I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

State DUNS Number

Number
796528263

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name
California Department of Health Care Services

Organizational Unit
Mental Health and Substance Use Disorder Services Division

Mailing Address
1501 Capitol Avenue, MS 0000 - P.O. Box 997413

City
Sacramento

Zip Code
95899-7413

II. Contact Person for the Grantee of the Block Grant

First Name
Toby

Last Name
Douglas

Agency Name
California Department of Health Care Services

Mailing Address
1501 Capitol Avenue, MS 0000 - P.O. Box 997413

City
Sacramento

Zip Code
95899-7413

Telephone
916-440-7400

Fax
916-440-7404

Email Address
Toby.Douglas@dhcs.ca.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Allen

Last Name

Scott

Telephone

916-324-8903

Fax

916-323-0653

Email Address

Allen.Scott@dhcs.ca.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Diana S. Dooley
Title	Secretary
Organization	California Health and Human Services Agency

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Diana S. Dooley
Title	Secretary
Organization	California Health and Human Services Agency

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee: Diana S. Dooley

Title: Secretary, California Health and Human Services Agency

Signature of CEO or Designee[1]: _____ Date: _____

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

Not Applicable

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

INTRODUCTION

Great challenges and opportunities await all Californians today. The state is slowly emerging from the Great Recession, the longest and deepest recession since World War II. More than 1 million jobs were lost in California and the unemployment rate rose to 12.6 percent, the third highest in the nation. Personal income dropped by 2.4 percent, the first decline since 1938. General Fund revenues fell much more, dropping 24 percent from the height of revenues in 2007-08 to the bottom in 2009-10.

With the state facing such significant challenges, opportunities open for considerable change and innovation focused on new and better ways of conducting business. The state's response to these challenging times took a multi-year approach, beginning in Fiscal Year 2011-12 with Public Safety Realignment and the start of state government reorganization activities. Realignment returns expenditure authority to local control allowing decisions to be made by those who have the direct knowledge and interest in providing the services. This is a major shift in how the state conducts business and significantly transforms the state/county relationship. At the same time, state government reorganization efforts are underway to make state government more effective and efficient.

While the state is undertaking these changes to create the ongoing infrastructure necessary for government to conduct business most efficiently, multiple state departments, in partnership with stakeholders, are planning and preparing for the implementation of the Affordable Care Act (ACA) in California. The ACA, the federal legislation passed in 2010, significantly expands and reforms the nation's health care system. In California, it means that an estimated four and a half million more individuals would have health insurance, either private or public (Medi-Cal). This will create a huge demand on systems and service providers to be ready by 2014 to meet this group of newly insured's health care needs.

California is rising to the challenge by transforming government at the state and local level to meet the needs of residents effectively and efficiently and to ensure that individuals, families and communities throughout the state benefit. State and local policy makers are shaping and re-crafting the substance use system and policies to create the greatest benefit for our communities.

Substance use and its consequences are well documented through numerous personal stories, national and state research, and multiple data sources. Wading through the mountains of data was a challenge undertaken through the production of California's FY 2013 State Needs Assessment Report. The report compiled relevant credible data presented within a policy context for substance use policy makers to consider in state and local planning and other decision-making processes. It was constructed to be a resource containing data and facts to help policy makers in advocating for the many benefits that the alcohol and other drug (AOD) service system provides to, and on behalf of, all Californians. The Department hopes that the presentation of substance

use data and other information will be of assistance to county governments in making informed decisions for AOD program improvements.

INVESTMENT IN SUBSTANCE USE PROGRAMS

There are many reasons for investment of resources to prevent and treat substance use. Oftentimes, the most compelling are the little known facts that the public in general, including policy makers, are not acquainted with, about the disease, use patterns and consequences. Substance use directly or indirectly impacts numerous other service systems, in particular primary health care service systems.

Substance Use Disorders (SUD) have significant impacts on individuals' health and consequently, health care costs. Independently, alcoholism reduces life expectancy by about 10-12 years. The earlier people begin drinking heavily, the greater their chance of developing serious illnesses later in life. Frequent and risky drinking and drug use lead to myriad health problems because of psychoactive substances' toxic effects. Consequently, SUD are associated with increased risk for pregnancy complications, cancer, and gastrointestinal, cardiovascular, pulmonary, renal, hematological, gynecological, and metabolic problems. Overall, substance use contributes to over 70 conditions that require medical care, and over half of individuals with SUD have another health condition as well. Chronic and serious medical conditions such as arthritis, asthma, hypertension, and ischemic heart disease are twice as prevalent among patients with SUD as in the rest of the patient population.

SUD also have negative impacts on mental health and behavior. Patients with SUD are over seven times as likely as patients without SUD to meet diagnostic criteria for anxiety disorders, and over ten times as likely to meet criteria for depression. The risk-taking behavior and needle sharing associated with many forms of substance use, also put individuals with SUD at increased risk, particularly for communicable diseases. Nationally, 30-40% of injection drug users are infected with HIV, and 60-90% have hepatitis. Because of the reduced inhibitions and increased aggression associated with substance use, SUD also increases risk for serious injury. Chronic drug use increases the probability of emergency room (ER) utilization by 30%, and individuals with SUD utilize the ER approximately three times as often as people who do not have these conditions. Consequently, individuals with SUD incur between two and three times the total medical expenses of people who do not have SUD.

Over time, significant health conditions develop for individuals with SUD. Research confirms that the early onset of substance use is a predictor for adult SUD and its associated problems. A number of surveys regarding youth substance use in California indicate that youth use a wide range of substances with alcohol and marijuana the two substances with the highest prevalence of use. Based on self-reported consumption patterns, nearly a third (30%) of 11th grade California students are categorized as high-risk users and/or excessive alcohol users. AOD use among students begins early and increases significantly in later grades signaling that the potential for increased health risks in adulthood are high for these young users.

Adult consumption of alcohol remains high at over 50%. It continues to be the major substance used and expectedly has the highest consequences from use. In 2010, 1,072 people died in alcohol-related motor vehicle collisions in California (on average approximately 3 people per day). Additionally, 198,249 people were arrested for driving under the influence, 121,159 for felony drug arrests, and another 253,680 for misdemeanor alcohol and drug arrests.

Economically, the consequences of substance use are high. Estimates of the costs to California are:

- California lifetime costs of alcohol and other drug use and abuse in 2010 are estimated at $172.6 billion ($52.6 billion direct tangible costs, $120 billion in quality of life losses).
- Alcohol-attributable costs represent 75% of the total estimated costs ($37.5 billion in tangible costs, $91.2 billion in quality of life costs).
- Estimated tangible costs of substance abuse in California in 2010 for all government agencies (shared local, state, and federal costs) totaled $12.5 billion, approximately 24% of total costs.
- The $12.5 billion in government costs includes medical and health care costs, lost tax revenue, police, fire department, adjudication, sanctioning and child protective services costs.

As articulated above, there are significant consequences for California communities related to substance use and abuse, particularly alcohol use since it is readily available, accepted and legal for ages 21 and older. Health consequences are many and severe for chronic users, however, many consequences are felt by persons who do not have a substance use disorder (or any use), as traffic and crime consequences often affect the greater community at large. The significant cost consequences of substance use and abuse is born by local communities in many ways, through the directing of local funds toward mitigating the consequences of use (e.g., health care, child welfare, criminal justice) rather than creating larger investments for the overall health of communities (i.e., community centers, youth programs, parks, recreational programs, etc.). Local planning efforts and policies will be key in turning these investments around over time, while balancing the immediate needs.

POLICY CONSIDERATIONS

There are three main drivers for the changes underway and required within the AOD system: The pending implementation of the ACA; the infrastructure changes taking place through realignment of funds to local control, and the transfer of State functions. Several important issues surface for decision makers in regard to each, detailed in the following discussion.

Health Care Reform

Health care reform, although requiring significant change to redefine how we provide SUD health care in this state, is an opportunity to expand access to care for Californians

and create an AOD system that is safe, effective, patient-centered, timely, efficient and equitable. There are several major components within the publicly-funded AOD system that will need to be addressed as part of the redesign effort, including new or modified payment systems, how services are delivered, the types of services delivered, the venues used to deliver services, the workforce that delivers services, how services are measured, and how the benefits are evaluated. In addition, there is great opportunity to build in practices that promote culturally competent service provision that will help eliminate health disparities within the AOD system.

New or Modified Payment Systems

The ACA will alter the payment mix for clients who currently receive AOD services through the publicly-funded system. Through the Medicaid expansion, Medi-Cal will see an increase in the number of individuals eligible to receive services. It is anticipated that some of the system's current AOD clients will begin to be covered under private insurance plans starting in 2014, or will become eligible for Medi-Cal, altering the payer of services from the Substance Abuse Prevention and Treatment (SAPT) Block Grant to Medi-Cal or other insurance carriers. Many additional individuals who have not been able to access the publicly-funded Medi-Cal AOD service system in the past will be eligible to seek services (e.g., indigent childless adults). It is expected that the public health and behavioral health systems will ultimately be reaching far more individuals and families in need of substance use and mental health services as a result of the ACA. With the potential of insurers paying for substance use services for the large influx of insured in California, there is a need to build capacity in systems that traditionally have not provided substance use services to the extent that it may be required under health care reform. Likewise it will be important to build or expand the capacity of the existing AOD service system to bill private insurance or Medi-Cal for services.

How Services are Delivered

The current AOD system has not widely employed the use of technology in the provision of services; however, there is great potential to expand behavioral health services into methods such as telemedicine and telepsychiatry. This would substantially expand the reach of service provision to remote locations, as well as create wider access to care for patients even in urban areas. Many forms of virtual technology are emerging as possible effective methods for delivering prevention, early interventions and treatment services, including web-based virtual worlds and computer simulated environments. Social marketing for outreach and messaging is another powerful method that can be utilized further.

Types of Services Delivered

There has been much research and literature published which provides a wealth of effective practices for the delivery of AOD prevention and treatment services. Much progress has been made in California in recent years regarding the push for utilization of evidence-based practices in the provision of services. However, the utilization of medication-assisted treatments (MAT) is still not widespread, although growing. The further implementation of MAT can be enhanced with the integration efforts into primary care settings.

Venues Used to Deliver Services
An important change that is anticipated with the implementation of the ACA is the integration of SUD and mental health services into primary care settings, which will create greater access for individuals to a comprehensive array of services in one setting. For the publicly-funded behavioral health system, this is a departure from the typical service structure which operates from a specialty service framework. However, since the passage of the ACA in 2010, much work has been done to investigate and test various integration and co-location strategies, including building the capacity for shared electronic health records. Integration efforts will improve coordination and services to co-morbid populations as well, which should result in better patient outcomes.

Community Health Homes is a model supported by the ACA that is a person-centered system of care that improves services and outcomes for patients. The provision of behavioral health services through Accountable Care Organizations (ACOs) or Federally Qualified Health Centers (FQHCs) will likely be critical in the re-design of health care services, and is already occurring to some extent in different locations around the state.

Workforce that Delivers Services
California's existing SUD workforce will face new challenges in meeting the ACA requirements for health care integration. The projected expansion of eligible Medi-Cal beneficiaries will put tremendous pressure on the existing system and workforce. Additionally, many existing treatment providers may lack the required degrees, licenses, accreditation, or certifications needed for the new environment. This could potentially reduce the number of qualified providers.

As work toward integration with primary care continues, the need for uniform education, training and competency standards for SUD counselors and service providers (that are compatible with the requirements of the health care system, including insurer licensure requirements) must be addressed. Existing and new service providers will need support and training to come into compliance with the educational, licensing and certification standards for reimbursable treatment services. There are eight National Commission for Certifying Agency (NCCA) accredited organizations that register and certify SUD counselors in California. These eight agencies all have their unique requirements for counselor certifications. In order to integrate the SUD workforce into the primary health care system, California will need to establish a set of statewide standards for all SUD programs and counselors that will meet the requirements of the new health care system, and ensure that the current experienced SUD workforce can be relevant in a post-health care reform environment.

How Services are Measured, and how the Benefits are Evaluated
Accountability and measurement of effectiveness of services is a standard business expectation of any publicly-funded system. Due to the different venues where services may be provided, and how they may be provided, the standardized collection of data to

measure progress could become complicated. California will give thoughtful consideration to this issue when moving forward with systems change efforts.

Culturally Competent Care

As the California demographic data show, the state is already quite diverse, and projections indicate that this trend will continue for the next forty years. As the state grows ever more diverse, public service systems must make the necessary adjustments to ensure services are culturally appropriate and competent. Ongoing efforts to reduce and eliminate health disparities for racial/ethnic groups (as well as other cultures) must become standard operating procedures for health organizations. This will not only ensure adequate access to services for traditionally underserved groups, but also ensure that these groups have the best chance for attaining a positive outcome once accessing public services.

The Culturally and Linguistically Appropriate Services (CLAS) standards for health organizations are one means to correct inequities that currently exist in the provision of health services, and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group. However, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services, thereby helping to reduce and eventually eliminate disparities for these groups. The standards also offer a practical framework for the implementation of services and organizational structures that can help health care organizations and providers be responsive to the cultural and linguistic issues presented by diverse populations.

Realignment of Funds to Local Control

Realignment, which began with the Governor's FY 2011-12 Budget, redefines the state county relationship. Realignment returns expenditure authority to cities, counties, special districts, and school boards, allowing decisions to be made by those who have the direct knowledge and interest. The realignment of funds moved program and fiscal responsibility to the level of government that can best provide the service, while also eliminating duplication of effort, generating savings and increasing flexibility.

Realignment allows government at all levels to focus on their core functions and become more efficient, more effective and less expensive. The transfer of funding for specific state AOD programs realigned from the State to local government are:

- Women's and Children's Residential Treatment Services
- Drug Court
- Non-Drug Medi-Cal Perinatal and regular
- Drug Medi-Cal (DMC) Perinatal and regular

Under Realignment, state sales tax comprises the dedicated revenue to support these programs. Revenue is deposited into the newly created Local Revenue Fund that contains several accounts for the realigned funds. Substance use funds are combined

with the mental health services funds into one Behavioral Health sub-account. It is local county discretion to make the decisions regarding how much to spend on each program. The challenge for local governments will be to balance the funding of entitlement and discretionary programs to meet the behavioral health needs of their communities.

A major component of this Public Safety Realignment, which directly impacts local provision of SUD services, is the implementation of the Community Corrections Grant Program authorized by AB 109. This program ends the costly revolving door of lower-level offenders and parole violators through the state's prisons. Lower-level offenders are now sentenced, housed, supervised, and treated locally. Many of these lower-level offenders returning to their communities will be a population in need of SUD treatment services. Each local jurisdiction will design their own programs and make their own decisions regarding how to handle these low-level offenders within their communities (e.g., build more jails, increase community supervision, increase local treatment capacity for mental health and substance abuse). Local governments are now in position to determine how to best engage and serve the needs of these returning community members for the health and well-being of their entire communities. In partnership with local governments, the state must determine how best to support these local efforts.

Transfer of State Functions

Concurrent with the implementation of Realignment, Governor Brown has begun an ongoing effort to make state government more effective and efficient through streamlining and reorganization activities. One component of this reorganization is the transfer and consolidation of all substance use functions into one state department and the elimination of the Department of Alcohol and Drug Programs (ADP). The transfer of the DMC program to the Department of Health Care Services occurred on July 1, 2012, as did the transfer of community mental health services. The placement of the remaining ADP functions, effective July 1, 2013, was determined through a planning and stakeholder input process that transferred the ADP AOD functions to the Department of Health Care Services (DHCS) and the problem gambling programs to the Department of Public Health.

This reorganization of AOD functions to DHCS offers numerous benefits to the SUD system. The result will be a state-administrative structure that will provide one state department for the substance use disorder system, align with federal and county partners, and promote opportunities for improving health care delivery services for the benefit of communities and consumers with substance use disorders. It also aligns the state structure to match the service models that will be necessary to most efficiently serve clients once the ACA is implemented.

CONCLUSION

The AOD system in California is entering a new era of possibilities. With the shifting landscape of structural changes at the state level, coupled with wider local control and

authority, and imminent implementation of the ACA on the horizon, the door is open to create positive changes to a system in transition. Coordinated strategies must be developed and embraced to systematically improve the effectiveness of services provided, reduce the number of individuals in need, and reduce disparities that exist.

Following are some recommendations California will consider in building a strategy to address opportunities for AOD system change:

- Support efforts to increase the capacity and reach of state and local resources to implement effective prevention policies and programs.
- Focus prevention efforts on mitigating the negative costs and consequences of alcohol consumption, especially underage drinking.
- Build partnerships across systems to plan and more fully address the underlying determinants of health, and the specific AOD risk and protective factors, to provide more holistic services that address the full range of individual and family needs.
- Further investigate patterns of use among California's diverse populations (e.g., age, gender, class, race/ethnicity, and other special populations) to assist in the development of a comprehensive approach to AOD prevention, treatment and recovery services, and better understand these populations' treatment needs.
- Adopt evidence-based practices and research-based strategies that allow resources to focus on prevention and treatment strategies that will support California's communities with the highest needs for AOD services.
- Build and utilize prevention and treatment performance measurement data to promote continuous quality improvements.
- Improve program performance and client outcomes by identifying and understanding racial and ethnic differences to reduce health disparities within the behavioral health system.
- In partnership with tribes, develop strategies to address the high AOD prevalence rate for AI/AN populations.
- Focus on sustainability with funding, infrastructure, capacity, workforce readiness and partnership development, as they are essential for the ACA to be successful in California.
- Continue to work to integrate SBIRT-type programming into the new health care reform integrated care models.
- Continue development and implementation of integrated models of care for all behavioral health services.

California's FY 2014/2015 SAPT Block Grant application builds upon the FY 2012/2013 application and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives.

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this

application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

OVERVIEW

Organizational Structure

The California Department of Health Care Services (DHCS) is one of 13 departments in the California Health and Human Services Agency (Agency, CHHSA). CHHS is a cabinet-level agency that reports to the Governor.

DHCS is organized into the following areas; Policy and Program Support, Health Care Programs and Mental Health and Substance Use Disorder Services with the following 22 divisions and 10 offices (please refer to the Section II, Planning Steps, Step 1 attachment to view the DHCS organizational chart).

Executive

- Administration
- Audits & Investigations
- CA Medicaid Management Information Systems Division
- Information Technology Services
- Office of Administrative Hearings & Appeals
- Office of Civil Rights
- Office of HIPAA Compliance
- Office of Legal Services
- Office of Legislative & Governmental Affairs
- Office of Medical Director
- Office of Public Affairs
- Office of Workforce Planning & Development
- Provider Enrollment Division
- Third Party Liability & Recovery Division
- Utilization Management Division

Health Care Delivery Systems

- Long Term Care Division
- Low Income Health Program
- Medi-Cal Managed Care Division
- Systems of Care Division

Health Care Financing

- Capitated Rates Development
- Fee-For-Service Rates Development
- Office of Selective Provider Contracting
- Safety Net Financing Division

Health Care Benefits & Eligibility

- Medi-Cal Benefits Division
- Medi-Cal Dental Services Division
- Medi-Cal Eligibility Division
- Office of Family Planning
- Pharmacy Benefits Division
- Primary & Rural Health

Mental Health & Substance Use Disorder Services

- Mental Health Services
- Substance Use Disorder Compliance Services
- Substance Use Disorder Prevention, Treatment & Recovery Services

DHCS’ Role in California’s Health Care Delivery System

DHCS’ programs serve approximately 7 million Californians. One in 6 Californians receives health care services financed or organized by DHCS, making the Department

the largest health care purchaser in the State. DHCS invests over $38 billion in public funds to provide health care services for low-income families, children, pregnant women, seniors and person's with disabilities and to maintain the health care provider safety net. The Department's programs provide access to comprehensive health services and emphasize prevention-oriented health care that promotes human health, well-being and individual choice. DHCS ensures appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

Designated Single State Agency (SSA)

DHCS has been designated as the Single State Agency (SSA) responsible for administering and coordinating the State's efforts in prevention, treatment, and recovery services for substance use disorder (SUD) services. DHCS is also the primary state agency responsible for interagency coordination of these services. DHCS has the responsibility for state leadership on substance use disorders and community mental health. The DHCS Director and the Mental Health and Substance Use Disorder Services (MHSUDS) Deputy Director are appointed by the Governor and confirmed by the Senate.

SUD Functions and Essential Services

Following are the core SUD functions and essential services of the SUD Prevention, Treatment and Recovery Services Division and the SUD Compliance Division within DHCS, Mental Health and SUD Services:

- Administers Substance Abuse and Mental Health Services Administration of (SAMHSA) Formulary (SAPT Block Grant) and Discretionary Grants;
- Conducts Statewide Needs Assessment and Planning (SNAP);
- Administers the Drug Medi-Cal Program (DMC);
- Licenses and Certifies SUD Treatment Programs and Facilities;
- Licenses Narcotic Treatment Programs (NTP);
- Ensures Access to Services;
- Conducts Public Education Campaigns;
- Assures Accountability through County and Program Monitoring;
- Certifies SUD Counselors;
- Collects, Analyzes and Disseminates Information on County, Program, and Client Outcomes;
- Conducts Population Level Prevention Initiatives;
- Coordinates with Other Systems, Agencies and Departments to Address Related Issues and Problems;
- Establishes Standards and Competencies for SUD Personnel
- Establishes Standards for Program Services and Competencies for personnel;
- Measures and Manages County and Program Performance;
- Provides a Statewide SUD Resource Center; and
- Provides Technical Assistance (TA) and Training to Improve the Use of the Strategic Planning Framework (SPF), Expand the Use of Evidence-Based Practices and Implement Culturally Appropriate Services

DHCS Mission and Vision

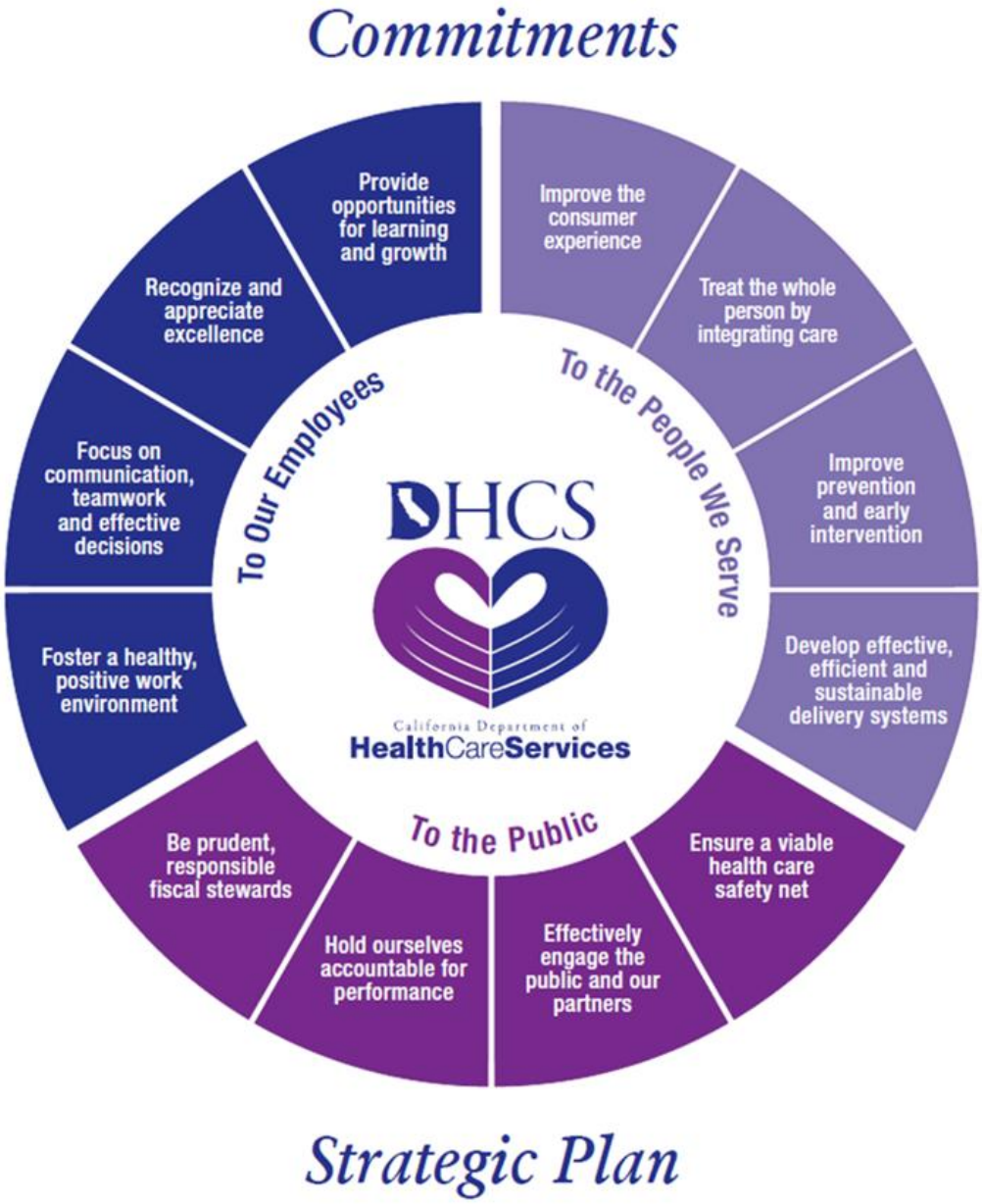
The DHCS mission is to provide low-income Californians with access to affordable, high-quality health care, including medical, mental health, substance use treatment services, and long term care. The DHCS vision is to preserve and improve the physical and mental health of all Californians and the

Core Values

The Department's mission and vision are imbued by its core values of integrity, service, accountability and innovations. These core values are linked to clear professional standards for all Department managers and employees.

DHCS 2013-2016 Strategic Plan

The DHCS 2013-2016 Strategic Plan is currently under development. The DHCS Strategic Plan will guide the Department's activities, practices, goals and aspirations as a health care purchaser and guardian of safety net services. The plan describes the Department's mission, vision, values, and identifies goals and corresponding objectives that we seek to accomplish. The DHCS Strategic Plan is the road map for the Department's work.



State-County Partnership

SUD prevention, early intervention, treatment, and recovery services are provided to clients through a partnership between the State and counties, which are the sub-state planning areas (please see below). DHCS contracts with counties for SUD services to be provided by locally administered and locally controlled substance use programs.

DHCS SUD staff meets or confers weekly with members of the County Alcohol and Drug Program Administrators Association of California (CADPAAC), a statewide organization whose members represent California's 58 counties. In partnership with CADPAAC and in cooperation with numerous private and public agencies, organizations and individuals, DHCS provides leadership and coordination in the planning, capacity building, development, implementation and evaluation of a comprehensive statewide SUD prevention, treatment and recovery system. The Department uses each of the 58 county alcohol and drug programs as brokers of service, and the counties in turn provide services to clients directly or by contracting with local service providers. DHCS ensures compliance with federal requirements through periodic county monitoring visits.

Advisory and Constituent Committees

California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, some of which are described below:

Governor's Prevention Advisory Council (GPAC)

The Governor's Prevention Advisory Council coordinates the State's efforts to reduce the incidence and prevalence of inappropriate alcohol, tobacco and other drug use by youth and adults. Members are appointed by the Governor and include key administrators from major state agencies involved with prevention issues, funding, and/or program-level support.

County Alcohol and Drug Program Administrators Association of California (CADPAAC)

CADPAAC is an organization of county alcohol and drug program administrators dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs. In addition, this body represents California's 58 county/sub-state planning areas.

Director's Advisory Council (DAC)

The Director's Advisory Council was created in 1993 to ensure the delivery of quality alcohol, drug abuse, and problem gambling services in California. Members include DHCS leaders, judges, directors of statewide provider organizations, the president of the County Alcohol and Drug Program Administrators Association of California, and the chairs of the eight constituency committees.

Constituent Committees

The eight Constituent Committees were established to advise and assist DHCS's Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population. The eight committees are; the African-American Constituent Committee, the Aging Constituent Committee, the Asian/Pacific Islander Constituent Committee, the Disability Constituent Committee, the Lesbian, Gay, Bisexual and Transgender Constituent Committee, the Latino Constituent Committee, the Native American Constituent Committee, and the Women's Constituent Committee

Narcotic Treatment Programs Advisory Committee (NTPAC)

The Narcotic Treatment Programs Advisory Committee meets to discuss emerging issues and provide information regarding the regulatory and policy issues associated with opiate treatment in California. Membership of the NTPAC is by invitation from the Director of DHCS. Committee members are selected on the basis of their NTP knowledge and expertise and commitment to ensuring safe access to replacement narcotic therapies.

External Stakeholder Groups
DHCS seeks collaboration and advice from many stakeholder groups as well, including; the California Association of Addiction Recovery Resources (CAARR), the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), the California Association of Drinking Driver Treatment Programs (CADDTP), the California Opioid Maintenance Providers (COMP), the County Alcohol and Drug Program Administrators Association of California (CADPAAC), and the National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate (NCADD).

In addition, the SSA Director, or his designee, serves as a member of the California Mental Health Planning Council (CMHPC). CMHPC is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

STATE DIRECTION FOR SUD SERVICES

Changing Landscape for Publicly-Funded Substance Use Disorder Services

California's publicly-funded system of SUD services has been evolving over the last several years to align practice more closely with scientifically derived models of effectiveness. Just as the federal government is moving towards a more accountable and effective system of SUD services, ADP and now DHCS has begun implementation of three efforts which are moving the department in the same direction: (1) building the capacity of the publicly-funded SUD services system as a chronic care model through the Continuum of Services System Re-engineering (COSSR) effort; (2) establishing an ongoing SNAP process in departmental operations; and 3) developing a framework for performance management at the State and local levels.

Section 1115 Medicaid Waiver

California remains at a significant crossroads in behavioral health with the approval of its Section 1115 demonstration waiver project, entitled "California's Bridge to Reform," in November 2010. Administered by the California Department of Health Care Services (DHCS), the goal of the 1115 waiver is to create more accountable, coordinated systems of care with an initial focus on enrolling seniors and persons with disabilities (SPDs) into managed care. The waiver will then implement integrated care models for dual eligibles[1], as envisioned by the ACA. The 1115 waiver's implementation plan is organized around the four principal vulnerable Medi-Cal populations and the programs that serve them in California:

- SPDs;
- Persons with Dual Medi-Cal and Medicare Eligibility;
- Children with Special Health Care Needs; and

[1] Individuals who are enrolled in both Medicare and Medicaid are called dual eligible.

- Persons with Behavioral Health Disorders and/or Substance Use Requiring Integration of Care

The 1115 waiver addresses the delivery of health care for the populations that are the most medically vulnerable, highest-cost, highest need and require the most coordinated care of all Medi-Cal beneficiaries. These beneficiaries are those with complex chronic conditions and co-morbidities. The 1115 waiver will result in improved integration of behavioral health and physical health care for these populations.

The 1115 waiver also immediately expanded coverage today for those who will become "newly-eligible" in 2014 under the ACA. Finally, the 1115 waiver will tests various strategies designed to strengthen and transform the state's public hospital health care delivery system for the additional numbers of people who will access health care once the ACA is fully implemented. In addition to the 1115 waiver renewal, in September 2010, two California bills were signed into law, which together created the framework for the California Health Benefit Exchange. California was the first state to form a board to oversee the implementation of its health insurance exchange after the passage of the ACA. Coupled with the 1115 waiver demonstration project, California is at the forefront of national health care reform and may serve as a model for other states beginning their health care reform planning.

The 1115 waiver has added coverage for countless low-income uninsured residents by taking advantage of the Coverage Expansion and Enrollment Demonstration (CEED) offered in the ACA. The CEED project builds upon the county-based health care coverage initiative (HCCI) formed in the previous 2005 Medicaid hospital financing 1115 waiver. County-based low-income health programs (LIHP) is being provided to two groups: the Medicaid Coverage Expansion (MCE) population and the HCCI population. Eligible adults will be enrolled in a medical home and receive a core set of services, including inpatient and outpatient services, prescription drugs, mental health (MH), and other medically necessary services. The 1115 waiver immediately begins phasing in coverage for the MCE population, which comprises "newly eligible" adults from ages 19 to 64 with incomes up to 133 percent of the federal poverty level (FPL), who are not otherwise eligible for Medicaid. The 1115 waiver also offers coverage for the HCCI population, which includes adults with incomes between 134 and 200 percent of the FPL, who beginning in 2014 will receive coverage through the Exchange.

The 1115 waiver does not mandate SUD services in the county-based LIHPs. However, counties can elect to provide SUD services in the LIHP benefit package if they provide the non-federal share of cost to receive the federal matching reimbursement. Several counties already include a range of SUD services in their LIHPs: Kern, Orange, Riverside, San Francisco, San Mateo, Santa Clara, Santa Cruz, and Tulare. As the 1115 waiver expands coverage to childless adults, these individuals will seek basic medical care in primary care settings. Many in this predominantly young adult population (less than 40 years old) are expected to need SUD services. The future delivery of SUD treatment services beginning in 2014 will increasingly involve referrals from physicians outside the traditional SUD system. The

1115 waiver is an opportunity to begin integrating SUD and primary care now by allowing counties to provide SUD services in their LIHP benefit package.

Continuum of Services System Re-engineering (COSSR)
COSSR is a systems change effort to evolve the publicly-funded continuum of SUD services system from an acute care system to one based on a chronic disease model. This change acknowledges that substance use causes problems of a continuous, chronic, and relapsing nature to both individuals and communities, necessitating continuing care and support.

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking from the approach that currently informs SUD systems. A new, integrated system of care is necessary in order to achieve desired outcomes for the prevention, treatment, and recovery of those individuals and communities served by the SUD field. This new system of care requires integration and coordination from the many stakeholders in the SUD field who work in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

The move toward this chronic disease model is expected to increase effectiveness of the system, as well as better position the system for integration with primary care. This department-wide change effort drives all programmatic activities and the administrative functions that support programming.

State Needs Assessment and Plan (SNAP)
SNAP informs COSSR efforts through the establishment of data-informed priorities and subsequent planning and implementation activities. SNAP is also an integral component in the process to determine departmental goals related to diversity and cultural competency needs as reflected in the Department's Cultural Competency Quality Improvement (CCQI) Strategic Plan, which will be further discussed later in this document.

The Needs Assessment is the first step in the SNAP process (assessment, planning, capacity building, implementation and evaluation). Central to this step is the establishment of an integrated substance use data monitoring, or surveillance, system to identify, evaluate, organize, and prioritize data sources and to track and analyze selected data indicators over time. This surveillance system will provide the SNAP process with the ongoing assessment data needed for data-informed planning, implementation and evaluation. This capacity building effort is currently underway through the grant-funded State Epidemiological Workgroup (SEW) project.

Performance Management
Performance management efforts started in 2007 between ADP, academic researchers at the University of California, Los Angeles—Integrated Substance Abuse Programs (UCLA-ISAP), and county SUD Administrator. This has produced positive results in collecting better data, increasing knowledge and use of performance measurement

practices, and identifying gaps in the current system to move towards a performance model. These efforts will be continued under DHCS.

Significant strides have been made using the California Outcome Measurement System (CalOMS) Treatment and Prevention databases to collect more timely, accurate, complete and useful data. The State and counties are working collaboratively to improve data reporting quality and completeness through web-based tools and training, onsite training, and help-desk TA. These efforts require ongoing diligence in monitoring, workforce training, and data evaluation on the part of numerous staff at the provider, county, and State levels.

Many counties have begun to use the data in both CalOMS systems to evaluate service provider performance, identify those in need of TA and training, as well as examine the practices of high performers in order to share greater system improvements. Within the Prevention system, counties have been required to link specific objectives from their SPF plans to each provider's contract and budget. This can improve the effectiveness of county oversight of specific performance goals and outcomes versus cost. Additionally, counties can monitor client treatment outcomes by provider and compare to countywide, or even statewide, outcomes within the treatment database to determine performance levels.

As DHCS implements the continuum of care as envisioned by COSSR and as performance measurement and management practices evolve within the SUD field, DHCS will be further modifying its data systems to ensure the data captured is useful for improving the quality of care, providing effective performance information for decision-makers, and demonstrating to the public the efficacy of SUD services.

These three change efforts provide a foundation upon which the State can build a more highly effective and adaptable service system. COSSR provides DHCS with a broad conceptual framework that covers the full continuum of services from prevention and treatment to recovery support. The SNAP process is integrating the SPF planning process into all departmental activities and creating an ongoing data tracking system to provide timely and useful data and analyses for DHCS decision makers. Efforts to improve performance management and measurement practices will be strengthened by the articulation of DHCS institutional goals and outcomes, and the establishment of a monitoring system to provide the information necessary to measure progress toward these outcomes. Together these efforts better allow DHCS to focus limited resources on efforts deemed the highest priority for California's publicly-funded system of SUD prevention, early intervention, treatment, and recovery support services.

Addressing the Diverse Needs of Californians by Ensuring Culturally Competent Services

Due to California's cultural and geographic diversity, the State-County Partnership is premised on the belief that SUD services provided at the community level help ensure equal access to all persons. These include individuals, who because of differences in language, cultural traditions, or physical disabilities, confront barriers to knowing about

or accessing SUD services. DHCS's SUD Prevention, Treatment and Recovery Support Services Division (SUD PTRSD) is charged with ensuring that the needs of special populations are met. SUD PTRSD organizational structure reflects DHCS's dedication to the underserved special populations within California. Within SUD PTRSD, a special unit—the Women and Youth Services Branch, now the Women's Perinatal Services and Health Access Units—was established to address the needs of women and youth services, as well as veterans and individuals with co-occurring disorders (COD) in a culturally competent manner. SUD PTRSD, along with the provision of TA to counties and providers through the new Culturally and Linguistically Appropriate Services (CLAS) initiative (further discussed below), support the SNAP process by ensuring that the SUD service system is culturally competent.

Prior to this effort, however, ADP/DHCS held a long-standing commitment toward meeting the needs of California's culturally and linguistically rich population, through a multi-year commitment with its TA contracts designed to serve populations that suffer disparities in health care with providers that specialize in serving special populations. TA efforts focused on increasing access to services by addressing the unique needs of California's diverse population, including racial and ethnic minorities, the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, and persons with disabilities. This long-standing commitment demonstrates the ADP/DHCS commitment to ensuring California implements a culturally and linguistically competent prevention, treatment and recovery continuum of care.

Culturally and Linguistically Appropriate Services (CLAS)

As previously mentioned, ADP/DHCS has also developed a CCQI Strategic Plan for 2010-12, which incorporated into the ADP/DHCS business and operational practices the CLAS standards developed by the Office of Minority Health, U.S. Department of Health and Human Services. To ensure that CLAS standards are effectively implemented in the field, ADP/DHCS has also launched the Community Alliance for CLAS, a multi-year effort that will ensure the SUD service system is culturally competent by achieving the following:

- <u>Assessing Agency Readiness</u>
  - Assess the readiness of SUD agencies to provide services under a CLAS delivery model. The assessments will guide training so that it is tailored to the assessed organizations' needs, functional activities of the workforce, and the needs of the population they serve.

- <u>Training and TA</u>
  - Provide a combination of comprehensive cultural competence training and TA. For example, some training will present a broad overview of CLAS to organizations that are receiving an introduction to CLAS standards. Other training will be specific to organizational plans based on assessed training needs. It will include workforce training on the cultural competence necessary to ensure the best client outcomes for communities with specialized characteristics, such as

gender, ethnicity, veteran status, LGBT and Intersex status, as well as other target populations.

- CLAS Guidelines Development
  - Develop and disseminate CLAS guidelines that identify and document evidence-based and best practice models for cultural and linguistic competency for SUD agencies. The guidelines are intended to improve standardization across the SUD treatment and recovery field, which will greatly influence client/consumer satisfaction. Guidelines will also serve as a foundation to start the policy discussion on the development of potential SUD CLAS regulations for the State of California.

- Marketing
  - Develop and implement statewide marketing strategies to inform the SUD treatment and recovery field of the availability of CLAS TA and training services to assure statewide access and service.

- Research/Clearinghouse
  - Serve as a clearinghouse for research and resources on evidence-based and promising practice models in cultural competence related to the provision of SUD services and improving client outcomes.

- Performance Evaluation
  - Continuously evaluate performance in meeting the overall contract goal of improving CLAS and client outcomes among SUD agencies. This includes distributing an evaluation form to all individuals/entities receiving services; following up with recipients of training and/or TA to assess the quality of services provided and ensure desired outcomes were achieved; developing and implementing a performance measurement process that identifies opportunities for continuous improvement; and developing and implementing an evaluation component that measures process and client outcomes among service recipients to determine the effectiveness of assessment and training and TA efforts.

SAMHSA Behavioral Health Policy Summit to Address Disparities within Healthcare Reform

As reported in the FY 2012/2013 SAPT Block California has continually sought opportunities to participate in national and statewide policy initiatives designed to address the needs of special populations. Such efforts resulted in California being selected as one of the seven states chosen by the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in its National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. California places such a high value on the information garnered from such learning collaboratives that even during these difficult economic times of limited staff resources, it remains a policy imperative to continue with such endeavors.

The National Policy Summit was designed to assist states and territories with the development and implementation of public policies that will contribute to the elimination of behavioral health disparities within health care reform. The Summit planned to accomplish the following:

- Further states' understanding of the ACA as it relates to health disparities;
- Provide TA and expert consultation regarding implementation of particular policy issues identified as priority relative to the ACA; and
- Offer designated time and expert facilitation to assist states in developing a strategic plan with specific action steps to address policy and program changes necessary to eliminate disparities in behavioral health care

California's delegation consisted of 22 delegates from state, county and community-based mental health and SUD agencies. During the National Policy Summit, California's delegates worked together to develop a Strategic Action Plan that outlines collaborative efforts aimed at reducing behavioral health disparities within the state. A Strategic Action Plan was developed by ADP and the former Department of Mental Health (DMH), focused on three areas of priority:

- Strategic Implementation of the ACA
  - Engage community and county representatives in efforts that support advancement of California's 1115 waiver
  - Employ culturally proficient/appropriate approaches, increase public awareness of the opportunities that are, or will become, available through the ACA, and
  - Support behavioral health workforce development/enhancement

- Integration of Behavioral Health and Primary Care Services
  - Support the establishment of the Person-Centered Health Home and
  - Engage key stakeholders within the health care field in discussions which will help to ensure that behavioral health is a priority/key consideration when designing the new infrastructure for healthcare

- Prevention and Wellness
  - Increase community involvement in prevention and wellness efforts
  - Identify and support culturally appropriate prevention activities

Overall, California's participation in the National Policy Summit positioned the State in getting a start on what is required to reduce health disparities as the ACA's expansion of insurance coverage in 2014 greatly increases access to mental health and SUD services. Now that ADP and DMH have been fully transitioned into the Department of Health Care Services, under Mental Health and Substance Use Disorder Services, the lessons learned in the Summit will continue to be implemented in a more coordinated effort by:

- Establishing partnerships/relationships with many important stakeholders within the behavioral health (and managed care) fields

- Laying the foundation for a plan which offers great opportunities to prepare the State to reduce behavioral health disparities by executing activities in the areas of community engagement, increased engagement of key stakeholders (State Insurance Commissioner, State agency leads, the Governor's Office, etc.), and the identification of existing resources (both in terms of culturally appropriate materials and existing federal funding) that can support workforce development (capacity and skill building), public education, and prevention efforts.

Bi-directional Integration of Behavioral Health and Primary Care Services
As reported in California's FY 2012/2013 Block Grant application, there have been conversations at the state and county level in California regarding the need to integrate and create a "no wrong door" set of policies on health care access for over a decade. Counties with combined substance use and mental health treatment systems have been collaborating with each on small scale pilots and initiatives as part of "systems of care" development. With growing recognition of the national conversations, in 2008 the California Institute for Mental Health (CIMH) began the Integration Policy Initiative (IPI); a collaborative project with the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). Funded by The California Endowment and IBHP, the project was developed to address the pressing need for improved linkages between the mental health, substance use and physical health care systems serving California's safety net population. The goals were to:

1. Develop a set of policy recommendations enhancing the interface between behavioral health and primary (physical) health care;
2. Share the recommendations with local and state policy makers; and
3. Accelerate systems (bi-directional) integration.

The vision of the IPI is: "Overall Health and Wellness Is Embraced as a Shared Community Responsibility."

In the fall of 2009 ADP began to reconfigure TA efforts with counties and providers to orient the field at scale on the concepts of integrated health care models, employing the services of UCLA–ISAP. Working through various advisory groups and the county administrators' quarterly meetings, ADP provided a sequenced set of trainings to educate our stakeholders on effective models and critical program components of integrated care. This work has continued through 2010, as ADP continued the TA to provide greater detail on integration approaches with primary care, including a learning collaborative and regional sessions.

This work highlights new areas of concern, such as sharing of client records. ADP is leading efforts to seek TA directly from SAMHSA on confidential client record sharing across mental health and SUD systems of care for persons with co-occurring disorders. Similarly, the California Mental Health Director's Association and CADPAAC have requested training and TA from SAMHSA independent of SSAs about data sharing across health care systems to address behavioral health and primary care in the new electronic era.

Finally, California has completed a state reorganization of the DHCS, DMH and ADP. The reorganization was designed to create increased efficiencies within state and local programs, and prepare California for implementation of the ACA. The current Administration sees many benefits for consumers, other stakeholders, counties, and the State, including an emphasis on bi-directional integration.
For consumers and stakeholders this reorganization:

- Improves the coordination, development and delivery of policies, programs and services for effectively dealing with co-occurring disorders.
- Improves access—providing a single point of contact and a stronger centralized voice for behavioral health policy and program coordination, development, implementation and monitoring as well as problem resolution.
- Places California in a stronger position to advocate for greater parity of behavioral health with physical health.
- Improves outcomes and provides better quality assurance, accountability and focus on professionalism of the caregiver/provider community and the counties that oversee them.
- Strengthens the platform and voice for the Consumer/Family Member networks as this consolidation will provide them a significantly stronger centralized, coordinated platform for input into state and federal decisions regarding behavioral health program and policy coordination, development, implementation and monitoring.
- Supports the movement towards integrating access to “health care homes” that offer comprehensive care management for Medi-Cal beneficiaries.
- Improves the ability to coordinate services for substance use disorders (SUDs) and mental health disorders with those for other physical conditions, thereby improving patient care for co-occurring conditions or disorders.

For counties and the State this reorganization:

- Provides a stronger and more focused state interface with the federal government during communications regarding our waiver and state plan amendments to appropriately integrate the rehabilitation, recovery, and resiliency model with existing federal requirements.
- Communicates a clear and consistent culture of accountability from the Single State Agency (SSA), as opposed to having the different cultures of DMH and ADP interpreting and implementing Medi-Cal policy separately from DHCS, program development, implementation, monitoring, and sanctions in different ways.
- Supports health care reform and the integration of SUDs with primary care and mental health by consolidating these services in DHCS, the department responsible for primary care and overall health care delivery.
- Supports health care reform and the federal government’s effort to encourage integration of mental health and substance use care. The new guidelines for the SAMHSA Block Grant application require states to explain how they will address and integrate co-occurring disorders.
- Provides a coordinated approach to dealing with potential waste, fraud, and abuse of Medi-Cal funds, which will reduce duplication of functions, costs, and confusion.

- Improves alignment with many behavioral health administrative structures at the county level, as many California counties already function administratively with consolidated mental health and alcohol/drug programs.
- Provides counties with a significantly stronger single point of contact and therefore, a more effective and efficient avenue for their input into state and federal deliberations and decisions regarding behavioral health program and policy coordination, development, implementation, and monitoring.
- Increases administrative and operating efficiencies at the state level.
- Increases the state's ability to address the infrastructure components of health care reform including electronic health records, complex billing, and data collection systems.

Provision of Recovery Support Services for Individuals with Mental or Substance Use Disorders

DHCS is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of public SUD services system based on acknowledging both the acute and chronic nature of SUD problems and addiction. Fundamental to this system is the recognition that addiction causes problems that are of a continuous, chronic, and relapsing nature for both individuals and communities, necessitating continuing care and support. It is essential to recognize the negative impacts of SUDs to other systems such as child welfare and foster care, criminal justice, mental health, and primary care in making the case for SUD prevention and treatment

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking about current SUD service systems and acknowledges the necessity of a new, integrated system of care in order to achieve desired outcomes for the prevention, treatment, and recovery. This new system of care requires integration and coordination from the many stakeholders in the SUD field working in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

DHCS will continue to emphasize Continuum of Services System Re-engineering (COSSR) in examining the current SUD services delivery system. The primary goal of the re-engineering process is to work with DHCS's stakeholders to reshape and reposition DHCS's operations to ensure system accountability, efficiency, and effectiveness, while delivering comprehensive, high-quality SUD services within the framework of a public system of services.

The Continuum of Services model contains the following elements:

- Intervention may occur at all levels in the continuum.
- Coordination of services within the SUD services model and with other service providers is a critical component of a successful system of care.
- All SUD services provided within the system should be sustainable, integrated, culturally competent, and evidence-based.

This recovery support services model formally acknowledges both the acute and chronic nature of SUD problems and represents a newer perspective of substance use and dependence as a chronic condition across systems.

Combined (SUD/MH) Plan for Expenditure of Funds for COD Services
Historically, California's state departments for SUD and mental health have effectively managed the various federal funding streams designated for specific components of the overall behavioral health systems. It has been recognized that this management of federal funds from multiple institutions has created separate and distinct systems of care for mental health and SUDs. In attempts to improve coordination, the majority of counties structure both systems under a behavioral health organizational model. Even though the county mental health and alcohol and drug agencies often remain separate programs under the same roof, there is improved communication on co-occurring disorders (COD) services and funding. This is evidenced by the work of both county associations and providers, who emphasize the importance of COD clients and funding options though their committee work and advocacy for funding. It is also emphasized locally where county financing options for these services continue to be designed for the most effective use of funds, and organized around cost centers that attempt to improve efficiency.

The Co-Occurring Joint Action Council (COJAC) Funding Subcommittee is another example of efforts to increase opportunities to strategically plan for ways to combine funding for COD services. Recently, the subcommittee released a COD services funding matrix that outlines all of the possibilities for potential funding, including, but not limited to, Medi-Cal, Local Revenue categorical programs, federal funds including Access to Recovery (ATR), and Minor Consent state-only Medi-Cal funding, etc.

Likewise, now that DMH and ADP have been transitioned into DHCS, we will continue to seek ways to untangle funding pathways to integrated services so that counties and providers have an easier time "braiding" funding sources for integrated prevention and treatment services. This is an extremely difficult task, as California has a complex array of funding streams that come with specific requirements and little flexibility. This is a result of varied policy choices and overlaying State legislative and federal priorities that have evolved over time.

Going forward, DHCS will continue to look for ways to combine funds where it is allowed. Certainly, the planned integration of behavioral health with primary care under health care reform presents promising options.

CONTINUUM OF SERVICES SYSTEM

Several specific programs and services operate within the continuum of services (COS) system. Some programs fund distinct types of services for specific subpopulations or serve a limited geographic area, while others serve eligible statewide participants and clients. Services in the COS system are supported by multiple funding streams, including combinations of state, local, and federal funds. Sources range from the SAPT

Block Grant, Local Revenue Fund (LRF), the State Medicaid (Medi-Cal) program, and discretionary grants from SAMHSA.

The following components form the California COS system for SUD prevention, early intervention, treatment, and recovery:

1. SAPT Block Grant Primary Prevention Set-Aside Services
2. SAPT Block Grant Treatment Services
3. DMC (Medicaid)
4. Women and Youth Services
5. California Access to Recovery Effort (CARE)
6. Strategic Prevention Framework State Incentive Grant (SPF SIG)
7. Services for Criminal Justice Populations
8. Local Funding from Various Sources

California's existing COS system begins with primary prevention services. The continuum also includes intervention and client-centered, culturally appropriate treatment and recovery services. Prevention, treatment and recovery approaches should be based on an individual's and community's needs, preferences, experiences, and cultural backgrounds.

PREVENTION SERVICES

The mission of the Substance Use Disorder (SUD) Prevention, Treatment, and Recovery Services Divisions, Policy and Prevention Services Branch (PPSB) is to develop and maintain a comprehensive statewide prevention system to prevent and reduce SUD problems and to improve the health and safety of the citizens of California by:

- Modifying social and economic norms, conditions, and adverse consequences resulting from alcohol, tobacco, and other drug availability, manufacturing, distribution, promotion, sales, and use; and,
- Effectively addressing at-risk and underserved populations and their environments.

Primary prevention serves populations at three levels of risk: 1) Universal, for the general public; 2) Selective, for sub-populations at higher than average risk for substance use; and 3) Indicated, for those already using alcohol or other drugs or engaging in other high-risk behaviors, but not yet defined as in need of treatment. Approximately four million persons receive primary prevention services annually. These services include the following populations: youth/minors (elementary, middle school, high school), parents/families, military including youth in military families, economically disadvantaged individuals, college students, adults/older adults, persons using substances, delinquent/violent youth, women & children, children of substance abusers, foster youth, youth in the juvenile justice system, tribal youth, and the LGBT population. The populations are those determined to be most in need by each county, through their Strategic Prevention Framework (SPF) planning process.

Strategic Prevention Framework (SPF)
Over the years, research has shown that prevention services are most effective when they are evidence-based, data-informed, and outcome-oriented. ADP and now DHCS has been working to apply these principles in our business practices and to facilitate their implementation at the local level. As resources diminish, following the SPF model in collecting data will become increasingly important, making counties more competitive for other available funding as they become data informed, build local coalitions, and implement evidence-based prevention. Prevention data is collected according to the SPF framework.

In order to begin the process of meeting the Center for Substance Abuse Prevention's (CSAP) requirements to incorporate the SPF into statewide prevention efforts, in 2007 ADP required the counties to conduct a local needs assessment to identify populations/communities at greatest risk. Based on the outcomes of their needs assessment, the State/County contract required counties to develop a strategic prevention plan to address their priorities. Given the new approach to planning, many counties needed assistance to obtain the data necessary to conduct a thorough needs assessment. ADP/DHCS assists counties by:

1. Providing counties with the results of the State Epidemiology Workgroup (SEW);
2. Providing counties with local data through updated versions of the Indicators of Alcohol and Other Drug Risk and Consequences for California Counties;
3. Supporting continued funding of the California Healthy Kids Survey, and the California Student Survey (CSS).
4. Providing counties with TA; and
5. Making available the SEW to assist DHCS Policy and Prevention Services Branch in identifying and obtaining statewide data

ADP and now DHCS has been collaborating with CADPAAC through the CADPAAC Prevention Committee to identify statewide prevention priorities that address populations and/or communities with the greatest risk factors, and to develop outcomes, both locally and statewide, that measure prevention effectiveness.

Center for Substance Abuse Prevention (CSAP) Strategies
The majority of the SAPT Block Grant Primary Prevention Set-Aside is allocated to counties to engage in the six CSAP strategies and their related activities to meet goals and objectives determined through their SPF-based planning.

1. <u>Information Dissemination</u>
The counties provide information dissemination services according to their SPF-based planning. At the state level, the DHCS Resource Center (RC) disseminates information, free-of-charge, throughout California. Examples include publications (select publications available in other languages), a toll-free information and referral line, and loaning of SUD-related books and videos.

2. Education

The counties provide education services according to their SPF-based planning. Examples of evidence-based educational services provided are Project Alert, Project Success and Too Good for Drugs. At the state level, DHCS conducts outreach and training to support youth, communities, and special service populations through TA contractors. As well, the RC maintains a portion of the DHCS Internet Website to provide current TA documents, some curricula, and educational publications (see http://www.adp.ca.gov/RC/rc_sub.shtml).

3. Alternatives

The counties provide alternative services according to their SPF-based planning. It includes youth development activities that engage youth in planning and leading community prevention actions. The largest statewide program engaging in Alternative activities is the Friday Night Live (FNL) program (FNL-high school, Club Live-middle school, FNL Kids-elementary school) (see http://www.fridaynightlive.org/About/About.htm).

The FNL system, based on a youth development framework, builds partnerships throughout the state for positive, healthy youth development by engaging young people as active leaders in their communities. The FNL system serves youth from all backgrounds, cultures, and demographics. FNL leadership is active in the Governors Prevention Advisory Council (GPAC) workgroups focused on high-rate substance and underage alcohol use. FNL programs across the State work closely with the California Highway Patrol and the Office of Traffic Safety to help young people buckle-up, slow down, prevent underage drinking and driving-while-under-the-influence.

4. Problem Identification and Referral

The counties provide problem identification and referral services according to their SPF-based planning. One California County developed the Individual Prevention Service (IPS) program based on the Brief Risk Reduction Interview and Intervention Model. Using the IPS, individuals are screened for SUD issues, and, if determined necessary, referred for a treatment assessment or more in-depth prevention education. At a statewide level through a GPAC workgroup focused on high-rate underage users, DHCS, the California Department of Education (CDE), the Office of the Attorney General (AG) and other GPAC members will promote student assistance programs for the 1,000 school districts in California.

5. Community-Based Process

The counties provide community-based process services as part of their SPF-based planning (for example, accessing services, assessing needs and resources, and multi-agency collaboration). DHCS provides TA services for local initiatives identified by community groups, prevention service providers, schools, neighborhood associations, and county administrators. This strategy will be supported by statewide TA and RC services to reach large population segments at an economical cost. The Community Prevention Initiative (CPI) TA service provides extensive, immediate access to quality resources (see http://www.ca-cpi.org/Publications/publications_main_page.htm).

6. Environmental

The counties provide environmental services according to their SPF-based planning. Examples include social host ordinances, Responsible Beverage Server (RBS) training, alcohol availability and accessibility policies, identifying and changing harmful social norms regarding substance use. Statewide, DHCS TA contractors develop, promote, and provide services on environmental prevention techniques for cities, emphasizing their local zoning authority and public policy development. As with the community-based strategy, the environmental strategy is strongly supported because it can reach larger population segments and use public policy to sustain effects.

State-Level Prevention Efforts

To support the delivery of prevention services at the local level, PPSB performs the following activities at the State level:

- Staffing and coordination of GPAC, which coordinates the State's strategic efforts to address substance use issues;
- Interagency collaboration and coordination with other state departments on prevention issues to ensure substance use problems are appropriately addressed;
- Administer services through discretionary grants;
- Statewide implementation of the SPF to facilitate effective program planning. PPSB works with counties to develop county prevention plans that are data informed, outcome driven and evidence based;
- Manage CalOMS Prevention which collects primary prevention data from SUD prevention providers throughout California to assure accountability for federal primary prevention funding and meet the federal National Outcome Measures;
- Tobacco Sales to Minors (the Synar Amendment), which requires states to pass and enforce laws that prohibit the sale of tobacco to individuals under 18 years of age and maintain a retailer violations rate that is at or below 20 percent;
- Research and analyze emerging issues (for example, evidence-based programming, binge drinking, marijuana legalization) to guide policy development;
- Provide TA and training to counties and service providers regarding strategic planning, data analysis, evaluation, evidence-based practices, and cultural and linguistic relevancy;
- Workforce development to increase capacity of the prevention field through the development and implementation of prevention professional competencies; and
- Collaborate across systems to prepare the prevention field for opportunities related to health reform.

In addition to the SPF framework and the six CSAP strategies, the following program components support the delivery of primary prevention services:

Governor's Prevention Advisory Council (GPAC)

As a means of working across California's multiple state systems, DHCS's Director, or his designee, chairs the GPAC which coordinates efforts to achieve measurable reductions in the incidence and prevalence of inappropriate use of alcohol, tobacco, and other drugs. Work with 16 agencies provides historical perspectives needed to attain

long-term, sustainable results. GPAC has focused on finding common goals members can work toward through their agencies and affiliates. Workgroups are established for: (1) Underage Drinking to work collaboratively to provide information for the Sober Truth on Preventing Underage Drinking (STOP) Act survey and support to more than 100 town hall meetings held in communities statewide; (2) Alcohol Policy to support the California of Public Health-led Healthy Retailer campaign; and, (3) the GPAC Exploratory Workgroup to revise the CPAC work plan.

Discretionary Grants

In the past, ADP/DHCS has been awarded federal discretionary grants to further State prevention efforts. The ADP/DHCS State Incentive Grant (SIG) focused on environmental prevention programs, strategies and policies. Social host ordinances created through this grant program have been used by other states to draft their legislation.

ADP/DHCS used the Safe and Drug Free Schools and Communities State Grant, Governor's Program, to increase services to selective and indicated populations through a county grant program. Services focused specifically on youth in foster care, high rate/binge drinking youth, and youth with parents in treatment. In addition to evaluating individual county program efforts, a peer-led cross-site evaluation of the Governor's Program was instituted. The evaluation process, along with other learnings from these grant programs will be incorporated into any future discretionary grants received.

Currently, DHCS administers the SPF SIG, a pilot project designed to help states and communities further data-driven planning, implement evidence-based prevention strategies, and reach desired outcomes quickly. ADP, in collaboration with the Governor's Prevention Advisory Council and the State Epidemiological Workgroup, determined that the priority of California's SPF SIG project will be to reduce underage and excessive drinking among youth and young adult's ages 12 to 25 years old. The SPF SIG is currently being implemented in 12 communities within 11 counties.

Early Intervention

Over the last few years, ADP has worked diligently with multiple stakeholders to increase awareness of Screening, Brief Intervention and Referral to Treatment (SBIRT) as a comprehensive, integrated approach to the delivery of early intervention to individuals at-risk for developing substance abuse disorders. Particularly, ADP worked to train physicians employed by Federally Qualified Health Centers (FQHC's) on SBIRT. In preparation for health reform implementation, DHCS staff is looking for ways in which they can work collaboratively with California's managed care systems to adopt SBIRT as a best practice in primary care settings.

DHCS stakeholders continue to lead the state in demonstrating the efficacy of SBIRT in a variety of settings. For example, a clinical study on SBIRT in a psychiatric setting is being developed by Principal Investigators at the University of California, Los Angeles (UCLA). The study will begin by recruiting over 1,000 individuals with anxiety, mood and psychotic disorders. These individuals will be randomly assigned to receive either

SBIRT or Health Education within multiple County Behavioral Health clinics in Ventura County. Those who are assigned to the SBIRT condition will receive the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) to assess their level of risk for a substance use disorder. Following the ASSIST, participants in this group will receive a brief intervention by a trained health educator to address risky substance use.

As the administration of the ASSIST takes place shortly after the participant's intake evaluation and prior to receiving a plan of care at Ventura County Behavioral Health, for those whose ASSIST score suggests high risk for substance dependence, the health educator will provide a summary of the ASSIST results to the Ventura County Behavioral Health staff. This procedure is expected to increase referrals to appropriate co-occurring disorders treatment. The SBIRT health educator will then provide two follow-up calls to the participant to facilitate engagement in treatment.

Individuals who are assigned to the Health Education control condition will not receive the ASSIST. These participants will receive an informational health education session of equivalent duration, in which various areas of health and well-being are described by a health educator and discussed with the participant. All study participants will be assessed at a 3-, 6-, and 12-month follow-up for alcohol and drug use, psychiatric symptoms, and addiction or co-occurring disorders treatment engagement and retention.

TREATMENT SERVICES

While each funding stream has its respective regulations and requirements, there is general conformity among the various treatment modalities and services, regardless of the funding source.

Across the existing COS system, there are several treatment modalities and services:

Assessment, Referrals, and Intake

The intake process begins with assessing the individual's needs to assure that clients are placed in the most appropriate treatment modality and are provided with a continuum of services that will adequately support recovery.

Case Management

Case Management services are activities involved in the integration and coordination of all necessary services to ensure successful treatment and recovery. Services may include outreach, intake, assessment, individual service plans, monitoring and evaluation of progress, and community resource referrals.

Nonresidential Treatment

Nonresidential treatment services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, and resource information about health, social, vocational, and other community services, with

assistance to some clients in obtaining services. These services are available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender-specific services tailored to meet the treatment, therapeutic, and recovery needs of women and their children. Perinatal providers must also make primary medical care available to the women and their children.

Rehabilitative Ambulatory Intensive Outpatient (Day Care Rehabilitative)
Day Care Rehabilitative (DCR) services are intensive outpatient counseling and rehabilitative services that typically last a minimum of 3 hours but are less than 24 hours per day for three or more days per week. DCR differs from non-intensive Rehabilitative/Ambulatory Outpatient services, in which clients participate according to a minimum attendance schedule and receive regularly assigned treatment activities.

Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free - Group
Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives SUD treatment services with or without medication, including counseling and/or supportive services.

Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free - Individual
Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives SUD treatment services with or without medication, including counseling and/or supportive services.

Outpatient Methadone Detoxification (OMD)
This service provides narcotic withdrawal treatment pursuant to the California Code of Regulations (CCR) Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.

Inpatient Methadone Detoxification (IMD)
In a controlled, 24-hour hospital setting, this service element provides narcotic withdrawal treatment pursuant to CCR Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.

Rehabilitative Ambulatory Detoxification (Other than Methadone)
Rehabilitative ambulatory detoxification is an outpatient treatment service rendered in less than 24 hours; it provides for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

Narcotic Replacement Therapy
Narcotic Treatment Programs (NTPs) provide narcotic replacement therapy using methadone, buprenorphine and any other Federal Drug Administration (FDA)-approved medications for the treatment of opioid addiction. Medication is dispensed on-site in

specialized clinics, as required by federal law. In addition to federal requirements, California also currently regulates the use of methadone. Federal statute allows buprenorphine to be prescribed by a physician in office-based practice who has obtained a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. California does not independently regulate the use of this medication and refers to the federal Center for Substance Abuse Treatment (CSAT) guidelines. Narcotic replacement therapy also includes assessment, treatment planning, urinalysis drug testing, group and individual counseling, and educational sessions.

Residential Treatment

DHCS must license all non-medical adult residential facilities that provide alcohol and drug treatment services on-site. Residential Adolescent Group Homes are licensed by the California Department of Social Services. Residential services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, detoxification services, and information about, and may include assistance in obtaining, health, social, vocational, and other community services. These services are available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender specific services tailored to meet the treatment, therapeutic, and recovery needs of women and their children. Perinatal providers must also make primary medical care available to the women and their children.

Free-Standing Residential Detoxification

Free-standing residential detoxification provides detoxification services in a non-hospital setting, which is designed to provide for safe withdrawal and transition to ongoing treatment.

Residential/Recovery Long Term (over 30 days)

Long-term residential care is typically more than 30 days of nonacute care in a setting with recovery/treatment services for substance use and dependency.

Residential/Recovery Short Term (up to 30 days)

Short-term residential care is typically 30 days or less of nonacute care in a setting with recovery/treatment services for alcohol and other drug abuse and dependency.

Other Services

The following services are part of the outreach, engagement, and treatment support services. They are an important part of the treatment continuum, and therefore are included here.

Outreach

Outreach activities are designed to identify and encourage eligible individuals with SUD to obtain treatment services, including intravenous drug users and pregnant and parenting women. Outreach may also be used to educate the professional community on perinatal services so that they become referral sources for potential clients.

SAPT BLOCK GRANT TREATMENT SERVICES

The SAPT Block Grant is an essential source of support for the COS in California. The SAPT Block Grant provides significant support for SUD treatment, prevention, and recovery services for the general population. California has also used its SAPT Block Grant award to categorically fund services for specific populations. These earmarked SAPT Block Grant funds support the criminal justice-related Female Offender Treatment Program (FOTP) for women released from custody with the goal of facilitating their reentry into society. Other earmarked SAPT Block Grant funds support Women and Youth Services (perinatal programs for pregnant/parenting women and adolescent treatment programs). Counties can also opt to use SAPT Block Grant funds to augment services for specific populations, such as youth and pregnant and parenting women.

DRUG MEDI-CAL (DMC) TREATMENT SERVICES

As part of the State Medicaid program, DMC provides *medically necessary* SUD treatment to California's Medicaid-eligible population statewide. DMC services include Outpatient Drug Free individual and group counseling, Narcotic Treatment, and Naltrexone Treatment. These are available to *all* eligible low-income people needing SUD treatment but lacking health insurance. This group also includes uninsured families and individuals whose incomes are too high to qualify for cash assistance but who otherwise qualify for California Work Opportunity and Responsibility to Kids (CalWORKs) or for Supplemental Security Income/State Supplementary Payment (SSI/SSP). Perinatal Residential SUD services are available only to pregnant and postpartum women with SUD diagnoses. Day Care Rehabilitative services are available to both pregnant and postpartum women and Early Periodic Screening Diagnosis and Treatment (EPSDT)-eligible beneficiaries. In addition, EPSDT Supplemental Services are available to youth through the Department of Health Care Services (DHCS) Treatment Authorization Request (TAR) process.
All services below are provided by staff lawfully authorized to provide, prescribe, and/or order these services within the scope of their practice or licensure:

<u>Outpatient Drug Free</u>
Outpatient Drug Free (medication-free) services are provided when the client does not reside in a treatment facility. Services are directed at stabilizing and rehabilitating persons with SUD diagnoses and consist primarily of counseling services. Once a licensed physician determines medical necessity, the patient can be admitted to Outpatient Drug Free services. These services include: intake, admission physical examinations, medical direction, medication services, body specimens, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling.

<u>Day Care Rehabilitative</u>
Day care rehabilitative services provide outpatient counseling and rehabilitation services at least three hours per day for three days per week to persons with SUD diagnoses, who are pregnant or in the postpartum period, and/or are EPSDT-eligible beneficiaries.

The range of services include: intake, admission physical examinations, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services and crisis intervention. Additionally, parenting education is available.

Naltrexone Treatment Services

This is an outpatient treatment service directed at serving detoxified clients with a SUD diagnosis of opiate dependence. Naltrexone is a medication that blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction. Naltrexone treatment services are provided only to individuals with a confirmed, documented history of opiate addiction and are at least 18 years of age; opiate free and not pregnant. The service regimen includes: intake, admission physical examination, treatment planning, medication services, individual counseling, group counseling, collateral services, and crisis intervention.

Perinatal Residential SUD Services

This category of DMC is a non-institutional, non-medical, residential program that provides rehabilitation services to pregnant and postpartum women with SUD diagnoses. Perinatal services address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills. Women reside in the treatment facility in order to support efforts to restore, maintain, and apply interpersonal and independent living skills, as well as access community support systems. General procedures include: intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention.

Services include the following:

- Mother/child habilitative and rehabilitative services
  - Development of parenting skills, training in child development, which may include child care
- Service access
  - Transportation to and from medically necessary treatment
- Parenting education
- Coordination of ancillary services
  - Assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant.

Narcotic Treatment Programs

Narcotic Treatment Programs (NTPs) provide narcotic replacement therapy (NRT) using methadone and other federally allowed medications as maintenance medication for detoxified clients with opioid dependence. Methadone is currently the only medication dispensed by NTPs that is reimbursable as a DMC benefit. (NTPs also serve some patients who are private payers.) Methadone is the most widely known and well-

researched treatment for opioid dependency. The goals of therapy are to prevent abstinence syndrome (relapse), reduce narcotic cravings and block the euphoric effects of opiate use. Methadone is used as one component of a comprehensive treatment program for narcotic addiction, along with a medical evaluation, treatment planning, urinalysis drug testing, group and individual counseling, and educational sessions.

The maintenance phase of treatment provides replacement narcotic medication to patients in sustained, stable, and medically determined doses. The purpose is to reduce or eliminate chronic opiate addiction while the patient is provided a comprehensive range of additional treatment services. Methadone maintenance treatment is proven as a cost-effective alternative to incarceration or hospitalization. Once patients are maintained on a stable dose level, it is often possible to address their other chronic medical and psychiatric conditions.
Patients stay on methadone as long as medically necessary to reduce or eliminate the craving to use opiates. A medical decision to discontinue methadone should come directly from the treatment provider's staff physician after discussing options with the patient, as methadone maintenance is a necessary component of an effective treatment plan for the patient. Methadone should not be discontinued without the full cooperation of both the physician and the patient.

WOMEN AND YOUTH SERVICES

Women's and Perinatal Services

The Perinatal Services Network includes approximately 215 SAPT Block Grant-funded treatment and recovery programs designed specifically to provide services for pregnant and parenting women. In previous block grant applications, the number of perinatal programs included programs that received only DMC funds. Those programs were excluded in this count because they are not required to comply with the SAPT Block Grant requirements for interim services and preferences.

Perinatal programs serve over 50,791 women annually. The target population includes pregnant and substance using; or parenting and substance using, with a child(ren) ages birth through 17. This parenting group also includes women attempting to regain legal custody of their child(ren). Perinatal programs are designed to empower women to achieve and maintain clean and sober living, deliver healthy infants, strengthen family units and lead productive lives. Perinatal programs provide or arrange for gender-specific, culturally relevant, SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and other needed services.

The following treatment modalities and ancillary services are available to women: Outpatient Drug-Free; Daycare Rehabilitative; Narcotic Replacement Therapy; Outpatient Detoxification Treatment (Other than Narcotic Treatment Detoxification); Residential Treatment; Transitional Living Centers; Alcohol and Drug-Free Housing; and Aftercare.

Additional components include:

- Outreach
  - identifies eligible pregnant and parenting women who need treatment services and encourages them to take advantage of these services

- Case management
  - facilitates access to primary medical care, primary pediatric care, and gender specific SUD recovery and treatment, and other needed services

- Transportation
- Child Care
  - on-site or through a licensed or licensure-exempt cooperative

- Education
  - educational/vocational training and life skills resources;
  - TB and HIV education and counseling;
  - parenting education; and
  - parenting skills building and child development information.

Adolescent Treatment Programs (ATP)

SAPT Block Grant funds support comprehensive, age-appropriate, SUD services to youth. DHCS currently oversees a statewide network of approximately 390 publicly funded SUD treatment programs that annually serve approximately 12,000 youth. The target population for youth treatment is individuals 12 through 17 years old (inclusive). The focus of services varies by county, depending upon local need and priorities.

ATP funds are allocated to counties to provide services such as:

- Outreach

- Early intervention
  - This level of care is delivered in a variety of settings and usually consists of brief contact or a series of contacts designed to explore and address problems or risk factors that are related to substance use. It is most appropriate for youth with low SUD problem severity (experimental and regular use) and those who do not meet the diagnosis for a substance-related disorder

- Low intensive outpatient treatment
  - The level of care equivalent to Adolescent Level I in the American Society of Addiction Medicine Patient Placement Criteria-2nd Revision (ASAM PPC-2R). This level of care may be provided in any age-appropriate setting and is appropriate for youth with low to medium problem severity

- High intensive outpatient treatment" (or day treatment)
  - The level of care equivalent to Adolescent Level II in the ASAM PPC-2R. This level of care is usually provided in a school or community-based program. It extends the school day to include a wide array of services. It is appropriate for youth with severe problems related to their substance use, which could potentially distract the youth from their recovery efforts

- Residential treatment in group home settings and juvenile detention facilities.

Additional ATP services components include:

- Screening, Initial & Continuing Assessment
- Diagnosis, Placement, & Treatment Planning
- Counseling
- Youth Developmental Approaches to Treatment
- Family Interventions and Support Systems
- Educational and Vocational Activities
- Structured Recovery-Related Activities
- Alcohol and Drug Testing
- Discharge Planning.

CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

The CARE program is the state's implementation of the federal Access to Recovery grant. Historically, California had limited resources for youth SUD services, so CARE initially focused exclusively on youth (12 to 20 year olds). In 2010, CARE expanded to also serve young military service members/veterans (through age 25) to help them access SUD services. CARE provides (virtual) vouchers for SUD services to eligible youth and service members/veterans who reside in one of five target counties (Butte, Los Angeles, Sacramento, Shasta, and Tehama). Once evaluated by a DHCS-approved assessment provider (sites and mobile clinicians), clients are issued vouchers and can select their service provider(s) from a variety of DHCS-approved organizations, including faith-based and grassroots organizations. CARE offers outpatient treatment and recovery support in a variety of settings.

Clinical services include: screening and assessment, case management, individual and group counseling, individual family therapy, education sessions, drug testing, and telephonic continuing care.

Recovery support services include: employment and educational services, therapeutic and structured recreation, peer coaching, spiritual coaching, and transportation.

CRIMINAL JUSTICE POPULATIONS

Parolee Services Network

These general fund (GF) services provide residential and non-residential alcohol and other drug treatment and recovery services for men and women paroled to the community from State prisons. These services are available in the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Marin, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma. The benefits of the program include:

- Placement of parolees in appropriate alcohol and other drug treatment and recovery programs, either from the community parole systems or immediately upon release from prison custody;
- Improvement of parolee outcomes as evidenced by fewer drug-related revocations and related criminal violations;
- Support of parolee reintegration into society by encouraging a clean and sober lifestyle; and
- Reduced General Fund costs for incarceration and parole supervision.

Female Offender Treatment Program (FOTP)

This program receives SAPT Block Grant funding for residential and outpatient alcohol and drug treatment and recovery services to female parolees in four counties. The FOTP provides six months of community residential SUD treatment for paroled women who complete the Forever Free program at the California Institution for Women. The four participating counties are Los Angeles, Orange, Riverside, and San Bernardino. Other women on parole who didn't complete the Forever Free Program may participate on a case-by-case basis if the Female Offender Treatment Project underutilizes the funding.

Driving-Under-the-Influence (DUI) Programs

DUI programs aim to reduce the number of repeat DUI offenses by persons who complete a state-licensed DUI program and provide participants an opportunity to address problems related to the use of alcohol and/or other drugs. The county board of supervisors, in concert with the county alcohol and drug program administrators, determines the need for DUI program services and recommends applicants to the state for licensure. DHCS licenses programs, establishes regulations, approves participant fees and fee schedules, and provides DUI information.

LOCAL FUNDING FROM OTHER SOURCES

Counties also contribute their own local funds to support SUD services.

RECOVERY SUPPORT SERVICES

Recovery support (aftercare) services (RSS) may begin during or following treatment services and involve coordination, relapse prevention, continuing comprehensive

assessments, motivational counseling, recovery maintenance planning, and exit planning. Referrals to additional services such as family preservation and reunification, child care, housing (sober living, safe housing, permanent housing), drop-in services, transportation, peer support and mentoring, and education/life skills training are often provided.

Despite scant funding, counties within the state have long used Recovery Support Services to meet the needs of communities. RSS are funded using county discretionary funds, SAPT Block Grant, California Mental Health Services Act funds, grants (e.g. State and/or SAMHSA grants), and through treatment providers.

California is in the early stages of building RSS within the COS by developing guidelines on RSS measurement and standardizing program performance and client outcome measures to test the efficacy of these services.

SPECIALIZED SERVICES

Specialized Services to Women and Women with Dependent Children

In accordance with 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e), DHCS ensures that specialized services for pregnant women and women with dependent children will be provided through a county based system in California. These will be "operationalized" through the State/County contracts entered into between DHCS and the counties. The State/County contracts will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements. DHCS will make annual funding allocations to the counties; these allocations will include a perinatal set-aside for each county. The counties, in turn, will provide the treatment services and/or will enter into agreements with local entities to provide perinatal services. DHCS estimates that 27,727 pregnant and/or parenting women annually will receive specialized services described below.

The "perinatal set-aside" funds will be expended by service providers in accordance with the Perinatal Services Network Guidelines (2009), which will be incorporated by reference in the State/County contracts.

To be eligible for perinatal funding, a program must serve women who are either:

- pregnant and substance using; or
- parenting and substance using, with a child(ren) ages birth through 17. Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

Programs must provide or arrange gender-specific substance abuse treatment and other therapeutic interventions for women who may address issues of relationships, sexual and physical abuse, and parenting.

Programs must provide or arrange sufficient case management to ensure that women and their children have access to primary medical care, primary pediatric care, gender-specific substance abuse recovery and treatment, and other needed services.

Transportation must be provided or arranged to and from the recovery and treatment site, and to and from ancillary services for women who do not have their own transportation.

Programs must provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

Child care must be available for program participant's children while the women are participating in on-site treatment program activities and off-site ancillary services. Depending on the age of the child, the following requirements apply:

1. Child care must be on-site for participant's children between birth and 36 months while the mothers are participating in the program (unless a waiver is approved by DHCS).

2. Child care may be provided on-site or off-site for participants children who are between 37 months and 12 years of age.

3. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children.

Programs must provide or arrange for the following services:

- educational/vocational training and life skills resources;
- TB and HIV education and counseling;
- education and information on the effects of alcohol and drug use during pregnancy and breast feeding; and
- parenting skills building and child development information.

Programs are required to provide or arrange primary medical care for women in treatment, including referrals for prenatal care. They also must provide or arrange primary pediatric care, including immunizations, for dependent children.

Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal SAPT Block Grant funds. Medi-Cal, Medicare, and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees providing the county approved schedule of fee assessment and collection is applied.

Counties must publicize that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them.

Counties are responsible for contracting with providers, ensuring that all perinatal programs meet their contractual requirements, and ensuring that quality perinatal services are provided. Staff from DHCS's, SUD Prevention, Treatment and Recovery Support Services Division, SUD Compliance Division, and Audit Services may conduct site visits to ensure compliance with the specific regulations monitored by each division.

The following SAPT Block Grant funded perinatal treatment modalities and services will be funded:

Outpatient Treatment
This modality provides alcohol and other drug (AOD) treatment services, with or without medication, in a non-residential setting. There is no minimum number of treatment hours prescribed.

Daycare Rehabilitative (DCR) Treatment
This modality provides AOD treatment services in a non-residential setting to each client for two or more hours, but less than 24 hours per day, for three or more days per week.

Narcotic Treatment Program (NTP)
This modality combines AOD treatment services with one of the following approved narcotic replacement drugs:

- *Methadone* treatment provides AOD treatment services in a non-residential facility along with methadone as prescribed by a physician to alleviate the symptoms of withdrawal from opiates (maintenance) or in decreasing amounts in a planned withdrawal from opiate dependence (detoxification).

- *LAAM* (levo-alpha-cetyl-methadol) treatment provides AOD treatment services in a non-residential facility, along with LAAM as prescribed by a physician to alleviate the symptoms of withdrawal from opiates.

Outpatient Detoxification Treatment (Other than Narcotic Treatment Detoxification)
This modality provides AOD treatment services, with or without medication, for safe withdrawal from alcohol or drugs in a non-residential, ambulatory setting for less than 24 hours per day.

Residential Treatment (Detoxification or Recovery)
This modality provides AOD treatment services in a residential, non-acute care setting.

Outreach
An element of service that identifies eligible pregnant and parenting women in need of treatment services and encourages them to take advantage of these services. Outreach

may include engagement of prospective program participants by informing them of available treatment services, and can serve as “pre-treatment” by reinforcing prevention and education messages prior to enrollment in treatment. Outreach also may be used to educate the professional community on perinatal services so that they become referral sources for potential clients.

Interim Services

These are services provided to pregnant women or injection drug using women seeking substance abuse treatment who cannot be admitted to a program due to capacity limitations. Interim services are defined as:

- Counseling and education about human immunodeficiency virus (HIV) and tuberculosis (TB), the risk of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
- Referrals for HIV or TB treatment services, if necessary.
- Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
- Referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children’s services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

Case Management

A participant-centered, goal-oriented process for assessing the needs of an individual for particular services; assisting the participant in obtaining those services; and reviewing participant accomplishments, outcomes, and barriers to completing recovery modality or a free-standing service.

Aftercare

Aftercare provides structured services in an outpatient setting to individuals who have completed treatment to support the gradual transition of the individual back into the community, prevent relapse, and ensure successful recovery. Aftercare may be either an element of a recovery and treatment modality or a free-standing service.

In the base year, FFY 1994, the amount expended was $26,349,134. DHCS is required to maintain this funding level, at a minimum.

Services to Intravenous Drug Abusers

In accordance with 42 U.S.C. §300x-23 and 45 C.F.R §96.126, DHCS ensures that admission preferences, interim services, treatment, outreach, and capacity and waiting list reporting requirements for Intravenous Drug Users (IVDU), will be provided through a county based system in California. The services and requirements related to IVDU will be “operationalized” through the State/County contracts entered into between the DHCS and the counties. The counties may operate IVDU programs, or they may enter into

agreements with local entities to operate the programs. DHCS estimates that it will annually serve approximately 17,864 unique individuals who are injection drug users. Programs and services for screening and intake of IVDU will include outpatient methadone maintenance; outpatient methadone detoxification; outpatient counseling treatment; residential detoxification; residential treatment; perinatal residential, outpatient, and day care rehabilitative services. Persons who use drugs intravenously and test positive for HIV will be referred to appropriate treatment and care. DHCS will meet federal requirements for services to IVDU through the following activities:

90 Percent Capacity Reporting

All alcohol and other drug (AOD) treatment providers receiving State or federal funds or licensed by the State to dispense methadone will be required to submit data to the State's Capacity/Waiting List Management Program called the Drug and Alcohol Treatment Access Report (DATAR) system each month. DHCS and the counties will use the data and reports to monitor capacity and utilization.

14-120 Day Performance Requirement

The monthly DATAR will contain specific information regarding the number of days IVDU applicants wait for admission to publicly-funded AOD programs. This information will be tabulated, and reports and information with aggregated data will be electronically available to County Alcohol and Drug Program Administrators for monitoring and planning.

To meet the SAPT Block Grant requirements and improve the effectiveness of this system, DHCS will post information on its website and collaborate with county alcohol and drug program administrators and direct providers. During the annual county compliance reviews, local procedures for maintaining contact with individuals awaiting admission and providing priority placement for IVDU and pregnant women will be examined.

Interim Services

DHCS will require counties; through State/County contracts to ensure that federally mandated interim services to IVDUs awaiting admission to treatment programs are provided. These services will include:

- Counseling and education about HIV and TB, risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to mitigate risks of HIV and/or TB transmission.
- Referral for HIV and TB testing, and if necessary, treatment through arrangements with county health departments.
- For pregnant women, counseling on the effects of alcohol and other drug use on the fetus and referral for prenatal care.

Providers will be required to document compliance with requirements to provide interim services and priority placement for IVDU and pregnant women. Procedures for

providing interim services for IVDU and pregnant women will be evaluated during DHCS's annual county compliance reviews.

Outreach

The SAPT Block Grant requirement on encouraging individuals that need IVDU treatment services to obtain services are contained in the State/County contracts. DHCS will require counties to include federal requirements for outreach activities in all their contracts with providers. Counties are required to monitor compliance with this requirement and to take corrective action for noncompliance. Technical assistance and information will be made available to providers as needed.

DHCS will continue its collaborative efforts with four counties – Los Angeles, Orange, Riverside and San Bernardino – in providing a continuum of community-based alcohol or drug abuse treatment and recovery services to female parolees released to those counties. The program provides up to six months (180 days) of alcohol and drug treatment services to each participant. The program is administered jointly by DHCS and the county alcohol and drug program office in each of the four counties with the specific intent to improve female parolee outcomes as evidenced by fewer drug-related revocations and related criminal violations.

Monitoring

DHCS's Performance Management Branch will perform annual compliance reviews of all county administrative systems to ensure compliance with SAPT funding requirements. DHCS will maintain DATAR. Publicly-funded programs will be required to report to DATAR. DHCS plans to continue efforts to improve DATAR, including the following activities:

- Providing ongoing DATAR training and technical assistance (TA) by telephone and DHCS's Web site to counties and direct providers to enhance accuracy and the rate of on-time reporting.
- Implementing new technologies to improve the quality of data transfer and processing, and
- Reducing the time required to accomplish these activities.

DHCS will provide and maintain a user-friendly Web-based application that will allow providers to submit DATAR data over the Internet. The objectives of the system are to provide more efficient, effective, and comprehensive source of management information needed for strategic program monitoring and resource allocation. The Web-based DATAR will allow on-demand monitoring and utilization reports for providers, counties, and the State. It also supports a process for the systematic reporting of treatment demand and public treatment capacity utilization.

Collecting outcomes information facilitates the improvement of service delivery and as such remains key to ensuring continuous quality improvement. Along with DATAR, the California Outcomes Monitoring System–Treatment (CalOMS-Tx) will promote

admission program compliance by asking how long an IVDU (or other) client waited for treatment admission.

Counties and direct providers will be required to collect CalOMS-Tx and DATAR data and submit this information electronically to DHCS. Counties and direct providers will be the single source of CalOMS-Tx and DATAR data collection and will submit data at least monthly to DHCS. However, data submission will not be limited to once per reporting month. For example, CalOMS-Tx and DATAR data files can be submitted hourly, daily, once a week, etc., during a given report month. Data submitted to DHCS will update the CalOMS-Tx and DATAR databases and counties and direct providers will be able to extract their data and reports from these databases for evaluation and planning purposes.

CalOMS-Tx data reporting will involve collecting the required CalOMS-Tx data elements from every participant each time he/she is enrolled in AOD treatment services at a reporting facility. Each participant's initial admission to the facility and any subsequent transfers or changes in service will be reported in a separate CalOMS-Tx record. If a participant remains in treatment for one year or longer, CalOMS-Tx annual update data will be collected and reported. When a participant leaves treatment, CalOMS-Tx discharge data will be collected and submitted to DHCS.

Data will be collected on all service recipients, by all providers that receive funding from DHCS and at all licensed narcotic treatment programs, regardless of the source of funds used for the service recipient. For example, if a provider receives DHCS funding, but provides services to a person using only county funds, or provides services to a private pay client, the provider will still collect and submit CalOMS-Tx data for that individual.

As part of DHCS's priority of increasing the effectiveness of its publicly-funded treatment services, DHCS will continue to survey and provide appropriate prevention and treatment services for the IVDU population. DHCS continues to collaborate with the California Department of Public Health's Office of AIDS as part of its continued effort to stay informed about factors that impact this population.

Tuberculosis (TB) Services

In accordance with 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127, DHCS ensures that tuberculosis (TB) testing, treatment, and referral requirements will be met through a county-based system in California. Meeting these requirements will be "operationalized" through the State/County contracts entered into between DHCS and the counties. The State/County contracts will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements. Everyone receiving substance use disorder (SUD) treatment services in California must provide documented evidence of their TB status, and if positive, evidence of ongoing treatment or a physician's clearance to participate in an SUD treatment program. County alcohol and other drug (AOD) programs and providers will refer individuals needing SUD treatment and TB testing/treatment to local public health departments for

specialized care. DHCS estimates that the number of SUD treatment unique clients diagnosed with TB will be approximately 1,997 annually.

Prospective clients lacking documented evidence or a physician's clearance will be referred to an allied health facility for a skin test, where in most cases, results are immediately evaluated. Or, alternatively, the skin test will be administered at the SUD treatment facility and interpreted by licensed health care professionals.

Treatment programs in California will continue their agreements with allied health facilities to provide TB testing and TB test evaluations. In some instances, treatment provider staff are certified as TB skin test clinicians (individuals must meet the requirement specified in the California Health and Safety Code beginning with Section 121360). California TB skin test clinicians can only administer the skin tests; interpretation of the results is limited to licensed health care professionals. Licensed health care professionals deemed capable to interpret TB skin tests are physicians, registered nurses, physician assistants, and nurse practitioners. In addition, licensed vocational nurses and medical assistants who are TB certified and work in TB clinics may also interpret skin tests.

DHCS's State Medical Director for Substance Abuse Services will provide medical expertise, analysis, advice and guidance on medical and policy issues associated with TB and other infectious diseases.

In addition, DHCS will work with California Department of Public Health (CDPH) tuberculosis liaison to ensure education in appropriate treatment and infection control is provided in substance abuse programs. As a disease control measure, substance abuse treatment providers will be required to obtain a physician or health care provider's clearance for clients who are diagnosed with tuberculosis prior to admission for AOD treatment.

CDPH will distribute appropriate client and other information to county health departments. County alcohol and drug program administrators will work closely with county health departments, which oversee TB control activities, to ensure all federal block grant requirements are appropriately met.
DHCS county liaisons and licensing/compliance analysts will provide ongoing technical assistance (TA) to each county to ensure adherence to federal block grant requirements.

DHCS's Performance Management Branch (PMB) will conduct annual compliance reviews of all county administrative systems to ensure compliance with SAPT funding requirements.

Human Immunodeficiency Virus (HIV) Services
In accordance with 42 U.S.C. §300x24(b) and 45 C.F.R. §96.128, DHCS ensures that human immunodeficiency virus (HIV) early intervention services (EIS) requirements will be met through a county-based system in California. Meeting these requirements will

be “operationalized” through the State/County contracts between DHCS and the counties. The State/County contracts will include SAPT Block Grant requirements for HIV EIS, and will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements.

DHCS will allocate HIV set-aside funds to counties annually. The allocation will include at least one county with a program in an urban area and one county with a program in a rural area. California will distribute at least $7,500 to each of the participating counties, so the least populous counties have sufficient funds to provide a basic HIV EIS program. Participant counties locally contract to provide HIV EIS.

DHCS will distribute 100 percent of the HIV EIS funding to 51 of the 58 counties. Six counties (Alpine, Calaveras, Colusa, Mariposa, Plumas, and Trinity) have minimal need for HIV EIS funds and declined these funds in the past. ADP does not anticipate a change in need during FY 2014-2015 for these counties. DHCS requires counties that elect not to receive HIV funds to indicate in writing how the need for HIV services will be met using non-SAPT funding.

As in past award years, DHCS will utilize the California Department of Public Health, Office of AIDS (CDPH-OA) needs-based methodology to allocate HIV set-aside funds. The methodology incorporates HIV and IVDU prevalence, at-risk populations, and other risk factors. HIV funds will be allocated using these indicators:

1. 40%: Number of Newly Reported HIV Cases (2007 to 2009)
2. 20%: Cumulative Living AIDS Cases Through December 31, 2010
3. 15%: African American population (2010 U.S. Census)
4. 7.5%: Male Syphilis Cases, 2009
5. 7.5%: Male Gonorrhea Cases, 2009
6. 5%: Hispanic population (2010 U.S. Census)
7. 5%: People Living Below Federal Poverty Line (U.S. Census Data 2009 Estimates)

The Number of Newly Reported HIV Cases refers to the cumulative sum of positive HIV tests (with no indication of a previously positive result) in the three most recent years of complete data reported to the State. Because the funding is based on need, there is a possibility that the amount each county will receive might change annually. DHCS will review allocations and county cost reports to determine compliance with the five percent minimum and maximum set-aside amount for HIV services and to ensure that at least one program is in a rural area. DHCS will monitor county systems, including provider subcontracts, through on-site visits to ensure compliance with federal HIV requirements and take appropriate action if instances of noncompliance are identified.
DHCS will continue to collaborate with CDPH-OA to promote HIV/AIDS prevention and treatment services and will maintain access to pre- and post-test HIV counselor training by alcohol and other drug service providers and county alcohol and drug program staff. CDPH-OA is responsible for monitoring HIV counseling and testing for compliance with state and federal statutes, regulations, and policies. CDPH-OA has requested input from the County Alcohol and Drug Programs Administrator’s Association of California

(CADPAAC) to participate in a focus group to target at-risk populations and to identify effective strategies for delivering HIV EIS services.

To ensure that DHCS will expend its FFY 2014-2015 HIV set-aside funds while providing the most effective early intervention services, DHCS will continue its practice of redirecting HIV set-aside funds from under-expending counties. It will also continue its collaboration with CDPH-OA and its role with CDPH-OA's HIV services planning group. DHCS plans to improve its HIV early intervention services by identifying best practices for providing EIS and targeting priority populations. DHCS is also planning to improve outreach and prevention services for target populations via a possible collaboration with OA's mobile testing units.

Pregnant Women Preferences

In accordance with 42 U.S.C. §300x27 and 45 C.F.R. §96.131, DHCS ensures that substance abuse services, including preferences in treatment services to pregnant women, will be provided through a county based system in California. The State/County contracts entered into between DHCS and the counties will incorporate by reference the requirements to provide admission preference, referral, and interim services to pregnant women. The *Perinatal Services Network Guidelines (2009)* will also be incorporated by reference into the State/County contracts. By signing and submitting the contracts, counties will indicate compliance with these requirements. All Perinatal Service Network (PSN) programs, regardless of funding source, will be required to comply with the PSN Guidelines as specified by the State/County contract between the state and the counties. The requirements include, but are not limited to those outlined below:

Perinatal Program Requirements

A**.** Target Population

To be eligible for perinatal funding, a program must serve women who are either:

- pregnant and substance using; or
- parenting and substance using, with a child(ren) ages birth through 17.

Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

B. Admission Priority (45 CFR 96.131)

Priority admission for all women in perinatal funded services must be given in the following order:

1. pregnant injection drug users;
2. pregnant substance users;
3. parenting injection drug users; and
4. parenting substance users.

A program's admission criteria must comply with the Americans with Disabilities Act (ADA) of 1990. Specific information regarding the ADA is contained in each county's State/County contract.

C. Referral to Other Programs and Interim Services (45 CFR 96.121 and 96.131)

1. When a program is unable to admit a substance-using pregnant woman because of insufficient capacity or because the program does not provide the necessary services, referral to another program must be made and documented.

   Pregnant women must be referred to another program or provided with interim services no later than 48 hours after seeking treatment services. Pregnant women receiving interim services must be placed at the top of the waiting list for program admission.

2. Injection drug-using women must be either:
   a. admitted to a program no later than 14 days after making the request; or
   b. admitted to a program within 120 days after making the request, if interim services are provided.

3. To assist programs in making appropriate referrals, each county must make available a current directory of its community resources.

4. Interim services are defined as:
   a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB), the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
   b. Referrals for HIV or TB treatment services, if necessary.
   c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care.
   d. Referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children's services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

The State/County contracts also require counties to maintain a system for monitoring the number of referrals made and interim services provided by each program. DHCS's Performance Management Branch (PMB) staff will conduct county monitoring annually to ensure appropriate processes are in place to comply with these requirements.

PRIMARY PREVENTION SERVICES STRENGTHS AND NEEDS

"Research shows preventing drug use before it begins is the most cost-effective, common-sense approach to promoting safe and healthy communities. Prevention results in better academic performance among teens who don't use drugs, fewer auto

accidents from reduced drugged driving, and more productive workplaces due to lower absenteeism. Preventing drug use also lowers HIV-transmission rates due to decreased injection drug use, creates safer home environments for children previously considered drug-endangered, and revitalizes neighborhoods due to coalition-based efforts. Put simply, drug prevention saves lives and cuts costs."[2]

DHCS's statewide priorities related to prevention services are intended to develop the necessary infrastructure of DHCS in order to target behavioral change at a statewide level. This will result in statewide prevention priorities/outcomes that are behavior-based rather than process-based. Although these have not been finalized, alcohol use by youth will be the primary focus.

Services to Youth

According to the report Adolescent Substance Use: America's #1 Public Health Problem released by The National Center on Addiction and Substance Abuse (CASA) at Columbia University in June, 2011, 90 percent of Americans who are suffering from addiction started smoking, drinking, or using other drugs before the age of 18, and underscores the fact that addiction is a disease with adolescent origins. The CASA report finds that 1 in 4 Americans who began using any addictive substance before age 18 are addicted compared to 1 in 25 Americans who started using at age 21 or older.

In order to reduce the age of onset, DHCS intends to continue to focus on alcohol, tobacco, and other drugs (ATOD) prevention services to youth through the FNL system, Student Assistance Programs, educational services, ATOD screenings, and programs aimed at reducing risk factors and increasing protective factors. All three of the statewide outcomes developed by the ADP/CADPAAC Prevention Subcommittee focus on youth and alcohol use.

Friday Night Live (FNL) is an example of a statewide prevention program that utilizes an evidence-based youth development framework. FNL builds partnerships for positive and healthy youth development that engage youth as active leaders and resources in their communities. FNL programs are youth-driven; therefore, they help to foster a sense of autonomy and power, promote the belief in a young person's capacity to contribute and provide meaningful roles for youth that offer opportunities to build community partnerships. Youth involved in FNL have the opportunity to develop programming skills and plan activities in concert with their peers and adult advisors using the Roadmap which is a project guide that aligns with the SPF that trains youth how to implement and carry out an action plan within their community. FNL participants across the state are working to change their schools and communities to limit access to alcohol, engage stakeholders and make an impact on the pro-drinking and drug taking cultural norms that promote Alcohol, Tobacco, and Other Drug (ATOD) use and underage access to ATOD. Examples are implementing youth driven and led Town Hall Meetings focusing on underage drinking prevention, promotion and passage of social

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[2] Office of National Drug Control Policy website, A Comprehensive Approach to Drug Prevention (http://www.whitehouse.gov/ondcp/prevention-intro)

host policies, education and policy passage of Targeting Responsibility for Alcohol Connected Emergencies (TRACE) with local law enforcement agencies, environmental scans and merchant recommendations, school district level policy adoption specific to underage drinking prevention, social norms campaigns, Lee Law education and policy development and partnering with local law enforcement for alcohol and tobacco compliance.

Each county funded for FNL must meet the Members In Good Standing (MIGS) requirements to ensure fidelity of the program. MIGS is a peer-driven process. The MIGS criteria demonstrate prioritized and proven youth development practices and evidence-based prevention strategies to achieve FNL program outcomes. The criteria includes, but is not limited to, utilizing the Roadmap, implementing the annual Youth Development survey to measure program effectiveness and engaging in programmatic training.

The California Friday Night Live Partnership (CFNLP) provides technical assistance, training and support to the entire FNL field. The CFNLP actively partners with the Office of Traffic Safety, the Allstate Foundation and the Office of Problem Gambling on distracted driving campaigns, a Youth Traffic Safety Summit and the Betting on Your Future Campaign. The CFNLP will continue to seek partners and leverage funding to provide California's youth with the skills and opportunities to become future leaders in our communities.

Services to Youth in Tribal Communities and Among Military Families

The SEW is planning on soliciting membership from individuals who are involved with AOD-related data for California tribes to increase the cultural competence of the SEW. The CFNLP is collaborating with the National Guard to target services to military families and their children as well as designing a FNL mentoring program specifically for the Native American culture. And, based on local needs assessments, each county will target this population using evidence-based programs, if appropriate. For example, in Alameda County, the Native American Health Center Inc. Youth Services Program works on four levels: individual, family, school/peers and community/environment. The program is designed to build resiliency factors by teaching positive health habits, strengthening families through parent involvement, counter peer pressure by developing youth role models, and by creating a healthy environment that maximizes participation in positive social activities with an outcome of lowering the risk of youth becoming involved in AOD use. The program is a comprehensive, culturally appropriate continuum of care that targets Native American youth as well as a broad spectrum of youth from all ethnic backgrounds. The rationale for the youth efforts is based on culturally relevant adaptation of prevention methods that minimize risk factors and strengthen resiliency factors.

Services to Address Prescription Drug Misuse and Abuse

According to the United States Drug Enforcement Administration, more people die from over-the-counter and prescription drug abuse than from cocaine, heroin and ecstasy combined. To combat this serious issue, ADP became a support agency for the

Prescription Drug Abuse Prevention Workgroup, which consists of ADP/DHCS staff and its stakeholders. Although DHCS does not focus on any one particular substance, prescription drug misuse is of growing concern. Increasing public awareness and support for the prevention of prescription drug abuse is one of the eight Strategic Initiatives identified by the Substance Abuse and Mental Health Services Administration (SAMHSA).
ADP has proposed a work plan for the Prescription Drug Abuse Prevention Workgroup. This work plan consists of four major project goals:

1. Collective Impact - Workgroup members will have a shared vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions.
2. Identify Best Practices - Through meetings and Learning Forums, workgroup members will share their successes and barriers of utilizing different strategies to prevent prescription drug abuse. The best practices and strategies that emerge from these discussions can be shared with the public and the prevention field.
3. Information Dissemination - The workgroup will disseminate information for the prevention of prescription drug abuse.
4. Progress Reports - The workgroup will provide updates and share their progress at meetings of The Governor's Prevention Advisory Council (GPAC) and the County Alcohol and Drug Program Administrators Association of California (CADPAAC), Prevention Committee.

Locally, many programs are being implemented in regards to the safe disposal and storage of prescription medications. One example is the Lock It Up Project, a community-based substance abuse prevention program designed to increase awareness of the risks and consequences associated with the illicit use of prescription drug painkillers by teens and youth adults ages 12-20 through the implementation of presentations, community-based outreach, and in-service trainings.

Technical Assistance to the Prevention Field
Through the Community Prevention Initiative (CPI), DHCS contracts with the Center for Applied Research Solutions to provide technical assistance to the prevention field to:

- promote widespread use of the SPF and IOM;
- engage rural and underserved communities throughout the state;
- integrate substance use prevention services and healthcare; and,
- develop and implement professional competencies for the prevention field.

CARS works in coordination DHCS and a vast pool of expert consultants to deliver technical assistance (TA) and training services through webinars, publications, prevention extension workshops, conferences, and one-on-one TA and training. In the last project year, webinars and workshops were implemented on topics such as youth in foster care, building capacity among prevention programs, working with underserved populations and social media technology in prevention to name a few (for the complete library of webinars visit www.ca-cpi.org.)

Evidence-Based Strategies, Policies, Programs, & Practices
DHCS Policy and Prevention Services Branch (PPSB) will continue to require that counties consider the use of evidence-based strategies, policies, programs and practices (EBPs) in their strategic planning process. Use of EBPs are tracked through CalOMS Pv. EBP-specific trainings and technical assistance are provided at no cost to California's ATOD prevention field. Over the last year, At ADP's Power of Prevention Summit, stakeholder groups focused on the need for a California-specific evidence-based registry. California has initiated work in this area in the past, utilizing GPAC to review cross-agency collaborative efforts and processes for determining EBPs among member agencies.

Data Collection

CalOMS-Pv
The California Outcome Measurement Service for Prevention (CalOMS Pv) is a web-based data collection service provided through a contract with KIT Solutions, LLC. Approximately 300 providers across California's 58 counties use CalOMS Pv to report their primary prevention service and activity data. The Planning Module houses an electronic copy of each county's Strategic Prevention Plan and provides the ability to input the specific problem statements, goals and objectives from the plan so provider service/activity data can be linked to specific objectives. An Evaluation Module allows for annual progress reports on the status of the county's goals and objectives. The Implementation Module captures all service/activity data and incorporates the three Institute of Medicine (IOM) categories as well as the six Center for Substance Abuse Prevention (CSAP) strategies. The Report Module houses more than 70 standard data reports to assist with data review, monitoring, planning, outcomes and standard operations. A Progress Tracker alerts counties and providers when any contractual reporting requirements are not being met.

California Healthy Kids Survey/ California Student Survey (CHKS)
DHCS and the California Department of Education (CDE) co-sponsor the CHKS, a powerful tool for use in Grades 5-12 that can help schools, districts, and local planning offices accurately identify areas of student and school strengths and weaknesses, and address related needs. It provides a comprehensive, data-driven, decision-making process to guide efforts to improve school climate, learning supports, and engagement, as well as identify and increase the quality of health, prevention, and youth development programs. County AOD offices and prevention providers rely on this survey as a source of local data for their needs assessment.

At the heart of the CHKS is a broad range of key learning and health-related indicators that are used to collect student data on attitudes, behaviors, and experiences related to school and learning. School connectedness, developmental supports and opportunities, safety, violence and harassment, substance use, and physical and mental health are some of the key areas assessed by the survey.

The research-based assessment of factors that promote resilience and positive youth development is one of the survey's many unique benefits. Additionally, the CHKS can be customized by schools and districts to meet local needs. The survey includes a general, core set of questions, plus a series of supplementary modules covering specific topics. Schools can add questions of their own choosing or creation on other topics of local interest via a search feature that identifies questions previously used by other schools. The customizability of the CHKS allows schools and districts to receive relevant, useful knowledge tailored to their needs. The CHKS surveys approximately 800,000-1,000,000 5th, 7th, 9th, and 11th graders.

The California Student Survey (CSS) dates back to 1985 and provides statewide trend data on AOD use and perceptions. The CSS includes all questions in the CHKS core module as well as on other topics identified as a priority. The CSS surveys approximately 10,000-14,000 7th, 9th and 11th graders.

Tobacco

Under the Stop Tobacco Access to Kids Enforcement (STAKE) Act, California law requires that $2 million of the annual SAPT Block Grant be transferred to the Department of Public Health (DPH) to comply with the Synar requirement. ADP's Policy and Prevention Services Branch (PPSB) and will continue to work with DPH on prevention of underage tobacco use in support of the STAKE Act. In 2012, California's rate of tobacco sales to minors increased to 8.7%, up from 5.6% in 2011. DHCS's Resource Center will continue to distribute publications, books, videos, and curricula on tobacco use prevention. Local programs also address tobacco issues.

Workforce Development

The SUD Prevention, Treatment and Recovery workforce in California is rapidly changing as the field prepares for healthcare reform and behavioral health service integration with primary care. ADP/DHCS recognizes that the education, licenses and skills of practitioners range from a high school education with no specialized licenses or certifications to a post graduate education with full accreditation. In addition, the SUD workforce includes those who are in direct service plus those who have the combined responsibility of managerial and supervisory duties.

To address these needs, a Workforce Development Task Force was created in January, 2013 to evaluate health reform related changes and their impact to the Substance Use Disorders (SUD) workforce. The resulting report, "Workforce Development Needs in the Field of Substance Use Disorders, A Report from Department of Alcohol and Drug Programs, June 26, 2013", contains a summary of health reform related changes, an assessment of the current workforce, recommendations for preparing the workforce to meet the changes required by health reform, and an implementation strategy.

The report recommendations are summarized as 5 problem statements: (1) ensure the report recommendations continue to make progress toward implementation by creating a Workforce Plan Development Work Group with responsibility and authority to ensure implementation of the recommendation; (2) increase the short term capacity of the

workforce to meet the increased demand for SUD services by expanding the number and types of workforce skilled and 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; (3) expand the capacity of the workforce by effectively using all members of the workforce; (4) develop a long term strategy to attract and retain members to the SUD workforce, provide them with a standard set of credentials, the tools to attain and maintain their credentials, and a system for monitoring and controlling the credentialing system; and (5) develop curricula and training for all healthcare workforce members who deliver SUD services.

To strengthen the prevention workforce, the PPSB identified prevention competencies. Establishing competencies will provide focus for ensuring best prevention practices are known, implemented and used by the prevention field. However, simply developing a list of competencies is insufficient to ensure adoption and use by the prevention workforce. Therefore, the PPSB is also implementing a structure or framework to support the field in the acquisition of the competencies. PPSB is working with the Center for Applied Research Solutions (CARS) to develop and implement a training plan focused on the competencies. This includes the development of online and onsite training materials and content delivery. The plan ensures that the field is oriented, informed and engaged in providing input as the competencies and trainings are developed and implemented.
The competencies integrate both the International Certification and Reciprocity Consortium (IC&RC) and Center for Substance Abuse Prevention (CSAP) domains and are reflective of the diverse approaches and workforce in California. The first competencies to be implemented are based on the SPF and can be accessed online by visiting http://www.ca-cpi.org/training/TA_Training.php

Affordable Care Act and Prevention Services
With the passage of the ACA in 2010, the Nation's health care system is being redesigned to increase coverage for more Americans and reduce health care costs, in part, by preventing health problems from occurring throughout all stages of life. The recently released National Prevention Strategy identifies seven priorities addressing the most serious threats to health: Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive Health, and Mental and Emotional Well-Being.
The Office of National Drug Control Policy (ONDCP) Director, Gil Kerlikowske stated that the ONDCP Drug Policy "recognizes that the most promising drug policy is one that prevents drug use in the first place."[3]

"Scientific evidence makes clear that drug prevention is the most cost-effective, common-sense approach to promoting safe and healthy communities. Youth who refrain from drug use have better academic performance. Communities enjoy reduced drugged driving and, therefore, safer roads. Employers experience lower absenteeism, resulting in more productive workplaces. Drug use prevention efforts also impact HIV

[3] Statement from ONDCP Director R. Gil Kerlikowske *Why Marijuana Legalization Would compromise Public Health and Public Safety*, Annotated Remarks, Delivered at the California Police Chiefs Association Conference, March 4, 2010, San Jose, CA

transmission rates by decreasing injection drug use, creating safer home environments by reducing the number of drug-endangered children, and revitalizing neighborhoods through coalition-based efforts." (ONDCP, National Drug Control Strategy 2011, pg. 4)

The National Prevention Strategy, the National Drug Control Strategy, as well as Healthy People 2020 provides the Department with a framework for identifying new partners and garnering support for AOD prevention efforts within the context of wellness and improving business operations to support counties and local prevention providers. DHCS's Policy and Prevention Services Branch (PPSB) will continue to provide assistance and information to local communities and counties so they are more competitive for funding as well as facilitating collaborative opportunities so critical to expanding AOD prevention services under the ACA in California.

To this end, Prevention Services Branch developed a strategic plan for incorporating AOD prevention in, and implementation of, the ACA with accompanying weighted criteria for selecting and achieving priorities.

Area One: Business Operations Process – To develop, improve, and/or expand vehicles of communication, information dissemination, data, partnerships, and relevant news that support and enhance community prevention efforts.
Sub-Area A: Improve information technology
Sub-Area B: Increase utility of SPF county prevention plans for Health Reform preparation and expansion
Sub-Area C: "Information Hub" – Collect, combine, and organize technical assistance tools and materials for dissemination

Area Two: Leadership and Relationship Building – Identify and Expand ADP's role in AOD prevention services during healthcare reform activities within California.
Sub-Area A: State planning and decision making
Sub-Area B: Relationship building
Sub-Area C: Internal education
Sub-Area D: Community education and awareness

Area Three: Improve and Expand Prevention Services – Promote effective and promising prevention practices and funding opportunities and share innovative community partnerships that demonstrate effectiveness.
Sub-Area A: ACA funding opportunities
Sub-Area B: Use of evidence-based practices and programs
Sub-Area C: Prevention partnership models
Sub-Area D: Form partnerships with organizations in healthcare

Area Four: Prevention Workforce Expansion – Prepare and expand the AOD prevention workforce.
Sub-Area A: Prevention workforce competencies
Sub-Area B: Continuing education for AOD Prevention Specialists
Sub-Area C: Explore the role of AOD Prevention Specialists

In addition, DHCS Policy and Prevention Services Branch plans to:

- announce funding to local programs;
- explore state-level partnerships that will facilitate local partnerships;
- advance individual billable services as well as environmental services under Health Reform; and
- explore more research-based, scientific prevention services that can be billed.

Information and Education

DHCS Policy and Prevention Services Branch (PPSB) will continue to operate the Resource Center, the only ATOD dedicated clearinghouse and resource center in California. With reductions in funding, providing these resources free of charge to the public and ATOD field is more important than ever. The Resource Center is also looking into various forms of social media/marketing such as YouTube, Facebook, Twitter, and Google+. These media tools will enable DHCS to help advance ATOD prevention and health reform by providing real time information on funding opportunities, news sources, and AOD prevention initiatives identified by the SAPT Block Grant, SAMHSA, ONDCP, CDC and other agencies and organizations.

Department of Health Care Services

July 25, 2013

916 440-7400
Office of the Medical Director
Neal Kohatsu, M.D., M.P.H.
MS 0000

916 440-7400
FAX 916 440-7404
DIRECTOR
Toby Douglas
MS 0000

Karen Johnson
Chief Deputy Director
Policy and Program Support
MS 0000

Mari Cantwell
Chief Deputy Director
Health Care Programs
MS 0000

916 440-7400
Associate Director
Leonard Finocchio, Dr.P.H.
MS 0000

916 440-7400
Health Reform Advisor
Brian Hansen
MS 0000

916 440-7550
Audits & Investigations
Bruce Lim
Deputy Director
MS 2000

916 440-7370
Office of Civil Rights
Jonathan Clarkson
Deputy Director
MS 0009

916 373-2600
CA-Medicaid Management Information Systems
Vicky Sady
Deputy Director
MS 4727

916 552-9444
Office of HIPPA Compliance
Phil Heinrich
Chief
MS 4721

916 552-9100
Utilization Management
Doug Robins
Chief
MS 4500

916 440-7525
Administration
LaVonne Coen
Deputy Director
MS 1000

916 440-7660
Office of Public Affairs
Norman Williams
Deputy Director
MS 0025

916 440-7500
Legislative & Governmental Affairs
Carol Gallegos
Deputy Director
MS 0006

916 323-2108
Office of Workforce Planning & Development
Robert W. Stroud
Chief
MS 0000

916 323-1945
Provider Enrollment
Tanya Homman
Chief
MS 4704

916 440-7340
Information Technology Services
Chris Cruz
Deputy Director
MS 6000

916 440-7700
Office of Legal Services
Douglas M. Press
Deputy Director & Chief Counsel
MS 0011

916 322-5603
Office of Administrative Hearings & Appeals
Sharon Stevenson
Chief
MS 0016

916 552-8006
Office of Medi-Cal Procurement
Kevin Morrill
Chief
MS 4200

916 650-0490
Third Party Liability & Recovery
Jeff Blackmon
Chief
MS 4720

916 440-7800
Health Care Delivery Systems
Jane Ogle
Deputy Director
MS 4000

916 552-9105
Long Term Care
Jon Shen
Chief
MS 0018

916 327-1400
Systems of Care
Louis Rico
Chief
MS 4517

916 449-5000
Medi-Cal Managed Care
Margaret Tatar
Chief
MS 4400

916 552-9197
Low-Income Health Program
Jalynne Callori
Chief
MS 4614

916 440-7800
Health Care Benefits & Eligibility
Rene Mollow
Deputy Director
MS 4000

916 552-9430
Medi-Cal Eligibility
Tara Naisbitt
Chief
MS 4607

916 449-5770
Primary & Rural Health
Sam Willburn
Chief
MS 8500

916 552-9500
Pharmacy Benefits
Harry Hendrix
Chief
MS 4604

916 464-3888
Medi-Cal Dental Services
Jon Chin
Acting Chief
MS 4708

916 552-9400
Benefits
Laurie Weaver
Chief
MS 4600

916 440-7800
Office of Family Planning
Christina Moreno
Acting Chief
MS 4000

916 440-7800
Health Care Financing
Mari Cantwell
Deputy Director
MS 4000

916 449-5000
Capitated Rates Development
Stuart Busby
Chief
MS 4400

916 552-9400
Fee-For-Service Rates Development
John Mendoza
Chief
MS 4612

916 552-9113
Safety Net Financing
Pilar Williams
Chief
MS 4504

916 440-7800
Mental Health and Substance Use Disorder Services
VACANT
Deputy Director
MS 4000

916 440-7800
Mental Health Services
Brenda Grealish
Chief
MS 4000

916 440-7800
Substance Use Disorder Compliance
Marlies Perez
Acting Chief
MS 4000

916 440-7800
SUD Prevention, Treatment and Recovery Services
Dave Neilsen
Chief
MS 4000

916 440-7800
CA Mental Health Planning Council
Jane Adcock
Executive Officer
MS 4000

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II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

California's Changing Environment

A component of assessing need is acknowledging and understanding the environmental changes that occur and factoring that into the discussion surrounding a data-informed decision-making process. The current state of the economy, along with the massive changes in the nation's health care system and the shifting federal focus, creates significant challenges and opportunities for the substance abuse field in moving the system in a direction that leverages scant resources while providing effective services for clients. Following is a discussion of the major environmental factors that will impact policy-setting and decision-making for the substance abuse field in the foreseeable future.

Budgetary Considerations

In the past few years the tremendous economic downturn has undercut the state's ability to maintain a stable level of funding for necessary publicly-funded services in many service sectors. Declining revenues, coupled with increases in the need for services due to health reform mandates, have lead legislative leaders to consider different methods of revenue generation, such as the legalization of marijuana and increasing alcohol taxes.

For California's system of publicly-funded substance abuse services, the budgetary shortfalls have resulted in the loss of significant funding to serve the offender population, however the requirement to serve this population remains in effect. County efforts to maintain services during this economic downturn have led to hard decisions at the local level, including shortening lengths of stay in treatment, reevaluating use of higher cost treatment modalities, and instituting or maintaining longer waiting lists. Conversely, it has also led some counties to leverage available resources through local partnerships and increase effectiveness through the implementation of process improvements and evidence-based practices.

The negative consequences of the budget shortfalls are evident. It is more important than ever to institute cost-effective ways to support individuals in need of services and to pool resources where possible. While the budgetary issues are significant, challenging times such as these can foster innovative solutions, unlikely partnerships and more cost-effective business practices.

The Health Care System and Reform

The Patient Protection and Affordable Care Act (ACA) requires major systems change efforts on the part of the substance use field and will substantially increase the pool of insured individuals, expand public benefit programs (e.g., Medicaid), support community-based services, enlarge the health-related prevention focus, support providers' transition to electronic medical records, improve quality and accountability of the service delivery system, and integrate substance abuse services with primary health care.
It is anticipated that some of California's current AOD clients will begin to be covered under private insurance plans starting in 2014, or will become eligible for Medi-Cal, altering the payer of services from the SAPT block grant to Medi-Cal or other insurance carriers. Many additional individuals who have not been able to access the publicly-funded

Medi-Cal AOD service system in the past will be eligible to seek services (e.g., indigent childless adults). It is expected that the public health and behavioral health systems will ultimately be reaching far more individuals and families in need of substance use and mental health services as a result of the ACA.

Health reform, although requiring significant change to redefine how California will provide SUD health care in this state, is an opportunity to expand access to care and create an AOD system that is safe, effective, patient-centered, timely, efficient and equitable. In addition, there is great opportunity to build in practices that promote culturally competent service provision that will help eliminate health disparities within the AOD system.

The National Survey on Drug Use and Health (NSDUH) defines all persons meeting criteria for alcohol and/or illicit drug dependence or abuse (using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria) as needing treatment. All those meeting these criteria who are not in treatment are then counted as needing but not receiving treatment. The age-specific estimates of persons needing but not receiving treatment are based on the NSDUH data for California. However, estimates of persons needing but not receiving treatment by gender and race/ethnicity use national NSDUH, data because California specific data are not available. The over three million Californians needing but not receiving treatment represents the number of potential new clients who are not currently receiving any SUD treatment services.

Table 4.17 Overall Population Age 12+ Needing But Not Receiving Treatment, California, 2010

Population	Percent Needing Tx for Illicit Drug Use	Percent Needing Tx for Alcohol Use	Percent Needing but Not Receiving Tx for either Illicit Drug or Alcohol Use[a]	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use
32,577,887	2.76	7.50	10.26	3,342,000

Note: Number needing but not receiving treatment is rounded to the nearest 1,000.
Source: Data from the National Survey on Drug Use and Health (NSDUH) are used to estimate California's treatment need.
Source for California Population Estimates: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050.* Sacramento, CA, July 2007.

California's Low Income Health Program (LIHP) allows counties to enroll low-income uninsured residents into Medi-Cal, and provide services in advance of 2014, when they would otherwise be eligible. This will increase and expand health care coverage up to an estimated 500,000 low-income uninsured residents, and allow for testing of various strategies to strengthen and transform the state's health care delivery system in preparation for the numbers of people who will have access to health care once the ACA is fully implemented.[1]

[1] California Department of Health Care Services, California Bridge to Reform A Section 1115 Waiver Fact Sheet, 2010. Retrieved August 2012 from http://www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf

The Federal Direction for Alcohol and Drug Abuse

Primary health care will be a major entry point for the provision of treatment for substance use disorders.

Over the last several years the Substance Abuse and Mental Health Services Administration (SAMHSA) has been developing and implementing the National Outcome Measures (NOMs) for prevention and treatment of substance use and mental disorders. NOMs captures standardized outcome data across states to measure outcomes in important life domains of clients as well as traditional prevention and treatment measures. The intention of the NOMS is performance management; the utilization of data to improve programs and services. Ultimately, the NOMs data is being positioned to serve as the measure of prevention and treatment effectiveness, accountability and efficacy of programming.

SAMHSA has identified 8 Strategic *Initiatives* to focus the Agency's work on improving lives and capitalizing on emerging opportunities. In addition to SAMHSA's efforts, the Office of National Drug Control Policy (ONDCP) has collaboratively developed the 2010 National Drug Control Strategy that takes into account the latest scientific evidence and innovations in the prevention, treatment and law enforcement fields. The implementation of the *Strategy* calls for a collaborative effort of local, State, tribal, Federal agencies, community-based organizations, and other nongovernmental partners.

Together, the *Initiatives* and *Strategy* map out the federal direction related to prevention, treatment and interdiction efforts related to substance use and abuse. Central to both plans is the premise that primary health care will be a major entry point for the provision of treatment for substance use disorders.

Assessment of the Continuum of Need

A variety of methods are used to estimate the population in need of AOD services in California as well as identify areas where there appears to be a gap between the need for services and the services currently being provided. The estimates shown here do not fully take into account the capacity of the private sector service system to provide both prevention and treatment services in the AOD field.

With the potential of insurers paying for substance use services for the large influx of insured in California, there is a need to build capacity in systems that traditionally have not provided substance use services to the extent that it may be required under health care reform. This has spurred much debate at the Federal level regarding the appropriate level of funding to be allocated to the different service systems (i.e., Medicaid, Behavioral Health). This Federal debate will be forthcoming as Federal lawmakers engage in upcoming discussions related to spending cuts to programs.

Of major importance to state and local policy makers, regarding preparing the AOD workforce for the future, are the many Federal discussions occurring which are focused on two main themes: 1) increasing credentialing/licensing requirements for the AOD field; and 2) increasing integration of services in behavioral health and primary care settings.

These are two critical results of the ACA that, if done well, will ensure higher quality of, and better access to, substance use services for Californians in need.

Several racial and ethnic populations are disproportionately represented in the ranks of the uninsured. As recently as 2009, 34% of Hispanics, 28% of AI/ANs, 23% of African Americans, and 18% of Asian Americans (compared with 14% of White Americans), were uninsured.[2] These groups are even less likely than Whites to seek out mental health services, substance abuse treatment, or health care services when they need it because of the cost or stigma of pursuing such services. Implementation of the Affordable Care Act (ACA), which will impact the numbers of uninsured individuals, must also address the reality that many racial and ethnic populations face systemic barriers to health care services, and experience worse health outcomes for a variety of reasons.

Emerging Trends

A variety of methods are used to monitor the prevalence and trends regarding substance abuse in California. Collecting data on substance use trends assists the State and counties with identifying, implementing, and measuring success of prevention, treatment, and recovery services.

In FY 2011-12, counties were queried regarding emerging or consistent patterns of drugs of abuse, methods of use, and drug-using populations. Information on how counties are addressing trends in their communities was also gathered. The most prevalent drugs of abuse identified were prescription drugs, heroin, marijuana, methamphetamine, alcohol, and synthetic marijuana. Other drugs identified were bath salts, cocaine, medical marijuana, over-the-counter drugs, ecstasy, and salvia.

Sixty-one percent of counties (35 of 57) identified that prescription drugs continue to be the most prevalent substance of abuse. However, this is an 18% decrease from the previous fiscal year. Counties attribute the decrease of prescription drug use to the increase of heroin use. Fifty-three percent of counties (30 of 57) identified heroin as a drug of use. This is an increase of 33% from the pervious fiscal year. The chart below identifies the alcohol and other drug trends identified in FY 2011-12.

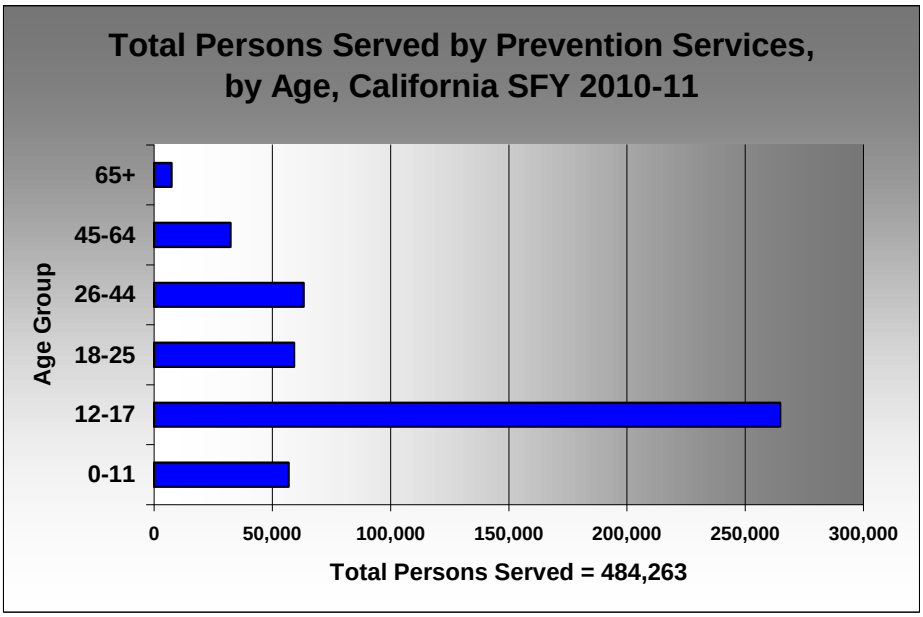
What emerging AOD trends do you see developing in the County?	
Drugs of Abuse:	
Prescription drugs (Rx)	61% of counties (35 of 57)
Heroin	53% of counties (30 of 57)
Marijuana	35% of counties (20 of 57)
Methamphetamine	33% of counties (19 of 57)
Alcohol	30% of counties (17 of 57)
Synthetic marijuana	19% of counties (11 of 57)
Bath salts	11% of counties (6 of 57)

[2] Substance Abuse and Mental Health Services Administration, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014.* HHS Publication No. (SMA) 11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration, pg 64, 2011. Retrieved July 2012 from http://store.samhsa.gov/shin/content//SMA11-4629/01-FullDocument.pdf, pg 64

Cocaine	11% of counties (6 of 57)
Medical marijuana	7% of counties (4 of 57)
Over the counter (OTC)	5% of counties (3 of 57)
Tobacco	4% of counties (2 of 57)
Ecstasy	4% of counties (2 of 57)
Salvia	2% of counties (1 of 57)
Other	4% of counties (2 of 57)

PREVENTION

During FY 2010-11 (the most current prevention data available through CalOMS–PV system), California's publicly-funded prevention system provided a breadth of information, education, alternative activities, referrals, and environmental and community-based prevention services to nearly one half million Californians. The table below identifies the number of persons served by publicly-funded prevention services in California in 2010-11, by age group.



The Department of Health Care Services (DHCS) serves as the leader in addressing the continuum of substance abuse problems, and by establishing prevention strategies that minimize AOD use and abuse, more costly treatment can be avoided.

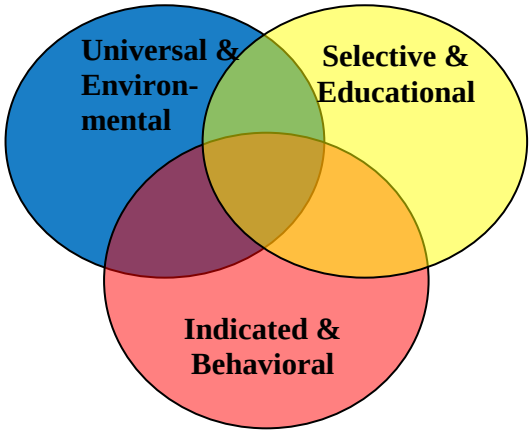
Evidence-Based Prevention Strategies

In order to determine the prevention services need in California, an understanding of the types of prevention strategies effective for the various target populations is necessary.

Given that substance abuse and dependence has a wide range of adverse consequences and society has limited resources, we need to be as efficient as possible in preventing and delaying initiation of substance use and reducing the harmful consequences of their use.

Prevention is defined by the Institute of Medicine Continuum of Care as serving three levels of risk categories:

- Universal preventive interventions are targeted to the general public or a segment of the entire population with an average probability of experiencing adverse AOD consequences and/or developing a substance use disorder.
- Selective preventive interventions are targeted to specific populations whose risk of adverse consequences or substance disorder is significantly higher than average, either imminently or over a lifetime.
- Indicated preventive interventions are targeted to designated individuals who have minimal but detectable signs or symptoms suggesting a disorder or who carry biological markers for a disorder often referred to as high risk.



In California's diverse environments and cultures, it is clear that interventions addressing only one level of risk will not be sufficient to reduce the problem. Thus, a comprehensive package of prevention policies, strategies and programs conducted at all three risk levels is required. It is important to stress that these approaches are NOT mutually exclusive. For example, two of the risk prevention approaches are often set against each other: Universal population-based approaches versus Indicated interventions with a focus on high-risk users. Not only is it possible to do both, but it is an essential part of a comprehensive approach to do both. Each approach has its advantages and disadvantages.

Delay or Stop AOD Initiation

According to the 2012 National Drug Control Strategy, stopping substance use before it begins, or delaying initiation, substantially increases an individual's chances of living a longer, healthier, and more productive life. Prevention strategies directed toward youth are especially important because there is a strong potential to avoid substance abuse problems before they start. Studies show, for example, that children who start drinking before the age of 15 are four times more likely to develop alcohol problems than those

who start after the age of 21. The chances of becoming dependent decreases by 14% for every year the onset of alcohol use is delayed.[3]

Youth and young adults (ages 12-25) represent a very large and diverse special population of over 7,700,000 in California. Nearly 5 million of these youth are under 21 years of age, and 3.8 million are of middle and high school age (12-18). The vast majority of substance users start when they are young, and the younger they initiate substance use, the more serious the risks, and more likely the consequences will be severe and long lasting.[4]

Estimates of Prevention Need

Given California's population of over 5 million youth (under 21 years of age), and the total persons (aged 0-25) served by prevention in 2010-11 (just over 380,000), it is evident that the number of Californian's in need of prevention is large. Both broad substance problems - underage drinking, and use of illicit substances – are illegal for youth under 21 years of age. In addition, non-medical use of prescription and over the counter (OTC) drugs among underage youth is harmful and carries with it high risk of adverse consequences.

As the table below displays, over 3 million youth 12-20 years of age have used alcohol or other drugs. These youth are in need of *Universal* prevention strategies.

California Youth Population Ages 12-20 in Need of Prevention

Age	CA Population Estimates 2010[a]	Estimated Percent of Students' AOD Use	Estimated Total Number of Students' AOD Use
12	527,182	29%	310,856
13	544,735		
14	569,432	60%	692,947
15	585,479		
16	596,384	74%	891,537
17	608,396		
18	624,345	53%	1,891,298
19	639,817		
20	627,136		
Total	**5,322,906**		**3,093,691**

Note. Data was retrieved from both the California Student Survey (CSS) and Behavioral Risk Factor Surveillance System (BFRSS), specifically CSS includes youth ages 12-17, and BRFSS includes 18-20 year olds. For CSS, 7th graders were 12-13 years old, 9th graders were 14-15 years old, and 11th graders were 16-17 years old. CSS assesses students' AOD lifetime use, and BRFSS assesses students' AOD use in the past 30 days

[3] EIC and NIAAA, *Spotlight on Underage Drinking*, No. 22; *The NSDUH Report*, 10/22/04; Spear, L.P., *The adolescent brain and age-related behavioral manifestations*, Neuroscience and Biobehavioral Reviews 24 (2000) 417-463.

[4] National Center on Addiction and Substance Abuse at Columbia University, Adolescent Substance Use; America'a #1 Public Health Problem, June 2011. Retrieved September 2012 from http://www.casacolumbia.org/upload/2011/20110629adolescentsubstanceuse.pdf

[a]Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050*.

In addition, according to the California Student Survey, 33 percent of 11th graders are classified as High Risk and/or Excessive Alcohol Users. This translated to approximately 300,000 16-17 year olds. This group will require more *selective and indicated* prevention interventions, such as Student Assistance Programs.

There are a number of other effective prevention and early intervention strategies to address preventing underage and reducing excessive consumption of alcohol and other drugs.[5] They include efforts to reduce availability of alcohol and other drugs, delay or reduce the consumption, change the social norms toward underage substance use, adult excessive consumption and abuse of illegal drugs, and reduce harm from the (excessive) consumption of these substances.

Evidence-based interventions often cover different aspects of the problem (e.g., youth drug use initiation, impaired driving, or violence), which make the use of complementary set of interventions more likely to be beneficial. Several interventions are best directed toward different aspects of the problem.

EARLY INTERVENTION

Reduction in Harm and Negative Consequences

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated public health approach to the delivery of early intervention to individuals at risk for developing substance abuse disorders. It is an effective intervention designed to intervene at the first signs of adverse consequences and reduce the harm and likelihood of future harm. The goal of SBIRT is to reduce the risks and consequences related to alcohol and other drug use consumption, to eliminate high-risk AOD use, and to increase motivation for behavioral change, up to and including referral to specialized AOD treatment services. It has been shown to reduce consumption among at risk AOD users and produce health care cost savings.

Estimates of Early Intervention Need

Other large groups in need of prevention/early intervention services are the young adult and adult groups who drink and use other drugs in risky and excessive ways. In nearly all categories of substances, young adults age 18-25 display the highest use patterns and harms related to risky and excessive use (i.e., binge drinking, illicit substance use, poly drug use, heavy use). This age group represents 4.6 million of the California population. For example, 38 percent of this age group engages in binge drinking and 13.8 percent report having driven under the influence of alcohol, according to the 2007-08 NSDUH surveys. This suggests that between 635,000 and 1.75 million young adults within this age group could benefit from early intervention services (such as SBIRT) and that the harms related to their risky drinking could be reduced substantially.

[5] For example PIRE Report cited earlier; Effectiveness of Behavioral Highway Safety Countermeasures. National Cooperative Highway Research Program Report # 622, WASHINGTON, D.C., 2008.

In addition, there are as many young adults and adults who have alcohol or other drug problems that do not meet the criteria for receiving a medical diagnosis of abuse or dependence. Given that these more moderate users often contribute a larger portion of the public health consequences (e.g., DUI convictions, college drinking problems), there is a major need to address this large population of moderate and lower risk users also. However, little attention has been paid to this group of individuals who use and potentially abuse substances, but are not, or not yet, dependent.

Taken as a whole, the benefits of substance abuse prevention and early intervention well outweigh the costs of providing that service. Cost-benefit ratios can guide the selection of an optimal intervention package within the available resources. Political feasibility, cultural and demographic differences, and local priorities also must be considered.

TREATMENT

Estimates of AOD Treatment Need

A variety of methods were used to estimate the population in need of AOD treatment services. Some methods use a national standard to define treatment need while others use AOD prevalence rates as a proxy for needing treatment. Using prevalence estimates alone tend to overestimate those in need of treatment since not all persons who use alcohol or other drugs meet abuse or dependence criteria.

The first sections of the treatment need (overall, age, gender, and race/ethnicity) use estimates from the National Survey on Drug Use and Health (NSDUH). NSDUH data comes from self-report surveys produced by the Office of Applied Studies (OAS) of the SAMHSA. Data on 70,000 randomly selected individuals, 12 years and older, are collected annually, and the survey provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use.

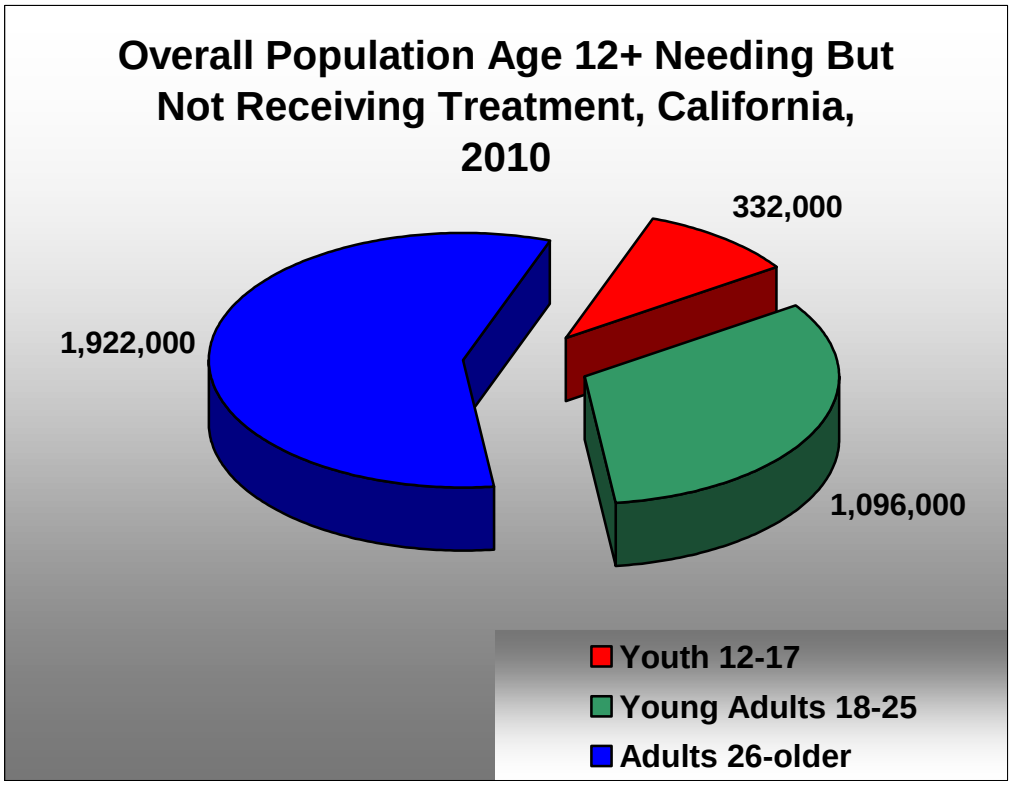
In NSDUH, all persons meeting criteria for alcohol and/or illicit drug dependence/abuse are counted as needing treatment. All those meeting these criteria who are not in treatment are then counted as needing but not receiving treatment. The majority (95.2 percent) of persons who meet the criteria for needing treatment do not receive it because they do not feel they need treatment. State specific percentages were only available for the overall and age categories using data from the combined 2006 and 2007 surveys. The California estimates of those needing but not receiving treatment for either illicit drug use or alcohol use were derived by summing the individual percentages (i.e. percentage needing but not receiving treatment for illicit drug use plus the percentage of needing but not receiving treatment for alcohol use). This results in the estimate being high because the sum of the percentages do not account for persons that abuse both alcohol and other drugs. NSDUH does not provide a combined California percentage to eliminate this overlap. National percentages were used to estimate the number of individuals needing but not receiving treatment by gender and race/ethnicity using 2008 survey data. These estimates use the combined percentage of either illicit drug or alcohol use.

Because the above methodology does not allow breakouts of special populations, the special populations sections describe various studies that show the prevalence of AOD

use and abuse among these groups. Studies specific to Californians are presented where available. The results of national studies are cited when no California specific data is available. Although these studies do not specially address treatment need, they provide valuable insight to describe patterns of AOD use among these subpopulations. Additionally, treatment data from ADP funded and/or licensed providers are presented to show the impact of these populations to the treatment system.

Overall

To estimate the number of all Californians 12 years and older who need but did not receive AOD treatment, the California population 12 years of age and older was multiplied by the sum of the percentage needing but not receiving treatment for illicit drug use and the percentage needing but not receiving treatment for alcohol use (both provided by NSDUH).



Note: Number needing but not receiving treatment is rounded to the nearest 1,000.
Source: Data from the National Survey on Drug Use and Health (NSDUH) are used to estimate California's treatment need.
Source for California Population Estimates: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050.*

As this chart shows, there are over 3.3 million Californians estimated to be in need of, but not receiving, AOD treatment services. Age groups are derived by multiplying the sum of the rates of needing but not receiving treatment for illicit drug use and the rates of needing but not receiving treatment for alcohol use (both provided by NSDUH). This sum overestimates the percentage needing alcohol or other illicit drug treatment because it doe

not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Gender

National estimates are used to determine the gender breakout of individuals in need but not receiving treatment. Percentages from the 2010 NSDUH were multiplied by the California population, by gender. National estimates account for the overlap in populations using both alcohol and illicit drugs.

The Gender estimates are based on the National estimates, whereas the overall Age estimates in previous tables are based on California estimates. The California estimates are higher than the national estimates.

Gender	2010 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drugs or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol
Males	16,180,448	10.8	1,747,000
Females	16,397,439	5.5	902,000

Notes: Numbers Needing but Not Receiving Treatment are rounded to the nearest 1,000.

Highlights

- Males have a higher percentage needing but not receiving treatment than females.

Race/Ethnicity

National estimates are used to determine the race/ethnic breakout of individuals in need but not receiving treatment. Percentages from the 2010 NSDUH were multiplied by the California population by race/ethnicity. The Gender and Race/Ethnicity estimates are based on the National estimates, whereas the overall Age estimates in previous tables are based on California estimates. The California estimates are higher than the national estimates.

Race/Ethnicity	2010 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drug or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol[b]
Hispanic	11,218,048	9.3	1,043,000
White	14,506,541	8.1	1,175,000
African American	1,934,999	7.7	149,000
American Indian	216,328	13.1	28,000
Pacific Islander	125,335	5.4	7,000
Asian	4,019,827	3.9	157,000
Multirace	556,808	9.0	50,000

Notes: Numbers Needing but Not Receiving Treatment are rounded to the nearest 1,000.

Highlights

- American Indians have the highest percentage of needing but not receiving treatment for illicit drug or alcohol use.
- Given their respective large percentages of the overall population, both Hispanics and Whites account for the largest numbers in need of treatment. Each group contributes over one million people to the estimate.

Summary of Population-based Estimates of Treatment Need

The information presented in the preceding sections estimates the number of individuals in need but not receiving AOD treatment by demographic characteristics. The NSDUH survey found only a small proportion of these individuals who need treatment actually sought treatment. Of the over three million Californian's over 12 years of age estimated to need but not receive treatment, about 4.8 percent or 160,000 felt they needed treatment, thus are more likely to seek treatment. The top three reasons for not seeking treatment are:

1. No Health Coverage/Could Not Afford Cost
2. Not Ready to Stop Using
3. Able to Handle Problem without Treatment

Survey respondents were allowed to list multiple reasons for not seeking treatment but these three reasons made up about 80 percent of them. Some of the other reasons mentioned include:

- No transportation/inconvenient
- No program having type of treatment
- Did not feel need for treatment at the time
- Did not know where to go for treatment
- Might cause neighbors/community to have negative opinion
- Might have negative effect on job.

Estimates of Treatment Need for Special Populations

NSDUH treatment need estimates are not available for the following special populations: pregnant women, older adults, homeless and veterans. Therefore, more general prevalence studies of these populations are used to estimate those in need of AOD treatment. Because these numbers may overlap to an unknown degree with the overall estimates provided above, their primary purpose is to highlight the need for treatment among the special populations. All of the following special population estimates use national level AOD prevalence information since California-specific information is not available. The only exception is for estimates for pregnant women who use alcohol. For this estimate, one of the studies cited is California-specific.

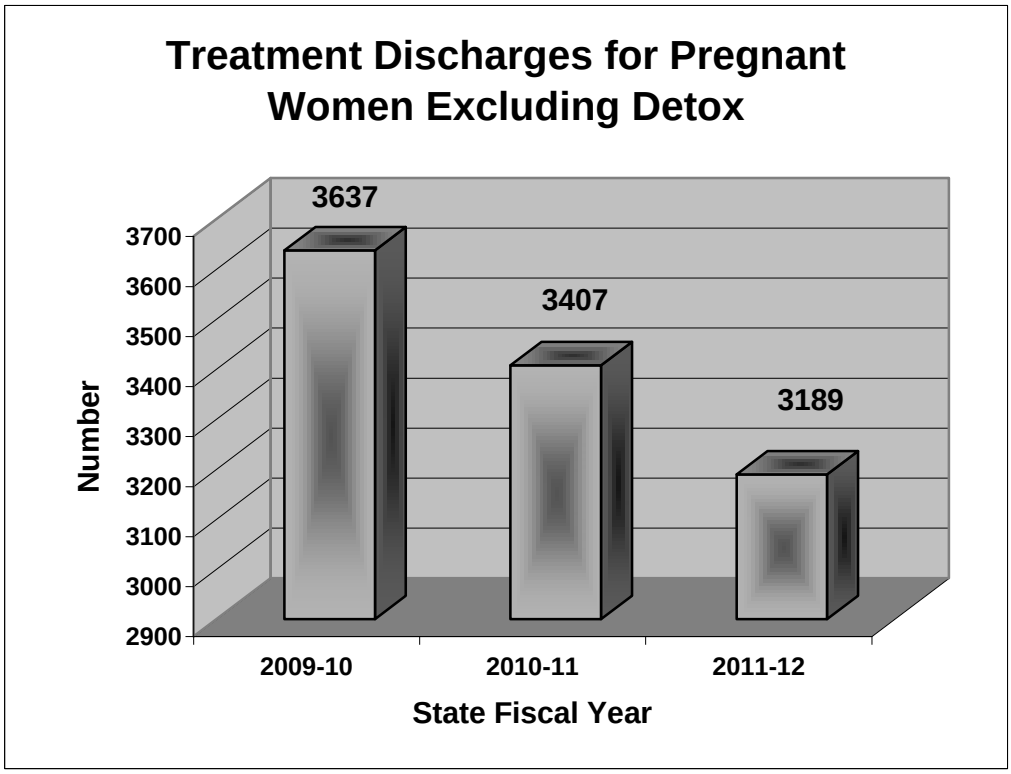
Pregnant Women

Many women unknowingly expose their fetus to alcohol or other drugs (AOD) before they realize they are pregnant; but others use and continue to use during pregnancy. A woman's pattern of drinking prior to pregnancy is a strong predictor of alcohol use during pregnancy.

Drinking during pregnancy raises the risk of low-birth weight babies and intrauterine growth retardation, increasing the danger of infection, feeding difficulties, and long-term developmental problems. Heavy-drinking during the early months of pregnancy can result in the birth of babies with fetal alcohol syndrome. Nationally, over 48,000 children are born annually with alcohol related disorders. Approximately 10% of the reported FASD births occur in California.

There are two main data sources on the use of alcohol by California pregnant and parenting women: the California Behavioral Risk Factor Survey (BRFS), and the Maternal and Infant Health Assessment (MIHA) survey. The most recent (2010) MIHA survey data found that, of the 501,100 women surveyed, 60,400 reported "any alcohol use during their 1st or 3rd trimester" of pregnancy.[6] Although that number represents only 12% of women surveyed, it reflects the potential for over sixty thousand children born in California with alcohol-related birth defects.

The following chart shows the number of pregnant women discharged from AOD treatment (excluding detoxification) for the last 3 years by ADP funded facilities. This includes women who were pregnant at admission or anytime during the treatment stay.



There is no available estimate on the percentage of those needing treatment who actually seek it for this specific subpopulation, therefore, the overall population estimate generated from NSDUH that documented about 4.8% of all individuals who need treatment seek it

[6] Maternal and Infant Health Assessment Survey, MIHA Snapshot, California by Maternal Age, 2010. Retrieved August 2012 from http://www.cdph.ca.gov/data/surveys/Documents/MO-MIHA-SnapshotbyAgeA2010.pdf

was used for the calculation. Using the 2010 MIHA survey results (60,400 reported any alcohol use during pregnancy) it is estimated that approximately 2,900 pregnant women are in need of, but not receiving treatment.

Better data on AOD use by pregnant women is needed. With increased data collection efforts, it may be possible to determine the extent of the treatment needs for these populations, and to design group-specific prevention, intervention, or other treatment programs for particular groups of women in the state.

Homeless

In many situations, substance abuse is a result of homelessness rather than a cause. People who are homeless may turn to drugs and alcohol to cope, in an attempt to attain temporary relief from their problems. In reality, however, substance dependence only exacerbates their problems and decreases their ability to achieve employment stability and get off the streets. Often, people with untreated mental illnesses use street drugs as an inappropriate form of self-medication.

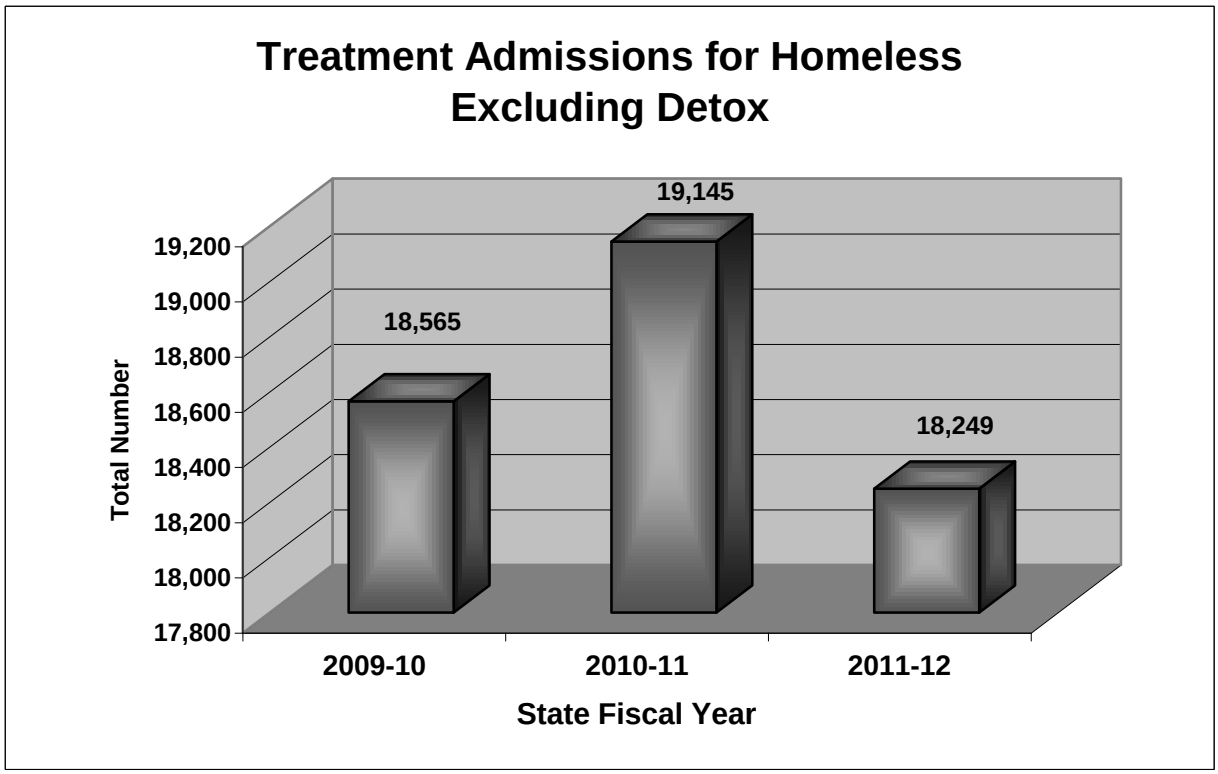
In December 2011, the U.S Department of Housing and Urban Development (HUD) released the results from the hundreds of point-in-time homeless counts that took place in January 2011. Data from more than 3,000 cities and counties (covering nearly all of California) revealed the following:

- California accounted for more than 1 in 5 homeless people in the United States (21.4%); an increase from last year growing by 2.3% and includes (on a single night in January 2011):
    - 139,785 total homeless
        - 111,299 total “individuals”
        - 28,486 total “persons in families” (people who are homeless as part of households that have at least one adult and one child).
        - 19,163 total veterans
    - 62.7% remain unsheltered, one of the highest rates in the nation.
    - 25% of the homeless are "chronically homeless"
        - Unaccompanied individual with a disability
        - Continuously homeless for a year or more, or
        - Experienced at least four episodes of homelessness in the last three years.[7]
- While the actual number of youth who experience homelessness in California is unknown, here is what we do know:

[7] The U.S. Department of Housing and Urban Development Office of Community Planning and Development, The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report, December 2011. Retrieved January 2012 from http://www.hudhre.info/documents/PIT-HIC_SupplementalAHARReport.pdf

- Based on the national survey estimates and California's youth population, it is likely that 200,000 youth under the age of 18, and thousands of 18-24 year olds, are homeless for one or more days during a year.[8]

Three years of CalOMS Tx data is shown in the chart below.



Based on this treatment admission data, approximately 14% of homeless Californians sought treatment for their AOD issues in 2011.

Veterans

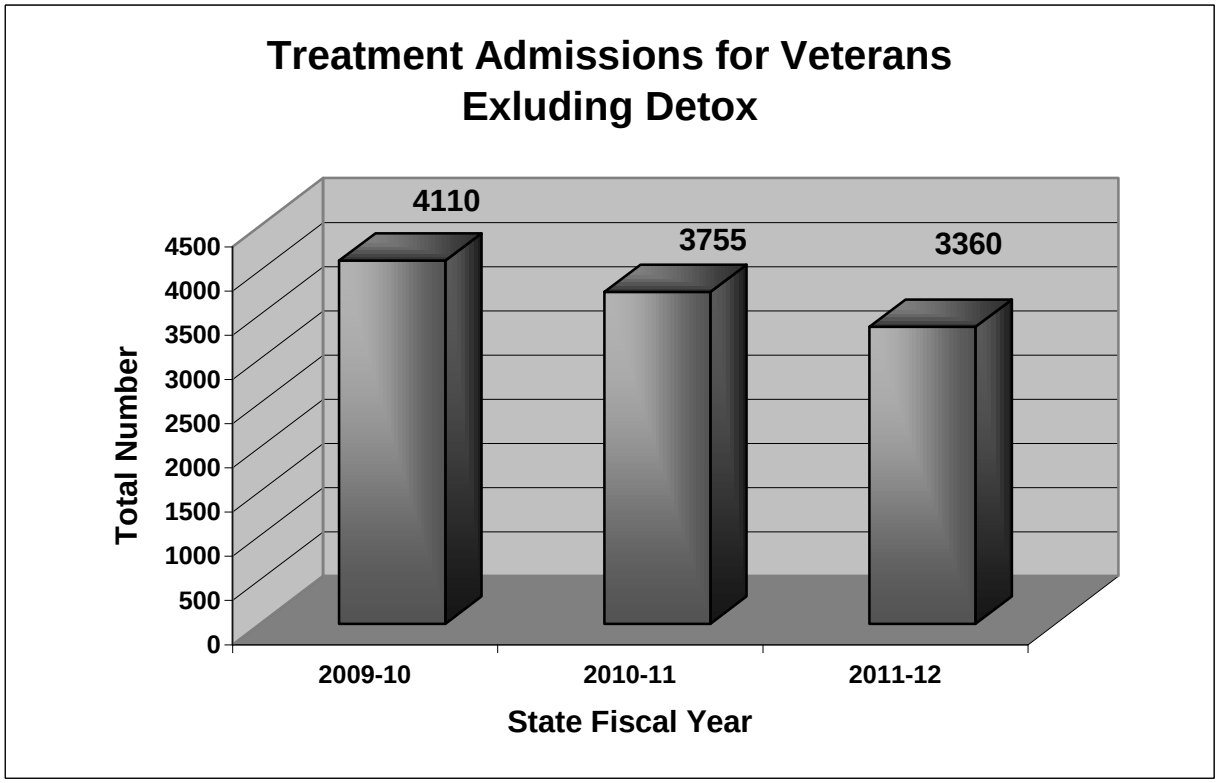
It has been widely reported and acknowledged that both active duty military and veterans have a high prevalence of substance use and abuse. Problems stemming from the misuse and abuse of alcohol and other drugs are by no means a new phenomenon, although the face of the issue has changed in recent years. National trends indicate substantial increases in the abuse of prescription medications. These increases are particularly prominent within the military, a population that also continues to experience long-standing issues with alcohol abuse.

California has the largest population of veterans in the nation, with an estimated 2,078,267.[9] The U.S. Department of Veterans Affairs estimates a 20% AOD prevalence

[8] This estimate is based on applying California's proportion of the national youth population (12 percent) to National estimates of homeless youth. The John Burton Foundation and the California Coalition for Youth, Too Big to Ignore: Youth Homelessness in California, cover letter, November 2009, http://www.cahomelessyouth.org/pdf/Toopercent20Bigpercent20topercent20Ignore.pdf.

rate for this group, which calculates to approximately 415,000 California veterans with AOD issues. Again using the 4.8% overall population estimate generated from NSDUH to estimate the percentage of this subpopulation in need of treatment who actually seek it (because there is no available estimate for this specific subpopulation), the unmet treatment need for this population is approximately 20,000 California veterans.

Many veterans have health benefits which cover treatment for substance abuse problems. Veterans who receive services from facilities that are run by the Department of Veterans Affairs or other facilities who are not required to submit data to ADP are not counted in ADP's treatment system. CalOMS treatment data system shows the following:



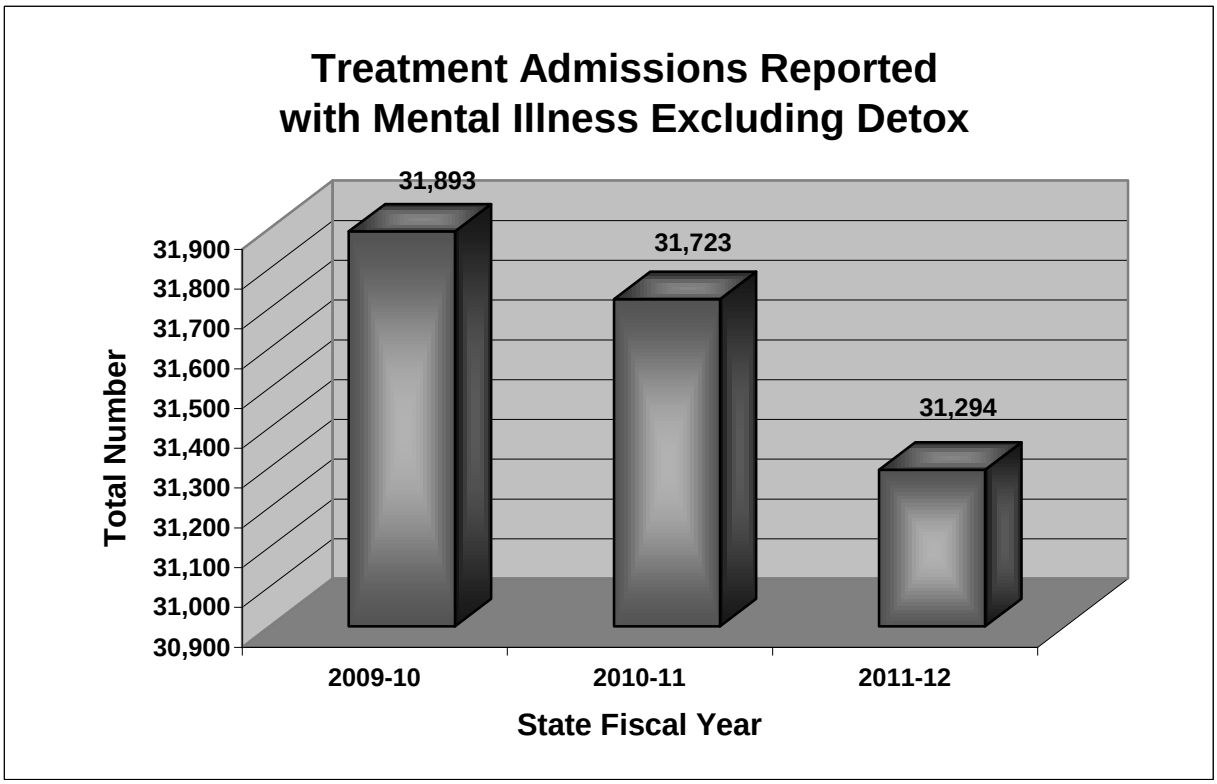
Drug abuse among military personnel is not a new crisis, but one that is compounded by the need for more counselors who are attuned to the specific needs of military clients with SUD and/or co-occurring disorders. As more veterans enter civilian treatment facilities, the SUD workforce must be prepared to serve them. As the military culture is radically different from civilian life, having substance use counselors with training in the cultural differences as well as effective treatment methods is critical to serve this population well.

Co-Occurring Disorders

The diagnostic term "co-occurring disorders" is used when at least one disorder of each type (substance abuse disorders and psychiatric disorders) can be established independent of the other, and is not simply a cluster of symptoms resulting from one

[9] California Department of Alcohol and Drug Programs, Veterans and Service Members, Veteran Issues. Retrieved July 2012 from http://www.adp.ca.gov/Veteran/issues.shtml

disorder. Use of substances – especially sustained use – may contribute to the development of a mental health disorder, whether due to impacts on brain chemistry or traumatic experiences connected to the criminality, homelessness, and violence sometimes associated with substance use.
Nationally, approximately 8.9 million adults have co-occurring disorders. Of those, only 7.4% of individuals receive treatment for both conditions with 55.8% not receiving treatment at all.[10] As reported in CalOMS-Tx, over 31,000 people were admitted to treatment with a reported mental illness in 2011-12. Over the past three years, a slight decrease in admissions with reported mental illness can be seen.



There is no available estimate on the percentage of those needing treatment who actually seek it for this specific subpopulation, therefore, the overall population estimate generated from NSDUH that documented about 4.8% of all individuals who need treatment seek it was used for the calculation. Based on this estimate, approximately 1,500 people with co-occurring disorders were in need of, but did not receive treatment

Related Public Health Issues

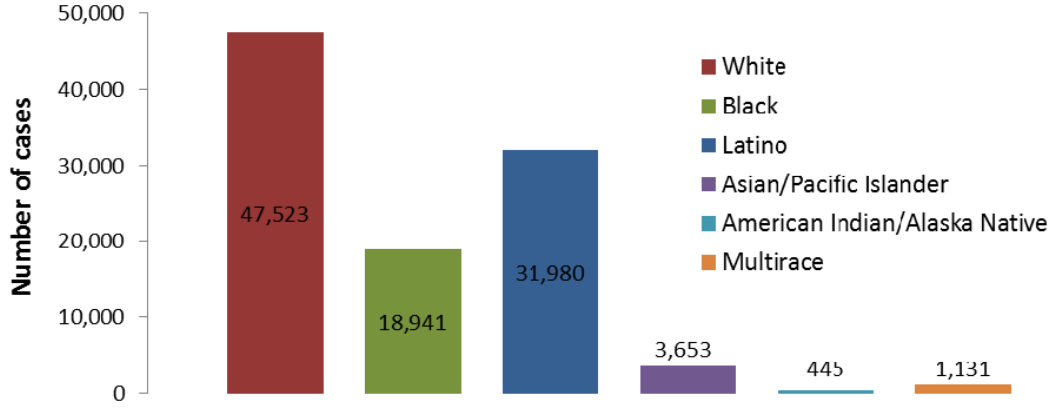
HIV/AIDS and Substance Use
The Human Immunodeficiency Virus (HIV) is the virus that can lead to Acquired Immune Deficiency Syndrome or AIDS, a chronic, life-threatening condition. In the United States, the spread of HIV/AIDS is fueled in part by risky sexual behavior and the use of illicit

[10] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009. Retrieved July 2012 from http://www.samhsa.gov/co-occurring/

drugs, namely injection drug use (IDU) and methamphetamine use. In addition to direct transmission through sharing injection-drug equipment, indirect transmission occurs through sexual contact with HIV-positive users. Moreover, the use of both injected and non-injected substances increase risk for HIV because of the effect these substances have on decision-making.

HIV and AIDS case reports are identified through passive and active surveillance efforts coordinated by California's 61 Local Health Departments. At the end of 2009, there were 268 people living with HIV infection for every 100,000 Californians.[11] The figure below shows the Racial/Ethnic breakdown totals. In 2010, Injection Drug Use was reported as the second highest exposure category for HIV/AIDS cases (at 9.3%) followed by MSM/Bisexual Male & IDU (at 8.9%).

Figure 4. Number of individuals living with HIV or AIDS in California



Hepatitis

Hepatitis means an inflammation of the liver and is usually caused by a viral infection. It is often referred to as a silent epidemic because many of these acute infections are asymptomatic or cause only mild disease. There are several unrelated viruses, but Types A, B and C are the most common.

Hepatitis C virus (HCV) is the most common blood-borne communicable disease in California and the leading cause of liver transplants in the United States.[12] HCV is spread through sexual transmission and blood contact. IDU is the most common risk factor for HCV. IDUs are more likely to contract HCV than HIV. Up to 91% of IDUs who share needles become HCV infected. Alcohol use, coupled with HCV, further compromises the liver and accelerates liver disease. HCV transmission is completely preventable through

[11] California HIV/AIDS Epidemiological Profile, 2009 Update http://www.cdph.ca.gov/programs/aids/Documents/RSEpiProfileUpdate2009.pdf

[12] National Institutes of Health, Management of Hepatitis C: 2002, Consensus Conference Statement, (June 10-12, 2002). Available from: http://consensus.nih.gov/2002/2002HepatitisC2002116html.htm

abstinence, safe sex and safe injection practices.[13] Approximately 600,000 people in California—approximately two percent of the state's population are infected with HCV.[14] As discussed in the study, 66 percent of those who tested positive for HCV reported substance abuse as a risk factor; as many as 396,000 of the 600,000 Californian's infected with HCV are related to substance abuse.

Tuberculosis (TB)

Besides increasing their risk of HIV, HBV and HCV infection, individuals who take drugs or engage in high-risk behaviors associated with drug use also put themselves and others at risk for contracting or transmitting tuberculosis (TB). TB is a disease caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain.

In 2011, 2,317 TB cases were reported in California, down slightly from the previous year. California accounted for 22 percent of all the TB cases in the United States in 2011, the most cases reported by a State in the nation. So, although the declining number of TB cases represents success in control and prevention efforts, TB continues to be a threat to California's public health.

Substance abuse is the most common behavioral risk factor reported by patients with TB in the United States.[15] The table below shows that in 2010, over 14 percent of the 2,327 persons with TB reported substance abuse as a risk factor for their exposure to TB.

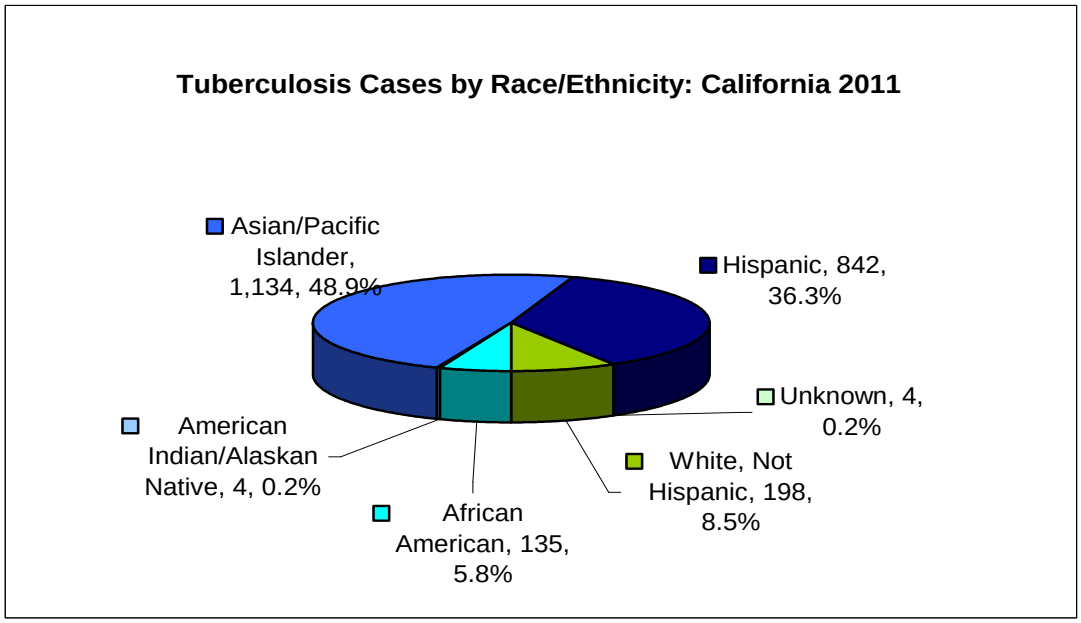
Substance Abuse TB Risk Factors Reported: California 2010		
	Total Cases	
Self-disclosed Risks	#	%
Injecting Drug Use	25	1.1
Non-injecting Drug Use	135	5.8
Excess Alcohol Use	167	7.2
Total Substance Abuse Risk Factors Reported	**327**	**14.1**
Total TB Cases Reported	2,327	100%

*Substance Abuse within the past 12 months
Source: California Department of Public Health, Tuberculosis Control Branch

Another high risk group is individuals born outside the United States. They account for over 79 percent of the TB cases in California in 2010.

[13] SAMHSA Tip 53, Addressing Viral Hepatitis in People with Substance Use Disorders. Retrieved June 2012 from http://store.samhsa.gov/shin/content//SMA11-4656/SMA11-4656.pdf
[14] Oeltmann et al. (2009). *Tuberculosis and Substance Abuse in the United States, 1997-2006*. Archives of Internal Medicine, 169 -189.
[15] California Department of Public Health
http://www.cdph.ca.gov/data/statistics/Documents/TBCB_Report_2011.pdf

The graph below shows TB cases in 2011 in California by race/ethnicity.



Source: California Department of Public Health, Tuberculosis Control Branch

NEEDS ASSESSMENT FINDINGS AND DEVELOPMENT OF STATE PRIORITIES

As a part of the SNAP process, the DHCS Mental Health and Substance Use Disorder Services in collaboration with County Alcohol and Drug Program Administrators will determine the state's priority areas based on the needs assessment findings and recommendations from the 2012 Needs Assessment Report.

California's publicly-funded AOD services system is moving in a direction that includes a fuller continuum of services, values scientifically supported practices, and promotes performance and data-informed planning and decision making. The vision for the system has been articulated, as has the expectation that cost efficiency and more effective services will be the outcomes.

The Continuum of Services

While many of the components of the system are in place, there is still a large capacity-building effort required in order to realize all the benefits.

- While prevention activities have been a component of the system for many years, the proliferation of evidence-based strategies and policies is not yet widespread throughout the system. As the data for youth shows, there is a large unmet prevention need. Employing more proven population-based strategies will be an effective method for impacting a large portion of the unmet need, therefore, reducing the future need for treatment and the resulting negative consequences.

  In addition, with the prevention emphasis related to health care, AOD prevention efforts become critically important because prevention has become a key

component of the health care model. New funding strategies and sources need to be identified in order to mirror that importance in the AOD system. When the "treatment" benefits from effective prevention efforts are examined as part of the system performance, a re-evaluation of traditional funding priorities must also be considered and new funding sources identified.

- SBIRT as an early intervention strategy is showing promising results in California. Currently, operating as projects under one-time funding, sustainability of training efforts and creating widespread interest in partner service systems will be paramount to building statewide capacity to provide this intervention in the appropriate venues. In addition, establishing other prevention and early intervention strategies that delay onset and reduce harm will ensure a comprehensive statewide approach in making these services available.

- The prevention and treatment system in California has been working over the past several years toward instituting evidenced-based practices, process improvements and performance measures to increase the effectiveness of treatment services. These efforts have been pursued not only as good business practice but also due to the recognition that there are many more people in need of treatment services than the publicly-funded system can currently accommodate, so making the best use of limited resources becomes even more critical. Unfortunately, priority populations in the treatment system are often set by the specific funding source (i.e., IVDU, pregnant and parenting women, criminal justice). As a result of categorical funding approaches, the treatment system has not been set up to serve all individuals with substance use conditions that coincide with what the prevalence data indicates. As a matter of public policy, other factors (e.g., public health, public safety, cost offsets) have been used to determine who receives publicly-funded treatment services.

- Evidence has shown that providing Recovery Support Services (RSSs) results in increased effectiveness of services and reduced preventable re-admissions, which can help lower overall treatment costs and other societal consequences that arise from AOD disorders. Currently in California, RSS is mostly unfunded except for special grants and pilot projects. For COSSR to be fully realized, investments in RSS must be made in order to fully benefit from a continuum of services system. As health care reform is implemented nationwide, now is a logical time to reevaluate funding streams to ensure RSS is a funded component of the continuum. Widespread capacity building will not be possible without a dedicated or allowable funding source.

- Performance measures and data-informed planning and decision making models continue to be implemented at the local and state level. These are not yet fully integrated throughout the system and are still being embedded within operations at the provider, county and state levels. Continuing in this direction will be important for the AOD system going forward.

Health Care Reform

The implementation of the major provisions of the PPACA in 2014 will mean substantial changes for the AOD system. The directions that the AOD system has been moving in over the last several years, however, will serve it well in transitioning to the new health care world. While there are many unknowns still related to the implementation of the PPACA that makes planning for the changes challenging, there are some known factors that should be used to spur planning activities.

Under the PPACA the primary health care system will be a major entry point for substance use screening, early intervention and treatment. As approximately 4.5 million more Californians obtain health care insurance, the potential to reach at least a portion of the 3.3 million currently in need of treatment, the 300,000 youth in need of early intervention, and the 3 million youth that could benefit from universal prevention strategies is huge. A primary health care system that is well educated on substance abuse will exponentially expand the capacity of the AOD system in California to prevent and treat substance abuse.

Since there will be varying levels of knowledge within that system, providing the primary care system with a toolkit of options and resources for educating, serving and/or referring patients with identified or suspected substance abuse is a value added activity that should be considered.

Also, of the 4.5 million additional insureds, a conservative estimate is that close to two million of those will be insured through the public benefit, Medi-Cal in California. If 10 percent (the rate of those needing but not receiving treatment) of those, or approximately 200,000 need treatment, then the Medi-Cal authorization, billing and monitoring system capacity needs to be expanded, as well as an aligning of the current primary care Medi-Cal system and the Drug Medi-Cal system which currently operate separately. A thorough examination of the changes required to the Medi-Cal system must be undertaken to sort out the issues and ensure an efficient system with the capacity for expansion.

For the 2.3 million Californians who will remain uninsured, the publicly-funded AOD system of services can provide a safety net for those that are in need of services. Exploring and defining who this population is likely to be comprised of and projecting their AOD needs will be an essential component of the planning process.

A key component of making the transition to the new health care world will be a concerted workforce development effort to ensure that AOD staff have the qualifications necessary for insurance reimbursement and delivery of effective services and activities. Along with qualified staff, a proven record of performance will be required. The primary care world and insurers put a high value on “preventable readmissions” so effective services will be a requirement of the partnership between the primary care and AOD systems.

Finally, data collection and reporting must be further developed and refined in order to provide accurate estimates, describe relevant aspects of current clients (i.e., insurance

status, parenting status, other public benefit status, matriculation through services), and project service use patterns for different levels of service need.

These are some fundamental steps that can be taken now:

- Develop a plan based on the “knowns” of health care reform and add to it as further information and details come to light.
- Consider how to partner and educate the primary care system on AOD issues.
- A thorough examination of the Medi-Cal system must be undertaken in relation to impacts on the AOD system and services.
- Understanding and planning for the uninsured population will be just as important as building capacity to serve additional insured individuals.
- Appropriately preparing and developing the AOD workforce will be a critical step.
- Further developing the data collection and reporting system capacity is an important component for the decision-making process going forward.

Priority Setting Process

Once county input has been received, the priority-setting process will commence with the DHCS Mental Health and Substance Use Disorder Services team using the following criteria as a guide for decision making. In addition, SAMHSA’s 8 Strategic Initiatives and highlights from the Office of National Drug Control Policy’s (ONDCP) National Drug Control Strategy will be used to inform the process.

Priority Setting Criteria

Consistent with DHCS vision, mission, and organizational structure:

- Consistent with and will not undermine essential vision/mission
- Fits into (or should be added to) existing organizational structure/activities

Feasibility of implementation and sustainability:

- Existence of infrastructure (e.g., staff and facilities, resources availability) or attainable through redirection of resources
- Funding available and sustainable
- Authority to implement is present or obtainable
- Political and cultural acceptability and support
- Workforce knowledge and skills and/or opportunities for training and technical assistance

Timeliness:

- Length of time to results/outcomes within a 3-year time period

Evaluation of program or policy:

- Ability to evaluate/measure effects

In addition to the priority setting criteria, the DHCS MHSUD Team must consider other key points in their decision making: Specifically, the transition of ADP to DHCS; the state staffing reductions; balancing operational needs versus strategic activities; the impact of

realignment on the state's role; and how to achieve real change through measurable outcomes.

The priorities selected from the needs assessment findings and recommendations should be geared toward building the capacity to significantly impact the substance abuse problems in California, and prepare for the implementation of health care reform. These statewide priorities should serve to support effective AOD services to all special or target populations. In conjunction with these priorities, DHCS will continue all operational activities that include work with constituent committees focusing on minority populations, pregnant and parenting women, individuals with co-occurring disorders, veterans, etc.

DISCUSSION OF SPECIAL POPULATIONS

In the prior application, the SNAP process was completed prior to the application submission and resulted in three priorities, which largely focused on system improvement. To address the requirements set forth in the new application (which is due prior to completion of the SNAP process), the following will detail some of the ADP and now DHCS expansive experiences and findings in working on the issues impacting California's special populations, as well as collaborative partnerships formed across systems. These will inform the development of new statewide priorities.

California's Diversity in Unmet Need: A Description of Underserved Populations
California's geographic, racial, and socio-economic diversity creates significant challenges and barriers in special populations accessing substance use disorder (SUD) prevention, treatment, and recovery support services. While DHCS has kept special populations' health disparities at the forefront of its program and policy work, persistent barriers remain. Although, ADP and now DHCS work with special populations spans over a decade, data from DHCS's Statewide Needs Assessment and Planning (SNAP) process indicates unmet needs for SUD services across various subgroups. A variety of behavioral, cultural and systemic issues are emerging that represent some of the key factors underlying ongoing health disparities. The salient issues among high-risk populations such as pregnant women, underserved racial and ethnic minorities, the chronically homeless, active military personnel and veterans, individuals with co-occurring disorders (COD), intravenous drug users (IDUs) and persons at risk for or living with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), as well as the criminal justice population are as broad and distinct as the populations in which they exist. The consequences and impacts of unmet treatment need, as well as programmatic and policy improvements required for client access and engagement, are as real as the individuals they impact.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Priority Area 1: Program Performance Standards/Measures-Goal 1

Priority Type: SAT

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, All Treatment Clients)

Goal of the priority area:

Goal 1- Develop measurement criteria.

Strategies to attain the goal:

a. Increase complete and accurate reporting of treatment admission, discharge, and annual update data.
b. Develop three treatment performance and client outcome measures.
c. Develop one treatment program performance and client outcomes scorecard for different service types.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure goal success: a) Monitor three data quality metrics to ensure data quality. b) Define three three treatment performance and client outcome measures. c) Develop one treatment scorecard for one treatment service type.

Baseline Measurement: (Initial data collected prior to and during SFY 2013): a) 3 data quality metrics identified for monitoring data quality: admissions open longer than one year without a discharge or annual update; percent administrative discharges. b) 3 performance/outcome measures for Outpatient Drug Free treatment established: abstinence at discharge, in treatment 90 days or longer, engaged in at least 4 days of social support at discharge .c) 0 scorecards for

other treatment service types have been implemented.

First-year target/outcome measurement: (Progress to end of SFY 2014): a) Improvements in all three 3 data quality metrics. b) 3 performance/outcome measures for other treatment services established. c) 1 scorecard for treatment implemented.

Second-year target/outcome measurement: (Final to end of SFY 2015): a) Improvements in all three 3 data quality metrics. b) 3 performance/outcome measures for treatment services established.c) 1 scorecard for treatment implemented.

Data Source:

California Outcomes Measurement System - Treatment (CalOMS-Tx)
Other data sources to be determined.

Description of Data:

The performance/outcome data will be primarily based on CalOMS Tx admission, discharge, and annual update data from publicly funded and/or monitored Substance Abuse Disorder treatment services in California.

Data issues/caveats that affect outcome measures::

Data reporting quality (including validity, reliability and completeness) is key 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. Further, 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. Therefore, an integral component of this work is data quality assurance including monitoring administrative discharges, open admissions, and annual update reporting.

Priority #: 2

Priority Area: Priority Area 1: Program Performance Standards/Measures-Goal 2

Priority Type: SAT

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, All Treat)

Goal of the priority area:

Goal 2-Promote continuous quality assurance

Strategies to attain the goal:

a. Increase complete and accurate reporting of treatment admission, discharge, and annual update data.
b. Develop three treatment performance and client outcome measures.
c. Develop one treatment program performance and client outcomes scorecard for different service types.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure goal success: a) Monitor three data quality metrics to ensure data quality. b) Define three three treatment performance and client outcome measures c) Develop one treatment scorecard for one treatment service type. .
Baseline Measurement:	(Initial data collected prior to and during SFY 2013): a) 3 data quality metrics identified for monitoring data quality: admissions open longer than one year without a discharge or annual update; percent administrative discharges. b) 3 performance/outcome measures for Outpatient Drug Free treatment established: abstinence at discharge, in treatment 90 days or longer, engaged in at least 4 days of social support at discharge . c) 0 scorecards for other treatment service types have been implemented.
First-year target/outcome measurement:	(Progress to end of SFY 2014): a) Improvements in all three 3 data quality metrics. b) 3 performance/outcome measures for other treatment services established c) 1 scorecard for treatment implemented. .
Second-year target/outcome measurement:	(Final to end of SFY 2015): a) Improvements in all three 3 data quality metrics. b) 3 performance/outcome measures for treatment services established. c) 1 scorecard for treatment implemented.

Data Source:

California Outcomes Measurement System - Treatment (CalOMS-Tx)
Other data sources to be determined.

Description of Data:

The performance/outcome data will be primarily based on CalOMS Tx admission, discharge, and annual update data from publicly funded and/or monitored Substance Abuse Disorder treatment services in California.

Data issues/caveats that affect outcome measures::

Data reporting quality (including validity, reliability and completeness) is key 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. Further, 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. Therefore, an integral component of this work is data quality assurance including monitoring administrative discharges, open admissions, and annual update reporting.

Priority #: 3

Priority Area: Priority Area 1: Program Performance Standards/Measures-Goal 3

Priority Type: SAP

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, All California Polulations)

Goal of the priority area:

Goal 3-Promote continuous quality assurance

Strategies to attain the goal:

a) Develop a plan to establish a California-specific Registry of Evidence-Based Programs and Practices (C-REPP);
b) Continue to report about current, relevant epidemiological data and data resources;
c) Collaborate with Indian Health Centers to develop culturally-informed, evidence-based practices and programs (EBPs) focused on substance use disorders in American Indian and Alaska Native (AIAN) populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure goal success: a) Assessment of the feasibility of establishing a C-REPP. b) Identification and development of annual AOD indicator data reports based on epidemiological data. c) Form workgroup comprised of Indian Health Center representatives and hold regular meetings.

Baseline Measurement: (Initial data collected prior to and during SFY 2014): a) Currently, there is no assessment of feasibility or plan for establishing C-REPP; b) Continue producing an annual update of

AOD indicators using epidemiological data;c) Initiate assessment of evidence-based practices in AIAN communities.

First-year target/outcome measurement: (Progress to end of SFY 2014): a) Identify gaps in EBPs using assessment process; b) Add one question to SUD Division's County Monitoring Unit's county monitoring tool regarding EBPs; collect and summarize these data; c) Establish Indian Health Workgroup with community partners to develop a model for culturally appropriate EBPs.

Second-year target/outcome measurement: (Final to end of SFY 2015): a) Establish and apply criteria for developing and selecting EBPs to fill gaps identified; b) Obtain and analyze information collected through county monitoring tool; c) Develop culturally informed EBP for SUD services for AIAN populations.

Data Source:

a) Applicant specific, but will include NREPP criteria to assess:
- Quality/comprehensiveness of research creating the intervention,
- significant behavioral outcomes,
- integration of culturally and linguistically appropriate program content, and
- readiness for dissemination of practices.
b) AOD prevalence (CA Healthy Kids Survey, CalOMS-Tx, NSDUH, OSHPD, BRFSS, CHIS)
c) N/A

Description of Data:

a) Establish criteria for EBPs based on NREPP standards; Information compiled about the specific intervention program
b) Available survey, treatment, injury, death, and other sources of data for development of AOD indicators
c) N/A

Data issues/caveats that affect outcome measures::

This is an exploratory project; the feasibility of establishing a C-REPP in the first year will determine future activities.

Priority #: 4

Priority Area: Priority Area 1: Program Performance Standards/Measures-Goal 4

Priority Type: SAP

Population (s): Other (Universal)

Goal of the priority area:

Goal 4-Increase the number of Friday Night Live (FNL) counties achieving Member in Good Standing (MIGS)

Strategies to attain the goal:

Through support and guidance from the California Friday Night Live Partnership (CFNLP), counties implement FNL using youth development standards of practice providing opportunities for youth to become leaders in their communities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of counties achieving 100% compliance in the Member in Good Standing (MIGS) process which includes 1) following the FNL Standards of Practice; 2) implementing the Roadmap (a strategic planning process); 3) completion of the annual Youth Development Survey; 4) meeting CalOMS Pv database reporting requirements; and, 5) attending FNL coordinator calls and the annual FNL Leadership Training Institute.
Baseline Measurement:	(Initial data collected prior to an during SFY 2014): 27 of 50 counties
First-year target/outcome measurement:	(Progress to end of SFY 2014): Increase number of counties by 5% (3 more counties)
Second-year target/outcome measurement:	(Final to end of SFY 2015): Increase number of counties by 5% (3 more counties)

Data Source:

California Friday Night Live Collaborative Peer Review Process

Description of Data:

Attendance sheets at the Leadership Training Institute and required FNL coordinator calls, CalOMS Pv data, CFNLP Reports

Data issues/caveats that affect outcome measures::

Not reporting into CalOMS Pv, project staffing, county resources

Priority #: 5

Priority Area: Priority Area 1: Program Performanxe Standards/Measures-Goal 5

Priority Type: SAP, SAT

Population (s): PWWDC

Goal of the priority area:

Goal 5-Identify service gaps and areas for improvement

Strategies to attain the goal:

Develop criteria to determine which counties have the highest need in the areas of Therapeutic Services for Children (TSC), Substance-Exposed Infants (SEI), Child Welfare (CW) Collaboration, and Life Skills. (Related Priority 2. Goal 1. EBPs).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Criteria to identify service gaps and areas for improvement
Baseline Measurement:	(initial data collected prior to and during SFY 2014): No criteria are developed to determine which counties have the highest need in the areas of Therapeutic Services for Children (TSC), Substance-Exposed Infants (SEI), Child Welfare (CW) Collaboration, and Life Skills. (Related Priority 2. Goal 1. EBPs)
First-year target/outcome measurement:	(progress to end of SFY 2014): Develop criteria to determine which counties have the highest need in the areas of Therapeutic Services for Children (TSC), Substance-Exposed Infants (SEI), Child Welfare (CW) Collaboration, and Life Skills and provide support on EBPs/RBPs. (Related Priority 2. Goal 1. EBPs)
Second-year target/outcome measurement:	(final to end of SFY 2015): Measure effectiveness of the process of providing support on EBPs/RBPs counties with highest indicated need for TSC, SEI, Child Welfare Collaboration, and Life Skills. (Related Priority 2. Goal 1. EBPs)

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Evaluation.

Description of Data:

OWPS Evaluation: Data on county perceived value added of program support provided based on identified need.

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Priority Area 1: Program Performance Standards/Measures-Goal 6

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

Goal 6-Develop a continuous quality improvement mechanism for evaluation of Perinatal Treatment Program performance.

Strategies to attain the goal:

Develop performance criteria for Perinatal Treatment Programs
Develop performance measures to monitor Perinatal Treatment Program performance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perinatal performance measures are established.

Baseline Measurement: (initial data collected prior to and during SFY 2014): No perinatal performance measures.

First-year target/outcome measurement: (progress to end of SFY 2014): Develop a Perinatal Data Indicator Report for Residential and Outpatient Treatment.

Second-year target/outcome measurement: (final to end of SFY 2015): Counties/providers are provided program support based on Perinatal Data Indicator Report performance.

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Tracking Log.

Description of Data:

OWPS Program Support Tracking Log: Data on program support provided.

Data issues/caveats that affect outcome measures::

Priority #: 7

Priority Area: Priority Area 2: Build Capcity-Goal 1

Priority Type: SAP, SAT

Population (s): PWWDC

Goal of the priority area:

Goal 1-To increase knowledge and use of Evidence-Based Practices (EBPs), Research-based Practices (RBPs) in communities with highest need.

Strategies to attain the goal:

Develop criteria to determine which counties have the highest need and provide program support on Evidence-Based Practices (EBPs), Research -based Practices (RBPs) to those counties in the areas of Therapeutic Services for Children (TSC), Substance-Exposed Infants (SEI), Child Welfare (CW) Collaboration, and Life Skills.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase knowledge and use of Evidence-Based Practices (EBPs), Research-based Practices (RBPs) in area of Therapeutic Services for Children (TSC).
Baseline Measurement:	(initial data collected prior to and during SFY 2014): 1.) Number of counties provided program support based on indicated need. 2.) Number of counties screening ALL children accompanying mothers to treatment.
First-year target/outcome measurement:	(progress to end of SFY 2014): Provide program support on EBPs/RBPs to the 10 counties with highest need for TSC.
Second-year target/outcome measurement:	(final to end of SFY 2015): Increase in the number of counties screening ALL children accompanying mothers to treatment.

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Tracking Log
County Monitoring (CM) Tool

Description of Data:

OWPS Program Support Tracking Log: Data on program support provided.
CM Tool: Data from annual monitoring tool (number of counties screening ALL children accompanying mothers to treatment)

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Increase knowledge and use of EBPs and RBPs in area of Substance-Exposed Infants (SEI).
Baseline Measurement:	(initial data collected prior to and during SFY 2014): 1.) Number of counties provided program support based on indicated need. 2.) Number of counties working on reducing SEIs in their Strategic Prevention Framework (SPF).
First-year target/outcome measurement:	(progress to end of SFY 2014): Provide program support on EBPs/RBPs to the 10 counties with highest need for SEI.
Second-year target/outcome measurement:	(final to end of SFY 2015): Increase in counties working on reducing SEIs in their Strategic Prevention Framework (SPF).

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Tracking Log.
CalOMS Prevention Database.

Description of Data:

OWPS Program Support Tracking Log: Data on program support provided.
CalOMS Prevention Database: Data of counties Strategic Prevention Framework (SPF).

Data issues/caveats that affect outcome measures::

Indicator #:	3
Indicator:	Increase knowledge and use of EBPs and RBPs in area of Child Welfare (CW) Collaboration.
Baseline Measurement:	(initial data collected prior to and during SFY 2014): Number of counties provided program support based on indicated need.

First-year target/outcome measurement:	(progress to end of SFY 2014): Provide program support on EBPs/RBPs to the 10 counties with highest need for Child Welfare Collaboration.
Second-year target/outcome measurement:	(final to end of SFY 2015): Increase in collaboration with child welfare services, mental health, and/or public health.

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Tracking Log
OWPS Program Support Evaluation

Description of Data:

OWPS Program Support Tracking Log: Data on program support provided.
OWPS Evaluation: Data on collaboration with child welfare services, mental health, and/or public health.

Data issues/caveats that affect outcome measures::

Indicator #:	4
Indicator:	Increase knowledge and use of EBPs and RBPs in area of Life Skills (employment, dependent living)
Baseline Measurement:	(initial data collected prior to and during SFY 2014): 1.) Number of counties provided program support based on indicated need. 2.) CalOMS Tx Data SFY12/13 (employment status, enrolled in job training.).
First-year target/outcome measurement:	(progress to end of SFY 2014): Provide program support on EBPs/RBPs to the 10 counties with highest need for Life Skills (employment, dependent living).
Second-year target/outcome measurement:	(final to end of SFY 2015): Increase in perinatal clients enrolled in job training and employed in counties provided program support on life skills.

Data Source:

Office of Women's and Perinatal Services (OWPS) Program Support Tracking Log.
CalOMS Tx –Data Elements: employment status; enrolled in job training

Description of Data:

OWPS Program Support Tracking Log: Data on program support provided.

CalOMS Tx: data elements capture the client's employment status and the number of clients enrolled in job training.

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area: Priority Area 2: Build Capcity-Goal 2

Priority Type: SAP

Population (s): Other (Universal)

Goal of the priority area:

Goal 2-Increase member attendance at quarterly meetings of the Governor's Prevention Advisory Council (GPAC).

Strategies to attain the goal:

Convene four Exploratory Workgroup meetings of the GPAC to develop a GPAC Organizational Plan.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completion of Organizational plan and four quarterly GPAC meetings.

Baseline Measurement: (Initial data collected prior to an during SFY 2014): Baseline for GPAC attendance is 10 of 32 members.

First-year target/outcome measurement: (Progress to end of SFY 2014): Completed Organizational Plan. Increase member attendance by 10%.

Second-year target/outcome measurement: (Final to end of SFY 2015): Increase member attendance by 10%.

Data Source:

sign-in sheets, workgroup meeting minutes, information disseminated/gathered at meetings.

Description of Data:

sign-in sheets to measure GPAC attendance, minutes to report on progress of organizational plan.

Data issues/caveats that affect outcome measures::

attrition, internal staffing, lack of buy-in.

Priority #: 9

Priority Area: Priority Area 2: Build Capacity-Goal 3

Priority Type: SAP

Population (s): Other (Universal)

Goal of the priority area:

Goal 3- Increase the number of prevention practitioners/professionals trained in prevention theories and frameworks.

Strategies to attain the goal:

Develop and implement professional competencies for the prevention field.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of prevention practitioners/professionals completing the professional competencies and number of curricula developed.

Baseline Measurement: (Initial data collected prior to an during SFY 2014): Baseline is 0 persons trained, as the first five competencies were released in June 2013. Baseline for number of competencies developed is 5.

First-year target/outcome measurement: (Progress to end of SFY 2014): 50 individuals trained in year 1 - through either the online training series, webinar series or on-site trainings. Three curricula developed and released.

Second-year target/outcome measurement: (Final to end of SFY 2015): 100 more individuals trained in year 2 - through either the online training series, webinar series or on-site trainings. Three more curricula developed and released.

Data Source:

Center for Applied Research Solutions (CARS) Quarterly Progress Reports.

Description of Data:

The CARS Quarterly Progress Report is a report prepared through the CPI Technical Assistance and Training contract. The report contains information on the deliverables achieved and successes/barriers of the project and overall evaluation of training/technical assistance provided.

Data issues/caveats that affect outcome measures::

funding for marketing, staffing, limited travel allowed for on-site trainings.

Priority #: 10

Priority Area: Priority Area 3: Underage and Excessive Drinking-Goal 1

Priority Type: SAP

Population (s): Other (Ages 12-25)

Goal of the priority area:

Goal 1-Increase number of counties reporting on statewide outcomes related to underage and excessive drinking.

Strategies to attain the goal:

Pilot counties to demonstrate adoption of the following statewide measures: 1) initiation of alcohol use by age 15; 2) drinking 3 or more days withing the past 30 days; and, 3) binge drinking within the last 30 days.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of counties adopting statewide outcomes measures.
Baseline Measurement:	(Initial data collected prior to an during SFY 2014): Baseline for number of counties adopting statewide outcome measures is 0.
First-year target/outcome measurement:	(Progress to end of SFY 2014): Establish 10 pilot counties to adopt statewide outcome measures.
Second-year target/outcome measurement:	(Final to end of SFY 2015): Increase the number of counties adopting the statewide outcome measures by 50%.

Data Source:

Report from WestEd on the number of California School Districts administering CHKS and Quarterly Progress Report from the Center for Applied Research Solutions that support pilot counties adopting statewide outcomes.

Description of Data:

TA contractor provided reports.

Data issues/caveats that affect outcome measures::

lack of funded mandate for CHKS infrastructure and administration, lack of school administration buy-in.

Priority #: 11

Priority Area: Priority Area 3: Underage and Excessive Drinking-Goal 2

Priority Type: SAP

Population (s): Other (Ages 12-25)

Goal of the priority area:

Goal 2-ncrease number of counties addressing underage and excessive drinking by using evidence-based environmental prevention strategies and measuring outcomes against a control group. Environmental prevention activities include: focusing on retail availability (minor decoy, RBS training/enforcement); social availability (party patrol); drinking and driving (check points, saturation patrols); and visability of actions (media).

Strategies to attain the goal:

The SPF SIG is a pilot project to demonstrate a streamlined SPF planning process, and the efficacy of utilizing evidence-based environmental prevention strategies to cause an effect on underage and excessive drinking among 12-25 year olds. An implementation grantee is conducting the SPF SIG project in 12 selected implementation communities by guiding the community planning process including development of a logic model and action plan. Successful implementation will be determined through changes in the data that can be attributed to the implementation strategies used by the 12 communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of communities implementing their action plans.

Baseline Measurement:	(Initial data collected prior to and during SFY 2013): Baseline is 0.
First-year target/outcome measurement:	(Progress to end of SFY 2014): Communities implementing action plans.
Second-year target/outcome measurement:	(Final to end of SFY 2015): measurement of decreases (TBD) in hospital admissions and ER visits due to alcohol use, evaluation of outcomes, recommendations.

Data Source:

SWITRS, EPI-CENTER Hospital Data.

Description of Data:

Statewide, county and target community counts of hospital admissions to the ER for alcohol-related incidents; counts of statewide, county and target community SWITRS reported incidents of alcohol related accidents/crashes.

Data issues/caveats that affect outcome measures::

In order to be able to assess the target communities, they must complete all the agreed upon tasks assigned in their action plans without over-reaching the SPF SIG grant allocated funds (though they may find matching.) They must have full participation of their identified enforcement staff.

Indicator #:	2
Indicator:	Number of alcohol-related Hospital admissions/ER admission counts, Statewide Integrated Traffic Records System (SWITRS) DUI data.
Baseline Measurement:	(Initial data collected prior to and during SFY 2013): Identifying and collecting the baseline data from 12 invervention and 12 control communities.
First-year target/outcome measurement:	(Progress to end of SFY 2014):Targets will vary by community and baselines established.
Second-year target/outcome measurement:	(Final to end of SFY 2015): measurement of decreases (TBD) in hospital admissions and ER visits due to alcohol use, evaluation of outcomes, recommendations

Data Source:

SWITRS, EPI-CENTER Hospital Data.

Description of Data:

Statewide, county and target community counts of hospital admissions to the ER for alcohol-related incidents; counts of statewide, county and target community SWITRS reported incidents of alcohol related accidents/crashes.

Data issues/caveats that affect outcome measures::

In order to be able to assess the target communities, they must complete all the agreed upon tasks assigned in their action plans without over-reaching the SPF SIG grant allocated funds (though they may find matching.) They must have full participation of their identified enforcement staff.

Priority #: 12

Priority Area: Priority Area 3: Underage and Excessive Drinking

Priority Type: SAP

Population (s): Other (Ages 12-25)

Goal of the priority area:

Goal 3-Increase number of counties addressing underage and excessive drinking in retail settings.

Strategies to attain the goal:

Partner with the California Department of Public Health to develop, plan and implement a campaign that will allow local public health and alcohol and other drug (AOD) advocates to work collectively to survey local merchants. The data collected in retail establishments on tobacco, alcohol and the availability of healthy food choices will provide local-level information to help inform and evaluate future efforts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of AOD county partners engaged in the Healthy Stores for a Healthy Community Campaign.

Baseline Measurement: (Initial data collected prior to an during SFY 2014): 0; This campaign was recently launched statewide.

First-year target/outcome measurement: (Progress to end of SFY 2014): Complete data collection and project planning.

Second-year target/outcome (Final to end of SFY 2015): 10 of 57 AOD county partners actively participating in the

measurement: Healthy Stores for a Healthy Community Campaign.

Data Source:

Healthy Retailers Survey; developed by UC Davis' Center for Evaluation and Research, Tobacco Control Evaluation Center.

Description of Data:

The Healthy Stores for a Healthy Community Survey is a multi-module data collection tool that is designed to be used electronically on a handheld device, such as an Ipod. The alcohol module has 42 questions related to pricing, display, flavoring, and promotion in and around the store.

Data issues/caveats that affect outcome measures::

Data is being collected from July-September 2013. Lack of partnerships at local level and lack of buy-in from merchants and community partners can impact overall project.

Footnotes:

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$171,522,495		$207,611,313	$	$316,583,240	$	$
a. Pregnant Women and Women with Dependent Children*	$35,750,646		$	$	$22,996,000	$	$
b. All Other	$135,771,84		$207,611,31	$	$293,587,24	$	$
2. Substance Abuse Primary Prevention	$47,136,881		$	$3,686,811	$	$	$
3. Tuberculosis Services	$42,024		$	$	$	$	$
4. HIV Early Intervention Services	$11,784,220		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$5,198,787		$	$853,839	$5,105,760	$	$
11. Total	$235,684,407	$	$207,611,313	$4,540,650	$321,689,000	$	$

* Prevention other than primary prevention

Footnotes:

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$12,580,086
Specialized Outpatient Medical Services	0	0.00	$12,580,086
Acute Primary Care			$
General Health Screens, Tests and Immunizations			$
Comprehensive Care Management			$
Care coordination and Health Promotion			$
Comprehensive Transitional Care			$
Individual and Family Support			$
Referral to Community Services Dissemination			$
Prevention (Including Promotion)			$49,107,922
Screening, Brief Intervention and Referral to Treatment	0	0.00	$49,107,922

Brief Motivational Interviews			$
Screening and Brief Intervention for Tobacco Cessation			$
Parent Training			$
Facilitated Referrals			$
Relapse Prevention/Wellness Recovery Support			$
Warm Line			$
Substance Abuse (Primary Prevention)			$
Classroom and/or small group sessions (Education)			$
Media campaigns (Information Dissemination)			$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$
Parenting and family management (Education)			$
Education programs for youth groups (Education)			$
Community Service Activities (Alternatives)			$
Student Assistance Programs (Problem Identification and Referral)			$
Employee Assistance programs (Problem Identification and Referral)			$
Community Team Building (Community Based Process)			$

Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$
Engagement Services			$11,134,249
Assessment	0	0.00	$11,134,249
Specialized Evaluations (Psychological and Neurological)			$
Service Planning (including crisis planning)			$
Consumer/Family Education			$
Outreach			$
Outpatient Services			$36,661,297
Evidenced-based Therapies	0	0.00	$36,661,297
Group Therapy			$
Family Therapy			$
Multi-family Therapy			$
Consultation to Caregivers			$
Medication Services			$32,940
Medication Management	0	0.00	$32,940

Pharmacotherapy (including MAT)			$
Laboratory services			$
Community Support (Rehabilitative)			$11,862,024
Parent/Caregiver Support	0	0.00	$11,862,024
Skill Building (social, daily living, cognitive)			$
Case Management			$
Behavior Management			$
Supported Employment			$
Permanent Supported Housing			$
Recovery Housing			$
Therapeutic Mentoring			$
Traditional Healing Services			$
Recovery Supports			$1,896,091
Peer Support	0	0.00	$1,896,091
Recovery Support Coaching			$

Recovery Support Center Services			$
Supports for Self-directed Care			$
Other Supports (Habilitative)			$199,131
Personal Care	0	0.00	$199,131
Homemaker			$
Respite			$
Supported Education			$
Transportation			$
Assisted Living Services			$
Recreational Services			$
Trained Behavioral Health Interpreters			$
Interactive Communication Technology Devices			$
Intensive Support Services			$8,356,546
Substance Abuse Intensive Outpatient (IOP)	0	0.00	$8,356,546
Partial Hospital			$
Assertive Community Treatment			$

Intensive Home-based Services			$
Multi-systemic Therapy			$
Intensive Case Management			$
Out-of-Home Residential Services			$63,958,910
Children's Mental Health Residential Services	0	0.00	$63,958,910
Crisis Residential/Stabilization			$
Clinically Managed 24 Hour Care (SA)			$
Clinically Managed Medium Intensity Care (SA)			$
Adult Mental Health Residential			$
Youth Substance Abuse Residential Services			$
Therapeutic Foster Care			$
Acute Intensive Services			$
Mobile Crisis	0	0.00	$
Peer-based Crisis Services			$
Urgent Care			$

23-hour Observation Bed			$
Medically Monitored Intensive Inpatient (SA)			$
24/7 Crisis Hotline Services			$
Other (please list)			$32,276,134
Other (Various)	0	0.00	$30,382,462
System Improvement Activities	0	0.00	$1,893,672

Footnotes:

DHCS can only attempt to complete Table 3 at the broad category level with expenditures only. The expenditures by service were grouped into the categories required in Table 3. The data was entered into the first entry field within each category but do not reflect the amount of expenditures for the individual entry field.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 171,522,495	
2 . Substance Abuse Primary Prevention	$ 47,136,881	
3 . Tuberculosis Services	$ 42,024	
4 . HIV Early Intervention Services**	$ 11,784,220	
5 . Administration (SSA Level Only)	$ 5,198,787	
6. Total	$235,684,407	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$ 12,309,181	
	Selective	$ 0	
	Indicated	$ 0	
	Unspecified	$ 0	
	Total	$12,309,181	
Education	Universal	$ 5,454,769	
	Selective	$ 4,294,516	
	Indicated	$ 1,530,229	
	Unspecified	$ 0	
	Total	$11,279,514	
Alternatives	Universal	$ 7,081,364	
	Selective	$ 882,639	
	Indicated	$ 115,198	
	Unspecified	$ 0	
	Total	$8,079,201	
Problem Identification and Referral	Universal	$ 449,361	
	Selective	$ 781,249	
	Indicated	$ 466,811	
	Unspecified	$ 0	

	Total	$1,697,421	
Community-Based Process	Universal	$ 13,645,179	
	Selective	$ 1,389,418	
	Indicated	$ 108,718	
	Unspecified	$ 0	
	Total	$15,143,315	
Environmental	Universal	$ 4,068,256	
	Selective	$ 7,699	
	Indicated	$ 292	
	Unspecified	$ 0	
	Total	$4,076,247	
Section 1926 Tobacco	Universal	$ 0	
	Selective	$ 0	
	Indicated	$ 0	
	Unspecified	$ 2,000,000	
	Total	$2,000,000	
Other	Universal	$ 0	
	Selective	$ 0	
	Indicated	$ 0	
	Unspecified	$ 0	
	Total	$	
Total Prevention Expenditures	$54,584,879		
Total SABG Award*	$235,684,407		
Planned Primary Prevention Percentage	23.16 %		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Actual SAPT Block Grant expenditures for primary prevention were used to forecast the planned expenditure. SAPT Discretionary dollars are used for primary prevention in addition to the SAPT Primary Prevention Set-Aside. Consequently, the total planned expenditure for primary prevention exceeds the primary prevention amount noted in Table 4 ($47,136,881) by $7,447,998.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 26,658,957	
Universal Indirect	$ 16,349,153	
Selective	$ 7,355,521	
Indicated	$ 2,221,248	
Column Total	$52,584,879	
Total SABG Award*	$235,684,407	
Planned Primary Prevention Percentage	22.31 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Actual SAPT Block Grant expenditures for primary prevention were used to forecast the planned expenditure. SAPT Discretionary dollars are used for primary prevention in addition to the SAPT Primary Prevention Set-Aside. Consequently, the total planned expenditure for primary prevention exceeds the primary prevention amount noted in Table 4 ($47,136,881) by $5,447,998. The total expenditure in this table is $2 million less than Table 5a due to excluding the Section 1926 Tobacco dollars from this forecast. California does not align those dollars with IOM categories. Per Table 5a they were categorized as "unspecified".

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	b
Tobacco	e
Marijuana	e
Prescription Drugs	e
Cocaine	e
Heroin	e
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	b
Military Families	e
LGBTQ	e
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	b
Rural	e
Underserved Racial and Ethnic Minorities	e

Footnotes:

The Targeted Substance is based on California's statewide outcomes. The Targeted Populations are based on an analysis of the prevention data submitted by California's 58 counties.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$	$	$ 416,891	$416,891				
2. Quality Assurance	$	$	$ 2,435,755	$2,435,755				
3. Training (Post-Employment)	$	$	$ 290,048	$290,048				
4. Education (Pre-Employment)	$	$	$ 0	$				
5. Program Development	$	$	$ 232,809	$232,809				
6. Research and Evaluation	$	$	$ 1,368,294	$1,368,294				
7. Information Systems	$	$	$ 0	$				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$	$ 0	$				
9. Total	$	$	$4,743,797	$4,743,797				

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage SUD Services

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

The State of California is evaluating different scenarios in regard to the responsibilities and roles that the state’s Medicaid agency, acting as the State Mental Health Authority (SMHA) and substance use disorder (SUD) Single State Authority (SSA), will have on January 1, 2014. Previously, the SMHA and SSA were separate entities within the State, and the Medicaid agency only has taken on Medicaid-funded substance abuse treatment services very recently. Many of the affected processes and decisions are still under review, including services that both Medicaid and Qualified Health Plans (QHPs) will provide.

California, however, relies upon counties to deliver directly or contract for many health services, including substance use, subject to state oversight. It is the goal of the State to educate county administrators on any particular developments with regard to matters such as essential health benefits to encourage the most efficient use of those funds. There is also in place a monitoring approach for Medicaid-funded services. It is a multi-faceted approach that includes reviews of medical necessity, frequency of services, qualify of care, and cost reimbursement data. This is in addition to specific audits performed by the agency to identify waste, fraud, and abuse of the program.

These current efforts remain subject both to ongoing acts of the Executive Branch and the California Legislature, which has chosen to address some of these concerns in a Special Session that is anticipated to adjourn by October 1, 2013, as well as explicit guidance from the US Department of Health and Human Services in regard to both the expansion of Medi-Cal and the operation of Covered California, our health marketplace. California will submit a revised Block Grant Plan to address these issues when details are known.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Health Insurance Marketplaces

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

The State of California is evaluating different scenarios in regard to the responsibilities and roles that the state’s Medicaid agency, acting as the State Mental Health Authority (SMHA) and the substance use disorder Single State Authority (SSA), state health exchange, welfare agencies, and partners will have on January 1, 2014. The State, however, relies upon counties to directly deliver or contract for many health services, including substance use services. It is the goal of the State to educate county administrators on any particular developments regarding the most efficient and coordinated use of those funds.

California uses a specific methodology to estimate caseload for Medicaid-funded substance abuse treatment programs. This estimate is derived from quarterly data on unique clients. However, because counties have more discretion in allocating Block Grant funds, it is not possible to use this process to estimate the number of individuals served by the Block Grant in any given year.

In addition, California utilizes a completely separate certification system for its substance abuse providers as distinct from Medicaid. Thus, it is impossible to estimate which providers are enrolled in both systems. Various efforts at sampling both datasets have suggested that the incidence of a provider being certified in both systems is, at least for substance use, very low. As the Department is still evaluating different scenarios for the operation of the Medi-Cal program after January 1, 2014, it is unknown if such an estimate would be any easier to derive in future years.

These current systems and processes are subject both to ongoing acts of the Executive Branch and the California Legislature, which has chosen to address some of these concerns in a Special Session that is anticipated to adjourn by October 1, 2013, as well as explicit guidance from the US Department of Health and Human Services in regard to both the expansion of Medi-Cal and the operation of Covered California, our health marketplace. California will submit a revised Block Grant Plan to address these issues when details are known.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity

Notification
Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

Question 1: Does the state have a program integrity plan regarding the SABG?

No, the state has multiple processes and procedures identified in this section to ensure program integrity but we do not have a specific documented program integrity plan.

Question 2: Does the state have a specific staff person that is responsible for the state agency’s program integrity activities?

No, the state has multiple processes and procedures involving several units within DHCS that are identified in this section to ensure program integrity.

Question 3: What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

Budget Review
The Department of Health Care Services’ (DHCS) Program and Fiscal Policy Branch (PFPB) has the following monitoring and oversight practice in the area of budget review. In December of each year, PFPB uses the Quarterly Federal Financial Management Reports (QFFMR) to identify counties which are under-spending the SAPT BG funds allocated by PFPB. PFPB then contacts the substance use disorder County Administrator of the under-spending county to offer program technical assistance to help solve the under-spending problem. After determining that the county will be unable to spend certain SAPT BG funds, PFPB asks if the county wants to voluntarily return a specific amount of those funds. If a county voluntarily returns funds, PFPB re-distributes the funds to other counties which can fully spend the funds by the spending deadline. PFPB re-distributes the returned funds to only those counties with histories of fully spending their SAPT BG allocations. This practice re-distributes SAPT BG funds to counties which are in need of additional funding to provide substance use prevention and treatment services.

Claim/Payment Adjudication
There are no claims or payments related to SAPT Block Grant. DHCS' Fiscal Management and Accountability Branch (FMAB) updates the county contracts based on the annual county allocations that are disseminated.

Expenditure Report Analysis
The FMAB analysts review the county cost report to determine if the allocation of a specific funding line, which is identified by grant award, is expended over a two-year period. If the counties identify an expenditure over the allocated amount over the two-year period, the expenditure amount is reduced and offset with the expenditures of the new money. (Expenditures will never exceed the allocation -- the old money is expended first.)

Below are the instructions in the FMAB cost report procedures related to tracking SAPT Block Grant funds:

Step 1: Review for overspent amounts
Review the Prior Year Block Grant Allocation, Approved Costs and Advances Comparison Worksheet. Each negative amount in the "Cost Under/(Over) Allocation Amount" column indicates that the county has reported more costs (overspent) to the prior year SAPT funding category identified than remained after the amount they expended in FY 2010-2011. Note: For each overspent category and amount; the county will need to identify changes on the Fiscal Detail to reduce their FFY 2011 SAPT expenditures to the allocated amount. Most often, this will involve shifting the excess amount from the overspent prior year (FFY 2011) SAPT block grant funding line (50-11) to the corresponding current year (FFY 2012) SAPT block grant funding line (50-12). However, if no current year funds are available in the corresponding category, the county will need to identify a different funding source to cover these costs.
TIP: Reduce the xx-11 expenditure and replace with xx-12 or some other funding source as directed by the county. Document all changes.

Step 2: Review for under-spent amounts
Review the Prior Year Block Grant Allocation, Approved Costs and Advances Comparison Worksheet. Each positive amount in the "Cost Under/(Over) Allocation Amount" column indicates that the county has not fully expended (under-spent) the funds remaining in the prior year SAPT funding category identified for that row after the amount they expended in FY 2010-2011. Note: For each under-spent category and amount; the county will need to identify changes in the Fiscal Detail, to fully expend the unspent funds. Most often, this will involve shifting the amount necessary to fully expend the under-spent funds from the corresponding current year (FFY 2012) SAPT block grant funding line to the under-spent prior year (FFY 2011) SAPT block grant funding line; other combinations are possible. Because federal law prohibits the supplantation of state or local funds with federal funds, it is possible that the county may not be

able to fully expend the prior year SAPT block grant funds if current year SAPT block grant funds usable for the same purpose are not available.
TIP: Reduce the xx-12 expenditure and replace with xx-11 to fully expend all SAPT monies. This is done at the direction of the county. Document all changes.

Once all changes have been documented and made in ADP's Paradox review Over / Under expenditures. Repeat if necessary to zero balance all Award Year, FY 2011 monies. (Immediately notify supervisor for further instruction, if the county is unable to fully expend.)

The example below is provided to demonstrate what overspent and under-spent amounts would look like:

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Calaveras

2010-11 NNA/Drug Medi-Cal Cost V.0

Prior Year Block Grant Allocation, Approved Cost and Advances Comparison Worksheet

SAPT - FFY 2010 Award - Fed 93.959

Funds	A Allocations FY 09-10 V1	B Allocations FY 10-11 V0	C Allocations Total (A+B)	D Cost FY 09-10 V0	E Cost FY 10-11 V0	F Cost Total (D+E)	G Cost Under/(Over) Allocation Amount (C-F)	H Advances FY 09-10 V0	I Advances FY 10-11 V0	J Advances Total (H+I)
SAPT Female Offender - FFY 2010	0		0			0	0	0	0	0
SAPT Discretionary - FFY 2010	308,769		308,769	231,577	361,966	593,543	-284,774	308,769	0	308,769
SAPT Adolescent/Youth Tmt. Prog. - FFY 2010	9,551		9,551	7,163	7,163	14,326	-4,775	9,551	0	9,551
SAPT Friday Night Live - FFY 2010	3,000	0	3,000			0	3,000	3,000	0	3,000
SAPT Club Live - FFY 2010	3,000		3,000			0	3,000	3,000	0	3,000
SAPT Primary Prevention - FFY 2010	81,977		81,977	14,498	14,498	28,996	52,981	81,977	0	81,977
SAPT HIV Set Aside - FFY 2010	0		0			0	0	0	0	0
SAPT Perinatal Projects - FFY 2010	4,978		4,978			0	4,978	4,978	0	4,978
SAPT Special Projects - FFY 2010	0		0			0	0	0	0	0
SAPT SATTA-Substance Abuse Testing/Discretionary - FFY 2010	21,416		21,416			0	21,416	21,416	0	21,416
Total:	432,691	0	432,691	253,238	383,627	636,865	-204,174	432,691	0	432,691

Overspent Amounts

Under-spent Amounts

Each over / under entry should equal zero.

Compliance reviews

The Department of Health Care Services' (DHCS) Performance Management Branch, County Monitoring Unit (CMU) has primary responsibility to monitor counties' adherence to the State-County contract requirements and the terms of the SAPT Block Grant. This is accomplished by an annual review of each county which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 45 and CFR 42.

The county monitoring process has been designed to operate in three-year cycles with alternating site and desk reviews conducted to ensure counties are in compliance with the SAPT BG and the State-County contract requirements. This process is completed through the use of a monitoring instrument that is revised annually to encompass different components of the SAPT BG and the State-County contract requirements, as well as other programmatic areas the Department deems necessary to oversee. Based on compliance rates or emphasis areas, some components may be reviewed annually rather than once in the three-year cycle. However, at minimum, all requirements are monitored and reviewed at least once during the three-year time period.

During the annual review process CMU collects information on the counties' adherence to the above requirements by administering a monitoring instrument to County Alcohol and Drug Program Administrators. The instrument elicits qualitative responses as well as certifications from County Administrators and their staff who directly oversee the provision of substance use services at the local level. The Department's monitoring analysts identify programmatic strengths as well as areas of deficiencies or concerns that ultimately may affect AOD services provided within the county. Once a county review has been completed, the monitoring analyst issues a report identifying compliance deficiencies, advisory recommendations, required follow-up and in some instances selected county highlights. Compliance deficiencies are classified as discoveries that within the context of the review process represent deficiencies, errors, or unacceptable program practices that could characterize a significant risk to program integrity. Advisory recommendations are suggestions put forth to improve county functions and AOD services. Counties are required to respond to the findings identified in the report with a corrective action plan documenting how the findings will be resolved.

County monitoring analysts also serve as a resource liaison between the Department and county AOD Administrators. It is the responsibility of the monitoring analyst to ensure counties receive requested technical assistance (TA) needed to improve services at the local level. This is accomplished by connecting counties with the appropriate subject matter experts within the Department and/or contracted TA providers.

While the County Monitoring process primarily serves to satisfy a compliance function, it also provides valuable data for program oversight and improvement

as well as long term planning at the state level by providing a snapshot of different components of the AOD system statewide.

To ensure that the 20 percent set aside for prevention is met, the Department of Health Care Services' (DHCS) Policy and Prevention Branch, Prevention Quality Assurance and Support Unit, requires counties to upload an electronic copy of their Strategic Prevention Plan into California Outcomes Measurement Service for Prevention (CalOMS Pv) and input the planning data including goals and objectives. The objectives are assigned to the prevention-funded provider sites and all services/activities are linked to objectives when they are reported. Narrative reports detailing the county's progress in achieving the goals and objectives within the plan are an annual requirement. The Evaluation Module in CalOMS Pv is designed for the submission of these progress reports.

All SAPT primary prevention-funded sites are required to use CalOMS Pv to submit service/activity data on a monthly basis. This is descriptive data that provides ADP details of how the prevention dollars are being utilized. The counties are required to review the data for accuracy and release it to ADP on a quarterly basis. After the data has been released, ADP staff conducts a review to ensure the services correlate with the Strategic Prevention Plan and the data elements are accurate. Staff communicate issues to the county, provide assistance where needed, and ensure corrections are completed.

To ensure accountability and full expenditure of the SAPT prevention dollars, PSB engages in a reconciliation process in which budget and cost data are utilized. PSB staff ensure that all funded providers report data in CalOMS Pv, the allocations for each service code coincides with the data reported in CalOMS Pv, and the total SAPT 20% Primary Prevention Set-Aside allocation for each county is equal to the amount identified in the cost data. The county is alerted of any discrepancies and offered assistance where needed.

Ongoing training and technical assistance for prevention planning, programming and the use of CalOMS Pv is continuously offered and available to the counties and provider sites by ADP prevention staff and contractors. PSB funds two technical assistance and training contracts: the Community Prevention Initiative (CPI) contract and the Friday Night Live Technical Assistance and Training contract. Friday Night Live is a statewide youth development program created and funded by ADP. The no-cost services of both contractors are available to all county and provider sites as well as community organizations. ADP Prevention staff provides one-on-one county support, conduct monthly web-based new user/refresher trainings for CalOMS Pv data reporting, and field the telephone calls and e-mails that come into the CalOMS Pv Help Desk.

Encounter/utilization/performance analysis

The Department of Health Care Services (DHCS), Substance Use Disorders (SUD) Prevention, Treatment, and Recovery Services Division (PTRSD), Office

of Applied Research and Analysis (OARA) does not collect encounter or utilization data on substance use disorder prevention or treatment services. The OARA does not conduct monitoring for appropriate use of funds, but rather provides research and evaluation support to internal programs conducting such monitoring. The primary databases used for collection, reporting, and monitoring substance use disorder prevention and treatment services are the California Outcomes Measurement System – Prevention (CalOMS-Pv) and CalOMS-Treatment (CalOMS-Tx). These databases were designed primarily to track outcomes of prevention and treatment services rather than prevention and treatment service utilization or program performance. Therefore, our ability to conduct in-depth analysis of utilization and performance is limited.
Following are some examples of the types of data analyzed for program performance and outcomes:

- Prevention services by prevention strategy type;
- Number and percent of persons served in prevention programs;
- Number and percent of persons served in treatment services;
- Admissions to treatment by service type or primary drug type;
- Percent of discharges by length of stay in treatment;
- Percent of discharges resulting in transfer to another service; and
- Changes between admission and discharge in alcohol and other drug use, participation in social support, and improvements in other life domains.

In addition to the examples above, OARA, and other program staff within the SUD-PTRSD work with the Data/Outcome Committee of the County Alcohol and Drug Program Administrators' Association of California on an ongoing basis to collaboratively develop performance and outcome benchmark criteria for substance use treatment services.

Audits
The Department of Health Care Services' (DHCS) Financial Audit Branch (FAB) of the Division of Administration role and responsibility includes addressing fraud risk and program integrity. FAB addresses these concerns by ensuring counties and providers comply with generally accepted government auditing standards in addition to compliance with all laws, regulations, and policies that promote fiscal and program integrity within our service delivery system.
FAB meets the requirement for determining appropriate use of Block Grant funds through its oversight and follow-up responsibility of the A-133 Single Audits, in which, all 58 counties are required to provide annual and independent audits. In addition, FAB also selects a sample of the counties through risk analysis, program referrals and, more recently, allocation amounts to conduct program specific audits of the Block Grant funds.

The scope of these financial-related and program specific audits, regardless of selection means, is specifically designed to address the appropriate use of Block Grant funds as they relate to services provided for alcohol and drug programs. In

instances when it has been determined that overpayments have been made, the recovery of the overpayments generally result in amounts being returned to the Federal Government.

In addition, we do not perform “Fraud” audits; however, should we have any reason to suspect fraud during the course of our routine financial and performance audit, we would refer the matter to the Department of Justice for fraud investigation.

The audit measures for program integrity activities established for the State and for DHCS’s FAB are designed to be proactive as a deterrent to counties and providers for the mismanagement and/or misuse of SAPT Block Grant Funds. To that extent, we have been and will continue to be an integral part of designing systems and processes that provide sufficient data for oversight and continue to identify risks.

Question 4: How does the state ensure that the allocation methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

In 1997, the California Department of Alcohol and Drug Programs (ADP) established a Policy Forum consisting of representatives of ADP, the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the ADP Director’s Advisory Council, and constituency groups for under-served populations. One purpose of the Policy Forum was to identify issues relating to ADP’s allocation of State and federal funds to counties. To resolve allocation issues, ADP, in conjunction with CADPAAC, developed a new allocation methodology for PFPB to allocate SAPT BG funds (excluding HIV Set-Aside funds) to counties. The methodology was first used in State Fiscal Year (FY) 1999-2000. For each $1,000,000 of SAPT BG funds to be allocated, the methodology provides $2,500 to each of the 57 California counties. Two counties are combined through a Joint Powers Agreement and provide substance use disorder services as one organization. The methodology then allocates the remainder to each county per capita, meaning the ratio of the county’s population to the State’s total population.

The Program and Fiscal Policy Branch (PFPB) uses a different methodology to allocate SAPT BG HIV Set-Aside funds to participating counties. The methodology uses weighted, needs-based factors; for example, People Living with HIV and AIDS (excluding prison cases); people living below the federal poverty level; and African American and Hispanic populations. The methodology then adjusts allocations so that each participating county receives an allocation of at least $7,500. PFPB and CADPAAC representatives determined that $7,500 was the minimum that a county needed to administer HIV services. This methodology ensures that the allocation of SAPT BG HIV funds to each

participating county is based on that county's HIV need, and is based on the minimum funds needed to administer HIV services.

PFPB maintains a Fiscal Work Group (FWG) consisting of PFPB staff, CADPAAC representatives and service provider representatives. PFPB leads monthly conference calls with the FWG to discuss and solve fiscal and programmatic issues. Before PFPB completes SAPT BG allocations to counties, it discusses any allocation issues with the FWG, and the FWG makes recommendations for State Executive Staff management.

These practices ensure continuing State/County agreement in how the PFPB allocates SAPT BG funds to counties, and ensure that the allocation methodologies are reasonable and appropriate for the type and quantity of services delivered.

Question 5: How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

SUD prevention, early intervention, treatment, and recovery services are provided to clients through a partnership between the State and counties. Each of the 58 county SUD programs serve as brokers of service, and the counties in turn provide services to clients directly or by contracting with local service providers. In partnership with the County Alcohol and Drug Program Administrators Association of California (CADPAAC), a statewide organization whose members represent California's 58 counties, and in cooperation with numerous private and public agencies, organizations and individuals, DHCS provides leadership and coordination in the planning, capacity building, development, implementation and evaluation of a comprehensive statewide SUD prevention, treatment and recovery system. Throughout these functions DHCS works to ensure compliance with federal requirements through a multi-faceted approach of county monitoring, technical assistance licensing, certification, standards and guidelines.

County Monitoring

The Department of Health Care Services' (DHCS) Performance Management Branch, County Monitoring Unit (CMU) has primary responsibility to monitor counties' adherence to the State-County contract requirements and the terms of the SAPT Block Grant. This is accomplished by an annual review of each county which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 45 and CFR 42.

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annually to encompass different components of the SAPT BG and the State-County contract requirements, as well as other programmatic areas the Department deems necessary to oversee. Based on compliance rates or emphasis areas, some components may be reviewed annually rather than once in the three-year cycle. However, at minimum, all requirements are monitored and reviewed at least once during the three-year time period.

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While the County Monitoring process primarily serves to satisfy a compliance function, it also provides valuable data for program oversight and improvement as well as long term planning at the state level by providing a snapshot of different components of the AOD system statewide.

County monitoring analysts also serve as a resource liaison between the Department and county AOD Administrators. It is the responsibility of the monitoring analyst to ensure counties receive requested technical assistance (TA) needed to improve services at the local level. This is accomplished by connecting counties with the appropriate subject matter experts within the Department and/or contracted TA providers.

Technical Assistance

Program Support and Grants Management

The Program Support and Grants Management (PSGM) Branch provides counties and providers technical assistance (TA) support with their compliance and quality improvement needs. It is comprised of four units: Office of Grants Management, Office of Women's and Perinatal Services (OWPS), Health Access and the California Access to Recovery Effort (CARE) (ATR III). Within PSGM certain staff are responsible for researching and providing support for specific populations and subject matter areas including: women, youth, co-occurring

disorders, older adult, veterans, Native Americans, as well as culturally and trauma informed practices.

An example of the type of program support and TA provided by the branch is the Office of Women's and Perinatal Services (OWPS). OWPS provides in-depth program support and technical assistance to counties and providers focused on the improvement of AOD services to women and their children in California. The support ranges from TA to assist counties and providers in meeting federal and state perinatal services requirements to in-depth support on improving overall program quality and performance. OWPS provides assistance based on the results of an in-depth assessment to ensure that the assistance is directly correlated to the program's areas of need.

Prevention

DHCS Policy and Prevention Branch (PPB) Analysts provide support to their assigned counties to ensure that services are reported in CalOMS Pv as required, that the programs are implemented with fidelity, and that providers work with program developers and TA providers if adaptations are necessary.

Licensing, Certification, Standards and Guidelines

DHCS has the sole authority in state government to license adult SUD recovery or treatment facilities and assuring that quality services are provided to all program participants in a safe and healthful environment.

Licensed Residential Alcohol and Other Drug (AOD) Programs

Site inspections of licensed residential AOD programs are performed at least once during every two-year period of licensure. Licensing standards for residential AOD programs are promulgated as regulations in the California Code of Regulations (CCR). Chapter 5, Title 9 of the CCR establishes the minimum requirement for site inspections at every two years.

Certified AOD Residential and Nonresidential Programs

Site inspections of certified AOD residential and nonresidential programs are conducted at least once during the two-year period of certification. Program certification is voluntary.

DHCS has a contract with the Alcohol and Drug Policy Institute to provide programmatic guidance to prospective providers who want to become licensed or certified by DHCS.

Narcotic Treatment Programs

A licensed Narcotic Treatment Program is subject to site inspection by DHCS without prior notice at least annually.

Independent Peer Review
The independent peer review function is the responsibility of the SUD Program Compliance Division in DHCS. The independent peer review contractor is required to submit monthly, quarterly, and final reports to DHCS.

Perinatal Services Network Guidelines
The Perinatal Services Network Guidelines outlines the requirements for Perinatal Services Network programs funded with SAPT Block Grant Perinatal Set-Aside funds. The counties adherence to the guidelines is monitored annually and technical assistance is provided to assist counties in meeting regulation requirements.

Youth Treatment Guidelines
DHCS has established Youth Treatment Guidelines that focus on ways to specialize treatment for youth and provide guidance to providers as they develop and operate their youth treatment services. The Youth Treatment Guidelines are included in DHCS' contract with counties, and most counties require that the providers with whom they subcontract must comply with the best practices contained within the guidelines. This helps ensure that youth intervention and treatment services are safe, appropriate and cost effective.

Question 6: How will that state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

It is expected that the public health and behavioral health systems will ultimately be reaching far more individuals and families in need of substance use and mental health services as a result of the ACA. With the potential of insurers paying for substance use services for the large influx of insured in California, there is a need to build capacity in systems that traditionally have not provided substance use services to the extent that it may be required under health care reform. Likewise it will be important to build or expand the capacity of the existing AOD service system to bill private insurance or Medi-Cal for services.

The State of California is evaluating different scenarios in regard to the responsibilities and roles that the state's Medicaid agency, acting as the State Mental Health Authority (SMHA) and substance use disorder (SUD) Single State Authority (SSA), will have on January 1, 2014. Previously, the SMHA and SSA were separate entities within the State, and the Medicaid agency only has taken on Medicaid-funded substance abuse treatment services very recently. Many of the affected processes and decisions are still under review, including services that both Medicaid and Qualified Health Plans (QHPs) will provide.

California, however, relies upon counties to deliver directly or contract for many health services, including substance use, subject to state oversight. It is the goal of the State to educate county administrators on any particular developments

with regard to matters such as essential health benefits to encourage the most efficient use of those funds. There is also in place a monitoring approach for Medicaid-funded services. It is a multi-faceted approach that includes reviews of medical necessity, frequency of services, qualify of care, and cost reimbursement data. This is in addition to specific audits performed by the agency to identify waste, fraud, and abuse of the program.

These current efforts remain subject both to ongoing acts of the Executive Branch and the California Legislature, which has chosen to address some of these concerns in a Special Session that is anticipated to adjourn by October 1, 2013, as well as explicit guidance from the US Department of Health and Human Services in regard to both the expansion of Medi-Cal and the operation of Covered California, our health marketplace.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

1. ***Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?***

Program Support and Grants Management Branch

The Program Support and Grants Management (PSGM) Brach provides counties and providers technical assistance (TA) support with their compliance and quality improvement needs. It is comprised of four units: Office of Grants Management, Office of Women’s and Perinatal Services (OWPS), Health Access and the California Access to Recovery Effort (CARE) (ATR III). A large portion of the branch’s TA functions include the tracking and disseminating of evidence-based and promising practices to counties and providers. Within PSGM certain staff are responsible for researching and providing support for specific populations and subject matter areas including: women, youth, co-occurring disorders, older adult, veterans, Native Americans, as well as culturally and trauma informed practices.

DHCS Resource Center

The DHCS Resource center maintains a comprehensive collection of alcohol, tobacco, and other drug prevention and treatment information. The Resource Center includes both lending services and a clearinghouse.

Prevention

DHCS Policy and Prevention Branch (PPB) Analysts provide support to their assigned counties to ensure that evidence-based primary prevention services are reported in CalOMS Pv as required, that the programs are implemented with fidelity, and that providers work with program developers and TA providers if adaptations are necessary.

The PPB supports programs developed in California that are working toward obtaining national recognition as evidence-based programs on SAMHSA’s National Registry of Evidence-Based Programs list. In addition, PPB staff work with the local innovative programs in California that are privileged to be part of SAMHSA’s Service to Science Academy.

2. ***Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?***

a) What information did you use?

A variety of sources to research evidence-based and promising practices including: the National Registry of Evidence-based Programs and Practices (NREPP), county reported evidence-based practice use, conferences, webinars, trainings, as well as discussions with other states, counties and programs.

b) What information was most useful?

The National Registry of Evidence-based Programs and Practices (NREPP), county reported evidence-based practice use, conferences, webinars, trainings, as well as discussions with other states, counties and programs.

3. How have you used information regarding evidence-based practices?

Program Support and Grants Management Branch
The PSGM Branch disseminates evidence-based and promising practice information through technical assistance provided to counties and providers, resource reports, through data driven outreach, and through the Office of Women's and Perinatal Services resource lending library.

An example of the type of program support and TA provided by the branch on evidence based practices (EBPs) is the TA provided by the Office of Women's and Perinatal Services which promotes the use of EPBs tailored to a counties and/or programs need. In State Fiscal Year 2012-13, the Office of Women's and Perinatal Services launched its Uplifting Services Project. The Uplifting Services Project is dedicated to the provision of in-depth technical assistance to counties and providers to improve overall program quality and increase the programs ability to successfully meet the needs of women and their children. OWPS assists the counties in successfully implementing quality improvement change by supporting counties through an assessment, planning, implementation, evaluation and sustainability process. Throughout this process, based on the results of the assessment, OWPS provides assistance and resource training on evidence-based and promising practices that directly correlate to the program's areas of need. Common areas that evidence-based and promising practices information are disseminated on include: drug of choice, screening, brief intervention and referral to treatment, therapeutic services for children, parenting skills, life skills, trauma-informed care, community collaboration and prevention activities.

OWPS keeps a lending library with a collection of up-to-date evidence-based and promising practices resources specific to women and children needs. This lending library allows programs to review resources prior to making county purchasing decisions to ensure the practice will fit the needs of their clients. Of the funds used to purchase materials for the OWPS resource library in the current 2012-13 state fiscal year 73% of those funds have been used to purchase materials for programs listed on the National Registry of Evidence-based Programs and Practice registry. The remaining resources purchased are comprised of promising practices staff have researched and learned

about through conferences, webinars, trainings, as well as discussions with other states, counties and programs.

In addition to PSGM Branch efforts the DHCS Resource Center also works to disseminate evidence-based and promising practices.

DHCS Resource Center
The Resource Center lending services loans materials to the public and government agencies. Materials include books, journals, reports, and videos specializing in alcohol, tobacco and other drugs. Many evidence-based and promising practices are available for lending through this service.

The clearinghouse makes materials available at no cost to the public. Copies of SAMHSA's Treatment Improvement Protocol (TIP) Series, Technical Assistance Publications (TAPs), and Evidence-Based Practices KITs are available to the public along with other drug booklets, pamphlets, research papers, posters, technical manuals.

The Resource Center uses social media to publicize the resources it has available through Facebook and Twitter. Resource Center staff also disseminates information at conferences throughout the state. The Resource Center works to provide information to educate public health agencies and provides resource for community health fairs and California school based health clinics.

Culturally and Linguistically Appropriate Services (CLAS)
ADP has developed a Cultural Competency Quality Improvement (CCQI) Strategic Plan which will be incorporated into DHCS' business and operational practices the CLAS standards developed by the Office of Minority Health, U.S. Department of Health and Human Services. To ensure that CLAS standards are effectively implemented in the field, DHCS has launched the Community Alliance contract for CLAS, a multiyear effort that includes the following deliverables which disseminate evidence-based and promising practices to the field:

- *Training and TA*
  Provide a combination of comprehensive cultural competence training and TA. This includes workforce training on the cultural competence necessary to ensure the best client outcomes for communities with specialized characteristics, such as gender, ethnicity, veteran status, LGBT and intersex status, as well as other target populations.

- *CLAS Guidelines Development*
  Develop and disseminate CLAS guidelines that identify and document evidence-based and best practice models for cultural and linguistic competency for SUD agencies.

- *Research/Clearinghouse*
  Serves as a clearinghouse for research and resources on evidence-based and promising practice models in cultural competence related to the provision of SUD services and improving client outcomes.

Statewide SUD Conference
In 2012 ADP hosted its fifth statewide conference; the theme and focus of the conference was, *Journey to Integration: Opportunities and Challenges*. The conference focused on innovative practices for integrating addiction prevention, treatment and recovery services with primary care and mental health services, social services, education, and criminal justice systems. In addition to its focus on integration, sessions and workgroups were provided that addressed evidence-based and promising practices for alcohol and other drug prevention, treatment and recovery support including specific populations in California: Native Americans, military veterans, women, and youth.

The expectation is that DHCS will continue to convene the annual Statewide SUD Conference.

California Substance Abuse Research Consortium
It is expected that DHCS will continue to sponsor the California Substance Abuse Research Consortium (SARC) meetings which have brought attention to treatment issues, trends, and practices across the state. The SARC meeting series offers an opportunity for discussion of the latest promising prevention and treatment practices, collaboration opportunities, and other relevant substance use disorder-related topics.

SARC meetings over the past years have included presentations on: use of data and evidence-based practices, implementation of performance models, motivational interviewing, screening, brief intervention, and referral to treatment (SBIRT), Network for the Improvement of Addiction Treatment (NIATx), indicated prevention, medical assisted treatment, trauma-informed approaches, adverse childhood events, Fetal Alcohol Spectrum Disorders (FASD), and culturally and logistically appropriate services.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
The State Medical Director has offered trainings on SBIRT, Medical Assisted Treatment and other topics in substance abuse treatment. The SBIRT training including culturally and linguistically appropriate practices was disseminated in several different formats to counties and providers.

Cross Agency Collaboration
DHCS participates in a variety of forums that promote the cross agency education of evidence-based and promising practice for our shared population.

- *Child Welfare Council*
  The California Child Welfare Council was established by the Child Welfare Leadership and Accountability Act of 2006 (Welfare and Institutions Code Sections 16540 – 16545) and serves as an advisory body responsible for improving the

collaboration and processes of the multiple agencies and the courts that serve the children in the child welfare system. The Council is co-chaired by the Secretary of the California Health and Human Services Agency and the designee of the Chief Justice of the California Supreme Court, and membership is comprised of state departments, county departments, nonprofit service providers, advocates, parents and former foster youth. The Council is charged with monitoring and reporting on program performance and the extent to which the agencies and courts are responsive to the needs of children in their joint care.

The Council accomplishes much of its work through four standing committees: Prevention and Early Intervention; Permanency; Child Development and Successful Youth Transitions; and Data Linkage and Information Sharing. Much of these committees work surrounds the identification and recommendation of evidence-based and promising practices that are a best fit for the needs of children in California.

- *State Interagency Team for Children and Youth (SIT)*
  The State Interagency Team for Children and Youth (SIT) is an ad hoc group of departments, convening for the purpose of assisting in program launching, program improvements; coordinating state department efforts to support county programs and special projects for children, youth and families in California. Comprised of deputy directors from multiple state agencies and departments; representation includes the Departments of Social Services, Education, Public Health, Health Care Services, Developmental Services and Employment Development, Corrections and Rehabilitation, the Administrative Office of the Courts, and the California Workforce Investment Board.

  DHCS currently participates in two work groups established by the SIT: Department of Public Health (DPH) California Home Visitation Work Group and the Work Group to Eliminate Disparities; each work group provides an opportunity to learn and educate other departments within the state of evidence-based and promising practices which can improve services throughout the State.

Prevention

DHCS Policy and Prevention Branch (PPB) Analysts provide support to their assigned counties to ensure that evidence-based primary prevention services are reported in CalOMS Pv as required, that the programs are implemented with fidelity, and that providers work with program developers and TA providers if adaptations are necessary.

The PPB supports programs developed in California that are working toward obtaining national recognition as evidence-based programs on SAMHSA's National Registry of Evidence-Based Programs list. In addition, PPB staff work with the local innovative programs in California that are privileged to be part of SAMHSA's Service to Science Academy.

Through the Community Prevention Initiative (CPI) Technical Assistance and Training contract, the Center for Applied Research Solutions (CARS) conducts webinars and

trainings on the evolution, strategy selection, and implementation of the COMMITTED and Brief Risk Reduction Interview and Intervention Model (BRRIIM) models as well as other promising practices and evidence-based strategies.

The Governor's Prevention Advisory Council (GPAC) convened a workgroup to gain an understanding of the role of EBP in alcohol and other drug (AOD) prevention within GPAC agencies. Two phases of assessments were conducted. The first phase was conducted to identify use of "evidence-based" standards or criteria policy, programs or services provided or funded by the GPAC member agencies. The second phase was a more in-depth survey about how evidence-based practices are used across systems. The results of both phases of investigations are available at http://www.adp.ca.gov/Prevention/gpac/ebp.shtml. At the October 2012 meeting of the GPAC, the Council explored the similarities and differences of programs identified as evidence-based across multiple disciplines such as education and public health.

a) Educating State Medicaid agencies and other purchasers regarding this information?

In addition to our program support, collaborative work, supported contracts and trainings the Resource Center staff also disseminates information at conferences throughout the state. The Resource Center works to provide information to educate public health agencies and provides resource for community health fairs and California school based health clinics.

The transfer of the Department of Alcohol and Drug Programs (ADP) SAPT BG functions to the Department of Health Care Services (DHCS), which administers the California Medicaid Program, provides for an enhanced opportunity for education on evidence-based and promising practices with the State Medicaid and SAPT BG program in the same Department.

b) Making decisions about what you buy with funds that are under your control?

Prior to July 1, 2013, ADP has taken a multifaceted approach to researching and disseminating evidence-based and promising practices throughout the State. From the purchasing of resource materials to ADP supported contracts and trainings, promoting the use of evidence-based and promising practices have permeated ADPs purchase decision making processes. These efforts will continue under DHCS.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

Section G: Quality is requested not required, therefore California has elected not to complete this section.
Pages 24 and 73 of the FY 2014-2015 SABG application discuss the Behavioral Health Barometer and indicate that it is under development by SAMHSA. According to SAMHSA, the barometer is in the final stages of clearance and should be available the summer of 2013.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

Notification
Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Our Licensing regulations require providers to perform a health screening and to record any health problems or conditions which require medical attention. Additionally, California’s voluntary Certification regulations require certificated programs to maintain documentation of psychological, social, physical, and/or behavioral problems related to alcohol and other drug (AOD) use. Particularly in women, such problems are frequently connected to experiences of trauma.

In the presentations at the ADP-sponsored series of trauma trainings in 2009 (please see question 4) the universal use of trauma assessments and the implementation of de-escalation and safety plans as foundations in creating trauma informed care systems was recommended. The training encouraged providers to undertake a trauma assessment for clients in order to provide context for current symptoms and as a guide to appropriate clinical approaches and recovery progress.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

Although our regulations do not specifically call for trauma referrals, the Licensing regulations do dictate that treatment providers shall make referrals to appropriate services identified in the health screening. Thus, programs have the latitude to do make such referrals.

In May 2007, ADP committed, as one of its pinnacle priorities, to develop gender-responsive, trauma-informed treatment guidelines for programs serving women, based on the substantial body of research identifying particular characteristics of women with substance use disorders (SUDs), frequently including a history of trauma. Consequently, in an effort to promote integrated programming approaches based on theories that fit the psychological, social, and developmental needs of females, a Women’s Treatment Guidelines Work Group developed guidelines calling for programming approaches that are relational and strength-based, trauma-informed, culturally competent, and involve healing of the family unit.

ADP hosted the work group, which was comprised of individuals who have a level of expertise and working knowledge of women’s services. The work group formulated recommendations in seven core competencies as basic elements essential for any program providing AOD treatment services to women. One of the core competencies identified by the Women’s Treatment Guidelines Work Group is “Trauma-Informed/Trauma-Specific”. The document, “Women's Treatment Guidelines – Core Competencies for All Programs Serving Women” is available via the former ADP website at http://www.adp.ca.gov/women/w_reports.shtml (please note, the

pertinent material on the former ADP website will be transferred to the DHCS website over the next few months).

"Women's Treatment Guidelines – Core Competencies for All Programs Serving Women" (issued December 2007) states that a program with trauma-informed/trauma-specific competency, "has a commitment to awareness and understanding of the prevalence of historical and current trauma, its impact on women and a further commitment to not re-traumatize or do further harm through interventions, policies or procedures."

ADP had circulated the guidelines to all county alcohol and other drugs (AOD) administrators and made the guidelines widely available to treatment providers. Criteria for a trauma-informed/trauma-specific program are identified:

- utilizes curriculum that is focused on trauma issues;
- conducts a trauma assessment (expectation, not exception);
- provides staff training (personnel files/documentation);
- conducts ongoing evaluation and quality assurance;
- solicits client feedback through focus groups or surveys.

3. Does your state have any policies that promote the provision of trauma-informed care?

The "Women's Treatment Guidelines - Core Competencies for All Programs Serving Women" is one such policy.

Following up on the screening mentioned above (item 1), which may include trauma screening, some programs in California have developed improved services through evidence-based practices such as increased mental health services and trauma services. DHCS will continue to encourage such voluntary trauma services and treatment through information and resources provided by the Department. On the former ADP website, "Substance Abuse Treatment Services For Women: A Review Of Policy Initiatives and Recent Research" offers information about the high prevalence of childhood and adult trauma exposure and/or PTSD among women entering into SUD treatment. Additionally, it references evidence that women who received trauma-informed treatment had better outcomes compared with those who received standard treatment. It also specifically identifies several evidence-based SUD treatment interventions that integrate treatment for trauma.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

In 2009 ADP co-operated with numerous other sponsors to provide a series of regional trainings on trauma and trauma-informed treatment. This training was designed particularly to provide current knowledge on trauma and its effect on the clients that SUD treatment and AOD prevention providers serve. The presentations, which continue to be available at http://www.cce.csus.edu/conferences/adp/rttic09/handouts.htm, encouraged providers to begin to change by identifying the principles that contribute to trauma informed environments and implementing these principles.

DHCS will continue to focus evidence-based trauma-specific interventions on women's treatment in general and perinatal treatment in particular.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Through a Department contract, all SUD treatment providers can access free technical assistance (TA) in a wide range of Culturally and Linguistically Appropriate Services. Training in trauma-specific interventions is available under that contract, as well as under another general TA contract. Both contracts provide for on-site, local, and telephonic assistance, as appropriate.

Additionally, as part of DHCS monitoring of county compliance with the Substance Abuse Prevention and Treatment (SAPT) Block grant, county contacts are encouraged to indicate if they feel the need for TA in a number of areas, including trauma-informed services. The DHCS employees in the Program Support and Grants Management branch, with subject matter expertise, provide requested specialized TA through telephone and email contact.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Yes, individuals involved in California’s Adult and Juvenile Justice system will be able to enroll in the same manner as any other citizen of the state will, provided criteria for eligibility is met. Specific enrollment plans being developed for offenders leaving the correctional system and as part of their post-release service planning would be determined by the California Department of Corrections and Rehabilitation (CDCR) and not the Single State Authority (SSA) for substance use disorder services.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Screening and services can be provided to individuals with substance use disorder issues facing criminal proceedings as part of the state’s Penal Code 1000 Drug Diversion or differed entry of judgment programs. In addition, California’s Drug Court programs also offer screening and services to those offenders that meet the criteria for Drug Court services. Screening services for each program include but are not limited to initial assessment of individual, counseling and outpatient or residential substance use disorder treatment (depending on the level of treatment needed), and in Drug Court programs, court supervision of the individual.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

DHCS, the SSA for substance use disorder services, has developed linkages with the state’s correctional system (CDCR) via county and provider level treatment services made available through various funding streams. California passed Assembly Bill 900 in 2007 which re-focused correctional efforts to use innovative and evidence-based programs both in prison and post release. This included a renewed commitment to reentry programming that many Alcohol and Other Drug (AOD) programs at the County and local levels became actively involved in, establishing linkages to treatment for offenders releasing from prison. In 2011, the state passed AB 109 which shifted post release supervision of low level offenders from the state to the counties, inclusive of

funding for AOD treatment for offenders. A key provision of AB 109 is the use of a newly established Community Corrections Partnership that includes County level AOD staff to assist with determining funding levels for each respective county. In many counties, funding is now available for substance use disorder treatment services for AB 109 offenders.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Enrollment and care coordination efforts for offenders involved in the adult and juvenile justice system are being addressed by CDCR and are not within the scope of DHCS. However, as the SSA for substance use disorder services, DHCS has been reviewing current treatment capacity levels to ensure services needed by future offender populations utilizing Medicaid and other state sponsored plans will have access to timely treatment services. DHCS also continues to be an active member on the California Rehabilitation Oversight Board (C-ROB), co-chaired by officials from CDCR and the state's Office of Inspector General. C-ROB members meet quarterly to examine the various mental health, substance abuse, educational, and employment programs for inmates and parolees operated by CDCR with the intent to identify and address gaps and issues with the interconnectivity between offenders and various services.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J. Parity Education

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

The federal Patient Protection and Affordable Care Act (ACA) creates for the first time in our nation's history a "culture of coverage," where being insured is the norm for everyone. Over the next decade, the ACA will completely reshape the California’s health system by making it easier for citizens to obtain, to afford, and keep healthcare coverage regardless of age, occupation, or pre-existing medical condition including substance use disorders (SUD). This expansion in coverage, acting in concert with California’s Wellstone-Domenici Parity Act (2008), will enable the SUD field to reach an even greater portion of those at risk of or suffering from SUDs, and provide several new opportunities for the delivery of services.

With these opportunities, however, come challenges in California. The AOD field must prepare for the key elements of the ACA that become effective in 2014. These challenges include accommodating the insurance industry changes, the increase in demand for SUD services brought on by expanded coverage and the delivery and financing of these services.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about the benefits (e.g., service benefits, cost benefits, etc.)?

DHCS hosts a WEB page to supplement existing federal, state and credible private websites covering the ACA, and, specifically, to provide information that will prepare the alcohol and other drug field for the ACA’s impact on California’s SUD health care system. As new material is made available, DHCS will update the contents of this page periodically so that it remains current and relevant

DHCS is presently engaged in discussions with counties regarding parity. It is the intention of the State and counties to continue these planning efforts. The California Health Benefit Exchange and Covered CA have web sites that serve as a repository of helpful health information, including parity, in both public and private sector settings. DHCS is working with the federal entities, and

coordinating with Covered California and the county enrollment process to see that consumers understand parity.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Going forward, questions still exist concerning coverage of certain substance use disorder treatments, such as methadone maintenance. DHCS is committed to ensuring that parity education is a priority and as planning for health care continues; DHCS will update SAMHSA regarding these efforts.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

Currently, thirty California counties offer, as a default, a managed care option for recipients of Medi-Cal (California’s version of Medicaid). Through this managed care approach, medical providers are better able to coordinate care for various medical conditions. However, a special provision in the contract for these services “carves out” mental health care. Based on that provision, Medi-Cal covered individuals are sent to the appropriate county agency for mental health services. “Specialty Medi-Cal”, which includes covered substance use disorder (SUD) treatment services, is also carved out in a similar way.

In eight counties, a special Coordinated Care Initiative (CCI), based on a special grant, is underway to address coordinated coverage for those who are dually eligible under Medicare and Medi-Cal. Under this CCI, the two carve-outs mentioned above continue.

Additionally, California’s Healthy Families Program (HFP), which serves low-income children whose family incomes exceed Medi-Cal limits, is transitioning its recipients to the Medi-Cal program for health insurance benefits. For SUD benefits under HFP, a doctor’s referral is not required for children to continue to access Medi-Cal alcohol and drug treatment services including outpatient group and individual counseling, intensive outpatient services, and limited inpatient services. Child beneficiaries may be referred to these services by their current provider, or they may seek these treatment services directly through their local county-administered alcohol and other drugs (AOD) programs.

(Detoxification services for these beneficiaries always require a physician’s order and are provided in a hospital (inpatient) setting.)

Additionally, California has just been awarded a federal grant of $2.7 million to design a new model of government health care payment. The grant will be used to produce a state plan to improve health care quality and reward value instead of volume by changing the payment structure.

The project will focus on people covered by Medicare, Medi-Cal and Healthy Families. California will have six months to submit its plan. The plan can then be used to apply for another grant to test the method over a three-year period.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

California has an 1115 Medi-Cal waiver plan. The plan is for integrating MH/SUD services into the "bridge to reform" that is poised to become the foundation for the Medi-Cal Expansion. Uninsured individuals who will want SUD treatment under the ACA, who now are cared for under the Substance Abuse Prevention and Treatment (SAPT) Block Grant (and other funding streams), will largely be part of the newly eligible population under the Medi-Cal Expansion. California is still working to understand the total cost of this care. It is possible that such care, in order to provide appropriate levels of care for SUD diagnoses, will require more funding than the limited five health care services that currently comprise the Drug Medi-Cal (DMC) Program. Accurately predicting the cost of care in the Mental Health/Substance Use Disorder (MH/SUD) Integration Plan is important to assure that recipients receive appropriate levels of care and the state gets the improved patient outcomes and cost reductions which are the two top priorities for health care reform. Calculations are complicated by some SUD treatment-related services that could be provided in other state Medi-Cal programs and/or delivered by a provider through other funding streams to meet those medical needs.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

The California Primary Care Association (CPCA) has presented a report to the meeting of the DHCS-supported County Alcohol and Drug Program Administrators Association of California (CADPAAC). This CPCA presence at the CADPAAC meeting opened up the opportunity for county officials to work more closely with CPCA. Additionally, DHCS employees have had conversations with CPAC, in order to increase CPAC awareness of county specialty care services, particularly SUD treatment.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

The California Department of Public Health (DPH) is the primary California agency addressing nicotine dependence issues. It provides extensive resources and information on the hazards of tobacco products, quitting smoking, tobacco-free environments, and related topics on multiple web sites: http://www.cdph.ca.gov/healthinfo/healthyliving/tobacco/Pages/default.aspx, http://www.tobaccofreeca.org/, http://www.cdph.ca.gov/programs/tobacco/Pages/default.aspx

DHCS supports tobacco-use prevention programs as part of its substance use prevention work, which is conducted by each of the counties, based on county direction. Additionally, one unit of DHCS provides periodic email updates concerning matters related to co-occurring disorders treatment and services. These updates provide nicotine dependence treatment and information resource links and documents, information on related training opportunities (especially webinars), etc. in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA) wellness program.

County mental health treatment and SUD treatment facilities follow state laws that restrict smoking in specific settings. Additionally, individual counties can choose to impose particular tobacco use restrictions as well as offer programs to address nicotine dependence.

State mental health hospitals, which are forensic, prohibit the possession and use of tobacco products by patients. This law applies to California's five state mental hospitals. Additionally the hospitals follow the following rules:

The Director must provide any requesting patient with smoking cessation information and assistance. At hospitals where possession and use of tobacco products is prohibited, the store or canteen at the facility may not sell tobacco products.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

Our licensed treatment facilities are non-medical facilities. They do not conduct such screenings or assessments.

6. Describe how your behavioral health providers are screening and referring for:

- ***a. heart disease,***
- ***b. hypertension,***
- ***c. high cholesterol, and/or***
- ***d. diabetes.***

Our licensed treatment facilities are non-medical facilities. They do not conduct such screenings or referrals.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as "ADP" for perspective and chronological purposes.

1. ***How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?***

   These services are tracked at the county level. The Department of Health Care Services' (DHCS) County Monitoring Unit (CMU) regularly conducts site visits to our 58 counties. These visits serve as an opportunity to discuss the counties' strategies for better understanding and serving their vulnerable populations. Each county must demonstrate how they and their subcontractors are complying with the enhanced National Culturally and Linguistically Appropriate Services (CLAS) Standards. These Standards provide guidance on collecting and analyzing demographic data and using that analysis for successful planning and implementation, with the goal of reducing disparities in access, service use, and outcomes.

2. ***How will you identify, address and track the language needs of disparity-vulnerable subpopulations?***

   As stated above, these service needs are identified and tracked at the county level. Those counties in need of assistance have access to support through the Community Alliance for CLAS, a DHCS-funded technical assistance (TA) and training project administered by ONTRACK Program Resources.

3. ***How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?***

   Each county is required to develop plans based on the diverse needs of their county. Each county's plan is reviewed by DHCS' CMU analysts to ensure that it addresses the behavioral health needs of its most vulnerable residents to achieve this goal. Those counties that need support in strengthening or implementing their plans are referred to ONTRACK Program Resources for TA and training.

4. **How will you use Block Grant funds to measure, track and respond to these disparities?**

   Through the ONTRACK Program Resources TA and training project, counties have received training on more effectively serving the diverse groups within their communities. Trainings and consultation provided by ONTRACK emphasize best practices, current research, and the tools and techniques that have proven effectiveness for these traditionally unserved or inappropriately served populations, balanced with emerging innovations that are demonstrating promise. Culturally and linguistically competent data collection and analysis is emphasized as a key tenet, so that programming can be tailored to local needs and disparities can be recognized and pro-actively addressed. Coaching calls, pre/post tests, evaluations, and thorough pre/post organizational assessments are utilized to ensure impactful individual and institutional changes.

Narrative Summary

The County Monitoring Unit regularly conducts site visits to our 58 counties. These visits serve as an opportunity to discuss the counties' strategies for better understanding and serving their vulnerable populations. Each county must demonstrate how they and their subcontractors are complying with the enhanced National Culturally and Linguistically Appropriate Services (CLAS) Standards. These Standards provide guidance on collecting and analyzing demographic data and using that analysis for successful planning and implementation, with the goal of reducing disparities in access, service use, and outcomes. Each county's plan is reviewed to ensure that it addresses the behavioral health needs of its most vulnerable residents to achieve this goal. Those counties that need support in strengthening or implementing their plans are referred to the Community Alliance for CLAS, a DHCS-funded technical assistance and training project administered by ONTRACK Program Resources. Partners on the project include the Center for Applied Research Solutions, NICOS Chinese Health Coalition, and the Latino Health and Education Consortium.

In addition to the county systems, our outreach is targeted to serve inner city and rural low-income providers and supporting institutions with high incidence of trauma, criminal justice involvement, low academic achievement, and other negative social determinants of health. Through the use of an extensive consultant pool, all support is customized to meet the demographic needs of the applicant (or region, in the case of regional trainings). California has a wide range of vulnerable populations, and each locale or agency is assessed to determine which population(s) are underserved. To aid in this assessment, the Community Alliance for CLAS has conducted extensive focus groups throughout the state with consumers of prevention, treatment and recovery services. The project also produces and disseminates reports on the status of our limited English proficient groups and how to best serve them. In California in October 2012, there were 13 distinct threshold languages. Further, 41%, or 3,294,230 of the individuals eligible for Medi-Cal, reported a language other than English as their primary language and met the statutory criteria for a threshold language population.

Since the project's inception in January 2011, we have provided training and/or technical assistance to 938 agencies statewide. In addition to general CLAS/cultural competency training, the field has received training on more effectively serving the following communities and individuals (partial list): transgender; lesbian, gay, and bisexual; disabled; juvenile justice involved; aging/older adults; limited English proficient; Latino/a; African American; Asian American, Southeast Asian Pacific Islander, and Native Hawaiian; Native American; and Former Soviet Union. Trainings and consultation emphasize best practices, current research, and the tools and techniques that have proven effectiveness for these traditionally unserved or inappropriately served populations, balanced with emerging innovations that are demonstrating promise. Culturally and linguistically competent data collection and analysis is emphasized as a key tenet, so that programming can be tailored to local needs and disparities can be recognized and pro-actively addressed. Coaching calls, pre/post tests, evaluations, and thorough pre/post organizational assessments are utilized to ensure impactful individual and institutional changes.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

Indicators/Measures (answer yes or no)

1. ***Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?***

   No

2. ***Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?***

   No

3. ***Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?***

   Yes

4. ***Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employments, peer-based crisis services, and respite care).***

   No

5. ***Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people***

with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Only for adolescents through the California Access to Recovery program

6. ***Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?***

   Yes

7. ***Does the state have an accreditation program, certification program, or standards for peer-run services?***

   No

8. ***Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.***

   California has a longstanding commitment to promoting person-centered and client directed services. In 2006, ADP commenced a task force of members representing a wide array of specialties within the alcohol and other drug (AOD) addiction field to address problems within the system of care and recommend improvements. The task force created a report, ADP Continuum of Services System Re-Engineering (COSSR) with goals and objectives through 2014. The section, "Prevention and Recovery Support Services" speaks to the need to promote client-directed services and is described further in the following goal: Empower and prepare individuals and communities to prevent, reduce, or manage their AOD risks and recovery. Objectives under this goal include: 1) providing outreach services to persons and their significant others who may or may not have gone through formal treatment and/or who may benefit from recovery support services; 2) ADP taking a leadership role in creating and implementing a recovery management system; 3) increasing the availability of an array of housing for sober and transitional living communities; and 4) organizing culturally-appropriate community resources to provide ongoing self-management support to individuals and communities to effectively reduce their risk of AOD problems.

This goal and its objectives promote effective self-management support strategies at individual and community levels to engage individuals in the recovery system as partners. Effective self-management in recovery acknowledges the communities' and individuals' central role in their care. The system of services must empower and prepare individuals to manage their recovery by using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow up, as well as telephone/internet supports, recovery community centers, and peer recovery coaching. The system must organize internal and community resources to provide ongoing self-management support to individuals. Using a collaborative approach, providers, communities, and individuals must work together to define problems, set priorities, establish goals, create recovery plans and solve problems along the way. This recovery-management goal will continue to be promoted by DHCS and its executive staff internally and externally at conferences, and in quarterly meetings with County Alcohol and Drug Administrators.

DHCS and its stakeholders have not yet developed or adopted a California-specific recovery definition or set of recovery values and/or principles. However, DHCS is supportive of SAMHSA's working recovery definition and guiding principles that recognize recovery 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." And while DHCS recognizes the need to support a recovery-oriented system of care, widespread capacity building is not possible without a dedicated or allowable fund source. This is also necessary to enhance the existing workforce to include trained family, youth and peer supports.

California's state behavioral health system does not ask or document whether employees are in recovery. However, some state employees, including those in leadership roles, choose to self-disclose their recovery process. They may find it appropriate at times to share their lived experience with other staff, or speak publicly about addiction and their personal journey. ADP had a long history of hiring individuals who seek to give back to the community by working in the substance abuse field and who often offer themselves up as living proof of the reality and transformative power of recovery.

Involvement of Individuals and Families

The COSSR report also specifically describes ADP's and now DHCS's efforts to support and help strengthen existing consumer and family networks. One of the primary goals is to work with stakeholders, including individuals and family members, to promote recovery support. Because of the reengineering effort's significant impact on the current AOD system of services, it was important to invite individuals and families who could represent their views. The group developed the overarching principle that: "the individual (family and community) receiv(es) the right prevention, intervention, and/or treatment and support, at the right level, for the right

period of time by the right practitioner, agency or sponsor, every time… In this principle will be the assurance of quality, efficiency and accountability to all stake *holders and the assurance that every individual has the best opportunity to achieve wellness and recovery."*

In California's governance structure for alcohol and drug programs, all federal funds administered by the state are provided to counties who are responsible for delivering services. They either provide the services directly or subcontract through providers. County alcohol and drug agencies, in their oversight of contracted programs, ensure that individuals in recovery and family members are utilized in the development and implementation of recovery support services. When necessary, DHCS offers technical assistance to support these goals. Specifically, DHCS will continue to provide training in Culturally- and Linguistically-Appropriate Services (CLAS) competencies, including special populations, and will offer technical assistance by DHCS staff to ensure counties have the resources they need to actively engage clients and families in their services and programs.

DHCS will also continue to sponsor statewide meetings through a contract with the County Alcohol and Drug Program Administrators Association of California (CADPAAC). These meetings are convened to discuss statewide policy and program matters and include topics that address how to promote opportunities to proactively engage individuals and family members in recovery planning and shared decision making. In addition, eight constituent committees representing various special populations advise and assist DHCS' director and management staff in developing strategies to plan and support culturally competent services. Committee members provide important input on involvement of individuals and families in an effort to support and help strengthen existing consumer and family networks. The committees provide a two-way communication with key constituent groups and provide alcohol and drug services knowledge, geographic area representation, and community involvement. The chair of each Constituent Committee serves as a member of the Director's Advisory Council.

Available Recovery Services

Despite scant funding, counties within the state have long used recovery support services to meet the needs of individuals and communities. These services are primarily funded using county discretionary funds, SAPTBG, California Mental Health Services Act funds, grants, and through individual provider fund raising. Services include supportive employment and educational services, consumer and family education, and sober living (recovery) housing.

California has had the opportunity to advance its recovery-oriented practices and services through its Access to Recovery (ATR) grant, called the California Access to Recovery Effort (CARE) program. Since 2005, CARE has offered and promoted recovery support services for adolescents, ages 12 through 21, to assist in removing barriers and providing resources to those contemplating, initiating, and maintaining

recovery from substance use problems. A major focus of the program is individual choice, and vouchers are given to clients to support self-directed care. CARE services rely on and foster the development of a diverse network of community and faith-based providers, of whom 65 percent provide recovery support services. Currently, approximately 50 percent of the voucher funds are being used by clients to purchase recovery support services. CARE provides a small and tightly-knit network of providers and close association with DHCS that allows for the implementation and evaluation of new and innovative practices. Such practices have included the implementation of Telephone Monitoring and Adaptive Counseling (TMAC), an evidence-based continuing care model, and the use of LifeWIRE, a behavioral health management program utilizing text messaging.

Peer-Delivered Services

Many recovery mutual aid services are available to individuals in California, such as Alcoholics and Narcotics Anonymous, Women for Sobriety, Oxford House and religious/faith-based recovery groups such as Celebrate Recovery. In addition, California is increasing the variety of peer-delivered services available to meet individual needs and preferences. There are now recovery community organizations or centers in several California counties. These community centers are geographically convenient, culturally diverse and are warmly welcoming to all people seeking recovery. Several partner with local agencies to serve the homeless and the lesbian, gay, bisexual and transgender (LGBT) population. These recovery centers create peer-led opportunities for education, wellness, advocacy and support services for individuals in or in need of long term recovery from alcohol and other drug addictions, and opportunities are equally available for support to impacted families and significant others.

In 2012, the CARE program began implementing a plan to offer peer recovery coaching to adolescents. Administrators and front line staff representing 50 CARE providers attended training on the principles of peer coaching as a recovery support service, including an overview of a recovery oriented system of care and a discussion of requirements, recruitment, supervision, and implementation. The purpose was to give providers an opportunity to learn if and how this service would fit into their organizations and community networks. The expected outcome was to increase California's ability to incorporate and implement recovery coaching in the CARE program and possibly sustain it beyond the ATR grant. In June 2012, with assistance from Altarum Institute, 30 individuals were trained as peer recovery coaches. The coaches are primarily young people (ages 18-25) in recovery, explicitly sharing their experience as a person in recovery with the individuals they are serving. Between August 2012 and January 2013, 122 CARE clients have chosen to receive peer recovery coach services.

California does not currently have its own certifying program or standards for peer-run services. However, some individuals in the state are certified coaches and trainers from recovery coaching academies such as Connecticut Community for Addiction Recovery, Friends of Recovery Vermont, or credentialed by the International Coach Federation. LifeHouse Recovery Connection in San Diego, California, has trainers certified by the Friends of Recovery Vermont and is now offering recovery coaching academies in California.

Housing

Efforts to reduce homelessness through substance use intervention and prevention acknowledge that the most effective strategy is "housing first." However, ADP and now DHCS' funding is generally unavailable for housing services for substance users or persons in recovery. Until recently, the voter approved Substance Abuse Crime Prevention Act (SACPA) allowed for the provision of housing but due to California's ongoing budgetary issues, this program funding was eliminated.

Despite the limited funding streams available to combat homelessness, ADP has worked closely with the Co-Occurring Joint Action Council (COJAC) for several years to address this problem. The COJAC Housing Subcommittee developed guiding principles for housing models that meet the needs of persons with co-occurring disorders (COD). The principles address the need for a range of housing options so that individuals can choose ones that are best suited to their needs and preferences. They also recommend that housing options be integrated into neighborhoods and communities and provide opportunities for recovery, resiliency, and community integration. It is expected that DHCS will continue this collaborative effort.

Obviously, transitional or recovery housing is a critical link to bridging the gap between homelessness, ongoing sobriety and permanent housing. Unfortunately, there are currently no funding sources within California's AOD service system that will provide a reimbursement mechanism to broaden this link. However, ADP had received clarification from SAMHSA on how to address housing needs with the SAPT Block Grant funds and is currently working with its stakeholders, including the County Alcohol and Drug Program Administrators of California, on implementation efforts.

DHCS will continue to work at the State level with other agencies to create opportunities for prevention, intervention, and treatment services in shelter programs and outreach to populations with especially high needs such as veterans and individuals with COD. These efforts include working with housing agencies regarding the provision of sober and transitional living.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N. Evidence Based Prevention and Treatment Approaches for the SABG

Notification

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1. ***How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?***

   California adopted the SPF process in State Fiscal Year (SFY) 2004-05. Marin, Los Angeles, Inyo and Kings Counties were amongst the first counties to use the SPF planning process. In SFY 2007-08, ADP required all counties to conduct a local needs assessment to identify populations and communities at greatest risk. Based on the outcomes of their needs assessment, the State contract required counties to develop a strategic prevention plan to address their priorities. Many counties need assistance to obtain the local data necessary to conduct a thorough needs assessment. ADP assists counties by:

   A. Providing Counties with local data through the Indicators of Alcohol and Other Drug Risks and Consequences for CA Counties Reports – These reports are prepared under the Community Prevention Initiative (CPI) training and technical assistance contract. The data is presented for 2004, 2007, and 2010 at both the county and state level to allow county rates to be evaluated against a relative average. The CPI contractor will be completing reports for 2013 over the next three years. The overall intent of the reports is to provide a simple, easy-to-use resource that helps synthesize and interpret the most relevant indicator data currently available to assess substance use problems in an effort to optimize prevention planning and outcome measurement efforts in communities throughout the state. The reports are used by administrators, researchers, and others to plan prevention efforts.
   The reports contain information on several key indicators of alcohol and drug prevalence and consequences for California populations in each of the following areas:

   - Prevalence data
   - Admissions to publicly-funded alcohol and drug treatment facilities
   - Crimes related to alcohol and other drug use
   - Alcohol-involved motor vehicle accidents
   - Hospitalization due to alcohol and drug use

- Deaths due to alcohol and drug use.

The reports can be viewed at
http://www.adp.ca.gov/Prevention/risk_indicators.shtml.

B. Supporting Continued Funding of the California Healthy Kids Survey - ADP and the California Department of Education (CDE) co-sponsor the CHKS, a powerful tool for use in Grades 5-12 that can help schools, districts, and local planning offices accurately identify areas of student and school strengths and weaknesses, and address related needs. It provides a comprehensive, data-driven, decision-making process to guide efforts to improve school climate, learning supports, and engagement, as well as identify and increase the quality of health, prevention, and youth development programs. County AOD and public health offices as well as prevention providers rely on this survey as a source of local data for their needs assessment.

At the heart of the CHKS is a broad range of key learning and health-related indicators that are used to collect student data on attitudes, behaviors, and experiences related to school and learning. School connectedness, developmental supports and opportunities, safety, violence and harassment, substance use, and physical and mental health are some of the key areas assessed by the survey.

The research-based assessment of factors that promote resilience and positive youth development is one of the survey's many unique benefits. Additionally, the CHKS can be customized by schools and districts to meet local needs. The survey includes a general, core set of questions, plus a series of supplementary modules covering specific topics. Schools can add questions of their own choosing or creation on other topics of local interest via a search feature that identifies questions previously used by other schools. The customizability of the CHKS allows schools and districts to receive relevant, useful knowledge tailored to their needs. The CHKS surveys approximately 800,000-1,000,000 5th, 7th, 9th, and 11th graders.

With the loss of Title IV funds and reduced funding statewide, the future of the CHKS was unknown. In 2011, ADP was able to identify SAPT funding to continue the CHKS; however, reduced funding at the local level may still create roadblocks to acquiring this data for all communities. ADP will continue to make funding of these surveys a priority as they are critical to both local and statewide needs assessments. Some of the counties use their SAPT BG funds to support CHKS locally.

C. Providing Technical Assistance and Training through CPI – The Center for Applied Research Solutions (CARS) works collaboratively with ADP in providing SPF TA and training to the prevention coordinators and other partners as they revise or update their SPF plans. They also provide more intensive assistance to counties that are struggling to understand and implement their SPF. Over the last three years, CARS has provided SPF TA and training to approximately 150

employees in 42 counties. The counties have improved their processes for planning and developing their SPF which in turn has improved their prevention program delivery.

Healthy Stores for Healthy Communities Campaign

DHCS in partnership with the California Department of Public Health's Tobacco Control Program (CTCP) has embarked on a long-term effort to explore the ways in which the retail environment can be utilized as a force to build healthier communities and neighborhoods. The campaign's goal is "to improve the health of Californians through changes to the retail environment." DHCS and CTCP will be supporting data collection and local interventions around ten areas of focus including point-of-sale marketing, retailer licensing, retailer density, and healthy retailer incentives. These focus areas in particular were selected as potential opportunities to integrate tobacco, alcohol, and healthy foods interventions within the retail environment.

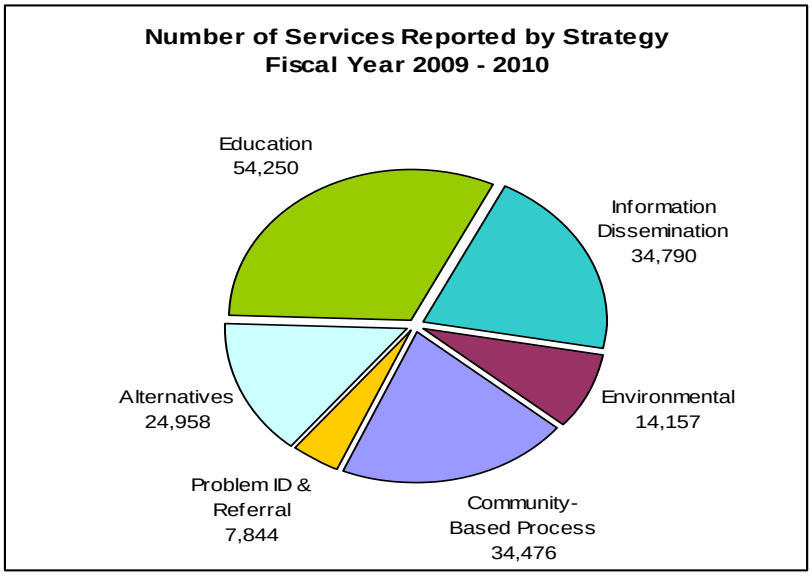
This campaign offers the opportunity to mobilize public health advocates around one environment and build critical mass to leverage social norm change. Within efforts to develop healthy retail environments, integration means working together in settings when appropriate at the local level. Integrating strategies can have several beneficial effects; including creating efficiencies in workload and resources and promoting systems change with larger potential impact. Some alcohol and tobacco control advocates have been working with their local partners to create healthy retail environments, with great success. DHCS and CTCP is encouraging local programs to integrate efforts around the retail environment as it makes sense, and is supporting this work through training, technical assistance, and by providing collaborative options for inclusion in local strategic plans.

2. *What specific primary prevention programs, practices and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?*

Over 4 million persons in California received primary prevention services in SFY 2010-11. These services were both population- and individual-based and included the following populations: youth/minors (elementary, middle school, high school); parents/families; military families; economically disadvantaged; college students; adults/older adults; persons using substances; delinquent/violent youth; women & children; youth in tribal communities; racial/ethnic minorities; Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex or Two-Spirit (LGBTQI2-S); and children of substance abusers. The populations served are those determined by each county, through their SPF planning process, to be most in need.

Counties engaged in the six CSAP strategies and their related activities directly and through contracted providers to meet goals, objectives, and outcomes

determined through their SPF-based planning. The chart below depicts the total number of services reported statewide for each of the six CSAP strategies as reported in CalOMS Pv for SFY 2009-10.



According to CalOMS Pv SFY 2009-10 data, the following activities were delivered in California for each of the six CSAP strategies is defined below.

1. **Information Dissemination** - In SFY 2009-10 the counties provided information dissemination services according to their SPF-based planning to an estimated 2,152,462 individuals[1]. These services included, but were not limited to 64,871 telephone information service calls, airing of 15,583 public service announcements, 19,631 speaking engagements, 52,755 media campaigns conducted, and 12,248 conferences/health fairs attended. The counties expended $12,309,181 of their Federal Fiscal Year (FFY) 2010 SAPT BG funds to provide Information Dissemination services.

   At the state level, the ADP Resource Center (RC) disseminates information, free-of-charge, throughout California.

   The ADP RC primary function is to disseminate Alcohol, Tobacco, and Other Drug (ATOD) information through telephone inquiries and referrals, clearinghouse publications, lending and conference services. In the fall of 2011, the RC began reaching out to social media users of Twitter and Facebook. Currently on Twitter @Prevention_Hub, 87 followers and 486 tweets have been created and posted. The Prevention_Hub Facebook page

[1] The total number is an estimate of the number of persons served based on demographics reported in CalOMS Pv for Education, Alternatives, Problem ID & Referral, and some services under Community-Based Process and Environmental. The numbers served does not include population-based services for Community-Based Process and Environmental.

has received 67 likes from the 96 individuals that have visited or subscribed to our page.

In SFY 2009-10, the RC disseminated the following:

- Out of 5,580 ATOD books and videos available for loan to the public through the Lending Service, the RC loaned out 413 pieces of material.
- The RC Clearinghouse carried over 700 titles of pamphlets, posters, research papers, technical manuals and activity books. 1,355 orders were received through an internet "shopping cart", mail, fax, e-mail, telephone, or in person, resulting in 374,332 publications disseminated. This figure does not include catalog items available online in PDF for consumer downloading. Information and materials were provided at no cost to the requestors.
- The RC provided 13,374 callers with ATOD information/referrals/transfers on the toll free telephone line provided for the public, 1,021 of which were in Spanish.
- The RC provided 162,813 publications and other materials for 408 ATOD-related conferences, workshops, or special events (e.g., Red Ribbon Week) throughout the state.

In SFY 2010-11, the RC disseminated the following:

- Out of 5,727 ATOD books and videos available for loan to the public through the Lending Service, the RC loaned out 318 pieces of material.
- The RC Clearinghouse carried over 700 titles of pamphlets, posters, research papers, technical manuals and activity books. 1,146 orders were received through an internet "shopping cart", mail, fax, e-mail, telephone, or in person, resulting in 574,633 publications disseminated.

  This figure does not include catalog items available online in PDF for consumer downloading. Information and materials were provided at no cost to the requestors.

- The RC provided 12,453 callers with ATOD information/referrals/transfers on the toll free telephone line provided for the public, 996 of which were in Spanish.
- The RC provided 184,661 publications and other materials for 403 ATOD-related conferences, workshops, or special events (e.g., Red Ribbon Week) throughout the State.

2. **Education** - In SFY 2009-10, approximately 244 providers delivered Education services to 154,204 individuals[1]. Classroom Educational Services, Educational Services for Youth Groups, Educational Services for Adult Groups, and Small Group Sessions served the majority of the recipients. The counties expended $11,279,515 of their FFY 2010 SAPT BG funds to provide Education services.

In SFY 2010-2011, approximately 231 providers delivered Education services to 202,424 individuals[1]. Classroom Educational Services, Educational Services for Youth Groups, Educational Services for Adult Groups, and Small Group Sessions served the majority of the recipients. The counties expended approximately $10,637,926 of their FFY 2011 SAPT BG funds to provide Education services.
(FFY 2011 SAPT BG expenditures are preliminary.)

At the state level, DHCS conducts outreach and training to support youth, communities, and special service populations through TA contractors. As well, the RC maintains a portion of DHCS's Internet Website to provide current TA documents, some curricula, and educational publications (see http://www.adp.ca.gov/RC/rc_sub.shtml).

3. **Alternatives** - The largest statewide program engaging in Alternative activities is the Friday Night Live (FNL) program (FNL-high school, Club Live-middle school, FNL Kids-elementary school) (see http://www.fridaynightlive.org/About/About.htm). The FNL system, based on a youth development framework, builds partnerships throughout the state for positive, healthy youth development by engaging young people as active leaders in their communities. The FNL system serves youth from all backgrounds, cultures, and demographics. FNL leadership participation in the Governor's Prevention Advisory Council (GPAC) workgroups focused on high-rate substance and underage alcohol use.

   In SFY 2009-10, approximately 168 providers delivered Alternative services to 233,404 individuals[1]. A majority of these services were Youth/Adult Leadership Activities and AOD Free Social/Recreational Events and were provided through the

   FNL system (see http://www.fridaynightlive.org/about-us/cfnlp-overview). The counties expended $8,079,201 of their FFY 2010 SAPT BG funds to provide Alternative services.

   In SFY 2010-11, approximately 172 providers delivered Alternative services to 196,628 individuals[1]. A majority of these services were Youth/Adult Leadership Activities and AOD Free Social/Recreational Events and were provided through the FNL system. The counties expended approximately $6,925,024 of their FFY 2011 SAPT BG funds to provide Alternative services.
   (FFY 2011 SAPT BG expenditures are preliminary.)

4. **Problem Identification and Referral** - The counties provide Problem Identification and Referral services according to their SPF-based planning. In SFY 2009-10, approximately 92 providers delivered Problem Identification and Referral services to 36,962 individuals[1]. The Prevention Screening and Referral Services and Student Assistant Programs were the most widely utilized. The counties expended $1,697,421 of their FFY 2010 SAPT BG funds to provide Problem Identification and Referral services.

In SFY 2010-11, approximately 86 providers delivered Problem Identification and Referral services to 16,212 individuals[1]. The Prevention Screening and Referral Services and Student Assistant Programs were the most widely utilized. The counties expended approximately $1,165,995 of their FFY 2011 SAPT BG funds to provide Problem Identification and Referral services. (FFY 2011 SAPT BG expenditures are preliminary.)

At a statewide level through a GPAC workgroup focused on high-rate underage users, ADP, the California Department of Education (CDE), the Office of the Attorney General (AG) and other GPAC members promote student assistance programs for the 1,000 school districts in California.

5. **Community-Based Process** – In SFY 2009-10, at the county level approximately 253 providers delivered services to 47,498 individuals[1] in these types of activities. A majority of these services were Community/Volunteer Training, Technical Assistance (TA), and Training Services. The counties expended $15,143,314 of their FFY 2010 SAPT BG funds to provide Community-Based Process services.

   In SFY 2010-11, at the county level approximately 252 providers delivered services to 26,951 individuals[1] in these types of activities. A majority of these services were Community/Volunteer Training, Technical Assistance (TA), and Training Services. The counties expended approximately $16,584,205 of their FFY 2011 SAPT BG funds to provide Community-Based Process services. (FFY 2011 SAPT BG expenditures are preliminary.)

   At the state level, DHCS provides TA and training for local initiatives identified by community groups, prevention service providers, schools, neighborhood associations, and county administrators. This strategy will be supported by statewide TA and RC services to reach large population segments at an economical cost. Also, the CPI TA service provides extensive, immediate access to quality resources (see http://www.ca-cpi.org/main.php

6. **Environmental** – The most widely used environmental strategies during SFY 2009-10 were social host ordinances, Responsible Beverage Service training, alcohol availability and accessibility policies, and identifying and changing harmful social norms regarding substance use. Approximately 172 providers delivered services to 19,502 individuals[1] in these types of activities. The counties expended $4,039,972 of their FFY 2010 SAPT BG funds to provide Environmental services.

   In SFY 2010-11, approximately 165 providers delivered services to 20,655 individuals[1] in these types of activities. The most widely used strategies were Environmental Consultation/Technical Assistance and Retail/Vendor Education on Compliance. The counties expended approximately $4,531,771 of their
   FFY 2011 SAPT BG funds to provide Environmental services. (FFY 2011 SAPT BG expenditures are preliminary.)

Statewide, DHCS TA contractors develop, promote, and provide services on environmental prevention techniques for cities, emphasizing their local zoning authority and public policy development. As with the Community-Based strategy, the Environmental strategy is strongly supported because it can reach larger population segments and use public policy to sustain.

Quality Assurance

DHCS takes steps to ensure that the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) dollars are used to purchase primary substance abuse prevention services in each county. Each county is assigned a specific PPSB analyst who serves as an advisor by assisting county staff with planning, identifying evidence-based strategies, and ensuring accurate reporting of data.

Prevention services/activity data is collected via the CalOMS Pv data base. This web-based service, provided through KIT Solutions, LLC, services 58 counties and approximately 307 providers. CalOMS Pv, designed around the SPF, incorporates the three Institute of Medicine (IOM) prevention interventions as well as the six Center for Substance Abuse Prevention (CSAP) strategies and their related services. More than 70 standard data reports are available to users to assist them with monitoring, reporting, planning, outcomes, sustainability, and standard operations. PPSB works continually with KIT Solutions on improvement to the CalOMS Pv system in order to improve data entry at the county level.

Counties are required to upload an electronic copy of their Strategic Prevention Plan into CalOMS Pv and input the planning data including goals and objectives. The objectives are assigned to the prevention-funded provider sites and all services/activities are linked to objectives when they are reported. Narrative reports detailing the county's progress in achieving the goals and objectives within the plan are an annual requirement. The Evaluation Module in CalOMS Pv is designed for the submission of these progress reports. The service activity data is reported by all funded primary prevention providers and is linked to the goals and objectives of their respective county plan. Services must be reported by the date of occurrence on a weekly basis.

The data reported into CalOMS Pv is descriptive data that provides DHCS details of how the prevention dollars are being utilized. The counties review county/provider data for accuracy and release it to DHCS on a quarterly basis. After the data has been released, PPSB staff conduct a review to ensure the services correlate with the Strategic Prevention Plan and the data elements are accurate. Staff communicate issues to the county, provide assistance where needed, and ensure corrections are completed.

To ensure accountability and full expenditure of the SAPT prevention dollars, PSB engages in a reconciliation process in which budget and cost data are utilized. PSB staff ensure that all funded providers report data in CalOMS Pv, the allocations for each service code coincides with the data reported in CalOMS Pv, and the total SAPT 20% Primary Prevention Set-Aside allocation for each

county is equal to the amount identified in the cost data. The county is alerted of any discrepancies and offered assistance where needed.

Technical Assistance

DHCS Staff
PPSB staff provide one-on-one county support, conduct monthly web-based new user/refresher trainings for CalOMS Pv data reporting, and field the telephone calls and e-mails that come into the CalOMS Pv Help Desk. In addition, PPSB analysts guide and assist county prevention staff and their providers in resolving identified issues.

Friday Night Live Technical Assistance
The California Friday Night Live Partnership (CFNLP) serves as a technical assistance intermediary, with a focus on providing the FNL field the most relevant training opportunities in an effort to support the successful implementation of FNL programs across California. Training is offered through various modalities, each with the aim of building. The CFNLP is committed to the belief that a youth development framework, which is inclusive, comprehensive, youth-driven, and founded on current research, will improve the lives of young people and the communities in which they live.

Community Prevention Initiative (CPI)
The CPI project is intended to serve California agencies and organizations involved in community-based prevention. CPI is able to provide no-cost technical assistance and training support for planning and prevention services that include a broad community perspective. Specifically, the purpose of Community Prevention Initiative is "to reduce and manage community-level risks and problems directly attributable to and/or collaterally resulting from Alcohol, Tobacco, and Other Drug (ATOD) availability, manufacture, distribution, promotion, sale and/or use." The CARS CPI TA team works in coordination with the DHCS team and with a pool of expert consultants to provide technical assistance and training services.

3. *How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?*

The PPSB has seen the prevention capabilities of California counties develop and grow as they increase their ability to integrate the Strategic Prevention Framework (SPF) into their everyday business practices. Over the last year, the PSB has also been involved in several statewide efforts to strengthen California's alcohol and other drug (AOD) prevention infrastructure by:

- Coordinating the Governor's Prevention Advisory Council (GPAC), a state interagency council that works strategically to support the State's efforts to reduce substance use;
- Collaborating with other state departments on prevention issues to ensure substance use problems are appropriately addressed;

- Administering services through discretionary grants;
- Implementing the SPF statewide to facilitate effective program planning. PSB works with counties to develop county prevention plans that are data-informed, outcome-driven and evidence-based;
- Managing the California Outcome Measurement Service for Prevention (CalOMS Pv) which collects primary prevention data from Substance Use Disorder (SUD) prevention providers throughout California to assure accountability for federal primary prevention funding and meet the federal National Outcome Measures;
- Working with the California Department of Public Health on the Tobacco Sales to Minors (the Synar Amendment), which requires states to pass and enforce laws that prohibit the sale of tobacco to individuals under 18 years of age and maintain a retailer violations rate that is at or below 20 percent;
- Researching and analyzing emerging issues (for example, evidence-based programming, binge drinking, marijuana legalization) to guide policy development;
- Providing Technical Assistance (TA) and training to counties and service providers regarding strategic planning, data analysis, evaluation, evidence-based practices, and cultural and linguistic relevancy;
- Developing the workforce to increase capacity of the prevention field through the development
  and implementation of prevention core competencies;
- Collaborating across systems to prepare the prevention field for opportunities related to health reform; and,
- Working closely with the California Alcohol and Drug Program Administrators Association of California (CADPAAC) to establish statewide outcomes for prevention.

Power of Prevention (PoP) Initiative

Over the last year, ADP has directed and participated in several efforts to promote cross-system collaboration, and to support ADP's state prevention partners as the prevention field prepares for health reform and as ADP prepares for transition into the Department of Health Care Services.

ADP hosted two summits that brought together extraordinary groups of experts from across California. The first was a smaller group that convened in December 2011 to begin the conversation of cross-system collaboration. The second, a much larger convening held in February 2013, continued and advanced the conversation. Multiple state departments and local public health, mental health, education, and SUD prevention agencies were represented, as well as non-profit advocacy groups, community-based organizations, and the research community. The purpose of the meetings was to promote the power of prevention and to foster integrated thinking, collective planning, and collaborative action around pursuing comprehensive prevention strategies. Attendees discussed opportunities to better integrate SUD prevention with other prevention approaches in communities across the state, and how to work across systems to develop inclusive strategies that address multiple issues such as workforce

development, health care reform readiness, policy development and implementation, and partnerships. These convening's have resulted in concrete recommendations for next steps. The recommendations will be presented to County Alcohol and Drug Program Administrators Association of California (CADPAAC), DHCS, the California Health and Human Services Agency, and all participants. Opportunities were made available to anyone interested for ongoing workgroup participation focused on moving the prevention agenda forward in California.

ADP hosted the CPI Annual Regional Trainings in June 2012. These regional trainings brought together state, county, and provider-level participants from the public health, education, mental health, and SUD fields. Emphasis was placed on building state and local cross-system collaborative prevention efforts for strategic planning and environmental policy change. Training participants looked for ways to streamline duplicative efforts, identify opportunities to learn from one another, and developed recommendations for next steps. After the CPI Regional Trainings, ADP has found that in many areas, the link across systems is strong. There is a shared understanding that each system complements the other and together they form the foundation of healthy children, individuals, families and communities. Along with recommendations came a commitment to continue to model those partnerships. Additionally, they cited other factors which will impact our communities, such as healthcare reform and its focus on prevention.

ADP is also actively participating in the California Department of Public Health's (CDPH) Retail Environment Campaign. This campaign is led by the California Tobacco Control Program and focuses on tobacco and alcohol price, placement and promotion, as well as the availability of nutritious foods in retail establishments. The overarching goal of this campaign is to create healthy and economically vibrant retail environments which support California communities as healthy places to live by encouraging healthy lifestyles and product choices.

Governor's Prevention Advisory Council

On a quarterly basis, as a means of working across California's multiple state systems, DHCS's Director, or his designee, chairs the Governor's Prevention Advisory Council (GPAC) which coordinates efforts to achieve measurable reductions in the incidence and prevalence of the inappropriate use of alcohol, tobacco and other drugs. Representatives from 16 agencies provide historical perspectives needed to attain long-term, sustainable results. GPAC has focused on finding common AOD prevention goals that members can work toward through their agencies and affiliates. At the February 23, 2012, meeting of the GPAC, representatives from the California Friday Night Live Partnership and the California National Guard spoke about the successes they've achieved through working collaboratively. In addition, Dr. Linda Rudolph presented on the Health in All Policies (HiAP) Task Force. During Dr. Rudolph's presentation, she stressed the importance of broadly engaging the community. She talked about 19 agencies tasked with developing recommendations that promote healthy communities. Finally, she presented the HiAP Report developed by the Strategic Growth Council. GPAC discussed the areas of focus and agreed that the SUD

field would have much to offer in the way of promoting public policy. The HiAP report can be found at:
http://www.sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf.

Prevention Workforce Development

The prevention workforce in California is rapidly changing as the field prepares for healthcare reform and behavioral health service integration with primary care. ADP/DHCS recognizes that the education, licenses and skills of practitioners range from a high school education with no specialized licenses or certifications to a post graduate education with full accreditation. In addition, the SUD workforce includes those who are in direct service plus those who have the combined responsibility of managerial and supervisory duties.

To address these needs, a Workforce Development Task Force was created in January, 2013 to evaluate health reform related changes and their impact to the Substance Use Disorders (SUD) workforce. The resulting report, "Workforce Development Needs in the Field of Substance Use Disorders, A Report from Department of Alcohol and Drug Programs, June 26, 2013", contains a summary of health reform related changes, an assessment of the current workforce, recommendations for preparing the workforce to meet the changes required by health reform, and an implementation strategy.

The report recommendations are summarized as 5 problem statements: (1) ensure the report recommendations continue to make progress toward implementation by creating a Workforce Plan Development Work Group with responsibility and authority to ensure implementation of the recommendation; (2) increase the short term capacity of the workforce to meet the increased demand for SUD services by expanding the number and types of workforce skilled and 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; (3) expand the capacity of the workforce by effectively using all members of the workforce; (4) develop a long term strategy to attract and retain members to the SUD workforce, provide them with a standard set of credentials, the tools to attain and maintain their credentials, and a system for monitoring and controlling the credentialing system; and (5) develop curricula and training for all healthcare workforce members who deliver SUD services.

To strengthen the prevention workforce, the PSB identified prevention competencies. Establishing competencies will provide focus for ensuring best prevention practices are known, implemented and used by the prevention field. However, simply developing a list of competencies is insufficient to ensure adoption and use by the prevention workforce. Therefore, PSB is also implementing a structure or framework to support the field in the acquisition of the competencies. PSB is working with CARS to develop and implement a training plan focused on the competencies. This includes the development of online and onsite training materials and content delivery. The plan ensures that

the field is oriented, informed and engaged in providing input as the competencies and trainings are developed.

The competencies integrate both the International Certification and Reciprocity Consortium (IC&RC) and CSAP domains and are reflective of the diverse approaches and workforce in California.

These prevention competencies are comprised of three main components: Core, Foundational and Specialized.

The five Core Competencies are based on the SPF and include:

- Assessment
- Capacity Building
- Planning
- Implementation
- Evaluation

The Core Competencies have been completed and reviewed by ADP. The trainings are be available via self-paced online trainings and live half-day webinars.

CARS has been diligently developing the Foundational curriculum, which has been drafted, and is currently under initial review. Next steps include making the modules available for ADP and peer review.

The Foundational Competencies are those that are “Cross-cutting” and include:

- Prevention Theories and Frameworks, or Key Concepts in Prevention
- Cultural Competence and Responsiveness
- Sustainability
- Professional Growth, Ethics and Responsibility

The last of the curricula to be developed are the Specialized Competencies (those that tend to be more specific to a particular prevention strategy or approach – can be added to over time)

- Skill Building
- Environmental Prevention and Public Policy
- Youth Development
- Screening and Brief Intervention

With the implementation of the Affordable Care Act, it will be critical that the health care workforce be knowledgeable and prepared for the increased number of individuals needing SUD prevention services. DHCS intends to make these curricula available to the SUD field and eventually market it to other systems, such as mental health and primary care.

4. ***What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?***

The PPSB continues to work collaboratively with the CADPAAC to establish a set of statewide outcome measures for prevention.

Considerations in determining the statewide outcome measures for prevention were based on common prevention priorities identified in state- and county-level needs assessment data. The proposed outcomes, focusing on underage drinking, are informed by recent California prevalence rates, supported by research and current literature, and are in alignment with federal and state priorities and performance reporting requirements.

The CADPAAC Prevention Committee also proposed a measurement approach that is already part of the current school survey system, the CHKS. The proposed outcome measures are 1) early onset of alcohol use; 2) frequency of drinking; and, 3) intensity of drinking.

The statewide outcome measures were adopted by CADPAAC at the September 2012, quarterly meeting. The CADPAAC Prevention Committee is now in the process of developing a means for implementing the outcomes statewide. Options for implementation were drafted and discussed at the March 2013, CADPAAC Prevention Committee meeting.

5. ***How is the state's budget supportive of implementing the Strategic Prevention Framework?***

California is looking for ways to streamline duplicative efforts and identify opportunities to learn from one another. DHCS works to create opportunities for counties to collaborate with other agencies such as mental health, public health and education that do financially support planning efforts such as mental health, public health and education. An example of this was the recent CPI regional forums aimed to support and facilitate cross-system prevention planning efforts. These forums explored innovative strategies for working together to collect and analyze relevant data, engage community members in planning and implementation processes, determine prevention priorities and build the needed capacity to effectively impact change. Emphasis was placed on building state and local collaborative prevention efforts for strategic environmental and policy change. Practical examples of promising and successful approaches were also highlighted.

6. ***How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)***

California has completed a state reorganization of the DHCS, DMH and ADP. The reorganization was designed to create increased efficiencies within state and local governments and prepare California for implementation of the Affordable Care Act

(ACA). The current Administration sees many benefits for communities, counties, and the State.

ADP/DHCS achieved the federal requirement to spend a minimum of 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse through terms and conditions contained in the State contracts with California's 58 counties. The majority of primary prevention services are carried out locally by the counties. The counties are required to use the SPF to determine how to expend their primary prevention funds to best meet identified community problems and priorities.

7. ***How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.***

PPSB analysts provide support to their assigned counties to ensure that evidence-based primary prevention services are reported in CalOMS Pv as required, that the programs are implemented with fidelity, and that providers work with program developers and TA providers if adaptations are necessary.

DHCS supports two programs developed in California that are working toward obtaining national recognition as evidence-based programs on SAMHSA's National Registry of Evidence-Based Programs list. First, is the COMMITTED model. This model provides the opportunity for diverse groups of youth and adults to address underage drinking and school climate concerns with a week by week session guide, fidelity system, pre/post survey, and key events/experiences. COMMITTED infuses youth development with environmental prevention strategies. Second, is the Individual Prevention Services Program which uses the Brief Risk Reduction Interview and Intervention Model (BRRIIM) core component. The BRRIIM model is an indicated-level assessment and education services that bridges the gap between prevention and treatment by identifying individual participants who may need intensive prevention services, or to be referred for further treatment assessment. The BRRIIM model has been replicated throughout California. The District of Columbia is currently receiving training on the model as well.
In addition, ADP staff work with the local innovative programs in California that are privileged to be part of SAMHSA's Service to Science Academy. They are as follows:

- Medicine Education Program – Gardena, California
- Lock It Up Project, California Health Collaborative – Fresno, California
- Countering Pro-Marijuana Influences, Vista Community Clinics – San Diego, California
- IMPACT, Asian American Family Enrichment Network – Rosemead, California
- Valley High Community Mobilization Project, People Reaching Out – Sacramento, California

In particular, representatives from the Lock It Up Project and the Valley High Community Mobilization Project have presented their programs to the GPAC and have developed partnerships with the member agencies.

Through the CPI Technical Assistance and Training contract, CARS conducts webinars and trainings on the evolution, strategy selection, and implementation of the COMMITTED and BRRIIM models as well as other promising practices and evidence-based strategies.

Evidence-Based Strategies Implemented

In SFY 2009-10, there were 365 evidence-based prevention programs and strategies funded in California. Project Alert was the evidence-based program most widely disseminated at 153 sites statewide. This is due to the Friday Night Live Mentoring Program, a cross-age mentoring program that matches high school mentors with middle school protégés. The program focuses on improving personal, academic and social outcomes for both the protégés and the mentors using the Project Alert curriculum.

In addition, the following evidence-based curricula were funded:

Evidence-based Program	Number of funded sites
Project Toward No Drugs (PTND)	72
Project Success	49
Too Good for Drugs (TGFD)	37
Life Skills Training (LST)	12
Strengthening Families	10
Guiding Good Choices	7
Second Step	4
Creating Lasting Family Connections (CLFC)	4
Education Support	4
Celebrating Families	3
Communities Mobilizing for Change on Alcohol	3
Keeping It Real	3
Wave - Keep A Clear Mind	2
Monument Corridor Anti-Drug & Alcohol Coalition	2

Environmental Strategies Implemented

As previous mentioned, approximately 165 providers delivered services to 20,655 individuals in FY 2010/2011. The most widely used strategies were Environmental Consultation/Technical Assistance and Retail/Vendor Education on Compliance. The counties expended approximately $4,531,771 of their FFY 2011 SAPT BG funds to provide Environmental services. (FFY 2011 SAPT BG expenditures are preliminary.)

Statewide, DHCS TA contractors develop, promote, and provide services on environmental prevention techniques for cities, emphasizing their local zoning authority and public policy development. As with the Community-Based strategy,

the Environmental strategy is strongly supported because it can reach larger population segments and use public policy to sustain.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescent Behavioral Health Services

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

Please answer the following questions:

1. ***How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?***

   Substance use disorder (SUD) services for children and adolescents ages 12 through 18 in California are provided through a partnership between DHCS and counties, which are the sub-state planning areas. DHCS contracts with counties for SUD services to be provided by locally-administered and locally-controlled substance use programs. California earmarks $7.33 million annually in SAPT Block Grant funds to support comprehensive, age-appropriate, SUD services to youth and adolescents. Counties can also opt to use discretionary funds (SAPT Block Grant, state general funds, or other funds) to augment services for children and youth.

   DHCS currently oversees a statewide network of approximately 390 publicly funded SUD treatment programs that annually serve approximately 12,000 youth ages 12 through 17 years old (inclusive). The focus of services varies by county, depending upon local need and priorities. These funds are used by counties to provide services such as outreach, early intervention, low intensive outpatient treatment, high intensive outpatient treatment (day treatment), and residential treatment in group home settings. These levels of care are provided in a variety of settings including community-based facilities, schools, churches, and group homes. Common service components for youth include screening, assessment and diagnosis, treatment planning, individual and group counseling, family interventions, educational and vocational activities, structured recovery-related activities, alcohol and drug testing, and discharge planning.

   DHCS ensures compliance with federal requirements through periodic county monitoring visits. DHCS' Performance Management Branch, County Monitoring Unit has primary responsibility to monitor counties' adherence to the contract requirements and the SAPT Block Grant terms. This is accomplished by an annual review of each county which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 45 and CFR 42. While the county monitoring process primarily serves to satisfy a compliance function, it also provides valuable data for program oversight and

improvement as well as long term planning at the state level by providing a snapshot of the status of different components of the SUD system statewide.

The county monitoring process improves fiscal and programmatic accountability of counties within the state and ensures that the use of SAPT dollars is maximized by identifying barriers and implementing solutions at the local level. Through the review process, monitoring analysts identify areas of deficiencies or concerns that may adversely affect SUD services provided within the county. Once a review has been completed, the monitoring analyst will submit a report to the county identifying highlights, findings, advisory recommendations and required follow up. The county is required to respond to the findings identified in the report by submitting a corrective action plan documenting how the findings will be rectified. When issues related to children and youth are identified, the monitoring analyst will contact DHCS' Program Support and Grants Management Branch to ensure that technical assistance is provided to the county and/or providers to address the local need.

2. ***What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?***

In 2002, ADP convened a group of diverse and experienced stakeholders who developed the *Youth Treatment Guidelines*. These guidelines focus on ways to specialize treatment for youth and provide guidance to counties and providers as they develop and operate their youth treatment services. The *Youth Treatment Guidelines* are included in ADP's contract with counties, and most counties require that the providers with whom they subcontract must comply with the best practices contained within the guidelines.

3. ***How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?***

DHCS collaborates with many agencies and groups as part of this planning process. DHCS staff meets or confers weekly with members of the County Alcohol and Drug Program Administrators Association of California (CADPAAC), a statewide organization whose members represent California's 58 counties.

DHCS also participates on the State Interagency Team for Children and Youth (SIT). The SIT was established in 2003 to coordinate policy, services and strategies for children, youth, and families in California. Comprised of deputy directors from ten state agencies, this group provides leadership and guidance to facilitate local system improvements. State agencies represented on the SIT include the Departments of Social Services, Education, Health Services, Alcohol and Drug Programs, Developmental Services, and Employment Development, as well as the Attorney General's Office, the California Children and Families Commission, and the Workforce Investment Board. DHCS participates on the SIT substance abuse work

group which is charged with strengthening services for children, youth, and families where there is a nexus between substance use and child safety, education, workforce readiness and success, maternal/child health, and mental health.

DHCS also participates in the Co-Occurring Joint Action Council (COJAC), a collaborative body with representatives from county and state-level substance abuse and mental health as well as service providers. COJAC developed and implements the Statewide Action Plan to improve the treatment of persons with Co-Occurring Disorders (COD) of mental illness and substance abuse. COJAC's Youth Committee specifically addresses the needs of youth with COD.

4. ***How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?***

To improve the competencies and skills of providers and staff serving youth with SUD, DHCS provides a combination of comprehensive cultural competence training and technical assistance. DHCS contracts with a qualified agency to support the development of culturally and linguistically competent programs for the diverse population of Californians with substance use disorders, including youth. This technical assistance contract is designed in accordance with the federal CLAS standards and other best practice cultural competency models. The agency provides introductory training on CLAS standards, training specific to organizational plans based on assessed training needs, and regional trainings.

Regional training designed for providers serving youth that are planned or were completed in State Fiscal Year 2012-2013 include the following:

- May 2013 – "Cultural and Gender Responsive Services for Girls," with a focus on Latinas, African Americans and teen dating violence.
- February 2013 – "Teen Substance Use and Its Impact on the Whole Family," addressed the multi-dimensional factors faced by youth using alcohol and other drugs and how those factors affect the dynamics and functioning of the entire family.
- December 2012 – "Kids at the Crossroads," which provided information and practical clinical techniques for working with youth at highest risk for involvement in the juvenile justice system through substance abuse, delinquency, and/or gang activity.
- August 2012 – "Motivational Interviewing with Adolescents," provided clinicians working with substance abusing youth and their families with knowledge, techniques and strategies for application of this evidence-based practice.
- May and June 2012 – "Meeting the Challenge: Incorporating Culturally and Linguistically-Appropriate Services Into the Continuum of Care for Youth," which helped establish a working definition of culture, including youth culture, its role and purposes exploring personal values in relation to the client, and how providers can embed cultural outcomes in each step of their planning process.
- February and March 2012 – "Telephone Monitoring and Adaptive Counseling,"

- which provided clinicians working with substance abusing adolescents with the knowledge, techniques and strategies for application of this evidence-based practice.

5. ***How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?***

   Information gathered during county monitoring site visits described in Question 1 above as well as data collected from the California Outcome Management System (CalOMS) are used to inform DHCS' Statewide Needs Assessment and Planning (SNAP) process. The SNAP process serves as a data-informed, decision-making and planning process, in which the state and counties set strategic priorities and direction aimed at being prepared to meet the challenges ahead, including monitoring and tracking the needs of children and youth and service utilization, costs, and outcomes.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

P. Consultation with Tribes

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

California is home to more people of American Indian/Alaska Native (AI/AN) heritage than any other state in the Country. The population of California's AI/AN is the largest in the United States (362,801), which represents 12 percent of the total AI/AN- alone population. The next largest AI/AN population is in Oklahoma (321,687) and then followed by Arizona (296,529). Although California has the largest tribal population in the United States, it has very little tribal land and as of 2005, only 3 percent of California's AI/AN population lived on a reservation or Rancheria, which means California's AI/AN population live predominately in urban areas.

Specific to California's Native American communities is the recognition that these population totals include descendants or members of California's 109 federally recognized tribes, which accounts for about 20 percent of all tribes in the United States. There are approximately 78 tribes in California with on-going petitions for federal recognition. Tribes in California currently have nearly 100 separate reservations or Rancherias and individual Indian trust allotments.

The California tribal population consists of a significant number of members of tribes not based in California. More than half of the AI/AN living in California are members of tribes located outside of California and this AI/AN-alone or -in-combination population makes up 2 percent of California's total population. Approximately 50 percent of California's AI/AN population is AI/AN in combination with one or more other races (predominantly white), and 50 percent of California's AI/AN population identifies as AI/AN alone.

Based on the 2000 U.S. Census, Los Angeles County, California, has the largest AI/AN-alone population (76,988) in the United States. Ten California counties are included in the 50 U.S. counties with the highest AI/AN-alone populations. The counties among the top 20 are : Los Angeles County (rank 1); San Diego County (rank 11); San Bernardino County (rank 14); Orange County (rank 15); and Riverside County (rank 17).

One of DHCS' goals and challenges is to ensure that all Californians have access to effective services provided in a manner compatible with their cultural health beliefs and practices. DHCS has for many years sought to improve the quality and accessibility of alcohol and other drug (AOD) services available to the AI/AN community through solicited input from representatives on DHCS policies and priorities. DHCS looks forward to continuing to develop its system for working with California's AI/AN communities. Through these efforts, DHCS looks forward to strengthening its outreach and support that will result in regular and meaningful communication with elected tribal leaders in California.

DHCS has a position serving as liaison to California's AI/AN communities. Requests made to ADP from AI/AN constituents or regarding AI/AN issues or needs are directed to the AI/AN liaison. The liaison also coordinates DHCS consultation with its AI/AN Constituent Committee (NAC Committee), elected tribal officials, California area Indian health boards, Southern California Tribal Chairman's Association, Tribal Health Operating Units, Single Tribe Health Clinics, and Urban Health Programs.

DHCS' NAC Committee offers DHCS advice on ways to improve and expand AOD services to California's AI/AN population. The NAC Committee consists of up to twelve representatives selected for their involvement in the AI/AN community and knowledge of AOD prevention, treatment, and recovery services, as well as the unique needs of the communities within the region of the state that they represent. The NAC Committee offers DHCS input on issues and concerns within the California AI/AN communities, and the NAC Committee is asked for input when DHCS proposes significant policy changes that may impact services to the AI/AN communities.

The Chair of DHCS' NAC Committee additionally serves on the DHCS Director's Advisory Council (DAC). The DAC members represent alcohol and drug program leaders, judges, directors of provider organizations, AOD educational organizations and/or Counselor Certification Organizations, the County Alcohol and Drug Program Administrator's Association of California, and DHCS' eight constituent committees. The DAC is intended to be responsive to critical issues from the larger AOD field, identify barriers to access for unserved/underserved populations, and provide feedback to the organizations and communities represented.

California statute (Health and Safety Code Section 11814) requires DHCS to allocate state and federal AOD treatment and prevention funds based on the population of each county. Counties receiving SAPT Block Grant allocations will be asked to annually assess the alcohol and other drug prevention, treatment, and recovery service needs of the AI/AN communities within their districts. These counties will be asked to develop and submit to the state for review and approval a plan for addressing the identified needs of the AI/AN communities. Counties will also need to describe their system for ongoing consultation with the tribal governments within their counties, specifying the names and contact information of the elected tribal leaders with whom they will collaborate. Additionally, counties are required to ensure compliance with the State-County contract and terms of the SAPT BG through an annual compliance monitoring review. Embedded in the review process is a section specific to tribal communities and organizations requiring counties to respond to questions related to collaboration efforts taking place within the county with federally recognized tribes and those that are not identified on the list of federally recognized tribes, identify barriers to collaboration and how counties attempt to mitigate those barriers as well as offer another avenue for counties to identify technical assistance needs.

DHCS has a technical assistance (TA) and training contract to improve AOD prevention, treatment, and recovery services provided to AI/AN Californians and to expand AI/AN community awareness of available AOD services. The nature and quantity of training requests and data received through pre- and post-evaluations assist the contractor in establishing a baseline understanding of the AOD service needs of Native Americans in California.

In 2010, ADP required bidders competing for its renewed AI/AN TA contract to perform an assessment of the current need for AOD services within California's AI/AN population and to describe how, utilizing evidence-based practices, strategies, or approaches, they would address the identified needs. In November 2011, the awarded contractor, the Oakland Native American Health Center, began submitting the first of three annual reports describing the effectiveness of the contractor's solutions to reducing systemic, programmatic, and fiscal barriers to prevention, treatment, and recovery of AOD problems. The reports have provided an update on the identified gaps in ADP services by county or geographic area and the effectiveness of its technical assistance and training for improving AOD prevention, treatment, and recovery services and expanded awareness of AOD prevention in all ages of Native American women. At the state level, California Outcomes Measurement System-Treatment (CalOMS-Tx) data is collected on individuals who self-identify as AI/AN and request treatment from publicly funded providers. Data collected from SAPT Block Grant providers and input received from the NAC Committee and TA provider is included in DHSC' Statewide Needs Assessment and Planning (SNAP) process. Additionally, the State Epidemiological Outcomes Workgroup is examining appropriate data sources to better inform the needs assessment pertaining to California AI/AN communities.

DHCS will be expanding its system for consulting with California AI/AN communities in several ways. As DHCS proposes significant policy changes and/or shares important updates on activities taking place within the AOD field, DHCS will work with key health care and tribal stakeholders to participate in meetings that convene all elected tribal leaders. California's elected tribal officials will be invited to attend and to participate in DHCS advice seeking and information sharing activities. DHCS will work with the Pacific Regional Office of the federal Bureau of Indian Affairs to obtain a list of California elected tribal leaders so that they may be notified of upcoming DAC meetings and be invited to attend and participate.

In 2010, the landmark legislation, the Tribal Law and Order Act (TLOA), was signed into law by President Obama. One of the major components of this legislation was the development and support of more effective prevention programs to combat alcohol and drug abuse among at-risk youth. A unique government-to-government relationship exists between Indian tribes and federal and state governments. As a state agency responsible for administering federal programs, our role in the development of a Tribal Consultation policy and the recognition of this special relationship to tribal communities remains at the forefront.

DHCS is committed to working collaboratively with tribes to improve the quality, availability, and accessibility to substance use disorder prevention, treatment, and recovery services for California's AI/AN communities. The involvement of tribes in the SNAP process will provide input on tribal needs and culturally appropriate approaches to addressing important issues. In 2011, ADP convened a meeting with elected and appointed tribal leaders of California's 109 federally recognized tribes to collaboratively develop a system for ongoing consultation between ADP and tribal leaders. To help ensure appropriate representation during this process, ADP worked with the Pacific Regional Office of the federal Bureau of Indian Affairs and California Rural Indian Health Board to establish a comprehensive list of elected and appointed tribal leaders.

An outcome generated from this meeting was the ongoing need for future meetings addressing consultation and relationship building that will assist in establishing communication channels with each tribe's elected leadership.
DHCS is committed to establishing mechanisms for addressing issues of both statewide and regional concern; making those concerns a part of DHCS' assessment and planning processes; and continuing with the coordination efforts with our partners at the local county administrator level.

This ongoing relationship will be beneficial to both DHCS and the tribes in increasing their knowledge and understanding of our programs and policies in our common goal to improving delivery of services and treatment to California's AI/AN communities. Input generated from tribal consultation will be integrated into DHCS' decision making process.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data and Information Technology

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

DHCS has data systems that are designed to meet the data collection and reporting systems necessary to respond to the reporting requirements for the SAPT Block Grant, Health Insurance Portability and Accountability Act, and the Access to Recovery Grant. The data systems are the following:

- California Outcomes Measurement System for Treatment (CalOMS Tx),
- CalOMS Prevention (CalOMS Pv),
- Drug and Alcohol Treatment Access Report (DATAR)
- Net Negotiated Amount and Drug Medi-Cal contract and cost reporting system (NNA/DMC),
- Master Provider File (MPF)
- Short-Doyle Medi-Cal ADP Remediation Technology (SMART),
- California Access to Recovery Effort (CARE).

Previously, ADP developed the Short-Doyle Medi-Cal ADP Remediation Technology (SMART) system as part of a larger project with the Department of Health Care Services (DHCS), which is the single state agency for Medicaid programs in California, and the Department of Mental Health (DMH). The purpose of the project was to ensure that all data systems that manage Medicaid payments for behavioral health services in California are fully HIPAA compliant. As ADP and DMH have been transitioned into DHCS, DHCS will continue working to implement the 5010 standard, which will require minimal remediation of the SMART system and more extensive enhancement for DHCS.

SMART data does collect client level data at the treatment episode level for the Medicaid funded program known as Drug Medi-Cal, however, it does not directly impact the data collected by the California Outcomes Measurement System (CalOMS). As of July 1, 2013, DHCS is the designated single state agency (SSA) and will be responsible for updating CalOMS to collect the necessary data. The minimal remediation to the SMART system is to become fully compliant with the HIPAA 5010 standard and ICD 10. Full deployment is dependent on the readiness of the Short-Doyle Medi-Cal system operated by the DHCS.

The CalOMS Tx system identifies clients who are publicly funded including DMC, SBG, State General Funds, and County funds. Data from CalOMS Tx and the SMART system are used to project annual Drug Medi-Cal (DMC) caseloads and a variety of other reports. Data from the State/County contract and cost report system are used for establishing DMC rates annually.

Last year ADP identified a potential modification to an existing data system that will make it possible for DHCS to collect data on each treatment episode for all service recipients funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

As reported earlier in this application, California has begun a state reorganization of the Department of Health Care Services (DHCS), Department of Mental Health (DMH) and the Department of Alcohol and Drug Programs (ADP). The reorganization is designed to create increased efficiencies within state and local programs, and prepare California for implementation of the Affordable Care Act (ACA). The transfer occurred on July 1, 2013. DHCS will continue discussions on the potential modification to an existing data system that will make it possible to collect data on each treatment episode for all service recipients funded by the SAPT Block Grant.

The modifications will be significant and will require extensive assessment and analysis and approval by a variety of control agencies. The following table provides an estimated timetable for the completion of the full lifecycle, including reviews and approvals.

Activity	Organization	Start	End
Assessment of necessary modifications to CalOMS	ADP/DHCS	01/2013	09/2013
Integration assessment of necessary modifications/consolidation of various Medi-Cal Outcome Measurement systems	DHCS	10/2013	09/2014
Complete business requirements	DHCS	10/2014	01/2015
Secure Control Agency approvals	DHCS/CHHS/CTA	02/2015	03/2015
Complete procurement process	DHCS	04/2015	06/2015
Complete detailed design	DHCS	07/2015	09/2015
Perform system development	DHCS	010/2015	05/2016
Complete integration and user acceptance testing	DHCS	06/2016	09/2016
Data conversion & quality assurance and user training	DHCS	10/2016	12/2016
Deploy system	DHCS	01/2017	01/2017
Begin data collection & system maintenance	DHCS	02/2017	On-going

The State of California has received a $1 million Exchange Planning and Establishment Grant, to be used to develop a detailed business and implementation plan leading up to the 2014 operation of the California Exchange.

The grant enables California to accomplish the following:

- Inventory and analyze existing state and local programs and resources,

- Develop appropriate workplans and timelines for Exchange implementation, and
- Begin to define the additional infrastructure, resources, data and coordination activities that will be needed to make the California Exchange operational by 2014, consistent with federal requirements and available federal funds.

DHCS participates in regularly scheduled meetings to plan the operation of the California Exchange. For the immediate future, funds designated for DMC, the California substance abuse option for providing treatment for Medicaid beneficiaries, will remain separate and distinct from the exchange. The group is exploring the options for data systems, and exchange of information between the general health care data system and the Substance Use Disorder (SUD) data systems. As the federal government provides more guidance on the provision of SUD services under HCA, ADP may become more directly involved in the California Exchange.

In State Fiscal Year (FY) 2010-11, the ADP Health Care Reform Committee, consisting of ADP staff, county representatives, and providers, met to identify standards for Electronic Health Records (EHR) to be used in the field. The current guidance provided to the counties and providers is that any EHR they adopt must be consistent with the standards developed by the Certification Commission for Health Information Technology (CCHIT). ADP conducted a readiness survey with stakeholders, and compiled the results using Survey Monkey. In addition, ADP notified stakeholders of the standards any EHR software application they adopt must meet. With the SSA transfer complete, the results of the readiness survey will be shared with DHCS to determine future actions related to EHRs.

As the Office of the National Coordinator for Health Care Technology (ONC) moved to the permanent certification program in 2012, the guidance to the California counties and providers was to adopt EHRs that are certified by an organization that is accredited by the American National Standards Institute (ANSI) as the ONC-Approved Accreditor (AA) for the Permanent Certification Program. The system must be one whose testing is consistent with the functional and conformance testing requirements, test cases, and test tools developed by the National Institute of Standards and Technology (NIST) to support the proposed Health IT Certification Programs. In addition, it will be necessary for the EHR system selected by each county and/or provider to comply with the Standards and Interoperability Framework to ensure seamless electronic exchange of health information between different organizations and EHR systems.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

R. Quality Improvement Plan

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

Prior to the elimination of ADP and the transfer of its programs and staff to DHCS, ADP was committed to addressing Continuous Quality Improvement (CQI). This commitment to CQI and the efforts described below will continue under DHCS. Examples of the quality improvement efforts at the state level include:

- ADP adhered to the Substance Abuse Prevention and Treatment (SAPT) Block Grant required independent peer review process to assess and improve the quality and appropriateness of treatment services delivered by providers that receive block grant funds. One of ADP's main goals of the peer review was to ensure that continuous quality improvement is practiced in all of its programs.

- The establishment of the Continuum of Services System Re-engineering (COSSR) Task Force to build a system of care based on the Institute of Medicine (IOM) Quality Chasm Series. The COSSR Task Force is working to move standards of care from an acute illness-based system to a chronic illness model to address the prevention, treatment, and RSS needs of consumers.

- The development of the Statewide Needs Assessment and Planning (SNAP) process to support ADP initiatives by generating data and information to facilitate departmental decision-making and operation innovations. (SNAP has been addressed further in the planning steps of the behavioral health assessment and plan within this application.)

- The draft development of *California's Best System Practices for Substance Use Conditions*, as adapted from the *National Quality Forum's National Consensus Standards for the Treatment of Substance Use Conditions.*

- The draft development of Treatment Standards for Substance Use Disorders: A Guide for Services to be Used to Enhance Current Provider Certification Standards.

- ADP and now DHCS contracts with experts to provide technical assistance and training services to help reduce and prevent problems associated with alcohol, tobacco, and other drug (ATOD) and problem gambling among the state's diverse populations. These services, provided free of charge to California agencies, organizations, community groups, and individuals, focus on specific populations and subject areas which assist the Department in the quality improvement of services provided at the State and local level.

In addition to the CQI efforts listed above, ADP also developed a Cultural Competency Quality Improvement (CCQI) Strategic Plan. Through an extensive and fast-track planning process, the Department adopted the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health, U.S. Department of Health and Human Services, as the guide for developing a Cultural Competency Quality Improvement Strategic Plan to support CQI in our service delivery system. This Plan supports not only the previous ADP Vision, Mission and Core Programs but supports DHCSs overall Strategic Goals as well.

CQI is addressed on an ongoing basis by DHCSs Performance Management Branch, County Monitoring Unit (CMU). The CMU has primary responsibility to monitor counties' adherence to State/County contract requirements and the SAPT Block Grant terms and conditions. In addition, programmatic oversight is achieved through the County Monitoring process. This is accomplished by an annual review of each County which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 45 and CFR 42.

The county monitoring process has been designed to operate in three-year cycles, all SAPT Block Grant and contract requirements are reviewed once in the three-year cycle. The monitoring instrument is revised annually to encompass different components of the requirements, as well as other programmatic areas the department deems necessary to oversee. Based on compliance rates or emphasis areas some components may be reviewed annually rather than once in the three-year cycle, however, at minimum all requirements are reviewed at least once in the three-year period of time. During the annual review process CMU collects information on the counties adherence to the State-County contract requirements by administering a monitoring instrument to County Alcohol and Drug Program Administrators. The instrument elicits qualitative responses as well as certifications from County Administrators and their staff who directly oversee the provision of substance use services at the local level.

The county monitoring process improves fiscal and programmatic accountability of Counties within the state and ensures that the use of SAPT dollars is maximized by identifying barriers and implementing solutions at the local level. Through the review process monitoring analysts identify areas of deficiencies or

concerns that may adversely affect alcohol and other drug (AOD) services provided within the County. Once a review has been completed, the monitoring analyst will submit a report to the county identifying highlights, findings, advisory recommendations and required follow up. The County is required to respond to the compliance deficiencies identified in the report by submitting a corrective action plan documenting how the findings will be rectified. It is the responsibility of the monitoring analyst to ensure that appropriate technical assistance is provided to Counties to assist in addressing local needs.

In addition to the standard compliance requirements, monitoring efforts continue to focus on ensuring that public dollars used at the county level to support AOD programs and services are expended for their intended purpose through an extensive evaluation of county policies, procedures and practices; gathering information regarding services available for special populations including people with Co-occurring Disorders (COD), Veterans, those involved with the Criminal Justice System, Homeless, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), and Tribal Communities; and providing treatment outcome information in the form of Data Indicator Reports to county administrators for the purpose of quality improvement of treatment services provided by counties and their sub-contracted providers.

These activities, in addition to the technical assistance provided, technical assistance documents developed and trainings conducted, continue to assist counties, contracted providers, and ADP in developing and maintaining quality and effective AOD programs and services at the local level.

While the County Monitoring process primarily serves to satisfy a compliance function, it also provides valuable data for program oversight and improvement as well as long term planning at the state level by providing a snapshot of the status of different components of the AOD system statewide.

ADP has made considerable efforts to improve accountability of California's treatment system. As part of this effort, ADP developed three Data Indicator Reports (DIRs), The County DIR, Non-NTP Outpatient Treatment Services report, The County Detailed DIR for Non-NTP Outpatient Treatment Services by Provider, and The County Race/Ethnicity Data Profile Non-NTP Outpatient Treatment Services which are discussed with counties as part of their monitoring review described above. These reports are used to assess county and provider performance using discharge status and criteria that research has shown improves a client's potential for long term recovery. Research indicates that clients who met the criteria identified are more likely to achieve and maintain abstinence, have positive outcomes at discharge, and maintain or have longer periods in recovery. The Non-NTP Outpatient Treatment modality was the first selected to assess county treatment outcomes because all counties within the State make available outpatient services, therefore performance could be reviewed statewide. The DIRs primarily serve as a tool for counties to measure

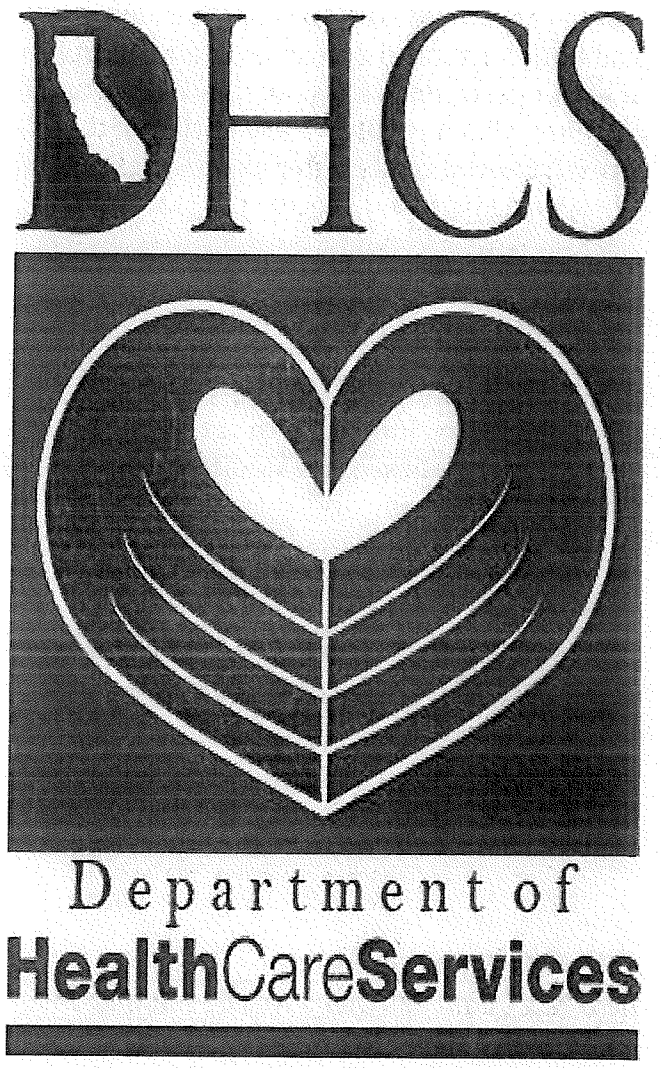
completed treatment percentages within each of the identified criteria and allows counties to compare their performance to California statewide averages.

In addition to looking at performance measures and outcomes related to completed treatment success, it is important to look at the correlation of successful treatment completion and race/ethnicity. As stated in the Department's Cultural Competency Quality Improvement Strategic Plan, one of the goals of ADP and now DHCS is to ensure that the Department institutionalizes goals, policies, operational plans, and management accountability. The County Race/Ethnicity Data Profile Non-NTP Outpatient Treatment Services was developed to measure how well our California AOD system of care is doing in terms of addressing the needs of diverse populations within the state. This report demonstrates potential gaps in cultural/diversity-specific treatment services and provides information on how specific race/ethnicity groups are referred into treatment, which groups are falling out of treatment prematurely and which groups are not reaching successful completion. Additionally, this report has been broken down into two sub-reports: County Race/Ethnicity DIR by Length of Stay Non-NTP Outpatient Treatment Services and County Race/Ethnicity DIR by Discharge Status. Both of these reports provide data by provider and allow for the opportunity to determine if specific providers could benefit from technical assistance related to particular race/ethnicities. As part of the Department's quality improvement effort, ADP will continue to share the DIRs with counties as well as provide regional trainings regarding the importance of using data for continuous program improvement.

Department of Health Care Services, Strategy for Quality Improvement in Health Care

The Department of Health Care Services (DHCS) has placed a renewed emphasis on achieving high quality and optimal clinical outcomes in all departmental programs. This focus closely aligns with the Department's mission: to preserve and improve the health of all Californians. To help achieve this mission, DHCS initiated the *DHCS Strategy for Quality Improvement in Health Care* (referred to hereafter as the *Quality Strategy*), which describes the goals, priorities, guiding principles, and specific programs related to quality improvement.

The initial version of the *DHCS Quality Strategy* is provided as an attachment for your review. The CQI efforts for the programs that were transferred to DHCS from ADP on July 1, 2013, will be incorporated into the *DHCS Quality Strategy*, over the next year of transition.



Toby Douglas, Director

Strategy for Quality Improvement in Health Care

November 2012

Introduction and Background

The Department of Health Care Services (DHCS) is placing a renewed emphasis on achieving high quality and optimal clinical outcomes in all departmental programs. This focus closely aligns with the Department's mission: to preserve and improve the health of all Californians. To help achieve this mission, we are initiating the *DHCS Strategy for Quality Improvement in Health Care* (referred to hereafter as the *Quality Strategy*), which describes the goals, priorities, guiding principles, and specific programs related to quality improvement.

Why the renewed emphasis on quality and outcomes in DHCS? Most importantly, we have an ethical obligation to provide the best possible care and service to Californians and to be responsible stewards of public funds. In addition, there is a confluence of other drivers. Addressing the issue of limited and declining health care resources, Donald Berwick, MD, former Administrator, Centers for Medicare and Medicaid Services (CMS) has noted on many occasions that the most effective and appropriate way to reduce health care costs is to do so by improving quality.

Another driver is the Department's five-year 1115 federal waiver, entitled *Bridge to Reform*, which is improving clinical quality through better coordination of care for vulnerable populations, care delivery redesign, population-focused interventions, and enhanced patient safety. By improving quality, these efforts will help to bend the health care cost curve. Finally, the Affordable Care Act (ACA) (P.L. 111-148)[1] addresses many important health care quality issues in domains such as prevention and health promotion, patient safety, coordinated and complex care, community health, and new care delivery models.

Development of the DHCS Quality Strategy

This initial version of the *DHCS Quality Strategy* was developed using the National Strategy for Quality Improvement in Health Care (National Quality Strategy or NQS) as a foundation (see Appendix for a summary of the NQS). Because quality improvement is challenging and resource-intensive, it is important to look for areas of vertical alignment—meaning there is consensus at the federal, state, regional, and provider levels. The NQS used an extensive and broad stakeholder engagement process, making it a reasonable starting point for the *Quality Strategy*. The *DHCS Quality Strategy*, however, specifically addresses the needs of Californians and focuses on the Department's programs.

Three Linked Goals

Consistent with the Institute for Healthcare Improvement's Triple Aim and the Three Aims of the NQS, *DHCS's Quality Strategy* is anchored by Three Linked Goals:

1. Improve the health of all Californians;
2. Enhance quality, including the patient care experience, in all DHCS programs; and
3. Reduce the Department's per capita health care program costs.

[1] Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010.

The Three Linked Goals are integral to the development, implementation, and ongoing updates of the *Quality Strategy*.

The Department's Seven Priorities

The Department's seven priorities of the *Quality Strategy* are to:

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

The first six priorities are very similar to those in the NQS since they are relevant to public- and private-sector care delivery across many patient populations. The seventh priority, "Eliminate Health Disparities," is particularly significant for the population served by DHCS programs, including Medi-Cal, and it is very similar to NQS Principle #3—which is a cross-cutting commitment to eliminate disparities due to race/ethnicity, gender, age, socioeconomic status, geography, and many other factors. The order of the seven priorities does not indicate prioritization. All seven domains are of high priority.

Additional commentary and specific examples associated with each priority is provided below. The examples are not an inventory of current DHCS quality efforts, which are extensive. An inventory is being completed and will be released at a later date. Instead, the examples are intended to illustrate the types of efforts that will be developed fully within the *Quality Strategy*.

Improve patient safety. In spite of the national attention devoted to patient safety since the publication of the Institute of Medicine (IOM) report, To Err is Human: Building a Safer Health System,[2] the burden of death and disability attributable to preventable medical error remains unacceptably high. It is essential that DHCS work closely with stakeholders to design policy and program interventions aimed at reducing health care-acquired conditions. Progress must also be tracked, quantitatively, to ensure the achievement of better health outcomes.

Examples of Patient Safety Initiatives

- ***Reduce Provider-Preventable Conditions through Implementation of Section 2702, ACA.*** Working closely with stakeholders, the Department will reduce preventable adverse events known as Provider-Preventable Conditions (PPCs). PPCs include events such as: a foreign object retained after surgery, advanced pressure ulcers, falls and trauma, and surgical site infections. They also include so-

[2] Kohn KT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999.

called never events involving surgery: wrong procedure, wrong site, and wrong patient. The State Plan Amendment to implement Section 2702 was recently approved by CMS with an effective date of July 1, 2012.

- ***Advance Patient Safety in California's Public Hospitals.*** The Delivery System Reform Incentive Pool (DSRIP) Program is an important component of the 1115(a) Medicaid Demonstration program, "Bridge to Reform." A significant portion of the DSRIP Program is devoted to patient safety. Details of this work can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx. Two areas of focus for all 17 designated public hospital systems are: (1) improved detection and management of sepsis (serious, life-threating blood infections); and (2) central line-associated bloodstream infection prevention. In addition, each public hospital system will be implementing other quality improvement initiatives that are relevant to the individual institutions. Each quality improvement focus will: (1) specify a measureable impact on population health; (2) have a strong evidence base; and (3) have the potential to reduce morbidity, mortality, or both in the public hospital population. Beginning July 2013, many of the designated public hospital systems will be launching a program to advance the quality of care provided to HIV/AIDS patients. This quality improvement program is part of the Low-Income Health Program (a component of the 1115(a) waiver).

- ***Enhance Maternal Quality of Care and Improve Obstetrical Outcomes.*** With over 45% of births covered by Medi-Cal, DHCS is committed to improving maternal quality of care and reducing the rate of elective deliveries prior to 39 weeks of gestation. Research indicates that elective deliveries before 39 weeks increase the risk of significant complications for the mother and the baby, as well as long-term health problems. DHCS will monitor the recently announced federal Strong Start Initiative, a public-private partnership to reduce the rate of early elective deliveries, that will make available a funding opportunity for providers, states and other applicants to test the effectiveness of enhanced prenatal care approaches to reduce preterm births for women covered by Medicaid and at risk for preterm births. In addition, DHCS will partner with the California Maternal Quality Care Collaborative on efforts to implement clinical best practices and quality improvement techniques to end preventable morbidity, mortality, and disparities in California maternity care.

- ***Reduce Neonatal Nosocomial Infections.*** Working with the California Perinatal Quality Care Collaborative (CPQCC), DHCS will reduce/eliminate catheter-associated blood stream infections and other hospital-acquired infections in California Children's Service (CCS)-approved Neonatal Intensive Care Units (NICUs). In addition to improving patient safety, the opportunity to share best practices with other NICUs will result in improved communication among hospitals and their staffs, and should also produce cost-savings for hospitals.

- ***Identify Quality Improvement Opportunities for Neonatal Intensive Care Units.*** Through the High Risk Infant Follow-up (HRIF) Quality of Care Initiative, DHCS, in collaboration with CPQCC, has developed a web-based HRIF Reporting System to

collect data for the CCS HRIF Program. The reporting system will: 1) identify quality improvement opportunities for NICUs in the reduction of long-term morbidity; 2) allow programs to compare their activities with all sites throughout the state; and 3) allow the state to assess site-specific successes. The system, collecting data on high-risk infants up to their third birthday who are enrolled in the CCS HRIF Program, will add value to the current CPQCC data already collected.

- ***Reduce Harm Caused in Hospitals.*** DHCS will engage stakeholders to determine the best ways to support the National Partnership for Patients (PfP) Initiative, which aims to: 1) keep patients from getting injured or sicker, and 2) help patients heal without complication. The goals of this public-private partnership are to decrease hospital-acquired conditions by 40% and preventable readmissions by 20% by 2013.

- ***Reduce Potentially Preventable Events (PPEs).*** DHCS is committed to improving all aspects of patient safety and the overall quality of care provided to its members. As such, DHCS will place an emphasis on reducing Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Complications (PPCs), Potentially Preventable Emergency Department Visits (PPVs), and Potentially Preventable Ancillary Services (PPSs). DHCS will work with its contracted managed care plans and contracted actuary, Mercer Health & Benefits LLC, to develop an evidence-based payment method focused on reducing PPAs as a first step. Development of a method such as this is justified by the need to reduce the incidence of PPEs, coupled with the strong evidence base that such reductions are achievable using readily available system-change strategies.

Deliver effective, efficient, affordable care. It is no longer tenable to simply look at the effectiveness or cost of care in isolation. As embodied in the Department's commitment to the Three Linked Goals, we must simultaneously consider the perspectives of population health, quality of care, and the per capita cost of care, given finite and shrinking budgets and the need to serve more Californians. The complexities of this challenge will require the development and testing of new models of care such as medical homes and accountable care organizations. Also included in this priority area is the need to eliminate ineffective care as well as fraud and abuse.

Examples of Effective, Efficient, Affordable Care Initiatives

- ***Improve Care Coordination for Seniors and Persons with Disabilities.*** The 1115 Waiver allows DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes by transitioning the Seniors and Persons with Disabilities (SPD) population into Medi-Cal Managed Care. Beginning June 2011, DHCS began enrolling the SPD population into managed care in 16 counties. The Governor's 2012-13 budget proposes to expand Medi-Cal managed care statewide starting in June 2013. The proposal combines strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives

and improve care continuity across medical services, long-term services, and behavioral health services.

- ***Integrate Care for Dual Eligible Individuals.*** DHCS is developing a pilot program to test innovative payment and person-centered delivery models that integrate the full range of acute, behavioral health, and long-term supports and services for members that are dually eligible for Medicare and Medi-Cal. DHCS is using federal funding to support this work through the federal Coordinated Health Care Office. The pilot goals are to: 1) coordinate Medicare and Medi-Cal benefits across care settings; 2) maximize the ability of dually eligible individuals to remain in their homes and communities with appropriate services and supports in lieu of institutional care; and 3) minimize or eliminate cost-shifting between Medicare and Medicaid. DHCS aims to achieve significant efficiencies and improved care for members that are dually eligible.

- ***Develop a Performance Outcome System for Early and Periodic Screening, Diagnosis, and Treatment in Mental Health Services.*** DHCS, in collaboration with stakeholders, is designing a mental health services performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment as mandated by Senate Bill 1009 (Chapter 34, Statutes of 2012). The specific aims of the system are to: (1) ensure access of eligible children and youth to appropriate mental health services; (2) provide information that improves quality at the patient and system levels; and (3) evaluate services, over time, for effectiveness and efficiency. While the focus of this system is on children, the Department plans to use what it learns from this process to similarly improve how it measures and continuously improves the mental health system's performance and outcomes for adults.

- ***Improve Health Outcomes for Members with Severe Mental Illness and Children with Serious Emotional Disorders.*** DHCS is committed to providing safe, effective, efficient, patient-centered care to Medi-Cal members with chronic physical and mental health conditions. Through the California Mental Health Care Management Program (CalMEND) Pilot Collaborative, DHCS has partnered with six California counties to implement care management quality improvement processes at the local level to improve the integration of mental health care and primary care services to Medi-Cal members with severe mental illness (SMI) and children with serious emotional disorders (SED). Going forward, CalMEND hopes to continue its quality improvement efforts in promoting safe and effective use of pharmacotherapy treatment for the SMI and SED populations.

- ***Improve Psychotropic Medication Use in Children and Youth in Foster Care.*** Building on the experience from the CalMEND project, DHCS is working with the California Department of Social Services (CDSS) to develop a project that seeks to dramatically improve psychotropic medication use within this population by 2015. Abuse of psychotropic medication in children and youth is prevalent among those in foster care. Measures of system improvements will include: improving care coordination, removing barriers and improving the efficient use of a health and

education passport, and improving care through strengthening partnerships with youth and families. Key elements of the project include: 1) strategies to engage providers to improve adherence to guidelines for prescribing and administering psychotropic medications; and 2) establishing an engaged partnership among youth and adults. Together, these elements will help to achieve success for the project.

- ***Improve Care Coordination for Children with Special Health Care Needs.*** DHCS will demonstrate improved care coordination for children with special health care needs through a Demonstration Project using four proposed pilot models: 1) Existing Managed Care Plans; 2) Enhanced Primary Care Case Management; 3) Specialty Health Care Plans; and 4) Provider-Based Accountable Care Organizations. Improved care coordination for this vulnerable population will result in improved health outcomes, improved cost-effectiveness and clearer accountability, improved satisfaction with care, and the promotion of timely access to family-centered care.

- ***Control Rising Cost of Care and Improve Quality of Care Through Implementation of Diagnosis-Related Group-Based Hospital Reimbursement.*** DHCS, in consultation with stakeholders, is developing a new method of paying for hospital inpatient services in the fee-for-service Medicaid program. Instead of paying hospitals on a cost or charge basis, effective January 1, 2013, hospitals will be paid prospectively on a fixed-price system based upon the diagnosis-related group (DRG) into which a patient is classified. By discouraging unnecessary and potentially harmful procedures, and by encouraging the concentration of complex procedures in facilities that conduct them frequently, DRGs have become widely recognized as one of the most important cost control and quality improvement tools that governments and private payers have implemented.

Engage persons and families in their health. There are many reasons why person and family engagement is important. Fundamentally, adult patients have the right to make informed decisions on all aspects of their care. Therefore, they must be engaged actively in health care decision-making. In addition, in many situations (e.g., when the patient is a minor), families must have an active role in health choices. Furthermore, engaging persons and families in their health is appropriate to foster adherence to lifestyle, medication, behavioral, and other medical recommendations that can have a major impact on health.

Example of an Emerging Engagement Initiative

- ***Leverage Social Media and Other Community Outreach Tools to Engage Members in their Health and Health Care.*** Social media tools such as Facebook, Twitter, text messaging, and blogs have the potential to transform relationships between health care providers and their members, as these tools provide opportunities for bi-directional conversations to take place. DHCS recognizes the importance of members taking an active role in their health and health care and is committed to collaborating with partners, including health plans and hospitals, to use social media and other community outreach tools to: (1) enhance transparency; (2) engage members to solicit their ideas, suggestions, and feedback; (3) connect

members to health-promoting resources in their communities; and (4) foster health-promoting social networks.

Enhance communication and coordination of care. To achieve coordinated care, it is essential to have rapid, consistent communication of all necessary clinical information among providers. Such communication will help to reduce medical errors and duplicative care and to advance health care quality. Effective communication among providers is especially important for persons with one or more chronic conditions to achieve effective and efficient management of their complex care needs. Enhanced communication and coordination depends primarily on thoughtful system design, which ensures that clinical decision-making can occur with ready access to all necessary information. Technology, such as electronic health records, e-prescribing, and telehealth, can support and facilitate effective coordinated care but will not be effective unless underlying information flow is designed appropriately.

Examples of Communication and Coordination Initiatives

- ***Increase the Adoption of Electronic Health Records.*** Electronic Health Records (EHRs) are a key enabling technology for improving the quality, safety, and efficiency of the health care system. By administering the Medi-Cal EHR Incentive Program, which is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, it is DHCS' goal that by 2015, 90% of Medi-Cal providers eligible for incentive payments will have adopted EHRs for meaningful use in their practices. EHR adoption will result in: 1) improved care coordination among Medi-Cal providers, as Medi-Cal providers and members will be able to use available electronic information to make informed health care decisions at the point of care; 2) greater member engagement, as members will have electronic access to their Personal Health Record and self-management tools by 2015; and 3) population health improvement, as member and population health data from EHRs will be shared bi-directionally between providers, DHCS, the California Department of Public Health (CDPH), the Office of Statewide Health Planning and Development, and other approved institutions. Such data sharing will support the essential functions of public health and assessment of the effectiveness, quality, accessibility, and cost of care.

- ***Participate in and Contribute to the Development of the Health Information Exchange (HIE) in California.*** The HITECH Act was passed nationally as part of the American Recovery and Reinvestment Act to provide the technology framework for care delivery transformation. DHCS is partnering with the other HITECH grantees and partners to develop and implement the policy framework, standards, and funding models for health information to be exchanged electronically to improve outcomes and reduce cost.

- ***Optimize Clinical and Administrative Data and Information to Advance the Three Linked Goals.*** To provide leadership and coordination for clinical data and information flows, the Department has recently appointed Linette Scott, MD, MPH as

Chief Medical Information Officer (CMIO) to work with counterparts in health plans and health care environments to improve clinical and administrative data necessary to monitor success in this priority area. The CMIO will also work across DHCS programs to maximize the impact of initiatives affecting data availability, such as the Medicaid Information Technology Architecture (MITA), HITECH, and Health Insurance Portability and Accountability Act (HIPAA) 5010 and International Classification of Diseases (ICD)-10 conversions. DHCS recognizes the importance of both clinical and administrative data to monitor progress throughout all aspects of the *Quality Strategy*.

Advance prevention. Advancing prevention encompasses primary, secondary, and tertiary prevention. Primary prevention prevents disease in healthy people. Secondary prevention prevents or reverses disease at an early or precursor stage. Tertiary prevention reduces mortality and morbidity in patients with established disease. Prevention interventions are usually not cost-saving. However, they are frequently cost-effective, meaning they are "good buys" when compared with other alternatives. More importantly, there is an ethical imperative that it is better to prevent rather than treat disease, where possible, because the goal of care at the individual and societal level is to preserve and enhance health.

Examples of Prevention Initiatives

- ***Reduce the Smoking Rate Among Medi-Cal Members.*** Although California has the second lowest smoking rate in the country at 12 percent, 3.6 million Californians are current smokers. Approximately 725,000 of these smokers are adult members in the Medi-Cal program. In addition, smoking rates are disturbingly high among certain subgroups such as low-income residents with diabetes and other chronic diseases. Through a coordinated, system-wide initiative, DHCS will promote adoption of the policy and systems-change strategies outlined in the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update* as recommended by the Agency for Healthcare Research and Quality (AHRQ). By making available the full complement of effective tobacco use treatments, adapting clinical systems to assess all patients for tobacco use, strongly advising those that smoke about the importance of quitting, referring smokers to evidence-based treatments, and training Medi-Cal providers on evidence-based tobacco use treatment strategies, DHCS will reasonably be able to reduce smoking prevalence by 25% among adult Medi-Cal members.

  Through the Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Program, authorized under section 4108 of the ACA, DHCS will test the effectiveness of providing incentives directly to Medicaid members who participate in the Medi-Cal Incentives to Quit Smoking (MIQS) Project and change their health risks and outcomes by adopting healthy behaviors. The MIQS Project will focus on offering incentives to Medi-Cal members for participation in tobacco cessation services through the nationally renowned California Smokers' Helpline. MIQS is expected to demonstrate that tobacco cessation benefits, including both pharmacological and behavioral treatments that are well promoted, barrier-free, and include modest incentives for

utilization and retention, are effective in increasing attempts to quit smoking, reducing smoking prevalence, and lowering Medi-Cal health care costs. The MIQS Project term is September 2011 through September 2016.

- ***Support the Million Hearts Initiative.*** Million Hearts™(MHI) is a national public-private sector initiative that was launched by the United States Department of Health and Human Services (DHHS) in September 2011 to prevent 1 million heart attacks and strokes over five years. The initiative aims to help millions of Americans improve their heart health by preventing and treating high blood pressure, high cholesterol, and tobacco use. Working with our own public and private partners, DHCS will determine the best way to support MHI through its existing programs and emerging quality improvement initiatives.

Foster healthy communities. Approximately half of all preventable mortality is attributable to four lifestyle issues: smoking, poor nutrition, physical inactivity, and alcohol abuse. While these are often viewed as individual choice issues, the most effective means of improving these risk factors in populations is through fostering healthy communities. For example, creation of the social and physical environment in California where non-smoking became the social norm led to a 50% reduction in the smoking rate over 20 years. Therefore, it is essential that the state commit to creating healthier communities to address the obesity and diabetes epidemics (and other public health problems) that threaten to overwhelm the health care system in California. CDPH, voluntary health agencies, community-based organizations, and many other stakeholders play leadership roles in fostering healthy communities. DHCS will work to coordinate with these partners to support this important priority.

Examples of Collaborations to Foster Healthy Communities

- ***Strengthen DHCS' Health Promotion Efforts.*** DHCS recognizes the importance of the collaboration between medicine and public health, acknowledging that behavioral patterns, social circumstances and environmental exposures oftentimes have unfavorable effects on health outcomes. As such, DHCS remains committed to its continued collaboration with CDPH to bridge the gap between health care and community-based improvements that promote healthy choices and environments. In addition to this collaboration, DHCS has established an Interagency Agreement with the U.C. Davis Institute for Population Health Improvement (IPHI), led by Kenneth W. Kizer, MD, MPH to provide thought leadership and technical assistance. Emphasizing the close working relationship, the Department has designated an IPHI scientist, Desiree Backman, DrPH, MS, RD as Chief Prevention Officer for DHCS, to improve population health by enhancing the link between health care and population health promotion.
-

Eliminate health disparities. Eliminating disparities in care is a key facet of health care quality according to the IOM,[3] and it is a core principle of the NQS. Disparities in health care include, but are not limited to, those based on race, color, national origin, sex, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography. The National Health Care Disparities Report[4] is a useful resource to better understand disparities linked to health care and will be used to provide context for the Department's efforts to eliminating such disparities.

Examples of Efforts to Eliminate Health Disparities

- ***Continue to Increase DHCS' Capacity to Eliminate Health Disparities and Support the Activities of the Office of Health Equity.*** DHCS is committed to eliminating disparities in the full continuum of care delivered to its members. As part of this commitment, DHCS will work to both identify and address health disparities using effective intervention and policy. A key partner in this work will be the newly created Office of Health Equity (OHE) within CDPH. Established through legislative mandate, effective July 2012, OHE consolidates DHCS' Office of Women's Health, CDPH's Office of Multicultural Health, Health in All Policies Task Force, the Healthy Places Team, and the Department of Mental Health's Office of Multicultural Services. This reorganization was implemented to better identify and ameliorate health disparities for disadvantaged and underserved communities by examining these issues through a more integrated approach to public health, behavioral health, and health care issues. DHCS recognizes that significant health disparities continue to exist within health care. Working with OHE and other stakeholders, the Department will strive to eliminate disparities in health and health care and to ensure that culturally competent care is provided equitably to those we serve.

Quality Strategy Guiding Principles

The *DHCS Quality Strategy* is anchored in a core set of guiding principles shared by stakeholders throughout California. These principles will guide the achievement of the Three Linked Aims and seven priorities of the *Quality Strategy*. The guiding principles include the following:

1. Person-centeredness and family engagement are central to high-quality care. Health outcomes and patient satisfaction can improve when: (1) patients' needs, experiences, and preferences are taken into account; (2) they are supported by a strong social system at the provider, community and family levels; and (3) they receive clear, understandable information that enables them to actively participate in their own care. DHCS is committed to improving systems of care to ensure the "whole person" is supported throughout the care delivery process.

[3] Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: Institute of Medicine; 2002.
[4] 2010 National Disparities Report, http://www.ahrq.gov/qual/qrdr10.htm

2. Science provides the foundation for policy. Medicine and population health are rapidly evolving fields. New findings from research can reduce mortality and disability, improve health, and help to bend the cost curve. To accomplish these goals, the Department will use evidence-based approaches, including best practices in quality improvement. A valuable resource is the *Quality and Patient Safety* section within the Agency for Healthcare Research and Quality (AHRQ) website.[5] The section provides extensive information on consumer assessment, standardized quality methods, quality metrics, the National Quality Measures Clearinghouse, patient safety, quality diagnostic tools for states, and other important topics. Other organizations providing useful resources for quality improvement include the National Committee for Quality Assurance, the National Quality Forum, the Joint Commission, the Institute for Healthcare Improvement, professional organizations, voluntary health organizations and many other public and private entities.

In the area of clinical prevention, the United States Preventive Services Taskforce (USPSTF) recommendations have been broadly adopted and are referenced in the ACA. Reflecting the constant advances in clinical sciences, the ACA mandates that the USPSTF provide an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. To bridge clinical practice and population health, with a focus on the social and environmental determinants of health, the National Prevention Strategy and the Guide to Community Preventive Services provide approaches that have been proven effective.

3. Integration and coordination of services and systems within the Department and among its partners will accelerate. Vertical and horizontal integration among the Department's programs and services is essential to positively impact the rapidly changing health care environment. Leveraging the efforts of our partners is equally important in creating an effective, patient-centered, continuum of care for our members. For example, one of the biggest opportunities for improving health care and overall health is improving the way we treat and prevent chronic illnesses. Health care providers can offer recommendations on how to stay healthy, but making changes in diet, physical activity, tobacco use, and other lifestyle behaviors is often difficult without community supports and resources. The Department is committed to advancing close coordination between health care providers and those working to improve the conditions in which people live.

4. Policy, interventions, and new innovations are designed and implemented with substantive stakeholder engagement and collaboration. As an entity of state government, DHCS exists to serve the people of California. Certainly patients and beneficiaries of the Department's programs are key stakeholders. Others include, but are not limited to the general public, other units of state government, local government, communities, the provider network, advocacy organizations, and others. DHCS values the voice of its stakeholders and appreciates that collaboration and engagement is necessary to drive innovation and system-wide advancements in care.

[5] AHRQ Quality and Patient Safety Page, http://www.ahrq.gov/qual/.

5. Ongoing evaluation and updates of the Quality Strategy represent a commitment to strive for the highest quality and best possible outcomes. DHCS will continually strive to provide the best possible care to Californians eligible for departmental services. This commitment to continuous quality improvement (CQI) includes:

- Developing integrated, efficient data systems;
- Using rapid-cycle learning and improvement;
- Advancing workforce and organizational development in CQI; and
- Disseminating quantitative and qualitative evidence.

Looking Forward

Initial Version of the Quality Strategy

This version of the *DHCS Quality Strategy* is meant to provide an overview of the Department's approach to quality, but will not have all of the detailed intervention methods and metrics that will be included in successive versions. The intent of releasing an overview was to engage stakeholders at the earliest stage of planning. The Department conducted a statewide webinar to introduce the *Quality Strategy* and administered a statewide stakeholder survey to obtain feedback from the health community. This version of the *Quality Strategy* includes feedback from DHCS staff and stakeholders.

To help inform future versions of the *Quality Strategy*, the Department recently conducted a comprehensive baseline assessment of its current quality improvement activities. The results of the baseline assessment will help inform the development of the next version of the *Quality Strategy*, which will incorporate specific aims, metrics, quality improvement strategies and initiatives, timelines, and evaluation reporting plans. We will focus on quality initiatives that meet the following criteria:

1. Addresses a significant population health issue;
2. There is good evidence that interventions, including program and policy, can improve outcomes and ideally reduce costs;
3. Specific aim(s), with timeframes, are clearly defined;
4. Valid and reliable metrics are employed;
5. Quality improvement management techniques are used; and
6. Ongoing evaluation and reporting are conducted.

The Department will continue to work with stakeholders as the *Quality Strategy* evolves and DHCS lays the groundwork for the next, more specific *Quality Strategy Implementation Plan.*

Quality Strategy Coordination

Neal Kohatsu, MD, MPH, DHCS Medical Director, in collaboration with DHCS senior leadership and in close partnership with stakeholders, is coordinating the development and implementation of the *Quality Strategy*. In addition, DHCS has developed a formal partnership with the U.C. Davis (UCD) IPHI directed by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UCD School of Medicine and the Betty Irene Moore School of

Nursing. Dr. Kizer and associates are providing thought leadership, technical assistance, consultation, and training for the Department and they are supporting the development, implementation, and evaluation of the *Quality Strategy*. Dr. Kizer has also assembled and is overseeing a national caliber advisory group to provide advice on the *Quality Strategy*.

Summary

The *DHCS Quality Strategy* is a living document that describes goals, priorities, guiding principles, and specific programs related to quality improvement within the Department. The ultimate purpose of the *Quality Strategy* is to improve health, enhance quality, and reduce per capita health care costs. In partnership with stakeholders, we will use the *Quality Strategy* to build and sustain a culture of quality that benefits Medi-Cal members and all Californians.

APPENDIX— Summary of the National Quality Strategy

Overview. As required by the ACA, the Secretary of DHHS established the NQS, which was published in March 2011.[6] The NQS was developed with the engagement of a broad range of stakeholders representing all health care sectors. It serves as a roadmap for improving the quality of care in both the public and private sectors. The NQS will be updated annually and enhanced to provide more detail related to goals, measures, and actions required for each component of the nation's health care system.

Three Aims. The NQS will pursue three broad aims:

1. Better Care—Improve the overall quality, by making health care more patient-centered, accessible, and safe;
2. Healthy People/Healthy Communities—Improve the health of the United States population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care; and
3. Affordable Care—Reduce the cost of quality health care for individuals, families, employers, and government.

Six Priorities. To advance the three aims, the NQS will focus on six priorities:

1. Making care safer by reducing harm caused in the delivery of care;
2. Ensuring that each person and family are engaged as partners in their care;
3. Promoting effective communication and coordination of care;
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
5. Working with communities to promote wide use of best practices to enable healthy living; and
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Ten Principles. The NQS is guided by ten principles (available at www.ahrq.gov/workingforquality) that were developed with extensive national stakeholder input. They are:

1. Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and health care improvement efforts;
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage;

[6] National Strategy for Quality Improvement in Health Care: Report to Congress. Washington, D.C.: U.S. Department of Health and Human Services, 2011.

3. Eliminating disparities in care—including but not limited to those based on race, color, national origin, gender, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography—will be an integral part of all strategies, goals and health care improvement efforts;
4. Attention will be paid to aligning the efforts of the public and private sectors;
5. Quality improvement will be driven by supporting innovation, evaluating efforts around the country, rapid-cycle learning, and disseminating evidence about what works;
6. Consistent national standards will be promoted, while maintaining support for local, community, and state-level activities that are responsive to local circumstances;
7. Primary care will become a bigger focus, with special attention towards the challenges faced by vulnerable populations, including children, older adults, and those with multiple health conditions;
8. Coordination among primary care, behavioral health, other specialty clinicians and health systems will be enhanced to ensure that these systems treat the "whole person;"
9. Integration of care delivery with community and public health planning will be promoted; and
10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them, will be encouraged.

Other National Quality Initiatives

There are two national quality initiatives, both public-private partnerships supported by DHHS that dovetail with the NQS.

Partnership for Patients (PfP). The Partnership consists of a range of health care stakeholders (including hospitals, employers, physicians, nurses, patient advocates, state and federal government, and others) committed to developing improved models of care to achieve two goals:

1. Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.

2. Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illnesses without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

DHHS will be using $1 billion from the ACA to address these goals. It is anticipated that other entities from the public and private sectors also will be committing resources to PfP.

Million Hearts Initiative (MHI). The MHI sets the ambitious national goal of preventing 1 million heart attacks and strokes in five years. The interventions will involve public health efforts to encourage healthier nutritional choices as well as improved clinical management of risk factors (targeting the "ABCS"—Aspirin, Blood pressure, Cholesterol, and Smoking cessation) that has been proven to reduce cardiovascular disease mortality and morbidity. Specific goals are listed in the table below:

Indicator	2011 Baseline	2017 Goal
Aspirin use for people at high risk	47%	65%
Blood pressure control	46%	65%
Effective treatment of high cholesterol (LDL-C)	33%	65%
Smoking prevalence	19%	17%
Sodium intake (average)	3.5g/day	20% reduction
Artificial trans fat consumption (average)	1% of calories/day	50% reduction

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

S. Suicide Prevention

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

California's most recent suicide prevention plan is the *2008 California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution* published by the then CA Dept. of Mental Health, now also reorganized into DHCS. A copy of the Plan is attached for your review.

SUD Prevention, Treatment & Recovery Services Division staff work in partnership with DHCS Mental Health Division staff in a coordinated effort to implement plan activities. The plan was developed through recommendations of an advisory committee consisting of experts in suicide prevention, survivors of suicide loss, representatives of mental health consumer and family member organizations, legislators, providers, crisis centers, and others.

Since publication, the Plan has been used extensively for state and local planning purposes. Until it's updated, CA will continue to use the plan.

At the state level, DHCS houses mental health suicide prevention programs also established by the Mental Health Services Act (MHSA). The Unit serves as a statewide resource center on suicide prevention and provides technical assistance and subject matter expertise for state and local partners.

In addition, the Unit serves as the liaison with national partners (including the Substance Abuse and Mental Health Services Administration (SAMHSA), Suicide Prevention Resource Center, American Association of Sociology, National Suicide Prevention Lifeline, and other state suicide prevention program coordinators) and facilitates a forum for information sharing for accredited suicide prevention crisis centers and county suicide prevention liaisons. The Unit aims to implement and support a full range of strategies throughout the prevention spectrum to prevent mental illness from becoming severe and disabling.

California Strategic Plan on Suicide Prevention:

Every Californian Is Part of the Solution

California Department of
Mental Health

California Strategic Plan on Suicide Prevention:
Every Californian Is Part of the Solution

Based on Recommendations of the
Suicide Prevention Plan Advisory Committee

This *Strategic Plan on Suicide Prevention (Plan)* was approved by the Governor's Office of the State of California on June 30, 2008.

Arnold Schwarzenegger
Governor, State of California

Kimberly Belshé
Secretary, Health and Human Services Agency

Stephen W. Mayberg, Ph.D.
Director, California Department of Mental Health

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ACKNOWLEDGEMENTS

In September 2006, Governor Arnold Schwarzenegger directed the California Department of Mental Health (DMH), through a veto message to Senate Bill 1356 (Lowenthal), to administratively develop a statewide strategic plan on suicide prevention. The DMH and the California Health and Human Services Agency were to build on work done by the California Suicide Prevention Advocacy Network and coordinate with all interested constituency groups and state and local agencies to develop the plan by May 1, 2008. The DMH convened the Suicide Prevention Plan Advisory Committee to provide recommendations for the plan.

The Advisory Committee met over approximately nine months to craft the strategic directions and recommended actions contained in this document. In addition to the committee meetings, two stakeholder workshops were held in September 2007 to ask the public, including youth, families, and survivors of suicide attempts, to provide input on the draft plan's preliminary recommendations.

We deeply appreciate the Advisory Committee's hard work and acknowledge the personal commitment and many contributions of the individuals listed on the following pages.

STEPHEN W. MAYBERG, Ph.D.
Director, California Department of Mental Health

ALFREDO AGUIRRE
Mental Health Director and
California Mental Health Directors Association
San Diego

PATRICIA AREAN
Associate Professor of Psychiatry
University of California, San Francisco

JOHN BATESON
Executive Director
Contra Costa Crisis Center
Walnut Creek

SUSAN BELL
Outreach Coordinator
Counseling and Psychological Services
University of California, Berkeley

SAM BLOOM
Board Member
Suicide Prevention Advocacy Network
–California

LISLE MARIE BOOMER
Volunteer
Protection & Advocacy Inc.
Berkeley

MARTIN BRAGG
Director of Health and Counseling Services
California Polytechnic State University,
San Luis Obispo

DELPHINE BRODY
Director of Mental Health Services Act Client Involvement
California Network of Mental Health Clients

JOHN BUCK
Chief Executive Officer
Turning Point Community Programs
Sacramento

RICK CAWTHORN
Mental Health/Addiction Therapist
Hoopa Valley Tribal Council Division of Human Services

MARK CHAFFEE
President
Suicide Prevention Advocacy Network
–California

DIANA E. CLAYTON
Vice President
National Alliance on Mental Illness,
Shasta County

BARBARA COLWELL
Psychiatric Social Worker
Los Angeles Unified School District

CAROLE LEE CORY
Assistant Director, Community Relations
California Department of Aging

REBECCA CRAIG
Field Representative
Department of Corrections and Rehabilitation

JOE CURREN
Executive Director
Redwood Coast Seniors
Fort Bragg

KITA CURRY
President and Chief Executive Officer
Didi Hirsch Community Mental Health Center and California Council of Community Mental Health Agencies
Los Angeles

LETICIA GARCIA
Legislative Aide
Office of State Senator Alan Lowenthal

LUIS GARCIA
Corporate Director
Latino Program Development,
Pacific Clinics, Arcadia, and
California Mental Health Planning Council

ALBERT GAW
Professor of Psychiatry
University of California, San Francisco, and
Medical Director, Quality Management
San Francisco Community Behavioral Health Services

JANET GOREWITZ
Licensed Psychologist

LEANN M. GOUVEIA
Executive Director
Fresno Survivors of Suicide Loss, Inc.

MARY HAYASHI
California State Assembly Member and
Mental Health Services Oversight and
Accountability Commissioner

MAJOR STEVEN KEIHL
Director of Mental Health
California National Guard

MORRIS LAWSON II
Student, Intern Therapist
Monrovia

TOM LEE
Deputy Director
California Department of Social Services

SEPRIEONO LOCARIO
Prevention Coordinator
Native American Health Center
Oakland

VICKIE MAYS
Professor of Psychology/Health Services
University of California
Los Angeles

ED MORALES
Chief Psychiatrist
Department of Corrections and
Rehabilitation
Division of Juvenile Justice

MARIA PEÑA
Student Services Coordinator
Mira Costa College
Disabled Students Programs and Services
Oceanside

MICHAEL PINES
Mental Health Consultant
Los Angeles County Office of Education

DEDE RANAHAN
Mental Health Services Act Policy
Coordinator
National Alliance on Mental Illness,
California

CHARLES ROBBINS
Executive Director
The Trevor Project
West Hollywood

CHAPLAIN MINDI RUSSELL
Executive Director and Senior Chaplain
Law Enforcement Chaplaincy
Sacramento

RUSTY SELIX
Executive Director
California Council of Community
Mental Health Agencies

ELIZABETH (BETSY) SHELDON
Education Programs Consultant
California Department of Education

CLYDE STEELE
Manager
California Department of Alcohol and Drug
Programs
Health Insurance Portability and
Accountability Act Compliance Project

ROGER TRENT
Chief
Injury Surveillance and Epidemiology
Section California Department of Public
Health

ALICE TRUJILLO
Supervisor
California Department of Alcohol and Drug
Programs
Co-Occurring Disorders Unit

BILLEE WILLSON
Program Planner
Sacramento County Department of Health
and Human Services

MICHELLE WOODS
Staff Mental Health Specialist
Mental Health Services Oversight and
Accountability Commission

TINA TONG YEE
Former Director
San Francisco Community Behavioral Health
Office of Cultural Competence and Client
Relations

The following individuals provided support for the Advisory Committee and development of the Plan

Consultants

STEVE SHIPPEN
California Department of Public Health
Health Information Strategic Planning
Planning and Data Analysis Section

LANNY BERMAN
Executive Director
American Association of Suicidology

JOHN DRAPER
Project Director
National Suicide Prevention Lifeline

DAVID LITTS
Associate Director
Suicide Prevention Resource Center

RICHARD MCKEON
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Facilitation Team

Center for Collaborative Policy
California State University, Sacramento

SUSAN SHERRY
Executive Director

DEB MAROIS
Lead Facilitator

SAM MAGILL
Assistant Facilitator

Plan Support

JANICE LOWEN AGEE
Editor

SHARLEEN DOLAN
Plan Consultant

PEGGY FISH
California State Library

JENNIFER MCLAUGHLIN
California State University, Sacramento

DMH Staff

EMILY NAHAT
Chief
Prevention and Early Intervention Section

BARBARA MARQUEZ
Mental Health Program Supervisor

BEVERLY WHITCOMB
Mental Health Program Supervisor

Lead Project Staff:

SANDRA BLACK

ORLANDO FUENTES

Other staff who contributed:

CIELO AVALOS

NICHOLE DAVIS

LINDSAY HAMASAKI

MICHELLE LAWSON

BERTHA MACDONALD

SONIA MAYS

DIANE STIDGER

CAITLIN VISCARDI

JUSTIN WHITCOMB

INTRODUCTION

The statistics about suicide are alarming. Suicide is the tenth leading cause of death in California. Every year approximately 3,300 Californians lose their lives to suicide. More suicide deaths are reported in our state than deaths caused by homicides. On average, nine Californians die by suicide every day. Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds.

> *"On average nine Californians die by suicide every day."*

The causes of suicide are complex and include an array of biological, psychological, social, environmental, and cultural risk factors. Too often, there is lack of coordination between service systems and providers and a lack of knowledge about how to recognize the warning signs of suicide. For far too long, suicide has been viewed as a taboo subject. Fear of stigma and discrimination surrounding suicide can be so pervasive that it often deters people from seeking help.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak that family members and other loved ones endure. This tragedy is even more distressing because suicide deaths are preventable.

Traditionally, suicide has been considered primarily a concern of the mental health system, largely due to the connection between mental illnesses, such as depression, and the elevated risk of suicide. However, in 2001, the President's New Freedom Commission called for a change that would place mental health

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into the context of the broader public health system. The transformed system would provide quality care for those in need, but it would also promote resiliency, recovery, and health.

In response to this change and in combination with other events, Governor Arnold Schwarzenegger in 2006 charged the Department of Mental Health (DMH) with the development of a strategic plan on suicide prevention. The DMH embarked upon this work in partnership with the Suicide Prevention Plan Advisory Committee composed of mental health experts, advocates, providers, researchers, and representatives from various nonprofit and government agencies. The Advisory Committee also included other important voices—survivors of suicide attempts and suicide loss.

The *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* (Plan) is built upon the vision that a full range of strategies, starting from prevention and early intervention, should be targeted to Californians of all ages, from children and youth to adults and older adults. To effectively reduce suicides and suicidal behavior, communities need prevention services to promote health and address problems long before they become acute, as well as a coordinated system of services to effectively respond to crisis situations.

This Plan serves as a blueprint for action at the local and state levels. The Plan is intended to guide the work of policy makers, program managers, providers, funders, and others in bringing systems together to better coordinate their efforts, and to enhance needed prevention and intervention services as well as postvention, or services provided after a suicide or suicide attempt that offer follow-up care for survivors.

The Plan consists of four major parts:

- Part I presents information about suicide's impact and magnitude from different sources and different perspectives.
- Part 2 describes successful and promising strategies, practices, and policies that have been used to prevent suicide.
- Part 3 provides the Advisory Committee's recommended actions to reduce suicide deaths and the incidence of suicidal behaviors in California. Many of the recommendations require a long-term effort, while others can be implemented more quickly.
- Part 4 lists the next steps for local and state action.

An Executive Summary of the Plan is also available that provides a brief overview of Parts 1 and 2 as well as the complete list of strategic directions, recommended actions, and next steps.

This Plan should be viewed as a dynamic document that will be periodically reviewed and revised to reflect evolving needs in California. Over time, it is anticipated that the full spectrum of strategies, from prevention through intervention, will be more comprehensively addressed.

Suicide prevention must be a priority in our state. While many challenges lie ahead in carrying out this work, tremendous opportunities also exist. With thousands of lives at stake each year, every Californian needs to be part of the solution.

PART 1: THE PROBLEM AND THE CHALLENGE

Suicide is defined as the intentional taking of one's own life.[a] It is the "final and most severe endpoint" along a continuum of self-harming behaviors.[1] The broader term of suicidal behavior also includes self-inflicted, potentially injurious behaviors.[2] Clearly, it is important to monitor the whole range of self-harmful or injurious behaviors because they may indicate an increased risk of suicide in the future. Suicides may be hidden from vital statistics data. They may include a lethal overdose of prescription or illegal drugs, single car collisions with a fixed object, or incidents when an individual engages in a life-threatening behavior to the degree that it compels a police officer to respond with deadly force.

What Causes Suicide?

The causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors (Table 1).

Many people who attempted or completed suicide had one or more warning signs before their death (Table 2). While warning signs refer to more immediate signs or symptoms in an individual, risk factors for suicide are generally longer-term factors that are associated with a higher prevalence of suicide in the population.[3] Recognition of warning signs has a greater potential for immediate prevention and

NOTES

[a] Assisted suicide is beyond the scope of this Plan.

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Table 1: Risk Factors for Suicide.

Bio-psycho-social Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance abuse disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relationship or social loss
- Easy access to lethal means
- Local clusters of suicides that have a contagion influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health and mental health services and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution to a personal dilemma)
- Exposure to suicide through the media and the influence of others who have died by suicide

Source: Suicide Prevention Resource Center

Table 2: Warning Signs of Suicide.

Signs of acute suicidal ideation:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves, e.g., seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide if this is unusual for the person

Additional warning signs:

- Expressing feelings of hopelessness
- Showing rage or anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Indicating a feeling of being trapped – like there is no way out
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or society
- Experiencing anxiety, agitation, inability to sleep, or sleeping all the time
- Showing dramatic changes in mood
- Expressing no reason for living, or no sense of purpose in life

Source: Suicide Prevention Resource Center

intervention when those who are in a position to help know how to appropriately respond.

Feelings of hopelessness and an inability to make positive changes in one's life are two consistent psychological precursors to suicidal behaviors.[4,5] Many of those who die by suicide are described by family or friends as having been depressed or as having problems with a current or former intimate partner.

Trauma has a significant impact on suicide risk across the life span. A survey of over 17,000 patients at a health clinic in San Diego found that a history of adverse childhood experiences was associated with a significant increase in the prevalence of attempted suicides.[6] For example, individuals reporting that their parents had separated or divorced were twice as likely to have attempted suicide, and those who were emotionally abused as children were five times as likely to have attempted suicide. For each additional adverse experience, the risk of attempted suicide increased by about 60 percent. This study also found a high prevalence of depression and substance abuse, suggesting that a history of adverse childhood experiences is associated with a host of negative outcomes.

What Are the Protective Factors Against Suicide?

Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors (Table 3).

Examining populations with lower suicide rates can help understand potential protective factors and focuses for prevention strategies. Social (including religious), political, and economic factors may help explain different rates of suicide between countries.[7] According to the World Health Organization, the highest suicide rate in the world is in Hungary (66.0) and the lowest is in Mexico (2.5).[b] Differences in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide.[7]

In the United States (U.S.), suicide rates among African American women, particularly in middle age, are very low.[8] In California, the lowest suicide rate is among Latinos between 55 to 64 years of age.[9] Sociocultural differences between population groups and between

Table 3: Protective Factors Against Suicide

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Source: Suicide Prevention Resource Center

NOTES

[b] These data should be interpreted cautiously, as they are compiled from various sources and studies. They may have employed different criteria and methods, which may result in under-reporting of actual suicide deaths.

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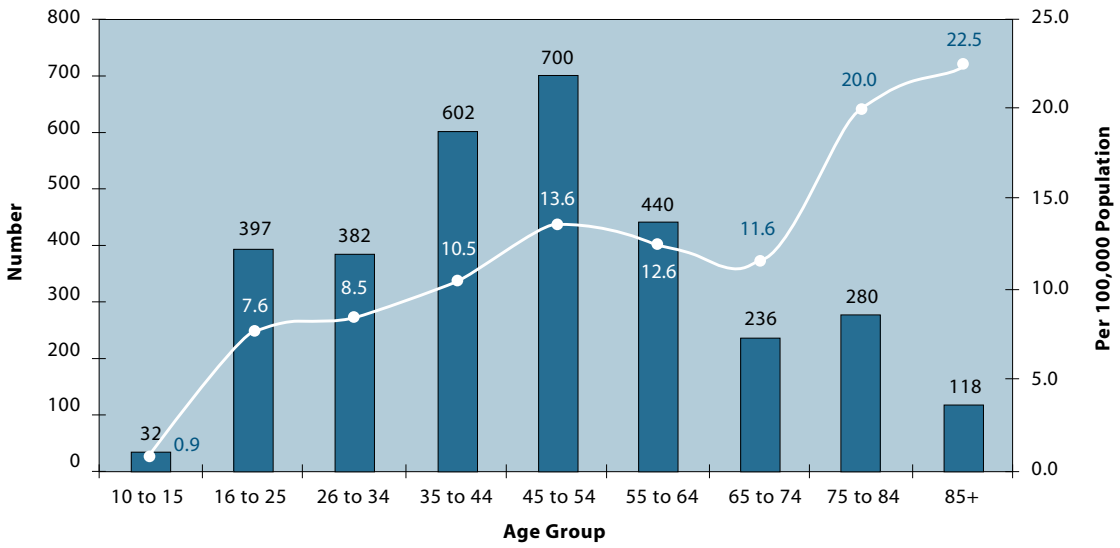
Figure 1. Suicide Death Rates and Number of Deaths in California by Age, 2005.



Source: California Department of Public Health

individuals, including social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors.[7]

> *"The rate of suicide increases significantly with advanced age."*

Who Dies by Suicide?

According to data from the CDPH, the age-adjusted[c] rate of suicide within the general population of the state is 8.8 per 100,000.[d] The most recent California County Health Status Profiles report indicates that the highest average number of suicide deaths from 2003 to 2005 was in Humboldt County (20.0), and that Los Angeles County had the lowest rate (7.2). In 2004, over 16,000 individuals were hospitalized for self-inflicted injuries in California (46.0).[9]

Age

The *rate* of suicide increases significantly with age (Figure 1). In California, adults over the age of 85 have the highest suicide rate in the state, at 22.5.[9] However the largest *numbers* of suicide deaths occur in the age range of 45 to 54, as shown in Figure 1. Of the 3,187 individuals who died by suicide in 2005, over 40 percent (1,302) were adults between 35 to 54 years of age.

Depression and chronic illness are significant risk factors for suicide among older adults.[10] In addition to heightened suicide risk, depression is linked to multiple adverse health outcomes, including premature mortality and diminished quality of life.[11] Depression rates are particularly high among older adults receiving

NOTES

[c] An age-adjusted rate allows for comparisons between groups with different age distributions.

[d] Throughout this report, all references of suicide rates are per 100,000 population.

Table 4. Ten Leading Causes of Death, California 2005, All Races, Both Sexes (County of Residence)

Rank	Age Group												
	<1	01-05 [a]	06-09 [b]	10-15	16-25	26-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 684	Unintentional Injury 222	Unintentional Injury 89	Unintentional Injury 191	Unintentional Injury 1,563	Unintentional Injury 1,203	Unintentional Injury 1,744	Malignant Neoplasms 4,936	Malignant Neoplasms 9,323	Malignant Neoplasms 12,953	Heart Disease 18,998	Heart Disease 25,367	Heart Disease 64,689
2	Short Gestation 453	Congenital Anomalies 76	Malignant Neoplasms 47	Malignant Neoplasms 74	Homicide 985	Homicide 577	Malignant Neoplasms 1,562	Heart Disease 3,499	Heart Disease 6,189	Heart Disease 8,991	Malignant Neoplasms 16,422	Malignant Neoplasms 8,528	Malignant Neoplasms 54,613
3	Maternal Pregnancy 174	Malignant Neoplasms 62	Congenital Anomalies 16	Homicide 73	Suicide 397	Malignant Neoplasms 409	Heart Disease 1,164	Unintentional Injury 2,019	Unintentional Injury 1,191	Chronic Low Resp. Dis. 2,622	Chronic Low Resp. Dis. 5,139	Cerebro-Vascular 6,431	Cerebro-Vascular 15,551
4	SIDS 151	Homicide 37	Chronic Low Resp. Dis. 7	Congenital Anomalies 39	Malignant Neoplasms 282	Suicide 382	Suicide 602	Liver Disease 1,116	Diabetes Mellitus 1,173	Cerebro-Vascular 1,986	Cerebro-Vascular 5,015	Alzheimer's Disease 4,920	Chronic Low Resp. Dis. 13.167
5	Placenta, Cord, Membranes 90	Heart Disease 19	Heart Disease 7	Suicide 32	Heart Disease 118	Heart Disease 280	HIV 468	Chronic Low Resp. Dis. 703	Chronic Low Resp. Dis. 1,140	Diabetes Mellitus 1,678	Diabetes Mellitus 2,360	Chronic Low Resp. Dis. 3,722	Unintentional Injury 10,926
6	Neonatal Hemorrhage 89	Influenza & Pneumonia 19	Homicide 6	Heart Disease 25	Congenital Anomalies 56	HIV 97	Liver Disease 420	Suicide 700	Chronic Low Resp. Dis. 1,046	Influenza & Pneumonia 772	Alzheimer's Disease 2,347	Influenza & Pneumonia 3,680	Alzheimer's Disease 7,694
7	Resp. Distress 89	Chronic Low Resp. Dis. 8	Influenza & Pneumonia 6	Chronic Low Resp. Dis. 9	Complicated Pregnancy 29	Liver Disease 57	Homicide 385	Diabetes Mellitus 660	Liver Disease 1,039	Unintentional Injury 705	Influenza & Pneumonia 2,291	Diabetes Mellitus 1,500	Diabetes Mellitus 7,679
8	Bacterial Sepsis 68	Chronic Low Resp. Dis. 6	Benign Neoplasms 4	Benign Neoplasms 8	Chronic Low Resp. Dis. 26	Diabetes Mellitus 55	Chronic Low Resp. Dis. 267	HIV 451	Suicide 440	Liver Disease 682	Unintentional Injury 1,035	Hypertension 1,351	Influenza & Pneumonia 7,537
9	Unintentional Injury 65	Perinatal Period 6	Chronic Low Resp. Dis. 3	Influenza & Pneumonia 7	Diabetes Mellitus 25	Congenital Anomalies 54	Diabetes Mellitus 219	Chronic Low Resp. Dis. 391	Influenza & Pneumonia 369	Nephritis 436	Parkinson's Disease 883	Unintentional Injury 887	Liver Disease 3,819
10	Intrauterine Hypoxia 62	Meningitis 5	Diabetes Mellitus 1	Diabetes Mellitus 6	HIV 15	Chronic Low Resp. Dis. 51	Influenza & Pneumonia 107	Viral Hepatitis 254	Nephritis 307	Hypertension 388	Hypertension 882	Athero-sclerosis 845	Suicide 3,188

Source: California Department of Public Health

[a] Septicemia also ranked 10th. [b] Liver Disease, Meningococcal Infection, Perinatal Period, and Septicemia also ranked.

in-home care or living in institutions and among those with chronic diseases such as asthma, chronic obstructive pulmonary disease, arthritis, and heart disease.[11]

Older adults are becoming an increasing proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of people over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million.[12] Thus, it is becoming increasingly important to pay attention to the high rates of suicide among older adults.

Another way to understand the data is to consider leading causes of death in California (Table 4). Although the rate of suicide among older adults is high, suicide is not one of the ten leading causes of death among adults aged 65 and older. Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death.

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Table 5. Age-Adjusted Suicide Death Rates by Race/Ethnicity and Sex, California, 2005.

Race/Ethnicity	Males	Females
Whites	19.3	5.9
African Americans	9.1	2.9
Asians	7.9	2.9
Latinos	7.5	1.4
2+ races*	5.9	3.3
All Races Combined	14.1	4.0

Source: California Department of Public Health **This rate is considered statistically unreliable.*

Nationally, more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung diseases combined.[13] Among specific groups, including females from 10 to 19 years of age and males between 15 to 19 years of age, national data indicate an increase in suicide rates in recent years.[14]

Data from a University of California (UC) survey illustrates the prevalence of suicidal behavior among young adults. Among students participating in the survey, nine percent reported serious suicidal ideation, and up to 80 percent of those had not received mental health services.[15] The incidence of suicidal behavior, including attempts, the number of students taking psychotropic medications, and the number of mental health and crisis visits to student health centers increased significantly between 2000 and 2005. The students identified at the highest risk for completing suicide included graduate students; gay, lesbian, bisexual, transgender, and questioning (GLBTQ) students; international students; and racially and ethnically underrepresented students.

Sex

In California, males are three times more likely to die by suicide than females.[9] After the age of 14, rates of suicide are significantly higher among males regardless of age, race, or ethnicity (Table 5).

However, it is important to note that women attempt suicide three times as frequently as men and are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging.[9] Sixty percent of hospitalizations for self-inflicted injuries are among females. Several studies have reported that women are both more likely than men to attempt suicide and also to have a history of sexual abuse.[6,16,17]

The difference between the sexes in suicidal behavior begins to emerge in adolescence (Table 6). Surveys of eighth grade students in California, Arizona, Nevada, and Wyoming found that girls were more likely to report suicidal ideation and attempts than boys and that girls were also more likely to feel like they had less control over their environment.[5]

In addition to mortality rates, the public health burden of suicide is also measured in terms

Table 6. Suicide Death Rates by Age and Sex, California, 2005.

Age Groups	Rates among males	Rates among females
All Ages	14.1	5.9
1-4	-	-
5-14	0.4	0.2
15-24	10.9	2.6
25-34	13.0	3.8
35-44	15.8	4.9
45-54	19.8	7.5
55-64	19.3	6.3
65-74	19.5	4.9
75-84	39.6	6.1
85 and older	53.5	6.6

Source: California Department of Public Health

of years of potential life lost and value of lost earnings. One study that used this approach found that middle-aged men contribute disproportionately to the burden.[19] The study suggested that concerns around stigma and help-seeking behavior may contribute to this problem among men.

Race and Ethnicity

Rates of suicide differ significantly among racial and ethnic groups (Figure 2). The most recent available data in California indicate that in 2005 Whites had the highest rate of suicide followed by Native Americans (American Indians), Pacific Islanders, African Americans (Blacks), Asians, people identifying as two or more races, and Latinos.[9] These rates vary among counties. It is important to note that even a small increase in the number of deaths can dramatically increase the rate in population groups that are relatively small in number, as evidenced by the increase in the suicide rate among Pacific Islanders in 2003 (Figure 2).

California data are consistent with national data, which indicate that Whites account for 84 percent of all suicide deaths.[20] However, despite the very high suicide rates among White males, few prevention programs target this demographic. This group is also one of the least likely to seek mental health treatment.[21]

Historically, African Americans have had lower rates of suicide than other racial and ethnic groups. However, national studies have noted that the suicide rate among African American males under the age of 35 has increased significantly over the last two decades, particularly among young men in the northern and western states.[22]

Among Latinos, suicide attempts are most prevalent in young females under the age of 18; data from the national Youth Risk Behavior Surveillance study of youth in grades seven, nine, and eleven found

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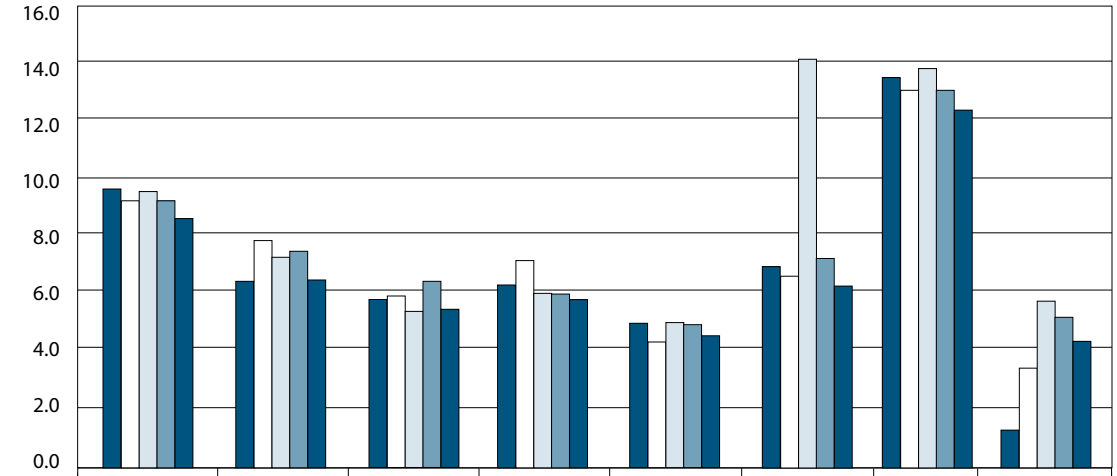
Figure 2. Age-adjusted Suicide Death Rates By Race/Ethnicity, California Residents, 2001-2005.



	Total	American Indian*	Asian	Black	Latino	Pacific Islander*	White	Two or More Races*
2001	9.7	6.5	5.6	6.1	4.9	7.0	13.4	1.3
2002	9.4	7.9	5.7	7.0	4.3	6.8	13.0	3.5
2003	9.7	7.4	5.2	5.9	4.9	14.3	13.7	5.9
2004	9.4	7.6	6.3	5.8	4.8	7.3	13.0	5.3
2005	8.8	6.6	5.3	5.7	4.4	6.3	12.3	4.5

*Includes unreliable rates for American Indian, Pacific Islander, and Two or More Races.

Source: California Department of Public Health

that more Latina students, nearly one quarter, reported suicidal ideation and behaviors than their White or African American female peers.[23,24]

Limitations of Race and Ethnicity Data

It is important to note that the suicide rates for American Indians and Pacific Islanders are considered unreliable due either to small population size or the relatively small number of events that are reported (less than 20 per year). However, national data indicate that American Indian and Alaska Native youth are at disproportionately high risk of suicide compared to non-Native youth. Suicide is the leading cause of death among American Indians and Alaskan Natives between 15 and 24 years of age, and from 1999 to 2004, young men in this population had a higher suicide rate (27.99) than any other racial and ethnic group of the same age.[20]

The discrepancy between the low number of reported incidents of suicide among certain racial/ethnic groups in California and what is known from national data suggest the need for improved research and surveillance activities that target these groups. It is critical to understand that suicide prevention research and surveillance activities need to determine whether there may be a significant difference between California's population and that in other states, or whether data reporting and analysis need to be strengthened for all population groups that may currently be underreported.

Mental Illness

The National Violent Death Reporting System found that nearly half of suicide cases involve at least one documented mental health diagnosis.[10] It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder.[25] Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide.[26] The risk tends to be highest among those who have frequent and severe recurrences of symptoms.[27]

Suicide is the leading cause of death among individuals with schizophrenia. Nearly 6 percent complete suicide, with most suicide deaths occurring early in the illness, and up to 40 percent attempt suicide at least once.[28,29] Co-occurring substance and alcohol abuse exacerbates the risk of suicide. In one national study, individuals diagnosed with major depressive disorder that used drugs or engaged in binge drinking were significantly more likely to report suicidal thoughts and to attempt suicide than those with major depressive disorders who did not abuse alcohol or drugs.[30]

Issues of stigma and discrimination related to mental illness and suicide may negatively impact accurate identification and reporting of suicide deaths. Ascertaining suicidal intent in determining cause of death is often a challenge. This challenge can be exacerbated by concerns about the impact of a determination of suicide on the families and others who lost a loved one and by concerns about confidentiality, particularly in small communities.

Criminal Justice System Involvement

Nationally, the number of individuals with mental illness who are in jails and prisons is higher than those that are in psychiatric hospitals.[31] More than half of all prison and jail inmates have a mental illness. This rate is three times that of the general population.[32]

Suicide is the third leading cause of death in California prisons.[144] Like other prison systems nationally, suicide deaths in California's prisons are predominantly among White males.

> *"Suicide is the third leading cause of death in California prisons."*

The U.S. Department of Justice reports that between 1994 and 2003, suicide was the second leading cause of death for individuals in custody.[33] Nationally, suicide accounted for 32 percent of local jail inmate deaths between 2000 and 2002. Suicide rates in local jails were three times that in state prisons. Violent offenders were nearly three times more likely to die by suicide than other inmates in jails.

In both jails and prisons across the country, White inmates have significantly higher rates of suicide than other races.[33] In prisons, male and female inmates die by suicide at similar rates. However, in jails, men are over 50 percent more likely to die by suicide than females. Finally, 80 percent of suicides occur within the cell.

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In prisons, the periods of highest risk for suicide are during the first month of incarceration and the first few weeks after release.[34,35] Nearly half of jail suicides occur within the first week of custody. Almost one quarter of these are on the date of admission or the following day.[33]

One study found that in 40 percent of the 196 intimate partner homicide cases in California that occurred in 1996, the perpetrator also completed suicide.[36] In these cases, the use of a gun and a perpetrator who was a White male were both significant predictors that the perpetrator would also complete suicide. Among older people who died by intimate partner homicide-suicide, the reasons were typically related to poor health or financial concerns.

Veterans

An analysis of data from national health surveys and the National Death Index from the middle 1980s to 1990s found that male veterans were twice as likely to die by suicide as the general male population, especially those who were White, less educated, and had physical disabilities.[37] Data collected prior to the Iraq War estimated that suicide rates among veterans currently using Veterans Affairs (VA) facilities were 45.0 per 100,000 among those over the age of 65, and as high as 83.0 per 100,000 for those under age 65.[38] Extrapolating from more recent national data, the VA estimates that there are 1,000 suicides per year among veterans receiving care through the VA health care system and as many as 5,000 per year among all veterans.[38] Some of the groups at highest risk include those with severe mental illnesses, combat-related post-traumatic stress disorder (PTSD), traumatic brain injury, traumatic amputation or disfigurement, military sexual trauma, and spinal cord injuries.

> *"Male veterans are twice as likely to die by suicide as the general male population."*

A study of patients in the VA health care system found that among veterans receiving treatment for depression, the rate of suicide was seven to eight times that of their counterparts in the general population (a rate of 88.25 among veterans versus a rate of 13.5 among the general population in 2004).[39] This study found that several trends in suicide deaths among veterans are different from those found in the general population. For example, the risk is higher among younger, rather than older, individuals, particularly in the presence of conditions such as PTSD. Furthermore, the relative suicide rates of male and female veterans are not as far apart as those in the general population.

Surveys of military personnel stationed in Iraq and Afghanistan indicate that as many as 17 percent met the criteria for major depression, generalized anxiety, or PTSD.[40] This is significantly higher than the rates among the general population. Of those personnel, less than 40 percent sought mental health care, and many reported being concerned about stigma and discrimination because of their mental health problems.

The danger of untreated mental illness among veterans is illustrated by the fact that among populations with high rates of suicide - older adults, those with a mental illness or substance abuse disorder, and those who are homeless – a large number are also veterans. The VA estimates that approximately one-third of all adults who are homeless are veterans.[41] Nearly half of homeless veterans have a mental illness, 70 percent suffer from alcohol or other drug abuse, and 56 percent are African American or Latino.[41] The number of homeless Vietnam-era veterans is greater than the number that died in that war. To address this problem and to prevent it from growing in the future, California's suicide prevention planning must take into account the unique needs of veterans who have recently, or will soon be, returning from the active field of war.

Homeless Individuals

Although individuals who are homeless often meet many of the criteria for elevated suicide risk, such as serious and untreated mental illness, social isolation, poverty, and substance abuse, the data about suicide in this population is limited.[42] Collecting accurate data about suicidality among individuals who are homeless presents a methodological challenge for many of the same reasons that put them at higher risk.

The Access to Community Care and Effective Services and Supports (ACCESS) program, a national Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project, served over 7,000 individuals experiencing serious mental illness and chronic homelessness at 18 sites nationally. Among a sample of these individuals, over 50 percent reported that they had attempted suicide, over 25 percent reported an attempt that resulted in hospitalization for their injuries, and eight percent reported an attempt in the previous 30 days.[43] The lifetime prevalence of suicidal ideation was 66 percent. Younger age, co-occurring substance abuse, and presence of psychiatric symptoms were all significantly associated with suicide attempts. Those who reported a recent attempt also reported higher rates of inpatient mental health care utilization.

Other studies have also found that individuals who are homeless longer than six months may be at particularly high risk of suicide.[44] Furthermore, suicide rates are highest among individuals 30 to 39 years old, although co-occurring substance abuse significantly increases the risk among older individuals.[45] Among homeless and runaway youth, factors such as depression, history of physical and sexual abuse, and having a friend who attempted suicide may all contribute to an increase in suicide risk.[46]

Immigrants

Several factors may influence the rates of suicide among certain groups, including accessibility of mental health services, especially services that are culturally and linguistically appropriate. Different cultural attitudes about suicide and mental health may also play an influential role in the willingness to seek help for mental health problems. For specific immigrant and refugee populations, factors related to acculturation and family conflict may play an important role.[24]

Riverside County is one of the fastest growing counties in California, primarily due to immigration. One study examined over 100,000 death certificates from first generation White immigrants who had died between 1998 and 2001.[47] There was

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significantly higher mortality from suicide among non-Hispanic White immigrants (including those born in Europe, the Middle East and North Africa), than U.S. born individuals of the same ethnicity.

Another study of coroner case records from the same time period examined some of the factors associated with the higher suicide risk among immigrants. Those at highest risk of suicide were more recently arrived; divorced, separated, or widowed; male; middle aged or older; and White.[48]

> *"Lesbian, gay, and bisexual individuals, particularly adolescents and youth, have significantly higher rates for suicidal behavior."*

Rural Populations

Rural states have the highest rates of suicide in the country, particularly among adult and older adult males and youth. One study found that among people diagnosed with bipolar disorder, those who live in rural areas have higher rates of suicide attempts than their urban counterparts.[49] Possible contributing factors to this higher rate include the availability and quality of mental health services, increased impact of stigma due to reduced anonymity in smaller communities, higher poverty rates, and the larger percentage of older adults in the population.[49,50]

One study compared the suicide rates in urban and rural counties in California with the per capita number of health (licensed physicians) and mental health providers in those counties.[51] The study confirmed that the rates of suicide were higher in rural counties, and also that the rate of suicides by firearm were higher the more rural the county. However, the rate of suicide was not correlated with the per capita number of health and mental health providers in the counties. This study was not able to address the issue of the quality and accessibility of appropriate services in rural areas. More research needs to be done to determine if issues of quality and accessibility play a role in the higher suicide rates in rural areas.

Sexual Minority Populations

Data from multiple national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) have demonstrated that lesbian, gay, and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts.[52,53,54,55,56]

Research within California confirms the national data:

- In a survey of over 2800 men who either identified as gay or bisexual or as having had sex with other men in four U.S. cities, including Los Angeles and San Francisco, over 20 percent of respondents had made a suicide plan and another 12 percent had attempted suicide at least once, typically before age 25.[57] This represents a three-fold increase in risk among gay and bisexual men compared to men in the general population.

- Ten percent of respondents in a survey of over 500 Los Angeles County men between ages 18 to 24 who identified as gay, bisexual, or questioning,

or having had sex with a man, reported having seriously considered suicide.[58] This group was also characterized by low rates of access to health care and health insurance coverage.

- A San Francisco survey of over 523 transgender individuals found that nearly one-third of the respondents had attempted suicide.[59] This study is unique in that it identified gender discrimination and physical victimization as independent risk factors for suicide attempts.

> *"Suicide is the second leading cause of postpartum maternal deaths."*

Coping with stigma and discrimination based on sexual orientation can be a particularly challenging issue for adolescents and young adults. A survey of over 1,700 California youth ages 12 to 18 years found that those who identified as lesbian, gay, or bisexual were at elevated risk for a range of health and mental health problems, especially those youth who reported being less comfortable with or uncertain about their sexual orientation.[60]

Social support in a community of peers is especially important to this vulnerable population, especially when family and school environments are stressful. One longitudinal study of lesbian, gay, and bisexual youth between ages 15 to 19 in the New York City area found that the strongest predictive factors of suicide risk were a history of parental psychological abuse and more gender atypical behavior in childhood, especially among males.[54]

Among gay or bisexual men, factors associated with higher risk included a perceived hostile environment related to their sexuality, less education, lower income, and lower employment.[57] Native Americans, older men, and men who were bisexual or did not identify as any specific sexual orientation had the highest prevalence of suicide attempts. Attempts were also higher among men who reported adverse childhood experiences, such as parental substance abuse, repeated childhood physical abuse, and childhood sexual coercion. This study found that the age of disclosure of sexual orientation has been steadily declining over time, but that reported harassment has increased dramatically among younger generations.

Women with Perinatal Depression

According to the National Women's Health Information Center, a service of the U.S. Department of Health and Human Service's Office on Women's Health, perinatal depression occurs during pregnancy or within the first year after childbirth. Although the exact prevalence of perinatal depression is not known, it is believed to be one of the most common complications women experience during and after pregnancy. Since some of its symptoms are very similar to typical changes that occur around pregnancy and birth, perinatal depression may be under-recognized.

Although suicide rates among women who are pregnant or recently gave birth are lower than the general population of women, suicide is the second leading cause

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of postpartum maternal deaths.[61] Up to 14 percent of women report suicidal ideation during pregnancy and the postpartum period.[61] Women who have a history of depression are at 70 times greater risk of suicide than those without this psychiatric history.[62] Throughout the first year after giving birth, over 30 percent of women who report postpartum depression continue to have depressive symptoms, and less than half improve within the first three months after giving birth.[63]

There may also be a link between maternal depression, recurrence of depression, and later behavioral problems in the child. Extended maternal depression can have a negative impact on attachment between mother and child, which may put the child at increased risk of developing behavioral problems.[64] Although perinatal depression was not specifically addressed in the Adverse Childhood Experiences Study, the study did find that children who grew up in a household where someone had a serious mental illness were more likely to attempt suicide at least once in their lifetime.[6] Therefore, it is important that pregnant women are screened for factors that may put them at higher risk for perinatal depression, including a history of depression and/or postpartum depression, throughout the year following birth in order to successfully recognize and treat maternal depression and also to reduce the likelihood of adverse impacts on the child.

The National Women's Health Information Center reports that postpartum psychosis is more rare than postpartum depression, occurring in approximately one or two out of every 1,000 births. It can include delusions, hallucinations, sleep disturbances, obsessive thoughts about the baby, and rapid mood swings. Postpartum psychosis typically begins within the first six weeks after childbirth. The risk of postpartum psychosis tends to be higher among women who have a serious mental illness, specifically bipolar disorder or schizoaffective disorder.

Means of Suicide

In a study of survivors of suicide attempts, almost half reported that less than one hour had passed between their decision to complete suicide and the actual attempt. Another 24 percent indicated it was less than five minutes.[65] The crisis leading up to suicide and suicide attempts is often short-lived, containing some impulsivity and ambivalence.[66] Restricting access to lethal means can put time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized and interventions to occur.

According to data from the CDPH, firearms are used in over 40 percent of suicides in California, followed by hanging (26 percent) and poisoning (19 percent). These three methods account for more than 85 percent of all suicide deaths. Almost half of males who died by suicide used a firearm, whereas the most common method used among females is poisoning (37 percent). Poisoning is the leading means of self-

inflicted, non-fatal injury, with alcohol and drug overdoses accounting for 77 percent of all poisoning incidents. The CDC defines a poison as any substance that is harmful to the body when eaten, breathed, injected, or absorbed through the skin. Poisoning occurs when too much of some substance has been taken, and generally the deaths that occur involve abuse of prescription or illegal drugs.

Addressing access to controlled substances and firearms is one way to prevent many suicides. The National Violent Death Reporting System (NVDRS) found that in 82 percent of firearm suicides among youth under 18, the firearm belonged to a family member, underscoring the importance of attention to safe storage of firearms in the home.[10] In many states, laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System.[67]

One explanation that has been suggested for the substantially higher rate of completed suicides among males is that females use means that may have a lower probability of lethality, such as poisoning. Among females, hanging or suffocation accounts for 71 percent of suicide deaths between 10 and 14 years of age, 49 percent of suicides between 15 and 19 years of age, and 34 percent between 20 and 24 years of age.[14] A review of over 600 coroner records in Riverside County, California, from the years 1998 to 2001, found that although women were over four times more likely to use poisoning than men, hanging was equally likely to be used by both sexes.[68] Furthermore, although women were 73 percent less likely to use firearms than men, firearms were the second most common means that women used.

The results of this study are supported by more current statewide data in California. Males and females are equally likely to use hanging as a method (26.5 percent and 26.2 percent respectively), and among females firearms are used in over 20 percent of suicide deaths.[9]

National data indicate that the use of lethal means, other than firearms, have increased, particularly among certain age and sex groups. Poisoning deaths accounted for 28 percent of the increase in the national suicide rate between 1999 and 2004.[h,69,70] In this same five-year period, the rate of suicide by hanging or suffocation increased, especially among adults ages 20 to 29 and 45 to 54.[70]

Given that the means to complete suicide by hanging or suffocation are usually more widely accessible and more difficult to control, prevention programs need to address access to lethal means in concert with education about suicide and psychosocial interventions that target groups at high risk.

Some research has suggested that individuals have a preference for a given means, and that if prevented from using it, an attempt may not occur.[66] The contagion effect,[e] personal ideas, and cultural factors all are likely to come into play when an individual is determining means.

NOTES

[e] The contagion effect is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

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The Cost of Suicide and Suicide Attempts

The emotional cost of suicide has both immediate and far-reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people.[71] In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends – may themselves be at increased risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social supports and mental health services.

> *"Each suicide seriously impacts at least six other people."*

Beyond the human suffering and emotional toll of suicide and self-inflicted injuries, there are also financial costs. The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. To estimate these costs, a formula has been derived based on costs incurred by individuals that attempted or died by suicide, families, employers, government programs, insurers, and taxpayers.[72] Estimates of the cost of self-injuries take into account hospitalizations and follow-up treatment; coroner and medical examiner costs; and transport, emergency department, and nursing home costs. Lifetime productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long-term disability for each individual who attempts or dies by suicide.

Using this formula based on suicide data from 1999 to 2003, the average medical cost per suicide in California was $4,781 and the average lifetime productivity loss for each individual was more than $1.2 million. The resulting cost of suicide deaths in a given year is nearly $15 million per year in medical costs and $3.8 billion in lost lifetime productivity for the individuals who die by suicide in a given year.

In 2003, there were over 16,000 hospitalizations for suicide attempts in California. The average medical cost per hospitalization was more than $12,000, and the average work-loss per case was over $14,000.[73] This amounts to $204 million in medical costs and over $230 million in lost productivity. The resulting cost of suicide attempts in a given year in California is $435 million.

Based on these figures, the combined estimated cost for suicides and suicide attempts in California is $4.2 billion per year.

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PART 2: STRATEGIES FOR SUICIDE PREVENTION

Suicide prevention encompasses a wide range of prevention, intervention, and postvention strategies that reduce suicidal behavior and its impact on family, friends, and communities. This spectrum includes mental health promotion strategies that offer education, foster resilience, and enhance protective factors in individuals and communities; build the capacity of providers and systems to offer appropriate services, including interventions to address mental health problems early and to reduce suicidal behaviors; and follow-up care services for those who have survived a suicide attempt and for family members and others who have suffered the loss of a loved one. Suicide prevention must also include research and surveillance to further understand demographic, cultural, social, and biological factors that reduce risk factors and promote help-seeking behavior. Evaluation is an essential element to ensure that programs are effective, as well as a program improvement tool. Recommendations for effective suicide prevention strategies have been reviewed in several key documents, such as the National Strategy for Suicide Prevention.[74,75,76]

Creating a System of Suicide Prevention

A system of suicide prevention would include a range of gender-specific services and programs designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds. The success of the system will be judged not solely on the value of any one component or service but rather how well the parts are coordinated and build upon one another. Linkages are critical because it can be anticipated that increased community outreach and education efforts to promote mental health, build resilience, and increase awareness of the

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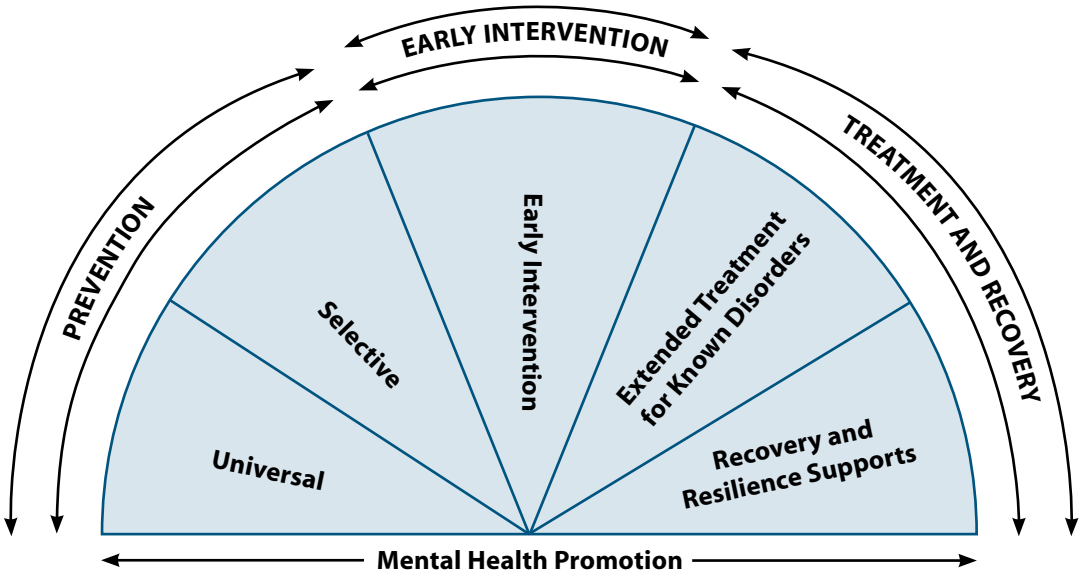
Figure 3: Mental Health Intervention Spectrum Diagram.



Source: Adapted from Mrazek and Haggerty (1994)[145] and Commonwealth of Australia (2000)[146]

suicide warning signs may result in increased service demands further along the Mental Health Intervention Spectrum (e.g., screening and assessment to early intervention and crisis services; see Figure 3). Fragmentation of systems presents a fundamental challenge to continuity of care that can cost lives.[77]

To ensure that the system for suicide prevention is effective, it is critical to assess the assets and gaps, make a plan, implement, and reassess. To create such a system, coordination and partnerships must occur at multiple levels. Collaborative models need to be developed to ensure that professionals from different disciplines and service systems that have important roles in preventing, assessing, and treating suicidal behavior can communicate with one another and coordinate their activities.

Coordination at the State Level

To achieve maximum benefit and efficiency throughout our large state, it is imperative that a centralized, coordinating body for the various suicide prevention activities is charged to effectively reach and serve the diverse populations of California.

This strategy has been effective in other states. Maryland implemented a model state prevention and awareness program and now has the fifth lowest suicide rate in the nation.[78] Coordinating programs at the state level has resulted in increased federal funding for suicide prevention activities and successful coordination of training for gatekeepers throughout the state. Other states, such as Colorado, Florida, and Nevada, have established an office to coordinate suicide prevention activities statewide.

On February 6, 2008, the California Department of Mental Health, in collaboration with Assembly Member Mary Hayashi, announced the establishment of an Office of Suicide Prevention (OSP). OSP will provide

a single point of contact and a central point of dissemination for information, resources, and data about suicide and suicide prevention programs. It will serve as a liaison with national partners, such as the Suicide Prevention Resource Center and the Substance Abuse and Mental Health Services Administration, as well as other states. The office will ensure that activities build upon resources and materials where they already exist, and it will provide expert consultation on local suicide prevention plans and activities.

The California Office of Suicide Prevention will support integration of resources and activities for suicide prevention through various state and county systems and organizations. It will centralize coordination of strategic suicide prevention, intervention, postvention, and research activities throughout the state, including dissemination of model training curricula and service guidelines targeted to different professional groups and settings. It will provide leadership in developing learning communities among the diverse partners throughout California and among stakeholders within the counties, through disseminating and coordinating resources for community planning, leadership training, and building program capacity. Additionally, the Office of Suicide Prevention would be a partner in the development of social marketing efforts focused on increasing community awareness and education, addressing stigma, and reducing suicidal behaviors.

> *"The California Office of Suicide Prevention will support integration of resources and activities throughout state and local systems."*

Finally, the office will oversee the development of a research agenda to fill gaps in knowledge about suicide and suicidal behavior of Californians from diverse backgrounds, and it will aid in the evaluation of interventions to ensure they are effective. It will also coordinate periodic review and update of this *Strategic Plan on Suicide Prevention*, including tracking selected indices of suicidal behavior over time.

Coordination at the Local Level

Many of the partners in a local system of suicide prevention are entities with county, municipality, or district-wide jurisdictions. Local coordination efforts need to include assessment, planning, implementation, and evaluation of the wide range of suicide prevention efforts needed at the community level.

Universal (community-wide) and targeted social marketing strategies are a critical component of the prevention efforts. Campaign activities should be designed to outreach to populations at risk, educate the general public on warning signs and resources, and engage with local media outlets on appropriate reporting guidelines. The messages and materials used should be culturally and linguistically appropriate as well as specific to the age and gender of the target population. Greater success may be achieved by coordinating public education efforts with supportive programs and policies.

Many effective practices integrate suicide prevention into existing community settings and services and utilize key points of contact or "gatekeepers," such as community health

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workers or promotoras, school staff, primary care providers and staff, and Area Agency on Aging personnel and volunteers.[1,79] These strategies are particularly effective for groups that are underserved by the traditional mental health system and are more likely to be identified by or seek help through other community supports. Some strategies offering a more effective response to suicide prevention and suicide include co-location of mental health services and primary care services, integrating mental health services into school-based clinics and aging services, and cross-discipline suicide assessment and intervention training. Working with youth development programs at schools, recreation centers, churches, and other locations also serve as possible venues for teaching problem-solving skills, conflict resolution, and building resiliency; all of which play a role in suicide prevention.

> *"Peer support models can play an essential role as part of a coordinated system."*

To effectively prevent suicide, it is critical that each county have well-coordinated crisis response services. These services should be able to respond to acute crisis situations involving emergency department and hospital staff, mental health providers, and law enforcement personnel. Crisis response services should also include hotlines and mobile outreach teams so that help is readily available when and where needed. Easily accessible and up-to-date directories of local suicide prevention and intervention resources would benefit individuals at risk, the general public, and providers in different systems.

Safety plans for facilities, such as school campuses, increase preparedness to effectively respond to a crisis, including suicide attempts.

Hospital emergency departments often treat individuals with self-inflicted injuries. However, discharge planning procedures for emergency departments vary in their provision of referrals for professional mental health assessments and follow-up services.[80] There needs to be consistency across hospital, emergency department, and other inpatient settings to implement protocols for follow-up care and effective referral to ensure the continuity of care that can save lives.

Peer support models can play an essential role as part of a coordinated system by improving quality of life, fostering recovery and resiliency, and preventing a crisis from developing. Support services provided by those who have experienced suicidal feelings, thoughts, and attempts, and who have survived and rebuilt their lives, can play a vital role in preventing suicide and in preventing the trauma that often accompanies the need for acute, emergency interventions. Peer support programs typically offer short-term, residential crisis services administered by peers; warm lines[f]; programs to promote health, wellness, and recovery; and forums to educate the public about mental illness and mental health.

The factors surrounding a suicide death are often complex, and the stigma of suicide may influence the accuracy of reporting, which can impact the ability to identify systemic changes

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[f] Warm lines are phone lines staffed by peers that provide support and education. Warm lines are generally intended to help prevent a situation from developing into a crisis.

that may be necessary to prevent future deaths.[81] A review of the local data and findings would be helpful to determine where additional attention to existing policies, services, or practices needs to be focused.

Enhancing Mental Health Early Intervention and Treatment

Intervention activities should target periods of time when research and surveillance data have indicated that suicide risk is high, such as initial onset of a mental illness and immediately after a hospital discharge.[29,82] However, one of the most promising ways to prevent suicide and suicidal behavior is through recognition of early signs of mental health problems stemming from depression, loneliness, and other needs.[7] Psychosocial therapy that strengthens problem-solving skills can help to address the feelings of hopelessness and of being overwhelmed and unable to change negative situations that lead to increased risk of suicide.[4] Due to the strong link between severity or recurrence of episodes of serious mental illness and risk of suicide, consistent and appropriate treatment is crucial to suicide prevention.[27] In addition to risk factors among the general population, individuals diagnosed with a serious mental illness have other specific risk factors, such as severity of symptoms and numerous relapses.[29]

> *"Surveys of individuals who have used hotlines indicate that levels of emotional distress and thoughts of suicide are decreased by the calls."*

Many mental illnesses are associated with an elevated risk of suicide, therefore identifying and treating mental illness early in its onset is an important prevention strategy. There is some evidence for the value of routine screening in certain primary care settings to identify early signs and symptoms of mental illness.[83] The U.S. Preventive Services Task Force, an independent panel of experts that develops recommendations for clinical practice, recommends the use of screening tools for depression in adults in primary care settings.[84] However, the Task Force found that the evidence for the effectiveness of screening for suicide risk in primary care settings is limited.[85]

Screening for depression during routine postnatal primary care visits is associated with a three-fold increase in detection of postpartum depression among women.[86] Multiple depression screening tools have been developed that are targeted for the primary care setting. The "PHQ-9 Two-Question Screen" includes a nine-symptom checklist that the primary care professional uses to assess potential mental health problems, including depression. Another example is the "four Quadrant Model" based on a similar model that the National Council for Community Behavioral Healthcare developed in 1998. This model separates individuals undergoing screening into four quadrants or categories of behavioral health and physical health, depending on the severity of their needs in each area. The model addresses a broad spectrum of health and mental health issues and co-occurring disorders, including various stages of depression.

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With enhanced screening efforts comes the responsibility to ensure that prevention programs and community services and supports that are culturally and linguistically competent, participant-driven, recovery-based, and trauma-informed are available to people who need them. A focus group study administered by the California Network of Mental Health Clients found that where there is a lack of voluntary, community-based mental health services and supports, many mental health clients who seek services fear that overly restrictive modes of treatment will be the only services available in a suicide crisis.

Sharing Information between Systems

Recent events have highlighted the issue of confidentiality laws and information sharing related to mental health. The *Report to the President on Issues Raised by the Virginia Tech Tragedy* found that there is variability in understanding confidentiality laws that can result in confusion and barriers between legitimate information sharing among service providers and systems.[67]

Confidentiality laws can be complex and often differ from state to state. States that allow for disclosure of mental health information usually limit it to diagnosis, prognosis, and information regarding treatment, generally medication.[87] Additionally, providers, clients, family members, and others disagree about when disclosure is appropriate. Confidentiality issues are of particular concern for the mental health system because of the ongoing problems of stigma and discrimination associated with mental illness. Until this larger problem is addressed, confidentiality issues will continue to be a significant challenge for strategies that seek to integrate systems and services.

Targeted Approaches

Several suicide prevention strategies enhance targeted crisis intervention services for individuals who may be contemplating suicide, or target specific population groups who may be at high risk of suicide. Targeted approaches are an important component of a system of suicide prevention that is responsive to diverse needs within communities.

Suicide Prevention Hotlines

Suicide prevention hotlines are an effective way for people in crisis to reach out for help, and those who use the lines report that they are helped by the calls. Surveys of individuals who have used hotlines indicate that reported levels of emotional distress and suicidal ideation are decreased by the end of the calls.[88,89] However, hotlines that are not accredited may differ in whether suicide risk assessment procedures are completed and in thoroughness of the assessment, which can result in uneven quality of response across locations.[88] Although the DMH requires each county's Mental Health Plan to operate a 24-hour, toll-free telephone line that provides information about accessing services and problem resolution processes, these lines may not include suicide prevention assessment and intervention.

The National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour, toll-free hotline funded by SAMHSA. The National Lifeline consists of over 125 accredited call centers in 45 states around the country. When a caller accesses the Lifeline, the call is immediately routed to the closest affiliated call center. Callers can remain anonymous, minimizing concerns about stigma that may inhibit people in need from seeking mental health services elsewhere. To address the needs of callers who do not speak English as their primary language, the Lifeline operates

a network of nine Spanish-language call centers across the nation, two of which are in California, and all Lifeline call centers have free access to a live language interpretation service that includes over 170 languages.

To become a member of the Lifeline, call centers must be accredited by an organization, such as the American Association of Suicidology, or licensed or certified by their county or state. This process ensures that responders are trained in evidence-based risk assessment procedures and that these procedures are consistently administered to all callers. The accreditation standards that the Lifeline accepts were developed with the involvement of national and international experts in suicide prevention to ensure incorporation of the latest research and information.[90] Call centers applying for accreditation for the first time may receive technical support from the organization that will review their application. Once accredited, call centers can apply for National Lifeline membership that includes a modest annual stipend, coverage of the phone line costs to calls placed to the Lifeline number, and ongoing technical assistance to ensure continuing, uniform quality across the network.

Currently, eight hotlines in California are members of the National Lifeline. Although anyone in California can call the Lifeline number, depending on their location, they may not reach a call center in their area or even in the state.

Data from the National Lifeline indicate that in 2007, approximately 20 percent of calls originating in California were answered by hotlines in other states. California-generated calls that come from counties that do not have a Lifeline-accredited call center are routed to accredited call centers in other counties based on their availability and capacity (e.g., staff availability, busy lines, billing limitations).

> *"In 2007, approximately 20 percent of calls that originated in California were answered by suicide prevention hotlines in other states."*

In a typical day, in addition to handling all the local calls in the Los Angeles area, the Didi Hirsch Community Mental Health Center takes calls from Santa Cruz, Fresno, Shasta, Sacramento, San Mateo, Kern, and Napa counties. When the Didi Hirsch Center cannot answer a call, such as when all its lines are busy, these California callers are served by a call center in Nebraska.

If calls are not answered locally, responders may not be able to refer individuals in crisis to local resources for follow-up care. California needs to increase the capacity of suicide prevention hotlines so that callers from every county can access a local, accredited call center. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple-language capacity, of suicide prevention hotlines.

Hotlines have also been used to target prevention activities for specific populations. The San Francisco Institute on Aging Center

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for Elderly Suicide Prevention operates the Friendship Line. The line offers phone-based services, such as 24-hour crisis intervention and elder abuse prevention, as well as grief counseling, well-being checks, and information and referral services.

Several hotlines target youth. For example, the Trevor Project is a national crisis and suicide prevention hotline that focuses on lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. This service is provided 24 hours per day, seven days per week and is free and confidential. The Trevor Project also hosts a website with education resources such as training models and teaching guides, and an online forum that serves as a virtual warm line.

Finally, the VA and SAMHSA have collaborated to provide suicide prevention hotline services that are targeted to veterans. Individuals may now call the National Lifeline and choose a prompt to identify their veteran status. They are immediately transferred to a hotline staffed by mental health professionals at a VA facility in upstate New York, who will have information about VA resources throughout the nation.

Population-Specific Interventions

Due to the unique characteristics of different age groups and ethnic populations and their disparities in access to services, effective approaches to suicide prevention need to include outreach and intervention strategies that specifically target these specific groups.[91,92]

Older Adults

Depression is a significant risk factor for suicide in older adults, and it is also a condition that may go unrecognized and thereby remain untreated.[93] Frequently, signs of mental health problems are missed because they are mistaken as a normal part of aging, or they are misdiagnosed as cognitive impairments that are increasingly common with advanced age.[11,94,95] Finally, where mental health problems are recognized, the stigma associated with mental illness may influence the likelihood of seeking mental health treatment.[95]

> *"The majority of older adults who died by suicide visited their physician within one month of their death."*

Although the majority of older adults visited their primary care physician within a month of their suicide, most of them were not receiving mental health treatment. Traditional mental health service systems are often not the most effective way to reach and serve older adults who may be at risk, and primary care services need to be improved.

Multiple evidence-based programs have been developed that target older adult mental health. Currently, ten programs are listed on the SAMHSA National Registry for Evidence-Based Programs and Practices (NREPP).[96] Most of these programs contain components for outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use.

Other effective approaches integrate mental health services into primary care, such as co-locating health and mental health services. The Prevention of Suicide in Primary

Care Elderly Collaborative Trial (PROSPECT) combines treatment guidelines for depression in primary care settings with comprehensive care management for older adults diagnosed with depression.[96] Trained clinicians work closely with the primary care provider, the older adult patient, and their family around treatment protocols and education. One outcome of this program was a statistically significant reduction in suicidal ideation among participants.[97]

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for patients 60 years or older who have major depression or dysthymic disorder.[96] The intervention is a collaborative care approach in which a nurse, social worker, or psychologist works with the primary care provider, a depression care manager, and the patient to develop a multi-modal course of treatment that includes medications, exercise, identifying positive activities to engage in, and education about late life depression. IMPACT has been evaluated with racially, ethnically, and linguistically diverse older adults, including Whites, Latinos, and African Americans. Outcomes of this intervention include significant reductions in depression and improvements with work, family, and other social relationships. The IMPACT model has also been shown to be more cost effective than usual medical-based care for depression in older adults.[11]

There is also a need to address Medicare and insurance reimbursement issues that may create barriers to mental health services for older adults.[94,98] The Program of All Inclusive Care for the Elderly (PACE) provides a model for coordinating Medicaid and Medicare financing with community-based social, mental health, and primary health services to provide an alternative to nursing home care.[96] An interdisciplinary treatment team oversees the implementation of the individualized treatment plan for each older adult enrolled in the program. Results from this program include decreased use of acute services, improved health and quality of life, and lower mortality rates.

Survivors of Suicide Attempts and Suicide Loss

Engaging those who have been directly impacted by the tragedy of suicide can be a powerful tool to prevent suicide and future attempts and to support those who have lost a friend, colleague, or loved one to suicide. A growing body of literature substantiates the effectiveness of services and supports offered by individuals directly impacted by mental illness, such as warm lines and peer-run support centers.[99] Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness are important sources of support, advocacy, and education for mental health clients and their family members.

In response to the high rate of suicide in Humboldt County, the California Network of Mental Health Clients recently organized Suicide Alternatives Workshops that bring together survivors of suicide attempts, family and friends of those who have died of suicide, clergy, mental health clients, mental health professionals, and physicians. The workshops are held monthly and provide ongoing community education, outreach and peer support, and recommendations for local policy and practice.

Another promising practice is web-based self-help, which is a cost effective approach to providing information and resources to those who have access to the Internet. Examples include the National Empowerment Center

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(www.power2u.org), a national consumer technical assistance center. Another example is "Beyond Blue," the national depression intervention initiative in Australia that hosts a website that offers self-assessment tools and resources to find mental health care, post notices on a bulletin board, and learn more about research (www.beyondblue.org).

Several programs, many of which are school-based, have been developed that facilitate peer support among high-risk youth. The Trevor Project hosts an online peer support venue for lesbian, gay, bisexual, transgender, and questioning youth. Models for implementing a range of youth peer support programs are available on the website for SAMHSA's National Registry for Evidence-based Programs and Practices.[96]

> *"Many evidence-based practices have not been tested among diverse populations."*

Racial, Ethnic, and Cultural Communities

The U.S. Surgeon General has reported significant disparities in access, availability, and quality of mental health treatment services for racial and ethnic populations as compared to Whites.[100] These disparities are evident in the paucity of culturally and linguistically appropriate mental health services and supports, including inconsistency in language access in services, hotlines, and informational materials, and in the fact that many evidence-based practices have not been tested among diverse population groups.

Cultural differences matter substantially. African Americans are more likely to be incorrectly diagnosed than Whites and are also more likely to leave psychiatric treatment earlier.[100] This situation may be due in part to the possibility that African Americans may present their symptoms and respond to treatment differently from what most clinicians are trained to expect.[100] Furthermore, African Americans are substantially less likely than Whites to have access to treatment providers who are of the same race.[100] Fears of racism may exacerbate the problems of stigma and discrimination around mental illness.

Other cultural factors may adversely impact the mental health and suicide risk of immigrants and refugees, such as intergenerational conflicts related to acculturation, family pressures around academic achievement, and adverse experiences from the home country, including war, torture, and genocide.

California is a diverse state. Data from the 2000 Census indicated that the majority (53.3 percent) of California's population identified as non-White, and 40 percent spoke a language other than English at home.[101,102] A quarter of the population was born outside of the U.S., and the majority of Asians and almost half of Latinos are foreign born.[103] A combined 63 percent of these populations are concentrated in the San Francisco Bay Area and Los Angeles. To address the needs of this diverse population, mental health and suicide prevention services

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need to identify and develop culturally appropriate outreach and engagement activities and diagnosis and treatment strategies.

Promising strategies include engaging diverse communities through natural community leaders and helpers, such as faith leaders, community health workers (e.g., promotoras), or indigenous healers. If trained to recognize and respond to warning signs of mental illness and suicide risk, these individuals are in a position to promote early intervention for individuals at risk who may not otherwise seek professional help. A process of community engagement to determine the strategies used and to evaluate their effectiveness, for example, through community participatory action research methods, can increase the validity, acceptability, and sustainability of culturally appropriate mental health and suicide prevention practices within diverse communities.[91] Interventions need to be specific, targeted, and culturally relevant, including the role of families, faith communities, traditions, and other values and attitudes that address perspectives on suicide and mental illness.

To address disproportionately high suicide rates in Native American communities, particularly among youth, effective approaches must be developed through an inclusive process. Although few evidence-based practices have been tested in Native American communities, tribes are actively engaged in developing and adapting best practices.[104,105]

For example, the Jicarilla Apache of Northern New Mexico developed a community intervention program involving tribal leadership, community members, youth, clinicians, university researchers, and the Indian Health Service that resulted in a 60 percent decline in suicides over a ten-year period.[106] Additionally, tribal programs in Phoenix and Alaska have implemented successful suicide prevention strategies that include training that incorporates not only suicide prevention and intervention, but also culturally-specific, traditional approaches and perspectives.[106]

The Zuni Life Skills Development program is a school-based curriculum designed to reduce suicide risk and enhance protective factors among Native American adolescents.[96] The curriculum includes topics such as building self-esteem, decreasing stress, increasing communication and problem-solving skills, and recognizing and eliminating self-destructive behaviors. Lessons are taught by a team of teachers and community resource leaders to ensure a high degree of cultural and linguistic relevance. The Zuni Life Skills Development curriculum served as the basis for the broader Life Skills Development curriculum that is now in use with other Native American populations.

It is also important that mental health and health providers reflect the diversity of the population they are charged with serving, including language diversity, so that people of all cultures, ethnicities, and languages can feel comfortable seeking services that they are confident will appropriately and effectively address their needs. More research is needed about effective models and to test existing practices for their effectiveness among diverse populations.

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Children, Youth, and Young Adults

It is important to promote protective factors against suicidal behavior in young people. A review of interventions by the Centers for Disease Control's (CDC) Task Force on Community Preventive Services reported that early childhood home visitation programs can prevent adverse outcomes, such as child abuse and neglect.[107] Furthermore, therapeutic foster care reduces violence among chronically delinquent juveniles. This is an important outcome, since 25 percent of serious violent offenses in the U.S. are committed by youth between the ages of 10 and 17 years. This task force did not evaluate the impact of these programs on suicide. However, the approaches promote protective factors and mitigate risk factors that can also lead to an increased risk of suicide in this vulnerable population.

Because school is where many youth spend a large part of their days, school staff are in the position to detect the early stages of mental health problems and potential suicide risk. By 2000, 77 percent of schools in the United States had implemented a suicide prevention program.[79] Some programs use early intervention strategies, such as screening instruments that detect warning signs of self-harm and suicidality. Mental health and suicide prevention programs that are school-based can be successful in encouraging students at risk to seek help, and to follow through on referrals to mental health services. The programs can also be successful in developing protocols to handle a suicide crisis that minimizes the chances of a contagion effect.

School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, conflict resolution, and nonviolent handling of disputes. One study found that a universal[9] intervention program (the Good Behavior Game) that focused on socializing first and second grade students toward reducing aggressive, disruptive behavior was associated with significant decreases in later onset of suicidal ideation and attempts.[108]

This approach may be particularly important for adolescents and youth who are coping with the stigma and prejudice associated with exploration of sexual orientation and gender identity. One study found that heterosexual students reported higher levels of protective factors, such as family connectedness, adult caring and involvement, and feeling that the school was a safe place, than homosexual students.[109]

Unfortunately, many young people who are at high risk of suicide may have already stopped attending school or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals through community groups and places where young people congregate. It is also important to train the program staff who provide services to at-risk youth to ensure they are able to recognize the warning signs of suicide and how to intervene early.

Nationally, many more children and youth need specialized mental health services than actually have access to them.[83] Several strategies have been recommended to improve service delivery and training of providers, particularly in primary care, who routinely come into contact with adolescents

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[9] Universal refers to an intervention that addresses an entire population, in this case, all first and second grade children enrolled in the schools were involved in this study, not solely those identified as at higher risk.

and youth who may be at heightened risk of emotional disorders or suicidal behavior. Examples are co-location and training of child mental health specialists to work in primary care settings, and enhanced training in medical school and for providers in practice.[83]

The tragic events at Virginia Tech raised national awareness of the need for earlier and better comprehensive mental health services on college campuses. Some of the key findings of the *Report to the President on Issues Raised by the Virginia Tech Tragedy* (2007)[67] are included as follows:

- Sharing critical information among education officials, health care providers, law enforcement personnel, and others can address obstacles resulting from confusion about confidentiality laws.
- Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it.
- There must be effective coordination of providers who are sensitive to the issues of safety, privacy, and provision of care to ensure that people with mental illness are integrated into the community.
- Full implementation of emergency preparedness and violence prevention plans is needed to address problems of school and community violence.

"Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it."

SAMHSA has launched a suicide prevention initiative that targets adolescents and youth. The Campus Suicide Prevention Grant Program provides funds to assist colleges and universities in their efforts to prevent suicide attempts and completions and to enhance services for students with mental health problems, such as depression and substance abuse that put them at risk for suicide and suicide attempts. Program requirements include providing suicide prevention training and education programs for students and campus personnel, enhancing the network of campus mental health services to include the broader community where needed, developing campus-based hotlines or linking hotlines with the National Lifeline, and disseminating materials to the campus community, as well as families, to educate them about the warning signs of suicide and to counter stigma and encourage help-seeking behaviors.

In addition, the State/Tribal Youth Suicide Prevention Grant Program provides funds to states or tribes to develop a public/private coalition among youth-serving institutions and agencies, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth-supporting organizations. This coalition is responsible for implementing a youth suicide prevention plan that includes enhanced assessment, early intervention, and treatment for at-risk youth.

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Increasing the availability of mental health and suicide prevention services on college campuses is an important step in preventing suicide among young adults. Reports from the California Department of Education and the University of California, among others, have recommended implementation of strategies to achieve this step.[15,110] However, a suicide prevention system for young people must include strategies that start much earlier than the presentation of suicidal ideation or acute mental health problems.

> *"A system of suicide prevention must include strategies that start well before the presence of suicidal ideation and acute mental health crises."*

Correctional Facilities and Law Enforcement

Many effective programs offer models for partnership between the criminal justice and mental health systems, for example, jail diversion and re-entry programs. By building local partnerships between and within the criminal justice system and at the community level, suicide risk among inmates can be reduced along with the medical cost of treating acute problems, which will provide a safer setting for inmates as well as staff.[111]

To address the mental health needs and suicide risk of individuals who, being released from jail, were repeat offenders, or were being discharged from an inpatient psychiatric facility, one community in Monroe County, New York, developed a coalition of community care providers, the county mental health department, local criminal justice systems, the courts, and the university psychiatry department to coordinated outreach and services.[112] Over 100 individuals received services through the program. Outcomes of this project included no suicide attempts, assaults, or other reportable incidents during the study period among subjects, and the reduction in jail and hospital expenses amounted to approximately three times the program's cost. The findings from research and data on the needs of this population provide strong support for implementing programs in jails and prisons as well as programs that support re-entry into the community.

According to the California Department of Corrections and Rehabilitation, California's prison system paroles over 100,000 inmates every year.[113] Many of these inmates will require community services to maintain their health, mental health, and well-being after release. Recently, the California Legislature has required the Department of Corrections and Rehabilitation and community agencies to work together to provide better re-entry programs and services for parolees. Collaboration between the prison system, community social services, and the community mental health system is necessary to support this effort to provide continuity of care,

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particularly as California's prison system continues to shift toward a recovery and rehabilitation model for inmates with severe mental illnesses.

Employers

Integrating suicide prevention into work settings is recommended to reach a large number of adults who may be at risk, but who are not currently utilizing or likely to seek out mental health services. Resources need to be developed and disseminated to employers that provide guidance about how to recognize and assist employees who may be exhibiting warning signs of suicidal behaviors, who are coping with family members or friends of individuals presenting with suicidal behaviors, or who are themselves survivors of suicide. Recently, the Partnership for Workplace Mental Health, which includes the American Psychiatric Association, the American Psychiatric Foundation, and business leaders, launched *Employer Innovations Online* (www.workplacementalhealth.org). This searchable online database provides resources, models, assessment tools, and detailed information for employers to develop strategies to address workplace mental health issues.[114] Another resource is the National Business Group on Health, an organization that provides information and resources on health and mental health issues in the workplace.[115]

Employers should be encouraged to access these resources as well as to build and maintain a directory of local prevention, treatment, and support services and make them readily available, in a non-stigmatizing manner, to all employees. Another approach is to build outreach and education about suicide prevention and mental health into existing support networks, such as employee assistance programs, to reach people who might not otherwise seek help.

Veterans and the Military

Given the magnitude of the problem of suicide among veterans, it is critical that the military and the reserves are partners in implementing the *California Strategic Plan for Suicide Prevention*, including the California National Guard and the VA medical centers in the state. Strategies to address suicide prevention among veterans must take into account the prevalence and characteristics of stigma and fears of discrimination in the military that constitute barriers to needed care. Strategies must also address access to mental health services, especially for veterans who may live far away from a VA Health Center. The increasing volume of need for mental health services among the thousands of veterans returning from Iraq and Afghanistan must also be met.

Beginning in fall 2003, the Army convened Mental Health Advisory Teams to annually review data on mental illness and suicide among deployed soldiers, assess quality and access to mental health care, and provide recommendations for improvements.[116] Recommendations from early MHAT reports led to the Army Suicide Event Report, a reporting and tracking mechanism that collects extensive data about suicides and attempts. The development of the VA Suicide Prevention Lifeline is another step toward addressing veterans' specific and urgent mental health needs.

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Multi-Level Public Health Approach

The Air Force Suicide Prevention Program is an evidence-based practice that was developed in response to a rise in the suicide rates in the Air Force in the early 1990s.[117] The program uses a multi-level intervention targeted at reducing risk factors and enhancing protective factors, including reducing stigma around seeking help, promoting education about mental health, changing policies, and shifting social norms. Eleven initiatives were implemented, including the following:

- Strong messaging from the Air Force Chief of Staff that promotes social support between officers, supervisors, and coworkers and the value of seeking mental health services early.
- Requiring personnel to receive suicide prevention training, and encouraging each Air Force installation to tailor training programs to the needs of the local community.
- Improving surveillance through an online database and developing a survey that provides specific feedback to help tailor interventions to each community.
- Developing local crisis and critical incident response management teams.
- Coordinating and integrating services among faith-based programs, mental health services, family support centers, child and youth programs, family advocacy programs, and health and wellness centers.

The program resulted in significant increases in Air Force personnel that were trained in suicide prevention and educated about violence prevention.[118] After implementation of the program, there were significant reductions in suicides, homicides, accidental deaths, and moderate and severe family violence. The success of this model indicates that systemic interventions that change social norms about seeking help from being a sign of weakness to a sign of strength, and institutionalization of training about suicide prevention can have substantial impact on promoting mental health and reducing a range of adverse outcomes.

The universal, multi-layered strategy exemplified by the Air Force Suicide Prevention Program is a good example of an approach that has been used to successfully address other public health problems, such as reducing cardiovascular disease.[119] Efforts to address the broader, modifiable risk factors that predispose individuals to heart disease were developed in parallel with technological advances that improved outcomes for people who have already developed the disease. Along with activities such as education about recognizing the warning signs of a heart attack, widespread training in cardiopulmonary resuscitation, and the development of new medicines and technologies were strategies that educated the public about the benefits of a healthy lifestyle and of reducing or eliminating behaviors that contribute to long term risk. Changes in public policy, such as laws related to smoking, supported this shift in cultural and social norms that has reduced the risk of a range of diseases.

There is a difference between the traditional, clinical-based approach to suicide prevention and the public health approach that was

employed by the Air Force Suicide Prevention program. The clinical approach rests on identifying and treating individual risk factors when evidence of disease is present. Typical suicide prevention strategies have focused largely on recognizing warning signs and individual-level risk factors rather than considering the important role of population-level mental health promotion with all individuals on a continuum of risk. Interventions are broad, multi-layered, and occur both well before a problem arises as well as at various phases after it is present. The Air Force Suicide Prevention program demonstrates that when a public health approach is applied to the problem of suicide and a broad range of prevention and early intervention strategies are put into place, the likelihood of multiple negative outcomes, including suicide, mental illness, and violence, are all reduced.[118,119]

Implementing Training and Workforce Enhancements

Effective suicide prevention strategies depend on a trained workforce and an educated public. It is imperative to ensure that providers in multiple service fields are equipped to recognize and intervene when suicide risk is present. Training and service guidelines need to be implemented, targeting the specific concerns and opportunities for intervention that are present in different settings, including primary care, mental health clinics, classrooms, juvenile justice facilities, substance abuse treatment programs, older adult and long term care programs, and the venues served by law enforcement and probation officers.

Establishing Guidelines for Professionals

A substantial precedent exists for establishing guidelines for training and service in selected occupations. For example, the American Psychiatric Association has developed guidelines for mental health professionals, and the SPRC has developed a curriculum for suicide prevention programs within law enforcement departments.

SAMHSA and the SPRC have developed materials that support the development of guidelines in campus settings. For example, *Promoting Mental Health and Preventing Suicide in College and University Settings* provides recommendations for institutions of higher education to assist with the implementation of suicide prevention programs.[120]

Finally, tools for assessment of suicide risk in emergency departments have been developed, as well as guidelines for emergency department providers around care and discharge planning for individuals who survived a suicide attempt.[82,121] Currently, SAMHSA, the SPRC, and the National Suicide Prevention Lifeline are working with the American Academy for Emergency Psychiatrists and the Emergency Nurses Association to raise awareness for providers and develop and disseminate training for emergency medical providers.[h]

Health, Mental Health, and Social Services

Health clinics, i.e., primary care and prenatal care, mental health centers, emergency response systems, crisis centers, and alcohol and drug programs, are key access points. Personnel in these systems need to have consistent guidelines for effective assessment and treatment interventions.

Unfortunately, there are many missed opportunities for prevention and early intervention among people who are at risk

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[h] For more information, visit the websites for SAMHSA (www.mentalhealth.samhsa.gov), SPRC (www.sprc.org), and the National Suicide Prevention Lifeline (www.suicideprevention lifeline.org/).

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of suicide. Improved training guidelines and service protocols will better prepare providers to appropriately respond when suicide risk is present. Equally critical is the need to appropriately assess for mental health conditions that are associated with significant increase in suicide risk, such as depression. Although routine screening has been shown to be effective in identifying and successfully treating depression among adults and older adults, it is important that screening be accompanied by policies ensuring confidentiality and protection from discrimination, along with the availability and accessibility of appropriate, quality, follow-up services.

> *"Mental health professionals in California do not have a licensing requirement specifically focusing on suicide risk assessment and treatment."*

In one study of physician visits by patients presenting with either major depression or an adjustment disorder, physicians asked questions about suicide in only 36 percent of visits.[122] Physicians were more likely to ask questions about suicide if they had personal experience with depression or if the patient prompted the discussion. Health providers may be reluctant to ask questions about suicide risk if they do not feel adequately trained in suicide assessment and treatment, or if they do not know how to refer patients to a mental health provider who can provide these services. Educating health professionals to recognize and treat depression and other conditions that present a heightened risk of suicide and providing them with the tools to consistently and properly address suicide can prevent suicide deaths.[122,123]

A survey of over 300 emergency departments in California found that most rely on external mental health professionals, such as mobile crisis, private psychiatric evaluation teams, or social workers to provide suicide assessments and referrals.[80] Yet mental health professionals in California do not have a standard competency or licensing requirement that specifically focuses on assessing, treating, and caring for patients at risk for suicide. The majority of respondents identified a need for increased access to mental health professionals to be able to adequately help individuals who enter emergency departments in mental health or suicide crises.

Older adults have the highest rate of suicide, and depression is a significant risk factor for suicide among older adults. It is critical that medical professionals who treat older adults and staff working in older adult services, long-term care, and adult protective services programs, should be trained to recognize warning signs and risk factors of depression and suicide in older adults.

Staff working in social services, child protection, foster care, and juvenile justice interact daily with high-risk youth and are in a critical position to identify and intervene when adverse childhood experiences have taken place or suicidal ideation and behavior are present. To appropriately identify and reduce suicidal behavior, staff in these systems need to be trained in age-appropriate prevention and early intervention strategies that are effective for the populations they serve.

Law Enforcement

Law enforcement officers are often the first on the scene when a suicide crisis emerges. They also come into contact with family members and other loved ones of individuals who have died by suicide. Several evidence-based training models exist that educate officers about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety.[32] For example, the Crisis Intervention Team (CIT) program provides officers with training that includes a simple eight-question assessment tool, along with techniques for de-escalating a crisis. CIT has been implemented in many locations nationwide, and has been shown to reduce officer injury rates five-fold.[124] Many local law enforcement agencies report that it is even more effective than a traditional mobile crisis response team because police are typically first responders who are on the scene within 10 to 15 minutes.[125]

Educating the Public to Take Action to Prevent Suicide

Personal or cultural beliefs about suicide and mental illness, concerns about stigma and discrimination, and feelings of hopelessness can dissuade people from seeking help. Strategies that promote help-seeking behavior encourage people to reach out to family, friends, and resources in their communities when they are in need. These resources may include mental health services, peer support groups, community helpers such as promotoras, and faith-based organizations.

Community Gatekeepers

Gatekeepers are defined as those who regularly come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk and how to refer people to services that can help. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services and supports or whose risk factors may not be visible to health and mental health professionals.

Gatekeeper training targets a broad range of people in the community. The following is a list of possible community gatekeepers, including those identified in the National Strategy for Suicide Prevention:[13]

- School health personnel
- Employers and supervisors
- Clergy and faith-based community leaders
- Natural community helpers such as promotoras, senior center staff and volunteers, and staff from cultural resource centers
- Personnel and volunteers in older adult services and long-term care, including home health care, adult protective services, in-home support services, congregate or home delivered meals, and caregiver support services
- Hospice and nursing home staff and volunteers
- Personnel in group homes and licensed care facilities
- Emergency health care personnel, including first responders such as Emergency Medical Technicians.

The above list is general; training strategies

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should consider the target population and ensure that individuals most likely to interact with those at risk in the community are included in the planning process. For example, in rural areas staff can be targeted in settings where individuals at high risk may be found, such as farm credit offices, unemployment offices, youth and women's shelters, DWI courts, and others.[50]

> *"Public policies that restrict access to lethal means and educate people about safe handling of lethal materials can save lives."*

Reducing Access to Lethal Means

Reducing access to lethal means is an important component of suicide prevention when it is integrated with other local, regional, and state-level activities that take into account target populations and consideration of methods that are frequently used in a particular locality.[126] Having a gun in the house is associated with higher risk of suicide among both adults and adolescents, and regions of the country with high rates of gun ownership also have higher overall suicide rates.[127,128] Using gun storage safety precautions, such as gun locks, storing guns unloaded, and storing ammunition in a separate, locked container, are associated with lower numbers of both suicide deaths as well as unintentional injuries.[128] Studies show that more restrictive firearm legislation, such as Child Access Prevention laws, has led to a significant decrease in suicide rates.[129,130] Public policies that restrict access to lethal means and educate people about how to safely handle potentially lethal materials – from firearms to medications – can save lives.

Information from the SPRC indicates that multiple efforts are under way in other states to address access to lethal means. Maine, New Hampshire, and Oregon provide educational materials and training about screening for access to lethal means in potentially suicidal patients who are in a primary care or emergency department setting, and how to provide counsel about reducing access to lethal means. Montana and Wyoming distribute free gun locks at community events.

There are examples of how reducing access to a particular form of lethal means can reduce the overall rate of suicide.[66] In England domestic coal-based gas once contained toxic levels of carbon monoxide, and many suicides occurred by this method. After the early 1960's, the gas was detoxified and the overall suicide rate declined by one-third. Installation of a barrier on the Duke Ellington Bridge in Washington, D.C. led to a reduction in the overall suicide rate in the city despite the presence of an equally high bridge one block away. National changes in firearms laws in Canada were followed by a reduction in suicide by firearms, particularly among youth; however, rates among older men, who are most likely to own guns, were not changed, and use of other methods by youths increased.

Most suicides by jumping occur from high-rise residential buildings.[131] However, in certain locations an iconic structure may attract a disproportionate number of suicide attempts.

This phenomenon may develop in part from media coverage about suicides from these structures, romanticized ideas about what it is like to die by that method, or identification with symbolism behind that particular location or means of death.

Barriers designed to prevent suicide by jumping, such as the safety railings that have been erected on the Eiffel Tower and the Empire State Building, are effective in reducing or eliminating suicides at those sites. This issue has been the source of considerable local controversy in areas where suicides by jumping are a problem. Barriers can be controversial due to their cost relative to the number of lives lost, aesthetics, impacts on tourism, and perceptions about the inevitability of someone completing suicide another way if they are prevented from doing so by a barrier. However, one study of 515 individuals who were restrained from attempting suicide from the Golden Gate Bridge found that approximately 90 percent of them did not subsequently die by suicide or other violent means, suggesting that when suicide is deterred, the vast majority of individuals do not substitute another method.[132]

Approximately 1,200 people have lost their lives by jumping from the Golden Gate Bridge since it opened in 1937. The Marin County Coroner's Office reports that in the 10-year period between July 1997 and June 2007, there were 206 known suicide deaths by jumping from the Golden Gate Bridge.[133] Over 90 percent of the individuals who died were from Northern California, and half were from four of the six counties that are within the Golden Gate Bridge District (Marin, Napa, Sonoma, and San Francisco).

In response, the Golden Gate Bridge, Highway and Transportation District (the District) has implemented several strategies to reduce the number of suicides. These include 11 emergency/crisis counseling telephones along the sidewalk along with signage; traffic surveillance cameras that assist in detecting persons exhibiting suicidal behaviors; and suicide prevention training for bridge patrollers and District personnel. California Highway Patrol officers that patrol the roadway also receive suicide prevention training. The District estimates that these strategies have helped deter approximately two-thirds of individuals who intend to complete suicide by jumping from the Bridge. However, the District recognizes that these non-physical deterrence methods are not always successful. In July 2008, the District will release an environmental study to develop and evaluate options for a physical suicide deterrent system, such as higher railings or a barrier, for the Bridge.[134]

Public Awareness Campaigns, the Media, and the Entertainment Industry

Stigma around mental health is a deeply engrained part of our culture, and discrimination is evident in policy decisions ranging from health insurance coverage and employment to research priorities.[135] Negative portrayals of individuals with mental illness and sensational coverage of a tragic event contribute to stigmatizing attitudes in the general public, which often lead to discrimination. Unfortunately, these depictions of people with mental health problems as unpredictable and even dangerous are common in films, television, and the news media. When not countered with education and awareness about the facts of mental illness, these stories fuel people's fears and promote self-stigma among individuals with a mental illness diagnosis.

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> *"It is estimated that nearly two-thirds of those who have significant mental health problems do not seek treatment because of fears of stigma and discrimination."*

It is estimated that nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination.[100] SAMHSA has launched an ongoing anti-stigma campaign that offers resources to states to develop their own targeted anti-stigma materials.136 Localized stigma and discrimination reduction projects are also under way in California through Mental Health Services Act funding. Development of a statewide suicide prevention campaign should complement local and national anti-stigma campaigns, peer-to-peer programs, and personal contact strategies that effectively increase awareness of suicide prevention and how to find help.

There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicidal behaviors, tailoring that message to include population-specific risk factors where appropriate. Such activities include designing messages that educate the public that suicide is preventable, raising awareness of the populations at risk, forging new and creative approaches to engage community partners, and promoting community-based support systems and cultural-specific ways of healing. Use of multiple media channels, including the ethnic media, is necessary to ensure that the message is far reaching. Linking with national campaigns, such as National Suicide Prevention and Awareness Week and National Depression Screening Day, should also be considered to maximize impact and exposure by reinforcing the messaging.

Public health has successfully used statewide social marketing campaigns to promote public awareness and to influence health behaviors on various topics. The California Tobacco Control Program (CTCP) was formed after Proposition 99 passed in 1988, providing California with the funds to initiate a comprehensive anti-tobacco program. The CTCP found that the most efficient way to reach its goal of decreasing tobacco-related deaths and disease is to implement initiatives statewide that seek to change social norms that influence individual behaviors.[137] The CTCP uses an approach of countering negative influences by depicting tobacco use as undesirable and socially unacceptable. The campaign also supports smoking cessation efforts through a helpline and community-based programs. Finally, the campaign includes a media education component to offset depictions of smoking as acceptable in movies and to counter tobacco industry advertising. Some of the results of the program include an increased desire and intention to quit among smokers, and the smoking prevalence in the state has declined by 33.6 percent since the program's inception.

When the number of stories about suicides increase, or a death is reported at length or featured prominently, the contagion effect can lead to an increase in suicides among susceptible individuals.[138,139] Guidelines have

been developed to inform the media about how to cover suicide incidents in a way that balances public safety with what is newsworthy.[140,141] Media coverage should be used as a positive tool to promote greater understanding of the risks and protective factors and how to get help.

National and state public health agencies have developed mechanisms to engage and educate the entertainment industry around health promotion and disease prevention. For example, Hollywood, Health & Society is a Norman Lear Center project that provides the entertainment industry with accurate and timely information for health storylines. The project is funded by the CDC, the National Cancer Institute, the Agency for Healthcare Research and Quality, the Health Resources Services Administration, and the California Department of Public Health. According to a 2001 survey, over half of regular television viewers reported that they learned about a disease or how to prevent it from watching a television show, and about one-third of regular viewers said they took some action after hearing about a health issue or disease on a television show. Finally, SAMHSA has begun to engage the entertainment industry via the VOICE Awards, an annual event that honors the television and movie industry for positive, recovery-oriented portrayals of mental illness.

Improving Program Effectiveness and System Accountability

Surveillance, Research, and Evaluation

Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. Due to the paucity of disaggregated data, there are gaps in knowledge about how suicide impacts certain racial and ethnic groups. While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve certain population groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda must be established to better design responsive policies and effective programs towards reducing the impact of suicide.

California is a large, diverse state with unique demographics. To strengthen suicide prevention, more needs to be known about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military service, and other factors related to identity. Many questions are yet unanswered about the causes and types of suicide, stages of suicidal behaviors (e.g., ideation, planning, attempt, and aftermath), and the impact of exposure to trauma such as adverse childhood events, historical trauma,[i] intergenerational conflicts,[j] and trauma history within an immigrant's country of origin. Understanding the role of multiculturalism and acculturation in the development of risk and protective factors in immigrant communities should be enhanced. More information is also needed about the relationship between suicide and postpartum depression, homicide, and other factors.

To increase knowledge on these issues, California needs to expand its capacity for surveillance, research, and evaluation on suicide and suicide prevention.

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[i] Historical trauma is the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide.

[j] Intergenerational conflicts occur between generations and are related to the acculturation process of immigrant families.

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Surveillance is the continuous collection of information on the entire population for the purposes of monitoring and describing a problem. Research refers to limited, focused efforts to answer specific questions that cannot be answered easily through surveillance alone. Evaluation aims to determine how best to design and improve programs. These three approaches often overlap and interact, and all are necessary to support effective policies and programs.

> *"Accurate, complete, and disaggregated information needs to be accessible to the public and policy makers."*

Fortunately, California has the necessary partners and elements to take on this work. Multiple state agency databases exist that can be coordinated, connected, and enhanced to fill gaps in knowledge. California hosts a wealth of world-class research universities and institutes. Existing statewide surveys can be expanded to provide a broader picture of suicidal behavior. These surveys include the California Healthy Kids Survey for middle and high schools, the California Behavioral Risk Factor Surveillance and Youth Risk Behavior Surveillance instruments, the California Health Interview Survey, and others.

Accurate and complete information, including disaggregated racial and ethnic data, about suicide prevalence and prevention need to be widely accessible to the public and to policymakers to inform service and system improvements. Nationally, one persistent challenge is that the information that flows into reporting systems may not be uniform and may come from different sources. For example, the death certificate may ultimately be completed and signed by medical examiners or coroners, or by a public official in the legal system, which may result in differences in how suicide deaths are determined and recorded.[7] One solution to this inconsistency is to implement a single set of criteria for identifying and reporting suicide deaths that is widely used across systems. Another is to explore ways to expand or link the data systems that already exist, such as public health and vital statistics, coroner's office, hospitals, crisis centers, mental health, alcohol and drug programs, law enforcement and corrections, and schools.

An example of how data system linkage can increase knowledge about suicide is the CDC's National Violent Death Reporting System (NVDRS). California is one of 17 states currently participating. The California NVDRS links data from death certificates, police reports, and medical examiner or coroner reports to provide a better understanding of the incidents and risks of violent deaths, including suicide. Information from this database is used to identify trends and risk factors that can inform program and policy decisions to more effectively prevent suicide. NVDRS is also used to identify additional information that needs to be collected to pinpoint the factors associated with suicide. Some examples of how states have used the NVDRS include the following:

- Maryland changed its mental health outreach strategies when it learned that men have much higher rates of suicide and lower rates of contact with the mental health system than women.

- South Carolina instituted new screening protocols when it found that two-thirds of youths who committed suicide were involved in the juvenile justice system.

- Oregon now helps medical professionals identify patients at risk in response to findings that 37 percent of older adults visited a physician in the month prior to their suicide.

- Rhode Island now gathers information on specialties of physicians prescribing drugs, because data from its reporting system suggested that inadequate drug counseling may be implicated in suicide by overdose.

- California's use of the NVDRS has documented that the following risk factors were present in eight out of ten suicide deaths in three Bay Area counties, providing a basis for prevention planning:
  - 60 percent had a mental illness.
  - 30 percent documented a role of physical health problems.
  - 25 percent had made previous attempts or had spoken about their intent.
  - 25 percent reported problems with substance abuse.
  - 21 percent were having interpersonal problems with their partner or another individual.
  - Smaller percentages involved issues with employment, finances, and deaths in the family.

Efforts to expand statewide data systems should be complemented by strategies to increase local capacity for data collection, surveillance reporting, and information dissemination. As critical local partners in reporting on suicide deaths, coroners and medical examiners should be engaged in this process.

It is important to explore innovative and community-based research methods. For example, community participatory action research represents a true collaboration between researchers and the communities that are impacted by the research. Communities are integrally involved in identifying research questions, methods, and defining outcomes that are relevant to the community. Other research methods including longitudinal studies, qualitative studies such as focus groups, ethnography, and oral histories, are also important methods that can be developed to clarify how we can improve suicide prevention strategies tailored to local problems.

One promising model is death review teams, which provide a mechanism for communication and collaboration between different service systems that have important roles in a case. Child death review teams address concerns about the underreporting of child homicides by bringing together a multidisciplinary group that includes medical examiners and coroners to determine cause of death and improve surveillance.[142]

In California all 58 counties have a child death review team. The purpose of these teams is to prevent child abuse and neglect by understanding the factors that contribute

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to each death and translating the learning into effective policies. Local teams are supported by a state team that oversees local activities, analyzes standardized local data into an annual report, and provides training on important confidentiality, procedural, and technical issues.

> *"Models for evaluating suicide prevention programs must be disseminated to increase the number of evidence-based practices in California."*

Some examples of policies that have changed as the result of child death review teams involve pool fencing and zero tolerance for guns on school property. Several counties have expanded the local child death review team into programs that also offer services and public education around issues such as bereavement, critical incident debriefing, and Sudden Infant Death Syndrome.

Currently, 25 counties have a Domestic Violence Fatality Review team. These teams are supported through a partnership between the California Health and Human Services Agency and the State District Attorney's Office. In 2000 a statewide advisory committee was formed that has developed a Review Team protocol to maintain consistency among review teams across the state. This committee now hosts regional trainings for local death review team participants. This effort has led to the development of a Risk Assessment Checklist for court judges and a database that tracks risk factors associated with domestic violence-related fatalities.

Counties may have other death review teams related to specific settings, such as deaths of individuals under treatment with the public mental health authority and in hospitals.

In San Francisco the recognition that 70 percent of suicide deaths were from traumatic self-injury (i.e., versus poisoning), along with the fact that two-thirds of those who died by suicide were in psychiatric treatment at the time of their death, led to the implementation of joint psychiatric and trauma service review teams at San Francisco General Hospital.[143] Suicide review teams created a feedback mechanism between different systems to improve care and ultimately prevent suicides in the city.

Finally, there is a need to identify and disseminate models for evaluating suicide prevention programs and activities to increase the number of evidence-based programs in California. This need includes collecting outcome measures that are consistent and relevant to improve programs and the experiences of service users. Culturally and linguistically appropriate approaches to suicide prevention need to be strengthened. Alongside statewide stigma reduction efforts, how the social norms change and their effects on rates of suicidal behavior and appropriate help-seeking behavior should be studied.

Several resources support the dissemination of evidence-based suicide prevention practices, such as the SPRC's Best Practices Registry and NREPP. The criteria required for inclusion in these registries (i.e., proven, promising, and emerging) has resulted in reliable sources of information about suicide prevention programs and practices, including whether they have been tested among diverse population groups.

PART 3: STRATEGIC DIRECTIONS AND RECOMMENDED ACTIONS

The California Strategic Plan on Suicide Prevention serves as a platform for developing and offering a comprehensive range of strategies.

The Suicide Prevention Plan Advisory Committee formulated four strategic directions and corresponding recommended actions to set the course for reducing suicides and suicidal behaviors in California. These recommendations are grounded in the data and evidence offered in the two preceding chapters and were refined through the course of many rich discussions by the committee.

The *California Strategic Plan on Suicide Prevention* serves as a platform for developing and offering a comprehensive range of strategies, starting from prevention and early intervention to crisis services and aftercare, for children and youth to adults and older adults from diverse backgrounds. The programs and services generated from this plan must go beyond traditional approaches that solely depend upon identifying and treating individual risk factors. A population-based approach is essential and will require community-wide strategies and responsive organizational and environmental policies and practices. State and local partners spanning multiple disciplines and settings must work together to create the coordinated system of suicide prevention that is needed to make a difference in California. Lastly, ongoing research and evaluation must be viewed as a keystone element to continuously review and assess the efforts and overall direction. The Plan represents the initial five-year phase of this process.

It is fortuitous that this Plan is being released when there is a concerted effort underway through the Mental Health Services Act to focus more on health, wellness, resiliency and recovery, and to reduce stigma associated with mental illness. With so many lives at stake, the time is now to make suicide prevention a priority.

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About Core Principles, Strategic Directions, and Recommended Actions

Six core principles are embedded in all levels of planning, service delivery, and evaluation. The Plan is further organized by two levels of focus for suicide prevention: strategic directions and recommended actions.

Strategic directions are broad levels of focus that serve as the central aim that the more specific recommended actions address. These recommended actions are not an exhaustive list, but they emerged as priorities at this point in time to reduce suicide and its tragic consequences on individuals, families, and communities throughout California.

Taken together, the core principles, strategic directions, and recommended actions are intended to lay a foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems, and identifies and fills gaps in services and programs.

Core Principle 1. *Implement culturally competent strategies and programs that reduce disparities.*

To be effective, systems, organizations, and services for suicide prevention must embrace behaviors, attitudes, and policies that are compatible with diverse belief systems and customs. A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic, and cultural groups that have been historically underserved. Planning and service improvement processes should involve members of the targeted racial, ethnic, and cultural groups.

Core Principle 2. *Eliminate barriers and increase outreach and access to services.*

Potential barriers must be addressed in designing and implementing outreach and service programs to ensure improved access for all Californians of diverse backgrounds and abilities. People who live in rural areas often must travel significant distances to access needed services. Many other individuals are isolated by physical and/or psychiatric disabilities, including age-related disabilities that render them homebound or marginalized from needed support systems. Information, programs, and materials need to be accessible and available in a variety of languages and formats. Programs and services must be accessible to those for whom English is not the primary language; with low literacy skills; and with vision, hearing, and cognitive impairments.

Core Principle 3. *Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations.*

Those who have survived a suicide attempt and their family members, friends, or caregivers bring important personal experience and unique perspectives to identifying service needs and gaps in the system and to delivering services. Additionally, when service improvements are under way that target specific populations, representatives of these groups must be involved in all aspects of planning and implementation. Peer support and education are invaluable components of a comprehensive system for suicide prevention.

Core Principle 4. *Use evidence-based models and promising practices to strengthen program effectiveness.*

Many existing programs and practices have demonstrated effectiveness, broadly or within specific populations. Attention should be given to replicating and disseminating or adapting these effective program models and promising practices. Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs. Evaluation data can be an invaluable tool to garner support for program implementation at all levels.

Many programs and providers currently offer needed and effective services to prevent suicide. Where such promising service or program models exist, the focus should be on coordinating and building upon their foundation towards the development of a more comprehensive system of suicide prevention.

Core Principle 5. *Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.*

To align with the call to action that "Every Californian Is Part of the Solution," it is critical that long-term partnerships be developed with a broad range of partners that transcend the traditional mental health system. These partnerships may include the business community, ethnic and cultural community-based organizations, senior centers and aging services, the spiritual and faith communities, private foundations, schools and institutions of higher education, health and human service organizations, criminal and juvenile justice entities, and military partners, such as Veterans Affairs and the National Guard.

Core Principle 6. *Employ a life span approach to suicide prevention.*

Suicide prevention and intervention strategies should be targeted to Californians of all ages from children and youth, to adults, and older adults. The life span approach seeks to prevent a crisis from emerging as well as to provide prevention and early interventions to address problems long before they become acute.

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Strategic Direction 1: Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations, and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion and prevention through crisis intervention.

Recommended Actions at the State Level

1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices, and community planning.

1.2 Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices that prevent suicide. These partners should include:

- Department of Aging
- Department of Alcohol and Drug Programs
- Department of Corrections and Rehabilitation
- Department of Education
- Department of Health Care Services
- Department of Managed Health Care
- Department of Mental Health
- Department of Public Health
- Department of Social Services
- Department of Veterans Affairs
- Managed Risk Medical Insurance Board
- National Guard

1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. The public and private partnerships should include:

- Community-based and ethnic-based organizations
- Community leaders
- Client, family, youth, and peer support advocacy groups
- Employers
- Health and mental health providers
- Insurance industry
- Local educational agencies and institutions of higher education
- Spiritual and faith-based organizations

1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.

1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.

Recommended Actions at the Local Level

1.8 In each county, appoint a liaison to the state Office of Suicide Prevention, and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention issues. Membership should reflect a broad range of local stakeholders with expertise and experience with diverse at-risk groups, including:

- Local government and nonprofit agencies, such as mental health, public health, law enforcement, education, and Area Agencies on Aging
- Coroners and medical examiners
- Tribal representatives
- Survivors of suicide attempts and family members
- Mental health clients

1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council. The plan should:

- Identify measurable goals, objectives, and expected outcomes toward creating a comprehensive system of suicide prevention that includes health and mental health promotion through crisis interventions.
- Establish clear protocols for communication, including sharing confidential information, among systems and providers.
- Identify target population groups and strategies or an inclusive process for doing so.
- Create and monitor an effective crisis response system.
- Identify opportunities and embed and expand quality suicide prevention activities in local programs across systems.
- Provide for technical assistance to peer support programs, such as peer-run crisis respite centers and peer warm lines.
- Coordinate with the state Office of Suicide Prevention.
- Provide for periodic review of the county's progress and updates to the plan.
- Identify mechanisms to report on suicide prevention activities in existing county reporting structures, such as those for Mental Health Services Act components and county cultural competence reports.

1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.

1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

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1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.

1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.

1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office of Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

Recommended Actions at the State Level

2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

At a minimum, occupations selected for guidelines and curricula development and training should include:

- Primary care providers, including physicians and mid-level practitioners
- First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
- Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
- Social workers and other staff in older adult programs, in-home support services, adult and child protective services, and foster care
- Adult and juvenile system correction officers and probation and parole officers
- Administrators and faculty in elementary, middle, and high schools and in colleges and universities

Service and training guidelines should

include direction and recommendations for the following:

- Promoting health, mental health, and prevention principles
- Addressing barriers related to mental health stigma and discrimination
- Increasing understanding of protective and risk factors, including the role of age, sex, culture, race, ethnicity, and gender identity and sexual orientation in suicide prevention
- Improving suicide risk assessment and treatment
- Establishing specific actions for follow-up care after a suicide attempt and/or discharge from an emergency room, urgent care center, hospital, or at the end of a visit with a physician or health care staff
- Reviewing guidelines in health insurance plans to ensure effective response and services to assess and address suicide risk or suicidal behavior
- Implementing promising practices for law enforcement, such as crisis intervention teams
- Considering how to promote incentives for community organizations to provide suicide prevention training and to employ trained gatekeepers

2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate

2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.

Recommended Actions at the Local Level

2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training, and the models, including peer support, which will be used for training. Using an inclusive process for input, develop and implement training plans that meet these targets.

2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.

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Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

Recommended Actions at the State Level

3.1 Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors, and how to get help.

3.2 Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

3.3 Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.

3.4 Promote information and resources about strategies that reduce access to lethal means, such as gun safety education and increasing compliance with existing gun safety laws, safe medication storage, and physical and non-physical deterrent systems on bridges or other high structures.

3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.

Recommended Actions at the Local Level

3.6 Build grassroots outreach and engagement efforts to coordinate with and tailor the statewide suicide prevention education campaign and activities to best meet community needs.

3.7 Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.

3.8 Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute warning signs.

3.9 Promote and provide suicide prevention education for community gatekeepers.

3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.

3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

DImprove data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

Recommended Actions at the State Level:

4.1 Develop a California surveillance and research agenda on suicide, suicide attempts, and suicide prevention to support data-driven policies and evidence-based programs.

4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to, and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.

Recommended Actions at the Local Level:

4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.

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4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.

4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory council could use the reports to inform local policy action recommendations. Members of the case review teams should include representatives of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.

4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

PART 4: NEXT STEPS

The *California Strategic Plan on Suicide Prevention* has identified four major strategic directions and numerous recommended actions to reduce the number of suicide deaths and the incidence of suicidal behaviors in California. The plan calls for a substantial coordinated effort by multiple partners to identify and successfully achieve the necessary program, policy, and system improvements. Many of the recommendations require a long-term effort; others can be implemented immediately. The purpose of this section is to outline initial steps that should be taken to implement the recommendations in this plan.

The Suicide Prevention Plan Advisory Committee recognized that to succeed in both the short and long term, it is essential during the first phase of implementation to establish a solid foundation upon which to build. Further, the Advisory Committee acknowledged the need to be deliberate and sequential in implementing the recommendations (e.g., the need to enhance the capacity of the workforce before launching a major campaign that would increase the demand for services). Lastly, the Advisory Committee implored that the funding to support the ongoing services be at a sufficient and sustained level.

Success will be achieved through a collective and well-integrated effort; it cannot be solely dependent upon one funding source nor can the responsibility be shifted to any one entity. The theme, "Every Californian Is Part of the Solution," must ring true throughout the implementation of the strategic plan if suicidal behaviors are to be decreased and lives are to be saved. As a result, the implementation of the recommended actions, and the next steps will be the responsibility of an array of state, local, public, and private partners.

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The Office of Suicide Prevention will serve as a coordination point for addressing many of the recommended actions in this plan. Leadership and support from other public agencies and private organizations must also play a paramount role. Thus, in conjunction with a number of key partners, the Office of Suicide Prevention will develop a detailed work plan to initiate its operation.

The DMH and the MHS Oversight and Accountability Commission (OAC), with support from the California Mental Health Directors Association (CMHDA), have recommended that counties direct approximately $14 million in MHSA funds each year for four years to support a statewide suicide prevention effort. A portion of the funding has been earmarked for Student Mental Health Initiative[k] funding for K-12, community colleges, and universities.

To launch this concerted effort to prevent suicide and suicidal behavior in California, the following activities should be considered for the initial five-year implementation phase that will provide a foundation for future work.

Strategic Direction 1: Create a System of Suicide Prevention

State Level

1.A Staff the Office of Suicide Prevention established within the California Department of Mental Health on February 6, 2008.

1.B Develop and issue an action plan that includes an assessment of the current level of activity and detection of major gaps, and identifies objectives toward implementing the initial activities described in this "Next Steps" section.

1.C Establish a technical assistance infrastructure of regional working groups/learning collaboratives, consultation, training, and other support methods, and a resource center to support local suicide prevention systems and efforts.

1.D Establish a statewide coalition of state-level organizations and public and private partners to better address the integration of effective suicide prevention policies, practices, and programs into existing service systems. The initial coalition will include the state agencies identified in Recommended Action 1.2 and be expanded to include the public and private partners identified in Recommended Action 1.3.

1.E Assess the current status of coverage and accreditation for suicide prevention hotlines in California. Beginning with call centers that are members of the National Lifeline, build a consortium of accredited suicide prevention hotlines statewide to expand access to standardized services throughout the state and to ensure full multilingual, cultural, and age-specific crisis coverage for all Californians.

1.F Provide technical support to expand functions for accredited suicide prevention hotline centers, such as training centers for various occupations and professions, including peer support providers and after-care service providers.

NOTES

[k] The Student Mental Health Initiative is aimed to strengthen mental health for students in both K-12 and higher education through training, mental health education, peer support, violence prevention and suicide prevention activities in local education agencies and higher education campuses.

[l] 211 lines provide information about community services and information related to health and human services.

1.G Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California. At minimum, collect information about calls and outcomes by age, sex, county location, and language.

1.H Provide technical assistance to expand or link accredited hotlines to additional venues and formats, including the Internet, 211 lines[l], Web-based self-help services, and other age-appropriate means to improve access to information on local suicide prevention and early intervention services.

1.I Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.

1.J Link and provide support to county-level advisory councils dedicated to developing the local coordinated suicide prevention system. Establish and maintain a collaborative relationship among the state and county liaisons.

Local Level

1.K Appoint a liaison to the state Office of Suicide Prevention in each county.

1.L Convene or build upon an existing entity to establish a county suicide prevention advisory council that is dedicated to developing the local coordinated suicide prevention system.

1.M Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the detection of major gaps that will inform the development of the local suicide prevention action plan, from health and mental health promotion through crisis intervention and after care.

1.N Develop a local suicide prevention action plan through an inclusive community process that includes review of the comprehensive assessment, identification of short-term and long-term objectives, establishment of milestones, and completion of a work plan. Establish the baseline of the targeted policy, program, and system improvements.

1.O Assess capacity of local or, where appropriate, regional accredited suicide prevention hotline(s) and take steps needed to achieve accreditation or build the capacity (e.g., as training centers or after-care service providers; expand or link to web-based formats) of already accredited hotlines.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

State Level

2.A Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population. Begin with a review of the various occupations and professions identified in this plan to determine the first cohort of training programs to be assessed and enhanced. Identify opportunities for training program enhancements and work cooperatively with appropriate agencies to implement needed improvements.

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2.B Convene expert work groups to recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers, including peer support providers, in California. Review licensing and credentialing processes to assess viability of new training requirements.

2.C Coordinate and review surveys on local training needs. Include in the Office of Suicide Prevention's action plan methods for supporting counties in addressing and providing the necessary training, utilizing distance-learning modalities, online services, and other effective methods. Secure resources and partnerships to expand available support.

2.D Deliver train-the-trainer sessions for targeted service providers.

Local Level

2.E Review local MHSA Workforce Education and Training component assessments to identify elements relevant to suicide prevention efforts. To supplement information, survey suicide prevention training programs and needs and assess gaps. In conjunction with the state efforts, set local training targets for selected occupations, develop a plan with responsible parties to meet those targets and a process to measure progress.

2.F Disseminate and promote service standards and training guidelines. Design and implement an inclusive community process to adapt guidelines to better serve local needs as necessary.

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

State Level

3.A In conjunction with any existing social marketing efforts, such as stigma and discrimination reduction activities, develop and implement an age-appropriate, multi-language education campaign and messages specifically designed and pilot-tested to positively influence attitudes about the preventability of suicide, to increase appropriate help-seeking behaviors, and to reduce suicidal behaviors.

3.B Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages in ways that will benefit target populations at risk for suicide. Develop, test, and produce accompanying outreach and educational materials.

3.C Support local efforts to engage and educate the media by disseminating selected resources from national and other suicide prevention organizations.

3.D Identify a strategy for reducing access to lethal means in California.

3.E Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.

3.F Conduct regional training to build local capacity for peer support programs.

3.G Design, produce, and maintain a web page for the Office of Suicide Prevention that provides links to the many sources of reliable information. Identify and develop additional new information needed to appropriately address the needs of all Californians.

Local Level

3.H Coordinate local outreach, awareness, and education activities with other social marketing campaign efforts as a means to expand suicide prevention messages and information in multiple languages.

3.I Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting of suicide deaths and suicide prevention information.

3.J Design a community education plan that may include:

- Developing a community calendar of events and activities promoting suicide prevention awareness and education
- Identifying opportunities to integrate suicide prevention information into ongoing services in education, primary care, older adult, first responder, faith community, and other systems
- Localizing national and state suicide prevention events

3.K Reach out to community gatekeepers, including staff and volunteers providing home-based services, to increase their awareness and participation in suicide prevention efforts.

3.L Develop and widely disseminate a directory of local suicide prevention services and supports in multiple formats. Design a process to ensure that the directory is kept up-to-date.

3.M Foster the development of peer support programs, including support groups and networks.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

State Level

4.A Working collaboratively with other local, state, and national entities develop a California-specific research agenda, including surveillance and evaluation, on suicide attempts and deaths and suicide prevention to support more effective policies and programs. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

4.B Work to improve the collection and reporting of data as well as the systems for surveillance for a better understanding of the suicide trends and rates, and the impact of protective and risk factors among California's diverse population groups that can lead to more appropriate policies and programs. Target research activities in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups, that are gender-specific, that address trauma and other factors, and that have effective application in multiple settings.

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4.C Develop an evaluation component to track and monitor the statewide effort, including a system for monitoring and tracking national, state, and local policy changes and system improvements leading to a reduction in suicidal behaviors and suicide deaths in California.

4.D Develop and disseminate data reports on special topics and specific target populations by age, sex, culture, race, ethnicity, and other factors to enhance programs and service delivery.

Local Level

4.E Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection across systems.

4.F Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation, including community participatory research methods.

4.G Complete an inventory of existing death review teams serving the county. In coordination with the local suicide prevention advisory council, build the capacity for conducting a suicide death review process in each county and provide for regular reporting on suicide deaths to the suicide prevention advisory council.

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Copies of The California Strategic Plan on Suicide Prevention and an Executive Summary of the Plan are available for download from the California Department of Mental Health web site at ***www.dmh.ca.gov***. Hard copies can be requested by contacting the Office of Suicide Prevention via postal mail, e-mail, or telephone.

Office of Suicide Prevention
Prevention and Early Intervention Section
California Department of Mental Health
1600 9th Street, Room 150
Sacramento, CA 95814
suicideprevention@dmh.ca.gov
(916) 651-1178

California Department of
Mental Health

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

The Department of Health Care Services will continue exploring options for using Interactive Communication Technologies (ICT) for a variety of uses while also ensuring the means for preserving the security, privacy and confidentiality of the data provided using those technologies. The following summarizes the Department of Alcohol and Drug Programs (ADP) efforts prior to transfer of its programs and staff to DHCS:

To date, ADP has used ICT for the California Access to Recovery Effort (CARE). The CARE program utilizes the Life:WIRE system to support clients' recovery. Life:WIRE is an interactive communication technology that uses text-messaging and email to engage, track and motivate clients. Access to Recovery (ATR) providers use Life:WIRE to remind clients of appointment times, ask questions to evaluate progress/status, and reinforce positive behaviors. Using a computer, counselors or case manager's log on to a secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant website to set up the time, frequency, and nature of text messages or emails to individual or multiple clients in their caseload. Customized questions prompt a single digit reply from the client via their cell phone, which in turn activate an automated response and/or notify the counselor if the client's reply is outside a prescribed range. The Life:WIRE system generates real-time data so that providers can continuously monitor client progress and analyze client responses.

DHCS will continue to support Life: WIRE through the vendor, for the duration of the grant, which is projected to continue through 2014. DHCS will continue to explore options for additional ICT applications and the support they require through the current transition period.

To encourage provider use of Life: WIRE, DHCS includes Life: WIRE as an allowable service under ATR. Through an ATR voucher, providers are reimbursed monthly for each client whom they set up with a Life: WIRE account and they are also reimbursed for the one-time set up fee charged by Life: WIRE. DHCS will continue to explore options for additional ICT applications in the future.

DHCS meets on a regular basis with members of the behavioral health field to enhance preparedness for implementation of health care reform. We will continue to work with behavioral and general health systems to explore effective use of ICT to support behavioral health integration.

At this time, DHCS does not plan to utilize Life: WIRE to collect data for CARE program evaluation. However, individual providers have the ability to use Life:WIRE data to

evaluate and help inform their clients' treatment and progress. DHCS will continue to explore options for use of ICT applications to collect program evaluation at the individual and provider levels in the future. DHCS will continue to explore measures and data collection options for promoting and judging use and effectiveness of ICT applications in the future.

In addition, DHCS's Prevention Resource Center is looking into various forms of social media/marketing such as YouTube, FaceBook, Twitter, and Google+. These media tools will enable DHCS to help advance alcohol, tobacco, and other drugs (ATOD) prevention and health reform by providing real time information on funding opportunities, news sources, and AOD prevention initiatives identified by the SAPT Block Grant, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of National Drug Control Policy (ONDCP), and other agencies and organizations.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

Notification
Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

1. What areas of technical assistance is the state currently receiving?

In 2012, California Department of Alcohol and Drug Programs (ADP) staff attended the Substance Abuse and Mental Health Services Administration (SAMHSA) Confidentiality, Substance Use Treatment, and Health Information Technology (HIT) Webinar Series, SAMHSA's Investment to Support HIT Field Trainers Update Meeting, SAMHSA Fetal Alcohol Spectrum Disorder (FASD) Center of Excellence Field Trainers Update Meeting and Fifth National Conference on Behavioral Health for Women and Girls Health, Empowerment, Resilience, and Recovery (It's all about HERR!).

2. What are the sources of technical assistance?

SAMHSA

3. What technical assistance is most needed by state staff?

<u>Working with Tribal Health Care Systems and Tribal Entities</u>
In light of ongoing funding for the Indian Healthcare Improvement Act (IHCIA), and inclusion of behavioral health programs in it, the California Department of Alcohol and Drug Programs (ADP) has requested technical assistance from the SAMHSA with regard to how behavioral health services provided to the Tribes under IHCIA dovetails and/or overlaps with substance use disorder (SUD) services provided by the Substance Abuse Prevention and Treatment (SAPT) Block Grant as well as the role of State's in "meaningful consultation" with the tribes under Executive Order (EO) 13175.

<u>Improvement of Data Systems to Comply with Health Care Reform</u>
ADP seeks technical assistance to explore our options to respond to new requirements for outcome and performance measurement, and health information exchange as they emerge.

<u>Capacity</u>
ADP requests technical assistance to help California define "capacity" for our Drug and Alcohol Treatment Access Report (DATAR) as we are having difficulty defining outpatient capacity in particular. There are also issues, even for residential providers, about the number of beds for which they are licensed versus the funding they are receiving – is there enough funding to fill all the licensed beds.

4. What technical assistance is most needed by behavioral health providers?

Workforce Development (Recovery Support Services/Peer Specialists)
Technical assistance is needed on setting up a system of Recovery Support Services in order to identify additional resources necessary to build that component of the continuum of care and how to incorporate, in an effective and cost efficient manner, recovery/peer specialists.

Workforce Development (Prevention)
Technical assistance is needed on setting up a network of qualified prevention trainers in California to ensure that the prevention workforce is sustained. ADP is actively working with the Center for Applied Research Solutions (CARS) to develop and disseminate a set of professional competencies. However, there is a need to survey and catalog skill sets of prevention professionals, as prevention services are carried out in a variety of settings. ADP has been in contact with the Center for the Application of Prevention Technologies (CAPT) to coordinate a Substance Abuse Prevention Specialist Training of Trainers in California.
There are not enough qualified, dedicated and diverse individuals entering the substance abuse prevention field. Therefore, technical assistance is also needed to create avenues to promote AOD prevention as a credible and viable career.

Identifying Evidence-Based Environmental and Community-Based Policies, Programs and Practices
More and more counties in California have moved toward incorporating environmental and community-based strategies in the alcohol, tobacco, and other drugs (ATOD) prevention efforts yet there are a minimal number of evidence-based programs identified. ADP requests assistance in identifying policies, programs and practices that will meet SAMHSA's requirements to utilize evidence-based programs. Assistance was requested from the Center for the Application of Prevention Technologies (CAPT), a SAMHSA Center for Substance Abuse Prevention (CSAP) technical assistance contractor, in 2009, 2010 and 2011 in the form of a summary of other state's efforts.

Improving the Performance of the SUD System
ADP seeks technical assistance for providers and County director's on how to use data to produce more true "networks" of care, identify deficiencies in the service system and strategize how to address these shortcomings.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

As indicated earlier in this application, California is transforming government at the state and local level to meet the needs of residents effectively and efficiently and to ensure that individuals, families and communities throughout the state benefit. State and local policy makers are shaping and re-crafting the substance use system and policies to create the greatest benefit for our communities.

Governor Brown has begun an ongoing effort to make state government more effective and efficient through streamlining and reorganization activities. One component of this reorganization is the transfer and consolidation of all substance use functions into one state department and the elimination of the Department of Alcohol and Drug Programs (ADP). The transfer of the DMC program to the Department of Health Care Services occurred on July 1, 2012, as did the transfer of community mental health services. The placement of the remaining ADP functions, effective July 1, 2013, was determined through a planning and stakeholder input process that transferred the ADP AOD functions to the Department of Health Care Services (DHCS).

This reorganization of AOD functions to DHCS offers numerous benefits to the SUD system. The result will be a state-administrative structure that will provide one state department for the substance use disorder system, align with federal and county partners, and promote opportunities for improving health care delivery services for the benefit of communities and consumers with substance use disorders. It also aligns the state structure to match the service models that will be necessary to most efficiently serve clients once the ACA is implemented.

While the state is undertaking these changes to create the ongoing infrastructure necessary for government to conduct business most efficiently, the following state departments and stakeholders are working in partnership with DHCS in planning and preparing for the implementation of the Affordable Care Act (ACA) in California.

<u>Administrative Office of the Courts (AOC)</u>

The AOC is the staff agency to the Judicial Council of California, the policymaking body of the state court system. It is responsible for a variety of programs and services to improve access to a fair and impartial judicial system. As such, the AOC addresses policy matters concerning substance use disorders diversion programs. AOC is a member of the SIT. AOC agrees to continue to consult with ADP on related matters.

California Department of Education (CDE)
CDE is a California agency that oversees public education. The department oversees funding and testing, and holds local educational agencies accountable for student achievement. Its stated mission is to provide leadership, assistance, oversight, and resources (via teaching and teaching material) so that every Californian has access to a good education. Also a member of the SIT and GPAC, CDE is poised to continue assist ADP in the development of programs and services that address related goals in the block grant including, but not limited to prevention, early intervention and treatment of substance use disorders.

California Department of Social Services (CDSS)
CDSS is a state department for many of the programs defined as part of the social safety net and is also a part of the California Health and Human Services Agency. Federal and State funds for adoptions, foster care, aid to the disabled, family crisis counseling, subsistence payments to poor families with children, child welfare services and many other efforts are distributed through this department. CDSS is a member of the SIT and the Green Book, an interagency group that addresses domestic violence and trauma issues; and agrees to continue to collaborate with ADP on related matters.

California Department of Public Health (CDPH)
The mission of the CDPH is to optimize the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. CDPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization. CDPH is working toward these goals through its programmatic and operational support activities and in collaboration with local health departments and other organizations throughout the State. CDPH is a member of the SIT, GPAC and the SEW and will continue to partner with ADP on related matters.

Director's Advisory Council (DAC)
Established in 1993 to ensure the delivery of quality alcohol, drug abuse, and problem gambling services in California. Members include ADP leaders, judges, directors of statewide provider organizations, the president of the County Alcohol and Drug Program Administrator's Association of California (CADPAAC), and the chairs of the eight constituency committees.

Governor's Prevention Advisory Council (GPAC)
GPAC coordinates the State's strategic efforts to reduce the incidence and prevalence of inappropriate alcohol, tobacco and other drug (AOD) use by youth and adults. Members are appointed by the Governor and include key administrators from major state agencies involved with prevention issues, funding, and/or program-level support.

County Alcohol and Drug Program Administrators Association of California, Inc. (CADPAAC)
CADPAAC is an organization of county alcohol and drug program administrators dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

Constituent Committees
The eight Constituent Committees were established to advise and assist the ADP Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population.

Committee members provide important input and two-way communication with key constituent groups and provide alcohol and drug services knowledge, geographic area representation, and community involvement. The chair of each Constituent Committee serves as a member of the Director's Advisory Council (DAC).

- African-American Constituent Committee
- Aging Constituent Committee
- Asian/Pacific Islander Constituent Committee
- Disability Constituent Committee
- Lesbian, Gay, Bisexual & Transgender Constituent Committee
- Latino Constituent Committee
- Native American Constituent Committee
- Women's Constituent Committee

External Stakeholders
- California Association of Addiction Recovery Resources (CAARR)
- California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
- California Association of Alcoholism and Drug Abuse Counselors (CAADAC)
- California Association of Drinking Driver Treatment Programs (CADDTP)
- California Opioid Maintenance Providers (COMP)
- County Alcohol and Drug Program Administrators Association of California (CADPAAC)
- National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate (NCADD)

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

W. State Behavioral Health Advisory Council

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

The application strongly encourages States to expand and use the same advisory council required under the Mental Health Services Block Grant to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system. At this time, California elects to continue to use existing advisory groups and to decline to use the same advisory council required under the Mental Health Services Block Grant; however, we may consider it in the future if the composition of its membership is expanded to include more representation from the substance use services system.

Some of the substance use service system disorders planning bodies, advisory panels, constituent and stakeholder groups are:

Governor's Prevention Advisory Council (GPAC)

The Governor's Prevention Advisory Council coordinates the State's efforts to reduce the incidence and prevalence of inappropriate alcohol, tobacco and other drug use by youth and adults. Members are appointed by the Governor and include key administrators from major state agencies involved with prevention issues, funding, and/or program-level support.

County Alcohol and Drug Program Administrators Association of California (CADPAAC)

CADPAAC is an organization of county alcohol and drug program administrators dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs. In addition, this body represents California's 58 county/sub-state planning areas.

Director's Advisory Council (DAC)

The Director's Advisory Council was created in 1993 to ensure the delivery of quality alcohol, drug abuse, and problem gambling services in California. Members include ADP leaders, judges, directors of statewide provider organizations, the president of the County Alcohol and Drug Program Administrators Association of California, and the chairs of the eight constituency committees.

Constituent Committees

The eight Constituent Committees were established to advise and assist ADP's Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population. The eight committees are; the African-American Constituent Committee, the Aging Constituent Committee, the Asian/Pacific Islander Constituent Committee, the Disability Constituent Committee, the Lesbian, Gay, Bisexual and Transgender Constituent Committee, the Latino Constituent Committee, the Native American Constituent Committee, and the Women's Constituent Committee

Narcotic Treatment Programs Advisory Committee (NTPAC)

The Narcotic Treatment Programs Advisory Committee meets to discuss emerging issues and provide information regarding the regulatory and policy issues associated with opiate treatment in California. Membership of the NTPAC is by invitation from the Director of ADP. Committee members are selected on the basis of their NTP knowledge and expertise and commitment to ensuring safe access to replacement narcotic therapies.

External Stakeholder Groups

ADP seeks collaboration and advice from many stakeholder groups as well, including; the California Association of Addiction Recovery Resources (CAARR), the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), the California Association of Drinking Driver Treatment Programs (CADDTP), the California Opioid Maintenance Providers (COMP), the County Alcohol and Drug Program Administrators Association of California (CADPAAC), and the National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate (NCADD).

In addition, the DHCS Director, or his designee, serves as a member of the California Mental Health Planning Council (CMHPC). CMHPC is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

The application strongly encourages States to expand and use the same advisory council required under the Mental Health Services Block Grant to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, which are described in Section W– State Behavioral Health Advisory Council. At this time, California elects to continue to use existing advisory groups and to decline to use the same advisory council required under the Mental Health Services Block Grant but may consider it in the future if the composition of its membership is expanded to include more representation from the substance use services system.

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

The application strongly encourages States to expand and use the same advisory council required under the Mental Health Services Block Grant to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, which are described in Section W– State Behavioral Health Advisory Council. At this time, California elects to continue to use existing advisory groups and to decline to use the same advisory council required under the Mental Health Services Block Grant but may consider it in the future if the composition of its membership is expanded to include more representation from the substance use services system.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

SAMHSA is no longer requesting or requiring states set-aside 3% to assist providers in improving their enrollment, billing, and business practices.
The Senate Committee has released its report regarding the Labor/HHS/Ed bill. The Senate Committee Labor/ HHS/Ed appropriations bill notes that enrollment, billing, and provider business practices are allowable block grant activities under current law.

X. Enrollment and Provider Business Practices, Including Billing Systems

Notification

Effective with the passage of the 2013-2014 California 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 the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as ”ADP” for perspective and chronological purposes.

SAMHSA is no longer requesting or requiring states set-aside 3% to assist providers in improving their enrollment, billing, and business practices. The Senate Committee has released its report regarding the Labor/HHS/Ed bill. The Senate Committee Labor/ HHS/Ed appropriations bill notes that enrollment, billing, and provider business practices are allowable block grant activities under current law.

However, current systems and processes are subject both to ongoing acts of the Executive Branch and the California Legislature, which has chosen to address some of these concerns in a Special Session that is anticipated to adjourn by October 1, 2013, as well as explicit guidance from the US Department of Health and Human Services in regard to both the expansion of Medi-Cal and the operation of Covered California, our health marketplace. California will submit a revised Block Grant Plan to address these issues when details are known.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on State Block Grant Plan

Notification

Effective with the passage of the 2013-2014 California Budget Act and associated legislation, the Department of Alcohol and Drug Programs (ADP) no longer exists as of July 1, 2013. All ADP data systems, programs and staff, except the Office of Problem Gambling, transferred to the Department of Health Care Services (DHCS). Throughout this application/Plan, activities or functions referenced that occurred prior to July 1, 2013, may be identified as" ADP" for perspective and chronological purposes.

Opportunities for public input into the State's planning process during the year preceding the development and after submission of the application at both the State and county levels include:

1. The Director's Advisory Council (DAC) advises the Director on AOD program and policy issues. The DAC is responsive to critical issues from the criminal justice field, counties and the larger alcohol and drug field. Members identify barriers to access for underserved populations and provide feedback to the communities they represent. Stakeholders identify and discuss issues and build consensus in major policy areas that impact the alcohol and other drug service systems and clients. The DAC includes eight constituent committees that represent a broad spectrum of the State's population to ensure appropriate services for the Californians that they represent. The DAC is comprised of the presidents of statewide AOD provider organizations, county alcohol and drug program administrators, and the chair of each constituent committee (African American; Aging; Asian, Pacific Islander; Disability; Lesbian, Gay, Bisexual, Transgender; Latino; Native American; and Women). The DAC provides a vehicle to communicate with and motivate all Californians to be involved in alcohol and drug policy issues; its meetings are open to the public.

2. DHCS staff regularly meets with the County Alcohol and Drug Program Administrators Association of California (CADPAAC) to update members on federal, State, and other funding requirements that impact the alcohol and drug field. DHCS staff works in collaboration with CADPAAC staff and *ad hoc* committees to discuss policy, allocation methodologies, the equitable distribution of funds consistent with federal and State requirements, and other issues affecting State/county administration of alcohol and other drug programs and services.

3. The legislative budget hearing process provides a broad-based public forum for discussion and revision of proposed expenditures of both federal block grant and State general funds. The budget hearing process invites and welcomes input on AOD concerns (i.e., funding constraints, decreases, increases, etc.) from various constituent groups, county alcohol and drug program administrators, provider organizations, consumers, and any interested California citizen.

4. DHCS forms various workgroups and task forces as needed to address current and emerging issues. The workgroups include representatives from CADPAAC, DAC, program executives, other social services systems, constituents/clients of the target population, and individuals with a wide variety of expertise in the related area. Examples of such workgroups include the: Offender Treatment Advisory Group, Fiscal Workgroup, Drug Medi-Cal Workgroup, Licensing and Certification Regulations Workgroup, and Continuum of Services System Re-engineering (COSSR) Task Force.

5. External constituent groups that meet with, or invite participation from, DHCS staff are the California Prevention Collaborative, California Organization of Methadone Providers, Driving Under the Influence (DUI) Advisory Workgroup, High Rate Underage Users Workgroup, Counselor Certification Oversight Workgroup, Counselor Certification Organizations Workgroup, and the California Association of Alcohol and Drug Program Executives.

In addition, copies of the Substance Abuse Prevention and Treatment Block Grant application are distributed to the: 1) Library of Congress, Washington, D.C.; 2) Governor's Office of Planning and Research; 3) Depository Libraries; 4) State Library; 5) State Archivist; 6) Research Librarian, Council of State Governments; and 7) DHCS' Resource Center, which distributes copies of the application upon request. Each year, the draft application is posted on DHCS' Web site for public review and comment before the application is submitted to the Substance Abuse and Mental Health Services Administration.

Exhibit A: Acronyms

ABC	Alcoholic Beverage Control
ACA	Affordable Care Act
ACTION	Adopting Changes to Improve Outcomes Now
ADA	Americans with Disabilities Act
ADAM	Arrestee Drug Abuse Monitoring
ADP	Alcohol and Drug Programs, Department of
AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
ASC	Accredited Standards Committee
ASI	Addiction Severity Index
ATOD	Alcohol, Tobacco and Other Drugs
ATR	Access to Recovery
BAC	Blood Alcohol Content
BHI	Behavioral Health Integration
CAARR	California Association of Addiction Recovery Resources
CADCA	Community Anti-Drug Coalitions of America
CADDS	California Alcohol and Drug Data System
CADPAAC	County Alcohol and Drug Program Administrators Association of California
CalOMP	California Outcome Monitoring Program
CalOMS-Pv	California Outcomes Measurement Service-Prevention
CalOMS-Tx	California Outcomes Measurement Service-Treatment
CalSTARS	California State Accounting and Reporting System
CalWORKS	California Work Opportunity and Responsibility to Kids
CARE	California Access to Recovery Effort
CARS	Center for Applied Research Solutions
CASA	National Center on Addiction and Substance Abuse
CASBIRT	California Screening, Brief Intervention, and Referral to

Exhibit A: Acronyms

	Treatment
CATES	California Addiction Training & Education Series
CCC	California Conservation Corps
CCQI	Cultural Competency Quality Improvement
CCR	California Code of Regulations
CDCR	California Department of Corrections & Rehabilitation
CDE	California Department of Education
CDPH	California Department of Public Health
CDPH-OA	California Department of Public Health-Office of Aids
CDVA	California Department of Veterans Affairs
CFNLP	California Friday Night Live Partnership
CEED	Coverage Expansion and Enrollment Demonstration
CFR	Code of Federal Regulations
CHHS	California Health and Human Services Agency
CHIS	California Health Interview Survey
CHKS	California Healthy Kids Survey
CIMH	California Institute for Mental Health
CLAS	Culturally and Linguistically Appropriate Services
CMHPC	California Mental Health Planning Council
CMI	California Methamphetamine Initiative
CMS	Centers for Medicaid and Medicare Services
COD	Co-Occurring Disorders
COJAC	Co-Occurring Joint Action Council
COS	Continuum of Services
COSSR	Continuum of Services System Re-engineering
CPC	California Prevention Collaborative
CPCA	California Primary Care Association
CPI	Community Prevention Initiative
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSS	California Student Survey

Exhibit A: Acronyms

DAC	Director's Advisory Council
DATA 2000	Drug Addiction Treatment Act of 2000
DATAR	Drug and Alcohol Treatment Access Report
DCR	Day Care Rehabilitative
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DEA	Drug Enforcement Administration
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMH	Department of Mental Health
DMV	California Department of Motor Vehicles
DOF	California Department of Finance
DPH-OA	Department of Public Health – Office of Aids
DUI	Driving-Under-the-Influence
DUIP	Driving-Under-the-Influence Program
EAU	Excessive Alcohol Use
EBP	Evidence-Based Practices
ED	Emergency Department
EDD	Employment Development Department
EIS	Early Intervention Services
ENCAL	Evaluation Services to Enhance the Data Management System in California
EPSDT	Early and Periodic Screening Diagnosis and Treatment
FASD	Fetal Alcohol Spectrum Disorders
FDA	Federal Drug Administration
FFY	Federal Fiscal Year
FY	Fiscal Year
FNL	Friday Night Live
FOTP	Female Offender Treatment Program
FPL	Federal Poverty Level
FQHCs	Federally Qualified Health Centers
GPAC	Governor's Prevention Advisory Council

Exhibit A: Acronyms

HCCI	Health Care Coverage Initiative
HHS	U.S. Department Of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinic Health
HIV	Human Immunodeficiency Virus
HRU	High Risk Use
IBHP	Integrated Behavioral Health Project
ICD	International Statistical Classification of Diseases
IDU	Injection Drug Users
IFB	Invitation for Bid
IHCIA	Indian Health Care Improvement Act
IMD	Inpatient Methadone Detoxification
IOM	Institute of Medicine
IPI	Integration Policy Initiative
IPRP	Independent Peer Review Project
ISAP	Integrated Substance Abuse Programs
IVDU	Intravenous Drug User
LAPD	Los Angeles Police Department
LASBIRT	Los Angeles Screening, Brief Intervention, and Referral to Treatment
LCSW	Licensed Clinical Social Worker
LGBT	Lesbian, Gay, Bisexual, and Transgender
LIHP	Low-Income Health Programs
MBA	Minimum Base Allocation (Counties)
MCE	Medicaid Coverage Expansion
MFT	Marriage and Family Therapist
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MHSA	Mental Health Services Act
MIGS	Members in Good Standing
MOE	Maintenance of Effort
MOU	Memo of Understanding

Exhibit A: Acronyms

NAR	Needs Assessment Report
NASADAD	Nation Association of State Alcohol/Drug Abuse Directors
NCE	No-Cost Extension
NCTIC	National Center for Trauma Informed Care
NIATx	Network for the Improvement of Addiction Treatment
NNA	Negotiated Net Amount
NNAC	Negotiated Net Amount Contract
NOMs	National Outcome Measures
NPI	National Provider Identifier
NPN	National Prevention Network
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
OARA	Office of Applied Research and Analysis
OCJC	Office of Criminal Justice Collaboration
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMD	Outpatient Methadone Detoxification
ONDCP	Office of National Drug Control Policy
ONTRACT	ONTRACT Program Resources, Inc.
OSHPD	Office of Statewide Health Planning and Development
OWPS	Office of Women's and Perinatal Services
PADS	Prevention Activities Data System
PEI	Prevention and Early Intervention
PES	Perinatal Environmental Scan
PHI	Protected Health Information
PIRE	Pacific Institute for Research and Evaluation
PMB	Performance Management Branch
PPACA	Patient Protection and Affordable Care Act
PPC	Patient Placement Criteria
PSATTC	Pacific Southwest Addiction Technology Transfer Center

Exhibit A: Acronyms

PSD	Program Services Division
PSN	Parolee Services Network
PTSD	Post Traumatic Stress Disorder
RC	Resource Center
RFP	Request for Proposal
RRHP	Resident-Run Housing Program
SACPA	Substance Abuse and Crime Prevention Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Student Assistance Program
SAPT	Substance Abuse Prevention and Treatment
SAPTBG	Substance Abuse Prevention and Treatment Block Grant
SARC	Substance Abuse Research Consortium
SASSI	Substance abuse Subtle Screening Inventory
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDFSC	Safe and Drug-Free Schools and Communities
SEOW	State Epidemiological Outcomes Workgroup
SEW	State Epidemiological Workgroup
SFY	State Fiscal Year
SGF	State General Fund
SIG	State Incentive Grant
SIM	System Improvement Model
SIT	State Interagency Team
SNAP	State Needs Assessment Planning
SPDs	Seniors and Persons with Disabilities
SPF	Strategic Prevention Framework
SPF-SIG	Strategic Prevention Framework - State Incentive Grant
SSA	Single State Agency
STAKE	Stop Tobacco Access to Kids Enforcement (Act)
STD	Sexually Transmitted Disease
STNAP	State Treatment Needs Assessment Program

Exhibit A: Acronyms

SUD	Substance Use Disorder
SUS	Substance Use Services
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TB	Tuberculosis
TC	Trauma Center
TCS	Tobacco Control Section
TEDS	Treatment Episode Data Specifications
TMAC	Telephone Monitoring and Adaptive Counseling
UCLA	University of California, Los Angeles
UCLA-ISAP	University of California, Los Angeles—Integrated Substance Abuse Programs
UPPL	Uniform Accident and Sickness Policy Provision Law
VA	United States Department of Veterans Affairs
VAI	Veterans Awareness Initiative
VHA	Veterans Health Administration
WestCAPT	Western Center for the Application of Prevention Technologies
WSN	Women's Services Network
YSR	Youth Situational Report