

# ***Helping Patients With Drug Use Disorders: Resources for Medical Professionals***

***Ask ~ Assess ~ Advise ~ Assist ~ Arrange***



**DBHR** Division of Behavioral  
Health and Recovery

Division of Medical Management  
Division of Customer Support

[www.dshs.wa.gov/dbhr](http://www.dshs.wa.gov/dbhr)

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## Introduction

This guide is written for primary care, emergency care and mental health professionals by the Washington State Department of Social and Health Services, with guidance from health and social service professionals.

One out of ten adults in Washington needs treatment for a drug use disorder, and for more than half of them the drug of choice is alcohol. Untreated drug use disorders impact individuals, families, their workplaces and communities. The economic impact on our state's health care, criminal justice, and social systems was an estimated \$2.45 billion in 1996.

Until now, 69 percent of youth and 74 percent of adults who need and qualify for chemical dependency treatment could not get it because of limited funding. **The good news is that more funding for treatment is available now.** The Legislature and Governor have authorized \$51 million for a major expansion of chemical dependency treatment services to Medicaid patients. The expanded treatment will be phased in over the next two years. **Patients needing alcohol/drug treatment should be referred to the Alcohol/Drug Helpline to see if they are eligible for state-funded treatment, and to locate a treatment agency. The Helpline number is 800-562-1240.**

Priority will be given to Medicaid patients designated as SSI-related aged, blind and disabled, and General Assistance Unemployable (GAU) adults with chemical dependency problems. There is also additional funding for low-income youth. With more people receiving the treatment they need for drug use disorders, state leaders expect to see significant savings in other health-related costs.

Now that more funding is available for treatment, we need your help in screening patients and referring them to the services they need. Studies show that when health professionals ask their patients about their alcohol or other drug use and explain how misuse affects their health and well-being, people with drug use disorders are much more likely to seek help. However, a study by the National Center on Addiction and Substance Abuse at Columbia University found that 94 percent of primary care physicians misdiagnose alcoholism. Forty-one percent of pediatricians fail to diagnose illegal drug use among teens.

We hope this guide provides useful information and tools for identifying patients with drug use disorders and starting them on the path to recovery.

## Purpose

The purpose of this guide is to:

- Improve health care providers' ability to effectively screen and identify people with alcohol or other drug use problems.

- Provide guidelines for screening and follow-up.
- Provide sample screening tools.
- Provide recommendations related to drug testing.
- Provide referral resource numbers.

## Definitions

**What is use versus abuse?** Use refers to any use of alcohol or other drugs. Abuse is a recurring pattern of alcohol or other drug use that impairs a person's ability to function in one or more important life areas, such as: family relationships, employment, social events, psychological or physical health, and legal matters. Any use by a youth is considered abuse.

**What is dependency?** A primary, chronic disease with genetic, psychological, and environmental factors influencing its development. Symptoms can include physical/physiological withdrawal, and a psychological dependence on a specific psychoactive substance, such as alcohol or other drugs.

**What is addiction?** A complex, progressive behavior pattern having biological, psychological, sociological, and behavioral components. Addicted individuals use drugs compulsively and cannot control their use.

**What is screening?** Methods used to identify risk of substance abuse, including self report, interview, and observation. Rescreening should be done if risk factors are present or if the patient has a history of alcohol or drug use.

**What is testing?** Laboratory testing to determine the presence or absence of a substance in a specimen. Universal testing may be used as a screening tool in some practices but is not recommended.

**What is assessment?** Comprehensive evaluation of a patient's risk for substance abuse. The following are characteristics of assessment:

- Collecting objective and subjective information.
- May include screening and lab testing.
- Should be timely and culturally appropriate.
- May result in a diagnosis and plan for intervention.
- Specialized assessments such as chemical dependency assessments may be part of an initial assessment or may follow screening.

## Frequently Asked Questions: Screening for Substance Abuse

**Which tools are most effective?** Interview-based or self-administered screening tools are the most effective way to determine risk and/or allow self reporting.

**What about tools for screening?** Brief questionnaires have demonstrated effectiveness for assessing alcohol and drug use. Examples of tools that have been validated for this population and take five to ten minutes or less include the UNCOPE, AUDIT, and CAGE (see Appendix A for samples).

**Who do I screen?** Use a screening tool with every patient and not just those who you suspect have a problem. Patients should be screened for alcohol, illicit drugs, tobacco, misuse of prescription drugs, and other substances. If the screening tool focuses on alcohol (for example, the AUDIT), another tool should be administered to screen for additional substances.

### ASK

#### How Do I Screen?

- Screening is a skill, and staff should be trained in interview techniques. The screening should be performed by the health care provider or other staff member who has an ongoing relationship with the patient. Results of the screen should be discussed with the patient and documented in the chart. If the patient is screened by someone other than the primary provider, the provider should review the results of the screen and give appropriate follow-up messages.
- Make substance abuse screening a routine part of care. This approach decreases subjectivity, discomfort, and bias. Ideally, individuals should be screened at each encounter.
- Include family members in questions about drug use. Know how to respond to both positive and negative responses to screening tools. As trust develops, patients who use are more likely to disclose. When use is disclosed, remember that screening tools identify risk but are not diagnostic. Know how to respond, including discussing risks of use, benefits of stopping, and resources for further evaluation.

#### How Do I Create a Respectful Environment?

Supportive questions about drug use can open the door to referral and treatment. In order to get an honest response, a safe and respectful environment is essential.

- Educate support staff about how important a positive and nonjudgmental attitude is in establishing trust and a welcoming environment.
- Observe and protect provider/patient confidentiality. For example, know the issues surrounding consent for testing patients.
- Ask every question in a health context. This reduces the stigma associated with drug misuse and expresses concern for the patient's health.
- Be empathetic, nonjudgmental, and supportive when asking about use; consider the patient's needs and life situation.
- Offer culturally appropriate screening in the patient's primary language.

### **How Do I Assess?**

#### **When a Patient Denies Use**

Acknowledge the wise choice with a patient that states they are abstaining from drugs and alcohol. Review the benefits of abstinence from substances. Continue to screen, ideally at each encounter. In some situations, patients may deny use, but a constellation of signs and symptoms suggest abuse. In this case, it may be prudent to re-screen frequently or conduct lab testing.

#### **When a Patient Admits Use**

A patient may feel safe enough to share with the medical provider but may not be ready to take the next step of a comprehensive assessment and treatment.

The *Stages of Change* model developed by Prochaska and DiClemente (1992) is one approach to understanding the steps to changing drug or alcohol use during pregnancy.

The stages of change are:

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Relapse

1. **Pre-contemplation:** The patient is not considering change during the pre-contemplation stage.
  - They may not believe it is necessary.
  - They may not know or understand the risks involved.
  - They have tried many times to quit without success, so they have given up and don't want to try again.

- They have gone through withdrawal before and are fearful of the process or effects on their body.
- They feel strongly that no one is going to tell them what to do with their body.
- They have a mental illness or developmental delay and do not have a good grasp of what using drugs and alcohol means, even when information is given to them.
- They have family members or partners who they depend on who use. They may not contemplate changing when everyone else continues to use.

The individual in pre-contemplation may present as resistant, reluctant, resigned, or rationalizing.

Presents as:	What the patient is saying:	Provider response:
Resistant	Don't tell me what to do.	Work with the resistance. Avoid confrontation by giving facts about what drugs and alcohol will do to them. Ask what they know about the effects; ask permission to share what you know, and then ask her opinion of the information. This often leads to a reduced level of resistance and allows for a more open dialogue.
Reluctant	I don't want to change; there are reasons.	Empathize with the real or possible results of changing (for example, if their partner left). It is possible to give strong medical advice to change and still be empathetic to possible negative outcomes to changing. Guide them to problem-solving.
Resigned	I can't change, I've tried.	Instill hope and explore barriers to change.
Rationalizing	I don't use that much.	Decrease discussion. Listen rather than responding to the rationalization. Respond to them by empathizing and reframing their comments to address the conflict of wanting to be healthy and not knowing whether "using" is really causing harm.

2. **Contemplation:** The patient is ambivalent about changing their behavior. They can think of the positive reasons to change but also is very aware of the negative sides of change.

Provider response: Health care providers can share information on the health benefits of changing. The patient in contemplation will hear these benefits but is very aware of the negative aspects of change in their life. Help the patient explore goals for health, and problem solve how to deal with the negative aspects of abstinence.

3. **Preparation:** The patient's ambivalence is shifting toward changing their behavior. They are exploring options to assist their process. They may be experimenting by cutting down or has been able to quit for one or more days. Although their ambivalence is lessening, it is still present and may increase when they are challenged by those around them, triggered by the environment, or is under other types of stress they have handled by using in the past.

Provider response: Acknowledge strengths; anticipate problems and pitfalls to changing, and assist the patient in generating their own plan for obtaining abstinence. Problem solve with them regarding barriers to success.

4. **Action:** The patient has stopped using drugs and/or alcohol.

Provider Response: Acknowledge their success and how they are helping themselves; have them share how they have succeeded and how they are coping with the challenges of not using. Offer to be available for assistance if they feel that they want to use drugs/alcohol again.

5. **Relapse:** Relapse is common and should not be thought of as failure, but as part of the recovery process.

Provider response: Discuss triggers, stressors, and social pressures that may lead to relapse and help the patient plan for them. At future visits, if the relapse has occurred, guide the patient toward identifying what steps they used to quit before. Offer hope and encouragement, and allow the patient to explore the negative side of quitting and what they can do to deal with those issues. Offer to help find resources to help the patient return to abstinence.

### **How Do I Advise?**

#### **Educational Messages for Patients**

Assume that all individuals have some knowledge of the effects of alcohol and other drugs. Ask the patient what they know and then fill in the missing pieces and clarify misconceptions. This is an excellent opportunity to educate the



patient about adverse effects of alcohol/drugs and the benefits of stopping use at any time. These messages can be reinforced through discussions not only by the primary provider, but the pharmacists, health nurse, and other health care staff.

## **How Do I Assist/Arrange?**

### **Referral to Treatment**

- Discuss the benefits of treatment and offer to provide the patient with a referral to a local chemical dependency treatment center. If the patient is unwilling to make that commitment, ask if they would like some information to take with them if they should change their mind.
- Schedule the next visit, continue to maintain interest in their progress, and support their efforts in changing. Monitor and follow-up on any co-existing psychiatric conditions.
- Know and maintain a current list of local resources. If possible, make the appointment while the patient is in the office.
- Discuss the possible strategies for them to stop; for example, individual counseling, 12-step programs, and other treatment programs. Studies have shown that people given choices are more successful in treatment.
- Become familiar with the Treatment Access Flow Chart.
- Tailor resources according to patient needs and health insurance coverage.
- Know the resources in your area, or find out by calling the Alcohol/Drug 24-hour Help Line at 1-800-562-1240. Resources may include:
  - County substance abuse services.
  - Twelve-step programs.
  - Hospital treatment programs.
  - Mental health programs.
- If immediate chemical dependency treatment or other support is not available, the primary provider or designated staff might meet with the patient weekly or biweekly to express concern and to acknowledge the seriousness of the situation.
- Maintain communication with the chemical dependency treatment provider to monitor progress.
  - Establish rules and goals, such as reducing use with the patient and their significant others. (See the section on Preventing Further Harm).

## **Laboratory Testing**

Urine toxicology determines the presence or absence of a drug in a fluids (urine, blood, oral) specimen. It may be useful as a follow-up to a positive interview screen.

### **What Are The Benefits of Lab Testing?**

- Confirms the presence of a drug.
- Determines the use of multiple drugs.

### **What Are The Limitations of Lab Testing?**

- Negative results do not rule out substance use.
- A positive test does not tell how much of a drug is used.
- A positive test does not identify user characteristics, such as intermittent use, chronic use, or addiction.
- Alcohol, which is the most widely abused substance, is the hardest to detect due to its short half-life.
- A patient who knows they will be tested may delay access to care because of fear of potential repercussions.
- False positive results can be devastating for a drug-free patient.
- Blood tests usually only identify those patients with long-term use in whom secondary symptoms have occurred, e.g. liver function tests.
- Patients may avoid detection by abstaining for one to three days prior to testing, substituting urine samples, or increasing oral beverage intake just before the testing to dilute the urine.

### **What Are the Indicators for Testing?**

Some risk indicators are more indicative of substance use than others. If positive risk indicators are identified at any time, rule out other identifiable causes, re-screen, test, or provide assessment as appropriate.

### **What Are High Risk Factors?**

- Little or no medical care.
- Inappropriate behavior (e.g. disorientation, somnolence, loose associations, unfocused anger).
- Physical signs of substance abuse or withdrawal.
- Smell of alcohol and/or chemicals.
- Recent history of substance abuse or treatment.

## **What Are the Risk Factors Requiring Further Assessment Before Fluids Toxicology Testing?**

- History of physical abuse or neglect.
- Intimate partner violence.
- Mental illness.

## **What Are the Signs and Symptoms of Substance Abuse?**

Because of the frequency of complications seen in patients with drug use disorders, it is important that the clinician be alert for clinical and historical cues that may indicate the possibility of misuse. Based on clinical observation, laboratory testing for substance misuse may be indicated in order to provide information for the health care of the patient.

### ***Behavior Patterns***

- Sedation
- Inebriation
- Euphoria
- Agitation
- Disorientation
- Prescription drug seeking behavior
- Suicidal ideations/attempt

### ***Medical History***

- Frequent hospitalizations
- Gunshot/knife wound
- Unusual infections
- Cirrhosis
- Hepatitis
- Pancreatitis
- Diabetes
- Frequent falls, unexplained bruises
- Chronic mental illness

### ***Physical Signs***

- Dilated or constricted pupils
- Tremors
- Track marks or abscesses/injection sites
- Inflamed/eroded nasal mucosa
- Increased pulse and blood pressure
- Hallucinations
- Nystagmus

### ***Laboratory***

- Elevated MCH, GGT, SGOT, Bilirubin, Triglycerides
- Anemia
- Positive urine toxicology for drugs
- MCV over 95

## **Preventing Further Harm**

Praise any reduction in use. Though drug/alcohol abstinence is the goal, any steps made toward reducing use and/or harmful consequences related to use are very important.

When abstinence is not possible, harm reduction assists a patient to take steps to reduce use and harm to themselves.

### **Strategies for Preventing Further Harm**

- Evaluate and refer for underlying problems.
- Encourage the patient to keep track of substance use.
- Decrease use:
  - Reduce dosage and frequency of use.
  - Recommend reducing their use by one-half each day; if this is not possible, any decrease in use is beneficial.
  - Intersperse use with periods of abstinence.
  - Use a safer route of drug administration.
  - Find a substitute for the substance.
- Avoid friends who use.

## Appendix A: Screening Tools for Drugs and Alcohol

**CAGE** (American Society of Addiction Medicine. Questions to Ask Patients pocket card, 2001. <http://www.asam.org/>)

1. Have you ever felt you should **C**ut down on your drinking or drug use?
2. Have people **A**nnoyed you by criticizing or complaining about your drinking or drug use?
3. Have you ever felt bad or **G**uilty about your drinking or drug use?
4. Have you ever had a drink or drug in the morning (**E**ye Opener) to steady your nerves or to get rid of a hangover?

A person who answers "yes," "sometimes," or "often" to two or more of the questions may have a problem with alcohol and/or drugs and should be referred for a chemical dependency assessment.

**UNCOPE** (Norman Hoffman, Ph.D)

- U** In the past year, have you ever drank or **used** drugs more than you meant to? Or—Have you spent more time drinking or using than you intended to?
- N** Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?
- C** Have you ever felt you wanted or needed to **cut down** on your drinking or drug use in the last year?
- O** Has anyone **objected** to your drinking or drug use? Or—Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?
- P** Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs? Or—Have you found yourself thinking a lot about drinking or using?
- E** Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?

**Two (2)** positive responses indicate a strong likelihood of an alcohol and/or drug abuse problem and should be referred for a chemical dependency assessment.

**Four (4) or more** positive responses strongly indicate an alcohol and/or drug dependence problem and should be referred for a chemical dependency assessment.

**AUDIT** [Sanders JB, et al. 1993. Development of the Alcohol Use Disorders Identification Test (AUDIT) *Addiction* 88(6)]

**Patients :** Because alcohol use can affect your health and interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Circle only one answer for each question.

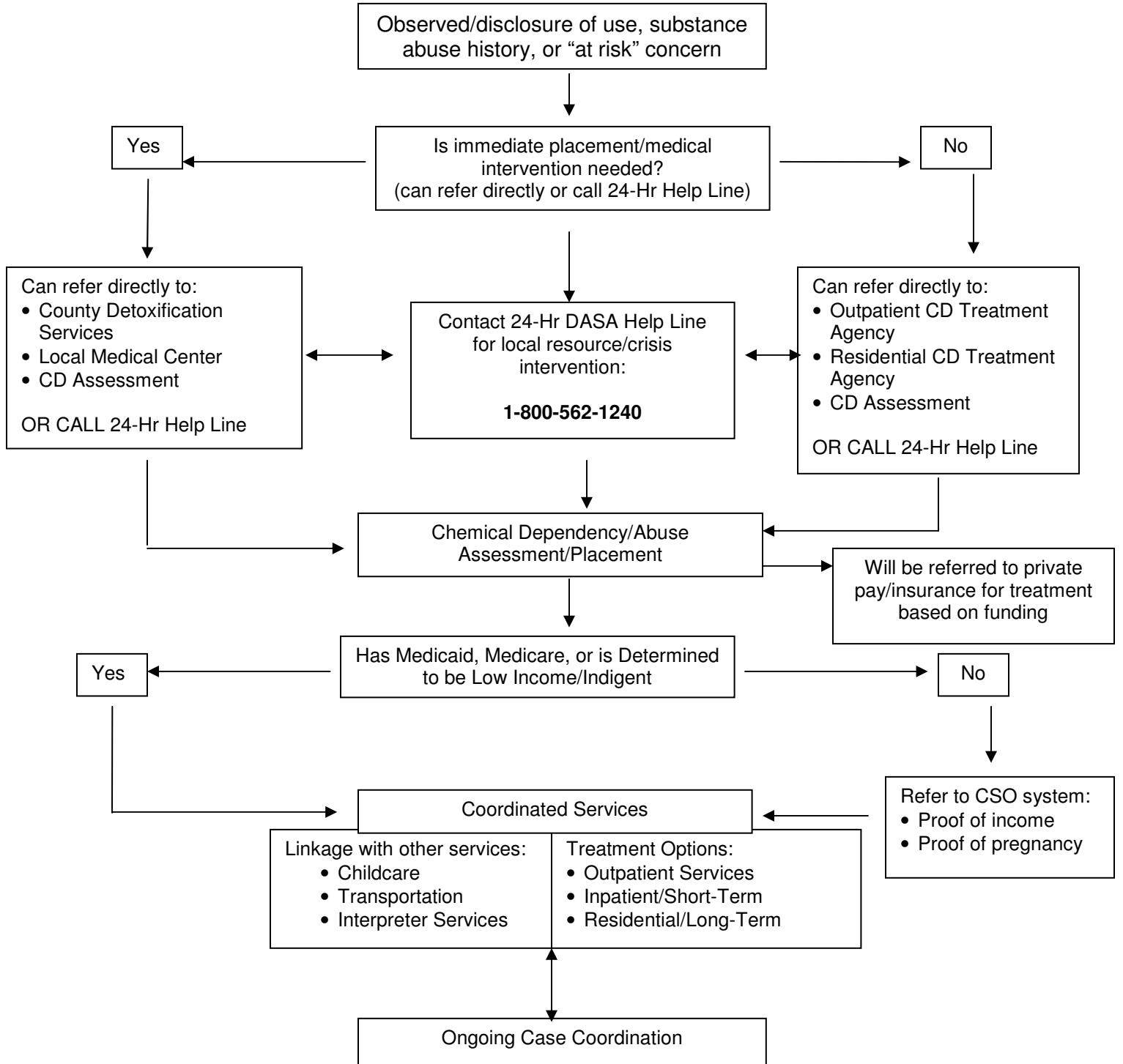
1. How often do you have a drink containing alcohol?
  - (0) Never
  - (1) Monthly
  - (2) 2-4 times a month
  - (3) 2-3 times a week
  - (4) 4 or more times a week
  
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
  - (0) 1-2
  - (1) 3-4
  - (2) 5-6
  - (3) 7-9
  - (4) 10 or more
  
3. How often do you have six or more drinks on one occasion?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily
  
4. How often during the last year have you found that you were unable to stop drinking once you started?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily
  
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily
  
7. How often during the last year have you felt guilt or remorse after drinking?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily
  
8. How often during the last year have you been unable to remember what happened the night before because of drinking?
  - (0) Never
  - (1) Less than monthly
  - (2) Monthly
  - (3) Weekly
  - (4) Daily or almost daily
  
9. Have you or someone else been injured as a result of your drinking?
  - (0) No
  - (1) Yes, but not in the last year
  - (2) Yes, during the last year
  
10. Has a friend, relative, doctor, or other health worker been concerned about your drinking or suggested you cut down?
  - (0) No
  - (1) Yes, but not in the last year
  - (2) Yes, during the last year

Total the numbers of all the circled answers. A score of eight or more is considered a positive screen and should be referred for a chemical dependency assessment.

**Appendix B: Treatment Access Flow Chart**

**CHEMICAL DEPENDENCY/ABUSE  
TREATMENT ACCESS FLOW CHART**





## Appendix C: Definition of Services

**Alcohol/Drug 24-hour Help Line:** Confidential 24-hour statewide telephone service to assist with alcohol/drug-related crisis intervention, guidance, information, and referrals to community resources.

**Chemical Dependency Treatment Agency:** Chemical dependency treatment services certified by DSHS's Division of Alcohol and Substance Abuse (DASA), listed in DASA's service directory.

**Chemical Dependency/Abuse Assessment:** Diagnostic services to determine a person's involvement with alcohol and other drugs and to recommend a course of action.

**Community Service Systems:** Statewide Community Services Office or access points that provide financial, medical, and food assistance to eligible patients. Assist with eligibility for Medical ID cards and referrals to other community programs and resources.

**Detoxification Services:** Assists patients in withdrawing from drugs, including alcohol.

- **Acute Detox:** Medical care and physician supervision for withdrawal from alcohol and other drugs.
- **Sub-Acute Detox:** Non-medical detoxification or patient self-administration of withdrawal medications ordered by a physician and provided in a home-like environment.

**Intensive Inpatient Treatment:** Residential inpatient primary alcohol/drug treatment program in a facility up to a 30-day stay. A concentrated intervention program that consists of therapy, education, and activities for detoxified alcoholics and addicts and their families. Development of community support systems and referrals.

**Outpatient Treatment:** Individual and group treatment services of varied duration and intensity for chemically dependent patients less than 24 hours per day in a non-residential setting.

- **Intensive Outpatient Treatment:** A concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families.
- **Outpatient Treatment:** Individual and group treatment services of varying duration and intensity according to a prescribed plan.

**Residential/Long Term Treatment:** Chemical dependency residential treatment program with personal care services for individuals with chronic histories of addiction and impaired self-maintenance capabilities. Long-term services are provided up to 180 days.

## Appendix D: Statewide and National Resources

### ***Alcohol/Drug 24-hour Help Line–1-800-562-1240***

Provides statewide referral information about treatment, counseling, and support services by county and city for teens and adults. Assistance for providers and patients.

### ***Teen Line–1-800-562-1240***

Assists providers, teens, and parents in statewide referrals and information related to chemical dependency, rape, and other issues. Volunteer teen counselors Monday-Friday, 4-8 p.m., as available.

### ***Washington State Alcohol Drug Clearinghouse–1-800-662-9111***

Provides continually-updated substance abuse information for youth and adults free of charge, such as printed brochures and posters, research publications, and videos.

### ***Alcohol/Drug Help Line Domestic Violence Outreach Project–1-800-652-1240***

Information about programs in Washington State addressing both domestic violence and chemical dependency.

### ***Washington State Division of Alcohol and Substance Abuse–1-877-307-4557***

Information related to DSHS-supported alcohol and drug treatment programs.

### ***Ending Discrimination Against People with Alcohol or Other Drug***

***Problems***–<http://www.jointogether.org/sa/files/pdf/discrimination.pdf>

### ***Doctors Ought To Care (DOC)–http://www.bcm.edu/doc/***

DOC, a membership organization, was founded in 1977 by a family physician to challenge the growing use and promotion of tobacco and alcohol products among adolescents.

### ***Join Together Online–www.jointogether.org***

A searchable database of alcohol, tobacco, and other drug information and news.

### ***Fetal Alcohol Spectrum Disorders Washington–www.fasdwa.org***

A Website for information in Washington State and nationwide on Fetal Alcohol Spectrum Disorders (FASD).

### ***National Institute on Alcohol Abuse and Alcoholism–http://www.niaaa.nih.gov/***

*A Clinician's Guide: Helping Patients Who Drink Too Much*, 2005 Edition.

### ***AlcoholScreening.org–http://www.alcoholscreening.org/***

This site has a self-initiated substance abuse screening tool that patients can use in the privacy of their own home.

## Appendix E: Alcohol and Drug County Coordinators

### **ADAMS COUNTY**

Kate Brueske (509) 488-5611

### **ASOTIN COUNTY**

Sherry Crawford (509) 758-9842

### **BENTON/FRANKLIN COUNTIES**

Dave Hopper (509) 783-5284

### **CHELAN/DOUGLAS COUNTIES**

Loretta Stover (509) 662-9673

### **CLALLAM COUNTY**

Florence Bucierka (360) 417-2366

### **CLARK COUNTY**

Cleve Thompson (360) 397-2130, Ext. 7823

### **COLUMBIA COUNTY**

(509) 382-4541

### **COWLITZ COUNTY**

Ronald Blake (360) 501-1212

### **DOUGLAS COUNTY**

(See Chelan County)

### **FERRY COUNTY**

Robert Schwartz (509) 775-3341

### **FRANKLIN COUNTY**

(See Benton County)

### **GARFIELD COUNTY**

Gayle Fleming (509) 843-3791

### **GRANT COUNTY**

Jennifer Lane (509) 765-5402

### **GRAYS HARBOR COUNTY**

Vera Kalkwarf (360) 532-8665, Ext. 284

### **ISLAND COUNTY**

Jackie Henderson (360) 678-7881

### **JEFFERSON COUNTY**

Ford Kessler (360) 385-3866

### **KING COUNTY**

Jim Vollendroff (206) 205-1312

### **KITSAP COUNTY**

Betsy Bosch (360) 337-4880

### **KITTITAS COUNTY**

Skip Mynar (509) 925-9821

### **KLICKITAT COUNTY**

Dena Kline (509) 493-1927, Ext. 2307

### **LEWIS COUNTY**

Holli Spanski (360) 740-1418

### **LINCOLN COUNTY**

Dan Pitman (509) 725-2111

### **MASON COUNTY**

(See Thurston County)

### **OKANOGAN COUNTY**

Roger Bauer (509) 826-6191

### **PACIFIC COUNTY**

Kevin Beck (360) 875-9343

### **PEND OREILLE COUNTY**

Steve Patton (509) 447-5651

### **PIERCE COUNTY**

Penni Newman (253) 798-6127

### **SAN JUAN COUNTY**

Barbara LaBrash Eastsound (360) 376-6242 or

Friday Harbor (360) 378-4474

### **SKAGIT COUNTY**

Maile Acoba (360) 336-9395

### **SKAMANIA COUNTY**

Richard Jessel (509) 427-9488

### **SNOHOMISH COUNTY**

Cammy Hart-Anderson (425) 388-7233

### **SPOKANE COUNTY**

Dan Finn (509) 477-4507

### **STEVENS COUNTY**

KayDee Steele (509) 684-4597

### **THURSTON/MASON COUNTIES**

Donna Bosworth (360) 786-5585, Ext. 17234#

### **WAHKIAKUM COUNTY**

Joell England (360) 795-8630

### **WALLA WALLA COUNTY**

Sharon Saffer (509) 527-3278

### **WHATCOM COUNTY**

Jackie Mitchell (360) 738-2504, Ext. 32017, or

(360) 676-6829

### **WHITMAN COUNTY**

Mike Berney (509) 334-1133

### **YAKIMA COUNTY**

Brian Hunt (509) 574-2749

## Appendix F: Native American Treatment Providers

### American Indian Community Center, AICC

Sophie Tonasket (509) 535-0886

### Chehalis Confederated Tribes

Gayle McCormick (360) 273-5595

### Chinook Indian Tribe

Penny Harris (360) 533-1093

### Confederated Tribes of the Colville Reservation\*

Tina Lussier (509) 634-2600

### Cowlitz Tribe\*

Jim Sherrill (360) 575-8276

### Duwamish Tribe

Cecile Hansen (206) 431-1582

### Healing Lodge of the Seven Nations\*

Louella Heavy Runner (509) 533-6910

### Hoh Indian Tribe

James Jamie (360) 374-6582

### Jamestown S'Klallam Tribe\*

Liz Mueller (360) 681-4628

### Kalispel Tribe of Indians

Bob Russell (509) 445-1147

### Lower Elwha Klallam\*

Dan Cable (360) 452-4432

### Lummi Nation\*

Adrienne Hunter (360) 360-0464

### Makah Tribe\*

Larry King (360) 645-3014

### Muckleshoot Tribal\*

Nancy Mellor (253) 804-8752

### N.A.T.I.V.E. Project\*

Toni Lodge (509) 325-5502

### Nisqually Indian Tribe\*

Linda Kramer (360) 459-5312 Ext. 133

### Nooksack Tribe's Genesis II\*

Peter Joseph (360) 966-7704

### NW Indian College

Cheryl Crazy-Bull (360) 676-2772 Ext. 4248

### NW Indian Treatment Center\*

June O'Brien (360) 482-2674

### Port Gamble S'Klallam Tribe\*

Dan Brewer (360) 297-9673

### Puyallup Tribe\*

Nancy Meyer (253) 593-0234

### Quileute Tribe

Shirley Anderson (360) 374-4109

### Quinault Indian Nation\*

Dave Hagen (360) 276-8211

### Samish Tribe

Leslie Eastwood (360) 293-6405

### Sauk-Suiattle Tribe

Norma Joseph (360) 436-1124

### Seattle Indian Health Board\*

Al Sweeten (206) 324-9360 ext: 201

### Shoalwater Bay Indian Tribe\*

Gary Hill (360) 267-6766 Ext. 125

### Skokomish Indian Tribe\*

Carlos Arroyo (360) 426-7788

### Small Tribes of Western Washington

Don Milligan (253) 589-7101 Ext. 236

### Snoqualmie Tribe\*

Marie Ramirez (425) 222-6900

### South Puget Intertribal Planning Agency (SPIPA)

Amadeo Tiam (360) 426-3990

### Spokane Tribe of Indians\*

Charlene Hayes (509) 258-7502 or 1-800-789-4282  
ext: 18

### Squaxin Island Tribe\*

Whitney Jones (360) 427-9006

### Steilacoom Tribe

Danny Marshall (253) 584-6308

### Stillaguamish Tribe\*

Tom Ashley (360) 435-9338 Ext: 11

### Suquamish Tribe\*

Chuck Wagner (360) 394-5200

### Swinomish Tribal Community

Kip Lewis (360) 466-7233

### Tulalip Tribes\*

Gayle Jones (360) 651-4408

### United Indians of All Tribes Foundation\*

John Lawson (206) 325-0070, Ext. 201

### Upper Skagit Tribe

Susan Dunthorne (360) 856-5501

### Confederated Tribes of Yakama Nation\*

Oscar Olney (509) 865-5121 Ext. 4519

## **Appendix G: INVOLUNTARY COMMITMENT INFORMATION**

Revised Code of Washington 70.96A.140 authorizes a designated county chemical dependency specialist to investigate and evaluate specific facts alleging that a person is incapacitated as a result of chemical dependency. If the designated chemical dependency specialist determines that the facts are reliable and credible, the specialist may file a petition for commitment of such a person with the superior or district court.

Each county has been asked to designate chemical dependency specialists to carry out the duties mentioned above. To find who the designated specialists are in a specific county or for additional information, you may call the Alcohol and Drug County Coordinator listed in Appendix E.