Changing the Landscape

A Study of the Impact of Alcohol and Other Drug Abuse in our Community – 2005

County of Sacramento Board of Supervisors

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1992 – 2002… "10 Years of Healing, Protecting and Caring"

January 1, 2005

To: Reader

Subject: *Changing the Landscape* Preliminary Report

We are pleased to provide you with a copy of the new *Changing the Landscape* report. This is the second such effort to gather data and provide information about the impacts of alcohol and other drug use on our community.

Changing the Landscape provides community leaders, program planners, agency directors and the community with an overview of the ways that alcohol and other drugs (AOD) impact the quality of life in our community. It is our hope that armed with information and knowledge stakeholders will find new and collaborative ways to address the adverse consequences that substance use creates.

The *Changing the Landscape* effort is a collaborative process, including participation of the Alcohol and Drug and Public Health Advisory Boards; the Alcohol and Drug Services and Public Health, Promotion and Education Divisions of the Department of Health and Human Services; and a myriad of other stakeholders including mental health, child protective services, law enforcement, community agencies, trauma centers, education and others.

Within the document you will find information about how alcohol and drug use affects six sectors - Alcohol Use; Health; Criminal Justice; Youth; Seniors and those with Co-occurring Mental Health issues. The data highlights problems that will benefit from structured efforts at solution-building, and critical problems where there is a lack of current data – seniors and perinatal substance exposure.

As an example, the pre-natal exposure of infants to substances is a problem of crucial proportion. Given old data, we can estimate that on average 2,800 new infants are born every year exposed to alcohol, tobacco and other drugs - the equivalent of 140 first grade classes. Yet, we lack current comprehensive data that could support efforts to address this critical problem and have a profound impact on the lives of mothers, children and the quality of life in our community.

We hope the information provided in this report is helpful. We hope that it encourages ideas and collaborative efforts to address the adverse consequences of substance use. This report is only a first step. In the near future, the *Changing the Landscape* collaborative will present the report to the County Board of Supervisors and the public. In addition, a new comprehensive strategic planning process is being launched to address AOD's adverse consequences.

This report is available on the Department of Health and Human Services website (www.sacdhhs.com). If you have any questions feel free to contact the Alcohol and Drug Services Division (916-875-2050). Thank you for your interest and support.

Warmest wishes:

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Alcohol and Drug Services Division

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PURPOSE

The purpose of the *Changing the Landscape* Report, and the related data gathering is to provide policy makers, program planners, and funding sources with information about the trends and patterns of alcohol and other drug (AOD) use in Sacramento County. It provides policy makers with a dynamic report card and program planners with a needs assessment, which reflects the changing pulse of AOD issues in Sacramento County. As a resource document, *Changing the Landscape* provides the basis for planning and responding to changing needs, and a benchmark for assessing the impact of AOD issues on our community. In addition, it provides a baseline of information to track the impacts of programmatic interventions over time.

It is, however, important to recognize that the report and the *Changing the Landscape* effort are dynamic and will change with every new version. It is also important to recognize that critical data gaps exist. Information about co-occurring disorders, perinatal substance exposure, seniors, youth, and ethnic and cultural groups are sparse or lacking altogether. As the effort continues it is an expectation that these limitations will be ameliorated.

BACKGROUND

This is the second edition of *Changing the Landscape.* The Public Health and Alcohol and Drug Advisory Boards submitted the first report to the Board of Supervisors on January 23, 2001. That effort was the by-product of a successful collaboration between the two Boards with support from the Public Health, Promotion and Education (PHPE) and Alcohol and Drug Services (ADS) Divisions of the Department of Health and Human Services (DHHS) and the Community Services Planning Council. It was the culmination of over 18 months of work by the Changing the Landscape (CTL) Task Force. As a result of that original effort, both policy makers and planners had access to a more unified and comprehensive status report on AOD use and abuse issues and the related adverse impacts. The report included ten recommendations to provide a foundation for action for both the County and the public. ADS submitted four key recommendations to the Board of Supervisors for approval and support.

The second edition of *Changing the Landscape* includes both updated data for trends reported in the first effort, and additional data to expand and enhance understanding of the impact of AOD use on Sacramento County. Finally, the document identifies areas of continuing need for service, and gaps in available data.

Changing the Landscape continues to be a collaborative product. Participants in this round included representatives from the Public Health and Alcohol and Drug Advisory Boards, Child Welfare, Mental Health, the Sheriff's Department, Probation, Coroner, local trauma centers and community-based agencies. Sacramento County Alcohol and Drug Services provided staff support for the effort. ADS contracted with LPC Consulting Associates, Inc. to conduct the primary research, data analysis and to draft the revised report.

The document reflects secondary data obtained from a variety of sources. In some instances the Task Force sought to include trends that were not previously available in existing data, from primary data collection and surveying. In other instances, in the absence of local data the report presents findings from state and national sources for extrapolating local impact. Data sources are noted throughout the document.

The updated version of *Changing the Landscape* is based on the foundation established in the original report. The underlying premises and assumptions of the original report remain valid. Its findings and conclusions are the subject of data updates.

The report also includes a brief status report on the original ten recommendations from the first edition of *Changing the Landscape* in Attachment A. However, the CTL Task Force asserts that progress on any of the recommendations in either the first or second report is critically dependent on the sustained efforts to address the first recommendation noted below. The quality of life in Sacramento County will only improve when we address the AOD impacts throughout our community.

It is important to reaffirm this report's emphasis on the primary recommendation from the first report, which was stated as follows:

> ***Recommendation: Establish alcohol and other drug issues (and the negative impact on the quality of life in our community) as one of Sacramento County's highest priorities.***

This recommendation continues to be both prescient and formidable. The Sacramento community continues to respond to the enormous social and economic consequences of AOD issues, from the County's human service systems, including criminal justice, through educational systems, impacts on homelessness, elder abuse, child abuse and neglect, domestic violence and premature death, among others. It is critical to acknowledge and recognize that AOD issues remain among the County's highest priorities as long as the consequences continue to impact our quality of life.

OVERVIEW OF THE REPORT

This report acknowledges six areas of AOD impact. The presentation of findings corresponds to these six areas, as follows:

Alcohol Use and Related Impacts

- Incidence and prevalence estimates;
- Consumption among young adults; and
- Alcohol sales revenue as an indicator of consumption.

Health Related Impacts

- Alcohol related collisions;
- Alcohol treatment admissions
- Hospital trauma center alcohol and drug screenings; and
- Perinatal substance exposure.

Criminal Justice Impacts

- Misdemeanor arrests; and
- Felony arrests.

Youth AOD Use Impacts

- Incidence and prevalence, California Healthy Kids Survey;
- Youth arrests for alcohol and drug related offenses; and
- Incidence and prevalence among Juvenile Hall detainees.

Senior AOD Use Impacts

- Incidence and prevalence; and
- Morbidity rates.

Co-Occurring AOD and Mental Health Issues

- Incidence and prevalence; and
- Diagnosis issues.

Highlights from each of these areas indicate what has changed since the previous report and any emerging trends. The summary analysis for each area includes trend data and identifies implications for the community. The report concludes with identification of data limitations and gaps, followed by recommendations based on the latest data and findings.

Alcohol Use and Related Impacts

In the first *Changing the Landscape* report, a major issue of emphasis was that alcohol was the primary substance of choice and the most problematic substance. This remains true for this report, as well. This is why it was an important step for the Sacramento County Board of Supervisors to formally acknowledge that alcohol was the most problematic substance. It is also why more work and effort must go into dealing with alcohol related problems including youth access, binge drinking and drunk driving.

As alcohol is the most widely consumed substance in Sacramento County, problems related to alcohol consumption cut across a broad spectrum of personal, professional, and environmental domains. Alcohol use is often a significant risk factor in child abuse, domestic violence, and criminal activity among both adults and minors. Traffic accidents, injuries, and fatalities, birth complications and defects, poor school performance, and a myriad of other health issues are heavily influenced by alcohol.

Based on the *California Health Interview Survey* (CHIS)[1], in Sacramento County nearly 516,126 persons (60% of the population) in Sacramento County consumed alcohol in the 30 days preceding the survey[2], and 141,396 (16% of the population) reported binge drinking in the 30 days preceding the survey. It is important to note that alcohol impact is not restricted to the problem drinker. Any alcohol consumption can create the opening for adverse consequences (e.g. drinking-driving accidents, injuries and death). The occasional, social drinker who believes they can drive home after drinking at a party is magnified by the sheer weight of numbers of individuals consuming alcohol in any given month. That creates a huge potential impact on the larger community. While the CHIS estimates must be reviewed with caution, they do provide a critical baseline to frame the consumption issue (see Figure 1).

This report also examines one population generally regarded as high risk - young people aged 18 to 22. In the absence of local data, this report includes an assessment of alcohol consumption based on findings from a national survey, which looked at the drinking behavior of this age group (see Figures 2 and 3). According to the 2002 results of the *National Survey on Drug Use and Health*, alcohol consumption is much higher among 18 to 22 year olds enrolled full time in college than the 18 to 22 year olds who are enrolled in college only part-time or not at all (Figure 3). A critical finding for this community is that nearly 44 percent of full-time college students report binge drinking in the 30 days prior to the survey, while 40 percent report themselves as heavy drinkers.

Alcohol consumption among 12 to 17 year olds represents another area of concern. Data from the *California Healthy Kids Survey* (CHKS) show that for seventh, ninth and eleventh grade students' alcohol consumption is becoming an increasingly critical problem in Sacramento County (see Figure 4).

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[1] The University of California Los Angeles Center for Health Policy Research, in collaboration with the California Department of Health Services and the Public Health Institute conducted a large scale telephone survey to residents of California. The survey encompassed most aspects of health including alcohol use, nutrition, exercise, brushing teeth, etc.) The sample responses were then extrapolated to project responses for the entire county. The adult sample included anyone over the age of 18. Approximately 1,231 persons were sampled. However, the data for this section was pulled for persons between the ages of 18 and 64.

[2] Alcohol prevalence/consumption defined as consuming at least 1 drink of alcohol in the month preceding the survey.

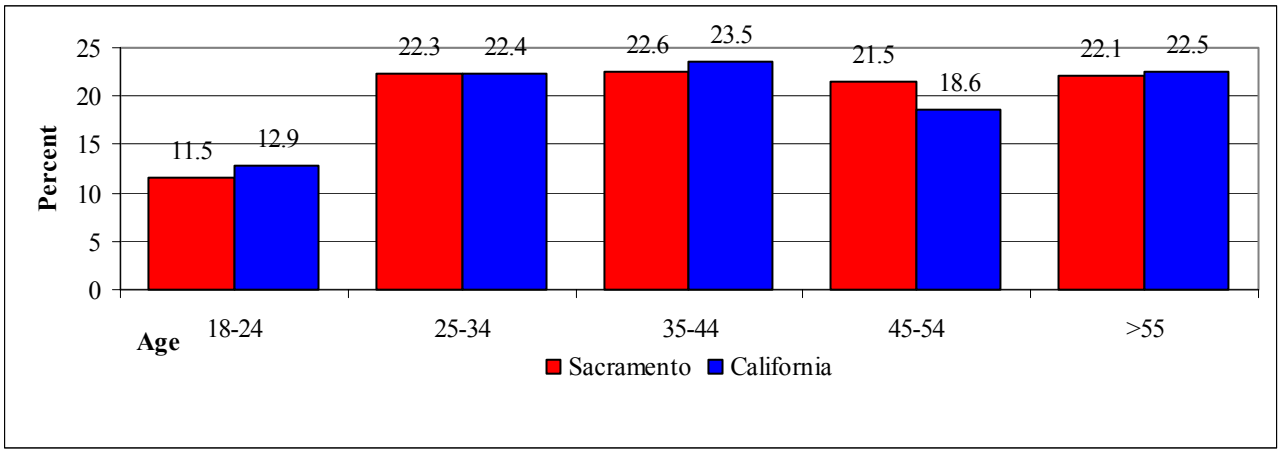
Incidence and Prevalence of Alcohol Use

In Sacramento County:

- 60% of the population consumed alcohol[3] in the 30 days preceding the survey (compared with 59% in California).
- 16% of the population reported binge drinking[4] in the 30 days preceding the survey (compared with 15% in California).

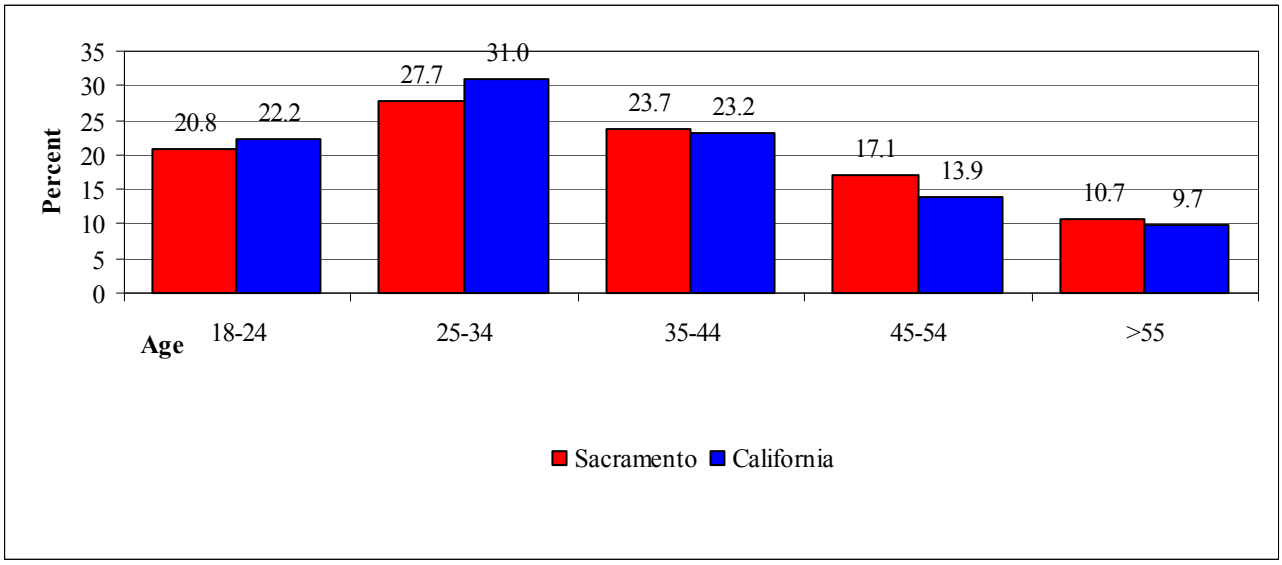
Source: 2001 California Health Interview Survey (UCLA)

Figure 1: Age Distribution of Alcohol Consumption in Sacramento County and California



Source: 2001 California Health Interview Survey (UCLA)

Figure 2: Age Distribution for Binge Drinkers in Sacramento County and California



Source: 2001 California Health Interview Survey (UCLA)

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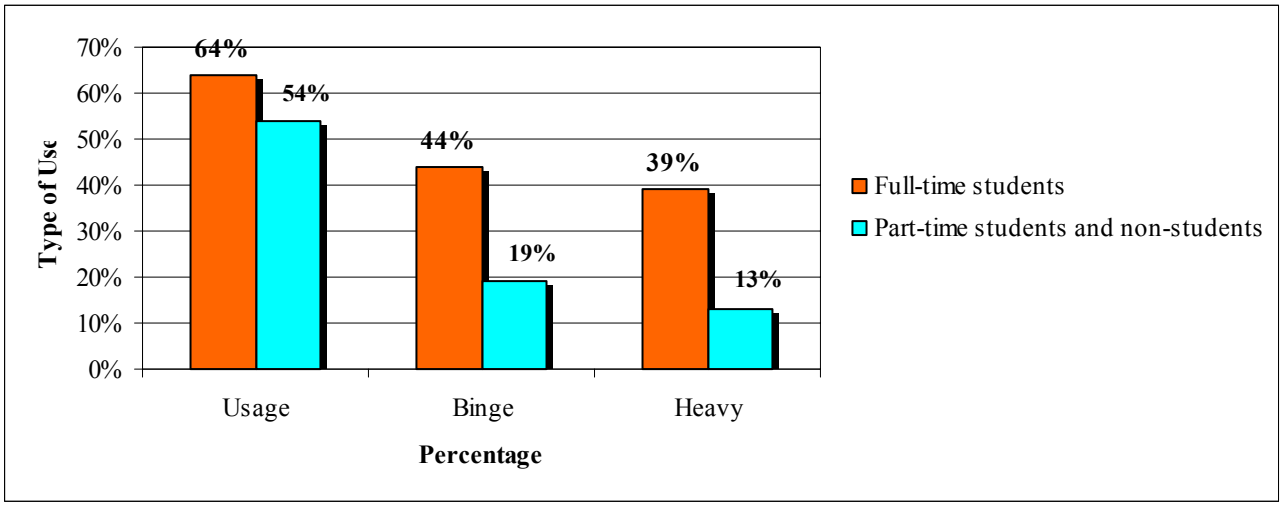
[3] *Alcohol prevalence/consumption is defined as consuming at least 1 drink of alcohol in the month preceding the survey.*

[4] *Binge drinker is defined as consuming at least 5 drinks at one time in the month preceding the survey.*

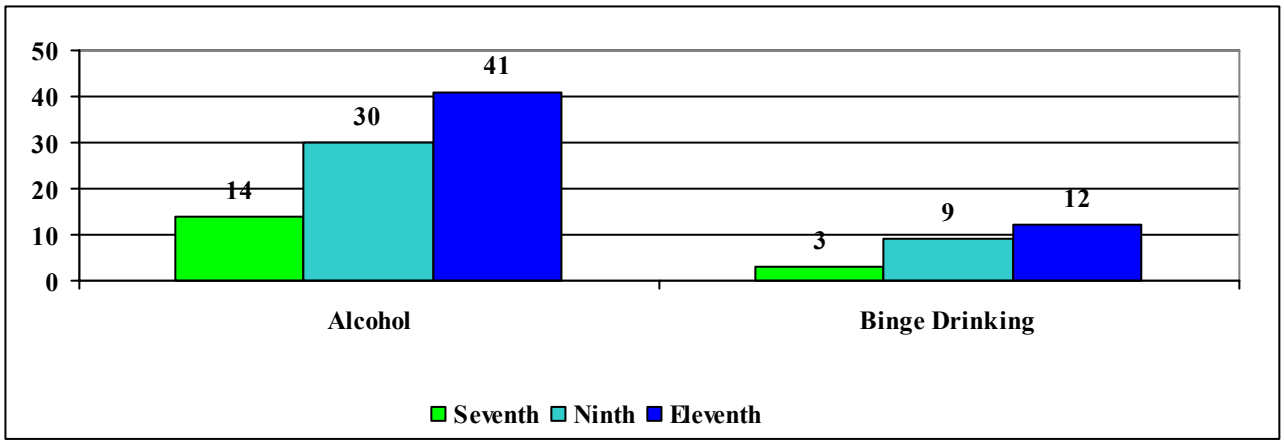
Incidence and Prevalence of Alcohol Use

Figure 3: Alcohol Consumption by Persons Age 18-22 Nationwide by Status of Enrollment in Higher Education



Source: Substance Abuse and Mental Health Services Administration: Results from 2002 National Survey on Drug Use and Health

Figure 4: Alcohol Consumption by Minors (% within the last 30 days) in Sacramento County



Source: Sacramento County California Healthy Kids Survey: 2001/02

The Sacramento County *CHKS* notes that surveyed youth feel that they have easy access to alcohol, as well as other drugs, on their campuses and in their lives. Youth access to alcohol is particularly troubling as it is a primary gateway substance for youth and creates some of the most harmful effects. Youth alcohol use is a contributing factor in the three leading causes of deaths of 12 – 18 year olds – accidents (vehicle and drowning), homicides and suicides.

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California Alcohol Sales Revenue and Consumption Estimates

In addition to indicators of drinking behavior, sales tax revenue on alcohol purchased provides another indicator of consumption, as shown in Figure 5. According to estimates made by the California State Board of Equalization, the state revenue from taxes collected on beer, wine, and distilled spirit sales has averaged between $250,000 and $350,000 per year since the 1993/94 fiscal year. Individually, beer and distilled spirits bring in the highest amount of revenue, each bringing in between $100,000 and $150,000 per year. Wine sales make up the smallest portion of the revenue from alcohol sales, bringing in less than $50,000 per year. These figures have stayed fairly constant since 1993/94, with the aggregate sales drifting upward slightly since 1999/00.

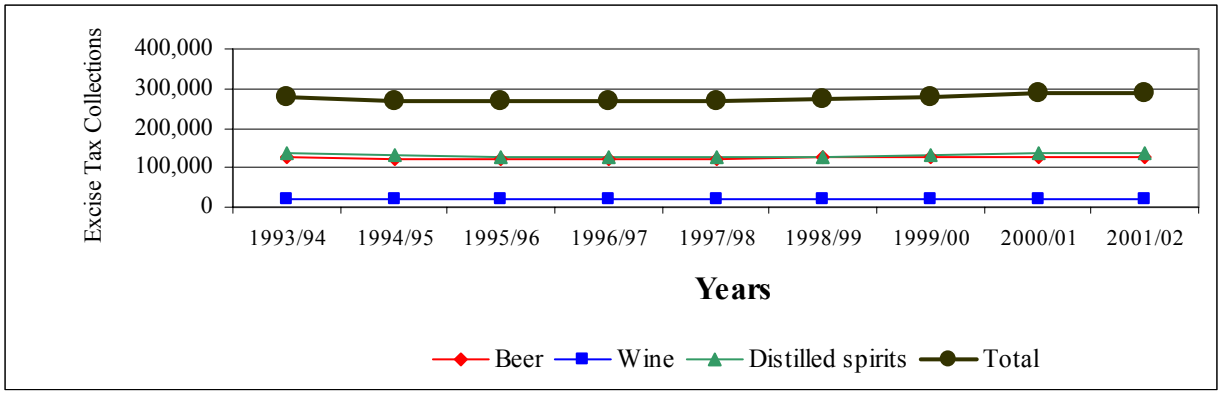
From the revenue stream, the Board of Equalization (BOE) estimations of the consumption of alcohol for the state are in Figures 6 and 7. According to BOE's estimates, the largest category of alcohol consumed is beer, with an estimated 600,000 to 650,000 gallons consumed each year. The estimated consumption of wine and distilled spirits is significantly lower, with roughly 100,000 gallons of wine and 40,000 gallons of distilled spirits consumed each year statewide. One explanation for the large difference in consumption might be the relatively low price of beer compared to other spirits.

Consumption of alcohol and in particular beer has been shown to be very price sensitive. In fact, one of the primary strategies for impacting youth consumption of beer is to raise the excise tax making it less affordable and thereby reducing overall youth consumption. However, it should be noted that the actual tax cost of beer to the consumer has diminished as it has not kept pace with inflation for over ten years. The problem is this makes alcohol more accessible for youth, which is why it is the primary substance of binge drinking and use for minors and young adults. Current estimates are that one-fourth of beer consumption is by underage drinkers, which equals close to 162,500 gallons of beer. According to the Center for Science in the Public Interest, for every one percent increase in the price of beer, the traffic fatality rate declines by 0.9 percent.[5]

[5] *Ruhm, CJ (1996). Alcohol policies and highway vehicle fatalities. Journal of Health Economics. 15 (4):435-454.*

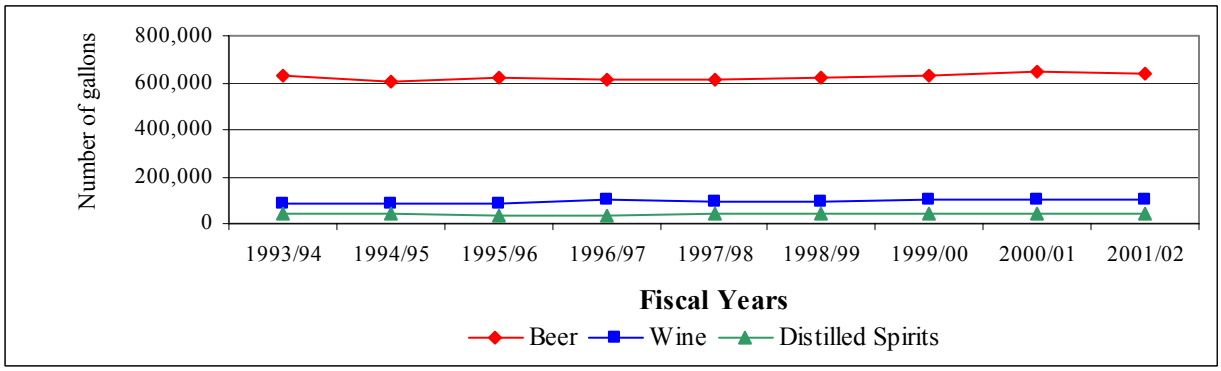
California Alcohol Sales Revenue and Consumption Estimates

Figure 5: Beer, Wine, and Distilled Spirits Excise Tax Collections in California (in thousands of dollars)



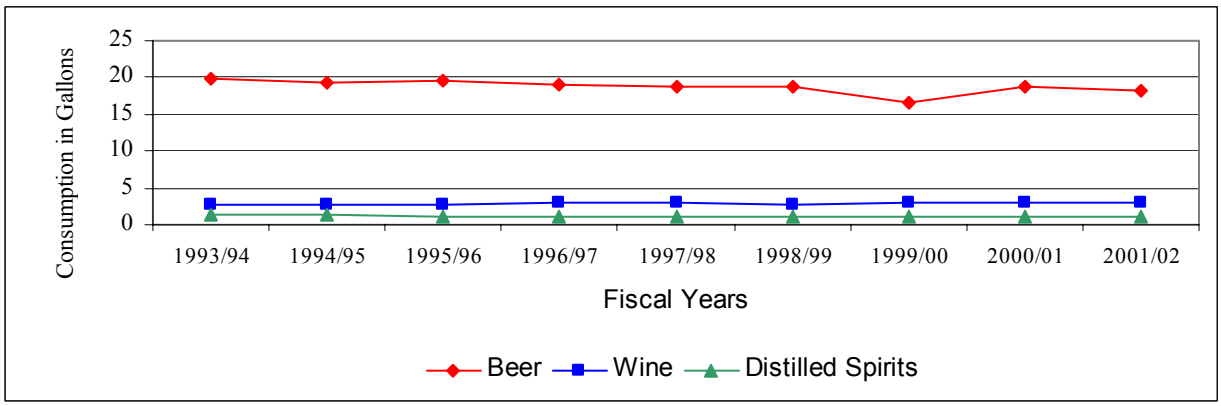
Source: California State Board of Equalization, Annual Report

Figure 6: Apparent Consumption of Beer, Wines and Distilled Spirits in California (in thousands of gallons)



Source: California State Board of Equalization, Annual Report

Figure 7: Apparent Consumption of Beer, Wines and Distilled Spirits in California per person (in gallons)



Source: California State Board of Equalization, Annual Report

Health Related Impacts

Health costs for alcohol and other drug impacts relate not only to the direct costs for treatment and medical services provided to individuals and families that are impacted by AOD related injuries and death, but include the value of lost productivity, which occurs through AOD related injuries and deaths. The physical health and emotional well-being of the County's residents are explicably linked to health costs associated with the adverse consequences of AOD use. From victims of Driving Under the Influence (DUI) accidents, to health care needs of affected seniors, to lost earnings and the full spectrum of treatment costs, everyone shares in the costs directly through insurance premiums, hospital costs, and taxes that support various services. Yet, huge savings can accrue to the community that addresses AOD adverse impacts as shown through the CalDATA study (1997), which noted $7.00 of savings for every $1.00 spent on treatment for the AOD involved. This section presents data trends related to some of the more prominent health consequences and services.

Alcohol Related Collisions

Alcohol related collisions data describes annual trends for fatalities, injury accidents, and the impact on drivers, passengers, pedestrians and bicyclists who share the roadways where drinking and driving occurs. Figure 8 through 11 present these findings.

In general, since 1994 there has been a slight increase in the number of fatal alcohol related collisions from 49 to 55 in 2001, the highest number in the past 8 years (see Figure 8). The number of alcohol related injury accidents generally decreased over the past 8 years, from 1,671 in 1994 to 1,507 accidents by 2002 (Figure 8). Overall the number of injuries declined over the 8-year time period and the number of fatalities increased[6]. These trends include drivers, passengers, pedestrians, and bicyclists.

While these statistics represent incidents that occurred, costs that attach to such incidents can include emergency medical care, loss of job, loss of income, rehabilitation costs, law enforcement and judicial interventions, and in the extreme the loss of life and all of its concomitant impacts.

According to the National Public Research Institute the estimated cost for an alcohol related fatality in California is $3.7 million, with $1.4 million in direct monetary costs and $2.3 million in quality of life losses. The estimated costs for an alcohol related injury is $91,000, with $41,000 in actual costs and $50,000 in quality of life losses. They note in their report that reducing alcohol related crashes by 10 percent would save over $290 million in the state of California in claims payments and loss adjustment expenses.[7] The 55 fatalities in 2002 in Sacramento County, by this estimation cost over $203 million.

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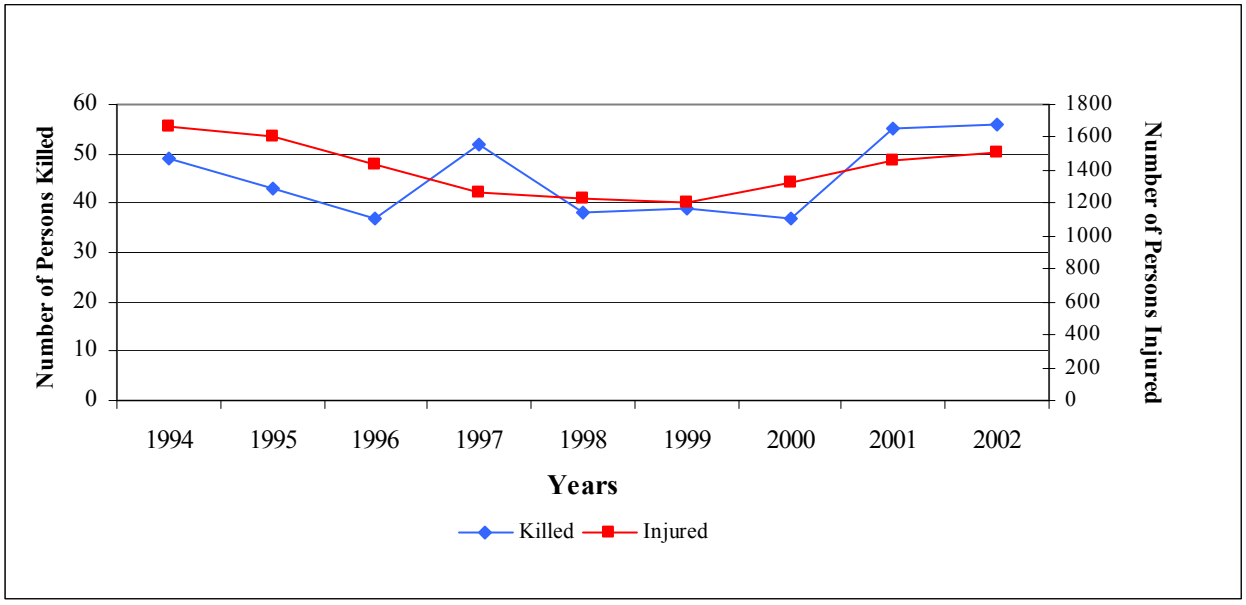
[6] *We do not know how many fatalities ensued per collision nor can we ascertain whether the increases are anomalies or trends.*

[7] *National Public Services Research Institute in cooperation with the National Traffic Safety Administration*

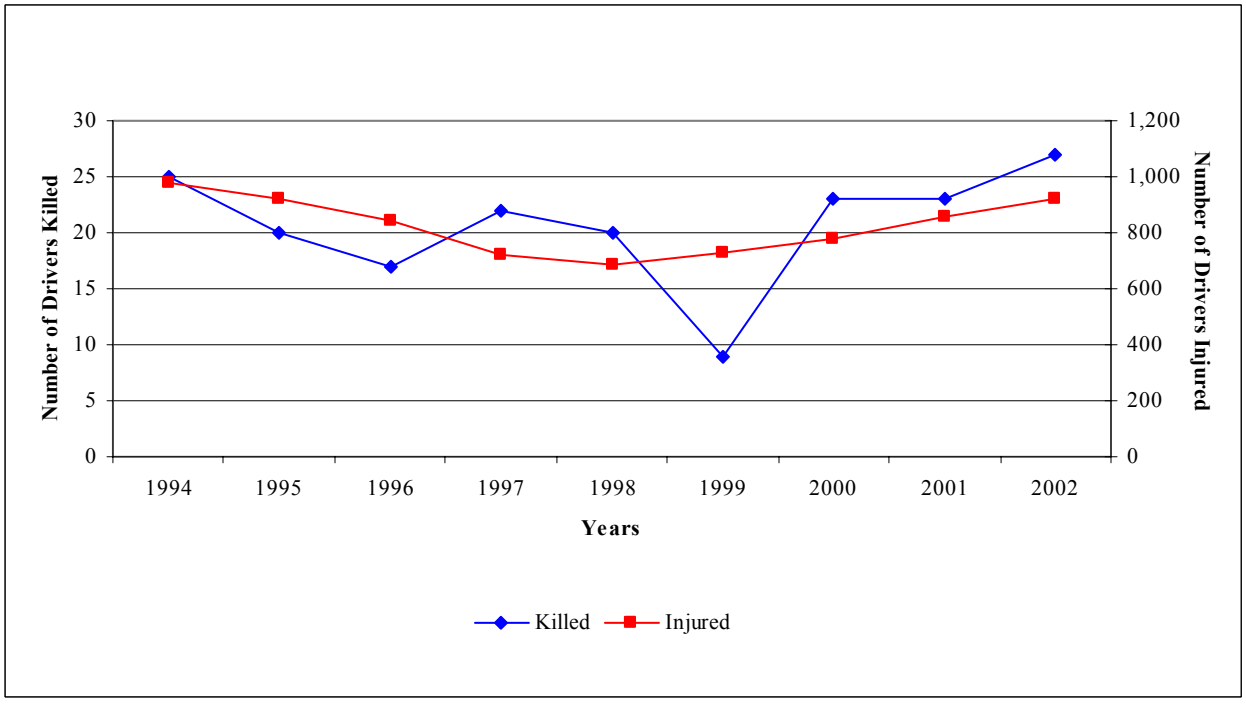
Alcohol Related Collisions – Sacramento County

Figure 8: Total Persons Killed And Injured in Alcohol Involved Collisions



Source: Statewide Integrated Traffic Reporting System (SWITRS)[i]

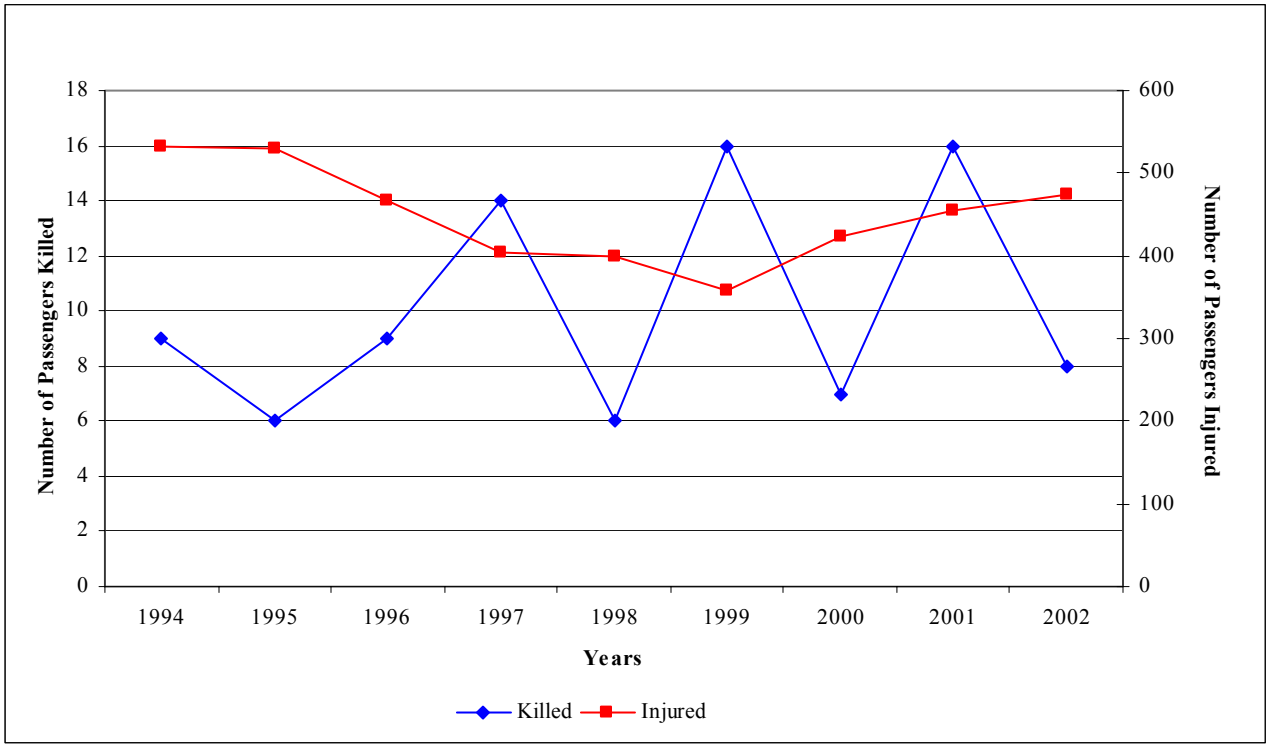
Figure 9: Drivers Killed and Injured in Alcohol Involved Collisions



Source: Statewide Integrated Traffic Reporting System (SWITRS)

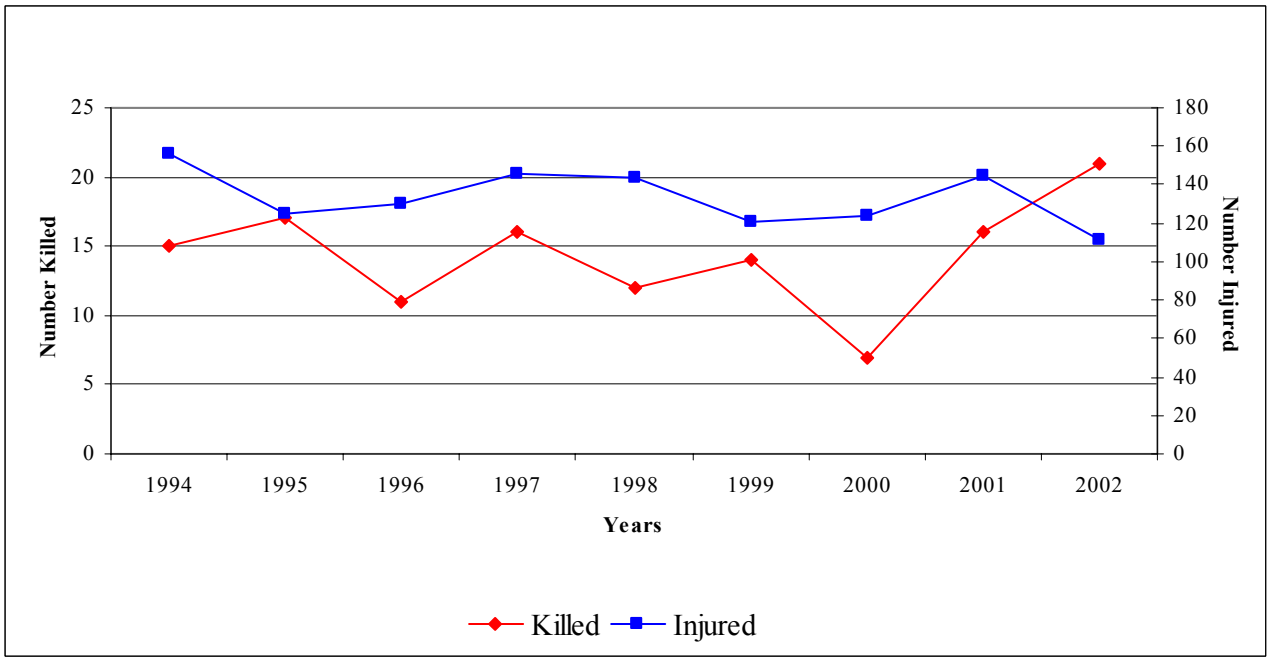
Alcohol Related Collisions – Sacramento County

Figure 10: Passengers Killed and Injured in Alcohol Involved Collisions



Source: Statewide Integrated Traffic Reporting System (SWITRS)

Figure 11: Pedestrians & Bicyclists Killed and Injured in Alcohol Involved Collisions



Source: Statewide Integrated Traffic Reporting System (SWITRS)

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Sacramento County Treatment Admissions

In each of the last two years, there were over 7,000 treatment admissions for alcohol and other drug (AOD) treatment for 6,000 non-duplicated individuals who seek and receive services from publicly funded community-based treatment programs. At the present time, it is not possible to estimate the number of individuals receiving treatment services through private agencies, hospitals, Employee Assistance Programs and other private venues. In addition, an undisclosed number of individuals participate in 12-step recovery programs like Alcoholics Anonymous or Narcotics Anonymous. However, even with these additional private resources the demand for services exceeds capacity. For example, if one considers binge drinkers, which is 16 percent of the population, as a likely target population needing treatment, that estimate accounts for over 141,000 individuals.

Since the 1998/99 fiscal year, the number of admissions into County funded treatment programs has increased from about 5,400 to 7,600 admissions (Figure 12). This represents more than a 70 percent increase in treatment admissions in the last five years. Increases have been supported by collaborative efforts with the Department of Human Assistance and CalWORKs, partnerships with Child Protective Services and Mental Health (both Children's and Adult) and the impact of the Substance Abuse and Crime Prevention Initiative authorized by Proposition 36.

According to the Alcohol and Drug Services Division *System of Care* report (FY 2002/03), the *substances reported as most frequently used* were alcohol (19%) followed by marijuana (17%) and methamphetamines (16%), (see Figure 13). While alcohol use is identified as the primary drug problem in Sacramento County it is important to note that even for persons entering treatment for a different primary drug of choice, alcohol is the most noted secondary drug in their poly-drug use. Methamphetamine use is becoming more prominent in treatment admissions, as shown in Figure 14. More than one-third of treatment participants identified methamphetamine use as their primary problem drug with about the same rate identifying alcohol as their secondary problem drug (36% to 37%).

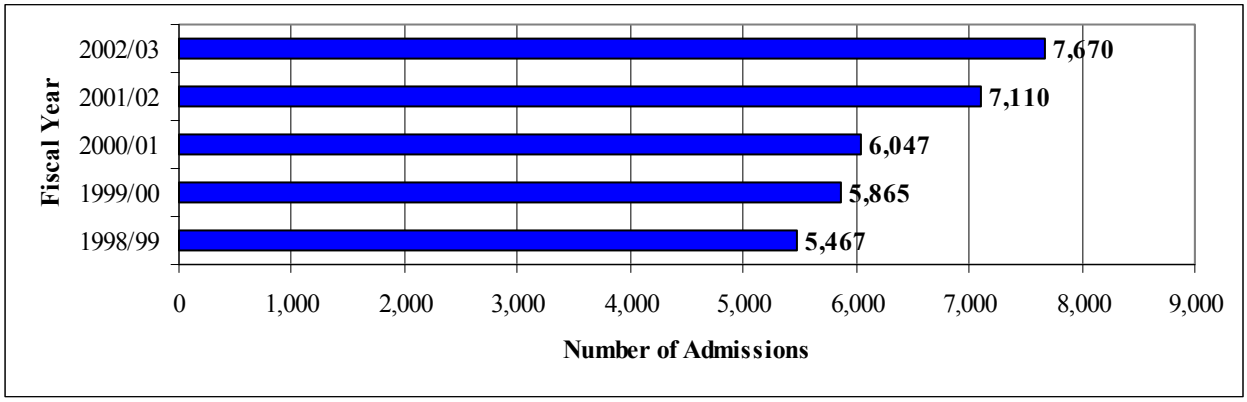
Currently, Sacramento County provides funding for 24 AOD treatment providers. In addition there are self-help groups located throughout the County with an unknown number of regular participants. While no single treatment modality serves the needs of all populations, recent experience shows that treatment supported by Recovery Specialists (case management) appears to improve the chances for participant success. This is particularly true for clients with multiple and complex needs. Key elements that are considered essential in a best practice model System of Care are:

- A full continuum of treatment services, including detoxification, residential, outpatient and continuing care;
- Ease of access to treatment services with few barriers for clients;
- Treatment which is individualized, culturally and gender appropriate; and
- Treatment that is available for sufficient duration (minimum of 3 months) to have an impact.

Sacramento has many of these components in place including a full continuum of care for adults. There are programs that are gender and culturally adept, although some components are more substantial than others (e.g. pregnant and parenting women's services compared to culturally specific and youth treatment services). Demand on the public care system puts pressure on treatment availability and client retention, but services are available that can keep clients engaged in some level of care for three months or longer.

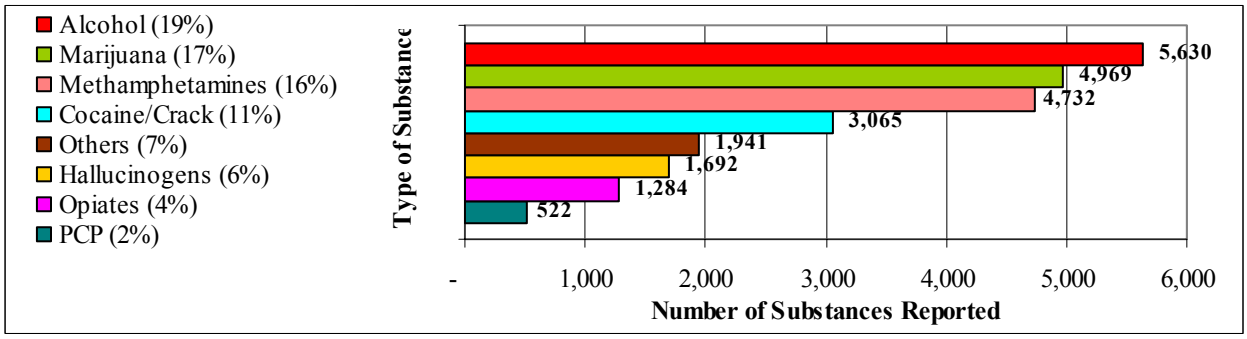
Sacramento County Treatment Admissions

Figure 12: Total Number of Treatment Admissions in Sacramento County



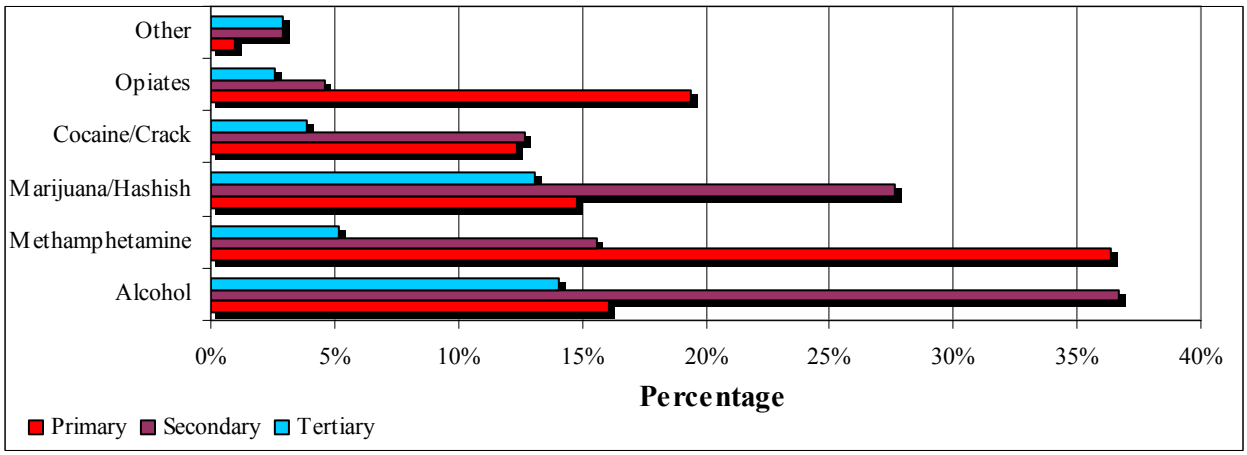
Source: LPC Consulting Associates, Inc. Sacramento County Alcohol and Drug Services Division. CADDS and CADDS Supplement Summary Information Report. July 2002 through June 2003.

Figure 13: Number and Percent of Substances Reported as Most Frequently Used in Sacramento County



Source: Sacramento County Department of Health and Human Services Alcohol and Drug Services Division System of Care Report; June 2002 – June 2003

Figure 14: Drug Problems for Poly-drug Clients in Sacramento County



Source: LPC Consulting Associates, Inc. Sacramento County Alcohol and Drug Services Division. CADDS and CADDS Supplement Summary Information Report. July 2002 through June 2003.

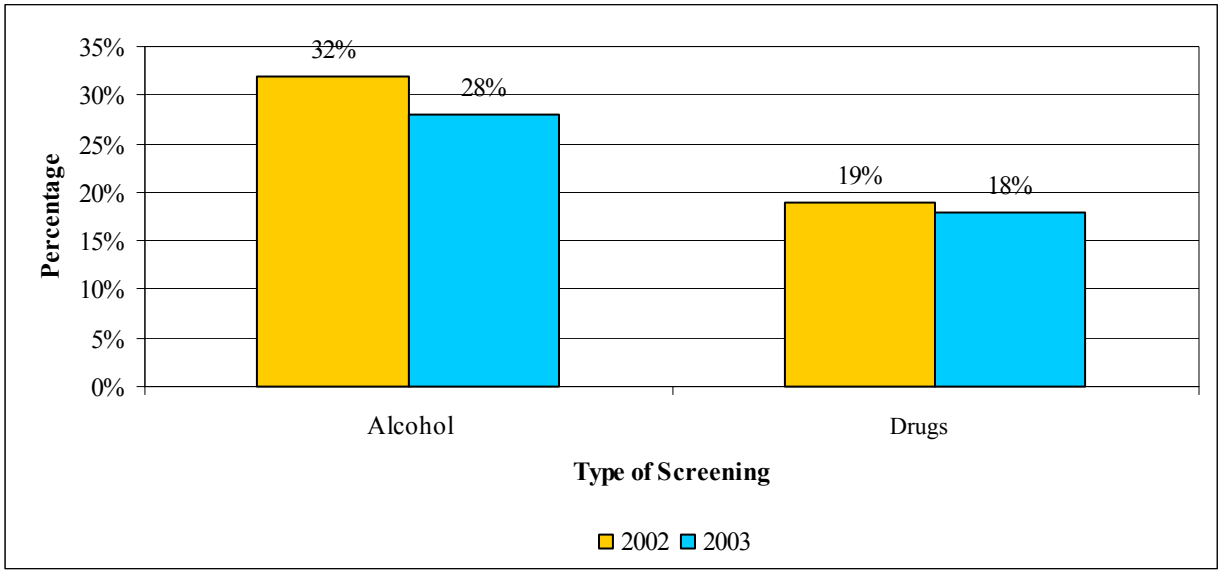
Hospital Trauma Center Alcohol and Drug Screenings

In Sacramento County there are two trauma centers, a Level 1 facility (UC Davis Medical Center) and a Level 2 facility (Mercy San Juan Medical Center). In cases of severe trauma patients are directed to one of these two sites for trauma services. UC Davis, as the Level 1 facility receives approximates 60 percent of all trauma incidents (2002 = 2,851; 2003 = 2,952). The hospital data in Figure 15 is based on reports from UC Davis' Trauma Center for 2002 and 2003. Approximately 70 percent of all trauma patients are being screened for alcohol and other drug use. The positive results for both the alcohol and drug screenings from 2003 decreased from 2002 levels.

The three most prevalent categories of trauma incidents are motor vehicle (driver and passenger), bicycle and pedestrian. UC Davis screens approximately trauma patients for alcohol levels and drugs (legal and illegal) in their system. These are two separate screening panels and patients who test positive for one (alcohol) may also test positive for the other (drugs), creating some overlap in the data.

It is important to note that current California regulations allow insurance providers to deny coverage for injuries and illnesses precipitated by the use of alcohol and other drugs. This may account for the low numbers of reported incidents in the trauma facilities. In addition, the cost of AOD screening is prohibitive and not reimbursable through insurance, which may account for less than universal testing. Recent legislative efforts to change the insurance regulations were not successful.

Figure 15: Positive Alcohol and Toxicology Screening in Sacramento County Trauma Center

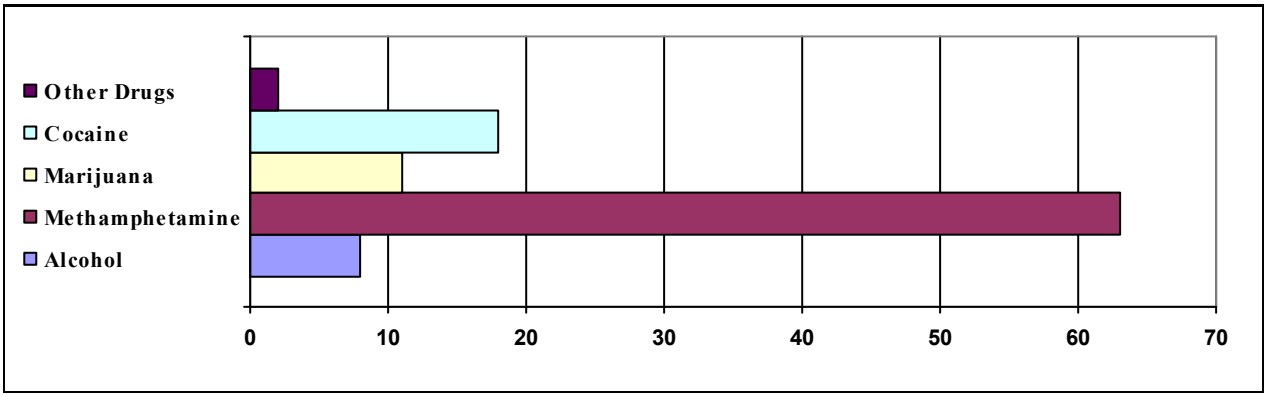


Perinatal Substance Exposure

The most recent comprehensive effort to study the impact on AOD use during pregnancy occurred in 1992, known as the *Profile of Alcohol and Drug Use during Pregnancy in California*. In that study the County of Sacramento had a higher rate of infants born to mothers who had used alcohol and other drugs during pregnancy (15.2%) than the overall rate for the State of California (11.4%).[8] Since that study, methamphetamine use has reached epidemic proportions, which increases the likelihood that use rates during pregnancy could be even higher. Using the 1992 prevalence rate on 2003 birth statistics (18,819) approximately 2,800 substance exposed[9] infants may have been born in Sacramento County. That is the equivalent of the enrollment of 140 first grade classes each year.

- According to the 2001 *Savings Babies Lives Community Health Plan,* the average cost of a healthy baby's birth is around $5,000, while the potential medical cost for a substance exposed infant can range from $100,000 to $150,000.[10]
- Neo-natal medical costs for substance-exposed infants can run as high as $1,500 - $2,000 per day.[11]
- County funds (Los Angeles) paid to nurseries for substance-exposed infants that could not be placed in foster care equaled $3,700 per month per child (August 2001).
- Costs related to hospital care, foster care and special education from birth to 18 years old for a substance-exposed child are approximately $750,000.[12]
- Over 250 substance-exposed infants were reported to Sacramento County Child Protective Services in FY 2002/03.
- Methamphetamine is the most impacting drug of choice for parents involved in Sacramento County's Dependency Drug Court (see Figure 16).

Figure 16: Sacramento County Dependency Drug Court Drug of Choice



[8] *Profile of Alcohol and Drug Use During Pregnancy in California, 1992. Vega, Wm A.; Kolody, Bohdan; et. al. September 1993*
[9] *Substance exposure was defined to include alcohol, tobacco and other drugs.*
[10] *Sacramento County Public Health Advisory Board Report; 2001.*
[11] *House Bill 1697; March 1997.*
[12] *Department of Justice; November 1997.*

Criminal Justice Impacts

The criminal justice system responds to many AOD use issues, due to the illegality of behaviors that occur while under the influence and by virtue of the illegal status of specific substances or age-related use. In fact, the CalDATA study indicated that the most significant savings from treatment expenditures accrues to the criminal justice system.

There are several sources of data from the criminal justice system that present trends related to AOD related arrests and other indicators that illustrate the impact of AOD on violence. The rate of alcohol and/or drug related arrests in Sacramento County gradually increased over the past 9 years, as noted below:

- The rate of alcohol-related misdemeanor arrests increased from 36% to 42% of misdemeanor arrests (an increase of 17%), (see Figure 17).
- Misdemeanor arrests for drug related offenses increased 6% over the 9-year period (from 5% to 11% or a 120% increase)[13].
- Adult felony drug arrests have remained constant between 1993 and 2002 (6%) with a slight decrease in 1995 to 5.5% and a slight increase in 1998 to 8%[14] (see Figure 17).

The percentage of male arrestees who tested positive for drugs increased[15] (see Figure 18).

- The percentage of arrestees who tested positive for any drugs increased from 71% in 1998 (n=472) to 79% in 2002 (n=1331).
- The percentage of arrestees testing positive for multiple drugs increased more substantially from 20% in 1998 to 31% in 2002 (55% increase).
- Methamphetamine use among arrestees increased steadily over the five years from 25% in 1998 to 36% in 2002.
- Cocaine use, which hovered around 18%, was the only drug that remained relatively constant over the 5-year period, with a slight decline to 16% in 1999 and a slight increase in 2002 to 20%.
- The Arrestee Drug Abuse Monitoring (ADAM) program collects self-reported data on arrestee alcohol consumption. The most recent ADAM report notes that for arrestees interviewed:
    - 54% binged in the prior 30 days;
    - 30.4% reported heavy alcohol use in the prior 30 days; and
    - 37% were at-risk for alcohol dependence[16]

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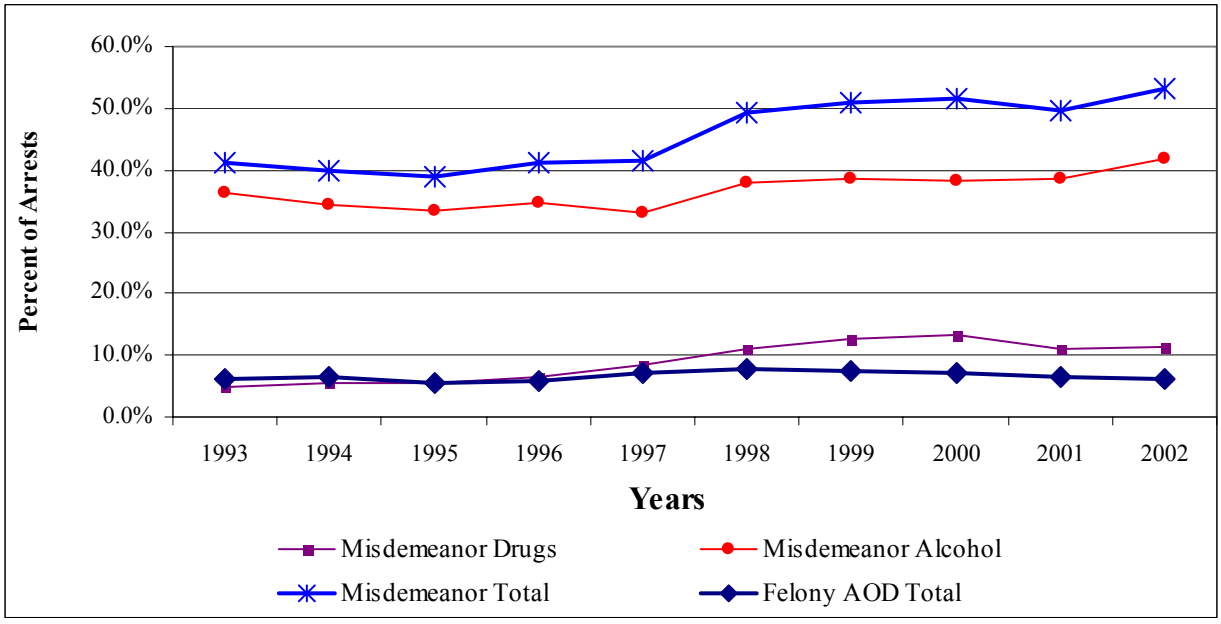
[13] *Misdemeanor drug and alcohol arrests include marijuana, other drugs, drunk, liquor law violations, driving under the influence, and glue sniffing.*
[14] *Felony drug offenses include narcotics, marijuana, other dangerous drugs, and driving under the influence (DUI).*
[15] *Drug tests were conducted via urine testing.*
[16] *Arrestee Drug Abuse Monitoring (ADAM) Program Annual Report 2001*

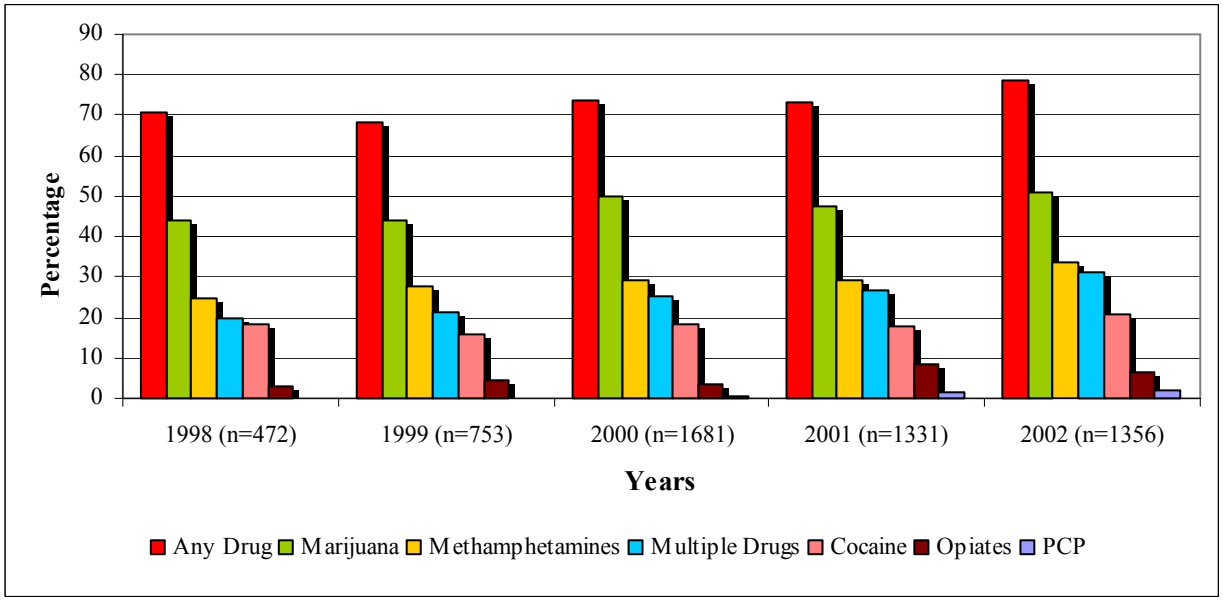
Arrest Incidence and Prevalence Data

Figure 17: Adult Alcohol and Drug Related Arrests in Sacramento County



Source: Criminal Justice Statistics Center[ii]

Figure 18: Percent of Male Arrestees that Test Positive for Drugs Sacramento County 1998-2001



Source: Arrestee Drug Abuse Monitoring (ADAM) Program Annual Reports 1998-2001[iii]

Youth AOD Use Impacts

Alcohol and other drug use among youth is an important indicator of health and social issues with implications for both current and future impact on the community. Most adults who abuse substances began use in adolescence. Substance use has direct consequences related to school performance, risky sexual activity, delinquent and criminal behavior, violence, and long-term health issues. This section presents findings related to the most severe indicators from the *California Healthy Kids Survey* (CHKS) and the *California Health Interview Survey* (CHIS); as well as drug use among juveniles admitted to Juvenile Hall.

California Healthy Kids Survey for Sacramento County

In 1998, the State of California began administering the CHKS to students in public schools. Most schools administer the CHKS every two years to 7th, 9th, and 11th grade students. The survey is a blend of questions from the California State Survey (CSS) and the Youth Risk Behavior Survey (YRBS). The questions address a range of subjects including substance use (e.g., tobacco, alcohol, and illicit drugs).

Incidence and prevalence of youth AOD use in Sacramento County

Lifetime prevalence of student substance use decreased between the 1999/00 survey cycle and the 2001/02 cycle as shown in Figure 19. Overall, the largest proportion of students reported using alcohol sometime in their lifetime (ranging from 30% to 70% dependent upon age) (see Figure 20). Alcohol consumption decreased slightly between the 1999/00 and the 2001/02 reporting cycles. For 9th and 11th grade students, the second most common drug of choice was marijuana, but in 7th grade inhalant use is similar to marijuana use. The percentages have also decreased between the two reporting cycles for each grade level.

The percentage of students reporting substance use in the 30 days preceding the survey were lower than those reporting substance use during their lifetime (see Figure 21). Alcohol is still the primary substance, followed by marijuana, and then inhalants. Overall, the percentages have decreased very slightly between the two reporting cycles and could be merely a reflection of the sample size or the group participating in each study cohort.

The CHKS also measures the extent to which students are engaging in high risk behavior. The percentage of students reporting being drunk or sick from drinking, increases substantially as they advance through school (6% in 7th grade, 15% in 9th grade, and 22% in 11th grade) (see Figure 22). Similarly, the percent of students reporting having ever been high from using drugs also increases with age (see Figure 23). Students reporting getting high three or more times increased from 3 percent in 7th grade to 31 percent in 11th grade. In addition, by 11th grade 14 percent of students report binge drinking three or more times in the 30 days preceding the survey.[17]

A third risk indicator for youth is the prevalence of students driving intoxicated or having been driven in a car by someone who is intoxicated (see Figure 24). One quarter (25%) of 9th grade students and 32 percent of 11th grade students reported just such risky behavior.

Given the extent to which use of alcohol and other drugs among youth contributes to numerous health and safety problems in later life, there must be a sustained commitment to support prevention programs, expansion of treatment capacity and continuing the CHKS survey.

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[17] *CHKS; 2001.*

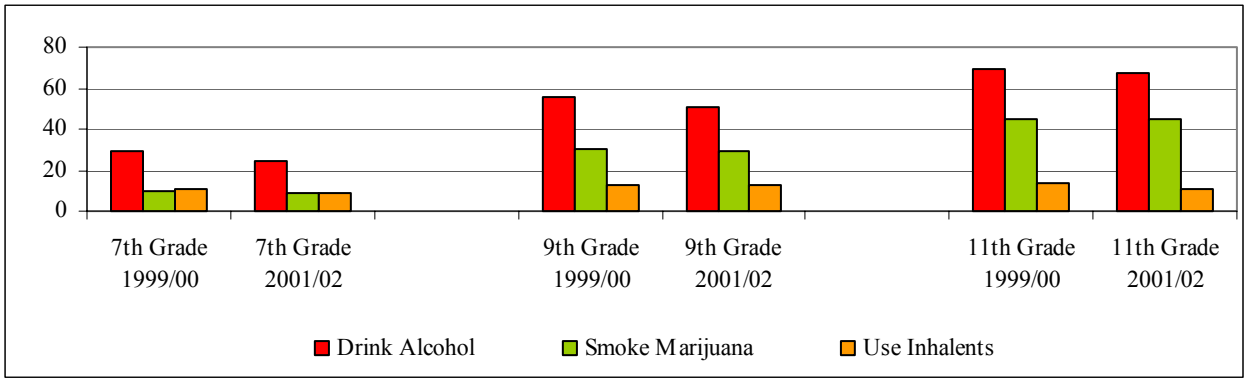
Youth Incidence and Prevalence Data

California Health Interview Survey – Sacramento County Youth Survey[18]

The California Health Interview Survey (CHIS) asked youth respondents about their lifetime consumption of alcoholic beverages. The following highlights represent trends among youth AOD use:

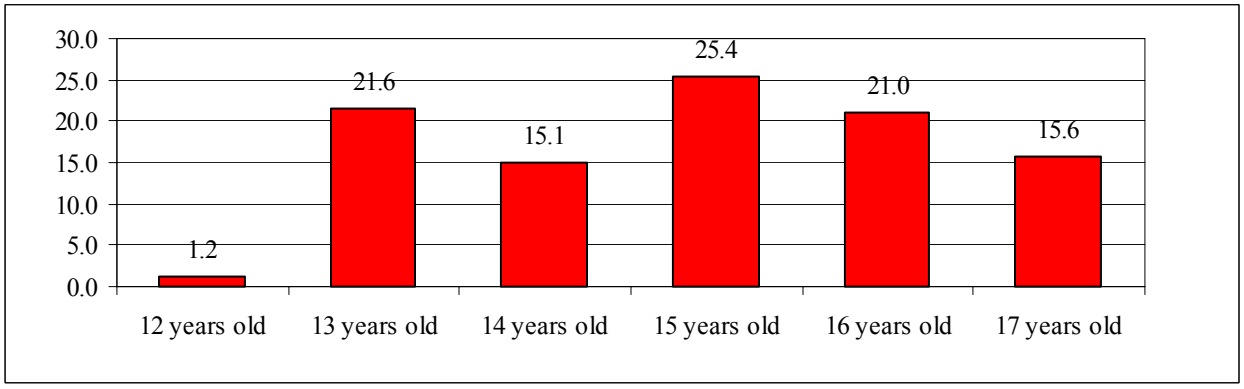
- Of the 109,682 youth in Sacramento County middle and high schools, 30% (33,342) reported any consumption of alcohol in their lifetime.
- 21% of youth reported consumption of alcohol at 13 years old compared to 1% of 12 year olds.
- Youth who have received psychological counseling in the past 12 months are 1.8 times more likely to have consumed an alcoholic beverage in their lifetime.
- Youth who have ever smoked cigarettes regularly are 25 times more likely to consume an alcoholic beverage in their lifetime.
- Youth who ever rode in a car or other vehicle with a driver who has been drinking are 13.6 times more likely to consume an alcoholic beverage.

Figure 19: Lifetime Prevalence of Student Use in Sacramento County



Source: California Healthy Kids Survey: Sacramento County Aggregated Results

Figure 20: Ever Consumed Alcohol by Age in Sacramento County



Source: 2001 California Health Interview Survey (UCLA) Adolescent Questionnaire

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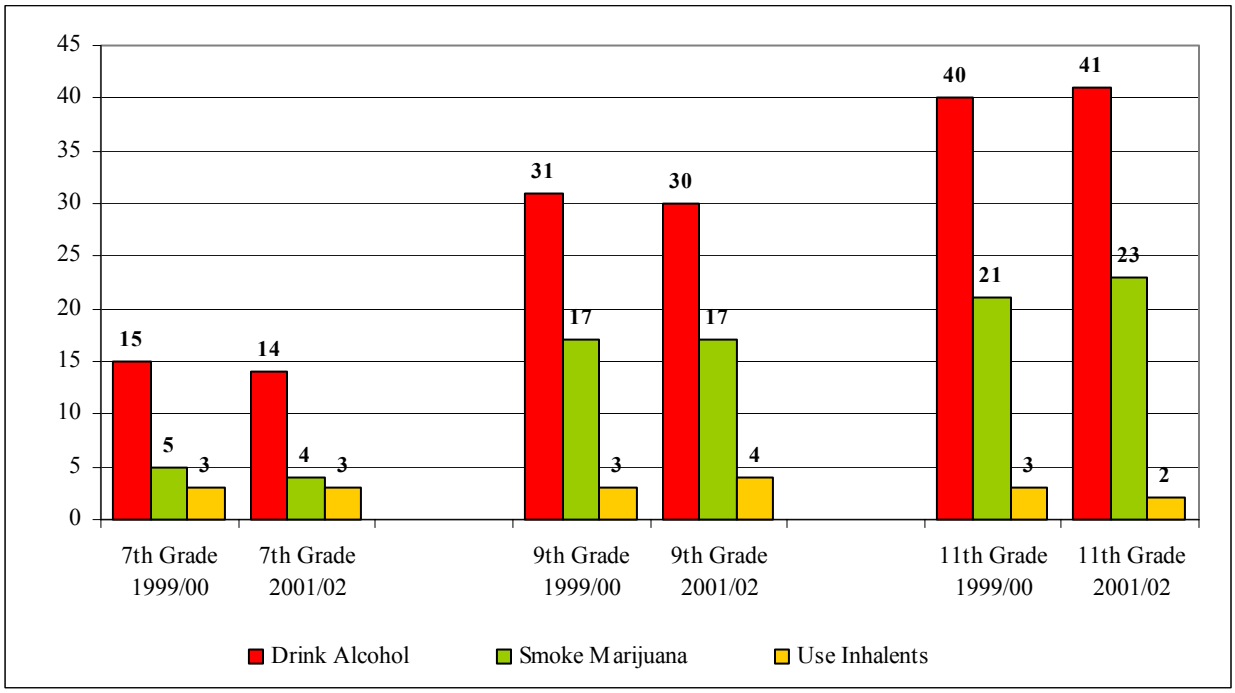
[18] *The University of California Los Angeles Center for Health Policy Research, in collaboration with the California Department of Health Services and the Public Health Institute conducted a large scale telephone survey to residents of California. The survey encompassed most aspects of health including alcohol use, nutrition, exercise, brushing teeth, etc.) The sample responses were then extrapolated to project responses for the entire county. Included in the adolescent sampling were persons between 12 and 17 years of age. The sample consisted of approximately 135 adolescents.*

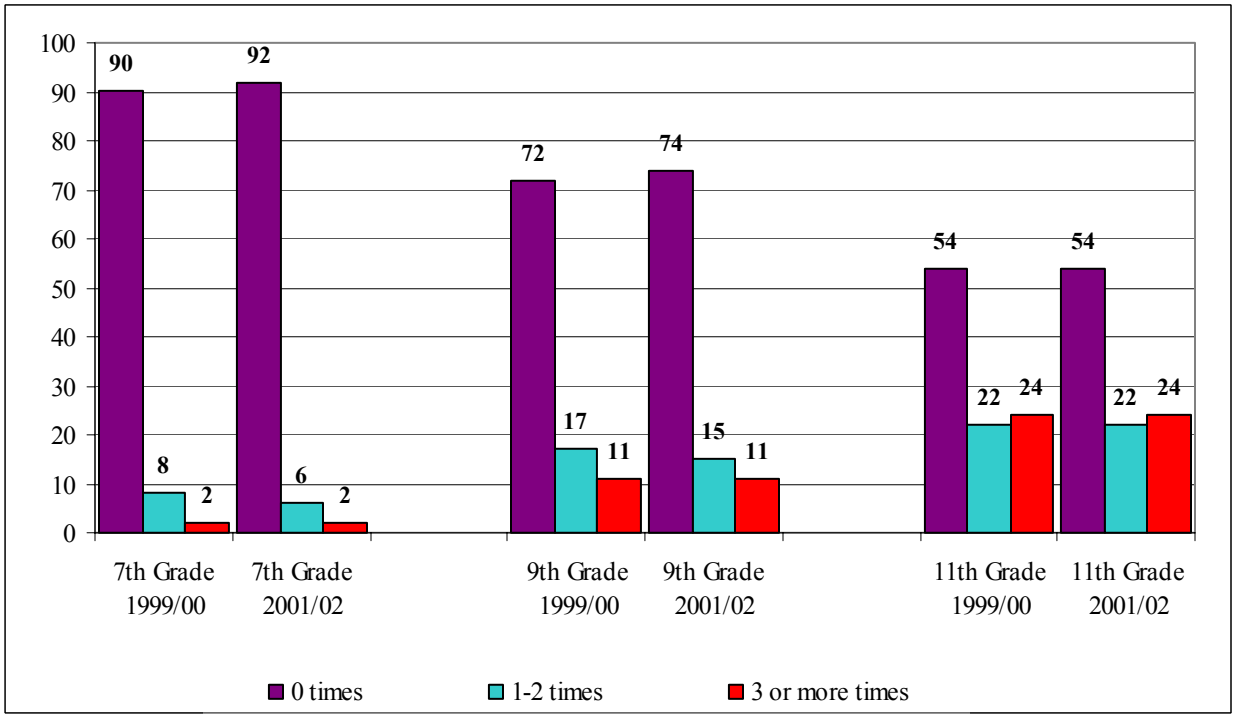
Youth Incidence and Prevalence Data

Figure 21: Student Substance Use Past 30 Days in Sacramento County



Source: California Healthy Kids Survey: Sacramento County Aggregated Results

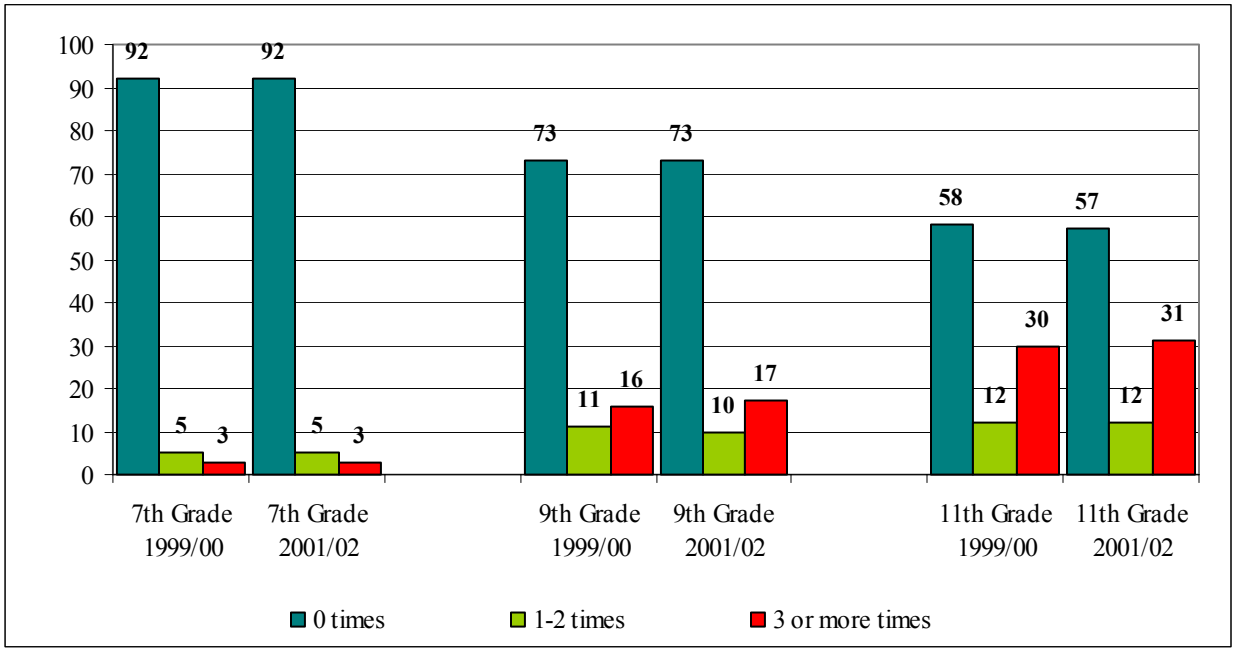
Figure 22: Ever Been Drunk or Sick from Drinking Alcohol (Sacramento County)



Source: California Healthy Kids Survey: Sacramento County Aggregated Results

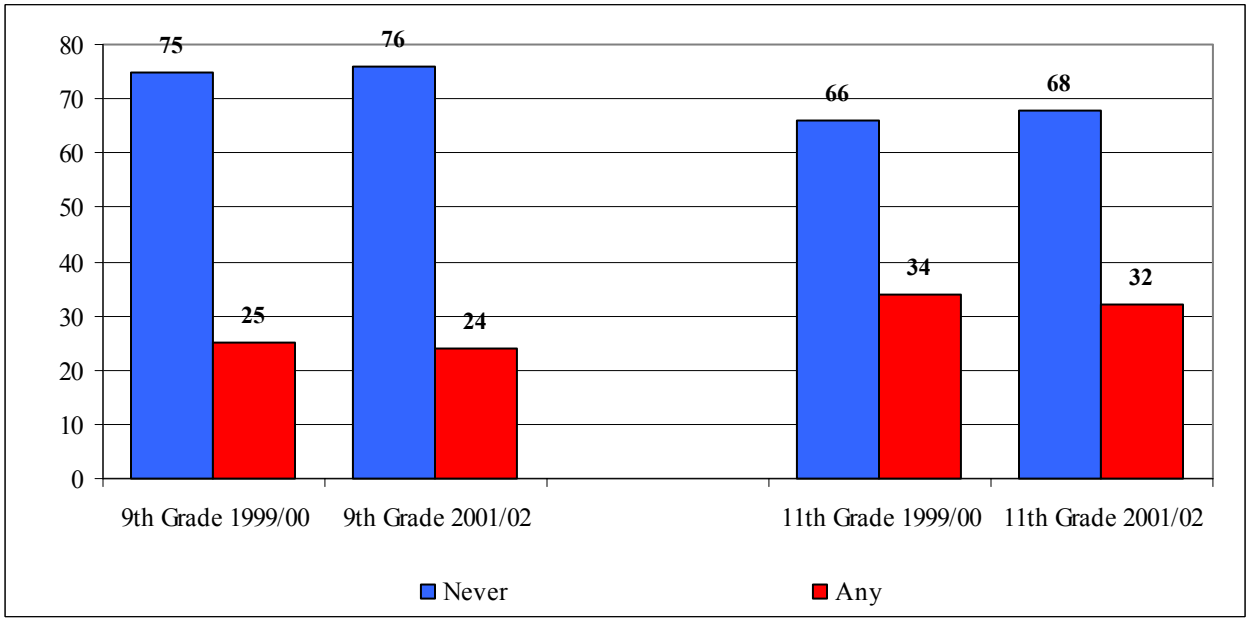
Youth Incidence and Prevalence Data

Figure 23: Ever Been High from Using Drugs (Sacramento County)



Source: California Healthy Kids Survey: Sacramento County Aggregated Results

Figure 24: Ever Driven After Drinking (either by respondent or by friend) in Sacramento County



Source: California Healthy Kids Survey: Sacramento County Aggregated Results

Youth Arrests for Alcohol and Drug Related Offenses in Sacramento County

In addition to their status as minors, adolescents who use alcohol and other drugs often have other legal troubles. Since 1993 there has been a dramatic increase in the number of alcohol related juvenile misdemeanor arrests as shown in Figure 25. The rate of juvenile arrests for alcohol related offenses increased from 48,000 to 87,500 arrests per 100,000 misdemeanor arrests (a 182% increase)[19]. While the number of arrest incidents is significantly less, the rate of juvenile drug related misdemeanor arrests more than tripled from 3,000 to 9,600 arrests per 100,000 juvenile misdemeanor arrests (a 320% increase). However, on the basis of sheer volume, alcohol remains the primary problem for substance using youth.

In contrast, the rate of juvenile drug related felony arrests decreased from 215 to 129 arrests per 100,000 (a decrease of 40%) as shown in Figure 25. The largest decline was from 1994 to 1995, where the rate of arrests dropped from 212 to 168 arrests per 100,000[20].

Incidence and Prevalence among Juvenile Hall Detainees in Sacramento County

In 2002, the Juvenile Delinquency Drug Court Planning Committee[21] conducted a three-month random drug test study (November 2002 to February 2003) to determine the extent of substance use among Juvenile Hall detainees. A total of 309 juveniles were included in the random sampling process, 174 of whom (56%) voluntarily agreed to the drug test.

Among the 174 detainees who consented to the drug test, 58 percent tested positive for one or more drugs (101 out of 174), see Figure 26. The highest proportion of this sample of juveniles tested positive for marijuana use (71%) and 25 percent tested positive for multiple drugs. Within the 25 percent, more than one-quarter (28%) used marijuana and cocaine followed by 16 percent who used marijuana and alcohol. This modest sample would seem to indicate a direct relationship between drug use and juvenile delinquency. Since almost half of the youth were unwilling to participate in the testing, the rates reported here are likely to be more conservative than actual rates of AOD use among juvenile detainees**.**

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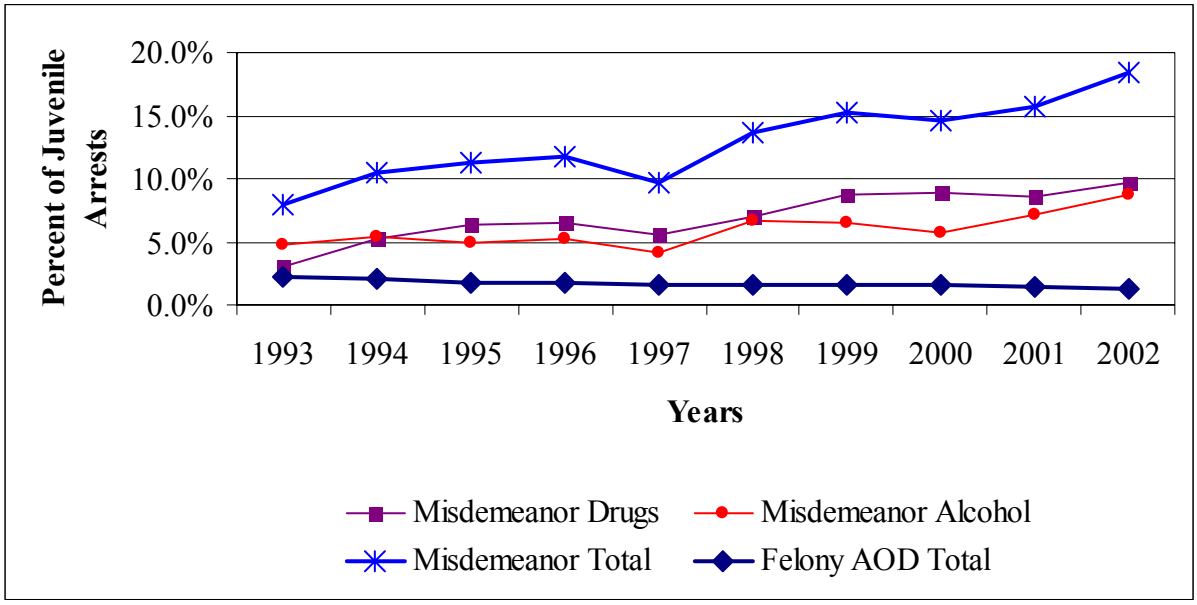
[19] *Juvenile misdemeanor arrests include marijuana, other drugs, drunk, liquor laws, driving under the influence (DUI), and glue sniffing.*

[20] *Juvenile felony arrests include narcotics, marijuana, dangerous drugs, and driving under the influence (DUI).*

[21] *Consisting of Sacramento Juvenile Court and staff from the Criminal Justice Cabinet, Probation Department, District Attorney, Public Defender, County Superintendent of Schools, Department of Health and Human Services – Mental Health and Alcohol/Drug Services Divisions, and The Effort substance abuse treatment center.*

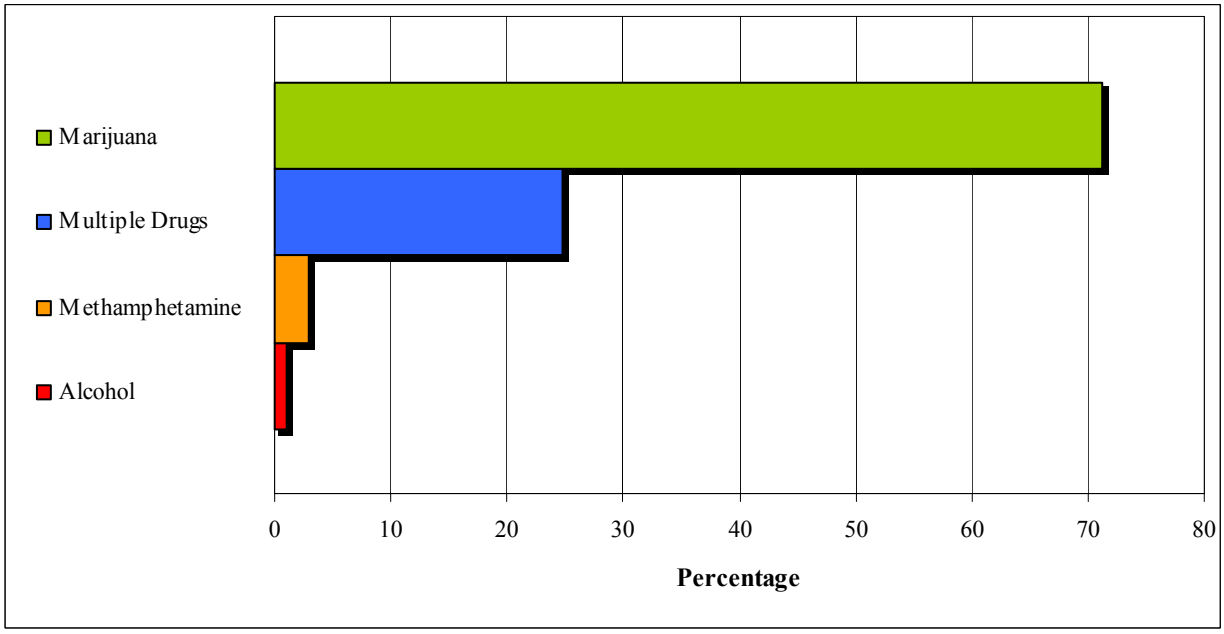
Youth Arrest Incidence and Prevalence Data

Figure 25: Juvenile Alcohol and Drug Related Arrests in Sacramento County



Source: Criminal Justice Statistics Center[iv]

Figure 26: Juvenile Detention Drug Usage in Sacramento County



Source: Juvenile Hall Random Drug Test Analysis and Report[v]

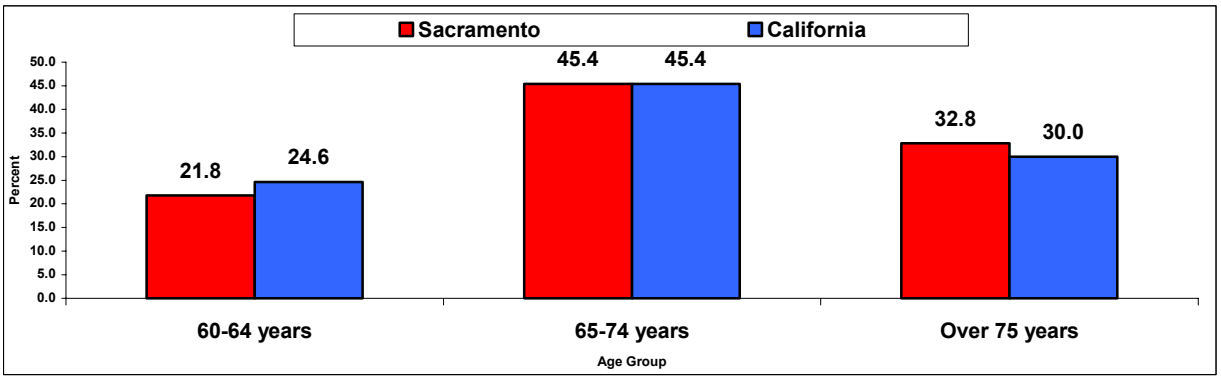
Seniors AOD Use Impacts

Currently, there is little data describing AOD use by Sacramento County's aging population. Thus, this report includes information based on national data and research findings. According to the Substance Abuse and Mental Health Services Agency (SAMHSA), 17 percent of older adults (60 years and over) are engaged in alcohol and prescription drug misuse. [22] The SAMHSA report notes that community prevalence rates for heavy alcohol use are from 3 to 25 percent and between 2 and 10 percent for alcohol abuse. Further, the report states that national studies show that 15 percent of men and 12 percent of women age 60 and above that are treated in primary care clinics drink in excess of recommended limits.

However, the incidence and prevalence rates among seniors remain difficult to measure. Often symptoms of AOD use are misidentified as natural symptoms of aging (e.g., inadequate balance, forgetfulness). Many seniors are not aware of the increased impact of alcohol on their changing metabolism. As noted in the first *Changing the Landscape* report, senior substance abuse is more challenging to detect because seniors use may be confined to private settings; many have incomes unaffected by substance problems; after retirement, they are not required to drug test for job applications; many no longer drive or drive very infrequently; and they are increasingly likely to participate in shrinking social circles which are disinclined to identify the problem. There is no systematic means of determining when alcohol and/or prescription drug misuse occurs.

Seniors are the most rapidly growing population. As the "baby boomers" begin to reach the age of 60 and older[vi] determining the extent of AOD use and related problems among this population are critical to the development of appropriate and adequate treatment capacity to respond to the need. There are over 190,000 adults over the age of 60 in Sacramento County, and if an estimated 17 percent may need treatment that would equal nearly 33,000 seniors. According to the *California Health Interview Survey* approximately 11,737 (6.7%) of Sacramento County seniors, age 60 and above, are defined as "heavy users."[23] The distribution of this population is shown in Figure 27.

Figure 27: Distribution of Heavy Users among Seniors in Sacramento County and California



Source: 2001 California Health Interview Survey (UCLA) Adult Questionnaire

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[22] *SAMHSA TIP26; 1997*

[23] *†Heavy use—defined as consuming 2 drinks daily on average for at least 28 days in the month preceding the survey.*

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Co-Occurring AOD and Mental Health Disorders

Due to the symbiotic relationship between substance use and mental health disorders, and the gap in treatment options for this population, it is important to target co-occurring disorders as an area of need for more information and services. The 2002 *National Survey on Drug Use and Health* (NSDUH) reports among adults with Serious Mental Illness (SMI) in 2002, 23 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was 8 percent.[24]

Annually, Sacramento County Alcohol and Drug Services (ADS) assesses the issue of co-occurring disorders; the most recent report is for FY 2002/03. To evaluate this information, ADS examined data from the California Alcohol and Drug Data System (CADDS) and the ADS Preliminary Assessment (PA) (see Figure 28). Dually-impacted individuals make up ten percent (n = 645) of the total population assessed (n = 6,349)[vii]. The largest proportion of this sample are chemically dependent and not in recovery (48%). Eighteen percent are chemically dependent and in recovery. One-quarter (26%) were identified as substance abusers, four percent as regular users, and five percent as occasional users. Based upon NSDUH findings, identification of individuals with co-occurring disorders in Sacramento County ADS system is under-reported.

In addition, the Sacramento County Division of Mental Health compiled data on co-occurring disorder prevalence for clients using mental health services (FY 2002/03 Client Activity Tracking System (CATS) database). Similar to ADS data, CATS relies on participant self-report information, which limits both accuracy and generalizability. The second graph (Figure 29) indicates 16 percent of this population has substance abuse issues affecting their mental health status. Of equal concern is the 34 percent combined "unknown" and "missing" who may have unidentified substance abuse complications.

Figure 30 indicates 14 percent of the assessed population had a "Secondary Axis 1[25] Substance Abuse Related Diagnosis" and 58 percent "Unknown" where the Secondary Axis was left blank because there was not a diagnosis or because a diagnosis was overlooked.

Sacramento County conducted a four-year study (1999-2003) to explore an alternate approach to dealing with the high percentage of people with mental illness who are incarcerated. The study was called the Mentally Ill Offender Crime Reduction Grant - Project Redirection (PR). The data from this study shows that rates of mental health disorders are four times higher among prisoners than in the general population, and rates of substance use are four to seven times higher (Robins & Regier, 1991). The PR report states:

- there was a higher than predicted co-occurring disorder population in the County jail;
- that a substance abuse specialist was particularly helpful to the treatment teams and the project's participants in managing the challenge of co-occurring disorders;
- increasing general staff knowledge and expertise as well as multiple weekly groups on dual disorders were beneficial; and
- the ability to treat both issues within the same agency with a single philosophy of treatment and without barriers to key treatment components was essential.

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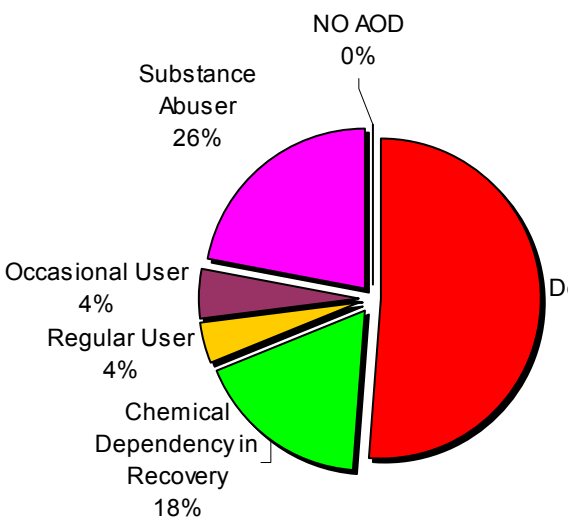
[24] SMI is defined for this report as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

[25] Axis 1 diagnosis is defined as: Clinical Disorders and/or Other conditions that may be a focus of clinical attention

AOD and Mental Health Incidence and Prevalence Data

Figure 28: Sacramento County ADS Assessment of Co-Occurring AOD/MH



The continuum of AOD use and abuse includes three categories:

- **Use** – routinely seeking a substance, with regular patterns of use
- **Abuse** – the use of alcohol or other drugs in any manner that increases the risk of harmful and hazardous consequences
- **Dependence** – obsessive or compulsive return to substance use regardless of the negative impacts to one's physical, emotional, mental or spiritual well-being

Figure 29: Substance Abuse as a Factor Affecting Mental Health

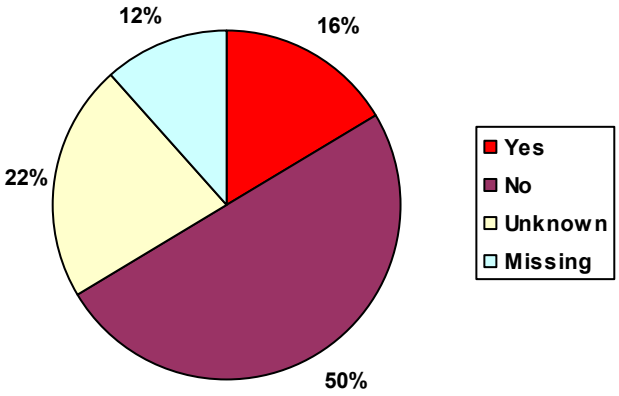
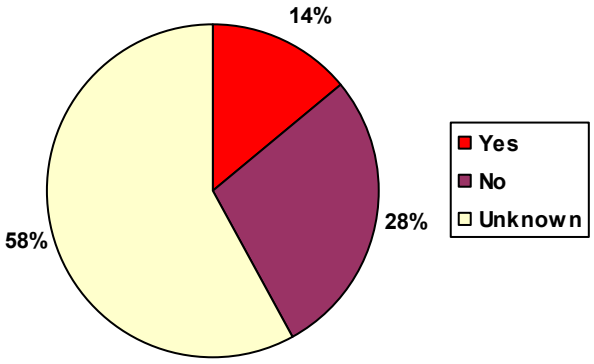


Figure 30: Substance Abuse as a Secondary Axis I Related Diagnosis



Barriers to Data Collection

The process of collecting and analyzing data for the *Changing the Landscape* reports has clarified where there are data gaps and limitations. In the absence of local statistics or trends the CTL Task Force extrapolated estimates from state and national sources whenever feasible. In some cases attempts to address the absence of data leads to new studies or needs assessments. Some of the issues related to data collection for AOD use by seniors and for co-occurring disorders have been noted by other prominent research groups

Throughout the preparation of this document, several barriers to data collection arose.

- Changes in reporting format made collecting trend data more difficult. Often, surveys changed methodology or strategies for analysis, thus rendering the data incomparable.
- There was significant lag time between collections of some of the data elements, so, data updates were unavailable at the time of this report.
- Some data elements were not specific to Sacramento County. Those data elements were extrapolated from state and national surveys and are therefore not as precise as those specific to Sacramento County.

There were some critical limitations or barriers specific to local data collection and reporting that were identified during the course of this effort.

- *Alcohol Use and Related Impact data*: There was little or no local data available for creating cost estimates of the various levels of impact on the community. This includes information about health, insurance, private industry and criminal justice costs, which could provide a local picture of the expense of substance abuse on the community.
- *Health Related Impact data*: Lack of access to hospital data created a barrier to determining actual health related incidents and costs. Other data that might otherwise be obtained from hospitals include perinatal-exposed births, admissions to hospitals for AOD related incidents, and deaths due to AOD related diseases can prove problematic. In some cases lack of direct access is associated with coding and record keeping for diagnoses and discharge information. In other cases, such as substance related deaths, changes in coroner data collection and substance testing preclude such data collection.
- *Criminal Justice Impact data*: While the impact of AOD abuse on juvenile and adult criminal behavior has been documented in many studies, estimates are often based on specific inquiries rather than as an integral data element for criminal justice records. Local data estimates have been related to specific studies and programs that address AOD use among arrestees and individuals confined to local jail facilities.
- *Youth AOD Use Impact data*: Youth AOD use estimates are primarily based on findings from the reoccurring California Healthy Kids Survey (CHKS) which contains many data elements related to use, abuse, and other risky behaviors. School districts administer the CHKS at different intervals and with a widely variable success rate. In some cases, the CHKS findings are not considered valid or reliable due to unrepresentative sample sizes. Moreover, while the CHKS data is an important indicator of incidence and prevalence, it is difficult to identify the range and capacity of various AOD use prevention efforts and services to address the needs. Understanding the local capacity to serve youth will depend on primary data collection efforts.

- *Senior Impact data*: Data gathering for the senior population proved challenging, due to social circumstances, lifestyle, and the absence of coordination among potential sources of information about AOD use or misuse. The senior population is more difficult to reach for standard surveys. Currently, there are no good methods for sharing pharmaceutical information between pharmacies. Thus, if a senior is obtaining prescriptions from multiple pharmacies, there is no efficient way to check for possible drug interactions. In addition, it would be extremely costly to collect and analyze data on concurrent use of prescription medications and alcohol.
- *Co-occurring AOD and Mental Health data*: Some data collection challenges associated with co-occurring disorders is related to the use of outdated technology that will now be replaced. The Sacramento County Division of Mental Health is undergoing an extensive database system redesign process that will solve the technological problems. However, many of the problems are "systemic" or "training" problems and pertain to identification of individuals with co-occurring disorders and increasing appropriate treatment resources for these individuals. Data on mental health and AOD use are based on services provided for either of these services, rather than actual incidence and prevalence estimates for the general population. Additionally, there is little treatment available to address both mental health and substance abuse problems simultaneously. Without the capacity to share data easily, there is no easy way to track individuals consuming services through both systems.

Changing the Landscape Recommendations

It is important for Sacramento County to continue to track the impact of alcohol and other drugs on the quality of life in this community. However, just having a regular accounting of the adverse impacts of AOD use will not, in and of itself propel either government or the community-at-large into action. It is clear from the last report that the confluence of attention to AOD issues can stimulate action at the policy and program levels, both intentional and accidental. However, if decision-makers, planners, and treatment providers expect to have an even greater impact on the problems generated by alcohol and other drug use it is imperative to not only "shine a bright light on the problems" but also to adopt a more consistent and systematic approach to addressing the issues.

The *Changing the Landscape* task force has considered a number of approaches to presenting recommendations to the community. First, we want to re-affirm our commitment to the original 10 recommendations delineated in the first report.

Original Recommendations

1. Establish alcohol and other drug issues (and the negative impact on the quality of life in our community) as one of Sacramento County's highest priorities.
2. Recognize that alcohol is the main substance of abuse in our community. Alcohol creates the largest negative impact on our quality of life.
3. Adopt a policy that AOD related data collection and tracking is an essential county function.
4. Support the development of a systematic evaluation and tracking system for perinatal substance exposure.
5. Promote policies and strategies to ensure implementation of best practice models of prevention, intervention, treatment, aftercare and community-building.
6. Respond to the diversity of our community through programs and strategies that are culturally competent and inclusive.
7. Support the development of a community-wide coalition to ensure that AOD problems continue to be high on the community agenda.
8. Expand collaborative efforts with the justice system, including the courts, probation, and law enforcement to support enforcement, prevention, treatment, and community-based services.
9. Expand collaborative efforts with educational institutions and systems such as public and private schools, colleges and universities to impact the adverse consequences of AOD abuse.
10. Support efforts by community groups, organizations and neighborhoods to address substance use/abuse at the local level.

In 2001, The Board of Supervisors took formal action on the first four recommendations. Activities on those items and many of the others have moved forward. Those activities are noted in the attachment of this report. However, many of the existing planning and implementation efforts, which support the *Changing the Landscape* goals and visions, occur in compartmentalized ways, with little reference or support for each other.

To propel the *Changing the Landscape* effort forward there are some critical next steps. Therefore, we recommend the following;

- **Launch an inclusive strategic planning process that will engage public agencies, elected officials and community partners to create a plan comprehensively addressing the adverse impacts of alcohol and other drug abuse in our community.**
- **The *Changing the Landscape* reports are the data baseline and foundation for this comprehensive strategic planning process.**
- **The strategic plan should address community engagement, policy, services, human and fiscal resources and knowledge, data gaps and measurable outcomes.**
- **The Department of Health and Human Services should serve as the lead agency for this strategic planning effort.**
- **The Alcohol and Drug Services Division will provide primary staff support for the strategic planning effort.**
- **Participation and involvement of other County agencies, including representation of the Board of Supervisors, in the strategic planning effort is crucial to the success of these efforts.**
- **Regular public updates on the *Changing the Landscape* strategic planning process should be provided through presentations to the Board of Supervisors and in community forums.**

Update on the Recommendations from *Changing the Landscape* – 2001 Attachment

In 2001, the *Changing the Landscape* task force developed ten recommendations that accompanied the report. Four of those recommendations were taken to the County Board of Supervisors. The Board passed a formal resolution accepting the full report and adopting the four recommendations. As an update to the original report, some of the most significant changes that have happened since 2001 are noted below. Several of the activities noted were taken as a result of the *Changing the Landscape* report, while others occurred independently.

Recommendation		Current Status
1	Establish alcohol and other drug issues (and the negative impact on the quality of life in our community) as one of Sacramento County's highest priorities.	• Formal Resolution adopted by Board of Supervisors, 2001 • The Alcohol and Drug Bureau was made into its own Division within the Department of Health and Human Services, equivalent to other Divisions such as Public Health and Mental Health. • The First Five Commission made AOD issues one of their priority concerns for funding to impact families with children under five years old. • Sacramento County provided critical funding support for the Dependency Drug Court and youth treatment. • Three County Supervisors, the District Attorney, Public Health Officer, and Sheriff served on the community anti-drug coalition's (Project Help) Charter Board of Directors • The Alcohol and Drug Services Division provided key staff support to help launch Project Help. • Project Help held two anti-drug summits and eight town hall meetings throughout the County. • Demand Treatment selected Project Help and Sacramento as partners in a national effort to address AOD treatment issues.
2	Recognize that alcohol is the main substance of abuse in our community. Alcohol creates the largest negative impact on our quality of life.	• Formal Resolution adopted by Board of Supervisors, 2001 • The Children's Report Card and the Youth Commission's Report on youth AOD issues to the Board of Supervisors echoed that alcohol is the primary problematic substance in the community. • The local University (California State University, Sacramento) implemented an Alcohol Advisory Council and numerous efforts to address alcohol consumption among its students. • The Alcohol and Drug Services Division applied for State Incentive Grant funding to specifically address binge drinking and youth access to alcohol. • Project Help and the Community Services Planning Council GIS mapped all of the alcohol retail sales outlets in Sacramento County.
3	Adopt a policy that AOD related data collection and tracking is an essential county function.	• Formal Resolution adopted by Board of Supervisors, 2001 • The state provided a data overview, *Community Indicators of Alcohol and Drug Abuse* Risk, in 2001 and again in 2004 as part of a statewide review of data. • The Alcohol and Drug Services Division conducts regular assessments of its consumers and systems including an annual review of California Alcohol and Drug Data System (CADDS) and CADDS Supplement data and System of Care assessment data.

		• The Sheriff's Department participates in the national comparison ADAM (Arrestee Drug Abuse Monitoring Program) study that looks at substance use among in-custody arrestees at the County Jail. • The County participated in three treatment impact studies: the national CalTOP (California Treatment Outcome Protocol); Project Impact study (assessing three counties' systems of care – Sacramento, Santa Clara and San Bernadino); and a national Women with Co-Occurring Disorders study looking at treatment service for women with AOD, mental health and domestic violence issues. • In 2001-02, the County added two additional evaluation efforts. The first analyzes the impacts of the Substance Abuse and Crime Prevention Act (Proposition 36) efforts. The second analyzes the impacts of the Dependency Drug Court.
4	Support the development of a systematic evaluation and tracking system for perinatal substance exposure.	• Formal Resolution adopted by Board of Supervisors, 2001 • The Alcohol and Drug Services and Public Health Promotion and Education Divisions, along with Project Help, created the Substance Exposed Infant Prevention Collaborative, which is working on training medical practitioners to conduct AOD screenings of pregnant women to reduce the number of substance exposed infants born in the County. The first training will occur in September 2004. • The Substance Exposed Infant Prevention Collaborative with support from the Alcohol and Drug Services and Child Protective Services (CPS) Divisions tracks the CPS Toxicology Report to monitor the numbers of cases of substance exposed infants reported to child welfare.
5	Promote policies and strategies to ensure implementation of promising and best practice models of prevention, intervention, treatment, aftercare and community building.	• The Alcohol and Drug Services Division supported the development of a Prevention Technical Assistance Coalition (TAC) led by People Reaching Out, which works with local prevention providers to raise their capacity to provide evidenced-based services. That successful venture has ensured that many of our prevention providers are now certified Substance Abuse Prevention Specialists. • The Alcohol and Drug Services Division successfully applied for two Safe and Drug Free Schools and Communities grants, which implemented research-based prevention programs to address the needs of at-risk middle school and homeless youth. • The Alcohol and Drug Services Division works with local treatment providers to improve the level of treatment services offered in the community; the process for accessing services; and the ability of local stakeholders to identify and work with substance impacted youth and adults, including those with co-occurring AOD and mental health needs.

6	Respond to the diversity of our community through programs and strategies that are culturally competent and inclusive.	• In Sacramento County, there are a number of treatment and prevention providers that offer culturally competent services. There are agencies that respond to the unique needs of the Asian Pacific Islander, Hispanic and African American populations. • In the recently implemented Safe and Drug Free Schools and Communities grants, specific funding was allocated to culturally expert service providers to ensure their availability to support culturally specific needs of participant families and youth.
7	Support the development of a community-wide coalition to ensure that AOD problems continue to be high on the community agenda.	• The Alcohol and Drug Services Division, along with other County agencies and leaders have provided support to a number of local collaborative efforts including the establishment of the Project Help community coalition, an Oak Park Multi-Service Center led prevention collaborative, and the Prevention Technical Assistance Collaborative. All of these efforts address AOD problems in the community and raise the level of importance of and community awareness in AOD issues.
8	Expand collaborative efforts with the justice system, including the courts, probation, and law enforcement to support enforcement, prevention, treatment, and community-based services.	• As the Substance Abuse and Crime Prevention Initiative (Proposition 36) was passed and Sacramento County put together an effective collaborative including the Courts, District Attorney, Public Defender, Probation, Alcohol and Drug Services Division, and local community treatment providers to implement treatment and monitoring programs that address the needs of the targeted criminal justice offenders. This successful effort is currently in its fourth year of operation. • A collaborative of the Juvenile Dependency Court, Alcohol and Drug Services, Child Protective Services, family and child attorneys and local treatment providers launched a Dependency Drug Court in Sacramento County, which became a national model. • Continuing efforts support the Adult Criminal Drug Court, a Drug Diversion program and a Women's Jail Treatment Program. • Efforts are currently underway to launch a Juvenile Drug Court modeled after the Dependency Drug Court. It is expected that this effort will pilot in the fall of 2004. • The Federal Office of National Drug Control Policy (ONDCP) included Sacramento in its 25 City Initiative. Two collaborative planning events have already occurred that focused on prevention, treatment and enforcement strategic planning efforts.

9	Expand collaborative efforts with educational institutions and systems such as public and private schools, colleges and universities to impact the adverse consequences of AOD abuse.	• The Alcohol and Drug Services Division continues to work with CSUS on their Alcohol Advisory Council around student substance use. Project Help is also a participant. • The ONDCP 25 Cities Initiative, organized collaboratively by the Alcohol and Drug Services Division and Project Help, conducted prevention planning that included participants from local school districts, the university, faith-based organizations, law enforcement and treatment organizations. • The Alcohol and Drug Services Division funded prevention and youth treatment agencies that work with local school districts to respond to their prevention and treatment needs. • The Safe and Drug Free Schools and Communities grants focus on the collaborative provision of prevention services for at-risk middle school and homeless youth in five middle schools in five school districts in the County. • The new State Incentive Grant (SIG) seeks to address youth alcohol access and binge drinking. The grant was developed in collaboration with Project Help, CSUS, the Sacramento County Office of Education and People Reaching Out and includes additional partners – Sacramento City College and the Sacramento City Unified School District. • Division staff continues to work with the Youth Service Providers Network (YSPN) on youth development issues and support the infusion of youth development concepts in youth services.
10	Support efforts by community groups, organizations and neighborhoods to address substance use at the local level.	• Alcohol and Drug Services Division continues to provide staff support in communities throughout the County in partnership with the Departments of Health and Human Services and Human Assistance. • The Alcohol and Drug Services Division provided support to two local Weed and Seed efforts in the Avondale Glen Elder and Rancho Cordova communities. • Project Help and the Division have worked to launch a Screening, Brief Intervention and Referral effort in the County's two hospital trauma centers.

Endnotes

[i] Department of California Highway Patrol: Information Services Unit

[ii] Office of the Attorney General: State of California Department of Justice. Criminal Justice Statistics Center. Retrieved January 14, 2004 from the World Wide Web: http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof02/34/4B/htm

[iii] National Institute of Justice: U.S. Department of Justice. *Annual Report 1998-2001* Arrestee Drug Abuse Monitoring Program. Retrieved from the World Wide Web on January 14, 2004 from http://www.adam-nij.net/report.asp.

[iv] Office of the Attorney General: State of California Department of Justice. Criminal Justice Statistics Center. Retrieved January 14, 2004 from the World Wide Web: http://justice.hdcdojnet.state.ca.us/cjsc_stats/prof02/34/4C/htm

[v] *Juvenile Hall Random Drug Test Analysis & Report: June 23, 2003.* Sacramento County Juvenile Delinquency Drug Court Planning Project. Prepared by Juvenile Delinquency Drug Court Planning Committee & Juvenile Institutions, Programs and Courts Committee. p.9.

[vi] Benshoff, J. and L. Harrawood (2003). Substance Abuse and the Elderly: Unique Issues and Concerns. Journal of Rehabilitation 69:2. 43-48.

[vii] Alcohol and Drug Services Division Dual Diagnosis Data: July 2001 to June 2002.