FY 2021

Statewide Needs Assessment and Planning Report

California Department of Health Care Services

Community Services Division

Contents

INTRODUCTION

The California Department of Health Care Services (DHCS) publishes the Statewide Needs Assessment and Planning (SNAP) Report biennially as required by the Code of Federal Regulations (CFR) 45 CFR § 96.133 governing recipients of the Substance Abuse Prevention and Treatment Block Grant (SABG). According to 45 CFR § 96.133(a)(1) through (a)(6), DHCS shall submit to the Secretary of the U.S. Department of Health and Human Services (HHS) an assessment of the need for SABG-authorized activities in California. The report is organized in accordance with the applicable statute. DHCS makes the final SNAP Report available on its website as a resource for behavioral health programs to utilize in developing and/or modifying existing strategies, goals and objectives, or creating future ones.

In the 2021 SNAP Report, California presents a broad range of data collected between 2015 and 2019. The data are taken from the most recent sources available at the time the report was written. Some data sources collect and/or report data biennially, others on the calendar year (CY), State Fiscal Year (SFY) or Federal Fiscal Year (FFY). There are different date ranges for the data used, however they are all from the most recent and current data available for the source. Some data sources made changes to the wording in their survey questionnaires over the past two years. Because these changes may have elicited different responses from participants, DHCS cannot draw conclusions regarding the increases or decreases, or make comparisons for year over year data. In such cases, DHCS notes and provides prior year's data for reference only.

Department of Health Care Services
August 2021

EXECUTIVE SUMMARY

The 2021 SNAP Report provides compelling substance use and misuse data providing a high-level overview of California's substance use disorder (SUD) incidence and prevalence, its capacity to meet the behavioral health needs of individuals, and a preview of the state's Strategic Initiatives designed to minimize, if not close, the gaps exposed during the assessment phase.

The 2021 SNAP Report paints a robust picture of the data captured to measure California's SUD incidence and prevalence rates among its Drug Medi-Cal (DMC) beneficiaries, racial and ethnic groups, and youth, and identifies related service utilization, client outcomes, and program performance. California data shows that alcohol misuse for junior high- and high school-aged youth as well as misuse of prescription medications for high school-aged youth has declined since 2015. Survey respondents who were 18 years or older also show a decline in the misuse of prescription medication. The data also show that past 30-day marijuana use and age of first marijuana use for the same age group appears to be stable since 2015, however, because of changes to survey questions, it is impossible to make accurate statistical comparisons.

Even though the percentages of alcohol use and drug misuse seem to be stabilizing or even decreasing, the number of hospitalizations and deaths due to alcohol and drug misuse is a grim fact. An estimated annual average of 11,026 alcohol-attributable deaths occurred in California for the period 2011 through 2015. Males accounted for a majority of these deaths. In 2019, California hospitals tallied 49,000 emergency department (ED) visits and 22,000 hospitalizations for non-fatal drug overdose. During the same year, 6,219 Californians died from a drug-related overdose; 3,000 of those were opioid-related and 1,500 involved fentanyl. Another fact that emerged during DHCS's assessment of California's SUD consumption and consequence data is that while the nation battled the opioid use disorder epidemic, the state has seen an alarming increase in overdose deaths related to psychostimulants with abuse potential such as cocaine and methamphetamine since 2015.

In response to the needs of Medi-Cal beneficiaries, and to improve health outcomes for SUD treatment services, DHCS expanded SUD treatment services through its Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS is a Medicaid Section 1115 Waiver (1115 Waiver) demonstration project, approved by the federal government in 2015. California's DMC State Plan and DMC-ODS service data show a slight increase in the number of beneficiaries served by more than 1,000 SUD treatment facilities during SFY 2017-2018. A majority of those served by admission to treatment services were males between the ages of 26 and 35 years, who identify as white, non-Hispanic. Of the five treatment outcomes measures DHCS tracks for clients participating in outpatient treatment (also known as outpatient drug-free or ODF) treatment services, Employment has consistently increased since SFY 2013-2014.

The most current national estimates for Californians needing but not receiving treatment services show that less than 3 percent of Californians were in need of treatment services for illicit drug use, and less than 6 percent of Californians were in need of treatment services for alcohol use. This is largely due to California no longer permitting treatment delays due to waitlists, timely treatment access standards require DMC-ODS plans to ensure patients receive timely treatment.

In addition to the DMC-ODS, California continues to innovate through implementation of the State Opioid Response (SOR) Grants. These grant programs have helped to increase access to medications for addiction treatment (also known as medication-assisted treatment or MAT) and availability of naloxone through widespread implementation of the California MAT Expansion Project. ate, the MAT Expansion Project has created 650 new access point locations for opioid use disorder (OUD) treatment, and has saved approximately 7,500 lives through its Naloxone Distribution Project, serving California's most underserved and vulnerable populations. The state's newest effort, the Tribal MAT Project, will duplicate these efforts for as much of California's expansive tribal community as possible.

Beginning in SFY 2019-2020, DHCS began re-evaluating its SABG funding methodology. In SFY 2019-2020, DHCS revised its contracting process with counties into a longer-term performance contract, requiring a simplified annual application. This served to relieve the administrative burden of triennial contract renewals, as well as executing 57 contract and budget amendments, annually. DHCS also amended its rules whereby any county can now voluntarily accept or decline to receive an annual allocation of Perinatal Set-Aside and/or youth services funds. This change removes pressure from some of the more sparsely populated, remote counties who must refer youth or perinatal clients to a larger, neighboring county. It also benefits some of the larger counties who may be able to expend more perinatal and youth funds than they had been allocated previously. Most recently, DHCS received approval from the Substance Abuse and Mental Health Services Administration (SAMHSA) to allow use of SABG funds for Cost Sharing Assistance, and to allow DHCS to set-aside 5 percent of its SABG funding for oral fluid rapid Human Immunodeficiency Virus (HIV) testing services.

Additionally, DHCS announced a 5 percent increase in the minimum percentage of SABG primary prevention funding it would spend, from 20 percent to 25 percent. DHCS anticipates this will facilitate an increase in the number of primary prevention services reported for each SFY. For SFY 2017-2018, California served approximately 741,270 individuals using five of the six Center for Substance Abuse Prevention (CSAP) Strategies, including Education, Alternative, Problem Identification and Referral, Community-Based Process, and Environmental. The sixth CSAP Strategy, Information Dissemination, was widely employed during the SFY but the nature of these activities does not lend itself to individual counts. DHCS has carefully considered the data collected for the 2021 SNAP Report and used it to develop five Strategic Initiatives. California plans to prioritize these initiatives over the next two SFYs to improve access to and availability of SUD treatment and prevention services for Californians. DHCS will report progress toward the completion of these initiatives in its 2022

and 2023 SABG Annual Report, copies of which will be available to the public, via DHCS's website, upon final submission to SAMHSA.

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 measuring the incidence and prevalence of SUD for a specified period. "Incidence" refers to the 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. The SNAP Report focuses on SUD-related consumption and SUD-related consequence to provide a snapshot of the impact of SUD on individuals.

Data for the 2021 SNAP Report are the most current information available for 2017 through 2019. Depending upon the source, however, data may be broken down by different time divisions within that period. For example, sections of this report may compare data from the most recent CY available, versus data based on the SFY.

SUBSTANCE USE DISORDER-RELATED CONSUMPTION DATA

California Healthy Kids Survey [1]

The California Healthy Kids Survey (CHKS) is an anonymous survey administered biennially to students at grades 5, 7, 9, and 11. CHKS collects data regarding local youth health risks including behavioral health, school connectedness, school climate, protective factors, and school violence.

In California, alcohol use among youth has decreased. The 2017-2019 CHKS data in Table 1 groups the frequency of alcohol use in the past 30 days into increments of days. However, the combined total for 7th graders who reported they drank one or more drinks in the past 30 days is 4.2 percent, 9.3 percent of 9th graders, and 16 percent of 11th graders. In comparison, the 2015-2017 CHKS shows a combined total of 5.1 percent of 7th graders, 14.6 percent of 9th graders, and 22.5 percent of 11th graders stated that they had used one or more drinks of alcohol in the past month.

[1] The California School Climate, Health, and Learning Survey (CalSCHLS) System - Reports & Data

Table 1: Frequency of Alcohol Use (One or More Drinks) in the Past 30 Days

Frequency	Grade 7		Grade 9		Grade 11	
	2015-2017	2017-2019*	2015-2017	2017-2019*	2015-2017	2017-2019*
0 days	94.9%	95.8%	85.4%	90.7%	77.5%	84.0%
1 or 2 days	4.4%	3.4%	10.6%	6.7%	14.8%	10.4%
3 to 9 days	0.5%	0.6%	2.4%	1.7%	5.3%	3.5%
10 to 19 days	0.1%	0.1%	0.8%	0.5%	1.4%	1.0%
20 or more days	0.2%	0.1%	0.8%	0.4%	1.1%	1.0%

* For 2017-2019 CHKS cycle, there were changes to the survey question (past 30-day alcohol use), and the results may not be comparable to previous years.

The 2017-2019 CHKS reports the percentage of students using marijuana in the past 30-days by smoking, vaping, eating, or drinking as 3.6 percent among 7th graders, 9.7 percent among 9th graders, and 16.1 percent among 11th graders. On the 2015-2017 CHKS, 9.5 percent of 9th graders and 16.7 percent of 11th graders reported using marijuana. Because of language changes to CHKS questions between 2015-2017 and the 2017-2019 surveys, statistical trend comparisons on 9th and 11th graders' past 30-day marijuana use would be inconsistent.

Table 2: Current Marijuana Use (Past 30 Days)

Data Year	Grade 7	Grade 9	Grade 11
2015-2017	2.3%	9.5%	16.7%
2017-2019	3.6%	9.7%	16.1%

* For 2017-2019 CHKS cycle, there were changes to the survey question (past 30-day alcohol use), and the results may not be comparable to previous years.

When examining responses to CHKS's age of onset of marijuana use question, we find that 4.3 percent of 7th graders first used marijuana at age 11 or 12, 10.2 percent of 9th graders reported first time use at age 13 or 14, and 16.1 percent of 11th grade were 16 when they first began using marijuana. According to this data, the age of onset appears to be dropping to a younger age than in past years. California prevention providers have recognized the need to provide primary prevention services at younger ages and, according to Table 12 of this report, provided a majority of those services to 12 to 14 year olds in SFY 2017-2018.

Table 3: Age of Onset - Marijuana Use

Age of Onset	Grade 7		Grade 9		Grade 11	
	2015-2017	2017-2019*	2015-2017	2017-2019*	2015-2017	2017-2019*
Never	96.1%	93.7%	83.6%	83.6%	69.0%	70.4%
10 years or under	0.6%	0.9%	1.3%	1.3%	1.4%	1.2%
11/12 years old	2.4%	4.3%	3.7%	3.4%	3.3%	2.5%
13/14 years old	0.7%	0.7%	9.8%	10.2%	10.3%	8.4%
15/16 years old	0.0%	0.1%	1.4%	1.2%	14.8%	16.1%
17 years old	0.2%	0.3%	0.2%	0.3%	1.2%	1.3%

* For 2017-2019 CHKS cycle, there were changes to the survey question (past 30-day alcohol use), and the results may not be comparable to previous years.

The legalization of adult use of marijuana in California appears to be contributing to the perception that marijuana is not harmful.[2] Additionally, if slightly older peers of 12 to 17 year olds perceive very little harm in marijuana use, it is likely students may try marijuana at younger ages.

The 2017-2019 CHKS asked students in grades 9 and 11 about their past 30-day use of prescription pain medications to get “high” or for reasons other than prescribed. The question included examples of prescription pain medications such as Vicodin, OxyContin, Percodan, Ritalin, Adderall, and Xanax.

The results showed that 4.8 percent of 9th graders reported past 30-day misuse of prescription pain medications, a 1.5 percent decrease from 2015-2017. Two percent of 11th graders reported misusing prescription pain medications, a 2.4 percent decrease from 2015-2017. The CHKS data show a decline in past 30-day misuse of prescription medications for surveyed students in 2017-2019.

Table 4: Past 30-day Misuse of Prescription Pain Medication

Data Year	Grade 7	Grade 9	Grade 11
2015-2017	Not Asked	3.5%	4.4%
2017-2019	Not Asked	2.0%	2.0%

[2] https://calschls.org/docs/marijuana_use_vol_1.pdf; and https://calschls.org/docs/marijuana_use_vol_2.pdf

California Health Interview Survey [3]

The California Health Interview Survey (CHIS) is the largest state health survey in the nation. CHIS is a web and telephone survey that asks questions on a wide range of health topics. The University of California Los Angeles Center for Health Policy Research conducts this web- and telephone-based survey on a continuous basis allowing the survey to generate timely one-year estimates.

The 2019 CHIS asked youth aged 12 to 17 if they had ever had more than a few sips of any alcoholic drink. The survey results showed that 808,000 of them reported having more than a few sips, a 1.8 percent increase from 24.4 percent in 2018, to 26.2 percent in 2019.

Table 5: Ever Had More than a Few Sips of an Alcoholic Drink

Data Year	Percentage	95% CI	Population
2017	22.6%	15.0 - 30.1	662,000
2018	24.4%	16.4 - 32.4	753,000
2019	26.2%	22.4 - 29.9	808,000

In CY 2019, 14,910,000 (45.1 percent) respondents aged 12 and older reported having ever tried marijuana or hashish in any form. This is a 4.2 percent decrease from CY 2018. Of those who reported having ever used marijuana or hashish, 34.7 percent of respondents aged 18 years or older reported using it within the past 30 days, an increase of 1.6 percent over CY 2018, and an increase of 6.2 percent over CY 2017.

Table 6: Ever Tried Marijuana or Hashish in Any Form

Data Year	Percentage	95% CI	Population
2017	47.4%	46.0 - 48.8	15,361,000
2018	49.3%	48.0 - 50.6	16,166,000
2019	45.1%	44.1 - 46.1	14,910,000

In CY 2019, Table 7 shows that 2.6 percent of CHIS respondents over the age of 18 reported using a prescription painkiller in the past year in a way that did not follow their doctor's directions. This is an increase of 0.5 percent from CY 2018, and 0.6 percent increase from CY 2017. While this is not a significant increase year over year, for individuals 18+ years old the percentage of 9th and 11th graders who reported misusing prescription pain medication significantly decreased to 2.0 percent according to Table 4 above.

[3] California Health Interview Survey (CHIS), University of California Los Angeles

Table 7: Misused a Prescription Pain Killer in the Past 12 Months

Data Year	Percentage	95% CI	Population
2017	2.0%	1.5 - 2.4	579,000
2018	1.9%	1.4 - 2.3	552,000
2019	2.6%	2.3 - 3.0	791,000

National Survey on Drug Use and Health [4]

SAMHSA, an agency of the HHS, began directing the National Survey on Drug Use and Health (NSDUH) in 1971 to provide up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States. SAMHSA conducts the NSDUH every year in all 50 states and the District of Columbia. National, State, and local governments, as well as individual research entities use information from the NSDUH to support prevention and treatment programs, monitor substance use trends, estimate the need for treatment, and inform public health policy.

According to the 2018-2019 NSDUH Report:

- 20.06 percent of Californians aged 12 and older used marijuana in the past year, a significant increase from 18.43 percent in CYs 2017 2018.
- The perception of risk from smoking marijuana once a month varies by age and those 18 to 25 years old perceived there to be the least risk.

The data represented above indicate a continued need to focus harm reduction and early intervention efforts for the young adult population as older youth are displaying increases in regular use and “normalized” perceptions of harm.

- 4.02 percent of Californians aged 12+ years reported illicit drug use other than marijuana in the past month, statistically higher than 3.52 percent in 2017-2018.
- 0.22 percent of Californians aged 12+ years reported heroin use in the past year, compared to 0.18 percent in 2017-2018.
- 2.75 percent of Californians aged 12+ years reported cocaine use in the past year, compared to 2.80 percent in 2017-2018.
- 0.95 percent of Californians aged 12+ years reported methamphetamine use in the past year, compared to 0.89 percent in 2017-2018.
- 0.58 percent of Californians aged 12+ years reported pain reliever use disorder[5] in the past year, compared to 0.52 percent in 2017-2018.

[4] NSDUH 2018-2019 Report.

[5] Pain Reliever Use Disorder is defined as meeting criteria for pain reliever dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

- 3.60 percent of Californians aged 12+ years reported pain reliever misuse[6] in the past year, compared to 3.81 percent in 2017-2018.

There were no notable changes in the use of specific illicit drugs, including heroin, cocaine or misuse of pain relievers. Though the percent change in illicit drug use is minimal, the finding may be that, despite public health efforts, the use of illicit drugs is not declining among the Californian population.

According to NSDUH, in CYs 2018-2019, the percentage of Californians aged 12+ years who reported alcohol use disorder or binge drinking remained relatively similar to past years. The data calculated a statistical difference; however, a change of approximately one percent does not represent a genuine public health impact.

- In CYs 2018-2019, 6.28 percent of Californians aged 12+ years reported an alcohol use disorder in the past year, down from 7.87 percent in CYs 2008-2009.
- In CYs 2018-2019, 23.37 percent of Californians aged 12+ years reported binge[7] alcohol use in the past month, statistically less than 24.46 percent in 2017-2018.
- The percentage of heavy drinkers[8] was similar in California (6.2 percent) as in the nation (6.5 percent).
- In California, non-Hispanic Whites had a higher prevalence of heavy drinking compared to individuals of other races/ethnicities.
- The percentage of binge drinkers[9] was the same in California (16.8 percent) as in the nation (16.8 percent).
- In California, the population groups with the highest prevalence of binge drinking were males and individuals aged 25-34.

SUBSTANCE USE DISORDER-RELATED CONSEQUENCE DATA

Drug Abuse

California continues to face a serious drug crisis with substantial health and economic impacts. According to the California Opioid Overdose Surveillance Dashboard,[10] in 2019, 6,219 Californians (15 per 100,000; age-adjusted) died from a drug-related overdose. More

[6] 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.
[7] NSDUH defines Binge Alcohol Use drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.
[8] Heavy drinking is defined as adult males having more than 14 drinks per week and adult females having more than seven drinks per week.
[9] 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.
[10] California Opioid Overdose Surveillance Dashboard.

than 3,000 Californians died from an opioid-related overdose and approximately half of those deaths were fentanyl-related. There were nearly 49,000 emergency department visits and 22,000 hospital admissions related to a non-fatal drug overdose. Even though California's overall rates of drug related deaths were lower than the national average (20.7 per 100,000; age-adjusted),[11] the absolute magnitude of the problem among California's nearly 40 million people is substantial.

Table 8 displays drug-related overdose deaths per 100,000 California residents for multiple types of drugs over time. The trend for opioid-related deaths in California is very concerning, with a recent significant spike in death rates. California has deployed many policy and delivery system interventions and this may have contributed to California's relative low overdose death rates compared to the rest of the country – until 2019. In recent years, fentanyl heavily dominated the illicit drug market, and this (combined with the impact of the pandemic, leading to more drug use in isolation instead of in groups), may help explain the dramatic rise in opioid deaths, and may contribute to stimulant deaths (as fentanyl heavily contaminates the stimulant drug supply). In 2019, the rate of overall opioid-related overdose deaths in California was 7.9 per 100,000 residents, the highest number recorded. Although opioid prescription-related fatal overdoses have consistently decreased, heroin and synthetic opioid (namely, fentanyl) fatal overdoses have consistently increased. Additionally, overdose deaths due to stimulant drugs (i.e. cocaine and psychostimulants with abuse potential such as methamphetamine) have also been increasing. Since 2015, California has seen a near three-fold increase in cocaine-related overdose deaths from 0.69 deaths per 100,000 California residents per year to 2.02 per 100,000, and a doubling of psychostimulant with abuse potential-related overdose deaths from 3.56 per 100,000 California residents per year to 6.91 per 100,000. This exponential increase in cocaine- and psychostimulant-related overdose deaths matches what the nation is currently experiencing, according to a recent professional journal article:

> Although opioids have dominated the 'triple wave epidemic' of drug-related overdose deaths, a 'fourth wave' of high mortality involving cocaine and methamphetamine use has been gathering force. There has been a major rise in drug-related overdose deaths: a 3-fold increase for cocaine-related mortality (from 1.4 to 4.5/100,000 pop.) and a fivefold increase for psychostimulant-related (mostly methamphetamine) mortality (from 0.8 to 3.9/100,000), 2012–2018. [12]

[11] Center for Disease Control and Prevention, Drug Overdose Data.

[12] Ciccarone, Daniel (2021) The rise of illicit fentanyls, stimulants and the fourth wave of the opioid overdose crisis. Current Opinion in Psychiatry: July 2021 - Volume 34 - Issue 4 – p 344-350. doi: 10.1097/YCO.0000000000000717

Table 8: Drug-Related Overdose Deaths in California by Drug Type, Age-Adjusted Rate (95% Confidence Interval) per 100,000 Residents, 2015-2019 [13]

Data Year	Any Opioid	Prescription Opioids (without Synthetics)	Synthetic Opioids (excluding methadone)	Heroin	Cocaine	Psycho-stimulants with Abuse Potential
2015	4.79 (4.58, 5.01)	2.96 (2.79, 3.13)	0.54 (0.47, 0.62)	1.41 (1.29, 1.53)	0.69 (0.61, 0.78)	3.56 (3.38, 3.75)
2016	4.87 (4.66, 5.09)	2.79 (2.63, 2.96)	0.87 (0.79, 0.97)	1.44 (1.32, 1.56)	0.87 (0.78, 0.96)	3.87 (3.67, 4.07)
2017	5.22 (5.0, 5.45)	2.75 (2.59, 2.92)	1.30 (1.20, 1.42)	1.70 (1.58, 1.84)	1.03 (0.93, 1.13)	4.58 (4.37, 4.79)
2018	5.82 (5.59, 6.06)	2.56 (2.41, 2.72)	2.15 (2.0, 2.29)	1.89 (1.75, 2.03)	1.45 (1.33, 1.57)	5.82 (5.59, 6.07)
2019	7.90 (7.63, 8.19)	2.55 (2.39, 2.71)	4.19 (3.99, 4.39)	2.35 (2.20, 2.51)	2.02 (1.89, 2.17)	6.91 (6.65, 7.17)

According to Figure 1 below, there is a wide variation in the number of deaths due to drug-related overdose across California counties. San Francisco County is currently of particular concern in California as San Francisco's age-adjusted rate per 100,000 residents for an opioid-related overdose death was 26.96 per 100,000 residents, totaling 279 deaths in 2019. This is the second highest death rate per 100,000 residents and the fourth largest death count among California counties. Of further concern is the drug overdose death variance by zip code. San Francisco's hardest hit zip code had an age-adjusted death rate of 153.13 per 100,000 residents, 10 times the statewide average. In sum, San Francisco County has experienced the largest burden of drug overdose fatalities within California.

[13] California Opioid Overdose Surveillance Dashboard, p. 6. Accessed on (December 30, 2020). Multiple Cause of Death and California Comprehensive Death Files. Prepared by the California Department of Public Health (CDPH) SAPB, December 2020. *Rates are age-adjusted and calculated per 100,000 population using CDCP Wonder population data.

Figure 1: All Opioid-Related Overdose Deaths in California, Age-Adjusted Rate per 100,000 Residents, 2020 [14]

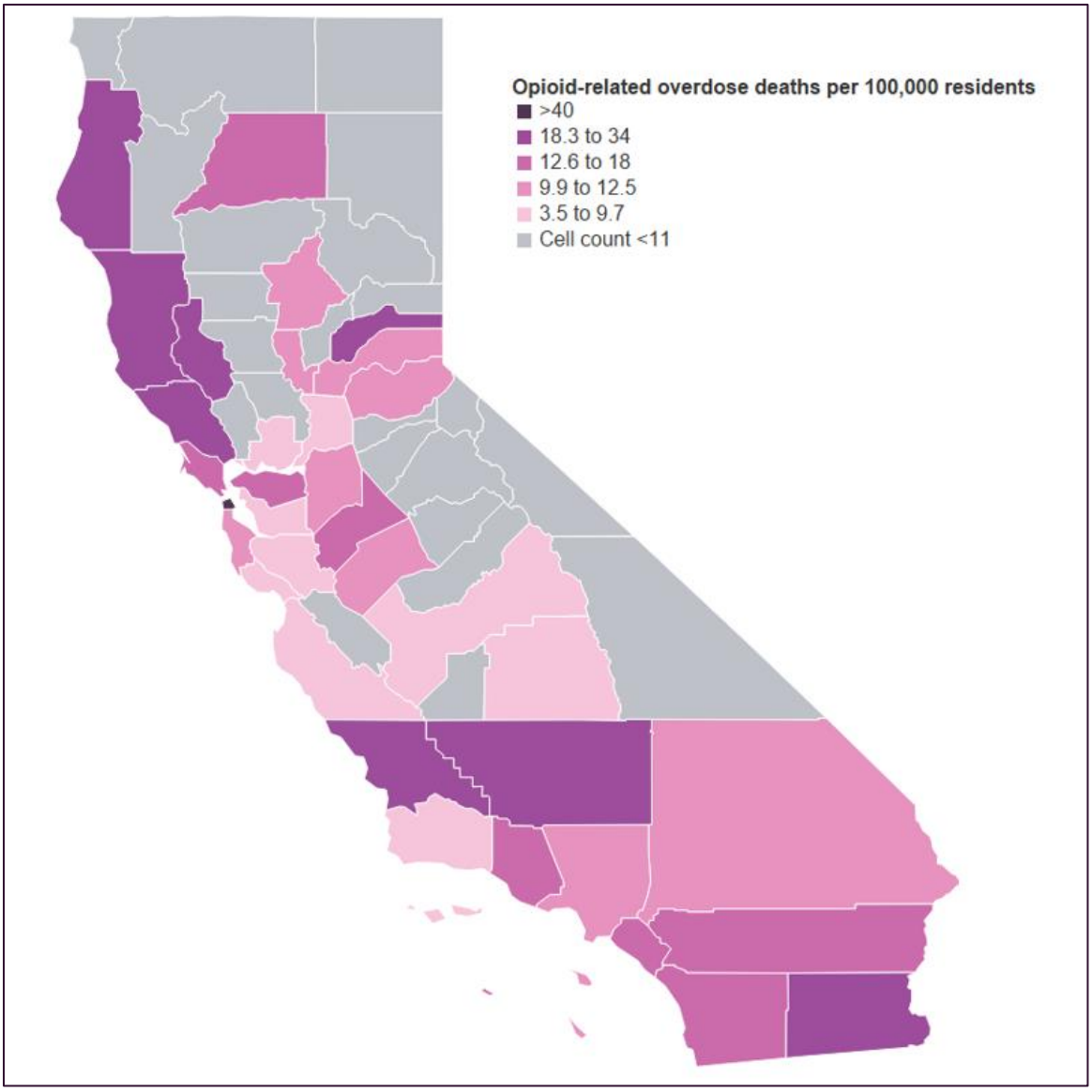


Table 9 shows the estimated number per 100,000 California residents for all drug-, any opioid-, amphetamine-, cocaine-, and cannabis-related non-fatal overdose ED visits. In 2019, there were 48,842 ED visits in California for a drug-related non-fatal overdose.[15] This marks a

[14] California Overdose Surveillance Dashboard. Accessed on August 26, 2021. Multiple Cause of Death and California Comprehensive Death Files. Prepared by CDPH SAPB, September 2021. *Rates are age-adjusted and calculated per 100,000 population using CDCP Wonder population data.

[15] Ibid. Accessed on December 28, 2020. Office of Statewide Health Planning and Development Emergency Department Data. Prepared by CDPH SAPB, December 2020.

7.4 percent increase in the rate of ED visits for a drug-related non-fatal overdose when compared to 2018.

Table 9: Emergency Department Visits for Non-Fatal Drug Overdoses in California by Drug Type; Age-Adjusted Rate (95% Confidence Interval) per 100,000 Residents, 2016-2019 [16]

Data Year	All Drug	Any Opioid	Amphetamines	Cocaine	Cannabis
2016	115.9 (114.8, 117.0	20.0 (19.6, 20.5	5.1 (4.9, 5.4)	0.8 (0.7, 0.9)	4.8 (4.5, 5.0)
2017	117.1 (116.1, 118.2	20.2 (19.7, 20.6	4.6 (4.4, 4.9)	1.1 (1.0, 1.2)	6.5 (6.2, 6.7)
2018	116.1 (115.1, 117.2	21.4 (21.0, 21.9	5.0 (4.8, 5.2)	1.3 (1.2, 1.4)	7.1 (6.8, 7.4)
2019	124.7 (123.6, 125.8	28.8 (28.3, 29.3	6.9 (6.6, 7.1)	1.8 (1.7, 2.0)	7.1 (6.8, 7.4)

Alcohol

Table 10 displays the Center for Disease Control and Prevention (CDCP) estimates that an average of 11,026 annual deaths in California during CYs 2011-2015 were attributable to chronic and acute alcohol-related conditions, with males accounting for the vast majority of the alcohol-attributable deaths (71 percent). The top four alcohol attributable, acute causes of deaths were alcohol-related poisonings, suicides, homicides, and motor vehicle traffic crashes. Of the 6,619 annual deaths attributable to chronic causes, 4,290 were 100% alcohol attributable, with the primary cause being alcoholic liver disease.

Table 10: Average Annual Alcohol-Attributable Deaths in California Due to Excessive Alcohol Use, by Gender – All Ages, 2011-2015 [17]

Causes	Males	Females	Overall
Chronic Causes	4,544	2,075	6,619
Acute Causes	3,301	1,105	4,407
Total	7,845	3,180	11,026

*Estimates are age-adjusted calculated per 100,000 population using CDCP Wonder population data.

[16] Ibid. Accessed on (December 30, 2020). Multiple Cause of Death and California Comprehensive Death Files. Prepared by CDPH SAPB, December 2020. *Rates are age-adjusted and calculated per 100,000 population using CDCP Wonder population data.
[17] CDCP. Alcohol-Related Disease Impact (ARDI) application, 2019.

OTHER SUBSTANCE USE DISORDER RELATED HEALTH AND SOCIETAL CONSEQUENCE DATA

Human Immunodeficiency Virus [18]

From 2014 through 2018, both the annual number and rate of new HIV diagnoses declined in California. The number of new diagnoses declined by 9.6 percent – from 5,249 in 2014 to 4,747 in 2018, while the rate of new diagnoses per 100,000 population declined by 11.9 percent, from 13.5 to 11.9 during the same time period. From 2014 through 2018, the number of persons in California living with diagnosed HIV infection increased from approximately 126,372 to over 136,000. In 2018, the prevalence rate of diagnosed HIV infection was 342.9 per 100,000 population, compared to 326.1 in 2014 – an increase of 5.2 percent.

The CDCP hierarchy of risk factors, from most likely to lead to HIV transmission to least likely, is as follows: male-to-male sexual contact (MMSC) and injection drug use (IDU), MMSC alone, IDU alone, receipt of clotting factor blood product for treatment of hemophilia or other chronic coagulation disorder, and high-risk-heterosexual contact. Among cisgender men newly diagnosed with HIV infection in 2018, 4.3 percent had MMSC and IDU as their transmission category and 3.8 percent had IDU alone as their transmission category. Among cisgender women newly diagnosed with HIV infection in 2018, 12.8 percent had IDU alone as their transmission category.

Among cisgender men living with diagnosed HIV infection in 2018, 7.5 percent had MMSC and IDU as their transmission category and 4.3 percent had IDU alone as their transmission category. Among cisgender women living with diagnosed HIV infection in 2018, 17.1 percent had IDU alone as their transmission category.

Hepatitis C [19]

In 2018, there were 35,448 newly reported cases of chronic hepatitis C in California and the rate of newly reported cases per 100,000 persons was 89 percent. The rate of newly reported chronic hepatitis C infection in California increased 15 percent between 2014 and 2017, from 86 to 99 per 100,000 population, and then decreased 10 percent between 2017 and 2018. Although people born during 1945-1965 ("baby boomers") had the highest rates of newly reported chronic hepatitis C infection in 2018 and made up 41 percent of newly reported cases, there has been an increasing proportion of newly reported chronic hepatitis C cases among adolescents and young adults over the last 10 years. In 2018, newly reported cases of hepatitis C totaled 12,373 among people 15-39 years of age. The rate of newly reported cases in this age group increased 43 percent from 2014 to 2016, but the number has

[18] California Department of Public Health, Office of AIDS, California HIV Surveillance Report — 2018.
[19] California Department of Public Health, Office of Viral Hepatitis Prevention, Chronic Hepatitis C in California 2018 Executive Summary.

remained stable since 2016. Today, transmission of hepatitis C is primarily through sharing needles, syringes or other drug injection paraphernalia.

Surveillance data for 2018 suggest a growing percentage of newly reported chronic hepatitis C cases in California are due to recent transmission. These findings are consistent with national surveillance data suggesting that the majority of infections among young people during this period were associated with IDU.[20] Newly reported chronic hepatitis C cases among adolescents and young adults indicate a need for hepatitis C prevention among people who inject drugs, including access to syringe service programs, opportunities for MAT programs, and comprehensive health services that include hepatitis C virus testing and linkage to care.[21]

Tuberculosis

In 2019, there were 2,115 cases of Tuberculosis reported in California. Of these cases, 26 (1.2 percent) occurred within the IDU population, compared to 28 (1.3 percent) reported in 2015.

DATA STRENGTHS AND LIMITATIONS

45 CFR 96.133(a)(1) requires that States provide a summary in their needs assessment describing the weakness and bias in the data used and any descriptions on how DHCS plans to strengthen data in the future. They are as follows:

- CHKS optional modules (which includes the Social Emotional Learning Module and Alcohol and Other Drug (AOD) Module) requires continuous marketing at the state and local levels to gain buy-in to administering these modules. Therefore, DHCS's State Epidemiological Workgroup plans to work with the survey developer, WestEd, to revise the AOD Module, expanding its scope to a broader behavioral health module.
- Changes in some CHKS question wording among survey years limit the ability to interpret longitudinal trends. Exercise caution in determining whether differences reflect actual behavior changes.
- Student surveys such as CHKS may not capture use among the general adolescent population, although the CHKS can be administered in continuation and charter schools.
- CHIS uses a well-established, reliable, and scientifically valid random-digit-dial telephone methodology to produce a representative sample of California's

[20] Zibbell JE, Asher AK, Patel RC, et al. Increases in Acute Hepatitis C Virus Infection Related to a Growing Opioid Epidemic and Associated Injection Drug Use, 2004 to 2014. Amer J Public Health. 2018 Feb; 108(2):175-81; Increases in Hepatitis C Virus Infection Related to Injection Drug Use among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012. MMWR. May 8, 2015 / 64(17); 453-458.
Infographic: Hepatitis C and Opioid Use Rates Among Young Adults in California (PDF)

[21] National Viral Hepatitis Action Plan 2017-2020.

non-institutionalized population. While the CHIS utilizes a large and representative adult sample, the adolescent sample is smaller.

- The AskCHIS query system is easy to navigate and allows users to customize their data tables to look at age, gender and race/ethnicity breakdowns.
- The NSDUH provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use among a representative sample of civilian, non-institutionalized persons aged 12 or older. The sample is relatively smaller than the CHIS and CHKS datasets.
- Ability to perform some contrastive analysis is limited for Primary Prevention data collected in the new Primary Prevention SUD Data System (PPSDS) versus the phased out the California Outcomes Measures System for Prevention (CalOMS Pv) data system. SFY 2017-2018 is the baseline year for PPSDS; trend data can be collected over time.
- Increases in the number of Administrative Discharges in the California Outcomes Measures System for Treatment (CalOMS Tx) contributes to the limitations in reporting reliable discharge data necessitating local technical assistance (TA) and continued enhancements to data reporting methodologies.
- DHCS is committed to strengthening public behavioral health reporting to improve transparency and accountability through its Comprehensive Behavioral Health Data Systems. This project intends to identify technology solutions to modernize and streamline data collection and reporting, analysis, and other data-related functions, and develop a consolidated reporting and analysis platform that integrates data from 12 existing behavioral health data systems. More information can be found by visiting DHCS Information Technology Projects.

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

INTENDED USE OF FUNDS RELATING TO PREVENTION AND TREATMENT

Description of Statewide Substance Use Disorder Primary Prevention Capacity

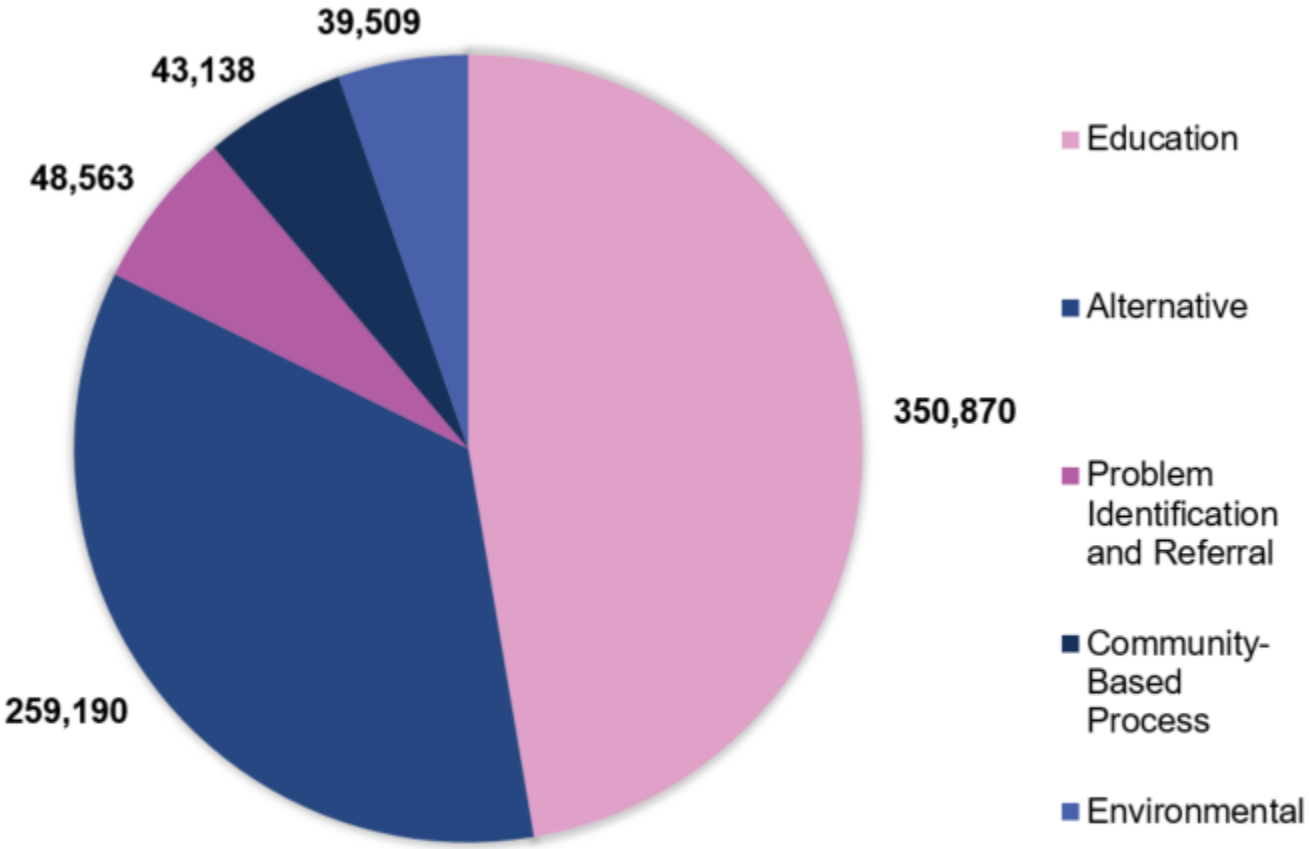
In SFY 2017-2018, DHCS disbursed approximately $58 million[22] of California's SABG funds to each of the 58 counties to conduct locally identified primary prevention activities.[23] Beginning in SFY 2020-21, California changed the requirement for counties to expend an additional five percent of their total allocation on primary prevention activities, five percent over the federal requirement. Counties are in a unique position to identify the most effective combination of service deliveries from each of SAMHSA's CSAP strategies based on the individual county's local needs. As of March 2021, there were 281 providers authorized by DHCS specifically to provide primary prevention services to Californians.

[22] DHCS MHSUDS INFORMATION NOTICE NO.: 17-013, Exhibit A
[23] DHCS MHSUDS INFORMATION NOTICE NO.: 17-013, Exhibit B

Additionally, in SFY 2017-2018, DHCS began using the PPSDS to collect service and demographic data. Unlike California's prior data collection system, CalOMS Pv, PPSDS may have duplicate counted individuals receiving multiple services. This resulted in a very large increase in the number of individuals served by CSAP strategy for SFY 2017-2018 over SFY 2016-2017.

Primary Prevention Activities – Strategies Used

Figure 2: Number of Individuals Served by Primary Prevention Service Strategies SFY 2017-2018



Data Source: Department of Health Care Services, Primary Prevention SUD Data Service | Data Represented: SFY 2017-2018 | Date Collected: 1/25/2021
Prepared by the Department of Health Care Services.

Information Dissemination Strategy

PPSDS does not collect quantitative and demographic data for Information Dissemination services as these types of activities serve the general population. The most commonly reported Information Dissemination Strategy activities for SFY 2017-2018 were:

- Community/School Outreach Events
- Presentations
- Printed Material Disseminated
- Resource and Information Service

Education Strategy

The number of Primary Prevention service activities reported under the Education Strategy for SFY 2017-2018 include:

- Classroom/School Educational Services = 202,941
- Community Educational Service = 46,034
- Mentoring = 26,699
- Parenting/Family Management Services = 23,015

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). [24] Currently, 47 out of 58 counties[25] 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 2017-2018 were:

- Youth/Adult Leadership Activities = 231,233
- Social/Recreational Events/Activities = 17,146
- Community Service Activities = 2,861

Problem Identification and Referral Strategy

Problem Identification and Referral Strategy services are instrumental in identifying early substance abuse behaviors and directing individuals to education, rather than referring individuals directly to treatment. The most commonly reported Problem Identification and Referral Strategy activities for SFY 2017-2018 were:

- Prevention Screening and Referral Services = 43,804
- Student Assistance Programs = 5,642

Community-Based Process Strategy

The Community-Based Process Strategy supports each county's effort to plan, coordinate, and build its capacity to provide effective prevention services. County providers predominately take advantage of available training and TA as well as make those services available to community stakeholders to build capacity. The most commonly reported Community-Based Process Strategy activities for SFY 2017-2018 were:

[24] https://fridaynightlive.tcoe.org/
[25] DHCS MHSUDS INFORMATION NOTICE NO.: 20-047, Exhibit B

- Training and TA = 29,399
- Intra/Inter-Agency Coordination/Collaboration = 5,501
- Coalition/Workgroup Activities = 5,073
- Assessing Community Needs/Assets = 830

Environmental Strategy

The Environmental Strategy focuses on creating systems and policy change in social, community and retail environments. For the SFY 2017-2018, the most commonly reported Environmental Strategy activities were:

- Community and Neighborhood Mobilization = 981 services
- Retail Policy = 477 services
- Commercial Host Liability = 367 services

Primary Prevention Activities – Demographics

Gender

More females than males were served in SFY 2017-2018 (see Table 11). The general population of California contains fewer males than females while individuals self-identifying as "other" are not reported in the larger population by Department of Finance (DOF) demographic sources. However, national information from the NSDUH 2017 Report supports the conclusion that all genders 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.

Table 11: Number of Individuals Served by Primary Prevention Service Strategies, by Gender, SFY 2017-2018 [26]

Gender	Persons Served	California Population[27]	Percentage of Populations Served	Percent of Total Population by Gender
Male	119,361	≈19,695,434	0.61%	49.75%
Female	131,084	≈19,895,179	0.66%	50.25%
Gender Unknown	80,992	N/A	N/A	N/A
Total	331,437	≈39,590,613	0.63%	100%

Age

Prevention services are primarily provided to youth under age 25 (see Table 12). Youth aged 15 to 20 were the largest group of recipients of prevention activities, even though this group makes up only 7 percent of California's population. The fewest number of individuals served occurred for ages 0-4, 6.2 percent of the general population. Approximately five out of every

[26] PPSDS.

[27] DOF Population Estimates.

1,000 persons aged 0-24, 15.4 percent of California's total population, are participating in some publicly funded primary prevention service activity.

Table 12: Number of Individuals Served by Primary Prevention Service Strategies, by Age Group, SFY 2017-2018 [28]

Age Group	Persons Served	California Population[29]	Percentage of Population Served	Percentage of Total Population by Age
0-4	241	≈2,456,350	0.001%	6.20%
5-11	13,969	≈3,619,479	0.040%	9.14%
12-14	22,420	≈1,525,246	0.060%	3.85%
15-17	15,238	≈1,549,445	0.040%	3.91%
18-20	1,753	≈1,888,576	0.004%	4.77%
21-24	1,590	≈2,470,949	0.004%	6.24%
25-44	7,410	≈10,559,576	0.020%	26.67%
45-64	5,241	≈9,921,052	0.010%	25.06%
65 and over	3,572	≈5,599,940	0.010%	14.14%
Age Not Known	260,003	N/A	0.660%	N/A
Total	331,437	≈39,590,613	0.840%	100%

Race

The Race/Ethnicity demographic in PPSDS prevention data are categorized by White, Hispanic or Latino, Black or African American, Native Hawaiian/Other Pacific Islander, Asian, American India/Alaska Native, More Than One Race, and Race Not Known. For comparison of individuals receiving prevention services, the California population data from the California DOF for 2017 are used.

Table 13 provides a brief summary of all prevention services delivered in SFY 2017-2018, by race. The reported highest number of persons served through SABG-funded Primary Prevention strategies is the White racial group, closely followed by Race Not Known. The remaining groups, in order of highest number of persons served, were Asian, More Than One Race, Black/African American, American India/Alaska Native, and Native Hawaiian/Pacific Islander.

[28] PPSDS.

[29] DOF Population Estimates.

Table 13: Number of Individuals Served by Primary Prevention Service Strategies, by Race, SFY 2017-2018 [30]

Race	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Race
White	169,853	14,872,102	0.43%	37.56%
Black or African American	6,722	2,363,339	0.02%	5.97%
Native Hawaiian/Other Pacific Islander	1,171	137,191	0.00%	0.35%
Asian	11,309	5,852,034	0.03%	14.78%
American India/Alaska Native	3,964	195,297	0.01%	0.49%
More Than One Race	13,640	876,699	0.03%	2.21%
Race Not Known or Other	124,778	15,293,951	0.32%	38.63%
Totals	331,437	39,590,613	0.84%	100.00%

Ethnicity

Table 14 provides a brief summary of all prevention services delivered in SFY 2017-2018 by ethnicity. The highest number of persons served by Primary Prevention Services Strategies is the Not Hispanic or Latino group, followed by Hispanic or Latino, then Ethnicity Unknown.

Table 14: Number of Individuals Served by Primary Prevention Service Strategies, by Ethnicity, SFY 2017-2018 [31]

Ethnicity	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Ethnicity
Hispanic or Latino	51,333	15,293,951	0.13%	38.60%
Not Hispanic or Latino	189,801	24,159,471	0.48%	61.00%
Ethnicity Unknown	90,303	137,191	0.23%	0.40%
Total	331,437	39,590,613	0.84%	100.00%

[30] PPSDS.
[31] Ibid.

Demographic data for both race and ethnicity collected in PPSDS are limited because demographic counts are not collected for population-based, community-wide interventions, information dissemination campaigns and other universal strategies that do not record a participants age, race or gender in the same manner as individual-based interventions. Moreover, identifying these possible disparities has informed programmatic decisions for other statewide prevention programs such as Elevate Youth CA, which primarily serves black and brown individuals in communities disproportionally affected by the war on drugs. Specifically, the Elevate Youth CA 2020 Annual Report describes that of all Elevate Youth CA service recipients, 45 percent identified as Hispanic/Latinx, 35 percent identified as Black, 6 percent as Asian and 6 percent white respectively.

Description of Statewide Substance Use Disorder Treatment Capacity

California contracts with counties to provide primary prevention services and requires counties to provide SABG-allowable treatment services. These services are to supplement, not supplant, SUD services not otherwise covered by California's Medicaid program, DMC.

Drug Medi-Cal State Plan Services

Covered DMC State Plan services include outpatient treatment services, intensive outpatient treatment (IOT) services, perinatal residential treatment services (perinatal only with a 16-bed limitation), narcotic treatment program (NTP) services, and in-patient hospital detoxification services. Twenty-one counties provide DMC State Plan services; however, 10 counties are interested in opting-in to the DMC-ODS with the renewal of the 1115 Waiver.

Drug Medi-Cal Organized Delivery System

DHCS continues to expand SUD services in California through the DMC-ODS to provide increased access to the SUD services in the least restrictive level of care based on the American Society of Addiction Medicine Criteria. All 58 California counties contract with DHCS to arrange for, provide, or subcontract for DMC State Plan SUD services. As of December 31, 2020, 37 counties provide DMC-ODS expanded SUD services. These expanded services include DMC State Plan services and expanded residential treatment services (multiple levels of care for all enrollees with no bed limitation), withdrawal management services recovery services, case management, physician consultation, additional MAT services (optional), and partial hospitalization (optional). California is applying for renewal of the DMC-ODS and is making changes based on lessons learned over the last five years of implementation. For more information on DHCS's DMC-ODS waiver project, and to view DMC-ODS Evaluation Reports, visit the Drug-Medi-Cal Organized Delivery System website.

California Advancing and Innovating Medi-Cal

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots (including but not limited to the Whole Person Care Pilots (WPC), Health Homes Program (HHP), and the

Coordinated Care Initiative) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

DHCS formally released the CalAIM proposal on October 29, 2019, at the Stakeholder Advisory Committee, and Behavioral Health Stakeholder Advisory Committee meetings. Between November 2019 and February 2020, DHCS conducted extensive stakeholder engagement for both CalAIM and the renewal of the federal authorities under which Medi-Cal operates (i.e., 1115 and 1915b waivers).

DHCS originally scheduled implementation of the CalAIM Initiative for January 1, 2021. However, DHCS deemed it necessary to postpone the implementation so that both DHCS and all of its partners could focus their limited resources on the needs arising from the public health emergency due to COVID-19.

DHCS released a revised CalAIM proposal on January 8, 2021, and held a webinar to review the components of the proposal including changes made based on stakeholder feedback. As implementation of various components of CalAIM begins, DHCS will provide updates on the CalAIM website.

California Child and Youth Behavioral Health Initiative

As part of the California 2021-2022 budget, the California Health and Human Services (CHHS) Agency is launching the Children and Youth Behavioral Health Initiative. This initiative intends to transform California's children and youth behavioral health system into an excellent, innovative, up-stream focused, ecosystem where all children and youth receive routine screenings, support, and service for emerging and existing behavioral health needs. Services will be statewide, evidence based, culturally competent, and equity focused. As a department under the authority of the CHHS, DHCS will oversee several components of the proposal including

- Implement a behavioral health service virtual platform;
- Build capacity and infrastructure for new behavioral health services in schools through partnerships with health plans, county mental health plans, community-based organizations, and schools;
- Develop and scale-up behavioral health evidence based programs;

- Build new behavioral health infrastructure, including new programs and facilities to address gaps in the continuum of care; and
- Enhance Medi-Cal benefits, such as the addition of a new dyadic care benefit allowing integration of behavioral health services with well child visits.

Behavioral Health Response and Rescue Project

The Behavioral Health Response and Rescue Project (BHRRP) is funded by SAMHSA through supplements to the SABG and the Community Mental Health Services Block Grant. SAMHSA made this additional funding available through passage of the Coronavirus Response and Relief Supplemental Appropriations Act and the American Rescue Plan Act. The BHRRP is currently offering the Peer Workforce Investment RFA, to expand behavioral health peer-run programs. This RFA is part of DHCS's Behavioral Health Workforce Development Project to expand, elevate, enhance, and empower behavioral health peer-run programs in every California community. DHCS has already contracted with Advocates for Human Potential, Inc. to facilitate implementation of this project. More information on the RFA is available on the BHRRP webpage.

Substance Abuse Prevention and Treatment Block Grant

With broadened implementation of DMC and DMC-ODS, DHCS has changed the way it administers SABG funding. Historically, DHCS calculated distribution of SABG funding to each California County using a population-based formula. Each county's annual allocation was broken down by set-aside with the balance going toward counties' discretionary spending budget. This process passed the federal requirement of minimum expenditure for primary prevention and perinatal services on to the county, and ensured that California met the SABG minimum spending requirements.

DHCS continues to use a population-based formula to distribute SABG funds, however, DHCS has relaxed its policy that only counties with a population of 140,000 or less may opt out of expending their youth allocation and Perinatal Set-Aside. This option is now open to all counties with the knowledge that the county relinquishes the amount of those set-aside funds to DHCS who will ensure that funds are expended appropriately. These funds may be redistributed to counties who have greater need and ability to appropriately expend additional funds, or DHCS may retain the funds to expend on state-level projects that align with the intended set-aside. Additionally, DHCS recently increased the minimum annual allocation counties are required to expend on primary prevention services to 25 percent, an increase of 5 percent over the federal requirement.

After June 30, 2020, to ease the burden of executing SABG county contracts every three years, and annually amending those contracts, DHCS integrated the SABG county contract into a County Performance Contract (CPC). The CPC sets forth conditions and requirements counties must meet in order to receive SABG funding. DHCS requires counties to prepare and submit an annual County SABG Application consisting of enclosures detailing various rules, regulations, and county requirements, in addition to program narratives and budgets.

Counties are required to adhere to the terms and conditions of the County SABG Application, as its enclosures are incorporated by reference in the CPC.

Recently, DHCS received authorization from SAMHSA to allow counties to use up to five percent of their total SFY SABG allocation for oral fluid rapid HIV testing as well as HIV pre- and post-test counseling. Beginning in SFY 2021-22, DHCS will establish an annual allowance for each county.

Lastly, beginning in SFY 2021-22, SABG funds can be used for Cost Sharing Assistance purposes for the maintenance of private health insurance coverage to individuals for behavioral health services. Block grant funds may be used to cover health insurance deductibles, coinsurance, copayments, or similar charges to assist individuals in meeting their cost-sharing responsibilities. Cost-sharing assistance does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

MAT Expansion Project

In April 2017, SAMHSA awarded DHCS with the Opioid State Targeted Response (STR) Grant, which it used to implement the MAT Expansion Project. The MAT Expansion Project consists of three primary components:

1. The California Hub and Spoke System aims to increase access to MAT services throughout the state, particularly in counties with the highest overdose rates;
2. Increase the availability and utilization of buprenorphine statewide, and
3. The Tribal MAT Project aims to promote opioid safety, improve the availability and provision of MAT, and facilitate wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments.

In September 2018, DHCS received the State Opioid Response (SOR) Grant and used it to implement the MAT Expansion Project 2.0. The MAT Expansion Project focuses on the following objectives:

1. Increase access to MAT;
2. Reduce unmet treatment needs; and
3. Reduce opioid overdose related deaths through prevention, treatment, and recovery services.

Through the MAT Expansion Project 2.0, DHCS is working towards the following goals and objectives:

1. Develop additional MAT locations through strategic access points;
2. Provide MAT services to specialized or underserved populations;
3. Transform entry points to individuals with an OUD and create effective referrals into treatment and develop coordinated referral processes to better manage high-risk transitions of care;
4. Engage prospective and current prescribers to increase provision of MAT; and

5. Enact overdose prevention activities to prevent opioid misuse and overdose deaths.

Funding from the SOR Supplemental grant has complimented and intersected with the MAT Expansion Project activities initiated with the STR and SOR grant programs. The SOR Supplemental grant funds California's MAT Expansion Project 2.0, which has a focus on increasing referrals into OUD services and prevention activities. The populations of focus are American Indian and Alaskan natives, perinatal, service members/veterans, and youth.

DHCS's aim is to utilize the grants to impact individuals through efforts to prevent opioid misuse and overdose deaths. With a focus on regions with the highest overdoes rates, project activities are concentrated in areas where individuals with an OUD may encounter services including primary care, hospitals, SUD providers, county touch points, and criminal justice settings.

The additional SOR Supplemental funding has allowed DHCS to allocate more funding towards current MAT Expansion programs.

During the three years DHCS awarded funding, the MAT Expansion Project has:

- Provided treatment to approximately more than 66,000 new patients;
- Saved approximately 37,000 lives with opioid overdose reversal medication (naloxone);
- Created 650 new access point locations where patients can receive treatment for OUD;
- Trained more than 18,000 individuals in the medical, substance use treatment and justice systems on the science of MAT and how it can help the people they serve;
- Established 208 hospitals and emergency rooms as centers for stabilization and referral to treatment for OUD while initiating and referring into treatment 10,471 individuals on buprenorphine; and
- Expanded access to treatment in jails and drug courts in 35 counties which have provided MAT services to 10,533 clients as a result of educational and TA programming and infrastructure funding through the MAT Expansion Project.

The SFY 2018-2019 SOR Grant Performance Progress Report are available online at https://www.dhcs.ca.gov/Documents/State-Opioid-Response-Grant_Performance-Progress-Report-Year-1.pdf, highlights many of the projects funded with Opioid STR/SOR grant funds, and details DHCS's activities, successes, and barriers during the most recent grant period; September 30, 2018, through September 29, 2019.

Elevate Youth California

Elevate Youth CA is a DHCS program funded with state cannabis tax dollars allocated to the Youth Education, Prevention, Early Intervention and Treatment Account. Elevate Youth CA provides for youth social justice, peer support and mentoring strategies in communities

disproportionally affected by the war on drugs. DHCS provides project news and updates on the Elevate Youth CA website.

With an operating budget of $26 million during FY 2019-2020, the program offered a Request for Application (RFA) seeking community-level partners who would develop or increase youth substance use disorder prevention, outreach and education. DHCS awarded up to $1 million to 26 partners who successfully provided:

- 320 prevention program activities for 3,959 participants
- 45 percent of whom identified as Hispanic, Latinx, or Spanish origin
- 35 percent of whom identified as Black/African American
- 79 percent of the youth engaged were 12 to 17 years old.

Some of the funded activities included:

- 18 youth listening sessions;
- 20 weekly diversion classes;
- Youth for Justice Academy (conducted virtually due to Coronavirus Disease 2019 (COVID-19) concerns);
- mentoring/case management/relationship building sessions; and
- 7 YouTube wellness videos.

Additionally, DHCS's contracted TA provider supplied over 127 hours of TA services to awardees; services that included application proposals, grantee orientations, and grantee data reporting.

For FY 2021-2022, Elevate Youth CA's budget has nearly doubled to more than $50 million due to an increase in cannabis tax revenue. This allows DHCS to offer dedicated capacity building and prevention innovations grants due out this year.

Federal Emergency Management Agency Crisis Counseling Assistance & Training Program/COVID-19 Health Emergency (FG-20-006)

CalHOPE began responding to the COVID-19 pandemic Regular Services Program (RSP) on November 9, 2020. CalHOPE is a Crisis Counseling Assistance and Training Program – Regular Service Program (CCP-RSP) funded through the Federal Emergency Management Agency in partnership with SAMHSA. CalHOPE's pandemic response includes an extensive array of resources and services offered through DHCS's CalHOPE website and the Mental Health Association of San Francisco (MHASF) Warm Line, the CalHOPE Connect chat service, and the California Consortium for Urban Indian Health CalHOPE Redline.

As the public health emergency continues, data show that California residents are continuing to seek CalHOPE resources. Since June 2020, the CalHOPE website received more than 1.2 million page views, with an average time spent on the website of about two minutes. In addition, since May 2020, the MHASF Warm Line received nearly 10,000 calls from

Californians. The CalHOPE Warm Line is taking approximately 800 calls a week and the recently added CalHOPE Connect Chat service, provided in partnership with California Mental Health Services Authority (CalMHSA), is providing more than 7,000 chat conversations a week.

In the next month, DHCS will expand crisis-counseling services in the state through a partnership with the California Mental Health Services Authority (CalMHSA). CalMHSA will roll out virtual, non-clinical emotional and crisis support in response to the COVID-19 pandemic and associated stressors. Individuals in need of emotional and/or crisis support can receive crisis counseling services by phone, videoconference, or computer chat. Family and/or group support sessions are available, and individuals may be connected to county-based services.

Finally, DHCS will provide CCP-RSP services for two wildfire grants that affect 22 counties in California. Through a partnership with CalMHSA, provider organizations in the affected counties will provide crisis-counseling services to individuals impacted by wildfires.

Pregnant and Parenting Women

DHCS continues to prioritize service delivery to the Pregnant and Parenting Women (PPW) population. DHCS annually updates the following items: the county monitoring tool, the Perinatal Practice Guidelines (PPG),[32] 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.

County Monitoring of SABG-funded Perinatal Programs

DHCS uses the county monitoring tool 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, DHCS will address the following priority areas for PPW in the monitoring instrument:

- Capacity Management
- Waitlist
- Interim Services

[32] DHCS Perinatal Practice Guidelines.

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.

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 clients. DHCS requires that SUD residential and NTP facilities be DHCS licensed. DHCS's Provider Enrollment Division must certify programs before they provide DMC State Plan or DMC-ODS SUD treatment services. DHCS does not license or certify SUD primary prevention providers; however, DHCS provides oversight and TA to counties to ensure that providers properly adhere to the same provisions and conditions as in their DMC State Plan or DMC-ODS Contract.

As of March 2021, California counties contracted with 1,053 SUD treatment facilities to provide a wide range of treatment services. There were 218 provider sites engaged in primary prevention services, and 30 provider sites engaged in secondary prevention services including early intervention, outreach, and referral screening and intake.

Treatment Utilization

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

Unique Clients Served

Unique clients served means all clients admitted during the year and clients 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 increase in the number of clients served in SFY 2017-2018, as compared to the decreases DHCS saw in SFY 2015-2016 and SFY 2016-2017.

During SFY 2017-2018, approximately 190,272 unique clients were served,[33] approximately 4,000 more clients than were served in SFY 2016-2017.

[33] Unique clients served means all clients admitted during the year and clients admitted prior to the current year that continue to receive treatment services during the year.

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. DHCS uses these "served" counts to estimate the number admissions in which the client is still participating in treatment to estimate current "active" treatment participation.

During SFY 2017-2018, the total served count was approximately 244,000, about a 2 percent increase from the 240,000 reported in SFY 2016-2017.

Of the total served count in SFY 2017-2018, Table 15 shows the percentages served in each major service type.

Table 15: Total Served by Service Type, SFY 2016-2017 through 2017-2018

Major Service Type	SFY 2016-2017	SFY 2017-2018
Outpatient Drug Free (ODF)	36.3	36.5
Narcotic Treatment Program (NTP)	31.2	30.5
Residential (Short/Long Term)	17.0	19.1
Residential Detoxification	9.3	8.3
Intensive Outpatient Treatment (IOT)	4.0	4.2
NTP Detoxification	2.2	1.3
Non NTP Detoxification	0.0	0.1

Examination of the various service types shows the following trends from SFY 2016-2017 through SFY 2017-2018:

- There was a decrease in NTP services.
- There were significant decreases in Residential and NTP Detoxification services.
- There were increases in outpatient treatment and IOT services.
- There was a significant increase in Residential (Short/Long Term) services.

One-Day Counts

On April 1, 2018, approximately 96,000 (95,929) clients were in treatment.[34] The distribution of the one-day counts among the service types was:

[34] CalOMS Tx.

Table 16: One-Day Counts by Service Type, SFY 2016-2017 through 2017-2018

Major Service Type	SFY 2016-2017	SFY 2017-2018
Narcotic Treatment Program (NTP)	58.6	52.9
Outpatient Drug Free (ODF)	29.7	33.3
Residential (Short/Long term)	8.1	10.2
Intensive Outpatient Treatment (IOT)	2.4	2.6
Residential Detoxification	0.5	0.6
NTP Detoxification	0.6	0.4
Non NTP Detoxification	0.0	0.0

Treatment Client Admission and Discharge Information

DHCS analyzes CalOMS Tx data on clients receiving SUD treatment services in publicly-funded treatment programs and all private, for-profit NTP programs, regardless of funding source. During SFY 2017-2018, there were approximately 159,502 admissions to treatment. This includes admissions to publicly monitored SUD detoxification, residential, and outpatient services, and about 120,934 unique clients admitted to treatment during the same period. Clients having multiple admissions to treatment during a year account for the difference between the number of admissions and the number of clients.

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

Table 17: Admissions per Service Type, SFY 2017-2018

Major Service Type	SFY 2016-2017	SFY 2017-2018
Outpatient Drug Free (ODF)	40.0	39.0
Residential (Short/Long Term)	22.0	25.0
Narcotic Treatment Program (NTP)	16.0	17.0
Residential Detoxification	17.0	12.0
Intensive Outpatient Treatment (IOT)	5.0	5.0
NTP Detoxification	N/A	2.0
Non NTP Detoxification	N/A	0.0

Detoxification by itself does not constitute complete SUD treatment, but 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 characterized by patterns of repeated relapse leading to stability.

Since 14 percent of the admissions in CalOMS Tx were for detoxification during SFY 2017-2018, including them in the analyses would distort the client characteristic statistics. Thus, for the summary below, detoxification admission data were not included. The figures in this section reflect admission data for over 136,500 non-detoxification admissions.

Client Characteristics

Compared with SFY 2016-2017, SFY 2017-2018 admissions among clients aged 18 and younger declined from 8 percent to 7 percent, and admissions among those in the 18-25 category saw an even larger decline from 17.3 percent to 14.6 percent. Admissions in the age groups 26-35 years through 55 and older were stable.

Table 18: Client Age, SFY 2017-2018

Age	SFY 2017-2018
Under 18 years	7.00%
18-25 years	14.60%
26-35 years	35.50%
36-45 years	20.80%
46-54 years	14.00%
55 and older	8.10%

Race/ethnic proportions for SFY 2017-2018 were about the same as for SFY 2016-17. Admissions by race/ethnicity were as follows:

Table 19: Client Race/Ethnicity, SFY 2017-2018

Race/Ethnicity	SFY 2017-2018
African American	10.0%
American Indian/Alaska Native	1.2%
Asian/Pacific Islander	2.1%
Hispanic	40.2%
Multiracial	2.3%
Other	2.8%
Non-Hispanic White	41.5%

Gender proportions for SFY 2017-2018 were also about the same as for SFY 2016-17. Admissions by Gender were as follows:

Table 20: Client Gender, SFY 2017-2018

Gender	SFY 2017-2018
Male	60.50%
Female	39.40%
Other	0.20%

*Due to rounding, some client characteristics percentage columns may not total 100%.

Primary Drug Reported at Admission

The primary drug reported at treatment admission is defined as the drug causing the greatest dysfunction to the client at the time of admission. The order of primary drug reported at admission remained the same for 2017-2018 as it was in 2016-2017. The percentages for all categories remained steady except for a slight decrease of 1.5 percent for alcohol and a nearly 2 percent decrease for marijuana.

Table 21: Primary Drug at Admission, SFY 2017-2018

Primary Drug	SFY 2016-2017	SFY 2017-2018
Methamphetamine	33.0	33.0
Heroin	25.0	25.0
Alcohol	18.0	20.0
Marijuana/Hashish	15.0	13.0
Other Opiates or Synthetics	3.0	3.0
Cocaine/Crack	3.0	3.0
Oxycodone/OxyContin	1.0	1.0
Other	1.0	2.0

Discharge Statistics

During 2017-2018, there were approximately 145,846 discharges from treatment services (i.e., detoxification residential, outpatient) for about 112,764 unique clients. There were approximately 131,000 non-detoxification discharges in 2017-2018. Similar to admissions, clients may have multiple discharges in a given year since facilities submit a discharge at the end of each treatment service to which the clients were admitted. This accounts for any difference between discharge counts and client counts. Detoxification services are brief and frequently repeated multiple times a year, therefore they have been excluded from the analyses in this section so as not to bias the discharge statistics.

Of the two types of discharges, Standard and Administrative, 53.9 percent of discharges were standard discharges and 46.1 percent of discharges were administrative during 2017-2018. In 2016-2017, 56 percent of discharges were Standard and 41 percent were Administrative. A Standard discharge is used whenever the client is available to respond to DHCS's outcomes measurement questions. When the client is not available to respond, DHCS categorizes the discharge as Administrative.

The five percent increase in the number of Administrative Discharges over 2016-2017 means that there is still a gap in a treatment provider's ability to collect data based on the criteria adopted in 2010 for any discharges coded as "completed treatment."

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

Length of Stay

The length of stay is the number of days a client stays in treatment from admission to discharge. Research verifies that longer stays in treatment are associated with positive outcomes. Conversely, shorter lengths of stay are related to a lack of engagement in treatment and poor treatment outcomes.

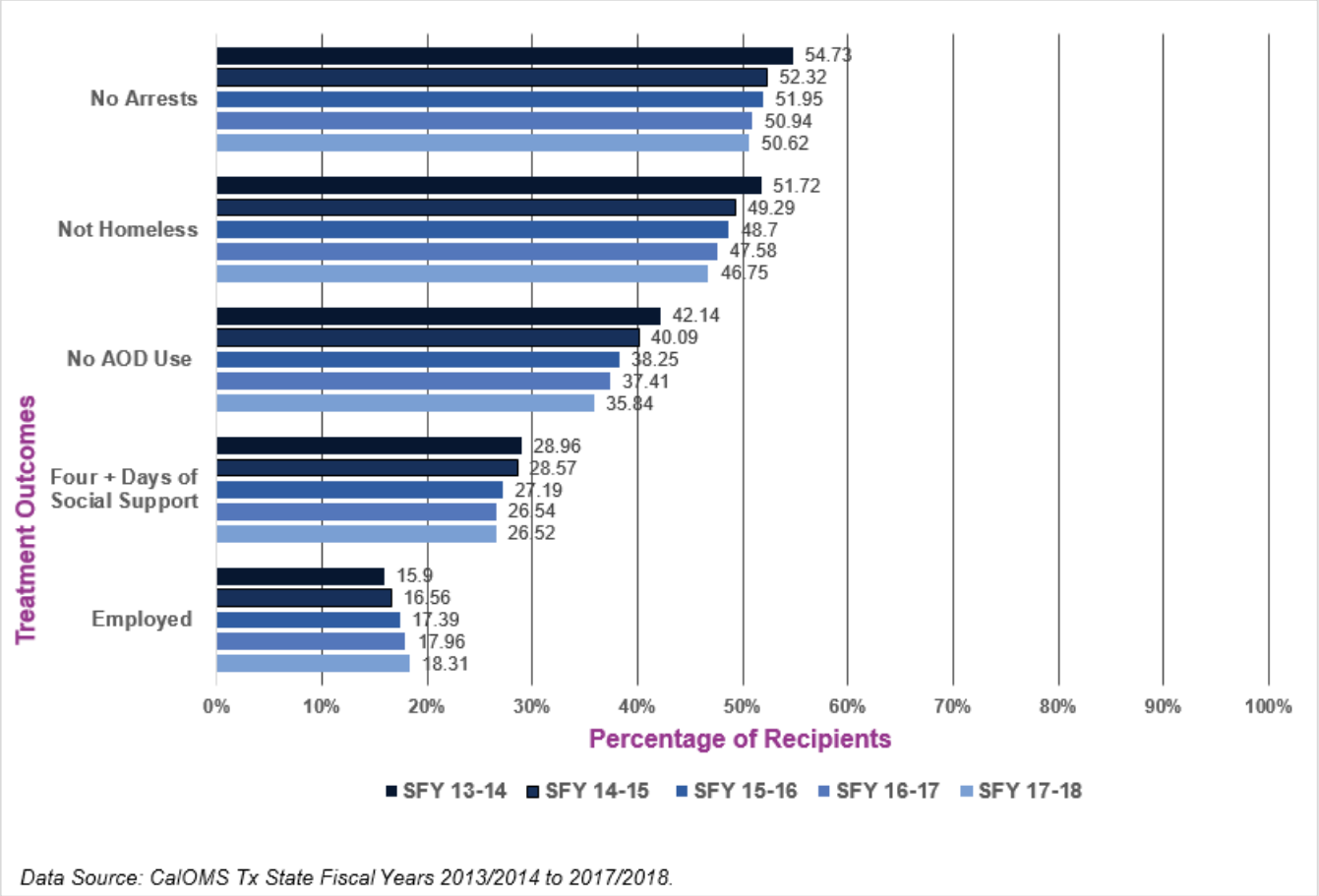
- The longest stays occur in NTP services, with 30.6 percent of the clients receiving services for one year or more.
- Over 44 percent of the clients receiving outpatient treatment services and almost 37 percent in intensive day-care programs stayed 90 or more days.
- In 2017-2018, about 33 percent of outpatient treatment stays were 30 or more days, a 1 percent increase over 2016-2017.

The one percent increase in length of outpatient treatment stay, along with the increased number of Administrative Discharges, indicates a continuing opportunity to improve treatment engagement strategies for treatment providers with higher rates of short stays.

Client Outcome Measures

Figure 3 shows five treatment outcomes measures from SFY 2013-2014 to SFY 2017-2018 for outpatient treatment services. Employment consistently increased over the past 5 years, while no arrests in the past 30 days and those receiving adequate social support percentages remained stable. No alcohol or other drug use and those not homeless had a slight percentage decrease among outpatient treatment clients during the study period.

Figure 3: Treatment Service Recipient Outcomes: Outpatient Drug Free



Data Source: CalOMS Tx State Fiscal Years 2013/2014 to 2017/2018.

Again, please note the increase in missing data related to administrative discharge reporting contributes to DHCS not being able to document outcomes for some clients. Outpatient treatment administrative discharges accounted 47.8 percent of all discharges for SFY 2017-2018.

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

Based on the data collected and the analyses performed during the production of this SNAP Report, the state has established the Strategic Initiatives described below for improving SUD treatment and prevention activities, and will report on progress for goals and objectives created to effect achievement of these initiatives during the annual SABG Application process.

Strategic Initiative #1: Continue to address the opioid and stimulant crises through the health, justice involved, Tribal and other delivery systems through California's MAT Expansion Project and Behavioral Health Response and Rescue Project.

Strategic Initiative #2: Design and implement CalAIM including waiver renewals, payment reform, documentation reform, pre-release enrollment, and administrative integration to expand access to SUD treatment and improve services.

Strategic Initiative #3: Strengthen California's prevention infrastructure through statewide strategic planning efforts and implement a state-supported program that will evaluate innovative primary prevention programs to achieve the level of evaluation rigor and measure evidence of positive outcomes.

Strategic Initiative #4: Improve access and reduce disparities among youth in school and community based settings through widespread implementation of California's Children and Youth Behavioral Health Initiative, Elevate Youth CA and other youth focused efforts especially in communities disproportionally affected by the war on drugs.

Strategic Initiative #5: Expand and increase programming for the Assisted Outpatient Treatment (Laura's Law) in California through supporting counties considering implementation and new implemented counties with TA and training. Laura's Law provides court-ordered treatment for individuals with co-occurring disorders.

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)

MEETING THE NEED FOR SERVICES

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, 2,769,000 (8.36 percent) of Californians were in need of but did not receive SUD treatment; specifically:

- 1,132,000 (3.42 percent) Californians aged 12+ were in need of SUD treatment at a specialty facility for illicit drug use in the past year, compared with 921,00 (2.8 percent) in CY 2015-2016; and
- 2,008,000 (6.07 percent) Californians aged 12+ were in need of SUD treatment at a specialty facility for alcohol use in the past year, compared with 1,776,000 (5.4 percent) in CY 2015-2016.

INTERIM SERVICES

California passes the strict network adequacy requirements for SABG recipients, outlined in the Public Health Services Act (42 USC § 300x 21 through 300x 66), through to California Counties via a DMC-ODS State-County Contract. When contracted counties are at capacity and cannot provide immediate services, DHCS has a process to authorize counties to refer clients in need of treatment services to a nearby county, thus ending waitlists in California.

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 clients receiving SUD treatment services from publicly monitored treatment programs. CalOMS Tx collects service data for DMC, DMC-ODS, 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, client's admission and discharge information, length of stay, client outcome measures, and program performance measures.

DRUG ALCOHOL TREATMENT ACCESS REPORT

The Drug 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 clients 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 meet client service needs.

PRIMARY PREVENTION SUD DATA SERVICE

As previously mentioned, 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 meet defined standards of quality, data that are timely, logical, accurate, complete, and valid. PPSDS allows counties to enter their Strategic Prevention Plan 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

Information presented in this SNAP Report is intended to give guidance to state and local planners working in the behavioral health field. Through ongoing administration of California's federal and state funded programs, DHCS utilizes data highlighted in this SNAP Report and continuously involves its stakeholders and program participants in planning processes that inform capacity-building needs and determine program priority areas and populations.

Proper monitoring by DHCS of its grant-funded programs involves allocating resources effectively for activities that generate the highest public benefit, and diligently improving program and process to address gaps and emerging trends in behavioral health effectively.

We can conclude from the multiple data presented in this report that youth marijuana use is on the rise in California after steadily declining between 2011/13 and 2015/17. Specifically, the CHKS's report on marijuana use surmises that there may be three contributing factors: a weakening of negative attitudes toward marijuana use; a leveling-off in declines in marijuana availability since 2015/17; and the rise of more diverse methods of administration such as inhalation through vaping devices such as electronic vaping devices and oral ingestion of edibles and liquids. Moreover, youth are beginning marijuana use at younger ages. California has recognized that primary prevention services must focus on younger age groups and, according to program data, has been serving a majority of youth between the ages of 12 to 17 as early as 2012. Nevertheless, there is more to do. DHCS has developed two Strategic Initiatives that will have an impact on youth prevention. Specifically, Strategic Initiative #3 plans to strengthen California's prevention infrastructure through statewide strategic planning efforts, and expand the number of California programs, practices and strategies deemed to have some level of evidence of positive outcomes. As well, Strategic Initiative #4 seeks to improve access and reduce disparities among youth in communities of color, tribal communities and other communities disproportionally affected by the war on drugs through widespread implementation of the Children and Youth Behavioral Health Initiative, Elevate Youth CA, and other statewide, culturally responsive youth empowerment efforts.

The implementation of California's MAT Expansion Project has saved many lives, and continues to save more by funding and coordinating 30 projects that provide more access points for MAT, reduce stigma of opioid addiction, and distribute and train on the use of the overdose reversal drug, naloxone. However, statistics still show that overdose ED visits and deaths continue to increase, and there is a threefold increase in the use of psychostimulants in California (including methamphetamine). To address the growing epidemic of stimulant use, DHCS will specifically focus on expanding treatment in diverse settings: health care, justice, Tribal, and other delivery systems and to leverage opportunities through CalAIM and BHRRP.

In order to continue to meet the behavioral health needs of individuals, DHCS will emphasize all of the Strategic Initiatives outlined above, to improve access to and availability of primary and secondary prevention, treatment, and support services to all Californian's. Through its continued strategic planning process, DHCS will examine each strategic priority and develop goals, objectives and strategies to address California's SUD problems. The CalAIM and Youth Behavioral Health Initiatives will be major shift in the way California provides behavioral health services in the state. DHCS will continue work collaboratively with its stakeholders, providers and community partners to address system gaps, evaluate system efficiency and effectiveness and make course correction where needed. Finally, the FFY 2021-2022 SABG application priorities, goals, and performance measures must take into account and plan around overarching and rapidly changing health care policy topics all in an effort to improve the physical, behavioral, and emotional health of all Californians.