2015

CALIFORNIA SUBSTANCE USE DISORDER BLOCK GRANT & STATEWIDE NEEDS ASSESSMENT & PLANNING REPORT

DHCS

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This report is dedicated to California's Department of Health Care Services (DHCS) whose work in the field of substance use disorder (SUD) has spanned over 35 years, and leaves a legacy of commitment and dedication to those we serve.

The 2015 California **Statewide Needs Assessment and Planning (SNAP)** report is a collaborative effort between numerous staff at DHCS, the **California Department of Public Health (CDPH)**, and the **UCLA Integrated Substance Abuse Program (ISAP)**.

The SNAP Report Development Team is led by Mental Health and Substance Use Disorder team members Rachelle Weiss and Eileen S. Gillis, who both guided development and production of this report. The team members include both internal DHCS and external contributors whose hard work and dedication made this report possible.

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Gratitude is also extended to the branches in the **SUD-Prevention, Treatment, and Recovery Services Division (PTRSD)** at DHCS that contributed information and expertise to the contents of this report.

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Analyzing information involves examining data in ways that reveal intricate relationships, patterns, and trends. By understanding the overall situation, DHCS can compare our information with data from other groups. The SNAP report is an informative, bi-annual SUD needs assessment required of all single state agencies receiving federal **Substance Abuse Prevention and Treatment Block Grant (SAPT BG)** funds. This assessment process helps us better understand our work and the effectiveness of our efforts to provide recovery relief to those individuals, families, and communities suffering from the impact of SUD.[1] The SNAP assessment is a critical component of federal, state, and community health care planning and clarifies the needs of our state residents, while encouraging informed decision making regarding the allotment of resources to meet these needs. Only with a proper evaluation of California's SUD recovery health care system can DHCS[2] and service providers be guided in efforts to create an effective strategic plan to promote patient-centered and positive prevention and treatment outcomes for those at risk for or suffering from SUD, a primary and chronic disease affecting us statewide.

Part I of the SNAP report seeks to answer the following questions:

- What are the problems or opportunities that the SAPT BG program addresses?
- What is the nature and magnitude of each problem or opportunities for prevention, treatment and recovery?
- What populations are affected?
- Are the populations' needs changing, and if so, in what manner?

Part 2 of the report lays out California's strategic initiatives for SAPT BG FY 2016–2017, which are informed by the strategic plan laid out in SAMHSA's: Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018.[3] Part II also incorporates state-specific goals into SAMHSA's national prioritized strategic initiatives, many of which are aligned with DHCS' 2014 Quality Strategy, which advances three goals:1) Improve the health of all Californians; 2) Enhance quality, including the patient care experience, in DHCS programs; and 3) Reduce the Department's per capita health care program costs.[4]

DHCS articulated seven priorities in its 2014 Quality Strategy:

1. Improve patient safety;
2. Deliver effective, efficient, affordable care;
3. Engage individuals and families in their health;
4. Enhance communication and coordination of care;
5. Advance prevention;
6. Foster healthy communities; and
7. Eliminate health disparities.

DHCS is proud to release this SNAP report, which will be circulated widely in order to gather stakeholder feedback on the needs assessment and strategic initiatives. The SNAP report and stakeholder feedback will serve as the basis of the strategic initiatives and priorities outlined in the SAPT BG 2016–2017 application.

DHCS Substance Use Disorder Services and Programs

Two divisions lead the effort to reduce alcoholism and drug addiction in California by developing, administering, and supporting prevention, treatment, and recovery programs. We endeavor to help Californians understand that alcoholism and drug addiction are chronic conditions that can be successfully prevented and treated.

The Substance Use Disorder Prevention, Treatment and Recovery Services Division (SUD-PTRSD) directs statewide prevention and treatment programs that address SUD. Its core functions include developing and implementing SUD prevention strategies, reviewing and approving county SUD treatment program contracts, and submitting grant applications for state and federal funds for SUD services.

The Substance Use Disorder-Compliance Division (SUD-CD) focuses on compliance with state and federal statute, regulations, and other governing requirements. SUD-CD oversees the licensing and certification functions, monitoring, and complaints for Driving Under the Influence Programs, Drug Medi-Cal, Narcotic Treatment Programs, and SUD outpatient and residential providers. SUD-CD also ensures compliance with counselor certification.

1 The SAPT BG program provides funds and technical assistance to all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity. Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services.

2 Please note: Effective with the passage of the 2013–2014 Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP programs and staff, except the Office of Problem Gambling, transferred to DHCS.

3 http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2

4 http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2014.pdf

The DHCS SNAP report is an informative, bi-annual SUD needs assessment required of all single state agencies receiving federal SAPT BG funds.[1] The SNAP report informs DHCS, individuals, or entities shaping federal, state, and local healthcare policy, SUD service providers, stakeholders, community and family members, and beneficiaries on the effectiveness of our statewide publicly-funded efforts towards SUD prevention and treatment services. The SNAP report is also designed to assist DHCS and its stakeholders to make informed decisions on allocating resources to meet the SUD prevention and treatment needs of individuals, families, and communities.

Part 1 of the SNAP report summarizes the statewide patterns of SUD and describes current prevention and treatment activities. This section also contains a **strength, weakness, opportunity, and threat (SWOT)** gap analysis for a comparison of actual performance with potential or desired performance.

Part 2 outlines California's strategic initiatives for SAPT BG FY 2016–2017. These initiatives incorporate the needs assessment, the federal strategic plan laid out in SAMHSA's Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018, and the DHCS 2014 Quality Strategy for Improvement of Health Care. [2,3]

1 The SAPT BG program provides funds and technical assistance to all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity. Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services.
2 http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2
3 http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2014.pdf

STATEWIDE NEEDS ASSESSMENT

The outline of Part 1 follows the state reporting requirements found in 42 U.S. Code §300x-29 and 45 CFR §96.133, governing reporting responsibilities of SAPT BG recipients.

INCIDENCE AND PREVALENCE OF SUBSTANCE USE, 45 CFR §96.133(a)(1)

Excluding marijuana, no significant change occurred over the past few years in either state or national illicit drug use.[1] During 2013, SUD was involved in 39.5% of all the arrests in California.

Binge Drinking: The statewide rate of binge drinking (males drinking 5 or more drinks on one occasion, females drinking 4 or more drinks on one occasion) was 17.4% among adults aged 18 and older, while the national rate was lower (16.8%). The percentage of heavy drinkers (adult men having more than two drinks per day and adult women having more than one drink per day in the past month) was higher in California (6.4%) than the nation (6.2%).

Marijuana: Across all age groups, the rate of marijuana "first use" in California in 2011–12 and 2012–13 was 2.26% and 2.12%, respectively, while nationally it remained stable at 1.9%. Marijuana first use in California among the 12–17 age group decreased significantly from 6.83% to 6.01%.

Youth: Approximately 33% of 11th graders used alcohol in FY 2011-13. Overall, the 12–17 age group data showed significant decreases in children and teen substance use. Please note, that while statistically significant decreases in use were found, they are not necessarily substantial.[2]

Deaths and ER Visits: Among deaths in 2012 where drugs were a contributing cause, those using any type of opioid (i.e. including opioid pharmaceuticals, heroin, and illicit narcotics) had the highest fatality rate. The rate of alcohol-related **emergency department (ED)** visits remains more than twice as high as the rate of other drug-related ED visits and is increasing.

HIV/AIDS and Hepatitis C: Overall, nearly 221,000 cases of HIV/AIDS cases were reported in California through June 30, 2014. Of those cases, 8.8% identified **injection drug use (IDU)** as the exposure category.

1 Illicit drug use patterns analyzed in this report includes marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription-type drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives) used non-medically.
2 California Healthy Kids Survey, 14th Biennial 2011-2013. Significance here means that the differences found between years are unlikely due to chance.

Another 8.8 % identified Men who have Sex with Men, Bisexual Male and IDU as the exposure category. Exposure to Hepatitis C now occurs predominantly through sharing needles and/or other injection equipment during injection drug use.

SUD PREVENTION AND TREATMENT ACTIVITIES, 45 CFR §96.133(a)(2)

This section describes current statewide SUD prevention, intervention, and treatment activities. DHCS is mindful that the goal of treatment is to increase the probability of positive health outcomes for those with a chronic, lifelong SUD.

PREVENTION

DATA

The prevention data collection system used by DHCS is the **California Outcome Measurement System for Prevention (CalOMS Pv)**.[3] The following review of data is taken from FY 2012–13.[4] Prevention services in California are primarily provided to youth aged 25 and younger. More females than males were served in FY 2012–13.

STRATEGIES

The six prevention service strategies, as defined by the Center for Substance Abuse Prevention, are as follows:

1. **Information Dissemination**: Strategies reached 299,476 individuals.
2. **Education**: Strategies served 126,189 individuals.
3. **Alternatives**: Strategies, which include community center activities and substance use-free social events, served over 107,425 individuals.
4. **Problem Identification and Referral**: Approximately 10,541 individuals received activities under Problem Identification and Referral strategies, including Alternatives to Violence Programs.
5. **Community-Based Process**: Approximately 69,287 people benefited from direct community-based process strategies that included planning, coordinating, technical assistance, and training.
6. **Environmental**: Advocate for positive environmental changes to reduce alcohol access to underage youth.

TREATMENT AND RECOVERY SERVICES

DHCS monitors the SAPT BG and distributes funds to 58 California counties to support services for SUD treatment. Efforts are specifically targeted to those with HIV and receiving **Early Intervention Services (EIS)**, and services to pregnant and parenting women.

SCREENING INTO TREATMENT

Effective January 1, 2014, California began offering the **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** benefit to adult Medi-Cal beneficiaries. SBIRT implements Affordable Care Act Section 4106, which clarifies that preventive services, aligned with the U.S. Preventive Services Task Force recommendations, will be offered to all Medi-Cal beneficiaries aged 18 and older in primary care settings.

TARGETED TREATMENT SERVICES

Youth: Youth substance use is prioritized by California counties as youth differ from adults physiologically and emotionally, so it is crucial that treatment be adapted to meet their specific needs.

Cultural Competency: Providing **Cultural and Linguistically Appropriate Services (CLAS)** also has a positive effect on SUD service delivery, as well as reduces disparities and improves access to quality care. Disparities in diagnosis of illness and access to SUD and mental health services are found in all races, ethnicities, sexual orientations, and gender identities/expressions.[5,6] To assist the SUD field in developing services that are culturally competent, DHCS uses the 15 CLAS Standards developed by the Office of Minority Health, U.S. Department of Health and Human Services.[7] Twenty six counties report providing SUD services in languages other than their identified threshold language.[8]

3 See: https://caprev.kithost.net/caprevent2014/psystem.aspx to view DHCS' CalOMS Pv data submission website.

4 Prevention services are provided for populations at three levels of risk: 1) universal for the general public; 2) selective for sub-populations at higher than average risk for substance abuse; and 3) targeted towards those who in the future, or likely already are, using alcohol or other drugs or engaging in other high risk behaviors, but are not yet defined as in need of treatment.

5 http://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=21156267 (Compared with non-Latino Whites with SUD, Black adolescents with SUD reported receiving less specialty and informal care, and Latinos with SUD reported less informal services). See also: U.S. Department of Health and Human Services. HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care. Washington, D.C.: U.S. Department of Health and Human Services, [April 2011] at http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

6 See http://www.cdph.ca.gov/programs/Documents/ADP_Race-Ethnicity_Report_Final.PDF for California specific SUD disparity analysis.

7 U.S. Department of Health and Human Services, OPHS Office of Minority Health, National Standards
for Culturally and Linguistically Appropriate Services in Health Care, March 2001

8 California Code of Regulations (CCR), Section 1810.410

American Indian/Alaskan Native (AI/AN): California is home to approximately 115 federally recognized American Indian tribes.[9] The AI/AN population is one of the most impacted by SUD issues. Efforts to better understand and meet the needs of this population are a high priority at both the national and state level.

Veterans: Substance use and mental illness are common co-occurring disorders among veterans presenting for treatment. Counties do and must continue to collaborate with their county **Veteran Services Office (VSO)** to ensure treatment services are available for this population.

Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ): Eighteen counties also have programs/providers that specifically serve the LGBTQ population.

Co-Occurring Disorders (COD): COD is the simultaneous existence of both substance use and mental health disorders. Providing integrated treatment for clients with COD is critical to improving their overall health. Many homeless individuals struggle with a COD and physical health issues. Efforts to develop housing for those still actively using substances are an important priority.[10]

Criminal Justice: Collaborative efforts to address substance use among the criminal justice population have flourished between county SUD departments and the courts, probation, law enforcement and other organizations.

TECHNICAL ASSISTANCE NEEDS, 45 CFR §96.133(a)(3)

This SNAP report outlines the need for technical assistance to carry out Block Grant activities, including the collection of incidence and prevalence data identified in paragraph (a)(1) of section 96.133. See also Part 2: Strategic Initiatives, Goals, and Technical Assistance Needs, for further discussion. One of the state's most urgent needs is training for computer programmers at the state level to upgrade data systems. The counties have also requested technical assistance on correctly entering data for purposes of CalOMS treatment tracking.

9 Tina Norris, Paula L. Vines, Elizabeth M. Hoeffel, American Indian and Alaskan Native Population:
2010, 2010 Census Briefs, January 2012. Retrieved August 2012 from http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

10 http://homeless.samhsa.gov/channel/permanent-supportive-housing-510.aspx (Harm reduction (or harm minimization) is a range of public health policies designed to reduce the harmful consequences associated with various human behaviors, both legal and illegal. Harm reduction policies are used to manage behaviors such as recreational drug use in numerous settings that range from services through to geographical regions.)

GOALS AND OBJECTIVES, 45 CFR §96.133(a)(4)

For a detailed description of these goals and prioritized objectives, **see Part II: Strategic Initiatives and Goals** in this report that details the state's efforts and activities taken in support of these goals and objectives.

SERVICE AVAILABILITY AND INTERIM SERVICES, 45 CFR §96.133(a)(5)

This section reports on the extent to which the availability of prevention and treatment activities are insufficient to meet the need, the available interim services, and the manner in which such services are made available, giving special attention to certain populations.

National Survey on Drug Use and Health's (NSDUH) estimates for individuals needing but not receiving treatment for California (using **Calendar Year (CY)** 2012 and 2013 combined data) and the nation (using 2013 data) are similar (2.60% vs. 2.42% for illicit drugs, and 6.79% vs. 6.4% for alcohol). California's rate has dropped off significantly (from the 2009 and 2010 combined estimate of 7.76%) for alcohol, but not yet for other illicit drugs. Among the 20.2 million individuals classified nationally in the SAMHSA 2013 NSDUH report as needing SUD treatment only, 908,000 (4.5%) reported that they perceived a need for treatment for their illicit drug or alcohol use problem.[11]

Pregnant women and individuals in need of treatment for intravenous drug use receive priority for admission to SUD treatment services. The availability of residential perinatal treatment providers has been decreasing in California. Given the number of women with SUD, the availability of residential treatment services are severely lacking.[12] During FY 2012–13, there were only 74 short- and long-term specialized perinatal residential providers in California.

STATE'S MANAGEMENT INFORMATION SYSTEM FOR CAPACITY AND WAITING LISTS, ADMISSION AND DISCHARGE INFORMATION, 45 CFR §96.133(a)(6)

This section documents the efforts in the state management information systems, in tracking treatment capacity, and in monitoring waiting lists. Prevention activities play a key role in this tracking effort by

11 http://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf

12 Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the specific needs of women. Treatment Improvement Protocol Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009, accessed at: http://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA14-4426 on March 30, 2015.

documenting which populations are at risk for SUD.

Drug and Alcohol Treatment Access Report (DATAR), the statewide DHCS system used to collect data on SUD treatment capacity and waiting lists, is used to capture the most complete and accurate information available. DHCS also uses the NSDUH estimates on those needing but not receiving SUD treatment in California to monitor treatment capacity. There are at least 2.2 million Californians who are estimated to need, but are not receiving, SUD treatment services.[13]

California Outcomes Measurement System, Treatment (CalOMS Tx)

CalOMS Tx reported that 274,000 clients were served during FY 2012–13. DHCS calculated that there were over 99,000 clients in treatment on April 1, 2013 (one-day count). Also during FY 2012–13, approximately 23% reported waiting one or more days for treatment, with residential services having the longest wait times.

There were over 175,000 admissions to treatment during FY 2012–13 for all services, representing 138,000 individuals (unique clients). There were over 161,000 discharges from treatment services (i.e., including detoxification, which is a precondition for residential outpatient treatment) for over 129,000 individual clients. Outpatient drug-free treatment had the largest admission percentage with 58%, while 23% were for residential (short and long term) treatment, 12% for narcotic replacement therapy services, and the remaining 7% for intensive day care.

13 The California estimates of those needing but not receiving treatment for either illicit drug or alcohol use are derived by summing the individual percentages (i.e. percent needing but not receiving treatment for illicit drug use plus the percent needing but not receiving treatment for alcohol use). This method results in the estimate being high because the sum of the percentages does not account for individuals who abuse both alcohol and other drugs. NSDUH does not provide a combined California percentage estimate to eliminate this overlap.

STRATEGIC INITIATIVES – CALIFORNIA SPECIFIC GOALS AND SAMHSA'S LEADING CHANGE 2.0: ADVANCING THE BEHAVIORAL HEALTH OF THE NATION 2015–2018

Part 2 of this SNAP report outlines California's strategic plan and guiding strategies for best use of SAPT BG funds over FY 2016–2017. California's plan closely follows the federal initiatives announced in SAMHSA'S Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018, and the state specific goals put forward in the DHCS 2014 Quality Strategy.14 The strategic plan goals are partly developed from the needs assessment and **Strengths, Weaknesses, Opportunities, and Threats (SWOT)** and gap analysis performed in Part 1.

Strategic Initiative #1: Prevention of Substance Use

Strategic Initiative #1 focuses on preventing substance use by maximizing opportunities to create environments where youth, adults, families, communities, and systems are empowered to manage their overall emotional, behavioral, and physical health. Special focus is placed on several high-risk populations: college students and transition-age youth, American Indian/Alaska Natives, ethnic minorities, service members/veterans and their families, the homeless, and LGBTQ.

Prevention priorities in Strategic Initiative #1 closely follow SAMHSA's Strategic Prevention Framework, which is a five-step planning process guiding the selection, implementation, and evaluation of evidence-based, culturally-appropriate, and sustainable prevention activities, enhanced by the involvement of stakeholders and other community members in all stages of the planning and execution process.[15]

Together, consumption, consequences, risk and protective data indicate targeted prevention efforts achieve some progress, but have had no major impact. This conclusion highlights the importance of better leveraging prevention and treatment strategies in order to meaningfully decrease SUD. DHCS needs to focus efforts on meeting the needs of underserved populations, encourage the widespread implementation of SUD evidence-based or best practices, and review, evaluate, and modify actions as needed to provide continual improvement.

14 http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2

15 http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework

Strategic Initiative #2: Health Care and Health Services Integration

Strategic Initiative #2 prioritizes integration in health care across systems, including systems of particular importance for individuals with SUD and co-occurring behavioral health needs, such as community health promotion, health care delivery, specialty health care, emergency care and response, and community living needs. DHCS has been very active on many fronts to pursue integration. In order to improve behavioral health outcomes, DHCS will need to continue designing new metrics supporting integration, make accurate measurements, and provide continuous quality improvement support to providers.

SBIRT: The new California Medi-Cal covered service, SBIRT, is a foothold in primary care settings, leading to better integration and coordination of primary care and SUD treatment systems for adults. Operating as a benefit since January 1, 2014, DHCS expects that primary care providers will screen and identify a larger pool of beneficiaries who engage in risky or hazardous drinking, and/or alcohol abuse.

Behavioral Health Forum (BHF): The department launched the BHF in March 2014, which meets on a quarterly basis, to solicit feedback and provide key stakeholders and other interested parties with information regarding critical policy and programmatic issues impacting public mental health and substance use disorder (MH-SUD) services.[16]

Drug Medi-Cal Organized Delivery Service (ODS) 1115 Demonstration Waiver: On August 13, 2015, DHCS received approval from the **Centers for Medicare and Medicaid Services (CMS)** to amend the Special Terms and Conditions of Waiver 11-W-00193/9, California's Section 1115 "Bridge to Reform" Demonstration (Demonstration Waiver) to make improvements to the DMC service delivery system, provide for more local control and accountability by concentrating on high quality providers, improve local coordination of case management services, and require implementation of evidence-based practices in SUD treatment and coordination with other systems of care, including physical health. The waiver may affect the use of SAPT BG funds as increased services will be supported under DMC, allowing SAPT BG funds to be used for discretionary, wrap-around services.

16 http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Voluntary Inpatient Detoxification: SAMHSA's strategic plan parallels federal, state, territorial, and tribal efforts to develop and implement new provisions under Medicaid and Medicare and further integration. For example, voluntary inpatient detoxification is now a covered benefit of the Medi-Cal program for qualifying beneficiaries as medically necessary, in accordance with Senate Bill X1-1 (Hernandez, Chapter 4, Statutes of 2013) Section 29 and the Patient Protection and Affordable Care Act, effective as of January 1, 2014.

Medicaid State Plan: By implementing parity principles, including those articulated in the Mental Health Parity and Addiction Equity Act, and the **Affordable Care Act (ACA)**, California has expanded services for substance use disorders in line with these legislative mandates.[17] Greater advances still need to occur, but California has expanded benefits by embracing the expansion population and gaining approval for two **State Plan Amendments (SPA)**. These SPAs include SPA 13-035, which adopted an alternative benefit plan supportive of integration for the expansion population that includes SUD treatment as one of the essential health benefits.[18] SPA 13-038 expanded SUD services for the Medi-Cal population.[19]

Strategic Initiative #3: Trauma and Justice, Implementation of Trauma- and Justice-Informed Services for SUD

Research, clinical experience, and users of behavioral health services have increasingly documented the connection between trauma and SUD. SAMHSA's Strategic Initiative #3 that focuses on trauma and justice encourages a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, human services, and related systems, with the intent to reduce both the observable and less visible harmful effects of trauma and violence on children and youth, adults, families, and communities.

DHCS has incorporated trauma-informed approaches into treatment services. For example, the Office of Women's, Perinatal and Youth Services creates and distributes customized technical assistance resource packets with materials on a variety of topics, including trauma. DHCS has also contracted with a cultural competency training organization to provide trauma-informed, culturally and linguistically appropriate training and technical assistance to county entities and providers.

Recent state legislation allows individuals in custody to be enrolled in Medi-Cal prior to their release (AB 720, Statutes of 2013, Chapter 646, added Penal Code §4011.11, and amended Welfare and Institutions Code §14011.10). AB 720 took effect January 1, 2014.

DHCS previously collaborated with drug courts in the effort to divert those needing SUD treatment out of the correctional system and into treatment. However, drug court funding has disappeared leaving a void in the system and a pause in DHCS' collaboration with corrections staff.

DHCS-SUD is now collaborating with the **California Board of State and Community Corrections (BSCC)**, established in 2012, to be included in their work involving stakeholders in the corrections industry.[20] The BSCC is an independent statutory agency that provides leadership to the adult and juvenile criminal justice systems, expertise on Public Safety Realignment issues, and a data and information clearinghouse strengthening the Board's ability to provide technical assistance on a wide range of community correctional issues. (Penal Code sec. 6024–6025). BSCC will implement the mandates of Proposition 47, the California ballot initiative reducing penalties for some crimes.[21] The BSCC routes Proposition 47 savings from reduced penalties to substance use and mental health treatment, among other initiatives.

Strategic Initiative #4: Recovery Support

Strategic Initiative #4 aims to encourage and promote partnering with people in recovery from SUD and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social support in their chosen communities.

Activities such as a having a safe home or meaningful job, attending school, volunteering, family caretaking, or

17 The Mental Health Parity and Addiction Equity Act of 2008 requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH-SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. See http://www.dol.gov/ebsa/mentalhealthparity/ for more information.

18 http://www.dhcs.ca.gov/formsandpubs/laws/Documents/13-035_ACA_Alt_Benef_Plan.pdf

19 http://www.dhcs.ca.gov/formsandpubs/laws/Pages/13-038.aspx

20 http://www.bscc.ca.gov/m_programs&services.php

21 http://ballotpedia.org/California_Proposition_47,_Reduced_Penalties_for_Some_Crimes_Initiative_(2014)

pursuing creative endeavors—and the independence, income, and resources they bring—are necessary for people to fully participate in communities. People need relationships supporting their recovery and social networks, such as family and friends, that provide positive reinforcement, friendship, love, and hope.

Health Home Initiative

The Medicaid Health Home State Plan Option, authorized under ACA Section 2703, allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based **long-term services and supports (LTSS)** needed by clients with chronic conditions. Assembly Bill 361 (AB 361) was enacted in 2013 and authorized California to submit a Section 2703 application, subject to several conditions, including cost neutrality and an evaluation after the first two years.

Through a complementary planning process, the **California State Innovation Model (CalSIM)** initiative developed a recommendation to create **"Health Homes for Patients with Complex Needs" (HHPCN)**. In collaboration with the CalSIM initiative and with respect to the requirements of Section 2703 and California's AB 361, the state has developed a set of policy goals that will guide the planning and implementation of the HHPCN. Medi-Cal intends to submit a Section 2703 SPA application in summer/fall of 2015, which would provide federal regulatory authority for implementing the HHPCN model for Medicaid beneficiaries.

DMC-ODS 1115 Waiver

The 1115 DMC-Organized Delivery System Demonstration Waiver will allow California's SUD treatment system to provide a more robust continuum of care, enable more local control and accountability, provide greater administrative oversight, create utilization controls to improve care and efficient use of resources, implement evidenced based practices in substance abuse treatment, and coordinate with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. Implementation of the waiver provisions is anticipated to help increase the behavioral health of those in the SUD treatment services system.

Strategic Initiative #5: Health Information Technology (HIT)

The adoption of HIT potentially will improve measurement and tracking of health disparities and, ultimately, reduce them. Strategic Initiative #5 places focus on California's efforts to promote technological development, increase use of health electronic records, enhance security and capacity, and promote broad dissemination of technology. There are several efforts under way within DHCS related not only to implementation of the ACA and the Health Information Technology for Clinical and Electronic Health, but also to comply with CMS requirements. These efforts include, but are not limited to, the Medicaid Information Technology Architecture effort and the implementation of ICD-10 in Medi-Cal billing systems.

In addition, there are efforts in the very early stages underway to identify ways to develop comprehensive behavioral health data systems. These efforts involve collaboration between the DHCS Mental Health Services Division and the **Substance Use Disorder-Prevention, Treatment, and Recovery Services Division (SUD-PTRSD)**. The long-term goal of such efforts is to develop technologies and standards to enable coordinated, integrated mental health and SUD data that can also be connected with other DHCS data sources for Medi-Cal.

All of the SUD data systems are in need of modifications or upgrades. DHCS SUD-PTRSD needs increased federal funding for ongoing system sustainability to leverage ongoing IT change management and system maintenance and for migrating SUD systems from **Information Technology Web Service (ITWS)** to DHCS servers. In addition, funding is needed to support development of new IT systems for coordinated, integrated behavioral health data collection.

Strategic Initiative #6: Workforce Development

An adequate supply of a well-trained workforce is the foundation for an effective service delivery system. With the implementation of recent parity and health reform legislation, behavioral health and SUD workforce development issues, which have been of concern for decades, have taken on a greater sense of urgency. The behavioral health and SUD recovery needs of minority communities have been historically and disproportionately under served. More trained providers must become sensitive to cultural issues, and become equipped with the necessary language skills that facilitate and promote effective service delivery.

DHCS set out nine workforce goals, consistent with research and reports from various sectors and stakeholder groups. These include increasing the pool of SUD treatment professionals who are better trained, and able to work in a variety of healthcare settings, and

responsive to a diverse population. Electronic Health Records technology must be adopted in order to make the workforce efficient.

An assessment of the current SUD workforce in California was consistent with the nationwide workforce demographics. Of concern is that the SUD workforce is not representative of the diversity of beneficiaries seeking treatment. The demographics of clinical directors and direct care staff members should expand to include those of diverse cultural backgrounds to better reflect the clients served. DHCS has created core competency curricula for prevention professionals. Webinars are offered through the **Community Prevention Initiative (CPI)** technical assistance project. CPI hosts a website that contains resources for prevention professionals.[22]

The DMC-ODS waiver expands the workforce to include Licensed Practitioner of the Healing Arts which includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, and Licensed Marriage and Family Therapists and licensed eligible practitioners working under the supervision of licensed clinicians. The **American Society of Addiction Medicine (ASAM)** has provided training on ASAM criteria to the California Behavioral Health Directors Association and DHCS. The 1115 Waiver will require ASAM to be used to place beneficiaries in the appropriate level of care. Training in ASAM for the SUD workforce will be a priority.

Ten certifying organizations were originally approved in regulations to register and certify individuals providing SUD counseling in California's licensed and/or certified SUD facilities. These certifying organizations ensured the minimum regulatory requirements were met and maintained by the counselor while also adhering to regulatory stipulations in order for their organization to remain approved by the State. To date, only three certifying organizations remain.

In 2014, AB 2374 was passed which granted DHCS the statutory authority to audit and sanction the certifying organizations for misconduct. The regulations package for DHCS' authority is currently in process and must be promulgated by December 31, 2017.

In 2014, DHCS developed and implemented a comprehensive SBIRT training program, using a broad array of strategies directed at individuals previously not identified to be in need of alcohol abuse treatment. The DHCS program strategy includes providing free SBIRT trainings across the state, in collaboration with the UCLA-ISAP.

To facilitate efforts to address high-level workforce development priorities in the future, funding will be needed for IT development of a robust credentialing system, staff training and development, integration of behavioral health and primary care, and the expansion of workforce capacity.

22 http://ca-cpi.org/about/

INTRODUCTION TO THE PLAN

The 2015 DHCS **statewide needs assessment and planning (SNAP)** report for **substance use disorders (SUD)** highlights a serious, complex, and multi-faceted problem: Californians with SUD. Part 1 of the SNAP report contains a needs assessment, summarizing statewide patterns of SUD, their harmful consequences, and a description of current SUD prevention and treatment activities and strategies.[1] The purpose of this needs assessment is, in part, to review the strengths and weaknesses in our current publicly-funded SUD treatment system. A gap analysis (comparison of actual performance with potential or desired performance) is also concurrently conducted and integrated into Part 1 to compare current prevention and treatment service activities to ideal performances.

This SNAP reports lays the groundwork for the reader to explore SUD recovery work and services, identify best practices, and design healthier approaches to improve and expand them. The SNAP report also informs publicly-funded program planners how to intentionally allocate resources and services around needs related to geographic areas and special populations.

The authors of this report have used accepted and reliable research methods to compile and make meaning out of relevant data collected internally. External research, including social indicator studies and household surveys, are also reviewed to draw a more accurate picture of the state's current needs, challenges, and barriers to providing best practices services to those requiring SUD treatment. From this assessment, the reader is encouraged to discover strategies to improve work done in this field.

Part 1 of the SNAP meets the state reporting requirements under 42 U.S. Code §300x-29 and 45 CFR §96.133, which govern the responsibilities of recipients of the SAPT BG. Throughout Part I, federal regulation references to 45 CFR §96.133 (a)(1)(2)(5)(6), are made to the required statewide needs assessment and gap analysis reporting requirements. Part 1 references to 45 CFR §96.133(a)(3–4) contain California's strategic plan for future service improvement and the state's technical assistance requests, as informed by the results of the needs assessment.

1 This SNAP report assumes that SUD is a chronic, lifelong condition and that recovery-oriented systems of care must support individuals across their lifespan, ideally in an environment integrating physical, mental, and SUD health services into a holistic system.

STATE INCIDENCE AND PREVALENCE OF DRUG AND ALCOHOL USE

Section §96.133(a)(1) of this report explores and finds meaning in data reported in four main areas that contain important and current SUD statistics concerning the prevalence and incidence of substance use:

- SUD-related consumption;
- SUD-related health consequences;
- SUD-related motor vehicle incidents; and,
- Criminal justice SUD-related arrests.

Mining and interpreting data from these four areas facilitates a comprehensive and accurate understanding of the incidence and prevalence of drug use, alcohol use, and alcoholism in California.[1] In addition, the conclusions drawn from this data point out statewide trends emerging in the population with SUD, which in turn allow for better targeting and improvement of future recovery services in the SUD treatment service delivery system.

The needs assessment data in this section generally includes the most current information available. Depending upon the source, data may cross over time spans. For example, sections of this report may compare data from the most recent calendar years available, versus data gathered from state fiscal year.

In preparing the SNAP report, DHCS-SUD researchers made the best effort to be transparent about the weaknesses and biases in the data from which conclusions are reached. By critically reviewing data reliability and strength, the state is mindful that it must work to develop strategies to strengthen data reliability in the future. These improvement strategies are outlined throughout the strategic initiatives articulated in Part 2 of this report, along with requests for federal technical assistance to leverage systems strengthening data reporting. Only by following an improvement cycle process can future needs assessments become more accurate, complete, and meaningful.[2]

1 "Incidence" refers to the number of new cases that emerge within a given period of time. "Prevalence" refers to the total number of cases at any given moment in time.
2 See also, Part 2: Strategic Initiative #5 for a detailed description of the data weaknesses, biases, and plans to strengthen reporting or collection efforts.

THE NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH)

The following estimates from the NSDUH are regarded as conservative based on a household sample, since it excludes some populations (e.g., homeless, incarcerated) who likely use drugs or alcohol at higher levels than those living in the household population. NSDUH only provides incidence rates for marijuana, so the discussion regarding all other drugs and alcohol will be limited to prevalence.

Substance Use Prevalence and Incidence

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** recently published CY 2012–13 state NSDUH estimates of past month substance use in adults and youth aged 12 and older (SAMHSA, 2014a).[3] In order to generate accurate state-level estimates, two years of NSDUH data are combined by SAMHSA for reporting. Therefore, in SAMHSA's recent report, CY 2012–13 data is compared with CY 2011–12 data to examine changes over time. Similar estimates previously published for CY 2009–10 (SAMHSA, 2014b) will also be discussed, where relevant, to examine recent changes within an expanded context.[4] State-level CY 2012–13 data was not available for online analyses, so this section is limited to discussion of the results in tables and reports published by SAMHSA as of January 2015.

Binge Drinking

Binge alcohol use is defined as drinking five or more drinks on the same occasion. Binge drinking in the past month is reported by over one-fifth of all individuals aged 12 and older during CY 2012–13 (21.2% in California, and 22.9% in the U.S.). The 18–25 age group had the highest percentage of binge drinking episodes (35.7% in California, and 38.7% in the U.S.). In California, the percentages of binge drinking occurrences for both age groups were approximately the same as the CY 2011–2012 percentages.

3 Substance Abuse and Mental Health Services Administration (2014a). 2012–2013 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) .Available at: http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/Tables/NSDUHsaeExcelTabs2013.xlsx
4 Substance Abuse and Mental Health Services Administration (2014b). National Survey on Drug Use and Health: Comparison of 2011–2012 and 2012–2013 Model-Based Prevalence Estimates. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.pdf

Illicit Drug Use

Illicit drugs included under this category include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription-type drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives) used non-medically. Although past month illicit drug use increased nationally between CY 2011–12 and CY 2012–13 (9.0% to 9.3%, p=<.05),[5] in California there was no statistically significant change in use (11.0% to 11.2%, p=.66) during the same period.[6] There was also no significant change in either state or national illicit drug use (when excluding marijuana). However, illicit drug use in California remained higher than the national percentage (11.2% vs. 9.3%, p<.05).[7]

Marijuana Use

Past month marijuana use mirrored the trends found in overall illicit drug use. There was no significant change in marijuana past month usage in California between CY 2011–12 and CY 2012–13 (9.1% vs. 8.9%, p=.70), even as use increased nationally (7.1% vs. 7.4%, p=<.05). Still, the percentage of those who reported using marijuana in the past month in CY 2012–2013 remained significantly higher in California than it did nationally (8.9% vs. 7.4%, p<.05).

Across all age groups, there was no significant reduction in first use of marijuana in California (2.3% vs. 2.1%, p=.12), or nationally (1.9% vs. 1.9%, p=0.92) in CY 2012–13. There was, however, a significant decrease in incidence of first use in California among the 12–17 age group (6.8% vs. 6.0%, p=<0.01). Nationally, a downward national trend was also apparent for this age group, but was not statistically significant (6.0% vs.5.8%, p=0.10).

Interestingly, the incidence decline was not tied to individual perceptions of great risk or the hazards of smoking marijuana once a month. Perceptions of risk decreased, both in California (30.2% to 28.3%, p=<.01) and nationally (31.4% to 29.5%, p<.001). In California, this declining view of risk occurred mainly in the 18 and older age group (31.1% vs 29.2%, p=.01). In the 12–17 age group, where marijuana use incidence declined significantly, there was actually a non-significant trend toward decreasing perceptions of risk (22.1% vs. 21.0%, p=.19). This suggests that youth in the 12–17 age group are avoiding marijuana for reasons other than perceptions of great risk.

Other Illicit Drugs

The review of NSDUH data covering CY 2011–2012 and CY 2012–2013 California data revealed no significant overall changes in use of other illicit drugs, including cocaine or non-medical use of pain relievers. The same flat data trends were true nationally for pain relievers.

Age Group Differences

Positive news was found in the data related to the 12–17 age group, as there were significant decreases in children and teen substance use in California.

For example:

- Past month alcohol use (13.1% to 11.6%, p=.029)
- Past year alcohol dependence or abuse (4.2% to 3.1%, p=.002)
- Past month illicit drug use (11.2% to 9.8%, p=.023)
- Past year illicit drug dependence or abuse (5.4% to 4.2%, p=.006)
- Past year cocaine use (1.1% to 0.8%, p=.038)
- Past month cigarette use (5.4% to 4.3%, p=.003)[8]

It is important to note that while “significant” statistical use decreases were found among children aged 12–17, “significance” here means that the differences between years are unlikely to be due to chance, not that they are necessarily substantial. While the decreases are relatively small, they suggest SUD prevention activities may be making an impact. However, many children are still starting to use drugs, indicating that more and improved prevention service efforts are needed. There

5 National numbers include California, so differences between our state and all other states are actually larger, as inclusion of California’s data in the total pulls the national numbers toward California’s. P-values were not reported for the California, and total U.S. comparisons, but significance can be conservatively inferred from the confidence intervals reported (SAMHSA, 2014b). If 95% confidence intervals for California and the U.S. do not overlap, then the two numbers are significantly different. This is a conservative interpretive method based on the statistics available. However, confidence intervals can overlap even if the numbers are significantly different. As a result, state-national differences reported here are clearly significant, but other differences may also exist that are not discussed herein.

6 A “p-value”, in this context, is the certainty that the difference between the percentages discussed is observed by pure chance. A p-value of 0.05 means that there is a 5% chance that the difference between the percentages in this survey sample doesn't actually exist in the population and a 95% chance that it does. Said differently, in this example, a p-value of 0.05 means a 95% certainty exists that the results were not due to chance.

7 Due to differences in available data, exact “p” values will be reported where available in the source report, but cutoffs (e.g. p<.05) are reported where exact “p” values are not available.

8 An unknown portion of this reduction may be due to the increase in e-cigarette use. For example, the number of never-smoking youth that used e-cigarettes was 263,000 in 2013. Bunnell, R.E., Agaku I.T., Arrazola, R.A., Apelberg B.J., Caraballo, R.S., Corey, C.G., Coleman, B.N., Dube, S.R., & King, B.A. (2015). Intentions to Smoke Cigarettes Among Never-Smoking US Middle and High School Electronic Cigarette Users: National Youth Tobacco Survey, 2011–2013. Nicotine and Tobacco Research, 17(2):228–35. doi: 10.1093/ntr/ntu166. The NSDUH survey did not define cigarettes; therefore participants may have omitted e-cigarettes in their reporting. Nevertheless, California remains substantially lower than the rest of the nation in tobacco use (19.05% vs 26.10%).

were no significant recent decreases in SUD in California among other age groups on these measures.There was a significant increase in illicit drug use other than marijuana among the California's aged 26 and older age group (2.7% to 3.4%, p=.021). The same was true nationally (2.5% to 2.8%, p=.024).

There was a "marginally" significant trend toward higher use of non-prescription pain relievers in the past year among those aged 18 and older in California (4.7% to 5.2%, p=.06), but not nationally (4.5% to 4.5%, p=.91).

Gender

Research shows that while males and females may start out drinking in similar rates, males end up with higher drinking rates later in life and have higher illicit drug use patterns throughout life. This pattern may indicate that prevention efforts need to include a special focus on males who experiment and abuse drugs more at later stages in life.

The following national information from the NSDUH 2013 report (not California specific data) supports the conclusion that while both sexes start out with similar drinking rates (based on past month data), male drinking becomes more prevalent as they age. In 2013, an estimated 57.1% of males aged 12 or older were current drinkers, while the rate for females was 47.5%. However, among youths aged 12–17, the percentage of males who were current drinkers (11.2%) was similar to the rate for females (11.9%). The rates for males and females aged 12–17 were lower than those reported in 2012 (12.6% and 13.2%, respectively).

Among young adults aged 18–25, an estimated 62.3% of males and 56.9% of females were current drinkers in 2013. In this age group, 44.4% of males and 31.4% of females reported binge drinking in 2013. In 2013, the rate of binge drinking among females aged 18–25 was lower than the rate reported in 2012 (33.2%). The rate of binge drinking in 2013 among males in this age group was similar to the rate in 2012 (45.8%).

Among individuals aged 26 or older, an estimated 62.2% of males and 50.1% of females reported current drinking in 2013. In this age group, the frequency of binge drinking for males was more than twice the rate for females (30.7% vs.14.7%).

NSDUH 2013 data also shows that illicit drug use is higher for males. In 2013, as in prior years, the rate of current illicit drug use among individuals aged 12 or older was higher for males (11.5%) than females (7.3%). Males were more likely to be current users of several different illicit drugs, including marijuana (9.7% vs. 5.6%, respectively), cocaine (0.8% vs. 0.4%, respectively), and hallucinogens (0.7% vs. 0.3%, respectively). In 2013, the rate of current illicit drug use was higher for males than females aged 12– 17 (9.6% vs. 8.0%, respectively). This represents a change from 2012 when the rates of current illicit drug use were similar among males and females aged 12-17 (9.6% and 9.5%, respectively), and reflects a decrease in the rate of current illicit drug use among females from 2012 to 2013.

Likewise, in 2013, the rate of current marijuana use was higher for males than females aged 12–17 (7.9% vs. 6.2%, respectively), which is a change from 2012 when the rates of current marijuana use for males and females were similar (7.5% and 7.0%, respectively). The rate decreased from 2011 to 2012 (7.5%) and remained stable in 2013 (7.9%). Among females aged 12–17, the rate of current marijuana use decreased from 7.2% in 2002 and 2003 to 6.2% in 2013.

SUBSTANCE USE ESTIMATES FROM THE CALIFORNIA HEALTHY KIDS SURVEY (CHKS)

The following review of the CHKS survey data provides estimates gathered from this statewide survey of youth patterns tracking current substance use in the past 30 days. CHKS is a large statewide survey generally used by service providers and educators as a powerful tool to help identify strengths, weaknesses, needs, resiliency, protective factors, and risky behaviors occurring in California children including grades 7, 9, and 11. The data presented below are drawn from the 2011–2013 CHKS combined sample of over 39,000 secondary school students.[9] The survey results help guide statewide efforts to improve school climates, increase availability of learning supports, and engage students in healthier lifestyle behaviors. CHKS helps those working with children and adolescents to identify and increase the quality of health, prevention, and youth development programs.

In the 2011–2013 CHKS report, alcohol use in the past 30 days was reported by 11% of seventh graders, 20% of ninth graders, and 33% of eleventh graders. Binge drinking (five drinks or more on the same occasion) among youth was a fairly common practice, occurring among 11% of ninth graders and 22% of eleventh graders.

Marijuana use in the past 30 days was reported as the second most frequently consumed substance by youth, with 15% of ninth graders and 24% of eleventh graders reported consuming marijuana in the last month.

9 http://chks.wested.org/resources/Secondary_State_1113Main.pdf

CHKS uncovered patterns showing that substance use is far more prevalent among high school students who also smoke tobacco. The ninth grade comparisons were:

- 9% of non-smokers were binge drinkers compared with 64% of smokers;
- The rate of marijuana use among non-smokers was 10% versus 71% of smokers;
- Cocaine use among non-smokers was 1%, while 24% of smokers used the drug;
- Methamphetamine/amphetamine use among non-smokers was 1%, while the rate of use by smokers was 22%. Use of Ecstasy/LSD/other psychedelics non-smokers was 2% versus 34% of smokers.[10]

The 11th grade comparisons between the smoking and non-smoking populations were:

- 15% of non-smokers reported binge drinking, while 68% of smokers did so;
- Marijuana use among non-smokers was 14% compared with 69% of smokers;
- Non-smoker use of cocaine was 1%, compared with 20% among smokers;
- Non-smoker methamphetamine/amphetamine use was 1%, compared with 16% of smokers;
- Non-smoker use of Ecstasy/LSD/other psychedelics was 2%, compared with 30% of smokers.

CALIFORNIA BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

BRFSS is funded by the U.S. Centers for Disease Control and Prevention, and is the world's largest ongoing telephone health survey system.[11] The survey was developed in the early 1980s in response to scientific research clearly showing that personal health behaviors play a major role in premature morbidity and mortality. Although national estimates of health risk behaviors among U.S. adult populations had previously been obtained through surveys conducted by the National Center for Health Statistics, these data were not available on a state-specific basis. Therefore, the BRFSS was developed to enable state health agencies to better capture and interpret data and target resources to reduce behavioral risks and their consequent illnesses. National data may not be applicable to the conditions found in any given state; however, achieving national health goals through monitoring data and targeting behavioral change interventions requires state and local agency participation to help inform and facilitate efforts to improve life-span health and longevity. The basic philosophy of the survey is to collect data with a specific focus on actual behaviors related to disease and injury rather than surveying attitudes or knowledge. Understanding a population's actions and habits is instrumental in facilitating efforts to plan, initiate, support, and evaluate health promotion and disease prevention programs.[12]

The BRFSS includes the Cell Phone Survey. By including cell phones in the survey, BRFSS is able to reach segments of the population that were previously inaccessible—those who have a cell phone but not a landline—and results are produced giving a more representative sample and higher quality data. Cell Phone Surveys were included in the Public release data set beginning in 2011.[13]

The BRFSS survey is conducted by the California Department of Public Health and the Public Health Institute. The emphasis of the survey is on health-related behaviors in the California adult population, with a specific focus on behaviors related to disease and injury. The annual sample size for this survey is approximately 5,000 interviews.

Prevalence estimates from the 2013 BRFSS show that the percentage of heavy drinkers (adult men having more than two drinks per day and adult women having more than one drink per day in the past month) was higher in California (6.4%) than the nation (6.2%). In California, individuals aged 65 years or older, women, and non-Hispanic Whites have higher rates of heavy drinking than the nation.

The percentage of binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion in the past month) was also higher in California (17.4%) than the nation (16.8%), and among individuals aged 65 or older, males, and non-Hispanic Whites.

10 See CHKS 2009–2011 at: http://chks.wested.org/resources/Secondary_State_0911_Tobacco.pdf
11 http://www.cdc.gov/BRFSS/

12 States can use BRFSS to address urgent and emerging health issues. For example, during the 2004–2005 flu seasons, the BRFSS was used to monitor the influenza vaccine shortage.
13 In 2011, a new weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that had been used with previous BRFSS data sets. In addition to age, gender, and race/ethnicity, raking permits more demographic variables to be included in weighting such as education attainment, marital status, tenure (property ownership), and telephone ownership. Details on this methodology are provided in the June 8, 2012 issue of the Morbidity and Mortality Weekly Report, which highlights weighting effects on trend lines - http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html

MATERNAL INFANT HEALTH ASSESSMENT(MIHA)

MIHA is an annual statewide-representative survey of women with a recent live birth in California.[14] MIHA collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during, and shortly after pregnancy, The information collected includes health status, attitudes and health behavior (including alcohol use), knowledge, and experiences before, during, and shortly after pregnancy. These data can be used to guide public health programs and services to improve the health of mothers and infants in California. The MIHA survey is modeled on the **Centers for Disease Control and Prevention's (CDC)**, Pregnancy Risk Assessment Monitoring System survey.

The DHCS-SUD Office of Women's, Perinatal, and Youth Programs, in collaboration with the Office of Applied Research and Analysis, uses data from the MIHA to assess the needs of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward goals that improve the health of mothers and infants.

The following data are drawn from the 2012 survey of nearly 7,000 women who recently gave birth to a live infant in California (see Figure 1).[15] In 2012, almost 21% of women reported drinking alcohol during their first or third trimester of pregnancy. Among the specified age groups, women aged 35 or older had the largest percentage (23.4%) consuming any alcohol. Among the race/ethnic groups, non-Hispanic White women reported the highest percentage (32.7%); Non-Hispanic Asian/Pacific Islander women reported the lowest percentage (11.7%).

Almost 14% of the women surveyed reported binge drinking in the three-month period before pregnancy. Women aged 20–34 had the largest percentage of prior binge drinking alcohol use (14.8%). Non-Hispanic White women reported the highest percentage (19.8%), and again, Asian/Pacific Islander women reported the lowest percentage (8.5%).

Fig 1: Percent of Women Who Report Binge Drinking 3 Months Before Pregnancy, or Use Alcohol during the 1st or 3rd Trimester of Pregnancy by Age, Race/Ethnicity, California, FY 2012

Maternal Age	Binge Drinking	Any Alcohol User
15-19	10.0%	15.5%
20-34	14.8%	20.7%
35 & older	11.9%	23.4%
Race/Ethnicity	**Binge Drinking**	**Any Alcohol User**
Hispanic	12.8%	15.7%
African American	9.8%	27.2%
White	19.8%	32.7%
Asian/ Pacific Islander	8.5%	11.7%
Other[a]	N/A	N/A
Total[b]	13.9%	20.9%

a Estimates not provided for "Other" Race. "Other" Race refers to all individuals identifying as one of the remaining race definitions adopted by the Office of Management and Budget (2008).
b Total includes records with missing race/ethnicity.
Source: Maternal Infant Health Assessment, FY 2012-13

SUBSTANCE USE DISORDER-RELATED HEALTH CONSEQUENCES

SUD-PTRSD of DHCS, in partnership with the Safe and Active Communities Branch of the California Department of Public Health, analyzes administrative data on deaths, hospital discharges, and **emergency department (ED)** encounters to track the numbers and rates of SUD-related health consequences. Currently, data strongly indicates that there is an increased need statewide for prevention, education, and provider training in opioid use and overdose avoidance. The data relied upon is compiled from multiple sources, as explained in detail in **Appendix A: Data Sources for Part I: Statewide Needs Assessment (a)(1)E. Substance Use Disorder-Related Health Consequences**.

Deaths

The rate of SUD-related deaths in California has been relatively stable over the past few years. Alcohol-related death rates were consistently higher than all other drug-related death rates. In 2012, the rate of alcohol-related deaths was 11.6 per 100,000 population. For all other drugs, the death rate was 10.5 per 100,000 population.

Among the deaths in 2012 where drugs were a contributing cause, those using any type of opioid (i.e. including opioid pharmaceuticals, heroin, and illicit

14 http://www.cdph.ca.gov/data/surveys/MIHA/Pages/MaternalandInfantHealthAssessment%28MIHA%29survey.aspx. MIHA is a collaborative effort of the Maternal, Child and Adolescent Health and the Women, Infant and Children Programs of the California Department of Public Health and the Center on Social Disparities in Health at the University of California, San Francisco

15 Table Source: Maternal Infant Health Assessment. Snapshot, 2012. Data obtained by online query: http://www.cdph.ca.gov/miha and prepared by the Office of Applied Research and Analysis, Substance Use Disorders Prevention, Treatment, and Recovery Services Division, DHCS.

narcotics[16]) had the highest fatality rate (4.4 per 100,000), followed by amphetamines (2.0 per 100,000), sedatives (1.4 per 100,000), and cocaine (0.6 per 100,000).

Hospitalizations

As with deaths, the rates of hospitalizations for alcohol and other drug-related health consequences in California have been relatively stable. The rates of alcohol-related hospitalizations are consistently higher than the rates of other drug-related hospitalizations. In 2013, the rate of alcohol-related hospitalizations was 85.0 per 100,000, compared with 56.8 per 100,000 for other drugs. Specifically, opioid-related hospitalizations had the highest rate (17.4 per 100,000), followed by sedatives (11.9 per 100,000), and amphetamines (2.1 per 100,000). It should be observed and addressed in future public health efforts that according to the federal government the high rate of opioid prescriptions poses an increasing threat of death or illness from drug overdoses and birth defects.[17]

Emergency Department Visits

As with deaths and hospitalizations, the rate of alcohol-related ED visits in California is higher than the rate of other drug-related ED visits. In fact, the rate of alcohol-related ED visits is more than twice as high as the rate of other drug-related ED visits (290.4 vs. 129.8 per 100,000 in 2013, respectively). Unlike the rates of deaths and hospitalizations, the rates of SUD-related ED visits have steadily increased over the past several years. Specifically in 2013, amphetamine-related ED visits had the highest rate at 27.3 per 100,000 population, closely followed by opioids (26.8 per 100,000), and sedatives (20.1 per 100,000). Of note, the rate of amphetamine-related ED visits had the greatest percentage point increase (5.1) from 2012 to 2013.

16 The term "illicit drugs" is commonly used to describe drugs which are under international control (and which may or may not have licit medical purposes) but which are produced, trafficked and/or consumed illicitly.

17 http://www.cdc.gov/media/releases/2015/p0122-pregnancy-opioids.html (stating that nearly one-third of women of reproductive age had had an opioid pain killer prescription filled every year from 2006 to 2012 and that experts fear the practice carried considerable risks for birth defects.) Accessed on April 14, 2015. See: http://www.nytimes.com/2015/01/13/us/after-stabilizing-overdose-deaths-rose-in-2013-.html (after stabilizing, overdose deaths rose in the U.S. in 2013, reversing progress made in 2012. A 39 percent jump in heroin deaths in 2013 continued increases for that drug for the third consecutive year. (Accessed April 14, 2015). See also: DHCS letter to Medi-Cal providers, dated March 11, 2014 stating that public health in California and across the U.S. is threatened by drug overdoses which now outnumber motor vehicle accidents as the leading cause of injury related mortality. The vast majority of these overdoses involve prescription opioids.
http://files.medi-cal.ca.gov/pubsdoco/BULLETINS/docs/Letter_22470.1.pdf
and http://www.cdc.gov/drugoverdose/index.html retrieved on March 14, 2015.

OTHER SUD HEALTH CONSEQUENCES

Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)

Over 220,000 HIV/AIDS cases were reported in California through June 30, 2014. Of those cases, 8.8% identified **injection drug use (IDU)** as the exposure category. Another 8.8 % identified Men who have Sex with Men/ Bisexual Male & IDU as the exposure category. Thus, nearly 18% of all HIV/AIDS cases were related to injection drug use.

HIV Early Intervention and Services Survey of Block Grant Providers

During 2013–14, federal HIV EIS block grant funding was provided to 51 (counting the merged Sutter and Yuba counties as one) out of 58 California counties. Six counties declined these funds due to minimal need. DHCS distributed at least $7,500 to each participating county. These funds were used to test over 31,000 individuals for HIV and/or hepatitis C. Of the total number of HIV tests, 0.43% individuals were positive.

Hepatitis C

Exposure to hepatitis C now occurs predominantly through sharing needles and/or other injection equipment during injection drug use. In 2011, a total of 33,190 new chronic hepatitis C cases were reported to the California Department of Public Health. This figure represents a rate of 88.3 new cases per 100,000 individuals. The rate of new hepatitis C infections peaked in 2007, when hepatitis C-related laboratory reporting was first mandated, at 137.6 cases per 100,000 individuals. This rate has gradually decreased as the state's hepatitis C registry has become more robust.

Tuberculosis-Intravenous Drug Use

In 2012, there were 2,189 cases of tuberculosis diagnosed in California. Forty two (2%) of those cases were within the IDU population. This is twice the number of IDU cases compared to 2011 (0.9%).

MOTOR VEHICLE INCIDENTS

Substance use contributes to the rate of injuries and deaths resulting from traffic crashes. Therefore, data on motor vehicle collisions and impaired drivers provide a valid indicator of substance use consumption and consequences. The data used in this report comes from two main sources, the **Statewide Integrated Traffic Records System (SWITRS)**[18] and the ***California Survey of Nighttime Weekend Drivers' Alcohol and Drug Use*** from the **Office of Traffic Safety (OTS)**.[19]

18 https://www.chp.ca.gov/programs-services/services-information/switrs-internet-statewide-integrated-traffic-records-system

19 http://www.ots.ca.gov/Media_and_Research/Press_Room/2012/doc/2012_Drug_And_Alcohol_Roadside_Survey.pdf

Statewide Integrated Traffic Records System

SWITRS is operated by the California Highway Patrol in partnership with the California Department of Motor Vehicles. The SWITRS database includes all property damage and injury crashes investigated by police in all California jurisdictions. In the 2012 SWITRS report, the California Highway Patrol reported 1,066 alcohol-involved fatal collisions with 1,169 individuals killed statewide. Additionally, there were 16,615 alcohol-involved injury collisions, with 23,095 individuals injured.

Office of Traffic Safety

In 2012, The OTS conducted the first ***California Roadside Survey of Nighttime Weekend Drivers' Alcohol and Drug Use***. Over 1,300 drivers provided anonymous breath and oral fluid samples for testing. Of those tested for substance use, 14% tested positive for at least one drug. The drug categories tested included marijuana, illegal drugs, and medications. Drivers tested positive for marijuana at the highest rate with a prevalence of 7.4%. Alcohol-positive tests occurred in 7.3% of drivers tested. One percent of these drivers had a blood-alcohol content of .08 or above.

Criminal Justice and Substance Use-Related Arrests

Substance use-related arrests occur when individuals are taken into custody because it is believed they have violated alcohol or other drug laws. Alcohol law violations include, driving-under-the-influence, public drunkenness, and liquor law infractions. Drug law violations include arrests for possession of narcotics (heroin, opium, etc.), marijuana, dangerous drugs (such as barbiturates, phencyclidine, etc.), and other drugs. Although arrest data are only one indicator of the underlying magnitude and nature of the substance use problem, the information gleaned from tracking this data also reflects the level of resources (e.g., funding and building of jails and prisons, corrections personnel costs) and attention (e.g. governmental priority) invested by the public and private sectors to address the wide-ranging consequences from substance use. Resource allocation and spending on these substance use-related arrests are therefore related to the underlying problem of substance abuse itself. For public planning purposes, arrest data provides a snapshot of the negative impact of substance use on the criminal justice system.

The **Monthly Arrest and Citation Register (MACR)** database, kept by the California State Department of Justice, contains information on arrests of juveniles aged 10-17 and adults aged 18 and older throughout the state.[20] In California, the MACR shows that during 2013 there were a total of 471,103 felony and misdemeanor arrests for substance use-related violations (253,082 for alcohol and 218,021 for other drugs). Of this population 459,508 were adults and 11,595 were juveniles. Among adults, 250,783 arrests were for alcohol and 208,725 arrests were for other drugs. Among juveniles, there were 2,299 arrests for alcohol and 9,296 arrests for other drugs. Cumulatively, there were 137,125 felony arrests for other drugs, and 4,830 were for alcohol. There were 248,252 misdemeanor arrests for alcohol and 80,896 misdemeanor arrests for other drugs.

During 2013 in California 471,103 felony and misdemeanor arrests involved alcohol or other drugs out of a total of 1,193,726 total arrests (39.5%). This data highlights the need for collaboration between SUD public policy planners and the criminal justice system, because substance use and driver-related policies appear to be a driver of circumstances leading to individuals being arrested.

SUMMARY INCIDENCE AND PREVALENCE

Meaningful analysis of the current data reported on the statewide incidence and prevalence of SUD provide important insights. The recognizable trends should be taken into account by planners and providers of SUD prevention and treatment services, as the insights gained allows for better targeting of future recovery services.

The NSDUH trends recognized in this report are as follows. The rate of binge drinking over the last month hasn't changed over recent time; 20% of 12 year olds and older still reported engaging in the behavior. Illicit drug use patterns have not changed either, and remain higher in California than nationally (11.17% vs. 9.27%, respectively). There was also no significant change in either state or national illicit drug use when excluding marijuana. SUD is far more prevalent among high school students who also smoke tobacco.

20 The MACR database provides information on felony and misdemeanor level arrests for adults and juveniles and status offenses (e.g., truancy, incorrigibility, running away, and curfew violations) for juveniles. The following data elements are included in this file: race/ethnicity, date of birth, gender, date of arrest, offense level, status of the offense, and law enforcement disposition. MACR data are published in Crime in California, Homicide in California, Juvenile Justice in California, and the Criminal Justice Profile series found at http://oag.ca.gov/cjsc/pubs. The MACR data, in a consistent format, is available from 1979 to the present.

Across age groups, there was no significant reduction in the first use of marijuana in California between 2011–12 and 2012–13 (2.3% vs. 2.1%), or nationally (1.9% vs. 1.9%). There was, however, a significant decrease in incidence of first use in California among the 12-17 age group (6.8% vs. 6.0%). Nationally, it appears there is also a downward national trend for this age group, but it was not statistically significant (6.0% vs. 5.8%). Interestingly, the decline in incidence was not tied to individual perceptions of great risk or the hazards of smoking marijuana once a month. Perceptions of risk decreased both in California (30.2% vs. 28.3%) and nationally (31.4% vs. 29.5%).

Among the 12-17 age group, there were significant decreases in children and teen substance use in California. But, there was also a significant increase in illicit drug use other than marijuana in the California 26 and older age group (2.7% vs. 3.4%). The same was true nationally (2.5% vs. 2.8%).

Approximately 33% of 11th graders used alcohol and 22% reported binge drinking in the last month.

The percentage of heavy drinkers (adult men having more than two drinks per day and adult women having more than one drink per day in the past month) is higher in California (6.4%) than the nation (6.2%), and among women, individuals aged 65 or older, and non-Hispanic Whites. The percentage of binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion in the past month) is also higher in California (17.4%) than the nation (16.8%), and among males, individuals aged 65 or older, and non-Hispanic Whites. In 2012, almost 21% of women reported drinking alcohol during their 1st or 3rd trimester of pregnancy. Non-Hispanic White women had a 32.7% reporting rate, registering as the highest rate by race/ethnicity.

Currently, data strongly indicates that there is an increased need statewide for prevention, education, and provider training in opioid use and overdose avoidance.

Among the deaths in 2012 where drugs were a contributing cause, those using any type of opioid (i.e., including opioid pharmaceuticals, heroin, and illicit narcotics) had the highest fatality rate (4.4 per 100,000), followed by amphetamines (2.0 per 100,000).

The rate of alcohol-related ED visits is more than twice as high as the rate of other drug-related ED visits in 2013 (290.4 versus 129.8 per 100,000, respectively). Unlike the rates of deaths and hospitalizations, the rates of SUD-related ED visits have steadily increased over the past several years. Exposure to hepatitis C now occurs predominantly through sharing needles and/or other injection equipment during injection drug use.

In 2012 the California Highway Patrol reported 1,066 alcohol-involved fatal collisions with 1,169 individuals killed statewide, and 16,615 alcohol-involved injury collisions with 23,095 individuals injured. During 2013, alcohol and other drugs were involved in 39.5% of all the arrests in California.

CURRENT SUBSTANCE USE DISORDER PREVENTION AND TREATMENT ACTIVITIES IN CALIFORNIA

This section of the SNAP report fulfills the legislative mandate of 45 CFR §96.133(a)(2), which requires the state agency receiving SAPT BG monies to describe current statewide SUD prevention, intervention, and treatment activities. The following is a summary of prevention and treatment efforts carried out in California and at DHCS. Strategies discussed specifically take into account each individual's risk factors. DHCS recognizes that the goal of prevention is to use early intervention strategies to reduce the impact of SUD on California's citizens and communities. In addition, DHCS is mindful that the goal of treatment is to increase the probability of positive health outcomes for those with the chronic, lifelong disease. Prevention activities and strategies are addressed in Part 1, followed by a description of treatment activities in Part 2.

A specific breakdown of California's receipt of SAPT BG funds is provided in **Appendix B**: Fiscal Year Award: SAPT Block Grant Funds by fiscal years.

Although 45 CFR § 96.133 (a)(2) requires the state to provide the identities of those who provide the services, and describe the services provided; a detailed description is not possible at this time. Due to an ongoing administrative process at DHCS, de-certification and recertification of a majority of the **Drug Medi-Cal (DMC)** providers is occurring in order to ensure system integrity and elimination of fraud, making the task of specifically identifying and describing service providers unfeasible. Nevertheless, a listing of the number of providers by modality per county is contained in **Appendix C: 2012–2013 County Count of Providers by Modality**.

PREVENTION DATA

Data

The California prevention data collection system used by DHCS is the **California Outcome Measurement System for Prevention (CalOMS Pv)**. This system is designed to help effectively manage and improve the provision of publicly-funded SUD prevention services at the state, county, and provider levels.[1] Prevention services are provided for populations at three levels of risk:

1. Universal for the general public;
2. Selective for sub-populations at higher than average risk for substance abuse; and,
3. Those presenting with indicators for using alcohol or other drugs, or engaging in other high risk behaviors but are not yet defined as in need of treatment.

CalOMS Pv collects data on participants engaged in prevention activities. All prevention services that are funded with SAPT BG funding must be reported to CalOMS Pv. All of the following data is taken from FY 2012–13.

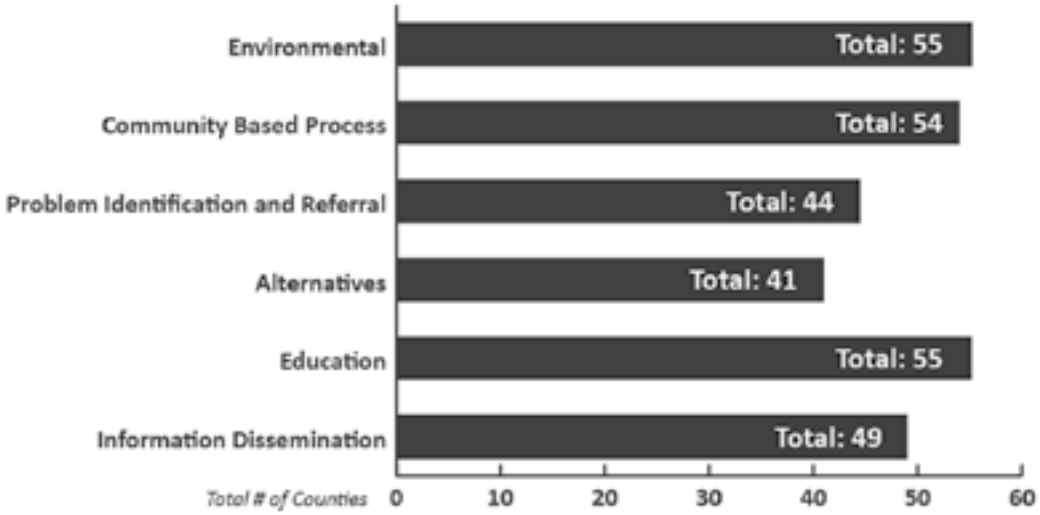
Fifty-four out of fifty-eight counties have a current strategic prevention plan. Twenty-six counties referred individuals for additional services from primary prevention service settings.

A total of twenty-eight counties conducted primary prevention screenings. Screenings were provided by counties in the following settings:

- Emergency Rooms (1 county),
- Other County Offices (4 counties),
- Student Health Centers (7 counties),
- County AOD Offices (9 counties),
- Other Settings (24 counties)

1 See: https://caprev.kithost.net/caprevent2014/psystem.aspx to view DHCS CalOMS Pv data submission web site.

Fig 2: Primary Prevention Service Strategies in FY 2012–13, by County



(Source) DHCS's California Outcome Measurement Service for Prevention

PREVENTION STRATEGIES

The six prevention service strategies, as defined by SAMHSA's **Center for Substance Abuse Prevention (CSAP)**, are Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental. Each of these strategies has multiple related services/activities that are quantifiably reported into CalOMS Pv by counties and prevention service providers (see Fig. 2 on previous page). With the exception of Information Dissemination, five strategies capture demographic data on participants that includes gender, age, and race/ethnicity.

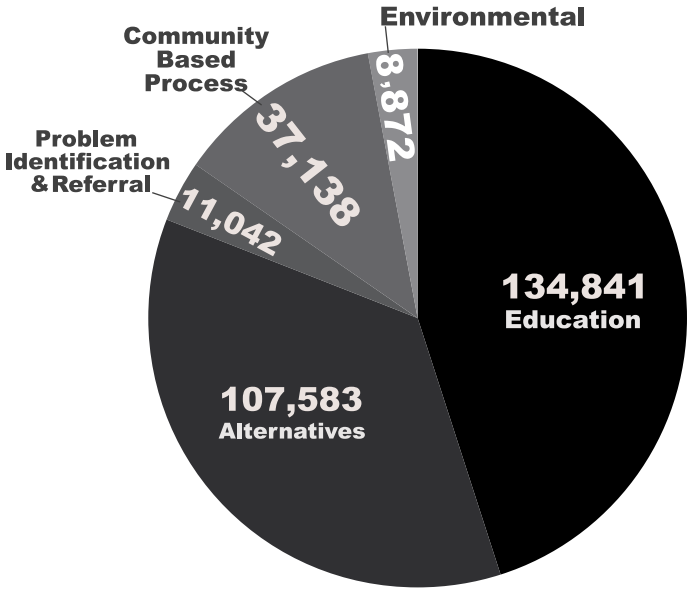
INFORMATION DISSEMINATION

Information Dissemination activities reported into CalOMS Pv include audio and visual material development and dissemination, conference/fair planning and attendance, media campaign development and implementation, resource directory development and dissemination, speaking engagements, and similar multi-media generating activities. Demographic data is available by age groups, race, or gender. In FY 2012–13, the highest totals reported by service frequency activity statewide were as follows (number of individuals served is not captured in these strategy descriptions):

- Printed Materials Disseminated = 6,876
- Printed Materials Developed = 5,118
- Speaking Engagements = 3,378
- Brochures/Pamphlets Disseminated = 3,281
- Health Fair/Promotion Planning = 1,391

Figure 3 displays the total individuals served by each strategy, with the exception of Information Dissemination. Publicly-funded providers reported that 299,476 Californians received some type of SUD prevention service. Education and Alternatives activities are provided to the largest number of prevention recipients, while Environmental activities serve the fewest individuals. Environmental and Community-Based Process strategies capture some individuals-served data, but many activities in these strategies are planning or coordination and occur at an organizational level, rather than involving direct prevention services to individuals, as reflected in the other strategies' data.

Fig 3: Number of Individuals Served by Strategy for FY 2012–13 in California



(Source) DHCS's California Outcome Measurement Service for Prevention

EDUCATION

Prevention service activities reported as Education include SUD prevention classroom and educational services for youth and adult groups, mentoring, parenting and family management services, peer leader and preschool prevention programs, theatre troupes, and children of substance abusers groups. The five activities with the highest number of individuals served were:

- Educational Services for Youth Groups = 50,133
- Classroom Educational Services = 38,609
- Small Group Sessions = 15,268
- Educational Services for Adult Groups = 14,752
- Parenting/Family Management Services = 7,427

ALTERNATIVES

Activities reported within Alternatives in CalOMS Pv include community center activities and operation, substance use-free social events, community service, youth and adult leadership, and Outward Bound. The highest numbers of individuals served through alternative activities are:

- Substance Use-Free Social/Recreational Events = 51,785
- Youth/Adult Leadership Activities = 44,896
- Recreational Activities = 6,930
- Community Service Activities = 2,357
- Community Drop-in Center Activities = 1,457

PROBLEM IDENTIFICATION AND REFERRAL

This strategy contains the fewest types of activities ranging from Alternatives to Violence to Student Assistant Programs.

1. Prevention Screening and Referral Services = 6,881
2. Student Assistance Programs = 3,660

COMMUNITY-BASED PROCESS

This strategy predominantly reflects activities in planning and coordination of prevention services along with technical assistance and training. The community-based process strategy includes serving and providing guidance to individuals who are “Intermediaries” (social workers, beverage servers, policy makers, law enforcement, etc.). The secondary impact on these participants is delivered through later actions of their agencies/services; however the quantity/demographics of these actions are outside the view of a prevention data system and are not captured in CalOMS Pv. The below reflects the three activities that report individuals served.

- Technical Assistance = 21,322
- Training Services = 9,524
- Community/Volunteer Training = 6,292

Not all of the activities under this strategy capture the number of individuals served, as many are indirect services rather than services provided to individuals. The remaining Community-Based Process activities are reported as a count of service types or frequency of occurrence. The most reported activities are as follows:

- Multi-Agency Coordination/Collaboration = 20,439 services
- Systemic Planning = 6,580 services
- Assessing Community Needs/Assets = 5,130 services

ENVIRONMENTAL

As with the Community-Based Process strategy, service frequency is reported for all environmental activities, but not all environmental activities collect data for individuals served. The Compliance Training sub-categories report the most individuals served as follows:

- Compliance: Training – Commercial Host and Management = 2,749
- Compliance: Training – Social Host and Management = 2,291
- Environmental Consultation/Technical Assistance = 1,985

The highest service frequencies reported for this strategy are:

- Media Strategies = 2,248 services
- Policies and Regulations = 1,705 services
- Community Development = 1,381 services
- Efforts with City and/or County Officials = 1,152 services

PREVENTION DEMOGRAPHICS

GENDER

More females than males were served in FY 2012–13 (see Fig. 4). The general population of California contains fewer males than females while individuals self-identifying as "other" is not reported in the larger population by California State Department of Finance demographic sources. However, as mentioned previously there are gender differences that may require future targeted planning efforts.

It is generally known that males end up with SUD more than females as they age. We also know that while males and females may start out drinking in similar rates, males end up with higher drinking rates later in life and have higher illicit drug use patterns throughout life. From the NSDUH 2013 Report, data shows that while both sexes start out with similar drinking rates (past month), male drinking is more prevalent as they age.[2] This observation leads researchers at DHCS-SUD-Prevention to ask: Should California have more prevention focus for males who experiment more with and use drugs later in life?

AGE

Prevention services in California are primarily provided to youth under age 25 (see Fig. 5). Youth aged 12–17 were the largest group of recipients of prevention activities, even though this group makes up only 8.1 percent of California's population. However, the fewest number of individuals served occurred in the 65 and older age group, which makes up 12.6% of the general population. Rates per 1,000 allows for comparison between subgroups and are as follows: there are 6,014,930 individuals aged 0–11 living in California, and for every 1,000 of the general population in that age group, nearly five are participating in some kind of publicly-funded Prevention service activity.

RACE/ETHNICITY

The Race/Ethnicity demographic in CalOMS Pv data is categorized by non-Hispanic White, Asian American, Hispanic/Latino, American Indian/Alaska Native, African American, Multiracial/Ethnic, Hawaiian/Pacific Islander, and Other (see Fig. 6, next page). As displayed in the following tables and charts, Multiracial/Ethnic is combined with Other in CalOMS Pv data. For comparison, the category of Other was used in the California Population data from the California State Department of Finance for 2013.

The following provides a brief summary of all prevention services delivered in FY 2012–13 by race/ethnicity group. To control for the wide variations in the total numbers of each race/ethnic group in the general California population, rates per 1,000 are utilized. This method allows more valid comparisons of the proportions of each group receiving some type of prevention service. The Pacific Islander group received the highest proportion

Fig 4: Individuals Served in FY 2012–13, by Gender

Gender	Persons Served	California Populations*	Rate/1000 Populations
Female	159,727	19,194,857	8.3
Male	137,929	19,007,349	7.3

(SOURCE) DHCS California Outcome Measurement Service for Prevention.

Fig 5: Individuals Served in FY 2012–13, by Age

Age Group	Persons Served	California Population*	Rate/1000 Population	Age Group % of Total CA Population
0-11	28,052	6,014,930	4.7	15.7
12-17	169,846	3,089,930	55.0	8.1
18-25	43,936	4,553,582	9.6	11.9
26-44	35,607	10,081,041	3.5	26.4
45-64	15,141	9,658,364	1.6	25.3
65 and Older	6,887	4,804,159	1.4	12.6

SOURCE) DHCS California Outcome Measurement Service for Prevention.

2 http://www.samhsa.gov/data/sites/default/files/2013MHDetTabs/NSDUH-MHDet-Tabs2013.pdf

Fig 6: Individuals Served in FY 2012–13, by Race/Ethnicity

Race/ Ethnicity	Persons Served	California Population*	Rate/1000 Population	Race/Ethnicity % of Total CA Population
American Indian	2,902	170,198	17.1	0.4
Asian	28,150	4,996,700	5.6	13.1
African American	43,127	2,215,348	19.5	5.8
Hispanic	111,247	14,692,509	7.6	38.5
Pacific Islander	3,363	138,815	24.2	0.4
White	87,971	14,994,349	5.9	39.2
Other/ Multiracial	22,716	994,287	22.8	2.6

(SOURCE) DHCS California Outcome Measurement Service for Prevention.

(24.2 per 1,000) followed by the Other/Multiracial group (22.8 per 1000), the African-American group (19.5 per 1,000), and the American Indian/Alaska Native group (17.1 per 1,000). The race/ethnic groupings receiving the least prevention services as a proportion of their varying population numbers are Asian (5.6 per 1,000), followed by non-Hispanic White (5.9 per 1,000), and Hispanic (7.6 per 1,000) groups.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

Effective January 1, 2014, California began offering the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit to adult Medi-Cal beneficiaries. Provision of the SBIRT benefit implements Affordable Care Act Section 4106, which clarifies that those preventive services, aligned with the U.S. Preventive Services Task Force recommendations, will be offered to all Medi-Cal beneficiaries aged 18 or older in primary care settings. SBIRT is a comprehensive health promotion approach for delivering early intervention and treatment services to adults with, or at risk for, alcohol abuse disorders. For a detailed examination of the DHCS effort to facilitate SBIRT services in California, refer to **Appendix E: Preventive Services – Screening, Brief Intervention and Referral to Treatment.**

TREATMENT AND RECOVERY SERVICES

As previously discussed, DHCS is the Single State Agency responsible for administering the SAPT BG in California. DHCS is responsible for allocating and monitoring the use of SAPT BG funds to all 58 counties, who then oversee the delivery of treatment and prevention programs. SAPT BG funds are used to support county-level services for primary prevention, substance use treatment, HIV early intervention services, services to pregnant and parenting women, and services for adolescents and youth.

All counties receiving grant funding are required to contract with DHCS through the State-County Contract, which outlines the terms pursuant to SAPT BG federal rules, state regulations and safety code, and other delivery requirements. Counties often then enter into agreements with contractors to provide SUD treatment and prevention services.

Additionally, the federal Anti-Drug Abuse Act of 1988 requires that for the fiscal year for which the grant is provided, no less than five percent of the providers receiving federal SAPT BG funds from the state must be reviewed by peers independent from the funding source. This process, otherwise known as the **Independent Peer Review (IPR)** Process, assesses quality, appropriateness, and efficacy of recovery/treatment services. The programs reviewed are chosen to be representative of the total population of such entities. The IPR process focuses solely on the treatment programs and SUD service system, rather than on individual practitioners. The IPR purpose is to inform the state in a manner allowing continuous improvement of client services. For a summary of the full IPR project report, **see Appendix D: Summary of SAPT Block Grant Independent Peer Review Project, 2013–2014**.

COUNTY DATA

The DHCS SUD County Monitoring Unit (CMU) systematically collects treatment data from the counties throughout the fiscal year (FY) to analyze and obtain understanding of various components of the SAPT BG-funded SUD treatment, and recovery service systems. This data is used to create the CMU Annual Report which contains data reported directly from county SUD program administrators and other county staff. This data provides a snapshot of the statewide SUD service system's adequacy, strengths, and weaknesses in specific areas. CMU uses the annual report to inform their work which consists of gathering data and conducting regular site visits to our 58 counties to validate county compliance of the terms and conditions for the Substance Abuse Prevention Treatment (SAPT) Block Grant (BG) through the state-county contract requirements. These visits also serve as an opportunity to discuss the counties' strategies for better understanding and serving their most vulnerable populations, such as pregnant women, youth, minorities and the LGBT population. CMU data is gathered from counties and is reviewed as it presents the best aggregated information about accomplishments across program areas, compliance and programmatic issues, and efforts required for continuous quality improvement. The CMU annual report is an internal document used to guide monitoring of the SAPT BG.

The CMU recognizes that monitoring California's 58 counties is challenging as they vary widely in size, population, demographics, and geography. This creates unique barriers and opportunities in addressing the diversity of issues that arise. The CMU approach, in order to make equivalent comparisons and determine allocations, is to follow the DHCS procedures which group counties by like-size populations. DHCS' allocation system treats counties with populations under 100,000 as Minimum Based Allocation (MBA) counties. Small counties are identified as those that have a population of 100,000 to less than 300,000. Medium counties are identified having a population of 300,000 to 750,000. Large counties are identified as those that have a population greater than 750,000. Additionally, Sutter and Yuba Counties deliver services in partnership; hence data and narrative regarding treatment services in this report is based on 57 county health organizations.

In California, a variety of approaches and practices are used by counties to address the diverse needs of their communities. The data represented in this report is a reflection of administrative and programmatic efforts of the 57 California counties to ensure that public dollars are appropriately used to support SUD programs and services.

ADOLESCENT YOUTH TREATMENT

A full continuum of care should be available to address the varying levels of services needed by youth, and allow for movement back and forth across levels as treatment progresses or regresses. In addition to formal treatment, the continuum of care for youth and their families should include pre-treatment options (mentoring, brief interventions, harm reduction, etc.), relapse prevention (before, during or after formal treatment), and aftercare services.

Youth substance use continues to be a public health issue for society, parents, and young adults. Adolescent years can be a time of experimentation with substances; however, young people who consistently use substances experience an array of issues. These may include academic struggles, health-related problems, distressed relationships, and potential for increased involvement with the juvenile justice system. Because youth differ from adults physiologically and emotionally, it is crucial that treatment be adapted to meet their specific needs.

YOUTH TREATMENT

Substance use among youth is a serious concern nationally and in California. In addition to possible health damage, substance use can have other substantial negative effects on youth and their families. California faces particular challenges in addressing youth substance use.

California's SUD treatment system was established to address adult treatment issues and needs. However, there are critical differences between youth and adult substance use-related problems and strong evidence that even experimental substance use among young people compounds other problems, and can lead to greater levels of substance use, violence, crime, school failure, mental health problems, out-of-home placement, and increased medical care. Comprehensive services, including substance use treatment and recovery support, are needed to address these complex problems.

CHALLENGES FACED BY YOUTH

Behavioral Health Issues: Depression is common among adolescents and is associated with higher prevalence of substance use. According to the NSDUH, in 2013, about 1 in 10 adolescents (10.7%) experienced a **major depressive episode (MDE)** in that year. Also in 2013, 1.4% of adolescents had a co-occurring MDE and SUD. Young females had an even higher rate of MDE prevalence, almost three times the rate for males in the same age group[3].Seven percent of California 9th graders and over 12% of 11th graders reported that substance use caused them mental health-related problems.[4] Depression can lead to academic disruption, social isolation, school avoidance, and even suicide if not addressed. Research indicates that substance use is second to depression/other mood disorders as the most frequent risk factors for suicide,[5] and 70% of youth who make a suicide attempt are frequent substance users.[6] Adolescent females are more likely to have attempted a drug-related suicide than adolescent males,[7] and LGBTQ youth report significantly higher rates of suicidal thoughts than their heterosexual peers (73% versus 53%).[8]

3 Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality (September 4, 2014) The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD
4 Austin, G., Skager, R. 13th Biennial Statewide Survey of California Students in Grades 7, 9, and 11. 2009–2010. WestEd, 2011.
5 Center for Substance Abuse Treatment. Substance Abuse and Suicide Prevention: Evidence and Implications—A White Paper. DHHS Pub. No. SMA-08-4352. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.
6 Suicide Prevention Education Alliance. Adolescent Depression and Substance Abuse. http://www.speaneohio.org/education
7 Substance Abuse and Mental Health Services Administration, Office of Applied Research. Emergency Department Visits for Drug-related Suicide Attempts by Adolescents: 2008. DAWN Report, May 13, 2010.
8 Hyatt, S. Struggling to Survive: Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Homeless Youth on the Streets of California. California Research Bureau, California State Library, http://cahomelessyouth.library.ca.gov/docs/pdf/strugglingtosurvivefinal.pdf

Trauma: Emotional health issues that may not appear on the surface to be trauma-related, such as depression, can be an individual's response to trauma. Additionally, trauma can contribute to substance use, and a large proportion of individuals who use substances are likely to have experienced traumatic stress.[9] Studies in the area of brain development and epidemiology have demonstrated that exposure to childhood trauma, particularly when it is experienced on a chronic level, can have a detrimental impact on children's functioning, including brain development, regulation of emotions, attachment, and cognitive and behavioral functioning. Exposure to multiple traumas has also been linked to academic and behavioral issues in the school setting, including an increased likelihood of failing grades, behavioral problems in school, and risky behaviors such as binge drinking, cigarette smoking, and marijuana use. An awareness of trauma-informed services is useful for treatment providers to prevent or reduce further traumatization and to increase retention of youth in treatment.[10]

Child Welfare: In 2010, children aged 11–20 made up almost half of the more than 58,000 minors in California's child welfare system, with African Americans, Native Americans, and LGBTQ youth over-represented.[11] Children who are in foster care are more likely to have experienced physical or sexual abuse, experienced depression, attempted suicide, used substances, and had fewer regular sources of medical care. Children who have been in foster care have a high rate of homelessness. Nationally, estimates vary (from 13% to 25%) but are generally 20% or greater.[12]

Crime And Violence: The 2003-2004, California Student Survey (CSS) , Tenth Biennial Report, Heavy Alcohol and Drug Use among High School Students Services, found that 20% of 9th grade, high risk users of illicit drugs (HRU) and 15% of HRU of same in 11th grade reported having problems with the police due to their substance use. Similar numbers of alcohol HRU in both grades reported having trouble or problems with the police.[13] Crime, violence, and substance use disrupts the school environment and prevents youth from focusing on academic and social tasks needed for developing into healthy productive adults.

9 The National Child Traumatic Stress Network. (2008). Making the Connection: Trauma and Substance Abuse. Funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. Retrieved July 2008: http://www.nctsnet.org/nctsn_assets/pdfs/SAToolkit_1.pdf.

10 Amaro, Hortensia; Chernoff, Miriam; Brown, Vivian; Arévalo, Sandra; Gatz, Margaret. (2007). Does Integrated Trauma-Informed Substance Abuse Treatment Increase Treatment Retention? Journal of Community Psychology, 35: 7, 845–862.

11 California Adolescent Health Collaborative, http://www.californiateenhealth.org/health-topics/foster-care, February 2014

12 California Research Bureau, Estimating California's Homeless Youth Population. October 2010.

13 The biennial California Student Survey was a joint effort between DHCS, the Attorney General's Office, and the Department of Education that has monitored substance use and other high-risk behaviors in grades 7, 9, and 11 from 1985 to 2010.

Delinquency is the factor most strongly associated with lifetime substance use outcomes among both child-welfare-involved and community youth.[14] Serious and chronic offenders are much more likely than other juvenile offenders to be substance users and to qualify as having SUD.[15] It is estimated that among adolescent offenders, approximately 56% of boys and 40% of girls test positive for drug use,[16] and among California youth involved in the juvenile justice system, approximately 40% to 70% have some mental health disorder or illness.[17]

Academic Failure and School Dropout: The estimated 2010-2011 school year dropout rate in California overall is 25%. High school dropouts in California are overrepresented by African Americans and Native Americans (38% and 30%, respectively, which is higher than the overall rate).[18] There are strong correlations in research among substance abuse, academic failure, and dropout.[19] CSS found that 4.4% of 9th graders and 6.8% of 11th graders reported missing school because of their substance use, but research also shows that when adolescents stop substance use, academic performance improves.

SPECIAL POPULATIONS

College Students: NSDUH national data on college students found that young adults aged 18–22 who were enrolled full time in college were more likely than their peers not enrolled full time (i.e., part-time college students and individuals not currently enrolled in college) to use alcohol in the past month, binge drink, and drink heavily. Among full-time college students in 2013, 59.4% were current drinkers, 39% were binge drinkers, and 12.7% were heavy drinkers, compared to 50.6%, 33.4% and 9.3%, respectively, among their peers. This pattern of higher rates of alcohol use among college students compared to their peers has remained consistent in NSDUH data since 2002. Consequences of college student substance use include unintentional alcohol-related injuries, alcohol-related arrests, rape, and sexual assault.

Military-Connected Youth: Youth in military-connected families (either parent(s) or siblings in the military) experience stressors that may increase the likelihood of using substances. Parental deployment can disrupt family routines, increase distress in the parent remaining home, and increase older children's family responsibilities. Youth who have a sibling in the military are also exposed to stress and uncertainty related to their

14 Fettes, D., Aarons, G., Green A. Higher rates of adolescent substance abuse in child welfare versus community populations in the United States. Journal of Studies on Alcohol and Drugs, November 2013, 74(6); 825–34.

15 US Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Substance Use and Delinquent Behavior Among Serious Adolescent Offenders, Juvenile Justice Bulletin, December 2010

16 Larsen-Rife, D. and Brooks, S. Promoting Positive Placements for Probationers, UC Davis Human Services Northern California Training Academy, Davis, CA. August 2009.

17 Berkeley Center for Criminal Justice. Mental Health Issues in California's Juvenile Justice System, Juvenile Justice Policy Brief Series, May 2010.

18 California School Boards Association (CSBA). California high school graduation and dropout rates, CSBA Fact Sheet, May 2013.

19 DuPont, R..L. et al. America's Dropout Crisis: The Unrecognized Connection to Adolescent Substance Use. Treatment Research Institute, Philadelphia, PA, March 2013.

sibling's deployment as well as shifts in responsibilities. If the sibling is a substance user, the youth may begin or increase use based on the sibling's role-modeling and/or possible increased access to substances. A recent study of data from the CHKS found that military-connected youth have a higher prevalence of substance use than their peers. Recent drug use was higher for those who had a parent in the military, and lifetime use of all substances was highest among youth who had a sibling in the military.[20]

Homeless: In California, homeless youth were most visible in large cities. In 2008–09, runaway/homeless youth shelters and transitional living programs in California reported serving 4,976 unaccompanied youth (through age 21).[21] LGBTQ youth make up approximately 15% to 25% of the homeless youth population.[22] Homeless youth have increased rates of mental health and substance use issues, unemployment, and lower educational attainment.[23]

The CalOMS Tx data variable "living arrangements" classifies clients into one of three groups: homeless, where the client has no permanent residence (e.g., shelters, couch surfing, and living in vehicle); dependent living, where the client lives in a supervised setting (e.g., lives with parents, group homes, foster care); and independent living, where the client is not supervised but lives in a stable environment (e.g., rent or own home, roommates, and contribute to the living costs). The majority of clients under age 18 reported dependent living (90%), less than one-tenth of clients reported independent living (9%), and less than 1% reported homeless as their living arrangement.

20 Gilreath, T. et al., Substance Use Among Military-Connected Youth, The California Health Kids Survey, American Journal of Preventive Medicine 2013; 44(2):150-153.
21 California Homeless Youth Project, California Research Bureau, California State Library. Estimating California's Homeless Youth Population. October 2010.
22 Hyatt, S. Struggling to Survive: Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Homeless Youth on the Streets of California. California Research Bureau, California State Library.
23 California Homeless Youth Project, California Research Bureau, California State Library. More Than a Roof: How California Can End Youth Homelessness. January 2013.

FIELD CAPACITY

Approximately 400 SUD providers offer publicly-funded youth treatment. Most counties offer youth treatment services in some or all of the following broad areas: Outreach, Screening, Assessment, Case Management, Counseling, and Family Intervention. All but ten counties implement **evidence-based practices (EBPs)** in the services they offer, and many of the counties reference the State's 2002 Youth Treatment Guidelines[24] as a best practice guide.

The focus of services for youths varies by county, depending upon local need and priorities. County services may take the form of early intervention, low or high intensive outpatient treatment, or residential treatment in group home settings. These levels of care, along with outreach, are offered by a variety of providers—most of whom are SAPT-funded—including community-based facilities, schools, churches, and group homes.

At this time, only six counties have no youth-targeted treatment services available. These six counties are among the 13 "exchange counties" that exchange their SAPT BG Adolescent/Youth Treatment funds for unrestricted funds.[25]

Counties notify the state about what types of services they offer youths through SAPT Youth Treatment funding or through other funding sources. (Counties use a wide range of funding for youth treatment, including the SAPT BG, special court and juvenile justice funds, MHSA, Alcohol/Drug Medi-Cal, and general county funding.[26]) However, each county has its own criteria for treatment of youth, whether outpatient or residential, and each county has different kinds of facilities and providers available. Six of the 57 counties have no youth treatment provider services available.

Annually, these publicly-funded county treatment providers admit over 21,000 adolescents in California,[27] but this number is only a small percentage of the

24 SUD PTRSD CMU Tool FY 2012–13.
25 CMU Tool responses FY 2013–14.
26 CMU Tool responses. FY 2013-14
27 From July 1, 2012, to June 30, 2013, per CalOMS Tx figures, exactly 21,548 unique youth clients aged 12–17, were admitted to treatment.

adolescents who are in need of treatment and recovery services. According to SAMHSA's National Survey on Drug Use and Health, among individuals aged 12 or older in 2009, 9.3% needed treatment for a substance use problem. This SAMHSA estimate, since it also addresses adults—who are more likely than youth to have advanced in their substance use to the level of a disorder—is likely a few percentage points higher than the actual need for youth treatment. With that in mind, 9.3% of the approximately five million youth aged 12–20 in California is about 465,000.[28] Using data from a 2012 DHCS needs assessment study[29] that projected 8.15% (approximately 407,500) of youth aged 12–17 are in need of treatment services.

Each youth client is assigned one referral source based on their response to the question at admission. Nearly 34% of all referrals for treatment for adolescents and youth come from school and educational sources, with individual (including self, friends, and family) being the second most common referral source (22%). Other community referrals and non-Substance and Crime Prevention Act court and criminal justice referrals are lower, but still significant, with other referral sources being quite minor.[30]

Various factors are preventing broader provision of youth services, and further research, possibly extending to direct contact on a county-by-county basis, will be needed to ascertain what those factors are.

28 According to SAMHSA's National Survey on Drug Use and Health, among individuals aged 12 or older in 2009, 9.3 percent needed treatment for an illicit drug or alcohol abuse problem. Applying this SAMHSA percent to the 2010 California census figure of approximately five million youth aged 12–20, 465,000 would be an approximate number of the youth aged 12–20 in need of treatment.

29 California Department of Health Care Services, California Mental Health and Substance Use System Needs Assessment, 2012. http://www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf

30 CalOMS Tx, FY 2012–13

CULTURAL COMPETENCY

Providing culturally competent services has a positive effect on SUD service delivery, as well as reduces disparities and improves access to quality care. Culture is the combination of knowledge, beliefs, behaviors, and institutions that are specific to ethnic, racial, religious, geographic, or social groups. In order to individualize care, SUD service providers must understand the cultural and linguistic needs of the clients they serve. Delivering culturally competent prevention and treatment services increases not only a client's understanding and adherence to treatment goals, but also heightens overall client satisfaction and confidence in the SUD system.

DHCS is committed to supporting the development and improvement of culturally and linguistically competent programs and services for California's diverse populations. To assist the SUD field in developing services that are culturally competent, DHCS uses the 15 **Culturally and Linguistically Appropriate Services (CLAS)** Standards developed by the Office of Minority Health, U.S. Department of Health and Human Services, as a baseline in this effort.[31] Through a contract with a cultural competence training consultant/business, DHCS utilized the SAPT BG to fund 4,818 days of technical assistance and training on cultural competence during 2011–14.

The primary purpose of the federal CLAS Standards is to increase the ability of organizations to incorporate cultural and linguistic competence into all aspects of program administration, including policy making, human resource planning and employment practices, outreach and marketing, and all aspects of direct service delivery. These standards serve as a framework that DHCS has adapted and required counties to use at the local level to reduce SUD-related health disparities and improve outcomes among the state's diverse racial, ethnic, linguistic, sexual minority, and other cultural populations. Twenty seven counties reported barriers and challenges in implementing the 15 CLAS Standards in the CMU Annual Report.

Counties receiving SAPT BG funds are required to ensure equal access to quality care for diverse populations. DHCS made the county adoption of the 15

31 U.S. Department of Health and Human Services, OPHS Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care, March 2001

CLAS Standards a requirement in the FY 2012–13 State-County contracts. While the adoption of all 15 CLAS standards is a requirement of the state-ounty contract, Standards 5–7 regarding communication and language access services for clients are mandated for all recipients of federal funds. Twenty six counties report providing SUD services in languages other than their identified threshold language.

There have been numerous anecdotal and research-based accounts of how language barriers negatively affect the ability of an individual with limited English proficiency to benefit from health care services. When these barriers go unaddressed, patients can be harmed because critical health information was not properly communicated. By contrast, research evidence demonstrates that patients are more satisfied and adhere better to treatment when language assistance is provided.[32]

Determining threshold languages within each county or service area is critical to ensuring effective communication, as well as providing the necessary standard of care to those that speak languages other than English. Threshold languages are based on the percentage of the population in an identified geographic area whose primary language is a language other than English. The limited ability or the inability to speak, read, write, or understand the English language makes it necessary for the consumer to speak in his/her primary language to effectively communicate. Therefore, SUD prevention and treatment services must be made available to the consumer in their own language.[33]

SPECIAL POPULATIONS & SPECIFIC RISK FACTORS

This section reports and provides guidance on best practice strategies to follow when providing SUD prevention and treatment services to specific populations who may be at greater risk for developing SUD.

32 Ibid.
33 California Code of Regulations, Section 1810.410

Diversity is one of California's greatest assets. Disparities in diagnosis of illness and access to SUD and mental health services are found in all races, ethnicities, sexual orientations, and gender identities/expressions.[34] The definition of a health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. DHCS efforts to reduce disparities in SUD prevention and treatment in specific populations are underway, but statewide activities to prioritize the importance of this issue cannot be understated.[35]

Native Americans

The California Native American population is diverse and no single behavioral health prevention or early intervention strategy is appropriate for everyone. Programs must consider the multiple needs of the individual, family, and community.

California is home to approximately 115 federally recognized American Indian tribes. According to the 2010 census, California has the largest population of individuals self-identified as **American Indian/Alaskan Native (AI/AN)**, with approximately 723,225 identifying as AI/AN alone or in combination with another race (representing 14% of the national AI/AN population).[36] The AI/AN population is one of the most impacted by SUD issues. Efforts to better understand and meet the needs of this population are a high priority at both the national and state level.

A long history of oppressive practices towards these communities has had a devastating effect on their health. Genocide, colonization, forced relocation, and

34 http://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=21156267 (Compared with non-Latino Whites with SUD, Black adolescents with SUD reported receiving less specialty and informal care, and Latinos with SUD reported less informal services). See also: U.S. Department of Health and Human Services. HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care. Washington, D.C.: U.S. Department of Health and Human Services, [April 2011] at http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
35 See http://www.cdph.ca.gov/programs/Documents/ADP_Race-Ethnicity_Report_Final.PDF for California specific SUD disparity analysis.
36 Tina Norris, Paula L. Vines, Elizabeth M. Hoeffel, American Indian and Alaskan Native Population:
2010, 2010 Census Briefs, January 2012. Retrieved August 2012 from http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

the outlawing of native languages and spiritual practices has resulted in an overall mistrust of government programs and health institutions. Historical Trauma is the term used to describe the cumulative emotional and psychological wounding of the AI/AN population over the lifespan and across generations that emanate from these oppressive practices. The response to Historical Trauma has emerged in native communities in various forms, including SUD. SUD is a significant problem for many AI/AN communities, and many of these communities are impacted by SUD-related issues.

In response to recognizing the need for strategic efforts to reduce disparities in prevention and treatment in the AI/AN population throughout California:

- 10 counties provide funding to Indian Health Clinics to mitigate barriers to treatment;
- 20 counties work directly with elected tribal leaders from the List of Federally Recognized Tribes, and;
- 7 counties work with tribes not identified on the List of Federally Recognized Tribes.

Twelve county tribes/native constituents identified the following as barriers to service for their population:

- Access to care;
- Funding to provide services within their community;
- Lack of understanding of native healing practices, and;
- 17 counties have requested technical assistance for services to the Native American Community.

Veterans

California has the largest population of veterans in the nation. There are an estimated 2,078,267 veterans in California, representing approximately 9.2% of the nation's total. With the increased veteran population comes the need for more accessible SUD treatment services.[37]

SUD and mental illness are common co-occurring disorders among veterans presenting for treatment. Symptoms of disorders, such as those arising from post-traumatic stress disorder, often include behaviors such as self-medicating with alcohol, illicit drugs, or other medications in the attempt to return to normalcy. Counties do and must continue to collaborate with their **Veteran Services Office (VSO)** to ensure treatment services are available for this population.

- 42 counties are providing services to member and former members of the military;
- 38 counties collaborate with their Veteran's Services Office;
- 27 counties work with clients who have active duty military status, and;
- 16 counties have requested technical assistance from DHCS for services to Veterans/Active Military.

DHCS data shows that 27 county SUD programs have programs where establishing stable housing is a component of the program. Also, 32 counties have special programs/providers serving the homeless population.

Criminal Justice

In October 2009, California Department of Corrections and Rehabilitation released data showing a substantial reduction in recidivism for offenders completing in-prison substance-abuse programs, followed by community-based substance-abuse treatment. The return to custody rate after two years for offenders completing both in-prison and community-based treatment in FY 2005–06 was 35.3%, compared to 54.2% for all offenders.[38]

On April 5, 2011, Governor Brown signed **Assembly Bill AB 109 (Public Safety Realignment)** that went into effect on October 1, 2011. AB 109 shifted the responsibility for incarcerating, monitoring, and rehabilitating low-level offenders from the state to the counties under Post Release Community Supervision.

The criminal justice information reported in this SNAP

37 "Veterans Issues", California Department of Alcohol and Drug Programs, http://cojac.ca.gov/veteran/issues.shtml (accessed November 19, 2012)

38 California Department of Corrections and Rehabilitation, Corrections/Year at a Glance Reports, accessed on March 29, 2015 at http://www.cdcr.ca.gov/Reports/CDCR-Annual-Reports.html

report highlights the collaborative efforts that county SUD departments established with courts, probation, law enforcement, and other organizations to meet the needs of individuals who may benefit from SUD prevention, treatment, and recovery services. Fifty six counties actively collaborate with relevant organizations to ensure SUD services are made available for AB 109 Post-Release Community Supervision Clients. In addition, 37 counties receive dedicated funding to support SUD services for AB 109 clients.

For more information on criminal justice strategic initiatives and SUD, please refer to **Part 2: Strategic Initiative #3: Trauma and Justice**.

Co-Occurring Disorders

Co-Occurring Disorders (COD) are the simultaneous existence of both SUD and mental health disorders. Individuals with SUD often have a mental health condition at the same time, and vice versa. For more information on diagnosis and treatment, see http://www.samhsa.gov/co-occurring.

Providing integrated treatment for clients who experience both substance use and mental health conditions at the same time is critical to improving their overall health. A client's SUD, mental health, and physical health issues must be treated concurrently. Services that address all conditions lower health costs and provide better health outcomes.

SUD treatment programs that provide treatment for clients who present with COD find that the presence of a mental illness disorder often makes effective SUD treatment more difficult. If the COD is untreated along with a client's SUD, outcomes are negatively affected. Conversely, integrated treatment is associated with more positive outcomes.

- 56 counties screen for COD;
- 54 counties offer some form of coordinated/integrated care for COD, and;
- 52 county SUD departments are integrated with Mental Health;
- 30 counties have requested technical assistance for COD.

The areas of interest include the following:

- Improving COD treatment for youth (22 counties);
- Improving trauma-informed care for better retention in COD treatment (21 counties);
- Screening for mental health for better COD treatment (19 counties);
- Approaches to addressing depression in SUD facilities for improved COD treatment (16 counties);
- Use of the Dual Diagnosis Capability in Addiction index to enhance COD treatment capability (16 counties),[39]
- Improving COD treatment for veterans (15 counties); and,
- Other (9 counties)

Homelessness

A common stereotype about the homeless population is that they are all alcoholics and/or substance users. The truth is that a high percentage of homeless people do struggle with SUD, but addictions should be viewed as illnesses that require treatment, counseling, and support to overcome. Substance Use is both a cause and a result of homelessness, often arising after people lose their housing.[40]

Estimating the number of homeless individuals dealing with SUD is difficult due to the fact that this population is in constant fluctuation, and multiple data sources provide conflicting information. In January 2014, a national Point-In-Time counting effort found 578,424 people nationally who were homeless on a given night. Most (69%) were staying in residential programs for homeless people, and the rest (31%) were found in unsheltered locations. Nearly one-quarter of all homeless

39 The DDCAT index was created and field tested, beginning in 2004. The DDCAT is based on the ASAMS taxonomy of program dual diagnosis capability. See: http://ahsr.dartmouth.edu/docs/DDCAT_Toolkit.pdf , retrieved on April 2, 2015.
40 "Substance Abuse and Homelessness"; National Coalition for the Homeless, http://www.nationalhomeless.org/factsheets/addiction.pdf (July 2009)

people were children under age 18 (23%, or 135,701), while ten percent (or 58,601) were age 18–24, and 66% (or 384,122) were aged 25 or older.[41]

Many of the homeless struggle with SUD, and also suffer from moderate to severe mental illness and physical health problems. Oftentimes, these individuals inappropriately use substances as a form of self-medication. Substance use is also a prevalent characteristic among unaccompanied youth. In all, it is estimated that nearly half of all individuals experiencing homelessness, and 70 percent of veterans experiencing homelessness, suffer from SUD. When both disorders are present they should be treated simultaneously in order to provide effective treatment.[42]

Many individuals with substance use problems face multiple barriers to accessing housing while suffering from addiction. Many shelters require sobriety to access their services and those with active addictions are "screened out" of public housing. Being without a stable place to live during substance use recovery only increases the likelihood that these treatments will fail.[43] Therefore, efforts to develop housing for those still active in their substance use is an important priority. Such programs focus on harm reduction and provide housing as a way to help transition those in the downward spiral of homelessness and substance use into a better setting where recovery services are available.[44]

Projects for Assistance in Transition from Homelessness (PATH)

California has been awarded federal homeless funds annually since 1985, initially through the Stewart B. McKinney Homeless Block Grant, and beginning in FY 1991–92, through the **McKinney Projects for Assistance in Transition from Homelessness (PATH)** formula grant.[45] The PATH grant funds community-based outreach, mental health and substance abuse referral/treatment, case management and other support services, and a limited set of housing services for the homeless mentally ill. In FY 2012–13, 42 of 58 counties elected to participate in the PATH program. While local programs serve thousands of homeless individuals with realignment funds and other local revenues, the PATH grant augments these programs by providing services to approximately 8,300 additional individuals annually. Each county determines the use of PATH funds based on local priorities and needs. These targeted funds provide much needed services to an extremely vulnerable population throughout California.

In accordance with federal procedures, DHCS PATH and housing staff developed guidelines that define the counties' responsibilities to clients who are homeless and have a mental illness. Counties receiving PATH funds must annually develop a service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities being provided. The estimated number of individuals served must also be included in the plan. Each county that receives PATH funds has established one or more programs of outreach and services for individuals who are homeless and have a mental illness.[46]

As of FY 2011–12, DHCS requires that all PATH programs provide outreach and case management services. Other allowable services include:

- Primary Service Referrals
- Outreach
- Habilitation and Rehabilitation
- Community Mental Health
- Alcohol/Drug Treatment
- Staff Training
- Service Coordination
- Housing Services

41 The U.S. Department of Housing and Urban Development, Office of Community Planning and Development (2014), The 2014 Annual Homeless Assessment Report to Congress, accessed on March 29, 2015 at https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf.

42 United States Interagency Council on Homelessness, Substance Abuse, accessed on March 29, 2015 at http://usich.gov/issue/substance_abuse.

43 Ibid

44 http://homeless.samhsa.gov/channel/permanent-supportive-housing-510.aspx (Harm reduction (or harm minimization) is a range of public health policies designed to reduce the harmful consequences associated with various human behaviors, both legal and illegal. Harm reduction policies are used to manage behaviors such as recreational drug use in numerous settings that range from services through to geographical regions.)

45 http://pathprogram.samhsa.gov/; see also: http://www.dhcs.ca.gov/services/MH/Pages/PATH.aspx

46 See: http://www.dhcs.ca.gov/services/MH/Documents/PATH/Building_Effective_PATH_Program.pdf for tips on county efforts to build an effective PATH program. Accessed on April 2, 2015.

- Supportive Services
- Screening and Diagnostic Treatment

In addition to demographic information, the PATH-funded programs also report outcomes relative to achievement of their objectives. The most fundamental goal for PATH programs is intensive community efforts to find homeless individuals and provide outreach and engagement to those who would otherwise not receive services due to the combined conditions of homelessness and serious mental illness.

There are solutions that work to help the homeless who are challenged with SUD and/or co-occurring conditions. Permanent supportive housing, which provides holistic case management and supportive services for substance use treatment, is an effective way to end chronic homelessness and substance use.[47]

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning

LGBTQ individuals use alcohol, tobacco, and other drugs differently than their peers in the general population. Social rejection and oppression, internalized negative feelings about their LGBTQ identities, the prominence of bars and clubs as safe centers for socialization, and alcohol and tobacco marketing targeting this population, increases LGBTQ risks for substance abuse. Early estimates of significantly higher rates of alcoholism/addiction in this population have not been confirmed by more recent studies. However, these studies have found that LGBTQ individuals are more likely to smoke cigarettes, less likely to abstain from alcohol, more likely to drink heavily and to do so later into life, more likely to use other drugs, and more likely to report problems relating to their drinking and drug taking than others.[48]

Eighteen Counties have programs/providers that specifically serve LGBTQ population.

47 Ibid. See also: http://homeless.samhsa.gov/channel/permanent-supportive-housing-510.aspx.
48 "Invisible Californians", CA ADP LGBT Constituent Committee, http://cojac.ca.gov/Advisory/CC/pdf/GLBT_position_paper_2004.pdf (May 2004)

TECHNICAL ASSISTANCE NEEDS, INCLUDING COLLECTION OF INCIDENCE & PREVALENCE DATA

In accordance with 45 CFR §96.133 (a)(3), this report includes the following State's description of the need for technical assistance to carry out SAPT BG activities, including activities relating to the collection of incidence and prevalence data identified in paragraph (a)(1) of section 96.133. In addition, Part 2: Strategic Initiatives, Goals, and Technical Assistance Needs, chronicles the State's technical assistance needs in the context of California's Strategic Plan to elevate the SUD treatment system. The priorities of both §96.133(a)(3) and (a)(4) (improvement goals and objectives) are interrelated in Part 2 of this report because they align with the strategic goals for California.

The state does not currently collect general population incidence and prevalence data on its own and relies on SAMHSA's state-level NSDUH reports for these purposes. If the state were to pursue its own collection of such data, a great deal of technical assistance and resources would be needed to ensure that this effort would be successful. It is unlikely that this would be the most efficient method of acquiring such data however. It would likely be more efficient for the state to add questions to an existing annual statewide survey being conducted by an outside entity than to conduct the survey itself. Technical assistance in this area is therefore not a priority.

Rather than focus new data collection on incidence and prevalence, a higher priority for technical assistance would be creating better estimates of treatment need, which is both a downstream result of incidence and prevalence of SUD and the most relevant estimate for treatment planning. Such estimates should include information on those with mild, moderate and or more severe (e.g., DSM 5) co-occurring mental health conditions. The state could benefit from federal technical assistance on use of synthetic estimation methods for this purpose.[1] Similarly the state could benefit from federal technical assistance with regard to alternative methods of estimating treatment capacity, particularly outpatient treatment capacity. In both cases, technical assistance could take the form of training or information on successful models from other state or federal efforts.

The State also needs training for computer programmers at the state level to upgrade data systems. **A more detailed examination of this need is explained in Section (a)(6)**.

County Requests for Technical Assistance: The counties have requested training for county and provider entities on how to correctly enter data for purposes of CalOMS treatment tracking.

1 Synthetic estimation involves matching people who have the same demographic characteristics and using information on the matched individual (e.g., need for treatment) to generate estimates at the local level while ignoring the original geographic location of the matched individual. This would potentially enable DHCS to estimate need and penetration rates at the county level, for example, even if sufficient data at that level does not exist to produce such estimates directly.

GOALS AND OBJECTIVES – ACTIVITIES TAKEN IN FURTHERANCE

This section requires the State to establish goals and objectives for improving SUD treatment and prevention activities, and to report on activities taken in support of these goals and objectives in its bi-annual SAPT-BG application. For a thorough description of these goals and prioritized objectives, **See Part II: Strategic Initiatives and Goals**. This section also contains a thorough discussion and detailed account of the state's efforts and activities taken in support of these goals and objectives.

NEEDING BUT NOT RECEIVING TREATMENT

This section requires the State to submit a detailed description about the extent to which the availability of prevention and treatment activities are insufficient to meet the state's need, the available interim services, and the manner in which such services are made available, giving special attention to the diverse populations described above.

NSDUH 2012–13 estimates of individuals needing but not receiving treatment are based on those who were classified as needing treatment (based on DSM-IV criteria) but did not receive treatment at a specialty clinic. Overall, both in California and nationally there was no significant change in the percentage of respondents aged 12 or older needing but not receiving treatment for either alcohol or illicit drug use in the past year. NSDUH's estimates for California (using CY 2012 and CY 2013 combined data) and the nation (using 2013 data) are similar (2.60% vs 2.42%, respectively, for illicit drugs, and 6.79% vs. 6.4%, respectively, for alcohol). California's rate has dropped significantly (from the CY 2009 and CY 2010 combined estimate of 7.76% for alcohol, but not yet for other illicit drugs.

The percentage of people in California aged 12–17 needing but not receiving treatment from CY 2011–12 to CY 2012–13 declined significantly for both illicit drug use (4.88% vs 3.97%, p=.016) and alcohol use (4.06% vs 2.92%, p=.001).

Based on CY 2013 California population of about 38 million (California Department of Finance, 2014), the CYs 2012–13 estimate of the population needing but not receiving treatment translates to about 920,000 for illicit drugs and about 2.2 million for alcohol. Some individuals needing but not receiving treatment for both alcohol and illicit drugs are included in both estimates, so it would not be accurate to add them together.

Most recently, SAMHSA released its 2013 NSDUH Report, dated September 4, 2014.[1] The report findings estimate our national population's need for and barriers to SUD treatment. The NSDUH survey performed annually surveys non-institutionalized U.S. population individuals aged 12 and older. The CY 2013 results show that among the 20.2 million individuals classified by NSDUH as needing SUD treatment based on the DSM-IV criteria, 908,000 (4.5% reported that they perceived a need for treatment for their illicit drug or alcohol use problem. Of the 4.5% identified, approximately 316,000 (34.8% reported that they made an effort to get treatment and 592,000 (65.2%) reported making no effort to get treatment. Furthermore, a review of CY 2010–13 combined NSDUH survey data led SAMHSA to conclude that for CY 2013, the most commonly reported reasons for not receiving treatment among those aged 12 or older needing but not receiving treatment were:

1. No health coverage/could not afford cost (37.3%);
2. Not ready to stop using (24.5%);
3. Did not know where to go for treatment (9.0%);
4. Had health coverage but it did not cover treatment or did not cover cost (8.2%); and,
5. No transportation or inconvenient hours (8.0%).

INTERIM SERVICES

Pregnant women and individuals in need of treatment for intravenous drug use are given priority in admission to SUD treatment services. Interim services are provided to these individuals to ensure engagement is sustained in the rare case that space is unavailable and a waitlist is enacted. Providing these services ensures individuals seeking SUD treatment receive immediate support while awaiting admission.

The availability of residential perinatal treatment providers has been decreasing. Rural areas experience the effects of this loss of services mostly due to issues of limited access to care, not enough individuals in a region to support a SUD program, and limited funding to support local level treatment. Many times, outpatient treatment is the only treatment available to these rural populations. Even with higher-population counties, individuals are often placed on waitlists for residential treatment services, and receive outpatient services until there is an opening in the residential treatment facility. Thirty-nine counties have a waiting list with a unique patient identifier.

1 http://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf

SPECIAL POPULATIONS

(I) Pregnant Addicts and (II) Women who have Dependent Children

A review of FY 2012–13 CalOMS Tx data showed that there were over 105,000 women served in California's DHCS publicly-monitored AOD Tx programs.[2] Of these women served, almost 5% (5,161) were pregnant at the time of admission and almost 47% of women (49,187) had one or more dependent children aged 17 or younger.[3]

Given the number of women with SUD, the availability of residential treatment services are severely lacking.[4] During FY 2012–13, there were 74 short- and long-term specialized perinatal residential providers that offered residential treatment services to women and their children in the following 29 counties:

Alameda, Butte, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Marin, Merced, Monterey, Nevada, Orange, Placer, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Tulare, Ventura, Yolo.[5]

California's 74 residential perinatal providers generally include short-term and long-term residential, but exclude residential detoxification. These 74 providers are publicly-funded using SAPT BG and DMC dollars, and are required to follow the Perinatal Service Network Guidelines, thus offering women-centered and trauma-informed care to women and their children. For a listing of these perinatal sites, please **see Appendix F: Perinatal Residential Providers**.

Pregnant and parenting substance-using women are more likely to face barriers to treatment than their male counterparts. Due to the severity and complexity of addiction, many women require intensive treatment services.

"In studies of substance abuse treatment among women, pregnancy and childbearing are important events because they may represent barriers to seeking, receiving, or completing treatment. Women with substance use disorders may avoid seeking treatment for fear of losing custody of their children (Ayyagari, Boles, Johnson, & Kleber, 1999; DeAngelis, 1993; Finkelstein, 1994; Grella, 1997), due to well-publicized cases of drug use during pregnancy resulting in prosecutions for child abuse, delivery of drugs to a minor, and other charges (Associated Press, 2003; Chavkin, Breitbart, Elman, & Wise, 1998; Paltrow, 1992, 1998).[6]"

SUD during pregnancy are harmful to the unborn child. If a substance-using pregnant women does not receive treatment services and continues to use during her pregnancy, her substance-exposed newborn is at a high risk for premature delivery, low birth weight, neurological and congenital problems, increased risk for sudden infant death syndrome, and developmental delays. Children of mothers with SUD are at a higher risk for emotional and developmental problems, delinquency and poor school performance, and have an increased risk of using drugs in the future. Some children exhibit emotional problems, such as depression, anxiety, and psychiatric disorders due to the instability of their parents and living environment. Difficulty bonding with their parents potentially leads to trouble trusting other people, which may affect their ability to maintain or develop relationships.

Providing prevention, early intervention, and treatment services to pregnant and parenting women that address their specific needs can help mothers deliver healthy babies, prevent the developmental and behavioral problems caused by SUD, and have a positive impact on interactions and relationships with their children.

A portion of SAPT BG funds are required to be used for women-specific treatment and recovery services, along with diverse supportive services for pregnant and parenting women and their children. All counties providing perinatal services must meet the requirements set forth in the Perinatal Services Network Guidelines 2014.[7]

Counties use other funds to provide perinatal treatment services outside of the SAPT BG perinatal set-aside funds:

Fifty-two counties provide perinatal services. Twenty-eight counties submitted technical assistance requests for the following perinatal services:

2 "Served" counts include all those admitted during that year, plus all those admitted prior to the year that continued to receive treatment during FY 2012–13

3 The percent pregnant and women with children aged 17 or younger are not mutually exclusive, a woman can be both pregnant and have a child aged 17 or younger.

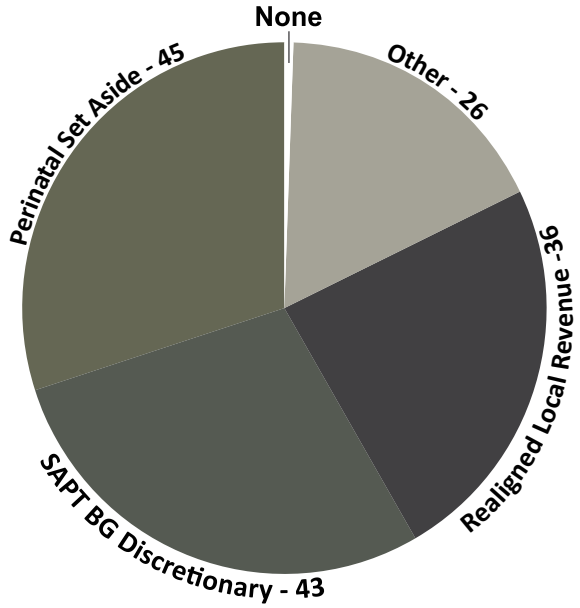
4 Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the specific needs of women. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009, accessed at: http://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA14-4426 on March 30, 2015.

5 Perinatal residential treatment providers were selected from a query using the FY 2012–13 cost report based on service codes 52 and 51 (short- and long-term residential) and perinatal program codes: 3, 10, 11, 93, 95, & 96. Providers were selected based on perinatal residential funding which is intended for gender specific residential services tailored to meet the recovery and treatment needs of women and their children (Title 22, July 1, 2012).

6 Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

7 http://www.dhcs.ca.gov/individuals/Documents/PSNG2014Final21214.pdf

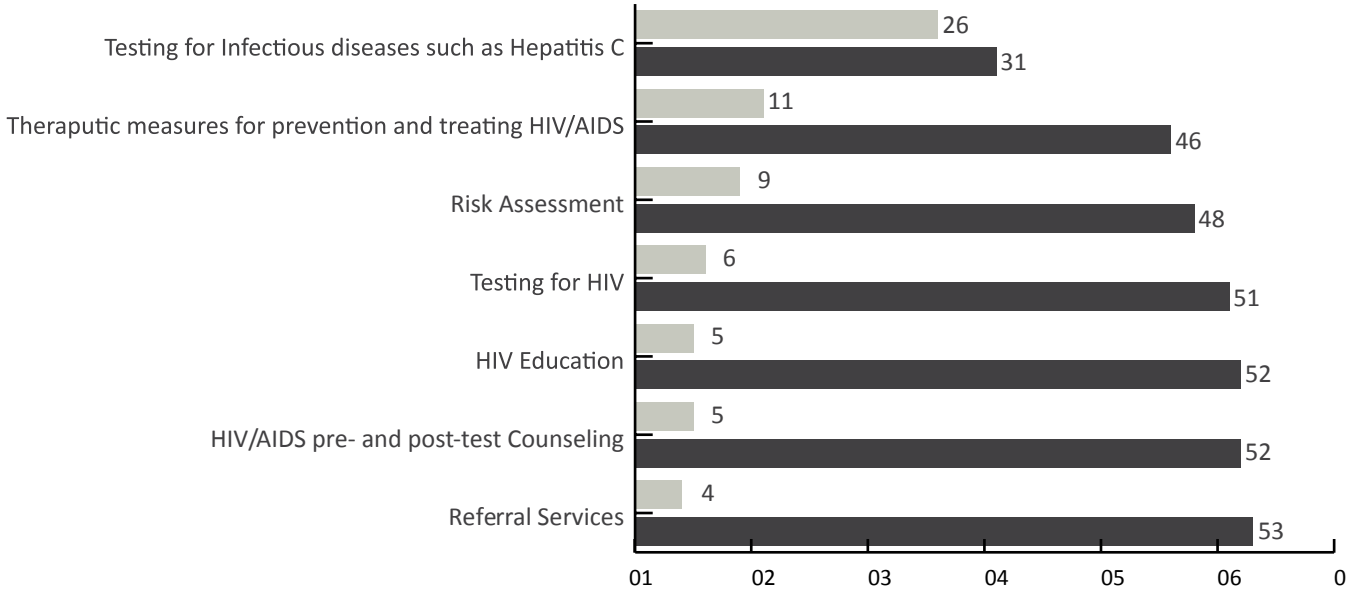
FIG 16: Types of Funds Used to Provide Perinatal Treatment Services in FY 2012–13, by Number of Counties



(SOURCE) 2012-13 CMU Annual Report

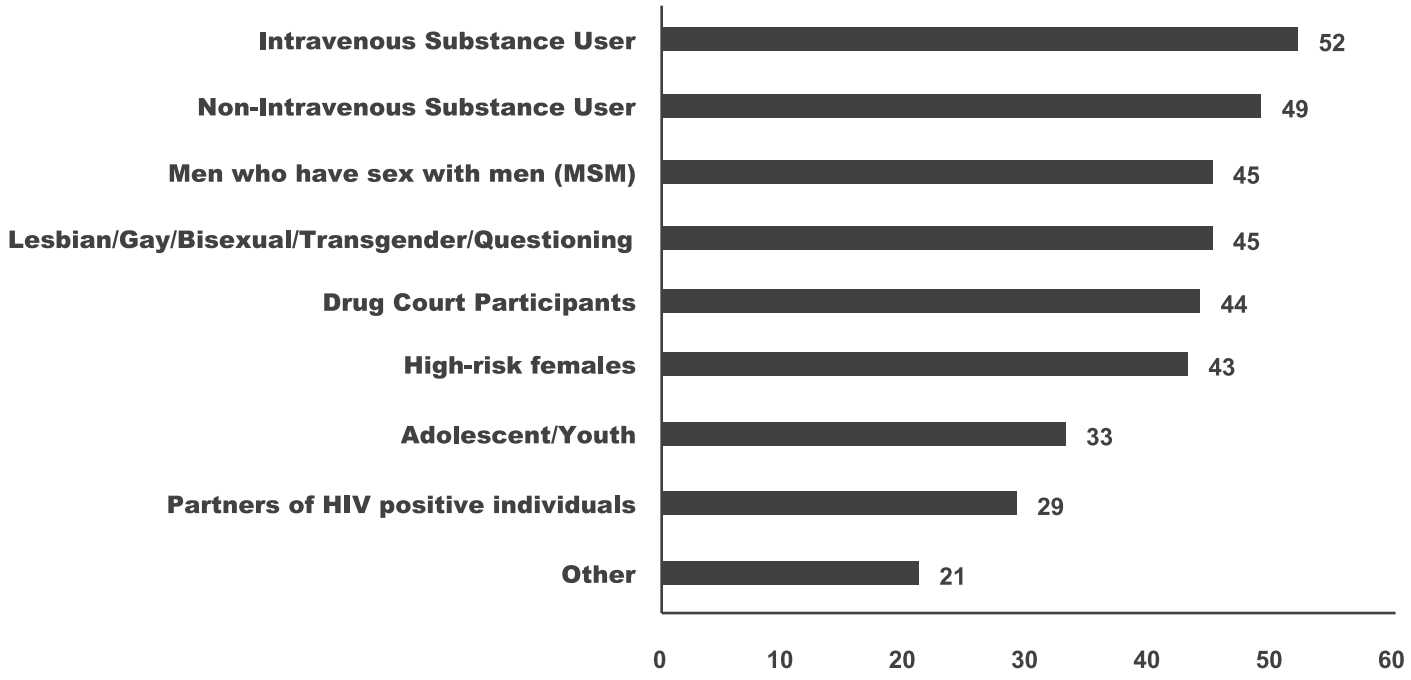
- Trauma-Informed Services (28 counties),
- Other perinatal areas (26 counties),
- Gender-Specific Services (19 counties),
- Fetal Alcohol Spectrum Disorder/Substance-Exposed Infants (18 counties),
- Therapeutic Services for Children (16 counties)

Fig 17: Types of HIV Services Made Available to SUD Clients in FY 2012–13, by Number of Counties



(SOURCE) 2012-13 CMU Annual Report

FIG 18: Types of Populations Served Through SAPT HIV EIS Funds, by Number of Counties



(SOURCE) 2012-13 CMU Annual Report

(III) Injecting Drug Users

CalOMS Tx data indicates that of the approximately 274,000 clients served in FY 2012–13, about 26% reported needle use in the past 12 months prior to treatment admission.

(IV) HIV Infected or have Tuberculosis

Of those reporting to CalOMS Tx, about 2.4% of clients served said they had been diagnosed with tuberculosis. technical assistance requests were received for HIV/EIS from 18 counties.

STATE'S MANAGEMENT INFORMATION SYSTEM

In accordance with 45 CFR §96.133 (a)(6), this needs assessment includes the following description of the State's management information system pertaining to capacity and waiting lists and information for admissions and discharges. As to prevention activities, this report also includes a description of the populations at risk of becoming substance users.

DHCS uses the NSDUH estimates on those needing but not receiving SUD treatment in California to monitor treatment capacity. Over three million Californians are estimated to need but are not receiving SUD treatment. The Affordable Care Act and the emphasis on reducing disparities for SUD and other mental health disorder services provide opportunities to increase needed service capacity and to attain parity in providing substance use services.

The regulatory requirements of §96.133(a)(6) requires DHCS to provide documentation describing how, using the state management information system, DHCS tracks treatment capacity and monitors waiting lists. The key capacity factors tracked include treatment admissions and discharges. Prevention activities play a key role in this tracking effort by documenting which populations are at risk for SUD.

Measuring treatment service "capacity" is a complex multifaceted task requiring extensive, timely, complete, and accurate data collection. Obviously, capacity fluctuates in relation to available funding. Definitions of capacity also vary in relation to residential versus outpatient service types, and individual versus group counseling availability at individual treatment providers. Also, often treatment recipients may receive a lower level of care (e.g., outpatient instead of residential), or an interim service, when the appropriate level of care is not available. Tracking assessed level of care and actual placement is not possible by DHCS at this time. Moreover, while shorter lengths of stay can increase the numbers of individuals seen during the year (in a sense increasing system "capacity"), research indicates that in general longer lengths of stay are related to more positive treatment outcomes.

Capacity also can be affected by types of funding. For instance, for many years the state of California provided large amounts of SUD treatment service funding for lower level criminal justice offenders as an alternative to incarceration. During this period many criminal justice offenders were admitted to SUD treatment who would not otherwise seek treatment. When that funding source was eliminated there were corresponding reductions in the numbers of criminal justice referred clients seeking and being admitted to treatment, even though the need for treatment had not decreased.

DHCS uses the Drug and Alcohol Treatment Access Report (DATAR) and the California Outcome Measurement System for Treatment (CalOMS Tx) systems to collect the data that is used to measure treatment capacity and waiting list information.

DRUG AND ALCOHOL TREATMENT ACCESS REPORT (DATAR)

DATAR is the statewide system used by DHCS to collect data on SUD treatment capacity and waiting lists. DATAR is intended to provide essential information about the capacity of California's publicly-funded SUD treatment system to meet the demand for services. Treatment providers that receive state or federal funding through the state or the county, as well as all licensed Narcotic Treatment Program providers, are charged with sending DATAR information to DHCS each month. The system retains information on each program's capacity to provide different types of SUD treatment to clients and how much of the capacity was utilized in a given month. DATAR includes summary information on waiting lists, if the provider has a waiting list for publicly-funded SUD treatment services. DHCS is working with providers to improve the timeliness, reliability and accuracy of the DATAR system in order to better meet beneficiary service needs.

CALIFORNIA OUTCOME MEASUREMENT SYSTEM FOR TREATMENT (CalOMS Tx)

The CalOMS Tx data system is used to establish reporting on several measures. These measures include: Treatment utilization, Client Admission and Discharge Information, Length of Stay, Client Outcome Measures, and limited Program Performance Measures.

TREATMENT CAPACITY

DHCS develops annual "served" counts using our CalOMS Tx database. DHCS uses CalOMS Tx to collect data from clients receiving SUD treatment services from publicly-monitored treatment programs. Total "served" means all those admissions to all service types (e.g. Detoxification, Residential, and Outpatient) during the year plus all those admitted prior to the current year that continued to receive treatment services during the year. Each admission is counted for clients who have multiple admissions during the year. DHCS uses these "served" counts to estimate the number of admissions in which the client is still participating in treatment to estimate current "active" treatment participation. During FY 2012–13, there were about 274,000 clients served.

DHCS calculates one-day counts using CalOMS Tx data as another method to estimate "capacity." For instance, there were over 99,000 clients in treatment on April 1, 2013. A sample of one-day counts throughout the year or over multiple years would show that one-day counts vary. Still, one-day counts provide a ballpark estimate of capacity on a given day. The one-day count uses a similar methodology as the "served" count to estimate the number of clients enrolled in treatment on a given day, regardless if the admission was opened during the current fiscal year or a prior fiscal year.

CalOMS Tx also contains the following question (from the Treatment Episode Data Set): "How many days were you on a waiting list before you were admitted to this treatment program?" During FY 2012–13, approximately 23% reported waiting one or more days for treatment, with higher wait days for those waiting for residential services.

TREATMENT CLIENT ADMISSION AND DISCHARGE INFORMATION

DHCS uses CalOMS-Tx to collect data from clients receiving SUD treatment services in publicly-funded treatment programs and all **narcotic replacement treatment (NRT)** programs, regardless of funding source. The following summarizes information from the analysis of data for FY 2012–13.

TREATMENT ADMISSION STATISTICS

There were over 175,000 admissions to treatment during FY 2012–13. This includes admissions to publicly-monitored SUD detoxification, residential, and outpatient services. There were about 138,000 individuals (unique clients) admitted to treatment during the year. Clients having multiple admissions to treatment during a year account for the difference between the number of admissions and the number of clients. For context, in order to provide a picture of the number of individuals in treatment on a typical day, there were over 99,000 clients in treatment on April 1, 2013.

Detoxification by itself does not constitute complete SUD treatment. It is considered a precursor to treatment and designed to treat the physiological effects of stopping SUD. Detoxification is short term and often repeated numerous times, given the chronicity of SUD that is characterized by patterns of repeated relapse before stability is achieved. Since 18% of the admissions in CalOMS-Tx were for detoxification during FY 2012–13, including them in the analyses distort the client characteristic statistics. For this summary, detoxification admission data are not included. The figures in this section reflect admission data for over 143,000 non-detoxification admissions. Percentages may not add to 100% due to rounding.

Regarding treatment service type, the largest percentage of admissions was 58% for **outpatient drug free (ODF)** services. Twenty three percent were for residential (short- and long-term) treatment, 12% were for NRT services, and the remaining 7% were for intensive day care.

CLIENT CHARACTERISTICS

Gender: Males made up the largest percent with 61% of admissions, while females made up 39%.

Race/Ethnicity: Non-Hispanic Whites made up most of the admissions with 40%, followed by Hispanics with 38%, and African Americans with 14%. Asian/Pacific Islanders, American Indians/Alaskan Natives, Multi-Racial, and Other comprised the remaining 8%.

Age at Admission: Clients under age 18 represented 16% of the admissions, while clients aged 18–25 represented 19% of admissions. Clients aged 26–35 had the largest percentage of admissions with 27%. Clients aged 36–45 comprised 17% of admissions, while clients aged 46–55 comprised 15%. Clients aged 55 and older had the smallest percentage of admissions with 6%.

Primary Drug Reported at Admission: The "primary drug" reported at treatment admission is defined as the drug causing the greatest dysfunction to the client at the time of admission. The most commonly reported drug by admitted clients was methamphetamine (30%). Marijuana was the second most commonly reported drug at admission (23%), followed by alcohol (20%), heroin (16%) and cocaine (5%). Other drugs made up the remaining 6%.

DISCHARGE STATISTICS

During FY 2012–13, there were over 161,000 discharges from treatment services (i.e. detoxification, residential, outpatient) for over 129,000 unique clients. Like admissions, clients may have multiple discharges in a given year since a discharge is submitted at the end of each treatment service to which they were admitted. This accounts for the difference between discharge counts and client counts.

Detoxification services are short in duration, often repeated multiple times a year, and therefore excluded from the analyses in this section so as not to bias the discharge statistics. There were a total of over 131,000 non-detoxification discharges in FY 2012–13. There are two main types of discharges from treatment:

Standard discharge: The client is asked all the CalOMS-Tx discharge questions that are used to measure client outcomes.

Administrative discharge: The client is not available to answer the CalOMS-Tx questions at discharge (i.e., stopped attending treatment sessions, died, or was incarcerated). The provider completes a minimum set of questions (e.g., discharge date, discharge status).

During FY 2012–13, standard discharges made up 60% of the all discharges; 40% were administrative discharges. The goal is to increase the number of standard discharges to get more information about client outcomes.

Discharge Status: There are eight specific reportable discharge statuses in CalOMS-Tx listed below. See the CalOMS-Tx Data Collection Guide for detailed descriptions of each status.[1]

- Completed Treatment, Referred/Standard
- Completed Treatment, Not Referred/Standard
- Left Before Completion, Satisfactory Progress/ Standard
- Left Before Completion, Satisfactory Progress/ Administrative
- Left Before Completion, Unsatisfactory Progress/ Standard
- Left Before Completion, Unsatisfactory Progress/ Administrative
- Death/Administrative
- Incarceration/Administrative

Upon examination of several years of CalOMS-Tx discharge data, it was determined that there was a lack of agreement by treatment providers as to what constitutes "treatment completion." In 2010, the following criteria were adopted for any discharges coded as "completed treatment":

- The client must reduce drug use or be abstinent; and
- The client must participate in social support recovery activities; and
- The client must stay in treatment for a sufficient length of time to obtain the maximum benefit from participation in the treatment program.

1 http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Until all treatment providers consistently use these criteria to measure "completed treatment," specific discharge statuses will not be used to measure this concept.

LENGTH OF STAY

The length of stay is measured by counting the number of days that a client stays in treatment from admission to discharge. Research verifies that longer stays in treatment are associated with more positive outcomes. The length of treatment varies depending on the type of service and client needs (e.g., severity of SUD problem, family issues, etc.). Also, some treatment services have time limitations. For example, most residential treatment services do not exceed 90 days. Often treatment consists of several service types, progressing from more intensive to less intensive services (e.g., residential to outpatient). This "step down" continuum of care is often needed because of the severe nature of the illness upon entry to treatment and potential for relapse. The analyses in this summary are based on the length of individual service stays (e.g., residential treatment) rather than the combined length of multiple service stays. Only services that may last more than 30 days are described.

The longest stays occur in NRT maintenance services, where 30% of the clients stayed over one year. Nearly half (47%) of the clients receiving outpatient drug-free services stayed for 90–364 days, compared with 43% of those in intensive day care programs.

CLIENT OUTCOME MEASURES

Historically, SUD treatment client outcomes measurements referred to changes in client functioning in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. The same client functioning questions (e.g., frequency of primary drug use in the past 30 days) are asked at two points in time: once when they are admitted to treatment and then again when they are discharged from treatment. Changes in client functioning were determined by matching the admission to the discharge record and comparing the responses to the same question at these two times. For simplicity, responses were often categorized into two groups: "positive" actions (e.g., no drug use) and "negative" actions (e.g., used drugs one or more times). The changes in client functioning resulting from SUD treatment were referred to as "client outcomes."

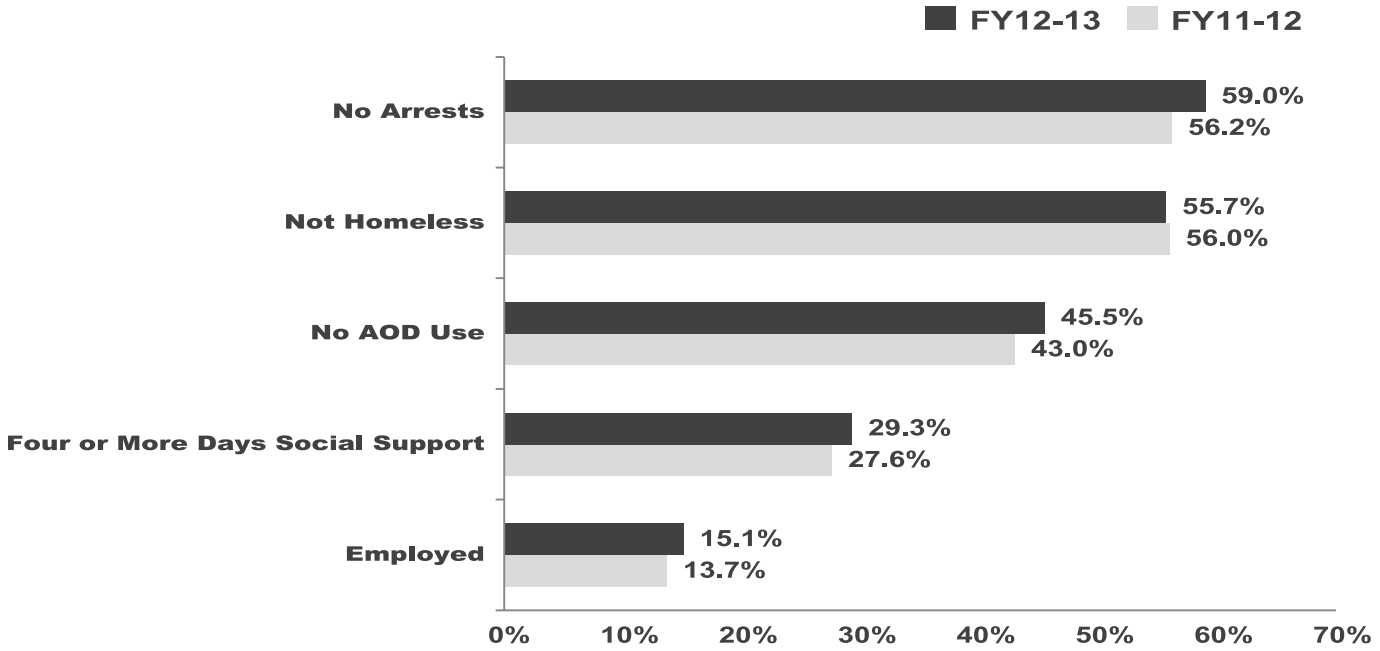
In the last few years, DHCS worked with the former **County Alcohol and Drug Program Administrators Association of California (CADPAAC)** Treatment Data/Outcomes Subcommittee, and others to reach the conclusion that it is often better to use client functioning at discharge to measure outcomes, instead of comparing admission and discharge data.[2] For instance, it is a more objective outcome measure to count the percent abstinent in the 30 days prior to treatment discharge rather than the change in abstinence from 30 days prior to admission to 30 days prior to discharge. One would expect that almost all clients entering treatment are presently using drugs, whereas all would be expected to have either reduced or achieved abstinence at treatment discharge. However, many clients admitted to a treatment service are coming from controlled environments (e.g., jail, prison) or other SUD treatment services. Many clients report not using drugs in the month prior to admission. Also, social support recovery activity participation is more important prior to discharge from treatment when the client is moving in the continuum of care from the treatment phase to the longer-term recovery phase (e.g., disease management) that follows.

Moreover, there are substantial variations across counties and years in the percentage of discharges that are administrative. This type of discharge is used when the client leaves the treatment service abruptly, and the provider is unable to contact the client (in person or by phone). For administrative discharges, very limited discharge data are collected. Because the client often cannot be reached to collect it, data on the client's functioning at discharge are not collected, therefore outcomes cannot be measured.

The largest percentage of admissions to treatment each year is to ODF services (as compared to Residential, Narcotic Treatment Programs, or Detoxification services).

2 The California Mental Health Directors Association and the CADPAAC both voted to merge into CBHDA.

Fig 19: Treatment Outcomes among Drug-Free Outpatient Clients



(SOURCE) California Outcomes Measurement System for Treatment.

ODF is also usually the last service type in an episode of treatment services. A treatment episode refers to when a client progresses through several treatment service types with less than 30 days between them (e.g., the client may first go into detoxification, then residential, and finally ODF services in a "step down model" from more intensive and shorter term stays to less intensive outpatient.)

This methodology (examining the percentage of clients meeting the desired level of client functioning at discharge and factoring in the number of administrative discharges) is used to report on ODF client outcomes in five key areas. Figure 19 shows relatively stable treatment client outcomes in FY 2011–12 compared with FY 2012–13 for ODF services on five key measures.

DATA CONSIDERATIONS FOR CLIENT OUTCOME MEASURES

There are substantial differences by county in various treatment outcome measures. Further work is needed to better understand variations in client outcomes by county. As a result, reporting county-level treatment outcomes is not advisable; county variations and the many factors for such variations are not fully understood to support meaningful county-to-county comparisons. Further data management and information technology resources to improve data collection, and ultimately data quality, are needed in order to fully assess and address data quality issues.

In general, it is reasonable to assume that the outcomes for clients that left treatment unexpectedly would be worse than for clients with planned discharges. Generalizing outcomes of all treatment clients from the outcome data collected in the standard discharges (i.e., from the clients with better outcomes) creates a positive bias. Paradoxically, counties (or fiscal years) with larger percentages of discharges missing outcome data (i.e. administrative discharges) may appear to produce more positive outcomes since the outcomes would be generalized from only the limited number of clients completing the standard discharge, who may have been more engaged in treatment. Outcome measurement bias and variability is reduced when the administrative/missing data are factored into comparisons across years and between counties or providers.

For example, during FY 2012–13, County A has 1,331 total discharge records. Only 12.6% (167) of these records are missing data. The 1,164 (1,331 – 167) discharge records with data show 261 clients are employed and 903 are not (261/1,164 = about 22% employed). County B has 83 total discharge records. But 81.9% (68) of these discharge records are missing data. The 15 (83-68) discharge records with data show that five are employed and 10 are not (5/15 = about 33% employed). These comparative statistics would erroneously show that County B has better employment outcomes than County A, if the records with missing data are excluded from the denominator when calculating percentages.

If the records with the missing data are included in the denominator, then more objective outcome comparisons across counties can be made. For example, County A had 1,331 total discharge records with 261 of them documenting employment at discharge. Therefore, County A shows 19.6% (261/1,331) employed at discharge. County B had 83 total discharges with five documenting employment. Therefore, County B shows 6.0% (5/83) employed at discharge.

The example above underscores the importance of ongoing data quality monitoring and management. CalOMS Tx contains numerous automated data quality controls to prevent erroneous data from entering the system. However, due to high turnover among county and provider staff, ongoing training and technical assistance by the state is needed to assist local agencies in understanding data errors and standards, correcting and resubmitting data rejected for error, and accurately reporting data.

In the past several years, DHCS has worked with counties, treatment providers, and other stakeholders to reduce the number of CalOMS Tx administrative discharges and to increase the treatment outcome data collection. It is important to factor in administrative/missing data to provide objective outcome comparisons. Counties and providers that increase their outcome data reporting and decrease administrative discharge record reporting should not be ranked lower in comparisons of outcomes. It is also important to factor in administrative/missing data when making comparisons across time periods (e.g., fiscal years) to provide more objective "apples to apples" outcome comparisons and trends.

Moreover, one of the key considerations in the development of the CalOMS Tx data system was client outcome measurement. It is recognized that client outcomes can include areas of client functioning that are often beyond the direct responsibility of the treatment provider. For instance, while the percent employed at discharge from treatment is an outcome measure, the treatment provider has limited influence over the immediate employability of the client and changing economic conditions in their area. Nevertheless, the effort to gather data, in this example, may encourage providers to attend to prioritizing client employment at discharge as a factor leading to better outcomes.

PROGRAM PERFORMANCE MEASURES

Program performance measures can be used to help evaluate the effectiveness of treatment programs in providing care to their clients. Previously DCHS also worked with the CADPAAC Treatment Data/Outcomes Subcommittee and others on possible program performance measures and models using CalOMS Tx data. The following information is based on those efforts.

CalOMS Tx collects a limited number of measures for evaluating program performance. More information needs to be collected to more thoroughly assess program performance. CalOMS Tx does not collect information on such areas as the percentage of clients who are engaged in treatment after being screened and assessed for needing treatment, level of service matching with assessed levels of SUD severity, and specific types and amounts of services each client received in treatment (e.g., number of counseling sessions). Though much work on developing and using data systems for program performance lies ahead, important steps in program performance measurement can be initiated with the basic measures now collected in CalOMS Tx.

Again, the largest percentage of admissions to treatment each year is to ODF services. ODF is also usually the last service type in a treatment episode. Therefore, the initial program performance work focused on the ODF service type.

Research indicates that clients who remain in treatment for at least 90 days are more likely to have positive outcomes at discharge and maintain recovery. For ODF services, staying in 90 plus days, being abstinent from drug use, and participating in four or more days of social support recovery activities in the 30 days prior to discharge are indicators of successful ODF treatment completion. These three CalOMS Tx measures, along with information about the percentage of discharges that are administrative, can be used to develop composite program performance measures and categories to compare ODF programs across years and counties.

Program performance measures and models serve best as “indicators” (not the only or absolute measures) to evaluate the effectiveness of treatment and to identify counties and individual programs with more effective services and those needing improvement. Not every client admitted to a treatment program for the first time or at any time, completes all treatment goals and is “cured” for life. There are many different paths and steps in the road to long-term recovery from the chronic lifelong illness of SUD. Nevertheless, research shows that people engaged in recovery efforts eventually do well. Even clients that only stay in treatment for shorter periods and do not complete all program goals often benefit from improved functioning and opportunities on the path to recovery. Long-term recovery often includes relapses and further treatment and recovery services.

The ODF Data Indicator Report (see Fig 20 on following page) illustrates eight categorical groupings of these data measures, and provides program performance comparisons for FYs 2011–12 and 2012–13. The eight columns range from the percentage of all discharges that meet all three of the treatment completion criteria (and provide standard discharges with the client outcome data), on the left side, to the percentage of discharges that meet none of the criteria, including not providing the client outcome data (an administrative discharge) on the right. Again, 90 days is used as the benchmark for minimum length of stay. Note: Length of stay is also obtained from administrative discharge records.

The percentage meeting all three criteria, and completing the standard discharge has remained stable at about 19% for both years. The percentage missing only adequate social support recovery has also been stable at about 13.5%. About one-third (19.1+13.6) of all the ODF clients we discharged drug-free and stayed in treatment 90 days or more during FY 2012–13.

The two furthest right hand columns provide information on the percentages of administrative discharge records for ODF services and have no outcome data reported. The administrative discharges still comprised more than a third (13.3+26.0) of all ODF discharges in FY 2012–13. The other middle columns provide some detail about program performance issues that need further attention for the ODF programs to meet all the program performance criteria.

DHCS will continue work to reduce administrative discharge reporting and support abstinence, adequate lengths of stay (retention), and client participation in social support recovery activities and other recovery support services. Future reports can include program performance measures and trends for other service types such as Detoxification, Residential, Intensive Day Care, and Outpatient Narcotic Treatment Program Maintenance. DHCS continues to strive to use continuous quality improvement models and systems, as well as data driven processes and systems, to improve health care quality.

Fig 20: ODF Data Indicator Report

Discharge Type	*Standard*	*Standard*	*Standard*	*Standard*	*Standard*	*Standard*	*Administrative[1]*	*Administrative[1]*
Performance Criteria	**90+ Days Stay**				**< 90 Days Stay**		**1 Criteria Met**	**No Criteria Met**
	3 Criteria Met	2 Criteria Met	2 Criteria Met	1 Criteria Met				
	Meets All 3 Criteria	Inade-quate Social Support	Drug Use Present	Adequate Length of Stay Only	Drug Ab-stinence	Drug Use	adequate length of stay only	meets no criteria
Drug Use Goal: 0 days	0 Days	0 Days	> 0 Days	> 0 Days	0 Days	> 0 Days	Data Not Collected	Data Not Collected
Length of Stay Goal: 90+ days	90+ Days	90+ Days	90+ Days	90+ Days	<90 Days	<90 Days	90 + Days	< 90 Days
Social Support Goal: 4+ days	4+ Days	<4 Days	4+ Days	<4 Days	*	*	Data Not Collected	Data Not Collected
% Total Discharges								
FY 2012-13	19.1%	13.6%	2.4%	4.9%	12.7%	7.9%	13.3%	26.0%
FY 2011-12	19.0%	13.4%	2.2%	5.2%	11.9%	7.7%	14.7%	25.9%

Notes:
Data for this report comes from the CalOMS Tx discharge data for Outpatient Drug Free (ODF) providers from FY 2011-12 through FY 2012-13.
Percents are calculated for each criteria group (columns) based on total client discharges for the corresponding fiscal year using CalOMS Tx Discharge Data.
[1]When providers conduct an administrative discharge they do not complete a standard discharge and data are not collected for Social Support and Drug Use.
Administrative discharges for death and incarcerated clients have been excluded.
*Some clients also meet the 4+ days social support recovery benchmark, but all clients stay less than 90 days.

(SOURCE) DHCS California Outcomes Measurement System for Treatment

Part 2 of this SNAP report outlines California's strategic plan and guiding strategy for best use of SAPT BG funds for FY 2016–2017. "California's strategic plan closely aligns with the federal initiatives announced in SAMHSA'S Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018.[1]) Six strategic plan priorities are identified in Part II, which are informed by the needs assessment conclusions in Part 1 and SAMHSA's 2015–2018 Behavioral Health strategic initiatives. Both federal and state strategic priorities are harmonized to target opportunities for measurable service improvements to minimize the harmful consequences of SUD. In accordance with 45 CFR §96.133, California's strategic plan lays out the SAPT BG-FY 2016–2017 priorities and goals, activities taken in furtherance of these goals, and the federal technical assistance requested for DHCS to accomplish its objectives in the future.

The six strategic initiatives guiding the use of SAPT BG funds include:

- Strategic Initiative #1: Prevention of Substance Use
- Strategic Initiative #2: Health Care and Health Services Integration
- Strategic Initiative #3: Trauma and Justice
- Strategic Initiative #4: Recovery Support
- Strategic Initiative #5: Health Information Technology
- Strategic Initiative #6: Workforce Development

1 http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2

INITIATIVE #1: PREVENTION OF SUBSTANCE USE

Strategic Initiative #1 focuses on preventing substance use by maximizing opportunities to create environments where youth, adults, families, and communities are motivated and empowered to manage their overall emotional, behavioral, and physical health. Special focus is placed on several high-risk diverse populations, including college students and transition-age youth; American Indian/Alaska Natives; ethnic minorities experiencing health and behavioral health disparities; service members, veterans, and their families; and LGBTQ individuals.

DISPARITIES

Significant behavioral health disparities persist in diverse communities across the U.S. Various subpopulations face elevated levels of mental and substance use disorders, and experience higher rates of suicide, poverty, domestic violence, childhood and historical trauma, and involvement in the foster care and criminal justice systems. Historically, these diverse populations tend to have less access to care, or experience disrupted service use, and poorer behavioral health outcomes. Through Strategic Initiative #1, California commits to addressing these disparities by improving cultural competence and access to prevention programs that serve all of these diverse groups and communities.

Prevention Priorities

The needs assessment performed in Part 1 of the SNAP report leads to the conclusion that DHCS must prioritize three prevention goals:

1. Improved data collection and review;
2. Planning for continuous quality improvement; and,
3. Building statewide capacity (organizational and field).

Part 1 gathers and interprets population-based data to understand the nature and extent of SUD and related behavioral health problems and consequences (i.e. outcomes). From the conclusions in Part 1, Strategic

Fig 21: Outcomes-Based Strategic Prevention Framework

Source: Substance Abuse and Mental Health Services Administration

Initiative #1 prevention priorities are developed that closely follow **SAMHSA's Strategic Prevention Framework (SPF)**, a five-step planning process guiding the selection, implementation, and evaluation of evidence-based, culturally-appropriate, and sustainable prevention activities.[2] The effectiveness of the SPF is enhanced by a clear understanding of community needs and depends on the involvement of community members in all stages of the planning and implementation process. DHCS uses a data-informed, outcomes-based approach throughout the SPF planning process, beginning with assessment of the negative consequences or outcomes that result from SUD. This approach allows DHCS to identify priority problems and recommend strategies that address these priorities. Based on the SUD and behavioral outcomes identified, risk and protective factors related to these outcomes are established and strategies are created and aligned to impact these factors (see Figure 21).

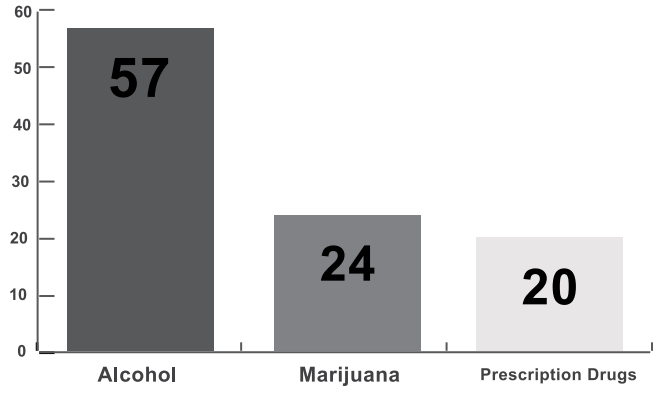
Although only a limited summary of data sources and data findings are presented in this SNAP report, DHCS-SUD staff based its ongoing assessments on Data Indicator and SNAP reports. Both the DHCS Office of Applied Research and Analysis and the Safe and Active Communities Branch of the California Department of Public Health have assisted our efforts to assess trends and current conditions. Though the availability of thorough data on risk and protective factors has proven difficult to attain, **Prevention, Treatment, and Recovery Services Division (SUD-PTRSD)** staff approaches this issue from a behavioral health perspective, identifying common or shared risk and protective factors across the life span and full socio-ecological spectrum from individual, family, community, and societal domains.

Consumption indicators continue to show that the rates of SUD (for several of the major substances) remain very high, starting at a very young age and increasing across the life span with alcohol (i.e., binge and heavy drinking) and marijuana use, peaking among young adults aged 18–29. Prescription drug use rates peak in the older, middle-aged group. Consequences data from health statistics (e.g., deaths, hospitalizations, and emergency room visits), law enforcement data (e.g., arrests, crime), and traffic data (e.g., driving under the influence) all indicate continued serious and widespread consequences from SUD.

Together, consumption, consequences, risk, and protective data indicate that targeted prevention efforts achieve some progress, but haven't made a major impact on minimizing the harmful consequences of Californians with an SUD. This conclusion highlights the importance of better leveraging prevention and treatment strategies in order to meaningfully decrease SUD. Thus, the role of SUD-PTRSD staff must be to drive systems change by recognizing the behaviors and activities that influence the ongoing and emerging SUD issues that negatively impact community health. Better targeted prevention efforts to meet the special needs of underserved populations will encourage the widespread implementation of SUD recovery evidence-based or best practices, and review, evaluate, and modify actions as needed to provide continual improvement. In order to create this systems change, DHCS must prioritize improving data collection and review, planning for continuous quality improvement, and building statewide capacity.

2 http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework

Fig 22: Major Topics in County Strategic Prevention Plans in FY 2012–13, by Number of Counties



SOURCE: California Outcomes Measurement Service for Prevention

Prevention Priorities: Strategic Prevention Framework - County Plans

CalOMS Pv collects the non-demographic data of participants engaged in prevention activities. The CalOMS Pv system contains county prevention Strategic Plans that are updated regularly by county staff. As part of the SPF process to develop or update these plans, counties collect available SUD-related prevalence and consequence data, and local information, to develop problem statements that describe local SUD issues. Goals and objectives are created from these problem statements to strategically address identified issues. Counties then assign objectives to specific prevention providers and budget funds for services. **Figure 22** outlines the general categories in which the problem statements fall: alcohol, marijuana, and prescription drug problems. The topics in the chart are identified using a using a broad word search within the CALOMS Pv system.

Strategic Prevention Framework-State Incentive Grant

DHCS is a cohort-four recipient of SAMHSA's Strategic Prevention Framework State Incentive Grant (SPF-SIG).[3] The project period is September 30, 2010, to September 29, 2015. At the state level, activities conducted under the grant include operation of the Advisory Council's implementation workgroup (see below), project implementation efforts of the Statewide Epidemiological Workgroup, monitoring of sub-recipient agreements and fiscal/programmatic tracking, and federal reporting. At the sub-recipient level, the community-level implementation activities conducted are consistent with the approved strategic action plans and logic models that have been used during the implementation phase of the project.

DHCS requested and received a one-year no-cost extension. This will allow prevention intervention activities to continue for eight additional months, and provides sufficient time for project close-out activities at both the county and state level, including the process and outcomes evaluation analyses.

Prevention Priorities-Interagency Prevention Advisory Council

The Interagency Prevention Advisory Council (IPAC) serves as the Advisory Council for the SPF-SIG project.[4] IPAC is a multi-agency council that meets quarterly, and has worked together since 2002. Membership includes state level agencies, criminal justice organizations, educational institutions, and emergency management agencies. Recognizing that SUD and the resulting consequences are costly to California, IPAC members work in a collaborative manner to leverage SUD prevention efforts, advising on best use of limited financial and human resources to contribute to the health and well-being of Californians, especially youth populations.This approach extends prevention efforts beyond those of a single agency.

3 The SPF-SIG program is one of SAMHSA's infrastructure grant programs and supports an array of activities to help grantees build a foundation for delivering and sustaining effective substance abuse and/or mental health services. Funded by the Center for Substance Abuse Prevention, the grant provides responsive, tailored, and outcomes-focused training and TA to SAMHSA Grantees to prevent substance abuse and related behavioral health issues. The grant targets efforts to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; reduce substance abuse-related problems in communities, and; build prevention capacity and infrastructure at the State/Jurisdiction/Tribe and community levels. See: http://captus.samhsa.gov/grantee/capt-clients/spfsig.

4 http://www.dhcs.ca.gov/provgovpart/Pages/SPFSIG.aspx

IPAC provides a mechanism to concentrate efforts on current prevention priorities, as well as the opportunity to "get in front of" emerging issues while minimizing duplication of effort or resources. Through an annual review and evaluation of priorities, IPAC creates a rolling multi-year plan that adjusts according to data and outcomes. Maintaining a focus on prevention priorities allows both short- and long-term goals to be addressed. Collaborative efforts will happen in the short term; and from a strategic perspective, expansion of the statewide prevention capacity will occur through the deliberate and combined efforts of multiple partners.

The following is a summary of IPAC primary functions:

- IPAC evaluates federal, state, and members' highest level departmental prevention priorities and then creates its own subset of annual prevention priorities identified as most likely to be influenced through its members' collaborative efforts.
- IPAC focuses its advisory role on aligning services and interventions with current prevention science, and building collaborative member relationships to expand the statewide capacity to address SUD.
- Each member's department or organization works autonomously and according to their respective department's strategic plans, while at the same time contributing to the achievement of IPAC's prevention priorities through collaborative efforts with other members.
- At the core of IPAC are workgroups that review research, evaluate emerging trends, plan for the future, and make recommendations to the general membership. The workgroups consist of both IPAC members and non-members who demonstrate expertise in the workgroup topic.

INITIATIVE #2: HEALTH CARE AND HEALTH SERVICES INTEGRATION

Strategic Initiative #2 focuses on efforts to increase integration in health care and across systems, including systems of particular importance for individuals with behavioral health needs, such as community health promotion, health care delivery, specialty health care, emergency care and response, and community living needs.

Integration efforts seek to: increase access to appropriate high quality prevention, treatment, recovery, and wellness services and supports; reduce disparities between the availability of services for mental illness (including serious mental illness) and SUD compared with the availability of services for other medical conditions, including those for people from minority populations who experience significant health disparities; and support coordinated care and services across systems.

Awareness is increasing about the high rates of co-occurring physical health, mental health, and SUD conditions. Co-occurring conditions drive increases in health care costs, reduce life expectancy, and require greater attention to the development of system-wide effective goals and strategies to support improved health for these individuals. Individuals with both physical and behavioral health conditions are served by fragmented systems of care with little to no coordination across providers or systems. This fragmentation leads to poor quality, disparate financing, and higher cost of care, as well as poor health, reduced productivity, and higher costs for businesses and publicly-funded systems such as justice, education, and human services. Behavioral health is essential to the overall health and well-being of individuals, families, and communities. Efforts must be made to tailor and customize aspects of health care systems to ensure access to treatment services and to support improved health for individuals with behavioral health needs, wherever they are present.

DISPARITIES

Historically, low-income minority populations were less likely to have coverage or access to health care. As such, delivery systems often lack awareness, data and information, and infrastructure to effectively treat these populations. Additionally, while much attention has focused on the vital role of primary care providers, it is necessary to focus on other key providers and systems to decrease fragmentation. Health care systems must be tailored and customized to support improved health for individuals with behavioral health conditions from underserved racial/ethnicity groups and LGBTQ populations. Integration must include public health and community living services and supports, as each is a necessary partner to decrease fragmentation and improve health disparities experienced by individuals with behavioral health needs, particularly those from minority populations, and improve both physical and behavioral health outcomes for all people.

FOSTER INTEGRATION BETWEEN HEALTH, SOCIAL SUPPORT, AND PREVENTION SYSTEMS

Santa Clara operates an innovative organized system of care for the prevention and treatment of SUD. Patients are assessed using the **American Society of Addiction Medicine (ASAM)** criteria at a Gateway site or satellite assessment center co-located in strategic sites (e.g. drug courts, detoxification sites) and sent to the appropriate treatment provider based on their needs and on system availability, which is known due to daily capacity reports. Once a patient is in treatment, providers can refer them directly to each other to meet changing patient needs, with the exception of increased levels of care or transitional housing, each of which must be pre-authorized by the county. Providers undergo continuous performance and outcome monitoring by the county's quality improvement unit and attend mandatory performance meetings. Multiple system performance measures are also monitored (e.g. daily capacity and waitlist, client outcome measures, average lengths of stay, etc.). The county is also integrating SUD services with primary care in their Moorpark Medical Home and Alexian Integrated Care Project. In each case, an SUD specialist is located on-site to provide brief interventions and to ensure a link to the specialty care system where and when needed.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT AND TECHNICAL ASSISTANCE NEEDS

The new California Medi-Cal covered service SBIRT is a foothold in primary care settings, leading to better integration and coordination of primary care and SUD treatment systems. California has offered the SBIRT benefit to adult Medi-Cal beneficiaries since January 1, 2014. As a result, DHCS expects that primary care providers will screen and identify a larger pool of beneficiaries who engage in risky or hazardous drinking or alcohol use. These patients need referral to treatment, and require expanded capacity in the current federally-funded service system. In order to align with the DHCS mission, which is to provide Californians with access to affordable, high-quality health care services, increased assessment of treatment needs and referrals must be met with broader availability of services.

The federal government can be instrumental in helping California increase treatment capacity, including facilitating increases of SUD provider availability for referral to services. Receipt of additional funding and technical assistance could support state, county, provider, and community-based efforts to expand cross-training of clinical staff to coordinate and integrate physical health, SUD, and MH treatment teams into a unified system. Federal incentives provided to expand resources and cross-train physical health, SUD, and MH multi-disciplinary teams are needed. Availability of cross-trained teams will increase capacity and the ability to provide quality treatments for alcohol use disorders. Federal incentives will also help develop and expand innovative practice settings to include care coordinators, open new venues, or co-locate services operating in a single setting where multi-disciplinary teams are readily available to beneficiaries.

BEHAVIORAL HEALTH FORUM

DHCS launched the **Behavioral Health Forum (BHF)** in March 2014, which will meet quarterly thereafter, to provide key stakeholders and other interested parties with updates regarding critical policy and programmatic issues impacting public **mental health-substance use disorder (MH-SUD)** services.[5] The BHF gives stakeholders an opportunity to learn about the status of more than

5 http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

100 program and policy issues identified in the DHCS Business Plan, as well as from other sources, such as the California Mental Health and Substance Use System Needs Assessment and Service Plan.[6] Stakeholder feedback has been organized into a grid format and assigned to six forums:

1. Strengthen Specialty Mental Health and Drug Medi-Cal County Programs and Delivery Systems;
2. Coordinated and Integrated Systems of Care for MH-SUD and Medical Care;
3. Coordinated and Useful Data Collection;
4. Utilization and Evaluation of Outcomes;
5. Client and Family Member Forum; and,
6. Simplified and Cost Effective Fiscal Models.

Each of these forums provides DHCS with a venue for updating stakeholders on identified priority areas. These forums also give stakeholders across the state and interested parties an opportunity to provide input on these priorities. Stakeholder participation will vary depending on the particular topic being addressed by that forum. If appropriate, DHCS will convene workgroups of key stakeholders and subject matter experts to develop recommendations related to specific program and policy issues.

Priorities for the BHF-Integration Forum for FY 2015–16 include:

- Ongoing Integration Efforts in the Development and Implementation of the 1115 Waiver Renewal Development and Implementation;
- Review of data related to success implementing best practices, screening, and assessment tools (e.g. SBIRT);
- Identifying and Supporting Best Practices;
- Workforce Development;
- Health Homes;
- Increasing DHCS collaboration cross-sector (e.g. Justice System, Education System);
- Review of the Substance Abuse and Mental Health Services Administration (SAMSHA) MH and SUD Block Grant: Needs Assessment and Strategic Initiatives as related to integration;
- Development of relationships between managed care plans and SUD providers, and the role of DHCS; and,
- Support Initiatives to Implement New Medicaid Provisions.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM 1115 DEMONSTRATION WAIVER

On August 13, 2015, DHCS received approval from the **Centers for Medicare and Medicaid Services (CMS)**. The waiver amendment will make improvements to the **Drug Medi-Cal (DMC)** service delivery system, provide for more local control and accountability by concentrating on high-quality providers, improve local coordination of case management services, and require implementation of evidence-based practices in SUD treatment and coordination with other systems of care, including physical health. The **Drug Medi-Cal Organized Delivery System (DMC-ODS)** amendment will demonstrate how organized SUD care increases the success and recovery of DMC beneficiaries while decreasing other health care system costs. The DMC-ODS 1115 Waiver effort also provides for a continuum of care modeled after the ASAM criteria for SUD treatment services.[7] 53 of California's 58 counties have expressed interest to opt in to the waiver. In short, the DMC-ODS 1115 Waiver model provides a more robust continuum of care.

This waiver amendment will allow the State to extend the DMC Residential Treatment Service as an integral aspect of the continuum of care to additional beneficiaries. Historically, the Residential Treatment service was only available to pregnant/postpartum beneficiaries in facilities with a capacity of 16 or fewer beds. The waiver will authorize a Residential Treatment service operable in facilities with no bed capacity limit, and no restriction on beneficiary type.

In California's larger Medi-Cal 2020 1115 Waiver, the state proposes a reform strategy that would encourage physical and mental health plans to implement an integrated care model at the provider level for patients with serious mental health and other chronic health conditions. Under this proposal, managed care plans would offer incentives based on tiers of increasing physical health and mental health integration to ensure that team-based care is provided to Medi-Cal members

6 http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf and http://www.dhcs.ca.gov/Documents/StakeholderRecommen_forMHSUD.pdf

7 http://www.asam.org/

with mental and physical health needs, using either a coordination or co-location approach. This could include incentivizing cross-training of providers, as well as the use of telehealth. Both primary care practices and mental health providers would be eligible to adopt this model, so there is "no wrong door" for a member who needs integrated care for both mental and physical health care who chooses to receive their care in each respective setting.

There are critical elements to receive approval for a pilot program under Medi-Cal 2020. Proposals must feature a clear governance structure that describes the role of the various partner entities and the proposed financing arrangements. Proposals must include a detailed plan for achieving care coordination and integration across all of the participating entities and must include behavioral health integration as a component, which includes SUD services.

The partnership must specify how they plan to structure care teams, how they will create individualized care plans for each patient that addresses the medical, behavioral, and social needs of the patient, and how they will select a single accountable individual on the care team that will be the patient's main contact and be accountable for ensuring the patient's care plan is carried out in a culturally competent manner. Pilots located in counties that are also expanding use of medical homes for complex patients will integrate their work with Health Homes and use those care coordination funds to advance patient support in the pilot.

VOLUNTARY INPATIENT DETOXIFICATION

SAMHSA's strategic plan priorities supports federal, state, territorial, and tribal efforts to develop and implement new provisions under Medicaid and Medicare. To this end, in accordance with Senate Bill X1-1 (Hernandez, Chapter 4, Statutes of 2013) Section 29 and the Patient Protection and Affordable Care Act, effective for dates of services on or after January 1, 2014, voluntary inpatient detoxification is now a covered benefit of the Medi-Cal program for qualifying beneficiaries as medically necessary. This is a fee-for-service benefit reimbursed by diagnosis-related group methodology for inpatient general acute care hospitals that do not participate in **certified public expenditure (CPE)**. reimbursement, and is reimbursed by CPE for designated public hospitals providing inpatient general acute care services.

EFFICIENT USE OF FINANCING MODELS

Analyzing essential SAMHSA-funded services not otherwise covered

Our current data analysis for the SAPT BG application surveys the range of SAPT BG services and the payments made for these services. These data are based on the annual cost report that is submitted by each county for any given fiscal year. Any service that is paid for by SAPT BG funds will, by definition, not be paid for by Medicaid, Medicare, or other insurance. DHCS is able to differentiate these services based on the associated funding per the cost report data from each county.

Innovations and studies on emerging payment models

The recently submitted DMC-ODS 1115 Waiver proposal will transform the current service delivery models to resemble Medi-Cal managed care plans that are currently in place within DHCS. This will have a significant effect on the use of SAPT BG funds as increased services will be supported. Movement in the direction of a managed care model for the SUD service delivery system will lay the groundwork for other potential alternative payment models. This will occur in conjunction with another initiative pursued by DHCS, a pilot study for the specialty mental health services counties exploring alternative payment models for the current managed care plans that are in place.

Collaboration with CMS regarding financing and delivery platforms

As mentioned above, the DMC-ODS 1115 Waiver creates a pathway for developing new financing and payment models. DHCS hopes that by enabling more flexibility, local authorities will spur more innovation in regard to financing and delivery platforms with the ultimate goal of strengthening the continuum of care.

Support application of SAMHSA's Theory of Change to SAMHSA funding decisions.

In order to improve behavioral health outcomes, DHCS will need to continue designing new metrics, make accurate measurements, and provide continuous quality improvement support to providers. The current outcomes measurement system, CalOMS, is dedicated to the SAPT behavioral health service providers and will need enhancements and updates in order to meet this objective.

California's Fiscal Forum

As described above, DHCS created the BHF to provide key stakeholders and other interested parties with updates regarding critical policy and programmatic issues impacting public MH-SUD services. Gathering stakeholder input on these issues is crucial. One of the six main forums is the Fiscal Forum, designed to tackle a multitude of issues surrounding behavioral health financing.

The Fiscal Forum Charter objectives include making efforts to specifically address key areas related to improving fiscal policy, reimbursement methodologies, and billing processes for MH-SUD. The Short-Doyle Medi-Cal objectives of the forum are to develop longer-term fiscal models to move forward in the areas of post-realignment and health care reform. In addition, the forum explores methods to pursue solutions to provide counties with greater flexibility to manage fiscal and program risks, as well as implement different program and fiscal models. In pursuing fiscal innovation, BHF objectives include reporting and gathering stakeholder input on DHCS efforts to develop better processes for state and counties to define roles and responsibilities. Financial risk must be managed and shared in order to establish effective policy and processes for purchasing services. Program oversight streamlining is sought to reduce administrative burden that could detract from investing funds in direct services. Within these objectives are efforts to establish effective policies and processes for purchasing services.

The Fiscal Forum FY 2014–15 Priorities included:

Improving fiscal policies, statutes, and regulations:

- A priority of the Fiscal Forum is to determine where authority lies for which types of decisions. Likewise, another goal is to determine the extent to which discontinuities exist between authority, responsibility, and financing, and where legislation, regulations, or new models are needed.
- There are a number of Drug Medi-Cal-specific statutes enacted since 1980 which should be explored further. Many of them outline the mode and method, even the number, of treatments available under the DMC program, as well as establish rate-setting and reimbursement models.
- DHCS recognizes rural and small county issues in financing and service delivery through Medi-Cal. The challenges of service delivery in the smallest counties should be considered in all finance-related decision making. Large counties contain rural areas with similar challenges that are in need of similar consideration.

Improve Reimbursement Methodologies

DHCS should further explore options for the design of state and county financing mechanisms, including continued fee-for-service, capitation, pay-for-performance, or other models. DHCS hopes to collaborate with the counties in this regard, while being responsive to their individualized needs.

DHCS must seek to provide counties the authority and tools to contract with high-performing, financially-responsible providers in order to provide cost-effective services that produce good clinical outcomes. County reimbursement of providers is aligned with outcomes. This is a phased process considering all the other changes on the horizon. The system has metrics on which outcome-incentivized reimbursements can be based.

Improve the Billing System/Process

Standardizing SUD fiscal systems, including budgeting, cost reporting, and billing formats and requirements must be done within the broader context of reducing and simplifying state-imposed administrative burdens. Budget, cost report, billing, and claims adjudication processes for DMC should conform to practices of Short-Doyle Medi-Cal (This means timelines, data elements, reporting requirements, communications between state

and counties, etc.) to ensure quality and efficiency in both communication and administration. Billing processes must be streamlined. The forum objectives include examining the legal and information technology system requirements/business rules/processes for timely reimbursement of claims and to reduce the number of disallowed claims. Increasing the efficiency and accuracy of the Medi-Cal Eligibility Determination System must occur. Simplifying Medi-Cal aid codes and enrollment and eligibility systems will move processes in the direction of simplification.

PARITY, THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA), AND THE AFFORDABLE CARE ACT (ACA)

California has expanded services for SUD in line with mandates of the ACA and in the spirit of parity with mental health and physical health services.[8] Greater advances still need to occur, but California has expanded benefits by embracing the expansion population, gaining approval for two State Plan Amendments, implementing SBIRT, and creating the BHF to elevate SUD issues to the forefront with mental health issues.

Expansion Population and Expanded Drug Medi-Cal Services

Passage and implementation of the ACA required an amendment to California's Medicaid State Plan. The ACA required that health insurance plans be made available to more citizens, mandated that SUD services be included as an essential health benefit on all health insurance plans, and increased the number of Californians eligible to receive Medi-Cal as their health plan. SUD benefits available to Medi-Cal beneficiaries are known as DMC. DMC services are accessed by beneficiaries through counties or community providers certified by DHCS to provide DMC services.

To conform to ACA requirements, DHCS completed two State Plan Amendments (SPA). SPA 13-035 adopted an alternative benefit plan for the expansion population that includes SUD treatment as one of the essential health benefits.[9] SPA 13-038 expanded SUD services for the Medi-Cal population.[10] A significant change is that Day Care Rehabilitative Treatment services have been renamed Intensive Outpatient Treatment services and made available to more beneficiaries. Previously available only to those who are pregnant, postpartum, or youth eligible for Early and Periodic Screening, Diagnosis and Treatment, Intensive Outpatient Treatment is now authorized for all beneficiaries who meet the requirement for medical necessity. The SPA also removed the 200-minute limit on counseling in narcotic treatment settings, as the ACA prohibits quantitative limits without medical necessity. The SPA added treatment planning as a component of the Narcotic Treatment, Naltrexone Treatment, and Outpatient Drug Free Treatment programs. Based on discussions with CMS beginning in January 2014, residential treatment services were removed from SPA 13-038. Nevertheless, the state and CMS continue discussing options for the provision of comprehensive SUD services including residential treatment. In addition, the DMC-ODS 1115 Waiver discussed above proposes an amendment to allow the State to extend the DMC Residential Treatment Service as an integral aspect of the continuum of care to additional beneficiaries.

SBIRT

As described earlier in this report, SBIRT serves as a crucial step in parity for SUD treatment by bridging the gap between the SUD treatment system and the primary care and mental health systems. Managed care plans hold little responsibility for SUD treatment, as the DMC program is entirely carved out.[11] Requiring plans to cover the screening for SUD treatment needs is the first step in fostering care coordination between a patient's primary care provider and SUD treatment provider. The contract DHCS maintains with MCPs requires them to create business associate agreements with counties, as well as create policies and procedures for referrals and care coordination of SUD clients between systems and providers. Implementation of SBIRT is still underway as it only became a requirement on January 1, 2014, but DHCS is working to review and approve these policies and procedures to aid in the care coordination between

8 The Mental Health Parity and Addiction Equity Act of 2008 requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. See http://www.dol.gov/ebsa/mentalhealthparity/ for more information.

9 http://www.dhcs.ca.gov/formsandpubs/laws/Documents/13-035_ACA_Alt_Benef_Plan.pdf

10 http://www.dhcs.ca.gov/formsandpubs/laws/Pages/13-038.aspx

11 Behavioral health carve-outs are defined as programs that contract directly with managed behavioral health organizations, separately from the remaining health care benefit package. Carve -outs include mental health and substance use disorder services specialists.

these historically-isolated treatment sectors. The BHF-Integration Forum has targeted discussion of these contracts for FY 2015–16.

Behavioral Health Forum

Again, the BHF provides a publicly visible forum to elevate parity and equity issues plaguing the SUD and MH treatment fields. Both of these behavioral health sectors are highlighted with equal weight in the BHF quarterly meetings in the spirit of integrating parity for both systems. Additionally, progress is made with gathering stakeholder feedback in these forums in advancing these two fields in order to showcase them equally with the primary care field. The objectives of all six BHF subcommittee forums include elevating the SUD and MH systems to have greater integration with primary care, upgrading DHCS data systems to be as robust as the medical sector, and strengthening the behavioral health services and system infrastructure in preparation for better integration and parity with primary care.

FOSTER IMPLEMENTATION OF QUALITY INDICATORS TO ADVANCE BEHAVIORAL HEALTH OUTCOMES IN THE HEALTH CARE DELIVERY SYSTEM

SAMHSA's strategic initiative encourages integrating key quality health indicators into all SAMHSA service programs. Regarding the SAPT BG, in 2014 and 2015, DHCS-SUD reported to SAMHSA efforts to develop quality indicators containing criteria to measure program performance standards/measures. DHCS-SUD developed three strategies to attain these goals. The strategies are as follows.

INCREASING COMPLETE AND ACCURATE REPORTING OF TREATMENT ADMISSION, DISCHARGE, AND ANNUAL UPDATE DATA

An integral component of this work to implement quality indicators is ensuring data quality. This work includes monitoring administrative discharges, open admissions, and annual update reporting. Data reporting quality (including validity, reliability, and completeness) is critical to accurate treatment program performance and client outcome measurements and comparisons. If outcome measures are calculated on an incomplete/inaccurate set of data, then biases may be introduced in the comparisons of service providers and counties with varying data quality. Furthermore, generalizations to the State may be biased since the performance and outcomes of those for missing data cannot be assumed to be exactly the same as those for which data was submitted.

For FY 2014–15, DHCS identified the following data quality metrics for monitoring:

1. Admissions open longer than one year without a discharge or annual update; and
2. Percent administrative discharges.

DEVELOP TREATMENT PROGRAM PERFORMANCE AND CLIENT OUTCOME MEASURES

Four Program performance and client outcome measures for Outpatient Drug Free treatment were established:

1. Abstinence at discharge;
2. In treatment 90 days or longer;
3. Engaged in at least four days of social support recovery activities at discharge; and
4. Submitting standard discharge containing the needed outcome measurement data. This performance/outcome data are from CalOMS Tx, and collected from publicly-funded and monitored SUD treatment services in California.

DEVELOP TREATMENT PROGRAM PERFORMANCE AND CLIENT OUTCOMES SCORECARDS FOR DIFFERENT SERVICE TYPES

Earlier in Part I of this SNAP report, the Statewide Needs Assessment provides a description and example of the methods used to develop the Outpatient Drug Free Indicator Report. In addition to this work, DHCS has drafted another **Perinatal Data Indicator Report (PDIR)** as well as a data report for each county-**Office of Women's Youth and Prevention Services (OWPYS)** County Data Reports.

The PDIR was developed to establish a benchmark to measure relative program performance for residential perinatal providers and counties. The PDIR serves as a continuous quality improvement model for SUD treatment programs serving pregnant women and women with dependent children.

Four program performance and client outcome measures for the Residential PDIR were established:

1. Abstinence at discharge;
2. In treatment 31 days or longer;
3. Engaged in at least eight days of social support at discharge;
4. Submitting standard discharge containing the needed outcome measurement data; and
5. The performance/outcome data are from CalOMS Tx, and collected from publicly-funded and monitored SUD treatment services in California.

OWYPS County Data Reports: Findings from the data reports are used to review demographic information and identify county and statewide trends and to facilitate comparison analysis. OWYPS uses this information to provide technical assistance and training to counties on a daily basis to help strengthen treatment services for women. The County Monitoring Unit within the Performance Management Branch references the data reports during site visits and desk reviews when monitoring programs at the county level.

INITIATIVE #3: TRAUMA AND JUSTICE—IMPLEMENT TRAUMA-INFORMED SERVICES IN BEHAVIORAL HEALTH

Research, clinical experience, and users of behavioral health services have increasingly documented the connection between trauma and mental and substance use disorders. SAMHSA's Trauma and Justice Strategic Initiative #3 encourages a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, human services, and related systems, with the intent to reduce both the observable and less visible harmful effects of trauma and violence on children and youth, adults, families, and communities. The importance of understanding trauma and implementing a trauma-informed approach is the foundation of Strategic Initiative #3 activities, which include:

- Integrating trauma approaches across service sectors;
- Coordinating training and technical assistance;
- Establishing a measurement strategy;
- Assisting communities in the preparation for, response to, and recovery from traumatic events that include disasters;
- Responding appropriately to those who have experienced military trauma;
- Understanding the effect of community trauma; and
- Providing tools for communities to promote resilience and effective responses.

While the effects of trauma and exposure to violence are found in all service sectors, it is particularly prominent among people with mental illness or SUD in the criminal and juvenile justice systems. Strategic Initiative #5 particularly focuses on improving the well-being and personal recovery of individuals with mental, substance use, or co-occurring disorders involved with the justice system through innovative diversion practices, strategic links with community-based providers and correctional health, effective re-entry programs, and policy development. Thus, while Strategic Initiative #5's activities are quite comprehensive and far-reaching, the

common element is focusing on the links between trauma and behavioral health issues for children and youth, adults, older adults, families, and communities.

DISPARITIES

Trauma, violence, and involvement with the criminal justice system disproportionately affect individuals, families, and communities of non-white ethnicity, including indigenous and native populations. Racial, ethnic, sexual, and gender minority individuals experience trauma not just as individuals, but often also in the context of historical, intergenerational, or community trauma, which further compounds the effects of specific traumatic events. Mass trauma, such as natural disasters, often leaves these communities underserved, unserved, or cut off from recovery resources. These communities are over-represented in the justice system, are provided less opportunities for diversion from the system, and often move deeper into a system that itself is traumatizing and not geared toward recovery for people with mental illness or SUD. For some people in these communities, the justice system becomes the de-facto behavioral health system.

The activities of Strategic Initiative #5 should include focusing on these often-underserved communities and promoting their healing and recovery from traumatic events and associated behavioral health issues. In this SNAP report, DHCS-SUD staff chooses to highlight ongoing statewide efforts to address trauma, justice, and disparity in the context of recovery from SUD for Native American populations. The approach used with this population is illustrative of how the issues of trauma, justice, and disparity should be considered throughout all service interventions with all populations.

Native American Populations

California is home to the largest population of Native Americans in the U.S., with well over 100 federally recognized and unrecognized tribes within the state.[12] In March 2012, the Native American Strategic Planning Workgroup produced *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans (Native Vision).*[13] The report was the culmination of two years of work by the eight-member Native American Strategic Planning Workgroup Advisory Committee. The summary below includes the authors' views on why historical trauma must be addressed when developing best practices and policy for Native American behavioral health services.

There are many reasons why disparities exist in mental health for Native Americans; the reasons stem from federal and local policies that governed the quality of life for Native Americans over the past 400 years. These government policies never had wellness as a goal or a strategy for Native Americans. In fact, the opposite was true; federal policies were initially directed at the extermination of Native Americans through genocide, outlawing of traditional and cultural practices, and removal from their homelands. When extermination efforts failed, the reservation system was implemented and created a dependence on government for basic life needs such as food and clothing. The next wave of cultural genocide came through the form of assimilation policies, which were directed to acculturate Native Americans into the mainstream society. Boarding schools were implemented and Native American children were taken from their homelands and forced to reject tribal culture and adapt to mainstream society. Severe punishments were issued for speaking Native languages, practicing ceremonies, and participating in anything culturally Native American. Academics often refer to this time period as the origin of historical trauma.

Former Surgeon General David Satcher pointed out in *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*, that the current mental health system is an outcropping of the American mainstream culture centered on the beliefs, norms, and values of white Americans. [14] The mental health system is not equipped or trained to deal with the mental health concerns of ethnic groups, as the mental health system itself is rooted in racist practices toward diverse populations. It is difficult to

12 United States Census 2010. http://www.census.gov/aian/census_2010/

13 http://nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf.

14 United States Department of Health and Human Services (USDHH) (2001), Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

access this system of care for many Native Americans who need mental health services. For many other Native Americans there is no interest in accessing services that are unhelpful and denigrating.

Former Surgeon General David Satcher called attention to the history of "legalized discrimination" against Native Americans and other ethnic groups in the United States. Many ethnic groups have endured historical persecution as well as present-day struggles with racism and discrimination.[15] The U.S. Department of Health and Human Services supplemental report references a series of studies to measure the impact of discrimination on mental health. The findings of these studies corroborate an existing and growing body of evidence that indicates that racism and discrimination are clearly stressful events that have physical and psychological impacts on the people who experience them, directly placing these people at increased risk for a large range of health disparities. Data show that an individual's race has an added impact over and beyond factors such as diet and exercise, or socioeconomic indicators of poverty and education. Racism and discrimination adversely affect physical and mental health, and place minorities at risk for mental disorders such as depression and anxiety.

Despite these findings, clinicians are rarely trained to take the stressful events of racism, discrimination, and genocide into consideration when drafting a diagnosis. The **Diagnostic and Statistical Manual of Mental Disorders (DSM) V**, a required tool for many mental health funding sources, does not take into account these historical and environmental factors. Consequently ethnic groups are often misdiagnosed and prescribed treatments that do not address the root cause of the conditions from which they suffer (USDHHS, 2001). In order for California to take practical and realistic steps toward addressing mental health disparities among Native Americans, it must acknowledge the limitations of its own role and look outside of the boundaries of its own operations to address the issues.

A more appropriate diagnosis for Native Americans that takes into consideration institutionalized discrimination is historical trauma and historical trauma response.

Historical trauma is a cumulative emotional and psychological wounding across generations. Historical trauma response is a collection of features in reaction to this trauma. These terms, which have been accepted and developed by Native American mental health practitioners, place prominent mental health conditions among Native communities in the context of genocidal policies and actions. Suicide and substance use are behaviors rooted as normal responses to overwhelming traumatic events, which include forced removal of children from a community to be institutionalized at boarding schools and the removal of whole tribes from traditional homelands to other areas. Native American boarding schools were rampant with widespread abuse and the eradication of tribal languages and cultural practices. Even though both the terms historical trauma and historical trauma response are often most appropriate diagnoses for Native Americans, neither are indexed in the DSM-V.

Culture and language affect the perception, utilization, and even the outcomes of mental health services. To reduce disparities for ethnic communities, services need to be provided in a manner that is congruent rather than conflicting with Native cultural norms.[16] Offering care only to individuals in a clinical setting is an example of mainstream values being thought of as a universal best practice for all cultural groups. Native Americans and other ethnic groups do not share the emphasis on individualism that is prominent in the mainstream culture. For group-oriented cultures, group-based or community-oriented interventions are often effective, more accepted, and many times more appropriate. Embedded in Native American culture are many protective factors to weather adversity and ward off the potential development of mental illness. As widely documented in psychosocial literature, some of these protective factors include belonging, feeling significant, and having a supportive social network of community that serve as counselors, mentors, and friends. An effective protective factor produced by Native American historical ceremonies is a strong cultural identity. Identity was targeted for attack by federal policies that outlawed Native American culture and literally made it illegal to be a Native American. The most successful Native American programs are those that

15 Ibid.

16 Ibid.

revive culture, thereby reducing the risk factor of isolation that many Native Americans experience being the only Native American in their school, classroom, or place of employment. Stigma is reduced when Native Americans are able to get services at agencies that understand the mental health conditions that are prevalent in California communities. While we would like to believe the state could provide this through existing county institutions, after all that has happened, and how minimal the change and support to Native American communities has been, Native Americans are not optimistic about this prospect. The approach that will yield the best chance of success and sustainability is to support and strengthen the efforts of community-defined programs and empower community experts to address the needs of Native American mental health.

The AI/AN population in California experience elevated rates of poverty, violence, substance use, depression, and other psychological maladies when compared to non-Hispanic whites.[17,18] Unfortunately, these factors are co-occurring, placing Native American individuals simultaneously at risk for each. Often federal and state funders of behavioral health services require providers to use **evidence-based practices (EBP)**. The practices, however, lack the diverse Native American communities' cultural, linguistic, and geographical differences within California. Moreover, counties and state agencies' inadequate outreach and understanding of Native American culture negatively impacts Native Americans' behavioral and physical health care.

California's Native Americans reside in metropolitan/urban, rural, and tribal reservation communities, each facing unique challenges to mental health. Nonetheless, for optimal effectiveness, the provision of mental health services must occur in a cultural network that integrates the patient's indigenous community into the treatment plan along with prevention and early intervention services. Providing services within a cultural network that includes family and community support, results in patients' greater acceptance of mental health therapies. Placing these services in familiar contexts, such as the community, creates a sense of trust and belonging. For example, talking circles are being used successfully in treatment and prevention services among Native American communities across California. The Red Road to Recovery, a healing model developed by Gene Thin Elk, is one of several SUD programs that has assisted thousands of Native Americans attain sobriety. The model is a holistic approach that combines indigenous and mainstream approaches into wellness and healing.[19]

Promising Practices and Effective Models among Native Americans

The California Native American population is diverse and no single behavioral health prevention or early intervention strategy is appropriate for everyone. Programs must consider the multiple needs of the individual, family, and community. Native Vision identifies a variety of promising practices and effective models that are proving effective in reducing mental health disparities among Native Americans. These models were generally grown from grassroots community perspectives. The successful implementation of community-defined behavioral health practices in California Native American communities involves a mixture of disciplines. Communities use indigenous-based cultural practices and Western-based practices to address their unique needs. Addressing co-occurring disorders, SUD, historical trauma, poverty, and other intersecting issues beyond behavioral health is essential in healing communities.

According to the National Registry of Evidence-based Programs and Practices, EBPs are approaches to prevention or treatment that are validated with scientific evidence. Evidence is often established through scientific research methods. As such, EBPs are difficult to align with tradition, convention, belief, or anecdotal evidence. Although, EBPs are scientifically proven designs for prevention and intervention among certain populations, rarely are they tested for cultural validity within Native American communities. Practice-based evidence, however, removes a practice from a controlled scientific environment and implements it within a specific community. If found effective, the practice gains community evidence that it works within the tested

17 California Tribal Epidemiology Center. 2009. California American Indian Community Health Profile. Sacramento, CA: California Rural Indian Health Board. http://www.crihb.org
18 California Rural Indian Health Board. 2010, October. American Indian and Alaska Native Health Assessment in California. Sacramento, CA: Author.

19 Thin Elk, G. 2011.

community. For California Native Americans, community validation appears as important as scientific validation because cultural values vary and can be unique among tribes. As such, what works within one community does not necessary work within others. Many of the promising practices and effective models supported by the Native American Strategic Planning Workgroup Report focused on **community-defined evidence (CDE)**. Practices validated by CDE as effective may not be measured empirically. Nonetheless, they did achieve a certain level of community acceptance as best practices.[20] Obtaining community-defined evidence helps identify cultural adaptations to EBPs that are effective among California Native Americans.

The following prevention and early intervention behavioral health practices were identified through the Native American California Reducing Disparities Project, 11 focus group gatherings, the eight-member Native American Strategic Planning Workgroup Advisory Committee, Native Vision staff, and input from tribal and urban Native American entities and individuals throughout the state. The following section contains an overview of projects highlighted within the Native Vision report.

Community Prevention/Education, Cultural and Subsistence Skill Development

Gathering of Native Americans (GONA) is a methodology consisting of a curriculum that provides a structured format for Native Americans to address SUD issues in a cultural context. The GONA curriculum was developed by a consensus of Native American professional educators and clinicians convened by the Center for Substance Abuse Prevention at SAMHSA. The GONA curriculum focuses on SUD and mental health issues underlying addictions and self-destructive behaviors. Community healing from historical and cultural trauma is a central theme of the GONA approach. This includes an understanding and healing of self, family, and community by validating the oppressiveness of experiences in the social context of historical trauma.

The California Native American **Holistic System of Care (HSOC)** for Native Americans was developed at the Community Wellness Department of the Native American Health Center for urban environments.[21] It is a community-focused intervention that provides behavioral health care, as well as promotes health and disease prevention. The HSOC integrates mental health and substance use services with medical, dental, and HIV services.

In Los Angeles County, the Learning Collaborative was created to provide a community-informed approach toward integrating traditional-based healing practices for Native Americans. The project's goal was to identify and support the community's strengths for bringing mental wellness to Native American residents. Traditional healing activities encompass a broad spectrum of cultural activities from drumming, bead making, attending Pow-wows and participating in sacred healing ceremonies.

SUD is a significant issue among the AI/AN population, and it is important to recognize the need for culturally-appropriate services, as these services are generally the most successful. There are, however, significant variations that exist among tribes. As such, it is important to recognize that what is effective within one tribe may not be within another. Similarly, what the field may consider a generally effective EBP among most populations may be completely inappropriate for Native American populations.

TRAUMA-INFORMED SERVICES

OWPYS at DHCS provides technical assistance to counties serving women, specifically pregnant women and women with dependent children. In response to requests from counties, OWPYS creates and distributes customized technical assistance resource packets with materials on a variety of topics, including trauma. During FY 2012–13, 38 counties requested technical assistance. Of these, 26 counties requested information on the topic of trauma. A total of 363 technical assistance materials were distributed, of which 21% of the materials were related to trauma. These materials offer information on trauma resources including published research, state and government regulations, evidence-based program curriculum, and links to web-based content.

20 Martinez, K. 2011, May. "Best Practices and the Elimination of Disparities: The Connection." Lecture, 2011 National Policy Summit to Address Behavioral Health Disparities within Health Care Reform, San Diego, CA.

21 Nebelkopf, E., and Wright, S. 2011. Holistic system of care: A ten-year perspective. J Psychoactive Drugs 43(4): 302–308.

EFFORTS TO CREATE CAPACITY AND SYSTEM CHANGE IN CRIMINAL JUSTICE AND BEHAVIORAL HEALTH SYSTEMS

Recent legislation helped to bridge the gap between health care while incarcerated and health care post-release by allowing individuals in custody to be enrolled in Medi-Cal prior to their release. AB 720, Statutes of 2013, Chapter 646, added Penal Code §4011.11, and amended Welfare and Institutions Code §14011.10. AB 720, which took effect January 1, 2014. Collectively, this legislation:

- Requires counties to suspend rather than terminate Medi-Cal benefits for all inmates, regardless of age, who were Medi-Cal beneficiaries at the time they became inmates of a public institution.
- Authorizes county **Boards of Supervisors (BOS)**, in consultation with the county sheriff, to designate an entity or entities to assist county jail inmates with their applications for a health insurance affordability program, and to act on behalf of county jail inmates for the purposes of applying for Medi-Cal coverage for acute inpatient hospital services provided to inmates away from the correctional facility.
- New legislation clarifies "The fact that an applicant is an inmate shall not, in and of itself, preclude a county human services agency from processing an application for the Medi-Cal program submitted to it by, or on behalf of, that inmate."

As such, this newly enacted legislation should aid in continuity of care for individuals coming out of the correctional system.

Collaboration with the Deaprtment of Corrections and Rehabilitation (CDCR)

In response to the shift in California's provision of substance use disorder services, CDCR has established the Integrated Care Committee (ICC) in order to redesign services for parolees. While the DMC-ODS waiver expands substance use disorder services, there are gaps in the system for the harder to treat criminal justice population. The ICC is comprised of providers, associates, internal CDCR partners, counties, other State Deaprtments and interested parties. The goal of the ICC is to redesign the rehabilitative model through the development of a short-term and long-term plan to maximize the benfits being provided to parolees. The redesign will allow the redirection of current funding to other important parolee needs including, housing, education, employment and services for parolees not eligible for Medi-Cal.

Partnering with the Board of State and Community Corrections

DHCS previously collaborated with drug courts in the effort to divert those needing SUD treatment out of the correctional system and into treatment. However, drug court funding has almost disappeared, leaving a void in the system and a pause in DHCS' collaboration with the corrections system.

DHCS has reached out to the California **Board of State and Community Corrections (BSCC)**, established in 2012, to be included in its work involving stakeholders in the correctional work arena.[22] The BSCC is an independent statutory agency that provides leadership to the adult and juvenile criminal justice systems, expertise on Public Safety Realignment issues, a data and information clearinghouse, and technical assistance on a wide range of community corrections issues. (Penal Code sec. 6024–6025). In addition, the BSCC promulgates regulations for adult and juvenile detention facilities, conducts regular inspections of those facilities, develops standards for the selection and training of local corrections and probation officers, and administers significant public safety-related grant funding. BSCC will implement the mandates of Proposition 47, the California ballot initiative reducing penalties for some crimes.[23] Proposition 47 allows for the set aside of monies saved from the incarceration into a Safe Neighborhoods and Schools Fund, which will become available in 2016. Spending for SUD prevention and treatment services could feasibly be increased as a result of Proposition 47. This is an area ripe for future exploration.

DHCS will work to facilitate the exchange of data from the correctional and SUD systems to greater understand how individuals from one system are accessing and being provided services in the other system. DHCS will also be attending meetings with appropriate committees

22 http://www.bscc.ca.gov/m_programs&services.php
23 http://ballotpedia.org/California_Proposition_47,_Reduced_Penalties_for_Some_Crimes_Initiative_(2014)

of the BSCC to provide feedback about evidence-based practices in SUD treatment in the hope that these two systems can better work together to provide treatment to those transitioning out of custody. The goal is to reduce recidivism rates, increase treatment outcomes, and improve the lives of individuals in the correctional system needing SUD treatment.

Capacity Change in Behavioral Health

The 1115 waiver aims to increase the SUD treatment system capacity by expanding the available providers allowed to offer DMC-reimbursable residential services. Under the waiver proposal, residential services will be available to all Medi-Cal beneficiaries in facilities with no bed limit. Additionally, the waiver's mandate to include EBPs will require providers to expand their workforce and workforce training. Workforce increases will allow for greater system capacity and responsiveness to trauma and justice issues with more counselors able to provide treatment. DHCS is aware of the workforce shortage and is examining the issue as it relates to capacity through the BHF and other efforts.

In addition to the other treatment services outlined in this strategic initiative, the Medi-Cal 2020 1115 proposed waiver includes the DMC-ODS, which is designed to provide a continuum of care modeled after the ASAM criteria for SUD treatment services. Components of the DMC-ODS portion of the waiver relative to criminal justice and recovery support services contain additional services for this population that may include the following:

Eligibility: Counties recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to expanded Medi-Cal SUD treatment services if the parolees and probationers are eligible

Lengths of Stay: Additional lengths of stay for withdrawal and residential services for criminal justice offenders if assessed for need (e.g. up to six months residential; three months FFP with a one-time 30-day extension if found to be medically necessary.

Promising Practices: Ensure counties utilize promising practices such as Drug Court services.

Decrease Impact of Disasters on Behavioral Health of Community, Family, Individual

Under the State of California Emergency Plan, Emergency Function/Public Health and Medical, DHCS is charged with ensuring that mental health and SUD services support and technical assistance be given to local governments that comprise the county behavioral health system. DHCS also administers the Federal Emergency Management Agency Crisis Counseling Program Grant and training through this county-based behavioral health system. DHCS also maintains a leadership role in promoting behavioral health disaster preparedness throughout the state.

California State University of Sacramento's Center for Collaborative Policy assisted DHCS with collaborative and consultative services to accomplish the following. Through a comprehensive statewide stakeholder process in 2012, the state developed Phase I of the State of California Mental/Behavioral Health Disaster Framework, dated December 17, 2012 (Framework). DHCS is now in the process of convening a similar statewide stakeholder process with the stakeholder workgroup called the "Core Planning Team" to develop the Phase II DHCS Behavioral Health Disaster Implementation Program Outline and Work Plan (Statewide Program Outline and Work Plan) to describe, organize, and integrate the disaster behavioral health response and recovery capabilities at multiple levels within California (behavioral health providers, county behavioral health departments, emergency medical services, public health venues, NGOs, non-profits); provide linkage to the Emergency Function-8 and Emergency Function-6/Mass Sheltering response structure; and provide a structure for developing needed key tools and products. This Statewide Program Outline and Work Plan will define and sequence the key products, training, tools and exercises that will guide DHCS and its various stakeholders during both planning and response with appropriate systems and resources before, during, and after the impact of a disaster on individuals in need of behavioral health services. This process will lead to Phase III Implementation of the Statewide Program Outline and Work Plan.

INITIATIVE #4: RECOVERY SUPPORT

Strategic Initiative #4 aims to encourage and promote partnering with people in recovery from SUD and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen communities. SAMHSA defines recovery from SUD as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Promoting access to quality evidence-based and best practice clinical treatment and recovery support services for all populations is a priority in Strategic Initiative #4.

SAMHSA has delineated four major dimensions that support a life in recovery: health, home, purpose, and community. To recover, people need good access to affordable, accessible, and high-quality health and behavioral health care (health). Overcoming or managing one's disease(s) or symptoms (for example: abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction), and—for everyone in recovery—making informed, healthy choices that support physical and emotional well-being, are essential to recovery. To recover, people also need a stable and safe place to live (home) and meaningful, productive, worthwhile activities (purpose).

Activities such as having a job, attending school, volunteering, family caretaking, or pursuing creative endeavors—and the independence, income, and resources they bring—are necessary for people to fully participate in communities. Lastly, to recover, people need relationships and social networks, such as family and friends, which provide support, friendship, love, and hope. The process or journey of recovery is relevant for all people with behavioral health conditions seeking to overcome behavioral health problems and live full and productive lives.

DISPARITIES

Many racial and ethnic groups experience greater levels of SUD and higher suicide rates than the general population. These groups also have higher rates of certain risk factors for mental, emotional, and behavioral problems, including poverty, domestic violence, and childhood and historical trauma, as well as involvement in the foster care and criminal justice systems. Behavioral health disparities are also present for AI/AN communities and tribes; people with disabilities; LGBTQ individuals; girls/young women; members of the military and veterans; family members; older adults; and transition-aged youth.

DHCS-SUD is committed to addressing these disparities by improving prevention, treatment, and recovery support programs that serve these populations. Examples of these efforts have been previously touched upon, and include gathering wide stakeholder input from community members as well as service providers in the DMC-ODS 1115 Waiver renewal process and through the BHF quarterly meetings during which the community and family member forum presents.

SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. DHCS behavioral health focus seeks to integrate those in recovery into systems of care addressing physical, mental, and SUD issues, as well as co-occurring conditions. The DMC-ODS 1115 waiver renewal proposed a continuum of care that addresses the need for housing, medication-assisted treatment, better assessment protocols through use of the ASAM criteria, and implementation of evidence-based practices, case management services, and broadening of recovery support by expansion of the workforce.

1115 DEMONSTRATION WAIVER

In Strategic Initiative #2, the Medi-Cal 2020-1115 Demonstration Waiver is outlined. In essence, the waiver will allow California's SUD treatment system to provide a more robust continuum of care, enable more local control and accountability, provide greater administrative

oversight, create utilization controls to improve care and efficient use of resources, implement evidence-based practices in SUD treatment, and coordinate with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to connect with other recovery supports and achieve sustainable overall health. Implementation of the waiver provisions is anticipated to help increase the behavioral health of those in the SUD treatment services system.

With the implementation of the DMC-ODS Waiver, SAPT BG funds that have historically been allocated to residential treatment and case management will likely be free to support other aspects of the treatment continuum. SAPT BG funds can then be used to bolster recovery residence housing and other transitional housing options on the treatment spectrum for those engaging in ongoing treatment and recovery activities.

Because recovery services are important to the recovery and wellness of all beneficiaries, the DMC-ODS component of the 1115 waiver is designed to link beneficiaries to applicable recovery services. When the treatment community can become a therapeutic agent, beneficiaries are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the need for, and utilization of, community resources to provide ongoing self-management support to patients. The recovery services that will be provided as medically necessary are:

Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.

Substance Abuse Assistance: Outreach, peer-to-peer services, relapse prevention, and substance abuse education.

Education and Job Skills: Linkages to life skills, employment services, job training, and education services.

Family Support: Linkages to childcare, parent education, child development support services, family/marriage education.

Support Groups: Linkages to self-help and support, spiritual and faith-based support.

Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

Under the DMC-ODS waiver, counties may present pilot program proposals that must feature a clear governance structure describing the role of the various partner entities and the proposed financing arrangements. Proposals must include a detailed plan for achieving care coordination and integration across all of the participating entities and must include behavioral health integration as a component, which includes SUD services.

Pilot programs located in counties that are also expanding use of medical homes for complex patients will integrate their work with Health Homes and use those care coordination funds to advance patient support in the pilot. (*See directly below for an in-depth look at Health Homes*.) To identify the needed social supports, pilot programs must assess the needs of the target population. The additional social supports could include the following social services:

- CalFresh (Federally known as Supplemental Nutrition Assistance Program);
- Child Care;
- Homeless Services;
- Foster Care supports;
- Job Training;
- Benefit Advocacy;
- Outreach and Engagement strategies;
- Housing and Enhanced Care Coordination and Tenancy Supports;
- Criminal Justice/Probation, and
- Public Health Services.

HEALTH HOME INITIATIVE

The Medicaid Health Home State Plan Option, authorized under ACA Section 2703, allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based **long-term services and supports (LTSS)** needed by beneficiaries with chronic conditions.[24] Federal matching funds are available for two years at 90%, and, if implemented in California, The California Endowment has offered to fund the remaining 10% of funds (up to $25 million per year) required for these additional services for that same two-year period. Assembly Bill 361 (AB 361), enacted in 2013, authorized California to submit a Section 2703 application subject to several conditions, including cost neutrality and an evaluation after the first two years.[25]

Through a complementary planning process, the **California State Innovation Model (CalSIM)** initiative developed a recommendation to create "**Health Homes for Patients with Complex Needs" (HHPCN)**. The HHPCN is one of four initiatives in the CalSIM Testing application that California made to the Center for Medicare and Medicaid Innovation. These initiatives are multi-payer.

In collaboration with the CalSIM initiative and with respect to the requirements of Section 2703 and AB 361, the state has developed a set of policy goals that will guide the planning and implementation of the HHPCN.

KEY COMPONENTS OF HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

DHCS intends to submit a Section 2703 SPA application in summer/fall 2015, which would provide federal regulatory authority for implementing the HHPCN model for Medicaid beneficiaries. HHPCN has several key components, which are outlined below.

Target Population

Per federal requirements, states can choose to define one or more of the following groups of eligible individuals for Section 2703 health home enrollment:

1. Individuals with two or more chronic conditions;
2. Individuals with one chronic condition and at risk for another; and
3. Individuals with serious and persistent mental illness.

HHPCN will target all three categories for health home eligibility with an emphasis on individuals with high costs, high risks, and high utilization who can benefit from increased care coordination of physical health, behavioral health, community-based LTSS, and social supports, resulting in reduced hospitalizations and emergency department visits, improved patient engagement, and decreased costs. Specific eligible conditions have not yet been finalized; however, SUD is one of the conditions that appear on California's current list of eligible chronic conditions that is being used to develop estimates of the eligible population and their current health care costs.

Health home services must be made available to all categorically-needy Medi-Cal enrollees who meet the eligibility criteria. DHCS plans to include all full scope Medi-Cal enrollees, including the Medicaid expansion aid category for patients who meet the eligibility criteria of HHPCN. For the individuals eligible through the Medicaid expansion, the state will receive a 100% federal match (gradually decreasing to 90% in 2020), rather than the enhanced federal match of 90% during the first eight quarters.

HEALTH HOME NETWORK INFRASTRUCTURE

Health homes as envisioned by California will be structured as a health home network with members functioning as a team to provide whole-person care coordination. This network would include a lead entity, one or more community-based care management entities, and community and social support services. The care management entity must include a dedicated care manager assigned to each enrollee. DHCS will leverage California's existing managed care, behavioral health, and community-based LTSS system infrastructure in the implementation of health homes.

24 http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf
25 http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

The health home network will serve as the central point for directing patient-centered care and will be accountable for:

- Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable ED visits;
- Providing timely post discharge follow-up, and
- Improving patient outcomes by coordinating physical health, behavioral health, and community-based LTSS.

This will be accomplished by the lead entity and the community-based care management entity either through direct provision of health home services, or through contractual arrangements with appropriate providers who will be providing integration through care coordination and planning of heath care services.

Qualifying Medi-Cal managed care plans can serve as health home lead entities and must partner with one or more community-based care management entities for the provision of health home services. The lead entity remains responsible for all health home program requirements, including services performed by the contracted health home providers. Payment for health home services will be paid by the state to the lead entity, which will then flow payment to appropriate network partners.

Community-based care management entities will provide care coordination and planning of the core health care services to all health home enrollees and will assign each enrollee a dedicated care manager. Care management entities will utilize community and social support services to facilitate referrals, provide resource information, and provide services that meet the enrollees' broader needs.

The enrollee's health action plan will be under the direction of a dedicated care manager who is accountable for facilitating access to physical health care, behavioral health care, and community-based LTSS. In addition, the dedicated care manager will provide linkages to community social supports, and coordinate with entities that authorize these services as necessary to support the achievement of individualized health action goals. The intensity of services provided will correspond to the need of the enrollee, and this may be formalized through program requirements in "service tiers."

Hospitals that are part of a health home network must have procedures in place for referring beneficiaries who seek or need treatment in a hospital ED or inpatient department to the enrollee's qualified health home.

DHCS will continue to explore the models for Medi-Cal beneficiaries who are receiving services for behavioral health conditions and children who are receiving services through California Children's Services (CCS). Behavioral health service providers and the CCS delivery system must be substantially integrated into the health home model for beneficiaries who meet health home eligibility requirements and access services through behavioral health and CCS providers.

PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

The state will leverage a technical assistance program designed through the CalSIM HHPCN program, with additional technical assistance provided as needed. Programs will likely be available through multiple modalities with webinars and a learning collaborative for all health home network partners, and selective individual practice coaching for providers who serve a high volume of the target population.

SERVICE DEFINITIONS

DHCS is assessing gaps between what Medi-Cal managed care plans and Medi-Cal behavioral health service providers currently provide and the services required under the health home provision. In the coming months, DHCS will finalize the definitions for the following core health home services:

Comprehensive Care Management:

Comprehensive care management primarily involves the activities related to developing the enrollees' comprehensive, individualized care plan, called a **health action plan (HAP)**. HAPs should incorporate the patient's physical and behavioral health needs, and any community-based LTSS. Care management

services include screenings and assessments with standardized tools, and issues identified will be included in the HAP. HAPs will be reassessed based on the enrollees' progress or changes in their needs. Dedicated care managers assess enrollees' readiness for self-management and promote self-management skills so the enrollee is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status, or prevent or slow declines in functioning. As appropriate, the enrollee's family should be incorporated in the initial health assessments and subsequent reassessments. Referrals and HAP goals should also be tracked through the HAP. The dedicated care manager will deliver this service primarily in person.

Care Coordination and Health Promotion:

Care coordination includes the implementation of the enrollees' comprehensive, individualized care plan, or HAP. At a minimum, the care coordination function includes:

- Developing a person-centered plan based on needs and desires of the enrollee;
- Sharing options with the enrollee for accessing care
- Providing information to the enrollee regarding care planning;
- Monitor medications and treatment adherence by enrollees; and
- Manage referrals, coordination, and follow-up to needed services and supports.

Care coordination may include case conferences in order to ensure that the enrollees' care is continuous and integrated among all service providers. The dedicated care manager will deliver this service with the work occurring in a variety of settings.

Comprehensive Transitional Care:

Comprehensive transitional care addresses the activities related to preventing patient admissions and readmissions. It requires the health home to have a process in place for prompt notification of an enrollees' emergency department admission or discharge, hospital inpatient facility, residential/treatment facility, or other. At a minimum, the care transition function includes: receipt of a summary care record or discharge summary; medication reconciliation, and; planning related to the timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners. Both the managed care plan and care management entity, led by the dedicated care manager, will be involved in the delivery of this service.

Individual and Family Support Services:

Individual and family support services include activities that ensure that enrollees and their families are knowledgeable about the enrollees' conditions with the overall goal of improving the enrollees' adherence to treatment. Communication and information shared with the enrollees, their families, and caregivers should meet health literacy standards and be culturally competent. At a minimum, individual and family support services could include: use of peer supports and/or support groups to work with enrollees and their families; use of self-care programs to help increase enrollees' understanding of their conditions and care plan. In addition, this service may include advocacy for the enrollees and their families to identify and obtain needed resources (e.g. transportation) that supports their ability to meet goals. The dedicated care manager and peer support staff would be key to the delivery of these services.

Referral to Community and Social Supports:

Referral to community and social supports addresses the identification of community-based resources to meet the whole-person needs of the enrollee and active referral and follow-up to these resources. Communication and information shared with the enrollees should meet health literacy standards and be culturally competent. Community and social supports include but are not limited to: housing, food, employment, child care, community-based LTSS, school- and faith-based services, and disability services. The dedicated care manager and peer support staff would be key to the delivery of these services.

INITIATIVE #5: HEALTH INFORMATION TECHNOLOGY

Attending to the vision of Strategic Initiative #5 will ensure that the behavioral health system—including states, community providers, patients, peers, and prevention specialists—fully participates with the general health care delivery system in the adoption of **health information technology (HIT)**.

Strategic Initiative #5 places focus on California's efforts to promote technological development, increase use of health electronic records, enhance security and capacity, and promote broad dissemination of technology. There are several efforts under way within DHCS related not only to implementation of the ACA and the **Health Information Technology for Clinical and Electronic Health (HITECH)**, but also to comply with CMS requirements. These efforts include, but are not limited to the **Medicaid Information Technology Architecture (MITA)** effort and the implementation of ICD-10 in Medi-Cal billing systems.

In addition, there are efforts in the very early stages to identify ways to develop comprehensive behavioral health data systems. These efforts involve collaboration between the DHCS MHSD and the SUD-PTRSD. The long-term goal of such efforts is to develop technologies and standards to enable coordinated and integrated mental health and SUD data that can also be connected with other DHCS data sources for Medi-Cal.

MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE

MITA is an effort being led by the DHCS Office of HIPAA Compliance. The MITA effort seeks to modify the DHCS IT infrastructure from a compilation of isolated data systems throughout DHCS to a standardized enterprise-wide architecture.[26] This effort pertains to the broader IT infrastructure for DHCS, and SUD and MHSD participate in this effort to ensure inclusion of DHCS behavioral health data systems in the development of enterprise solutions. MITA is currently in the early stages of examining the various cost-reporting data systems used by DHCS to identify and develop standardized cost-reporting IT solutions.

26 See: http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/MITA.aspx

Implementation of ICD-10

ICD-10 codes are used to report medical diagnoses. The prior version, ICD-9, is being replaced by ICD-10. DHCS-MHSD is leading the effort to implement the ICD-10 codes in behavioral health data systems to meet the October 2015 deadline for ICD-10 implementation.[27] The transition to ICD-10 is required for everyone covered by HIPAA. This transition effort includes staff from SUD-PTRSD to ensure coordination across MHSD and SUD-PTRSD in implementing ICD-10 codes.

42 CFR 2

A major challenge to achieving interoperable exchange of data across health and behavioral health systems of care is the Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 Code of Federal Regulations, Part 2).[28] These regulations clarify appropriate sharing of SUD treatment data and confidentiality restrictions for purposes of health and behavioral health service delivery, as well as for research and evaluation purposes. Health and behavioral health providers often seek state technical assistance and guidance in order to develop mechanisms for appropriate exchanges of information across service delivery systems administered by DHCS.

In addition, regulatory language should be added to clarify appropriate sharing of SUD treatment data with other service systems, such as criminal justice and social service systems. As currently written, the regulations prevent DHCS from sharing data with other service systems to support research and evaluation in order to better understand the impact of SUD on other public systems.

RESOURCE NEED FOR INFORMATION TECHNOLOGY SYSTEMS

A variety of factors over the past several years have resulted in major challenges for SUD-PTRSD related to challenges to improving data collection and data quality. For example, the recession and the recent transition from former Department of Alcohol and Drug Programs to DHCS have resulted in a significant reduction in both fiscal and human IT resources. As a result, SUD-PTRSD has not had the capacity to monitor and enforce data

27 http://www.dhcs.ca.gov/services/MH/Pages/ICD-10.aspx
28 http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl

reporting and quality standards, which has impacted the completeness of data collected through DATAR, as well as CalOMS Tx.

In addition, SUD-PTRSD data systems remain on the Information Technology Web Services (ITWS) server, which was hosted by the former Department of Mental Health, and the systems must be moved out of the ITWS server to comply with DHCS standards. Furthermore, all of the SUD data systems are in need of modifications or upgrades. The reasons include that outdated technologies exist which are no longer compatible with current technology, lack of expertise in the programming language used in the data system (e.g. Paradox, outdated programming language), or lack of skillset and system knowledge to make changes in the data system (e.g., CalOMS Tx, complex programming, loss of contractors).

Therefore, SUD-PTRSD needs increased state and federal funding for ongoing system sustainability to leverage ongoing IT change management and system maintenance and for migrating SUD systems from ITWS to DHCS servers. In addition, funding is needed to support development of new IT systems for coordinated, integrated behavioral health data collection. Enhanced funding would support the overall strategic initiative to promote development of technologies and standards to enable interoperable exchange of behavioral health data. Without funding for both sustainability and new IT projects to support HIT behavioral health goals, SUD-PTRSD cannot improve current data collection or implement new data systems to integrate SUD data systems into other HIT data system efforts.

INITIATIVE #6: WORKFORCE DEVELOPMENT

An adequate supply of a well-trained workforce is the foundation for an effective service delivery system. With the implementation of recent parity and health reform legislation, behavioral health and SUD workforce development issues, which have been of concern for decades, have taken on a greater sense of urgency. In order to address the effect that behavioral health workforce issues have on the infrastructure of the health care delivery system, Strategic Initiative #6 provides a focus for its programs and activities to advance the behavioral health of the nation and an individual's SUD recovery trajectory.

Strategic Initiative #6 will support active strategies to strengthen and expand the behavioral health and SUD workforce, and improve the behavioral health knowledge and SUD-related skills of those health care workers not considered behavioral health specialists. DHCS continues to request SAMHSA for technical assistance and training to promote an integrated, aligned, and competent workforce. The department is also committed to creating partnerships, and using traditional and social media outreach to enhance the workforce. These efforts will increase the availability of prevention and treatment for SUD, strengthen the capabilities of behavioral health professionals, and promote health system infrastructure that can deliver competent and organized physical health, mental health, and SUD recovery services. This initiative focuses on monitoring and assessing the needs of youth, young adults and adult peers, communities, and health professionals in meeting behavioral health needs within America's transforming health promotion and health care delivery systems.

SAMHSA also recognizes the growing understanding and value of peer providers to assist with engagement, support, and peer services. The federal goals of workforce development include increasing the peer and paraprofessional workforce, and increasing the evidence base for the best uses of peer and paraprofessional behavioral health services and supports, will require additional commitment and will help to expand the reach of limited professional treatment and support professionals. DHCS is mindful of the national focus on peer providers and will continue its current efforts to explore this alternative as the state seeks to develop its continuum of care into a robust treatment- and recovery-oriented matrix.

DISPARITIES

The behavioral health and SUD recovery needs of minority communities have been historically and disproportionately underserved. Few trained providers are sensitive to cultural issues and equipped with the necessary language skills that facilitate and promote effective service delivery. The proportion of SUD service providers from diverse groups generally does not represent the proportion of those various diverse groups in the United States. DHCS commits to addressing these SUD workforce disparities by expanding recruitment and training opportunities, as well as identifying effective retention strategies for prevention, treatment, and recovery support providers and providers who are or who serve members of racial, gender, and ethnic minority populations or other minority groups such as military members, veterans, and their families; LGBTQ individuals; and AI/AN tribal members.

This section specifically addresses DHCS workforce development goals, strategies, activities taken in furtherance of those objectives, and areas needing technical assistance to achieve these goals.

In June 2013, the former Department of Alcohol and Drug Programs (since transitioned to the Department of Health Care Services) released a report, Workforce Development Needs in the Field of Substance Use Disorders.[29] The report contains a summary of health reform-related changes, an assessment of the current workforce, and recommendations for preparing the workforce to meet the changes required of health reform. The following narrative summarizes the highlights of that report.

WORKFORCE GOALS

The following assumptions were made in the study underlying the report and are consistent with the findings identified in several reports produced by SAMHSA, UCLA, CADPAAC, and the National Association of Alcoholism and Drug Abuse Counselors.

1. In the next five years, more SUD treatment professionals will be needed who are able to care for individuals with SUD in a variety of managed health care settings, recognize co-occurring disorders, and be culturally competent.
2. SUD professionals will need to be aware of the impact that SUD have on other domains of health (mental health, physical health) in order to successfully serve individuals with multiple chronic health conditions.
3. Applicants for open treatment positions in SUD treatment facilities need to be well-qualified and trained in evidence-based practices. The workplace will be competitive.
4. The workforce needs to be diversified and able to operate in integrated settings and collaborate between providers regarding a patient's care plan.
5. Health reform offers California an opportunity to address the SUD workforce concerns and make forward progress in recognizing the SUD field as a standard component of health care.
6. SUD treatment facilities must adopt and implement **Electronic Health Records (EHR)** systems to remain a part of the changing healthcare environment. The workforce must learn and adopt EHR systems and other technology that create efficiencies.
7. Now is the time to commit to an SUD professional Scope of Practice and credentialing system with a solid workforce ladder.
8. The existing workforce must be provided tools.

29 http://cchealth.org/SUD/pdf/Workforce-Development-Needs-in-the-Field-of-Substance-Use-Disorders.pdf

WORKFORCE DEMOGRAPHICS

An assessment of the current SUD workforce in California was consistent with the nationwide workforce demographics summarized below.

Clinical directors are predominantly white, middle-aged women with no military affiliation. These clinical directors are educated professionals who began their career in the SUD treatment field and have an average of 17 years of experience in the field. About one-third identify as being in recovery from SUD. The demographic of clinical directors should expand to include those of diverse cultural backgrounds to better reflect the clients served.

Direct care staff members supervised by the clinical director respondents are also mostly white women with no military affiliation. Direct care staff members tend to be younger on average than clinical directors and have less years of experience at their current places of employment. Direct care staff members are also educated professionals. The highest degree status of direct care staff that was most commonly reported was a Master's degree. Furthermore, the majority of direct care staff is currently licensed/certified or is seeking licensure/certification. Slightly less than one-third of direct care staff are in recovery from SUD as estimated by their clinical directors. The demographic of direct care providers should expand to include those of diverse cultural backgrounds to better reflect the clients served.

Almost one-third of clinical directors are only somewhat proficient in web-based technologies, and almost half of SUD facilities do not have an EHR system in place.

FEEDBACK FROM THE WORKFORCE

Based on California surveys, the SUD workforce appears to be prepared to make workplace changes.

Twenty percent of respondents indicated that it was very likely (highly probable/definite) that they will be changing their place of employment within the next two years, and 13% indicated that it was very likely that they would leave the SUD treatment field altogether. The same reasons were indicated for both changing place of employment but staying in the field and/or leaving the field and include: greater pay and/or benefits, greater responsibility/authority, and better management/administration.

The top five personnel training and technical assistance needs indicated by respondents include: providing trauma-informed or trauma-sensitive services; providing services for co-occurring disorders; providing clients with integrated treatment services for addiction, physical health, and mental health disorders; improving client problem solving skills; improving behavioral management of clients or improving client thinking skills; and improving cognitive focus of clients during group counseling.

PRIORITIES

The report recognizes the need for providers to improve their capacity to deliver evidence-based services. Providing quality care to identify and reduce risky substance use and diagnosing, treating, and managing addiction, will require both specialty service providers and other health professionals to shift towards delivering more science-based SUD interventions and services. Several significant barriers stand in the way of making these critical shifts, including: (a) an addiction treatment workforce starved of resources, operating outside the medical profession, and lacking capacity to deliver services that utilize a full range of evidence-based practices to address clients' SUD behaviors, physical health, and mental health; (b) health care and mental health providers who are not equipped to provide evidence-based addiction screening, intervention, treatment, and management services; and (c) inadequate oversight and quality assurance.

The high level priorities identified in the report:

- Increase the short-term capacity of the workforce to meet increased demand for SUD services by expanding the number and types of providers appropriately trained in delivering SUD services, expanding the number and types of services eligible for insurance reimbursement, and expanding the number and types of facilities authorized to deliver SUD services.
- Change the licensing and credentialing structure to allow the workforce to better meet the increased demand for services.

- Expand capacity by effectively using all members of the workforce.
- Create methods to correctly identify and treat SUD problems, as well as share information between providers.
- Increase the long-term capacity of the workforce by expanding the delivery of prevention and recovery support services. Effective use of prevention addresses community-level risk factors and reduces the need for specialty SUD care through the use of early diagnosis of community problems, implementation of evidence-based practices, and highly-visible messaging. Increased use of recovery support emphasizes a recovery-oriented approach and building collaborative relationships with family members who share decision making for treatment options.
- Develop a long-term strategy to attract and retain members to the SUD workforce and provide them with a standard set of credentials, tools to attain and maintain their credentials, and a system for monitoring and controlling the credentialing system.
- Develop curricula and training for all healthcare workforce members who deliver SUD services. Make the training easy to access, affordable, and broad enough to address all elements of delivering SUD services in a wide variety of healthcare settings.

ACTIVITIES TAKEN IN FURTHERANCE OF WORKFORCE DEVELOPMENT

Since the release of this report, workforce development activities have occurred in the following areas:

- The SUD-PTRSD of DHCS has created core competency curricula for prevention professionals. Webinars are offered through the **Community Prevention Initiative (CPI)** technical assistance project. CPI hosts a website that contains resources for prevention professionals.[30]
- DHCS is currently working with CMS to develop a statewide 1115 waiver that may expand the landscape of available SUD and MH treatment options and add to the list of reimbursable practitioners in the DMC treatment program.
- The number of National Commission for Certifying Agencies accredited organizations to register and certify alcohol and other drug counselors in California has been reduced from 9 to three. Efforts are underway to evaluate the existing credentialing structure and develop a consistent statewide SUD professional credentialing system.
- ASAM has provided training on ASAM criteria to the California Behavioral Health Directors Association and DHCS. The 1115 Waiver will require ASAM to be used to place beneficiaries in the appropriate level of care. Training in ASAM for the SUD workforce will be a priority.
- In 2014, DHCS developed and implemented a comprehensive SBIRT prevention program, using a broad array of strategies directed at individuals previously not identified to be in need of alcohol abuse treatment. The DHCS program strategy includes providing free SBIRT trainings across the state, in collaboration with UCLA-ISAP. ISAP researchers identified venues for thirty trainings statewide, accommodating a minimum of fifty providers, and set in convenient locations. By focusing on finding free or very low-cost training venues, the ISAP project team maximizes the amount of funding that goes towards the delivery of SBIRT trainings and evaluation activities. A total of 24-hour SBIRT trainings were held through May 2015. In addition to posting a master searchable calendar and updated registration flyer on the ISAP site (http://www.uclaisap.org/sbirt), and the DHCS (http://www.dhcs.ca.gov/) website, project staff from DHCS and Harbage Consulting routinely send targeted marketing emails to Medi-Cal managed care plans and other PCP organizations in the geographic areas in which trainings are scheduled to encourage PCPs to register for the available training,

TECHNICAL ASSISTANCE NEEDS

To facilitate efforts to address high level workforce development priorities in the future, technical assistance will be needed for:

- IT development of a robust credentialing system;
- Staff training and development;
- Integration of behavioral health and primary care; and
- The expansion of workforce capacity.

30 http://ca-cpi.org/about/

TECHNICAL ASSISTANCE WORKFORCE NEEDS SPECIFIC TO YOUTH

Efforts to revise California's regulatory structure related to youth: As a part of the technical assistance process, DHCS-SUD requests federal assistance, introductions and "warm-handoffs," via conference calls or webinars, directly to officials in other states to begin conversations about navigating challenges in efforts to revise regulations to include youth-specific approaches. Many of these regulations would further workforce development and cross-training. Technical assistance is needed to identify and compile a comprehensive listing of those involved in other states that have strong experience developing regulatory approaches to strengthen youth SUD services. Information about compliance and monitoring activities would be also useful. Introductions to leaders in youth-related issues in other states would be most helpful, specific to the names of individuals and their roles in the organizations to facilitate treatment, compliance, and monitoring activities (including information on development of MOUs and interagency agreements that clarify each party's role and responsibility in the regulatory process.)

Evidence-Based strategies for Youth Treatment: Technical assistance is also needed to help DHCS-SUD develop a crosswalk of evidence-based strategies for youth treatment and recovery support services. The crosswalk would include information on where these strategies are currently being successfully implemented, special populations with whom these practices are best utilized, and challenges and pitfalls faced in the implementation of these strategies. Information on next steps and where these strategies fit on a continuum of care for youth would also contribute to a robust crosswalk.

Peer Mentor/Recovery Coach Services: Recognizing that developing a broader Peer Mentoring/Recovery Coaching Services structure is a promising practice, especially for the youth population, DHCS requires technical assistance to begin exploring development of a broader initiative strengthening state support of these services. Information from other states that are specific to the following populations would be helpful in this respect: women, pregnant & parenting women, LGBTQ, specific populations within LGBTQ youth, youth involved in child and family services, and adults involved in child and family services. Technical assistance to create robust funding, delivery and monitoring processes is a specific need.

This SNAP report is intended to give guidance to state and local planners working in the substance use disorder prevention and treatment field. This report includes an Executive Summary, Part 1 containing an informative needs assessment, followed by California's six strategic priorities in Part 2, which are:

1. Prevention of SUD;
2. Health Care and Health Systems Integration;
3. Trauma and Justice;
4. Recovery Support;
5. HIT Tools; and,
6. Workforce Development.

Through the SNAP process, the SAPT BG supports efforts to continually improve California's federally-funded SUD prevention, treatment, and recovery services. The gathering of stakeholder feedback on identified priorities is the next step required to implement strategies and promote interventions designed to bring about better outcomes. Broad stakeholder feedback is the key to the SAPT BG monitoring process and is required to help the Department create goals and performance measurements aimed to achieve the purpose outlined in the six strategic priorities over the next two-year grant cycle. DHCS is mindful that gathering input involves establishing, implementing, and documenting processes for consultation with both county stakeholders and the federally-recognized tribal governments, or governing tribal lands within our borders, during the block grant planning process.

DHCS stewardship of over $250 million in SAPT BG Federal funds awarded annually involves more than ensuring that resources are allocated and expended responsibly. The Department must manage the Federal SAPT BG healthcare investments to ensure that taxpayer dollars are safeguarded and spent conscientiously. Proper monitoring by DHCS of the SAPT BG involves allocating resources effectively for activities that generate the highest public benefit.

DHCS pledges to continue placing emphasis on identifying opportunities to improve the SAPT BG program efficiency and effectiveness. The outcomes found in the needs assessment reveal that the key focus of our strategic priorities must be on reducing health care disparities and facilitating efforts to remove barriers to equity and parity. Now begins the task of identifying and articulating goals and strategies to overcome the identified health inequalities faced by our diverse communities. Each strategy followed in furtherance of these improvement goals must contain plans, measurable steps, and/or performance indicators to meet unmet service needs and gaps over the next two years.

The six strategic priorities outlined above will also be reiterated in the DHCS's FFY 2016-17 SAPT BG application, due to SAMHSA October 1, 2015. Between release of this report and the due date of the application, DHCS will seek extensive stakeholder feedback crucial to the process of developing goals and performance measurements. Goals should be viewed as a set of ambitious but realistic performance objectives that the DHCS will pursue within a 24-month period.

The strategic planning process must also identify key factors or potential barriers that are external to the DHCS, are beyond its control, and could significantly affect the achievement of the strategic goals. These factors include economic, demographic, social, and environmental risks. Strategies must be developed to overcome these challenges.

Finally, the FFY 2016-17 SAPT BG application priorities, goals, and performance measures must take into account and plan around the health care policy topics articulated in SAMHSA's Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018, with its six strategic initiatives, issued in late 2014.[1] These initiatives reflect SAMHSA's programmatic priorities and policy drivers including the new Health and Human Services strategic plan and the transition to full implementation of the Affordable Care Act.[2]

One method for stakeholder's to submit feedback is through e-mail communications directed to SNAP2015@dhcs.ca.gov. We look forward to receiving stakeholder input upon the release and broad circulation of this report. Great emphasis will be placed on incorporating stakeholder feedback into the SAPT BG monitoring process.

1 http://store.samhsa.gov/shin/content/PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf
2 http://www.hhs.gov/strategic-plan/priorities.html

DATA SOURCES FOR PART I: STATEWIDE NEEDS ASSESSMENT (A)(1)E – ALCOHOL AND OTHER DRUG-RELATED HEALTH CONSEQUENCES

Death data comes from the Center for Health Statistics and Informatics (CHSI) at the California Department of Public Health, who is responsible for registering all death certificates for California through the Electronic Death Registration System.[1] With assistance from the National Center for Health Statistics, CHSI produces Death Statistical Master and Multiple Cause of Death files annually that use the ICD-10 codes to classify the cause and manner of deaths.

For deaths, the CDHP's **Safe and Active Communities Branch (SACB)** developed a set of criteria and selection rules. (See the SACB website http://epicenter.cdph.ca.gov for details.) The "single underlying cause of death" is used to identify all deaths in which an SUD-related mental disorder, poisoning, or physical disease contributed to the death. The "multiple cause of death" diagnoses are used to capture the specific drugs involved in the poisoning overdose deaths. This can lead to more than one substance diagnosis per death. Thus, the sum of the specific substance categories may be greater than the total number of overdose deaths.

Hospitalization and ED data are collected by the **Office of Statewide Health Planning and Development (OSHPD)**.[2] OSHPD collects inpatient and ED data from all licensed hospitals and EDs in California, including general acute care, acute psychiatric care, chemical dependency recovery, psychiatric health facilities, and produces annual hospital patient discharge and ED files. The annual hospital file includes a record for each hospital discharge; therefore the file may contain multiple records for the same individual if they were hospitalized more than once during the year. The same is true for the ED files. The hospital and ED records contain demographic, clinical, payer, and facility information. The clinical information is recorded in a principal diagnostic code and up to 24 other diagnostic codes using the ICD-9-Clinical Modification codes. The principal diagnosis is the condition established to be the chief cause of the patient's admission to the facility for care. There are also principal external cause of injury codes and four additional secondary injury codes (E-code) that reflect the mechanism(s) that caused the admission to the hospital or ED.

SACB and the DHCS Office of Applied Research and Analysis developed a set of criteria and selection rules for identifying SUD-related records from the hospitalization and ED data files. In general, the inclusion criteria for SUD–related cases have been restricted to ICD codes that refer to either: 1) conditions 100% attributable to alcohol, or 2) specific drug codes that only include drugs with the potential to cause SUD or abuse and dependence (e.g., excludes anti-depressants). Health consequences include poisoning (overdoses), mental disorders, and physical diseases that are 100% attributable to SUD, but not indirect consequences of SUD (e.g., motor vehicle injuries due to SUD impairment).

For hospital discharges and ED visits, SUD consequences are presented only for the "principal diagnosis" where the SUD diagnosis was the main or most serious condition. A patient record is included if it contains either a principal diagnostic code or principal E-code indicating the presence of alcohol or other drugs with abuse potential. Using only the principal codes provides a conservative estimate of the number of hospitalizations related to SUD.

Often the drugs individuals used are not specified on the death certificate or in the hospital discharge or ED records. Therefore, the data shown in this report do not fully describe the extent of SUD problems that exist, but provide a useful conservative estimate of the toll SUD has on health.

1 http://www.cdph.ca.gov/programs/HISP/Pages/default.aspx
2 http://www.oshpd.ca.gov/

SAPT BLOCK GRANT FUNDS BY AWARD YEAR

BLOCK GRANT	TOTAL AWARD
FFY2012	$248,892,428
FFY2013	$235,684,407
FFY2014	$249,086,920
FFY2015	$250,323,608

FY 12-13 COUNTY PROVIDERS BY MODALITY

County	Outpatient Drug Free	Residential	Intensive Outpatient Treatment	Narcotic Treatment Program	TOTAL
Alameda	43	19	22	9	93
Alpine	1		2		3
Amador	1		2		3
Butte	16	3	6	1	26
Calaveras	2	1	2		5
Colusa	1		1		2
Contra Costa	22	11	12	3	48
Del Norte	1		1		2
El Dorado	14	7	2		23
Fresno	76	8	7	5	96
Glenn	3		1		4
Humboldt	4	2	4		10
Imperial	12	2	4	3	21
Inyo	3		2		5
Kern	25	6	8	3	42
Kings	13	2	2		17
Lake	6	2	4		12
Lassen	9		1		10
Los Angeles	738	113	92	43	986
Madera	6		2		8
Marin	18	5	13	1	37
Mariposa	2		1		3
Mendocino	4	1	2	1	8
Merced	11	2	3	1	17
Modoc	1		2		3
Mono	1		1		2
Monterey	6	2	1	2	11
Napa	16	2	7		25
Nevada	5	2	3		10
Orange	40	14	15	6	75
Placer	19	5	5	1	30
Plumas	2		1		3
Riverside	76	18	20	4	118
Sacramento	69	14	18	5	106
San Benito	2	1	2		5
San Bernardino	53	13	23	3	92
San Diego	71	23	26	10	130
San Francisco	21	14	2	15	52
San Joaquin	9	4	2	5	20
San Luis Obispo	21	1	5	1	28
San Mateo	22	12	19	1	54
Santa Barbara	41	8	12	2	63
Santa Clara	62	13	26	4	105
Santa Cruz	19	7	4	2	32
Shasta	11	3	3		17
Sierra	1		4		5
Siskiyou	1		5		6
Solano	22	6	15	1	44
Sonoma	13	8	17	2	40
Stanislaus	17	2	4	2	25
Sutter	2		3		5
Tehama	2	1	2		5
Trinity	3	1	2		6
Tulare	37	7	8	1	53
Tuolumne	1		1		2
Ventura	21	4	8	4	37
Yolo	6	3	1		10
Yuba	3	1	1	2	7
Grand Total	**1727**	**373**	**464**	**143**	**2707**

SUMMARY OF SAPT BLOCK GRANT (BG) INDEPENDENT PEER REVIEW PROJECT, 2013–2014 FINAL REPORT

The federal Anti-Drug Abuse Act of 1988 requires that for the fiscal year for which the grant is provided, no less than five percent of the providers receiving federal SAPT BG funds from the state are reviewed by peers, independent from the funding source. This process, otherwise known as an Independent Peer Review (IPR), assesses quality, appropriateness, and efficacy of recovery/treatment services. The programs reviewed shall be representative of the total population of such entities. SAPT BG statutes and regulations governing the IPR are Title 42 of the United States Code, Chapter 6A, Section 300x-53(a)(1), and Title 45 of the Code of Federal Regulations Part 96, Section 96.136. States must ensure that independent peer review is not conducted as a part of the program licensing/certification process. To comply with these requirements, DHCS entered into a contract with the **California Consortium of Addiction Programs and Professionals (CCAPP)** to administer the peer review process and produce the FY 2013–14, Project Year 16, IPR Report.[1]

The IPR process focuses solely on the treatment programs and SUD service system, rather than on individual practitioners. The IPR purpose is to inform the state in a manner allowing continuous improvement of client services provided to alcohol and drug abusers.

The IPR must adhere to specific statutory and regulatory guidelines. Title 42 CFR, Section 96.136, defines "Quality" as the provision of treatment services which, within the constraints of technology, resources, and patient/client circumstances, meets accepted standards and practices to improve patient/client health and safety, in the context of recovery. "Appropriateness," for purposes of this section means the provision of treatment services consistent with the client's identified clinical needs and level of functioning. "Efficacy" in this context is the ability of treatment to produce a desired or intended result for the client.

The independent peer reviewers are to be chosen for their expertise in the field of alcohol and drug use treatment. They must be representative of the various disciplines utilized by the program under review, be knowledgeable about the modality being reviewed, and understand the program's theoretical approach to addiction treatment. Reviewers must also be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

To determine quality and appropriateness of treatment, reviews must include an examination of a representative sample of client/patient records while adhering to all Federal and State confidentiality requirements, including 42 CFR Part 2.

FINAL REPORT SUMMARY

As required by law, DHCS randomly selected 45 programs for review and provided the list to CCAPP. Chosen programs were located in the following counties: Inyo (2), Los Angeles (12), Orange (10), Riverside (9), San Bernardino (4), and San Diego (8). Of the 45 programs chosen for review, 34 sites were screened as appropriate and these programs then received a peer review. The number of sites reviewed and reported upon is roughly equivalent to five percent of providers funded by the SAPT BG.

Programs reviewed included those that are licensed and/or certified residential or non-residential SUD recovery treatment programs, Narcotic Treatment Programs, and County outpatient and detoxification services. The IPR included programs serving women, men, co-ed, and women and children.

The IPR process was followed to recruit appropriate peer reviewers by distributing recruitment letters and reviewing applications to choose individuals possessing the appropriate experience and qualifications. Twenty-eight reviewers were ultimately chosen by CCAPP and trained during an orientation session. During the session, appropriate peer review instruments were explained and reviewers were given direction on the process of on-site peer reviews. Reviewers and programs were assigned or matched based on expertise in modalities and to ensure that there was no conflict of interest. Best efforts were made to pair reviewers with appropriate programs matched according to cultural competency, ethnicity, or gender of clients served. When more than one reviewer was appropriate, peer review teams of two or three were assigned to work together.

1 CAARR has now merged with the California Association of Alcoholism and Drug Abuse Counselors to become the California Consortium of Addiction Programs and Professions.

SUMMARY OF IPR FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Each chosen program was reviewed for quality, appropriateness, and efficacy. The result of the 2013–2014 review fulfilled its purpose to provide the state with an assessment enabling it to improve services for SUD clients.

The results of the IPR provided DHCS with insights into whether California's SUD treatment programs meet accepted standards and practices and lead to a positive result for our beneficiaries. When improvement is indicated, DHCS is positioned to make changes. In general, the reviewers found that the programs reviewed generated a high score in their operations, including the provision of appropriate services by properly credentialed staff. Recovery environments were found to be positive and encouraging of recovery in clients, while ensuring protection of health and safety. The programs reviewed had low staff turnover, and client records and files were thoroughly kept, with complete charting done, consisting of clearly noted goals, progress reports, and discharge plans. Appropriate referrals for mental and physical health treatment were given, and the general administration of cases met the standards of care expected of quality SUD recovery treatment programs. A large majority of programs reviewed positively impacted family and significant others of the client, encouraging strong support systems. Almost three-quarters of program files showed evidence of post-discharge follow up with the client in efforts to guard against relapse. Programs reported internal quality assurance efforts with defined improvement plans or procedures put in place to determine a need for program change as it arises. Strong linkages to community resources and social service programs were reported by 99% of the programs reviewed.

The review teams solicited feedback from the programs on the IPR project process. In general, the observations conveyed that reviewers were respectful, courteous, and professional throughout. Reviewers were valued for their skills, knowledge, and insight by the programs. In short, programs reported that the IPR process itself was useful and helpful for program development.

Technical assistance recommendations made to client programs included training on:

- Continuing education updates;
- Confidentiality/HIPAA requirements;
- Treatment planning and documentation;
- Progress notes;
- Exit planning;
- Quality assurance;
- Drug Medi-Cal;
- Disability access; and,
- Electronic health records.

The IPR contractor, CCAPP, recommended specific improvements for the next round of reviews. Reviewers working in teams at program sites found such a structure beneficial to themselves and the service providers. DHCS is asked to give the list of programs to be reviewed to the contractor in a more timely fashion to facilitate completion of site visits. One of CCAPP's recommendations to DHCS is to consider changing the request for application process to choose an entity to conduct the IPR. CCAPP recommends DHCS should use the request for proposals process that emphasizes the experience and content of the bid, rather than a preference for amount (lowness) of the bid.

PREVENTIVE SERVICES: SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

Effective January 1, 2014, California began offering the Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit to adult Medi-Cal beneficiaries. Provision of the SBIRT benefit implements Affordable Care Act Section 4106, which clarifies that preventive services, aligned with the **U.S. Preventive Services Task Force (USPSTF)** recommendations, will be offered to all Medi-Cal beneficiaries aged 18 or older in primary care settings. SBIRT is a comprehensive health promotion approach for delivering early intervention and treatment services to adults with, or at risk for, developing alcohol use disorders. SBIRT screening for alcohol misuse is used to identify persons engaging in risky or hazardous drinking. California Medi-Cal-funded **primary care practitioners (PCPs**) must provide SBIRT, which includes a brief behavioral counseling intervention aimed to reduce alcohol misuse, make appropriate referrals to mental health, and provide alcohol use disorder services. The USPSTF recommendation for alcohol misuse screening is based on research supporting that primary care screening and counseling interventions can decrease adult unhealthy drinking behaviors. Empirical evidence supports that widespread implementation of SBIRT results in significant reductions in adult alcohol use, binge drinking episodes, and frequency of excessive drinking. In addition, providing SBIRT in primary care settings is cost effective, with investment in the "SBIRT" services offset by money saved due to reduced injury .[1]

In California, PCPs can claim federal reimbursement using HCPCS code H0049 for alcohol screening and code H0050 for brief interventions. Medi-Cal Managed Care Plans are also required to cover and pay for an expanded alcohol screening for members aged 18 or older who answer "yes" to the alcohol question in the DHCS Staying Healthy Assessment (considered a "pre-screen"), or at any time the PCP identifies a potential alcohol misuse problem.[2] Also, Managed Care Plans shall cover and pay for up to three brief interventions per year for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder.[3] Any member screened positive should be referred to the SUD program in the county where the member resides for evaluation and treatment. But, Medi-Cal reimburses SBIRT services in connection with adult alcohol abuse only and not for drug-related services. See http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx for more information.

In 2014, DHCS developed and implemented a comprehensive SBIRT prevention program, using a broad array of strategies directed at individuals previously not identified to be in need of alcohol abuse treatment. The DHCS program strategy includes providing free SBIRT trainings across the state, in collaboration with the UCLA - ISAP. ISAP researchers identified venues for 30 trainings statewide, accommodating a minimum of 50 providers, and set in convenient locations. By focusing on finding free or very low-cost training venues, the ISAP project team maximizes the amount of funding that goes towards the delivery of SBIRT trainings and evaluation activities. A total of 23 four-hour SBIRT trainings were held through May 2015. In addition to posting a master searchable calendar and updated registration flyer on the ISAP website (http://www.uclaisap.org/sbirt), and the DHCS website (http://www.dhcs.ca.gov/), project staff from DHCS and Harbage Consulting routinely send targeted marketing emails to Med-Cal Managed Care Plan providers and other PCP organizations in the geographic areas in which trainings are scheduled to encourage PCPs to register for the available trainings.

In the near future, DHCS will release an evaluation report on SBIRT trainings, including a review and analysis of Post-Training Evaluation (Government Performance and Results Act Evaluation Forms), and the gathering of data through follow-up questionnaires about SBIRT implementation in their respective clinical settings.

1 Fleming, M.F., Mundt, M.P., French, M.T., Manwell, L.B., Stauffacher, E.A., & Barry, K.L. (2000). Benefit –Cost analysis of brief physician advice with problem drinkers in primary care settings. Medical Care, 38, 7-8; Fleming, M.F., Mundt, M.P., French, M.T., Manwell, L.B., Sauffachers, Ea.A.,& Barry, K. L. (2002). Brief advice for problem drinkers: Long-term efficacy and benefit-cost analysis. Alcoholism: Clinical and Experimental Research, 26, 36-43.

2 The Staying Healthy Assessment is posted at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

3 See DHCS All Plan Letter 14-004 at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-004.pdf. For Rural Health Clinic and Federally Qualified Health Center providers, the costs of providing SBIRT services are included in the all-inclusive prospective payment systems rate, see: http://www.dhcs.ca.gov/services/medi-cal/Documents/prev_m01o03.pdf. For Indian Health Services (HIS), in accord with the Memorandum of Agreement 638 Clinics, SBIRT services that meet the definition of a "visit," are reimbursable. See ibid.

The DHCS strategy to increase widespread use of alcohol screenings includes informing stakeholders about SBIRT practices and gathering input from them on implementation challenges and successes. An example of stakeholder involvement includes the DHCS October 2, 2014, Behavioral Health Forum, where the ISAP project team presented to stakeholders, giving a brief overview of the background and rationale of SBIRT for alcohol use and a review of SBIRT training and evaluation activities. In addition, UCLA-ISAP was a featured exhibitor at the 11th Statewide Conference: Integrating Substance Use, Mental Health, and Primary Care Services in Our Communities, held October 22-23, 2014, in Universal City, California (attended by more than 900 behavioral health staff and PCPs).

Due to the initial lag in the ability to collect encounter measures, DHCS cannot yet release reliable data related to the penetration of SBIRT use by PCPs in California. Providers have 12 months to fulfill SBIRT training requirements. Without proper training, in most settings providers cannot bill Medi-Cal for SBIRT services. Therefore, DHCS expects to capture and evaluate data indicating a meaningful increase in SBIRT provision.

REQUEST FOR FEDERAL TECHNICAL ASSISTANCE

California has offered the SBIRT benefit to adult Medi-Cal beneficiaries since January 1, 2014. As a result, DHCS expects that PCPs will screen and identify a larger pool of beneficiaries who engage in risky or hazardous drinking or alcohol abuse. These patients will need referral to treatment, and will require expanded capacity in the current federally-funded service system. In order to align with the DHCS Mission, which is to provide Californians with access to affordable, high-quality health care services, increased treatment needs and referrals must be met with broader availability of services.

The federal government can be instrumental in helping California increase treatment capacity, including increasing SUD provider availability for referral to services. Receipt of additional funding and technical assistance could support state, county, provider, and community-based efforts to expand cross-training of clinical staff to coordinate and integrate physical health, mental health, and SUD treatment teams into a unified system. Federal incentives provided to expand resources and cross-train physical health/SUD/mental health, multi-disciplinary teams is needed. Availability of cross-trained teams will increase capacity and the ability to provide quality treatments for alcohol abuse. Federal incentives will also help develop and expand innovative practice settings to include care coordinators, open new venues, or co-locate services operating in a single setting where multi-disciplinary teams are readily available to beneficiaries.

PERINATAL/RESIDENTIAL PROVIDERS: 2012-2013

County Name & Code	Provider Name & Code
Alameda (1)	Bi-Bett - 010070
	The Solid Foundation - 010156
	Solid Foundations - 010153
	Magnolia Women's Recovery Program, Inc - 010114
	East Bay Community Recovery Project - 010106
Butte (4)	Skyway House - 040413
Contra Costa (7)	Ujima Family Recovery Services - 070040
	Bi-Bett - 070737
	Ujima Family Recovery Services - 070712
El Dorado (9)	Progress House, Inc. - 090920
	Progress House, Inc. - 090913
	Progress House, Inc. - 090905
Fresno (10)	Spirit of Woman of California, Inc.- 101034
	Westcare California, Inc.- 101020
Kern (15)	Bakersfield Recovery Services - 151536
	Bakersfield Recovery Services - 151515
	Kern County Hispanic Commission - 150022
Kings (16)	Champions Recovery Alternative Programs, Inc. - 161633
Los Angeles (19)	Southern California Alcohol and Drug Programs, Inc. - 196760
	South Bay Alcoholism Services - 197321
	Southern California Alcohol and Drug Programs, Inc. - 197262
	Watts Healthcare Corporation - 196982
	Southern California Alcohol and Drug Programs, Inc. - 190106
	South Bay Alcoholism Services - 190086
	Asian American Drug Abuse Program, Inc. - 197255
	Asian American Drug Abuse Program, Inc. - 197214
	National Council Alcohol and Drug Dependency Long Beach - 196701
	Bernie's Lil Women Center, Inc. - 197118
	California Hispanic Commission on Alcohol and Drug Abuse, Inc. - 196996
	His Sheltering Arms, Inc. - 190055
	Prototypes, Centers for Innovation in Health, Mental Health and Social Services - 196791
	Tarzana Treatment Centers, Inc. - 196780
	Behavioral Health Services, Inc. - 190020
	Mid Valley Recovery Services, Inc. - 190077
Marin (21)	Center Point Life Start - 212150
Merced (24)	Community Social Model Advocates - 242403

PERINATAL/RESIDENTIAL PROVIDERS: 2012-2013

County Name & Code	Provider Name & Code
Monterey (27)	Community Human Services - 272721
Nevada	Community Recovery Resources - 292901
	Community Recovery Resources - 290001
Orange	Southern California Alcohol and Drug Programs, Inc. - 308096
	Heritage House North - 303028
Placer (31)	Progress House, Inc. - 313107
	New Leaf Services, Inc. - 313111
	James N. Hardwick - 313105
Riverside (33)	ABC Recovery Center, Inc. - 333334
	MFI Recovery Center, Inc. - 330010
	MFI Recovery Center, Inc. - 333317
	Riverside Recovery Resources - 330101
Sacramento (34)	Associated Rehabilitation Program for Women, Inc. - 343462
	Volunteers of America, Inc. - 343460
	Associated Rehabilitation Program for Women, Inc. - 340090
	National Council on Alcoholism and Drug Dependence - 343408
San Diego (37)	McAlister Institute for Treatment and Education, Inc. - 378773
	Mental Health Systems, Inc. - 373773
	North County Serenity House, Inc. - 373711
San Francisco (38)	Mount Saint Joseph Saint Elizabeth's - 383843
	Jelani, Inc. - 380145
	Bayview Hunter's Point Foundation for Community - 383816
San Joaquin (39)	San Joaquin County Residential Drug Program - 390014
San Mateo (41)	Free at Last: Community Recovery and Rehailitation Services - 414110
	Women's Recovery Association - 414135
	Service League of San Mateo County - 414137
Santa Barbara (42)	Casa Serena, Inc. - 424295
	Casa Serena, Inc. - 424296
Santa Clara (43)	Parisi House on the Hill, Inc. - 430031
Santa Cruz (44)	Janus of Santa Cruz - 444496
Shasta (45)	Empire Recovery Center - 450001
	VOTC, Inc. - 454524
Solano (48)	Bi-Bett - 484804
Sonoma (49)	Women's Recovery Services - 490030
	Athena House - 494915
Tulare (54)	Tulare County Alcoholism Council, Inc. - 545415
Ventura (56)	Prototypes, Centers for Innovation in Health, Mental Health and Social Services - 565638
Yolo (57)	Progress House, Inc. - 575704
Total Provider Count: 74	

LIST OF ACRONYMS USED IN REPORT	
AB	Assembly Bill
ACA	Affordable Care Act
ADP	Department of Alcohol and Drug Programs
AI/AN	American Indian/Alaskan Native
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
BH	Behavioral Health
BHF	Behavioral Health Forum
BOS	Board of Supervisor
BRFSS	Behavioral Risk Factor Survey Surveillance System
BSCC	California Board of State and Community Corrections
CAARR	California Association of Addiction Recovery Resources
CADPAAC	County Alcohol and Drug Program Administrators Association of California
CalOMS Pv	California Outcome Measurement System for Prevention
CalOMS Tx	California Outcomes Measurement System for Treatment
CALSIM	California State Innovation Model
CCS	California Children's Services
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDE	Community Defined Evidence
CDPH	California Department of Public Health
CHKS	California Healthy Kids Survey
CHSI	Center for Health Statistics and Informatics
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
CMU	County Monitoring Unit
COD	Co-Occurring Disorders
CPE	Certified Public Expenditure Reimbursement
CPI	Community Prevention Initiative
CSAP	Center for Substance Abuse Prevention
CSUS	California State University Sacramento
CY	Calendar Year
DATAR	Drug and Alcohol Treatment Access Report
DHCS	Department of Health Care Services
DHCS-SUD	Department of Health Care Services - Substance Use Disorder Division
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMH	California Department of Mental Health
DSM-V	Diagnostic and Statistical Manual of Mental Disorders V
EBP	Evidence-Based Practices

LIST OF ACRONYMS USED IN REPORT	
ED	Emergency Department
EIS	Early Intervention Services
FEMA	Federal Emergency Management Agency
FY	Fiscal Year
FQHC	Federally Qualified Health Center
GONA	Gathering of Native Americans
HAP	Health Action Plan
HIPAA	Health Insurance Portability Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Clinical and Electronic Health
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSOC	Holistic System of Care
ICD-10	International Classification of Diseases, 10th Edition
IDU	Injection Drug Use
IPAC	Interagency Prevention Advisory Council
IPR	Independent Peer Review
ISAP	Integrated Substance Abuse Program
ITWS	Information Technology Web Services
LGBTQ	Lesbian, Gay, Bisexual, Transgendered, and Questioning
LTSS	Long-Term Services and Supports
MACR	Monthly Arrest and Citation Register
MBA	Minimum-Based Allocation
MCP	Managed Care Plans
MDE	Major Depressive Episode
MHPAEA	Mental Health Parity and Addiction Equity Act
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division
MH-SUD	Mental Health and Substance Use Disorder
MIHA	Maternal Infant Health Assessment
MITA	Medicaid Information Technology Architecture
MSM	Men Who Have Sex with Men
NREPP	National Registry of Evidence-Based Programs and Practices
NRT	Narcotic Replacement Treatment
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
OARA	Office of Applied Research and Analysis
ODF	Outpatient Drug Free
OSHPD	Office of Statewide Health Planning and Development
OTS	Office of Traffic Safety
OWPYS	Office of Women's, Perinatal and Youth Services

LIST OF ACRONYMS USED IN REPORT	
PATH	Projects for Assistance in Transition from Homelessness
PBE	Practice-Based Evidence
PCP	Primary Care Providers
PIP	Positive Indian Parenting
PTRSD	Prevention, Treatment, and Recovery Services Division
SACB	Safe and Active Communities Branch
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT BG	Substance Abuse Prevention and Treatment Block Grant
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SHA	Staying Healthy Assessment
SI	Strategic Initiative
SNAP	Statewide Needs Assessment Planning
SPA	State Plan Amendments
SPF	Strategic Prevention Framework
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
STC	Special Terms and Conditions
SUD	Substance Use Disorder
SUD-CD	Substance Use Disorder Compliance Division
SUD-PTRSD	Substance Use Disorders Prevention, Treatment and Recovery Services Division
SWITRS	Statewide Integrated Traffic Records System
SWOT	Strength, Weakness, Opportunity, and Threat
UCLA	University of California, Los Angeles
UCLA-ISAP	University of California, Los Angeles Integrated Substance Abuse Program
USDHHS	U.S. Department of Health and Human Services
USPSTF	U.S. Preventive Services Task Force
VSO	Veteran Services Office
W & I	Welfare and Institutions