TOBACCO, ALCOHOL, & OTHER DRUG **2008 Report**

Abuse Trends IN WASHINGTON STATE

Washington State
Department of Social & Health Services
Division of Alcohol and Substance Abuse
www1.dshs.wa.gov/dasa

NEW/CHANGING TRENDS

- Washington State has among the highest rates of non-medical use of prescription pain relievers in the nation. (page 69)
- Total medical savings for individuals receiving chemical dependency treatment as a result of treatment expansion were $19.6 million for the 2005-2007 Biennium. (page 310)

Direct inquiries for additional copies of

Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State,

to:

Washington State Alcohol Drug Clearinghouse
1-800-662-9111
or (206) 722-3700 (from out of state)

This report is also available on the
Division of Alcohol and Substance Abuse website:
www1.dshs.wa.gov/dasa/

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State

2008 Report

David H. Albert

December 2008

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CHRISTINE O. GREGOIRE
Governor

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Message from the Governor

November 2008

I am pleased to share with you the 2008 edition of *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State*. This report makes clear the great stake we all share in finding ways to combat the misuse of alcohol, tobacco, and drugs, which exact such a heavy toll upon Washington's communities.

This publication provides a wealth of information regarding the prevalence of substance abuse among youth and adults, as well as its effects upon our health and well-being. Addiction to alcohol, tobacco, and drugs is both a public-health and public-safety issue. It results in increased violence, crime, delinquency, birth defects, and illnesses. It inhibits economic vitality, saps our productivity, and makes our efforts to improve education much more difficult.

Fortunately, as this Trends report makes clear, prevention strategies and treatment programs are working. The substantial expansion of quality, effective chemical dependency treatment programs that I authorized in 2005 is now being implemented, and the results are indeed exciting. The coordinated efforts of prevention and treatment professionals, law enforcement, the judiciary, and schools are helping to build a safer, healthier Washington for all of us.

As we prepare to meet our future challenges, I am acutely aware of the importance of having reliable and comprehensive information to assist decision-making at both the state and local level. This report serves as an important and valuable tool for distributing facts to guide us in our continuing efforts to make Washington an even better place in which to live, work, and raise a family.

Sincerely,

Christine O. Gregoire
Governor

Message from the Acting Director

It is a privilege for me to introduce the publication of this 16th edition of *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*. As this and previous reports amply demonstrate, the economic, social, and health benefits resulting from the provision of quality substance abuse prevention and treatment services far outweigh the costs of providing them. Benefits include lower crime and criminal justice-related costs, lower medical costs and less reliance on public assistance, higher rates of employment and worker productivity, lower child welfare costs and fewer Child Protective Services referrals, lower social service costs, better school performance, lower school dropout rates, and reduced youth delinquency.

This year, the Division undertook a major strategic planning process with the assistance of the Citizens Advisory Council on Alcoholism and Drug Addiction and representatives of the Association of County Human Services. As part of its efforts to ensure one of the most extensive reviews of stakeholder input in its history, DASA reviewed needs assessments and six-year prevention and treatment plans submitted by all 39 counties. These in turn were based on input received from thousands of individuals, county administrative alcohol and drug boards, community-based prevention and treatment providers, representatives from local law enforcement, criminal justice, and social services agencies, and elected officials.

The results are a renewed commitment to an array of services designed to meet the prevention, intervention, treatment, and aftercare (PITA) needs of individuals, families, and communities, to articulate and integrate a full continuum of care and, for clients experiencing substance abuse problems, to provide the supports necessary to their recovery.

The *Trends* Report documents the effectiveness of these efforts. Proven, evidence-based prevention practices implemented in SFY 2007 will save the State almost $18 million during the lifetime of those served. The Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program has proven effective in intervening in the lives of substance-abusing emergency department patients before they become chemically dependent. Cost offsets in Medicaid from the expansion in treatment access authorized by the Legislature and Governor in 2005 are substantially greater than anticipated. Support services made possible through the Access to Recovery (ATR) program enhance treatment and retention, and move patients toward healthier, more productive lives in their families and communities.

With the alarming increase in prescription drug abuse among both youth and adults, and continued misuse and abuse of alcohol and other drugs by individuals 18-25, there is more work to be done. With our partners at the local, state, and federal levels, DASA will continue our commitment to a healthier Washington. We look forward to the continuing opportunity to support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and supporting individuals in their recovery from the disease of chemical dependency.

John Taylor

The Division of Alcohol and Substance Abuse: Mission and Strategic Goals

In 2008, the Division of Alcohol and Substance Abuse (DASA), with the assistance of a joint committee of the Citizens Advisory Council on Alcoholism and Drug Addiction and the Association of County Human Services and others, adopted a new Strategic Plan for 2009-2013. In doing so, DASA revisited its Mission Statement to ensure that it continues to reflect the needs of Washington residents and the philosophy behind the Division's operations.

Mission

The Mission of the Department of Social and Health Services is to improve the quality of life for individuals and families in need. We will help to achieve safe, self-sufficient, healthy and secure lives. The Division of Alcohol and Substance Abuse promotes strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency.

To succeed in its Mission, the Division of Alcohol and Substance Abuse is dedicated to building collaborative partnerships with communities, tribes, counties, service providers, schools, college and universities, the criminal justice system, and other agencies within the private sector and within local, state, and federal governments. The Division is committed to ensuring services are provided to individuals and communities in ways that are culturally relevant, and honor the diversity of Washington State.

To carry forth our Mission, the Division of Alcohol and Substance Abuse will:

- Develop policy options, and plan for the development and delivery of an effective continuum of chemical dependency prevention and treatment services.
- Provide and ensure quality services that support individuals and families in their efforts to raise children who are free of alcohol, tobacco, and other drugs.
- Educate communities about the importance of maintaining healthy lifestyles, and provide opportunities, tools and resources to enable communities to define and meet their local substance abuse prevention needs.
- Implement a continuum of intervention and treatment services to meet local, regional, tribal and statewide needs, and that specifically address the needs of low-income adults, youth, women, children, and families.
- Support continued recovery from addiction and a return to competitive employment by helping individuals surmount barriers to self-sufficiency.
- Develop standards, and assist providers in attaining, maintaining, and improving the quality of care for individuals and families in need of prevention, intervention, treatment, and aftercare services.

- Provide training and professional development opportunities for the chemical dependency field.
- Oversee and coordinate research that identifies need for publicly funded services, and assesses prevention and treatment outcomes, costs, and benefits.
- Design, develop, implement, and maintain management information services and decision support systems for internal and external customers.
- Manage available resources in a manner consistent with sound business practices.
- Advocate for enhanced resources for prevention, intervention, treatment, and aftercare services. These services serve as a primary avenue for protecting and promoting the public health and safety of all Washington residents.

Strategic Goals

As part of its Strategic Plan and to serve its broad mission, the Division of Alcohol and Substance Abuse has set five strategic priorities for 2009-2013:

- Reaffirm our commitment to evidence-based, targeted substance abuse prevention, and continue to implement efforts to combat underage drinking.
- Expand the range and location of intervention services available to non-chemically dependent, substance-abusing youth and adults.
- Assure delivery of a full range of high quality chemical dependency treatment services to adults and youth who are eligible and in need of them.
- Promote the wider availability of aftercare and support services to assist individuals in their recovery from alcohol and other drug addiction.
- Ensure an adequate, diverse, and competent workforce capable of meeting the substance use-related needs of Washington residents.

Introduction

The Division of Alcohol and Substance Abuse (DASA) first published the *Tobacco, Alcohol, and Other Drug Abuse Trends Report* in 1993 as an effort to document and monitor Washington State's progress towards the ***Healthy People 2000: National Health Promotion and Disease Prevention Objectives***. Published in 1990, ***Healthy People 2000*** provided statistical milestones by which health policy makers and analysts can measure progress in the prevention of morbidity and mortality. A successor – ***Healthy People 2010*** – published by the U.S. Department of Health and Human Services, sets new objectives for the current decade.

Healthy People 2000 noted the significant impact that alcohol, tobacco, and other drugs have on the health of individuals and communities:

> Recognition and acknowledgement of the gravity of alcohol and other drug problems in the United States are changing the social climate. Almost every national opinion poll places alcohol and other drug problems as a priority concern, and the national effort to prevent these problems have mobilized government, schools, communities, businesses, and families...Progress will depend greatly upon increasing levels of education and awareness.[1]

Public education and awareness are integral parts of DASA's goal – to reduce the likelihood of individuals becoming chemically dependent, and to provide an opportunity for chemically dependent persons to achieve and maintain recovery. This *Report* represents an important tool in our ongoing efforts towards this goal.

This is the 16th edition of *Tobacco, Alcohol, and Other Drug Abuse Trends.* We continue to expand and refine the *Report.* This year we have provided new data related to patients who are addicted to prescription-type opiates, many of whom receive opiate substitution treatment. The section on underage drinking is significantly enhanced. Reducing underage drinking is one of DASA's strategic priorities for 2009-2013. This section documents the impact of underage drinking, and the relationship between early initiation of alcohol use and future alcohol problems and alcoholism among both youth and adults. There is substantial new data added on the effectiveness of the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) project, as well as the impact of the Access to Recovery (ATR) grant. Data regarding the extent of substance use, substance use disorders, and need for treatment is updated. Areas where new or changed trends are now being identified are clearly marked. The "DASA on Brief" section provides an update on the Division's budget and the results of the most recent Legislative Session.

[1] U.S. Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives, pp. 164-165. Washington, DC: U.S. Department of Health and Human Services, 1990.

The federal Controlled Substance Act (CSA) of 1970 gave Congress the authority to regulate the interstate commerce of drugs, and established five schedules that classify all substances, which were in some manner regulated under existing federal law. The placement of each drug is based upon the substance's medical use, potential for abuse, safety, and risk of dependence. The Act also provides a mechanism for substances to be controlled, or added to a schedule; decontrolled, or removed from control; and rescheduled or transferred from one schedule to another.

In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered as follows:

- The drug's actual or relative potential for abuse.
- Scientific evidence of the drug's pharmacological effects.
- The state of current scientific knowledge regarding the substance.
- Its history and current pattern of abuse.
- The scope, duration, and significance of abuse.
- What, if any, risk there is to public health.
- The drug's psychic or physiological dependence liability.
- Whether the substance is an immediate precursor of a substance already controlled.

Schedule I

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Some Schedule I substances are heroin, LSD, marijuana, and methaqualone.

Schedule II

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Schedule II substances include morphine, PCP, cocaine, methadone, and methamphetamine.

Schedule III

- The drug or other substance has a potential for abuse less than the drugs or other substances in Schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- Anabolic steroids, codeine, and hydrocodone with aspirin or Tylenol, and some barbiturates are Schedule III substances.

Schedule IV

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Included in Schedule IV are Darvon, Talwin, Equanil, Valium, Xanax, and Soma.

Schedule V

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- Over-the-counter cough medicines with codeine are classified in Schedule V.

Controlled Substances Uses and Effects

Drugs	CSA Schedules	Trade or Other Names	Medical Uses
NARCOTICS			
Heroin	I	Diacetylmorphine, Horse, Smack	None in U.S., Analgesic, Antitussive
Morphine	II	Duramorph, MS-Contin, Oramorph SR, Roxanol	Analgesic
Codeine	II, III, V	Empirin w/Codeine, Fiorinal w/Codeine, Robitussin A-C, Tylenol w/Codeine	Analgesic, Antitussive
Hydrocodone	II, III	Lorcet, Hycodan, Tussionex, Vicodin	Analgesic, Antitussive
Hydromorphone	II	Dilaudid	Analgesic
Oxycodone	II	Percocet, Percodan, Roxicet, Roxidodone, Tylox	Analgesic
Methadone and LAAM	I, II	Dolophine, levomethadyl acetate, Orlaam	Analgesic, Treatment of Dependence
Fentanyl and Analogs	I, II	Alfenta, Duragesic, Innovar, Sufenta	Analgesic, Anesthetic
Other Narcotics	II, III, IV, V	Puprenex, Buprenorphine, Subutex, Suboxone, Darvon, Demerol, Opium, Talwin	Analgesic, Antidiarrheal, Treatment of Dependence
DEPRESSANTS			
Chloral Hydrate	IV	Noctec, Somnos, Felsules	Hypnotic
Barbiturates	II, III, IV	Amytal, Florinal, Nembutal, Seconal, Tuinal	Anesthetic, Anticonvulsant, Sedative, Hypnotic, Veterinary Euthanasia Agent
Benzodiazepines	IV	Ativan, Dalmane, Diazepam, Halcion, Librium, Paxipam, Rohypnol[2], Serax, Tranxene, Valium, Versed, Xanax	Antianxiety, Sedative, Anticonvulsant, Hypnotic
Glutethimide	II	Doriden	Sedative, Hypnotic
Gamma Hydroxybutyrate[1]	I	GHB, Georgia Home Boy, Liquid Ecstasy	None in U.S.
Other Depressants	I, II, III, IV	Equanil, Miltown, Noludar, Placidyl, Valmid, Soma	Antianxiety, Sedative, Hypnotic

Source: U.S. Department of Justice, Drug Enforcement Administration

[1] Washington State Board of Pharmacy has GHB and related analogs included in Schedule III.
[2] Some of the following drug names are products that may contain other active agents.

Physical Dependence	Psychological Dependence	Tolerance	Duration (Hours)	Usual Method	Possible Effects	Effects of Overdose	Withdrawal Syndrome
NARCOTICS							
High	High	Yes	3 - 6	Injected, Sniffed, Smoked	• Euphoria • Drowsiness • Respiratory depression • Constricted pupils • Nausea	• Slow & shallow breathing • Clammy skin • Convulsions • Coma • Possible death	• Watery eyes • Runny nose • Yawning • Loss of appetite • Irritability • Tremors • Panic • Cramps • Nausea • Chills & sweating
High	High	Yes	3 - 6	Oral, Smoked, Injected			
Moderate	Moderate	Yes	3 - 6	Oral, Injected			
High	High	Yes	3 - 6	Oral			
High	High	Yes	3 - 6	Oral, Injected			
High	High	Yes	4 - 5	Oral			
High	High	Yes	12 - 72	Oral, Injected			
High	High	Yes	10 - 72	Injected, Trans-dermal Patch			
High-Low	High-Low	Yes	Variable	Oral, Injected			
DEPRESSANTS							
Moderate	Moderate	Yes	5 - 8	Oral	• Slurred speech • Disorientation • Drunken behavior without odor of alcohol	• Shallow respiration • Clammy skin • Dilated pupils • Weak & rapid pulse • Coma • Possible death	• Anxiety • Insomnia • Tremors • Delirium • Convulsions • Possible death
High-Mod.	High-Mod.	Yes	1 - 16	Oral, Injected			
Low	Low	Yes	4 - 8	Oral, Injected			
High	Moderate	Yes	4 - 8	Oral			
Unknown	Unknown	Yes	Dependent on dose	Oral, Snorted			
Moderate	Moderate	Yes	4 - 8	Oral			

Controlled Substances Uses and Effects

Drugs	CSA Schedules	Trade or Other Names	Medical Uses
STIMULANTS			
Cocaine	II	Coke, Flake, Snow, Crack	Local anesthetic
Amphetamine/Methamphetamine	II	Adderall, Desoxyn, Dexedrine	Attention deficit disorder, narcolepsy, weight control
Methylphenidate	II	Ritalin	Attention deficit disorder, narcolepsy
Khat (cathinone/cathine)	I, IV	Kat, Qat, Chat, Tohai, Tschat, Mirraa	None
Other Stimulants	II, III, IV	Adipex, Didrex, Ionamin, Melfiat, Meridia, Plegine, Prelu-2, Preludin, Sanorex, Tenuate, Tepanil	Weight control
CANNABIS			
Marijuana	I	Acapulco Gold, Grass, Mary Jane, Pot, Reefer, Sinsemilla, Thai Sticks	None
Tetrahydrocannabinol	I, II	Marinol, THC	Antinauseant
Hashish and Hashish Oil	I	Hash, Hash Oil	None
HALLUCINOGENS			
LSD	I	Acid, Boomers, Microdot, Trips	None
Mescaline & Peyote	I	Buttons, Cactus, Mescal	None
Amphetamine Variants	I	DOM, DOB, Ecstasy, MDA, MDMA, Nexus, STP	None
Phencyclidine & Analogs	I, II	Angel Dust, Hog, Loveboat, PCE, PCP, TCP	None
Ketamine	III	Ketaject, Ketalar	General anesthetic
Other Hallucinogens	I	Bufotenine, DMT, Ibogaine, Psilocybin, Psilocyn	None
ANABOLIC STEROIDS			
Testosterone (Cypionate, Enanthate)	III	Androderm, Delatestryl, Depo-Testosterone	Hypogonadism
Nandrolone (Decanoate, Phenpropionate)	III	Deca-Durabolin, Durabolin, Nortestonsterone	Anemia, Breast cancer
Oxymetholone	III	Anadrol-50	Anemia

Source: U.S. Department of Justice, Drug Enforcement Administration; National Institute on Drug Abuse

Physical Dependence	Psychological Dependence	Tolerance	Duration (Hours)	Usual Method	Possible Effects	Effects of Overdose	Withdrawal Syndrome
STIMULANTS							
Possible	High	Yes	1 - 2	Sniffed, Smoked, Injected	• Increased alertness • Excitation • Euphoria • Increased pulse rate & blood pressure • Insomnia • Loss of appetite	• Agitation • Increased body temperature • Hallucinations • Convulsions • Possible death	• Apathy • Long periods of sleep • Irritability • Depression • Disorientation
Possible	High	Yes	2 - 4	Oral, Injected, Smoked			
Possible	High	Yes	2 - 4	Oral, Injected			
Unknown	Moderate	Possible	1 - 2	Oral			
Possible	High	Yes	2 - 4	Oral, Injected			
CANNABIS							
Unknown	Moderate	Yes	2 - 4	Smoked, Oral	• Euphoria • Relaxed inhibitions • Increased appetite • Disorientation	• Fatigue • Paranoia • Possible psychosis	• Occasional reports of insomnia • Hyperactivity • Decreased appetite
Unknown	Moderate	Yes	2 - 4	Smoked, Oral			
Unknown	Moderate	Yes	2 - 4	Smoked, Oral			
HALLUCINOGENS							
None	Unknown	Yes	8 - 12	Oral	• Illusions and hallucinations • Altered perception of time and distance	• More intense "trip" episodes • Psychosis • Possible death	• Unknown
None	Unknown	Yes	8 - 12	Oral			
Unknown	Unknown	Yes	Variable	Oral, Injected			
Unknown	High	Yes	Days	Oral, Smoked			
Unknown	Unknown	Yes	Variable	Injected, Oral, Smoked			
None	Unknown	Possible	Variable	Smoked, Oral, Injected, Sniffed			
ANABOLIC STEROIDS							
Unknown	Unknown	Unknown	14 - 28 Days	Injected	• Virilization • Acne • Testicular atrophy • Gynecomastia • Agressive behavior • Edema	• Unknown	• Possible depression
Unknown	Unknown	Unknown	14 - 21 Days	Injected			
Unknown	Unknown	Unknown	24	Oral			

Street Prices for Illicit Drugs, 2007

DRUG	UNIT	AVERAGE STREET PRICE	RANGE
Heroin	GRAM OUNCE	$69 $690	$20-$200 $250-$2,000
Cocaine	GRAM OUNCE	$68 $673	$40-$100 $500-$1,100
Methamphetamine	GRAM OUNCE	$69 $1,350	$28-$100 $417-$1,350
Cannabis	GRAM OUNCE	$21 $233	$10-$80 $125-$400

Source: Northwest High Intensity Drug Trafficking Area (HIDTA), *Threat Assessment and Strategy for Program Year 2009*.

The Northwest High Intensity Drug Trafficking Area (HIDTA) periodically gathers data on both street prices and availability of common illicit drugs of abuse. Information is compiled from the Drug Enforcement Agency, U.S. Border Patrol, area narcotics taskforces, sheriff's offices, police departments, and the Coast Guard. Both price and availability can vary widely, both by region and by county.

Average street prices for all four drugs of abuse were higher in 2007 than in 2006.

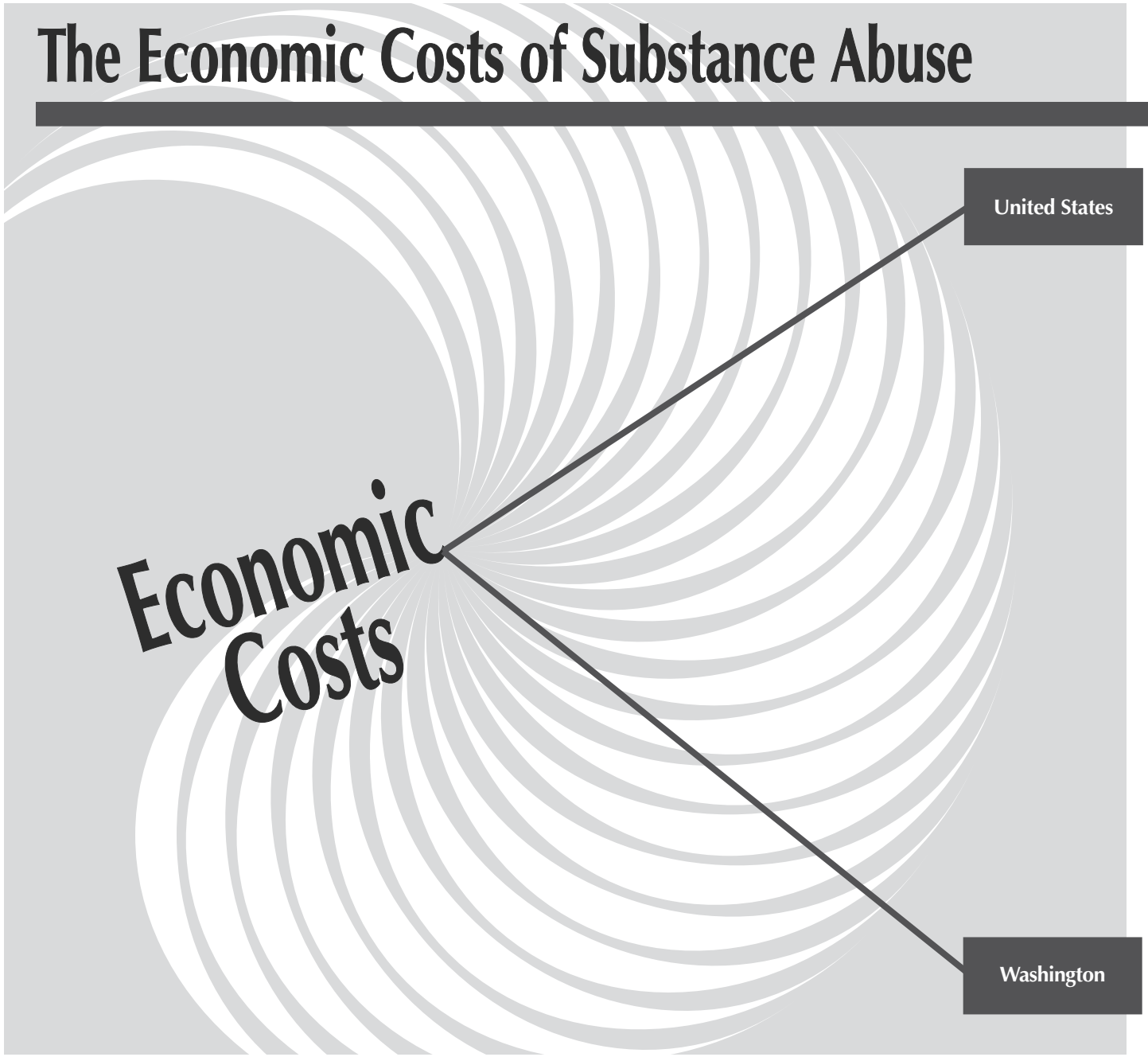
New/Changing Trends for 2008

Preparation of the *Trends Report* annually makes it possible to examine data for new or changing trends. Such trends can mark the success or failure of a recent legislative effort, a new intervention or change in public health practice, or changes in behavior. They may point the way toward increased need for surveillance, research and analysis, or reorientation in the delivery of public services.

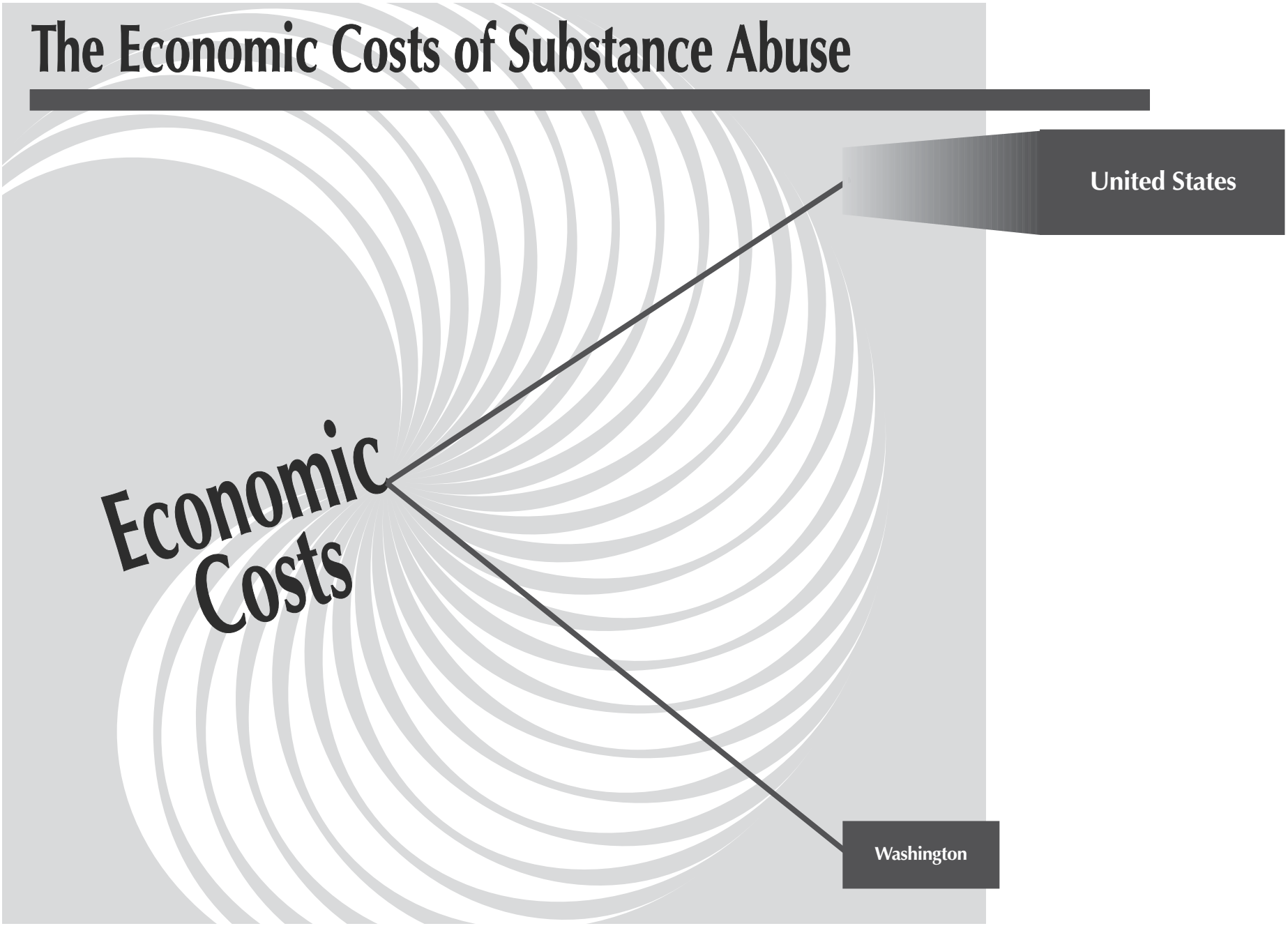
For 2008, the following new or changing trends are worthy of note:

- Steroid use among students in Washington State is increasing. (page 48)
- More than one in ten Washington 10th and 12th graders used prescription pain medications to get high in the past 30 days. (page 49)
- Almost one-fifth of 10th and 12th graders reported being drunk or high at school in the past year. (page 52)
- Washington State has among the highest rates of non-medical use of prescription pain relievers in the nation. (page 71)
- Smoking prevalence among adults and young adults, both men and women, is on the decline. (pages 72-75)
- Per capita alcohol consumption in Washington State has risen significantly since 2001. (page 76)
- Adult heavy drinking rates in Washington State are at their highest point in this decade. (page 78)
- In 2006, the rate of low birth weight births rose significantly in Washington State. (page 83)
- The infant mortality rate in Washington State is at its lowest point ever. (page 84)
- In Washington State, while the number of drinking driver-involved fatalities has remained stable, the number of drug driving-involved fatalities is rising (page 88)
- The drug-induced death rate is increasing rapidly. (page 94)
- More than one drug was detected in 75% of drug-caused deaths in Seattle-King County in the past 10 years. (page 95)
- The number of drug-caused deaths in Seattle-King County in which prescription-type opiates are involved is substantially higher than a decade ago. (page 97)
- The number of drug-caused deaths in Seattle-King County in which methamphetamine is involved has risen rapidly in the past decade. (page 98)
- The number of acute care hospital discharges in which there was a primary alcohol-related diagnosis is now increasing. (page 101)
- The lung cancer death rate in Washington State is declining. (page 102)
- Deferred prosecution, including two years of chemical dependency treatment, results in reduced DUI recidivism. (page 116)
- The number of reported methamphetamine laboratories and dump sites in Washington State has fallen dramatically. (page 120
- The number of adults and youth admitted to DASA-funded treatment for methamphetamine has fallen for the first time in this decade. (pages 193, 222)
- Adult admissions to DASA-funded treatment for prescription-type opiates have almost quadrupled since SFY 2003. (page 194)
- The number of individuals addicted to non-heroin opiates entering DASA-funded opiate substitution treatment is rising rapidly. (page 195)
- The number of admissions of military veterans to publicly funded treatment has grown by more than a third since SFY 2002. (page 201)

The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse in the United States

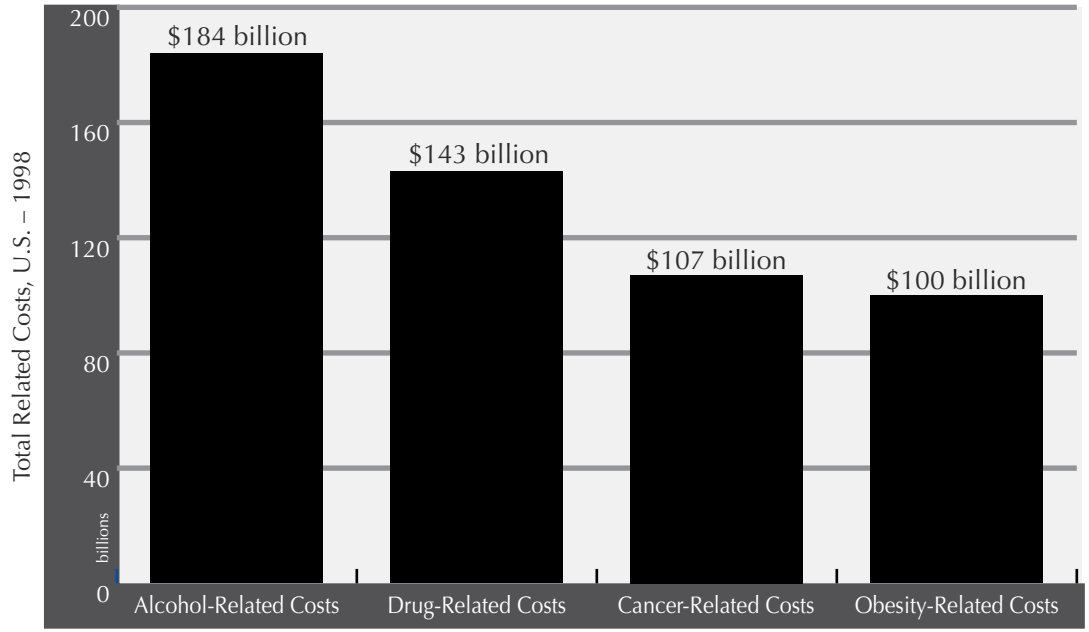
Two studies – one sponsored by the National Institute on Alcohol Abuse and Alcoholism, the other by the White House Office of Drug Control Policy – estimate the total economic costs of alcohol and drug abuse in the United States at $328 billion in 1998.[1]

Among the studies' key findings were:

- Alcohol abuse accounted for 56.3% of the total economic costs; 43.7% were attributable to drug abuse.
- More than 55,000 deaths were attributable to substance abuse, 65% of them to alcohol.
- Total medical costs related to alcohol and drug abuse ($31.8 billion) were approximately two-and-a-half times that spent on substance abuse treatment ($12.9 billion).
- Of the $143.4 billion in economic costs related to drug abuse, 69% were in lost productivity, 9% in health care costs, and 22% in other costs, including the costs of crime, police, and the criminal justice system.
- Health costs related to alcohol abuse ($18.9 billion) were 68% higher than for drug-related health costs ($12.9 billion).
- Only 3.9% of total economic costs were for alcohol/drug treatment.

[1] Harwood, H. *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update, and Data.* Rockville. MD: U.S. Department of Health and Human Services, U.S. Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2000; Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-1998.*Washington, DC: Executive Office of the President, 2001.

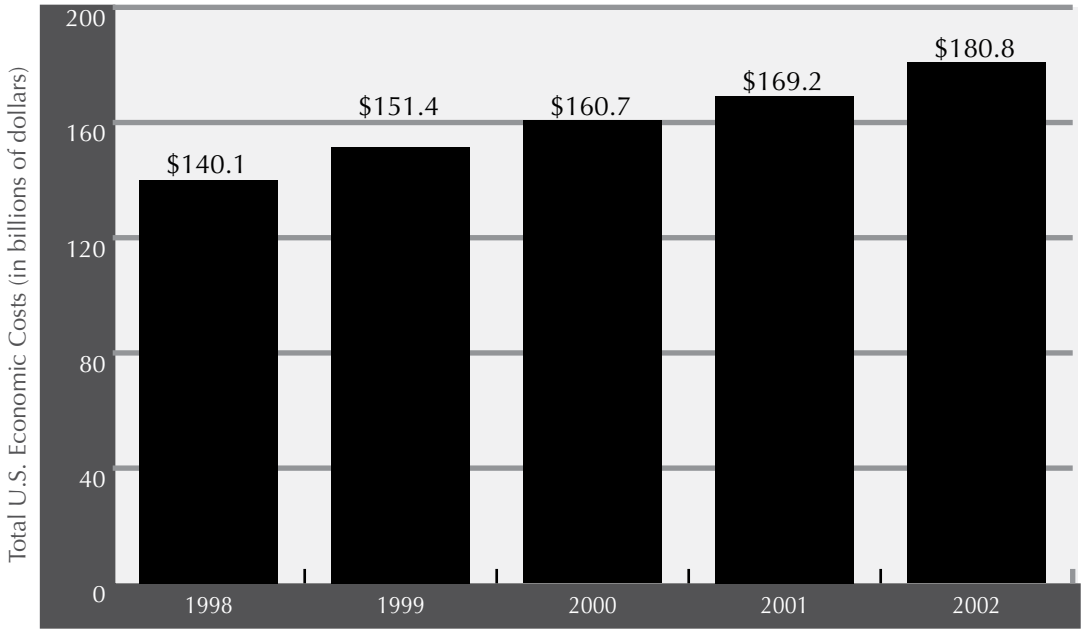
Alcohol Abuse and Alcoholism Cost the Nation Substantially More than Cancer, Obesity, or Drug Abuse and Addiction.



Source: Harwood, H., *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update, and Data*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 2000.

While drug abuse and addiction often receive more public attention, national costs related to alcohol abuse and alcoholism ($189.0 billion in 1998) – including morbidity and mortality, health care costs, crime and criminal justice costs, and lost productivity – are 28.3% higher than drug abuse and addiction-related costs ($143.4 billion).

Through 2002, the National Economic Costs of Drug Abuse Continued to Rise

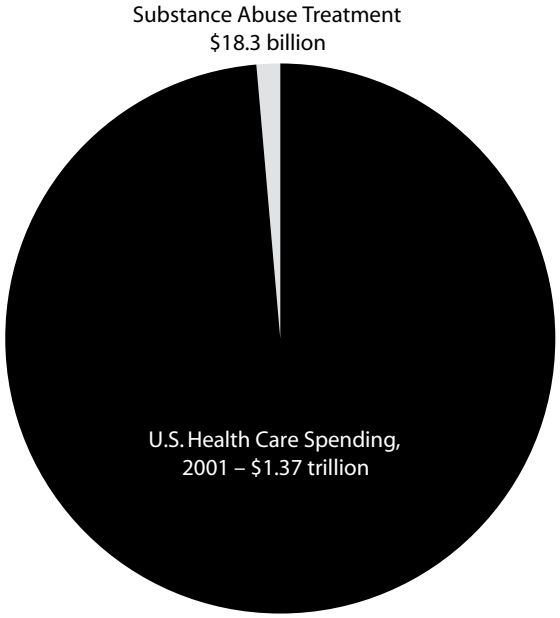


Source: Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States*, 1992-2002. Washington, DC: Executive Office of the President, 2004.

Total U.S. economic costs related to drug abuse rose more than 5.3% a year between 1992-2002. The largest portion of costs is productivity-related, representing 71.2% of the total, the greatest share of that being related to criminal activity. In addition, total costs for drug-related state and federal corrections were $14.2 billion, the bulk for the operation of prisons. In 2002, there were almost 330,000 individuals incarcerated for drug-specific offenses, and an estimated 135,000 for income-generating or other crimes related to drug abuse. That year, approximately two million individuals were arrested for drug-related offenses or drug abuse-related crimes.[1]

[1] Office of National Drug Control Policy. The Economic Costs of Drug Abuse in the United States, 1992-2002. Washington, DC: Executive Office of the President, 2004.

Nationally, Only 1.3% of the Almost $1.4 Trillion Spent on Health Care in the United States Goes for Substance Abuse Treatment.

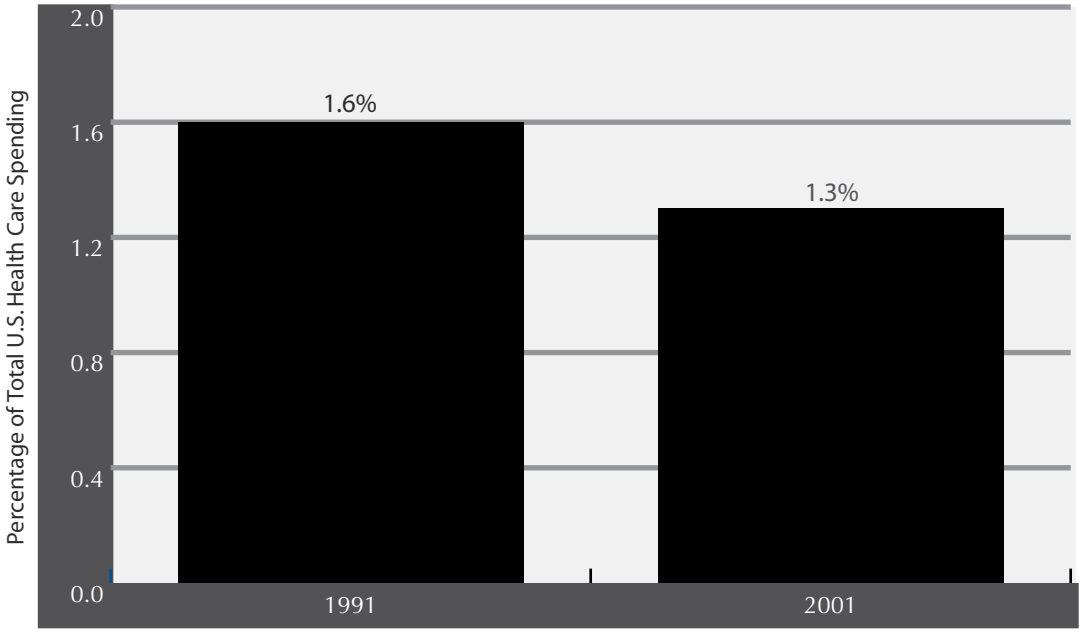


Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that of the $1.37 trillion spent on health care in the United States in 2001, only $18.3 billion (1.3%) went for substance abuse treatment.

Despite scientifically demonstrated cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs, chemical dependency treatment remains extremely underfunded at both the state and federal level.

As a Percentage of Total U.S. Spending on Health Care, Spending on Substance Abuse Treatment Declined 14.5% Between 1991 and 2001.



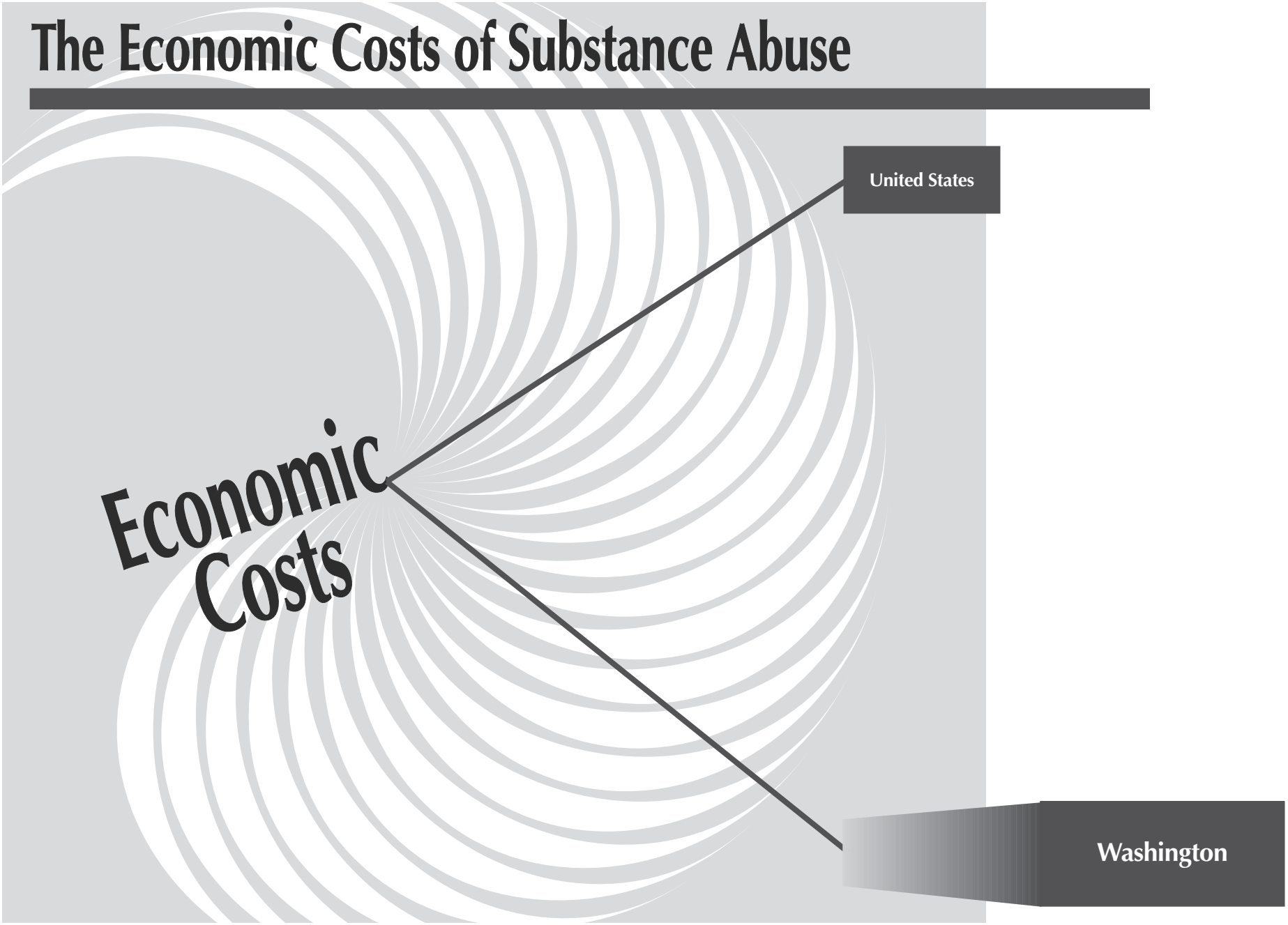
Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that as a percentage of the total spent on health care in the United States, spending on substance abuse treatment fell from 1.6% in 1991 to 1.3% in 2001, representing a 14.5% decline.

Substance abuse treatment has been scientifically proven to produce cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs. Despite this, chemical dependency treatment remains extremely underfunded at both the state and federal level. Of the $4,851 spent per person on health care in the U.S. in 2001, only $65 went for substance abuse treatment.[1]

[1] Mark, T. et al. "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, March 29, 2005.

The Economic Costs of Substance Abuse



The Economic Costs of Substance Abuse in Washington State

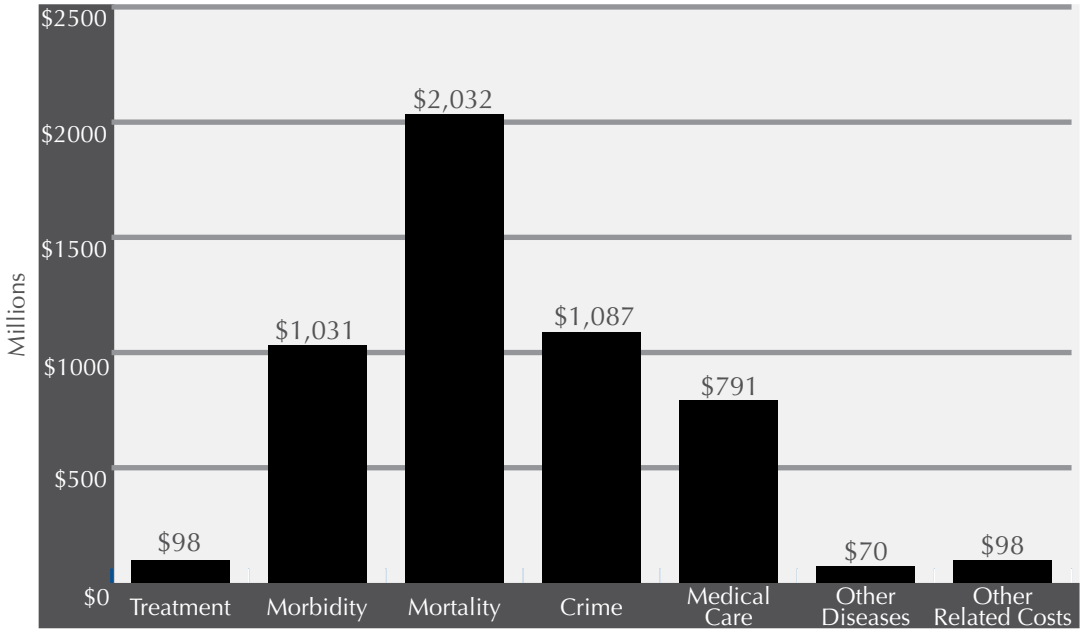
A study commissioned by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at $5.21 billion in 2005, a 105% increase over 1996. This represents $832 for every non-institutionalized resident in the state, an inflation-adjusted per capita increase of 47% over 1996.[1]

Among the study's key findings were:

- *Alcohol abuse accounted for 56% of total economic costs; drug abuse for 44%.*
- *There were 3,244 deaths in Washington State in 2005 caused by or related to alcohol or drug abuse, representing approximately 89,000 years of potential life lost.*
- *Of the 3,244 deaths, 2,388 (74%) were alcohol-related, and 836 (26%) were drug-related.*
- *Leading causes of substance abuse-related deaths were accidental drug-related poisoning (677 deaths), alcohol-related cirrhosis and liver damage (437 deaths), and suicide (233 deaths).*
- *Of 154 arrests for homicide, 48 (31%) were alcohol-related, and 24 (16%) were drug-related.*
- *Of 5,128 arrests for felonious assault, 1,379 (27%) were alcohol-related, and 513 (10%) were drug-related.*
- *There were approximately 39,000 hospital discharges classified as alcohol- or drug-related, representing an increase of 140% since 1996. Total cost of treating these hospital cases was $377 million, of which $316 million (84%) resulted from diseases and injuries classified as alcohol-related.*
- *Total estimated alcohol- and drug-related crime costs in 2005 doubled from $541 million in 1996 to $1.087 billion in 2005.*

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State*, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.



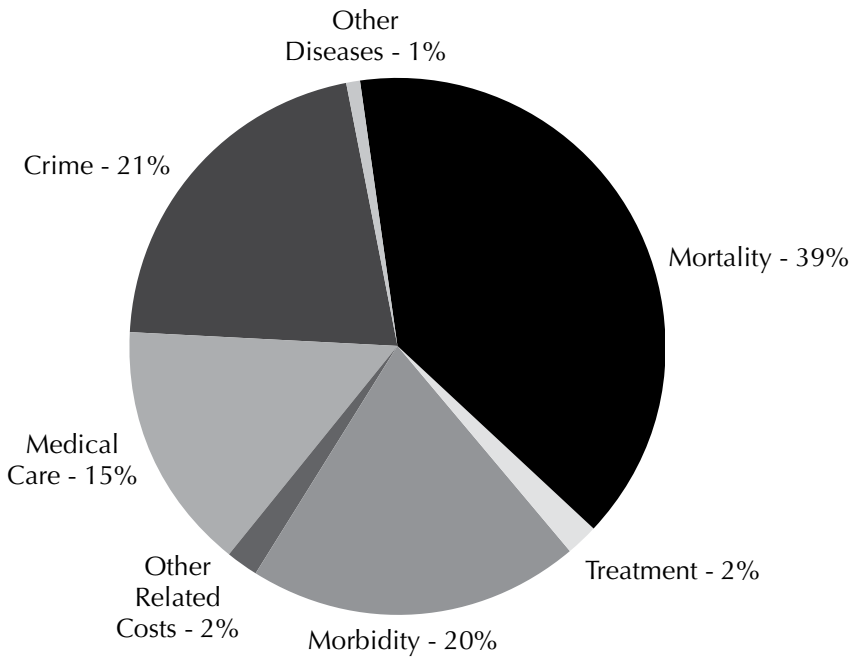
Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Division of Alcohol and Substance Abuse, 2007.

This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 2005. The estimated cost per death measured in terms of lost income was $630,000. Medical care costs ($791 million) - including hospital, outpatient medical care, prescription drugs, nursing homes, and other professional costs - were almost four times what they were in 1996 ($211 million).[1]

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State*, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Treatment Represented Only 2% of the Total Economic Costs of Alcohol and Other Drug Abuse in 2005.

Distribution of Drug and Alcohol-Related Costs

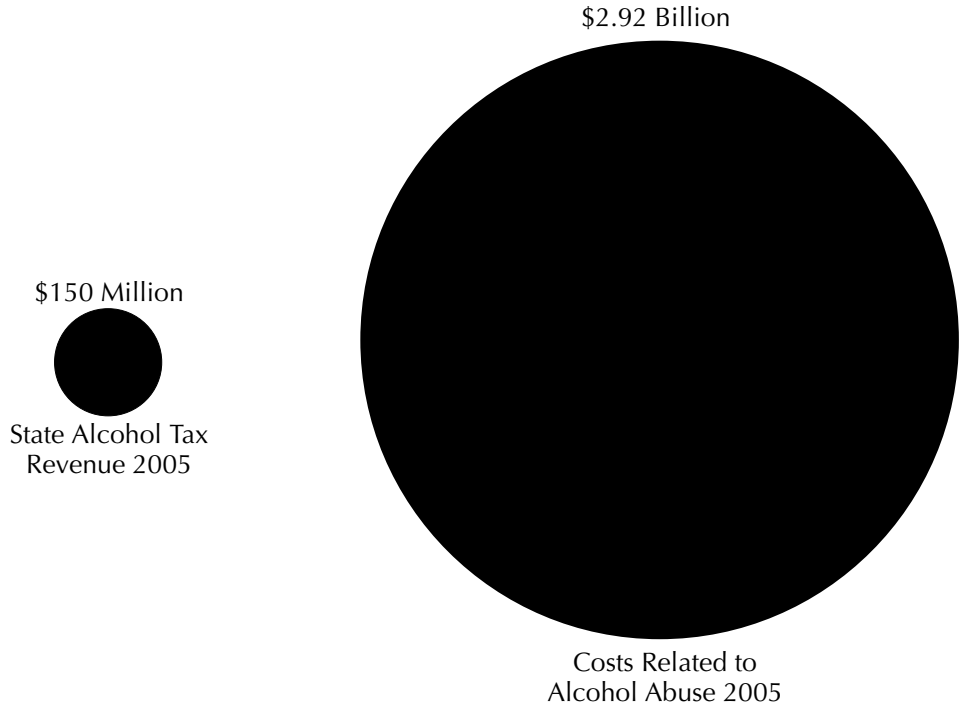


Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

This chart indicates that alcohol and drug treatment represents a very small fraction (2%) of the total economic costs of substance abuse in Washington State.[1] Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infectious diseases, and lower medical costs. Alcohol and drug treatment continues to be a wise investment in the health and safety of communities, and the economic vitality of Washington State.

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Costs Related to Alcohol Abuse in Washington State in 2005 were Approximately 20 Times Greater than Revenues Received from State Alcohol Taxes.



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

In fiscal year 2005, approximately $150 million was gathered through state alcohol taxes levied on beer, wine, and spirits. This is 53% more than the total ($98 million) spent by the state on alcohol and drug treatment combined.[1]

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Impacts of Substance Abuse on the Washington State Budget

A 2001 study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated 1998 state government spending on the consequences of substance abuse in Washington State at $1.5 billion. Only 4% of that total was spent on prevention and treatment.[1]

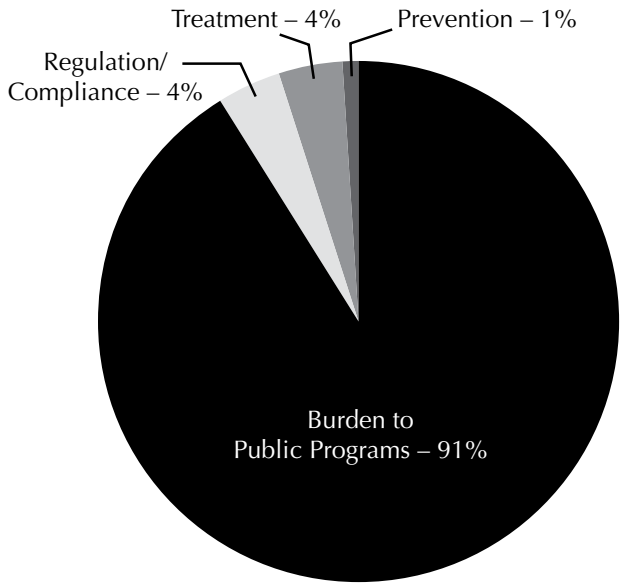
Other key findings of the study included:

- *Nationally, of a total of $620 billion in state government spending, $81.3 billion (13.1%) was used to deal with substance abuse and addiction.*
- *Of every such dollar spent by states, 96 cents went to "shoveling up the wreckage of substance abuse and addiction"; only four cents were used to prevent and treat it.*
- *Combined, states spent 113 times as much to deal with the devastation substance abuse and addiction wrought upon children as they did to prevent and treat it.*
- *Of the $25 billion spent on dealing with the impacts of substance abuse on children, $16.5 billion was borne by the public education system; another $5.3 billion was spent on services for children who were victims of substance abuse and neglect; and almost $3 billion was spent serving substance-involved youth in states' juvenile justice systems.*
- *Each American paid $277 per year in state taxes to deal with the burden of substance abuse and addiction within social programs, and only $10 for prevention and treatment.*

[1] National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: The Impact of Substance Abuse on State Budgets.* New York, NY: 2001.

Of the $13.9 Billion in Washington State Government Spending in 1998, $1.5 Billion (10.9%) was Spent on Services Related to Impacts of Substance Abuse.

Distribution of State Spending Related to Impacts of Substance Abuse

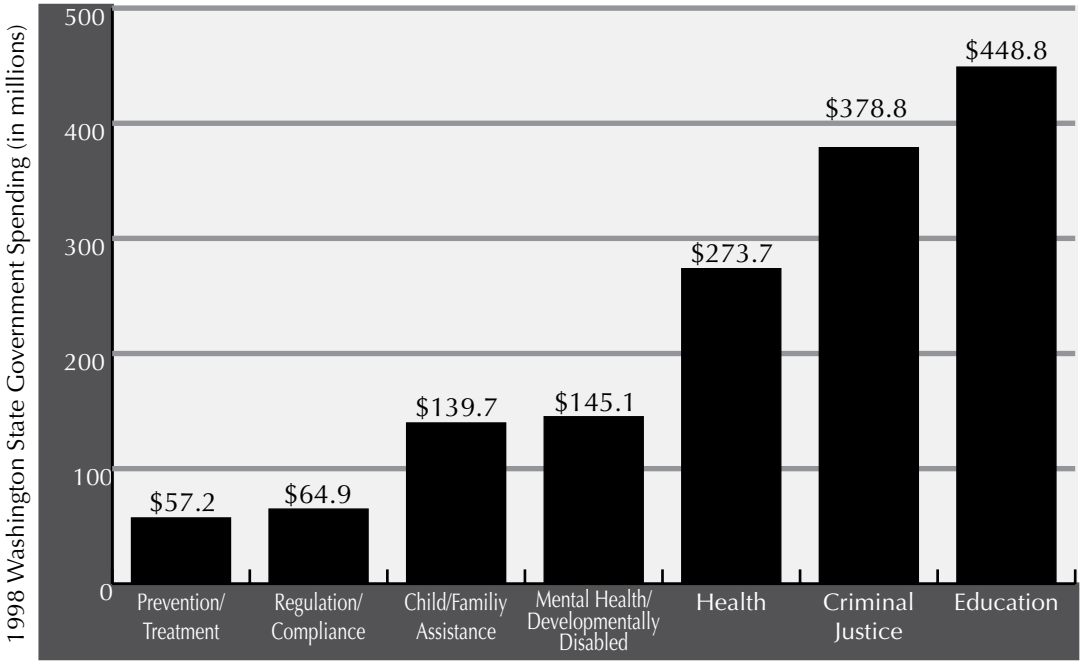


Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets,* 2001.

In 1998, the $1.51 billion of Washington State government spending related to the impacts of substance abuse compares with $2.65 billion spent on higher education, $1.46 billion spent on Medicaid, and $1.09 billion spent on transportation.[1]

[1] National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: The Impact of Substance Abuse on State Budgets.* New York, NY: 2001.

Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.

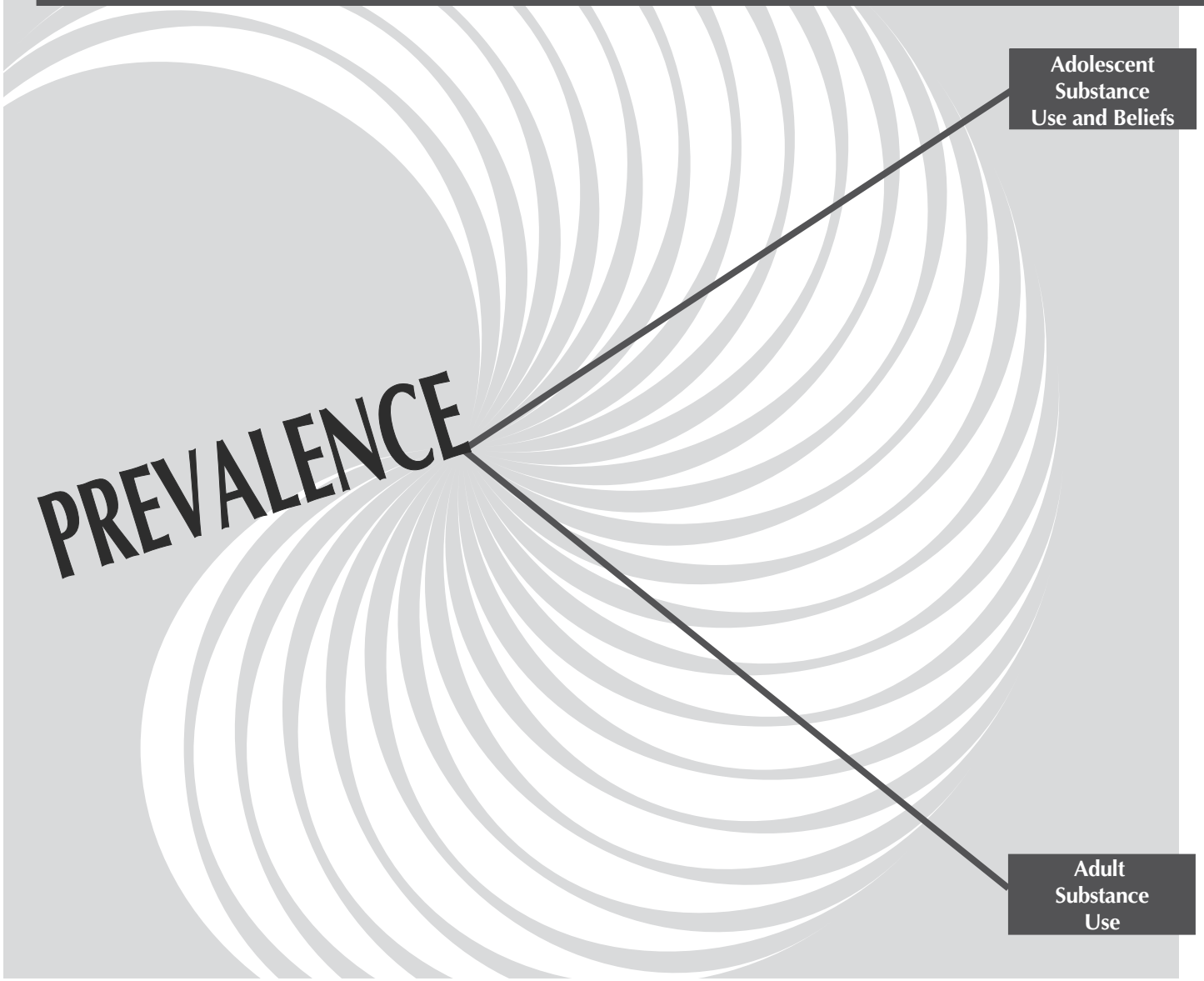


Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets,* 2001.

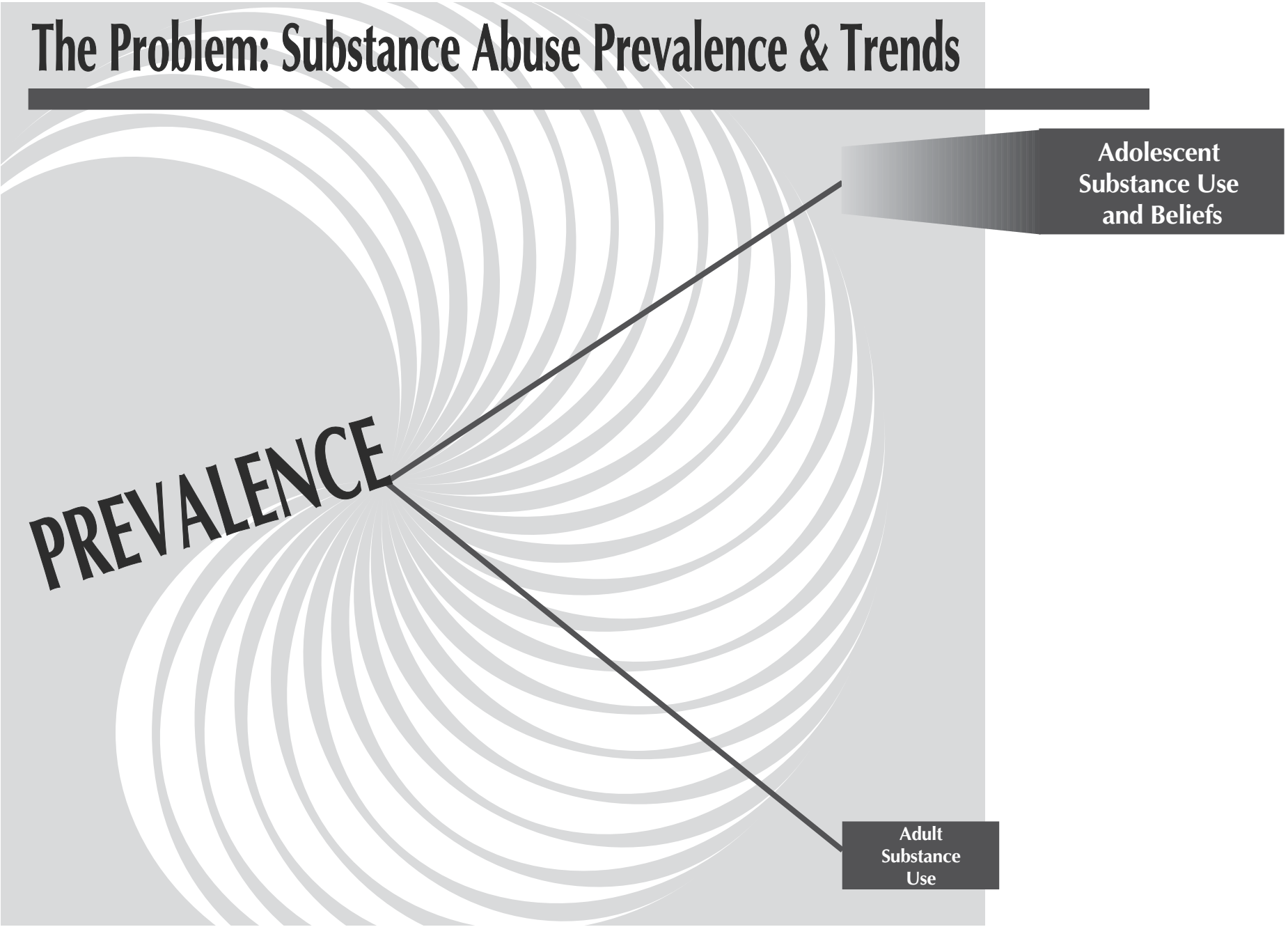
In 1998, 10% of Washington State government spending, or $248 for every resident, was related to impacts of substance abuse. Only approximately $10 of this amount went for prevention and treatment.[1]

[1] National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: The Impact of Substance Abuse on State Budgets.* New York, NY: 2001.

The Problem: Substance Abuse Prevalence & Trends



The Problem: Substance Abuse Prevalence & Trends



Washington's Healthy Youth Survey

In Washington State, multiple state agencies have been conducting surveys of youth health behavior since 1988. The surveys have been based on two different national surveys: Monitoring the Future supported by the National Institute on Drug Abuse; and the federal Centers for Disease Control and Prevention's Youth Risk Behavior Survey. In 1995, a Communities That Care survey, developed by the University of Washington, became an important component of the survey effort, integrating risk and protective factors. More recently, a Youth Tobacco Survey was incorporated.

To better coordinate these survey efforts, and to prevent the need for survey data from becoming an undue burden on schools, interested state agencies – Office of Superintendent of Public Instruction; Department of Social and Health Services' Division of Alcohol and Substance Abuse; Department of Health's Tobacco Control Program and Maternal and Child Health Program; Department of Community, Trade & Economic Development, Community Mobilization; and the Family Policy Council – resolved to cooperate on the administration of a single survey of youth behaviors every two years, to be administered in the fall. In 2008, the Liquor Control Board joined the coalition of agencies that support the single survey.

The goals of this collaborative effort are:

- To describe youth health behavior, habits, risks, and outcomes.
- To describe school, community, family, and peer/individual risk and protective factors.

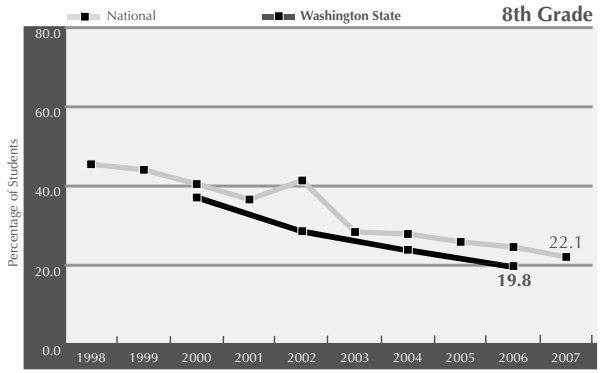
To achieve these goals, it was agreed that the survey must:

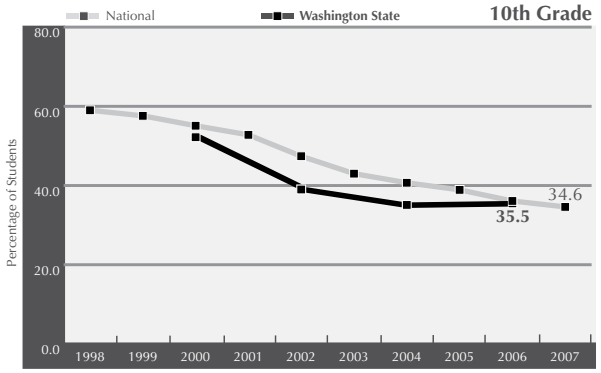
- Gather state-level data in a consistent manner (with predictable timing and using comparable measures over time).
- Support local-level data collection and use of data for planning, assessment, and evaluation of programs to serve youth.

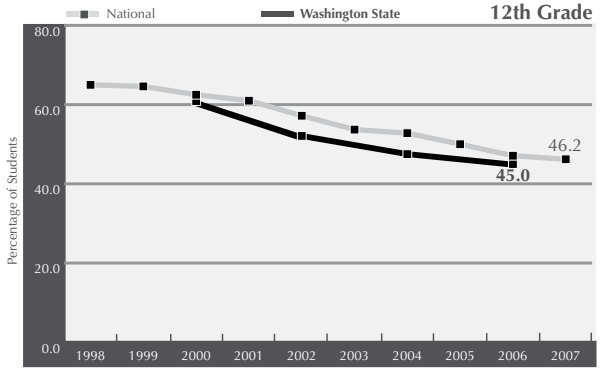
The data represented on the following pages are from the Healthy Youth Survey, which represent the result of these collaborative efforts. Data from the Healthy Youth Survey are available on-line at www.hys.wa.gov. A new website with a menu of user-friendly reports and a query function is under development at www.askhys.net.

The Prevention Standing Committee of the Governor's Council on Substance Abuse has set a series of state targets for prevention efforts. These targets are continually revised as progress is made in improving the effectiveness of prevention strategies.

The Percentage of Students, Both in Washington and Nationally, Who Have Ever Tried Smoking is Declining.*







Tobacco use is the leading cause of preventable illness and death in the United States.[1] A 1996 federal Centers for Disease Control and Prevention Study suggests that 33% of young smokers will eventually die as a result of tobacco use, if current use patterns continue.[2]

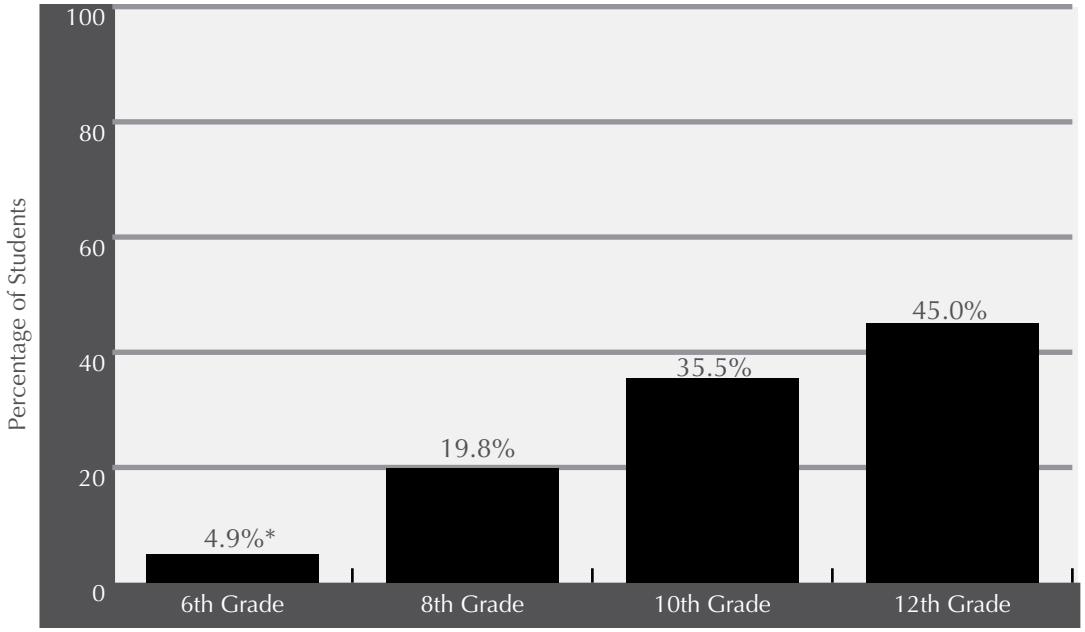
These graphs indicate that experimentation with tobacco is on the decline, both in Washington State and nationally. The state target is to raise the average age of adolescents' first use of tobacco products to 16.

[1] U.S. Surgeon General. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.
[2] Centers for Disease Control and Prevention. "Projected Smoking-Related Deaths Among Youth – United States," *Morbidity and Mortality Weekly Report* 45, 1999.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey.*

By 12th Grade, Almost Half of Washington Adolescents Have Tried Smoking.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

The percentage of Washington State students who have experimented with smoking is declining. Use of smokeless tobacco, on the other hand, increased between 2004 and 2006.[1]

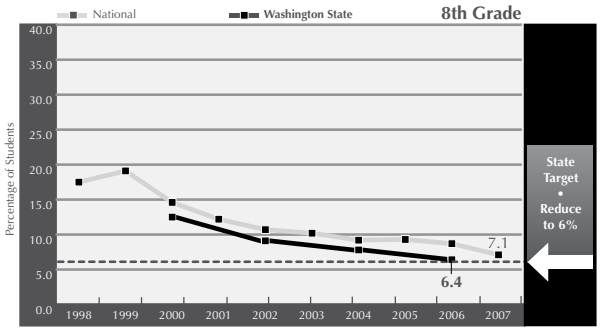
Research indicates that increasing tobacco taxes on cigarettes, when combined with anti-smoking campaigns, is one of the most cost-effective short-term strategies to prevent tobacco initiation among youth.[2] A recent study found that 70% of U.S. youths ages 14-17 report they can purchase cigarettes within five blocks of their home.[3] However, the Washington State Healthy Youth Survey found that only 22% of 10th grade youth reported they usually obtained tobacco by purchasing it themselves; 64% obtained it from others.[4]

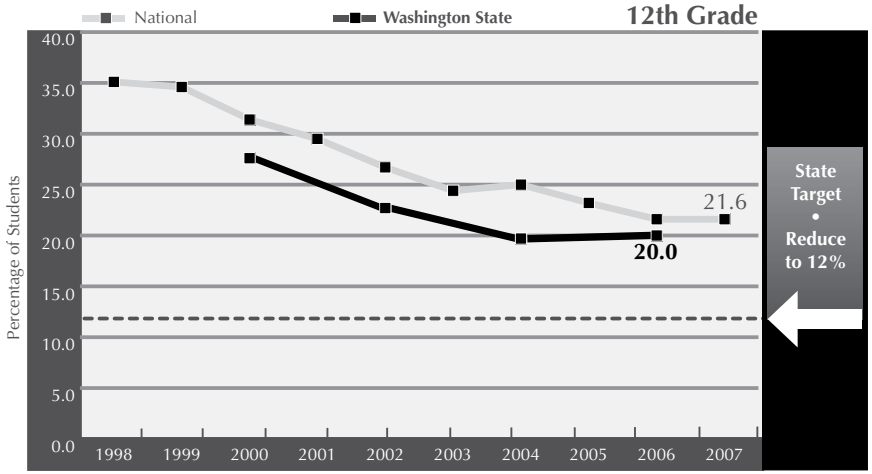
**6th grade percentage is for students smoking a whole cigarette; 8th, 10th, and 12th grade data are for students trying smoking, "even just a puff".*

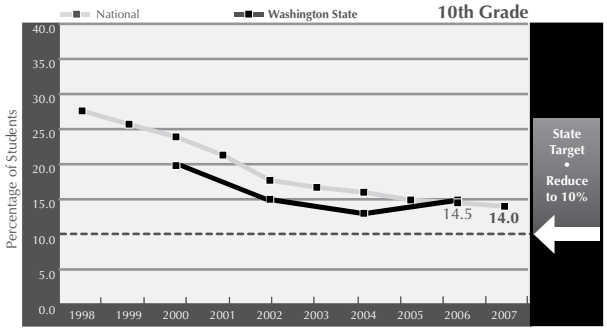
[1] Washington State Office of the Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council. *Healthy Youth Survey - 2006*. Olympia, WA: 2007.
[2] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-6. Washington, DC: 2000.
[3] Institute for Adolescent Risk Communication. *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.
[4] *Healthy Youth Survey*, op. cit.

In 2006, the Percentage of Washington State 10th and 12th Graders Who Smoked a Cigarette in the Past 30 Days Rose Slightly.

Recent smoking by youth in Washington State and nationally have declined over the past decade, but appears to be leveling off. Studies indicate that youth and young adult smokers are more price-responsive than other smokers, and that a 10% increase in price could reduce the number of teenagers who smoke by 7%.[1]







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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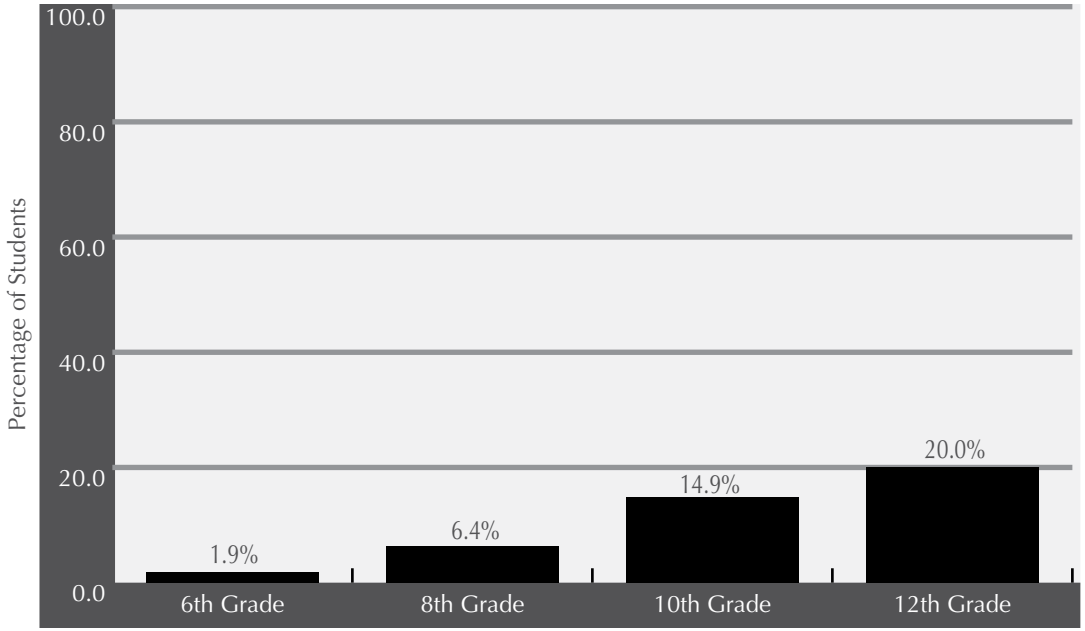
[1] Schneider Institute for Health Policy, Brandeis University. *Substance Abuse – The Nation's Number One Health Problem: Key Indicators for Policy – Update February 2001*. Princeton, NJ: The Robert Wood Johnson Foundation, 2001.

A Fifth of Washington High School Seniors Report Having Smoked a Cigarette in the Past 30 Days.

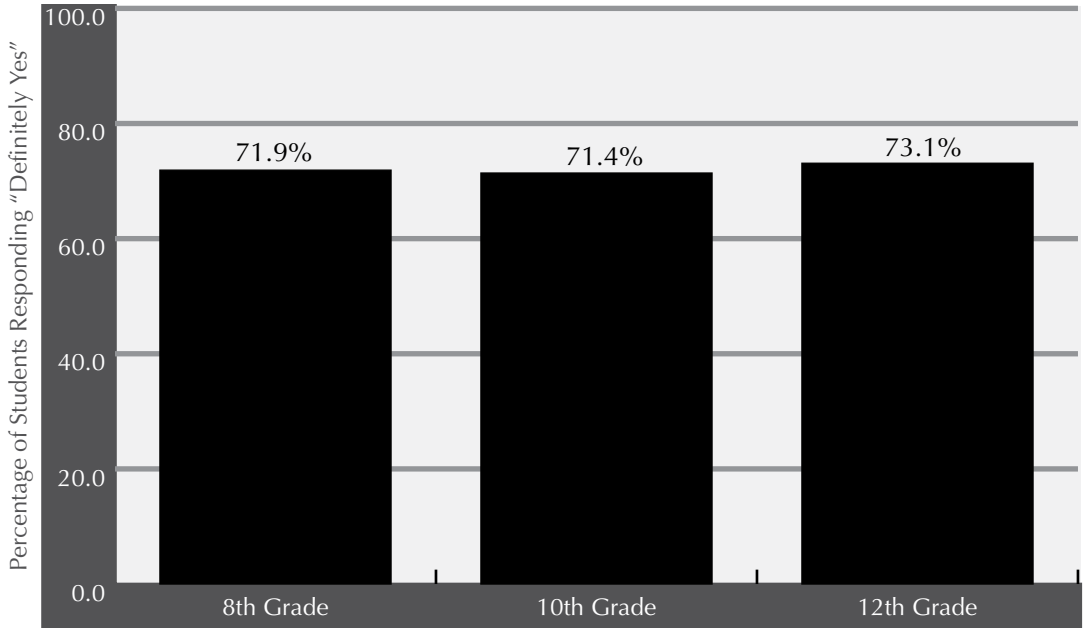


Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to do so as adults.[1] In 2004, 41.6% of Washington State 12th graders who smoke reported they wanted to quit immediately. However, only 13.2% of 12th grade smokers had ever participated in a program to help them quit.[2]

[1] U.S. Surgeon General. *Tobacco Use Among Young People – A Report of the Surgeon General.* Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.
[2] Washington State Office of the Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2004*. Olympia, WA: 2005.

In 2006, Most Washington State Students Believed that Young People Risk Harming Themselves by Smoking 1-5 Cigarettes Per Day.

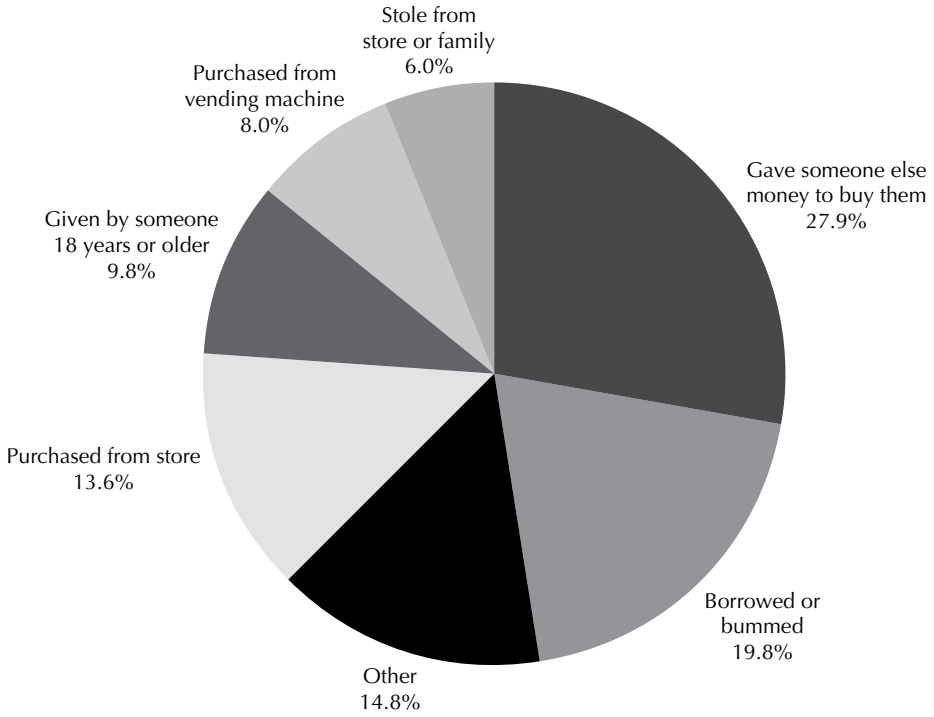


Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

Most Washington State students perceive a high degree of risk from smoking cigarettes, though this perception declined slightly in all grades in 2006. Nonetheless, the rate of smoking among students increases as they get older. This suggests that expanded efforts need to be focused on helping current young smokers quit. In 2004, 46% of Washington State 10th graders, and 42% of 12th graders who smoke reported they would like to quit immediately. However, only 19% of 10th grade smokers, and 13% of 12th grade smokers participated in a program to help them quit tobacco use.[1]

[1] Washington State Office of the Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council. *Healthy Youth Survey - 2004*. Olympia, WA: 2005.

Most 10th Grade Smokers in Washington State Obtain Cigarettes from Others.

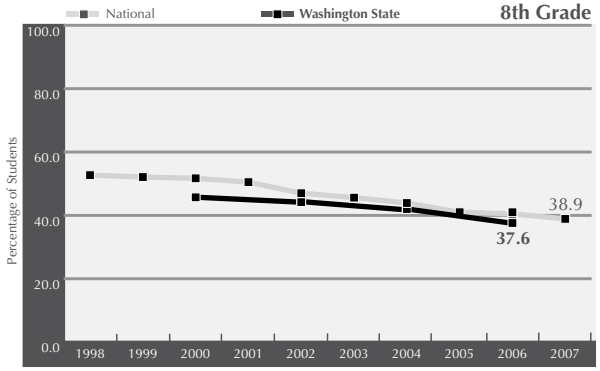


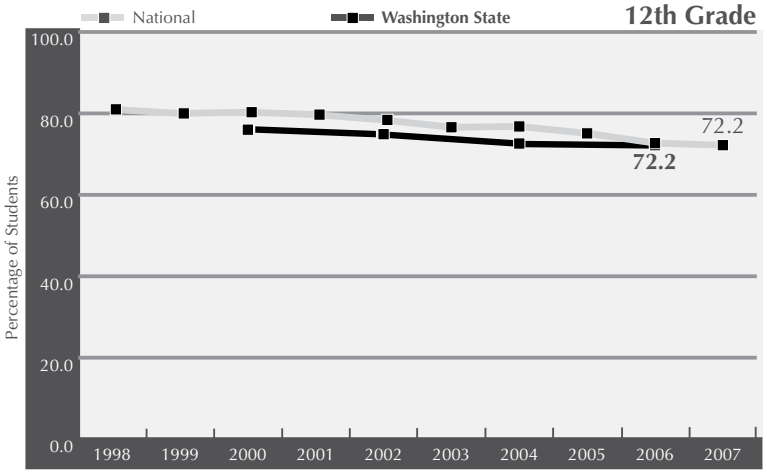
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

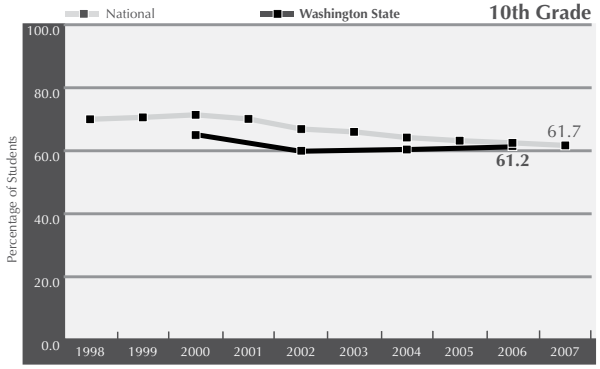
Only 21.6% of Washington State 10th grade smokers obtain cigarettes by purchasing them. Almost 80% of 10th graders obtain them through others. This suggests that there is a culture around smoking that still makes it socially acceptable for others to participate in young people developing a highly dangerous health habit.

The Percentage of Students, Both in Washington and Nationally, Who Have Tried Alcohol is Relatively Constant.*

In 2001, underage drinkers (ages 12-20) consumed 17.5% of alcohol consumed in the United States, accounting for $22.5 billion in total alcohol sales. Youth who start drinking at age 14 or younger are four times more likely to become alcohol dependent in their lifetimes than those who start drinking at age 20 or older.[1] The state target is to raise the average age of adolescents' first use of alcohol to 16.







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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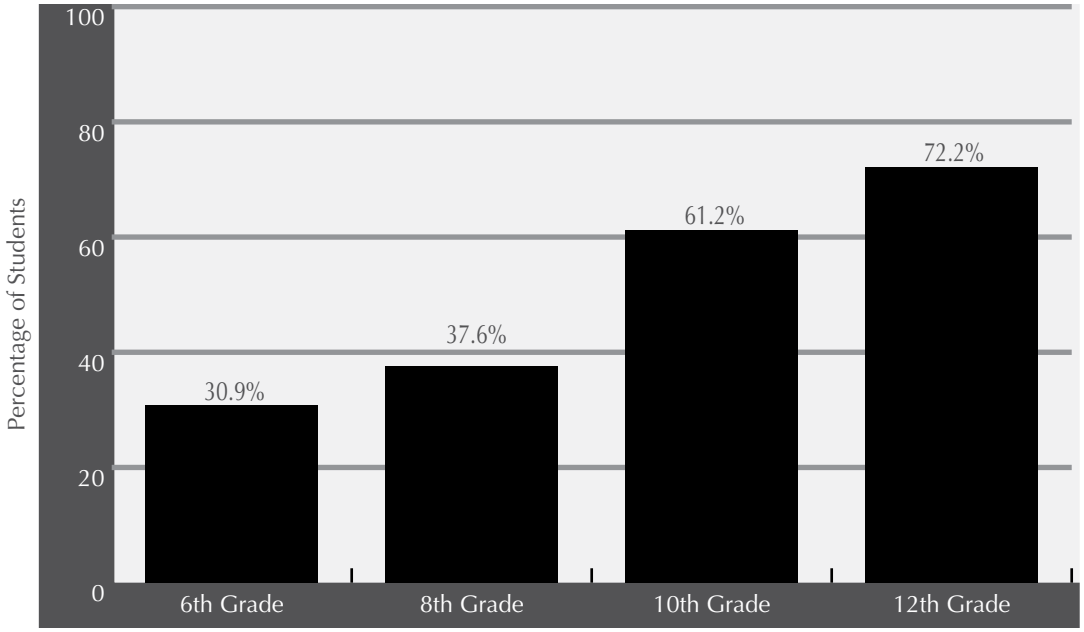
[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Almost a Third of Washington 6th Graders Have Tried Alcohol.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

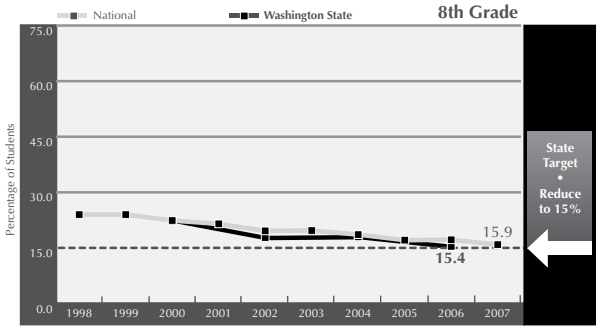
Teenage drinking can physically damage the brain; interfere with mental and social development; interrupt academic progress; increase chances of risky sexual behavior and teen pregnancy, juvenile delinquency, and crime; compromise health; and result in unintended injury and death.[1]

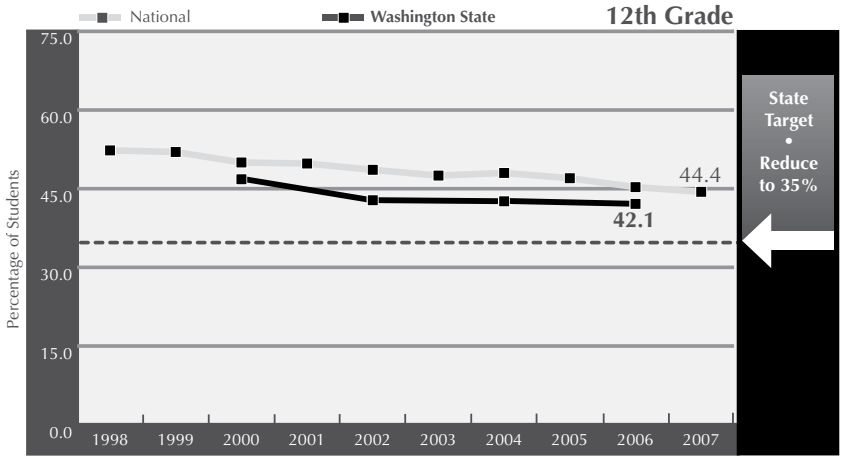
Almost half of Washington students have tried alcohol before they reach high school. Children who begin experimenting with and/or using alcohol at or before 7th grade are significantly more likely at age 23 to be alcohol dependent; use marijuana weekly; sell marijuana; commit felonies; and be arrested.[2] A recent study found that youth who witness or experience abuse as a child (witness domestic violence, experience physical abuse, experience sexual abuse) before age 10 are significantly more likely to drink before age 13.[3]

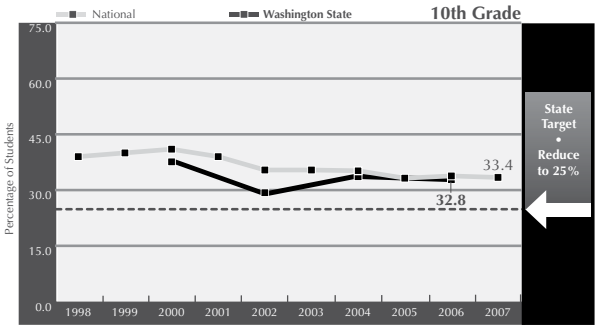
[1] Foster, S. et al. "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* Vol. 289 No. 8, February 26, 2003.
[2] Ellickson, P., Tucker, J., and Klein, D. "Ten-Year Prospective Study of Public Health Problems Associated with Early Drinking," *Pediatrics* 111(5), 2003.
[3] Hamburger, M., et al. "Childhood Maltreatment and Early Alcohol Use Among High-Risk Adolescents." *Journal of Studies of Alcohol and Drugs* 69(2), 2008.

Use of Alcohol in the Past 30 Days by Washington State 10th and 12th Graders has Leveled Off, and Slightly Declined Among 8th Graders.*

Recent alcohol use among youth appears to be dropping, both nationally and in Washington State. Research indicates that initiation of alcohol use at an early age increases the risk that teenagers will become heavier drinkers as adults, with alcohol-related problems later in life.[1]







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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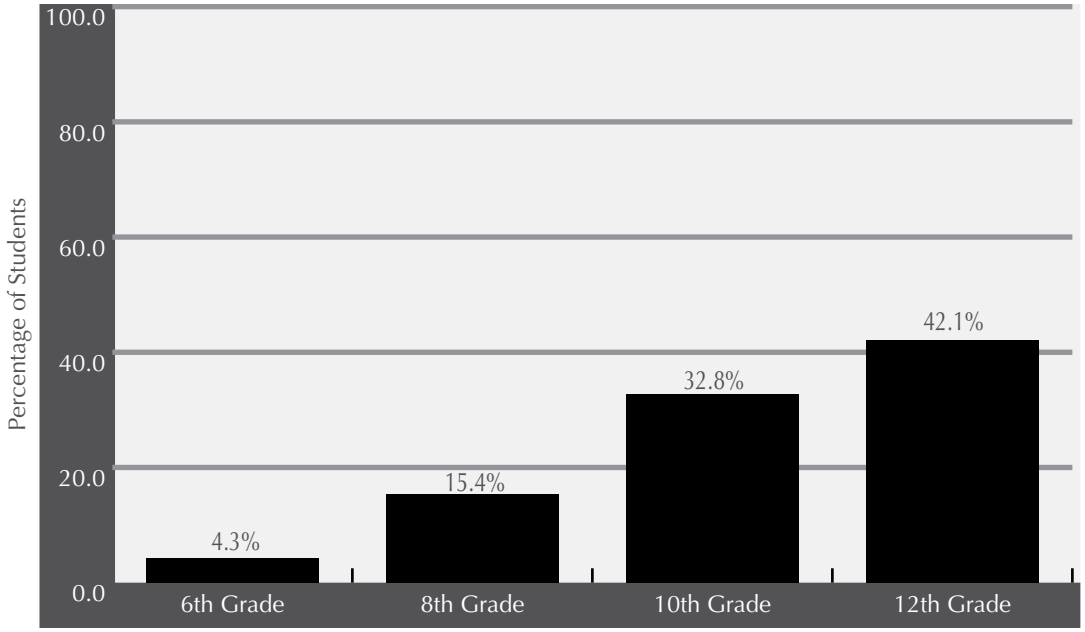
[1] Dewit, D., et al. "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders," *American Journal of Psychiatry* 157, 2000; Grant, B., and Dawson, D. "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey," *Journal of Substance Abuse* 9, 1997.

More than One Out of Six Washington 8th Graders Report Having Used Alcohol in the Past 30 Days.



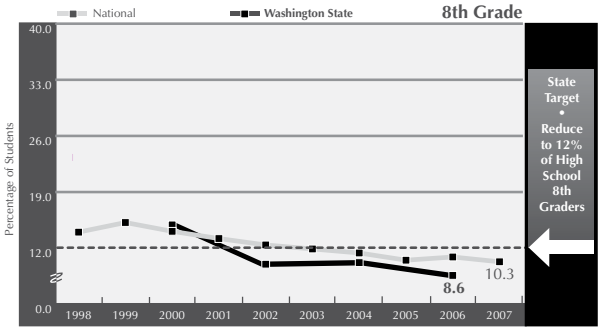
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

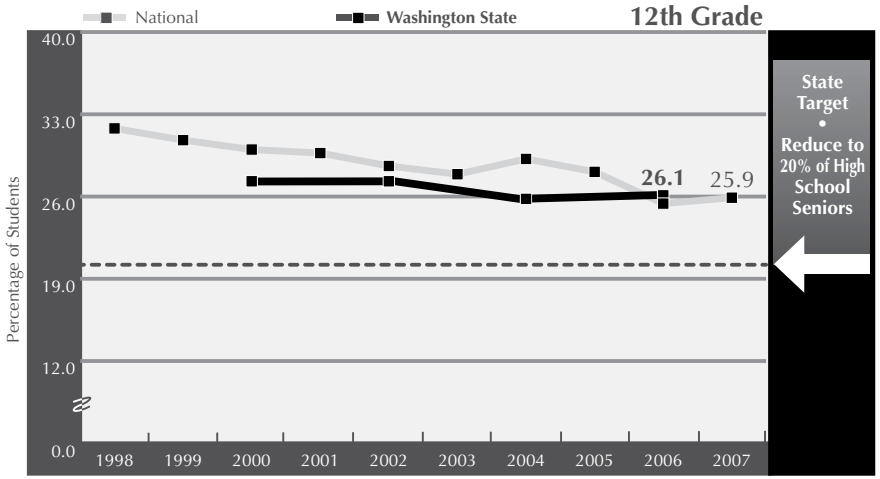
A recent study indicates that youth ages 12-20 are responsible for 17.5% of all alcohol consumed in the United States.[1] Despite the fact that it is illegal, more than 40% of Washington high school seniors report using alcohol in the past 30 days. Teenage drinking is associated with a full range of academic, social, and medical consequences, including juvenile delinquency and crime, risky sexual behavior and teen pregnancy, poor academic progress and school dropout rates, and unintentional injuries and death.[2]

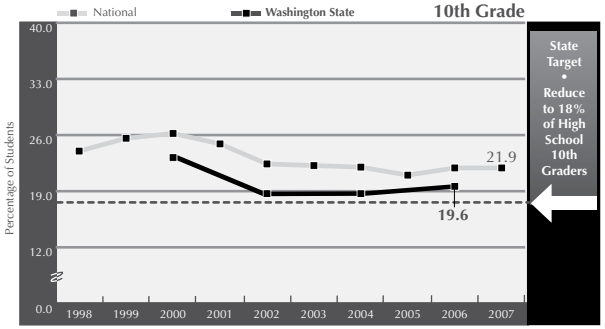
[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.
[2] *Ibid*.

Recent Binge Drinking by Washington State 10th and 12th Graders Has Increased Slightly.*

Recent binge drinking among Washington State 10th and 12th graders rose in 2006, though it fell among 8th graders. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks. Youth who begin binge drinking at an early age are much more likely to continue as binge drinkers as adults.[1]







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey.*

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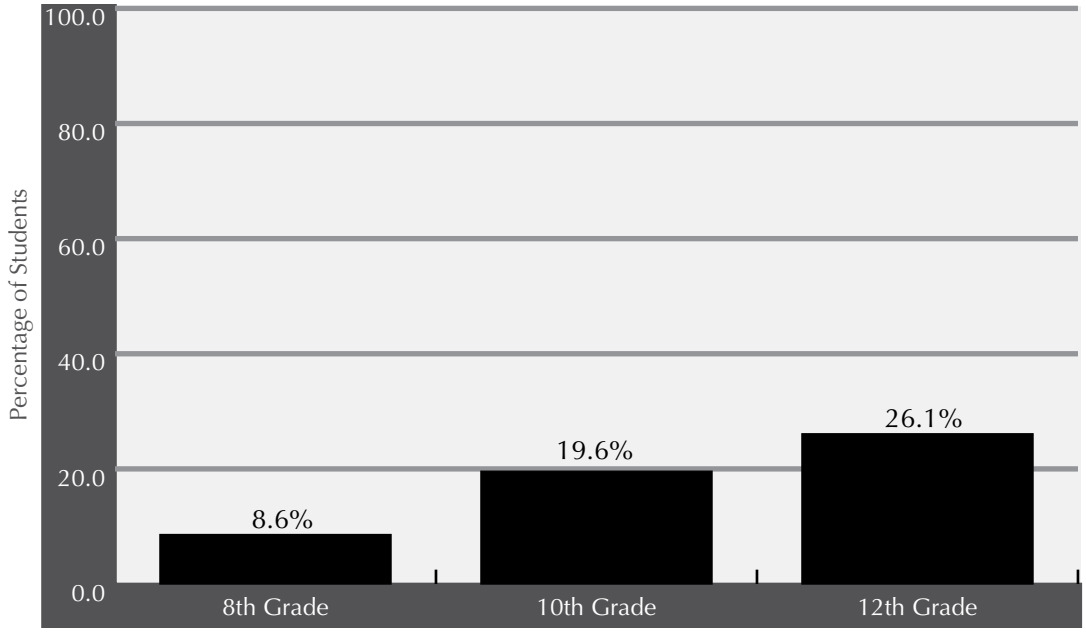
[1] McCarty, C., et. al. "Continuity of Binge and Harmful Drinking from Late Adolescence to Early Adulthood," *Pediatrics* 114(3), 2004.

More Than a Quarter of Washington Seniors Have Engaged in Recent Binge Drinking.

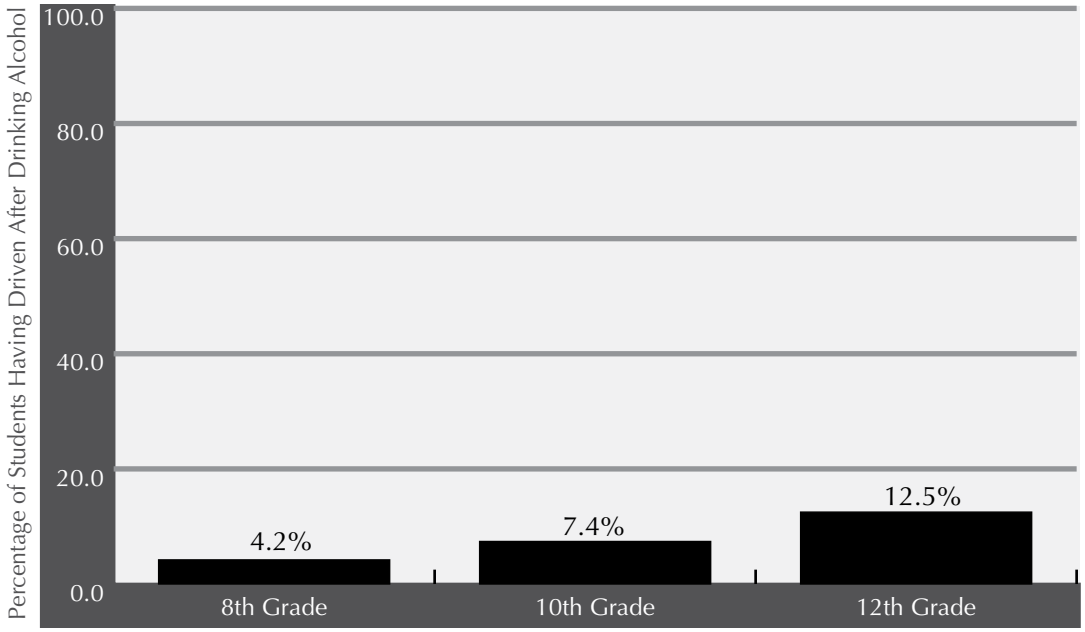


Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006.*

Recent binge drinking is defined as consuming five or more drinks in a row on at least one occasion in the past two weeks. A 2000 survey of Washington students indicates that binge drinking may start as early as the 6th grade, or earlier.[1] Heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system.

[1] Office of Superintendent of Public Instruction. *Washington State Survey of Adolescent Health Behaviors – 2000*. Olympia, WA: 2000.

In 2004, More than 4% of Washington State 8th Graders Had Driven a Vehicle After Drinking Alcohol.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

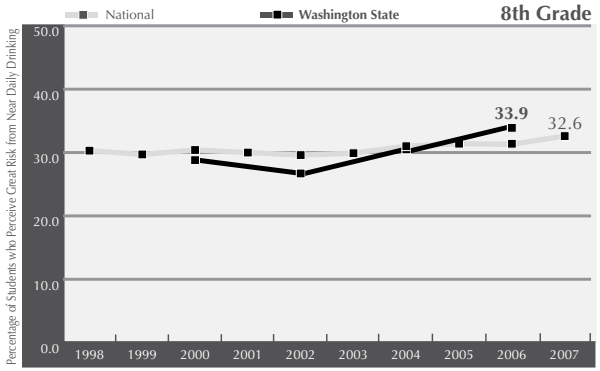
The *Washington State Healthy Youth Survey* facilitates the cross-tabulation of substance abuse among students with other behaviors in schools and communities. Significant percentages of Washington students in 8th, 10th, and 12th grades have driven after drinking alcohol. This is true even among students too young to possess a valid drivers license.

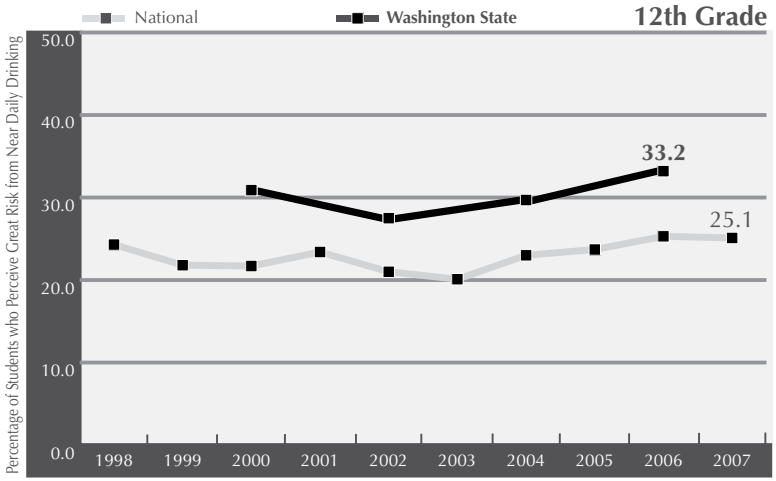
According to the National Highway Traffic Safety Administration, nationally 7,898 drivers ages 15-20 were involved in fatal crashes in 2003. Some 3,620 of those killed were drivers, 29% of whom had been drinking, and 24% of whom had blood alcohol concentrations over .08. Motor vehicle fatalities are the leading cause of death among youth ages 15-20, and an additional 303,000 youth drivers were injured. Severity of crashes increases with alcohol involvement.[1] In Washington State, between 1993-2003, there were 1,181 youth traffic deaths (ages 15-20); 487 (41%) involved youth drivers who had been drinking.[2] In 2005, there were 20 fatalities among young drivers 16-19 who had been drinking.[3]

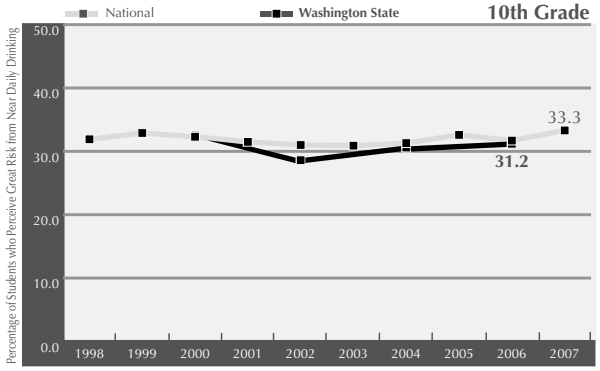
[1] National Center for Statistics and Analysis, National Highway Traffic Safety Administration. "Traffic Safety Facts - 2004 Data: Young Drivers." Washington, DC: U.S. Department of Transportation, 2007.
[2] Fatal Accident Report System, Washington Traffic Safety Commission, 2004.
[3] *Washington State's Strategic Highway Safety Plan: Target Zero*. Olympia, WA: Washington State Office of the Governor, February 2007.

Only One-Third of Washington State 8th, 10th, and 12th Graders Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day.*

These graphs indicate that approximately 70% of Washington 8th, 10th, and 12th grade students do not perceive great risk in near-daily alcohol consumption. National data indicate that student perception of risk regarding both regular use of alcohol and heavy drinking is relatively low, perhaps suggesting a high degree of acceptability of alcohol consumption among students.







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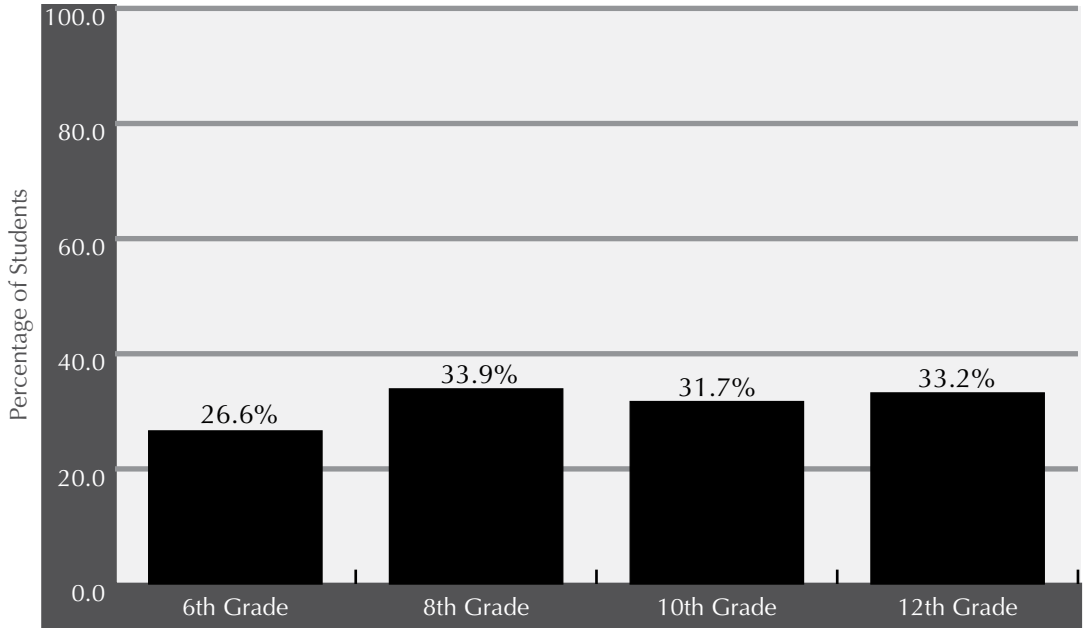
Only About One-Quarter of Washington State 6th Graders Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

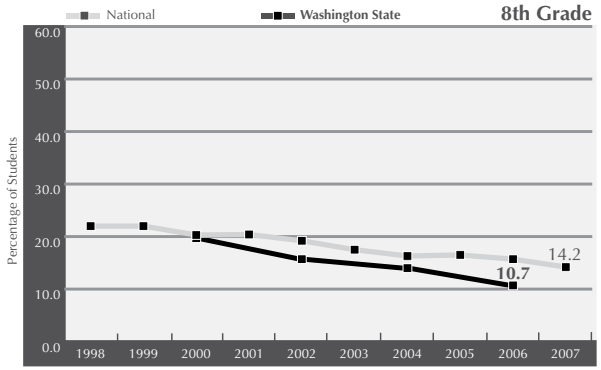
Research indicates that attitudes about specific drugs and alcohol are among the most important determinants of actual use.[1] Perception of great risk from near-daily use of alcohol among Washington State students is increasing, but very slowly, and is still a small fraction of the total number of students. Perception of risk also does not increase with age (and hence exposure to anti-alcohol-related programs), likely meaning efforts to increase risk perception are offset by other societal and advertising messages.

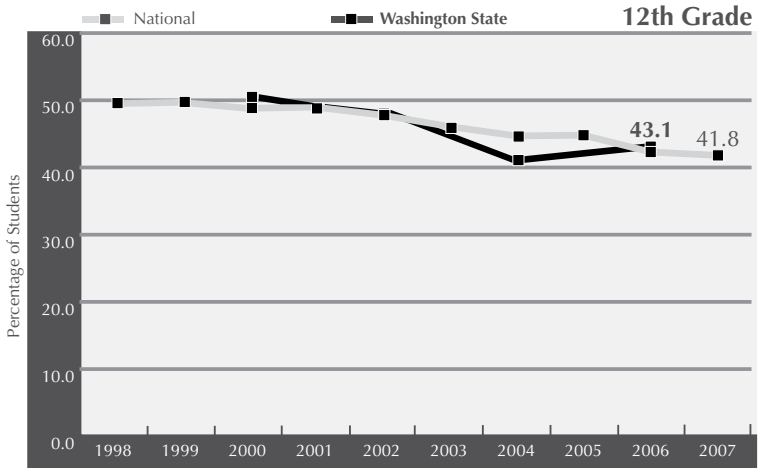
[1] Bachman, J., Johnston, L., and O'Malley, P. "Explaining Recent Increases in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval," *American Journal of Public Health* 88(6), 1988.

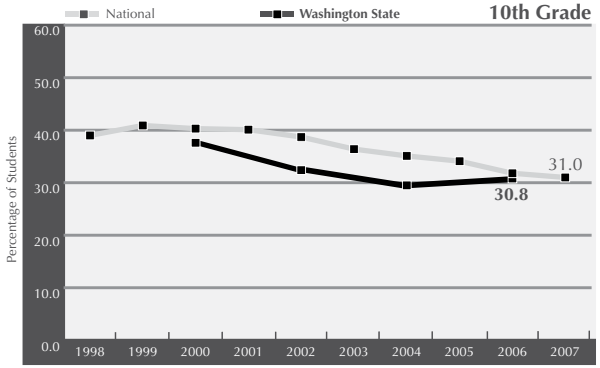
The Percentage of 10th and 12th Grade Students Who Had Tried Marijuana Increased in 2006.*

Besides being associated with a variety of health risks, marijuana use can contribute to risky behaviors and adverse physical and social consequences. Marijuana use among students in Washington State appears to be on the decline. The state target is to raise the average age of adolescents' first use of marijuana to 16.

A 2002 national study indicates that 36% of youth ages 14-17 report they can purchase illegal drugs within five blocks of their home.[1]







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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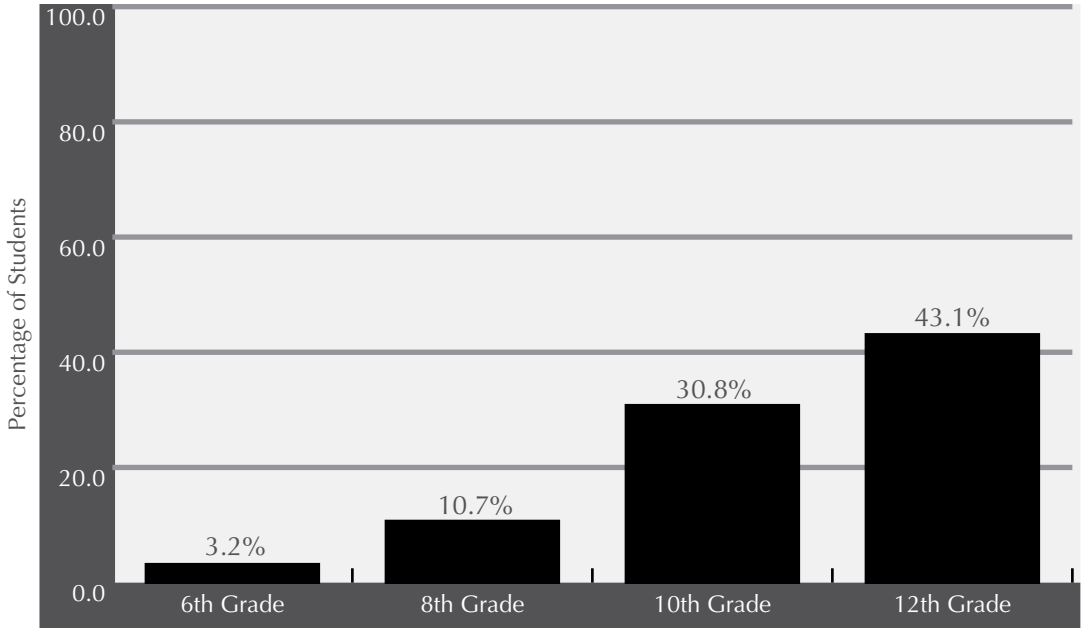
[1] Institute for Adolescent Risk Communication. *Access to Risky Products and Perceptions of Risky Behavior and Popularity.* Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

By 12th Grade, Over 40% of Washington Students Have Tried Marijuana.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

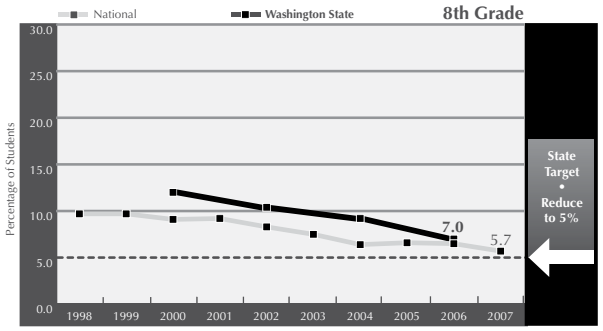
Many Washington students begin use of marijuana while they are in middle school. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added $41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, children being left behind, student assistance programs, property damage, injury, and counseling.

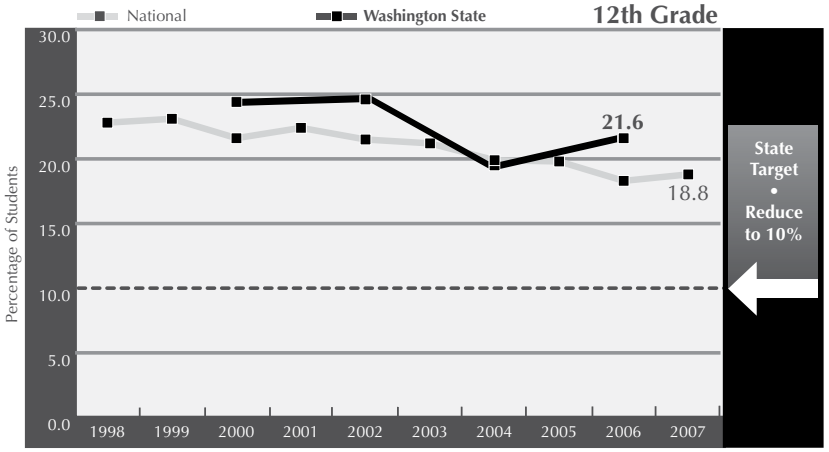
CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana.[1]

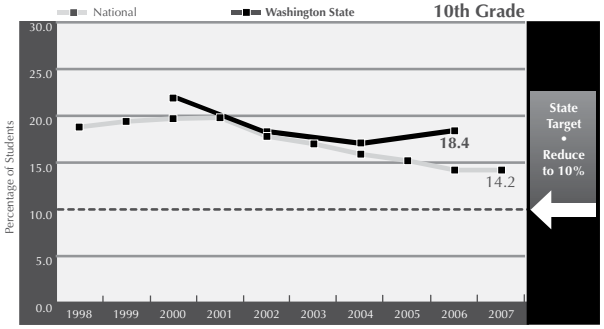
[1] *Malignant Neglect: Substance Abuse and America's Schools.* New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, 2001.

Marijuana Use in the Past 30 Days Among Washington State 10th and 12th Grade Students Increased in 2006.*

While nationally there is a trend toward lower past-30-day marijuana use among students, marijuana use among Washington State 10th and 12th graders is increasing. Only among 8th graders has past-30-day marijuana use declined.







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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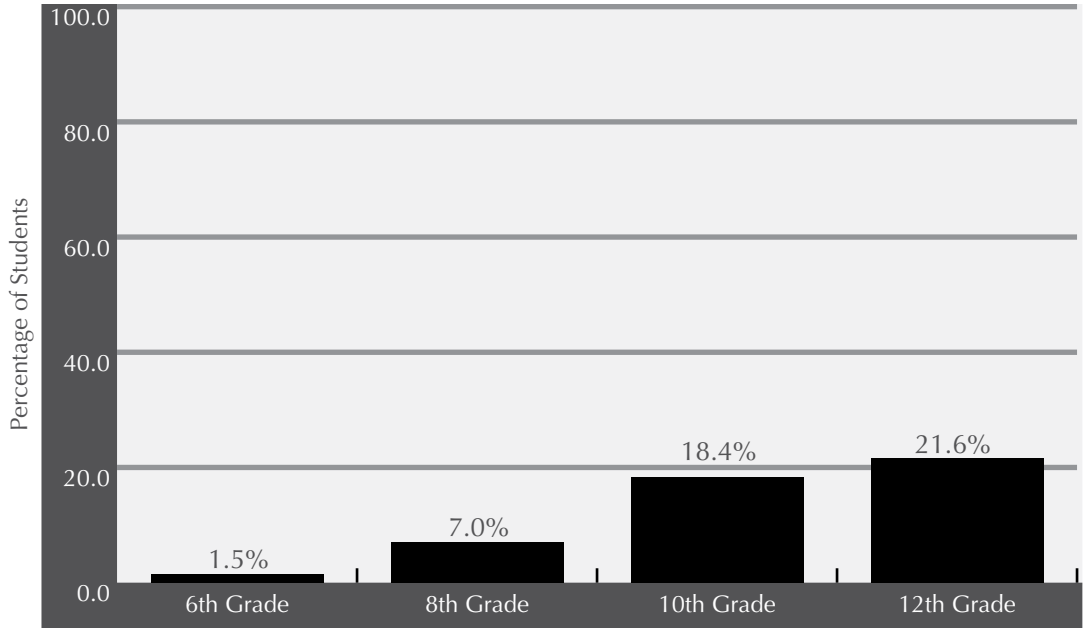
More than One-Fifth of Washington High School Seniors Report Having Used Marijuana in the Past 30 Days.



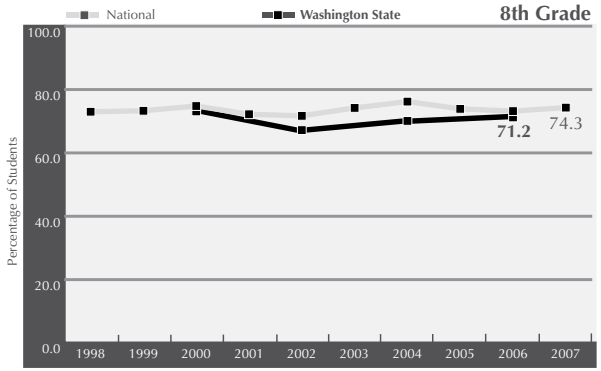
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

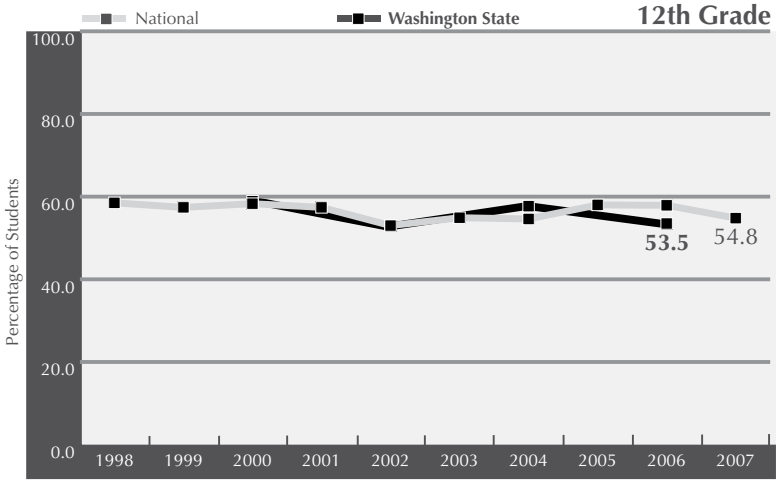
Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. *Healthy People 2010* recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.[1]

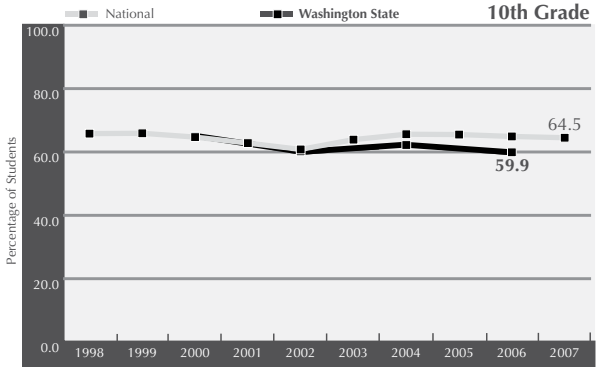
[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-28. Washington, DC: 2000.

The Percentage of Washington State 10th and 12th Graders Who Perceive Great Risk from Regular Marijuana Use Has Declined.*

In 2006, as perception of great risk from regular marijuana use declined among 10th and 12th graders, past-30-day use increased. Both nationally and in Washington State, perception of risk from regular marijuana use declines as students get older.







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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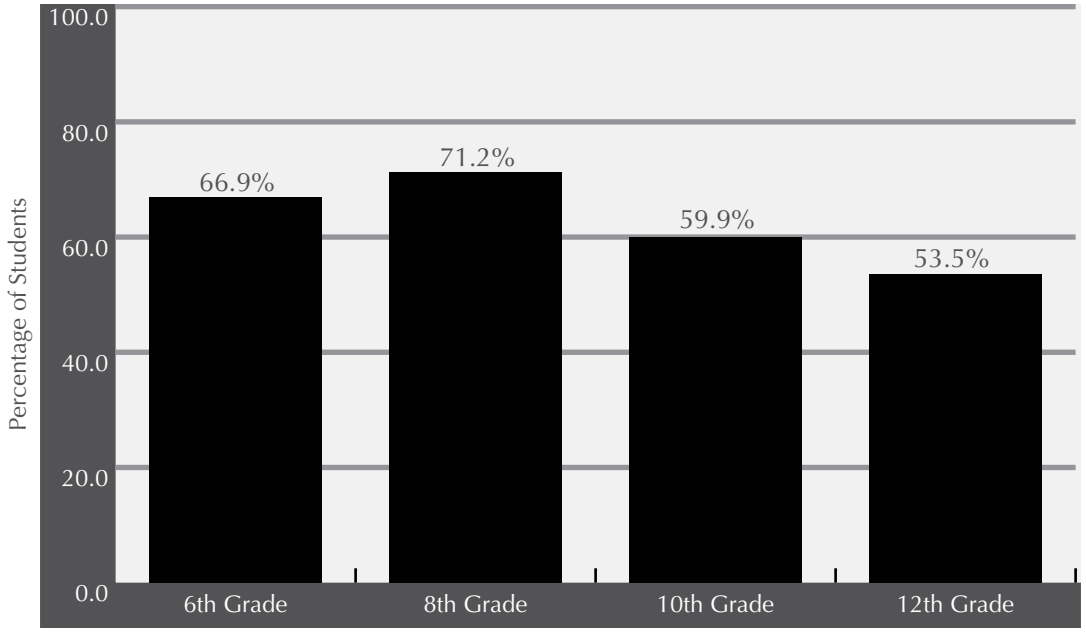
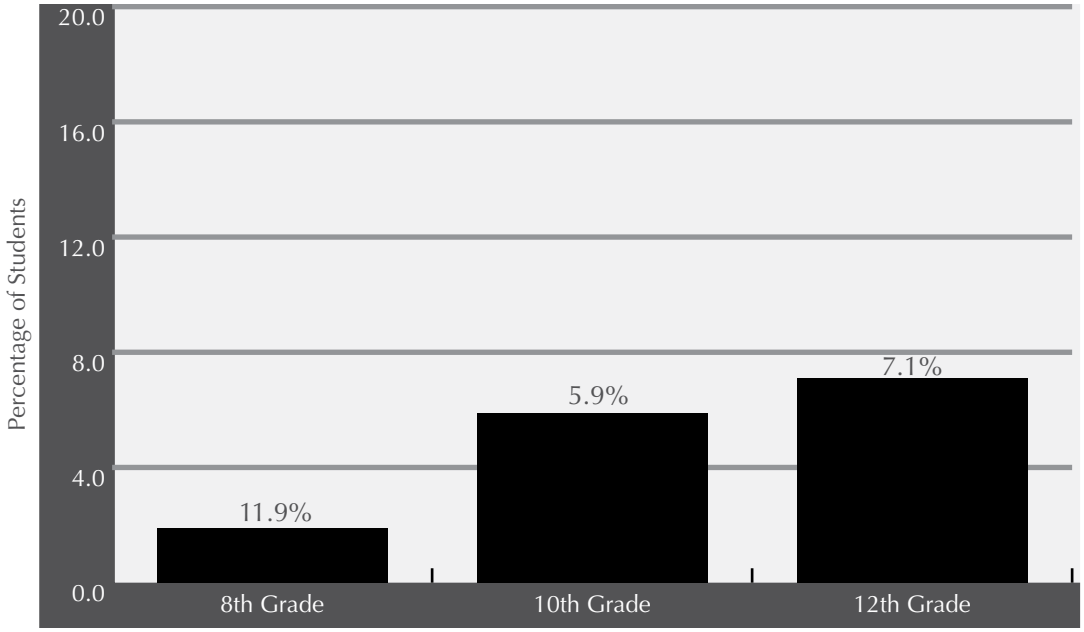
The Percentage of Washington State Students Who Perceive Great Risk from Regular Marijuana Use Declines as They Get Older.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

The percentage of students in Washington State and nationally, who perceive great risk from regular marijuana use declines as they get older. This is contrary to the way students perceive the risk of regular cigarette use, which increases with age.

In 2006, More than 7% of Washington State High School Seniors Reported Having Tried Methamphetamine.



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

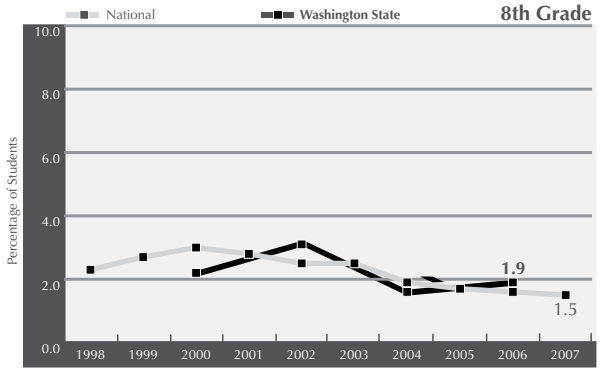
Researchers funded by the National Institute on Drug Abuse have found a range of negative cognitive effects from use of methamphetamine, often associated with brain cell damage. Some of this damage is long-term, and users may not fully recover after they have become abstinent.[1]

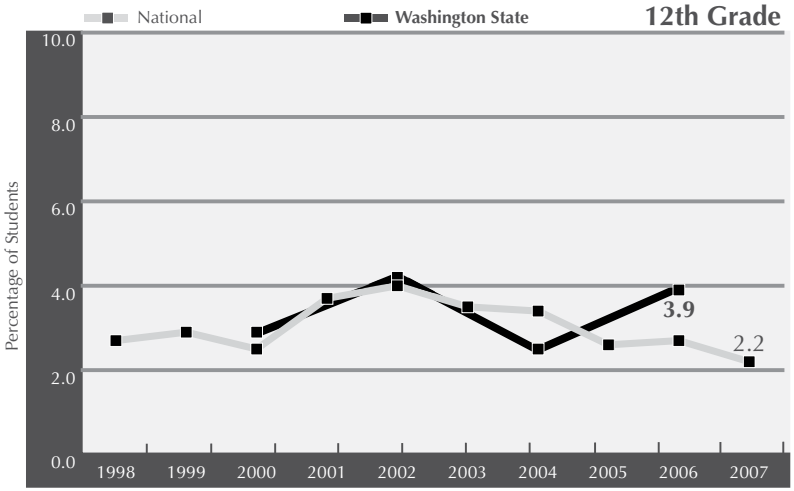
[1] National Institute on Drug Abuse. "Brain Imaging Studies Show Long-Term Damage from Methamphetamine Abuse," *NIDA Notes* 15(3), August 2000; National Institute on Drug Abuse, "Methamphetamine Abuse Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters," *NIDA Notes* 17(1), April 2002.

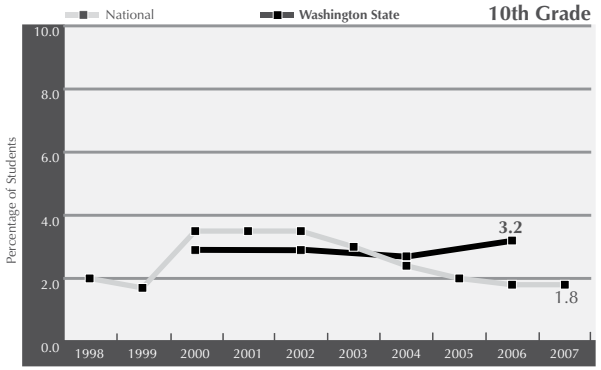
NEW/CHANGING TREND

In 2006, There were Significant Increases in Lifetime Steroid Use Among Washington Students in 8th, 10th, and 12 Grades.*

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.[1] Lifetime steroid use among Washington students appears to again be on the rise, and is higher than the national rate.







Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

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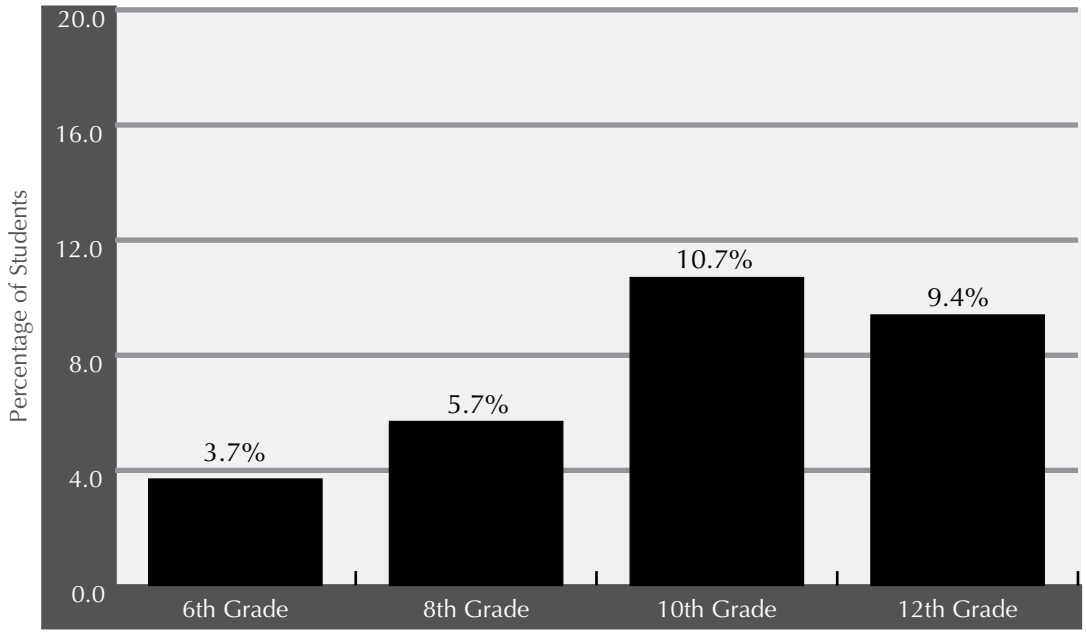
[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-36. Washington, DC: 2000.

Lifetime Use of Inhalants Among Washington State 8th, 10th, and 12th Grade Students is Increasing.



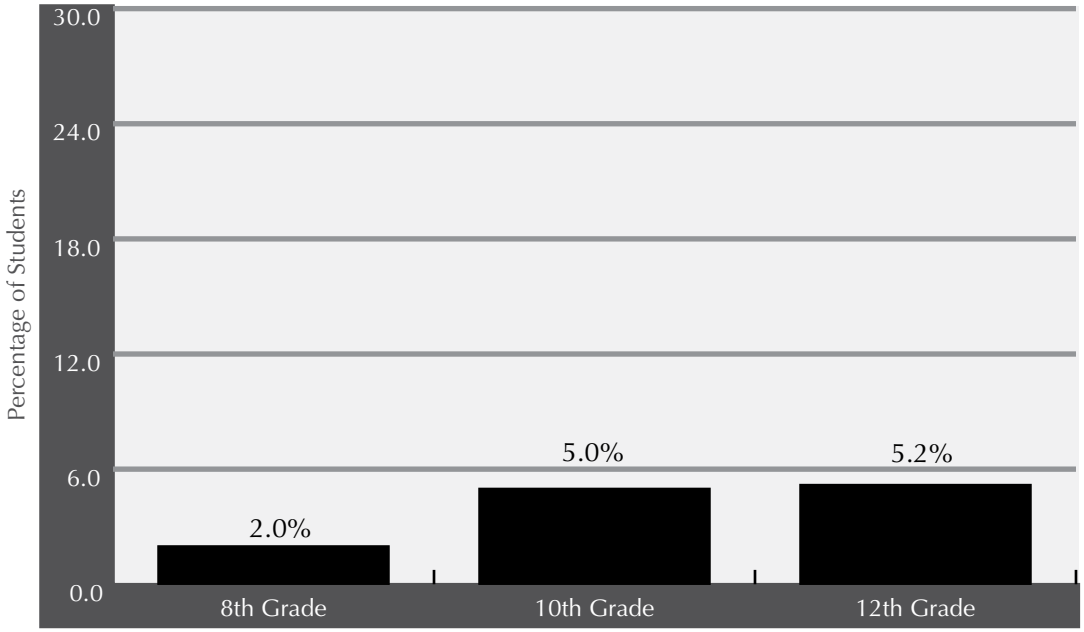
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

Inhalants are substances whose vapors can be inhaled to produce a mind-altering effect. These include volatile solvents (paint thinners, degreasers, and glue); aerosols (hair sprays and vegetable oil sprays); ether, nitrous oxide, and propane; and nitrites. A single, prolonged session of inhalant use can produce rapid and irregular heart rhythms, heart failure, and death. Chronic exposure can cause widespread and long-lasting damage to the nervous system and other vital organs.[1]

There have been substantial increases in lifetime inhalant use among Washington 8th, 10th, and 12th grade students. Among 8th graders, lifetime use increased from 5.3% in 2004 to 5.7% in 2006; among 10th graders, from 6.6% in 2004 to 10.7% in 2006; and among 12th graders, from 7.1% in 2004 to 9.4% in 2006.

[1] National Institute on Drug Abuse. "Facts About Inhalant Abuse," *NIDA Notes* 15(6), January 2001.

In 2006, More than 5% of Washington State 10th and 12th Graders Reported Using Ritalin Illicitly in the Past 30 Days.



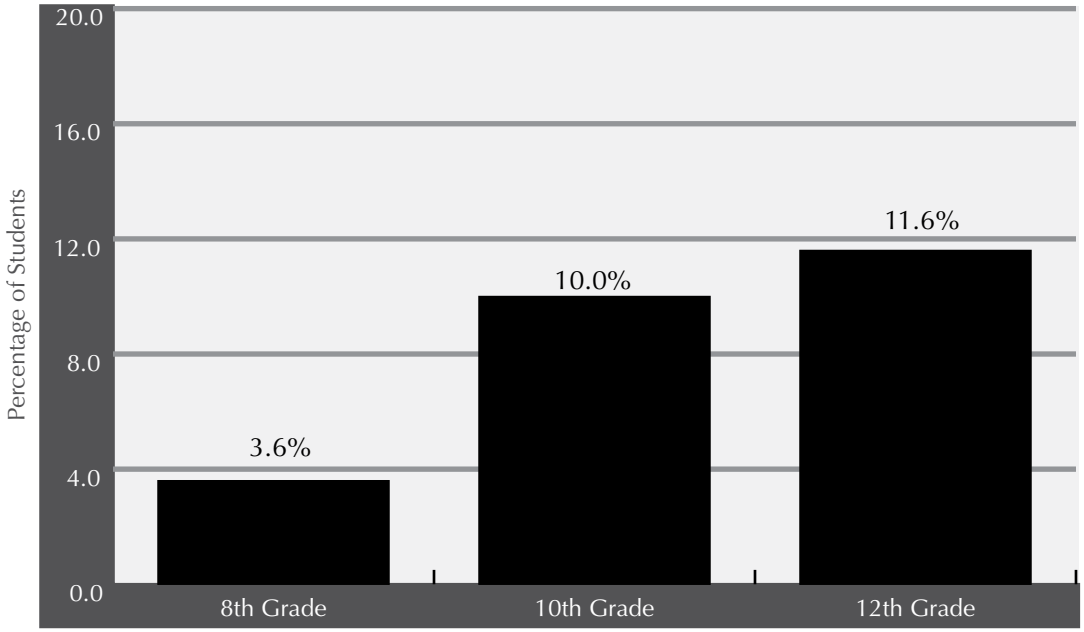
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

Illicit use of Ritalin by high school students nationwide appears to be on the increase. A recent study found that 10% of youth ages 12-17 had abused Ritalin (and Adderall) at least once. The euphoria produced by excessive, intranasal, or intravenous use of Ritalin is similar to that produced by cocaine and other amphetamines. High doses can lead to delirium, hallucination, and toxic psychosis.[1]

Concern regarding the abuse of Ritalin is part of a larger concern about the growing abuse of prescription drugs, especially by teens, which tripled between 1992 and 2003.[2] There have been substantial increases in past-30-day illicit Ritalin use among Washington 10th and 12th grade students. Among 10th graders, past-30-day use increased from 4.2% in 2004 to 5.0% in 2006; among 12th graders, from 3.6% in 2004 to 5.2% in 2006.

[1] The National Center on Addiction and Substance Abuse at Columbia University (CASA). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the United States*. New York, NY: CASA, July 2005.
[2] Ibid.

More than One in Ten Washington State 10th and 12th Graders Used Prescription Pain Medications to Get High in the Past 30 Days.*



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

In 2006, students were asked if they had used pain medications "to get high" during the past 30 days. The results were significantly elevated, higher, for example, than youth methamphetamine use.

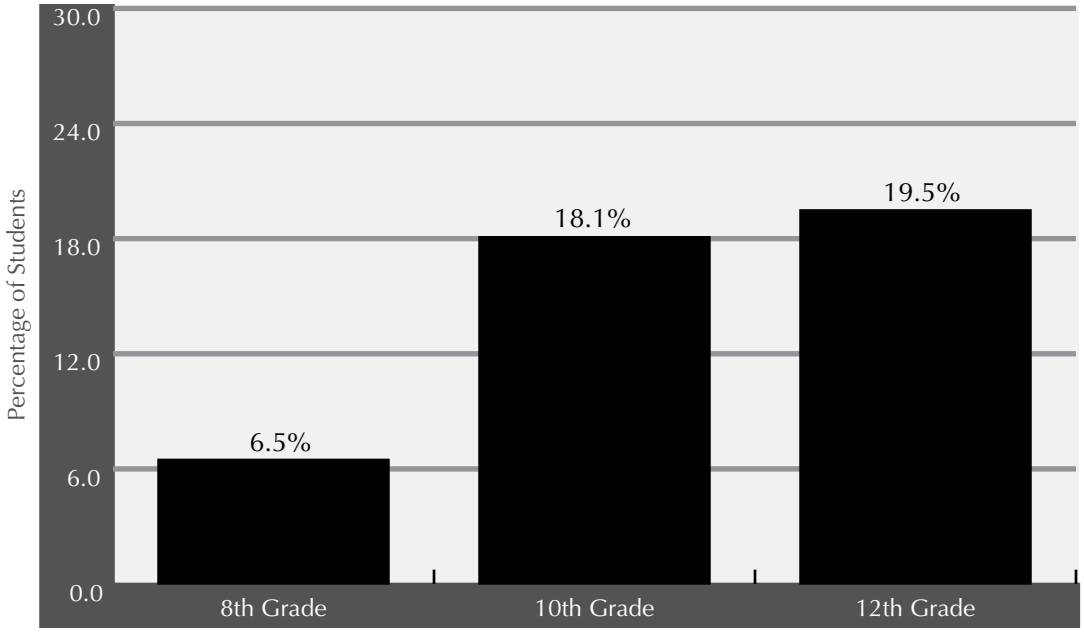
Maintaining a balance between providing adequate pain management and preventing misuse of prescription opiates presents a challenge for policymakers. Approximately 19% of U.S. adults received a prescription for opiates in 2005. Sales of prescription opiates - especially oxycodone, hydrocodone, and methadone - have grown rapidly in the past decade, as have related emergency department visits, and drug-caused deaths in which prescription opiates are present.[1] It is thought that the general household availability of prescription opiates is a factor in abuse of these drugs by youth. In 2005-2006, Washington State ranked sixth in the nation in the percentage of individuals ages 12 and older using prescription pain relievers for non-medical purposes (6.13%).[2]

**Prescription opiates include codeine, fentanyl, oxycodone, hydromorphone, hydrocodone, meperidene, methadone, propoxyphene, and morphine.*

[1] Banta-Green, C., et al. *The Use & Abuse of Prescription-Type Opiates in Washington State (ADAI Research Brief)*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, March 30, 2007.
[2] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

NEW/CHANGING TREND

Almost One-Fifth of Washington State 10th and 12th Graders Reported Being Drunk or High at School in the Past Year.



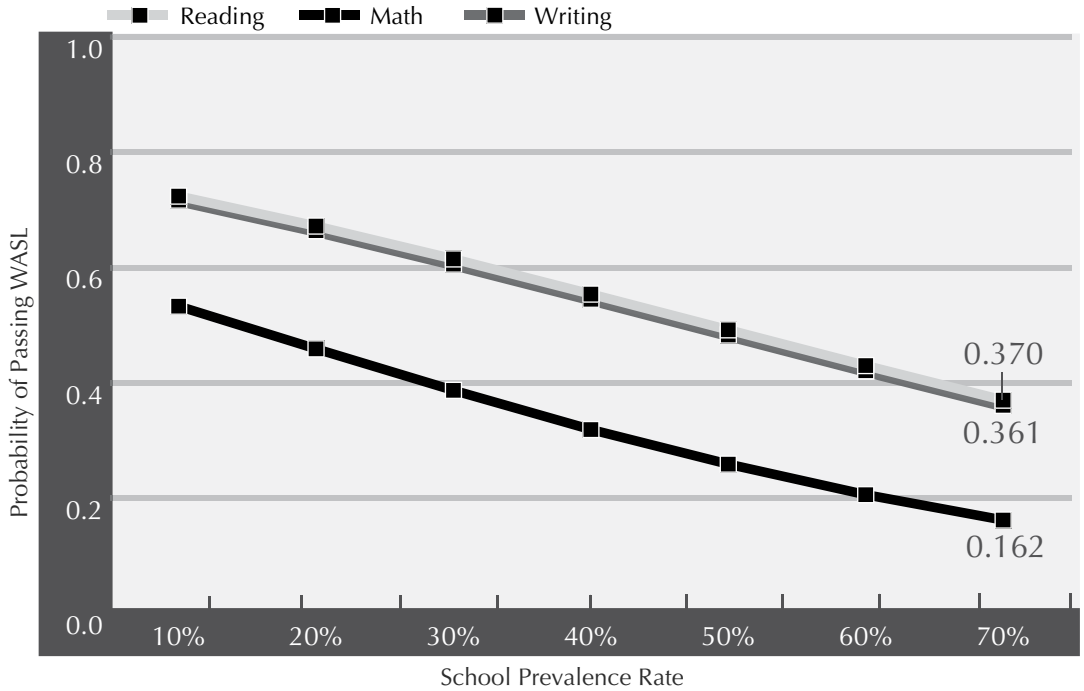
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

A substantial proportion of Washington State middle and high school students have attended school either drunk or high. Peer substance abuse has been shown to have highly negative effects upon school performance.[1]

[1] Arthur, M., and Brown, E. "Levels of Risk, Protection and Drug Use Predict Students' WASL Scores." Seattle, WA: University of Washington, Social Development Research Group, May 2006.

Peer Substance Abuse Has Significant Negative Impacts on School Performance.

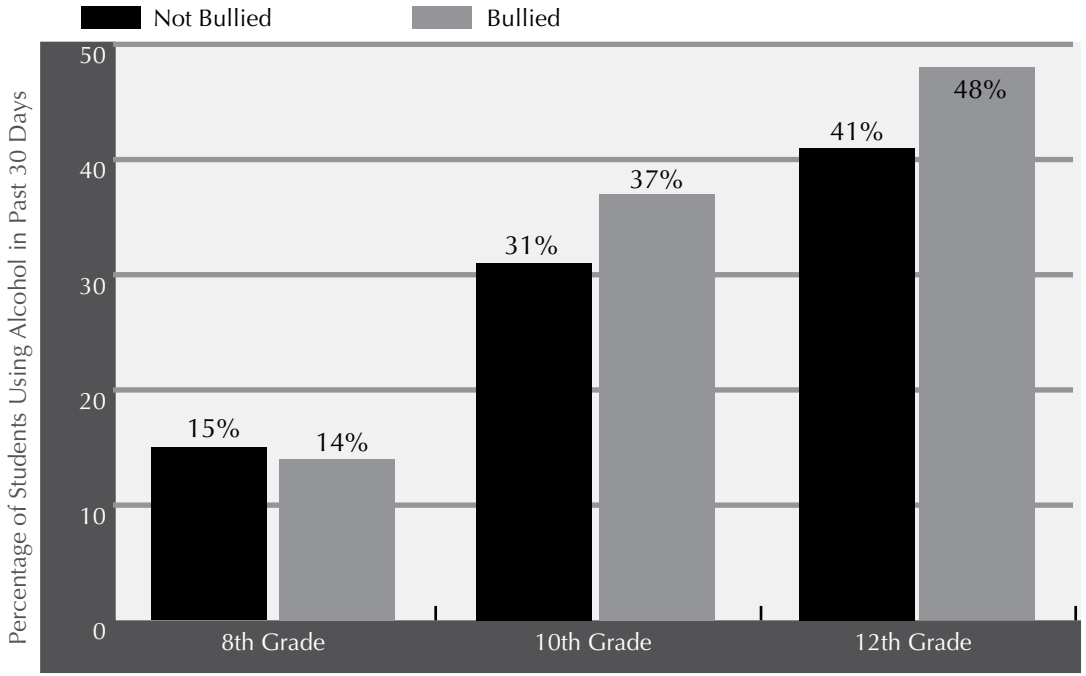
Relationship Between Past 30-Day Alcohol Use and Probability of Passing WASL (10th Graders)



Source: Arthur, M., and Brown, E., "Levels of Risk, Protection and Drug Use Predict Students' WASL Scores." Seattle, WA: Social Development Research Group, University of Washington, May 2006.

A 2006 analysis of data from the *Washington State Healthy Youth Survey* indicates a strong relationship between peer substance abuse and school performance. As the prevalence of past-30 day alcohol use within a school population rises, the percentage of those who pass the tenth-grade Washington Assessment of Student Learning (WASL) in math, reading, and writing declines. Therefore, it is likely that successful efforts to curb underage drinking will have significant impacts on student performance.

Washington State 12th Graders Who Reported Being Bullied were More Likely to Report Recent Alcohol Use.

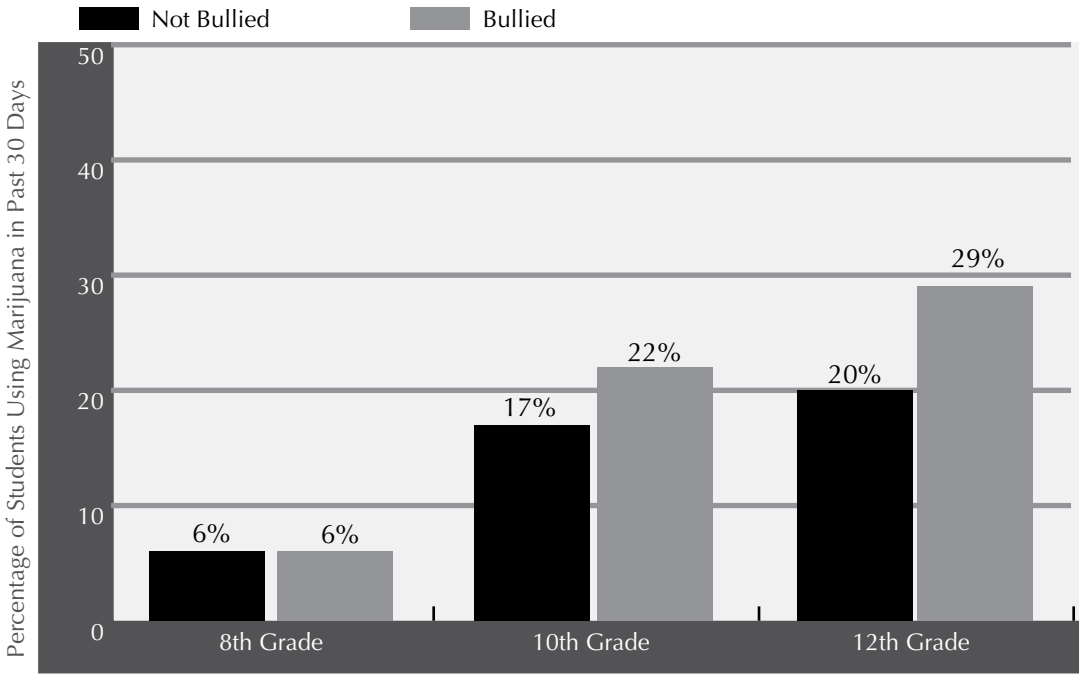


Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey – 2006*.

Among 12th grade Washington State students who reported being bullied, alcohol use in the past 30 days was 17% higher than among students who were not bullied. In 2006, past-month bullying in school was reported by 27% of 8th graders, 23% of 10th graders, and 16% of 12th graders. Students report being bullied on account of race/ethnicity, religion, sexual orientation, gender, health or disabilities, and other reasons.[1] Being bullied or not feeling safe in school is also associated with academic failure.

[1] Washington Statte Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Developement, and Family Policy Council. *Healthy Youth Survey - 2006*. Olympia, WA: 2008.

Washington State 12th Graders Who Reported Being Bullied were Substantially More Likely to Report Recent Marijuana Use.



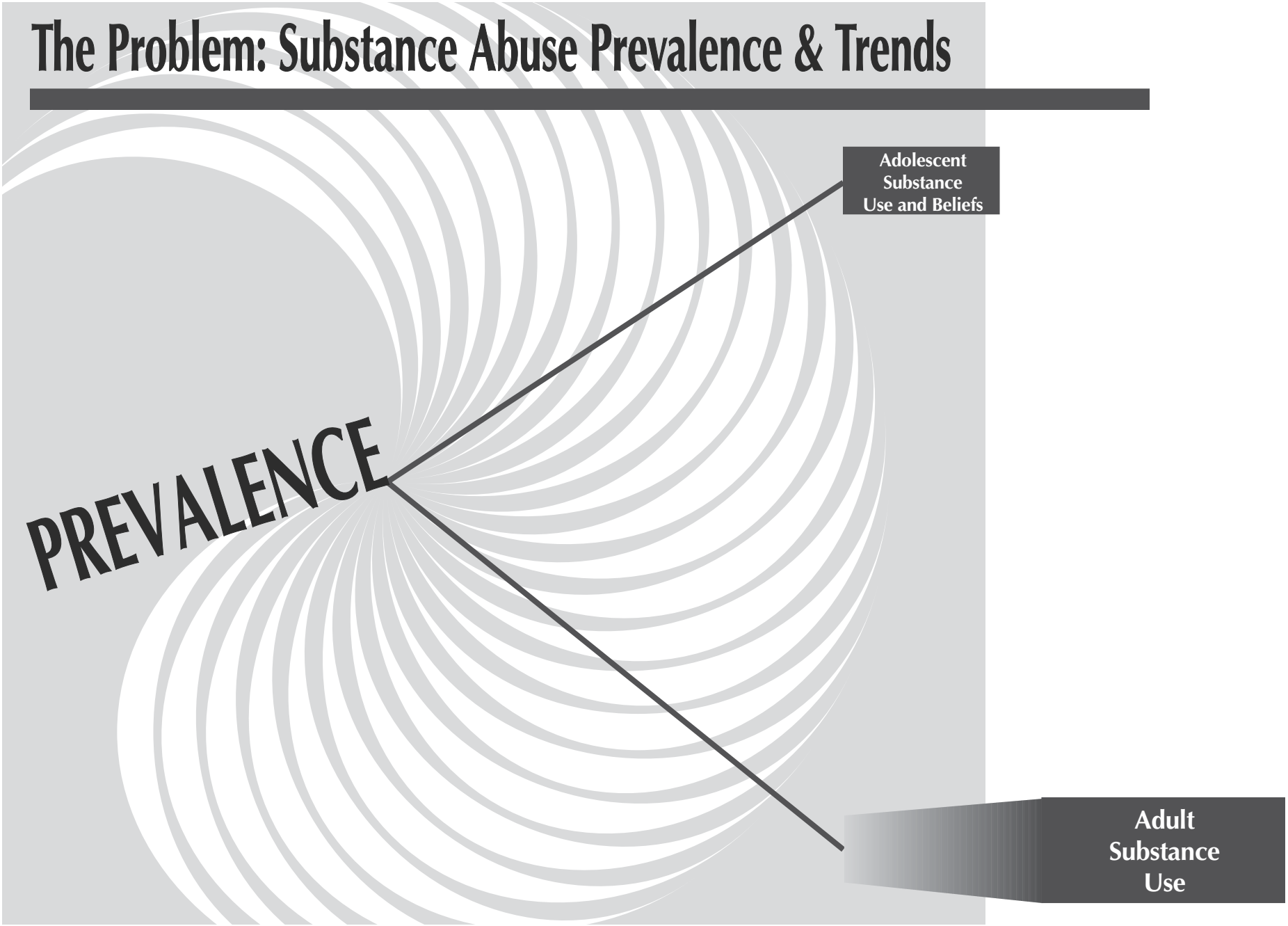
Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey – 2006*

Among 12th grade Washington State students who reported being bullied, alcohol use in the past 30 days was 45% higher than among students who were not bullied. Students report being bullied on account of race/ethnicity, religion, sexual orientation, gender, health or disabilities, and other reasons. Being bullied or not feeling safe in school is also associated with academic failure.

In 2006, past-month bullying in school was reported by 27% of 8th graders, 23% of 10th graders, and 16% of 12th graders.[1]

[1] Washington Statte Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Developement, and Family Policy Council. *Health Your Survey* - 2006. Olympia, WA: 2008.

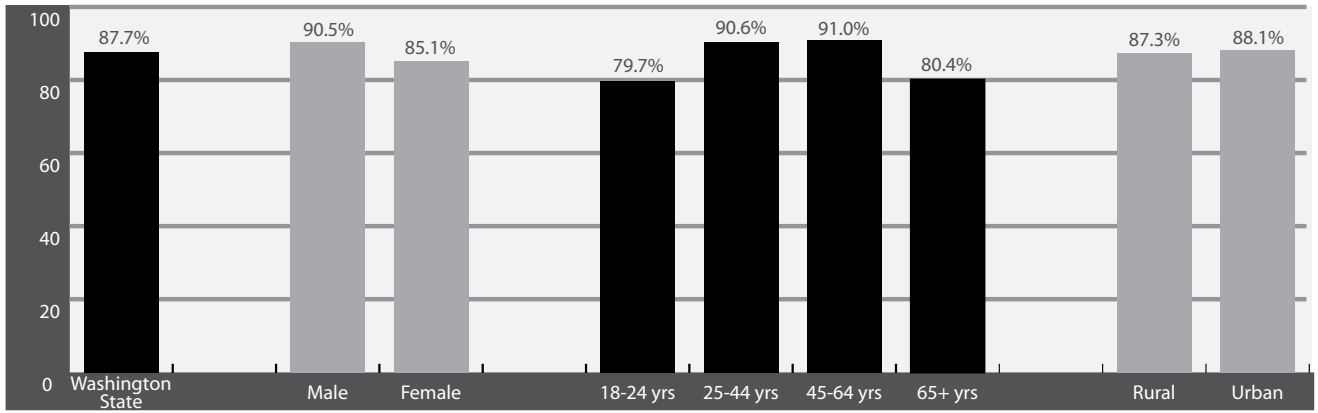
The Problem: Substance Abuse Prevalence & Trends



Males and Those Ages 25-44 Have Higher Rates of Alcohol Use.

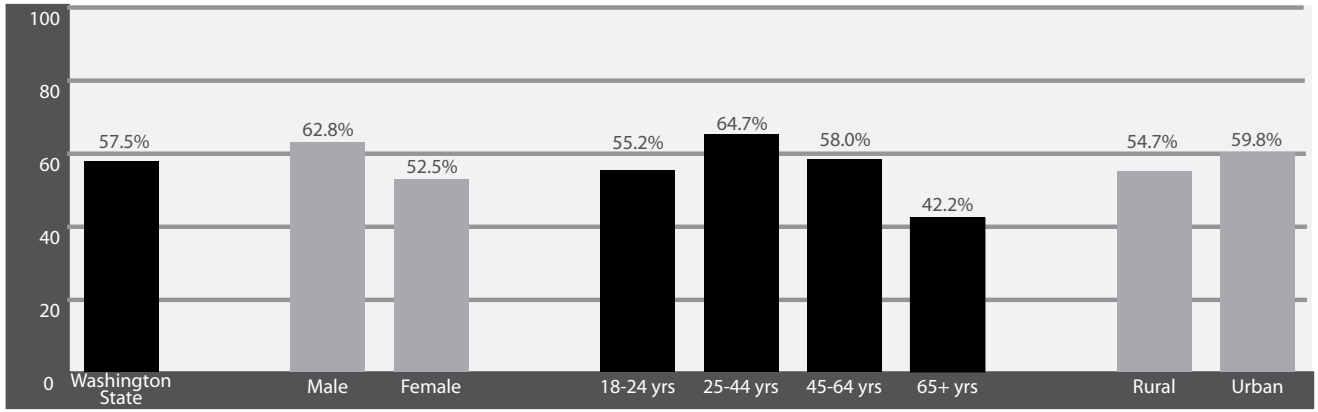
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



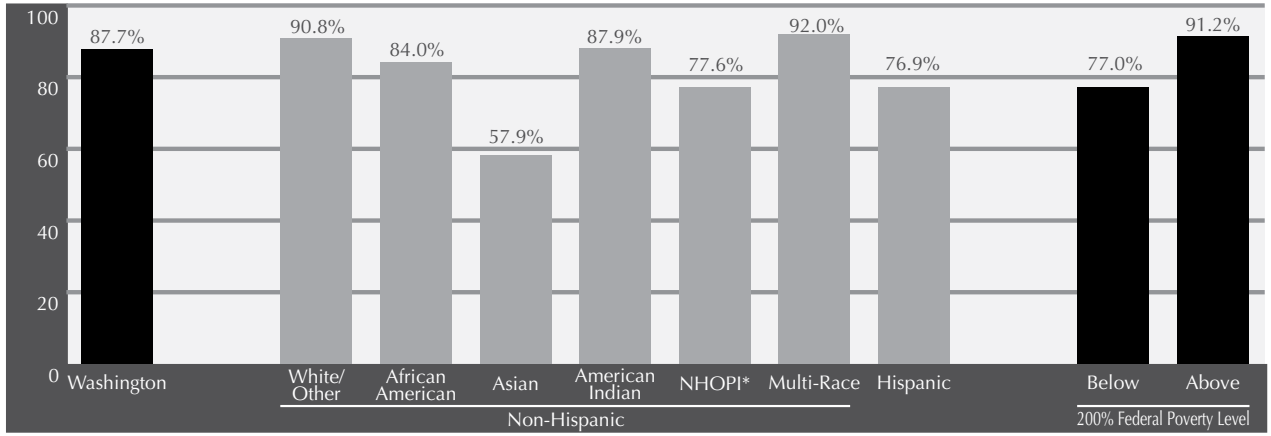
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Asian-Americans, Hispanics, and Lower-Income Individuals Have Lower Rates of Alcohol Use.

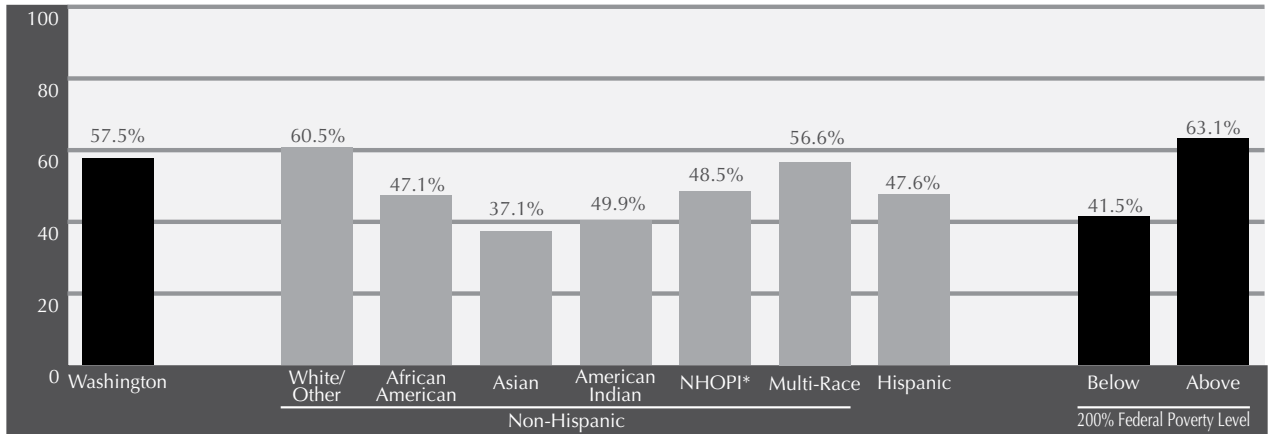
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



*Native Hawaiian or Pacific Islander

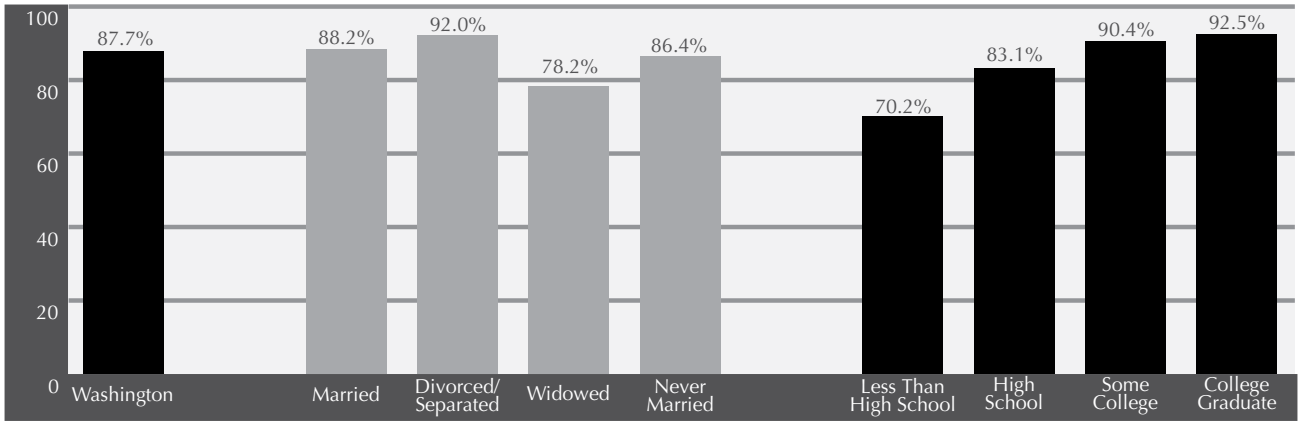
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Alcohol Use.

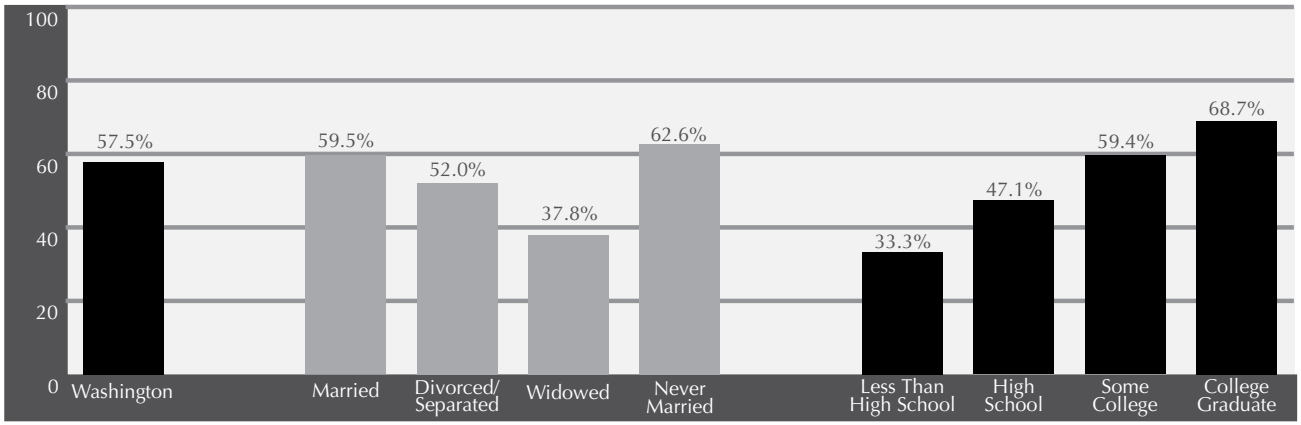
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



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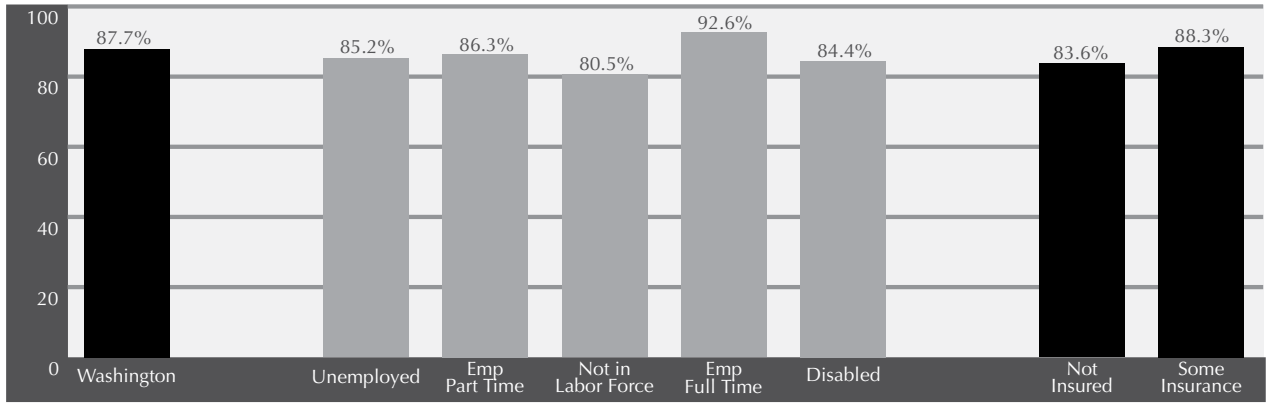
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Individuals Not in the Labor Force and Disabled, or Who are Without Health Insurance are Less Likely to Have Used Alcohol in the Past 30 Days.

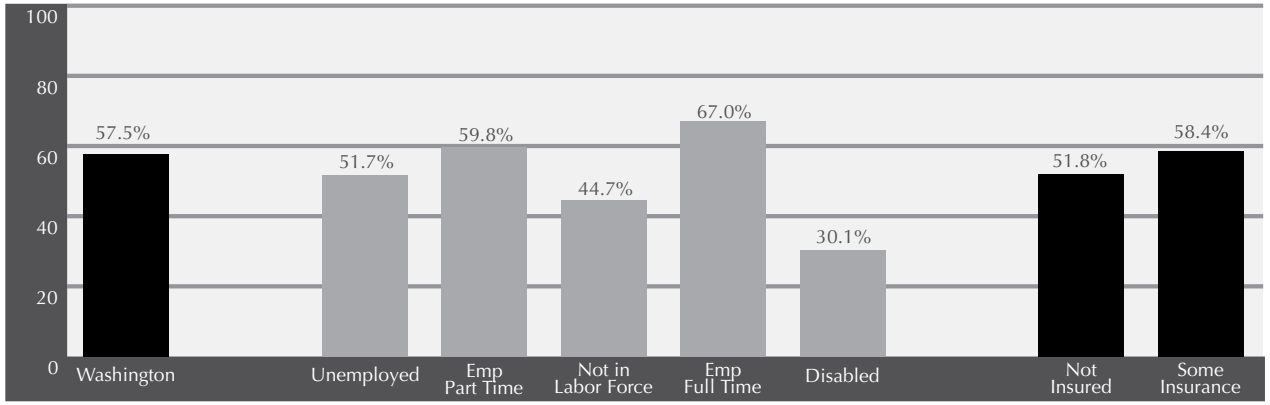
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



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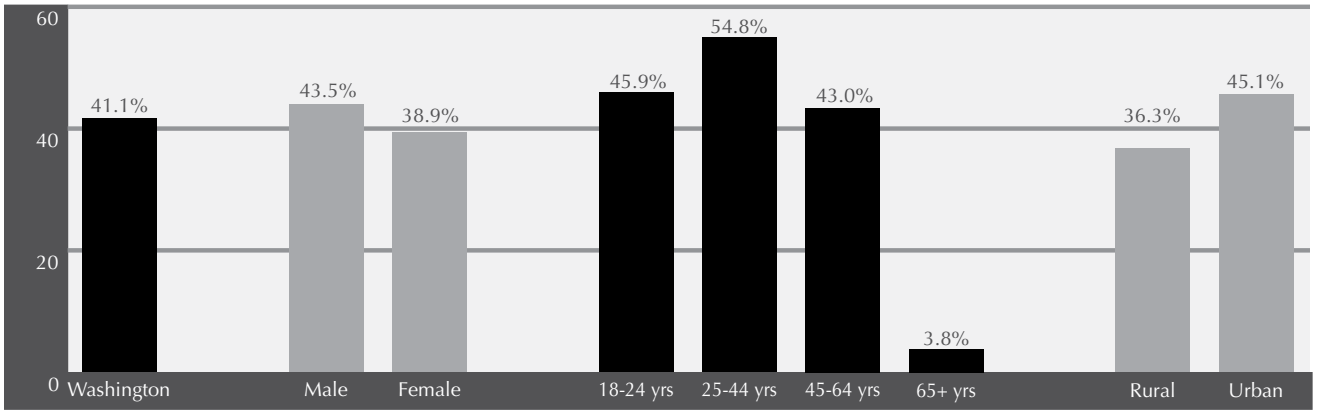
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Individuals Over Age 65 and Rural Residents Have Lower Rates of Marijuana Use.

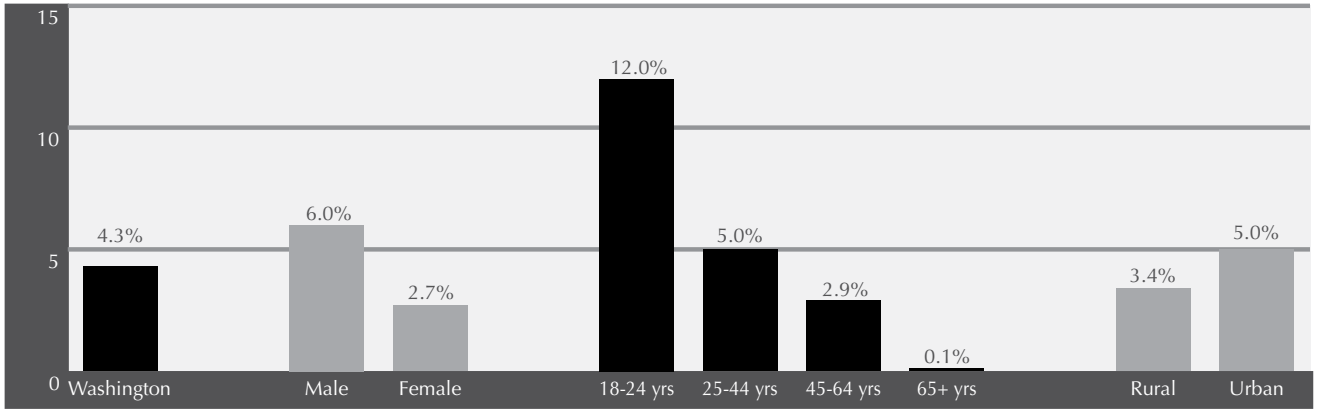
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



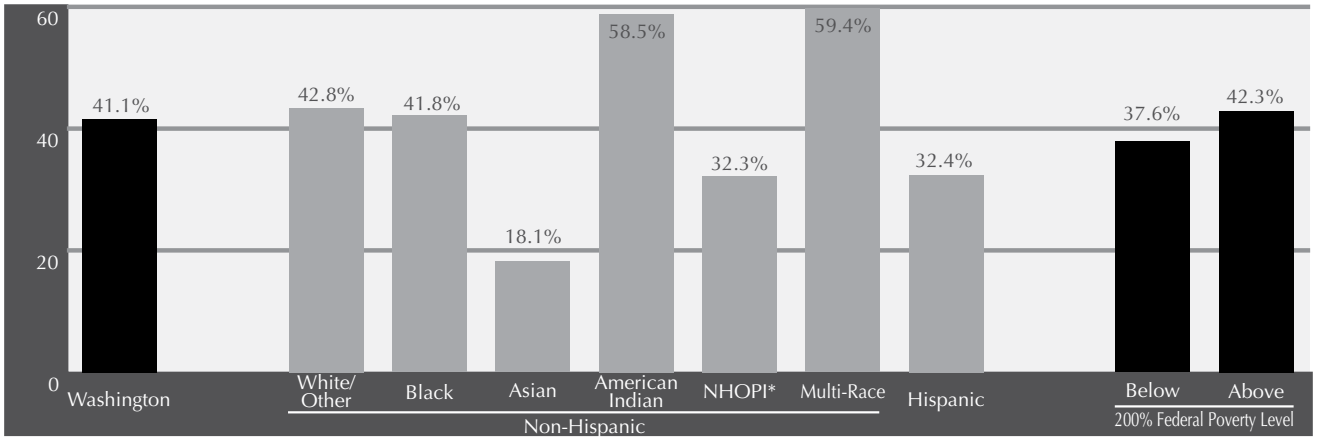
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

Asian-Americans and Native Hawaiians/ Pacific Islanders Have Lower Rates of Marijuana Use.

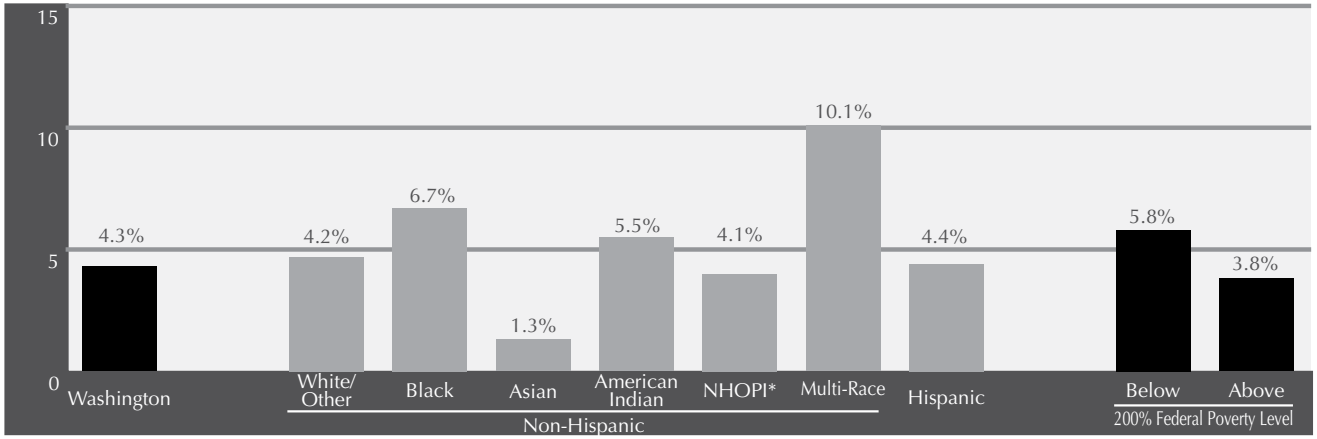
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



*Native Hawaiian or Pacific Islander

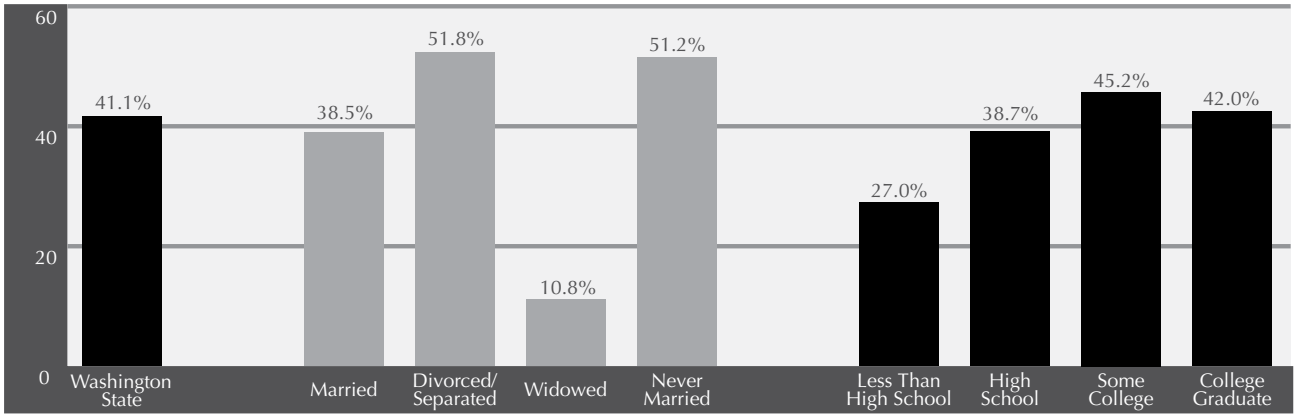
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Marijuana Use.

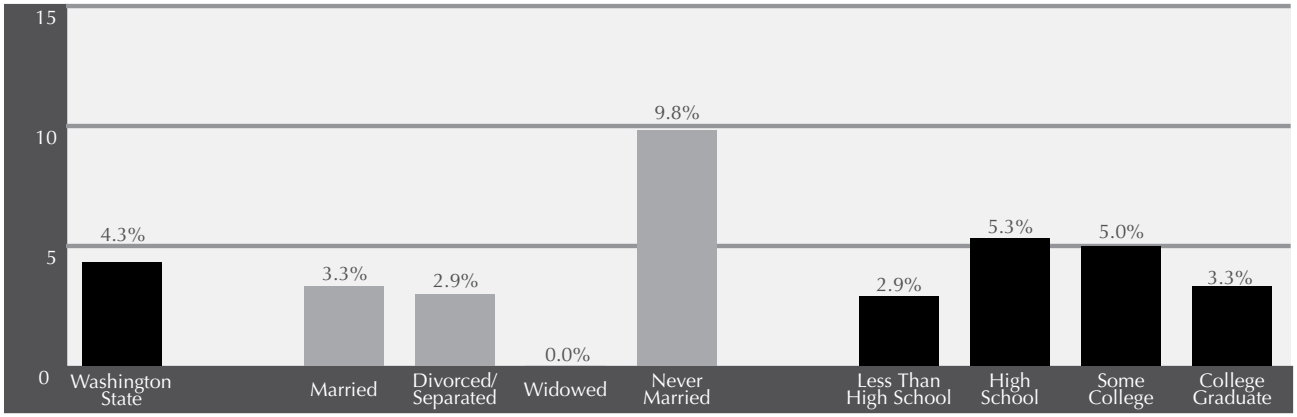
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



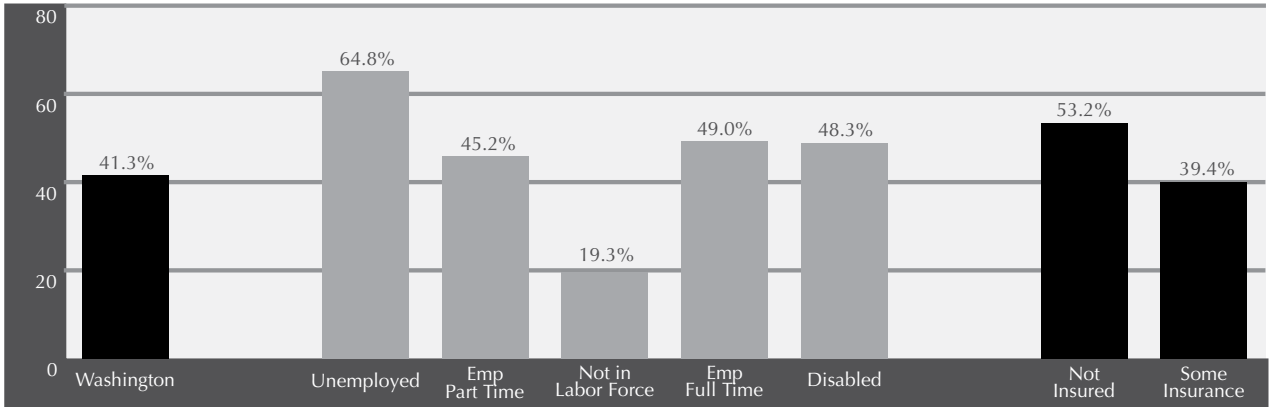
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

Individuals Not in the Labor Force, and Those With Health Insurance are Less Likely to Have Used Marijuana in the Past 30 Days.

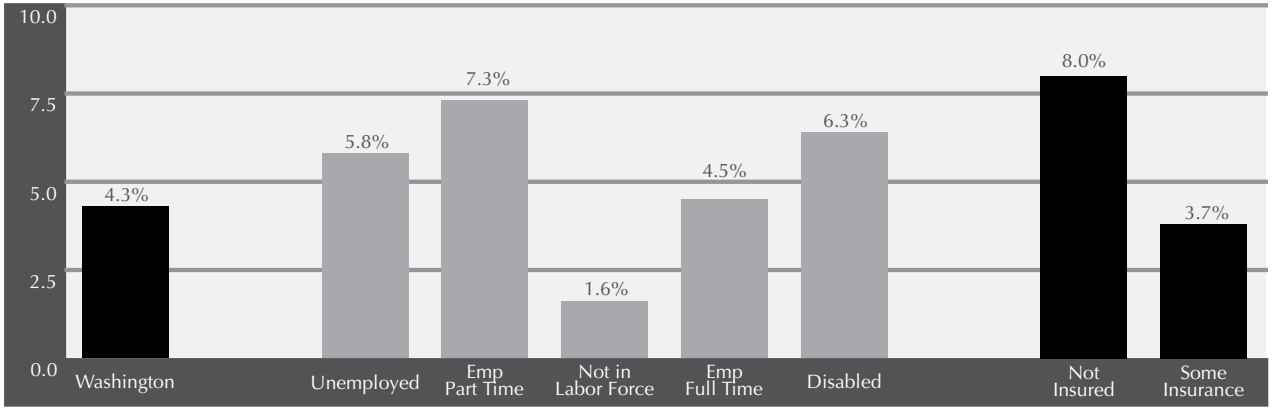
Lifetime Marijuana Use

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



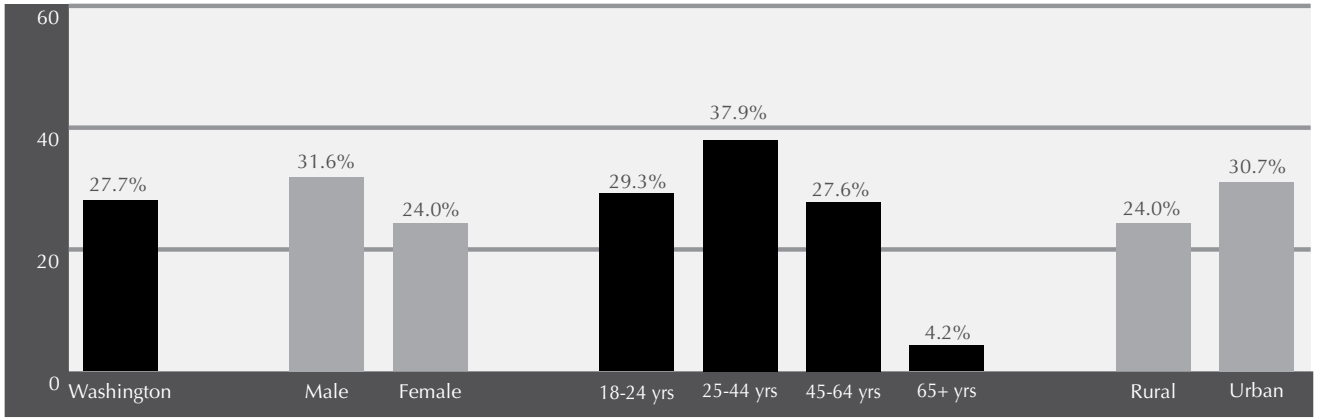
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 da

Individuals Over Age 65 and Rural Residents Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

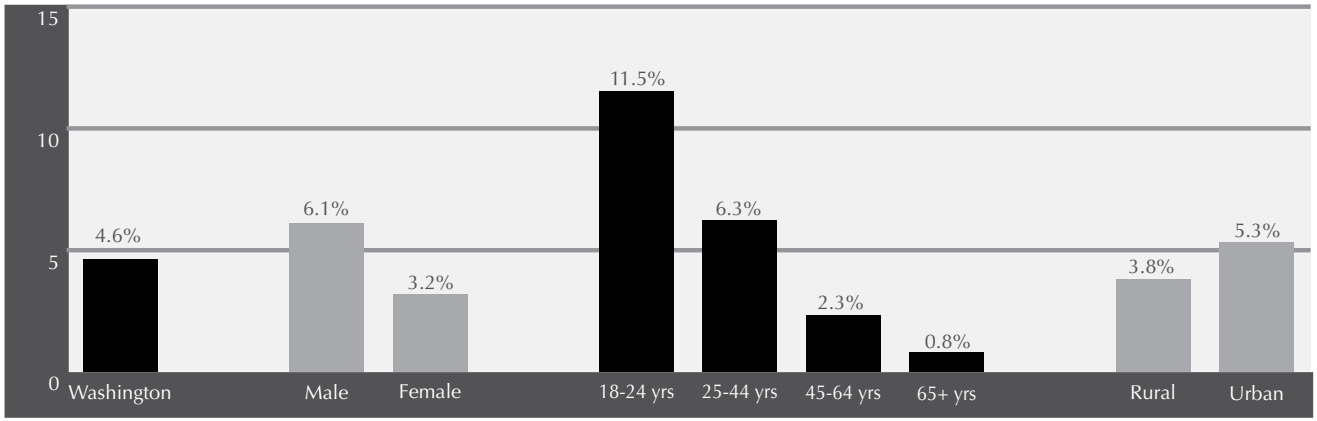
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

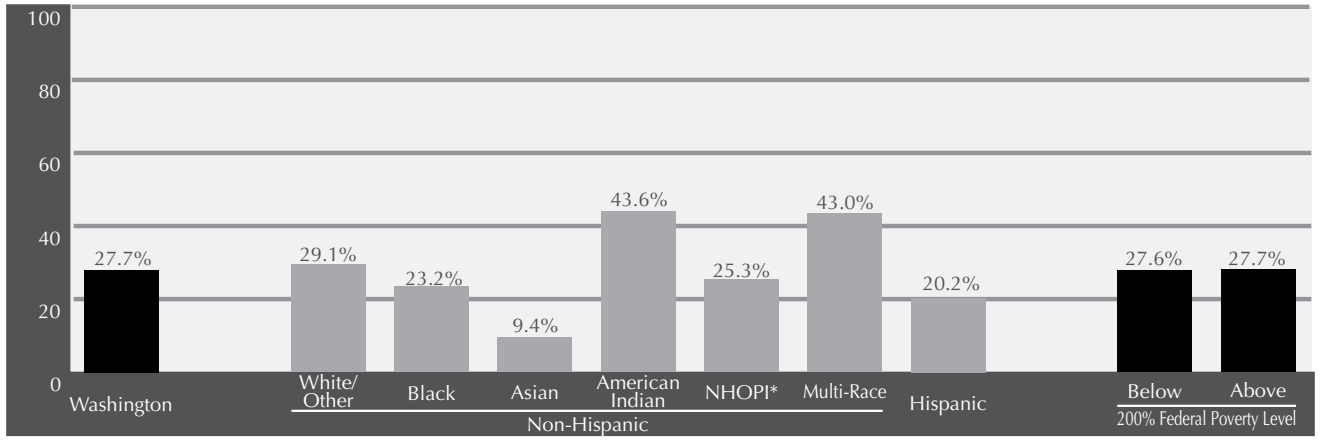
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

American Indians and Multi-Race Individuals Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*

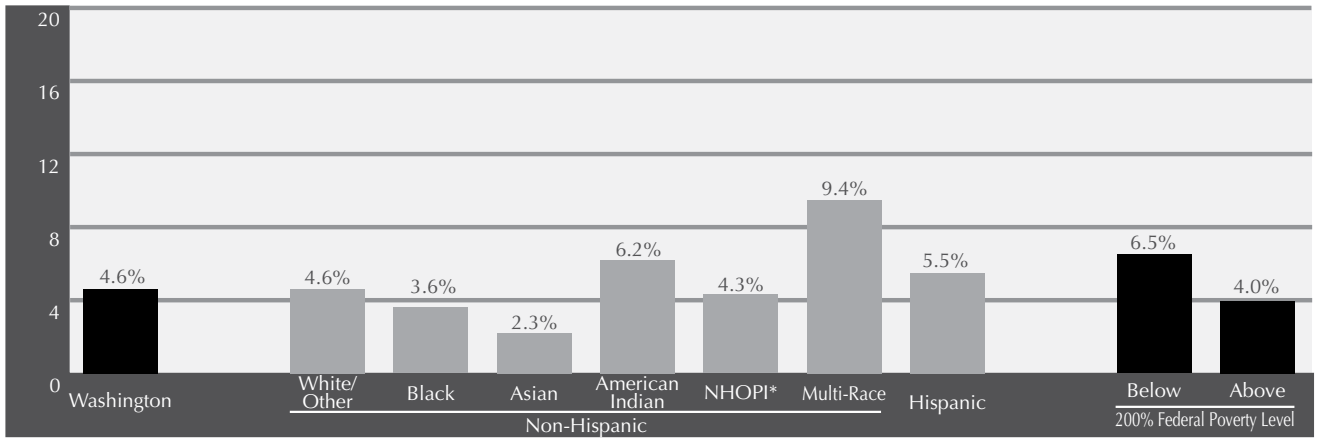
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



**Native Hawaiian or Pacific Islander

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

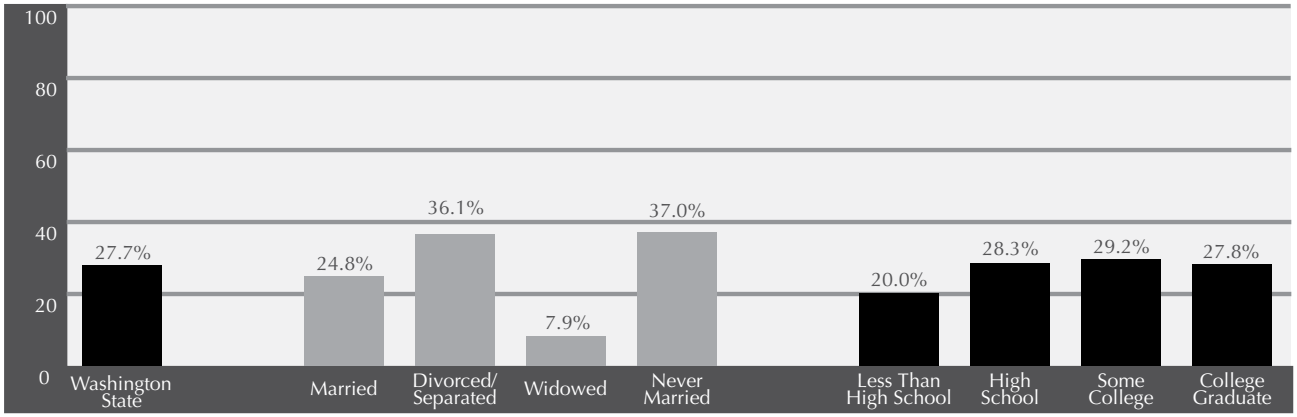
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

Widowed Individuals and Those Who Never Graduated from High School Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

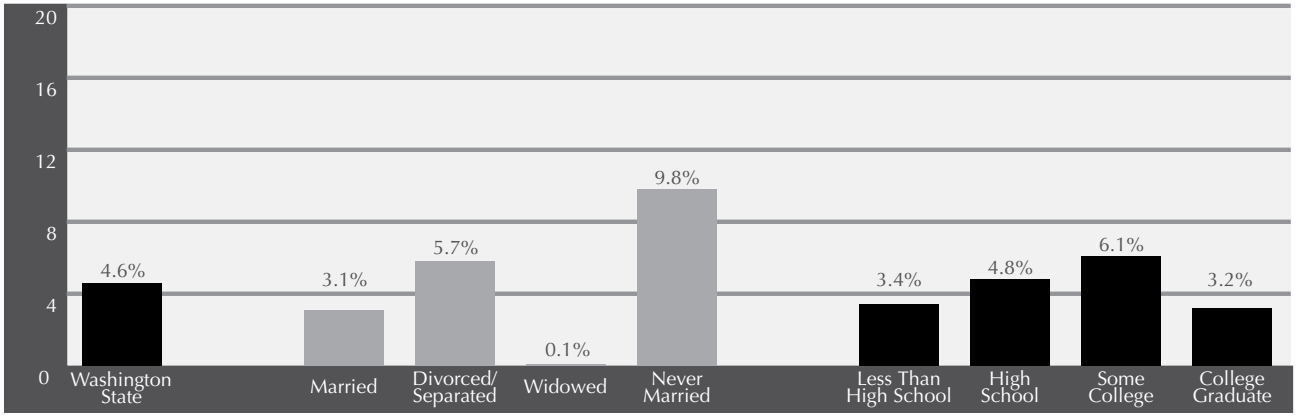
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

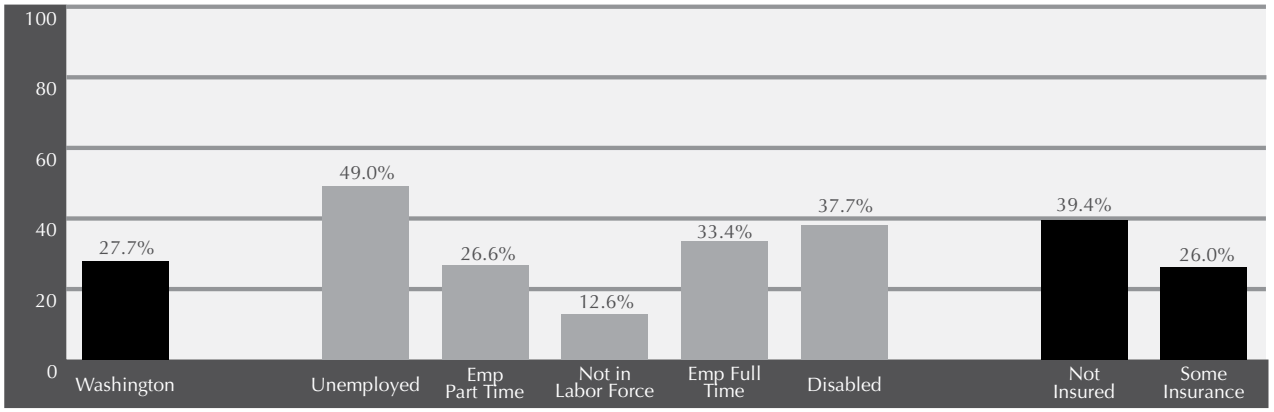
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

Individuals Who are Unemployed, Disabled, and Lack Health Insurance Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*

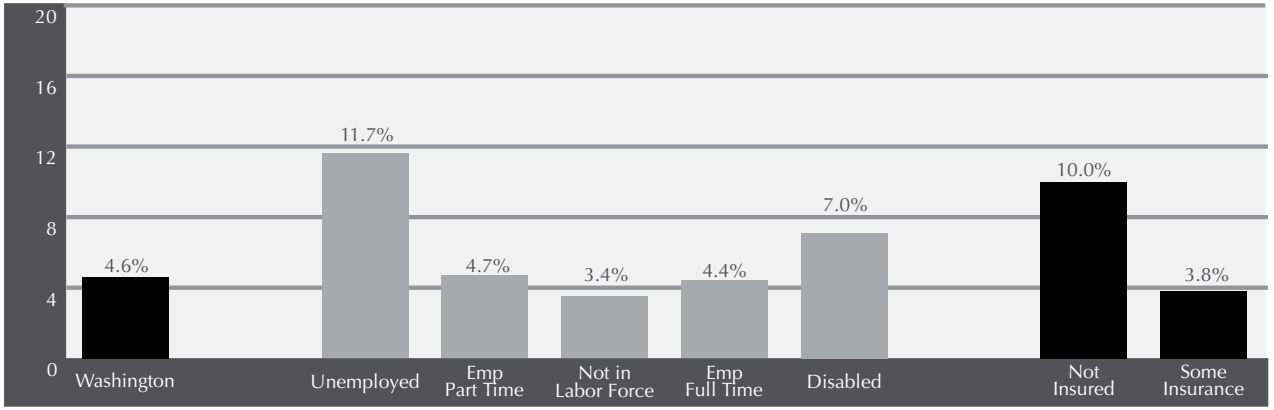
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Months Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2007 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

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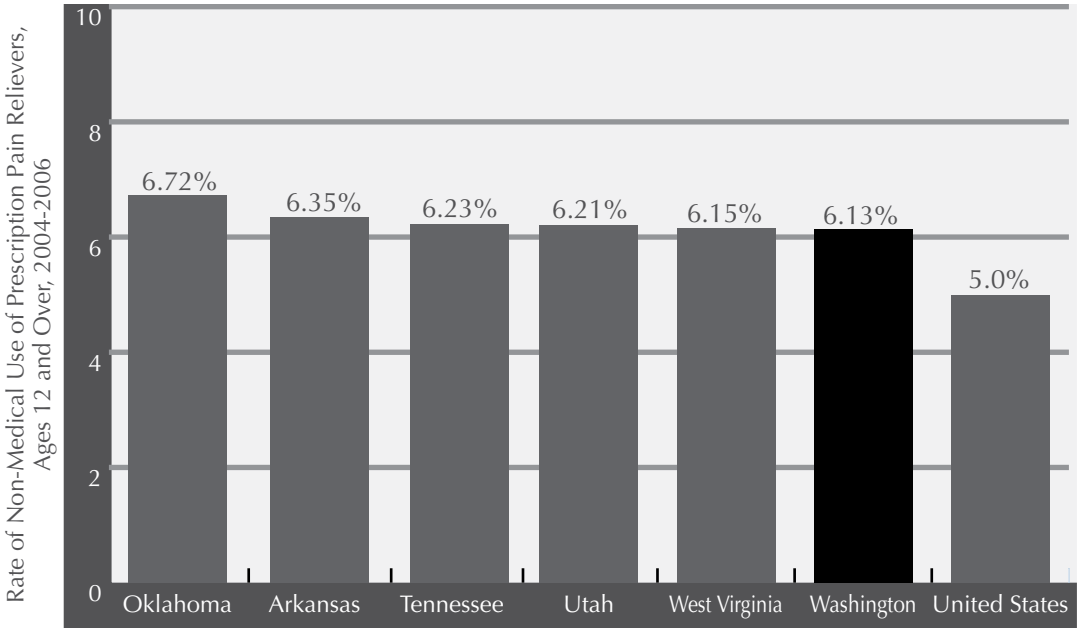
Washington State Has Among the Highest Rates of Non-Medical Use of Prescription Pain Relievers in the Nation.



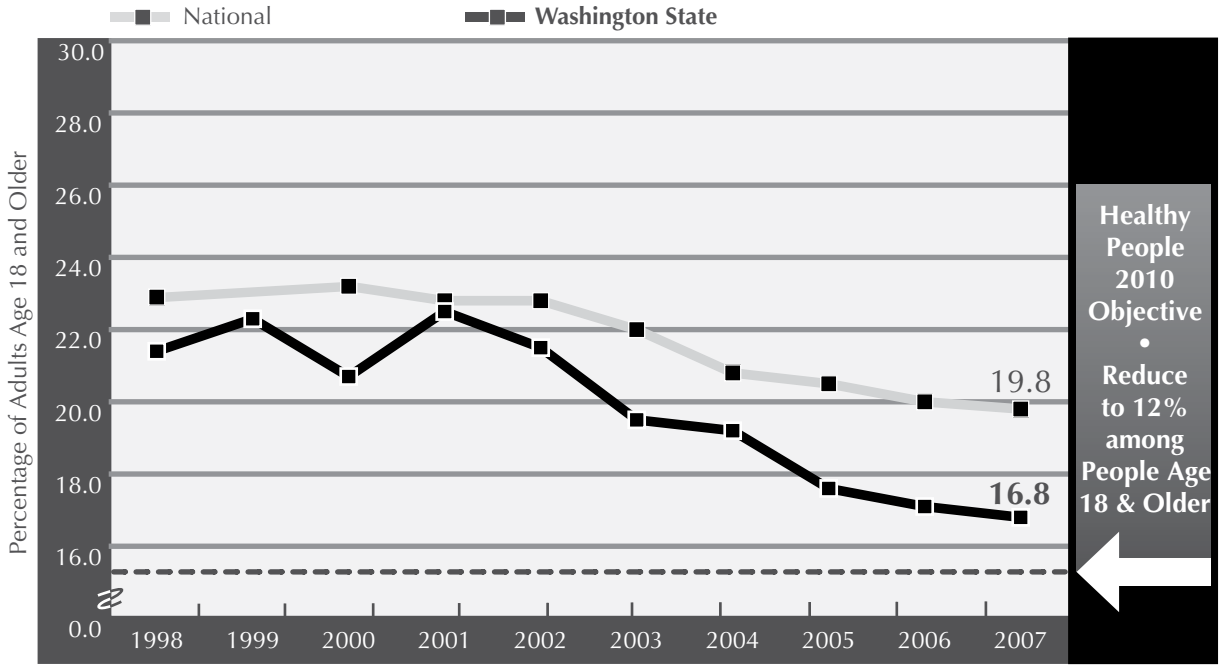
Source: Office of Applied Studies, State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.

Washington State ranks sixth among states in rate of non-medical use of pain relievers (mostly prescription-type opiates) by those ages 12 and over. It also ranks high among states in users ages 18-25, and 25 and above.[1] Within the state, highest rates of use are in Seattle-King County.[2]

[1] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.
[2] Office of Applied Studies.*The NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.

NEW/CHANGING TREND

Washington State Tobacco Control Efforts are Resulting in Lower Smoking Prevalence Among Adults.



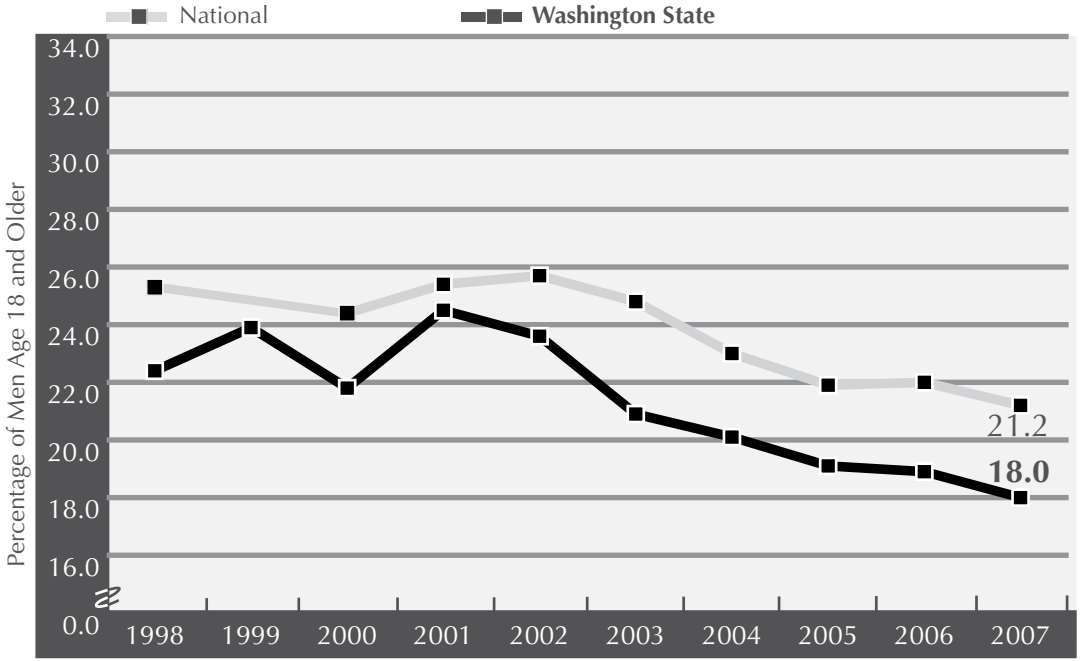
Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Cigarette smoking in the United States causes serious illnesses among an estimated 8.6 million Americans annually, with $157 billion in health-related economic costs.[1] Tobacco use causes approximately 440,000 deaths each year. Since the release of the Surgeon General's 1964 report on smoking and health, more than ten million Americans have died from smoking-related diseases, including heart disease, lung cancer, emphysema, and other respiratory diseases.[2] It is estimated that in 2000, there were 276,600 Washington residents with smoking-attributable diseases and conditions.[3]

Smoking rates in Washington State are clearly on the decline. Studies indicate that the more funds that states spend on comprehensive tobacco-control programs, the greater the reduction in smoking. The Washington State Department of Health's (DOH) Tobacco Prevention and Control Program estimates state health care spending resulting from tobacco use at $1.5 billion per year. In 2008, smoking cessation benefits - including pharmaceuticals and nicotine patches - were added to the State Medicaid Plan.

[1] Centers for Disease Control and Prevention. "Cigarette Smoking-Attributable Morbidity—United States, 2000," *Morbidity and Mortality Weekly Report* 2003 (52); "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51).
[2] Centers for Disease Control and Prevention. "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51); U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: 2000.
[3] Hyland, A. et al. *Cigarette Smoking-Attributable Morbidity by State.* Buffalo, NY: Roswell Park Cancer Institute, Department of Health Behaviors, September 5, 2003.
[4] Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults – United States, 2003." *Morbidity and Mortality Weekly Report* 2004 (53).

Smoking Prevalence Among Men in Washington State is Declining.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

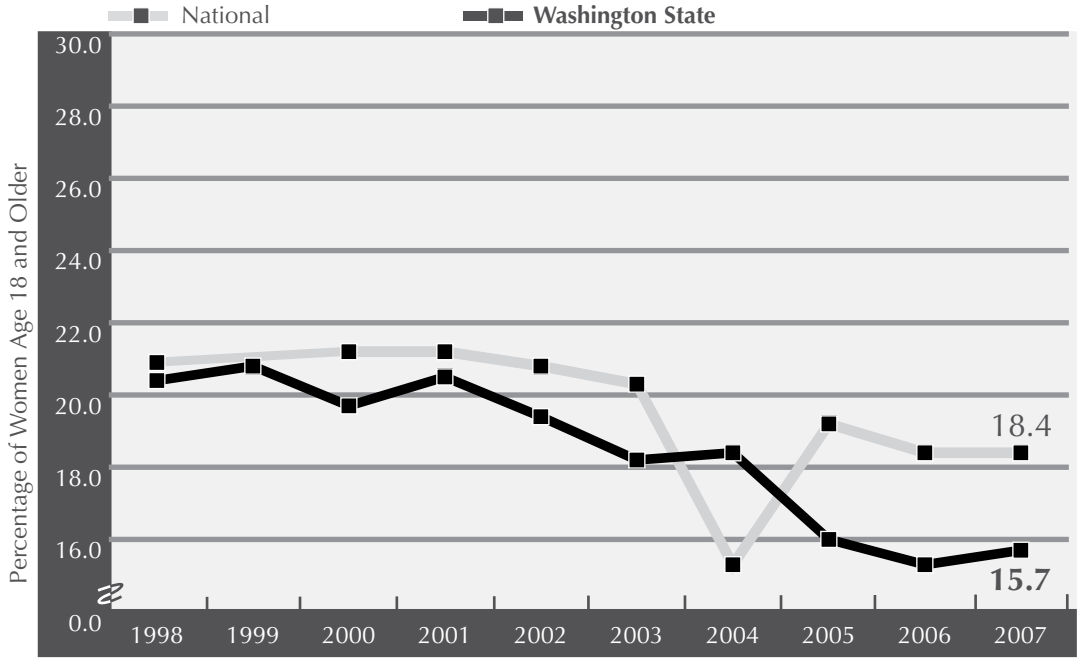
Smoking is closely associated with heart disease, cancer, emphysema, and other respiratory diseases. Since the release of the first Surgeon General's report on smoking and health in 1964, more than ten million Americans have died from smoking-related diseases.[1] The Behavioral Risk Factor Surveillance System 2006 survey indicates that higher smoking prevalence rates are associated with lower incomes, lower levels of educational attainment, African-Americans, and males.[2]

This graph demonstrates that smoking prevalence among Washington men is lower than men nationally, is declining, and is at its lowest point in a decade.[3] In 2002, some 52.7% of Washington residents who smoked daily tried to quit. The Washington State Department of Health's Tobacco Prevention and Control Program indicates that some 8,000 Washington residents die from tobacco-related causes annually.

[1] U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, GA: 2000.
[2] National Center for Chronic Disease Prevention & Health Promotion. Behavioral Risk Factor Surveillance System 2006 Prevalence Data. Atlanta, GA: Centers for Disease Control and Prevention, 2007.
[3] Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults—United States, 2002," Morbidity and Mortality Weekly Report 2004 (52).

NEW/CHANGING TREND

Smoking Prevalence Among Women in Washington State Continues to Decline.



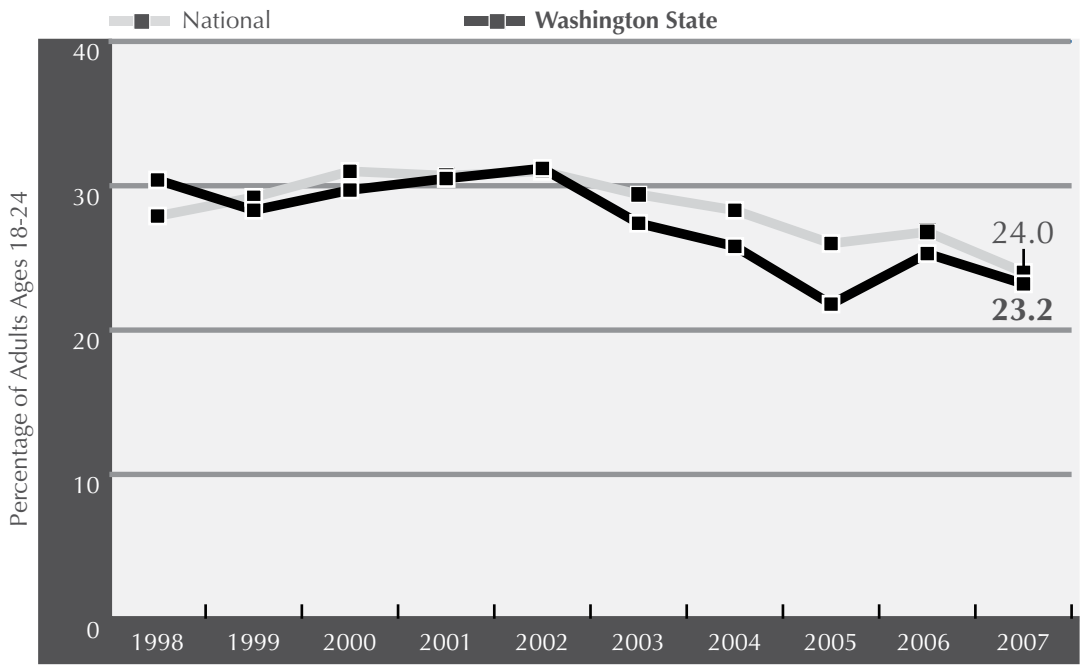
Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Besides being linked with heart disease, cancer, emphysema, and other respiratory diseases[1], evidence is accumulating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefs[2], and with Sudden Infant Death Syndrome.[3] More than ten million Americans have died from smoking-related diseases since the Surgeon General released the first report on smoking and health in 1964.[4]

This graph indicates that smoking prevalence among Washington women is lower than among women nationally, and is declining. Since the Washington State Department of Health initiated its Tobacco Prevention and Control Program in 2000, smoking among women during pregnancy has declined by 30%; about 3,000 fewer babies per year were exposed to cigarette smoke during pregnancy; and more than 1,400 health care workers who serve low-income and high-risk mothers have been taught tobacco intervention skills.[5]

[1] U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, GA: 2000.
[2] U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition), 27-3. Washington, DC: 2000.
[3] Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," Journal of the American Medical Association, March 8, 1995.
[4] Reducing Tobacco Use, op. cit.
[5] Tobacco Prevention & Control Program Progress Report - March 2007. Olympia, WA: Washington State Department of Health, 2007.

Smoking Prevalence Among Young Adults Ages 18-24 Has Declined Over the Past Decade.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

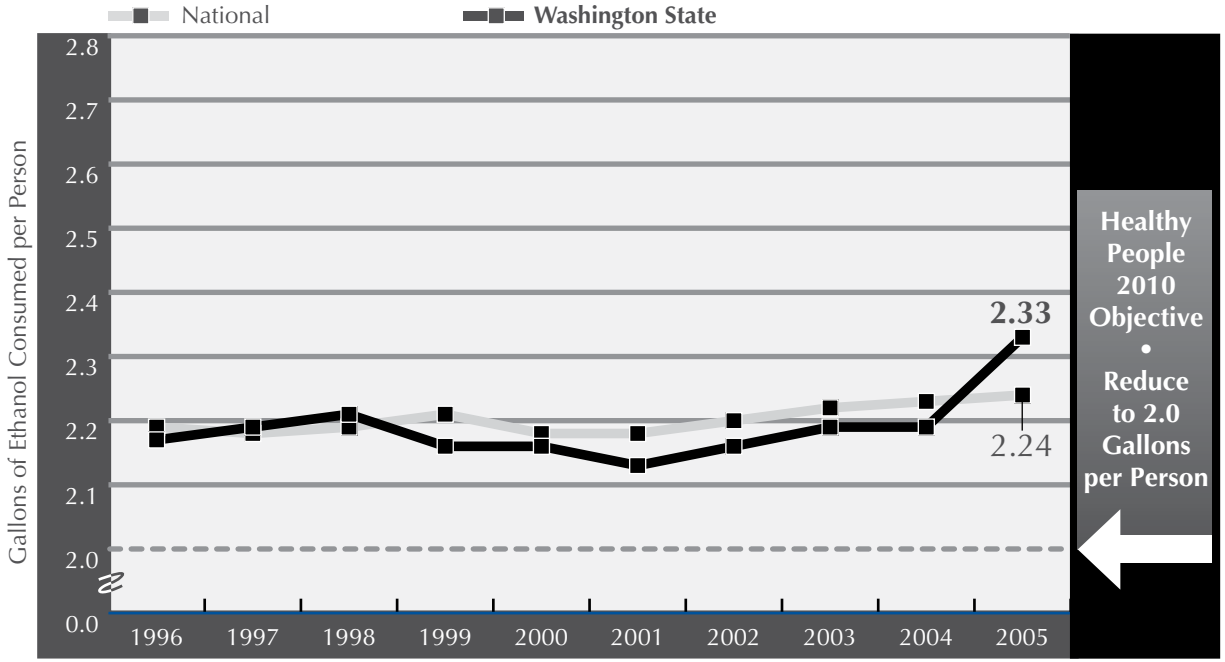
Adult smoking peaks among 18-24 year olds, and declines thereafter. Studies indicate that the more funds that states spend on comprehensive tobacco-control programs, the greater the reduction in smoking.[1]

Since the 1998 nationwide settlement with tobacco companies for tobacco-related harms, the Washington State Department of Health (DOH) has launched a tobacco prevention and control program, with heavy targeting of underage smoking. Preventing underage tobacco use is a key strategy to reducing smoking among adults. The budget for the DOH program has been approximately $29 million per year, and nationally ranks seventh in per capita tobacco prevention and control spending. It is estimated that tobacco prevention and control efforts have prevented 68,000 early tobacco-related deaths among Washington residents since 2000.[2]

[1] Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults – United States, 2003." *Morbidity and Mortality Weekly Report* Vol. 53 (44), November 2004.
[2] *Tobacco Prevention & Control Program Progress Report* – March 2007. Olympia, WA: Washington State Department of Health, 2007.

NEW/CHANGING TREND

Per Capita Alcohol Consumption in Washington State Has Risen Significantly Since 2001.

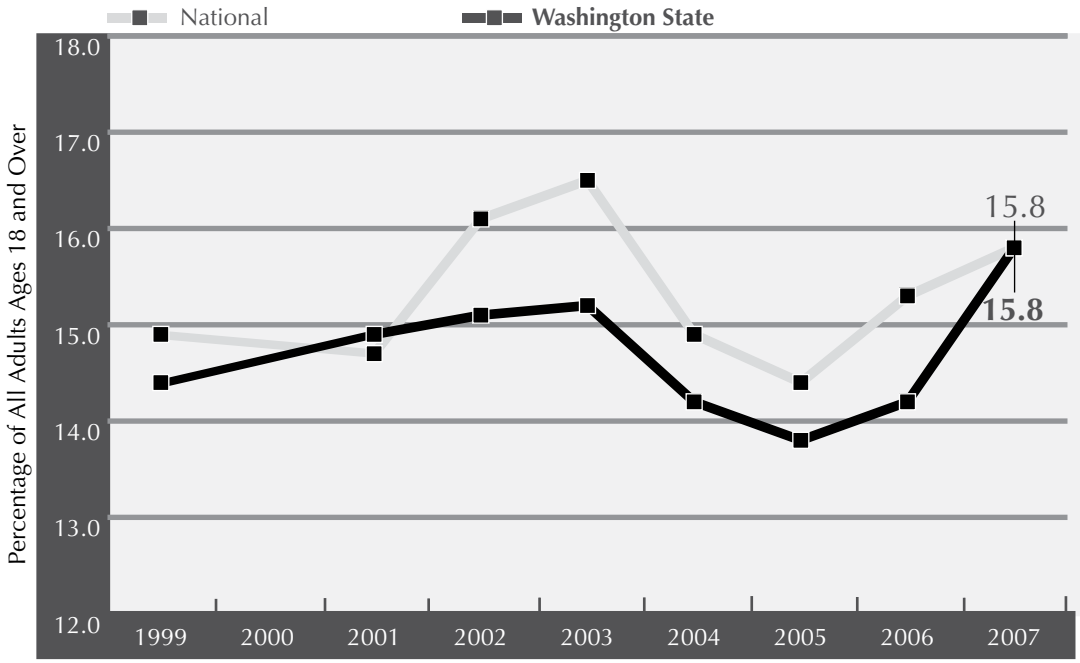


Source: National Institute on Alcohol Abuse and Alcoholism, *Surveillance Report #82: Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1970-2005*.

Per capita alcohol consumption in Washington State is at its highest point in a decade, as is adult binge drinking, and adult heavy drinking. Consumption trends appear to have accelerated. In 2006, almost one in five Washington State 10th grade students reported binge drinking in the past 30 days.[1]

[1] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council. *Healthy Youth Survey - 2006*. Olympia, WA: 2007.

Adult Binge Drinking in Washington State is at Its Highest Rate in a Decade.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

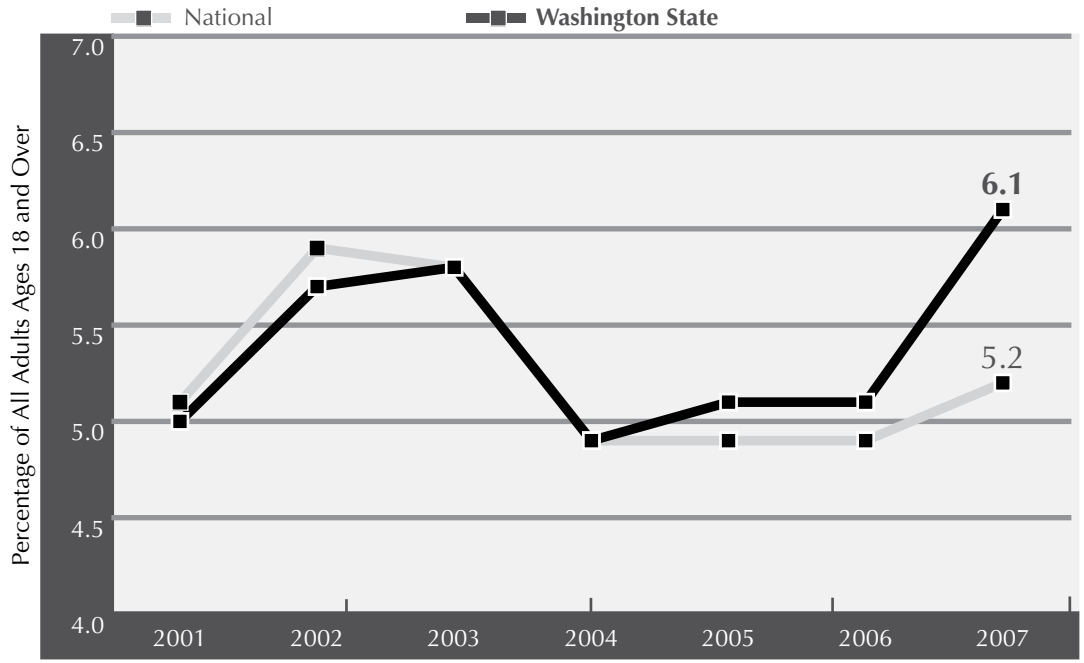
Binge drinking is a particularly dangerous form of alcohol consumption, and is associated with traffic fatalities, accidents, drownings, emergency department admissions, and alcoholism. Binge drinking rates among college students (40% in 2005[1]) are more than twice the rate for all adults, and are associated with increased incidence of unplanned and unprotected sex, alcohol-related sexual assaults, and date rape.[2]

Binge drinking was formerly defined as having five or more alcoholic drinks at one occasion, one or more times in the past month. After several years of research and consensus building, in 2004 the National Institute on Alcohol Abuse and Alcoholism redefined binge drinking as "a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds to consuming five or more drinks (male), or 4 or more drinks (female), in about two hours."[3]

[1] Johnston, L. et al. *Monitoring the Future National Survey Results on Drug Use, 1975-2005, Volume I, Secondary School Students.* Bethesda, MD: National Institute on Drug Abuse, 2006.
[2] Taskforce on College Drinking, National Advisory Council on Alcohol Abuse and Alcoholism. *A Call to Action: Changing the Culture of Drinking at U.S. Colleges.* Bethesda, MD: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 2002.
[3] National Institute on Alcohol Abuse and Alcoholism. *NIAAA Newsletter* 2004(3).

NEW/CHANGING TREND

Adult Heavy Drinking Rates in Washington State are at Their Highest Point in This Decade.



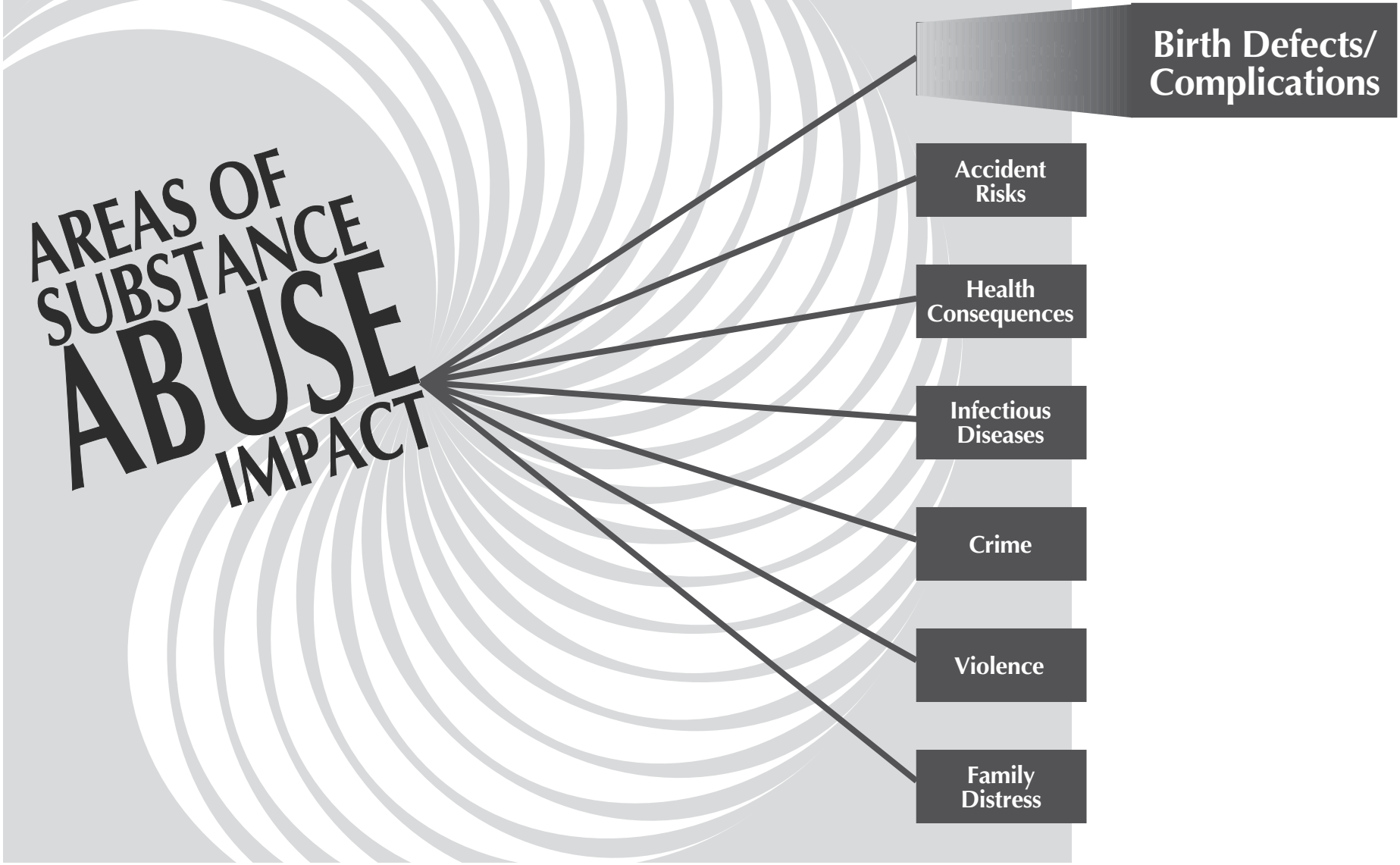
Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

The rate of adult heavy drinking in Washington State has risen dramatically since 2004. Adult binge drinking rates and per capita alcohol consumption are also at their highest points in a decade. Chronic alcohol consumption has been linked to osteoporosis, pancreatitis, and risk for cancer of the mouth, upper airways, larynx, breast, digestive tract, and liver.[2]

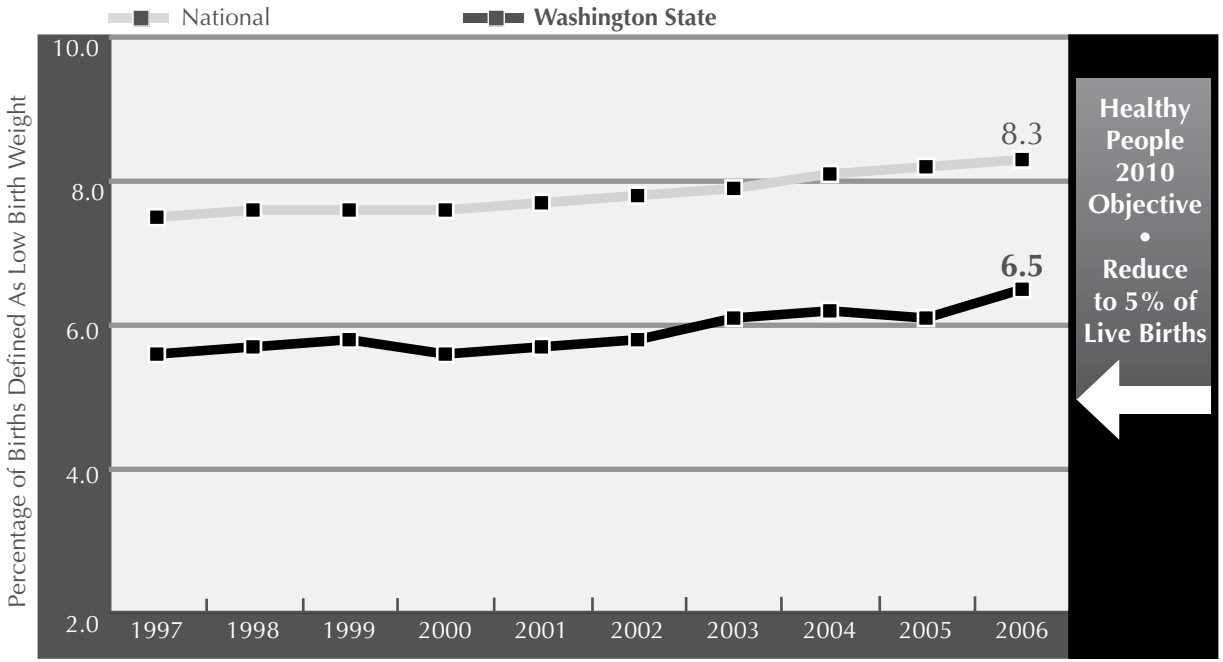
[2] Washington State Department of Health. *The Health of Washington State, 2007*. Olympia, WA: 2007.

The Problem: Substance Abuse Prevalence & Trends

The Problem: Substance Abuse Prevalence & Trends



In 2006, the Rate of Low Birth Weight Births Rose Significantly in Washington State.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

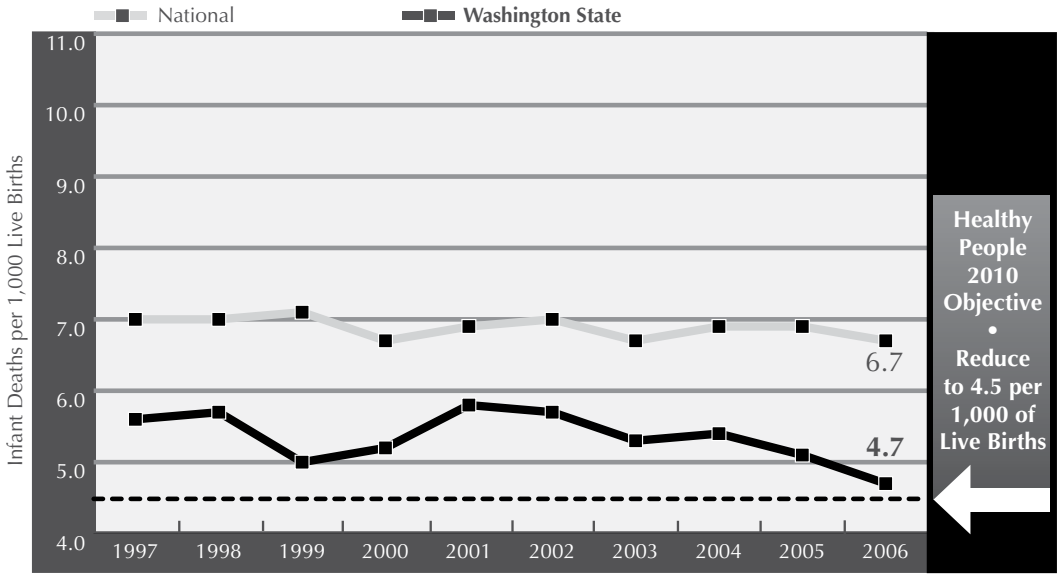
Smoking is associated with 20-30% of all low birth weight (LBW) births, as well as being the risk factor most closely associated with neonatal deaths.[1] Low birth weight is also associated with teen births.[2] In 2006, both nationally and in Washington State, teen births among those ages 15-17 rose for the first time since 1991.

LBW infants are newborns weighing less than 2,500 grams (5 pounds, 8 ounces) and include those born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.[3] A Washington State study found that substance abusing women who received chemical dependency treatment while pregnant were 34% less likely to give birth to a LBW baby, compared with women who did not receive treatment.[4]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC, 2000.
[2] Hoffman, S. *By the Numbers: The Public Costs of Teen Childbearing.* Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2006.
[2] Ibid.
[3] Cawthon, L. "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

NEW/CHANGING TREND

The Infant Mortality Rate in Washington State is at Its Lowest Point Ever.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

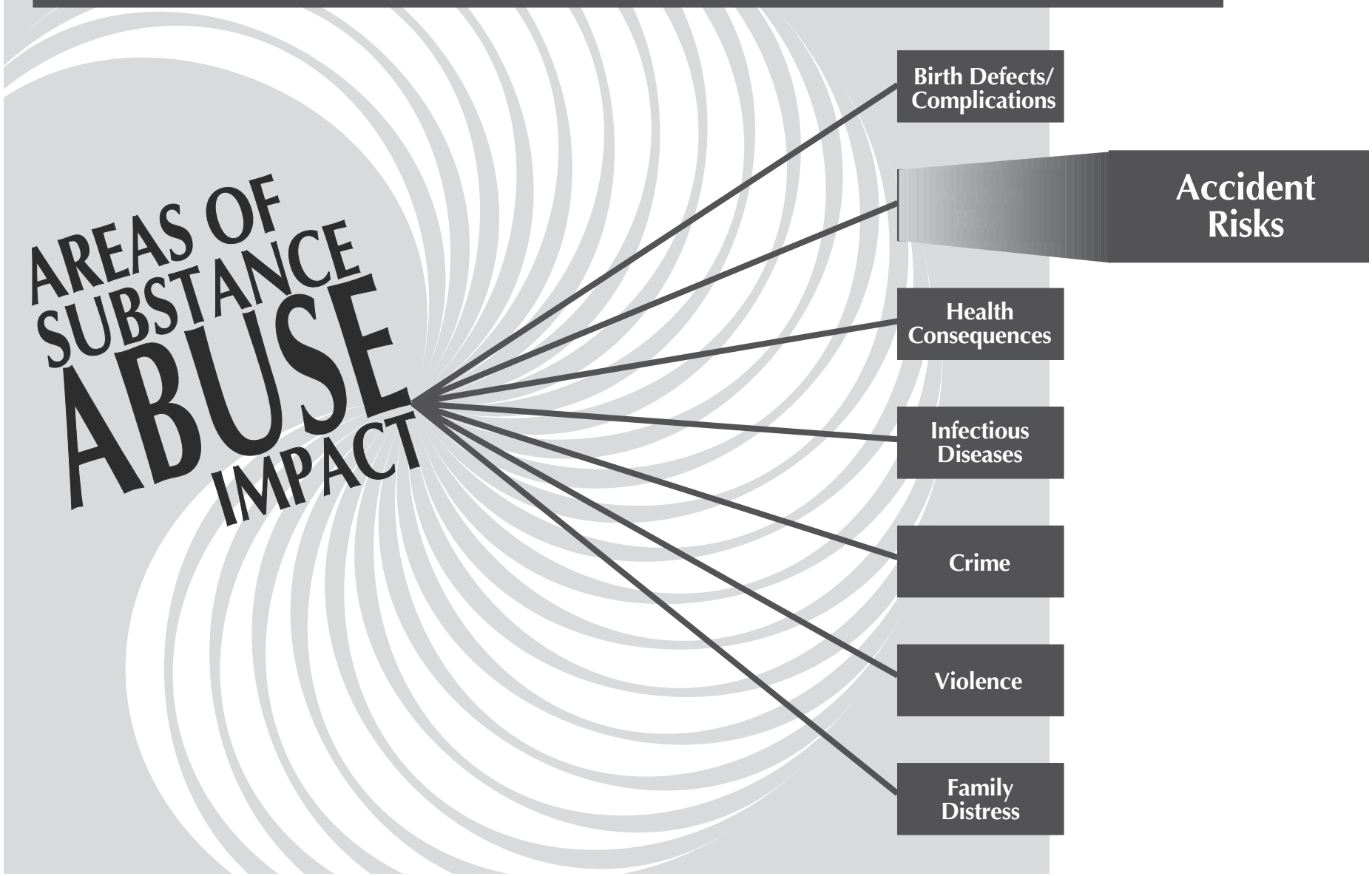
There is a clear association between overall rates of alcohol use during pregnancy and infant mortality rates. Infant mortality rates for children born to mothers on Medicaid in Washington State and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.[1]

Infant mortality rates represent the number of infants per thousand live births who die within their first year of life. The three leading causes of infant mortality in Washington State are congenital malformations (21.9%), Sudden Infant Death Syndrome (SIDS, 12.3%), and short gestation/low birth weight (10.3%).[2] SIDS, the leading cause of post-neonatal death, has been linked with passive smoking in the infant's environment and maternal smoking during the time period of breastfeeding.[3] More recent research suggests an association between prenatal exposure through maternal smoking and alcohol use and adverse development of the brainstem serotonin system, eventually resulting in SIDS.[4]

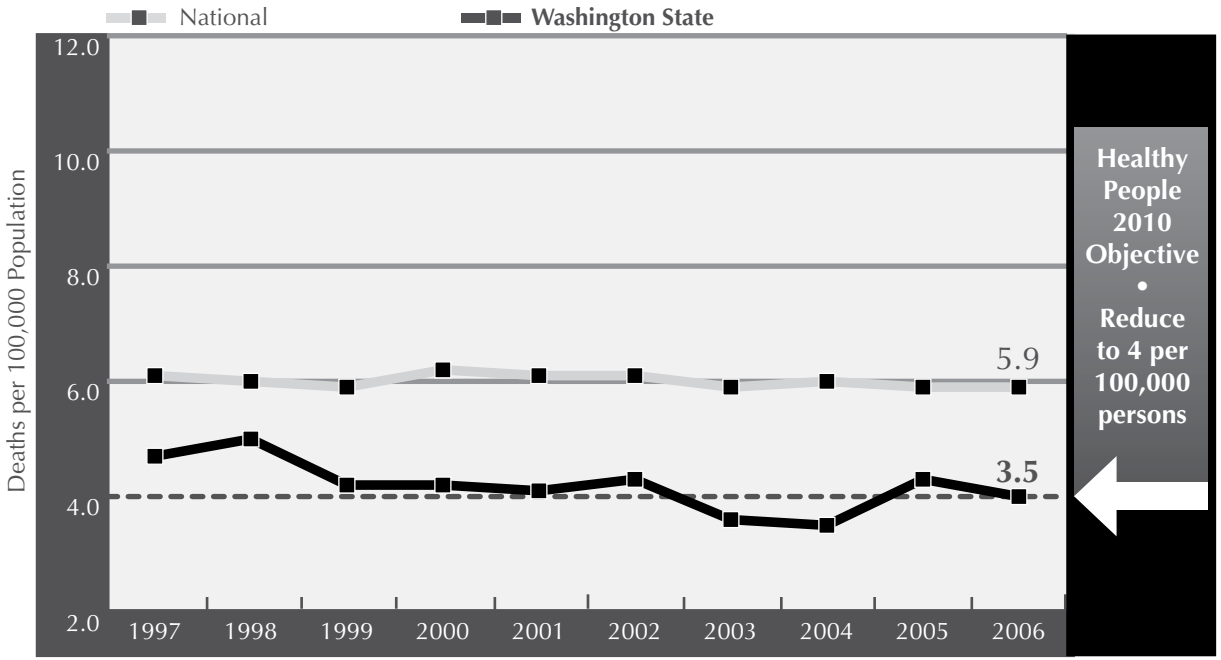
Washington State has had consistently lower infant mortality rates than the nation and rates have declined substantially since 2001. There were 406 infant deaths in Washington State in 2006. SIDS deaths have declined more than 50% since 1995. Advances in medical technology, coupled with public education campaigns (including campaigns to ensure infants are put to sleep on their backs to lower SIDS risk), are given credit for the downward trend.

[1] First Steps Database, 1990-1997. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1999.
[2] Center for Health Statistics, Washington State Department of Health, 2008.
[3] Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome." *Journal of the American Medical Association*, 273(10), March 8, 1995.
[4] Paterson, D. et al. "Multiple Brainstem Abnormalities in Sudden Infant Death Syndrome," *Journal of the American Medical Association* 296(17), November 1, 2006.

The Problem: Substance Abuse Prevalence & Trends



Both Nationally and in Washington State, Alcohol-Related Motor Vehicle Fatality Rates are Relatively Unchanged Since 1999.



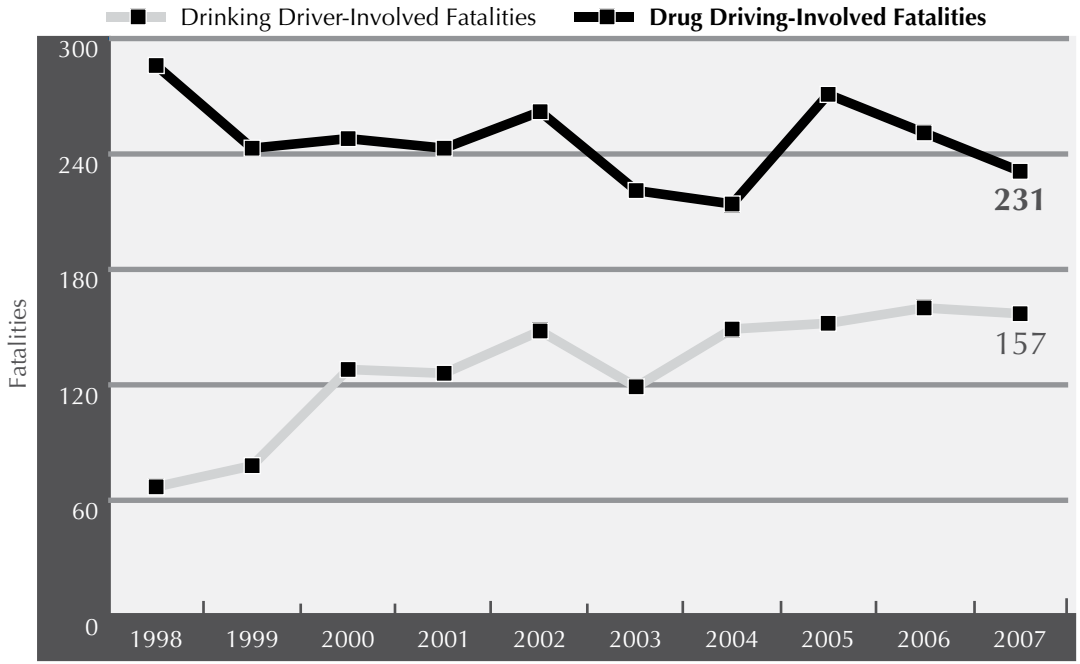
Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

Enhancements to Washington State's Driving-Under-the-Influence (DUI) statutes, including a lowering of the blood-alcohol concentration (BAC) for a DUI determination from .10% BAC to .08% BAC, went into effect in 1999. However, it should be noted that arrests under DUI statutes are made in a tiny fraction of drinking-and-driving episodes. Nationally, it has been estimated that one arrest is made for driving under the influence for every 772 episodes of driving within two hours of drinking, and for every 88 episodes of driving over the legal limit.[1] Enforcement of existing statutes may play a critical role in reducing morbidity and mortality resulting from alcohol-related motor vehicle crashes.

[1] Zador, P., Krawchuk, S. and Moore, B. "Drinking and Driving Trips, Stops by Police, and Arrests: Analysis of the 1995 National Survey of Drinking and Driving Attitudes and Behavior." Rockville, MD: National Highway Traffic Safety Administration, in press.

NEW/CHANGING TREND

In Washington State, While the Number of Drinking Driver-Involved Fatalities Has Remained Stable, the Number of Drug Driving-Involved Fatalities is Rising.

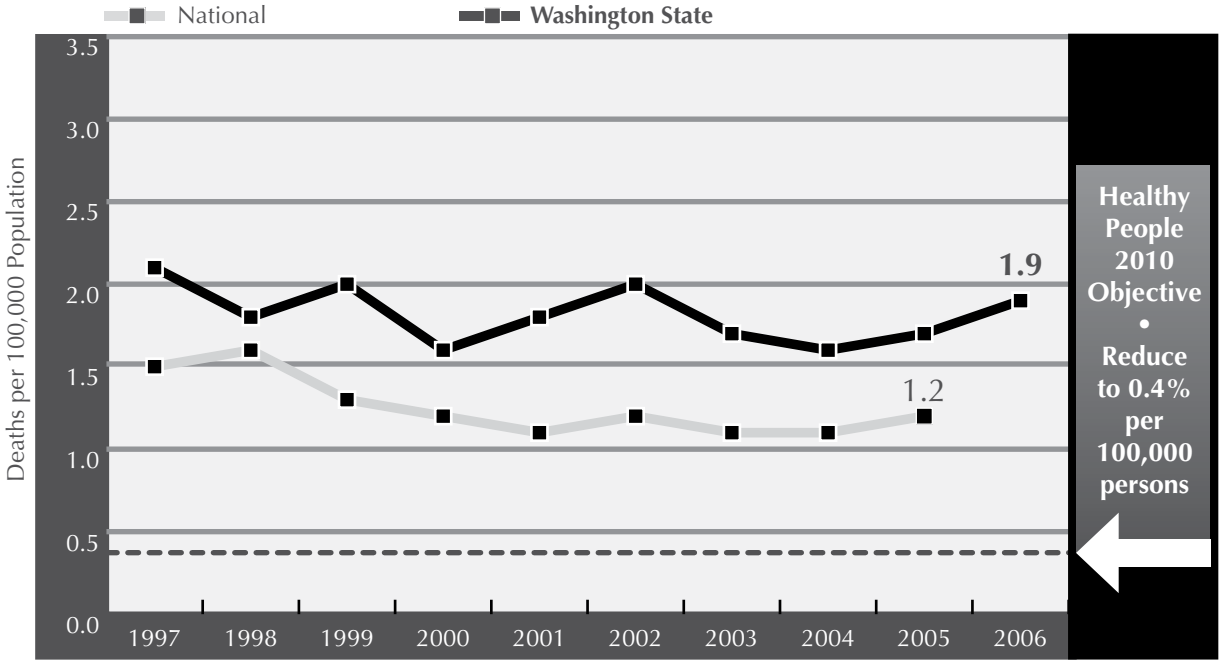


Source: Fatal Accident Reporting System (FARS), Washington Traffic Safety Commission, 2008.

Drinking driver-involved fatalities are defined as deaths resulting from a collision in which at least one driver had a positive alcohol test or police reported alcohol involvement. Drug driver-involved fatalities are deaths resulting from a collision in which at least one driver exhibited a presence of any drug in drug test results. It is likely that some of the increase in drug driver-involved fatalities is due to better testing and reporting. In 2004-2006, it is estimated that 13.8% of drivers ages 18 and older drove under the influence of alcohol or illicit drugs in the past year.[1]

[1] Office of Applied Studies. *State Estimates of Driving Under the Influence of Alcohol and Illicit Drugs in the Past Year Among Current Drivers Aged 18 or Older: Average of 2004-2006*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



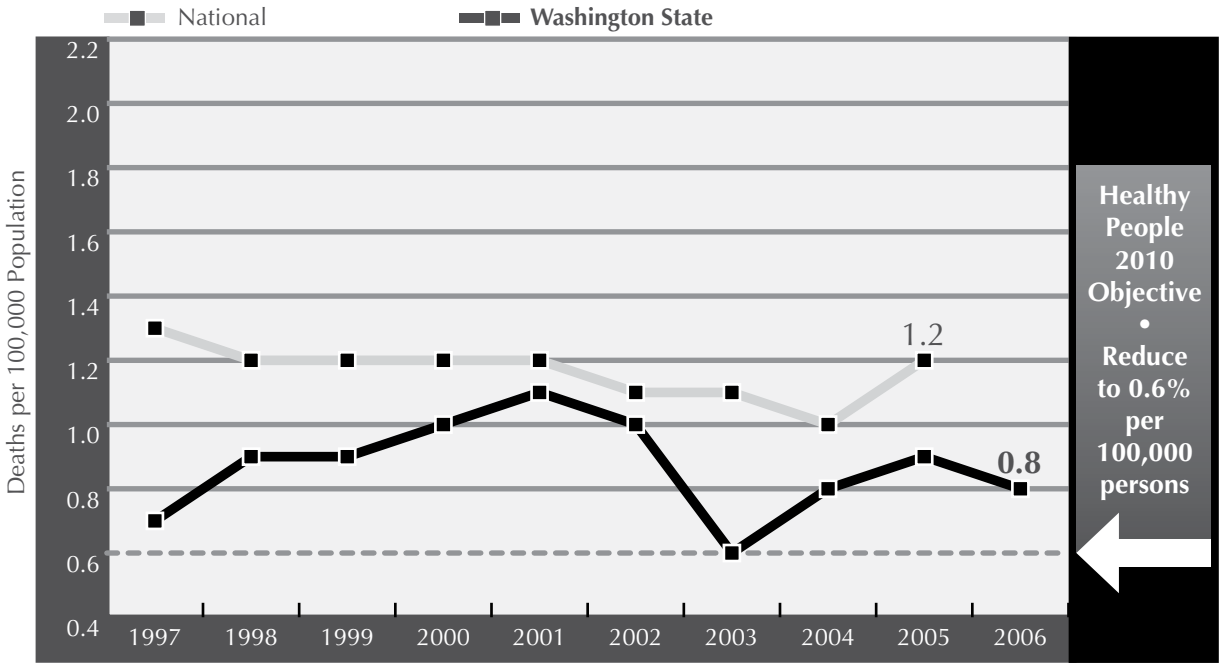
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate. There were 123 drowning deaths in 2006 in Washington State, up from 104 in 2005. Nationally, drowning is the second leading cause of injury-related deaths for children and youth ages 1-19.[2]

Alcohol is involved in approximately 50% of deaths associated with water recreation.[1]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-40. Washington, DC: 2000.
[2] Ibid.

The Rate of Death Due to Residential Fires in Washington State is Lower than the Nation.



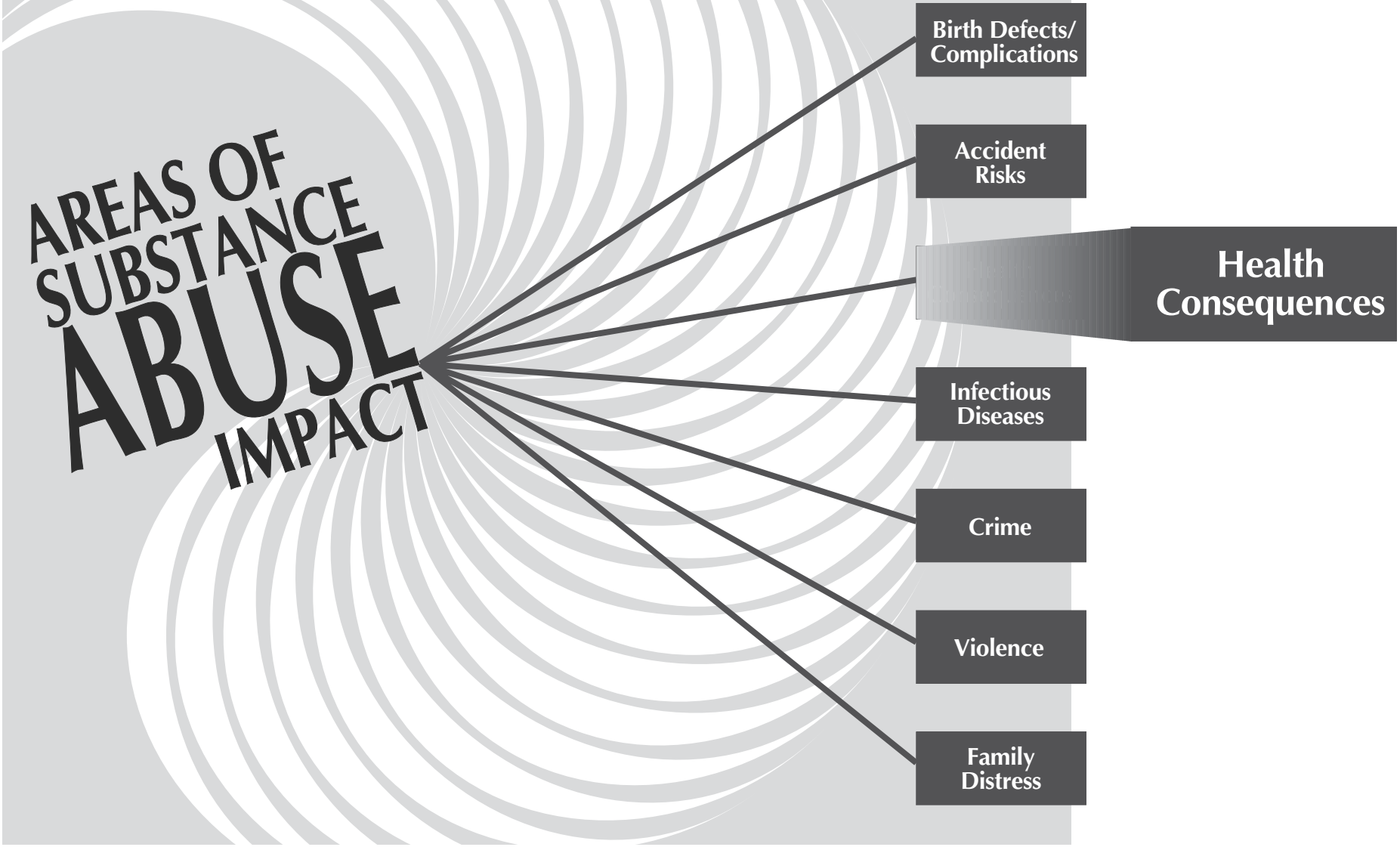
Source: National Data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the death rate due to residential fires in Washington State is lower than the nation. There were 53 such deaths in 2006.

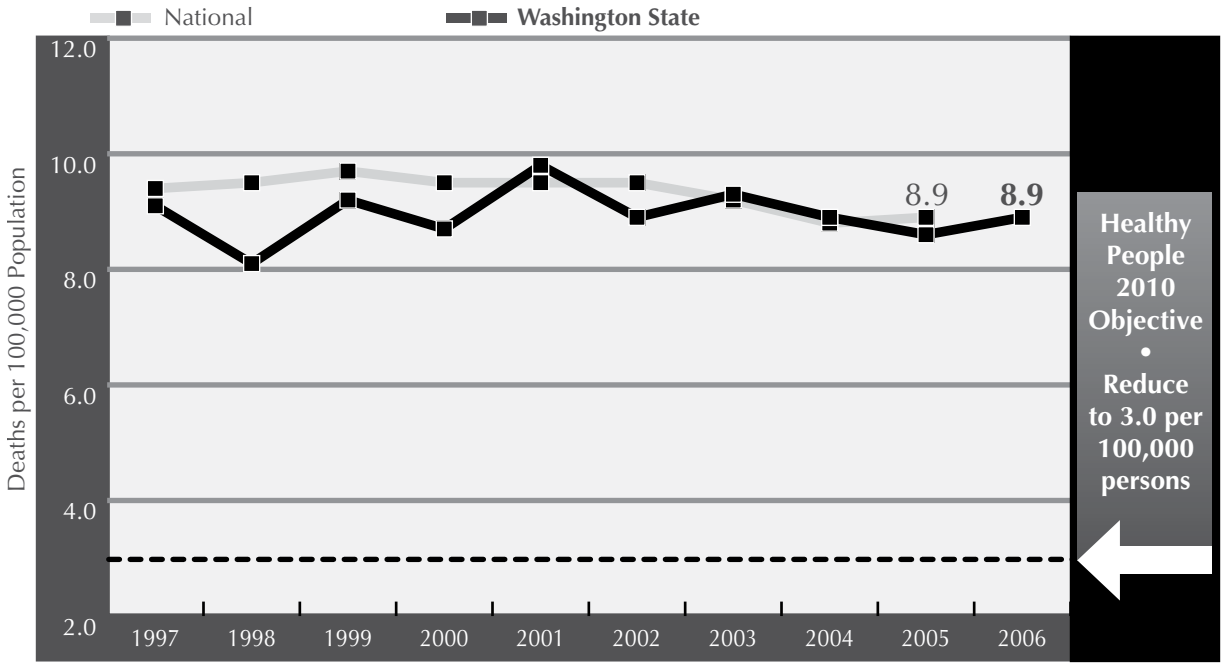
Fires are the second leading cause of unintentional injury death among children. Compared to the total population, children under age four have a fire death rate more than twice the national average. Two-thirds of fire-related deaths and injuries among children under age five occur in homes without working smoke alarms.[1] Tobacco use is the leading cause of residential fire deaths.[2] Smoking causes an estimated 30% of U.S. fire deaths; costs related to fires have fallen in association with lower rates of smoking.[3] Alcohol use contributes to an estimated 40% of residential fire deaths.[4]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-35. Washington, DC: 2000.
[2] Centers for Disease Control and Prevention. *Fire Deaths and Injuries.* Atlanta, GA: 2000.
[3] Leistikow, B., et al. "Fire Injuries, Disasters, and Costs from Cigarettes and Cigarette Lights: A Global Overview," *Preventive Medicine* 31:2, 2000.
[4] Smith, G., Branas, C., and Miller, T. "Fatal Nontraffic Injuries Involving Alcohol: A Meta-Analysis," *Annuals of Emergency Medicine* 33(6), 1999.

The Problem: Substance Abuse Prevalence & Trends



Sustained Alcohol Consumption is the Leading Cause of Chronic Liver Disease and Cirrhosis Deaths.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

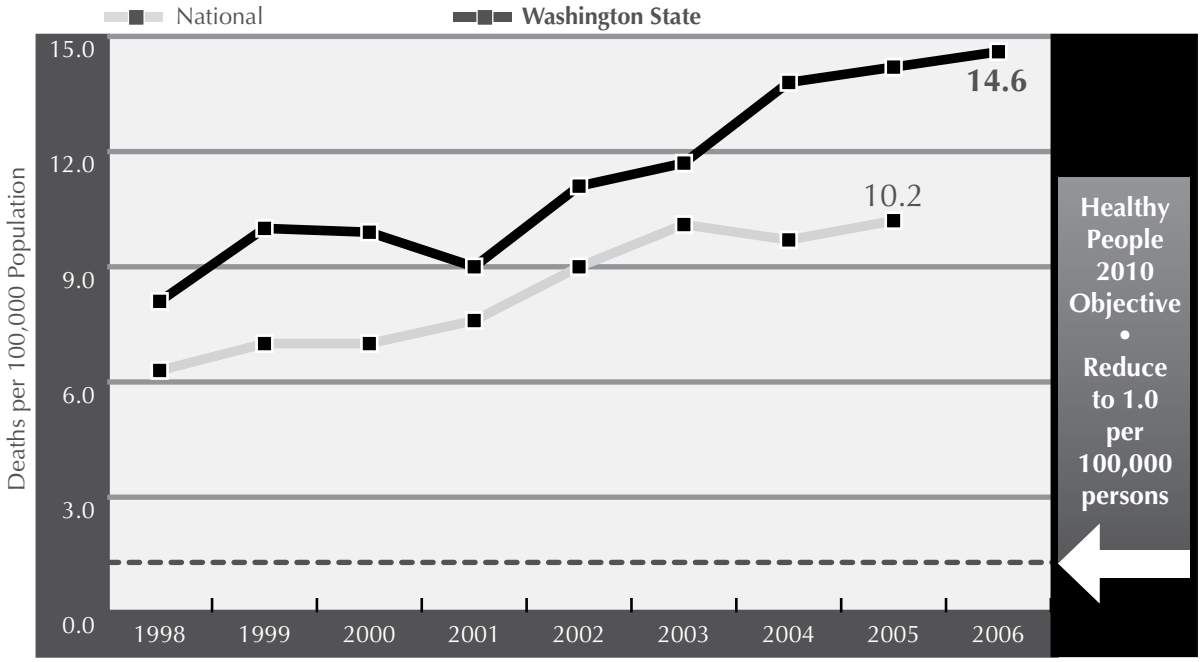
Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.[1] Cirrhosis is also associated with hepatitis C and, though less commonly in the United States, with hepatitis B[2], which are often transmitted during intravenous drug use. Once the liver is severely damaged, treatment is often limited to liver transplants.

Little progress has been made in Washington State or nationally in the past decade toward the *Healthy People 2010* target objective. There were 592 chronic liver disease and cirrhosis deaths in Washington State in 2006.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-16. Washington, DC: 2000.
[2] National Digestive Diseases Information Clearinghouse (NDDIC). *Cirrhosis of the Liver*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2003.

NEW/CHANGING TREND

The Drug-Induced Death Rate in Washington State is Increasing Rapidly.



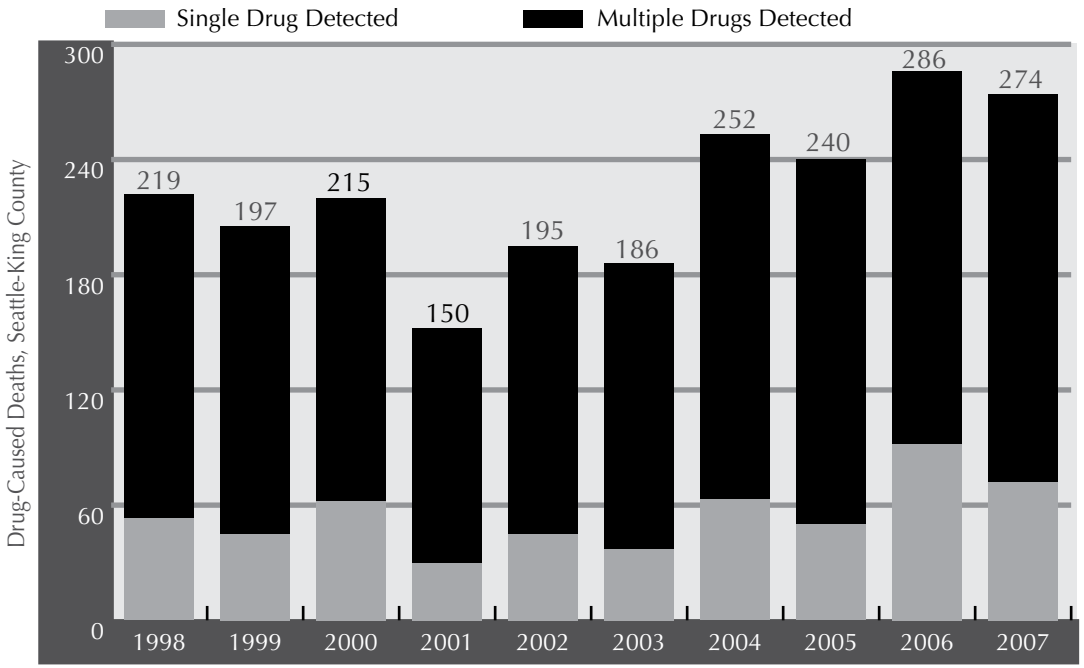
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Drug-induced death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-induced include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulting from illicit drug use or overdoses.

This graph indicates that Washington continues to have a higher drug-induced death rate than the nation, with 961 deaths in 2006. Drug-induced deaths have more than doubled since 1997. Much of this increase reflects drug-caused deaths involving the use of prescription opiates, which, in Seattle-King County, rose from 22 in 1997 to 131 in 2005.[1]

[1] King County Medical Examiner. In 120 (91.6%) of the 2005 deaths, there were drugs other than prescription opiates in the decedents' systems at time of death.

More than One Drug was Detected in 77% of Drug-Caused Deaths in Seattle-King County in the Past 10 Years.

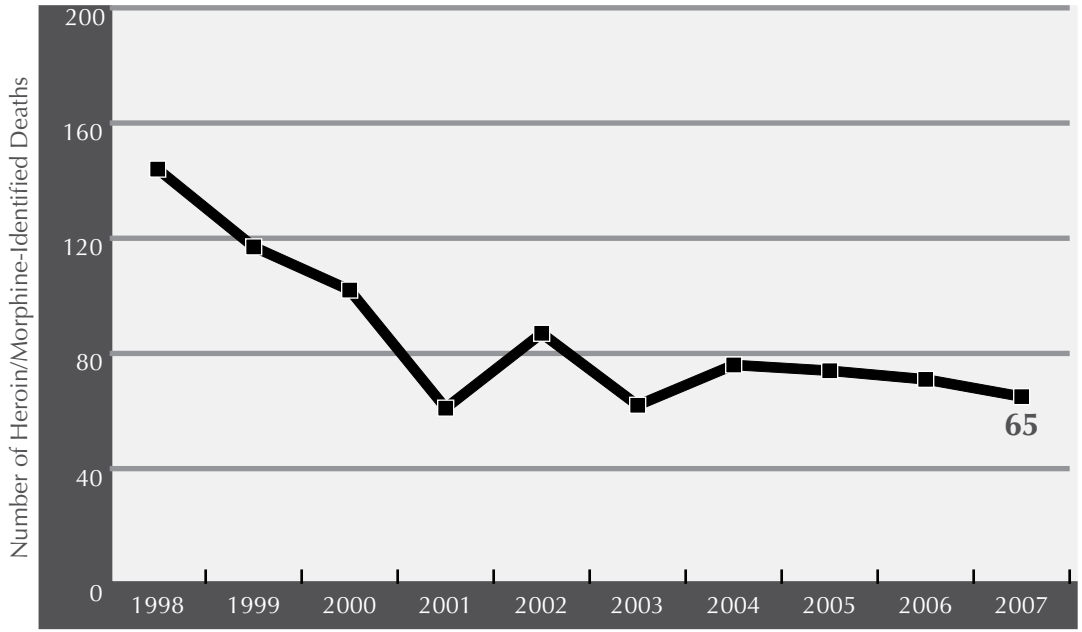


Source: King County Medical Examiner

In the past three years, drug-caused deaths in Seattle-King County have been on the rise. In the overwhelming majority of cases, more than one drug (including alcohol) is detected in the decedent by the Medical Examiner, making it very difficult to determine the role that any single drug played in the death. Of the 2,214 drug-caused deaths in Seattle-King County in the past decade, 1,705, representing 77% of the total, were multi-drug-involved.

Most individuals who enter publicly funded chemical dependency treatment abuse more than one substance.

After Reaching a High in 1998, the Number of Drug-Caused Deaths in Seattle-King County in Which Heroin is Involved is on the Decline.



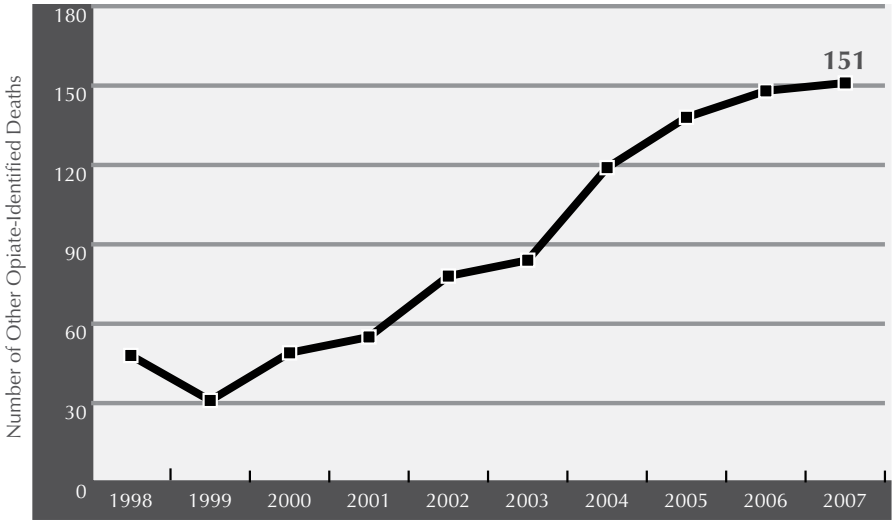
Source: King County Medical Examiner.

This graph indicates that drug-caused deaths in which heroin/morphine were involved in Seattle-King County have declined 54% since 1998, from a high of 144 to 65 in 2007.

Much of the decline is likely due to public health measures adopted by city and county governments to address heroin addiction, including a substantial increase in publicly funded treatment admissions. Heroin was the primary drug of abuse for 13.7% of total publicly funded treatment admissions in Seattle-King County during SFY 2007.[1] It should be noted that among the 65 Seattle-King County deaths between 1997-2006 in which heroin was detected in the decedent by the Medical Examiner, 83% had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths.[2]

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.
[2] Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area 2007." *Epidemiologic Trends in Drug Abuse*, 2008.

The Number of Drug-Caused Deaths in Seattle-King County in Which Prescription-Type Opiates* are Involved is Substantially Higher than a Decade Ago.



Source: King County Medical Examiner.

The rise in prescriptions for opiates to treat pain has been very rapid. In Washington State, the number of doses of prescription opiates legally dispensed almost tripled between 1997-2007. In the same time period, the number of grams of active ingredient prescribed of methadone (for pain only) rose 1,042%; Oycodone (including OxyContin) - 500%; Morphine - 223%; and Hydrocodone -166%.[1]

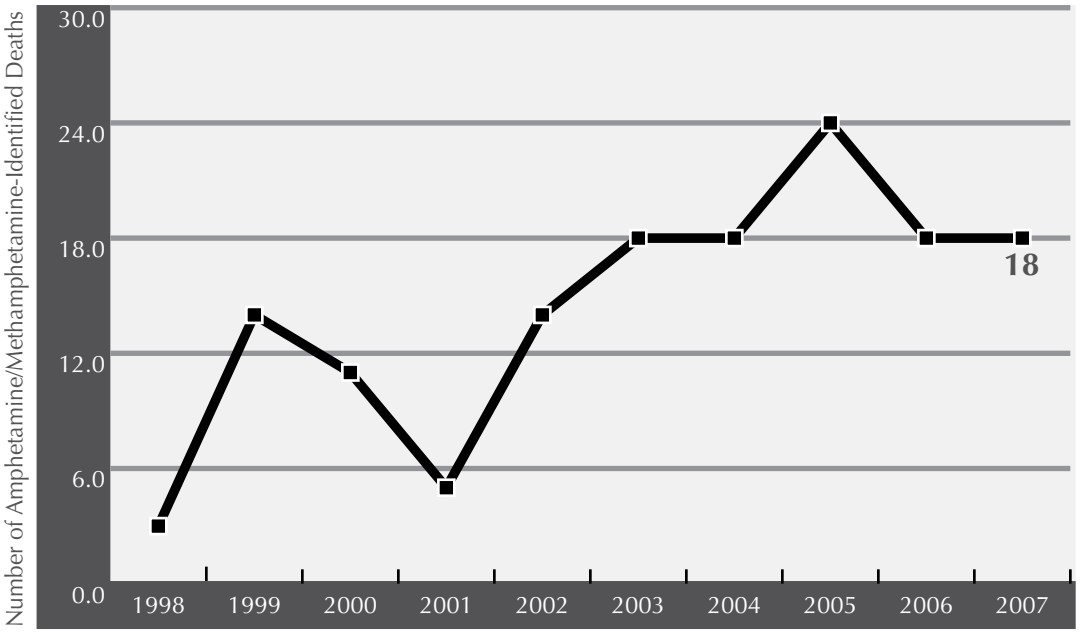
The expanded prescriptive use of opiates has created new opportunities for diversion and illicit use. In Seattle-King County in 2006, 54% of the emergency department drug reports for prescription-type opiates were drug-abuse related, with 18% for overmedication and 13% for adverse reactions.[2] In 2005-2006, Washington State ranked sixth in the nation in the percentage of individuals ages 12 and older using prescription pain relievers for non-medical purposes (6.13%).[3] Highest concentration of illicit use was in Seattle-King County.[4] The number of drug-caused deaths in Seattle-King County in which prescription-type opiates were involved rose from 22 in 1997 to 151 in 2007. It should be noted that among the 844 deaths between 1998-2007 in which prescription opiates were detected in the decedent by the Medical Examiner, 96% had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths.[5]

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

[1] Drug Enforcement Administration, 2007.
[2] Banta-Green, C. et al. "Recent Drug Abuse Trends in the Seattle-King County Area, June 2007," *Epidemiologic Trends in Drug Abuse*, June 2007.
[3] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.
[4] Office of Applied Studies. *THE NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008
[5] Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area 2007." *Epidemiologic Trends in Drug Abuse*, 2008.

NEW/CHANGING TREND

The Number of Drug-Caused Deaths in Seattle-King County in Which Methamphetamine is Involved Has Risen Rapidly in the Past Decade.*



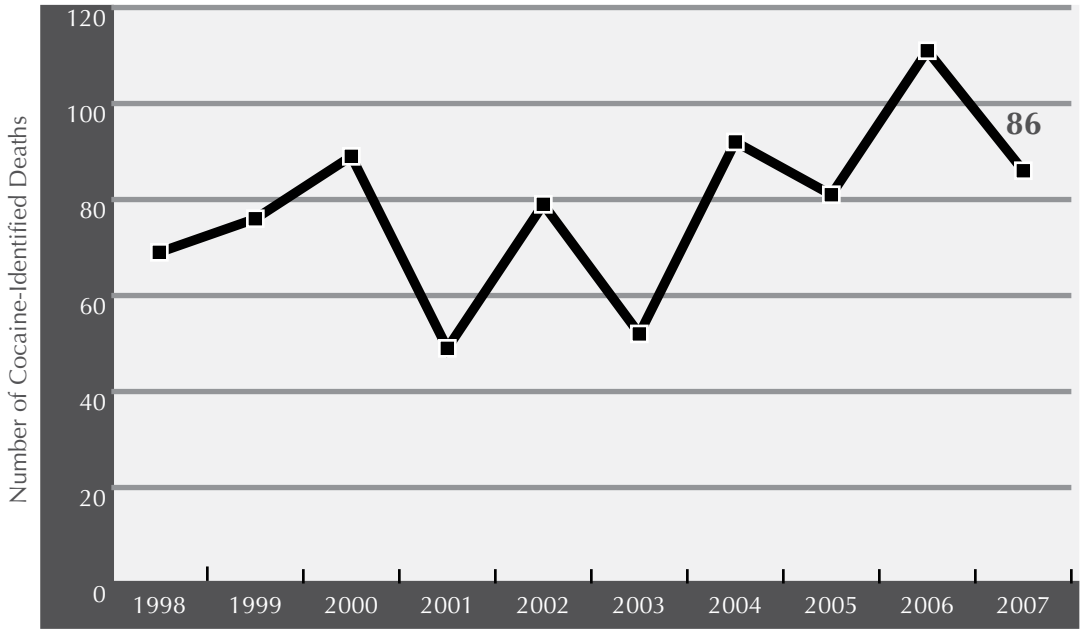
Source: King County Medical Examiner

The number of drug-caused deaths in Seattle-King County in which methamphetamine was involved rose from 3 in 1998 to 18 in 2007. The number of treatment admissions among King County residents whose primary drug of abuse is methamphetamine has also risen dramatically in that timeframe. At the same time, there are fewer methamphetamine laboratories/dumpsites reported. Federal law enforcement sources report that less methamphetamine is being manufactured in Washington, but that the growing demand is being met by an increasing supply from Mexico and California[1], as well as precursor chemicals being imported from Canada.[2] It should be noted that in the 18 Seattle-King County deaths in 2007 in which methamphetamine was detected in the decedent by the Medical Examiner, 10 (56%) had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths.[3]

**Includes other amphetamines.*

[1] Banta-Green, C. et al. "Recent Drug Abuse Trends in the Seattle-King County Area, January 2006," *Proceedings of the Community Epidemiology Workgroup*, March 2006.
[2] U.S. Drug Enforcement Agency. Fact Sheet - June 2006.
[3] Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area 2007." *Epidemiologic Trends in Drug Abuse*, 2008.

The Number of Drug-Caused Deaths in Seattle-King County in Which Cocaine is Involved Has Risen Since 2001.



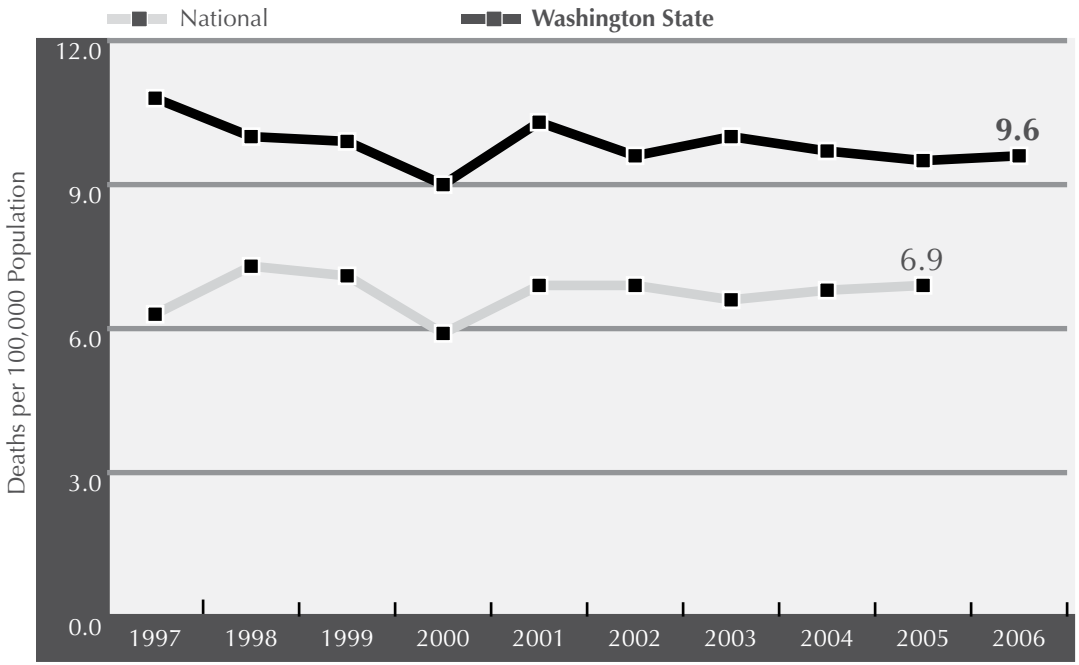
Source: King County Medical Examiner.

The number of drug-caused deaths in Seattle-King County in which cocaine was involved rose from 49 in 2001 to 86 in 2007, representing a 96% increase. It should be noted that in among those 86 deaths in which cocaine was detected in the decedent by the Medical Examiner, 79% had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths.[1]

Cocaine continues to be a major drug of abuse, with high levels of mortality and treatment admissions, especially among African-Americans. It is the drug most commonly named among King County adult residents calling the 24-Hour Alcohol/ Drug Help-Line (with approximately one-quarter of all calls), as well as being the drug most commonly associated with drug-related emergency department visits.[2]

[1] Banta-Green, C., et al. "Update Brief – Drug Abuse Trends in the Seattle-King County Area, 2007." *Epidemiologic Trends in Drug Abuse*, 2008.
[2] Ibid..

Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.



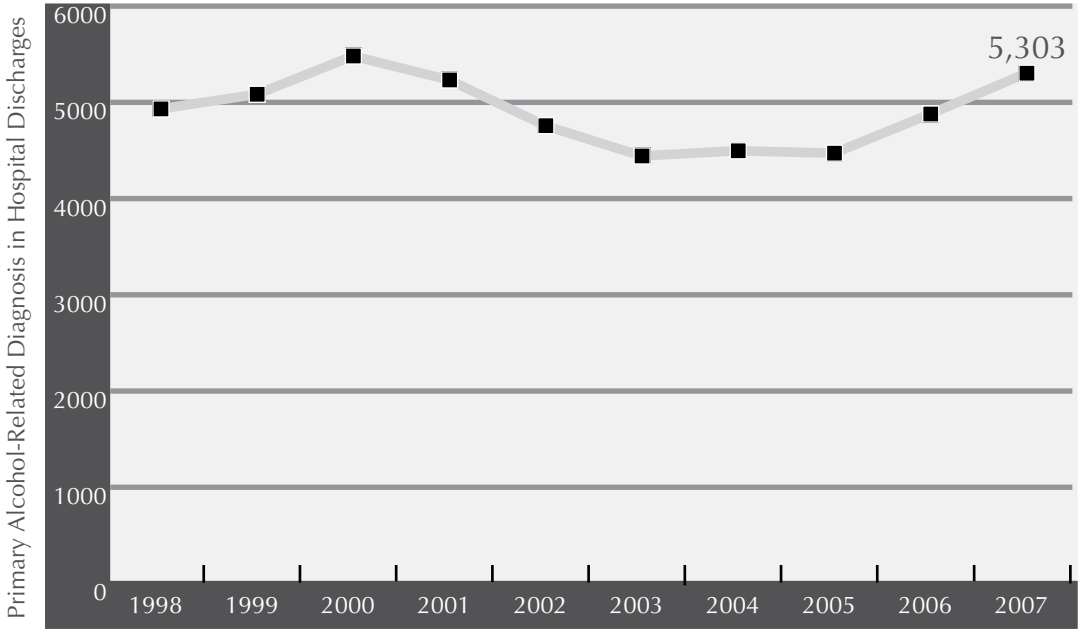
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol-related death data provide a direct indication of the high human and social costs of alcohol use. Long-term heavy drinking increases risks for high blood pressure, heart rhythm irregularities (arrhythmias) and heart muscle disorders (cardiomyopathy), and stroke. It increases risks for certain forms of cancer, especially esophagus, mouth, throat, and larynx, for cirrhosis and other liver disorders, and worsens outcomes for individuals with hepatitis C. It is also linked with death from traffic crashes, falls, fires, and drowning, and is associated with homicide, suicide, domestic violence, and child abuse.[1]

This graph indicates that Washington State has had a consistently greater alcohol-induced death rate than the nation. There were 647 alcohol-induced deaths in Washington State in 2006.

[1] U.S. Department of Health and Human Services. Healthy People 2010 (Conference Edition), 26-4. Washington, DC: 2000.

The Number of Acute Care Hospital Discharges in Washington State in Which There was a Primary Alcohol-Related Diagnosis is Now Increasing.



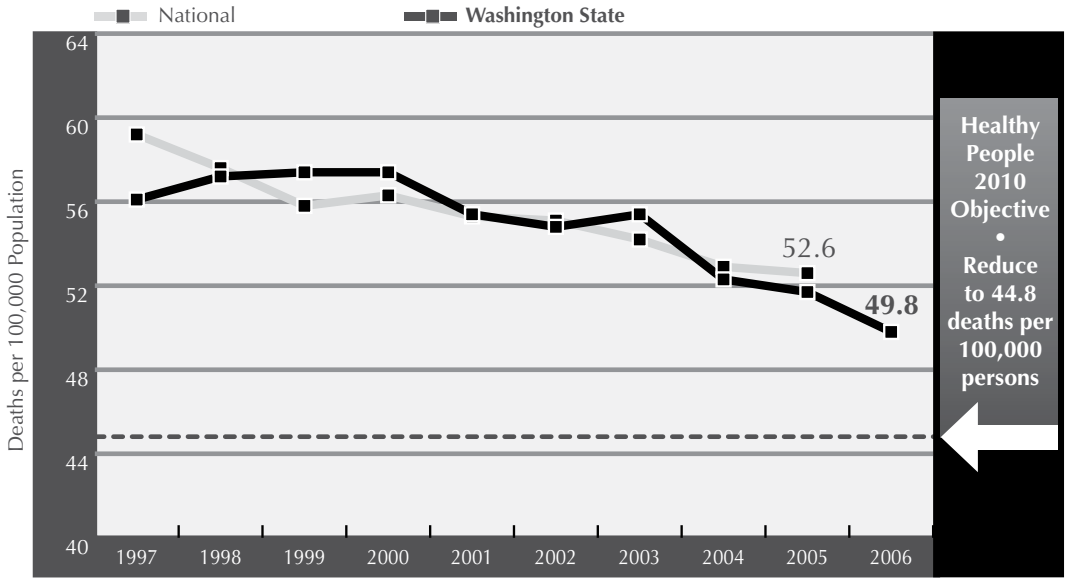
Source: Comprehensive Hospital Abstract Report System (CHARS), Washington State Department of Health, 2008.

Patients discharged with primary alcohol-related diagnoses from acute care hospitals have been diagnosed with principal alcohol-related conditions such as alcohol psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. These diagnoses do not include alcohol-related trauma such as injuries from motor vehicle crashes or discharges associated with maternity stays. When discharges with primary or secondary alcohol-related diagnoses are added together, there were 12,444 such discharges in Washington State in 2007.

With a grant from the federal Substance Abuse and Mental Health Services Administration, the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program provides screening and brief interventions related to substance abuse in nine hospital emergency departments, and referrals to brief therapy or treatment when appropriate.

NEW/CHANGING TREND

The Lung Cancer Death Rate in Washington State is Declining.



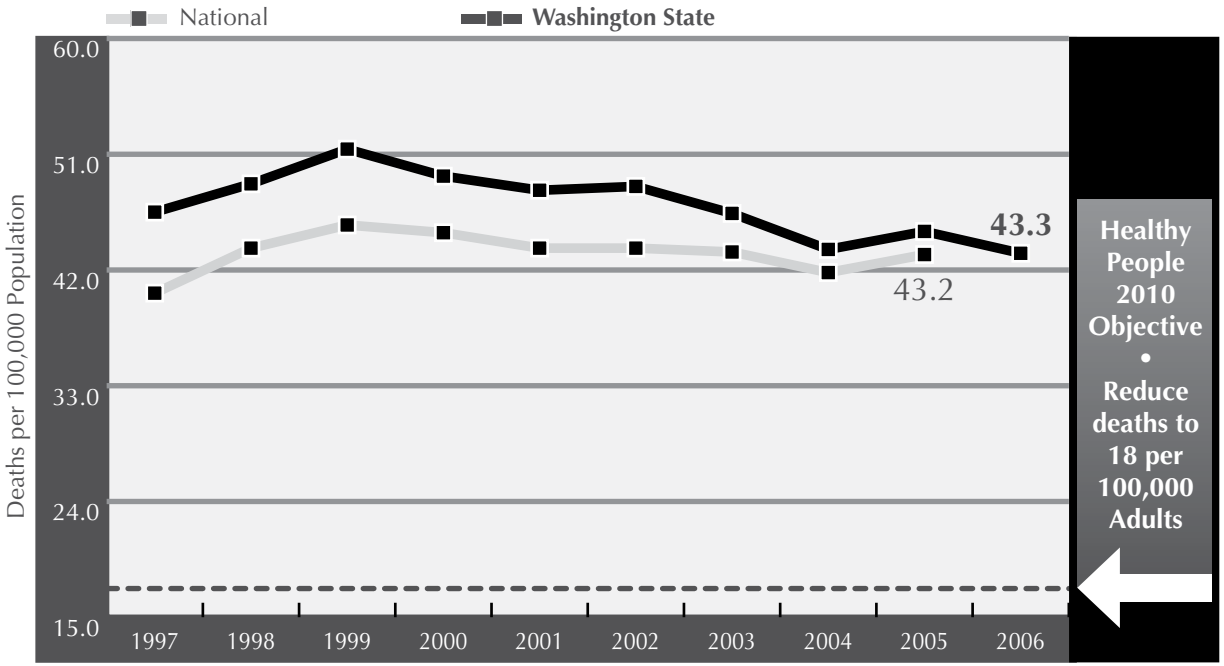
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Lung cancer is the most common category of cancer mortality in the U.S. The vast majority of lung cancer cases are attributable to cigarette smoking, accounting for 68-78% of lung cancer deaths among females, and 88-91% of deaths among males.[1] The risk of developing lung cancer is about 23 times higher in male smokers and 13 times higher in female smokers compared to lifelong non-smokers.[2] Smoking cessation decreases the risk of lung cancer to 30-50% of that of continuing smokers after ten years of abstinence.[3] Among males, the lung cancer death rate has been dropping by approximately 1.8% per year since 1991. However, death rates for women have been increasing steadily, and since 1987, more women have been dying each year from lung cancer than from breast cancer.[4] Secondhand smoke causes approximately 3,000 lung cancer deaths among U.S. nonsmokers every year.[5]

Tobacco is the leading preventable cause of death in Washington State, and kills approximately 8,000 Washington residents each year.[6] In 2006, 17.1% of Washington adults were current smokers, representing a 23.7% drop since 1999. This translates to $2.1 billion saved in future health care costs.[7] This graph indicates that lung cancer death rates in Washington State are now in significant decline.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 3-12. Washington, DC: 2000.
[2] Office on Smoking and Health, Centers for Disease Control and Prevention, U. S. Department of Health and Human Services, *The Health Consequences of Smoking - A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, 2004.
[3] *Healthy People 2010* (Conference Edition), Op. cit.
[4] American Cancer Society, *Cancer Facts and Figures 2004.*
[5] *Health Consequences of Smoking*, op. cit.
[6] Tobacco Prevention and Control Program, Washington State Department of Health, *Progress Report - March 2007.*
[7] Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2006.

The Death Rate in Washington State from Chronic Lower Respiratory Disease is Slightly Higher than the Nation.



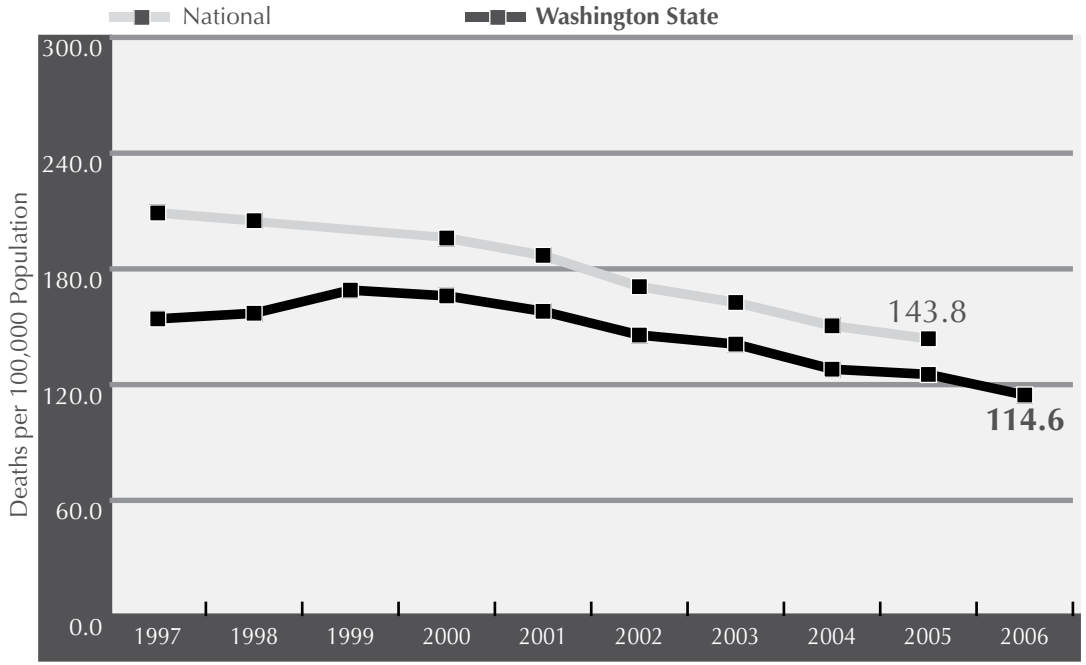
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) occurs most often in people over age 65. Between 80-90% of cases are attributable to cigarette smoking.[1]

This graph indicates that the mortality rate from chronic lower respiratory disease in Washington State is slightly higher than nationally. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction. Both conditions often exist together.[2] There is clear evidence that smoking cessation relieves symptoms and slows the progression of chronic lower respiratory disease, reduces the risk of lung and other cancers, and increases life expectancy.[3]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 24-8. Washington, DC: 2000.
[2] *Ibid.*
[3] Rigotti, N. "Treatment of Tobacco Use and Dependence," *New England Journal of Medicine* 346(7), February 14, 2002.

The Ischemic Heart Disease Death Rate in Washington State is Lower than the Nation.

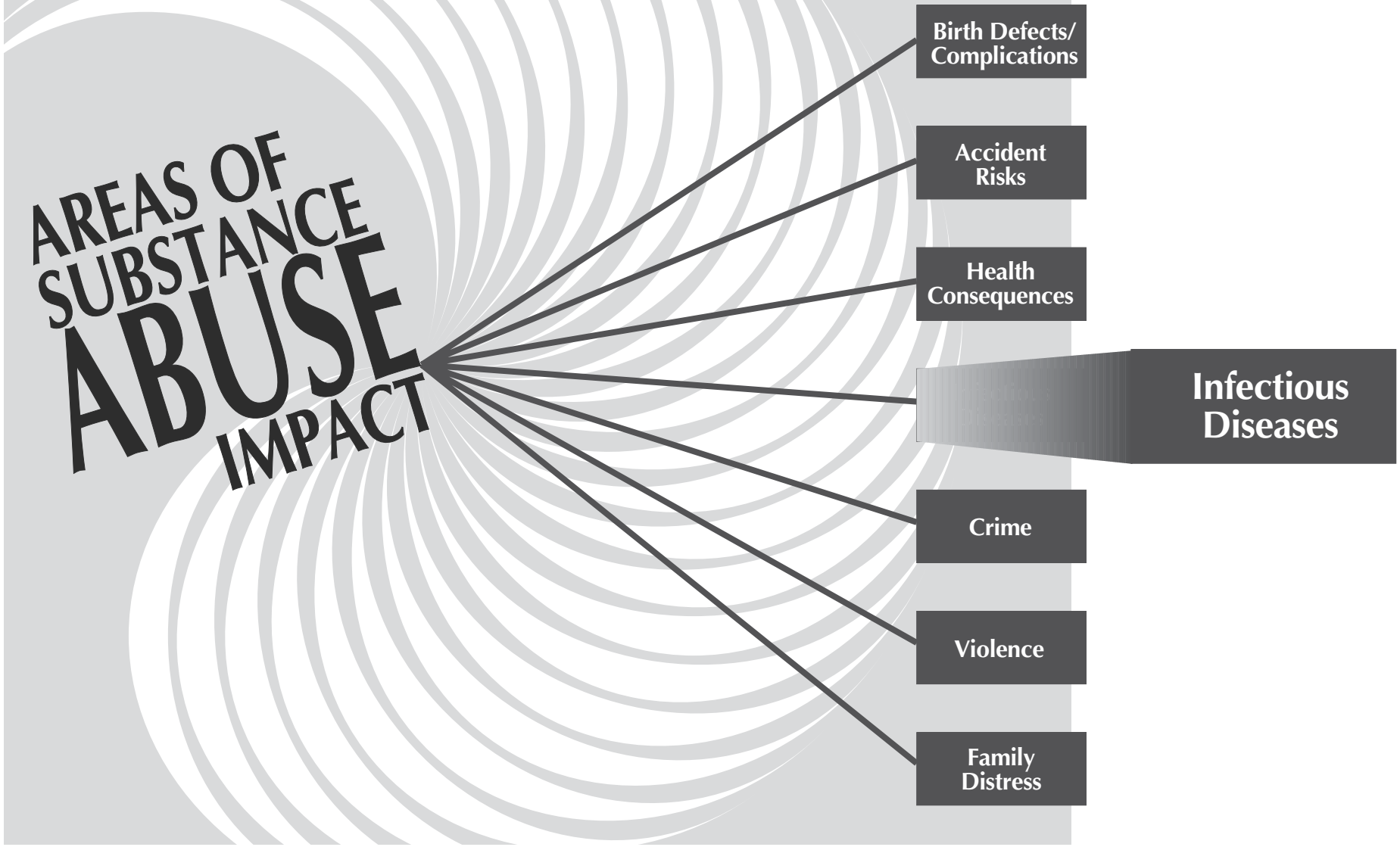


Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

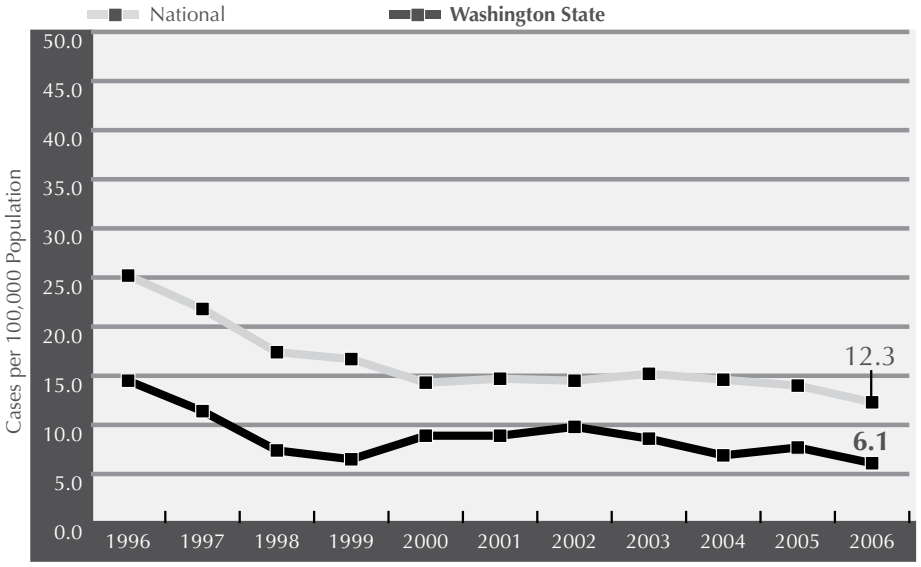
Heart disease is the leading cause of mortality in the United States, and ischemic heart disease (heart attacks) accounts for the largest portion of heart disease deaths. About 12 million Americans have ischemic heart disease. Prevention strategies include reducing blood cholesterol, high blood pressure, obesity and excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.[1] In 2000, obesity and lack of physical activity caused 400,000 U.S. deaths, 16% of the total, and is now considered the nation's second leading killer, after tobacco use.[2] Quitting smoking reduces risks of heart disease and heart attacks regardless of age of cessation.[3] There were 7,264 deaths from ischemic heart disease in Washington State in 2006.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 12-6. Washington, DC: 2000.
[2] Mokdad, A. et al. "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291(10), March 10, 2004.
[3] Taylor, D. et al. "Benefits of Smoking Cessation for Longevity," *American Journal of Public Health* 92(6), 2002.

The Problem: Substance Abuse Prevalence & Trends



The Reported AIDS Case Rate in Washington State is About Half that of the Nation.*



Source: National and state data from the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2006*, Vol. 18, 2008.

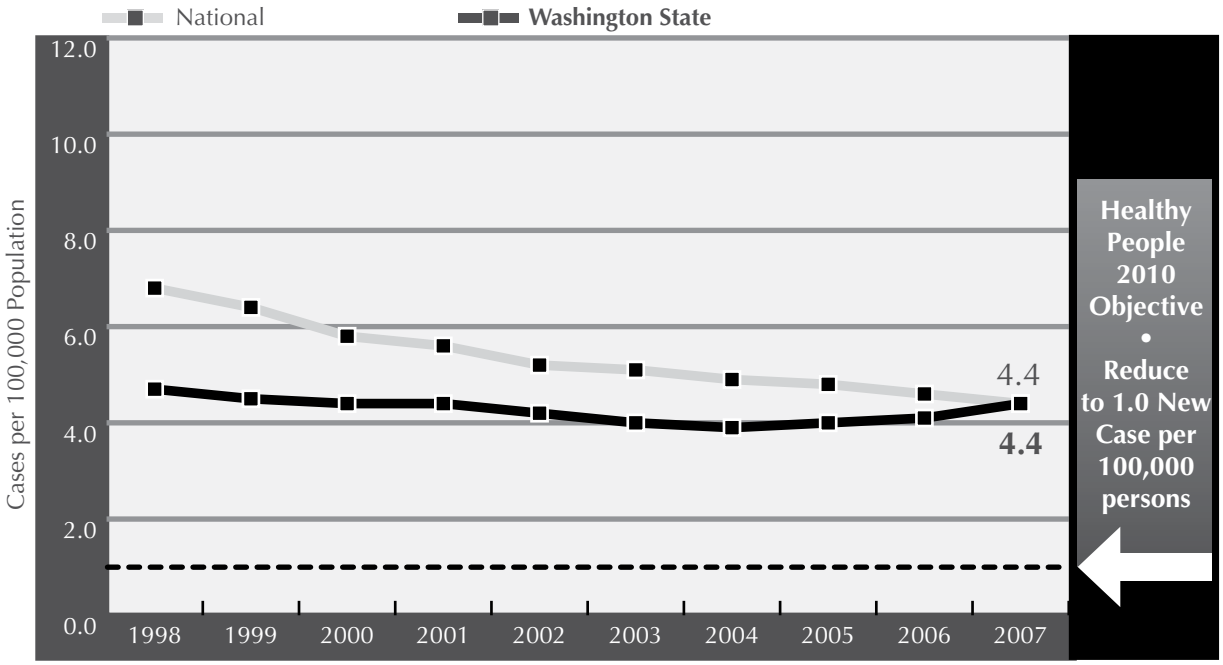
From 1982 through 2007, 12,167 AIDS (Acquired Immune Deficiency Syndrome) cases were reported in Washington State, and there were 5,246 deaths from the disease. As of December 2007, there were 5,650 Washington residents living with AIDS. Some 18% of AIDS cases in Washington State were traceable to possible exposure from injection drug use, substantially lower than the percentage of cases attributed to injection drug use nationally.[1] Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic - such as Seattle and Tacoma - have much lower infection rates among injection drug users (IDUs).

This graph indicates that the reported AIDS case rate in Washington is consistently lower and is now approximately half that of the nation. Since 1995, the AIDS case rate has generally been in decline, reflecting the effectiveness of new treatments in preventing HIV (human immunodeficiency virus) infection from progressing to AIDS. However, there is concern about an increase in behaviors that put individuals at risk for HIV transmission. Nationally, well over half of individuals diagnosed with AIDS live longer than 9 years after the diagnosis.[2]

** Case counts are provisional; reporting is considered incomplete for several years.*

[1] Office of HIV Prevention and Education, Washington State Department of Health, 2008.
[2] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2005* Vol. 17, 2006.

The Case Rate for New Tuberculosis Cases in Washington State Ticked Upward in 2007.



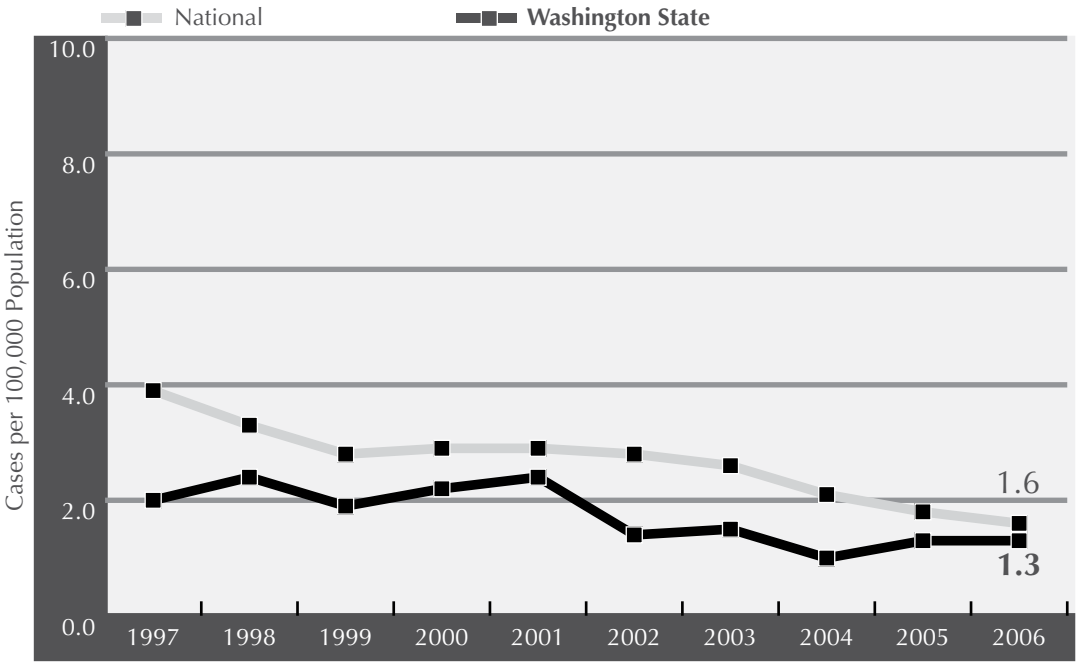
Source: National data from the Division of Tuberculosis Elimination, Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from Assessment Unit – Infectious Disease and Reproductive Health, Washington State Department of Health.

Multiple risk factors, including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic, are associated with new tuberculosis cases. Ensuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. Washington State has adopted treatment provider regulations to screen all chemical dependency patients to help prevent and control the spread of the disease.

This graph indicates that until 2007 Washington State had a consistently lower tuberculosis rate than the nation. There were 291 new tuberculosis cases in Washington State in 2007, 161 in King County, the highest number in 30 years, and where the case rate of 8.6/100,000 was almost twice the state case rate. Some 76% of the King County cases were to foreign-born individuals, and 12% were resistant to at least one tuberculosis medication.[1]

[1] Epidemiology, Prevention Division, Public Health - Seattle and King County *Epi-Log*, 48(3), March 2008.

The Rate of Acute Hepatitis B in Washington State Has Declined By More than Half in the Past Decade.



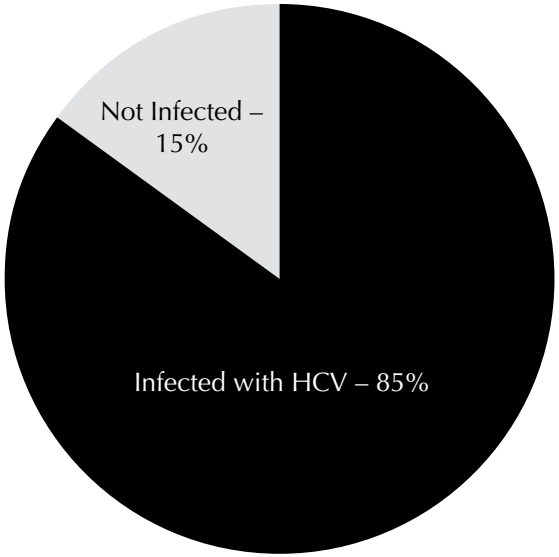
National data from the Epidemiology Program Office, National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *Washington State Communicable Disease Report 2006*.

Injection drug use is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected partners. It may also be transmitted perinatally.[1]

This graph indicates that the rate of acute hepatitis B cases in Washington State has declined substantially over the past decade. Hepatitis B is a serious disease that attacks the liver, and chronic hepatitis B infection, which may be carried without sign of infection, is associated with cirrhosis, liver cancer, and liver failure. The greatest decline in infections over the past decade has been in children and adolescents, and associated with routine childhood vaccination.[2] Nationally, the acute hepatitis B case rate in 2006 was the lowest ever recorded.[3] There were 80 reported acute hepatitis B cases in Washington State in 2006.[4]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-15. Washington, DC: 2000.
[2] Centers for Disease Control and Prevention. "Incidence of Acute Hepatitis B - United States, 1990-2002," *Morbidity and Mortality Weekly Report* 52(51), January 2, 2004.
[3] Centers for Disease Control and Prevention. "Surveillance for Acute Viral Hepatitis - United States, 2005," *Morbidity and Mortality Weekly Report* 56(SS03), March 16, 2007.
[4] Washington State Department of Health. *Washington State Communicable Disease Report 2006*. Olympia, WA: 2007.

Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV).



Source: Community Epidemiology Work Group, National Institute on Drug Abuse, National Institutes of Health, *Recent Drug Trends in the Seattle-King County Area,* January 2006.

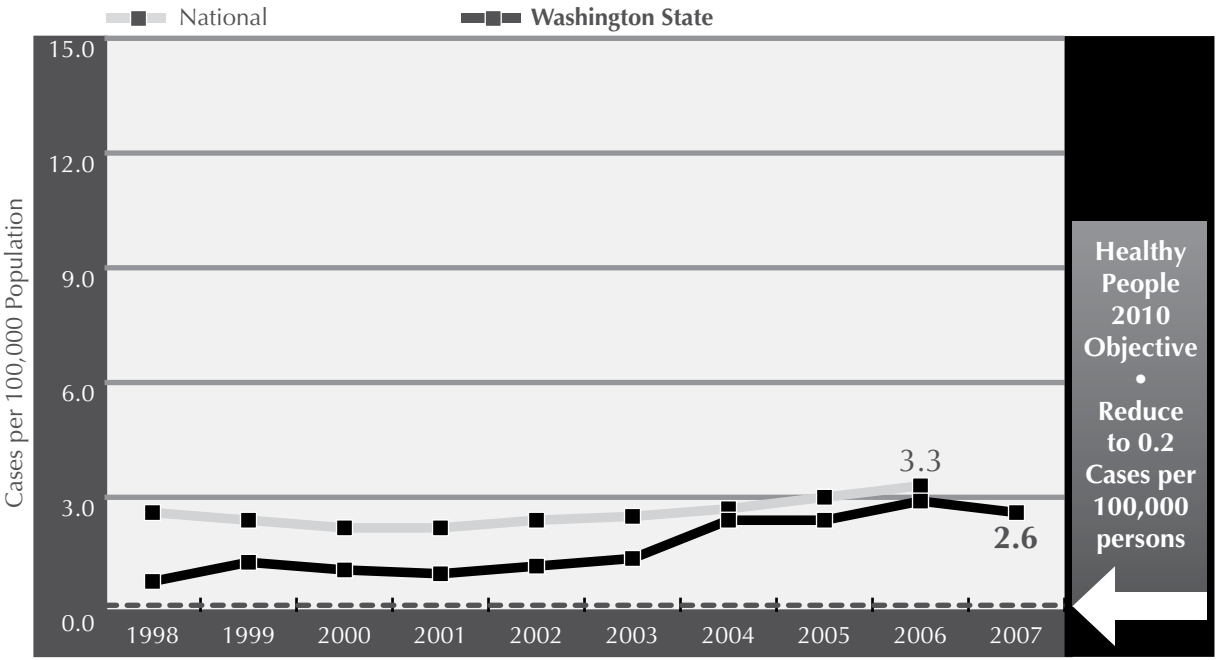
Of the 15,000-18,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with the hepatitis C virus (HCV). Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.[1]

HCV is the most common chronic bloodborne viral infection in the United States. It is estimated that some 4.1 million, representing 1.6% of the population, have been infected with HCV, of whom 3.2 million are chronically infected. Most new infections are caused by injection drug use, though those who received blood clotting factors in the course of medical care before 1987 are at high risk. Infection can also be transmitted perinatally (risk = 4%) or through sexual contact. Some 70% of chronically infected persons develop chronic liver disease or liver cancer. HCV is the leading reason for liver transplantation.[2]

While 40,000 individuals in Washington State are known to be infected with HCV, it is estimated that 110,000 are infected, of which 70,000 will develop chronic infection. Of these, it is estimated that 15,000 may develop cirrhosis within 20 years, and as many as 1,000 will develop liver cancer. Approximately 250 deaths in Washington State occur each year as a result of hepatitis C. While treatment protocols are improving rapidly, there is no known cure, and no effective vaccine against infection.[3] Even moderate use of alcohol is known to exacerbate liver injury resulting from HCV.

[1] Banta-Green, C. et al. "Recent Trends in the Seattle-King County Area, January 2006," *Epidemiologic Trends in Drug Abuse*, 2006.
[2] Centers for Disease Control and Prevention. *Hepatitis C Fact Sheet*, May 25, 2005.
[3] Office of Infectious Disease, and Reproductive Health. *Hepatitis C Virus in Washington State.* Olympia, WA: Washington State Department of Health, March 2007.

Washington State Experienced a Slight Decline in the Rate of Primary and Secondary Syphilis in 2007.



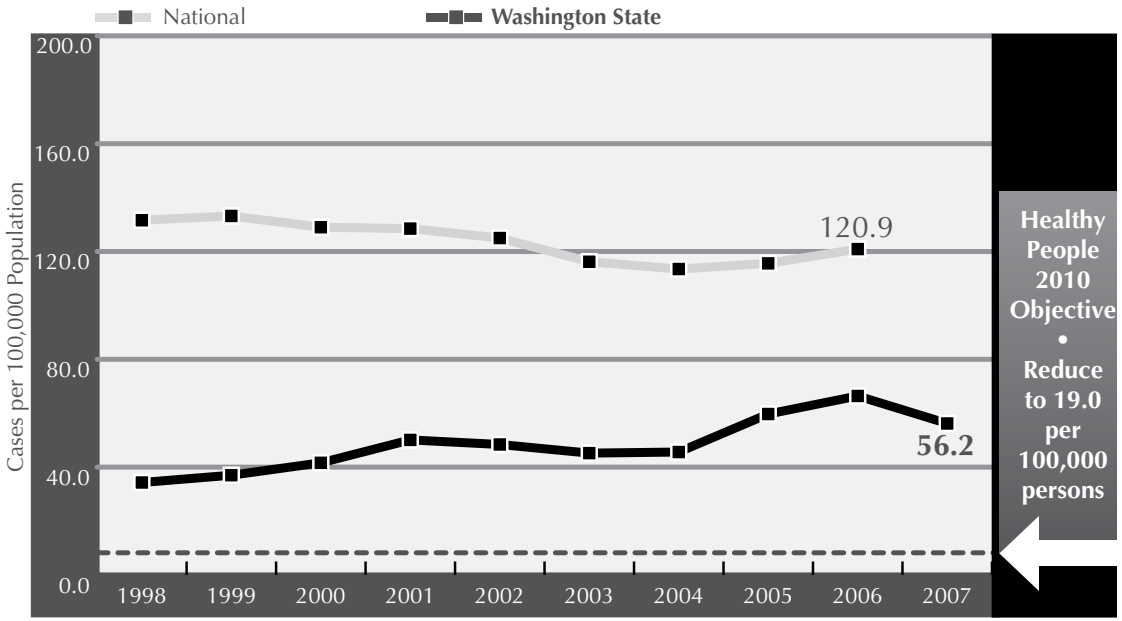
Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, *Washington State 2007 Sexually Transmitted Disease Morbidity.*

The spread of sexually transmitted diseases (STDs), including syphilis, is often linked to the use of alcohol and other drugs. The introduction of new illicit substance use into a community often can substantially alter sexual behavior in high-risk sexual networks. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.[1]

From a low of nine cases in 1996, Washington State has experienced a substantial increase in the number of primary and secondary (P&S) syphilis cases, though there was a decline in 2007. There were 167 cases in 2007, more than double the 82 cases in 2003. King County, which only had a single case in 1996, accounted for 27% of the newly reported 2007 cases. Transmission is strongly associated with men having sex with men[2], and may be associated with substance abuse, notably methamphetamine and inhaled nitrites.[3] Counts of P&S syphilis cases may understate the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.
[2] STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health. *Washington State 2007 Sexually Transmitted Disease Morbidity.* Olympia, WA: 2008.
[3] Public Health, Seattle & King County. *Screening Guidelines for Men Who Have Sex with Men (MSM).* Seattle, WA: 2001.

Gonorrhea Rates in Washington State Declined 21% in 2007, But are Well Higher than a Decade Ago.



Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, *Washington State 2007 Sexually Transmitted Disease Morbidity.*

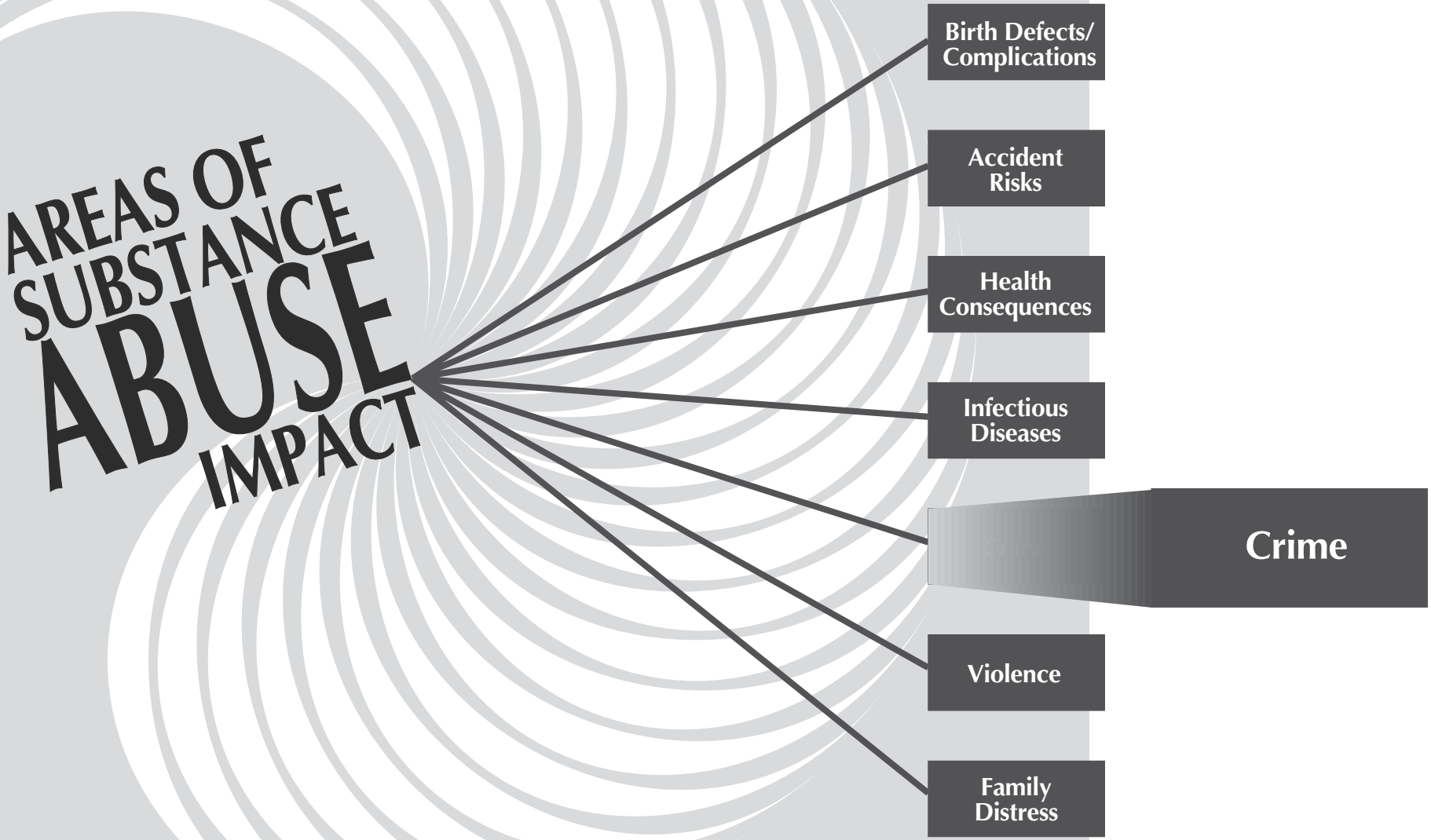
The spread of sexually transmitted diseases (STDs), including gonorrhea, is often associated with substance abuse. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.[1]

Washington State has experienced a serious resurgence in gonorrhea cases, from 1,955 cases in 1997 to 3,646 cases in 2006, representing an 86.5% increase. Much of this increase is associated with cases among men having sex with men. However, highest incidence is among females in the 20-24-year age range (186 cases per 100,000). The number of cases did decline by 21% in 2007.[2]

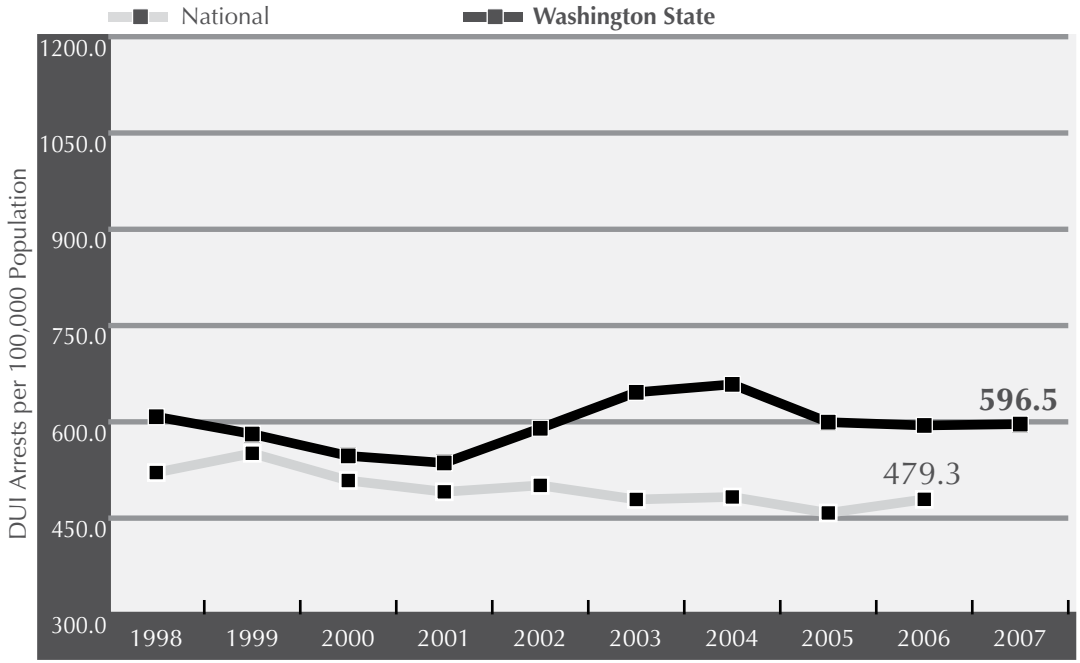
Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain. Epidemiologic studies indicate that gonococcal infections such as gonorrhea may facilitate HIV transmission.[3]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.
[2] STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health. *Washington State 2007 Sexually Transmitted Disease Morbidity*. Olympia, WA: 2008.
[3] Ibid.

The Problem: Substance Abuse Prevalence & Trends



Driving-Under-the-Influence Arrest Rates in Washington State Were Little Changed in 2007.

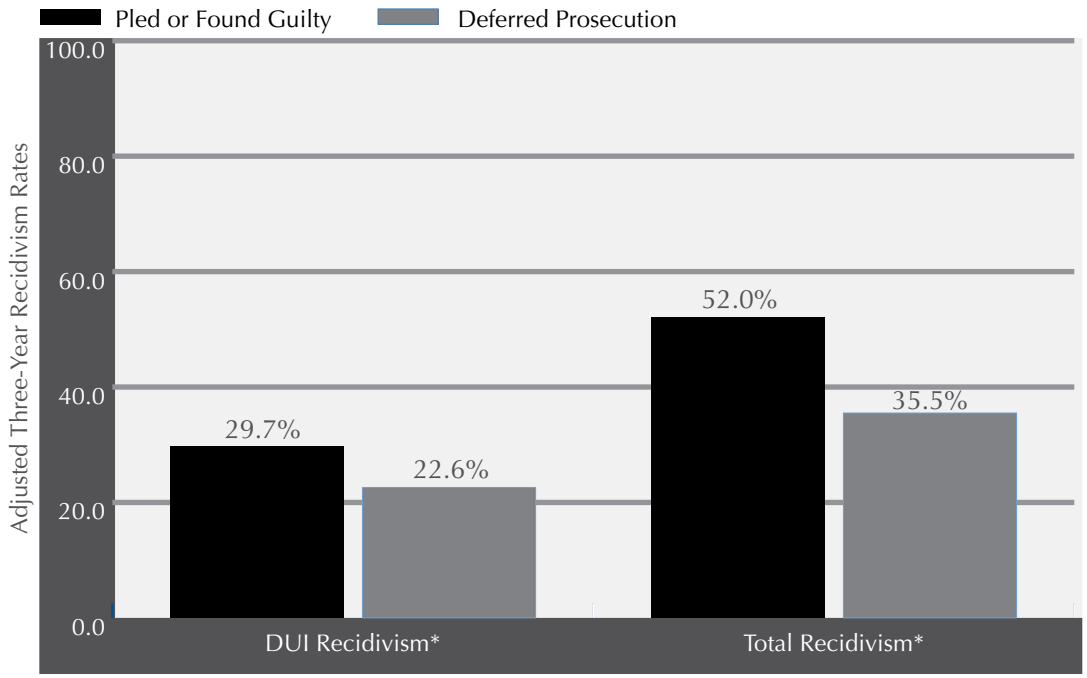


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* Annual Report. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for alcohol-related motor vehicle arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. Washington State enacted new alcohol-related motor vehicle statutes in 1998, including lowering the blood alcohol concentration (BAC) for proof of intoxication to .08, and zero tolerance for drivers under age 21. Driving-Under-the-Influence arrest rates in Washington State were little changed in 2007.

NEW/CHANGING TREND

Deferred Prosecution, Including Two Years of Chemical Dependency Treatment, Results in Reduced DUI Recidivism.



Source: Washington State Institute for Public Policy, *Deferred Prosecution of DUI Cases in Washington State: Evaluating the Impact on Recidivism*. Olympia, WA: August 2007.

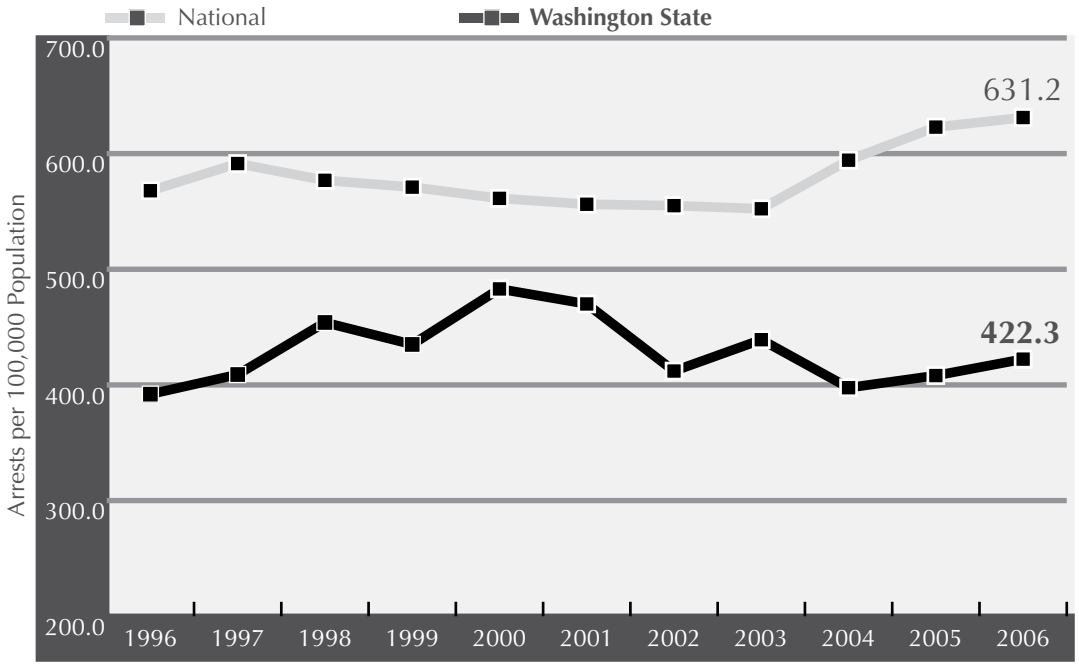
Deferred prosecution is a unique Washington State program in which chemically dependent driving-under-the-influence (DUI) offenders can petition to have their charges deferred if they meet certain conditions, including participation in a chemical dependency treatment program for two years.

A 2007 study indicates that defendants who received a deferred prosecution were 23.9% less likely to be arrested for another DUI within three years of the first case when compared with those who pled or were found guilty, and 31.7% less likely to have a subsequent DUI, criminal traffic, or alcohol-related case filed.[1]

** Includes subsequent DUI, criminal traffic, or alcohol-related case file.*

[1] Washington State Institute for Public Policy. *Deferred Prosecution of DUI Cases in Washington State: Evaluating the Impact on Recidivism*. Olympia, WA: August 2007.

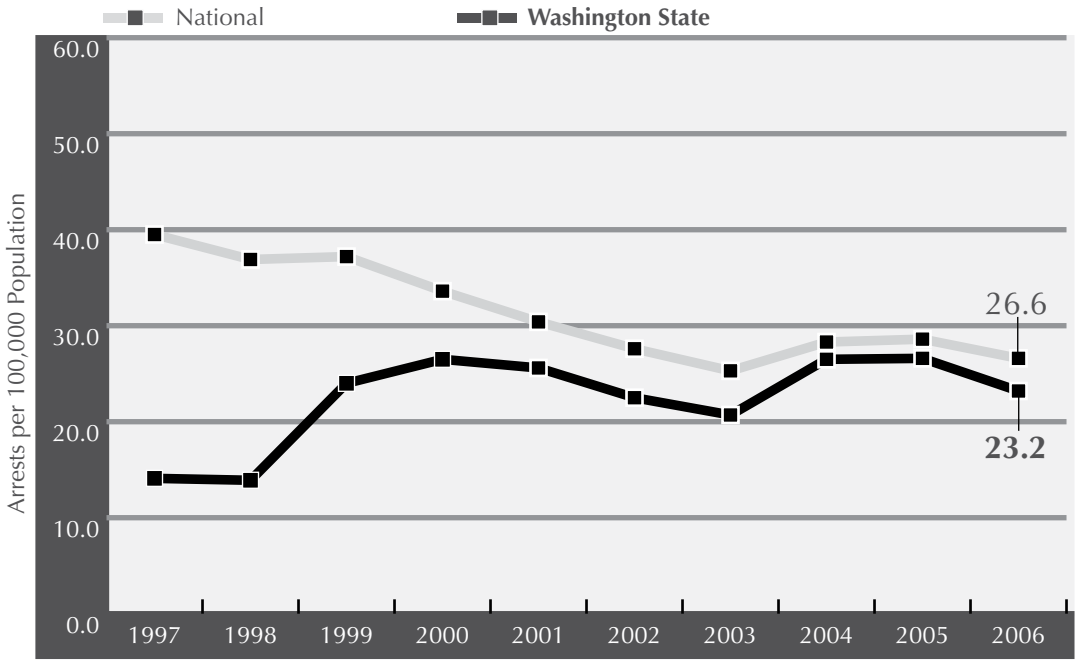
The Rate of Drug-Related Arrests in Washington State Rose Significantly in 2006.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* Annual Reports. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for drug-related arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of drug violations committed. There were 27,385 adult and 2,967 youth arrested for drug violations in 2005. Many individuals now receive judicially supervised treatment in lieu of incarceration with funds provided under the Criminal Justice Treatment Account. Drug-related arrests in Washington State increased by 18.9% in 2006.

Arrest Rates in Washington State for Prostitution are Below the National Rate.



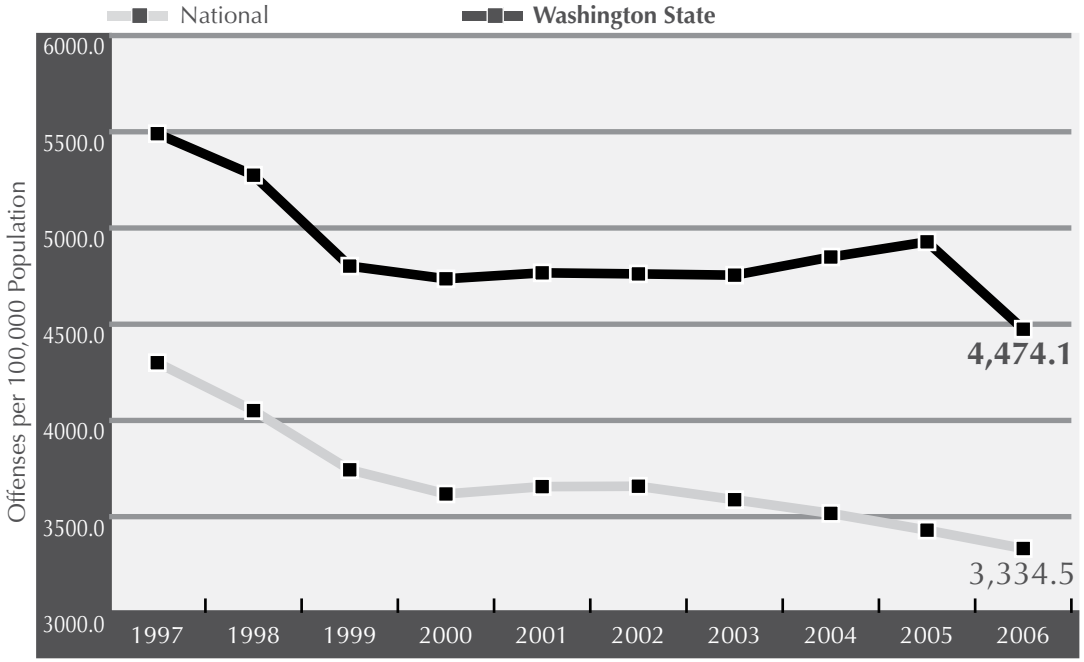
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The Arrestee Drug Abuse Monitoring Program reported that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.[1] Prostitution is associated with the spread of HIV/AIDS and other sexually transmitted diseases.

This graph indicates that arrest rates for prostitution in Washington State are lower than that of the nation. Of the 1,476 prostitution arrests in Washington State in 2005, 424 (representing 28.7% of the total) were male. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.

[1] Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 1999 Annual Report.* Washington, DC: U.S. Department of Justice, 2000.

Washington State Has a Higher Property Crime Index than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

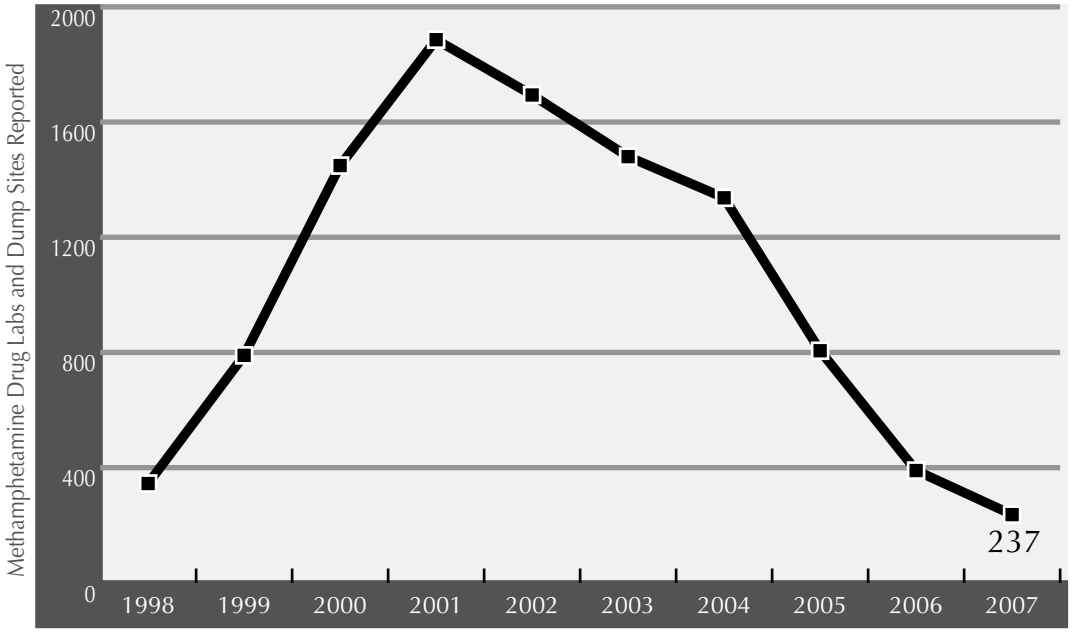
The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County, and 71.5% arrested for property offenses in Spokane County tested positive for illegal drugs.[1]

This graph indicates that the Washington State property crime index is higher than the nation, and has been relatively steady. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson offenses.

[1] Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports* (Prerelease), 139-146. Washington, DC: U.S. Department of Justice, 2001.

NEW/CHANGING TREND

The Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State Has Dropped Precipitously.



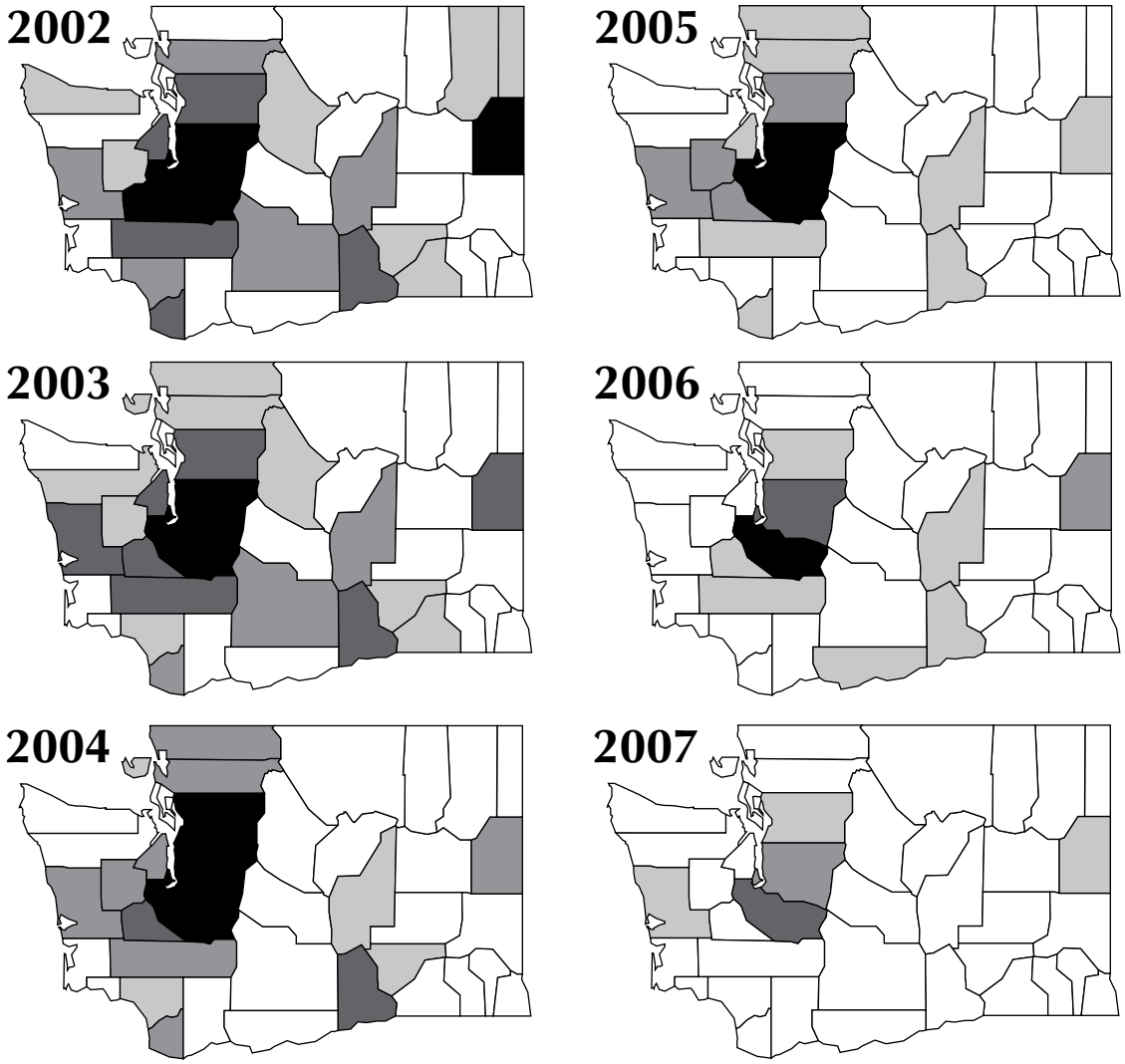
Source: Washington State Department of Ecology, 2008.

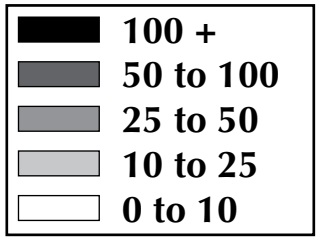
This graphic indicates that after dramatic increases since 1997, the number of illegal methamphetamine (meth) laboratories and dump sites in Washington State continues to drop, and has fallen 87.5% since 2001. The largest number of reports in 2007 came from Pierce (76), King (42), and Snohomish (15) Counties.

It is possible, but not yet substantiated, that the number of meth lab reports reflects a decline in the level of illicit use of the drug in communities. It is also suggested by law enforcement agencies, however, that drug dealers are now importing finished product from elsewhere, rather than manufacturing it, and that there is now a smaller number of large labs, accounting for most of the documented decline. Strong legislative efforts have also likely stemmed the availability of precursor chemicals. The Northwest High Intensity Drug Trafficking Area (NW HIDTA) Threat Assessment considers methamphetamine the greatest illicit drug threat to Washington State.[1]

[1] Northwest High Intensity Drug Trafficking Area. *Threat Assessment and Strategy for Program Year 2009*. Seattle, WA: 2008.

Distribution of Methamphetamine Drug Laboratories and Dump Sites Reported by County





Source: Washington State Department of Ecology

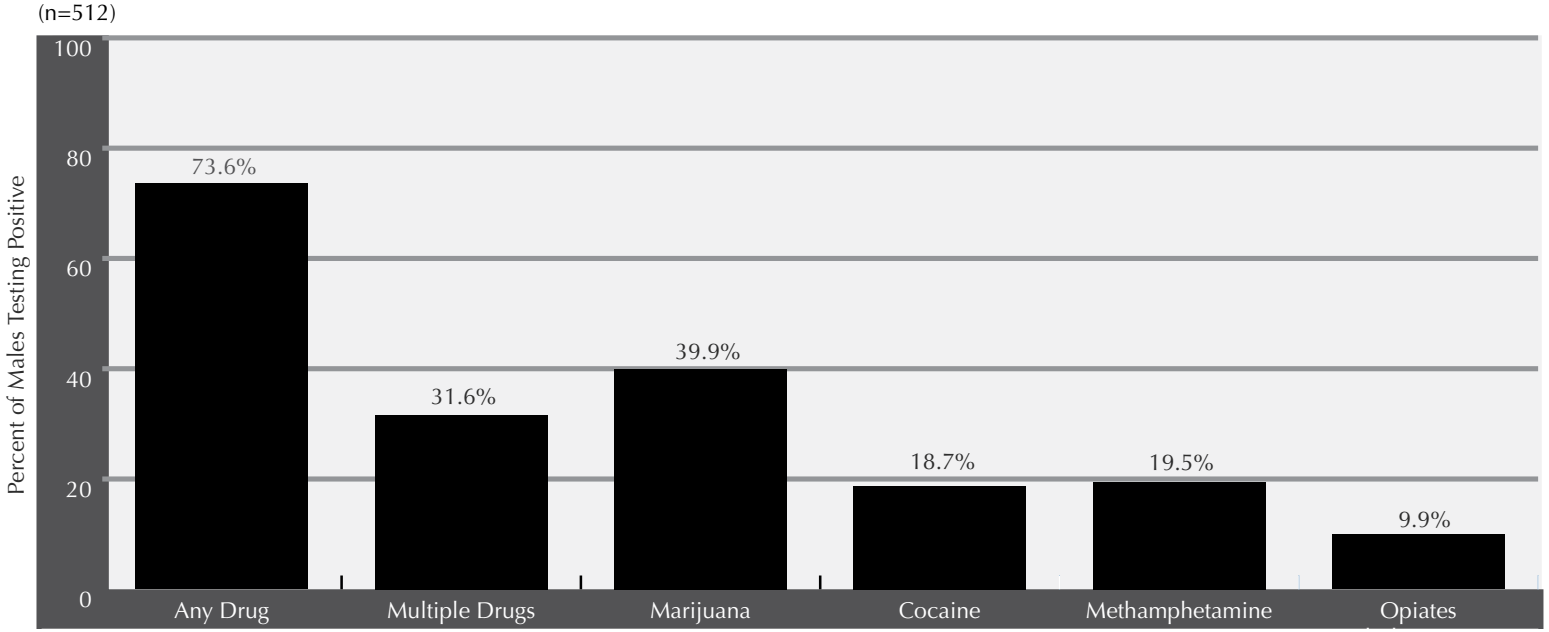
These maps indicate that reports of drug labs and dump sites have declined precipitously in the past five years, and are now less than a fifth of what they were in 2001. There have been very substantial declines in Pierce, King, Snohomish, Spokane, Kitsap, and Thurston Counties.

Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State

County	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Adams	1	-	1	-	3	4	4	0	0	1	0
Asotin	-	-	1	1	5	3	4	0	0	0	0
Benton	4	7	38	52	85	87	82	57	16	13	9
Chelan	-	-	2	14	34	15	13	9	3	0	6
Clallam	3	3	-	1	3	10	2	2	0	2	3
Clark	20	12	16	34	57	57	35	28	18	9	6
Columbia	-	-	1	3	2	1	4	1	0	1	0
Cowlitz	9	2	8	7	9	28	18	11	7	5	3
Douglas	-	1	1	6	5	7	4	8	6	0	0
Ferry	-	-	-	7	4	0	0	0	0	0	0
Franklin	-	1	8	10	15	11	13	14	2	1	0
Garfield	-	-	2	-	-	4	1	0	1	0	0
Grant	-	-	2	19	27	46	34	14	11	15	0
Grays Harbor	5	5	16	24	41	32	50	27	28	1	14
Island	1	2	5	1	5	5	14	18	5	6	4
Jefferson	1	1	2	7	6	4	12	2	1	5	0
King	17	48	107	231	271	241	202	199	123	63	42
Kitsap	-	1	21	45	54	60	50	44	18	2	1
Kittitas	-	1	3	-	5	3	5	3	6	0	3
Klickitat	1	3	-	6	4	2	1	0	1	11	1
Lewis	9	31	33	43	61	83	67	30	21	14	3
Lincoln	-	-	-	-	5	3	2	1	1	1	1
Mason	4	10	21	32	30	22	15	31	32	6	4
Okanogan	2	3	2	2	3	3	1	4	0	3	1
Pacific	4	1	6	2	3	4	3	2	2	0	0
Pend Oreille	2	6	10	12	5	12	6	7	5	2	0
Pierce	42	129	318	545	589	438	466	541	349	148	76
San Juan	-	-	-	-	1	1	0	0	0	0	0
Skagit	-	4	2	5	11	34	12	31	12	9	4
Skamania	-	-	2	1	2	3	3	1	1	2	2
Snohomish	6	5	13	37	69	83	98	101	43	14	15
Spokane	7	11	36	137	248	189	91	42	21	28	14
Stevens	1	-	5	4	15	10	3	5	5	3	2
Thurston	63	58	86	139	151	115	96	61	37	10	6
Wahkiakum	-	-	1	-	2	2	2	0	1	1	0
Walla Walla	-	2	8	12	16	15	16	9	4	1	8
Whatcom	-	-	-	-	5	9	24	25	12	6	2
Whitman	-	-	-	1	3	4	0	2	5	0	0
Yakima	1	2	12	14	36	43	27	7	9	7	7
TOTAL	**203**	**349**	**789**	**1,454**	**1,890**	**1,693**	**1,480**	**1,337**	**806**	**390**	**237**

Source: Washington State Department of Ecology.

Almost Three-Quarters of Male Arrestees Booked Into the Snohomish County Jail Between November 2002 – February 2003 Tested Positive for Drugs.



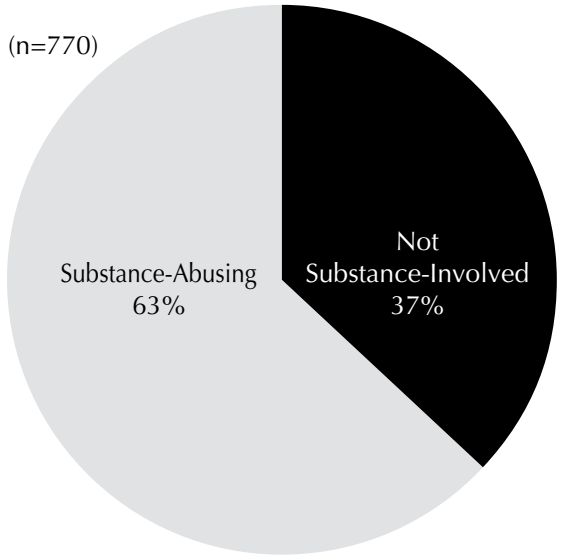
Source: Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study*. Olympia, WA: Looking Glass Analytics, 2003.

Modeled on an approach pioneered by the defunded federal Arrestee Drug Abuse Monitoring Program, males arrested and booked into the Snohomish County Jail between November 2002 – February 2003 were tested for drug use via urine sampling, and interviewed. Almost three-quarters (73.6%) tested positive for illicit drugs. Some 39.9% of arrestees were classified as drug-dependent, with 23.7% classified as dependent upon alcohol. Arrestees that reported heavy substance use were more likely to have been arrested in the past 12 months, reported a greater number of lifetime arrests, and reported spending more time in jail than those who did not report heavy substance use.

Only 29% of Snohomish County arrestees reported receiving any treatment for chemical dependency during the previous year.[1]

[1] Gilson, M., and Kabel, J. *The Snohomish County Arrestee Substance Abuse (SCASA) Study: Characteristics of Drug Use Among Arrestees Booked Into Snohomish County Corrections Including Comparisons to Booked Arrestees in King and Spokane Counties*. Olympia, WA: Looking Glass Analytics, 2003.

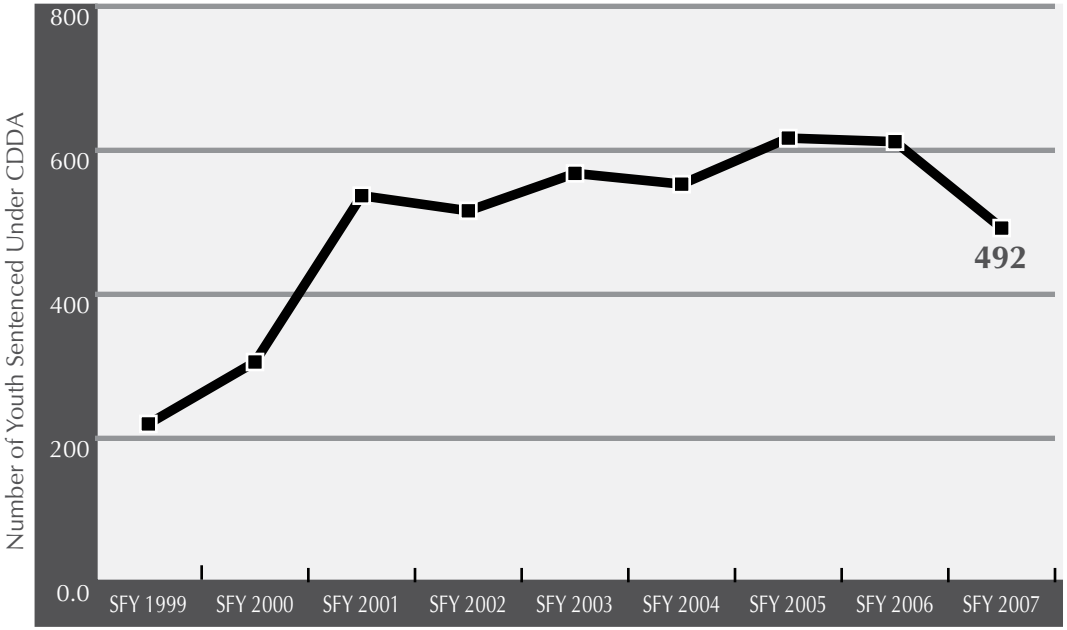
Almost Two-Thirds of Youth Entering Juvenile Rehabilitation Administration Facilities in SFY 2007 Had Substance Abuse-Related Problems.



Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, June 2008.

More than half of youths admitted to Juvenile Rehabilitation Administration (JRA) institutions had substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse. In SFY 2007, 390 youth discharged from JRA facilities had received inpatient, intensive outpatient, or outpatient treatment.

In State Fiscal Year 2007, 492 Youths Who Committed Offenses were Admitted to Treatment Under the Chemical Dependency Disposition Alternative.

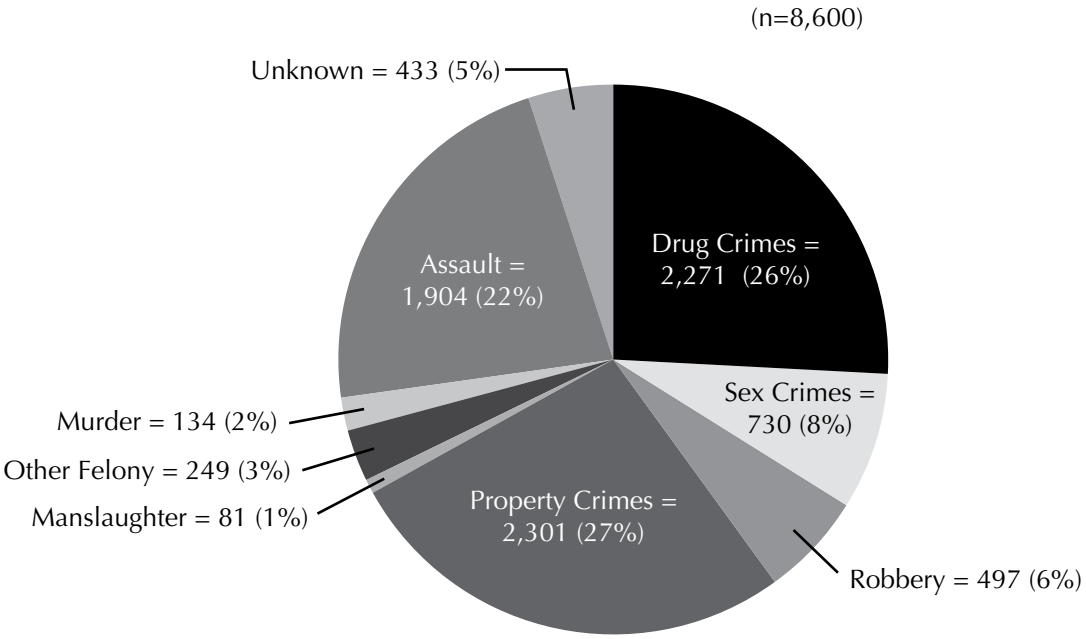


Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, June 2008.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts may sentence chemically abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration among the Juvenile Rehabilitation Administration, Division of Alcohol and Substance Abuse, Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. A 2004 report to the Legislature prepared by the Alcohol and Drug Abuse Institute, University of Washington, found that committable youth completing CDDA incurred fewer convictions; were less likely to be detained; were more likely to be enrolled in school; were more likely to be working full-time; reported better family and social relationships; and reported fewer emotional difficulties.[1]

[1] Rutherford, M., et al. *Report to the Legislature: Chemical Dependency Disposition Alternative.* Olympia, WA: Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration, 2004.

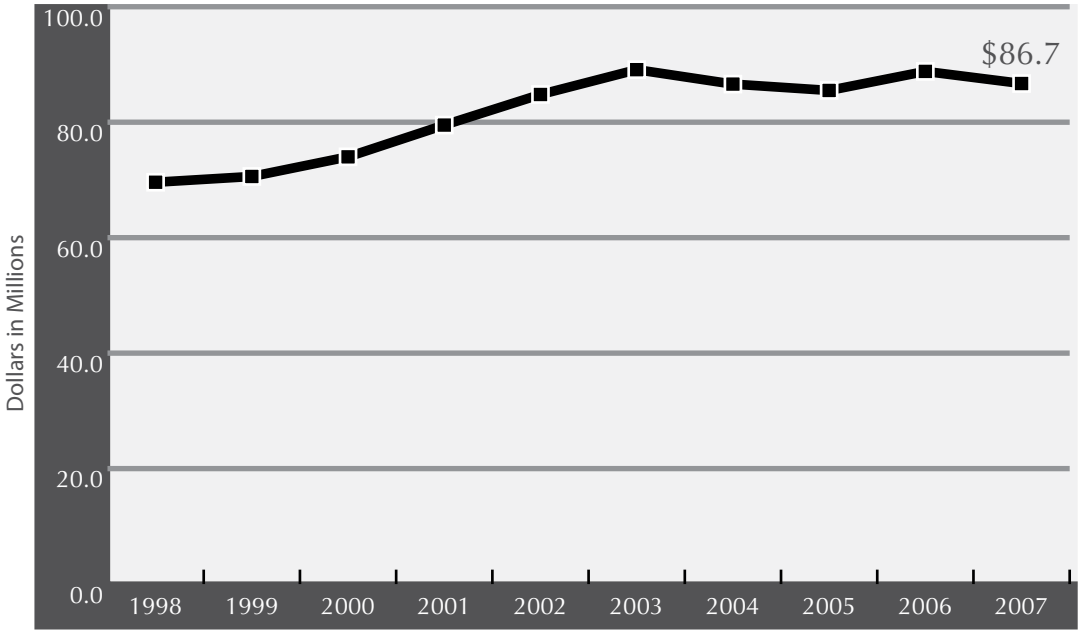
More than a Quarter of the Convictions for Which Individuals were Sentenced to Department of Corrections Custody in SFY 2007 were for Drug Crimes.



Source: Washington State Department of Corrections, July 2008.

Drug crimes account for more than a quarter of the convictions for which individuals are sentenced to Department of Corrections custody. In addition, a substantial number of other crimes committed were drug-related, or were committed under the influence of alcohol or drugs. Approximately one-half of individuals admitted to total confinement are in need of chemical dependency treatment.

The Costs* of Imprisoning Drug Offenders in Washington State Have Leveled Off.

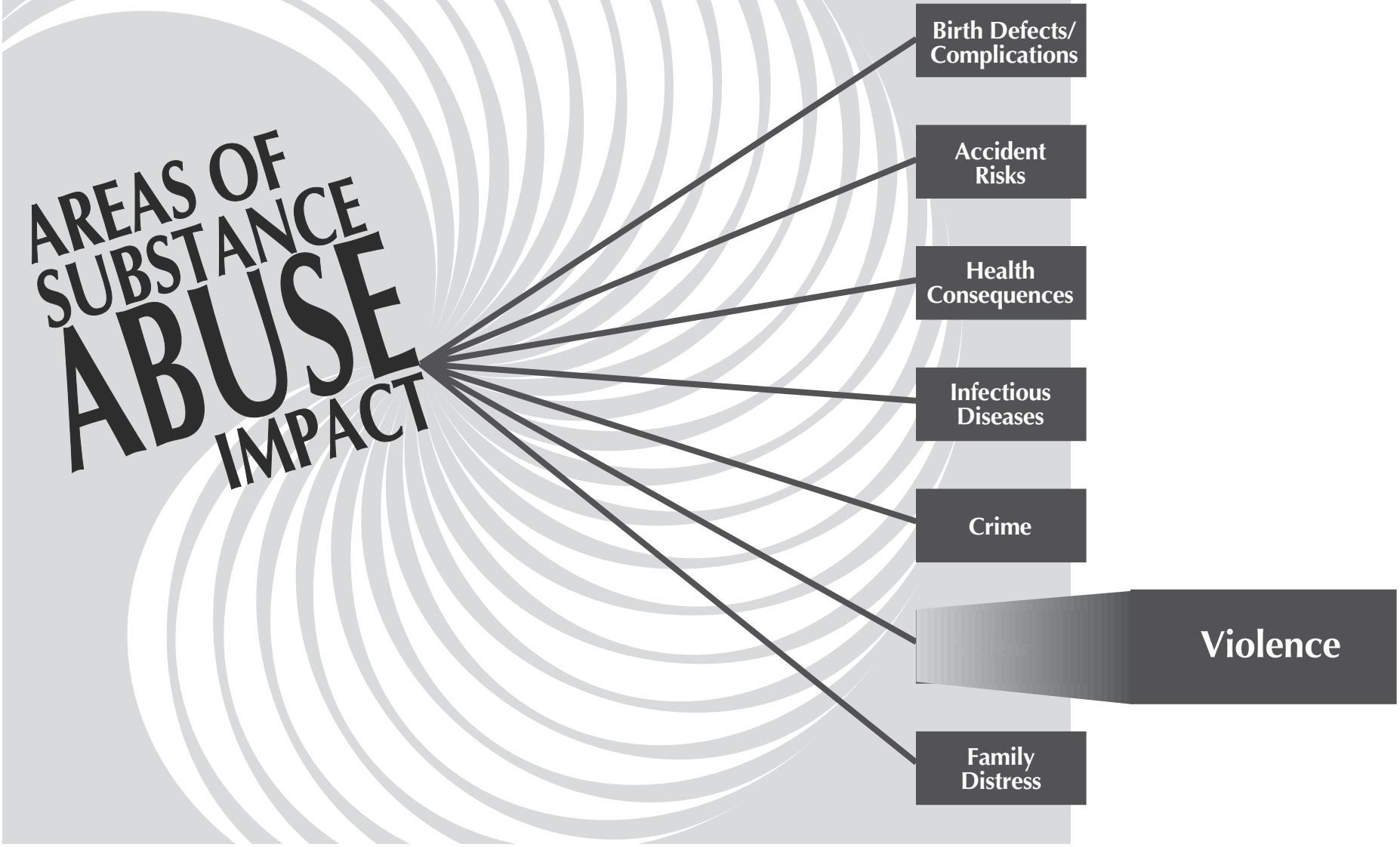


Source: Washington State Department of Corrections, July 2008.

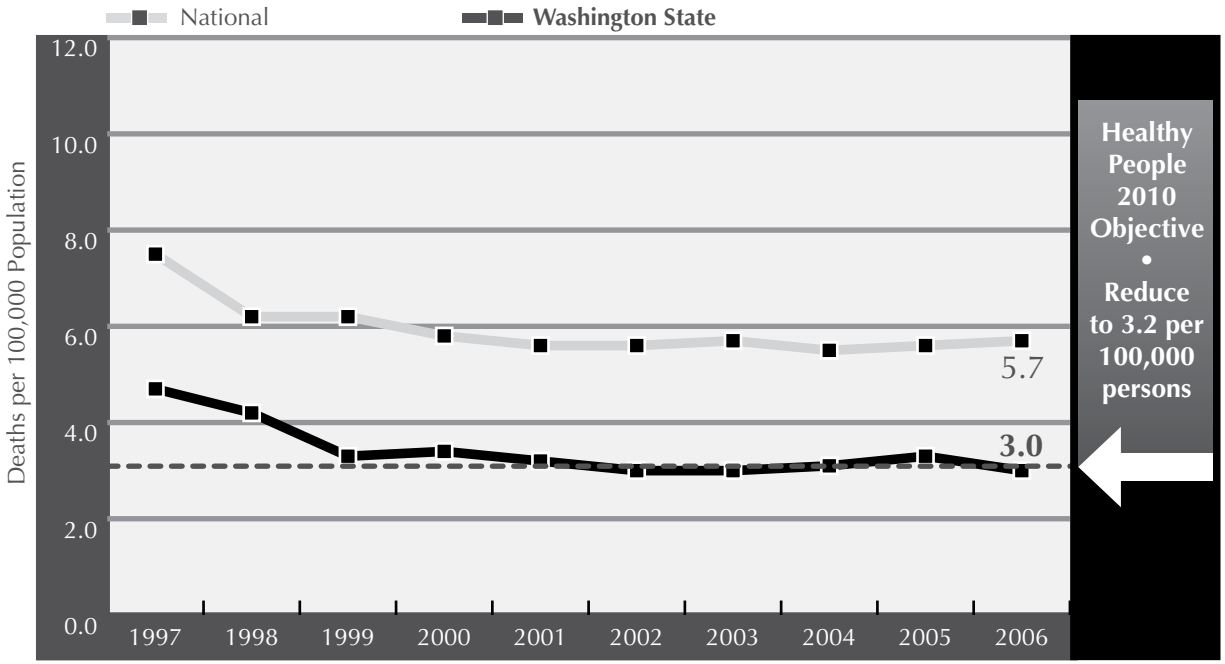
Costs* for imprisoning felony drug offenders in Washington State have grown faster than those for imprisoning other types of offenders. However, sentencing initiatives are now diverting a larger portion of drug offenders into chemical dependency treatment, and more treatment is now available through the Department of Corrections.

**Operating expenses only; excludes capital and supervision costs.*

The Problem: Substance Abuse Prevalence & Trends



The Homicide Rate in Washington State is Significantly Below the National Rate.



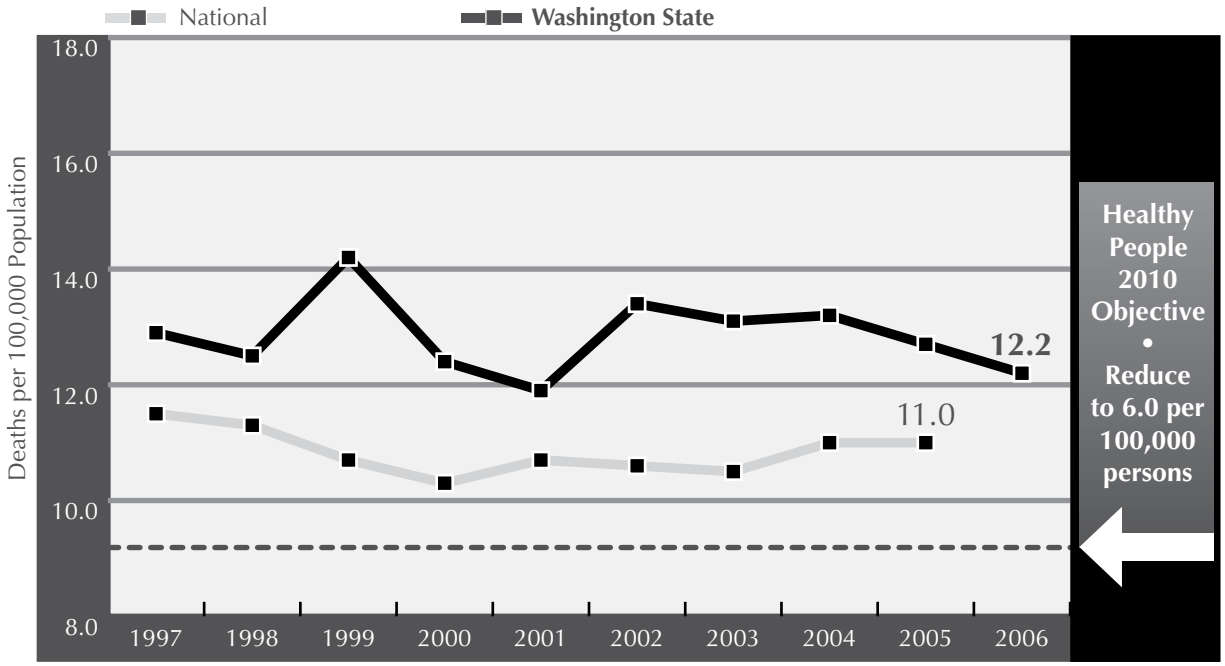
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from the Washington Association of Sheriffs and Police Chiefs, *Crime in Washington State* annual reports.

There were 188 homicides reported in Washington State in 2006. Of these, 14 were drug-related, and eight occurred as a result of brawls while under the influence of alcohol. It is unknown how many of the 164 homicides listed as "other than felony", including the 58 that may be related to child abuse and domestic violence, were associated with alcohol and other drug use.[1]

This graph indicates that Washington State's homicide rate has been lower than the national rate for more than a decade, and fell below the *Healthy People 2010* objective in 2006.

[1] Washington Association of Sheriffs & Police Chiefs. *Crime in Washington State 2006 Annual Report.* Olympia, WA: 2007.

The Suicide Rate in Washington State is Consistently Higher than the Nation.



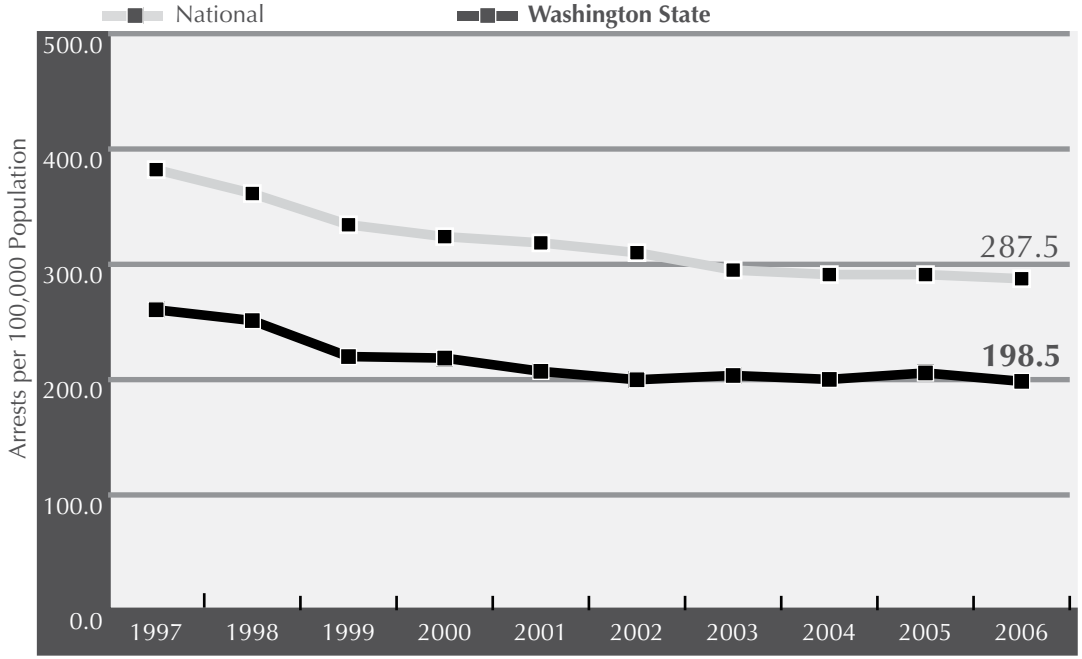
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol and drug abuse are closely associated with the risk of suicide. A 1997 study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.[1] However, the actual role of alcohol and other drugs in suicide is not clear. Some researchers see alcohol/drug involvement as self-medication to relieve depression or other psychological problems that eventually lead to suicide.[2] Others suggest that they loosen inhibitions or impair psychological and cognitive processes that normally constrain people from suicide.[3] Another perspective is that alcohol/drug use is part of the social disintegration that accompanies suicide.[4]

Washington State has a consistently higher suicide rate than the nation. There were 796 suicides in Washington in 2006. Suicide remains the second leading cause of death among young people ages 15-24 in Washington.

[1] Rivara, F. et al. "Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home," *Journal of the American Medical Association* 278(7), 1997.
[2] Shaffer, D. "Suicide: Risk Factors and the Public Health," *American Journal of Public Health* 83, 1993.
[3] Zeichner, A. et al. "Alcohol and Aggression: Effects of Personal Threat on Human Aggression and Affective Arousal," *Alcoholism: Clinical and Experimental Research* 18, 1994.
[4] Yang, B. "The Economy and Suicide," *American Journal of Economics and Sociology* 51, 1992.

The Rate of Aggravated Assaults in Washington State Remains Well Below the National Rate.

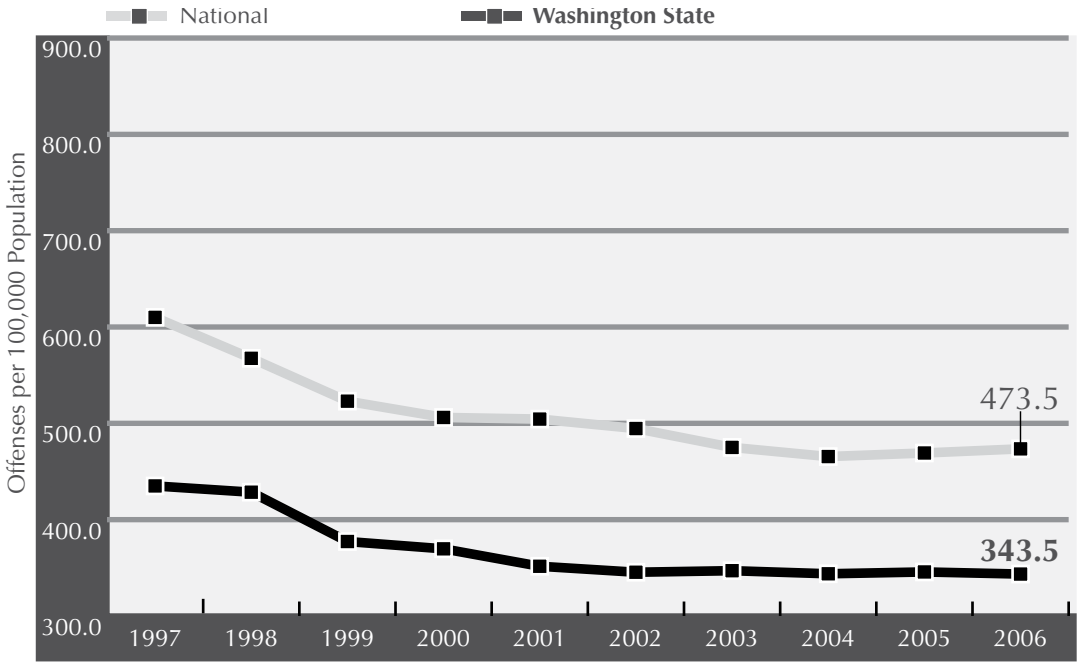


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting or aggravating bodily injury. An assault of this type is usually accompanied by the use of a weapon, or by means likely to produce death or severe harm.

This graph indicates that Washington State has a consistently lower rate of aggravated assaults than the nation.

Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.



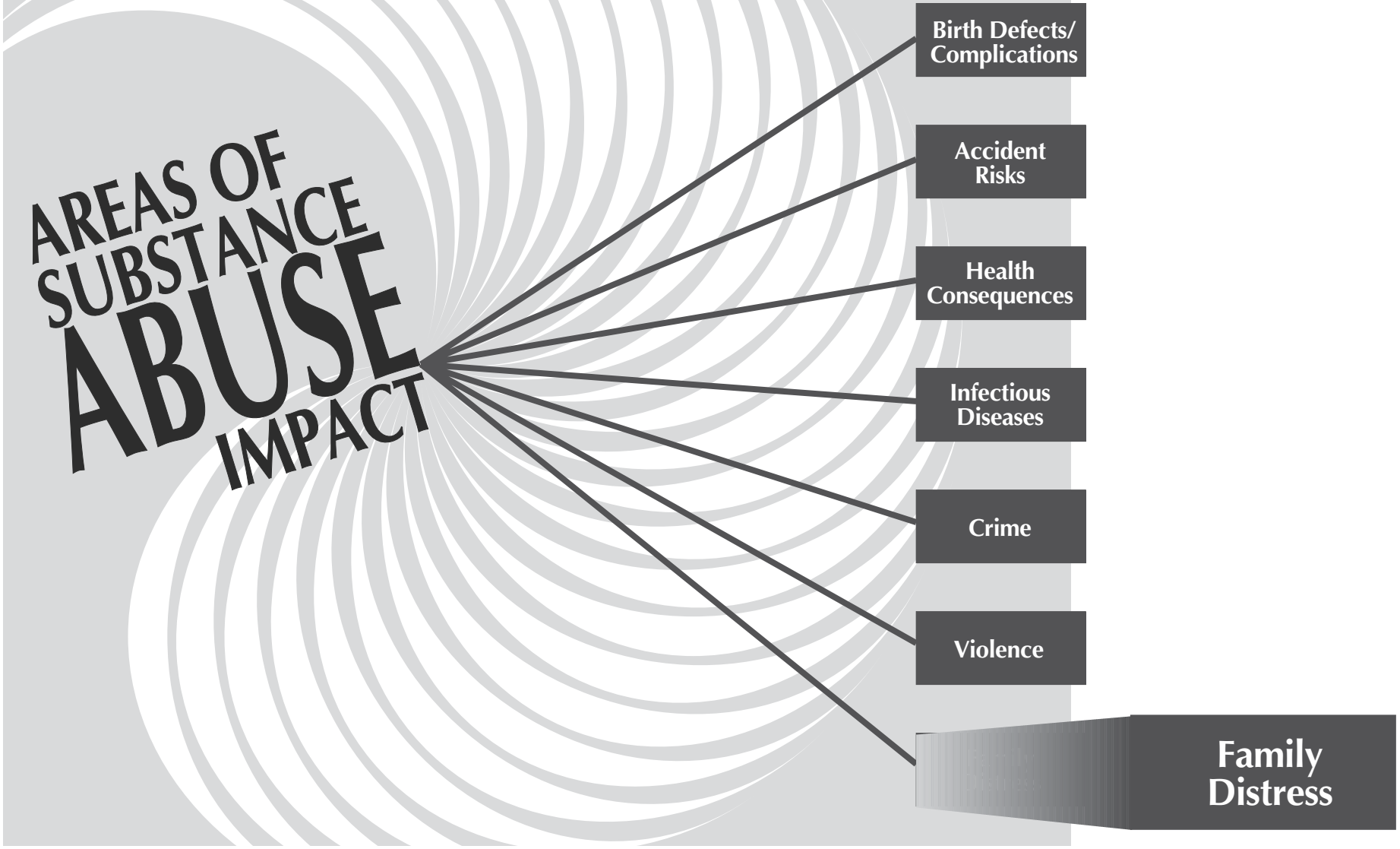
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

This graph indicates that Washington State has had a consistently lower incidence of violent crime than the nation for more than a decade. Violent crime rates are falling, both in the state and the nation. The Arrestee Drug Abuse Monitoring Program found that in 2004, 67.3% of adult males arrested for violent crimes in Seattle and 69.5% of adult males arrested for violent offenses in Spokane tested positive for illegal drugs.[1]

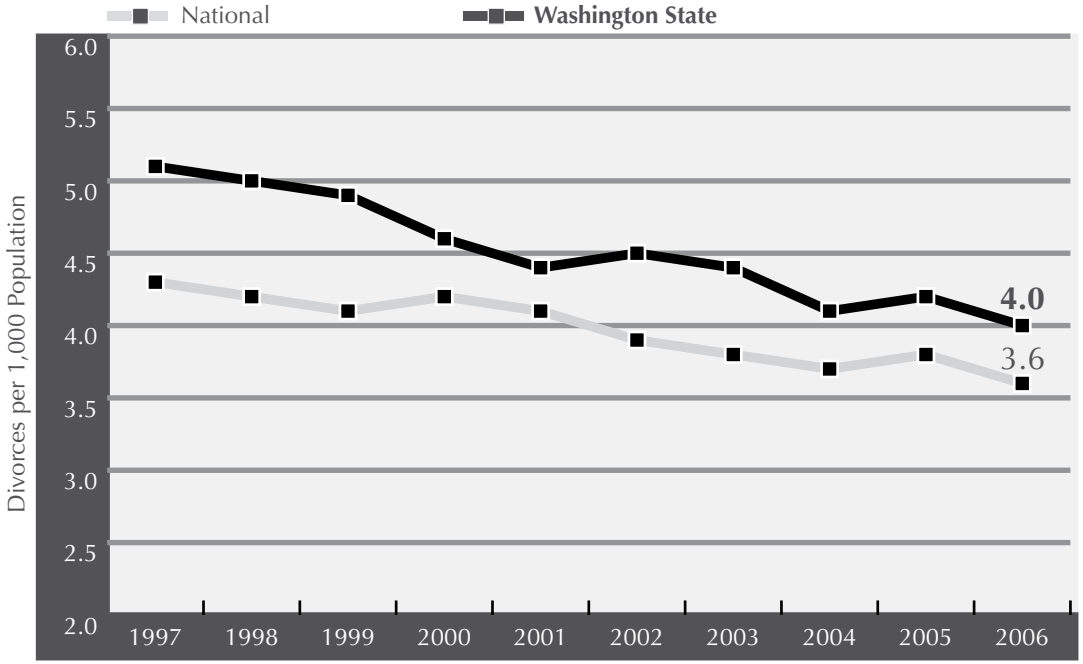
The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

[1] Arrestee Drug Abuse Monitoring Program, Office of Justice Programs, National Institute of Justice. *Drug Use and Related Matters Among Adult Arrestees,2003*. Washington, DC: U.S. Department of Justice. 2004.

The Problem: Substance Abuse Prevalence & Trends



The Divorce Rate in Washington State Has Declined Over the Past Decade.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

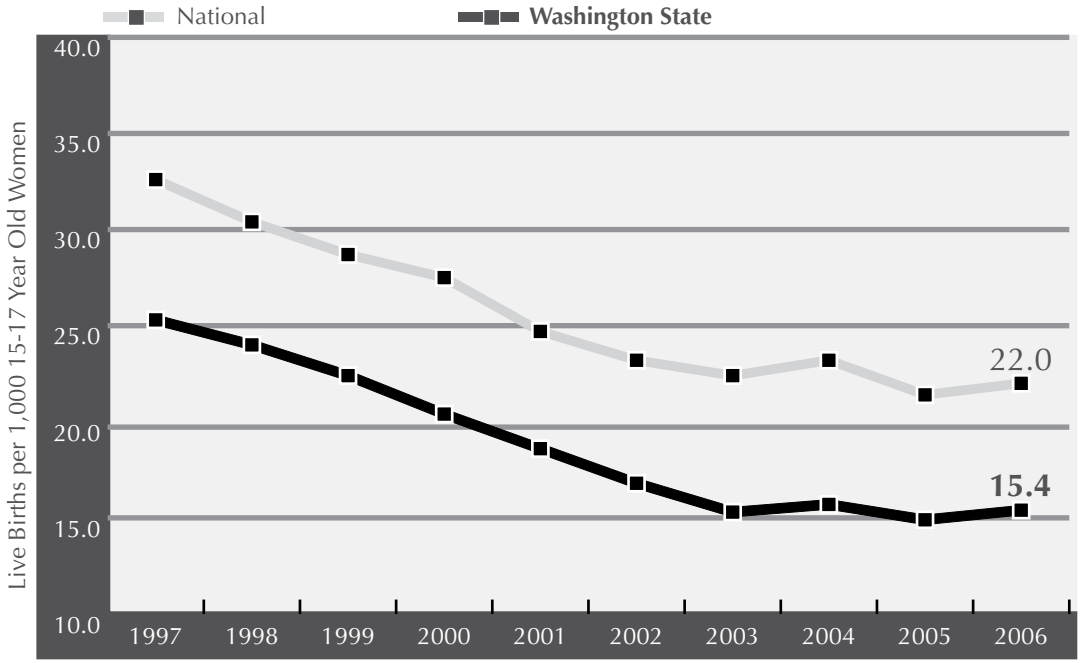
Studies indicate that children from homes broken by marital discord are at a higher risk of drug use.[1]

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationally. In 2006, at least 52.1% of the 25,313 divorces in Washington State involved families with children.[2] Nationally and in Washington State, the divorce rate is at its lowest point in more than three decades. Caution must be exercised in interpreting divorce rates, as they are computed based on the total population, rather than upon the number of individuals actually married.

[1] Kabel, J. et al. *Profile on Risk and Protection for Substance Abuse Planning in Washington State.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, 1997.
[2] Washington State Department of Health, Center for Health Statistics, 2007.

NEW/CHANGING TREND

In 2006, the Birth Rate Among Teens Ages 15-17 in Washington State and Nationally Rose for the First Time Since 1991.



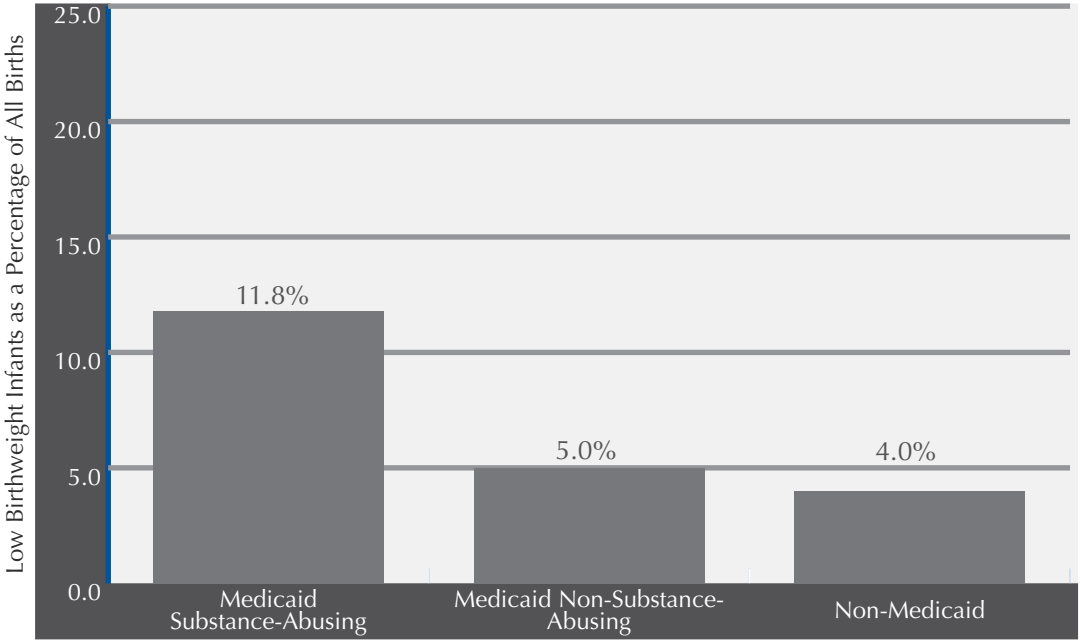
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Teen pregnancy has long been associated with alcohol and other drug use. In a survey of women in Washington State who were 18 years old or younger at the time of their first pregnancy, almost one-quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.[1] Alcohol and drug use in pregnancy is closely associated with a range of health effects among children, including Fetal Alcohol Spectrum Disorders and mental retardation. Maternal age is also a significant risk factor for infant mortality.[2]

This graph indicates that the rate of births per thousand among teens ages 15-17 is lower in Washington State than the nation, but rose significantly in 2006. In 2006, there were 2,062 live births to women ages 15-17 in Washington State, representing a 4.9% increase over 2005. Some 157 of these infants already had at least one older sibling.[3] It is estimated that teen pregnancy (ages 19 and younger) cost Washington State $115 million in 2004 ($43 million in federal funds; $72 million state and local). Nationally, the cost is estimated annually at $9.1 billion.[4]

[1] Boyer, D., & Fine D. "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 241(1), 1992, 4-12.
[2] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-3. Washington, DC: 2000.
[3] Center for Health Statistics, Washington State Department of Health, 2008.
[4] Hoffman, S. *By the Numbers: The Public Costs of Teen Childbearing.* Washington, DC: National Campaign to Prevent Teen Pregnancy, 2006.

Infants Born to Low-Income, Substance-Abusing Women are Much More Likely to Be Low Birthweight.



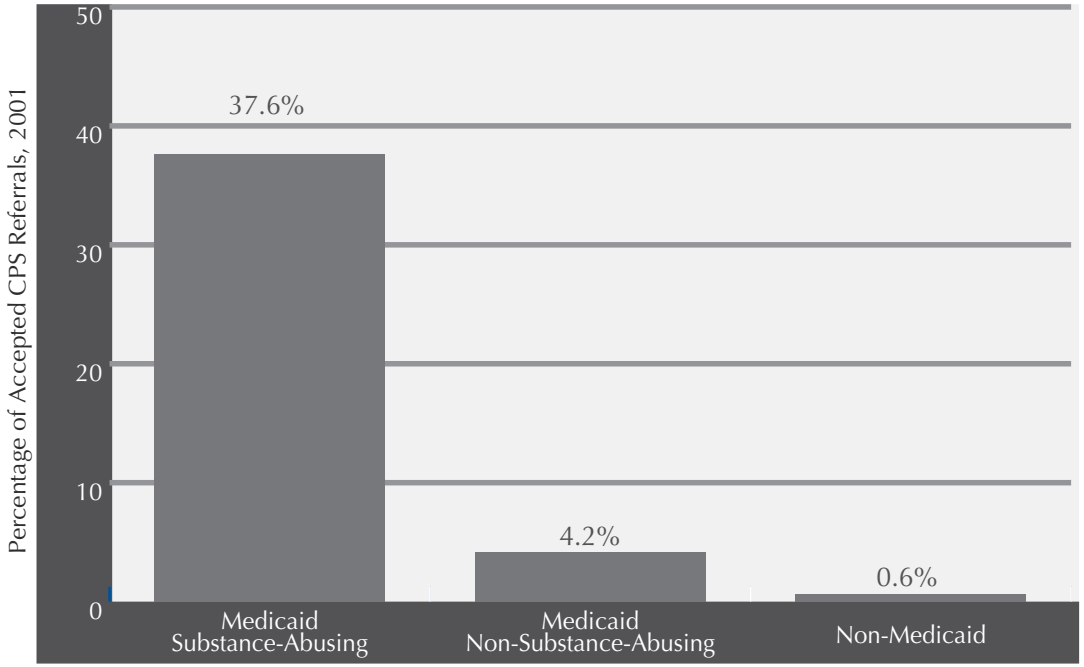
Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Infants born to low-income, substance-abusing mothers are substantially more likely to be born with low birth weight (LBW), weighing less than 2,500 grams (5 pounds, 8 ounces). This includes those who are born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.[1]

Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.[2]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC: 2000.
[2] Krohn, M. "Preliminary Findings for MOMS Project," *Focus, 1993*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny, F., and Cawthon, L. *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

Infants Born to Low-Income Substance-Abusing Women are More Likely to Be Reported to Child Protective Services as Being at High Risk of Imminent Harm.

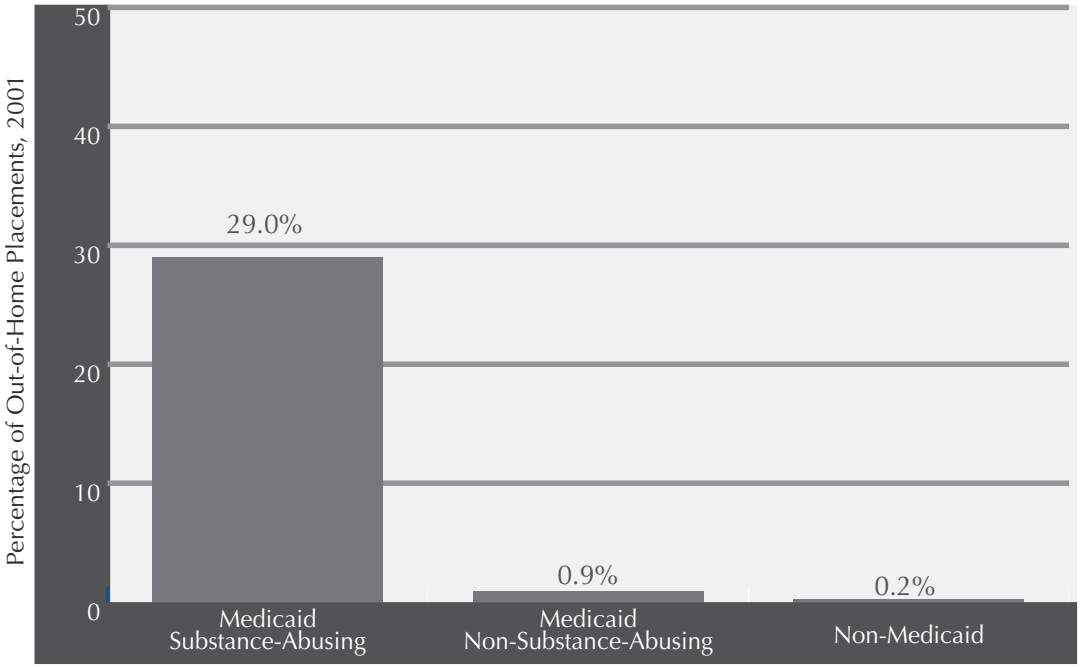


Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 2006 Child Maltreatment Report from the federal Children's Bureau found 905,000 substantiated cases of child maltreatment nationwide. Some 64% of reports were for neglect; 16% for physical abuse; 9% for sexual abuse; and 7% for psychological abuse. An estimated 1,530 children died due to child abuse or neglect in 2006, including nine in Washington State.[1]

[1] Children's Bureau, *Children Maltreatment 2006*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2008.

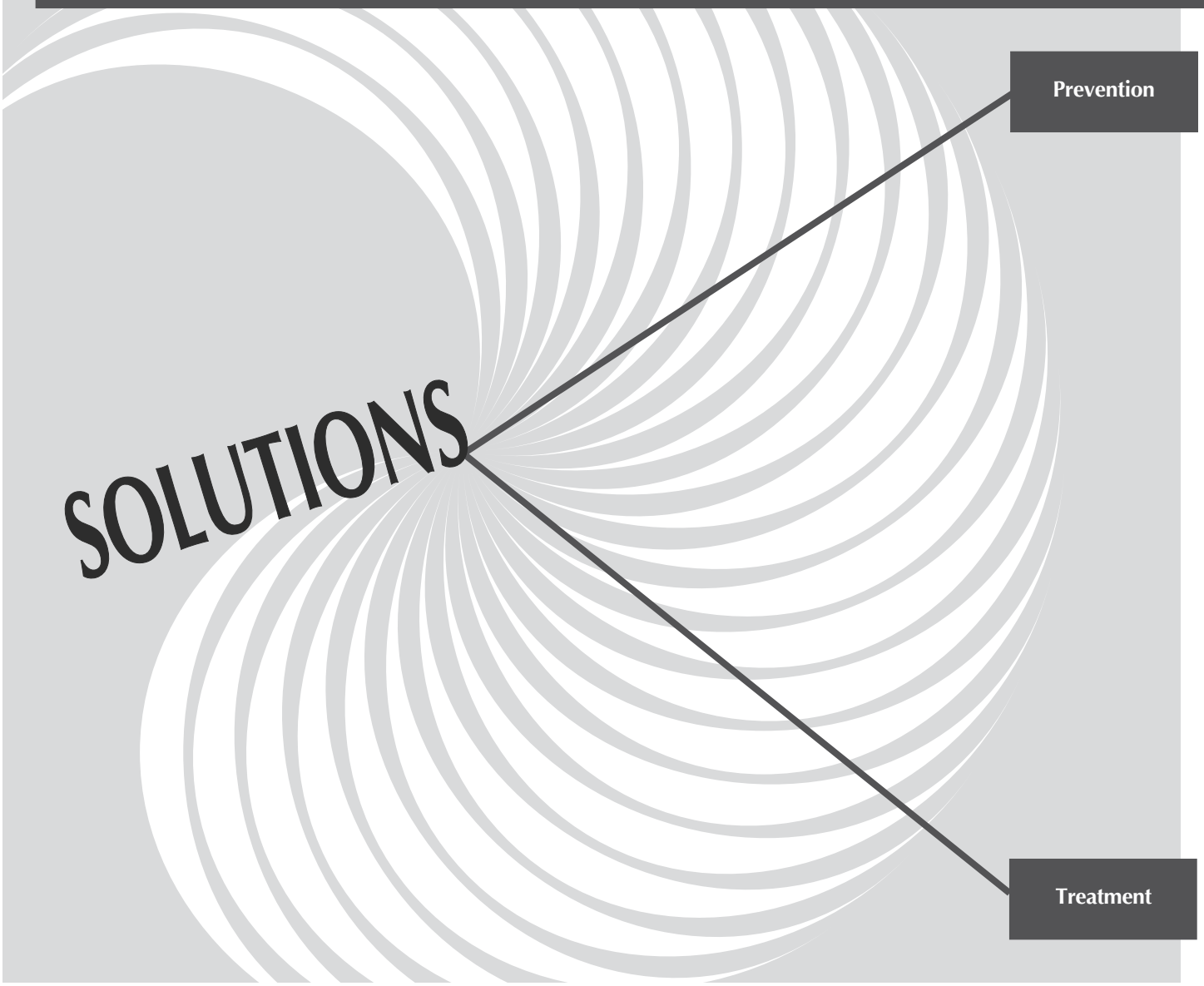
Infants Born to Low-Income, Substance-Abusing Women are More Likely to Be Placed Out of Home.



Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Women receiving Medicaid who are substance abusers are some 30 times more likely to have their infants removed from their care by Child Protective Services and placed out-of-home than women on Medicaid who are not substance abusers. Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect.

Solutions: Substance Abuse Prevention & Treatment



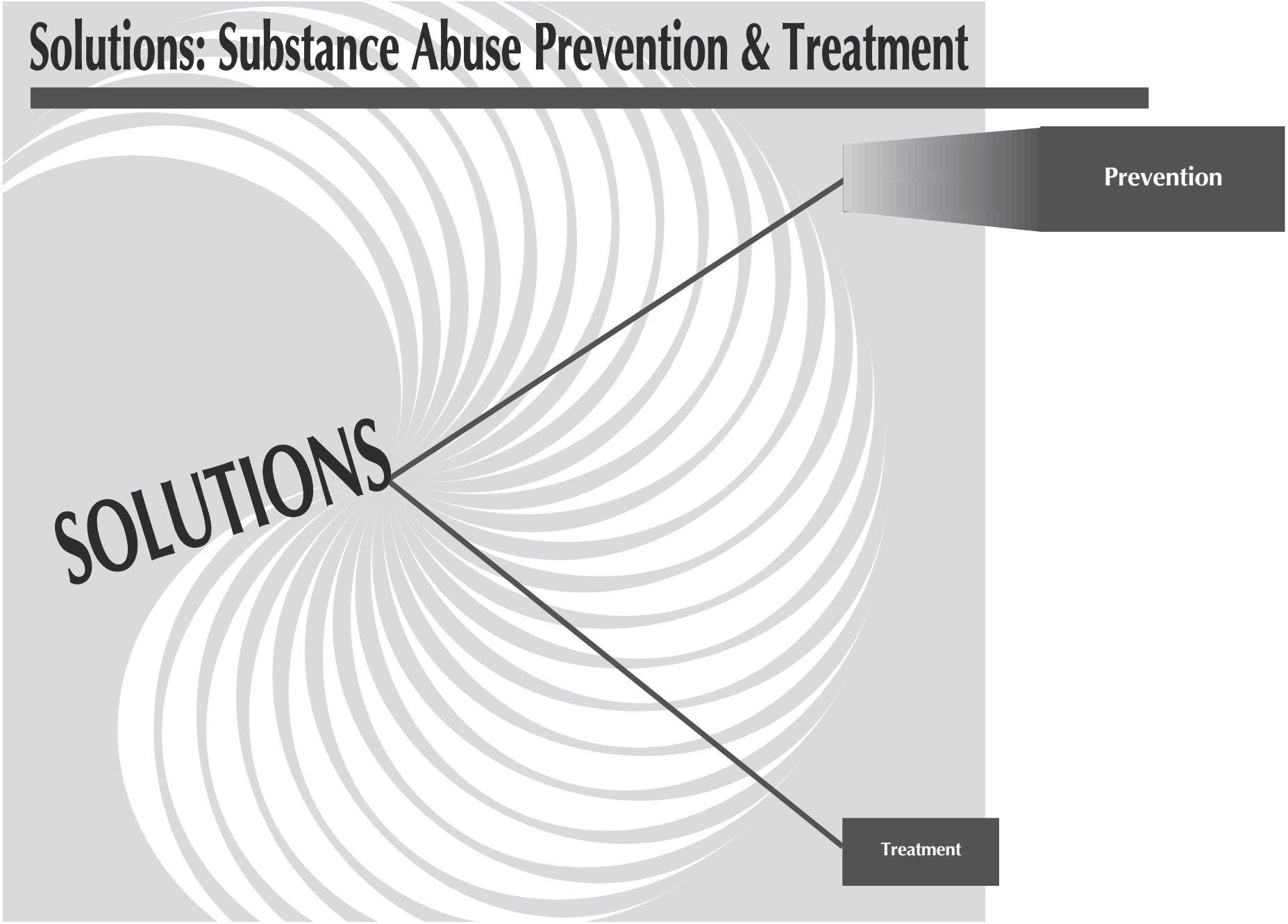
Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the "single state" agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention, intervention, treatment, and aftercare service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on available funding, and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment



Prevention

Washington's youth are faced with choices every day that may result in a variety of problem behaviors. Among the most dangerous of those behaviors is the abuse of alcohol, tobacco, and other drugs. It is the Division of Alcohol and Substance Abuse's (DASA) policy that any use of illicit drugs and the inappropriate use of legal drugs, including alcohol, are considered drug abuse. DASA's goal for the majority of prevention programs it supports is two-fold: programs should act to *delay* the onset of alcohol and tobacco use, and also act to *prevent* the abuse of alcohol, tobacco, and other drugs.

DASA contracts with counties and tribes to provide services at the community level. The Risk and Protective Factor Framework is the cornerstone of all program investments.

Risk and Protective Factor Framework

Over the past two decades, much research has focused on determining how drug abuse begins and how it progresses. Just as medical researchers have found risk factors for heart disease (e.g., lack of exercise, smoking), prevention research has identified a set of risk factors and protective factors related to drug abuse. The more risk factors a child is exposed to, the more likely the child will abuse drugs, alcohol, or tobacco. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years. At each stage, risks exist that can be mitigated through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which, in turn, put children at further risk for drug abuse later in life.

Many risk factors associated with adolescent substance abuse are also tied to other problem behaviors, including: delinquency, teen pregnancy, school dropout, violence, and depression/anxiety. While the primary focus of prevention programs supported by DASA is substance abuse, addressing its risk factors will likely impact multiple problem behaviors.

Not every young person who is exposed to multiple risks becomes a substance abuser, juvenile delinquent, school dropout, or teen parent. There are conditions – known as protective factors – that can counter the risks. Protective factors are buffers in the lives of young people that either reduce the impact of the risk or change the way a person responds to the risk. A strong parent-child bond is an example of a protective factor. When children are strongly attached to positive families, friends, schools, and communities, they are more likely to be committed to achieving the goals valued by these groups and are less likely to develop problems as a teenager.

Risk and protective factor-focused prevention programs are based on a simple premise: to prevent a substance abuse problem, we must identify those factors that increase the likelihood of that problem developing and then intervene in ways that reduce the risk. At the same time, we must identify protective factors that buffer individuals from the risks present in their environments and then find ways to strengthen that protection.

Risk and protective factors fall into four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage in or experience problem behaviors can be substantially reduced.

The four domains are: community, family, school, and individual/peer.

Risk Factors and Adolescent Problem Behavior

RISK FACTORS BY DOMAIN ▼	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression/ Anxiety
Community						
Availability of Drugs	■				■	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	■	■			■	
Transitions and Mobility	■	■		■		■
Low Neighborhood Attachment and Community Disorganization	■	■			■	
Extreme Economic Deprivation	■	■	■	■	■	
Family						
Family History of the Problem Behavior	■	■	■	■	■	■
Family Management Problems	■	■	■	■	■	■
Family Conflict	■	■	■	■	■	■
Favorable Parental Attitudes and Involvement in the Problem Behavior	■	■			■	
School						
Academic Failure Beginning in Late Elementary School	■	■	■	■	■	■
Lack of Commitment to School	■	■	■	■	■	
Individual/Peer						
Early and Persistent Antisocial Behavior	■	■	■	■	■	■
Rebelliousness	■	■		■		
Friends Who Engage in the Problem Behavior	■	■	■	■	■	
Favorable Attitudes Toward the Problem Behavior	■	■	■	■		
Early Initiation of the Problem Behavior	■	■	■	■	■	
Constitutional Factors	■	■			■	■
Gang Involvement	■	■			■	

Source: Social Development Research Group, University of Washington.

DASA Prevention Programs Achieve Cost Offsets.

Funds spent on prevention services are a sound investment in reducing taxpayer burdens in future years.

Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provides a cost-benefit analysis and comparison of prevention programs. By and large, prevention programs save money through reduced costs associated with alcohol abuse and drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant.[1]

Division of Alcohol and Substance Abuse (DASA) prevention providers utilize many of the programs researched, as described on the following pages. By selecting programs with proven research results behind them, DASA prevention providers save Washington State taxpayers millions of dollars.

Several thousand additional participants were in programs not analyzed in the WSIPP study. All DASA prevention programs conform to the standards of the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse* Prevention[2] to ensure quality programming.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.
[2] Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Division of Knowledge Development and Education, 2001. Details of the principles can be found at www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

DASA Prevention Programs Save the State Millions of Dollars Over the Lifetimes of the Participants.

SFY 2008

Program Name	Net Lifetime Cost Benefit per Participant*	DASA Participants**	Total Lifetime Cost Benefit
All Stars	$120	176	$21,120
CASASTART	($610.00)	38	-$23,180
Guiding Good Choices/Preparing for the Drug Free Years	$6,918	306	$2,116,908
Home Visiting	$6,077	10	$60,770
Life Skills Training Program	$717	4,025	$2,885.925
Mentoring: Big Brothers/Big Sisters	$2,822	8	$22,576
Parents as Teachers	$800	29	$23,200
Project ALERT	$54	2,023	$109,242
Project Northland	$1,423	635	$903,605
SMART Leaders	$485	12,827	$6,221,095
Strengthening Families Program: Ages 6-11	$485	213	$103,305
Strengthening Families Program: Ages 10-14	$5,805	950	$5,514,750

Total: $17,959,316

Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provides a cost-benefit analysis and comparison of prevention programs. By and large, prevention programs save money through reduced costs associated with alcohol use and drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant.[1] By multiplying the cost benefit per participant by the number of participants in these Division of Alcohol and Substance Abuse-funded programs in SFY 2008, the total lifetime cost benefit to the state is estimated at almost $18 million.

*Source: Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington Institute for Public Policy (WSIPP), 2004.
** Calculated by multiplying the number of participants enrolled in each program by the cost savings per participant listed in the WSIPP report.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.

DASA Prevention Programs Save the State Money.

The following programs found to provide significant cost benefits to taxpayers by the Washington State Institute on Public Policy[1] are being implemented in the state:

All Stars reinforces the belief that risky behavior is not normal or acceptable by the adolescent's peer group. It also cultivates the belief that risky behavior does not fit with the youth's personal ideals and future aspirations, creates strong voluntary personal and public commitments to not participate in risky behaviors, and strengthens relationships between the adolescent, social institutions, and family.

Big Brothers/Big Sisters is a mentoring program which matches an adult volunteer to a child, with the expectation that a caring and supportive relationship will develop. Support of that match through ongoing supervision and monitoring by a professional staff member is an important component.

CASASTART (Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered substance abuse and violence prevention program aimed at high-risk 8-13-year-olds, their families, and the neighborhoods in which they live. The program brings together key stakeholders in the community – schools, law enforcement agencies, social services and health organizations – and uses intensive case management to work with youth.

Guiding Good Choices™, formerly known as Preparing for the Drug Free Years, is a multi-media program that provides parents of children in 4th through 8th grades the knowledge and skills they need to guide their children through early adolescence. The program aims to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and to resist alcohol, tobacco, and other drug use.

Home Visiting provides a bridge between a parent with a young child and the outside world by way of a visitor who cares about child-raising. The visitor may provide cognitive information, emotional support, or both. Visitors can be nurses, social workers, preschool teachers, psychologists, or paraprofessionals.

LifeSkills® Training is a 3-year prevention curriculum designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. It is intended for middle school or junior high students.

Parents as Teachers is an early childhood parent education and family support program serving families from pregnancy through kindergarten. The program provides personal visits with certified parent educators, group meetings with other parents, developmental screenings, and linkages to community resources.

Project ALERT is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets tobacco, alcohol, and marijuana use.

DASA Prevention Programs Save the State Money.

Project Northland consists of social-behavioral curricula in schools, peer leadership (designed to increase peer pressure resistance and social competence skills), parental involvement/education, and community-wide taskforce activities aimed at changing the larger environment.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) provides a full range of substance use prevention and early intervention services. It places highly trained professionals in schools to work with high-risk youth 14-18 years old.

Strengthening Families Program (SFP) involves elementary school-aged children (6 to 11 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by: improving family relationships, improving parenting skills, and increasing the youth's social and life skills.

The Strengthening Families Program (ages 10-14), resulted from an adaptation of the Strengthening Families Program (SFP). Formerly called the Iowa Strengthening Families Program, the long range goal of the curriculum is reduced substance use and behavior problems during adolescence. Intermediate objectives include improved skills in nurturing and child management by parents, improved interpersonal and personal competencies and pro-social skills among youth.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy, 2004.

School-Based Prevention Stratagies

Many of the evidence-based prevention practices used across Washington State are based in schools, usually as part of the health education curriculum. Schools make the investment in time and resources that prevention programs require because of the link between substance use and academic outcomes. The direction of that link is not clear. That is, researchers cannot say that substance use causes academic problems, nor that academic problems lead to substance use. The relationship is more complex than that, and it likely changes at different grade levels as challenges change. However, research has demonstrated that students who initiate substance use before seventh grade are at higher risk of school failure, poor academic achievement, and school dropout.[1]

Prevention programs that are best practices used with younger children focus on social-emotional competence, promoting skills to inhibit impulsive behavior, regulate feelings, and correctly interpret the perceptions of others. Children who do not master these developmentally appropriate social tasks may develop behaviors that put them at considerable risk for later problems such as delinquency, substance abuse, and school dropout.[2]

Best-practice middle school programs also focus on social competence. Competence-enhancement approaches to prevention work with the assumption that adolescents lacking in social skills are more susceptible to influences that promote drug use, and may be motivated to use drugs as an alternative to more adaptive coping strategies.[3] These programs emphasize the teaching of generic social and personal skills such as communication, assertiveness, decision-making, goal-setting, self-control, and coping. The same skills that help youth to resist drug use help them to maintain commitment to school and other pro-social behaviors.

[1]Ellickson, P., Tucker, J., & Klein, D. "High-Risk Behaviors Associated with Early Smoking: Results from a 5-Year Follow-Up, "*Journal of Adolescent Health* 28, 2001; Fleming, C., et al., "Do Social and Behavioral Characteristics Targeted by Preventive Interventions Predict Standardized Test Scores and Grades?" *Journal of School Health* 75, 2005.
[2]Flory, K., et al. "Relation Between Childhood Disruptive Behavior Disorders and Substance Use and Dependence Symptoms in Young Adulthood: Individuals with Symptoms of Attention-Deficit/Hperactivity Disorder are Uniquely At Risk," *Psychology of Addictive Behaviors* 17, 2003; Greenberg. M., et al., "The PATHS Curriculum: Theory and Research on Neuro-Cognitive Development and School Success," in Zins, J., Weisberg, R., & Walber. J. (eds.) *Building School Success on Social and Emotional Learning*. New York: Teachers College Press, 2004; White, H., et al., "Psychopathology as a Predictor of Adolescent Drug Use Trajectories." *Psychology of Addictive Behaviors* 15, 2001.
[3]Botvin. G. "Preventing Drug Abuse in Schools: Social and Competence Enhancement Approaches Targeting Individual-Level Etiological Factors," *Addictive Behaviors* 25, 2000.

School-Based Programs in Use in Washington State

PAL® (Peer Assistance and Leadership) includes the following: group and one-to-one peer tutoring and mentoring; facilitation of activities and group discussions on issues such as substance use and career choices; peer mediation and conflict resolution services; development and participation in community service projects. The programs seek to develop communication, decision-making, problem-solving, team and relationship building, confidentiality, and refusal skills.

Positive Action aims to improve the academic achievement and behavior of children and adolescents. It is intensive, with lessons at each grade level from kindergarten through 12th grade that are reinforced all day, school-wide, at home, and in the community.

Second Step is a classroom-based social skills program for preschool through junior high students. It aims to reduce aggressive behaviors and increase children's social-emotional competence.

Sembrando Salud is a culturally sensitive tobacco and alcohol use prevention program specifically adapted for migrant Hispanic youth and their families. The program enhances parent-child communication skills as a way of improving and maintaining healthy youth decision-making. It uses a school and family curriculum delivered by bilingual/bicultural college students.

Storytelling for Empowerment uses stories to pass on values and cultural identity and as such is a natural vehicle for nurturing protective factors in youth. It is school-based secondary prevention designed for club and classroom settings serving American Indian and Latino middle school youth.

Too Good for Drugs (TGFD) is a K-12 multifaceted, interactive social influence intervention. The program is a long-term intervention that builds skills sequentially with the intention of preventing substance use and promoting healthy decision-making and positive, healthy youth development. This program is designed to benefit everyone in the school by enhancing social and emotional competencies.

Tutoring improves academic success among elementary school students who have serious academic problems in reading and/or mathematics.

Other Best and Promising Practices in Use in Washington State

BASICS (Brief Alcohol Screening and Intervention of College Students) is a preventive intervention aimed at students who drink alcohol heavily and have experienced or are at risk of experiencing alcohol-related problems, such as poor class attendance, missed assignments, accidents, sexual assault, and violence.

Birth to Three is designed for a broad range of parents with infants and young children (0-7 years of age). The mission is to strengthen families and promote the well-being of children through parent education and support.

Communities Mobilizing for Change on Alcohol works to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. The intervention approach involves activating the citizenry of communities to achieve changes in local public policies.

Communities That Care provides research-based tools to help communities mobilize to promote the positive development of children and youth and to prevent adolescent problem behaviors that impede positive development, including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

Community Trials Intervention to Reduce High-Risk Drinking is a multi-component, community-based program developed to alter alcohol use patterns of people of all ages (e.g., drinking and driving, underage drinking, binge drinking), and related problems.

Creating Lasting Connections (CLC) is a comprehensive family strengthening curriculum that assists youth and families in high-risk environments to become strong, healthy, and supportive people.

Houston Parent-Child Development Center was developed to assist low-income, Mexican-American families in helping their children do well in school and foster intellectual and social competence. The program was designed to provide a wide range of educational and support services, to deliver these services in ways that are responsive to the families' poverty, and to be sensitive to people's culture.

Incredible Years is a family program designed to improve parents' communication skills with their children, learn limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short term objectives include reduction of the frequency and number of conduct problems and improvement of pro-social skills.

Prevention Best Practices By County

The table below displays prevention best practices being utilized in the 2007-2009 Biennium by each of Washington State's 39 counties:

Program ▼ / COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston-Mason	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima
All Stars									■		■	■			■							■														
BASICS (Brief Alcohol Screening & Intervention of College Students)												■																								
Birth to Three Program															■																					
CASASTART													■													■										
Communities Mobilizing for Change on Alcohol																																			■	
Communities That Care								■				■			■													■								
Community Trials Intervention to Reduce High-Risk Drinking																					■								■							
Creating Lasting Connections (CLC)															■																					
Friendly PEERsuasion												■																								
Great Body Shop																								■												
Guiding Good Choices															■									■						■		■				
Home Visiting					■										■														■							
Incredible Years					■										■																					■
Keep A Clear Mind												■										■	■									■				
Let Each One Teach One																																			■	
Life Skills Training Program				■					■	■	■				■		■			■			■	■				■	■	■		■	■			■
Make Parenting a Pleasure															■																					
Mentoring: Big Brothers / Big Sisters						■							■		■			■						■			■	■			■			■		
NICASA Parent Project		■																																		
Nurturing Program		■				■									■				■										■						■	
PAL Peer Assistance and Leadership																								■												

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Prevention Best Practices By County

The table below displays prevention best practices being utilized in the 2007-2009 Biennium by each of Washington State's 39 counties:

Program ▼ / COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston-Mason	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima
Parenting Skills Program															■																					
Parenting Wisely	■				■						■						■	■													■					
Parents as Teachers																																			■	
Positive Action																													■							
Project ALERT	■		■							■				■	■							■					■			■	■			■		■
Project Northland				■			■																								■					
Project SUCCESS																																				
Protecting You/Protecting Me														■						■											■					
Retailer-Directed Interventions												■																								
Say It Straight																												■								
Second Step: A Violence Prevention Curriculum				■																									■							
Sembrando Salud																										■										
Staying Connected with Your Teen														■								■														
Strengthening Families Program						■		■																												■
Strengthening Families Program: 10-14		■	■	■			■	■	■		■	■				■		■		■			■	■	■	■	■		■	■	■			■	■	■
Strengthening Multi-Ethnic Families & Communities															■									■				■								
Tribes Learning Communities																								■												
Tutoring										■						■								■			■		■							

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Using Prevention Science

Most participants enrolled in prevention programs funded by the Division of Alcohol and Substance Abuse (DASA) receive services proven to be effective in reducing substance use and other problem behaviors. DASA stresses the use of strategies scientifically proven to reduce substance abuse, while at the same time recognizing the importance of local innovation to develop programs for specific populations or emerging problems.

Best Practices

Best practices are those strategies, activities, or approaches that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. DASA utilizes best practices listed by the Center for Substance Abuse Prevention, Western Center for the Application of Prevention Technologies. This list includes programs deemed research-based by scientists and researchers at: National Institute of Drug Abuse; Center for Substance Abuse Prevention; National Center for the Advancement of Prevention; Office of Juvenile Justice and Delinquency Prevention; and the federal Centers for Disease Control and Prevention.

Promising Practices

Promising practices are programs and strategies that have some quantitative data indicating positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes.

Innovation

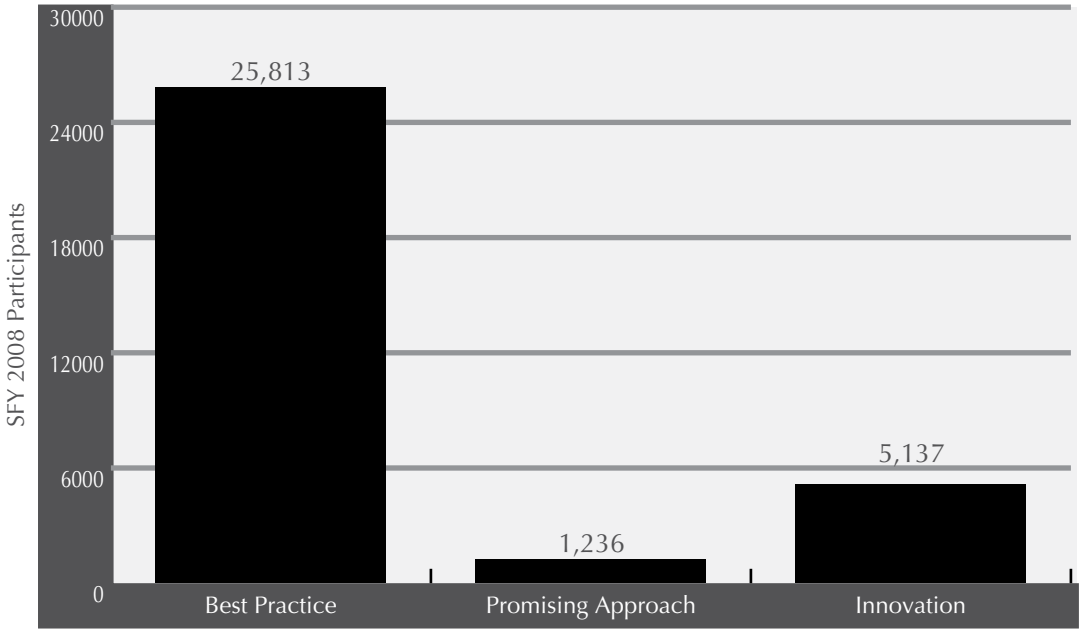
Innovative programs and strategies are developed locally to address a specific need or issue. Development is guided by proven principles of effectiveness. These programs have generally not undergone the rigorous scientific review of a best practice.

Principles of Effective Substance Abuse Prevention

In Washington State, DASA contracts with county prevention providers. Providers are required to use scientifically based best or promising practices for a least 50% of programming. In SFY 2008, 72% of DASA-funded prevention programs represent best or promising practices. When choosing to design and implement other programs, providers are required to refer to the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse Prevention* and apply these principles to their work in communities.[1]

[1] Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Division of Knowledge Development and Education, 2001. Details of the principles can be found at www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

The Majority of Participants in DASA-Funded Prevention Programs are in Programs Using Best Practices.



Source: Washington State Performance-Based Prevention System.

The Division of Alcohol and Substance Abuse stresses the use of proven strategies to reduce substance abuse, while recognizing the importance of local innovation to develop programs for specific populations or emerging problems. Best practices are strategies, activities, or approaches which have been shown scientifically to prevent and/or delay substance abuse. Promising practices have some quantitative data demonstrating positive outcomes, but not enough research or replication to support generalizable outcomes. Innovative programs or strategies are developed locally to address a specific need or issue.

Statewide Prevention Services and Programs

The Division of Alcohol and Substance Abuse (DASA) funds statewide services primarily by way of interagency agreements and partnerships with state agencies and non-profit organizations. The following programs are either partially or fully funded by DASA:

School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. During SFY 2008, more than 300 Prevention/Intervention Specialists implemented programs in nine Educational Service Districts and three school districts. These services were offered in all the regions of the state and were delivered to 12,890 kindergarten through twelfth grade students.

Healthy Youth Survey

OSPI administers an adolescent health behavior survey every other year. Substance abuse prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2006 Healthy Youth Survey was the ninth time health-related attitudes and behaviors of Washington's public school students have been assessed. More than 198,000 students in elementary, middle, and high schools across the state participated in the survey.

Reducing Underage Drinking Initiative (RUaD)

RUaD's goal is to prevent or reduce the consumption of alcohol by minors, especially through increased enforcement of underage drinking laws. The RUaD program has received annual block grant awards since 1998 from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The block grants have supported public education efforts, Liquor Control Board enhancements, a RUaD track and/or workshops at the State Prevention Summit, youth leadership activities, and community-based coalitions. In addition to the block grants, DASA is the recipient of three discretionary grants. These funds support the efforts of communities as they implement comprehensive approaches to the problem of underage drinking, with an emphasis on increasing law enforcement activity. The Washington State RUaD Coalition, with membership of 24 state agencies and statewide organizations, is actively pursuing its mission largely through the efforts of three subcommittees. One is focused on communication strategies to change parental norms about their children's alcohol use; the second is designing ways to encourage local law enforcement and the criminal justice system to address this issue; and the third is developing a community action tool to address alcohol industry marketing to youth.

Reducing Access to Tobacco Products (Synar Regulation)

The Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The Synar Regulation requires that states reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. Washington's success in meeting the Synar requirements is due to DASA's positive and effective relationship with two other state agencies, the Department of Health (DOH) and the Liquor

Control Board. DOH develops a randomized list of tobacco retailers in the state and then asks local health jurisdictions to implement unannounced youth access compliance checks. Local health jurisdictions are responsible for implementing the Synar compliance checks assigned to them through the statewide sampling. They report the results of the checks back to DOH. In 2007, the non-compliance rate was 9.5%.

College Coalition for Substance Abuse Prevention

Central Washington University facilitates the College Coalition for Substance Abuse Prevention. Coalition members administer campus-based prevention services targeting students and university communities. The College Coalition was established to develop, implement, and continue substance abuse prevention programming at all college and university campuses in Washington State. The Coalition meets four times each academic year, and sponsors training opportunities that support the findings from the survey of college and university student alcohol and other drug use published in 2004.

Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school. CTI counties include Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, and Spokane. These counties have developed mentoring programs based on a nationally recognized model. In addition, parents and families are enrolled in family strengthening programs. Since 2005, CTI has used an innovative evaluation strategy for the mentoring component of the program, and found that high quality mentoring relationships were formed, and youth participants showed improvement in a variety of attitudes and behaviors, including school performance.

Alcohol/Drug Clearinghouse

DASA funds the Alcohol/Drug Clearinghouse to provide a wide range of timely resource material and information for Washington State residents, including non-English-speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for requesting resources, including a system for receiving requests by telephone from the hearing-impaired community, a website, and a video lending library. Requests for information or materials are usually processed within 24 hours. The Clearinghouse also maintains an electronic newsletter to communicate federal, state, and local prevention news and activities/campaigns to individuals and organizations in Washington State. During the 2005-2007 Biennium, the Clearinghouse distributed over 800,000 resource items, and made resources available to over 250 community and school-based events. For more information about Clearinghouse resources, call 1-800-662-9111.

Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, including individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the nominations and approves those meeting the selection criteria. Members of the

committee also nominate and select additional awardees for their special contributions to the field. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level. The awards process is conducted in cooperation with the Lieutenant Governor's Office, the Citizens Advisory Council on Alcoholism and Drug Addiction, and the Washington Interagency Network.

Public Education and Media Program

DASA's Public Education Program provides educational materials and technical assistance to communities in Washington State about drug abuse impacts, trends, prevention, intervention, treatment and aftercare. DASA also implements statewide public education media campaigns with support from state, federal and national organizations and media partners. During SFY 2008, the value of donated advertising and news media coverage for DASA's public education program totaled $345,000.

Educational materials can be downloaded from DASA's Public Information webpage, and ordered free of charge from the Washington State Alcohol/Drug Information Clearinghouse. Priority education initiatives during the 2007-2009 Biennium include: educating parents about reducing underage drinking (www.StartTalkingNow.org); problem gambling prevention and treatment (www.notagame.org); and treatment expansion (www1.dshs.wa.gov/dasa).

The Alcohol and Drug 24-Hour Help Line and Teenline

The Alcohol and Drug 24-Hour Help Line (1-800-562-1240) and Teenline (1-877-345-8336) provide statewide crisis services and referrals to treatment and recovery programs. They provide education and intervention assistance to individuals, families, and social and health professionals. Volunteers receive extensive training in crisis counseling before they begin providing services on the Help Line or Teenline.

The Help Line is also a key partner in state and local initiatives such as increasing access to treatment and recovery, reducing stigma, and providing domestic violence outreach. During 2007, the Help Line assisted nearly 18,000 callers through the help of volunteers who donated 2,392 hours of time. More information about the Help Line, including statewide trend data from callers, is available online: www.adhl.org

Washington State Prevention Summit

DASA coordinates, and is the primary funding source for, an annual statewide substance abuse prevention conference. The conference attracts prevention professionals, community members, school personnel, parents, students, faith-based organizations, law enforcement, and mental health and treatment professionals. Conference planning is a collaborative effort with the Governor's Substance Abuse Advisory Committee, the Lieutenant Governor's Office, the Department of Health, the Office of Superintendent of Public Instruction, TOGETHER! of Thurston County, Community Trade and Economic Development, Washington State National Guard Demand Reduction Program, Reducing Underage Drinking Initiative, and the Washington State Mentoring Partnership.

Drug Free Communities

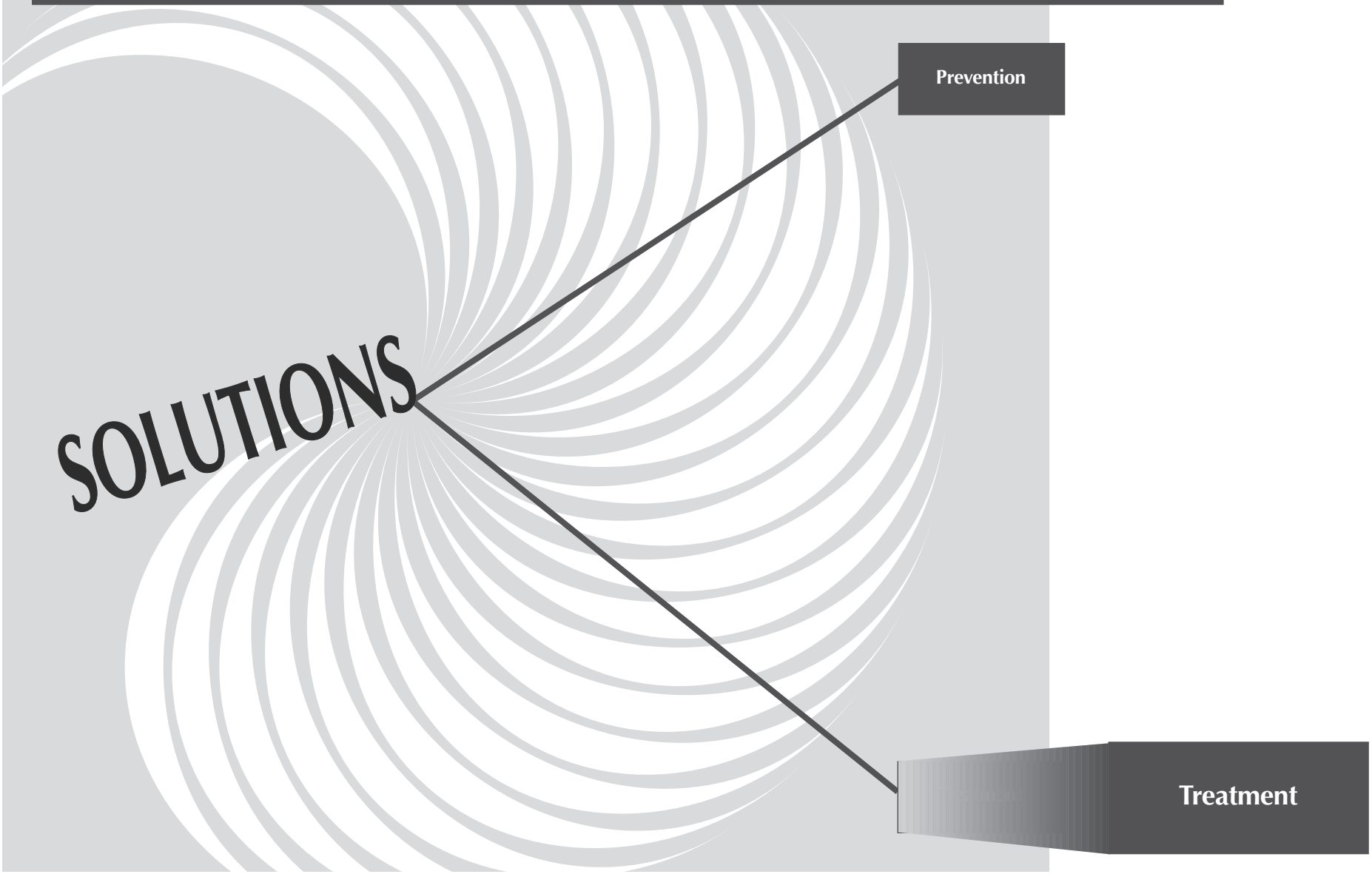
Thirty community coalitions in Washington have received annual grants of up to $100,000 each from the federal Drug Free Communities Support Program, funded by the White House Office of National Drug Control Policy. The intent of the program is to reduce substance abuse through engaging coalitions in effective community-wide change initiatives. A broad range of communities receive this competitive funding – from inner city Cambodian communities of Seattle, to the rural and isolated community of Quincy in Grant County.

The coalitions have formed a network that shares information, support, and training opportunities with each other. DASA hosts a meeting for the network of Washington Drug Free Communities (DFC) grantees twice a year. Grantees meet in the fall during the Prevention Summit, and are invited to attend a workshop each spring sponsored by DASA to build capacity to apply for this funding. The DASA liaison with the DFC program is available to provide technical assistance, and support existing coalitions as well as encourage new coalitions to form.

State Prevention Framework-State Incentive Grant (SPF-SIG)

In October 2004, Washington received a State Prevention Framework-State Incentive Grant (SPF-SIG) through the Center for Substance Abuse Prevention for $2.35-million per year for five years. The goals of the grant are to: 1) Prevent the onset and reduce the progression of substance abuse, including underage drinking; 2) Reduce substance-related problems in communities; 3) Build prevention capacities and infrastructure at state and community levels; and, 4) Implement a process of infusing data across all SPF steps for improved decision-making. Washington's SPF-SIG project is focused on reducing underage drinking in 12 communities and on enhancing agency cooperation at the state level.

Solutions: Substance Abuse Prevention & Treatment



Introduction

Individuals are eligible for DASA-funded services if they are low-income (generally below 200% of the Federal Poverty Level) or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Additional funds have been allocated to expand treatment access to those who have primary Medicaid eligibility (those receiving General Assistance-Unemployable, General Assistance-Expedited, Supplemental Security Income, and Temporary Assistance to Needy Families). Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating those addicted to alcohol or other drugs. Treatment is also offered for individuals with problem or pathological gambling issues, and is not means-tested.

Contracted treatment and support services include:

- Diagnostic evaluation.
- Alcohol/Drug detoxification.
- Outpatient treatment.
- Opiate substitution (methadone) treatment.
- Intensive inpatient treatment.
- Recovery house.
- Long-term residential treatment.
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction.
- Youth residential treatment.
- Youth outpatient treatment.
- Residential treatment for pregnant and parenting women (with therapeutic childcare).
- Outpatient treatment for pregnant and parenting women (with childcare).
- Treatment for co-occurring disorders.
- Tribal treatment programs.
- Monolingual programs for non-English speakers.
- Treatment program for the deaf/hard of hearing.
- Urine screening.
- Brief interventions and referral from emergency departments.
- Treatment through drug courts.
- Group care enhancement.
- Outpatient treatment for problem and pathological gambling.
- Support services for those accessing treatment and recovery services.
- Alcohol and Drug 24-Hour Help Line.

Specialized contracted support services for eligible individuals include:

- Child care.
- Translation services (including interpreters for persons who are deaf or hard of hearing).
- Transportation assistance.
- Integrated crisis response/secure detoxification services.
- Case management/Intensive case management.
- Youth outreach.
- Cooperative housing (Oxford House) and other transitional housing support.

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children.
- Families receiving Temporary Assistance for Needy Families (TANF).
- Child Protective Services referrals.
- Youth.
- Injection drug users (IDUs).
- People with HIV/AIDS.

DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.[1] As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational cycle of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

[1]See, for example: Wickizer, T., and Longhi, D. *Economic Benefits and Costs Associated with Substance Abuse Treatment Provided to Indigent Clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).* Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse, 1997. See also: Schrager, L. Joyce, J., and Cawthon, L. *Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State.* Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis, 1995.

Substance Use and Current Need for Treatment

Based on the *2003 Washington State Needs Assessment Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, and updated in 2008, 10.8% of the Washington State adult population (age 18 and older) living in households were estimated to be in need of substance abuse treatment in 2007.[1] Treatment need for adolescents (ages 12 to 17) living in households is estimated at 8.7%. (The definition of need for treatment is provided on the following page.)

Alcohol is by far the most used substance in Washington State, and the one for which there is the highest rate of treatment need.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	87.7%	72.6%	57.5%
Any Illicit Drug	44.2%	9.5%	5.6%
Marijuana	41.1%	7.3%	4.3%
Methamphetamine	5.9%	0.3%	0.1%
Cocaine	15.2%	1.1%	0.4%
Heroin	1.6%	0.1%	0.0%

[1] *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2007). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Current Need for Treatment Among Population Subgroups in Washington State

Based on data from the *2003 Washington State Needs Assessment Household Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division and updated for 2007, the current estimated need for treatment varies widely across population subgroups:

- Compared with the overall treatment need rate of 10.8% of adults living in households, some subgroups have lower rates of treatment need. These include: those ages 45-64 (7.7%) and 65+ (1.8%); females (7.1%); African-Americans (10.7%) and Asians (4.7%); and those who are married (7.8%); or widowed (3.6%).
- Other subgroups have higher estimated needs for treatment. These include: those ages 18-24 (23.1%) and 25-44 (13.6%); males (14.6%); American Indians (16.5%) and multi-race individuals (16.4%); and those never married (22.0%).

Need for chemical dependency treatment is associated with income. Adults living in households with incomes above 200% of the Federal Poverty Level (FPL) have lower rates of treatment need (9.8%) than do adults living in households with incomes below 200% FPL (13.5%).

Those classified as in need of chemical dependency treatment in the past year met one or more of the following conditions:

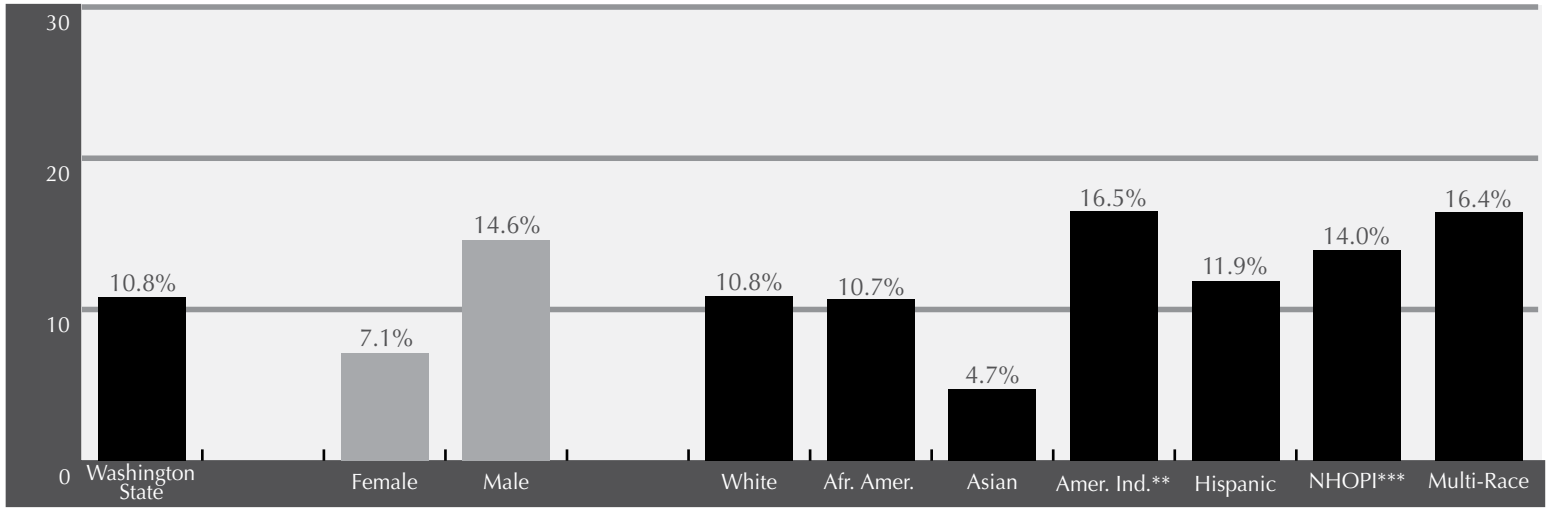
1. Reported life DSM-IV* alcohol or drug abuse or dependence symptoms, reported at least one symptom in the past 12 months, and used alcohol or drugs in the past 12 months.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and were using alcohol or drugs regularly during the past 12 months. Regular alcohol use is defined as having three or more drinks at least one day per week. Regular drug use is defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs eight or more times in the past 12 months.
4. Reported heavy use of drugs or alcohol in the past 12 months. Heavy alcohol use is defined as four or more drinks per drinking day, three or more days per week during the past 12 months. Heavy drug use is defined as using any illicit substance 34 or more times during the past 12 months.

**DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association in 1994. It contains diagnostic criteria for the most common mental disorders, and includes findings on description, diagnosis, treatment, and research.*

More than One Out of Ten Washington State Adult Residents is in Need of Chemical Dependency Treatment.*

Current Need for Treatment

Percent of Adults in Households

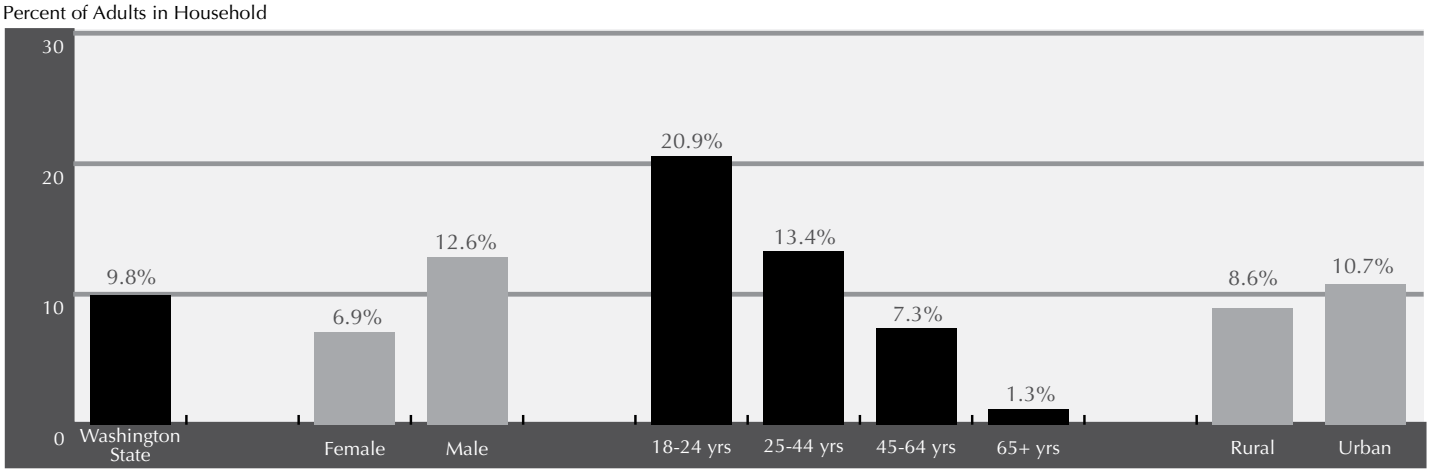


Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2007). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

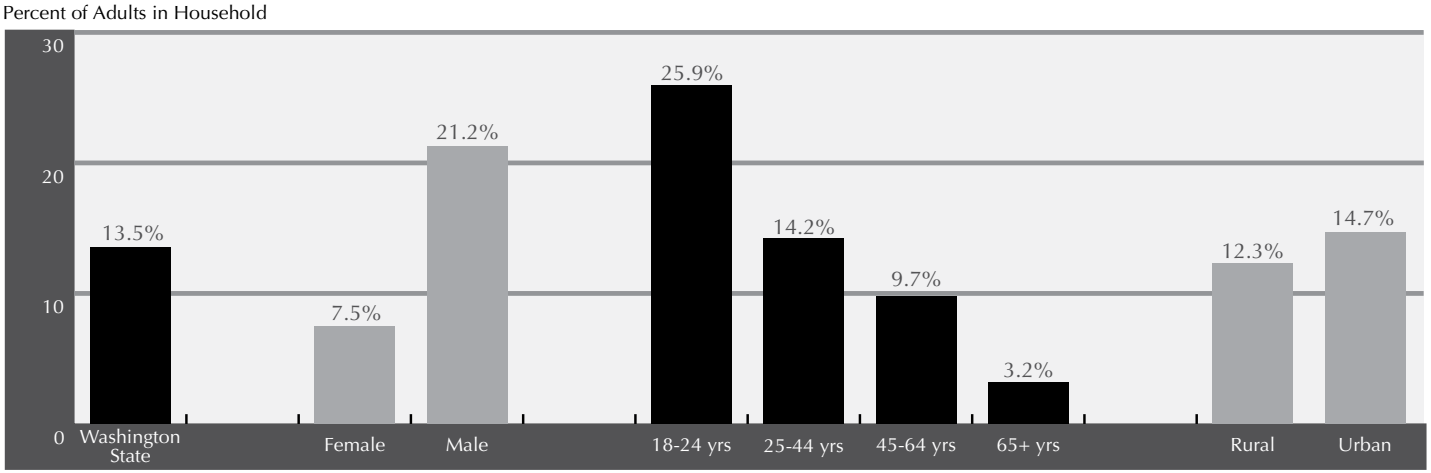
** For definition of Current Need for Treatment, see page 180.*
** American Indian Includes Alaskan Natives.
*** Native Hawaiian or Pacific Islander.

Younger Adults (Ages 18-24), Males, and Urban Residents Have Higher Rates of Need for Chemical Dependency Treatment.*

Current Need for Treatment Among Adults Above 200% of Federal Poverty Level



Current Need for Treatment Among Adults at or Below 200% of Federal Poverty Level



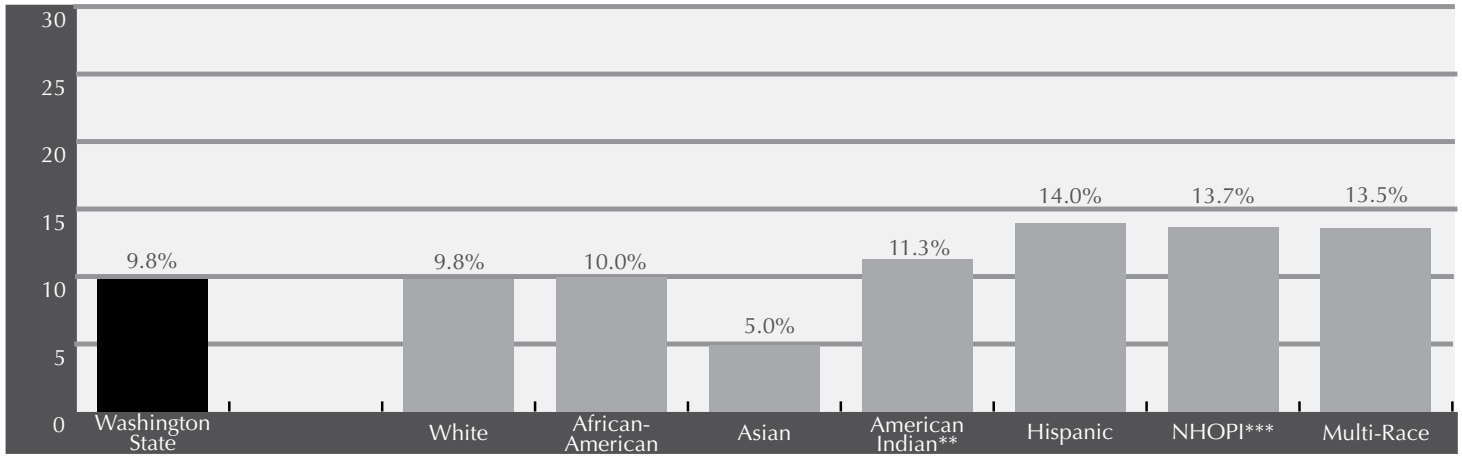
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* updated 2007. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 22008.

** For definition of Current Need for Treatment, see page 180.*

White, American Indian, and Multi-Race Washington State Adult Residents Have Higher Rates of Chemical Dependency Treatment Need.*

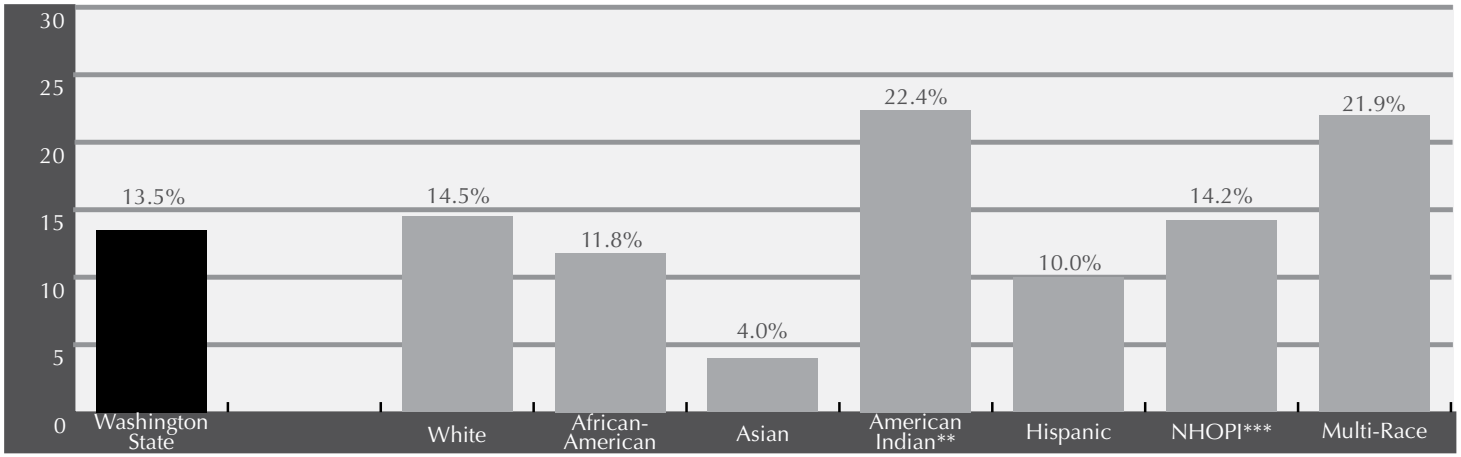
Current Need for Treatment for Adults Above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or Below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2007). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

*For definition of Current Need for Treatment, see page 180.
**American Indian includes Alaskan Natives.
***Native Hawaiian or Pacific Islander.

Computing the DASA Treatment Gap

The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for Division of Alcohol and Substance Abuse (DASA)-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those with private insurance, access to military health services, or who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number, as these individuals would be expected to access chemical dependency treatment services without use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap:

$$\textbf{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county numbers and using the same formula. Counts of persons receiving DASA-funded treatment are drawn from DASA's TARGET system. These counts represent cases that were open in SFY 2007. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and denominator. Results by county are displayed on page 180.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone number are found on the back cover.

The Treatment Gap

SFY 2007 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults with children under 18	39,609	13,923	25,686	64.8%
Adults without children under 18	71,189	21,747	49,442	69.5%
ALL ADULTS 18 AND OLDER	**110,798**	**35,670**	**75,128**	**67.8%**
ADOLESCENTS (AGES 12 - 17)	**19,591**	**6,160**	**13,431**	**68.6%**
TOTAL	**130,389**	**41,830**	**88,559**	**67.9%**

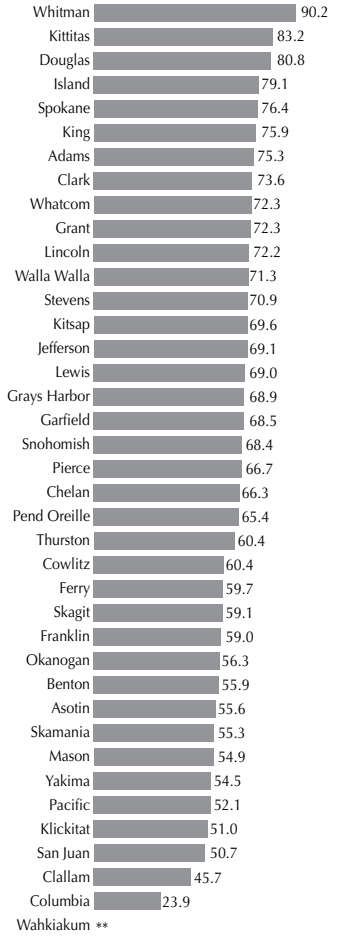
Estimates exclude detox, transitional housing, and Department of Corrections. Also excluded are adults who have private, Washington Basic Health Plan, or military health insurance. An additional adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.

Statewide, in SFY 2007, 67.8% of Adults in Households Who Qualified for and were in Need of DASA-Funded Chemical Dependency Treatment Did Not Receive It.*

County	Percent of Adults <200% FPL & in Need of Treatment & Eligible for DASA-Funded Services	Number of Adults Receiving DASA-Funded Treatment	Number of Eligible Adults Not Receiving DASA-Funded Treatment	Penetration Rate	Treatment Gap
Adams	8.5%	110	288	27.6%	72.4%
Asotin	9.4%	216	267	44.7%	55.3%
Benton	9.2%	1,051	1,382	42.2%	56.8%
Chelan	8.7%	498	970	33.9%	66.1%
Clallam	9.4%	769	684	55.9%	44.1%
Clark	9.2%	1,722	4,391	28.2%	71.8%
Columbia	8.0%	62	27	69.7%	30.3%
Cowlitz	9.3%	777	1,118	41.0%	59.0%
Douglas	8.5%	152	624	19.6%	80.4%
Ferry	12.2%	114	162	41.3%	58.7%
Franklin	8.3%	563	772	42.2%	57.8%
Garfield	8.6%	22	47	31.9%	68.1%
Grant	9.0%	588	1,455	28.8%	71.2%
Grays Harbor	9.2%	574	1,225	31.9%	68.1%
Island	8.9%	289	860	25.2%	74.8%
Jefferson	8.6%	172	396	30.4%	69.6%
King	9.1%	7,161	19,553	26.8%	73.2%
Kitsap	8.4%	1,124	2,589	30.3%	69.7%
Kittitas	12.8%	211	897	19.0%	81.0%
Klickitat	9.4%	217	233	48.2%	51.8%
Lewis	9.2%	494	1,075	31.5%	68.5%
Lincoln	8.4%	59	140	29.6%	70.4%
Mason	9.5%	445	528	45.7%	54.3%
Okanogan	9.8%	547	735	42.7%	57.3%
Pacific	8.2%	222	250	47.0%	53.0%
Pend Oreille	9.1%	107	206	34.2%	65.8%
Pierce	9.1%	4,034	8,178	33.0%	67.0%
San Juan	8.7%	135	136	49.8%	50.2%
Skagit	8.7%	847	1,201	41.4%	58.6%
Skamania	9.2%	106	127	45.5%	54.5%
Snohomish	8.6%	2,896	5,962	32.7%	67.3%
Spokane	10.4%	2,516	7,216	25.8%	74.2%
Stevens	9.7%	341	790	30.2%	69.8%
Thurston	10.0%	1,302	2,298	36.2%	63.8%
Wahkiakum	10.6%	48	11	**	**
Walla Walla	10.0%	392	916	30.0%	70.0%
Whatcom	11.8%	1,419	3,549	28.6%	71.4%
Whitman	14.0%	144	1,535	8.6%	91.6%
Yakima	8.7%	2,676	2,918	47.8%	53.2%

Treatment Gap Rates



*Estimates exclude adults who have private, Washington Basic Health Plan, or military health insurance. An additional adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

**Treatment penetrations rates suppressed for counties with 60 or fewer adults estimated to need and be eligible for DASA-funded treatment.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.

Estimates of Substance Abuse and Treatment Need in Washington State, 2007

	Adult Household Residents		Adults In Household at or below 200% of Federal Poverty Level	
	# of Residents	% of Residents	# of Residents	% of Residents
NEED FOR TREATMENT				
Current Need for Substance Treatment	509,853	10.8%	164,778	13.5%
ALCOHOL OR DRUG DISORDER				
Lifetime Alcohol or Drug Use Disorder	948,875	20.1%	247,298	20.2%
Past 12-Month Alcohol or Drug Use Disorder	364,093	7.7%	112,732	9.3%
ALCOHOL USE DISORDER				
Lifetime Alcohol Use Disorder	793,145	16.8%	190,787	15.6%
Past 12-Month Alcohol Use Disorder	327,334	7.0%	92,365	7.7%
DRUG DISORDER				
Lifetime Drug Use Disorder	330,074	7.0%	114,769	9.4%
Past 12-Month Drug Use Disorder	85,956	1.8%	42,833	3.5%
ALCOHOL USE				
Lifetime Use of Alcohol	4,188,667	87.7%	964,876	77.0%
Past 12-Month Use of Alcohol	3,446,107	72.6%	721,064	58.1%
Past 30-Day Use of Alcohol	2,722,669	57.5%	503,377	41.5%
USE OF ANY ILLICIT DRUG				
Lifetime Use of Any Illicit Drug	2,072,320	44.2%	501,355	41.0%
Past 12-Month Use of Any Illicit Drug	447,981	9.5%	152,647	12.6%
Past 30-Day Use of Any Illicit Drug	261,414	5.6%	90,579	7.5%
MARIJUANA USE				
Lifetime Use of Marijuana	1,923,704	41.1%	467,648	37.6%
Past 12-Month Use of Marijuana	343,162	7.3%	115,247	9.5%
Past 30-Day Use of Marijuana	201,274	4.3%	70,359	5.8%
METHAMPHETAMINE				
Lifetime Use of Meth	276,750	5.9%	89,535	7.5%
Past 12-Month Use of Meth	16,689	0.3%	11,355	0.9%
Past 30-Day Use of Meth	5,638	0.1%	4,332	0.3%
COCAINE USE				
Lifetime Use of Cocaine	710,844	15.2%	186,267	15.3%
Past 12-Month Use of Cocaine	52,649	1.1%	24,369	2.0%
Past 30-Day Use of Cocaine	16,688	0.4%	7,881	0.7%

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

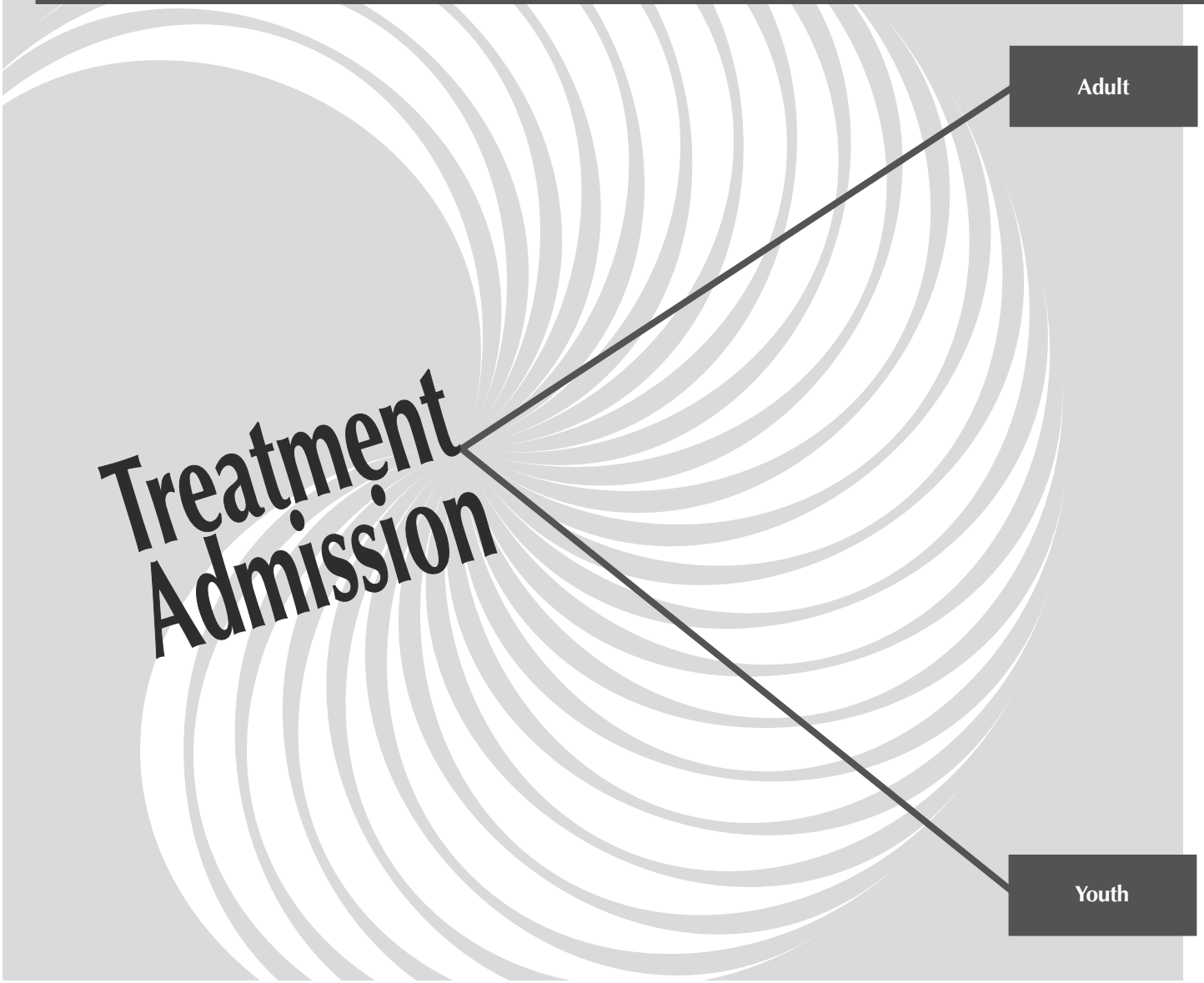
Estimates of Current Need for Substance Abuse Treatment in Washington State, 2007

	Adult Household Residents			Adults In Household at or below 200% of Federal Poverty Level		
GROUP	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment
Total	4,736,864	509,853	10.8%	1,221,721	164,778	13.5%
AGE						
18-24	562,708	130,069	23.1%	251,366	65,039	25.9%
25-44	1,778,818	242,127	13.6%	480,293	68,204	14.2%
45-64	1,591,785	122,794	7.7%	243,435	23,704	9.7%
65+	803,554	14,863	1.8%	246,626	7,832	3.2%
SEX						
Male	2,327,380	339,128	14.6%	534,643	113,460	21.2%
Female	2,409,484	170,725	7.1%	687,078	51,319	7.5%
RACE/ETHNICITY						
White-NH	3,842,334	416,717	10.8%	855,201	123,882	14.5%
Black-NH	135,945	14,563	10.7%	52,654	6,220	11.8%
Asian	265,873	12,439	4.7%	75,761	3,013	4.0%
Amer. Indian*	63,731	10,528	16.5%	30,130	6,747	22.4%
NHOPI**	30,779	4,298	14.0%	12,898	1,846	14.3%
Multi-Race	85,760	14,063	16.4%	29,190	6,399	21.9%
Hispanic	312,442	37,245	11.9%	165,887	16,670	10.0%
MARITAL						
Married	2,792,518	213,791	7.8%	518,982	51,575	9.9%
Div/Sep	702,368	76,564	11.1%	243,841	25,461	10.4%
Widowed	316,670	11,155	3.6%	134,196	4,827	3.6%
Never Mar	925,309	199,976	22.0%	324,702	82,915	25.5%
EDUCATION						
Not HS Grad	417,593	45,603	10.9%	254,918	26,137	10.5%
HS Graduate	4,319,217	464,250	10.7%	966,803	135,644	14.3%
POVERTY						
Below 200%	1,221,721	164,778	13.5%	1,221,721	164,778	13.5%
Above 200%	3,515,143	345,074	9.8%	-	-	-

*American Indian includes Alaskan Native
**Native Hawaiian or Pacific Islander

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Treatment Admission Trends



Modality categories are defined as follows:

Detoxification

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals. DASA now has two pilot intensive crisis response/secure detoxification programs in Pierce and the North Sound Counties.

Intensive Inpatient

Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

Recovery House

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

Long-Term Residential

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who reside at the treatment facility. Individuals who are chronically chemically dependent or present a likelihood of serious harm to themselves or others, or are gravely disabled by alcohol or other drug addiction, may be committed to long-term residential treatment under the Involuntary Treatment Act.

Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth and adults.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social and Health Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation; and linkages to other community alcohol and drug services.

New group care enhancement contracts also make it possible for providers to deliver on-site services to adults living in nursing homes and assisted living facilities under the Treatment Expansion initiative.

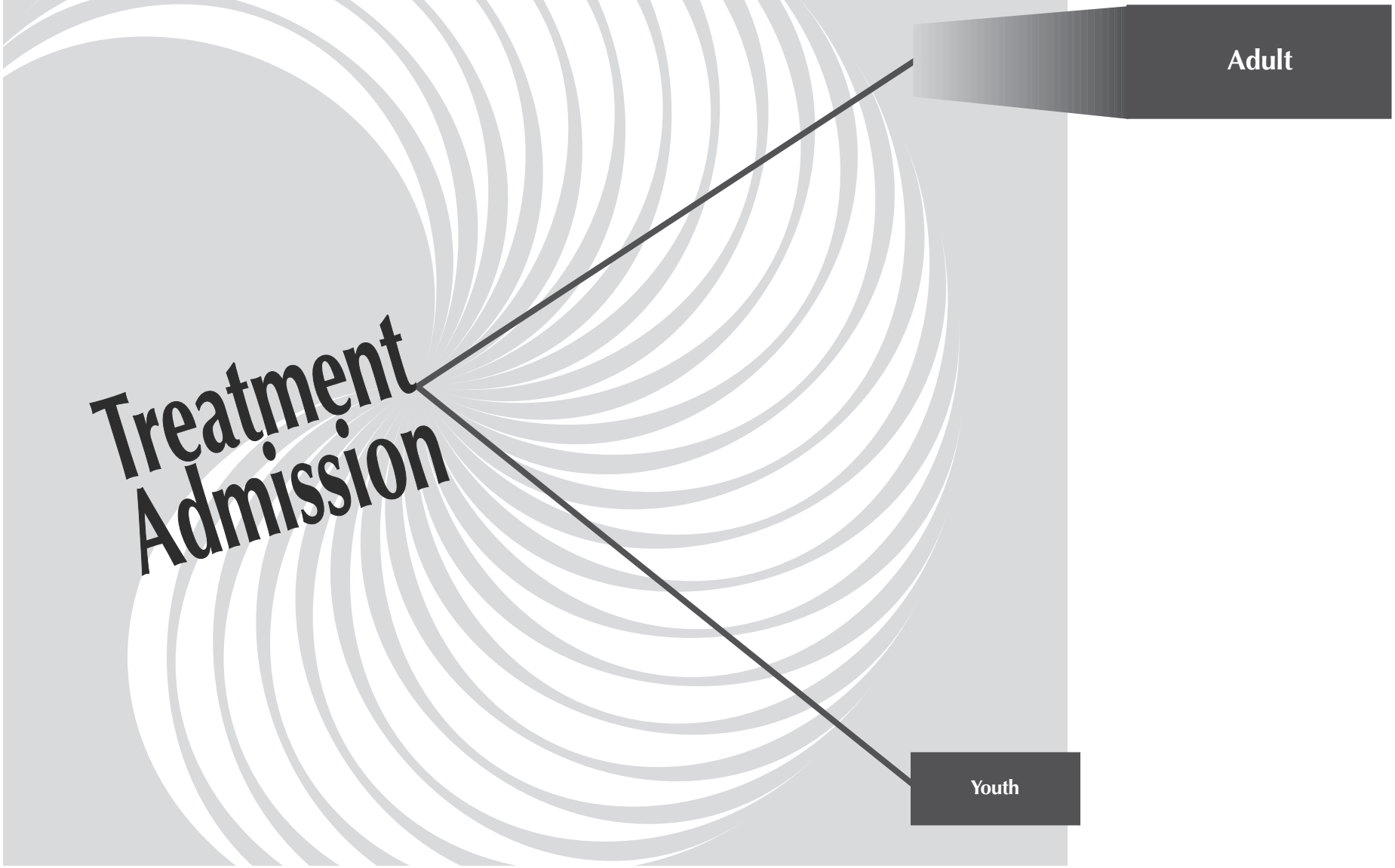
Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

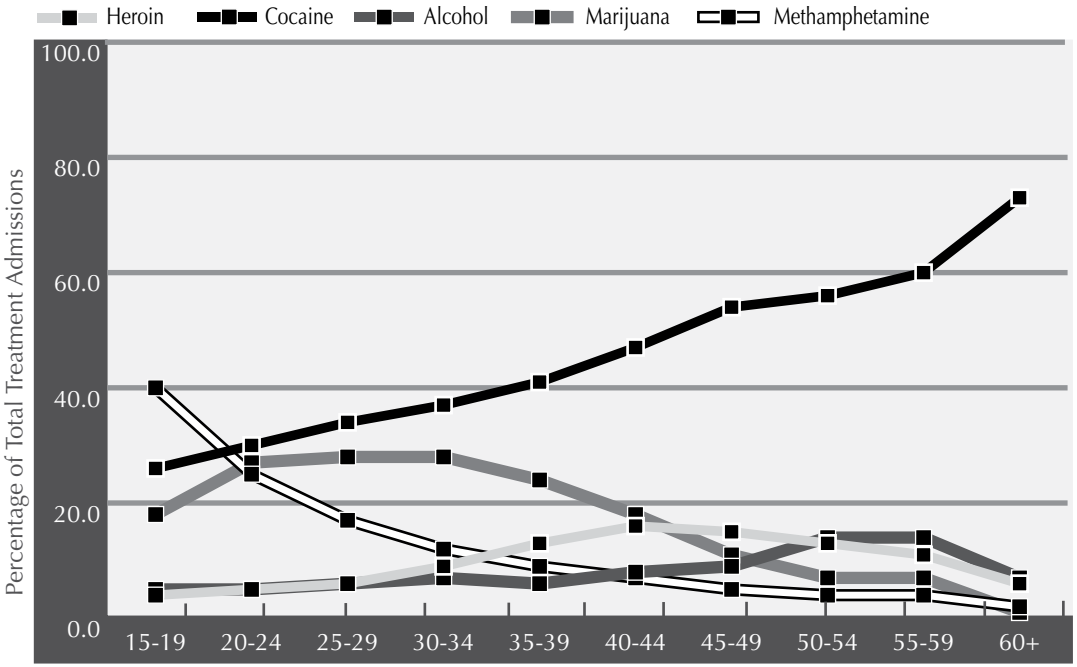
Opiate Substitution Treatment

Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

Treatment Admission Trends



Primary Drug of Abuse in Adult DASA-Funded Treatment Admissions Varies Significantly By Age.*

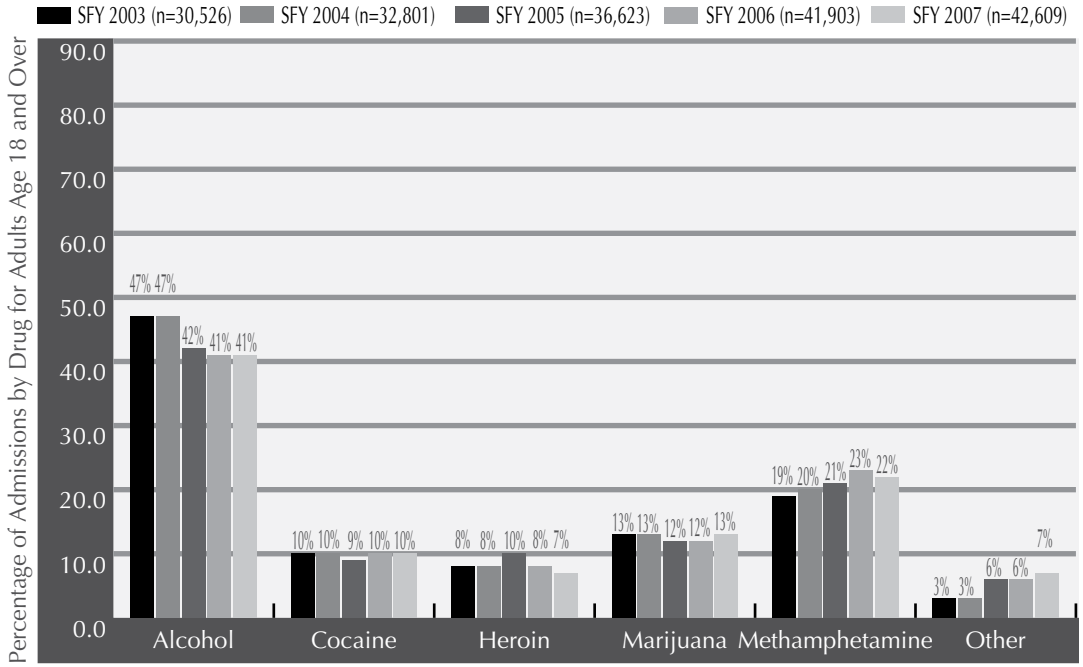


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

Primary drug of abuse upon treatment admission reflects drug use in the wider population. This graph indicates that adult DASA-funded admissions by primary drug of abuse vary widely by age cohort. As a percentage of treatment admissions by age cohort, admissions for alcohol and heroin rise as patients get older until age 50, when they diverge. Marijuana admissions are highest for the youngest cohort; methamphetamine admissions are high for patients in their 20s and 30s.

**Excludes detoxification and transitional housing.*

Alcohol Continues to Be Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

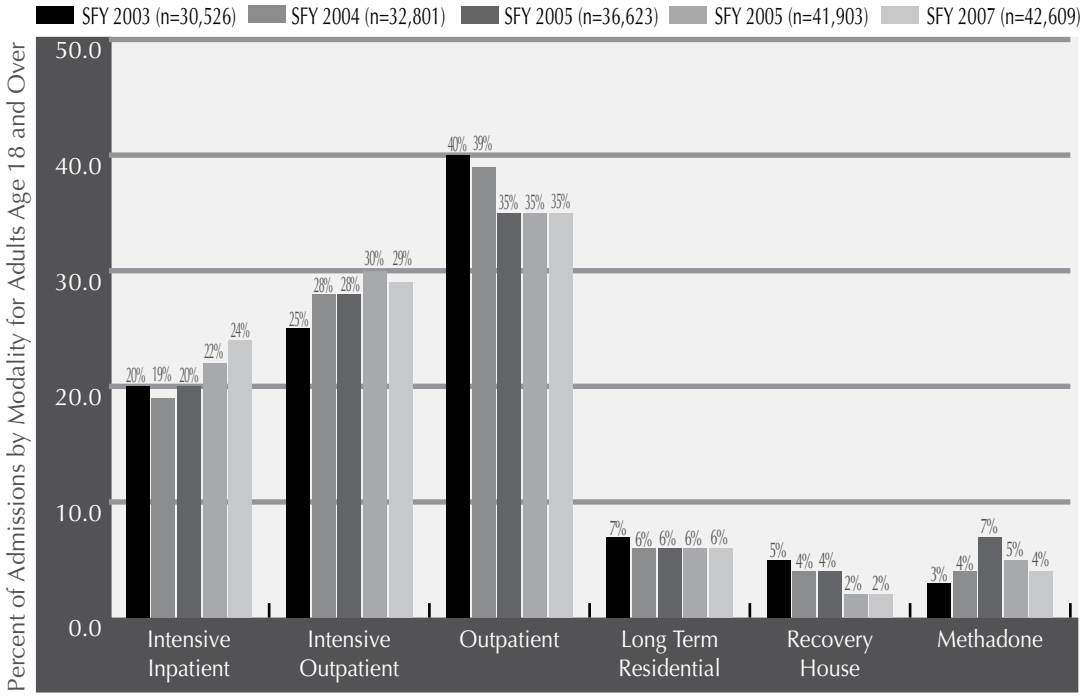
This graph indicates that in SFY 2007, alcohol remained the primary drug of abuse for adult admissions to DASA-funded treatment. While alcohol has declined as the primary drug of abuse as a percentage of all adult admissions, the actual number of alcohol-related admissions has risen substantially, from 14,288 in SFY 2003 to 17,623 in SFY 2007, representing a 23.3% increase. Adult admissions to treatment for methamphetamine addiction fell by 8.3% between SFY 2006 and SFY 2007. Admissions where other non-heroin opiates or synthetics, oxycodone/hydrocodone, or prescribed opiate substitute are indicated as primary drug of abuse have risen from 577 in SFY 2003 to 2,190 in SFY 2007, representing a 380% increase.

The number of total adult admissions to DASA-funded treatment has increased 39.6% since SFY 2003. This reflects new avenues to access treatment as a result of the continuing treatment expansion initiative, funding through the Criminal Justice Treatment Account (CJTA), and increased availability of opiate substitution treatment.

Note: Data may include multiple admissions for a single individual over the course of a year.

**Excludes detoxification and transitional housing.*

Almost Two-Thirds of Adult Admissions to DASA-Funded Treatment are for Outpatient and Intensive Outpatient Services.*

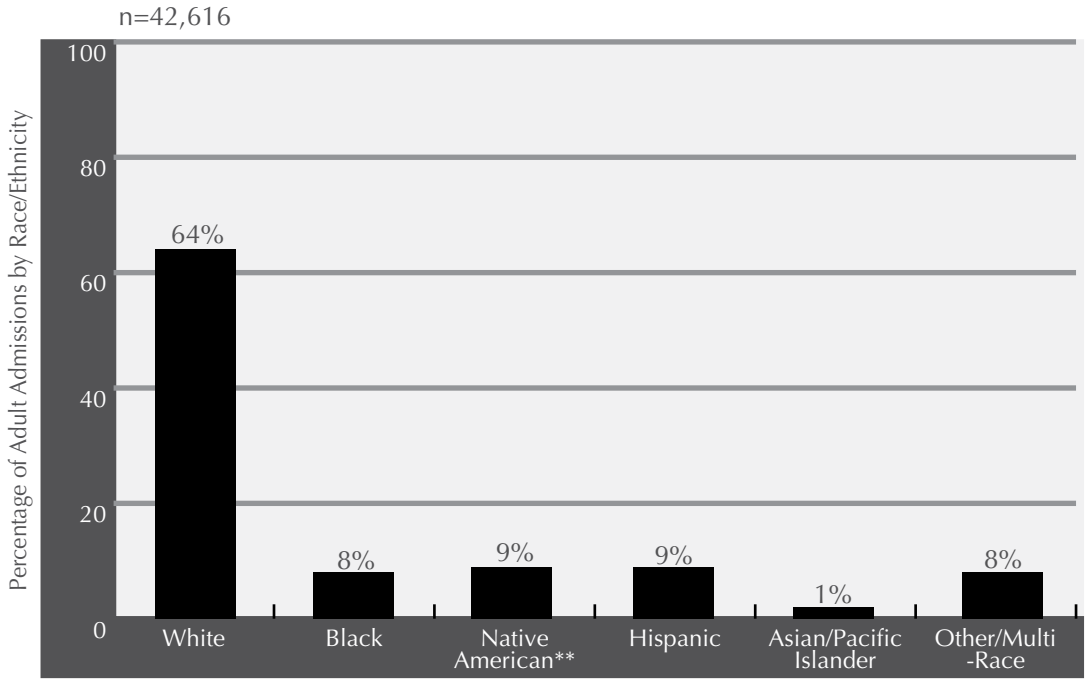


Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that almost two-thirds of adult admissions to DASA-funded chemical dependency treatment are for intensive outpatient and outpatient services. The total number of adult admissions has risen 16.3% since SFY 2005, reflecting new avenues for treatment access as a result of the legislatively mandated treatment expansion for Medicaid-eligible clients and funding through the Criminal Justice Treatment Account (CJTA). Intensive inpatient admissions rose from 7,338 in SFY 2005 to 10,195 in SFY 2007, representing a 38.9% increase.

** Excludes detoxification and transitional housing.*

In SFY 2007, Racial and Ethnic Minorities Comprised 36% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.

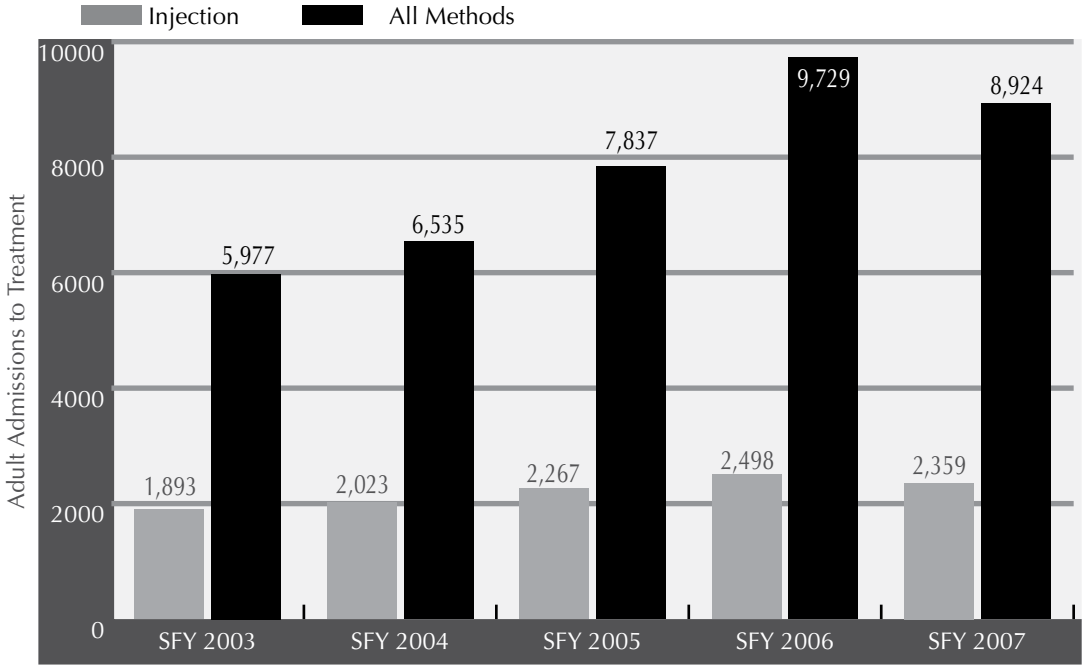


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprise approximately 36% of adult admissions to DASA-funded chemical dependency treatment. Percentages of adults from different groups receiving DASA-funded treatment vary across modalities.

** Includes Eskimo/Alaskan Native/Aleut*

The Number of Adults Admitted to DASA-Funded Treatment for Methamphetamine Has Fallen for the First Time in This Decade.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

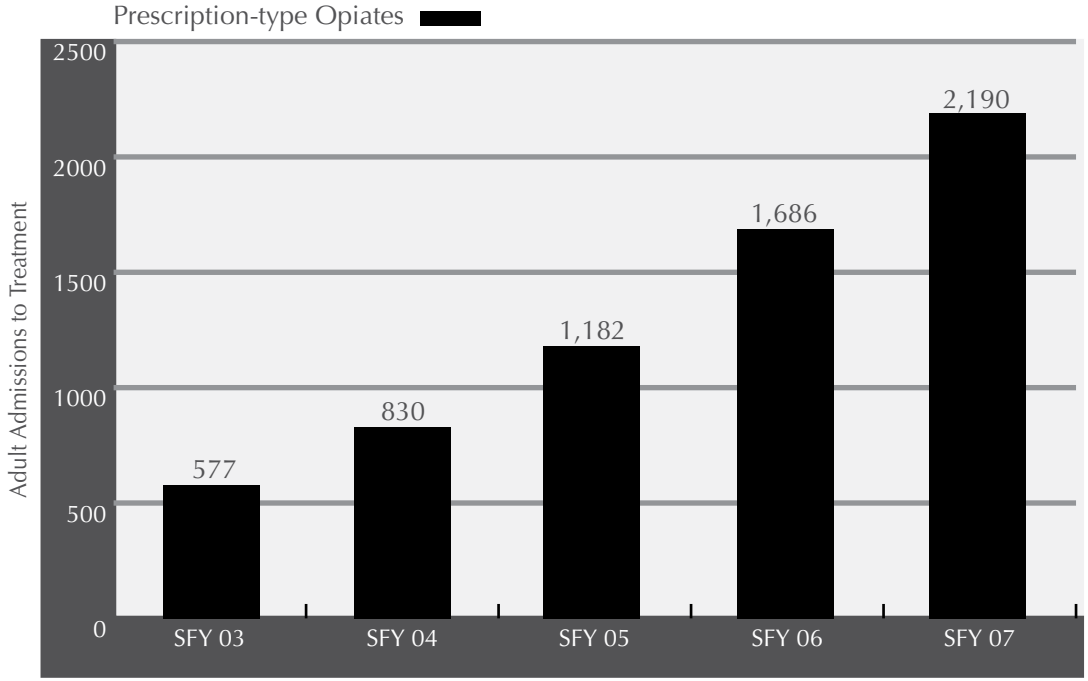
The number of adults admitted to DASA-funded treatment for methamphetamine is now falling, and declined 8.3% in SFY 2007. This parallels the precipitous decline in the number of methamphetamine laboratories and dumpsites in Washington State now being reported to the Department of Ecology. The majority of adults admitted to DASA-funded treatment for methamphetamine administer the drug via routes other than injection. A large majority of individuals dependent on methamphetamine are polydrug users.

Treatment for methamphetamine addiction has been demonstrated to be effective in reducing arrests, convictions, and health care costs.[1]

[1] Nordlund, D., et al. *Treatment of Stimulant Addiction Including Addiction to Methamphetamine Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

NEW/CHANGING TREND

Adult Admissions to DASA-Funded Treatment for Prescription-Type Opiates Have Almost Quadrupled Since SFY 2003.

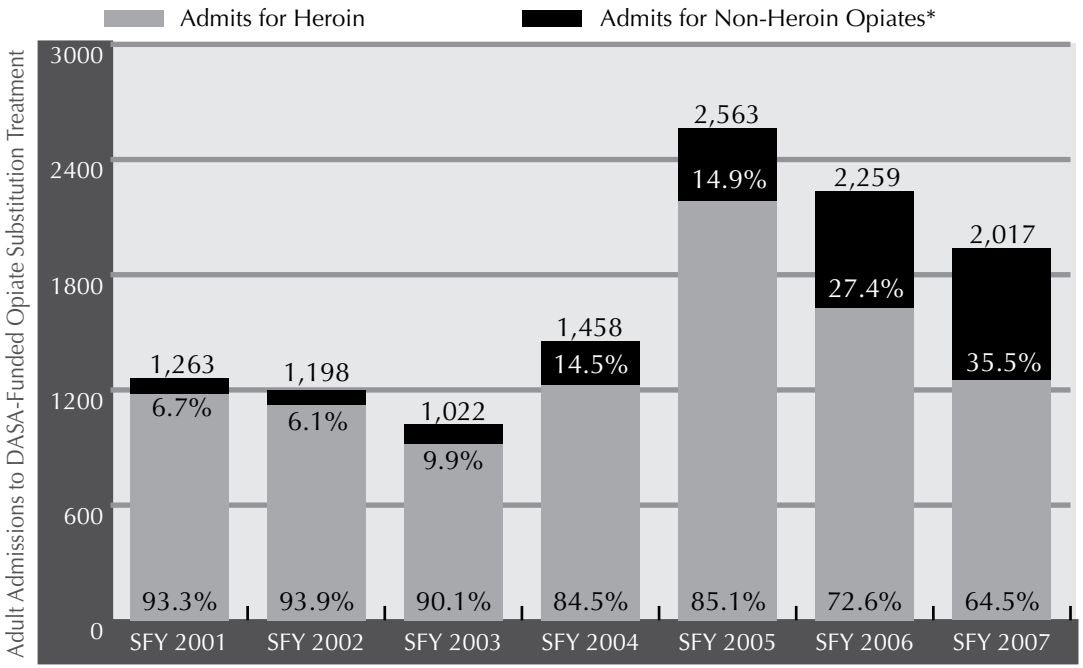


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

The number of DASA-funded treatment admissions where prescription-type opiates (non-heroin opiates and synthetics, oxycodone/hydrocodone, prescribed opiate substitute) are the primary substance of abuse has risen precipitously in this decade. The rise in prescriptions for opiates to treat pain has been very rapid. In Washington State, the number of doses of prescription opiates legally dispensed almost tripled between 1997-2007.[1] The expanded prescriptive use of opiates has created new opportunities for diversion, illicit use, and subsequent addiction. In 2005-2006, Washington State ranked sixth in the nation in the percentage of individuals ages 12 and older using prescription pain relievers for non-medical purposes (6.13%).[2]

[1] Drug Enforcement Administration, 2007.
[2] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

The Number of Individuals Addicted to Non-Heroin Opiates Entering DASA-Funded Opiate Substitution Treatment is Rising Rapidly.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

In recent years, there has been a substantial shift in admissions to DASA-funded opiate substitution treatment. Both the number and percentage of those being admitted whose primary substances of abuse are non-heroin opiates have been rising rapidly, with a more than eight-fold increase in patients since SFY 2001. Almost none of these individuals (fewer than 2%) are injection drug users.

**Less than 2% are for drugs other than opiates. Non-heroin opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene. Morphine is classed with heroin.*

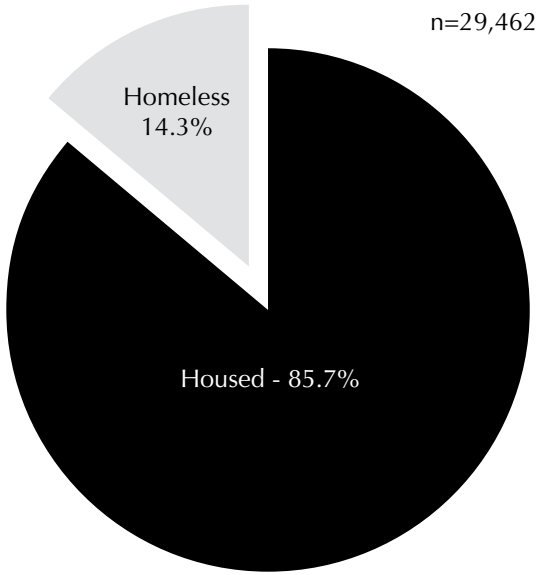
NEW/CHANGING TREND

Comparison of Adults Addicted to Heroin and Non-Heroin Opiates Admitted to DASA-Funded Opiate Substitution Treatment, 2005-2006

	Heroin	Non-Heroin Opiates*
Number of Individuals	2,890 (78.8% of total)	776 (21.2% of total)
Median Age	42	34
Gender	54% male/46% female	37% male/63% female
Employment Status	7% employed full- or part-time	18% employed full- or part-time
Race	Caucasian – 77%; African-American – 12%; Asian/Pacific Islander – 1%; American Indian – 4%; Other/Multi-Race – 6%. Hispanic Origin – 6%.	Caucasian – 78%; African-American – 4%; Asian-Pacific Islander – 2%; American Indian – 11%; Other/Multi-Race – 5%. Hispanic Origin – 5%.
% with Previous Admission	51%	30%
% with Treatment Readmission	22%	12%
Criminal Justice Involvement	43% arrested at least once in previous year	32% arrested at least once in previous year
% with Children in the Home	17%	45%
Housing Status	20% homeless**	5% homeless**
% Injection Drug Users	100%	2%
% in Treatment 1-90 days	20%	21%
% in Treatment 91-180 days	16%	13%
% in Treatment 181-270 days	12%	8%
% in Treatment 271-365 days	9%	7%
% in Treatment > 365 days	43%	54%

**Less than 1% are for drugs other than opiates. Non-heroin opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene. Morphine is classed with heroin.*
***Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Approximately 14% of Individuals Admitted to DASA-Funded Chemical Dependency Treatment Services are Homeless at Time of Admission.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

In SFY 2007, there were 4,210 individuals who were homeless admitted to DASA-funded treatment services. They are significantly more likely to be admitted to residential treatment (55%) than housed patients (27%).

Compared with housed patients, homeless patients admitted to treatment are more likely to be: older (median age 38 v. 34); male (66% v. 60%), and African-American (16% v. 8%). They are less likely to have alcohol as their primary substance of abuse (36% v. 44%), and more likely to have methamphetamine (22% v. 19%), cocaine (16% v. 8%), or heroin (12% v. 7%) as their primary substance of abuse. They are less likely to have been arrested in the previous year (55% v. 61%), more likely to inject drugs (19% v. 12%), and less likely to be employed full- or part-time (4% v. 23%).

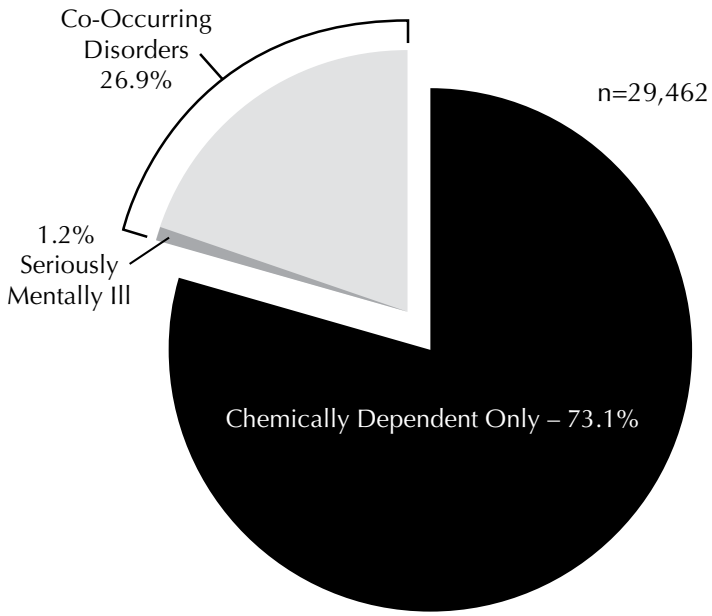
Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

Comparison of Adults Who are Homeless and Those Who are Housed Admitted to DASA-Funded Treatment, SFY 2007

	Homeless*	In Housing
Number of Individuals	4,210 (14.3% of total)	25,252 (85.7% of total)
Median Age	38	34
Gender	66% male / 34% female	60% male / 40% female
Race/Ethnicity	Caucasian - 68%; African-American - 16%; Asian/Pacific Islander - 2%; American Indian - 7%; Multi-Racial/Other Race - 7%. Hispanic Origin - 6%	Caucasian - 69%; African-American - 8%; Asian/Pacific Islander - 2%; American Indian - 10%; Multi-Racial/Other Race - 11%. Hispanic Origin - 11%
Employment Status	4% employed full- or part-time	23% employed full- or part-time
Primary Drug	Alcohol - 36%; Methamphetamine - 22%; Cocaine - 16%	Alcohol - 44%; Methamphetamine - 19%; Marijuana - 14%
% with Previous Admission	45%	40%
Criminal Justice Involvement	55% arrested at least once in previous year	61% arrested at least once in previous year
% with Children in the Home	7%	28%
% with Co-Occurring Disorder	33%	26%
Completion Rate Residential/Outpatient	74% / 28%	77% / 44%

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Approximately 27% of Individuals Admitted to DASA-Funded Chemical Dependency Treatment Services Have Co-Occurring Mental Health and Chemical Dependency Disorders.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

Individuals with co-occurring disorders are here defined as patients who were admitted to DASA-funded treatment services who received a psychological evaluation, with results revealing a positive indication for a mental health problem. Some 1.2% of individuals admitted had spent 15 or more days in a psychiatric hospital in the past year.

Integrated treatment for mental health and chemical dependency disorders has proven effective in enhancing health-related outcomes and reducing use of acute care services.[1] Beginning in January 2007, DASA and DSHS Mental Health Division treatment providers serving publicly funded patients started using a common co-occurring disorders screening and assessment process.

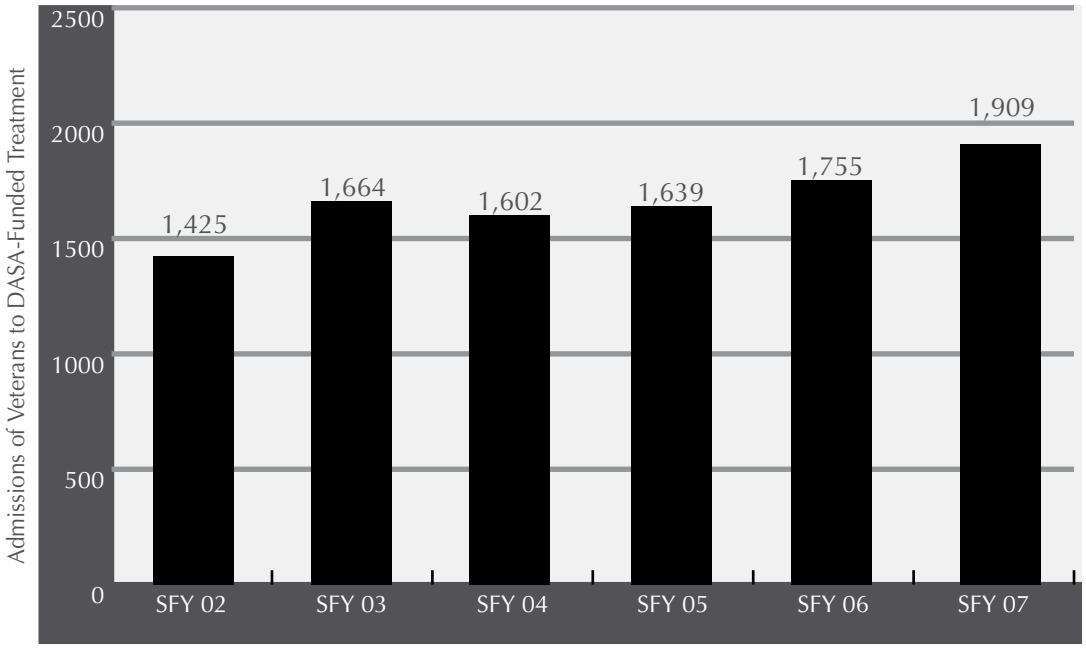
[1] Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

Comparison of Adults with Co-Occurring Chemical Dependency and Mental Health Disorders and Non-Co-Occurring Patients Admitted to DASA-Funded Treatment, SFY 2007

	Co-Occurring	Non-Co-Occurring
Number of Individuals	7,932 (26.9% of total)	21,530 (73.1% of total)
Median Age	37	33
Gender	49% male / 51% female	65% male / 35% female
Race/Ethnicity	Caucasian - 77%; African American - 10%; Asian/Pacific Islander - 2%; American Indian - 6%; Multi-Racial/Other Race - 5%. Hispanic Origin - 6%	Caucasian - 66%; African American - 8%; Asian/Pacific Islander - 2%; American Indian - 11%; Multi-Racial/Other Race - 13%. Hispanic Origin - 12%
Employment Status	9% employed full- or part-time	25% employed full- or part-time
Primary Drug	Alcohol - 38%; Methamphetamine - 19%; Marijuana - 13%	Alcohol - 45%; Methamphetamine - 19%; Marijuana - 14%
% with Previous Admission	48%	38%
Criminal Justice Involvement	52% arrested at least once in previous year	63% arrested at least once in previous year
% with Children in the Home	20%	27%
Housing Status	17% homeless*	13% homeless*
Completion Rate (residential/outpatient)	75% / 33%	77% / 46%

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

The Number of Admissions of Military Veterans to Publicly Funded Treatment Has Grown By More than a Third Since SFY 2002.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

The number of military veterans receiving DASA-funded treatment has grown significantly in recent years. Compared to non-veterans admitted to treatment in SFY 2007, veterans are significantly older (median age 46 v. 34 for non-veterans), more likely to be male (93% v. 59%), less likely to have children in the home (12% v. 26%), and more likely to have alcohol as their primary substance of abuse (61% v. 42%).

Military veterans returning home from Iraq and Afghanistan suffer from high rates of post-traumatic stress disorder, traumatic brain injuries, depression, suicide, and substance abuse.[1] As the number of returning veterans increases, providing needed substance abuse and mental health resources will likely prove a challenge to state and federal agencies.

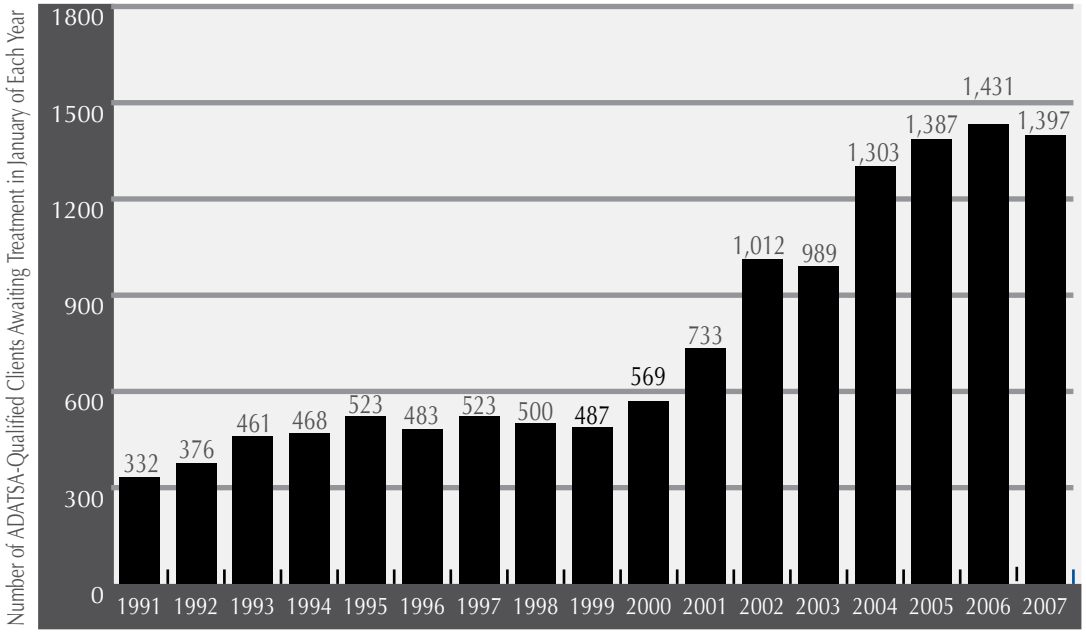
[1] Tanielian, T. & Jaycox, L., eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* Santa Monica, CA: RAND Center for Military Health Policy Research, 2008.

Comparison of Veterans and Non-Veterans Admitted to DASA-Funded Treatment, SFY 2007

	Veterans	Non-Veterans
Number of Individuals	1,388 (4.7% of total)	28,074 (95.3% of total)
Median Age	46	34
Gender	93% male / 7% female	59% male / 41% female
Race/Ethnicity	Caucasian - 77%; African American - 11%; Asian/Pacific Islander - 1%; American Indian - 7%; Multi-Racial/Other Race - 4%. Hispanic Origin - 4%	Caucasian - 69%; African American - 9%; Asian/Pacific Islander - 2%; American Indian - 10%; Multi-Racial/Other Race - 10%. Hispanic Origin - 12%
Employment Status	15% employed full- or part-time	21% employed full- or part-time
Primary Drug	Alcohol - 61%; Methamphetamine - 4%; Marijuana - 11%	Alcohol - 42%; Methamphetamine - 20%; Marijuana - 14%
% with Previous Admission	39%	41%
Criminal Justice Involvement	56% arrested at least once in previous year	58% arrested at least once in previous year
% with Children in the Home	12%	26%
Housing Status	17% homeless*	14% homeless*
Completion Rate (residential/outpatient)	87% / 49%	76% / 42%

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

The Waiting List in Washington State for Treatment Under the Alcohol and Drug Abuse Treatment and Support Act Has More than Quadrupled Since 1991.

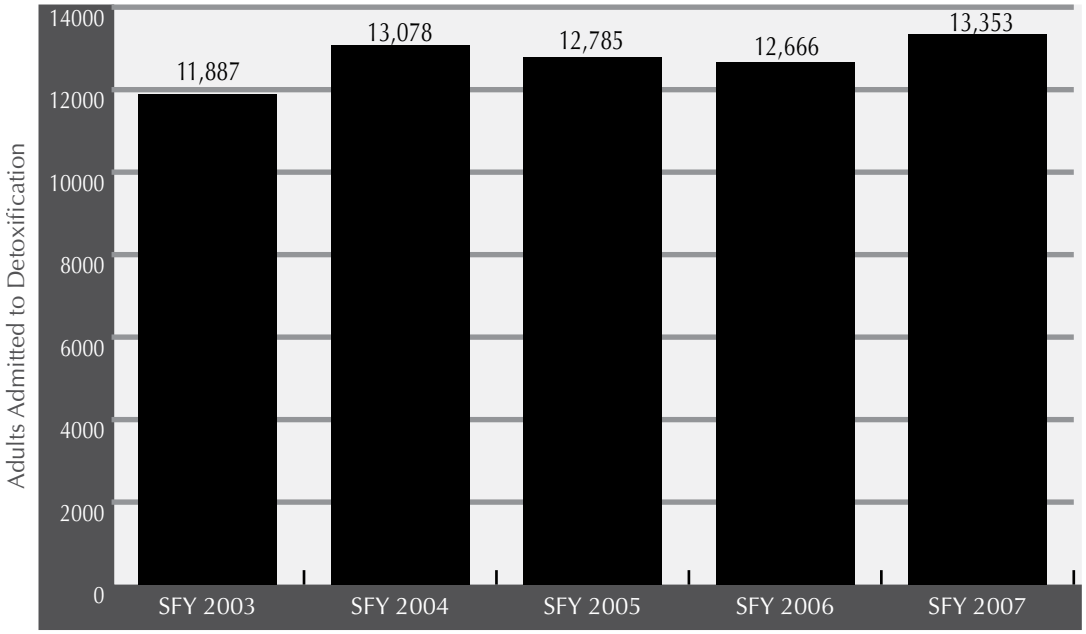


Source: Washington State Division of Alcohol and Substance Abuse, June 2008.

In 1989, the Washington State Legislature recognized in statute that, "alcoholism and drug addiction are treatable diseases, and that most persons with this illness can recover" (RCW 74.50.011). Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals who are incapacitated from receipt of gainful employment and meet specific eligibility requirements.

The waiting list for ADATSA treatment services has more than quadrupled since 1991, and its growth is accelerating. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. However, in SFY 2007, 38.2% of ADATSA clients (as compared with 30.4% in SFY 2006) already assessed as needing treatment were never admitted to treatment at all.

The Number of Adult Admissions to DASA-Funded Detoxification Has Reached a New High.

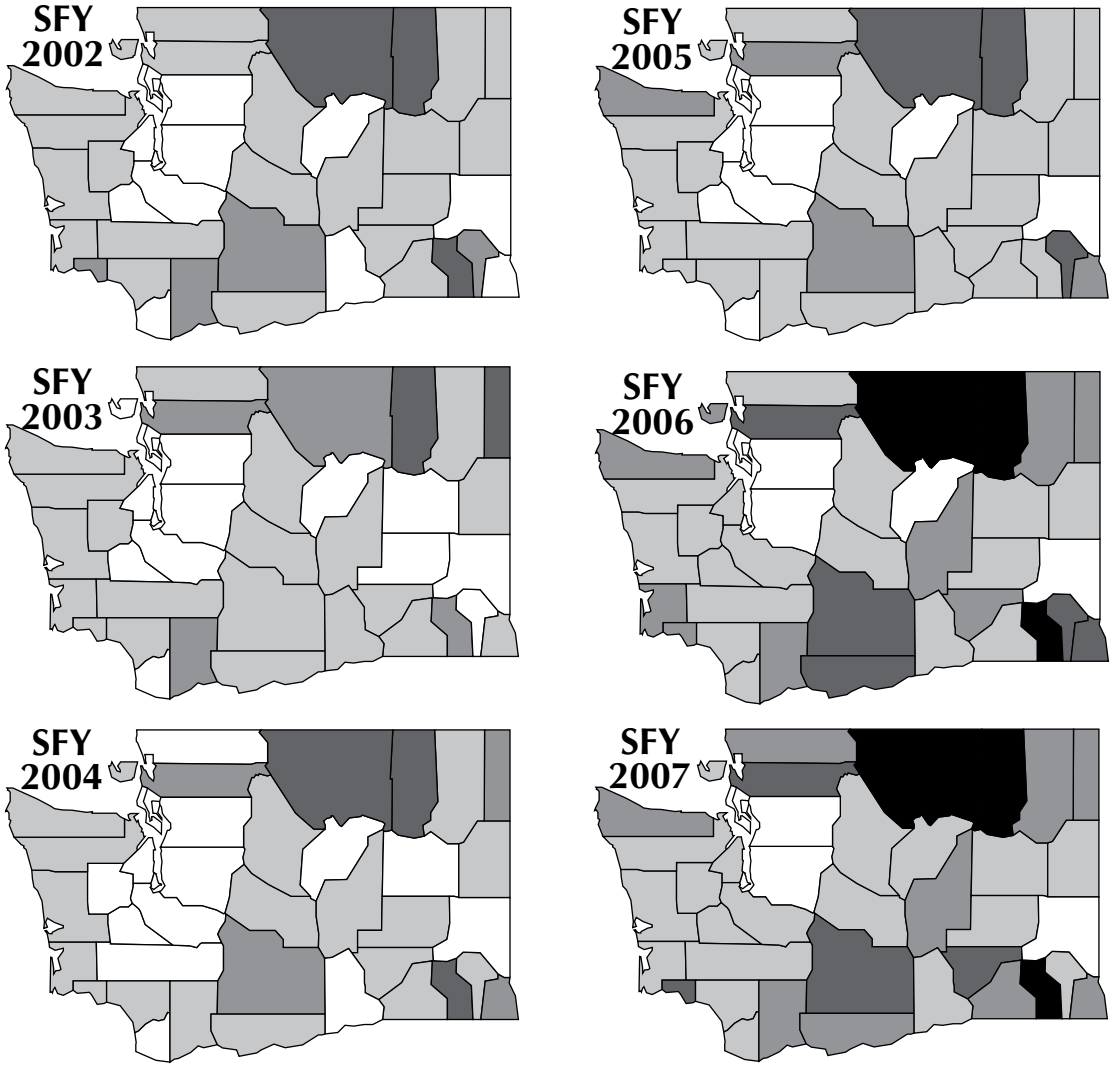


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that the number of adult admissions to DASA-funded detoxification services has risen 20.5% since SFY 2002 and has reached a new high. The largest increase has been in detoxification for alcohol, which now accounts for 56.4% of all detoxification admissions. Binge drinking and heavy drinking among adults in Washington State are also at their highest points in a decade.

Detoxification is part of the array of services available to people in crisis, and is often a necessary precursor to chemical dependency treatment. In 2006, DASA initiated two new integrated crisis response/secure detoxification programs, in Pierce and the North Sound Counties.

Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population



- 1,000 to 1,500
- 750 to 1,000
- 500 to 750
- 250 to 500
- 0 to 250

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

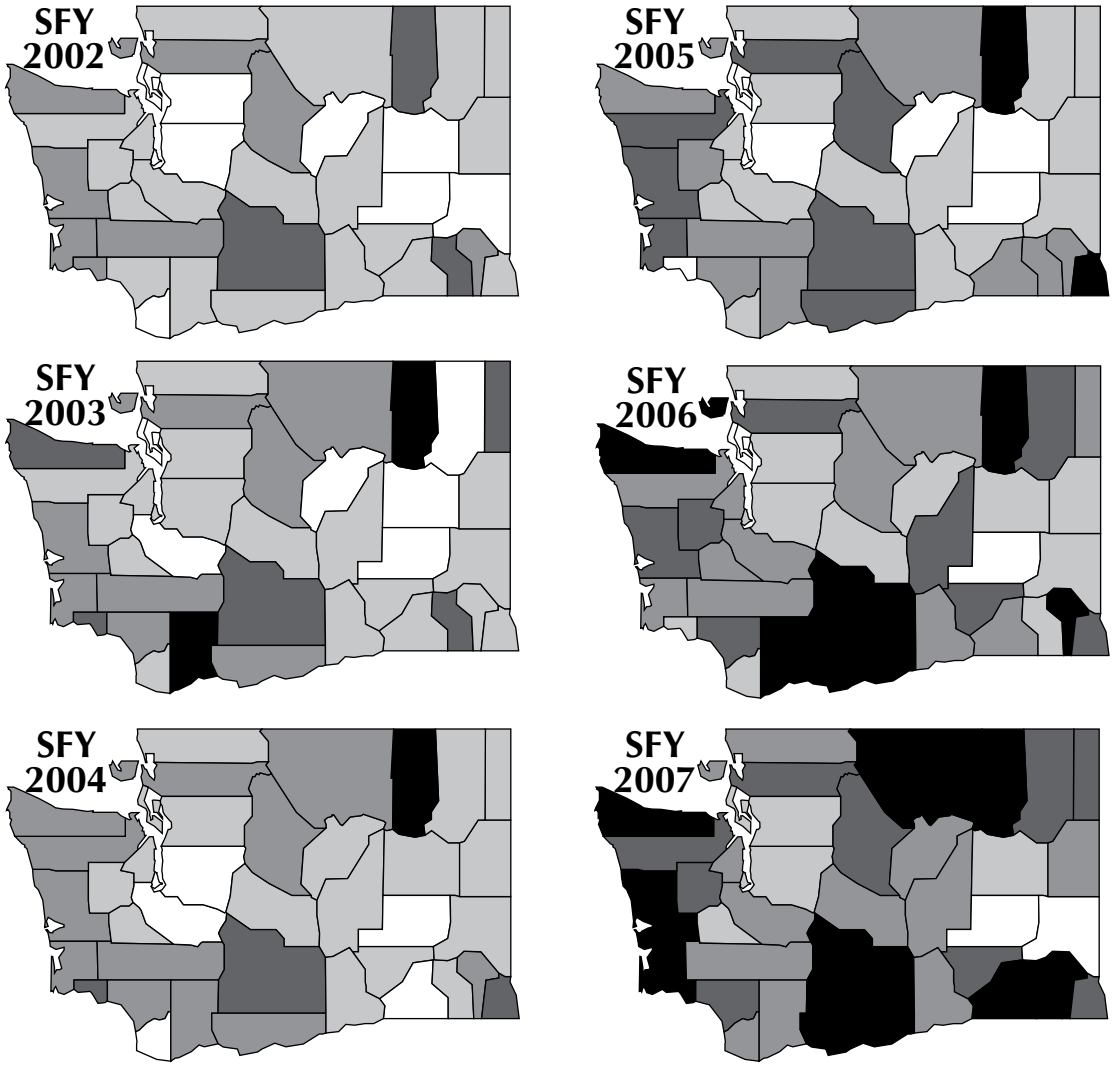
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Alcohol

County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	55	331.1	32	192.8	48	287.4	42	258.3	55	470.2	57	477.4
Asotin	23	111.1	55	267.0	118	570.0	130	653.9	143	889.9	96	590.2
Benton	354	239.8	404	266.5	367	236.6	394	260.4	461	399.3	548	466.7
Chelan	232	343.2	218	321.1	256	374.3	200	304.9	203	393.2	241	458.3
Clallam	236	363.6	270	413.5	280	424.9	378	595.1	346	641.5	392	717.3
Clark	649	178.6	551	148.0	583	152.1	681	182.3	739	251.4	890	293.7
Columbia	33	804.9	27	658.5	36	878.0	19	484.5	43	1,348.4	34	1,063.2
Cowlitz	384	406.8	358	377.2	341	357.8	243	266.6	261	360.2	217	295.5
Douglas	57	172.2	59	175.6	67	195.9	71	215.3	61	236.6	69	262.5
Ferry	60	821.9	81	1,109.6	58	794.5	56	776.3	58	1,031.0	69	1,214.3
Franklin	196	382.1	181	337.7	171	300.0	219	377.1	298	692.6	353	779.0
Garfield	12	500.0	2	83.3	7	291.7	19	833.8	17	935.5	6	336.1
Grant	235	307.6	237	307.4	277	353.8	282	373.7	361	643.1	301	522.1
Grays Harbor	214	312.9	221	321.2	243	351.2	208	312.3	203	379.6	217	402.3
Island	153	209.3	147	198.6	182	243.3	105	144.5	125	212.8	144	240.7
Jefferson	71	266.9	83	310.9	104	385.2	94	356.1	81	350.4	83	353.1
King	3,100	174.7	2,482	139.5	2,616	146.3	3,024	174.3	3,371	233.3	3,570	243.1
Kitsap	559	238.2	557	235.0	590	246.3	466	202.8	579	318.1	546	297.6
Kittitas	103	296.0	143	406.2	108	301.7	132	374.7	117	386.5	113	363.7
Klickitat	80	414.5	51	264.2	72	373.1	90	485.2	113	764.0	107	717.5
Lewis	210	299.1	184	261.4	169	239.0	189	277.1	231	421.6	179	320.4
Lincoln	26	254.9	22	217.8	32	313.7	35	367.7	23	294.6	33	417.2
Mason	141	283.1	180	358.6	137	269.7	155	311.6	168	405.3	170	397.7
Okanogan	314	788.9	289	729.8	328	828.3	371	985.3	355	1,203.4	336	1,135.2
Pacific	99	471.4	81	387.6	91	433.3	92	454.2	92	533.3	81	465.9
Pend Oreille	54	457.6	95	805.1	67	563.0	31	265.8	59	634.8	56	586.3
Pierce	1,290	177.9	1,185	161.5	1,327	178.4	1,387	192.0	1,724	300.2	1,517	257.8
San Juan	50	342.5	34	229.7	59	390.7	53	360.5	80	617.5	43	326.8
Skagit	356	338.7	567	531.4	798	733.5	757	717.5	836	981.7	863	991.4
Skamania	57	575.8	57	575.8	44	435.6	39	395.2	56	704.4	48	596.5
Snohomish	1,018	162.1	1,239	194.4	1,201	186.3	1,264	201.7	1,213	244.1	1,159	227.8
Spokane	1,116	262.2	1,290	301.0	1,236	286.1	1,320	317.5	1,369	407.1	1,501	438.0
Stevens	131	324.3	140	344.8	139	341.5	164	417.5	191	620.1	199	630.5
Thurston	457	215.3	421	196.0	506	231.6	465	216.1	518	294.3	618	340.1
Wahkiakum	23	605.3	27	710.5	18	473.7	11	293.3	16	523.4	25	794.8
Walla Walla	146	263.5	219	392.5	209	368.6	202	371.3	178	399.6	234	520.5
Whatcom	736	427.4	597	342.1	568	320.4	570	329.6	627	439.7	783	536.1
Whitman	55	135.5	82	200.0	61	146.3	95	231.2	86	241.4	72	202.2
Yakima	1,472	654.2	1,322	585.0	1,436	631.2	1,439	661.4	1,509	931.2	1,621	986.9
Total	14,557	240.9	14,190	232.7	14,950	226.1	15,492	259.0	16,966	351.5	17,591	357.3

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population



- 200 to 300
- 150 to 200
- 100 to 150
- 50 to 100
- 0 to 50

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

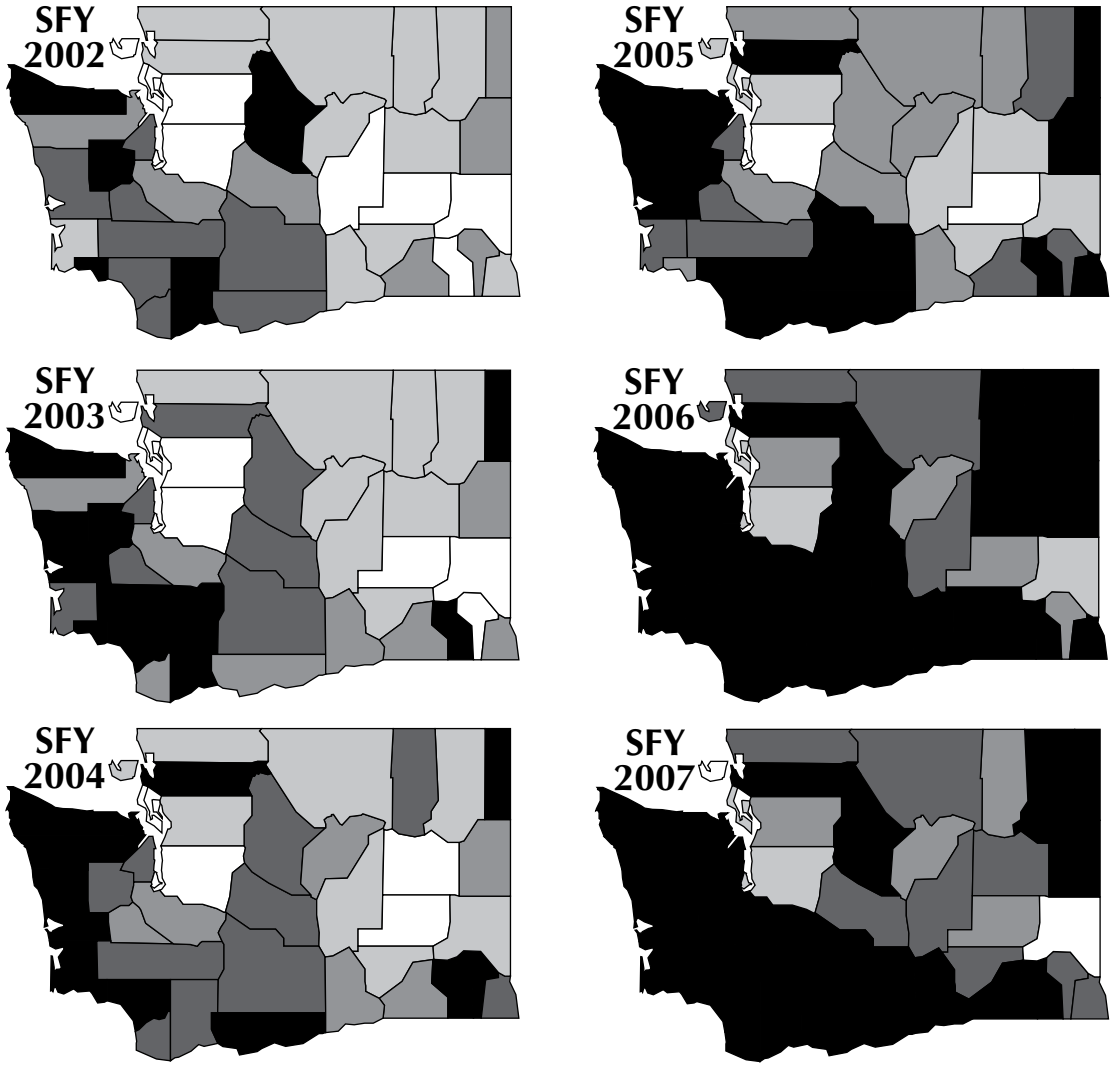
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Marijuana

County Name	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.0	3	18.1	2	12.0	6	12.0	3	25.6	5	41.9
Asotin	18	87.0	15	72.8	34	164.3	49	246.5	30	186.7	29	178.3
Benton	111	75.2	114	75.2	99	63.8	133	87.9	152	131.7	141	120.1
Chelan	68	100.6	82	120.8	84	122.8	99	150.9	68	131.7	84	159.7
Clallam	80	123.3	107	163.9	91	138.1	91	143.3	137	254.0	130	237.9
Clark	214	58.9	195	52.4	177	46.2	220	58.9	260	88.5	314	103.6
Columbia	7	170.7	7	170.7	4	97.6	5	127.5	17	533.1	11	344.0
Cowlitz	81	85.8	113	119.1	129	135.4	123	134.9	139	191.8	125	170.2
Douglas	12	36.3	15	44.6	26	76.0	15	45.5	17	65.9	35	133.1
Ferry	11	150.7	16	219.2	16	219.2	20	277.2	35	622.2	25	440.0
Franklin	43	83.8	40	74.6	44	77.2	54	93.0	71	165.0	89	196.4
Garfield	3	125.0	2	83.3	3	125.0	3	131.6	4	220.1	4	224.1
Grant	56	73.3	52	67.4	69	88.1	66	87.5	99	176.4	66	114.5
Grays Harbor	77	112.6	87	126.5	83	119.9	130	195.2	93	173.9	116	215.1
Island	25	34.2	35	47.3	43	57.5	34	46.8	46	78.3	36	60.2
Jefferson	21	78.9	25	93.6	39	144.4	43	162.9	25	108.2	41	174.4
King	611	34.4	512	28.8	570	31.9	677	39.0	851	58.9	910	62.0
Kitsap	148	63.1	155	65.4	199	83.1	187	81.4	223	122.5	213	116.1
Kittitas	19	54.6	23	65.3	29	81.0	33	93.7	30	99.1	36	115.9
Klickitat	15	77.7	21	108.8	24	124.4	37	199.5	61	412.4	63	422.5
Lewis	55	78.3	82	116.5	75	106.1	76	111.4	61	111.3	77	137.8
Lincoln	3	29.4	5	49.5	8	78.4	3	31.5	5	64.0	6	75.9
Mason	25	50.2	50	99.6	42	82.7	65	130.7	81	195.4	70	163.8
Okanogan	38	95.5	52	131.3	52	131.3	54	143.4	44	149.2	85	287.2
Pacific	21	100.0	26	124.4	28	133.3	32	158.0	22	127.5	35	201.3
Pend Oreille	11	93.2	23	194.9	11	92.4	10	85.7	12	129.1	19	198.9
Pierce	426	58.8	442	60.2	514	69.1	606	83.9	728	126.8	682	115.9
San Juan	16	109.6	15	101.4	18	119.2	18	122.4	34	262.4	15	114.0
Skagit	116	110.4	129	120.9	146	134.2	162	153.5	166	194.9	148	170.0
Skamania	8	80.8	20	202.0	14	138.6	10	101.3	17	213.8	14	174.0
Snohomish	265	42.2	329	51.6	329	51.0	314	50.1	344	69.2	354	69.6
Spokane	264	62.0	250	58.3	277	64.1	305	73.4	329	97.8	411	119.9
Stevens	29	71.8	25	61.6	37	90.9	25	63.6	52	168.8	60	190.0
Thurston	174	82.0	189	88.0	167	76.4	171	79.5	204	115.9	174	95.8
Wahkiakum	4	105.3	7	184.2	6	157.9	1	26.7	3	98.1	9	286.1
Walla Walla	28	50.5	50	89.6	52	91.7	59	108.4	65	145.9	92	204.6
Whatcom	172	99.9	140	80.2	130	73.3	134	77.5	131	91.9	159	108.9
Whitman	14	34.5	22	53.7	22	52.8	24	58.4	30	84.2	12	33.7
Yakima	447	198.7	358	158.4	436	191.6	403	185.2	441	272.1	545	331.8
Total	3,738	61.9	3,833	62.9	4,129	66.9	4,497	75.2	5,130	106.3	5,440	110.5

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population



- 200 to 250
- 150 to 200
- 100 to 150
- 50 to 100
- 0 to 50

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

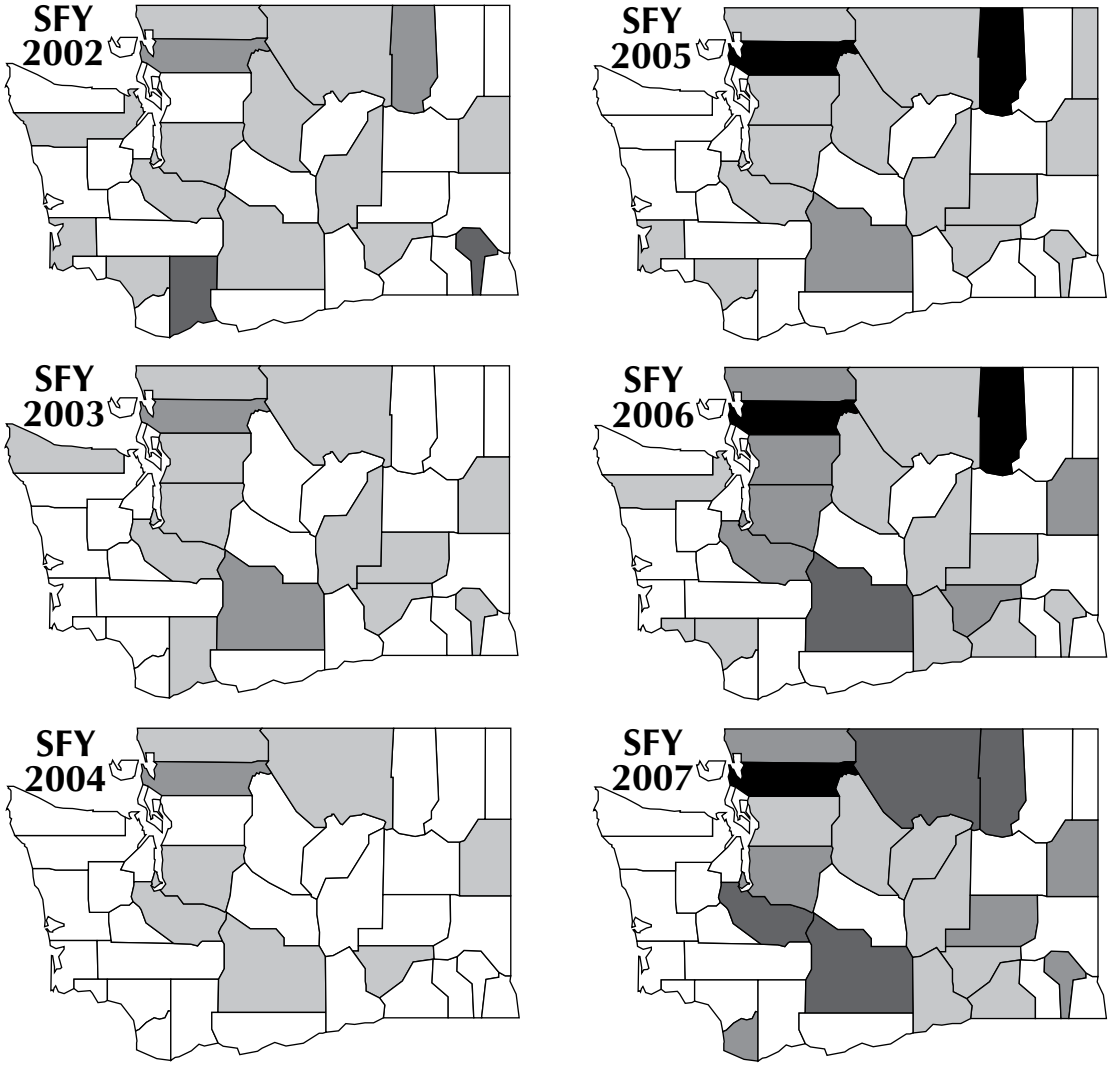
TARGET Treatment Admissions to Publicly Funded Treatment Service

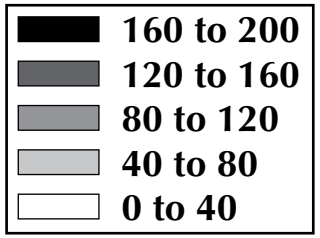
Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	5	30.1	1	6.0	7	41.9	4	24.6	12	102.6	12	100.5
Asotin	21	101.4	25	121.4	37	178.7	63	316.9	64	398.3	36	221.3
Benton	165	111.8	156	102.9	177	114.1	225	148.7	345	298.9	332	282.7
Chelan	137	202.7	105	154.6	109	159.4	93	141.8	136	263.5	134	254.8
Clallam	152	234.2	204	312.4	225	341.4	212	333.8	254	470.9	234	428.2
Clark	576	158.5	542	145.6	581	151.6	827	221.3	921	313.3	861	284.1
Columbia	1	24.4	12	292.7	10	243.9	8	204.0	8	250.9	10	312.7
Cowlitz	185	196.0	261	275.0	276	289.6	380	416.8	440	607.2	359	488.9
Douglas	33	99.7	31	92.3	38	111.1	37	112.2	26	100.9	39	148.4
Ferry	5	68.5	7	95.9	11	150.7	10	138.6	14	248.9	6	105.6
Franklin	29	56.5	48	89.6	48	84.2	50	86.1	106	246.4	87	192.0
Garfield	4	166.7	1	41.7	5	208.3	4	175.5	2	110.1	3	168.1
Grant	36	47.1	67	86.9	69	88.1	70	92.8	108	192.4	69	199.7
Grays Harbor	126	184.2	149	216.6	148	2213.9	197	295.7	241	450.6	237	439.4
Island	32	43.8	29	39.2	37	49.5	37	50.9	40	68.1	38	63.5
Jefferson	28	105.3	28	104.9	60	222.2	57	215.9	99	428.3	58	246.8
King	659	37.1	488	27.4	679	38.0	849	48.9	1,117	77.3	1,037	70.6
Kitsap	363	154.7	406	171.3	422	176.2	418	181.9	449	246.7	393	214.2
Kittitas	43	123.6	53	150.6	56	156.4	49	139.1	74	244.5	60	193.1
Klickitat	34	176.2	21	108.8	48	248.7	46	248.0	85	574.7	66	442.6
Lewis	136	193.7	180	255.7	138	195.2	132	193.5	157	286.5	149	266.7
Lincoln	10	98.0	7	69.3	3	29.4	9	94.5	25	320.2	15	189.6
Mason	108	216.9	116	231.1	88	173.2	141	283.4	141	340.2	130	304.1
Okanogan	21	52.8	23	58.1	35	88.4	49	130.1	50	169.5	47	158.8
Pacific	33	157.1	34	162.7	47	223.8	32	158.0	52	301.5	50	287.6
Pend Oreille	13	110.2	34	288.1	30	252.1	29	248.7	27	290.5	36	376.9
Pierce	1,079	148.8	889	121.2	870	116.9	1,078	149.2	1,475	256.8	1,193	202.7
San Juan	7	47.9	6	40.5	8	53.0	9	61.2	22	169.8	6	45.6
Skagit	103	98.0	190	178.1	240	220.6	320	303.3	377	442.7	273	313.6
Skamania	42	424.2	28	282.8	20	198.0	32	324.2	52	654.0	37	459.8
Snohomish	301	47.9	370	58.0	414	64.2	518	82.6	679	136.7	680	133.7
Spokane	462	108.6	557	130.0	637	147.5	841	202.3	922	274.2	840	245.1
Stevens	23	56.9	31	76.4	28	68.8	64	162.9	77	250.0	88	278.8
Thurston	342	161.1	327	152.2	306	140.0	346	160.8	353	200.6	434	238.9
Wahkiakum	10	263.2	12	315.8	8	210.5	4	106.7	20	654.2	17	540.5
Walla Walla	66	119.1	70	125.4	75	132.3	85	156.2	98	220.0	119	264.7
Whatcom	142	82.5	117	67.0	114	64.3	182	105.2	229	160.6	241	165.0
Whitman	19	46.8	10	24.4	23	55.2	24	58.4	30	84.2	13	36.5
Yakima	379	168.4	359	158.8	385	169.2	444	204.1	694	428.2	783	476.7
Total	5,930	98.2	5,994	98.3	6,512	105.6	7,975	133.3	10,021	207.6	9,222	187.3

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population





Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

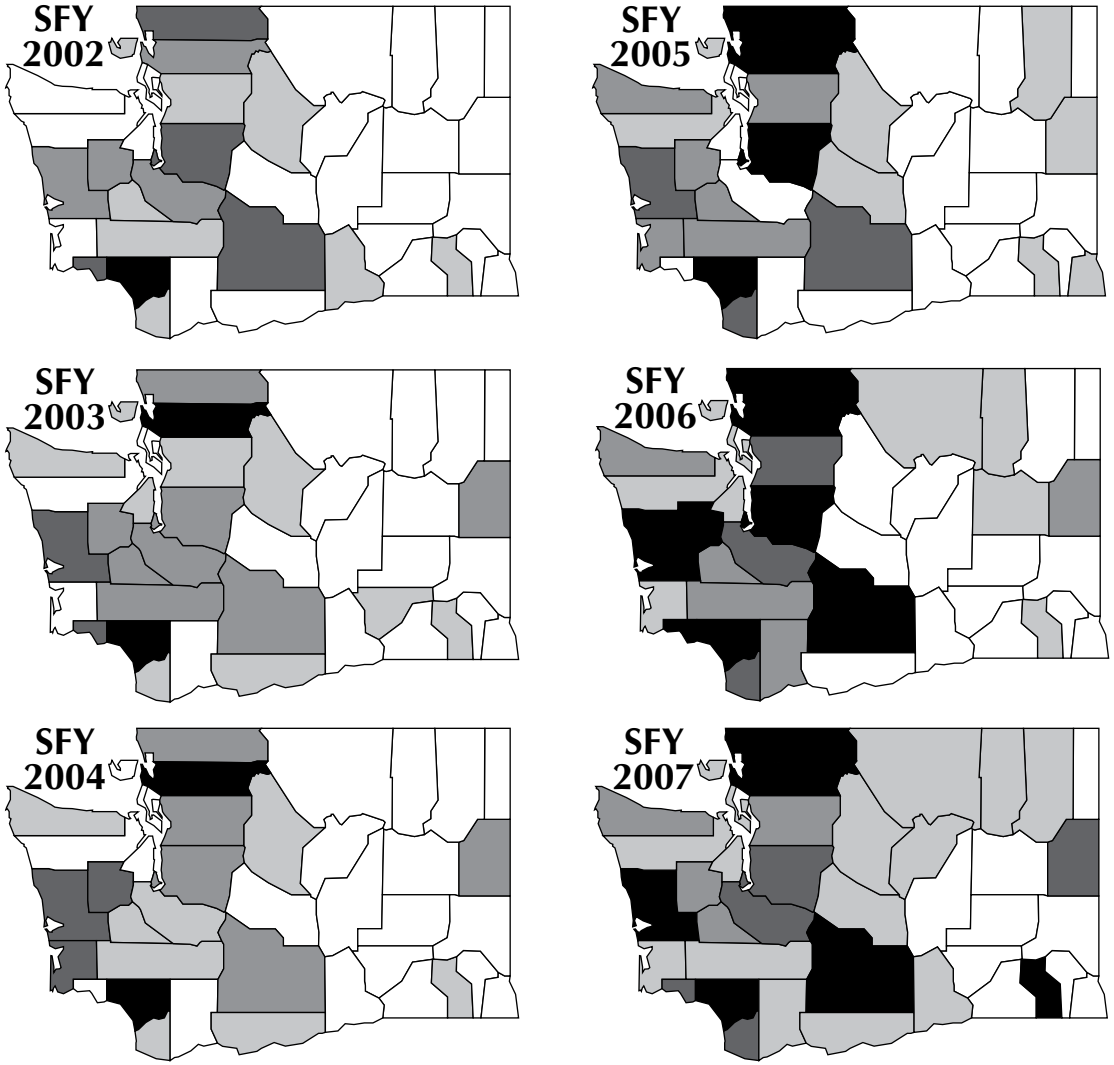
TARGET Treatment Admissions to Publicly Funded Treatment Service

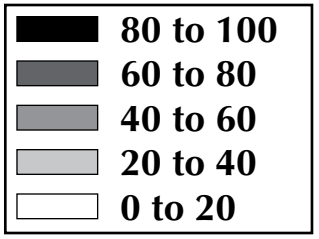
Washington State Adult Treatment Admissions* Primary Drug = Cocaine

County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	4	24.1	8	48.2	2	12.0	9	55.4	8	68.4	12	100.5
Asotin	0	0.0	0	0.0	0	0.0	4	20.1	1	6.2	6	36.9
Benton	46	31.2	37	24.4	41	26.4	44	29.1	68	58.9	62	52.8
Chelan	28	41.4	27	39.8	26	38.0	27	41.2	35	67.8	31	59.0
Clallam	14	21.6	32	49.0	20	30.3	16	25.2	16	29.7	18	32.9
Clark	116	31.9	88	23.6	113	29.5	116	31.0	109	37.1	130	42.9
Columbia	0	0.0	1	24.4	0	0.0	1	25.5	1	31.4	0	0.0
Cowlitz	51	54.0	33	34.8	35	36.7	41	45.0	33	45.5	29	39.5
Douglas	6	18.1	8	23.8	11	32.2	13	39.4	4	15.5	15	57.1
Ferry	6	82.2	1	13.7	2	27.4	13	180.2	27	480.0	8	140.8
Franklin	30	58.5	30	56.0	38	66.7	34	58.5	51	118.5	36	79.4
Garfield	3	125.0	1	41.7	0	0.0	1	43.9	1	55.0	2	112.0
Grant	40	52.4	38	49.3	33	42.1	34	45.1	39	69.5	27	46.8
Grays Harbor	7	10.2	16	23.3	19	27.5	11	16.5	12	22.4	17	31.5
Island	10	13.7	13	17.6	22	29.4	15	20.6	16	27.2	12	20.1
Jefferson	11	41.4	7	26.2	4	14.8	4	15.2	14	60.6	6	25.5
King	974	54.9	895	50.3	960	53.7	1,337	77.1	1,537	106.4	1,733	118.0
Kitsap	61	26.0	69	29.1	98	40.9	56	24.4	59	32.4	68	37.1
Kittitas	5	14.4	9	25.6	3	8.4	0	0.0	4	13.2	11	35.4
Klickitat	1	5.2	1	5.2	2	10.4	1	5.4	2	13.5	2	13.4
Lewis	2	2.8	4	5.7	9	12.7	3	4.4	8	14.6	2	3.6
Lincoln	1	9.8	0	0.0	3	29.4	0	0.0	2	25.6	1	12.6
Mason	8	16.1	9	17.9	18	35.4	11	22.1	13	31.4	13	30.4
Okanogan	17	42.7	24	60.6	22	55.6	29	77.0	22	74.6	38	128.4
Pacific	12	57.1	6	28.7	5	23.8	9	44.4	3	17.4	6	34.5
Pend Oreille	2	16.9	3	25.4	0	0.0	6	51.4	3	32.3	3	31.4
Pierce	416	57.4	418	57.0	463	62.2	483	66.9	681	118.6	729	123.9
San Juan	5	34.2	3	20.3	3	19.9	3	20.4	4	30.9	2	15.2
Skagit	88	83.7	116	108.7	163	149.8	198	187.7	199	233.7	162	186.1
Skamania	15	151.5	5	50.5	4	39.6	1	10.1	0	0.0	0	0.0
Snohomish	243	38.7	273	42.8	273	42.3	288	45.9	413	83.1	323	63.5
Spokane	238	55.9	316	73.7	305	70.6	262	63.0	340	101.1	372	108.5
Stevens	8	19.8	12	29.6	3	7.4	13	33.1	7	22.7	11	34.8
Thurston	59	27.8	42	19.6	39	17.8	47	21.8	29	16.5	65	35.8
Wahkiakum	0	0.0	1	26.3	0	0.0	0	0.0	2	65.4	1	31.8
Walla Walla	8	14.4	12	21.5	21	37.0	12	22.1	19	42.7	18	40.0
Whatcom	87	50.5	119	68.2	90	50.8	112	64.8	148	103.8	163	111.6
Whitman	8	19.7	7	17.1	4	9.6	7	17.0	4	11.2	0	0.0
Yakima	280	124.4	229	101.3	221	97.1	188	86.4	200	123.4	237	144.3
Total	2,910	48.2	2,913	47.8	3,075	49.9	3,449	57.7	4,134	71.0	4,371	88.8

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population





Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

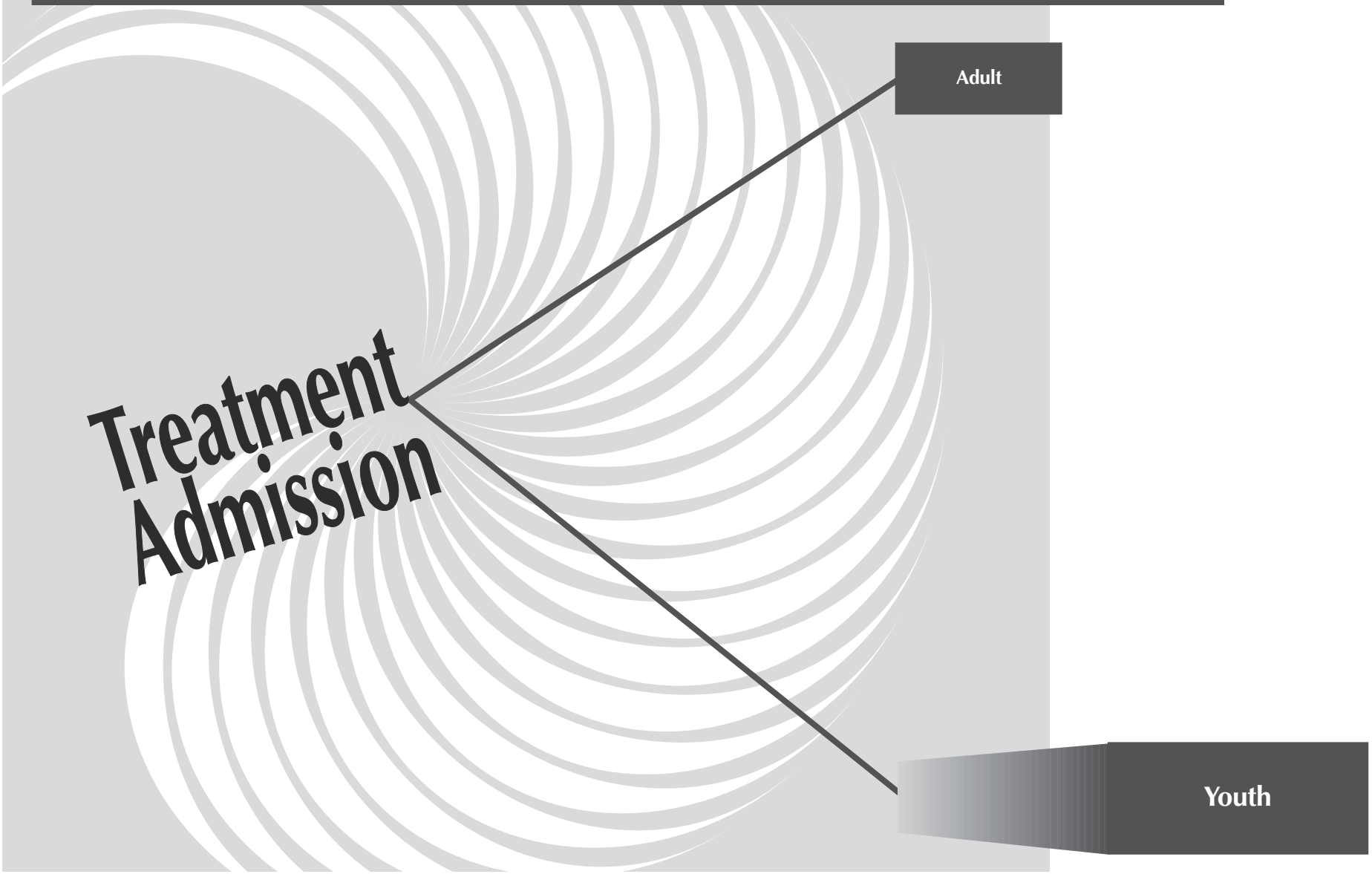
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Adult Treatment Admissions* Primary Drug = Heroin

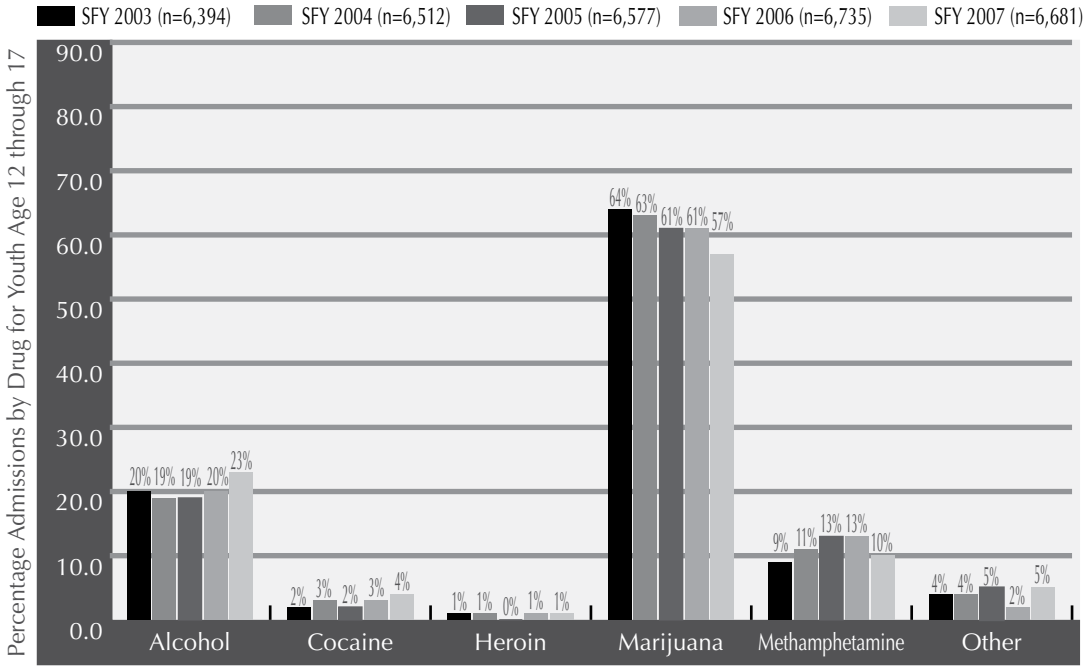
County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.0	0	0.0	0	0.0	0	0.0	1	8.5	0	0.0
Asotin	0	0.0	1	4.9	1	4.8	5	25.1	3	18.7	1	6.1
Benton	31	21.0	22	14.5	18	11.6	21	13.9	19	16.5	29	24.7
Chelan	16	23.7	15	22.1	19	27.8	19	29.0	5	9.7	15	28.5
Clallam	8	12.3	16	24.5	22	33.4	27	42.5	30	55.6	22	40.3
Clark	131	36.0	112	30.1	96	25.0	244	65.3	200	68.0	187	61.7
Columbia	1	24.4	1	24.4	1	24.4	1	25.5	1	31.4	4	125.1
Cowlitz	89	94.3	91	95.9	90	94.4	97	106.4	81	111.8	116	158.0
Douglas	4	12.1	4	11.9	0	0.0	0	0.0	4	15.5	7	26.6
Ferry	0	0.0	0	0.0	1	13.7	0	0.0	2	35.6	2	35.2
Franklin	9	17.5	14	26.1	10	17.5	5	8.6	6	13.9	3	6.6
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	5	6.5	12	15.6	3	3.8	6	8.0	6	10.7	4	6.9
Grays Harbor	31	45.3	55	79.9	45	65.0	49	73.6	45	84.1	52	96.4
Island	5	6.8	2	2.7	7	9.4	7	9.6	12	20.4	19	31.8
Jefferson	2	7.5	2	7.5	3	11.1	8	30.3	5	21.6	7	29.8
King	1,200	67.7	783	44.0	984	55.0	1,844	106.3	1,485	102.8	1,171	79.7
Kitsap	37	15.8	56	23.6	43	18.0	34	14.8	46	25.3	41	22.3
Kittitas	3	8.6	2	5.7	0	0.0	0	0.0	1	3.3	8	25.7
Klickitat	0	0.0	6	31.1	7	36.3	0	0.0	1	6.8	3	20.1
Lewis	20	28.5	36	51.1	28	39.6	39	57.2	22	40.2	16	28.6
Lincoln	1	9.8	1	9.9	2	19.6	0	0.0	3	38.4	0	0.0
Mason	22	44.2	32	63.7	32	63.0	29	58.3	35	84.4	19	44.5
Okanogan	2	5.0	3	7.6	6	15.2	2	5.3	6	20.3	8	27.0
Pacific	4	19.0	4	19.1	15	71.4	11	54.3	5	29.0	5	28.8
Pend Oreille	0	0.0	2	16.9	1	8.4	0	0.0	0	0.0	1	10.5
Pierce	367	50.6	321	43.8	264	35.5	267	37.0	383	66.7	364	61.9
San Juan	4	27.4	3	20.3	1	6.6	5	34.0	5	38.6	4	30.4
Skagit	46	43.8	93	87.2	152	139.7	141	133.6	148	173.8	137	157.4
Skamania	1	10.1	0	0.0	2	19.8	1	10.1	4	50.3	3	37.3
Snohomish	151	24.0	142	22.3	282	47.1	308	49.1	331	66.6	249	48.9
Spokane	174	40.9	203	47.4	178	41.2	148	35.6	173	51.4	229	66.8
Stevens	4	9.9	1	2.5	1	2.5	8	20.4	5	16.2	8	25.3
Thurston	83	39.1	120	55.9	78	35.7	124	57.6	72	40.9	85	46.8
Wahkiakum	3	78.9	3	78.9	0	0.0	0	0.0	5	163.6	2	63.6
Walla Walla	4	7.2	9	16.1	3	5.3	3	5.5	4	9.0	8	17.8
Whatcom	120	69.7	93	53.3	87	49.1	143	82.7	147	103.1	152	104.1
Whitman	0	0.0	8	19.5	1	2.4	0	0.0	0	0.0	3	8.4
Yakima	176	78.2	122	54.0	134	58.9	116	62.1	148	91.3	153	93.1
Total	2,755	45.6	2,390	39.2	2,617	42.4	3,712	62.1	3,449	71.5	3,137	63.7

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Admission Trends



Marijuana is the Most Frequently Cited Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

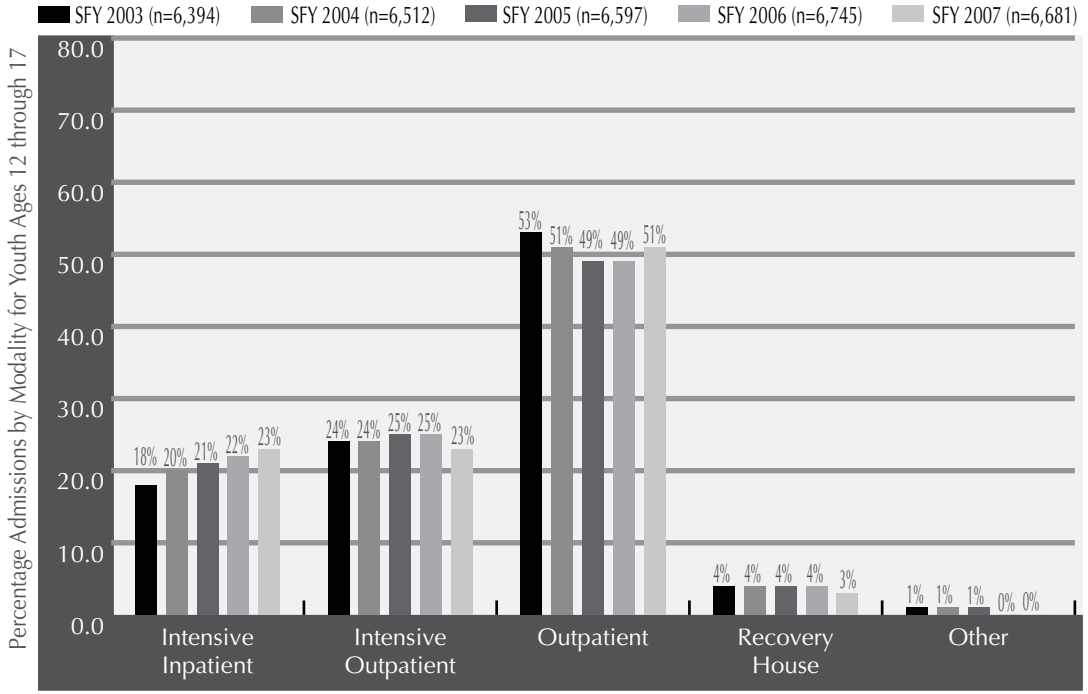
This graph indicates that the majority of youth admissions to DASA-funded treatment are for marijuana. However, marijuana admissions declined 6.6% between SFY 2003 and SFY 2007. Admissions for alcohol increased by 14.7% between SFY 2006 and SFY 2007. There was a precipitous fall in admissions for methamphetamine abuse, from 876 in SFY 2006 to 622 in SFY 2007, representing a 29.0% decline.

Of special note is the increase in youth admissions where the primary drug of abuse was a prescription-type opiate (non-heroin opiates and synthetics, oxycodone/hydrocodone, and prescribed opiate substitute). There were 104 such admissions in SFY 2007, up from 77 in SFY 2006, and 38 in SFY 2003.

Note: Data may include multiple admissions for a single individual over the course of a year.

** Excludes detoxification and transitional housing.*

The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.*



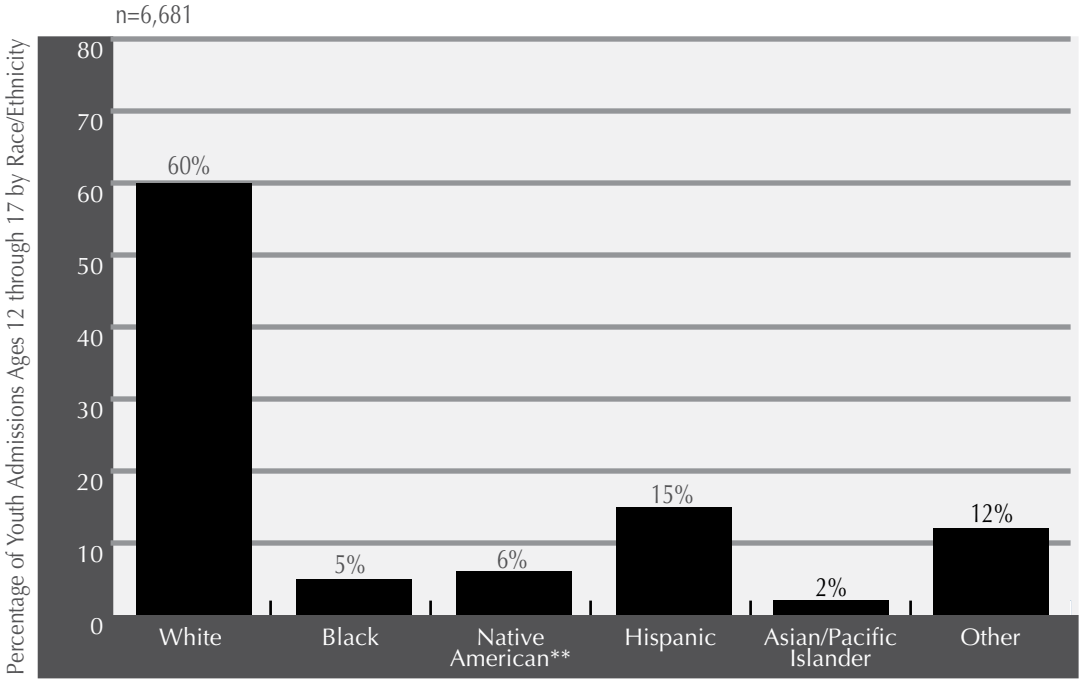
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

Almost three-quarters of youth admissions to DASA-funded chemical dependency treatment are for outpatient and intensive outpatient services.

Note: Data may include multiple admissions for a single individual over the course of a year. "Other" includes group care enhancement, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

** Excludes detoxification and transitional housing.*

Racial and Ethnic Minorities Comprise 40% of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.



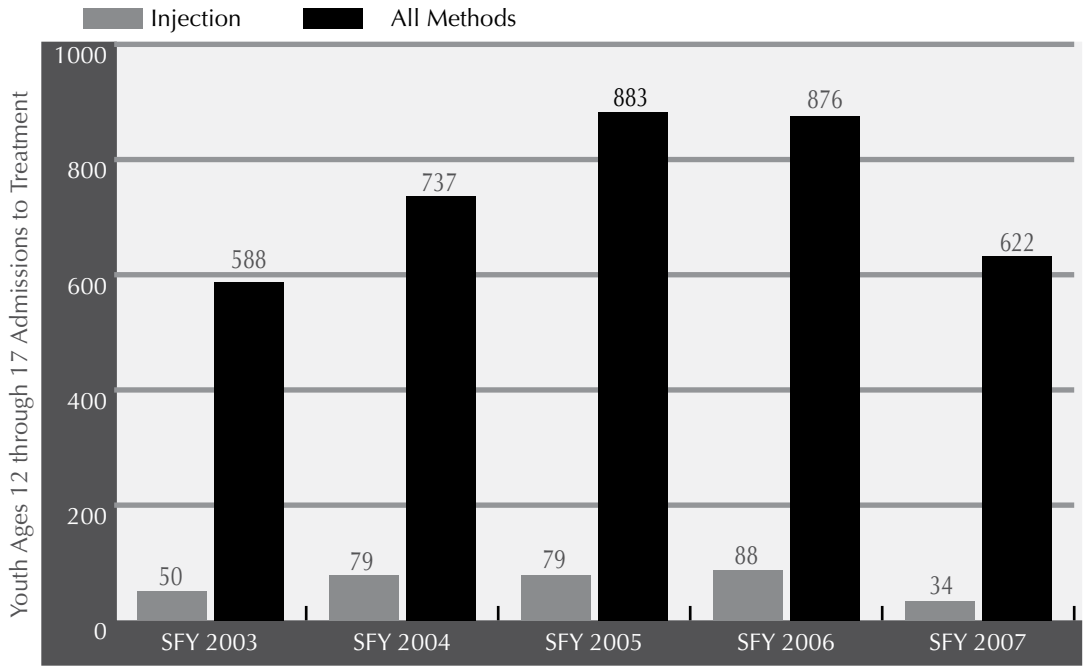
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprised approximately 40% of youth admissions to DASA-funded chemical dependency treatment in SFY 2007. Percentages of youth from different groups receiving DASA-funded treatment vary across modalities.

** Includes Eskimo/Alaskan Native/Aleut*

NEW/CHANGING TREND

DASA-Funded Youth Treatment Admissions for Methamphetamine Have Declined Precipitously.



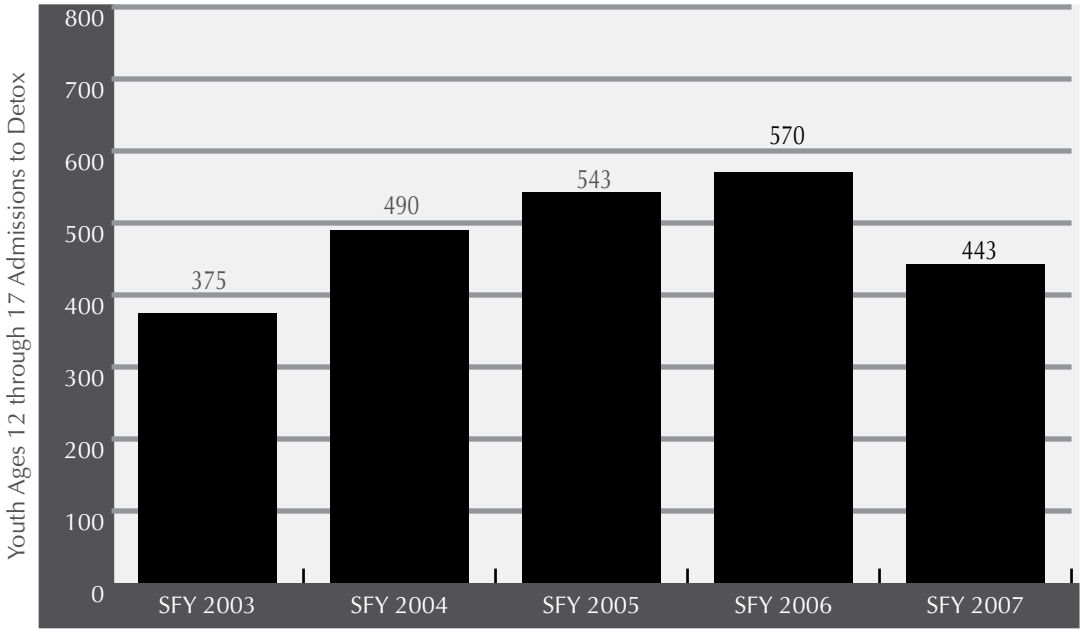
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

DASA-funded youth admissions for methamphetamine abuse have dropped substantially, by 29% between SFY 2006 and 2007. The number of youth who entered treatment having injected methamphetamine declined by more than half, and is at it lowest point in this decade.

At the same time as methamphetamine-related youth admissions are decreasing, treatment admissions for abuse of prescription-type opiates (non-heroin opiates and synthetics, oxycodone/hydrocodone, prescribed opiate substitute) have increased substantially, from 38 in SFY 2003 to 104 in SFY 2007.

Note: Data exclude detoxification and transitional housing, private-pay, and Department of Corrections admission; includes total unduplicated admissions within counties.

The Number of Youth Admissions to DASA-Funded Detoxification Declined in SFY 2007.

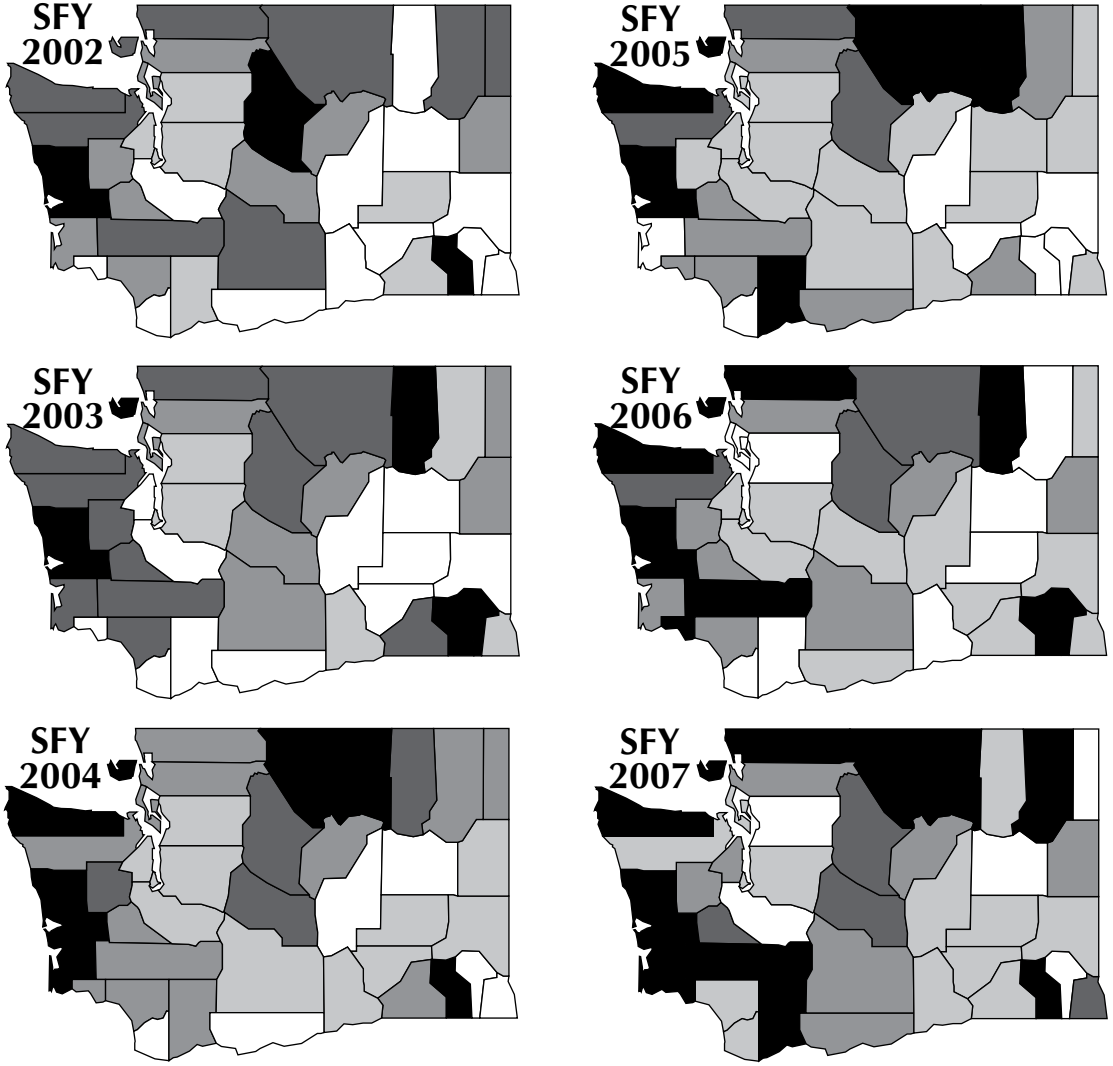


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that the number of youth admissions to DASA-funded detoxification services fell in SFY 2007. A plurality of DASA-funded youth admissions to detoxification services are for marijuana.

Detoxification is part of the array of services available to youth in crisis, and is often a necessary precursor to chemical dependency treatment.

Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population



- 200+
- 150 to 200
- 100 to 150
- 50 to 100
- 0 to 50

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

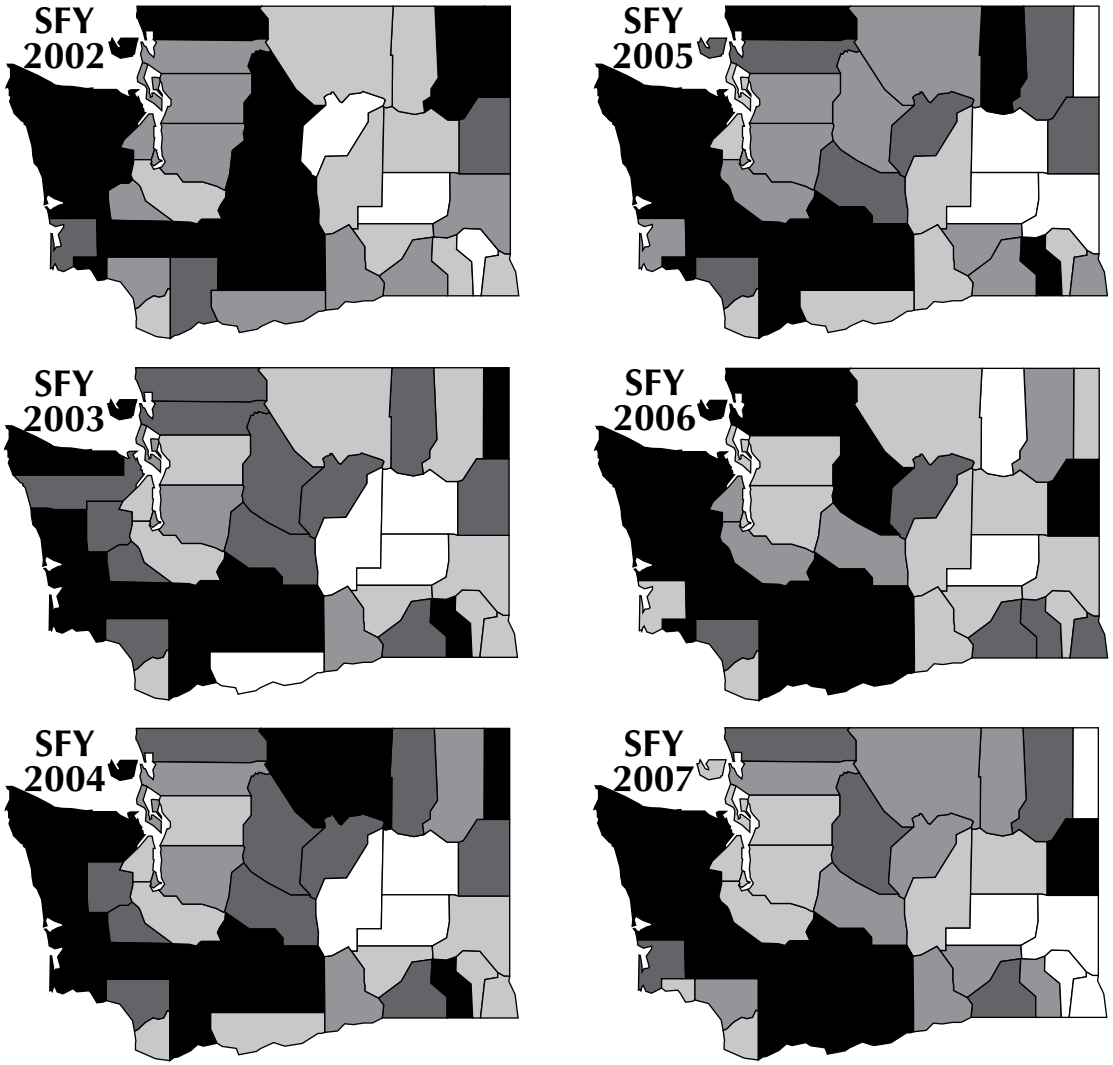
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions * Primary Drug = Alcohol

County Name	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	5	89.7	2	36.3	4	72.9	3	54.1	0	0.0	4	70.7
Asotin	0	0.0	4	78.9	2	39.8	5	99.4	5	99.4	9	178.8
Benton	18	41.8	32	73.1	25	56.4	24	53.6	22	48.7	37	81.4
Chelan	77	415.3	35	190.2	31	169.1	34	184.9	32	173.2	28	150.4
Clallam	23	164.7	21	151.8	40	290.5	63	456.6	39	281.4	62	447.5
Clark	39	38.1	37	35.7	26	24.6	52	48.6	46	42.0	66	59.0
Columbia	3	313.3	10	1,060.0	6	644.7	0	0.0	3	329.3	3	332.6
Cowlitz	27	109.0	47	191.2	27	110.7	36	148.0	27	111.0	15	61.5
Douglas	14	146.3	12	125.0	14	144.8	9	92.6	12	120.9	13	129.9
Ferry	0	0.0	5	264.9	3	161.1	4	214.2	4	213.4	1	53.5
Franklin	1	5.7	7	38.7	10	52.5	8	39.8	11	52.0	20	90.5
Garfield	0	0.0	2	332.4	0	0.0	0	0.0	2	343.2	0	0.0
Grant	11	45.7	10	41.7	11	45.6	10	41.3	16	65.4	15	60.4
Grays Harbor	54	314.2	53	310.7	53	312.7	44	259.9	64	378.2	52	308.4
Island	19	104.1	20	109.7	23	126.2	15	81.8	9	48.8	11	59.3
Jefferson	10	197.0	8	159.7	6	120.3	8	159.0	9	177.0	4	78.5
King	281	71.8	263	67.7	285	73.8	226	58.3	260	66.6	295	75.1
Kitsap	35	56.9	30	48.8	33	53.7	44	72.0	39	63.5	62	101.1
Kittitas	8	114.8	9	129.6	11	158.0	6	85.2	6	84.2	11	152.2
Klickitat	1	19.6	2	39.7	2	40.2	5	100.4	4	79.9	5	100.2
Lewis	33	181.0	30	166.3	21	117.3	25	139.3	38	209.8	72	394.8
Lincoln	1	39.7	0	0.0	1	40.9	2	83.6	1	41.8	1	41.8
Mason	14	122.2	21	184.4	18	158.2	8	69.6	17	145.9	17	143.4
Okanogan	18	167.0	18	170.1	26	248.8	24	232.1	16	155.3	28	274.4
Pacific	5	113.9	7	162.8	14	329.1	2	47.0	6	141.2	9	213.5
Pend Oreille	6	198.0	3	100.4	3	100.9	3	99.6	2	66.5	0	0.0
Pierce	84	43.4	85	43.9	100	51.4	102	52.0	107	53.7	99	49.0
San Juan	5	184.2	7	259.0	11	405.5	8	291.7	6	218.7	9	328.1
Skagit	36	133.0	32	117.9	28	102.3	38	137.5	35	125.2	38	134.5
Skamania	2	77.6	1	39.3	3	116.8	7	269.7	0	0.0	12	452.3
Snohomish	100	59.1	92	54.1	89	52.2	108	62.8	72	41.2	88	49.6
Spokane	122	113.7	117	109.6	93	87.4	86	80.7	148	137.6	126	116.1
Stevens	22	194.0	8	71.2	14	125.8	12	107.6	4	35.4	24	209.9
Thurston	73	138.6	83	157.6	55	103.8	67	124.4	60	108.9	91	161,6
Wahkiakum	0	0.0	0	0.0	1	118.9	1	117.3	3	355.9	2	234.0
Walla Walla	13	97.6	25	188.6	18	135.3	14	104.6	12	89.8	11	82.4
Whatcom	73	179.6	61	150.1	56	137.2	74	179.4	92	220.7	87	205.9
Whitman	2	28.0	3	42.2	6	84.3	3	41.8	7	97.6	7	98.7
Yakima	128	182.3	75	107.5	69	99.3	68	97.8	84	120.4	78	111.5
Total	1,363	89.5	1,277	84.0	1,238	81.3	1,248	81.5	1,320	85.2	1,512	96.6

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population



- 400+
- 300 to 400
- 200 to 300
- 100 to 200
- 0 to 100

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

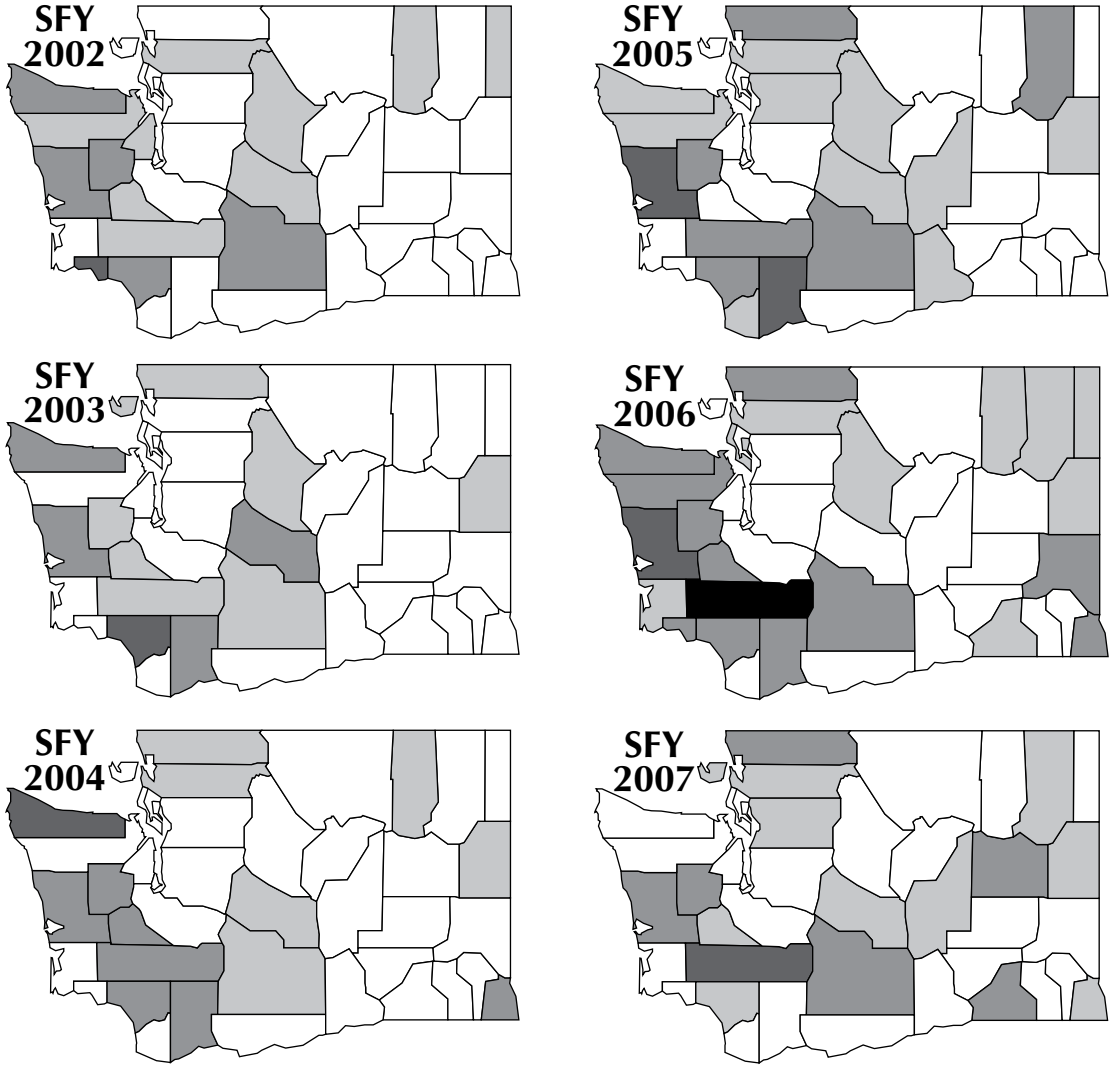
TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions * Primary Drug = Marijuana

County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	2	36.3	2	36.4	0	0.0	1	17.8	4	70.7
Asotin	10	193.7	6	118.4	12	119.3	14	278.5	17	337.9	3	59.6
Benton	95	220.6	92	210.3	79	207.7	81	180.9	89	197.1	114	250.7
Chelan	76	409.9	71	385.8	52	387.2	46	250.2	83	449.2	59	316.9
Clallam	75	537.1	83	599.8	112	602.7	99	717.6	100	721.4	99	714.6
Clark	139	135.9	166	160.1	167	157.1	189	176.5	182	166.1	196	175.1
Columbia	1	104.4	5	530.0	2	537.2	5	543.4	3	329.3	2	221.7
Cowlitz	66	266.5	92	374.3	125	377.1	75	308.4	75	308.2	61	250.2
Douglas	9	94.1	29	302.1	30	300.0	36	370.3	33	332.6	25	249.7
Ferry	2	104.4	6	317.9	2	322.2	9	482.0	1	53.3	5	267.7
Franklin	24	137.4	25	138.3	24	131.2	45	224.0	41	193.6	46	208.3
Garfield	0	0.0	1	166.2	0	168.3	1	170.1	1	171.6	0	0.0
Grant	28	116.4	19	79.1	25	78.7	48	198.4	38	155.3	39	156.9
Grays Harbor	108	628.4	103	603.7	96	607.7	80	472.6	80	472.8	74	438.9
Island	47	257.5	47	257.7	47	258.0	25	136.4	29	157.2	22	118.5
Jefferson	35	689.4	20	399.2	25	400.9	25	496.8	29	570.4	29	569.1
King	955	243.9	921	237.2	827	238.5	801	206.8	721	184.8	622	158.3
Kitsap	151	245.3	91	148.1	92	148.2	111	181.6	135	219.9	112	182.7
Kittitas	31	444.7	24	345.6	45	344.8	28	397.4	19	266.5	19	262.8
Klickitat	12	234.8	5	99.2	10	100.4	7	140.6	29	579.0	26	521.3
Lewis	109	597.8	102	565.3	86	569.9	103	573.9	81	447.3	83	455.1
Lincoln	5	198.6	2	81.4	3	81.7	2	83.6	4	167.2	3	125.5
Mason	61	532.5	45	395.2	66	395.6	47	408.8	51	437.7	59	497.6
Okanogan	19	176.3	21	198.5	16	201.0	29	280.4	19	184.5	25	245.0
Pacific	17	387.2	40	930.6	15	940.3	9	211.3	7	164.7	14	332.1
Pend Oreille	17	560.9	12	401.7	1	403.7	1	33.2	5	166.3	2	65.6
Pierce	374	193.2	360	185.8	409	185.1	394	200.9	361	181.3	338	167.3
San Juan	12	442.0	12	444.0	8	442.4	9	328.1	13	473.8	4	145.8
Skagit	73	269.7	82	302.1	95	299.7	103	372.8	120	429.4	84	297.4
Skamania	9	349.0	12	471.0	9	467.0	16	616.4	11	415.2	13	490.0
Snohomish	352	208.0	335	197.0	333	196.7	355	206.4	281	160.6	277	156.0
Spokane	387	360.7	398	372.8	408	374.0	320	300.3	446	414.7	522	481.1
Stevens	46	405.7	31	275.7	41	278.5	40	358.6	32	283.3	43	376.0
Thurston	150	284.7	187	355.1	237	353.0	270	501.4	300	544.6	264	468.9
Wahkiakum	4	460.9	4	468.5	4	475.4	2	234.6	6	711.8	1	117.0
Walla Walla	36	270.2	48	362.2	28	360.7	29	216.8	42	314.4	41	307.3
Whatcom	169	415.9	155	381.3	180	379.8	172	417.0	189	453.3	154	364.5
Whitman	16	224.1	12	169.0	8	168.5	4	55.7	12	167.3	7	98.7
Yakima	467	664.9	426	610.6	351	612.8	389	559.6	304	435.9	320	457.5
TOTAL	4,187	275.0	4,092	269.2	4,072	267.6	4,019	262.4	3,990	257.6	3,811	243.5

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population



- 300+
- 200 to 300
- 100 to 200
- 50 to 100
- 0 to 50

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

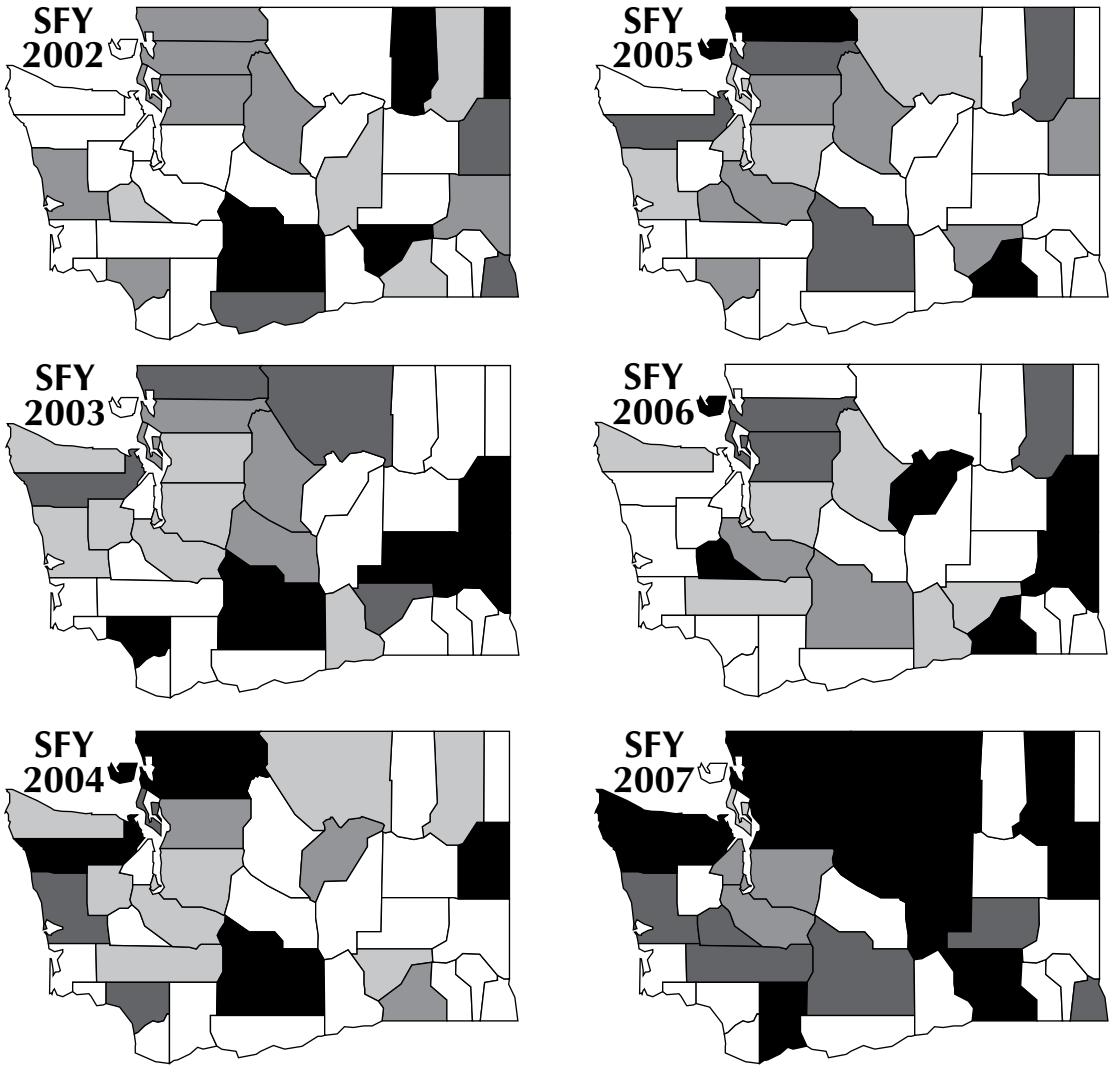
TARGET Treatment Admissions to Publicly Funded Treatment Service

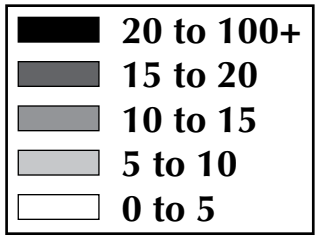
Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	0	0.0	1	18.0	0	0.0	1	17.7
Asotin	2	38.7	2	39.5	7	139.2	1	19.9	6	119.3	5	99.3
Benton	17	39.5	11	25.1	20	45.1	25	55.8	22	48.7	16	35.2
Chelan	15	80.9	11	59.8	9	49.1	13	70.7	14	75.8	7	37.6
Clallam	15	107.4	20	144.5	29	210.6	13	94.2	19	137.1	5	36.1
Clark	48	46.9	37	35.7	45	42.6	68	63.5	46	42.0	19	17.0
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	25	100.9	54	219.7	47	192.6	34	139.8	31	127.4	19	77.9
Douglas	2	20.9	4	41.7	3	31.0	3	30.9	4	40.3	3	30.0
Ferry	1	52.2	0	0.0	1	53.7	0	0.0	1	53.3	0	0.0
Franklin	6	34.3	2	11.1	1	5.2	4	19.9	7	33.1	5	22.6
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	5	20.8	0	0.0	11	45.6	13	53.7	9	36.8	13	52.3
Grays Harbor	21	122.2	29	170.0	21	123.9	39	230.4	40	236.4	17	100.8
Island	4	21.9	3	16.4	10	54.9	5	27.3	11	59.6	0	0.0
Jefferson	4	78.8	2	39.9	2	40.1	5	99.4	9	177.0	2	39.3
King	68	17.4	79	20.3	72	18.6	86	22.2	48	12.3	52	13.2
Kitsap	31	50.4	15	24.4	22	35.8	21	34.4	26	42.3	25	40.8
Kittitas	6	86.1	7	100.8	3	43.1	5	71.0	0	0.0	4	55.3
Klickitat	2	39.1	0	0.0	4	80.3	1	20.1	2	39.9	2	40.1
Lewis	15	82.3	18	99.8	19	106.2	26	144.9	56	309.2	39	213.8
Lincoln	0	0.0	1	40.7	0	0.0	0	0.0	1	41.8	3	125.5
Mason	15	130.9	11	96.6	12	105.5	17	147.9	16	137.3	14	118.1
Okanogan	4	37.1	2	18.9	5	47.8	2	19.3	1	9.7	2	19.6
Pacific	2	45.5	1	23.3	1	23.5	2	47.0	4	94.1	1	23.7
Pend Oreille	3	99.0	0	0.0	1	33.6	0	0.0	3	99.8	1	32.8
Pierce	39	20.1	64	33.0	72	37.0	68	34.7	60	30.1	50	24.7
San Juan	0	0.0	2	74.0	1	36.9	1	36.5	0	0.0	2	72.9
Skagit	22	81.3	13	47.9	18	65.8	15	54.3	16	57.3	17	60.2
Skamania	0	0.0	3	117.8	3	116.8	7	269.7	4	151.0	1	37.7
Snohomish	59	34.9	61	35.9	81	47.5	107	62.2	81	46.3	90	50.7
Spokane	48	44.7	57	53.4	93	87.4	81	76.0	104	96.7	57	52.5
Stevens	5	44.1	3	26.7	2	18.0	1	9.0	6	53.1	6	52.5
Thurston	46	87.3	41	77.9	59	111.4	81	150.4	95	172.4	49	87.0
Wahkiakum	2	230.4	0	0.0	0	0.0	0	0.0	1	118.6	0	0.0
Walla Walla	3	22.5	5	37.7	3	22.5	4	29.9	13	97.3	15	112.4
Whatcom	17	41.8	22	54.1	27	66.2	53	128.5	76	182.3	58	137.3
Whitman	0	0.0	0	0.0	3	42.1	3	41.8	9	125.5	3	42.3
Yakima	102	145.2	45	64.5	50	71.9	85	122.3	73	104.7	73	104.4
TOTAL	654	42.9	625	41.1	757	49.7	890	58.1	914	59.0	676	43.2

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population





Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

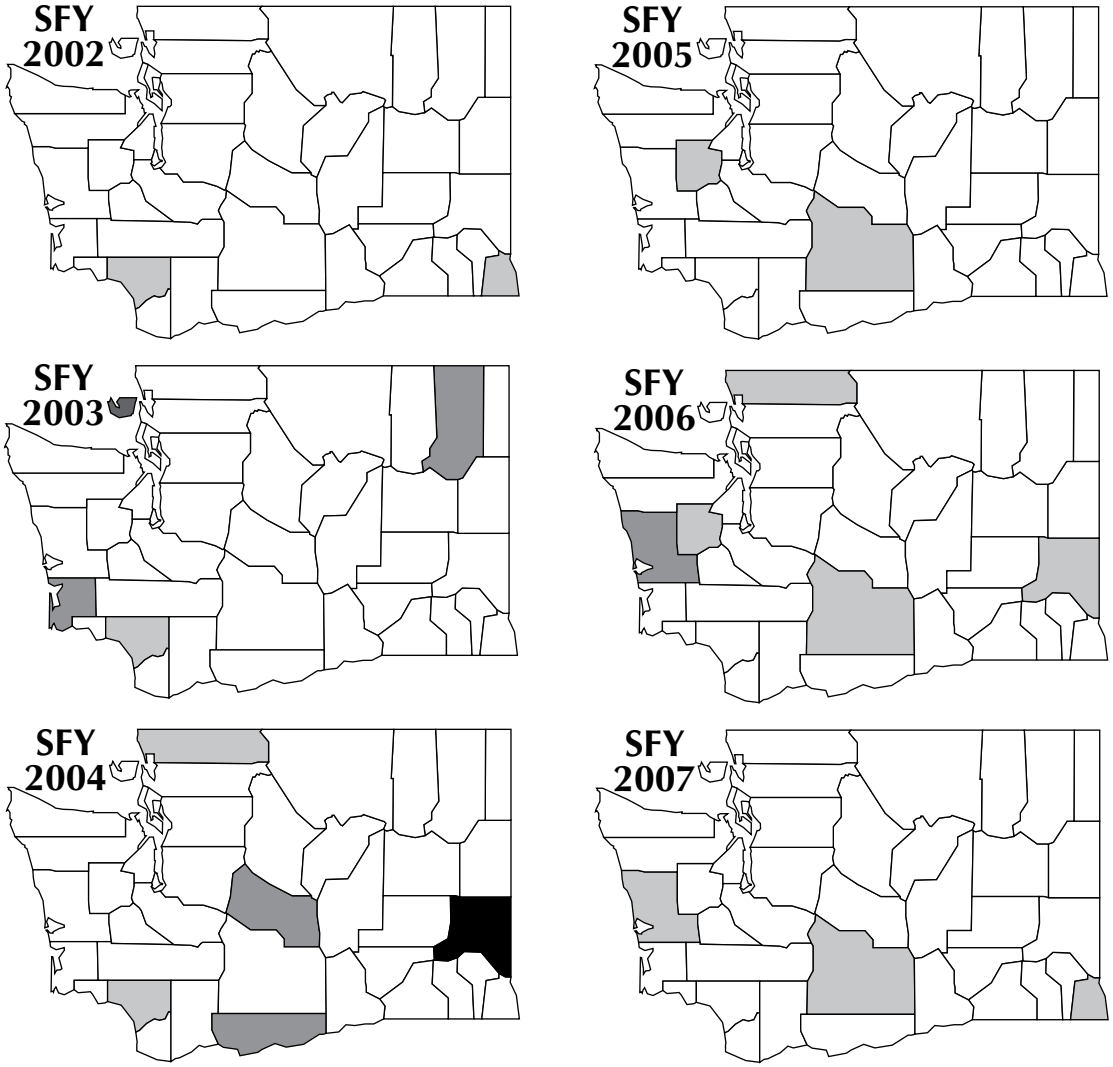
TARGET Treatment Admissions to Publicly Funded Treatment Service

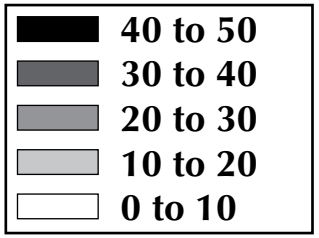
Washington State Youth Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	2	36.3	0	0.0	0	0.0	0	0.0	1	17.7
Asotin	1	19.4	0	0.0	0	0.0	0	0.0	0	0.0	1	19.9
Benton	1	2.3	3	6.9	1	2.3	2	4.5	4	8.9	6	13.2
Chelan	2	10.8	2	10.9	0	0.0	2	10.9	1	5.4	4	21.5
Clallam	0	0.0	1	7.2	1	7.3	0	0.0	1	7.2	3	21.7
Clark	3	2.9	1	1.0	1	0.9	1	0.9	2	1.8	2	1.8
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	3	12.1	7	28.5	4	16.4	3	12.3	0	0.0	0	0.0
Douglas	0	0.0	0	0.0	1	10.3	0	0.0	3	30.2	2	20.0
Ferry	1	52.2	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Franklin	5	28.6	3	16.6	1	5.2	3	14.9	2	9.4	6	27.2
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	2	8.3	1	4.2	1	4.1	1	4.1	1	4.1	6	24.1
Grays Harbor	2	11.6	1	5.9	3	17.7	1	5.9	0	0.0	3	17.8
Island	2	11.0	2	11.0	3	16.5	1	5.5	3	16.3	1	5.4
Jefferson	0	0.0	1	20.0	2	40.1	1	19.9	0	0.0	2	39.3
King	12	3.1	22	5.7	35	9.1	30	7.7	24	6.2	52	13.2
Kitsap	1	1.6	0	0.0	3	4.9	5	8.2	3	4.9	7	11.4
Kittitas	0	0.0	1	14.4	0	0.0	0	0.0	0	0.0	0	0.0
Klickitat	1	19.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Lewis	0	0.0	0	0.0	1	5.6	0	0.0	1	5.5	3	16.4
Lincoln	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mason	0	0.0	1	8.8	1	8.8	0	0.0	0	0.0	0	0.0
Okanogan	0	0.0	2	18.9	1	9.6	1	9.7	0	0.0	3	29.4
Pacific	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pend Oreille	2	66.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pierce	4	2.1	10	5.2	11	5.7	26	13.3	22	11.0	30	14.8
San Juan	0	0.0	0	0.0	1	36.9	2	72.9	5	182.2	0	0.0
Skagit	4	14.8	4	14.7	8	29.2	5	18.1	5	17.9	8	28.3
Skamania	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	37.7
Snohomish	20	11.8	11	6.5	24	14.1	23	13.4	28	16.0	36	20.3
Spokane	17	15.8	28	26.2	26	24.4	12	11.3	23	21.4	37	34.1
Stevens	1	8.8	0	0.0	1	9.0	2	17.9	2	17.7	5	43.7
Thurston	5	9.5	2	3.8	0	0.0	6	11.1	13	23.6	11	19.5
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	1	7.5	0	0.0	2	15.0	5	37.4	14	104.8	8	60.0
Whatcom	6	14.8	8	19.7	17	41.7	20	48.5	17	40.8	15	35.5
Whitman	1	14.0	3	42.2	0	0.0	0	0.0	0	0.0	0	0.0
Yakima	21	29.9	19	27.2	18	25.9	11	15.8	9	12.9	12	17.2
TOTAL	118	7.7	135	8.9	167	11.0	163	10.6	262	16.7	265	16.9

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population





Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

Washington State Youth Treatment Admissions* Primary Drug = Heroin

County	SFY 2002		SFY 2003		SFY 2004		SFY 2005		SFY 2006		SFY 2007	
Name	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asotin	1	19.4	0	0.0	0	0.0	0	0.0	0	0.0	1	19.9
Benton	2	4.6	1	2.3	10	0.0	0	0.0	0	0.0	0	0.0
Chelan	1	5.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Clallam	0	0.0	2	1.9	50	0.0	0	0.0	0	0.0	0	0.0
Clark	0	0.0	2	1.9	5	4.7	0	0.0	4	3.7	5	4.5
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	3	12.1	4	16.3	3	12.3	0	0.0	1	4.1	1	4.1
Douglas	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ferry	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Franklin	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grays Harbor	0	0.0	0	0.0	0	0.0	1	5.9	4	23.6	3	17.8
Island	0	0.0	0	0.0	1	5.5	0	0.0	0	0.0	0	0.0
Jefferson	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
King	7	1.8	8	2.1	5	1.3	6	1.5	6	1.5	6	1.5
Kitsap	4	6.5	0	0.0	3	4.9	1	1.6	2	3.3	0	0.0
Kittitas	0	0.0	0	0.0	1	20.1	0	0.0	0	0.0	0	0.0
Klickitat	0	0.0	0	0.0	1	20.1	0	0.0	0	0.0	0	0.0
Lewis	1	5.5	1	5.5	0	0.0	0	0.0	0	0.0	0	0.0
Lincoln	0	0.0	0	0.0	0	0.0	0	0.0	0	17.2	0	0.0
Mason	0	0.0	0	0.0	0	0.0	2	17.4	2	17.2	0	0.0
Okanogan	0	0.0	0	0.0	0	0.0	1	9.7	0	0.0	0	0.0
Pacific	0	0.0	1	23.3	0	0.0	0	0.0	0	0.0	0	0.0
Pend Oreille	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pierce	4	2.1	2	1.0	3	1.5	0	0.0	5	2.5	4	2.0
San Juan	0	0.0	1	37.0	0	0.0	0	0.0	0	0.0	0	0.0
Skagit	2	7.4	1	3.7	0	0.0	0	0.0	0	0.0	0	0.0
Skamania	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Snohomish	0	0.0	3	1.8	2	1.2	5	2.9	6	1.9	12	6.8
Spokane	4	3.7	2	1.9	4	3.8	2	1.9	2	1.9	0	0.0
Stevens	1	8.8	3	26.7	0	0.0	0	0.0	0	1.8	0	0.0
Thurston	2	3.8	2	3.8	2	3.8	1	1.9	1	1.8	1	1.8
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Whatcom	3	7.4	3	7.4	7	17.2	1	2.4	6	14.4	4	9.5
Whitman	0	0.0	0	0.0	4	56.2	0	0.0	1	13.9	0	0.0
Yakima	7	10.0	1	1.4	4	5.8	7	10.1	8	11.5	8	11.4
TOTAL	42	2.8	35	2.3	45	3.0	27	1.8	49	3.2	45	2.9

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Through the Criminal Justice Treatment Account

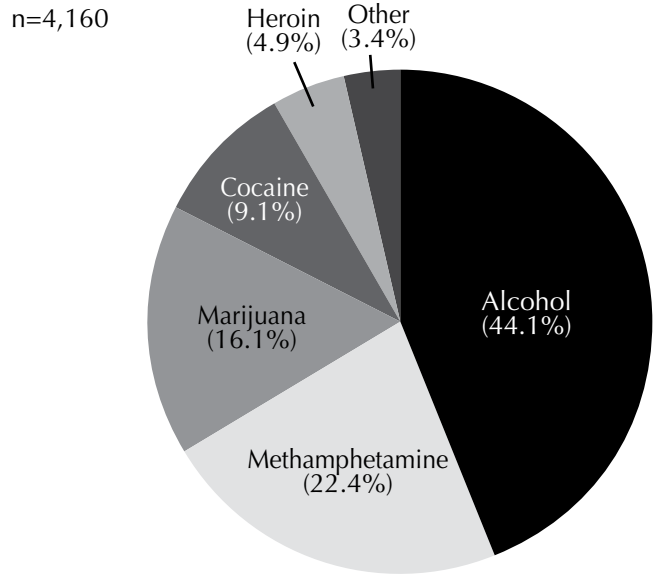
Criminal Justice Treatment Account (CJTA)

In 2003, the Legislature and Governor created the Criminal Justice Treatment Account (CJTA). Its history goes back to the previous year, when, in the 2002 Session, the Legislature effected a shift in adult felony drug offender sentencing policy, reducing sentences for many adult felony drug offenses, and designating the projected savings for use in providing substance abuse treatment for offenders, both in prison and in the community.

Administered by the Division of Alcohol and Substance Abuse (DASA), CJTA funds are used solely for providing substance abuse treatment and treatment support services for offenders who have a substance abuse problem and have been filed upon by a county prosecutor. The intent is to provide judicially supervised treatment in lieu of incarceration, with the objective of generating additional jail and prison bed savings, both in the short-term through treating offenders rather than incarcerating them, and in the long-term by reducing recidivism among those offenders. Use of the funds is determined at the county level, and may include drug courts, provided the funds are used only for treatment and treatment support services.

In SFY 2007, 4,160 individuals received treatment under CJTA.

In State Fiscal Year 2007, Alcohol was the Primary Substance of Abuse for the Majority of Individuals in Treatment Under the Criminal Justice Treatment Account.

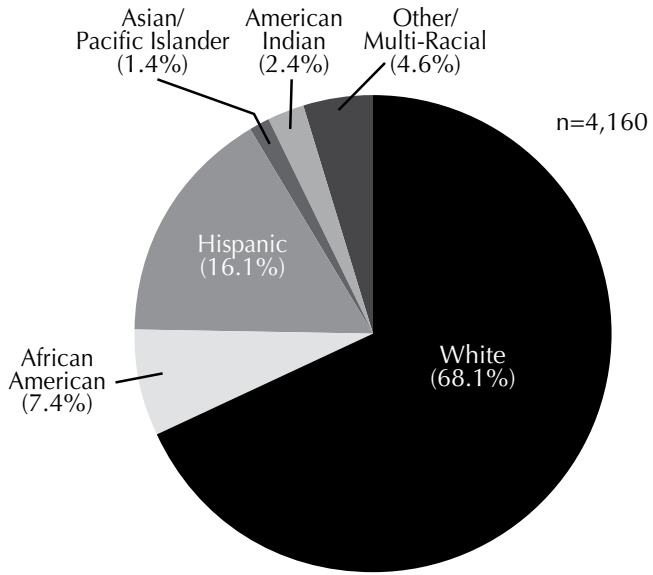


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2008.

In SFY 2007, alcohol was the primary substance of abuse for individuals in treatment under the Criminal Justice Treatment Account (CJTA). Both in Washington State and nationally, alcohol remains the single largest cause of mortality-, crime-, and health-related costs among all substances of abuse.

In SFY 2009, $9,005,731 is being transferred into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration. The percentage of CJTA clients being treated for methamphetamine abuse and addiction fell from 24.8% in SFY 2006 to 22.4% in SFY 2007.

In State Fiscal Year 2007, 31.9% of Those Receiving Treatment Under the Criminal Justice Treatment Account were Racial and Ethnic Minorities.

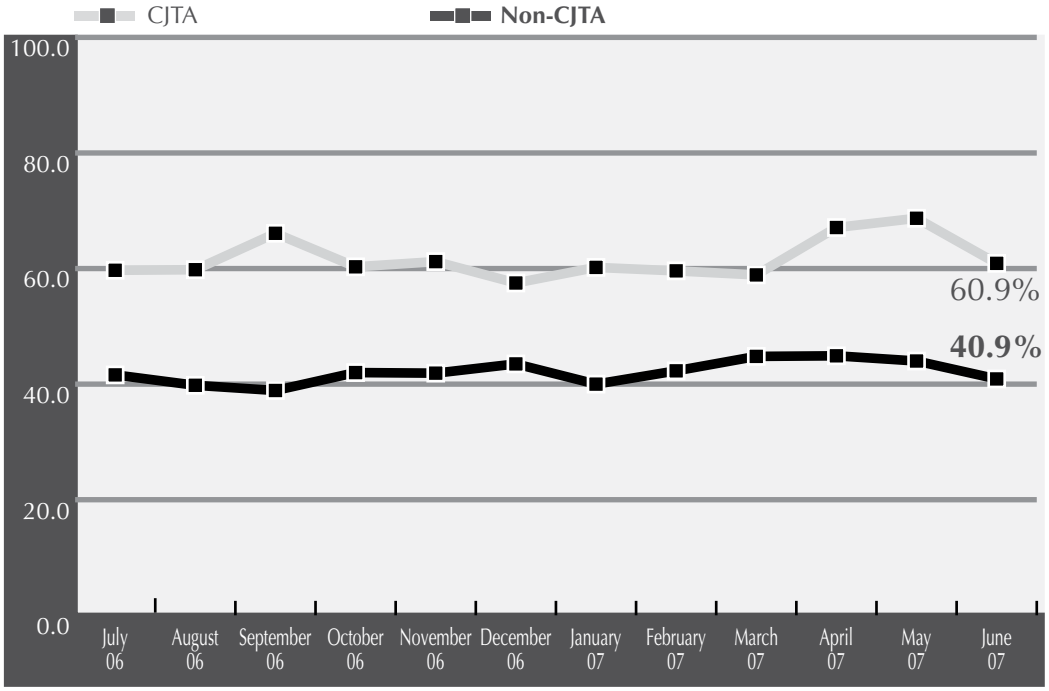


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2008.

In SFY 2006, almost a third of those receiving treatment under the Criminal Justice Treatment Account (CJTA) were racial and ethnic minorities. The median age was 32; 38.0% of patients were between 21 and 30 years old. Some 71% were male, 29% female.

In SFY 2009, $9,005,731 is being transferred annually into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration.

Patients Receiving Outpatient Treatment under the Criminal Justice Treatment Account were 49% More Likely to Complete Treatment than Other DASA-Funded Patients.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

In SFY 2007, patients receiving judicially supervised outpatient care under the Criminal Justice Treatment Account were significantly more likely to complete treatment than other DASA-funded patients (60.9% v. 40.9%). It is likely that the possibility of judicial sanctions has played a role in increasing treatment completion rates.

Treatment Through the Department of Corrections

The Washington State Department of Corrections Responds to the Need for Chemical Dependency Treatment.

Over the past decade, the need for quality chemical dependency treatment among inmates in the custody of the Washington State Department of Corrections (DOC) has become increasingly apparent. More than a quarter of individuals (26%) sentenced to DOC custody in SFY 2007 were convicted of drug offenses.[1] An even higher proportion was under the influence of alcohol or other drugs at the time they committed their offense.

Responding to this need, DOC provides a multi-phased continuum of care which includes: addiction pre-screening; comprehensive diagnostic assessment; intensive treatment and aftercare; and coordinated transition and case management services. The treatment regime is abstinence-based, and employs offender-specific, research-based best practices. All 42 DOC treatment sites are certified by the Division of Alcohol and Substance Abuse. The goal of DOC's program is to reduce reoffense, enhance the safety of communities, and prepare offenders for more productive lives once they are released.

Offenders screened and found to be chemically dependent, who are within two years of release from total confinement, or under community supervision, may be referred for a comprehensive diagnostic assessment conducted by a chemical dependency treatment professional, and admitted to treatment according to priorities set by DOC policy:

Primary Treatment - DOC provides two primary treatment modalities, which are Residential Therapeutic Community and Intensive Outpatient. The offender's severity of addiction, custody level, risk management classification, and time to serve in total confinement all factor into treatment placement.

- *Residential Therapeutic Community (Long-Term Residential)* is a progressive, phase-based level of care nine to twelve months in length, and is the most intensive form of primary treatment available within DOC. Employing best practices, the modified Residential Therapeutic Community provides separate living area and a highly structured treatment regime combining accountability, an emphasis on "right living", and chemical dependency treatment.

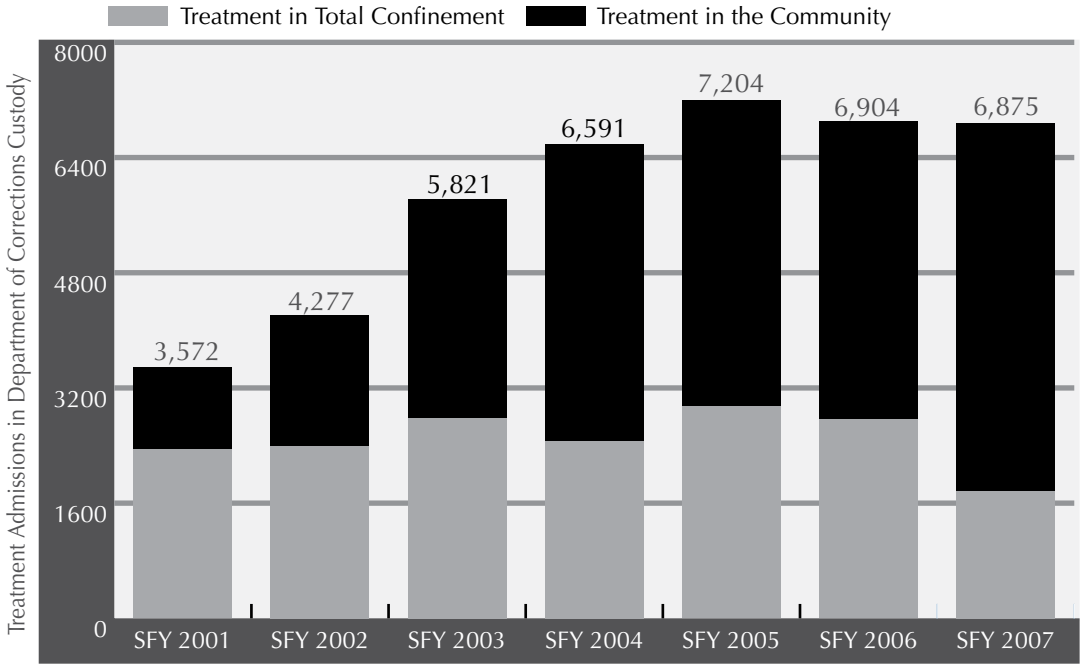
- *Intensive Outpatient (IOP)* is a highly structured intervention available in total and partial confinement facilities, as well as in community settings. IOP is offered in varying lengths of stay in order to meet the sentence structure and treatment needs of offenders in different institutions and in the community.

Outpatient Treatment (continuing care or aftercare) - Following completion of any primary level of treatment, offenders are admitted to outpatient treatment. Based on the offender's clinical progress, outpatient treatment may continue as needed, with a minimum of three months of outpatient treatment occurring upon release from total confinement. A transitional therapeutic community outpatient program is available at selected work release sites for those leaving the highly structured therapeutic community environment.

Community-Based Treatment - Offenders sentenced under the Drug Offender Sentencing Alternative (DOSA) and high-risk offenders residing in areas where DOC does not provide treatment are referred to other contract chemical dependency treatment providers for appropriate services. Within available resources, the Department of Corrections reimburses vendors for pre-authorized treatment. As a result of legislation enacted in 2005, DOSA offenders may now receive residential chemical dependency treatment in the community as part of their sentences.

[1] Washington State Department of Corrections, July 2008.

Washington State Has Made a Major Commitment to Providing Chemical Dependency Treatment to Offenders in Total Confinement and Community Custody.



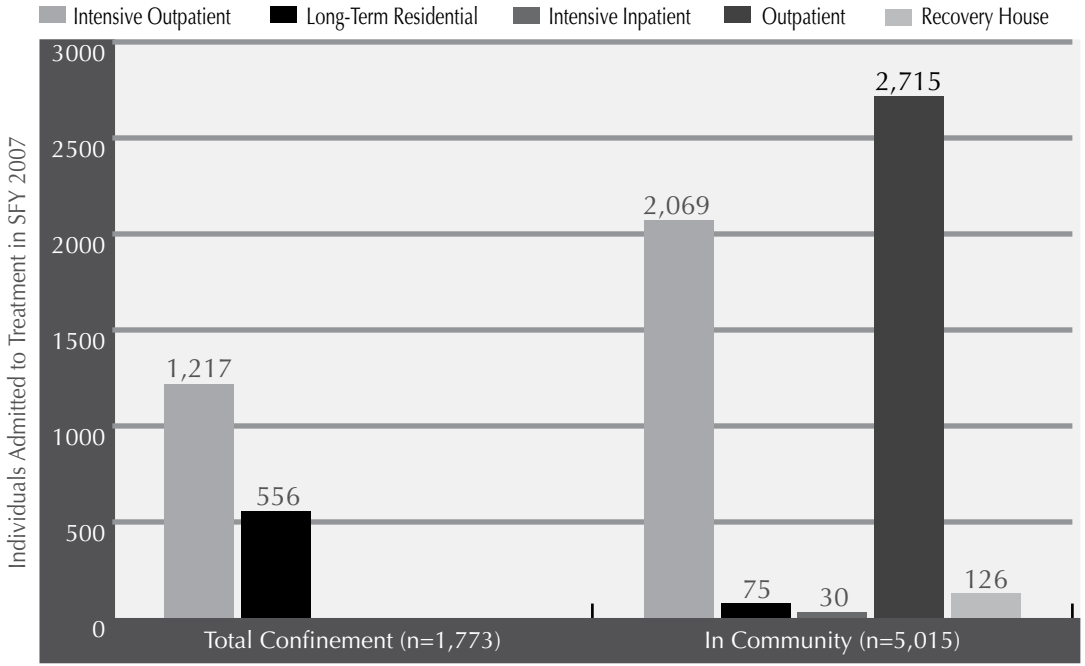
Source: Washington State Department of Corrections, July 2008.

This graph indicates the depth of commitment Washington State has made in recent years toward the provision of alcohol and drug treatment services to offenders in the state correctional system. Especially noteworthy is the expansion of services to offenders in community custody. Admissions to treatment in the community now represent 74% of total admissions.

Consistent with best practices, offenders are admitted to treatment as close to release from total confinement as possible. Based on an offender's clinical progress while in confinement, outpatient treatment may continue as needed, with a minimum of three months of treatment occurring after release.

The Majority of Individuals Admitted to Chemical Dependency Treatment in the State Correctional System Receive Intensive Outpatient Treatment.

Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2007

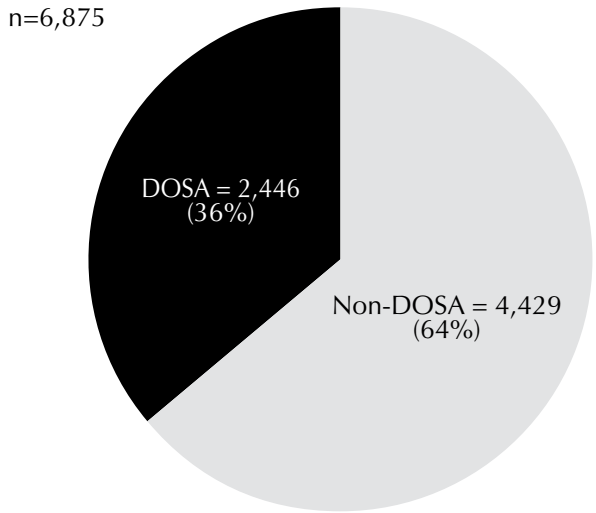


Source: Washington State Department of Corrections, July 2008.

The Washington State Department of Corrections provides five levels of chemical dependency treatment to offenders in custody who are assessed as in need. Long-term residential treatment is delivered in modified therapeutic communities, providing a highly structured living and treatment environment. Intensive outpatient treatment is provided both in correctional facilities and in communities in the form of highly structured interventions. A minimum of three months of outpatient treatment is provided in the community once an individual leaves total confinement. Legislation enacted in 2005 amended the Drug Offender Sentencing Alternative statute to provide for a residential chemical dependent treatment alternative in addition to the community custody option. A small number of individuals in the community receive recovery house services.

One-Quarter of Individuals Receiving Chemical Dependency Treatment in the State Correctional System are Sentenced Under the Drug Offender Sentencing Alternative (DOSA).

Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2006

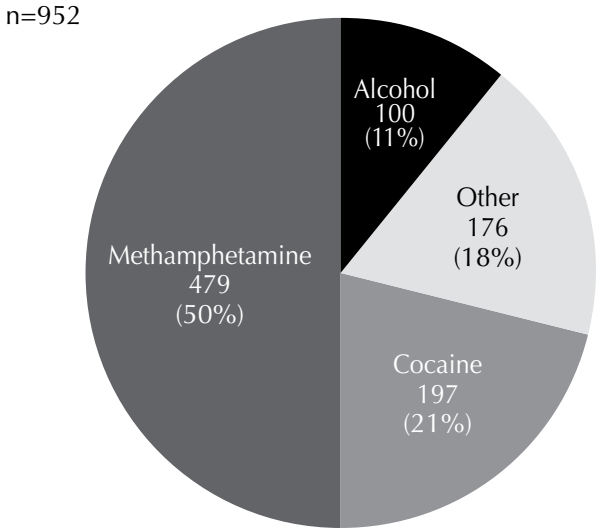


Source: Washington State Department of Corrections, July 2008.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring those offenders who: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted due to substance abuse problems may receive chemical dependency treatment through the Department of Corrections. To qualify, offenders must have no current or prior sex or violent offenses and must not have used a deadly weapon in the commission of the offense. Additionally, if the offense was a violation of the Uniform Controlled Substance Act, the offense must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder of the term to be served in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Services continue when the offender is released into community custody. Failure to meet conditions of the sentence – which can include drug testing and monitoring, and education or employment training – can result in imposition of the balance of the original sentence. As a result of legislation enacted in 2005, offenders may now receive residential chemical dependency treatment in the community as part of their sentences.

Half of Individuals Sentenced Under the Drug Offender Sentencing Alternative (DOSA) and Assessed in SFY 2007 Reported Methamphetamine as Their Primary Substance of Abuse.

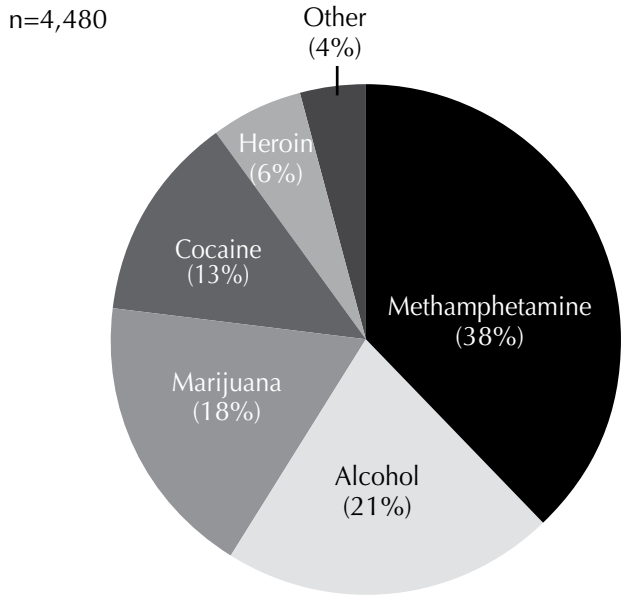


Source: Washington State Department of Corrections, July 2008.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring offenders may receive chemical dependency treatment through the Department of Corrections. Offenders must: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted by substance abuse problems. Offenders must have no current or prior sex or violence offenses or have used a deadly weapon in commission of the offense. If the offense was a violation of the Uniform Controlled Substance Act, it must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Sentences continue when the offender is released into community custody. As a result of legislation enacted in 2005, offenders may now receive residential chemical dependency treatment in the community as part of their sentences.

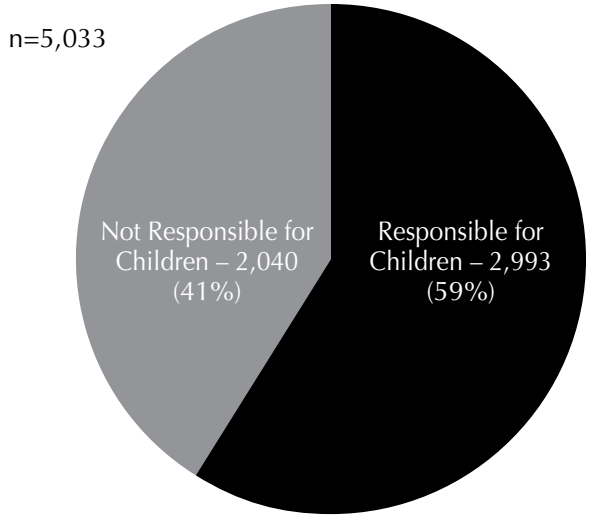
In SFY 2007, More than a Third of Individuals Assessed and Found in Need of Treatment By the Department of Corrections Reported Methamphetamine as Their Primary Substance of Abuse.



Source: Washington State Department of Corrections, July 2008.

Some 4,480 Department of Corrections clients assessed in SFY 2007 were found to be in need of treatment. The number of clients in need of treatment whose primary substance of abuse was methamphetamine has more than doubled, from 691 in SFY 2001 to 1,701 in SFY 2007.

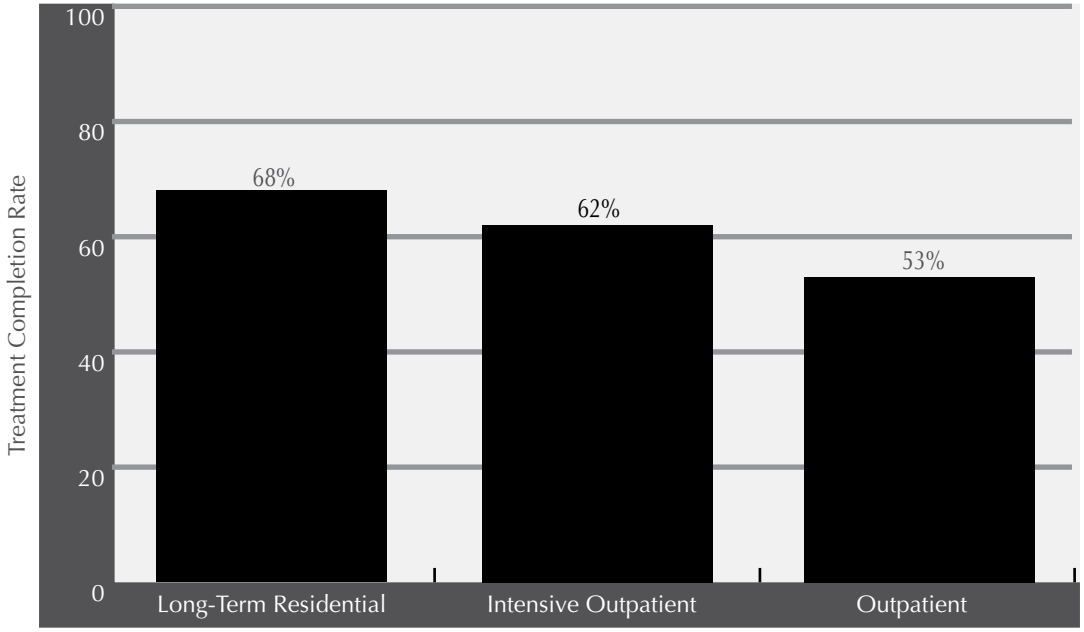
Almost 60% of Inmates in Department of Corrections Custody Admitted to Chemical Dependency Treatment During SFY 2007 were Responsible for Minor Children.



Source: Washington State Department of Corrections, July 2008.

Well over half of Department of Corrections custody in both total confinement and community custody admitted to chemical dependency treatment in SFY 2007 were responsible for minor children. Chemical dependency treatment is an important step in helping inmates recover from addiction and lead productive lives whereby they can care for their families.

In SFY 2007, More than Half of Those Receiving Chemical Dependency Treatment Through the Department of Corrections Completed It.



Source: Washington State Department of Corrections, July 2008.

Well more than half of those receiving chemical dependency treatment through the Department of Corrections complete it. Treatment completion is considered an important measure for inmates re-entering the community from incarceration, and should be associated with reduced criminal recidivism.

Washington State Brief Intervention, Referral, and Treatment Project (WASBIRT)

Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) Project

In the fall of 2003, the Washington State Governor's Office was awarded funding from the U.S. Department of Health and Human Services, Center for Substance Abuse Treatment (CSAT) for a five-year cooperative agreement, titled the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project. The Governor's Office directed the Division of Alcohol and Substance Abuse (DASA) to implement WASBIRT in large hospital emergency departments (EDs) across the state.

WASBIRT is designed to achieve the following goals:

- Maximize the number of ED patients with substance abuse problems who can be identified through screening.
- Deliver brief counseling - "brief intervention" - to patients who screen positive for substance use disorders.
- Deliver brief outpatient therapy through certified treatment organizations.
- Increase referrals of chemically dependent individuals to chemical dependency treatment agencies.
- Reduce subsequent emergency department use rates, medical costs, criminal behavior, disability, and death for patients with alcohol and/or other drug problems of all severity levels.
- Examine the degree to which substance abuse services can be expanded to include early intervention.
- Improve links between the medical and chemical dependency treatment communities so that providing screenings and interventions for substance use disorders can be sustained over time.

As a result of this grant, chemical dependency professionals (CDPs) have been providing substance use screenings, brief interventions, and referrals in nine hospitals in Clark, King, Pierce, Snohomish, Thurston, and Yakima Counties. Although federal grant funding for WASBIRT ended on September 30, 2008, the success of WASBIRT has led to sustainability and diffusion activities that will allow SBIRT services in King, Clark, Snohomish, Pierce, and Thurston Counties to continue without federal funding.

Of the 102,857 patients who received services through WASBIRT between April 2004 and August 2008, 49,650 (48%) were screened but required no additional action; 49,680 (48%) received both a screening and brief intervention; and 3,527 (3%) were also provided with brief therapy or traditional chemical dependency treatment.

About the Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) Program

WASBIRT utilizes a public health model to identify, intervene in, and treat substance use problems before they rise to the level of substance dependence, as well as providing direct referral to traditional chemical dependency (CD) services for those who need it. WASBIRT provides a continuum of services for patients at various levels of involvement with substance use. Successful outcomes can include: reduction in substance use to safe levels; self-imposed abstinence from substances; involvement in brief therapy with a corresponding change in risk behaviors (including but not limited to total abstinence); and engagement in higher levels of traditional CD services.

Screening

Screening at participating hospital emergency departments is universal; patients are not pre-identified as "substance users" prior to screening. All patients who are 18 years of age or older, not in police custody, or who are unable to consent to the process (unconscious, extreme trauma or pain, psychotic, or intoxicated) are candidates for screening. The screening, designed to identify individuals who have an alcohol and/or other drug use problem or are at risk for developing one, takes from 3-5 minutes to complete.

Brief Intervention

Once identified and risk is assessed through the screening process, patients may receive a brief intervention (BI) in the emergency department. BI is an individual, evidence-based, protocol-driven counseling process in which concerns about an individual's substance use behavior are expressed and strategies for behavioral change are explored. BI may also be oriented toward increasing a patient's motivation to engage in higher levels of care, either in the form of brief therapy (BT), or referral to traditional CD services. Each WASBIRT BI takes from 5-15 minutes, and is based on motivational interviewing techniques.

Brief Therapy

BT is a focused application of therapeutic techniques specifically targeting a substance use symptom or behavior and oriented toward a limited length of treatment. As with BI, reducing the risk of psycho-social or health-related problems attributable to alcohol and/or other drug use (including but not limited to total abstinence) is the primary goal of BT. BT can be delivered either within the hospital or in a traditional CD setting. Following BT, patients may be referred to traditional CD services if further treatment is warranted.

Medical Costs Declined Among Emergency Department Patients Who Received Brief Interventions for Substance Abuse Problems.

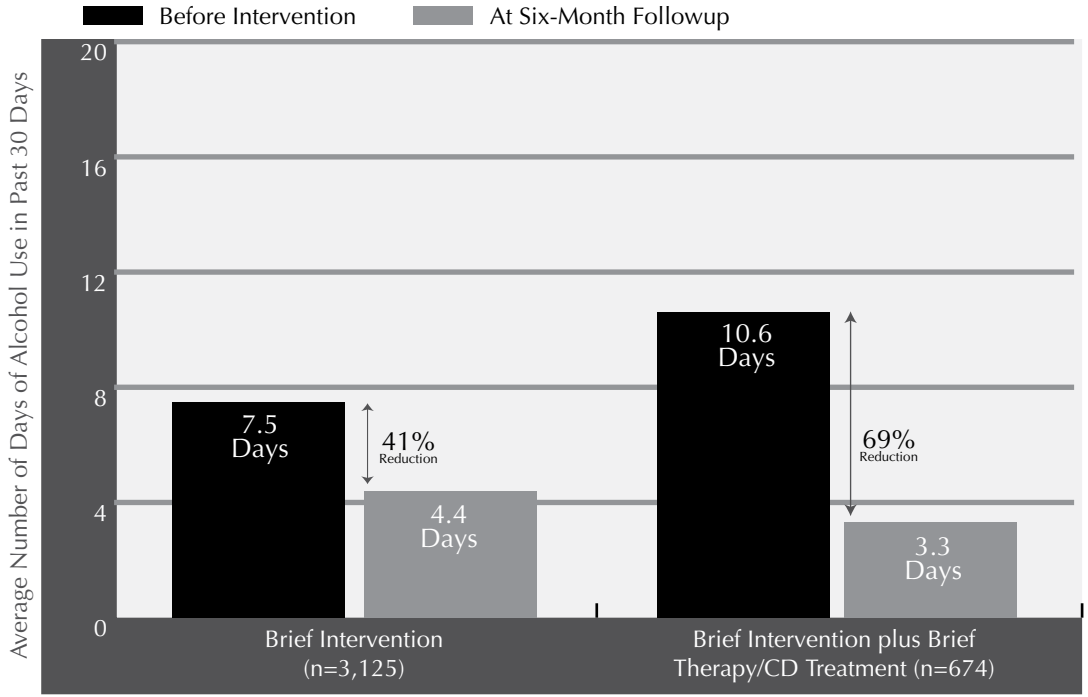
Savings for Medicaid-only aged, blind or disabled clients who received at least a brief intervention	
Total Medicaid Costs	$185 – $192 per member per month
Reduction in Inpatient Hospitalization Cost From Emergancy Departmeent Admissions	$238 – $269 per member per month

Source: Estee, S., et al., *Medicaid Costs Declined Among Emergency Department Patients Who Received Brief Interventions for Substance Use Disorders through WASBIRT* - Interim Report, 4.61.2007.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2007.

Following a brief intervention for substance abuse problems (and, when necessary, a referral to brief therapy or chemical dependency treatment), Medicaid aged, blind, or disabled clients who were screened in hospital emergency departments through the Washington State Screening, Brief Intervention, Referral and Treatment Program (WASBIRT) experienced a substantial reduction in future medical costs, compared with those who did not receive such an intervention. Potential reductions in total Medicaid costs could be as high as $2.7 to $2.8 million per year for working-age disabled clients who would receive at least a brief intervention if the WASBIRT program were to continue in the future once federal funding ends.[1]

[1] Estee, S., et al. *Medicaid Costs Declined Among Emergency Department Patients Who Received Brief Interventions for Substance Use Disorders through WASBIRT* - Interim Report, 4.61.2007.2 .Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, September 2007.

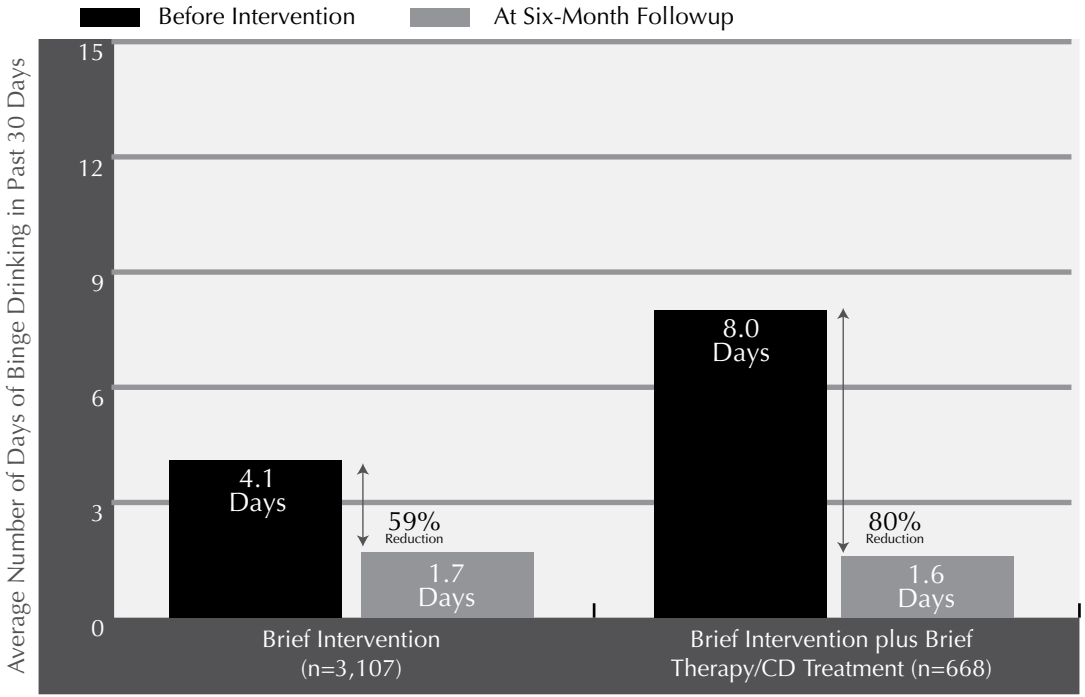
Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Substantial Declines in Average Number of Days of Alcohol Use.



Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Preliminary Report 4.60.WA.2008.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, average number of days of alcohol use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Days of alcohol use dropped 41% among those who received a brief intervention only, and 69% among those who additionally received brief therapy and/or chemical dependency treatment.

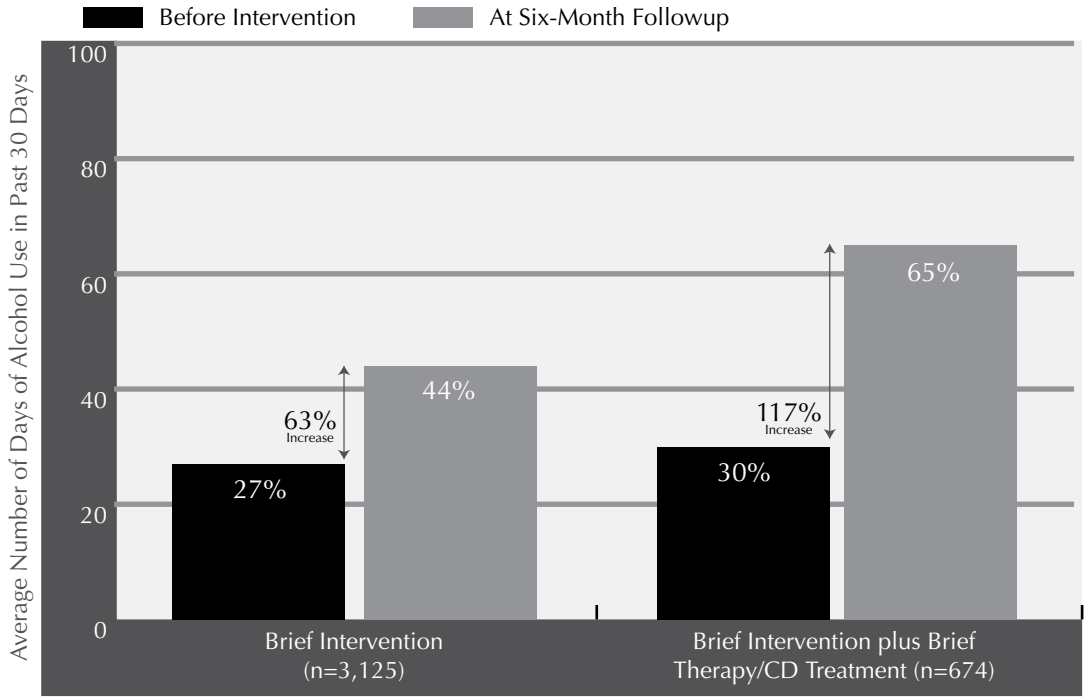
Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Substantial Declines in Average Number of Days of Binge Drinking.



Source: Estee, S., He, L. et al., *Washington State Screening, Brief Intervention Referral and Treatment (WASBIRT) Substance Use Outcomes – Preliminary Report 4.60.WA.2007.1*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, average number of days of binge drinking in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Binge drinking days decreased by 59% among those who received a brief intervention only, and 80% among those who additionally received brief therapy and/or chemical dependency treatment.

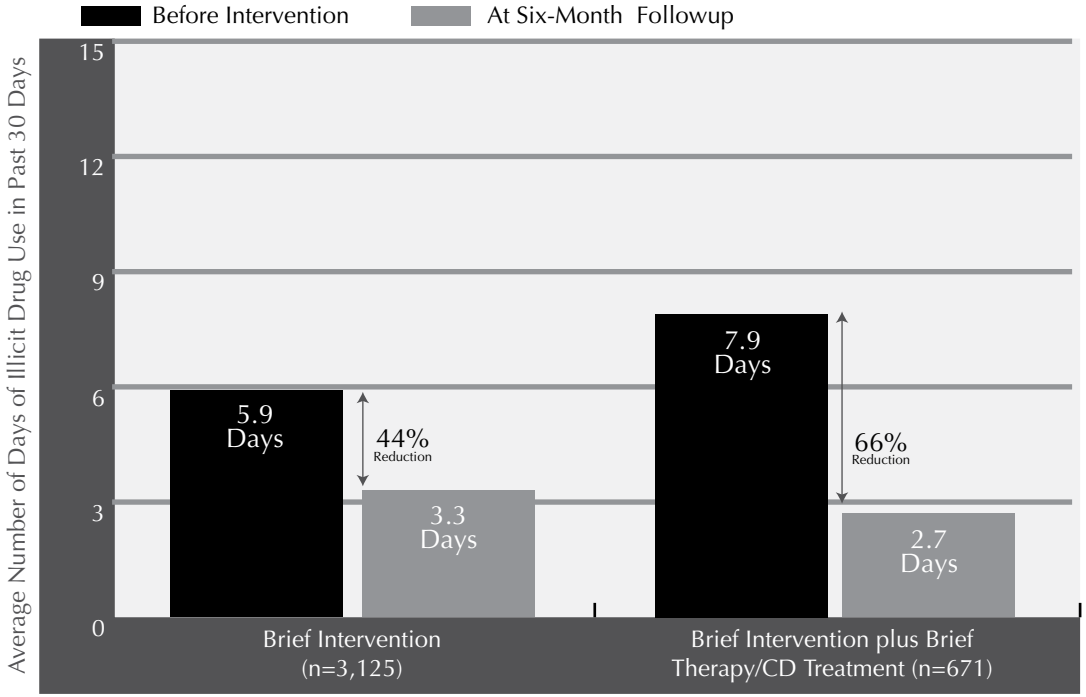
Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Significant Increases in Abstinence from Alcohol Use.



Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Preliminary Report 4.60.WA.2008.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, the percentage of those abstaining from alcohol use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 63% among those who received a brief intervention only, and 117% among those who additionally received brief therapy and/or chemical dependency treatment.

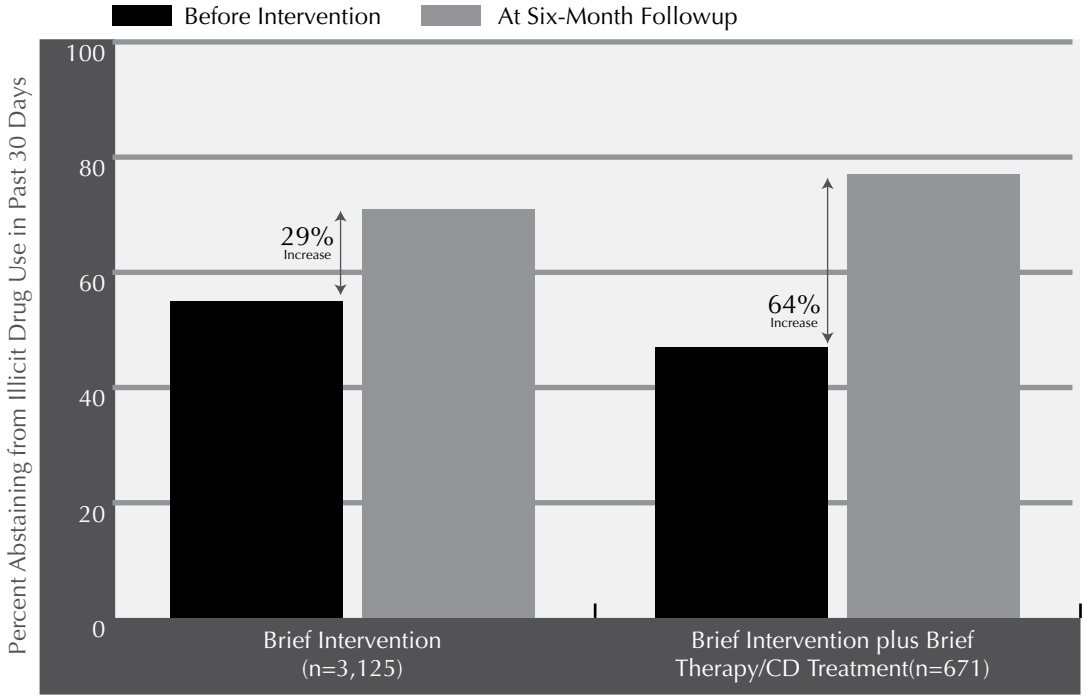
Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Substantial Declines in Average Number of Days of Illicit Drug Use.



Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Preliminary Report 4.60.WA.2008.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, average number of days of illicit drug use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Days of illicit drug use decreased by 44% among those who received a brief intervention only, and 66% among those who additionally received brief therapy and/or chemical dependency treatment.

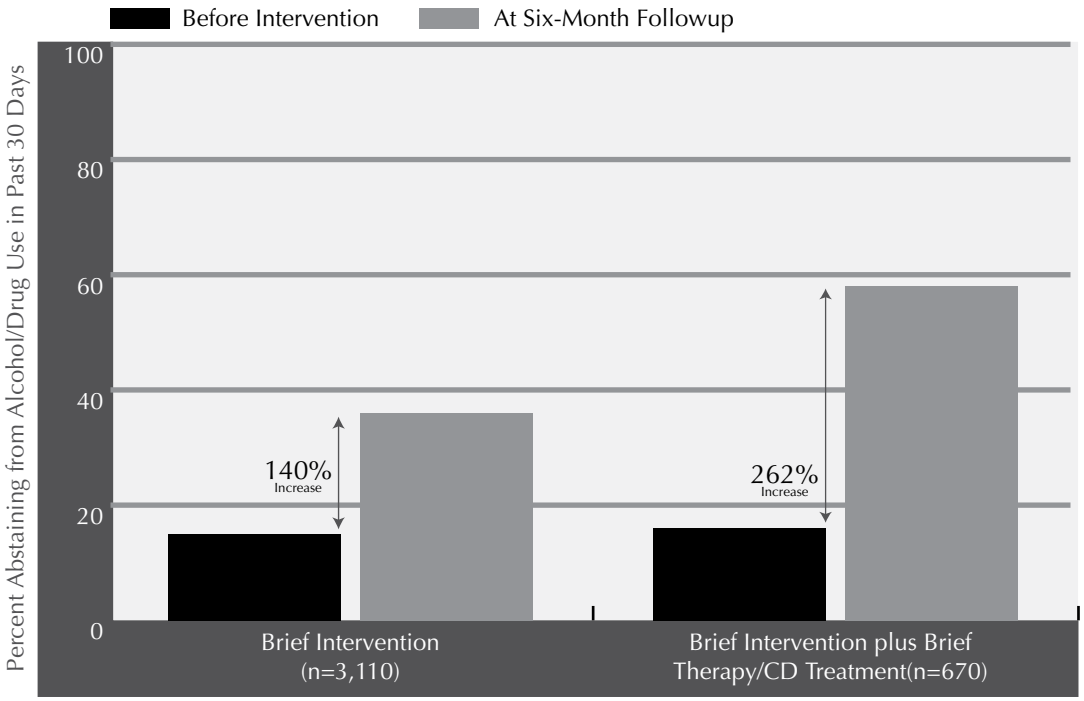
Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Significant Increases in Abstinence from Illicit Drug Use.



Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Preliminary Report 4.60.WA.2008.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, the percentage of those abstaining from illicit drug use in the past 30 days increased significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 29% among those who received a brief intervention only, and 64% among those who additionally received brief therapy and/or chemical dependency treatment.

Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Show Up in Emergency Departments Result in Significant Increases in Abstinence from Alcohol and Illicit Drug Use.



Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Preliminary Report 4.60.WA.2008.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2008.

At the six-month followup, the percentage of those abstaining from alcohol and illicit drug use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 140% among those who received a brief intervention only, and 262% among those who additionally received brief therapy and/or chemical dependency treatment.

Access to Recovery (ATR)

Access to Recovery (ATR)

In 2004, Washington State received a three-year, $22.8 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to set up an Access to Recovery (ATR) pilot program. ATR is designed to provide vouchers to pay for services or purchase needed items to eliminate barriers and support individuals in their recovery.

The goal of ATR is to expand capacity and increase the array of faith-based and community-based providers of treatment and recovery support services. Critical to the program is individual choice: once a client is assessed, and a recovery plan established, the client can choose any authorized provider for each recovery service identified. Examples of recovery services include: mental health counseling, transportation, preventive services for family members, housing assistance, child care, job readiness/vocational counseling. All clients receive case management services. Through individual choice, clients are provided the flexibility needed to find their own paths to recovery.

ATR was implemented in Washington's six largest counties: Clark, King, Pierce, Snohomish, Spokane, and Yakima. More than 11,800 individuals received treatment and recovery support services under the grant, exceeding the target of 9,900.

In December 2007, Washington State received a second three-year ATR grant of $13.9 million from SAMHSA. Under ATR II, individuals with a recent history of methamphetamine use or incarceration receive priority in enrollment. In addition, the Division of Alcohol and Substance Abuse has added a priority for National Guard and military veterans returning from duty in Iraq or Afghanistan who are in need of recovery support services.

Profile of Individuals Participating in Access to Recovery (ATR) in Washington State

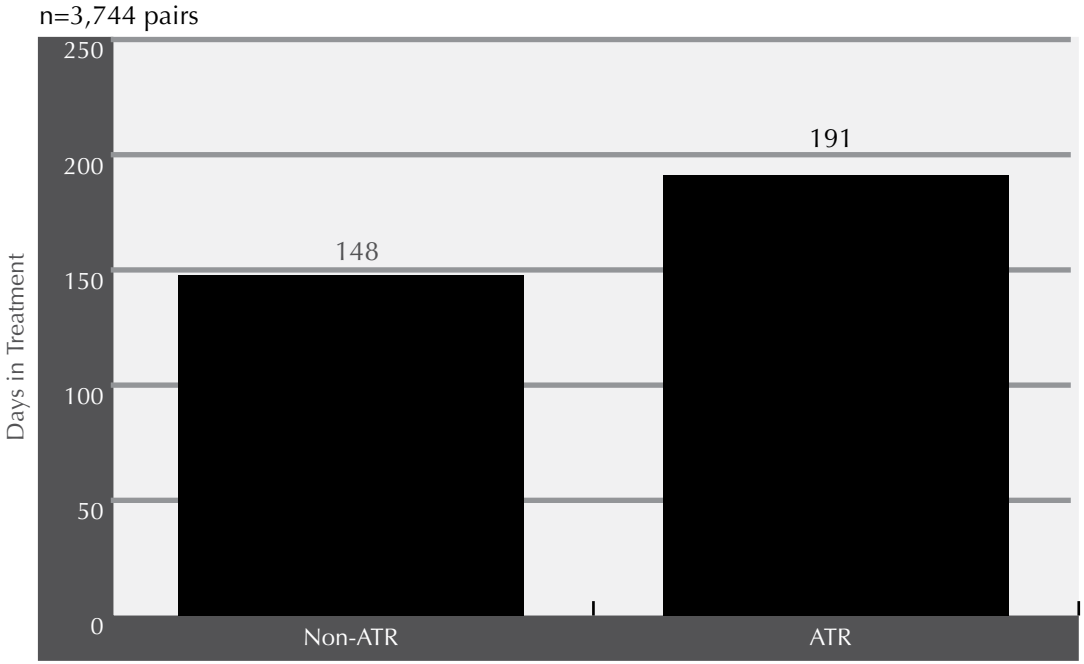
A profile of individuals receiving services funded by the first Access to Recovery (ATR) grant, September 2004 through October 2007, reveals the following profile:[1]

Number of Individuals Participating:	11,355
Number/% in Treatment during Active ATR Recovery Plan:	9,688/85%
Median Age:*	37
Race/Ethnicity:*	Caucasian - 70%; African-American - 12%; Asian/Pacific Islander - 2%; American Indian - 5%; Other/Multi-Race - 11%. Hispanic Origin - 11%.
*Employment Status**:*	Employed (full- or part-time) - 19%; Unemployed - 81%
*Primary Substance of Abuse**:*	Alcohol - 35%; Methamphetamine - 20%; Heroin - 19%; Cocaine - 11%.
*% with Previous Admission**:*	40%
*Criminal Justice Involvement**:*	54% arrested at least once in previous year
*% with Children in the Home**:*	23%
*Housing Status**:*	15% homeless***

* Includes unduplicated individuals having an ATR voucher with an active ATR recovery plan.
** Includes individuals with an active ATR recovery admission admitted to publicly funded chemical dependency treatment.
***Includes homeless, shelter/mission, on the street, transient quarters, no stable arrangement categories.

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, August 2008. Data includes unduplicated admissions to the Access to Recovery Program, September 2004 - October 2007.

Patients Who Received Services Through Access to Recovery (ATR) Stayed in Chemical Dependency Treatment 29% Longer than Those Who Did Not Receive ATR Services.

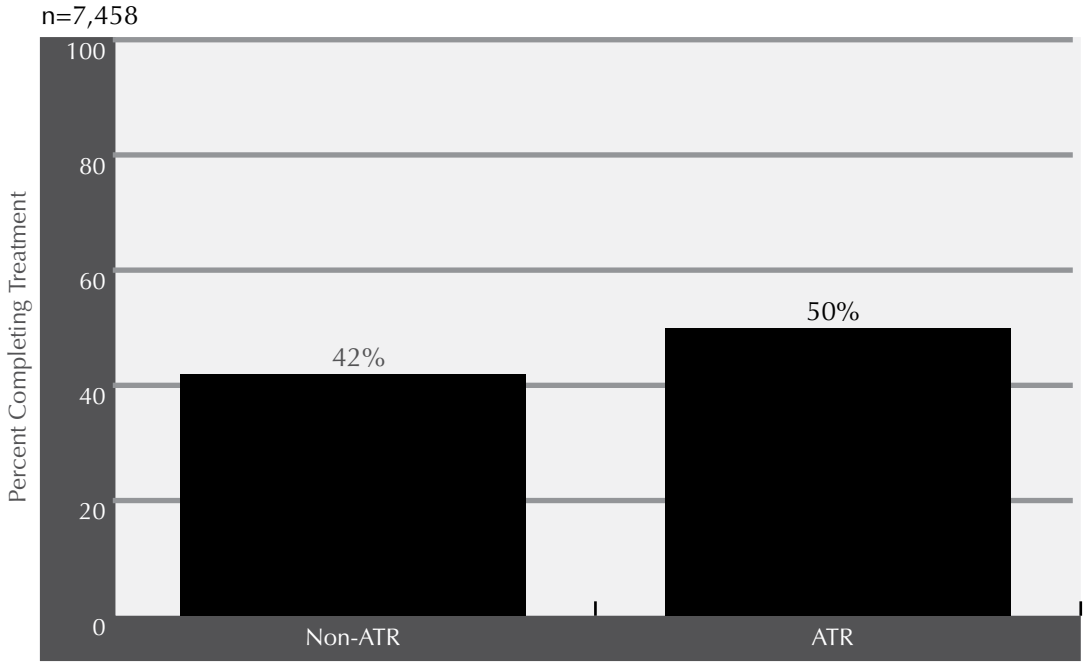


Source: Krupski, A., et al., "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

A recent study compared patient outcomes of individuals receiving Access to Recovery (ATR) services while in chemical dependency treatment with clients who did not receive ATR services. On average, patients who received ATR services remained in treatment longer.[1] Length-of-stay in treatment is associated with longer-term positive outcomes.

[1] Krupski, A., et al. "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

Patients Who Received Services Through Access to Recovery (ATR) were 19% More Likely to Complete Chemical Dependency Treatment than Those Who Did Not Receive ATR Services.

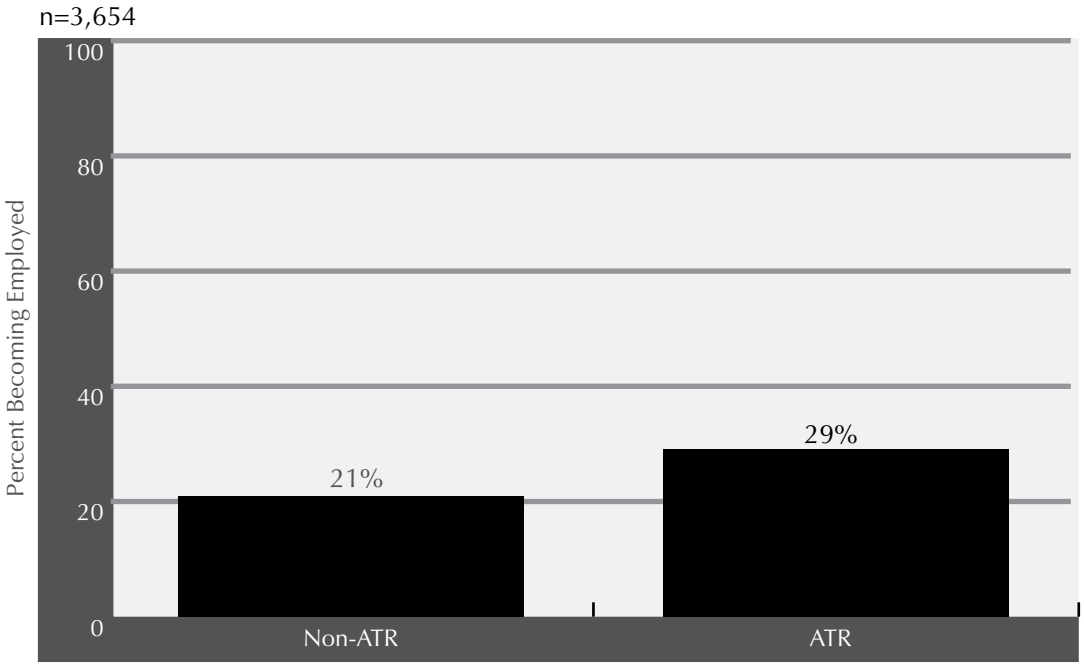


Source: Krupski, A., et al., "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

More than 11,800 individuals received Access to Recovery (ATR) services between September 2004 and October 2007. A recent study compared patient outcomes of individuals receiving services while in chemical dependency treatment with clients who did not receive ATR services. On average, patients who received ATR services were significantly more likely to complete treatment.[1] Treatment completion is associated with better long-term outcomes.

[1] Krupski, A., et al. "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

Clients with No Earning History in the Prior Year Who Received Access to Recovery (ATR) Services were 38% More Likely to Become Employed in the Following Nine Months than Non-ATR Clients.



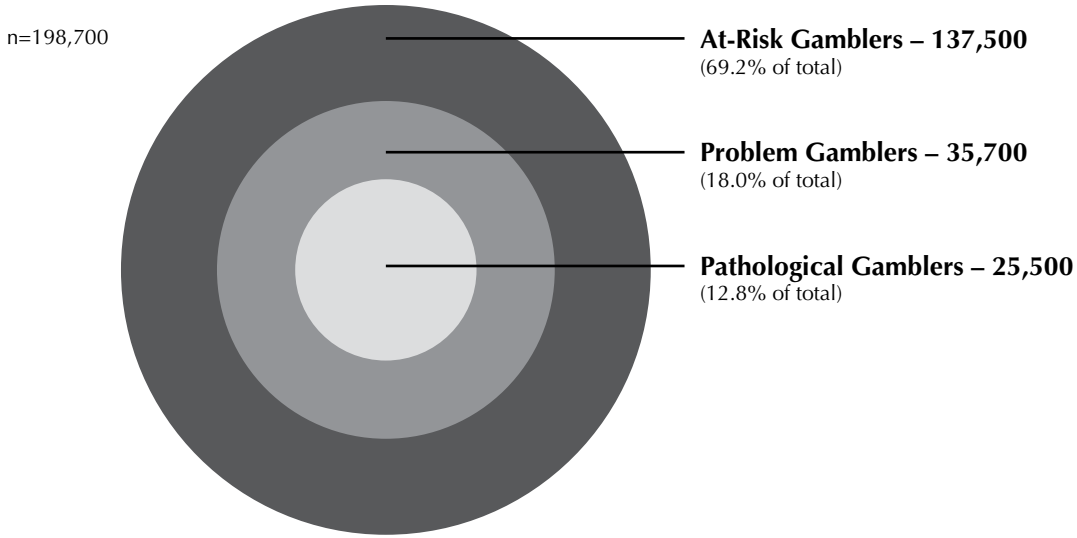
Source: Krupski, A., et al., "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

In 2004, Washington State received a three-year, $22.8 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to set up an Access to Recovery (ATR) pilot program. More than 11,800 individuals received Access to Recovery (ATR) services between September 2004 and October 2007. A recent study compared client outcomes of individuals receiving services through ATR with clients who did not receive ATR services. On average, clients who with no earnings history in the prior year who received ATR services were significantly more likely to become employed in the following nine months. In addition, these clients earned 31% more than non-ATR clients.[1]

[1] Krupski, A., et al. "What is the Impact of ATR Services on Client Outcomes in Washington State? Preliminary Findings." Seattle, WA: University of Washington at Harborview Medical Center, 2008.

Problem and Pathological Gambling

In 2005, There were Almost 200,000 At-Risk, Problem, and Pathological Gamblers in Washington State.



Source: Research and Data Analysis Division, Washington State Department of Social and Health Services, *2003 Washington State Needs Assessment Household Survey (updated for 2005)*.

It is estimated that approximately 7.2% of all adult gamblers in Washington State develop what the *Diagnostic and Statistical Manual - Fourth Edition* of the American Psychiatric Association defines as indicators of persistent and recurrent maladaptive gambling behavior. These are subdivided into a range from at-risk, to problem, to pathological gambling, based on the severity of symptoms.

In recognition of this problem, in 2005 the Washington State Legislature and Governor enacted legislation mandating a publicly funded program addressing the prevention and treatment of pathological gambling, to be administered by the Division of Alcohol and Substance Abuse. There is strong evidence of substantial comorbidity between pathological gambling and a range of substance abuse and mental health disorders. A 2005 study of comorbidity found that 73.2% of lifetime pathological gamblers had an alcohol use disorder; 38.1% a drug use disorder; and 60.4% were nicotine dependent.[1]

[1] Petry, N., Stinson, F., & Grant, B. "Comorbidity of DSM-IV Pathological Gambling and Psychiatric Disorders: Result form the National Epidemiologic Survey on Alcohol and Related Conditions," *Journal of Clinical Psychiatry* 66, 2005.

The Problem Gambling Program

The Division of Alcohol and Substance Abuse (DASA) Problem Gambling Program was created by the Legislature and Governor in the 2005 Legislative Session. It is funded by a tax on net profits earned by public and private gambling enterprises, and is overseen by a 17-member advisory committee, including representatives of recovery and advocacy groups, gaming industry, state agencies, law enforcement, and Indian Tribes and tribal organizations. In its third year of operation, the Problem Gambling Program has implemented a strategic plan that provides for prevention of problem and pathological gambling, and intervention and treatment for individuals and families already struggling with problem and pathological gambling's negative impacts.

Prevention

The program has launched campaigns to raise awareness about problem gambling. General posters and brochures in both English and Spanish have been designed and widely distributed. Materials target specific populations, including seniors, women with children, adolescent card players, and male college students have been distributed state wide.

A multi-year media campaign targeting the mothers of teen gamblers is in its final contract year. It is being revised to include more specific information, including the fact that one in seven teens gamble. The website that accompanies this campaign, www.notagame.org, will also be revised to give more specific gambling information about teen gambling. The new web site will have a place where questions can be answered by problem gambling treatment professionals and an archive where a reader can browse previous questions and answers. A new television commercial accompanying this campaign will air at the end of 2008. Radio and outdoor advertising in some locations will reinforce the television message.

The Problem Gambling Program is a participant in the planning and facilitation of the annual DASA Prevention Summit, which targets high school youth and adults working in the youth prevention field.

Intervention

Through a contract with the Evergreen Council on Problem Gambling, the Problem Gambling Program funds a 24 hour/seven day a week toll-free helpline. There is an average of 100-125 calls for gambling help per month. The number of calls has dropped by 20% in the past two years. However, in the same time period, the 'Not-a-Game' prevention effort has placed advertising on YouTube.com and Meta Café.com. YouTube.com is getting more than 7,000 hits per month on the problem gambling ad and Meta Café gets more than 1,500 per month. From those sites, viewers are sent to the www.notagame.org website where there are information and referral resources.

The State Council also trains casino workers to recognize signs that a patron may be in trouble with gambling, by recognizing signs of frustration, depression, or evidence that a patron is gambling more than s/he can afford. This training allows casino staff to make a brief intervention in a patron's gambling behavior. Individuals are given helpline referral information.

Treatment

DASA currently contracts with 22 agencies at 25 sites in 11 counties to provide assessment and treatment of problem and pathological gambling. Through June 2008, there have been 868 admissions to treatment since treatment was first offered in September 2005. Some 60% of clients treated for problem and pathological gambling are women, 75% of whom are over 40 years of age. Of the clients served in the program, approximately half are married, and 80% are Caucasian.

Youth can receive treatment at several agencies. However, only 1% of clients treated in 2008 were under age 21. Problem gambling treatment is available in Spanish at two sites. Non-English speaking patients can receive treatment with the assistance of translator services at any publicly funded problem gambling treatment site.

Because the field of problem gambling treatment is so young, it is essential to build capacity and expertise among treatment providers. Toward that end, DASA has contracted with the Evergreen Council on Problem Gambling to provide continuing education to behavioral health professionals who intend to provide problem gambling treatment. The Program has partnered with Evergreen Council on Problem Gambling to hold a state conference in both 2007 and 2008. The conference has been well attended with participants not only from Washington, but from around the region and Canada.

During the current biennium, the Problem Gambling Treatment Program is contracting to measure program effectiveness. The goal is to evaluate outcomes of the Problem Gambling Treatment Program in order to assess what assists problem gamblers and family members in the recovery process, and what needs to be changed programmatically in order to better facilitate recovery.

Profile of Individuals Admitted to Publicly Funding Problem Gambling Treatment in Washington State

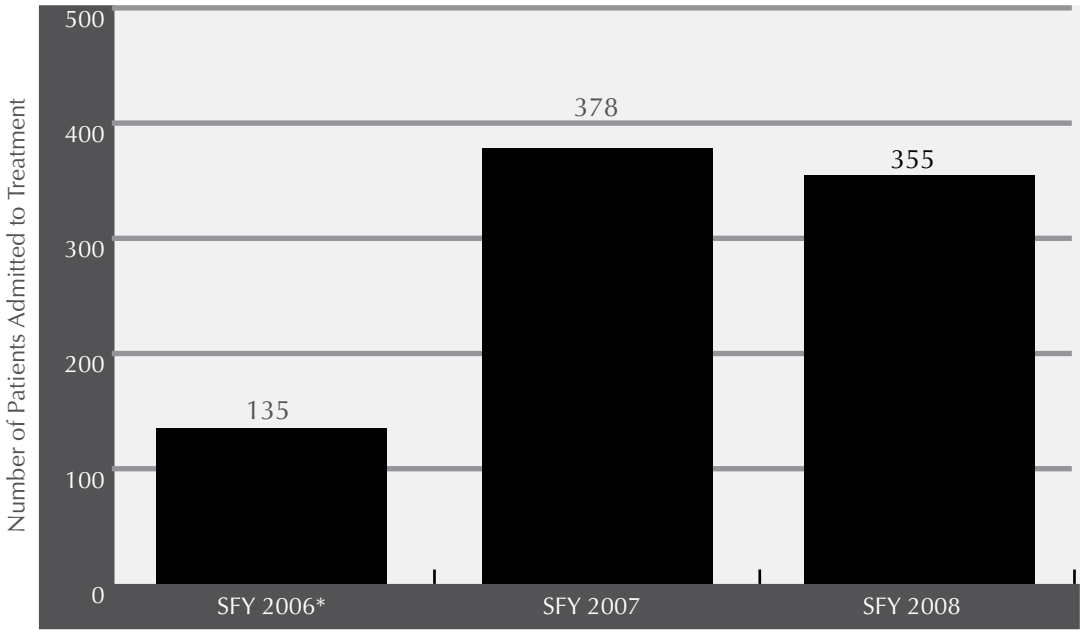
A profile of individuals admitted to publicly funded treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	378
Median Age:	47
Gender:	60% Female; 40% Male
Race/Ethnicity:	Caucasian - 78%; African-American - 4%; Asian/Pacific Islander - 11%; American Indian - 2%; Other/Multi-Race - 5%. Hispanic Origin - 3%.
Employment Status:	Employed (full- or part-time) - 61%; Unemployed - 39%
Primary Drug:	No Substance Abuse - 60%; Alcohol - 30%; Methamphetamine - 2%; Marijuana - 3%; Cocaine - 3%; Other Substances - 2%.
% with Children in the Home:	30%
% with Co-Occuring Disorder:	23%
Housing Status:	11% homeless*

** Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report General Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, August 2008. Data include unduplicated admissions to treatment.

Since Its Inception, There Have Been More than 800 Admissions to the DASA-Funded Problem Gambling Treatment Program.

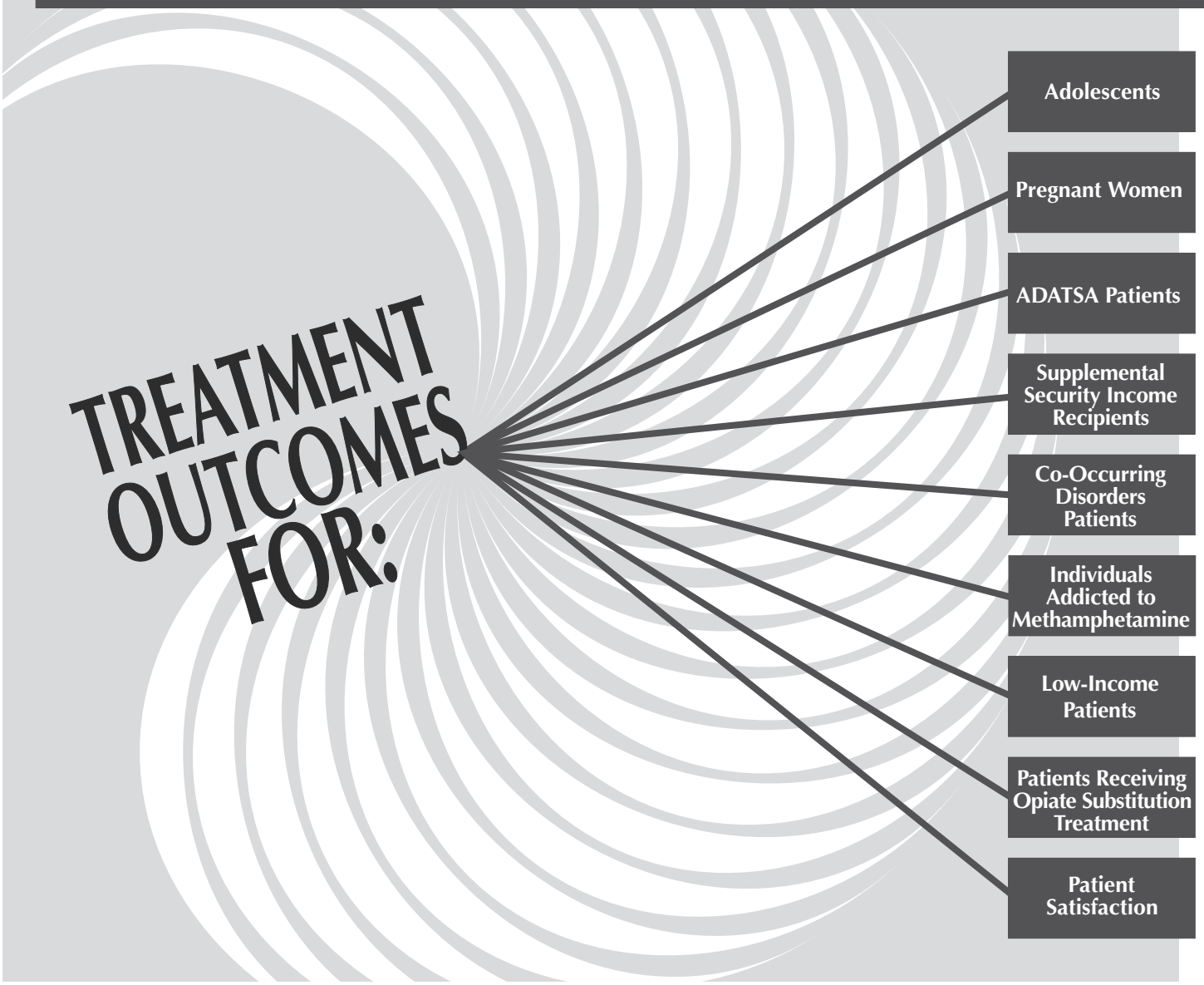


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

The Division of Alcohol and Substance Abuse currently contracts with 22 agencies at 25 sites in 11 counties to provide assessment and treatment of problem and pathological gambling. DASA offers training to increase the number of counselors who can provide problem gambling treatment, and it is hoped that eventually treatment will be available statewide, The program is also supported by a Problem Gambling Hotline that refers callers to treatment agencies and through the 'Not-A-Game' website – www.notagame.org.

** First patients were admitted to treatment in September 2005.*

Outcomes: The Benefits of Prevention & Treatment



The Work of the DASA Evaluation and Quality Assurance Section

The Division of Alcohol and Substance Abuse's (DASA's) Evaluation and Quality Assurance Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS), "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DASA is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; and assuring public safety and helping to build strong, healthy communities. Research also aids in the development of "best practices" that can be utilized by chemical dependency treatment providers in improving the quality of care, and provides the scientific basis for the development of sound public policy.

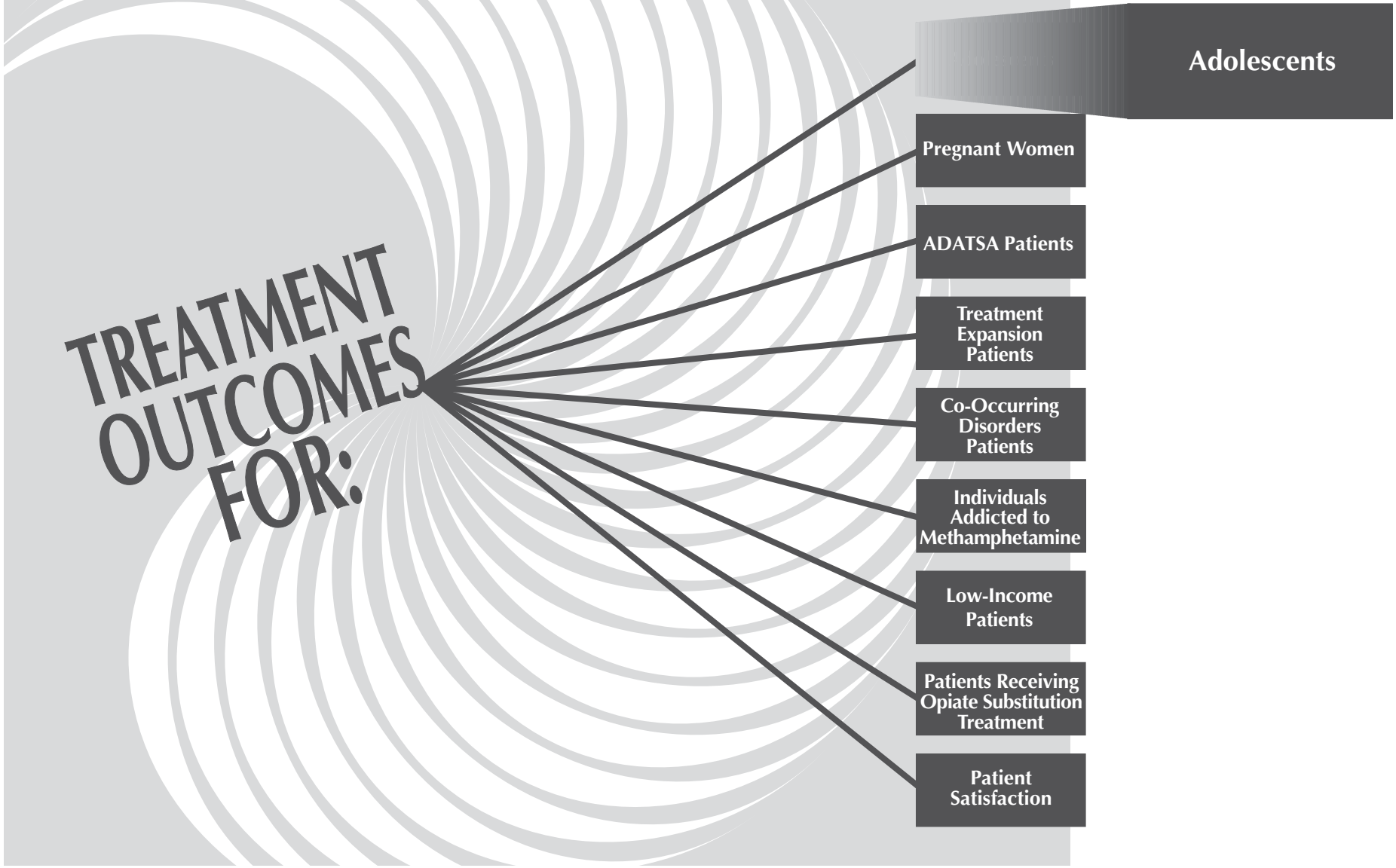
DASA's productivity in research and evaluation is due, at least in part, to the strong partnerships it has developed with the research community for more than a decade. This is most evident in the 90-member Research Subcommittee of the Citizens Advisory Council on Alcoholism and Drug Addiction, which focuses on treatment issues. A new Prevention Research Subcommittee was formed in 2007. Members of both Subcommittees are drawn from research institutions throughout the Northwest.

Current Research Efforts

Some of the results of the outcomes research conducted under the auspices of DASA are displayed on the following pages. Below is a partial list of research projects currently being undertaken:

- Costs Offsets of Treatment for Aged, Blind, Disabled (including Supplemental Security Income), General Assistance-Unemployable (GA-U), and General Assistance-Expedited Medicaid Disability (GA-X) Patients.
- Study of the Network for the Improvement of Addiction Treatment (NIATx) Process Improvement Initiatives.
- Study of Co-Occurring Disorders Among Publicly Funded Patients.
- Study of the Use of Evidence-Based Practices in Treatment Programs.
- Evaluation of the State Incentive Grant for Prevention: Cross-Site Implementation of the Strategic Prevention Framework; Outcomes in 12 Grantee Sites.
- Evaluation of the Adolescent Treatment Infrastructure Grant.
- Evaluation of the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project.

Outcomes: The Benefits of Prevention & Treatment



Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington State

A profile of adolescents admitted to publicly funded treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	4,978
Median Age:	16
Gender:	64% male; 36% female
School Attendance:	68% in school (at least part-time); 32% out of school
Primary Drug:	Marijuana - 59%; Alcohol -25%; Methamphetamine - 7%
% with Previous Admission:	21%
Criminal Justice Involvement:	56% arrested at least once in previous year
Housing Status:	1% homeless*

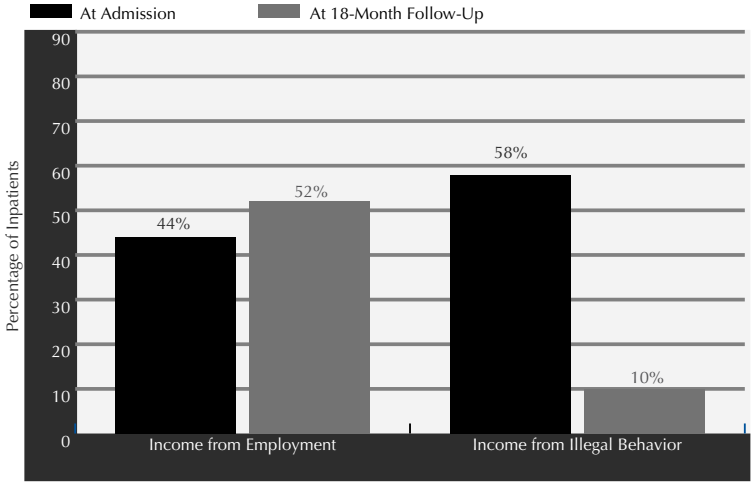
A 1999 study of adolescents (age 20 and younger) receiving publicly funded chemical dependency treatment in Washington State revealed the following profile:

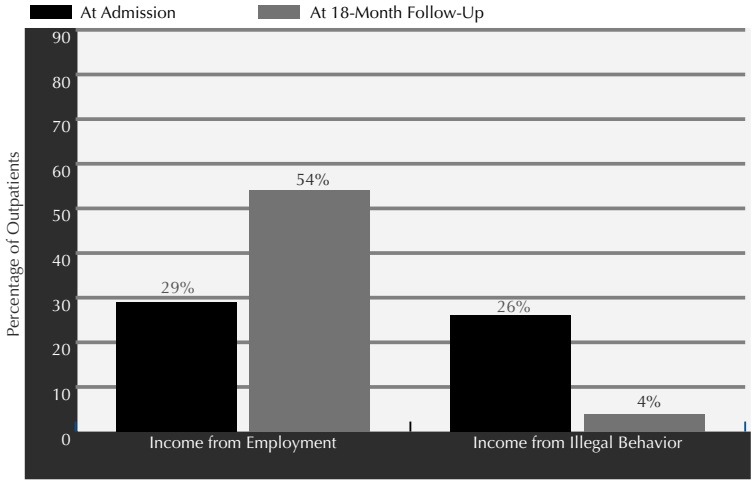
- Between 55-70% of youth admitted to residential treatment had run away from home at least once in their lives.
- Between 23-34% of youth had one or more emergency room visits in the year prior to admission.
- 90% of youth admitted to treatment began using their primary substance of abuse prior to age 16.
- Between 70-90% reported at time of admission that they currently smoke cigarettes.
- Between 23-37% of those admitted to residential treatment had been domestic violence victims.[2]

** Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] Rodriquez, F. *Profile of Youth Clients Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

After Treatment, More Adolescents Reported Income Earned from Employment, and Fewer Reported Income Earned from Illegal Behavior.

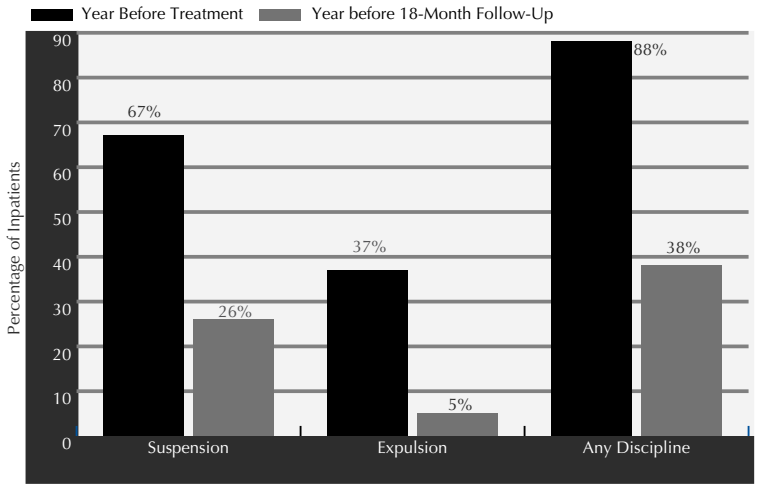


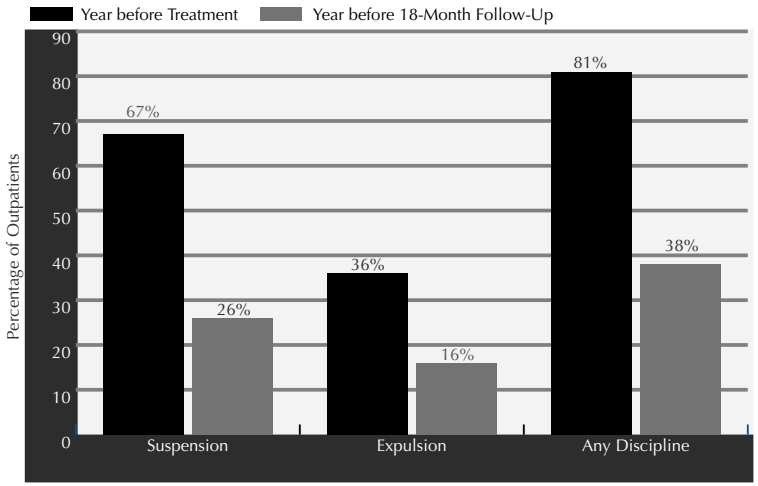


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

At the time of admission, adolescent inpatients were more likely to report income from illegal behavior than from legitimate employment, while outpatients were almost equally as likely to report income from both sources. At the time of the 18-month follow-up, however, adolescents who had been in either inpatient or outpatient treatment were five times more likely to report income from employment rather than illegal behavior.

School Discipline Problems for Adolescent Patients Decreased After Treatment.

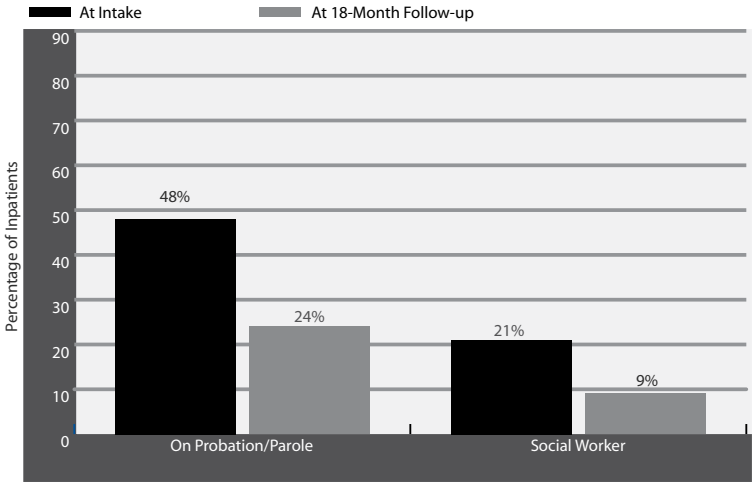


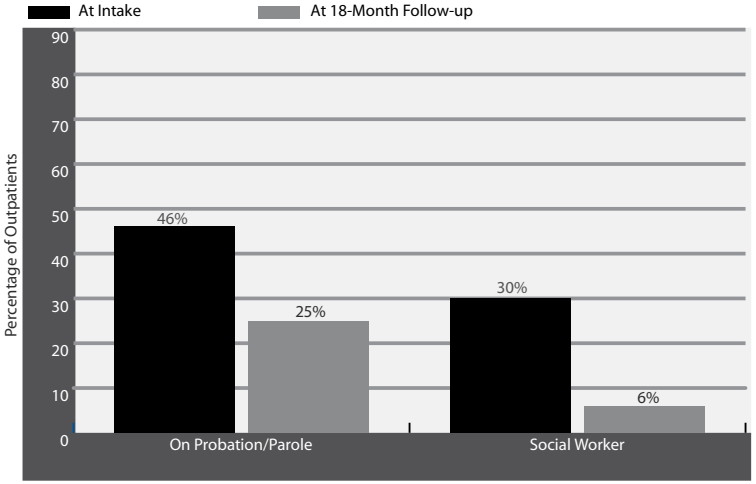


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report.* St. Paul, MN: New Standards, Inc., 1997.

Not surprisingly, adolescents with substance abuse problems tend to experience behavioral problems when attending school. After substance abuse treatment, however, the number of adolescents reporting any school discipline problems in the preceding year dropped by 50%. An especially encouraging outcome is the substantial reduction in school expulsions for youth receiving either inpatient or outpatient treatment. Additional study results also showed a corresponding improvement in school grades after treatment.

A Lower Percentage of Adolescent Patients were Under Legal Supervision 18 Months After Treatment.



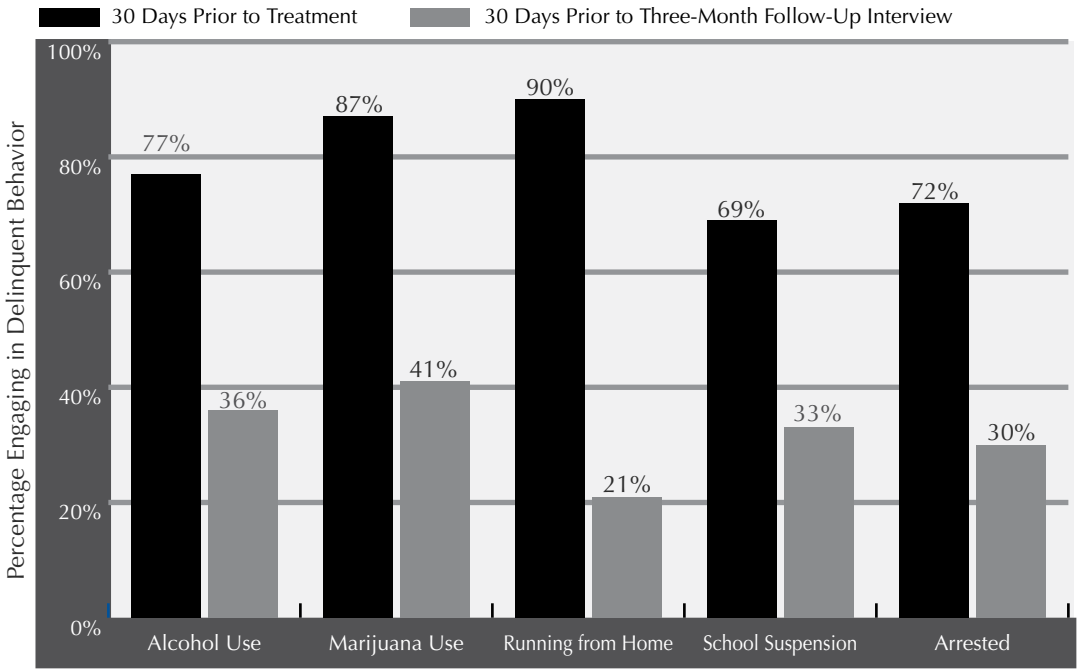


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report.* St. Paul, MN: New Standards, Inc., 1997.

A large proportion of children involved in the juvenile justice system have substance abuse problems and, similarly, a large portion of juveniles in chemical dependency treatment programs are involved in criminal activities. Therefore, it is expected that obtaining substance abuse treatment will have a positive effect on criminal behavior, as well as decreasing or ceasing substance use.

As expected, legal involvement by adolescents decreased considerably after treatment for both inpatients and outpatients. Compared to their status at intake, approximately half as many adolescents were on parole or probation at the time of follow-up. There was a similar reduction in supervision by social workers for inpatients, and only 6% of outpatients were under a social worker's supervision at the 18-month follow-up, compared to 30% at intake.

"Becca" Youth Who Complete Residential Chemical Dependency Treatment Are Much Less Likely to Use Alcohol or Marijuana, Less Likely to Run Away from Home, and Less Likely to Be Suspended from School or Arrested.

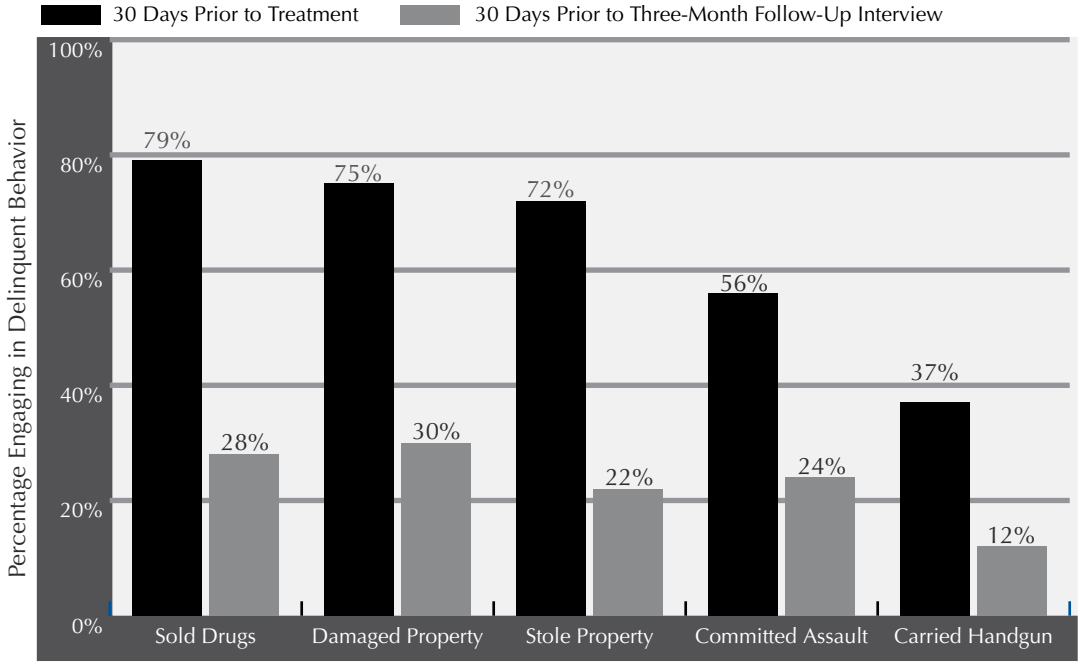


Source: Peterson, P., et al., *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the "Becca" Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

The 1995 At-Risk/Runaway Youth Act created the "Becca" program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent's control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

While the needs of Becca Youth are very high, this graph indicates that residential chemical dependency treatment results in significant positive changes in behavior following treatment completion.

Rates of Delinquent Behavior Among "Becca" Youth Decline Substantially Following Completion of Residential Chemical Dependency Treatment.

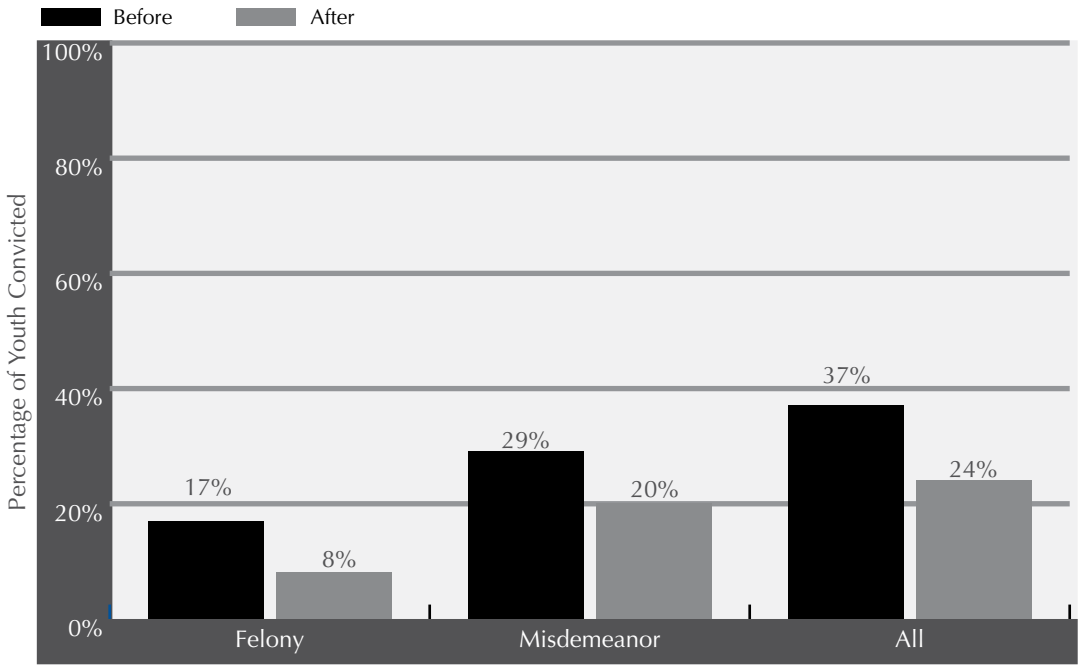


Source: Peterson, P., et al., *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the "Becca" Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

This graph indicates that Becca youth who receive chemical dependency treatment are much less likely to engage in delinquent behavior following treatment completion. In this 1997 study conducted by the University of Washington, the percentage of Becca youth involved in selling drugs declined by 64.6%; those stealing property dropped by 60.4%; and the percentage of those who committed assault dropped by 57.1%.

The 1995 At-Risk/Runaway Youth Act created the "Becca" program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent's control and/or are chronic runaways. These youth are estimated at approximately 3-4% of youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14-16.

There are Significant Declines in Criminal Convictions Among Youth Who Receive Chemical Dependency Treatment.

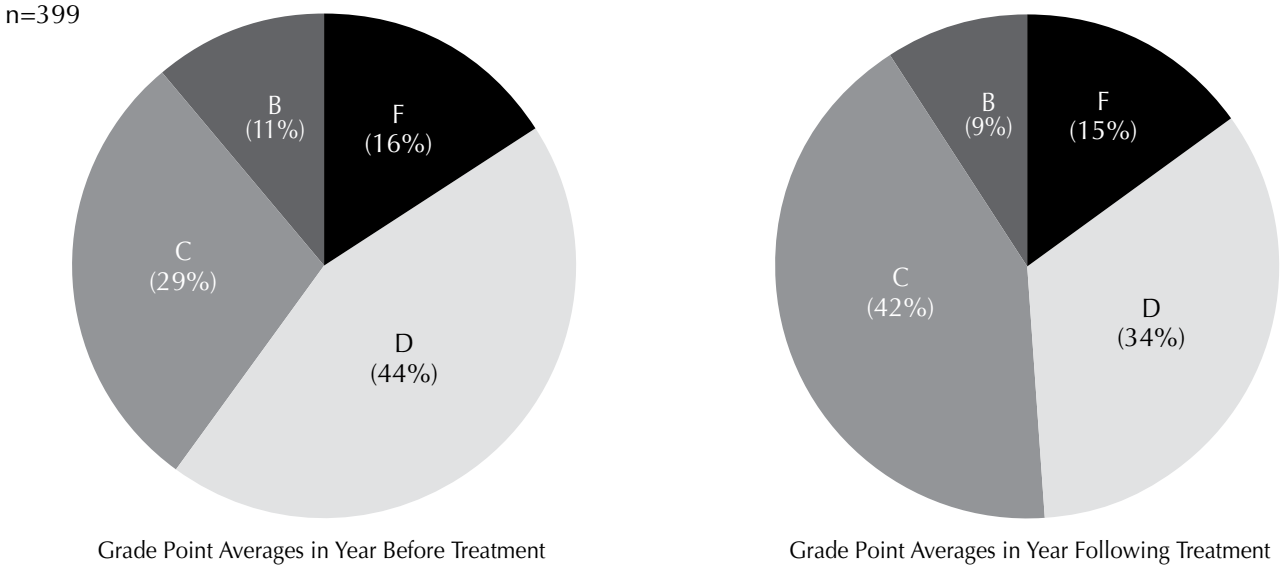


Source: Luchansky, B., et al., "Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment." Olympia, WA: Washington State Department of Social and Health Services, 2003.

A 2003 study of almost 6,000 Washington State youth ages 14-17 found significant declines in criminal convictions following chemical dependency treatment. The rate of all convictions fell from 37% in the 18 months prior to treatment to 24% in the 18 months following treatment, representing a 35% decline. Felony convictions declined by 56%; misdemeanors fell by 30%.

Significant strides have been made in recent years in ensuring more timely access to publicly funded chemical dependency treatment for youth. Average wait times for youth residential treatment in August 2007 were approximately 1-3 weeks.

High School Youth Ages 15-17 Who Receive and Complete Chemical Dependency Treatment See Their Grades Improve Compared to the Year Before Treatment.

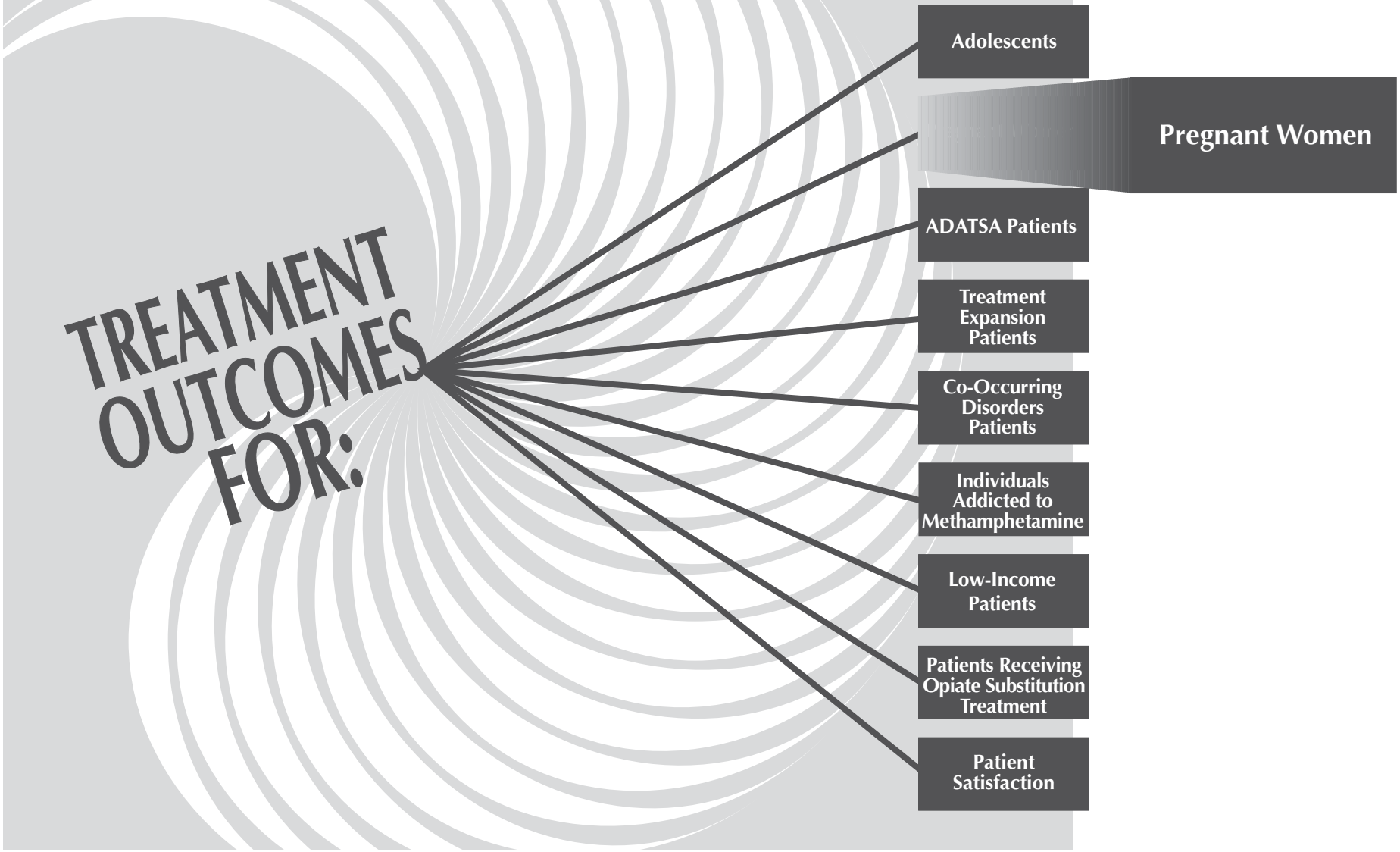


Source: Longhi, D., and Felver, B., "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

Chemical dependency treatment is associated with better outcomes for school-age youth in need of treatment, including lower rates of delinquent behavior, felonies and misdemeanors, and legal supervision. It is also associated with improved school outcomes, including lower school dropout rates.

These graphs indicate that full-time students who complete chemical dependency treatment demonstrate better school performance in the year following treatment, compared with the year before. The percentage of students with grade point averages of "C" or better increased from 40% to 51%, representing a 27.5% increase.

Outcomes: The Benefits of Prevention & Treatment



Profile of Pregnant Women Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of pregnant women admitted to publicly funded treatment in Washington State in SFY 2006 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	586
Median Age:	25
Employment Status:	Employed (full- or part-time) – 9%; Unemployed – 91%
Primary Drug:	Methamphetamine - 33%; Alcohol – 21%; Marijuana - 15%
% with Previous Admission:	41%
Criminal Justice Involvement:	50% arrested at least once in previous year
% with Children in the Home:	35%
Housing Status:	10% homeless*

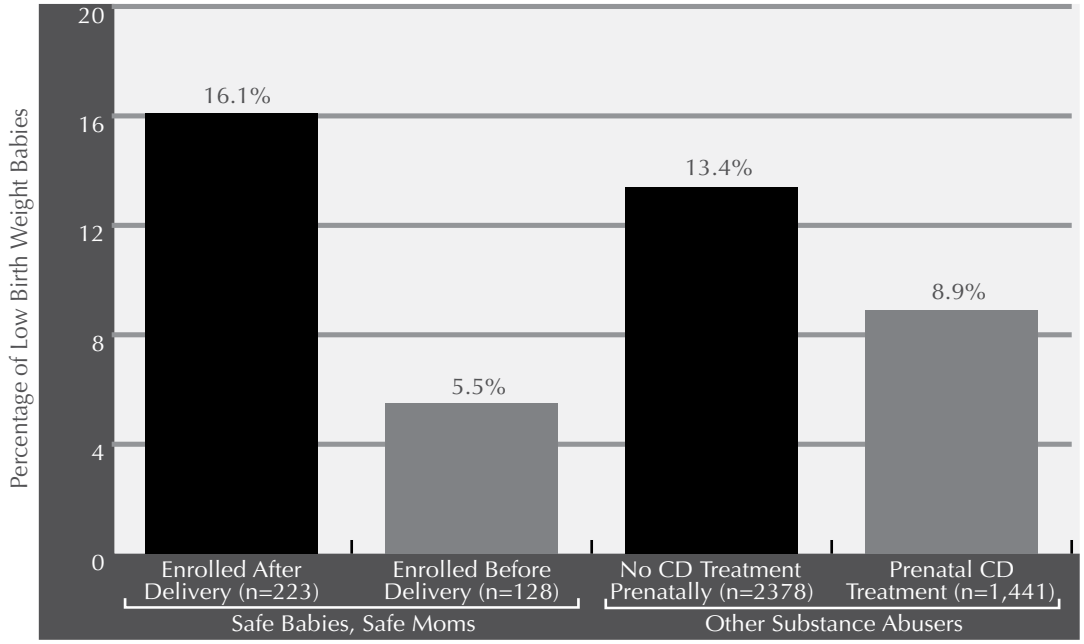
A 1999 study of pregnant, post-partum, and/or parenting women (PPWs) admitted to publicly funded chemical dependency treatment in Washington State indicated:

- More than 60% of PPWs admitted to treatment had been victims of domestic violence.
- Over 50% reported public assistance as their primary source of income.
- Over one-quarter reported having received mental health treatment in the year prior to admission.[2]

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] Rodriquez, F., *Profile of Pregnant, Post-Partum, and/or Parenting Women (PPWs) Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Substance-Abusing Women Who Received Chemical Dependency Treatment were Less Likely to Have a Low Birth Weight Baby.



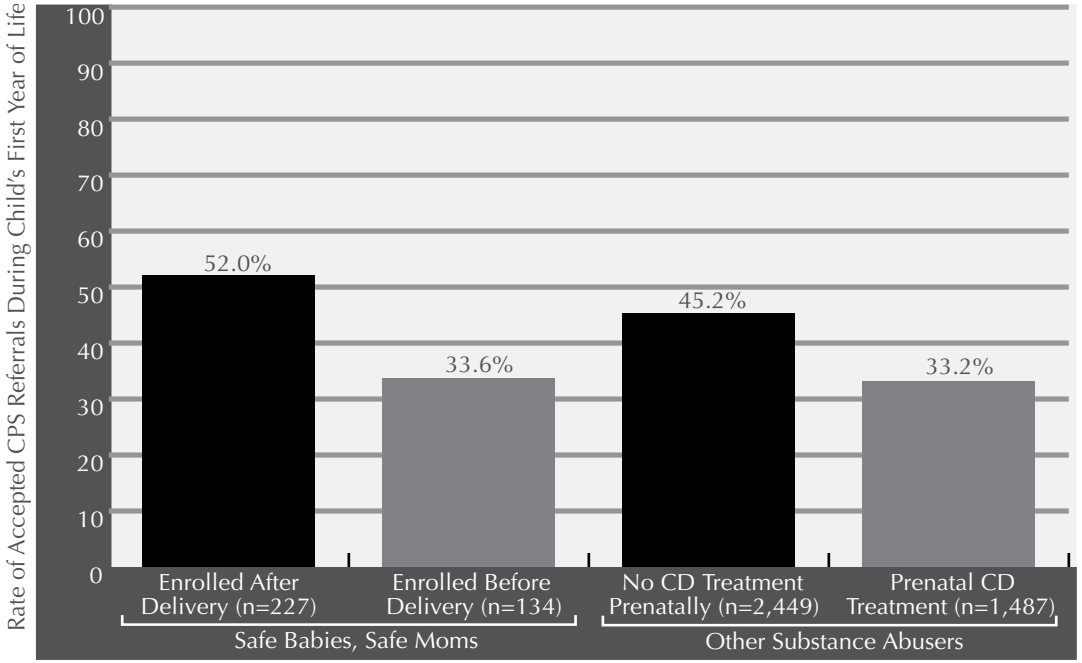
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Low birth weight (LBW) – newborn infants weighing less than 5.5 pounds, or 2,500 grams—is the risk factor most closely associated with neonatal death, and is associated with a wide range of disorders, including neurodevelopmental conditions, mental retardation, vision and hearing impairments, and other developmental disabilities. Alcohol and other drug abuse is linked to LBW.[1]

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment, through the Safe Babies, Safe Moms program, were 66% less likely to give birth to a LBW baby, compared with substance-abusing women who enroll after delivery. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 34% less likely to give birth to a LBW baby, compared with women who did not receive treatment.[2]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.
[2] Cawthon, L, "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Substance-Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Be Referred Later to Child Protective Services.



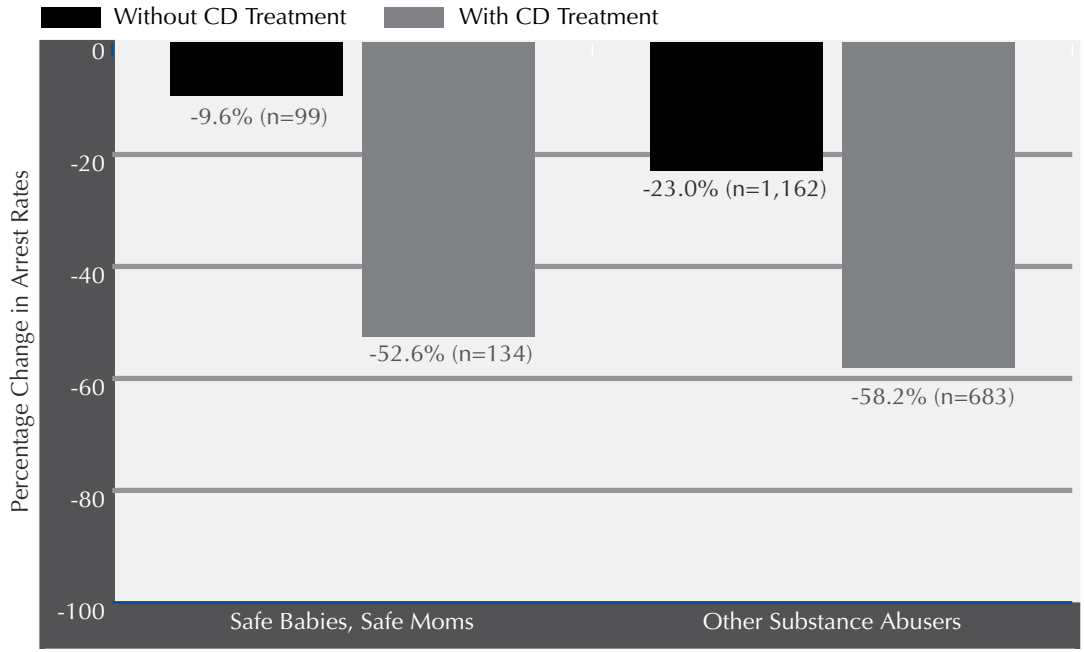
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Child abuse and neglect is one of the most important consequences of maternal substance abuse. The rate of accepted referrals to Child Protective Services (CPS) during a child's first year of life is ten times higher (45.2%) when their substance-abusing mothers did not receive chemical dependency treatment than for infants on Medicaid whose mothers are not substance abusers (4.5%).

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment prenatally, through the Safe Babies, Safe Moms program, were 35.4% less likely to be referred to CPS during the first year of their child's life than those enrolling after their child was born. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 26.5% less likely to be referred to CPS during the first year of their child's life than substance-abusing women who did not receive treatment.[1]

[1] Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Substance-Abusing Pregnant Women Who Received Chemical Dependency Treatment were Less Likely to Be Arrested.



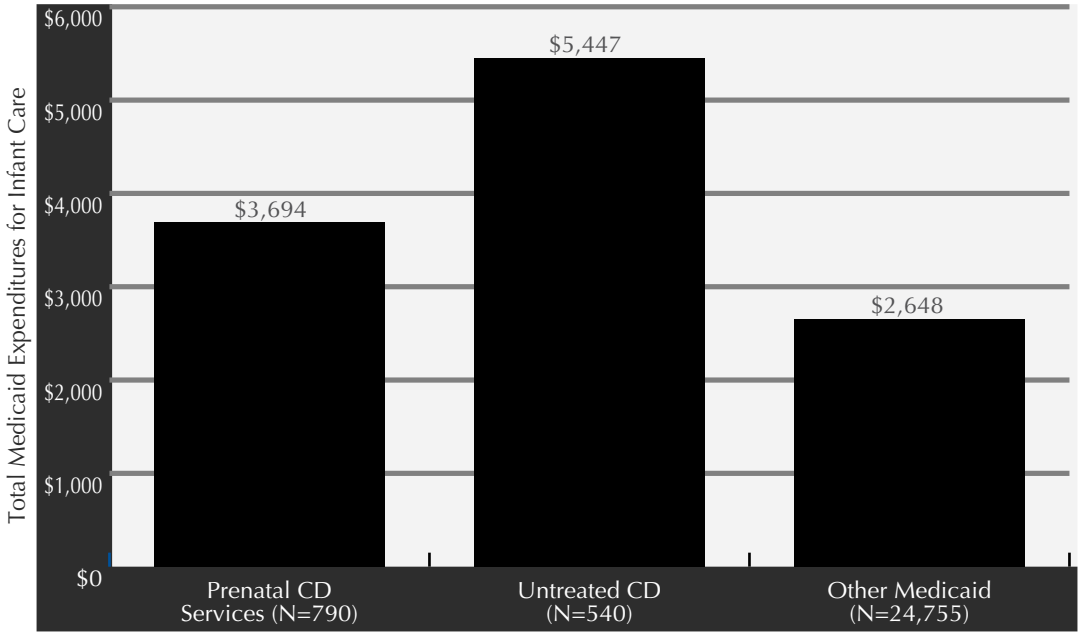
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Criminal justice involvement is a significant issue for many pregnant, substance-abusing women. In addition to the burden of drug- and alcohol-related crime on society, crime presents serious health and developmental risks to children, both prenatally and after they are born.

Among women enrolled in the Safe Babies, Safe Moms program, those who received chemical dependency treatment had more than a five times greater reduction in arrest rates in the following two years compared with those who did not receive treatment. Outside of the program, among substance-abusing pregnant women, those who received chemical dependency treatment had more than double the reduction in arrest rates in the following two years after delivery compared with those who did not receive treatment.[1]

[1] Cawthon, L. "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Average Medicaid Costs During the First Two Years of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.



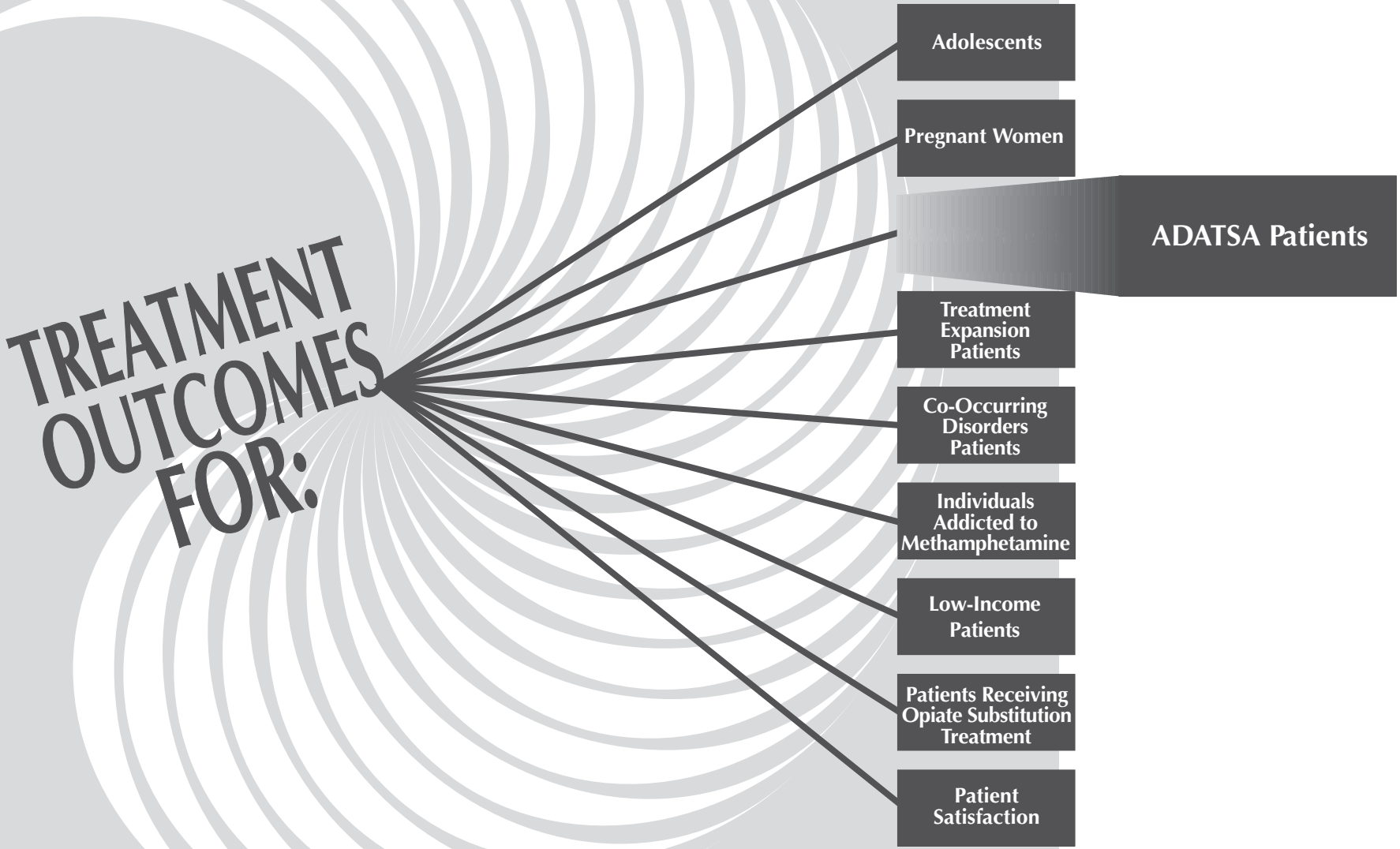
Source: Cawthon, L., & Schrager, L., "Substance Abuse Treatment and Birth Outcomes for Pregnant and Postpartum Women in Washington State." *First Steps Database* 5(1). Washington State Department of Social and Health Services, 1995.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the single most important factor in determining infant medical care expenditures during the neonatal period. Alcohol and other drug use is associated with LBW.[1]

This graph indicates that average Medicaid expenditures for care during the first two years of life for infants born to untreated substance abusers was 47.5% higher than for substance-abusing women who received chemical dependency treatment during pregnancy, and more than twice that for infants born to non-substance abusing women receiving Medicaid.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

Outcomes: The Benefits of Prevention & Treatment



Profile of ADATSA Patients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of patients admitted to publicly funded treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	6,590
Median Age:	35
Gender:	71% Male; 29% Female
Employment Status:	Employed (full- or part-time or temporary) – 5%; Unemployed – 95%
Primary Drug:	Alcohol – 40%; Methamphetamine – 27%; Cocaine/Crack – 12%; Marijuana - 11%
% with Previous Admission:	45%
Criminal Justice Involvement:	59% arrested at least once in previous year
% with Children in the Home:	7%
Housing Status:	27% homeless*

Enacted in 1987, the ADATSA legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. Patients may be admitted to either residential or outpatient treatment modalities as individually required. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocational skills. Success is expected to result in patients moving toward a long-term objective of self-sufficiency.

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

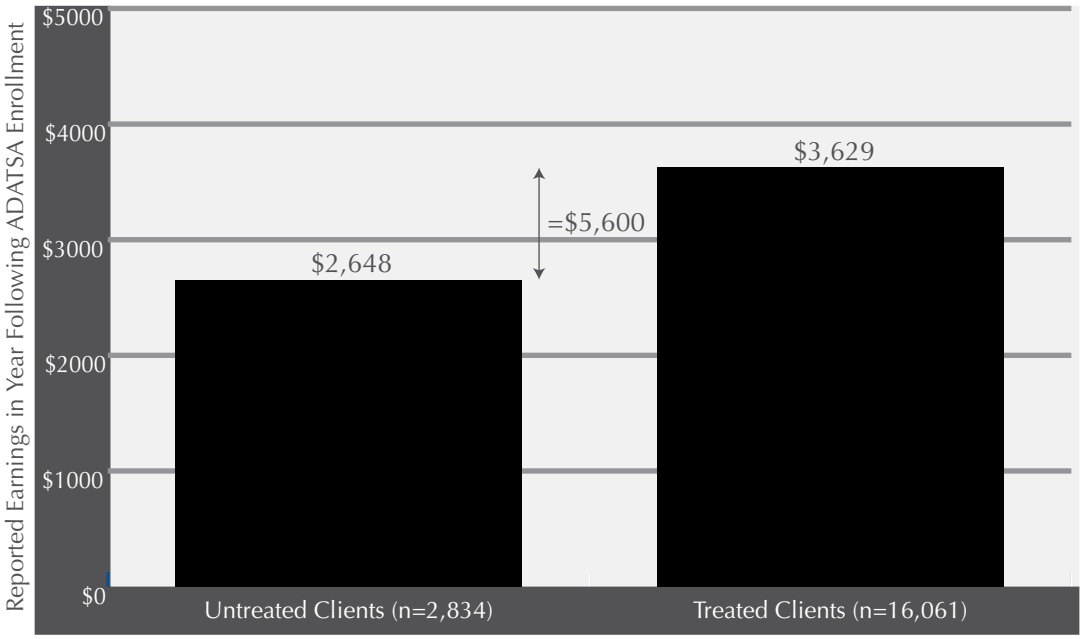
Average Medical Costs for ADATSA Clients Who Received Chemical Dependency Treatment were 29% Lower in the Year Following Enrollment than for Clients Who were Untreated.

Source: Mancuso, D., et al., *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

Under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), individuals who are disabled and unable to work due to an alcohol or drug disorder may qualify for assessments, chemical dependency treatment, and financial support. A study of ADATSA-eligible clients in SFY 2002-2004 found that clients who received chemical dependency treatment and were subsequently eligible for Medicaid had medical costs that were 29% lower in the year following enrollment than those who did not receive treatment. The savings in the year following enrollment totaled $2,868, more than the average $2,629 cost of providing treatment.[1] There were likely subsequent savings in future years.

[1] Mancuso, D., et al. *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

ADATSA Clients Who Received Chemical Dependency Treatment Earned 37% More in the Year Following Enrollment than Clients Who were Untreated.



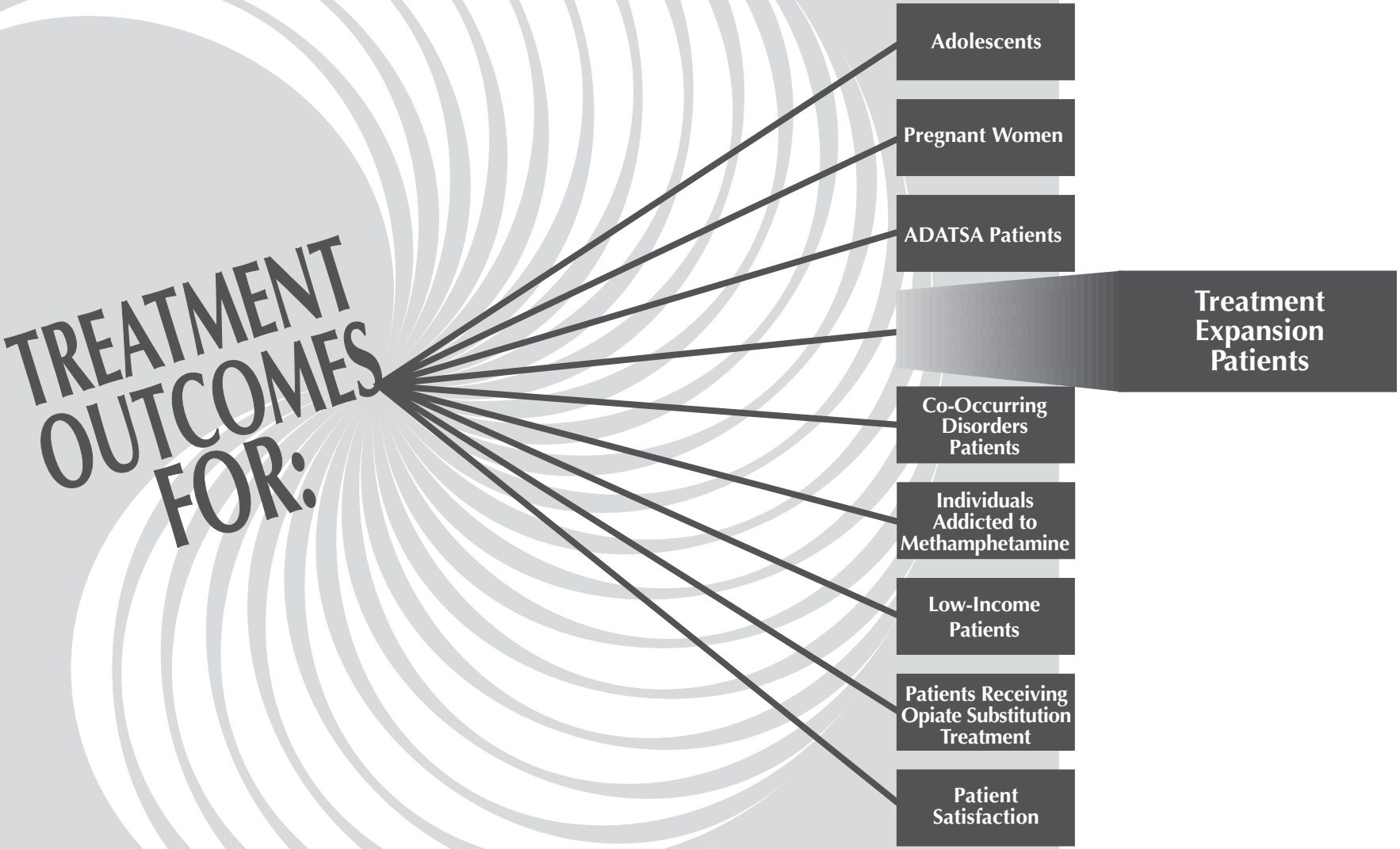
Source: Mancuso, D., et al., *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

Under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), individuals who are disabled and unable to work due to an alcohol or drug disorder may qualify for assessments, chemical dependency treatment, and financial support. A study of ADATSA-eligible clients in SFY 2002-2004 found that clients who received chemical dependency treatment earned 37% more in the year following enrollment than those who did not. Some 51% of treated clients had earnings recorded in Employment Security Department wage data, compared to 39% of untreated clients.

Criminal recidivism was also 32% lower among ADATSA clients with a prior arrest who received treatment than those who did not.[1]

[1] Mancuso, D., et al. *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

Outcomes: The Benefits of Prevention & Treatment



Profile of Adult Treatment Expansion Patients Receiving Chemical Dependency Treatment in Washington State

In 2005, the Legislature and Governor enacted the Omnibus Mental Health and Substance Abuse Disorders Treatment Act. The Act expanded funding for alcohol and drug treatment for adults on Medicaid or receiving General Assistance, and for low-income youth. The adult expansion was funded through assumed savings in medical and long-term care costs, based on the results of earlier pilot projects providing chemical dependency treatment to Supplemental Security Income (SSI) recipients.

A profile of adult patients in the Treatment Expansion categories admitted to publicly funded treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	12,591
Median Age:	36
Gender:	45% Male; 55% Female
Employment Status:	Employed (full- or part-time) – 10%; Unemployed – 90%
Primary Drug:	Alcohol – 38%; Methamphetamine – 19%; Marijuana – 13%; Heroin – 11%
Criminal Justice Involvement:	52% arrested at least once in previous year
% with Children in the Home:	36%
Housing Status:	14% homeless*

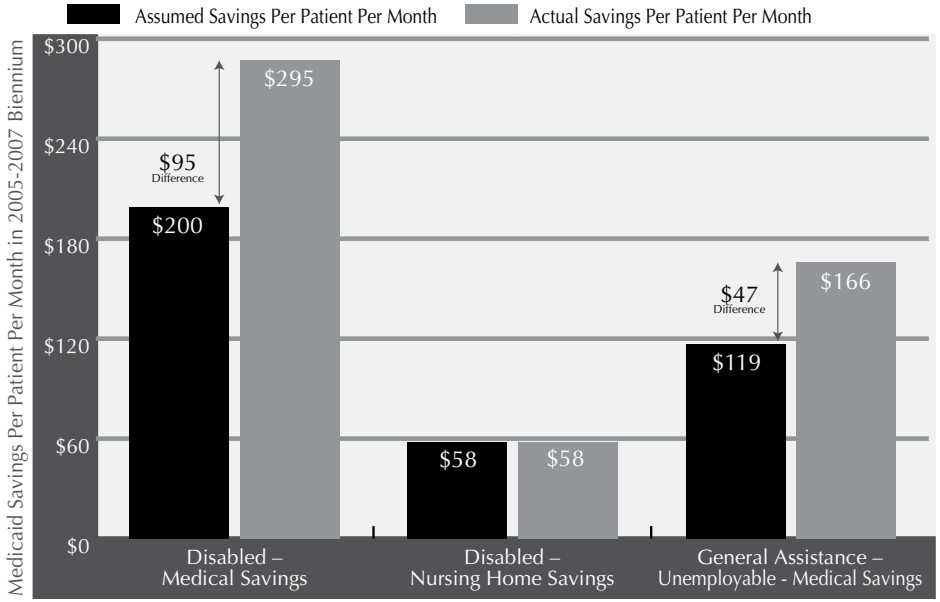
As a result of Treatment Expansion:

- The number of Medicaid Disabled clients receiving chemical dependency treatment increased from 9,041 in SFY 2006 to 10,016 in SFY 2007, representing a 10.8% increase.
- The number of General Assistance-Unemployable clients receiving chemical dependency treatment rose from 2,193 In SFY 2006 to 2,666 in SFY in 2007, representing a 21.6% increase.
- The number of other adults on Medicaid (including those receiving Temporary Assistance for Needy Families) who received chemical dependency treatment increased from 9,498 in SFY 2006 to 9,591 in SFY 2007, representing a 1.0% increase.

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Total Medical Savings for Individuals Receiving Chemical Dependency Treatment as a Result of Treatment Expansion were $19.6 Million for the 2005-2007 Biennium.



Mancuso, D., et al., *Division of Alcohol and Substance Abuse Treatment Expansion: April 2008 Update - Report 4.66*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

In 2005, the Legislature and Governor enacted the Omnibus Mental Health and Substance Abuse Disorders Treatment Act. The Act expanded funding for alcohol and drug treatment for adults on Medicaid or receiving General Assistance, and for low-income youth. The adult expansion was funded through assumed savings in medical and long-term care costs, based on the results of earlier pilot projects providing chemical dependency treatment to Supplemental Security Income (SSI) recipients.

While the ramp-up in providing treatment to qualified clients was slower than anticipated, the graph above indicates that per patient per month savings resulting from access to chemical dependency treatment were significantly higher than expected. Total estimated medical savings in the 2005-2007 Biennium were $19.6 million.[1]

[1] Mancuso, D., et al. *Division of Alcohol and Substance Abuse Treatment Expansion: April 2008 Update - Report 4.66*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

Profile of Supplemental Security Income (SSI) Recipients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

Under the Supplemental Security Income (SSI) program, the federal government provides public assistance to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

A profile of SSI recipients admitted to publicly funded chemical dependency treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	3,055
Median Age:	42
Gender:	56% Male; 44% Female
Employment Status:	Employed (full- or part-time or temporary) – 3%; Unemployed – 97%
Primary Drug:	Alcohol – 40%; Methamphetamine – 14%; Cocaine – 14%
% with Previous Admission:	54%
Criminal Justice Involvement:	50% arrested at least once in previous year
% with Children in the Home:	13%
Housing Status:	15% homeless*

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

As a result of the Omnibus Mental Health and Substance Abuse Treatment Act enacted by the Legislature in 2005, DASA substantially expanded treatment access to Medicaid-eligible individuals, including those receiving SSI.

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Chemical Dependency Treatment Lowers Medical Costs and is Associated with Better Criminal Justice Outcomes Among Supplemental Security Income (SSI) Recipients.*

The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients to determine need for and receipt of chemical dependency treatment services.[1] Some 16% were found to be in need of treatment, and, of these, 50% received chemical dependency treatment between July 1997 and December 2001.

Medical, mental health, and nursing home cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical expenses, and also subtracting costs of chemical dependency treatment (including detoxification), average monthly costs were $252 higher per month for individuals who did not receive treatment than for those who received at least some treatment. The differential was even greater for those completing chemical dependency treatment.

In addition, chemical dependency treatment for SSI recipients was associated with better criminal justice outcomes: for those who completed treatment, a 43% reduced likelihood of arrest; a 38% reduced likelihood of any conviction; and a 48% reduced likelihood of a felony conviction.

As a result of new funds made available with the enactment of the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005, some 10,016 Medicaid Disabled patients - a significant portion of whom were SSI recipients - received treatment in SFY 2007.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.

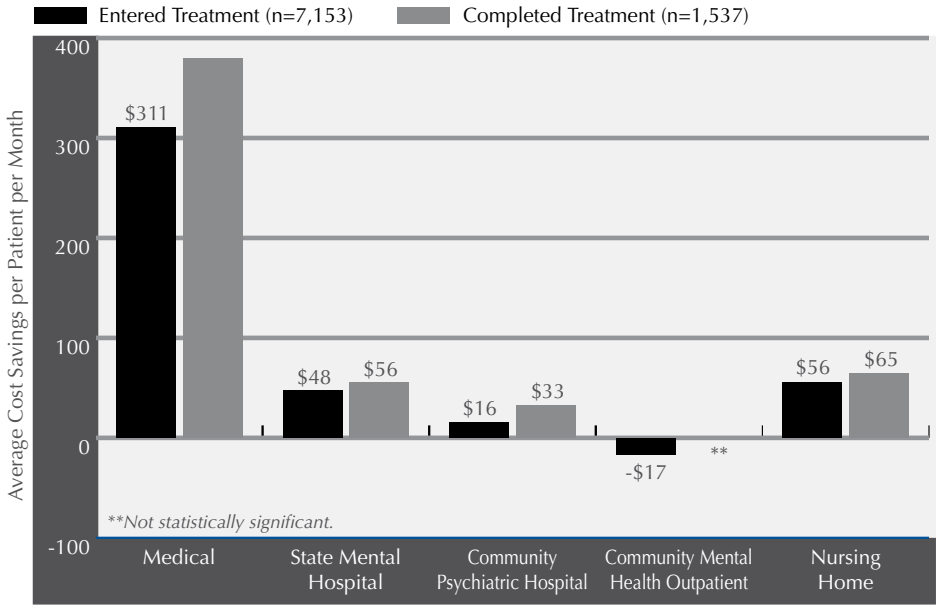
Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, the average monthly medical costs were $414 per month higher for those who did not receive treatment. Even after including the cost of chemical dependency treatment, there was a net cost offset of $252 per month or $3,024 a year. The net cost offset rose to $363 per month per client for those who completed treatment.[1]

[1] Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients Who Complete Treatment.*



Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

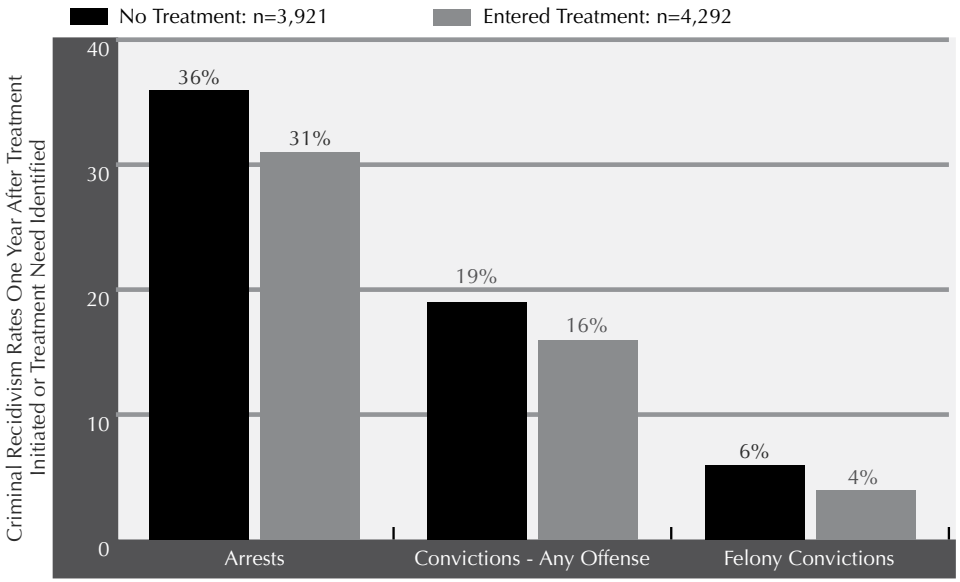
Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, there were found to be significant savings in medical, mental health, and nursing home costs. Overall reductions were $414 per month per client for those who entered chemical dependency treatment compared with those in need of treatment but who did not receive it, and even higher ($530 per month) for those who completed treatment.[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Chemical Dependency Treatment is Associated with Fewer Criminal Arrests and Convictions Among Supplemental Security Income (SSI) Recipients.*

Criminal Recidivism Rates One Year After Treatment Initiated or Treatment Need Identified



Source: Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.* Washington Department of Social and Health Services, Research and Data Analysis Division, February 2003.

The Department of Social and Health Services' Research and Data Analysis Division examined criminal arrest and conviction and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients.[1] Some 8,743 SSI recipients were found to have an arrest or conviction in the two years prior to initiating chemical dependency treatment or having a need for such treatment indicated. In the following year, those who entered treatment were found to be 16% less likely to have been arrested, and 34% less likely to have a felony conviction compared to those who did not enter treatment. Similarly, among clients who entered chemical dependency treatment and had a recent record of arrest or conviction, those who completed chemical dependency treatment were 43% less likely to be arrested, and 48% less likely to be convicted of a felony.[2]

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[1] Estee, S. and Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2003.
[2] Percentages are based on multivariate proportional hazards models that take account of age, gender, and race/ethnicity. See *Ibid.*, pp. 31-35 for details.

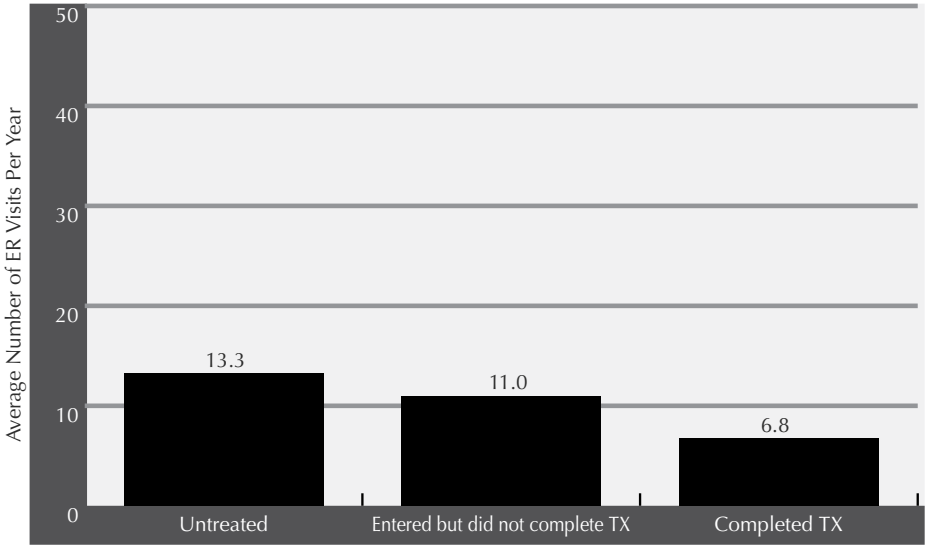
Savings in Emergency Room Costs Associated with Chemical Dependency Treatment Provided to Supplemental Security Income (SSI) Recipients More Than Offsets the Cost of Treatment.*

Source: Nordlund, D., et al., "Chemical Dependency Treatment Reduces Emergency Room Costs and Visits: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

In a study of almost 124,000 Supplement Security Income (SSI) recipients between July 1997 and December 2001, it was found that average monthly emergency room costs for those who were in need of chemical dependency treatment and received it were $154 lower than for those who needed treatment but did not receive it. The number of visits per year was 19% lower, and average cost per visit was 29% lower. The saving in emergency room costs alone almost offset the average monthly cost of chemical dependency treatment ($162).

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

Following Chemical Dependency Treatment, Emergency Room (ER) Visits are Significantly Reduced among Supplemental Security Income (SSI) Recipients Who are Frequent ER Visitors.*



Source: Mancuso, D., Nordlund, D., & Felver, B., "Reducing Emergency Room Visits Through Chemical Dependency Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, July 2004.

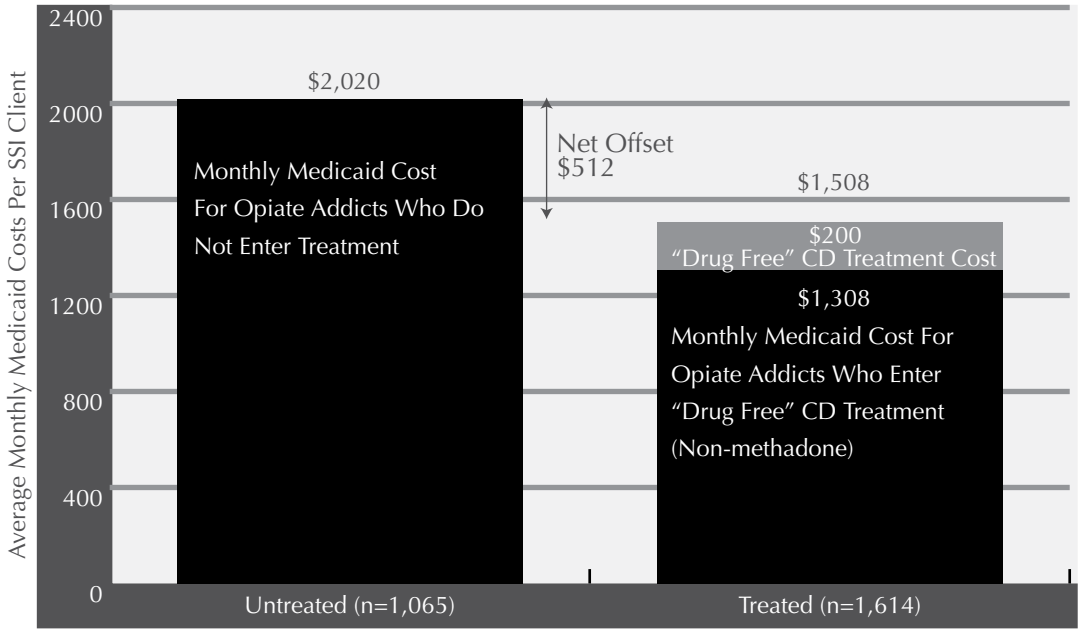
Providing treatment to chemically dependent SSI recipients results in substantial Medicaid cost savings. Reductions in emergency room costs account for 37% of the $414 per month overall Medicaid cost offset that results from providing chemical dependency treatment to SSI recipients. Reductions in ER costs alone ($154 per client) almost completely offset the average $162 per client per month treatment costs.[1]

The graph above indicates that for SSI recipients who are frequent emergency room visitors (12 or more visits a year), there is a 17% reduction in average number of visits for those who enter but do not complete chemical dependency treatment, and a 48% reduction in visits for those who complete treatment.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Estee, S. and Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2003.

Providing Drug-Free Chemical Dependency Treatment to Opiate-Addicted Supplemental Security Income (SSI) Recipients Reduces Medical Costs.*



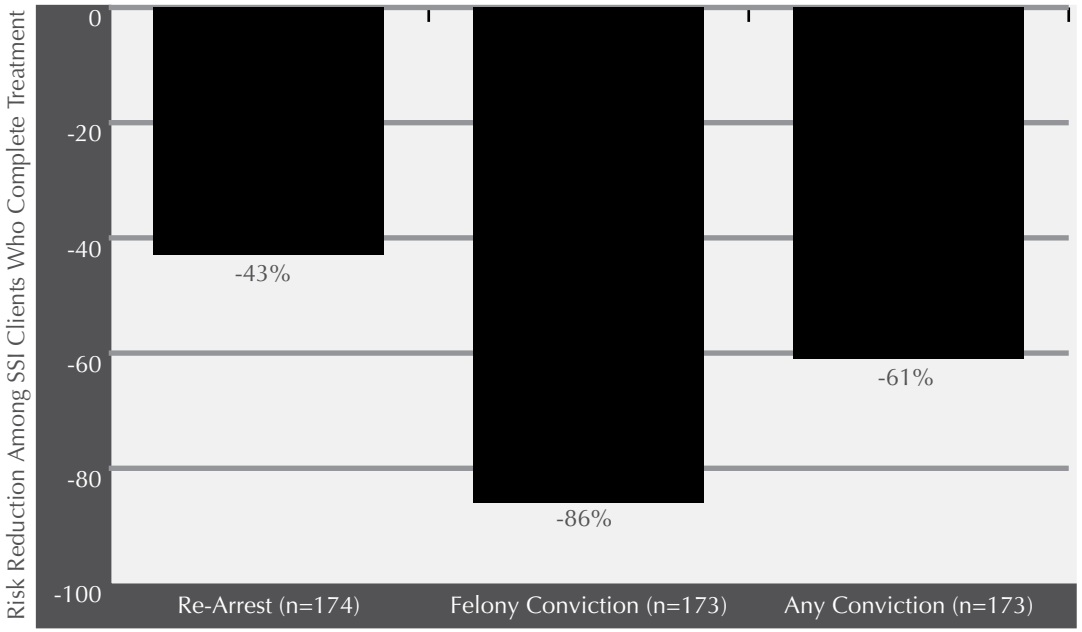
Source: Nordlund, D., et al., "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly reduced when opiate-addicted SSI recipients participate in "drug-free" (non-methadone) chemical dependency treatment programs. After costs of treatment are deducted, the average monthly net cost offset is $520. Monthly net cost offsets are higher for those who complete treatment ($629) than for those who do not ($479).[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot quality for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Nordlund, D., et al. "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients - Research and Data Analysis Division, 4.50fs." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

Opiate-Addicted Supplemental Security Income (SSI) Recipients Who Complete Drug-Free Chemical Dependency Treatment Have Dramatically Reduced Risks of Re-Arrest, Felony Conviction, and Any Conviction.*



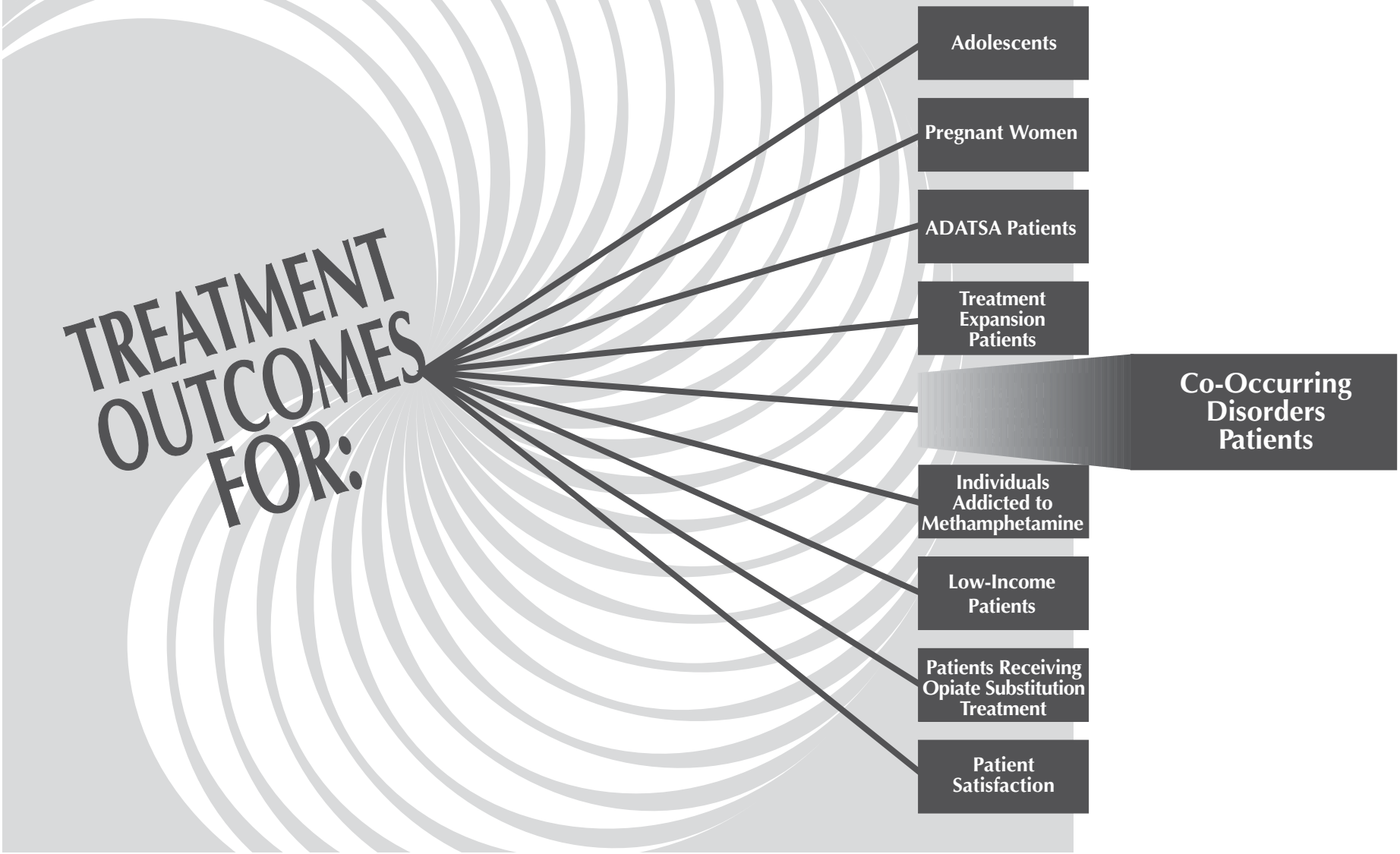
Source: Nordlund, D., et al., "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

Completion of "drug-free" (non-methadone) chemical dependency treatment by opiate-addicted SSI results in substantially lower risks of criminal recidivism, felony conviction, and any conviction. It also results in dramatically lower Medicaid-paid medical costs.[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot quality for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Nordlund, D., et al. "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients - Research and Data Analysis Division, 4.50fs." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

Outcomes: The Benefits of Prevention & Treatment



Profile of Co-Occurring Patients Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients with co-occurring mental health and chemical dependency problems admitted to publicly funded treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	7,933
Median Age:	37
Gender:	49% Male; 51% Female
Employment Status:	Employed (full- or part-time or temporary) – 9%; Unemployed – 91%
Primary Drug:	Alcohol – 38%; Methamphetamine – 19%; Cocaine – 12%
% with Previous Admission:	48%
Criminal Justice Involvement:	52% arrested at least once in previous year
% with Children in the Home:	20%
Housing Status:	17% homeless*

Data from the Division of Alcohol and Substance Abuse's TARGET system indicate that 26.9% of admissions to publicly funded chemical dependency treatment in SFY 2007 were for patients with co-occurring mental health problems. Some 1.2% are considered seriously mentally ill, having spent 15 or more days in a psychiatric hospital in the previous year.

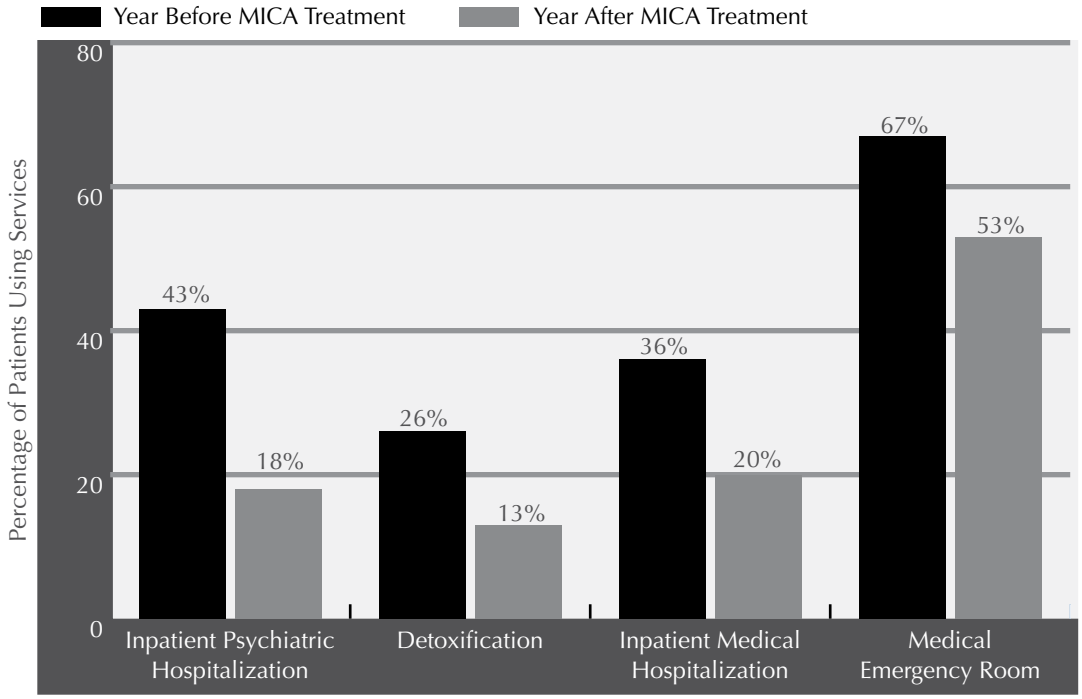
Compared with individuals without co-occuring mental health problems who receive DASA-funded treatment services, co-occurring patients are: older; more likely to be female; less likely to be employed at time of admission; less likely to have alcohol as their primary substance of abuse; less likely to have been arrested in the previous year; and less likely to have children in their home.

A 1999 study found that individuals with co-occurring disorders discharged from residential chemical dependency treatment had an age-adjusted death rate 1.7 times greater than the general population.[2] Over a five-year period, among patients in Washington State psychiatric hospitals, and after adjusting for age, individuals with co-occurring disorders or substance abuse disorders were almost 50% more likely to die than those with mental illness only. Some 21% of deaths among patients with co-occurring disorders were due to illnesses related to drug or alcohol abuse and addiction.[3]

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded. Co-occurring patients are defined as those who received a mental health evaluation, wiith results revealing a positive indication for a mental health problem.
[2] Maynard, C., et al., "Utilization of Services for Mentally Ill Chemical Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services and Research*, 26, 1999.
[3] Maynard, C., et al., "Substance Abuse and Five-Year Survival in Washington State Mental Hospitals," *Administration and Policy in Mental Health*, 31(4), March 2004.

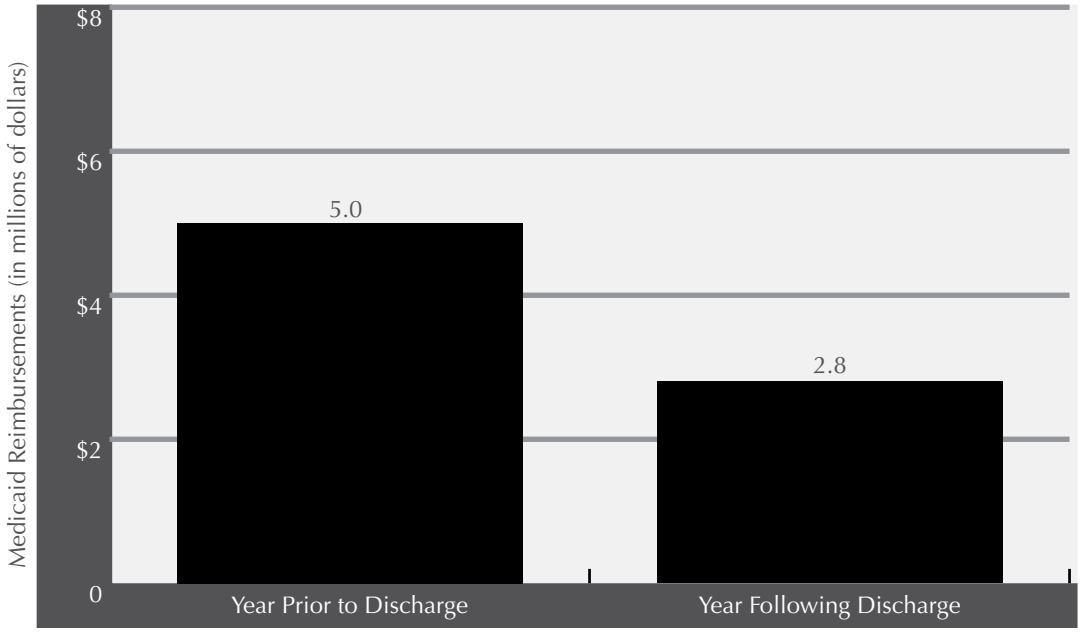
Patients with Co-Occurring Mental Health and Chemical Dependency Disorders Utilize Fewer Medicaid Services Following Discharge from Residential Treatment.



Source: Maynard, C., et al., "Utilization of Services for Mentally Ill Chemically Abusing (MICA) Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

A significant number of Medicaid patients are diagnosed with both mental health and chemical dependency disorders. Treating these co-occurring disorders in an integrated manner has proven effective in enhancing health-related outcomes. Medicaid expenses for patients with co-occurring disorders receiving coordinated services in a residential chemical dependency treatment program decreased by 44% in the year following discharge from the year prior to treatment.

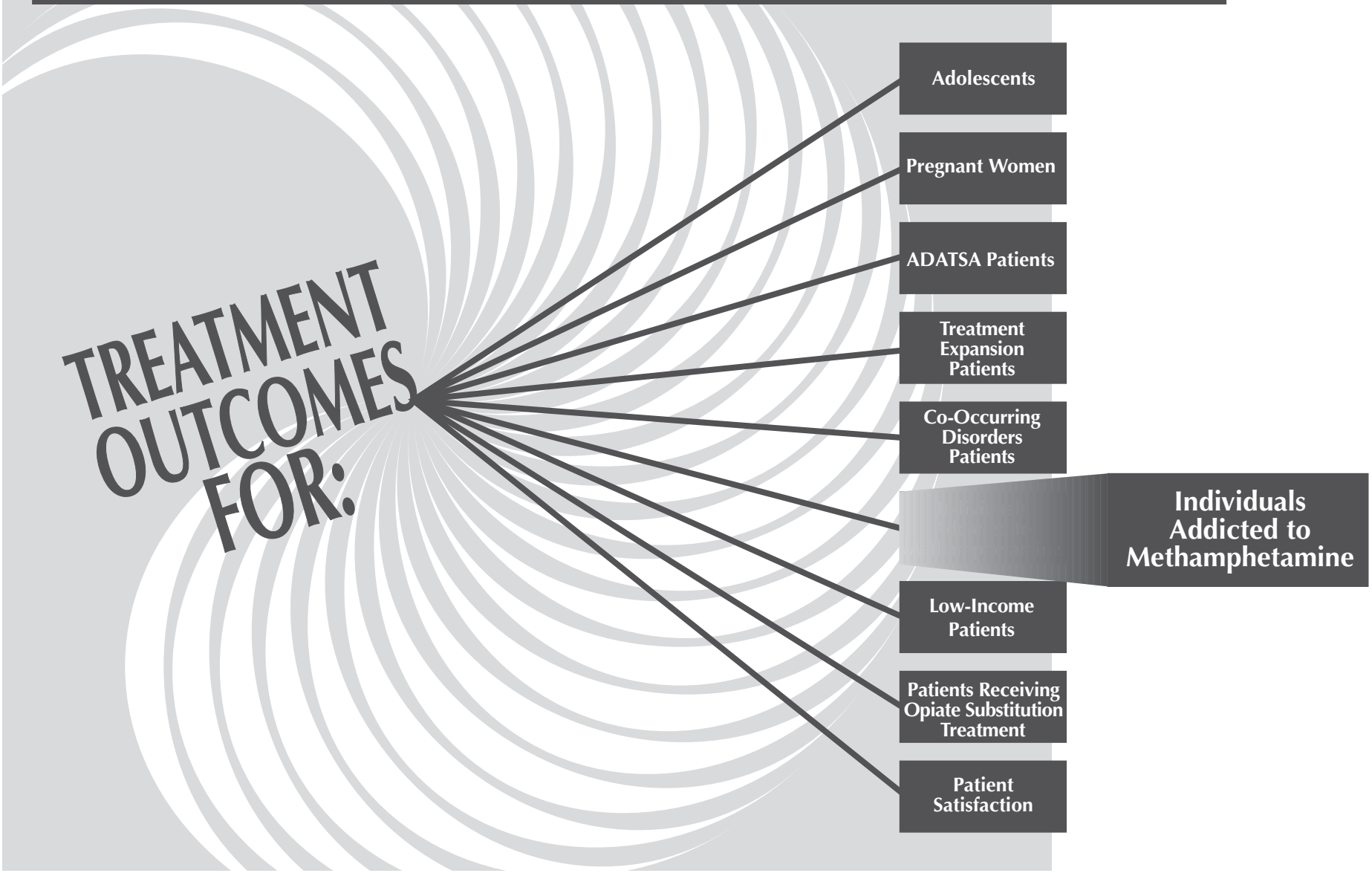
Use of Expensive Acute Care Services Decreased for Patients with Co-Occuring Mental Health and Chemical Dependency Disorders Following Discharge from Residential Treatment.



Source: Maynard, C., et al., "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

Integrated treatment for mental health and chemical dependency disorders has proven effective in reducing use of acute care services. In the year following discharge from residential chemical dependency treatment programs that provided integrated treatment for co-occurring disorders, the percentage of patients requiring psychiatric hospitalization fell by 58%; detoxification by 50%; medical hospitalization by 44%; and use of emergency rooms by 21%.

Outcomes: The Benefits of Prevention & Treatment



Profile of Adults Receiving Publicly Funded Chemical Dependency Treatment for Methamphetamine Addiction in Washington State

A profile of adults admitted to publicly funded chemical dependency treatment with methamphetamine as their primary substance of abuse in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	5,678
Median Age:	30
Gender:	49% Male; 51% Female
Employment Status:	Employed (full- or part-time) – 12%; Unemployed – 88%
% with Previous Admissions:	41%
Criminal Justice Involvement:	60% arrested at least once in previous year
% with Children in the Home:	24%
Housing Status:	16% homeless*

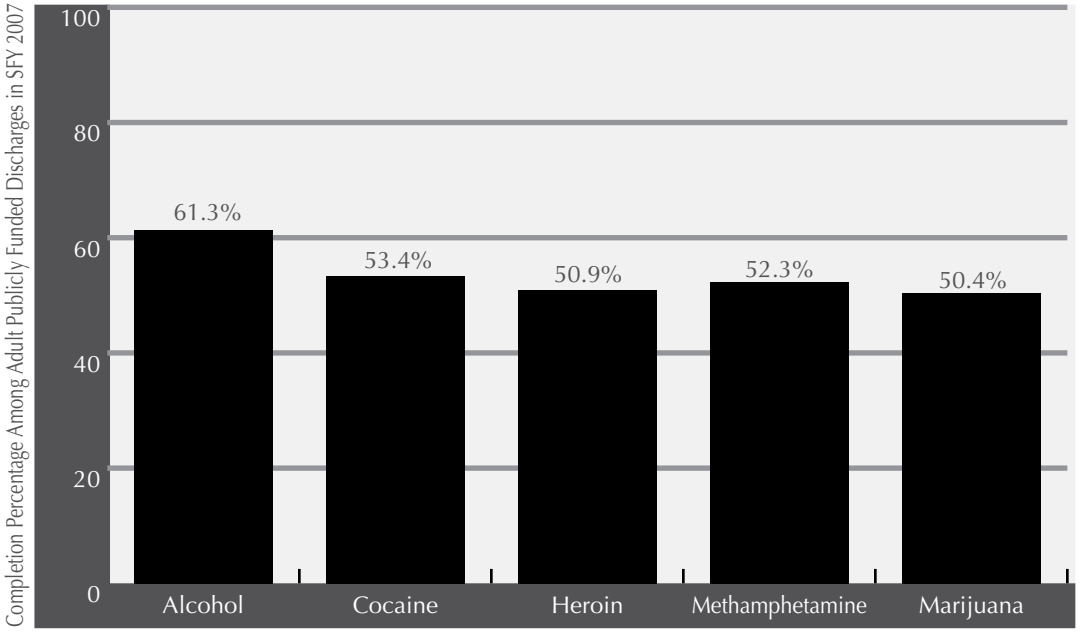
**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Compared with all low-income adults receiving publicly funded treatment in Washington State in SFY 2007, those treated for methamphetamine addiction are substantially younger (median age 30, as opposed to 34 for low-income adults receiving treatment); more likely to be female (51% v. 39%); and less likely to be employed (12% v. 20%).

The number of adults receiving publicly funded treatment for methamphetamine addiction decreased from 6,030 in SFY 2006 to 5,678 in SFY 2007, representing a 5.8% decline.

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Adult Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.

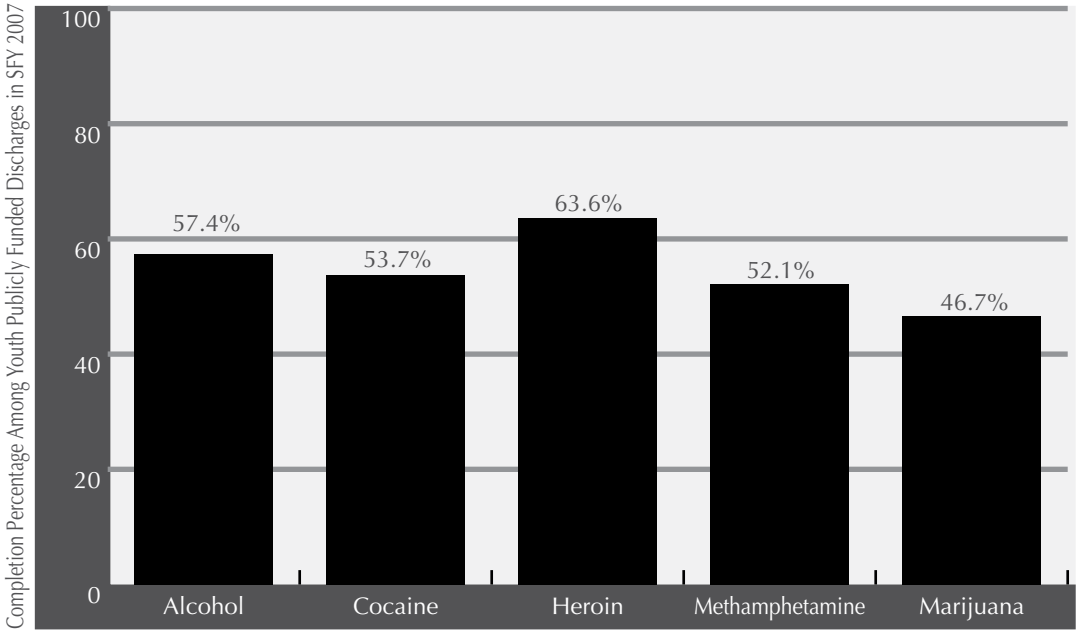


Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse.

This graph indicates that adults receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to (actually slighter higher than) adults addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of individuals addicted to methamphetamine are polydrug users.

Youth Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.

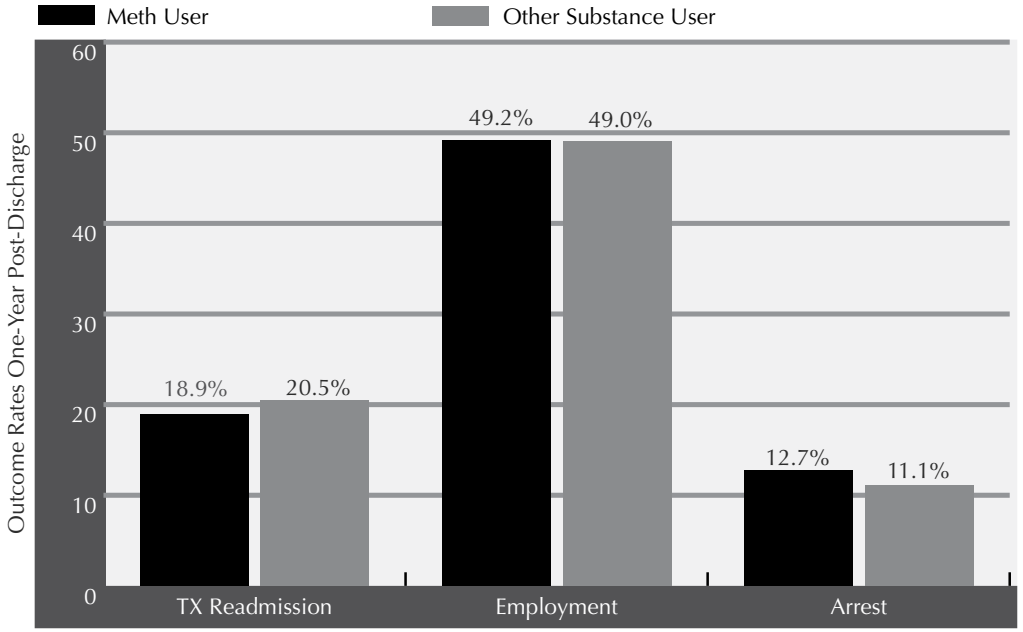


Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse.

This graph indicates that youth ages 12-17 receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to youth addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of youth addicted to methamphetamine are polydrug users.

Adult Treatment Outcomes for Methamphetamine Addiction are Similar to Outcomes for Other Drugs.

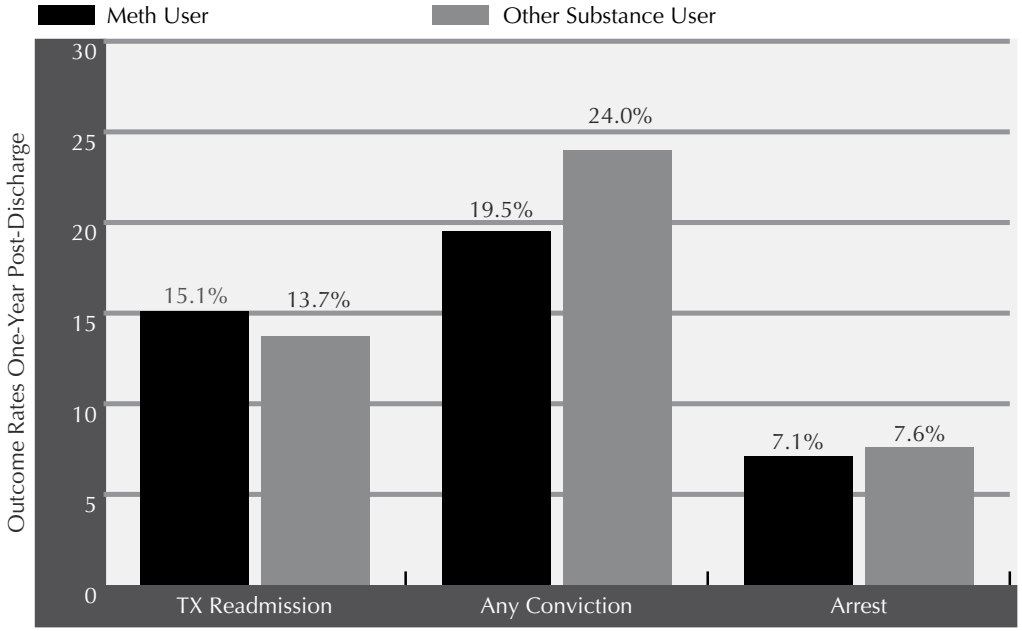


Luchansky, B., *Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug*. Olympia, WA: Looking Glass Analytics, December 2003.

Adult treatment outcomes one-year post-discharge in readmission, employment, and arrests for individuals addicted to methamphetamine are similar to those receiving treatment for other drugs. The exception is that methamphetamine users who receive treatment have 36% fewer hospital admissions per 100 patients one-year post-discharge than those receiving treatment for other drugs.[1]

[1] Luchansky, B., *Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug*. Olympia, WA: Looking Glass Analytics, December 2003.

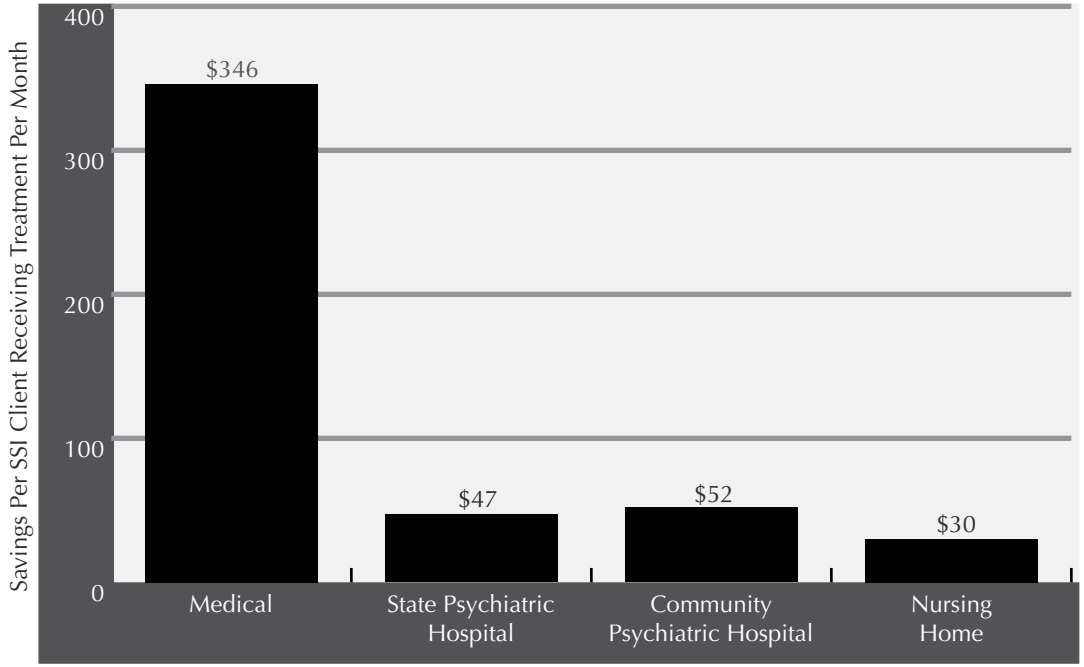
Youth Treatment Outcomes for Methamphetamine Addiction are Similar to Outcomes for Other Drugs.



Luchansky, B., *Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug.* Olympia, WA: Looking Glass Analytics, December 2003.

Youth treatment outcomes one-year post-discharge in readmission, any convictions, and felony convictions for individuals addicted to methamphetamine are similar to those receiving treatment for other drugs.

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Substantial Savings in Health Care Costs Among Supplemental Security Income Recipients.

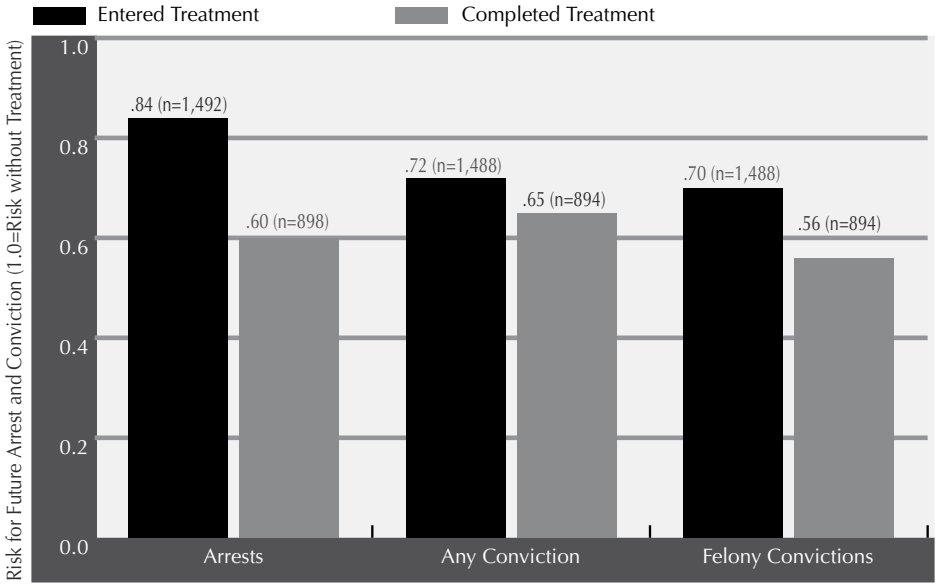


Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantial savings in health care costs for Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. Even factoring in the cost of chemical dependency treatment ($178 per month), the net savings in health care costs are $296 per month or $3,552 per year.

Providing treatment for stimulant (methamphetamine) addiction for SSI recipients in fact results in higher net cost savings ($296/month) than treatment for addiction to other substances ($267/month).

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Reduced Risk for Arrest and Conviction Among Supplemental Security Income Recipients.*

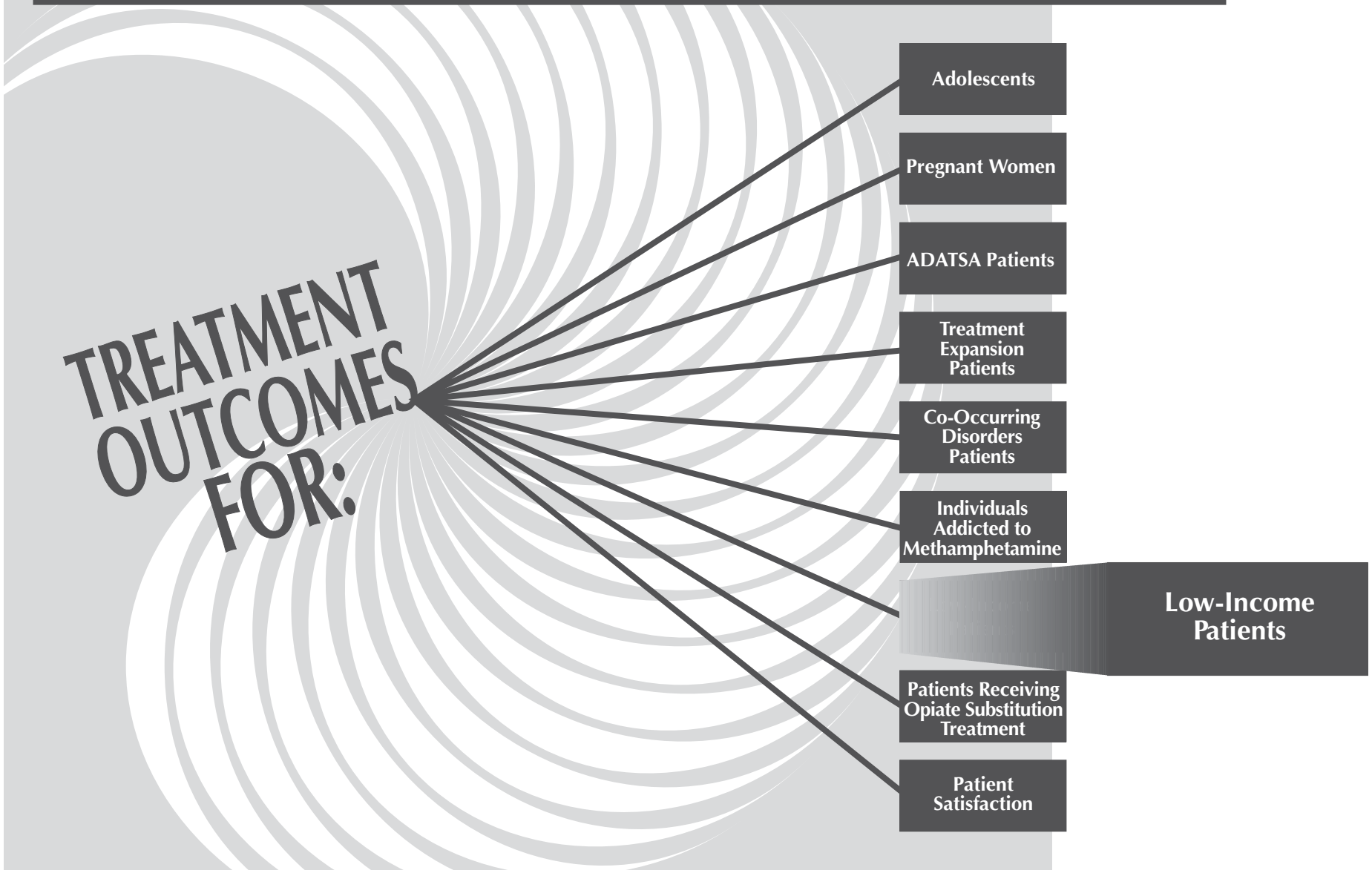


Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantially reduced risks for arrest and conviction for Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. The risk of arrest is 16% for those who enter treatment, and 40% lower for those who complete treatment. The risk of felony conviction is 30% lower for those who enter treatment, and 44% lower for those who complete treatment. Chemical dependency treatment for those addicted to methamphetamine is thus a good investment in safer communities and lower criminal justice costs.

** Risks reflect results of proportional hazard models in which the effects of covariates on re-arrest or conviction rates (e.g., age, gender, race/ethnicity) are controlled.*

Outcomes: The Benefits of Prevention & Treatment



Profile of Low-Income Adults Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of low-income adults admitted to publicly funded chemical dependency treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	29,466
Median Age:	34
Gender:	61% Male; 39% Female
Employment Status:	Employed (full- or part-time) – 20%; Unemployed – 80%
Primary Drug:	Alcohol – 43%; Methamphetamine - 19%; Marijuana - 13%
% with Previous Admission:	41%
Criminal Justice Involvement:	60% arrested at least once in previous year
% with Children in the Home:	25%
Housing Status:	14% homeless*

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Publicly Funded Residential Chemical Dependency Treatment Results in Improved Outcomes in Employment and Medical Status, Lower Substance Use and Higher Rates of Abstinence, and Reduced Criminal Activity.

A 1999 study was undertaken by the University of Washington's Alcohol and Drug Abuse Institute to assess the quality and effectiveness of the Division of Alcohol and Substance Abuse's publicly funded adult residential chemical dependency treatment system. Some 577 low-income patients were assessed at admission to treatment, and six months following their discharge. The study found:

- Patients were much less likely to use alcohol and illegal drugs following treatment. Self-reported abstinence rates for alcohol use in the past 30 days increased by 87%, and by 109% for drug use. Of those who continued to report any drug use, the percentage of patients who used any illegal drugs for seven or more of the past 30 days declined 74%, from 50% at treatment admission to 13% at follow-up.

- The average number of self-reported days of illegal activity declined 85%. Average 30-day earnings from illegal activity declined 93%, from $485 at admission to $32 at follow-up.

- In the 30 days prior to admission to treatment, only 19.8% of patients worked ten or more days. In the 30 days prior to the six-month post-discharge follow-up, 40.7% worked ten or more days, representing a 94% increase. Average monthly income increased from $159 at admission to $568 at follow-up.

- The percentage of patients reporting no days of medical problems during the past 30 days increased by 25% at the post-discharge follow-up. The number of days with mental health distress was reduced by 48%.

- The number of days with significant family conflict during the past 30 days declined by 62% at the post-discharge follow-up.[1]

[1] Carney, M., & Donovan, D., *Washington State Outcomes Project: Clinical Improvement from the Adult Residential Treatment System 6 Months Post-Discharge.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1999.

Profile of Adults Receiving Temporary Assistance for Needy Families Served By Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	4,060
Median Age:	29
Gender:	23% Male; 77% Female
Employment Status:	Employed (full- or part-time) – 15%; Unemployed – 85%
Primary Drug:	Alcohol – 33%; Methamphetamine - 26%; Marijuana – 15%
% with Previous Admission:	40%
Criminal Justice Involvement:	50% arrested at least once in previous year
% with Children in the Home:	75%
Housing Status:	7% homeless*

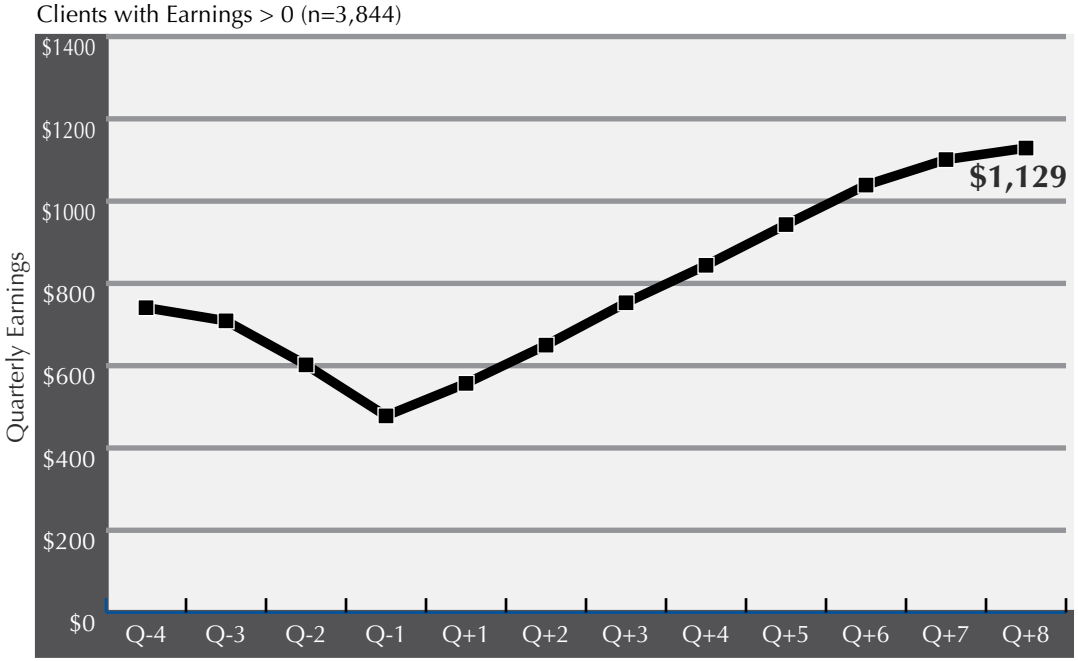
A study of adults receiving TANF admitted to publicly funded chemical dependency treatment in Washington State, July 1998 – June 1999, indicated:

- One out of three women did not have a high school diploma or GED.
- Three out of four women reported they had been victims of domestic violence at some point in their lives.
- 21% reported receiving mental health treatment in the previous year.
- One out of three women reported using injection drugs at some point in their lives.[2]

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] Rodriquez, F. *Key Characteristics of TANF Adults Admitted to Publicly Funded Treatment in Washington State, July 1998 – June 1999.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2000.

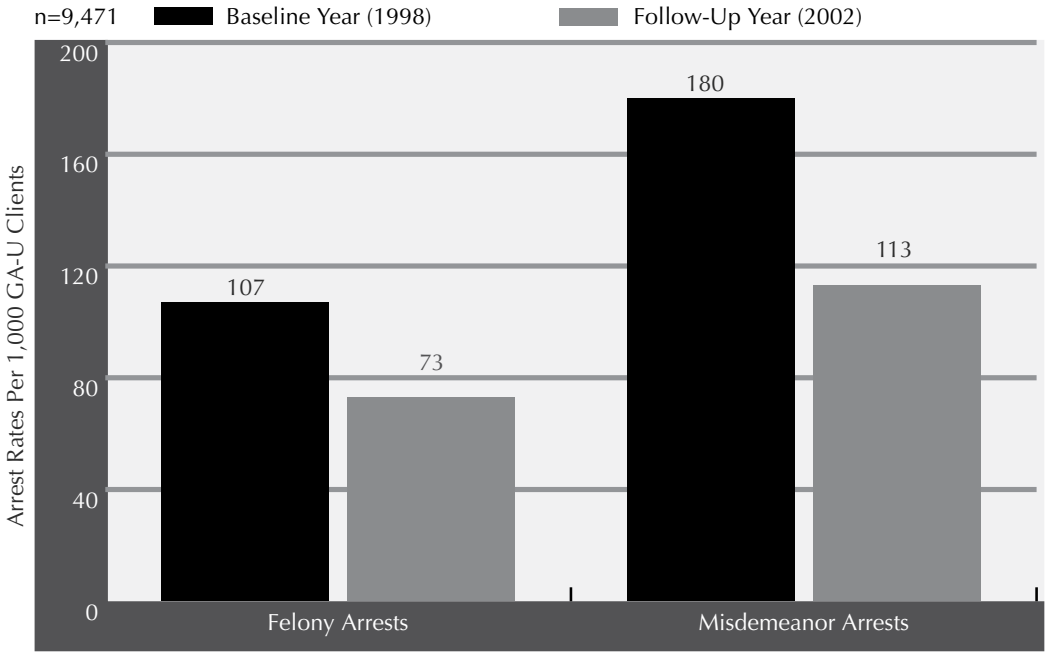
AFDC Clients Who are Employed Show Major Increases in Earnings Following Chemical Dependency Treatment.



Source: Wickizer, T., et al.,"Employment Outcomes Among AFDC Recipients Treated for Substance Abuse in Washington State," *The Millbank Quarterly* 78(4), 2000.

This graph indicates that chemically dependent clients receiving AFDC ("Aid to Families with Dependent Children") support showed marked declines in employment income in the year prior to receiving chemical dependency treatment, and more than doubled their average employment income in the two years following treatment. AFDC in Washington State has now been replaced by TANF ("Temporary Assistance for Needy Families"). This 2000 study confirms the results of earlier studies indicating that chemical dependency treatment assists low-income patients in moving toward self-sufficiency.

Rates of Arrest for Individuals Receiving General Assistance-Unemployable (GA-U) Decline Substantially Even Four Years Following Chemical Dependency Treatment.

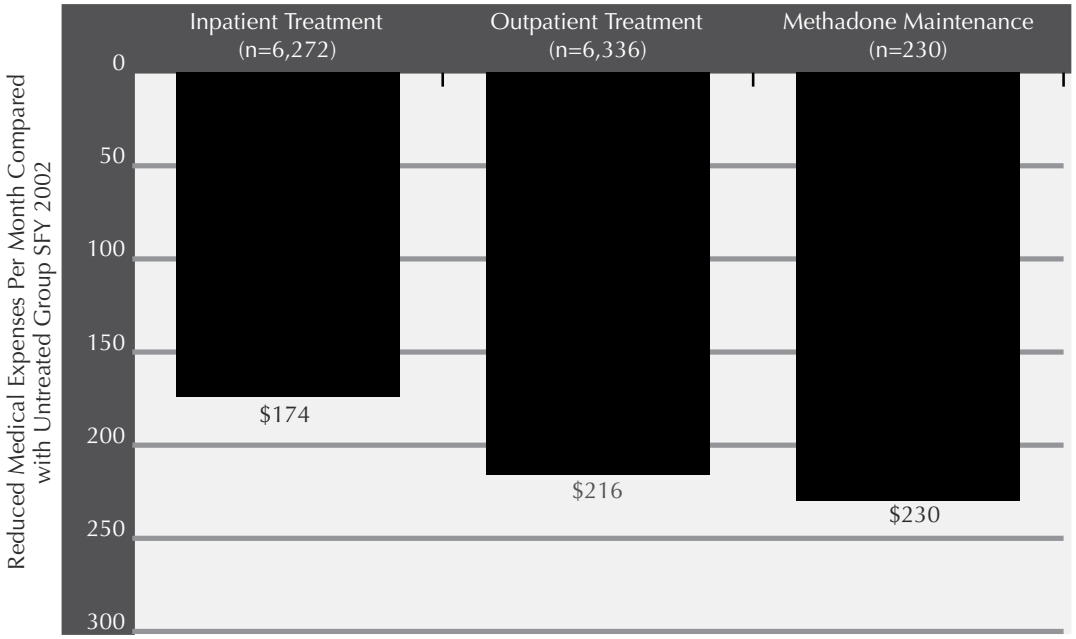


Source: Wickizer, T., et al.,"Substance Abuse Treatment of Welfare Clients in Washington State, Part I: Need for Treatment and Criminal Activity Outcomes." Manuscript in press, 2007.

The General Assistance-Unemployable (GA-U) program is a state-paid welfare program for individuals who are unemployable due to a physical or mental disability lasting at least 90 days. A recent study found that 12.3% of GA-U clients are in need of substance abuse treatment.[1] The study found that among GA-U clients who received chemical dependency treatment in 1998, felony arrests four years later were 31.8% lower, and misdemeanor rates 37.2% lower than in the year treatment was received.

[1] Wickizer, T., et al. "Substance Abuse Treatment of Welfare Clients in Washington State, Part I: Need for Treatment and Criminal Activity Outcomes." Manuscript in press, 2007.

Medical Care Expenses are Significantly Lower for Individuals Receiving General Assistance-Unemployable (GA-U) Three Years Following Chemical Dependency Treatment.

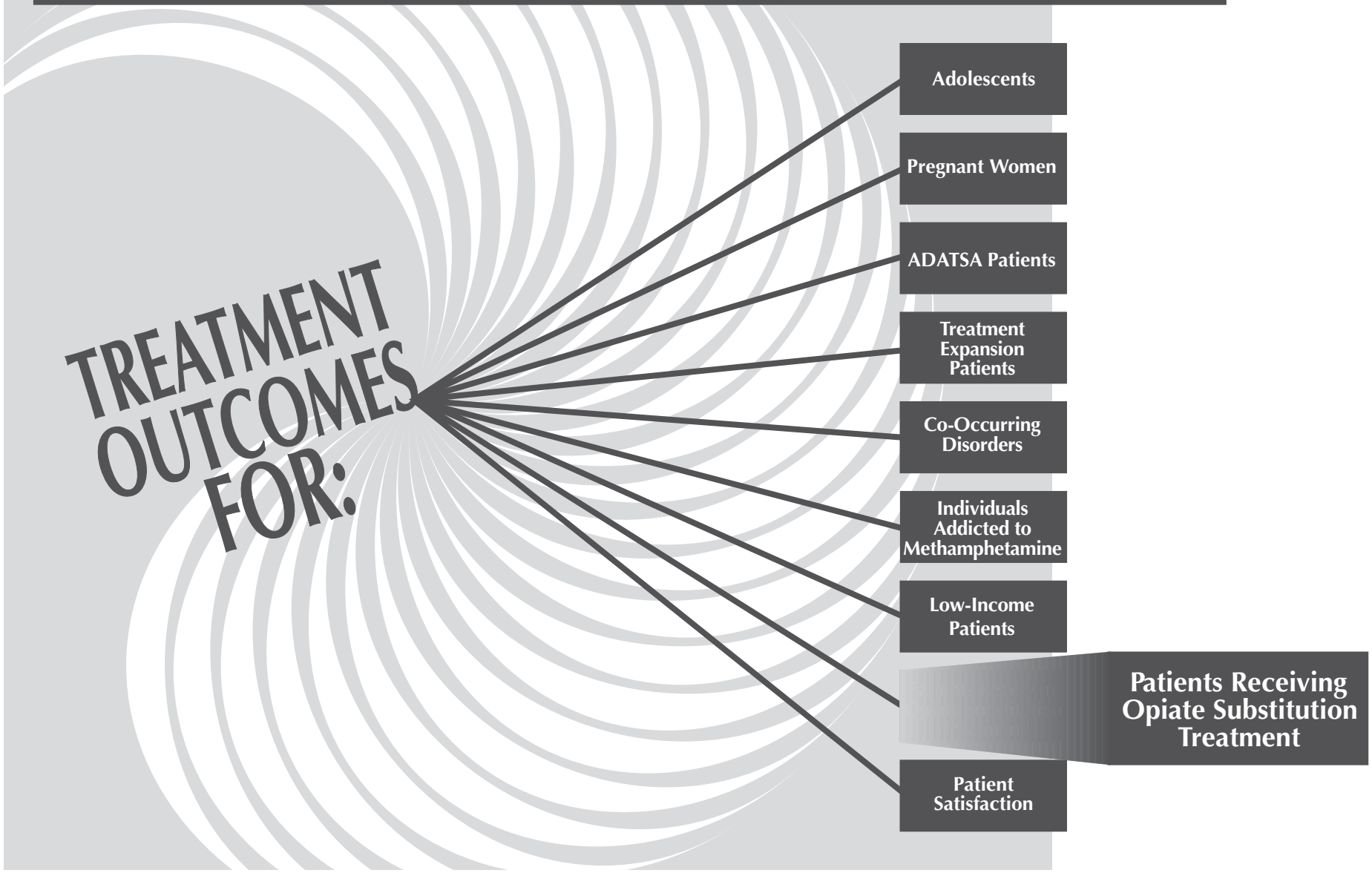


Source: Wickizer, T., et al.,"The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State." *Milbank Quarterly* 84, 2006.

The General Assistance-Unemployable (GA-U) program is a state-paid welfare program for individuals who are unemployable due to a physical or mental disability lasting at least 90 days. A recent study found that among GA-U clients who received chemical dependency treatment in SFY 1999, medical expenses in SFY 2002 were substantially lower than for those who were in need of treatment but did not receive it. Savings were $2,087/year for those receiving inpatient treatment, $2,587 for outpatient, and $2,763 for those receiving methadone maintenance.[1]

[1] Wickizer, T., et al. "The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State." *Milbank Quarterly* 84, 2006.

Outcomes: The Benefits of Prevention & Treatment



Profile of Patients Receiving Publicly Funded Opiate Substitution Treatment in Washington State

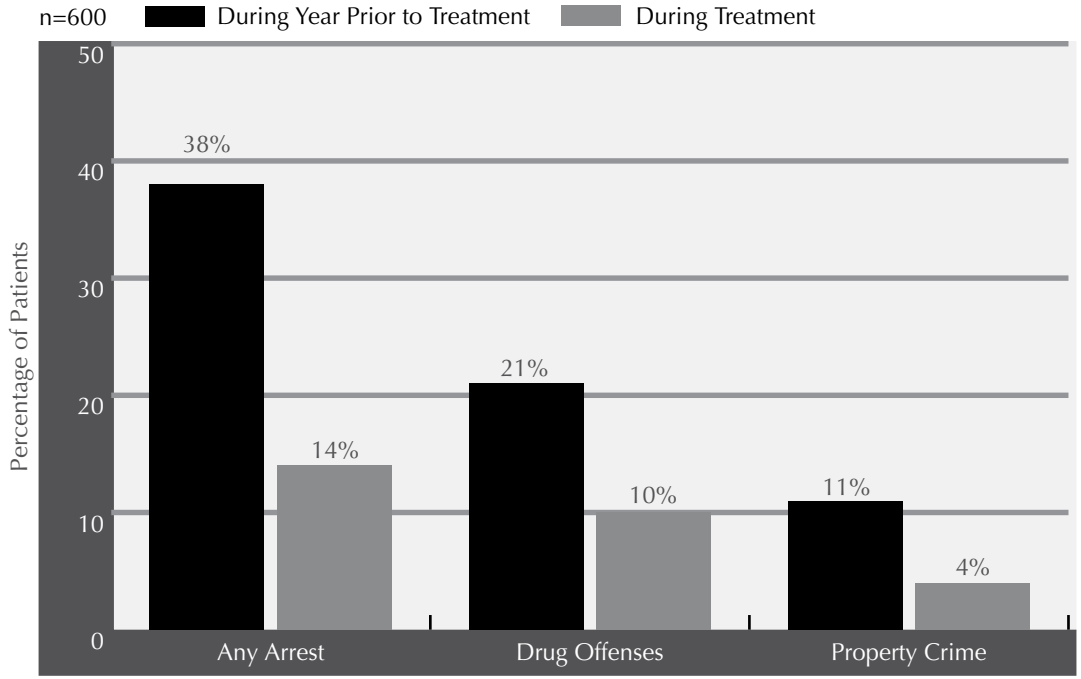
A profile of patients admitted to publicly funded opiate substitution treatment in Washington State in SFY 2007 reveals the following characteristics at time of admission:[1]

Number of Individuals Admitted:	1,841
Median Age:	39
Gender:	49% Male; 51% Female
Employment Status:	Employed (full- or part-time or temporary) – 12%; Unemployed – 88%
Primary Drug:	Heroin – 66%; Other – 34%
% with Previous Admission:	54%
Criminal Justice Involvement:	39% arrested at least once in previous year
% with Children in the Home:	27%
Housing Status:	17% homeless*

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2008. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Criminal Arrests Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment*, 2002.

This graph indicates that patients receiving publicly funded opiate substitution treatment are less likely to be arrested for a crime during treatment than in the year prior to treatment.

It is estimated that in 2000, almost 31,000 Washington State adults were in need of treatment for heroin addiction.[1] Twenty opiate substitution clinics currently provide treatment through administration of methadone and delivery of counseling services. In addition, patients receive education, random urine drug screening to monitor drug use, and are subject to stringent rules regarding compliance. In SFY 2006, 7,363 patients were enrolled in opiate substitution programs in Washington State, 4,004 (54.4%) of whom were publicly funded.[2]

[1] Albert, D. *Determining the Value of Opiate Substitution Treatment*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, January 2004.
[2] Data do not include patients enrolled in Veterans Administration programs.

Patients Receiving Opiate Substitution Treatment Have a Significantly Reduced Risk of Arrest.

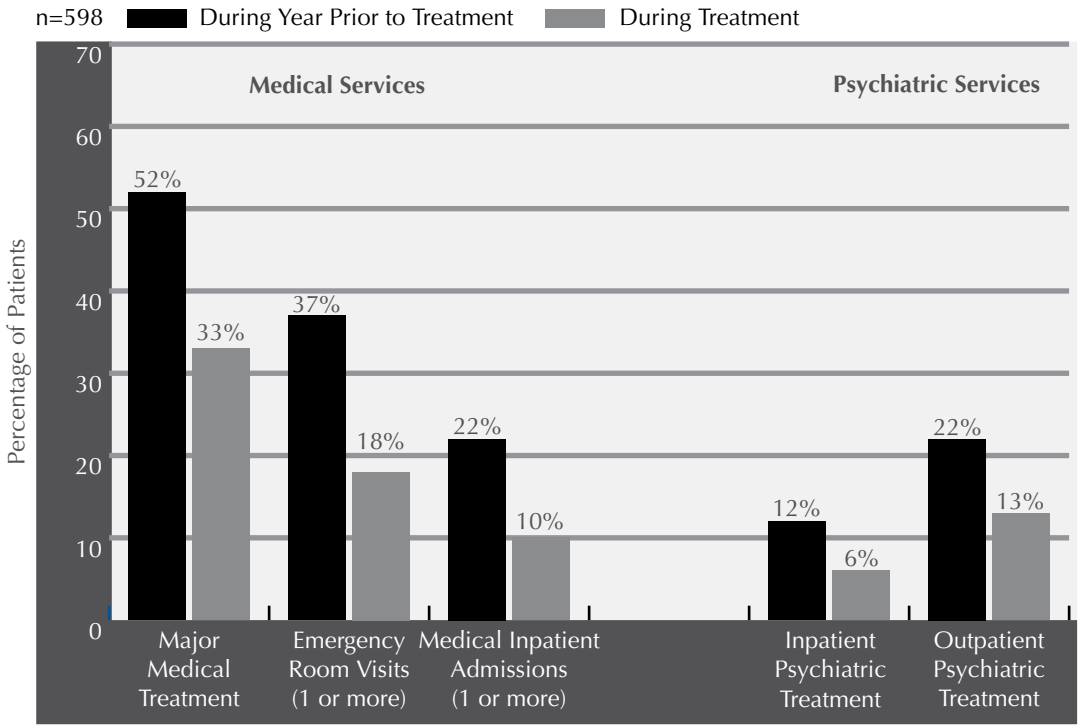
A DASA-funded three-year prospective study of the impact of substance abuse treatment on arrests among 12,962 opiate users in Washington State indicated a significantly reduced risk of arrest among patients receiving opiate substitution treatment.[1] This was especially true among those who remained in treatment for more than 90 days.

The study found:

- Those receiving opiate substitution treatment for more than 90 days had a 42% lower risk of arrest while in treatment than those who never received treatment. The risk for those in treatment less than 90 days was 22% lower.
- For those without a recent (past-year) history of felony or gross misdemeanor arrest, those receiving opiate substitution treatment for more than 90 days had a 48% lower risk of arrest while in treatment than those who never received treatment. The risk for those in treatment less than 90 days was 36% lower.
- For those with a recent (past-year) history of felony or gross misdemeanor arrest, those receiving opiate substitution treatment for more than 90 days had a 25% lower risk of arrest while in treatment than those who never received treatment. The difference in risk for those in treatment less than 90 days was not statistically significant.

[1] Campbell, K., Deck, D., and Krupski, A. "Impact of Substance Abuse Treatment on Arrests Among Opiate Users in Washington State," *The American Journal on Addictions* 16(6), 2007.

Health Care Utilization Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



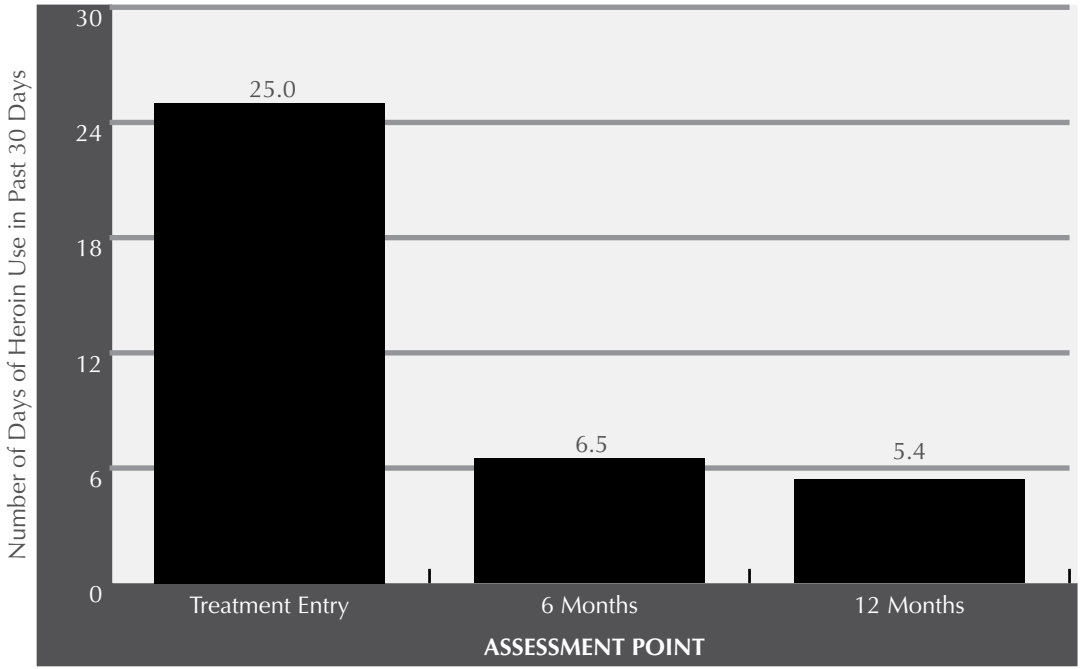
Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment* - 2002.

Opiate substitution treatment has been scientifically shown to work. The federal Office of National Drug Control Policy called methadone therapy, "one of the longest-established, most thoroughly evaluated forms of drug treatment."[1] A Consensus Panel convened by the National Institutes of Health in 1997 concluded, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity."[2]

This graph indicates that patients receiving publicly funded opiate substitution treatment use fewer health care and psychiatric services during treatment than in the year prior to treatment. This results in significant cost savings throughout the health care system.

[1] Office of National Drug Control Policy. *The National Drug Control Strategy: 2000 Annual Report*. Washington, DC: Office of the White House, 2000.
[2] National Institutes of Health. *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*. November 17-19, 1997 15(6).

Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Heroin Use.

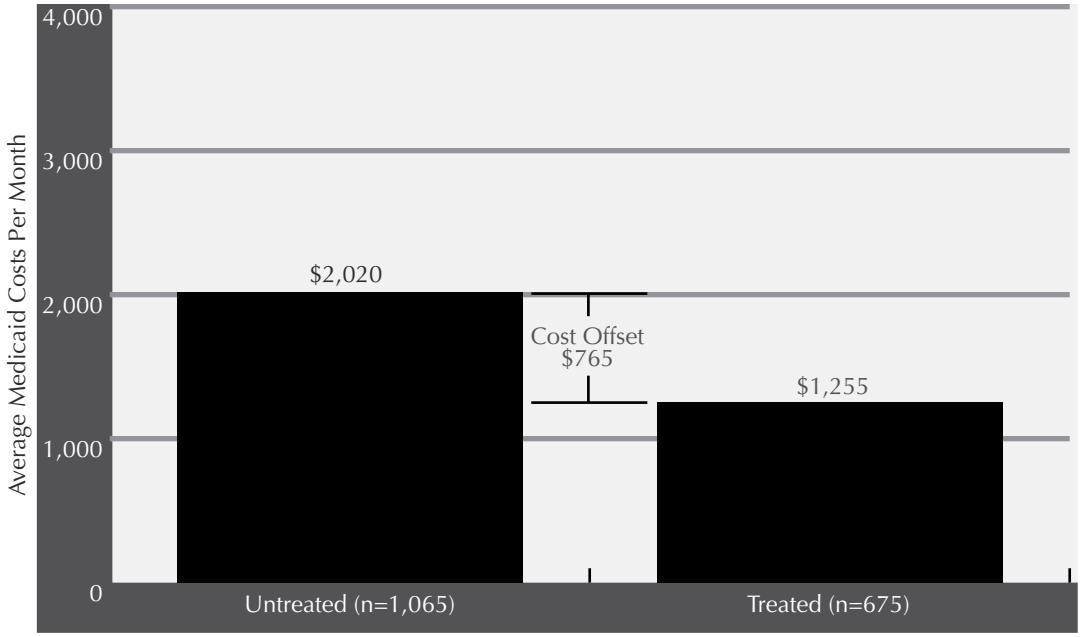


Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in heroin use. At entry into treatment, patients reported an average of 25 days of heroin use in the past 30 days. At six months, this was reduced to 6.5 days, and at 12 months, to 5.4 days, representing a 78% decline. More than four out of five patients reported a reduction in the number of days using heroin at the six- and 12-month follow-ups.[1]

[1] Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Providing Methadone Treatment for Opiate-Addicted Supplemental Security Income Recipients Reduces Health Care Costs.



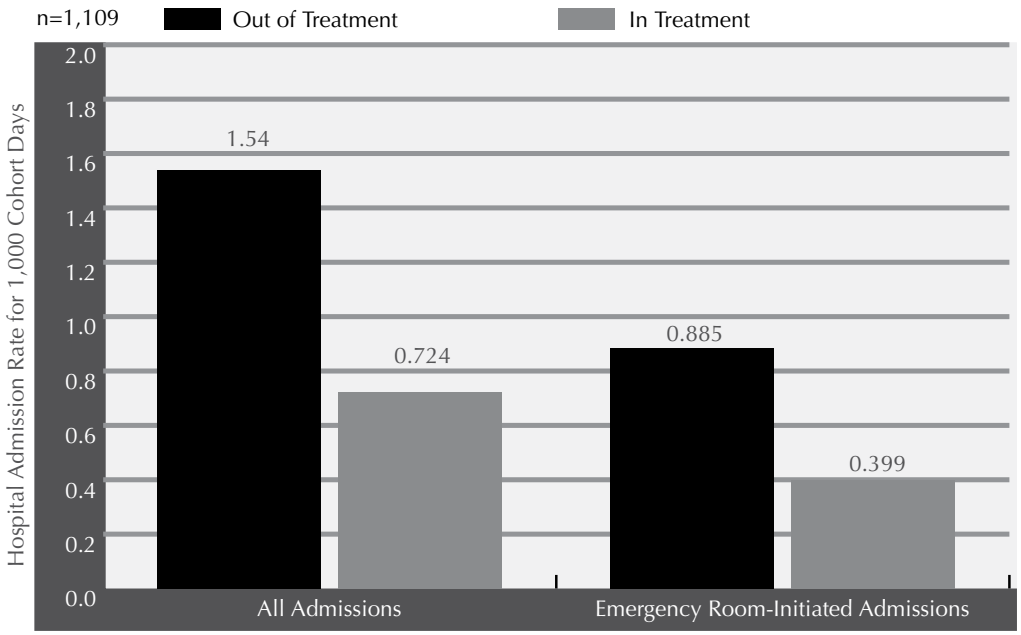
Source: Nordlund, D., et al., "Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly lower for Supplemental Security Income (SSI) recipients addicted to opiates who receive methadone treatment, compared to those who remain untreated. Even after the monthly cost of treatment ($219/month) is included, the net cost savings per patient is $765 per month, or a potential savings of $9,180 per treated SSI recipient per year.

Savings are substantial ($725/month) even for SSI recipients who are opiate-addicted even if they leave treatment within the first 90 days. However, for those who remain in treatment for at least one year, cost offsets rise to $899 per month per recipient.

[1] Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Patients Receiving Opiate Substitution Treatment Have Significantly Lower Hospital Admissions Rates While in Treatment.

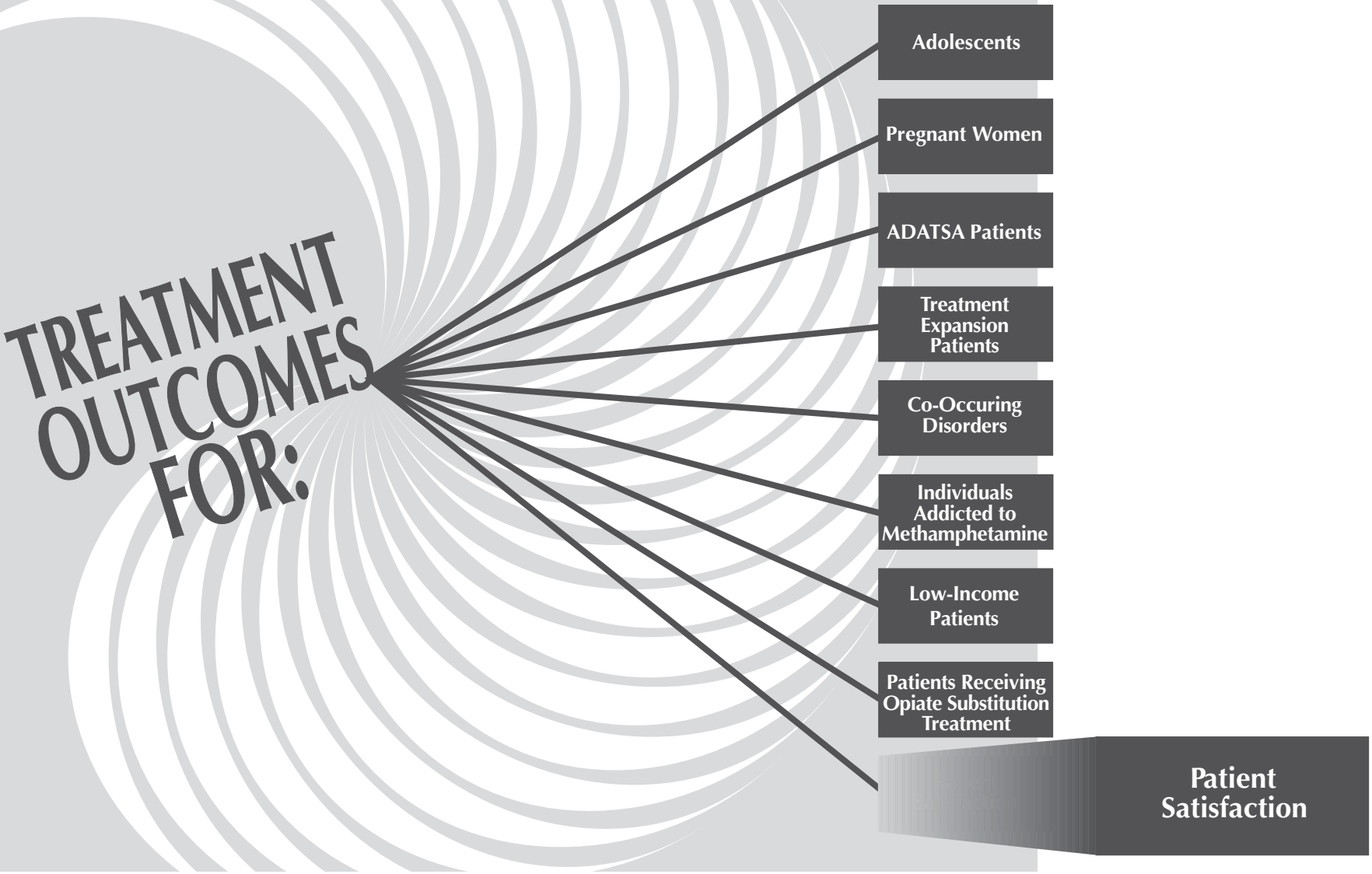


Source: Luchansky, B., et al., "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analysis from Washington State." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis and Division of Alcohol and Substance Abuse, 2006.

A recent study of 1,109 opiate-addicted patients in and out of opiate substitution treatment found patients in treatment had 52.9% fewer hospital admissions while in treatment than when out of treatment. These same patients had 54.9% fewer emergency room-initiated (ER) admissions. Some 56% of these hospital admissions were through the ER, and 21% through an urgent care facility. Medicaid or Medicare paid for 82% of these admissions. Reduced medical service utilization and hence reductions in health care costs are among the major outcomes of opiate substitution treatment.[1]

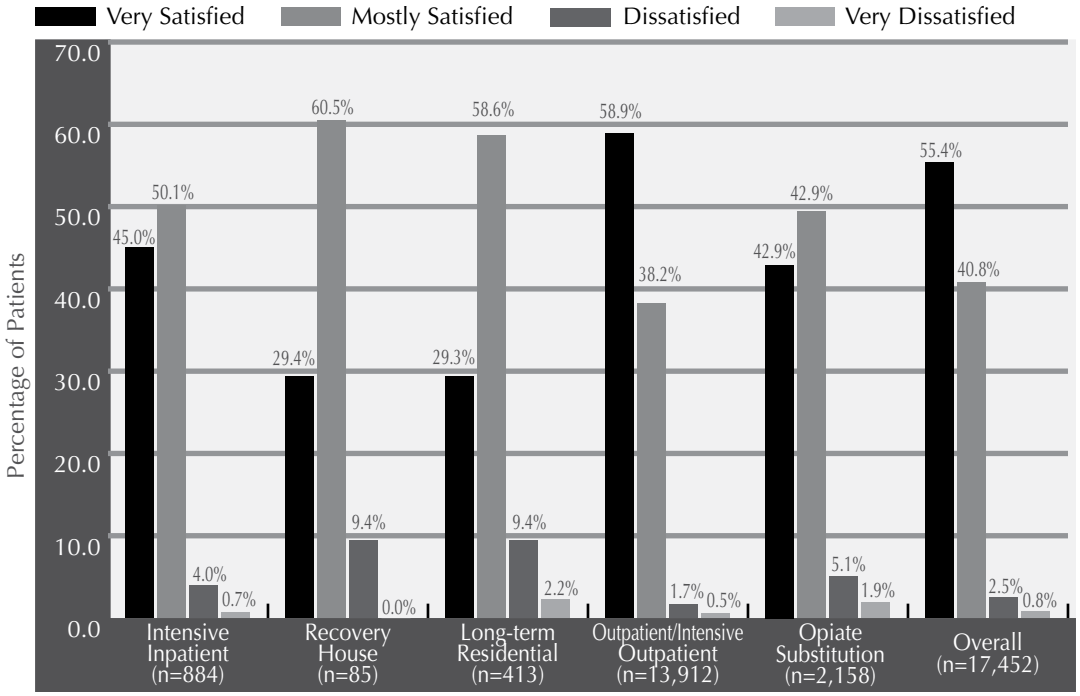
[1] Luchansky, B. et al. "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analysis from Washington State." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis and Division of Alcohol and Substance Abuse, 2006.

Outcomes: The Benefits of Prevention & Treatment



In 2007, 96% of Adult Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported Overall Satisfaction with the Service They Received.

"In an overall, general sense, how satisfied are you with the service you have received?"



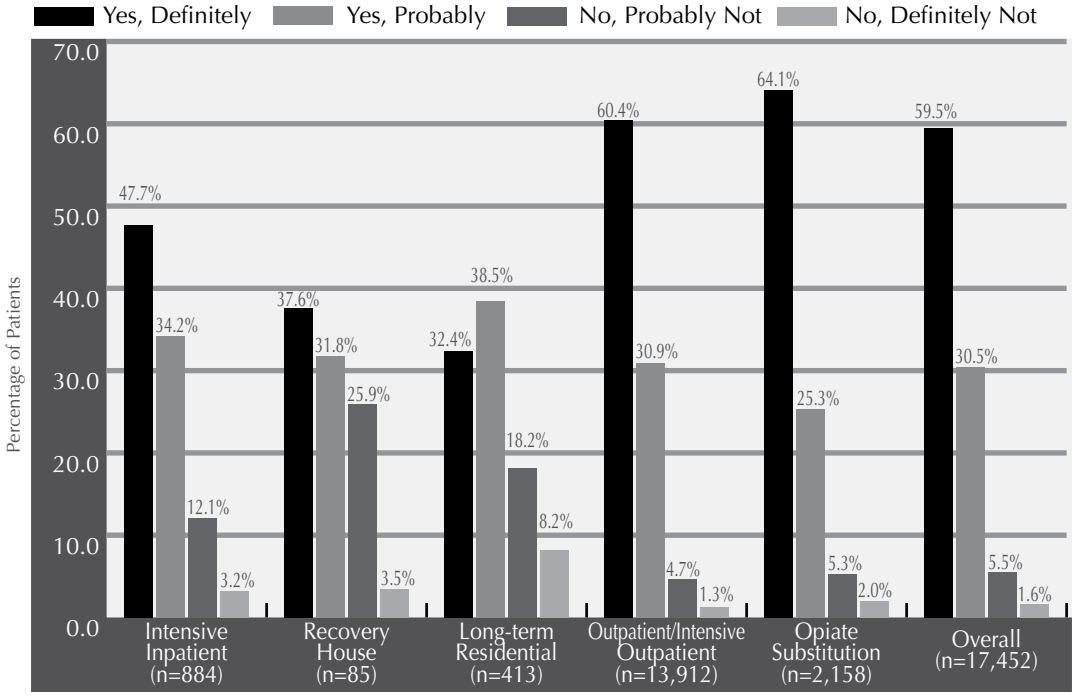
Source: Rodriquez, F., *Patients Speak Out 2007: Seventh Annual Statewide Patient Satisfaction Survey.* Olympia, WA: Division of Alcohol and Substance Abuse, 2007.

In March 2007, DASA conducted its seventh statewide patient satisfaction survey. It was administered at 460 community-based and correctional treatment centers to 20,252 patients, or 79% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 95% of adult patients treated in community-based agencies reported they were satisfied with the comfort and appearance of their treatment facilities; 82% said they were always treated with respect by staff; 92% rated group sessions as helpful, and 87% reported they found individual counseling to be helpful. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

In 2007, 90% of Adult Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported They Would Return to the Same Program If They Needed Help Again.

"If you were to seek help again, would you come back to this program?"



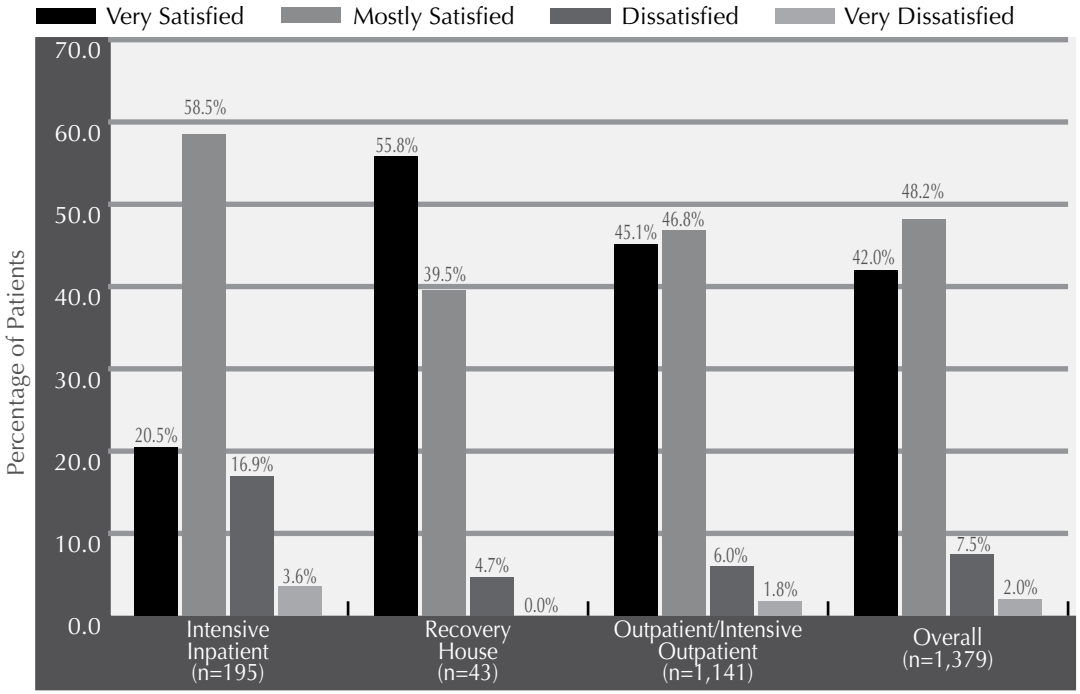
Source: Rodriquez, F., *Patients Speak Out 2007: Seventh Annual Statewide Patient Satisfaction Survey*. Olympia, WA: Division of Alcohol and Substance Abuse, 2007.

In March 2007, DASA conducted its seventh statewide patient satisfaction survey. It was administered at 460 community-based and correctional treatment centers to 20,252 patients, or 79% of those receiving treatment in the participating agencies during the week of the survey.

Many patients receiving chemical dependency treatment require other services as well. Treatment agencies play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them: 76% of adult patients said their treatment program was helpful in connecting them to legal services: 77% to medical services; 74% to family services; 74% to mental health services; 63% to educational or vocational services; and 56% to employment services.

In 2007, 90% of Youth Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported Overall Satisfaction with the Service They Received.

"How satisfied are you with the service you have received?"



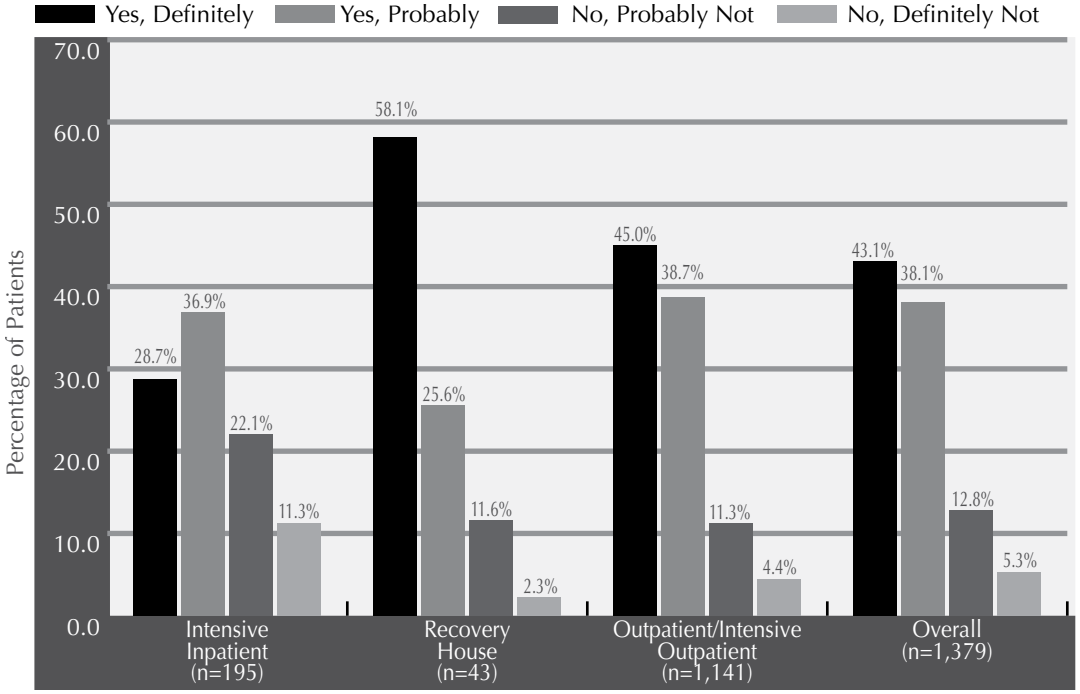
Source: Rodriquez, F., *Patients Speak Out 2007: Seventh Annual Statewide Patient Satisfaction Survey.* Olympia, WA: Division of Alcohol and Substance Abuse, 2007.

In March 2007, DASA conducted its seventh statewide patient satisfaction survey. It was administered at 460 community-based and correctional treatment centers to 20,252 patients, or 79% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 90% of youth patients treated in community-based agencies reported they were satisfied with the comfort and appearance of their treatment facilities; 75% said they were always treated with respect by staff; 84% rated group sessions as helpful, and 81% reported they found individual counseling to be helpful. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

In 2007, 81% of Youth Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported They Would Return to the Same Program If They Needed Help Again.

"If you were to seek help again, would you come back to the same program?"



Source: Rodriquez, F., *Patients Speak Out 2007: Seventh Annual Statewide Patient Satisfaction Survey*. Olympia, WA: Division of Alcohol and Substance Abuse, 2007.

In March 2007, DASA conducted its seventh statewide patient satisfaction survey. It was administered at 460 community-based and correctional treatment centers to 20,252 patients, or 79% of those receiving treatment in the participating agencies during the week of the survey.

This is the sixth year the patient satisfaction survey was conducted among youth. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

Underage Drinking

The U.S. Surgeon General Issues Call for Action on Underage Drinking

In 2007, noting that underage alcohol consumption is a widespread and persistent public health and safety problem, Acting Surgeon General Kenneth P. Moritsugu, M.D., M.P.H., issued a "Call to Action to Prevent and Reduce Underage Drinking." The 107-page, science-based document summarizes the latest research on underage drinking, and makes particular note of the emerging body of research on the negative effects of underage alcohol use on adolescent brain development. The Call to Action is based on five overarching principles:

- Underage alcohol use is a phenomenon that is directly related to human development.
- Factors that protect adolescents from alcohol use as well as those that put them at risk change during the course of adolescence.
- Protecting adolescents from alcohol use requires a comprehensive, developmentally based approach.
- The prevention and reduction of underage drinking is the collective responsibility of the nation.
- Underage alcohol use is not inevitable.

The Surgeon General outlined six goals for the nation:

1. Foster changes in American society that facilitate health adolescent development and that help prevent and reduce underage drinking.
2. Engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences.
3. Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences.
4. Conduct additional research on adolescent alcohol use and its relationship to development.
5. Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
6. Work to ensure that policies at all levels are consistent with the national goal of prevention and reducing underage alcohol consumption.

The full report, which includes the rationale, challenges associated with combating underage drinking, and specific strategies for achieving each goal, can be found at www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf.

Washington State Focuses on Underage Drinking.

The Division of Alcohol and Substance Abuse (DASA) has chosen reducing underage drinking as one of its key strategic priorities for 2009-2013. As the following pages demonstrate, research is increasingly indicating powerful short-term and long-term negative impacts resulting from youth drinking.

When all available data about youth substance abuse was recently analyzed to determine a statewide priority for the federal Strategic Prevention Framework-State Incentive Grant (SPF-SIG), youth alcohol use was found to have substantially more profound consequences on youth and their communities than either tobacco or marijuana use. Alcohol prevalence rates among youth are highest, trends are increasing most, economic impact is greatest, and there is the largest association with negative consequences.[1] While the negative impacts of binge drinking on the growing brains of adolescents has been recognized for some time, what is now better understood is that early initiation of alcohol use, even at relatively low levels, has harmful effects both during adolescence and when youths reach adulthood.

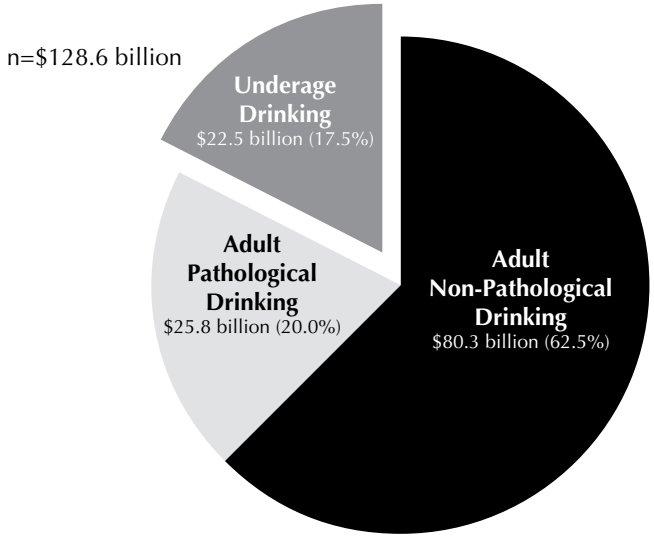
Drinking Behavior	Behavior/Consequence	How much more likely are youth who drink to exhibit the problem behaviors than non-drinking youth?
Youth who drink 1-2 days in the past 30 days but did not get drunk	Showing up to school drunk or high	3.2 times more likely (16% for 1-2 day drinkers vs. 5% for non-drinkers)
Youth who drink 3-5 days in the past 30 days but did not get drunk	Getting D's and F's in classes	1.8 times more likely (15% for 3-5 day drinkers vs. 8% for non-drinkers)
Youth who drink 3-5 days in the past 30 days or had been drunk once	Seriously considered suicide	2 times more likely (22% for 3-5 day drinkers vs. 11% for non-drinkers)
Youth who drink 6+ days in the past 30 days or had been drunk two or more times	Low commitment to school	2.1 times more likely (65% for 6+ day drinkers vs. 31% for non-drinkers)

Source: Campbell, K., & Gabriel, R., *Analysis of 2006 Washington State Healthy Youth Survey*, 2007.

The 12 communities involved with the SPF-SIG project and the four communities involved with the Reducing Underage Drinking (RUaD) projects are leading the way for the state as a whole to learn how best to reduce underage drinking. Lessons learned from the SPF-SIG and RUaD projects will be applied throughout the DASA prevention and treatment systems.

[1] *Washington State Strategic Prevention Framework State Incentive Grant (SPF-SIG) Implementation Plan, 2006.* Olympia, WA: Washington State Division of Alcohol and Substance Abuse, 2006.

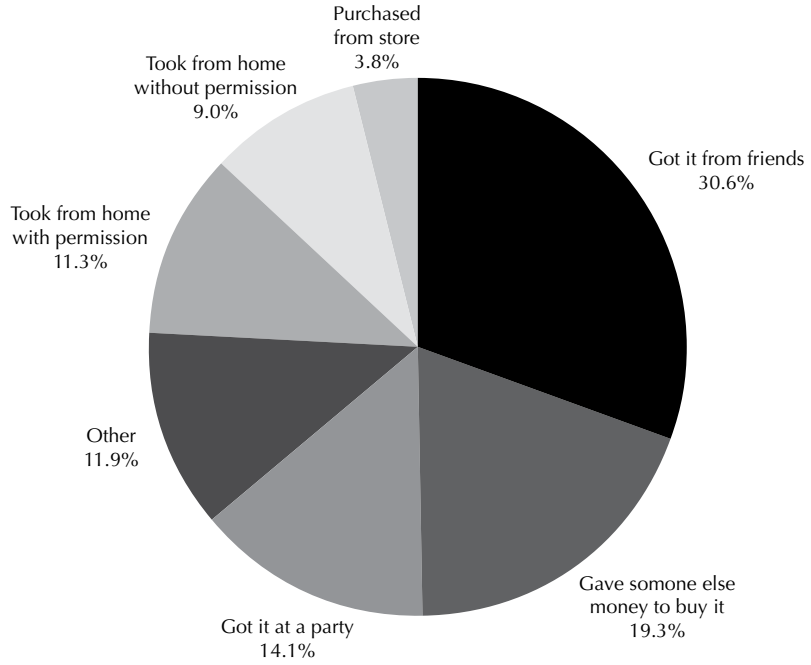
Underage Drinking Accounted for 17.5% of the Cash Value of Total U.S. Consumer Expenditures for Alcohol in 2001.



Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Taken together, drinking among youth ages 12-20 and pathological drinking among adults (abuse and dependence) accounts for almost 38% of total U.S. expenditures for alcohol.

Most Washington State 10th Grade Students Who Drink Obtain Alcohol from Others.

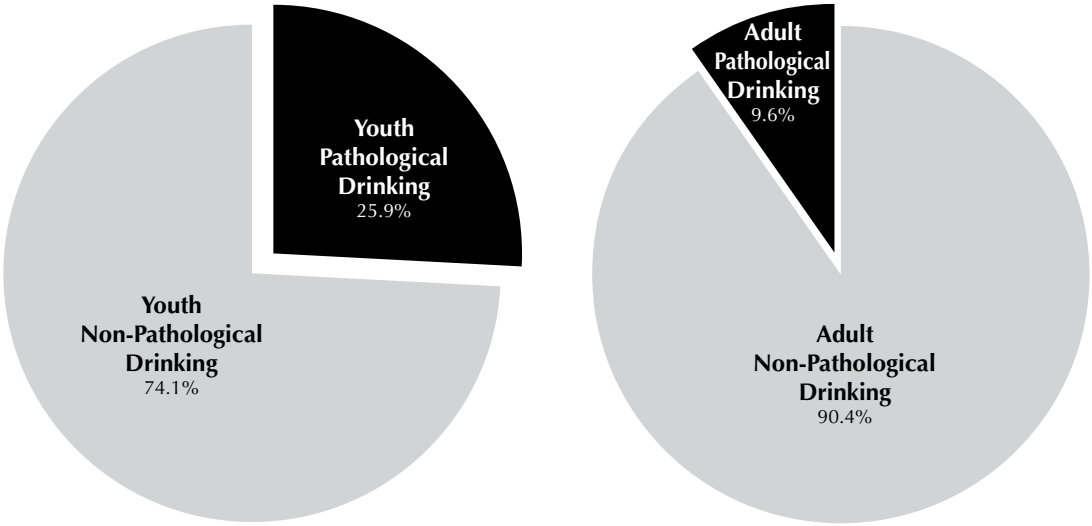


Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

In Washington State, the level of compliance with alcohol sales laws prohibiting sales to individuals under age 21 is very high. Nevertheless, youth are able to obtain alcohol from social sources. Most drinking is done with friends and at parties, but more than one in ten of the 31.1% of 10th graders who drank in the past 30 days obtained alcohol at home with their parents' or guardians' permission.[1]

[1] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council. *Healthy Youth Survey - 2006*. Olympia, WA: 2007.

Youth Ages 12-20 Who Drink Alcohol are More than Twice as Likely to Be Pathological Drinkers than Adult Drinkers.

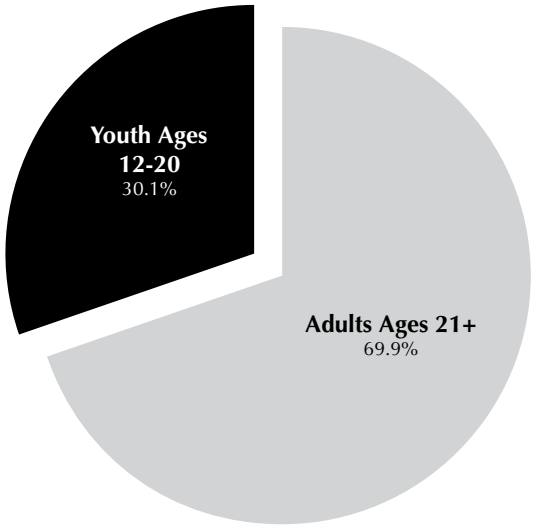


Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Pathological drinkers are those meeting criteria for alcohol abuse or dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* of the American Psychiatric Association. In 2001, the percentage of youth ages 12-20 who drank alcohol in the past 30 days (47.1%) was similar to the rate for adults (53.7%). The rate of youth who were alcohol dependent (12.2%) was more than twice that of adults.[1]

[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Youth Ages 12-20 Account for 30% of All U.S. Abusive and Dependent Drinkers.



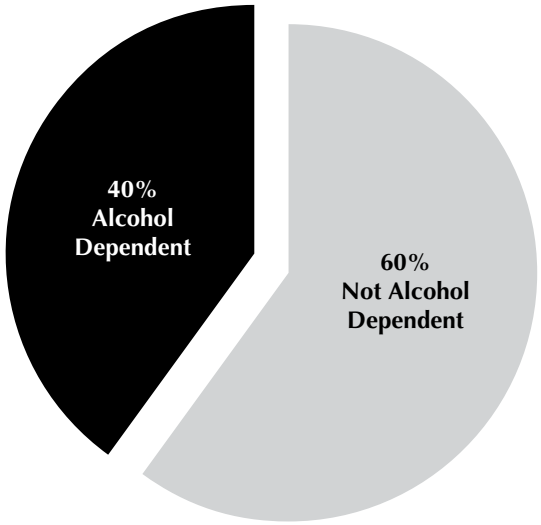
Alcohol-Abusing and Dependent Youth Ages 12-20 as a Percentage of All Abusing and Dependent Drinkers Ages 12 and Above, 2001

Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

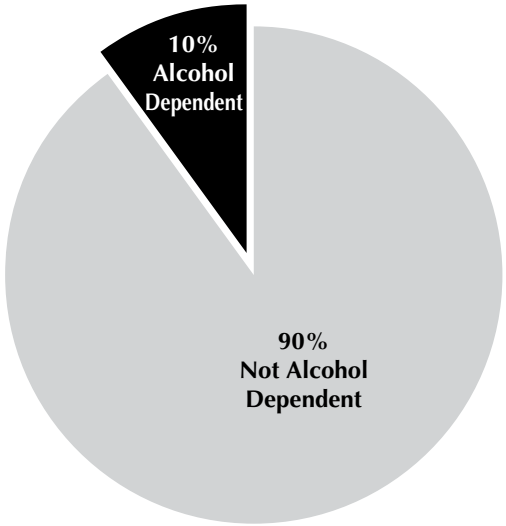
Although youth 12-20 represented only 15.4% of the population in 2001, they accounted for 30.1% of individuals meeting criteria for abusive or dependent drinking as defined by the *Diagnostic and Statistic Manual of Mental Disorders – Fourth Edition* published by the American Psychiatric Association. Underage drinkers are much more likely to remain or become abusive or dependent drinkers as adults.[1]

[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Youth Who Start Drinking at Age 14 or Younger are Four Times More Likely to Become Alcohol Dependent in Their Lifetimes than Those Who Start Drinking at Age 20 or Older.



Rate of Lifetime Alcohol Dependence for Individuals Who Begin Drinking At or Before Age 14



Rate of Lifetime Alcohol Dependence for Individuals Who Begin Drinking At or After Age 20

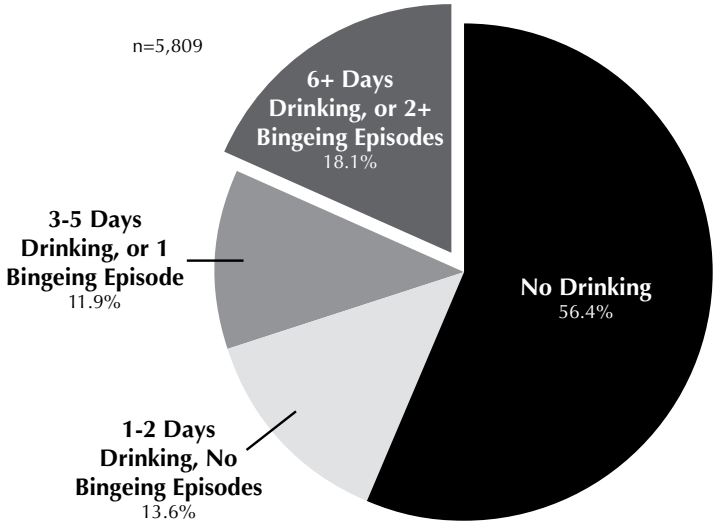
Source: Grant, B. & Dawson, D., "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiology Study," *Journal of Substance Abuse* 9, 1997.

Early onset of alcohol use is an excellent predictor of future lifetime abuse and dependence. The probability of an individual becoming alcohol dependent during his/her lifetime decreases by 14% with each increasing year of age (after age 14) at onset of use. The probably for lifetime alcohol abuse decreases by 8% with each increasing year of age at onset of use.[1] This suggests that prevention strategies that aim at delaying age of onset of drinking might be effective in reducing future alcohol abuse and dependence among adults. A recent study found that youth who witness domestic violence or experience physical or sexual abuse before age 10 are significantly more likely to drink before age 13.[2]

[1] Grant, B. & Dawson, D. "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiology Study," *Journal of Substance Abuse* 9, 1997.
[2] Hamburger, M., et al. "Childhood Maltreatment and Early Alcohol Use Among High-Risk Adolescents." *Journal of Studies of Alcohol and Drugs* 69, 2008.

By 12th Grade, Almost One Out of Five Washington State Students is Already a Problem Drinker.

Drinking by Washington State 12th Graders in Past 30 Days, 2006



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

In 12th grade, 18.1% of Washington State students are already problem drinkers, with six or more days of drinking during the past 30 days or two binge drinking episodes in the previous two weeks. Early drinking and high school problem drinking set the stage for more serious alcohol abuse and dependence for adolescents and adults.

Evidence-Based Strategies Can Reduce Underage Drinking.

The science of prevention has shown there are proven strategies for reducing underage drinking. These strategies fall into two broad categories:

- Environmental strategies seek to influence all the youth in a community by reducing the availability of alcohol for minors, and by changing community permissiveness for youth drinking. The first approach is usually to increase enforcement of and penalties for violation of laws related to the legal drinking age.
- Behavioral or individual-level strategies are aimed at knowledge, attitudes, and skills that help youth to resist influences that support alcohol. These strategies are usually delivered in small group settings, often in schools, and sometimes with groups that include family members.

Environmental Strategies

The most widely studied strategies for impacting alcohol use among the general population focus on law enforcement and training of people who serve alcohol. Indirectly these strategies may have an effect on youth by changing the cultural norms associated with alcohol use. More direct strategies aim at underage drinking laws, "social availability" (obtaining alcohol from family, friends, etc.), and advertising and other types of promotion.

Availability

According to an abundance of survey data, including the Washington State Healthy Youth Survey, few youth obtain alcohol by purchasing it from stores. They get it at parties, from friends, and from family. Decreasing this "social availability" is thus critical to reducing underage drinking. Intervention research related to social availability is in its infancy, but Washington is among many states focusing on this issue now with two federal grants, the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), and the Reducing Underage Drinking (RUaD) Grant.

One of the reasons youth do not buy alcohol is because of the successful enforcement of laws against selling alcohol to minors. The State Liquor Control Board (LCB) has agents across the state who regularly conduct compliance checks in stores and bars. Communities that receive RUaD grants often add additional compliance checks by working with local police departments. The LCB also provides training for restaurant and bar servers to make sure they understand the laws and penalties, and know how to check age documentation.

There is a large body of research showing that higher alcohol prices are associated both with less alcohol consumption and fewer associated problems.[1] While most youth do not buy alcohol from retail sources, some researchers have calculated that increasing the cost of alcohol commensurate with inflation would yield a 19% reduction in heavy drinking among today's youth.[2] Besides the direct impact on kids who give money to others who buy alcohol for them, higher prices for young adults may reduce their willingness to share their alcohol with youth.

Advertising

The authors of Reducing Underage Drinking: A Collective Responsibility argue that there are compelling reasons to reduce youth exposure to alcohol advertising[3], and there is increasing evidence to support this. While television (both advertising and program content) and song lyrics get much attention from parents and community groups, seemingly mundane advertising on storefronts also exposes youth to positive images of drinking. One study published in 2007, for example, found that higher exposure of 6th graders to outdoor advertising near their schools was associated with increased intentions to use alcohol at the end of 8th grade.[4] The authors of this study demonstrate that, given the repetitive, daily exposure of children and young adolescents to advertising near their schools, it is particularly critical that the density of alcohol advertising around schools be subject to public discourse.

The 2007 U.S. Surgeon General's Call to Action suggests that alcohol companies have a public responsibility to ensure that the placement of their advertising does not disproportionately expose youth to messages about alcohol.[5] In 2003, the alcohol industry adopted voluntary restrictions on their advertising, promising to limit ads where youth make up more than 30% of the audience. However, a 2007 study released by the Center on Alcohol Marketing and Youth indicates that more than a third of alcohol radio ads placed in 2006 were more likely to be heard by underage youth than adults.[6]

Laws

Public policies, laws, and regulations all affect the availability of alcohol and can limit the promotion of alcohol. However, their potential for affecting alcohol use strongly depends upon their consistent and effective enforcement within the justice system. The evidence indicates that as the actual and/or perceived likelihood of being detected and arrested or cited for law violations increases, so does compliance.

A list of policies or regulations in Washington State include:

- Taxation, which increases the price of alcohol.
- Increase in minimum legal drinking age to 21.
- Lowered allowable blood alcohol content (BAC) for drinking-and-driving violations.
- Zero tolerance.
- Graduated drivers' licensing.

These prevention efforts focus on the formal laws and regulations related to alcohol use. However, social and cultural norms and values around drinking affect the acceptability or unacceptability of the behavior. Youth living in environments in which drinking and/or excessive drinking is not the norm tend to drink less. Research suggests that community norms that result in stronger laws and better enforcement of existing laws are the most effective deterrent to alcohol use among youth.

Behavioral Strategies

There are many well-researched prevention programs that address behaviors known to be risk factors for alcohol use. The most widely used are universal strategies – that is, they are appropriate for all youth who might use alcohol.

School-Based Programs

School is a setting in which most youth can be easily reached, and there is usually a place in the school curricula for alcohol to be addressed. Addressing alcohol use is consistent with the broader goals of education. Research on school-based prevention efforts indicate that programs that rely on information alone, fear tactics, or messages about not drinking until one is "old enough" are ineffective in reducing alcohol use.[7] They may increase knowledge, but they do not affect behavior positively.

One evidence-based program sponsored by the Division of Alcohol and Substance Abuse is called All Stars. The goal of this program is to support non-drinking norms among students by demonstrating that substance use among their peers is not as high as they might think, and that it is generally not approved of by their peer group. Research indicates that eleventh graders who participated in the program in fifth grade had lower levels of alcohol and tobacco use than their peers who did not participate in the program.[8]

The LifeSkills Training program is a broader personal and social skills training curricula for middle school children, and is designed to prevent tobacco, alcohol, and marijuana use. With 10 published evaluations, LifeSkills has shown demonstrated reductions in substance use of up to 50-75% at the seventh-grade follow-up.[9] A recent six-year follow-up of 4,466 students who were enrolled in the program in 7th grade indicates that results erode only slightly by the end of high school, with a 66% reduction in substance use.[10]

Family-Based Programs

Parents are the primary influence in their children's decisions about drinking.[11] Family-based prevention programs encourage parents to set and consistently enforce clear rules about drinking, and to monitor their children's activities. There is often also an emphasis on family management practices and communication skills.

One universal program widely implemented in Washington is the Strengthening Families Program (SFP) for parents with children who are 10-14. SFP helps to improve family communication strategies that aid children in avoiding the risks commonly faced by adolescents. While not focused specifically on alcohol use, researchers have found in follow-up studies that children whose families participate in SFP while their children are 10-14 have reduced alcohol use when they are 16.[12] SFP also changes the environment of schools in which the program is offered, because even students whose families do not participate benefited from the program.[13]

Some family-based prevention projects have an alcohol-specific focus. Guiding Good Choices (formerly called Preparing for the Drug-Free Years) was developed at the University of Washington and is meant for families with children 8 to 14.

This program empowers parents with the skills needed to enhance protective factors (i.e., improving bonding by increasing opportunities for involvement and interaction) and reduce risk factors with training on effective family management techniques and instruction on reducing family conflict.[14]

Prevention, Early Intervention, and Treatment for High-Risk Children

Children in families with histories of alcohol dependence have elevated risk factors for dependence. Targeted strategies to reduce parental and sibling alcohol dependence, as well as improve family management, have been shown to be effective in reducing the young children's risk level. The type and intensity of these early interventions should be matched to the type and severity of problems among the children and families being served. One well-researched program for children whose parents are substance abusers, and that has been implemented in Washington State, is the original Strengthening Families program.[15]

Analysis of the Washington State Healthy Youth Survey indicates that the best predictor of heavy drinking among youth is the risk factor, "friends who use". Given the powerful influence that peers have on youth behavior, it is likely that intervening and, when needed, providing treatment for heavy drinkers among youth could have a ripple effect among peers. The high percentage of heavy drinkers among youth combined with the relatively low number of youth in treatment for primary alcohol problems indicates that relatively few youth with primary drinking problems receive treatment. Current services may not be optimally designed for this population. Youth prefer easy-access, low-threshold approaches that accentuate strategies adolescents normally use to stop drinking[16], and treatments that do not remove them from their primary home or academic settings.[17] Brief intervention tailored to salient adolescent concerns may be the desired approach.[18]

[1] Chaloupka, F. "The Effects of Price on Alcohol Use, Abuse, and Their Consequences," in *Reducing Underage Drinking: A Collective Responsibility*, Bonnie, R., & O'Connell, M., eds., National Research Council and Institute of Medicine. Washington, DC: The National Academies Press, 2004.
[2] Laixuthai,A., & Chaloupka, F. "Youth Alcohol Use and Public Policy." *Contemporary Policy Issues* 11(4), 1993.
[3] *Reducing Underage Drinking: A Collective Responsibility*, op. cit..
[4] Pasch, K. , et al. "Outdoor Alcohol Advertising Near Schools: What Does It Advertise and How Is It Related to Intentions and Use of Alcohol Among Young Adolescents?" *Journal of Studies on Alcohol and Drugs* 68:587-596, 2007.
[5] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking.* Rockville, MD: Department of Health and Human Services, Office of the Surgeon General, 2007.
[6] CAMY Monitoring Report: Youth Exposure to Alcohol Advertising on Radio 2006. Washington, DC: The Center on Alcohol Marketing and Youth, Georgetown University, September 2007.
[7] Ibid.
[8] Taylor, B., et al. "Modeling Prevention Program Effects on Growth in Substance Use: Analysis of Five Years of Data from the Adolescent Alcohol Prevention Trial." *Prevention Science* 1(4), 2000.
[9] Botvin, G., et al. "Preventing Tobacco and Alcohol Use Among Elementary School Students Through Life Skills Training," *Journal of Child & Adolescent Substance Abuse* 12(4), 2003.
[10] Botvin, G., et al. "Long-term Follow-up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-class Population." *Journal of the American Medical Association* 273(14), 1995.
[11] Barnes, G., et al. "The Effects of Parenting on the Development of Adolescent Alcohol Misuse: A Six-Wave Latent Growth Model." *Journal of Marriage and Family* 62, 2000.
[12] Spoth, R., Redmond, C., and Shin, C. "Randomized Trial of Brief Family Interventions for General Populations: Adolescent Substance Use Outcomes 4 Years Following Baseline." *Journal of Consulting and Clinical Psychology* 69, 2001.
[13] Spoth, R., et al. "Brief Family Intervention Effects on Adolescent Initiation: School-level Growth Curve Analysis 6 Years Following Baseline." *Journal of Consulting and Clinical Psychology* 72, 2004
[14] Park, J., et al. "Effects of the "Preparing for the Drug Free Years" Curriculum on Growth in Alcohol Use and Risk for Alcohol Use in Early Adolescence." *Prevention Science* 1(3), 2000.
[15] Kumpfer, K., & DeMarsh, J.,"Prevention of Chemical Dependency in Children of Alcohol and Drug Abusers." *NIDA Notes* 5, 1985; Kumpfer, K., "Selective Prevention Interventions: The Strengthening Families Program." *NIDA* Monograph 177, 1999.
[16] Metrik, J., et al. "Strategies for Reduction and Cessation of Alcohol Use: What Do Adolescents Prefer?" *Alcoholism: Clinical and Experimental Research* 27, 2003.
[17] Brown, S.A. "Facilitating Change for Adolescent Alcohol Problems: A Multiple Options Approach," in Wagner, E. & Waldron, H., eds. *Innovations in Adolescent Substance Abuse Intervention.* Oxford, UK: Elsevier Science, 2001.
[18] D'Amico, E., et al. "Alcohol-Related Services: Prevention, Secondary Intervention, and Treatment Preferences of Adolescents." *Journal of Child & Adolescent Substance Abuse* 14, 2004

Washington State Responds to Underage Drinking

Washington State administers two large federal grants focusing on underage drinking, implementing strategies both statewide and in grantee communities.

Reducing Underage Drinking (RUaD) - Statewide Efforts

The Division of Alcohol and Substance Abuse (DASA) has been the recipient of the federal Office of Juvenile Justice and Delinquency Program's (OJJDP) Enforcing Underage Drinking Laws grants since 1998. In Washington State, these efforts are known as Reducing Underage Drinking (RUaD).

Key leaders representing 24 state agencies and statewide organizations meet monthly to provide collaborative leadership on reducing underage alcohol use in Washington State. The purpose of the Washington State Coalition to Reduce Underage Drinking (RUaD Coalition) is to:

- Increase public awareness about the harmful effects of underage drinking.
- Serve as a communication hub for underage drinking issues.
- Provide guidance that may impact public policy.
- Collect information and concerns from local communities.
- Provide an advisory body for the OJJDP-funded Reducing Underage Drinking programs and support the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) Advisory Council and other underage drinking-related initiatives, where appropriate.
- Review, track, and disseminate relevant data.
- Provide opportunities to share information and coordinate efforts among state agencies, tribes, statewide organizations, and others.

Spring 2008, DASA's RUaD program supported Town Hall Meetings on Underage Drinking in 94 communities across the state. Some 4,158 adults and teens focused on the consequences of underage alcohol use and developed ideas for taking action in their local communities. The RUaD Coalition is using the recommendations from the Town Hall Meetings to develop their action plan while the local communities continue their work to reduce alcohol use among young people. The three strategic priorities are:

1. Reduce youth exposure to alcohol industry marketing.
2. Support local law enforcement efforts to enforce underage drinking laws.
3. Conduct an adult-focused communications campaign that supports local efforts to reduce underage drinking.

RUaD Community-Based Efforts

The Rural RUaD Initiative Grant is funding enforcement and environmental strategies that have been shown to be effective in reducing underage drinking. Seven states are involved in this initiative, and research is being conducted to determine the effectiveness of the strategies in rural communities. Strategies include: retail compliance checks; increased law enforcement efforts to cite those who provide alcohol to minors; and working with community leaders to change the social perception that underage drinking is a "right of passage".

Media is also a major component of these grants. Not only is each recipient involving their local newspaper in getting the word out about their activities, e.g., which stores sold to minors during the compliance checks, but also using social marketing materials aimed at parents and other adults designed to get them to change their behavior with respect to underage alcohol use and access.

The Rural Initiative has sites in Othello School District/Adams County, White Pass School District/Lewis County, CWU/Ellensburg/Kittitas County, and Dayton/Columbia County.

Strategic Prevention Framework-State Incentive Grant (SPF-SIG)

The SPF-SIG is a five-year grant funded by the Center for Substance Abuse Prevention. The primary focus of the grant program is to demonstrate the implementation of the five-step planning process known as the Strategic Prevention Framework. In Washington State, this framework is being employed in 12 communities to target underage drinking. These communities were selected randomly from a large group of schools that had high rates of eighth grade alcohol use. Each will receive more than $600,000 over five years to develop the ability to sustain the SPF process, and to implement their strategic plans to reduce underage drinking.

The 12 sites are based in middle schools in:

- Asotin, Asotin County
- Burlington, Skagit County
- Franklin Pierce School District, Pierce County
- Kelso, Cowlitz County
- Naches, Yakima County
- Port Angeles, Clallam County
- Port Gamble S'Klallam Tribe (tribe rather than middle school based), Kitsap County

- Seattle (two sites), King County
- Warden, Grant County
- Wenatchee, Chelan County
- White Swan, Yakima County

Statewide Goals

Statewide, the goals of SPF-SIG are broader:

- Prevent the onset and reduce the progression of underage drinking.
- Reduce substance abuse-related problems in grantee communities.
- Build prevention capacity and infrastructure at the state and community levels to support implementation of the SPF process.
- Infuse data-based decision-making across all steps of the SPF process.

Evaluation Strategy

In an ambitious plan promoted by the SPF-SIG Advisory Council, the design of the evaluation breaks new ground in the field of prevention. Using Healthy Youth Survey data, the project identified all the schools in the state that had high eighth grade alcohol use. Forty-seven of the schools passed the readiness eligibility requirement and submitted applications. From these, ten communities were randomly drawn to receive funds, with the others to act as comparison sites. In addition, two Native American communities were selected to receive grant funding.

Two basic evaluation questions frame the approach to the outcome evaluation:

1. Are communities that implement Strategic Prevention Framework more successful at reducing underage drinking and related problems than those that do not?
2. What characteristics of SPF-SIG communities and their prevention efforts are associated with greater success in reducing underage drinking and related problems?

State Epidemiology Workgroup

In order to promote data-based decision-making, the federal Center for Substance Abuse Prevention requires that each SPF-SIG state maintain a State Epidemiology Workgroup (SEW). Washington State has been in the forefront of states collecting statewide needs assessment data. Therefore the SEW is able to refine their mandate to include: (a) study of health-related disparities among subpopulations of state residents; (b) coverage of its survey data collection systems to include older age groups and out-of-school youth; and (c) enhanced availability of data from other state systems at subcounty geographic levels.

State Prevention Framework-State Incentive Grant (SIG)

Prioritized Environmental Influences and Risk/Protective Factors in SPF-SIG Communities

Based on an analysis of community data, the SPF-SIG communities selected a range of environmental influences and risk and protective factors to receive prioritized focus in the development of programming to prevent underage drinking.

	Asotin	Burlington	Eckstein	Huntington	Madison	Morris Ford	Mt. Adams	Naches Valley	Orchard	Port Gamble	Roosevelt/Port Angeles	Warden
ENVIRONMENTAL INFLUENCES												
Social Access to Alcohol						■		■	■	■	■	■
Enforcement of Underage Drinking Laws	■		■	■	■		■				■	■
Promotion of Alcohol		■										
PSYCHOSOCIAL RISK FACTORS												
Early Initiation of Drug Use	■	■		■	■	■			■	■		■
Community Laws & Norms Favorable to Drug Use	■				■	■	■	■	■	■		
Perceived Risk of Drug Use									■			
Poor Family Management		■	■		■						■	■
Parental Attitudes Favorable to Drug Use	■						■					
Friends' Use of Drugs								■		■	■	
(Youth) Favorable Attitudes Towards Drug Use			■									
Parental Attitudes Favorable to Antisocial Behavior						■						
Intentions to Use			■						■			
Early Initiation of Antisocial Behavior				■								
PSYCHOSOCIAL PROTECTIVE FACTORS												
Belief in the Moral Order				■							■	
Interaction with Prosocial Peers											■	

Treatment Completion

Treatment Completion Improves Patient Outcomes

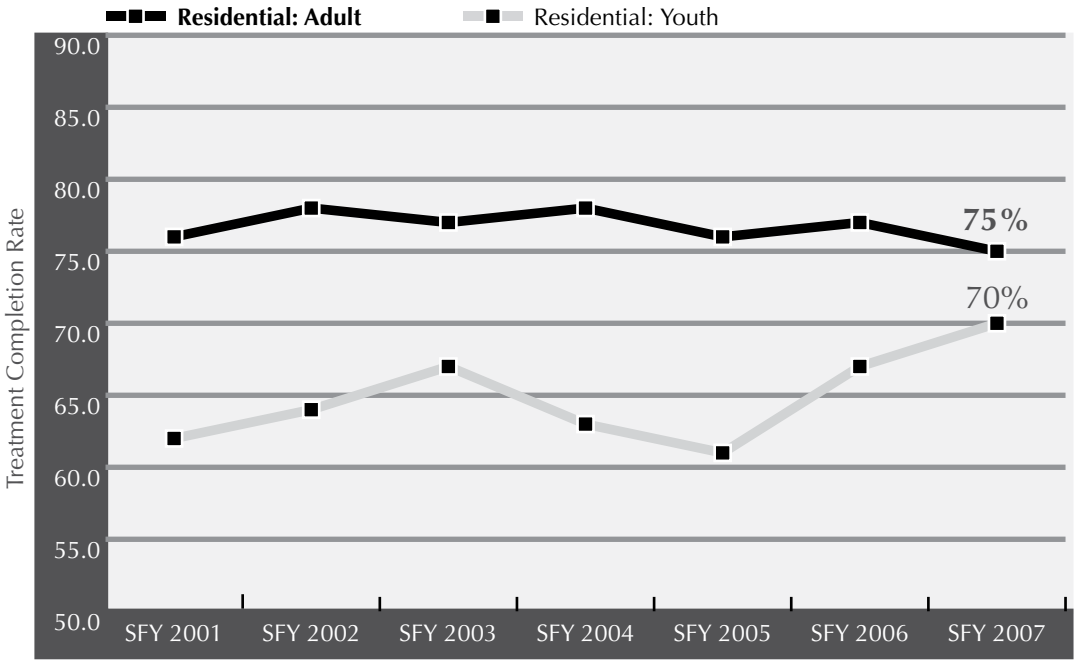
As part of the Department of Social and Health Services' pledge to ensure better outcomes for the state residents it serves, the Division of Alcohol and Substance Abuse (DASA) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment.

Multiple studies, conducted in Washington State and elsewhere, demonstrate that outcomes following from treatment participation are significantly enhanced when patients complete treatment. For example, relative to patients who did not complete treatment, completers have been found to:

- Have higher employment and wages following discharge from treatment.
- Be arrested and convicted less frequently after discharge.
- Have significantly fewer inpatient medical hospital admissions and are less likely to require emergency medical services after discharge.
- If pregnant, are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths.
- Produce higher cost savings to public systems following discharge.

In the pages that follow, results from studies that illustrate the above points are featured. All studies have been conducted in Washington State with publicly funded clients. Taken together, they suggest that improving treatment completion rates is one of the most powerful ways to maximize benefits from the limited public resources available to fund chemical dependency treatment. DASA is now working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

Three-Quarters of Adults and More than Two-Thirds of Youth Who Enter Residential Treatment Complete It.

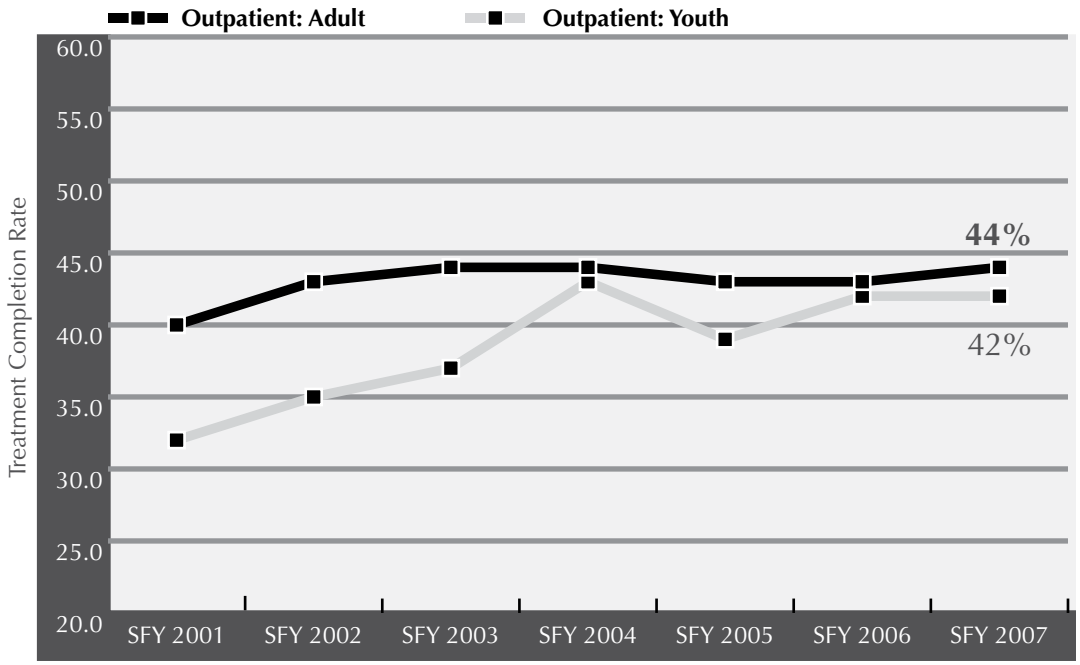


Source: Program Review, Division of Alcohol and Substance Abuse, June 2008.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent adults and youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth.

A critical concern is that once residential treatment is completed, continuity of care is maintained through transition of patients back to outpatient treatment in the community.

Outpatient Completion Rates for Both Adults and Youth Have Risen Significantly Since SFY 2001.



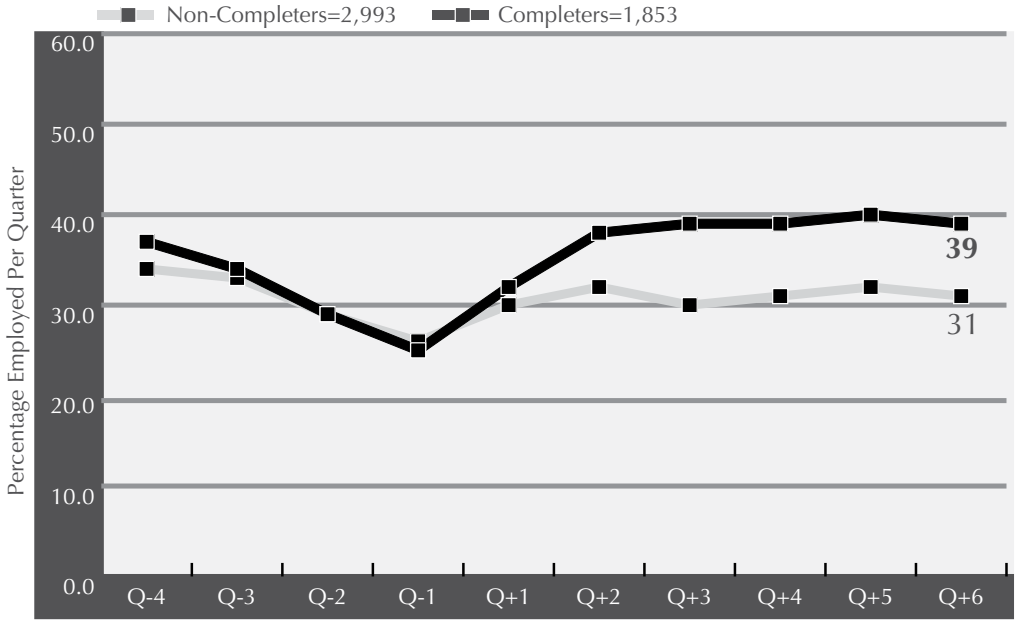
Source: Program Review, Division of Alcohol and Substance Abuse, June 2008.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent adults and youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth.

Patients receive outpatient treatment either as their primary modality of care or after completing a course of residential treatment. This graph indicates that outpatient completion rates are rising, with youth outpatient completion rates increasing by 31% since SFY 2001.

Treatment Completers are More Likely to Become Employed After Treatment.

Percentage of ADATSA Patients Employed During the Four Quarters Before Admissions and Six Quarters After Discharge from Chemical Dependency Treatment



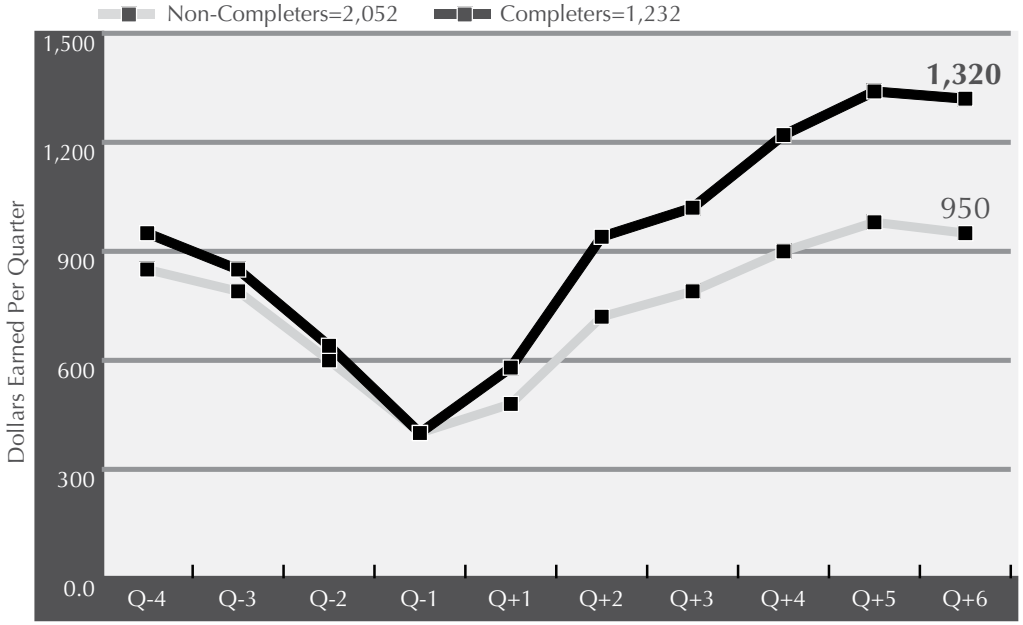
Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients[1], employment trends among treatment completers and non-completers were tracked. Prior to treatment, both completers and non-completers experienced declining rates of employment (see Quarters –4 through –1 on graph above). After treatment, employment rates rose for both groups, but the rise was significantly greater for completers: during the sixth quarter after treatment began, 39% of the completers were employed compared to 31% of the non-completers, representing a difference of 25.8%.[2]

[1] ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.
[2] Luchansky, B. and He, L. *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

Treatment Completers Show Pronounced Post-Treatment Wage Increases.

Quarterly Wages for ADATSA Patients During Four Quarters Before Admission and Six Quarters After Discharge from Chemical Dependency Treatment

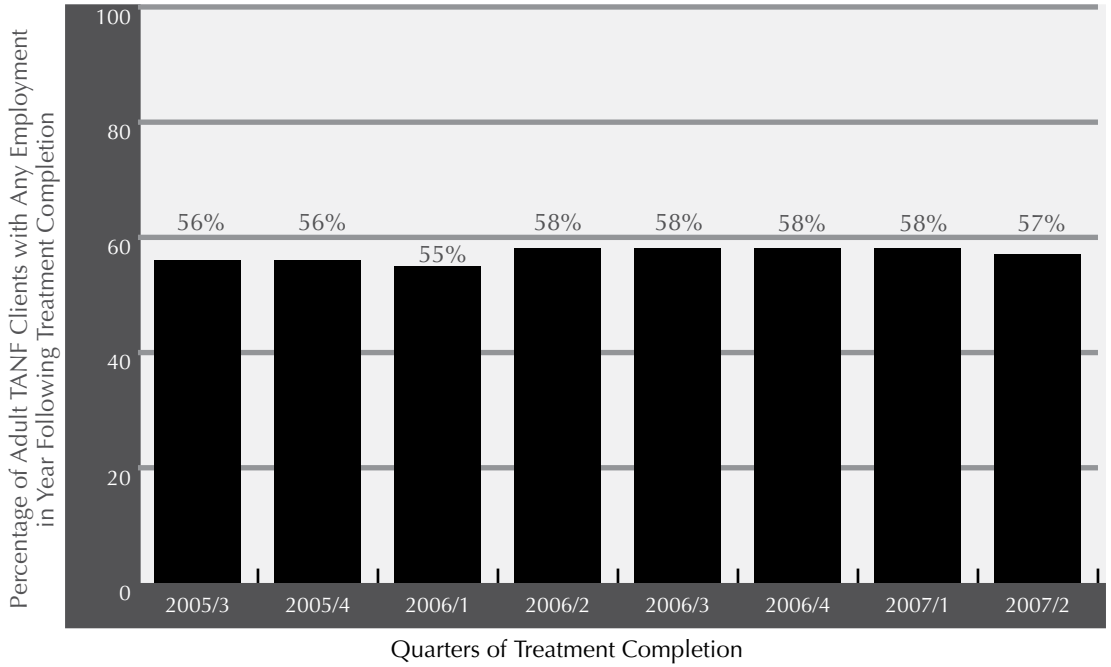


Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients[1], among those who were employed, it was found that pre-treatment wages for those who completed and those who did not complete chemical dependency treatment were similar. For both groups, wages began to decline four quarters before beginning treatment and continued to decline until treatment began. After treatment, wages rose for both groups. However, the increase in wages for treatment completers was more pronounced than for non-completers. During the sixth quarter after treatment began (see Q+6 on chart), completers earned $1,316 on average, while non-completers earned $941, a difference of $375, representing a 39.8% difference.[2]

[1] ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.
[2] Luchansky, B., and He, L. *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

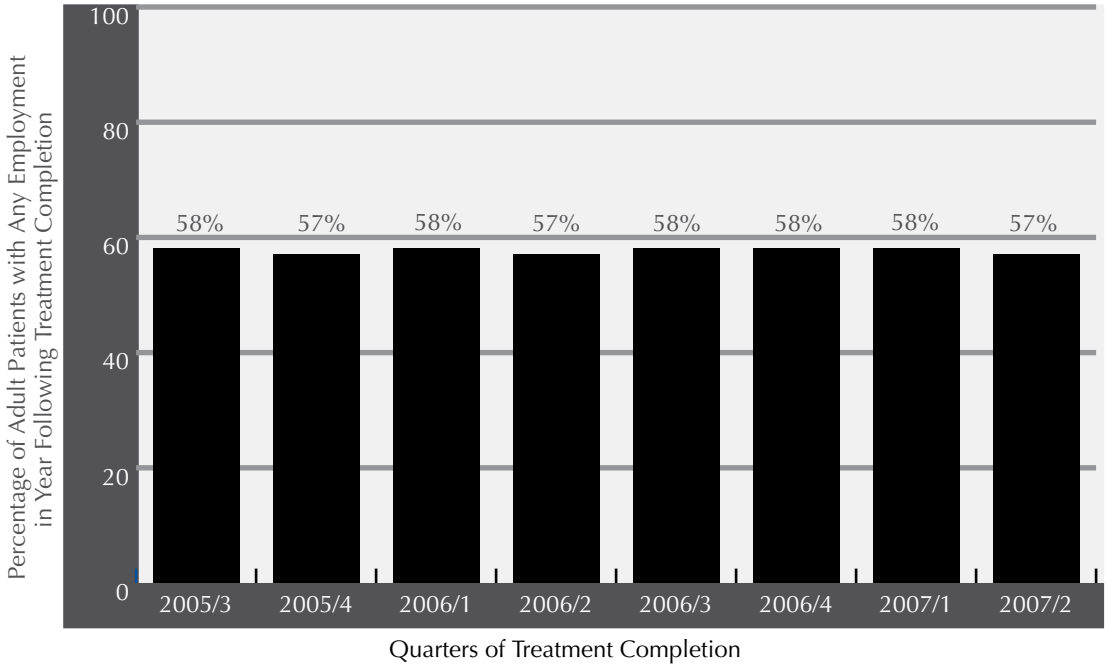
On Average, More than Half of Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.



Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

This graph indicates that of clients enrolled in the Temporary Assistance for Needy Families (TANF) program who completed chemical dependency treatment in the second quarter of SFY 2007, and did not require further treatment, 57% became employed in the following 12 months. Some 65% of those employed worked more than 20 hours a week; 45% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency. However, as more clients leave the TANF program and move toward self-sufficiency, the difficulties faced by those clients remaining on the program in moving toward employment may be greater.

Almost Three Out of Five Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.

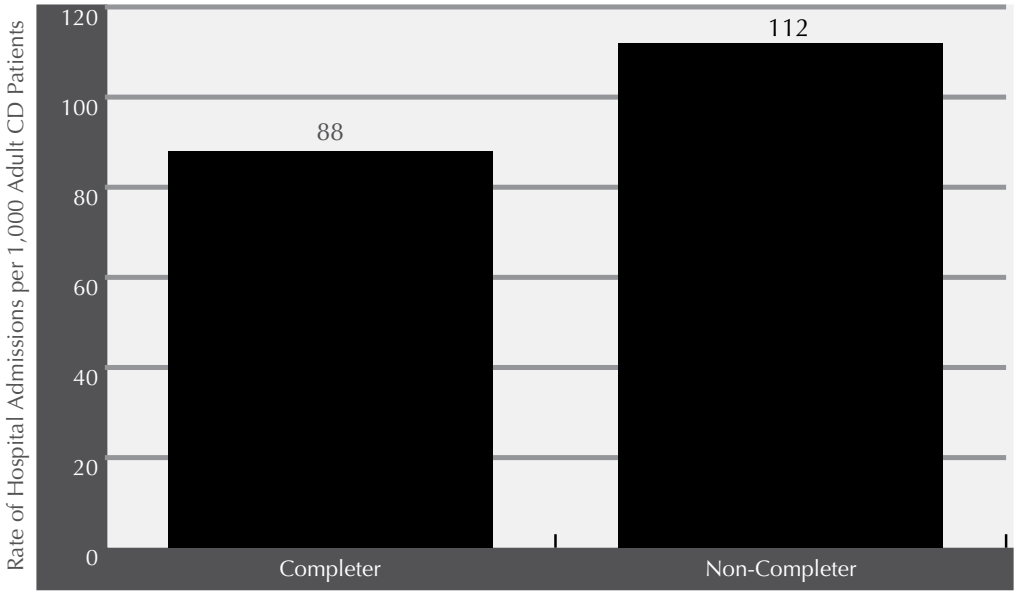


Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2008.

This graph indicates that almost three out of five low-income adults who completed chemical dependency treatment in the second quarter of SFY 2007, and did not require further treatment, became employed in the following 12 months. Average monthly wages were $903. Almost two-thirds of those employed (65%) worked more than 20 hours a week; 45% earned wages above the Federal Poverty Level. Chemical dependency treatment clearly helps move individuals with substance abuse problems toward economic self-sufficiency.

Treatment Completers Had Lower Hospital Admission Rates Following Chemical Dependency Treatment.

Adjusted Rates of Hospital Admissions per 1,000 Patients in the Year Following a Treatment Episode



Source: Luchansky, B., et al., Substance *Abuse Treatment and Hospital Admissions: Analyses from Washington State,* 2002.

A study of almost 10,000 adult patients who received publicly funded chemical dependency (CD) treatment in 1995 showed that patients who completed CD treatment were 21% less likely to be admitted to a hospital in the year following discharge compared to patients who did not complete treatment.[1]

[1] Luchansky, B. et al. Substance *Abuse Treatment and Hospital Admissions: Analyses from Washington State.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

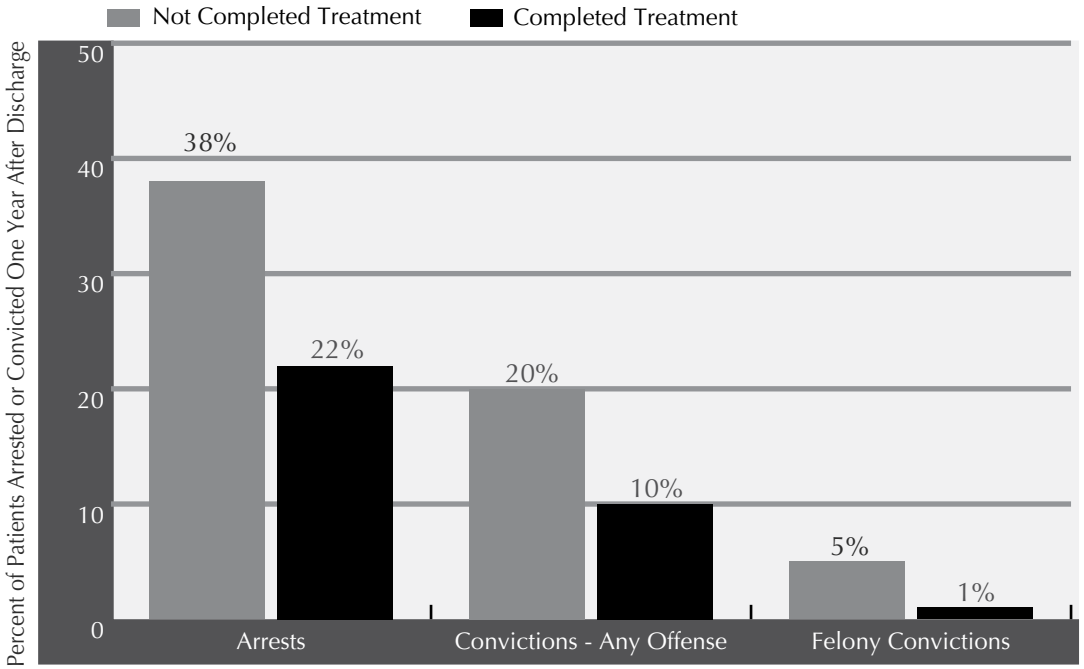
Completion of Treatment and Treatment Retention are Associated with Reduced Risk of Felony Arrests Among Adults, and Convictions Among Youth.

Research, both in Washington State and elsewhere, has consistently shown that admission to chemical dependency treatment is associated with lower crime rates, fewer arrests, and lower criminal justice costs. More recent studies highlight the benefits of both treatment completion and longer retention in treatment:

- A 2002 study of over 10,000 adult patients who received publicly funded chemical dependency treatment in 1995 demonstrated that the probability for a felony offense was 21% lower in the following year for patients completing treatment when compared to patients who did not complete treatment. For patients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than for patients with shorter treatment episodes.[1]
- A 2003 study of almost 6,000 youth who participated in substance abuse treatment between 1997 and 1998 indicated that patients completing treatment had a 29% reduction in the risk of a subsequent felony conviction, and a 17% reduction in risk of any conviction in the year following discharge, compared to non-completers.[2]

[1] Luchansky, B., et al. *Substance Abuse Treatment and Arrests: Analyses from Washington State (Fact Sheet 4.42).* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, 2002.
[2] Luchanski, B., et al. *Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment. Journal of Addictive Diseases* 25(1), 2006.

Treatment Completion was Associated with Reductions in Arrests and Convictions Among Supplemental Security Income Recipients.*



Source: Estee, S., & Nordland, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.*

A study completed in 2003 indicates that Supplemental Security Income (SSI) recipients who completed chemical dependency treatment had lower rates of arrest, convictions for any type of offense, and felony convictions one year after discharge than those who did not complete treatment. Rates of arrest were 42% lower, rates of convictions 50% lower, and rates of felony conviction 80% lower.[1]

** Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Supplemental Security Income Recipients Who Completed Chemical Dependency Treatment Had Lower Medical, Psychiatric, and Nursing Home-Related Costs than Those Who Did Not Complete Treatment.*

Source of Costs[1]	Treatment Completers	Treatment Non-Completers
Medical Costs	-$380	-$292
Mental Health Costs		
State Hospital Costs	-$56	-$46
Community Psychiatric Hospital Costs	-$33	-$11
Nursing Home Costs	-$65	-$53

Source: Estee, S., & Nordland, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.*

In a study of over 7,000 Supplemental Security Income (SSI) recipients who entered chemical dependency treatment, those who completed treatment had lower monthly medical, psychiatric, and nursing home costs, and hence higher monthly cost offsets than those who did not. Medical care expenses for SSI recipients who completed treatment were $380 lower than the cost of medical care for those who needed chemical dependency treatment but remained untreated. SSI recipients who did not complete treatment also had lower costs, but by only $292, or 22.4% less.[2]

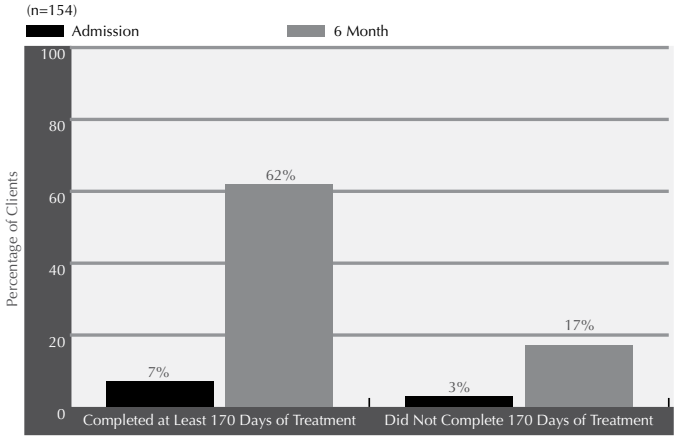
** Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Costs represent the adjusted average monthly per person difference in costs for SSI recipients receiving chemical dependency treatment compared to costs for those who needed treatment but did not get it.
[2] Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

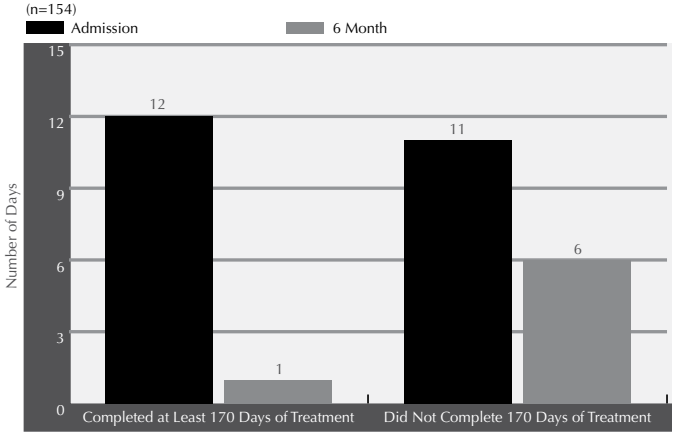
Remaining in Treatment Results in Improved Outcomes Among Patients Receiving Methadone Treatment.

A 2001 study of 154 patients admitted to methadone treatment found that at a six-month follow-up, those who completed at least 170 days of treatment reported substantially higher rates of abstinence from heroin use, fewer days of illegal activity, and substantial decreases in money obtained through illegal activity.

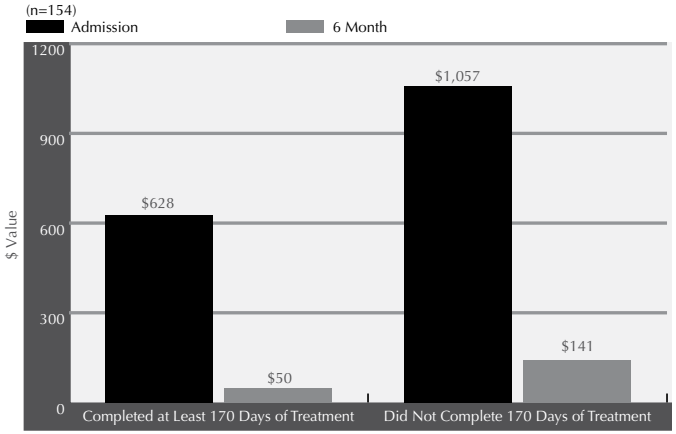
Abstinence from Heroin in Prior 30 Days



# of Days Engaging in Illegal Activity in Prior 30 Days

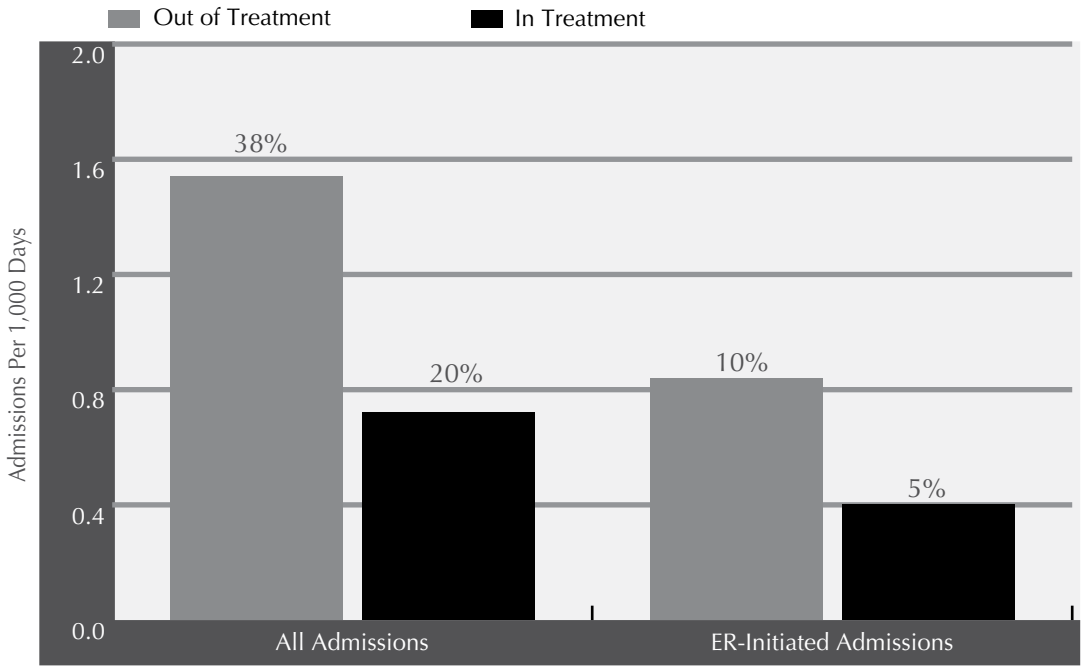


Average $ from Illegal Sources in Prior 30 Days



Source: Carney, M. *Drug Use, Jail Time, and Illegal Activities Among Clients Admitted to Methadone Maintenance at Admission and 6 Months Later*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2001.

Opiate Substitution Treatment Patients are Less Likely to Be Admitted to Hospitals While in Treatment.



Source: Luchansky, B., et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript accepted for publication, 2006.

A recent study conducted for the Division of Alcohol and Substance Abuse reported that publicly funded opiate substitution treatment patients were significantly more likely to be admitted to a hospital while they were out of treatment as compared to when they were in treatment. Patients in treatment were 33% less likely to experience a hospital admission than those who left treatment. Most of the hospital admissions came through either the emergency room (56%) or through an urgent care facility (21%). Such acute care services are among the most costly. Medicaid or Medicare paid for 82% of these hospital admissions; only 15% were paid by a private payer.[1] Thus, retention in opiate substitution treatment results in better health for patients, and lower costs to the public.

[1] Luchansky, B. et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State.* Manuscript accepted for publication. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2006

Longer Retention in Opiate Substitution Treatment is Associated with Higher Methadone Dose.

	Average Peak Methadone	Average Number of Days in Treatment
Opiate Substitution Treatment Program #1	109 mg/day	284.2
Opiate Substitution Treatment Program #2	83.1 mg/day	193.5

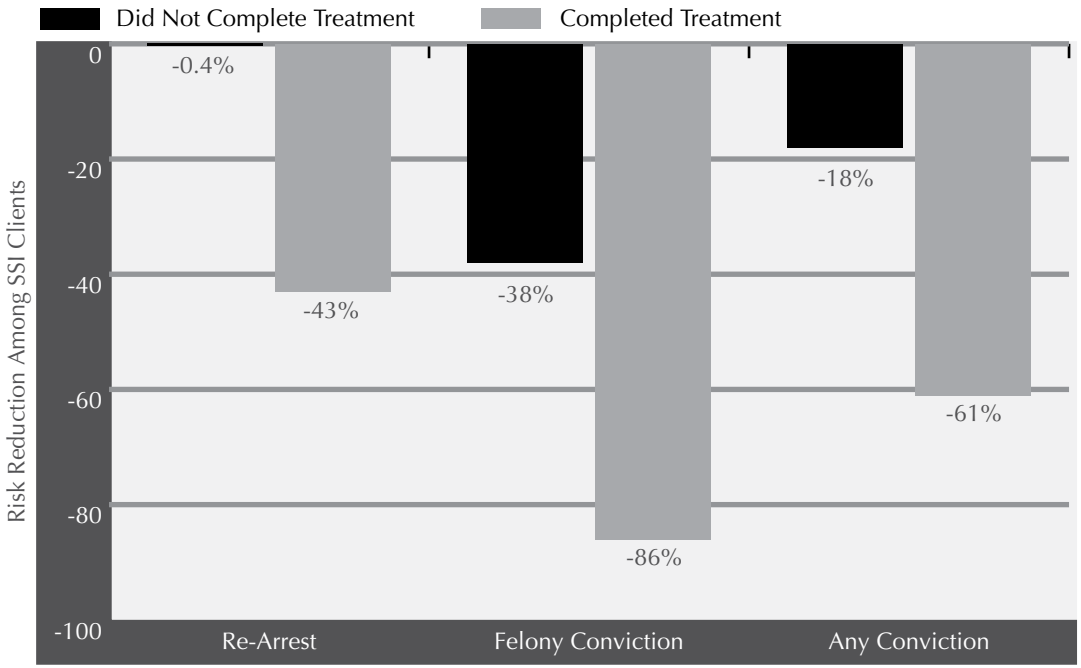
Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Longer retention in opiate substitution treatment is associated with better outcomes: less crime and involvement with the criminal justice system, fewer medical hospitalizations and emergency room visits, lower medical costs, fewer psychiatric hospitalizations, and less reliance on public assistance.

A 2003 study of 135 individuals admitted to two Washington State opiate substitution treatment programs found a close association between average peak methadone dose and average number of days in treatment. Patients in the programs where average peak dose was 109 mg/day remained in treatment an average of 90.7 days longer than those in the program where average peak dose was 83.1 mg/day, a difference of 46.8%. In addition, it was found that patients whose peak methadone dose was less than 75 mg/day were significantly more likely to leave treatment prior to 170 days. The mean peak methadone dose for patients who left treatment prior to 170 days was 78.0 mg/day, compared with a peak dose of 104.6 mg/day for those who remained in treatment at least 170 days.[1]

[1] Source: Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Opiate-Addicted Supplemental Security Income (SSI) Recipients Who Complete Drug-Free Chemical Dependency Treatment Have More Greatly Reduced Risks of Re-Arrest, Felony Conviction, and Any Conviction than Non-Completers.*



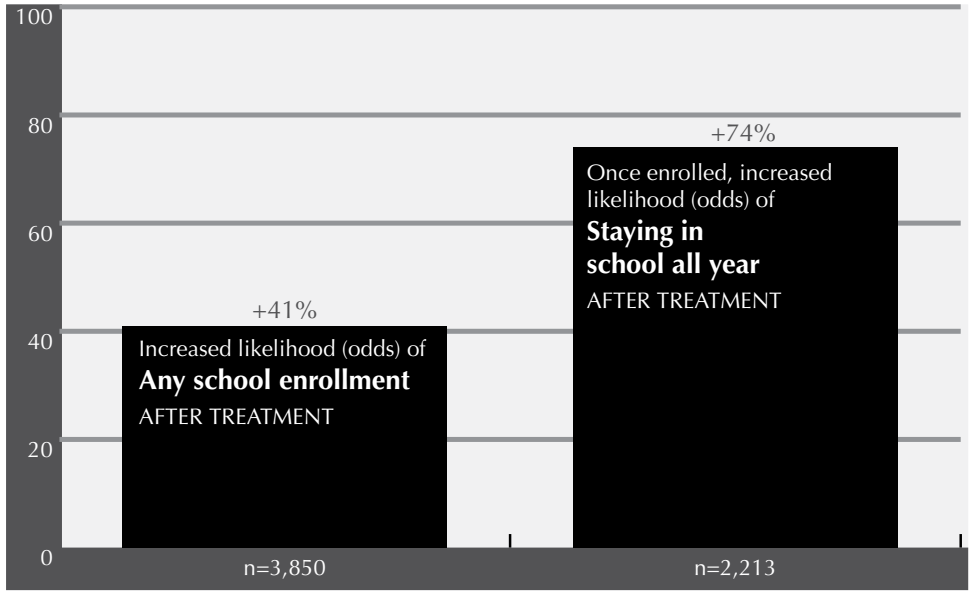
Source: Nordlund, D., et al., "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

While admission to "drug-free" (non-methadone) chemical dependency treatment by opiate-addicted SSI results in lower risks of criminal recidivism, felony conviction, and any conviction, completion of treatment dramatically lowers such risks. Treatment completion also results in signifcantly lower Medicaid-paid medical costs.[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot quality for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Nordlund, D., et al. "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients - Research and Data Analysis Division, 4.50fs." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

High School Youth Ages 15-17 Who Complete Chemical Dependency Treatment Significantly Increase Their Likelihood of Staying in School Beyond Those Who Do Not Complete Treatment.



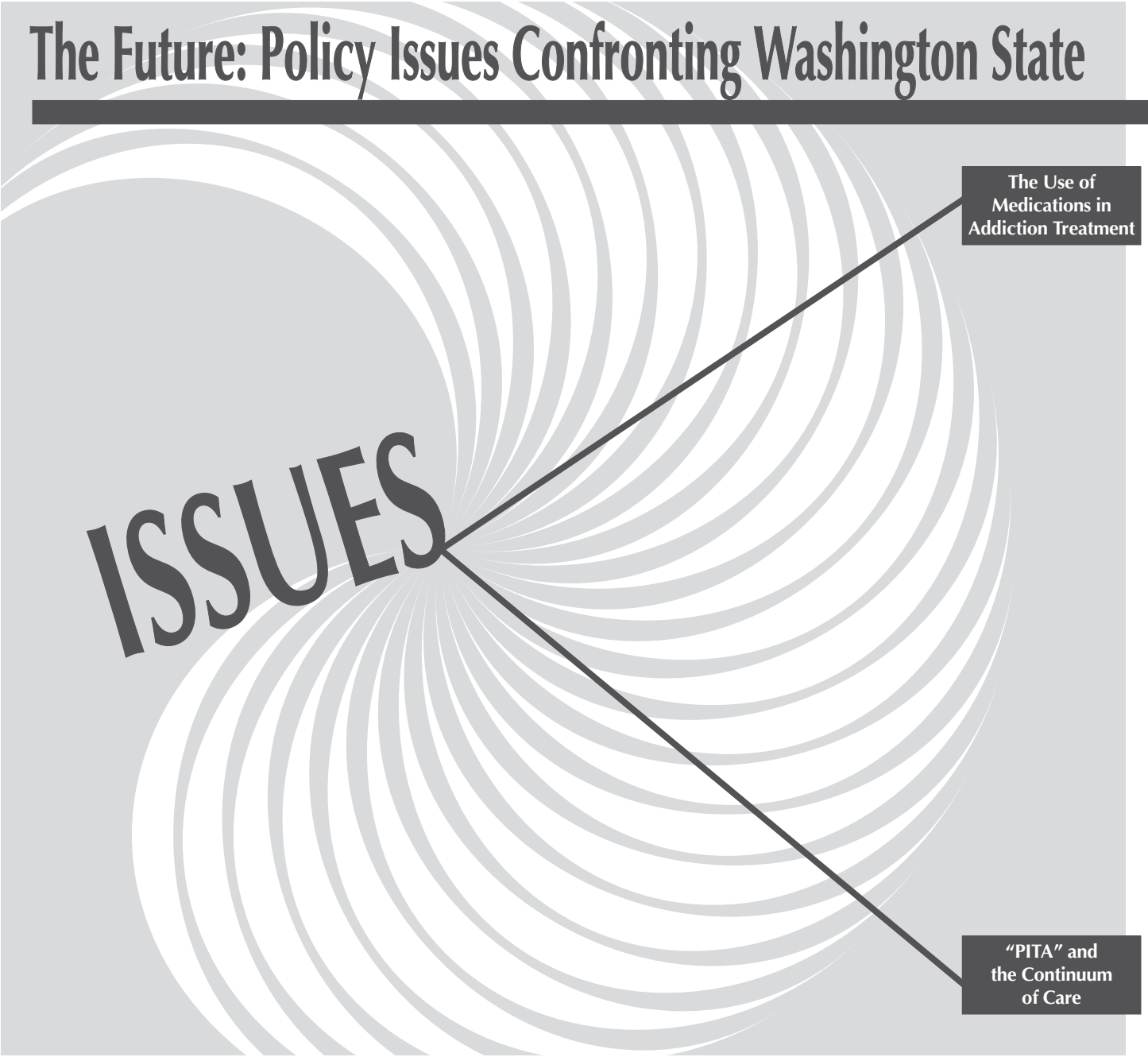
Source: Longhi, D., and Felver, B., "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

Chemical dependency treatment is associated with better outcomes for school-age youth in need of it, including lower rates of delinquent behavior, felonies and misdemeanors, and legal supervision. It is also associated with improved school outcomes, including lower school dropout rates, and better school performance.

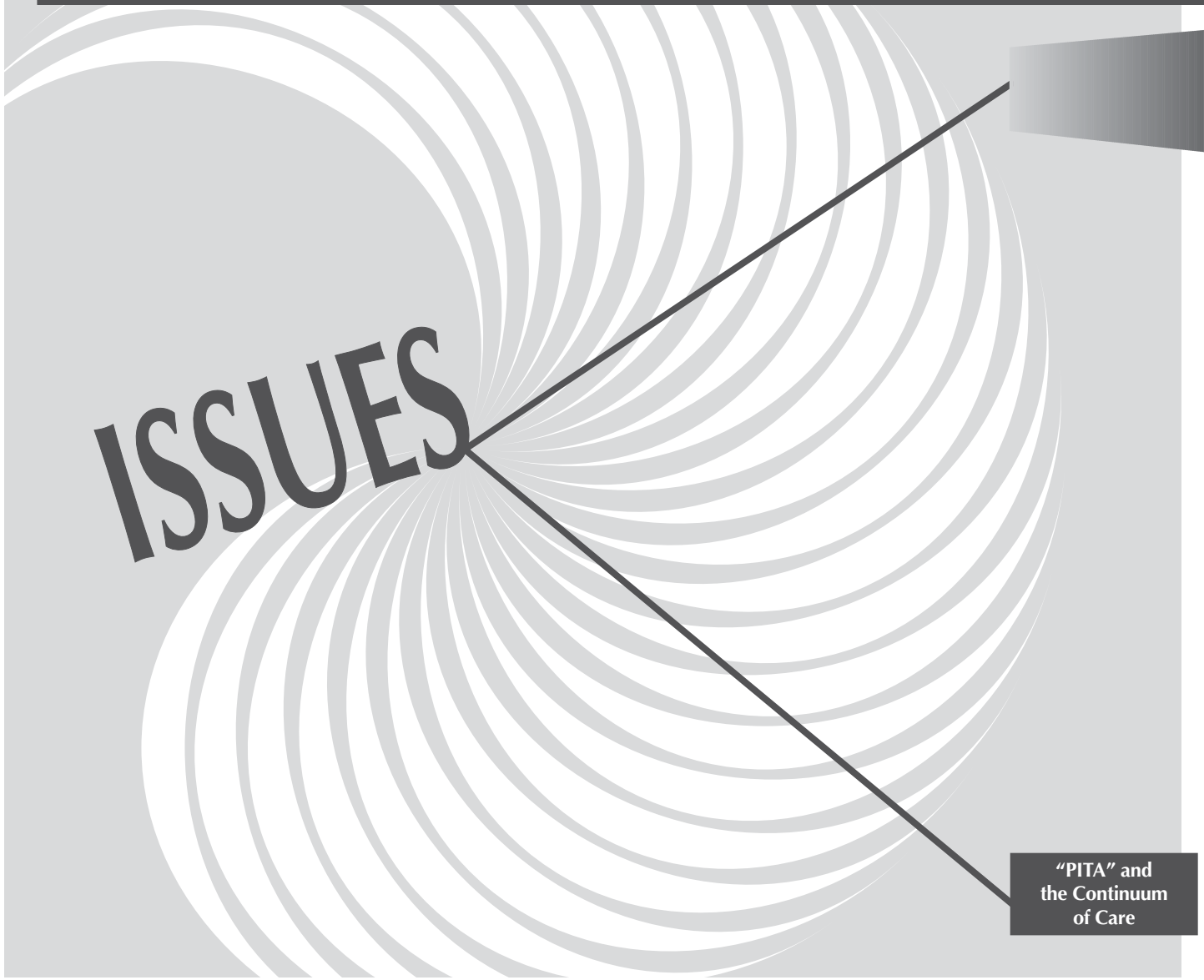
A recent study of youth ages 15-17 receiving chemical dependency treatment found that those completing treatment were 41% more likely to be enrolled in treatment than those who did not complete treatment. In addition, those who complete treatment were 74% more likely to remain in school the entire year following treatment completion.[1]

[1] Longhi, D., and Felver, B. "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

The Future: Policy Issues Confronting Washington State



The Future: Policy Issues Confronting Washington State



The Use of Medications in Addiction Treatment

"PITA" and the Continuum of Care

The Use of Medications in Addiction Treatment

Medications can play an important role in the treatment of alcohol and other drug addiction and relapse prevention. Three new medications – naltrexone, acamprosate, and Suboxone – are particularly promising. When indicated, medications for the treatment of alcohol and drug addiction work best used in tandem with psychosocial interventions.

The New Medications

Over the past ten years, several new medications have become available which have demonstrated effectiveness in the treatment of alcohol or drug addiction, and in relapse prevention. There are three of particular importance: naltrexone, in both its short and long acting forms, acamprosate; and Suboxone. In the past, many treatment professionals have resisted the use of medications beyond acute detoxification in the treatment of addictions. This is understandable, given the somewhat checkered history of medications which, though promised to be non-abusable, have ended up significantly abused, such as certain benzodiazepines, and, more recently, opiates for "pain management". However, it would be short-sighted for Washington State addiction treatment personnel to not examine both the cost and benefits of the use of medications on a case-by-case basis. The above three medications have all received Federal Drug Administration approval for the treatment of addictions or relapse prevention, and all have been highly scrutinized.

Naltrexone

Naltrexone or Revia®, is not actually new. It was developed as an opiate receptor blocker many years ago and has been used in treatment programs as an opiate antagonist for persons who have become dependent on opiates, especially with recovering anesthesiologist physicians. Clinical observation in some patients taking naltrexone revealed that certain patients who also used alcohol seemed to drink less and reported that it affected them less. This resulted in a number of randomized clinical trials in the early 1990's, which in most cases showed that, in specific alcohol-dependent populations, patients who took oral naltrexone drank less and for fewer days. A new development around naltrexone has been the production of a long-acting injectable form that can be given monthly (Vivitrol®). Findings from a recent study indicate that, even in relatively unmotivated alcohol-dependent patients, there were significantly fewer days of drinking and, when drinking happened, less was consumed and though relatively low, higher rates of complete abstinence than placebo. Other studies have shown that naltrexone can reduce drinking in alcohol abusers, not just those who are dependent.

Side Effects and Potential Toxicities: The main side effects observed with naltrexone are mild to moderate nausea, and at times, vomiting, especially during the first week or two of use. Some patients also experience mild to moderate dysphoria. Since naltrexone is an opiate receptor blocker, if persons need to take opiates for acute pain relief, the opiates either will be ineffective, or a markedly increased dose of them will need to be given. The long acting injectable form of naltrexone has a much better side effect profile and is better tolerated.

Dosage: Naltrexone is usually started at 25mg per day and over the next few weeks moved to either 50, 75, or 100mg per day. It is covered for six months by Medicaid, provided the person is involved in a certified addiction treatment program. DASA has been flexible in approving its use for patients with co-occurring disorders involved at a mental health center. The new, once-a-month injectable form which appears especially effective, is now available, but requires certain criteria for Medicaid coverage. The cost of the medication ranges from about $3-8 per day, depending on dosage.

Acamprosate

Acamprosate (brand name, Campral®), which is made by Forest Pharmaceuticals, was released in the United States in early 2005 with FDA approval for the maintenance of abstinence from alcohol dependence. Acamprosate has been available in a variety of European and other countries for over ten years. Unlike naltrexone which works as a blocker of the opiate receptor, acamprosate appears to work by stabilizing the balance between the inhibitory-GABA system and the excitatory-glutamate/NMDA system. With chronic alcohol dependence, the excitatory system appears to upregulate in order to deal with the chronic onslaught of alcohol on the inhibitory GABA system. It is thought that acamprosate works by stabilizing this system. Some recent studies which have used intensive psychosocial treatment have shown little additional benefit from adding either naltrexone or acamprosate to intensive treatment. Research studies demonstrating positive effects have included less intensive psychosocial treatment.

Side Effects and Potential Toxicities: Acamprosate interacts with almost no other medications, vital functions, vital signs, or other body systems. It is excreted only in the urine and is not metabolized in the liver. It thus is safe for patients with significant liver impairments, unlike Antabuse® or naltrexone, which are liver-metabolized. In large studies, the only side effect slightly more common than with placebo was mild diarrhea in the first two weeks of use. It has not been found either safe or toxic in pregnancies, and thus should be stopped if a woman becomes pregnant while taking it. It has no effect on euphoria or mood, and does not cause any kind of tolerance or withdrawal symptoms, whether patients use it alone or along with alcohol. There is at present no demonstrated effectiveness with acamprosate for addictions other than alcohol dependence.

Dosage: Due to the way it is absorbed, acamprosate must be taken as two pills three times a day, with each dosage period separated by at least four hours. It is recommended that patients take the medicine continuously for at least three months, whether they relapse or not, and then use is renegotiated. Unlike the injectable naltrexone, acamprosate has not been shown effective in patients with less than moderate motivation to be abstinent. The strongest findings from the outcome studies indicate that acamprosate is most effective in increasing complete abstinence from alcohol, or increasing the time before the first drink. The cost of acamprosate is approximately $120 per month. It is also covered by Medicaid for up to one year if a person is enrolled in a certified chemical dependency treatment program, seeing a licensed addiction provider, or is in a mental health-based co-occurring disorders program.

Suboxone

Suboxone is a combination medication composed of the mixed opiate agonist-antagonist buprenorphine and the antagonist naloxone. Its sole indication is for the treatment of opiate dependence, and it is classified as an opiate substitution medication.

It was hoped that the use of buprenorphine-based Suboxone would allow for a broader array of opiate dependent patients to seek and enroll in some sort of addiction treatment, and this appears to be the case. Studies have shown many opiate addicts refuse the rigor of daily dosing and urine tests at methadone clinics, though certainly, without this degree of contact and rigor of treatment, there would be no hope for many. On the other hand, those with milder opiate dependence, or those who may have been on methadone for some years, may desire a less monitored atmosphere. They may prefer a weekly or even monthly dispersal of Suboxone

and attend Narcotics Anonymous or weekly addiction counseling, especially if they are working and have a family. It is also hoped that buprenorphine, with its mixed activity at the opiate receptor, may allow for more patients who may have had longer term opiate dependency to gradually taper their medication and potentially adopt a totally drug free lifestyle. Some initial studies have found this to be the case, though its role as an opiate maintenance medication has been more studied.

Side effects and potential toxicities: For most patients, Suboxone has few if any side effects. Because it tightly attaches to the opiate receptor, if patients need to take opiates for pain relief for acute surgery or other reasons, either it has to be stopped or markedly increased doses of the opiate need to be given. If patients have been on methadone, especially at doses over 30mg per day within the last two weeks, induction onto Suboxone is often problematic because buprenorphine will kick methadone off the opiate receptor, inducing a minor or even a major withdrawal syndrome. Thus, if moving from methadone onto Suboxone, patients should taper down on methadone to the lowest possible dose, then wait for longest period into active withdrawal before being induced using small doses of Suboxone, generally 2-4mg. Most heroin addicts can be easily dosed onto Suboxone by giving them 2-8mg sublingually approximately 15-20 hours after their last heroin use while they are in significant withdrawal. Dosage adjustment up to the usual standard daily doses of 12-24mg (range 2-32mg) sublingually per day should happen over the first few days.

The Suboxone combination of buprenorphine and naloxone is directed at preventing diversion of the medication for illicit intravenous use. Use of Suboxone intravenously would result in immediate and serious withdrawal. When taken sublingually, little of the naloxone is absorbed, while most of the buprenorphine is absorbed. The sublingual dose goes directly into the circulatory system without needing to pass through the liver, and thus is more effective.

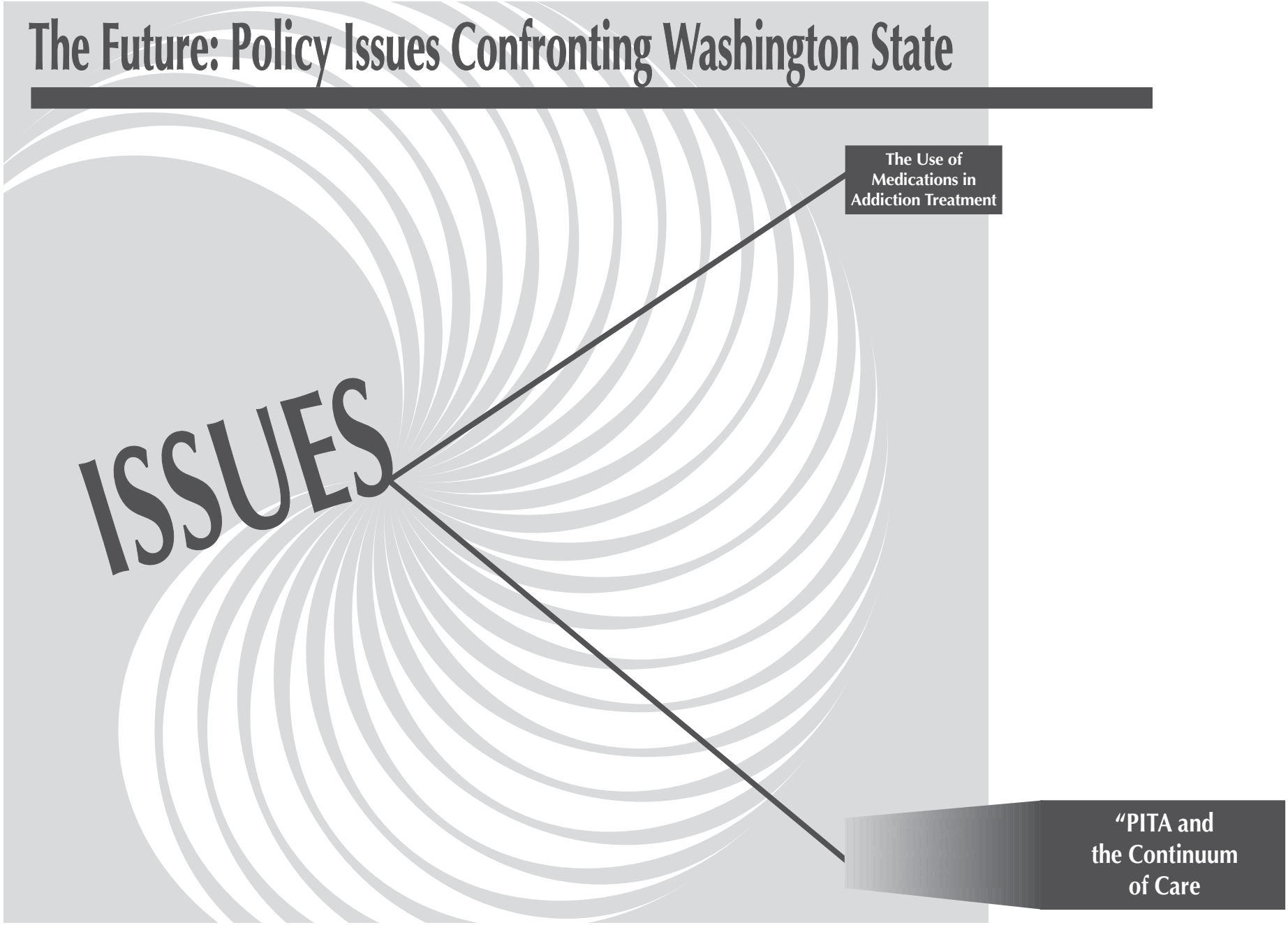
There appears to be a definite street market for diverted Suboxone. Anecdotally it is reported that Suboxone may be used by those addicted to heroin to detoxify themselves. Suboxone has also been evaluated and found effective as an acute detoxification agent for persons coming into hospitals or detox centers with opiate dependence. The cost of Suboxone is approximately $4-16 per day, depending on dosage. It is covered by Medicaid for six months, providing the person is enrolled in a certified addiction treatment program.

In Tandem

Pharmacological aids definitely have a place in the treatment of alcohol and other drug addiction. They are not substitutes for psychosocial interventions, and the two work best in tandem. Just as it might be hoped that medical professionals will become more open to using psychosocial and even spiritual interventions in helping patients with chronic medical illness to restore and maintain better health and functioning, it is also to be hoped that chemical dependency professionals will be supportive of assisting patients to use medications in treatment and prevention as appropriate.

-- *Prepared by Richard Ries, M.D., Medical Director, Washington State Division of Alcohol and Substance Abuse*

The Future: Policy Issues Confronting Washington State



"PITA" and the Continuum of Care

The mission of the Division of Alcohol and Substance Abuse (DASA) is to promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. In order to succeed in its mission, DASA provides an array of services across the "PITA" continuum – Prevention, Intervention, Treatment, and Aftercare. In addition, for individuals already impacted by substance abuse problems or who are chemically dependent, research indicates better outcomes may be achieved when they are linked to an integrated continuum of care.

Together with its partners, DASA delivers an array of substance abuse-related services across a continuum of need. These services, taken together, are designed to improve the health of Washington residents and their families, and increase the vitality and productivity of Washington communities and the state as a whole. This array can be captured in the acronym "PITA" – Prevention, Intervention, Treatment, and Aftercare.

Prevention

Prevention can be directed at an entire population through provision of information and skills, or through environmental strategies that can change the culture surrounding substance use. The primary focus of DASA's prevention programs is on children who have not yet begun use of substances or are still only experimenting. DASA uses a risk-and-protective-factor framework, which is based on a simple premise: by identifying those personal, family, or community characteristics that increase the likelihood of a problem developing, programs can intervene in ways that reduce risk. Similarly, by identifying factors that buffer individuals from risks present in the environment, programs can be implemented to strengthen that protection.

The Institute of Medicine identifies prevention programs by the audience for whom they are intended:

Universal prevention programs strategies are directed toward the general population, such as all students in a school, all parents of middle school students, or an entire community.

Selective prevention programs target groups, communities, or subsets of the population determined to be at higher risk.

Indicated prevention programs identify individuals who exhibit early signs or consequences of substance use and target them with activities to prevent further problems.

DASA provides prevention services through contracts with counties, tribes, statewide organizations, or through interagency agreements with other state agencies. Providers are required to utilize scientifically based best or promising practices for at least 50% of programming. Based on a study by the Washington State Institute for Public Policy participation in DASA-funded evidence-based prevention programs in SFY 2008 resulted in a lifetime benefit to the state of almost $18 million.

Intervention

Intervention services are aimed at reducing the risk of harm to individuals from substance abuse before it has developed into chemical dependency. Alternatively, such services may also be aimed at those who are chemically dependent but, at least initially, seek to decrease problem behaviors and connect individuals to needed services before they are prepared to be wholly abstinent.

Early interventions may provide education about substance abuse to individuals referred by courts who are not chemically dependent to assist them in making decisions about alcohol and drug use. Examples include: alcohol and drug information school for individuals convicted of a driving-under-the-influence charge but who are not assessed

as having a significant problem with alcohol or drugs; counseling services provided to college students to reduce their drinking; or helpline services.

Brief interventions utilize a public health model to identify, intervene in, and treat substance abuse problems before they rise to the level of substance dependence. With a grant from the federal Substance Abuse and Mental Health Services Administration, DASA has implemented the Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) program, providing services and referrals in nine hospital emergency rooms. Evaluative follow-ups indicate that those who receive WASBIRT services show significant declines in both alcohol and drug use, substantial increases in abstinence, and reductions in need for medical services, resulting in medical cost savings. Similar models could be implemented in schools and in physicians' offices and clinics.

Detoxification services are offered through counties and community hospitals. These short-term residential services are for individuals withdrawing from the effects of excessive or prolonged alcohol and drug abuse. Detoxification may include counseling, medical care, and use of pharmacological agents. While primarily serving a public health and safety function, detoxification may also serve as an intervention that facilitates entry of individuals into chemical dependency treatment.

DASA has a pilot project to provide *integrated crisis response/secure detoxification* services to individuals gravely disabled by the use of alcohol or other drugs, and/or pose a danger to themselves or others. The project provides for involuntary detention, detoxification, evaluation, and initial treatment, and referral to appropriate treatment agencies following release. DASA has a pilot project to provide *integrated case management* services to high-risk individuals, linking them to housing and a full range of health and social services. Costs associated with emergency room and sobering/detoxification services utilization are substantially reduced as a result.

Drug courts, family therapeutic courts, and *DUI courts* also represent intervention opportunities for individuals experiencing adverse behavioral impacts from the abuse of alcohol and other drugs.

Treatment

DASA-funded treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating adults and youth recovering from alcohol and other drug addiction. DASA contracts with counties and tribes for the delivery of outpatient services. Other services are delivered through contracts with direct service providers.

Services include:

- Diagnostic evaluation.
- Outpatient treatment (adult and youth).
- Opiate substitution (methadone) treatment.
- Intensive inpatient treatment (adult and youth).
- Recovery house (adult and youth).
- Long-term residential care.
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction.
- Residential treatment for pregnant and parenting women (with childcare).
- Outpatient treatment for pregnant and parenting women (with childcare).

- Treatment for co-occurring disorders.
- Tribal treatment programs.
- Monolingual programs for non-English speakers.
- Treatment program for the deaf/hard of hearing.
- Urinanalysis.

In recent years, several new programs have been initiated. With funds from the *Criminal Justice Treatment Account (CJTA)*, judicially supervised treatment and support services are being made available to chemically dependent offenders in community-based treatment programs in lieu of incarceration. The goal is to generate savings in prison and jail bed costs, both in the short-term through treating offenders rather than incarcerating them, and in the long-term by reducing recidivism among these offenders.

In 2005, the Legislature and Governor created a program for the prevention and *treatment of problem and pathological gambling*. In keeping with its five-year problem gambling strategic plan, DASA is building treatment capacity. Since its inception, there have been more than 800 admissions to the DASA-funded problem gambling treatment program. There is strong evidence of substantial comorbidity between pathological gambling and substance abuse disorders.

Aftercare and Support Services

There is increasing recognition that while treatment is critical for individuals who are chemically dependent to turn their lives around, aftercare and support services are important adjuncts in helping to ensure individuals can move toward healthy lifestyles and return to active, productive lives in their families and communities.

DASA offers specialized contracted support services in a number of areas:

- Childcare, including therapeutic childcare.
- Translation services (including interpreters for individuals who are deaf or hard of hearing.
- Transportation assistance.
- Case management.
- Cooperative housing (Oxford House) and other transitional housing support services.

Through a federal grant, DASA's *Access to Recovery (ATR)* program provides recovery services to individuals and families. These include: mental health counseling, medical care, preventive services for family members, childcare, transportation, and housing assistance. What is unique about ATR is that the program is customer-driven, with patients selecting from a menu of services those services they believe are most critical in aiding them on the path to recovery.

Washington State is home to more than 180 *Oxford Houses*, with over 1,500 Oxford House beds, the largest number of any state in the country. These are cooperative houses in communities that provide post-treatment housing to individuals who participate in recovery programs. Each house is alcohol- and drug-free. There are several houses exclusively for women, or for parents with children.

Through the *Parent-Child Assistance Program (P-CAP),* DASA offers paraprofessional advocacy services for substance-abusing women with young children. Advocates help women identify and prioritize realistic goals and steps to meet them, make referrals to chemical dependency treatment and recovery services where needed, and help individuals access local resources.

DASA's *Safe Babies, Safe Moms* programs provides up to 18 months of housing support services for chemically dependent women who are pregnant, postpartum, or parenting and for their children in drug-free residences.

Articulating and Integrating the Continuum of Care

As seen from the above, DASA offers a rich array of evidence-based PITA services. Besides enhancing the array of services, over the past several years, DASA has worked hard together with its providers to ensure a higher rate of service completion. Treatment completion in particular has been demonstrated to be associated with improved long-term outcomes.

For optimal outcomes, PITA services need to be linked as seamlessly as possible. Interventions and assessments may identify individuals in need of treatment or other services, but without clear and timely links to those services, the benefits of the intervention may be lost. Waiting lists make it less likely that individuals will access treatment at the time at which engagement is most likely to occur. Individuals who successfully complete residential treatment need to reintegrate into their communities, engage with recovery support services, and continue their treatment in outpatient settings.

With the wealth of services available, the need is to link them, from the patient's point of view, into a clearly articulated path to recovery.

DASA is participating in the Network for the Improvement of Addiction Treatment (NIATx) process. Recognizing that interruptions or delays in a patient's entry into and progress through the treatment system represents a serious threat to recovery, the NIATx process focuses on redesigning work and systems to smooth the path to recovery. In doing so (and reducing wait times, "no-shows", and increasing admissions and patient continuation in treatment), process improvements enhance the ability of agencies to deliver quality care while increasing their own viability.

Toward a Recovery-Oriented System of Care

Although addiction is considered a chronic disease, most treatment is oriented towards acute care interventions rather than a disease management approach. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) is leading a national effort to shift to a chronic care approach known as a recovery-oriented system of care. This approach recognizes that recovery from alcohol and other drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life, and that there are multiple paths to recovery.[1]

A recovery-oriented system of care builds upon the continuum of care in recognizing the critical role an individual's home and community plays in recovery. It builds upon the continuum of care by providing a role for faith-based and community-based providers, and by expanding client choices in the recovery process. As recovery-oriented systems of care become more generally accepted, there will be need for increased support for the continuing development of recovery support services responsive to the needs of individuals and families.

[1] Center for Substance Abuse Treatment. *The Role of Recovery Support Services in Recovery-Oriented Systems of Care.* Rockville, MD: U.S. Department of Social and Health Services, Substance Abuse and Mental Health Administration, May 2008.

Data Sources

DATA SOURCES

Data Sources

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2008 contains information and data from a wide variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regard to methodology, sampling and collection procedures, as well as in the reliability and validity of the data. Report users are encouraged to consult the original data sources for more detailed information.

National Sources

Monitoring the Future (MTF) (www.isr.umich.edu/src/mtf)

Conducted by the Institute for Social Research, University of Michigan, and supported by research grants from the National Institute on Drug Abuse, the Monitoring the Future (MTF) project studies changes in the beliefs, attitudes, and behavior of young people in the United States. Surveys have been carried out each year since 1975. Students in the 8th, 10th, and 12th grades complete self-administered, machine-readable questionnaires in their classrooms. Surveys are administered from February to May, invalidating direct comparisons with results from a similar survey – the Washington State Healthy Youth Survey – which is administered in October. Data are used to monitor trends in substance use and abuse among adolescents, and progress toward national education goals for safe, disciplined, and alcohol- and drug-free schools. Results are also used in development of the White House National Drug Control Strategy.

National Institute on Drug Abuse (NIDA) (www.nida.nig.gov/)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA seeks to accomplish this mission through the strategic support and conduct of research across a broad range of disciplines. NIDA supports over 85% of the world's research on health-related aspects of drug abuse and addiction. NIDA also works to ensure the rapid and effective dissemination and use of results from research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA is one of the 19 institutes that comprise the National Institutes of Health (NIH).

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa/nih/gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIAAA provides leadership in the national effort to reduce alcohol-related problems by:

- Conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks of alcohol consumption, and the benefits of prevention and treatment.
- Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues.
- Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work.

Data Sources

- Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA-supported research and direction are aimed at:

- Removing the stigma associated with the common and complex disease of alcoholism.
- Revealing genetic, other biological, and sociocultural origins of variations in individual responses to alcohol and the consequent risks and benefits of alcohol to health.
- Developing effective prevention and treatment programs that address the physical, behavioral, and social risks attributable to excessive and underage alcohol consumption, and the chronic relapsing nature of alcoholism.
- Improving the acceptance of, and access to, quality care.

Bureau of Justice Statistics (BJS) (www.ojp.usdog.gov/bjs/)

The Bureau of Justice Statistics (BJS), part of the Office of Justice Programs within the U.S. Department of Justice, is the nation's leading source for criminal justice-related data. BJS collects, analyzes, publishes, and disseminates data on crime, criminal offenders, victims of crime, and the operation of, and expenditures related to, justice systems at all levels of government. These data are used by federal, state, and local policymakers.

Annually, BJS publishes *Bureau of Justice Statistics Key Crime Statistics at a Glance*, a summary of information and data most recently gathered. This report can be found at www.ojp.usdoj/bjs/glance.htm#Crime.

Federal Bureau of Investigation (FBI) – Uniform Crime Reports (www.fbi.gov/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from nearly 17,000 law enforcement agencies across the United States, covering approximately 95% of the population. Data are gathered by state and local agencies and submitted to the FBI. Data related to eight categories of crime are gathered: 1) murder and nonnegligent manslaughter; 2) forcible rape; 3) robbery; 4) aggravated assault; 5) burglary; 6) larceny-theft; 7) motor vehicle theft; and 8) arson.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reported levels may vary from community to community as a result of a wide variety of factors, including funding and aggressiveness of local law enforcement agencies. The FBI operates two other reporting systems. The National Crime Victimization Survey collects data on unreported as well as reported crime by surveying a representative sample of households. The National Incident-Based Reporting Systems presents comprehensive, detailed information about crime incidents to law enforcement, researchers, and planners.

Data Sources

Centers for Disease Control and Prevention (CDC) (www.cdc.gov)

The federal Centers for Disease Control and Prevention (CDC) is the lead federal agency charged with protecting the health and safety of Americans, providing information for making health decisions, and promoting and protecting the nation's health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers.

National Center for Injury Prevention and Control (NCIPC) (www.cdc.gov/ncipc/)

The National Center for Injury Prevention and Control (NCIPC) works to reduce morbidity, disability, mortality, and costs associated with injuries occurring outside the workplace. One of the federal Centers for Disease Control and Prevention, NCIPC conducts and supports research about causes, risk factors, and preventive measures for injuries outside the workplace, including:

- Unintentional injuries related to falls, fires, drowning, poisoning, motor vehicle crashes (including those involving pedestrians), sports and recreational activities, and playgrounds and day-care settings.
- Intentional injuries related to homicide, suicide, youth violence, intimate partner violence, child maltreatment, and sexual violence.
- Improving health and quality of life after injuries and preventing secondary conditions among people with disabilities.

NCIPC also funds research by universities and other public and private groups studying the three phases of injury control (prevention, acute care, and rehabilitation) and the two major disciplines of injury control (epidemiology and biomechanics).

HIV/AIDS Surveillance Report (www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm)

The HIV/AIDS Surveillance Report is published annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC. It contains data about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, gender, race/ethnicity, age, vital status, and case definition category.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) – Division of Sexually Transmitted Diseases (www.cdc.gov/nchhstp)

CDC's Division of Sexually Transmitted Diseases (STDs) provides national leadership through research, policy development, and support of effective services to prevent STDs (including HIV infection) and their complications, such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancers. The Division assists health departments, health care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development

Data Sources

of goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHSTP) – Division of Tuberculosis Elimination (www.cdc.gov/nchhstp/tb/surv/surv.htm

The NCHSTP Division of Tuberculosis Elimination (DTBE) seeks to provide leadership in preventing, controlling, and eventually eliminating tuberculosis (TB) in the U.S., in collaboration with partners at the community, state, and international levels. To accomplish this mission, the DTBE carries out the following activities:

- Develops and advocates effective and appropriate TB prevention and control policies.
- Supports a nationwide framework for monitoring TB morbidity and mortality.
- Detects and investigates TB outbreaks.
- Conducts clinical, epidemiological, behavioral, and operational research to enhance TB prevention and control efforts.
- Evaluates prevention effectiveness.
- Provides funding and technical assistance to state and local health departments.
- Provides training, education, and technical information services to state and local health departments.

DBTE publishes an annual TB Surveillance Report. The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc.).

Behavioral Risk Factor Surveillance System (BRFSS) (http://www.cdc.gov/brfss)

CDC's National Center for Chronic Disease Prevention and Health Promotion administers the Behavioral Risk Factor Surveillance System (BRFSS), the world's largest telephone survey. Based on an understanding that personal health behaviors play a major role in premature morbidity and mortality, BRFSS facilitates the collection of behavior-related data on a state-specific basis. State-level surveillance of prevalence of major behavioral risks assists states in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

National Center for Health Statistics (NCHS) (www.cdc.gov/nchs)

CDC's National Center for Health Statistics (NCHS) provides statistical information to be used by policymakers and health professionals to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. NCHS has two major types of data systems: those based on

Data Sources

populations, containing data collected through personal interviews or examinations; and those containing data collected from vital and medical records.

National Highway Traffic Safety Administration – Fatality Analysis Reporting System (FARS) (www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) facilitates the collection and reporting of data for all fatal crashes involving automobiles in the United States, and provides a basis for evaluation of overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Data is available through a web-based "encyclopedia".

Data Sources

State Sources

Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

Office of Financial Management – Population Trends for Washington State (http://www.ofm.wa.gov)

The Office of Financial Management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

Washington State Department of Health – Center for Health Statistics (http://www.doh.wa.gov/)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Washington State Vital Statistics are compiled each year from certificates received before April 15 of the previous year.

Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.

Data Sources

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

Washington Traffic Safety Commission (http://www.wa.gov/wtsc/index.htm)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitated these efforts in Washington State since 1967. Governor Christine Gregoire serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

Washington State Healthy Youth Survey (HYS) (http://www3.doh.wa.gov/HYS/)

The Washington State Healthy Youth Survey provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of Superintendent of Public Instruction (OSPI). HYS includes a sample of public school students in 6th, 8th, 10th, and 12th grades. The survey provides information on tobacco, alcohol, and other drug use; violence; related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

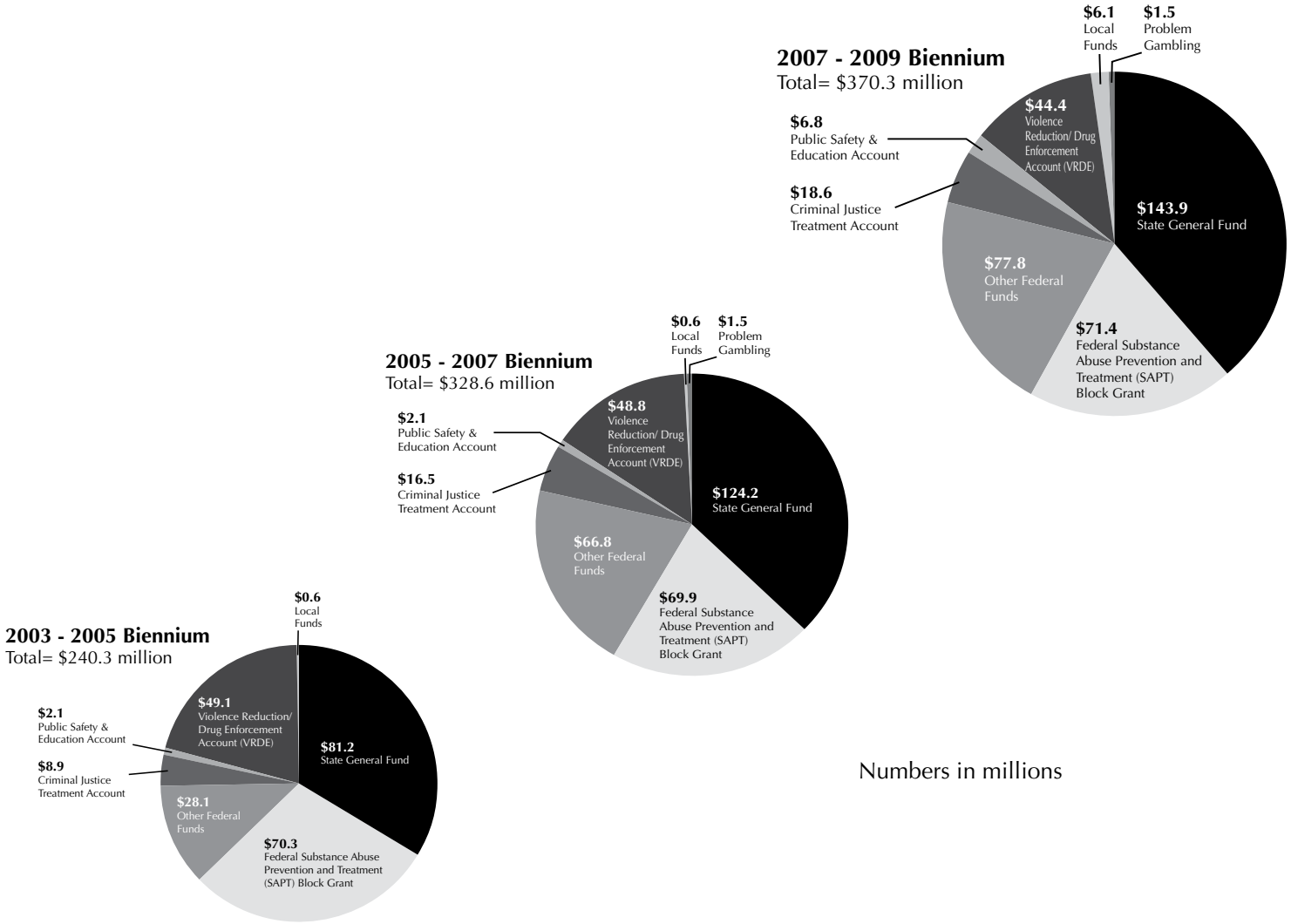
- The student survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2002), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.

DASA in Brief: 2007 - 2009 Biennium

DASA in Brief

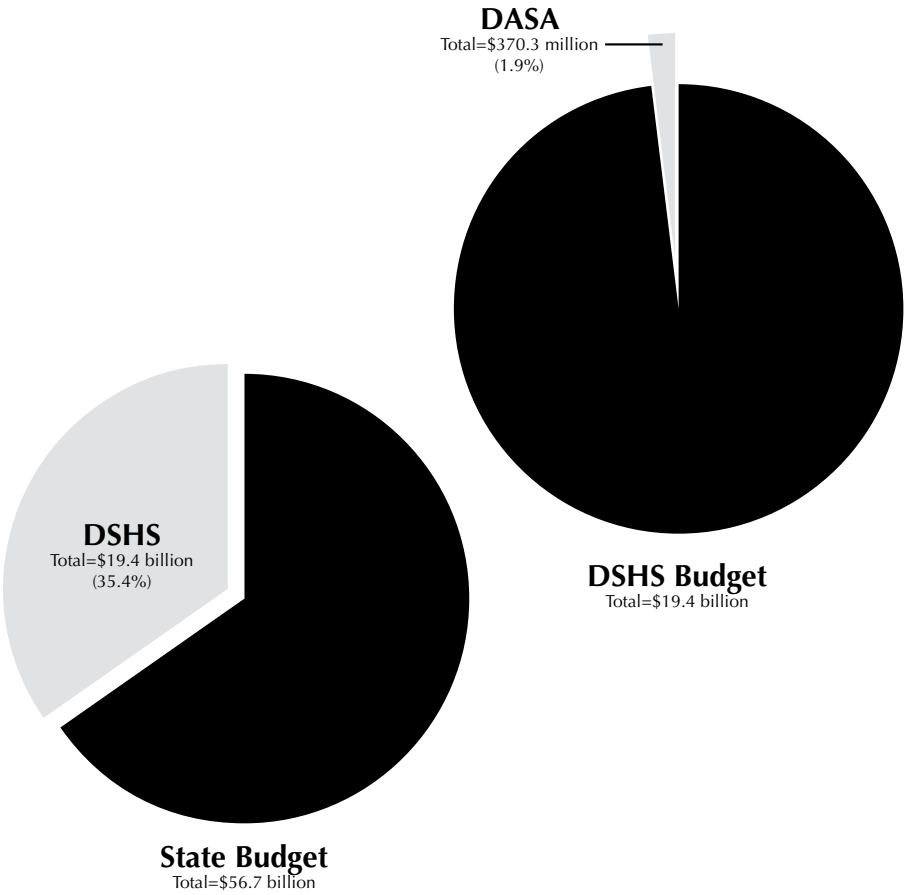
The Division of Alcohol and Substance Abuse 2007-2009 Budget

DASA's projected 2007-2009 Biennium budget of $370.3 million represents a 12.7% increase over 2005-2007.

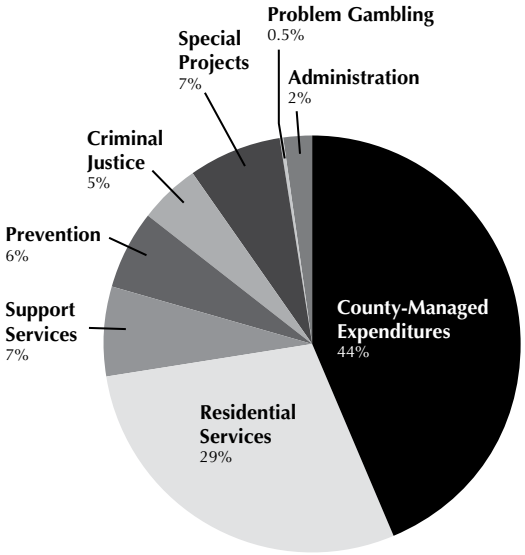


The Division of Alcohol and Substance Abuse 2007-2009 Biennium Budget is a Small Fraction of that of the Department of Social and Health Services.

DASA's projected 2007-2009 Biennium Budget of $370.3 million represents 1.9% of the Department of Social and Health Services' Budget.

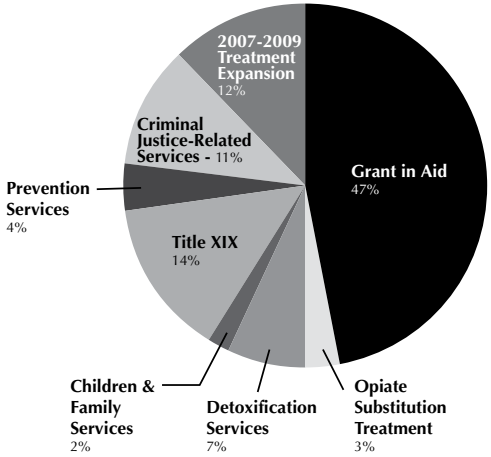


Only 2% of the Division of Alcohol and Substance Abuse 2007-2009 Biennium Budget Will Be Spent on Administration.



Total DASA 2007-2009 Biennium Budget	$370.3 million	
County-Managed Services	$163.0 million	44%
Residential Services	$106.6 million	29%
Support Services	$26.0 million	7%
Prevention Services	$20.7 million	6%
Criminal Justice-Related Services	$17.5 million	5%
Special Projects	$26.7 million	7%
Problem Gambling	$1.5 million	0.5%
Administration	$8.3 million	2%

Approximately Half of the Division of Alcohol and Substance Abuse 2007-2009 Biennium Budget is for County-Managed Services.



Total County-Managed Substance Abuse Services 2007-2009 Biennium Budget	**$173.6 million**	
Grant in Aid	$81.4 million	47%
Opiate Substitution Treatment	$5.3 million	3%
Detoxification Services	$11.4 million	7%
Children & Family Services	$4.2 million	2%
Title XIX	$23.7 million	14%
Prevention Services	$7.4 million	4%
Criminal Justice-Related Services	$19.6 million	11%
2007-2009 Treatment Expansion	$20.7 million	12%

DASA passes half of its biennial budget through to counties to provide alcohol- and drug-related prevention, intervention, and treatment services. The largest portion of these funds – Grant in Aid – can be used flexibly to meet areas of greatest need in each county.

Results of the 2008 Legislative Session

The 2008 Legislative Session represented a year of consolidation and further implementation of the gains achieved by the Division of Alcohol and Substance Abuse (DASA) in the 2005-2007 Biennium. While 2008 was not a Budget Session, through the Supplemental Budget both the Legislature and Governor expressed their continuing confidence in the work undertaken by the substance abuse field. This is based on the increasing recognition that the provision of quality substance abuse prevention, intervention, and treatment services results in improved public health and safety, reduced medical and psychiatric costs, less crime and lower criminal justice costs and, among youth, better school performance and less delinquency. There were also significant pieces of legislation enacted of interest to the substance abuse prevention and treatment field.

Legislation

ESHB 2551 - Expanding the types of treatment programs provided under the suspended disposition alternative for juveniles. Under the new law, treatment programs other than those for chemical dependency must be either research-based best practice programs as identified by the Washington State Institute for Public Policy or the Joint Legislative Audit and Review Committee. Chemical-dependency treatment programs or services must be evidence-based or research-based best practice programs.

E2SHB 2674 – Modifying credentialing standards for counselors. The new law abolishes the registered counselor credential as of July 1, 2010, and creates new categories of counseling health professions and associate/trainee licenses, including a certified chemical dependency professional trainee (CDPT) category.

E2SHB 3254 – Accountability for persons driving under the influence of intoxicating liquor or drugs (Ignition interlock).

Beginning January 1, 2009, a person convicted of an offense involving the use, consumption, or possession of alcohol while operating a motor vehicle, except vehicular homicide or assault, or who has his/her license suspended, revoked, or denied, may apply to DOL for an ignition interlock driver's license. There is a $100 application fee.

Any person convicted of an alcohol-related DUI or physical control violation must be required by the court to apply for an ignition interlock driver's license and have an ignition interlock device (IID) installed on all motor vehicles operated by the individual.

A pilot program is created to monitor compliance by persons required to use ignition interlock devices and by ignition interlock companies and vendors.

The time a person has to request a hearing is reduced from 30 days to within 20 days after receipt of the notice that their license has been suspended.

Persons with an ignition interlock driver's license must pay the cost of installing, removing, and leasing the IID and pay an additional fee of $20 per month to an interlock device revolving account to assist in the costs of ignition interlock devices for indigent person.

The Governor vetoed a provision that allowed for a first offense deferred prosecution of an individual assessed as not needing treatment for alcohol, drug, or mental problems. The veto was based on the understanding that the legislative intent of Washington's deferred prosecution law is to reduce the likelihood that DUI offenders with substance dependence will re-offend unless their illness is treated.

Engrossed SB 6421 – Smoking cessation programs. The law provides coverage for smoking cessation counseling services, including prescription and nonprescription drugs, for clients enrolled in the medical assistance and medical

care services programs. DSHS is to track expenditures for a cohort of clients receiving smoking cessation benefits and submit a cost-benefit analysis of providing the services to the Legislature by January 1, 2012. DSHS may implement rules regarding appropriate coverage limitations to encourage the use of effective, evidence-based services.

ESSB 6665 – Intensive case management and integrated crisis response pilot programs.

Removes the expiration dates of the intensive case management and integrated crisis response pilot programs and makes their continuation "subject to funds appropriated for this specific purpose."

Authorizes DASA to contract with other Regional Support Networks or counties to implement additional pilot programs "subject to funds appropriated for this specific purpose."

Adds a provision that allows for a 60-day commitment to secure detoxification under a less-restrictive treatment order.

Allows a detained person to request an involuntary commitment hearing be postponed for 48 hours and continued for 24 hours.

Extends the evaluation of the pilot projects by the Washington State Institute for Public Policy (WSIPP) for one additional year, requiring a second preliminary report by June 30, 2008, and a final report by June 30, 2010.

The Governor vetoed a section of the bill that would have established a third integrated crisis response program in Spokane. Funds had only been allocated for start-up costs and two months of operation.

Engrossed SSB 6791 - Clarifying permitted uses of moneys currently collected under the county legislative authority sales and use tax for chemical dependency or mental health treatment programs and services or therapeutic courts. This law clarifies that money collected by counties may be used for:

The operation or delivery of programs and services, "which includes, but is not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service."

To replace lapsed federal funding that previously provided for the operation or delivery of chemical dependency or mental health treatment services and programs.

Budget

Expansion of Youth Residential Treatment - $362,000 of General Fund-State is provided for DASA to reach a target goal of 111 additional youths receiving treatment. The 2007-2009 budget assumed a higher proportion of youth would receive less expensive outpatient treatment. That assumption is now adjusted to allow for intensive inpatient treatment, with the same overall goal of numbers to be served.

Extension of the Intensive Crisis Response/Secure Detox and Intensive Case Management Pilot Projects - $4,449,000 of General Fund-State and $1,000,000 of the Criminal Justice Treatment Account is provided to extend the pilot projects to June 30, 2009. An additional $23,000 was provided to the Washington State Institute for Public Policy (WSIPP) to evaluate the pilot projects for one additional year. WSIPP is directed to produce a second preliminary report by June 30, 2008, and a final report by June 30, 2010. Funds were also provided to cover court filing fees. See ESSB 6665 below.

Discontinuation of Support of Prometa Treatment Services – There is a reduction of $105,000 in General Fund-State to contract with Pierce County for a pilot program of family therapeutic court services using the Prometa treatment protocol. Remaining funds can only be used to treat patients already enrolled in the Prometa protocol prior to March 11, 2008, and for a study currently contracted at the University of Washington (UW). To the extent that the UW cannot evaluate the Pierce County pilot program, the UW may summarize other research on the efficacy of the Prometa protocol.

Provision of Fetal Alcohol Syndrome Screenings – $100,000 in General Fund-State is provided for DASA to contract with providers in Spokane, Everett, and Yakima to screen an estimated 50 children to detect Fetal Alcohol Spectrum Disorders (FASD).

DASA looks forward to an exciting biennium in working with our partners in implementing the new legislation and continuing our efforts to expand access to quality prevention, intervention, treatment, and aftercare services.

Washington State
Department of Social
& Health Services

Division of Alcohol and Substance Abuse
www1.dshs.wa.gov/dasa

DSHS 22-055 (Rev 11/08)

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