

STATEWIDE NEEDS ASSESSMENT AND PLANNING REPORT

Fiscal Year 2023

For the Substance Use Block Grant Federal Reporting Requirement

**California Department of Health Care Services
Community Services Division**



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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 Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). 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 SUBG-authorized activities in California. The report is organized in accordance with the applicable statute. The final SNAP Report is made available on the DHCS 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 2023 SNAP Report, California presents a broad range of data collected between 2015 and 2021. 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 2023

EXECUTIVE SUMMARY

The 2023 SNAP Report provides compelling substance use and misuse data providing a high-level overview of California's substance use disorder (SUD) incidence and prevalence, the 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 2023 SNAP Report provides California's SUD incidence and prevalence rates among 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 been steadily declined since 2017. Survey respondents who were 18 years or older also show a decline in the misuse of prescription medication. The data also shows reductions for past 30-day marijuana use, age of first marijuana use, and methods of marijuana ingestion, for the same age group.

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 15,443 alcohol attributable deaths occurred in California for the period 2015 through 2019. Males accounted for a majority of these deaths. In 2021, California hospitals tallied 57,000 emergency department (ED) visits and 21,000 hospitalizations for non-fatal drug overdose. During the same year, 10,898 Californians died from a drug-related overdose; 7,000 of those were opioid-related and 5,810 involved fentanyl.¹ 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 (OUD) epidemic, the state has seen an alarming increase in overdose deaths related to psychostimulants with abuse potential such as cocaine and methamphetamine since 2015.

With substantial investment in behavioral health at the federal level from the American Rescue Plan Act of 2021 and Coronavirus Response and Relief Supplemental Appropriations Act of 2021, and the state level, California continues to implement innovative initiatives focused on improving outcomes for all beneficiaries receiving prevention, harm reduction, treatment, and recovery services. While the SNAP meets the

¹ [CA Overdose Dashboard](#). Accessed on (May 15, 2023).

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federal reporting requirements for SUBG, this report will also highlight other various behavioral health programs.

Beginning SFY 2019-2020, DHCS began re-evaluating the methodology for allocating SUBG funding. In SFY 2019-2020, DHCS revised the contract period 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 policy 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 SUBG funds for Cost Sharing Assistance, and to allow DHCS to set-aside 5 percent of its SUBG funding for oral fluid rapid Human Immunodeficiency Virus (HIV) testing services.

Additionally, DHCS announced a 5 percent increase from 20 to 25 percent as the minimum percentage of SUBG primary prevention funding to spend. 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 2023 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 the 2022 and 2023 SUBG 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 2023 SNAP Report are the most current information available for 2019 through 2021. 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 Survey²

The State California Healthy Kids Survey (CHKS) is an anonymous statewide survey administered biennially to students at grades 7, 9, and 11. CHKS collects data to assess the well-being of California students and how well California schools are meeting student needs. The data collected covers key indicators of student engagement, positive development, mental health, and risk behavior, and particularly substance use. For the purpose of this SNAP Report, DHCS will utilize 2017-2019 and 2019-2021 CHKS data to report youth substance use perceptions and patterns.

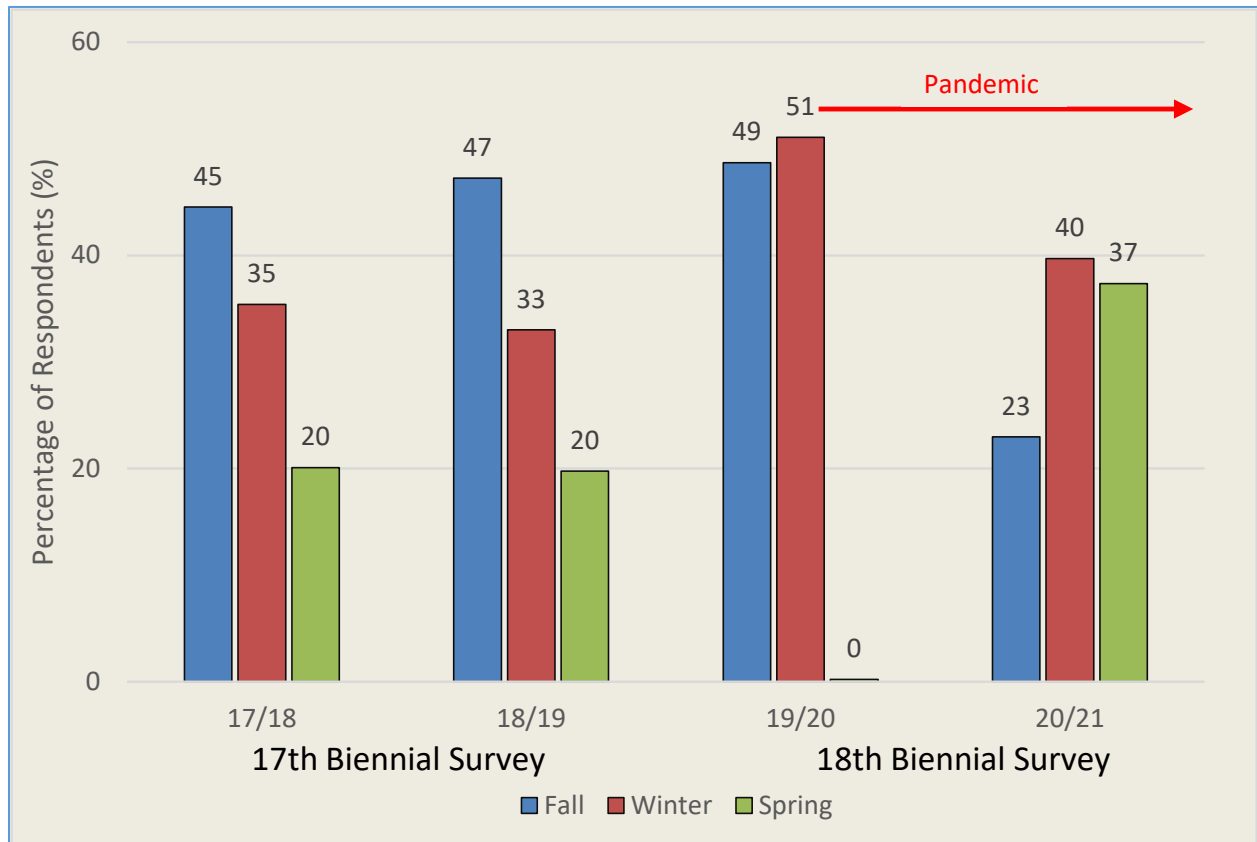
Data collection for the Eighteenth Biennial State CHKS 2019-2021 differed dramatically from previous administrations due to the COVID-19 pandemic. First, survey administration in the 2019-2020 academic year ceased in mid-March 2020 when the vast majority of California schools ended in-person instruction and nearly all students continued their schooling remotely. Second, school buildings remained closed for most of the 2020-2021 academic year. As of the end of April 2021, most students in California were still distance learning. The consequences of pandemic-related school building closures on the timing of survey administration can be seen in Exhibit 1 which shows

² [The California School Climate, Health, and Learning Survey \(CalSCHLS\) System - Reports & Data](#)

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that, for the *Eighteenth Biennial State CHKS*, just a handful of students took the survey in spring 2020. Moreover, schools were less likely to administer the survey in fall 2020 than in a typical survey year. Only 23 percent of schools administered the survey in fall 2020-2021 compared to 45-47 percent in a typical survey year.³

Exhibit 1: Survey Administration Timing by Season and Survey Year



Source: *Biennial State California Healthy Kids Survey Data, 2017–19 and 2019–21*
 Fall is defined as October through December, winter as January through March, and spring as April through June.

In California, alcohol use among youth has decreased. The 2019-2021 CHKS data in Table 1 groups the frequency of alcohol use in the past 30 days into increments of days. The combined total for students who reported they drank one or more drinks in the past 30 days is 2.7 percent of 7th graders, 6.5 percent of 9th graders, and 13.6 percent of 11th

³ Typically, approximately 60% of participants take the survey during the first year of the biennial period and 40% take the survey during the second year. This pattern held true for the *Eighteenth Biennial CHKS Report*

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graders. In comparison, the 2017-2019 CHKS shows a combined total of 4.2 percent of 7th graders, 9.3 percent of 9th graders, and 16 percent of 11th graders stated that they had used one or more drinks of alcohol in the past month.

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

Frequency	Grade 7		Grade 9		Grade 11	
	2017-2019*	2019-2021	2017-2019*	2019-2021	2017-2019*	2019-2021
0 days	95.8%	97.2%	90.7%	93.5%	84.0%	86.3%
1 or 2 days	3.4%	2.3%	6.7%	4.8%	10.4%	9.2%
3 to 9 days	0.6%	0.3%	1.7%	1.0%	3.5%	3.2%
10 to 19 days	0.1%	0.0%	0.5%	0.3%	1.0%	0.6%
20 or more days	0.1%	0.1%	0.4%	0.4%	1.0%	0.6%

In addition, the level of alcohol use among youth has been steadily declining since 2017-2021. The 2019-2021 CHKS data in Table 2 measures the level of alcohol use for lifetime drinking and driving involvement, binge drinking (5 drinks in a single setting), and very drunk or sick after drinking alcohol. The combined total among high schoolers for lifetime drinking and driving involvement is 44.3 percent, binge drinking (5 drinks in a single setting) is 11 percent, and very drunk or sick after drinking alcohol is 21 percent. In comparison, the 2017-2019 combined total for high schoolers lifetime drinking and driving involvement is 49.5 percent, binge drinking (5 drinks in a single setting) is 14.2 percent, and very drunk or sick after drinking alcohol is 25 percent.

Table 2: Measures of Level of Alcohol Use

Frequency	Grade 7		Grade 9		Grade 11	
	2017-2019*	2019-2021	2017-2019*	2019-2021	2017-2019*	2019-2021
Lifetime drinking and driving involvement	28.4%	25.6%	8.3%	7.0%	12.8%	11.7%
Binge Drinking (5 drinks in a row at a single setting)	1.3%	0.8%	4.3%	2.8%	8.4%	7.4%
Very drunk or sick after drinking alcohol	2.8%	1.8%	9.1%	6.8%	18.6%	15.7%

The 2019-2021 CHKS data in Table 3 shows a decrease among students using marijuana in the past 30-days by smoking, vaping, eating, or drinking compared to 2017-2019. Reductions also occurred for engaging in each of the methods of marijuana ingestion (smoking, vaping, and oral ingestion), with one exception: vaping marijuana remained level among 11th graders. About one-fifth of high school students reported ever vaping, and they were more likely to have vaped marijuana than a nicotine/tobacco product.

Table 3: Current Marijuana Use (Past 30 Days)

Data Year	Grade 7	Grade 9	Grade 11
2017-2019	3.6%	9.7%	16.1%
2019-2021	1.5%	6.1%	12.1%

When examining responses to CHKS’s age of onset of marijuana use question, we find the highest percentage of 7th graders first used marijuana at age 11 or 12, 9th graders at age 13 or 14, and 11th graders at age 15 or 16. According to this data, the age of onset appears to be dropping to a younger age than in past years.

Table 4: Age of Onset - Marijuana Use

Age of Onset	Grade 7		Grade 9		Grade 11	
	2017-2019*	2019-2012*	2017-2019*	2019-2021*	2017-2019*	2019-2021*
Never	93.7%	95.6%	83.6%	87.0%	70.4%	72.8%
10 years or	0.9%	0.6%	1.3%	0.8%	1.2%	0.9%
11/12 years old	4.3%	3.0%	3.4%	2.7%	2.5%	2.0%
13/14 years old	0.7%	0.4%	10.2%	8.5%	8.4%	9.4%
15/16 years old	0.1%	0.1%	1.2%	0.7%	16.1%	13.9%
17 years old	0.3%	0.4%	0.3%	0.3%	1.3%	0.9%

The 2019-2021 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 in Table 5 show an overall decline in past 30-day misuse of prescription medications for surveyed students in 2019-2021 compared to 2017-2019.

Table 5: Past 30-day Misuse of Prescription Pain Medication

Data Year	Grade 7	Grade 9	Grade 11
2017-2019	Not Asked	2.0%	2.0%
2019-2021	Not Asked	1.2%	1.4%

California Health Interview Survey⁴

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.

⁴ [California Health Interview Survey \(CHIS\), University of California Los Angeles](#)

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The CY 2021 CHIS asked youth aged 12 to 17 if they ever had more than a few sips of an alcoholic drink. The survey results showed out of 673,000 youth, 145,368 (21.6 percent) reported having more than a few sips, which remains steady from the previous year.

Table 6: Ever Had More than a Few Sips of an Alcoholic Drink

Data Year	Percentage	95% CI	Population
2019	26.2%	22.4 - 29.9	808,000
2020	21.5%	18.6 - 24.4	676,000
2021	21.6%	18.9 - 24.4	673,000

In CY 2021, survey results in Table 7 showed that out of 15,225,000 youth aged 12 and older, 7,079,625 (46.5 percent) reported having ever tried marijuana or hashish in any form. This is a 1 percent increase from CY 2020. Of those who reported having ever used marijuana or hashish, 34.6 percent of respondents aged 18 years or older reported using it within the past 30 days, an increase of 1.1 percent over CY 2020.

Table 7: Ever Tried Marijuana or Hashish in Any Form

Data Year	Percentage	95% CI	Population
2019	45.1%	44.1 - 46.1	14,910,000
2020	45.5%	44.5 - 46.4	14,911,000
2021	46.5%	45.7 - 47.2	15,225,000

In CY 2021, Table 8 shows that 2 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. There was no change from CY 2020.

Table 8: Misused a Prescription Pain Killer in the Past 12 Months

Data Year	Percentage	95% CI	Population
2019	2.6%	2.3 - 3.0	791,000
2020	2.0%	1.7 - 2.3	603,000
2021	2.0%	1.7 - 2.2	583,000

National Survey on Drug Use and Health⁵

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. Additionally, 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 indicates 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 disorder⁶ in the past year, compared to 0.52 percent in 2017-2018.

⁵ [NSDUH 2018-2019 Report](#).

⁶ 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).

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- » 3.60 percent of Californians aged 12+ years reported pain reliever misuse⁷ 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 binge⁸ alcohol use in the past month, statistically less than 24.46 percent in 2017-2018.
- » The percentage of heavy drinkers⁹ 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 drinkers¹⁰ 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.

⁷ 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.

⁸ 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.

⁹ Heavy drinking is defined as adult males having more than 14 drinks per week and adult females having more than seven drinks per week.

¹⁰ 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.

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 Overdose Surveillance Dashboard,¹¹ in 2021, 10,898 Californians (27 per 100,000; age-adjusted) died from a drug-related overdose. More than 7,000 Californians died from an opioid-related overdose and 83 percent of those deaths were fentanyl-related. There were over 57,000 emergency department visits and 21,000 hospital admissions related to a non-fatal drug overdose. Even though California's overall rates of drug related deaths were about the same as the national average (28 per 100,000; age-adjusted),¹² the absolute magnitude of the problem among California's nearly 40 million people is substantial.

Table 9 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. In 2021, the rate of overall opioid-related overdose deaths in California increased 128 percent since 2019; 18.0 per 100,000 residents, the highest number recorded. Although opioid prescription-related fatal overdoses had consistently decreased, there was a slight increase in 2020 that remained in 2021. Synthetic opioid-related fatal overdoses (namely, fentanyl) have continued to consistently increase.

Additionally, overdose deaths due to stimulant drugs (i.e., cocaine and psychostimulants with abuse potential such as methamphetamine) have also been increasing. Since 2019, California has seen an increase in cocaine-related overdose deaths from 2.0 deaths per 100,000 California residents per year to 3.4 per 100,000, and a doubling of psychostimulant with abuse potential-related overdose deaths from 6.9 per 100,000 California residents per year to 14.1 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:

¹¹[California Overdose Surveillance Dashboard](#).

¹²[Center for Disease Control and Prevention, Drug Overdose Data](#).

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a 3-fold increase for cocaine-related mortality (from 1.4 to 4.5 per 100,000 residents) and a fivefold increase for psychostimulant-related (mostly methamphetamine) mortality (from 0.8 to 3.9 per 100,000 residents), 2012-2018.¹³

Table 9: Drug-Related Overdose Deaths in California by Drug Type, Age-Adjusted Rate (95 percent Confidence Interval) per 100,000 Residents, 2017-2021¹⁴

Data Year	Any Opioid	Prescription Opioids (without Synthetics)	Synthetic Opioids (excluding methadone)	Heroin	Cocaine	Psycho-stimulants with Abuse Potential
2017	5.2 (5.0, 5.5)	2.8 (2.6, 2.9)	1.3 (1.2, 1.4)	1.7 (1.6, 1.8)	1.0 (0.9, 1.1)	4.6 (4.4, 4.8)
2018	5.8 (5.6, 6.1)	2.6 (2.4, 2.7)	2.2 (2.0, 2.3)	1.9 (1.8, 2.0)	1.5 (1.3, 1.6)	5.8 (5.6, 6.1)
2019	7.9 (7.6, 8.2)	2.6 (2.4, 2.7)	4.2 (4.0, 4.4)	2.4 (2.2, 2.5)	2.0 (1.9, 2.2)	6.9 (6.7, 7.2)
2020	13.5 (13.2, 13.9)	2.9 (2.7, 3.0)	10.0 (9.7, 10.3)	2.4 (2.3, 2.6)	2.9 (2.7, 3.0)	10.7 (10.3, 11.0)
2021	18.0 (17.6, 18.5)	2.9 (2.7, 3.1)	15.5 (15.1, 15.9)	1.9 (1.7, 2.0)	3.4 (3.2, 3.5)	14.1 (13.7, 14.5)

According to Table 10 below, there was a wide variation in the number of deaths due to drug-related overdose across California counties in 2021. Mendocino County had the largest opioid-related overdose death rate of 54.7 per 100,000 residents which totaled 47 deaths. Lake County followed closely with an opioid-related overdose death rate of 49.8 per 100,000 residents which totaled 31 deaths. Los Angeles County had an opioid-

¹³[Ciccarone, Daniel \(2021\) The rise of illicit fentanyl, 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](#)

¹⁴[California Overdose Surveillance Dashboard](#). Accessed on (January 5, 2023). Multiple Cause of Death and California Comprehensive Death Files. Prepared by the California Department of Public Health (CDPH) Substance and Addiction Prevention Branch (SAPB), January 2023. Age-adjusted rates are calculated using the projected year 2000 U.S. standard population using the direct method.

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related overdose death rate of 15.4 per 100,000 residents and accounted for the largest death count of 1,573.

San Francisco County continued to be of particular concern in California as San Francisco’s age-adjusted rate per 100,000 residents for an opioid-related overdose death was 42.0 per 100,000 residents, totaling 435 deaths in 2021. This is the third highest death rate per 100,000 residents and the fifth largest death count among California counties. Of further concern is the opioid-related overdose death variance by zip code. San Francisco’s hardest hit zip code had an age-adjusted death rate of 409.7 per 100,000 residents for opioid-related overdose.

Table 10: Any Opioid Related Overdose Deaths in California, Age Adjusted Rate per 100,000 Residents, 2021 ¹⁵

Death Rate (per 100,000 residents)	County List
>40	Lake, Mendocino, San Francisco
>25 to <40	Butte, Humboldt, Kern, Nevada, San Luis Obispo, Shasta, Sonoma, Ventura
>16 to <25	Contra Costa, El Dorado, Marin, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Stanislaus, Sutter, Yuba
>11 to <16	Alameda, Los Angeles, Madera, Placer, Sacramento, San Mateo, Santa Barbara, Santa Cruz, Solano, Tulare
0 to <11	Fresno, Imperial, Kings, Merced, Mono, Monterey, Napa, Santa Clara, Sierra
Count 1-10*	Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Plumas, San Benito, Siskiyou, Tehama, Trinity, Tuolumne, Yolo

**Rate is or may be unstable*

¹⁵[California Overdose Surveillance Dashboard](#). Accessed on (January 5, 2023). Multiple Cause of Death and California Comprehensive Death Files. Prepared by California Department of Public Health (CDPH) Substance Addiction Prevention Branch (SAPB), January 2023. Age-adjusted rates are calculated using the projected year 2000 U.S. standard population using the direct method.

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Table 11 shows the estimated number of all drug-, any opioid-, amphetamine-, cocaine-, and cannabis-related non-fatal overdose ED visits per 100,000 California residents. In 2021, there were 57,499 ED visits in California for a drug-related non-fatal overdose. This marks a 13 percent increase in the rate of ED visits for a drug-related non-fatal overdose when compared to 2020.

Table 11: Emergency Department Visits for Non-Fatal Drug Overdoses in California by Drug Type; Age-Adjusted Rate (95 percent Confidence Interval) per 100,000 Residents, 2017-2021 ¹⁶

Data Year	All Drug	Any Opioid	Amphetamines	Cocaine	Cannabis
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)
2020	130.7 (129.6, 131.9)	41.0 (40.3, 41.6)	7.4 (7.2, 7.7)	1.9 (1.7, 2.0)	7.0 (6.8, 7.3)
2021	148.2 (147.0, 149.4)	53.8 (53.1, 54.6)	7.8 (7.5, 8.1)	1.8 (1.7, 2.0)	7.0 (6.7, 7.3)

Alcohol-Related Disease Impact

Table 12 displays the Center for Disease Control and Prevention (CDC) estimates that an average of 15,443 annual deaths in California during CYs 2015-2019 were attributable to chronic and acute alcohol-related conditions, with males accounting for the vast majority of the alcohol-attributable deaths (69 percent). The top four alcohol attributable acute causes of deaths were alcohol-related poisonings, motor vehicle

¹⁶[California Overdose Surveillance Dashboard](#). Accessed on (January 26, 2023). California Department of Health Care Access and Information (HCAI), formerly Office of Statewide Health Planning and Development - Emergency Department visit and patient discharge data. Prepared by California Department of Public Health (CDPH) Substance and Addiction Prevention Branch (SAPB), December 2022. Age-adjusted rates are calculated using the projected year 2000 U.S. standard population using the direct method.

traffic crashes, suicides, and homicides. Of the 9,943 annual deaths attributable to chronic causes, 4,867 were 100 percent alcohol attributable, with the primary cause being alcoholic liver disease.

Table 12: Average Annual Alcohol-Attributable Deaths in California Due to Excessive Alcohol Use, by Gender – All Ages, 2015-2019 ¹⁷

Causes	Males	Females	Overall
Chronic Causes	6,517	3,426	9,943
Acute Causes	4,148	1,351	5,500
Total	10,665	4,778	15,443

Other Substance Use Disorder Related Health and Societal Consequence Data

Human Immunodeficiency Virus ¹⁸

From 2017 through 2021, both the annual number and rate of new HIV diagnoses declined in California. The number of new diagnoses declined by 9.4 percent – from 4,905 in 2017 to 4,444 in 2021, while the rate of new diagnoses per 100,000 population declined by 10.5 percent, from 12.4 to 11.1 during the same time period. From 2017 through 2021, the number of persons in California living with diagnosed HIV infection increased from approximately 135,468 to over 141,000. In 2021, the prevalence rate of diagnosed HIV infection was 352.9 per 100,000 population, compared to 343.1 in 2017 – an increase of 2.9 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), heterosexual contact (non-high-risk), high-risk-heterosexual contact, perinatal, injection drug use (IDU) alone, MMSC and IDU. Among cisgender men newly diagnosed with HIV infection in 2021, 67.4 percent had MMSC alone, 4.3 percent had IDU alone, and 3.8 percent had MMSC and IDU as their transmission categories. Among cisgender women newly diagnosed with HIV infection in 2021, 14.6 percent had IDU alone as their transmission category.

¹⁷[CDC. Alcohol-Related Disease Impact \(ARDI\) application, 2022.](#)

¹⁸[California Department of Public Health, Office of AIDS, California HIV Surveillance Report — 2021.](#)

Among cisgender men living with diagnosed HIV infection in 2021, 77.1 percent had MMSC alone, 4.0 percent had IDU alone, and 7.1 percent had MMSC and IDU as their transmission categories. Among cisgender women living with diagnosed HIV infection in 2021, 16.1 percent had IDU alone as their transmission category.

Tuberculosis

In 2021, there were 1,1752 cases of Tuberculosis reported in California. Of these cases, 18 (1.0 percent) occurred within the IDU population, compared to 26 (1.2 percent) reported in 2019.¹⁹

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 includes the CORE module and Alcohol and Other Drug (AOD) Module which requires continuous marketing at the state and local levels to gain buy-in to administering these modules. DHCS's State Epidemiological Workgroup worked collaboratively with the survey developer, WestEd, to revise the Core and AOD Module in 2020-2021, expanding the scope to a broader behavioral health module and to provide support to students in various instructional settings including in-person and at home.
- » 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 non-institutionalized population. While the CHIS utilizes a large and representative adult sample, the adolescent sample is smaller. However, the methodology for collecting the data changed in 2019, CHIS transitioned to a

¹⁹ [TB Disease Data and Publications](#)

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mixed-mode survey (web and telephone), this is a change from being just a telephone survey.

- » 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. The 2018-2019 NSDUH data was used because the 2019-2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) is no longer available and there currently isn't any newer data at the time of this publication. The 2019-2020 State estimates for these years are no longer available due to methodological concerns with combining 2019 and 2020 data. Because of the COVID-19 pandemic, most respondents answered the survey via the web in Quarter 4 of 2020, even though all responses in Quarter 1 were from in-person interviews.
- » 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 and continued enhancements to data reporting methodologies.
- » DHCS is committed to strengthening public behavioral health reporting to improve transparency and accountability through the Comprehensive Behavioral Health Data Systems Project. 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)

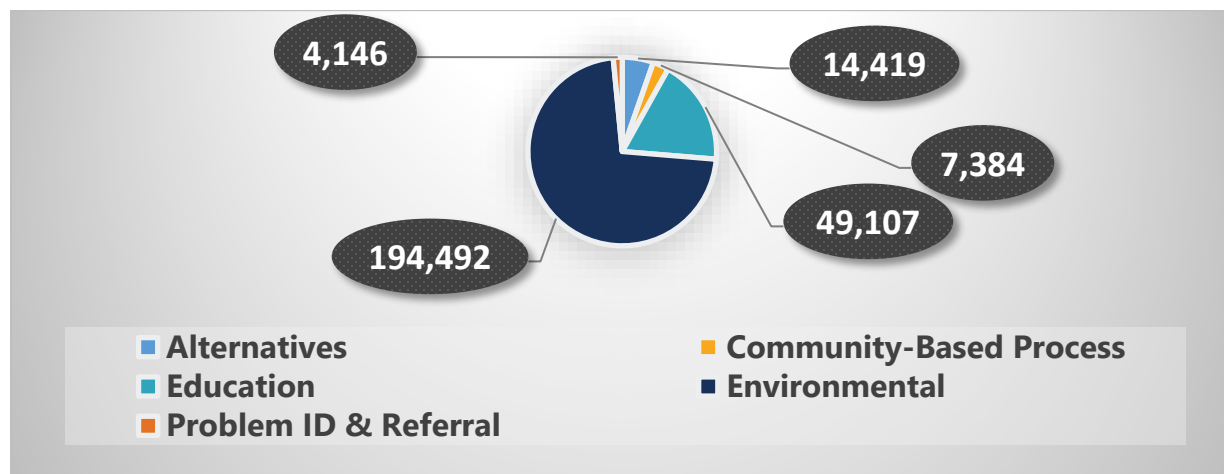
Intended Use of Funds Relating to Prevention and Treatment

Description of Statewide Substance Use Disorder Primary Prevention Capacity

In SFY 2020-2021, DHCS disbursed approximately \$58 million²⁰ of SUBG funds to each of the 58 counties to conduct locally identified primary prevention activities.²¹ Beginning in SFY 2020-2021, DHCS changed the requirement for counties to expend 25 percent of the total allocation on primary prevention activities, a five percent increase from previous years. 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 February 23, 2023, there were 242 providers authorized by DHCS specifically to provide primary prevention services to Californians.

Primary Prevention Activities – Strategies Used

Figure 1: Number of Individuals Served by Primary Prevention Service Strategies SFY 2020-2021 | Date Collected: 12/13/2022



Data Source: DHCS, Primary Prevention SUD Data Service | Prepared by: DHCS

²⁰ [DHCS BH INFORMATION NOTICE No: 20-034, Exhibit A](#)

²¹ [DHCS BH INFORMATION NOTICE No: 20-034, Exhibit B](#)

Information Dissemination Strategy

DHCS' primary prevention data collection system in SFY 2020-2021 did 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 2020-2021 were:

- » Social Media Development and Maintenance
- » Presentations
- » Multi-Media
- » Community/School Outreach Events

Education Strategy

The number of primary prevention service activities reported under the Education Strategy for SFY 2020-2021 include:

- » Classroom/School Educational Services = 4,485
- » Community Educational Service = 3,323
- » Student Assistance Programs = 3,100
- » Mentoring = 1,281

Alternative Strategy

A majority of the activities reported within the Alternative Strategy include those conducted for and by participants in California's youth development and leadership model, [Friday Night Live \(FNL\)](#).²² In SFY 2020-2021, 47 out of 58 counties²³ coordinated 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 service activities for SFY 2020-2021 were:

- » Youth/Adult Leadership Activities = 111,175
- » Social/Recreational Events/Activities = 972
- » Community Service Activities = 87

²² [Friday Night Live \(tcoe.org\)](#)

²³ [DHCS MHSUDS INFORMATION NOTICE NO.: 20-047, Exhibit B](#)

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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 service activities for SFY 2020-2021 were:

- » Prevention Screening and Referral Services = 1,876
- » Student Assistance Programs = 728

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 service activities for SFY 2020-2021 were:

- » Training and Technical Assistance = 6,541
- » Coalition/Workgroup Activities = 6,309
- » Program Development & Improvement = 2,599
- » Assessing Community Needs/Assets = 1,744

Environmental Strategy

The Environmental Strategy focuses on creating systems and policy change in social, community and retail environments. For the SFY 2020-2021, the most commonly reported Environmental Strategy service activities were:

- » Community and Neighborhood Mobilization = 963 services
- » Efforts with City, County, Tribal, and/or State Officials = 490 services
- » Media Advocacy = 233 services

Primary Prevention Activities – Demographics

Gender

More individuals self-identifying as females than males were served in SFY 2020-2021 (see Table 13). The general population of California contains fewer males than females while individuals self-identifying as "Gender Unknown" 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

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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 13: Number of Individuals Served by Primary Prevention Service Strategies, by Gender, SFY 2020-2021²⁴

Gender	Persons Served	California Population ²⁵	Percentage of Populations Served	Percent of Total Population by Gender
Male	82,257	≈19,851,556	0.41%	49.90%
Female	88,823	≈19,930,863	0.45%	50.210%
Gender Unknown	98,468	N/A	N/A	N/A
Total	269,548	≈39,782,419	0.68%	100%

Age

Prevention services data in SFY 2020-2021 below (see Table 14) showed youth aged 12-14 were the largest group of recipients of prevention services. This group makes up nearly 1.57 percent of California's youth population. Though California has been serving a majority of youth between the ages of 12 to 17 as early as 2012, there is still more work to be done in this age group.

²⁴ DHCS primary prevention data collection system.

²⁵ [DOF Population Estimates](#).

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Table 14: Number of Individuals Served by Primary Prevention Service Strategies, by Age Group, SFY 2020-2021²⁶

Age Group	Persons Served	California Population ²⁷	Percentage of Population Served	Percentage of Total Population by Age
0-4	7,792	≈2,306,492	0.34%	5.80%
5-11	8,135	≈3,535,395	0.23%	8.89%
12-14	24,675	≈1,571,051	1.57%	3.95%
15-17	20,125	≈1,592,189	1.27%	4.00%
18-20	5,879	≈1,773,073	0.33%	4.46%
21-24	8,420	≈2,337,930	0.36%	5.88%
Total	75,026	≈13,116,130	.0057%	32.98%

Race

The Race/Ethnicity demographic in DHCS' primary prevention data collection system are categorized by White, Hispanic or Latino, Black or African American, Native Hawaiian/Other Pacific Islander, Asian, American Indian/Alaska Native, More Than One Race, and Race Not Known. For comparison of individuals receiving prevention services, the 2020 California population data from the California DOF is used.

Table 15 provides a summary of all prevention services delivered in SFY 2020-2021, by race. The reported highest number of persons served through SUBG-funded primary prevention strategies is the Race Not Known group, followed by the White racial group. The remaining groups, in order of highest number of persons served, were Asian, More Than One Race, Black/African American, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native.

²⁶ DHCS primary prevention data collection system.

²⁷ [DOF Population Estimates](#).

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Table 15: Number of Individuals Served by Primary Prevention Service Strategies, by Race, SFY 2020-2021²⁸

Race	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Race
White	91,168	15,187,246	0.60%	38.17%
Black or African American	4,804	2,283,480	0.21%	5.74%
Native Hawaiian/Other Pacific Islander	1,708	143,420	1.19%	0.36%
Asian	16,098	5,216,606	0.31%	13.11%
American India/Alaska Native	1,529	173,029	0.88%	0.43%
More Than One Race	7,211	1,097,117	0.66%	2.76%
Race Not Known or Other	147,030	15,681,521	0.94%	39.42%
Totals	269,548	39,782,419	0.68%	100.00%

Ethnicity

Table 16 provides a summary of all primary prevention services delivered in SFY 2020-2021 by ethnicity. The highest number of persons served by Primary Prevention Services Strategies is the Ethnicity Unknown, followed by Not Hispanic or Latino group, then Hispanic or Latino.

²⁸DHCS primary prevention data collection system.

Table 16: Number of Individuals Served by Primary Prevention Service Strategies, by Ethnicity, SFY 2020-2021²⁹

Ethnicity	Persons Served	California Population	Percentage of Population Served	Percentage of Total Population by Ethnicity
Hispanic or Latino	77,704	15,681,521	0.50%	39.42%
Not Hispanic or Latino	88,373	24,100,898	0.37%	60.58%
Ethnicity Unknown	103,471	N/A	N/A	N/A
Total	269,548	39,782,419	0.68%	100.00%

Demographic data for both race and ethnicity collected in DHCS’ primary prevention data collection system 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 disproportionately 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.

Behavioral Health Prevention Plan

DHCS has launched an initiative to create the state’s first [Behavioral Health Prevention Plan](#) (BHPP) with the goal of preventing SUDs and address cooccurring mental health needs. The BHPP will utilize concepts from SAMHSA’s Strategic Prevention Framework.

The BHPP will support California’s behavioral health prevention system by identifying system gaps, root causes and contributing factors to determine priority problems and assess the state’s readiness to address the disparities in behavioral health prevention statewide. The BHPP will promote the use of evidence-based, evidence-informed, and best practices statewide, focuses on building capacity, supports implementation that

²⁹ [DOF Population Estimates.](#)

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advances prevention science for continuous quality improvement, and streamlines process and evaluation data collection.

The BHPP will be used as a tool for counties to utilize in developing and submitting a primary prevention plan to DHCS and requires counties to identify which DHCS goals they align with and the strategies they will implement to better serve their community. Counties will report strategy implementation data in the primary prevention data collection system. Counties will begin implementing the new BHPP strategies in SFY 2024-2025.

Advance Behavioral Health Prevention California

Advance Behavioral Health Prevention California (ABHPC) is a statewide SUD prevention training and technical assistance program and provides capacity building services to support behavioral health prevention workforce development throughout California. Services and resources provided through ABHPC will provide support to DHCS in the implementation and evaluation of the Behavioral Prevention Workforce, through the development, implementation, and evaluation of best practice and research-based curricula and provide no-cost training and technical assistance at the individual, county, regional and statewide level.

Prospectus Group/ECCO System

DHCS contracts with Prospectus Group, LLC to provide services that support the collection of primary prevention data related to SUD and OUD by utilizing the Ecco 10 Namba application. The contract provides the necessary services to DHCS to capture primary prevention data, meet SAMHSA's reporting requirements, and provide ongoing training and support to stakeholders, including counties and providers. Ecco collects program data, tracks provider progress, offers one touch reporting in real time and prepares an annual statewide prevention activity report that captures demographics, evidence-based implementation, and other grant application requirements. The contract additionally provides DHCS data informed recommendations for quality improvement and available prevention literature, as well as statewide quantitative and qualitative data through evaluation surveys and completed reports.

Substance Use Prevention Evidence Based Resource

Led by the University of California, Los Angeles's Integrated Substance Abuse Programs, the Substance Use Prevention Evidence Based Resource, also known as the Expert Think Tank, will consist of experts in academic and clinical evidence-based practices, implementing national and state best practice programming, and on implementation of science and evaluation best practices, including other policy and youth advocacy stakeholders. In addition, the Expert Think Tank will collaborate with the DHCS

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Statewide Epidemiological Workgroup (SEW) to expand the statewide use of evidence-based practices, programs, policies, and strategies to impact statewide outcomes for prevention and meet California's diverse behavioral health needs.

State Epidemiological Workgroup

The [SEW](#) enhances statewide analytical capacity by functioning as an expert data advisory group that recognizes the importance of consistent statewide evaluations to monitor and track outcomes.

The SEW has coordinated efforts with DHCS and California Department of Education to provide feedback on the CHKS Core and AOD modules, provided feedback on the BHPP development, and support the California Department of Public Health through collaboration on the California Opioid Overdose Surveillance Dashboard through the Strategic Prevention Framework-Partnerships for Success Epidemiological contract.

Behavioral Health Response and Rescue Project

[The Behavioral Health Response and Rescue Project](#) (BHRRP) is funded by SAMHSA through supplements to the SUBG and the Community Mental Health Services Block Grant.

BHRRP increases access to behavioral health care for all Californians by assisting communities in need by expanding the behavioral health workforce, supporting mobile crisis services, and funding other projects such as behavioral health justice intervention services, telehealth expansion, and recovery services.

Behavioral Health Workforce Development initiative

DHCS is committed to the statewide expansion of California's behavioral health workforce, as well as all other behavioral health professions, to improve consumer access to and productive participation in behavioral health services. As part of this commitment, in 2021 DHCS implemented the Behavioral Health Workforce Development (BHWD) initiative through the BHRRP to support the Medi-Cal Peer Support Specialist Certification program, peer-run organization start-up activities, implementation of continued efforts by non-profit behavioral health providers, tribal organizations, and county-operated providers to increase behavioral health workforce through trainings, internships, and retention strategies.

California's peer-run behavioral health programs are critically positioned to support the overall expansion of the state's behavioral health peer-run workforce through their pivotal role of facilitating access to care, supporting retention in services, and advocating for others in their recovery process. Through program expansion and enhanced collaboration with health and social services and other systems, peer-run

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programs can help move California closer to its goal of equity in behavioral health services in every community.

Peer Workforce Investment (PWI) project

Through the PWI project, DHCS aims to expand, elevate, enhance, and empower behavioral health peer-run programs in every California community by providing up to \$500,000 per organization. Peer-run behavioral health programs will expand program staffing and capacity; elevate the profile of behavioral health peer-run programs with other entities in communities and statewide through outreach and collaboration; enhance the quality of peer-run programming through education, training, and improved monitoring and supervision; and empower peer-run programs to realize the full potential, including through organizational capacity building, strategic planning, and management support.

DHCS has awarded two rounds of PWI projects. The first PWI cohort provided support to 45 nonprofit organizations, which added 506 staff to the behavioral health workforce through the organizations funded; that staff provided services to more than 22,000 individuals from April 2022, through December 2022. The second PWI cohort will support a total of 5 nonprofit organizations, from June 2023, through December 2024.

Expanding Peer Organization Capacity (EPOC) project

Through the EPOC project, DHCS aims to expand peer-run organizational capacity to provide peer services for mental health and SUD recovery supports and behavioral health services and deliver services under the upcoming Medi-Cal Peer Support Services benefit by awarding up to \$200,000 per organization. Peer-run behavioral health programs participating in EPOC will expand the number of mental health and SUD peer staff through increased and targeted recruitment; improve access for individuals with mental health and SUD challenges; expand peer-run programs' information technology and telehealth infrastructure; and implement activities to develop peer-run programs' capacity and infrastructure, specifically achieving nonprofit status in preparation for the new Medi-Cal peer support services benefit.

DHCS has awarded two rounds of EPOC projects. The first EPOC cohort provided support to 14 emerging peer service providers, which added 170 staff to the behavioral health workforce through the organizations funded; that staff provided services to more than 6,000 individuals from April 2022, through December 2022. The second EPOC cohort will support a total of 23 emerging peer service providers, from June 2023, through December 2024.

Mentored Internship Program (MIP) project

Through the MIP project, with Opioid Settlement Funds, DHCS aims to expand the prevention, treatment, and recovery workforce for individuals with or at risk of developing OUD by awarding up to \$500,000 per organization. The goals of the MIP are to train BH providers and professionals serving individuals with, or at risk of developing OUD; enhance BH providers' ability to effectively prevent, treat and support individuals recovering from OUD; increase the diversity of the BH workforce and inclusion of BH professionals with lived experience; collaborate with local partners to implement internships in conjunction with their local educational institutions beyond 2024 when grant funding ends; and enhance BH providers' abilities to make job offers to better prepared job candidates who have completed the MIP.

DHCS has awarded three rounds of MIP projects. The first MIP cohort provided support to 84 non-profit organizations and county-operated behavioral health service providers across 127 sites in 34 counties from April 2022, through September 2023. The second MIP cohort will support a total of 39 non-profit organizations and county-operated behavioral health service providers, from May 2023, through December 2024. A final round of funding was awarded to 120 behavioral health providers to extend and expand the MIP to previously awarded MIP grantees.

Behavioral Health Recruitment and Retention (BHRR) project

Through the BHRR project, DHCS aims to support behavioral health agencies to develop a personnel framework; plan and implement comprehensive strategies for recruiting, onboarding, engaging, and retaining behavioral health staff; and create inclusive workplaces by awarding up to \$350,000 per organization from July 2023, through January 2025. The intent of the BHRR project is to improve knowledge and implementation of best practices in behavioral health workforce development and change management; strengthen capacity to effectively recruit and retain skilled staff; increase diversity to better reflect the individuals in need of service; and increase sustainability and ability to respond to changing environments by supporting development of and adherence to longer-term strategic plans.

California Friday Night Live

The [California Friday Night Live \(FNL\) Program](#) prioritizes high school-aged youth and is motivated by youth-adult partnerships that create essential opportunities to enhance and improve local communities and create positive and healthy youth development. FNL engages youth as active leaders and resources in their community and encourages youth driven and youth led programming. DHCS uses SUBG funds to provide stipends to counties to support the widespread implementation of the FNL Program. DHCS also

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contracts with [the Tulare County Office of Education, California Friday Night Partnership \(CFNLP\)](#), to allocate funding to counties to support the widespread implementation of the FNL program and provide no-cost program training and technical assistance to providers ensuring program components are followed with fidelity. The CFNLP and partners have developed a myriad of resources over the years to support the FNL Program.

Description of Statewide Substance Use Disorder Treatment Capacity

DMC is a treatment funding source for eligible Medi-Cal members. In order for DMC to pay for covered services, eligible Medi-Cal members must receive SUD services at a DMC certified program. SUD services funded by DMC are listed in Title 22, CCR, Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment. Each of California's 58 counties contracts with DHCS to provide a continuum of primary prevention services and requires counties to provide SUBG allowable treatment services. These services are to supplement, not supplant, SUD services not otherwise covered by [California's Medicaid State Plan \(Title XIX\)](#), DMC. California also sponsors various other SUD initiatives, programs, partnerships, and activities. For more information about DMC services visit [Drug Medi-Cal Overview](#).

Drug Medi-Cal Organized Delivery System

The [Drug Medi-Cal Organized Delivery System \(DMC-ODS\)](#) is Medi-Cal's five-year effort to dramatically expand, improve, and reorganize its system for treating people with SUD. It's a demonstration project that was established through a Medicaid Section 1115 waiver approved by the federal government in 2015.

Prior to DMC-ODS, people with Medi-Cal frequently did not have access to medications. DMC-ODS added all Food and Drug Administration-approved drugs to its formulary, ensuring that doctors and other providers could prescribe whichever medications would be best for their patients' needs. Besides medications, treatment includes counseling and other medical and supportive therapies. The DMC Standard Program included services for outpatient drug-free treatment, intensive outpatient treatment, residential SUD services for perinatal women only (limited to facilities with 16 beds or fewer), naltrexone treatment, narcotic treatment program (NTP) (methadone only), and in-patient hospital detoxification. The DMC-ODS expanded these services to include multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with 16 beds or fewer), case management, NTP expansion to include buprenorphine, disulfiram, and naloxone, withdrawal management (at least one

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American Society of Addiction Medicine level), recovery services, physician consultation, partial hospitalizations, and additional MAT.

The DMC-ODS is a voluntary pilot program which offers California counties the opportunity to expand access to high-quality care for Medi-Cal members with an SUD. The goal of the DMC-ODS is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS are required to provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine Criteria. This approach is expected to provide eligible Medi-Cal members with access to the care and services they need for a sustainable and successful recovery.

There are 38 counties that have submitted Implementation Plans to participate in the DMC-ODS Pilot. Counties must undergo an approval process by both DHCS and Centers for Medicare and Medicaid Services (CMS) before they can begin DMC-ODS services.

In December 2021, DHCS received approval from CMS to reauthorize DMC-ODS, shifting the managed care authority to the consolidated [California Advancing and Innovating Medi-Cal \(CalAIM\) 1915\(b\) waiver](#) and using the Medicaid State Plan to authorize the majority of DMC-ODS benefits. Authority to provide reimbursable Medi-Cal services for DMC-ODS members residing in institutions for mental disease remains in the [1115 demonstration](#) through December 31, 2026. To learn more about DMC-ODS program and updates pursuant to CalAIM, please see [BHIN 23-001](#).

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 changes across the Medi-Cal program. CalAIM identifies and manages member's risk and needs through whole person care approaches and addresses social determinants of health, moves Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and improves quality outcomes, reduces health disparities, and drives delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

CalAIM will strengthen the state's behavioral health continuum of care and promote better integration with physical health care, streamline policies to improve access to behavioral health services, simplify how treatment and prevention services are funded, and support administrative integration of mental illness SUD treatment.

Substance Use Prevention, Treatment, and Recovery Services Block Grant

With broadened implementation of DMC and DMC-ODS, DHCS has changed the way it administers SUBG funding. Historically, DHCS calculated distribution of SUBG 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 SUBG minimum spending requirements.

DHCS continues to use a population-based formula to distribute SUBG funds; however, DHCS has implemented 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 five percent over the federal requirement.

After June 30, 2020, to ease the burden of executing SUBG county contracts every three years, and annually amending those contracts, DHCS integrated the SUBG county contract into a County Performance Contract (CPC). The CPC sets forth conditions and requirements counties must meet in order to receive SUBG funding. DHCS requires counties to prepare and submit an annual County SUBG 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 SUBG Application, as its enclosures are incorporated by reference in the CPC.

DHCS has received authorization from SAMHSA to allow counties to use up to five percent of their total SFY SUBG allocation for oral fluid rapid HIV testing as well as HIV pre- and post-test counseling. Beginning in SFY 2021-2022, DHCS will establish an annual allowance for each county.

Lastly, beginning in SFY 2021-2022, SUBG funds could 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

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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.

California DHCS Opioid Response

The DHCS created the California Medication Assisted Treatment (MAT) Expansion Project to increase access to MAT, reduce unmet treatment need, and reduce opioid overdose-related deaths by investing in prevention, harm reduction, treatment, and recovery. DHCS has renamed the California MAT Expansion Project as the [California DHCS Opioid Response](#) to reflect its comprehensive response to the opioid crisis. The California DHCS Opioid Response has expanded the initial California MAT Expansion Project through the extension or creation various initiatives, programs, and partnerships with the aim of prevention opioid misuse and overdose deaths. The projects focus on populations with limited MAT access including youth, people in rural areas, and American Indian and Alaska Native tribal communities. Additionally, these projects prioritize underserved communities in promoting health and racial equity. Some California DHCS Opioid Response projects are also made available through California State General Funds and Opioid Settlement Funds such as the [ATLAS Treatment Locator](#), [MAT Access Points](#), and [Naloxone Distribution Project](#) to name a few. For more information about current projects visit [California DHCS Opioid Response](#).

Naloxone Distribution Project

The [Naloxone Distribution Project \(NDP\)](#) is funded by State General Funds, Opioid Settlement Funds, and federal grants and is administered by the DHCS. The NDP aims to reduce opioid overdose deaths through the provision of free naloxone in its nasal spray and intramuscular formulations. Eligible entities include law enforcement agencies such as police departments, county jails and probation; fire, emergency medical services and first responders; schools and universities; county public health and behavioral health departments; harm reduction organizations; and community organizations. As of May 4, 2023, the NDP has approved 7,792 applications for naloxone and distributed 2,367,460 kits of naloxone, which have been used to reverse more than 146,927 opioid overdoses, since the project began in October 2018.

California Youth Opioid Response Project

Since 2018, the DHCS has included youth access to services as a key focus of the statewide opioid response through the [California Youth Opioid Response \(YOR California\)](#) project. YOR California seeks to strengthen capacity and access to prevention, treatment, and recovery services, as well as access points to MAT, for youth ages 12 to 24, and their family members. YOR California is providing additional funds to new

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grantees for implementation projects, which provide treatment services to youth, and capacity building projects, which increase access to quality services but don't provide direct treatment. The YOR California project also includes peer-to-peer learning through learning collaboratives, and technical assistance to support grantee efforts. YOR California is supported by federal State Opioid Response fund through a grant provided by the DHCS.

CA Bridge State Opioid Response

The DHCS engaged the [CA Bridge Program](#) in 2018 under the State Opioid Response (SOR) I grant and 2020 SOR II grants from the SAMHSA. Through the success of the 2020 [Behavioral Health Pilot Project](#), SAMHSA awarded DHCS a SOR III grant in 2022, to expand access to MAT for OUD in California hospitals. Since 2018, SOR programs have been awarded \$37,163,339 in funds to expand access to MAT at urgent care, emergency departments, inpatient hospital wards, and hospital-based specialty clinic settings for onsite OUD patients with behavioral health navigators, through the development of community outreach, training, and technical assistance to providers, clinicians, and administrative personnel. CA Bridge SOR I, II, and III, have provided services to 269,781 patients for SUD or mental health issue, with 204,119 patients identified with an OUD, and where 86,628 encounters where MAT was prescribed or administered.

CalBridge Behavioral Health Navigator Program

In the spring of 2022, DHCS allocated \$40 million in American Rescue Plan Act funding to the [CalBridge Behavioral Health Navigator Program](#) for general acute care hospital emergency departments, hospital foundations, and physician's groups statewide, to serve as primary access points for evidence-based treatment of behavioral health symptoms through expanding access to low barrier MAT; providing referral to specialty behavioral health care systems; and using the Community Health Worker as navigators. The program establishes and trains behavioral health navigators to expand access to substance use and mental health services in emergency department settings.

As of April 2023, 278 hospitals have received funding under the CalBridge program, with the program awarding \$36 million in grants directly to hospitals. Behavioral health navigators identify, screen, and interview patients with SUD and co-occurring mental health conditions and link them to appropriate treatment. Under the CalBridge program, 92,949 patients have been seen for a SUD or mental health issue, 74,753 patients identified with an OUD, and 26,316 encounters where MAT was prescribed or administered.

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Other California DHCS Opioid Response Projects include:

- » [Addiction Treatment Starts Here Equity-Centered Community Learning Collaborative and Learning Network](#) which supports primary care health centers in California with designing new or expanding existing for MAT programs,
- » [California Hub and Spoke System](#), which increase access to MAT services throughout the state, particularly in counties with the highest overdose rates,
- » [California Overdose Prevention Network](#), which created a statewide learning network for coalitions, organizations and individuals working with OUD patients,
- » [California Substance Use Line](#), which provides free tele-consultation services for SUD evaluation and management for clinicians,
- » [DUI MAT Integration/Outreach](#), which provides the framework to optimize select driving under the influence programs to become new and effective access points for MAT and other treatment modalities,
- » [Emergency Medical Services Buprenorphine Use Project](#), which supports the implementation of opioid overdose intervention and treatment in the prehospital setting by engaging emergency medical services agencies and 911 transport providers in partnership with public health departments to provide opioid use prevention and treatment,
- » [First Dose Buprenorphine](#), which supports local emergency medical service agencies and providers to provide treatment and access points for patients with an OUD,
- » [MAT Access Points](#), which increases access to comprehensive prevention, education and treatment for opioid and stimulant use disorders and to improve health outcomes for communities of color disproportionately impacted by and penalized for SUDs,
- » [MAT Toolkits and Government Performance and Results Act \(GPRA\) Data Collection](#), which provides various project support and data oversight through the development of educational materials about the benefits of MAT to promote access to this evidence-based treatment,
- » [Media Campaign](#), in partnership with Media Solutions, to create a multi-media and multilingual advertising campaign covering various cities within the state of California, specifically targeting highly effected communities,

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- » [Provider Training – General](#), which provides various training programs regarding current OUD treatment, prevention, and barriers, such as regarding the X-waiver elimination to prescribe buprenorphine,
- » [Residency Program Training](#), where California residency programs improve education, outreach, and treatment for patients SUD disease, including stimulants and opioids,
- » [Systems of Care](#), which provides structured and supported efforts to address health equity and rigorous program quality improvement practices across treatment and recovery ecosystems,
- » [Tribal MAT Project](#) which promotes opioid safety, improves the availability and provision of MAT, and facilitates wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments,
- » [Young People in Recovery](#), which provides support services for organization focused on creating recovery ready communities throughout the nation for young people in or seeking recovery, and
- » [Youth Peer Mentor Program](#), which train justice-involved youth to provide recovery support to peers and assist them with their substance use and rehabilitative challenges.

Pregnant and Parenting Women

DHCS continues to prioritize service delivery to the Pregnant and Parenting Women (PPW) population. DHCS annually updates the county monitoring tool and the Perinatal Directory. DHCS updates the Perinatal Practice Guidelines (PPG)³⁰ as needed.

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 SUBG Perinatal Set-Aside. Providers must adhere to the requirements as outlined in the PPG.

³⁰ [DHCS Perinatal Practice Guidelines](#).

County Monitoring of SUBG-funded Perinatal Programs

DHCS uses the county monitoring tool during on-site monitoring visits to ensure counties are meeting the requirements for SUBG-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:

- » Outreach and Engagement
- » Transportation
- » Child Care

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.

Perinatal Substance Use Disorder Training and Technical Assistance

DHCS provides training and technical assistance to California Counties. The purpose is to understand the County/Provider perinatal programs and to tailor requested technical assistance to the County/Provider's specific needs. In addition, the training and technical assistance, assist California Counties with minimizing compliance deficiencies during annual visits and/or desk reviews conducted by the Department. Training and Technical Assistance may be requested by emailing DHCSPerinatal@dhcs.ca.gov or contact Perinatal Services at (916)713-8555.

Perinatal Annual Collaborative Event

As of SFY 2021-2022, DHCS plans, coordinates, and provides oversight for the Perinatal Annual Collaborative Event (PACE). DHCS holds the PACE to provide an avenue for peer resources sharing and strengthen the partnership and collaboration between DHCS and SUD Coordinators. During PACE, DHCS reviews the roles and responsibilities provided by DHCS, the importance and benefits of Perinatal SUD Training and Technical Assistance Calls and Reports, and facilitates open discussions between the SUD Coordinators. In addition, DHCS invites and collaborates with Perinatal SUD County Coordinators to present their successes, challenges, strategies, and best practices during PACE.

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 SUBG 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 February 2023, California counties contracted with 964 SUD treatment facilities to provide a wide range of treatment services. There were 242 provider sites engaged in primary prevention services, and 37 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 decrease in the number of clients served in SFY 2020-2021, as compared to the increase DHCS saw in SFY 2017-2018.

During SFY 2020-2021, approximately 164,200 unique clients were served,³¹ approximately 26,072 less clients than were served in SFY 2017-2018.

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

³¹ 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.

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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 2020-2021, the total served count was approximately 205,043, about a 15.97 percent decrease from the 244,000 reported in SFY 2017-2018.

Of the total served count in SFY 2020-2021, Table 17 shows the percentages served in each major service type.

Table 17: Total Served by Service Type, SFY 2017-2018 and 2020-2021

Major Service Type	SFY 2017-2018	SFY 2020-2021
Outpatient Drug Free (ODF)	36.5	31.8
Narcotic Treatment Program (NTP)	30.5	38.3
Residential (Short/Long Term)	19.1	16.7
Residential Detoxification	8.3	5.9
Intensive Outpatient Treatment (IOT)	4.2	7.0
NTP Detoxification	1.3	0.2
Non NTP Detoxification	0.1	0.0

Examination of the various service types shows the following trends from SFY 2017-2018 through SFY 2020-2021:

- » There were decreases in ODF, Residential (Short/Long Term), Residential Detoxification, NTP Detoxification, and Non NTP Detoxification services.
- » There were increases in NTP and IOT services.

One-Day Counts

On April 1, 2021, 94,356 clients were in treatment.³² The distribution of the one-day counts among the service types was:

³² CalOMS Tx.

Table 18: One-Day Counts by Service Type, SFY 2017-2018 and 2020-2021

Major Service Type	SFY 2017-2018	SFY 2020-2021
Narcotic Treatment Program (NTP)	52.9	60.1
Outpatient Drug Free (ODF)	33.3	27.2
Residential (Short/Long term)	10.2	8.8
Intensive Outpatient Treatment (IOT)	2.6	3.4
Residential Detoxification	0.6	0.4
NTP Detoxification	0.4	0.2
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 2020-2021, there were approximately 89,563 admissions to treatment. This includes admissions to publicly monitored SUD detoxification, residential, and outpatient services, and about 117,215 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 19: Admissions per Service Type, SFY 2017-2018 and SFY 2020-2021

Major Service Type	SFY 2017-2018	SFY 2020-2021
Outpatient Drug Free (ODF)	39.0	35.0
Residential (Short/Long Term)	25.0	23.5
Narcotic Treatment Program (NTP)	17.0	21.0
Residential Detoxification	12.0	10.1
Intensive Outpatient Treatment (IOT)	5.0	10.0
NTP Detoxification	2.0	0.3
Non NTP Detoxification	0.0	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,

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given the chronicity of SUD, a disease characterized by patterns of repeated relapse leading to stability.

Detoxification admission data were not included for the summary below. The figures in this section reflect admission data for 105,037 non-detoxification admissions.

Client Characteristics

Compared with SFY 2017-2018, SFY 2020-2021 admissions among the following clients saw similar declines, aged 18 and younger declined from 7 percent to 3 percent, those in the 18-25 category declined from 14.6 percent to 11.7 percent, and those in the 46-54 category declined from 14 percent to 11.9 percent. Admissions among the following clients saw similar increases, those in the 26-35 category increased from 35.5 percent to 38.7 percent, those in the 36-45 category from 20.8 percent to 24.4 percent, and those 55 and older increased from 8.10 percent to 10.5 percent.

Table 20: Client Age, SFY 2020-2021

Age	SFY 2020-2021
Under 18 years	3.00%
18-25 years	11.70%
26-35 years	38.7%
36-45 years	24.4%
46-54 years	11.9%
55 and older	10.5%

Race/ethnic proportions for SFY 2020-2021 were about the same as for SFY 2017-2018. Admissions by race/ethnicity were as follows:

Table 21: Client Race/Ethnicity, SFY 2017-2018

Race/Ethnicity	SFY 2020-2021
African American	9.9%
American Indian/Alaska Native	1.1%
Asian/Pacific Islander	2.0%
Hispanic	40.8%
Multiracial	2.5%
Other	2.7%
Non-Hispanic White	40.9%

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Gender proportions for SFY 2020-2021 were also about the same as for SFY 2017-2018. Admissions by Gender were as follows:

Table 22: Client Gender, SFY 2020-2021

Gender	SFY 2017-2018
Male	60.60%
Female	39.20%
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 2020-2021 as it was in 2017-2018. The percentages for methamphetamine decreased by 2.4 percent and marijuana decreased by 4.4 percent. The percentages for alcohol saw an increase of 2.8 percent and other opiates or synthetics increased by 3.2 percent. The percentages for the remaining categories were about the same as reported in 2017-2018.

Table 23: Primary Drug at Admission, SFY 2017-2018 and SFY 2020-2021

Primary Drug	SFY 2017-2018	SFY 2020-2021
Methamphetamine	33.0	30.6
Heroin	25.0	24.6
Alcohol	20.0	22.8
Marijuana/Hashish	13.0	8.6
Other Opiates or Synthetics	3.0	6.2
Cocaine/Crack	3.0	2.4
Oxycodone/OxyContin	1.0	1.9
Other	2.0	1.5

Discharge Statistics

During 2020-2021, there were approximately 112,580 discharges from treatment services (i.e., detoxification residential, outpatient) for about 87,753 unique clients. There were approximately 100,948 non-detoxification discharges. 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, 51.7 percent of discharges were standard discharges and 48.3 percent of discharges were administrative during 2020-2021. In 2017-2018, 53.9 percent of discharges were standard, and 46.1 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. To respond to public comment, DHCS did add a short narrative on DHCS effort to reduce the number of admin discharges, as the public comment was an accurate assumption. The two percent increase in the number of administrative discharges from 2017-2018 to 2020-2021 indicates that there are ongoing challenges in a treatment provider's capacity to collect data to measure the following 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.

In an effort to mitigate the growing percentage of administrative discharges, DHCS has begun engaging counties in listening sessions, technical assistance, and monthly monitoring of progress to decrease administrative discharges. The counties targeted for this outreach are counties that have over 50 percent high percentages of administrative discharges.

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 26.8 percent of the client's receiving services for one year or more.
- » There were 31 percent of the clients receiving outpatient treatment services and 7.8 percent in intensive day-care programs that stayed 31 or more days.

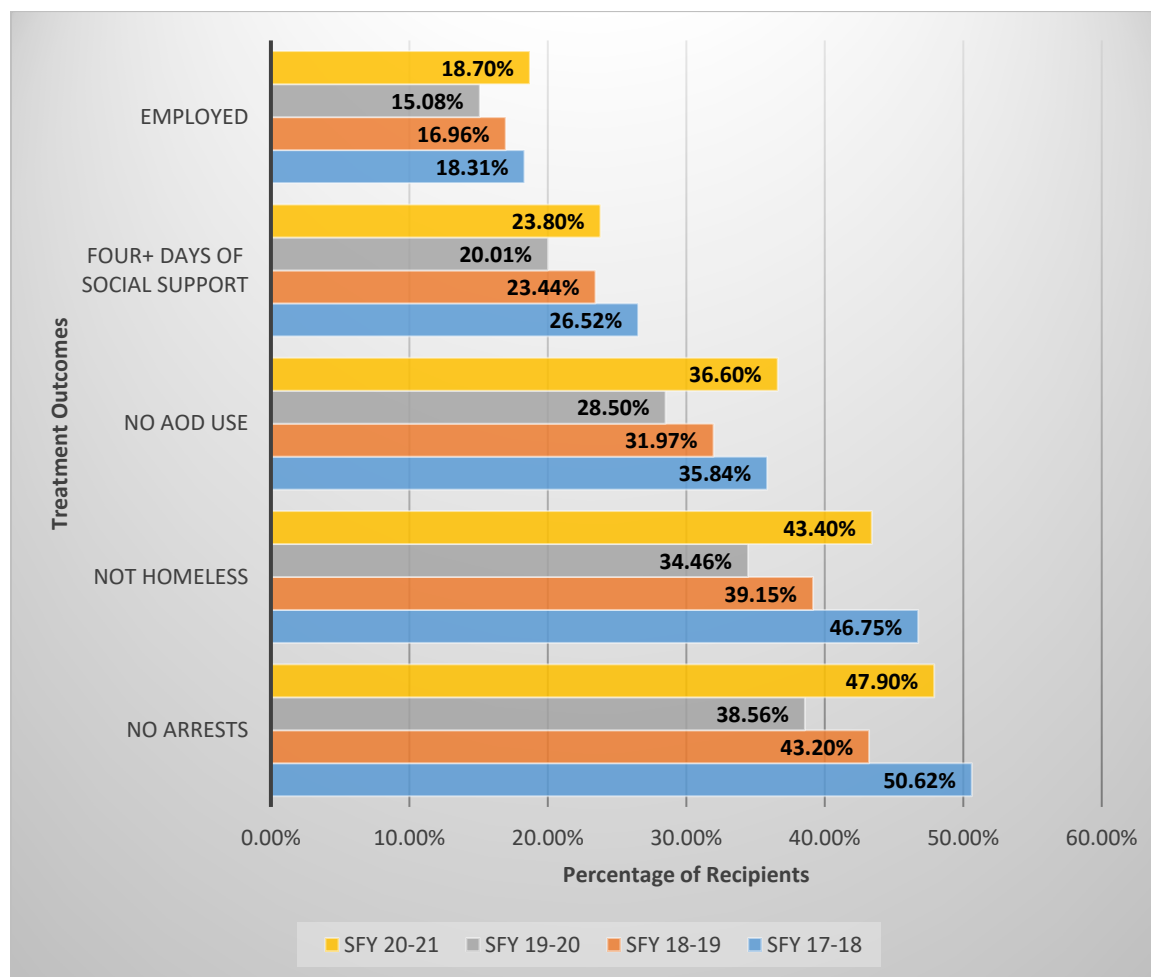
» There were 9.5 percent of outpatient treatment stays were 30 or fewer days.

The decrease in length of outpatient treatment stays, 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 2 shows five treatment outcomes measures from SFY 2017-2018 through SFY 2020-2021 for outpatient treatment services. The cross-year comparisons of treatment outcomes measures include Administrative Discharges, which may be partially responsible for the decreases in percentages for selected outcome criteria during previous reporting years. Employment, adequate social support, no alcohol or other drug use, those not homeless, and no arrests all saw an increase among outpatient treatment clients during the study period.

Figure 2: Treatment Service Recipient Outcomes: Outpatient Drug Free



Data Source: CalOMS Tx SFY 2017/2018 through 2020/2021

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Again, please note the increase in missing data related to administrative discharge reporting contributes to DHCS not being able to document outcomes for almost half of the clients. Outpatient treatment administrative discharges accounted 51.1 percent of all discharges for SFY 2020-2021. The increase in administrative discharges (i.e., outcome data not collected) may be one reason for the decrease in the percentage of discharges measuring and meeting the treatment outcome criteria.

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 SUBG Application process.

Strategic Initiative #1: Expand programs that address the opioid and stimulant epidemic through the health, justice-impacted, Tribal, youth and other delivery systems through California's MAT Expansion Project, Home and Community-based Services' ED-based MAT programs, and other opioid prevention and treatment initiatives.

Strategic Initiative #2: Continue Cal-AIM initiative implementation 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 implementation of a state-level Behavioral Health Prevention Plan and expanded State Epidemiological Workgroup activities and scaling up evidence-based and community-defined evidence programs.

Strategic Initiative #4: Improve access and reduce disparities among youth in school and community-based settings through widespread implementation of youth focused efforts especially in communities disproportionately affected by the war on drugs.

Strategic Initiative #5: Build

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, 4,817,000 (14.55 percent) of Californians age 12+ were in need of but did not receive SUD treatment; specifically:

- » 2,327,000 (7.03 percent) Californians aged 12+ were in need of SUD treatment at a specialty facility for illicit drug use in the past year, compared with 1,132,000 (3.42 percent) in CY 2017-2018; and
- » 3,371,000 (10.18 percent) Californians aged 12+ were in need of SUD treatment at a specialty facility for alcohol use in the past year, compared with 2,008,000 (6.07 percent) in CY 2017-2018.

Interim Services

California passes the strict network adequacy requirements for SUBG 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, SUBG, 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 Substance Use Disorder Data Service

As previously mentioned, Primary Prevention SUD Data Service (PPSDS) replaced the CalOMS prevention 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 SUBG 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 stakeholders and program participants in planning processes that inform capacity-building needs and determine program priority areas and populations.

Proper monitoring by DHCS of 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 once again on the decline in California after a slight rise in 2017-2019. Specifically, the CHKS's report on marijuana use surmises that despite the increase in diverse methods of administration, there has been a reduction by students' inhalation through smoking and oral ingestion of edibles and liquids. The one exception that remained level is vaping marijuana among 11th graders. Moreover, youth are beginning marijuana use at younger ages. California continues to recognize 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 disproportionately affected by the war on drugs through widespread implementation of the Children and Youth Behavioral Health Initiative, Elevate Youth CA, California YOR Project, and other statewide, culturally responsive youth empowerment efforts.

The implementation of California's DHCS Opioid Response 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

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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. CalAIM and the Children and Youth Behavioral Health Initiative will be the major shift in the way California provides behavioral health services in the state. DHCS will continue to 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 2024-2025 SUBG 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.