



FY 2019

**STATEWIDE NEEDS
ASSESSMENT AND PLANNING
REPORT**

California Department of Health Care Services
Substance Use Disorder Services

STATEWIDE NEEDS ASSESSMENT AND PLANNING REPORT

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INTRODUCTION

The Department of Health Care Services (DHCS) Statewide Needs Assessment and Planning (SNAP) Report is a biennial needs assessment required of all single state agencies receiving Substance Abuse Block Grant (SABG) funds. This SNAP Report is intended to meet the reporting requirements in accordance with 45 Code of Federal Regulations (CFR) section 96.133(a)(1-6).

The Executive Summary details compelling substance use and misuse data discovered during the development of the statewide assessment. Additionally, the Executive Summary provides a high-level overview of California's capacity to meet the behavioral health needs of its citizens, and a preview of California's Strategic Initiatives designed to minimize, if not close, the gaps exposed during the assessment phase.

Immediately following the Executive Summary, the Assessment Section of the SNAP presents a more robust picture of the data captured to measure California's Substance Use Disorder (SUD) incidence and prevalence rates among its low-income beneficiaries, and identifies related service utilization, beneficiary outcomes, and program performance. The Assessment section also provides information on the current capacity and effectiveness of SUD prevention and treatment services and training to its workforce, and conveys the priorities to address unmet prevention, treatment, and recovery service needs. The data presented in the SNAP Report are taken from the most recent sources available at the time the report was written. A Table of Data Sources is located in Appendix B of this report.

The Assessment Section of the SNAP Report outlines DHCS's strategic initiatives for state fiscal year (SFY) 2020-21, aligning state-specific goals with the five priority areas and five core principles identified in the "Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Plan FY 2019-2023,"¹ and "DHCS's Strategy for Quality Improvement in Health Care 2018."²

Through the SNAP process, DHCS strives to make strategic decisions in awarding SABG funds for overall improvements to SUD prevention, treatment, and recovery infrastructure in California.

EXECUTIVE SUMMARY

State Incidence and Prevalence of Substance Use 45 CFR § 96.133(a)(1)

Marijuana:

According to the University of California Los Angeles' (UCLA) California Health Interview Survey (CHIS), 60 percent of adolescents (ages 12-17) who have tried

¹ https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf

² https://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2018.pdf

marijuana have used it one or more times in the last 30 days; double the rate of adults (ages 18+).

According to the California Healthy Kids Survey (CHKS), marijuana use in the past 30 days was the second most frequently consumed substance by youth, with 9.5 percent of ninth graders and 16.7 percent of eleventh graders reporting consuming marijuana in the past month; decreases from 2013-2015 (13.4 percent and 20.1 percent, respectively).

[Amphetamines/Methamphetamines:](#)

Methamphetamine is the most prevalent drug reported at treatment admission; 33 percent. Less than 1 percent of the general population uses Methamphetamine; however, it accounts for more than 33 percent of the admissions for drug treatment in California.

[Maternal Opioid Use:](#)

According to data from the Maternal Infant Health Assessment (MIHA), California experienced a 350 percent increase in opioid overdose death rates occurring in women of childrearing age from 1999-2017.

[American Indians/Alaska Native Opioid Use:](#)

According to the California Tribal Epidemiology Center (CTEC), American Indians/Alaska Natives (AI/AN) experience a very high opioid overdose death rate (almost double any other race/ethnicity category); a problem exacerbated by unavailability or inaccessibility to Indian Health Services (IHS).

Nearly 80 percent of AI/AN overdose deaths resulted from prescription opioids.

[Alcohol:](#)

Alcohol use is down over all. Both national and state data confirm declines in alcohol use across all age groups from SFY 2015-16 to FY 2016-17.

Current Substance Use Disorder Prevention and Treatment Activities 45 CFR § 96.133(a)(2)

California Outcomes Measurement System – Prevention (CalOMS Pv) Data for SFY 2016-17

The total number of individuals receiving primary prevention services in SFY 2016-17 totaled 221,203.³ The total number of individuals served slightly decreased since SFY 2014-15, in which 268,750 individuals were served. The total numbers do not include totals from information dissemination strategy services.

- Information Dissemination Strategies are aimed to educate the general public and do not capture the number of individuals served.
- Education strategies served 92,834 individuals.
- Alternative activities were provided to 75,150 individuals.
- Problem Identification and Referral strategies were provided to 5,905 individuals.
- Community-Based Process strategies were provided to 37,243 individuals.
- Environmental strategies reached 10,071 individuals and/or communities.

California Outcomes Measurement System – Treatment (CalOMS Tx) Data for SFY 2016-17

- Approximately 186,000 unique beneficiaries were served; approximately 9,000 fewer beneficiaries than were served in SFY 2014-15.
- Nearly 86,000 beneficiaries were in treatment on April 1, 2017, in California (one-day count).
- There were over 160,000 admissions to treatment for all services, including admissions to publicly-monitored SUD detoxification, residential, and outpatient services. Of the 160,000 admissions, 120,000 were unique beneficiaries.
- The largest percentage of admissions to treatment occurred in Outpatient Drug-Free (ODF) treatment with 40 percent. Residential (short-term and long-term) treatment admissions was 22 percent, 17 percent for Detoxification, 16 percent for Narcotic Treatment Program (NTP) maintenance services, and 5 percent for Intensive Outpatient Treatment (IOT).
- There were over 157,000 treatment discharges for approximately 122,000 beneficiaries.

Technical Assistance Needs to Carry Out Substance Abuse Prevention and Treatment Block Grant Activities 45 CFR § 96.133(a)(3)

DHCS invests a portion of its SABG award toward Training and Technical Assistance (TTA) for the SUD workforce across the continuum of care. DHCS works with a variety of nationally recognized organizations to ensure that TTA recipients receive relevant

³ The total number of beneficiaries served for SFY 2016-17 is based on preliminary data due to cost reports not settled at the time of this report.

and innovative information to inform their local program implementation. In 2018, the Center for Applied Research (CARS) surveyed SUD prevention professionals to assess the training needs of the field. Survey results found the following topics as top priority:

- Implementing youth marijuana prevention programs
- SUD prevention programming in rural communities
- Social Determinants of Health
- Opioid use among adults and older adults

DHCS will work with multiple contractors toward making TTA available on these topics. DHCS will also complete surveys of the youth workforce in an effort to continue its assessment of the characteristics of the overall SUD workforce.

Goals and Objectives 45 CFR § 96.133(a)(4)

Strategic Initiative #1: Reduce opioid misuse, use disorder, overdose, and related health consequences through continued implementation of the California Medication Assisted Treatment (MAT) Expansion Project and Strategic Prevention Framework Partnerships for Success (SPF PFS) grant.

Strategic Initiative #2: Reduce youth marijuana use and related consequences and contributing factors by expanding youth SUD prevention programs.

Strategic Initiative #3: Improve access to SUD services through continued implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, and advance county understanding of the use of SABG funding as it pertains to California's Drug Medi-Cal (DMC) program, especially in rural communities.

Strategic Initiative #4: Broaden statewide availability of evidence-based, outcome-driven SUD services for youth and other special populations across the continuum of care.

Strategic Initiative #5: Increase the number of trained and culturally competent professionals and paraprofessionals to address California's prevention, treatment and recovery workforce needs.

Strategic Initiative #6: Expand and improve the data collection, analysis, evaluation, and dissemination of information related to SUDs and receipt of services.

Extent to Which Availability of Services is Insufficient and Interim Services 45 CFR § 96.133(a)(5)

Based annual averages for CYs 2016 and 2017; "National Survey on Drug Use and Health" (NSDUH) estimates the following:

- 2.8 percent of Californians ages 12+ reported needing, but not receiving, treatment at a Specialty Facility for illicit drug use in the past year, compared to 3.1 percent in CYs 2015-16.

- 5.4 percent of Californians ages 12+ reported needing, but not receiving, treatment at a Specialty Facility for alcohol use in the past year, compared to 6.2 percent in CYs 2015-16.

State Information Management System 45 CFR § 96.133(a)(6)

In SFY 2016-17, California continued utilizing the CalOMS Tx data system to track treatment capacity, including treatment admissions and discharges; the Drug and Alcohol Treatment Access Report (DATAR) system to collect waitlist data; and, the CalOMS Pv data system to collect and report data on implemented prevention strategies and service deliveries, as well as to identify Institute of Medicine (IOM) categories of risk and populations served.

Recently, all three data systems began migration to new data platforms. DHCS selected a third party vendor to host the new prevention data system and, as of 2019, both the CalOMS Tx and DATAR systems have migrated to a behavioral health services information system environment.

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STATEWIDE ASSESSMENT

Infrastructure Overview

DHCS's ongoing mission is to provide Californians with access to affordable, integrated, and high-quality health care, including medical, dental, mental health, SUD prevention and treatment, and long-term care services. DHCS's vision is to preserve and improve the overall health and well-being of all Californians.⁴ DHCS's success is only possible through collaboration and cooperation with federal and other state agencies, counties, and stakeholders.

DHCS is the backbone of California's health care safety net, funding health care services for approximately 13 million Medi-Cal beneficiaries, plus additional low-income individuals who do not qualify for Medi-Cal. About one-third of Californians receive health care services financed or organized by DHCS, making DHCS the largest health care provider in California. According to the Governor's SFY 2019-2021 budget, DHCS has been allocated over \$106 billion in public funds for the care of low-income families, children, pregnant women, seniors, and persons with disabilities.⁵

DHCS is the single state agency responsible for administering California's DMC program. In addition, DHCS currently administers four SAMHSA Grants 1) the SABG, 2) the State Targeted Response to Opioid Crisis Grant, 3) the State Opioid Response Grant, and 3) the SPF PFS Grant.

As of July 2019, 28 California counties are contracted to deliver State Plan DMC services, while 30 counties provide expanded DMC services through the DMC-ODS demonstration waiver with the Centers for Medicare and Medicaid Services.

While California seeks to align its strategic initiatives with the national strategic plan, it is important to note that in November 2016, California passed Proposition 64 (Prop. 64), legalizing the recreational use of marijuana for persons 21 and over. A portion of the tax revenue is disbursed to DHCS for SUD prevention programs for youth.

Also in 2019, DHCS mental health and SUD state-level staff reorganized to become an integrated behavioral health division. This organizational structure is designed to improve efficiencies department-wide, increase program administration accountability, improve service delivery, decrease processing times, and increase communication and engagement for stakeholders and employees.

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

As determined by statute, this section of the SNAP Report provides data and information to measure the incidence and prevalence of SUD. "Incidence" refers to the

⁴ <https://www.census.gov/quickfacts/CA>

⁵ <http://www.ebudget.ca.gov/2019-20/pdf/Enacted/GovernorsBudget/4000/4260.pdf>

number of new cases that emerge within a given time period. “Prevalence” refers to the total number of cases at any given moment in time. This Report focuses on four main areas that provide a snapshot of the impact of SUD on individuals:

- SUD-related consumption
- SUD-related health consequences
- SUD-related motor vehicle incidents
- SUD-related arrests

Analyzing data from these four areas facilitates a comprehensive and accurate understanding of the incidence and prevalence of substance use and abuse in California. These categories capture a point-in-time picture of statewide trends across prevention, treatment, and recovery services in California’s SUD delivery system.

The needs assessment data generally includes the most current information available. Depending upon the source, data may cover multiple time spans. For example, sections of this report may compare data from the most recent CYs available, versus data based on the SFY.

In preparing the 2019 SNAP Report, DHCS made every effort to be transparent regarding the weaknesses and biases in the data from which conclusions were reached. By critically reviewing data reliability and validity, DHCS is mindful about developing strategies to improve the data and resulting information to inform program policies and services in the future. DHCS outlines the strategies for improvement in the strategic initiatives articulated in this report, along with requests for federal TTA to leverage the quality of system data reporting. By following a quality improvement process, DHCS can improve services and make future needs assessments more accurate, complete, and meaningful.

Substance Use Disorder-Related Consumption Data

National Survey on Drug Use and Health

The following estimates from the SAMHSA NSDUH are based on household face-to-face interview samples and exclude some populations (e.g., homeless, incarcerated) who likely use substances at higher levels than individuals living in the household population.

SAMHSA published the NSDUH state estimates of past month substance use among individuals ages 12+ for CYs 2016-17.⁶ To generate accurate state-level estimates,

⁶ SAMHSA (2018). NSDUH: Comparison of 2015–2016 and 2016–2017 Population Percentages. Available at: <https://www.samhsa.gov/data/report/comparison-2015-2016-and-2016-2017-nsduh-population-percentages-50-states-and-district>.

SAMHSA combines two years of NSDUH data. In its most recent report, SAMHSA compares CYs 2015-16 data with CYs 2016-17 data to examine changes over time.⁷

Please note that this section is limited to a discussion of the results in tables and reports published by SAMHSA as of February 2019.

Alcohol Use

- In CYs 2016-17, 5.5 percent of Californians ages 12+ reported an alcohol use disorder, down from 6.4 percent in CYs 2015-16.
- In CYs 2014-15, 3.5 percent of Californians ages 12+ reported an alcohol dependence disorder in the past year, up slightly from 3.3 percent in CYs 2013-14.⁸

Illicit Drug Use

Illicit drugs includes the misuse of prescription psychotherapeutics (i.e., pain relievers, tranquilizers, stimulants, and sedatives) or the use of marijuana, cocaine (including crack), inhalants, hallucinogens, heroin, or methamphetamine.

- In California, there was no significant change in past month illicit drug use; from 12.6 percent in CYs 2015-16 to 13.1 percent in CYs 2016-17.

Marijuana Use

Data estimates on marijuana use revealed statistically significant increases.

- In CYs 2016-17, 17.4 percent of Californians ages 12+ used marijuana in the past year, a significant increase from 16.2 percent in CYs 2015-16.
- Marijuana past month usage in California significantly increased from 10.5 percent in CYs 2015-16 to 11.3 percent in CYs 2016-17.
- Perception of risk of marijuana use in California is lower than the national average among youth under age 18.
- Marijuana use rates among emerging adults ages 18 to 25 in California is higher than the national average.

⁷ A p-value of 0.05 was used to determine significance. A “p-value,” in this context, is the certainty that the difference between the percentages discussed is observed by pure chance. A p-value of 0.05 means that there is a 5 percent chance that the difference between the percentages in this survey sample does not actually exist in the population and a 95 percent chance that it does. For example, a p-value of 0.05 means a 95 percent certainty exists that the results were not due to chance.

⁸ The two different alcohol disorder categories in these NSDUH estimates use the *American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV) criteria of ‘alcohol abuse’ and ‘dependence’. Under DSM-IV, anyone meeting one or more of the “abuse” criteria within a 12-month period would receive the “abuse” diagnosis. Anyone with three or more of the “dependence” criteria during the same 12-month period would receive a “dependence” diagnosis. NSDUH uses the term “alcohol use disorder” for the ‘alcohol abuse’ level. For more understanding of the two levels and specific criteria, see page 2 of the following document: <https://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf>.

Other Illicit Drugs

The review of NSDUH California data covering CYs 2015-2016 and CYs 2016-2017 revealed no significant overall changes in use of other illicit drugs, including cocaine or misuse⁹ of pain relievers.

- In CYs 2016-17, 2.7 percent of Californians reported using cocaine in the past year, compared with 2.4 percent in CYs 2015-16.
- In CYs 2015-16 and CYs 2016-17, Californians ages 12+ reported using heroin in the past year decreased from 0.24 percent to 0.19 percent.
- Californians ages 12+ reported past year misuse of pain relievers decreased from 4.7 percent (CYs 2015-16), to 4.3 percent (CYs 2016-17).⁸

Age Group Differences

DHCS found positive news in the data related to the different age groups, as there were significant decreases in substance use in California from CYs 2015-16 when compared to CYs 2016-17. For example:

Ages 12+

- Past year pain reliever use disorder (0.63 percent vs. 0.51 percent)^{5 10}
- Past year alcohol use disorder (6.4 percent vs. 5.5 percent)¹¹

Ages 12 to 17

- Past month cigarette use (2.7 percent vs. 2.1 percent)¹²

Ages 18 to 25

- Past year misuse of pain relievers (8.0 percent vs. 6.8 percent)
- Past month illicit drug use other than marijuana (8.2 percent vs. 7.0 percent)
- Past month cigarette use (19.3 percent vs. 17.0 percent)
- Past year pain reliever use disorder (0.9 percent vs. 0.6 percent)

Ages 26+

- Past year alcohol use disorder (6.2 percent vs. 5.2 percent)
- Past year substance use disorder (7.2 percent vs. 6.7 percent)¹³

⁹ Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

¹⁰ Pain Reliever Use Disorder is defined as meeting criteria for pain reliever dependence or abuse as defined by the DSM-IV.

¹¹ Alcohol Use Disorder is defined as meeting criteria for alcohol dependence or abuse as defined by the DSM-IV.

¹² While cigarette smoking has declined, it may be due to use of electronic vaporizing devices for delivering nicotine. Research on cigarette and e-cigarette use is needed to continue monitoring these developments. NSDUH does not currently ask separate questions about e-cigarette use.

¹³ Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse as defined by the DSM-IV.

It is important to note that while significant statistical use decreases were found among different age groups, significance here means the differences between years is unlikely to be due to chance, regardless of whether or not they are substantial. While the decreases are relatively small, they suggest SUD prevention activities may be making an impact. A majority of the decreases reported here are clearly significant, but other differences may also exist that are not discussed in this report.

There was a significant increase in past month marijuana use among adults ages 26+ (8.7 percent vs. 9.7 percent). There was also a significant increase in past-year marijuana use among young adults ages 18-25 (34.0 percent vs. 36.5 percent) and adults ages 26+ (13.5 percent vs. 14.6 percent).

Alcohol Use – By Gender and Age Group¹⁴

Research shows that males and females begin drinking at similar rates, but that males report higher drinking rates later in life and have greater illicit drug use throughout life.

The following national information from the NSDUH 2017 report supports the conclusion that both sexes start out with similar drinking rates (based on past month data), but male drinking becomes more prevalent with age.

Ages 12+

- In CY 2017, an estimated 55.5 percent of males ages 12+ were current drinkers, while the rate for females was 48.1 percent.

Ages 12-17

- In CY 2017, among youth ages 12-17, the percentage of females who were current drinkers (11.0 percent) was higher than for males (8.8 percent).

Ages 18-25

- Among young adults ages 18-25, an estimated 57.2 percent of males and 55.4 percent of females were current drinkers in CY 2017.

Ages 26+

- Among individuals ages 26+, an estimated 61.0 percent of males and 51.1 percent of females reported current drinking in CY 2017.

Illicit Drug Use¹³

NSDUH CY 2017 (not California specific) data also show that illicit drug use is higher for males than females, as reported in prior years as well.

¹⁴ Center for Behavioral Health Statistics and Quality. (2018). "2017 National Survey on Drug Use and Health: Detailed Tables." Substance Abuse and Mental Health Services Administration, Rockville, MD. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf>

- In CY 2017, the rate of current illicit drug use among individuals ages 12+ was higher for males (13.7 percent) than females (8.8 percent), which are both increases from CY 2016 rates (12.8 percent and 8.5 percent, respectively).

Males were more likely than females to be current users¹⁵ of several different illicit drugs in CY 2017, including, but not limited to:

- Marijuana (11.9 percent vs. 7.3 percent, respectively)
- Cocaine (1.1 percent vs. 0.5 percent, respectively)
- Hallucinogens (0.7 percent vs. 0.4 percent, respectively)
- Methamphetamine (0.4 percent vs 0.2 percent, respectively)
- Misuse of Pain Relievers (1.3 percent vs. 1.1 percent, respectively)
- Misuse of Opioids (1.5 percent vs. 1.1 percent, respectively)¹⁶

California Rural Indian Health Bureau, Inc.

The California Rural Indian Health Bureau, Inc. (CRIHB) supports the work of the CTEC. According to CTEC’s “California American Indian/Alaska Native Community Health Profile,” September 2015, California’s AI/AN population is treated for opioid use at a higher rate than that of non-Indian counterparts during the same time period. The highest prevalence of AI/ANs receiving a diagnoses for misuse of opioids was in Humboldt, Riverside, Sacramento and Sonoma Counties. Over 52 percent of the opioid misuse among American Indians occurred in the 20 to 40 age range.¹⁷

California Outcomes Measurement System – Treatment

According to CalOMS Tx data for SFY 2014-15, the peak age for first use of a substance by youth who had been admitted to a DHCS monitored SUD treatment facility was age 13, a statistic that remained unchanged from FY 2013-14. Most significantly, CalOMS Tx data highlighted that 18 percent of youth began using substances when they were 11 years old or younger.

California Healthy Kids Survey

The following review of CHKS survey data provides estimates gathered from this statewide survey of youth patterns tracking current substance use in the past 30 days. CHKS is a large statewide survey generally used by service providers and educators as a powerful tool to help identify strengths, weaknesses, needs, resiliency, protective

¹⁵ Current Use or Misuse* For substances other than prescription psychotherapeutic drugs (pain relievers, tranquilizers, stimulants, or sedatives), current use refers to any reported use of a specific substance in the past 30 days (also referred to as “past month use”). For prescription psychotherapeutic drugs, current misuse refers to misuse of psychotherapeutics in the past 30 days. (Respondents were not asked about any use of psychotherapeutics in the past 30 days).

¹⁶ Opioid misuse refers to the use of heroin or the misuse of prescription pain relievers (past month or year use). Prescription pain relievers do not include over-the-counter drugs. Prescription pain relievers could include some non-opioids because respondents could specify that they misused other pain relievers that are not opioids.

¹⁷ https://crihb.org/wp-content/uploads/2018/07/CTEC_Opioid-Surveillance-Update.pdf

factors, and risky behaviors occurring among children in grades 7, 9, and 11. DHCS collected the following data from the CHKS 2015-17 combined sample of 45,264 secondary school students. The survey results help guide statewide efforts to improve school climates, increase availability of learning supports, and engage students in healthier lifestyle behaviors. CHKS helps individuals working with children and adolescents to identify and increase the quality of health, prevention, and youth development programs. In reviewing the CHKS 2015-17 data, there are declines in overall alcohol and drug use and frequent/heavy use. Although trends are in the right direction, rates of use among eleventh graders remain disconcerting. In the CHKS 2015-17 report:

- Alcohol use in the past 30 days was reported by 5.1 percent of seventh graders, 14.6 percent of ninth graders, and 22.5 percent of eleventh graders, which were all decreases from 2013-15 (8.2 percent, 18.6 percent, and 29.1 percent, respectively).
- Binge drinking (five drinks or more on the same occasion) among youth was a common practice, occurring among 6 percent of ninth graders, and 11.6 percent of eleventh graders; decreases from 2013-15 (9.6 percent and 17.6 percent, respectively).
- Marijuana use in the past 30 days was the second most frequently consumed substance by youth, with 9.5 percent of ninth graders and 16.7 percent of eleventh graders reporting consuming marijuana in the past month; decreases from 2013-2015 (13.4 percent and 20.1 percent, respectively).

California Behavioral Risk Factor Surveillance System

The California Behavioral Risk Factor Surveillance System (BRFSS) is funded by the U.S. Centers for Disease Control and Prevention (CDCP), and is a widespread, ongoing telephone health survey system. BRFSS was developed to enable state health agencies to better capture and interpret data and target resources to reduce behavioral risks and their consequent illnesses. National data may not be applicable to the conditions found in any given state. However, achieving national health goals through monitoring data and targeting behavioral change interventions requires state and local agency participation. Monitoring data helps inform and facilitate efforts to improve lifespan, health, and longevity. The basic philosophy of the survey is to collect data with a specific focus on actual behaviors related to disease and injury, rather than surveying attitudes or knowledge. Understanding a population's actions and habits is instrumental in facilitating efforts to plan, initiate, support, and evaluate health promotion and disease prevention programs.

BRFSS includes the Cell Phone Survey. By including cell phones in the survey, BRFSS is able to reach segments of the population that were previously inaccessible (individuals who have a cell phone but not a landline) and results in a more

representative sample and higher quality data. Cell Phone Surveys were included in the public release data set beginning in 2011.¹⁸

BRFSS is conducted by the Division of Behavioral Surveillance in the CDCP's Public Health Surveillance and Informatics Program office. BRFSS prevalence estimates for 2017 show:

- The percentage of heavy drinkers¹⁹ was the same in California (6.3 percent) as the nation (6.3 percent).
- In California, the population groups with the highest rates of heavy drinking were male individuals, ages 18-24, and non-Hispanic Whites.
- The percentage of binge drinkers²⁰ was higher in California (17.6 percent) than the nation (17.4 percent).
- In California, the population groups with the highest rates of binge drinking were among male individuals, ages 25-34, and multiracial non-Hispanics.

California Health Interview Survey

In 2016, DHCS sponsored a series of substance use and misuse questionnaires through the CHIS to measure and monitor existing and emerging problems in California, such as the ongoing opioid overdose epidemic. CHIS, conducted by UCLA's Center for Health Policy Research, is a comprehensive statewide, population-based, telephone survey. The survey collects extensive information for all age groups on a wide range of health topics across California's 58 counties. CHIS provides timely and high quality data accurately capturing the rich diversity of the California population and geographic areas.

CHIS data enables researchers and practitioners to identify diverse, ethnic, and hard-to-reach special sub-groups at highest risk for poor health outcomes at the individual, community, and policy levels.

Key highlights from CHIS 2017 substance use data:

Marijuana

- Over 47 percent of Californians ages 12+ have tried marijuana or hashish at least once in their lives.

¹⁸ In 2011, a new weighting methodology—raking, or iterative proportional fitting—replaced the post stratification weighting method that were used with previous BRFSS data sets. In addition to age, gender, and race/ethnicity, raking permits more demographic variables to be included in weighting such as education attainment, marital status, tenure (property ownership), and telephone ownership. Details on this methodology are provided in the June 8, 2012, issue of the "Morbidity and Mortality Weekly Report," which highlights weighting effects on trend lines.

<http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html>

¹⁹ Heavy drinking is defined as adult males having more than 14 drinks per week and adult females having more than 7 drinks per week.

²⁰ Binge drinking is defined as males having five or more drinks on one occasion and females having four or more drinks on one occasion in the past month.

- Among those who have tried marijuana, nearly 30 percent of adults (ages 18+) last used it within the past month, and almost 60 percent of adolescents (ages 12-17) have used it one or more days in the past 30 days.
- The prevalence of past-month marijuana use was higher among rural, male, AI/AN, and gay, lesbian, and bisexual adults compared to their counterparts.
- Past-month marijuana use among adults increased as levels of income decreased. Adults living below 100 percent Federal Poverty Level (FPL) had a higher prevalence of use (33.5 percent) than adults with higher incomes at 300 percent FPL and above (26.8 percent).

Prescription Drugs

- Approximately 2.0 percent of adults in California reported having misused prescription painkillers in the past year, and the misuse was generally higher among adults ages 25-39.
- Low-income adults (<100 percent FPL) had a prevalence of misuse over two times higher than higher-income adults (300 percent FPL and above).

Heroin

- Roughly 1.0 percent of adults have used heroin in the past year. Heroin use was more common among males than females.

Maternal Infant Health Assessment

The MIHA is an annual, statewide survey of women who participated in California's Women, Infants, and Children Program during pregnancy with a recent live birth in California. MIHA collects information on maternal and infant experiences before, during, and shortly after pregnancy. DHCS uses MIHA data to help inform programs and services, and improve the health of substance-using mothers and their infants.

The following statistics on alcohol use and cigarette smoking are from the SFY 2013-15 MIHA survey of 20,762 women who recently gave birth to a live infant in California (see Tables 1 through 4).

- 15.1 percent reported binge drinking three months before pregnancy.
- 7.3 percent reported any alcohol use during the third trimester.
- 10.8 percent reported smoking cigarettes in the three months before pregnancy.
- 2.7 percent reported smoking cigarettes during the third trimester.
- 5.4 percent reported smoking cigarettes postpartum (after giving birth).
- Women ages 20-34 had the highest percentage of binge drinking in the three months before pregnancy, smoking cigarettes in the three months before pregnancy, and smoking in the third trimester (Table 1).
- Women ages 35+ had the highest percentage of any alcohol use in the third trimester (Table 1).

Table 1: Percent of Females in California Who Report Binge Drinking Three Months before Pregnancy, or Any Alcohol Use during the Third Trimester, by Maternal Age, SFY 2013-15

Maternal Age	Binge Drinking Three Months before Pregnancy	Any Alcohol Use in Third Trimester
15 – 19	10.0%	0.4%
20 – 34	16.3%	6.9%
35+	12.0%	11.0%

Source: MIHA Survey Data Snapshots, 2013-2015. CDPH, 2018.²¹

- White females had the highest percentages of binge drinking in the three months before pregnancy, and any alcohol use in the third trimester (Table 2).

Table 2: Percent of Females in California Who Report Binge Drinking Three Months before Pregnancy, or Any Alcohol Use during the Third Trimester, by Race/Ethnicity, SFY 2013-15

Race/Ethnicity	Binge Drinking Three Months before Pregnancy	Any Alcohol Use in Third Trimester
White	21.0%	15.3%
Hispanic	13.9%	3.7%
African American	13.3%	6.1%
Asian/Pacific Islander	7.9%	4.4%
Statewide ^a	15.1%	7.3%

Source: MIHA Survey Data Snapshots, 2013-15. CDPH, 2018.²²; ^aTotal includes records with missing race/ethnicity.

- Females ages 15-19 had the highest percentage of postpartum smoking (Table 3).

Table 3: Percent of Females in California Who Report Smoking Three Months before Pregnancy, or Any Smoking during the Third Trimester or Postpartum, by Maternal Age, SFY 2013-15

Maternal Age	Smoking Three Months before Pregnancy	Any Smoking in Third Trimester	Any Smoking Postpartum
15 – 19	10.5%	2.5%	6.6%
20 – 34	11.8%	3.1%	5.9%
35+	7.0%	1.2%	3.1%

Source: MIHA Survey Data Snapshots, 2013-15. CDPH, 2018.²⁴

²¹ https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/Snapshot_ByMaternalAge_2013-2015.pdf

²² https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/Snapshot_ByRaceEthnicity_2013-2015.pdf

- African Americans had the highest percentages of smoking cigarettes across all three smoking categories (Table 4).

Table 4: Percent of Females in California Who Report Smoking Three Months before Pregnancy, or Any Smoking during the Third Trimester or Postpartum, by Race/Ethnicity, SFY 2013-15

Race/Ethnicity	Smoking Three Months before Pregnancy	Any Smoking in Third Trimester	Any Smoking Postpartum
African American	18.1%	6.0%	12.1%
White	16.6%	4.9%	9.3%
Hispanic	7.8%	1.4%	3.1%
Asian/Pacific Islander	6.3%	1.5%	2.4%
Statewide ^a	10.8%	2.7%	5.4%

Source: MIHA Survey Data Snapshots, 2013-15. CDPH, 2018.²⁴; ^aTotal includes records with missing race/ethnicity.

Substance Use Disorder-Related Health Consequence Data

Alcohol-Related Health Consequences

Excessive use of alcohol (i.e., underage, binge and heavy drinking) continues to have major health consequences in California. CDCP has created the Alcohol Related Disease Impact (ARDI) application²³ that estimates the harmful effects of excessive use of alcohol. It calculates the chronic and acute effects of excessive alcohol use for both 100 percent alcohol-attributable causes (e.g., Alcoholic liver disease, alcohol poisoning) and other direct and indirect alcohol-attributable fractions for related causes (e.g., Unspecified liver cirrhosis, motor vehicle crashes, firearms, self-harm).

Deaths

Table 5 displays the CDCP estimates that an average of over 10,600 annual deaths in California during CYs 2006-2010 were attributable to chronic and acute alcohol-related conditions, with males accounting for the vast majority of the alcohol-attributable deaths. The top five alcohol-attributable, acute causes of deaths were motor vehicle traffic crashes, homicides, poisonings, suicides, and falls. Over 4,000 California resident deaths per year were solely due to alcohol-attributable causes, with the predominant effect related to chronic diseases.

²³ CDCP. ARDI application, 2013. Available at www.cdc.gov/ARDI.

Table 5: Average Annual Alcohol-Attributable Deaths in California Due to Excessive Alcohol Use, by Gender – All Ages, 2006-2010

Causes	Males	Females	Overall
Chronic Causes	3,880	1,653	5,533
Acute Causes	3,795	1,318	5,113
Total for All Causes	7,675	2,971	10,645 ²⁴

SOURCE: CDCP. ARDI application, 2013.²²

Table 6 shows that overall California residents lost over 300,000 years of potential life (i.e., premature deaths) each year from chronic and acute alcohol attributable conditions due to excessive alcohol use. The 20-34 year age group accounted for the largest portion of acute causes, whereas the older age groups (35-49; 50-64) accounted for the majority of the alcohol-attributable chronic causes.

Table 6: Average Annual Years of Potential Life Lost in California Due to Excessive Alcohol Use, by Age Group, 2006-2010

Causes	Ages 0-19	Ages 20-34	Ages 35-49	Ages 50-64	Ages 65+	Overall
Chronic Causes	1,152	6,430	41,866	56,811	20,389	126,648
Acute Causes	22,628	72,912	48,979	27,095	8,406	180,017
Total for All Causes	23,780	78,342	90,845	83,906	28,792	306,665

Based on the 100 percent alcohol-attributable conditions presented above, CDPH Safe and Active Communities Branch (SACB) has updated the estimated number of alcohol-attributed deaths and injuries requiring medical services in California, as shown in Tables 7 through 9 below. In Table 7, there were over 5,000 alcohol-attributed deaths with an age adjusted rate of 11.5 deaths per 100,000 residents in 2017. The vast majority of these deaths were related to chronic conditions. [Note: the CDCP numbers include all alcohol-attributed infractions for causes, whereas the data below include only the 100 percent alcohol-attributed causes.]

²⁴ Due to rounding, amounts in the Total column may not equal the sum of the numbers.

Table 7: Number and Rate* of 100 Percent Alcohol-Attributed Deaths in California, 2010-2017**

Year	All Alcohol-Attributable Number/Rate	Chronic Causes Number/Rate	Acute Causes Number/Rate
2010	4,220/10.9	2,884/10.0	336/0.9
2011	4,405/11.1	4,107/10.3	298/0.8
2012	4,359/10.7	4,088/10.1	271/0.7
2013	4,505/10.9	4,189/10.1	316/0.8
2014	4,692/11.1	4,385/10.3	307/0.8
2015	5,116/11.9	4,812/11.2	304/0.8
2016	5,023/11.6	4,754/10.9	269/0.7
2017	5,058/11.5	4,763/10.8	295/0.7

* Age-adjusted rate per 100,000 residents

** Numbers differ slightly from published data (2010-2013) on the SACB EpiCenter because of the use of revised codes for 100 percent alcohol attributed causes.

Source: Death Statistical Master and California Comprehensive Death Files; CDPH Center for Health Statistics and Informatics; prepared by: SACB staff, May 2019

Hospitalizations

Table 8 displays the increasing number (and age adjusted rate) of hospitalizations for 100 percent alcohol-attributed conditions from 2010 with nearly 40,000 hospital admissions in 2017.

Table 8: Number and Rate* of 100 Percent Alcohol-Attributed Hospitalizations in California, 2010-2017

Year	All Alcohol-Attributable Number/Rate	Chronic Causes Number/Rate	Acute Causes Number/Rate
2010	30,245/79.6	29,422/77.4	850/2.3
2011	30,704/79.7	29,861/77.5	888/2.3
2012	31,507/80.3	30,705/78.3	841/2.2
2013	31,455/79.4	30,633/77.3	867/2.2
2014	33,522/83.5	32,705/81.4	862/2.1
2015	35,597/87.1	34,823/85.2	797/2.0
2016	39,390/95.8	38,844/94.4	546/1.4
2017	39,649/95.6	39,050/94.2	599/1.5

* Age-adjusted rate per 100,000 residents

** Numbers differ slightly from published data (2010-2013) on the SACB EpiCenter because of the use of revised codes for 100 percent alcohol attributed causes.

Source: ED Discharge Files, California Office of Statewide Health Planning and Development (OSHPD); prepared by: SACB staff, May 2019.

Emergency Department Visits

Table 9 highlights the increasing magnitude of alcohol-related health consequences in California. In 2017, there were nearly 130,000 ED visits for 100 percent alcohol-attributed conditions. The age adjusted rate for these ED visits in 2017 was 319 ED visits per 100,000 residents.

Table 9: Number and Rate* of 100 Percent Alcohol-Attributed ED Visits in California, 2010-2017

Year	All Alcohol-Attributable Number/Rate	Chronic Causes Number/Rate	Acute Causes Number/Rate
2010	95,205/249.9	94,376/247.7	829/2.2
2011	99,111/257.6	98,007/254.7	1,104/2.8
2012	106,804/274.1	105,689/271.3	1,115/2.9
2013	110,133/280.0	109,000/277.1	1,133/2.9
2014	119,144/300.0	117,781/296.6	1,363/2.5
2015	125,094/311.2	123,093/306.3	2,001/5.0
2016	133,006/329.9	129,913/322.2	3,093/7.6
2017	129,594/319.0	126,767/312.0	2,827/7.0

* Age-adjusted rate per 100,000 residents

** Numbers differ slightly from published data (2010-2013) on the SACB EpiCenter because of the use of revised codes for 100 percent alcohol attributed causes.

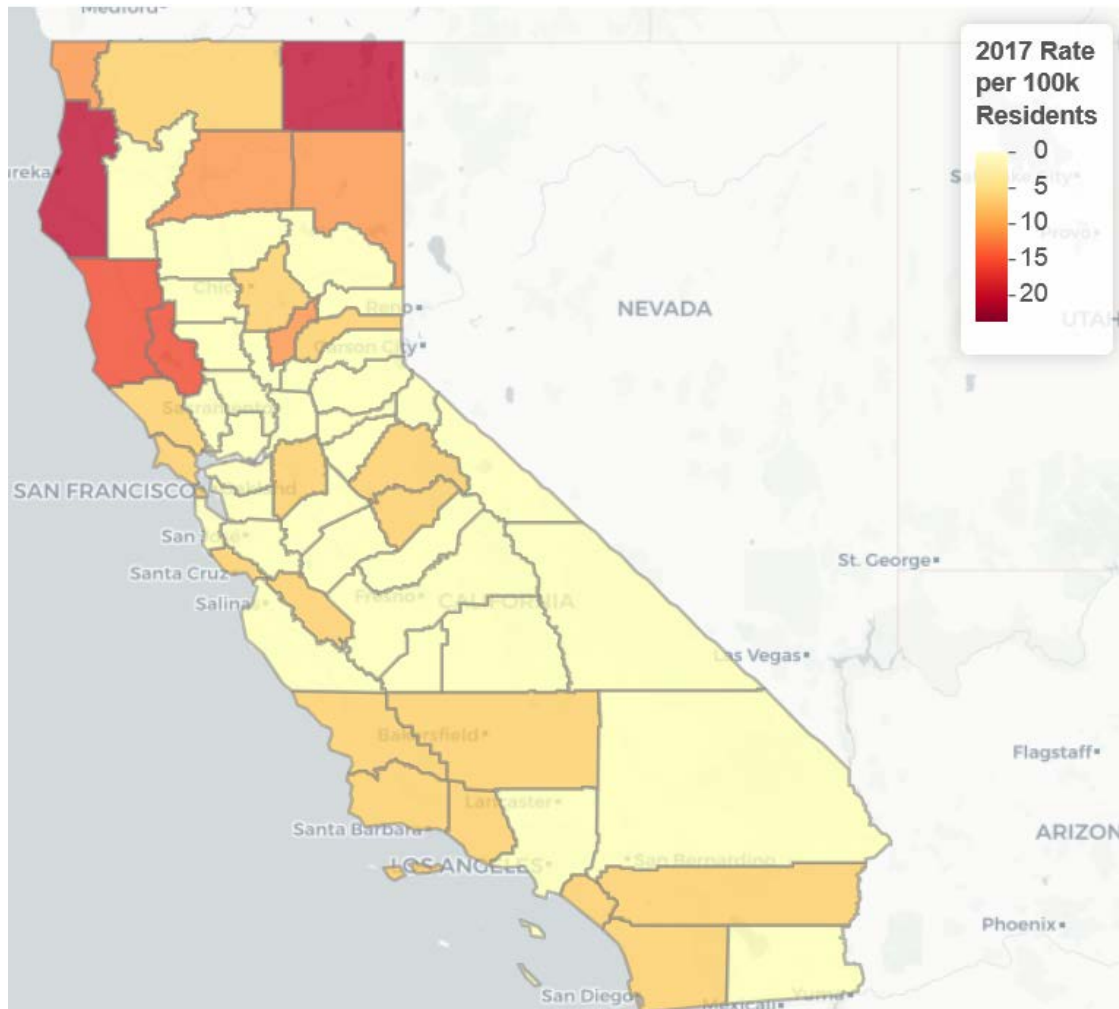
Source: ED Discharge Files, OSHPD; prepared by: SACB staff, May 2019

Drug-Related Health Consequences

Deaths

With approximately 2,200 opioid related overdose deaths in 2017 (over 50 percent involving prescription opioids), another nearly 8,000 hospital and ED admissions, and nearly 22 million opioid prescriptions written, California continues to face a serious opioid, public health crisis having substantial health and economic impacts. Even though California's overall rates of opioid-related deaths and non-fatal overdoses are lower than the national average, the absolute magnitude of the problem among California's nearly 40 million people is substantial. As shown in Figure 1, there is also wide variation across counties with some county overdose rates higher than the national average.

Figure 1: All Opioid Overdose Deaths in California, Age-Adjusted Rate per 100,000 Residents, 2017



Source: California Opioid Overdose Surveillance Dashboard (<https://discovery.cdph.ca.gov/CDIC/ODdash/>), Retrieved May 2019.

Table 10 displays trend data from the California Opioid Overdose Surveillance Dashboard²⁵ for multiple types of opioids over time. The trend for overall opioid-related deaths in California shows a roller coaster journey, as some policy and other interventions have effectively reduced overdoses and deaths for several years, only to see the epidemic morph and the crisis ultimately worsen. In 2017, the rate of overall opioid-related overdose deaths in California was 5.2 per 100,000 residents, up from previous highs in 2010 and 2014. This dynamic and rapidly changing opioid epidemic can be partially explained by the breakdown of opioid types. Although opioid prescription-related overdoses have consistently decreased, heroin and synthetic opioids (including fentanyl) have consistently increased.

²⁵ <https://discovery.cdph.ca.gov/CDIC/ODdash/>

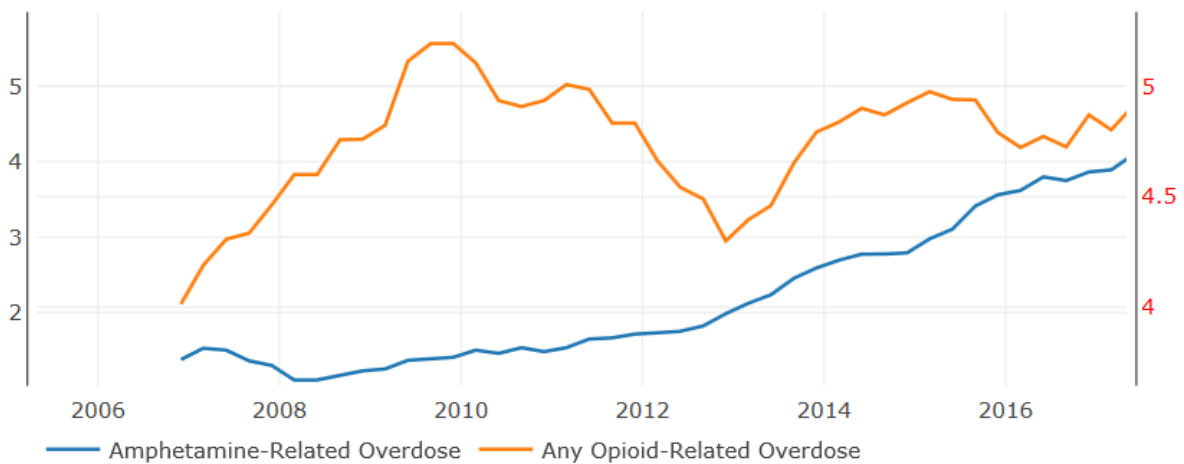
Table 10: Rates of Opioid-Related Overdose Deaths in California, All Ages, 2010-2017

Data Year	Any Opioid	Prescription Opioids (w/o Synthetics)	Synthetic Opioids	Fentanyl	Heroin
2010	4.93	3.65	0.52	N/A ²⁶	0.84
2011	4.83	3.67	0.41	0.26	0.91
2012	4.30	3.08	0.37	0.21	0.92
2013	4.79	3.20	0.42	0.21	1.21
2014	4.92	3.19	0.47	0.26	1.38
2015	4.79	2.96	0.54	0.33	1.41
2016	4.87	2.79	0.87	0.59	1.44
2017	5.22	2.75	1.31	1.06	1.70

Source: Multiple Cause of Death and California Comprehensive Death Files. Prepared by CDPH SACB, May 2019. * Rates are age-adjusted and calculated per 100,000 population using CDCP Wonder population data.

In 2017, opioid-related poisoning (overdose) deaths still outnumbered the amphetamine related overdose death counts (with about a 25 percent overlap of both drugs present), but the gap is narrowing (Figure 2). There were 2,194 opioid-related deaths (5.2 per 100,000 residents) and 1,909 amphetamine-related deaths (4.6 deaths per 100,000 residents), using age-adjusted rates.

Figure 2: Amphetamine-Related Overdose Deaths Compared to Any Opioid-Related Overdose Deaths, Total Population – 12-Month Moving Average (Age-Adjusted Rates)

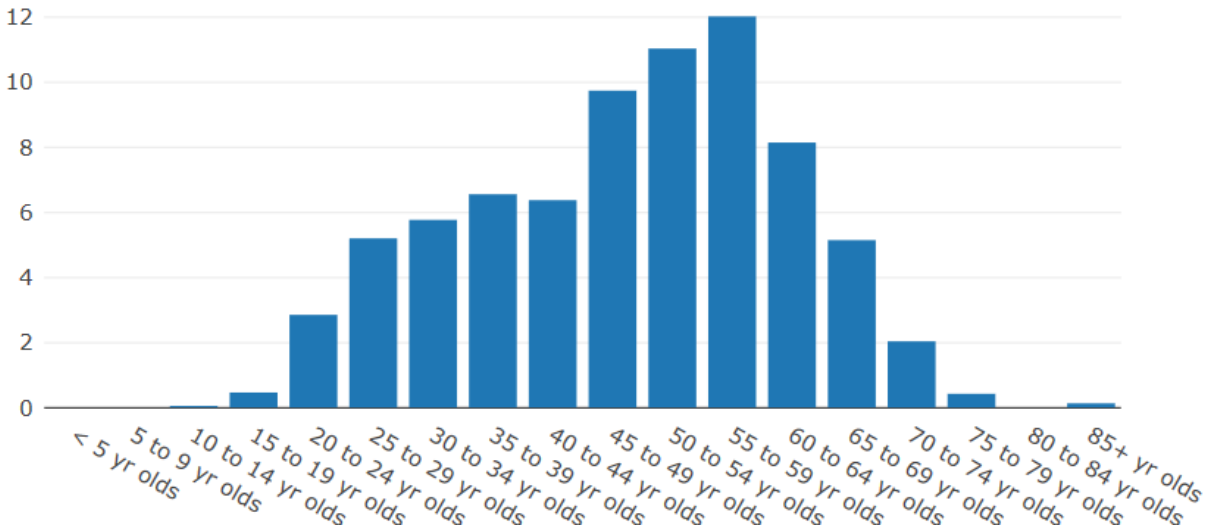


Source: <https://discovery.cdph.ca.gov/CDIC/ODdash/>

²⁶ No data was available for Fentanyl in the Data Year 2010.

Data shows that 75 percent of amphetamine-related overdose deaths are among males. The age range with the highest rates of amphetamine-related overdose deaths is between 45 and 65. (Figure 3).

Figure 3: Amphetamine-Related Overdose Deaths by Age Groups, 2017 (Crude Rate per 100,000 Residents)



Source: <https://discovery.cdph.ca.gov/CDIC/ODdash/>

Emergency Department Visits

Data from ED encounters, tracked by OSHPD, provides a wider picture of non-fatal drug overdoses (poisoning) for multiple substances with abuse potential. Table 11 not only shows opioid-related ED visits consistently increasing each year since 2010, but also shows a general upward trend in amphetamine-related overdoses between 2010 and 2015, before dropping to 2010 levels in recent years. Comparable ED cannabis data specific to poisoning became available in 2016 and shows an increasing trend since that time.

Please note that past SNAP drug data included and combined physical, mental health, and poisoning codes, but these data only includes overdose/poisoning.

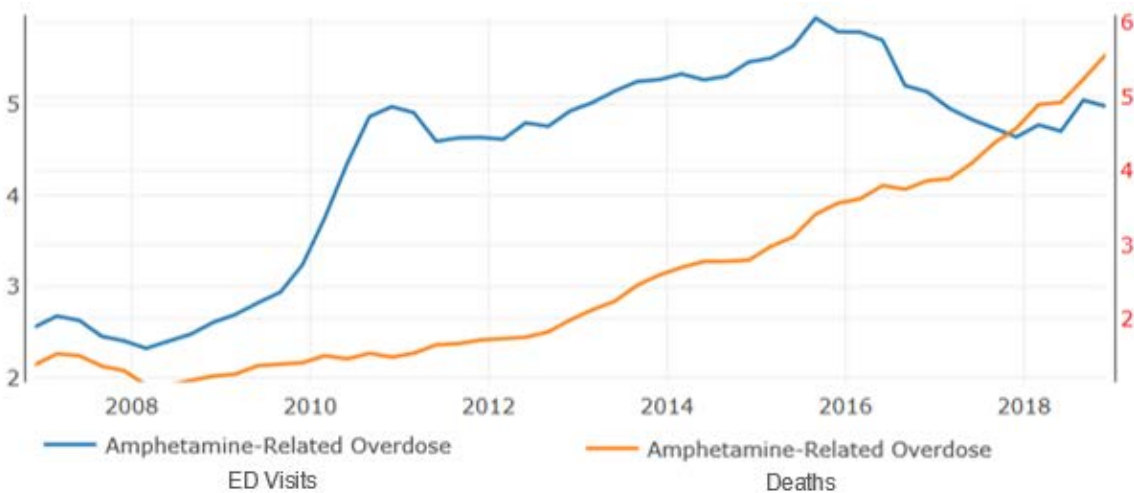
Table 11: Rates for ED Encounters for Drug Poisonings in California Related to Selected Drugs, All Ages, 2010-2018

Data Year	Opioids	Amphetamines	Cannabis
2010	14.69	4.98	N/A
2011	16.45	4.64	N/A
2012	16.89	4.93	N/A
2013	17.56	5.27	N/A
2014	18.31	5.47	N/A
2015	19.04	5.80	N/A
2016	20.04	5.14	4.75
2017	20.16	4.65	6.44
2018	21.31	4.96	7.04

Source: OSHPD ED Data. Prepared by CDPH SACB. * Rates are age-adjusted calculated per 100,000 population using CDCP Wonder population data.

In 2017 the number of ED visits for amphetamine-related overdoses, 1,832, was nearly equal the number of amphetamine-related overdose deaths, 1,909, (Figure 4) with both age-adjusted rates at 4.6 per 100,000 residents. However, the deaths have been increasing significantly while the non-fatal ED visits have been dropping, perhaps due to the increasing poly-drug involvement of more lethal fentanyl.

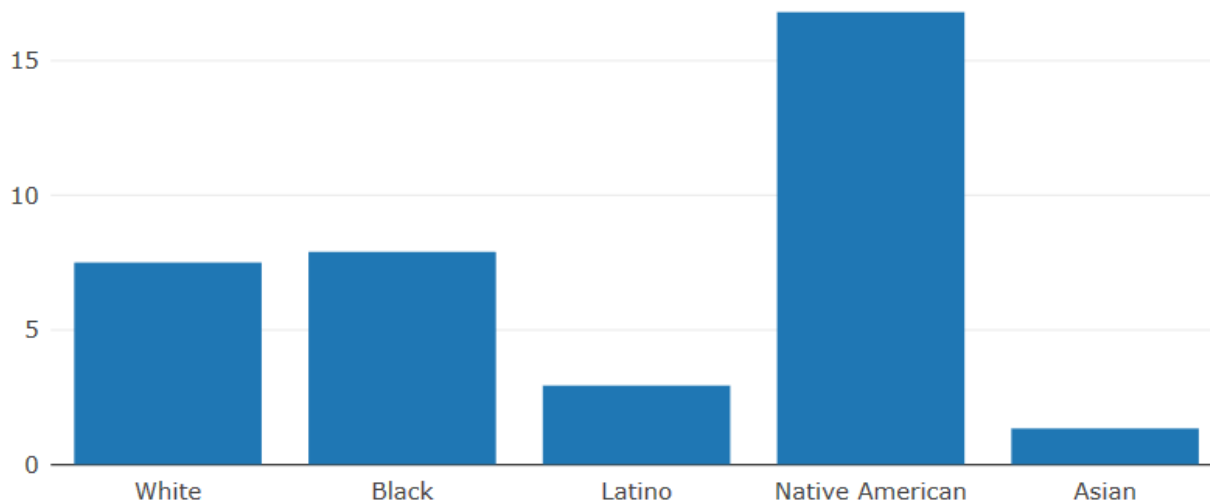
Figure 4: Amphetamine-Related Overdose ED Visits Compared to Amphetamine-Related Overdose Deaths, Total Population (Age-Adjusted Rate per 100,000 Residents)



Source: <https://discovery.cdph.ca.gov/CDIC/ODdash/>

Most striking in Figure 5 is the disproportionately higher rate of amphetamine-related overdose deaths for NA/AI populations (16.8 per 100,000), however, these figures are based on small numbers and likely undercounts the total NA/AI population, thus making it less reliable. Additionally, both White and Black (African American) populations have significantly higher death rates than the overall average, 7.5 and 7.9 per 100,000, respectively, compared to the state rate of 4.6.

Figure 5: Amphetamine-Related Overdose Deaths by Race/Ethnicity, 2017 (Crude Rate per 100,000 Residents)



Source: <https://discovery.cdph.ca.gov/CDIC/ODdash/>

Substance Use among California’s Pregnant and Postpartum Women

In the United States, drug overdose with any opioid continues to be the leading cause of accidental death, including prescription and illicit opioids.²⁷ In 2017, synthetic opioids (other than methadone) were involved in 47,600 overdose deaths and were the main driver of drug overdose deaths. According to the CDCP, California experienced a significant increase of 4.5 percent in its overdose death rate from 2016, to 2017.²⁸ Consequently, opioid-specific SUD is a growing epidemic among women. Prescription opioid-related deaths increased between 1999 and 2017 among women ages 30–64 years (492 percent increase), with the largest increases among those ages 55–64 years (500 percent). During this same period, rates of drug overdose deaths increased for those involving synthetic opioids (1,643 percent), heroin (915 percent), benzodiazepines (830 percent), prescription opioids (485 percent), cocaine (280 percent), and antidepressants (176 percent).²⁹

²⁷ Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. “[Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017](#)”. WR Morb Mortal Wkly Rep. ePub: 21 December 2018.

²⁸ <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

²⁹ <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6801-H.pdf>

Specifically, ensuring treatment services for pregnant and postpartum women with SUD is especially important due to the increased risk of adverse outcomes for both mother and child. Children of substance-using mothers are at risk for a host of health issues, including neonatal abstinence syndrome, birth defects, and premature births.³⁰ Many women who are pregnant or have young children either do not seek treatment or drop out of treatment early because they are unable to care for their children and may fear that authorities will remove their children from their care.³¹ ³² Furthermore, individuals who do seek and attend treatment frequently may be overwhelmed with the burden of childcare and other responsibilities.

For women of childbearing age (ages 15 to 44), the number of opioid-related ED visits has also seen a steady increase from 2010 to 2018. Comparable ED cannabis data specific to poisoning became available in 2016.

Table 12: Crude Rates of ED Encounters for Drug Overdoses/Poisonings in California Related to Selected Drugs, Females of Childbearing Ages 15-44, 2010-2018*

Data Year	Opioids	Amphetamines	Cannabis
2010	16.10	6.82	N/A
2011	17.98	6.32	N/A
2012	18.54	6.63	N/A
2013	19.10	6.46	N/A
2014	19.50	6.87	N/A
2015	20.32	7.12	N/A
2016	21.46	5.97	7.54
2017	20.65	5.77	10.37
2018	21.56	5.34	9.77

Source: OSHPD ED Data. Prepared by CDPH SACB, May 2019. *Crude rates calculated per 100,000 population using California Department of Finance (DOF) population data

³⁰ <http://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx>

³¹ <https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use-disorder-treatment>

³² [Center for Substance Abuse Treatment \(CSAT\). "Substance Abuse: Clinical Issues in Intensive Outpatient Treatment." Rockville \(MD\): Substance Abuse and Mental Health Services Administration \(US\); 2006. \(Treatment Improvement Protocol \(TIP\) Series, No. 47.\) Chapter 9. Adapting Intensive Outpatient Treatment for Specific Populations. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64083/#A89609](https://www.ncbi.nlm.nih.gov/books/NBK64083/#A89609)

Substance Use among California's American Indian and Alaska Native Populations

California has the largest AI/AN population in the United States. Approximately two percent of California's population, or 720,000 individuals, identify as AI/AN individuals. This represents 109 Federally Recognized Tribes, numerous State Recognized Tribes, and Non-Federally Recognized Tribes.³³ There are an estimated 78 state Tribes currently petitioning for Federal recognition.³⁴

Unlike other states, where most AI/ANs live on Tribal land owned by their own Tribe, California AI/ANs are dispersed across rural and urban areas throughout the state – a consequence of Federal Government policies that relocated AI/ANs from reservations to urban areas.³⁵ IHS, an agency within the US Department of Health and Human Services, provides direct medical and public health services to Federally Recognized AI/AN Tribes.³⁶ Access to health care services can be complicated for AI/AN populations because IHS facilities in California are limited,³⁷ and the diversity of Tribal and urban Indian organizations providing resources for opioid use disorder treatment varies regionally in California. There are ten Urban Indian Health Programs which serve AI/AN people in select cities with a range of services including community health, residential treatment and comprehensive primary health care services.³⁸

Nationally, from 1999 to 2009, death rates involving opioid pain relievers were higher among AI/AN than among any other racial or ethnic minority group.³⁹ According to SAMHSA, between 2006 and 2012, nearly 80 percent of AI/AN drug overdose deaths across Northwestern states (Washington, Idaho, and Oregon) were from prescription opioids (e.g., hydrocodone, oxycodone and oxycodone extended-release). In California, opioid overdose rates in AI/AN communities are extremely high.

³³ US Census, 2010; Bureau of Indian Affairs, 2014.

³⁴ California Courts, 2019.

³⁵ Intertribal Friendship House & Lobo, 2002.

³⁶ Indian Health Service, 2015.

³⁷ Indian Health Service California Area Office, 2015.

³⁸ Urban Indian Health Institute, 2017.

³⁹ Paulozzi, Kilbourne, & Desai, 2011.

Table 13: Average Native American Opioid Overdose Death Rate in California per 100,000 Residents, by County, 2015-2017

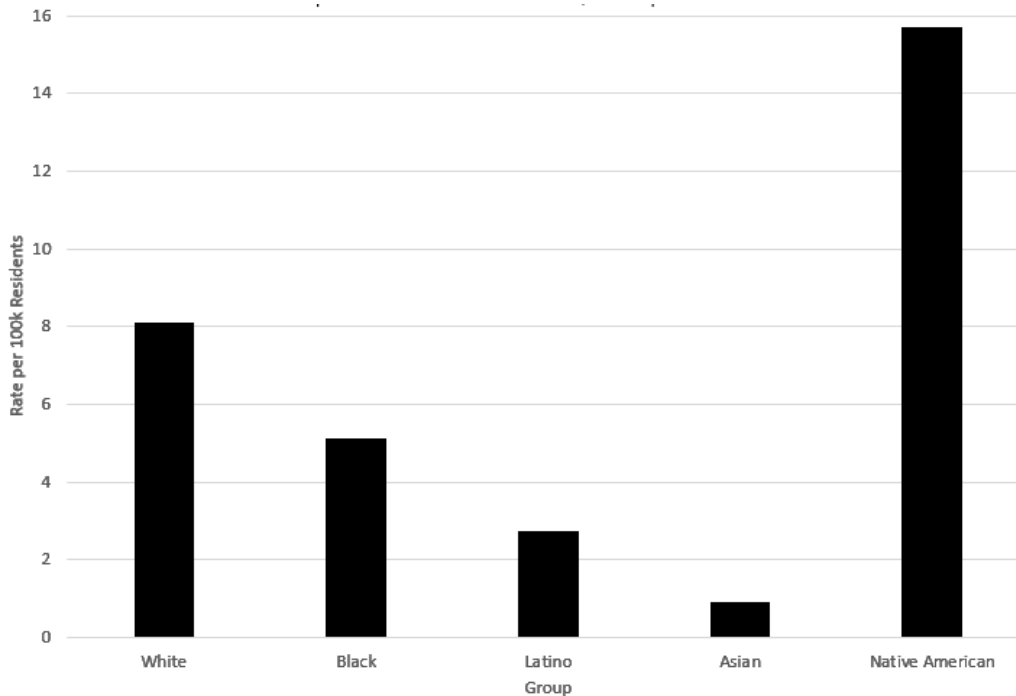
County	Number of Opioid Overdose Deaths
Tuolumne	65
Santa Barbara	55
Lake	52
Amador	47
Imperial	42
Marin	42
Humboldt	40
Ventura	40
Nevada	32
San Francisco	27
Mendocino	25
Placer	25
San Diego	25
San Joaquin	24
Merced	24
Yolo	23
Fresno	19
Siskiyou	16
Del Norte	15
San Bernardino	12
Orange	11
Kern	10
Riverside	9
Butte	8
Contra Costa	8
Sonoma	7
Los Angeles	7
Sacramento	6
Alameda	6
All Other Counties	0

Source: California Opioid Overdose Surveillance Dashboard.⁴⁰

AI/AN communities have disproportionately been impacted by the opioid epidemic with the second highest opioid-related overdose death rate compared to other ethnic groups.

⁴⁰ <https://discovery.cdph.ca.gov/CDIC/ODdash/>.

Figure 6: Opioid Overdose Deaths per 100,000 California Residents, by Race/Ethnicity, 2017



Source: CDPH Vital Statistics Multiple Cause of Death Files, California Opioid Overdose Surveillance Dashboard.⁴¹

As previously demonstrated in Figure 3, and mentioned above, data show a disproportionately higher rate of amphetamine related overdose deaths in the AI/AN population (16.8 per 100,000), it is based on small numbers and likely undercounts the total, making it less reliable.

The diversity among California AI/AN tribes, including regional differences in economic opportunities, tribal affiliation, and organization resources and infrastructure, requires a strong community-based, partnership approach to assess global statewide patterns in service availability, acceptability, and utilization, as well as capturing the unique challenges and service needs within each region.⁴²

Other Substance Use Disorder-Related Health and Societal Consequence Data

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

Over 242,274 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) cases were reported in California in 2016. Of those cases,

⁴¹ <https://discovery.cdph.ca.gov/CDIC/ODdash/>

⁴² "Statewide collaborative partnerships among American Indian and Alaska Native (AI/AN) communities in California to target the opioid epidemic: Preliminary results of the Tribal Medication Assisted Treatment (MAT) key informant needs assessment;" I. Zeledon, A. West, V. Antony, V. Telles, C. Begay, B. Henderson, J.G. Unger, C. Soto; Elsevier Journal of Substance Abuse Treatment, 10 April 2019.

8.4 percent identified injection drug use (IDU) as the exposure category. In addition, 8.7 percent of the 242,274 cases identified Men Who Have Sex with Men/Bisexual Male and IDU as the exposure categories. Thus, 17.4 percent of all HIV/AIDS cases were related to injection drug use.⁴³

In November 2015, SAMHSA’s CSAT State Project Officer notified DHCS that California’s AIDS case rate had fallen below threshold guidelines and, thus, the State no longer qualified as an HIV EIS designated state. As a result of this notification, on April 8, 2016, DHCS notified California’s 58 counties that beginning October 1, 2016, the State would no longer distribute SABG HIV EIS funding.

DHCS discontinued setting aside the SABG HIV EIS funds and now deems them to be discretionary funding normally expended by the counties for other SABG authorized SUD prevention, treatment, and recovery support services.

The statute requires “designated states” to expend five percent of each SABG award for HIV EIS. Per PHSA section 1924(b), a state is a “designated state” if its rate of cases of AIDS is 10 or more cases per 100,000 individuals. The statistical data for determining a designated state are based on the number of Stage 3 AIDS cases reported to and confirmed by the Director of the CDCP for the most recent calendar year for which data are available.

The matrix below shows California’s Stage 3 AIDS Infection Rate from the annual HIV Surveillance Reports produced by the CDCP, National Center for HIV/AIDS, by SFY:

Table 14: California’s Stage 3 AIDS Infection Rate (10 or more per 100,000), 2011- 2015

SFY	Rate
2011	11.6
2012	9.5
2013	8.6
2014	6.9
2015	6.3

Hepatitis C

In 2016, CDPH received 38,656 new reports of chronic Hepatitis C infections. The rate of newly reported chronic Hepatitis C infection in California increased 14 percent between 2014 and 2016, from 86 to 98.2 per 100,000 population. Chronic Hepatitis C remains one of the most frequently reported communicable diseases in California. The occurrence of chronic Hepatitis C infections among individuals ages 15-29 totaled 13,683, a 50 percent increase in the three-year period from 2014 to 2016. Individuals

⁴³ Data from CDPH, Office of Aids, Surveillance, Prevention, Evaluation and Reporting Branch, Cumulative HIV/AIDS Case Counts both Living and Dead, 2015-2017.

who inject drugs are more likely to be out of care and thus more likely to be undiagnosed and unreported, except when they are incarcerated in state prisons.⁴⁴

Tuberculosis-Intravenous Drug Use

In 2016, there were 2,062 cases of Tuberculosis reported in California. Of these cases, 23 (1.1 percent) occurred within the IDU population, compared to 27 (1.3 percent) reported in 2015.⁴⁵

Motor Vehicle Incidents

Substance use contributes to the rate of injuries and deaths resulting from traffic crashes. Therefore, data on motor vehicle collisions and impaired drivers provides a valid indicator of substance use consumption and consequences. The data used in this report come from the Statewide Integrated Traffic Records System (SWITRS).

SWITRS is operated by the California Highway Patrol (CHP) in partnership with the California Department of Motor Vehicles. The SWITRS database includes all property damage and injury crashes investigated by police in all California jurisdictions. In the 2014 SWITRS report, the CHP reported 1,053 alcohol-involved fatal collisions with 1,155 individuals killed statewide. Additionally, there were 16,821 alcohol-involved injury collisions, with 23,993 individuals injured.

Criminal Justice Substance Use Disorder-Related Arrests

Substance use-related arrests occur when individuals are taken into custody because they have violated alcohol or other drug laws. Alcohol law violations include driving under the influence, public drunkenness, and liquor law infractions. Drug law violations include arrests for possession of narcotics (heroin, opium, etc.), marijuana, dangerous drugs (barbiturates, phencyclidine, etc.), and other drugs. Although arrest data are only one indicator of the underlying incidence and prevalence of the substance use problem, the information gleaned from tracking these data also reflects the level of resources (e.g., funding and building of jails/prisons and correctional personnel costs) and attention (e.g., governmental priority) invested by the public and private sectors to address consequences.

The Monthly Arrest and Citation Register (MACR) database, kept by the California Department of Justice, contains statewide arrest data for juveniles ages 10-17 and adults ages 18+. In 2016, MACR reported:

- 421,370 felony and misdemeanor arrests for substance use-related violations (201,380 for alcohol and 219,990 for other drugs) out of 1,113,428 arrests (37.8 percent).

⁴⁴ https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ChronicHCVSurvReport_ExecSum_2016.pdf

⁴⁵ https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB_Report_2016_Tables.xlsx

- Of this population, 413,678 were adults and 7,692 were juveniles.
- Among adults, 200,000 arrests were for alcohol and 213,678 arrests were for other drugs.
- Among juveniles, there were 1,380 arrests for alcohol and 6,312 arrests for other drugs.
- Cumulatively, there were 38,988 felony arrests for other drugs, and 5,228 were for alcohol. There were 196,152 misdemeanor arrests for alcohol, and 181,002 misdemeanor arrests for other drugs.

These data highlights the need for collaboration between SUD policy planners and the criminal justice system. It should be noted that in November 2014, California voters passed Proposition 47 that reduced some felony offenses (such as drug offenses) to misdemeanors. These changes affected the number of felony offenses reported. Caution should be used when comparing felony and misdemeanor arrest data to prior years.

CURRENT SUBSTANCE USE DISORDER PREVENTION AND TREATMENT ACTIVITIES 45 CFR § 96.133(a)(2)

As determined by statute, this section of the SNAP Report fulfills the requirement for the single state agency receiving SABG funds to provide a detailed description of the state's current SUD prevention, treatment, and recovery support services. This includes the following:

- 1) a detailed description of DHCS's intended use of SABG funds relating to prevention and treatment,
- 2) a detailed breakdown of primary prevention strategies used, including specific activities conducted and the age, race/ethnicity and gender of the special population being served by the prevention activity,
- 3) a detailed description of California's SUD treatment capacity,
- 4) a description of entities that provide treatment and primary prevention services and the services provided; and,
- 5) information on treatment utilization to describe the type of care and the utilization according to primary diagnosis of alcohol or drug abuse, or a dual diagnosis of drug and alcohol abuse

Intended Use of Funds Relating to Prevention and Treatment

DHCS currently allocates SABG funds to all 58 California counties who oversee delivery of SUD services at the local level. DHCS is also responsible for monitoring each county's appropriate use of SABG funds for county-level SUD services including SUD treatment, treatment services for pregnant and parenting women (PPW), and treatment services for adolescents and youth, as well as primary prevention services. All counties receiving SABG funding must contract with DHCS through a state-county contract that outlines agreements pursuant to federal rules, state laws and regulations, safety codes,

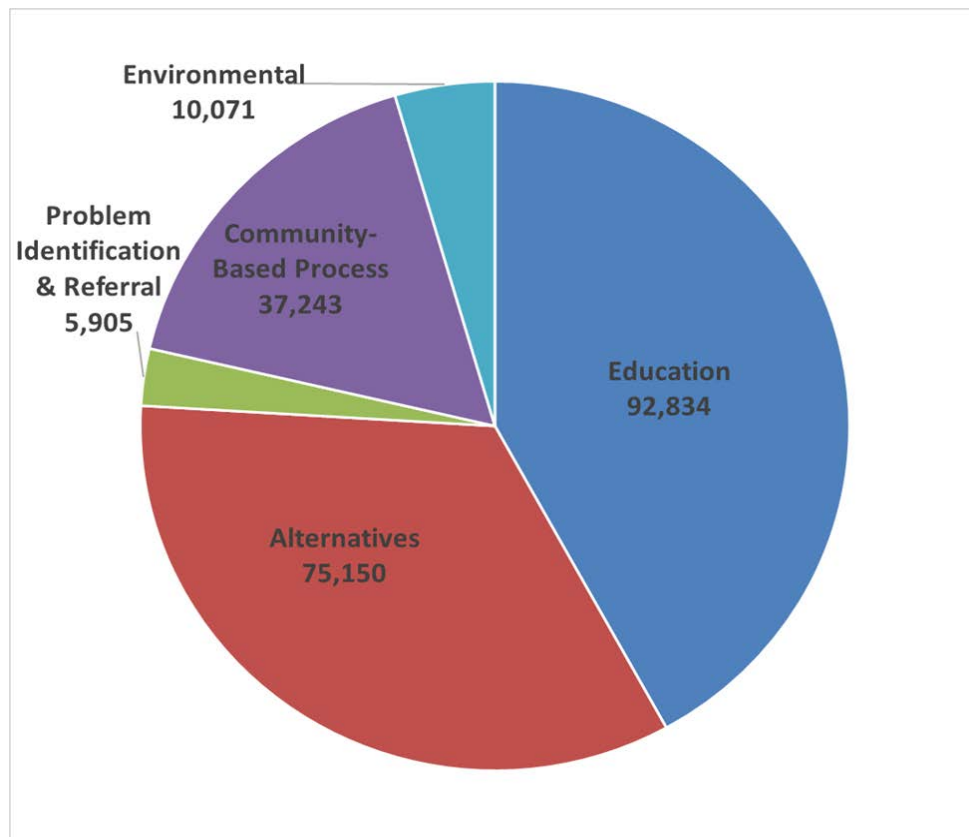
and other SUD delivery requirements. Counties provide services directly to beneficiaries or enter into agreements with subcontractors to deliver SUD services. Additionally, DHCS oversees the federal Anti-Drug Abuse Act of 1988 requirement that, for the fiscal year for which the grant is provided, no less than five percent of the providers receiving SABG funds be reviewed by peers independent from the funding source. This process, otherwise known as the Independent Peer Review (IPR), assesses the quality, appropriateness, and effectiveness of treatment and recovery services.

Description of Statewide Primary Prevention Capacity

Approximately \$40 million of California’s SABG funds are disbursed to each of its 58 counties to conduct locally-identified primary prevention activities. Every three to five years, each county is required to conduct a SUD needs assessment and use those data to develop a Strategic Prevention Plan (SPP) based on the elements of SAMHSA’s Strategic Prevention Framework (SPF). Activities are identified based on local needs which include service deliveries from each of the six prevention strategies as defined by SAMHSA’s Center for Substance Abuse Prevention (CSAP).

Primary Prevention Activities – Strategies Used

Figure 7: Number of Individuals Served by Primary Prevention Service Strategies, SFY 2016-2017



Information Dissemination Strategy

Information Dissemination is a strategy for which it is challenging to collect quantitative and demographic data as recipients take the form of a broad audience of general population. The most commonly reported Information Dissemination Strategy activities for SFY 2016-17 were:

- Speaking Engagements/Health Fairs Attended/Promotions Conducted
- Printed Materials/Brochures/Pamphlets Developed and Disseminated
- Media Campaign Development and Implementation
- Websites Developed

Specific Information Dissemination Strategy Activities Conducted:

Prescription Drug Summit⁴⁶ – On September 19-20, 2018, San Diego County conducted their annual summit on Pain Management and Opioid Drugs. The event was a joint event with the 30th World Summit on Psychology, Psychiatry and Psychotherapy and the 7th International Conference on Addictive Disorders, Addiction Medicine and Pharmaceuticals.

Marijuana Summit⁴⁷ – On April 25, 2018, the Coalition for a Safe and Healthy Arden Arcade and the Sacramento County Coalition for Youth presented the first annual Sacramento Marijuana Prevention Summit. As the region began implementing recreational marijuana legalization, their goal was to prevent adverse consequences in their youth.

San Diego Rx Abuse Task Force⁴⁸ – The San Diego Prescription Drug Abuse Task Force is a Countywide initiative comprised of key stakeholders, community members and local experts working together to decrease the harms associated with the misuse and abuse of prescription drugs in San Diego County.

Let's Talk Cannabis⁴⁹ – The Let's Talk Cannabis Community Toolkit is designed by CDPH to help individuals start a conversation in their community about how cannabis (marijuana) affects our bodies, minds and health. The toolkit includes customizable fact sheets, a media advisory template, information and message points, a data slide deck, a summary of cannabis licensing and regulation and more. These ready-to-use digital resources can be printed, downloaded, and shared in community settings and on social media.

⁴⁶ <https://opioids.conferenceseries.com/scientific-program>

⁴⁷ <https://sacscip.org/wp-content/uploads/2018/02/Marijuana-Prevention-Summit-1.pdf>

⁴⁸ <https://www.sandiegorxabusetaaskforce.org/>

⁴⁹ <https://www.cdph.ca.gov/Programs/DO/letstalkcannabis/Pages/Community-Toolkit.aspx>

[Ventura County Limits](http://www.venturacountylimits.org/)⁵⁰ –Ventura County hosts the Ventura County Responds website to provide information and resources to address the opioid crisis and the resulting heroin abuse epidemic.

[Future Forward: Youth Marijuana Prevention Campaign](http://sacramentoccy.org/)⁵¹ – The Sacramento County Youth Marijuana Prevention Campaign is web- and social media-based and designed to reach youth and parents, providing updated information on the law, the drug itself and the effects of marijuana on youth. The goal is to educate the Sacramento Community, offer information and resources, and provide an opportunity to get involved in creating change to protect young people from increased accessibility to marijuana in the community.

Education Strategy

Prevention service activities reported as the Education Strategy include SUD prevention classroom and educational services for youth and adult groups, mentoring, parenting and family management services, peer leader programs, theatre troupes, and groups for children of substance abusers. The most commonly reported Education Strategy activities for SFY 2016-17 were:

- Classroom Educational = 58,226
- Educational Services for Adult Groups = 13,711
- Educational Services for Youth Groups = 8,803
- Small Group Sessions = 4,563
- Parenting/Family Management Services = 3,939

Specific Education Strategy Activities Conducted:

- Botvin LifeSkills Training Parent Program – Alameda, Contra Costa, Monterey
- Botvin LifeSkills Training Student Program – Del Norte, Fresno, Kings, Lassen, Los Angeles, Monterey, Plumas, Sacramento, Tehama, Tulare, Sutter-Yuba
- Guiding Good Choices – Glenn, Los Angeles, Orange
- Project Alert – Fresno, Humboldt, Lake, Los Angeles, Orange, San Joaquin, Santa Barbara, Sutter-Yuba
- Project SUCCESS – Alameda, Amador, Contra Costa, Humboldt, Lake, Los Angeles, Napa, Orange, San Joaquin, Santa Barbara, Sonoma, Sutter-Yuba
- Strengthening Families – Butte, Glenn, San Benito, San Francisco, Santa Clara, Sutter-Yuba
- Too Good for Drugs – Amador, Fresno, Imperial, Los Angeles, Mendocino, Santa Clara

⁵⁰ <http://www.venturacountylimits.org/>

⁵¹ <http://sacramentoccy.org/>

Alternative Strategy

A majority of the activities reported within the Alternative Strategy include those conducted for and by participants in California's youth development model, [Friday Night Live \(FNL\)](#)⁵². Forty-nine out of fifty-eight counties coordinate FNL Chapters in many of their local, junior high and high schools, as well as in local community centers. The most commonly reported Alternative Strategy activities for SFY 2016-17 were:

- Youth/Adult Leadership Activities = 39,996
- Substance Use-Free Social/Recreational Events = 25,007
- Recreational Activities = 5,076
- Community Service Activities = 3,766

Specific Alternative Strategy Activities Conducted:

FNL Chapter Activities – The FNL program encourages peer-oriented, youth-driven, and youth-led programming and empowers young people as active leaders and community resources. Currently, 49 out of 58 California counties have active chapters in several of their school districts.

FNL Roadmap – The FNL Roadmap Chapter Program and Guide was created to lead FNL chapters through an action process modeled after the five steps of the SPF: Assessment, Capacity Building, Planning, Implementation, and Evaluation. Chapters pursue a solution that has a policy change component by first determining the vision and doing the initial research on the issues and problems.

FNL Youth Leadership Training Summit and Technical Assistance – The FNL Program is managed by the [Tulare County Office of Education, California Friday Night Live Partnership \(CFNLP\)](#).⁵³ The CFNLP coordinates TTA to each county's FNL Program Coordinator and each Chapter's FNL Administrator. The CFNLP also coordinates an annual training summit for young people to develop leadership and life skills.

Problem Identification and Referral Strategy

Of the six CSAP primary prevention strategies, the Problem Identification and Referral Strategy is the most misunderstood because it appears to crossover from primary prevention into intervention and treatment. A key aspect of this strategy is that the services and/or activities are geared toward behavioral change, not therapy for SUD treatment. California is careful to make subrecipients aware that administration of addiction diagnosis and severity instruments, case management, and/or preparation for treatment intervention are not components of this strategy and cannot be funded with the SABG Primary Prevention Set-Aside dollars. The most commonly reported Problem Identification and Referral Strategy activities for SFY 2016-17 were:

- Prevention Screening and Referral Services = 3,522

⁵² <https://fridaynightlive.tcoe.org/>

⁵³ <http://www.tcoe.org/CFNLP/index.shtm>

- Student Assistance Programs = 2,383

Specific Problem Identification and Referral Strategy Activities Conducted:

Brief Risk Reduction Interview and Intervention Model⁵⁴ – The Brief Risk Reduction Interview and Intervention Model (BRRIM) is the innovative prevention process designed to screen and educate individuals in the Selected or Indicated Institute of Medicine Risk Category who may be at high risk for alcohol and other drug problems but have not yet been determined as being in need of treatment. BRRIM is currently implemented in three California counties.

Student Assistance Programs⁵⁵ – Local behavioral health agencies and local education agencies work together in many counties on identifying problem behaviors that affect academic success. Student Assistance Programs (SAP) are a flexible model that can be customized to fit the infrastructure and staffing available at a school-site or district. SAPs can be initiated by the school/district and are often supported by county behavioral health or community based agencies.

Community-Based Process Strategy

This strategy predominantly reflects activities pertaining to the planning and coordination of prevention services, and TTA. The community-based process strategy includes serving and providing guidance to individuals who are “Intermediaries” (social workers, beverage servers, policy makers, law enforcement, etc.). The secondary impact on these participants is delivered through later actions of their agencies/services. The most commonly reported Community-Based Process Strategy activities for SFY 2016-17 were:

- Technical Assistance = 22,232
- Community/Volunteer Training = 9,465
- Training Services = 5,546
- Multi-Agency Coordination/Collaboration = 15,408 services
- Assessing Community Needs/Assets = 3,820 services
- Evaluation Services = 2,086 services

Specific Community-Based Process Strategy Activities Conducted:

The Strategic Training and Education for Prevention Planning Project⁵⁶ – The Strategic Training and Education for Prevention Planning (STEPP) Project is a process specifically designed to help counties and agencies develop a SPP. Contractually, DHCS requires counties to develop a three- to five-year SPP to identify specific alcohol and other drug problems, and develop goals and objectives to guide services and activities to address their prevention needs. The 16-month STEPP support process

⁵⁴ http://www.npnconference.org/wp-content/uploads/2015/10/Individual_Prev_Service_Poster.pdf

⁵⁵ <https://www.cde.ca.gov/ls/he/at/sap.asp>

⁵⁶ <http://www.ca-cpi.org/welcome-to-a-new-year-of-the-stepp-project/>

includes group activities, one-on-one technical assistance, and topical resources. STEPP Project training and technical assistance services are also available to other state entities and prevention professionals developing strategic plans.

[Statewide Opioid Safety Workgroup](#)⁵⁷ – The Statewide Opioid Safety (SOS) Workgroup, spearheaded by CDPH, provides a forum to encourage collaboration across various state sectors to align activities and messages in addressing the opioid epidemic in California. The SOS Workgroup brings together over 40 state-level, local-level, and non-government stakeholder organizations/agencies to improve coordination and expand joint efforts.

[Northern Sierra Opioid Safety Coalition](#)⁵⁸ – Plumas, Lassen, Sierra, and Modoc Counties have teamed up to create a regional coalition intent on effecting change in their communities. Their website provides resources for opioid safety and tools and strategies for rural opioid work.

[The Sacramento County Coalition for Youth](#)⁵⁹ – The Sacramento County Coalition for Youth (SCCY) is a youth coalition led by the Sacramento County Office of Education and supported by the Behavioral Health Services Division of the Sacramento County Department of Health Services. SCCY engages youth, families, schools, neighborhoods, and communities reflective of the cultural, racial, ethnic, linguistic, and Lesbian Gay Bisexual Transgender Questioning diversity in Sacramento County. Their current focus is on underage and binge drinking and underage marijuana use.

[San Marcos Prevention Coalition](#)⁶⁰ – The San Marcos Prevention Coalition’s mission is to reduce youth alcohol and drug use and advocate for safe and healthy neighborhoods by improving environmental norms and community policies and enhancing efforts to promote and deliver effective substance abuse prevention.

[Community Coalition](#)⁶¹ – Community Coalition, also known as CoCo, is an organization based in South Los Angeles that works with residents (Black and Latino) to empower young people in order to influence policies and transform their community. Their youth program, South Central Youth Empowered thru Action, leverages SABG Primary Prevention funding with multiple funding sources to address a variety of social issues including SUD.

[Environmental Strategy](#)

The Environmental Strategy consists of efforts to change public laws and policies that limit social and commercial availability of alcohol, tobacco or marijuana products that

⁵⁷ <https://www.cdph.ca.gov/Pages/StatewideOpioidSafetyWorkgroup.aspx>

⁵⁸ <https://www.plumascounty.us/2448/Northern-Sierra-Opioid-Safety-Coalition>

⁵⁹ <http://sacramentoccy.org/index.cfm?go=Main.AboutUs>

⁶⁰ <http://sanmarcospreventioncoalition.org/>

⁶¹ <http://cocosouthla.org/>

may appeal to youth, such as flavored malt beverages, novelty marijuana products, and vape liquids.

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

- Compliance: Training – Commercial Host and Management = 4,735
- Compliance: Training – Social Host and Management = 3,225
- Compliance: Retailer/Vendor Education = 1,466

The highest service frequencies reported for this strategy were:

- Environmental Other = 9,339 services
- Policies and Regulations = 3,214 services
- Media Strategies = 2,656 services
- Efforts with City and/or County Officials = 2,535 services

Specific Environmental Strategy Activities Conducted:

[Sonoma Responsible Beverage Service Training Program](#)⁶² – Sonoma County leverages SABG funding to provide responsible beverages service (RBS) trainings to its business owners, managers and employees regarding California State Alcohol Beverage Control Laws and regulations, local city and county alcohol ordinances, preventing service to minors, and checking legally acceptable forms of identification. In some areas of Sonoma County, RBS training is mandated every three years by Municipal Code or Conditional Use Permit.

[Healthy Stores for a Healthy Community](#)⁶³ – In 2012, the Let’s Get Healthy California Task Force developed a ten year plan that included six goals and key indicators to measure progress toward becoming the healthiest state in the nation. The Healthy Stores for a Healthy Community (HSHC) is a coalition of public health advocates specializing in tobacco control, nutrition and alcohol prevention are working together to improve the health of Californians through changes in community stores and to educate people on how in-store marketing influences consumption of unhealthy products. DHCS and many communities across California have participated in HSHC Town Hall Meetings focusing on mobilizing neighborhood retailers not only to make healthier food choices available, but to place them more prominently in their stores, as well as purposefully placing alcoholic beverages and tobacco products less prominently as to reduce accessibility to minors.

⁶² <http://sonomacounty.ca.gov/Health/Services/Responsible-Beverage-Service-Training/>

⁶³ <https://letsgethealthy.ca.gov/the-healthy-stores-for-a-healthy-community-campaign/>

[Storefront Signage Affects Health and Safety – A Plan to Limit Storefront Signage in Selma](#)⁶⁴ – The Fresno County Department of Public Health created a plan to limit storefront signage in Selma. They organized a workgroup to strategize and develop a plan to present to the Selma City Council. To align with the HSHC statewide campaign, the County Departments of Behavioral and Public Health continues to concentrate its efforts on reducing signage on visible facilities that market and promote unhealthy choices, including alcohol, tobacco, and unhealthy food products.

[Commercial Cannabis Regulation in Unincorporated Alameda County](#)⁶⁵ – Alameda County adopted ordinance amendments addressing standard conditions of cannabis retail operators making it illegal for a “retail operator to deliver, distribute, provide or allow to be provided cannabis to any person except those persons who are 21 years of age or older or who are 18 years of age or older and primary caregivers, qualified patients or persons with an identification card, as defined by California Health and Safety Code section 11362.7.”

[Prescription Drug Take Back Days](#)⁶⁶ – Countless numbers of counties and communities across California have conducted prescription drug take back days. For example, the Northern Sierra Opioid Safety Coalition and the Plumas County Department of Public Health have coordinated with the Plumas County Sheriff’s Department and the Drug Enforcement Agency to promote Drug Take Back Days year-round.

Primary Prevention Activities – Demographics

Gender

More males than females were served in SFY 2016-17 (see Table 15). The general population of California contains fewer males than females while individuals self-identifying as “other” is not reported in the larger population by DOF demographic sources. However, national information from the NSDUH 2017 Report supports the conclusion that both sexes start out with similar drinking rates (based on past month data), but male drinking becomes more prevalent with age. Accordingly, these gender differences will require future targeted planning efforts.

⁶⁴ <https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/substance-use-disorder-prevention>

⁶⁵ <https://www.acgov.org/cda/planning/landuseprojects/medical-cannabis.htm>

⁶⁶ <https://www.plumascounty.us/2468/Drug-Take-Back-Days>

Table 15: Number of Individuals Served by Primary Prevention Service Strategies, by Gender, SFY 2016-2017

Gender	Persons Served	California Population	Percentage of Population Served	Percent of Total Population by Gender
Male	118,175	19,685,009	0.6%	49.7%
Female	102,243	19,925,547	0.5%	50.3%
Other	788	N/A	N/A	N/A
Total	221,206	39,610,556	0.6%	100%

Source: CalOMS Pv

Age

Prevention services are primarily provided to youth under age 25 (see Table 16). Youth ages 12-17 were the largest group of recipients of prevention activities, even though this group makes up only 4 percent of California’s population. The fewest number of individuals served occurred for ages 65+, 0.1 percent of the general population. Approximately four out of every 1,000 persons ages 0-11, approximately 15.4 percent of California’s total population, are participating in some kind of publicly-funded, primary prevention service activity.

Table 16: Number of Individuals Served by Primary Prevention Service Strategies, by Age Group, SFY 2016-2017

Age Group	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Age
0 – 11	22,200	6,101,588	0.4%	15.4%
12 – 17	125,703	3,136,957	4.0%	7.9%
18 – 25	29,995	4,209,550	0.7%	10.6%
26 – 44	24,454	10,423,446	0.2%	26.3%
45 – 64	11,712	10,081,167	0.1%	25.5%
65+	7,142	5,657,848	0.1%	14.3%
Totals	221,206	39,610,556	0.6%	100%

Source: CalOMS Pv

Race/Ethnicity

The Race/Ethnicity demographic in CalOMS Pv data is categorized by non-Hispanic White, Asian American, Hispanic/Latino, AI/AN, African American, Multiracial/Ethnic, Hawaiian/Pacific Islander, and Other. As displayed in the following tables and charts, Multiracial/Ethnic is combined with Other in CalOMS Pv data. For comparison, the category of Other was used in the California population data from the California DOF for 2017.

Table 17 provides a brief summary of all prevention services delivered in SFY 2016-17, by race/ethnicity group. To control for the wide variations in the total numbers of each

race/ethnic group in the general California population, rates per 1,000 are utilized. This method allows more valid comparisons of the proportions of each group who are receiving some type of prevention service. The highest number of persons served by Primary Prevention Services Strategies is the Hispanic group (391 per 1,000), closely followed by White (386 per 1,000). The remaining groups, in order of highest number of persons served, were Asian (131 per 1,000), African American (57 per 1,000), Other/Multiracial (27 per 1,000), AI/AN (40 per 1,000), and Pacific Islander (40 per 1,000).

Table 17: Number of Individuals Served by Primary Prevention Service Strategies, by Race/Ethnicity, SFY 2016-17

Race/Ethnicity	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Race/Ethnicity
Hispanic	89,933	15,468,912	0.6%	39.1%
White	81,101	15,303,554	0.5%	38.6%
Asian	16,678	5,200,016	0.3%	13.1%
African American	15,079	2,269,951	0.7%	5.7%
Other/Multiracial	13,059	1,053,464	1.2%	2.7%
American Indian/Native American	2,977	171,820	1.7%	0.4%
Pacific Islander	2,379	142,839	1.7%	0.4%
Totals	221,206	39,610,556	0.6%	100%

Source: CalOMS Pv

Description of Statewide Substance Use Disorder Treatment Capacity

Integration to a Behavioral Health Model

Until June 30, 2019, two divisions within DHCS oversaw the SUD system of care: Substance Use Disorder Program Policy and Fiscal Division (SUD-PPFD) and Substance Use Disorder Compliance Division (SUD-CD). While both divisions had similar and overlapping roles in administering the SUD system of care, SUD-PPFD was largely responsible for providing leadership, coordination, administration, monitoring, and oversight of DMC, DMC-ODS, and SABG-funded programs.

SUD-CD was responsible for issuing licenses and certifications to SUD treatment providers, as well as monitoring and ensuring that licensed and certified SUD providers were compliant with state and federal laws, regulations, and other governing requirements. SUD-CD also approved initial applications, submissions and renewals, assessed licensing and certification fines and fees, conducted site visits, provided technical assistance, resolved complaints, conducted death investigations, and, oversaw all narcotic treatment and driving-under-the-influence programs. Both divisions

had responsibilities in reviewing, approving, and monitoring providers in the DMC Program and the DMC-ODS waiver.

Moving forward, these SUD Divisions will be integrated with the Mental Health Services Division for a more efficient program administration that provides for better accountability, improved service delivery, decreased processing times, and increased communication and engagement for stakeholders and employees.

Behavioral Health Stakeholder Advisory Committee

In 2019, the Behavioral Health Stakeholder Advisory Committee (BH-SAC) was created as an ongoing effort to integrate behavioral health with the rest of the health care system, and bring together several existing committees and workgroups that have advised DHCS on behavioral health issues and provided feedback on proposed program design. The new committee will replace some existing stakeholder groups including the Driving Under the Influence Advisory Group, NTP Advisory Committee, Performance Outcomes System Stakeholder Advisory Committee, Interagency Prevention Advisory Council (IPAC), and the Youth Advisory Group (YAG). The BH-SAC will advise DHCS on the behavioral health components of the Medi-Cal program, as well as behavioral health policy issues, including DMC, and SUD Treatment and Prevention.

Drug Medi-Cal State Plan Services

The DMC contract between DHCS and contracting counties specifies that the contracting county “shall establish assessment and referral procedures and shall arrange, provide, or subcontract for covered services in the Contractor’s service area.” Covered DMC State Plan services include:

- ODF treatment;
- Narcotic replacement therapy;
- Naltrexone treatment;
- IOT; and,
- Perinatal Residential Substance Abuse Services (excluding room and board).

In 2018, DHCS notified counties of their obligation to provide, arrange or subcontract for all contracted DMC State Plan services.

Drug Medi-Cal Organized Delivery System Waiver Expansion

DHCS continues its efforts to expand SUD services through participation in the 1115 Demonstration Waiver program. Counties choosing to participate in DMC-ODS receive Federal Financial Participation reimbursement for an expanded array of SUD services for Medi-Cal enrollees, compared to the existing DMC State Plan system, as shown below in Figure 9.

Figure 8: Drug Medi-Cal Organized Delivery System Benefits vs. Drug Medi-Cal State Plan Benefits

DMC-ODS Benefits	DMC State Plan Benefits
Outpatient Drug-Free Services	Outpatient Drug-Free Services
Intensive Outpatient Treatment Services	Intensive Outpatient Treatment Services
Residential Treatment (multiple levels of care for all enrollees with no bed number limitation)	Perinatal Residential Treatment (perinatal only with 16 bed limitation)
Withdrawal Management (ASAM continuum)	Inpatient Hospital Detoxification
Narcotic Treatment Program Services	Narcotic Treatment Program Services
Recovery Services	
Case Management	
Physician Consultation	
Additional Medication Assisted Treatment (optional)	
Partial Hospitalization (optional)	

As of July 1, 2019, 30 California counties have opted into the DMC-ODS waiver and have contracted with DHCS to provide SUD services as prescribed by the DMC-ODS waiver. As California enters the final year of its 1115 Waiver pilot program, DHCS intends to expand the DMC-ODS waiver programs to California’s rural and frontier counties through collaboration with Partnership Health Plan. DHCS will also seek an extension of the DMC-ODS waiver in its next waiver renewal application.

Substance Abuse Prevention and Treatment Block Grant

With broadened implementation of DMC and DMC-ODS, DHCS began evaluating utilization of the SABG, reminding counties to utilize SABG as a payer of last resort. This shift has allowed for increased prevention, early intervention and recovery support services to be funded using the SABG discretionary dollars. DHCS created a SABG Policy Manual⁶⁷ as a tool for counties to better understand allowable use of SABG. The SABG manual is a living document that, in the future, will be amended to align with statewide DMC policy.

Medication Assisted Treatment Expansion Project

Finally, DHCS’s MAT Expansion Project is well underway. The Tribal MAT Expansion Project was a core component of the original California MAT Expansion Project and is continued through the California MAT Expansion Project 2.0. In close partnership with representatives of the communities being served, DHCS developed the Tribal MAT Project with special consideration for Tribal and Urban Indian values, culture, and treatments.⁶⁸ DHCS sees the project as a vehicle to expand primary prevention outreach and education to this hugely underserved population.

⁶⁷ https://www.dhcs.ca.gov/services/Documents/SABG%20Policy%20Manual/SABG_Policy_Manual_V1.pdf

⁶⁸ <http://www.californiamat.org/2019/05/20/tribal-mat/>

DHCS collaborates with the CDPH SACB to analyze administrative data on deaths, hospital discharges, and ED encounters to track the numbers and rates of SUD-related health consequences. Currently, data on the opioid crisis strongly indicates there is an increasing need for statewide provider training in pain management, recognition of addiction symptoms and referral to effective MAT for opioid use disorders. The data also highlight the continuing need for broader substance abuse education and prevention, and for increased availability of MAT and other SUD treatment.

Youth Services

Early Periodic Screening, Diagnostic, and Treatment Services

Consistent with state and federal law and regulations for Early Periodic Screening, Diagnostic, and Treatment (EPSDT), Medi-Cal covers all medically necessary services, including those to “correct or ameliorate” defects and physical and mental illnesses or conditions. This includes behavioral health services. In California, on-line resources are available to inform counties on the use of the EPSDT benefit at no-cost to individuals under age 21 who are Medi-Cal eligible.⁶⁹

Youth Treatment Infrastructure

According to the most recent DHCS Licensing and Certification Section Status Report, there were only 193 residential beds for youth statewide. Additionally, the Status Report identified only 21 homes as Department of Social Services licensed group homes that provide residential services to youth.

Early Intervention services for at-risk youth are implemented in a variety of settings in California involving family, school, and the community, and may consist of assessment and screening. SABG funding largely covers the costs of early intervention for at-risk youth because these services are not reimbursable under DMC or DMC-ODS.

DHCS allocates approximately \$7.3 million of the SABG Award per year for adolescent treatment and recovery. Generally, these are services for adolescents in group home settings that aren’t otherwise covered under Medi-Cal. Other SABG funded services for youth include services for transitioning into the community after discharge from institutional facilities, recovery programs in the community, and life skills services at school sites as a component of the comprehensive treatment plan. However, further TTA for counties on how to best utilize SABG to fill gaps in service for youth early intervention, treatment and recovery is needed.

Youth Stakeholder Involvement

Until 2019, DHCS had been collaborating with a variety of partners and interested stakeholders, through the YAG. The work of the YAG was to modify the existing Youth Treatment Guidelines and improve operative standards for youth SUD services. Understanding the gap in access to youth residential treatment, DHCS worked within

⁶⁹ <https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Coverage-for-EPSDT.pdf>

the YAG to collect further information and data on the geographical challenges and locations of residential treatment beds for youth. The YAG also collected information that will be used to inform next steps for California to educate and maintain an adequate number of SUD professionals trained to address the specific and complex needs of youth. As of April 2019, this work will be carried out by the BH-SAC.

In addition, the California Institute for Behavioral Health Solutions (CIBHS), under a grant from the Blue Shield of California Foundation, sponsored a youth summit to examine promising and best practices in adolescent early intervention and treatment. Summit participants included administrators, local partners, and other stakeholders. The summit provided the time to build collaborative partnerships that were key to designing and delivering SUD services.⁷⁰

Proposition 64

On November 8, 2016, Prop. 64 was passed by voters allowing adults, ages 21 years or older, to possess and use marijuana for recreational purposes. Prop. 64 created two new taxes, the revenues of which are deposited into the California Cannabis Tax Fund. In the Governor's SFY 2019-2020 budget, DHCS was allocated approximately \$119 million from the cannabis tax fund to be used specifically for SUD education and prevention services for youth. DHCS is in the beginning stages of program planning and implementation. Over time, the revenue source created by Prop. 64 will allow for expanded and improved evidence-based youth SUD prevention programming in California. Prior to passage of Prop. 64, the SABG 20 percent Primary Prevention Set-Aside was the largest source of prevention dollars allocated to county and local organizations.

Pregnant and Parenting Women

DHCS continues to prioritize service delivery to the PPW population. DHCS annually updates the following items: the county monitoring tool, the Perinatal Practice Guidelines (PPG)⁷¹, formerly the Perinatal Services Network Guidelines, and the Perinatal Directory.

Perinatal Practice Guidelines

The PPG is a set of established policies, guidelines, and best practices to address SUD treatment services for women, specifically PPW seeking or referred to SUD treatment. The purpose of the PPG is to ensure California providers deliver quality SUD treatment services and adhere to state and federal regulations. The PPG provides guidance on perinatal requirements in accordance with DMC and the SABG Perinatal Set-Aside. Providers must adhere to the requirements as outlined in the PPG.

⁷⁰ <https://www.cibhs.org/conference/adolescent-early-intervention-and-sud-treatment-summit>

⁷¹ https://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf

[County Monitoring of SABG-funded Perinatal Programs](#)

The county monitoring tool is used during on-site monitoring visits to ensure counties are meeting the requirements for SABG-funded treatment programs for the PPW population. The section of the monitoring instrument that addresses the PPW population outlines specific requirements in the PPG. These requirements are based on the requirements set forth in 45 CFR § 96. Over the next two years, the following priority areas for PPW will be addressed in the monitoring instrument:

- Case Management
- Outreach and Engagement
- Capacity

[Perinatal Directory](#)

The Perinatal Directory provides information on publicly funded SUD treatment programs for women and children in California. This directory provides detailed information about programs for women and children including address, contact information, and program service modalities. The Directory is to ensure that California counties have access to a comprehensive list of SUD treatment programs for PPW.

2016-17 Independent Peer Review Project

In accordance with the Federal Anti-Drug Abuse Act of 1988, and as a requirement for receiving SABG funding, DHCS annually selects peer reviewers to perform independent peer reviews on at least five percent of providers receiving SABG funds. Through its IPR Project process, DHCS selects reviewers for their expertise in the field of alcohol and drug use treatment. Reviewers must be representative of the disciplines used by the program; knowledgeable about the modality; and understand the program's theoretical approach to SUD treatment. Reviewers must also be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

[Report Summary](#)

DHCS entered into a three-year contract with the California Consortium of Addiction Programs and Professionals (CCAPP) to administer the peer review process and produce the SFY 2016-17 IPR Report.

DHCS randomly selected 40 programs to review from Inyo, Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties. CCAPP was contracted to review licensed or certified SUD non-residential treatment programs, county outpatient programs, detoxification programs, perinatal programs, and NTPs receiving SABG funds.

CCAPP sent recruitment letters to programs in the counties being reviewed announcing the IPR Project and enclosing an application for consultants. DHCS reviewed each responding application for appropriate experience and specified qualifications and selected eight reviewers. CCAPP conducted a training and orientation session at the

CCAPP office in Sacramento, California, prior to beginning the reviews. During this orientation session, the peer review instruments and the on-site, peer review process were thoroughly explained.

Summary of Independent Peer Review Findings, Conclusions, and Recommendations

Design and Approach

- Reviewers found that 100 percent of the programs reviewed had a clearly defined target population and provide services appropriate to the needs of that population.
- 85 percent were observed to impact parents, spouses, siblings, and significant others as appropriate.
- 90 percent of the programs seem to be initiating some innovative approaches and utilizing various resources and networks to accomplish this goal.

Staff

- 100 percent of the programs reported that staff turnover is not a factor for their facility.
- 90 percent of facilities were staffed by individuals with the appropriate credentials, training, and ratio for clients served.

Client Records/Assessments

- Reviewers found that an assessment was conducted prior to and/or on the day of admission in 80 percent of the facilities reviewed.
- 80 percent of programs found the assessment provided sufficient information on which to base a recovery and treatment plan.

Client Records/Recovery and Treatment Planning

- In 85 percent of programs reviewed the files were complete and the recovery/treatment plans were appropriate. Goals and objectives were clearly stated and progress towards said goal was charted.

Client Records/Program Notes

- 90 percent of program notes show that goals and objectives identified in the recovery/treatment plan are being addressed.
- 90 percent of the programs are reported to document group notes in such a way that notations for an individual are recorded if necessary.

Client Records (Discharge and Aftercare Planning)

- 90 percent of the discharge plans appear to be individualized and to address identified client needs at discharge.

- Accordingly, 90 percent of the programs suggest that planning begins before discharge and there is evidence of post-discharge follow up in 80 percent of the programs.
- 100 percent of programs reviewed provide relapse prevention counseling.

Case Management/Ancillary Services

- The programs appear to devote adequate resources to reviewing the clients' progress in 100 percent of the reviews, while records indicate appropriate referrals for client and family in 90 percent, and family services appear to be a vital part in 90 percent of the programs.

Quality Assurance Improvement

- 100 percent of programs reported formal quality assurance/improvement plans or procedures.
- 80 percent of the programs have an adequate system for tracking the progress of clients through various program levels.
- 90 percent of the programs monitor themselves to determine a need for program changes.

Physical Environment

- 100 percent of the programs are reported to have an ambience that is conducive to a positive and supportive recovery/treatment environment.
- 100 percent of the reviewers found the environment safe and secure for staff and clients.

Recovery/Treatment Environment

- Reviewers reported that 100 percent of the programs reviewed appear to be actively and effectively engaging clients in recovery/treatment.
- Clients appear to progress in the program environment in 100 percent of the programs.
- This year 100 percent of programs have a policy in place to determine client satisfaction.

Network, Continuum, Diversity of Funding

- 90 percent of the programs were reported to have linkages and good relationships within the community and with other social service programs.
- 90 percent have a variety of funding sources.

Identities of Service Providers and Their Programs

Each California County is responsible for providing SUD treatment and primary prevention services through their behavioral health, public health or AOD office, or through contracts with local service providers. Counties are responsible to provide DMC State Plan services or DMC-ODS services, and SABG primary prevention and

treatment services to their own resident beneficiaries. SUD residential and NTP facilities must be licensed by DHCS. DHCS's Provider Enrollment Division must certify programs before they provide DMC State Plan or DMC-ODS SUD treatment services. SUD primary prevention providers are not licensed or certified by DHCS, however, DHCS provides oversight and technical assistance to counties, as they are responsible for ensuring that providers properly adhere to the same provisions and conditions as in their state-county contract.

As of February 2019, there were 1,889 licensed and/or certified SUD treatment facilities providing DMC State Plan or DMC-ODS services to Californians. As of June 2017, there were 246 providers authorized by DHCS specifically to provide primary prevention services to Californians.

Treatment Utilization

DHCS develops annual "served" counts using our CalOMS Tx database. These data allow DHCS to use the state management information system to track treatment capacity and service utilization.

Unique Beneficiaries Served

Unique beneficiaries served means all beneficiaries admitted during the year and beneficiaries admitted prior to the current year that continue to receive treatment services during the year. Using CalOMS Tx data submitted to DHCS, there was a slight decrease in the last several years in the counts of beneficiaries served.

- During SFY 2016-17, approximately 186,000 unique beneficiaries were served, approximately 9,000 fewer beneficiaries than were served in SFY 2014-15.

Total Served

The term "total served" means all admissions to all service types (e.g., Detoxification, Residential, and Outpatient) during the year plus all admissions prior to the current year that continued to receive treatment services during the year. Each admission is counted for beneficiaries who have multiple admissions during the year. DHCS uses these "served" counts to estimate the number of admissions in which the beneficiary is still participating in treatment to estimate current "active" treatment participation.

- During SFY 2016-17, the total served count was approximately 240,000 (about a 3.6 percent decrease from the 249,000 reported in SFY 2014-15).

For SFY 2016-17, the following are the percentages served in each major service type:

- ODF: 36.3%
- NTP Maintenance: 31.2%
- Residential: 17.0%

- Residential Detoxification: 9.3%
- IOT: 4.0%
- NTP Detoxification: 2.2%

Examination of the various service types shows the following trends from SFY 2014-15 through SFY 2016-17:

- There were decreases in ODF and NTP Detoxification.
- There were slight increases in Residential Services, IOT, and NTP Maintenance.
- Non-NTP Detoxification was relatively stable.

One-Day Counts

DHCS calculates one-day counts using CalOMS Tx data as a method to estimate SUD service capacity. For instance, over 86,000 beneficiaries were in treatment on April 1, 2017. A sample of one-day counts throughout the year or over multiple years would show that one-day counts vary. Still, one-day counts provide an estimate of capacity on a given day. The one-day count uses a similar methodology as the “served” count to estimate the number of beneficiaries enrolled in treatment on a given day, regardless if the admission was opened during the current or prior fiscal year.

The distribution of the one-day capacity count among the service types was as follows:

- NTP Maintenance: 58.6%
- ODF: 29.7%
- Residential: 8.1%
- IOT: 2.4%
- Residential Detoxification: 0.5%
- NTP Detoxification: 0.6%

Treatment Beneficiary Admission and Discharge Information

DHCS analyzes CalOMS Tx data on beneficiaries receiving SUD treatment services in publicly-funded treatment programs and all private, for-profit NTP programs, regardless of funding source. The following summarizes information from the analysis of SFY 2016-17 data.

- There were about 160,000 admissions to treatment during SFY 2016-17. This includes admissions to publicly monitored SUD detoxification, residential, and outpatient services.
- There were about 120,000 unique beneficiaries admitted to treatment during the year.

Beneficiaries having multiple admissions to treatment during a year account for the difference between the number of admissions and the number of beneficiaries. Admission counts can provide more current information on service utilization and more

current trends since served counts also include beneficiaries admitted prior to the year (some many years ago) that are still in treatment.

Regarding treatment service type, the approximate admission-based percentages were as follows:

- ODF: 40%
- Residential (short-and long-term): 22%
- NTP Maintenance: 16%
- IOT: 5%
- Detoxification: 17%

Detoxification by itself does not constitute complete SUD treatment. It is considered a precursor to treatment and designed to treat the physiological or medical effects of SUD. Detoxification is often short term and repeated numerous times over a person's lifetime, given the chronicity of SUD, a disease that is characterized by patterns of repeated relapse leading to stability.

Since 17 percent of the admissions in CalOMS Tx were for detoxification during SFY 2016-17, including them in the analyses would distort the beneficiary characteristic statistics. Thus, for the summary below, detoxification admission data were not included. The figures in this section reflect admission data for over 133,000 non-detoxification admissions.

[Beneficiary Characteristics](#)

Gender

- Males: 60%
- Females: 40%

Race/Ethnicity

Race/ethnic proportions for SFY 2016-17 were about the same as for SFY 2014-15. Admissions by race/ethnicity were as follows:

- Non-Hispanic Whites: 42%
- Hispanics: 39%
- African Americans: 10%
- Asian/Pacific Islanders, AI/AN, Multi-Racial, and Other: 8%

Age at Admission

Compared with SFY 2014-15, SFY 2016-17 admissions among beneficiaries ages 18 and younger declined from 10 percent to 8 percent, ages 18-25 admissions were stable, and ages 26-35 admissions increased from 32 percent to 35 percent. Beneficiary admissions among beneficiaries ages 36+ were also stable.

- Under 18: 8%
- 18-25: 17%
- 26-35: 35%
- 36-45: 20%
- 46-54: 14%
- 55+: 7%

Primary Drug Reported at Admission

The primary drug reported at treatment admission is defined as the drug causing the greatest dysfunction to the beneficiary at the time of admission.

- Methamphetamine: 33%
- Heroin: 25%
- Alcohol: 18%
- Marijuana: 15%
- Other opiates and opiate synthetics: 3%
- Cocaine: 3%
- Oxycodone/OxyContin: 1%
- Other drugs: 1%

The main changes from SFY 2014-15 to SFY 2016-17 are a slight increase in heroin-related admissions from 23 percent to 25 percent, and a small decrease in marijuana-related admissions, from 17 percent to 15 percent.

Discharge Statistics

During SFY 2016-17, there were over 157,000 discharges from treatment services (i.e., detoxification, residential, outpatient) for about 122,000 unique beneficiaries. Like admissions, beneficiaries may have multiple discharges in a given year since a discharge is submitted at the end of each treatment service to which they were admitted. This accounts for the difference between discharge counts and beneficiary counts. Detoxification services are short in duration, often repeated multiple times a year, and therefore excluded from the analyses in this section so as not to bias the discharge statistics.

- There were over 131,000 non-detoxification discharges in SFY 2016-17.

There are two main types of discharges from treatment:

- Standard discharge: The beneficiary is asked all the CalOMS Tx discharge questions that are used to measure beneficiary outcomes.
- Administrative discharge: The beneficiary is not available to answer the CalOMS Tx questions at discharge (i.e., stopped attending treatment sessions, died, or was incarcerated). The provider completes a minimum set of questions (e.g., discharge date, discharge status).

During SFY 2016-17, the percentages of discharges were as follows:

- 56% were standard discharges
- 41% were administrative discharges

It is necessary to increase the number of standard discharges to obtain more information about beneficiary outcomes. This will improve services and treatment.

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

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

Until all treatment providers consistently use these criteria to measure “completed treatment,” DHCS will not use specific discharge statuses to measure this concept.

[Length of Stay](#)

The length of stay is the number of days a beneficiary stays in treatment from admission to discharge. Research verifies that longer stays in treatment are associated with positive outcomes. Conversely, shorter lengths of stay (e.g., fewer than 30 days), especially for ODF services, are related to a lack of engagement in treatment and poor treatment outcomes.

The length of treatment varies depending on the type of service and beneficiary needs (e.g., severity of SUD problem, family issues, etc.). Also, some treatment services have time limitations. For example, most residential treatment services do not exceed 90 days. Treatment often consists of several service types, progressing from more-intensive to less-intensive services (e.g., residential to outpatient). This “step down” continuum of care is often needed because of the severe nature of the illness at treatment admission and potential for relapse. The analyses in this summary are based on the length of beneficiary service stays (e.g., residential treatment) rather than the combined length of multiple service stays. Only treatment services that may last more than 30 days are described.

- The longest stays occur in NTP maintenance services, with 33 percent of the beneficiaries receiving services for over one year.
- Over 44 percent of the beneficiaries receiving ODF services, and almost 37 percent in intensive day-care programs, stayed 90 or more days.
- In SFY 2016-17, about 32 percent of ODF stays were 30 or fewer days compared to only 26 percent in SFY 2014-15.

This last statistic indicates an opportunity to improve treatment engagement strategies for treatment providers with higher rates of short stays.

Beneficiary Outcome Measures

Historically, SUD treatment beneficiary outcomes measurements referred to changes in beneficiary functioning in seven life domains:

- Alcohol Use
- Other Drug Use
- Employment/Education
- Legal/Criminal Justice
- Medical/Physical Health
- Mental Health
- Social/Family

DHCS asks the same beneficiary functioning questions (e.g., frequency of primary drug use in the past 30 days) at two points in time:

- Upon admission to treatment
- Upon discharge from treatment

DHCS determined changes in beneficiary functioning by matching the admission to the discharge record and comparing the responses to the same question at these two times. For simplicity, DHCS categorized responses into two groups: “positive” actions (e.g., no drug use) and “negative” actions (e.g., used drugs one or more times). DHCS referred to the changes in beneficiary functioning resulting from SUD treatment as “beneficiary outcomes.”

DHCS has worked with various subcommittees to reach the conclusion that it is often better to use beneficiary functioning at discharge to measure outcomes, instead of comparing admission and discharge data. For instance, it is a more objective outcome measure to count the percent abstinent in the 30 days prior to treatment discharge rather than the change in abstinence from 30 days prior to admission to 30 days prior to discharge. One would expect that almost all beneficiaries entering treatment are using drugs, whereas all beneficiaries would have either reduced or achieved abstinence at treatment discharge. However, many beneficiaries admitted to a treatment service are coming from controlled environments (e.g., jail, prison) or other SUD treatment services. Many beneficiaries report not using drugs in the month prior to admission. Also, participation in social support recovery activities is more important prior to discharge from treatment when the beneficiary is moving in the continuum of care from the treatment phase to the longer-term recovery phase (e.g., disease management) that follows.

Moreover, there are variations across counties and years in the percentage of discharges that are administrative. DHCS uses this type of discharge when the

beneficiary leaves the treatment service abruptly, and the provider is unable to contact the beneficiary (in person or by phone). For administrative discharges, very limited discharge data are collected. Because counties often cannot contact the beneficiary to collect data on the beneficiary's functioning at discharge, these data are sometimes not collected, and therefore all outcomes cannot be measured.

The largest percentage of admissions to treatment each year is to ODF services (as compared to Residential, NTP, or Detoxification services). ODF is also usually the last service type in an episode of treatment services. A treatment episode refers to when a beneficiary progresses through several treatment types with fewer than 30 days between them (e.g., the beneficiary may first go into detoxification, then residential, and finally ODF services in a "step-down model" from more intensive and shorter term stays to less intensive outpatient). DHCS used this methodology (examining the percentage of beneficiaries meeting the desired level of beneficiary functioning at discharge while ignoring the number of administrative discharges) to report on ODF beneficiary outcomes in five key areas. Missing discharge data are frequently the result of beneficiaries leaving treatment early and therefore not being available for a discharge interview. It is likely that these beneficiaries have worse outcomes in the 30 days prior to discharge than beneficiaries who were available for the interview. This means the missing data could bias pre/post outcome comparisons by making the differences appear more positive than they would if discharge outcome data were available for all beneficiaries. Administrative discharges and reports missing data increased from about 39 percent in SFY 2012-13 to almost half of all reports in SFY 2016-17.

From SFY 2012-13 through SFY 2016-17 there was little change in the treatment outcomes for ODF beneficiary with standard discharges. Approximately 97 percent of the beneficiaries had no arrests in the 30 days prior to discharge, and about 91 percent were not homeless. Adequate social support fluctuated slightly, but stayed at about 51 percent of beneficiaries. Employment steadily increased over the years from about 25 percent to just over 34 percent. No alcohol or other drug use fell from 75 percent to just over 71 percent. Note that the above statistics are based on just half of those entering treatment. Outcome data were not reported for 47.6 percent of the beneficiaries.

TECHNICAL ASSISTANCE NEEDS TO CARRY OUT SABG ACTIVITIES, INCLUDING COLLECTION OF INCIDENCE AND PREVALENCE DATA 45 CFR § 96.133(a)(3)

California invests in the provision of technical assistance for services across the continuum of care. DHCS considers the need for technical assistance as critical a component in the effective advancement of DHCS's statewide goals and objectives as is the collection of quality incidence and prevalence data. This section provides information about available technical assistance and training to California's SUD professionals and outlines future training needs.

Current Technical Assistance Capacity

[The Regents of the University of California, Los Angeles](#) – DHCS entered into a contract with The Regents of UCLA, Integrated Substance Abuse Programs (ISAP), to provide evaluation services and technical assistance on the current SUD treatment system with specific emphasis on the impact of policy changes (e.g.: ODS Waiver) on system performance, patient outcomes, access, and collaboration. This includes evaluation of whether policy changes are associated with improvements in SUD treatment access, coordination of services, and quality of care; as well as recommends strategies to improve policies, practices, and data quality. The report also includes an evaluation to measure and monitor outcomes of the DMC-ODS, using information gathered from existing state data sources, as well as new data collected specifically for the DMC-ODS evaluation. Quantitative methods were used to analyze trends, while qualitative methods were used to help interpret quantitative data.

[California Institute for Behavioral Health Solutions](#) – The CIBHS assists mental health and SUD professionals through a variety of training methods to help providers deliver effective services. For example, on October 23-24, 2018, CIBHS held the Cultural Competence Summit, “Honoring California’s Diversity: A Call to Action,” which focused on highlighting innovative programs to reduce stigma and increase behavioral health services and substance use treatment to underserved communities. The conference objectives aimed to educate and inform attendees about effective cultural strategies for reaching diverse populations.

[University of California, San Francisco](#) – DHCS contracted with the University of California, San Francisco (UCSF) to provide training and technical assistance to SUD professionals and providers throughout California. UCSF conducted a series of three trainings in each of five regions of the state and provided technical assistance on the application of Evidenced Based Practices for Early Intervention, Cognitive Behavioral Therapy, and Trauma-Informed Therapy. UCSF will implement these trainings in five regions across the state. DHCS recognizes the need to make future opportunities for TTA on evidence-based treatment practices available to the SUD workforce.

[ONTRACK Program Resources, Inc.](#) – DHCS contracted with ONTRACK Program Resources, Inc. (ONTRACK) to provide TTA around implementing a pilot program in Alameda County on the National Standards for Culturally and Linguistically Appropriate Services (CLAS). The pilot program makes CLAS TTA available to staff who provide direct services to African American transitional age youth ages 18-25 and adults receiving SUD treatment. The pilot program objective seeks to increase community involvement and support for SUD recovery services, raise SUD treatment completion rates, and increase positive treatment outcomes for all beneficiaries receiving treatment. Alameda County performed services resulting in the development of an outreach plan to provide training for SUD professionals to implement CLAS materials in residential treatment programs for this special population. DHCS and ONTRACK intend that the CLAS materials be customizable for use in CLAS trainings for other special populations

throughout the state. In the future, DHCS will use a data-informed approach in its purchasing decisions, and determination of target populations.

[Center for Applied Research Solutions](#) – CARS is the contractor that implements the Community Prevention Initiative (CPI). The CPI is a no-cost TTA platform that provides SUD providers with a vast array of resources on science-based prevention. Through the CPI, CARS provides annual learning communities, regional trainings, scientific briefs and individualized TTA services. Topics of TTA include, but are not limited to, strategic prevention planning and evaluation, social determinants of health, best practice strategies to serve at-risk youth or build community capacity to address problems directly attributable to substance use.

[California Friday Night Live Partnership](#) – CFNLP serves as a technical assistance intermediary, with a focus on providing the FNL field with the most relevant training opportunities in an effort to support the successful implementation of FNL programs throughout California. DHCS will continue to collaborate with CFNLP to offer training materials, toolkits and in-person trainings upon request, free of charge, to each county or region through various modalities, all with the aim of building the capacity of FNL coordinators, staff, agency and community partners, and of course, FNL youth.⁷²

Substance Use Disorder Primary Prevention Workforce

To meet the ongoing challenge to expand the role of California Certified Prevention Specialist (CCPS) certified individuals, a potential next step is to assess the prevention field's readiness to acknowledge and accept prevention roles that converge on health care and community-setting boundaries. Employing CCPS-certified individuals within their communities builds community trust that can lead to reducing health disparities at the local level.

DHCS has expanded the number of training opportunities aligning with each of the required domains of the International Certification and Reciprocity for Prevention, and expanded trainings offered through the CPI on social determinants of health, prevention ethics and cultural competency.

Substance Use Disorder Treatment Workforce

UCLA, ISAP conducted a survey and published "California's Drug Med-Cal Organized Delivery System 2018 Evaluation Report"⁷³ that provided data outcomes of the DMC-ODS demonstration project. The report indicated the following outcomes were needed in the field:

1. County tailored trainings on evidence-based data to ensure high priority issues can be addressed in a timely manner.

⁷² <https://fridaynightlive.tcoe.org/technical-assistance>

⁷³ <http://uclaisap.org/dmc-ods-eval/assets/documents/2017-2018%20UCLA%20DMC-ODS%20Evaluation%20Report%2011192018.pdf>

2. Trainings to help counties with staff retention to lower staff turnover.
3. Provide TTA in the following areas: American Society of Addiction Medicine Criteria assessment and placement, patient flow along the continuum of SUD treatment, especially provision of additional service after discharge from residential treatment and withdrawal management, and evidence-based practices.
4. Consider additional technical assistance on the implementation of the case management benefit with a focus on:
 - a. Overall understanding of the service terms, case management and care coordination, in the context of the SUD continuum of care and whole person care under the DMC-ODS, and
 - b. Billing and reimbursement strategies for allowable services.
5. Facilitate collaborative learning on a variety of implementation topics related to care coordination. In many cases, counties were struggling with very complex issues (e.g. the best ways to approach case management, care coordination across systems, transitioning patients from one level of care to another, linkage to and delivery of recovery support services, and/or overcoming financial barriers to expansion). These may be best addressed via collaborative learning efforts.

Independent Peer Review Project Reviewer Feedback

The review teams solicited feedback from the programs on the IPR Project process. The observations conveyed that reviewers were respectful, courteous, and professional throughout. Reviewers were valued for their skills, knowledge, and insight. In short, programs reported that the IPR process itself was useful and helpful for program development. TTA recommendations made to beneficiary programs included training on:

- Trainings for DMC compliance
- Grant writing assistance
- Family and group training
- Trauma-informed care
- Training on DSM to *International Classification of Diseases, 10th Edition*
- On-site training for staff to obtain Continuing Education Units
- File management and documentation
- Education for parenting and family wellness
- Education on 42 CFR
- Education on Electronic Health Records
- Facilitator trainings of evidence-based practicum
- Evidence-based curriculum and group therapy

Additional Technical Assistance Needs

In addition to the technical assistance needs noted in the Executive Summary section of this Report, additional TTA is needed to help strengthen existing statewide capacity to work across systems and with special populations. These needs are noted below.

[Collaborating with American Indian/Alaska Native Communities](#)

As identified in the SUD consequence data for California's AI/AN populations, there is a need to improve access to health care services. However, building partnerships with the multitude of tribal governments in California, and understanding the history of the relationship between the government and tribes, and general information about tribal governance and cultures is needed. Therefore, DHCS will look to available resources to provide TTA in this area.

[Expanding Youth Services](#)

As discussed in the SUD Treatment Capacity section of this SNAP Report, youth services are a high priority in California. DHCS is actively collaborating with state, local, professional and individual stakeholders to identify ongoing needs, DHCS recognizes the presence of gaps in SUD prevention and treatment services for California's youth, and will seek TTA to address these gaps.

[Advancing the State Epidemiological and Evidence-based Practices Workgroups](#)

State Epidemiological Workgroup

The vision of California's State Epidemiological Workgroup (SEW) is to enhance statewide analytical capacity by functioning as an expert data advisory group that recognizes the importance of regular statewide evaluations to monitor and track outcomes. SEW provides support for SABG, current and future federal discretionary grants, as well as provides data advisory group support to multiple state-level efforts. An Executive Leadership Team functions as the core of the SEW, and plans, organizes, and leads efforts related to the following:

- Peer review data, data analyses, and evaluation methodologies and reports.
- Provide guidance to data collection efforts and encourage data-informed decision making to IPAC prevention priorities, multiple state departments, state indicator reports, the SNAP report, etc.
- Review, analyze and report trends related to substance use and mental health issues and disorders that cause harm.

Over the next year, DHCS will look to its TTA resources, and field experts of the SEW, to organize relevant data on current and emerging behavioral health issues and provide expert guidance with the development of programmatic evaluation deliverables.

Evidence-based Practices Workgroup

The vision of the Evidence-based Practices Workgroup (EBPW) for Primary Prevention is to expand the statewide use of evidence-based practices (EBP), programs, policies,

and strategies to positively impact statewide outcomes. The EBPW provides support for SABG, current and future federal discretionary grants, and provides input and support to multiple state, county, and provider efforts. EBPW works to streamline the process of moving from problem identification to achieving changes in outcomes. The methodology used will include the most efficient and effective methods to change behaviors, perceptions, attitudes, and policies related to consumption, consequences, and contributing factors of substance misuse and abuse. Currently, California uses a very narrow definition of EBPs that is limited to those listed on SAMHSA's National Registry of Evidence-Based Programs and Practices.

DHCS plans to seek TTA to assist in advancing the following work:

- Creating and sustaining a California-specific EBP model;
- Developing criteria to allow for and support innovation;
- Creating a well-defined EBP structure customized to local-control needs;
- Minimizing existing EBP tiers to lessen assessment and level of monitoring needed; and,
- Establishing a review committee to periodically assess the effectiveness of the framework and provide infrastructure to ensure longevity.

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

As mentioned previously, DHCS is in alignment with the 2020-21 Strategic Initiatives as outlined in "SAMHSA's Strategic Plan for FY 2019-23." DHCS has harmonized federal and state strategic priorities to leverage opportunities for service improvement to reduce consumption and prevent or minimize the harmful consequences of SUD.

Based on the data collected and the analyses performed during the production of this SNAP Report, the state has established the goals and objectives described below for improving SUD treatment and prevention activities, and will report on actions taken in support of these goals and objectives during the annual SABG Application process.

[Strategic Initiative #1](#): Reduce opioid misuse, use disorder, overdose, and related health consequences through continued implementation of the California MAT Expansion Project and the SPF PFS grant.

[Strategic Initiative #2](#): Reduce youth marijuana use and related consequences and contributing factors by expanding youth SUD prevention programs.

[Strategic Initiative #3](#): Improve access to SUD services through continued implementation of the DMC-ODS waiver, and advance county understanding of the use of SABG funding as it pertains to California's DMC program, especially in rural communities.

[Strategic Initiative #4](#): Broaden statewide availability of evidence-based, outcome-driven SUD services for youth across the continuum of care.

[Strategic Initiative #5](#): Increase the number of trained and culturally competent professionals and paraprofessionals to address California’s prevention, treatment and recovery workforce needs.

[Strategic Initiative #6](#): Expand and improve the data collection, analysis, evaluation, and dissemination of information related to SUDs and receipt of services.

EXTENT TO WHICH THE AVAILABILITY OF PREVENTION AND TREATMENT ACTIVITIES IS INSUFFICIENT TO MEET THE NEED FOR SERVICES, AND AVAILABILITY OF INTERIM SERVICES 45 CFR § 96.133(a)(5)

The State’s priority on reducing health care disparities between populations for SUD and other mental health disorder services provides opportunities to increase service capacity and to attain parity in providing SUD services. NSDUH’s data estimates are an invaluable resource in assisting DHCS with monitoring California’s treatment capacity. According to NSDUH’s estimates, 2,346,000 (7.2 percent) of Californians were in need of but did not receive SUD treatment; specifically:

- 921,000 (2.8 percent) Californians ages 12+ were in need of SUD treatment at a specialty facility for illicit drug use in the past year, compared with 1,125,300 (3.1 percent) in CY 2015-16; and
- 1,776,000 (5.4 percent) Californians ages 12+ were in need of SUD treatment at a specialty facility for alcohol use in the past year, compared with 2,260,600 (6.2 percent) in CY 2015-16.

Interim Services

The PHSA (42 USC § 300x-21 through 300x-66) authorizes the use of SABG funding and requires DHCS to provide interim services to IDUs and pregnant women, or IDU drug-using women seeking SUD treatment, who cannot immediately be admitted to a program due to capacity limitations. Pregnant, postpartum and parenting women, and IDUs in need of treatment, receive priority for admission to SUD treatment services. These federally-mandated, interim services are solely provided through a county-based system and are operationalized through state-county contracts between DHCS and the 58 counties. With successful implementation of the DMC-ODS waiver in a majority of California counties, and strict network adequacy requirements outlined in the DMC-ODS county contracts, It is important to note that wait lists are not allowed for Medi-Cal beneficiaries.

STATE INFORMATION MANAGEMENT SYSTEM 45 CFR § 96.133(a)(6)

California Outcomes Measurement System – Treatment

DHCS maintains the CalOMS Tx data system as the statewide database that provides data regarding all beneficiaries receiving SUD treatment services from

publicly-monitored treatment programs, including DMC, SABG, and all NTP programs, regardless of funding source and the outcomes achieved at the time of discharge from treatment. CalOMS Tx is used to report many facets of treatment including: treatment utilization, beneficiary admission and discharge information, length of stay, beneficiary outcome measures, and program performance measures.

Drug and Alcohol Treatment Access Report

DATAR is intended to provide essential information about the capacity of California's publicly-funded SUD treatment system to meet the demand for services. Treatment providers that receive state or federal funding through the state or county, as well as all licensed NTP providers, are required to send DATAR information to DHCS each month. The system is intended to retain information on each program's capacity to provide different types of SUD treatment to beneficiaries and assess how much capacity was utilized in a given month. DHCS is working with providers to improve the timeliness, reliability, and accuracy of the DATAR system to better meet beneficiary service needs.

California Outcomes Measurement System – Prevention

For many years, the CalOMS Pv data system was utilized for collection of SABG-required primary prevention information. The CalOMS Pv web-based system was designed to collect meaningful process and programmatic outcomes for all SABG-funded SUD primary prevention programs, as well as capturing data necessary for federal reporting requirements. The internal modules are organized according to the SPF (assessment, capacity, planning, implementation and evaluation). Every California County receiving SABG primary prevention set-aside funds has been required to enter data into CalOMS Pv. The system allowed users to extract county-specific data relevant for assessing future needs and evaluating the effectiveness of services specific to each county including:

- Targeted risk and protective factors;
- Services, activities and community prevention initiatives aimed at accomplishing county goals and objectives;
- Progress made on identified goals and objectives;
- IOM categories of risk; and
- Population(s) served.

As of 2017, the CalOMS-Pv data collection system has been phased out and replaced with the Primary Prevention SUD Data Service (PPSDS).

Primary Prevention SUD Data Service

As mentioned above, PPSDS replaced the CalOMS Pv data collection system formerly used by California counties to collect and report primary prevention SUD program and activity data. All counties and subcontracted providers funded with SABG primary prevention dollars are contractually obligated to report data that meets defined

standards of quality, data that are timely, logical, accurate, complete, and valid. PPSDS allows counties to enter their SPP including problem statements, goals, and objectives; CSAP Strategies; service deliveries; progress on goals and objectives; and evaluations of programmatic and process outcomes. Because the data are uploaded in real time, the information is immediately available for review by DHCS analysts for quality and appropriateness; as well as for meeting federal statutory reporting requirements.

CONCLUSION

DHCS will emphasize the six strategic initiatives, outlined herein, in DHCS's FFY 2020-21 SABG application, due to SAMHSA October 1, 2019. Through its continued strategic planning process, DHCS will examine each strategic priority and develop goals, objectives and strategies to address California's SUD problems. Contributing factors including economic, demographic, social, and environmental risks will also be considered throughout the planning process. DHCS will work collaboratively with its stakeholders and TTA providers to address system gaps, evaluate system efficiencies and effectiveness and make course correction where needed. Finally, the FFY 2020-21 SABG application priorities, goals, and performance measures must take into account and plan around the overarching and rapidly changing health care policy topics.

Stakeholders are invited to submit feedback through e-mail communications directed to SABGPublicComment@dhcs.ca.gov. DHCS looks forward to receiving stakeholder input upon the release and broad circulation of this SNAP Report. DHCS will place a strong emphasis on incorporating stakeholder feedback into the SABG continuous planning process.

APPENDIX A – LIST OF ACRONYMS

AI/AN.....	American Indian/Alaska Native
AIDS.....	Acquired Immunodeficiency Syndrome
ARDI.....	Alcohol Related Disease Impact
BH-SAC.....	Behavioral Health-Stakeholder Advisory Committee
BRFSS.....	Behavioral Risk Factor Surveillance System
BRIIMM.....	Brief Risk Reduction Interview and Intervention Model
CalOMS Pv.....	California Outcomes Measurement System – Prevention
CalOMS Tx.....	California Outcomes Measurement System – Treatment
CARS.....	Center for Applied Research Solutions
CCAPP.....	California Consortium of Addiction Programs and Professionals
CCPS.....	California Certified Prevention Specialist
CDCP.....	Center for Disease Control and Prevention
CDPH.....	California Department of Public Health
CFNLP.....	California Friday Night Live Partnership
CFR.....	Code of Federal Regulations
CHIS.....	California Health Interview Survey
CHKS.....	California Healthy Kids Survey
CHP.....	California Highway Patrol
CIBHS.....	California Institute for Behavioral Health Solutions
CLAS.....	National Standards for Culturally and Linguistically Appropriate Services
CPI.....	Community Prevention Initiative
CRIHB.....	California Rural Indian Health Bureau
CSAP.....	Center for Substance Abuse Prevention
CSAT.....	Center for Substance Abuse Treatment
CTEC.....	California Tribal Epidemiology Center
CY.....	Calendar Year
DATAR.....	Drug and Alcohol Treatment Access Report
DHCS.....	Department of Health Care Services
DMC.....	Drug Medi-Cal
DMC-ODS.....	Drug Medi-Cal Organized Delivery System
DOF.....	California Department of Finance
DSM-IV.....	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
EBP.....	Evidence Based Practices
EBPW.....	Evidence Based Practices Workgroup
ED.....	Emergency Department
EIS.....	Early Intervention Services
EPSDT.....	Early Periodic Screening, Diagnosis, and Treatment
FFY.....	Federal Fiscal Year
FNL.....	Friday Night Live
FPL.....	Federal Poverty Level
HIV.....	Human Immunodeficiency Virus
HSHC.....	Healthy Stores for a Healthy Community
IDU.....	Injection Drug Use
IHS.....	Indian Health Services

IOM Institute of Medicine
 IOT Intensive Outpatient Treatment
 IPAC Interagency Prevention Advisory Council
 IPR Independent Peer Review
 ISAP Integrated Substance Abuse Program
 MACR Monthly Arrest and Citation Register
 MAT Medication Assisted Treatment
 MIHA Maternal Infant Health Assessment
 NSDUH National Survey on Drug Use and Health
 NTP Narcotic Treatment Program
 ODF Outpatient Drug Free
 ONTRACK ONTRACK Program Resources, Inc.
 OSHPD Office of Statewide Health Planning and Development
 PHSA Public Health Service Act
 PPG Perinatal Practice Guidelines
 PPSDS Primary Prevention Substance Use Disorders Data System
 PPW Pregnant and Parenting Women
 Prop. 64 Proposition 64
 RBS Responsible Beverage Service
 SABG Substance Abuse Prevention and Treatment Block Grant
 SACB Safe and Active Communities Branch
 SAMHSA Substance Abuse and Mental Health Services Administration
 SAP Student Assistance Program
 SCCY Sacramento County Coalition for Youth
 SACB Safe and Active Communities Branch
 SEW State Epidemiological Workgroup
 SFY State Fiscal Year
 SNAP Statewide Needs Assessment and Plan
 SOS Statewide Opioid Safety
 SPF Strategic Prevention Framework
 SPF PFS Strategic Prevention Framework-Partnerships for Success
 SPP Strategic Prevention Plan
 STEPP Strategic Training and Education for Prevention Planning
 SUD Substance Use Disorder
 SUD-CD Substance Use Disorders-Compliance Division
 SUD-PPFD Substance Use Disorders-Program, Policy, and Fiscal Division
 SWITRS Statewide Integrated Traffic Records System
 TTA Training and Technical Assistance
 UCLA University of California Los Angeles
 UCSF University of California San Francisco
 USC United States Code
 YAG Youth Advisory Group

APPENDIX B – TABLE OF DATA SOURCES

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