



CALIFORNIA NEEDS ASSESSMENT REPORT

SEPTEMBER 2010

Prepared by:
California Department of Alcohol and Drug Programs
Program Services Division
Performance Management Branch

Dedication

This report is dedicated to Michael Cunningham.
Without your vision and leadership
SNAP would still be a wish and a thought unrealized.

Table of Contents

EXECUTIVE SUMMARY	1
CHAPTER 1: INTRODUCTION.....	3
SNAP, as Envisioned.....	3
The Changing Environment.....	4
Roadmap of the Needs Assessment Report	11
CHAPTER 2: AOD CONSUMPTION AND CONSEQUENCE.....	12
Consumption: Supply and Availability.....	12
Consequences of Alcohol and Other Drug Use	23
Related Public Health Issues.....	42
Problem Gambling in California.....	48
In Summary	59
CHAPTER 3: THE PUBLIC AOD SERVICES SYSTEM.....	62
Continuum of Services (COS).....	62
<i>Prevention.....</i>	<i>64</i>
<i>Screening, Brief Intervention, and Referral to Treatment (SBIRT).....</i>	<i>73</i>
<i>Treatment</i>	<i>77</i>
<i>Recovery Support Services.....</i>	<i>92</i>
<i>California Problem Gambling Treatment Services Program.....</i>	<i>94</i>
In Summary	98
CHAPTER 4: CALIFORNIA’S CONTINUUM OF NEED	101
Assessment of the Continuum of Need.....	101
<i>Prevention.....</i>	<i>101</i>
<i>Early Intervention</i>	<i>108</i>
<i>Treatment</i>	<i>109</i>
<i>Estimates of Treatment Need for Special Populations</i>	<i>113</i>
<i>Treatment Need.....</i>	<i>120</i>
Recovery Support Services Need.....	124
California Gambling Services Need	125
In Summary	126
CHAPTER 5: WHAT DOES THE DATA TELL US?	129
The AOD System Findings.....	129
Substance-Based Findings.....	132
Population-Based Findings	135
In Summary	137
CHAPTER 6: NEXT STEPS IN THE SNAP PROCESS	139
Going Forward	139
ACKNOWLEDGEMENTS	141
APPENDICES.....	142

Executive Summary

The cost of substance abuse to society has reached unsustainable levels. With the annual cost of alcohol use in California at \$38.4 billion and illicit drug abuse at \$23.8 billion, the combined toll on the state (\$62.2 billion) cannot be sustained from a fiscal standpoint. This, in conjunction with the very real human toll the disease of addiction takes on individuals, families and communities, makes it critical for policy makers to take a proactive role in addressing the complex substance abuse issues facing the state.

Recognizing the costly nature of addiction on many public service systems, California's publicly funded Alcohol and Other Drug (AOD) services system has been on a path over the last several years to increase effectiveness and cost efficiency of services to those Californians in need. The AOD Field has made much progress in instituting evidence-based practices, process improvements and performance measures to increase effectiveness of services as part of its Continuum of Services System Re-engineering efforts.

The state Department of Alcohol and Drug Programs (ADP) has taken the next step in re-engineering efforts by instituting system improvements through development of a data-informed planning and decision making process. The Statewide Needs Assessment and Planning (SNAP) process has been established within ADP business operations to fill that role. This first report represents the beginning of the assessment phase of the process which will culminate in establishing state-level priorities. This is followed by a planning, implementation and evaluation phase.

Based on the data analysis in this report the following recommendations were developed to be considered in establishing state-level priorities.

Recommendations for the Continuum of Services

- Employ more science-based population level prevention strategies.
- Identify new funding or resource strategies to expand Prevention activities in California.
- Build the AOD system capacity for early intervention strategies such as SBIRT.
- Continue to focus on increasing treatment effectiveness through strategies such as evidence-based practices, process improvements, performance measures, etc.
- Build the AOD system capacity for Recovery Support Services including identifying funding or other resource strategies.

Recommendations for Health Care Reform

- Develop a plan based on the "knowns" of health care reform and add to it as further information and details come to light.
- Consider how to partner with and educate the primary care system on AOD issues.

- A thorough examination of the Medicaid and California's Medi-Cal system must be undertaken in relation to impacts on the AOD system and services.
- Understanding and planning for the uninsured population will be just as important as building capacity to serve additional insured individuals.
- Appropriately preparing and developing the AOD workforce will be a critical step.

Recommendations for Specific Substances

- Institute specific programs aimed at preventing and reducing the high rate of underage and excessive alcohol use and abuse.
- Institute strategies to arrest the growth of prescription drug and opiate abuse.

Recommendations for Specific Populations

- To address overall need:
 - Target youth aged 12 through 20 for evidence-based universal prevention strategies.
 - Target youth aged 16 and 17 years old for evidence-based selective prevention strategies.
 - Target young adults aged 21 through 25 for evidence-based early intervention strategies.
 - Target youth aged 18 through 25 for evidence-based prevention, early intervention, and treatment services.
- Complete an in-depth analysis of race/ethnicity data to understand its relationship to the AOD service needs in California to inform program decisions.
- Consider instituting programs to increase the treatment capacity for the following subpopulations in the listed order:
 - Veterans
 - Individuals with SMI and a concurrent AOD problem
 - Pregnant women
 - Homeless individuals

These are all strategies that the data in this report indicate would be of most value in impacting the state's substance use issues. Decisions related to the setting of state-level priorities will be made by senior leaders within the AOD Field at the state and county levels. While the data suggest certain courses of action, decisions must also factor in resource and other environmental issues.

Chapter 1: Introduction

*Two roads diverged in a wood, and I . . . I took the one less traveled by,
And that has made all the difference.*

In light of the current environment of declining resources and budget shortfalls, the timing is right to continue down the road of refining the Department of Alcohol and Drug Program's (ADP) planning process, allowing us to target limited resources to efforts deemed the highest priority for California's public system of Alcohol and Other Drug (AOD) prevention, treatment, and recovery support services.

Those who are drawn to work in the substance abuse field often do so out of a passion and commitment to help the alcoholic/addict, who still suffers from the disease, regain balance and sobriety in their lives or prevent our youth from going down the same path. While our passion to alleviate the human tragedy associated with the disease drives us to do work that brings us satisfaction, our decisions are often driven mainly by our hearts rather than by data and statistics. Maintaining and harnessing our passion to drive a thoughtful and successful system of decision-making in prioritizing statewide needs, will ensure that appropriate values remain in the forefront of all decisions that are data informed.

With this principle firmly in mind, beginning in 2008 as part of re-engineering the system of services, ADP began a journey to reassess the business and decision-making processes related to setting state-level priorities using an expanded statewide needs assessment and planning (SNAP) process. This is the first published Needs Assessment Report, which is the first step in the SNAP process. This report will provide decision-makers with a scan of major environmental factors for consideration, as well as data-informed recommendations.

SNAP, as Envisioned

The SNAP process has been designed to operate in three-year cycles and is modeled after the Strategic Prevention Framework (i.e., assessment, planning, implementation, evaluation) currently in use for planning community prevention efforts. While preliminary planning and testing has already occurred, the first three-year cycle will begin in 2010 and coincide with the requirements of the 2011 Substance Abuse Prevention and Treatment (SAPT) block grant application. The preliminary work begun in 2008 was dedicated to planning and establishing the business blueprint for integrating the SNAP process into departmental operations. In 2009 efforts were devoted to developing the template for the Needs Assessment Report and compiling as much data and information as possible to test its use in the planning, implementation and evaluation phases of the process. This testing year was critical to provide valuable information going forward to improve the process and determine additional focus areas. The current year, 2010, is devoted to improving the report and process through lessons learned and

input received via the previous year's evaluation, as well as reevaluating the state-level priorities developed during the testing year.

The SNAP process and the Needs Assessment Report (NAR) provide ADP with a mechanism for developing statewide priorities and a subsequent plan based on the identified data-informed priorities. In addition, it will assist local counties by providing targeted areas for local planning efforts.

The Changing Environment

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

Annual Cost of Alcohol use in California \$38.4 Billion

Source: Rosen, SM, Miller, TR, Simon, M (2008). The Cost of Alcohol in California. *Alcoholism: Clinical and Experimental Research* Vol. 32 No. 11.

Annual Cost of Drug abuse in California \$23.8 Billion

Source: Office of National Drug Control Policy. (December 2004). *The Economic Costs of Drug Abuse in the United States: 1992-2002*. Washington, DC: Executive Office of the President. (Publication No. 207303)

Budgetary Considerations

In the past few years the tremendous economic downturn has undercut the state's ability to maintain a stable level of funding for necessary publicly funded services in many service sectors. California enters the state fiscal year (SFY) 2010-2011 facing a \$19.1 billion deficit. Declining revenues coupled with increases in the need for services due to record high unemployment have lead legislative leaders to consider different methods of revenue generation, such as the legalization of marijuana and increasing alcohol taxes.

For California's system of publicly funded substance abuse services, the budgetary shortfalls have resulted in the loss of significant funding to serve the offender population. In SFY 2009-2010, dedicated state funding for the Substance Abuse and Crime Prevention Act of 2000 (SACPA), which is a diversion program for offenders, was eliminated, however the requirement to serve this population remains in effect. The budget for SFY 2010-2011 further reduces dedicated funding for the offender population.

County efforts to maintain services during this economic downturn have lead to hard decisions at the local level. Those decisions have included shortening lengths of stay in

treatment, reevaluating use of higher cost treatment modalities, and instituting or maintaining longer waiting lists. Conversely, it has also led some counties to leverage available resources through local partnerships and increase effectiveness through the implementation of process improvements and evidence-based practices.

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

The Health Care System and Reform

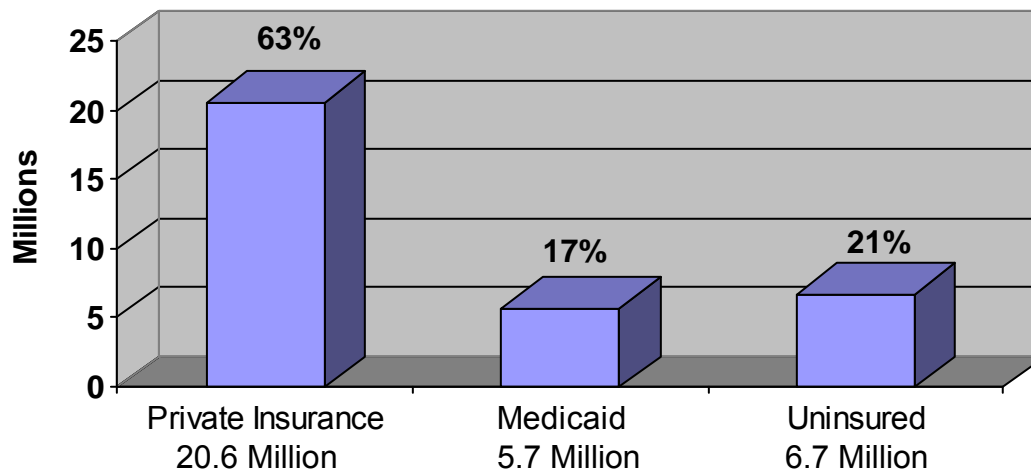
Nearly four and a half million Californians will become insured in 2014.

On March 23, 2010, the President signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), legislation which seeks to reform the nation's health care system. This law will require major systems change efforts on the part of the substance use field in order to flourish under the law's provisions. Basically, the law will substantially increase the pool of insured individuals, expand public benefit programs (e.g., Medicaid), support community-based services, enlarge the health-related prevention focus, support providers' transition to electronic medical records, improve quality and accountability of the service delivery system, and integrate substance abuse services with primary health care. (See Appendix A for a summary of the PPACA.)

It is estimated that once the law is implemented in 2014 exponentially expanding the number of insureds, 94 percent of Californians will be insured, either through their employer, a new health insurance exchange market, or expansions to public benefit programs.¹ This means that six percent of Californians will remain uninsured or (using today's population numbers) approximately 2.3 million people. Using the following 2008 data as a gauge to calculate a rough estimate, nearly four and a half million uninsured Californians will become insured in 2014.

¹ California HealthCare Foundation. (May, 2010). *The Affordable Care Act: What Californians Should Know*. Retrieved from <http://www.chcf.org/~media/Files/PDF/A/PDF%20AffordableCareActWhatCAsShouldKnow.pdf>

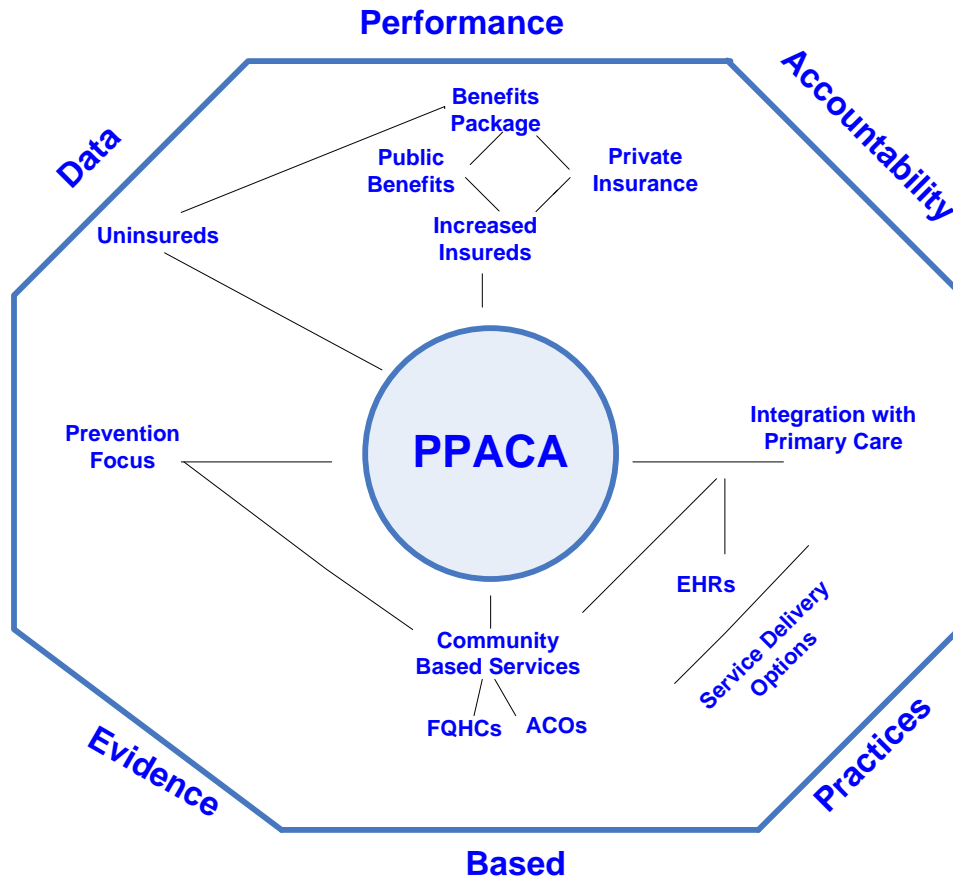
2008 CA Health Insurance Coverage for the Nonelderly (under age 65) Population



Source: CA Healthcare Foundation www.chcf.org

This could have a significant impact on the AOD system in California as the most prevalent reason that people in need of treatment cite for not receiving treatment is that they do not have insurance or the financial means to afford treatment. It is unknown at this time how many of these newly insured individuals will be able to receive services for their substance use conditions through the primary care system and how many will need a specialty care provider.

The changes that will be required are significant. Following is a simplified diagram of basic impact areas of the PPACA that the substance abuse field must consider in their planning processes.



Source: Performance Management Branch, Department of Alcohol and Drug Programs, August 2010

The issue becomes much more complex when interpreting what these areas mean for the AOD field. For example, considerations in the area of health insurance expansion:

- Medicaid, the public benefit, is expected to expand considerably, probably in excess of one million additional Medi-Cal eligible individuals in California. It will become a major payer of substance abuse services; therefore, building the capacity to bill for services through the Medicaid system is critical. As will the ability to provide services in line with the Medicaid rules and regulations, provide wraparound services to ensure effective practices are in place, and ensure the AOD workforce has the necessary licensures and other credentials necessary to provide services within the Medicaid system.
- The number of privately insured individuals will potentially expand by upwards of three million people in California. This greatly increases the chances of identifying individuals with substance abuse issues through the primary care system. It will be critical to partner with the primary care system to ensure: 1) appropriate AOD screening is in place to identify individuals with substance use issues; 2) linkages exist between the primary care and AOD system to ensure a

- seamless referral process for those individuals identified as needing specialty treatment, as well as linking through electronic health records; 3) educating primary care doctors/staff in appropriate prevention and treatment strategies; and 4) ensuring the AOD workforce has the necessary licensures and other credentials to be reimbursed for services from private insurers.
- The number of uninsured individuals in California will be significantly reduced, however, at approximately 2.3 million people, there will still be a substantial number that may need services but have no financial options for obtaining it. A safety net will still be required for individuals needing treatment with no financial resources.

The above is a very brief discussion of PPACA impacts to the AOD field. There is much work to be done and questions still to be answered to understand the full scope of the impacts. However, we do have a basic map that can guide our preparation in order to take full advantage of this unique opportunity to broaden the AOD field to include many more options for clients.

The Federal Direction for Alcohol and Drug Abuse

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

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

In addition, to continue improving the delivery and financing of prevention, treatment, and recovery support services, SAMHSA has identified 8 Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities (See Appendix B for SAMHSA's 8 Strategic Initiatives).

In addition to SAMHSA's efforts, the Office of National Drug Control Policy (ONDCP) has collaboratively developed the 2010 National Drug Control Strategy that takes into account the latest scientific evidence and innovations in the prevention, treatment and law enforcement fields. The implementation of the *Strategy* calls for a collaborative effort of local, State, tribal, Federal agencies, community-based organizations, and other nongovernmental partners. (See Appendix C for highlights.)

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

California's Changing Substance Use Landscape for the Publicly Funded System

California's publicly funded system of substance abuse services has been evolving over the last several years to align practice more closely with scientifically derived models of effectiveness. Just as the Federal Government is moving towards a more accountable and effective system of AOD services, ADP has begun implementation of three efforts which is moving the department in the same direction: 1) building the capacity of the public AOD services system as a chronic care model through the Continuum of Services System Re-engineering (COSSR) effort; 2) establishing an ongoing Statewide Needs Assessment and Planning (SNAP) process into departmental operations; and 3) developing standards for performance management at the state and local levels.

COSSR is a systems change effort to evolve the public AOD services system from an acute care system to include a chronic disease model. The move toward this chronic disease model is expected to increase effectiveness of the system, as well as better position the system for integration with primary care. This state and department-wide change effort drives all programmatic activities and the administrative functions that support programming. The COSSR structure and efforts, as well as data representing the continuum are discussed in more detail in Chapter 3.

SNAP will inform COSSR efforts through the establishment of data-informed priorities and subsequent planning and implementation activities. SNAP is also an integral component in the process to determine departmental goals related to diversity and cultural competency needs.

Following are the priorities established during the 2009 SNAP testing year which will be reevaluated at the conclusion of the 2010 SNAP assessment phase.

- Primary prevention should serve those populations and/or communities with the greatest risk factors for alcohol and other drug misuse and abuse.
- The department should focus on building Screening, Brief Intervention and Referral to Treatment (SBIRT) services in other service delivery systems throughout California.
- The department should focus upon increasing the effectiveness of publicly funded treatment.
- The department's planning should include consideration of the state's shifting demographics.
- The department should focus attention on the impacts and consequences of alcohol use and abuse.

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

Performance management efforts started in 2007 between the Department, UCLA Integrated Substance Abuse Program (ISAP) researchers, and County AOD Administrators has produced positive results in collecting better data, increasing knowledge and use of performance measurement practices, and identifying gaps in the current system to move towards a performance model.

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

Many Counties have begun to use the data in both CalOMS systems to evaluate service provider performance, identify those in need of technical assistance and training as well as examine the practices of high performers for greater system improvements. Within the Prevention system, Counties have been encouraged to link specific objectives from their Strategic Prevention Framework plans to each provider's contract and budget. This can increase a county's oversight of specific performance goals and outcomes versus cost. Additionally, Counties can monitor client treatment outcomes by provider compared to countywide, or even statewide, outcomes within the Treatment database to determine performance levels.

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

These three change efforts provide a foundation upon which the state can build a more highly effective and adaptable service system. COSSR provides ADP with a broad conceptual framework that covers the full continuum of services from prevention and treatment to recovery support. The SNAP process is integrating the SPF planning process into all departmental activities and creating an ongoing data tracking system to provide timely and useful data and analyses for ADP decision makers. Efforts to improve performance management and measurement practices will be strengthened by the articulation of ADP institutional goals and outcomes, and the establishment of a

monitoring system to provide the information necessary to measure progress toward these outcomes. Together these efforts will allow ADP to focus limited resources to efforts deemed high priority for California's public system of AOD prevention, treatment, and recovery support services.

Roadmap of the Needs Assessment Report

The remainder of this document consists of the presentation of the data, the analysis of the data, followed by a description of the next steps in the process. It is structured in chapters to present information in an organized and easily readable format. Following is a brief description of the contents of each of the remaining chapters.

- **Chapter 2** displays information related to drug and alcohol supply and consumption, and the subsequent consequences of substance abuse, as well as prevalence data related to problem gambling in California.
- **Chapter 3** describes, in narrative and data, the State's public continuum of services system – prevention, intervention, treatment, recovery support and gambling.
- **Chapter 4** portrays the statewide and selected populations' numbers in need of treatment, as well as a discussion of prevention and early intervention practices and projected need.
- **Chapter 5** provides an analysis of the data contained in Chapters 2, 3 and 4.
- **Chapter 6** discusses the next steps in the SNAP process.

It should be noted that the SNAP is an evolving process and future needs assessment reports will mature along with the process as further refinements are made. This report should not be considered a final assessment of treatment need and prevention targets, but rather a document that gives an indication of treatment need based on the data compiled, and areas for prevention consideration.

Chapter 2: AOD Consumption and Consequence

This chapter relies upon law enforcement, population-based survey and public health data to look at drug supply trends and alcohol availability, and the subsequent consequences of alcohol and drug use and abuse.

The United States has 4 percent of the world's population, but consumes 65 percent of the world's supply of hard drugs.

Consumption: Supply and Availability

Drug Supply

Interdiction and other drug intelligence data gathered by federal, state and local law enforcement agencies can shed light on trends regarding the type of drugs available to the public. Drug supply data can also serve as an indicator of potential areas for prevention and treatment efforts. The following information is summarized from the National Drug Intelligence Center, *National Drug Threat Assessment 2009*, an annual U.S. Department of Justice publication analyzing current drug intelligence and other reports to assess the drug threats and trends in the U.S. The chart below reflects the nationwide drug threats by U.S. region. California is reflected in two different regions. Central and Northern California is included in the Pacific region and Southern California is included in the Southwest region.

Greatest Drug Threat, by Region, as Reported by State and Local Law Enforcement Agencies

Region	% Reporting as Greatest Drug Threat by Region												Total*
	Powder Cocaine	Crack Cocaine	Total Cocaine	Heroin	Powder Meth	Ice Meth	Total Meth	Marijuana	MDMA	ODDs	Pharmaceuticals	No Response	
Florida/Caribbean	16.4	51.8	68.2	0	7.7	5.5	13.2	8.4	0	0	10.1	0	100
Great Lakes	9.7	35.4	45.1	11.9	9.3	7.8	17.1	15.1	1	0.2	9.4	0.2	100
Mid-Atlantic	9.9	38.8	48.7	24.5	0.5	0.5	1	14.6	0	0.3	10.9	0	100
New England	17.4	22.2	39.6	30	0.2	0	0.2	15.2	0	0.3	14.5	0.2	100
New York/ New Jersey	11.1	31.8	42.9	22.1	0	0	0	27.2	0	0	7	0.8	100
Pacific	1.3	4.5	5.8	1.1	22.5	64.8	87.3	4	0	0	1.9	0	100
Southeast	3.7	55	58.7	1.3	7.8	19.1	26.9	3.6	0	0.4	9.1	0	100
Southwest	9.5	16.6	26.1	2	15.3	42.2	57.5	8.7	0	0.3	5.4	0	100
West Central	7.8	17.9	25.7	2.8	25.9	34.3	60.2	6	0.1	0.1	5	0	100
United States	8.7	32.2	40.9	9.8	10.3	19.1	29.4	11.3	0.2	0.2	8.1	0.1	100

Source: National Drug Threat Survey 2008, National Drug Intelligence Center, U.S. Department of Justice.

* Sum of percentages may not equal 100.0 percent because of rounding.

Illicit drug marketing and sales

Information about drug seizures in California by the U.S. Drug Enforcement Administration for a five-year period is presented below.¹ Drug seizure data is important for a number of reasons. These data:

- Provide an indication of the types, availability and distribution of various illicit substances.
- May serve as a measure of drug-related public safety due to criminal activity associated with their distribution and sale.
- May serve as an indication of potential public health concerns about drug-related poisonings and overdoses and the associated emergency department visits, hospitalizations, and deaths. Chemical analyses of the ‘purity’ of the drugs that are seized may indicate other public health concerns.
- Provide information to law enforcement officials about the relative success of prevention and interdiction efforts and the production and distribution networks corresponding to particular types of substances.
- May help in state and local planning with respect to prevention, treatment, and recovery needs and the associated allocation of resources.

California has a diverse culture and a unique geography. Many issues can affect the amounts and types of illicit drugs in the state at any given time. Drugs such as cocaine and heroin are smuggled into the state via Mexico; however, most methamphetamine and marijuana are produced or cultivated in large quantities within the state. Likewise, year-to-year trends in drug seizure data can be influenced by a number of factors, including changes in drug enforcement policies and priorities, the amount of funding allocated to interdiction efforts, the success of prior year drug seizures, and other reasons.

The table below shows the amount of drugs seized by DEA for four major drug types.

Drug Enforcement Administration Drug Seizures in Kilograms, California, 2003-2007

YEAR	Heroin	Methamphetamine	Cocaine	Marijuana
2003	194	1,698	4,489	371,948
2004	140	1,025	3,351	175,151
2005	105	1,772	8,123	218,541
2006	243	2,504	9,456	175,400
2007	215	1,569	7,315	199,377

Source: El Paso Intelligence Center, Drug Enforcement Administration; special data request, Summer 2009

¹ These data only reflect drug seizures reported by federal agencies.

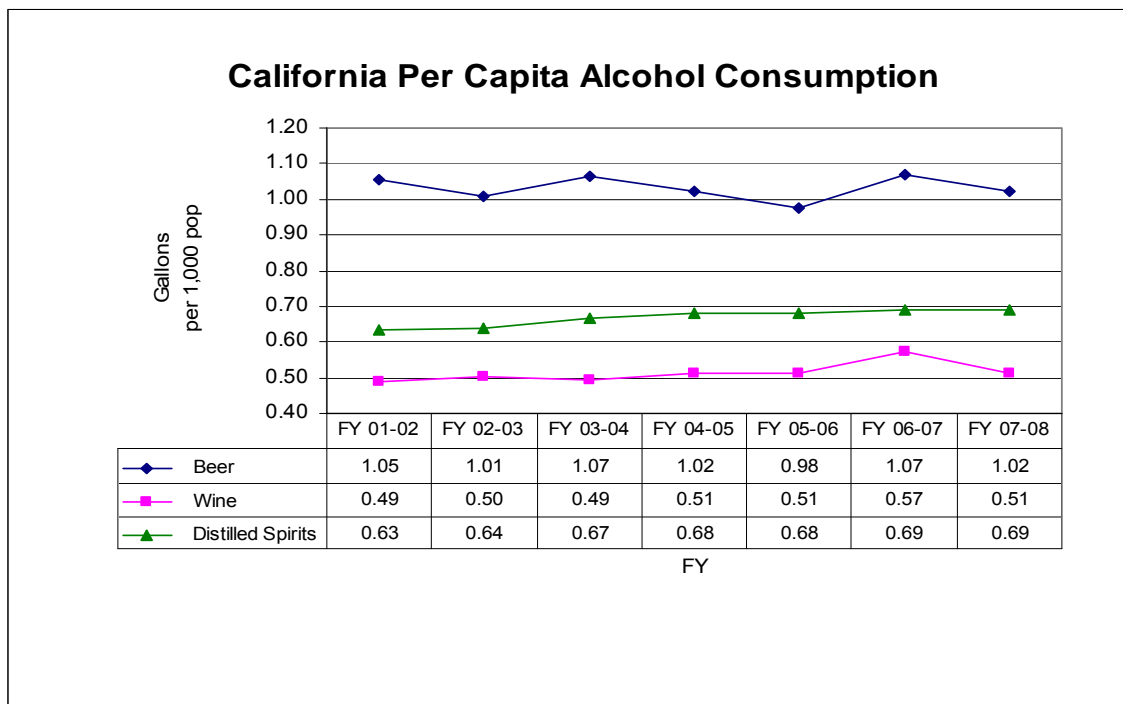
Highlights

- The amount of marijuana seized by the authorities between 2003 and 2007 was greater than drug seizures for any other substance. Drug seizures for cocaine were second highest during this period.
- In 2006, drug seizures increased noticeably for heroin, methamphetamine, and cocaine. The following year, drug seizures dropped across the board, except for marijuana.

Alcohol Availability

California Apparent Per Capita Alcohol Consumption

Apparent per capita consumption of ethanol (pure alcohol) is estimated using sales and tax receipt data on alcoholic beverages sold by manufacturers, importers, or wholesalers in California for distribution within the state. The term apparent consumption is used because this measure does not capture when the retail sale is made or when the consumption of the alcoholic beverage occurs. An ethanol conversion coefficient (i.e. percent of ethanol for each beverage type) is applied to the number of gallons of beer, wine, and distilled spirits sold to determine the proportion of pure alcohol for each type of beverage. State population estimates for persons ages 14 and older are used as the denominator to calculate the per capita consumption figures.



Source: Alcohol Epidemiologic Data System. LaVallee, R.A.; Williams, G.D.; and Yi, H. Surveillance Report #87: Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1970–2007. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention Research (September 2009).

Highlights

- Over the period of observation, the pattern of beer consumption in California has fluctuated. Beer consumption decreased in 2003-05, increased by 2006-07, then decreased again by 2007-08.
- Californians' consumption of wine remained steady for most of the period of observation, except for a spike during 2006-07.
- Consumption of distilled spirits increased steadily from SFY 2003-04 to 2007-08.

National Survey on Drug Use and Health

According to the National Survey on Drug Use and Health (NSDUH), conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), findings for California for 2007 highlight alcohol as the top drug reported used among underage youth (12-20), with 26.5 percent reporting past month alcohol use and 17 percent reporting binge drinking within the past month. Tobacco, marijuana and non-medical use of prescription drugs were all a close second with 30-day use percentages of 6.9 percent, 6.8 percent and 6.6 percent respectively.

Nationally, NSDUH also highlighted the emerging problem of non-medical use of prescription drugs. State estimates for 2007 indicate that approximately seven million persons 12 and older took a psychotherapeutic drug for non-medical purposes in the 30 days before the survey. Most reported abusing opiate pain relievers in particular. In fact, 2.2 million persons aged 12 and over initiated abuse of pain relievers in the past year. Young adults (ages 18-25) by far showed the greatest use overall.

Drug Use in California by Age Group: Percentages, Annual Averages based on 2006-07 NSDUHs				
Measure	12+	12 thru 17	18-25	26+
ALCOHOL				
Past Month Alcohol Use (Persons Aged 12 to 20)		26.5***	*** 12 thru 20	
Past Month Binge Alcohol Use (Persons Aged 12 to 20)		17.2***	*** 12 thru 20	
Past Month Alcohol Use	49.6	15.5	58.6	52.8
Past Month Binge Alcohol Use	21.6	9.8	38.2	20.1
TOBACCO PRODUCTS				
Past Month Tobacco Product Use	22.7	8.7	33.6	22.7
Past Month Cigarette Use	19.8	6.9	29.3	19.9
ILLICIT DRUGS				
Past Month Illicit Drug Use	9.1	10.0	20.5	6.8
Past Month Marijuana Use	6.6	6.8	17.0	4.5
Past Month Use of Illicit Drugs Other Than Marijuana 4.0		4.7	8.4	3.1
Past Year Marijuana Use	11.2	13.0	28.2	7.8
Past Year Cocaine Use	2.4	1.7	6.6	1.7
NON-MEDICAL USE OF PRESCRIPTION DRUGS				
Past Year Non-medical Pain Reliever Use	5.4	6.6	12.0	3.9

NOTE: Selected measures only

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007. Retrieved from <http://oas.samhsa.gov/2k7/State/California.htm#Fig2.2> .August 2010.

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health and the Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, August 2010.

California Student Survey - Findings for All Grades

The California Student Survey is a self report survey conducted on a representative sample of 5th, 7th, 9th and 11th graders every other year that covers a wide range of behaviors and attitudes of students in regular and non-traditional schools in California. Because it gathers data from each of the four grade levels, it provides a finer level of age breakdowns than the standard tables provided from the NSDUH. Therefore, it presents a better picture of the overall developmental trajectory of alcohol and drug use patterns among school age youth.

Data about Lifetime and Past 30 Day AOD use for 11th grade students are reported below. According to the CSS, substance use is wide spread among CA students. By 11th grade, less than a third of students report having never used one or more substances (excluding tobacco) during their relatively short lifetimes. When considering all grades, the overall percentage of students who report having never used drugs reflects a generally worsening condition from 2001-02 to 2007-08.

Lifetime Use of AOD among 11th Graders, CA, 2001-08				
	2001-02	2003-04	2005-06	2007-08¹
	Percentages			
Alcohol²	65.3	63.2	61.9	66.4
OTHER DRUGS				
Cocaine	9.2	7.6	7.3	10.4
Inhalants	12.6	8.9	9.5	15.2
Marijuana	44.0	38.7	38.2	41.6
Methamphetamines or Amphetamines	9.0	7.6	7.0	7.2
Prescription Painkillers³	--	--	15.1	17.6
Any Pill or Medicine⁴	--	--	--	34.8
Any Illegal Drug⁵	47.4	42.7	45.0	45.6
NO AOD⁶	31.6	33.1	32.8	31.5

¹The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.

² Question asks about a "full drink".

³ Questions specifically about use of prescription painkillers was not asked until the 2005-2006 survey.

⁴ In 2007-08, questions on use of "medicinal" drugs, including prescription and over-the-counter medicine were added.

⁵ "Any Illegal Drug" includes "Other Drugs" listed above, plus ecstasy and psychedelics.

⁶ No AOD means no alcohol or other drug use and does not include tobacco.

Source: California Student Survey, 2001-08, WestED, Inc. April 2010.

Prepared by: Safe and Active Communities (SAC) Branch, California Department of Public Health, and the Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, April 2010.

Past 30-Day Use of AOD among 11th Graders, CA, 2001-08

	2001-02	2003-04	2005-06	2007-08 ¹
Percentages				
ALCOHOL				
Alcohol Use	40.7	37.1	35.8	41.9
Binge Alcohol Use	26.2	23.3	21.4	29.0
OTHER DRUGS				
Cocaine	4.0	4.8	3.9	4.0
Inhalants	4.0	4.6	3.8	7.1
Marijuana	23.0	19.8	19.2	23.9
Methamphetamine or Amphetamine	5.0	5.0	3.9	4.7
Any Illegal Drug ²	24.6	22.8	22.4	26.2
NO AOD³	55.6	56.8	57.8	53.7

¹ The 2007-08 survey expanded the number of response options for use frequency and added additional drug categories to "any drugs". The authors state that increases in use prevalence appear to be a psychometric effect of these changes.

² "Any Illegal Drug" refers to the use of cocaine, inhalants, marijuana, methamphetamines, and psychedelics.

³ No AOD means no alcohol or other drug use, but does not include tobacco.

Source: California Student Survey, 2001-08, WestED, Inc. April 2010.

Prepared by: Safe and Active Communities (SAC) Branch, California Department of Public Health, and the Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, April 2010.

High Risk Users (HRU)¹ and Excessive Alcohol Users² (EAU): Grades 7, 9, and 11, California, 2001-2008

	2001-2002	2003-2004	2005-2006	2007-2008 ³
Percentages				
GRADE 7				
HRU	2.8	3.2	4.3	3.0
EAU	2.9	4.4	5.5	5.6
Total EAU and/or HRU	4.4	6.2	7.4	6.4
GRADE 9				
HRU	10.4	9.3	10.9	8.3
EAU	17.1	14.3	13.7	17.5
Total EAU and/or HRU	20.0	17.4	17.2	19.2
GRADE 11				
HRU	21.3	17.3	17.3	16.8
EAU	32.4	29.9	27.4	29.2
Total EAU and/or HRU	35.7	33.6	32.2	33.4

¹Inclusion based solely on engaging in any of the following behavior over the past six months: Cocaine use in any form (including crack); Frequent poly drug use (three or more times); Regular marijuana use (weekly or more frequent); or a pattern of use of numerous other illicit drugs besides cocaine or marijuana, or of high frequencies of use of individual drugs; and alcohol use at least once as a control.

² Inclusion based on reporting any of the following behaviors: Drank five drinks in a row three days in the past 30-Days; or Was very drunk or sick three or more times in lifetime; or Likes to drink to get drunk or feel the effects a lot.

³ The 2007-08 survey expanded the number of response options for use frequency. The authors state that increases in use prevalence appear to be a psychometric effect of these changes.

Source: California Student Survey, 2001-08, WestED, Inc. April 2010.

Prepared by: Safe and Active Communities (SAC) Branch, California Department of Public Health, and the Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, April 2010.

Highlights

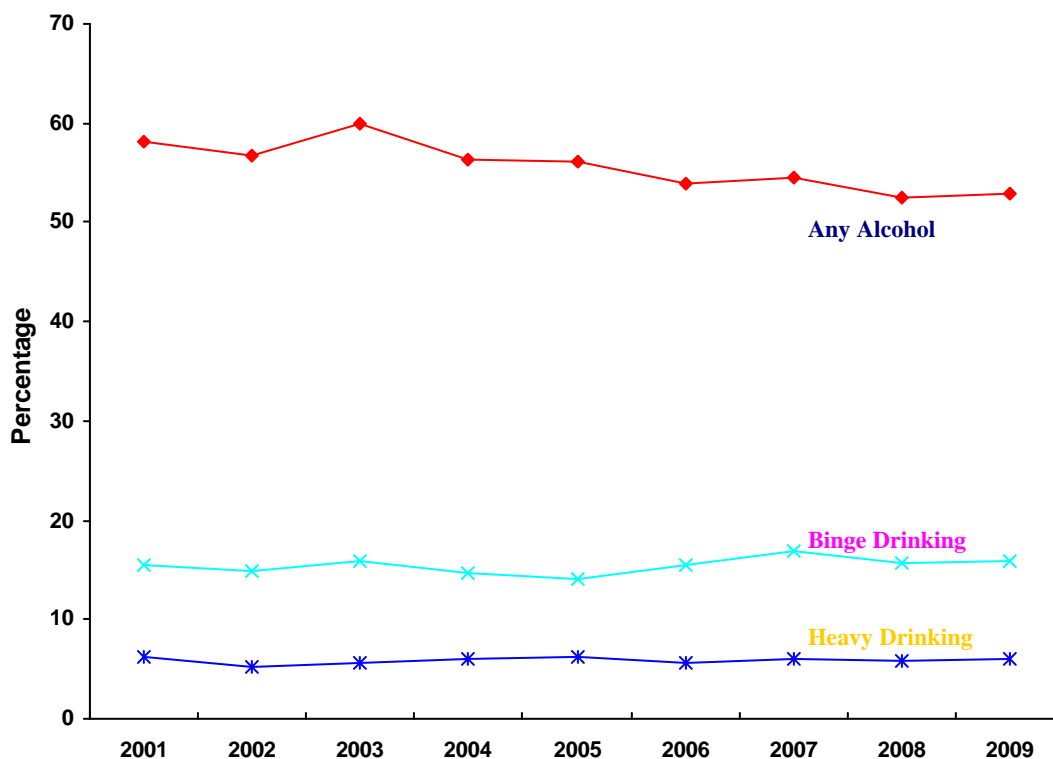
- Students documented to be high-risk users are represented at significant levels at all grade levels.
- Over six percent of 7th graders, 19 percent of 9th graders and a third (33 percent) of 11th graders are either High Risk Users and/or Excessive Alcohol Users.

The 2007-08 data clearly suggest that underage drinking continues to be an integrated part of CA student and adult cultures, with drinking being extremely common among school-age adolescents. Across all grades, alcohol is the most commonly used substance on both 30 day and lifetime measures, and binge drinking remains a continuing and significant problem. Nearly twice as many students consistently report use of alcohol compared to any other drug across all grades, with reported lifetime alcohol use nearly tripling from 7th to 11th grade (24 percent, 47 percent, and 66 percent, respectively). There is also a nearly five-fold increase in binge drinking among CA students from the 7th to the 11th grade (6 percent, 16 percent, and 29 percent, respectively).

Students' use of marijuana and tobacco are the next most consumed substances. Reported 30-day marijuana use nearly quadrupled between the 7th (7 percent) and 11th (24 percent) grades. Cigarette smoking triples. Lifetime marijuana and tobacco use also more than quadruples, from 9 percent to 42 percent, and 7 percent to 34 percent, respectively.

The reported non-medical use of prescription painkillers and over-the-counter (OTC) drugs has become a significant emerging problem, an area under-assessed by most state and national surveys until recently. Lifetime use of painkillers without a prescription showed a three percent increase from the 2005-06 survey to the 2007-08 survey for both 9th graders, from 9 percent to 12 percent (not presented here), and 11th graders, from 15 percent to 18 percent. In 2007-08, additional questions on the use of other "medicinal" drugs were used to better capture the non-medical use of prescription and OTC drugs. Nearly one third of all 9th graders and 35 percent of 11th graders reported such use, reflecting a major growing problem.

Past 30-Day Alcohol Use among Adults, California, 2001-2009



Source: Behavioral Risk Factor Surveillance Survey, Centers for Disease Control and Prevention, 2001-2008. Retrieved from <http://apps.nccd.cdc.gov/brfss/> August 2010.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs. August 2010.

Highlights

- Among CA adults (18+ years old), 53 percent drank alcohol in the past 30 days, a decrease from the high of 60 percent in 2003.
- Binge and heavy drinking among adults continues to hold steady over time at around 16 percent and six percent, respectively.

Alcohol and Tobacco Consumption for Women, Pregnant Women and Parenting Women

Past 30-Day Use of Alcohol¹ among Women by Age, Race, and Ethnicity California, 2005-2008

	2005	2006	2007	2008
AGE				
18 – 24	50.3%	42.6%	44.2%	38.3%
25 – 34	49.1%	46.7%	48.0%	44.5%
35 – 44	56.6%	53.7%	48.5%	48.8%
45 – 54	54.7%	53.2%	52.0%	49.8%
55 – 64	52.1%	48.0%	46.2%	48.1%
65 +	47.6%	44.3%	43.8%	44.0%
RACE				
African American	40.8%	40.6%	43.0%	40.5%
Asian/Other	42.0%	36.2%	32.0%	28.1%
White	63.8%	61.5%	60.6%	59.4%
ETHNICITY				
Hispanic/Latina	35.9%	31.0%	30.2%	28.3%
TOTAL	52.0%	48.6%	47.4%	45.9%

¹ Weighted prevalence estimate of women reporting any drinking in past month. Data are weighted according to the 2000 Census for California women age 18 and older.

Source: California Women's Health Surveys, 2005-2008. Special data run by Maternal, Child, Adolescent Health Program's Epidemiology, Assessment and Program Development Section, California Department of Public Health (CDPH) received July 2010.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, August 2010.

Highlights

- In 2008, 46 percent of women reported drinking alcohol during the past 30 days, decreasing from 52 percent over the four-year trend.
- In 2008, Whites, and those between 35-64 years of age, reported drinking more often than the statewide average. Women between the ages of 18-34 and over 65 years old, as well as African American and Asian/Other women, reported drinking less often than the statewide average.
- Hispanic/Latina women report drinking less than non-Hispanic/Latino women.

Maternal Infant Health Assessment Survey

The Maternal Infant Health Assessment (MIHA) is an annual, population-based self-administered survey of about 3,500 women randomly chosen who are at least 15 years old and recently gave birth to a live infant in California. MIHA asks women to report on their behaviors and experiences that occur before, during, and after pregnancy, and is modeled after the Centers for Disease Control and Prevention's Pregnancy Risk Assessment Monitoring System (PRAMS). As with the California Women's Health Survey, MIHA does not include many questions about substance use.

**Percentage of Adult Women^[1] Giving Birth Who Reported Drinking During
Pregnancy by Age, Race, and Ethnicity, California, 2005 - 2008**

	2005	2006	2007	2008
AGE				
18 – 19	10.80%	8.10%	12.00%	n/a ⁴
20 – 34	17.50%	15.10%	8.00%	12.70%
35 +	20.10%	23.60%	6.10%	16.00%
RACE²				
African American	15.50%	16.30%	13.00%	16.80%
Asian/Pacific Islander	9.40%	14.90%	n/a ⁴	n/a ⁴
White	28.60%	28.30%	14.60%	24.70%
Other	28.60%	20.50%	n/a ⁴	n/a ⁴
ETHNICITY²				
Hispanic/Latina	10.90%	8.20%	4.60%	7.30%
TOTAL^{2,3}	17.30%	15.80%	7.90%	12.90%

¹ Percentages represent the proportion of women who report drinking in either the 1st and/or 3rd trimester.

² The estimates for race and ethnicity include data for the small group of women who participated in the survey younger than 18 years old.

³ Survey response data are weighted to the California population of women who gave birth in 2005, 2006, and 2008, respectively

⁴ The sample cell size was < 20.

Source: Maternal Infant Health Assessment (MIHA) Surveys, 2005, 2006, and 2008. Special data run by Maternal, Child, Adolescent Health Program's Epidemiology, Assessment and Program Development Section, California Department of Public Health (CDPH) received July 2010.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, August 2010.

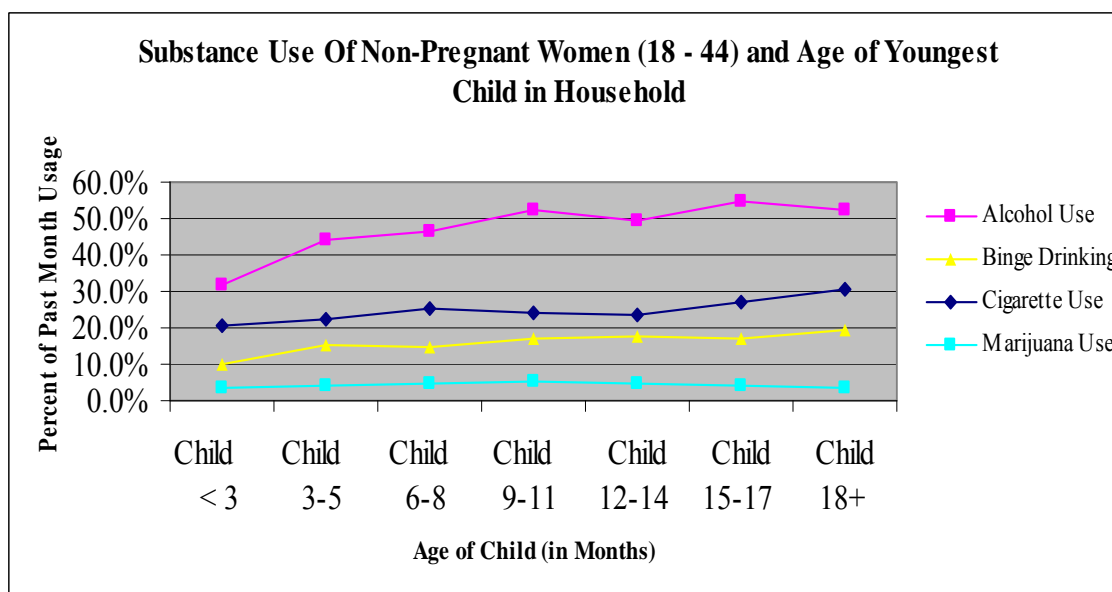
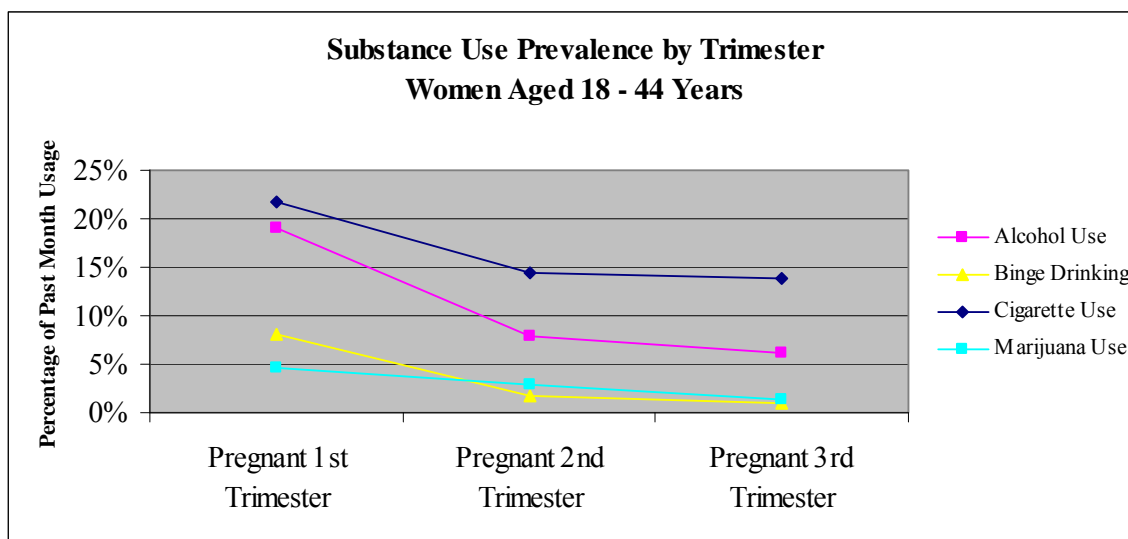
Highlights

- Almost 13 percent of women reported drinking alcohol during their pregnancy in 2008. This is a clear decrease from 2005.
- Whites reported substantially higher rates (24.7 percent) of drinking during pregnancy when compared to others, as did women 35 and older.
- When compared to the non-Hispanics, Hispanic women reported the lowest rates of drinking during pregnancy, while White (non-Hispanic) women reported the highest rates.

**Substance Use Prevalence by Trimester
Compared to Non-Pregnant/Parenting Women Aged 18 - 44 Years**

Women (aged 18 – 44 Years)	Not Pregnant No Child	Pregnant 1 st Trimester	Pregnant 2 nd Trimester	Pregnant 3 rd Trimester
Past Month Alcohol Use	63%	19%	7.8%	6.2%
Past Month Binge Drinking	32.6%	8.0%	1.8%	1.0%
Past Month Cigarette Use	33.3%	21.8%	14.4%	13.9%
Past Month Marijuana Use	10.9%	4.6%	2.9%	1.4%

Source: NSDUH Combined 2002 to 2007 data



Source: NSDUH Combined 2002 to 2007 data

Highlights

- Pregnant women reduce alcohol, binge drinking, cigarette and marijuana use as pregnancy progresses through the third trimester.
- Non-pregnant women with infants increase alcohol, binge drinking and cigarette use as their children age.

Consequences of Alcohol and Other Drug Use**Arrests****Monthly Arrest and Citation Register (MACR)**

MACR contains information on adult and juvenile (under 18 years of age) arrests throughout the state. These tables and charts display adult felony and juvenile and misdemeanor arrests for drug offenses for Californians. Arrest data should never be used as a direct indicator of the magnitude or nature (i.e., demographic breakdown) of the AOD problem. Arrests often reflect the level of resources (e.g. funding, staff) and attention (e.g. governmental) devoted to addressing a problem more than the underlying nature of the problem itself. However, arrests do provide an indication of the actual impact of AOD on the criminal justice system. A limited set of indicators are presented as indications of the data available.

AOD-related arrests occur when persons are taken into custody because they are believed to have violated alcohol or drug laws. Drug law violations include narcotics (heroin, opium, etc.), marijuana, dangerous drugs (barbiturates, phencyclidine, etc.), and other drugs. Alcohol law violations include driving-under-the-influence, public drunkenness, and liquor law infractions.

Arrests are divided into two major groups: adult arrests (18 years of age and older) and juvenile arrests (12-17 years of age).

DUI Arrests**Adult and Juvenile Misdemeanor and Felony DUI Arrests, California, 2002-2008**

	2002	2003	2004	2005	2006	2007	2008
Juvenile							
Misdemeanor	1,482	1,513	1,403	1,380	1,621	1,570	1,426
Felony	83	72	98	67	82	73	69
Adult							
Misdemeanor	172,266	178,561	175,653	175,004	191,282	198,296	209,737
Felony	5,832	5,827	5,617	5,963	6,162	6,257	5,969

Note: DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.

Source: Adult and Juvenile Arrests Reported, 2008; Criminal Justice Statistics Center, California Office of the Attorney General.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, March 2010.

Highlights

- There were over 200,000 DUI arrests made in 2008, with the vast majority being misdemeanor arrests.
- Misdemeanor DUI arrests greatly outnumber felony DUI arrests for juveniles and adults each year of observation.
- The total number of misdemeanor arrests in 2008 was substantially higher than those in prior years.
- From 2002 through 2005, the rates of DUI arrests were relatively static; from 2005 through 2008 there is a steady increase in DUI arrests.

Adult and Juvenile Felony and Misdemeanor DUI¹ Arrests by Race and Ethnicity, 2008

Race & Ethnicity	% ²	N ³	R ⁵
White	39.6 85	,235	593.2
Hispanic	45.6 98	,387	930.1
African American	7.3 15	,859	828.3
Other	7.5 16	,225	344.7

¹ DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.

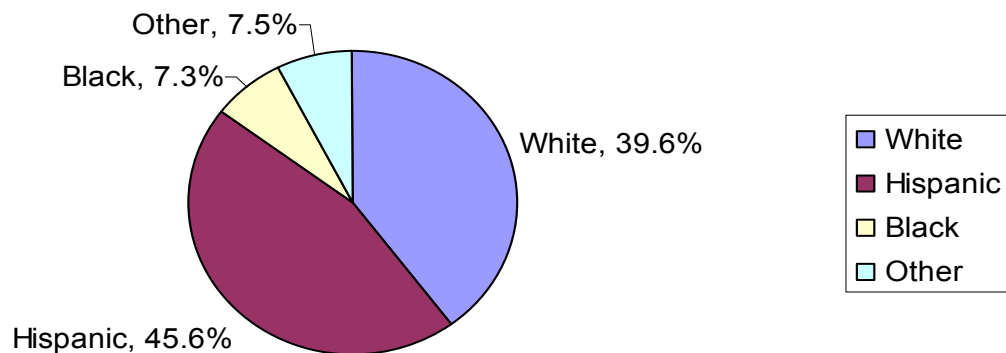
²Percentage of total arrest per category.

³The number of arrests per category. Age 12+.

⁵ Arrest rate per 100,000 per category.

Source: Adult and Juvenile Arrests Reported, 2008; Criminal Justice Statistics Center, California Office of the Attorney General.

Adult and Juvenile Felony and Misdemeanor DUI Arrests by Race and Ethnicity Age 12+



Felony Drug Offense Arrests by Race and Ethnicity, California, 2008

	NARCOTICS ¹			Marijuana			Dangerous Drugs ²			Other Drug Violations		
	% ³	N ⁴	R ⁵	%	N	R	%	N	R	%	N	R
RACE & ETHNICITY												
White	24.6%	13,071	90.2	31.6%	5,409	37.3	40.3%	23,049	159.0	37.8%	599	4.1
Hispanic	29.6%	15,741	147.9	30.9%	5,285	49.7	44.5%	25,465	239.3	37.2%	590	5.5
African American	42.1%	22,367	1165.5	31.2%	5,351	278.8	8.5%	4,851	252.8	19.9%	316	16.5
Other	3.7%	1,956	41.3	6.3%	1,081	22.8	6.1%	3,508	74.1	5.1%	81	1.7
TOTAL	100	53,135	167.1	100.0%	17,126	53.9	99.4%	56,873	178.9	100.0%	1,586	5.0
TOTAL ARREST RATE	167.1			53.9			178.9			5.0		

¹Narcotics: Plant derivatives such as heroin, cocaine, etc.

²Dangerous Drugs: Manufactured drugs such as barbiturates, phencyclidine, methamphetamines, etc.

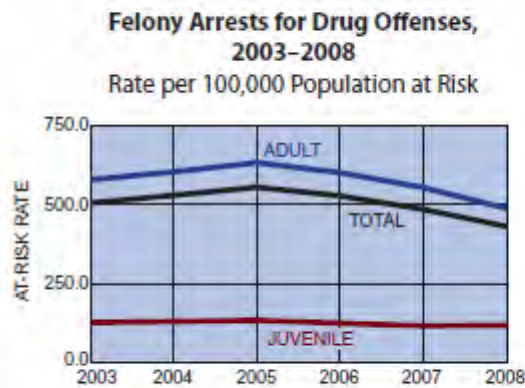
³Percentage of total arrest per category.

⁴The number of arrests per category. Age 12+.

⁵Arrest rate per 100,000 per category.

Source: Adult and Juvenile Arrests Reported, 2008; Criminal Justice Statistics Center, California Office of the Attorney General.

Arrests for Drug Offenses



Source: Table 22

From 2007 to 2008:

- The rate of total drug offense arrests decreased 11.2 percent.
- There was a 12.0 percent decrease in the rate of adult arrests and a 1.3 percent increase in the rate of juvenile arrests.

Comparing 2003 to 2008:

- The rate of total drug offense arrests decreased 14.7 percent.
- There was a 15.7 percent decrease in the rate of adult arrests and a 7.1 percent decrease in the rate of juvenile arrests.

Population at risk is age 10 to 69

Source: Criminal Justice Statistics Center, California Office of the Attorney General (2008). *Crime in California, 2008*. Sacramento, CA: <http://ag.ca.gov/cjcs/pubs.php>

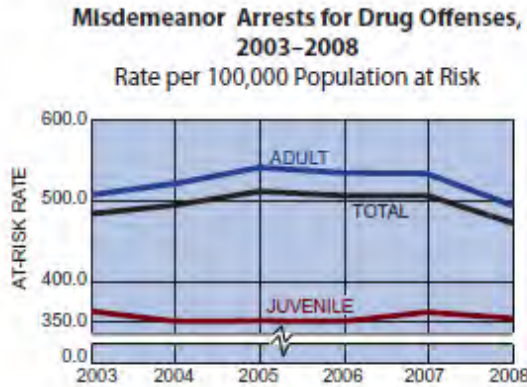
Misdemeanor Drug Offense Arrests by Race and Ethnicity, California, 2008

	Marijuana			Other Drugs			Public Intoxication			Liquor Laws		
	% ¹	N ²	R ³	%	N	R	%	N	R	%	N	R
RACE & ETHNICITY												
White	37.7%	23,163	159.8	43.3%	34,612	238.8	48.2%	59,219	408.5	48.4%	9,634	66.5
Hispanic	37.6%	23,071	216.8	35.3%	28,198	264.9	37.6%	46,111	433.2	37.1%	7,386	69.4
African American	18.5%	11,330	590.4	16.6%	13,220	688.9	9.1%	11,151	581.1	6.6%	1,323	68.9
Other	6.2%	3,824	80.8	4.8%	3,828	80.9	5.1%	6,321	133.5	7.9%	1,584	33.5
TOTAL	100	61,388	193.1	100.0%	79,858	251.2	100.0%	122,802	386.3	100.0%	19,927	62.7
TOTAL ARREST RATE												
	193.1			251.2			386.3			62.7		

¹Percentage of total arrest per category. ²The number of arrests per category. Age 12+. ³Arrest rate per 100,000 per category
Source: Adult and Juvenile Arrests Reported, 2008; Criminal Justice Statistics Center, California Office of the Attorney General.

Drug Offense Arrests

Includes under the influence, possession, and paraphernalia.



Source: Table 27.

In 2008, of the 141,246 arrests for drug offenses:

- Adult arrests accounted for 88.4 percent (124,913).
- Juvenile arrests accounted for 11.6 percent (16,333).

From 2007 to 2008:

- The rate of total drug offense arrests decreased 6.7 percent.
- There was a 7.4 percent decrease in the rate of adult arrests and a 2.1 percent decrease in the rate of juvenile arrests.

Comparing 2003 to 2008:

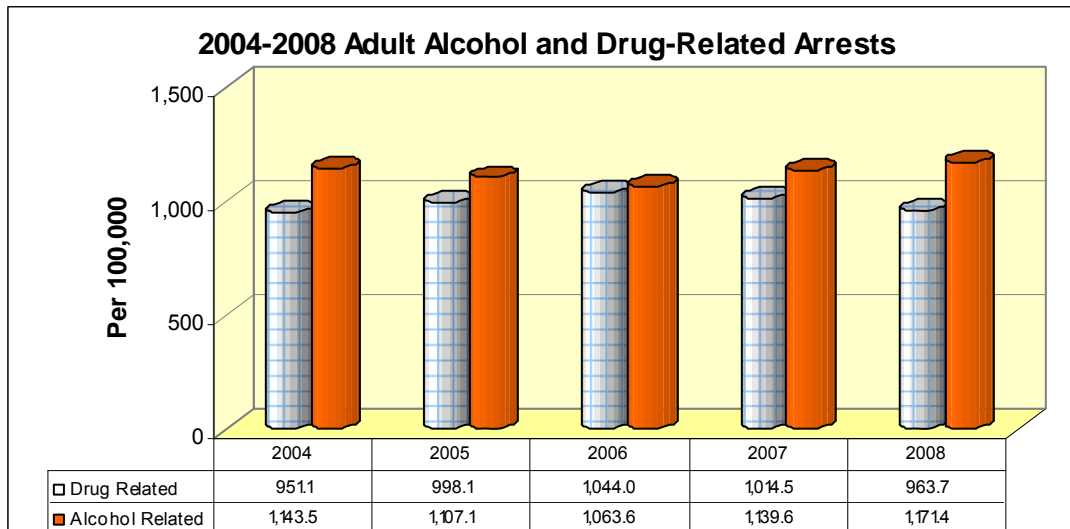
- The rate of total drug offense arrests decreased 2.4 percent.
- There was a 2.6 percent decrease in the rate of adult arrests and a 2.4 percent decrease in the rate of juvenile arrests.

Population at risk is age 10 to 69

Source: Criminal Justice Statistics Center, California Office of the Attorney General (2008). *Crime in California, 2008*. Sacramento, CA: <http://ag.ca.gov/cjsc/pubs.php>

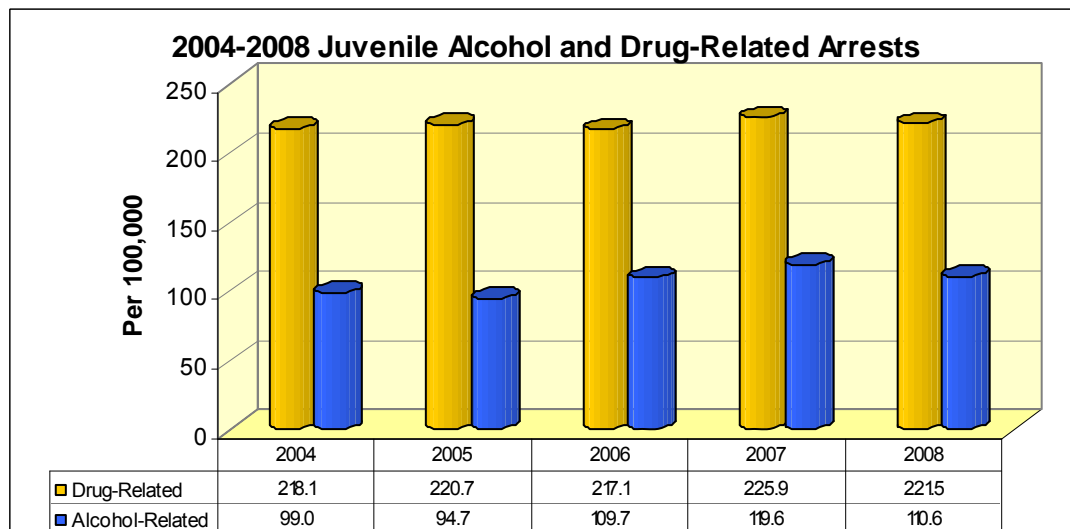
Highlights

- African Americans have the highest arrest rates for all drug offenses, except for liquor law violations, for both felony and misdemeanor offenses. The differences in arrest rates are particularly pronounced for misdemeanor marijuana and other drug offenses, and for narcotics and marijuana.



Source: Adult and Juvenile Arrests Reported, 2008; Criminal Justice Statistics Center, California Office of the Attorney General.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, April 2010.



Source: California Department of Corrections and Rehabilitation, special data request.

Prepared by: Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, June 2010.

Highlights

- Among juveniles, the rates of drug arrests were about two times greater than alcohol arrests.

- Juvenile drug arrests remained fairly steady between 2004 and 2008. The rates of juvenile arrests for alcohol offenses increased from 2004 to 2008.

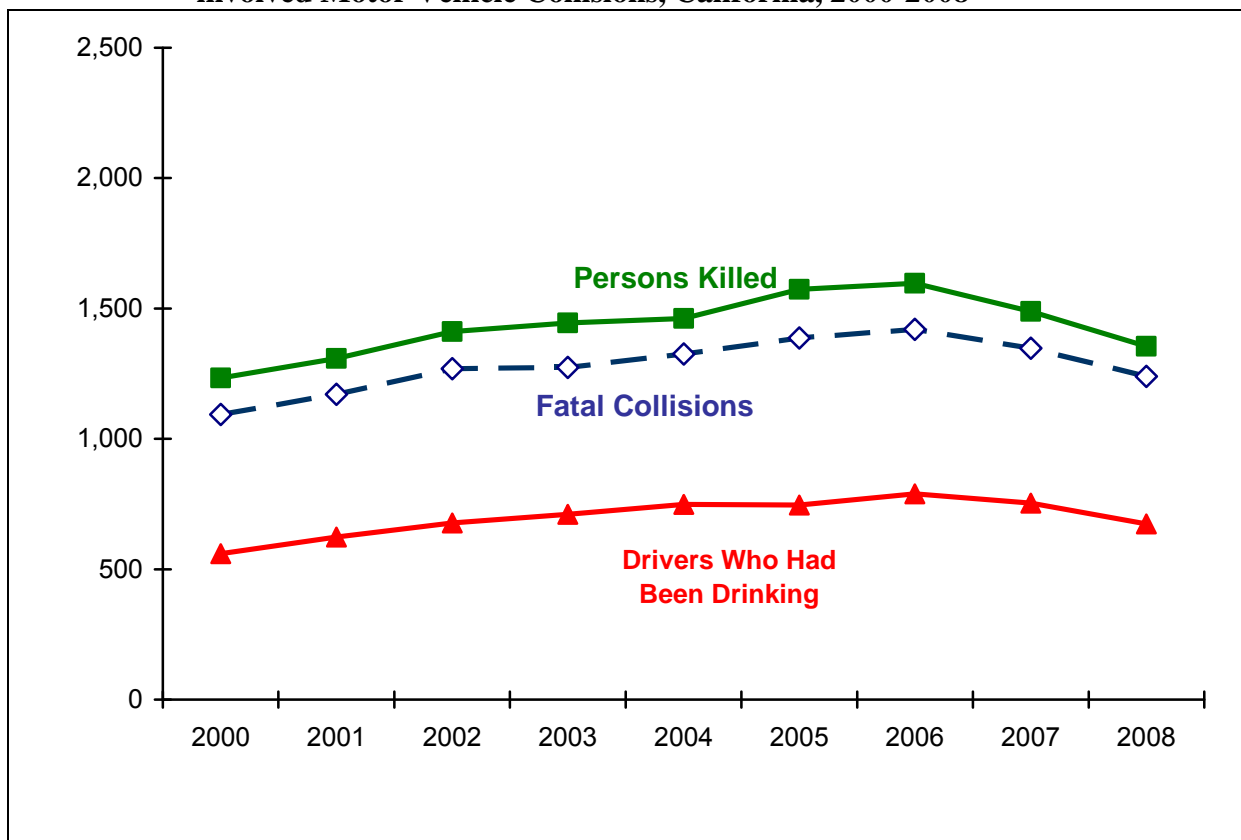
Alcohol-related Fatal and Injury Motor Vehicle Collisions

There are two good sources of statewide data that document alcohol and other drugs traffic related consequences: California’s Statewide Integrated Traffic Records System (SWITRS) and the federal Fatality Analysis Reporting System (FARS). SWITRS includes information on all motor-vehicle collisions, whereas FARS focuses on fatal collisions only and provides toxicology results of blood alcohol levels.

Statewide Integrated Traffic Records System (SWITRS)

The data provided on alcohol-involved motor vehicle collisions comes from the Statewide Integrated Traffic Records System (SWITRS) operated by the California Highway Patrol in partnership with the California Department of Motor Vehicles. The database includes all property-damage and injury crashes investigated by police in all California jurisdictions.

Fatal Collisions, Persons Killed, and Drivers Who Had Been Drinking in Alcohol-involved Motor Vehicle Collisions, California, 2000-2008



Source: 2008 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions; California Department of Highway Patrol. Retrieved from <http://www.chp.ca.gov/switrs/xls/2008-sec5.xls> March 2010.

Highlights

- In the five-year period between 2004 and 2008 there were approximately 109,620 alcohol-involved motor-vehicle collisions, resulting in 152,693 people being injured, and 7,477 persons killed. In 2008, 1,355 people were estimated to have died in alcohol-related motor vehicle collisions.
- Between 2000 and 2006 the numbers of alcohol-involved fatal collisions, persons killed in these accidents, and drivers who had been drinking in these accidents increased steadily. Between 2006 and 2008, all three of these events have decreased.
- Since 2006 the numbers of alcohol-involved injury collisions, persons injured in these accidents, and drivers who had been drinking in these accidents have decreased.

Fatality Analysis Reporting System (FARS)

In 1975, the U.S. Department of Transportation, National Highway Traffic Safety Administration created FARS. FARS provides annual estimates of alcohol/drug involvement (of the driver) for all motor vehicle crashes on public roads that result in the death of an occupant of a vehicle or a non-motorist within 30 days of the crash. The data system allows comparisons over time and among local jurisdictions. Data are gathered from several sources (police reports, coroners' reports, EMS, hospitals, and others) and are combined to ensure corroborated and complete information coded with strong quality control.

Persons Killed in Alcohol-related Crashes by Driver's Blood Alcohol Concentration and Age California, 2008

AGE	Blood Alcohol Concentration ¹ (BAC)	
	0.01 – 0.07	0.08+
< 16	0	3
16 - 20	39 11	4
21-24	23 22	5
25-44	82 53	7
45-64	41 25	9
65+	14	36
Unknown	0	5
TOTAL	199	1,179

¹Grams per deciliter

Notes: Excludes individuals for whom BAC level was 0.0 % and those for whom BAC level was not ascertained.

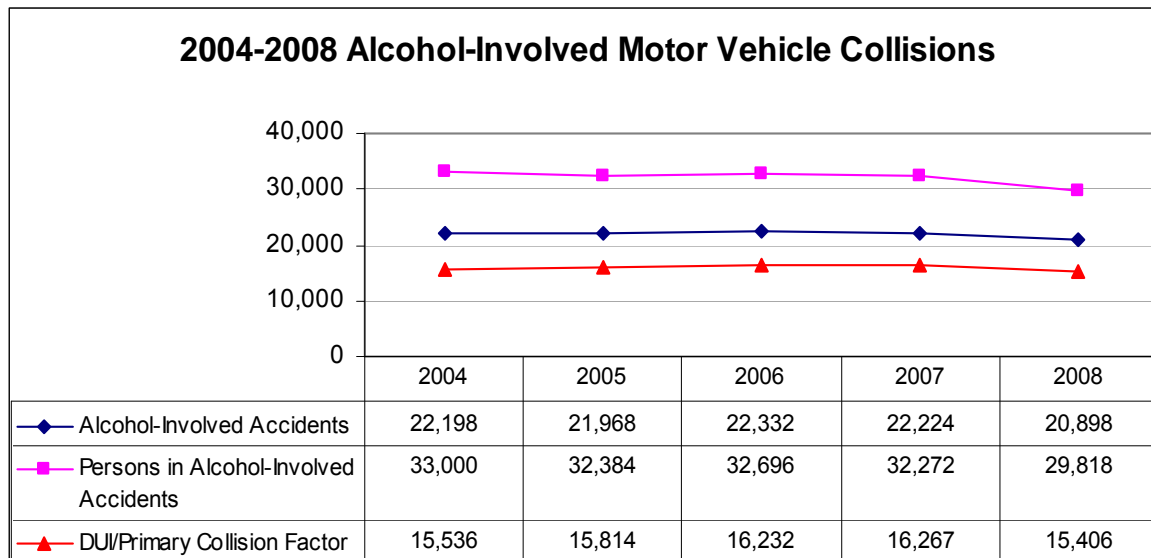
Source: Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration; Retrieved March 2010 from <http://www-fars.nhtsa.dot.gov/Main/index.aspx>.

Highlights

- According to FARS data, approximately 1,378 persons were killed in 2008 in alcohol-related traffic collisions. This number is slightly larger than the estimate of 1,355 fatalities due to alcohol-related traffic collisions provided by state-level SWITRS data for 2008.
- Overall, almost six times as many deaths occurred in vehicles where the driver’s BAC was 0.08 and above than in vehicles where the driver’s BAC was between 0.01 to 0.07 gm/dl.
- This consequence was most apparent for adults between 21-44 years old—almost 10 times as many deaths occurred when drivers’ BAC was greater than .08 than in vehicles where drivers had less to drink.

Statewide Integrated Traffic Records System

The tables below show the number of all motor vehicle collisions, and number of persons involved in alcohol-related collisions.

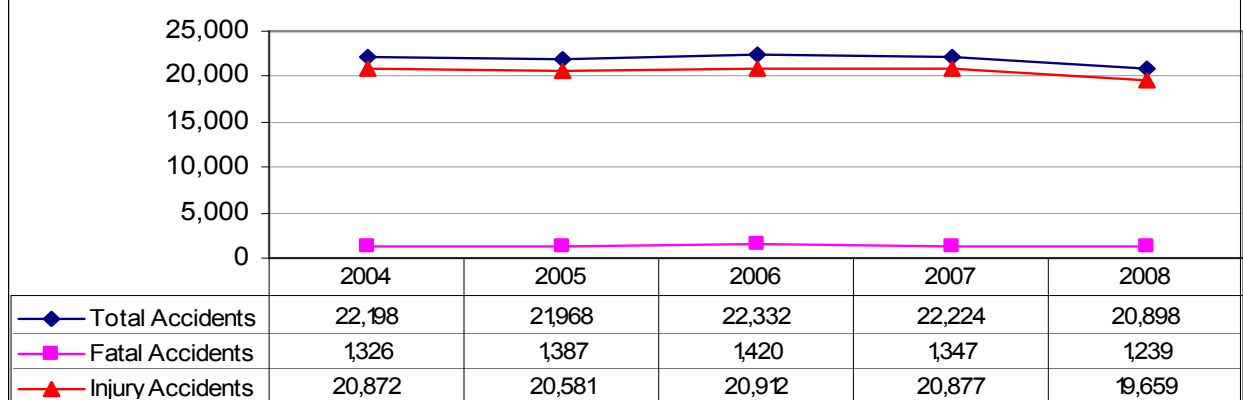


Source: 2007 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions; California Department of Highway Patrol. Retrieved from <http://www.chp.ca.gov/switrs/xls/2007-sec5.xls>

Highlights

- The number of alcohol-involved motor vehicle collisions, and number of persons in these motor vehicle collisions who were killed or injured, remained fairly level between 2004 and 2007, but had dropped by 2008.
- The number of motor vehicle collisions in which the driver was cited for driving under the influence of alcohol and/or other drugs increased between 2004 and 2007, but had dropped by 2008.

2004-2008 Fatalities and Injuries in Alcohol-Involved Motor Vehicle Accidents



Source: 2007 Annual Report of Fatal and Injury Motor Vehicle Traffic Collisions; California Department of Highway Patrol.
Retrieved from <http://www.chp.ca.gov/switrs/xls/2008-sec5.xls>

Highlights

- The number of alcohol-involved *fatal* motor vehicle collisions and motor vehicle injury collisions decreased between 2004 and 2008.
- Between 2004 and 2008, about one of every 16 alcohol-involved motor vehicle collisions resulted in a fatality.

Health Consequences

Office of Statewide Health Planning and Development

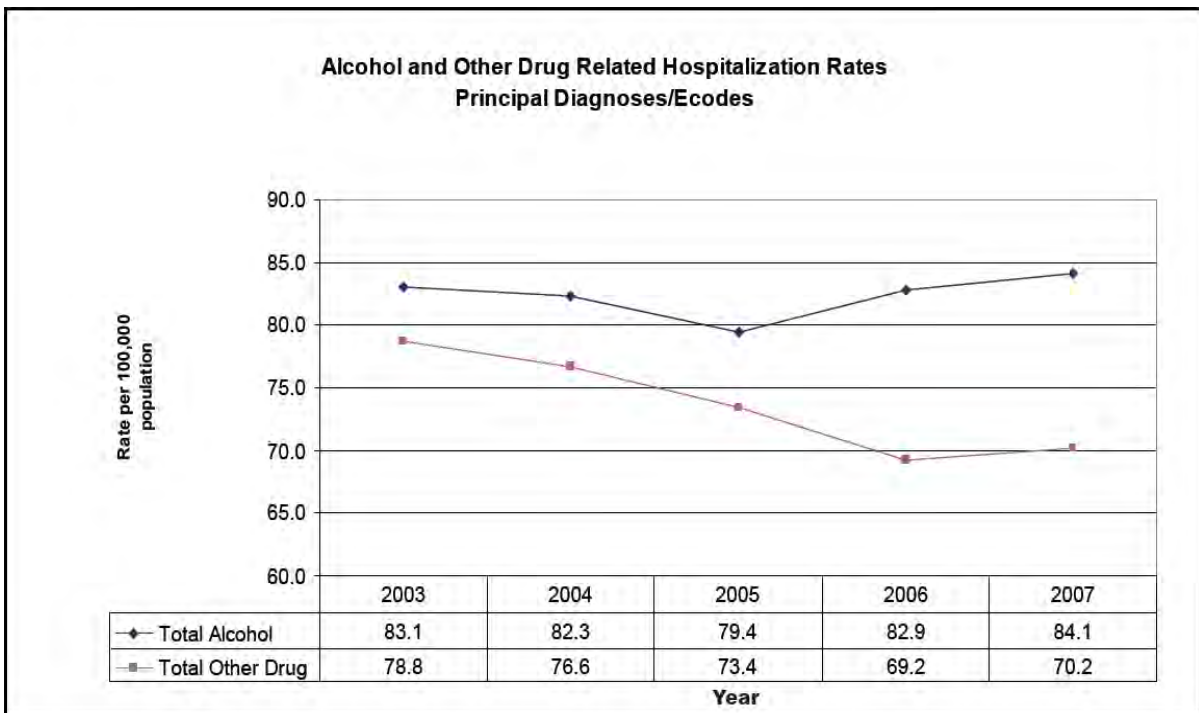
The Office of Statewide Health Planning and Development (OSHPD) oversee the collection of data on hospital inpatient discharges and, more recently (2005), Emergency Department (ED) visits for California residents. Only those causes of death that can be 100 percent attributed to alcohol or drugs respectively are included.

Annual Hospital Inpatient Discharge files may contain multiple records for the same individual if they were hospitalized more than once during the year. Each individual patient discharge record contains demographic, clinical, payer, and facility information.

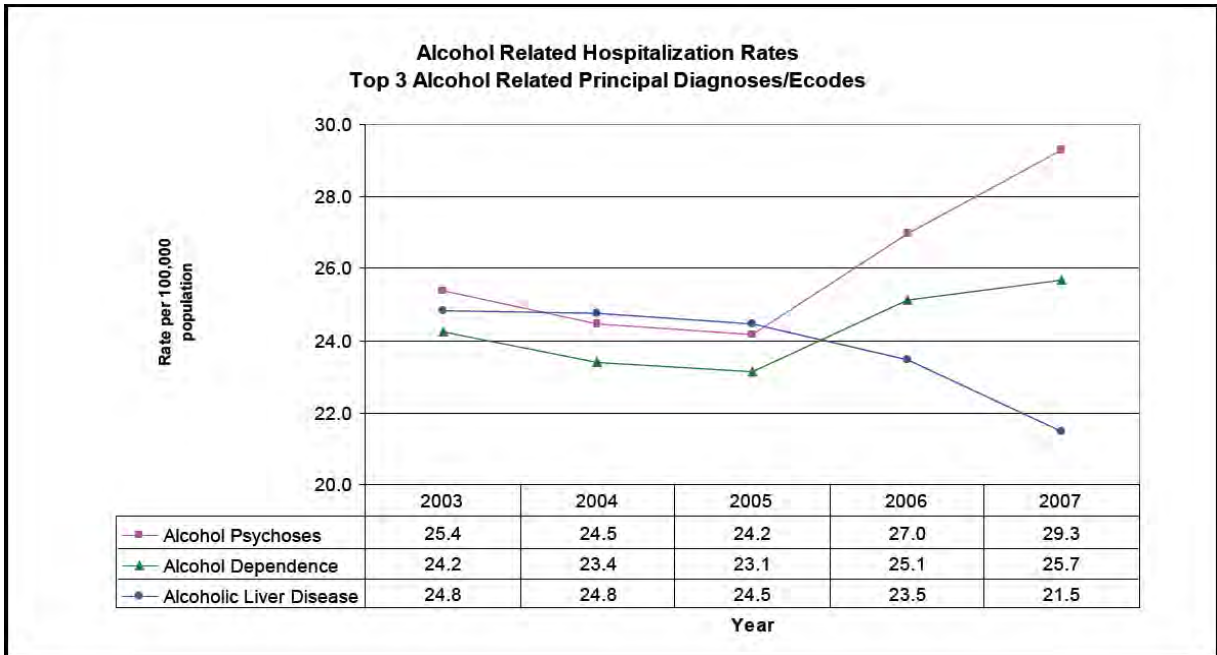
The clinical information is recorded in a principal diagnostic code and up to 24 other diagnostic codes. The principal diagnosis is the condition established to be the chief cause of the patient's admission to the facility for care. Often the drugs patients use are not specified in the hospital discharge record. Therefore, the data shown in this report do not fully describe the extent of the specific drug problems that exist in the hospital population, but are included to provide the reader with a sense of the toll alcohol and other drug use has on health.

“Principal Codes Analysis” of Hospitalizations

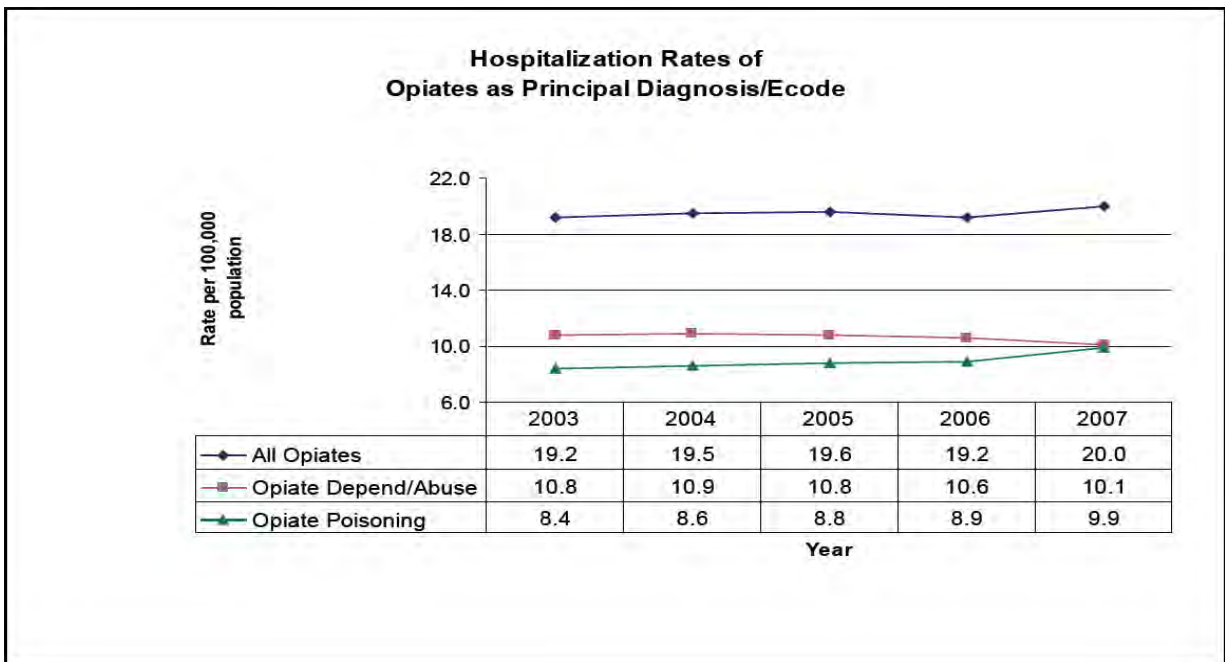
AOD related inpatient hospitalizations are included in this analysis if the patient record contains either a principal diagnostic code or principal E-code mention indicating the presence of alcohol or other drug abuse and dependence. The AOD related codes include mental/behavioral disorders, physical disorders, and poisonings. Psychotropic drugs used primarily for treating mental health problems (e.g., anti-depressants) are excluded. A small proportion of records have both a principal “Alcohol” and a principal “Other Drug” related ICD-9-CM code for the same hospital visit. These records are counted separately for each analysis. Using only the principal codes provide a conservative estimate of the number of hospitalizations related to AOD use. For example, if a patient is hospitalized for an opiate overdose (the principal diagnosis), the record is counted. However, if a patient is hospitalized with a principal diagnosis of a broken arm but is also drug dependent (one of the other diagnoses), the record is not counted.



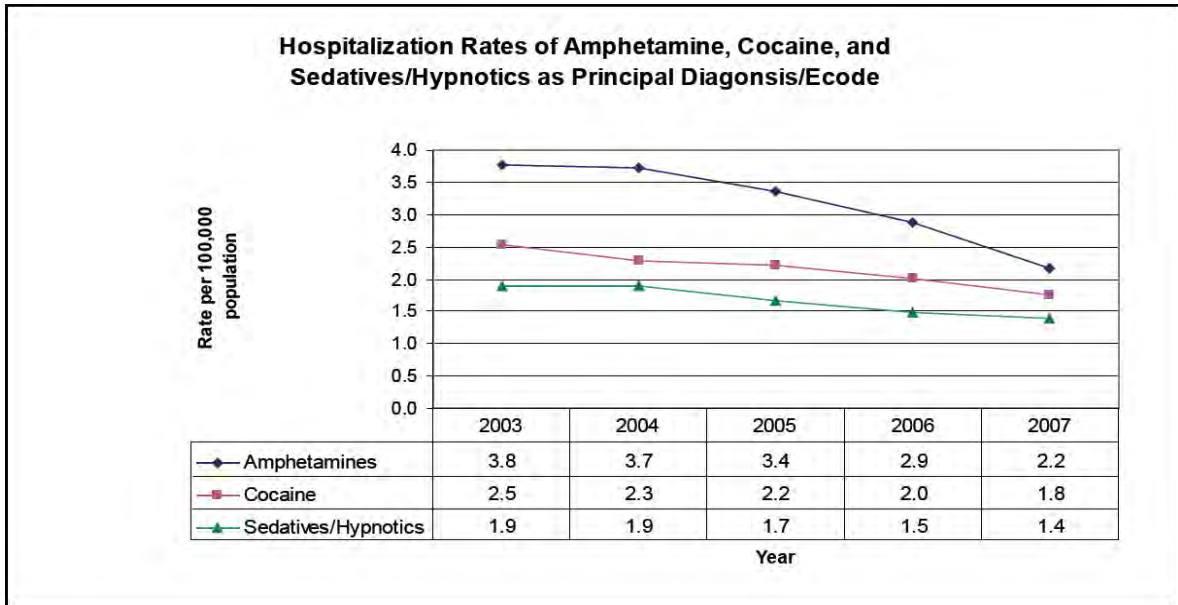
- From 2003 through 2007, the rates for alcohol-related hospitalizations are substantially higher than for other drugs.



- The rate of hospitalizations related to alcohol psychoses and alcohol dependence increased while the rate of hospitalizations for alcoholic liver disease decreased from 2003 through 2007.



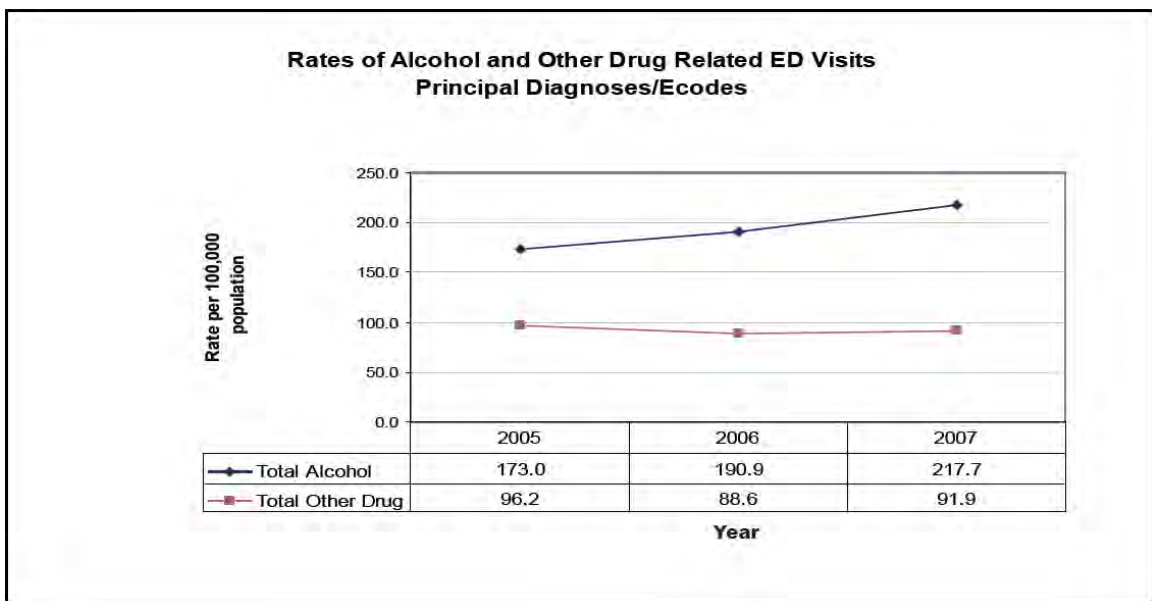
- Opiates make up the largest specific category of drugs other than alcohol. While the overall rate of hospitalizations due to opiates was fairly stable from 2003 through 2007, the rate of hospitalizations related to opiate poisonings increased while the rate of opiate dependence/abuse decreased.



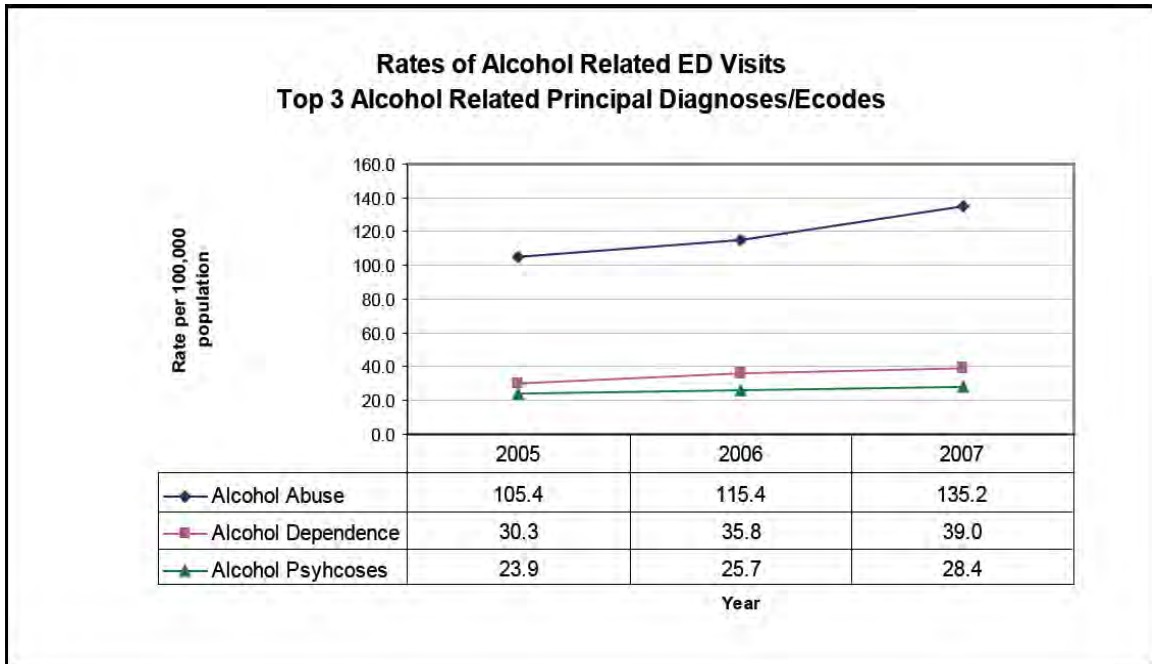
- The rates of hospitalizations related to drug dependence, abuse, and poisoning decreased for most major drugs (other than opiates), especially for amphetamines which decreased 42 percent from 2003 to 2007.

OSHPD “Principal Codes Analysis” of Emergency Department (ED) Visits

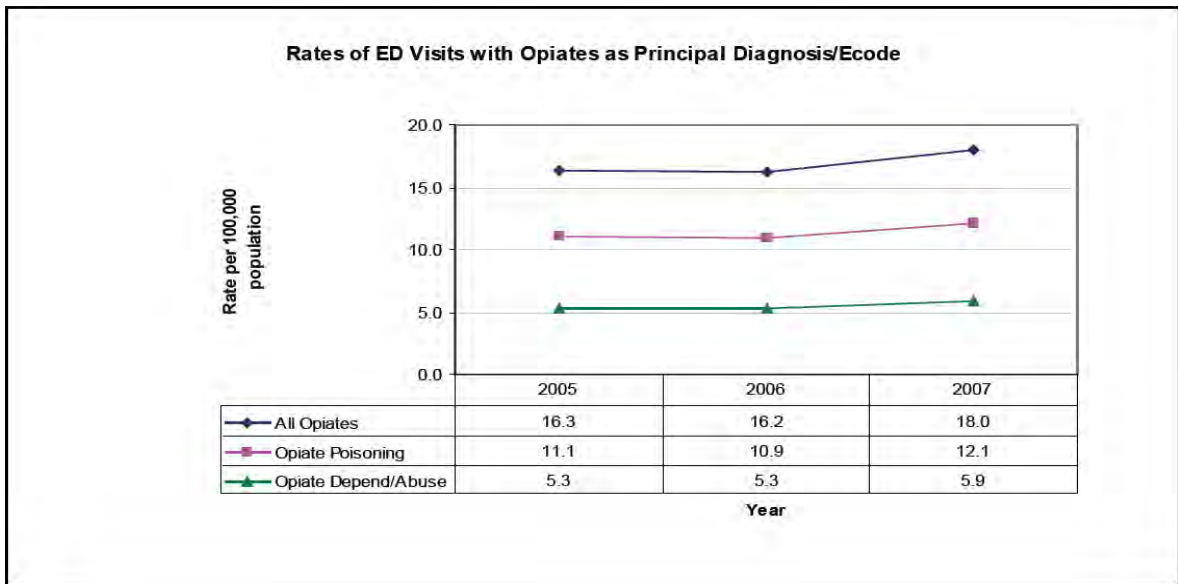
OSHPD began collecting ED data in 2005; therefore, only three years of trend data are shown. The same “Principal Codes Analysis” methodology is used as in the analysis of hospitalizations previously described for this analysis of ED visits data.



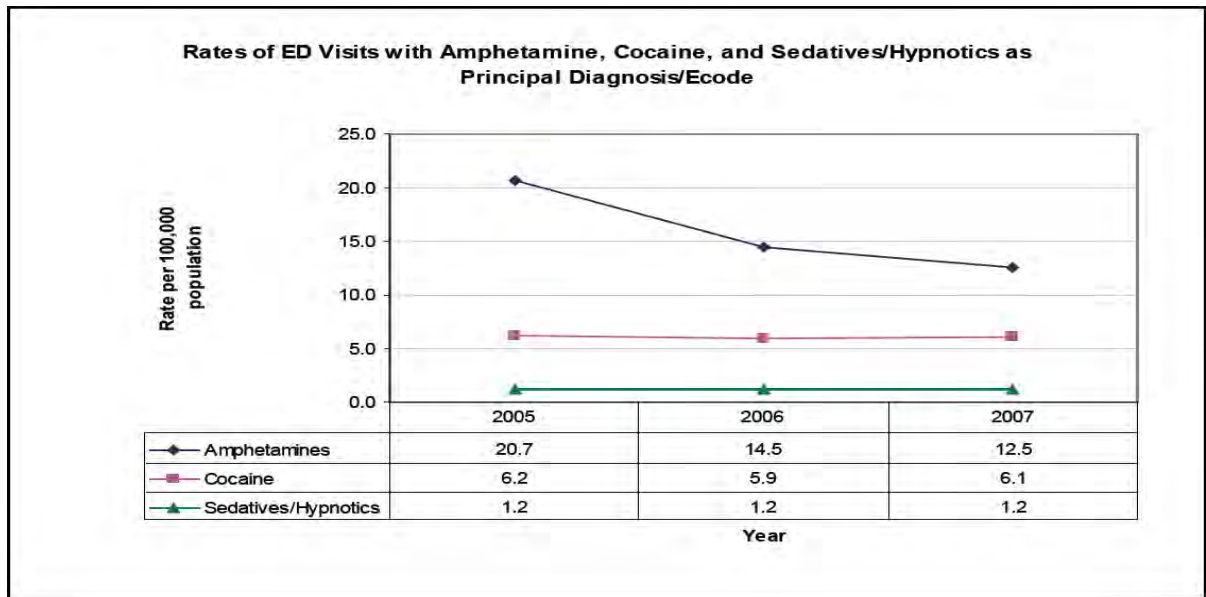
- From 2005 through 2007 the rate of alcohol-related ED visits is higher than the rate of other drug-related ED visits.



- From 2005 to 2007 the rate of ED visits related to alcohol abuse increased 28 percent, alcohol dependence increased 29 percent, and alcohol psychoses increased 19 percent.



- The overall rate of ED visits related to opiates increased 10 percent from 2005 to 2007, due to increases in both opiate dependence/abuse and opiate poisonings.



- The rate of ED visits for amphetamine dependence/abuse decreased 40 percent from 2005 to 2007 while the rates of ED visits for cocaine and sedatives/hypnotics dependence/abuse remained stable.

Highlights

- The rates for Alcohol related hospitalizations and ED visits are substantially higher than for Other Drugs.
- The trend in the rates for Alcohol related hospitalizations and ED visits are increasing especially for alcohol abuse and dependence.
- The rates for All Opiate related hospitalizations and ED visits are increasing, with a 10 percent increase in ED visits and a slight increase for hospitalizations.
- The rate of hospitalizations due to Opiate Poisonings had the greatest increase, 18 percent, followed by the rate of ED visits due to Opiate Dependence/Abuse, 11 percent.
- Substantial decreases are seen among Amphetamine related hospitalizations and ED visits.

Death

Centers for Disease Control and Prevention (CDC) Alcohol-Related Disease Impact

The CDC uses Alcohol-Related Disease Impact (ARDI) software to generate estimates of Alcohol-Attributable Deaths and Years of Potential Life Lost due to alcohol consumption. To do this, ARDI either calculates or uses pre-determined estimates of the proportion of deaths from various causes that are due to alcohol – Alcohol-Attributable Fractions (AAFs). These AAFs are then multiplied by the number of deaths caused by a specific condition (e.g., liver cancer) to obtain the number of alcohol-attributable deaths. The ARDI software uses both 100 percent attributable and direct and indirect estimates to determine AAFs. The data presented on alcohol-related deaths may be underestimated due to the reliance on self-report data (i.e., from the Behavioral Risk Factor Surveillance

System), reports of current alcohol consumption, and the impact of secondary causes of death. Five year totals are used to generate a measure of the magnitude of alcohol health consequences.

**Estimated Number of Annual Alcohol-Attributable
Deaths Due to Medium and High Average Daily Alcohol
Consumption, California, 2001-2005**

	Chronic Causes	Acute Causes	Total (All Causes)
ALL AGES			
Male	3,663	3,500	7,163
Female	1,468	1,133	2,601
Total Adult All Ages	5,131	4,633	9,764
YOUTH (<21)			
Male	12	425	437
Female	5	99	104
Total Youth (<21)	17	524	541

Source: Alcohol-Attributable Deaths Report, Average for California 2001-2005; Centers for Disease Control and Prevention; Retrieved February 2008 from <http://apps.nccd.cdc.gov/ardi/Homepage.aspx>.

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

**Estimate of Alcohol Attributable Years of Potential Life
Lost Due to Medium and High Average Daily Alcohol
Consumption Average for California, 2001-2005**

	Chronic Causes	Acute Causes	Total (All Causes)
ALL AGES			
Male	83,037	130,928	213,965
Female	34,674	38,953	73,627
Total All Ages	117,711	169,881	287,592
YOUTH (<21)			
Male	829	24,460	25,289
Female	423	6,415	6,838
Total Youth (<21)	1,252	30,875	32,127

Source: *Years of Potential Life Lost Report, Average for California 2001-2005*; Centers for Disease Control and Prevention. Retrieved February 2008 from <http://apps.nccd.cdc.gov/ardi/Homepage.aspx>.

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, California Department of Public Health, February 2008.

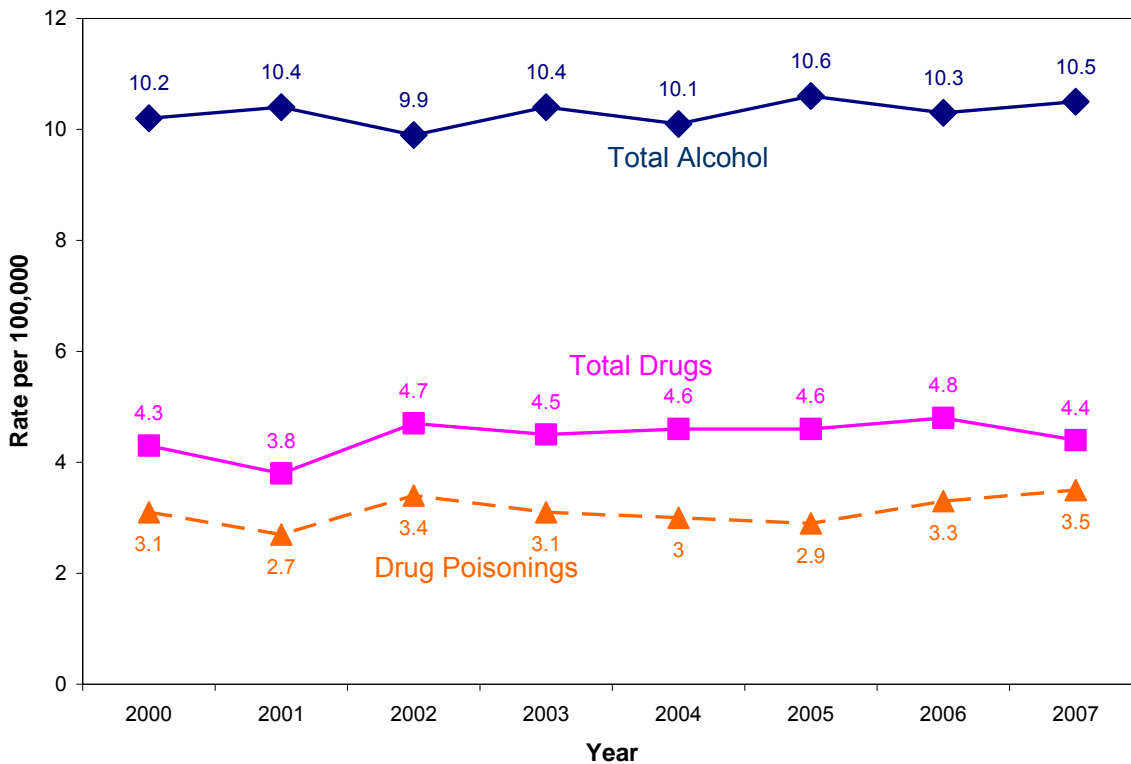
Highlights

- Over 10,000 deaths were attributed to alcohol over the five year period examined, with the vast majority of deaths occurring among adults.
- Nearly three quarters of all alcohol-attributable deaths were males.
- Adults were more likely to die from chronic causes (e.g., alcoholic liver disease, alcohol dependence; alcohol-induced stroke) than from acute causes (e.g., motor vehicle accidents, homicide, suicides).
- For those under 21 years old, the reverse was true—youth were much more likely to die from acute causes rather than chronic causes.
- The average alcohol-attributable potential years of life lost for all ages was 29.5 years per death (29.9 years per death for men, and 28.3 years per death for women).
- While there are more alcohol-attributable deaths due to chronic causes when compared to deaths due to acute causes, acute causes are associated with substantially earlier deaths and thus more years of potential life lost.
- The average alcohol-attributable potential years of life lost for all ages due to acute causes was 36.7 years per death versus 22.9 for chronic causes.
- Those who died younger than 21 years old lost 59.4 years per death.
- Younger females fared much worse in terms of alcohol-attributable potential years of life lost (57.9 years per death for men, and 65.8 years per death for women).

California Death Statistical Master Files

Substance use has both acute health consequences, such as poisoning overdoses and substance-related risk behaviors leading to unintentional and intentional injuries, and long-term health impacts, such as chronic liver disease and lung cancer. Obviously, the most severe health consequence of AOD use and abuse is death. The following two charts show the rates of death related to alcohol and other drug use among California residents. Only those causes of death that can be 100 percent attributed to alcohol or drugs respectively are included, producing very conservative estimates. The data are based on the California Death Statistical Master Files that contain the official record of all deaths in California.

Trends for Alcohol and Drug-related Deaths, CA, 2000-07



Notes: CA residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100 percent attributable to alcohol or drugs, respectively.

Data Source: Death Statistical Master Files, 2000-07; Office of Vital Statistics, California Department of Public Health (CDPH).

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

Highlights

- Rates of alcohol- and drug-related deaths have been fairly constant over the eight-year period for CA.
- The eight-year average rate in CA for alcohol-related deaths (10.3 per 100,000) is over two times greater than the average rate for drug-related deaths (4.5 per 100,000).
- Drug-related death rates in CA increased in 2002 and have stayed relatively stable until 2007. Drug poisonings make up the majority of total drug-related deaths, reaching 80 percent of the total in 2007.

**Number and Rates of Alcohol and Drug-Related Deaths by
Type California, 2005-2007**

	2005		2006		2007	
	#	Rate	#	Rate	#	Rate
ALCOHOL						
Mental and Behavioral Disorders	1,042		993		660	
Physical Conditions	2,831		2,828		3,039	
Poisonings	54		42		264	
Total	3,928	10.6	3,863	10.3	3,966	10.5
DRUG						
Mental and Behavioral Disorders	621		534		325	
Physical Conditions	0		2		0	
Poisonings	1,084		1,252		1,333	
Pregnancy-related	8		7		5	
Total	1,713	4.6	1,795	4.8	1,663	4.4
TOTAL	5,638	15.3	5,658	15.1	5,629	14.9

Note: California residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100 percent attributable to alcohol or drugs, respectively.

Source: Death Statistical Master and Birth Statistical Master files, 2005-07, Office of Vital Records, California Department of Public Health (CDPH); Race/Ethnic Population with Age and Sex Detail, 2000-2050, California Department of Finance, July 2007

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

**Number of Alcohol and Drug-related Deaths by Age,
Gender, and Race/Ethnicity, California, 2007**

	Alcohol	Drug	Total
AGE			
0-20 Years	14	59	73
21-29 Years	75	156	231
30-39 Years	246	267	513
40-49 Years	980	533	1,513
50-59 Years	1,384	499	1,883
60+ Years	1,267	149	1,416
GENDER			
Male	2,990	1,166	4,156
Female	976	497	1,473
RACE/ETHNICITY			
Hispanic/Latino	1,288	368	1,656
African-American	236	207	443
American Indian	52	15	67
Asian	106	19	125
Pacific Islanders	5	2	7
White	2,257	1,033	3,290
Multiple Race	16	18	34
Other/Unknown	6	1	7
TOTAL	3,966	1,663	5,629

Note: California residents only. Alcohol and drug-related deaths only include deaths with ICD-10 underlying cause of death codes 100 percent attributable to alcohol or drugs, respectively.

Source: California Death Statistical Master Files, 2005-07

Prepared by: Epidemiology and Prevention for Injury Prevention Branch, CDPH, March 2009.

Highlights

- Most alcohol-related deaths are due to physical conditions (such as tissue damage, hepatitis, etc.) rather than mental or behavioral disorders (late-onset psychotic disorder, delirium tremens, alcoholic dementia, etc.). The vast majority of other drug-related deaths were classified as due to poisoning (e.g., opioid analgesics).
- Each year, the number and rate of alcohol-related deaths greatly exceed those of drug-related deaths. Of the 5,629 deaths in 2007 attributable to psychoactive substance use, 70 percent are due to alcohol.
- Two-thirds of decedents who died of alcohol-related causes are 50 years or older, 75 percent are men, and 57 percent are non-Hispanic Whites.
- Sixty-two percent of drug-related deaths are among decedents between 40 and 59 years old. Less than 30 percent of drug-related deaths are among decedents less than 40 years old. 70 percent are men, and 62 percent are non-Hispanic Whites.
- Generally, older adults are more likely to die from alcohol and other drug-related causes: 59 percent of those who died from alcohol and other drug causes were 50 years of age or older, and 85 percent were 40 years old or older.

- On average in 2007 there were 15.4 alcohol or other drug related deaths per day in California.

Related Public Health Issues

HIV/AIDS and Substance Use

AIDS is a diagnosis associated with a set of symptoms and infections resulting from damage to the human immune system caused by a virus called the Human Immunodeficiency Virus (HIV).

Substance use increases ones risk for HIV transmission.¹ It is well known that injecting drug users (IDU) are at great risk for HIV infection when sharing equipment with other users. Infected blood can be drawn up into a syringe and then injected along with the drug into the next user of the syringe. However, HIV infection can happen even through small amounts of blood on cookers, filters, tourniquets, on hands, or in rinse water. In 2006, of the estimated new HIV infections nationwide, 12 percent were attributable to the IDU transmission mode. Those who reported both male-to-male sexual contact and IDU accounted for an additional four percent.² Less often discussed are the addictive and intoxicating effects of substance use which may increase the likelihood an individual participates in unsafe sexual behavior. HIV infection risk is further increased when substance use is combined with commercial sex for money/drugs, or sex with multiple partners.

HIV/AIDS in California

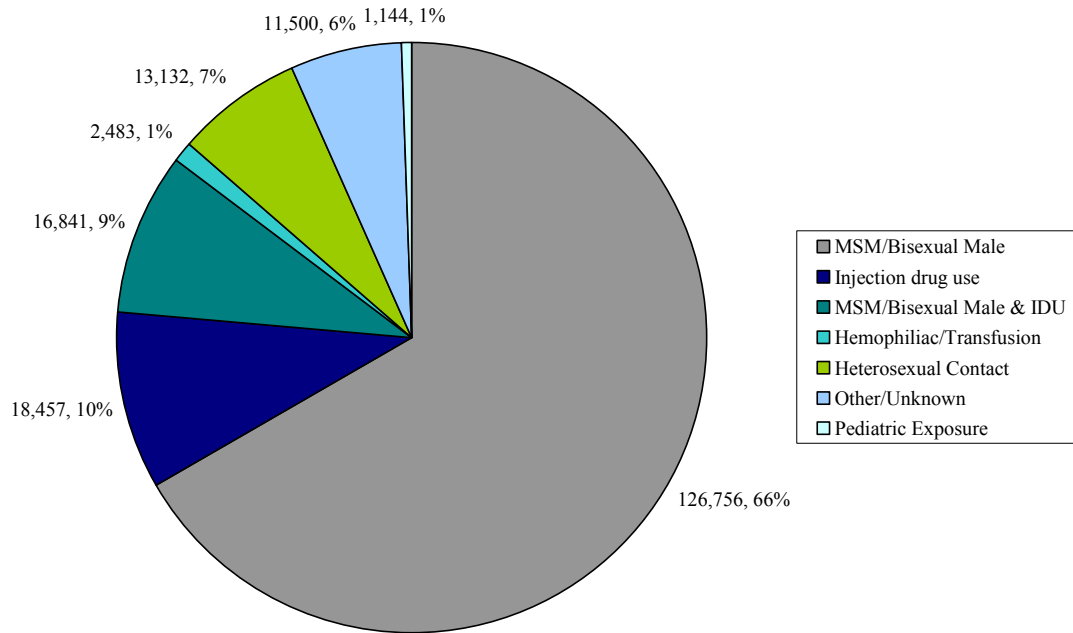
California originally started collecting AIDS case data in 1983. More recently HIV reporting has been included. HIV reporting began with non-name code in 2002 and evolved to HIV reporting by name in 2006.

The following pie chart shows the cumulative living HIV/AIDS cases by suspected mode of transmission. Since it is impossible to be certain how an individual was infected, the mode of exposure may include multiple transmission modes. For instance in the chart below there are categories for both IDU only and for men who have sex with men/bisexual in combination with IDU (MSM/Bi IDU).

¹ Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *HIV/AIDS*. Retrieve March 12, 2009, from <http://www.dpt.samhsa.gov/comor/hiv/aids.aspx>

² California Department of Justice, Criminal Justice Statistics Center. (2008). *Crime in California, 2008*. Sacramento, CA: <http://ag.ca.gov/cjsc/pubs.php>

California Cumulative Cases Living with HIV/AIDS by Exposure Category

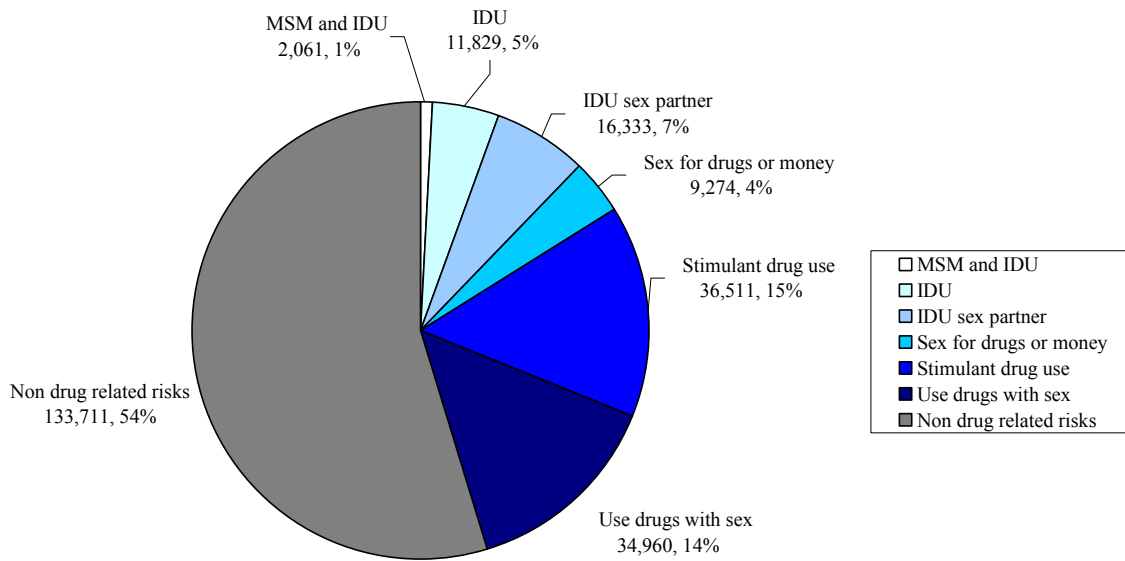


Source: California Department of Public Health, Office of AIDS, HIV/AIDS Case Registry Section, data as of April 30, 2009. HIV reporting began in April 2006; AIDS reporting began in March 1983.

As of April 30, 2009, IDU and MSM/Bi IDU mode of exposure accounts for 19 percent of all living HIV/AIDS cases reported in California which is higher than the national average.

Another data source available to help determine HIV prevalence and mode of exposure is California’s publicly funded HIV counseling and testing data. The following pie chart shows the self-disclosed risks of all individuals receiving publicly funded HIV counseling and testing services in 2007.

**Self Disclosed Risks Reported by Individuals Tested for HIV:
2007 California Publicly Funded HIV Counseling and Testing Data***

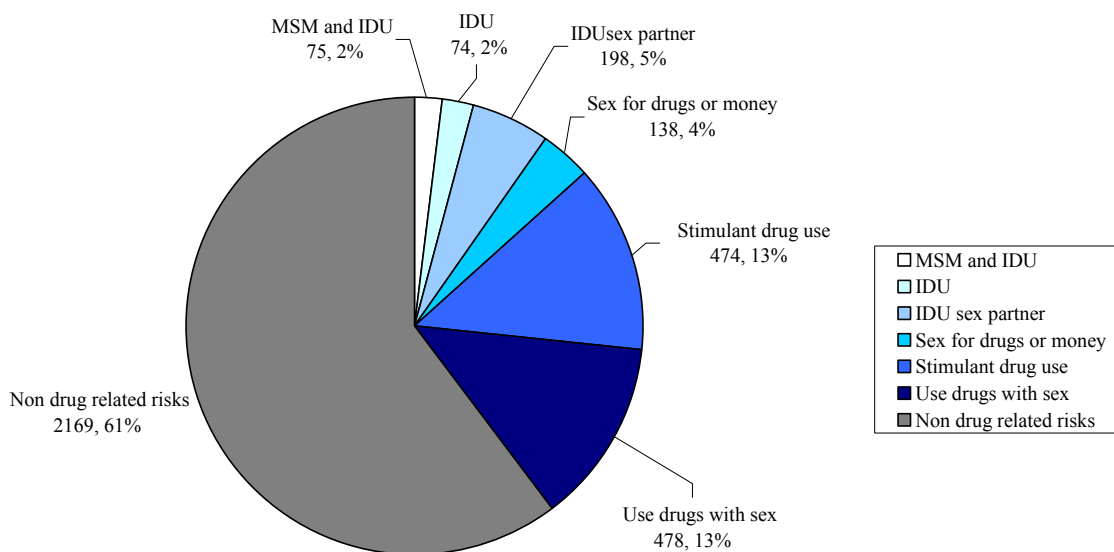


* Based on HIV C&T data received and processed as of November 13, 2008. Data may be incomplete.
Source: California Department of Public Health, Center of Infectious Diseases, Office of AIDS

The data show of all the self reported increased risk factors for HIV transmission **46 percent** were related to drug use.

The second pie chart illustrates, of those who tested positive, or indeterminate, the number that disclosed a drug-related risk.

Self Disclosed Risks Reported by Individuals that Tested HIV Positive:
2007 California Publicly Funded HIV Counseling and Testing Data***



* Based on HIV C&T data received and processed as of November 13, 2008. Data may be incomplete.

** Indeterminate test result means additional testing is needed to rule out a false positive.

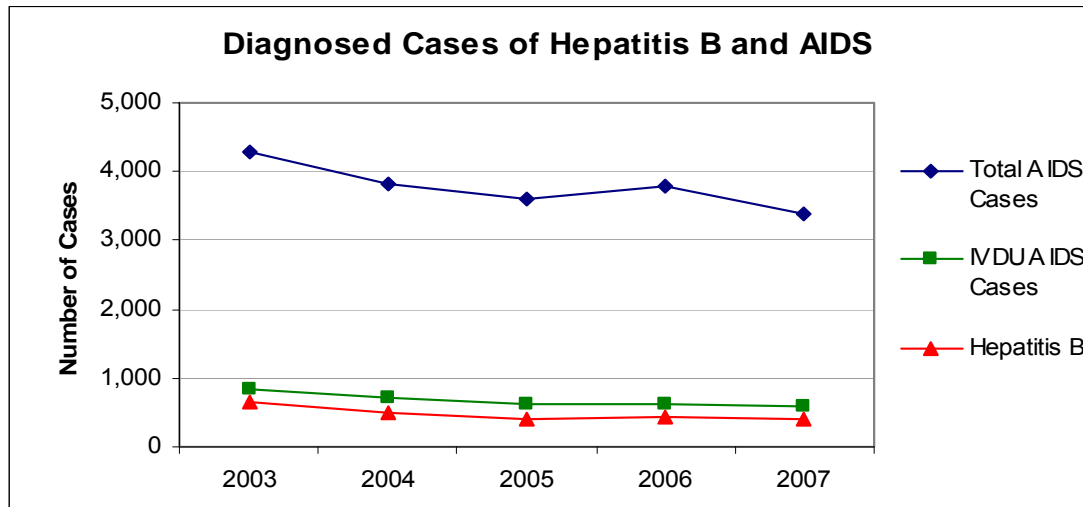
Source: California Department of Public Health, Center of Infectious Diseases, Office of AIDS

Of those that tested HIV positive or indeterminate, a 39 percent drug-related risk was reported. This data further illustrates the high correlation between substance use and HIV infection.

Diagnosed Cases of Hepatitis (Type B) and AIDS

Serum Hepatitis (Type B) is an inflammation of the liver, usually accompanied by fever and other systemic manifestations. The reporting physician makes a diagnosis of either Type A or B. Both homosexual males and users of illicit injectable drugs are among the groups acquiring the highest rate of Type B.

Intravenous drug users (IVDU) are at risk of HIV, (possibly leading to an AIDS diagnosis) and Hepatitis B infection, by sharing needles with infected persons. Non-intravenous drug users may acquire these diseases when they engage in risky behavior that they might not engage in while they are under the influence of alcohol or other drugs.



Tuberculosis (TB)

TB and Substance abuse

Substance abuse is the most common behavioral risk factor reported by patients with TB in the United States. Furthermore, due to delayed diagnosis, TB patients that report substance abuse are more contagious and remain contagious longer. This delayed diagnosis may be caused by decreased access to routine medical care. Patients that abuse substances are also less likely to begin and complete treatment for their TB. This is compounded by the fact that anti-tuberculosis medication is usually metabolized by the liver, which is often damaged by substance abuse.¹

TB in California

In 2008, 2,695 TB cases were reported in California. Although this was the lowest ever reported, the rate of decline slowed from five percent a year declines in 2003-2006 to less than two percent in 2007 and only one percent in 2008. California accounted for 21 percent of all the TB cases in the United States in 2008 the most cases reported by a State in the nation. So, although the declining number of TB cases represents success in control and prevention efforts, TB continues to be a threat to California's public health.²

¹ Oeltmann et al. (2009). *Tuberculosis and Substance Abuse in the United States, 1997-2006*. Archives of Internal Medicine, 169 -189.

² California Department of Public Health. (2008). *Report on Tuberculosis in California, 2007*. Retrieved from www.cdph.ca.gov/data/statistics/documents/TB_Report_2007.pdf

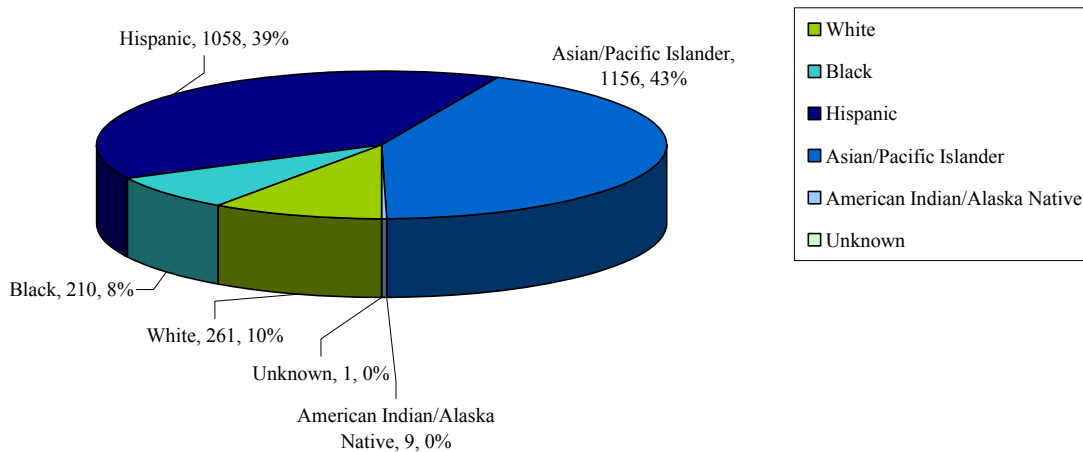
The table below shows that in 2008 nearly 18 percent of the 2,695 persons with TB reported substance abuse as a risk factor for their exposure to TB.

Substance Abuse TB Risk Factors Reported: California 2008		
	Total Tested	
<i>Self-disclosed Risks</i>	#	%
Injecting Drug Use	37	1.4%
Non-injecting Drug Use	176	6.7%
Excess Alcohol Use	257	9.7%
Total Substance Abuse Risk Factors Reported	470	17.8%
Total TB Cases Reported	2,695	100 %

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

The graph below shows TB cases in 2008 in California by race/ethnicity. Asian/Pacific Islander and Hispanic populations may be at particular risk for TB infection: these groups accounted for 82% of the TB cases in California in 2008.

Tuberculosis Cases by Race/Ethnicity: California 2008



Source: California Department of Public Health, Tuberculosis Control Branch

Another high risk group is individuals born outside the United States. They account for over 75 percent of the TB cases in California in 2008; however, substance use is still the most common behavioral risk factor. Another risk factors is homelessness.

Hepatitis C (HCV)

HCV and Substance Abuse

Hepatitis C viral (HCV) infection causes an estimated 8,000 to 10,000 deaths in the United States annually.¹ Individuals who abuse substances have an increased risk for HCV infection.² At 60 percent, Intravenous Drug Users are at the highest risk of HCV infection, but even non-injecting drug users are at an increased risk when compared to the general population. The general population rate of HCV infection is lower than two percent.³ In a recent study of HCV, of those who reported a current or prior substance use disorder 26 percent tested positive for HCV. Of those that did not report a substance use disorder only five percent tested positive. Furthermore, 66 percent of those who tested positive reported a substance use disorder.⁴ Unlike Hepatitis A and B, no vaccine exists against HCV. Prevention of HCV relies on identifying those at high risk for HCV infection and providing screening, testing, and counseling services to those individuals.⁵

HCV in California

Approximately 600,000 people in California—approximately two percent of the state’s population are infected with HCV.⁶ As discussed in the study, 66 percent of those who tested positive for HCV reported substance abuse as a risk factor; as many as 396,000 of the 600,000 Californian’s infected with HCV are related to substance abuse.

Problem Gambling in California

According to the 2006 California Problem Gambling Prevalence Survey the majority of Adults in California, 83 percent, have gambled at some point in their lives. While playing the lottery was the most common gambling activity Californians engaged in, casinos were the preferred place to gamble in 2006. Following the lottery, casinos and private wagering, participation in other gambling activities such as racetracks, cardrooms, bingo and the internet were extremely low.

For many people gambling can be a source of entertainment. However for a minority of people, gambling can lead to the development of significant and debilitating problems. These problems both vary in the duration and severity. The following are explanations of commonly used terms to describe different levels of gambling severity.

Pathological- Is a progressive mental disorder. “[the]most severe end of the continuum of gambling problems. Pathological Gambling is a treatable mental disorder characterized

¹ California Department of Public Health, Office of AIDS (2008). *Hepatitis Virus Co-infection*. Retrieved from <http://ww2.cdph.ca.gov/programs/aids/Documents/FSHEPC2008-04.pdf>

² National Digestive Diseases Information Clearinghouse. Chronic Hepatitis C: Current Disease Management. Retrieved March 25, 2009 from <http://digestive.niddk.nih.gov/ddiseases/pubs/chronichepc/>

³ Hagedorn et. al. (2007). *Integrating hepatitis prevention services into a substance use disorder clinic*. Journal of Substance Abuse Treatment 32, 391-398.

⁴ Huckans et. al. (2007). Interferon alpha therapy for hepatitis C: treatment completion and response rate among patients with substance use disorder. *Substance Abuse Treatment, Prevention, and Policy*, 2-4.

⁵ Centers for Disease Control and Prevention. (March 21, 2008). *Surveillance for Acute Viral Hepatitis- United States, 2006*. Morbidity and Mortality Weekly Report, Vol. 57.

⁶ Oeltmann et al. (2009). *Tuberculosis and Substance Abuse in the United States, 1997-2006*. Archives of Internal Medicine, 169 -189.

by loss of control over gambling, chasing of losses, lies and deceptions, family and job disruption, financial bailouts and illegal acts.”¹

Problem- Is participation in any form of gambling to the extent that it creates negative consequences to the gambler, their family, employment or community.

At-risk- Are individuals who score lower on problem gambling. These individuals are a group of concern because of the possibility of them developing more serious problems over time.²

Both Problem and At-risk gamblers are important groups to target public awareness and education campaigns because evidence suggest they are more likely to change in their behavior as a result of these activities, and Problem and At-risk gamblers represent a larger proportion of the population than pathological gamblers.

“Based on the lifetime [NORC DSM Screen for Gambling Problems (NODS)], the prevalence of pathological gambling in California [in 2006 was] 1.5 percent and the prevalence of problem gambling [was] 2.2 percent. The lifetime prevalence of at-risk gambling in California [was] 9.5 percent. The overall prevalence rate of problem and pathological gambling in California [was] at the higher end of the range of prevalence rates in other states and nationally identified using this screen. Based on the most recent [State] census data, there [were] between 296,500 and 490,100 pathological gamblers and another 449,700 to 713,300 problem gamblers. An additional 2.2 million to 2.7 million California adults can be classified as at-risk gamblers.”³

Awareness of Problem Gambling Services

California provides a problem gambling helpline. The helpline is a service to Californians available 24-hours, provides Masters level counselors, and is toll-free. Only one in five Californians surveyed indicated that they were aware of the State’s problem gambling helpline. However, awareness was higher among problem gamblers. One in three problem gamblers and one in two pathological gamblers were aware of the helpline.

Barriers to seeking out treatment for problem gambling differ by gender, age and ethnicity; however, the most common reason for not seeking treatment was not wanting to stop gambling. Other common reasons included: shame or embarrassment, denial that gambling is causing problems and the assumption that treatment would not work.⁴

¹ Volberg et al. (2006). *2006 California Problem Gambling Prevalence Survey*. Retrieved from http://www.adp.state.ca.us/OPG/pdf/CA_Problem_Gambling_Prevalence_Survey-Final_Report.pdf

² Ibid

³ Volberg et al. (2006). *2006 California Problem Gambling Prevalence Survey*. Retrieved from http://www.adp.state.ca.us/OPG/pdf/CA_Problem_Gambling_Prevalence_Survey-Final_Report.pdf

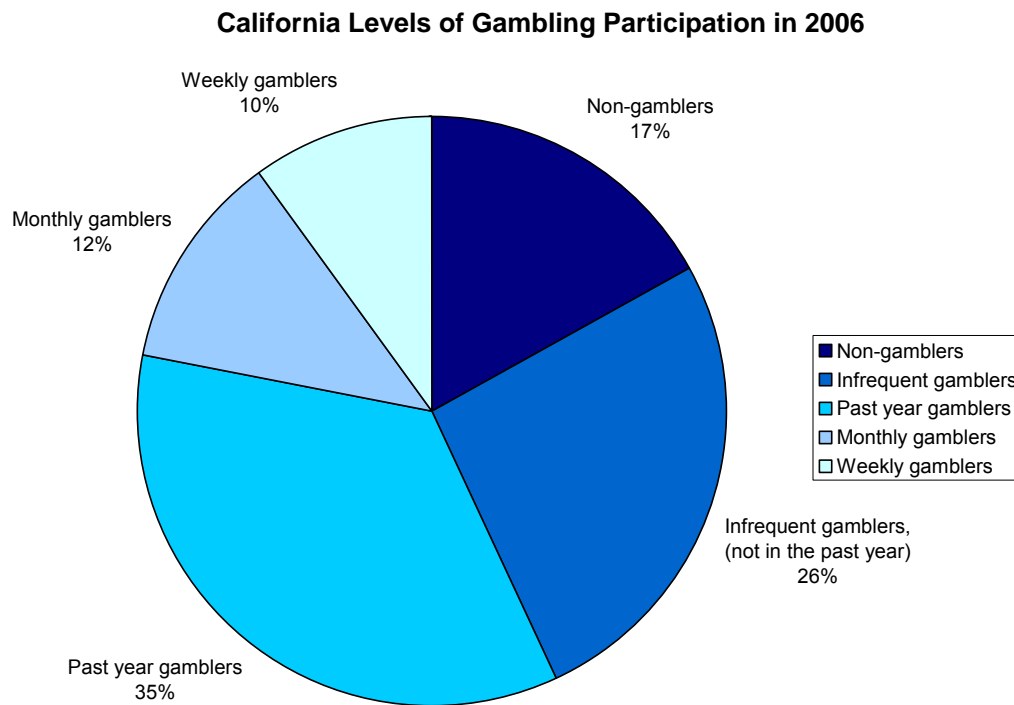
⁴ Ibid

Demographics of Problem Gambling in California

Frequency of Gambling Participation

In the 2006 California Problem Gambling Prevalence Survey for the purpose of analysis of levels of gambling participation, respondents were divided into five groups:

- **non-gamblers**- who have never participated in any type of gambling;
- **infrequent gamblers**- who have participated in one or more types of gambling but not in the past year;
- **past year gamblers**- who have participated in one or more types of gambling in the past year but not on a monthly or weekly basis;
- **monthly gamblers**- who participate in one or more types of gambling on a monthly basis; and
- **weekly gamblers**- who participate in one or more types of gambling on a weekly basis.



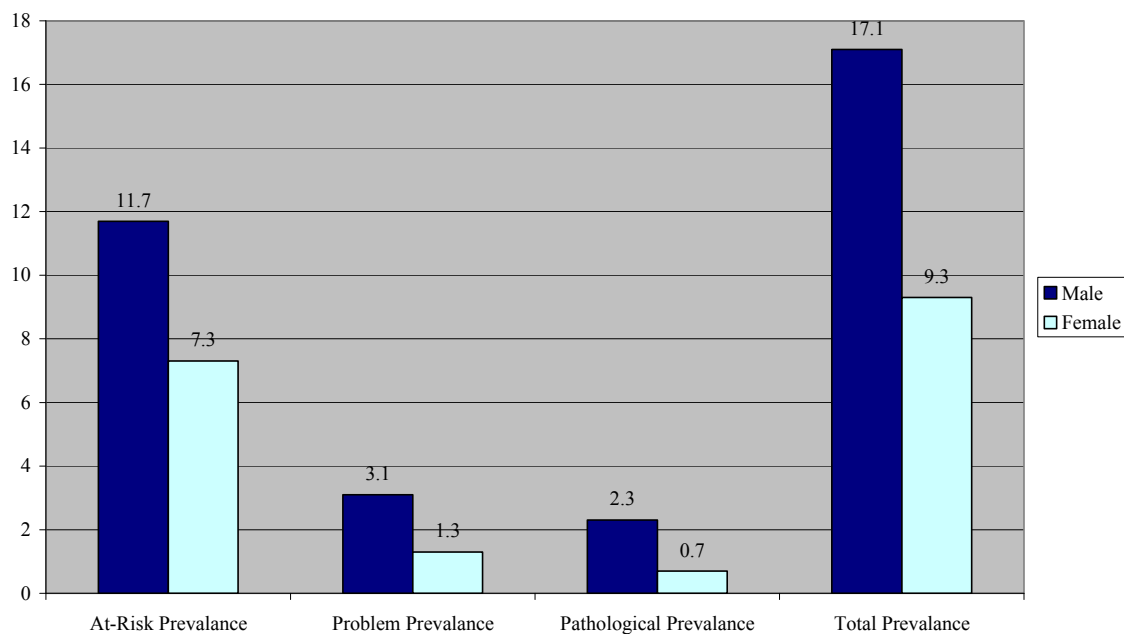
In 2006, 57 percent of California adults had gambled in the past year and 22 percent had gambled once a month or more often. Only 10 percent of Californians had gambled once a week or more often.

The monthly and weekly gamblers in California were considerably more likely to be male and to be divorced. Weekly gamblers were substantially more likely to be over the age of 65, African American or Hispanic. In addition weekly gamblers were: less likely than monthly gamblers to be employed, less likely to have gone to college or graduate school, most likely to be disabled, more likely to be Catholic and to be foreign born.¹

Lifetime Prevalence Estimates

The following tables and charts show the difference in the lifetime prevalence of problem gambling in the different subgroups in the adult California population as reported in the 2006 California Problem Gambling Prevalence Survey.

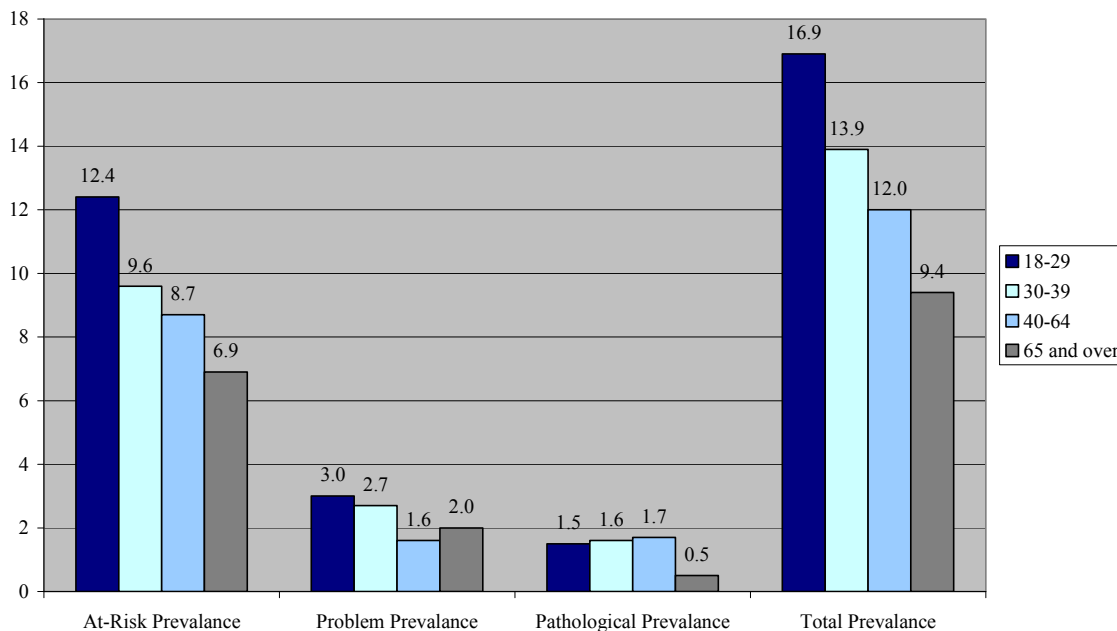
**Percentage of California Population
Gambling Prevalence data by Severity and Gender; 2006**



Source: 2006 California Problem Gambling Prevalence Survey

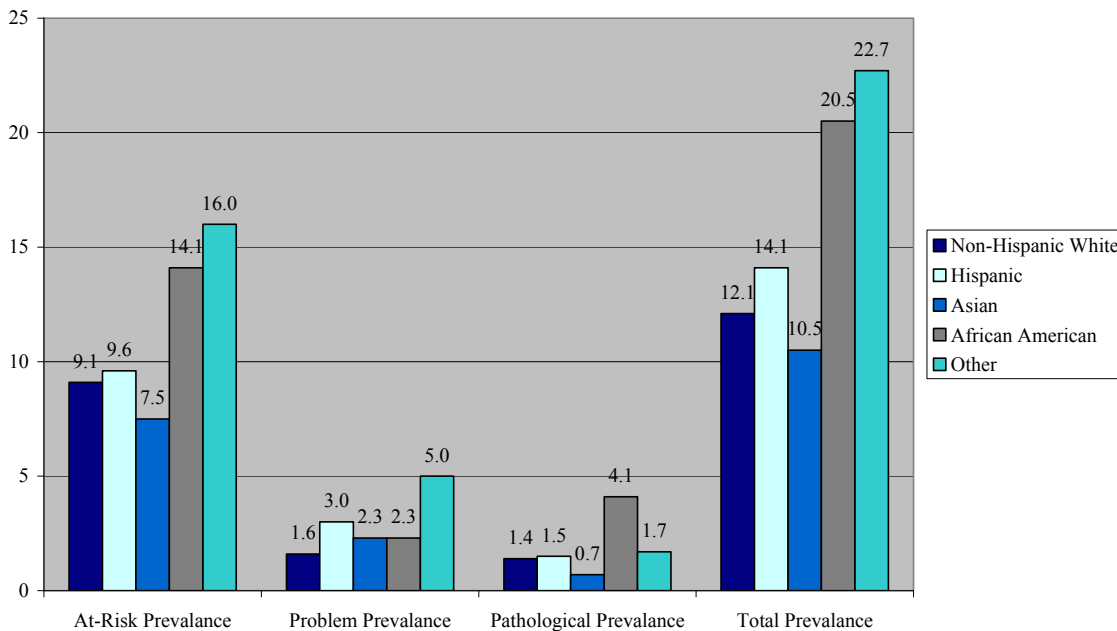
¹ Volberg et al. (2006). *2006 California Problem Gambling Prevalence Survey*. Retrieved from http://www.adp.state.ca.us/OPG/pdf/CA_Problem_Gambling_Prevalence_Survey-Final_Report.pdf

**Percentage of California Population
Gambling Prevalance data by Severity and Age; 2006**



Source: 2006 California Problem Gambling Prevalence Survey

**Percentage of California Population
Gambling Prevalance data by Severity and Race/Ethnicity 2006**

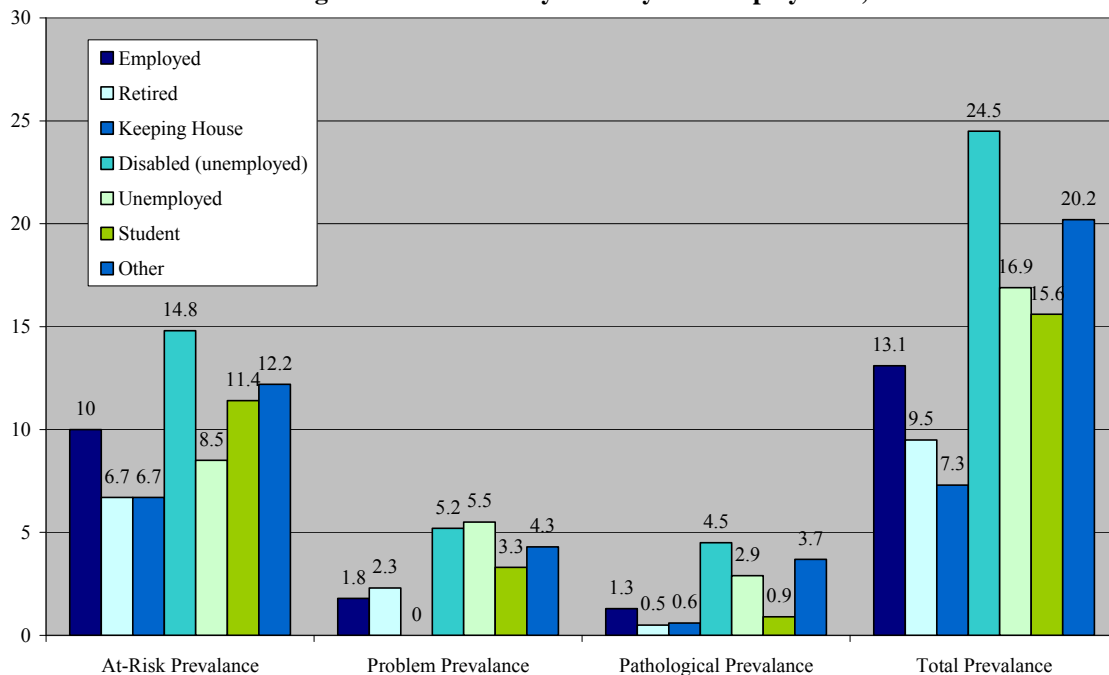


Source: 2006 California Problem Gambling Prevalence Survey

*Includes Native Hawaiian and Pacific Islander.

**Includes Native American, Middle Eastern, multi-racial and unspecified other.

**Percentage of California Population
Gambling Prevalance data by Severity and Employment; 2006**



Source: 2006 California Problem Gambling Prevalence Survey

Highlights

- The lifetime total prevalence of at-risk, problem and pathological gambling in California is particularly higher among men 17.1 percent compared to women 9.3 percent.
- Young adults (18-29) have a higher total gambling prevalence (16.9%) compared with older adults (65 and over, 9.4%).
- Both African Americans (20.5%) and individuals classified as ‘other’ (22.7%) have a higher prevalence compared to other racial and ethnic groups.
- There is a higher prevalence among respondents who are disabled (24.5%) and unemployed (16.9%).
- Prevalence of specifically pathological gambling is particularly high in men, African Americans and those who are disabled.

Youth and Gambling

In the fall of 2009, outcome data was collected from over 1,900 ninth and eleventh grade students at eight high schools throughout southern California through a gambling-specific survey sponsored by ADP. The results were documented by WestEd in the March 15, 2010 report *Adolescent Gambling Survey Development: Findings & Reliability Information*. Following are highlights from the report.

Demographic variables for study participants

Demographic Variable	Num (n=1934)	%
<u>Gender</u>		
Male	1097	56.8%
Female	835	43.2%
<u>Age</u>		
14 years old or younger	742	38.5%
15 years old	226	11.7%
16 years old	730	37.8%
17 years old or older	232	12.0%
<u>Grade</u>		
9th grade	928	48.1%
10th grade	32	1.7%
11th grade	916	47.4%
12th grade	55	2.9%
<u>Ethnicity*</u>		
American Indian or Alaska Native	5	0.3%
Native Hawaiian or Pacific Islander	40	2.1%
Asian or Asian American	269	13.9%
Black or African American	42	2.2%
Hispanic or Latino/Latina	834	43.1%
White (Caucasian/non-Hispanic)	391	20.2%
Multi-Ethnic	269	13.9%
Other	74	3.8%
Missing	10	0.5%
*Categories are mutually exclusive; multi-ethnic was computed for respondents who selected more than one ethnic group.		

The above table displays the demographics of the study participants. It should be noted that the sample characteristics are not particularly representative of the larger California population demographics.

Percentage and number of responses to: “During the past 12 months, how often have you bet/gambled, even casually, for money or valuables in the following ways?” by gambling activity (n=1934)

Gambling Activity	Not at all	Less than once a month	1 to 3 times a month	Once a week or more
1. Card games (such as poker, blackjack)?	63.6% (1226)	21.1% (406)	9.2% (177)	6.1% (118)
2. Personal skill games (such as pool, darts, coin tossing, video games)?	56.2% (1084)	18.9% (364)	11.6% (223)	13.4% (259)
3. Betting on sports?	65.6% (1263)	17.7% (340)	9.3% (178)	7.4% (143)
4. Lottery (such as scratch cards, numbers, lotto)?	82.1% (1586)	12.2% (235)	3.3% (64)	2.5% (48)
5. Bingo?	85.4% (1648)	10.5% (203)	2.0% (38)	2.1% (40)
6. Dice games?	85.2% (1644)	8.9% (171)	3.7% (71)	2.2% (43)
7. Gambling machines?	95.2% (1839)	2.9% (56)	0.6% (12)	1.2% (24)
8. Horse racing?	94.6% (1827)	3.6% (69)	0.8% (16)	1.0% (20)
9. Online (internet) gambling?	91.1% (1758)	4.0% (78)	2.3% (45)	2.5% (49)
10. Dominoes?	86.0% (1660)	7.9% (152)	3.8% (74)	2.3% (44)
11. Personal challenges (like a dare)?	57.4% (1106)	23.2% (447)	11.8% (227)	7.6% (147)
12. Bet/gambled in some other way?	70.1% (1350)	16.8% (324)	7.6% (147)	5.5% (106)

Results for the activities items show that the most common gambling activities among students surveyed were, in descending order, Personal Skill Games (44%), Personal Challenges (43%), Card Games (36%), and betting on Sports (34%). Least popular were Online/Internet gambling (9%), Gambling Machines (5%) and Horse Racing (5%). The lower participation in these activities is not surprising given the barrier to accessibility student age presents.

The following table depicts the number and percentage of respondents by location for students who indicated that they gambled at one or more locations (i.e., students who are gamblers, n=980).

Number and percentage of responses to: "If you bet/gamble, please mark all of the places you make bets"*		
Location	Num (n=980)	%
Home	734	73.8%
Friend's house	601	60.5%
School	406	40.9%
Stores (lottery games)	76	7.7%
Internet/online	109	11.0%
Casino	34	3.4%
Card club	30	3.0%
Sporting event	289	29.1%
Horse racing track	56	5.6%
Neighborhood (streets, park, etc.)	331	33.3%
Other	263	26.5%
* Excludes respondents who marked "I don't not bet/gamble" or left the entire item blank.		

Results indicate that the most common places students who gamble report gambling are at Home (74%), at Friends homes (61%), and at School (41%). The least common locations to gamble are again where age is most likely to be a barrier: Casino and Card club (3%), Horse racing track (6%), and Stores/lottery (8%). The percentage reported of students who gamble at Stores/lottery may be an underestimated because questions raised by some students during the survey administration suggest that they considered where they “scratched” their lottery tickets rather than where they purchased them.

Potential problem gambling could be estimated by the intensity or frequency of participation a respondent indicates across one or more gambling activities. However, a more direct measure of problem gambling was included on the survey in the form of a series of twelve statements that research indicates are related to problem gambling and for which respondents were asked to, “Mark all of the statements that are TRUE about your betting/gambling over the past 12 months (Mark All that Apply).” Additionally, students could indicate, “I did not bet in the past 12 months” or “I bet in the past 12 months, but none of the previous statements are true for me.”

The following table includes the number and percentage of responses to each statement among those students who marked at least one statement other than “I did not bet in the last 12 months” (n=843).

Number and percentage of responses to symptoms of "at risk" gambling items: "Mark all of the statements that are TRUE about your betting/gambling over the last 12 months"*		
Problem Gambling Statement	Num (n=843)	%
I borrowed or asked for money that I used for betting.	121	14.4%
My betting caused an argument with someone important to me.	75	8.9%
My betting interfered with my regular activities.	45	5.3%
I spent more time betting than I meant to.	43	5.1%
I bet more money (or valuables) than I meant to.	69	8.2%
I felt the need to bet more and more money or valuables.	31	3.7%
I lied to someone important to me about how much I bet.	47	5.6%
I lost track of time while betting.	68	8.1%
I felt sad or depressed for two weeks or longer because of betting and losing.	20	2.4%
I tried to win back losses after betting and losing.	112	13.3%
I bet more after winning because I felt I was "on a roll" (would keep winning).	115	13.6%
I bet regularly, once a week or more.	83	9.9%
* Excludes respondents who: (1) marked "I did not bet in the past 12 months" (2) Did not respond to the item.		

As the study authors note, marking any one of the problem gambling statements alone is not necessarily a reason for concern; however, multiple marks by a student may suggest a potential gambling problem. Of the 843 students who responded to this item series and indicated gambling in the last 12 months, 57% marked none of the problem gambling statements, 22% marked only one, 8% marked two, and 13% marked 3 or more. Using that criteria, adolescent gambling does not appear to be a problem to the majority of respondents.

Number and percentage of gamblers* responses to: "In the past 12 months, what is the largest amount of money (or valuables) you placed in a single bet/wager?"		
Amount Wagered	Num (n=975)	%
Less than \$10	520	53.3%
\$10 to \$25	219	22.5%
\$26 to \$50	90	9.2%
\$51 to \$100	72	7.4%
\$101 to \$200	27	2.8%
More than \$200	47	4.8%
*Excludes respondents who indicated they had not bet/gambled in the past 12 months or left the item blank.		

Notably, of students who reported wagering, 75 percent reported wagering \$25 or less. Responses at the higher end of the options for this question can imply a potential for problem gambling especially when viewed along with the other problem gambling items. Approximately five percent of youth reported wagering more than \$200 in a single bet.

Gambling and Substance Abuse

In the 2006 California Problem Gambling Prevalence Survey of adults both lifetime problem and pathological gamblers in California were significantly more likely than other gamblers and non-gamblers to smoke cigarettes daily. Problem and pathological gamblers were also more likely to have used cocaine, tranquilizers or other illicit drugs in 2006. Gamblers were more likely than non-gamblers to consume alcoholic beverages on a regular basis and the frequency of regular consumption of alcoholic beverages increases with problem gambling severity. It is important to note that while problem and pathological gamblers were more likely than the general population to use substances the majority of problem and pathological gamblers still did not smoke, use drugs or drink often. One in four smoked daily, less than two in ten drank more often than one a week; and less than one in ten had used illicit drugs in the past year. Furthermore, substance use was significantly correlated to gamblers that cited past year depression, or mental and physical disabilities.¹

¹ Volberg et al. (2006). *2006 California Problem Gambling Prevalence Survey*. Retrieved from http://www.adp.state.ca.us/OPG/pdf/CA_Problem_Gambling_Prevalence_Survey-Final_Report.pdf

In Summary

This chapter presented consumption and consequence data related to alcohol and other drug use and problem gambling prevalence in California. Consumption data was characterized by supply, availability, interdiction and survey data which gives an indication of prevalence of substance use and problem behaviors. Consequence data was represented by AOD arrest data, motor vehicle injury and fatality data, hospitalizations and emergency department visits, death data and other related health consequences of substance use. Following are the highlights of this chapter.

Alcohol Prevalence

The data clearly show that alcohol constitutes the biggest substance use problem in California probably in large part due to its legal status. Specifically:

- Alcohol consumption has remained relatively steady in California over the seven-year period of observation with slight differences in use patterns by group.
- For underage youth (12 through 20 years), alcohol is by far the most abused substance with past month use at 26.5 percent and past month binge drinking at 17.2 percent.
- Nearly 17 percent of 11th grade students can be classified as High Risk Users, and 29 percent can be classified as Excessive Alcohol Users.
- Forty-two percent of 11th grade student report using alcohol within the past 30 days, while 29 percent report binge drinking monthly.
- Fifty-nine percent of young adults (18 to 25 years old) report using alcohol within the past 30 days, while 38.2 percent report binge drinking monthly.
- Fifty-three percent of adults 26 and older report using alcohol within the past 30 days, while 20.1 percent report binge drinking monthly.
- Alcohol use trends among California adult women shows a decline in use, however, remains relatively high at 46 percent. Alcohol use is highest for White women at 59 percent, with African American women second highest at 41 percent.
- Although on the decline, in 2008, 13 percent of women reported drinking alcohol while pregnant. Hispanic women reported the lowest rates of drinking during pregnancy at just over 7 percent, while White women reported the highest rates at nearly 25 percent. Women 35 years and older reported the highest rate of drinking during pregnancy at 16 percent.
- Non-pregnant women with infants increase alcohol use and binge drinking after giving birth.

Consequences of Alcohol Use

The high alcohol use in the state predictably leads to high consequences. Specifically:

- The rates of alcohol-related arrests are higher than the rate of drug-related arrests for adults.

- Among juveniles, the rates of drug arrests were about two times greater than alcohol arrests.
- The number of adult misdemeanor DUI arrests has steadily increased to over 200,000 in 2008.
- Hispanics comprise the highest percentage of adult and juvenile felony and misdemeanor DUI arrests at 46 percent with whites second at 40 percent.
- African American clearly have the highest arrest rates for AOD-related crimes.
- Between 2004 and 2008 there were approximately 109,620 alcohol-involved motor-vehicle collisions, resulting in 152,693 injuries, and 7,477 deaths.
- Overall, almost six times as many deaths occurred in vehicles where the driver's Blood Alcohol (BAC) level was 0.08 and above than in vehicles where the driver's BAC was between 0.01 to 0.07 gm/dl.
- Between 2004 and 2008, about one of every 16 alcohol-involved motor vehicle accidents resulted in a fatality.
- The rates for alcohol-related hospitalizations are substantially higher than the total for all other drugs.
- The rate of hospitalizations related to alcohol psychoses and alcohol dependence increased while the rate of hospitalizations for alcoholic liver disease decreased.
- The rates for alcohol-related emergency department (ED) visits are substantially higher than the total for all other drugs.
- From 2005 to 2007 the rate of ED visits related to alcohol abuse increased 28 percent, alcohol dependence increased 29 percent, and alcohol psychoses increased 19 percent.
- The eight-year average (2000 – 2007) rate in California for alcohol-related deaths (10.3 per 100,000) is over two times greater than the average rate for drug-related deaths (4.5 per 100,000).

Burgeoning Prescription Drug and Opiate Abuse

The data also indicates increases in the prevalence of prescription drug and opiate misuse and the beginnings of the related consequences. Specifically:

- Lifetime non-medical use of prescription painkillers is 17.6 percent among 11th grade students.
- Lifetime non-medical use of all prescription drugs and over the counter medicines is 34.8 percent among 11th graders.
- For youth aged 18 to 25 past year non-medical use of pain relievers is 12 percent.
- There is some indication that the misuse of prescription painkillers is associated with heroin use, a readily available and inexpensive opiate.
- While the overall rate of hospitalizations due to opiates was fairly stable from 2003 through 2007 (increasing only slightly), the rate of hospitalizations related to opiate poisonings increased while the rate of opiate dependence/abuse decreased.
- The overall rate of ED visits related to opiates increased 10 percent from 2005 to 2007, due to increases in both opiate dependence/abuse and opiate poisonings.

Other Notable AOD Data/Trends

Additional data of note in this chapter related to AOD is:

- Law enforcement data still indicates that methamphetamine is still a threat in California.
- The rates of hospitalizations related to drug dependence, abuse, and poisoning decreased for most major drugs (other than opiates), especially for amphetamines which decreased 42 percent from 2003 to 2007.
- The rate of ED visits for amphetamine dependence/abuse decreased 40 percent from 2005 to 2007.
- Drug poisonings make up the majority of total drug-related deaths (80 percent of the total in 2007).
- Generally, older adults are more likely to die from alcohol and other drug-related causes: 59 percent of those who died from alcohol and other drug causes were 50 years of age or older, and 85 percent were 40 years old or older.
- On average in 2007, there were 15.4 alcohol or other drug related deaths per day in California.
- IDU and MSM/Bi IDU mode of exposure accounts for 19 percent of infections for those persons living with HIV/AIDS in California (higher than the national average).

Problem Gambling Prevalence

Problem gambling, like substance use, has varying levels of severity and consequences. Based on the 2006 California Problem Gambling Prevalence Survey. Specific findings are:

- Fifty-seven percent of California adults had gambled in the past year. Of those, 12 percent gambled monthly and 10 percent gambled weekly.
- The lifetime prevalence of gambling is nearly twice as high for men as for women.
- Young adults (18-29) have a higher total gambling prevalence (16.9 percent) compared with older adults 65 years and older (9.4 percent). However, the young adults fall primarily in the “at risk” level of severity rather than the pathological problem gambling category.
- Both African Americans (at 20.5 percent) and individuals classified as “other” (at 22.7 percent) have a higher prevalence compared to other racial/ethnic groups.
- By employment status, the highest prevalence is among individuals who are disabled and unemployed at 24.5 percent.
- The prevalence specifically for pathological gambling is particularly high for men, African Americans, and those who are disabled/unemployed.

Chapter 3: Public AOD Services System

Continuum of Services (COS)

The Vision of COS

The Department of Alcohol and Drug Programs (ADP) is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of public alcohol and other drug (AOD) services system based on acknowledging both the acute and chronic nature of AOD problems and addiction. Fundamental to the system change effort is the recognition that the current system is designed to address AOD problems as only acute conditions; however, addiction causes problems that are of a continuous, chronic, and relapsing nature to both individuals and communities, necessitating ongoing continuing care and support.

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking about current systems for addressing AOD problems to believing that a new, integrated system of care is necessary in order to achieve the desired outcomes for the prevention, treatment, and recovery for those individuals and communities served by the AOD field. This new system of care would require integration and coordination from the many stakeholders in the AOD field working in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

In 2006, ADP established the Continuum of Services System Re-Engineering (COSSR) Task Force to assist ADP in examining the current AOD services delivery system and to develop a plan for overall systems change. The primary goal of the re-engineering process is to work with ADP's stakeholders to reshape and reposition ADP's operations to ensure system accountability, efficiency, and effectiveness, while delivering comprehensive, high-quality AOD services within the framework of a public system of services funded by ADP and/or used by the public system of service providers.



The continuum of services model above reflects the COSSR Task Force’s perspective and served as the basis for its core recommendations:

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

The model formally acknowledges both the acute and chronic nature of AOD problems and addiction. This newer perspective of substance abuse, dependence and addiction as a chronic condition requires a major shift in thinking.

In Phase I the task force identified gaps and needs, established principles, developed a conceptual framework and a set of recommendations for integrating the AOD system of care in California. In Phase II, the task force developed an implementation plan for re-engineering using the Phase I recommendations as a starting base. In Phase III and beyond, ADP continues to work with stakeholders to identify ways to build capacity and mobilize re-engineering efforts in their own communities. In addition, ADP is assessing readiness for change at the state and local levels and assisting counties in the implementation and evaluation of pilot projects. This evolution is expected to increase effectiveness of the system, as well as better position the AOD system for integration with primary care.

The following sections of this chapter contain information and data on Prevention, Intervention, Treatment, and Recovery services currently provided in California with public funds. It will provide a picture of the publicly funded AOD services system and context for the analysis of the data in Chapter 5.

Prevention

The Office of National Drug Control Policy (ONDCP) Director, Gil Kerlikowske has stated that the ONDCP Drug Policy “recognizes that the most promising drug policy is one that prevents drug use in the first place.”¹ According to Iowa State University researchers substance abuse prevention programs are economically beneficial; there is a nearly \$10 return for every dollar invested in prevention. The scope of AOD related problems that may be prevented and reduced through AOD prevention are immense. More and more Americans are beginning to acknowledge and appreciate the tremendous value of prevention efforts. According to a public opinion survey released by the Trust for American’s Health and the Robert Wood Johnson Foundation, Americans overwhelmingly support increasing funding for prevention programs: “By a wide margin, American voters believe that prevention will save us money, rather than cost us money. . . (77 percent say ‘prevention will save us money’)”² While Americans believe that prevention will save money, “American voters, from coast to coast and across the political spectrum, make it clear that not only do they view prevention as an important part of health care reform, but they are overwhelmingly in favor of increasing our investment in prevention programs. On this issue, people believe it’s less about cost and more about keeping people healthy and improving quality of life, as voters strongly support investing in prevention even if it does not save us money.”³

Over the years, research has shown that prevention services are most effective when they are evidence-based, data informed and outcome oriented. ADP has been working to apply these principles in our business practices and facilitate their implementation at the local level.

Making Data Available at the Local Level

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

- providing counties with the results of the State Epidemiology Outcomes Workgroup (SEOW) and the County Indicator Reports,
- supporting continued funding of the California Healthy Kids Survey,
- providing counties with technical assistance, and

¹ Statement from ONDCP Director R. Gil Kerlikowske *Why Marijuana Legalization Would compromise Public Health and Public Safety*, Annotated Remarks, Delivered at the California Police Chiefs Association Conference, March 4, 2010, San Jose, CA

² *Americans Overwhelmingly Support Investment in Prevention, Disease Prevention Plays a Lead Role in Health Care Reform*, Greenberg Quinlan Rosner Research and Public Opinion Strategies, May 18, 2009. Retrieved from <http://healthyamericans.org/assets/files/health-reform-poll-memo.pdf>

³ Ibid

- making standardized and customized pre- and post surveys available on CalOMS Prevention (Pv), ADP's Prevention data collection service.
- The SEOW will also assist Prevention Service in identifying and obtaining statewide data.

Aligning State and County Priorities, Resources and Outcomes

Once counties have the tools necessary to conduct a thorough needs assessment, ADP can then collaborate with the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) to identify statewide prevention priorities that address populations and/or communities, both locally and statewide, with the greatest risk factors. ADP has also been collaborating with CADPAAC through the CADPAAC Prevention Outcomes Workgroup to develop outcomes, both locally and statewide, that measure prevention effectiveness. These efforts will help link SNAP and local efforts.

As the pattern of federal monies being redirected from grants to the SSAs, to competitive mini-community grants, following the SPF model in collecting data will become increasingly important, making counties more competitive as they become data informed, build local coalitions, and implement evidence-based prevention.

Governor's Prevention Advisory Council (GPAC)

As a means of working across California's multiple state systems, ADP's Director chairs the GPAC which coordinates efforts to achieve measurable reductions in the incidence and prevalence of inappropriate use of alcohol, tobacco and other drugs. Work with 16 agencies provides historical perspectives needed to attain long-term, sustainable results. GPAC has focused on finding common goals members can work toward through their agencies and affiliates. Workgroups are established for: (1) California Screening, Brief Intervention and Referral to Treatment federal grant managed by ADP; (2) Underage Drinking that worked on alcoholic energy drinks, town hall meetings and ADP web content; (3) evidence-based practices as this applies to different agencies; and, (4) State Epi Outcomes seeking participation of other GPAC members that have AOD data that can inform GPAC and ADP.

Friday Night Live Programs

The Friday Night Live (FNL) system of statewide youth development programs utilizes ADP's CalOMS Pv data collection system to track services provided and demographic information on participants. In addition, the FNL collaborative of county coordinators had adopted a peer-led process of determining and monitoring FNL program standards. The Members in Good Standing process is an attempt to hold FNL programs accountable to evidence-based principles of prevention and track progress towards program goals.

A youth gambling public awareness campaign was established in collaboration with the Friday Night Live Partnership. This campaign has empowered youth to be advocates of change by raising awareness not only about the risks of problem gambling but also by

informing others about existing resources through video and live presentations. The presentations are evaluated through pre and post surveys administered to youth participants and audience members who viewed the completed projects. A statistical report evaluating the project data will be available by December 2010.

Discretionary Grants

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

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

Prevention Data

California Outcome Measurement Service – Prevention (Cal OMS Pv) is California's data collection and outcomes measurement system that is designed to help ADP effectively manage and improve the provision of publicly funded alcohol and other drug prevention services at the state, county, and provider levels. Prevention serves populations at three levels of risk: 1) Universal for the general public; 2) Selective for sub-populations at higher than average risk for substance abuse; and 3) Indicated for those already using alcohol or other drugs or engaging in other high risk behaviors but not yet defined as in need of treatment.

CalOMS Pv collects non-demographic data and self-reported demographic data of participants engaged in prevention activities. All prevention services that are funded with SAPT Block Grant dollars must be reported into the CalOMS Pv. The application also supports data submissions for services funded by other sources including state and county funds, and even donations and grants.

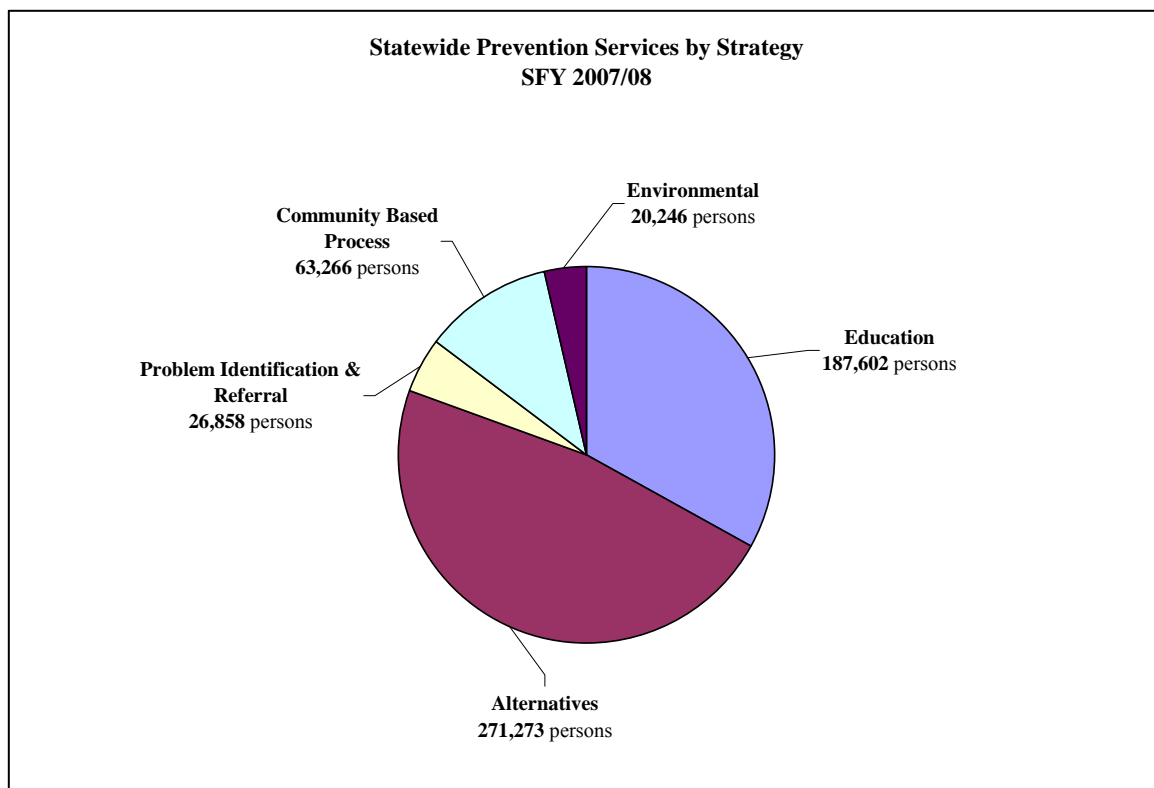
The six prevention service strategies, defined by the Center for Substance Abuse Prevention (CSAP), are Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental. Each of these strategies has multiple related services/activities that are quantifiably reported into CalOMS Pv by counties and prevention service providers. With the exception of Information Dissemination, five strategies capture demographic data of participants that includes gender, age, and race/ethnicity.

Information Dissemination

Information Dissemination activities reported into CalOMS Pv include audio and visual material development and dissemination, conference/fair planning and attendance, media campaign development and implementation, resource directory development and dissemination, speaking engagements and similar multi-media generating activities. Data for this strategy reflects the frequency since, as noted above, no valid/accurate demographic data is attainable by age categories, race or gender. In SFY 2007-08, the highest totals reported by activity statewide were as follows (number of persons served is not captured in this strategy):

1. Printed Materials Disseminated (8,062 service frequency)
2. Brochures/Pamphlets Disseminated (7,611 service frequency)
3. Printed Material Development (3,610 service frequency)
4. Speaking Engagements (2,978 service frequency)
5. Brochure/Pamphlet Development (1,960 service frequency)

The following chart displays the totals of persons served for each strategy with the exception of Information Dissemination. In SFY 2007/08, publicly-funded providers reported 569,245 Californians received some type of AOD prevention service. Alternatives and Education activities are provided to the largest number of prevention recipients while Problem Identification & Referral activities serve the fewest persons. Environmental and Community-Based Process strategies capture some persons-served data but many activities in these strategies are planning or coordination and occur at an organizational level rather than direct prevention services to individuals as reflected in the other strategies' data.



Education

Prevention service activities reported in Education include classroom and educational services for youth and adult groups, mentoring, parenting and family management services, peer leader and preschool prevention programs, theatre troupes, and children of substance abusers groups. The five activities reported with the highest number of persons served were:

1. Classroom Educational Services (65,054 persons)
2. Educational Services for Youth Groups (38,993 persons)
3. Educational Services for Adult Groups (29,988 persons)
4. Small Group Sessions (18,507 persons)
5. Parenting/Family Management Services (16,418 persons)

Alternatives

Activities reported within Alternatives in the CalOMS Pv include community center activities and operation, AOD free social events, community service, youth and adult leadership, and Outward Bound. The highest numbers of persons served reported through alternative activities are:

1. AOD Free Social/Recreational Events (123,806 persons)
2. Youth/Adult Leadership Activities (69,035 persons)
3. Community Drop-in Center Activities (37,084 persons)
4. Recreational Activities (28,215 persons)
5. Community Service Activities (12,934 persons)

Problem Identification and Referral

This strategy contains the fewest types of activities ranging from alternatives to violence programs to Student Assistant Programs.

1. Prevention Assessment and Referral Services (20,435 persons)
2. Student Assistant Programs (5,978 persons)

Community-Based Process

This strategy predominately reflects activities in planning and coordination of prevention services along with technical assistance and training. Below reflect the three activities that report persons served.

1. Community/Volunteer Services or Training (26,326 persons)
2. Technical Assistance (22,220 persons)
3. Training Services (14,720 persons)

Not all of the activities under this strategy capture the number of persons served as many are indirect services rather than services provided to individuals. The remaining Community-Based Process activities are reported as a count of service types or frequency of occurrence. The most reported are as follows:

1. Multi-agency Coordination/Collaboration (14,891 services)
2. Assessing Community Needs/Assets (4,749 services)
3. Systematic Planning Services (2,175 services)

The community-based process strategy will include serving persons who are “intermediaries” (social workers, beverage servers, policy makers, law enforcement, etc.) The larger, secondary impact of these participants is delivered through later actions of their agencies/services; the quantity/demographics of these actions are outside the view of a prevention data system.

Environmental

As with the Community-Based Process strategy, service frequency is reported for all activities but not all Environmental activities collect data for persons served. The most reported persons served are within Environmental Consultation sub-categories as follows:

1. TA to Communities – Other (9,566 persons)
2. Training for Media Advocacy (3,268 persons)
3. TA to Develop Drug Free School (2,213 persons)

The highest service frequencies reported for this strategy are:

1. Community Development (3,891 services)
2. Efforts with City and/or County Officials (1,608 services)
3. Neighborhood Mobilization (1,077 services)

Prevention Demographics (SFY 2007/08)

Gender

Slightly more females than males were served in SFY 2007/08. The general population of California contains fewer males than females while “other” is not reported in the larger population by Department of Finance demographic sources.

Gender	Persons Served*	California Population **	Rate Per 1,000 Population
Female	286,585	18,939,596	15.1
Male	279,090	18,870,986	14.8
Other	3,570	not available	n/a

* 2007/08 Persons served data is not collected for the Information Dissemination Strategy activities and some activities in Community-based Process and Environmental strategies.

**Department of Finance 2007.

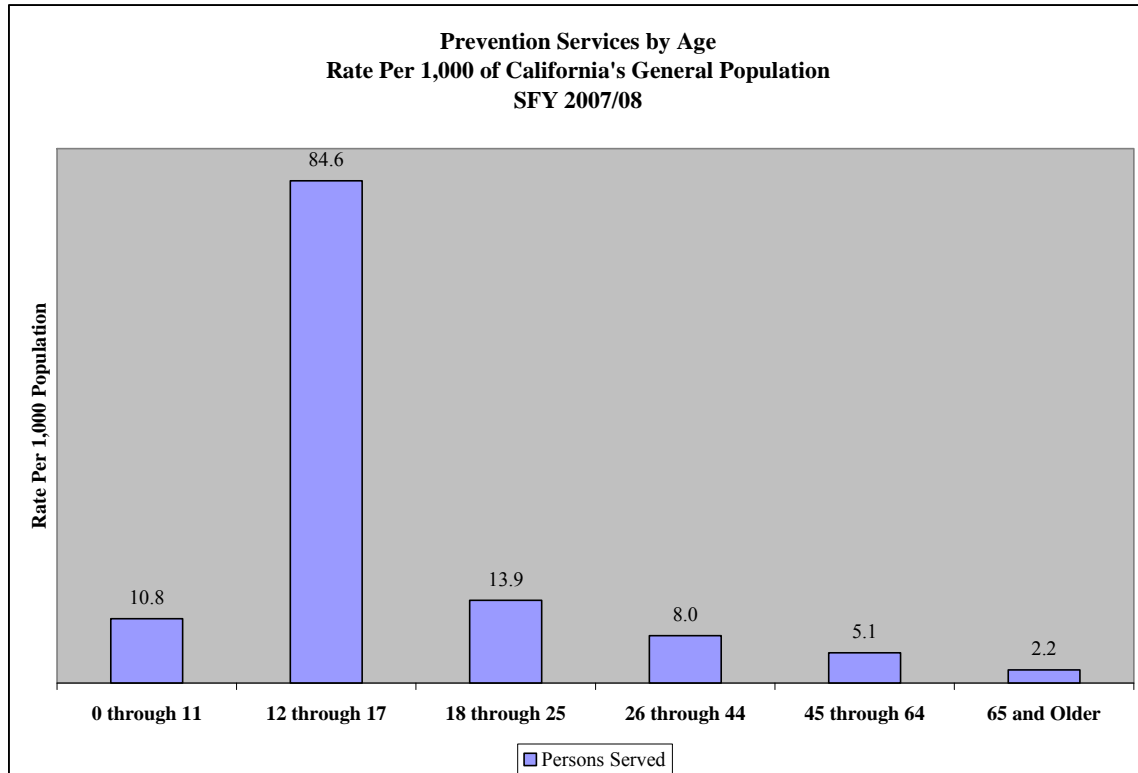
Age

Prevention services in California are primarily provided to youth under the age of 25. Youth between the ages of 12 through 17 were the largest group of recipients of prevention activities, even though this group makes up only 9.4 percent of California’s

population. However, the fewest number of persons served fell in the 65 and older group which makes up 10.8 percent of the general population. Rate per 1,000 allows for comparison between subgroups and can be read as follows: there are 6,444,543 persons between the ages of 0 through 11 living in California and for every 1,000 of the general population in that age group, at least ten are participating in some kind of publicly funded Prevention service activity.

Age Group*	Persons Served	California Population	Rate Served Per 1,000 Population	Age Group's Percentage of Total California Population
0 through 11	69,903	6,444,543	10.8	17.04%
12 through 17	301,320	3,562,958	84.6	9.42%
18 through 25	60,653	4,352,488	13.9	11.51%
26 through 44	81,221	10,170,687	8.0	26.90%
45 through 64	47,051	9,182,593	5.1	24.29%
65 and Older	9,092	4,097,313	2.2	10.84%

*CalOMS Pv data age range groups are slightly different than data presented from CalOMS Treatment in this report (Treatment data age breakdown is 26-45, 46-65, 66 and Older).

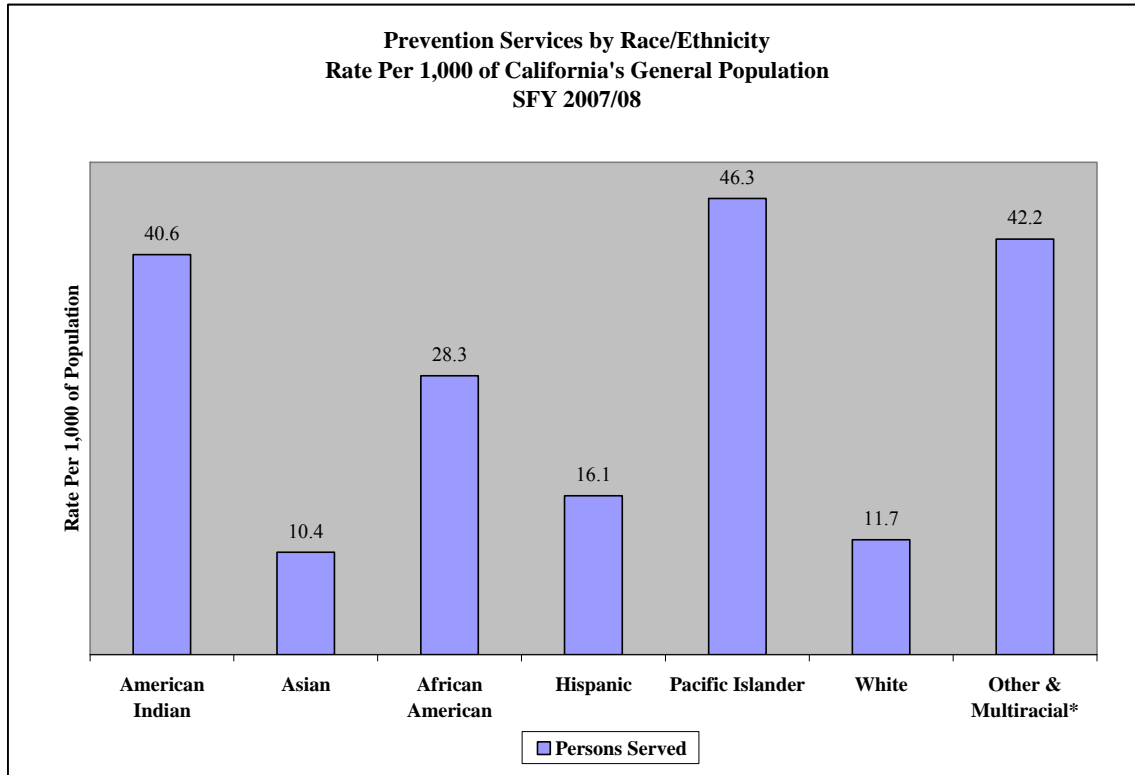


Race/Ethnicity

The Race/Ethnicity demographic in CalOMS Pv data is categorized by White not Hispanic, Asian American, Hispanic/Latino, Native American/Alaska Native, African American, Multiracial/Ethnic, Hawaiian/Pacific Islander and Other. For the following tables and charts, Multiracial/Ethnic is combined with Other in CalOMS Pv data. For comparison, the category of Other was used in the California Population data from the Department of Finance 2007. Out of all prevention services delivered in SFY 2007/08, the Hispanic cohort received the most prevention services while Pacific Islanders the fewest. However, the Rate Served Per 1,000 in the general population illustrates that for every 1,000 Pacific Islanders in California, 46 received some type of prevention service while 16 persons of Hispanic background out of 1,000 engaged in a prevention activity. The data seems to suggest that Racial/Ethnic groups that are represented in lower numbers within California's population receive a higher number of prevention services within their group when compared to majority populations such as Hispanic and White.

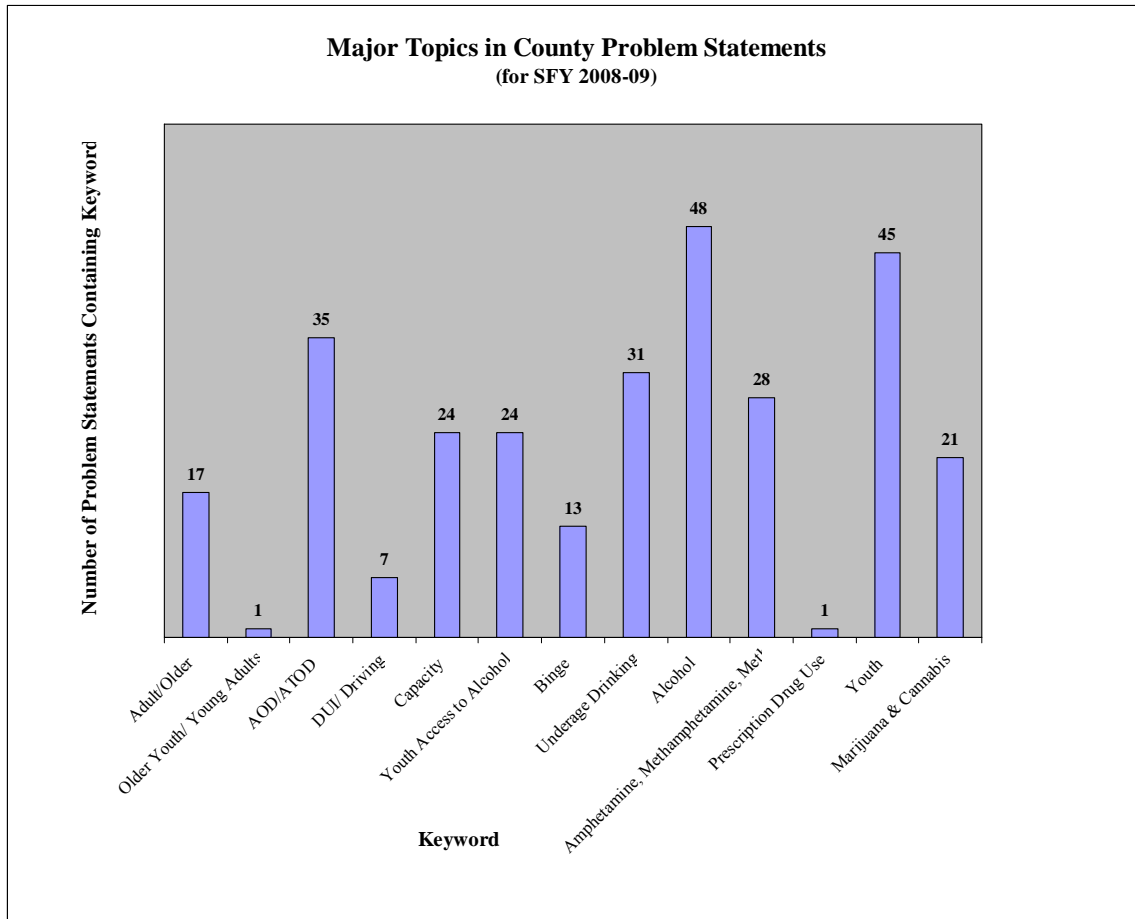
Race/Ethnicity	Persons Served	California Population	Rate Served Per 1,000 Population	Group's Percentage of Total California population
American Indian	9,138	224,927	40.6	0.59%
Asian	46,088	4,428,922	10.4	11.71%
African American	64,119	2,263,690	28.3	5.99%
Hispanic	218,306	13,539,990	16.1	35.81%
Pacific Islander	6,378	137,608	46.3	0.36%
White	191,787	16,423,530	11.7	43.44%
Other & Multiracial*	33,429	791,915	42.2	2.09%

*Other and Multiracial demographic categories were combined from CalOMS Pv data. California population category of Other was used from Department of Finance 2007.



Strategic Prevention Framework

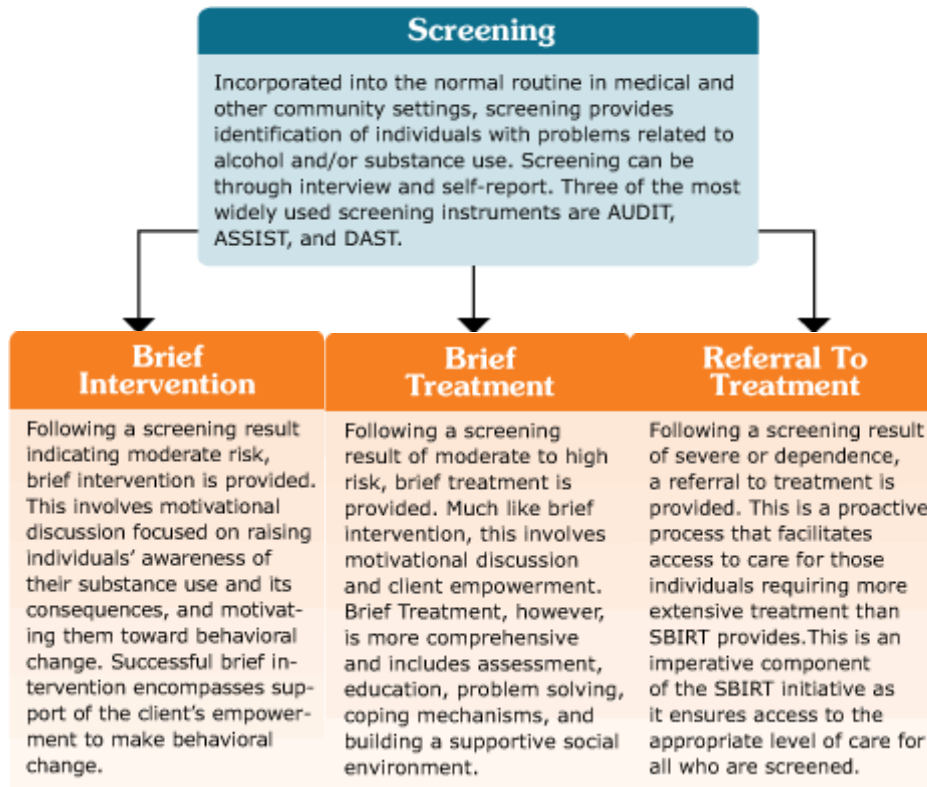
The CalOMS Pv system contains County Prevention Strategic Plans that are updated as needed by county staff. As part of the Strategic Prevention Framework (SPF) process to develop or update these plans, counties collect available AOD-related prevalence and consequence data and local information to develop problem statements that describe local AOD issues. Goals and objectives are created to strategically address the problem statements. Counties then assign objectives to specific prevention providers along with budgeted funds for services. The chart below contains general categories the problem statements fall under. A note of caution is given to the reader as this chart serves as a broad indication of the topics identified using a word search function within the CalOMS Pv system; for example the actual number of problem statements related to binge drinking could be higher than illustrated below if another term was used in the problem statement. The chart is not inclusive of all the problems statements within CalOMS Pv as it only includes those identified by the queried categories.



The highest number of problem statements contain issues related to alcohol, youth, AOD/Alcohol Tobacco and Other Drug (ATOD), underage drinking and Methamphetamines, while DUI, Older Youth/Young Adults and prescription drug use categories contained the fewest number of county created problem statements in state fiscal year 2007/08 county strategic plans.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

With the rising costs of health care and the large aging Baby-Boomer population, prevention of chronic diseases and wellness programs are increasingly being adopted by primary health care professionals and integrated into the health system at large. SBIRT is an integrated approach to the delivery of early intervention and treatment services for patients with substance use disorders, as well as those who are at risk of developing these disorders, within a medical or other setting. The goal of this model is to provide an appropriate level of service before there is a need for specialized drug treatment, serious costly medical conditions or severe consequences resulting from alcohol and/or drug use and abuse.



Source: Table from SAMHSA, SBIRT webpage, retrieved June 10, 2009.

SBIRT in California

California received a five year, \$17.4 million dollar grant from the Center for Substance Abuse Treatment (CSAT) in September 2003 and has funded two demonstration projects and one training initiative. The federal grant period, originally scheduled to end in September 2008, has been extended through September 2010. Following is a description of the grant-funded SBIRT activities.

CASBIRT

ADP partnered with San Diego County to implement the California Screening, Brief Intervention, and Referral to Treatment (CASBIRT) Program with multiple county emergency rooms, trauma centers and health care sites providing SBIRT to voluntary patients. At these participating sites, willing patients 18 years and older are screened by certified bilingual Health Educators using (Alcohol, Smoking and Substance Involvement Screening Test) ASSIST. The ASSIST was developed by the World Health Organization in 1997 and the revised version (V3.0) contains eight questions that can be answered by most patients in ten minutes.¹ These interviews identify the misuse of alcohol, drugs, medication and tobacco by assessing the patient's risk level. For patients that score at a particular risk level, the following services are given:

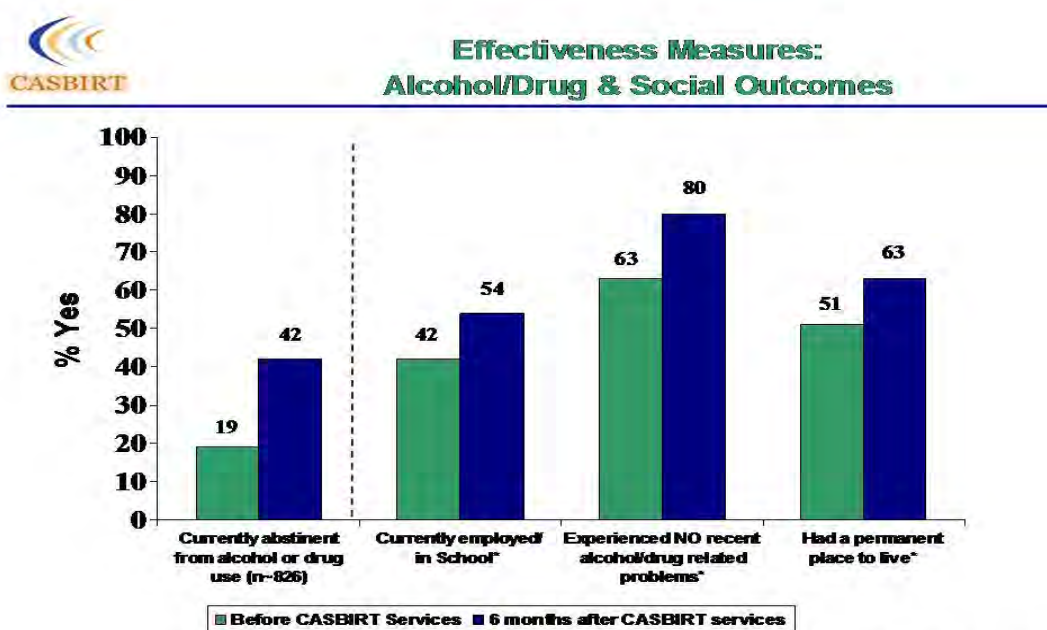
¹ World Health Organization (2006). *The ASSIST project - Alcohol, Smoking and Substance Involvement Screening Test*. Retrieved 2010 from http://www.who.int/substance_abuse/activities/assist/en/index.html

Risk Level	Intervention
Low	Reinforcement
At Risk (primary target)	Brief Intervention
High	Brief Treatment
Severe	Referral to Outside Agency

Source: Table from CASBIRT webpage, retrieved June 10, 2009.

Beginning in July, 2007, data was collected from the participating CASBIRT medical facilities located throughout San Diego County. Currently, twelve sites provide CASBIRT services. Health educators, screened 130,000 patients, provided almost 29,000 motivational interventions to patients at risk for health problems and made over 10,000 referrals to substance abuse treatment and smoking cessation services. The following graph provides details of the CASBIRT preliminary outcomes.

Changes in Use



*Sample size of High/Severe risk individuals approx. 133 patients

Source: All CASBIRT data provided by San Diego County, CASBIRT, on March 9, 2010

Highlights

- These findings reflect only those individuals 18 years and older who willingly participated in the assessment process and scored in one of the at risk levels.

- More females than males were classified with a risk level and received CASBIRT interventions.
- Six month follow-up interviews indicate an improvement in participants' abstinence from AOD use, employment/school status, housing status, and alcohol/drug related problems.
- Non-Hispanics were assessed at greater risk for substance use disorders than Hispanics. Whites were assessed at greater risk than other racial groups.
- Alcohol was the highest reported substance used, followed by Marijuana/Hashish.

LASBIRT

In 2008, ADP contracted with Los Angeles County Department of Public Health Alcohol and Drug Programs Administration (ADPA) to administer the Los Angeles Screening, Brief Intervention, and Referral to Treatment Demonstration Project (LASBIRT). While SBIRT had originated in primary care settings, this demonstration project was established in a criminal justice setting through a collaborative partnership between ADPA and the Los Angeles County Sheriff's and City Police Departments.

The LASBIRT project targets short-term detainees for a prescreening of substance use upon their processing for release. The Los Angeles Police Department Metropolitan Jail and the Sheriff's Community Transition Units in the Los Angeles Men's Central Jail became pre-screening sites. Detainees are encouraged through the use of incentives to visit an off-site facility to undergo an in-depth screening, and if necessary, a brief intervention and referral for treatment. In addition, at least 500 community clients will be enrolled through the Community Assessment Service Center (CASC) sites to facilitate integration of screening, brief intervention, referral and treatment principles into Los Angeles County's current treatment continuum. Integration of these principles will allow the County to better match clients with a full range of treatment options and preserve traditional, long-term treatment services for persons with the most severe substance abuse problems.

Providing SBIRT services to short term detainees has proven very challenging. While the data suggest that this population is at high risk for substance use, federal grant limitations on providing services within jail settings coupled with the mobility of the target population are barriers to serving this population. To increase participants' engagement and retention, LASBIRT integrated contingency management strategies, and leased space from a bail bond agency to do screenings at a site easily accessible to detainees released from the county jail.

Preliminary findings suggest that detainees receiving SBIRT services reported less use of alcohol at follow up compared to intake, less use of alcohol to intoxication at follow up compared to intake, and reduced use of illegal drugs at follow up compared to intake. Also, more participants reported being housed at follow up compared to intake and less involvement with criminal justice. Data collection has only recently begun and is ongoing.

SBIRT Training Initiative

UCLA Integrated Substance Abuse Programs (ISAP) has been providing statewide training on Screening and Brief Intervention (SBI) techniques. The goal is to promote further development and implementation of SBI programs. The trainings were initially limited to Emergency Department (ED) and Trauma Center (TC) personnel across California, however, as a result of feedback from the field, the initiative evolved to include behavioral health (mental health and addiction services) and primary health care providers, as well as the inclusion of modules discussing screening with adolescents and older adults. Also, Continuing Medical Education (CME) credits are offered to physicians in attendance.

Treatment

A top priority of the addiction field is delivering quality treatment for substance abuse disorders. For the successful advancement of the field in the health care arena, substance abuse treatment is under intense pressure to measure and monitor performance of programs and outcomes of clients more systematically. Performance measures, by definition are used at the program level to estimate and monitor the extent to which the actions of a program conform to standards of quality. Information gained from measuring program performance can be used to identify where service problems exist, which programs are meeting or exceeding treatment expectations of quality, and what, if any, changes should be made to service delivery. Performance measures contrast with outcome measures, which examine critical life functioning areas of clients that are expected to be positively influenced by treatment.

Treatment Data

The California Outcomes Measurement System Treatment (CalOMS Tx) was implemented in 2006 to comprehensively measure client outcomes based largely on the NOMS federally required reporting mandates. Prior to CalOMS Tx, treatment data was collected via the California Alcohol and Drug Data System (CADDSS). The function of CalOMS Tx is to allow ADP to effectively manage and improve alcohol and other drug services at the state, county, and provider levels. Any provider that receives any public funding for AOD treatment services and all licensed Narcotic Treatment Program (NTP) providers must report CalOMS Tx data for all of their clients receiving treatment. Data is routinely collected from programs during treatment to monitor program outcomes. The current task is to use the data to develop measures of performance which includes:

- Providing *timely access* to treatment
- *Engaging* clients in the treatment process
- *Retaining* clients in treatment for a specified period
- Assuring the *use of practice standards* (evidence-based, promising)
- *Transitioning* clients to needed levels of care¹

¹ Gonzales, R., & Rawson, R. Evaluation of the California Outcomes Monitoring System for Treatment. UCLA Integrated Substance Abuse Program, January 28, 2009.

Data Limitations

CADDS, CalOMS Tx and California Department of Finance data for ages 0 – 11 are excluded from this analysis.

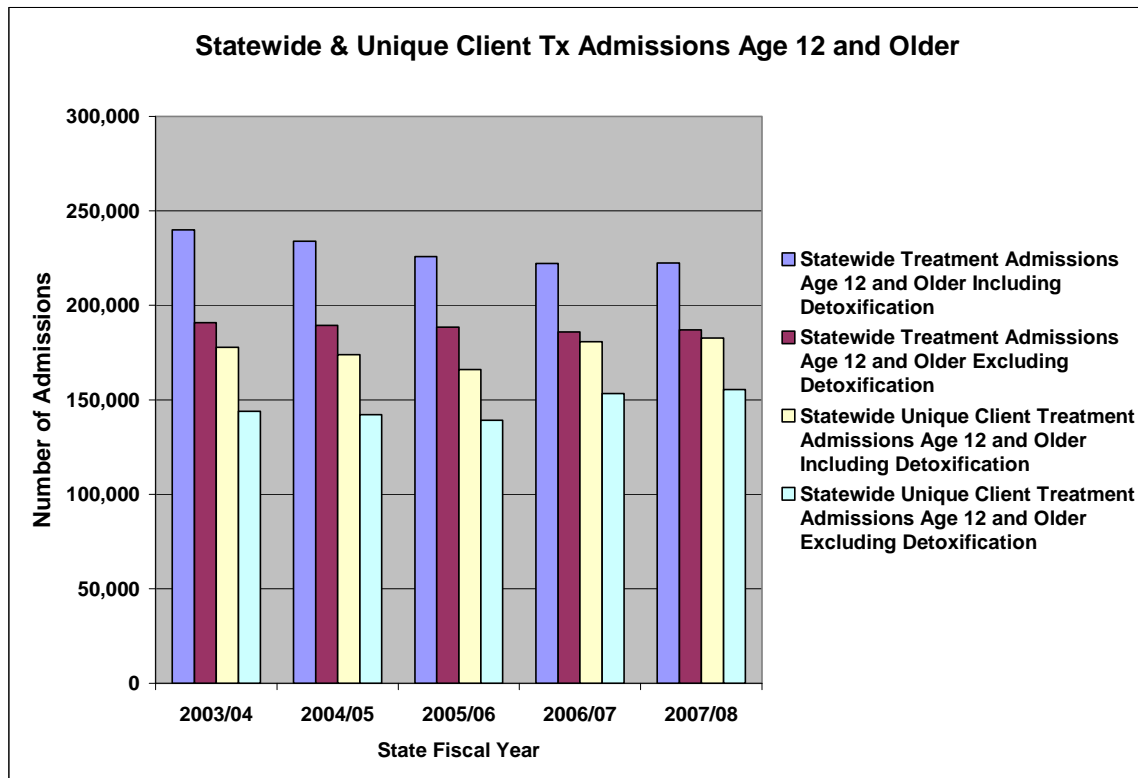
The use of the CADDS system ends with FY 2005/06 and use of the CalOMS Tx system begins with FY 2006/07. Therefore, the last full FY of CADDS data was FY 05/06 and the first FY of CalOMS Tx data was FY 06/07. As a result, there may be data results that appear to drop substantially between the FYs 2005/06 and 2006/07.

Counts of treatment admissions reflect admissions to programs during the period of observation. They do not necessarily refer to the admission of a unique client, unless so specified in the chart, since some clients may have been admitted to a treatment program multiple times. As a result, any discussion of the demographic characteristics of clients in treatment is biased toward clients with multiple admissions. This is particularly true for charts that include detoxification clients in the counts because detoxification services are short term, often repeated numerous times, and used primarily for alcohol or heroin detoxification treatment. Those charts that exclude detoxification counts are so labeled. Also, for charts labeled as unique client counts, it refers to that specific year's count. If a client is admitted for treatment for more than one year, they are counted again in each subsequent year they are admitted for treatment.

The composition of the AOD treatment population is impacted by the proportion of clients referred to treatment through the criminal justice system. Criminal justice referrals often get priority over individual or community-based referrals due to limited treatment resources available locally. This affected the trends in admissions related to client demographics, drug types, and services received.

The following analysis used “Rate Per 1,000 Population” to compare the number of admissions to the total population for California. Rates are often used instead of absolute counts because they allow comparisons of changes in prevalence across time, while incorporating the normal changes in the population over time.

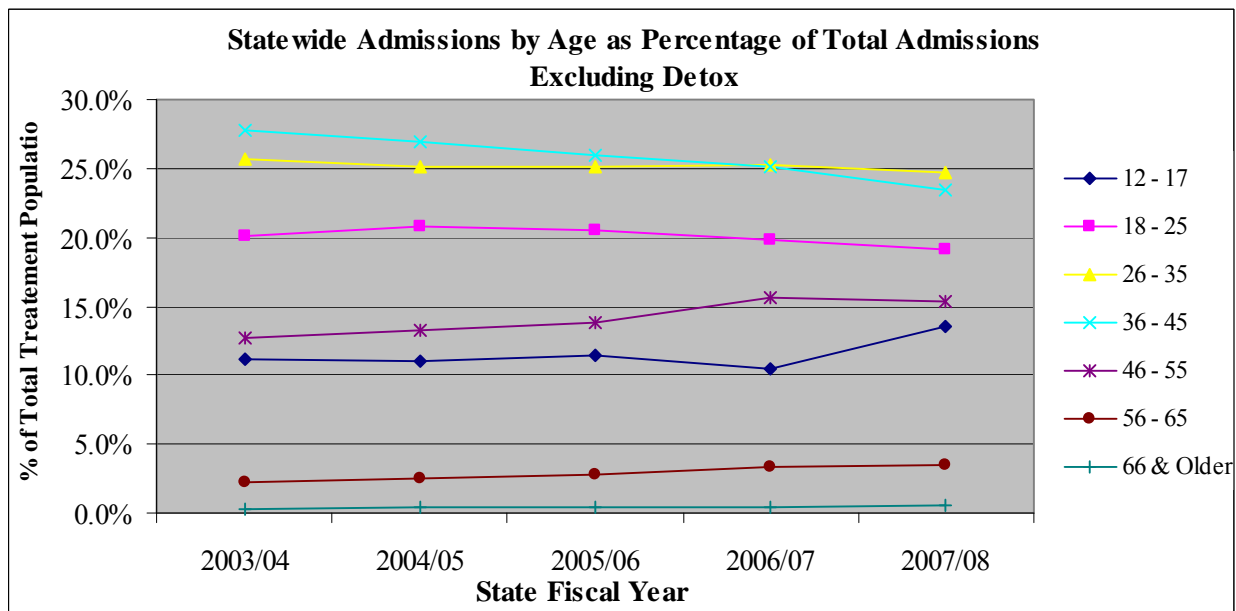
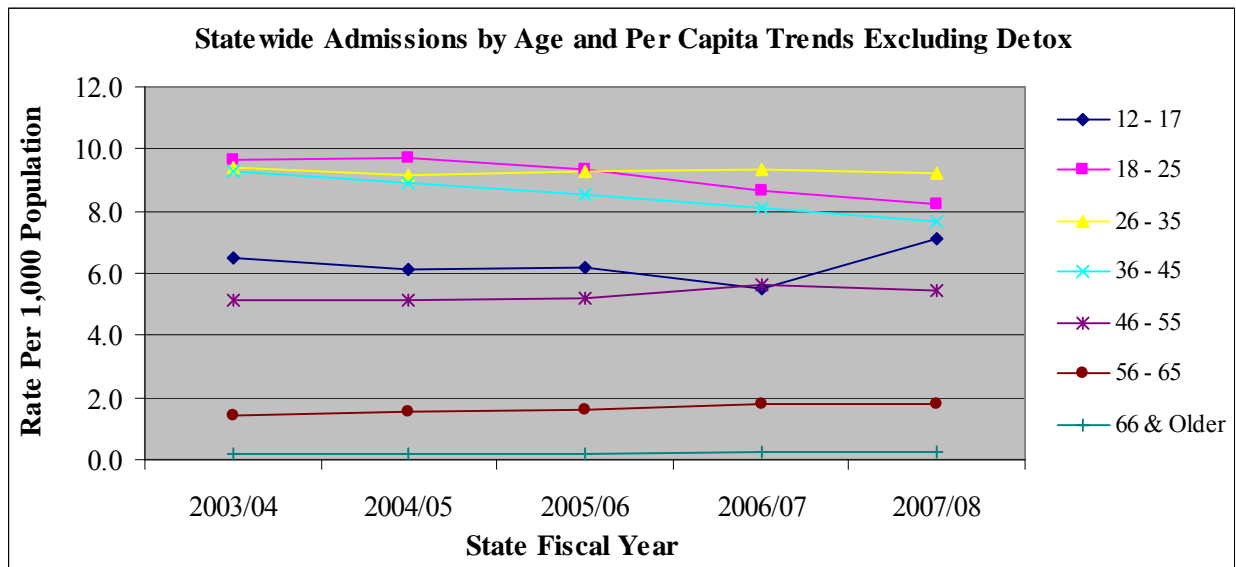
Statewide Admissions



Highlights

- There was a decrease in statewide admissions from 2003-04 through 2006-07 and then a slight increase in total admissions from 2006-07 to 2007-08 for both admissions including and excluding detoxification.
- There was a slight increase in statewide unique client admissions from 2006-07 to 2007-08 for both unique client admissions including and excluding detoxification.

Age

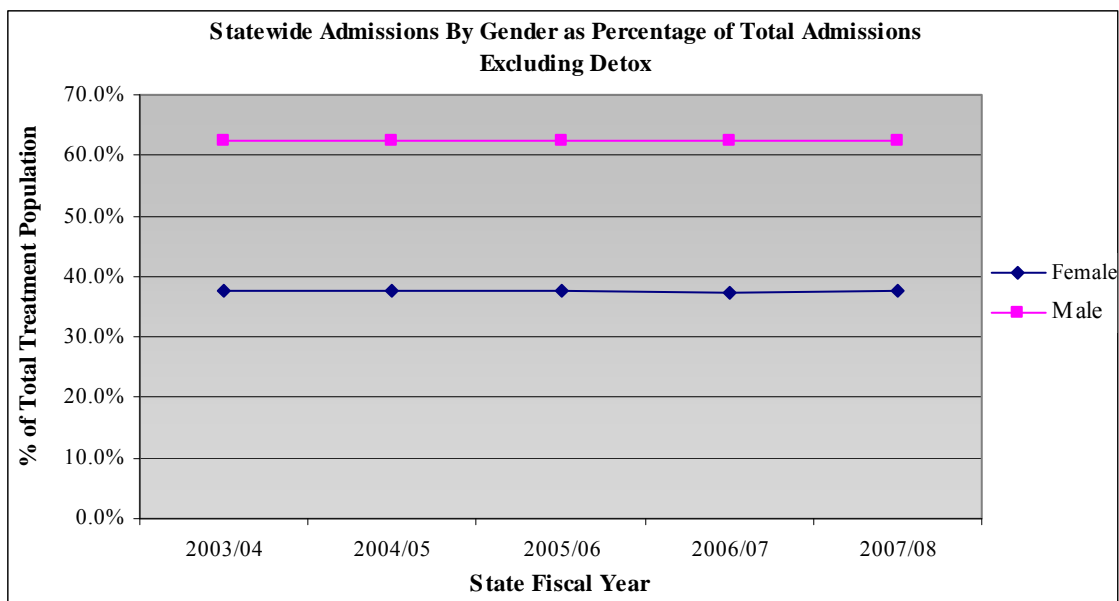


Highlights

- Clients aged 18 through 25 age group had the highest per capita admission rates up until the 2005/06 state fiscal year when this age group converged with the 26 through 35 age group which then became the highest per capita admission rate during the 2006/07 through 2007/08 state fiscal years. The 46 through 55 age group, the 55 through 65 age group, and the 66 and older age group per capita admission rates remained fairly steady throughout these state fiscal years.

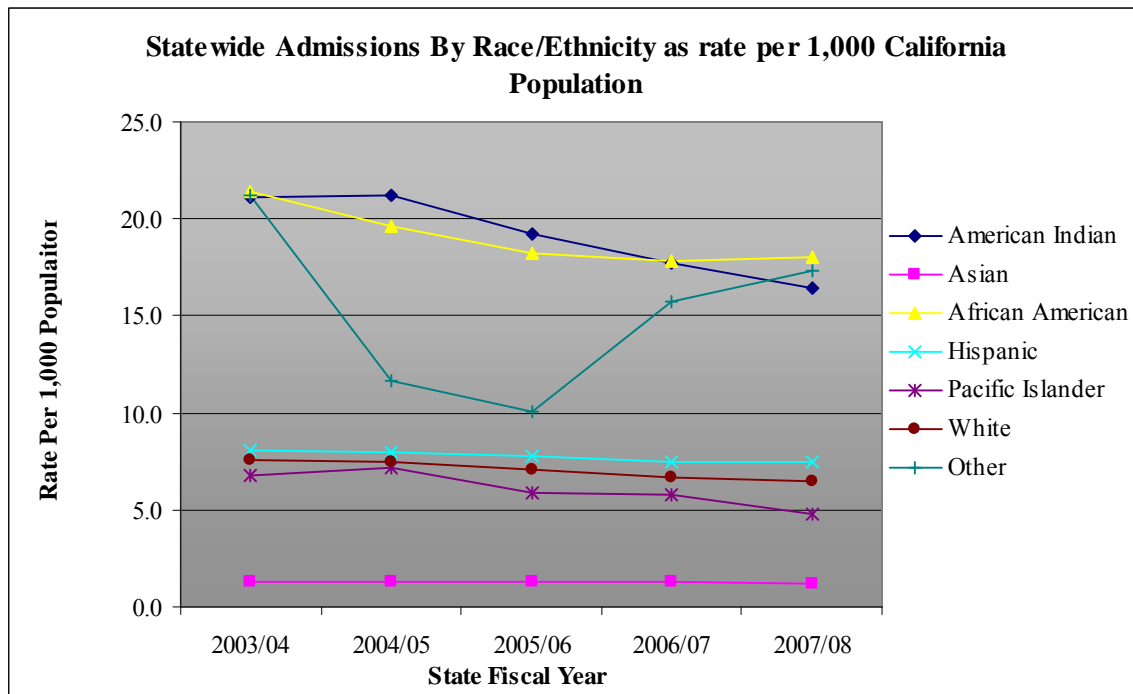
- Clients aged 12-17 showed an increase in rate per capita of admission and percentage of total admissions. This is the only age group that has increased.
- The 26-35 and 36-45 age groups while representing a significant percentage of total admissions declined by 5.1 percent of admissions or almost 12,000 admissions.
- Clients aged 36 through 45 had the highest admission rates and showed a steady decline over the five-year period.
- The 26 through 35 age group and the 18 through 25 age group had the next highest admission rates respectively.
- The 66 and older age group remained steady at very low levels.

Gender

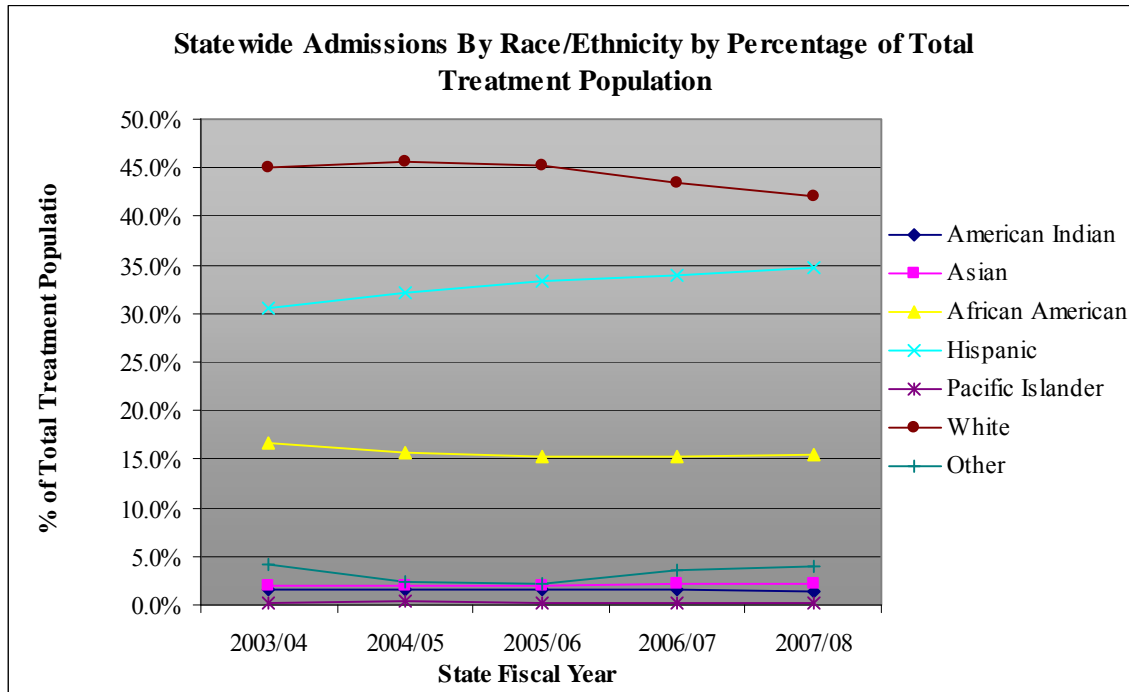


Highlights

- Male admission rates were approximately twice the admission rates for females. Male and female admissions decreased at a similar rate over the five-year period. The same finding was discovered when comparing the female and male treatment admissions to the total females and males in California.

Race/Ethnicity***Highlights***

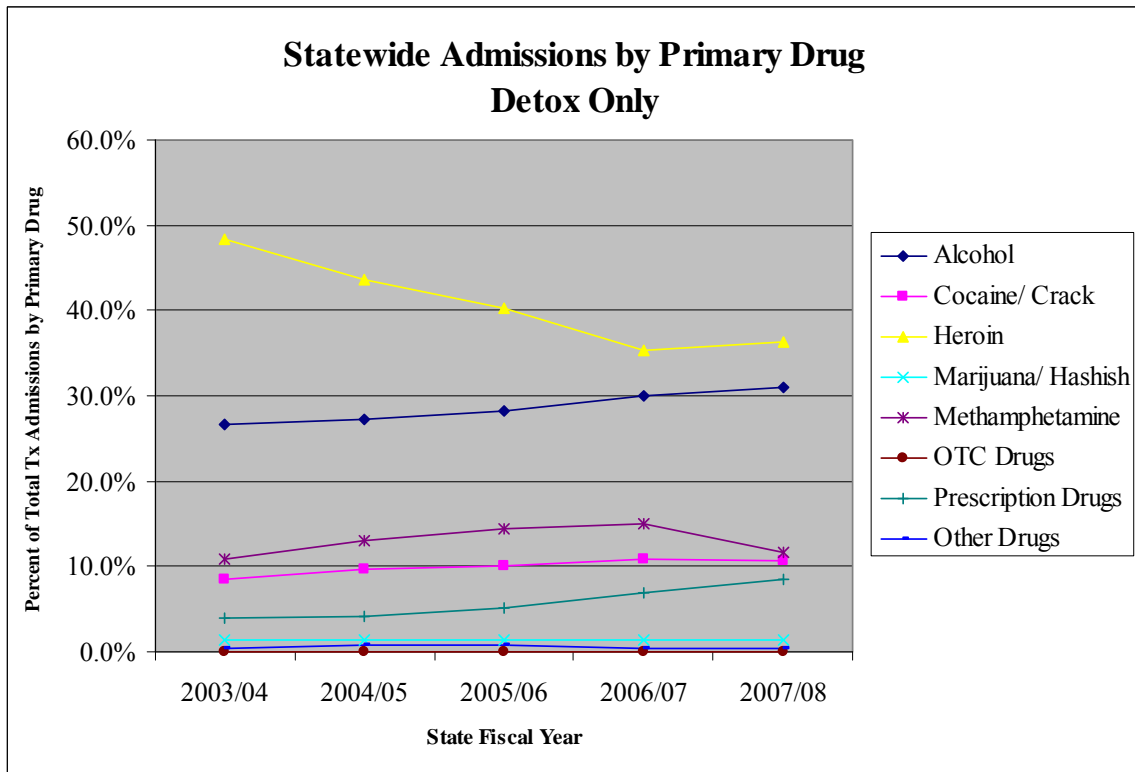
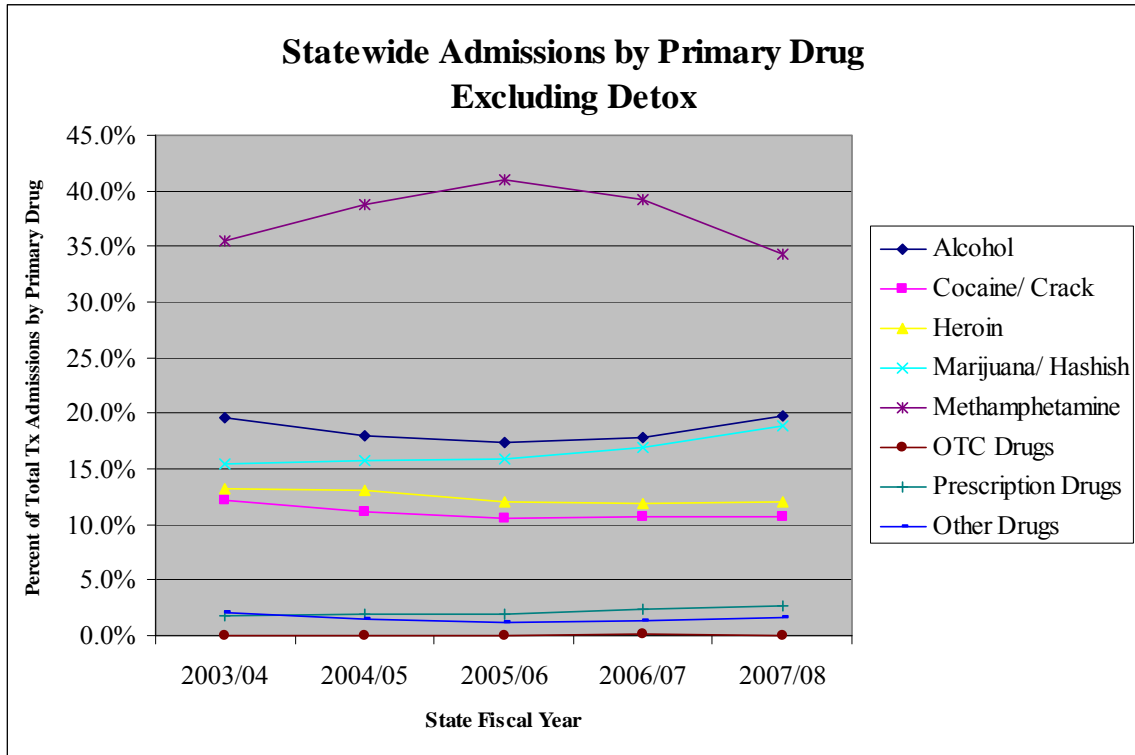
- Two race/ethnicity subgroups – American Indian and African-American – had the highest rate of per capita admissions and showed a similar pattern of steady decline. All other race/ethnicity groups had significantly lower rates of per capita admissions and remained relatively constant. With the exception of the Asian population, who had a lower rate of per capita admissions.
- The “Other” race/ethnicity group (identification with no particular race/ethnicity group, multiracial, other, or not inclined to self identify) had a considerable per capita decrease over SFYs 2003/04 – 2005/06 and a considerable per capita increase from SFYs 2005/06 – 2007/08.



Highlights

- Two race/ethnicity subgroups – White and Hispanic – had the highest percent of admissions; Whites showed a pattern of steady decline while Hispanics showed a pattern of steady increase.
- All other race/ethnicity groups had significantly lower percentages of admissions, except for African Americans that had a lower percent but not significantly lower.

Primary Drug



Highlights

- Cocaine/crack treatment admissions have a steady decrease from 2003/04 – 2005/06 and remain constant from 2006/07 – 2007/08.
- Heroin admissions show slight but steady decline of the total treatment admissions excluding detoxification over the 5 year period.
- Marijuana/Hashish treatment admissions increase from 15.5 percent to 18.8 percent of the total treatment admissions excluding detoxification over the five year period.
- Although Methamphetamine treatment admissions have the highest percentage of the total treatment admissions, there was a steady increase from 2003/04 – 2005/06 and then a noticeable decrease from 2006/07 – 2007/08.
- Alcohol treatment admissions have a steady decrease from 2003/04 – 2005/06, but increase from FY 2005/06 – 2007/08.
- Other primary drug admissions are less than five percent of the total treatment admissions over the five year period.

Top 5 Primary Drugs at Admission by Fiscal Year Excluding Detoxification

Fiscal Years	Primary Drugs				
	Methamphetamine	Alcohol	Marijuana/Hashish	Heroin	Cocaine/Crack
2003/04	35.5 %	19.6 %	15.5 %	13.3 %	12.2 %
2004/05	38.7 %	17.9 %	15.7 %	13.0 %	11.1 %
2005/06	41.1 %	17.3 %	15.9 %	12.0 %	10.6 %
2006/07	39.2 %	17.8 %	16.9 %	11.9 %	10.6 %
2007/08	34.3 %	19.8 %	18.8 %	12.0 %	10.7 %

Top 5 Primary Drugs at Admission by Fiscal Year Detoxification Only

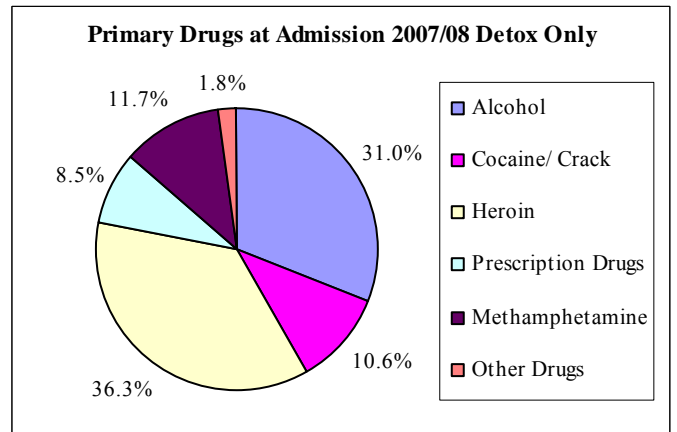
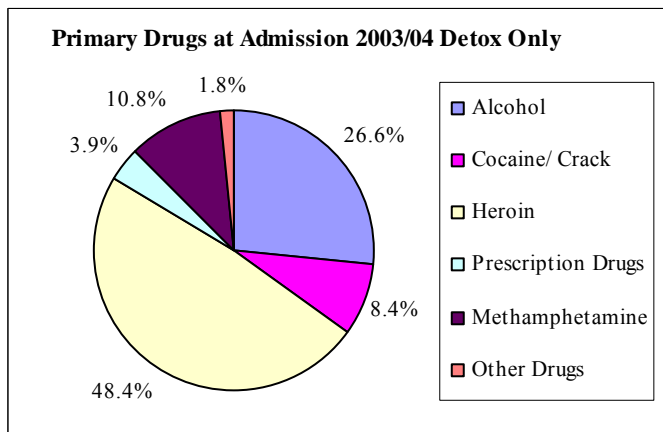
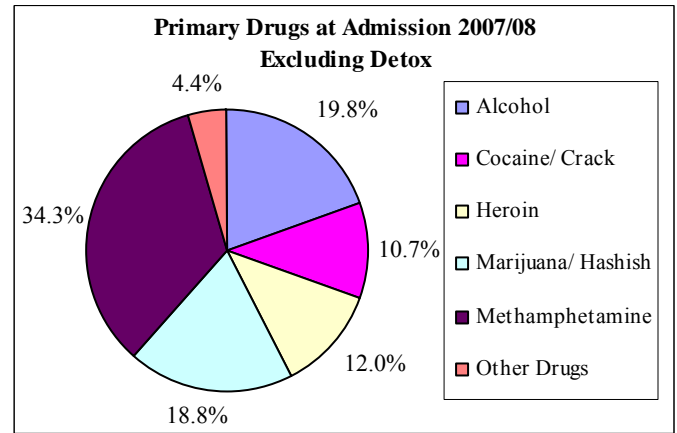
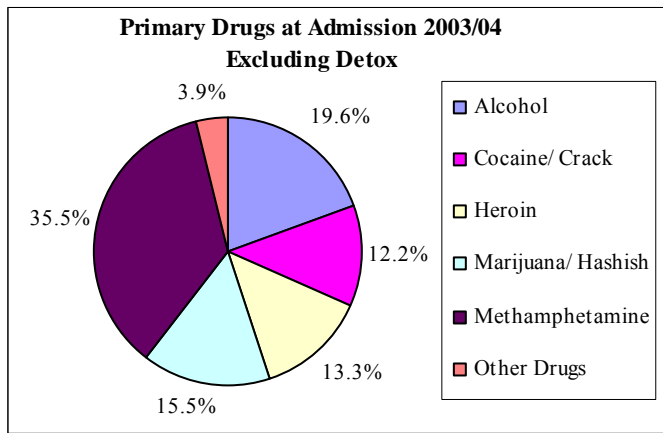
Fiscal Years	Primary Drugs				
	Heroin	Alcohol	Methamphetamine	Cocaine/Crack	Prescription*
2003/04	48.4 %	26.6 %	10.8 %	8.4 %	3.9 %
2004/05	43.6 %	27.2 %	13.0 %	9.7 %	4.1 %
2005/06	40.3 %	28.2 %	14.3 %	10.0 %	5.1 %
2006/07	35.3 %	30.0 %	15.1 %	10.8 %	7.0 %
2007/08	36.3 %	31.0 %	11.7 %	10.6 %	8.5 %

*Prescription includes: Barbiturates, Other Sedatives or Hypnotics (Chloral Hydrate, Placidyl, Doriden, etc), Tranquilizers (Benzodiazepine: Diazepam, Flurazepam, Chlordiazeposice, Clorazepate, Lorazepam, Alprazolam, Oxazepam, Temazepam, Prazepam, Riazolam, Clonazepam, and Halazepam), Other Tranquilizers, Non-Prescription Methadone, OxyCodone/OxyContin, Other Opiates and Synthetics (Codeine, Dilaudid, Morphine, Demerol, Opium, and any other drug with morphine-like effects).

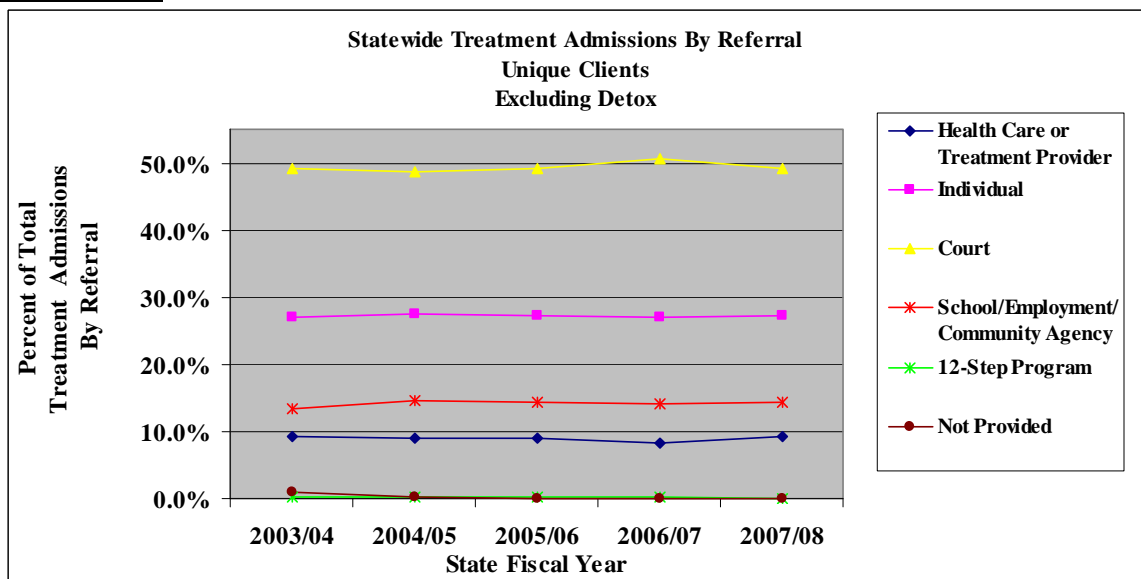
Highlights

- The top five primary drugs at admission are consistent through the five year period.
- Alcohol and heroin are the top primary drugs for detoxification only.

- Prescription drug detoxification increases from 3.9 percent in 2003-04 to 8.5 percent in 2007-08.



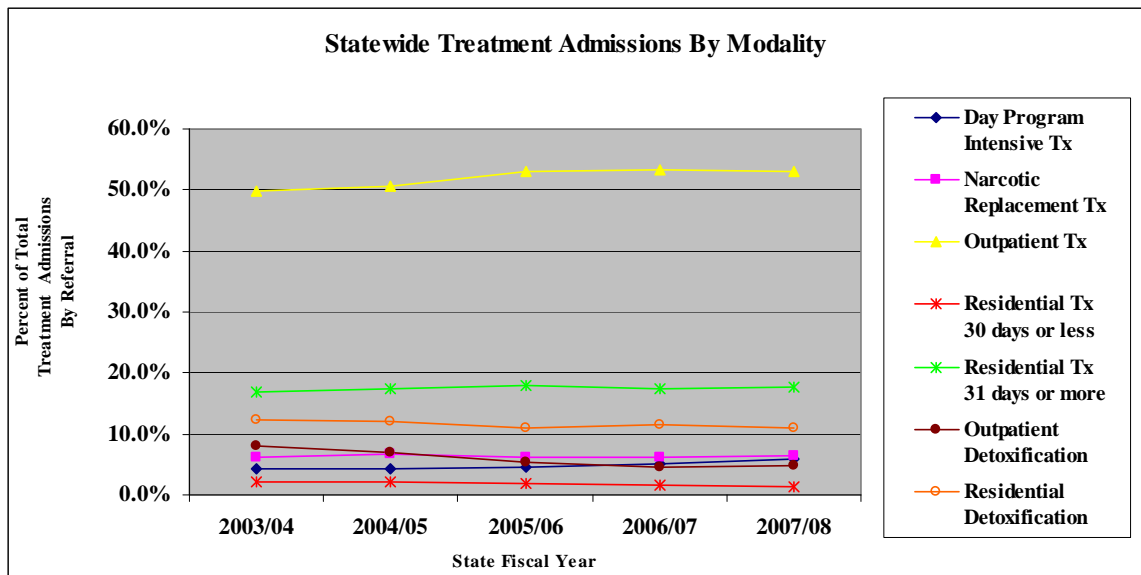
Referral Source

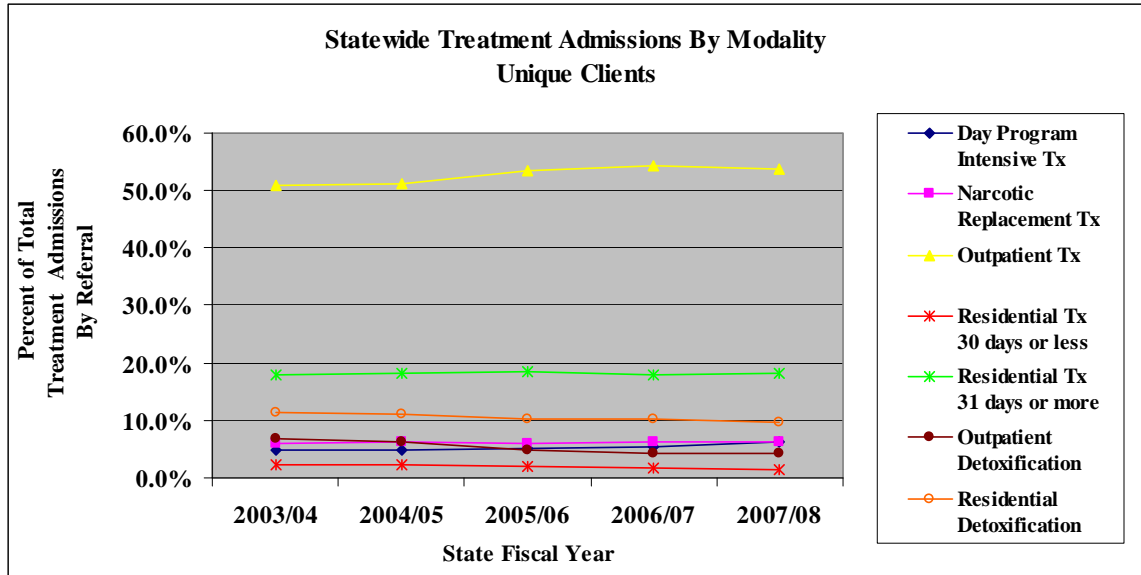


Highlights

- The Health Care or Treatment Provider category includes: Alcohol/Drug Abuse Care Program, Other Health Care Provider
- The Individual Referral category includes: Individual, including self-referral
- The Court category includes: DUI/DWI, Drug Court Partnership, Comprehensive Drug Court Implementation, Non-SACPA Court/Criminal Justice; and Dependency Court/Child Protective Services, SACPA Court/Probation and SACPA Parole
- The School/ Employment/ Community Agency category includes: School/Educational, Employer/EAP, and Other Community Referral
- The 12-Step Program category includes: 12-Step Mutual Aid
- The single highest number of treatment admission referrals is from court referrals, which comprise approximately 50 percent of all referrals over the five-year period.
- Individual referral is the second highest referral source and remains stable over the five year period.
- All referral sources remain relatively constant over the five year period.

Service Modality





Highlights

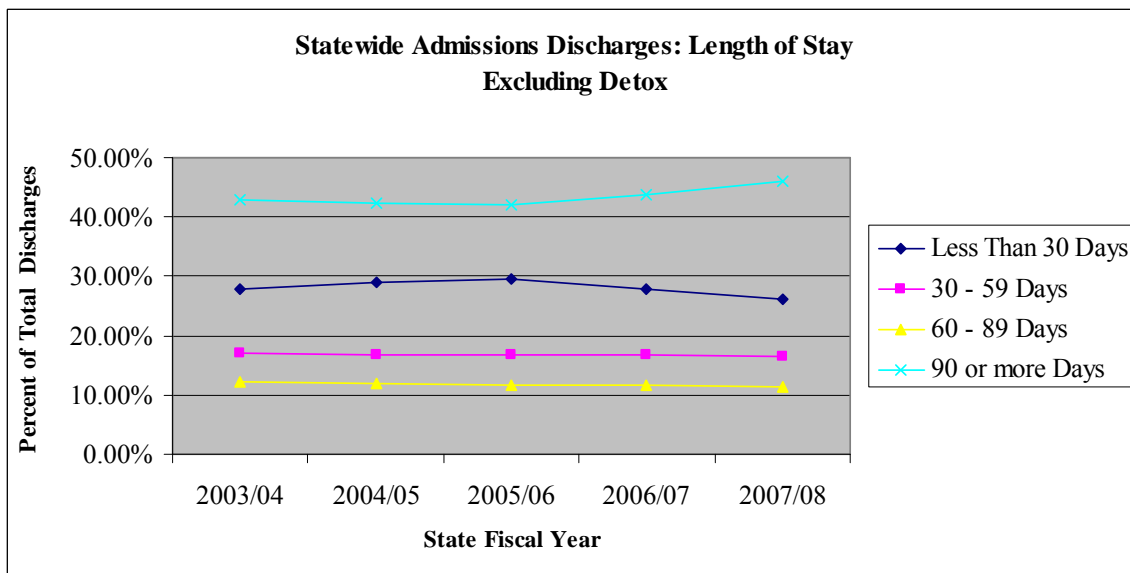
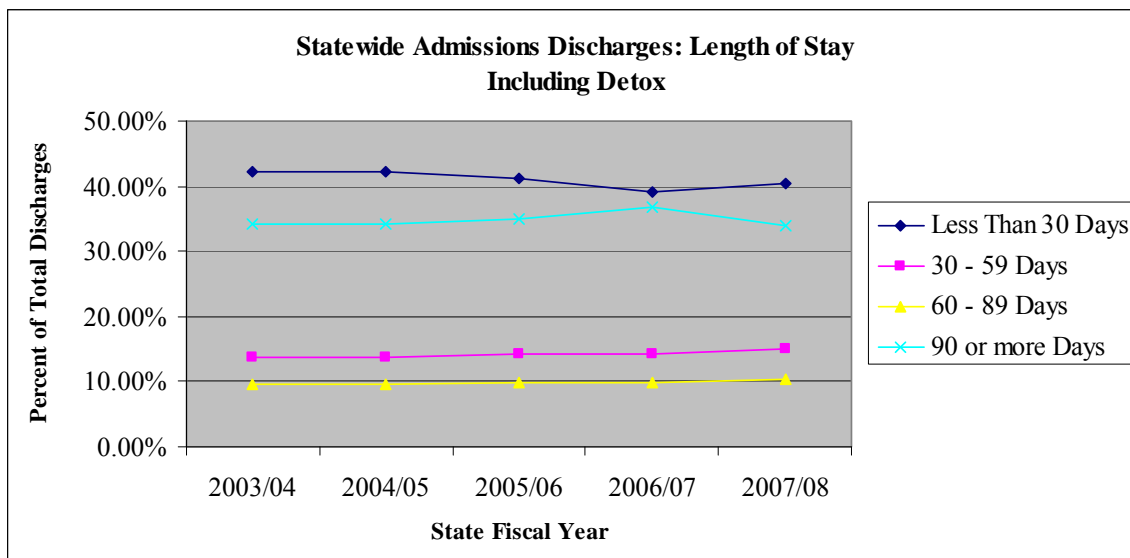
- The Narcotic Replacement Treatment category includes: Nonresidential/Outpatient Treatment/Recovery and Nonresidential/Outpatient Day Program-Intensive/Day Care Habilitative
- The Outpatient Treatment category includes: Nonresidential/Outpatient Treatment/Recovery and Nonresidential/Outpatient Day Program-Intensive/Day Care Habilitative
- The Residential Treatment category includes: Residential Treatment/Recovery (30 days or less) and Residential Treatment/Recovery (31 days or more)
- Narcotic replacement treatment service modality admissions remained constant when compared to total treatment admissions over the five-year period.
- Outpatient treatment service modality admissions increased over the five-year period.
- The outpatient treatment service modality is most frequently used of all service modalities.
- Residential treatment service modality admissions remained constant when compared to total treatment admissions over the five-year period.
- Outpatient detox services have decreased over the five year period.

Statewide Treatment Length of Stay

Length of stay refers to the amount of time a client remains in treatment. The statistics below are based on the number of days from admission to discharge from one service modality. If a unique client attends a series of modalities (e.g. goes to residential, then outpatient) these services stays are counted as separate lengths of stay. ADP is planning to also begin analyzing total lengths of stay for uninterrupted stays in a series of modalities (known as an “episode of care”). The length of stay statistics below include all service stays regardless of if the client completed treatment or not. In the first table below, the treatment length of stay totals do not

reflect unique clients; one client could be represented multiple times. Research indicates that clients enrolled in longer treatment stays experience more positive outcomes, such as abstinence from alcohol and other drug use.

Treatment length of stay statewide trends were analyzed to compare four intervals at the statewide level: Less than 30 days, 30 - 59 days, 60 - 89 days, and 90 or more days.



Highlights

- The highest lengths of stay including detoxification over the five-year period are for less than 30 days (around 40 percent) and 90 days or more (34 – 35 percent).

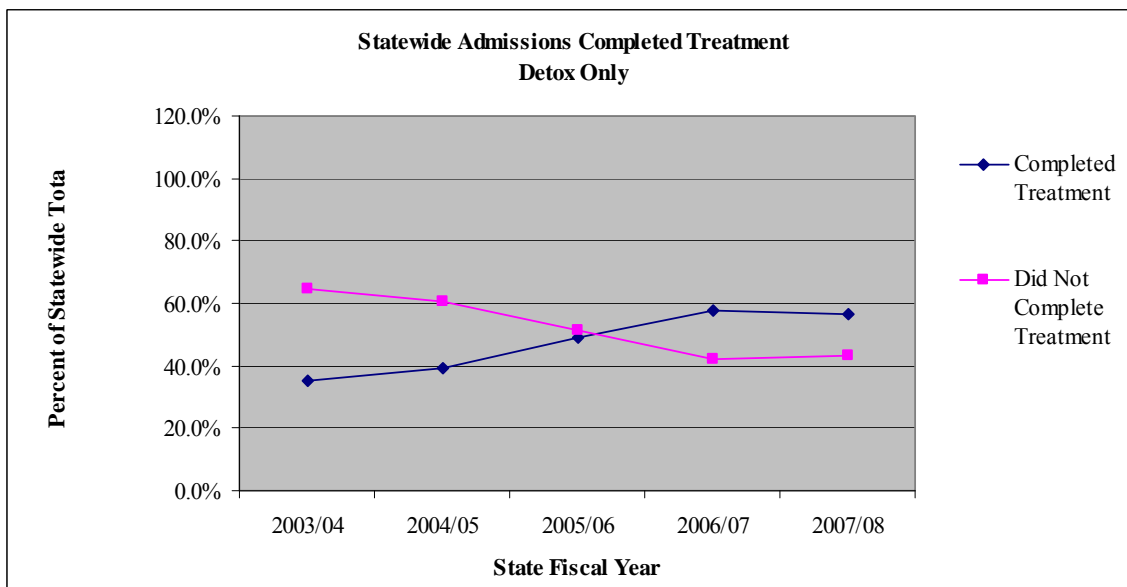
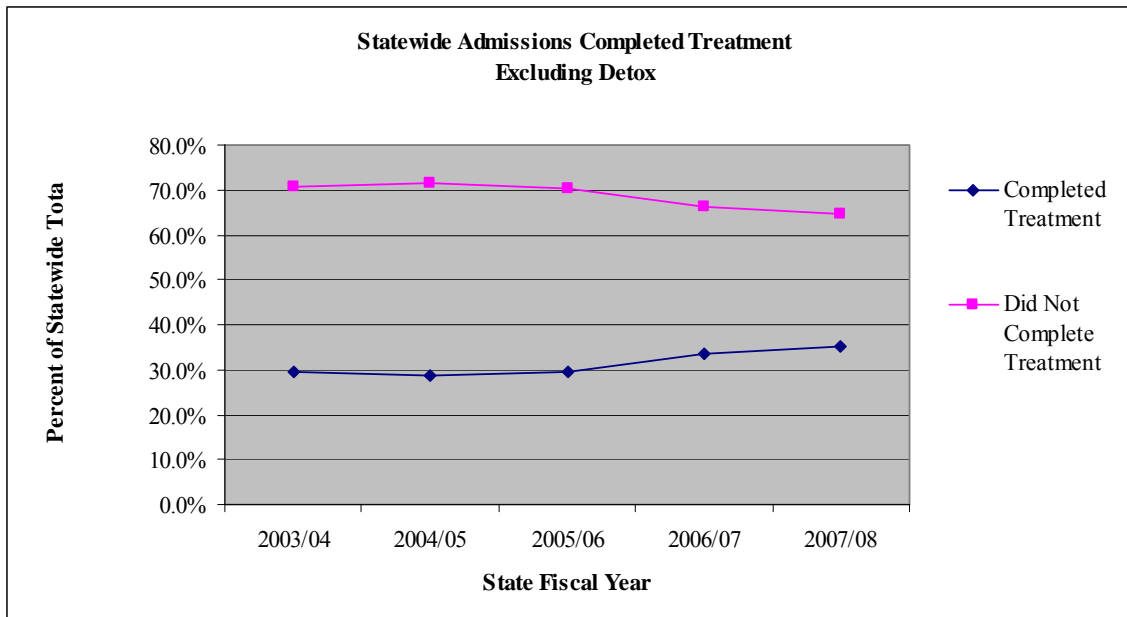
- The highest lengths of stay excluding detoxification over the five-year period are for 90 days or more which increases from FY 05-06 through FY 07-08.
- Less than 30 days is the second highest for lengths of stay excluding detoxification.
- Shorter lengths of stay for both including and excluding detoxification over the five-year period are for 30 – 59 days (14 - 15 percent) and 60 – 89 days (around 10 percent).

Statewide Complete and Incomplete Treatment

Completed treatment is based on an admission and a matching “standard discharge” (discharge status 1, 2, 3, 5) and incomplete treatment is based on an admission and a matching “administrative discharge” (discharge status 4, 6, 7, 8). There are eight CalOMS Tx discharge codes/statuses that determine whether a discharge is an administrative discharge (no treatment outcomes collected) or a standard discharge (treatment outcomes are collected). The eight discharge codes/statuses include:

- Status 1 – Completed treatment/recovery plan goals, referred standard discharge
- Status 2 – Completed treatment/recovery plan goals, not referred standard discharge
- Status 3 – Left before completion with satisfactory progress, referred standard discharge
- Status 4 – Left before completion with satisfactory progress, not referred administrative discharge
- Status 5 – Left before completion with unsatisfactory progress, referred standard discharge
- Status 6 – Left before completion with unsatisfactory progress, not referred administrative discharge
- Status 7 – Death administrative discharge
- Status 8 – Incarceration administrative discharge

An analyses of CalOMS- Tx data conducted by the Department of Alcohol and Drug Programs (ADP) and University of California, Los Angeles' Integrated Substance Abuse Program (UCLA ISAP) revealed a high percentage of administrative discharges being reported to ADP. Interviews or discussions with AOD treatment providers and county staff indicate an inconsistent interpretation of the proper use of the CalOMS Tx discharge statuses/codes. The data below will reveal a higher amount of incomplete treatment than complete treatment due to these issues of interpretation of discharge codes.



Highlights

- The number of Total Completed and Incomplete Treatment is consistently less than the Total Treatment Admissions over the five-year period.

Recovery Support Services

There are various types of recovery support service programs¹. Peer Recovery Support Services (PRSS), or mutual support groups, are comprised of programs for emotional support, information support, instrumental support and affiliation support. Faith-Based Organizations provide services within the context of a religious framework of beliefs and rituals. These services may or may not be peer-driven, and can be used as a compliment to treatment or sometimes as an alternative to treatment services. These services are often used by treatment providers as an adjunct to the individual's publicly funded treatment services.

Some of the more popular PRSS include self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Rational Recovery (RR), Secular Organizations for Sobriety (SOS), Women for Sobriety, and SMART Recovery. The accessibility of self-help groups is one of their most attractive features. Since no dues or fees are required for most of these recovery programs, these self-help organizations are the most cost-effective recovery options available. There is also a growing trend in self-help online support communities. Chat-rooms, bulletin boards and electronic mailing lists all provide convenient, around-the-clock access to peer support. For the more rural and isolated regions of California, accessibility through electronic media like the internet make support for recovery possible with these on-line support sites.

From a federally funded trial that compared three alcohol treatment programs (cognitive behavior, motivational enhancement therapy, and 12-step), data from 1,706 participants found that those who attended AA meetings drank less, drank less frequently and had fewer depression symptoms. In the study, the authors wrote, "AA attendance appears to help individuals to increase abstinence and to reduce the intensity of drinking when lapses do occur, partially by reducing symptoms of negative affect." "Most treatment programs refer patients to AA or similar 12-steps groups, and now clinicians can tell patients that, along with supporting abstinence, attending meetings can help improve their mood."² Another study from Stanford University found that a 12-step oriented treatment program that included Alcoholics Anonymous meetings boosted two-year sobriety rate by 30 percent compared to cognitive-behavioral programs. The study which appeared in the journal Alcoholism: Clinical and Experimental Research touched on the cost as being 30 percent less than CB-based treatment for addiction and said the spiritual dimension of AA may explain why recovering alcoholics in such programs are better able to resist the temptation to return to drinking.³

¹ ATTC Unifying science, education and services to transform lives. (2009). *What are Recovery Support Services?*. Retrieved April, 2009, from <http://www.attnetwork.org/learn/topics/rosr/rss.asp>

² University of Wisconsin-Madison. (2006). *Innovations for Recovery Model: A Synopsis*. Retrieved April 22, 2009, from <http://www.innovationsforrecovery.com/System/System.aspx>

³ James T. (May 2008). *Exploring the Potential of the Web-based Virtual World of Second Life to Improve Substance Abuse Treatment Outcomes*. Network for the Improvement of Addiction Treatment University of Wisconsin-Madison.

Recovery in the Continuum of Services

Recovery Support Services is a critical component in the continuum of services in California which is currently being formally incorporated into the menu of available services. In the past, the majority of recovery services have been delivered through non-professional, mutual support groups comprised of members who share the same addiction or AOD related problem and support one another in recovery of the issue. Increasing recovery services in California has begun through ADP sponsored pilot projects undertaken by several counties and the Access to Recovery (ATR) Grant from SAMHSA called California Access to Recovery Effort (CARE). In its second three-year grant cycle, the CARE program has demonstrated the efficacy of Telephone Monitoring and Adaptive Counseling (TMAC) in maintaining sobriety after treatment. This continuing care protocol has been adapted as a six-month adolescent-specific version with initial face-to-face orientation sessions followed by weekly calls agreed upon by counselor and client. TMAC utilizes Motivational Interviewing and Cognitive Behavioral methodologies to allow for the best outcomes and maintain the client centered approach.

Referrals to a PRSS during treatment services is a common practice amongst AOD counselors as well as creating discharge plans or recovery plans that include continued participation in mutual support groups. The Department and counties have long recognized that more options are needed to maintain abstinence after treatment and together have begun working towards instituting recovery services within the public AOD services system.

While the COSSR framework has highlighted the importance of recovery services, other pilot projects have sparked interest in the measurement of recovery services. These pilots sponsored by ADP through UCLA ISAP include recovery services such as recovery centers, continuous telephone recovery monitoring, and recovery management. It should be noted that currently there are not any Recovery Support Services maintained or reported on in the CalOMS system.

The lessons learned, and the barriers identified include:

- Significant lack of funding for Recovery Support Services (RSSs) in California may limit the ability of counties to provide and measure the efficacy of RSSs.
- The definition of recovery continues to be unclear across counties.
- Collecting and using data within RSSs appears to be challenging.
- There are no clear guidelines on RSS measurements and there are few standardized performance/outcome measures to test the efficacy of RSSs.
- Lessons learned from existing RSS models implemented in other states will be crucial guidelines to plan next steps for recovery services and measurement in California.
- The counties have identified specific improvements or a change in their local system that they will work on to enhance recovery services.

The results of these pilots which should be completed by mid-year 2011 will be evaluated and shared with all stakeholders. Recommendations will be provided to the State on strategies to measure recovery support service delivery and the outcome of these services.

California Problem Gambling Treatment Services Program

ADP established the California Problem Gambling Treatment Services Program (CPGTSP). CPGTSP is a stepped-care, statewide approach to treating and preventing problem and pathological gambling. The stepped-care approach encompasses a continuum of integrated services, including harm reduction and abstinence-based alternatives, which will deliver a broad spectrum of evidence-based treatments to California residents. Licensed mental health treatment providers will be eligible to participate in the CPGTSP. The providers will be required to complete a comprehensive training and supervision program which will be provided at no cost by the state.

Authorized CPGTSP providers and supervisors will be reimbursed on a fee-for-service basis, after service has been provided. Patients will be eligible to receive up to eight state-funded counseling sessions. Providers may submit a Request for Additional Services using the Data Management System to ADP and/or its designee for an additional block of treatment services to be state funded. Additional blocks of service must be approved by ADP and/or its designee before treatment services are provided.

Treatment services will:

- Be allocated and distributed to four high-need and high-risk pilot regions of California.
- Target problem and pathological gamblers and directly-involved affected individuals.
- Target populations that are underserved, highly vulnerable and at the most risk to develop problem and pathological gambling (females, elderly, physically challenged, adolescents, underserved ethnic minorities).
- Have ongoing quality control and quality assurance reviews, oversight, and monitoring processes allowing for real-time analyses of treatment system implementation, effectiveness and quality of care.
- Be relevant to the needs of a diverse, multicultural population.

Outreach is a critical element of the CPGTSP and will be used to connect CPGTSP ideas or practices to the efforts of other organizations, groups, specific audiences or the general public for the purposes of increasing the workforce of trained treatment providers to work with problem and pathological gamblers while enhancing the awareness of treatment resources available for the general public. Outreach will be conducted to various associations and individuals to recruit therapists meeting criteria for training.

Associations include, but are not limited to: Southern California Psychiatric Society, American Academy of Addiction Psychiatry, California Association of Marriage and Family Therapists, California Psychological Association, National Association of Social Workers – California Chapter, and County Alcohol and Drug Program Administrators'

Association of California (CADPAAC). In addition, ADP will provide outreach through community partners, contractors, other State agencies including The Department of Mental Health (DMH), and multi-cultural associations.

CPGTSP components include:

- Training (to include web-based)
- Treatment Provider Network
- Clinical Innovation Program

Training

Providers meeting the criteria must attend a 30-hour curriculum-based training to be an authorized CPGTSP provider. Criteria for acceptance into provider training are as follows:

- Must possess a licensed clinical degree, current and in good standing: Medical Doctorate (MD); Doctor of Psychology (PsyD); Doctor of Psychology (PhD); Doctor of Osteopathy (DO); Marriage and Family Therapist (MFT); or Licensed Clinical Social Worker (LCSW). A copy is required to be on file.
- No violations or pending actions as a result of a formal complaint to the California Board of Behavioral Sciences, Board of Psychology, and Medical Board of California.
- Current malpractice insurance.
- Must have computer and Internet access and be able to comply with HIPPA.

CPGTSP will provide ongoing instruction which will allow providers the opportunity to receive updated and advance problem gambling training.

A network of clinical supervisors was created to provide direct clinical supervision to therapists. Clinical supervisors in the CPGTSP will be mental health professionals who have a high degree of experience and expertise in working with pathological and problem gamblers and their families. Each supervisor will provide 60 hours of supervision during a 12-month period. Criteria to become an authorized supervisor are as follows:

- Must possess a licensed clinical degree, current and in good standing: Medical Doctorate (MD); Doctor of Psychology (PsyD); Doctor of Psychology (PhD); Doctor of Osteopathy (DO); Marriage and Family Therapist (MFT); or Licensed Clinical Social Worker (LCSW). A copy is required to be on file.
- No violations or pending actions as a result of a formal complaint to the California Board of Behavioral Sciences, Board of Psychology, or the Medical Board or the boards relevant to specific licenses in a supervisor's home state.
- National Council on Problem Gambling (NCPG), California Council on Problem Gambling (CCPG) certified gambling therapist or board-certified in Addiction Psychiatry or Addiction Medicine.
- Actively treating problem gamblers in treatment (minimum of 5 hours per week)

- Have experience as a clinical supervisor in working with trainees or supervisees within the last 12 months (10 hours prerequisite).
- Commit to 60 hours per year to provide supervision to California therapists.
- Completed and approved CPGTSP Application.
- Have documented completion of 10 hours of Problem Gambling CEUs within the last 12 months prior to application to become a supervisor.

Once a therapist has completed training and qualifies to become an authorized provider in the CPGTSP Provider Network, he/she will be eligible for reimbursement for services. Providers will submit an invoice on a fee for service basis. Once approved, the provider will receive reimbursement under the CPGTSP.

During 2010-2011, a two-day CPGTSP Online Training Program consisting of curriculum content and online training materials will be developed and delivered.

Treatment Provider Network

The treatment provider network will establish a statewide multimodal system of care for the CPGTSP. This network will incorporate telephone intervention, outpatient treatment, intensive outpatient treatment and residential treatment services.

Problem Gambling Telephone Intervention (PGTI)

In 2009 existing problem gambling helpline services received 5,009 calls: 78.5 percent of the calls were from a gambler; 7.5 percent from a spouse of a gambler; 3.5 percent from a child of a gambler; 2.1 percent from a parent of a gambler; and 2.2 percent from a sibling of a gambler. Of the 5,009 calls, 56.7 percent were male and 43.3 percent were female. The three top age ranges of incoming calls were ages 36-45 years at 25 percent followed by ages 26-35 years (24.9 percent) and ages 46-55 years (22.9 percent). The three top primary gambling preferences were Indian Casinos (62.9 percent), Card Rooms (20.5 percent), and the Lottery (4.1 percent).

Existing problem gambling helpline services will be used to implement the PGTI. One existing helpline service will offer the technical capacity and clinical ability to conduct eight weekly, one-hour telephone sessions based on the “Freedom from Problem Gambling” self-help workbook. These services will be offered in English and Spanish to residents of California. A second existing helpline service will offer the same helpline intervention project in Chinese languages to residents of California. By making PGTI services available, it will make service provision available to those in rural areas who cannot reach outpatient providers.

Outpatient Treatment

The specific types of treatment provided to problem and pathological gamblers will be a combination of state-provided treatment materials, knowledge and skills acquired from the trainings, and techniques from the therapist’s own orientation and clinical experience.

Intensive Outpatient Program (IOP)

This treatment component of the CPGTSP will deliver intensive outpatient services (IOP) to pathological gamblers and their family members. IOP programs will offer at least three days per week of integrated treatment for pathological gamblers and their families. The purpose of IOP programs is to serve as a bridge for patients transitioning from residential treatment to outpatient care and also for patients who require more clinical care than that offered by standard outpatient treatment. IOP for pathological gamblers will utilize providers with experience in treating pathological gamblers.

Residential Treatment

This treatment component of the CPGTSP will deliver residential treatment to pathological gamblers and their family members. Residential treatment will provide care, recovery activities and support 24 hours per day. During the pilot phase of state-funded treatment, this residential treatment program will be conducted within an existing and licensed substance abuse treatment program with experience in treating pathological gamblers.

Each provider will be required to enter information regarding services provided under the CPGTSP into a statewide data management system. This system will provide pertinent information pertaining to the success of the CPGTSP. ADP will be able to track outcomes and patient recidivism rates for the program. In addition, the system will provide invoicing and billing modules to allow for tracking of funding.

Clinical Innovation Program

In order to establish best treatment practices and evidence-based treatments for problem and pathological gamblers in California, three pilot projects will be conducted:

1. Manualized Treatment for Pathological Gamblers

This clinical project will examine the effectiveness of a treatment manual for problem and pathological gamblers. A therapist and patient manual will both be tested.

2. Enhancing Counselor Performance with Problem Gamblers

This clinical project will focus on increasing the clinical readiness and skills of counselors (non-licensed health professionals) who are trained to treat problem gambling. Counselors will receive gambling training and will be monitored and evaluated as they provide care to problem gamblers.

3. Treatment for Affected Individuals of Problem Gambling

This clinical project will focus on the development of a treatment manual to be used for affected individuals (friends and family) of problem gambling. First, a 6-session treatment manual will be created. Second, a pilot project will be conducted to examine the feasibility, acceptability and efficacy of a manual designed to reduce the distress experienced by individuals affected by problem gambling.

In Summary

This chapter looks at the current continuum of publicly funded alcohol and other drug, and gambling services in California. It is presented in narrative and data to ensure the reader a full understanding of the system, as well as the numbers and demographics of the Californians receiving services. Following are the highlights of this chapter.

Prevention

- In FY 2007-08 over 500,000 prevention services were delivered in California.
- Youth aged 12 through 17 receive substantially more prevention services with a rate of 84.6 per 1,000 population than any other age group. The 18 through 25 age group is a distant second at 13.9 per 1,000 population.
- The fewest number of persons served fell in the 65 and older group with a rate of 2.2 per 1,000 population.
- While Hispanics and Whites received services for a greater *number* of individuals, Pacific Islanders, Multiracial, and American Indians received services at a higher *rate* for their group within the California population.
- Per county problem statements (part of Strategic Prevention Framework) that describe local AOD prevention issues the top issues are alcohol and youth, and the least identified issues were prescription drug use and older youth/young adults.

SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an early intervention model that is considered an evidence-based practice. California's SBIRT capacity is currently being built through two grant-funded demonstration projects and a training initiative. Preliminary outcomes from six month follow-up interviews suggest an improvement in participants' abstinence from AOD use, increases in employment/school and housing status, and decreased alcohol/drug related problems.

- Health educators screened 130,000 patients since July 2007. Over 10,000 referrals to substance abuse treatment and smoking cessation services were made.
- Alcohol was reported as the substance most used, and marijuana/hashish was the next highest substance used.

Treatment

- Statewide treatment admissions were highest for the 26 through 35 and 36 through 45 age groups in FY 2007/08, however, the 36 through 45 age group has shown a steady decline over the five year period.
- Statewide treatment admissions for the 12 through 17 age group has shown an upward trend from FY 2006/07 to 2007/08 increasing to nearly 15 percent of total admissions.
- As a rate per 1,000 of the California population, African American, Native American and other are the highest represented race/ethnicities for treatment admissions for FY 2007/08. However, Native Americans are showing a decline in admissions over the five year period.
- As a percentage of the total treatment population, White and Hispanic are the highest represented race/ethnicities for treatment admissions for FY 2007/08 with Whites showing a steady decline in admissions and Hispanics showing a steady increase over the five year period.
- Heroin and alcohol are the top two primary drugs for detoxification only treatment admissions
- Detoxification treatment admissions for prescription drugs more than doubled over the five year period to 8.5 percent in 2007/08.
- Methamphetamine treatment admissions are showing a steady decline since its peak in 2005/06.
- The single highest number of treatment admission referrals (excluding detox) has been from court referrals, which comprise just over 50 percent of all referrals during the five-year period. Individual referrals was the second highest at just under 30 percent.
- The outpatient treatment service modality is the most frequently used of all service modalities.
- The highest length of stay in treatment is for 90 or more days (nearing 50 percent) which is showing an increase in the trend since 2005/06.
- The second highest length of stay in treatment is for less than 30 days (just over 25 percent) which is showing a decrease in the trend since 2005/06.
- The percent of individuals in treatment that did not complete treatment is approximately double those that did complete treatment.

Recovery

- While identified as an important component of effective treatment strategies, lack of a dedicated funding source impedes the ability of counties to provide and measure recovery support services.
- Good progress is being made through pilot programs and future results should help shape the ability to accurately measure and report recovery support service outcomes.

Gambling

The California Problem Gambling Treatment Services Program (CPGTSP) has been established as a result of a growing problem in California related to problem and pathological gamblers. It is comprised of required training for a network of providers who are reimbursed on a fee for service basis, a variety of available treatment interventions, and a concerted outreach effort. As this is a newly established program, data is not yet available to determine the program's impact on problem gambling in California.

Chapter 4: California's Continuum of Need

Assessment of the Continuum of Need

This chapter uses a variety of methods to estimate the population in need of AOD services in California. The level of need is assessed and identifies areas where there appears to be a gap between the need for services and the services currently being provided.

The first sections address estimates of the broader need for prevention and early intervention services which, to the degree that these services are effective, will impact the future need for treatment services. The subsequent section focuses on estimating treatment need in order to assess the potential impact on the public AOD treatment services system. In addition, based on the 2006 California Problem Gambling Prevalence Survey, an estimate of treatment need for pathological gamblers is derived.

The estimates produced for this report do not fully take into account the potentially vast, but not well understood, capacity of the private sector service system to provide both prevention and treatment services in the AOD and problem gambling fields. As health care reform is implemented along with the implementation of mental health and substance abuse treatment parity, more uninsured people may become eligible for and use both public and non-public health insurance coverage for AOD and problem gambling services.

Prevention

There is a substantial gap between what is currently in place in terms of prevention strategies, policies, and programs and what is actually needed to meet the substance abuse prevention needs of California's population. The gap in prevention services is especially critical for the publicly funded system. ADP serves as the leader in addressing the continuum of substance abuse problems. By establishing prevention strategies that minimize AOD use and abuse, more costly treatment can be avoided.

Evidence-Based Prevention Strategies

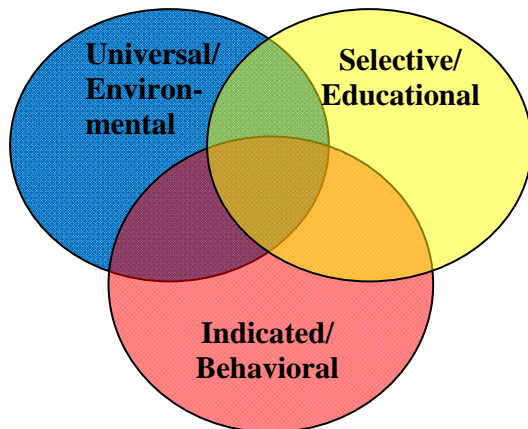
In order to determine the Prevention services need in California, an understanding of the types of Prevention strategies effective for the various target populations is necessary. The following discussion will serve to provide the context for the determination of the Prevention services need in California.

Prevention is defined by the Institute of Medicine Continuum of Care as serving three levels of risk categories. Universal preventive interventions are targeted to the general public or a segment of the entire population with an average probability of developing a

disorder, risk, or condition. Selective preventive interventions are targeted to specific populations whose risk of a substance disorder is significantly higher than average, either imminently or over a lifetime. Indicated preventive interventions are targeted to designated individuals who have minimal but detectable signs or symptoms suggesting a disorder or who carry biological markers for a disorder often referred to as high risk.

Given that substance abuse has a wide range of adverse consequences and society has limited resources, there is a need to optimally reduce consumption and its adverse consequences. In California's diverse environments and cultures, it is clear that no single intervention will reduce the problem so dramatically that no further public action is desirable. Thus, a comprehensive package of prevention programs and strategies is required. "Given the number and diversity of proven interventions, optimal resource allocation requires selecting the most complementary, politically feasible, and culturally and demographically appropriate set to maximize a return on investment within the available funding. Of critical concern is to identify a sensible package of interventions that complements existing interventions."¹

Effective Prevention is Comprehensive



For example there are two broad approaches to prevention: one with a focus on high-risk users and the other a population approach.

- High-risk: change extreme, high-risk individuals, treatment may be needed
- Population: change majority, the *conditions* that shape *everyone's* behavior.

It is important to stress that these approaches are NOT mutually exclusive. Not only is it possible to do both, but it is an essential part of a comprehensive approach to do both.

Each approach has its advantages and disadvantages. For the population or public health approach the potential advantages are:

¹ Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

- Large population benefits
- Broad target audience
- Longer lasting effects

And the potential disadvantages are:

- May limit personal freedoms
- Resistance from invested parties
- Counter-intuitive

THE PREVENTION PARADOX PROVIDES AN ALCOHOL DRINKING EXAMPLE OF THE COUNTER-INTUITIVE ASPECT OF THE PUBLIC HEALTH APPROACH. THE GREATEST RISK HEALTH HARMS OCCUR AMONG EXTREME DRINKERS. HOWEVER, THERE ARE FEW EXTREME DRINKERS AND MANY “MODERATE” DRINKERS. THE “MODERATE” DRINKERS ARE ALSO AT RISK. THE VAST MAJORITY OF HEALTH HARMS IN A COLLEGE SETTING ARISE AMONG STUDENTS WHO DRINK AT MODERATE OR LOW LEVELS. THUS, THE GREATEST HEALTH GAINS ARE FROM INCREMENTALLY MOVING THE MAJORITY.

THE RESEARCH LITERATURE HAS DOCUMENTED CONSISTENT FINDINGS OF EFFECTIVE UNIVERSAL POLICY AND ENVIRONMENTAL STRATEGIES¹, INCLUDING:

- MINIMUM DRINKING AGE
- ENFORCEMENT
- ALCOHOL TAXES
- SERVER TRAINING
- ALCOHOL OUTLETS

THESE FINDINGS ARE CONSISTENT WITH A PUBLIC HEALTH APPROACH AND THE PREVENTION PARADOX.

For the high-risk approach the potential advantages are:

- Intervention tailored/targeted to the individual
- Clear benefits (when achieved) to the individual
- Intuitive

¹ Institute of Medicine of the National Academies. Division of Behavioral and Social Sciences and Education. *Reducing Underage Drinking: A Collective Responsibility*, 2004. Available at http://books.nap.edu/openbook.php?record_id=10729&page=R1

And the potential disadvantages are:

- Difficult and costly to ID “at-risk” individuals
- Effects palliative, temporary
- Low odds success
- Modest benefit to the population

A GOOD EXAMPLE OF THE HIGH RISK APPROACH IS THE FOCUS ON THE HIGH RISK DRUG AND EXCESSIVE ALCOHOL USERS. GPAC’S HIGH RISK USER GROUP HAS MADE RECOMMENDATIONS AND SUPPORTED STATE AND LOCAL ACTIONS TO SUPPORT SCHOOL STUDENT ASSISTANCE PROGRAMS TO ADDRESS HIGH RISK USERS.

Delay or Stop AOD Initiation

Prevention strategies directed toward youth are especially important because there is a strong potential to avoid substance abuse problems before they start. The research literature is extremely strong in documenting the value of stopping or delaying youth from ever starting to use. Currently at least 40 percent of young adolescents in 11th grade report not using alcohol or other drugs and less than half of youth under 14 report having used any substance.

As shown in the example below, as one part of a broad ongoing comprehensive set of prevention strategies, universal implementation of effective school-based prevention programs could delay at least three percent to 25 percent of youth from starting to use.

EXAMPLE: Cost Benefit Analysis of Universal Implementation of Effective School-Based Prevention

This analysis of prevention needs and opportunities for California represents an initial effort to replicate the methodology and analyses conducted by Drs. Ted Miller and Delia Hendrie of PIRE published in *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*¹. Not only the analyses, but also this section text, borrow heavily from their work adapted to the California situation.

¹ Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

For illustrative purposes, the universal implementation of effective school-based prevention programs¹ is used as the model to demonstrate the potential value-added of prevention services. The rationale is that “Nearly every youth ages 12–14 is at risk for trying alcohol, tobacco, and drugs and may be aware of social norms and feel peer pressure to start using these substances.” This initial analysis was based on estimating the number of youth who would not have tried or would not regularly use these substances if effective school-based prevention programs were in place nationwide. To determine these estimates for California, the number of youth ages 12–14 was multiplied by the medium estimate of the percentage of youth who would delay initiating use of each substance if they received effective school-based prevention programming. The effectiveness estimates were drawn from two meta-analyses on the effectiveness of school-based youth substance abuse prevention programs².

BASED ON UNIVERSAL IMPLEMENTATION OF EFFECTIVE PREVENTION PROGRAMS IN CALIFORNIA IN 2007, SUBSTANCE ABUSE INITIATION WOULD HAVE DECLINED FOR NEARLY 100,000 OF THE 1,743,000 CALIFORNIA YOUTH 12-14 YEAR OLD, AND BE DELAYED FOR TWO YEARS ON AVERAGE. AS IS WELL DOCUMENTED IN THE LITERATURE, A DELAY IN ONSET REDUCES A WIDE RANGE OF SUBSEQUENT PROBLEMS LATER IN LIFE. USING PREVALENCE DATA FROM THE CALIFORNIA STUDENT SURVEY FOR 2007-08, AN ESTIMATED:

- **3.1 PERCENT FEWER YOUTH AGES 12-14 WOULD HAVE ENGAGED IN DRINKING;**
- **7.0 PERCENT FEWER YOUTH WOULD HAVE USED MARIJUANA;**
- **26.7 PERCENT FEWER YOUTH WOULD HAVE USED COCAINE;**
- **5.3 PERCENT FEWER YOUTH WOULD HAVE SMOKED REGULARLY.**

Based on their review the average effective school-based program costs \$220 in 2002 dollars (corrected to \$255 for 2007 dollars) per pupil, including materials and teacher training. Implementing these programs universally throughout California could save an estimated \$33 per \$1 invested. Full implementation of school-based effective programming in 2007 would have reduced the social costs of substance-abuse-related medical care and other resources, and lost productivity and preserved the quality of life over the lifetime of those students affected for a total value of \$14.8 billion.

¹ Ibid, Appendix pp 41-54.

² S. Aos, R. Lieb, J. Mayfield, M. Miller, A. Pennucci. (2004) Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia: Washington State Institute for Public Policy, available at <http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf>

³ CA Cost Benefit Analysis Worksheet in Appendix

Programs designed to strengthen families generally cost more than the school-based life skills programs. Several of them also were highly cost-beneficial and offered much larger returns in the aggregate per youth served than the school-based life skills programs. In a program targeting families with low income, intensive home visitation, coupled with preschool enrichment, reduced infant/toddler abuse (Aos et al., 1999; Karoly et al., 1998).

As these toddlers reach adolescence and adulthood, visitation programs also can reduce a range of problems including substance abuse and violence. However, the net returns are often realized in the long term (for actual longitudinal cost-benefit results see Karoly, et al., 1998; Schweinhart, et al., 1993).

Estimates of Prevention Need

As the data shows, substance use starts young (<14), increases exponentially throughout the middle and high school years, and peaks among young adults (18-25). The 2007-08 California Student Survey shows 2/3 of all 11th graders report lifetime use of alcohol and 42 percent drank in the past 30 days, with 29 percent reporting binge drinking. Twenty-four percent report use of marijuana within the past 30 days and 42 percent report lifetime use. The emerging documentation of the non-medical use of prescription drugs (18 percent report lifetime use) and over-the-counter medicines (35 percent report lifetime use of any pill or medicine) raise new concerns about the immediate and long term consequences of substance use.

The number of Californian's in need of prevention is large. The first large group is adolescent and young adults. As the Table below displays, there are 5.3 million youth 12-20 years of age, and over 3 million of them have used alcohol or other drugs. Both broad substance problems - underage drinking, and use of illicit substances - are illegal for youth under 21 years of age. In addition non-medical use of prescription and OTC drugs among underage is harmful and carries with it high risk of adverse consequences. Thus the need to prevent youth from ever starting to use and to reduce their level of use to prevent the full range of immediate and long term consequences from AOD use is extremely high.

California Youth Population Ages 12-20 in Need of Prevention

Age	CA Population Estimates 2010*	CA Any Lifetime AOD Prevalence Estimates
Age:12	527,182	CSS 7 th grade: 29%
Age:13	544,735	310,856
Age:14	569,432	CSS 9 th grade: 60%
Age:15	585,479	692,947
Age:16	596,384	CSS 11 th grade: 74%
Age:17	608,396	891,537
Age:18	624,345	BRFS 18-24 (past month): 53%
Age:19	639,817	1,891,298
Age:20	627,136	
Total	5,322,906	3,093,691

*Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050*. Sacramento, CA, July 2007

Over 3 million youth ages 12 – 20 are in need of *Universal* prevention strategies.

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

There are a number of other effective prevention and early intervention strategies to address preventing underage and reducing excessive consumption of alcohol and other drugs.¹ They include efforts to reduce availability of alcohol and other drugs, delay or reduce the consumption, change the social norms toward underage substance use, adult excessive consumption and abuse of illegal drugs, and reduce harm from the (excessive) consumption of these substances.

The identified evidence-based interventions often cover different aspects of the problem (such as youth drug use initiation, impaired driving, and violence), which make a complementary set of interventions more beneficial. Several interventions are best directed toward different aspects of the problem. If they are massed against the same aspect, the size of that aspect will shrink, and the return on added interventions will decline below the levels shown in this study.

¹ For example PIRE Report cited earlier; Effectiveness of Behavioral Highway Safety Countermeasures. National Cooperative Highway Research Program Report # 622, WASHINGTON, D.C., 2008.

Early Intervention

Reduction in Harm and Negative Consequences

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

Estimates of Early Intervention Need

Other large groups in need of prevention/early intervention services are the young adult and adult groups who drink and use other drugs in risky and excessive ways. In nearly all categories of substances, young adults age 21-25 display the highest use patterns and harms related to risky and excessive use (i.e., binge drinking, illicit substance use, poly drug use, heavy use). This age group represents 2.8 million of the California population. For example, 46 percent of this age group engages in binge drinking and 27 percent report having driven under the influence of alcohol, according to the 2006 NSDUH survey. This suggests that between 750,000 and 1.3 million young adults within this age group could benefit from early intervention services (such as SBIRT) and that the harms related to their risky drinking could be reduced substantially.

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

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

In Summary, the author's of the PIRE report conclude: "The cost of substance abuse could be offset by a nationwide implementation of effective prevention policies and programs. SAMHSA's Strategic Prevention Framework should include a planning step that considers cost-benefit ratios. Communities should consider a comprehensive prevention strategy based on their unique needs and characteristics and use cost-benefit

ratios to help guide their decisions. Model programs should include data on costs and estimated cost-benefit ratios to help guide prevention planning.”

Treatment

Estimates of AOD Treatment Need

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

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

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

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

Overall

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

Young Adults Age 18-25 Needing but Not Receiving Treatment

2009 CA Population (age 18-25)	Percentage Needing Tx for Illicit Drug Use (age 18-25)	Percentage Needing Tx for Alcohol Use (age 18-25)	Percentage Needing Tx for either Illicit Drug or Alcohol Use ^a (age 18-25)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 18-25)
4,598,102	7.07	16.8	23.87	1,098,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

Highlights

- Over 3.3 million Californians are estimated to need, but are not receiving AOD treatment.

Age

The California population was categorized by the same age groups as those in the NSDUH survey. To estimate the number of Californians who need but did not receive treatment, the California population age groups were multiplied by the sum of the rates of needing but not receiving treatment for illicit drug use and the rates of needing but not receiving treatment for alcohol use (both provided by NSDUH).

Adults Age 26 and Over Needing but Not Receiving Treatment

2009 CA Population (age 26+)	Percentage Needing Tx for Illicit Drug Use (age 26+)	Percentage Needing Tx for Alcohol Use (age 26+)	Percentage Needing Tx for either Illicit Drug or Alcohol Use ^a (age 26+)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 26+)
24,097,858	1.48	6.43	7.91	1,906,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

^aThis percentage is derived by adding the percentage needing but not receiving alcohol treatment to the percentage needing but not receiving illicit drug treatment. This sum overestimates the percentage needing alcohol or other illicit drug treatment because it does not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Young Adults Age 18-25 Needing but Not Receiving Treatment

2009 CA Population (age 18-25)	Percentage Needing Tx for Illicit Drug Use (age 18-25)	Percentage Needing Tx for Alcohol Use (age 18-25)	Percentage Needing Tx for either Illicit Drug or Alcohol Use ^a (age 18-25)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 18-25)
4,598,102	7.07	16.8	23.87	1,098,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

Adults Age 26 and Over Needing but Not Receiving Treatment

2009 CA Population (age 26+)	Percentage Needing Tx for Illicit Drug Use (age 26+)	Percentage Needing Tx for Alcohol Use (age 26+)	Percentage Needing Tx for either Illicit Drug or Alcohol Use ^a (age 26+)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 26+)
24,097,858	1.48	6.43	7.91	1,906,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

^aThis percentage is derived by adding the percentage needing but not receiving alcohol treatment to the percentage needing but not receiving illicit drug treatment. This sum overestimates the percentage needing alcohol or other illicit drug treatment because it does not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Highlights

- Young adults 18-25 years of age have the highest, and youth age 12-17 have the lowest percentage needing but not receiving treatment for alcohol use.
- Young adults 18-25 years of age have the highest, and adults age 26 and over have the lowest percentage needing but not receiving treatment for illicit drug use.
- Overall young adults 18-25 years of age have the highest percentage needing but not receiving AOD treatment. They account for over one million people in need of treatment.
- Although the 26+ group has the lowest overall percentage needing treatment, it has the largest overall population. Therefore, this age group accounts for nearly two million people in need of treatment.

Gender

National estimates are used to determine the gender breakout of individuals in need but not receiving treatment. Percentages from the 2008 NSDUH were multiplied by the California population by gender.

Gender	2009 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drugs or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol ^b
Males	15,991,019	10.7	1,711,000
Females	16,202,246	6.1	988,000

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

^bThese estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates..

Highlights

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

Race/Ethnicity

National estimates are used to determine the race/ethnic breakout of individuals in need but not receiving treatment. Percentages from the 2008 NSDUH were multiplied by the California population by race/ethnicity.

Race/Ethnicity	2009 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drug or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol ^b
Hispanic	10,934,876	9.2	1,006,000
White	14,503,410	8.4	1,218,000
African American	1,927,834	8.2	158,000
American Indian	211,174	10.2	22,000
Pacific Islander	122,184	*	**
Asian	3,952,810	3.8	150,000
Multirace	540,977	9.1	49,000

*Low precision; no estimate reported.

** Unable to calculate.

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

^bThese estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates..

Highlights

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

Summary of Population-based Estimates of Treatment Need

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

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

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

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

Estimates of Treatment Need for Special Populations

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

this estimate one of the four studies cited is California specific. We need better ways to identify the percentage of and reasons why these subpopulations do not seek treatment.

Pregnant Women

Drinking during pregnancy raises the risk of low-birth weight babies and intrauterine growth retardation, increasing the danger of infection, feeding difficulties, and long-term developmental problems. Heavy-drinking during the early months of pregnancy can result in the birth of babies with fetal alcohol syndrome.

The California Department of Public Health's birth records provide the number of pregnant women in California. It should be noted this data does not take into account those mothers who gave birth to multiple babies and those who had unsuccessful pregnancies/stillbirths.

The prevalence rate of alcohol use among pregnant women is from the Morbidity and Mortality Weekly Report, Alcohol Use Among Pregnant and Non-pregnant Women of Childbearing Age-United States, 1991-1995. The annual percentage of any alcohol use among pregnant women was 12.2 percent.

The prevalence rate of alcohol use was multiplied by the number of California women who gave birth in 2008 to determine the number of women who used alcohol during their pregnancy.

Number of CA Women who Gave Birth 2008	Rate of Alcohol Use	Number of Pregnant Women who Used Alcohol
551,567	12.2	67,000

Note: Number of pregnant women who used alcohol is rounded to the nearest 1,000.

The prevalence rate of drug use among pregnant women was obtained from ADP's Perinatal Environmental Scan Summary Report prepared by Children and Family Futures, Inc. This report cites four studies with prevalence rates for drug use during pregnancy ranging from 3.5 percent to 11 percent. For this report, the mean rate, 7.2 percent was used to estimate the number of pregnant women who used drugs.

Number of CA Women who Gave Birth 2008	Rate of Drug Use	Number of Pregnant Women who Used Drugs
551,567	7.2	40,000

Note: Number of pregnant women who used drugs is rounded to the nearest 1,000.

The total number of pregnant women who need AOD treatment was estimated by adding the number of pregnant women who used alcohol to the number who used drugs. This method doesn't account for the overlap of pregnant women who use both alcohol and

other drugs, but provides a reasonable estimate in the absence of information on the overlap of use of alcohol and illicit drugs in this population.

Number of Pregnant Women who Used Alcohol	Number of Pregnant Women who Used Drugs	Pregnant Women Needing AOD Treatment
67,000	40,000	107,000

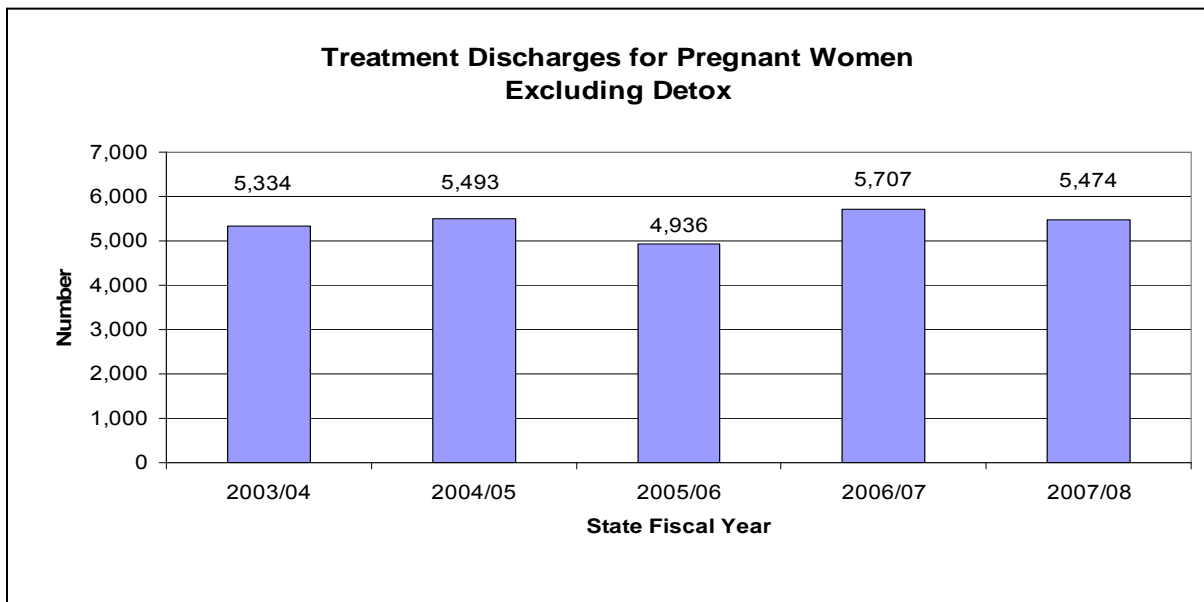
Note: Number of pregnant women who need treatment is rounded to the nearest 1,000.

Highlights

- Approximately 107,000 pregnant women in California used alcohol and/or drugs during pregnancy.

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

The following chart shows the number of pregnant women discharged from AOD treatment (excluding detoxification) for the last 5 years by ADP funded/licensed facilities. This includes women who were pregnant at admission or anytime during the treatment stay. There were 5,474 treatment discharges (excluding detoxification) in SFY 2007/08 for pregnant women.



Older Adults

The proportion of older Californians is expected to grow substantially over the next few decades. Substance abuse in older adults 60 years of age and older is frequently an invisible problem. SAMHSA’s Treatment Improvement Protocol (TIP26) reports that up to 17 percent of older adults misuse alcohol and prescription drugs. Multiplying California’s population 60 and older by this prevalence rate provides an estimate of those needing AOD treatment.

2009 CA Population (age 60+)	Rate of Alcohol and Prescription Drug Misuse (age 60+)	Number Needing Treatment (age 60+)
6,143,524	17.0	1,044,000

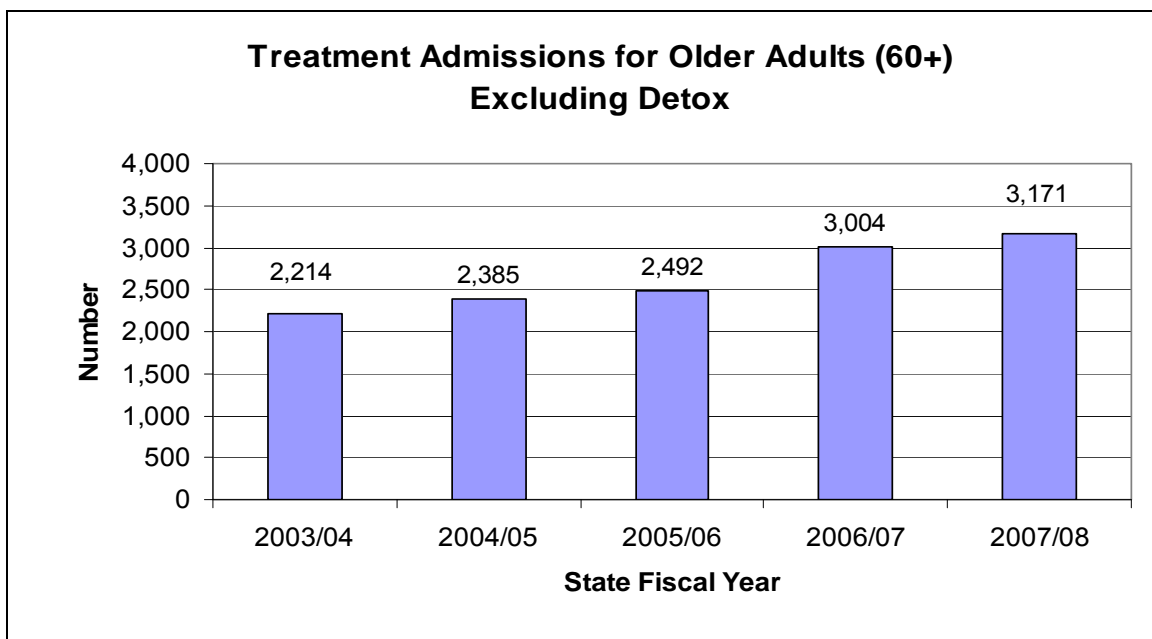
Note: Number needing treatment is rounded to the nearest 1,000.

Highlights

- Over one million older adults (60+) in California need services to prevent and treat drug misuse and abuse problems.

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

The following chart shows publicly-funded/licensed treatment admissions for older adults during the past 5 years. The number of older adults receiving AOD treatment increased 43% from SFY2003/04 to SFY 2007/08.



For this population, the estimate of service need is based on information on misuse of alcohol and other drugs. Therefore, this estimate does not meet the criteria for needing AOD abuse or dependence treatment. Not all of the service need estimate is for AOD treatment. Reducing and treating drug use problems will require an integrated system of care that combines prevention, medical and behavioral health services to fully address the spectrum of AOD use related problems among the growing elderly population.

Homeless

Although obtaining an accurate, recent count is difficult, the Substance Abuse and Mental Health Services Administration (2003) estimates, 38 percent of homeless people were dependent on alcohol and 26 percent abused other drugs. Alcohol abuse is more common in older generations, while drug abuse is more common in homeless youth and young adults (Didenko and Pankratz, 2007). Substance abuse is much more common among homeless people than in the general population.

The homeless population is difficult to estimate since it constantly fluctuates and a variety of methodologies are used by different agencies using various definitions of homelessness. For the purposes of this report, the number of homeless in California for 2007 was obtained from the National Alliance to End Homelessness' website. This number is a point in time (one day) estimate of 159,732.

2007 CA Homeless Population	Prevalence Rate of Alcohol Abuse among the Homeless	Prevalence Rate of Drug Abuse among the Homeless	Combined AOD Abuse Prevalence	One Day Count of Number of Homeless Needing AOD Tx
159,732	38%	26%	64%	102,000

Note: Number needing treatment is rounded to the nearest 1,000

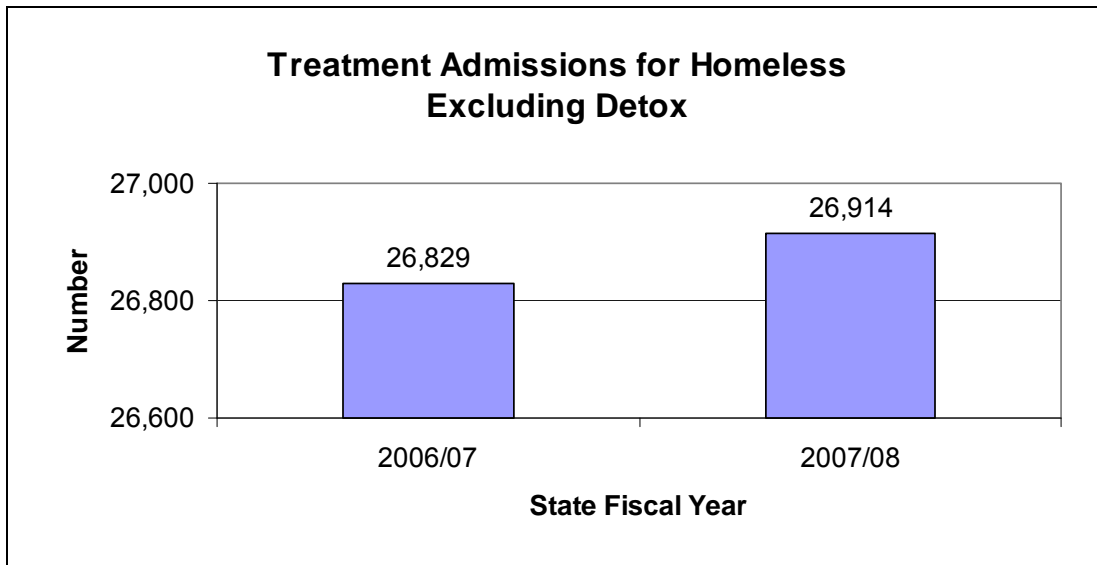
This method doesn't account for the overlap of homeless who use both alcohol and other drugs, but provides a reasonable estimate in the absence of information on the overlap of use of alcohol and illicit drugs in this population.

Highlights

- Over 100,000 California are homeless and in need of AOD treatment on any given day. This estimate varies from those for the other special populations in that it is a one day estimate rather than an annual estimate.

Once again, the 4.8% overall population estimate generated from NSDUH is used to estimate the percentage of this subpopulation in need of treatment who actually seek it, because there is no available estimate for this specific subpopulation.

Homelessness was collected as an optional data item on CADDSS; therefore the data does not show a reliable representation of the treatment population and is not shown here. Two years of CalOMS treatment data is shown in the chart below.



Veterans

The number of veterans in California was obtained from the 2007 American Community Survey. This survey uses set standard age groups for veterans. The group “Age 18 and over” was used for this analysis.

The U.S. Department of Veterans Affairs estimated that one fifth (20 percent) of veterans had a substance use disorder between 2001 and 2005.

The number of veterans in need of treatment is estimated by multiplying the number of California vets by the percentage estimated to have a substance abuse disorder.

2007 CA Veteran Population (Age 18 and older)	Percentage with Substance Abuse Disorder	Number Needing Substance Abuse Treatment
2,079,606	20%	416,000

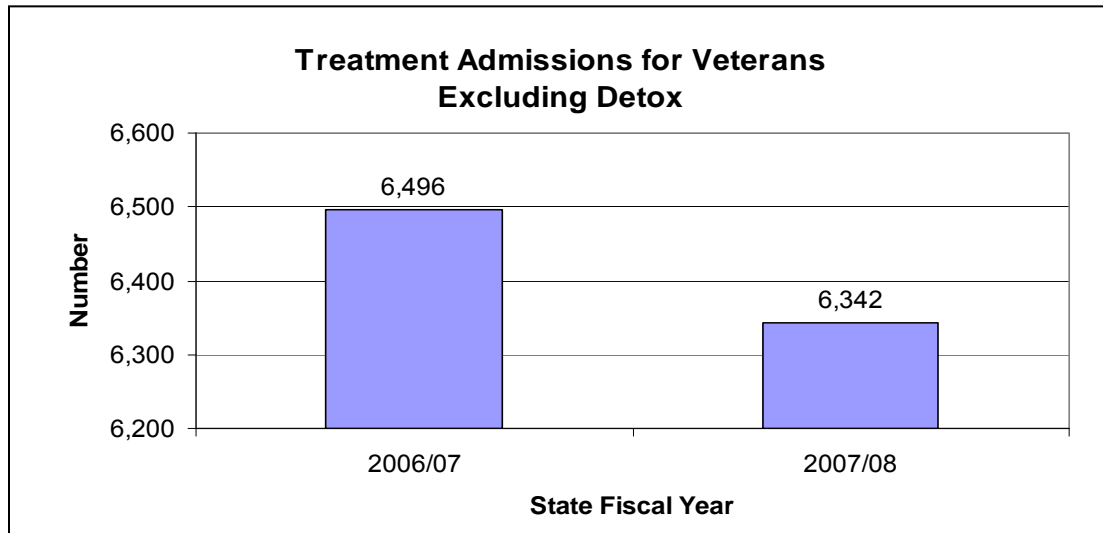
Note: Number needing treatment is rounded to the nearest 1,000

Highlights

- Approximately 416,000 veterans in California need AOD treatment.

Once again, the 4.8% overall population estimate generated from NSDUH is used to estimate the percentage of this subpopulation in need of treatment who actually seek it, because there is no available estimate for this specific subpopulation.

Many veterans have health benefits which cover treatment for substance abuse problems. Veterans who receive services from facilities that are run by the Department of Veterans Affairs or other facilities who are not required to submit data to ADP are not counted in ADP's treatment system. Information on veteran's status is collected in the CalOMS treatment data system but was not collected in CADDs. Therefore, only two years of treatment data is shown in the chart below.



Co-Occurring Disorders

The National Survey on Drug Use and Health (NSDUH) includes questions for adults aged 18 or older to assess serious mental illness (SMI) during the year prior to the survey interview. SMI is defined for the NSDUH report as having had at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

Co-occurring disorders (COD) refers to a combination of at least one SMI and at least one substance abuse disorder. NSDUH found that during 2002 about eight percent of all adults had a SMI in the past year, and that about 23 percent of these persons also were dependent on or abused alcohol and/or an illicit drug. NSDUH also found that 52 percent of adults with co-occurring SMI and a substance use disorder received neither mental health nor specialty substance use treatment during the past year.

Given these NSDUH findings the following California estimates are provided of adults with co-occurring disorders and those who need treatment:

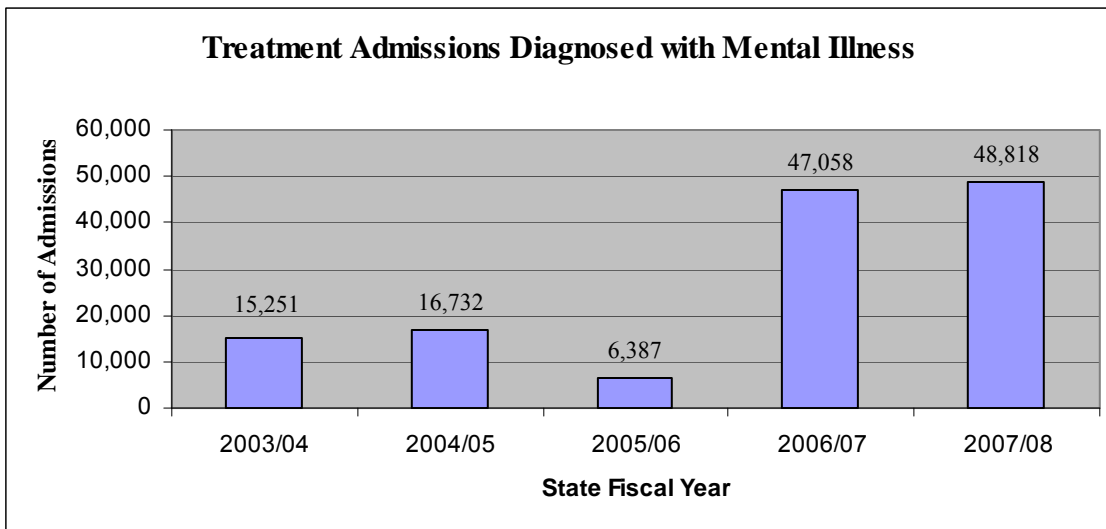
2009 CA Adult Population	Prevalence Rate of Co-occurring Disorders (8 % x 23 %)	Number of Adults with Co-occurring Disorders	Percentage of Co-occurring Not Receiving Mental Health or AOD Treatment	Number of Adults with Co-Occurring Disorders Needing Substance Abuse Treatment
28,695,960	1.8%	528,000	52%	275,000

Note: Numbers with co-occurring disorders and needing treatment are rounded to the nearest 1,000

Highlights

- There are approximately 275,000 adults in California with serious mental illnesses that also need AOD treatment.

Diagnosed with mental illness moved from an optional data collection question in the CADDs Tx data system (2003/04 - 2005/06) to a required data collection question in the CalOMS Tx data system (2006/07 – 2007/08), which likely accounts for the increase in incidence. Treatment admissions diagnosed with mental illness is fairly stable with a slight increase of 47,058 to 48,818 over the two years of required reporting. Because treatment admissions diagnosed with mental illness data is based on client self reporting; due to the nature of mental health issues it is believed that this data is under-reported.



Treatment Need

This section compares the demographic characteristics of persons needing but not receiving AOD treatment developed in the previous section with: a) California general population, and b) ADP’s CalOMS treatment population.

For comparability each of these groups only include persons 12 years of age and older. The estimates of persons needing but not receiving treatment by age group are based on NSDUH data for California. However the estimates of persons needing but not receiving

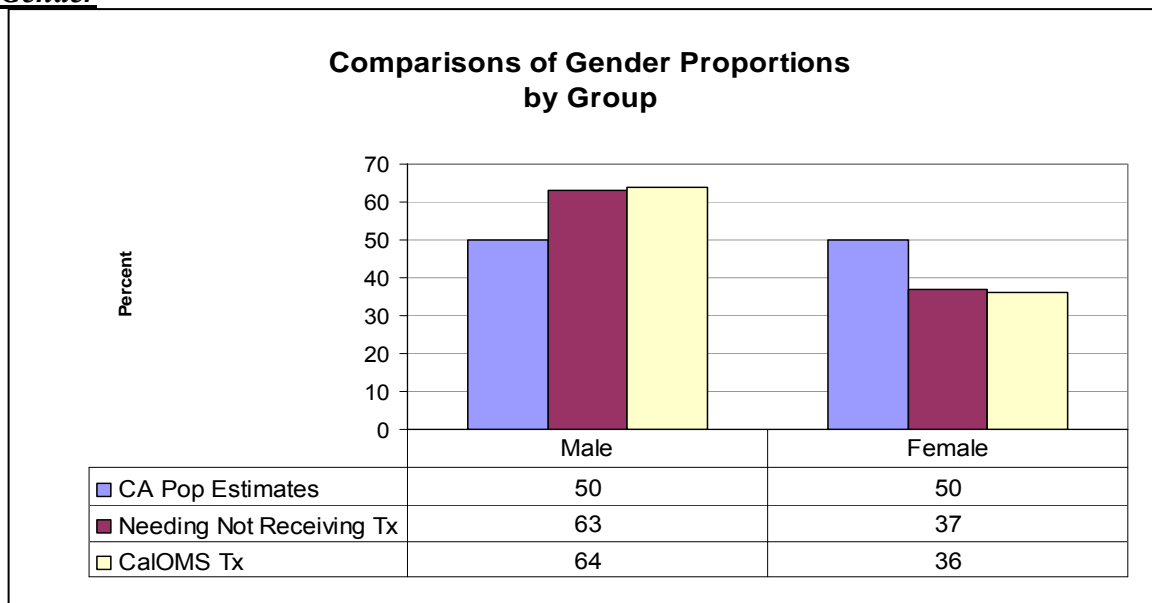
treatment by gender and race/ethnicity groups use national NSDUH data because California specific data was not available. The approximately three million Californians needing but not receiving treatment represents the number of potential new clients who are not currently receiving any AOD treatment services. However, NSDUH estimates that only 4.8 percent of these clients felt they needed treatment, and thus would likely seek it. Some of these clients may seek treatment in facilities under ADP’s purview while others may seek treatment from other facilities.

The California Department of Finance’s Demographic Research Unit developed the California population estimates with demographic characteristics for 2009.

CalOMS collects data on clients that receive treatment services from ADP monitored and/or publicly-funded programs. The data represents unique clients served during SFY 07-08. The number of clients served is the sum of the number of new admissions and the number of clients admitted in a prior year but still receiving treatment services during SFY 07-08. CalOMS does not collect data from clients receiving services from tribal or federal governmental entities or from many private, for-profit facilities. CalOMS clients typically include people of low socio-economic status (e.g. income, education, and occupation) and many are referred to treatment through the criminal justice system. Therefore, the characteristics of clients receiving treatment in CalOMS do not represent the characteristics of all clients in treatment.

Conclusions based on comparisons between these groups should not be made in isolation of other indicator data. Other data sources may reveal patterns within subgroups that are not shown using only NSDUH data. For example, it may not appear that African Americans overall need focused treatment efforts. However data from another source may indicate that African American youth have a particular high need for treatment services. Furthermore, barriers to treatment should be identified specific to subgroups so that services can be provided to those in greatest need of treatment services.

Gender



Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates a higher proportion of males need treatment than are represented in the general California population.
- Conversely, a lower proportion of females need treatment than the proportion found in the general California population.

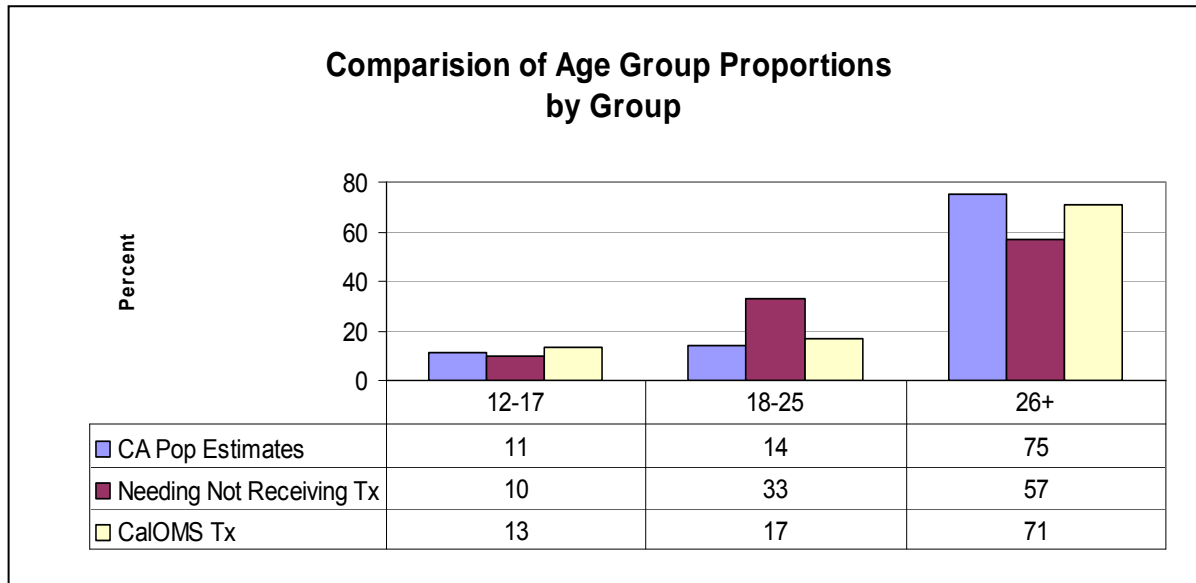
Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- The gender proportions in CalOMS are very similar to the proportions needing but not receiving treatment estimated by NSDUH.

Implications

- If the additional clients estimated by NSDUH to need treatment were to seek it, their gender proportions would be very similar to those already receiving treatment in ADP monitored/funded treatment programs. However, as previously mentioned the characteristics of the CalOMS clients do not represent the entire population who need AOD treatment.

Age Group



Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates that lower proportions in the 12 through 17, and 26 and older age groups still need treatment, compared with their respective proportions of the general California population.

- NSDUH estimates that a higher proportion in the 18 through 25 age group still needs treatment compared with their proportion of the general California population.

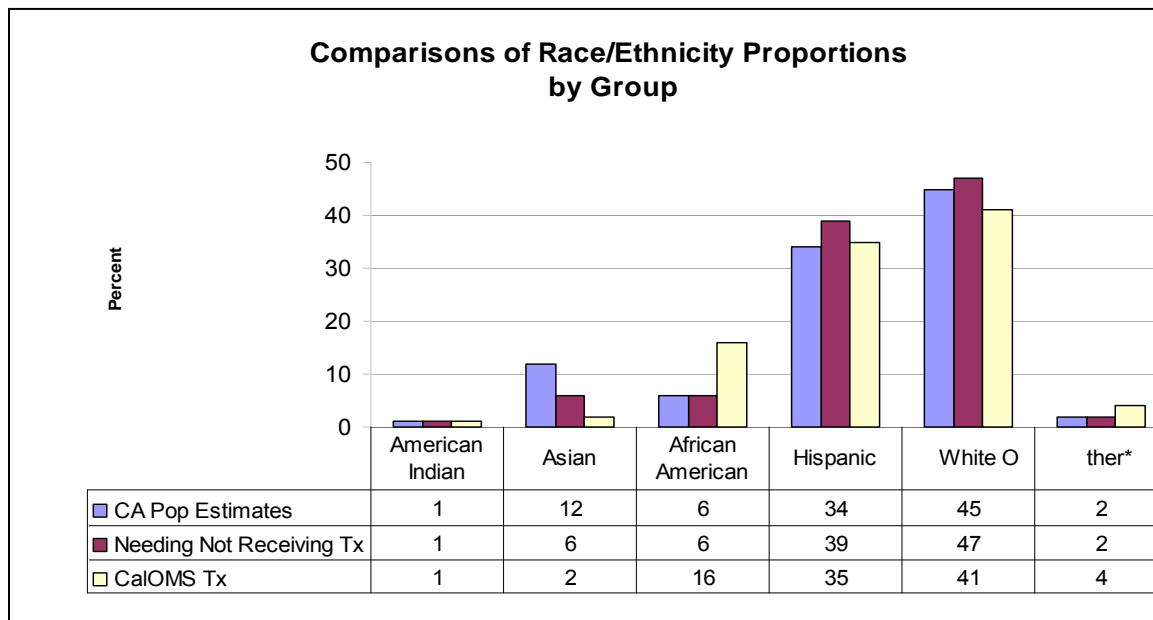
Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- Those in age groups 12 through 17, and 26 and older have higher percentages in treatment than their respective percentages of the total needing but not receiving treatment.
- Conversely, those in the 18 through 25 age group have a higher percentage needing but not receiving treatment than their respective percentage of the total in treatment.

Implications

- If the additional clients estimated by NSDUH to need treatment were to seek it, a larger proportion would be from the 18 through 25 year old age group than those already receiving treatment in ADP monitored/funded treatment programs. As previously mentioned, characteristics of CalOMS clients do not represent the entire population who need treatment in California. Also, the NSDUH estimates of treatment need are based on criteria of abuse and dependence that may surpass use patterns for the younger 12 through 17 age group. Therefore further investigation of those in the younger age groups whose use patterns that did not meet the dependence criteria may reveal a need for less intensive services including prevention, intervention and/or brief treatment. .

Race/Ethnicity



* Other includes Pacific Islanders and Multiple Race Groups

Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates a higher need for treatment in the Hispanic and White populations than their proportions of the general California population.
- Asians, on the other hand, have less needing but not receiving treatment than their proportion of the general California population.
- American Indians, African American, and the "Other" race/ethnicity group, have percentages needing but not receiving treatment that are equal to their respective proportions of the general population.

Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- American Indians have equal percentages of the total in treatment, and needing treatment.
- Asians, Hispanics, and Whites have higher percentages needing but not receiving treatment compared with their respective percentage of the total in treatment.
- African Americans and the "Other" race/ethnicity group have higher percentages in treatment compared with their respective percentage of the total needing but not receiving treatment.

Implications

- If additional treatment was available, the NSDUH estimates show that certain race/ethnicities have higher proportions of their group needing treatment than others. In particular, Asians, Hispanics and Whites have higher percentages needing treatment than are currently being treated in publicly monitored treatment. However, as previously mentioned, the characteristics of CalOMS clients do not represent the entire population who need treatment in California. Additional data sources should be examined to determine specific treatment needs and barriers (e.g., socioeconomic, language, transportation) to treatment among the various race/ethnic subpopulations.

Recovery Support Services Need

Evidence has shown that providing Recovery Support Services (RSSs) results in increased effectiveness of services and reduced preventable re-admissions, which can help lower overall treatment costs and other societal consequences that arise from AOD disorders. Currently in California, RSS is mostly unfunded except for special grants and pilot projects. For COSSR to be fully realized, investments in RSS must be made in order to fully benefit from a continuum of services system. As health care reform is implemented nationwide, now is a logical time to reevaluate funding streams to ensure RSS is a funded component of the continuum.

California Gambling Services Need

Based on prevalence estimates in the 2006 California Problem Gambling Prevalence Survey, following are the number of California problem gamblers by severity for age, gender and race/ethnicity. All population numbers used for calculating the need came from the State of California Department of Finance, *Race/Ethnic Population with Age and Sex Detail 2000-2050*, July 2007.

Age	Total At Risk Gamblers	Total Problem Gamblers	Total Pathological Gamblers	Total Prevalence %	Total Need*
18-29	829,131	200,596	100,298	16.90%	1,130,026
30-39	500,590	140,791	83,432	13.90%	724,813
40-64	1,086,921	199,894	212,387	12%	1,499,202
>65	296,810	86,032	21,508	9.40%	404,350
Totals	2,713,452	627,313	417,625		3,758,390

*Total Need varies as prevalence rates for specific population groups vary.

Race	Total At Risk Gamblers	Total Problem Gamblers	Total Pathological Gamblers	Total Prevalence %	Total Need*
White	1,216,750	213,934	187,192	12.10	1,617,876
Hispanic	889,035	277,823	138,912	14.10	1,305,770
Asian	271,460	83,248	25,336	10.50	380,044
African American	240,205	39,182	69,847	20.50	349,234
Other**	118,600	37,063	12,601	22.70	168,264
Total	2,736,050	651,250	433,888		3,821,188

*Total Need varies as prevalence rates for specific population groups vary.

**Other includes: Native Hawaiian, Pacific Islander, Native American, Middle Eastern, Multi-Racial and unspecified other.

Gender	Total At Risk Gamblers	Total Problem Gamblers	Total Pathological Gamblers	Total Prevalence %	Total Need*
Male	1,661,776	440,300	326,674	17.10%	2,428,750
Female	1,057,970	188,406	101,449	9.30%	1,347,825
Total	2,719,746	628,706	428,123		3,776,575

*Total Need varies as prevalence rates for specific population groups vary.

Highlights

- Approximately 3.8 million Californians have some level of gambling issue (i.e., at risk, problem or pathological).
- Approximately one million Californians need treatment for problem or pathological gambling.
- While African Americans have the highest prevalence rate, Whites and Hispanics have a larger number of people with gambling issues due to their higher numbers in the overall population.

While the data above show a sizeable number of Californians with gambling issues, the research suggests that anywhere from 3 percent to 10 percent of problem and/or pathological gamblers would seek treatment for their problem. This means that between 30,000 to 100,000 would seek treatment.

In Summary

This chapter relies on a variety of methodologies to assess and estimate the AOD continuum of services and problem gambling need in California. Prevention, early intervention, and treatment estimates of need are calculated for the California population by age, gender, race/ethnicity and for the special subpopulations of pregnant women, older adults, the homeless, veterans, and individuals with co-occurring disorders. Treatment need for problem gamblers is also estimated. The specific findings are:

Prevention/Early Intervention Need

Prevention and early intervention services are critical components of the continuum of services in California. The degree to which these services are effective will impact the future need for treatment services.

- Prevention strategies directed toward youth are especially important because there is a strong potential to avoid substance abuse problems before they start. Universal implementation of effective school-based prevention programs could delay at least three percent to 25 percent of youth from starting to use.
- Over 3 million youth ages 12 to 20 are in need of Universal prevention strategies.
- Approximately 300,000 16 to 17 year olds are in need of Selective prevention interventions, such as Student Assistance Programs.
- Early intervention strategies such as SBIRT reduce the risks and consequences related to alcohol and other drug use consumption, eliminate high-risk AOD use, and increase motivation for behavioral change, up to and including referral to specialized AOD treatment services.

- Young adults age 21 to 25 display the highest use patterns and harms related to risky and excessive use (i.e., binge drinking, illicit substance use, poly drug use, heavy use).
- Between 750,000 and 1.3 million young adults age 21 to 25 could benefit from early intervention services (such as SBIRT).

Treatment Need

- Over 3.3 million Californians age 12 and older are estimated to need, but are not receiving, AOD treatment.
- Overall young adults 18 to 25 years of age have the highest percentage (23.87 percent) needing, but not receiving AOD treatment. They account for over one million people in need of treatment.
- Although the 26 and older age group has the lowest overall percentage (7.91 percent) needing treatment, it has the largest overall population, therefore, they account for nearly two million people in need of treatment.
- Males have a higher percentage and number needing, but not receiving treatment, than females.

Subpopulation Treatment Need

- American Indians have the highest percentage (10.2 percent) needing, but not receiving treatment with Hispanics second highest (9.2 percent).
- Given their respective large percentages of the overall population, both Hispanics and Whites account for the largest proportions in need of treatment. Each group constitutes over one million people in need of treatment.
- Approximately 107,000 pregnant women in California used alcohol and/or drugs during pregnancy in 2008.
- Over one million older adults aged 60 and older need treatment primarily for alcohol and prescription drug misuse.
- Over 100,000 Californians are homeless and in need of AOD treatment on any given day.
- Approximately 416,000 veterans in California need AOD treatment.
- There are approximately 275,000 adults in California with serious mental illnesses that also need AOD treatment.

Problem Gambling Treatment Need

- Approximately 3.8 million Californians have some level of gambling issue (i.e., at risk, problem or pathological).
- Approximately one million Californians need treatment for problem or pathological gambling.

Chapter 5: What Does the Data Tell Us?

The data in this report suggest many things specific to AOD and problem gambling service need. They outline use trends over time, estimates of service need, the current system's operations, and discussions of effective strategies and practices. This chapter provides an analysis of the data and categorizes findings by system, by substance, and by population.

The AOD System Findings

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

The Continuum of Services

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

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

In addition, with the prevention emphasis related to health care, AOD prevention efforts become doubly important because prevention has become a key component of the health care model. New funding strategies and sources need to be identified in order to mirror that importance in the AOD system. When the "treatment" benefits from effective prevention efforts are examined as part of the system performance, then a re-evaluation of traditional funding priorities must also be considered and new funding sources identified.

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

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

The treatment system path has been set and should continue focusing on increasing treatment effectiveness for those it serves as it continues to transition to a chronic disease model of treatment.

- Recovery support services are recognized as critical components of the continuum of services in California and need further development. Widespread capacity building will not be possible without a dedicated or allowable funding source.
- Performance measures and data-informed planning and decision making models continued to be implemented at the local and state level. These are not fully integrated throughout the system as of yet and are still being embedded within operations at the provider, county and state levels. Continuing in this direction will be important for the AOD system going forward.

Health Care Reform

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

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

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

Also, of the 4.5 million additional insureds, a conservative estimate is that in excess of one million of those will be insured through the public benefit, Medi-Cal in California. If 10 percent (the rate of those needing but not receiving treatment) of those, or approximately 100,000 need treatment, then the Medi-Cal authorization, billing and monitoring system capacity needs to be expanded, as well as an aligning of the current primary care Medi-Cal system and the Drug Medi-Cal system which currently operate separately. A thorough examination of the changes required to the Medi-Cal system must be undertaken to sort out the issues and ensure an efficient system with the capacity for expansion.

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

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

Finally, data collection and reporting must be further developed and refined in order to provide accurate estimates, describe relevant aspects of current clients (i.e., insurance status, parenting status, other public benefit status, matriculation through services), and project service use patterns for different levels of service need.

These are some fundamental steps that can be taken now:

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

- Further developing the data collection and reporting system capacity is an important component for the decision-making process going forward.

Substance-Based Findings

The data in the preceding chapters is used in the following analysis of determining the substances for priority setting consideration.

Alcohol

The data in this report clearly indicates that alcohol is the biggest substance problem in the state. The following two tables summarize the overall substance use patterns presented in the preceding chapters. The first table displays the relative prevalence of alcohol and other drug usage among California's overall population 12 years old and older, and the estimated percentage of these people needing but not receiving, treatment. The second table highlights the primary drugs of choice among people entering publicly funded treatment services.

Drug Use in California 12 years and older based on 2006-07 NSDUH

	12 years and older
Past month alcohol use	49.6%
Past month binge drinking	21.6%
Past month marijuana use	6.6%
Past month other illicit drug use	4.0%
Past year non-medical use of pain relievers	5.4%
% needing but not receiving tx for illicit drugs	2.57% (827,367 Californians)
% needing but not receiving tx for alcohol	7.8 % (2,511,075 Californians)

Top 5 Primary Drugs for 07/08 admissions

Top 5 Primary Drugs at Admission excluding detox – CalOMS 07/08	% of Total	Top 5 Primary Drugs at Admission Detox only – CalOMS 07-08	% of Total
Methamphetamine	34.3%	Heroin	36.3%
Alcohol	19.8%	Alcohol	31.0%
Marijuana/Hashish	18.8%	Methamphetamine	11.7%
Heroin	12.0%	Cocaine/Crack	10.6%
Cocaine/Crack	10.7%	Prescription Drugs	8.5%

Together these tables indicate:

- Alcohol is by far the most prevalently used substance.

- The second highest used substance is marijuana which is used 7 ½ times less than alcohol.
- The number needing but not receiving treatment for alcohol abuse or dependence is over three times more than those needing but not receiving treatment for illicit drug abuse or dependence.
- 80 percent of admissions into the publicly funded treatment system (excluding detoxification services) were for illicit drugs and 20 percent were for alcohol. This proportion has been relatively stable over the five years of data presented in this report. (This is likely the result of the treatment system's categorical funding structure which requires priority for specific populations. The 50 percent treatment referral rate from the criminal justice system impacts the treatment admissions by primary drug which accounts, at least in part, for the high percentage of illicit primary drug admissions.)

Based on student surveys, the consumption patterns for California's youth are similar. In 2007/08, 41.9 percent of 11th graders reported past 30-day use of alcohol, 29 percent past 30-day binge alcohol use and 26.2 percent past 30-day illegal drug use. Reported lifetime use for 11th graders was 66.4 percent alcohol, and 45.6 percent any illegal drug. Those considered High Risk Users (illicit drug) and Excessive Alcohol Users show progressively higher percentages of use from 7th grade through 11th grade as shown below with over 12 percent more Excessive Alcohol Users than High Risk Users.

California Student Survey - 2007/08

	7 th Graders	9 th Graders	11 th Graders
High Risk Users – Illicit Drugs	3.0%	8.3%	16.8%
Excessive Alcohol Users	5.6%	17.5%	29.2%

The research indicates that stopping or delaying youth from starting AOD use has a strong potential to avoid substance abuse problems before they start. The CalOMS Prevention data below indicates that youth is the major focus of publicly funded prevention efforts currently.

CalOMS Prevention Services by Age – 2007/08

Age Group	Number of Persons Served	% of Total Served	Rate Served per 1,000 population
0 through 11	69,903	12.3%	10.8
12 through 17	301,320	52.9%	84.6
18 through 25	60,653	10.7%	13.9
26 through 44	81,221	14.3%	8.0
45 through 64	47,051	8.2%	5.1
65 and older	9,092	1.6%	2.2

According to the CalOMS Prevention data, nearly 2/3 of publicly funded prevention services are targeted to the under-18 year old age groups.

These substance-based findings consistently show that consumption patterns and need for treatment are highest for alcohol. According to the NSDUH survey, 50 percent of 12+ year olds in California are estimated to have drunk alcohol, and 22 percent have reported binge drinking, within the past 30 days. Although alcohol consumption is legal for adults (21 years and older), the widespread use of alcohol is related to substantial negative individual, family and societal consequences. This is especially true for underage drinkers, with 30-day alcohol prevalence rates of 42 percent for 11th graders, and 26 percent reporting binge drinking. Estimates of treatment need are consistently highest for alcohol as well. However, publicly funded treatment data do not show alcohol as the number one drug of choice among those admitted for treatment services.

Marijuana

Marijuana is consistently reported as the second most commonly used drug after alcohol, and by far the number one illegal drug used. The 2006-07 NSDUH estimate for California is 6.6 percent of all 12+ year olds, but the California Student Survey (CSS) numbers suggest a much higher prevalence (24 percent) among young students.

Prescription drugs and opiates

There has been a growing awareness, and recent documentation of, the emerging problems related to the non-medical use of prescription drugs, primarily opioids such as hydrocodone and oxycodone, and other over the counter drugs. Although there are no direct comparisons to other substances for 30-day use, the California NSDUH estimate for past year non-medical use of prescription drugs is 5.4 percent and the CSS estimate for lifetime usage among 11th grade students is 18 percent. The percentage climbs to 35 percent when over the counter drugs are included. These numbers suggest a rapidly growing problem with potentially severe consequences (e.g., overdose poisoning and deaths).

Based on hospitalization and emergency department trend data, the rates for opiate related hospitalizations and emergency department visits is increasing particularly for opiate poisonings. There is also some indication that the increase in the prescription drug problem (primarily opioids) is leading to higher use of heroin.

Methamphetamine

Even though law enforcement still considers methamphetamine the greatest drug threat in California from a criminal justice perspective, prevalence and consequence data from other perspectives suggest a focus on other substances. There have been substantial decreases in amphetamine related hospitalizations and emergency department visits over the three year trend observed, 42 percent and 40 percent respectively. There has also been a corresponding decrease in CalOMS Treatment admissions for methamphetamine from a high in 2005/06 of 41 percent to just over 34 percent in 2007/08. While still the highest primary drug of abuse for treatment admissions, that trend is showing a decline.

Population-Based Findings

The data in the preceding chapters is used in the following analysis of specific populations.

Overall Need

Overall AOD services need has been estimated in this report. Following is a summary of the general findings for the continuum of services need in California.

- Over 3 million youth aged 12 through 20 could benefit from universal prevention strategies.
- Approximately 300,000 youth 16 to 17 years old could benefit from selective prevention strategies.
- Approximately 750,000 to 1.3 million 21 to 25 year olds can benefit from early intervention strategies.
- Overall treatment need in California is estimated to be 3.3 million people.

Age Comparisons

Population*	Age 12+	Ages 12-17	Ages 18-25	Age 26+
% of CA population aged 12 years and older	100%	10.9%	14.3%	74.8%
Prevalence Rates (NSDUH)				
% Past month alcohol use	49.6%	15.5%	58.6%	52.8%
% Past month marijuana use	6.6%	6.8%	17%	4.5%
% Past month illicit drug use excluding marijuana	4%	4.7%	8.4%	3.1%
% Past year non-medical use of pain relievers	5.4%	6.6%	12%	3.9%
% Needing but not receiving tx for alcohol/illicit drugs	10.37%	9.74%	23.87%	7.91%
Services and Needs				
% of 07/08 CalOMS Pv served	100%	60.3%	12.1%	27.5%
% of 07/08 CalOMS Tx admissions excluding detox	100%	13.5%	19.1%	67.4%
% of overall total Treatment Need in CA	100%	10.2%	32.9%	57%

*NSDUH survey data is available only for persons 12 and older. Prevention and Treatment services are available for younger person but are excluded in this chart for comparison purposes.

It is clear strictly from a numbers perspective that the 26 and older age group has the highest number of people who could benefit from substance abuse services because it includes the broadest range of ages (i.e., over 40 years); however, the 18 to 25 year old age cohort has the highest rates of alcohol and illicit drug use, the highest percentage needing but not receiving treatment and the second highest percentage of the treatment need, likely a function of the smaller cohort size compared to the 26 years and older age group.

The 18 to 25 year old age group should be a priority population for prevention, early intervention and treatment activities. However, because the vast majority of youth in this age group start their AOD use in their earlier teen years, focusing prevention efforts on the younger age group is also a method of positively impacting the prevalence rates for the 18 to 25 year old age group.

Race/Ethnicity

A thorough analysis of how race/ethnicity impacts prevalence rates; service need, use and outcomes; and the consequences of AOD use is critical in a state as diverse as California. The analysis can enhance understanding of the needs of the population requiring services, provide a data-informed approach to setting policies that could impact different groups, and focus service strategies on the most effective practices.

Limited race/ethnicity data was provided in this report which only serves to inform the reader on some of the issues specific to certain races/ethnicities (i.e., high rate of Hispanic DUI arrests, high rate of African American narcotics arrests, high rate of white women using alcohol during pregnancy). However, all the data necessary to conduct the analysis described above was not available at the time of this report. Subsequent reports must include this data and analysis for a more complete understanding of the AOD service needs in California.

Specific Subpopulations

Specific subpopulations that were examined in this report are listed by priority below based on total estimated number in need of treatment. Only the subpopulations examined in this report are considered for discussion. It should be noted however, that other public service systems may also provide substance abuse treatment services for their specific population which is not calculated into the estimated need identified below (e.g., Veterans Administration, County Mental Health Departments).

1. Approximately 416,000 veterans in California are in need of treatment services.
2. Approximately 275,000 Californians with a serious mental illness and a concurrent alcohol and/or drug problem are in need of treatment services.
3. Approximately 107,000 pregnant women in California are in need of treatment services.
4. Approximately 102,000 homeless Californians are in need of treatment services.

In addition, there are over one million older adults aged 60 years or older who need some level of AOD service. This estimate is based on AOD misuse rather than abuse or dependence, therefore, treatment is not necessarily indicated. The evidence suggests that the misuse is primarily with alcohol and prescription drugs.

In Summary

Based on the foregoing analysis, the following recommendations are provided.

Recommendations for the Continuum of Services

- Employ more science-based population level prevention strategies.
- Identify new funding or resource strategies to expand Prevention activities in California.
- Build the AOD system capacity for early intervention strategies such as SBIRT.
- Continue to focus on increasing treatment effectiveness through strategies such as evidence-based practices, process improvements, performance measures, etc.
- Build the AOD system capacity for Recovery Support Services including identifying funding or other resource strategies.

Recommendations for Health Care Reform

- Develop a plan based on the “knowns” of health care reform and add to it as further information and details come to light.
- Consider how to partner with and educate the primary care system on AOD issues.
- A thorough examination of the Medicaid and California's Medi-Cal system must be undertaken in relation to impacts on the AOD system and services.
- Understanding and planning for the uninsured population will be just as important as building capacity to serve additional insured individuals.
- Appropriately preparing and developing the AOD workforce will be a critical step.

Recommendations for Specific Substances

- Institute specific programs aimed at preventing and reducing the high rate of underage and excessive alcohol use and abuse.
- Institute strategies to arrest the growth of prescription drug and opiate abuse.

Recommendations for Specific Populations

- To address overall need:
 - Target youth aged 12 through 20 for evidence-based universal prevention strategies.

- Target youth aged 16 and 17 years old for evidence-based selective prevention strategies.
- Target young adults aged 21 through 25 for evidence-based early intervention strategies.
- Target youth aged 18 through 25 for evidence-based prevention, early intervention, and treatment services.
- Complete an in-depth analysis of race/ethnicity data to understand its relationship to the AOD service needs in California to inform program decisions.
- Consider instituting programs to increase the treatment capacity for the following subpopulations in the listed order:
 - Veterans
 - Individuals with SMI and a concurrent AOD problem
 - Pregnant women
 - Homeless individuals

Chapter 6: Next Steps in the SNAP Process

It is important to note that the SNAP process is evolving and expected to improve with every cycle. As additional stakeholders become engaged in the process, the benefits of this data-informed decision making process will become more widespread as well. Much work has been done, but there is much work yet to be done to fully realize the vision of SNAP.

Going Forward

AOD Surveillance System

Of primary importance to the SNAP effort is identifying and developing valid reliable data sources. To that end, since 2007 ADP has received SAMHSA funds and partnered with the California Department of Public Health (CDPH) to establish a Statewide Epidemiological Outcomes Workgroup (SEOW) Project whose primary task is to build state ADP and local capacity to create and maintain an AOD surveillance system. The SEOW Project has developed criteria for identifying and assessing data sources and indicators:

- Valid measurements
- Reliable measurement
- Representative of populations of interest
- Appropriate level of focus (i.e., national, state, county, neighborhoods/communities, program)
- Capture relevant information
- Available on regular, timely & affordable basis
- Services data system

The SEOW Project has also developed a conceptual framework for organizing the data sources and indicators to be included in the surveillance system as presented in Chapter 2. Once the data sources are identified, their strengths and weaknesses are assessed and data indicators are selected for each domain. Not all domains have data sources that meet all or most of the criteria for useful surveillance data. Finally the data indicators for each domain are summarized and prepared for analyses. Chapter 2 summarizes the results of these analyses for those domains where useful valid and reliable data are available.

The SNAP Process

The next step in the SNAP process is planning. Based on lessons learned from last year's test process, ADP has established an explicit decision making process for selecting priority focus areas and allocating resources. A preliminary model has been used by ADP's Governor's Prevention Advisory Council (GPAC) to select its interagency

priorities. The model is based on the recently published priority setting criteria employed by the Military Injury Prevention Working Group. This model makes explicit that the decision making process can be data informed, but also involves several equally important factors.

The interdepartmental management team in partnership with a selection of county administrators will apply these criteria to select the priorities. Once selected, the priorities will be shared widely within ADP and stakeholder groups. Management and budget will allocate resources among priorities based on continuing commitments and new or expanded efforts. Staff can then develop/modify strategic and operational plans. These plans will include:

- SMART (Specific, Measurable, Attainable, Realistic, Timely) objectives
- Logic model with testable rationales for each assumption
- Best practices
- Ongoing performance management & measurement
- Process benchmarks
- Short and medium term outcomes
- Evaluation design
- Feedback to SNAP process

The SNAP process, the AOD surveillance system, and the annual Needs Assessment Reports (NAR) will provide ADP with a framework and the ongoing data tools necessary for developing statewide data-informed priorities and subsequent plans based on the identified priorities. It will also be of value to local county planning efforts by modeling the SPF process at the state level, providing valuable guidance on data sources and analyses, and setting clear statewide goals and expected outcomes.

Aknowledgements

The 2010 California Needs Assessment Report is a collaborative effort between numerous Department of Alcohol and Drug Programs (ADP) Executives, Managers, Staff, and other State and County agencies. Through support from ADP's Director Renee Zito and Chief Deputy Director Michael Cunningham the Performance Management Branch (PMB) was able to develop a data-informed Statewide Needs Assessment and Planning (SNAP) process and deliver a product that will help decision makers in setting state-level priorities.

The SNAP Report Development Team (RDT) lead by Marcia Yamamoto, PMB manager, under the direction of Dave Neilsen, Deputy Director of the Program Services Division, guided development and production of this report. The RDT members consisted of internal ADP and external contributors whose hard work and dedication made this report possible. ADP Team members are Amy Peterson, Brian Snow, Mary Dodson, Katrina Parker, and Dr. Stephen Bright. The RDT external Team member is Dr. Steve Wirtz from the Department of Public Health. Former ADP Team members who were instrumental in the completion of the report were Tara Murphy and Denise Wallace Warrick.

Gratitude must also be extended to the many ADP divisions who have provided information and lent their expertise to the contents of this report. Those contributing Offices/Divisions are the Office of Criminal Justice Collaboration, the Office of Applied Research and Analysis (OARA), Program Services Division Treatment and Prevention, and the Office of Problem Gambling. Other acknowledgements go to the Division of Administration, the Information Management Services Division, the Office of Grants Management and the Resource Center.

Special thanks go to Stephen Bright, Ph.D., Coordinator, State Epidemiological Outcomes Workgroup (SEOW) and Research Scientist, OARA, ADP, and to Steve Wirtz, Ph.D., Chief, Violent Injury Surveillance Unit, Safe and Active Communities Branch, California Department of Public Health for their due diligence and expertise in analyzing AOD trends and projections. Special thanks also go to Craig Chaffee, Research Program Specialist II, OARA, and Sally Jew-Lochman, Research Program Specialist II, OARA, for their major contributions in calculating the treatment need and providing additional data and expertise to this effort.

Technical assistance was received through the joint effort between the SEOW Project, a partnership between the Safe and Active Communities Branch of the California Department of Public Health and ADP through an interagency agreement funded through Synectics from SAMHSA.

And special acknowledgement must be extended to Johnny Walker and Sharee Knight for their technical expertise and assistance in the packaging and production of this report.

Appendices

The Patient Protection and Affordable Care Act Summary of Provisions

The health reform law (Affordable Care Act) that President Obama signed on March 23, 2010 significantly enhances access to health care, including services for mental illness and substance use disorders for millions of Americans. Overall, the legislation:

- Requires that by 2014 new insurance plans include a mental health and substance use disorder benefit that is administered at parity with medical/surgical benefits.
 - This requirement also will apply to the Children's Health Insurance Plan (CHIPRA).
 - Existing employer coverage and Medicare will not need to comply with this requirement.
- Provides immediate access to insurance for adults who are uninsured because of a pre-existing condition through a temporary national high risk pool beginning in 2010.
- The prohibition against use of pre-existing condition limitations permanently becomes effective for children in 2010 and for adults in 2013.
- Expands Medicaid eligibility to adults (including those without children) who earn under 133% of the Federal Poverty Level (FPL) which is a group that disproportionately has untreated mental health and substance use disorders.
- Includes essential mental health and substance use disorder services and prevention services (including depression screening and rehabilitative SBIRT) as health benefits for new insurance policies after 2013.
- Provides for grants to community mental health programs for co-locating primary and specialty Mental Health/Substance Use Disorder care.
- Provides changes to the Medicaid program to expand types of home and community-based services supported for individuals with mental health and substance use disorders.
- Allows state Medicaid programs to establish health homes for those with chronic illnesses (states that seek this option must consult and coordinate with SAMHSA regarding the prevention and treatment of mental illness and substance use disorders for those with chronic illnesses).

- Creates a grant program to be implemented this year for school-based health clinics to provide mental health and substance use disorder assessments, crisis intervention, counseling, treatment and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care and outpatient programs.
- Creates a Primary Care Extension Program to support education of primary care providers about a number of chronic conditions, including prevention and treatment of mental health and substance use disorders.
- Establishes a grant program to develop Centers of Excellence through the nation to promote use of evidence-based care models to providers and the public.
- Includes provisions to encourage use of prevention services under Medicaid, such as enhanced prevention services under the Rehabilitation option, enhanced federal match for prevention services, elimination of beneficiary cost-sharing for prevention services and beginning this year requiring that Medicaid cover smoking cessation counseling and drugs for pregnant women.
- Provides for a variety of demonstration projects that impact how mental health and substance use disorder treatment is provided and paid for.
 - Included is a project to examine whether the current exclusion of institutions of mental diseases (IMD) from Medicaid payment should be maintained for psychiatric hospitals.
 - Additional projects will examine use of alternative payment methodologies including bulk rates and capitation to produce more flexibility, accountability and cost control.

Source: www.samhsa.gov/About/summary.aspx 8/11/2010

SAMHSA 8 Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness

Goal – Create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to promote emotional health and prevent and reduce mental illness, substance abuse including tobacco, and suicide across the lifespan.

2. Trauma and Justice

Goal – Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral healthcare systems and to divert people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

3. Military Families – Active, Guard, Reserve, and Veteran

Goal – Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

4. Health Reform

Goal – Broaden health coverage and the use of evidence-based practices to increase access to appropriate and high quality care, and to reduce disparities that currently exist between the availability of services for substance use and mental disorders and other medical conditions.

5. Housing and Homelessness

Goal – Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience to accessing effective programs that sustain recovery.

6. Health Information Technology for Behavioral Health Providers

Goal – Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of health information technology.

7. Data, Outcomes, and Quality – Demonstrating Results

Goal – Realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families, and communities.

8. Public Awareness and Support

Goal – Increase understanding of mental and substance use disorder prevention and treatment services to achieve the full potential of prevention and help people recognize and seek assistance for these health conditions with the same urgency as any other health condition.

The 2010 National Drug Control Strategy Highlights

The following goals are to be attained by 2015:

Goal 1: Curtail illicit drug consumption in America

- 1a. Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%
- 1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%
- 1c. Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%
- 1d. Reduce the number of chronic drug users by 15%

Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- 2a. Reduce drug-induced deaths by 15%
- 2b. Reduce drug-related morbidity by 15%
- 2c. Reduce the prevalence of drugged driving by 10%

A summary of the approach is as follows:

Strengthen Efforts to Prevent Drug Use in Communities: Research shows that preventing drug use before it begins is the most cost-effective, common-sense way to build safe and healthy communities. Therefore, the *Strategy* focuses on:

- Developing a community-oriented national prevention system focused on young people
- Collaborating with States to help communities implement evidence-based prevention initiatives
- Providing sound information about the dangers of drug use to young people, their parents, and other caring adults
- Supporting mentoring initiatives, especially among youth at greater risk
- Expanding research on drugs used by youth
- Collaboration between public health and public safety organizations to prevent drug use
- Curtailing drugged driving by encouraging States to establish and enforce laws and by launching a national effort to educate the public about the serious public health and safety threat posed by drugged driving

Seek Early Intervention Opportunities in Health Care: Studies indicate that most healthcare spending related to substance abuse goes to the avoidable, catastrophic consequences of addiction rather than to its treatment. Therefore, the *Strategy* focuses on:

- Increasing substance use screening and early intervention in all healthcare settings
- Increasing healthcare providers' knowledge of screening and brief intervention techniques through medical schools and continuing education programs
- Curbing prescription drug abuse by expanding prescription drug monitoring programs, community prescription take-back initiatives, education efforts and working with physicians to achieve consensus standards on opiate painkiller prescribing
- Expansion of reimbursement for screening and brief interventions in primary care

Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery: In cases of severe addiction, Addiction treatment can be a critical resource, but only if it is readily available and of high quality. Therefore, the *Strategy* focuses on:

- Expanding addiction treatment in community health centers and within the Indian Health Service
- Supporting the development of new medications to treat addiction and implementation of medication-assisted treatment protocols
- Improving the quality and evidence base of substance abuse treatment
- Fostering the expansion of community-based recovery support programs

Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration: Drug use is often interwoven with criminal and delinquent behavior. The criminal justice system plays an important role, therefore, in reducing drug use and its consequences, and the *Strategy* focuses on:

- Supporting law enforcement's efforts to reduce drug availability and to educate the public about the dangers and legal consequences of drug trafficking and drug abuse
- Encouraging partnerships and collaboration between law enforcement and community organizations to increase cooperation and understanding and to reduce open-air drug markets and gang activity
- Promoting and supporting alternatives to incarceration such as drug courts
- Reducing drug use by those under criminal justice supervision through drug testing
- Mandating treatment and court monitoring for chronic drug-using offenders
- Supporting post-incarceration reentry efforts by facilitating in job placement, access to drug-free housing, and developing adult reentry programs
- Developing and disseminating more effective models of addressing substance use disorders among youth in the juvenile justice system

Disrupt Domestic Drug Trafficking and Production: Drug-trafficking organizations move large quantities of illicit drugs into the United States and distribute these drugs throughout the Nation. The resources of the United States must be marshaled to disrupt the organizations that conduct this trade, and the *Strategy* focuses on:

- Maximizing Federal support for law enforcement drug task forces
- Assisting tribal authorities in combating trafficking on tribal lands
- Implementing the Administration's border plan
- Interdicting the southbound flow of currency and weapons
- Disrupting counterintelligence operations of drug-trafficking organizations to improve interdiction and protect the safety of United States personnel
- Countering domestic methamphetamine production and reducing retail diversion of pseudo ephedrine used to produce methamphetamine
- Eliminating high-potency indoor grow labs and marijuana cultivation on public lands
- Disrupting the no medicinal criminal distribution of prescription medications

Strengthen International Partnerships: It is in the interest of the United States to work collaboratively with international partners to reduce the global drug trade because such actions protect the health and safety of our citizens. Therefore, the *Strategy* focuses on:

- Conducting joint counterdrug law enforcement operations with international partners to cause major disruptions in the flow of drugs, money, and chemicals
- Intensifying counterdrug training and technical assistance internationally, particularly in the Western Hemisphere
- Promoting alternative livelihoods for coca and opium farmers to reduce drug production
- Improving our understanding of the vulnerabilities of drug-trafficking organizations by pooling the knowledge of our intelligence and law enforcement agencies
- Targeting the illicit finances of drug-trafficking organizations
- Expanding support for international prevention and treatment initiatives
- Increasing medication-assisted treatment for drug addiction

Improve Information Systems for Analysis, Assessment, and Local Management:

Science should help inform policy and rigorously evaluate its effects. This can be possible only with near real-time information on drug use patterns, associated problems, and the results of previously implemented policies. To achieve better management information, the *Strategy* focuses on:

- Enhancing current data systems that identify the number of drug users, drug-related offenders, drug-related emergency room admissions, and other key public health and public safety indices
- Assessing the availability, price, and purity of illicit drugs on the street so it is known when our programs have a measurable impact on drug markets
- Developing and implementing community-based data systems focused on drug use and drug-related problem indicators