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Policy and Prevention Branch

Office of Women's, Perinatal, and Youth Services

DRAFT Youth Substance Use Disorder Treatment  
Services Needs Assessment

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## Introduction

Today's youth are the future of California. They make up 23 percent of the total population.<sup>1</sup> However, there are thousands of youth admitted to publicly funded substance use disorder (SUD) treatment facilities every year. They are a complex population, and the prevalence of alcohol and drug use in youth culture makes them at risk of continuing use or developing other SUD related health problems.

This report focuses on youth in SUD treatment, utilizing data from the California Outcomes Measurement System – Treatment (CalOMS Tx) database. As a result, this report analyzes youth from the perspective of admission to SUD treatment. It is important to note that CalOMS Tx does not have data pertaining to early intervention or support services. To have a better understanding of the data in this database, the following provides the background of the Department of Health Care Services (DHCS) and the agency that it serves.

The California Health and Human Services (CHHS) “oversees departments and offices that provide a wide range of services in the areas of health care, mental health, public health, alcohol and drug treatment, income assistance, social services, and assistance to people with disabilities.”<sup>2</sup> DHCS is one of 13 departments under CHHS and provides a range of health care, mental health and SUD services, social services, income assistance, and public health services.<sup>3</sup> DHCS also provides leadership and coordination in the planning, development, implementation, and evaluation of a comprehensive statewide SUD prevention, treatment, and recovery system.<sup>4</sup>

There are over 600 SUD treatment providers,<sup>5</sup> over 120 narcotic treatment facilities,<sup>6</sup> approximately 1,000 licensed and/or certified residential and outpatient facilities,<sup>7</sup> and about 140 county administrators that provide SUD treatment services for adult and youth in the state.<sup>8</sup> DHCS monitors these facilities and programs through site visits or financial reports for public funding sources.

There are two major public funding sources for the facilities monitored by DHCS. One of the funding sources is the federal Substance Abuse Prevention and Treatment Block

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<sup>1</sup> California Quick Facts, United States Census Bureau, 2015. Estimates for 2015 based on population census 2010. <http://www.census.gov/quickfacts/table/PST045215/06>. Accessed January 21, 2016

<sup>2</sup> California Health and Human Services Agency. <http://www.chhs.ca.gov/Pages/Home.aspx>. Accessed July 18, 2017.

<sup>3</sup> Department of Health Care Services Strategic Plan 2013-2017, 5.

<sup>4</sup> Department of Health Care Services, Division Descriptions, 14. <http://www.dhcs.ca.gov/Documents/DHCS-Divison-Descriptions-12-2014.pdf>

<sup>5</sup> FY 2013-14 Cost Report.

<sup>6</sup> Narcotic treatment Program Director received on February 23, 2017. [http://www.dhcs.ca.gov/individuals/Documents/Narcotic\\_Treatment\\_Program\\_Directory%201.23.2017.pdf](http://www.dhcs.ca.gov/individuals/Documents/Narcotic_Treatment_Program_Directory%201.23.2017.pdf)

<sup>7</sup> Licensed and/or Certified Residential and Outpatient Facilities Directory received on February 23, 2017. [http://www.dhcs.ca.gov/provgovpart/Documents/Status\\_Report\\_February\\_2017.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Status_Report_February_2017.pdf)

<sup>8</sup> County Program Administrators Director received on February 23, 2017. <http://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx>

Grant (SAPT BG) fund and the other is Drug Medi-Cal (DMC). DMC is available to beneficiaries who are eligible for Medicaid/Medi-Cal.

It is important to understand these funding sources because if a facility receives any funds from SAPT BG or DMC then all of their clients' treatment data is reported to the state through CalOMS Tx.<sup>9</sup> The funds received from any of these sources could be for only one client. In addition, whether or not the client used private or public funds for treatment, the data is entered in CalOMS Tx. In order to avoid confusion regarding the client data entered into CalOMS Tx, references to data used from CalOMS Tx refer to all clients that received treatment from DHCS monitored treatment facilities or programs. This client data is not limited to Medicaid eligible clients.

### **Purpose**

In collaboration with its stakeholders, DHCS is working to develop a youth SUD system of care that encompasses services across the continuum of care.<sup>10</sup> This process is still in its infancy stage and does not include promotion, prevention, early intervention, and recovery services. Consequently, this is the initial development of a needs assessment for the state that presents a snapshot of youth who received SUD treatment services in DHCS monitored facilities during FY 2013-14 and FY 2014-15. As a working document, this report will continue to develop as stakeholders and field experts provide further input.

The purpose of this report is to provide information on youth SUD treatment data that will work towards building a youth SUD infrastructure. This report primarily utilizes data components available in CalOMS Tx, which illustrates that the youth in SUD treatment are diverse and cannot be limited to just certain demographics, such as, race/ethnicity or socio-economic levels making their treatment needs just as diverse. In addition, the geographical diversity of California presents challenges to youth seeking SUD treatment; however, access to treatment facilities is not simply reduced to rural versus urban counties.

### **Target Population and Terminology**

The target population for data pulled in this report are children and youth under the age of 18 and transitional age youth from ages 18-24. For purposes of this document, references to youth include children and youth under 18. References to adolescents are from ages 12-17, unless stated otherwise. The variation in definition and age of data pulled is dependent on the various data sources, which have their own age criteria and definitions.<sup>11</sup>

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<sup>9</sup> California Outcomes Measurement System Treatment (CalOMS Tx) Data Collection Guide NNA Contract – Document 3J. File Version 2.0. Department of Health Care Services, January 2014.

<sup>10</sup> Institute of Medicine Continuum of Care.

<sup>11</sup> SAMHSA's National Registry of Evidence-based Programs and Practices defines TAY as "people between the ages of 16 and 25."

<http://nrepp.samhsa.gov/Docs/Literatures/NREPP%20Learning%20Center%20Literature%20%20Review>

The decision to pull data for youth under the age of 18 was based on past reports from CalOMS Tx. Past reports indicated that out of approximately 15,000 youth admitted to treatment in FY 2013-14, 10 percent reported age of first use under the age of 11. In FY 2014-15, out of approximately 12,000 youth admitted to treatment, 11 percent reported they were under the age of 11 years.<sup>12</sup> In other words, almost 1,600 youth in FY 2013-14 and 2,200 in FY 2014-15 were under 11 years of age when they first used alcohol or drugs.<sup>13</sup>

## **Methodology**

### DHCS CalOMS Tx Data

The primary treatment database accessed for this report was the CalOMS Tx database. The CalOMS Tx database is updated by counties or their providers on clients in DHCS monitored SUD treatment facilities upon admission and discharge. The data pulled, in large part, were only for unique clients. Unique client counts an individual only once during a given time period even though they may have been admitted to more than one service (e.g., withdrawal management, residential, outpatient).<sup>14</sup>

To place CalOMS Tx data in context with other data sets, other public domain databases were accessed. The following are the other databases used:

- United States Census Bureau
- Income by Zip Code
- Centers for Disease Control and Prevention
- California Healthy Kids Survey
- National Survey on Drug Use and Health

### Youth Advisory Group (YAG)

In 2016, DHCS established the Youth Advisory Group (YAG) in an effort to develop and implement a SUD system of care for youth. The YAG members consist of representatives from various counties, state departments, subcommittee chairs of the County Behavioral Health Directors Association of California, and other field experts, including youth who have received prevention and/or treatment services. Since this stakeholder group is in its infancy stage, a consistent membership is not yet established.

To date, the YAG has provided feedback to DHCS regarding the gaps that exist in youth SUD treatment services. Those perspectives were included in this report.

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[Transition-age%20Youth.pdf](#). Accessed July 14, 2017. In this Literature Review on transition-age youth, “emerging adulthood”, ages 18-25 is also considered transition-age youth by social science researchers.

<sup>12</sup> CalOMS Treatment FY 2013-14 and FY 2014-15.

<sup>13</sup> CalOMS Treatment FY 2013-14 and FY 2014-15.

<sup>14</sup> CalOMS Treatment.

## Overview of California

During FY 2013-14 approximately 15,000 youth (aged 17 or younger) were admitted to a SUD treatment program.<sup>15</sup> The number admitted in FY 2014-15 was a little over 12,000.<sup>16</sup> A limitation for the data collected in CalOMS Tx is that it does not reveal the gaps in the delivery of treatment services, such as, whether the delivery of treatment was developmentally, culturally, and linguistically appropriate for the clients. In addition, it is not clear whether the counties were inclusively reaching youth in need of SUD treatment to populations such as the homeless, foster children, or other disparate population.

The difference from FY 2013-14 and FY 2014-15 also is not indicative of a decrease in youth with SUD since there were also a large number of treatment facility closures and suspensions during those years. In FY 2013-14, for example, there were over 190 SUD programs decertified and 4 in FY 2014-15. The use of these two fiscal years were merely to indicate trends without concluding that there are less youth in need of SUD treatment.

Note: After writing this initial report, FY 2015-16 CalOMS Tx data became available which can be incorporated as this document continues to develop.

### Population

According to the United States Census Bureau, California has a population of over 39 million people. In 2016, its population under the age of 18 made up 23.2 percent of the total population.<sup>17</sup> The Centers for Disease Control indicated that from 1999-2015, drug and alcohol-induced deaths of youth between the ages 15-19 occurred throughout the State of California.<sup>18</sup> Although there is not a definitive number of deaths due to suppressed data (in large part because of privacy concerns), there are over 200 deaths in some areas due to drug and alcohol-induced deaths. In counties with higher populations, there were higher number of deaths.<sup>19</sup> Nonetheless, one death is one too many.

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<sup>15</sup> CalOMS Treatment FY 2013-14 and FY 2014-15.

<sup>16</sup> The totals number of adolescents admitted to treatment are unique client counts unless otherwise stated. For unique client counts, the individual is counted only once during a given time period even though they have been admitted to treatment more than once.

<sup>17</sup> California Quick Facts, United States Census Bureau, 2015. Estimates for 2015 based on population census 2010. <http://www.census.gov/quickfacts/table/PST045215/06>. Accessed January 21, 2016.

<sup>18</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. <http://wonder.cdc.gov/ucd-icd10.html>. Accessed June 27, 2017.

<sup>19</sup> Due to the categorization of data in the Centers for Disease Control database and suppressed data for ages under 15, data pulled were for ages 15-19 years.

## Geographical Landscape of Youth Treated in DHCS Monitored SUD Facilities

California is the third largest state with a landmass of over 160,000 square miles.<sup>20</sup> With the Pacific Ocean on the west and the Sierra Nevada mountain range on the east, the states of Oregon, Nevada, Arizona, and the Mexican state of Baja lie at its remaining borders. The terrain within those borders range from the high, cold peaks of Mount Whitney in Yosemite National Park to the lowest, hottest point of North America, Badwater Flat in Death Valley. The landscape ranges from nature's bucolic terrain to a developed metropolis. In addition to extreme geographical differences, cities in California range in population size from approximately 185 people, such as in Amador City, to about 3.8 million in Los Angeles.<sup>21</sup>

With a land mass of over 160,000 square miles and differences in population size, youth SUD treatment services vary from county to county. Of the 58 counties, 53 have some level of SUD treatment for youth.

There was a higher density of youth with SUD admitted to DHCS monitored treatment facilities in the following counties:

Counties with youth <18 admitted into SUD Treatment > 500
Fresno
Los Angeles
Riverside
Sacramento
San Diego
Santa Barbara
Santa Clara
Tulare

Comparing the total number of youth under the age of 18 in California with the number of youth under the age of 18 in SUD treatment, the top five counties with the highest proportion of youth (over 500) admitted into DHCS monitored SUD treatment facilities were:<sup>22</sup>

- Fresno
- Los Angeles
- San Diego
- Sacramento

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<sup>20</sup> State Guides USA, <http://california.stateguidesusa.com/answers-to-my-questions/what-is-the-geographical-landscape-of-california?/>. Accessed February 24, 2016.

<sup>21</sup> Together We Teach Education Resources. Source data: U.S. Census Bureau, Census 2010 <http://www.togetherweteach.com/TWTIC/uscityinfo/05ca/capopr/05capr.htm>. Accessed March 14, 2016.

<sup>22</sup> CalIOMS Tx FY 2013-14.



- Riverside

Youth are admitted into SUD treatment throughout the state, however the unique client counts reflected a saturation of youth admitted to a DHCS monitored SUD treatment facility in higher populated counties. In order to understand how the counties compared to each other, the proportions of youth under 18 admitted to SUD treatment were calculated and ranked using the average number of youth in California under the age of 18 in the U.S. Census Bureau estimates on population.

Twenty-two counties ranked above the California average and 31 below. Of the 22 ranked above the California average, the top five counties were as follows:

County	State-wide ranking
Fresno	1
Santa Barbara	2
Alpine	3
Napa	4
Sierra	5

Of the 31 counties below the California average, the bottom five were as follows:

County	State-wide ranking
Yuba + Sutter	47
Stanislaus	46
San Joaquin	45
Madera	44
Mono	43

It is important to note that the rankings are not reflective of the quality of services provided to youth. For example, a higher admittance of youth into treatment could be indicative of effective outreach programs. Likewise, lower admittance is not reflective of ineffective treatment services. Instead, lower admittance could be a reflection of effective prevention services that deter youth indulgence in substance use. The findings do indicate that there was a broad range of county sizes and geographic locations of where youth with SUD were admitted to DHCS monitored treatment facilities.

In addition to the counties without any SUD treatment for youth, there are other challenges to access. One of the largest concerns that exists is the location of residential treatment facilities for youth. There are only 193 residential beds for youth licensed by the California Department of Social Services (DSS) and certified by DHCS.<sup>23</sup> By cross-referencing the DHCS Licensing and Certification Section Status Report, we were able to identify 21 homes as DSS licensed group homes that provide residential services to youth.<sup>24</sup>

The DSS residential treatment facilities include 82 beds to accommodate girls, 74 for boys, and 37 for co-ed. The average length of stay for both girls and boys range from 30 days to 12 months. These residential treatment facilities are located in the following counties:

- Southern California
  - Los Angeles
  - Orange
  - San Diego
- Central California
  - Stanislaus
- Northern California
  - Sacramento
  - Placer
  - Sonoma
  - Marin
  - Santa Cruz
  - Santa Clara

In FY 2013-14, 4.6 percent (or almost 1,000 youth) of the approximately 15,000 youth admitted to DHCS monitored SUD treatment facilities were in residential care. Of almost 1,000 youth in residential care, approximately 300 youth were admitted to residential care from 8-30 days and about 250 admitted for 120 days or more.<sup>25</sup> (Note: Admittance counts may include clients that receive more than one service type in a continuum of treatment. The number of admittance counts occurred within the fiscal year.) In FY 2014-15, out of about 12,120 youth admitted to DHCS monitored SUD treatment facilities, the total number of youth in residential treatment was approximately 900, with the majority in residential care from 8-30 days, while about 150 youth required a stay of over 120 days. With this high percentage of youth in residential care, a

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<sup>23</sup> Department of Health Care Services licensing and Certification Section Status Report. DHCS, 01 July 2017. [http://www.dhcs.ca.gov/provgovpart/Documents/Status\\_Report\\_July\\_2017.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Status_Report_July_2017.pdf). Accessed July 17, 2017.

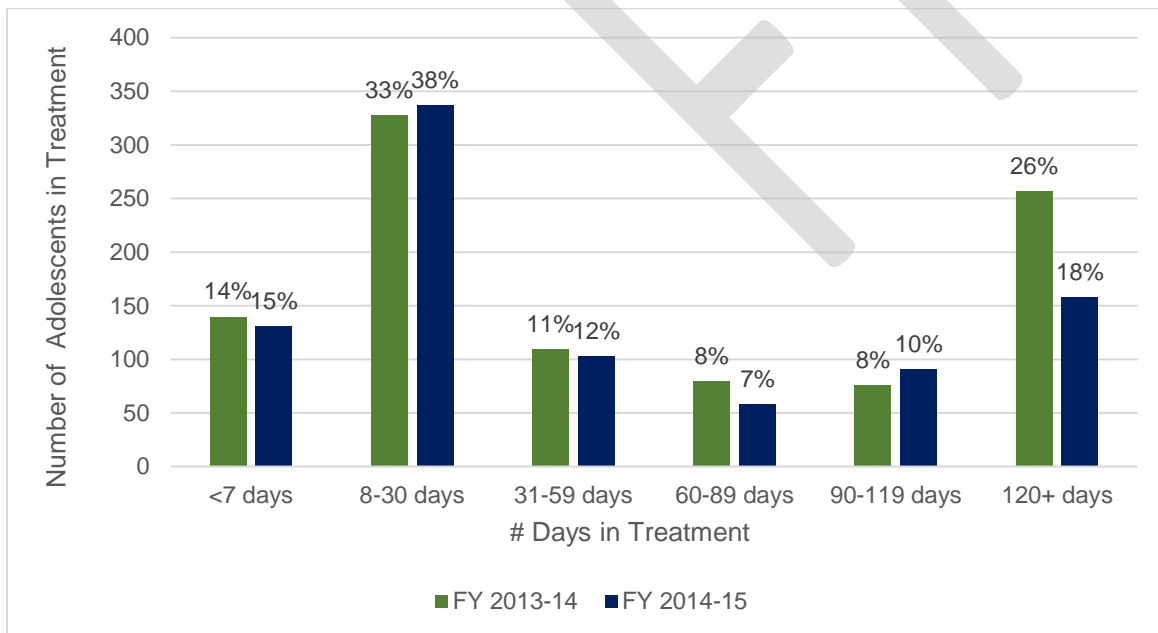
<sup>24</sup> Ibid.

<sup>25</sup> CalIOMS Tx, FY 2013-14.

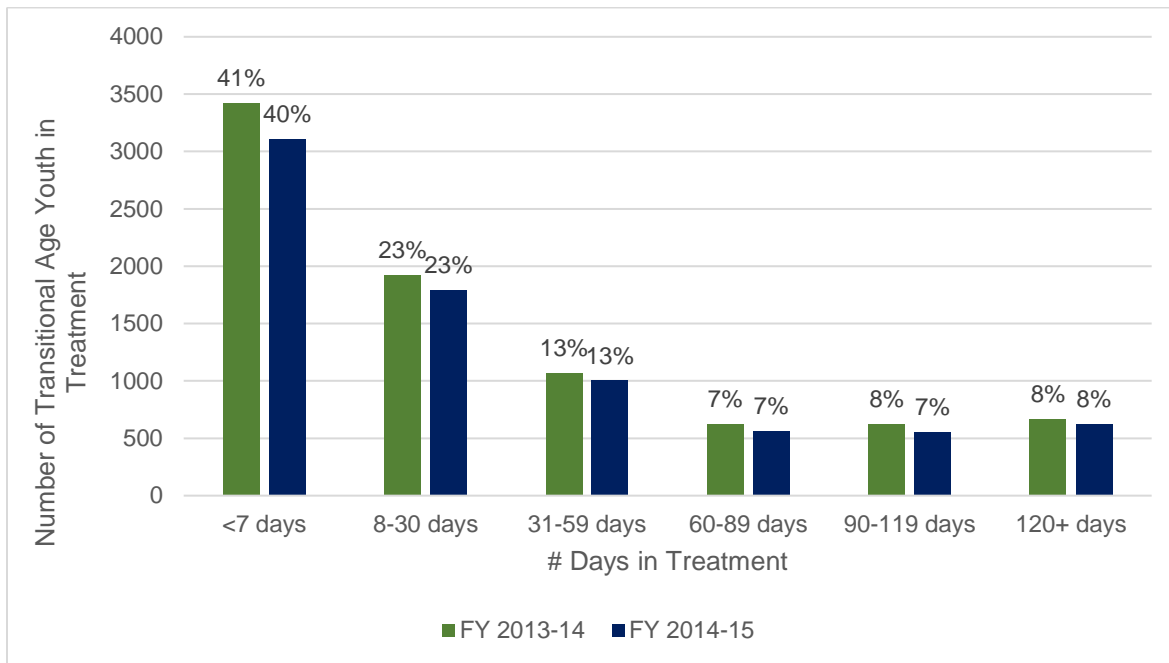
consideration that might be addressed is recovery support within the SUD system of care for youth. Chart 1 illustrates the number of youth in residential treatment by length of stay for FY 2013-14 and FY 2014-15.

In contrast, out of approximately 20,000 TAY admitted to DHCS monitored SUD treatment programs in FY 2013-14, there were approximately 8,000 TAY in residential treatment. Out of approximately 22,000 admitted to SUD treatment in FY 2014-15, there were approximately 7,600 TAY in residential treatment. The majority of TAY in residential care for both fiscal years had a length of stay of 30 days or less. In addition, the number of TAY in residential treatment for 120 days or more was lower than the youth count. In FY 2013-14, there were about 650 TAY in residential treatment for 120 days or more, and in FY 2014-15 there were about 600 TAY with the same length of stay. Chart 2 illustrates the number of TAY in residential treatment by length of stay for FY 2013-14 and FY 2014-15.

**Chart 1: CalOMS Tx Residential Treatment for Youth (<18)**



**Chart 2: CalOMS Tx Residential Treatment for Transitional Age Youth (18-24)**



### Transportation

The reasons that make transportation a barrier varies by county. The geographical challenges and location of residential treatment beds for youth are two areas that the YAG has recognized as presenting access barriers to SUD treatment for youth. Moreover, according to a DHCS pharmacologist, there is a higher number of SUD-related death rates in rural counties. This is partially due to the inaccessibility to treatment centers and appropriate medication, among many other factors.<sup>26</sup> This does not preclude the fact that the absolute number of deaths correlates with communities with larger populations.<sup>27</sup>

The following are additional considerations as to why transportation might be a barrier:

- The inability of parents or guardians to take the youth to a treatment facility because they are working two or three jobs.
- A facility might be in close vicinity to the home, but the community where the youth lives is too dangerous to walk through because of drug and gang activity.
- Seasonal conditions might be a barrier.
  - For example, roads with direct access to a treatment facility might be closed due to snow or other weather conditions that make it impossible to drive through.

<sup>26</sup> After a film viewing of Undertaken 2, a speaker (DHCS Psychiatric and Substance Use Disorder Pharmacist) shared this information. September 21, 2016.

<sup>27</sup> Follow up email communication with DHCS Psychiatric and Substance Use Disorder Pharmacist, July 13, 2017.

With transportation as a barrier, schools could be a good location for treatment sites; however, receiving treatment services in schools may present issues of privacy transgressions as well as negative stigma from peers if seen going to a treatment facility.

These are some examples of transportation barriers provided by stakeholders. To have a better understanding of the needs related to transportation, further input from stakeholders with contextual knowledge is required.

### Household Income

In a health disparities report by the Office of Health Equity (OHE), there was a correlation between low-income children who live in areas with poor health and a lower life expectancy.<sup>28</sup> In addition, the OHE report stated that the “prevalence of psychiatric disorders, including neurotic disorders, functional psychoses, and alcohol and drug dependence, is consistently more common among lower-income people.”<sup>29</sup>

When comparing the OHE and CalOMS Tx data for the same timeframe, the household income level of youth admitted to SUD treatment correspond to low income areas, such as Fresno County.

In contrast, the CalOMS Tx data also indicates that a high number of youth treated for SUD live in densely populated areas with higher income levels and low unemployment rates. For example, in 2014, San Diego had approximately 3.2 million residents and ranked second in the state for unemployment rates (less than six percent).<sup>30</sup> In addition, in FY 2013-14, San Diego’s median household income was \$60,235 and the overall median house income for California was \$58,322.<sup>31</sup>

However, San Diego is one of the counties identified as having a higher number of youth admitted to SUD treatment during FY 2013-14. Using the zip codes for the youth population in our CalOMS Tx database and cross referencing them with the median incomes for the respective zip codes, we found that a greater number of youth who sought treatment in a DHCS monitored facility came from zip codes where the average median household was around \$48-68,000.<sup>32</sup> Approximately 54 percent of youth admitted to treatment were from average middle-income median households. Chart 3,

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<sup>28</sup> Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity, 30.

<sup>29</sup> Portrait of Promise, 30.

<sup>30</sup> California Unemployment Rate by County, <http://data.bls.gov/map/MapToolServlet> and California Department of Finance Demographic Research, E-2, California County Population Estimates and Components of Change.

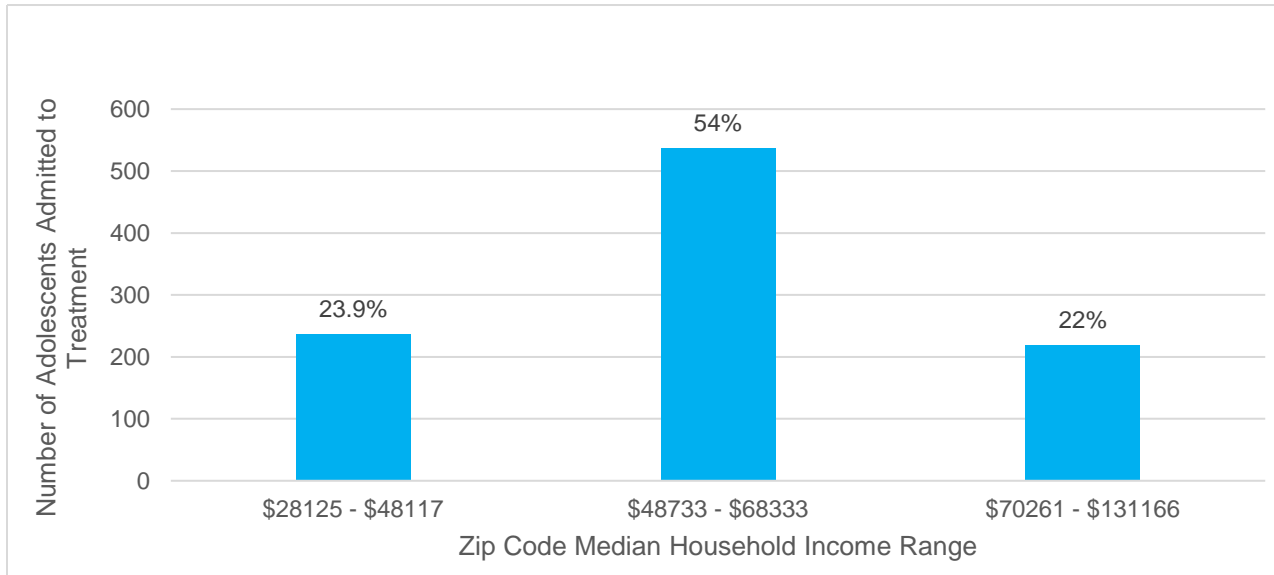
<sup>31</sup> County Health Rankings & Roadmaps, 2014.

<http://www.countyhealthrankings.org/app/california/2014/measure/factors/63/data?sort=sc-2>

<sup>32</sup> *Income by Zip Code* was accessed to obtain median household income for all adolescent residential zip codes reported in CalOMS Tx for San Diego in FY 2013-14. For example, <https://www.incomebyzipcode.com/california/92075>. Access August 2016.

below, reflects the number of youth admitted into DHCS monitored treatment facilities in San Diego County according to their household income level.

**Chart 3: Youth (<18) Admitted to DHCS Monitored SUD Treatment by Zip Code Median House Income Range (San Diego County), CalOMS Tx FY 2013-14**



### Homeless Youth

According to the California Homeless Youth Project, nearly 270,000 students experienced homelessness during the school year 2012-13.<sup>33</sup> These individuals represent 21 percent of the homeless students in the United States. In other words, 3 percent of California’s youth were homeless compared to 1.7 percent homeless youth in the United States.

In the CalOMS Tx data for FY 2014-15, there were 93 homeless youth admitted in a DHCS monitored SUD treatment facility. However, it is unclear if all homeless youth were captured in the CalOMS Tx data, as the definition of homelessness can vary. For example, a youth’s living arrangement could be in a motel, shelter, or living in a vehicle.<sup>34</sup> In addition, it is unknown at this time whether homeless youth receive adequate outreach about SUD treatment services and other health care services.

### Youth Admitted to SUD Treatment by Race/Ethnicity

<sup>33</sup> Shahera Hyatt, Brynn Walzer, and Patricia Julianelle. “California’s Homeless Students: A Growing Population,” California Homeless Youth Project, September 2014. [http://cahomelessyouth.library.ca.gov/docs/pdf/CaliforniasHomelessStudents\\_AGrowingPopulation.pdf](http://cahomelessyouth.library.ca.gov/docs/pdf/CaliforniasHomelessStudents_AGrowingPopulation.pdf). Accessed February 2016.

<sup>34</sup> DHCS CalOMS Treatment Data Collection Guide NNA Contract – Document 3J. File Version 2.0, January 2014, 78.

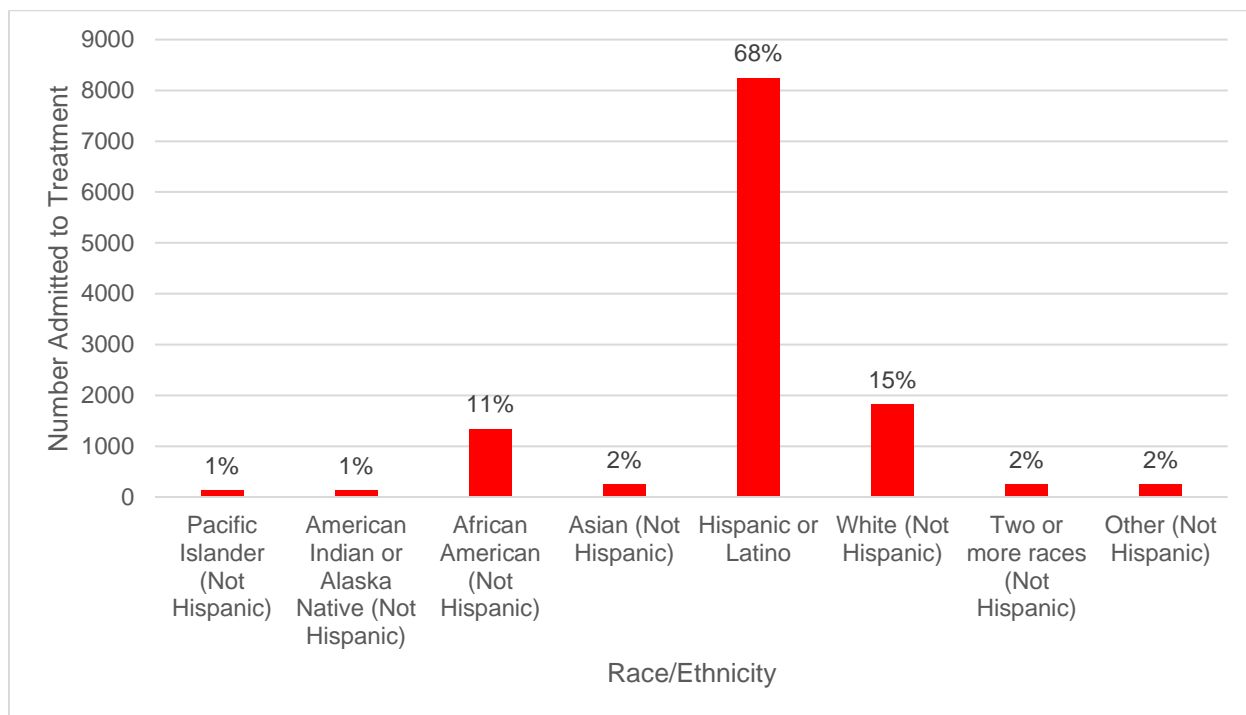
With a total population of approximately 39 million, California has the greatest racial and ethnic diversity in the nation.<sup>35</sup> Although the white population remains the largest in California at approximately 73% of the population, the Hispanic/Latino population is the largest and fastest growing minority race/ethnicity at approximately 39 percent. The Asian population follows them at approximately 15 percent, Black or African American population at 7 percent, American Indian/Alaska Native Tribes at 2 percent, and Native Hawaiian/Pacific Islander population at less than 1 percent. Those who identified as being two or more races are 3.8 percent of the population.

Chart 4 indicates that the majority of the youth admitted to SUD treatment in FY 2014-15 identified as being Hispanic, and the second highest population identified as being white. California's diversity extends beyond race/ethnicity and age with other subpopulations such as Lesbian, Gay, Bisexual, Transgender, Queer, and Intersexed/Inquiring (LGBTQI) community, persons with disabilities, undocumented immigrants, and many others. However, currently, there is no data collected on populations such as LGBTQI, persons with disabilities, or undocumented immigrants.

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<sup>35</sup> California Quick Facts, United States Census Bureau, 2015. Estimates for 2015 based on population census 2010. <http://www.census.gov/quickfacts/table/PST045215/06>. Accessed January 21, 2016.

**Chart 4: CalOMS Tx FY 2014-15 Youth (<18) Admitted to DHCS Monitored Substance Use Disorder Treatment by Race/Ethnicity (n=12,120)**



### Education and Youth in SUD Treatment

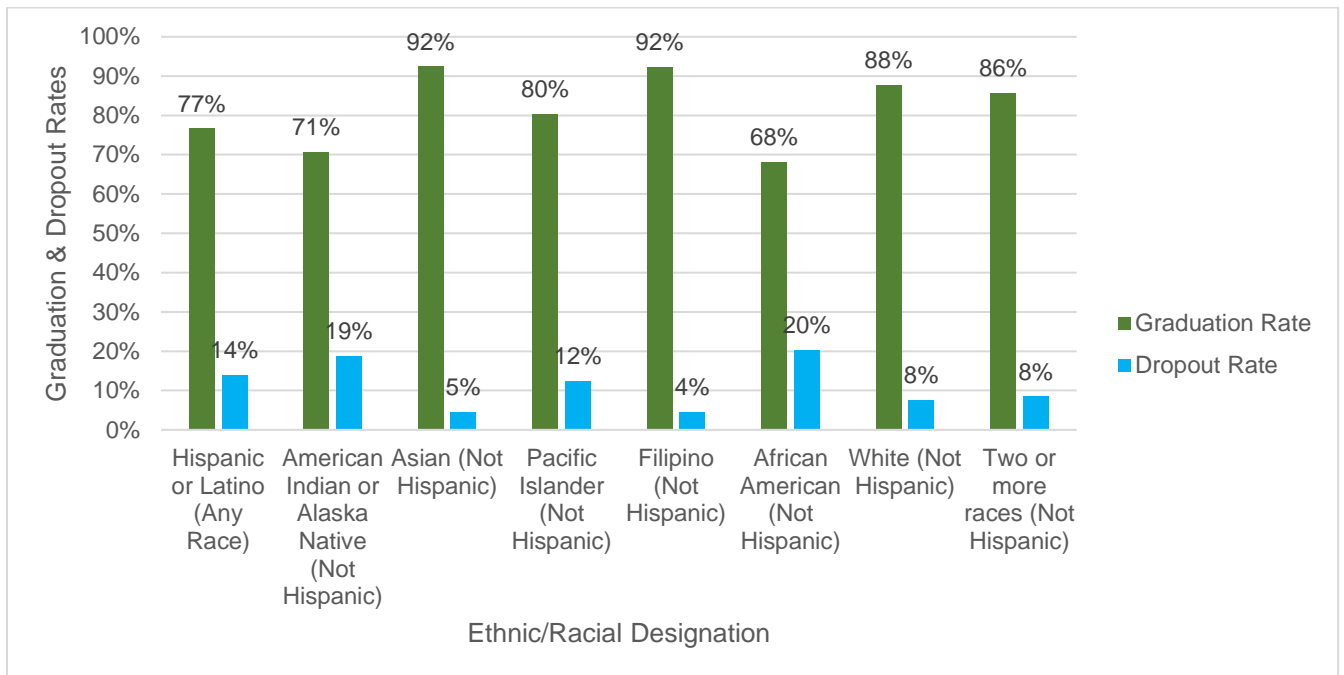
The California Department of Education (CDE) has an initiative to develop its younger population by focusing on increasing high school graduation rates. According to a CDE report in 2015, there was not only an increase in graduation rates, but also a decrease in dropout rates.<sup>36</sup> Moreover, cohort data for graduation rates of Hispanic students, which at one time were low, showed the highest increase at 76.6 percent, up about 0.7 percent from the year before.

The high school dropout charts, illustrated in Chart 5 on page 17, also reflect a lower disparate difference between ethnicities.

<sup>36</sup> California Department of Education, “State Schools Chief Tom Torlakson Reports High Graduation Rate,” April 28, 2015. <http://www.cde.ca.gov/nr/ne/yr15/yr15rel34.asp>. Accessed February 2016.



**Chart 5: Cohort Data 2013-14 Graduation Percentages by Race/Ethnicity<sup>37</sup>**



Unlike the relatively lower disparity of students enrolled in public schools who either graduated high school or dropped out, illustrated in Chart 5, Hispanic youth admitted to SUD treatment in Chart 4 are much higher than other ethnicities. In FY 2014-15, over 90 percent of the approximately 12,000 youth who received SUD treatment were enrolled in school.<sup>38</sup> However, this does not take into consideration individuals enrolled in school who may have been truant or absent a majority of the time. Likewise, this also does not take into consideration the youth who dropped out of school and were using drugs but not admitted to treatment.

An interagency collaboration and input from stakeholders would help provide a more accurate analysis on the educational background of youth admitted to SUD treatment.

### **Age of Youth Receiving SUD Primary Prevention and Treatment Services**

Data from the CalOMS Prevention (Pv) database indicate that in FY 2013-14, approximately 204,000 youth received prevention services, and about 15 percent of those youth were ages 11 years old and under. The highest percentage of prevention services delivered were to ages 12 through 14 at 37 percent.<sup>39</sup> The next highest age

<sup>37</sup> California Department of Education, "State Schools Chief Tom Torlakson Reports High Graduation Rate." April 28, 2015.

<sup>38</sup> CalOMS Tx FY 2014-15. There were 11,085 adolescents enrolled and 1,030 not enrolled in school.

<sup>39</sup> CalOMS Pv data retrieved 7/13/15. FY 2013-14 data represents a six-month time period from 7/1/14 to 12/31/14.

range to receive prevention services were from ages 15 through 17, at 34 percent.<sup>40</sup> Chart 6 illustrates the primary prevention strategies delivered by age in FY 2013-14.

**Chart 6: Primary Prevention by Age for FY 2013-14, CalOMS Pv (n=203,884)**

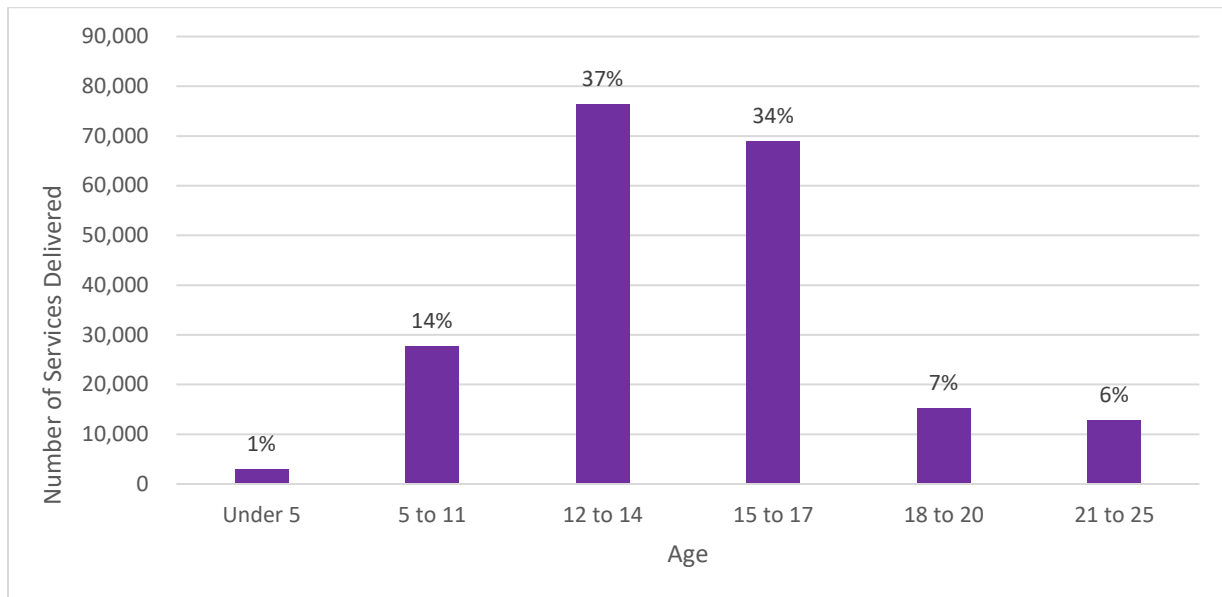
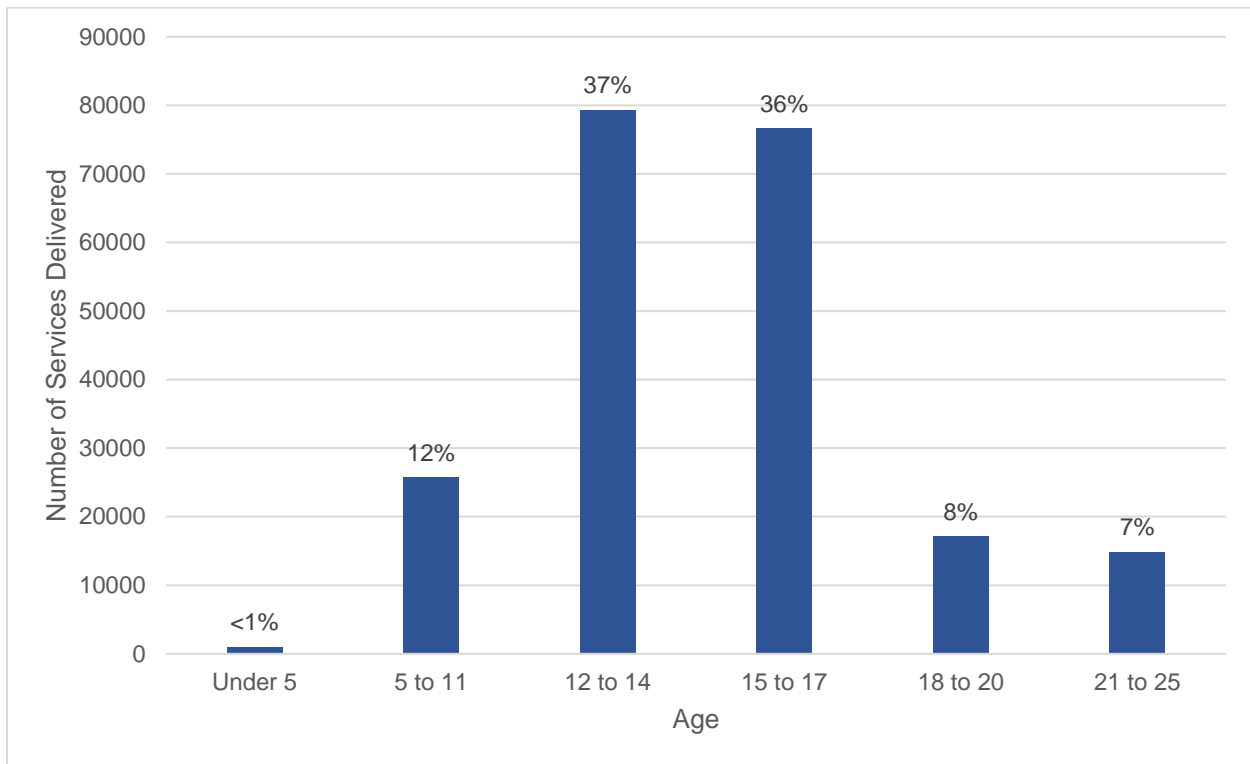


Chart 7 illustrates that primary prevention services were delivered to 12 percent of youth ages 11 and under out of approximately 214,000 youth who received primary prevention services.

<sup>40</sup> CalOMS Pv data retrieved 7/13/15, FY 2013-14 data represents a six-month time period from 7/1/14 to 12/31/14.

**Chart 7: Primary Prevention by Age for FY 2014-15, CalOMS Pv (n=215,366)**

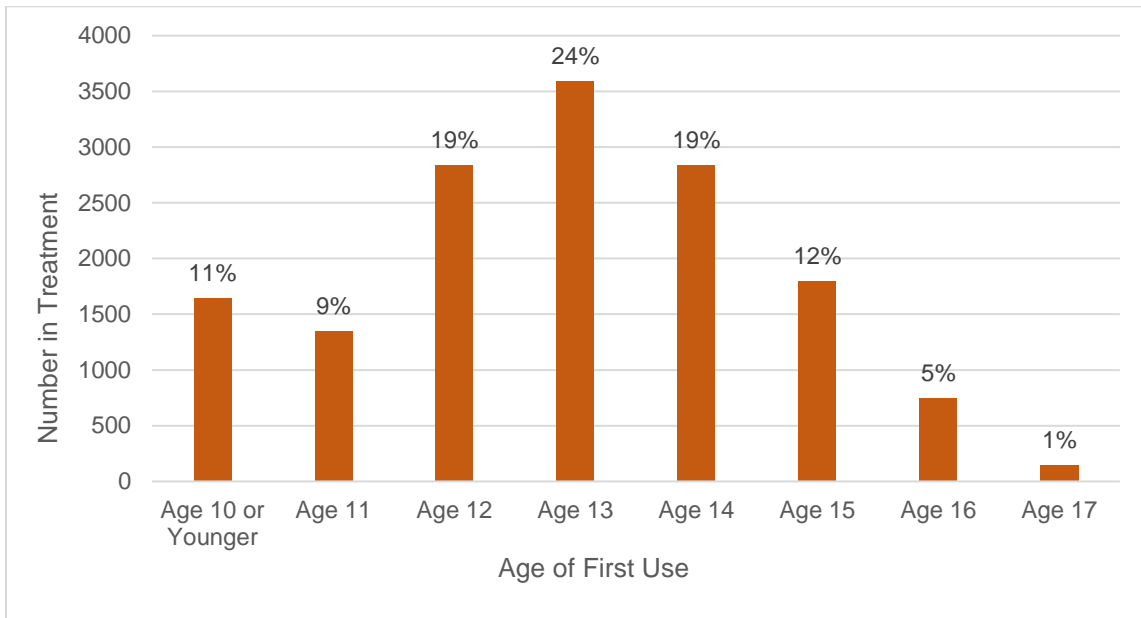


According to the FY 2013-14 CalOMS Tx data (reflected in Chart 8), the peak age for first use of a substance by youth admitted to a DHCS monitored SUD treatment facility was age 13, at 24 percent. The next highest percentage was 19 percent for ages 12 and 14. In other words, 62 percent of first-time users were ages 12 to 14. The data also indicates that 20 percent of approximately 15,000 youth began using substances when they were 11 and under.

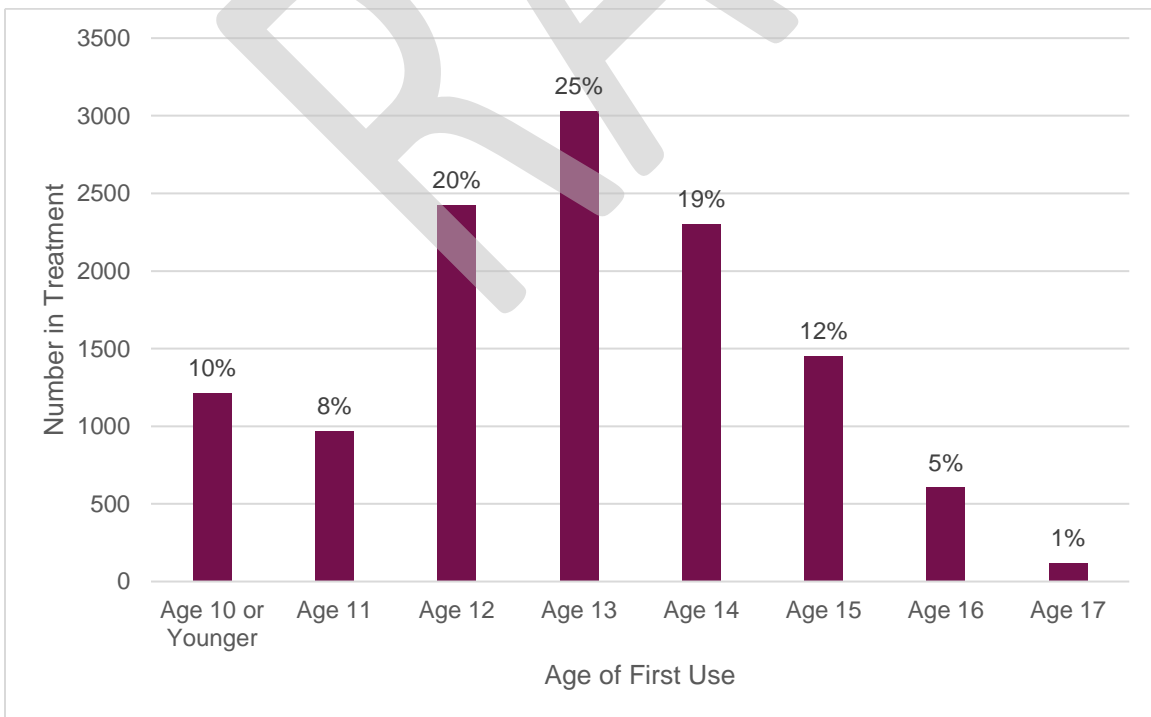
During FY 2014-15, CalOMS Tx data (reflected in Chart 9) indicates that of about 12,120 youth, the peak age of first use of a substance was age 13 at 25 percent, followed by age 12 at 20 percent and age 14 at 19 percent. For FY 2014-15, 64 percent were ages 12 to 14, and 18 percent of the youth in SUD treatment were 11 and under.

Although there were approximately 204,000 youth in FY 2013-14 and approximately 214,000 youth in FY 2014-15 that received primary prevention services, it is unknown whether any of the youth admitted to SUD treatment actually received prevention services. The two databases are not connected, and the CalOMS Tx database does not capture whether or not the youth admitted to SUD treatment received primary prevention services. However, this comparison invokes the possibility that prevention services should increase at earlier ages since the age of first use begins at age 11 and under. This is where DHCS and the YAG can collaborate to work towards resolving the data gap between prevention and treatment services.

**Chart 8: Age of First Use for Youth (<18) in DHCS Monitored SUD Treatment (CalOMS Tx, FY 2013-14)**



**Chart 9: Age of First Use for Youth (<18) in DHCS Monitored SUD Treatment (CalOMS Tx, FY 2014-15)**



## Primary Drug of Use among Youth

Among youth treated in DHCS monitored SUD facilities, the highest-used substance is marijuana for FY 2013-14 and FY 2014-15. According to Substance Abuse and Mental Health Services Administration, marijuana was also the most common-used illicit drug in the United States in 2013.<sup>41</sup> One reason attributed to the high use of marijuana is the fact that many of the youth believe there are little or no risks from using marijuana.<sup>42</sup> In contrast, marijuana can be addictive and affects brain development. In fact, when marijuana users begin as youth, the drug may reduce thinking, memory, and learning functions. It also affects how the brain builds connections between the areas necessary for those functions to occur.<sup>43</sup>

The use of marijuana as the highest used substance differs from other public domain resources such as California Healthy Kids Survey (CHKS) and the National Survey on Drug Use and Health (NSDUH), where alcohol is the substance reported as most used.

The group of participants that CHKS polls for their self-reporting survey are students in 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade. The results of the survey indicate whether a student drank or used a particular substance within a specified timeframe, such as the past month, week, or days.<sup>44</sup>

NSDUH limits its data to ages 12 and older, whereas the CalOMS Tx data includes youth 11 years and under. The NSDUH dataset is also built on self-reported data regarding substance dependence, abuse, and treatment. Similar to the CHKS survey, the NSDUH survey measures use of a substance within a specified timeframe, such as the month or year. In addition, the answers to the survey questions are used to classify substance dependence or abuse according to the 4<sup>th</sup> edition of the *Diagnostic and Statistical Manual of Mental Disorders*.<sup>45</sup>

CalOMS Tx data are the counts of the youth admitted into treatment, which differs from both CHKS and NSDUH self-reported data. Moreover, the age range collected in both CHKS and NSDUH differ from the youth reported in this document. It is also unknown as to whether the youth surveyed were admitted to SUD treatment or diagnosed with SUD, which is the focus of this report.

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<sup>41</sup> Substance Abuse and Mental Health Services Administration, CBHSQ Report, "Marijuana Use and Perceived risk of Harm from Marijuana Use Varies Within and Across Stages," July 26, 2016. [https://www.samhsa.gov/data/sites/default/files/report\\_2404/ShortReport-2404.html](https://www.samhsa.gov/data/sites/default/files/report_2404/ShortReport-2404.html). Accessed December 2016.

<sup>42</sup> National Institute on Drug Abuse, DrugFacts: Marijuana, Revised September 2015. <https://www.drugabuse.gov/publications/drugfacts/marijuana>. Accessed February 18, 2016.

<sup>43</sup> Ibid.

<sup>44</sup> California Department of Education, California health Kids Survey. <http://www.cde.ca.gov/ls/he/at/chks.asp>.

<sup>45</sup> SAMHSA, Center for Behavioral Health Statistics and quality, National Survey on Drug Use and Health, 2013 and 2014.

There are speculations for the difference between highest used substances reported in the surveys as opposed to data of youth admitted into treatment. For example, there could be a perception of alcohol being more socially acceptable. Longer lasting physical effects from use of marijuana could affect academic functioning in school or social functioning that might deter reporting its use. Another possibility might be the addiction to alcohol might be a slower physical process than that of marijuana. The answer to why the difference requires much more data gathering and knowledge as the development of this needs assessment is undertaken.

In a 2015 report by the National Institute on Drug Abuse (NIDA), individuals who started smoking marijuana heavily during adolescence, and individuals who had an ongoing cannabis use disorder lost an average of eight intelligence quota points between the ages of 13 and 38. In addition, the mental abilities that were lost did not fully return when they quit using marijuana as adults. According to NIDA, the number of people addicted to marijuana increases if they either started using marijuana as an adolescent (approximately 17 percent), or if they used marijuana on a daily basis (about 25-50 percent). This report also indicates that heavy marijuana users have poorer mental and physical health, less academic success, and a higher likelihood of dropping out of school.

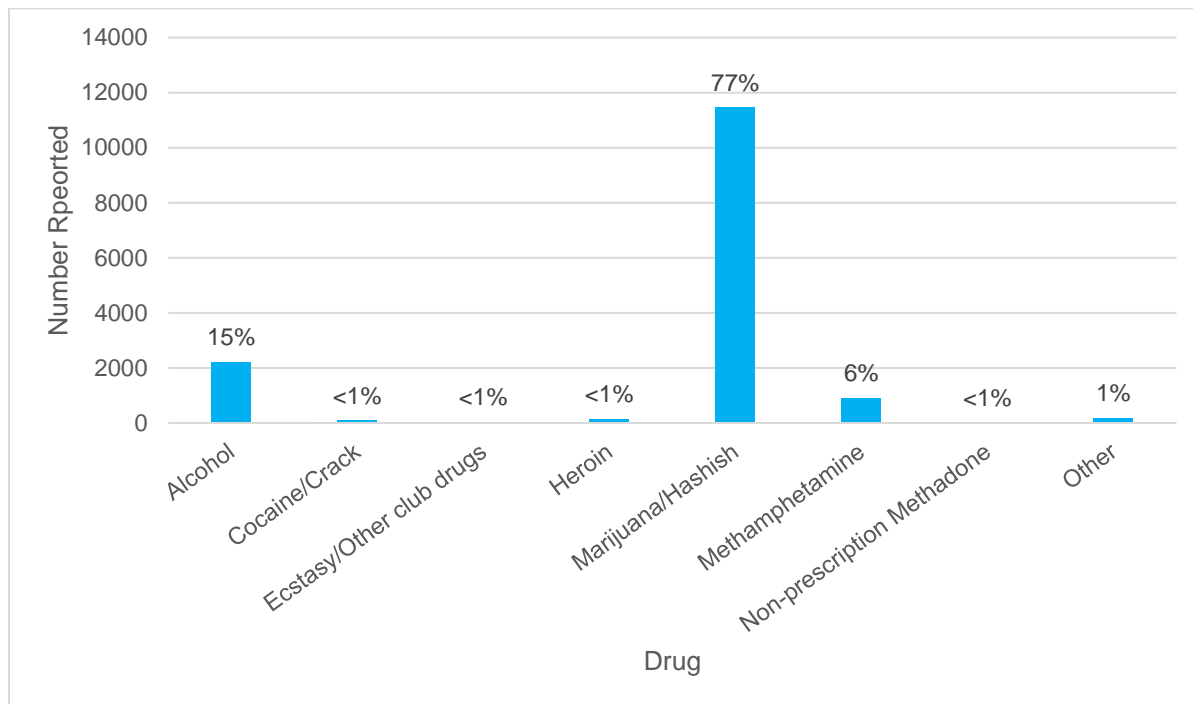
In 2016, the passage of the Control, Regulate and Tax Adult Use of Marijuana Act (AUMA), which legalizes recreational marijuana in California for adults 21 and older, accelerated concerns regarding youth having increased access to and use of marijuana. The passing of AUMA has led to an investigation of anti-marijuana campaigns and other preventive strategies to increase knowledge about the effects of marijuana to decrease the use of marijuana by youth.

Chart 10 and Chart 11 indicates that alcohol is the second highest drug of choice at admission for youth. The National Institutes of Health (NIH) released a report regarding a study on adolescent alcohol consumption conducted by the National Institute on Alcohol Abuse and Alcoholism. The study indicated that adolescent binge drinking could disrupt gene regulation and development in ways that promote anxiety and excessive drinking behaviors that can persist into adulthood.<sup>46</sup> Furthermore, the genes that lie within deoxyribonucleic acid, commonly known as DNA, increases the propensity to alcohol consumption in youth. This discovery creates a larger gap when working to identify effective treatment techniques to reduce alcohol and binge drinking among youth.

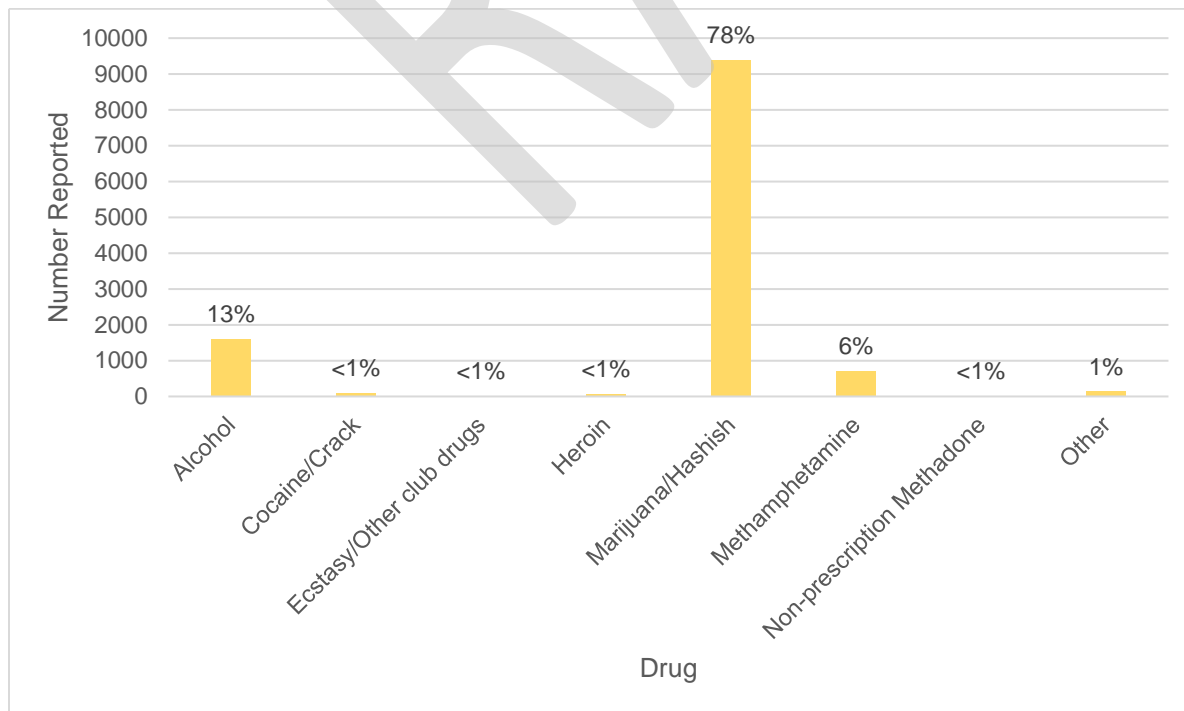
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<sup>46</sup> NIH News, April 2, 2015. <http://www.niaaa.nih.gov/news-events/news-releases/study-defines-brain-and-behavioral-effects-teen-binge-drinking>. Accessed March 14, 2017.

**Chart 10: Substance Use Disorder Drug Reported at Admission (CalOMS Tx, FY 2013-14) <18**



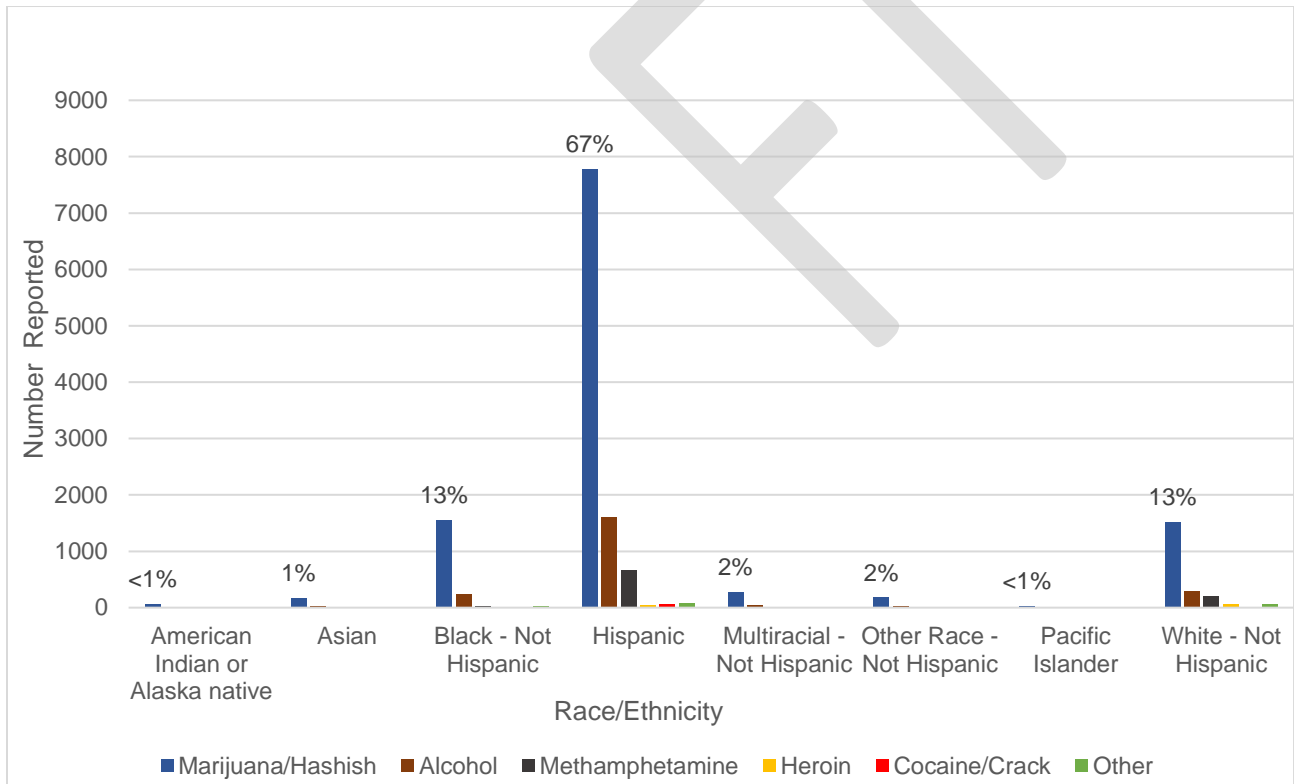
**Chart 11: Substance Use Disorder Drug Reported at Admission (CalOMS Tx, FY 2014-15) <18**



From FY 2013-14 to FY 2014-15, California’s adolescent marijuana and alcohol use dropped across ethnicities, but remains highest among Hispanics. The number of Hispanic adolescents that identified marijuana as their primary drug of choice dropped from approximately 8,000 to a little over 6,000.

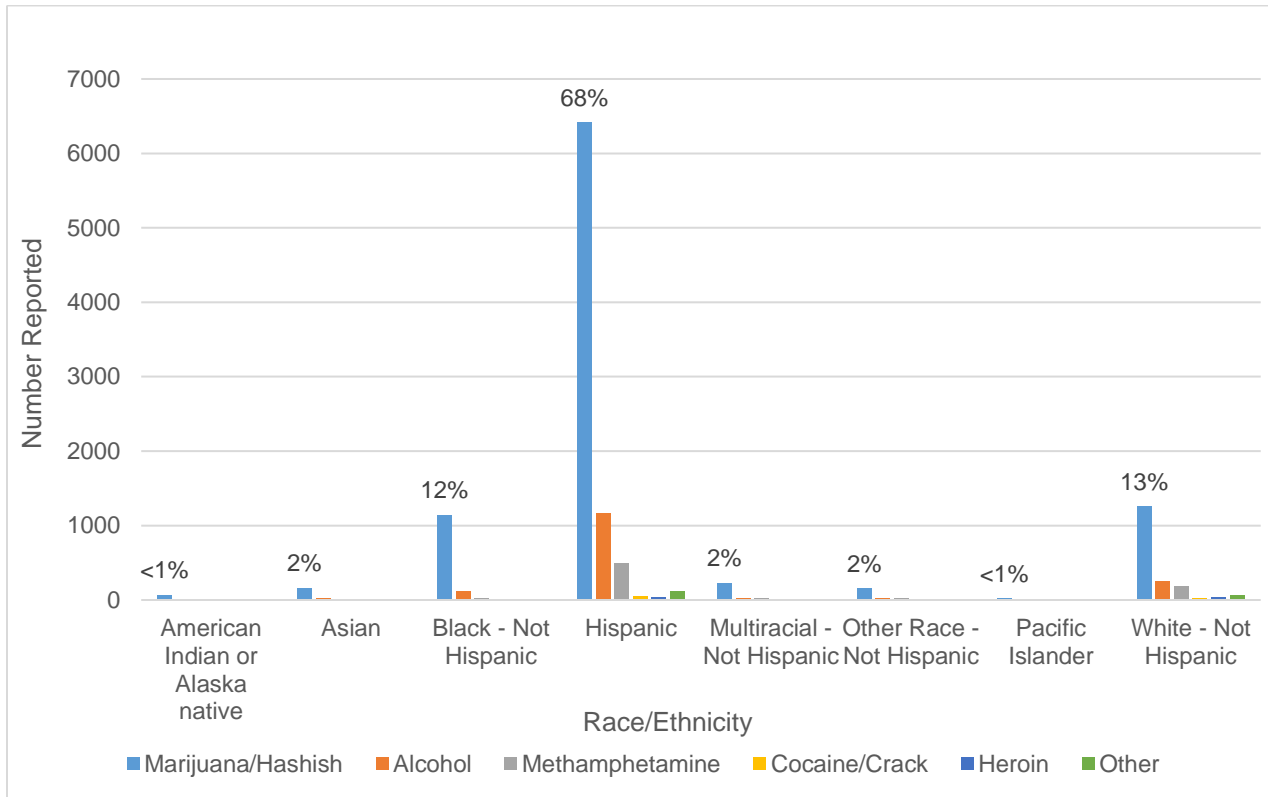
In FY 2013-14, the second highest ethnic group who identified marijuana as their primary drug of choice were Black, at approximately 1,500 followed by White, at about 1,450. In FY 2014-15, the marijuana use by Black and White reversed, at approximately 1,100 and 1,300, respectively. Preliminary findings for FY 2015-16 indicate that marijuana and alcohol use continues to drop. For a detailed illustration of these data, please see Charts 12 and 13.

**Chart 12: Primary Drug of Use at Admission by Race/Ethnicity (CalOMS Tx, FY 2013-14) <18**





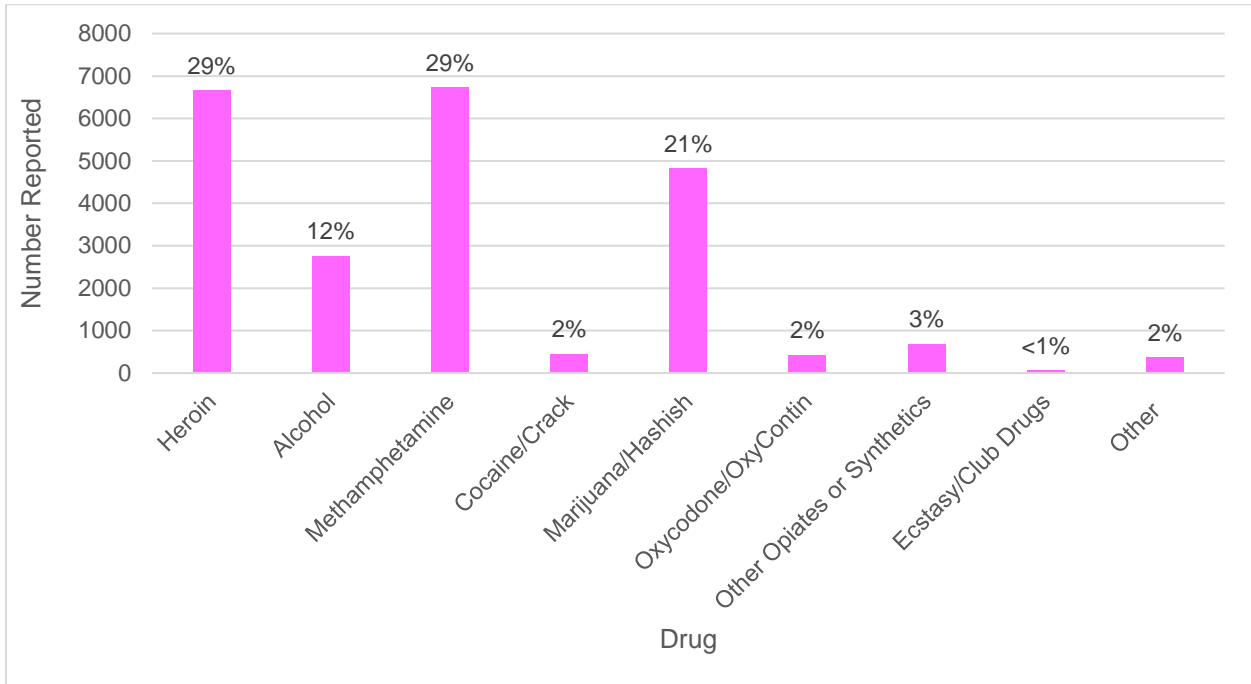
**Chart 13: Primary Drug of Use at Admission by Race/Ethnicity (FY 2014-15) <18**



**Primary Drug of Choice among Transitional Age Youth**

While marijuana and alcohol were the primary drug of choice reported for youth, TAY report a different primary drug of choice at admission. The highest primary drugs of choice reported for TAY in FY 2014-15 were methamphetamine and heroin. Approximately 10,000 TAY reported use of methamphetamine and heroin compared to approximately 4,000 TAY who reported marijuana as the primary drug. Chart 14 portrays the primary drug of choice at admission for TAY.

**Chart 14: Substance Use Disorder Drug Reported at Admission (CalOMS Tx, FY 2014-15) for Transitional Age Youth (18-24)**



In FY 2014-15, the largest TAY users of heroin were White, at approximately 3,600, and Hispanics at approximately 1,200 individuals. However, there was a higher number of Hispanic TAY using methamphetamine, at approximately 2,700 compared to about 2,000 Whites.

The cause(s) for the difference of the primary drug choice between adolescents and TAY is unknown. Further research and feedback from stakeholders who have first-hand experience with youth in treatment would provide a better understanding of the abrupt shift in primary drug of choice.

**Gaps in Adequately Serving California’s Youth**

Treatment Access

In addition to having large geographic areas without residential facilities to treat youth with SUDs across the continuum of care, the delivery of service requires a trained workforce in treating youth with SUDs. YAG stakeholders have indicated that there are counties with limited staffing, which can result in staff burnout.

Barriers to Developing a Trained Workforce

The YAG stakeholders indicated there is a shortage of a trained workforce in youth SUD treatment due to educational and training limitations. Currently, higher education classes do not include SUD treatment for youth in the curriculum for behavioral sciences. In addition, continuing education courses are limited in this field of study. The draft YSPM requires that a Licensed Practitioner of the Healing Arts (LPHA) or a

California certified counselor provide SUD treatment services; however, due to the lack of a trained workforce, this requirement is difficult to meet.

In addition to the lack of higher education in SUD treatment for youth, classes in cultural competency are necessary; however, data is not available to indicate whether counselors or practitioners receive cultural competency training. With the higher percentages of non-white youth in DHCS monitored SUD treatment facilities, classes in cultural competency would ensure effective, culturally and linguistically appropriate services.

In order to develop a trained workforce, DHCS needs to enter into a collaborative process with CDE and other oversight agencies to expand training opportunities.

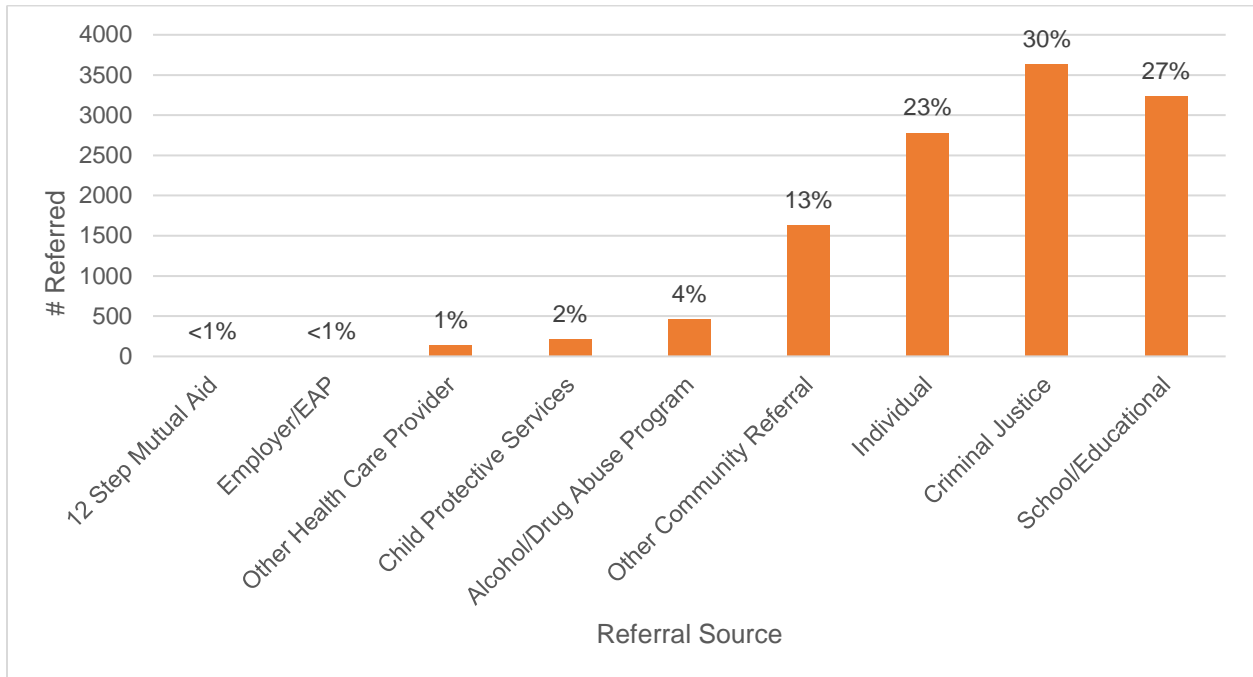
### Referrals to Treatment

According to the CalOMS Tx data pulled for this assessment, the two major sources for referral of youth to SUD treatment are the criminal justice system and schools. Nearly 30 percent of all youth referrals to SUD treatment are from the criminal justice system and 27 percent are from schools and educational sources. Chart 15 indicates the percentage of youth referred to SUD treatment by referral source.

However, CalOMS Tx does not identify whether AOD counselors working in the criminal justice or education systems are certified. In addition, it is not certain whether the AOD counselors are trained to diagnose and deliver services in various treatment modalities for youth with SUDs.

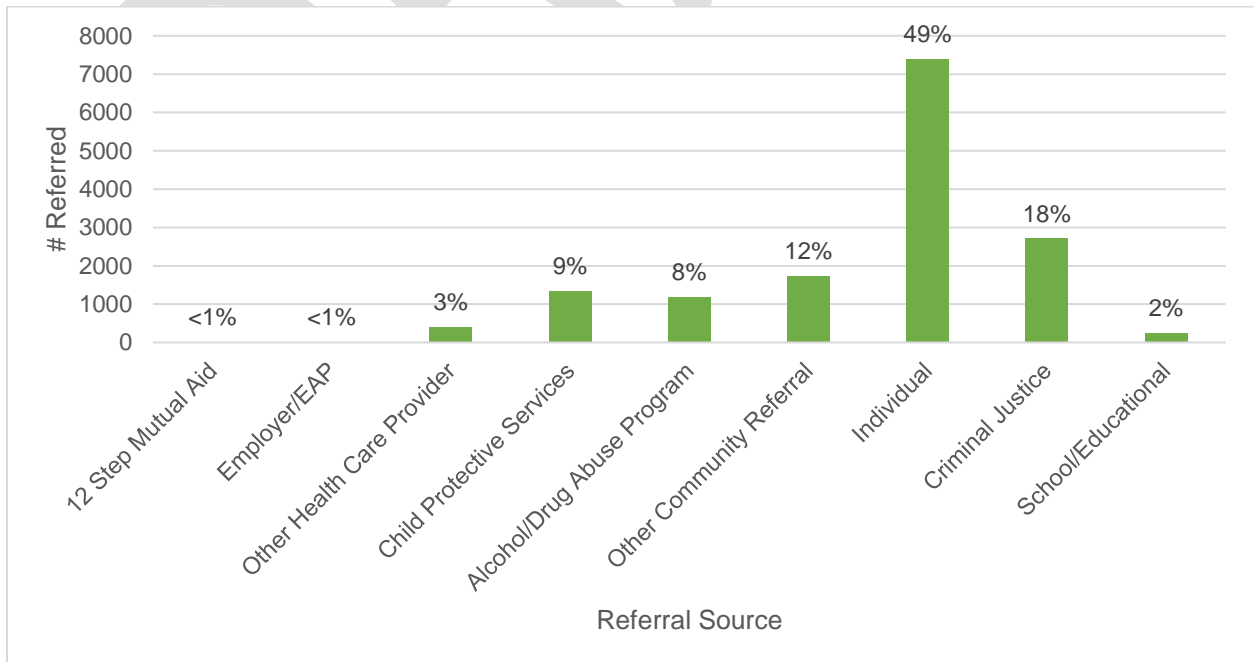
Furthermore, YAG stakeholders indicated that referrals by the criminal justice system were often problematic because “doing the time” of the sentence becomes the focus of treatment rather than the actual treatment time necessary for recovery. In other cases, court sentences referred youth to incorrect level of treatment services.

**Chart 15: Referral Source to Treatment <18 (CalOMS Tx, FY 2014-15)**



While criminal justice is the most prevalent referral source for adolescents to SUD services, the highest TAY referral source is individual referral, including self-referrals. Over 7,000 referrals for TAY to SUD treatment were individuals compared to approximately 2,700 referred by the criminal justice system. Chart 16 illustrates the significant difference of referral source.

**Chart 16: Referral Source to Treatment 18-24 (CalOMS Tx, FY 2014-15)**



## **Funding**

Every fiscal year, counties receive SAPT BG funds distributed by the state to support youth SUD treatment services. Annually, the amount of SAPT BG funds allocated to youth SUD treatment can vary. In the federal fiscal year (FFY) 2013-14<sup>47</sup>, there was approximately \$7.3 million allocated to youth SUD treatment. Based on client data submitted for FY 2013-14, there were around 25,720 SUD youth served, and the state expended approximately \$285 per person for SUD treatment services. In addition, there are discretionary dollars allocated to counties as part of the SAPT BG, and these can be used to fund any portion of the continuum of care (e.g., early intervention and recovery support); however, many counties have the money earmarked for other SUD services.

Some providers receive DMC reimbursements for individuals that qualify for Medi-Cal benefits. Medi-Cal qualifications are determined primarily on family income and assets. Treatment programs receive reimbursable SUD treatment funds for eligible Medi-Cal beneficiaries. In FY 2013-14, the statewide total for SUD services to all ages was approximately \$141,733,000. Reimbursable funds for intensive outpatient treatment totaled about \$11.5 million in FY 2013-14 and about \$19.6 million in FY 2015-16.

In addition to these federal and state resources, the counties work with other individualized funding sources at the local level as well.

According to YAG stakeholders, funding is the largest barrier to building capacity, increasing access, and developing workforce. The lack of funding to increase youth treatment services and the number of residential beds makes it difficult to increase capacity. In addition, decreases in federal funding for treatment services requires a collective effort to develop innovative capital projects to increase treatment and residential facilities statewide.

## **Conclusion**

The data presented in this assessment reported data on youth and TAY admitted into SUD treatment from FY 2013-14 to FY 2014-15. It revealed several gaps in current youth SUD treatment services that exist statewide. This includes a funding gap for early intervention and recovery support services for youth.

It also reaffirms the complexity of the categorization of youth with SUDs and the need for a diverse strategy to lower rates of youth with SUDs. To address this diversity, collaborative input from YAG members would provide a more accurate and individualized approach for youth SUD treatment services for each county. In addition, this assessment highlighted areas where there are challenges to access SUD services, disparities in the population served, and lack of funding resources. Moreover,

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<sup>47</sup> The Federal Fiscal Year runs from October 1 through September 31.

stakeholder feedback indicated an underlying necessity for a holistic system of care for youth.

A holistic system of care for youth offers client-centered, family-supported SUD treatment and recovery services that are age appropriate. In accordance with the National Cultural and Linguistically Appropriate Services (CLAS), delivery services must be delivered with cultural and linguistic competency.

Moving forward, this assessment provides information to assist DHCS and its interagency partners and stakeholders to create a collaborative strategic plan to build a statewide SUD treatment system of care for youth. Youth are the future of California, and the investment by DHCS, the members of the YAG, community leaders, families, and other stakeholders to address the areas of need to ensure their health and wellbeing is the beginning for a healthier California.

DRAFT