

**Clinical Practice Guideline:
Behavioral Health Screening, Assessment, and Treatment**

BEHAVIORAL HEALTH SCREENING, ASSESSMENT, AND TREATMENT

GOAL

To outline methods for identifying patients with possible behavioral health (mental health or substance use) disorders and provide guidance for decisions to refer for specialized behavioral health treatment.

SCREENING TOOLS AND INTERVENTIONS FOR COMMON BEHAVIORAL HEALTH DISORDERS SEEN IN PRIMARY CARE

- **Depression**

- Depression is a potentially life-threatening illness that affects up to 9% of Adult Americans (or approximately 14.8 million people) in any given year. It is the leading cause of disability in the United States for those between the ages of 15 and 44.
- Prevalence in the United States of dysthymic disorder and major depressive disorder is 11.2% of 13-18 year olds. Girls are more likely than boys to experience depressive disorders. Additionally, 3.3 % of 13 to 18 year olds have experienced a seriously debilitating depressive disorder.

- **Screening and Follow-up for Depression in Adults**

- The US Preventive Services Task Force recommends screening adults for depression in primary care when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
- Some of the most common and recommended screening tools for depression are the **PHQ-9** and the **PHQ-2**:
 - **Patient Health Questionnaire-9 (PHQ-9)** – A nine question depression scale that is based on the nine diagnostic criteria for major depressive disorders in the Diagnostic and Statistical Manual Fifth Edition (DSM-5). It is helpful in diagnosing depression and monitoring response to treatment. The PHQ-9 is available in English and Spanish for download on the WASBIRT site at: <http://www.wasbirt.com/content/screening-forms>
 - **For additional languages go to:** <http://phqscreeners.com/overview.aspx?Screener=02> **PHQ-9**
 - **Patient Health Questionnaire-2 (PHQ-2)** – http://www.cgaimh.org/pdf/tool_phq2.pdf The PHQ-2 is a “pre-screener” that inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a “first step” approach. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.
- To learn more about other validated screening tools go to: <http://emedicine.medscape.com/article/1859039-overview#a1>

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- Scoring and intervention guidelines for using the PHQ-9 with Adults

PHQ-9 Scores and Proposed Treatment Actions for Depression in Adults

PHQ-9 SCORE	DEPRESSION SEVERITY	PROPOSED TREATMENT RECOMMENDATION
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting, repeat PHQ-9 at follow-up visit
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately severe	Active treatment with pharmacotherapy or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, *Psychiatric Annals* 2002;32:509-521

- All positive screenings should be followed up with a full assessment using standard diagnostic criteria such as those listed in the American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing, also known as DSM-5.
- Ongoing Monitoring of Depression in Adults
 - **Engagement Education:** Provide education and document that the patient and his/her family are actively engaged in self-management practices, based on understanding of the diagnosis, risk/benefits of treatment options, and consideration of patient preferences.
 - **Ongoing Contacts:** Implement a system to assure ongoing contacts with the patient during the first 6-12 months of care (scheduled follow-up appointments, phone calls, etc.) and based on use of the PHQ-9 or other standardized screening tool used at each contact to track response to treatment.
- **Resources:**
 - Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: Adult Depression in Primary Care Guideline: <https://www.icsi.org/asset/fnhdm3/Depr.pdf>
 - Instructions for using PHQ Screeners: https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

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- **Depression in Children and Adolescents**

- According to the Preventive Services Task Force, the benefits of regular screening of children and adolescents are unknown. The predictive value of positive screening tests has been found to be lower in children and adolescents than in adults. However, studies have found that screening tests perform reasonably well in adolescents and treatments have proven effective. Therefore, primary care providers should be alert for possible signs of depression in younger patients.

- **Screening and Follow-up for Depression in Children and Adolescents**

- Depression among children and adolescents is common but frequently unrecognized. The clinical spectrum of the disease can range from simple sadness to a major depressive or bipolar disorder. Risk factors include a family history of depression and poor school performance. Evaluation should include a complete medical assessment to rule out underlying medical causes. A structured clinical interview and various rating scales such as the **Pediatric Symptom Checklist** are helpful in determining whether a child or adolescent is depressed.

- The **Pediatric Symptom Checklist (PSC)** is a brief screening questionnaire that is used by pediatricians and other health professionals to improve the recognition and treatment of psychosocial problems in children. There are two versions of the checklist:

- **Children ages 4- 16: PSC Pediatric Symptom Checklist (by parent)** and
- **PSC by Youth (11-17)**. The National Quality Forum has given the PSC its full endorsement as a national standard for assessing quality and outcomes in child health and mental health care. *The DSM 5 has ongoing research scales for children using DSM 5.
http://brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklist.pdf

- **Adolescents:**

- **Patient Health Questionnaire-A (PHQ-A)** – The PHQ-A is a modified version of the PHQ-9 that was developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ. <http://www.uacap.org/uploads/3/2/5/0/3250432/phq-a.pdf>
- **The Guidelines for Adolescent Depression in Primary Care (GLAD-PC)** is a toolkit to assist primary care providers identify adolescents with depression and determine and implement appropriate treatment strategies. It was developed in partnership with primary care providers. <http://www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf>

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PSC Scoring Guidelines

AGE OF CHILD	CUT OFF SCORE	PROPOSED RECOMMENDATION
3-5 years	24 or above = impaired (For this age group, the scores on elementary school related items 5,6,17, and 18 are ignored and a total score based on the 31 remaining items is computed.)	A positive score on the PSC suggests the need for further evaluation by a qualified health (M.D., Midlevel, R.N.) or mental health (Ph.D., LICSW, LMHC, Psy.D.) professional.
6-18 years	28 or above = impaired	A positive score on the PSC suggests the need for further evaluation by a qualified health (M.D., Midlevel, R.N.) or mental health (Ph.D., LICSW, LMHC, Psy.D.) professional.

- Treatment Guidelines for Depression in Children and Adolescents

- Evidence-based treatment guidelines from the literature are limited. Psychotherapy appears to be useful in most children and adolescents with mild to moderate depression. Because the risk of school failure and suicide is quite high in depressed children and adolescents, prompt referral or close collaboration with a mental health professional is often necessary.
- **Resources:**
 - PAL Washington Partnership Access Line - <http://www.palforkids.org/>
 - TeenScreen Primary Care: Screening Questionnaire Overview from the National Center for Mental Health Checkups at Columbia University - <http://www.nachc.org/client/TeenScreen%20Screening%20Questionnaire%20Overview%202017%202011.pdf>

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- **Generalized Anxiety Disorder (GAD)**

- This common sub-type of anxiety disorders is the most common seen in primary care practices. GAD is more common in women than in men and prevalence rates are high in mid-life. Research has found that there is considerable co-morbidity with depression and that patients with this disorder often demonstrated a high degree of impairment and disability.

- **Screening and Follow-up for Generalized Anxiety Disorder in Adults**

- Our plan recommends the use of the GAD-7, the most common screening tool for this disorder, for patients exhibiting patterns of persistent worry, anxiety symptoms, and inattention. This screening tool, available in English and Spanish, is available at WASBIRT: <http://www.wasbirt.com/content/screening-forms>

GAD-7 Scoring Guidelines & Proposed Intervention

SCORE	RISK LEVEL	INTERVENTION
0	No to Low Risk Level	None, rescreen annually
5	Mild	Provide general feedback, repeat GAD-7 at follow up
10	Moderate	Further Evaluation Recommended and referral to mental health program
15+	Severe	Further Evaluation Recommended and referral to mental health program

Source: Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7

- **Treatment for Generalized Anxiety Disorder in Adults:**

- Treatment may include medications or psychotherapy, either alone or in combination. Cognitive behavioral therapy has been found to be particularly useful in the treatment of anxiety disorders.

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- **Anxiety in Children and Adolescents**

- Anxiety disorders affect one in eight children. Research shows that children with untreated anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse. Anxiety disorders also often co-occur with other disorders such as depression, eating disorders, and attention-deficit/hyperactivity disorder (ADHD).

- **Screening and Follow-up for Anxiety in Children and Adolescents**

- **Screen for Child Anxiety Related Disorders (SCARED)** – Our plan recommends the use of the Screen for Child Anxiety Related Disorders (SCARED) for this disorder. The screener comes in two versions, one to be filled out by the parent and another version that can be filled out by the youth.

- **For the parent version go to:**

- <http://www.psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Parent.pdf>

- **For the youth version go to:**

- <http://www.psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child%20with%20scoring.pdf>

Source: Developed by Boris Birmaher, MD, Sunneet Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD, Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). birmaherb@upmc.edu.

- **Treatment Guidelines for Anxiety in Children and Adolescents**

- Treatment may include medications or psychotherapy, either alone or in combination. Cognitive behavioral therapy has been found to be particularly useful in the treatment of anxiety disorders.
- Cognitive-behavioral therapy (CBT) has been extensively studied and has shown good efficacy in treatment of childhood anxiety disorders. A combination of CBT and medication may be required for moderate to severely impairing anxiety disorders and may improve functioning better than either intervention alone. Selective serotonin reuptake inhibitors are currently the only medications that have consistently shown efficacy in treatment of anxiety disorders in children and adolescents.
- **Resource:**
 - Anxiety and Depression Association of America - <http://www.adaa.org/living-with-anxiety/children/treatment>

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- **Alcohol Misuse and Dependence**

- Alcohol use disorders are medical conditions that doctors can identify when a patient’s drinking causes distress or harm. According to the National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, in the United States about 18 million people have an alcohol use disorder, classified as either alcohol dependence—perhaps better known as alcoholism—or alcohol abuse. Alcoholism, the more serious of the disorders, is a disease that includes symptoms such as:
 - Craving—a strong need, or urge, to drink.
 - Loss of control—not being able to stop drinking once drinking has begun.
 - Dependence—Withdrawal symptoms, such as nausea, sweating, shakiness, and negative emotional states such as anxiety, after stopping drinking.
 - Tolerance—the need to drink greater amounts of alcohol to feel the same effect.

- Screening and Follow-up for Alcohol Misuse and Dependence in Adults

- The US Preventive Services Task Force recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking patterns with brief behavioral counseling interventions to reduce alcohol misuse.
- Many effective screening tools are available, however Our plan recommends that PCP's utilize a brief screening procedure known as the "Screening, Brief Intervention, and Referral for Treatment (SBIRT)" on an annual basis with all patients.
- Along with a pre-screener, screening tools for depression, anxiety, and drug use, the SBIRT model utilizes the **Alcohol Use Disorders Identification Test or AUDIT** to screen for alcohol use and has been shown to be effective in detecting alcohol misuse, abuse, and dependence.

- Scoring and Proposed Treatment Actions for Alcohol Misuse and Dependence in Adults

- A positive full screen on the AUDIT should be followed by a brief intervention. The scores that qualify as positive on the AUDIT differ based on gender and age. A positive full screen score on the AUDIT are as follows:

AUDIT SCORE	POPULATION EFFECTED	PROPOSED ACTION
Greater than or equal to 7	Females (18-65) and all persons 65 and older	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan to which the patient is willing to commit.
Greater than or equal to 8	Males (18-65)	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan to which the

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		patient is willing to commit.
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*Source: Washington Screening, Brief Intervention and Referral to Treatment: <http://www.wasbirt.com/content/brief-interventions>

- **Resources** for conducting Brief Interventions: SAMHSA-HRSA SBIRT-Brief Interventions: <http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions>

- **Referral to Treatment for Alcohol Misuse and Dependence in Adults**
 - After screening and providing a brief intervention, the third component of the SBIRT model is referral to treatment. The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting.
 - **Resources** to assist with the referral to treatment process can be found at: SAMHSA-HRSA-SBIRT-Referral to Treatment: <http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment> and the Washington Screening, Brief Intervention and Referral to Treatment: <http://www.wasbirt.com/content/find-services>

- **Drug Abuse and Dependence in Adults**
 - Illicit drug use and abuse are serious problems among adolescents, adults, and pregnant women. According to the National Institute on Drug Abuse (NIDA) illicit drug use in America has been increasing. In 2012, an estimated 23.9 million Americans aged 12 or older—or 9.2 percent of the population—had used an illicit drug or abused a psychotherapeutic medication (such as a pain reliever, stimulant, or tranquilizer) in the past month. This is up from 8.3 percent in 2002.
 - The rates for Washington State have remained at or above national rates, particularly with nonmedical use of pain relievers for all individuals 12 and older. These rates are consistently among the highest in the country. This is especially true in the military population. Although illicit drug use is fairly low in this group, in 2008, 11 percent of service members reported misusing prescription drugs, up from 2 percent in 2002 and 4 percent in 2005. Most of the prescription drugs misused by service members are opioid pain medications.

- **Screening and Follow-up for Drug Abuse and Dependence in Adults**
 - Many effective screening tools are available, however our plan recommends that PCP's utilize a brief screening procedure known as the "Screening, Brief Intervention, and Referral for Treatment (SBIRT)" on an annual basis with all patients.
 - Along with a pre-screener, screening tools for depression, anxiety, and alcohol use, SBIRT utilizes the **Drug Abuse Screening Test or DAST-10** to screen for drug use. The DAST-10 is a 10-item self-report instrument that can be used with adults and adolescents.

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- Scoring and Proposed Treatment Actions for Drug Abuse and Dependence in Adults
 - A positive full screen on the DAST should be followed by a brief intervention. A positive full screen score on the DAST is as follows:

DAST SCORE	POPULATION EFFECTED	PROPOSED ACTION
Greater than or equal to 1	For all Patients	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan to which the patient is willing to commit.

*Source: Washington Screening, Brief Intervention and Referral to Treatment: <http://www.wasbirt.com/content/brief-interventions>

- Referral to Treatment for Drug Abuse and Dependence in Adults
 - After screening and providing a brief intervention, the third component of the SBIRT model is referral to treatment. The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting.
 - **Resources** to assist with the referral to treatment process can be found at: SAMHSA-HRSA-SBIRT-Referral to Treatment: <http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment> and the Washington Screening, Brief Intervention and Referral to Treatment: <http://www.wasbirt.com/content/find-services>
 - For more information on SBIRT and resources for providers in Washington, including training, screening forms, and reimbursement information, visit <http://www.wasbirt.com/content/clinical-resources>
 - **Resources:**
 - SAMHSA-HRSA-SBIRT: <http://www.integration.samhsa.gov/clinical-practice/sbirt>
 - Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition - <http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243188&PDFSource=6>

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- **Alcohol Misuse and Dependence in Children and Adolescents**

- Adolescent alcohol use remains a pervasive problem. The percentage of teenagers who drink alcohol is slowly declining; however, numbers are still quite high. Nearly 30 percent of adolescents report drinking by 8th grade, and 54 percent report being drunk at least once by 12th grade (Johnston et al., 2013).

- **Screening and Follow-up for Alcohol Use in Children and Adolescents**

- Our plan recommends that PCP's utilize one of the following screening tools to screen children and adolescents for alcohol use as early as 9 years of age.
 - **Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide:** Produced in collaboration with the American Academy of Pediatrics, this guide offers a simple, quick, empirically derived tool for identifying youth at risk for alcohol-related problems. For use in Children and adolescents aged 9 – 18 years of age. http://www.integration.samhsa.gov/clinical-practice/sbirt/Guide_for_Youth_Screening_and_Brief_Intervention.pdf
 - The **CRAFFT screening tool** is a validated 6-item behavioral health screening test for use with children under the age of 21 years. <http://www.ceasar-boston.org/clinicians/crafft.php>.
- **Resource:**
 - Primary Care Provider Guide to using CRAFFT: http://www.integration.samhsa.gov/clinical-practice/sbirt/adolescent_screening_brief_intervention_and_referral_to_treatment_for_alcohol.pdf

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- **Drug Abuse and Dependence in Children and Adolescents**

- According to the American Academy of Child & Adolescent Psychiatry, the use of illegal drugs is increasing, especially among young teens. The average age of first marijuana use is 14, and alcohol use can start before age 12. The use of marijuana and alcohol in high school has become common.
- Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgment which may put teens at risk for accidents, violence, unplanned and unsafe sex, and suicide.

- **Screening and Follow-up for Drug Use in Children and Adolescents**

- Our plan recommends that PCP's utilize one of the following screening tools to screen children and adolescents for drug use:
 - The **CRAFFT screening tool** is a validated 6-item behavioral health screening test for use with children under the age of 21 years. <http://www.ceasar-boston.org/clinicians/crafft.php>.
 - **Drug Abuse Screening Test or DAST-10:** 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. Available for download in both English and Spanish on the WA-SBIRT site at: <http://www.wasbirt.com/content/screening-forms>.
- **Resources:**
 - **Primary Care Provider Guide to using CRAFFT:** <http://www.integration.samhsa.gov/clinical-practice/sbirt/adolescent-screening-brief-intervention-and-referral-to-treatment-for-alcohol.pdf>
 - Additional information about the DAST screener, including a longer version for adolescents: Guide for Using the Drug Abuse Screening Test (DAST), Harvey A. Skinner, Ph.D. York University, Toronto - http://www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

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EDUCATION RESOURCES

Patient and family education about behavioral health disorders can be very useful. Helpful websites for information include:

Depression

- Anxiety and Depression Association of America
<http://www.adaa.org/>
- National Alliance on Mental Illness NAMI-WA
www.namiwa.org
- National Institute of Mental Health - Depression page
<http://www.nimh.nih.gov/health/topics/depression/index.shtml>

Anxiety Disorders (stress)

National Institute of Mental Health – Anxiety Disorders page
<http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>

Substance Abuse

- National Institute on Drug Abuse
 - Patients & Families: <http://www.drugabuse.gov/patients-families>
 - Parents & Educators: <http://www.drugabuse.gov/parents-educators>
 - Children & Teens: <http://www.drugabuse.gov/children-and-teens>
- Alcoholics Anonymous:
www.aa.org
- National Institute on Alcohol Abuse and Alcoholism:
<http://www.niaaa.nih.gov/alcohol-health>
- Narcotics Anonymous:
www.na.org

Other

- Local Resources for substance use treatment and mental health issues:
 - National Alliance on Mental Illness NAMI-WA
www.namiwa.org
 - Substance Abuse and Mental Health Services Administration (SAMHSA)
<http://www.samhsa.gov/Treatment/>
Washington Recovery Help Line - 1-866-789-1511 <http://www.warecoveryhelpline.org/>

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