may revoke the authority to release this information at any time, but that information, once released, cannot be retrieved.

Making an Appointment with the Referral Resource

The person making the formal/active referral needs to find out what time is convenient for the participant and how she plans to get to the assessment unit. Then a specific referral plan can be made. The referral resource should he contacted only after the participant agrees to the plan. If possible, it is a good idea to let the participant listen to the phone call, or, if the WIC Program is co-located with the assessment unit, a staff member can accompany the participant to the unit. The staff member can introduce the participant and help set up a later appointment.

- When contacting the referral resource, staff should find out whom the participant will see, the time of the appointment, how the participant can get to the facility, whether she can bring a relative or children, and what other information she will need.
- A formal/active referral appointment should be made immediately, if possible. On occasion the referral agency may not be able to accommodate additional referrals; if so, staff should schedule an appointment at a later time or try to schedule an appointment with a different referral resource.
- It is important to keep a copy of the signed release form from the participant as documentation of authority to contact the referral agency and release information to them.

Encouraging Follow-through

Staff should encourage the participant to keep the referral appointment and later ask whether she went and how she was received (but not about the outcome). Participants who have followed through deserve praise; those who have not should be encouraged to make another appointment.

Handling Refusals

Although staff may make every effort to refer women suspected of having substance-related problems, some referrals will be refused. Although as much attention and support as possible should be offered, the participant's acceptance of a suggested referral is voluntary.

Documenting Formal/Active Referrals and Results

Copies of all the recommended actions and completed forms for the participant should be kept in her records. These forms may include the screening sheet, informed consent to release information, any report returned by the referral resource indicating whether the appointment was kept, and any other written instructions given to the participant. Complete records help the agency avoid potential problems caused by staff turnover and any future questions about referral suggestions and recommendations.

Summary of Steps in the Formal/Active Referral Process

- Engaging the participant
- Selecting and obtaining permission to contact a referral resource
- Making an appointment with the referral resource
- Encouraging follow-through
- Handling refusals
- Documenting formal/active referrals and results

Treatment Programs for Substance Abuse During Pregnancy

Treatment programs offer a range of comprehensive services specifically designed for women. In most cases, services include medical care, intensive psychosocial counseling (for the individual and the family), support services such as child care and transportation, health education, and legal counseling. Examples of successful programs include the Perinatal Addiction Center at Northwestern Hospital in Chicago and the Family Care Center at Jefferson Hospital in Philadelphia.

At a minimum, the medical services provided by exemplary programs entail **on-site prenatal care and a substance treatment regimen** designed for the individual pregnant woman. The medical staff are highly trained in the implications for the mother and the fetus of substance withdrawal during pregnancy, and design a specific treatment regimen based on the involved drug or drugs.

Medical care may also include pediatric care for other children in the family and medical services for any problems of the mother separate from the pregnancy, such as hepatitis and AIDS. Programs have also developed affiliations with hospitals with pediatric units trained in the special problems of the substance-addicted or -affected newborns.

Because many of the addictive substances abused by pregnant women do not have a pharmacologic treatment, as does heroin, **counseling** plays a critical role in treatment. Programs offer both individual and group counseling. Group sessions include pregnant and postpartum women, and extend as long as one year beyond delivery. The aim of this extended counseling is relapse prevention and enhancement of the parenting skills of the women. Many programs also involve key family members in counseling. This facilitates reentry for the women, especially if the program is residential.

Another critical component of programs is **aftercare**, which is a step-by-step plan tailored to meet an individual woman's need for specific services to help her find a job, secure day care, resolve a legal problem, or address any other issues that may impede her recovery.

Health education is another important part of the substance treatment process. Specific topics include understanding and coping with the symptoms of pregnancy, preparation for childbirth, infant development, infant care, and nutrition. Nutritional counseling is particularly important because of the appetite suppression caused by many drugs. Health education provides the knowledge necessary to allow the woman greater control over her health and the health of her children. Some programs feature education programs for the children of substance abusers to help the children understand and cope with the behavior of their addicted parents.

Legal counseling may be a necessary component of a comprehensive drug treatment program. For example, in an instance where a substance-abusing woman may have been declared an unfit mother and may have to deal with the legal system to regain custody of her children. Or, perhaps a woman may have been involved in illegal acts to obtain money for drugs and must deal with the legal ramifications of those acts. Comprehensive programs often have social workers or legal counselors work on these issues with participants.

Staffing of comprehensive drug treatment programs usually includes physicians, nurses, counselors (such as social workers or psychologists), nutritionists, and health educators. Because many of these programs are either hospital-based or part of drug treatment agencies, staff from the larger organizations may act as consultants to the programs. The critical component seems to be **participant accessibility to services and staff**. The participant goes to one location and receives multiple services under one roof. Also, there are female staff members of ethnic backgrounds similar to those of the participants whenever possible. Further, the staff in most direct contact with the participants should be constant so that participants can develop relationships with the staff.

Cost is another important factor in the design of treatment programs for pregnant addicts. Many women who need these services have low incomes and cannot afford to pay full fees. As a result, many of the programs designed for this population have sliding fee scales. Participants are not turned away because of their inability to pay or lack of health insurance, but this may contribute to the limited number of slots available to pregnant women. All of the services discussed are costly and are not fully covered by patient fees. As such, the exemplary programs discussed must rely on supplemental funds (e.g., private funds, Federal dollars). When these funds are limited, so are the treatment opportunities for substance-dependent women.

Providing a Formal/Active Referral

As you make a referral, you may play an active role to help foster greater commitment. In fact, when you facilitate an active connection – such as taking action on behalf, and with the permission of, the participant, or having a WIC participant take action during your meeting with her – there is a 100% chance that the connection will be made.[122]

For example:

"Based on what you have told me, I believe you could benefit from a visit to _____________. As discussed, stopping [substance use] will help you have a healthier baby. May we make an appointment for you?"

Or

"Based on what you have told me, you seem to know that, if you stop smoking, it can help you to have a healthier baby. Let's take your phone out and, together, we can call **1-800-QUIT-NOW** (or text **Smokefreetxt.gov**)."

Make the appointment with the referral source before the woman leaves.
Have your list of local referral options handy.

Obtain agreement to attend the appointment and troubleshoot possible barriers to keeping the appointment.

For example:

"We have made an appointment with ___________ on [month/day/time]."

"Is there anything that might make it hard to keep this appointment or miss the appointment?" (Depending on responses, brainstorm solutions here together.) Write down the appointment time, place, and name of the counselor (if known).

"I believe this is a great thing you are doing for yourself and your baby!"

APPENDIX 1

Training Materials and Resources for WIC Staff

The following table is a sample of existing training and information materials that may be useful to WIC agencies. The table is not an inclusive list, nor is it formatted in such a way that necessarily recommends one material over another. Rather, it is meant to provide resources (or a starting point of resources) for WIC staff to learn more about conducting screening (if applicable) and providing education and referrals related to substance use prevention. WIC agencies are encouraged to utilize the material(s) that are most useful and applicable to their activities related to substance use prevention.

The table provides brief information on the selected material as well as a way to access the material. The access information (availability) often includes a URL that is a direct link to a PDF document and the Web site where a user can access the PDF. Including the Web site where the PDF can be found also provides a place for the user to search for the document for which s/he is looking if the link to the PDF is broken. Additionally, the Web site may contain the information within the PDF document as well as additional information or resources that may be useful.

Of note is that not all materials or tools are specifically designed to use with pregnant or breastfeeding women; however, general information and techniques provided on topics such as brief interventions and motivational interviewing may prove useful.

The following materials are (1) designed for use with pregnant and postpartum women and (2) comprehensive in their inclusion of the impacts of substance use as well as screening, brief intervention, and/or referral strategies and tools.

Name of Material	Publisher	Year	Substance(s) Covered
A Guide for Counseling Women Who Smoke: Helping Women Eliminate Tobacco Use and Exposure	North Carolina Division of Public Health	2008	Tobacco (smoking and chewing)

Attributes

Availability and Type of Material(s)

- Web site availability for the:
  - Manual: http://whb.ncpublichealth.com/provpart/pubmanbro.htm

Audience

- Designed for use by professional and paraprofessional staff as well as church and community leaders

Content Related to Substance Use and Abuse

- Includes health consequences of tobacco use on pregnant women, the fetus, breastfed infants and breastfeeding mothers
- Includes section on secondhand smoke, including health consequences of exposure before, during, and after pregnancy and counseling suggestions

Content Related to Counseling Strategies and Techniques

- Includes section on cultural perspectives with information and tailored counseling suggestions for African American, American Indian, Asian American and Pacific Islander, Caucasian, and Hispanic women
- Includes section on counseling through the life span with information and tailored counseling suggestions for adolescents and preconceptional, pregnant, postpartum, and breastfeeding women
- Provides examples of how to optimize one-on-one communication skills and build rapport with participants
- Reviews several mnemonic aids to help counselors remember counseling strategies
- Promotes assessing a client's stage of change in order to provide tailored advice
- Includes "Handling Difficult Questions" section, which provides examples of several potential treatment barriers and sample responses for how the counselor can address them
- Provides strategies for how to handle withdrawal symptoms to help prevent relapse and for stopping/reducing tobacco use, including "40 Ways to Give Up Smoking" handout

Name of Material	Publisher	Year	Substance(s) Covered
Certification Program – *WIC Orientation Module, Section VI: Providing Drug Abuse Information in the WIC Program and Section VII: Providing Referrals in the WIC Program*	Colorado WIC	2011	Tobacco (smoking and chewing), Alcohol, Illicit drugs, Prescription drugs

Attributes

Availability and Type of Material(s)

- Web site availability for the module (which is part of a larger Colorado WIC training manual): https://www.colorado.gov/cdphe/wic-certification-program (Level 1 Modules, WIC Orientation)
- A PDF of the module is available at: https://www.colorado.gov/pacific/sites/default/files/PF_WIC_Orientation-Module_1.pdf

Audience

- Designed for use by professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Includes health consequences of tobacco, alcohol, illicit drug, and prescription drug use on pregnant and breastfeeding women and the fetus
- Discusses risk of secondhand smoke

Content Related to Counseling Strategies and Techniques

- Not tailored to any particular race or ethnic group(s)
- Provides tips for how to optimize one-on-one communication skills; reviews method for screening, brief intervention, and referral to treatment
- Promotes feedback be delivered using affirming statements rather than negative comments, with examples of each

Name of Material	Publisher	Year	Substance(s) Covered
FASD Clinician Guide (a part of the *Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders (FASD) Prevention Tool Kit*)	American Congress of Obstetricians and Gynecologists (ACOG); supported by Centers for Disease Control and Prevention (CDC)	2006	Alcohol

Attributes

Availability and Type of Material(s)

- Web site availability for the FASD Clinician Guide (site also includes accompanying training tools (Assess Readiness, Strategies for Change) and screening and patient education tools): https://www.acog.org/-/media/Departments/Tobacco-Alcohol-and-Substance-Abuse/FASD-Clinician-Guide.pdf?dmc=1&ts=20160429T1136380431

Audience

- Designed for use by clinicians but could be adapted for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Includes overview of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders, including risk factors and symptoms
- Standard Drink Pocket Card provides illustrated examples of types of alcohol and the amount of each that makes up one standard drink

Content Related to Counseling Strategies and Techniques

- Not tailored to any particular race or ethnic group(s)
- Includes mnemonic aids to help counselors remember counseling strategies
- Includes sample language for how to optimize one-on-one communication skills and build rapport with participants
- Provides examples of how to provide feedback to clients
- Promotes assessing patients' readiness to change
- Provides referral resources and referral and follow-up mechanisms

Name of Material	Publisher	Year	Substance(s) Covered
Responding to Prenatal Substance Use: A Guide for Local Health Departments	North Carolina Department of Health and Human Services	2000	Tobacco (smoking and chewing), Alcohol, Illicit drugs, Prescription drugs

Attributes

Availability and Type of Material(s)

- Web site availability for the manual: http://whb.ncpublichealth.com/provpart/pubmanbro.htm (found under *Peritnatal Substance Abuse Manual*)

Audience

- Designed for use by clinicians, but is adaptable for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Includes health consequences of tobacco, alcohol, illicit drug, and prescription drug use on pregnant women, the fetus, and mothers

Content Related to Counseling Strategies and Techniques

- Not tailored to any particular race or ethnic group(s)
- Provides tips for how to engage participants in the topic of substance use in a nonjudgmental manner and how to effectively provide positive feedback to participants
- Includes techniques (with both tips and example statements) for optimizing one-on-one communication skills and building rapport with participants
- Reviews selected brief screening tools with mnemonic aids; includes possible advantages and disadvantages of each
- Includes treatment options for problem drinking, smoking cessation, and drug abuse

The following material is (1) designed for use with WIC participants and (2) covers intervention and referral strategies.

Name of Material	Publisher	Year	Substance(s) Covered
WIC Parent Connections Video (Touching Hearts, Touching Minds Project)	Massachusetts WIC	Undated	none

Attributes

Availability and Type of Material(s)

- Web site availability for the video: https://wicworks.fns.usda.gov/
- **Audience**
- Designed for use by WIC staff

Content Related to Substance Use and Abuse

- Focuses on emotion-based techniques and does not include substance use as a stand-alone topic

Content Related to Counseling Strategies and Techniques

- Depicts examples of emotion-based techniques demonstrated by real WIC counselors and parents in actual group discussions

The following materials are (1) designed for a general audience (i.e., do not take into account the unique considerations that must be considered when screening adolescents or pregnant women) and (2) include aspect(s) of the impacts of substance use and screening, brief intervention, or referral counseling strategies/tools.

Name of Material	Publisher	Year	Substance(s) Covered
The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	World Health Organization (WHO)	2010	Tobacco (smoking and chewing), Alcohol, Illicit drugs, Prescription drugs

Attributes

Availability and Type of Material(s)

- Web site availability for the ASSIST manual: http://www.who.int/substance_abuse/activities/assist/en/
- A PDF of the ASSIST manual is available at: http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382_eng.pdf

Audience

- Designed for use by primary care health-care workers, but is adaptable for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Includes problems related to substance use
- Includes specific health problems associated with individual substances, including tobacco, and illicit and prescription drugs as well as inhalants (glue, paint thinners, etc.)

Content Related to Counseling Strategies and Techniques

- Not tailored to any particular race or ethnic group(s)
- For use with adult (18–60 yr.) population
- Provides an overview of a screening tool, ASSIST: Alcohol, Smoking, and Substance Involvement Screening Test

Name of Material	Publisher	Year	Substance(s) Covered
College Drinking – Changing the Culture: Motivational Interviewing	National Institute on Alcohol Abuse and Alcoholism (NIAAA)	2005	Alcohol

Attributes

Availability and Type of Material(s)

- Web site availability of the information (content on Web page): http://www.collegedrinkingprevention.gov/NIAAACollegeMaterials/trainingmanual/module_4.aspx

Audience

- Though this resource is designed to address drinking among college-aged students, motivational interviewing (MI) techniques in general are appropriate to use with WIC participants

Content Related to Substance Use and Abuse

- Focuses on motivational interviewing and does not include alcohol as a standalone topic

Content Related to Counseling Strategies and Techniques

- Provides some basic information on motivational interviewing such as key elements of MI and MI techniques

Name of Material	Publisher	Year	Substance(s) Covered
Helping Patients Who Drink Too Much: A Clinician's Guide	National Institute on Alcohol Abuse and Alcoholism (NIAAA)	2005	Alcohol

Attributes

Availability and Type of Material(s)

- Web site availability for the Clinician's Guide (content on Web pages): http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- A PDF of the Clinician's Guide is available at: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf

Audience

- Designed for use by clinicians, but could be adapted for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Provides examples of how problem drinking can negatively impact families and lead to legal trouble

Content Related to Counseling Strategies and Techniques

- Features the AUDIT (Alcohol Use Disorders Identification Test) screening tool
- Includes flowcharts to guide providers through screening and brief intervention

Name of Material	Publisher	Year	Substance(s) Covered
Illicit Drug Screening, Brief Intervention, and Treatment Placement	University of Arizona – MethOIDE (Methamphetamine and Other Illicit Drug Education)	Undated	Illicit drugs

Attributes

Availability and Type of Material(s)

- Web site availability of the information (content on Web pages): http://methoide.fcm.arizona.edu/infocenter/index.cfm?stid=242

Audience

- Designed for use by clinicians, but could be adapted for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Provides brief information on the health effects of selected substances (methamphetamine, cocaine, and heroin)
- Provides information on treatment options for drug abuse and strategies for stopping
- Provides referral services information that is specific to Arizona residents

Content Related to Counseling Strategies and Techniques

- Reviews FRAMES model: *Feedback, Responsibility, Advice, Menu, Empathy,* and *Self-efficacy,* a model to help clinicians deliver a brief, motivation-enhancing intervention
- Briefly reviews motivational interviewing (MI) principles and skills
- Topic areas have accompanying pieces (links for which are located to the right of the material/page) to emphasize concepts:
  - Video reviewing MI principles
  - A chart with strategies the provider can use that correspond with each stage of change

Name of Material	Publisher	Year	Substance(s) Covered
Motivational Interviewing Strategies and Techniques: Rationales and Examples	Health Council of Southeast Florida	2008	None

Attributes

Availability and Type of Material(s)

- Web site access to the PDF: http://www.navigate-pbc.org/tools--materials.html
- A PDF of the material is available at: http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Audience

- Professionals and paraprofessionals working in community programs

Content Related to Substance Use and Abuse

- Focuses on motivational interviewing and does not include substances or substance use as a standalone topic

Content Related to Counseling Strategies and Techniques

- Provides comprehensive approach to motivational interviewing and contains rationale for and examples of:
  - introducing sensitive topics, such as substance abuse, in a non-threatening manner
  - optimizing one-on-one communication skills and building rapport
  - providing personalized advice and feedback
  - assessing readiness through importance, confidence, and readiness to change rulers

Name of Material	Publisher	Year	Substance(s) Covered
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Boston University School of Public Health BNI ART Institute	Undated	Alcohol and Illicit drugs

Attributes

Availability and Type of Material(s)

- Web site availability for the videos: http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/

Audience

- While these videos feature clinicians, they demonstrate the application of SBIRT techniques in real world settings and are adaptable to a WIC setting

Content Related to Substance Use and Abuse

- Demonstrates SBIRT and does not include substances or substance use as a standalone topic

Content Related to Counseling Strategies and Techniques

- Demonstrates screening, brief intervention, and referral to treatment techniques
  - *SBIRT for Drug Use*
  - *SBIRT for Alcohol/Drugs with Adolescents*
  - *SBIRT for Alcohol Use: College Student*
  - *SBIRT for Alcohol Use: Family*

Name of Material	Publisher	Year	Substance(s) Covered
Screening for Drug Use in General Medical Settings Resource Guide AND *NIDA Quick Screen*	National Institute on Drug Abuse (NIDA)	Undated	Tobacco (smoking and chewing), Alcohol, Illicit drugs, Prescription drugs

Attributes

Availability and Type of Material(s)

- Web site availability for the:
  - Resource Guide (content on Web pages): http://www.drugabuse.gov/publications/resource-guide
  - NIDA Quick Screen (content on Web page): http://www.drugabuse.gov/publications/resource-guide/nida-quick-screen
- A PDF of the Resource Guide is available at: http://www.drugabuse.gov/sites/default/files/resource_guide.pdf

Audience

- Designed for use by clinicians, but could be adapted for use by other professional and paraprofessional staff

Content Related to Substance Use and Abuse

- Provides an abbreviated summary paragraph of the consequences of substance use

Content Related to Counseling Strategies and Techniques

- Provides instruction for administering for NIDA Quick Screen, a single- question screening tool to assess alcohol, tobacco, and drug use
- Features the 5 A's: Ask, Advise, Assess, Assist, and Arrange counseling method for screening, brief intervention, and referral to treatment and provides sample language to start a dialogue
- Includes an appendix that addresses patient resistance

APPENDIX 2

Education Materials for WIC Participants

The following table is a sample of existing education materials on substance use for potential use with WIC participants. The table is not an inclusive list, nor is it formatted in such a way that necessarily recommends one material over another. Rather, it is meant to provide resources (or a starting point of resources) for WIC agencies to obtain education materials related to substance use prevention for use with participants. WIC agencies are encouraged to utilize the material(s) that are most useful and relevant to their participants; appendices 5A and 5B, which contains sample staff and participant evaluation forms to evaluate the appropriateness of materials, may prove helpful in determining how useful and relevant a material is to your Program.

The table provides brief information on the selected material as well as a way to access the material. The access information (availability) often includes a URL that is a direct link to a PDF document and the Web site where a user can access the PDF. Including the Web site where the PDF can be found also provides a place for the user to search for the document for which s/he is looking if the link to PDF is broken. Additionally, the Web site may contain the information within the PDF document, as well as additional information or resources that may be useful.

Name of Material	Publisher	Year	Substance(s) Covered
Alcohol Can Harm the Way Your Baby Learns and Behaves	Substance Abuse and Mental Health Services Administration (SAMHSA)	2005	Alcohol

Attributes

Availability and Type of Material(s)

- Web site to view, download, and order the one-page flyer for free: http://store.samhsa.gov/product/Alcohol-Can-Harm-the-Way-Your-Baby-Learns-and-Behaves/AV245
- Spanish version also available: http://store.samhsa.gov/product/El-alcohol-puede-danar-la-habilidad-de-su-bebe-para-aprender-y-para-comportarse-/AV245S

Audience

- Not tailored to any particular race or ethnic group(s)

Content

- Briefly reviews the consequences of drinking while pregnant on the child

Name of Material	Publisher	Year	Substance(s) Covered
Before You Get Pregnant	American Congress of Obstetricians and Gynecologists (ACOG); supported by Centers for Disease Control and Prevention (CDC)	2006	Alcohol

Attributes

Availability and Type of Material(s)

- A PDF of the handout is available at: https://www.acog.org/-/media/Departments/Tobacco-Alcohol-and-Substance-Abuse/Before-You-Get-Pregnant.pdf?dmc=1&ts=20160429T1146057005

Audience

- Not tailored to any particular race or ethnic group(s)

Content

- Briefly reviews risks of drinking while pregnant to the fetus

Name of Material	Publisher	Year	Substance(s) Covered
Break Your Smoking Addiction: Stages to Success	Krames Sataywell Patient Education	Undated	Tobacco (smoking)

Attributes

Availability and Type of Material(s)

- Web site to download the 16-page interactive guide: http://www.wrinstitute.org/downloadable_brochures.aspx
- A PDF of the guide is available at: http://www.wrinstitute.org/files/frontporch3/files/BreakYourSmokingAddiction.pdf

Audience

- Designed for diverse audiences, including Hispanic/Latina, African American/Black, Native American, Asian/Pacific Islander
- Does *not* contain content specific to pregnancy or breastfeeding

Content

- Encourages interactive use by providing opportunities for the reader to think about the presented information, relate it to personal experiences, and write responses
- Encourages consideration of nonhealth and safety benefits of quitting smoking
- Provides strategies for quitting smoking and motivational enhancement and provides space to create a plan for quitting
- Promotes self-efficacy and provides examples of how to build social support as well as information on relapse prevention and management

Name of Material	Publisher	Year	Substance(s) Covered
Detox and Pregnancy: What You Need to Know	Massachusetts Department of Public Health	2011	Tobacco (smoking), Alcohol, Illicit drugs, Prescription drugs

Attributes

Availability and Type of Material(s)

- Web site to download or order the 15-page booklet: http://www.maclearinghouse.com/ALCH/SA3510.html
- A PDF of the booklet is available at: http://files.hria.org/files/SA3510.pdf

Audience

- Designed for diverse audiences, including Hispanic/Latina, African American/Black, Native American, Asian/Pacific Islander

Content

- Includes a glossary of difficult terms; provides support to the reader
- Provides examples of potential health impacts on the fetus when smoking during pregnancy
- Provides information on treatment options for smoking cessation
- Includes a variety of strategies to stop using illicit and prescription drugs (including detox options) and to avoid triggers for drug use
- Addresses potential barriers to changing substance use behavior
- Promotes self-efficacy and includes a section dedicated to life after quitting and suggestions for preventing relapse

Name of Material	Publisher	Year	Substance(s) Covered
Drinking and Your Pregnancy	National Institute for Alcohol Abuse and Alcoholism (NIAAA)	2009	Alcohol

Attributes

Availability and Type of Material(s)

- Web site that contains the content and a link to the PDF ("print version"): http://pubs.niaaa.nih.gov/publications/fas/fas.htm
- A PDF of the brochure is available at: http://pubs.niaaa.nih.gov/publications/fas/fas.pdf

Audience

- Designed for diverse audiences, including Hispanic/Latina, African American/Black, Native American, Asian/Pacific Islander

Content

- Briefly explains transmission of alcohol from a pregnant woman to the fetus
- Briefly reviews the risks of a pregnant woman's alcohol use on the fetus and the potential lifelong behavioral and physical health problems
- Includes information on treatment options for problem drinking, including how to contact treatment programs and how to access online resources
- Provides ways in which pregnant women can avoid these consequencese

Name of Material	Publisher	Year	Substance(s) Covered
Have a Healthy Baby	SAMHSA	2007	Alcohol

Attributes

Availability and Type of Material(s)

- Web site to view, download, and order the one-page flyer for free: http://fasdcenter.samhsa.gov/grabGo/nativeKit.aspx
- A PDF of the flyer is available at: http://www.fasdcenter.samhsa.gov/documents/NI_Have_Healthy_Baby.pdf (part of the American Indian/Alaska Native/Native Hawaiian Resource Kit: Fetal Alcohol Spectrum Disorders [FASD])

Audience

- American Indian/Alaska Native/Native Hawaiian

Content

- Prevention message on abstaining from alcohol while pregnant

Name of Material	Publisher	Year	Substance(s) Covered
If You're Pregnant	ACOG; supported by CDC	2006	Alcohol

Attributes

Availability and Type of Material(s)

- Web site availability for the one-page handout: http://www.acog.org/Search?Keyword=alcohol
- A PDF of the handout is available at: http://www.acog.org/~/media/Department%20Publications/IfYourePregnant.pdf?dmc=1&ts=20130701T1426176620

Audience

- Not tailored to any particular race or ethnic group(s)

Content

- Briefly reviews risks of drinking while pregnant to the fetus
- Includes strategies for stopping alcohol use

Name of Material	Publisher	Year	Substance(s) Covered
If You Smoke and Are Pregnant	North Carolina Health Start Foundation	2010	Tobacco (smoking)

Attributes

Availability and Type of Material(s)

- A PDF of the self-help guide is available at: http://www.nchealthystart.org/wp-content/uploads/2015/06/If_You_Smoke.pdf

Audience

- Designed for diverse audiences, including Hispanic/Latina, African American/Black, Asian/Pacific Islander

Content

- Reviews health consequences of smoking on pregnant women, including miscarriage and health problems in the last trimester
- Highlights specific health consequences of smoking on the fetus and baby
- Defines secondhand and thirdhand smoke and reviews their effects
- Addresses personal norms around self-image
- Provides list of strategies for quitting smoking and space to create a detailed personal plan
- Promotes self-efficacy and includes examples of how to build social support and content on relapse prevention
- Permits interactive use by providing opportunities for the reader to think about and relate the information to personal experiences and write responses

Name of Material	Publisher	Year	Substance(s) Covered
Pregnancy and Drugs	ETR Associates	2007	Tobacco (smoking and chewing), Alcohol, Caffeine, Illicit drugs, Prescription drugs, Over-the-Counter (OTC) drugs

Attributes

Availability and Type of Material(s)

- Pamphlet available for purchase at: http://pub.etr.org/ProductDetails.aspx?id=100000156&itemno=078

Audience

- Not tailored to any particular race or ethnic group(s)

Content

- Includes (in a chart format) the health consequences of alcohol, caffeine, illicit drug, prescription drug, and OTC drug use, as well as smoking, on pregnant women, the fetus, and the baby

Name of Material	Publisher	Year	Substance(s) Covered
Smoke-Free for a Healthy Baby	Channing Bete	2010	Tobacco (smoking)

Attributes

Availability and Type of Material(s)

- Booklet available for purchase at: http://shop.channing-bete.com/onlinestore/storeitem.html?iid=175545&lang=0&pcode=&item=Smoke-Free+For+A+Healthy+Baby&totalProductsQty=0&from=search.html%3FnewQS%3D1%26key%3DSmoke%2BFree%2Bfor%2Ba%2BHealthy%2BBaby%26gsa%3Dn

Audience

- Designed for diverse audiences, including Hispanic/Latina, African American/Black, Native American, Asian/Pacific Islander

Content

- Reviews the consequences of smoking and breathing in secondhand smoke on the fetus
- Includes health consequences of smoking while pregnant on the fetus and baby
- Provides examples of strategies for quitting smoking, including cold turkey, avoiding triggers, talking to a health-care provider, and seeking social support through friends, family, or support groups
- Promotes self-efficacy by providing options for reinforcing abstinence, such as avoiding triggers, chewing on healthy snacks, and asking others not to smoke around you

Name of Material	Publisher	Year	Substance(s) Covered
Smoking and Your Baby: Tips & Information for Quitting	West Virginia Bureau for Public Health, Office of Epidemiology and Health Promotion, Division of Tobacco Prevention	Undated	Tobacco (smoking)

Attributes

Availability and Type of Material(s)

- A PDF of the booklet is available at: http://www.wvdhhr.org/bph/shared/content/News_objects/Attachment/PMBwebversion.pdf

Audience

- Not tailored to any particular race or ethnic group(s)

Content

- Includes short- and long-term health consequences of smoking on pregnant women, the fetus, and the baby
- Provides examples of strategies for quitting smoking
- Promotes self-efficacy by providing a section dedicated to life after quitting, including things to anticipate when you quit and tips for preventing relapse

Name of Material	Publisher	Year	Substance(s) Covered
Smoking and Your Pregnancy (factsheet) AND *Mommy Quit for Me* (brochure) (materials have similar information, thus are included as one material)	West Virginia Bureau for Public Health, Office of Epidemiology and Health Promotion, Division of Tobacco Prevention	Undated	Tobacco (smoking)

Attributes

Availability and Type of Material(s)

- Web site to access the PDFs of the factsheet and brochure: http://www.dhhr.wv.gov/wvdtp/cessation/tobaccofreepregnanc/Pages/default.aspx
- A PDF of the factsheet is available at: http://www.dhhr.wv.gov/wvdtp/Documents/Pregnancy-Fact-Sheet.pdf
- A PDF of the brochure is available at: http://www.dhhr.wv.gov/wvdtp/cessation/tobaccofreepregnanc/Documents/Baby-Brochure.pdf

Audience

- Not tailored to any particular race or ethnic group(s)

Content (for both factsheet and brochure)

- Briefly reviews some consequences of smoking on pregnant women and the benefits of quitting for breastfeeding women and their children
- Provides suggestions to getting starting in quitting

Name of Material	Publisher	Year	Substance(s) Covered
Substance Use: Risks to You and Your Family (Note: same title for publications #508 [handout] and #509 [brochure])	Missouri Department of Health	Updated 2012	Tobacco (smoking), Alcohol, Illicit drugs, Prescription and OTC drugs

Attributes

Availability and Type of Material(s)

- Web site to access the PDFs of the handout (#508) and brochure (#509): http://health.mo.gov/living/families/wic/wiclwp/publications.php
- A PDF of the handout is available at: http://health.mo.gov/living/families/wic/wiclwp/pdf/R_0508_WIC_SubstanceBroShort.pdf
- A PDF of the brochure is available at: http://health.mo.gov/living/families/wic/wiclwp/pdf/R_509_SubstanceUseBro.pdf

Audience

- Developed specifically for WIC participants
- Handout designed for use during initial nutrition education contact

Content

- Handout briefly reviews some consequences of alcohol, tobacco, specific illicit drugs, and OTC and prescription drugs on the fetus, the child, and/or pregnant and breastfeeding women
- Brochure provides more detailed information on the health consequences of use of alcohol, tobacco, and illicit and prescription drugs on pregnant and breastfeeding women, the fetus, and baby

Name of Material	Publisher	Year	Substance(s) Covered
WIC Health and Behavior Workbook (two versions: participant and counselor's guide) Project CARE – Cease Alcohol-Related Exposure	Public Health Foundation Enterprise (PHFE) WIC Program O'Connor and Whaley; supported by NIAAA	2003	Alcohol

Attributes

Availability and Type of Material(s)

- Web site for interactive participant workbook: http://www.phfewic.org/Projects/Care.aspx

Audience

- Developed for use with WIC participants and is available in English, Spanish, Vietnamese, and Chinese
- Designed for use by participants during discussion/brief intervention with WIC staff

Content

- Reviews risks of alcohol use to the fetus, including long-term health and behavior effects
- Provides illustrated examples of types of alcohol and the amount of each that makes up one standard drink, as well as common beverages that contain more than one standard drink
- Includes interactive sections on reasons for drinking, strategies for stopping/reducing alcohol consumption, examples of ways of coping with risky situations, and ways to cut down on drinking

APPENDIX 3

Additional Links and Resources

General/Organizations

- American College of Obstetricians and Gynecologists (ACOG): http://www.acog.org/
- American Academy of Pediatrics (AAP): www.aap.org
- Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/
- National Institute on Alcohol Abuse and Alcoholism (NIAAA): http://www.niaaa.nih.gov/
- National Institute on Drug Abuse (NIDA): http://www.drugabuse.gov/
- Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samhsa.gov/
- The National Center on Addiction and Substance Abuse at Columbia University: http://www.casacolumbia.org/templates/Home.aspx?articleid=287&zoneid=32
- U.S. Food and Drug Administration (FDA): http://www.fda.gov/
- WIC Works Resource System: https://wicworks.fns.usda.gov/
- WIC Fact Sheet: http://www.fns.usda.gov/wic/about-wic

Participant Resources: Breastfeeding Mothers and Medications

It should be noted that although this database can provide useful information to breastfeeding mothers, women should always be encouraged to talk with their doctor about medications they are taking and any concerns they have about taking those medications while breastfeeding.

Organization	Resource	Provides information on:
HHS, NIH	http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT	• Possible effects of medications on lactation and breastfed infants

Participant Resources: Substance Use Information

Alcohol		
Organization	**Resource**	**Provides information on:**
CDC	http://www.cdc.gov/Features/FASD/	• Signs, treatments, and what you can do about Fetal Alcohol Spectrum Disorders (FASDs)
	http://www.cdc.gov/ncbddd/fasd/women.html	• 5 things woman should know about drinking alcohol during pregnancy
NIAAA	http://www.rethinkingdrinking.niaaa.nih.gov/	• Alcohol use, what counts as a drink, and strategies for reducing use • Tools for users to quickly check their drinking pattern and obtain feedback
	http://pubs.niaaa.nih.gov/publications/DrinkingPregnancy_HTML/pregnancy.htm	• Drinking during pregnancy • Getting help and confidential information

Participant Resources: Substance Use Information (cont'd)

Tobacco		
Organization	**Resource**	**Provides information on:**
American Lung Association	http://www.lung.org/stop-smoking/smoking-facts/women-and-tobacco-use.html	• Facts about women and tobacco use
CDC	http://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/	• Smoking during pregnancy
	http://www.cdc.gov/breastfeeding/disease/tobacco.htm	• Tobacco use and breastfeeding
University of North Carolina Center for Maternal and Infant Health	http://www.youquittwoquit.com/	• Facts and the benefits of quitting smoking for pregnant women, infants, and new moms • Getting support when quitting

Multiple Substances (alcohol, tobacco, as well as prescription, over-the-counter (OTC) and illicit drugs)		
Organization	**Resource**	**Provides information on:**
HHS, Office of Women's Health	http://www.girlshealth.gov/substance/index.html	• Drugs, alcohol, and smoking that is geared towards teens – positive peer pressure
	http://womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.html	• Smoking, alcohol, and illegal drugs (Pregnancy: Staying healthy and safe)
NIDA	http://www.drugabuse.gov/publications/science-addiction/addiction-health	• Addiction and health • Impacts of addiction
	http://easyread.drugabuse.gov/	• Effects of drugs, addiction, recovery, and treatment
HHS	http://www.nlm.nih.gov/medlineplus/pregnancyandsubstanceabuse.html	• Pregnancy and substance abuse overview and additional information

Participant Resources: Treatment Locators/Getting Help

Alcohol		
Organization	**Resource**	**What you'll find:**
NIAAA	http://pubs.niaaa.nih.gov/publications/DrinkingPregnancy_HTML/pregnancy.htm (See "For Help and Information" at the bottom of the page)	• Contact information for AA, NIAAA, SAMSHA, and other organizations
The Partnership at Drugfree.org	http://www.alcoholscreening.org/Home.aspx	• Find a treatment program for alcohol by city and state or zip code

Participant Resources: Treatment Locators/Getting Help (cont'd)

Tobacco		
Organization	**Resource**	**What you'll find:**
CDC	http://www.cdc.gov/tobacco/campaign/tips/	• Tips from former smokers • Quit Guide and quitting resources
HHS	http://www.smokefree.gov/	• Quit Guide for various stages of change • Interactive tools
	http://www.smokefree.gov/smokefreetxt/ (or Text the word QUIT to IQUIT (47848) from your mobile phone)	• Sign up for text messages that offer encouragement, advice, and tips to stop smoking
	http://smokefree.gov/talk-to-an-expert (or call 1-800-QUIT NOW)	• Toll free quit line where quit coaches deliver advice, support, information, and referrals • Quit coach helps caller develop personalized plan
	http://betobaccofree.hhs.gov/	• Tips from former smokers • General information on smoking and secondhand smoke • Link to information on effects of smoking on pregnancy in the "Quit Now" section
American Heart Association	http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/QuittingResources/Resources-for-Quitting-Smoking_UCM_307934_Article.jsp	• Compilation of selected organizations that may offer personalized help or listings of classes and support groups in one's community
National Cancer Institute (NCI)	1-877-44U-QUIT	• Smoking cessation counselors are available to answer smoking-related questions in English or Spanish

Non-specific Treatment Locators		
Organization	**Resource**	**What you'll find:**
SAMHSA	https://findtreatment.samhsa.gov/	• Locate drug and alcohol treatment programs in your state or territory
	http://www.samhsa.gov/treatment/	• Treatment for substance abuse as well as other resources for substance use
	1-800-662-HELP	• Treatment Referral Helpline refers callers to treatment facilities, support groups, and other local organizations that can provide help for their specific needs
United Way Worldwide and the Alliance for Information and Referral Systems	http://www.211us.org/	• Connects people to community resources

Staff Resources: Information & Fact Sheets

Alcohol	
Organization	**Resource**
ACOG	• At-risk Women and Alcohol Health Effects: http://www.acog.org/alcohol
CDC	Fetal Alcohol Spectrum Disorders (FASDs): • Materials: http://www.cdc.gov/ncbddd/fasd/freematerials.html • One Woman's Story: http://www.cdc.gov/Features/FASDAwareness/ • Alcohol and Public Health Topics: http://www.cdc.gov/alcohol/index.htm
SAMHSA	• FASD Among Native Americans: http://store.samhsa.gov/product/Fetal-Alcohol-Spectrum-Disorders-FASD-Among-Native-Americans/SMA06-4245

Tobacco	
Organization	**Resource**
Dartmouth Medical School in collaboration with ACOG and CDC	• Smoking Cessation For Pregnancy And Beyond: A Virtual Clinic: https://www.smokingcessationandpregnancy.org/
CDC	• Preventing Smoking and Exposure to Secondhand Smoke Before, During, and After Pregnancy: http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/smoking.pdf

Multiple Substances (alcohol, tobacco, as well as prescription, over-the-counter (OTC) and illicit drugs)	
Organization	**Resource**
CDC	• Therapeutic Drug Use Fast Stats: http://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm • Illegal Drug Use Fast Stats: http://www.cdc.gov/nchs/fastats/drug-use-illegal.htm
FDA	• Questions and Answers on the Pregnancy and Lactation Labeling Rule: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Labeling/ucm093311.htm
NIDA	• Trends & Statistics: http://www.drugabuse.gov/related-topics/trends-statistics • Facts About Commonly Used Drugs: http://www.drugabuse.gov/drugs-abuse • Specific Drugs and Their Effects: http://www.drugabuse.gov/drugs-abuse/prescription-drugs
NIH	• U.S. National Library of Medicine/National Institutes of Health's PubMed search engine: http://www.ncbi.nlm.nih.gov/pubmed
SAMHSA	• Data, Outcomes, and Quality: http://www.samhsa.gov/data/
The White House	• Office of National Drug Control Policy Women, Girls, and Substance Abuse: http://www.whitehouse.gov/ondcp/women-children-families • Collaborating with Native Americans and Alaskan Natives: http://www.whitehouse.gov/ondcp/native-americans-and-alaskan-indians

Information & Tips on Screenings & Referrals

Organization	Resource
CDC	• Fetal Alcohol Syndrome Multimedia and Tools: discusses steps to detect and intervene with women who drink alcohol at risky levels: http://www.cdc.gov/ncbddd/fasd/multimedia.html (To view the video, go to "Medscape Video: Alcohol and Women: How to Screen and Intervene" and click "View Video.")
NIH	• Clinical Trials https://www.drugabuse.gov/clinical-trial/search
SAMHSA	• Behavioral Health Treatment Facility Locator: http://findtreatment.samhsa.gov
WIC Works	• Resources for substance use and medication safety: https://wicworks.fns.usda.gov/ (search "substance use")

Training Information/Programs on the Effects of Substance Use

Organization	Resource
CDC	• List of Alcohol-related Programs: http://www.cdc.gov/alcohol/resources.htm
HHS	• Quick Reference Guide for Clinicians: Treating Tobacco Use and Dependence: http://www.tn.gov/assets/entities/health/attachments/TQL_Quick_Reference.pdf
NIDA	• Preventing Drug Use among Children and Adolescents: http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents
SAMHSA	• Prevention of Substance Abuse and Mental Illness: http://www.samhsa.gov/prevention/

Training Information on Screenings, Brief Interventions, Referrals, And More

Organization	Resource
ACOG	• Motivational Interviewing: A Tool for Behavior Change: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Motivational_Interviewing_A_Tool_for_Behavior_Change
American College of Surgeons	• Self-training Resources and Guidelines: http://www.facs.org/trauma/publications/sbirtguide.pdf
CDC	• Fetal Alcohol Spectrum Disorders (FASDs) Training & Education: http://www.cdc.gov/ncbddd/fasd/training.html • Alcohol Screening: http://www.cdc.gov/vitalsigns/alcohol-screening-counseling/index.html
NIDA	• Screening Guide: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment
NIAAA	• Alcohol-Screening Instruments for Pregnant Women: http://pubs.niaaa.nih.gov/publications/arh25-3/204-209.htm • Boston University SBIRT (Screening, Brief Intervention, and Referral to Treatment) Videos: http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/ • Alcohol Alert- Brief Interventions: http://pubs.niaaa.nih.gov/publications/AA66/AA66.htm
SAMHSA	• Enhancing Motivation for Change in Substance Abuse Treatment: http://store.samhsa.gov/shin/content//SMA12-4097/SMA12-4097.pdf • Brief Interventions and Brief Therapies for Substance Abuse: http://www.store.samhsa.gov/shin/content//SMA06-4136/SMA06-4136.pdf

Developing Education Materials

Organization	Resource
CDC	• Guide for Creating Materials: http://www.cdc.gov/healthliteracy/pdf/simply_put.pdf
Center for Medicare and Medicaid Services'	• Toolkit for Written Material: http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit
Harvard School of Public Health	Using health literacy to develop educational materials for participants: • Studies: http://www.hsph.harvard.edu/healthliteracy/practice/
NCI	• Making Health Communication Programs Work: http://www.cancer.gov/publications/health-communication/pink-book.pdf
NIH	• Clear Communication: A Health Literacy Initiative: http://www.nih.gov/clearcommunication/
U.S. Agency for International Development	• Nonverbal Communication Cultural Differences: http://erc.msh.org/mainpage.cfm?file=4.6.0.htm&module=provider&language=English
WIC Works	• Resources on creating educational materials: https://wicworks.fns.usda.gov/ (search "health literacy," "plain language," and "assessing written materials")

APPENDIX 4

Teratogenic Research: Alternatives and Their Limitations

A teratogenic substance is a drug or other agent that causes abnormal development of an embryo.[123] Knowledge of a drug's teratogenic potential is a critical part of that drug's benefit/risk profile[124] and is crucial in guiding doctors' prescribing behavior for pregnant women.[125] However, pregnant women are rarely included in clinical trials,[124] since scientists cannot ethically test drug safety by administering potentially dangerous substances to pregnant women and observing what happens to them and their offspring. Therefore, the only data on fetal effects initially available in the product labeling usually come from animal research.[124]

A major limitation to animal research is the problem of extrapolation – applying information from animal research to humans. Species differences in anatomy, organ structure and function, toxin metabolism, chemical and drug absorption, and mechanisms of DNA repair – among myriad other differences between humans and other species – can give us inadequate or erroneous information when we attempt to apply animal data to human diseases and drug responses. A good example of the deficiencies in animal testing is the research on thalidomide, which did not have harmful effects when administered to pregnant rats and mice (although it did cause limb defects when fed to pregnant rabbits).

Although scientists do not conduct direct clinical studies on humans, they do review available data on drug exposure during pregnancy to assess whether the therapeutic use of a drug results in an increase in adverse fetal effects. Such data come from observational studies such as case reports and epidemiological studies, including case control studies. However, case reports cannot distinguish coincidence from causation and cannot be used to assess teratogenic risk.[124]

Epidemiological studies can identify *associations* between a drug and abnormalities in newborns, and they can quantify the strength of associations; however, maternal attributes such as age, race, weight, parity, geographic location, and socioeconomic status can cause confounding, as can certain medical conditions (e.g., diabetes). These and other factors make it difficult to pinpoint probable causes of specific birth defects.

Moreover, case control studies are retrospective, and thus are subject to recall bias (i.e., there are limitations to the specificity with which mothers can recall their drug exposures during pregnancy, particularly if a drug is used only occasionally for an indication that may not be easily recalled [e.g., pain reliever for a headache]). A mother of an infant born with a major birth defect may be more likely to carefully recall all gestational events and exposures than the mother of an infant who has no birth defects.[124]

Prospective epidemiological studies can address some of the limitations of the retrospective studies, but have limitations of their own. For example, the strength of a cohort study design is the prospective, systematic collection of data, including exposures, confounders, and outcome information. However, generally small numbers of specific birth defects will be seen, even if there is a large study population. Furthermore, the small number of women exposed to specific drugs within the cohort makes it very difficult, if not impossible, to detect even a substantial drug-induced increase in the rate of any birth defect.[124]

With pregnancy exposure registries (a type of cohort study), obtaining an appropriate comparison group is challenging, and registries are often limited by self-referral bias (women who enroll may be more or less likely to have malformed infants). Additionally, loss to follow-up can limit the interpretability of registry data and the length of time an infant is monitored, and the source of the information can influence the number of defects detected.[124]

APPENDIX 5A

Evaluating Education Materials

Sample Education Material Evaluation Form for Staff

Title of education material:

Target group:

Evaluator: Date:

Date last updated:

State teaching objectives of material:

When is the material used?

In class Individual appointment

How frequently used? Place a checkmark in appropriate box:

Daily Once per week Once per month Once every 6 months

Rate by checking the appropriate box:

Readability	Yes	No
3-syllable words are limited; simple medical terminology is used.		
Medical and technical words are defined.		
Writing style	**Yes**	**No**
Headings are used to introduce a new topic.		
Simple sentences are written in the active voice.		
Writing style is conversational, if appropriate.		
Setup	**Yes**	**No**
There is sufficient white space (about one third of the document).		
Diagrams and drawings are easy to understand, if appropriate.		
Information is clearly and logically presented.		
Sentences are short and simple.		
The title reflects the content.		
Content	**Yes**	**No**
The amount of information is not overwhelming.		
The purpose of the education piece is clear.		
The information is presented in a concise manner that is to the point.		

Layout	Yes	No
The majority of print is 14-point type. (This is 14-point type.)		
Use the same font throughout the piece.		
There are no more than four sizes of font in one education piece.		
The font should be "serif" such as Bookman Old Style, Georgia, Times New Roman, or Calisto MT.		
Text is in upper and lower case. All-capital letters are not used.		
There is no underlining.		
There is limited bolding for emphasis.		
Grade level and revision date are included as a footer on last page.		
Visuals	**Yes**	**No**
Graphics are easy to understand and illustrate a single concept.		
Graphics support the purpose of the education piece.		
If using photos rather than clip art, be sure that the photos print clearly in black and white.		

Please write any additional comments in the space below, and attach a copy of the education piece you are evaluating.

APPENDIX 5B

Evaluating Education Materials

Sample Participant Review of Handout

Participant Review of Handout Titled: ______________________________

1. The size of the print in the handout is easy for me to read.

Yes Not sure No

2. The handout is written using words I understand.

Yes Not sure No

3. The handout is well written and helps me understand the topic.

Yes Not sure No

4. The amount of information in the handout is enough to help me understand the topic.

Yes Not sure No

5. Drawings, charts, or checklists are easy to understand.

Yes Not sure No

Does Not Apply

6. Is there anything in the handout you do not understand?

No Yes (please describe):

7. Do you have any questions the handout does not answer?

No Yes (please describe):

8. Do you think we need to make changes to this handout?

No Yes (please describe):

Thank you!

Adapted from the VA Greater Los Angeles Healthcare System, Nutrition and Food Service patient education review form

APPENDIX 6

Guidelines for Developing Education Materials

These guidelines are to help ensure participant understanding of printed materials. These guidelines can also help when evaluating existing materials for use in the WIC Program.

Contrast

Contrast provides visual interest and can aid in the organization of material. Each page should have definite light and dark areas, with ample white space. There are a variety of ways to provide contrast:

- Use two different typefaces. Use 13-point Georgia for the body of the work, because it is easier to read. For headings, use Arial in a larger point size and bolded to provide contrast.
- *Do not use a script typeface*, outline or shadow effects, or USE ALL CAPS, since these are difficult to read. Use bolded type sparingly for titles, headings, and selected items for emphasis.
- Use thick lines, bullets, clip art, borders, tables, and photographs to add contrast. <u>Be careful when underlining, since it reduces readability.</u> Notice that the underline cuts through the lowercase letters that extend below the baseline. Limited use of underlining can add emphasis when making an important point. If you have space, you can use the drawing toolbar to add a line underneath a sentence that will not cut through the text.
- About one third of each page should be white space.
- The use of **color** can be very effective in providing contrast, but **always** remember that the material may be reproduced in black ink. Colors in the green-blue-violet spectrum become grayer looking and should be avoided with elderly readers; mauve is a good color to use.
- **Avoid Reverse** Use sparingly for headings, since it is more difficult to read.
- Dark text is easier to read on a light rather than a gray background. Use a 15% gray background sparingly to provide contrast or help set information apart. Do not place text on top of textured backgrounds.

Proximity

The basic principle of proximity is that you group related items together.

This is an example of poor spacing between text and title. Notice the equal spacing before and after the title.

Typical Title

This text is too far away from the title. Keep related items grouped together. If items are not related, move them apart from each other.

This is an example of improved spacing between text and title. It also illustrates adding contrast by using a gray background.

Typical Title
The text following the title should be close to the title. Avoiding too many separate visual elements on a page will enable you to present a cleaner, crisper look.

Alignment

Be consistent with alignment for a professional look.

- Align objects on a page with the edge of some other object or text. Every item on a page should have a visual connection with something else on the page.
- A flush-left alignment is easiest to read.
- Text is justified if the text lines up to both the left and right margins. Justified text is not recommended if you end up with awkward gaps between words.
- Avoid centering long blocks of type, particularly for three or more lines. Readers have to search for the beginning of each line, which makes centered type more difficult to read.

Adapted from *NFS Guidelines for Developing Veterans Health Education Materials*, VA Greater Los Angeles Healthcare System, Nutrition and Food Service

Repetition

Repeating some aspect of design throughout the entire piece can bring unity to the document.

- Be consistent with margins, indents, and spacing between elements on a page.
- Be consistent with style and size of fonts used for headings and the body of the text, unless you want to emphasize a point.
- Be consistent with clip art. Use the same style of clip art throughout a document, and do not mix clip art with photographs.
- Be consistent with placement and thickness of ruled lines and borders.

Visuals

Clip art, photographs, graphics, and diagrams add visual interest to a document and can enhance readers' comprehension of the material.

- Only use visuals that are relevant to the text.
- Graphics and diagrams should be easy to understand and illustrate a single concept.
- Graphics should be suitable for the culture, religion, ethnicity, and gender of the audience.
- Copyrighted graphics should not be used unless you have a written copyright release. If needed, the phrase "Copyrighted graphics used with permission" should be included. Materials produced by Federal employees are not copyrighted and are considered public domain. See page 110 for more information on copyright.
- If noncolor copies are to be printed, be certain color photos, logos, clip art, and other visuals reproduce clearly in black ink. Make a photocopy to check. What looks wonderful in color can look a lot less appealing in black and white.

- Use of colored paper can add interest to a document. However, black ink on a dark color does not provide a good contrast and is more difficult to read.

Readability

There is often a mismatch between a clinician's level of communication and a participant's level of comprehension. Participants may not understand what clinicians tell them because of inadequate health literacy. Adopt a more participant-friendly communication style to improve participants' understanding of healthcare information.

- Materials should be between the 5th- and 8th-grade reading level. Determine the reading level by using Microsoft Word readability statistics.
- Use everyday words. If possible, use words of two syllables or less. Use simple medical terminology. Medical and technical words should be understandable or defined in the text. Most readers do not use glossaries.
- Additional resources for developing understandable health-based educational materials include, but are not limited to:

  http://www.cdc.gov/healthliteracy/developmaterials/index.html

  http://www.cdc.gov/healthliteracy/developmaterials/guidancestandards.html

  http://www.plainlanguage.gov/

Writing Style

Write in a style that appeals to participants, is easy to understand, and improves retention.

- Present the most important information first and last. Key points should be summarized and repeated.
- Limit information to three or fewer key points. Prioritize and teach less, not more.
- The text and graphics should be suitable for the culture, religion, ethnicity, and gender of the audience.
- Group like information together and follow a logical sequence.
- The title should reflect the content. Use clear and simple headings to introduce new topics and express complete ideas.

  Typical Heading: Seat Belts

  Better Heading: Wear Your Seatbelt – It Could Save Your Life
- Use personal pronouns and a conversational style that reflects how your intended audience speaks.

  Yes: If you go near this chemical, you could get sick.

  No: Exposure to this chemical could cause adverse health effects.

- Provide more DOs than DON'Ts so that the information is about what people *can* or *should* do, which can be more helpful and actionable than what not to do.
- Draw attention to important facts by using visual elements such as headline and text boxes, indenting text, using borders, drawing lines, highlighting, etc.
- Use strategies to engage readers. Build in participants' stories that may relate to readers. Questions often work well as headings and make your materials seem interactive.
- Write in the active voice and avoid using the verb "to be."

  Active: Sue will bring a salad.
  Passive: The salad will be brought by Sue.

  Active: Several people reviewed the memo in draft form.
  Passive: The memo was reviewed in draft form by several people.

Sentence Structure

The length of sentences impacts readability. Think of how difficult a newspaper would be to read if it did not contain columns.

- Keep sentences short and simple. Make most sentences eight to 10 words.
- Paragraphs should not be more than five inches in width. It is acceptable to have long blocks of sentences for no more than three or four lines of text.
- Keep paragraphs narrow by using large margins, columns, tables, or bulleted lists.
- Consider adding space between lines. Use the paragraph option to select line spacing that is 1.2 to 1.5 between lines to make it easier to read.
- Limit lists to five or six items to improve retention. At the most, do not use more than seven bullets per list.
- Do not hyphenate words or wrap text around illustrations.
- Use correct spacing between words. The old rule of having two spaces after a period applied to typewriters, but does not apply to word processing programs. Only one space is needed after any punctuation mark that separates two sentences.
- Place a comma before the conjunction when listing items in a series.

  Preferred: Study the rules for the use of the comma, the semicolon, and the colon.

  Avoid: Study the rules for the use of the comma, the semicolon and the colon.

Copyright

Materials put out by the U.S. government are not copyright protected and are considered to be in the public domain.

- You have to note "Copyrighted material (or graphics) used with permission" in a document if you use any copyrighted materials. This would normally be put in the footer or possibly below a graphic such as a chart. You need to keep a copy of the permission letter or email as evidence this has been obtained and keep it on file with the document. If the document is then used in the public domain, it should not be changed and should be used for its intended purpose (i.e., used for training or education and not used for profit or to promote a product). Save the file in a PDF or XPS format so it cannot be easily modified. It is a professional courtesy to give credit to an author even if his or her work is not copyrighted.
- You can use the free graphics offered by Microsoft without having permission. However, you would need to be able to prove this was the source of your graphics if needed. Graphics from other Internet sources are generally copyrighted. Just because you can copy a graphic does not mean it's not copyrighted!
- You have to consult the vendor if you use a graphic from a site you paid to use, since it will be in the public domain.
- Use trademark symbols if you use/reference trademarked products.

APPENDIX 7

Sample Data Collection Instruments

Following are samples of two instruments that may be used to collect data from WIC staff and participants.

Sample Evaluation Checklist for Staff

	Select one	
	Yes	No
Screening		
1. Screening completed		
2. Evidence of substance use		
Information Dissemination		
1. Information presented		
2. Material discussed with participant		
3. DVD or video shown		
4. Participant questionnaire completed		
Referral		
1. Referral made		
2. If yes, what type of referral resource was suggested?		

Outcome Evaluation: Sample Evaluation Questionnaire for Participants

This information is confidential. Do not put your name on this form.

To our participants: It is important that facts about alcohol, tobacco, other drugs, and pregnancy be given to our participants. Please answer the following questions so that we can see if this information is being given successfully.

	Select one: Yes	No
1. Have you smoked cigarettes during the past six months?		
2. Have you drunk any alcoholic beverages (beer, wine, wine coolers, cocktails, or liquor) during the past six months?		
3. Have you used any street drugs during the past six months?		
4. Were you given information about how using alcohol, cigarettes, and other drugs during pregnancy can hurt your baby?		
5. Was this information helpful to you?		
6. Did you learn anything new?		
7. Have you done anything differently since you were given this information?		

If yes, can you tell us what you have done?
Please check (√) as many as apply:

- a. stopped smoking cigarettes
- b. stopped drinking alcoholic beverages
- c. stopped using street drugs
- d. cut down on smoking cigarettes
- e. cut down on drinking alcoholic beverages
- f. cut down on using street drugs
- g. gotten help with an alcohol, cigarette, or other substance use problem
- h. other (please specify):

	Select one: Yes	No
8. Were you given a referral for an alcohol, cigarette, or other substance use problem?		

If yes, please answer the following questions:

	Yes	No
a. Did you seek help at the place that you were referred to?		
b. Was the referral helpful?		

If no, please tell us why not:

9. What is your age?

10. What is your race or ethnicity?
(Provision of this information is optional.)

Please check (√) one answer:

- a. African American (not of Hispanic origin)
- b. American Indian or Alaska Native
- c. Asian or Pacific Islander
- d. Caucasian (not of Hispanic origin)
- e. Hispanic

Thank you for taking the time to fill this out. If you have any ideas about making this program better, please tell us:

APPENDIX 8

Legal and Confidentiality Issues

Before screening procedures are developed, several relevant legal issues need to be resolved. Current laws and reporting requirements about WIC participant substance use must be considered in light of the WIC confidentiality regulations at 7 CFR Section 246.26(d).

There are three possible State reporting requirements:

1. to law enforcement (criminal);
2. to social services (child protection); and
3. to public health (treatment or statistics, or both).

Applicable State statutes for the protection of participant confidentiality and specific State regulations governing consent by emancipated minors must also be considered. Laws governing these issues may vary from State to State. WIC local agencies should seek State agency guidance regarding legal issues.

Under the provisions of WIC confidentiality regulations, there are specific instances in which disclosure of WIC information is allowable. Below is a summary of the regulations; for more specific and complete information, see CFR 246.26 (d) and (h).

1. Information obtained from WIC participants may be released to individuals directly associated with the administration or enforcement of the WIC Program. This includes providing information to Federal, State, or local authorities investigating or prosecuting WIC Program violations.

2. WIC Program information may be released to public organizations pursuant to a written agreement with the State agency. The following criteria are necessary in order to be party to such an agreement: a public institution must administer health or welfare programs serving WIC's eligible population; each agreement must specify that the information is only to be used to establish a participant's eligibility for the organization's services or conducting outreach or both; and the public organization must agree not to disclose the information to a third party.

3. WIC Program information may be released to the Comptroller of the United States for the purposes of auditing and examining the program.

The sole exception to the WIC confidentiality provisions is that information gathered from WIC participants may be released under State or local laws when such laws have been enacted pursuant to or consistent with Federal policy as reflected in Federal law or regulations. One example of this is the case of child abuse reporting laws. Congress has enunciated a Federal policy encouraging States to establish State Programs to combat the problem of child abuse.

If a State or local law requires reporting of known or suspected child abuse, then reporting that information to State or local authorities is permissible. It would be inappropriate to interpret WIC confidentiality regulations to conflict with direct expressions of Congressional intent. At the same time, however, WIC confidentiality regulations should not be routinely overridden by any State or local law. Federal regulations have the force and effect of Federal law and supersede conflicting State or local law or policy.

It is important to understand that it is not enough that there is a Federal policy encouraging States to adopt child abuse reporting laws. If there are no State or local reporting laws in effect, then it would be inappropriate for the WIC Program to release information in contravention of the WIC regulations. There must be both a specifically stated Federal policy *and* a State or local law requiring an action.

To the extent that prenatal substance use is considered to be child abuse under a State or local law, which also requires reporting of known or suspected child abuse, then reporting that information to State and local authorities is permissible. The definition of "child" for purposes of child abuse reporting laws will vary among States, however, and thus the duty to report suspected or known child abuse will also vary. WIC local agencies should consult with their State agency for specific guidance on this subject.

Confidentiality of Substance Abuse Information

It is important to note that WIC confidentiality regulations permit the release of WIC information for a substance use referral to a public organization administering health or welfare programs serving the WIC population under the State agency's agreement with that organization. It is, therefore, legally permissible for

WIC to release information a participant provides to such an organization in making a referral for counseling or treatment without first obtaining a signed release form.

Also, it may be that in some areas only one entity is available to serve WIC substance use referrals.

- If this entity is party to an agreement with the State agency to share some WIC information, the local agency may assume that such an agreement alleviates the need to have each WIC participant sign a release form at the time of referral. This would be permissible according to WIC regulations.
- Because this is a sensitive area, however, local agencies might prefer to have each individual referred for assessment sign a separate release form specifically acknowledging and allowing the release of substance use–related information.

The main difference in these two approaches is that the information sharing pursuant to an interagency agreement is involuntary – by applying for WIC benefits, an applicant agrees to the exchange of information. A release form, on the other hand, is a voluntary process.

Depending upon the type and extent of WIC local agency substance use/abuse information and referral activities, different Federal regulations and State laws regarding the confidentiality of information collected or recorded about participants' substance abuse will apply.

Current WIC regulations and instructions pertaining to confidentiality of information apply in the usual situations of providing information on substance use and/or abuse in general nutrition education sessions, handing out brochures on substance abuse, providing a list of local resources for counseling and treatment to a participant, or performing minimal basic screening for purposes of informal/passive or formal/active referral for further assessment. (FNS Instruction 800-1 "WIC Program – General Administration: Confidentiality")

The legislation does not impose any specific degree of confidentiality on WIC substance use screening, education, and referral information. Substance use information obtained from a WIC participant, therefore, does not warrant an added degree of protection, and such information may be shared pursuant to interagency agreements. Thus, if a WIC case file is released for any purpose under a sharing agreement, substance use information may properly be included as part of that file. For that reason, some WIC agencies may choose to segregate substance use information from other information contained in a case file, although such protection is not required.

Depending, however, on the orientation of WIC local agencies and their staff, it is possible to conduct substance use/abuse screening and referral activities in such a way as to make the substance use information obtained on WIC participants subject to the Department of Health and Human Services (HHS) "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, 10-1-10 Edition.[126] In general, if an agency goes beyond the minimum mandates of P.L. 100-690 and has drug and alcohol abuse specialists whose primary function is to conduct screening and referral activities, or has a separate unit whose primary function is drug and alcohol abuse diagnosis, treatment, or referral for treatment, these actions will trigger applicability of HHS confidentiality regulations.

WIC professionals who receive brief training, such as a seminar, in detection of substance abuse would *not* be considered to be substance abuse specialists. Any advanced training a WIC employee might have in substance use screening, diagnosis, or treatment should not affect the application of the HHS confidentiality regulations unless the individual applies this training in the WIC substance screening and referral process to extend the type of basic screening activities outlined in this Guide.

WIC agencies performing activities that cause HHS confidentiality regulations to apply must adhere to these regulations or potentially face criminal penalty. HHS confidentiality regulations specifically mandate, for example, the content of written release forms, the notice of Federal confidentiality requirements, and security of the records that contain substance abuse information.

The required content of written release forms is addressed in detail later in this section. Under HHS regulations, the participant must be given notice that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records, and must be given a written summary of the Federal law and regulations. Written records that are subject to HHS confidentiality regulations must be maintained in a secure room, locked file cabinet, safe, or other similar container when not in use. Written procedures must be adopted which regulate and control access to and use of written records that are subject to these regulations.

As local agencies develop substance use/abuse information and referral systems, they are encouraged to consult with WIC State agency staff to determine whether HHS confidentiality regulations must be followed in addition to the WIC confidentiality requirements. A copy of the HHS confidentiality regulations may be obtained at local libraries by asking for the volume of the *Code of Federal Regulations* which contains 42 CFR Part 2; it is also available online at http://www.ecfr.gov. Single copies of the regulations may be requested from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600 or (800) 729-6686, http://store.samhsa.gov/home.

In addition to Federal regulations, once WIC agencies screen participants for substance use, they may, depending on the answers given, possess information deemed confidential by the State or by the code of ethics governing the professional conduct of the screener. To ensure that local agencies are in compliance with Federal regulations, as discussed above, and with the laws operating in their State pertaining to confidentiality issues, they should carefully review procedures with their State agency prior to implementation.

Since this area is controversial and may require additional staff resources, local agencies may wish to adopt a conservative policy to protect both staff and participants. Within the WIC Program, staff responsible for screening should not discuss screening results with other staff except in the context of case management (e.g., to work out an approach for assisting the participant) or to obtain guidance or assistance from a supervisor or other staff member with knowledge about or skill in handling screening and informal/passive or formal/active referrals. Procedures should be established for informing the participant that information is confidential and for ensuring the participant's privacy in any screening and informal/passive or formal/active referral activities at the local agency level. As previously mentioned, although substance use information obtained from a participant does not warrant an added degree of protection, some agencies may choose to segregate substance use information from other information contained in the case file. This, however, is not required.

Unless the participant has given specific written consent for release of the information, screening results are confidential information that should not be shared verbally or in writing, nor made physically accessible to anyone outside the WIC Program except as authorized by the WIC regulations, Section 246.26(d), FNS Instruction 8OO-1, and HHS confidentiality regulations, depending upon applicability.

Even if WIC activities trigger HHS confidentiality regulations, the WIC confidentiality regulations still must be followed in their entirety. In such instances, both regulations apply. As a practical matter, the more stringent regulation will govern. Although in some instances the HHS regulation may be more stringent (such as security of files), the WIC regulations may be more stringent in others (sharing pursuant to State and local laws is strictly limited).

WIC agencies whose substance use/abuse referral activities are governed by the WIC regulations and FNS Instruction 800-1, "WIC Program – General Administration: Confidentiality," should follow the written consent procedures outlined in the instruction. Agencies whose activities also require them to comply with HHS confidentiality regulations must obtain written consent in conformance with these regulations. Specific information must be included in a release form in order to comply with HHS regulations (see DHHS required information for Information Release Form). Other elements, however, may be added. It is recommended that a sentence be added to the release form to stress that receipt of WIC benefits does not hinge on an individual's consent for substance use referral, nor does failure to sign the release form in any way jeopardize program eligibility or participation.

Because legal requirements for reporting substance use by pregnant women vary by State, no hard and fast rules can be offered about WIC's response to this issue. WIC local agencies should consult with their WIC State agency regarding reporting procedures.

For a sample of suggested wording for a release form, see appendix 16: Sample Information Release Forms.

APPENDIX 9

NIDA Quick Screen

NIDA Quick Screen V1.0[1]

Name: .... Sex ( ) F ( ) M Age.......

Interviewer...................................... Date ....../....../......

Introduction (Please read to patient)

Hi, I'm __________, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses <u>other than prescribed</u>. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **<u>In the past year</u>, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says "NO" for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes" to one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information art **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders.
- If patient says **"Yes" to use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html.
- If the patient says **"Yes" to use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1]This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.jamanetwork.com/article.aspx?articleid=225770) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http:/www.who.int/substance_abuse/activities/assist_v3_english.pdf).

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should <u>not</u> indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.**
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST **2.** <u>In the past three months</u>, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. <u>In the past 3 months</u>, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. **<u>During the past 3 months</u>, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. **<u>During the past 3 months</u>, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **<u>ever used</u>** (i.e., those endorsed in the Question 1).

6.	Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a.	Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b.	Cocaine (coke, crack, etc.)	0	3	6
c.	Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d.	Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e.	Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f.	Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h.	Street opioids (heroin, opium, etc.)	0	3	6
i.	Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j.	Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

PDF of NIDA ASSIST Screening Tool:
http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

Online Questions:
http://www.drugabuse.gov/nmassist/?q=qm_json&pageId=questions_1&pageName=QuickScreen&token_id=4128

APPENDIX 10A

Sample Three-Part Screening Instrument — Lifestyle Questionnaire

The following Lifestyle Questionnaire is an example of a screening instrument that flags certain answers with an asterisk (*) in order to alert staff to a response that requires attention.

Welcome to Our Clinic!

Just by being here, you show that you really care about yourself and your baby and that you want this pregnancy to be a successful one. We want the same things for you. We are here to help you and your baby become strong and healthy.

To do this, we need to ask some questions about the food you eat, how much you exercise, how you deal with problems, and how you feel about things in general. The answers to these questions will be kept confidential, so please answer carefully and honestly.

Check (√) the answer to each question.

Exercise

1. Before you were pregnant, how often did you exercise? (walking, bicycling, jogging, swimming, dancing, exercising with television shows, etc.)

   Three or more times per week

   * Fewer than three times per week

2. How often do you exercise now?

   Three or more times per week

   * Fewer than three times per week

3. What kind of exercise do you like best?

   ____

Nutrition

4. How would you describe your appetite?

   Good: I enjoy food and I like to eat

   Fair: Food is okay; but I have trouble eating sometimes

   Poor: I don't enjoy eating very much. I find it hard to eat.

5. Before you were pregnant, how often did you eat?

	Almost always	Sometimes	Never
Breakfast			*
Lunch			*
Dinner			*
Snacks			*

6. Now that you are pregnant, how often do you eat?

	Almost always	Sometimes	Never
Breakfast			*
Lunch			*
Dinner			*
Snacks			*

7. Are you taking any vitamins now?

   Yes   No

8. Are you interested in food stamps or the WIC Program?

   Yes   No   I need more information

Smoking

9. Before you were pregnant, how many cigarettes did you smoke?
   ☐ /day

10. Now that you are pregnant, how many cigarettes do you smoke?
   * ☐ /day

11. How long have you smoked?
   ☐ years

Alcohol/Drugs

12. Before you were pregnant, how often did you drink beer, wine, or another alcoholic beverage?
   * ☐ daily ☐ x/week ☐ x/month ☐ never

13. Now that you are pregnant, how often do you drink beer, wine, or another alcoholic beverage?
   * ☐ daily ☐ x/week ☐ x/month ☐ never

14. What do you usually drink? ☐

15. How many drinks do you have at one time?
   ☐ drinks/time

16. Does your drinking sometimes lead to problems between you and your family, that is, husband, partner, children, parent, or close relative?
   * Yes No

17. During the past year, have close relatives or friends worried or complained about your drinking/drug use?
   * Yes No

18. Has a friend or family member ever told you about anything you said or did while you were drinking that you did not remember?
   * Yes No

19. Have you, within the past year, started to drink alcohol/ use drugs and found it difficult to stop before becoming intoxicated?
   * Yes No

20. Has your father or mother ever had problems with alcohol or other drugs?
   * Yes No

21. Has your husband or partner ever had problems with alcohol or other drugs?
   * Yes No

22. Have you been treated for chemical dependency?
   * Yes No

   When? ☐

23. Have you used any of the following in the past two years?
   * Marijuana * Speed * Downers/tranquilizers
   * Cocaine * Opium or heroin
   * Other street drugs * Prescribed pills

24. Have you used any of these drugs in the past six months?
   * Yes No

   How often?
   * daily ☐ x/week ☐ x/month ☐ never

Mental Health

25. When was the last time you were depressed?
   ☐

   How long did it last?
   ☐

   What did you do for it?
   ☐

26. How much stress is in your life right now?
   (least) 1 2 3 4 5 (most)

Developed by St. Paul Maternal & Infant Care Project, St. Paul-Ramsey Medical Center; St. Paul, MN (1984). Credit St. Paul MIC Project in the duplication of this material. HEALTH START, INC.

APPENDIX 10B

Sample Three-Part Screening Instrument — Lifestyle Assessment

Date: ______ M T W T F a.m. p.m.

Name: ______ Age: ______ Date: ______

Address: ______ Interviewer: ______

Exercise

Before: ☐ x/week

Now: ☐ x/week

Type: ______

Information Given

Nutrition

Appetite: Good Fair Poor

	Almost always	Sometimes	Never
Breakfast			
Lunch			
Dinner			

Referral

Quit smoking Social worker

Lifestyle support C. D. assessment

Nutritionist

WIC Food stamps

Community resource ______

Alcohol

Before: ☐ x/week

Now: ☐ x/week

☐ # drinks/occasion (before)

☐ # drinks/occasion (now)

Information given

Drugs

History of use:

Marijuana Speed Other

Current use:

Marijuana Speed Other

Current frequency:

x/week x/month

Information given

☐ Family history of alcohol/drug abuse

Mother Father Husband Partner

☐ Chemical dependency treatment Date: ______

Follow-Up

Date: ______

Re: Smoking Alcohol Drugs

Notes:

Smoking

Before: ☐ x/day

Now: ☐ x/day

Smoked for: years

Stopped for: ______

Information given

Self-motivated

Attend group

Not motivated

Resistant

Goals

APPENDIX 10C

Sample Three-Part Screening Instrument — Assessment Response

Now that you have obtained information on the lifestyle habits of the participant, you are ready to review the findings with her. In each of the lifestyle areas, *mark one (or more) of the choices* that you would use in discussing these lifestyle issues with your patient, *based on the data* you have obtained in the interview.

Exercise

Affirm present level of exercise as healthy and worthwhile

Give information flyer on exercise

Encourage patient to exercise more than present level

Nutrition

Affirm good appetite and eating habits

Refer to nutritionist for assistance with nutrition/appetite needs

Smoking

Affirm "no smoking" habit

Affirm reduced smoking level since pregnancy

Educate patient on physiological changes due to smoking and resulting risks to a healthy pregnancy

Initiate goal-setting with patient to reduce the number of cigarettes smoked

Alcohol/Drug Use

Affirm "no use"

Educate patient on physiological effects of chemicals on a healthy pregnancy

Ask patient to cut frequency or amount of chemical use

Express concern over pattern of chemical use, asking patient to see a specialist for assessment

Mental Health

Affirm positive mental attitude and skills

Discuss coping skills

Inform patient of resource person to help with stressful life situations (resource persons such as social workers, community agencies, etc.)

HEALTH START, INC.

APPENDIX 11

Sample Health Questionnaire

The Health Questionnaire developed by Dr. Marcia Russell and Dr. Sheila B. Blume is an example of a widely used screening self-test that may be photocopied and used by other agencies. It was designed for patients with good reading skills to self-administer, but can be given by a staff interviewer.

Health Questionnaire

Please check answers below.

1. When you are depressed or nervous, do you find any of the following helpful to feel better or to relax?

	Very helpful	Not helpful	Never tried
a. Smoking cigarettes			
b. Working harder than usual at home or job			
c. Taking a tranquilizer			
d. Taking some other kind of pill or medication			
e. Having a drink			
f. Talking it over with friends or relatives			

2. Think of the times you have been most depressed; at those times did you:

	Yes	No
a. Lose or gain weight?		
b. Lose interest in things that usually interest you?		
c. Have spells when you couldn't seem to stop crying?		
d. Suffer from insomnia?		

3. Have you ever gone to a doctor, psychologist, social worker, counselor, or clergyperson for help with an emotional problem?

   Yes No

4. How many cigarettes a day do you smoke? Check one.

   More than 2 packs 1–2 packs

   Less than 1 pack None

5. How often do you have a drink of wine, beer, or a beverage containing alcohol?

   Three or more times a day Once or twice a week

   Twice a day Once or twice a month

   Almost every day Less than once a month

   Never

6. a. If you drink wine, beer, or beverages containing alcohol, how often do you have four or more drinks?

   Almost always Frequently

   Sometimes Never

   b. If you drink wine, beer, or beverages containing alcohol, how often do you have one or two?

   Almost always Frequently

   Sometimes Never

7. What prescribed medications do you take?

8. What other drugs or medications do you use?

	Yes	No
9. Does your drinking or taking other drugs sometimes lead to problems between you and your family, that is, wife, husband, children, parent, or close relative?		
10. During the past year, have close relatives or friends worried or complained about your drinking or taking other drugs?		
11. Has a friend or family member ever told you about things you said or did while you were drinking or using other drugs that you do not remember?		
12. Have you, within the past year, started to drink alcohol and found it difficult to stop before becoming intoxicated?		
13. Has your father or mother ever had problems with alcohol or other drugs?		

Developed by: Marcia Russell, PhD, Research Scientist V, New York State Division on Alcoholism and Alcohol Abuse, Research Institute on Alcoholism, 1021 Main Street, Buffalo, NY 14203 and Sheila B. Blume, MD., CAC, Medical Director, Alcoholism, Chemical Dependency and Compulsive Gambling Program, South Oaks Hospital, 400 Sunrise Highway, Amityville, NY 117111. This form may be copied.

APPENDIX 12

Stages of Change Model

Prevention education can be viewed as a three-step process: (1) provide accurate information, (2) change attitudes and beliefs, and (3) change behaviors. To facilitate successfully accomplishing each of these steps, employing the Stages of Change Model may be useful. This model describes five stages of readiness and provides a framework for understanding the change process.

Identifying a participant's stage of change during one-on-one counseling can help to tailor interventions to the individual's "readiness" to progress to the next stage. Though prevention campaigns cannot be so personally individualized, designing a campaign that addresses multiple stages of change can help reach individuals in each of the various stages.

What follows is an adaptation of the Stages of Change as a potential framework for substance use prevention efforts, through both campaign efforts and individual sessions, in the WIC Program.

Stage 1: Pre-contemplation

– avoidance (not seeing a problem behavior or not considering change).

With this stage, **the goal is to engage the attention of participants and create awareness that risk is real and personally threatening**. The potentially negative consequences of substance use during pregnancy must become real and personal. Messages must break through the natural denial and optimistic sense of personal invulnerability common in adolescents and young adults. This is the stage for presenting accurate information to increase participants' understanding.

Stage 2: Contemplation

– acknowledging that there is a problem but struggling with ambivalence. Weighing pros and cons and the benefits and barriers to change.

With this stage, **the goal is to convince participants that risk can be eliminated or reduced:** that stopping substance use before or during pregnancy increases the chances for a normal delivery and a healthy baby; for breastfeeding participants, that stopping substance use while breastfeeding increases the chances that the infant will be healthy and grow and develop normally.

Counter hopelessness or fatalism with facts about the importance of stopping substance use and improving the odds for better parenting and a happier child. Teach/promote effective strategies and techniques for quitting smoking, cigarettes, drinking, or other drug use.

Stage 3: Preparation

– taking steps and getting ready to change.

This stage involves a shift in attitudes and motivation and the **belief that change is personally necessary**. The participant must believe that a healthy lifestyle is both desirable and attainable. This belief implies emotional commitment and resolve. A review of the personal costs of substance use versus likely benefits from change is often conducted during this stage. This is the point when the participant first sees that she needs to change.

Stage 4: Action

– making the change and living the new behaviors.

The goal of stage 4 is for the participant to **believe that activities for reducing risk are practical and realistic, that she is both personally responsible for and capable of changing her behavior**. She must accept or develop a realistic action plan to stop or reduce substance use and feel sufficiently competent and confident to start following the plan right away. This is the point at which attitudes become behaviors.

Stage 5: Maintenance

– maintaining the behavior change that is now integrated into the participant's life.

During stage 5, **the participant is working toward a healthy, substance-free lifestyle and following her action plan**. This is a crucial stage, during which relapses are likely. The participant needs all the support and encouragement she can garner from friends, family, and professionals, including constant reassurance that her actions are important and socially approved. Peers who have stopped substance use successfully can be helpful. They are proof that success is possible and that the participant is not alone in her struggles.

For more information on the Stages of Change Model, visit http://www.samhsa.gov/co-occurring/topics/training/change.aspx.

APPENDIX 13

Handling Issues Outside WIC Staff's Scope of Practice

Disclosure of partner violence, inadequate housing, food insecurity, and other issues can come up during conversations about substance use, or at any time during the course of a interaction with a participant. As these issues are outside WIC's scope of practice, they can be difficult issues to respond to; however, it is important to do so in order to move the conversation forward and, if possible, facilitate getting the participant the assistance she needs.

The following chart is adapted from Futures Without Violence's publication *The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*.[127] It offers follow-up questions/responses and offers space for compiling resources. Sample dialogue is included in quotation marks. In addition, the chart can serve as a template for compiling and maintaining a list of local referrals and/or resources to have available for WIC participants, as needed; at minimum, a hotline or Web site resource can be offered. Together, WIC staff can identify and maintain the list of these resources and keep all staff informed so that there is a protocol to be followed.

Follow-up Questions/ Responses	• "Do you feel you are in danger?/Are you in immediate danger?" (domestic violence) • "Do you have somewhere safe to go?" (domestic violence, housing) • "Have you taken any actions so far?" (general) • "Have you talked to anyone else about this?" (general) • "Have you been referred to a program/service for this issue?" (general) • "Have you applied for any programs to assist you with this issue?" (general)
Validation Statements	• "You don't deserve the abuse, and it is not your fault." (domestic violence) • "You are not alone, and help is available." (general) • "Your situation concerns me, and here's why…" (general) • "It sounds like you have a lot going on." (general) • "It sounds like you are in a tough/stressful situation." (general)
Promote Self-Efficacy	• Encourage participant to take action (get help/assistance). • Provide verbal support (expressing that you have confidence in her ability to [insert appropriate goals/desired outcomes]).
National Resources	Domestic Violence • National Hotline: (800) 799-SAFE (7233) or TTY (800) 787-3224 Food Security • Supplemental Nutrition Assistance Program (SNAP): http://www.fns.usda.gov/snap/applicant_recipients/apply.htm • Child Nutrition Programs: http://www.fns.usda.gov/child-nutrition-programs • School Breakfast Program (SBP): http://www.fns.usda.gov/sbp • Fresh Fruit and Vegetable Program (FFVP): http://www.fns.usda.gov/ffvp • Special Milk Program (SMP): http://www.fns.usda.gov/smp • Summer Food Service Program (SFSP): http://www.fns.usda.gov/summer-food-service-program-sfsp • Child and Adult Care Food Program (CACFP): http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program-cacfp • National School Lunch Program (NSLP): http://www.fns.usda.gov/cnd/Lunch/ Housing • ____________________ • ____________________ Suicide • ____________________ • ____________________ Other • ____________________ • ____________________
Local Resources	• ____________________ • ____________________

Providing validation:

- Listen nonjudgmentally
- State that you are concerned for her safety and the safety of her children
- Let her know that she is not alone and that help is available

What to do if a participant says "no":

- Respect her response
- Let the participant know that that there are resources available should the situation ever change
- If the participant says "no" but you believe she may be at risk, offer information and resources that are available

Making referrals to local resources/promoting self-efficacy:

- Encourage participant to take action
- Describe any advocacy and support systems and local referral agencies
- Refer the participant to advocacy and support services within the community
- Refer the participant to organizations that address her unique needs, such as organizations with multiple language capacities, or those that specialize in working with specific populations (e.g., teens, specific ethnic or cultural communities, disabled, deaf, or hard of hearing)
- Offer a choice of available referrals, including on-site advocates, social workers, local resources, hotlines, and/or Web sites
- Provide verbal support, expressing that you have confidence in her ability to make the changes she is striving to make

Reporting to law enforcement or social service agencies:

- Some states have requirements to report current domestic violence victimization to law enforcement or social services.
- Learn applicable statutes in your State
- If your clinic is located in a State with a mandated reporting law, inform participants about any limits of confidentiality prior to conducting assessment. *Also see appendix 8: Legal and Confidentiality Issues*.

For additional information, see http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf.

APPENDIX 14

Local Referral Directory Form

Service Name:

General Description:

Location/Service Details

Address:

Telephone number:

Contact person:

Service hours:

Access via public transportation:

Costs/Medicaid participation:

Language(s) spoken:

Specific services:

Staffing pattern (ethnic composition of staff, ratio of males to females, number of physicians and nurses):

Philosophy:

Accepts/prioritizes pregnant women: Yes No

Eligibility criteria:

Availability of child care:

Web site address:

Optional Information:

Comments and recommendations:

Links to news articles/Web site printouts about the service:

APPENDIX 15

Resource for Conveying Technical Language

Conveying Technical Information in a Less "Technical" Manner

When working with WIC participants, it is helpful to avoid technical language. Rather, try to use simple language to convey technical information.

Examples of simple messaging (the topic here is alcohol use during pregnancy):[120]

- "If you drink, your unborn baby drinks too."
- "Drinking when you are pregnant can harm your unborn baby."
- "Some babies whose mothers drank during pregnancy:
  - are born very small and have a hard time growing healthy and strong";
  - have faces that are deformed or look different (if asked: no upper lip, smooth between nose and lip, and smaller eye openings)";
  - have problems in other parts of their bodies, like their hearts";
  - grow up to have trouble learning in school and may be mentally retarded";
- "Even if they don't have such serious problems, some babies:
  - are difficult to care for because they have trouble eating or sleeping";
  - are very active when they are growing up and have trouble paying attention in school";
  - are slower to learn to talk and develop language";
  - have trouble remembering things and doing well in school";
  - have problems with their hearing or vision."

The Colorado Department of Public Health and Environment's WIC Certification orientation module provides guidance for conveying substance use information to WIC participants.

The module (which is part of a larger Colorado WIC training manual) can be found at: https://www.colorado.gov/cdphe/wic-certification-program (Level 1 Modules, *WIC Orientation*).

The PDF of the Level 1 Module/WIC Orientation may be downloaded from this Web page: https://www.colorado.gov/pacific/sites/default/files/PF_WIC_Orientation-Module_1.pdf.

APPENDIX 16

Sample Information Release Forms

Suggested wording for release of confidential information is provided on the Sample Information Release Forms below.

Department of Health and Human Services (HHS) Required Information for Information Release Form

1. I, ____________________ , Request Authorize
(name of client)

2. Name or general designation of program making disclosure:
____

3. To disclose (kind and amount of information to be disclosed):
____

4. To (name or title of the person or organization to which disclosure is to be made):
____

5. For (purpose of the disclosure):
____

6. Date (on which this consent is signed): __________

Signed: ____________________
(signature of participant)

____
(signature of parent or guardian – if required)

____
(signature of person authorized to sign in lieu of the participant – if required)

This consent is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

____
(specific date, event, or condition)

Sample Information Release Form

I, ______________________________, authorize the
(type/print name)

______________________________ to disclose my alcohol and
(WIC agency)

other drug use screening results to ______________________________
(person or organization)

only for the purpose of further assessment.

Date: __________

Signed: ______________________________
(signature of participant)

____
(signature of parent or guardian – if required)

____
(signature of person authorized to sign in lieu of the participant – if required)

This release form is subject to revocation at any time except to the extent that the WIC agency has already taken action in reliance on it. If not previously revoked, this consent will terminate upon

____
(specific date, event, or condition)

Receipt of WIC benefits does not hinge on consent for substance use referral, nor does failure to sign this form in any way jeopardize program eligibility or participation.

APPENDIX 17

Glossary of Drug User Terminology

Bad Trip – A panic reaction or other seriously disturbing psychological reaction to a psychoactive drug, such as marijuana or LSD.

Bag – An amount or retail unit of heroin sold on the street.

Balloon – A unit of measure similar to a bag.

Base – (1) Crack, a smokable form of cocaine; (2) to smoke a specially prepared form of cocaine in a water pipe.

Belushi – (after John Belushi) A speedball, alternative injections of cocaine and heroin.

Binges – Intermittent sprees of heavy drinking of alcohol or heavy use of other drugs.

Bogart – Keeping a marijuana cigarette to oneself, as opposed to passing it to others in the group.

Bong – A large, cylindrical water pipe for smoking marijuana.

Boot – (1) To inject a drug directly into a vein; to mainline; (2) to draw up blood into a syringe and mix with a substance, usually cocaine.

Bummer – A bad experience from a drug.

Burnout – A person whose intelligence and motivation are noticeably diminished as a result of using drugs.

Bust or Busted – An arrest. To be "busted' means to be arrested.

Clean – Not using drugs, especially after having been dependent on them.

Coming Down – To be experiencing the gradual disappearance of a drug's psychic effects as the drug wears off.

Connection – A source from whom a drug can be obtained.

Conversion Kit – A kit for converting cocaine to a smokable form.

Cooker – A bottle cap or spoon used to dissolve heroin in water.

Cop – To obtain or buy a drug.

Crash – To come down from the effects of a drug, sometimes with accompanying extreme fatigue or depression.

Cut – To adulterate a drug to increase its bulk (and the dealer's profit). Also refers to the material that is used to adulterate the drug. Most street drugs are cut and may contain 10 percent or less of the drug.

Dealing – Trafficking in drugs illegally.

Dillies – Prescription synthetic morphine.

Dirty – (1) Containing drugs, as in "He had a dirty urine" (i.e., a drug-containing urine sample); (2) using heroin or speed, especially after being clean.

Doing – To make use of a drug, as in "He was doing coke" (cocaine).

Drop – To swallow a drug.

Dry – Not carrying any drugs.

Fix – To inject drugs, especially heroin; an injection of drugs.

Freak Out – To have a panic or psychotic reaction to a drug (or other frightening experience).

Freebase – To smoke a form of cocaine in a water pipe; a smokable form of cocaine.

Good Stuff – Originally referred to high-quality heroin, but now used to refer to any drug that is potent or more pure than usual.

Head – Someone who uses a drug regularly, as in "He's a pothead" (a marijuana user).

High – The condition of being intoxicated on a drug, including alcohol.

Hit – A dose of a drug, as in "Give me a hit."

Hold – To have drugs in one's possession.

Key – A kilogram (2.2 pounds) of a drug, especially a compressed block of marijuana weighing one kilogram.

KJ – "Killer joint," marijuana cigarette with PCP.

Lid – About an ounce of marijuana.

Mainline – To inject a drug into a vein.

Mike – A street term for a microgram (1/1,000,000 gram) of a drug, usually LSD. A typical dose of LSD may range from 100 to 250 micrograms.

Narc – A narcotics agent. Also spelled nark.

Nod – A state of drowsiness or dreaminess caused by a drug, usually heroin.

OD – Overdose; results range from unconsciousness to death.

Outfit – Syringe and needle.

Overamp – Overdose of speed, usually in the sense of too intense a sensation.

Papers – Cigarette papers that are used to hand-roll marijuana cigarettes.

Paraphernalia – Equipment for preparing or consuming illegal drugs. Such merchandise may be sold as a sideline to another major business, such as a record or poster shop, or sold in a "head shop," a store devoted primarily to the needs of users of illicit drugs.

Redi-rock – A small piece of specially prepared cocaine, often inserted in a cigarette for instant availability.

Relapse – A return to using drugs after a period of sobriety ("falling off the wagon").

Rig – Syringe and needle.

Roach Clip – Clip or tweezers used to hold the butt ("roach") of a marijuana cigarette so that the butt can be smoked to as short a length as possible.

Run – To inject drugs. To be "on a run" is to use intravenous (IV) drugs continuously.

Rush – The first intensely pleasurable feeling produced after taking a drug; the term is often associated with cocaine.

Skin-popping – Injecting a drug (usually heroin) under the skin rather than into a vein. Skin-popping frequently suggests an earlier stage in drug dependency than mainlining.

Snort – To inhale a drug through the nose in a manner similar to that used in taking tobacco to snuff. Cocaine is probably the most common drug consumed in this way.

Spaced Out – Under the influence of a mind-altering, illegal drug to the extent that communication is difficult or the drug's effects are evident to the bystander.

Speedball – Alternative injections of cocaine and heroin.

Stash – A personal supply of drugs; a hiding place for drugs.

Stoned – A synonym for being high, or drug-intoxicated.

Straight – Not using drugs; someone who doesn't use drugs.

Street Names for Various Substances

- **Alcohol:** Booze, hooch, brew, juice.
- **Amphetamines:** Speed, uppers, pep pills, bennies, dexies, meth, crystal, black beauties, crank, ice, Skippy, the smart drug, vitamin R, roses, hearts.
- **Cocaine:** C, Coke, snow, girl, toot, nose candy, blow, flake.
- **Crack:** Cloud 9, rock, cokesmoke, super white, Scotty. (Crack cocaine is a form of the drug that has been processed to make a rock crystal, which, when heated, produces vapors that are smoked.)
- **Hallucinogens:** PCP – loveboat, hog, killer weed, angel dust, lovely, peace pill, superpot (when combined with marijuana); LSD – acid; Mescaline – mesc; Peyote – buttons; Psilocybin – mushrooms, magic mushrooms.
- **Inhalants and Solvents:** Glue, sniff, poppers, locker room, whippets, laughing gas, tywol.
- **Marijuana:** Pot, grass, joint, weed, reefer, dope, herb, Acapulco gold, sinsemilla (a very strong variety); Hashish or "hash," made from the resin of the marijuana plant, is considered stronger than most marijuana, but usually not as strong as sinsemilla.
- **Opiates and Synthetic Narcotics:** Heroin – junk, smack, horse, H, boy, mud, scag, black tar, China white, brown sugar; Methadone – meth, hillbilly heroin, oxy, OC, oxycotton, percs, happy pills, vikes.
- **Sedative-Hypnotic and Anxiolytic Medications:** Trade names – Nembutal, Seconal, Valium, Xanax, Ativan, Dolman; Street names – downers, barbs, ludes, pills, yellow jackets, red or blue devils, reds, red birds, yellows, tooies, candy, sleeping pills, zombie pills, tranks, A-minus.
- **Tobacco and Nicotine:** Butt, smoke, cigs, chaw, quid, snuff, dip, chew, snus, hookah, bidi, cigarillos.

Strung Out – To be seriously dependent on a drug and have evident effects from using it or have withdrawal symptoms from discontinuing using it.

Toke – A puff on a marijuana cigarette.

Turn On – To get high on a drug or to get someone else high or introduce him or her to an illicit drug.

Wasted – To be extremely intoxicated on a drug, including alcohol.

Zonked – To be extremely intoxicated on a drug, including alcohol.

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