The 2003 Washington State Needs Assessment Household Survey

State Report

Substance Use, Substance Use Disorders, and Need for Treatment in Washington State

SEPTEMBER 2005

4.52.40

This report provides detailed estimates of substance use, the need for substance abuse treatment, and use of substance abuse treatment services in Washington State.

AUTHORS

David Mancuso, Ph.D.
Michael Gilson, Ph.D.
Barbara Felver

We would also like to acknowledge the following individuals for their many contributions:

Kenneth D. Stark, Director, Division of Alcohol and Substance Abuse
Antoinette Krupski, Ph.D., Division of Alcohol and Substance Abuse
Elizabeth Kohlenberg, Ph.D., Director, Division of Research and Data Analysis
Sharon Estee, Ph.D., Division of Research and Data Analysis

And also the following:

David Albert
Thom Allen
Ray Antonsen
Håkan Axelsson
Jim Friedman
Harvey Funai
Fred Garcia
Ella Hanks
Dick Jones
Sandra Mena
John Tarnai, Ph.D.
John Taylor

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RDA conducts evaluation and program research for the Washington State Department of Social and Health Services from the department's central headquarters in Olympia, Washington.

Electronic copies of this report, county reports, and supplemental tables can be obtained from the RDA website at: http://www1.dshs.wa.gov/rda/research/4/52/

Or from the DASA website: http://www1.dshs.wa.gov/dasa/

For additional copies of this report contact:

The Washington State Alcohol/Drug Clearinghouse
6535 Fifth Place South
Seattle, Washington 98108-0243
1.800.662.9111
206.725.9696 *(within Seattle or outside Washington State)*
clearinghouse@adhl.org (e-mail)

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2003 NEEDS ASSESSMENT

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Washington State
Department of Social
& Health Services

Research & Data Analysis
Division

Executive Summary: Findings From the 2003 Washington State Needs Assessment Household Survey

WASHINGTON STATE's Needs Assessment Household Survey project interviewed 6,713 adults to estimate the prevalence of substance use and the need for substance abuse treatment among adult household residents. The 2003 survey estimates update findings from a similar survey conducted 10 years ago. Detailed reports for each of Washington's 39 counties and supplemental tables are available separately. All reports can be accessed at: www1.dshs.wa.gov/rda/research/4/52 or at www1.dshs.wa.gov/dasa/. Key findings from the 2003 survey are presented below.

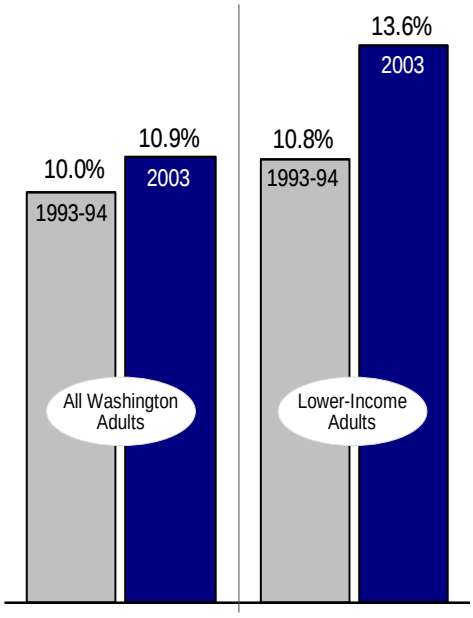
2003 SURVEY ESTIMATES

HIGHLIGHTS | Treatment Need and Treatment Penetration

Need for treatment has increased since 1993-94

- **One in ten adult household residents needs substance abuse treatment** (10.9 percent). A decade ago, the estimate was 10.0 percent.
- **Need for treatment has increased among lower-income adults.** In 2003, 13.6 percent of adults living at or below 200 percent of the federal poverty level need substance abuse treatment, compared to 10.8 percent of lower-income adults in 1993-94.
- **Need for treatment has increased among Hispanics** (12.6 percent) **and Asians** (4.9 percent) compared with 1993-94 rates (7.7 percent and 2.2 percent, respectively).

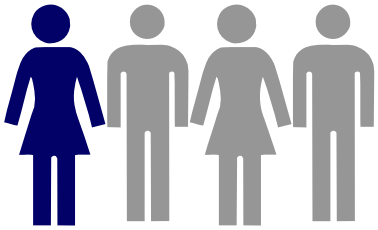
Need for Substance Abuse Treatment
TEN YEAR CHANGE



Most adults who need substance abuse treatment do not receive it

- **The 2003 treatment penetration rate among adults eligible for state-funded treatment is 26.2 percent.** That is, roughly 1 out of 4 adults eligible for DASA-funded treatment actually receives treatment.

One in Four Receives Treatment
WASHINGTON STATE, 2003



David Mancuso, Ph.D.
Michael Gilson, Ph.D.
Barbara Felver, MES, MPA

In collaboration with

Division of Alcohol and Substance Abuse

Kenneth D. Stark, Director
Antoinette Krupski, Ph.D.

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The survey was carried out by the DSHS Division of Research & Data Analysis on behalf of DASA.

The full report, county reports, and supplemental tables are available at:

www1.dshs.wa.gov/rda/research/4/52/

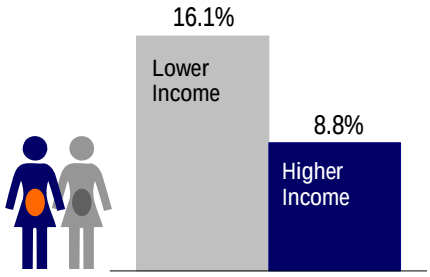
www1.dshs.wa.gov/dasa/

HIGHLIGHTS | Pregnant Women and Substance Use

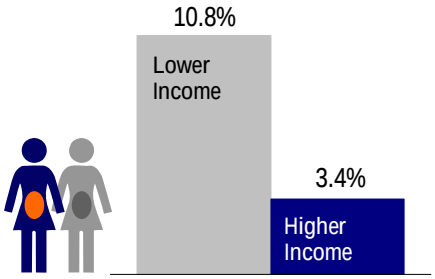
Lower-income pregnant women face greater risks

- **Lower-income pregnant women were twice as likely to use an illicit drug during the past year** (11.4 percent) compared to higher-income pregnant women (5.7 percent).
- **Lower-income pregnant women were twice as likely to drink alcohol in the past month** (16.1 percent) compared to higher-income pregnant women (8.8 percent).
- **Need for substance abuse treatment is three times as likely among lower-income pregnant women** (10.8 percent), compared to higher-income pregnant women (3.4 percent).
- **Lower-income pregnant women were more than twice as likely to smoke cigarettes during the past month** (24.7 percent) compared to higher-income pregnant women (11.9 percent).

Past Month Drinking by Pregnant Women
WASHINGTON STATE, 2003



Need for Treatment Among Pregnant Women
WASHINGTON STATE, 2003



HIGHLIGHTS | Need for Treatment Varies by Race/Ethnicity

- Compared to other racial and ethnic groups, **need for substance abuse treatment is highest among American Indian/Alaska Natives and multi-race adults** (15.8 percent and 16.2 percent, respectively). Need for treatment is lowest among Asians (4.9 percent).

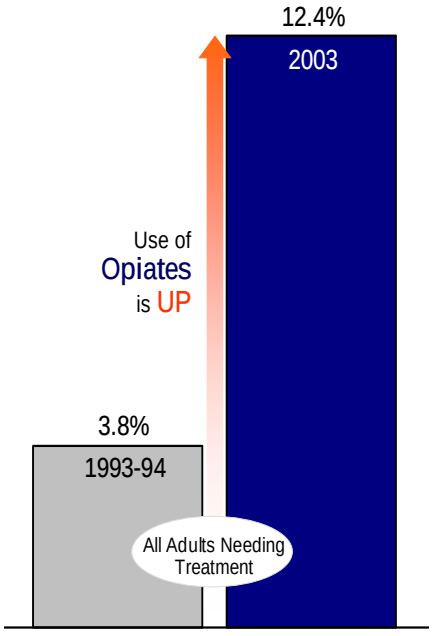
HIGHLIGHTS | Non-Heroin Opiate Use

Use of Non-Heroin Opiates Has Increased

Illicit use of non-heroin prescription opiates (e.g. Oxycontin) represents a growing problem:

- **Past year use of opiates other than heroin (2.0 percent) and sedatives** (1.5 percent) has **increased** from 1993-94 levels (0.5 percent and 0.6 percent, respectively).
- Among illicit drugs, **the prevalence of past year non-heroin opiate use trails only marijuana use** (7.4 percent).
- **Non-heroin opiate use is more common among lower-income adults** (3.0 percent) than higher-income adults (1.7 percent).
- **Adults who need treatment are now more likely to have used non-heroin opiates during the past year** (12.4 percent), compared to 1993-94 (3.8 percent).

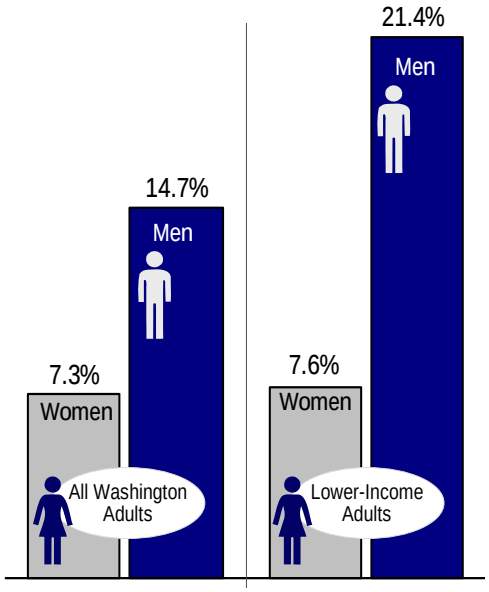
Illicit Use of Non-Heroin Opiates Among Adults Who Need Treatment
WASHINGTON STATE, 2003



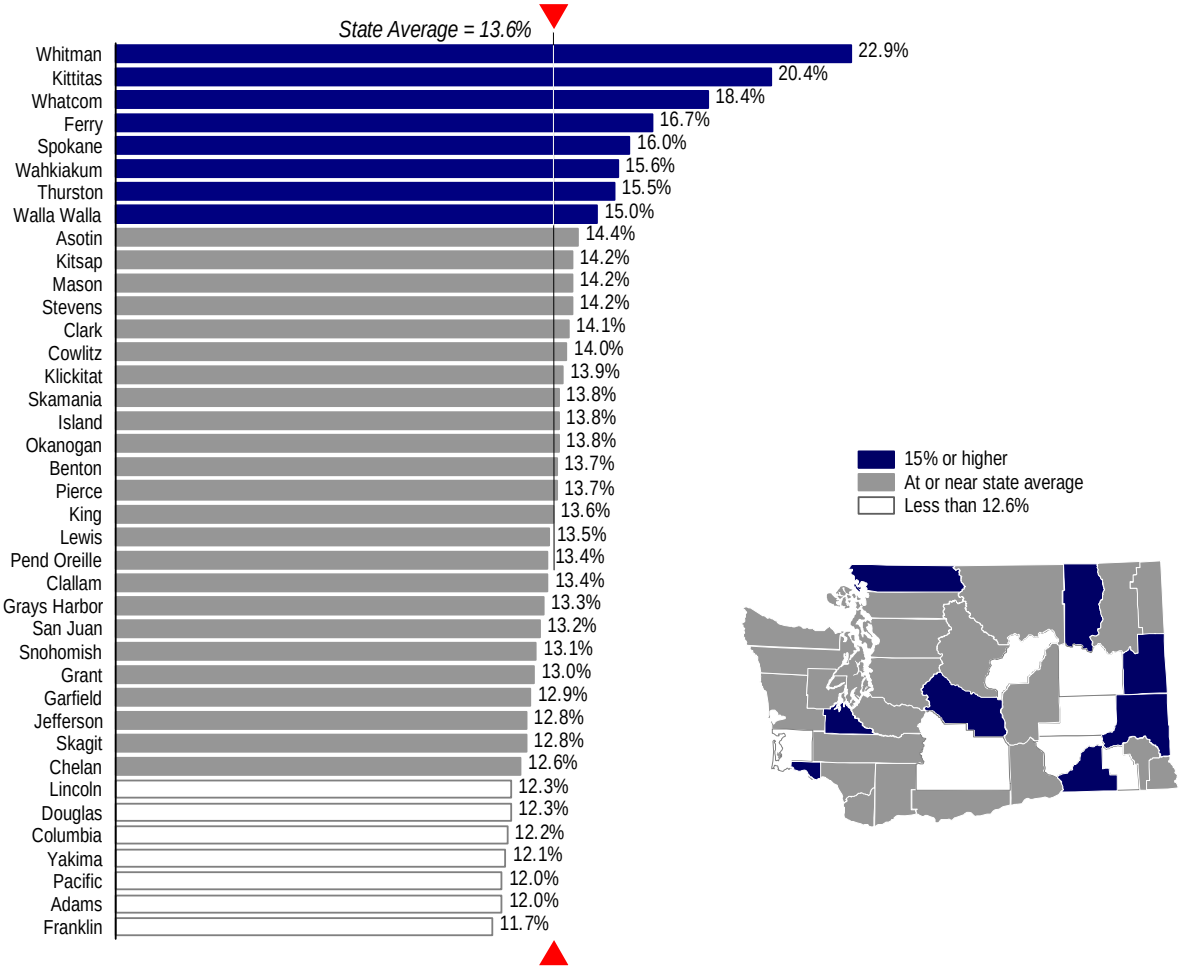
KEY FINDINGS | Need for Substance Abuse Treatment

- **Overall, men are twice as likely to need substance abuse treatment** (14.7 percent) compared to women (7.3 percent).
- **Among lower-income adults, men are nearly three times as likely to need substance abuse treatment** (21.4 percent) compared to lower-income women (7.6 percent).
- **Despite an overall increase in need for substance abuse treatment among lower-income adults, the relationship among counties has changed little over the past 10 years.** The correlation between 2003 and 1993-94 county need for treatment estimates is 91 percent.
- **Need for treatment is highest in Whitman** (22.9 percent), Kittitas (20.4 percent), **and Whatcom** (18.4 percent) **counties.** Need is higher in these counties because they have a relatively high proportion of young adults (each of the three counties is home to a major university) and need for treatment is higher among younger adults.
- **24 of 39 counties are within one percent of the state average** (13.6 percent).

Need for Treatment Higher Among Men
WASHINGTON STATE, 2003



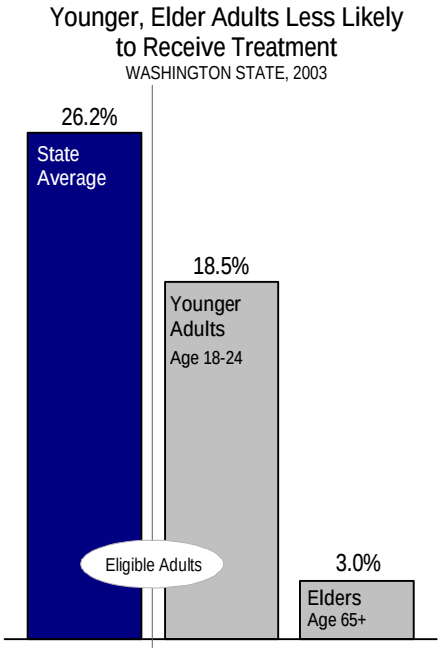
2003 County Need for Treatment Estimates – Lower-Income Adults

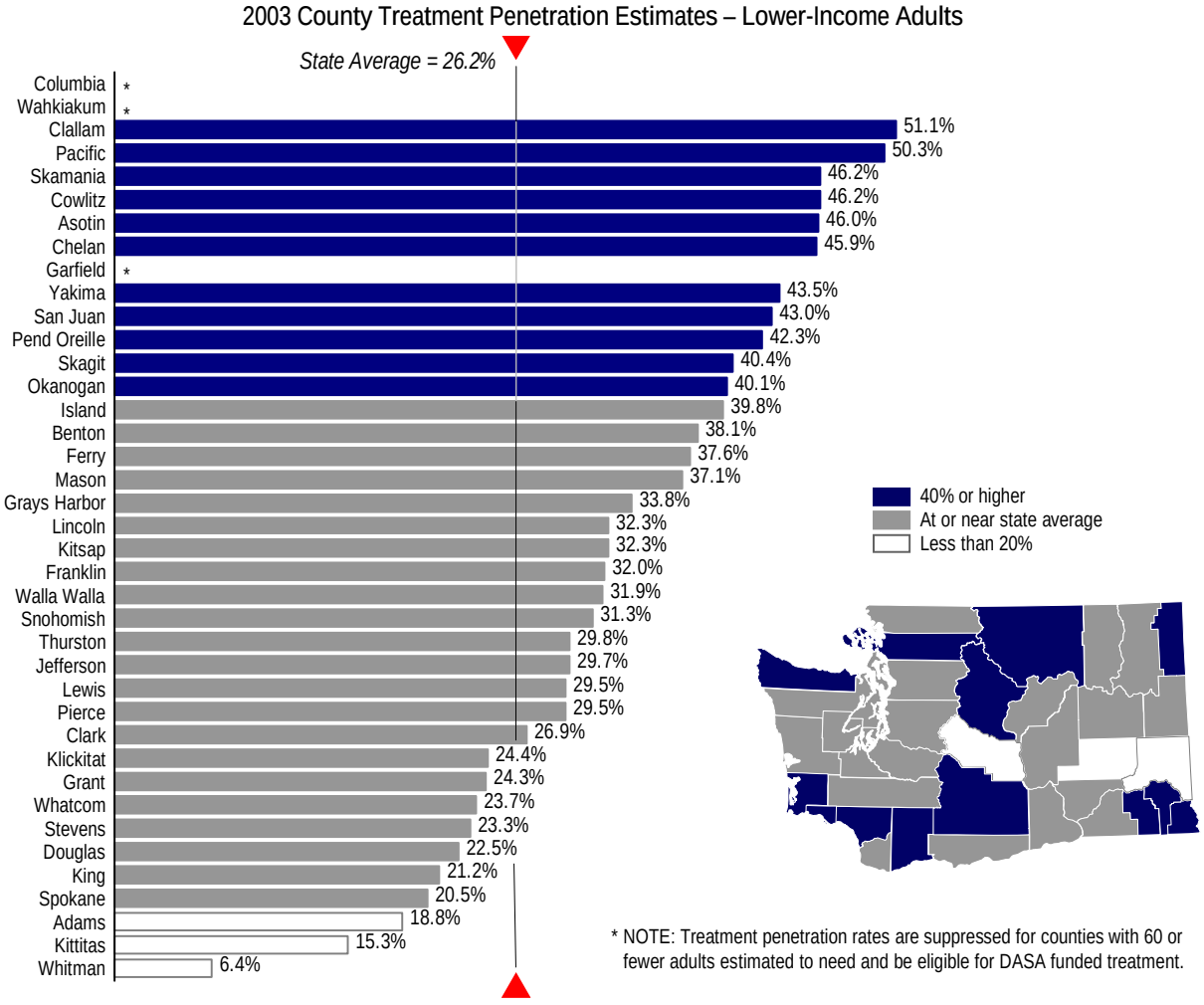


KEY FINDINGS | Treatment Penetration Rates

NOTE: Information from the Treatment and Assessment Report Generation Tool (TARGET) was used to estimate treatment penetration among lower-income adults eligible for DASA-funded treatment.

- **Treatment penetration varies considerably by age, with older adults least likely to receive needed treatment.** The treatment penetration rate among adults aged 65 and older is only 3 percent.
- **Treatment penetration is lower among Native Hawaiian or Other Pacific Islander adults (20.1 percent) and Asians (20.2 percent).** Penetration rates are higher for African Americans (36.8 percent) and American Indians or Alaska Natives (31.7 percent).
- **Higher-income adults who need treatment are less likely to receive treatment than lower-income adults.**





* NOTE: Treatment penetration rates are suppressed for counties with 60 or fewer adults estimated to need and be eligible for DASA funded treatment.

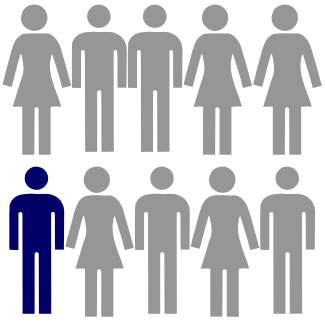
KEY FINDINGS | Illicit Drug Use

- **1 in 10 adults used an illicit substance during the past year** (9.6 percent). Marijuana (7.4 percent) and opiates other than heroin (2.0 percent) are the two most frequently used illicit drugs.
- **Nearly 1 in 4 adults aged 18 to 24 used an illicit substance during the past year** (23.8 percent).
- **Past year illicit drug use among Hispanics** (11.0 percent) **increased to nearly twice the 1993-94 rate** (5.6 percent).

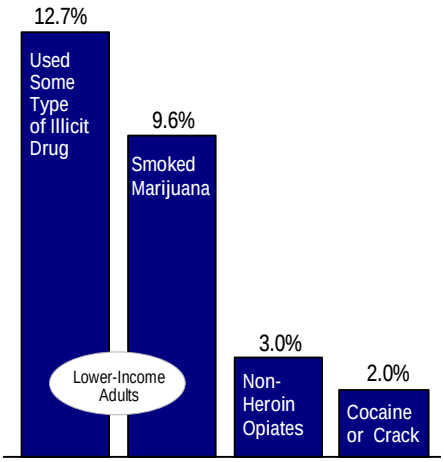
Illicit drug use is higher among lower-income adults

- **Past year use of any illicit drug is higher among lower-income adults** (12.7 percent), compared to higher income adults (8.7 percent). This is an increase over the 1993-94 estimate (10.1 percent).
- **Marijuana** (9.6 percent) **is the substance most commonly used by lower-income adults in the past year** followed by non-heroin opiates (3.0 percent) and cocaine (2.0 percent).
- Among lower-income adults, **American Indian and Alaska Natives** (16.5 percent) **and adults reporting two or more races** (22.9 percent) are most likely to have used an illicit drug during the past year. Asians (3.6 percent) are least likely to have used an illicit substance during the past year.

1 in 10 Used Illicit Drugs in Past Year
WASHINGTON STATE, 2003



Past Year Illicit Drug Use
Among Lower-Income Adults
WASHINGTON STATE, 2003



DEFINITIONS

Types of Illicit Drugs

Marijuana: Mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant, *Cannabis sativa*. The primary psychoactive ingredient in marijuana is delta-9-tetrahydrocannabinol (THC).

Cocaine or Crack: A white crystalline powder, the principle alkaloid in the leaves of *Erythroxylon coca*. Cocaine is a powerful central nervous system stimulant. Crack is the freebase form of cocaine.

Stimulants: Increases alertness and physical activity – more widely used are methamphetamines and amphetamines, but methylphenidate (Ritalin) is also a concern. Cocaine is presented separately in this report.

Hallucinogens: Among the oldest known group of drugs used for their ability to alter human perception and mood. Hallucinogenic agents include mushrooms, LSD, Ecstasy (MDMA), PCP, Mescaline, and Peyote.

Heroin: A highly addictive opiate processed from morphine, derived from the resin of the poppy plant.

Non-Heroin Opiates: A broad class of drugs that includes morphine, codeine, and semi-synthetic derivatives of morphine – percocet, percodan, Demerol, methadone, Vicodin, and Oxycontin. *Presented separately from heroin in this report.*

Tranquilizer: A class of drugs that slows the central nervous system. The active chemical is some form of benzodiazepine or meprobamate. Common tranquilizers include Valium, Xanax, Rohypnol, and Librium.

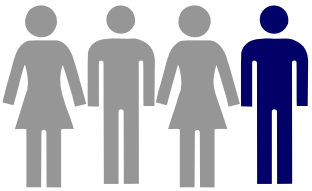
Sedatives: Depresses the central nervous system and may also have effects on cognitive and motor functions; includes barbiturates and methaqualone.

Inhalants: Refers to a diverse group of substances that includes volatile solvents, gases, and nitrites that are sniffed, snorted, huffed, or bagged to produce intoxicating effects.

KEY FINDINGS | Alcohol Use

- **Past year use of alcohol is more common among higher-income adults** (77.5 percent) compared to lower-income adults (58.4 percent).
- **3 out of 4 adults** (72.9 percent) **drank alcohol during the past year; 1 in 4** (25.9 percent) **adults engaged in binge drinking during the past year** (see box below). Lower-income adults were twice as likely to have engaged in "bender" drinking in their lifetime (10 percent vs. 5 percent).

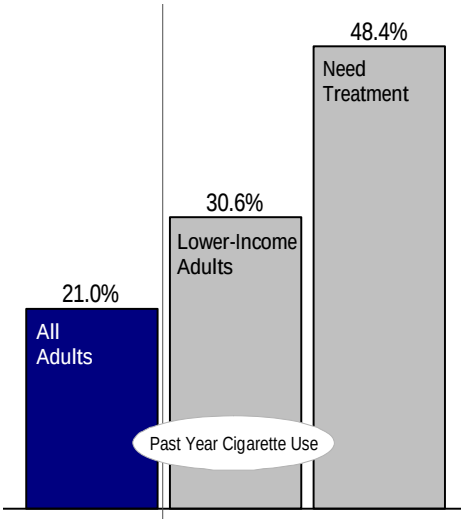
One in Four Binge Drank in Past Year
WASHINGTON STATE, 2003



KEY FINDINGS | Tobacco Use

- **1 out of 5 adults** (21.0 percent) **smoked cigarettes during the past year.**
- **Past year cigarette use is more common among lower-income adults** (30.6 percent), **compared to higher-income adults** (17.9 percent).
- **1 in 10 lower-income adults is a current "heavy smoker"** (9.4 percent). Heavy smokers smoked a pack of cigarettes or more per day during the past month.
- **Past year cigarette use is more common among American Indian and Alaska Natives** (41.2 percent) **and among multi-race adults** (33.2 percent). Past year cigarette use is lowest among Asians (12.5 percent).
- **Past-year cigarette smoking is more common among adults needing substance abuse treatment** (48.4 percent) compared to those who do not (17.6 percent).

Smoking Higher Among Low-Income Adults and Adults Needing Treatment
WASHINGTON STATE, 2003



DEFINITIONS

What is a binge? What is a bender?

BINGE DRINKING – The term "binge drinking" refers to the consumption of five or more drinks on the same day for men or four or more drinks on the same day for women.

A standard "drink" is defined as:

- A shot of hard liquor
- A 5 ounce glass of wine
- A 12 ounce can of beer

The binge drinking definition is intended to measure the consumption of a sufficient amount of alcohol to place the drinker at increased risk of experiencing alcohol-related problems and to place others at risk of experiencing secondhand effects.

Gender-specific cut points are used to account for gender differences in problem levels of alcohol consumption. Research consistently demonstrates that women experience alcohol-related problems at lower drink levels than do men even after controlling for body mass differences. This measure is used extensively in population-based research including in the National Survey on Drug Use and Health (NSDUH).

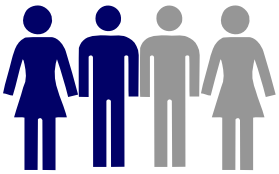
BENDER DRINKING – The term "bender drinking" refers to a prolonged period of intoxication or excessive heavy drinking that can last for days or weeks.

Respondents who endorsed the following survey item were defined as engaging in bender drinking: "Have you ever gone on binges where you kept drinking for a couple of days or more without sobering up?"

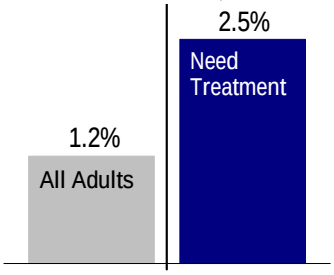
KEY FINDINGS | Gambling

- **More than half of all adults** (54 percent) **gambled for money during the past year.** Higher-income adults are more likely to have gambled (57 percent) than lower-income adults (43 percent).
- **Problem or pathological gambling** (see box below) **is more than twice as common among adults needing substance abuse treatment** (2.5 percent) compared to the state average (1.2 percent).
- **Lower-income adults were more likely to have a pathological gambling symptom** (4.6 percent) compared to higher-income adults (3.7 percent).
- **Problem gambling varies by race.** For lower-income adults, American Indian and Alaska Natives (3.3 percent) and Native Hawaiian or Other Pacific Islanders (3.5 percent) were more likely to be problem or pathological gamblers. Asians (0.8 percent), Whites (1.0 percent), and Hispanics (1.1 percent) were less likely to be problem or pathological gamblers.

Half of All Adults Gambled for Money in the Past Year
WASHINGTON STATE, 2003



Problem and Pathological Gambling Higher Among Adults Who Need Treatment
WASHINGTON STATE, 2003



DEFINITIONS

Who is a "Pathological" Gambler?

A Pathological Gambler is defined under the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) as a person who exhibits persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

- Preoccupied with gambling. Preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble.
- Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
- Repeated unsuccessful efforts to control, cut back, or stop gambling.
- Restless or irritable when attempting to cut down or stop gambling.
- Gambles as a way of escaping from problems or of relieving a dysphoric mood. This may include feelings of helplessness, guilt, anxiety, or depression.
- After losing money gambling, often returns another day to get even ("chasing" one's losses).
- Lies to family members, therapist, or others to conceal the extent of involvement with gambling.
- Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling.
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- Relies on others to provide money to relieve a desperate financial situation caused by gambling.

Under DSM-IV, this gambling behavior is not better accounted for by a Manic Episode.

Measuring Problem Gambling

Definitions of "at risk," "problem," and "pathological" gambling are based on the DSM-IV.* These are the accepted standards by which substance use and gambling disorders are measured. WANAHS measured DSM-IV problem gambling symptoms using the National Opinion Research Center (NORC) DSM Screen for Gambling Problems (NODS). We use the following definitions:

AT RISK – Persons reporting one or two DSM-IV gambling symptoms are classified as gamblers "at-risk" of developing problem or pathological symptoms.

PROBLEM – Persons reporting three or four DSM-IV symptoms are classified as "problem" gamblers.

PATHOLOGICAL – Persons reporting five or more DSM-IV symptoms.

*Gerstein, D., et al. (1999). *Gambling impact and behavior study: Report to the national gambling impact study commission.* Chicago, IL: National Opinion Research Center at the University of Chicago.

ABOUT THE SURVEY

The Department of Social and Health Services (DSHS), Division of Alcohol and Substance Abuse (DASA) received a federal grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to conduct a statewide household survey to determine the need for substance abuse treatment among Washington adults. Data were collected from February 2003 through February 2004. The Research and Data Analysis Division (RDA) of DSHS conducted the project on behalf of DASA. Telephone interviews were performed by Washington State University's Social and Economic Sciences Research Center. The survey achieved a response rate of 50 percent and a cooperation rate of 69 percent. The sample was weighted to U. S. Census data to provide direct statewide estimates of substance use and the need for substance abuse treatment services.

Population Groups for Analysis

Overall prevalence estimates are provided for three primary populations of interest:

1. All adult household residents: Household residents aged 18+, regardless of income
2. Adults above 200% FPL: Household residents aged 18+ living above 200 percent of the federal poverty level
3. Adults at or below 200% FPL: Household residents aged 18+ living at or below 200 percent of the federal poverty level

In Washington State, 24 percent of adult household residents are at or below 200 percent of the federal poverty level.

Measures of Substance Use

The survey measured use of alcohol, tobacco, and illicit drugs. Measures of substance use include having: a) ever used a substance (lifetime use), b) used a substance in the past 12 months, and c) used a substance in the past 30 days.

Need for Treatment

The survey also assessed current need for alcohol or drug treatment. Respondents were classified as having a current need for treatment if they met any of the following four conditions:

1. Reported symptoms of lifetime Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) alcohol or drug abuse or dependence, reported at least one symptom in the past 12 months, and used alcohol or drugs in past 12 months. See pages 3-2 and 3-3 in the state report for a description of the DSM-IV substance abuse and dependence criteria.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and used alcohol or drugs regularly during the past 12 months. Regular alcohol use was defined as having 3 or more drinks at least one day per week. Regular drug use was defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs 8 or more times in the past 12 months.
4. Reported heavy use of alcohol or drugs during the past 12 months. Heavy alcohol use was defined as having 4 or more drinks per drinking day, 3 or more days per week during the past 12 months. Heavy drug use was defined as using any illicit substance 34 or more times during the past 12 months.

Most respondents (72 percent) were determined to need substance abuse treatment based on the first condition.

Measuring Treatment and Penetration Rates

To measure treatment use and estimate treatment penetration, the WANAHS data are supplemented by data from DASA's Treatment and Assessment Report Generation Tool (TARGET), a database of services provided under DSHS funded programs. Clients used to calculate the treatment penetration rate were selected based on the following conditions:

1. Eligible treatment was limited to residential, outpatient, and methadone services. Clients who received detoxification or transitional housing services were not included.
2. Clients had to reside in a personal residence or a group/foster home. The homeless or institutionalized were not included in these client counts.
3. Treatment had to be funded by DASA. Clients who paid for services through private funds or had their treatment paid for by the Department of Corrections or non-DASA state funds were not counted.
4. Clients had to receive treatment services during the 2003 calendar year.

In addition, penetration rates are calculated only for lower-income adults who are estimated to be eligible for DASA-funded services. Clients eligible for DASA-funded services include adults at or below 200 percent of the federal poverty level who need substance abuse treatment and who do not have private health insurance, Basic Health Plan coverage, or military health insurance.

This represents a change from previous reports using 1993-94 household survey data. Previously, all adult household residents living at or below 200 percent of the federal poverty level who needed substance abuse treatment were included in the penetration rate calculation, regardless of their health insurance coverage status. The net result of this change is that the 2003 treatment penetration rate estimates will be higher than earlier estimates.

Chapter 1

About the Survey

About the Washington State Needs Assessment Household Survey

The 2003 Washington State Needs Assessment Household Survey (WANAHS) interviewed 6,713 adult household residents about their substance use – including tobacco use, substance use disorders, drug or alcohol treatment experiences, and gambling behaviors.

The primary purpose of the WANAHS study was to update estimates of substance use and need for substance abuse treatment in Washington State. These estimates have broad applications for state and county policy and program planning. Since 1995, state and local policymakers have relied on estimates from the 1993-1994 adult household survey. These data have become outdated in the decade since they were collected given changes in demographics, drug use patterns, and economic trends.

The 2003 WANAHS survey provides estimates of:

- Prevalence of substance use
- Need for substance abuse treatment
- Proportion of those with identified treatment need who are receiving publicly funded substance abuse treatment services

The Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA) conducted the project on behalf of the DSHS Division of Alcohol and Substance Abuse (DASA). Surveys were conducted by telephone by the Washington State University Social and Economic Sciences Research Center (SESRC). The project was funded by a grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment to DASA.

Data Collection and Design

Telephone interviews were conducted from February 2003 through February 2004 by SESRC staff. Interviews were structured and computer assisted. A stratified sampling design was implemented that included over sampling young adults, poorer persons and members of ethnic and racial minority groups. In addition to random digit dialing (RDD) methods, phone numbers were obtained from Food Stamps client lists, school lists, birth certificate records, and ethnic surname sampling of listed telephone numbers. The interview was offered in six languages: English, Spanish, Russian, Chinese, Korean, and Vietnamese. Responses were weighted to U.S. Census population counts to provide direct statewide estimates of substance use and the need for substance abuse treatment services.

Survey Response Rate

A number of techniques were used to increase survey response rates. An advance letter with a brief description of the survey and a one-dollar bill was sent to sampled households with available address information. SESRC attempted a minimum number of 20 callbacks until a final disposition was reached. Experienced interviewers made refusal-conversion attempts, except when respondents expressed a clear desire not to participate in the survey.

The 2003 survey obtained a response rate of 50 percent (proportion of eligible households completing an interview) and a cooperation rate of 69 percent (proportion of contacted eligible households completing an interview). The charts on the facing page describe response rates and data collection efforts in greater detail. The charts highlight the increased difficulty of conducting telephone interviews in 2003 compared to 1993. For example, the 2003 WANAHS survey required two and a half times the number of phone calls (340,791) to obtain a slightly smaller number of completed interviews, compared to the 1993-94 survey (136,215 phone calls).

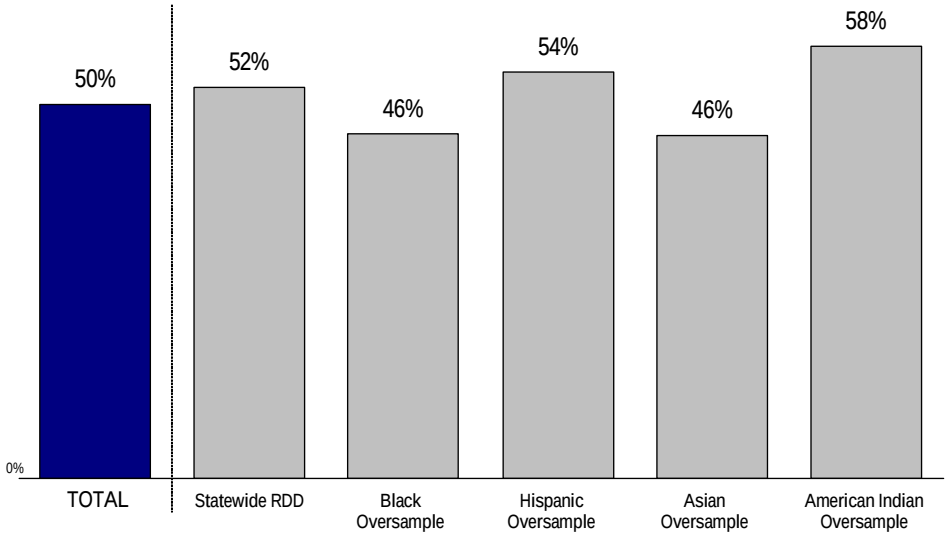
ADDITIONAL INFORMATION

For more detail on the WANAHS study, including technical information on the research design and sampling methodology, please contact Research and Data Analysis at (360) 902-0707 or the Division of Alcohol and Substance Abuse at (360) 725-3700. Either agency may also be contacted via mail at:

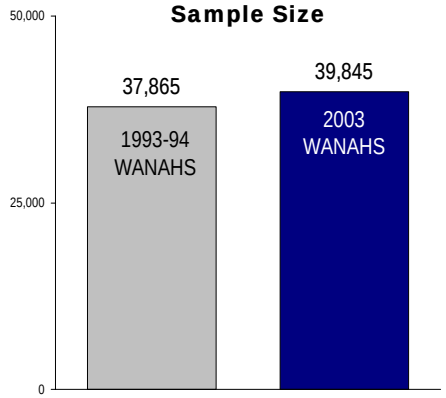
Research and Data Analysis
Department of Social and Health Services
PO Box 45204
Olympia, WA 98504-5204

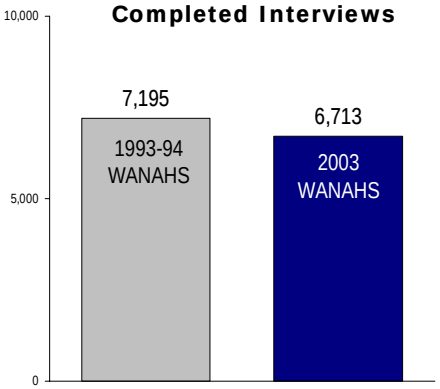
Division of Alcohol and Substance Abuse
Department of Social and Health Services
P.O. Box 45330
Olympia, WA 98504-5330

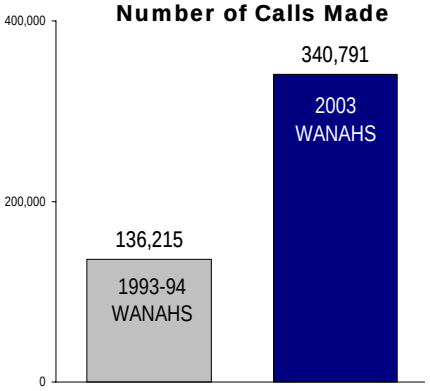
2003 WANAHS Response Rates



	TOTAL	Statewide RDD	Black Oversample	Hispanic Oversample	Asian Oversample	American Indian Oversample
Complete	6,713	2,304	1,543	1,037	799	1,030
Partial	151	41	52	23	20	15
Ineligible	6,339	806	2,992	557	971	1,013
Refusal	5,905	1,592	2,294	518	888	613
	Based on . . .	*RDD*	*Geographic RDD, Food Stamps, Birth Certificates*	*Surname*	*Surname, Food Stamps, Birth Certificates*	*Geographic RDD, Food Stamps, Birth Certificates, School Districts*







NOTES

- The Washington State University Social and Economic Sciences Research Center (SESRC) conducted interviews for both surveys.
- Although the number of completed interviews was similar between the two surveys, SESRC made two and a half times as many calls to complete the 2003 WANAHS.

Measures of Substance Use and Demographic Subgroups

This report provides prevalence estimates for nine classes of illicit drugs – marijuana, powder or crack cocaine, stimulants, hallucinogens, heroin, opiates other than heroin, sedatives, tranquilizers, and inhalants. The inclusion of tranquilizers and inhalants provides additional substance use detail not available in the 1993-94 survey data. Estimates of lifetime, past year, and past 30 day use are provided for each class of substance.

In addition to illicit substances, estimates of alcohol and tobacco use are provided. To focus on problem drinking, much of the discussion of alcohol focuses on "binge drinking" behavior.

We also provide estimates of current need for alcohol or drug treatment, participation in alcohol or drug treatment, and problem or pathological gambling. Identification of need for treatment is based primarily on the American Psychiatric Association's Diagnostic and Statistical Manual, 4th edition (DSM-IV).

Poverty Subgroups

This report presents estimates for several population subgroups. Income level is of primary interest because of the role it plays in determining eligibility for state-funded treatment services. In general, we present prevalence estimates for three primary populations:

- **Total state population:** This includes all Washington State household residents age 18 or above. Homeless persons and persons residing in institutions (e.g. correctional facilities) are excluded from this population.
- **Adults above 200% FPL:** Adults living above 200 percent of federal poverty.
- **Adults at or below 200% FPL:** Adults living at or below 200 percent of federal poverty.

Race Classification Updated

The race groups used in this report are consistent with federal Office of Management and Budget guidelines. The main changes from the race categories used in the 1993-94 WANAHS are the separation of Asians and Native Hawaiian or other Pacific Islanders into separate race categories, and the addition of the 2+ race category for respondents who identified themselves as belonging to more than one race group.

Sub-analyses will also explore differences among Asian and Hispanic respondents based on primary language, and differences among American Indian or Alaska Native respondents based on reservation status.

DRUG DEFINITIONS

Marijuana: Marijuana is a mixture of the dried, shredded leaves, stems, seeds, and flowers of the hemp plant, *Cannabis sativa*. The primary psychoactive ingredient in marijuana is delta-9-tetrahydrocannabinol (THC).

Cocaine or Crack: Cocaine, a white crystalline powder, is the principle alkaloid in the leaves of *Erythroxylon coca*, a bush indigenous to the Andean region of South America. Cocaine is a powerful central nervous system stimulant. Crack is the freebase form of cocaine.

Stimulants: Stimulants serve to increase alertness and physical activity. The more widely used forms include amphetamine and methamphetamine. However, the abuse of methylphenidate (Ritalin) is also of concern. Although cocaine has stimulant properties, it is considered separately and is not included as a member of the class of stimulants presented in this report.

Hallucinogens: Hallucinogens are among the oldest known group of drugs used for their ability to alter perception and mood. Hallucinogenic agents include mushrooms, LSD, Ecstasy (MDMA), PCP, Mescaline, and Peyote.

Heroin: Heroin is a highly addictive opiate processed from morphine. Heroin is derived from the resin of the poppy plant which grows predominantly in southeast and southwest Asia, Mexico, and now in Colombia.

Opiates Other Than Heroin: A broad class of drugs that includes morphine, codeine, and semi-synthetic derivatives of morphine – Percocet, Percodan, Demerol, methadone, Vicodin, and Oxycontin. Heroin is considered separately and is not included in the class of opiates in this report.

Tranquilizer: A class of drugs that slow down the central nervous system. The active chemical is some form of benzodiazepine or meprobamate. Common tranquilizers include Valium, Xanax, Rohypnol, and Librium.

Sedatives: Sedatives depress the central nervous system and may also have mild effects on cognitive and motor functions. Sedatives are commonly taken as sleeping pills and referred to as "downers." The most common forms include barbiturates and methaqualone.

Inhalants: Inhalants refer to a diverse group of substances that includes volatile solvents, gases, and nitrites that are sniffed, snorted, huffed, or bagged to produce intoxicating effects similar to alcohol.

Demographic Subgroups

DEFINITIONS

Defining 200% of the Federal Poverty Level

FAMILY SIZE	ANNUAL HOUSEHOLD INCOME
One	$17,720
Two	$23,880
Three	$30,040
Four	$36,200
Five	$42,360
Six	$48,520
Seven	$54,680
Eight	$60,840
For each additional person, add:	$6,160

Poverty status is determined based on income and size of household. The table on the left lists the household income level corresponding to 200 percent of the federal poverty level for different household sizes in 2002.

For this report, 200 percent of the federal poverty level was used to approximate eligibility for publicly funded substance abuse treatment services.

SOURCE: Based on Federal Poverty Guidelines for 2002. See *Federal Register*, Vol. 67, No. 31, February 14, 2002, pp. 6931-6933.

DEFINITIONS

Demographic Categories Used in Report

GENDER
- **Men**
- **Women**

AGE
- **18-24**
- **25-44**
- **45-64**
- **65+**: Adults aged 65 years or older.

RESIDENCE
- **Urban**: Urban counties were identified based on population density, percent of persons living in census defined urban places, and percent of persons employed in agriculture, forestry or fishing. King, Pierce, Snohomish, Kitsap, Clark, and Spokane Counties were classified as urban.
- **Rural**: All other counties.

RACE/ETHNICITY
- **Hispanic**: Hispanic origin, regardless of race.
- **Black**: All non-Hispanic persons indicating Black or African American.
- **Asian**: All non-Hispanic persons indicating Asian.
- **Am Indian**: All non-Hispanic persons indicating American Indian or Alaska Native.
- **NHOPI**: All non-Hispanic persons indicating **N**ative **H**awaiian or **o**ther **P**acific **I**slander.
- **White**: All non-Hispanic persons indicating White. Also includes small proportion of persons indicating "Other" race.
- **2+ Races**: All non-Hispanic persons indicating two or more races.

MARITAL STATUS
- **Married**: Includes living with a partner.
- **Divorced/Separated**
- **Widowed**
- **Never Married**

EDUCATION
- **Less than High School**: No H.S. diploma or GED
- **High School**: H.S. degree or GED AND no additional college or training
- **Some College**: H.S. degree or GED AND some college or occupational training AND no 4-year degree.
- **College Graduate**: 4-year degree or higher.

EMPLOYMENT STATUS
- **Unemployed**: Not employed and in the labor force.
- **Employed Part Time**: Working less than 35 hours per week.
- **NILF: N**ot **I**n **L**abor **F**orce respondents are retired, full-time homemakers, or full-time students.
- **Employed Full Time**: Working 35 or more hours per week or on active military duty.
- **Disabled**: Unable to work due to disability.

HEALTH INSURANCE
- **Not Insured**: No health insurance coverage.
- **Some Insurance**: At least some medical expenses covered by health insurance. Coverage may be through an employer or union provided plan, a state or federal government health insurance program, or some other form of insurance.

Changes in Survey Methods Affect National Drug Use Estimates

This section compares national substance use estimates from the National Survey on Drug Use and Health (NSDUH, formerly the National Household Survey on Drug Abuse) with Washington State use rates obtained from the 1993-94 and 2003 WANAHS surveys. Comparisons between state and the national surveys indicate that WANAHS estimates tend to be similar to the national estimates prior to recent changes in the methods used in the national survey.

NSDUH Survey Procedures

The national survey methodology differs in several ways from the telephone survey methodology used in WANAHS. The national survey involves in-person interviews and computer-assisted interviewing (CAI), while the WANAHS surveys uses computer-assisted telephone interviewing (CATI). Beginning in 1999, the national survey procedures underwent several changes that had significant impacts on response rates and estimates of substance use.

First, in 1999 the CAI was altered to include an audio computer-assisted self-interviewing (ACASI) component to provide a more confidential setting to complete sensitive portions of the interview. The logic here was that the privacy of the ACASI would decrease social desirability pressures to underreport substance use.

Next, analyses conducted in conjunction with the 1999 survey revealed that interviews completed by newer field staff yielded higher prevalence rates than those completed by more experienced staff. As the Substance Abuse and Mental Health Services Administration (SAMHSA) reported, "Anecdotal evidence suggested that the newer interviewers were following the survey protocol more closely than the veteran staff…. …[T]o address this problem, a series of changes in field procedures were implemented during 2001, and they were institutionalized in the 2002 survey" (Substance Abuse and Mental Health Services Administration, 2003).

Finally, due to declining response rates, a $30 incentive payment was offered to respondents beginning with the 2002 NSDUH. In 2001, a field experiment was conducted during the national survey to assess the costs and benefits of an incentive payment. Initial analyses of the experiment showed substantial improvement in response rates leading to lower data collection costs. Initial studies also found little impact on substance use prevalence rates.

However, SAMHSA later reported that the impact of the methodological improvements implemented in the 2002 NSDUH have contributed to an increase in prevalence rates: "The 2002 data are simply not comparable with data from previous surveys. With no other basis for explaining these and other results, it would appear this problem is a consequence of changes in the survey process" (Substance Abuse and Mental Health Services Administration, 2003).

Comparing WANAHS with National Rates

The 2003 WANAHS estimates of illicit substance use are not comparable to the 2003 national estimates. The 2003 WANAHS estimates are similar to national estimates obtained in the pre-2000 waves of the national survey, but are lower than the national estimates obtained following the recent changes in NSDUH survey methods. Estimates of past year and 30 day alcohol use from the 2003 WANAHS survey exceed the national estimates from the 2002 and 2003 NSDUH surveys (see charts on facing page).

WANAHS ESTIMATES

ALL ADULTS

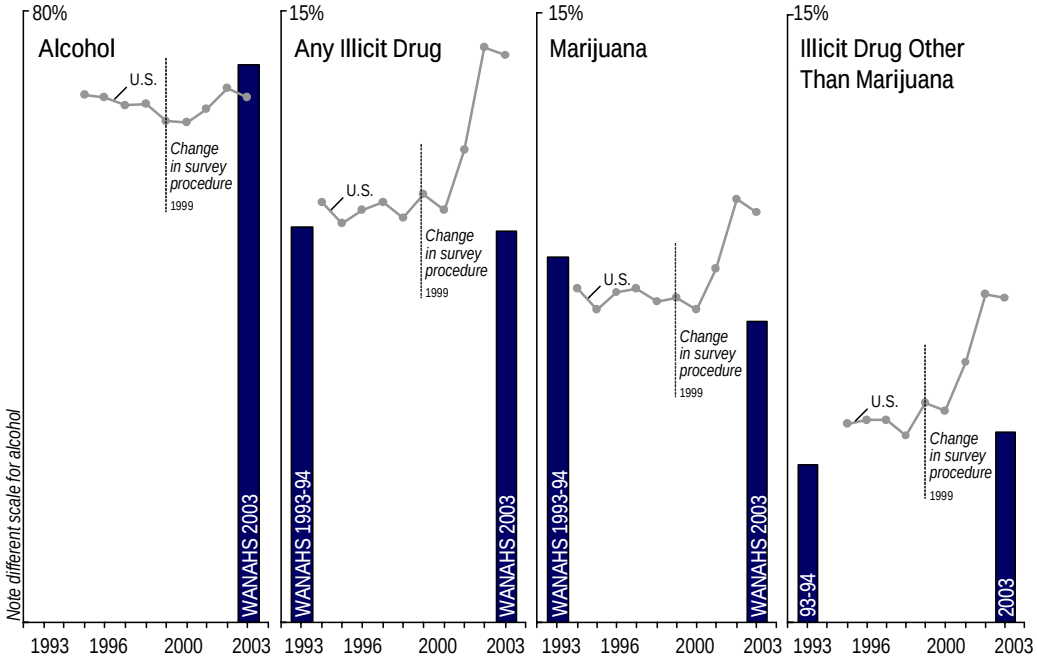
Past Year Substance Use

Comparisons With National Estimates

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Substance Use in Past Year



ALL ADULTS

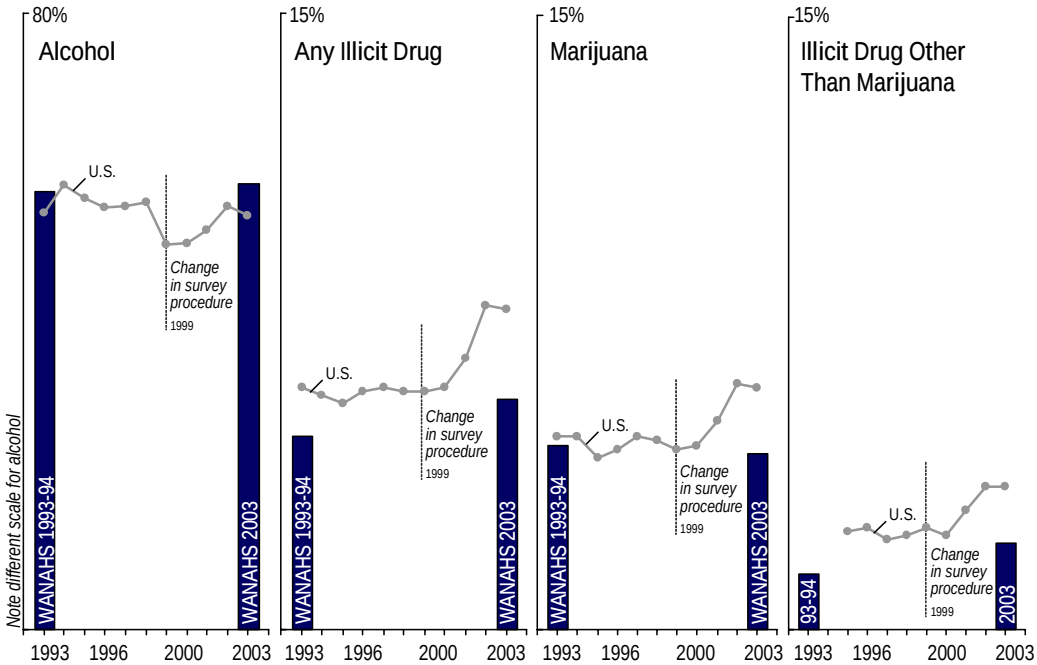
30 Day Substance Use

Comparisons With National Estimates

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Substance Use in Past 30 Days



Chapter 2

Prevalence of Alcohol and Drug Use in Washington State

Nearly Half of Washington State's Adult Household Residents Have Used Illicit Drugs In Their Lifetime

This chapter describes the prevalence of alcohol and drug use among Washington State adult household residents. We first report statewide lifetime, past-year, and 30-day substance use patterns. We then describe demographic differences in substance use patterns for selected substances. Where possible, we compare estimates from the 2003 survey with estimates from the 1993-94 household survey, and indicate which changes over time are statistically significant.

Most (88.0 percent) adult household residents report drinking alcohol during their lifetime. Lifetime use of alcohol is more common among higher-income adults (91.4 percent) than among lower-income adults (77.2 percent).

The 2003 estimate of lifetime alcohol use (88.0 percent) is lower than was found in the 1993-94 survey (92.8 percent). However, it is important to note that the 2003 survey asked about alcohol use in a different manner than the 1993-94 survey. The current survey contains a clause in the lifetime alcohol question, not found in the 1993-94 survey, instructing respondents to discount instances where they "only had a sip or two from a drink." The more restrictive wording of the question may account for the lower reported lifetime alcohol use in the 2003 survey.

Nearly half (45.2 percent) of adult household residents report using an illicit drug during their lifetime. The most frequently used illicit substance is marijuana (42.2 percent).

Lifetime marijuana use is more common among higher-income adults (43.4 percent), compared to lower-income adults (38.4 percent). In contrast, lifetime use of heroin and other non-heroin opiates is more common among lower-income adults compared to higher-income adults (see table below).

Overall, lifetime use of illicit drugs is up significantly from the levels reported in the 1993-94 Washington Needs Assessment Household Survey. With regard to specific types of drugs, the 2003 survey found significantly higher lifetime use of powder or crack cocaine, hallucinogens, and non-heroin opiates.

Stimulants are a notable exception to this pattern of increased lifetime drug use. Lifetime stimulant use decreased from 1993-94 levels. However, this decrease is significant only among lower-income adults.

Ten-year comparisons of rates of use of tranquilizers and inhalants are not possible because use of these substances was not measured in the 1993-94 survey.

TEN-YEAR COMPARISON

Lifetime Substance Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	88.0%	45.2%	42.2%	15.8%	14.5%	16.6%	1.7%	8.7%	5.4%	5.0%	4.2%
1993-94	92.8%	41.6%	39.9%	13.0%	17.0%	13.0%	1.6%	6.3%	N/A	5.0%	N/A
Difference	(–4.8%)	+3.6%	+2.3%	+2.8%	(–2.5%)	+3.6%	+0.1%	+2.4%	N/A	+0.0%	N/A

ADULTS ABOVE 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	91.4%	46.3%	43.4%	15.7%	14.4%	16.4%	1.2%	8.0%	5.2%	4.8%	4.1%
1993-94	94.6%	42.5%	40.9%	13.1%	16.0%	12.3%	1.4%	6.7%	N/A	4.9%	N/A
Difference	(– 3.2%)	+3.8%	+2.5%	+2.6%	(–1.6%)	+4.1%	(-0.2%)	+1.3%	N/A	(-0.1%)	N/A

ADULTS AT OR BELOW 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	77.2%	41.8%	38.4%	15.8%	14.6%	17.1%	3.4%	10.8%	6.2%	5.9%	4.6%
1993-94	87.3%	38.7%	36.9%	12.4%	19.9%	15.3%	2.2%	5.0%	N/A	5.3%	N/A
Difference	(–10.1%)	+3.1%	+1.5%	+3.4%	(–5.3%)	+1.8%	+1.2%	+5.8%	N/A	+0.6%	N/A

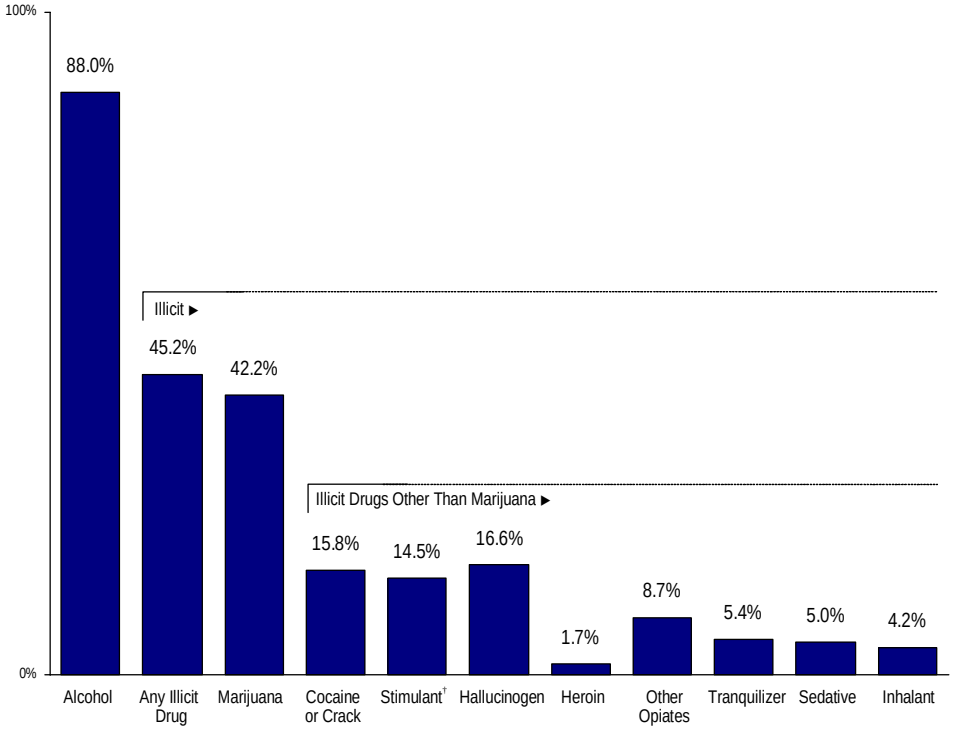
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Lifetime Substance Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Aged 18+



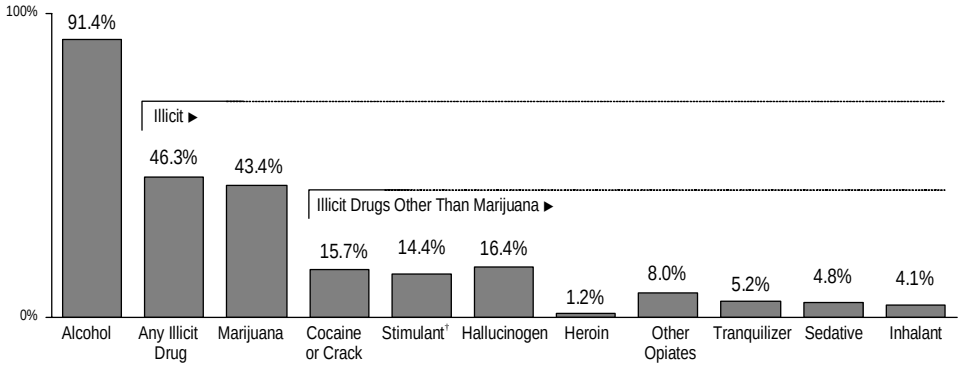
By Income

Household Income

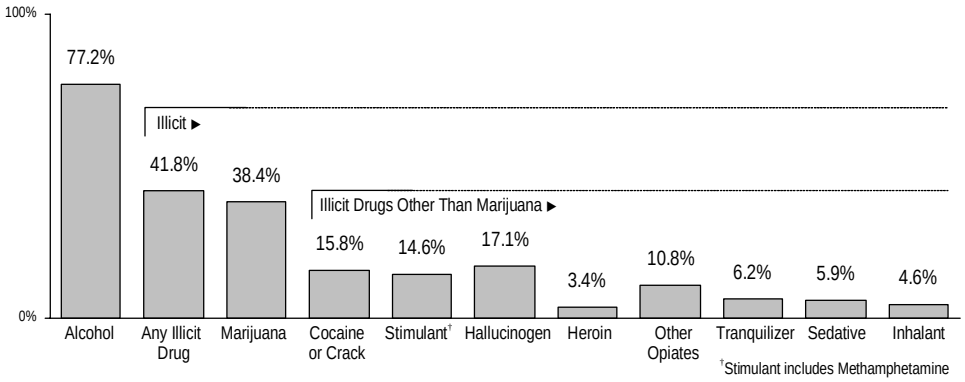
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Past Year Non-Heroin Opiate and Sedative Use Has Increased

Nearly 3 out of 4 (72.9 percent) adult household residents used alcohol during the past year. Past year alcohol use is considerably higher among adults above 200 percent of the federal poverty level (77.5 percent), compared to adults at or below 200 percent of federal poverty level (58.4 percent).

One in 10 adult household residents (9.6 percent) used an illicit substance during the past year. Marijuana was most frequently used (7.4 percent), followed by non-heroin opiates (2.0 percent) and sedatives (1.5 percent).

In contrast to the pattern for lifetime drug use, lower-income adults were *more* likely to use illicit drugs in the past year (12.7 percent), compared to adults above 200 percent of the federal poverty level (8.7 percent). Past year drug use among lower-income adults was also higher for each specific substance, with the exception of heroin.

Comparing 2003 Use To 1993-94 Estimates

Overall, estimates of past year use of any illicit drug were very similar in the 1993-94 survey (9.7 percent) and the 2003 survey (9.6 percent). However, closer examination reveals that, while past year illicit drug use declined slightly among higher-income adults, past year illicit drug use increased among lower-income adults from 10.1 percent in 1993-94 to 12.7 percent in 2003.

There were also significant changes in the use of stimulants, non-heroin opiates, and sedatives. Past year stimulant use declined from 1.8 percent of all adult household residents in 1993-94 to 0.5 percent in 2003. This decline is significant among both adults above and adults at or below 200 percent of the federal poverty level.

While past year stimulant use is down from 1993-94 levels, past year use of non-heroin opiates and sedatives is up. The overall rate of past year non-heroin opiate use quadrupled from 0.5 percent in 1993-94 to 2.0 percent in 2003. Past year sedative use more than doubled from 0.6 percent in 1993-94 to 1.5 percent in 2003.

Increases in past year use of non-heroin opiates and sedatives were found for both higher income and lower income adults, although the increase in sedative use among adults at or below 200 percent of the federal poverty level did not attain statistical significance.

The 1993-94 survey did not ask about past year use of alcohol, therefore, ten-year comparisons are not available. In addition, changes in the use of tranquilizers and inhalants could not be estimated because use of these substances was not measured in the 1993-94 survey.

TEN-YEAR COMPARISON

Past Year Substance Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	72.9%	9.6%	7.4%	1.1%	0.5%	0.9%	0.1%	2.0%	0.7%	1.5%	0.2%
1993-94	N/A	9.7%	9.0%	1.6%	1.8%	1.3%	0.1%	0.5%	N/A	0.6%	N/A
Difference	N/A	(–0.1%)	(–1.6%)	(–0.5%)	(–1.3%)	(–0.4%)	+0.0%	+1.5%	N/A	+0.9%	N/A

ADULTS ABOVE 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	77.5%	8.7%	6.7%	0.8%	0.3%	0.6%	0.1%	1.7%	0.6%	1.5%	0.2%
1993-94	N/A	9.6%	8.9%	1.3%	1.6%	1.2%	0.0%	0.5%	N/A	0.5%	N/A
Difference	N/A	(-0.9%)	(-2.2%)	(-0.5%)	(–1.3%)	(-0.6%)	+0.1%	+1.2%	N/A	+1.0%	N/A

ADULTS AT OR BELOW 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	58.4%	12.7%	9.6%	2.0%	1.2%	1.7%	0.1%	3.0%	1.0%	1.7%	0.3%
1993-94	N/A	10.1%	9.0%	2.2%	2.5%	1.6%	0.3%	0.5%	N/A	1.1%	N/A
Difference	N/A	+2.6%	+0.6%	(–0.2%)	(–1.3%)	+0.1%	(–0.2%)	+2.5%	N/A	+0.6%	N/A

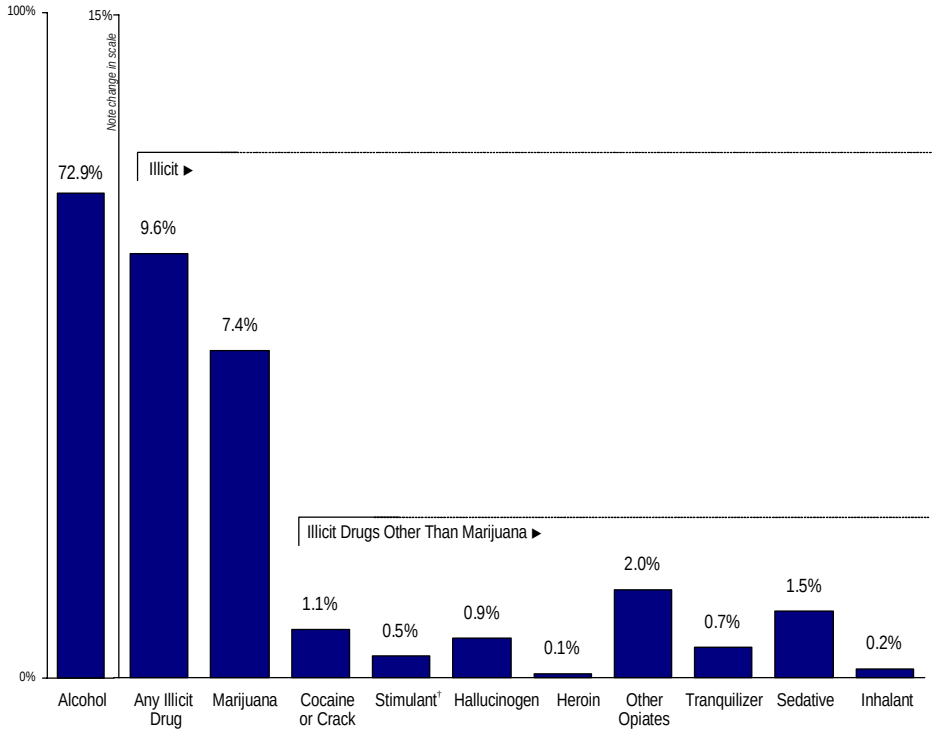
Bold type indicates statistical significance at p <.05

ALL ADULTS

Past Year Substance Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Aged 18+



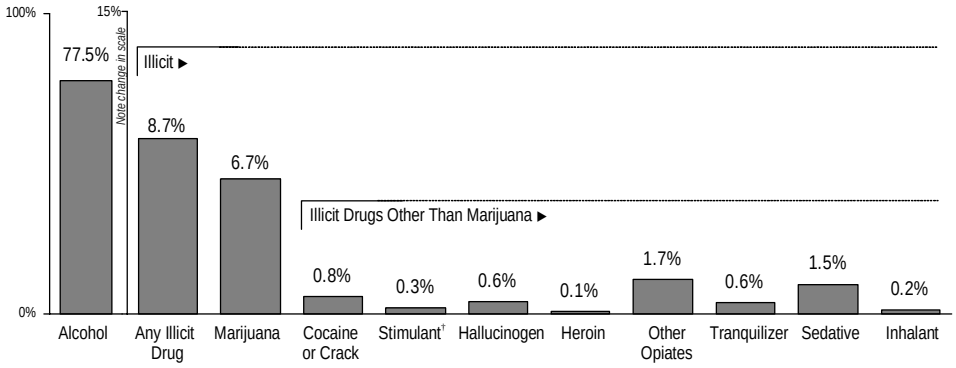
By Income

Household Income

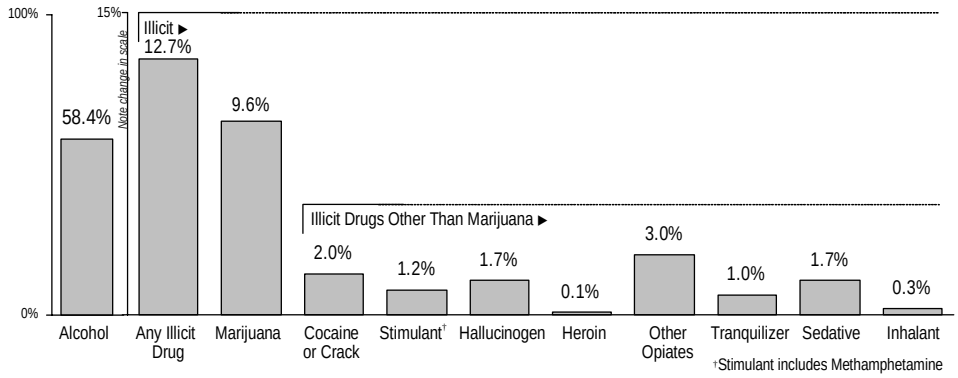
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Past 30 Day Non-Heroin Opiate and Sedative Use Has Increased

Over half (57.9 percent) of adult household residents used alcohol during the past 30 days. Alcohol use during the past 30 days is higher among adults above 200 percent of the federal poverty level (63.0 percent) than adults at or below 200 percent of the federal poverty level (41.6 percent).

About 1 in 20 (5.6 percent) adult household residents used an illicit substance during the past 30 days. Marijuana (4.3 percent) was the most frequently used illicit substance during the past month, followed by non-heroin opiates (0.9 percent) and sedatives (0.8 percent).

Adults at or below 200 percent of the federal poverty level were *more* likely to use an illicit drug (7.5 percent) during the past 30 days than adults above 200 percent of the federal poverty level (5.0 percent).

Past month drug use among adults at or below 200 percent of the federal poverty level is also higher for each of the substances, with the exception of heroin, sedatives, and inhalants.

Comparing 2003 Use To 1993-94 Estimates

Past 30 day rates of alcohol use were similar from 1993-94 (56.9 percent) to 2003 (57.9 percent). Past 30-day use rates of any illicit drug increased slightly from 1993-94 (4.7 percent) to 2003 (5.6 percent). However, this increase was not statistically significant. Closer examination again reveals significant changes in the use of stimulants, non-heroin opiates, and sedatives.

Past month stimulant use is down from 0.8 percent of all adult household residents in 1993-94 to only 0.1 percent in 2003. This decline is also significant among adults at or below 200 percent of the federal poverty level but not significant for adults above 200 percent of the federal poverty level.

Non-heroin opiate use during the past 30 days (0.9 percent) is significantly higher when compared with 1993-94 estimates (0.1 percent). Significant increases from 1993-94 rates of non-heroin opiate use were found for both adults above 200 percent of the federal poverty level and adults at or below 200 percent of the federal poverty level.

Sedative use during the past 30 days (0.8 percent) increased significantly from 1993-94 levels (0.1 percent). This increase was not statistically significant among adults at or below 200 percent of the federal poverty level.

Ten-year comparisons of rates of use of tranquilizers and inhalants are not possible because use of these substances was not measured in the 1993-94 survey.

TEN-YEAR COMPARISON

30 Day Substance Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	57.9%	5.6%	4.3%	0.4%	0.1%	0.2%	0.0%	0.9%	0.2%	0.8%	0.1%
1993-94	56.9%	4.7%	4.5%	0.5%	0.8%	0.2%	0.1%	0.1%	N/A	0.1%	N/A
Difference	+1.0%	+0.9%	(–0.2%)	(–0.1%)	**(–0.7%)**	+0.0%	(–0.1%)	+0.8%	N/A	+0.7%	N/A

ADULTS ABOVE 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	63.0%	5.0%	3.9%	0.3%	0.0%	0.1%	0.0%	0.7%	0.2%	0.8%	0.1%
1993-94	60.8%	4.2%	4.2%	0.5%	0.6%	0.2%	0.0%	0.1%	N/A	0.0%	N/A
Difference	+2.2%	+0.8%	(-0.3%)	(-0.2%)	**(–0.6%)**	(-0.1%)	+0.0%	+0.6%	N/A	+0.8%	N/A

ADULTS AT OR BELOW 200% FPL

	Alcohol	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant
2003	41.6%	7.5%	5.9%	0.7%	0.4%	0.4%	0.0%	1.4%	0.4%	0.5%	0.1%
1993-94	45.1%	6.0%	5.5%	0.5%	1.7%	0.2%	0.3%	0.2%	N/A	0.3%	N/A
Difference	**(–3.5%)**	+1.5%	+0.4%	+0.2%	**(–1.3%)**	+0.2%	(–0.3%)	+1.2%	N/A	+0.2%	N/A

Bold type indicates statistical significance at p <.05

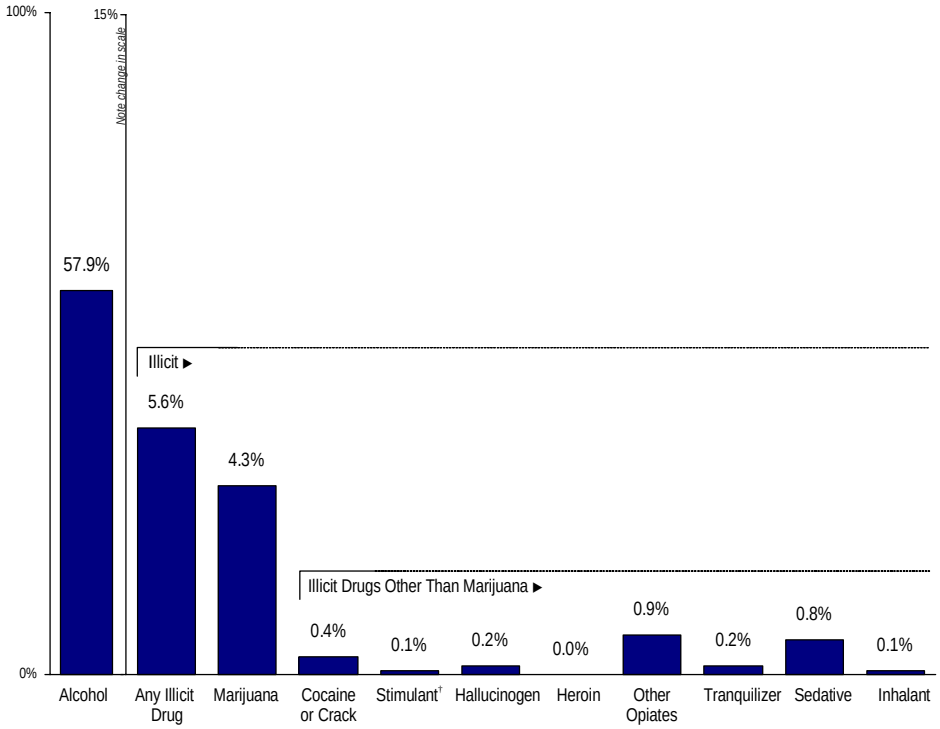
2003 SURVEY ESTIMATES

ALL ADULTS

Past 30 Day Substance Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Aged 18+

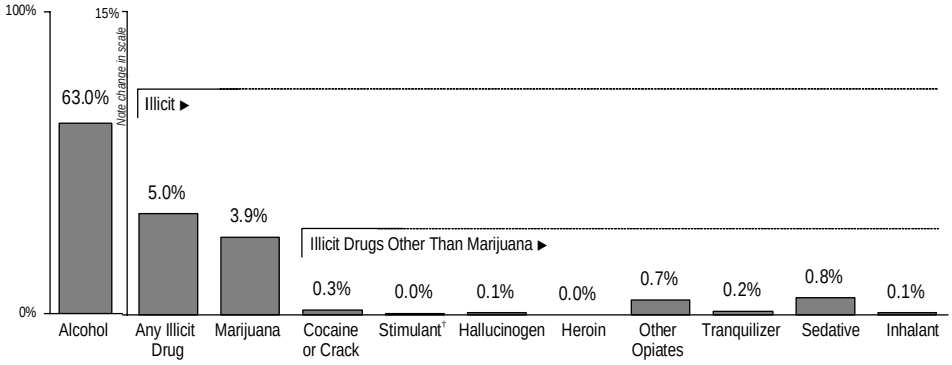


By Income

Household Income

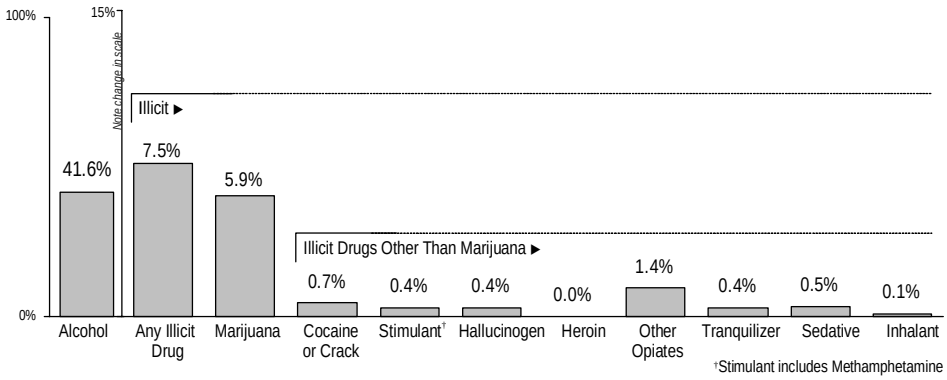
ABOVE 200% Poverty

Adults Above 200% FPL



AT OR BELOW 200% Poverty

Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Current Stimulant Users Predominantly Use Methamphetamine

The previous sections detailing lifetime, past year, and past 30 day substance use contained measures of stimulant use that combined methamphetamine with other types of stimulants. In this section we distinguish between the use of methamphetamine and other stimulants.

NOTE: Although cocaine has stimulant properties, it is considered separately and is *not* included as a member of the class of stimulants presented in this report.

Recent Stimulant Use More Likely To Be Methamphetamine

The charts on the facing page show the proportion of stimulant users using methamphetamine. Among adult household residents who have used stimulants in their lifetime, 42 percent have used methamphetamine, alone or in addition to other stimulants, while 58 percent have only used other types of stimulants.

In contrast, adults who have used stimulants more recently are much more likely to be using methamphetamine:

- 68 percent of adult residents using stimulants in the past year used methamphetamine in the past year.
- 82 percent of adult residents using stimulants in the past month used methamphetamine in the past month.

This pattern holds true for both higher and lower-income adults:

- Among adult stimulant users in higher-income households, only 39 percent of those who ever used stimulants have ever used methamphetamine. In contrast, 91 percent of past 30 day stimulant users were using methamphetamine in the past month.
- Among lower-income adults, about 80 percent of past month and past year stimulant users were using methamphetamine, compared to only 53 percent of lower-income adults who have ever used stimulants in their lifetime.

DEFINITIONS

Distinguishing Between Methamphetamine and Other Stimulants

OTHER STIMULANTS – Stimulants affect the central nervous system (CNS) serving to increase alertness and physical activity. The more widely abused forms include amphetamine and methamphetamine. However, the abuse of methylphenidate (Ritalin) is on the rise among youth and young adults (Johnston, O'Malley, Bachman, & Schulenberg, 2003; http://www.dea.gov/). Other stimulants include Khat and methcathinone. Street terms for stimulants include "Uppers" and "Speed."

METHAMPHETAMINES – (Methadrine) is one of the many amphetamine derivatives. Methamphetamine is closely related chemically to amphetamine, but the CNS effects of methamphetamine are greater. The CNS actions that result from taking even small amounts of methamphetamine include increased wakefulness, increased physical activity, decreased appetite, increased respiration, hypothermia, and euphoria. Other CNS effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. Hypothermia and convulsions can result in death. Methamphetamine is made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients that contain the requisite precursor chemicals. These factors combine to make methamphetamine a drug with high potential for widespread abuse. Street terms for methamphetamine include: "Meth", "Crystal Meth", "Ice", "Glass", "Crank", and "Poor Man's Cocaine."

Methamphetamines have received considerable notoriety in the press in recent years, in part due to the ready availability of precursor chemicals and the toxic waste produced by its manufacture in clandestine "Meth Labs." A number of steps have been put into place to restrict access to these ingredients, including tighter regulations on over-the-counter cold and asthma medications containing ephedrine or pseudoephedrine.

CLOSEUP

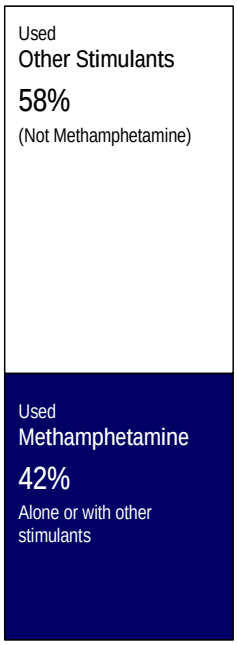
Adults Reporting Stimulant Use

What type of stimulants were used?

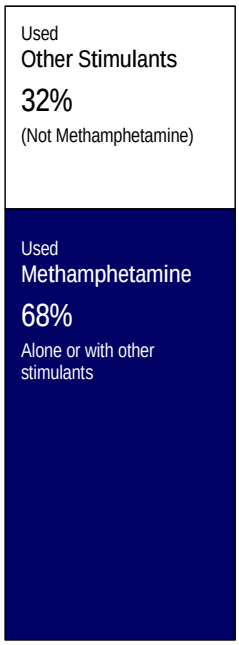
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

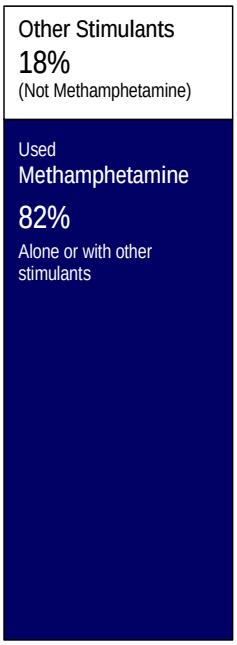
Lifetime Use...



Past Year Use...



30 Day Use...



By Income

Household Income

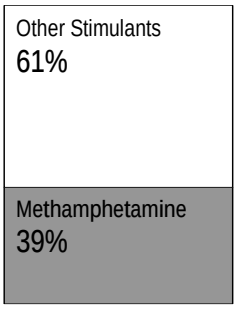
ABOVE

200% Poverty

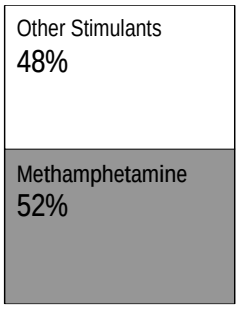
AT OR BELOW

Adults Above 200% FPL

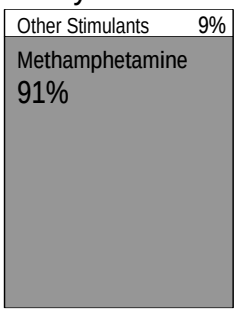
Lifetime Use...



Past Year Use...

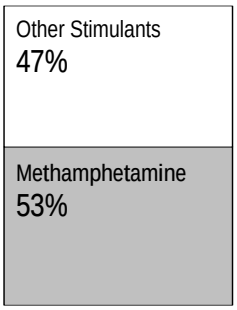


30 Day Use...

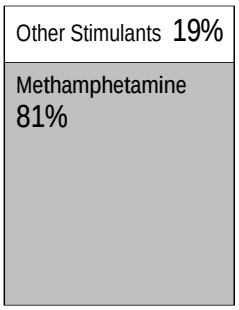


Adults At or Below 200% FPL

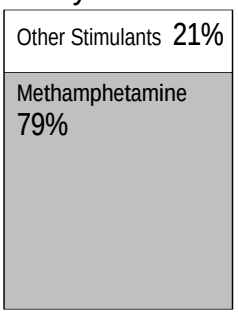
Lifetime Use...



Past Year Use...



30 Day Use...



One in Four Adults Report Binge Drinking in Past Year

Moderate or occasional alcohol use is common, with nearly 9 in 10 adults reporting ever drinking alcohol, and almost 3 in 4 adults consuming alcohol in the past year. This section focuses on more intense and potentially problematic alcohol use by examining the prevalence of two measures of heavier alcohol use: binge drinking and "bender" drinking. These terms are defined in the box below.

Binge Drinking Common, Regardless of Income

About two-thirds (67.8 percent) of the adult population reported ever engaging in binge drinking behavior. Lifetime binge drinking is more common among higher-income adults (71.0 percent) than among lower-income adults (57.5 percent).

The prevalence of past year binge drinking is considerably lower, with 1 in 4 (25.9 percent) of the total adult household population engaging in this behavior in the past 12 months. Additionally, differences between adults above 200 percent of the federal poverty level and adults at or below 200 percent of the federal poverty level disappear when binge drinking is limited to the past year.

"Bender" Drinking More Common Among Lower-Income Adults

"Bender" drinking, or drinking heavily for multiple days in a row, occurs with less frequency. Only 6.1 percent of the total adult household population ever engaged in "bender" drinking behavior.

"Bender" drinking is much more common among lower-income adults. Adults at or below 200 percent of the federal poverty level are twice as likely to have ever engaged in "bender" drinking (9.8 percent) than adults above 200 percent of the federal poverty level (4.9 percent). The direction of this poverty effect is opposite to that found when any alcohol consumption or binge drinking is considered.

Past year "bender" drinking occurred in 1.1 percent of the overall adult household population. Adults at or below 200 percent of the federal poverty level were more than three times as likely to engage in "bender" drinking (2.5 percent), compared to higher-income adults (0.7 percent).

DEFINITIONS

What is a binge? What is a "bender"?

BINGE DRINKING – The term "binge drinking" refers to the **consumption of five or more drinks on the same day for men** or **four or more drinks on the same day for women**.

A standard "drink" is defined as:

- A shot of hard liquor
- A 5 ounce glass of wine
- A 12 ounce can of beer

This binge drink definition is intended to measure the consumption of a sufficiently large amount of alcohol to place the drinker at increased risk of experiencing alcohol-related problems and to place others at risk of experiencing secondhand effects.

Gender specific cut points are used to account for gender differences in problem levels associated with alcohol intake. Research consistently demonstrates that women experience alcohol-related problems at lower drink levels than do men even after controlling for body mass differences.

This measure is used extensively in population-based research including in the National Survey on Drug Use and Health (NSDUH).

BENDER DRINKING – The term **"bender drinking" refers to a prolonged period of intoxication** or **excessive heavy drinking that can last for days or weeks.**

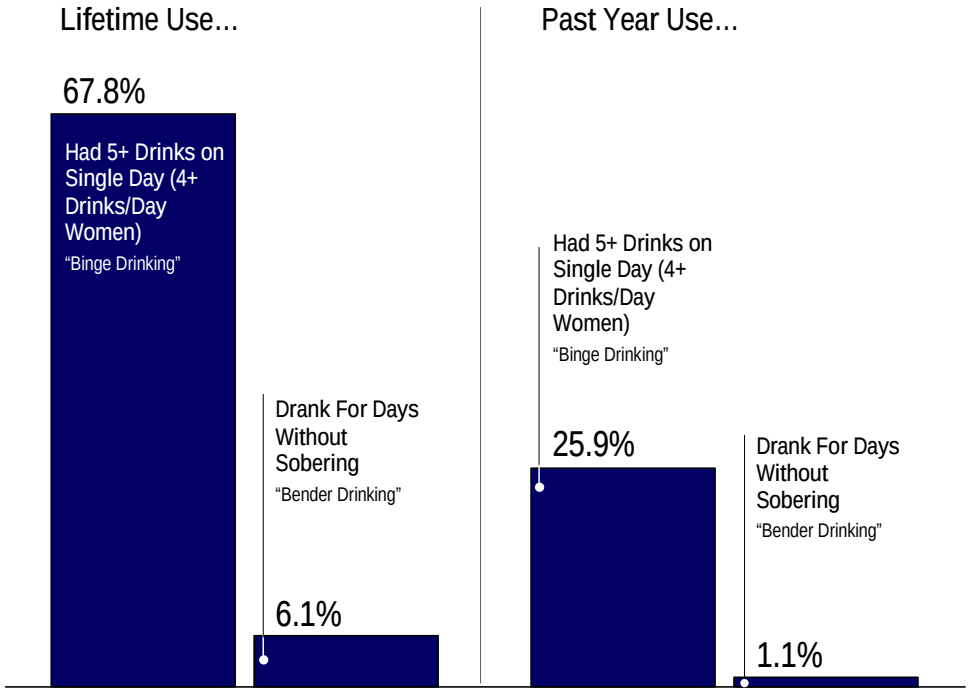
Respondents who endorsed the following survey item were defined as engaging in "bender" drinking: **"Have you ever gone on binges where you kept drinking for a couple of days or more without sobering up?"**

ALL ADULTS

Heavy Alcohol Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

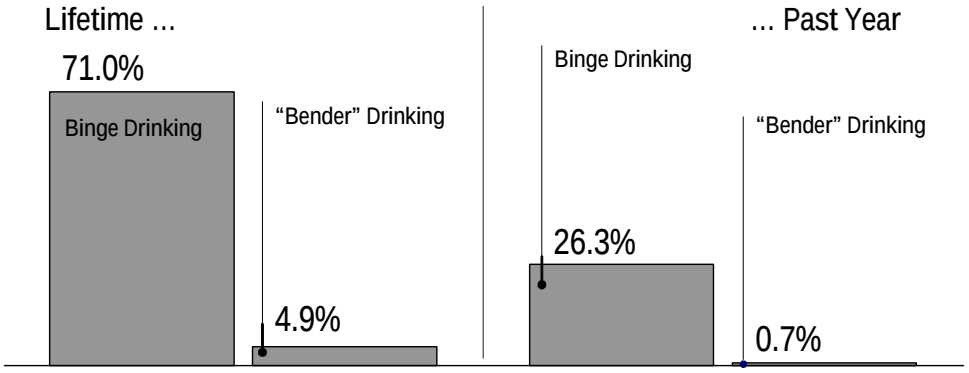
Household Income

ABOVE

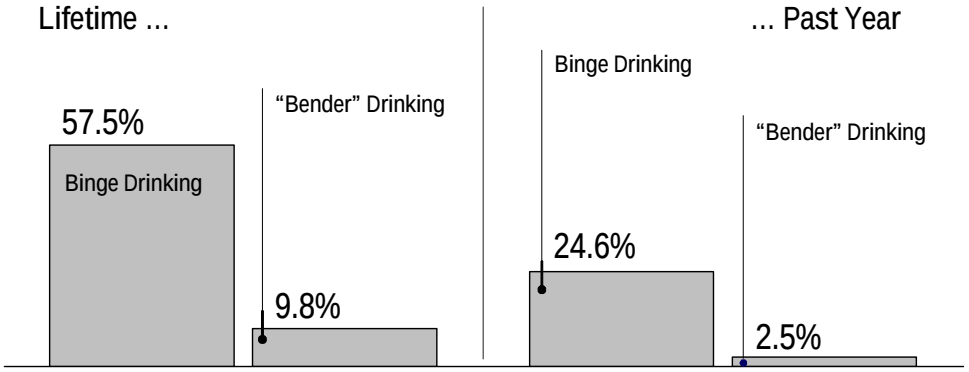
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At or Below 200% FPL



Multiple Drug Use Is More Common Among Lower-Income Adults

This section describes the prevalence of multiple substance use, including the use of illicit drugs and alcohol and the use of multiple illicit drugs. In this analysis we use the higher "binge drinking" threshold of alcohol use, rather than "any" alcohol use. Binge drinking is the consumption of five or more drinks on the same day for men or four or more drinks on the same day for women.

Illicit Drug Use and Binge Drinking

Twenty-nine percent of the adult household population either used an illicit drug or engaged in binge drinking during the past year. The chart on the facing page separates this group into three mutually exclusive components: binge drinking only, illicit drug use only, and both binge drinking and illicit drug use.

- The majority of past year use consisted of binge drinking only.
- Overall, 6.5 percent of all adults used illicit substances *and* engaged in binge drinking during the past year.
- A higher percentage of adults at or below 200 percent of the federal poverty level both used an illicit drug *and* engaged in binge drinking (8.5 percent).

Use of Multiple Illicit Drugs

The chart on the facing page also describes the percentage of adults using multiple illicit substances in the past year, separating past year illicit drug use into two mutually exclusive components, single drug use and multiple drug use.

Most adults using drugs in the past year used a single illicit substance; only 2.8 percent of the overall adult household population used two or more illicit substances during the past year. Among adults living at or below 200 percent of the federal poverty level, a higher proportion (4.2 percent) used two or more illicit substances in the past year. Past year use of multiple illicit drugs was nearly twice as high among lower income adults compared with those living above 200 percent of the federal poverty level (2.4 percent).

UNDERAGE DRINKING

CLOSEUP

Majority of Adults Under Age 21 Have Consumed Alcohol

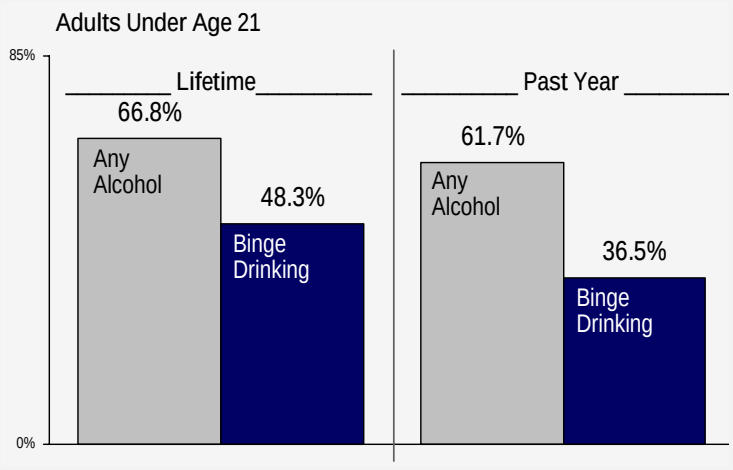
Although it is illegal to obtain or consume alcohol before the age of 21 this legal restriction is frequently ignored.

As the figure to the right shows, roughly 2 out of 3 adults under the age of 21 (66.8 percent) have ever drank alcohol and nearly half (48.3 percent) have ever engaged in binge drinking. These rates are lower than the overall adult household population, however, past year binge drinking among adults under the age of 21 (36.5 percent) is considerably higher than among the total adult population (25.9 percent) reported on page 2-11.

A further examination of age of first alcohol use is presented on page 3-18 of this report.

The Healthy Youth Survey (HYS) (http://www3.doh.wa.gov/HYS/) provides additional information about adolescent health and substance use in Washington.

Alcohol Use Among Adults Under Age 21



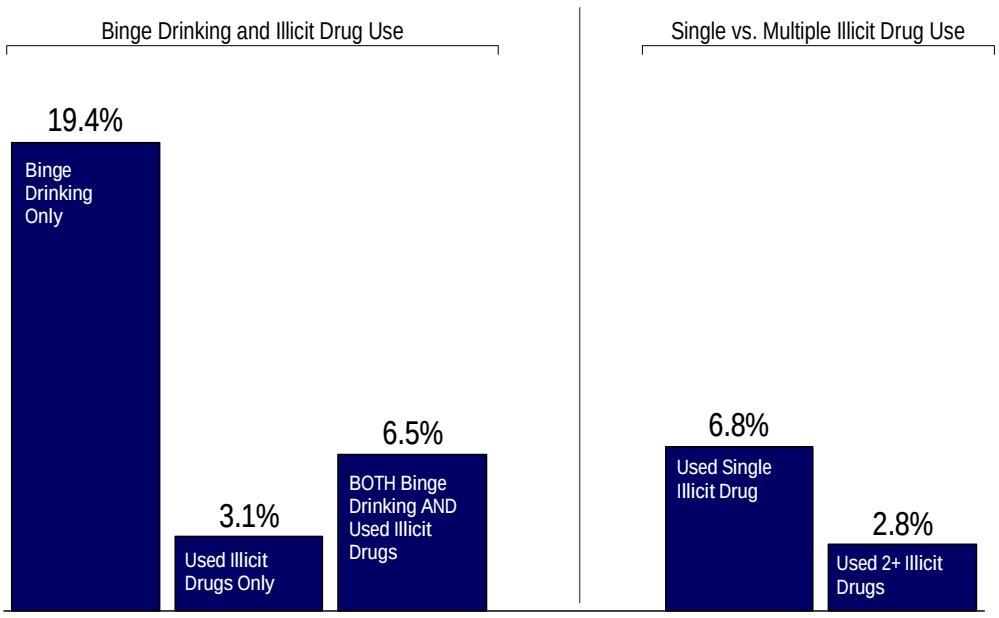
ALL ADULTS

Past Year Multiple Substance Use

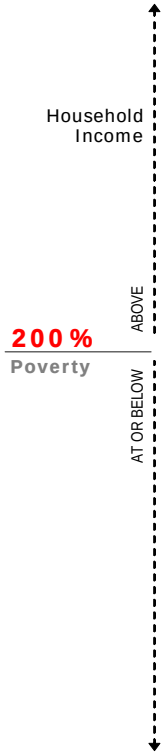
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

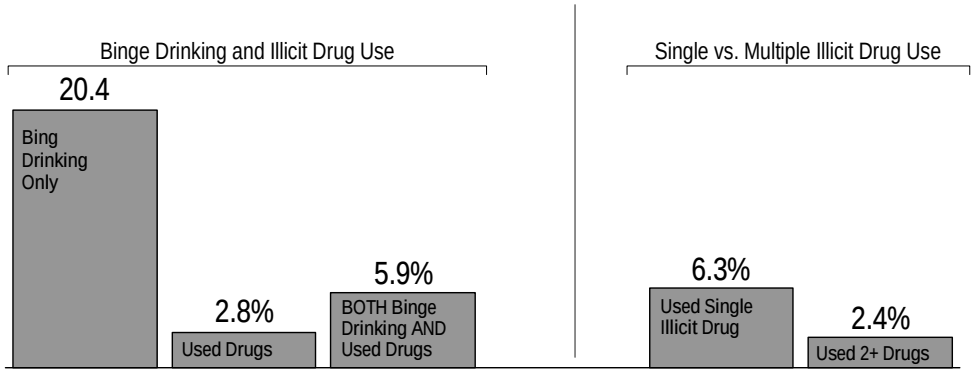
Past Year Use...



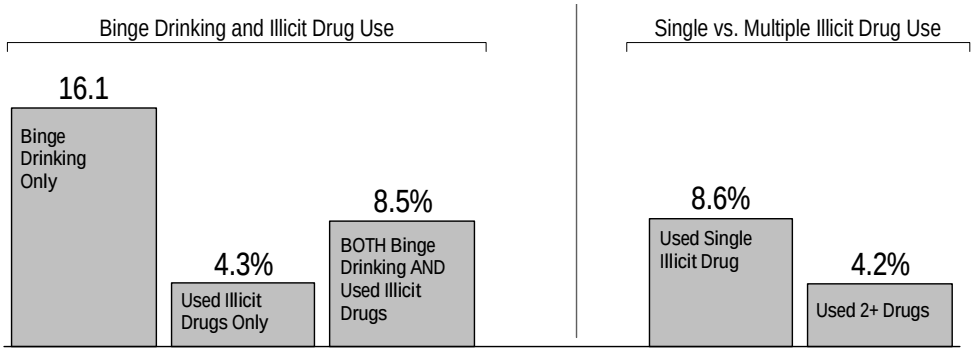
By Income



Adults Above 200% FPL



Adults At or Below 200% FPL



Binge Drinking Is More Common Among Younger Adults, Males

This section describes how the prevalence of past year binge drinking (5+ drinks in a day for males, 4+ drinks in a day for females) varies by gender, age, and region of residence.

Overall, approximately 1 in 4 adult household residents engaged in binge drinking during the past year. This figure was slightly higher for adults above 200 percent of the federal poverty level (26.3 percent), compared with lower income adults (24.6 percent).

Males were more likely than females to engage in binge drinking. About 1 in 3 males (32.5 percent) engaged in binge drinking during the past year. For females, the rate was about 1 in 5 (19.7 percent). This pattern holds for both higher income and lower income adults.

The likelihood of engaging in binge drinking during the past year was strongly associated with age, with younger adults much more likely to engage in binge drinking than were older adults.

Almost half (45.2 percent) of adults between the ages of 18 and 24 binge drank in the past year. In contrast, only 6.2 percent of adults aged 65 and older binge drank in the past year. This pattern was consistent regardless of poverty status.

Among young adults age 18 to 24, Those at or below 200 percent of the federal poverty level were slightly more likely to binge drink (46.9 percent), compared young adults above 200 percent of the federal poverty level (43.9 percent).

Binge drinking occurs with similar frequency, regardless of whether adults reside in an urban or rural county.

DRINKING IMPAIRMENT

Impairment Due to Binge Drinking

The definition of binge drinking was developed in part to provide a measure of alcohol consumption that places the drinker at an increased risk for experiencing alcohol-related consequences. The extent of impairment produced by alcohol consumption depends upon an individual's blood alcohol content (BAC). BAC is dependent upon a number of factors beyond the quantity of alcohol consumed. The charts below estimate BAC and the level of impairment given the number of drinks consumed, gender, and body weight. The binge drinking definition corresponds with significant impairment and meets or exceeds Washington State's legal definition of intoxication (BAC=.08).

MEN

Approximate Blood Alcohol Percentage

Drinks	Body weight in pounds								
	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.04	.03	.03	.02	.02	.02	.02	.02	Impairment begins
2	.08	.06	.05	.05	.04	.04	.03	.03	Driving skills significantly affected & Possible criminal penalties
3	.11	.09	.08	.07	.06	.06	.05	.05	
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	
6	.23	.19	.16	.14	.13	.11	.10	.09	
7	.26	.22	.19	.16	.15	.13	.12	.11	Legally intoxicated & Criminal penalties
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

Subtract .01% for every 40 minutes of drinking.
One drink is 1.25 oz of 80 proof liquor, 12 oz. of beer, or 5 oz. of table wine.

WOMEN

Approximate Blood Alcohol Percentage

Drinks	Body weight in pounds								
	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.05	.05	.04	.03	.03	.03	.02	.02	Impairment begins
2	.10	.09	.08	.07	.06	.05	.05	.04	Driving skills significantly affected & Possible criminal penalties
3	.15	.14	.11	.10	.09	.08	.07	.06	
4	.20	.18	.15	.13	.11	.10	.09	.08	
5	.25	.23	.19	.16	.14	.13	.11	.10	
6	.30	.27	.23	.19	.17	.15	.14	.12	
7	.35	.32	.27	.23	.20	.18	.16	.14	Legally intoxicated & Criminal penalties
8	.40	.36	.30	.26	.23	.20	.18	.17	
9	.45	.41	.34	.29	.26	.23	.20	.19	
10	.51	.45	.38	.32	.28	.25	.23	.21	

Subtract .01% for every 40 minutes of drinking.
One drink is 1.25 oz of 80 proof liquor, 12 oz. of beer, or 5 oz. of table wine.

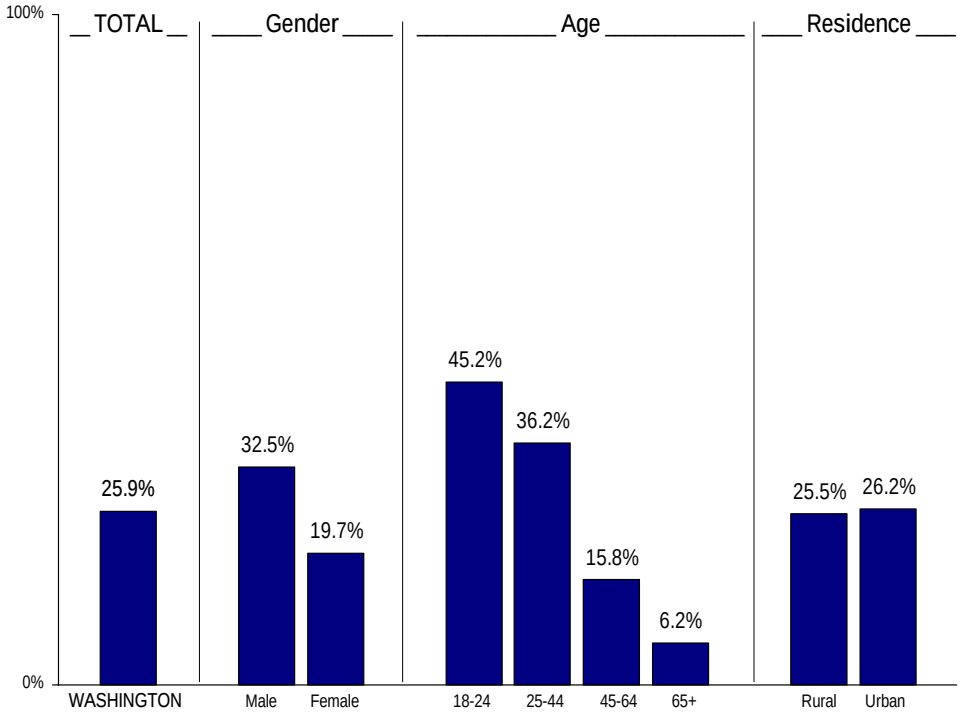
Source: U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information (http://www.health.org/nongovpubs/bac-chart/).

ALL ADULTS

Past Year Binge Drinking

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



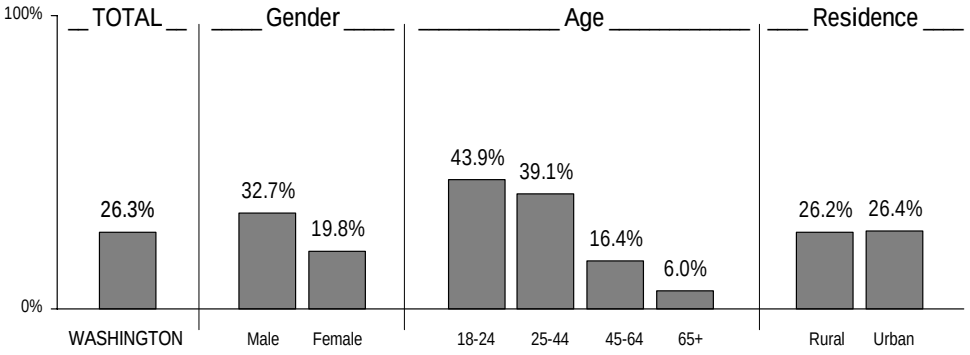
By Income

Household Income

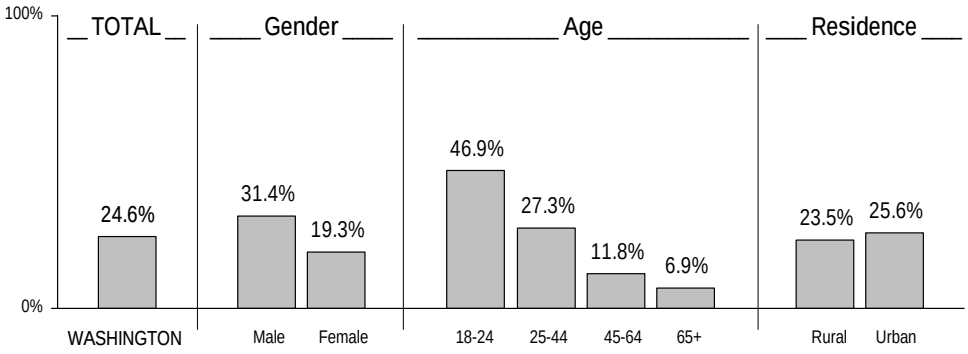
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Asians and African-Americans Least Likely to Binge Drink

This section describes how the prevalence of past year binge drinking varies by race and ethnicity. Asian adults reported the lowest prevalence of past year binge drinking (12.5 percent). African-American adults also reported low rates of past year binge drinking (17.2 percent).

Binge Drinking Highest Among Multirace Adults

Adults who reported belonging to more than one non-Hispanic race group reported the highest rate of past year binge drinking (34.1 percent).

Among Asians and Hispanics, poverty status is strongly related to the prevalence of binge drinking. Asians above 200 percent of the federal poverty level were more than twice as likely to binge drink when compared with Asians at or below 200 percent of the federal poverty level (15.1 percent vs. 7.3 percent).

Similarly, Hispanics above 200 percent of the federal poverty level were half again as likely to binge drink when compared with Hispanics at or below 200 percent of the federal poverty level (34.1 percent vs. 22.9 percent).

While there was a general tendency for rates of past year binge drinking to be higher among adults above 200 percent of the federal poverty level, Whites and American Indian or Alaska Natives did not follow this pattern. White and American Indian or Alaska Native adults who were at or below 200 percent of the federal poverty level were slightly more likely to engage in past year drinking behavior (27.0 percent and 29.6 percent, respectively) than were those above 200 percent of the federal poverty level (26.6 percent and 27.2 percent, respectively).

DEMOGRAPHIC DETAIL OF PAST YEAR USE

Additional Demographic Detail Available in Appendix Tables

Due to space considerations, demographic differences in past year substance use are limited to a few selected substances. These substances are supplemented by a more comprehensive appendix detailing demographic differences for alcohol use, illicit substance use, and tobacco use. Appendix A includes three tables. The first table describes demographic differences among all adult household residents, the second is limited to those above 200 percent of the federal poverty level, and the third describes those at or below 200 percent of the federal poverty level.

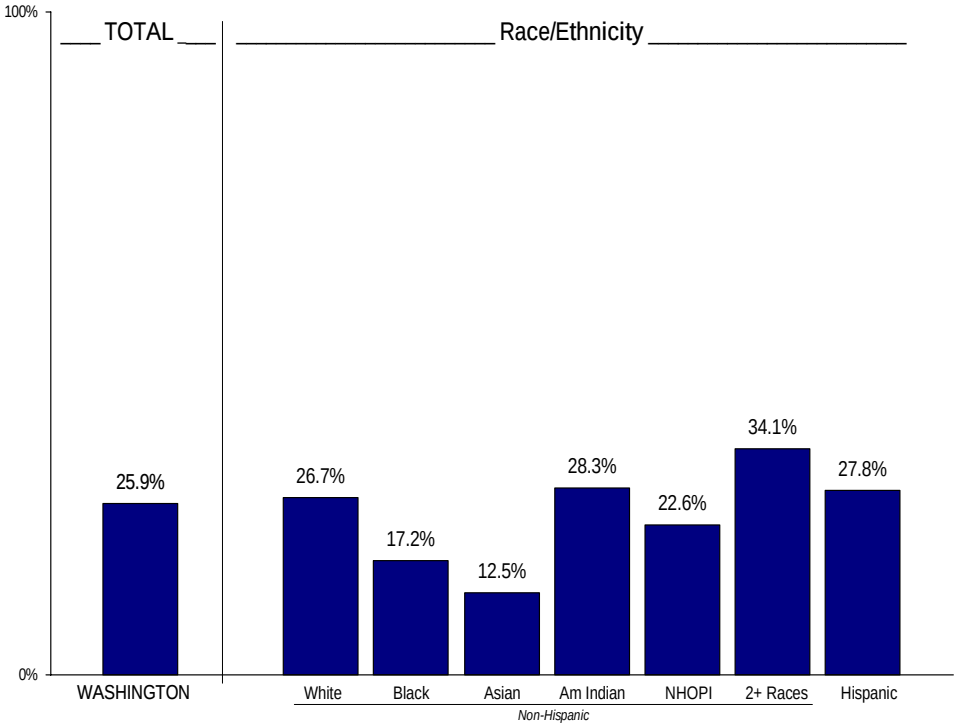
Ten year comparisons are not included in these tables. If additional information about the 1993-94 WANAHS report is desired, the full report is available online at: http://www1.dshs.wa.gov/rda/research/4/25/40.shtm.

ALL ADULTS

Past Year Binge Drinking

NEEDS ASSESSMENT

Washington State Household Residents Age 18+

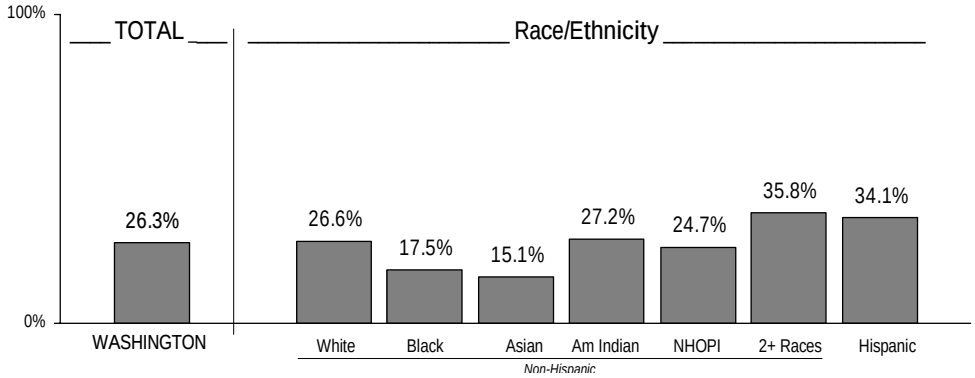


By Income

Household Income

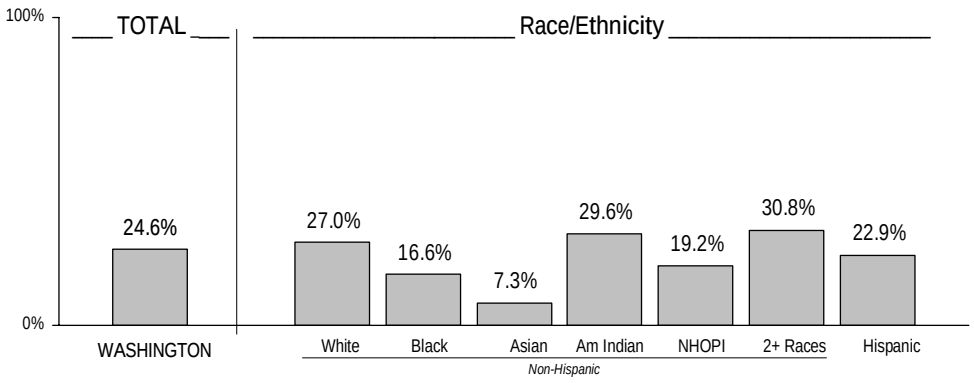
ABOVE 200% Poverty

Adults Above 200% FPL



AT OR BELOW 200% Poverty

Adults At Or Below 200% FPL



One in Five Women with Children Engaged in Binge Drinking During Past Year

This section describes how the prevalence of **past month** drinking and **past year** binge drinking varies among pregnant and parenting women. As discussed in the box below, lower-income women who are currently pregnant are much more likely to report drinking alcohol in the past 30 days, compared to higher-income pregnant women.

Classifying Pregnant and Parenting Women

Women under the age of 51 were asked whether or not they were currently pregnant or had given birth in the past year. Women aged 51 and older were not asked these questions and were classified as not currently pregnant and not giving birth in the past year. In addition, all respondents were asked whether they had children living in their household for whom they had primary care responsibilities. Overall, 2.4 percent of women were classified as currently pregnant, 4.9 percent were classified as having given birth in the past year, and 38 percent were classified as having children in the household for whom they had primary care responsibilities.

Binge Drinking Rates Similar For Pregnant, non-Pregnant Women

Prevalence of past year binge drinking among currently pregnant women (18.6 percent) is nearly as high as binge drinking among women that are not currently pregnant (19.7 percent). Rates of binge drinking were similar across poverty status.

Rates of binge drinking were somewhat lower among women who had given birth during the past year (14.3 percent) compared with those who had not (19.9 percent). Again, this pattern held regardless of poverty status.

Rates of past year binge drinking were slightly higher among women with children (21.6 percent) than women without children (18.4 percent). This pattern held regardless of poverty status.

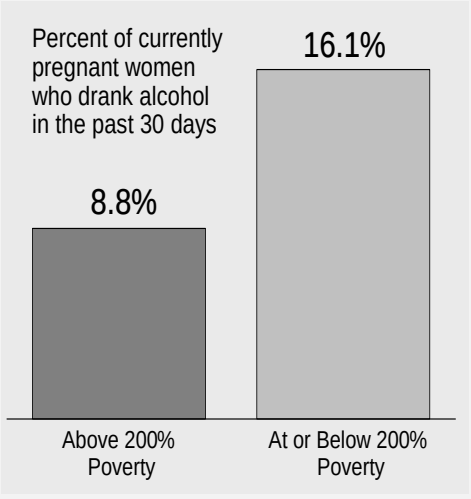
DRINKING DURING PREGNANCY

CLOSEUP

Lower-Income Pregnant Women Twice as Likely to Drink in Past Month

Drinking during pregnancy is of particular interest given the potential for fetal alcohol syndrome and other teratogenic effects. As described above, rates of past year binge drinking among currently pregnant women did not vary by poverty status. One limitation of this analysis, however, is that it is not possible to determine whether or not drinking actually occurred during pregnancy or whether it occurred before the pregnancy.

The chart to the right describes drinking during the past 30 days among currently pregnant women. Use of this time frame greatly increases the probability that drinking is occurring during pregnancy. When this more recent measure of alcohol use is used, a striking difference in rates of alcohol use emerges by poverty status. Pregnant women who were at or below 200 percent of the federal poverty level were nearly twice as likely to drink alcohol in the past month (16.1%) compared with higher income women (8.8%).



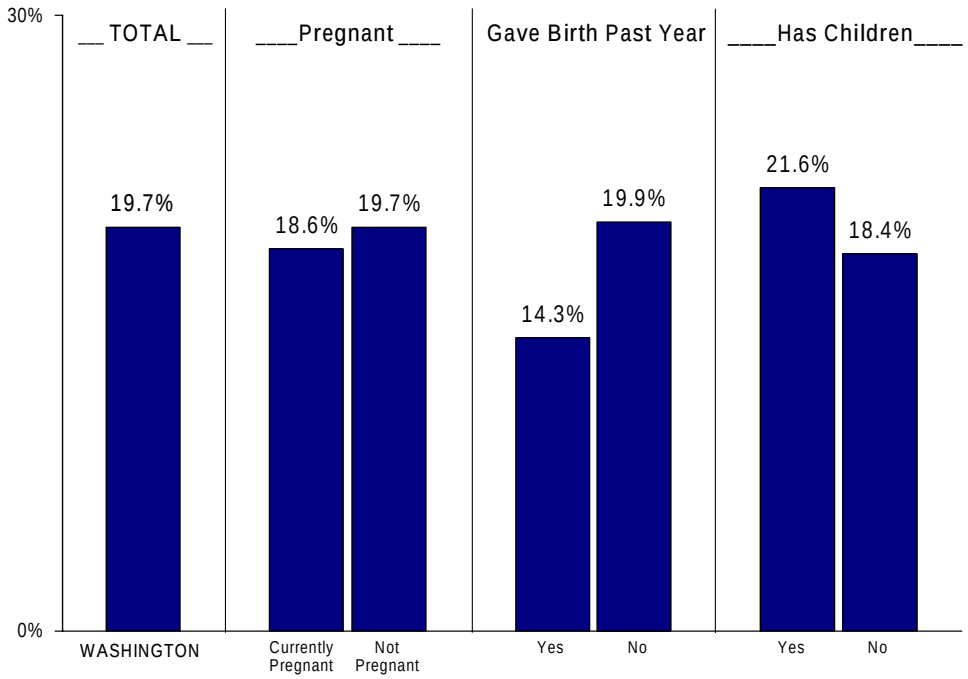
CLOSEUP

Pregnant and Parenting Women: Binge Drinking

2003 NEEDS ASSESSMENT

Washington State Household Residents

Past Year Binge Drinking



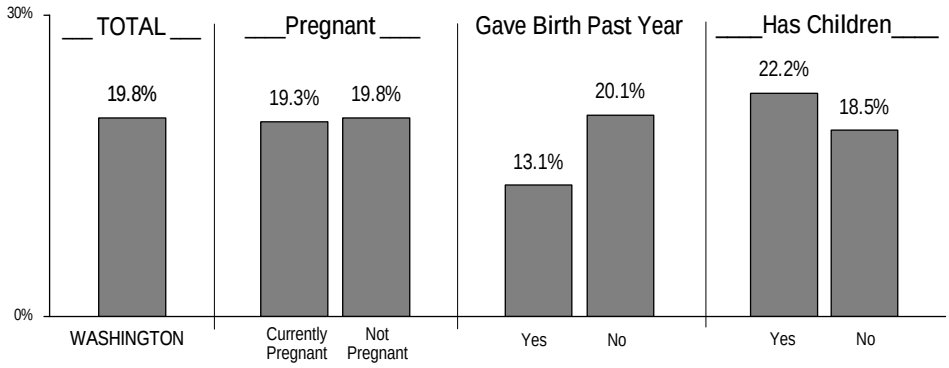
By Income

Household Income

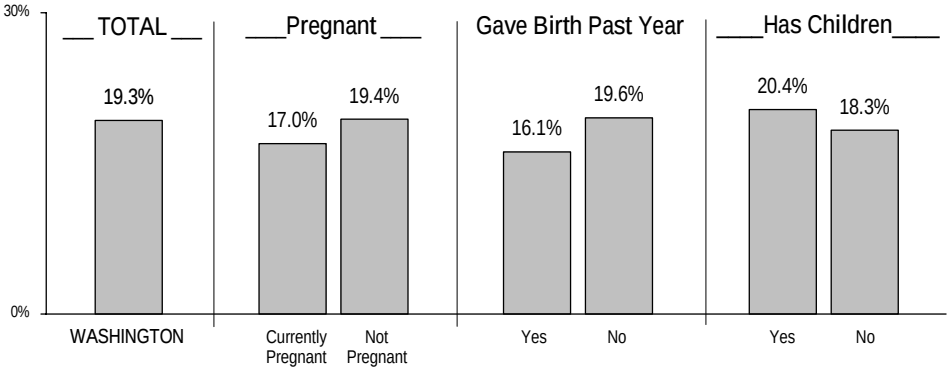
ABOVE **200%** Poverty

AT OR BELOW

Past Year Binge Drinking - Women Above 200% FPL



Past Year Binge Drinking - Women At Or Below 200% FPL



Use of Illicit Drugs Is More Common Among Men, Young Adults, and Urban Residents

This section describes changes in the prevalence of past year illicit drug use between 1993-94 and 2003. In addition, variations by gender, age, and region are presented.

Ten-Year Comparison

The overall rate of past year illicit drug use remained consistent from 1993-94 to 2003, with about 1 in 10 adult household residents using drugs in the past year. However, several significant changes in illicit drug use patterns emerge when gender, age, and regional differences are considered.

Significantly more adults aged 45 to 64 reported using an illicit substance during the past year in 2003 (5.0 percent) compared with those adults aged 45 to 64 in 1993-94 (2.4 percent).

Among adults living at or below 200 percent of the federal poverty level, however, a number of statistically significant differences are noted between 1993-94 and 2003 rates. Specifically, in 2003 significantly higher rates of past year drug use were noted for:

- Males
- Adults aged 45 to 64
- Adults residing in rural counties

2003 Survey Estimates

The charts on the facing page present 2003 rates of past year any illicit drug use by gender, age, and region of residence. These charts show that males, regardless of poverty status are more likely to use an illicit substance in the past year.

Past year use of any illicit substance is strongly associated with age – younger adults are much more likely to use an illicit substance in the past year than are older adults. Adults aged 18 to 24 were the most likely to use any illicit substance in the past year (23.8 percent) and rates of past year drug use decrease steadily with age.

Less than one percent of adults aged 65 and older used any illicit substance in the past year. The relationship between past year drug use and age is similar regardless of poverty status.

Adults residing in urban counties, regardless of poverty status, were more likely to use an illicit substance during the past year than adults residing in rural counties.

TEN-YEAR COMPARISON

Past Year Any Illicit Drug Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	9.6%	12.2%	7.2%	23.8%	12.7%	5.0%	0.8%	7.7%	11.2%
1993-94	9.7%	13.2%	6.4%	29.4%	12.4%	2.4%	0.0%	7.2%	10.8%
Difference	(–0.1%)	(–1.0%)	+0.8%	(–5.6%)	+0.3%	+2.6%	+0.8%	+0.5%	+0.4%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	8.7%	10.6%	6.7%	21.5%	12.7%	4.4%	0.7%	6.6%	10.2%
1993-94	9.6%	13.4%	5.7%	32.4%	12.4%	2.2%	0.0%	7.7%	10.3%
Difference	(–0.9%)	(–2.8%)	+1.0%	(–10.9%)	+0.3%	+2.2%	+0.7%	(- 1.1%)	(-0.1%)

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	12.7%	17.8%	8.8%	27.0%	12.6%	8.6%	1.2%	10.8%	14.6%
1993-94	10.1%	12.5%	8.2%	23.5%	12.4%	3.6%	0.0%	6.3%	12.7%
Difference	+2.6%	+5.3%	+0.6%	+3.5%	+0.2%	+5.0%	+1.2%	+4.5%	+1.9%

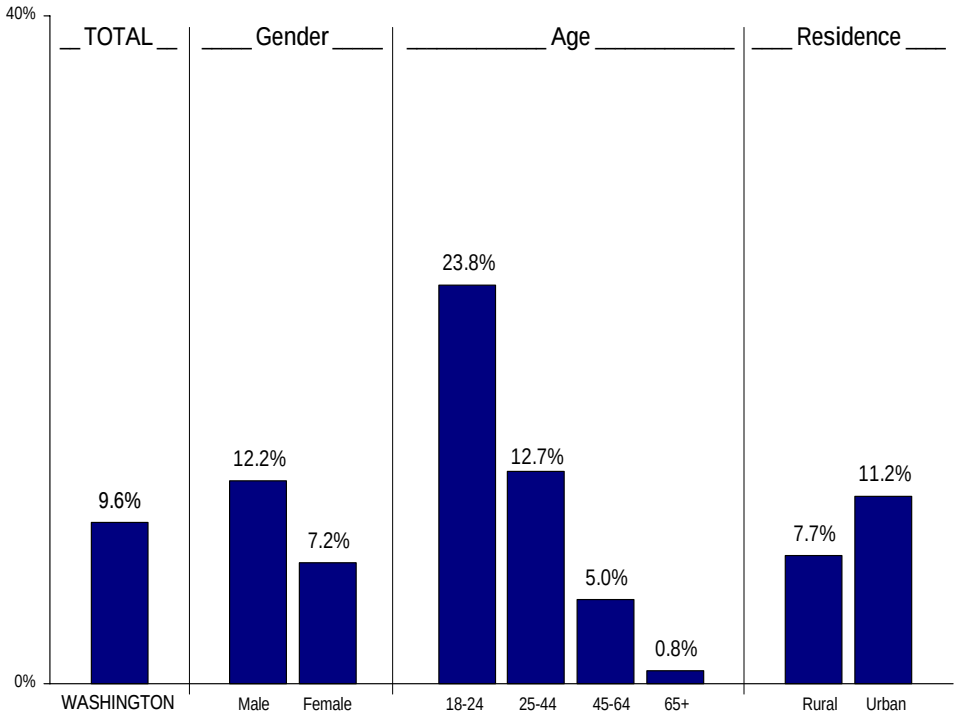
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Past Year Illicit Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



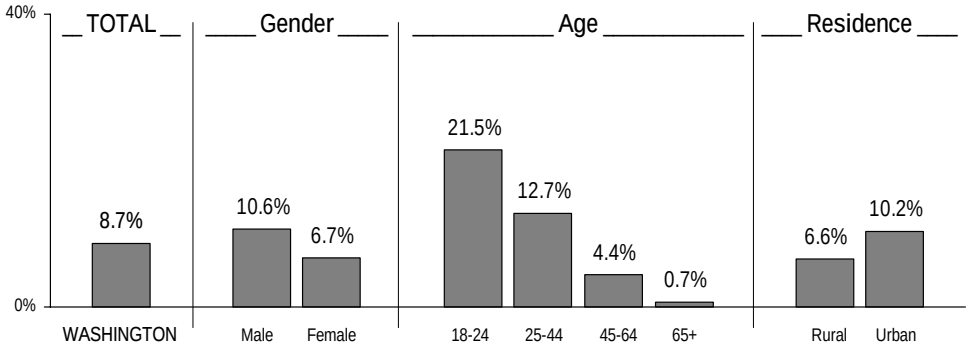
By Income

Household Income

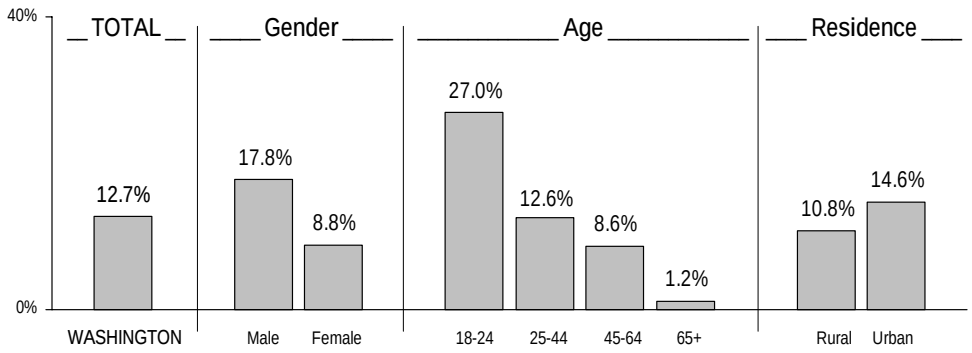
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Past Year Illicit Drug Use Highest Among Multirace Adults, Lowest Among Asians

This section describes the prevalence of any illicit substance use during the past year by racial and ethnic groups. First, comparisons with 1993-94 rates are presented where available. Next, variations among 2003 rates are described.

Ten-Year Comparisons

The table below compares past year use of any illicit substance by racial or ethnic group in 2003 with 1993-94 rates. Significant changes from 1993-94 include:

- In 2003, about twice as many Hispanics used an illicit substance in the past year compared to 1993-94.
- A significantly greater proportion of Asians reported past year drug use in 2003 than in 1993-94.

The increase in estimated drug use among Asians since 1993-94 is particularly striking given that Native Hawaiian and Pacific Islander (NHOPI) adults were shifted from the Asian group to a separate race group in the reported estimates for 2003.

2003 Survey Estimates

The charts on the facing page present rates of past year any illicit drug use by racial and ethnic groups.

Past year use of any illicit substance was highest among adults that reported belonging to more than one non-Hispanic racial group (18.6 percent) and lowest among Asians (4.2 percent).

Overall, more adults at or below 200 percent of the federal poverty level used an illicit substance during the past year, however, this relationship was not consistent across racial groups. Past year use of any illicit substance was actually higher among Blacks, Asians, and Hispanics that were *above* 200 percent of the federal poverty level.

TEN-YEAR COMPARISON

Past Year Any Illicit Drug Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	9.6%	9.6%	11.3%	4.2%	12.0%	8.1%	18.6%	11.0%
1993-94	9.7%	10.2%	10.8%	2.4%	14.5%	N/A	N/A	5.6%
Difference	(–0.1%)	(–0.6%)	+0.5%	+1.8%	(-2.5%)	N/A	N/A	+5.4%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	8.7%	8.4%	12.0%	4.5%	8.6%	4.8%	16.4%	13.3%
1993-94	9.6%	10.0%	9.8%	2.5%	13.7%	N/A	N/A	6.6%
Difference	(–0.9%)	(–1.6%)	+2.2%	+2.0%	(-5.1%)	N/A	N/A	+6.7%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	12.7%	14.0%	10.0%	3.6%	16.5%	13.7%	22.9%	9.3%
1993-94	10.1%	11.0%	12.5%	2.4%	15.4%	N/A	N/A	4.6%
Difference	+2.6%	+3.0%	(-2.5%)	+1.2%	+1.1%	N/A	N/A	+4.7%

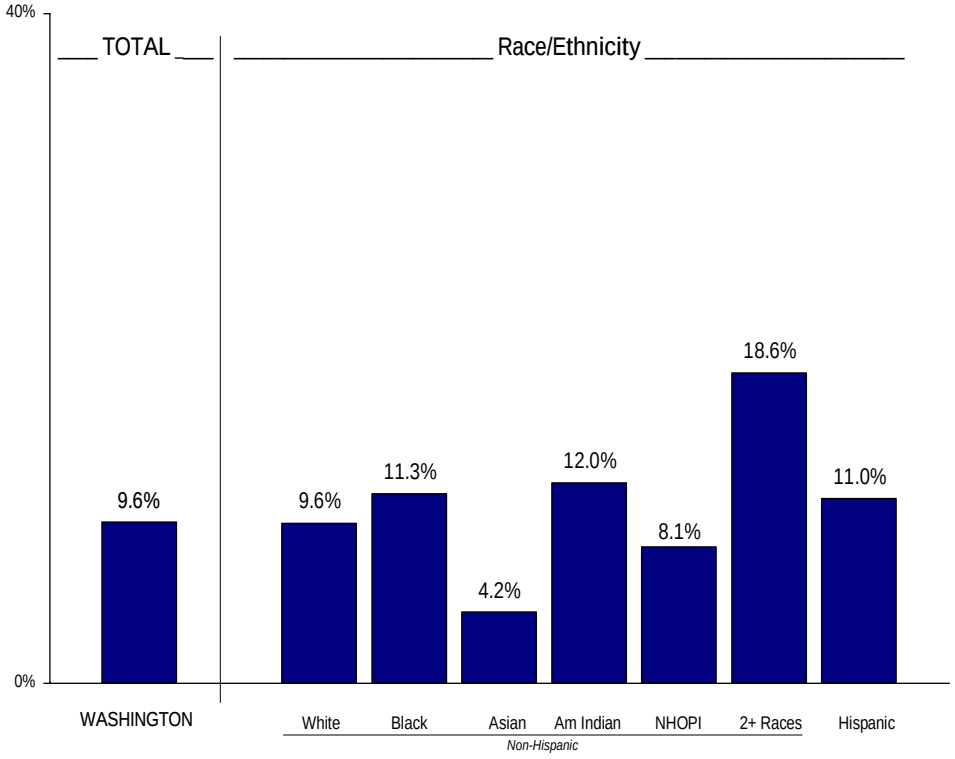
Bold type indicates statistical significance at $p < .05$ *The 1993-94 survey did not separately identify Native Hawaiian or other Pacific Islanders, instead they were included with Asians.

ALL ADULTS

Past Year Illicit Drug Use

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

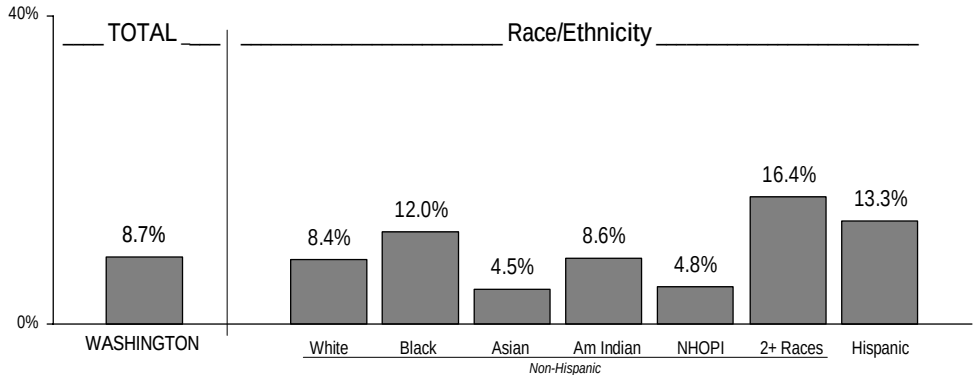
Household Income

ABOVE

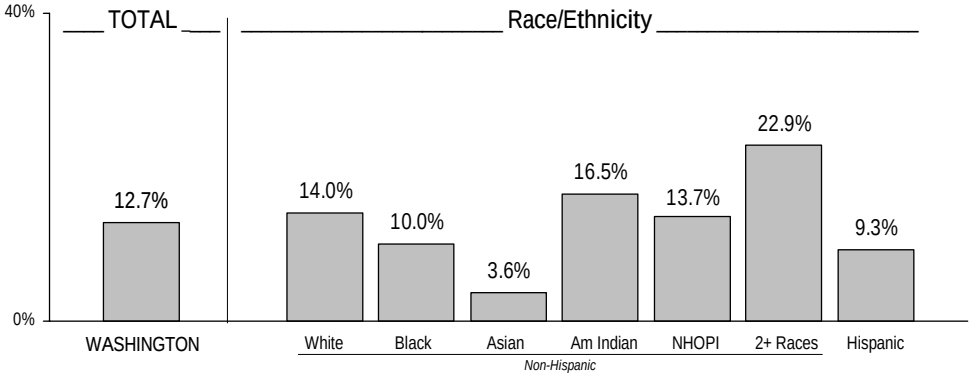
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Past Year Illicit Drug Use Higher Among Lower-Income Pregnant Women

This section reports the prevalence of **past year** use of any illicit drugs among pregnant and parenting women. Results show that, in some cases, rates of any illicit drug use are higher for pregnant and parenting women compared with other women.

Overall, past year illicit drug use among currently pregnant women (7.6 percent) was about the same as among women who were not currently pregnant (7.2 percent). However, pregnant women at or below 200 percent of the federal poverty level were much more likely to report past year illicit drug use (11.4 percent), compared to pregnant women above this poverty threshold (5.7 percent).

Rates of past year illicit drug use were higher among women who had given birth during the past year (11.6 percent) than among women that had not given birth (7.0 percent). The prevalence of drug use here differs by poverty status. Among women above 200 percent of the federal poverty level, illicit drug use was more common among those women who gave birth during the past year (14.1 percent) compared with those who had not (6.3 percent). Among women at or below 200 percent of the federal poverty level, giving birth in the past year had little relationship with past year drug use.

DRUG USE DURING PREGNANCY

CLOSEUP

Teratogenic Properties of Illicit Drugs

Like alcohol, illicit drugs can cross into the placenta and adversely affect development, especially if introduced into the mother's body in large quantities over a prolonged period of time. While it is often difficult to separate teratogenic effects from social and environmental correlates of specific substance abuse, a large number of studies have successfully linked specific illicit substances, including marijuana, to compromised fetal development.

Exposure to drugs *in utero* may cause the following: spontaneous abortion, premature birth, low birth weight, damage to the central nervous system, mild to severe withdrawal symptoms, congenital physical malformations, stillbirth, fetal strokes, upper respiratory infections, respiratory abnormalities, visual, auditory, and/or motor impairments, and significantly increased risk of Sudden Infant Death Syndrome (Brick, 2004; Free, Russell, Mills, & Hathaway, 1990; Hoegerman et al, 1990; Jessup, 1990; Kronstadt, 1989; O'Connor, Kilbride, & Hayen, 1993; Robins & Mills, 1993; Vega et al., 1993).

Drug use during pregnancy may lead to infants being born suffering from substance withdrawal. For example, maternal use of heroin, methadone, methamphetamine, or phencyclidine may produce a neonatal withdrawal syndrome characterized by increased muscle tone, tremors, and a high-pitched cry. Prenatal exposure to drugs may also affect an infant's behavior at birth, thereby interfering with their ability to interact with their environment, to respond to stimuli, and to interact appropriately with the mother or caretaker (Chasnoff & Lowder, 1999).

It is particularly difficult to identify the effects of a single illicit drug on perinatal outcome because the lifestyle associated with the use of any illicit drug usually includes co-use of other drugs (i.e., tobacco, alcohol, other psychoactive drugs).

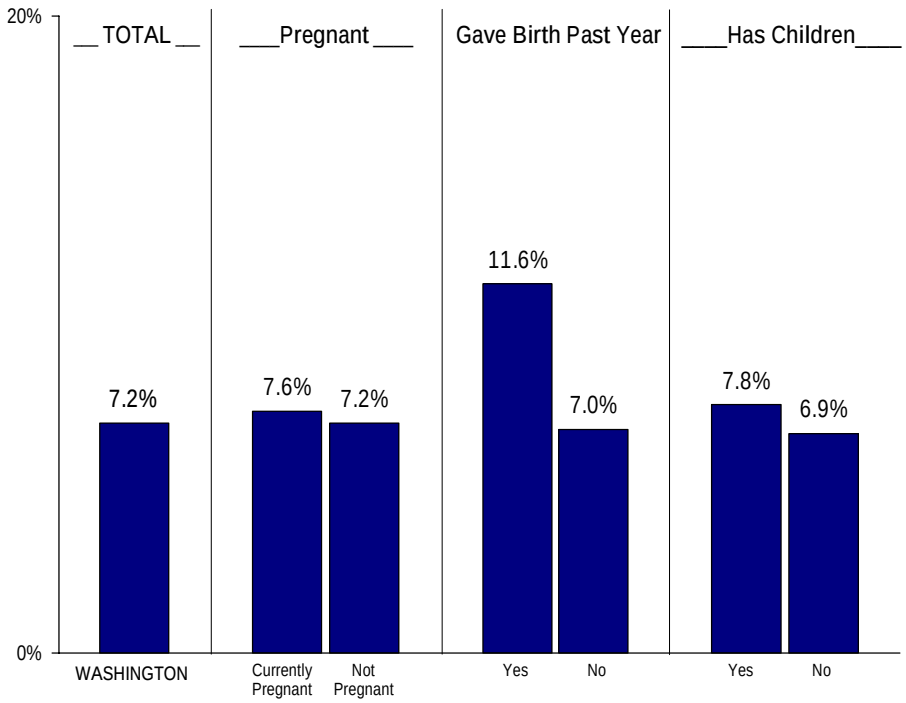
CLOSEUP

Pregnant and Parenting Women: Illicit Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents

Past Year Illicit Drug Use



By Income

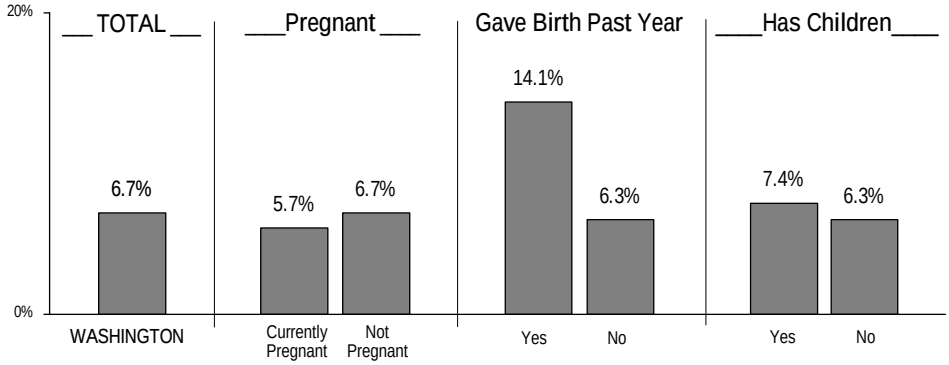
Household Income

ABOVE

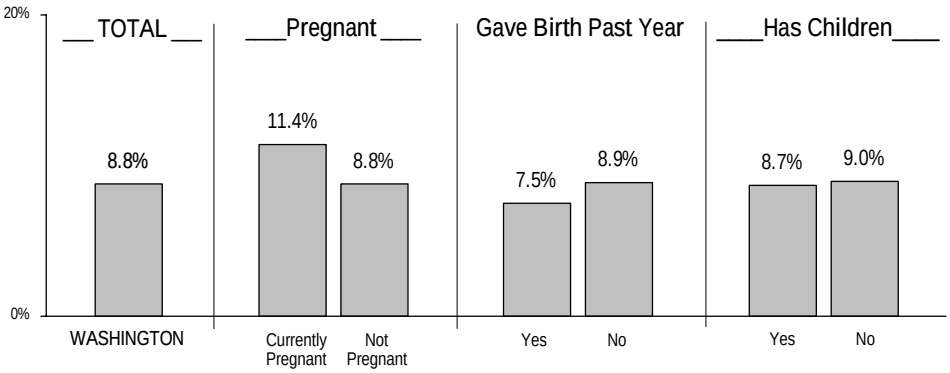
200% Poverty

AT OR BELOW

Past Year Illicit Drug Use – Women Above 200% FPL



Past Year Illicit Drug Use – Women At Or Below 200% FPL



Past Year Use of Non-Heroin Opiates on Rise, Particularly Among Males and Adults in Poverty

This section describes the prevalence of past year non-heroin opiate use by gender, age, and region. This includes non-medical use of such medications as OxyContin and methadone. First, past year 2003 rates are compared with 1993-94 rates. Next, the variations in 2003 estimates are discussed.

Ten-Year Comparison

The overall rate of non-heroin opiate use increased significantly from just 0.5 percent in 1993-94 to 2.0 percent in 2003. Non-heroin opiate use has increased across virtually all of the demographic groups listed in the table below. Particularly noteworthy changes include:

- Use among all males increased by a factor of five – from 0.6 percent to 3.0 percent.
- Use among adults at or below 200 percent of the federal poverty level increased by a factor of six – from 0.5 percent to 3.0 percent.
- Use among adults aged 18 to 24 did not increase for those above 200 percent of the federal poverty level (3.6 percent for both), however, among those aged 18 to 24 at or below 200 percent of the federal poverty level use increased from 0.1 percent to 7.4 percent.

2003 Survey Estimates

The charts on the facing page present 2003 past year non-heroin opiate prevalence rates. These charts show that males, regardless of poverty status, are more likely to use non-heroin opiates in the past year.

Past year use of non-heroin opiates is also strongly associated with age. Younger adults aged 18 to 24 are much more likely (5.2 percent) to use non-heroin opiates than are older adults. The association between past year non-heroin opiate use and age is consistent regardless of poverty status. It is interesting to note that adults who are *both* in poverty and who are aged 18 to 24 appear to be at the greatest risk for using non-heroin opiates.

Little difference in the use of non-heroin opiates was found between adults residing in rural or urban counties.

TEN-YEAR COMPARISON

Past Year Non-Heroin Opiate Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	2.0%	3.0%	1.1%	5.2%	2.9%	0.8%	0.0%	1.7%	2.3%
1993-94	0.5%	0.6%	0.4%	2.4%	0.5%	0.0%	0.0%	0.8%	0.4%
Difference	+1.5%	+2.4%	+0.7%	+2.8%	+2.4%	+0.8%	+0.0%	+0.9%	+1.9%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	1.7%	2.6%	0.8%	3.6%	3.0%	0.6%	0.0%	1.4%	2.0%
1993-94	0.5%	0.7%	0.3%	3.6%	0.3%	0.0%	0.0%	1.1%	0.3%
Difference	+1.2%	+1.9%	+0.5%	+0.0%	+2.7%	+0.6%	+0.0%	+0.3%	+1.7%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	3.0%	4.5%	1.8%	7.4%	2.6%	1.6%	0.1%	2.8%	3.1%
1993-94	0.5%	0.4%	0.6%	0.1%	1.0%	0.1%	0.0%	0.1%	0.8%
Difference	+2.5%	+4.1%	+1.2%	+7.3%	+1.6%	+1.5%	+0.1%	+2.7%	+2.3%

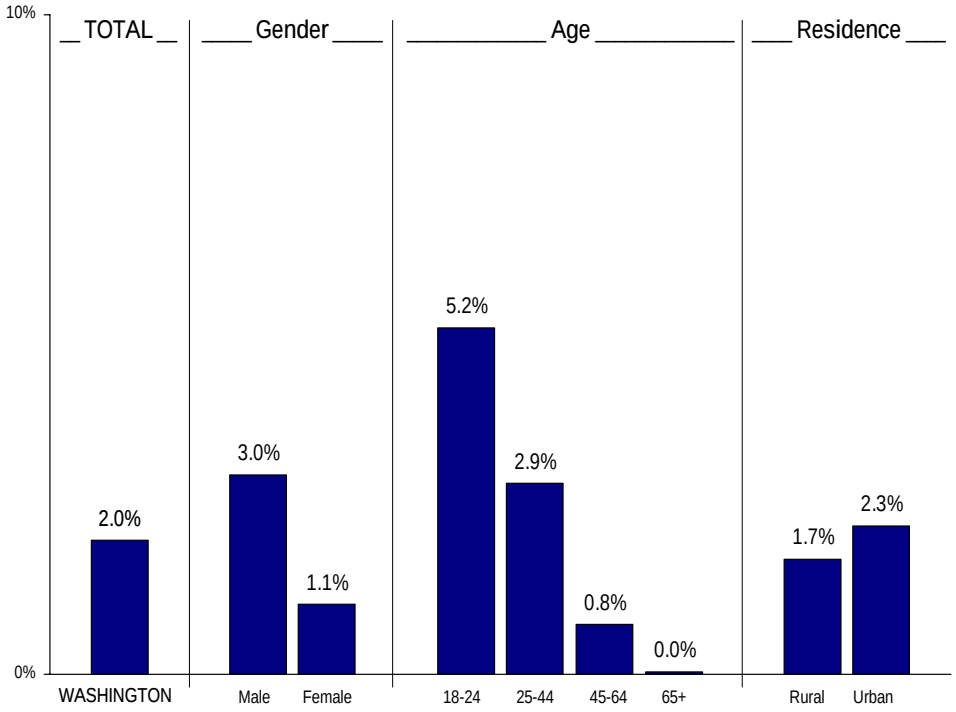
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Past Year Non-Heroin Opiate Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



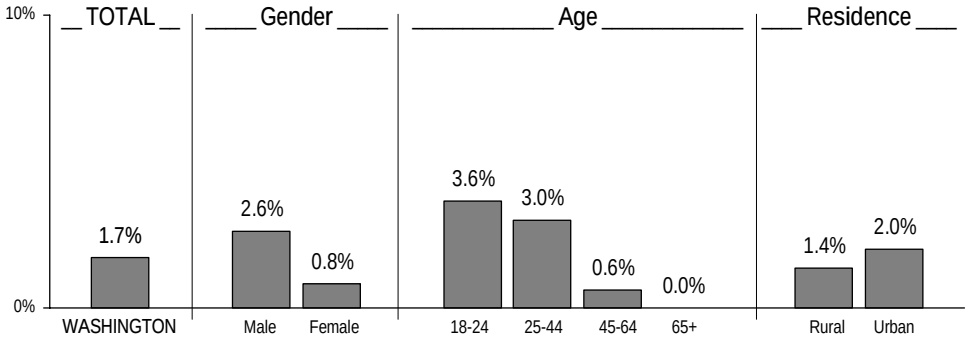
By Income

Household Income

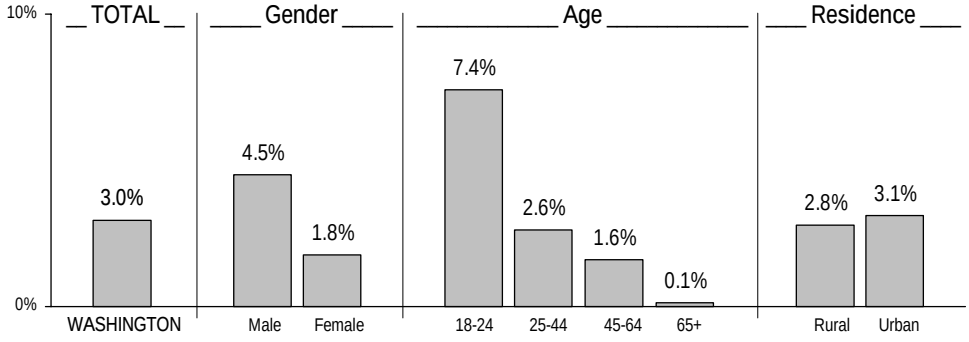
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Increases in Non-Heroin Opiate Use Are Significant Among Whites, Asians, and Hispanics

This section describes the prevalence of past year non-heroin opiate use by race. The table below examines racial and ethnic differences in past year opiate use, comparing 1993-94 rates with 2003 rates. Next, variations within 2003 estimates are presented.

Ten-Year Comparison

Non-heroin opiate use increased in the total adult household population across all racial and ethnic groups. Statistically significant increases included:

- Non-heroin opiate use among Whites paralleled the overall change in the state rates, increasing from 0.5 percent to 2.0 percent.
- Use among Asians increased from 0.1 percent to 0.8 percent.
- Hispanics experienced the largest growth in non-heroin opiate use, increasing from 0.7 percent to 2.8 percent.

Among adults above 200 percent of the federal poverty level, statistically significant increases in rates of past year non-heroin opiate use were found in only two groups, Whites and Hispanics. Rates among both of these groups nearly tripled.

Among adults at or below 200 percent of the federal poverty level, the increase in rates of non-heroin opiate use attained statistical significance for all racial or ethnic groups with one exception. Among American Indian or Alaska Natives the rate more than doubled from 2.0 percent in 1993-94 to 4.5 percent in 2003, however, this did not quite achieve statistical significance (p=.07).

2003 Survey Estimates

The charts on the facing page present rates of past year non-heroin opiate use by racial and ethnic groups. Use was highest among adults indicating they belonged to more than one racial group (4.2 percent) and lowest among Asians (0.8 percent) and Blacks (1.1 percent).

Among adults above 200 percent of the federal poverty level, Hispanics (3.7 percent) followed by multirace (3.2 percent) were the two groups with the highest rates of non-heroin opiate use.

Among adults at or below 200 percent of the federal poverty level, non-heroin opiate use was highest among residents indicating that they belonged to more than one racial group (6.3 percent), Native Hawaiian or Pacific Islanders (5.3 percent), and American Indians or Alaska Natives (4.5 percent).

TEN-YEAR COMPARISON

Past Year Non-Heroin Opiate Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	2.0%	2.0%	1.1%	0.8%	2.2%	2.6%	4.2%	2.8%
1993-94	0.5%	0.5%	0.3%	0.1%	1.3%	N/A	N/A	0.7%
Difference	+1.5%	+1.5%	+0.8%	+0.7%	+0.9%	N/A	N/A	+2.1%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	1.7%	1.7%	0.7%	0.6%	0.5%	0.9%	3.2%	3.7%
1993-94	0.5%	0.5%	0.4%	0.1%	0.6%	N/A	N/A	1.3%
Difference	+1.2%	+1.2%	+0.3%	+0.5%	(-0.1%)	N/A	N/A	+2.4%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	3.0%	3.2%	1.9%	1.1%	4.5%	5.3%	6.3%	2.0%
1993-94	0.5%	0.5%	0.1%	0.1%	2.0%	N/A	N/A	0.2%
Difference	+2.5%	+2.7%	+1.8%	+1.0%	+2.5%	N/A	N/A	+1.8%

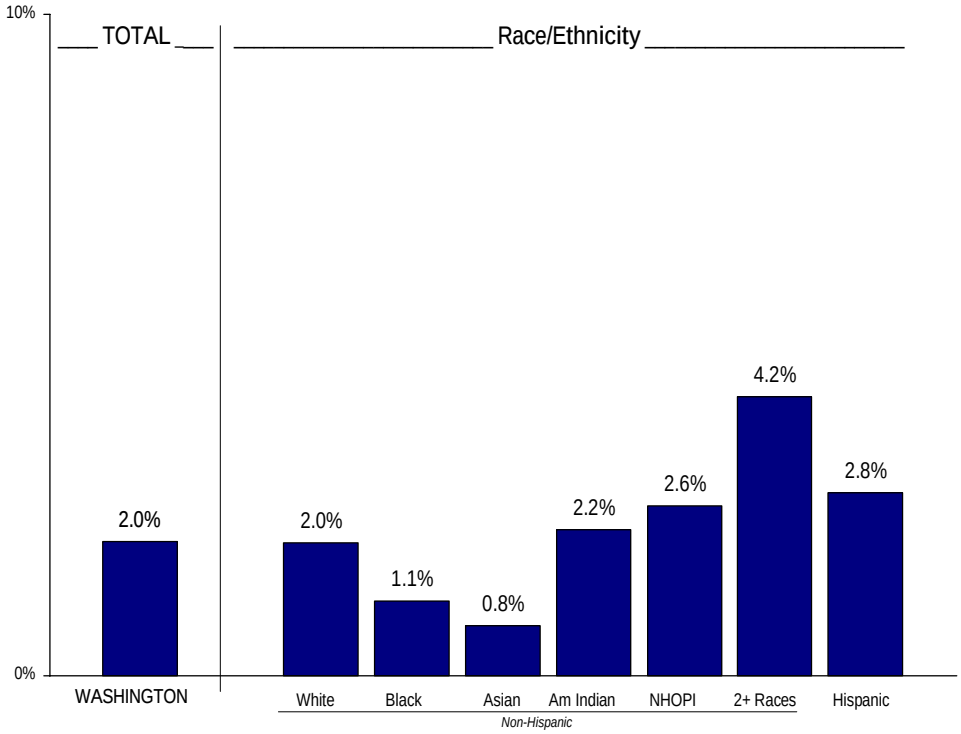
Bold type indicates statistical significance at p <.05 *The 1993-94 survey did not separately identify Native Hawaiian or other Pacific Islanders, instead they were included with Asians.

ALL ADULTS

Past Year Non-Heroin Opiate Use

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

Household Income

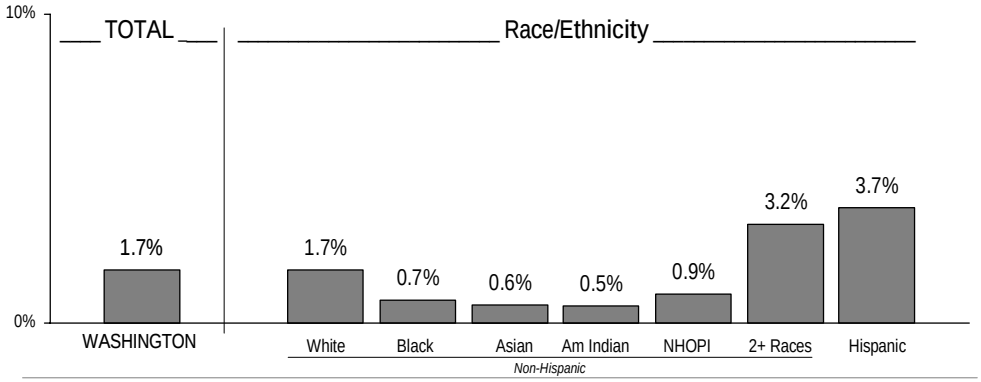
ABOVE

200%

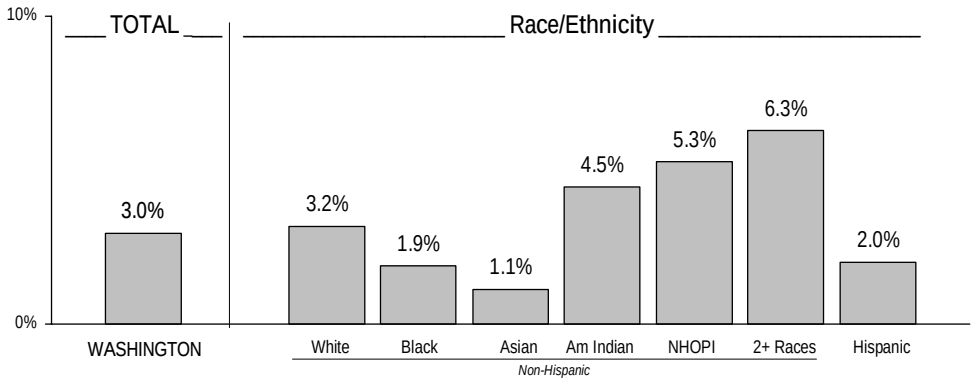
Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Stimulant Use Declined From 1993-94 Levels

This section describes the prevalence of past year stimulant use by gender, age, and region of residence. First, 2003 rates are compared with 1993-94 rates. Next, variations in the 2003 estimates are discussed.

Ten-Year Comparison

The overall rate of past year stimulant use declined significantly from 1.8 percent in 1993-94 to 0.5 percent in 2003. Stimulant use declined for most of the demographic characteristics described in the table below. Specific changes worthy of mention include:

- Use among all males dropped by about a factor of four – from 2.5 percent to just 0.6 percent.
- Use among all adults aged 18 to 24 dropped from 6.3 percent to 1.7 percent.
- Stimulant use among males above 200 percent of the federal poverty level declined from 2.3 percent to 0.3 percent.

2003 Survey Estimates

The charts on the facing page present rates of past year stimulant use in 2003. Stimulant use was more common among adults at or below 200 percent of the federal poverty level (1.2 percent) than among adults above this poverty threshold (0.3 percent).

These charts also show that stimulant use occurs with similar prevalence among both males and females with the exception of adults living at or below 200 percent of the federal poverty level. Among these lower-income adults, males were twice as likely to use stimulants (1.6 percent) than were females (0.8 percent).

Past year use of stimulants occurred most frequently among adults aged 18 to 24 (1.7 percent), and use rates tend to decline with age.

Little difference in stimulant use was noted between adults residing in rural or urban counties.

TEN-YEAR COMPARISON

Past Year Stimulant Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	0.5%	0.6%	0.4%	1.7%	0.6%	0.2%	0.1%	0.4%	0.6%
1993-94	1.8%	2.5%	1.1%	6.3%	2.0%	0.5%	0.0%	1.7%	1.8%
Difference	(–1.3%)	(–1.9%)	(-0.7%)	(–4.6%)	(-1.4%)	(-0.3%)	+0.1%	(-1.3%)	(-1.2%)

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	0.3%	0.3%	0.3%	1.2%	0.5%	0.0%	0.0%	0.1%	0.4%
1993-94	1.6%	2.3%	0.8%	6.3%	1.8%	0.4%	0.0%	1.7%	1.5%
Difference	(–1.3%)	(–2.0%)	(-0.5%)	(–5.1%)	(-1.3%)	(-0.4%)	+0.0%	(-1.6%)	(-1.1%)

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	1.2%	1.6%	0.8%	2.4%	0.9%	1.2%	0.4%	1.2%	1.1%
1993-94	2.5%	3.3%	1.8%	6.3%	2.8%	0.8%	0.0%	1.8%	2.9%
Difference	(-1.3%)	(-1.7%)	(-1.0%)	(-3.9%)	(-1.9%)	+0.4%	+0.4%	(-0.6%)	(-1.8%)

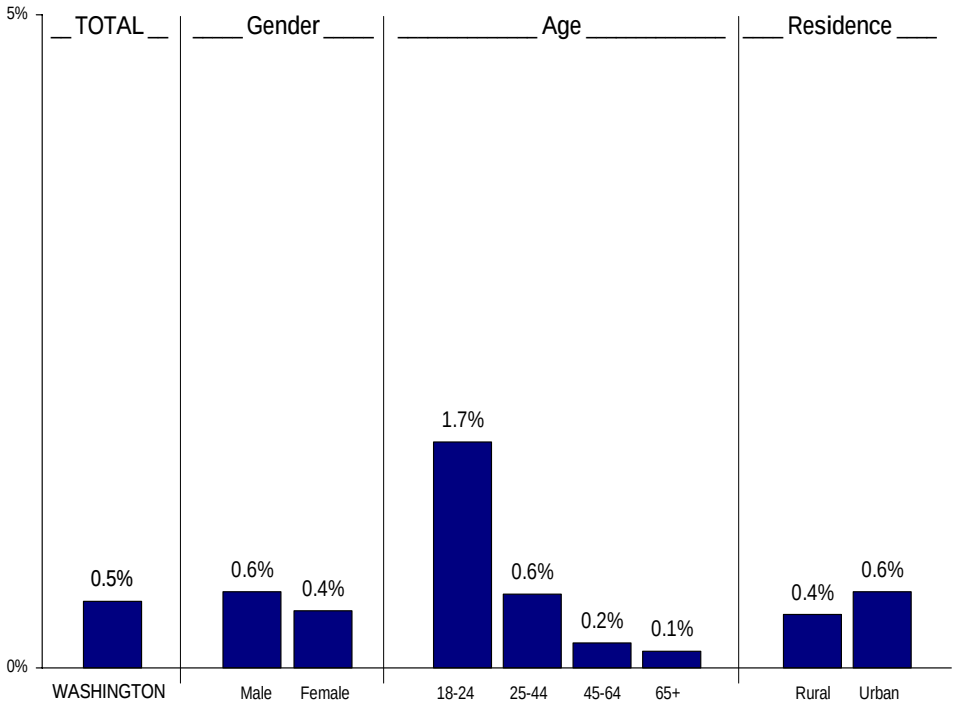
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Past Year Stimulant Use

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

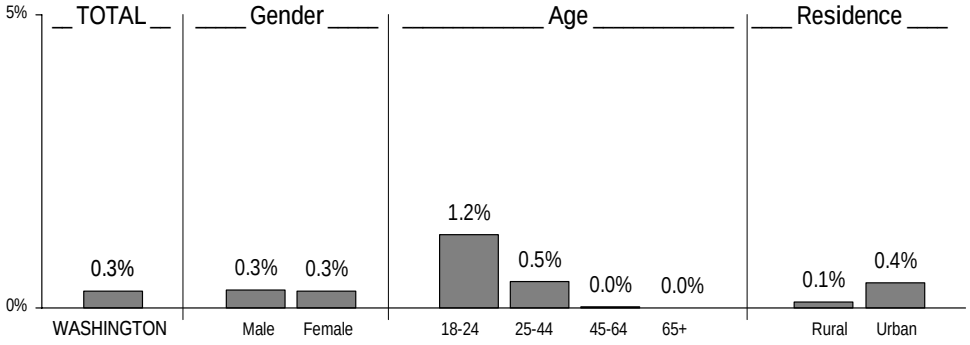
Household Income

ABOVE

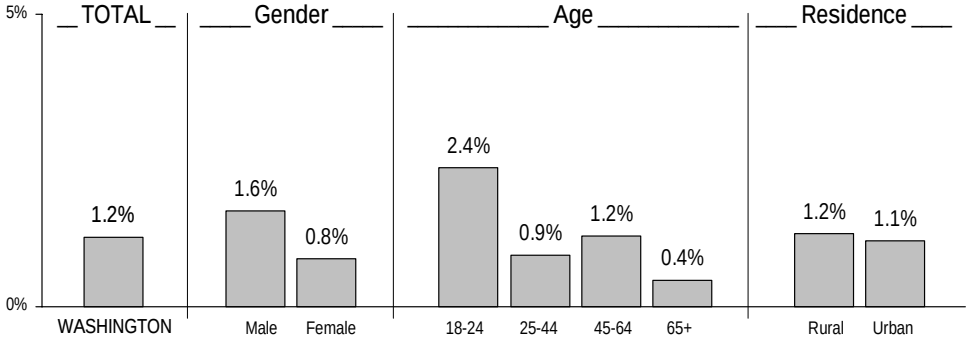
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Stimulant Use Highest Among American Indians and Multirace Adults

This section presents the prevalence of past year stimulant use by racial and ethnic groups. First, comparisons between 2003 rates and 1993-94 rates are presented. Next, variations in 2003 rates are discussed.

Ten-Year Comparison

The table below shows that stimulant use was down from 1993-94 levels among all groups except Asians. Use among Asians increased from 0.1 percent in 1993-94 to 0.3 percent, however, this was not statistically significant. The only statistically significant change among total adult household residents was among Whites who decreased from 1.9 percent in 1993-94 to 0.4 percent in 2003.

Among adults above 200 percent of the federal poverty level, stimulant use dropped significantly for two groups:

- Use of stimulants among whites declined from 1.7 percent in 1993-94 to 0.2 percent.
- Among American Indians or Alaska Natives use declined from 1.9 percent 1993-94 to 0.2 percent.

Among adults at or below 200 percent of the federal poverty level, the decline in stimulant use was significant only among Hispanics, where use dropped from 2.0 percent in 1993-94 to 0.4 percent in 2003.

2003 Survey Estimates

The charts on the facing page present 2003 rates of past year stimulant use by racial and ethnic groups. Stimulant use was highest among residents indicating they belonged to two or more races (1.6 percent) and American Indians or Alaska Natives (1.4 percent). Prevalence rates for the other racial groups were each under 1.0 percent.

Among adults above 200 percent of the federal poverty level, stimulant use was highest among Hispanics (1.5 percent).

Among Adults at or below 200 percent of the federal poverty level, stimulant use was highest among adults reporting they belonged to two or more races (3.2 percent) and American Indians or Alaska Natives (3.0 percent).

It is interesting to note that, while rates of stimulant use were higher for lower-income adults, rates of use among Hispanics, Asians, and Blacks were higher for those that were *above* 200 percent of the federal poverty level.

TEN-YEAR COMPARISON

Past Year Stimulant Use: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	0.5%	0.4%	0.6%	0.3%	1.4%	0.3%	1.6%	0.9%
1993-94	1.8%	1.9%	1.4%	0.1%	3.0%	N/A	N/A	1.5%
Difference	(-1.3%)	(–1.5%)	(-0.8%)	+0.2%	(-1.6%)	N/A	N/A	(-0.6%)

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	0.3%	0.2%	0.7%	0.4%	0.2%	0.0%	0.8%	1.5%
1993-94	1.6%	1.7%	1.5%	0.1%	1.9%	N/A	N/A	1.1%
Difference	(-1.3%)	(–1.5%)	(-0.8%)	+0.3%	(-1.7%)	N/A	N/A	+0.4%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	1.2%	1.4%	0.3%	0.0%	3.0%	0.7%	3.2%	0.4%
1993-94	2.5%	2.7%	1.2%	0.1%	4.2%	N/A	N/A	2.0%
Difference	(-1.3%)	(-1.3%)	(-0.9%)	(-0.1%)	(-1.2%)	N/A	N/A	(-1.6%)

Bold type indicates statistical significance at p <.05 *The 1993-94 survey did not separately identify Native Hawaiian or other Pacific Islanders, instead they were included with Asians.

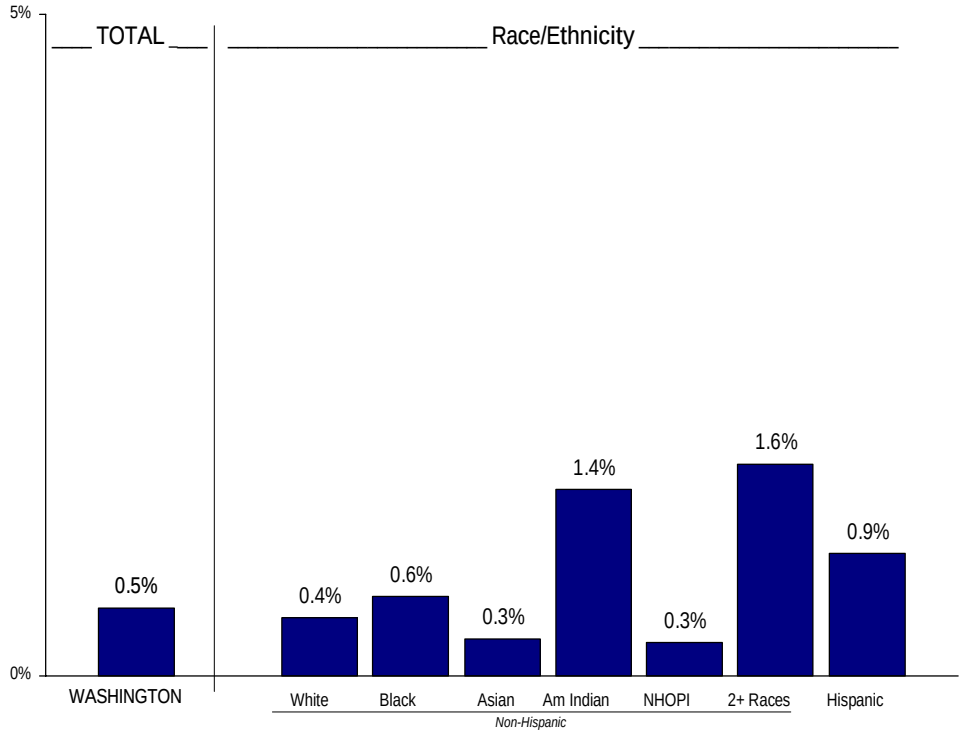
2003 SURVEY ESTIMATES

ALL ADULTS

Past Year Stimulant Use

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

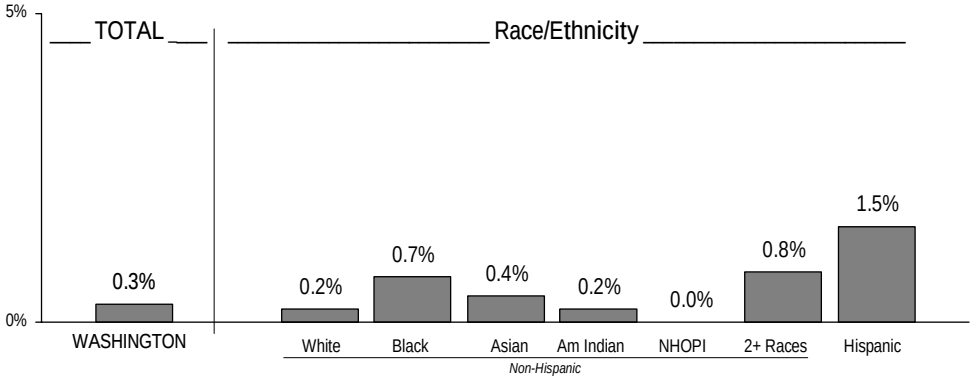
Household Income

ABOVE

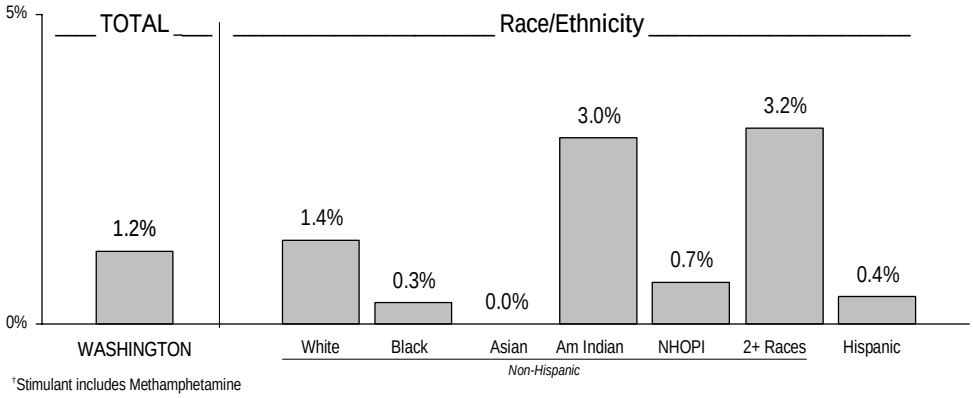
200%
Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Lifetime Injection Drug Use Higher Among Males, Urban Residents

This section describes the prevalence of **lifetime** injection drug use by gender, age and region. Respondents indicating they had ever used any type of illicit substance were asked about their use of injection drugs: "Have you ever injected any drug in order to get high, even just once?"

While it is tempting to infer that injection drug use is indicative of heroin use, it is not possible from these data to determine what substance was being injected. A number of illicit substances other than heroin (e.g., methamphetamine) can also be injected.

The charts on the facing page present 2003 lifetime injection drug rates. The charts show that lifetime injection drug use is about twice as common (2.9 percent) among adults living at or below 200 percent of the federal poverty level, compared with higher-income adults (1.4 percent).

Regardless of poverty status, males are more likely than females to use injection drugs. Lifetime injection drug use is somewhat higher among adults living in urban counties (2.2 percent) than among those residing in rural counties (1.2 percent). This pattern is found regardless of poverty status.

Among adults living at or below 200 percent of the federal poverty level, lifetime injection drug use is most common among adults aged 45 to 64 (7.4 percent).

INJECTION RISKS

CLOSEUP

Significant Health Risks Associated with Injecting Illicit Drugs

Injection or intravenous (IV) drug use involves injecting a drug directly into the bloodstream. This method can be used for heroin, stimulants, cocaine, and, less often, certain benzodiazepines. This method can make the user feel that they are getting the most out of the drug and produce a more intense "rush" compared with other methods.

The most serious health risk of injecting drugs results from sharing injection devices (e.g., syringe, needle, filter, spoon, and water) as these can spread the HIV virus and hepatitis. Injecting drugs can also lead to a host of other infections and to abscesses. Injecting drugs can cause a "shake" or "cotton fever." A shake or cotton fever is caused by bacteria entering the bloodstream during injection and the risk of this is increased with dirty and blunt needles. Infections may also be caused by the leakage of drugs out of veins during the injection (extravasation) and tissue death (necrosis) due to toxic materials in drugs.

Drugs that are not properly dissolved may introduce solid masses into the bloodstream and these can lead to blood clots, blocked veins, and embolisms.

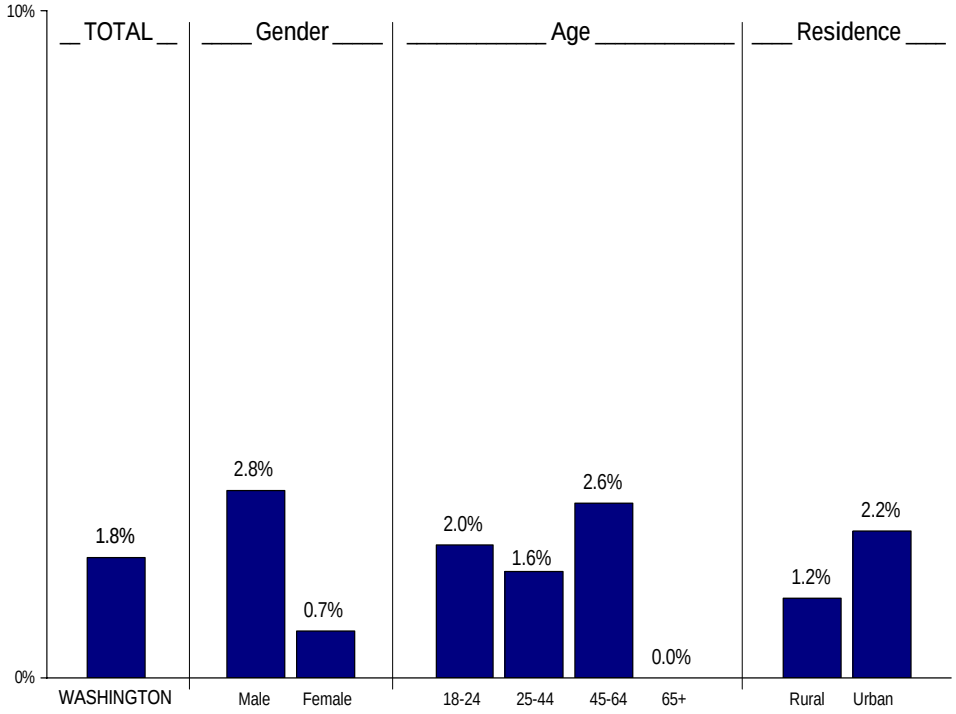
Source: Much of this material was obtained from the King County Health Department (http://www.metrokc.gov/health/apu/menuhr.htm) and StreetWorks (http://www.streetworks.ca/pro/srhealthifidu.html), a harm reduction program.

ALL ADULTS

Lifetime Injection Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



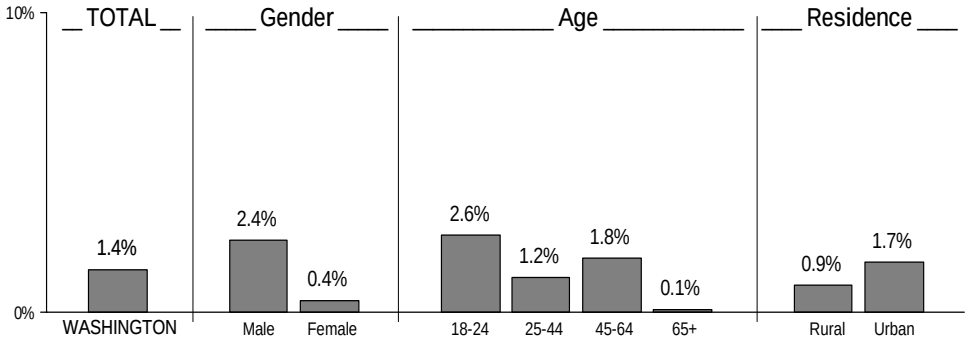
By Income

Household Income

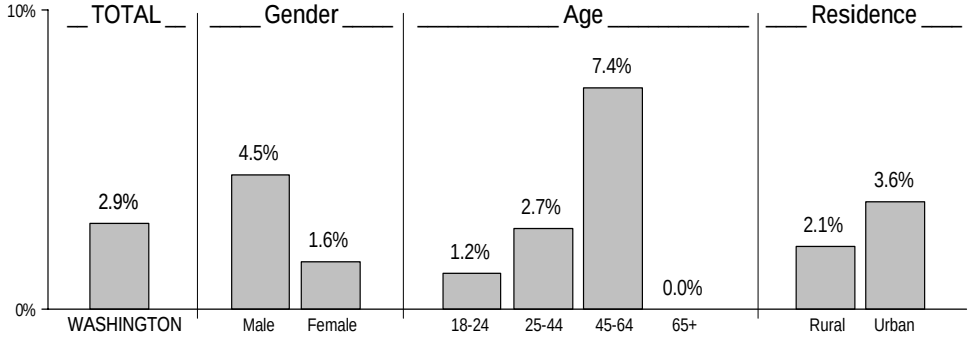
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Injection Drug Use Highest Among American Indians and Multirace Adults

This section describes the prevalence of **lifetime** injection drug use by race and ethnicity. As shown in the charts on the facing page, lifetime injection drug use is highest among American Indians and Alaska Natives (6.2 percent).

Adults self-identifying themselves as belonging to two or more non-Hispanic races also used injection drugs at higher rates (4.5 percent). Among this population, poverty seems to play an important role. Lifetime injection drug use was much higher among multirace adults living at or below 200 percent of the federal poverty level (8.8 percent) than among multirace adults above 200 percent of the federal poverty level (2.3 percent).

Lifetime prevalence rates of injection drug use were lowest among Asians (0.2 percent) and Native Hawaiian or Pacific Islanders (0.5 percent).

Poverty status played an important role in rates of lifetime injection drug use among every race except American Indians and Alaska Natives. Among all other racial or ethnic groups, lifetime injection drug use was more common for those living at or below 200 percent of the federal poverty level.

NEEDLE EXCHANGE PROGRAMS

CLOSEUP

Needle exchange programs are a component of a larger treatment strategy called *harm reduction*. The harm reduction perspective posits that it is unrealistic to expect substance use to be eliminated and that considerable benefit may be derived from efforts directed at getting users to adopt safer behaviors. For injection drug users (IDUs), harm reduction programs emphasize needle exchange programs.

Needle or syringe exchange programs began in Holland in the 1970s in response to a hepatitis outbreak. One of the first openly operating needle exchange programs in the U.S. began in Tacoma during the late 1980s. Needle exchange is a public health program viewed by many as an important component of a comprehensive effort to reduce the spread of HIV/AIDS and other blood-borne infections. Nationally, injection drug use is linked to almost one third of all AIDS cases and one-half of hepatitis C cases.

Needle exchange programs provide new, sterile syringes in exchange for used, contaminated syringes. Needle exchange programs also help drug users access drug treatment and health care and provide important risk reduction information. Other services may include:

- HIV/AIDS education, testing, counseling, and crisis intervention
- Screening for tuberculosis, hepatitis B, hepatitis C, and other infections
- Distribution of alcohol swabs to prevent abscesses and other bacterial infections
- Distribution of condoms to prevent sexual transmission of HIV and other sexually transmitted diseases
- Safe disposal of contaminated equipment

Needle exchange programs have been shown to be an effective way to link some hard-to-reach IDUs with important public health services. Studies have also found that needle exchange programs do not encourage drug use among program participants and do not recruit first-time drug users. In 1997 the National Institutes of Health Consensus Panel on HIV Prevention stated:

"An impressive body of evidence suggests powerful effects from needle exchange programs… Can the opposition to needle exchange programs in the United States be justified on scientific grounds? Our answer is a simple and emphatic no. Studies show reduction in risk behavior as high as 80% with estimates of a 30% or greater reduction of HIV in IDUs."

In 2000, a survey by The International Center for the Advancement of Addiction Treatment found that Washington state is a leading provider of needle exchange programs, ranking behind only California in the number of exchange programs offered and number of syringes exchanged. Currently, needle exchange is available in 12 counties across the State (ADAI Research Brief, 2004).

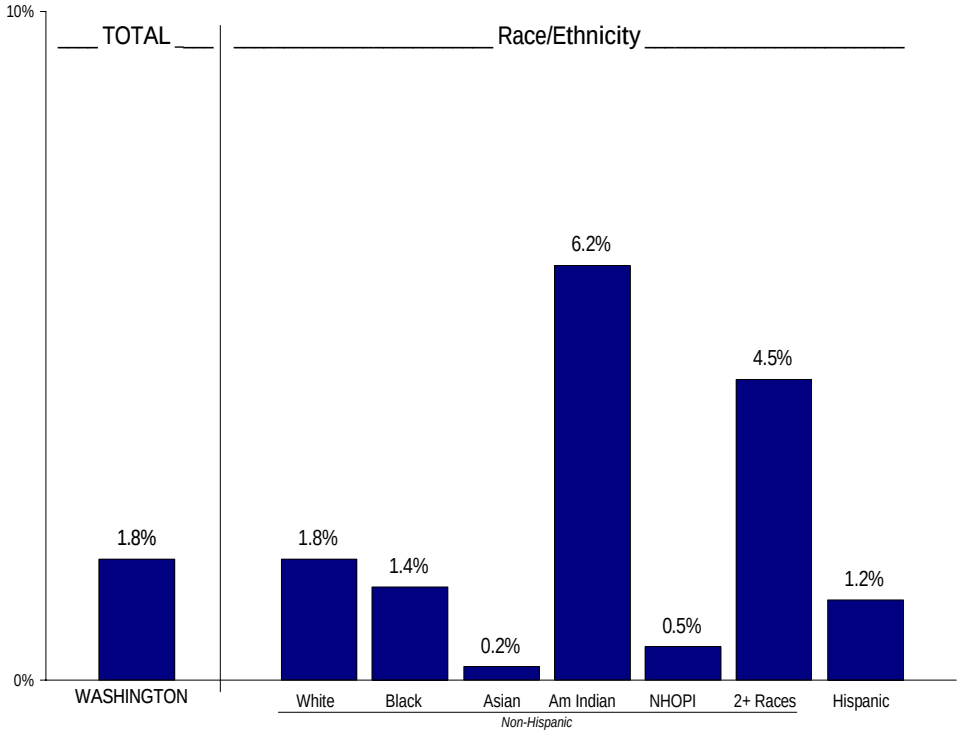
Source: Much of this information was provided by the Department of Health and Human Services Center for Disease Control and Prevention (Academy for Educational Development, 2000).

ALL ADULTS

Lifetime Injection Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

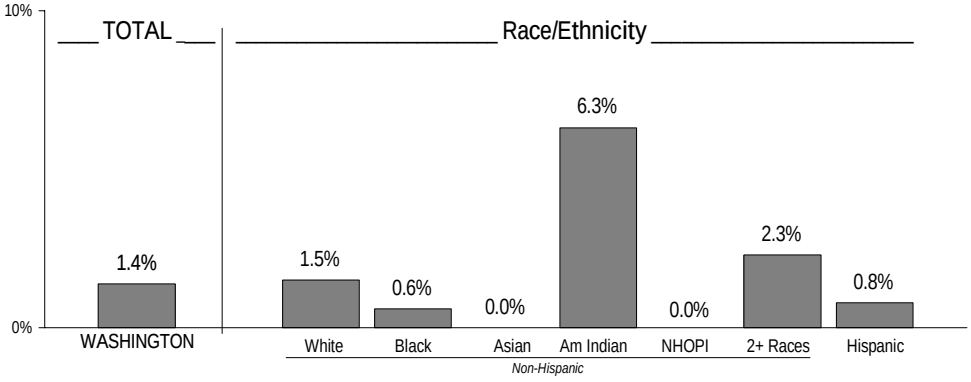
Household Income

ABOVE

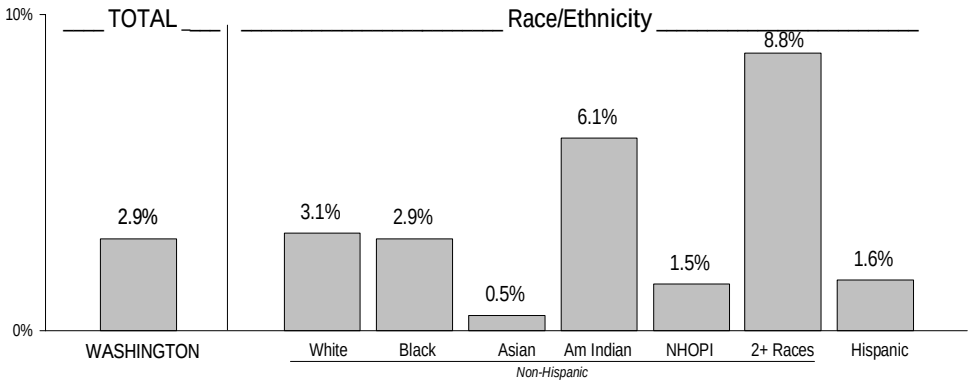
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Examining The Demographics Of Substance Use In A Multivariate Framework

Thus far, estimates of substance use rates by different demographic characteristics have considered each characteristic in isolation from the others. While this information is useful, it does not account for the possibility that differences in some demographic dimensions may in fact be due to the effect of another underlying demographic factor.

For example, racial and ethnic group substance use rates have been presented without controlling for differences in age or poverty status that may help account for the observed differences in use rates. To better identify the separate influence of demographic variables on substance use, we examine past year binge drinking and any illicit drug use in a multivariate framework.

The chart below and on the facing page present odds ratios derived from logistic regression models.

Binge Drinking

The odds of binge drinking in the past year decline significantly with age. Young adults aged 18 to 24 were nearly 14 times as likely to engage in binge drinking during the past year compared to adults aged 65 and above. Compared to women, men were twice as likely to engage in binge drinking during the past year.

American Indian and Alaska Natives and adults reporting two or more non-Hispanic races (multiracial) did not differ significantly from Whites in frequency of past year binge drinking. All other racial and ethnic groups were significantly less likely to engage in binge drinking during the past year, when compared to Whites. The largest effect by far was found for Asians who do not speak English. The effects of region of residence and poverty status were not statistically significant.

2003 SURVEY ESTIMATES

Odds Ratios Associated With Past Year Binge Drinking

ALL ADULTS

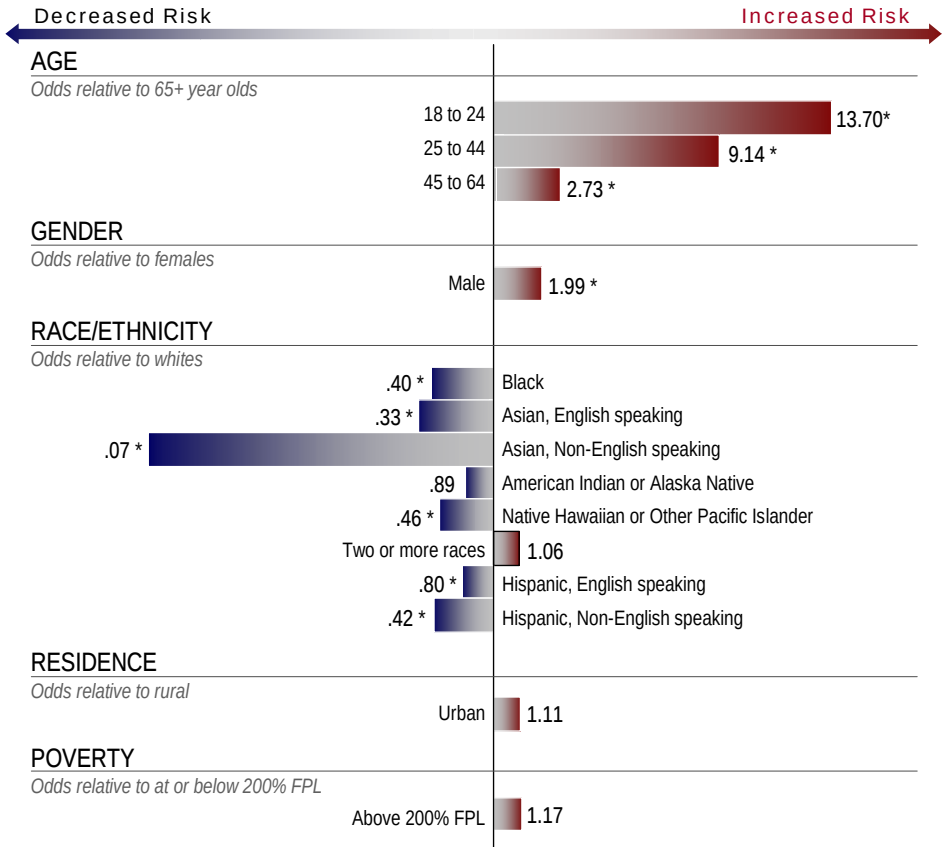
Past Year Binge Drinking

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Chart reads: 18 to 24 year olds have 13.7 times the odds of binge drinking, compared to persons age 65 and older.

*Significantly different from 1 at p <.05



Any Illicit Drug Use

Past year use of any illicit drug (including marijuana) declines with age. Young adults aged 18 to 24 were 38 times more likely to use an illicit drug use in the past year compared to adults aged 65 and above. Compared to women, men had 1.8 times the odds of illicit drug use in the past year.

Blacks, American Indian and Alaska Natives, and English speaking Hispanics did not differ from Whites in the frequency of past year illicit drug use. Asians, Native Hawaiian or Other Pacific Islanders, and non-English speaking Hispanics were all significantly less likely to use an illicit drug during the past year, compared to Whites. Adults reporting two or more races were significantly more likely to use an illicit drug.

Adults residing in urban counties were significantly more likely to use an illicit drug during the past year. Adults living above 200 percent of the federal poverty level were significantly less likely to use an illicit drug during the past year.

2003 SURVEY ESTIMATES

Odds Ratios Associated With Any Illicit Drug Use

ALL ADULTS

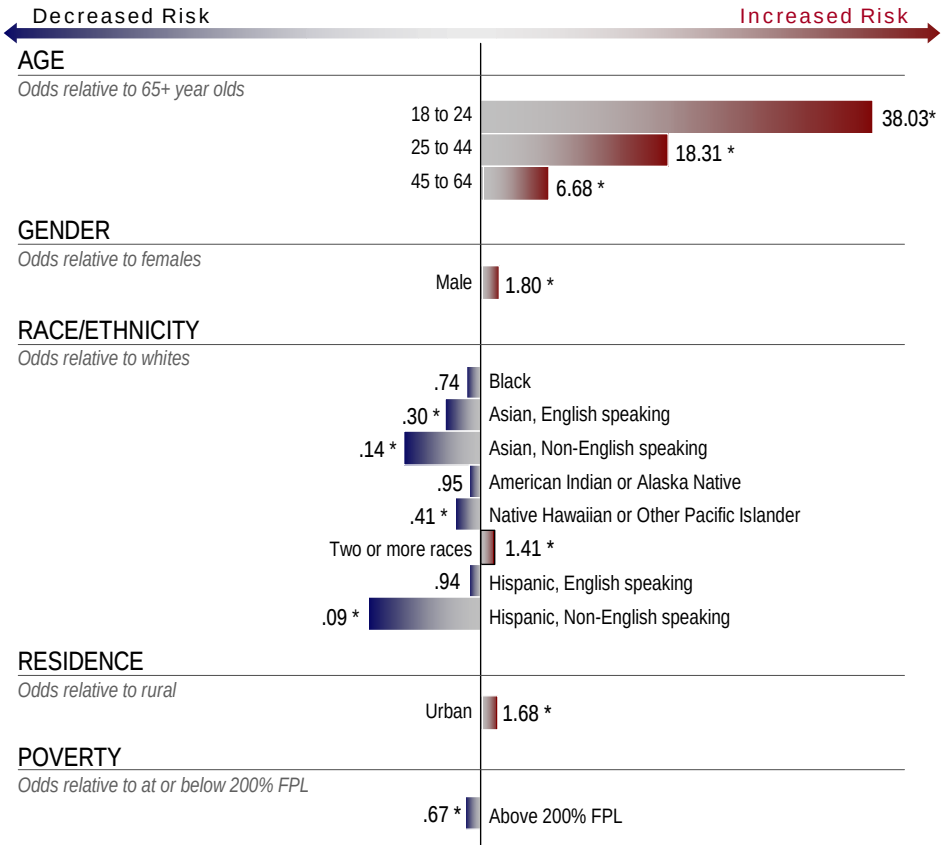
Past Year Illicit Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Chart reads: 18 to 24 year olds have 38 times the odds of using any illicit drug compared to persons 65 and older

*Significantly different from 1 at p <.05



INTERPRETING ODDS RATIOS

The odds of an event is the number of times it occurred (a) divided by the number of times it didn't (b), or a/b. This contrasts with the probability of an event which is the number of times it occurred divided by the number of times it could have occurred, or a/a+b. The odds ratio is the ratio of the odds of an event in one group divided by the odds in another group (the "reference" group).

An odds ratio of 1 indicates no difference between the groups being compared. An odds ratio of less than 1 would mean that having that characteristic indicates a smaller chance of experiencing that event. Alternately, having an odds ratio greater than 1 indicates a greater chance of experiencing that event. The odds ratio has a lower bound at 0, but no upper limit. It is important to realize this when comparing the relative magnitudes of odds ratios. For example, an odds ratio of 10 may sound more impressive than an odds ratio of 0.1; however, these represent effects that are identical in size (in the opposite direction). Odds ratios less than 1 can be expressed in the same scale as odds ratios greater than 1 simply by taking their inverse.

Binge Drinking, Any Illicit Drug Use Higher Among Adults Reporting Two or More Races

This section examines the aspects of race and substance use in more detail. The charts on the facing page describe the prevalence of past year binge drinking and any illicit drug use among adults reporting one race and among adults endorsing two or more races. For example, adults reporting that they are White alone are compared with adults reporting that they were White in combination with one or more other races.

The 2+ Race categories contain duplicate counts, in that adults indicating that they are White and Black are included in both the White 2+ Race category and the Black 2+ Race category.

Adults endorsing two or more races consistently reported both higher rates of past year binge drinking and any illicit drug use than adults endorsing a single race.

Binge drinking and any illicit drug use differences between adults reporting a single race and those reporting two or more races were smallest among American Indians and Alaska Natives. The tendency for multirace adults to report higher rates of substance use was particularly strong among African Americans, Asians, and Native Hawaiian or Other Pacific Islanders.

We also examined whether the observed higher rates of substance use among multirace adults could be explained by underlying differences in age (i.e., a tendency for adults reporting two or more races to be younger than those reporting a single race). However, we found that differences between single race and multirace adults in age-adjusted rates of substance use were similar to the unadjusted differences reported here (not reported in a separate exhibit).

DEFINING RACE

Multiracial Classification

Survey respondents were read a list of five separate races: White, Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Asian. Respondents were instructed to indicate whether they considered themselves to belong to each of these groups. Respondents indicating two or more of these racial groups were classified as belonging to a multirace (2+ Races) group.

Survey respondents were asked about Hispanic ethnicity in a separate question, "Are you Hispanic or Latino(a)?" Respondents indicating that they were Hispanic were classified as such, regardless of whether they indicated more than one racial category.

Multiracial Combinations

494 survey respondents were classified as belonging to 2+ races.

These respondents all indicated that they were not Hispanic and endorsed 2 or more races.

The different multiracial groups endorsed by respondents are identified at right, in descending order of frequency.

White + American Indian/Alaska Native	219
White + Black	70
White + Asian	57
White + Native Hawaiian/Pacific Islander	27
Black + American Indian/Alaska Native	25
Asian + Native Hawaiian/Pacific Islander	23
White + Black + American Indian/Alaska Native	18
Asian + American Indian/Alaska Native	9
Black + Asian	8
White + Asian + Native Hawaiian/Pacific Islander	7
White + American Indian/Alaska Native + Native Hawaiian/Pacific Islander	6
Black + Native Hawaiian/Pacific Islander	5
Multirace*	5
American Indian/Alaska Native + Native Hawaiian/Pacific Islander	3
American Indian/Alaska Native + Other (unspecified)	3
White + Black + Asian	2
Asian + Other (unspecified)	2
White + Black + Asian + American Indian/Alaska Native	2
All Others	3
TOTAL	**494**

* Five respondents reported their race as "multirace"; however, they failed to endorse any specific racial groups.

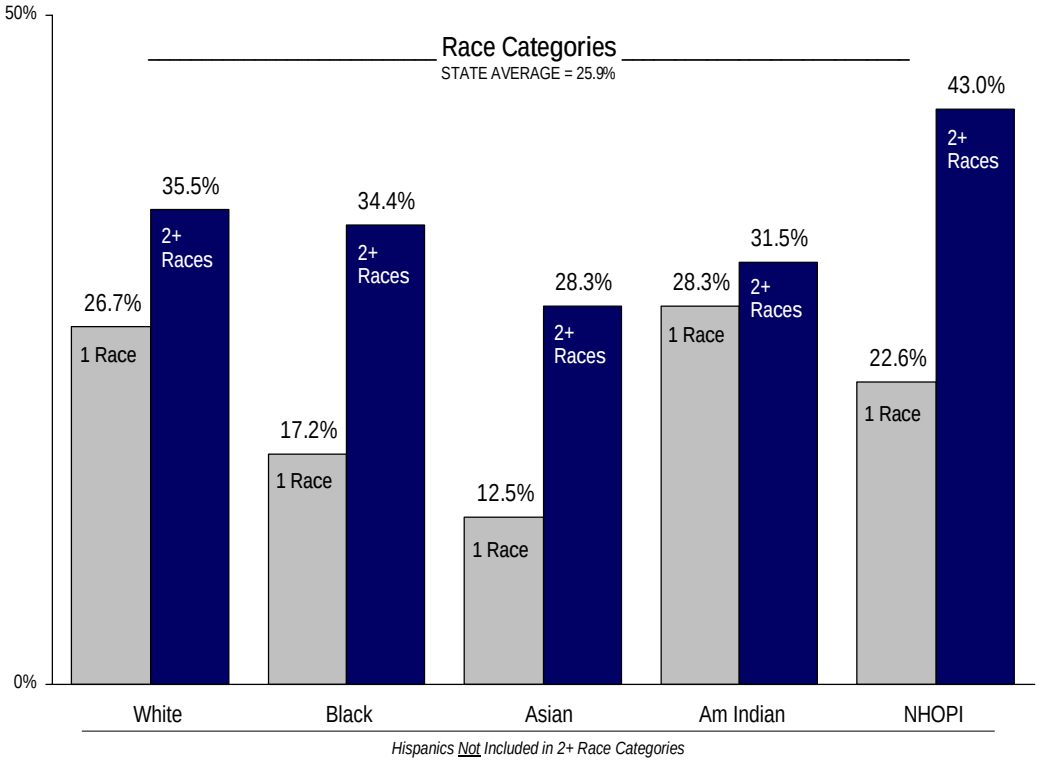
Past Year Binge Drinking

CLOSEUP

Multiracial Comparisons: Binge Drinking

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



Hispanics Not Included in 2+ Race Categories

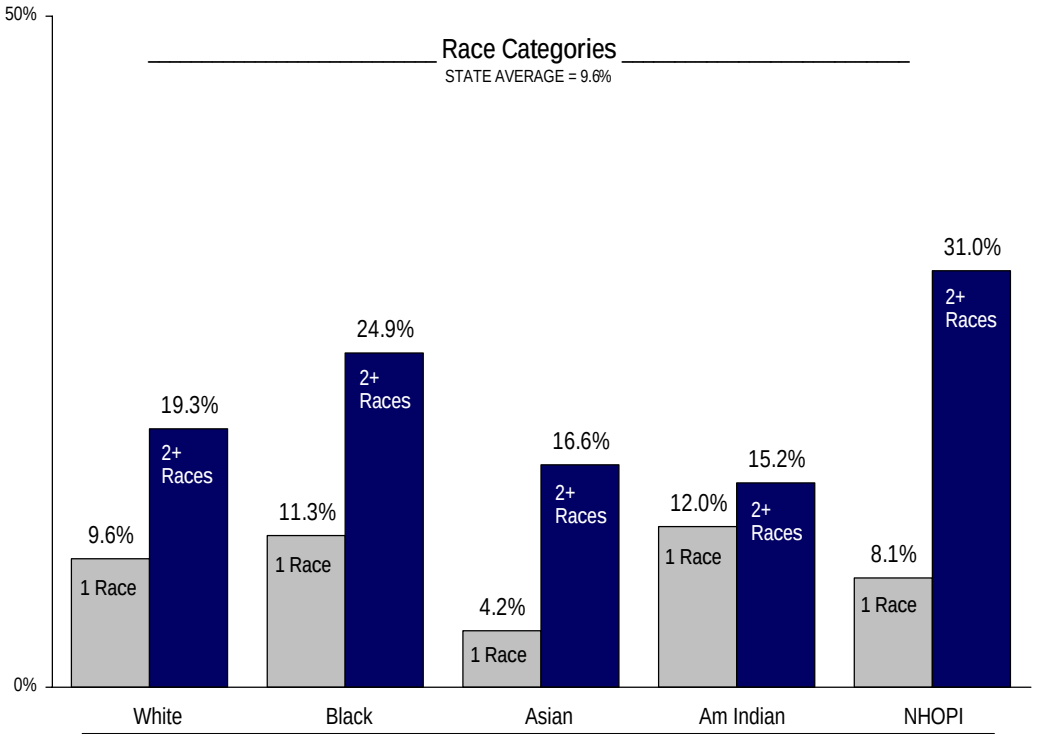
Past Year Any Illicit Drug Use

CLOSEUP

Multiracial Comparisons: Illicit Drug Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



Hispanics Not Included in 2+ Race Categories

Asians And Hispanics: Past Year Binge Drinking, Drug Use More Common Among English Speakers

Charts below examine rates of past year binge drinking and illicit drug use among Asians and Hispanics. Comparisons are made between those who completed the interview in English and those completing the interview in another language. The survey was offered in Russian, Spanish, Chinese, Korean, and Vietnamese for respondents who did not speak English.

Among Asians and Hispanics, respondents completing the interview in English reported higher rates of past year binge drinking and illicit drug use.

Among Hispanics

- Roughly 3 out of 10 Hispanics interviewed in English engaged in binge drinking during the past year. Among Hispanics who did not speak English, the number binge drinking in the past year was less than 2 out of 10.
- Hispanics who spoke English were seven times as likely to use an illicit drug (14.7 percent) as Hispanics who did not speak English (1.9 percent).

Among Asians

- Asians surveyed in English were more than six times as likely to report past year binge drinking (14.9 percent), compared to Asians surveyed in another language (2.3 percent).
- Asians who spoke English (4.8 percent) were more than twice as likely to report past year illicit drug use, compared to Asians who did not speak English (1.8 percent).

Country of Origin for Asians Not Born in U.S.

Vietnam	214
China, Taiwan, Hong Kong	196
South Korea	154
Philippines	79
Japan	42
India	21
Cambodia	20
Thailand	13
Canada	7
Laos	7
Indonesia	6
All Others or Unknown	29
TOTAL	**809**

2003 SURVEY ESTIMATES

CLOSEUP

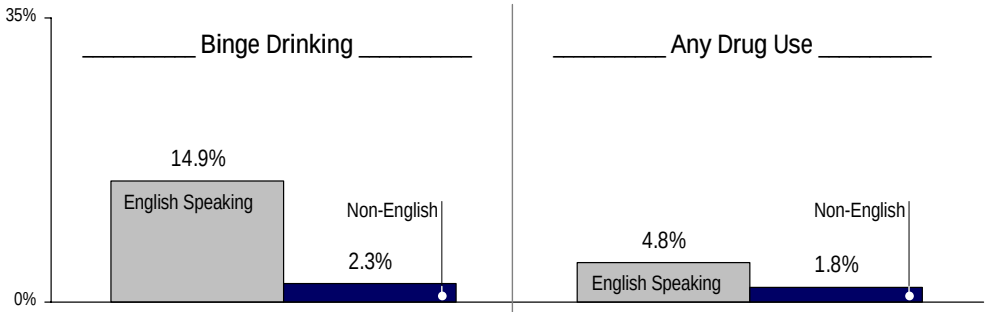
Past Year Use

Asian and Hispanic Adults

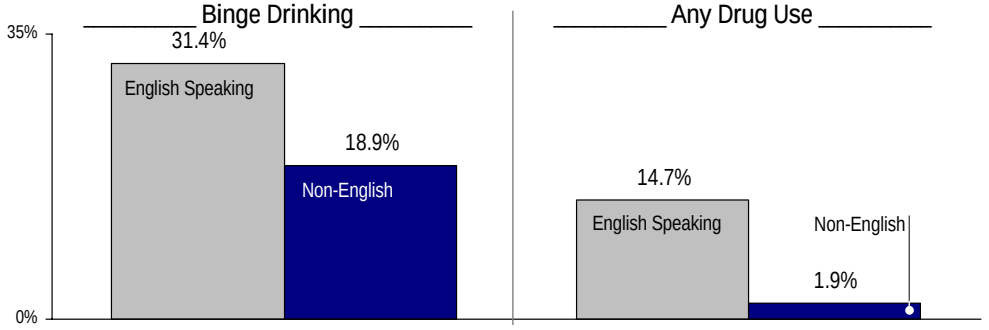
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Asian Origin



Hispanic Origin



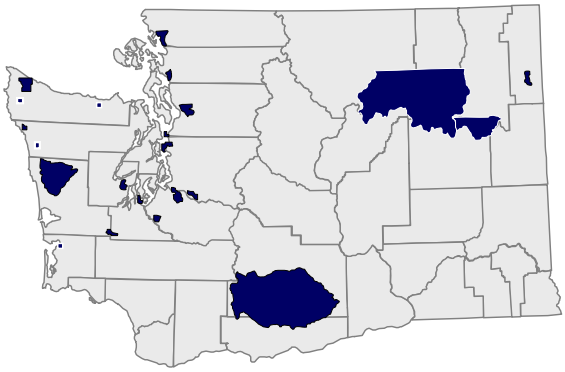
Illicit Drug Use Varies Among American Indians by Reservation Status

The table below describes the prevalence of past year binge drinking and any illicit substance use among American Indian and Alaska Natives residing on or near reservations and those residing off reservation.* These residents were also classified as residing in either rural or urban counties. All non-Hispanic respondents that endorsed American Indian or Alaska Native, regardless of whether or not they indicated any other races, were included in this analysis.

Past year binge drinking and any illicit drug use followed a similar pattern – in rural regions use was higher on/near reservations, in urban regions use was lower on/near reservations.

The rate of past year drug use among American Indian or Alaska Natives residing in an urban region is worth further note. Use among those who resided off-reservation (16.6 percent) was over three and a half times as likely compared to use among those residing on or near a reservation (4.6 percent).

Washington's American Indian Reservations



Dark shaded areas indicate reservation lands.

2003 SURVEY ESTIMATES

CLOSEUP

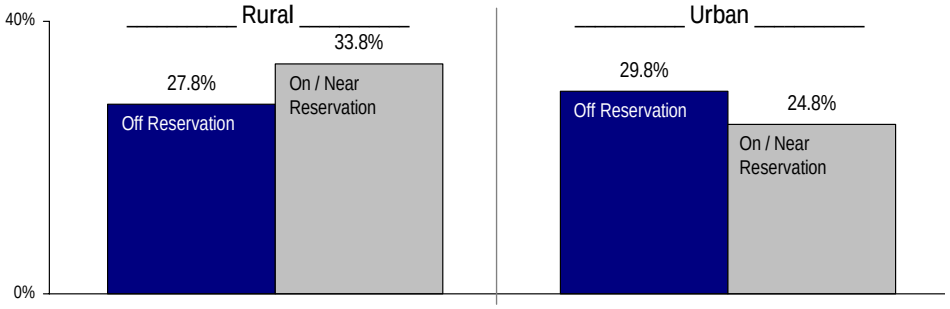
Past Year Use

American Indian or Alaska Native Adults

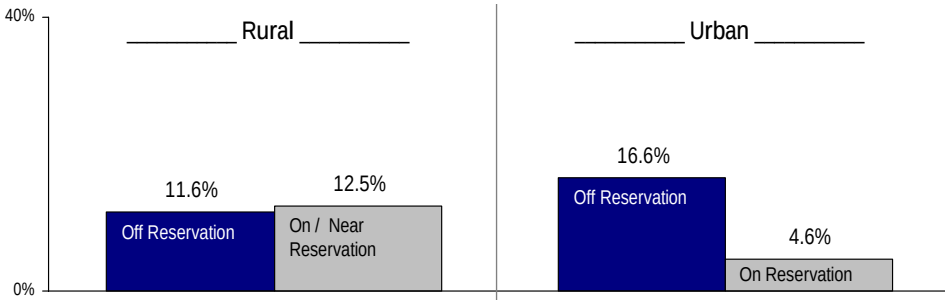
NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Binge Drinking



Any Illicit Drug Use



*Reservation status was determined by respondent zip codes. Respondents living in a zip code that contained a reservation were classified as living on or near a reservation. Respondents that lived in a zip code that did not contain a reservation were classified as living off reservation.

Chapter 3

Current Need for Treatment in Washington State

Defining Need for Treatment

This chapter provides estimates of the current need for substance abuse treatment in Washington State. First, we describe our definition of current need for substance abuse treatment. Next, we provide estimates of need for treatment among different demographic groups. Where possible, we compare estimates from the 2003 survey with estimates from the 1993-94 survey, and indicate which changes over time are statistically significant.

Respondents were classified as needing alcohol or other drug (AOD) treatment in the past year if they met one or more of the following conditions:

1. Reported lifetime **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 past 12 months. See the text boxe on the facing page for more detail about the DSM-IV criteria.
2. **Received professional alcohol or drug treatment** (excluding detoxification) during the past 12 months.
3. Reported having a **problem with alcohol or drugs** and reported **using alcohol or drugs regularly** during the past 12 months. Regular alcohol use was defined as having 3 or more drinks at least one day per week. Regular drug use was defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs 8 or more times in the past 12 months.
4. Reported **heavy use of drugs or alcohol** during the past 12 months. Heavy alcohol use is defined as 4 or more drinks per drinking day, 3 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.

These criteria were identical to those used in previous analyses of the 1993-94 survey data, with two notable modifications. First, DSM-III-R criteria were used in the previous survey. Second, a 12-month time frame for symptoms and substance use was used in the 2003 survey, instead of the 18-month time frame used in the 1993-94 survey.

Most respondents identified to have a current need for AOD treatment met the condition based on the DSM-IV abuse and dependence criteria.

DEFINITIONS

DSM-IV Criteria for Substance Abuse

DSM is short for the "Diagnostic and Statistical Manual of Mental Disorders" – the guide used by medical practitioners, psychologists, and social workers to classify most mental disorders.

Over the years the DSM criteria have been updated several times. This study uses diagnostic criteria described in the fourth version, and these guidelines are commonly referred to as simply the **DSM-IV Criteria**.

———————————

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a **failure to fulfill major role obligations at work, school, or home;** examples are repeated absences or poor work performance related to substance use, substance-related absences, suspensions, expulsions from school, and neglect of children or household
2. **Recurrent substance use in situations in which it is physically hazardous**, for example driving an automobile or operating a machine when impaired by substance use
3. **Recurrent substance-related legal problems**, such as arrests for substance-related disorderly conduct
4. **Continued substance use despite having persistent or recurrent social or interpersonal problems** caused or exacerbated by the effects of the substance; this may include arguments with spouse about consequences of intoxication, physical fights

The symptoms have never met the criteria for Substance Dependence for this class of substance.

DSM-IV Criteria for Substance Dependence

The DSM-IV defines **substance dependence** as a maladaptive pattern of substance abuse, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. **Tolerance**, as defined by a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of the substance
2. **Withdrawal**, as manifested by the characteristic withdrawal syndrome for the substance, or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in **larger amounts** or over a l**onger period** than was intended
4. **Persistent desire** or **unsuccessful efforts to cut down or control** substance use
5. A great deal of **time is spent in activities necessary to obtain the substance** (e.g., visiting multiple doctors or driving long distances), **use the substance** (e.g., chain-smoking), or **recover from its effects**
6. Important **social, occupational, or recreational activities are given up or reduced** because of substance use
7. The substance **use is continued despite knowledge of having a persistent or recurrent physical or psychological problem** that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Need For Treatment Higher Among Males, Younger Adults

This section describes the prevalence of current need for substance abuse treatment by gender, age, and residence. First, 2003 rates are compared with 1993-94 need for treatment estimates. Next, variations in 2003 estimates are discussed.

Ten-Year Comparison

The overall rate of current need for treatment increased slightly from 10.0 percent in 1993-94 to 10.9 percent in 2003. This increase is driven by an increase in the need for treatment among adults living at or below 200 percent of the federal poverty level (from 10.8 to 13.6 percent).

Some 2003 need for treatment estimates were significantly different from 1993-94 rates when age and residence are examined. Need for treatment nearly doubled from 1993-94 levels among adults aged 45 to 64 years, rising from 4.0 percent to 7.8 percent. This change was driven largely by adults above 200 percent of the federal poverty level where need for treatment increased from 2.9 percent to 7.4 percent. In 1993-94 few (less than 0.1 percent) adults aged 65 years and older living at or below 200 percent of the poverty level needed treatment; however, in 2003 this rate had risen significantly to 3.1 percent. Last, need for treatment increased significantly among rural adults living at or below 200 percent of the federal poverty level.

2003 Survey Estimates

The charts on the facing page present 2003 need for treatment prevalence rates. These charts show that males, regardless of poverty status, are more likely to need treatment than are females. This gender difference is particularly evident among adults at or below 200 percent of the federal poverty level where males are nearly three times as likely to need treatment (21.4 percent) than are females (7.6 percent).

A strong association exists between need for treatment and age, with the rate of need for treatment being much greater among younger adults. This pattern holds for both higher and lower-income adults.

Need for treatment is somewhat higher among adults residing in urban counties than among those residing in rural counties.

These variations in need for treatment closely parallel variations in rates of any illicit drug use as described in the charts on page 2-21.

TEN-YEAR COMPARISON

Current Need For Alcohol or Drug Treatment (Past 12 Months): 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	10.9%	14.7%	7.3%	22.6%	13.5%	7.8%	1.8%	9.9%	11.7%
1993-94	10.0%	14.2%	5.9%	27.2%	11.4%	4.0%	3.4%	8.7%	10.5%
Difference	+0.9%	+0.5%	+1.4%	(–4.6%)	+2.1%	+3.8%	(-1.6%)	+1.2%	+1.2%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	10.0%	12.8%	7.1%	20.6%	13.3%	7.4%	1.2%	8.9%	10.9%
1993-94	9.7%	13.4%	5.9%	28.3%	11.6%	2.9%	5.1%	9.2%	9.8%
Difference	+0.3%	(–0.6%)	+1.2%	(–7.7%)	+1.7%	+4.5%	(-3.9%)	(- 0.3%)	+1.1%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Gender		Age				Residence	
		Male	Female	18-24 yrs	25-44 yrs	45-64 yrs	65+ yrs	Rural	Urban
2003	13.6%	21.4%	7.6%	25.4%	14.1%	9.8%	3.1%	12.7%	14.5%
1993-94	10.8%	16.9%	6.1%	25.2%	10.9%	9.5%	0.0%	7.6%	13.0%
Difference	+2.8%	+4.5%	+1.5%	+0.2%	+3.2%	+0.3%	+3.1%	+5.1%	+1.5%

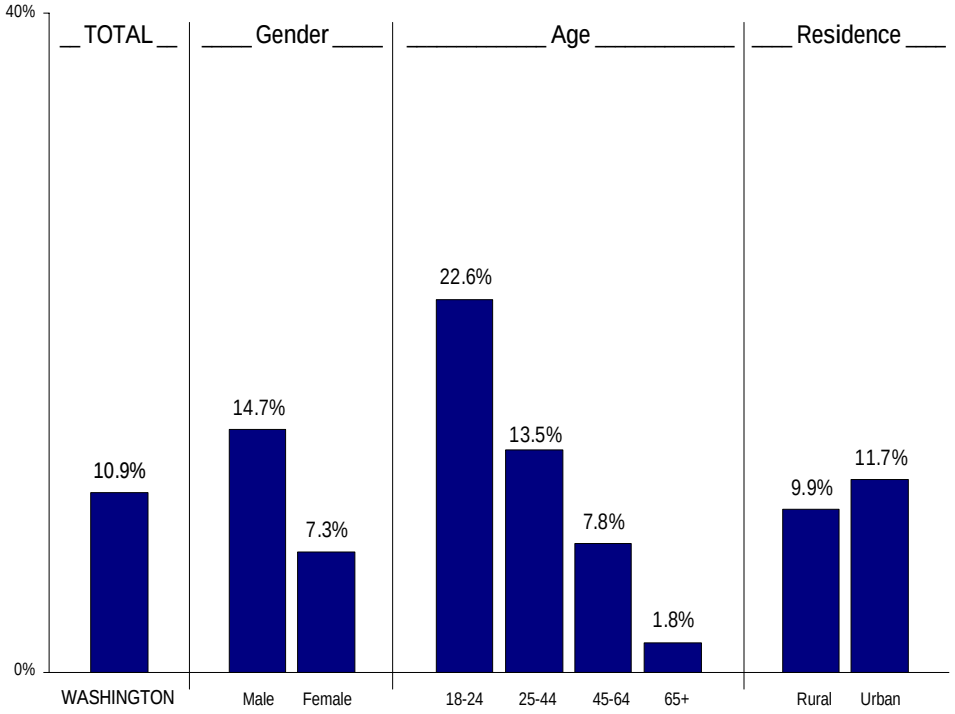
Bold type indicates statistical significance at p <.05

ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



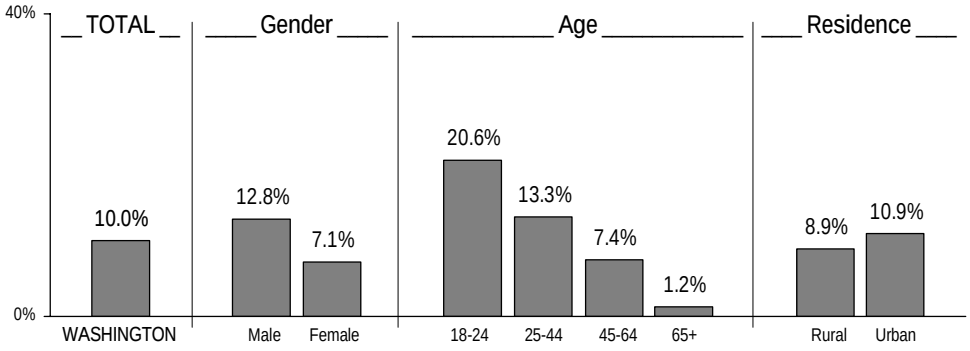
By Income

Household Income

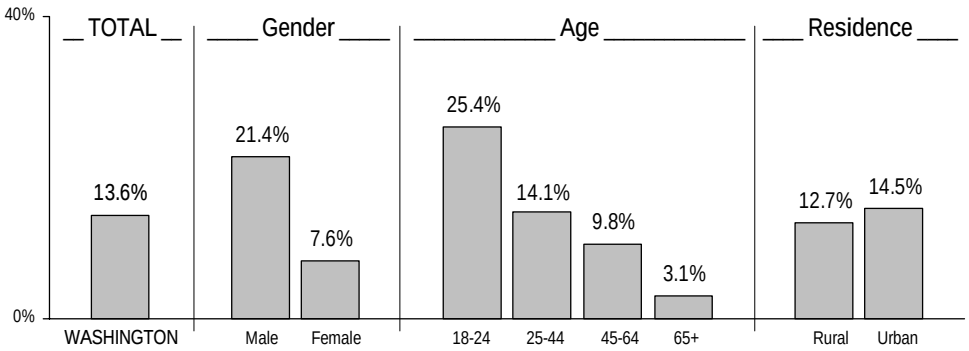
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Need For Treatment Increasing Among Hispanics and Asians

This section describes the prevalence of current need for treatment among racial and ethnic groups. First, 2003 rates are compared to 1993-94 estimates. Next, variations in 2003 rates are discussed.

Ten-Year Comparison

In 2003, a significantly higher percentage of Asians needed drug or alcohol treatment (4.9 percent), compared to 10 years ago (2.2 percent). The increase was particularly significant among Asians above 200 percent of the federal poverty level.

Need for treatment also increased significantly among Hispanics, rising from 7.7 percent in 1993-94 to 12.6 percent in 2003. The increase in need for treatment was statistically significant for both higher-income and lower-income Hispanics. No statistically significant changes were found for other racial groups.

For both Asians and Hispanics, this increase in need for treatment mirrors the increase in any illicit drug use described on page 2-22 of this report.

2003 Survey Estimates

The charts on the facing page present 2003 estimates of the prevalence of current need for treatment by racial and ethnic groups.

Need for treatment is highest among American Indian or Alaska Natives (15.8 percent) and multiracial adults (16.2 percent). This is particularly evident among lower-income adults, with 22 percent of American Indian or Alaska Natives and multiracial adults estimated to have a current need for substance abuse treatment.

Need for treatment is considerably lower among Asians (4.9 percent), compared to other racial and ethnic groups.

Variations in need for treatment by race/ethnicity parallel differences in rates of substance use as described in the charts on page 2-23.

TEN-YEAR COMPARISON

Current Need For Alcohol or Drug Treatment (Past 12 Months): 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	10.9%	10.9%	10.4%	4.9%	15.8%	13.7%	16.2%	12.6%
1993-94	10.0%	10.5%	7.5%	2.2%	16.8%	N/A	N/A	7.7%
Difference	+0.9%	+0.4%	+2.9%	+2.7%	(-1.0%)	N/A	N/A	+4.9%

ADULTS ABOVE 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	10.0%	10.0%	9.8%	5.4%	11.2%	13.7%	13.4%	14.3%
1993-94	9.7%	10.0%	7.7%	2.1%	13.8%	N/A	N/A	10.0%
Difference	+0.3%	+0.0%	+2.1%	+3.3%	(-2.6%)	N/A	N/A	+4.3%

ADULTS AT OR BELOW 200% FPL

	WASHINGTON TOTAL	Race/Ethnicity						
		White	Black	Asian	American Indian	NHOPI*	2+ Races	Hispanic
2003	13.6%	14.7%	11.6%	3.8%	22.1%	13.8%	21.9%	11.3%
1993-94	10.8%	11.9%	7.1%	2.5%	20.1%	N/A	N/A	5.6%
Difference	+2.8%	+2.8%	+4.5%	+1.3%	+2.0%	N/A	N/A	+5.7%

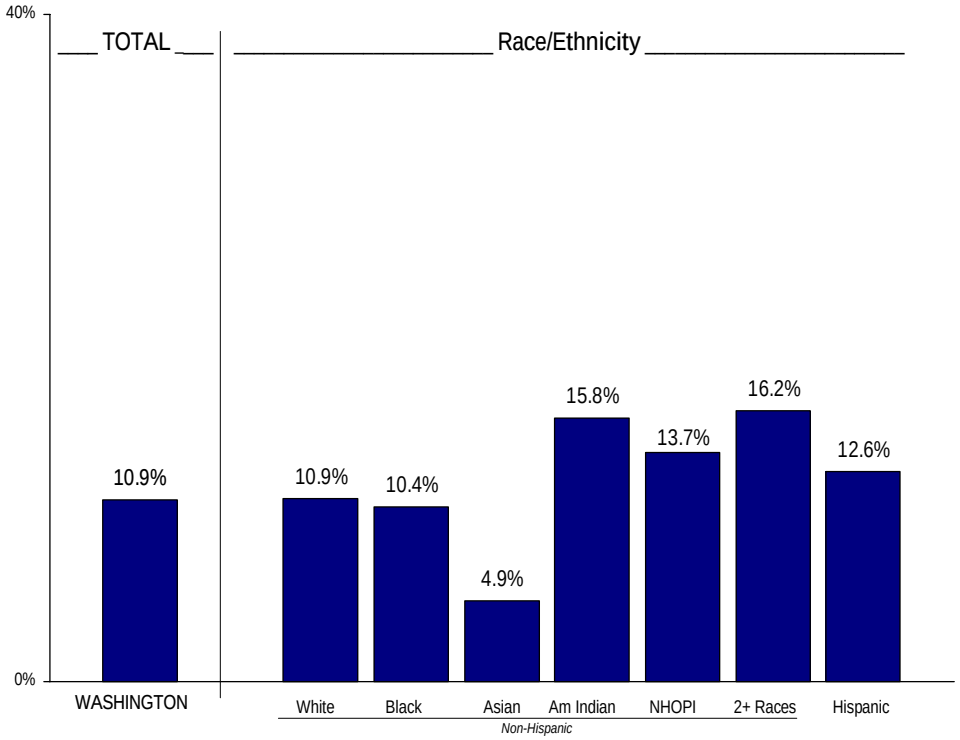
Bold type indicates statistical significance at $p < .05$ *The 1993-94 survey did not separately identify Native Hawaiian or other Pacific Islanders, instead they were included with Asians.

ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



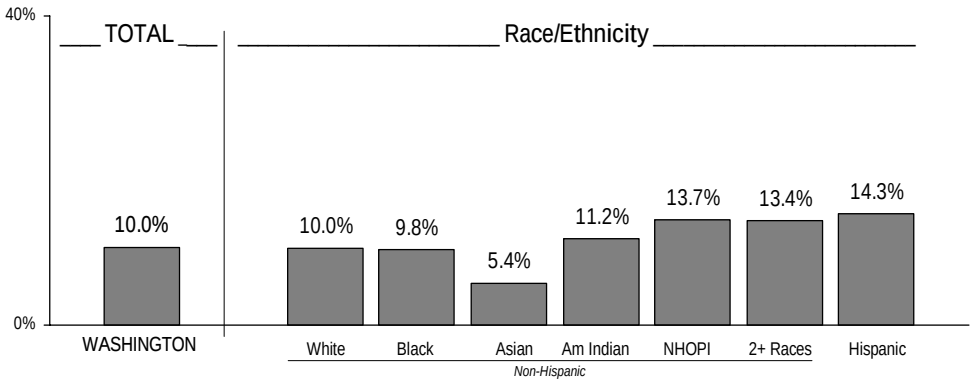
By Income

Household Income

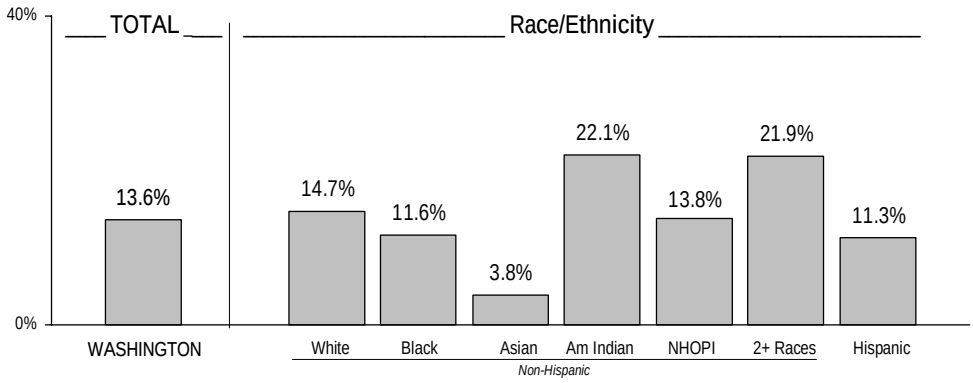
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Need For Treatment By Marital Status And Education

This section describes the prevalence of current need for treatment by marital status and level of education. First, 2003 rates are compared with 1993-94 estimates. Next, variations in 2003 estimates are described.

Ten-Year Comparison

As indicated in the table below, few significant changes were found between 1993-94 and 2003 among the marital and education categories examined. The only statistically significant change found was among adults at or below 200 percent of the federal poverty level that had less than a high school education. Here, need for treatment increased significantly from 5.7 percent in 1993-94 to 10.9 percent in 2003.

2003 Survey Estimates

The charts on the facing page present 2003 prevalence rates of current need for treatment by marital status and level of education.

Current need for treatment varied widely by marital status. Need for treatment was highest among adults that were never married (21.5 percent) and lowest among adults that were widowed (3.9 percent). These differences largely reflect underlying age differences.

The prevalence of need for treatment among married adults (8.0 percent) was somewhat higher than among widowed adults. The prevalence of need for treatment among divorced or separated adults (11.2 percent) was higher yet.

Little difference in need for treatment was found by level of education. Need for treatment was lower among college graduates (8.1 percent), but other levels of education were all within a percentage point of each other.

Among adults living at or below 200 percent of the federal poverty level, having some college education was associated with a higher level of need for treatment (17.0 percent).

TEN-YEAR COMPARISON

Current Need For Alcohol or Drug Treatment (Past 12 Months): 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

		Marital Status				Education			
	WASHINGTON TOTAL	Married	Divorced	Widowed	Never Married	Less Than High School	High School	Some College	College Graduate
2003	10.9%	8.0%	11.2%	3.9%	21.5%	11.5%	12.5%	12.4%	8.1%
1993-94	10.0%	6.0%	17.2%	1.0%	22.0%	10.2%	10.5%	11.2%	7.4%
Difference	+0.9%	+2.0%	(-6.0%)	+2.9%	(-0.5%)	+1.3%	+2.0%	+1.2%	+0.7%

ADULTS ABOVE 200% FPL

		Marital Status				Education			
	WASHINGTON TOTAL	Married	Divorced	Widowed	Never Married	Less Than High School	High School	Some College	College Graduate
2003	10.0%	7.6%	11.3%	4.2%	19.6%	12.4%	12.5%	10.9%	7.8%
1993-94	9.7%	5.6%	17.8%	0.8%	22.5%	16.4%	9.7%	10.9%	6.9%
Difference	+0.3%	+2.0%	(-6.5%)	+3.4%	(-2.9%)	(-4.0%)	+2.8%	+0.0%	+0.9%

ADULTS AT OR BELOW 200% FPL

		Marital Status				Education			
	WASHINGTON TOTAL	Married	Divorced	Widowed	Never Married	Less Than High School	High School	Some College	College Graduate
2003	13.6%	9.9%	10.9%	3.6%	25.2%	10.9%	12.5%	17.0%	10.6%
1993-94	10.8%	7.4%	15.4%	1.3%	20.9%	5.7%	12.3%	12.1%	11.3%
Difference	+2.8%	+2.5%	(-4.5%)	+2.3%	+4.3%	+5.2%	+0.2%	+4.9%	(-0.7%)

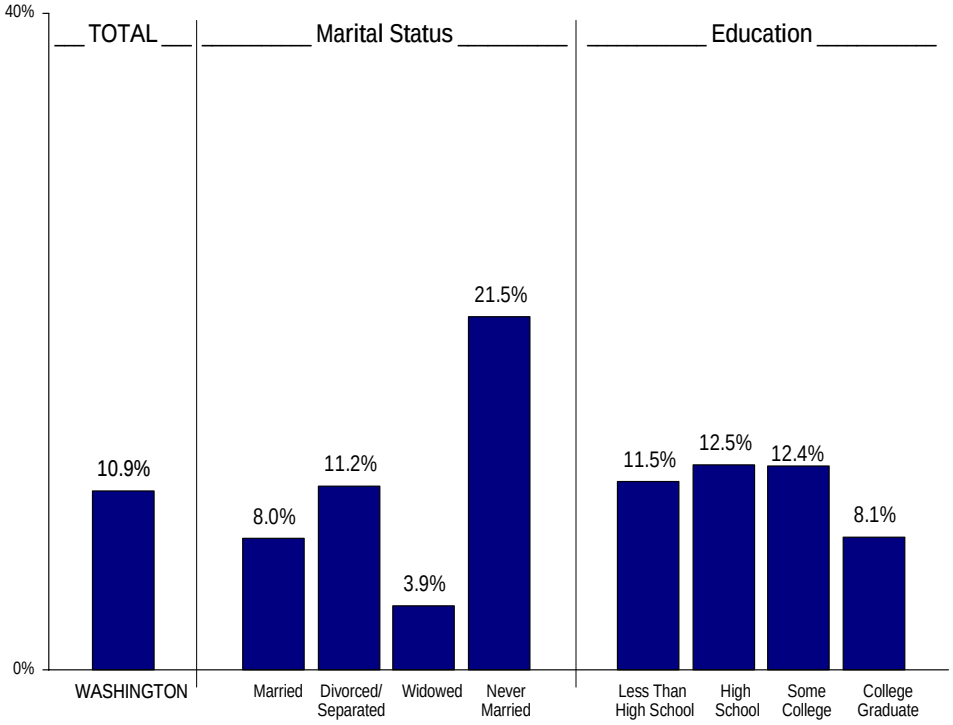
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

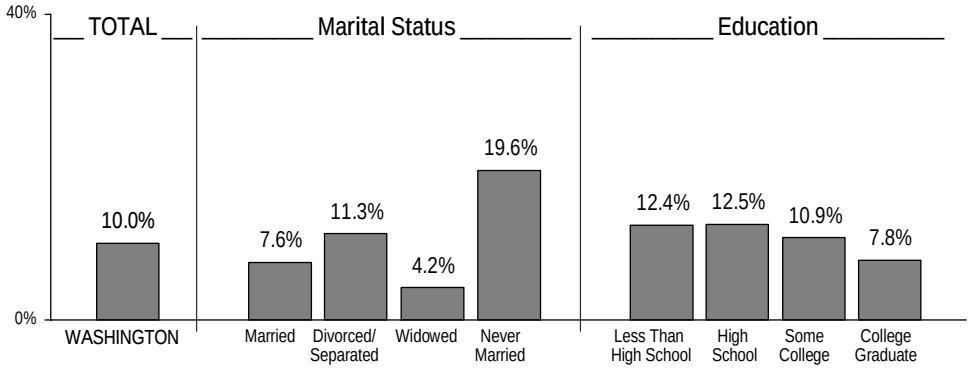
Household Income

ABOVE

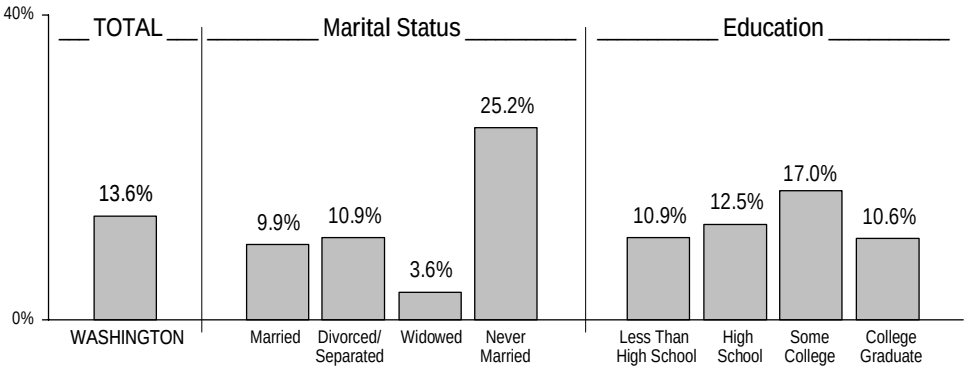
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Need For Treatment Higher Among The Uninsured

This section describes the prevalence of current need for substance abuse treatment by employment and health insurance status. First, 2003 estimates are compared with 1993-94 estimates. Next, variations in 2003 estimates are described.

Ten-Year Comparison

As reported in the table below, need for treatment increased significantly among adults employed part-time. In this group, the estimated rate of need for treatment nearly doubled from 6.8 percent in 1993-94 to 13.0 percent. The increase was largest among adults at or below 200 percent of the federal poverty level.

Need for treatment also increased significantly among adults at or below 200 percent of the federal poverty level who had health insurance. Here, the rate rose from 8.0 percent in 1993-94 to 12.1 percent in 2003. Estimated need for treatment also increased among higher-income adults who are uninsured (from 14.1 to 21.3 percent), although this change was not statistically significant.

2003 Survey Estimates

The charts on the facing page present 2003 need for treatment rates by employment and health insurance status.

Need for treatment was highest among unemployed (20.3 percent) and disabled (18.7 percent) adults and lowest among adults not in the labor force (5.4 percent).

Need for treatment was twice as high among adults without health insurance (19.3 percent), compared with adults with health insurance (9.7 percent).

TEN-YEAR COMPARISON

Current Need For Alcohol or Drug Treatment (Past 12 Months): 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

		Employment Status					Health Insurance	
	WASHINGTON TOTAL	Unemployed	Part Time Employment	Not in Labor Force	Full Time Employment	Disabled	Not Insured	Some Insurance
2003	10.9%	20.3%	13.0%	5.4%	11.4%	18.7%	19.3%	9.7%
1993-94	10.0%	13.6%	6.8%	5.6%	12.7%	N/A	16.5%	8.9%
Difference	+0.9%	+6.7%	+6.2%	(-0.2%)	(-1.3%)	N/A	+2.8%	+0.8%

ADULTS ABOVE 200% FPL

		Employment Status					Health Insurance	
	WASHINGTON TOTAL	Unemployed	Part Time Employment	Not in Labor Force	Full Time Employment	Disabled	Not Insured	Some Insurance
2003	10.0%	20.2%	11.5%	4.3%	11.0%	18.6%	21.3%	9.1%
1993-94	9.7%	9.9%	6.7%	5.7%	12.1%	N/A	14.1%	9.1%
Difference	+0.3%	+10.3%	+4.8%	(-1.4%)	(-1.1%)	N/A	+7.2%	+0.0%

ADULTS AT OR BELOW 200% FPL

		Employment Status					Health Insurance	
	WASHINGTON TOTAL	Unemployed	Part Time Employment	Not in Labor Force	Full Time Employment	Disabled	Not Insured	Some Insurance
2003	13.6%	20.6%	17.0%	7.9%	13.8%	18.8%	17.5%	12.1%
1993-94	10.8%	19.8%	6.9%	5.4%	15.4%	N/A	19.1%	8.0%
Difference	+2.8%	+0.8%	+10.1%	+2.5%	(-1.6%)	N/A	(-1.6%)	+4.1%

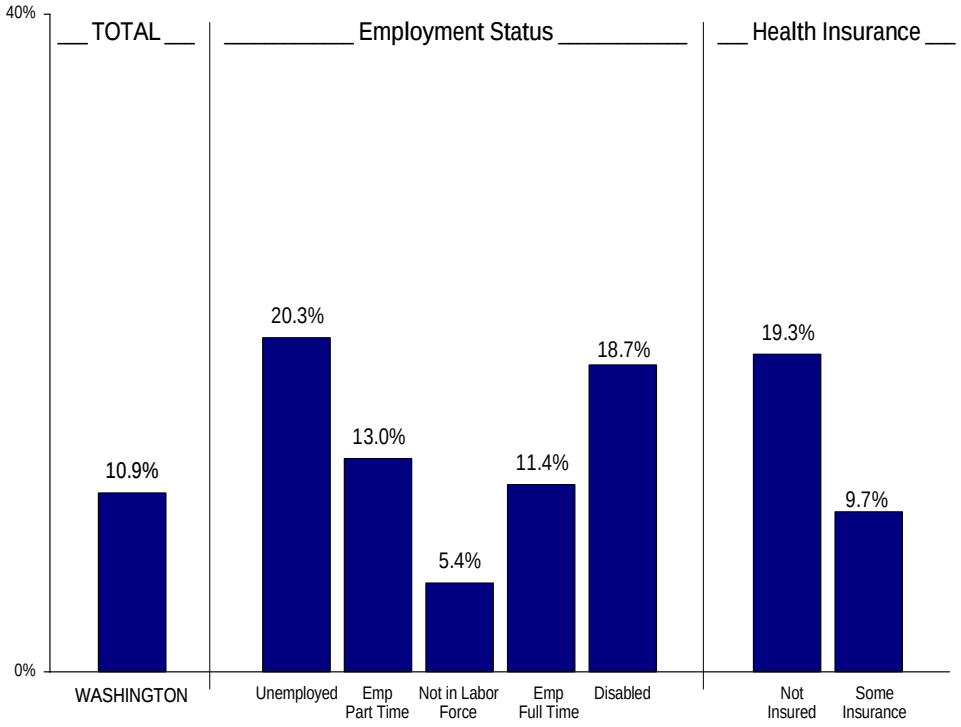
Bold type indicates statistical significance at $p < .05$

ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

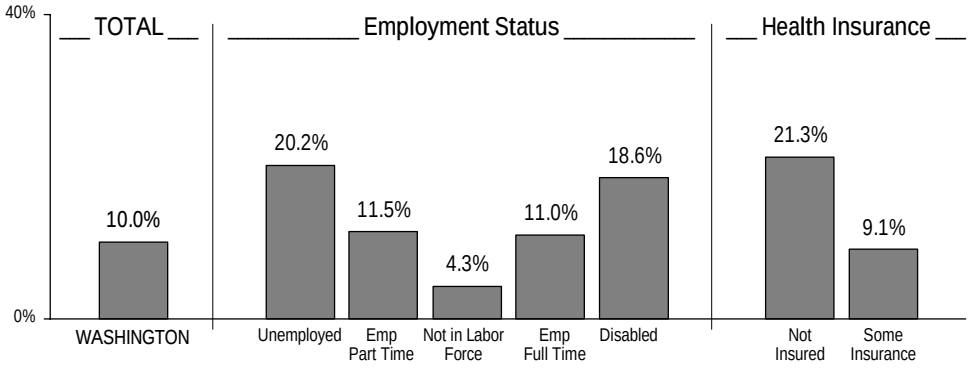
Household Income

ABOVE

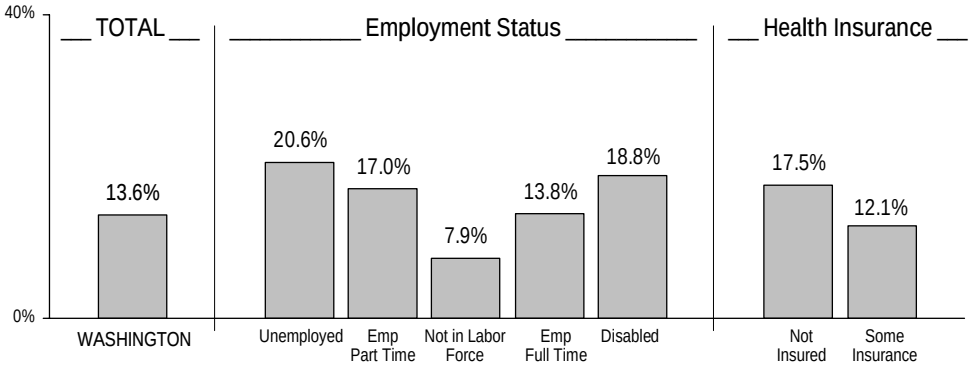
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Need For Treatment Higher Among Lower-Income Pregnant Women

This section describes the prevalence of current need for treatment among pregnant and parenting women.

Only women under the age of 51 were asked about being currently pregnant and whether they had given birth within the past year. Women who were aged 51 and older were coded as not being pregnant or giving birth within the past year. All women, regardless of age, were asked about the presence of children in their home.

Currently Pregnant Women

Overall, need for treatment was lower among women who were currently pregnant (5.8 percent), compared to women who were not currently pregnant (7.3 percent). However, considerable differences emerge when poverty status is examined. Lower-income pregnant women are three times as likely to report having a current need for treatment (10.8 percent), compared to higher-income pregnant women (3.4 percent).

Women Giving Birth in Past Year

Overall, need for treatment was lower among women who had given birth within the past year (4.7 percent) compared to those who had not (7.4 percent). Again, differences emerge when poverty status is considered. Need for treatment was nearly three times as common among women who had given birth within the past year that were at or below 200 percent of the federal poverty level (7.7 percent) compared with those women who had given birth within the past year that were above this poverty threshold (2.8 percent).

Women With Children

The need for treatment rate was slightly higher among women with children residing in their home (8.3 percent) compared with those who did not have any children (6.6 percent). This pattern was consistent across poverty status.

A description of past year illicit substance use among pregnant and parenting women may be found on page 2-24 of this report.

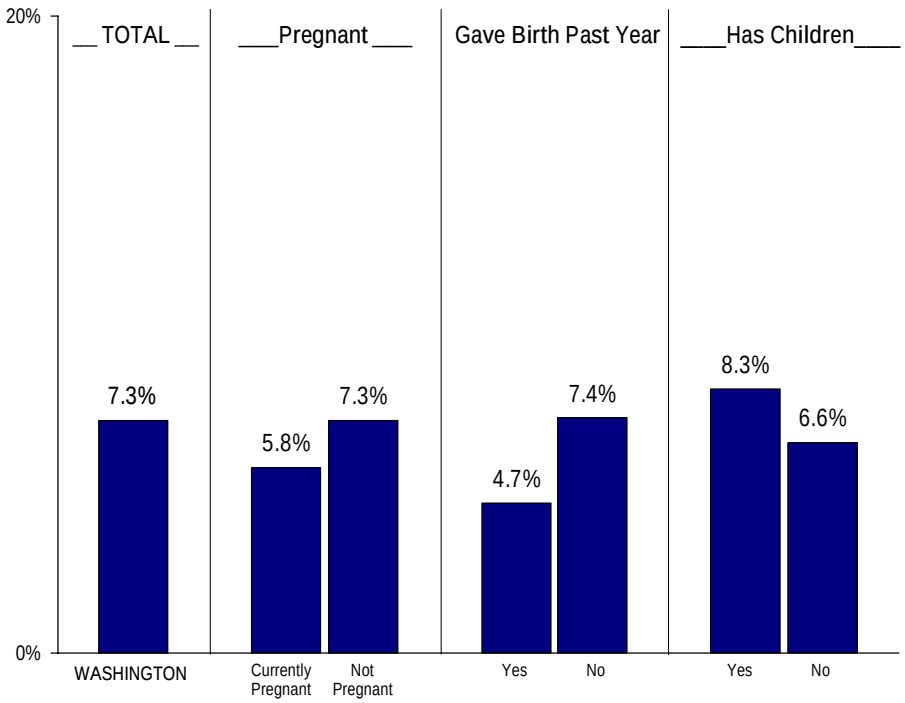
CLOSEUP

Pregnant and Parenting Women: Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents

Current Need for Treatment



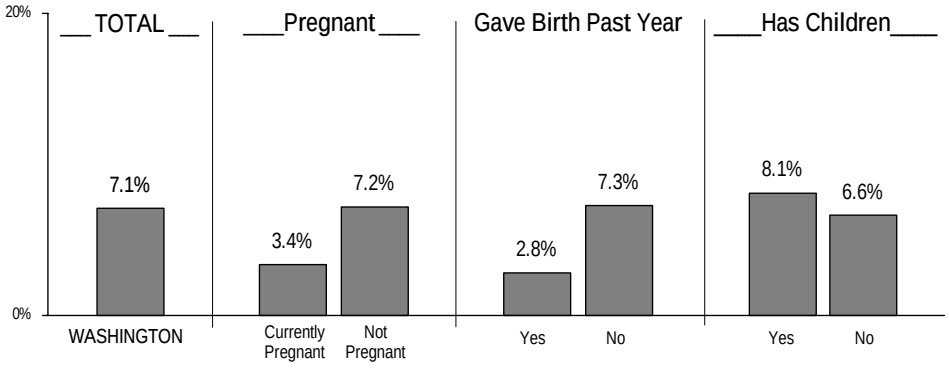
By Income

Household Income

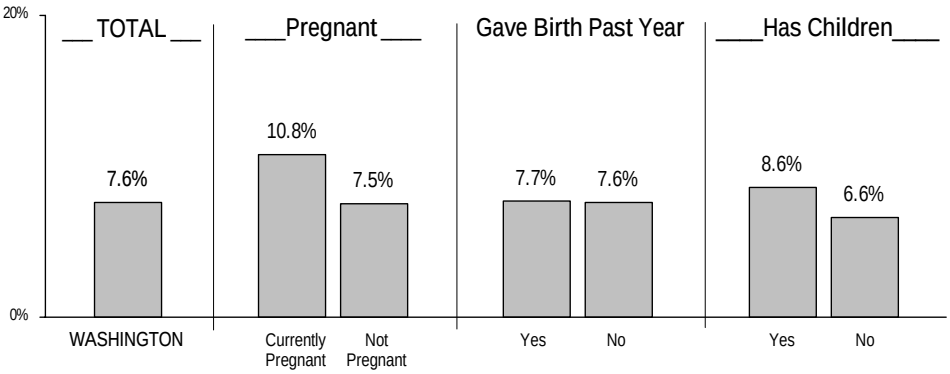
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Current Need for Treatment – Women Above 200% FPL



Current Need for Treatment – Women At Or Below 200% FPL



County Need for Treatment Estimates

This section provides county level estimates of need for treatment. Estimates in this section are limited to adults at or below 200 percent of the federal poverty level.

First, 1998 county estimates of need for treatment that are based upon the 1993-94 data are compared with 2003 estimates. The chart below shows that, while the statewide need for treatment among adults at or below 200 percent of the federal poverty level increased from 10.8 percent in 1993-94 to 13.6 percent, levels of county need remained generally consistent relative to one another. The correlation between the 1993-94 and 2003 county estimates was quite high (91 percent), indicating that counties with higher need for treatment levels in 1993-94 tended to have higher levels of need in 2003.

The chart on the facing page lists the 2003 need for treatment estimates for each county. Highlights include:

- 24 of 39 counties were within one percentage point of the state estimate of need for treatment.
- Need for treatment in 8 of 39 counties was more than one percentage point higher than the state level. Need for treatment estimates were highest in Whitman (22.9 percent), Kittitas (20.4 percent), and Whatcom (18.4 percent) counties. Need is higher in these counties because they have a relatively high proportion of young adults (each of the three counties is home to a major university) and need for treatment is higher among younger adults.
- Need for treatment in 7 of 39 counties was more than one percentage point lower than the state level.

Detailed estimates of need for substance abuse treatment are available as part of a series of separate county reports. These reports are available online at: www1.dshs.wa.gov/rda/research/4/52/ or at w1.dshs.wa.gov/dasa/.

2003 SURVEY ESTIMATES

CLOSEUP

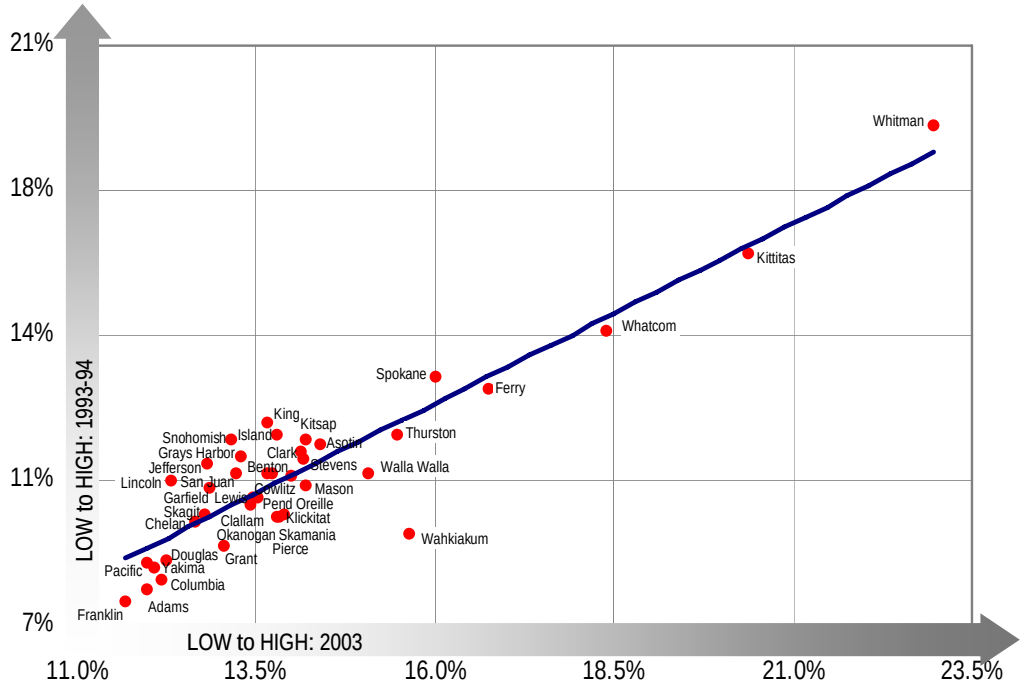
County Estimates for Lower Income Households

How do new estimates compare to ten years ago?

NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Correlation Between 1993-94 and 2003 County Need Estimates



Correlation between 1993-94 and 2003 = 91%

CLOSEUP

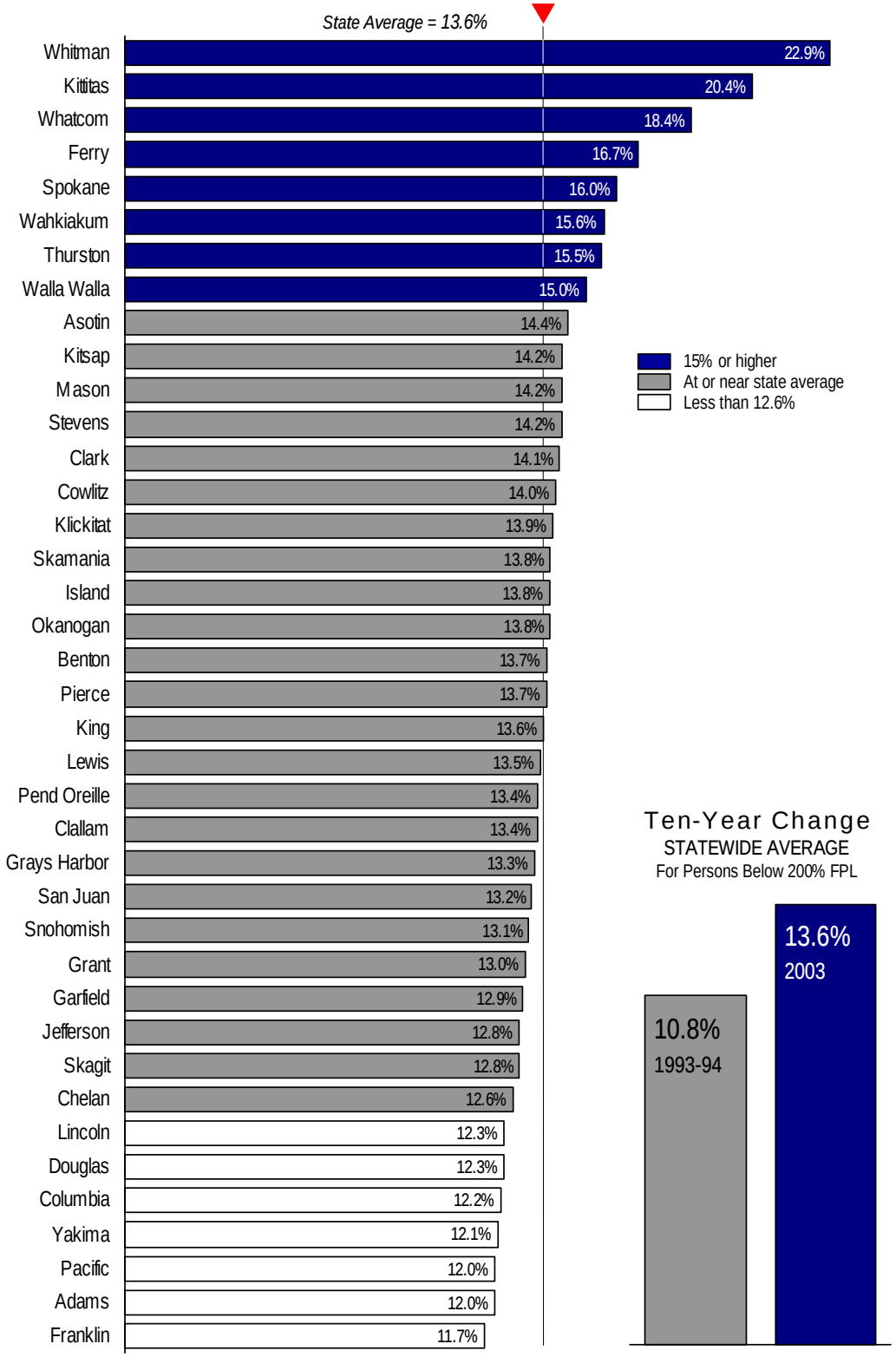
County Estimates for Lower Income Households

What counties have the highest treatment need rates?

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

County Need for Treatment Rates for Adults At or Below 200% FPL



Ten-Year Change

STATEWIDE AVERAGE
For Persons Below 200% FPL

Half of Adults Needing Treatment Used Illicit Drugs in Past Year, Three Out of Four Engaged in Binge Drinking

This section examines substance use among adults identified as having a current need for alcohol or drug treatment. As expected, past year substance use by adults in need of treatment is considerably greater than in the overall state population (see page 2-4).

Ten-Year Comparison

The table below compares 2003 with 1993-94 rates of use among adults in need of alcohol or drug treatment. Rates of use of two types of drugs, stimulants and opiates, changed significantly from 1993-94 levels. Stimulant use among adults in need of treatment decreased from 12.3 percent in 1993-94 to 4.4 percent in 2003. Opiate use among adults in need of treatment increased from 3.8 percent in 1993-94 to 12.4 percent in 2003. These changes were statistically significant regardless of poverty status.

High Levels of Binge Alcohol, Drug Use Among Adults Needing Treatment

The charts on the facing page describe the prevalence of substance use during the past year among those adults classified as needing alcohol or drug treatment. Key findings include:

- 3 out of 4 adults needing treatment engaged in binge drinking during the past year.
- Nearly half (49.6 percent) of all adults needing treatment used an illicit substance during the past year.
- Non-heroin opiate use, reported by 12.4 percent of those in need of treatment, is second only to marijuana use (41.4 percent).

While the prevalence of past year binge drinking was comparable across poverty groups, drug use tended to be higher among those adults in need of treatment who were at or below 200 percent of the federal poverty level. Key differences include:

- Cocaine or Crack use is nearly twice as common among adults at or below 200 percent of the federal poverty level (12.7 percent), compared with those above (6.7 percent).
- Stimulant use is three times as common among adults below the poverty threshold (8.3 percent), compared with those above (2.7 percent).
- Non-heroin opiate and hallucinogen use were nearly twice as common among adults below 200 percent of the federal poverty level.

TEN-YEAR COMPARISON

Past Year Substance Use Among Those Needing Treatment: 1993-94 to 2003 Change

ALL ADULT HOUSEHOLD RESIDENTS

	Binge Drinking	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Opiate	Tranquilizer	Sedative	Inhalant
2003	74.9%	49.6%	41.4%	8.5%	4.4%	6.2%	0.9%	12.4%	5.1%	7.7%	1.6%
1993-94	N/A	49.7%	44.9%	13.2%	12.3%	11.8%	0.8%	3.8%	N/A	5.9%	N/A
Difference	N/A	(-0.1%)	(-3.5%)	(-4.7%)	(-7.9%)	(-5.6%)	+0.1%	+8.6%	N/A	+1.8%	N/A

ADULTS ABOVE 200% FPL

	Binge Drinking	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Opiate	Tranquilizer	Sedative	Inhalant
2003	75.9%	44.3%	38.4%	6.7%	2.7%	4.8%	1.1%	10.0%	4.8%	7.3%	1.5%
1993-94	N/A	48.8%	43.5%	11.3%	9.9%	10.9%	0.1%	3.5%	N/A	4.8%	N/A
Difference	N/A	(-4.5%)	(-5.1%)	(-4.6%)	(-7.2%)	(-6.1%)	+1.0%	+6.5%	N/A	+2.5%	N/A

ADULTS AT OR BELOW 200% FPL

	Binge Drinking	Any Illicit Drug	Marijuana	Cocaine or Crack	Stimulant	Hallucinogen	Heroin	Opiate	Tranquilizer	Sedative	Inhalant
2003	72.5%	61.8%	48.1%	12.7%	8.3%	9.3%	0.5%	18.0%	5.8%	8.7%	1.9%
1993-94	N/A	52.1%	48.7%	18.2%	18.8%	14.2%	2.5%	4.5%	N/A	8.9%	N/A
Difference	N/A	+9.7%	(-0.6%)	(-5.5%)	(-10.5%)	(-4.9%)	(-2.0%)	+13.5%	N/A	(-0.2%)	N/A

Bold type indicates statistical significance at $p < .05$

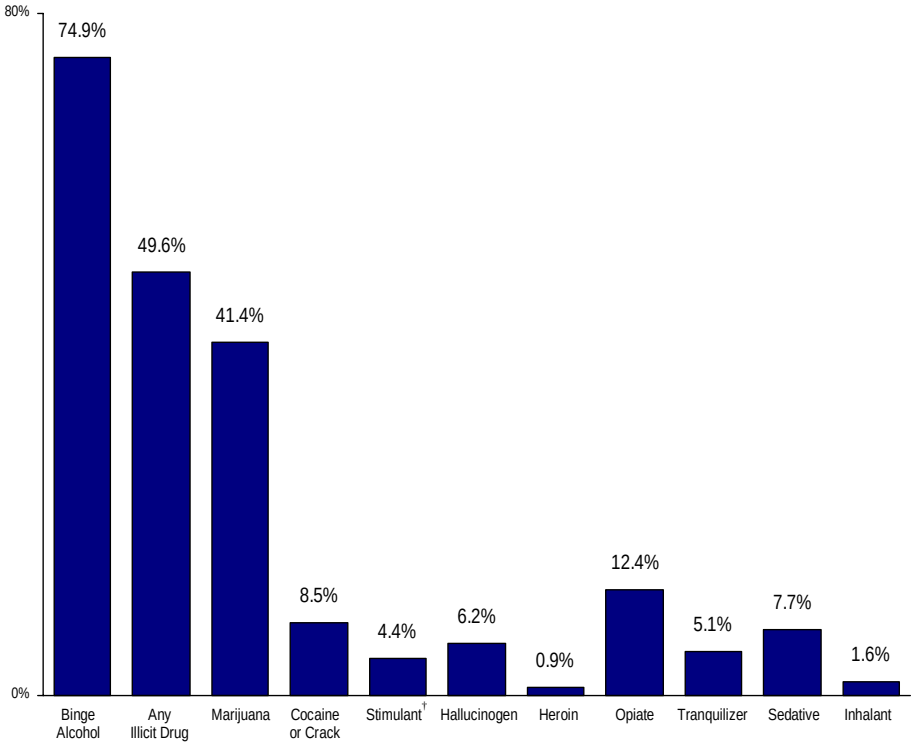
2003 SURVEY ESTIMATES

CLOSEUP

Past Year Substance Use Among Adults Needing Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

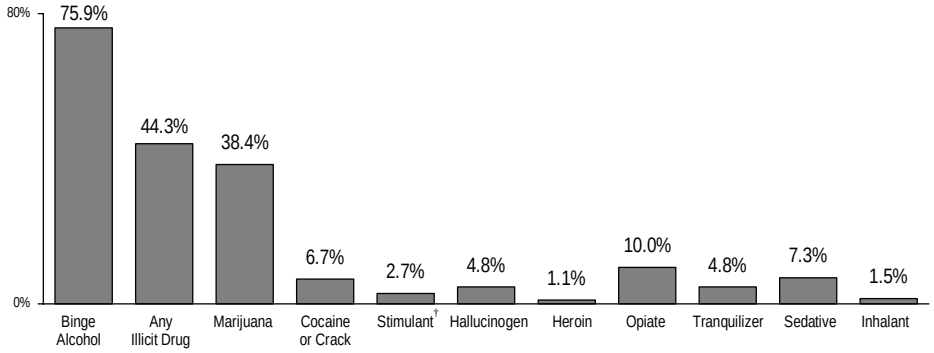
Household Income

ABOVE

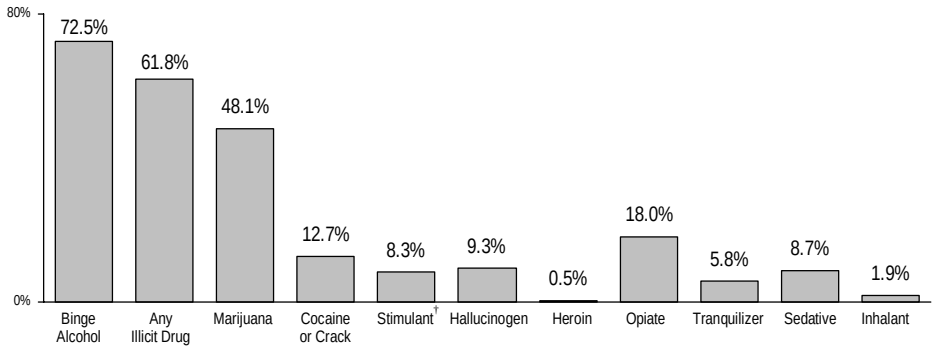
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



†Stimulant includes Methamphetamine

Need For Treatment Higher Among Adults Reporting Earlier Age of First Alcohol Use

Age of first alcohol use is of particular interest given that alcohol use at young ages is associated with alcohol problems later in life (e.g. Warner & White, 2003). Earlier in this report (page 2-12) the extent of drinking among adults who are younger than the legal drinking age (21 years) was described. This section of the report examines need for substance abuse treatment by age of first alcohol use, paralleling a recent NSDUH report, "Alcohol Dependence or Abuse and Age at First Use" (SAMHSA, 2004).

Half of Adults Aged 21+ Drank Alcohol Before Age 18

Nearly three out of four adults aged 21 or older (72.1 percent) reported that they had first used alcohol before the current legal drinking age of 21. This group consists of adults aged 21 or older who first used alcohol before the age of 15 (18.1 percent), adults who first used alcohol between the ages of 15 and 17 (30.0 percent), and adults who first used alcohol between the ages of 18 and 20 (24.1 percent). Among adults aged 21 and older, 16.7 percent reported they had first used alcohol after the age of 21 and 11.1 percent reported that they had never used alcohol.

Need for Treatment

The charts on the facing page examine the prevalence of current need for treatment by age of first alcohol use. The relationship between age of first alcohol use and current need for treatment is clear – adults who reported using alcohol at earlier ages were more likely to have a current need for treatment. Adults aged 21 and older who reported first using alcohol before the age of 15 were nearly two and a half times as likely to need treatment (26.8 percent) when compared with the overall state average. Conversely, adults who reported first drinking alcohol after the age of 21 were far less likely to currently need treatment (2.4 percent) compared to the overall state average. Current need for treatment was rare among those adults aged 21 and over who indicated that they had never used alcohol (0.1 percent).

The relationship between age of first alcohol use and current need for treatment was consistent regardless of income level. Regardless of age of first use, need for treatment was higher among adults at or below 200 percent of the federal poverty level.

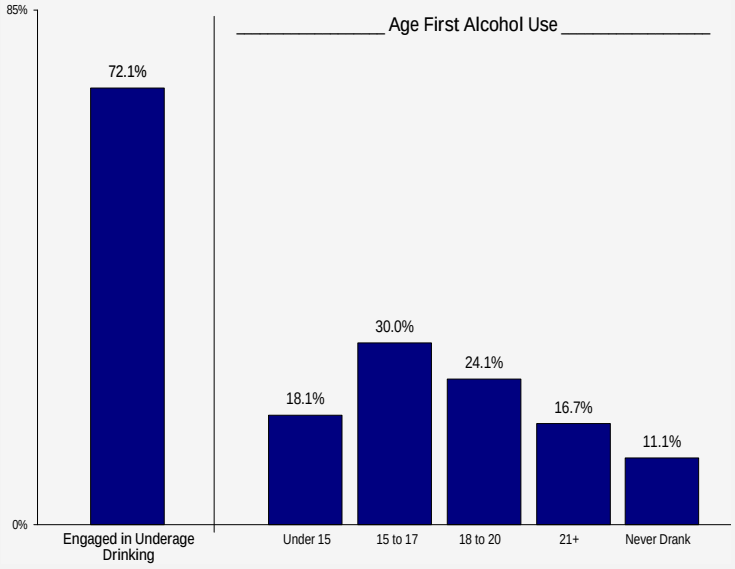
AGE FIRST ALCOHOL USE

Majority of Adults Engaged in Underage Drinking

The figure to the right describes the age of first alcohol use among adults aged 21+. Nearly 3 out of 4 adults (72.1 percent) drank alcohol before the legal drinking age of 21 and nearly half (48.1 percent) before the age of 18. Nationally, nearly 74 percent of adults aged 21 and older reported using alcohol before the current legal drinking age of 21 and 47 percent before the age of 18 (SAHMSA, 2004).

Only about 1 in 10 adults above the age of 21 (11.1 percent) had not used alcohol. This figure was quite similar to the national rate (12 percent).

Age of First Use Among Adults Aged 21+

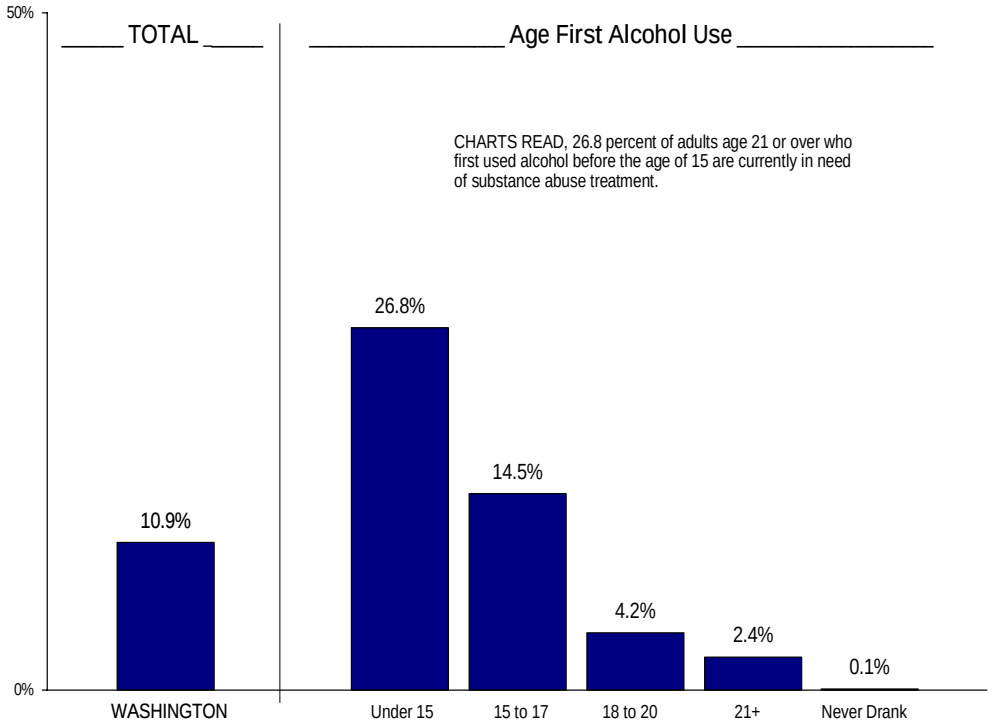


ALL ADULTS

Current Need for Treatment

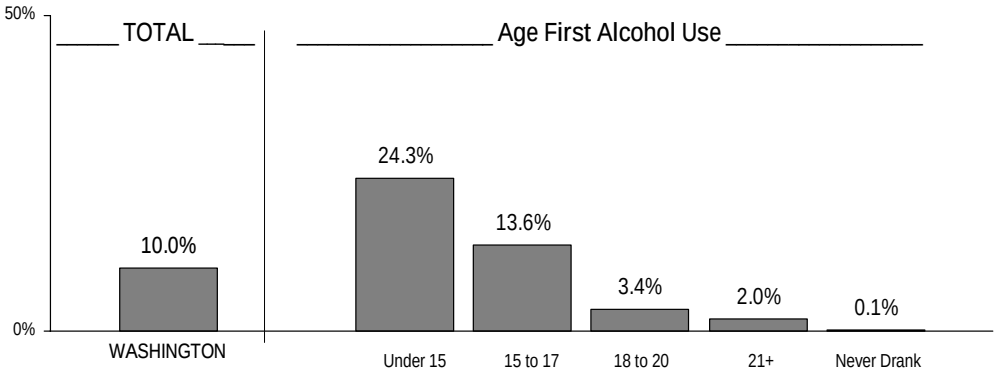
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 21+



By Income

Adults Above 200% FPL



Household Income

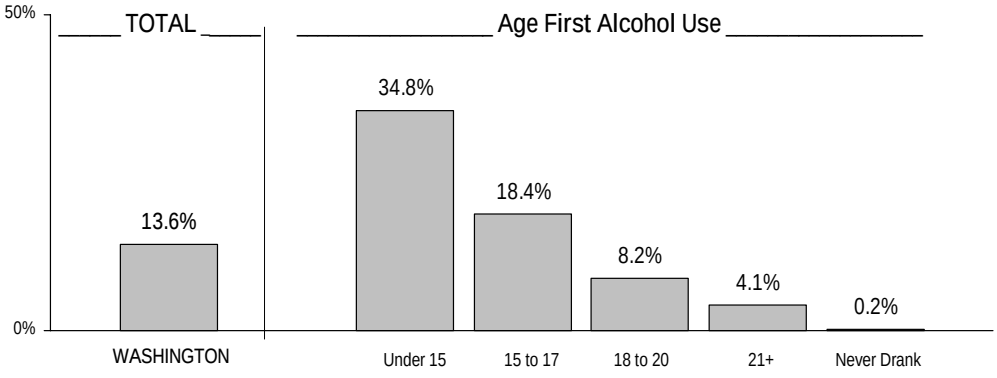
ABOVE

200%

Poverty

AT OR BELOW

Adults At Or Below 200% FPL



Need For Treatment Over Three Times as High Among Adults Using Marijuana Before Age 15

Approximately one out of three adults aged 21 or older (35.6 percent) reported that they had first used marijuana before the age of 21. This group consists of adults aged 21 or older who first used marijuana before the age of 15 (9.0 percent), adults who first used marijuana between the ages of 15 and 17 (15.6 percent), and adults who first used marijuana between the ages of 18 and 20 (11.0 percent). Among adults aged 21 and older, 6.8 percent reported they had first used marijuana after the age of 21 and 57.6 percent reported that they had never used marijuana (see table below).

Current Need for Treatment

The charts on the facing page examine the prevalence of current need for treatment by age of first marijuana use. Adults aged 21 and older who reported using alcohol at earlier ages were more likely to have a current need for treatment than were adults who reported using marijuana for the first time at older ages.

Adults aged 21 and older who reported first using marijuana before the age of 15 were over three times as likely to need treatment (33.9 percent) when compared with the overall state average. Adults aged 21 and older who first used marijuana after the age of 21 were somewhat less likely to have a current need for treatment (8.7 percent) compared to the overall state average. Current need for treatment was lower still among those adults aged 21 and over who indicated that they had never used marijuana (3.0 percent).

The relationship between age of first marijuana use and current need for treatment was consistent regardless of income level. Regardless of age of first use, need for treatment was higher among adults at or below 200 percent of the federal poverty level.

Need for treatment rates declined among higher-income adults who first used marijuana at an older age. This pattern was also found among lower-income adults; however, the decrease in rates was considerably smaller resulting in a flatter age profile (see figures at right). Little difference in need for treatment was found among higher-income adults who first used marijuana before age 15 (33.6 percent) compared with lower-income adults who first used marijuana before age 15 (34.6 percent). Differences between lower and higher-income adults are more pronounced when age of first use is higher. Only 7.2 percent of higher-income adults who first used marijuana after age 21 were classified as currently needing substance abuse treatment compared to 16.8 percent of lower-income adults who first used marijuana after age 21.

AGE FIRST MARIJUANA USE

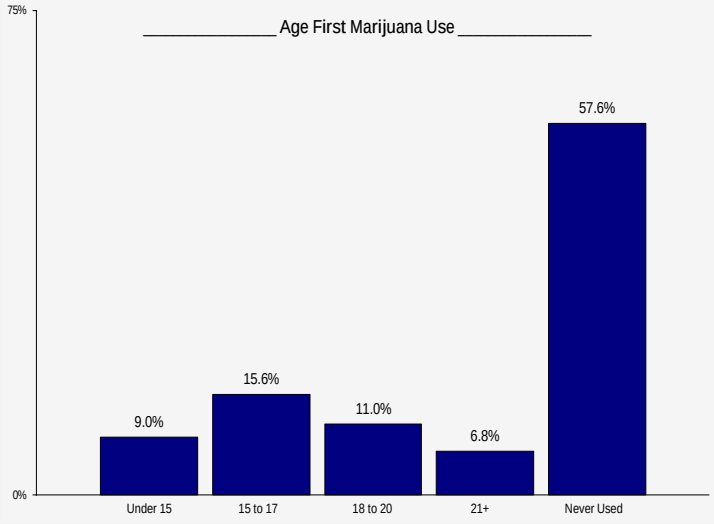
Most Marijuana Users First Try Marijuana Before Age 21

The figure to the right describes the age of first marijuana use among adults aged 21+. Roughly one out of three of all adults aged 21 or older (35.6 percent) first used marijuana before the age of 21 and nearly 1 in 4 (24.9 percent) before the age of 18.

Nationally, 23 percent of all adults age 18+ reported using marijuana before age 18* (SAMHSA, 2005).

* Estimate derived from pooled 2002-2003 NSDUH data. The complete report may be accessed from the SAMHSA website under the title, "Age at First Use of Marijuana and Past Year Serious Mental Illness."

Age of First Use Among Adults Aged 21+

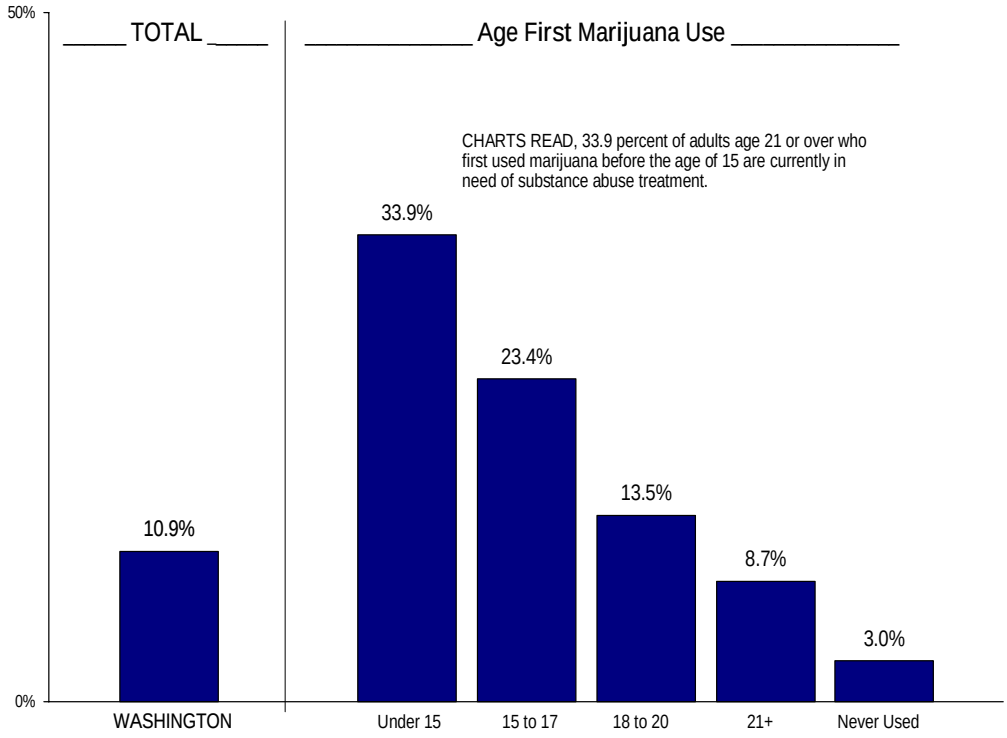


ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 21+



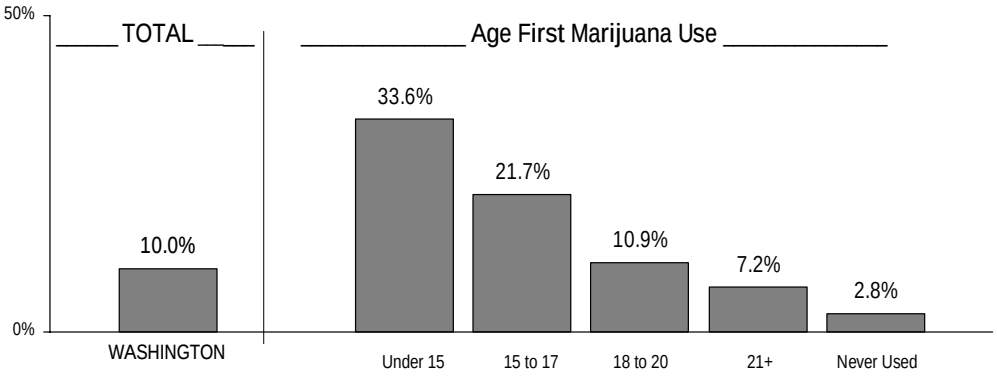
By Income

Household Income

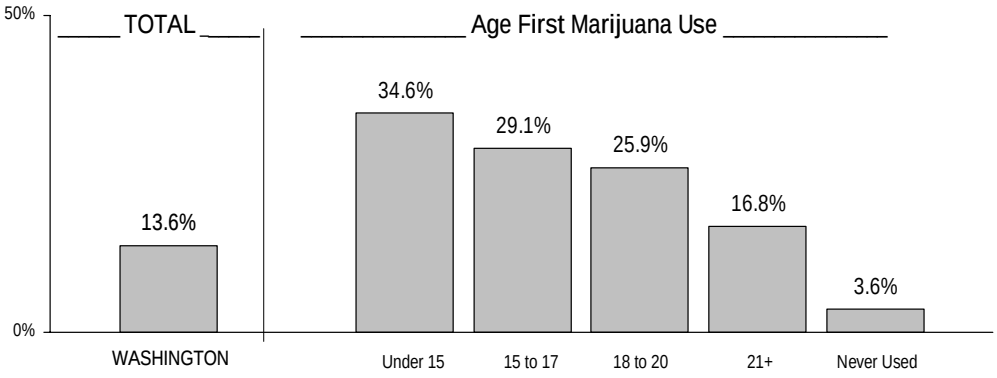
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Use of an Illicit Drug Other Than Marijuana at Younger Age Associated with Higher Levels of Need for Treatment

One out of five adults aged 21 or older (21.0 percent) reported that they had first used an illicit drug other than marijuana before the age of 21. This group consists of adults aged 21 or older who first used an illicit drug other than marijuana before the age of 15 (4.3 percent), adults who first used an illicit drug other than marijuana between the ages of 15 and 17 (8.2 percent), and adults who first used an illicit drug other than marijuana between the ages of 18 and 20 (8.5 percent). Among adults aged 21 and older, 7.6 percent reported they had first used an illicit drug other than marijuana after the age of 21 and 71.5 percent reported that they had never used an illicit drug other than marijuana.

Current Need for Treatment

The charts on the facing page examine the prevalence of current need for treatment by age of first use of any illicit drug other than marijuana. Adults aged 21 and older who reported using an illicit drug other than marijuana were more likely to have a current need for treatment. Further, adults who used an illicit drug other than marijuana at a younger age were more likely to have a current need for treatment than were adults who reported using an illicit drug other than marijuana for the first time at an older age.

Adults aged 21 and older who reported first using an illicit drug other than marijuana before the age of 15 were nearly four times as likely to need treatment (41.4 percent) when compared with the overall state average. Adults aged 21 and older who first used an illicit drug other than marijuana after the age of 21 were also more likely to have a current need for treatment (16.4 percent) compared to the overall state average. Current need for treatment was lowest among those adults aged 21 and over who indicated that they had never used an illicit drug other than marijuana (3.7 percent).

The relationship between age of first drug use other than marijuana and current need for treatment was consistent regardless of income level. Regardless of age of first use, need for treatment was higher among adults at or below 200 percent of the federal poverty level.

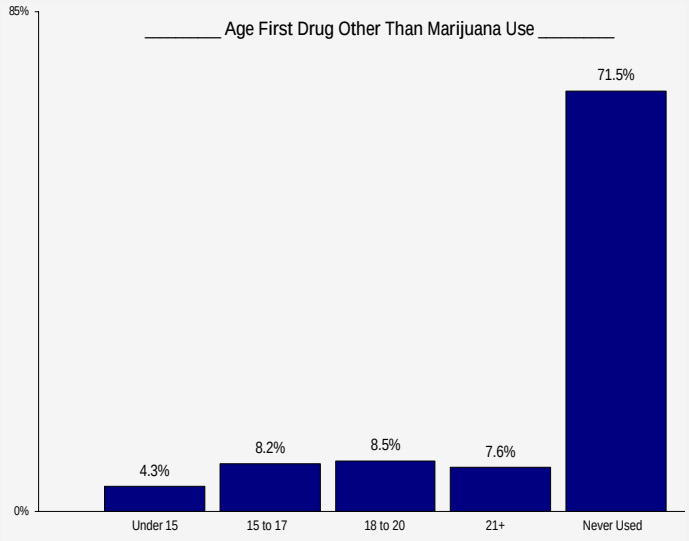
Similar to the pattern described on page 2-20, need for treatment rates declined more rapidly among higher-income adults as they reported an older age of first use. The flatter age profile among lower-income adults (see figures at right) results in a greater difference in need for treatment rates by poverty status at older ages of first use.

AGE FIRST DRUG OTHER THAN MARIJUANA USE

One in Five Adults Report Using Illicit Drug Other Than Marijuana Before Age 21

The figure to the right describes the age of first illicit drug use other than marijuana among adults aged 21+. Approximately 1 out of 5 adults (21.0 percent) used an illicit drug other than marijuana before the age of 21 and 1 in 8 (12.4 percent) before the age of 18.

Age of First Use Among Adults Aged 21+

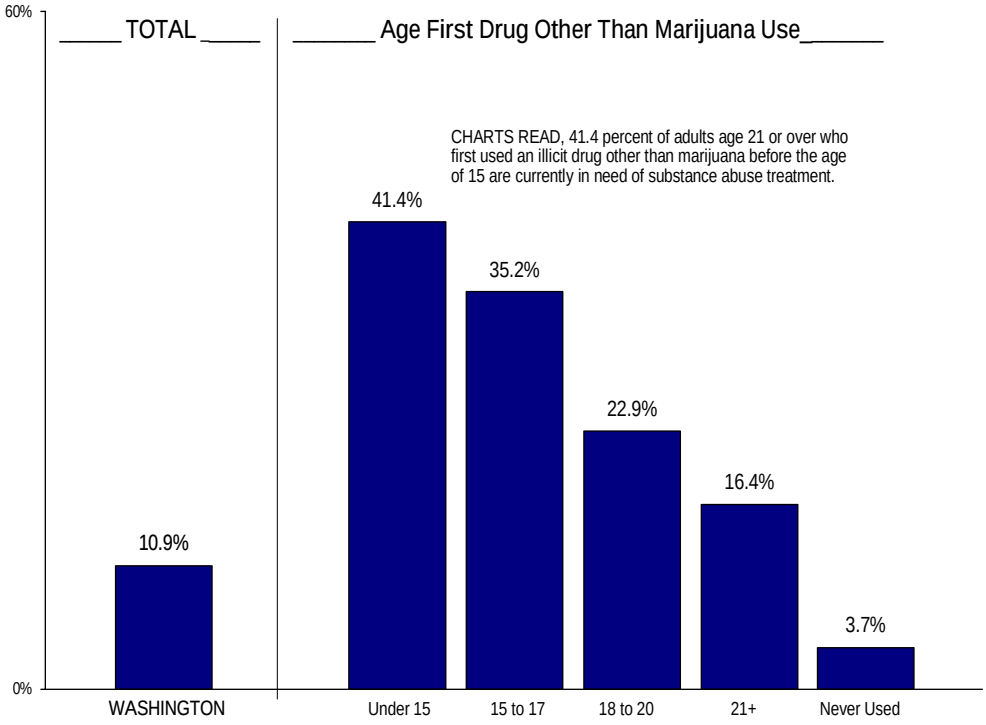


ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 21+



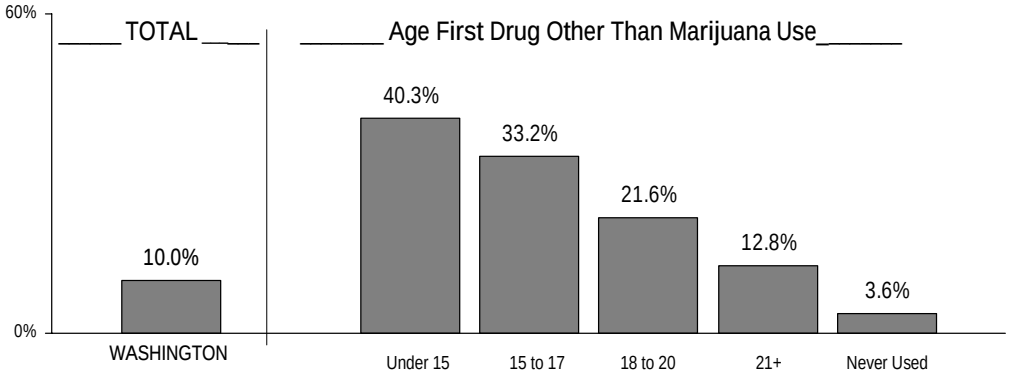
By Income

Household Income

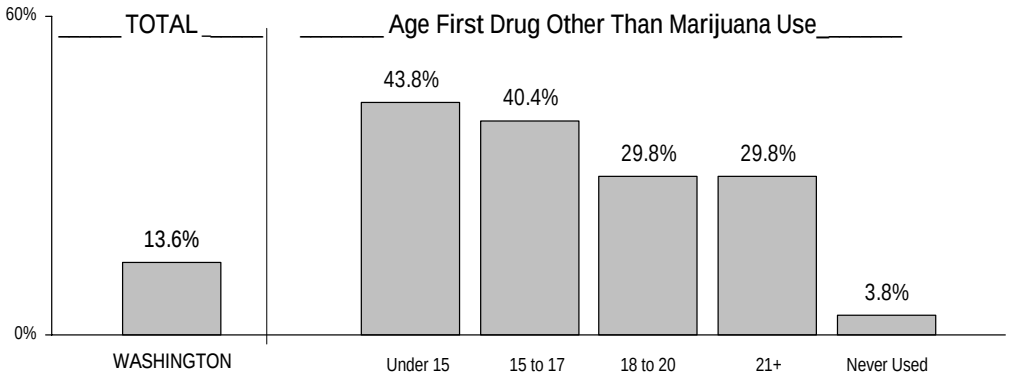
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Multiple Races, Language, and Reservation Status Related to Need for Treatment

This section further examines the relationship between race and need for alcohol or drug treatment. The box below examines differences in rates of need for treatment by the language spoken by Asian and Hispanic respondents. The box at the bottom of the facing page describes the relationship between reservation status and need for treatment among American Indian and Alaska Natives.

Need for Treatment Higher Among Adults Reporting Two or More Races

The chart at the top of the facing page compares need for treatment among adults who indicated only one non-Hispanic race with adults who indicated both that race and at least one other non-Hispanic race. For all races, with the exception of American Indian and Alaska Natives, the need for treatment rate was higher for adults who endorsed more than one race.

- Adults indicating they were Asian and at least one other race were three times as likely to need alcohol or drug treatment (15.6%), compared to adults who reported being Asian alone (4.9%).
- Adults indicating they were Native Hawaiian or Other Pacific Islander in combination with at least one other race were more than twice as likely to need treatment (30.2%), compared to adults indicating they were Native Hawaiian or Other Pacific Islander alone (13.7%).

The higher need for treatment patterns for adults endorsing more than one non-Hispanic race mirror the patterns for binge drinking and any illicit drug use presented on page 2-41.

ASIANS AND HISPANICS

CLOSEUP

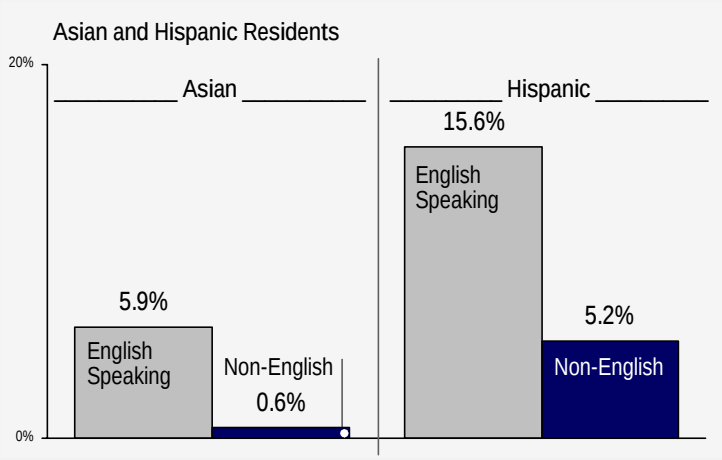
Need for Treatment Higher Among English Speaking Asians and Hispanics

The adjacent chart compares need for treatment among English and non-English speaking Asians and Hispanics. Among both groups, need for alcohol or drug treatment was considerably higher among those who completed the interview in English.

- Need for treatment was ten times higher among Asians who spoke English (5.9%), compared with those who did not (0.6%).
- Need for treatment was three times higher among Hispanics who spoke English (15.6%), compared with those who did not (5.2%).

See page 2-42 for a similar analysis of binge drinking and any illicit drug use.

Current Need for Alcohol or Drug Treatment



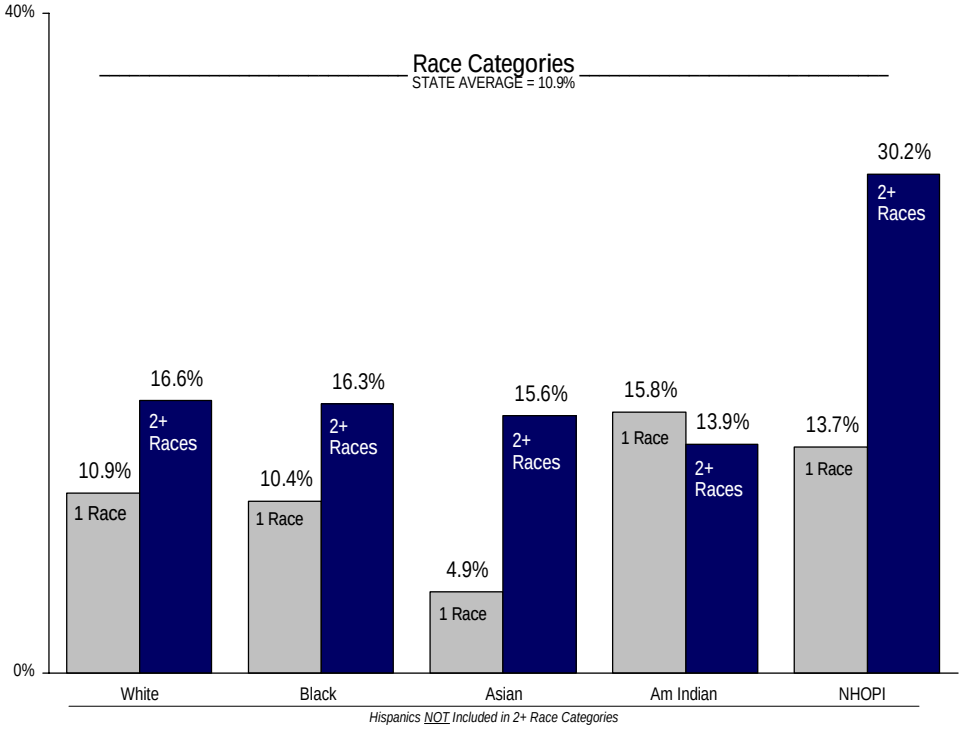
2003 SURVEY ESTIMATES

ALL ADULTS

Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



RESERVATION STATUS

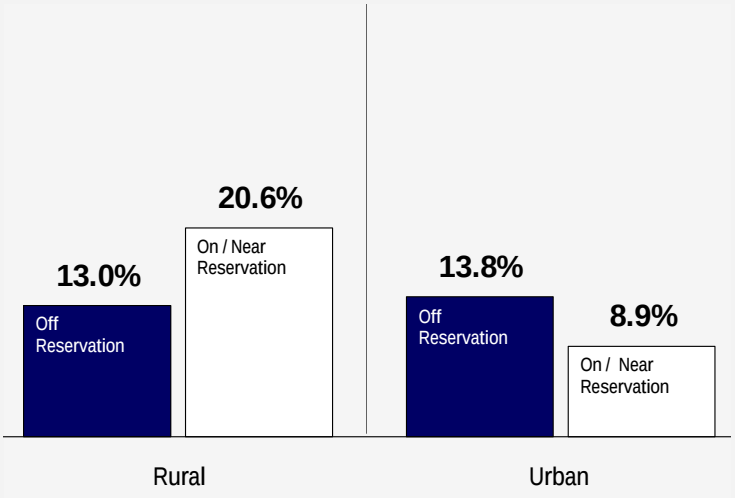
CLOSEUP

Need for Treatment Lowest Among Urban American Indian and Alaska Natives Residing On or Near a Reservation

This chart identifies need for treatment by reservation status for those non-Hispanic adults identifying themselves as an American Indian or Alaska Native. This population includes all non-Hispanic American Indian or Alaska Native residents regardless of whether they reported any other race.

The relationship between need for treatment and reservation status differed depending upon whether they resided in an urban or rural county. In rural counties need for treatment was *higher* for those identified as residing on/near a reservation. In urban counties need for treatment was *lower* for those residing on/near a reservation.

Current Need for Alcohol or Drug Treatment



Reservation status was determined by respondent zip code in the manner described on page 2-43.

Estimating Need for Opiate Substitution Treatment

Opiate substitution treatment (OST) is an important treatment modality for opiate addiction. This form of treatment is described in the text box below. OST has become even more important given the recent rise in illicit use of non-heroin opiates (see page 2-26) and the emergence of more accessible, non-methadone OST alternatives.

OST Need Estimate Based on NSDUH and TARGET data

Need for OST is estimated based on the overall need for treatment for heroin or other opiate addiction, with an adjustment for the proportion of adults estimated to be appropriate for the OST modality. Because WANAHS data do not provide this information we used NSDUH and TARGET data to estimate need for OST.

The NSDUH asks about past year abuse or dependence for each substance separately and these data are used to generate national past-year estimates of heroin or other opiate abuse or dependence. We requested from SAMHSA's Office of Applied Studies (OAS) a special NSDUH run and were able to obtain estimates of past-year abuse or dependence on non-heroin opiates for Washington State. However, past-year abuse or dependence on heroin was too rare to produce a reliable state-level estimate; instead OAS provided a state-level estimate of lifetime heroin use. A state-level estimate of past-year heroin abuse or dependence was generated by taking the ratio of lifetime heroin use in Washington to the national estimate and multiplying this ratio by the national past-year heroin abuse or dependence estimate.

Data from DASA's TARGET database indicate the proportion of clients receiving OST among those who abuse or are dependent on heroin or non-heroin opiates. Analysis of 2003 TARGET data showed that 44 percent of adults receiving treatment for heroin and 11 percent of adults receiving treatment for non-heroin opiates received OST. These rates are similar to national rates. According to recent national Drug and Alcohol Services Information System (DASIS) reports, methadone treatment was planned for 40 percent of all heroin admissions and 20 percent of all non-heroin opiate admissions. Based on these treatment use rates, we estimate that 50 percent of those who abuse or are dependent on heroin and 20 percent of those who abuse or are dependent on non-heroin opiates would be appropriate for OST.

Using this method, we estimate that a total of 10,891 adult residents needed OST in 2003. The textbox on the facing page provides greater detail about this calculation.

DEFINITIONS

Opiate Substitution Treatment

Opiate substitution treatment (OST) is one form of treatment on a continuum of care for opiate addiction. OST involves the use of a medically prescribed opioid agonist to reduce the craving for illicit opiates. Medications are long acting, requiring less frequent doses to avoid withdrawal. Most commonly, OST includes methadone although levo-alpha-acetyl-methadol (LAAM) and buprenorphine are also used. Typically, OST involves treatment at a methadone clinic. Buprenorphine, because it is considered to be less likely to cause psychological or physical dependence than Methadone or LAAM, is subject to less stringent government regulation, permitting treatment in an office setting.

Considerable evidence exists documenting the effectiveness of OST. The National Institutes of Health (NIH) recently released a consensus statement, *Effective Medical Treatment of Opiate Addiction*, which stated "…MMT (methadone maintenance treatment), combined with attention to medical, psychiatric, and socioeconomic issues, as well as drug counseling, has the highest probability of being effective" (NIH, 1997). The Office of National Drug Control Policy (ONDCP, 2000) concludes that MMT is one of the most monitored and regulated medical treatments in the United States and holds that MMT, "is safe and efficacious for the treatment of narcotic withdrawal and dependence." The Alcohol and Drug Abuse Institute at the University of Washington recently released a report (ADAI, 2003) that found OST programs are successful in reducing the negative consequences of heroin addiction and helping patients achieve safe, secure, self-sufficient, and healthy lives. Further, the ADAI found that OST contributes to significant reductions in crime, utilization of acute health care and psychiatric services, and a decreased reliance on public assistance.

OST clinics have been operating in Washington State for more than 25 years. Presently, DASA-certified OST clinics are operating in seven counties; Clark, King, Pierce, Snohomish, Spokane Thurston, and Yakima. DASA maintains a list of certified OST clinics on their website: http://www1.dshs.wa.gov/DASA/dasaservices.shtml. SAMHSA maintains a list of physicians or physician groups that provide office-based buprenorphine treatment in Washington (http://www.buprenorphine.samhsa.gov/).

GENERAL FORMULA

Formula to Estimate Need for Opiate Substitution Treatment

Counties may estimate the number of residents needing opiate substitution (OST) by applying the following general formula to their population:

Need for OST = 0.25% × Adult Household Population

Thus, we estimate that a county with 100,000 adult residents would contain 250 residents who need OST.

This formula simplifies a number of the underlying steps involved in estimating need for OST. A more detailed explanation of the components used to generate this formula is presented in the text box below.

Previously, the Division of Alcohol and Substance Abuse (DASA) estimated the need for OST by multiplying the adult county population by 0.245 percent, which is almost identical to the new estimate of 0.25 percent based on more recent NSDUH, TARGET, and DASIS data. The older 0.245 percent estimate was derived from a heroin use rate estimate obtained from the 1990 National Household Survey on Drug Abuse, combined with an adjustment factor to estimate the proportion of heroin users who would be appropriate for opiate substitution treatment.

ESTIMATING OST NEED

Parameters Used to Calculate Need for Opiate Substitution Treatment

2002-03 NSDUH Adjusted Washington Abuse or Dependence Rates

	LOWER-INCOME	HIGHER-INCOME
Heroin	**0.40%**	**0.06%**
Other Opiates	**1.46%**	**0.70%**

These rates are subsequently multiplied by the number of Washington adult residents to produce an estimated need for treatment count, using 2003 OFM population estimates.

2003 Estimated Number Needing Treatment for Heroin or other Opiate Abuse or Dependence

	LOWER-INCOME	HIGHER-INCOME
Heroin	**4,236**	**2,005**
Other Opiates	**15,460**	**23,390**

An adjustment factor of 50 percent for heroin and 20 percent for other opiates was used to estimate the number of adults eligible for OST from the total population needing treatment for heroin or other opiate abuse or dependence. This adjustment factor was based on TARGET treatment data and supported by national DASIS reports.

Opiate Substitution Treatment Adjustment Factor

Heroin	**50%**
Other Opiates	**20%**

Finally, counts of adults needing OST were generated from the product of the estimated number of adults needing treatment for heroin or other opiates and the OST adjustment factor:

2003 Estimated Number of Adults Needing OST

	LOWER-INCOME	HIGHER-INCOME
Heroin	**2,118**	**1,003**
Other Opiates	**3,092**	**4,678**

This method produced a total need for OST estimate of **10,891** adults.

Young Adults Most Likely to Need Treatment

The demographic detail presented earlier in this chapter considered each demographic variable in isolation from one another. This section of the report considers the relationship between need for treatment and demographic characteristics in a multivariate framework. The chart below presents odds ratios derived from a logistic regression model.

These odds ratios show that all age groups are significantly more likely to need treatment than adults aged 65 and older. Further, the younger the age group, the more likely adults are to need treatment, with adults aged 18 to 24 having more than 15 times the odds of needing treatment compared to adults aged 65 and older.

Males are significantly more likely to need treatment than females. Blacks, Asians (both English and Non-English speaking), and non-English speaking Hispanics are all significantly less likely to need treatment than are Whites.

Region of residence did not have a significant impact on need for treatment when considered in this multivariate model. However, adults living at or below 200 percent of the federal poverty level were significantly more likely to need treatment than adults above this threshold.

See text box on page 2-39 for discussion of how to interpret odds ratios.

2003 SURVEY ESTIMATES

ALL ADULTS

Current Need for Treatment

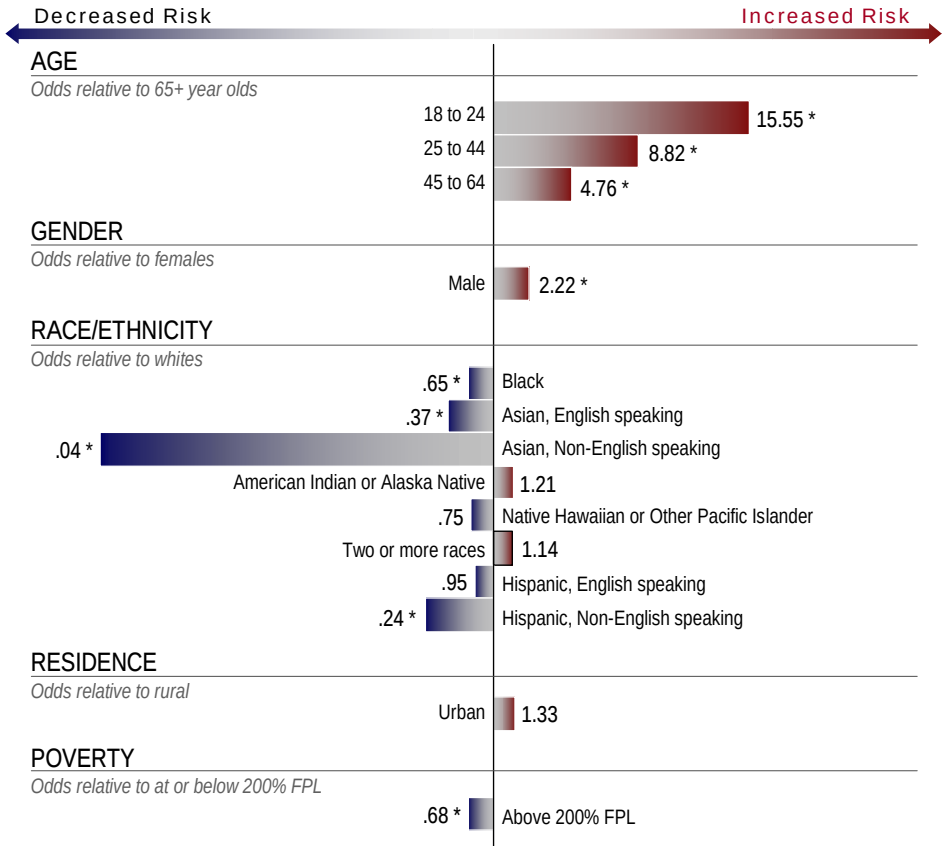
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Chart reads: 18 to 24 year olds have 15.55 the odds of needing substance abuse treatment compared to persons 65 and older.

*Significantly different from 1 at p <.05

Odds Ratios Associated With Need for Alcohol or Drug Treatment



Chapter 4

Alcohol and Drug Treatment Penetration

Measuring Substance Abuse Treatment Penetration

This chapter provides estimates of the proportion of lower-income, DASA-eligible adults in need of substance abuse treatment who actually receive substance abuse treatment services. This proportion is commonly referred to as the treatment penetration rate and its inverse as the treatment gap.

WANAHS survey measures of need for substance abuse treatment are combined with treatment data provided by the Division of Alcohol and Substance Abuse (DASA). DASA maintains a database of services provided under its programs called the Treatment and Assessment Report Generation Tool (TARGET). Because reporting is mandatory for treatment agencies providing public sector contracted or funded treatment services, TARGET includes data on all services provided by or funded by DASA.

Identifying Eligible Clients

Some clients in the TARGET database were excluded from the estimates in this report. First, eligible treatment was limited to residential, outpatient, and methadone services. Clients who received detoxification or transitional housing services were not included. Second, clients needed to reside in a household; homeless or institutionalized individuals were not included in these client counts. Third, treatment had to be state funded by the Department of Social and Health Services. Any clients who paid for services through private funds or clients who had their treatment funded through the Department of Corrections or through non-DASA state funds were excluded from this report.

Treatment Modalities

Treatment activities are classified into three separate modalities:

Residential: Residential services include a range of services where the client stays overnight for treatment. Services in this modality include extended care, intensive inpatient, long-term residential, MICA residential, and recovery house.

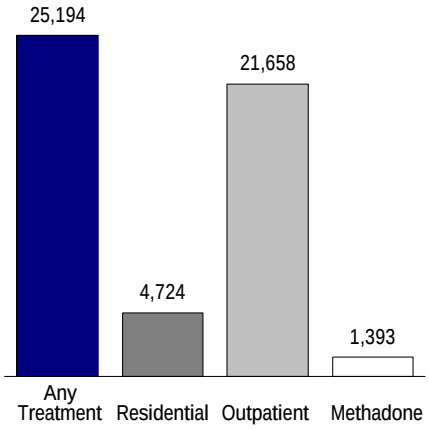
Outpatient: Outpatient treatment refers to a broad range of nonresidential treatment services where the client does not stay overnight for treatment. Services in this modality include group care enhancement, intensive outpatient, MICA outpatient, and outpatient treatment.

Methadone: Methadone treatment refers to the prescribing of methadone for the treatment of narcotic withdrawal and dependence. Included in this modality is methadone/opiate substitution treatment.

Most Clients Received Outpatient Treatment

The chart below describes the total number of clients treated during the 2003 calendar year. Clients were only counted once within any particular treatment modality, regardless of the number of times treated or number of 2003 admissions. For example, a client who was admitted to more than one outpatient program during 2003 will only be counted once. However, clients could receive treatment in more than one modality. Thus, in the figure below, a client counted as receiving outpatient treatment could also be included in residential and methadone treatment counts.

Number of Adult Clients Receiving Treatment During 2003 by Treatment Modality



* Clients may be counted in more than one modality.

Service Summary By Demographics

The table on the facing page describes the number of eligible clients receiving substance abuse treatment during 2003 by demographic characteristic and treatment modality. This table shows that a total of 25,194 adults received some form of DASA funded alcohol or drug treatment during 2003. Highlights include:

- More men than women received each type of treatment during 2003.
- Methadone treatment occurred with greater frequency in urban counties.

NEEDS ASSESSMENT

Unduplicated Adult Client Counts by Treatment Modality and Demographics (2003 Calendar Year)

	Any Treatment CLIENTS	Residential Treatment CLIENTS*	Outpatient Treatment CLIENTS*	Methadone Treatment CLIENTS*
WA State	25,194	4,724	21,658	1,393
Gender				
Male	15,237	2,604	13,354	655
Female	9,957	2,120	8,304	738
Age				
18-24	5,611	1,055	4,981	72
25-44	14,856	2,991	12,788	711
45-64	4,592	669	3,775	595
65+	135	9	114	15
Residency				
Urban	13,304	2,433	10,963	1,141
Rural	11,859	2,274	10,670	250
Unknown	31	17	25	2
Race				
White/Other Alone NH	17,762	3,584	15,073	1,072
Black Alone NH	1,604	279	1,310	172
Asian Alone NH	412	18	391	10
AI/AK NH	2,300	423	2,021	58
NHOPI Alone NH	121	18	108	7
Two or More Races NH	232	52	208	8
Hispanic	2,763	350	2,547	66
Marital Status				
Married	5,645	859	4,935	336
Divorced/Separated	8,028	1,657	6,822	516
Widowed	360	42	285	65
Never Married	11,161	2,166	9,616	476
Education				
Less than HS	8,615	1,648	7,458	383
HS Grad/Unknown	14,978	2,829	12,796	907
Some College	962	168	838	61
College Grad	639	79	566	42

* Counts for persons served in multiple treatment modalities are duplicated across modality categories.

Treatment Penetration Is Low Among Adults Aged 65+

This section presents treatment penetration rate estimates by gender, age, region of residence, race/ethnicity, marital status, and education.

Treatment penetration (defined in the box below) refers to the proportion of individuals receiving substance abuse treatment among those needing treatment who are eligible for DASA-funded treatment services. Because TARGET counts only include those receiving DASA funded treatment, penetration rates are limited to adults residing at or below 200 percent of the federal poverty level. A separate method using survey-based estimates of receipt of treatment services will be used later to estimate penetration rates among higher-income adults.

Overall, about one in four (26.2 percent) eligible lower-income adults who needed treatment actually received treatment during 2003.

Considerable variation in treatment penetration rates was found among different demographic groups:

- Treatment penetration was higher among women (34.2 percent) than men (22.7 percent).
- Treatment penetration was very low among adults aged 65+ (3.0 percent).
- Blacks (36.8 percent) and American Indian and Alaska Natives (31.7 percent) had higher treatment penetration rates compared to other racial or ethnic groups.
- Treatment penetration was much lower for adults with some college (2.3 percent) and among college graduates (9.6 percent), compared to adults with fewer years of education.

DEFINING PENETRATION RATE

Treatment penetration refers to the proportion of "DASA-eligible" adults needing treatment in 2003 who received alcohol or drug treatment in 2003, or:

$$\text{Treatment Penetration Rate} = \frac{\text{\# Adult household residents receiving DASA funded treatment}}{\text{\# Adult DASA eligible household residents needing treatment AND living at or below 200\% FPL}} \times 100$$

In this equation, counts of persons receiving DASA-funded treatment (the numerator) were drawn from the TARGET database. Only persons receiving inpatient, outpatient, or methadone treatment service in 2003 were included. Clients were counted once, regardless of the type or number of treatment admissions.

The number of adult household residents currently in need of treatment (the denominator) was estimated from the WANAHS survey. Adults were included in this denominator if they:

1. Needed substance abuse treatment in 2003
2. Were living at or below 200 percent of the federal poverty level
3. Did **not** report having primary health insurance coverage from private, Washington Basic Health Plan, or military health care sources.

The inclusion of this third condition distinguishes the 2003 penetration rate from the formula used in earlier reports based on the 1993-94 household survey. The result of this change is that the denominator includes a smaller population than has been used in earlier reports, which serves to increase the penetration rate estimate.

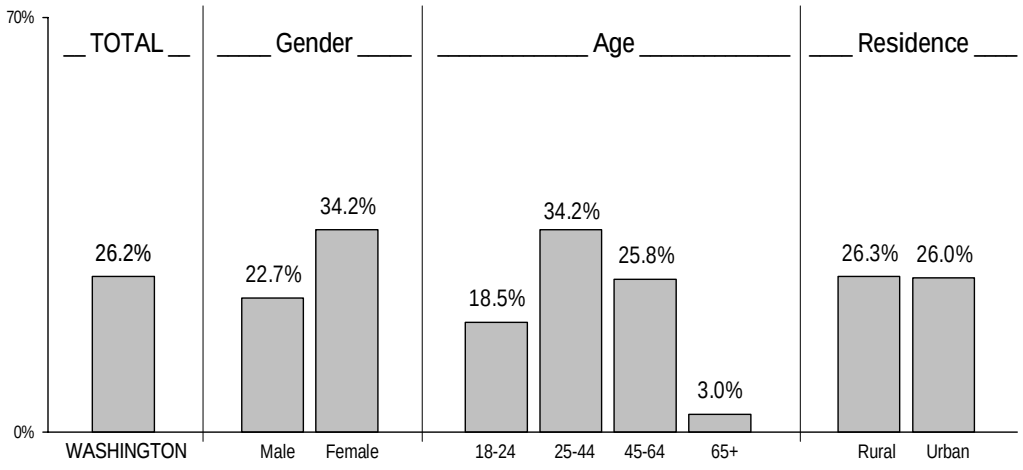
The change in the formula precludes making ten-year comparisons of changes in treatment penetration rates. However, the revised formula uses a more precise estimate of the number of DASA-eligible adults who need substance abuse treatment and provides a better estimate of the proportion of these adults who receive treatment.

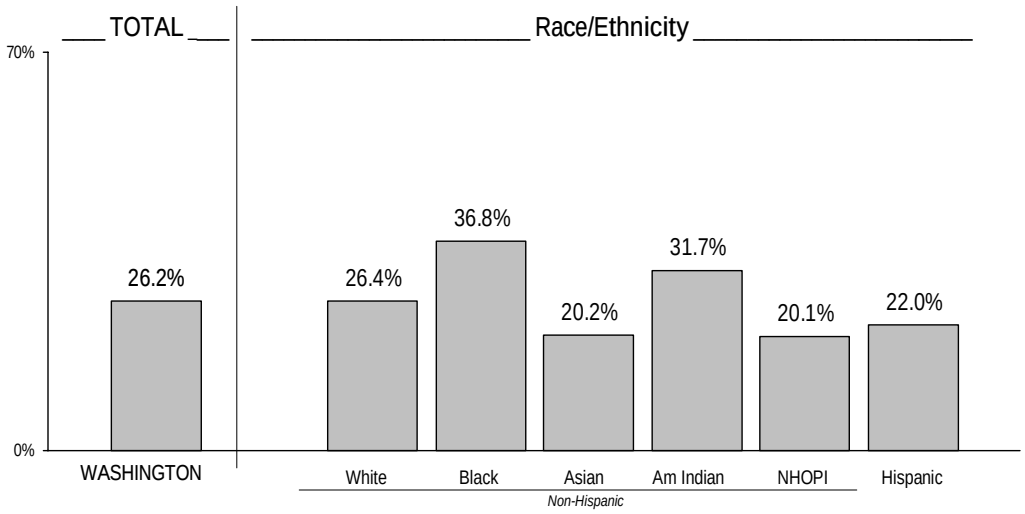
CLOSEUP

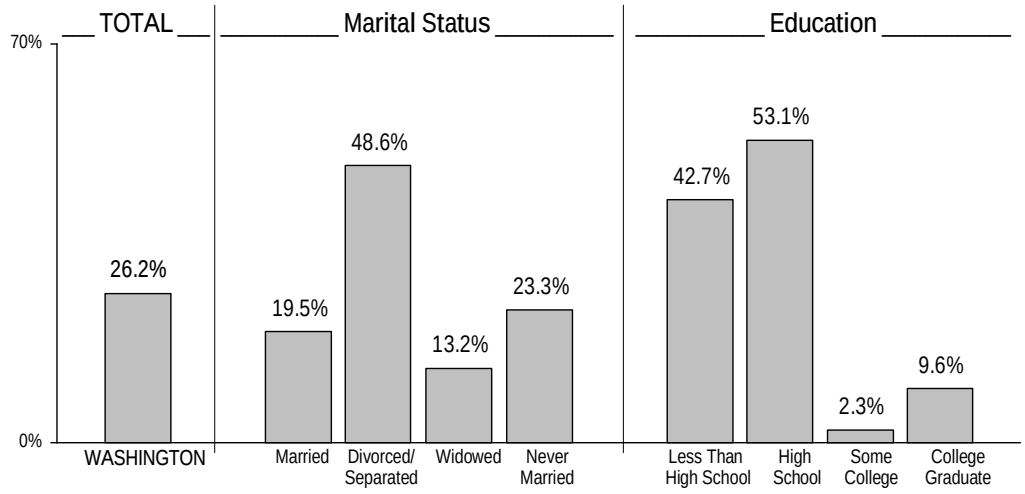
Treatment Penetration Rates At or Below 200% FPL

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+







2003 County Treatment Penetration Estimates

This section provides estimates of treatment penetration rates at the county level. Estimates are limited to DASA-eligible adults at or below 200 percent of the federal poverty level. The 2003 penetration rates are calculated differently from the 1993-94 rates and are, at the state level, considerably higher. While directly comparing 1993-94 county rates with 2003 rates is not particularly meaningful, it is still possible to compare the relationship of rates among the counties. This comparison (chart below) shows that the relative estimates of county treatment penetration rates remained generally consistent from 1993-94 to 2003.

The correlation between 1993-94 and 2003 county penetration estimates was 63 percent, indicating that counties with higher treatment penetration rates in 2003 tended to have higher treatment penetration rates in 1993-94.

The chart on the facing page lists treatment penetration estimates for each county.

- Treatment penetration rates for 22 counties were estimated at between 20 and 40 percent.
- Treatment penetration rates exceeded 40 percent for 11 of the counties. The highest estimates were for Clallam (51.1 percent) and Pacific (50.3 percent) counties.
- Treatment penetration rates in 3 counties were less than 20 percent and lowest in Whitman County (6.4 percent).

Estimates of treatment penetration for the three smallest counties (Columbia, Wahkiakum, and Garfield) are not provided, as the numbers of individuals estimated to be eligible for DSHS-funded treatment were too few to produce reliable estimates.

TEN-YEAR COMPARISON

CLOSEUP

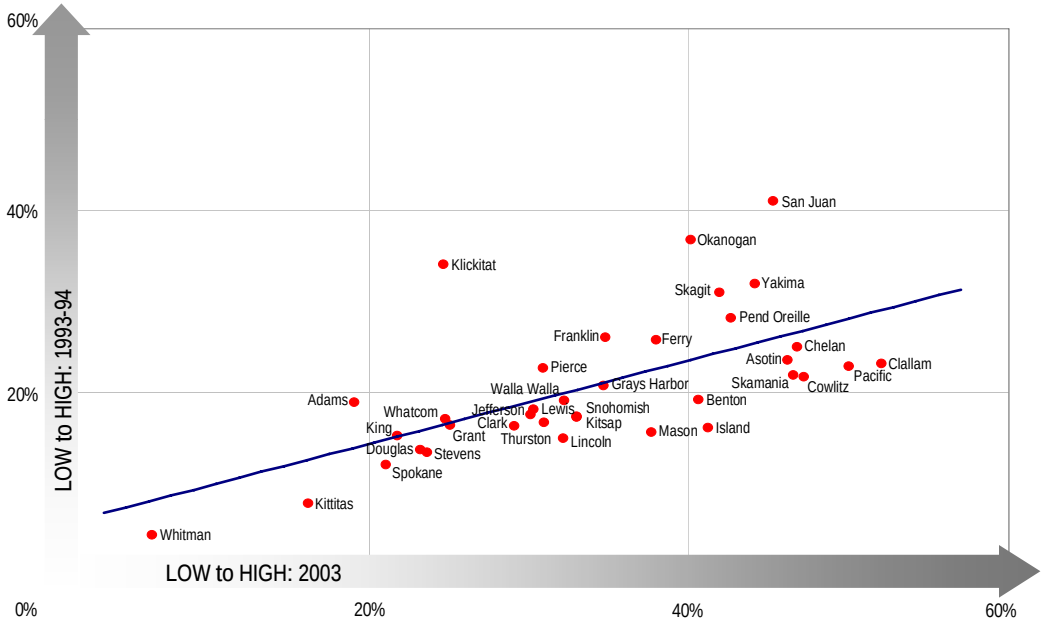
County Estimates for Lower Income Households

How do new estimates compare to ten years ago?

NEEDS ASSESSMENT

Washington State Household Residents Age 18+

Correlation Between 1993-94 and 2003 Penetration Estimates



Correlation between 1993-94 and 2003 = 63%

CLOSEUP

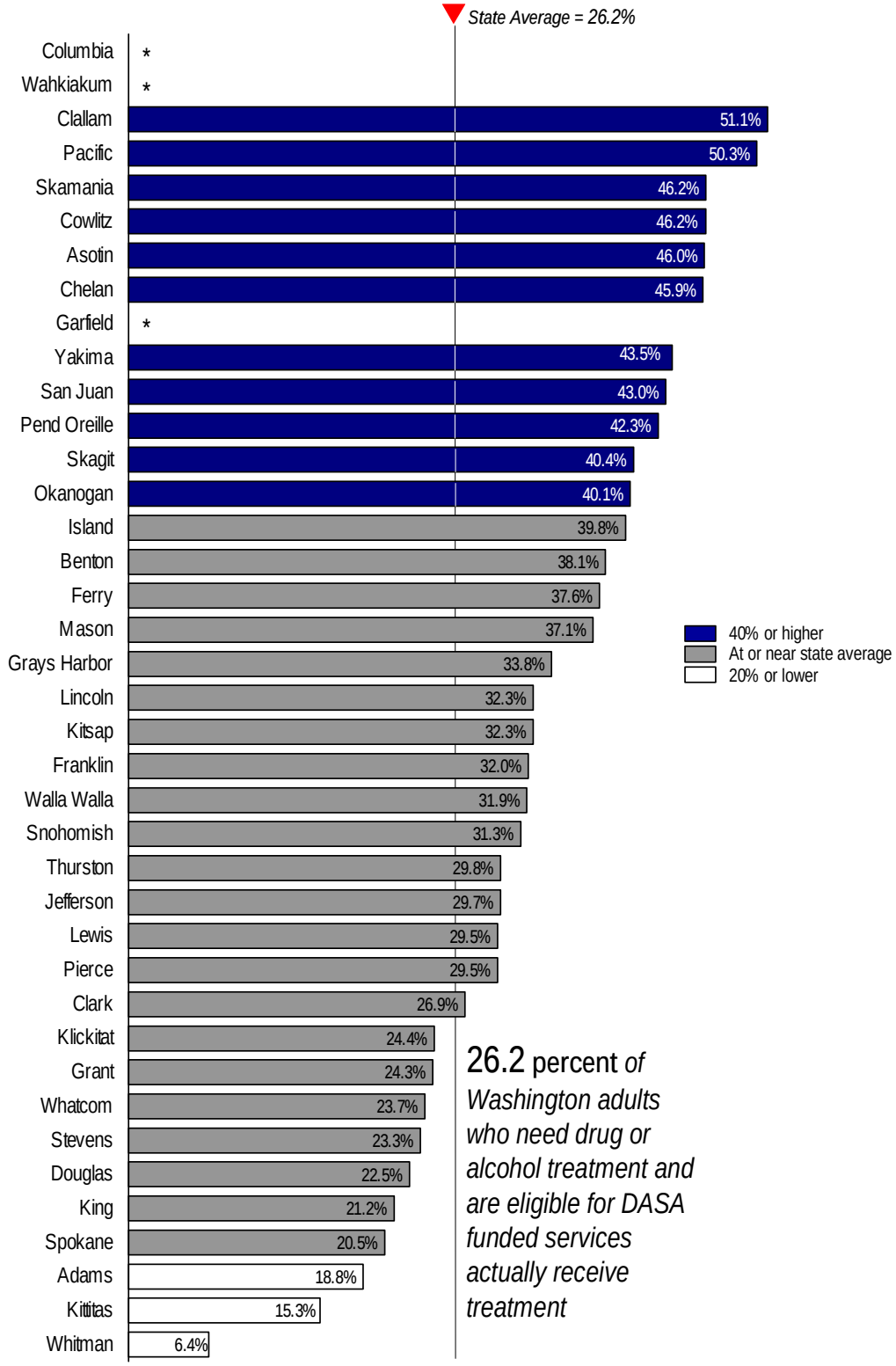
DASA-Eligible Adults at or Below 200% FPL

What counties have the highest treatment penetration rates?

NEEDS ASSESSMENT

Washington State Household Residents Age 18+

County Treatment Penetration Rates



26.2 percent *of Washington adults who need drug or alcohol treatment and are eligible for DASA funded services actually receive treatment*

Treatment Penetration Rates Are Low For Higher-Income, Privately-Insured Adults

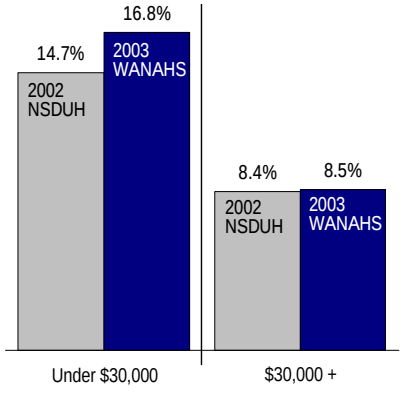
A limitation in using TARGET data to measure treatment is that non DASA-funded treatment is not generally captured in this system. While TARGET reporting is required for agencies providing public sector contracted or funded treatment services, it is optional for persons with private insurance. However, the WANAHS survey asked questions about treatment experiences and can be used to measure treatment penetration rates for populations that are not covered in TARGET.

Comparing WANAHS Survey Based Treatment Rates with NSDUH Rates

Although survey-based estimates of treatment penetration are lower than TARGET-based estimates, the WANAHS survey provides penetration rate estimates that are very similar to national estimates derived from the National Survey on Drug Use and Health (NSDUH).

In the chart below, WANAHS survey-based penetration rates are compared with those obtained using 2002 NSDUH data. The overall WANAHS rate (11.5 percent) was comparable to the overall NSDUH rate (10.9 percent). Both surveys report higher treatment penetration among lower-income adults compared to higher-income adults. Treatment penetration among lower-income adults appears to be higher in Washington State than in the nation as a whole.

Comparison of NSDUH and WANAHS Survey-Based Treatment Penetration Rate, by Household Income



Low Penetration Rates for Higher-Income Adults

Survey-based treatment penetration estimates show that lower-income adults have a much higher treatment penetration rate (16.6 percent), compared to higher-income adults (9.3 percent), indicating that lower-income adults are more likely to receive treatment services.

Low Penetration Rates for Privately Insured

The survey-based methodology also allows for an examination of treatment rates among adults with different forms of health insurance. Respondents were asked to indicate their primary source of insurance. Responses were classified into one of four groups:

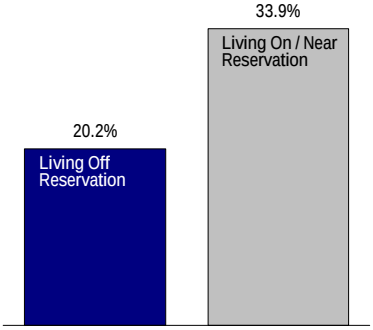
- **Uninsured**: Does not currently have health insurance coverage.
- **Private Insurance**: Health insurance is provided through an employer or union paid plan, a privately purchased plan, a plan purchased by someone outside of the household, or is obtained by "other" means. Most residents classified as having private insurance obtained coverage through their employer or union paid plan.
- **DSHS Funded**: Insurance provided through a DSHS funded medical assistance program such as Medicaid, Healthy Options, ADATSA, or GAU.
- **Other Government Funded**: Includes Medicare, military health care such as CHAMPUS, CHAMP-VA, TRICARE, or VA, Indian Health Service, and Washington Basic Health Plan.

Adults with private insurance had by far the lowest treatment penetration rate (4.4 percent). Adults with DSHS-funded insurance had the highest penetration rate (30.4 percent).

Higher Treatment Penetration Rates for Lower-Income American Indian or Alaska Natives Residing On/Near Reservations

The survey-based treatment penetration rate for lower-income American Indian or Alaska Natives was 24.9 percent; however, this rate was considerably higher (33.9 percent) for those that live on or near a reservation.

Survey Based Penetration Rates Among American Indian or Alaska Natives by Reservation Status



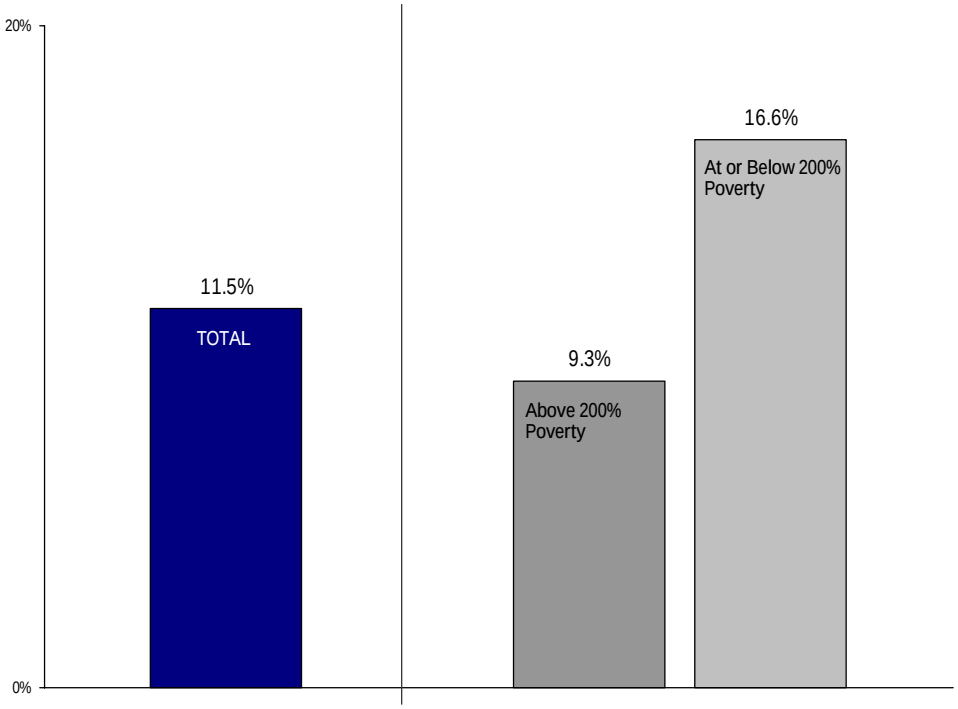
2003 SURVEY ESTIMATES

ALL ADULTS

Survey Based Treatment Penetration Rates by Poverty Status

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+

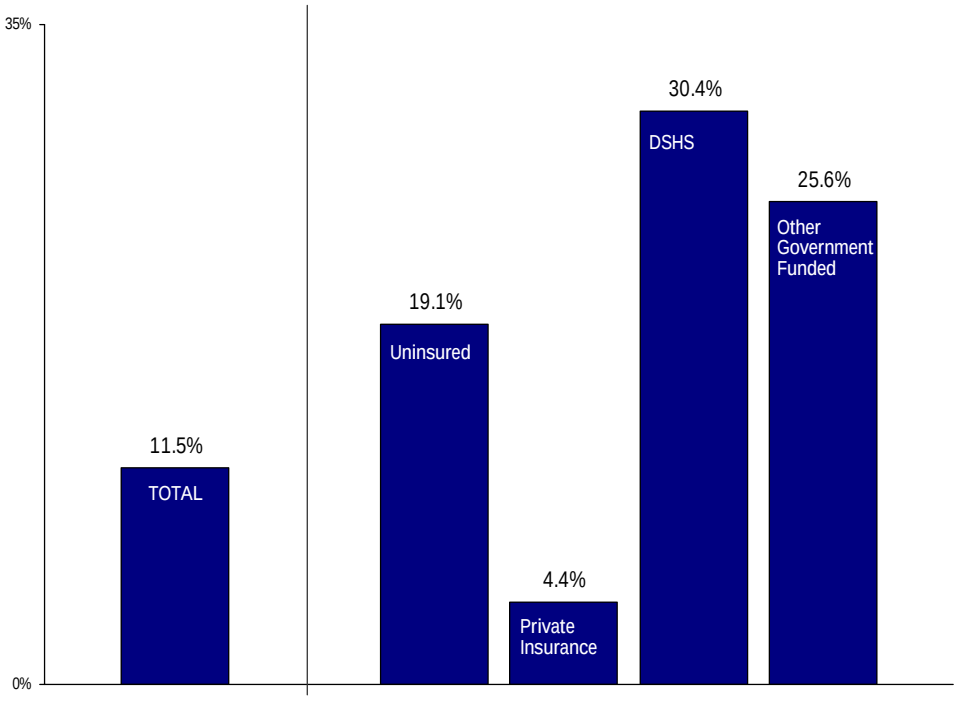


ALL ADULTS

Survey Based Treatment Penetration Rates by Primary Insurance

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



Chapter 5

Tobacco Use in Washington State

Lower-Income Adults Are More Likely To Smoke Cigarettes

This chapter describes tobacco use and its relationship with substance use and the need for substance abuse treatment. Because the 1993-94 survey did not ask respondents about tobacco use, 10-year comparisons are not presented in this chapter.

The figures on the facing page describe the percentage of adults who reported using different forms of tobacco products.

Approximately 3 out of 10 adults (29.0 percent) indicated that they used a tobacco product during the past year. Past year tobacco use was somewhat higher among adults at or below 200 percent of the federal poverty level (35.7 percent) compared with those above this income threshold (26.9 percent).

Cigarettes were the most commonly used tobacco product, regardless of income status. Overall, two out of ten adults (21.0 percent) smoked a cigarette during the past year. Three out of ten adults (30.6 percent) who were at or below 200 percent of the federal poverty level smoked a cigarette during the past year.

Approximately 1 in 10 adults (9.5 percent) reported smoking cigars during the past year. Cigar use was slightly higher among those adults above 200 percent of the federal poverty level (10.0 percent), compared with those at or below this poverty threshold (7.8 percent).

Chewing tobacco was used by 4.2 percent of the total adult household population. Rates of past year chewing tobacco use did not differ significantly by poverty status.

Pipe tobacco was the least frequently used form of tobacco (1.3 percent of the overall adult household population). The past year pipe tobacco use did not differ by poverty status.

COSTS OF TOBACCO USE ARE HIGH

Tobacco Use is the Leading Cause of Preventable Death

According to a 2004 report by the Centers for Disease Control and Prevention (CDC), tobacco use is the leading cause of death preventable in the United States. The health and economic costs associated with tobacco are high, specifically:

- Cigarette smoking ends in death or disability for half of all regular smokers.
- Cigarette smoking is responsible for more than 440,000 deaths each year.
- More than 8.6 million people in the U.S. have at least one serious illness caused by smoking.
- If current smoking patterns persist, 6.4 million people currently under age 18 will die prematurely from a tobacco-related disease.
- Smoking costs more than $75 billion per year in health-related expenses.
- Smoking costs an additional $80 billion per year in lost productivity.

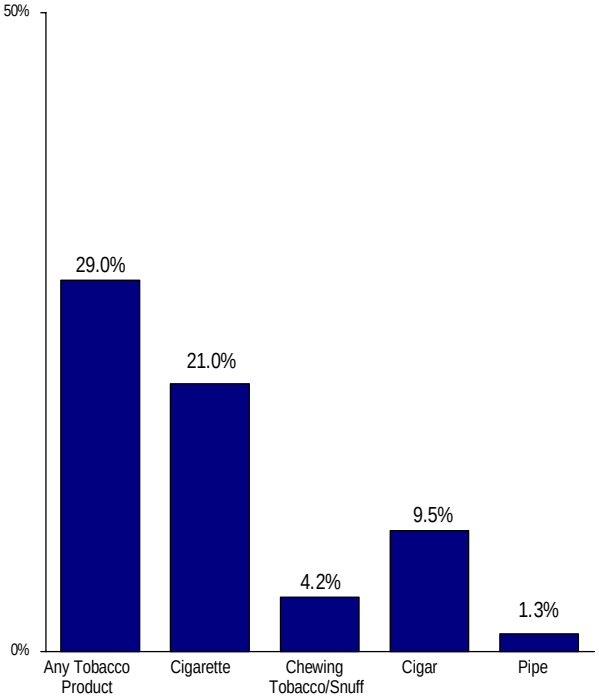
Source: Centers for Disease Control and Prevention (http://www.cdc.gov/tobacco).

ALL ADULTS

Past Year Tobacco Use

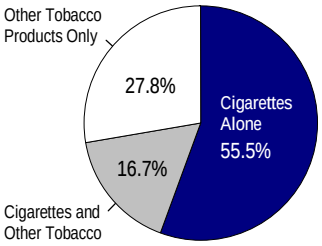
2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



CLOSEUP –TOBACCO USERS ONLY

Cigarettes: The Most Commonly Used Tobacco Product



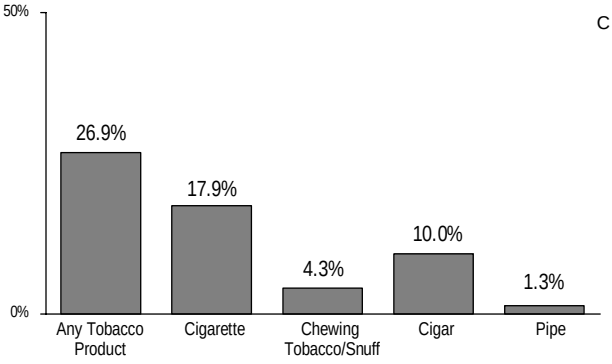
By Income

Household Income

ABOVE 200% Poverty

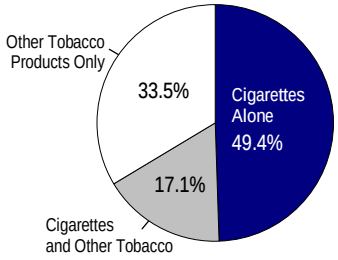
AT OR BELOW

Adults Above 200% FPL

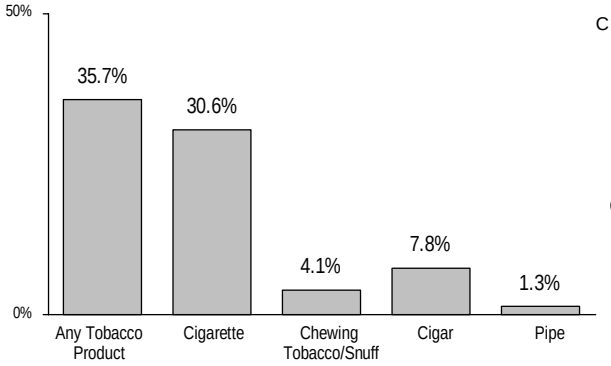


CLOSEUP –TOBACCO USERS ONLY

Other Tobacco Product Use Higher Among Persons Above Poverty

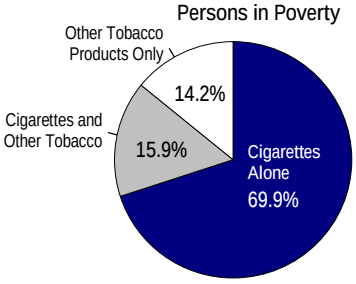


Adults At Or Below 200% FPL



CLOSEUP –TOBACCO USERS ONLY

Cigarette Use Higher Among Persons in Poverty



Lower-Income Adults Are More Likely To Be Heavy Current Smokers

The figures on the facing page describe the prevalence of cigarette smoking at increasing levels of intensity, beginning with any lifetime use and ending with heavy smoking (one or more packs per day) in the past 30 days.

Nearly two out of three adults reported ever smoking part or all of a cigarette (63.3 percent). However, less than half of all adults reported smoking 100 or more cigarettes (at least 5 packs) in their lifetime.

Approximately 2 out of 10 (21.0 percent) of all adults smoked a cigarette during the past year. Almost as many adults (18.1 percent) smoked during the past month. Overall, 7.1 percent of adults smoked one or more pack per day during the past month.

There is little difference in lifetime cigarette use by poverty status. However, rates of more recent cigarette use are significantly higher among adults at or below 200 percent of the federal poverty level:

- Past month cigarette smoking was twice as common among adults at or below 200 percent of the federal poverty level (28.0 percent), compared with higher-income adults (14.9 percent).
- Heavy past month cigarette use was more common among lower-income adults (9.4 percent), compared to higher-income adults (6.3 percent).

QUITTING REDUCES HEALTH RISKS

Quitting Smoking Yields Dramatic Health Benefits

The U.S. Surgeon General has stated that smoking cessation represents the single most important step that smokers can take to enhance the length and quality of their lives. People who stop smoking greatly reduce their risk of dying prematurely. Benefits are greater for people who stop at earlier ages, but cessation is beneficial at all ages.

The benefits of quitting begin almost immediately:

20 Minutes After Quitting – Heart rate begins to drop.

12 hours After Quitting – Carbon monoxide level in bloodstream drops to normal.

2 Weeks to 3 Months After Quitting – Heart attack risk begins to drop and your lung function begins to improve.

1 to 9 Months After Quitting - Coughing and shortness of breath decrease.

1 Year After Quitting - Added risk of coronary heart disease is half that of a smoker's.

5 Years After Quitting - Stroke risk is reduced to that of a nonsmoker's 5-15 years after quitting.

10 Years After Quitting – Lung cancer death rate is about half that of a smoker's. Risk of cancers of the mouth, throat, esophagus, bladder, kidney, and pancreas decreases.

15 Years After Quitting – Risk of coronary heart disease is back to that of a nonsmoker's.

The American Cancer Society offers additional information about the benefits of quitting and offers a number of tips and resources designed to assist a smoker to quit (http://www.cancer.org/).

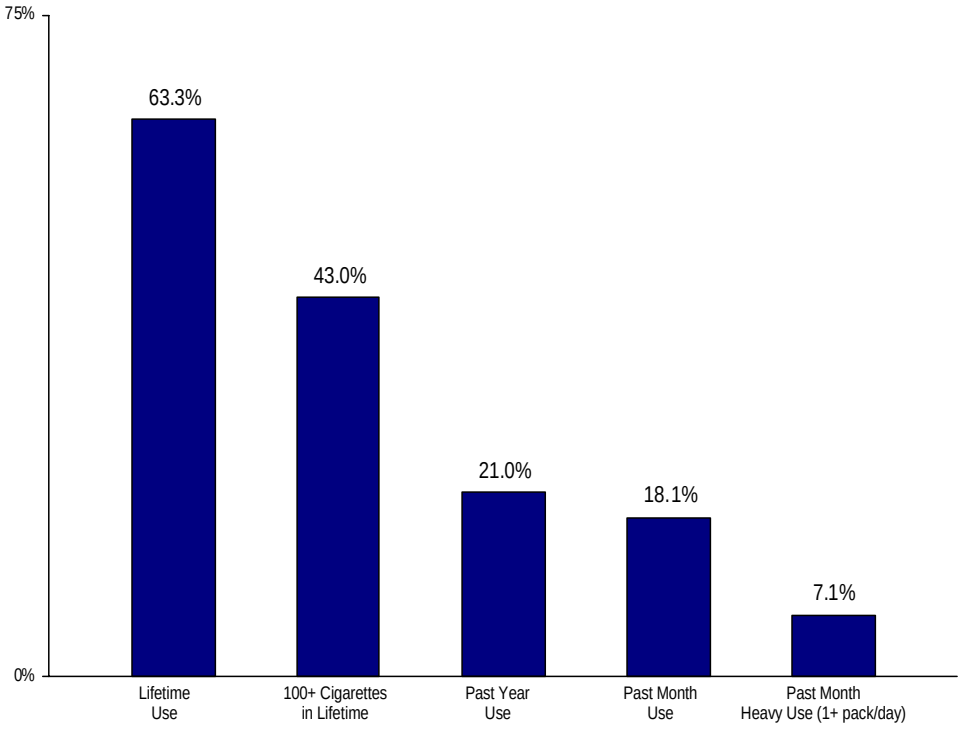
Source: Centers for Disease Control and Prevention (http://www.cdc.gov/tobacco).

ALL ADULTS

Recency of Cigarette Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



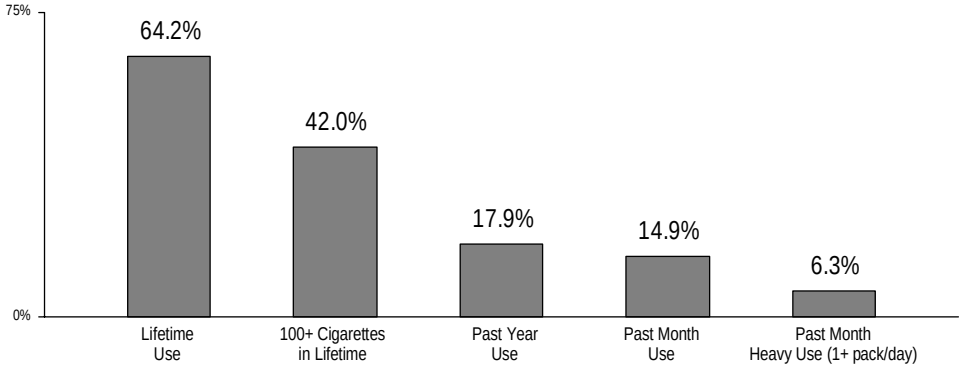
By Income

Household Income

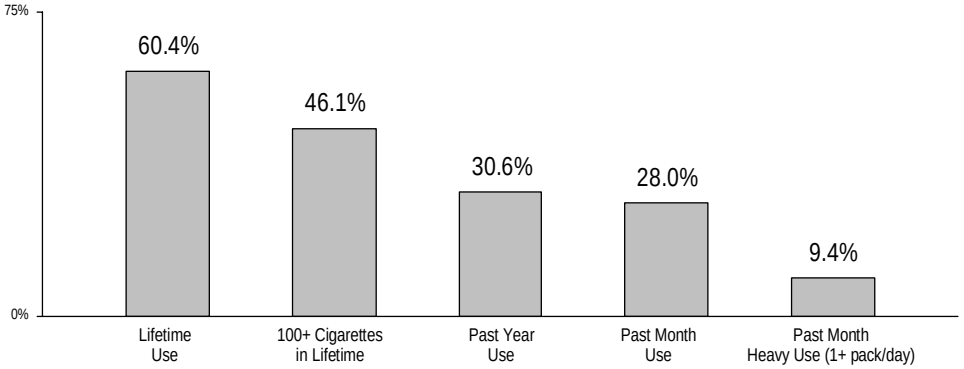
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Past Year Cigarette Use Higher Among Young, Lower-Income Adults

This section examines past year cigarette smoking among different demographic groups. The figures on the facing page describe differences in the prevalence of past year cigarette smoking by gender, age, and region.

Overall, approximately 1 in 5 adult household residents (21.0 percent) smoked cigarettes during the past year. This figure was higher for adults at or below 200 percent of the federal poverty level (30.6 percent) compared with those above (17.9 percent).

Rates of past year cigarette smoking varied little by gender; females were slightly less likely than males to smoke during the past year.

Overall, younger adults between the ages of 18 and 24 were the most likely to smoke (27.3 percent), with rates decreasing with age. Adults aged 65 and older were the least likely to smoke (6.8 percent). The low prevalence of past year smoking among older adults may in part reflect the impact of smoking on mortality rates.

Among low income adults under the age of 65, the prevalence of past year cigarette smoking does not vary with age; about one in three low income adults in the 18-24, 25-44, and 45-64 age categories smoked in the past year.

Cigarette smoking is somewhat more common among adults residing in urban counties.

NICOTINE WITHDRAWAL

DSM-IV Criteria for Nicotine Withdrawal

Nicotine is the primary component in tobacco that acts upon the brain and it is well established that nicotine is physically addictive. Nicotine is absorbed through the skin and mucosal lining of the mouth and nose or by the lungs.

The National Institute on Drug Abuse (NIDA) reports that most smokers use tobacco regularly because they are addicted to nicotine (NIDA, 2001).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines Nicotine Withdrawal using the following criteria:

A. Daily use of nicotine for at least several weeks.

B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:

(1) Dysphoric or depressed mood
(2) Insomnia
(3) Irritability, frustration, or anger
(4) Anxiety
(5) Difficulty concentrating
(6) Restlessness
(7) Decreased heart rate
(8) Increased appetite or weight gain

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

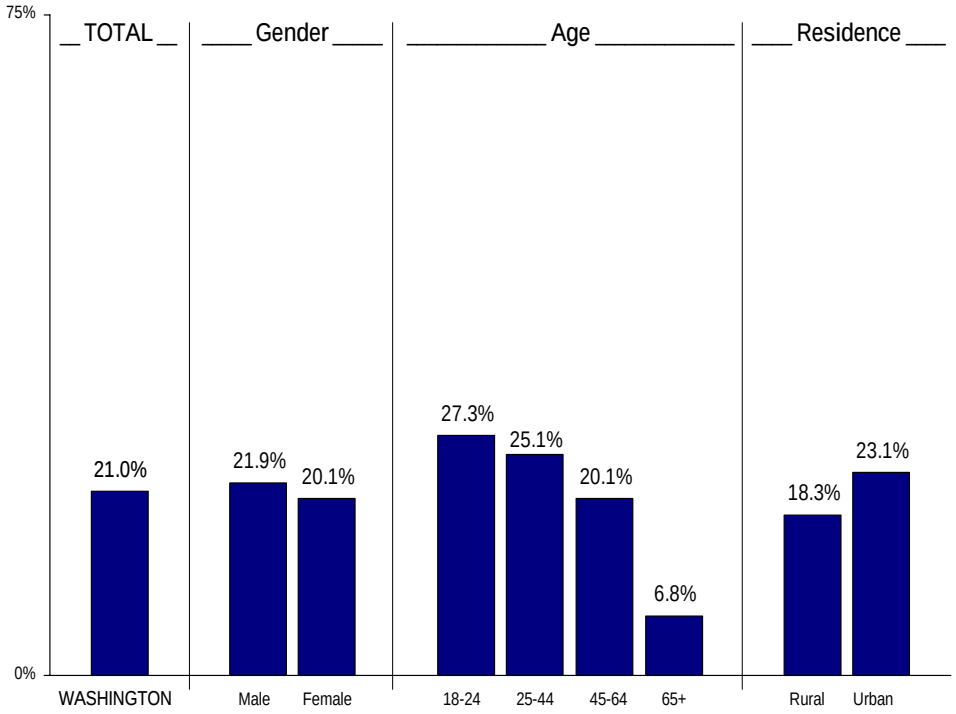
D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

ALL ADULTS

Past Year Cigarette Use

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



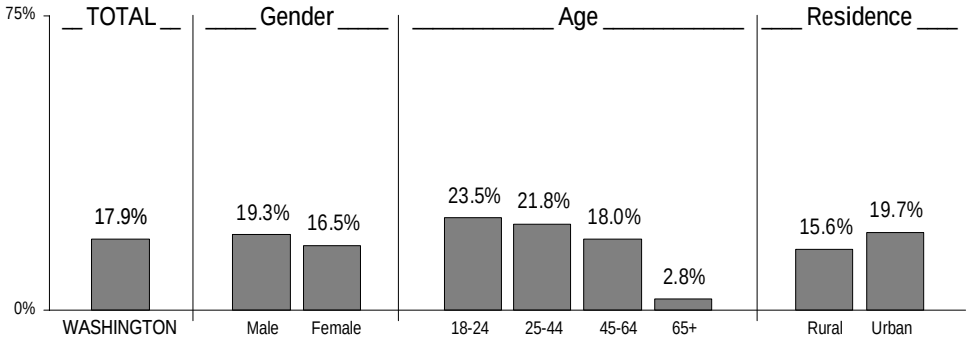
By Income

Household Income

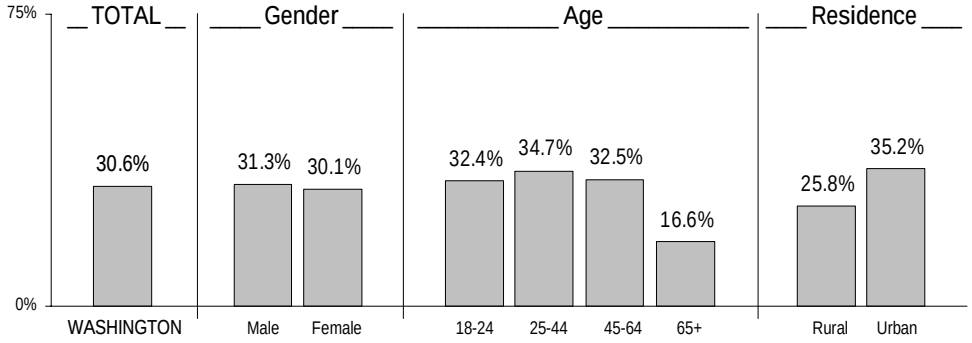
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Cigarette Smoking Most Common Among American Indians

This section examines past year cigarette smoking by race and ethnicity. American Indian or Alaska Native adults reported the highest rates of past year cigarette smoking (41.2 percent), while Asian adults reported the lowest prevalence of past year cigarette smoking (12.5 percent).

Among all groups except Asians and Hispanics, lower-income adults were much more likely to smoke during the past year. For example, half (50.3%) of American Indian or Alaska Native adults at or below 200 percent of the federal poverty level smoked cigarettes in the past year, compared to one third (34.4 percent) of those above 200 percent of the federal poverty level.

Among Asians and Hispanics, the differences in past year cigarette smoking between higher-income and lower-income adults were relatively small.

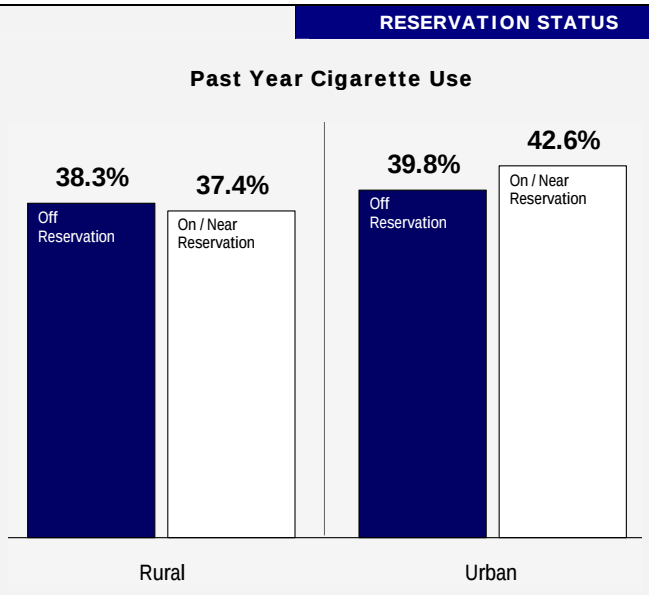
CLOSEUP

Rates of Smoking Similar Among American Indians Residing On / Near and Off Reservations

This chart describes past year cigarette smoking by reservation status for those non-Hispanic adults identifying themselves as an American Indian or Alaska Native. This population includes those American Indian or Alaska Native residents that also reported belonging to other racial groups.

Little difference was found in rates of past year cigarette use by reservation status.

Reservation status was determined by respondent zip code in the manner described on page 2-43.

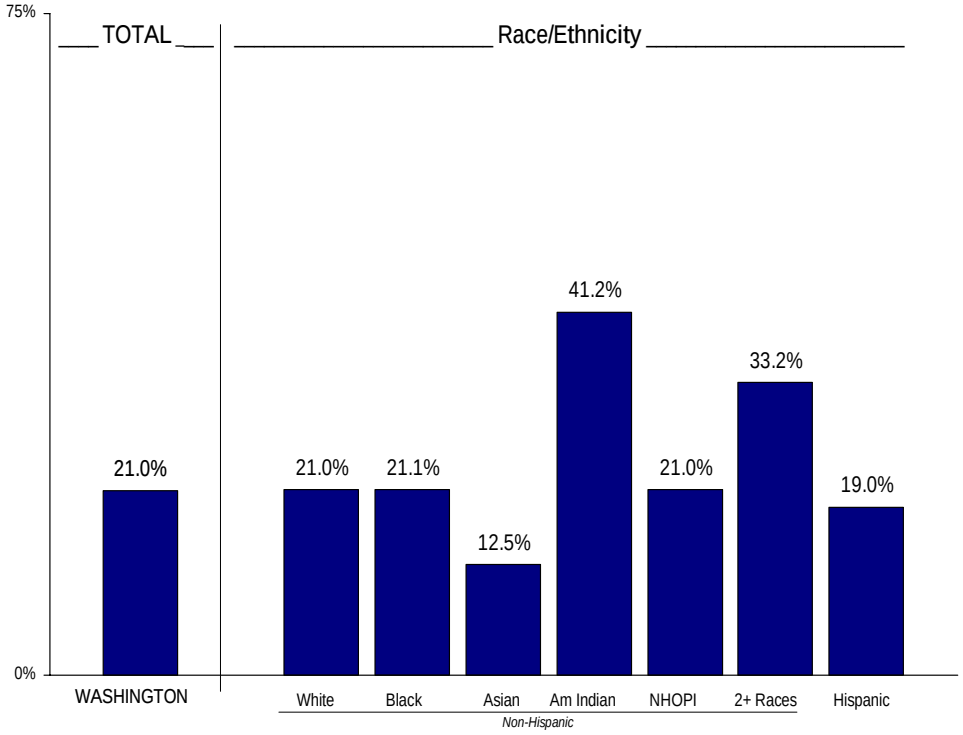


ALL ADULTS

Past Year Cigarette Use

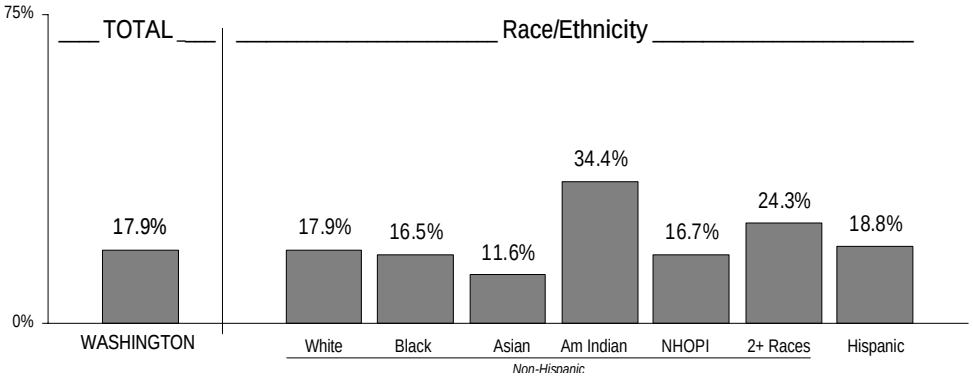
NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

Adults Above 200% FPL



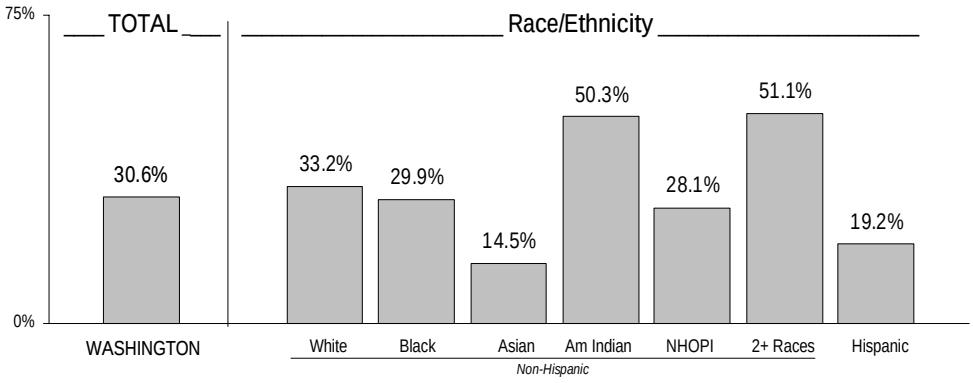
Household Income

ABOVE

200% Poverty

AT OR BELOW

Adults At Or Below 200% FPL



Lower-Income Pregnant Women Are More Likely To Smoke During Past Month

This section describes how the prevalence of **past month** and **past year** cigarette use varies among pregnant and parenting women. As discussed in the box below, lower-income women who are currently pregnant are considerably more likely to report smoking cigarettes in the past 30 days compared to higher-income pregnant women.

Women under the age of 51 were asked whether or not they were currently pregnant or had given birth in the past year. Women aged 51 and older were not asked these questions and were classified as not currently pregnant and as not giving birth in the past year. In addition, all respondents were asked whether they had children living in their household for whom they had primary care responsibilities.

Prevalence of past year cigarette use among currently pregnant women (22.3 percent) is slightly *higher* than cigarette use among women that are not currently pregnant (20.0 percent).

Rates of past year cigarette smoking are considerably higher among women who are at or below 200 percent of the federal poverty level.

Rates of past year cigarette use were higher among women who had given birth during the past year (28.7 percent) compared with those who had not (19.6 percent). This pattern was evident among higher-income women, however, little difference was found between lower-income women who had given birth during the past year (31.2 percent) and lower-income women who had not given birth (30.0 percent).

Rates of past year cigarette use were higher among women with children (25.9 percent) than women without children (16.5 percent). This pattern held regardless of poverty status. Among lower-income women, nearly 4 out of 10 women with children reported smoking during the past year (38.5 percent).

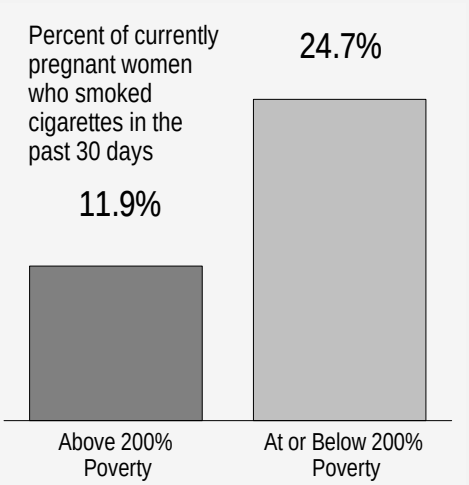
CLOSEUP

Lower-Income Pregnant Women Twice as Likely to Smoke Cigarettes in Past Month

The 2004 Surgeon General's Report found that women's smoking during pregnancy increases the risk of pregnancy complications, premature delivery, low-birth-weight infants, stillbirth, and sudden infant death syndrome (SIDS) (CDC, 2004). One limitation of looking at past year use among pregnant women is that it is not possible to definitively determine whether the behavior occurred before or during the pregnancy.

The chart to the right describes cigarette smoking during the past 30 days among currently pregnant women. Use of this shorter time frame greatly increases the probability that smoking is occurring during pregnancy. Pregnant women who were at or below 200 percent of the federal poverty level were over twice as likely to smoke cigarettes in the past month (24.7%) compared with higher-income pregnant women (11.9%).

SMOKING DURING PREGNANCY



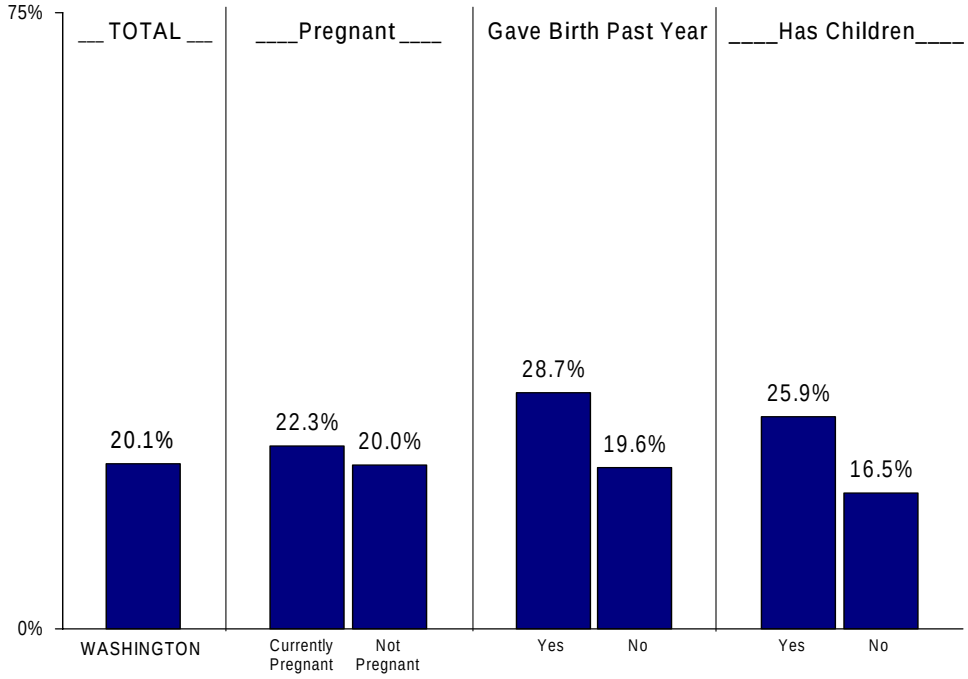
CLOSEUP

Pregnant and Parenting Women: Cigarette Use

2003 NEEDS ASSESSMENT

Washington State Household Residents

Past Year Cigarette Use



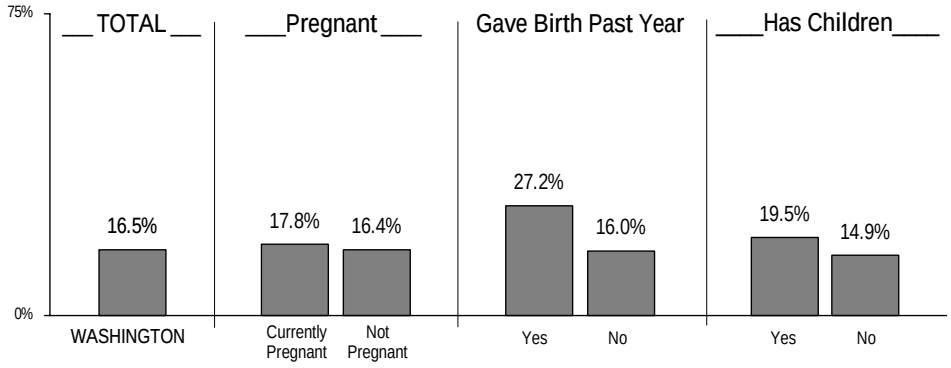
By Income

Household Income

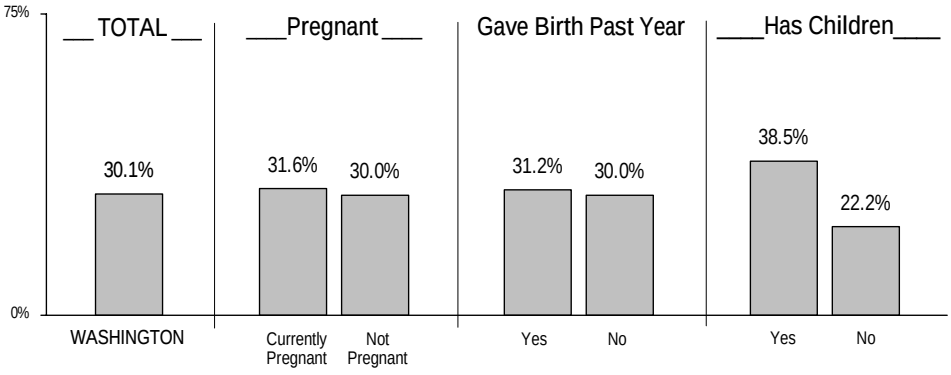
ABOVE 200% Poverty

AT OR BELOW

Past Year Cigarette Use - Women Above 200% FPL



Past Year Cigarette Use - Women At Or Below 200% FPL



Substance Use, Need for Treatment Higher Among Smokers

This section compares the prevalence of substance use and need for treatment between cigarette smokers and non smokers.

The charts on the facing page describe the prevalence of past year substance use and need for treatment among adults who smoked during the past year (dark bars), compared with adults who did not smoke during the past year (white bars).

Adults who smoked cigarettes in the past year reported higher rates of substance use and a higher rate of need for substance abuse treatment, compared with adults who did not smoke cigarettes during the past year.

Key findings include:

- Binge drinking was more than twice as common among smokers (44.8%) than non-smokers (20.9%).
- Use of any illicit drug was more than three times as common among smokers (22.0%) than non-smokers (6.4%).
- Need for alcohol or drug treatment was more than three times as common among smokers (25.1%) than non-smokers (7.1%).

The relationship between cigarette use, substance use, and need for substance abuse treatment was similar for adults above and below 200 percent of the federal poverty level.

SMOKING AMONG ADULTS NEEDING TREATMENT

Smoking Higher Among Adults In Need of Substance Abuse Treatment

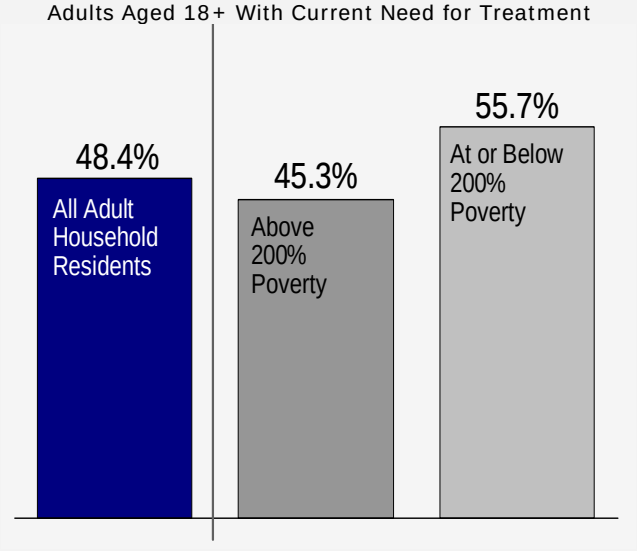
Another useful way to examine the relationship between smoking and need for substance abuse treatment is to examine the prevalence of smoking among adults who currently need treatment.

Focusing only on adults in need of substance abuse treatment, we see that the prevalence of smoking is much higher; nearly half (48.4 percent) of these adults smoked cigarettes during the past year. This rate is even higher among lower-income adults (55.7 percent).

In contrast, only 17.6 percent of all adults who do not need substance abuse treatment reported smoking cigarettes in the past year.

Half of All Adults Needing Treatment Smoke Cigarettes

Adults Aged 18+ With Current Need for Treatment



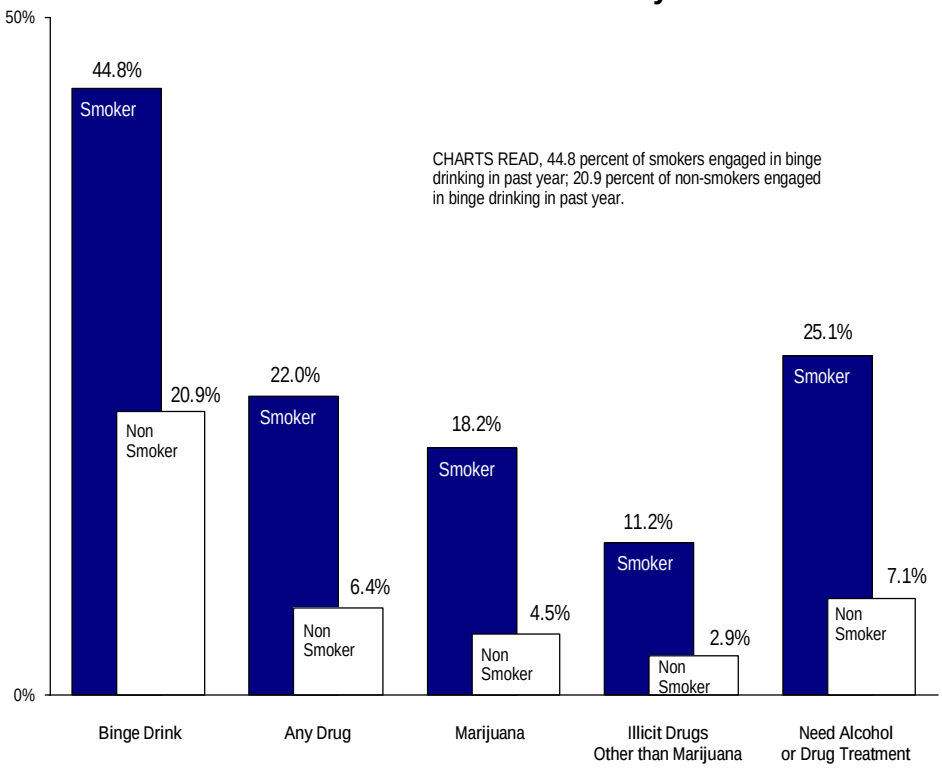
Prevalence of Substance Use and Need for Treatment by Smoker Status

ALL ADULTS

Substance Use and Current Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



CHARTS READ, 44.8 percent of smokers engaged in binge drinking in past year; 20.9 percent of non-smokers engaged in binge drinking in past year.

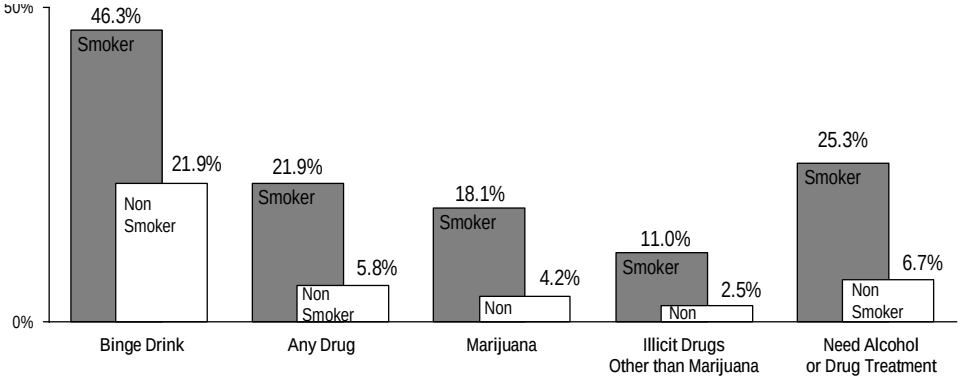
By Income

Household Income

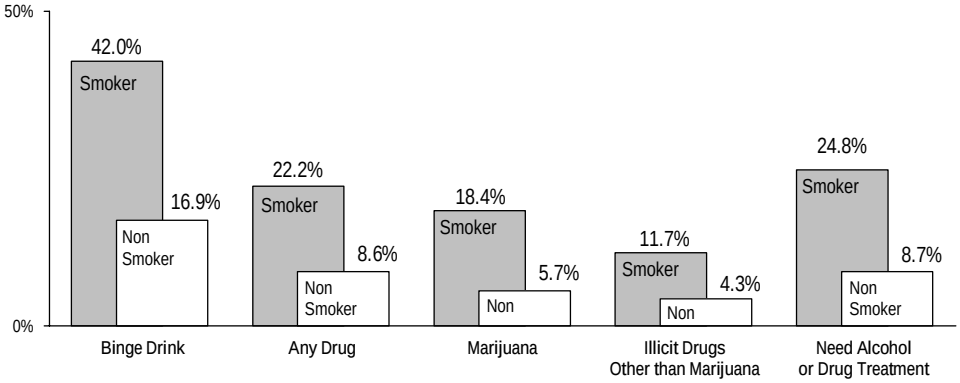
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Chapter 6

Prevalence of Gambling in Washington State

Majority of Adults Gambled for Money in Past Year

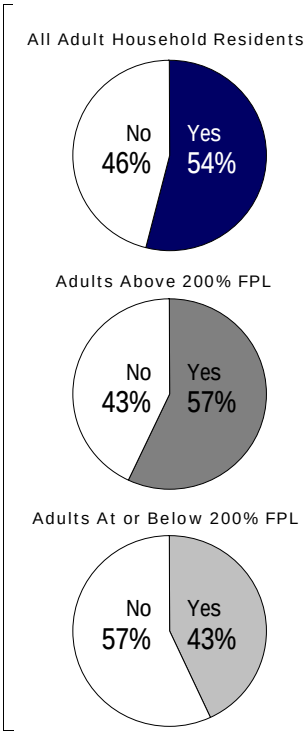
Over half (54 percent) of adult household residents reported engaging in some form of gambling during the past year. Gambling behaviors include a diverse range of activities from casino gambling to purchasing lottery tickets. Gambling was more prevalent among adults above 200 percent of the federal poverty level (57 percent) compared with lower-income adults (43 percent).

While most adults who engage in gambling do not meet the clinical definition of pathological gambler (see definition below), problem gambling affects many residents. The chart on the facing page describes the prevalence of problem gambling. In addition to pathological gamblers, this chart includes adults who are problem gamblers as well as those at risk for developing problem or pathological gambling.

Statewide, 3.9 percent of adults are at risk for or meet the criteria for problem or pathological gambling. Although participating in gambling is more common among adults above 200 percent of the federal poverty level, adults at or below this poverty threshold are slightly more likely to be at risk for or meet the DSM-IV criteria for problem or pathological gambling (4.7 percent).

Participated in any gambling during the past 12 months?

- Casino Gambling
- Lotteries
- Bingo
- Playing Golf, Pool or Cards for Money
- Wagering on Sporting Event
- Horse Races
- Other Gambling



DEFINITIONS

Who is a "Pathological" Gambler?

A Pathological Gambler is defined under DSM-IV diagnostic criteria as a person who exhibits persistent and recurrent maladaptive gambling behavior as indicated by **five (or more)** of the following:

- **Preoccupied with gambling.** Preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble.
- **Needs to gamble with increasing amounts of money** in order to achieve the desired excitement.
- **Repeated unsuccessful efforts to control, cut back, or stop** gambling.
- **Restless or irritable** when attempting to cut down or stop gambling.
- **Gambles as a way of escaping from problem**s or of relieving a dysphoric mood. This may include feelings of helplessness, guilt, anxiety, or depression.
- **After losing money gambling, often returns another day** to get even ("chasing" one's losses).
- **Lies to family members, therapist, or others** to conceal the extent of involvement with gambling.
- **Has committed illegal acts** such as forgery, fraud, theft, or embezzlement to finance gambling.
- **Has jeopardized or lost a significant relationship, job, or educational or career opportunity** because of gambling.
- **Relies on others to provide money** to relieve a desperate financial situation caused by gambling.

Under DSM-IV, this gambling behavior is not better accounted for by a Manic Episode.

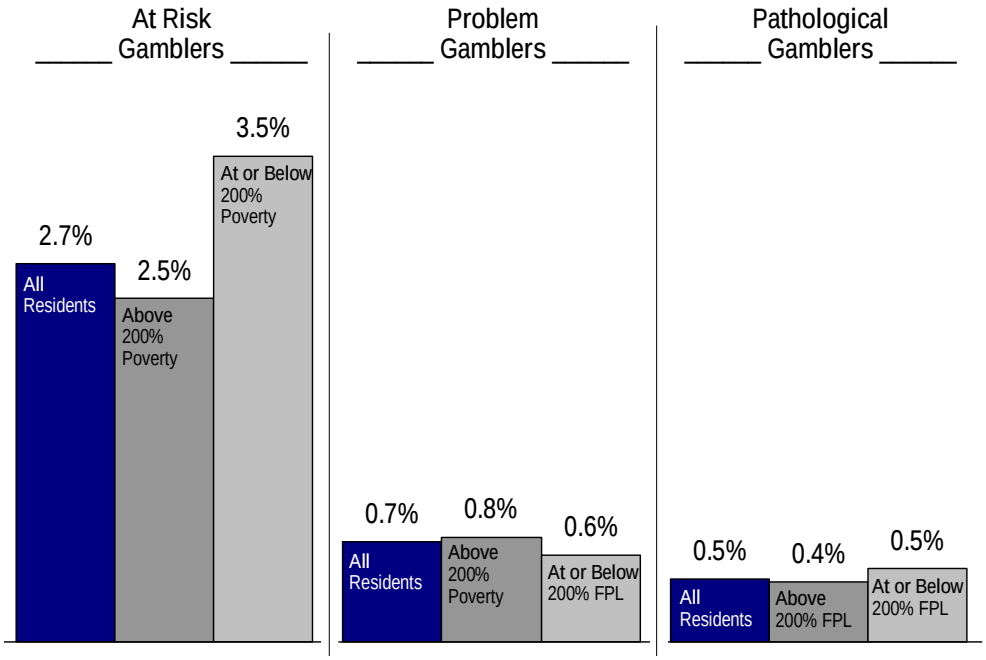
2003 SURVEY ESTIMATES

ALL ADULTS

Past Year Prevalence of At Risk, Problem, and Pathological Gambling

NEEDS ASSESSMENT

Washington State Household Residents Age 18+



DEFINITIONS

Measuring Problem Gambling

Definitions of "**at risk**," "**problem**," and "**pathological**" gambling are based on the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV). These are the accepted standards by which substance use and gambling disorders are measured.

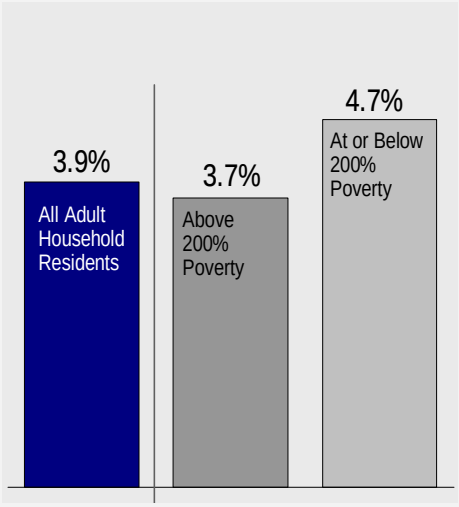
WANAHS measured DSM-IV problem gambling symptoms using the **N**ational **O**pinion Research Center (NORC) **D**SM **S**creen for Gambling Problems (**NODS**). Since its introduction in 1999, the NODS has become the standard screening instrument for gambling problems. We use the following definitions developed by Gerstein, et al, for the 1999 national gambling impact study:

AT RISK – Persons reporting **one or two** DSM-IV gambling symptoms are classified as gamblers "at-risk" of developing problem or pathological symptoms.

PROBLEM – Persons reporting **three or four** DSM-IV symptoms are classified as "problem" gamblers.

PATHOLOGICAL – Persons reporting **five or more** DSM-IV symptoms are classified as "pathological" gamblers.

Presence of Pathological Gambling Symptom



Problem Gambling Prevalence Similar for Men and Women

This section describes how the prevalence of problem or pathological gambling varies by gender, age, and region.

Overall, problem or pathological gambling is found in roughly 1 out of every 100 adult household residents (1.2%). This rate did not vary by poverty status. The prevalence of problem or pathological gambling was also similar among men and women.

In the overall adult household population, problem or pathological gambling was most prevalent among those aged 25 to 44 years (1.4%) and 45 to 64 years (1.3%), and lowest among adults aged 65 years and older (0.4%).

Overall, problem gambling was somewhat more prevalent among those residing in rural counties (1.5%) compared with those residing in urban counties (0.9%). However, this finding does not hold for adults at or below 200% of the federal poverty level.

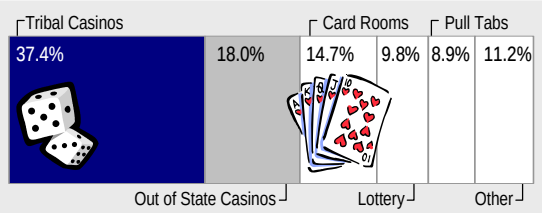
GAMBLING LOSSES

Washington Residents' Gambling Losses Exceeded $1.5 Billion During 2002

The amount of money lost to gambling is considerable. According to a recent report documenting gaming industry revenue, **Washington residents lost over $1.5 billion to gambling in 2002**.

These losses exclude social gambling (e.g., office sports pools, private poker parties). Casino and card room gambling, both in and out-of-state, accounted for over two-thirds ($1.1 billion) of the money lost to gambling.

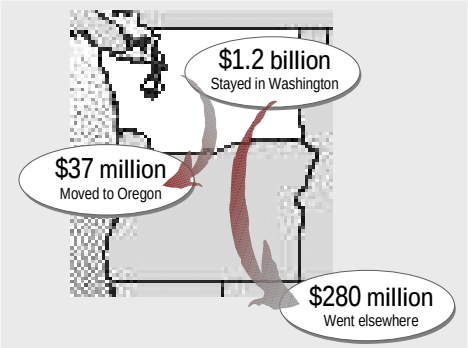
Money lost to in-state Tribal Casinos ($572 million) accounted for one-third of the total gambling losses.



The "Other" category includes charity gambling, horse and dog racing, illegal internet gambling, and other illicit gambling.

The totals produced in this report closely parallel those listed by the Washington Gambling Commission (http://www.wsgc.wa.gov/) with a few notable exceptions. This report included estimates of out-of-state gambling revenue and the estimates are based upon calendar rather than fiscal year totals.

Where was the money spent?

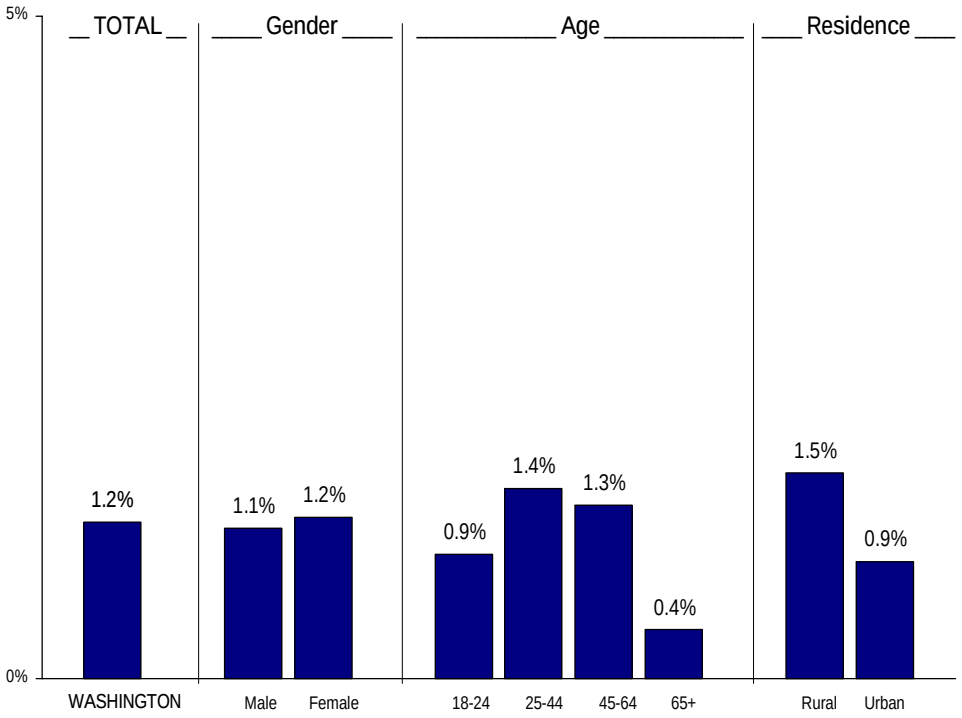


SOURCE: 2002 Oregon and Washington Gaming Markets and Oregon Casino Survey, ECONNorthwest, http://www.econw.com/pdf/2002gamerep.pdf.

ALL ADULTS

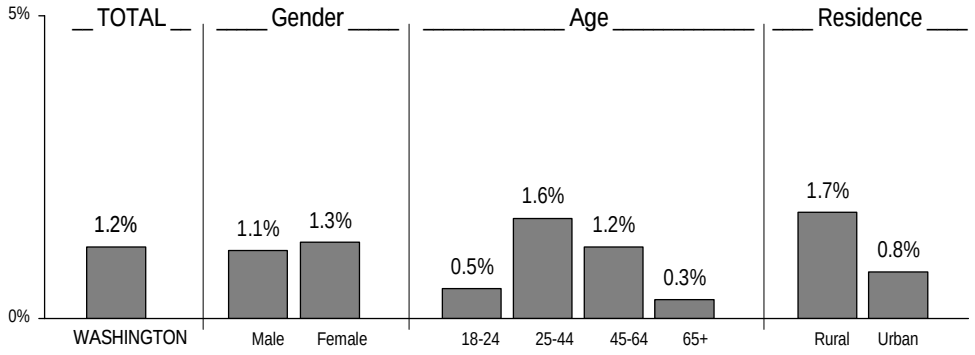
NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

Adults Above 200% FPL



Household Income

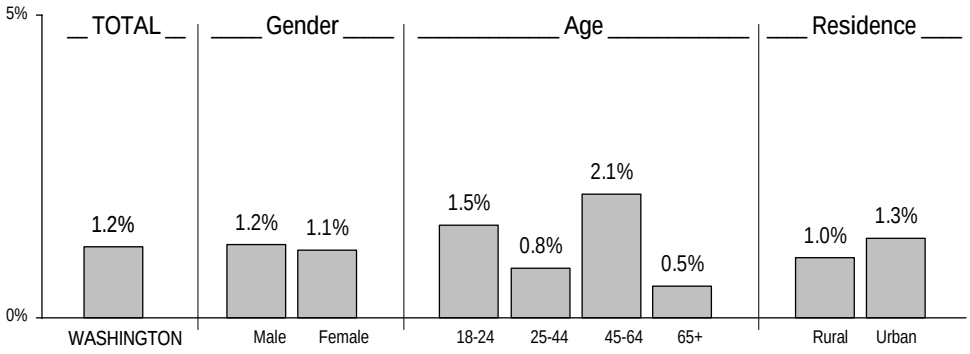
ABOVE

200%

Poverty

AT OR BELOW

Adults At Or Below 200% FPL



Problem Gambling Highest Among American Indians, Blacks, and Multirace Adults

This section describes how the prevalence of problem or pathological gambling varies by race and ethnicity.

Problem or pathological gambling is highest among American Indian or Alaska Native adults (3.1%). Problem gambling is also more common among adults who endorsed more than one race (3.0%) and Blacks (2.6%). Problem gambling was lowest among Asians (1.0%), Whites (1.1%), and Hispanics (1.3%).

Poverty status played an important role in problem gambling for Native Hawaiian or Other Pacific Islanders and in Multirace adults.

- Problem or pathological gambling is over twice as common among Native Hawaiian or Other Pacific Islanders that were at or below 200% of the federal poverty level (3.5%), compared with those above this poverty threshold (1.3%).
- Problem or pathological gambling was over twice as common among Multirace adults that were above 200% of the federal poverty level (3.7%), compared with those below this threshold (1.6%).

TRIBAL CASINOS

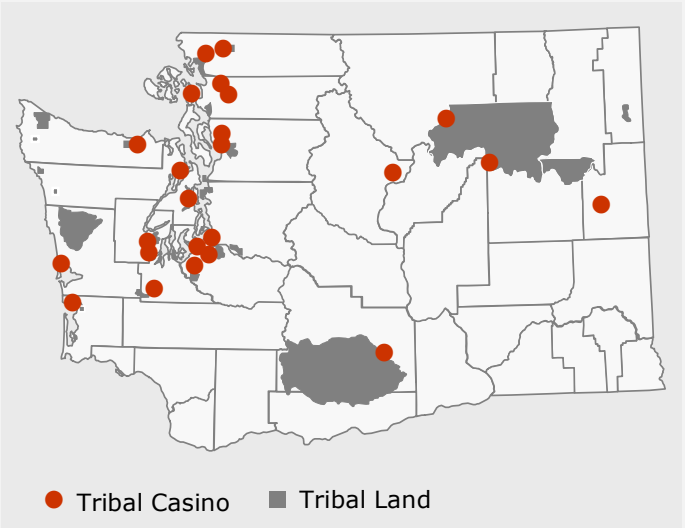
CLOSEUP

Tribal Casinos Operate Throughout State

In 1988, President Reagan signed into law the Indian Gambling Regulatory Act. This Federal Act confirmed the rights of tribes to conduct gambling on Tribal land through agreements with states (Tribal-State Gaming Compacts). There are 29 federally recognized tribes in Washington State and 27 of those have Class III gaming compacts. Class III compacts are the least restrictive, permitting "Nevada-style" gaming. Class III games include such activities as blackjack, craps, roulette, baccarat, poker, keno, and off-track betting.

This map lists the locations of each of the casinos operating under the federally required Tribal-State Compacts in Washington State.

Source: The Washington State Gambling Commission (http://www.wsgc.wa.gov/).

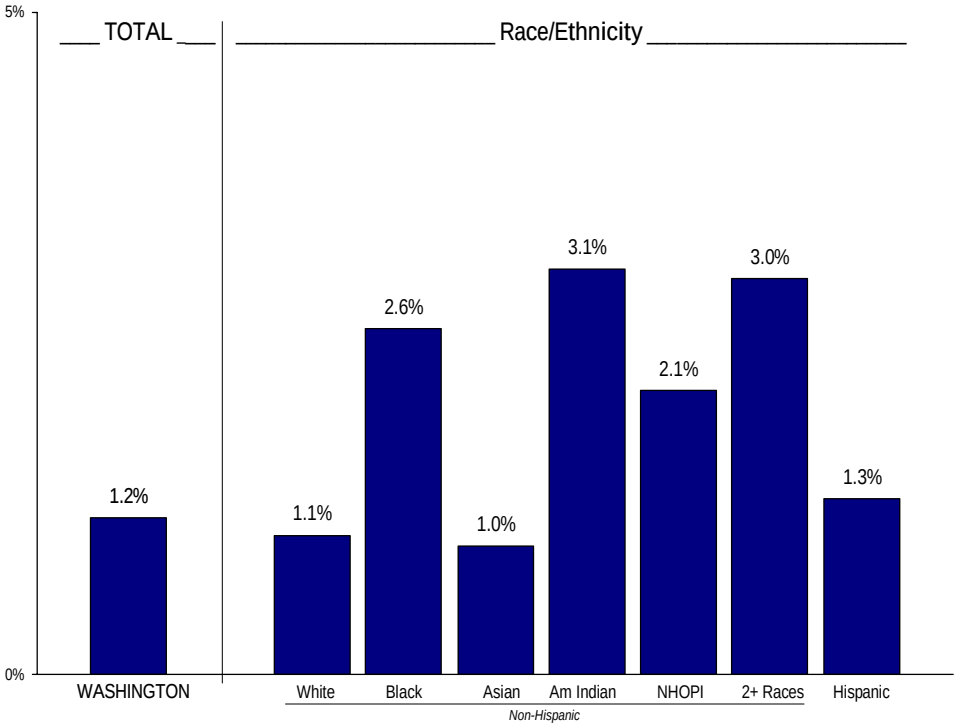


ALL ADULTS

Problem Gambling

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



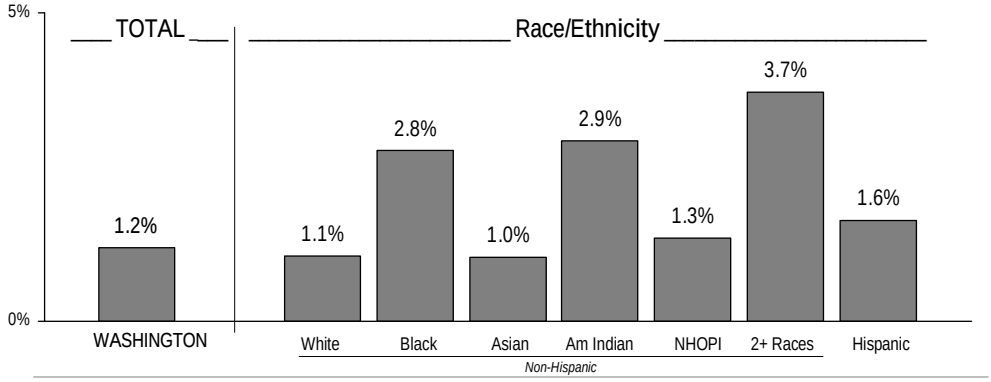
By Income

Household Income

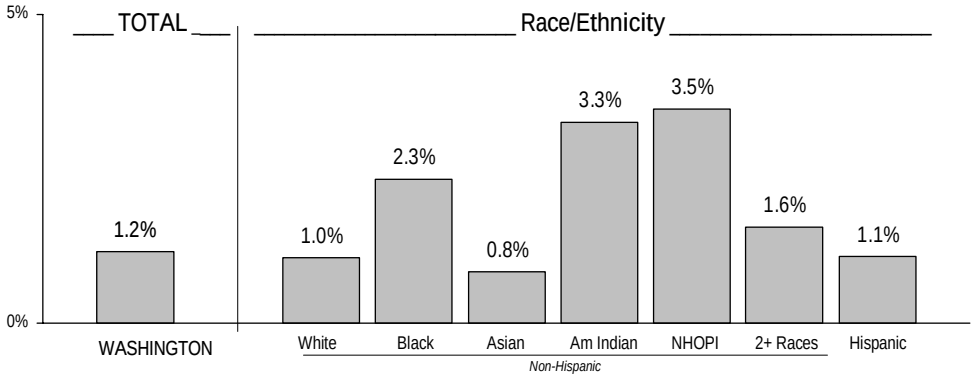
ABOVE 200% Poverty

AT OR BELOW 200% Poverty

Adults Above 200% FPL



Adults At Or Below 200% FPL



Substance Use, Need for Substance Abuse Treatment Higher Among Problem Gamblers

This section compares the prevalence of substance use and need for treatment between adults who are problem gamblers and adults who are not problem gamblers (which includes non gamblers).

Adults with a gambling problem reported higher rates of substance use and higher need for alcohol or drug treatment, compared with adults who do not have a gambling problem.

The figures on the facing page describe the prevalence of past year substance use and need for treatment among problem gamblers (dark bars) as well as those adults without a problem or pathological gambling disorder (white bars).

Key findings include:

- Problem gamblers were twice as likely to smoke cigarettes in the past year (40.0 percent), compared to adults without a gambling problem (20.7 percent).
- Problem gamblers are nearly three times as likely to use illicit drugs other than marijuana (12.6 percent), compared to adults who do not have a gambling problem (4.6 percent).
- Problem gamblers were twice as likely to need alcohol or drug treatment (23.2 percent), compared to adults without a gambling problem (10.7 percent).

PROBLEM GAMBLING AMONG ADULTS NEEDING TREATMENT

Adults Who Need Treatment At Higher Risk for Problem Gambling

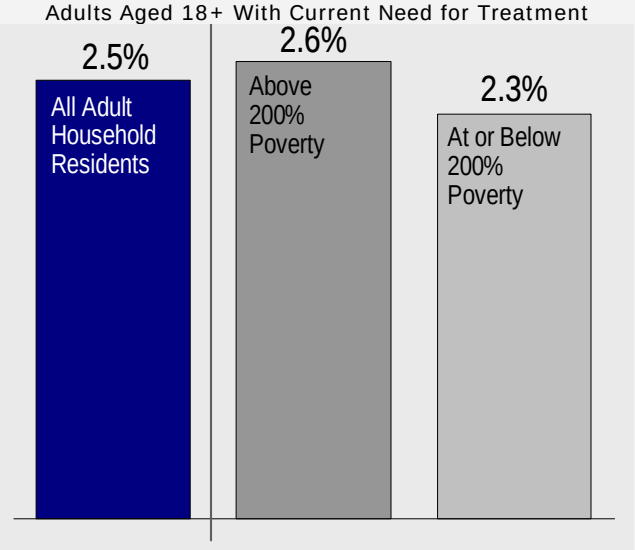
Another useful way to examine the relationship between gambling and need for substance abuse treatment is to examine the prevalence of problem gambling among adults in need of substance abuse treatment.

Focusing only on adults in need of substance abuse treatment, we see that they are at higher risk for problem gambling behaviors; the rate is over twice that (2.5 percent) found in the general population. The prevalence varies little by income level.

In contrast, only 1.0 percent of all adults who do not need substance abuse treatment are problem gamblers.

Problem Gambling Higher Among Adults Needing Treatment

Adults Aged 18+ With Current Need for Treatment



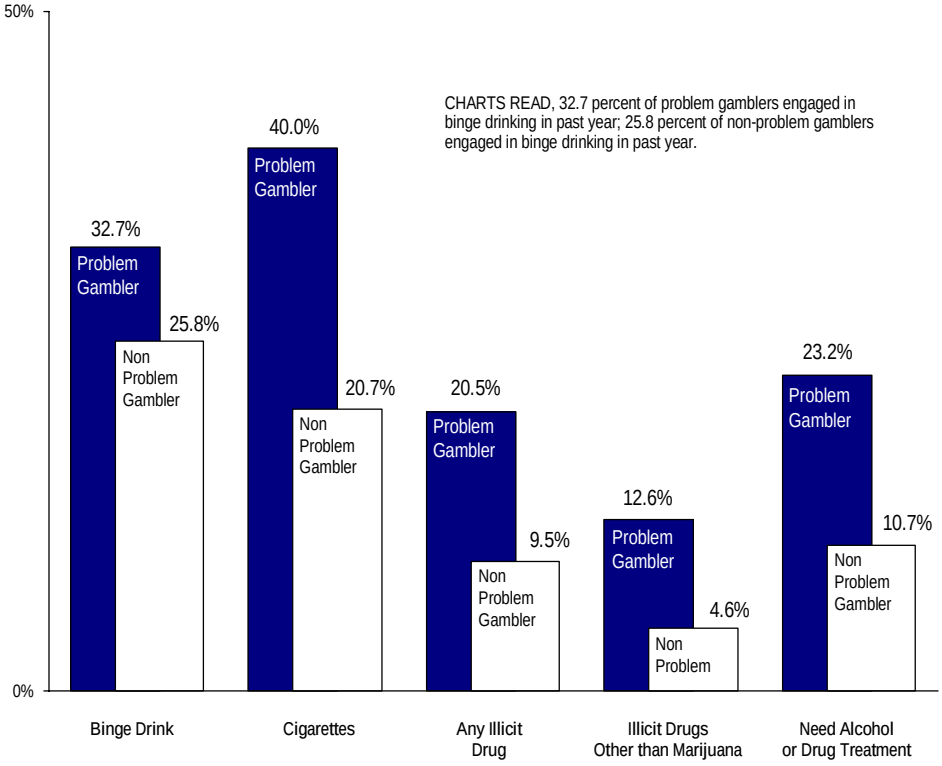
Prevalence of Substance Use and Need For Treatment by Problem Gambler Status

ALL ADULTS

Past Year Gambling, Substance Use and Need for Treatment

2003 NEEDS ASSESSMENT

Washington State Household Residents Age 18+



By Income

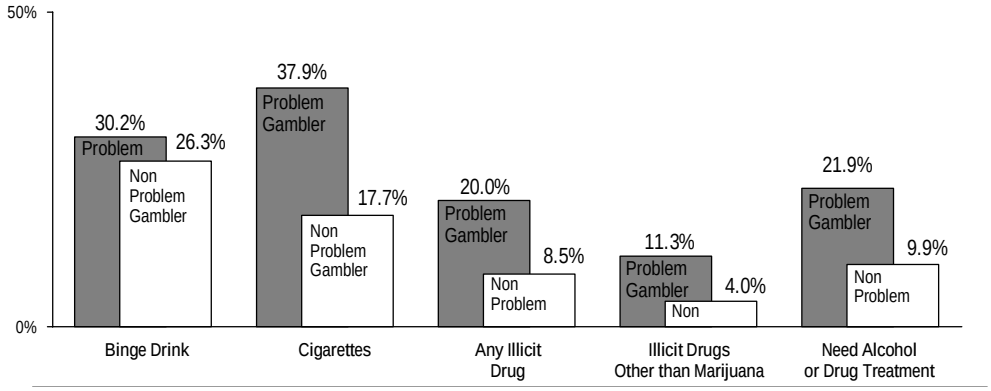
Household Income

ABOVE

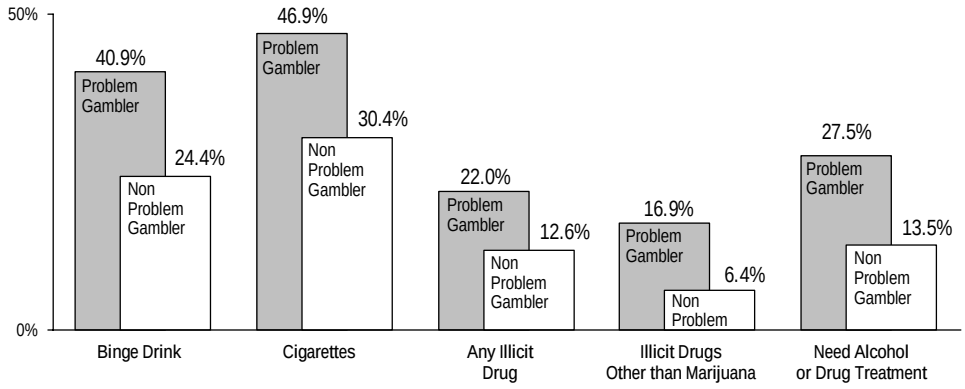
200% Poverty

AT OR BELOW

Adults Above 200% FPL



Adults At Or Below 200% FPL



Appendix A

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Past Year Substance Use by Demographics

NEEDS ASSESSMENT 2003

Washington State Substance Use Rates

2003 Needs Assessment Household Survey Estimates

All Adults	PAST YEAR USE AGE 18+													
	ALCOHOL		ILLICIT										TOBACCO	
	Any Alcohol	Binge Alcohol	Any Illicit	Marijuana	Cocaine or Crack	Stimulant[1]	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant	Any Tobacco	Cigarettes
OVERALL	**72.9%**	**25.9%**	**9.6%**	**7.4%**	**1.1%**	**0.5%**	**0.9%**	**0.1%**	**2.0%**	**0.7%**	**1.5%**	**0.2%**	**29.0%**	**21.0%**
GENDER														
Men	75.6%	32.5%	12.2%	9.6%	1.6%	0.6%	1.2%	0.2%	3.0%	0.7%	1.5%	0.4%	36.2%	21.9%
Women	70.4%	19.7%	7.2%	5.3%	0.6%	0.4%	0.5%	0.0%	1.1%	0.7%	1.6%	0.1%	22.2%	20.1%
AGE														
18-24	73.1%	45.2%	23.8%	20.8%	3.5%	1.7%	5.1%	0.1%	5.2%	0.8%	2.7%	1.3%	40.8%	27.3%
25-44	78.8%	36.2%	12.7%	9.3%	1.5%	0.6%	0.7%	0.0%	2.9%	1.3%	2.0%	0.2%	35.7%	25.1%
45-64	72.8%	15.8%	5.0%	3.7%	0.3%	0.2%	0.0%	0.3%	0.8%	0.2%	0.9%	0.0%	25.8%	20.1%
65+	57.0%	6.2%	0.8%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	8.9%	6.8%
RESIDENCE														
Rural	70.5%	25.5%	7.7%	5.8%	0.9%	0.4%	0.7%	0.0%	1.7%	0.4%	1.4%	0.2%	26.3%	18.3%
Urban	74.9%	26.2%	11.2%	8.6%	1.3%	0.6%	1.0%	0.2%	2.3%	0.9%	1.6%	0.3%	31.2%	23.1%
MARITAL STATUS														
Married	74.3%	22.6%	7.0%	5.2%	0.4%	0.2%	0.5%	0.0%	1.2%	0.5%	1.5%	0.2%	24.6%	16.8%
Divorced/Separated	71.8%	25.8%	8.5%	4.7%	1.3%	0.4%	0.6%	0.0%	2.5%	0.8%	1.6%	0.0%	35.8%	29.8%
Widowed	53.8%	7.2%	1.4%	1.3%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	14.2%	12.5%
Never Married	75.3%	41.3%	20.8%	17.9%	3.4%	1.8%	2.5%	0.5%	4.6%	1.4%	2.1%	0.7%	41.8%	29.4%
RACE/ETHNICITY														
NON-HISPANIC														
White	75.5%	26.7%	9.6%	7.3%	1.0%	0.4%	0.8%	0.1%	2.0%	0.7%	1.6%	0.2%	29.5%	21.0%
Black	62.7%	17.2%	11.3%	9.4%	1.4%	0.6%	0.6%	0.1%	1.1%	0.1%	2.1%	0.1%	27.7%	21.1%
Asian	51.5%	12.5%	4.2%	2.7%	0.2%	0.3%	0.7%	0.0%	0.8%	0.5%	0.7%	0.1%	16.5%	12.5%
American Indian	59.3%	28.3%	12.0%	8.9%	1.7%	1.4%	1.1%	0.4%	2.2%	0.6%	1.7%	0.1%	49.7%	41.2%
NHOPI	67.3%	22.6%	8.1%	5.6%	0.0%	0.3%	1.1%	0.0%	2.6%	0.0%	0.6%	0.0%	25.8%	21.0%
Two or More Races	75.2%	34.1%	18.6%	15.3%	3.1%	1.6%	2.4%	0.5%	4.2%	1.1%	0.7%	1.0%	42.4%	33.2%
HISPANIC	65.1%	27.8%	11.0%	8.3%	2.0%	0.9%	1.7%	0.0%	2.8%	0.6%	0.9%	0.2%	26.0%	19.0%
EDUCATION														
Less than HS	49.1%	18.7%	6.5%	5.0%	0.8%	0.8%	0.9%	0.1%	1.3%	0.3%	1.4%	0.2%	33.7%	28.4%
HS Grad/Unknown	66.2%	27.1%	11.6%	9.2%	0.9%	0.8%	0.7%	0.0%	2.4%	0.2%	2.0%	0.1%	34.2%	28.1%
Some College	74.6%	28.9%	11.4%	8.3%	1.7%	0.7%	1.3%	0.0%	2.7%	1.2%	2.0%	0.2%	31.5%	23.6%
College Grad	80.9%	23.7%	7.3%	5.8%	0.7%	0.0%	0.5%	0.2%	1.3%	0.5%	0.7%	0.3%	22.0%	11.9%

[1] Includes methamphetamine

NEEDS ASSESSMENT 2003

Washington State Substance Use Rates

2003 Needs Assessment Household Survey Estimates

Adults Above 200% FPL	PAST YEAR USE AGE 18+													
	ALCOHOL		ILLICIT										TOBACCO	
	Any Alcohol	Binge Alcohol	Any Illicit	Marijuana	Cocaine or Crack	Stimulant[1]	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant	Any Tobacco	Cigarettes
OVERALL	**77.5%**	**26.3%**	**8.7%**	**6.7%**	**0.8%**	**0.3%**	**0.6%**	**0.1%**	**1.7%**	**0.6%**	**1.5%**	**0.2%**	**26.9%**	**17.9%**
GENDER														
Men	78.5%	32.7%	10.6%	8.6%	1.3%	0.3%	0.8%	0.2%	2.6%	0.5%	1.3%	0.3%	34.9%	19.3%
Women	76.6%	19.8%	6.7%	4.8%	0.4%	0.3%	0.4%	0.0%	0.8%	0.6%	1.6%	0.1%	18.8%	16.5%
AGE														
18-24	73.9%	43.9%	21.5%	19.2%	2.3%	1.2%	4.1%	0.1%	3.6%	0.1%	2.4%	1.4%	39.5%	23.5%
25-44	83.4%	39.1%	12.7%	9.3%	1.6%	0.5%	0.6%	0.0%	3.0%	1.4%	2.2%	0.2%	34.2%	21.8%
45-64	76.9%	16.4%	4.4%	3.6%	0.0%	0.0%	0.0%	0.3%	0.6%	0.0%	0.8%	0.0%	24.2%	18.0%
65+	64.9%	6.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	5.4%	2.8%
RESIDENCE														
Rural	75.1%	26.2%	6.6%	5.3%	0.7%	0.1%	0.4%	0.0%	1.4%	0.2%	1.4%	0.1%	24.0%	15.6%
Urban	79.4%	26.4%	10.2%	7.8%	0.9%	0.4%	0.7%	0.2%	2.0%	0.9%	1.5%	0.3%	29.1%	19.7%
MARITAL STATUS														
Married	78.0%	23.1%	6.7%	5.1%	0.3%	0.0%	0.3%	0.0%	1.1%	0.5%	1.5%	0.2%	22.9%	14.4%
Divorced/Separated	79.0%	28.4%	8.1%	4.5%	1.1%	0.2%	0.6%	0.0%	2.5%	0.9%	1.7%	0.0%	32.3%	25.0%
Widowed	59.5%	5.3%	2.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.6%	8.2%
Never Married	79.3%	42.2%	18.1%	15.6%	3.0%	1.4%	1.8%	0.6%	3.8%	0.8%	1.7%	0.5%	42.0%	28.0%
RACE/ETHNICITY														
NON-HISPANIC														
White	79.0%	26.6%	8.4%	6.5%	0.7%	0.2%	0.4%	0.1%	1.7%	0.6%	1.6%	0.2%	27.1%	17.9%
Black	67.1%	17.5%	12.0%	9.5%	1.3%	0.7%	0.1%	0.0%	0.7%	0.0%	2.3%	0.0%	24.6%	16.5%
Asian	62.2%	15.1%	4.5%	3.2%	0.1%	0.4%	1.0%	0.0%	0.6%	0.4%	0.5%	0.1%	16.6%	11.6%
American Indian	63.0%	27.2%	8.6%	6.8%	0.5%	0.2%	0.7%	0.0%	0.5%	0.0%	1.0%	0.0%	44.3%	34.4%
NHOPI	74.7%	24.7%	4.8%	3.9%	0.0%	0.0%	0.9%	0.0%	0.9%	0.0%	0.9%	0.0%	20.8%	16.7%
Two or More Races	81.0%	35.8%	16.4%	14.3%	3.0%	0.8%	2.9%	0.2%	3.2%	0.6%	0.6%	1.1%	35.7%	24.3%
HISPANIC	73.5%	34.1%	13.3%	11.4%	2.4%	1.5%	2.9%	0.0%	3.7%	1.1%	0.7%	0.4%	29.3%	18.8%
EDUCATION														
Less than HS	59.2%	18.6%	4.2%	3.8%	0.0%	0.2%	0.7%	0.0%	0.8%	0.0%	0.1%	0.3%	35.1%	28.1%
HS Grad/Unknown	72.4%	30.3%	12.2%	10.0%	0.6%	0.9%	0.5%	0.0%	2.5%	0.0%	2.3%	0.1%	32.4%	25.2%
Some College	76.4%	28.1%	9.5%	6.7%	1.2%	0.3%	0.8%	0.0%	2.0%	1.0%	2.2%	0.1%	28.7%	20.5%
College Grad	82.8%	23.7%	6.7%	5.5%	0.7%	0.0%	0.5%	0.3%	1.3%	0.5%	0.6%	0.3%	21.9%	11.1%

[1] Includes methamphetamine

NEEDS ASSESSMENT 2003

Washington State Substance Use Rates

2003 Needs Assessment Household Survey Estimates

Adults At/Below 200% FPL	PAST YEAR USE AGE 18+													
	ALCOHOL		ILLICIT										TOBACCO	
	Any Alcohol	Binge Alcohol	Any Illicit	Marijuana	Cocaine or Crack	Stimulant[1]	Hallucinogen	Heroin	Other Opiates	Tranquilizer	Sedative	Inhalant	Any Tobacco	Cigarettes
OVERALL	58.4%	24.6%	12.7%	9.6%	2.0%	1.2%	1.7%	0.1%	3.0%	1.0%	1.7%	0.3%	35.7%	30.6%
GENDER														
Men	65.1%	31.4%	17.8%	13.4%	2.9%	1.6%	2.8%	0.1%	4.5%	1.2%	2.1%	0.5%	41.2%	31.3%
Women	53.2%	19.3%	8.8%	6.7%	1.3%	0.8%	0.9%	0.0%	1.8%	0.8%	1.4%	0.0%	31.5%	30.1%
AGE														
18-24	72.0%	46.9%	27.0%	23.1%	5.3%	2.4%	6.4%	0.1%	7.4%	1.8%	3.2%	1.1%	42.6%	32.4%
25-44	65.3%	27.3%	12.6%	9.1%	1.4%	0.9%	0.9%	0.0%	2.6%	0.9%	1.5%	0.0%	40.1%	34.7%
45-64	48.5%	11.8%	8.6%	4.8%	1.7%	1.2%	0.0%	0.2%	1.6%	1.3%	1.4%	0.0%	35.5%	32.5%
65+	37.6%	6.9%	1.2%	0.4%	0.0%	0.4%	0.0%	0.0%	0.1%	0.0%	0.6%	0.0%	17.6%	16.6%
RESIDENCE														
Rural	57.8%	23.5%	10.8%	7.5%	1.3%	1.2%	1.6%	0.0%	2.8%	1.1%	1.3%	0.2%	32.8%	25.8%
Urban	59.0%	25.6%	14.6%	11.6%	2.7%	1.1%	1.8%	0.1%	3.1%	0.9%	2.0%	0.3%	38.5%	35.2%
MARITAL STATUS														
Married	56.4%	20.5%	8.7%	5.6%	1.2%	0.7%	1.3%	0.0%	1.7%	0.5%	1.5%	0.0%	32.4%	27.9%
Divorced/Separated	57.0%	20.5%	9.2%	5.2%	1.7%	0.9%	0.5%	0.0%	2.6%	0.5%	1.2%	0.0%	43.1%	39.8%
Widowed	45.5%	10.1%	0.5%	0.2%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	19.5%	19.0%
Never Married	67.3%	39.3%	26.3%	22.5%	4.2%	2.6%	3.8%	0.1%	6.2%	2.5%	2.9%	0.9%	41.4%	32.3%
RACE/ETHNICITY														
NON-HISPANIC														
White	61.7%	27.0%	14.0%	10.8%	2.2%	1.4%	2.1%	0.0%	3.2%	1.2%	1.9%	0.3%	38.9%	33.2%
Black	54.3%	16.6%	10.0%	9.2%	1.4%	0.3%	1.5%	0.3%	1.9%	0.3%	1.7%	0.3%	33.8%	29.9%
Asian	30.0%	7.3%	3.6%	1.7%	0.3%	0.0%	0.3%	0.0%	1.1%	0.7%	1.1%	0.0%	16.3%	14.5%
American Indian	54.3%	29.6%	16.5%	11.8%	3.4%	3.0%	1.6%	0.8%	4.5%	1.4%	2.7%	0.1%	56.9%	50.3%
NHOPI	55.1%	19.2%	13.7%	8.4%	0.0%	0.7%	1.5%	0.0%	5.3%	0.0%	0.0%	0.0%	34.0%	28.1%
Two or More Races	63.4%	30.8%	22.9%	17.5%	3.1%	3.2%	1.4%	1.1%	6.3%	2.2%	0.9%	0.9%	55.7%	51.1%
HISPANIC	58.5%	22.9%	9.3%	5.8%	1.8%	0.4%	0.8%	0.0%	2.0%	0.2%	1.0%	0.1%	23.4%	19.2%
EDUCATION														
Less than HS	42.3%	18.8%	8.1%	5.7%	1.4%	1.1%	1.1%	0.1%	1.7%	0.6%	2.3%	0.1%	32.7%	28.6%
HS Grad/Unknown	53.7%	20.5%	10.3%	7.7%	1.7%	0.7%	1.2%	0.1%	2.2%	0.4%	1.3%	0.0%	37.7%	34.0%
Some College	69.2%	31.2%	17.1%	13.4%	2.9%	2.0%	2.8%	0.0%	4.8%	1.8%	1.4%	0.5%	40.2%	32.8%
College Grad	62.3%	23.7%	12.8%	8.9%	1.0%	0.2%	0.8%	0.0%	1.5%	0.9%	2.1%	0.2%	23.2%	20.2%

[1] Includes methamphetamine

Appendix B

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This report provides detailed estimates of substance use, the need for substance abuse treatment, and use of substance abuse treatment services in Washington State.

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Washington State
Department of Social
& Health Services

RDA Research & Data
Analysis Division