

Summary: *Statewide Needs Assessment and Planning Report (SNAP) 2015*

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Prepared for the California Mental Health Planning Council

Why is this report written?

The SNAP report is written because the federal government requires that it be written in order to ensure that block grant funds are being spent by states in the most effective manner. The state of California receives funding through the **Substance Abuse and Treatment Block Grant (SAPT BG)**, therefore, every two years, the Department of Health Care Services (DHCS) must produce a Statewide Needs Assessment and Planning report (**SNAP**)

How does the SNAP report benefit stakeholders and policy makers?

The SNAP report is informative about current trends in substance use and clarifies the needs of our state in regards to Substance Use Disorders (SUD). The report also encourages informed decision making about how the block grant funds should be spent. “This assessment process helps us better understand our work and the effectiveness of our efforts to provide recovery relief to those individuals, families, and communities suffering from the impact of SUD”.

Who wrote the SNAP report?

The report is a collaborative effort between DHCS, California Department of Public Health (CDPH), and the UCLA Integrated Substance Abuse Program (ISAP). DHCS has put the report together in order to gather feedback from behavioral health stakeholders regarding the **Needs Assessment (Part I)** and **Strategic Initiatives (Part II)**.

Two parts:

“Part 1 of the SNAP report summarizes the statewide patterns of Alcohol and Other Drug (AOD) use and describes current prevention and treatment activities.”

“Part 2 outlines California’s strategic initiatives for SAPT BG FY 2016–2017.”

PART I

Needs Assessment Data Highlights:

The following are just some of the results from the data in the SNAP report.

Incidence and Prevalence of Substance Use:

- During 2013, Alcohol and Other Drugs (AOD) were involved in 39.5% of all the arrests in California.
- The statewide rate of binge drinking (having 5 or more drinks on the same occasion) among people age 12 and older was 21%. 18-25 had the highest percentage of binge drinking at 35.7%. Binge drinking was higher among college students than among similar age peers not in college.
- The incidence of first time marijuana use in California went down in calendar year (CY) 2013. It was noted in the report that the decline may not be connected to the perception of great risk or the hazards of smoking marijuana. Perception of marijuana risks dropped in California which suggests that youth age 12-17 are avoiding marijuana for reasons other than health risks or hazards.
- Approximately 33% of 11th graders used alcohol in CY 2013.
- There was positive news in the data about those ages 12-17. The rate of drug use is dropping in this age group. It reflects that SUD prevention activities may be making an impact and that more and improved prevention services are needed.
- Among deaths in 2012 where drugs were a contributing cause, those using opioids had the highest fatality rate. This number includes opioid pharmaceuticals, heroin, and narcotics.
- 8% of those who tested positive for HIV/AIDS reported injection drug use.
- Among California's 26 and older age group there was a significant increase in illicit drug use other than marijuana.
- "The following national information from the NSDUH 2013 report (not California specific data) supports the conclusion that while both sexes start out with similar drinking rates (based on past month data), male drinking becomes more prevalent as they age. In 2013, an estimated 57.1% of males aged 12 or older were current drinkers, while the rate for females was 47.5%. However, among youths aged 12-17, the percentage of males who were current drinkers (11.2%) was similar to the rate for females (11.9%)."
- The report pulled information from the California Healthy Kids Survey regarding the connection between tobacco use and AOD use. For instance, 15% of non-smokers

reported binge drinking while 68% of smokers did so. Among 11th graders, Non-smoker marijuana use is 14%, while smokers have a marijuana use rate of 69%.

- Clients who remain in treatment for at least 90 days are more likely to have positive outcomes at discharge and maintain recovery. This is especially true if clients spend four or more days in Social Support Recovery activities in the 30 days prior to discharge.

Alcohol and Other Drugs (AOD) Related Health Consequences:

The California Department of Public Health tracked emergency room encounters to discover the rates of AOD health consequences. This is a prominent section of the report which outlines financial consequences of SUD to the state.

- Alcohol related deaths were 1% higher than deaths caused by other illicit drugs. However, hospitalization due to alcohol is 30% higher than for illicit drugs.
- Exposure to Hepatitis C now occurs predominantly through sharing needles.
- 1,169 individuals were killed statewide in alcohol related crashes. Additionally, there were 23,095 individuals injured.
- “In California, during 2013 there were a total of 471,103 felony and misdemeanor arrests for AOD-related violations (253,082 for alcohol and 218,021 for other drugs). Of this population 459,508 were adults and 11,595 were juveniles. Among adults, 250,783 arrests were for alcohol and 208,725 arrests were for other drugs. Among juveniles, there were 2,299 arrests for alcohol and 9,296 arrests for other drugs.”

Prevention Strategies:

Six prevention strategies are defined by the Center for Substance Use Prevention. In 2012-13 among those 25 and older, more females were provided prevention services than males. This is interesting because the rate of AOD use among males is significantly higher than it is for females. The strategies and number of individuals reached by the strategy are as follows:

1. **Information Dissemination:** Strategies reached 299,476 individuals.
2. **Education:** Strategies served 126,189 individuals.
3. **Alternatives:** Strategies, which include community center activities and AOD-free social events, served over 107,425 individuals.
4. **Problem Identification and Referral:** Approximately 10,541 individuals received activities under Problem Identification and Referral strategies, including Alternatives to Violence Programs.
5. **Community-Based Process:** Approximately 69,287 people benefited from direct community-based process strategies that included planning, coordinating, technical assistance, and training.
6. **Environmental:** Strategies which include influence of policy with local city and county agencies, training efforts to improve compliance with current policies, and media strategies reached 8,872 individuals.

54 out of 58 counties have a current strategic prevention plan. Twenty-six counties referred individuals for additional services directly from primary prevention settings.

SBIRT:

“Effective January 1, 2014, California began offering the Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit to adult Medi-Cal beneficiaries. Provision of the SBIRT benefit implements Affordable Care Act Section 4106, which clarifies that those preventive services, aligned with the U.S. Preventive Services Task Force recommendations, will be offered to all Medi-Cal beneficiaries aged 18 or older in primary care settings.” Standardized screening tools are used to identify needs. Brief intervention is then provided along with referrals.

Field Capacity:

Annually, publicly-funded county treatment providers admit over 21,000 adolescents in California, but this number is only a small percentage of the adolescents who are in need of SUD treatment and recovery services. According to SAMHSA’s National Survey on Drug Use and Health, among individuals aged 12 or older in 2009, 9.3% needed treatment for an AOD problem. 9.3% of the approximately five million youth aged 12–20 in California is about 465,000. Various factors are preventing broader provision of youth services, and further research, possibly extending to direct contact on a county-by-county basis, will be needed to ascertain what those factors are.

Cultural Competency:

Providing culturally competent services has a positive effect on SUD service delivery. To individualize care, providers must understand the culture and linguistic needs of clients. This increases the clients understanding and adherence to treatment goals as well as giving the client increased confidence and satisfaction with the treatment. DHCS utilized the SAPT BG fund to provide 4,818 days of technical assistance and training on cultural competence during 2011-2014. The report identifies specific risk factors for the following special populations; Native Americans, Veterans, Criminal Justice, Co-Occurring disorders, Homeless, and LGBTQQ.

Technical Assistance Needs to Collect Data:

“The state does not currently collect general population incidence and prevalence data on its own and relies on SAMHSA’s state-level NSDUH reports for these purposes. If the state were to pursue its own collection of such data, a great deal of technical assistance and resources would be needed to ensure that this effort would be successful.” Technical assistance in this area is therefore not a priority. “Rather than focus new data collection on incidence and prevalence, a higher priority for technical assistance would be creating better estimates of treatment need.”

Needing but Not Receiving Treatment:

“Based on CY 2013 California population of about 38 million (California Department of Finance, 2014), the CYs 2012–13 estimate of the population needing but not receiving treatment translates to about 920,000 for illicit drugs and about 2.2 million for alcohol.” As a result of these numbers, it is necessary to take a look at the barriers to SUD treatment in California. Five significant barriers were listed from greatest to smallest in percentages. They were 1. No health coverage (37.3),

2. Not ready to stop (24.5), 3. Did not know where to go (9.0), 4. Health coverage did not cover treatment (8.2), 5.No transportation (8.0).

Part II

California's Strategic Plan

Part II of the SNAP report outlines California's Strategic plan and strategy for best use of SAPT BG funds for FY 2016-2017. Six plan priorities are identified in Part II. These priorities have been informed by the needs assessment conclusions in Part I. The six strategic initiatives which will guide the use of SAPT BG funds include:

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

Prevention of Substance Use: The strategy is to create environments where youth, adults, families, and communities are motivated and empowered to manage their overall emotional, physical, and behavioral health. Special focus is placed on diverse groups as well as high risk groups such as college students, LGBTQQ, veterans and their families, ethnic minorities, and Native Americans. One significant method of prevention outlined in the report was to increase cultural competence and access to prevention services. There will also be a focus to improve data, plan for continuous improvement, and building up statewide capacity.

Health Care and Health Services Integration: This initiative focuses on efforts to increase integration in health care across systems such as behavioral health, physical health, emergency care, and specialty health care. Awareness is increasing about the high rates of co-occurring physical health, mental health, and SUD. The report states:

“Individuals with both physical and behavioral health conditions are served by fragmented systems of care with little to no coordination across providers or systems. This fragmentation leads to poor quality, disparate financing, and higher cost of care, as well as poor health, reduced productivity, and higher costs for businesses and publicly-funded systems such as justice, education, and human services”.

Santa Clara County was pointed out as having an innovative system of care for prevention and treatment of SUD. Patients are assessed at strategic sites such as drug courts.

An effort to improve integration was started at DHCS in March of 2014 in the form of Behavioral Health Forums. This quarterly forum allows stakeholders to learn about the status and work of more than 100 programs and policy issues.

The new California Medi-Cal service **SBIRT**, mentioned in Part I, was highlighted as an effort to increase integration and collaboration across areas of service.

Trauma and Justice: This initiative implements trauma-informed services in behavioral health settings. Research, clinical experience, and users of behavioral health services have increasingly documented the connection between trauma and behavioral health disorders. The initiative includes integrating trauma approaches across service sectors, coordinating training and technical assistance, establishing a measurement strategy, assisting communities to prepare for, respond to, and recover from traumatic events, respond to those who have military trauma, understand the effects of community trauma, and provide tools for communities to promote resilience and effective responses.

Recovery Support: Initiative #4 aims to promote partnering with people in recovery from SUD and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience. SAMHSA has delineated four dimensions that support a life in recovery: health, home, purpose, and community. People in recovery need health care, a stable and safe place to live, a job, school experience, or volunteer effort, and a community of friends and family who provide on-going support. The Health Home initiative was highlighted in the report as one that authorizes states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community based long term services and supports (LTSS) needed by beneficiaries with chronic conditions. These supports would greatly benefit those experiencing homelessness.

Health Information Technology: This initiative will ensure that the behavioral health system- including states, community providers, patients, peers, and prevention specialists- fully participate with the general health care delivery system in the adoption of health information technology. This includes the promotion of an increased use of health electronic records, enhanced security, and the promotion of broad dissemination of technology.

Workforce Development: “An adequate supply of a well-trained workforce is the foundation for an effective service delivery system. With the implementation of recent parity and health reform legislation, behavioral health and SUD workforce development issues, which have been of concern for decades, have taken on a greater sense of urgency. Strategic Initiative #6 will support active strategies to strengthen and expand the behavioral health and SUD workforce, and improve the behavioral health knowledge and SUD-related skills of those health care workers not considered behavioral health specialists. SAMHSA also recognizes the growing value of peer providers to assist with engagement, support, and peer services. The federal goals of workforce development include increasing the peer and paraprofessional workforce. The behavioral health and SUD recovery needs of minority communities have been historically and disproportionately

underserved”. The report points out that clinical directors and direct care staff are predominantly white and female with no military affiliation. Slightly less than one-third of direct care staff are in recovery.

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

California Substance Use Disorder Block Grant and Statewide Needs Assessment and Planning Report. (2015). California Department of Health Care Services, Substance Use Disorder, Prevention, Treatment and Recovery Division, 1500 Capitol Avenue, Sacramento, CA.