ASSEMBLY BILL 75 (AB 75)
ANNUAL REPORT TO THE LEGISLATURE

Transfer of Administrative and Programmatic Functions of the Department of Alcohol and Drug Programs to the Department of Health Care Services

February 2017
(For Calendar Year 2016)

Submitted by the Department of Health Care Services
In Fulfillment of Requirements of
Health and Safety Code, Section 11750.1

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I. Overview

Background

Enactment of the 2011 Public Safety Realignment marked a significant shift in the State's role in administering programs and functions related to substance use disorder (SUD) services. Realignment also redirected funding for the Drug Medi-Cal (DMC) Treatment Program and discretionary SUD programs to the counties. Reflecting this shift, the Administration announced its intent in the Fiscal Year (FY) 2011-12 May Revision, and then proposed in the FY 2012-13 Governor's Budget, to reorganize the Department of Alcohol and Drug Programs (ADP). As part of the FY 2013-14 budget process, Governor Brown signed Assembly Bill (AB) 75 (Committee on Budget, Chapter 22, Statutes of 2013), which enacted law to eliminate ADP and transfer all remaining administrative and programmatic functions from ADP to the Department of Health Care Services (DHCS), with the exception of the Office of Problem Gambling which transferred to the California Department of Public Health. Previously, in FY 2011-12, Governor Brown signed AB 106 (Committee on Budget, Chapter 32, Statutes of 2011), which enacted law to transfer the administration of the DMC Treatment Program from ADP to DHCS, effective July 1, 2012.

Consolidating responsibility for SUD services and community mental health services under DHCS aligned the State of California with its federal, state, and county counterparts. Nearly all community mental health programs from the former Department of Mental Health (DMH) transferred to DHCS with the enactment of the FY 2012-13 Budget, effective July 1, 2012.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has been moving towards administrative integration in the application for its block grant by encouraging states to submit one combined application. As of May 2015, 35 other states had SUD and mental health services combined into one department and 56 of California's 58 counties had also combined these areas.

DHCS and ADP began collaborating on transitions in early 2011, when they began planning for the transfer of the DMC Treatment Program. For the transfer of the remaining administrative and programmatic functions of ADP, both departments built upon that infrastructure.

The two departments had a joint Executive Steering Committee, which included senior staff from both DHCS and ADP. They also had a joint Transition Team, which consisted of unit-level managers from the departments. Each department identified a Project Manager and created a work plan for the transition. A Project Manager for DHCS and a Project Manager for ADP each participated in the Transition Team, and were focused on implementing the transition work plans of each department.

Department Overview

DHCS' mission is to preserve and improve the health status of all Californians by providing residents with access to affordable, high-quality health care, including medical, dental, mental health, SUD, and long-term services and supports. DHCS' vision is to preserve and improve the physical and mental health of all Californians. DHCS works closely with federal officials, health care professionals and organizations, county governments and health plans in the administration of health care programs and services. DHCS plays a critical role in supporting a health care safety net for California's low-income and disabled persons.

As of June 2016, the programs administered by DHCS serve over 12.5 million Californians. One in three Californians receives health care services financed or organized by DHCS, making DHCS the largest health care purchaser in the State. DHCS invests over $70 billion in public funds to provide health care services. DHCS provides access to comprehensive health services and emphasizes prevention-oriented health care that promotes human health, well-being and individual choice. DHCS oversees appropriate and effective expenditure of public resources to serve those with the greatest health care needs. The health care programs and services administered by and financed through DHCS help maintain the health care delivery safety net by providing California's low-income persons and families, children, pregnant women, seniors and persons with disabilities with access to critical health care.

DHCS programs are designed to:

- Deliver health care services to low-income persons and families who meet defined eligibility requirements;
- Emphasize prevention-oriented health care measures that promote health and well-being;
- Provide access to comprehensive health services through the use of public and private resources; and
- Oversee the appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

The transfer of administrative and programmatic functions from ADP provides the opportunity for improved efficiencies, maximization of resources, and improved coordination and integration of physical health care services. These opportunities align with the commitment strategies and actions outlined in the DHCS Strategic Plan. (Note that underlined texts in this report are links to information on the DHCS website.)

Purpose of the Report

AB 75 directs DHCS to report annually to the Joint Legislative Budget Committee and the appropriate budget subcommittees and policy committees of the Legislature on SUD programs. The report addresses impacts of the transition of ADP programs to DHCS and establishes a baseline for evaluating, on an ongoing basis, how and why alcohol

and other drug prevention and treatment service delivery has improved, or otherwise changed, as a result of this transition.

II. Continuity of Care

There have been no reported disruptions in prevention, treatment and recovery services reported to DHCS since the transfer of administrative and programmatic functions from ADP. In fact, since the two SUD Divisions transitioned to DHCS, opportunities for program expansion have been developed such as the Drug Medi-Cal Organized Delivery System.

III. Savings (or Costs) to State and Local Government

In the first years, all costs for transferring the administrative and programmatic functions from ADP to DHCS were absorbed within existing resources of ADP and DHCS. No additional budget authority was authorized. The primary costs to transfer the functions were associated with the transfer of information technology (IT) systems and relocation of staff. Additional costs were incurred due to investment of significant staff time in planning, tracking and operationalizing the transfer.

DHCS received six complex IT systems from ADP and more than 200 additional staff with computing needs, as a part of the transfer. The goal of the IT transition activities was to ensure the transition of these systems and meet staff computing needs while avoiding infrastructure and security risks to the DHCS network.

DHCS' Enterprise Innovation Technology Services Division (EITSD) continues to work collaboratively with the SUD divisions to identify business needs, prioritize IT efforts (projects, enhancements, upgrades), consolidate functionality of the IT systems where applicable, and provide improvements through process re-engineering. Progress on various IT solutions will be presented in the subsequent sections of this report.

In early 2014, a significant number of administrative staff from human resources, legal services, accounting, IT, etc., were relocated to the East End Complex. Program staff were relocated to the East End Complex in December 2014. The costs for relocation of staff were absorbed.

DHCS partners and stakeholders have indicated that the transfer has resulted in increased costs related to contract and payment delays, staff time related to the recertification process for the DMC Treatment Program, and processing contract amendments with counties, vendors and service providers. In 2013, transitioning federal authority for SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SAPT BG), Strategic Prevention Framework State Incentive Grant (SPF SIG) and California Access to Recovery (CARE) grants delayed payments to the State which resulted in late payments to counties and providers. Since that time, the SPF SIG and CARE grants have been closed out and DHCS received a new grant known as the Strategic Prevention Framework Partnerships for Success Grant.

IV. Improved Efficiency and Maximization of Resources

The transfer of the remaining SUD administrative and programmatic functions from ADP to DHCS reunited the State administration of the DMC Treatment Program with the rest of the SUD programs. This consolidated the SUD programs within DHCS to: foster coordination of SUD programs with community mental health and primary care; improve efficiencies in the administration of the programs; and maximize resources. The reorganization offered numerous benefits to the SUD system, including:

- Aligned with federal and county partners;
- Promoted opportunities for improvement of health care delivery;
- Coordinated SUD, mental health and primary care programmatic expertise within DHCS;
- Enhanced oversight of SUD programs; and
- Reflected realignment.

In anticipation of the transfer of programs from the former DMH and the DMC Treatment Program from ADP, DHCS began an effort in early 2011 to identify key business processes transferring from the departments to conduct risk assessments and to identify opportunities for process improvement. The Business Process Reengineering (BPR) effort provided collaboration between DHCS, DMH, and ADP subject matter experts and stakeholders. The BPR identified key business processes to be examined and assessed for ease of transfer to DHCS, identification of efficiencies that could be operationalized at transfer, and/or any potential risks. The BPR Team identified seven ADP business processes to document. This effort, led by DHCS' Internal Audits Branch of the Audits and Investigations Division, worked with ADP subject matter experts, and flow-charted the processes. Claims processing and payments, cost report and settlement, and financial audits and appeals were selected and additional stakeholder input was gathered.

DHCS' Internal Audits Branch conducted a risk assessment on the remaining four processes and gathered the related statutory language. As a result, EITSD worked with the Short Doyle system to ensure system improvement to more accurately improve the system processes. DHCS' Internal Audits Branch continues to provide information to DHCS on historical perspectives of the processes in place prior to the transition of ADP. Once ADP transitioned into DHCS, business processes were taken over by SUD divisions, and improvements are made as needed.

<u>Contract and Grant Administration</u>

DHCS Contracts Management Unit (CMU) worked with ADP contract staff prior to the transfer to determine the most efficient means to transfer county contracts. The team developed an efficient and expeditious method to amend and extend existing county and direct-provider contracts transitioning authority to DHCS. This method was effective in eliminating potential service disruptions. Currently, the SUD divisions work through the Clinical Assurance and Administrative Support Branch (CAASD). CAASD is

intended to serve as the liaison between CMU and SUD divisions. CAASD also provides assistance to program staff in assembling contracts, navigating the request for proposal process, and choosing contracting models.

In May 2016, the SUD divisions applied for three federal discretionary grants from SAMHSA. DHCS' Director's Office, Budget and Accounting Offices and CAASD all played a role in successful submission of each of the applications. These administrative offices also play a significant role in the annual submission of the SAPT BG application. Since transition, each of the administrative offices continue to learn about specific requirements of SUD grant funding.

IT and Data Management

DHCS' IT infrastructure provides an opportunity to improve some longstanding issues with California Outcomes Measurement System-Treatment (CalOMS Tx). For example, one vision in early stages of CalOMS Tx development under ADP was for an online reporting system into which counties and providers could directly enter CalOMS Tx data. However, ADP did not have the IT infrastructure to support such an online platform. As a result, counties and providers built local systems and submitted data in monthly batches. The greater capacity of DHCS' IT infrastructure may provide an opportunity to move toward an alternative reporting platform that improves local reporting of CalOMS Tx data. Recently, IT and program staff convened to review the current functionality of CalOMS Tx in order to write updated business requirements and begin the migration process of the CalOMS Tx system to a cloud-based server.

Since SUD services systems are now under DHCS, there are opportunities to streamline data systems, data reporting requirements, and data collection. As DHCS implements the federal Affordable Care Act, there is opportunity to take a holistic approach to data reporting systems across primary care, mental health and SUD service delivery systems while reducing the data-reporting burden of counties, providers, and health plans. A possible long-term outcome of the transfer is increased capacity to simplify data collection and reporting across service systems; analyze individual system performance as well as performance in areas of service integration; and implement, support, and maintain continuous quality improvement in both service delivery and data quality.

For example, in 2015, DHCS' EITSD began work on a web-based application for the SUD cost report. The new system, the Substance Use Disorder Cost Report System (SUDCRS), replaced the Paradox database for cost report data management and reporting. Paradox was an obsolete application that was no longer supported by EITSD or by external resources, making it extremely difficult and time consuming to manage annual updates needed due to policy and program changes. In addition, it did not support multi-user capability and was incompatible with current county technology and systems.

The SUDCRS is being implemented in phases. Phase one, the county interface, went live on April 20, 2016, for counties to submit their Fiscal Year 2014-15 cost report data. It provides a user-friendly interface that allows multiple users to enter data, which has helped streamline the reporting process, especially for larger counties. The second phase is the DHCS interface, was completed April 3, 2017. This phase will replace some of the manual data compilation and computations currently performed by the Fiscal Management and Accountability Branch and provide report capability. The last and final phase will be an interface with other business units and include data import utilities and other enhancements. The estimated completion date is June 15, 2017.

Public Reporting of Treatment Statistics

While the transfer to DHCS has impacted public reporting of treatment statistics, the transfer also provides opportunity to improve in this area. The SUD Office of Applied Research and Analysis, DHCS' specialized SUD research branch, may have access to additional data and analysis tools and resources. Where research/evaluation were historically focused primarily on treatment data, there may be opportunities in the future to look at service recipients across treatment services. Such research and evaluation could provide a greater understanding of all services accessed and utilized, service outcomes, program performance, and long-term health outcomes of SUD service recipients.

In addition, there is opportunity to align and streamline policies and practices related to Health Insurance Portability and Accountability Act and 42 Code of Federal Regulations, Part 2, as they pertain to public reporting of treatment statistics. Though public reporting of treatment statistics has been limited since the transfer, reviewing policies and practices will ultimately lead to clarification of what aggregate statistics can be provided, simplification of review, and reduced turnaround time. This, in turn, may help shift resources (currently used to study and discuss what can be released and make possible changes to policies) to new research and valuation functions and/or focus in SUD populations.

V. Improved Coordination and Integration of Physical Health Care Services

The transfer of programs from ADP to DHCS has resulted in improved coordination and integration of physical health care services with SUD treatment services, both at the State and local level.

The DHCS Deputy Director of Mental Health and Substance Use Disorder Services (MHSUDS) oversees the two SUD divisions and Mental Health Services Division (MHSD) within DHCS. By law, this position is appointed by the Governor and confirmed by the Senate. The Deputy Director reports directly to the Director of DHCS.

Through the establishment of MHSUDS, SUD programs are easily and efficiently able to collaborate with multiple DHCS divisions involved in physical health care (e.g. Managed

Care Quality and Monitoring, Benefits, Provider Enrollment, Audits and Investigations, Pharmacy Benefits). This newly expanded and collaborative approach has increased integration of SUD programs with mental health and other health programs to improve health outcomes for beneficiaries receiving services via multiple delivery systems (e.g. managed care, fee-for-service, and county delivery systems). DHCS staff from various divisions meet internally and externally with stakeholders on a regular basis to ensure crosscutting issues are addressed appropriately. As a result, the transfer of SUD programs into DHCS directly connects those programs to the physical health care issues, policies and delivery systems in a way that had never occurred previously.

Staff in the SUD divisions work with counterparts from MHSD to ensure improved coordination and integration of physical health care through attendance at DHCS meetings with medical directors from managed care and mental health plans.

VI. Access and Effectiveness of Substance Use Disorder Prevention and Treatment Services

Prevention Services

Prevention of Substance Use Disorders (SUD)

Substance use is a behavior that begins as experimental and can lead to various negative consequences, including later onset of a SUD, which is a chronic, clinical condition. According to SAMHSA, SUD prevention is defined as activities directed at individuals who do not require treatment for an SUD. Such activities may include education, counseling, or changes to the social/community environment that reduce risk factors and increase protective factors, thereby reducing the risk of individuals developing a SUD.

The major federal funding source for SUD prevention services in California is the SAPT BG 20 percent Primary Prevention Set-Aside. The Primary Prevention Set-Aside is administered by the DHCS SUD Program, Policy and Fiscal Division (PPFD), Policy and Prevention Branch (PPB) and distributed to all counties through a population-based allocation formula. The annual allocation for the Federal Fiscal Year 2016 is $47,162,776.

Prevention Services Data Sources

Each of California's 58 counties are required by contract to develop a Strategic Prevention Plan, with measurable goals and objectives, using SAMHSA's Strategic Prevention Framework (SPF). The SPF consists of five phases: needs assessment, capacity building, planning, implementation, and evaluation. The needs assessment includes collecting and analyzing local data to determine the major contributing factors associated with SUD use locally, and an assessment of local capacity and resources to reduce and/or prevent SUD use.

DHCS works to make data readily available for county needs assessments by providing funding from the Substance Abuse Prevention and Treatment Block Grant and Strategic Prevention Framework Partnerships for Success Grant for the infrastructure of the California Healthy Kids Survey, California Department of Public Health's Epi Center, and the California Friday Night Live (FNL) Youth Development Survey. In 2016, the SUD PPFD worked with CDPH to add questions on adult marijuana use to the Center for Disease Control's Behavioral Risk Factor Surveillance System. The ongoing support for data collection will help the state and counties understand which communities are most impacted by harms and consequences associated with use of various drugs so they may plan for prevention and/or treatment services.

Through the SPF process, counties prioritize areas of focus, develop goals and objectives, and select strategies from SAMHSA's approved Center for Substance Abuse Prevention (CSAP) strategies to meet the goals. The CSAP strategies for allowable use of SAPT BG funding are:

- **Information Dissemination** to provide awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. This dissemination is usually a one-way communication from a source to an audience, with limited contact between the two (e.g., printed materials, websites).
- **Education** is two-way communication between an educator/facilitator and the participants (e.g., classroom curriculum). Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities.
- **Alternatives** provide opportunities to participate in activities that exclude substance use. Activities must contain an SUD component and provide for youth leadership opportunities (e.g., youth involvement in a local coalition focusing on preventing excessive alcohol consumption at annual community events).
- **Problem Identification and Referral** involves identifying those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. This strategy does not include any activity designed to diagnose if a person is in need of treatment.
- **Community-Based Process** enhances the ability of the community to more effectively provide prevention services for SUD. Activities in this strategy include

organizing, planning, enhancing efficiency and effectiveness of services implemented, interagency collaboration, coalition building, and networking.
- **Environmental** efforts establish or change community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives (e.g., social host ordinances, establishing policies) and those that relate to the service and action-oriented initiatives (e.g., law enforcement and retailer education, media campaigns).

SPF process data is collected using the California Outcomes Measurement System for Prevention (CalOMS Pv). The data is reported to SAMHSA annually in the SAPT BG application. In 2016, the SUD PPB developed a Request for Proposal for a new prevention data collection provider. It is expected that the new system will be published by July 2017. The new system will offer a more streamlined and user-friendly cloud-based solution that will allow for easier and more efficient reporting by counties and providers.

Access to Prevention Services

SUD Prevention Services are provided at the individual and population levels. Individual-level prevention services are characterized as one-on-one or group sessions that are interactive and engage participants in structured SUD prevention services. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent SUD use. Individual-level services allow for demographic information to be collected.

Population-level prevention focuses on settings such as neighborhoods. Prevention services at this level are typically designed to impact the climate, community processes, and policies in a given system. Social norm and marketing campaigns are often used to foster neighborhood climates that promote healthy relationships. Because population-level prevention is delivered to the community at large, demographic data is not collected.

This comprehensive prevention service delivery structure allows counties to provide the maximum benefit for the largest number of people, thereby mitigating service access issues.

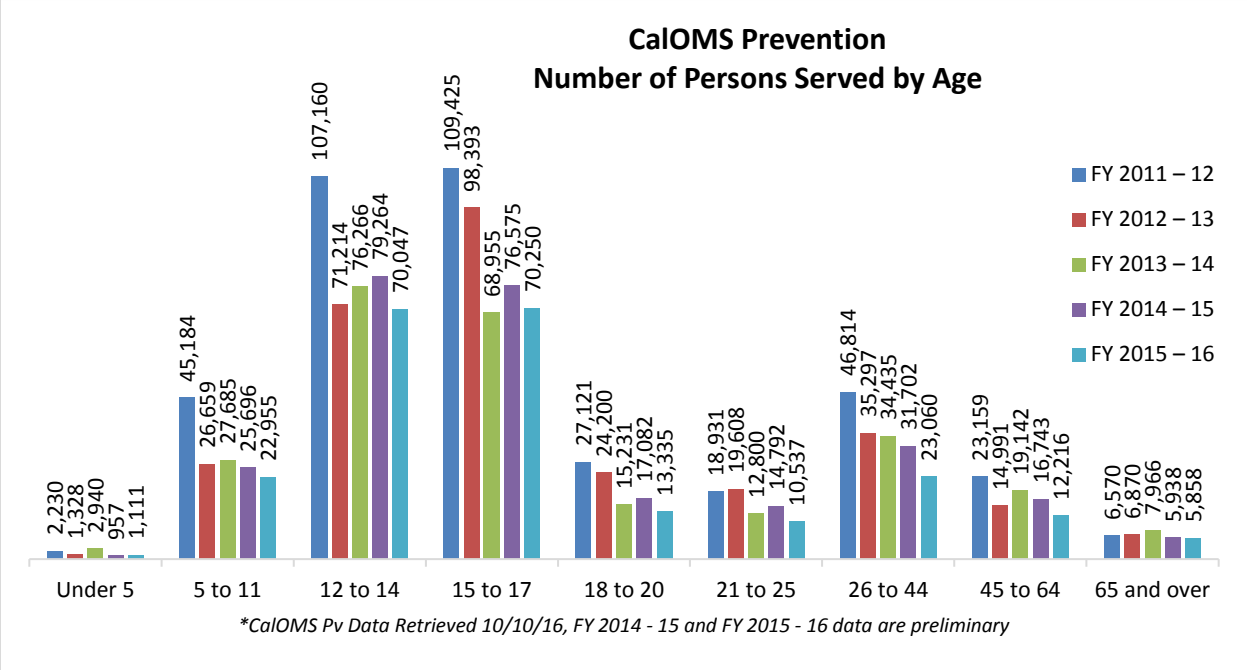
In FY 2011-12, a total of 386,594 persons received an individual-level service. The following demographic information was collected:

- 79.6 percent of the total number of persons served was youth and young adults (11.7 percent aged 5-11, 27.7 percent aged 12-14, 28.3 percent aged 15-17, and 11.9 percent aged 18-25).
- Slightly more than half (53.4 percent) of persons served were female.

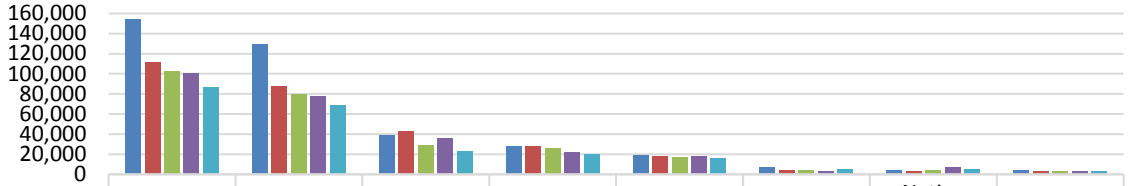
- Nearly 40 percent of the persons served identified their race/ethnicity as Hispanic/Latino, while one third (33.3 percent) identified as White, Not Hispanic. African Americans represented the third largest group (10.2 percent) and Asian Americans represented the fourth largest group (7.4 percent).

The total number of persons served has steadily decreased in FY 2011-12 (386,594 persons), FY 2012-13 (298,560 persons) and FY 2013-14 (265,420 persons), but increased slightly in FY 2014-15 (268,749 persons) to then decrease again in FY 2015-16 (229,369 persons). Please note that the total number of persons served for FY 2014-15 and FY 2015-16 are based on preliminary data. Updated figures will be reported in the 2017 AB 75 Transfer Report. The decline in the number of persons served is due to an increased number of counties reporting services that align with the Community-Based Process strategy, which does not collect demographic data. Counties and providers often use this strategy to report weekly aggregated entries of indirect and/or administrative duties.

The following charts depict data on age, race and gender collected in CalOMS Pv. Note that counties are only required to report services in CalOMS Pv that are funded with SAPT BG dollars; services provided with other funds are not reflected. Also, the FY 2014-15 and FY 2015-16 CalOMS Pv data are preliminary until year-end cost reports are received and reconciled.



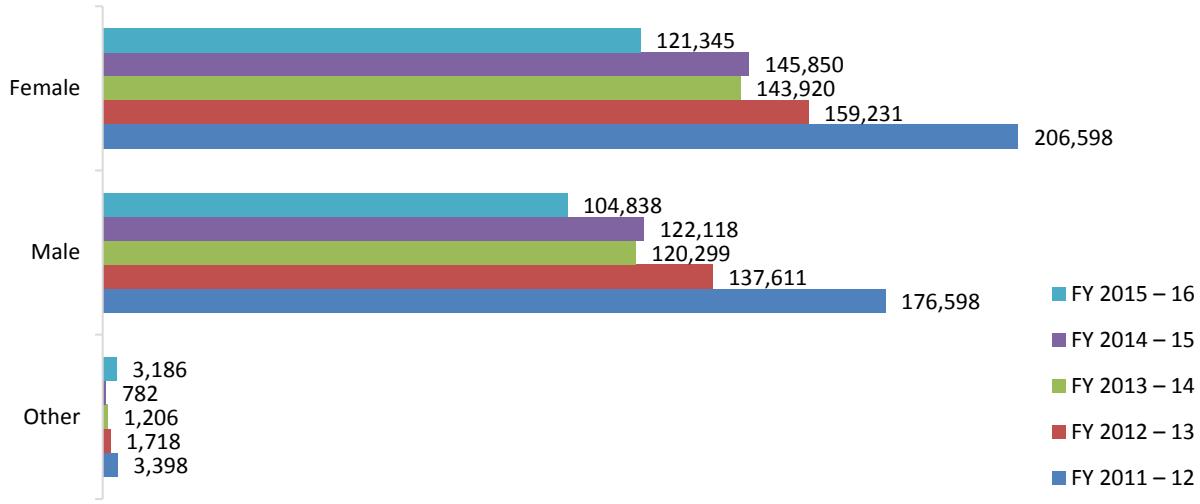
CalOMS Prevention
Number of Persons Served by Race



	Hispanic or Latino	White not Hispanic	African American	Asian American	Multi-racial	Other	Native Hawaiian or Pacific Islander	Native Am or Alaska Native
FY 2011 – 12	154,937	128,960	39,359	28,495	19,245	6,976	4,637	3,985
FY 2012 – 13	111,112	87,695	43,032	28,120	18,357	4,081	3,265	2,898
FY 2013 – 14	102,341	79,685	28,933	25,810	17,266	4,514	4,112	2,764
FY 2014 – 15	101,005	77,837	36,399	22,175	18,264	2,598	6,992	3,480
FY 2015 – 16	86,870	68,829	23,220	19,967	16,505	5,675	5,123	2,931

**CalOMS Pv Data Retrieved 10/10/16, FY 2014 - 15 and FY 2015 - 16 data are preliminary*

CalOMS Prevention
Number of Persons Served by Gender



**CalOMS Pv Data Retrieved 10/10/16, FY 2014 - 15 and FY 2015 - 16 data are preliminary*

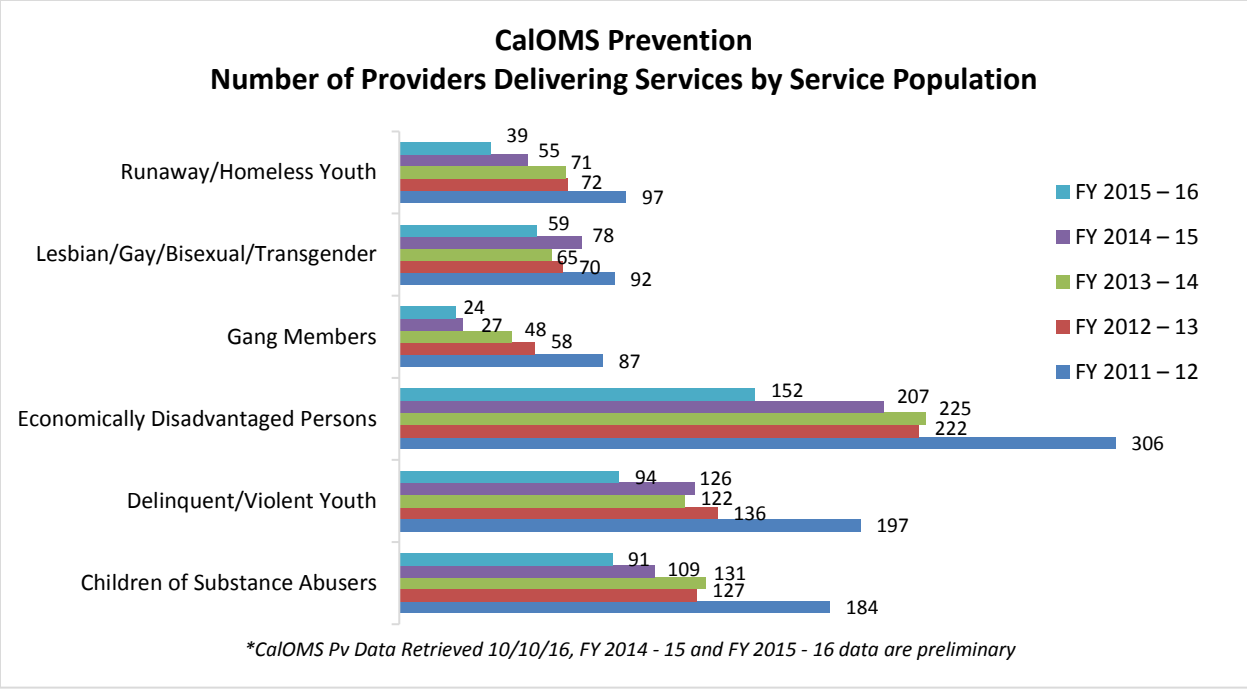
Prevention Services for Vulnerable and Underserved Populations

Due to limited space and the need to focus on improving the SUD system delivery, the SUD Resource Center functions were eliminated. Counties and providers were encouraged to take the clearinghouse publications and make them available at the local level. The toll free telephone line, which provides information and referrals to the public in both English and Spanish, was redesigned utilizing a phone tree. The mental health ombudsman also fields phone calls and assists when necessary. For calendar year 2016, a total of 35,162 calls were fielded. Of those callers, 2,348 chose the Spanish Language Selection.

SUD staff provide basic services regarding publications. Through the Community Prevention Initiative (CPI), a publications and resources webpage was established to share relevant information on emerging trends such as prescription drug misuse as well as current research and best practices in prevention.

At the local level, while many counties serve vulnerable and underserved populations, these populations are seldom reported as specific targeted populations for SUD prevention services. As mentioned previously, counties are required to engage in a strategic planning process that identifies specific local needs. Through this process, counties may identify needs for specific underserved and vulnerable populations and contract with providers to address those specific populations. The CalOMS Pv data collection system allows service providers to identify the underserved and vulnerable populations they serve, but it is not a requirement for the submission of data. Note that CalOMS Pv does not have the capacity to capture specific individual level demographics for underserved/vulnerable populations but rather the number of providers that deliver services to these populations. The chart below represents the most frequently identified service populations considered to be underserved and/or vulnerable.

Per the SAPT BG application, economically disadvantaged persons are defined as persons with net income less than 130 percent of the poverty level. This aligns with other similar federal requirements for free school lunches, Women, Infants and Children, etc. The terminology “economically disadvantaged persons” aligns with the terminology used by CSAP.



Prevention Services System Capacity and Infrastructure

The SUD PPFD PPB develops and maintains a comprehensive, statewide prevention system that aims to avert and reduce substance use to improve the health, safety, and economic conditions of California residents. The SUD PPFD PPB provides technical assistance and guidance to the counties and their providers, as well as oversight that the requirements for the SAPT BG funds are being met. As previously stated, the SAPT BG 20 percent Primary Prevention Set-Aside is the primary funding source for SUD prevention efforts in California, the majority of which is allocated to the counties, making SUD prevention in California county-driven, guided by the counties' strategic prevention plan. Counties determine the focus of their prevention efforts and identify target populations and any gaps in services. This process allows for expanded county-level service capacity.

Performance Management and Accountability

Strategic Planning

As previously stated, each of California's 58 counties are required by contract to have a Strategic Prevention Plan, with measurable goals and objectives, developed using SAMHSA's SPF. Every three to five years, counties submit a new strategic plan to DHCS for review and approval, enter the identified priorities, goals and objectives into CalOMS Pv, and assign each objective to one or more contracted providers.

Service Delivery

When the providers report SUD prevention services in CalOMS Pv, each service must align with the county-assigned objective. This allows both the county and DHCS to ensure that the services, strategies, goals and objectives meet county need based on data. Over time, progress toward meeting the goals are tracked and modifications are made as necessary.

Technical Assistance

DHCS and the current contractor of the DHCS-funded Community Prevention Initiative, Center for Applied Research Solutions (CARS), provide free technical assistance and training to counties that need assistance with strategic plan development, meeting reporting requirements, understanding the fiscal reconciliation process, and selecting and implementing appropriate strategies including evidence-based programs.

The Strategic Training and Education for Prevention Planning (STEPP) Project was developed by DHCS staff and CARS to coordinate and provide cohesive, strategic technical assistance services to counties that have strategic prevention plans due to expire. The STEPP is designed to transform a complex process into a segmented, easy-to-follow format. Ongoing SPF training and strategic prevention plan training by competent prevention experts has increased the quality of strategic prevention plans submitted by the counties.

When counties incorporate SPF into their everyday business practices and utilize available technical assistance and training, it allows for expanded local system capacity. One phase of the SPF is to build local capacity. This includes working with a county so it has the resources and readiness to support its chosen prevention programs and practices. Programs and practices that are well supported are more likely to succeed and to be sustained over time.

Performance Tracking and Indicators

Since the transfer from ADP, the SUD PPFD PPB continues its priority development and strategic planning with the DHCS Office of the State Medical Director. The following SUD PPFD PPB goals have been included in the DHCS Strategy for Quality Improvement in Health Care that outlines DHCS' seven quality strategy priorities:

- Quality Strategy Priority 5: Advance Prevention: The SUD PPFD PPB's goals are related to: developing partnerships with existing statewide efforts to provide a comprehensive response to the prescription drug epidemic, increasing participation of the Interagency Prevention Advisory Council (IPAC), identifying gaps in youth treatment services, and working to improve the youth treatment infrastructure in California.

- Quality Strategy Priority 6: Foster Healthy Communities: The SUD PPFD PPB's

goals relate to SPF SIG which addresses underage and excessive drinking by utilizing evidence-based programs, and increasing FNL program fidelity. FNL is a statewide youth development program.

The ways in which the SUD PPFD PPB has strategized to meet these goals include: 1) developing and implementing professional competencies for the prevention field; 2) building a core staff of competent prevention trainers; 3) piloting statewide outcomes in ten counties; 4) collaborating with DHCS' Managed Care Quality and Monitoring Division to include SBIRT services for all Medi-Cal beneficiaries; 5) implementing the SPF SIG goals in 12 communities; and 6) developing and implementing the FNL Roadmap, in all counties that administer FNL programs.

Fiscal Reconciliation Process

To provide accountability and full expenditure of the SAPT BG prevention dollars, DHCS engages in a reconciliation process in which budget and cost data are compared to the services reported in CalOMS Pv.

The chart below indicates the number of prevention providers in the state engaging in each CSAP strategy. Note: The figures captured below illustrate higher counts as providers are able to select more than one CSAP strategy per service.

CalOMS Prevention
Number of SUD Prevention Providers Reporting per CSAP Strategy

CSAP Strategy	FY 2011 – 12	FY 2012 – 13	FY 2013 – 14	FY 2014 – 15	FY 2015 – 16
Information Dissemination	241	209	222	206	193
Education	227	178	181	164	152
Alternatives	165	140	149	128	120
Problem Identification and Referral	71	55	48	46	36
Community-Based Process	246	220	240	224	202
Environmental	150	154	170	165	154
**CalOMS Pv Data Retrieved 10/10/16, FY 2014 - 15 and FY 2015 - 16 data are preliminary*					

Prevention Services System Outcomes

The SUD PPFD PPB, in collaboration with the SAPT + Prevention Subcommittee of the County Behavioral Health Directors Association (CBHDA), has been working to identify priorities and associated goals to collect prevention outcomes statewide.

Based on a keyword analysis conducted in FY 2012-13 of State-and county-level needs assessment data, underage alcohol use was identified as the top priority. Research shows that the early onset of alcohol use, frequency of drinking, and intensity of drinking among youth are predictors of later substance abuse and other risky behaviors or harmful consequences.

The three priority areas identified to address underage and excessive drinking are:

- Reduce the percentage of youth ages 12-16 who report the initiation of alcohol use by age 15 (Too Early);
- Reduce the percentage of youth between 9th and 11th grades who report drinking three or more of the past 30 days (Too Often); and
- Reduce the percentage of youth between 9th and 11th grades who report engagement in binge drinking within the past 30 days (Too Much).

Although these outcomes were approved by CBHDA in September 2012, implementation at a statewide level has been met with some barriers, as noted below.

- Many counties are in the middle of implementing three to five-year strategic prevention plans and may be locked into contracts with providers.
- Some counties may have identified other priorities based on their local needs assessment.
- Many counties rely on the California Healthy Kids Survey – the largest youth survey in the nation on substance use, school climate, and student health – for local data to use as a baseline and measurement for outcomes. With the loss of Title IV funding (Safe and Drug Free Schools and Communities), and its requirement to collect school-level data, many schools lack the resources to continue administering the survey.
- County Indicator Reports prepared by DHCS through the CPI often contain older datasets and lack local data. To ensure compliance with Title 42 Code of Federal Regulations, small cell sizes are masked and rural county data is combined in regions so local conditions affecting specific rural counties may go unreported.

To address these barriers, DHCS worked in collaboration with the State Epidemiological Outcomes Workgroup (a multi- agency collaborative of researchers convened as a requirement of the SAPT BG and other SAMHSA discretionary grants) to develop and implement a data indicator toolkit that would empower counties and providers to collect and analyze local data. The toolkit was piloted at the 2016 CPI Regional Trainings.

DHCS also used the SPF SIG grant project to pilot a study using evidence-based programs and practices. In September 2010, ADP was awarded SAMHSA's SPF SIG to streamline existing SPF processes at the county and community level, and demonstrate effective implementation of research-based prevention strategies in communities.

In following the SPF five-phase process, the SPF SIG Workgroup conducted a statewide needs assessment, the results of which identified underage and excessive drinking among 12 to 25 year-olds as the priority of the California SPF SIG project. Environmental prevention strategies were implemented in 12 communities in California. Results were compared to 12 control communities that have been matched with the SPF SIG communities. The SPF SIG implementation communities were selected based on local alcohol and other drug use and consequence data. The communities were: Livermore (Alameda County); Antioch (Contra Costa County); Walnut Creek (Contra Costa County); Santa Monica (Los Angeles County); San Rafael (Marin County); Merced (Merced County); Huntington Beach (Orange County); Folsom (Sacramento County); Redlands (San Bernardino County); Santa Barbara (Santa Barbara County); Santa Rosa (Sonoma County); and Ventura (Ventura County).

These communities focused on underage and binge drinking and employed evidence-based strategies that fall into three primary strategies: 1) retail access; 2) social access; and 3) drinking and driving. To date, the following strategies have been used: Driving Under the Influence (DUI) roadside checkpoints, DUI saturation patrols, responsible beverage service training, party patrols, downtown foot patrols, compliance checks, Remind and Reward Programs, conditional use permits, deemed approved ordinances, social host liability, keg registration, neighborhood watch, place-of-last-drink surveys, alcohol use permits, entertainment permits, minor decoy operations, and visibility messaging on both compliance and enforcement operations.

Archival data from various sources were used to evaluate intervention effects on community-level outcomes, such as alcohol-related motor vehicle crashes, assaults, injuries, and underage drinking. Baseline and follow-up surveys of 2,400 18 to 30 year-olds (~100 per city) and 1,500 adolescents (~60 per city) were conducted in 2013 and 2015. Process and outcomes evaluations are complete.

The process evaluation will help to understand the paths to success and why initiatives in some communities may have worked better than initiatives in other communities. All findings will be disseminated to county behavioral health directors, county prevention coordinators, and will be available on the DHCS website (www.dhcs.ca.gov/provgovpart/Pages/SPFSIG.aspx). Information, tools and techniques from the project also will be incorporated into the workshops and trainings of the CPI technical assistance contract.

Treatment Services

Treatment Services Data Sources

Data on SUD treatment services and service recipients come from CalOMS Tx. CalOMS Tx collects SUD treatment admission and discharge data from publicly funded treatment services and/or licensed Narcotic Treatment Programs (NTP) in California. For future reference, these are called “publically monitored treatment services.” Pursuant to AB 75, FY 2011–12 data are included as baseline data. FY 2012–13,

FY 2013–14 and FY 2014–15 are included for trend analyses. FY 2014–15 is the most current and completed fiscal year of CalOMS Tx data available.
Treatment data include the following treatment service modalities:

- Outpatient Drug Free – individual and/or group counseling provided in an outpatient setting;
- NTP Maintenance – provision of narcotic replacement medications such as methadone or buprenorphine in an outpatient setting and includes individual and/or group counseling;
- Intensive Outpatient Treatment – provision of three hours of counseling and rehabilitation services three days per week;
- Outpatient Detoxification – rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting. Services are designed to support and assist participants undergoing a period of planned withdrawal from SUD dependence and explore/develop plans for continued service. Administration of prescribed medication may be included in this type of service;
- NTP Detoxification – rendered in less than 24 hours and provide narcotic withdrawal treatment to clients undergoing a period of planned withdrawal from narcotic dependence;
- Residential Detoxification – includes hospital and non-hospital detoxification services. Hospital detoxification services are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services are provided in a residential facility which support and assist the participant during a planned SUD withdrawal period; and
- Residential Treatment – includes short-term (less than 30 days) and long-term (more than 30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery/treatment planning; educational sessions; social/recreational activities; individual and group sessions; and information about/assistance in obtaining, health, social, vocational, and other community services.

Access to Treatment Services
CalOMS Tx collects data on individuals admitted to publically monitored treatment services. This data does not include those seeking but not receiving publically monitored treatment.

The following provides CalOMS Tx based demographic information on persons admitted into SUD treatment (see Appendix 1). These statistics provide counts of all admissions for all service types. (Note: An individual may be admitted to multiple service types in a given year or be admitted to the same service type multiple times. Therefore, admissions will not equal the number of unique treatment service recipients.)

The following summary of CalOMS Tx admissions is for FY 2014–15. The overall number of admissions has decreased slightly from almost 170,000 in FY 2011–12 and

over 175,000 in FY 2012–13, to about 166,000 in FY 2014–15. Most of the service recipient information has remained relatively stable for FY 2012–13 through FY 2014–15 except where noted.

- Almost one-third of admissions into SUD treatment (31.4 percent) are for service recipients 26 to 35 years old. The 36 to 45 age group represents 19.4 percent of the total, followed by the 18-25 age group (17.4 percent) and the 46 to 55 age group (16.5 percent). Those under 18 years of age represent 8.0 percent, and those 56 and older represent 7.3 percent. Since FY 2011–12, there has been an annual decrease in the percent of service recipients who are under 18 years of age.
- 62.8 percent of the admissions were males and 37.2 percent were females.
- Most admissions were for service recipients identifying their race-ethnicity as either White (44.9 percent) or Hispanic (35.8 percent). The percent of African Americans decreased from 14.4 percent in FY 2011–12 to 11.7 percent in FY 2014–15.
- 44.2 percent of admissions referred themselves to treatment or are referred by a relative or friend. 29.6 percent are referred from the criminal justice system, and 8.3 percent from other sources in the community. While only 2.7 percent are presently referred from other health care providers, this source may become more common as health care coverage reform and integration of primary care and SUD services occur. The remaining 15.2 percent are referred from other SUD programs, schools, etc.
- The most commonly reported primary drug used at admission is methamphetamine (30.1 percent), an increase from 25.8 percent in FY 2011 – 12. Heroin is second (25.1 percent), followed by alcohol (20.1 percent), marijuana (14.3 percent), and cocaine/crack (3.6 percent). The remaining 6.8 percent is comprised of a variety of other drugs. The percent of service recipients reporting heroin as the primary drug has gradually increased since FY 2011– 12, with the greatest increase between FY 2012–13 and FY 2013–14.
- 27.2 percent of admissions report injecting drugs in the past year. Prior intravenous drug use has risen in proportion to the increase in heroin users entering treatment. About 76 percent of these heroin users report injection as the main route of administration in FY 2014–15. It is also worth noting that over 15 percent of those admitted with methamphetamine as their primary drug report injection as their route of administration.

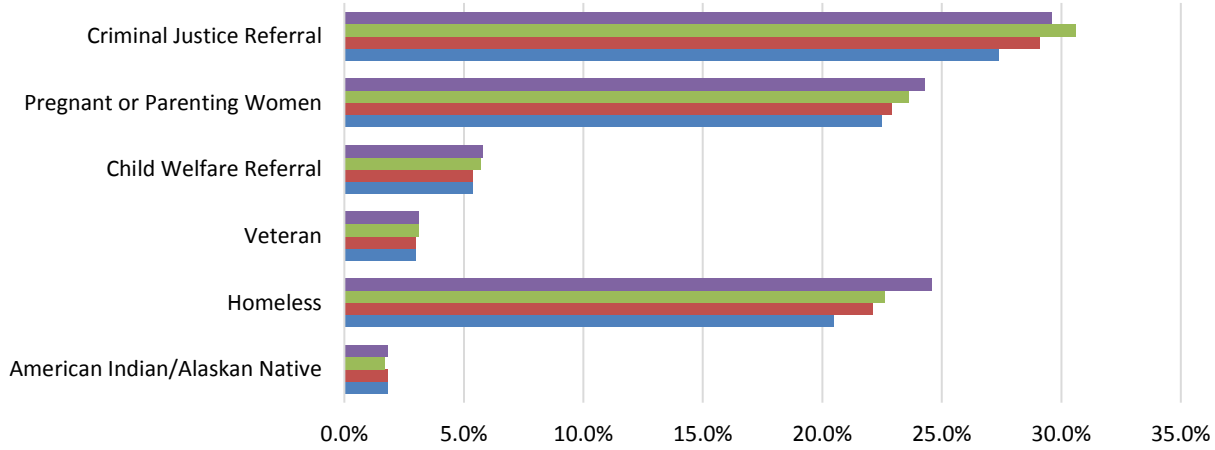
Note that drug trends for those in treatment are not necessarily reflective of drug use trends in the general population. For instance, while alcohol is the most commonly used and abused drug in the general population, methamphetamine is the most commonly reported primary drug for those in treatment.

Treatment Services for Vulnerable and Underserved Populations

CalOMS Tx collects information on the following vulnerable and underserved populations (see chart below and Appendix 2). Service recipients may be included in more than one of these populations. The overall number of admissions to CalOMS Tx has decreased slightly from almost 170,000 in FY 2011–12 and over 175,000 in FY 2012–13, to about 166,000 in FY 2014–15. This graph shows that the vulnerable and underserved populations remained relatively stable, with two exceptions:

- After a small increase from 27.4 percent of total admissions in FY 2011-12, criminal justice referrals stabilized at about 30 percent in FY 2012-13 through FY 2014-15.
- In FY 2011-12, the homeless population was 20.5 percent of total admissions. By FY 2014-15, they had increased to 24.6 percent of total admissions.

CalOMS Treatment Admissions
Percent of Vulnerable and Underserved Populations



	American Indian/Alaskan Native	Homeless	Veteran	Child Welfare Referral	Pregnant or Parenting Women	Criminal Justice Referral
FY 2014 – 15	1.8%	24.6%	3.1%	5.8%	24.3%	29.6%
FY 2013 – 14	1.7%	22.6%	3.1%	5.7%	23.6%	30.6%
FY 2012 – 13	1.8%	22.1%	3.0%	5.4%	22.9%	29.1%
FY 2011 – 12	1.8%	20.5%	3.0%	5.4%	22.5%	27.4%

Treatment Services System Capacity and Infrastructure

The following provides CalOMS Tx based information on persons served in SUD treatment. "Served" counts provide information on all "active" service recipients during a given period (e.g., FY 2014–15). These counts include service recipients admitted during the year plus those admitted in prior years but still receiving

treatment services during the year. Each admission is counted for service recipients with multiple admissions.

The treatment "served" counts decreased slightly from approximately 258,000 in FY 2011–12, to approximately 251,000 in FY 2014–15. The following provides more specific information by service type (see Appendix 3).

- Outpatient Drug Free – This service type has the largest percent of total served. The percent served in this service type decreased slightly each year from 47.2 percent in FY 2011–12 to 39.7 percent in FY 2014–15.
- NTP Maintenance – The percent served in this service type increased from 21.2 percent in FY 2011–12 to 29.6 percent in FY 2014–15.
- Intensive Outpatient Treatment – The percent served in this service type declined slightly from 4.1 percent in FY 2011–12 and 4.5 percent in FY 2012–13, to 3 percent in FY 2014–15.
- NTP Detoxification – The percent served in this treatment type decreased slightly from a high of 4.5 percent in FY 2012–13 to 2.6 percent in FY 2014–15.
- Residential Detoxification – The percent served in this service type remained relatively stable in each of the four years with between 8.9 and 9.5 percent of all those served.
- Long Term Residential (>30 Days) – The percent served in this treatment type remained stable in each of the four years with approximately 15 percent of all those served.
- Short Term Residential (<31 Days) and Outpatient Detoxification (non-NTP) each comprised less than one percent of all service recipients served in each of the four years.

In addition to examining "served" counts, waiting list information also provides insight about treatment system capacity. Out of all treatment admissions during FY 2014–15 (165,779), about 23.9 percent of service recipients reported waiting at least one day to gain admission to treatment services. The percent waiting at least one day has been relatively stable for the last four years with 24.3 percent in FY 2011–12.

The percent that reported waiting at least one day varies by service type. Those seeking residential services had the largest percentages waiting for treatment admission. The percent waiting at least one day to receive residential services has decreased slightly from 52.6 percent in FY 2011–12 to 49.5 percent in FY 2014–15.

VII. Contribution to Discussions of Delivery of Health Care Services

As demonstrated throughout this report, the transfer of ADP administrative and programmatic functions to DHCS provides SUD issues a greater and more prominent platform for public policy discussions related to the delivery of health care services in California. There is increased recognition of the relationship between high costs and

poor outcomes for individuals with co-occurring SUD, mental illness, and chronic health conditions.

State-level integration of the administration of SUD and mental health programs and primary care facilitate coordination of health care to benefit health outcomes for individuals with SUD and co-occurring disorders. The consolidation of mental health and SUD services under one directorate in DHCS demonstrates the commitment to integration of physical and behavioral health. Substantive discussions of behavioral health programs in the delivery of health care services within DHCS, with federal and county partners and stakeholders, such as CBHDA are enriched through this integration.

SUD program staff were key DHCS participants in the implementation of Senate Bill 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015), an effort to establish full scope Medi-Cal coverage for all children under the age of 19 regardless of immigration status.

VIII. Stakeholder Involvement

To ensure continued engagement with stakeholders on improving SUD programs, DHCS has maintained, and continues working with the advisory groups that ADP convened prior to the transfer.

DHCS maintains engagement with:

- County Behavioral Health Directors Association (CBHDA)
- Interagency Prevention Advisory Council (IPAC)
- Counselor Certification Advisory Committee
- NTP Advisory Committee
- DUI Advisory Group

Beyond maintaining the advisory groups from ADP, opportunities for stakeholder involvement have both changed and enhanced as a result of the transition. SUD stakeholders now have direct access to DHCS leadership and the extensive resources of DHCS regarding SUD program and policy issues.

Of note, stakeholder involvement of the IPAC has expanded over the last year, adding the Department of Motor Vehicles and the California Department of Veteran's Affairs to the Council membership. Structurally, the IPAC has changed immensely. The IPAC was once a forum utilized for networking and information sharing. Over the last year, the IPAC has transformed into an action-oriented council with a strategic plan based on data. Through the planning process, workgroups were established to address priorities. As well, strategic partnering areas were established in order to map onto greater state-level efforts. This allows IPAC partners to reduce redundancies in stakeholder participation. The workgroups and strategic partnering areas are as follows:

- Underage Marijuana Prevention Workgroup
- Underage Alcohol Use Workgroup
- Access to Care Workgroup (with a focus on college populations)
- Suicide and Depression
- Prescription Drug Misuse
- Impaired Driving

More information on IPAC and the Annual Report on IPAC priorities can be found at http://www.dhcs.ca.gov/provgovpart/Pages/IPAC.aspx

Finally, in 2016, a Youth Advisory Group was convened by DHCS as a quarterly workgroup to examine the youth treatment and recovery infrastructure in California. The workgroup is comprised of county behavioral health offices, providers, and community non-profits that serve youth. The initial deliverable of the workgroup is to provide feedback on the updated Youth Treatment Guidelines. More information on the Youth Advisory Group can be found by visiting http://www.dhcs.ca.gov/provgovpart/Pages/Youth-Advisory-Group.aspx

The updated guidelines incorporate the entire continuum of care for youth. Stakeholder feedback has been collected. Program challenges and successes will be discussed over the next several months.

IX. Appendix 1 – Statewide Treatment Admissions Data

California Outcomes Measurement System – Treatment (CalOMS – Tx)
Statewide Admission Data for Fiscal Years (FY) 2012 – 13 Through 2014 – 15

Total Admissions Client and Service Characteristics	FY 2011 – 12	FY 2012 – 13	FY 2013 – 14	FY 2014 – 15
	169,875	175,114	170,742	165,779
Age				
Under 18 years	14.9%	13.5%	9.7%	8.0%
18-25 years	18.0%	18.2%	17.8%	17.4%
26-35 years	25.7%	27.1%	29.2%	31.4%
36-45 years	18.6%	18.2%	18.9%	19.4%
46-55 years	16.6%	16.4%	17.2%	16.5%
56-65 years	5.5%	5.8%	6.5%	6.5%
66 and older	0.7%	0.8%	0.7%	0.8%
Gender				
Male	61.9%	62.6%	63.0%	62.8%
Female	38.1%	37.4%	37.0%	37.2%

Race/Ethnicity				
African American	14.4%	14.5%	12.8%	11.7%
American Indian/Alaskan Native	1.3%	1.3%	1.2%	1.3%
Asian/Pacific Islander	2.2%	2.3%	2.2%	2.1%
Hispanic	35.2%	35.4%	35.9%	35.8%
Multiracial	2.0%	2.0%	2.2%	2.3%
Other	1.9%	1.8%	1.6%	1.9%
White	43.0%	42.7%	44.1%	44.9%
Primary Drug Used				
Alcohol	22.5%	21.8%	19.2%	20.1%
Cocaine/Crack	5.9%	5.1%	4.3%	3.6%
Heroin	17.9%	19.1%	24.0%	25.1%
Marijuana/Hashish	20.2%	19.4%	16.0%	14.3%
Methamphetamine	25.8%	27.5%	29.4%	30.1%
Other	7.7%	7.1%	7.1%	6.8%
Route				
Oral	29.5%	28.6%	26.1%	26.7%
Smoking	47.3%	47.0%	44.7%	44.2%
Inhalation	4.6%	4.9%	5.2%	5.5%
Injection	18.2%	19.2%	23.5%	23.2%
Other	0.4%	0.3%	0.5%	0.4%
Used Needles (in past 12 mos.)				
Yes	21.7%	22.9%	27.3%	27.2%
No	78.3%	77.1%	72.7%	72.8%
Referral Source				
12 Step Mutual Aid	0.1%	0.1%	0.1%	0.1%
SUD Program	5.8%	5.9%	6.9%	7.0%
Child Protective Services	5.4%	5.4%	5.7%	5.8%
Criminal Justice	27.4%	29.1%	30.6%	29.6%
Employer/EAP	0.2%	0.1%	0.1%	0.1%
Individual	42.1%	40.7%	42.8%	44.2%
Other Community Referral	11.4%	11.5%	8.5%	8.3%
Other Health Provider	2.2%	2.4%	2.4%	2.7%
School/Education	5.4%	4.8%	2.9%	2.2%

X. Appendix 2 – Special or Vulnerable Populations Admissions

California Outcomes Measurement System – Treatment (CalOMS – Tx)
Special or Vulnerable Populations Admission Information
Statewide Data for Fiscal Years (FY) 2011 – 12 Through 2014 – 15

	FY 2011 – 12		FY 2012 – 13		FY 2013 – 14		FY 2014 – 15	
Total Admissions	169,875		175,114		170,742		165,779	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Special or Vulnerable Populations (Number/ Percent)								
Criminal Justice Referral	46,602 27.4%	123,273 72.6%	50,961 29.1%	124,153 70.9%	52,259 30.6%	118,483 69.4%	49,068 29.6%	116,711 70.4%
Pregnant or Parenting Women	14,533 22.5%	50,157 77.5%	14,998 22.9%	50,573 77.1%	14,923 23.6%	48,260 76.4%	15,006 24.3%	46,665 75.7%
Homeless	34,895 20.5%	134,980 79.5%	38,610 22.1%	136,504 77.9%	38,681 22.6%	132,061 77.4%	40,758 24.6%	125,021 75.4%
Child Welfare Referral	9,142 5.4%	160,733 94.6%	9,395 5.4%	165,719 94.6%	9,686 5.7%	161,056 94.3%	9,701 5.8%	156,078 94.2%
Veteran	5,108 3.0%	164,767 97.0%	5,238 3.0%	169,876 97.0%	5,269 3.1%	165,743 96.9%	5,167 3.1%	160,612 96.9%
American Indian/Alaskan Native	3,016 1.8%	166,859 98.2%	3,089 1.8%	172,025 98.2%	2,857 1.7%	167,885 98.3%	3,021 1.8%	162,758 98.2%

XI. Appendix 3 – Statewide Treatment Services

California Outcomes Measurement System – Treatment (CalOMS – Tx) Statewide Service Recipients Served* Data for Fiscal Years (FY) 2012 – 13 Through 2014 – 15				
	FY 2011 – 12	**FY 2012 – 13**	**FY 2013 – 14**	**FY 2014 – 15**
Service Type	**Frequency/Percent**			
Outpatient Drug Free	121,784	115,544	104,818	99,745
	47.2%	44.9%	41.5%	39.7%
Narcotic Treatment Program (NTP) Maintenance	54,655	56,865	65,958	74,469
	21.2%	22.1%	26.1%	29.6%
Intensive Outpatient Treatment	10,454	11,475	9,656	7,554
	4.1%	4.5%	3.8%	3.0%
Outpatient Detoxification	142	225	225	234
	0.1%	0.1%	0.1%	0.1%
NTP Detoxification	8,374	8,630	8,021	6,553
	3.2%	4.5%	3.2%	2.6%
Residential Detoxification	22,860	24,408	23,388	23,447
	8.9%	9.5%	9.3%	9.3%
Short-Term Residential (<31 Days)	1,773	1,318	1,297	1,326
	0.7%	0.5%	0.5%	0.5%
Long-Term Residential (>30 Days)	38,214	38,703	39,095	37,995
	14.8%	15.1%	15.5%	15.1%
Total	258,256	257,168	252,458	251,323
	100.00%	100.0%	100.0%	100.0%

*Served counts include service recipients admitted into treatment during the year plus those admitted in prior years, but are still receiving treatment services during the year. Each admission is counted for service recipients who have multiple admissions during the year.