STRATEGIC PREVENTION PLAN

July 2020 - June 2025

Substance Use Prevention Services

July 2020

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

Table of Contents

Chapter 1: Introduction

VISION

Healthy communities that are safe and free from substance use problems.

MISSION

To implement effective prevention initiatives, guided by best practices and data, to systematically reduce community substance use problems.

DEPARTMENT OF PUBLIC HEALTH-SUBSTANCE ABUSE PREVENTION AND CONTROL'S (DPH-SAPC) COMMITMENT TO PREVENTION

When addressing public health challenges, including substance use, the Los Angeles County (LAC) Department of Public Health (DPH) looks not only at implementing effective prevention strategies (e.g., policy development, advocacy, media efforts, education, services) but also at the impact of the physical and social environments on health (e.g., land use, safety, poverty, educational attainment).

Understanding key factors related to health and the impact of substance use on the individual, family, society, and environment can lead to more effective and comprehensive substance use prevention services. Select indicators from the LAC DPH June 2017 Key Indicators of Health and the 2018 Los Angeles County Health Survey (LACHS) by Service Planning Areas (SPA) are referenced in Table 1.

The Substance Abuse Prevention and Control (SAPC) will work collaboratively with prevention providers on an on-going basis to assess community needs and resources to develop effective, culturally responsive prevention strategies. Particular emphases on promoting the inclusion of all provider/community members and their diverse perspectives, ideas, and strategies will build rapport and credibility at the local level, and improve prevention services and care delivery.

PROFILE OF LOS ANGELES COUNTY

LAC has the largest population (10,278,834) of any county in the nation and is larger than 43 States, ranking ninth behind California, Texas, New York, Florida, Illinois, Pennsylvania, Ohio, and Georgia. Geographically, LAC poses unique challenges to providing services to all its residents, encompassing approximately 4,000 square miles with beaches, mountains, forests, and deserts.

LAC is divided into eight SPAs as shown in Table 1. Each region varies in size, population density, socio-economic status, health status, and other demographic characteristics.

Table 1. Differentiating characteristics of LAC service planning areas

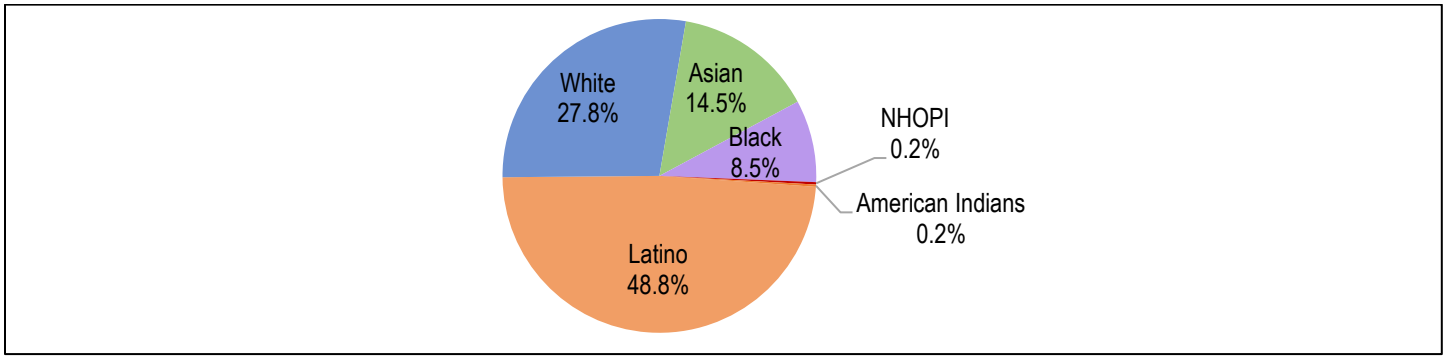
SPA	Location	Population	Examples of differentiating characteristics
SPA 1:	Antelope Valley	397,583	Highest % of adults with a disability: 29.9% (Table 4)
SPA 2:	San Fernando Valley	2,262,277	Highest % past month use of illicit drugs (except marijuana), ages 18-25: 7.2% (Table 6)
SPA 3:	San Gabriel Valley	1,808,263	Lowest % of binge drinking, ages 18-25: 31.7% (Table 6)
SPA 4:	Metro	1,185,794	Highest % of past month binge alcohol use, ages 18-25: 38.5% (Table 6)
SPA 5:	West	667,863	Highest % of past year use of Rx opioids, ages 18-25: 9.1% (Table 6)
SPA 6:	South	1,057,694	Highest % of population under 138% FPL: 41.6% (Table 4)
SPA 7:	East	1,321,304	Highest % past month use of illicit drug (except marijuana), ages 12-17: 4.0% (Table 6)
SPA 8:	South Bay	1,578,056	Highest % of perceiving easy access to marijuana, ages 12+: 86.5% (Table 8)

ISD population estimates 2018 FPL: Federal Poverty Level.

More than one-fourth (26%) of California's residents live in LAC. About half (50.7%) are female; 21.9% are younger than 18, and 13.3% are 65 or older.

More than half (56.9%) of LAC residents speak a language other than English at home (U.S. Census, 2017). Among Medi-Cal eligible individuals, 50.3% speak a language other than English at home. Racial/ethnic composition of county residents is presented in Figure 1, and Table 2 lists the 12 non-English threshold languages spoken in LAC.

Figure 1. Population by Race/Ethnicity, Los Angeles County 2018



NHOPI = Native Hawaiian for Other Pacific Islander

Table 2. Threshold Languages, Los Angeles County 2014

Arabic	*Farsi*	*Russian*
Armenian	*Hmong*	*Spanish*
Cambodian (Khmer)	*Korean*	*Tagalog*
Cantonese	*Mandarin*	*Vietnamese*

*The State of California defines a "Threshold Language" as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410(a)(3).Source: State of California – Health and Human Services Agency, Department of Health Care Services. Retrieved September 23, 2019 from https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf

Social Determinants of Health: Socioeconomic Status (SES) and Built Environment

Socioeconomic and environmental conditions are major influences on health and substance use. Specifically, age, where people are born, grow up, live, work, and the systems addressing illness, education, employment, social networks/support and community cohesion have been associated with positive or negative health outcomes.

The built environment, which includes presence of dilapidated/deteriorating buildings, has been associated with negative health outcomes including alcohol problems/heavy drinking (Bernstein, et al., 2007). Similarly, Jitnarin et al. (2015) found that negative perceptions of neighborhood infrastructures were significant predictors of smoking and binge drinking. Table 3 shows various aspects of SES by SPA, LAC, and State.

Table 3. Socioeconomic indicators for state, county and service planning areas (SPAs)

Key Indicators	CA	LAC	SPA							
Population under 100% FPL (LAC ISD, 2018)	16.8 %*	14.3 %	SPA 1: 17.7%	SPA 2: 11.7%	SPA 3: 10.8%	SPA 4: 18.2%	SPA 5: 9.5%	SPA 6: 25.8%	SPA 7: 13.0%	SPA 8: 13.4%
Population under 138% FPL (LAC ISD, 2017)	-	24.2 %	SPA 1: 27.0%	SPA 2: 20.0%	SPA 3: 19.2%	SPA 4: 29.5%	SPA 5: 13.5%	SPA 6: 41.6%	SPA 7: 24.6%	SPA 8: 23.8%
Unemployed and looking for work, ages 16+ (ACS, 2013-2017)	3.9%*	7.9%	SPA 1: 9.1%	SPA 2: 7.4%	SPA 3: 7.0%	SPA 4: 8.1%	SPA 5: 6.5%	SPA 6: 10.7%	SPA 7: 7.8%	SPA 8: 7.9%
Less than high school education, ages 25+ (ACS, 2013-2017)	36.3 %*	21.8 %	SPA 1: 21.0%	SPA 2: 17.2%	SPA 3: 19.9%	SPA 4: 25.1%	SPA 5: 6.0%	SPA 6: 40.8%	SPA 7: 29.9%	SPA 8: 18.2%
Divorced, ages 15+ (ACS, 2013-2017)	9.4%	8.3%	SPA 1: 8.7%	SPA 2: 8.8%	SPA 3: 7.7%	SPA 4: 8.0%	SPA 5: 9.6%	SPA 6: 7.0%	SPA 7: 7.2%	SPA 8: 9.5%
Have a disability, ages 18+ (LACHS, 2018)	29.7 %†	24.6 %	SPA 1: 29.9%	SPA 2: 24.5%	SPA 3: 22.8%	SPA 4: 24.1%	SPA 5: 24.1%	SPA 6: 26.2%	SPA 7: 20.4%	SPA 8: 28.4%
Low food security, households <300% FPL (LACHS, 2018)	-	26.8 %	SPA 1: 29.8%	SPA 2: 24.4%	SPA 3: 21.6%	SPA 4: 31.8%	SPA 5: 18.0%	SPA 6: 35.1%	SPA 7: 25.9%	SPA 8: 27.5%

Households who spend >30% income on housing (LACHS, 2018)	-	42.1 %	SPA 1: 43.4% SPA 2: 42.4% SPA 3: 37.6% SPA 4: 46.2% SPA 5: 34.0% SPA 6: 47.7% SPA 7: 46.8% SPA 8: 40.6%
Perceived fair or poor health, ages 18+, (LACHS, 2018)	16.6 %	21.5 %	SPA 1: 20.9% SPA 2: 19.7% SPA 3: 19.4% SPA 4: 24.1% SPA 5: 11.2% SPA 6: 32.5% SPA 7: 22.7% SPA 8: 21.2%
Difficulty accessing medical care, age 18+ (LACHS, 2018)	10.3 %*	21.3 %	SPA 1: 24.4% SPA 2: 19.5% SPA 3: 18.3% SPA 4: 28.8% SPA 5: 12.5% SPA 6: 29.3% SPA 7: 20.1% SPA 8: 20.8%
Believed their neighborhood was safe from crime, ages 18+ (LACHS, 2018)	63.8 %*	85.0 %	SPA 1: 93.6% SPA 2: 91.1% SPA 3: 84.9% SPA 4: 76.4% SPA 5: 88.8% SPA 6: 69.0% SPA 7: 87.0% SPA 8: 87.5%

FPL: Federal poverty level. * AskCHIS, 2017. † AskCHIS, 2016.
Red and green font indicate highest and lowest percentage, respectively among SPAs.

PRIOR STRATEGIC PREVENTION PLAN (SPP) OVERVIEW

DPH-SAPC system of services is designed to provide services to all residents of LAC. No one regardless of their race or economic status is refused services. Community-based prevention program services and strategies are designed to engage all community residents, public service organizations, and other concerned citizens.

Given the diversity of LAC residents, DPH-SAPC is committed to continuing the practice of implementing programs and services that adequately and appropriately address the cultural, linguistic, and regional needs of communities and individuals.

Achievements FY 1718

Reduce prescription drugs and over-the-counter medication misuse and abuse

- During fiscal year 2017-18, DPH-SAPC providers collected 20,961 pounds of prescription drugs waste, compared to 19,864 pounds for fiscal year 2018-19.

- Prevention providers from all SPAs participated in the Safe Med LA (www.SafeMedLA.org) community education efforts. They developed age-appropriate, culturally-competent printed materials (e.g., flyers, brochures, pamphlets) and presentations for community youth, adults, and stakeholders regarding the harms of abusing prescription drug medications and the safe usage, storage, and disposal of these medications. Reduce marijuana use by youth

- Providers from the eight SPAs participated in Rethinking Access to Marijuana (RAM) Workgroup meetings to actively work toward reducing marijuana access and use by L.A. County youth.

- Following the passage of Proposition 64, prevention providers from numerous SPAs (2, 3, 4, 6, 7, 8) conducted the RAM Community Health Environmental Survey Scan (CHESS) to examine the marijuana dispensary landscape (i.e., changes in location and number of marijuana dispensaries and marijuana

advertisements) to inform future efforts with city officials about reducing the accessibility and availability of marijuana for community youth.

- Providers developed partnerships with elected city officials to provide public comment and advocate for policies that would reduce harms associated with all forms of smoking in outdoor places, including marijuana smoking, and reduce marijuana use among youth.

- In partnership with Fraser Communications, DPH-SAPC launched a marijuana use prevention media campaign to reach teens via innovative approaches (e.g., digital media, peer-to-peer messaging).

Decrease underage drinking and binge drinking

- Working with the California Alcohol Policy Alliance (CAPA), prevention providers from SPAs 2, 5, and 8 engaged with community stakeholders and city decision-makers to oppose the 4 am bar bill (SB 905)

- As members of the L.A. Drug and Alcohol Policy Alliance (LA DAPA), prevention staff from SPAs 2 and 4 helped establish the Alcohol Restricted Use Sub-District (ARUS) ordinance that would allow city council members to prohibit new liquor licenses in areas within each council district to reduce alcohol-related harms associated with the over-concentration of alcohol outlets.

- Prevention providers from SPAs 3, 6, and 8 collaborated with community members and local agencies (e.g., law enforcement, local businesses) to promote messaging about the Social Host Ordinance (SHO) and the Parents Who Host Lose the Most (PWHLM) campaigns.

Reduce availability of and access to methamphetamine use by youth and young adults

- To better address the growing methamphetamine problem in Antelope Valley, the SPA 1 program evaluator created a methamphetamine needs assessment to identify key areas of improvement and key stakeholders who could assist with prevention efforts.

- Prevention staff from SPA 4 engaged in bi-monthly monitoring of public parks and met with the City of Los Angeles Department of Recreation and Parks to successfully disrupt and reduce illicit drug activity in a Skid Row park by improving park's lighting. Staff also facilitated numerous community meetings and collaborated with the Mayor's Office to develop a community hygiene center in Skid Row.

Lessons Learned

Due to the size and population of LAC, developing standardized measures to evaluate prevention efforts is a recurring challenge. DPH-SAPC understands the necessity to exercise flexibility and that best practices in community mobilization efforts work best in a feedback/engagement model to address and assist with prioritizing community needs. The utilization of policy advocacy and effective evidence-based practices coupled with the development of better outcome measures will help LAC achieve and expand its collective impact goal.

As funding restricts resources and SUD prevention research, DPH-SAPC will need to strategize how to allocate limited assets towards the SPAs in most need.

DPH-SAPC's network of prevention providers continue to face workforce retention issues. High staff turnover requires spending substantial time to train new staff interfering with sustainability and service implementation. The SAPC network of providers are well connected, passionate, engaged, resourceful and have historical knowledge of the SUD prevention field. DPH-SAPC is dedicated to supporting and retaining a robust and committed network of providers.

The Prevention Survey and Prevention Summit (September 2015) involved Alcohol and Other Drug Prevention Service (AODPS) contractors, also called prevention providers. DPH-SAPC sought to collect information and recommendations to:

- Enhance the system of services and training needs,
- Further understand resources, opportunities and challenges AOD prevention providers experience, and
- Explore innovative and collaborative approaches to prevention.

The following findings guided DPH-SAPC during the prior SPP, and continue to guide the current SPP:

1. Adopt approaches that could significantly enhance the prevention system of services;
2. Support prevention providers' efforts to engage a broad base of partners on common issues contributing to substance use, misuse, and abuse: violence, crime, equity, and other health related factors;
3. Be flexible to address emerging community issues in need of immediate attention;
4. Establish Learning Communities designed to provide a forum for providers to exchange effective approaches and projects and learn from each other;
5. Hold regular data evaluation meetings to learn about available data, reports, and how to use and access data to guide efforts;
6. Involve providers, evaluators, and DPH-SAPC in creating a process for identifying culturally relevant risk and protective factors and other underlying conditions;
7. Focus on specific topics, e.g. purpose of data collection; methods; California Health Interview Survey (CHIS);
8. Engage in problem solving and peer technical assistance;
9. Adapt to cultural shifts on how communities view AOD use: mobilize new messengers with new messages;
10. Implement effective prevention efforts with passion, skill and urgency;
11. Expand and collaborate to broaden the prevention base using a comprehensive, holistic approach;
12. Coordinate and integrate the full continuum of prevention, treatment and recovery services;
13. Promote workforce development through training opportunities and researching new knowledge and skills for the prevention field to capitalize on, and expand promising practices.

Chapter 2: Assessment

In this comprehensive assessment, the county presented and analyzed data pertaining to community needs and resources specific to LAC and by SPA, when available. LAC examined the overall context within which AOD problems commonly occur, and the prevalence and consequences of AOD use. This comprehensive assessment of the local community needs will guide the County's prevention services.

DATA SOURCES

Local data from a variety of quantitative data sources that demonstrated the magnitude, time trend, or severity of AOD problems were gathered and analyzed to help target prevention efforts to appropriately address the specific needs of LAC. State or national level data were included for comparison purposes. These data were used to clarify the impact of AOD problems on potentially under-resourced communities, and to inform the prioritization of AOD problems. The consumption, contributing factor, and consequence data sources included:

- Alcohol Beverage Control, 2016
- American Community Survey (ACS), 2013-2017
- California Department of Justice (DoJ), Criminal Justice Statistics Center, 2005-2016
- California Health Interview Survey (CHIS) 2016, 2017
- California Healthy Kids Survey (CHKS), 1999 – 2015
- California Student Tobacco Survey (CSTS), 2017-2018
- CDC WONDER, 1999-2017
- Community Needs Assessment (CNA) - SAPC, 2017
- Controlled Substance Utilization Review and Evaluation System (CURES)
- Fatality Analysis Reporting System (FARS), 2016
- Los Angeles City Department of Cannabis Regulation, 2019
- Los Angeles County Health Survey (LACHS), 2011, 2015, 2018
- Los Angeles County Participant Reporting System (LACPRS), FY1617-FY1819
- Los Angeles County Sheriff Department (LASD) crime data, 2016
- Los Angeles Police Department (LAPD) crime data, 2016
- National Survey of Drug Use and Health (NSDUH), 2010-2012, 2012-2014, 2014-2016
- Office of Statewide Health Planning and Development (OSHPD), 2005-2017
- State of California, Cannabis Portal, 2019
- Statewide Integrated Traffic Records System (SWITRS), 2016
- Vital Records Business Intelligence System (VRBIS), 2005-2018
- WeedMaps, 2019
- Youth Risk Behavior Surveillance Survey (YRBS), 2001-2017

Limitations of Data Sources and Findings

The most recent estimates available were presented and may not reflect current rates for some measures due to the lags in data released. Although NSDUH provides local and community level estimates of alcohol and other drug use prevalence (e.g., alcohol, marijuana, prescription drugs), separate rates for SPAs 1 and 5 are not available due to small sample size and some SPA-level estimates are statistically unstable. Data by SPA are not readily available except zip codes for OSHPD and LACPRS. SPA location was assigned based on zip code centroids and is subject to error.

Substance Use Disorders in Los Angeles County

Approximately 8.4% of individuals in LAC ages 12 and older have reported issues with substance use, with young adults (ages 18-25) representing the largest age group with substance use issues (18.0%).[1] Drug overdose has been one of the leading causes of premature death in LAC, reducing life expectancy by an average of 30 years.[2] It is estimated that alcohol and drug (AOD) use cost the county nearly $13 billion annually due to expenses associated with medical, criminal, and productivity loss.[3] However, it is estimated that for every dollar invested in prevention, screening, and treatment services, the county could see savings between $4 and $36.[4]

Table 4. Trends in Adult Use of Marijuana by SPA, 2005 to 2018

Service Planning Area	2005	2011	2015	2018
Antelope Valley	8.0%	7.8%	14.2%	24.8%
San Fernando	10.4%	9.5%	11.1%	17.9%
San Gabriel	4.5%	4.8%	7.7%	13.0%
Metro	12.9%	11.1%	15.1%	21.8%
West	8.6%	10.2%	15.2%	26.7%
South	7.5%	6.9%*	11.9%	18.3%
East	5.5%	7.1%	9.8%	17.4%
South Bay	8.5%	10.9%	13.0%	17.2%

According to the Youth Risk Behavior Survey, in 2017 an estimated 2.7% of LAC high school students reported having used meth at least once in their lifetime.[5] During the same survey period, 35.9% of LAC high school students reported having used marijuana at least once during their lifetime and 7.2% tried it prior to age 13.[6] An estimated 19.1% admitted to the current use of marijuana; 6.5% reported trying synthetic marijuana products at least once in their lifetime.[7]

Between 2005 to 2017, LAC experienced a 117% increase in alcohol-related emergency department (ED) visits and a 20% increase for alcohol-related hospitalizations.[8] According to the 2018 LACHS, 53.8% of LAC residents reported drinking alcohol at least once in the past month, with the highest consumption among those 25-29 years of age (62.6%).[9] Additionally, 17.9% of LAC residents reported binge drinking in the past month, with the highest levels (28.2%) among 18-24 year olds.[10]

SUBSTANCE CONSUMPTION

According to the NSDUH, 8.4% of individuals aged 12+ abused or were dependent on substances in the past year, particularly among young adults aged 18-25 years (18.0%) (Table 5).

[1] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/CostBriefFinal.pdf
[2] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/PrimaryCareSUDBriefFinal.pdf
[3] Ibid.
[4] Ibid.
[5] https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=LO
[6] Ibid.
[7] Ibid.
[8] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/AlcoholBriefFinal.pdf
[9] http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm
[10] Ibid.

The specific substances with the highest rates of use included alcohol (21.8% were current binge drinkers), marijuana (15.3% used marijuana in past year; the most commonly used federally illicit drug), and prescription (Rx) opioids (4.7% used Rx opioids non-medically in the past year) (Table 5, Figure 2). There were increases in the use rates of alcohol, marijuana, Rx opioids, cocaine, and illicit drugs in general from 2004 to 2014.

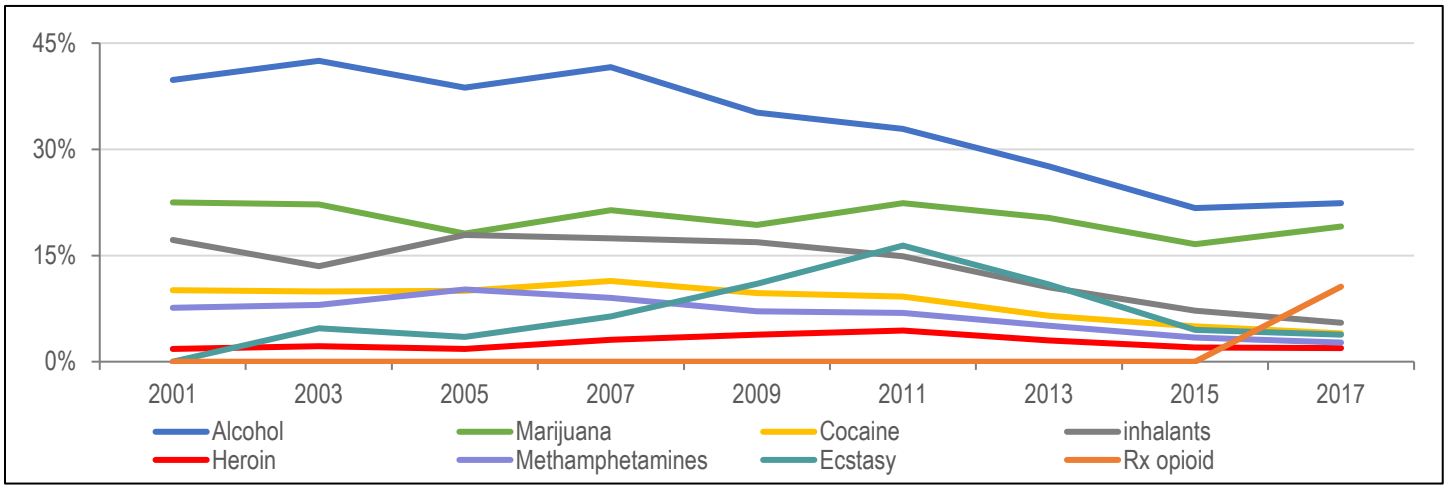
The most recent prevalence rates for commonly used substances among youth (ages 12-17), young adults (ages 18-25), adults (ages 18+), and all ages (12+) are presented in Table 6 at the LAC level and SPA level, along with state and national levels for comparison where available.

Table 5. Prevalence of alcohol and other drug use, LAC

	Alcohol		Rx	Illicit Drug				Overall
Age group (years)	Binge drinking[ac]	Alcohol use disorder[bd]	Rx opioid use[ad]	Marijuana use[bd]	Cocaine use[bd]	Illicit drug use[ac]	Illicit drug use disorder[ad]	Substance use disorder (SUD)[ad]
Youth (12-17)	6.3%	2.4%	4.7%	12.9%	0.8%	10.1%	4.2%	5.9%
Young Adult (18-25)	34.7%	10.5%	8.3%	32.2%	6.6%	22.9%	8.0%	18.0%
Adult (26+)	21.3%	5.7%	4.0%	12.6%	2.0%	8.8%	1.6%	6.9%
Total (18+)	23.4%	6.4%	4.7%	15.5%	2.7%	11.0%	2.6%	8.7%
Total (12+)	21.8%	6.1%	4.7%	15.3%	2.5%	10.9%	2.8%	8.4%

Most recent data available from NSDUH. [a] 2012-2014 data. [b] 2014-2016 data. [c] Past month. [d] Past year.

Figure 2. Prevalence of alcohol and other drugs among 9th-12th graders, LAC, 2001-2017



YRBS data. Past month use data for alcohol and marijuana; Ever use data for all other drugs.

Table 6. Prevalence of commonly misused substances, by geography

Key Indicator	US	CA	LAC	SPA							
Prescription Drugs											
Past month misuse of prescription medications, ages 12+ (CNA, 2017)	-	-	2.8%	SPA1:	1.9%	SPA2:	1.7%	SPA3:	3.1%	SPA4:	3.1%
				SPA5:	3.5%	SPA6:	5.6%	SPA7:	1.2%	SPA8:	1.2%
Past year non-medical use of pain relievers, ages 12-17 (NSDUH 2012-2014)	4.9%	5.2%	4.7%	SPA1:	4.6%	SPA2:	4.8%	SPA3:	4.3%	SPA4:	4.8%
				SPA5:	4.6%	SPA6:	5.2%	SPA7:	4.7%	SPA8:	4.7%
Past year non-medical use of pain relievers, ages 18-25 (NSDUH 2012-2014)	8.9%	8.8%	8.3%	SPA1:	9.1%	SPA2:	9.0%	SPA3:	7.8%	SPA4:	8.3%
				SPA5:	9.1%	SPA6:	8.2%	SPA7:	7.8%	SPA8:	8.1%
Past year misuse of prescription drugs, ages 18+ (LACHS, 2015)	4.2% [a]	2.0% [c]	5.5%	SPA1:	5.8%	SPA2:	3.9%	SPA3:	4.7%	SPA4:	7.0%
				SPA5:	5.2%	SPA6:	6.8%	SPA7:	5.9%	SPA8:	6.3%
Marijuana											
Past month use, ages 12+ (CNA 2017)	8.5% [b]	10.2% [b]	13.8%	SPA1:	16.9%	SPA2:	10.5%	SPA3:	14.1%	SPA4:	15.5%
				SPA5:	15.4%	SPA6:	17.2%	SPA7:	9.8%	SPA8:	12.7%
Past month use, ages 12-17 (NSDUH 2014-16)	7.0%	8.0%	7.6%	SPA1:	8.8%	SPA2:	7.7%	SPA3:	6.0%	SPA4:	7.9%
				SPA5:	8.8%	SPA6:	8.4%	SPA7:	7.3%	SPA8:	8.0%
Past month use, ages 18-25 (NSDUH 2014-16)	20.1%	22.5%	21.3%	SPA1:	25.0%	SPA2:	21.1%	SPA3:	17.2%	SPA4:	22.4%
				SPA5:	25.0%	SPA6:	22.8%	SPA7:	19.7%	SPA8:	23.4%
Past year use, ages 18+ (LACHS, 2018)	13.7% [b]	16.1% [b]	18.2%	SPA1:	24.8%	SPA2:	17.9%	SPA3:	13.0%	SPA4:	21.8%
				SPA5:	26.7%	SPA6:	18.3%	SPA7:	17.4%	SPA8:	17.2%
Average age of first use (CNA, 2017)	-	-	17 years	SPA1:	16	SPA2:	17	SPA3:	17	SPA4:	18
				SPA5:	19	SPA6:	17	SPA7:	17	SPA8:	17
Alcohol											
Past month use, ages 12-17 (NSDUH 2014-16)	10.1%	10.1%	9.4%	SPA1:	10.7%	SPA2:	10.2%	SPA3:	8.5%	SPA4:	9.1%
				SPA5:	10.7%	SPA6:	8.5%	SPA7:	9.0%	SPA8:	10.0%
Past month use, ages 18-25 (NSDUH 2014-16)	58.4%	55.6%	53.0%	SPA1:	61.7%	SPA2:	55.9%	SPA3:	51.4%	SPA4:	57.2%
				SPA5:	61.7%	SPA6:	42.5%	SPA7:	46.9%	SPA8:	56.1%
Past month binge* use, ages 12-17 (NSDUH 2012-14)	6.5%	6.4%	6.3%	SPA1:	6.4%	SPA2:	6.2%	SPA3:	5.5%	SPA4:	6.3%
				SPA5:	6.4%	SPA6:	6.5%	SPA7:	6.6%	SPA8:	6.7%
Past month binge* use, ages 18-25 (NSDUH 2012-14)	38.4%	35.8%	34.7%	SPA1:	-	SPA2:	33.5%	SPA3:	31.7%	SPA4:	38.5%
				SPA5:	-	SPA6:	-	SPA7:	33.8%	SPA8:	35.2%
Past month use, ages 18+ (LACHS, 2018)	56.0% [b]	54.4% [b]	53.8%	SPA1:	53.1%	SPA2:	58.6%	SPA3:	52.7%	SPA4:	52.8%
				SPA5:	70.6%	SPA6:	41.5%	SPA7:	49.7%	SPA8:	52.3%
Past month binge* use, ages 18+ (LACHS, 2018)	24.7% [a]	15.1% [e]	17.9%	SPA1:	19.6%	SPA2:	15.3%	SPA3:	16.0%	SPA4:	21.7%
				SPA5:	20.3%	SPA6:	16.2%	SPA7:	20.2%	SPA8:	18.3%

Past month heavy drinking†, ages 18+ (LACHS, 2018)	-	-	4.8%	SPA1:	8.0%	SPA2:	4.7%	SPA3:	3.0%	SPA4:	4.9%
				SPA5:	8.8%	SPA6:	4.2%	SPA7:	5.2%	SPA8:	4.4%
Other illicit drugs												
Past year use of cocaine, ages 12-17 (NSDUH 2014-16)	0.6%	0.9%	0.8%	SPA1:	-	SPA2:	0.8%	SPA3:	0.8%	SPA4:	-
				SPA5:	-	SPA6:	1.0%	SPA7:	0.9%	SPA8:	0.7%
Past year use of cocaine, ages 18-25 (NSDUH 2014-16)	5.2%	7.1%	6.6%	SPA1:	7.4%	SPA2:	7.2%	SPA3:	5.9%	SPA4:	-
				SPA5:	7.4%	SPA6:	4.6%	SPA7:	5.5%	SPA8:	6.3%
Past month use of illicit drug other than marijuana, ages 12-17 (NSDUH 2012-14)	3.4%	3.8%	3.8%	SPA1:	3.8%	SPA2:	3.9%	SPA3:	3.5%	SPA4:	3.9%
				SPA5:	3.8%	SPA6:	3.8%	SPA7:	4.0%	SPA8:	3.6%
Past month use of illicit drug other than marijuana, ages 18-25 (NSDUH 2012-14)	6.7%	6.7%	6.3%	SPA1:	7.0%	SPA2:	7.2%	SPA3:	5.6%	SPA4:	6.2%
				SPA5:	7.0%	SPA6:	5.4%	SPA7:	6.8%	SPA8:	5.4%

[a] NSDUH 2012-2014 [b] NSDUH 2014-2016 [c] AskCHIS, 2017.
* Binge drinking: 5 drinks for men, 4 drinks for women. † Heavy drinking: average of 2+ drinks per day for males and 1+ per day for females.
Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

CONTRIBUTING FACTORS TO SUBSTANCE USE

Many amendable factors contribute to substance use and serve as potential targets for interventions that reduce substance use among youth, young adults, or other age groups in LAC or specific areas.

Risk Perceptions

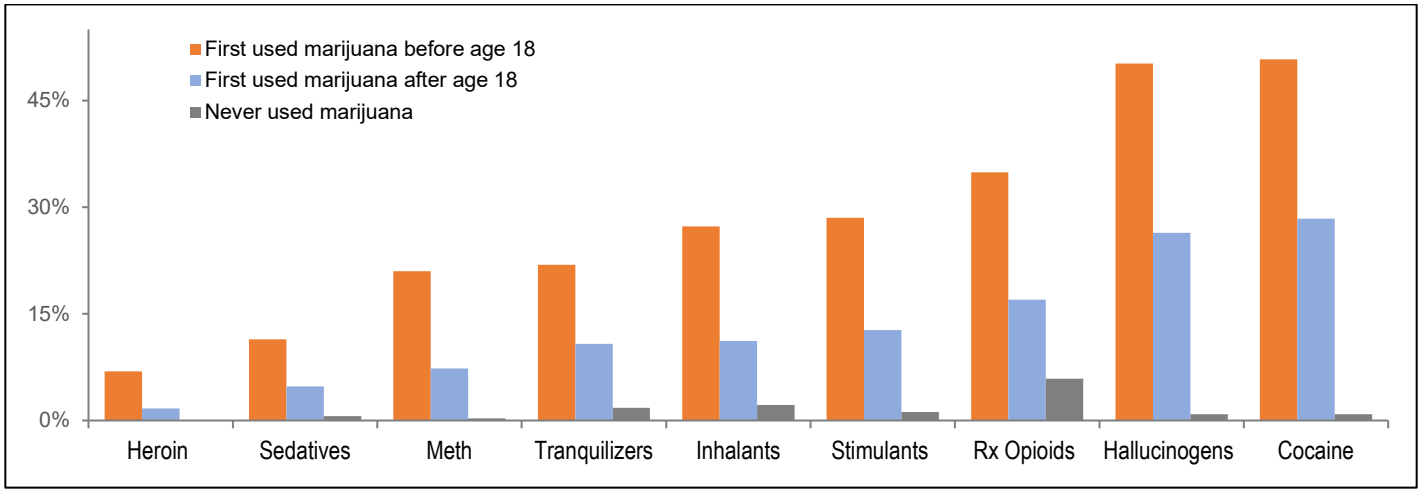
A large proportion of people do not perceive misuse of prescription drugs and marijuana to be a great risk (Table 7) in LAC. Prescription drugs are legally prescribed by doctors to treat medical conditions and may be considered by some people as safe to use, even if it is to get high. With widespread use of marijuana among youth and young adults, along with the recent legalization of recreational marijuana use and sales, some people may believe that there is little risk using marijuana. However, there is evidence that marijuana use, especially early and regular use, is harmful to brain development and function (NIDA; Ventura County, 2014), and is correlated with lifetime use of other drugs (Figure 3).

Table 7. Risk perceptions of prescription drugs and marijuana by geography

Key Indicator	LAC	SPA
Prescription Drugs		
Perceived great risk for youth occasionally misusing Rx medications, ages 12+ (CNA, 2017)	54.4%	SPA1: 60.8% SPA2: 51.6% SPA3: 55.2% SPA4: 54.7% SPA5: 50.9% SPA6: 51.2% SPA7: 61.2% SPA8: 63.6%
Perceived great risk for adults occasionally misusing Rx medications, ages 12+ (CNA, 2017)	45.0%	SPA1: 43.8% SPA2: 42.7% SPA3: 47.0% SPA4: 44.2% SPA5: 34.5% SPA6: 47.3% SPA7: 50.7% SPA8: 51.5%
Agree it is safer to use Rx medication to get high than illegal street drugs, age 12+ (CNA, 2017)	29.7%	SPA1: 26.3% SPA2: 34.9% SPA3: 25.7% SPA4: 38.1% SPA5: 27.9% SPA6: 29.3% SPA7: 28.8% SPA8: 19.8%
Marijuana		
Perceived great risk of youth using marijuana regularly, ages 12+ (CNA, 2017)	49.8%	SPA1: 43.0% SPA2: 56.4% SPA3: 47.2% SPA4: 51.9% SPA5: 43.3% SPA6: 47.4% SPA7: 57.6% SPA8: 55.1%
Perceived great risk of adults using marijuana regularly, ages 12+ (CNA, 2017)	32.7%	SPA1: 23.7% SPA2: 38.9% SPA3: 28.9% SPA4: 34.1% SPA5: 18.8% SPA6: 30.5% SPA7: 42.8% SPA8: 38.1%
Perceived great risk of daily marijuana use, ages 18+ (LACHS, 2018)	32.5%	SPA1: 23.8% SPA2: 35.3% SPA3: 36.3% SPA4: 27.0% SPA5: 16.1% SPA6: 42.6% SPA7: 39.6% SPA8: 25.1%
Agree that marijuana use is harmful to brain development of youth, ages 18+ (LACHS, 2018)	79.5%	SPA1: 81.4% SPA2: 82.1% SPA3: 76.0% SPA4: 81.7% SPA5: 69.9% SPA6: 81.9% SPA7: 83.5% SPA8: 76.9%

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Figure 3. Lifetime illicit drug use by marijuana use, CA, 2012-2013



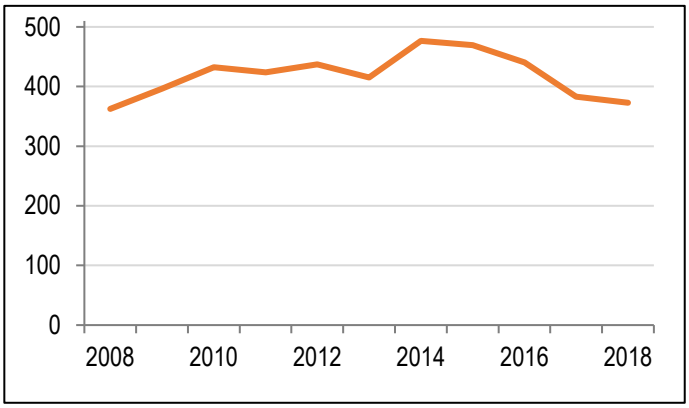
NSDUH 2012-2013 data

Access/Availability

Substances are widely available in LAC neighborhoods. Although there are some restrictions in place, including a doctor's prescription for controlled substances, legal age requirements, and zoning restrictions, prescription drugs, marijuana, and alcohol are widely perceived to be easily accessible.

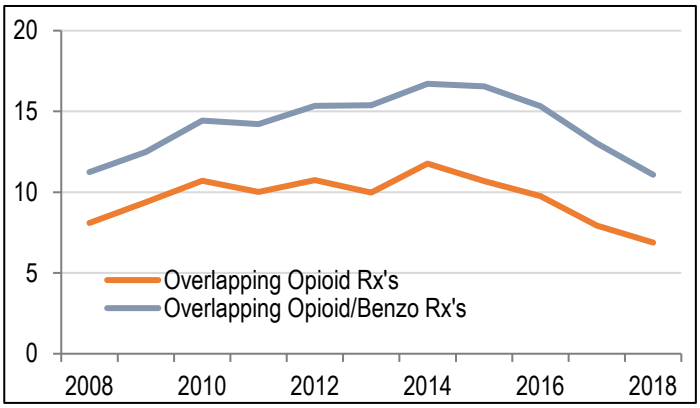
A large number of patients are prescribed opioids in LAC. In 2010-2018, about 400 opioid prescriptions were filled per 1,000 residents each year, which is enough to supply a bottle of opioids to about half of all adults in LAC (Figure 4). Many were prescribed in high dosages or with dangerous combinations of two or more overlapping opioids or overlapping opioid and benzodiazepine prescriptions (Figure 5). Rates of opioid prescriptions increased from 2008 to 2014 and has since decreased, although the rates still remain high.

Figure 4. Opioid prescription rate per 1,000 population, LAC



CURES

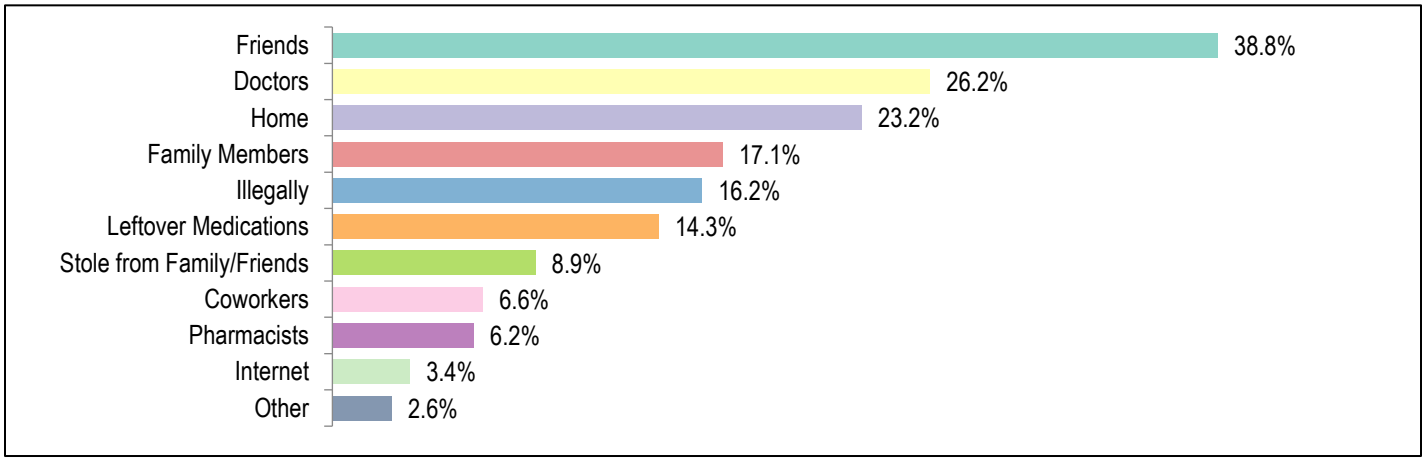
Figure 5. Overlapping opioid and overlapping opioid and benzodiazepine prescription rate per 1,000 population, LAC



CURES

With the large supply of prescription opioids in the communities, misusers often obtain their prescription medications from friends or family (Figure 6). Moreover, nearly half (47.1%) of individuals in LAC believed it is easy or very easy for someone to get prescription medication in their neighborhood (Table 8).

Figure 6. Source of Rx medications for misuse among ever misusers of Rx medications, 2017

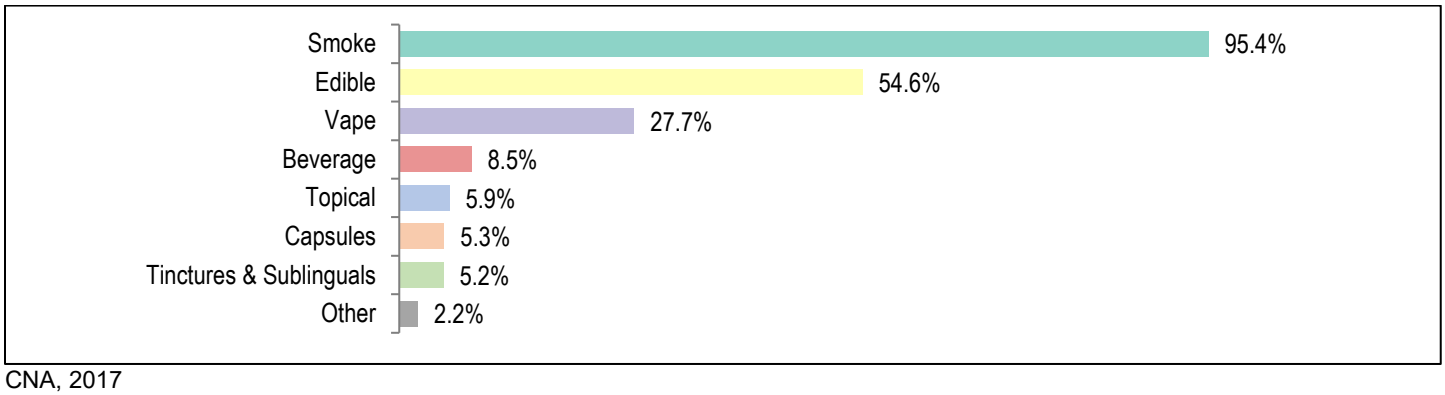


CNA, 2017

In addition to licensed marijuana dispensaries, a larger number of illegal unlicensed marijuana dispensaries are open across LAC that sell a variety of marijuana products such as edibles and vapes (Table 8, Figure 7), some of which are of high dosage and potency. The majority (81.2%) of individuals believe it is easy or very easy to get marijuana in their neighborhood (Table 8).

Since alcohol sales to adults age 21 or older is legal and profitable at alcohol outlets for onsite (e.g. restaurants) and offsite (e.g. liquor stores, grocery stores) consumption, alcohol outlets are ubiquitous in LAC (Table 8). The wide variety of alcoholic beverages are available to consumers, including “alcopops”, which are popular among youth due to their sweet taste, assortment of flavors, low price, and high alcohol content, but also are associated with youth binge drinking (Albers et al., 2015). Alcohol outlet density and proximity has been associated with alcohol consumption and alcohol-related consequences, including violent crimes, vehicle crashes, ED visits, hospitalizations, and death (LAC DPH, 2016; Rowland et al., 2015; Chen et al., 2010; Hingson & White, 2014).

Figure 7. Route of administration of marijuana among ever users of marijuana, 2017



CNA, 2017

Table 8. Access and availability of prescription drugs, marijuana, and alcohol by geography

Key Indicator	LAC	SPA							
Prescription Drugs									
Perceived easy access to prescription medication, age 12+ (CNA, 2017)	47.1%	SPA1:	57.9%	SPA2:	50.0%	SPA3:	42.2%	SPA4:	49.0%
		SPA5:	36.6%	SPA6:	57.9%	SPA7:	47.5%	SPA8:	45.6%
Perceived major prescription medication misuse problem in neighborhood, ages 12+ (CNA, 2017)	16.9%	SPA1:	20.8%	SPA2:	16.5%	SPA3:	10.0%	SPA4:	21.0%
		SPA5:	16.6%	SPA6:	27.5%	SPA7:	14.8%	SPA8:	18.7%
Marijuana									
Marijuana dispensaries, rate per 100,000 population (WeedMaps, CA State, LA City, 2019)	11.1	SPA1:	1.0	SPA2:	14.4	SPA3:	3.4	SPA4:	24.7
		SPA5:	10.3	SPA6:	11.9	SPA7:	8.7	SPA8:	8.3
Perceived easy access to marijuana, ages 12+ (CNA, 2017)	81.2%	SPA1:	84.9%	SPA2:	81.1%	SPA3:	82.9%	SPA4:	86.4%
		SPA5:	79.5%	SPA6:	79.5%	SPA7:	78.1%	SPA8:	86.5%
Perceived that marijuana use is a major problem in the neighborhood, ages 12+ (CNA, 2017)	23.4%	SPA1:	16.6%	SPA2:	27.7%	SPA3:	15.0%	SPA4:	33.5%
		SPA5:	14.0%	SPA6:	39.0%	SPA7:	25.0%	SPA8:	22.4%
Alcohol									
Alcohol Outlets, offsite consumption, rate per 100,000 population (ABC, 2016)	60.5	SPA1:	45.9	SPA2:	56.3	SPA3:	55.0	SPA4:	67.7
		SPA5:	61.3	SPA6:	52.6	SPA7:	71.3	SPA8:	67.0
Alcohol Outlets, onsite consumption, rate per 100,000 population (ABC, 2016)	93.2	SPA1:	57.3	SPA2:	80.7	SPA3:	86	SPA4:	160.8
		SPA5:	191.4	SPA6:	20.2	SPA7:	65.9	SPA8:	107.7

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Social Norms

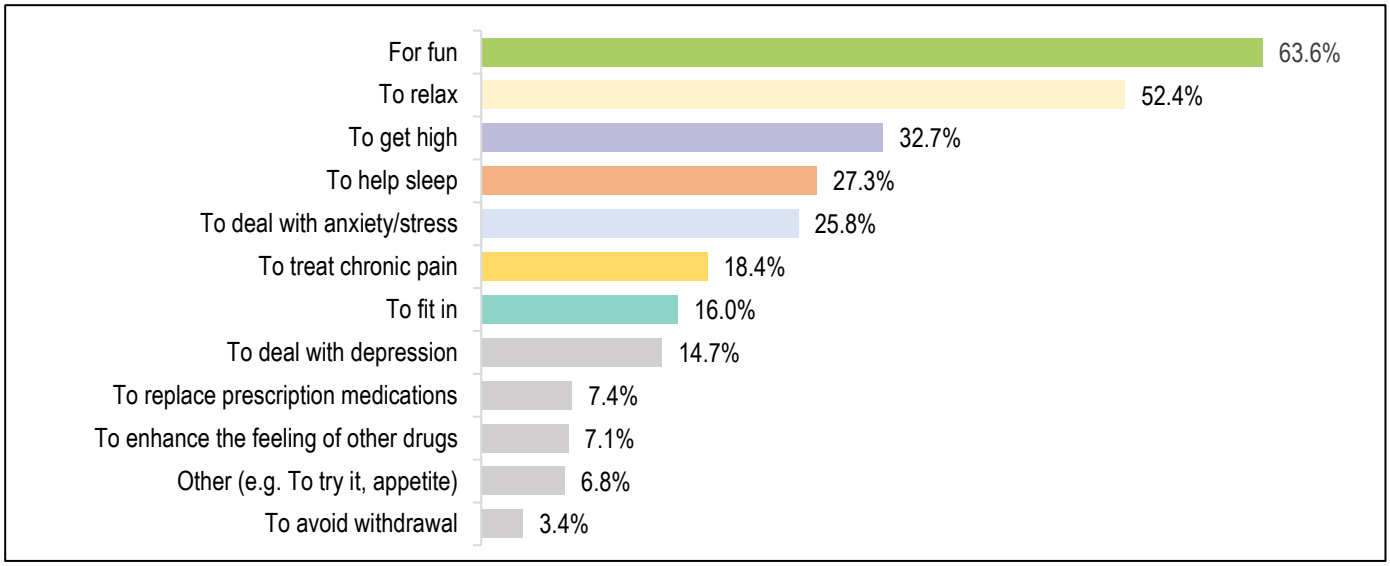
Family practices, peers, media website advertisements, music, movies, advertising, laws, and regulations influence social values and norms, individual beliefs and attitudes, and actual use of alcohol and drugs (Primack et al., 2010; Murphy et al., 2009; Mrug & McCay, 2013; Martino, 2009; SAMHSA, 2013). Marijuana use has become normalized since California legalized medical marijuana in 1996, passed additional marijuana decriminalization legislation in the years following, and even legalized recreational marijuana use and sales to adults aged 21 or older in 2016. A large proportion of individuals use marijuana (Table 9), or have close friends (43.1%) or family members (38.4%) that use marijuana (Table 9). Marijuana users report they often use marijuana for fun, to relax, or to get high (Figure 8), and usually use marijuana with friends (Figure 9).

Table 9. Marijuana use among close friends and family by geography

Key Indicator	LAC	SPA
Marijuana		
Close friends use marijuana, age 12+ (CNA, 2017)	43.1%	SPA1: 48.7% SPA2: 37.8% SPA3: 46.5% SPA4: 44.8% SPA5: 58.0% SPA6: 47.1% SPA7: 34.0% SPA8: 37.9%
Family members use marijuana, age 12+ (CNA, 2017)	38.4%	SPA1: 45.6% SPA2: 33.4% SPA3: 40.1% SPA4: 37.4% SPA5: 43.5% SPA6: 47.5% SPA7: 33.9% SPA8: 34.4%

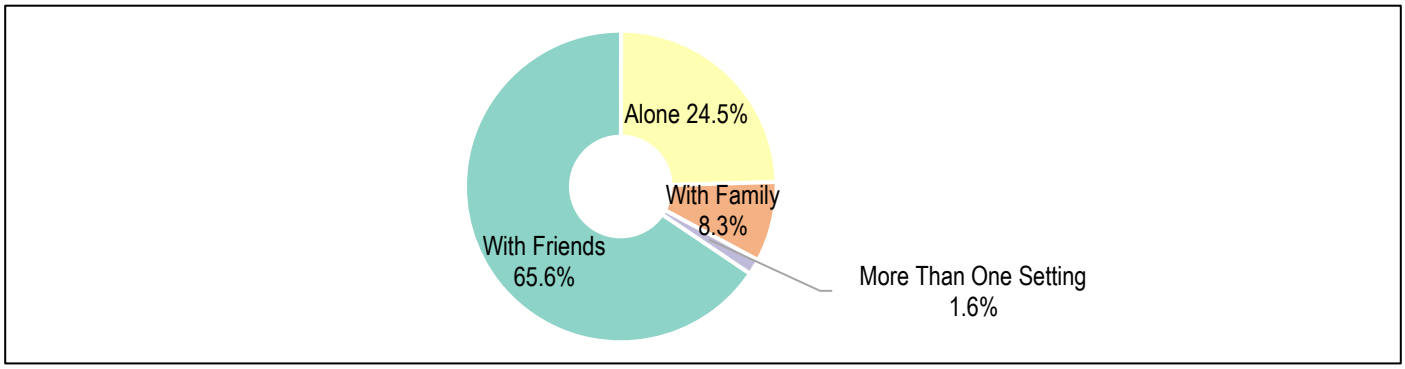
Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Figure 8. Reasons for using marijuana among ever users of marijuana, 2017



CNA, 2017

Figure 9. Setting of marijuana use among ever users of marijuana, 2017



CNA, 2017

SUBSTANCE USE RELATED CONSEQUENCES

Substance use affects the brain and body, and can lead to many adverse acute and chronic health problems including cognitive impairment, mental disorders, motor and coordination skills, injuries, overdose/poisoning, and physical disease (e.g. liver cirrhosis).

In addition to the heavy disease burden, AOD use also incurs a large economic burden of nearly $13 billion ($9.5 billion for alcohol, $3.4 billion for illicit drugs) annually in tangible costs, which includes medical, wage and household work, criminal justice system, public services, property damage, and motor vehicle crash costs (LAC DPH, 2019).

Operating Under the Influence

AOD affects the ability to carry out normal functions, and it is often illegal in many settings to operate under the influence of AOD. Despite this, over a third (36.1%) of individuals age 12+ reported misusing prescription medication before or during work or school, and over a quarter (27.2%) reported having gone to work or school under the influence of marijuana (Table 10).

Alcohol and drug impaired driving increases the risk of crashes (Asbridge et al., 2012). The number of DUI arrests in LAC increased from 2005 to 2008, then decreased thereafter, but remained high at nearly 28,000 in 2016 (Figure 10). Fatal collisions in LAC involving a driver that tested positive for AOD generally increased from about 2011 to 2016. The most common substance that tested positive among drivers in fatal collisions were alcohol, followed by marijuana, prescription drugs (i.e. stimulants, sedatives, and opioids, in order), and hallucinogens/inhalants (Figure 11).

Table 10. Operating under the influence of Rx drugs, marijuana, and alcohol by geography

Key Indicator	LAC	SPA							
Prescription Drugs									
Ever misused prescription medication before or during work/school, ages 12+ (CNA, 2017)	36.1%	SPA1:	44.6%	SPA2:	36.3%	SPA3:	44.9%	SPA4:	29.1%
		SPA5:	34.9%	SPA6:	30.4%	SPA7:	41.4%	SPA8:	18.2%
Marijuana									
Ever gone to work/school under the influence of marijuana, ages 12+ (CNA, 2017)	27.2%	SPA1:	34.8%	SPA2:	22.7%	SPA3:	31.1%	SPA4:	27.3%
		SPA5:	12.3%	SPA6:	26.4%	SPA7:	26.0%	SPA8:	23.7%
Drove under the influence of marijuana in past year, ages 18+ (LACHS, 2018)	3.7%	SPA1:	6.4%	SPA2:	3.7%	SPA3:	2.7%	SPA4:	5.6%
		SPA5:	5.8%	SPA6:	3.1%	SPA7:	2.0%	SPA8:	3.8%
Alcohol									
Alcohol-involved injury or fatal traffic collisions, rate per 100,000 (SWITRS, 2016)	79.5	SPA1:	96.8	SPA2:	84.2	SPA3:	67.3	SPA4:	91.3
		SPA5:	79.8	SPA6:	85.9	SPA7:	85.9	SPA8:	63.5

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Figure 10. DUI arrests, LAC

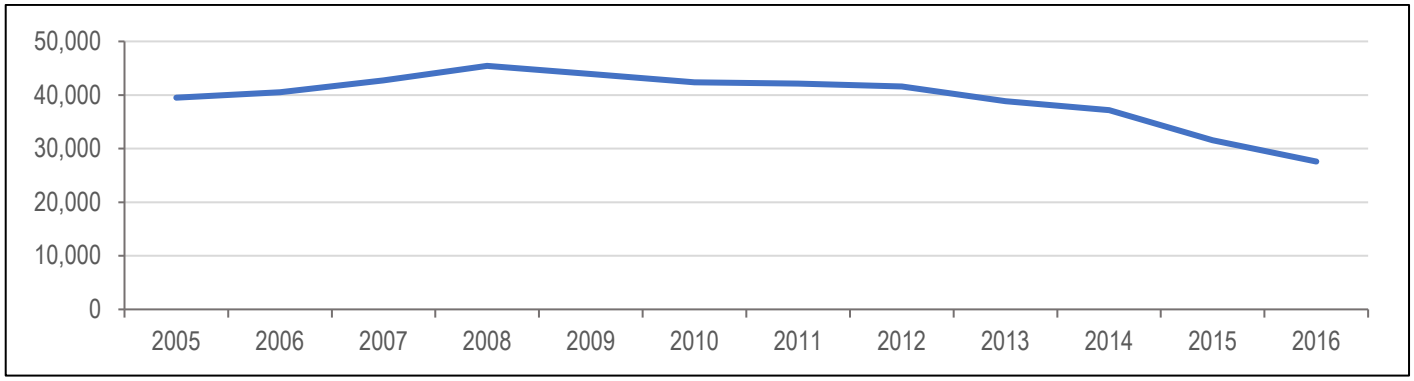


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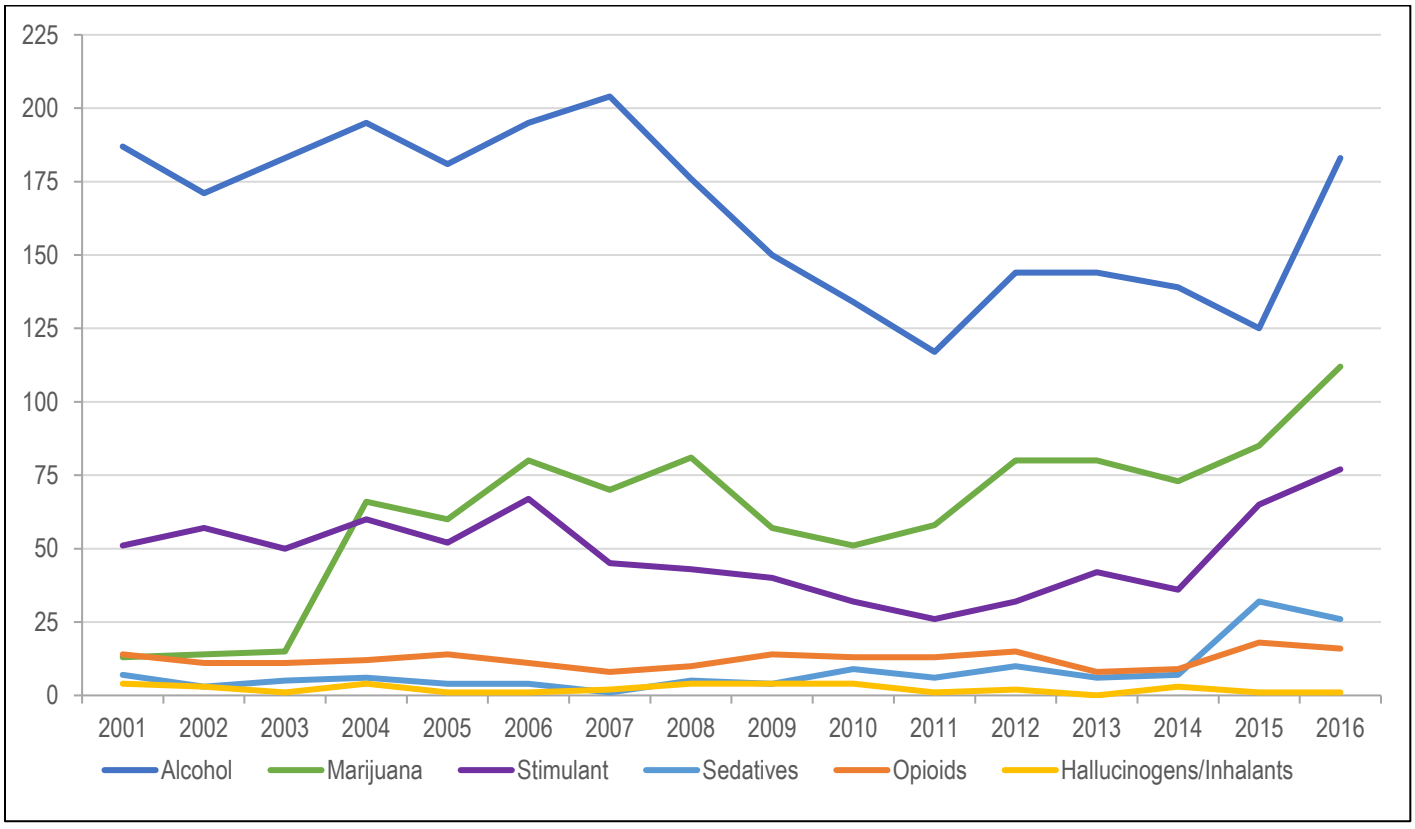
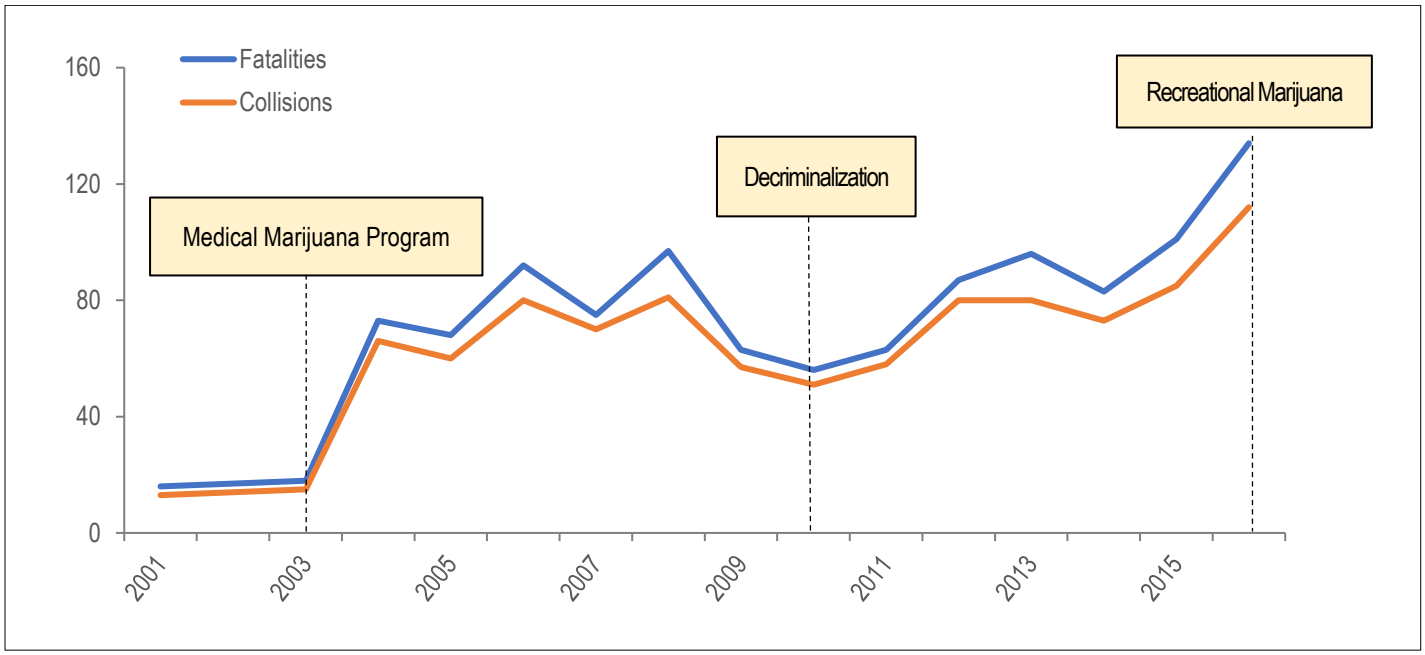
Figure 11. Fatal collisions involving a driver testing positive for alcohol or drugs, LAC



FARS

In LAC, increases in traffic crashes and its fatalities involving marijuana co-occurred with the passage of the Compassionate Use Act which initiated the Medical Marijuana Program, and the decriminalization of marijuana which reduced the penalty for possession of <1oz from a misdemeanor to an infraction (Figure 12).

Figure 12. Fatalities and fatal collisions involving a driver testing positive for marijuana, LAC



FARS

Healthcare Utilization

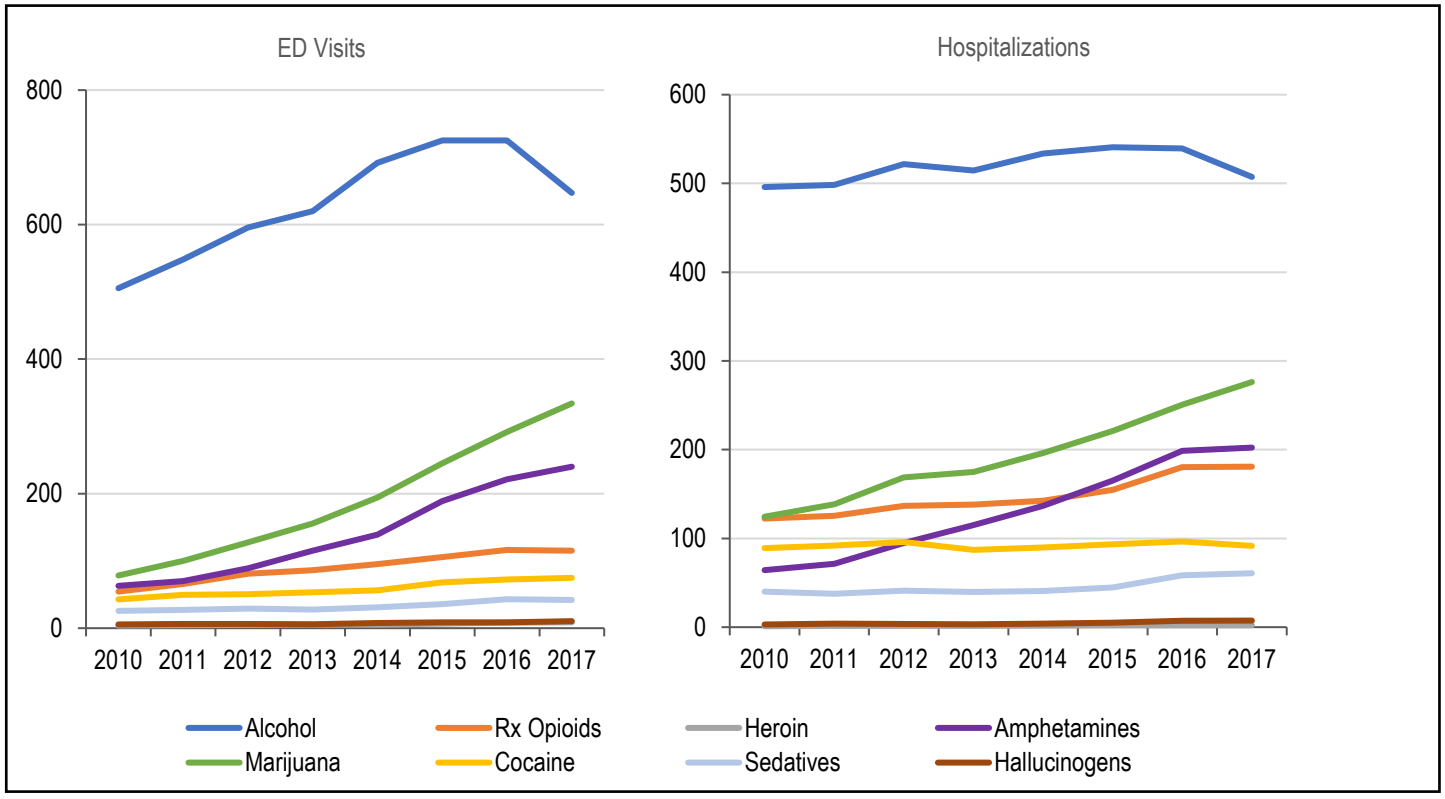
In LAC, the most commonly mentioned substances of abuse, dependence, or poisoning as a diagnosis or external-cause-of-injury in emergency department (ED) visit records was alcohol, followed by marijuana, amphetamines, prescription opioids, cocaine, sedatives, and hallucinogens. There were consistent large increases from 2010 to 2017 in the rate of ED visits that involved marijuana (326% increase), amphetamines (281% increase), Rx opioids (112% increase) and heroin (130% increase), hallucinogens (87%), and cocaine (75% increase). The rate of ED visits that involved alcohol increased 43% from 2010 to 2016, then decreased 11% in 2017. The rate of ED visits that involved sedatives increased 67% from 2010 to 2016, then plateaued through 2017 (Figure 13).

The patterns and burden of specific substance-related hospitalization rates in LAC were similar to substance-related ED visit rates, though the trends were slightly different. There were consistent large increases from 2010 to 2017 in the rate of hospitalizations that involved amphetamines (215% increase, surpassing Rx opioids in 2015), hallucinogens (143%), and marijuana (122% increase). The rate of hospitalizations that involved Rx opioids, heroin, and sedatives increased from 2010 to 2016 (48%, 103%, 51% respectively), then plateaued in 2017. The rate of hospitalizations that involved alcohol and cocaine remained relatively stable over the period (Figure 13).

The rates of ED visits and hospitalizations per 100,000 population in 2017 for youth aged 12-17, young adults aged 18-25, and all ages for LAC and SPA are presented in Tables 11 and 12. Prescription drugs, marijuana,

alcohol, and methamphetamine[11] accounted for the largest burdens of high-cost and resource-intense healthcare utilization for patients of all ages in LAC, particularly young adults aged 18-25, with ED visit and hospitalization rates that were generally higher than the overall rates for all ages (except alcohol, which is associated with more chronic physical conditions that manifest in older adults).

Figure 13. ED visit and hospitalization rates per 100,000 population by substance, LAC



OSHPD data: Records listing substance abuse, dependence, or poisoning as a diagnosis or external-cause-of-injury, excluding cases in remission.

[11] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/MethamphetamineBriefFinal.pdf

Table 11. ED Visits by geography, LAC

Key Indicator	LAC	SPA							
Prescription Drugs									
Rx opioid-related ED visits, ages 12-17, rate per 100,000 (OSHPD, 2017)	15.5	SPA1:	30.7	SPA2:	16.8	SPA3:	16.3	SPA4:	8.3
		SPA5:	14.7	SPA6:	10.2	SPA7:	16.1	SPA8:	16.5
Rx opioid-related ED visits, ages 18-25, rate per 100,000 (OSHPD, 2017)	123.9	SPA1:	132.3	SPA2:	217.8	SPA3:	81.7	SPA4:	146.0
		SPA5:	188.5	SPA6:	63.2	SPA7:	64.3	SPA8:	108.1
Rx opioid-related ED visits, all ages combined, rate per 100,000 (OSHPD, 2017)	115.1	SPA1:	145.5	SPA2:	133.6	SPA3:	89.3	SPA4:	136.9
		SPA5:	110.0	SPA6:	96.8	SPA7:	74.4	SPA8:	142.5
Rx sedative-related ED visits, ages 12-17, rate per 100,000 (OSHPD, 2017)	62.8	SPA1:	41.8	SPA2:	71.5	SPA3:	70.4	SPA4:	38.8
		SPA5:	67.4	SPA6:	54.8	SPA7:	70.7	SPA8:	60.9
Rx sedative-related ED visits, ages 18-25, rate per 100,000 (OSHPD, 2017)	64.6	SPA1:	71.5	SPA2:	74.3	SPA3:	58.8	SPA4:	69.5
		SPA5:	94.9	SPA6:	41.3	SPA7:	46.6	SPA8:	77.6
Rx sedative-related ED visits, all ages combined, rate per 100,000 (OSHPD, 2017)	41.9	SPA1:	58.1	SPA2:	45.9	SPA3:	36.5	SPA4:	37.9
		SPA5:	52.8	SPA6:	32.5	SPA7:	33.2	SPA8:	50.5
Marijuana									
Marijuana-related ED visits, ages 12-17, rate per 100,000 (OSHPD, 2017)	299.2	SPA1:	331.8	SPA2:	294.9	SPA3:	275.3	SPA4:	318.9
		SPA5:	211.1	SPA6:	341.1	SPA7:	284.7	SPA8:	314.2
Marijuana-related ED visits, ages 18-25, rate per 100,000 (OSHPD, 2017)	868.1	SPA1:	886.7	SPA2:	648.9	SPA3:	609.5	SPA4:	1,160.2
		SPA5:	615.8	SPA6:	1,372.5	SPA7:	650.3	SPA8:	1,172.4
Marijuana-related ED visits, all ages combined, rate per 100,000 (OSHPD, 2017)	334.1	SPA1:	427.0	SPA2:	225.9	SPA3:	217.1	SPA4:	397.6
		SPA5:	262.6	SPA6:	654.9	SPA7:	233.9	SPA8:	448.7
Alcohol									
Alcohol-related ED visits, ages 12-17, rate per 100,000 (OSHPD, 2017)	160.0	SPA1:	122.7	SPA2:	206.0	SPA3:	157.3	SPA4:	181.7
		SPA5:	211.1	SPA6:	122.8	SPA7:	122.7	SPA8:	148.1
Alcohol-related ED visits, ages 18-25, rate per 100,000 (OSHPD, 2017)	645.3	SPA1:	522.0	SPA2:	667.1	SPA3:	560.0	SPA4:	938.5
		SPA5:	716.1	SPA6:	595.6	SPA7:	570.1	SPA8:	655.8
Alcohol-related ED visits, all ages combined, rate per 100,000 (OSHPD, 2017)	647.1	SPA1:	667.8	SPA2:	621.3	SPA3:	515.7	SPA4:	783.5
		SPA5:	615.9	SPA6:	804.7	SPA7:	556.6	SPA8:	708.3
Methamphetamine									
Meth-related ED visits, ages 12-17, rate per 100,000 (OSHPD, 2017)	52.0	SPA1:	55.8	SPA2:	58.9	SPA3:	43.0	SPA4:	55.5
		SPA5:	41.0	SPA6:	64.0	SPA7:	51.9	SPA8:	42.8
Meth-related ED visits, ages 18-25, rate per 100,000 (OSHPD, 2017)	376.9	SPA1:	350.4	SPA2:	310.2	SPA3:	302.9	SPA4:	592.0
		SPA5:	286.2	SPA6:	476.8	SPA7:	357.6	SPA8:	401.9
Meth-related ED visits, all ages combined, rate per 100,000 (OSHPD, 2017)	240.1	SPA1:	257.6	SPA2:	179.4	SPA3:	195.1	SPA4:	385.1
		SPA5:	176.5	SPA6:	318.9	SPA7:	210.5	SPA8:	263.1

Records listing substance abuse, dependence, or poisoning as a diagnosis or external-cause-of-injury, excluding cases in remission.
Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Table 12. Hospitalizations by geography, LAC

Key Indicator	LAC	SPA							
Prescription Drugs									
Rx opioid-related hospitalizations, ages 12-17, rate per 100,000 (OSHPD, 2017)	17.9	SPA1:	30.7	SPA2:	21.0	SPA3:	17.1	SPA4:	15.3
		SPA5:	29.3	SPA6:	9.1	SPA7:	17.0	SPA8:	17.3
Rx opioid-related hospitalizations, ages 18-25, rate per 100,000 (OSHPD, 2017)	114.3	SPA1:	82.2	SPA2:	160.5	SPA3:	95.9	SPA4:	122.3
		SPA5:	183.1	SPA6:	58.1	SPA7:	74.9	SPA8:	134.1
Rx opioid-related hospitalizations, all ages combined, rate per 100,000 (OSHPD, 2017)	180.9	SPA1:	220.7	SPA2:	188.7	SPA3:	146.5	SPA4:	172.6
		SPA5:	227.7	SPA6:	158.5	SPA7:	139.8	SPA8:	234.6
Rx sedative-related hospitalizations, ages 12-17, rate per 100,000 (OSHPD, 2017)	36.1	SPA1:	16.7	SPA2:	39.0	SPA3:	69.0	SPA4:	38.8
		SPA5:	35.2	SPA6:	17.3	SPA7:	28.7	SPA8:	22.2
Rx sedative-related hospitalizations, ages 18-25, rate per 100,000 (OSHPD, 2017)	63.5	SPA1:	42.9	SPA2:	74.3	SPA3:	63.3	SPA4:	78.3
		SPA5:	124.8	SPA6:	23.9	SPA7:	54.3	SPA8:	63.2
Rx sedative-related hospitalizations, all ages combined, rate per 100,000 (OSHPD, 2017)	60.8	SPA1:	52.7	SPA2:	63.8	SPA3:	57.8	SPA4:	66.9
		SPA5:	95.6	SPA6:	36.8	SPA7:	46.8	SPA8:	70.2
Marijuana									
Marijuana-related hospitalizations, ages 12-17, rate per 100,000 (OSHPD, 2017)	244.1	SPA1:	262.1	SPA2:	249.3	SPA3:	321.3	SPA4:	212.2
		SPA5:	219.9	SPA6:	232.5	SPA7:	213.1	SPA8:	209.8
Marijuana-related hospitalizations, ages 18-25, rate per 100,000 (OSHPD, 2017)	559.7	SPA1:	445.1	SPA2:	511.4	SPA3:	584.8	SPA4:	591.1
		SPA5:	512.7	SPA6:	616.9	SPA7:	489.7	SPA8:	640.2
Marijuana-related hospitalizations, all ages combined, rate per 100,000 (OSHPD, 2017)	276.2	SPA1:	299.1	SPA2:	234.3	SPA3:	244.1	SPA4:	279.4
		SPA5:	258.2	SPA6:	421.6	SPA7:	221.0	SPA8:	320.0

Alcohol									
Alcohol-related hospitalizations, ages 12-17, rate per 100,000 (OSHPD, 2017)	90.1	SPA1:	50.2	SPA2:	96.7	SPA3:	150.6	SPA4:	90.1
		SPA5:	73.3	SPA6:	71.1	SPA7:	68.0	SPA8:	65.8
Alcohol-related hospitalizations, ages 18-25, rate per 100,000 (OSHPD, 2017)	267.2	SPA1:	185.9	SPA2:	258.9	SPA3:	334.6	SPA4:	301.7
		SPA5:	238.7	SPA6:	223.3	SPA7:	222.5	SPA8:	292.1
Alcohol-related hospitalizations, all ages combined, rate per 100,000 (OSHPD, 2017)	507.3	SPA1:	450.2	SPA2:	452.2	SPA3:	473.5	SPA4:	574.3
		SPA5:	428.1	SPA6:	641.1	SPA7:	458.4	SPA8:	572.5
Methamphetamine									
Meth-related hospitalizations, ages 12-17, rate per 100,000 (OSHPD, 2017)	33.4	SPA1:	16.7	SPA2:	28.8	SPA3:	54.9	SPA4:	45.8
		SPA5:	29.3	SPA6:	27.4	SPA7:	30.4	SPA8:	22.2
Meth-related hospitalizations, ages 18-25, rate per 100,000 (OSHPD, 2017)	251.2	SPA1:	168.0	SPA2:	220.5	SPA3:	285.0	SPA4:	333.4
		SPA5:	176.3	SPA6:	256.2	SPA7:	230.7	SPA8:	272.7
Meth-related hospitalizations, all ages combined, rate per 100,000 (OSHPD, 2017)	202.3	SPA1:	179.6	SPA2:	161.7	SPA3:	202.6	SPA4:	257.7
		SPA5:	156.7	SPA6:	225.6	SPA7:	196.9	SPA8:	232.3

Records listing substance abuse, dependence, or poisoning as a diagnosis or external-cause-of-injury, excluding cases in remission.
Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

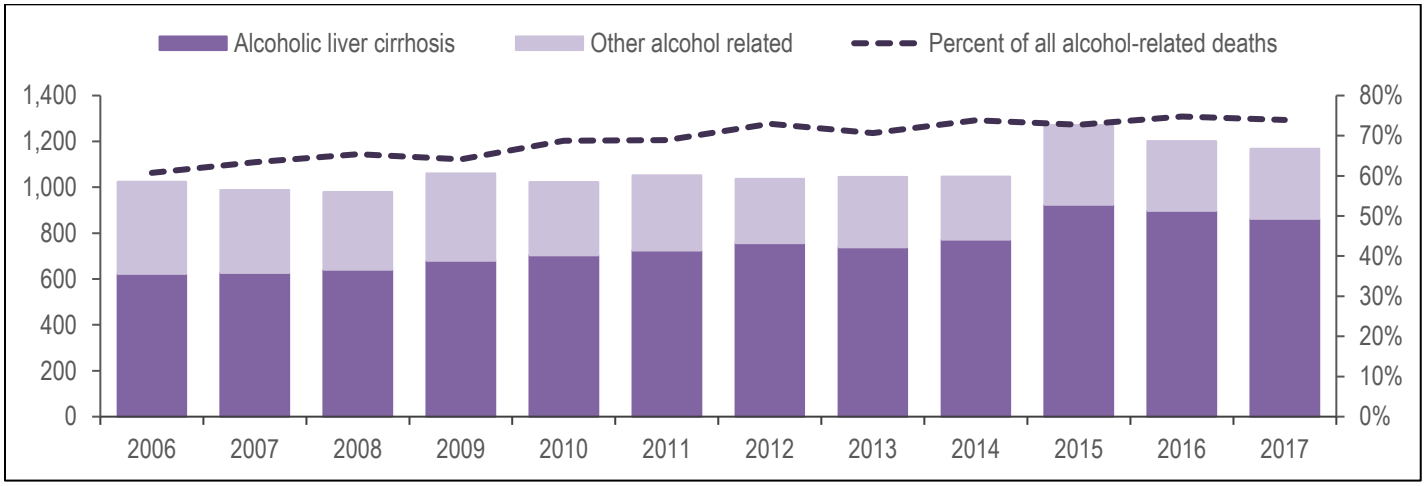
Substance Use Related Deaths

In LAC, there are over 1,000 alcohol-related deaths each year, of which nearly three-quarters are attributable to alcoholic liver cirrhosis (Figure 14).

While deaths listing cocaine abuse, dependence, or poisoning as a contributing cause of death decreased 50% from 2006-2015, cocaine-related deaths increased 22% from 2015-2017. Deaths listing methamphetamine as a contributing cause of death consistently increased 189% from 2006-2017 (Figure 15).

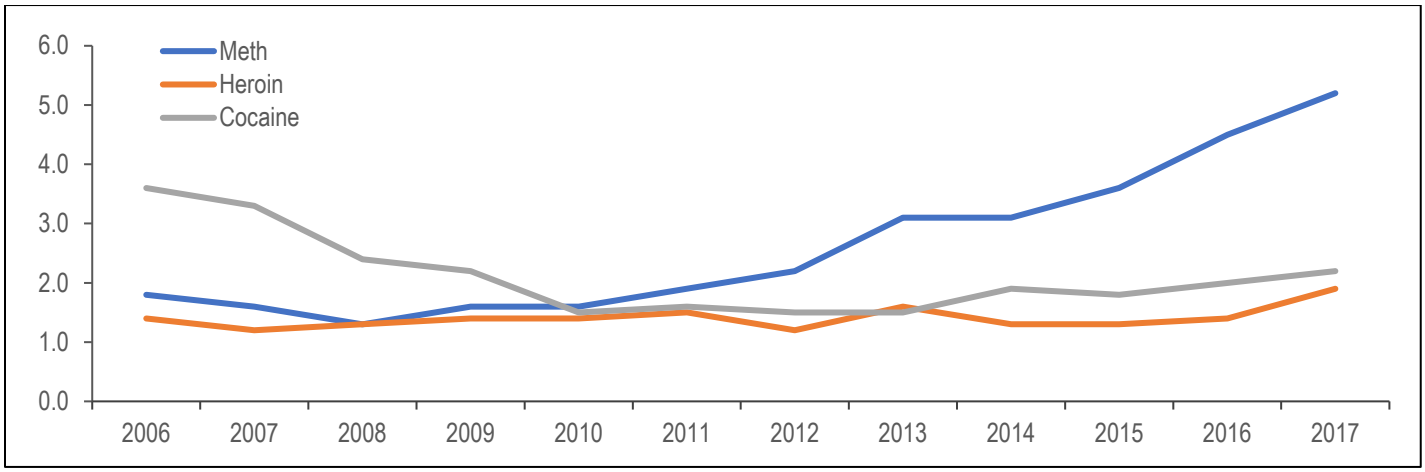
Individuals who died from drug overdose died an average of 30 years prematurely (Figure 16), accounting for many years of potential life lost. The rates of death per 100,000 population that involved substances in 2017 for young adults aged 18-25 and all ages for LAC and SPA, along with state and national comparisons, are presented in Table 13.

Figure 14. Alcohol-related deaths, LAC



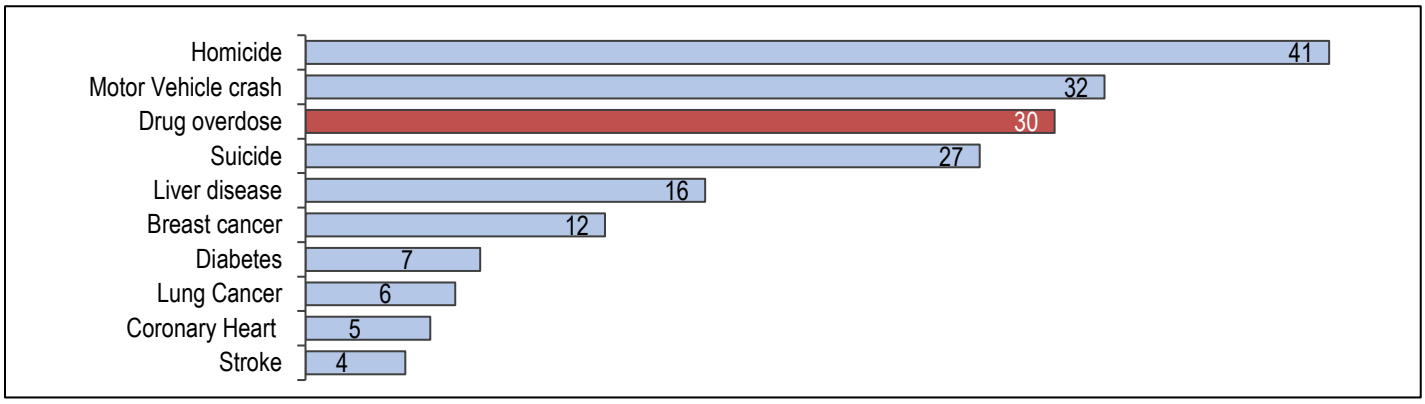
CDC WONDER data: Cases are those listing alcohol abuse, dependence, poisoning, or physical disease as a cause of death on the death certificate.

Figure 15. Illicit drug-related death rate per 100,000 population



CDC WONDER data: Cases are those listing substance abuse, dependence, or poisoning as a cause of death on the death certificate.

Figure 16. Years of potential life lost by underlying cause of death, LAC



LAC DPH, 2019

Table 13. Death rates per 100,000 population from common substances

Key Indicator	US	CA	LAC	SPA							
Prescription Drugs											
Rx opioid-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	12.6	4.5	3.7	SPA1:	3.6	SPA2:	4.7	SPA3:	2.3	SPA4:	3.5
				SPA5:	5.4	SPA6:	1.3	SPA7:	3.5	SPA8:	5.5
Rx opioid-related deaths, all ages combined, rate per 100,000 (VRBIS, 2017)	13.7	5.0	3.7	SPA1:	5.9	SPA2:	3.8	SPA3:	2.3	SPA4:	3.4
				SPA5:	5.7	SPA6:	4.4	SPA7:	3.2	SPA8:	4.1
Rx sedative-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	4.1	2.5	1.9	SPA1:	0	SPA2:	2.0	SPA3:	0.9	SPA4:	3.5
				SPA5:	6.8	SPA6:	0.6	SPA7:	1.8	SPA8:	1.7
Rx sedative-related deaths, all ages combined, rate per 100,000 (VRBIS, 2017)	4.5	2.1	1.2	SPA1:	0.8	SPA2:	1.2	SPA3:	0.9	SPA4:	1.7
				SPA5:	2.8	SPA6:	0.5	SPA7:	1.1	SPA8:	1.5
Alcohol											
Alcohol-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	3.5	2.2	1.4	SPA1:	1.8	SPA2:	0.8	SPA3:	0.9	SPA4:	1.8
				SPA5:	0	SPA6:	1.9	SPA7:	2.4	SPA8:	1.1
Alcohol-related deaths, all ages, rate per 100,000 (VRBIS, 2017)	22.2	22.2	18.8	SPA1:	25.2	SPA2:	16.8	SPA3:	17.2	SPA4:	21.5
				SPA5:	9.4	SPA6:	22.1	SPA7:	19.6	SPA8:	20.1

Methamphetamine and other illicit drugs												
Amphetamine-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	3.3	3.4	3.2	SPA1:	5.4	SPA2:	3.2	SPA3:	2.3	SPA4:	1.8
				SPA5:	1.4	SPA6:	0	SPA7:	1.2	SPA8:	1.1
Amphetamine-related deaths, all ages combined, rate per 100,000 (VRBIS, 2017)	4.4	7.8	5.0	SPA1:	9.9	SPA2:	4.5	SPA3:	4.2	SPA4:	5.0
				SPA5:	3.7	SPA6:	5.1	SPA7:	4.0	SPA8:	6.4
Cocaine-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	3.9	1.7	1.3	SPA1:	1.8	SPA2:	2.0	SPA3:	0.9	SPA4:	0.9
				SPA5:	2.7	SPA6:	0	SPA7:	1.2	SPA8:	1.7
Cocaine-related deaths, all ages combined, rate per 100,000 (VRBIS, 2017)	5.5	1.7	2.2	SPA1:	1.0	SPA2:	1.3	SPA3:	0.7	SPA4:	3.4
				SPA5:	2.8	SPA6:	5.3	SPA7:	1.4	SPA8:	2.8
Heroin-related deaths, ages 18-25, rate per 100,000 (VRBIS, 2017)	5.3	2.2	1.4	SPA1:	1.8	SPA2:	3.2	SPA3:	0.5	SPA4:	1.8
				SPA5:	1.4	SPA6:	0	SPA7:	1.2	SPA8:	1.1
Heroin-related deaths, all ages combined, rate per 100,000 (VRBIS, 2017)	4.8	1.9	1.8	SPA1:	3.6	SPA2:	2.5	SPA3:	0.7	SPA4:	2.4
				SPA5:	2.2	SPA6:	1.3	SPA7:	1.4	SPA8:	1.6

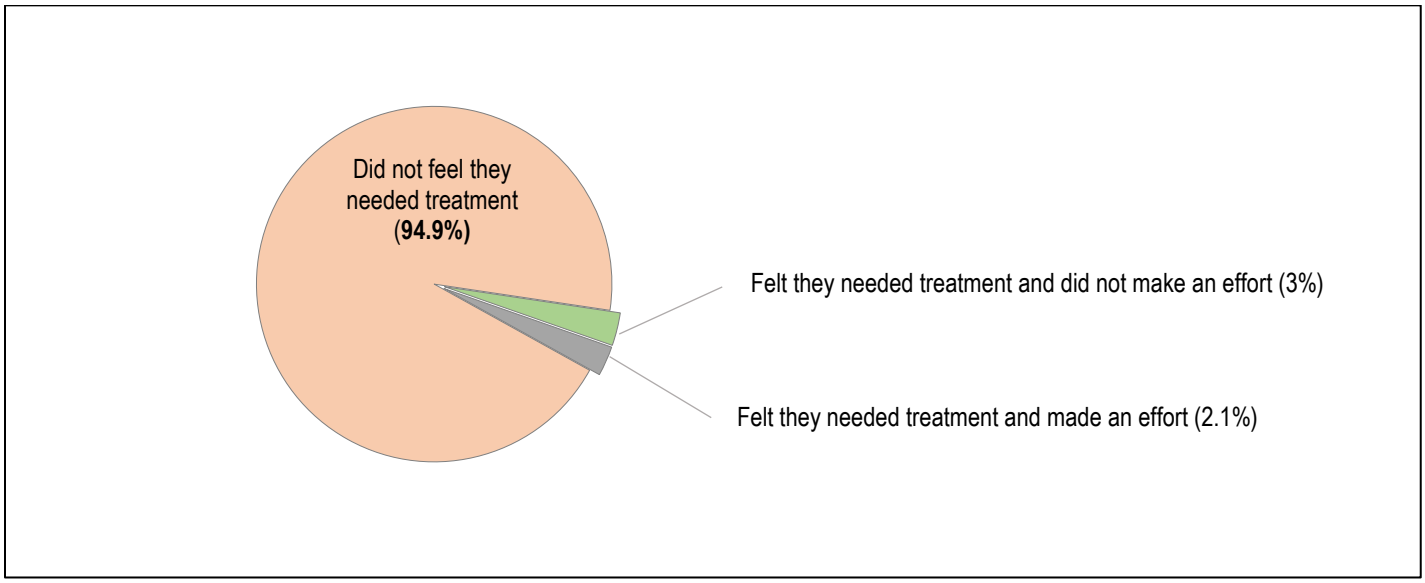
Cases are those listing abuse, dependence, or poisoning as a cause of death on the death certificate.
* CDC WONDER data
Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Substance Use Disorder (SUD) Treatment

While SUDs are increasingly acknowledged as chronic diseases that can be prevented and treated, rates of individuals in treatment compared to rates of individuals with SUDs reveal that most people in need of SUD treatment did not receive treatment. The vast majority (94%) of those who had a SUD and needed but did not receive SUD treatment felt they did not need treatment (Figure 17).

Among patients in publicly funded SUD treatment programs in LAC, the most common primary drug problem for youth aged 12-17 was marijuana, accounting for over three-quarters of all admissions in the past three fiscal years, followed by methamphetamine and alcohol. The most common primary drug problem for young adults was methamphetamine, accounting for over one-third of all admissions in the past three fiscal years, followed by heroin, marijuana, and alcohol (Table 14). The rates per 100,000 population of SUD treatment admission for youth aged 12-17 and young adults aged 18-25 by primary drug is presented in Table 15.

Figure 17. Treatment received among those who needed SUD treatment, 2018



NSDUH, 2017

Table 14. Primary drug problem reported at admission to publicly funded substance use disorder treatment programs, LAC

	2016-2017		2017-2018		2018-2019	
	Age 12-17	Age 18-25	Age 12-17	Age 18-25	Age 12-17	Age 18-25
Marijuana	77.7%	18.9%	81.0%	16.0%	82.8%	17.3%
Methamphetamine	10.0%	33.8%	8.1%	38.5%	4.7%	42.9%
Alcohol	7.4%	9.7%	5.6%	11.2%	4.3%	11.6%
Heroin	0.6%	30.6%	0.4%	26.5%	0.2%	20.5%
Rx Opioids	0.6%	3.2%	0.4%	2.8%	0.2%	2.5%
OTC/Rx Other	1.8%	1.0%	2.3%	1.8%	3.3%	2.6%
Cocaine	0.9%	2.0%	1.4%	2.4%	1.2%	1.9%
Other drugs	1.0%	0.7%	0.9%	0.8%	1.3%	0.8%

LACPRS
Red font indicates highest percentage.

Table 15. Treatment admission rates per 100,000 population for common primary drug problems reported at admission to publicly funded substance use disorder treatment programs, LAC

Key Indicator	LAC	SPA							
Prescription Drugs									
Primary Rx opioid treatment admissions, ages 12-17, rate per 100,000 (LACPRS, FY1819)	0.4	SPA1:	0	SPA2:	0	SPA3:	1.5	SPA4:	1.4
		SPA5:	0	SPA6:	0	SPA7:	0	SPA8:	0
Primary Rx opioid treatment admissions, ages 18-25, rate per 100,000 (LACPRS, FY1819)	11.2	SPA1:	46.5	SPA2:	13.0	SPA3:	13.8	SPA4:	7.0
		SPA5:	10.9	SPA6:	3.2	SPA7:	7.1	SPA8:	8.3
Marijuana									
Primary marijuana treatment admissions, ages 12-17, rate per 100,000 (LACPRS, FY1819)	217.8	SPA1:	94.8	SPA2:	175.4	SPA3:	321.3	SPA4:	266.2
		SPA5:	23.5	SPA6:	194.9	SPA7:	348.3	SPA8:	121.7
Primary marijuana treatment admissions, ages 18-25, rate per 100,000 (LACPRS, FY1819)	79.5	SPA1:	93.0	SPA2:	64.0	SPA3:	79.4	SPA4:	91.5
		SPA5:	21.7	SPA6:	124.5	SPA7:	89.7	SPA8:	64.9
Alcohol									
Primary alcohol treatment admissions, ages 12-17, rate per 100,000 (LACPRS, FY1819)	10.8	SPA1:	11.2	SPA2:	9.6	SPA3:	14.8	SPA4:	23.6
		SPA5:	2.9	SPA6:	7.1	SPA7:	5.4	SPA8:	10.7
Primary alcohol treatment admissions, ages 18-25, rate per 100,000 (LACPRS, FY1819)	54.9	SPA1:	48.3	SPA2:	48.6	SPA3:	66.1	SPA4:	72.1
		SPA5:	21.7	SPA6:	57.4	SPA7:	47.8	SPA8:	59.3
Methamphetamine									
Primary meth treatment admissions, ages 12-17, rate per 100,000 (LACPRS, FY1819)	11.5	SPA1:	13.9	SPA2:	13.8	SPA3:	17.1	SPA4:	27.7
		SPA5:	2.9	SPA6:	6.1	SPA7:	6.3	SPA8:	3.3
Primary meth treatment admissions, ages 18-25, rate per 100,000 (LACPRS, FY1819)	202.1	SPA1:	135.9	SPA2:	158.5	SPA3:	267.1	SPA4:	289.4
		SPA5:	81.4	SPA6:	272.3	SPA7:	180.6	SPA8:	159.6

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

Risky Sexual Behavior Among Adolescents

Studies have suggested that risky sexual behaviors are associated with various substance use behaviors among adolescents (Ritchwood 2016). Although lower than national and state estimates, in LAC, nearly one-third of high school students have had sexual intercourse, and nearly one-fifth are currently sexually active. High school students in LAC were more likely to have had sexual intercourse for the first time before age 13 years and to have had more than 4 sexual partners compared to State statistics. Among sexually active high school students in LAC, about 16% did not use any method to prevent pregnancy, and 17.2% drank alcohol or used drugs during their last sexual intercourse, which are higher than those estimates for the State. Risky sexual behavior was more common among SUD treatment clients than in the general population (Table 16).

Adolescents that experience dating violence victimization are also at increased risk for various substance use behaviors (Yohros 2018). About one in twelve LAC high school students have experienced sexual violence in the past year, and 7.0% have been physically forced to have sexual intercourse in their lifetime (Table 16).

Sexual health is both a risk factor and consequence of substance use. While sexual exposure can increase the risk of substance use, substance use among adolescents and young adults can also increase the risk of engaging in risky sexual behaviors which can lead to unintended pregnancies and sexually transmitted infections (Swartzendruber 2013). Sexual health is a prominent issue in LAC, where the estimated STI rates are much higher than those of state and national estimates (Table 16).

Table 16. Sexual behaviors, sexual violence victimization, and sexual health by geography

Key Indicator	US	CA	LAC
Sexual behaviors			
Ever had sexual intercourse, high school students (YRBS, 2017)	39.5%	32.3%	30.0%
Currently sexually active, high school students (YRBS, 2017)*	28.7%	22.5%	18.8%
Had sexual intercourse for first time before age 13, high school students (YRBS, 2017)	3.4%	2.1%	3.8%
Had sexual intercourse with 4+ persons in lifetime, high school students (YRBS, 2017)	9.7%	5.7%	6.9%
Did not use any method to prevent pregnancy during last sexual intercourse among sexually active high school students (YRBS, 2017)*	13.8%	10.8%	15.7%
Did not use condom during last sexual intercourse among sexually active high school students (YRBS, 2017)*	46.2%	45.2%	38.0%
Drank alcohol or used drugs before last sexual intercourse, high school students (YRBS, 2017)*	18.8%	16.0%	17.2%
Sexual violence			
Experienced sexual violence by anyone in the past year, high school students (YRBS, 2017)	9.7%	10.1%	8.4%
Experienced sexual dating violence in the past year, high school students (YRBS, 2017)†	6.9%	11.8%	4.7%
Experienced physical dating violence in the past year, high school students (YRBS, 2017)	8.0%	8.3%	6.7%
Physically forced to have sexual intercourse in lifetime, high school students (YRBS, 2017)	7.4%	7.0%	7.0%
Sexual health			
Teen births, rate per 1000 live births among females aged 15-19 (CDPH, 2015-2017)	22.3	15.7	15.0
Gonorrhea rate per 100,000 population (CDPH, 2018)	126.6	199.4	265.9
Chlamydia rate per 100,000 population (CDPH, 2018)	476.1	583.0	661.8
Syphilis rate per 100,000 population (CDPH, 2018)	7.5	19.1	23.0
Persons living with HIV rate per 100,000 population (YRBS, 2017)	-	340.3	500.4
Never tested for HIV, high school students (YRBS, 2017)	90.7%	89.5%	89.6%

Data for non-missing values. * The most recent LAC estimate was for 2015. † The most recent CA estimate was for 2015.

DATA FINDINGS SUMMARY

Target Priority Area 1: Alcohol Use

Excessive alcohol use contributes to a host of health problems/alcohol-related illnesses, high-risk behaviors, traffic accidents/DUI, falls, suicides, poisoning, and occupational injuries. Risk taking behavior, including risky sexual behaviors among adolescents and young adults, is compounded when combined with alcohol use. Research (NIAAA, 2006) shows that the younger the age of alcohol initiation, the greater the likelihood of experiencing legal, social, mental health, and other problems including risky sexual activity, poor school performance, use of other substances and development of substance use disorders (SUD). Thus, investing in prevention efforts to delay initiation and reduce consumption may be the best way to avoid the costly consequences of risky use and addiction.

Alcohol outlet density and the proximity of outlets to one's residence have been associated with negative consequences such as violence, crime, injury, and high-risk sex (Rowland et al., 2015). SPA 7 is reported to have the highest rate of off-premise alcohol outlet density (71.3 in SPA 7 vs 60.5 for LAC overall per 100,000 population) and the highest rate of alcohol-involved traffic collisions (85.9 for SPA 7 vs 79.5 for LAC overall per 10,000; see Table 7).

Target Priority Area 2: Marijuana Use

Marijuana is the most commonly used "illicit" drug in LAC with 7.6% of youth (age 12-17) and 21.3% of young adults (age 18-25) reporting current use (NSDUH, 2014-2016). Marijuana has been associated with increased risky sexual activities[12]. Adverse long-term effects of marijuana use include addiction, altered brain development, poor educational outcomes, cognitive impairment, diminished life achievement and satisfaction, and increased risk for chronic psychotic disorder in persons with a predisposition to such disorders; these findings are strongly associated with initial marijuana use early in adolescence (Volkow, 2014).
From 2005 to 2011, the percent of adults who reported using marijuana in the past year remained relatively unchanged (8.2% and 8.5%, respectively).[13] Cannabis use increased from 8.5% in 2011 to 18.2% in 2018. Adults ages 18-24 years (35.0%) and 25-29 years (30.4%) reported the highest cannabis use in the past year compared to all other age groups, while those ages 65 years and older (6.5%) reported lowest cannabis use.[14] Dual cannabis and vaping use among youth and young adults have become more common and problematic.

Target Priority Area 3: Methamphetamine Use

The picture of methamphetamine use in LAC is different when compared to other geographic regions. Methamphetamine related hospitalizations, emergency visits, and deaths have increased consistently in LAC since 2008[15]. According to LACPRS (2015), treatment admissions have been increasing since 2012. In 2019, methamphetamine became the most commonly reported drug problem among clients admitted to LAC public treatment programs. Although methamphetamine use is a significant problem in LAC overall, it is especially problematic among women and the impact has increased; the number of women admitted to SUD treatment

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3793248/
[13] http://publichealth.lacounty.gov/ha/docs/2015LACHS/LA_Health_Briefs_2018/CannabisBrief_FINAL.pdf
[14] http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm
[15] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/MethamphetamineBriefFinal.pdf

who were primary methamphetamine users increased nearly six-fold from 1996 to 2011 (TEDS, 2014). Methamphetamine is heavily associated with increased risk for psychotic behavior, poor cardiovascular and dental health, sexually transmitted infections[16], including HIV and hepatitis, crime, unemployment and child abuse (NIDA, 2012).

Target Priority Area 4: Prescription Drug Misuse

When used as directed, and by the intended recipient, prescription medications can effectively manage short-term and chronic health conditions. However, opioids (Vicodin, OxyContin, codeine, morphine etc.), central nervous system depressants (Valium, Xanax, other tranquilizers and sedatives etc.) and stimulants (Adderall, Ritalin etc.) can also be used to get high and can become addictive.

There has been a dramatic increase in prescriptions of analgesic opioids in the United States (Jurcik et al., 2015). Recently, from 2015 to 2017, prescription opioid-related deaths increased 27 percent with over 300 deaths taking place annually (VRBIS, 2017). Nearly 75 percent of residents who misuse prescription drugs obtain them from relatives or friends (Gunzenhauser, 2015). In 2017, there were 70,237 drug overdose deaths in the United States, 68% of which involved opioids (Scholl, 2019). This marks the highest number of opioid related drug deaths than any previous year.

In LAC from 2007 to 2017, there were 6,068 drug-related deaths; 53 percent of those deaths involved a commonly abused prescription drug. Data from 2017 DPH-SAPC Community Needs Assessment show that the average rate of prescription misuse in the past 30 days was 2.9%, with the highest reported use among individuals who self-identify as non-heterosexual (7%).[17] Opioid-related emergency visits and hospitalizations increased by 284% and 84% respectively from 2006 to 2017.[18] Opioid-related emergency visits were highest among white males, followed by African American females, African American males, and white females.[19]

PRIORITY AREAS

An understanding of the prevalence of substance use, related risk factors, and the consequences of substance use among youth and young adult populations help to inform prevention strategies that target the individual, family, community, and cultural risk factors through priority substance use areas. Although it is important to address all addictive substances in a comprehensive manner (Center on Addiction and Substance Abuse, 2015), LAC is prioritizing prescription drug misuse, marijuana use, alcohol use, and methamphetamine use among youth and adults as key priority areas in LAC.

[16] https://www.drugabuse.gov/publications/research-reports/methamphetamine/are-people-who-misuse-methamphetamine-risk-contracting-hivaids-hepatitis-b-c
[17] http://publichealth.lacounty.gov/sapc/prevention/PM/071418/CNAandOtherOpioidData.pdf
[18] http://publichealth.lacounty.gov/sapc/MDU/MDBrief/OpioidBriefFinal.pdf
[19] Ibid.

Risk Factors for Priority Areas

Priority Areas	Risk Factor
Alcohol Use	Low perception of harm among youth (individual, cultural) Retail availability of alcohol to teens (community) Youth lack the life skills to develop resiliency around their own health and wellness (individual) Use of alcohol prior to sexual intercourse youth (individual, cultural)
Marijuana Use	Low perception of harm among youth (individual, cultural) Availability of marijuana to teens by retailers (community) Youth lack the life skills to develop resiliency around their own health and wellness (individual) Use of marijuana prior to sexual intercourse among youth (individual, cultural)
Methamphetamine Use	Lack of community awareness of methamphetamine use (community) Youth lack the life skills to develop resiliency around their own health and wellness (individual) Use of methamphetamines prior to sexual intercourse among youth (individual, cultural)
Prescription Drug Misuse	Excessive prescribing of prescription drugs among adults (community) Community is unaware of proper disposal methods (community) Youth lack the life skills to develop resiliency around their own health and wellness (individual) Use of prescription drugs prior to sexual intercourse among youth (individual, cultural)

Prioritizing Risk Factors

The following risk factors for each priority area were ranked based on local data, community needs and resources, and provider feedback.

Priority Area: Alcohol Use	Importance		Changeability		Priority Rank
	Low	High	Low	High	
Risk Factors					
Low perception of harm among youth		X		X	2
Availability of alcohol to teens by retailers		X		X	1
Youth lack the life skills to develop resiliency around their own health and wellness		X		X	4
Use of alcohol use prior to sexual intercourse		X		X	3

Priority Area: Marijuana Use	Importance		Changeability		Priority Rank
	Low	High	Low	High	
Risk Factors					
Low perception of harm among youth		X		X	2
Availability of marijuana to teens by retailers		X		X	1
Youth lack the life skills to develop resiliency around their own health and wellness		X		X	4
Use of marijuana prior to sexual intercourse		X		X	3

Priority Area: Methamphetamine Use	Importance		Changeability		Priority Rank
	Low	High	Low	High	
Risk Factors					
Lack of community awareness of methamphetamine use		X		X	1
Youth lack the life skills to develop resiliency around their own health and wellness		X		X	2
Use of methamphetamines prior to sexual intercourse		X		X	3

Priority Area: Prescription Drug Misuse	Importance		Changeability		Priority Rank
	Low	High	Low	High	
Risk Factors					
Excessive prescribing of prescription drugs among adults		X		X	1
Community is unaware of proper disposal methods		X	X		4
Youth lack the life skills to develop resiliency around their own health and wellness		X		X	2
Use of prescription drugs prior to sexual intercourse		X		X	3

PROBLEM STATEMENTS

Priority 1: Alcohol Use
Goal: Decrease Alcohol Use Among Youth
Problem Statement: Alcohol consumption rates among youth are high due to low perception of harm, availability of alcohol to teens by retailers, lack of life skills to develop resiliency around their own health and wellness, and the use of alcohol prior to sexual intercourse.

Priority 2: Marijuana Use
Goal: Decrease Marijuana Use Among Youth
Problem Statement: Marijuana use is a priority in LAC following legalization. The low perception of harm by youth, increased availability of marijuana by retailers, lack of resiliency skills, and use of marijuana prior to sexual intercourse among youth contribute to increased marijuana use among youth.

Priority 3: Methamphetamine Use
Goal: Decrease Methamphetamine Use Among Youth
Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines prior to sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lack the life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth.

Priority 4: Prescription Drug Misuse
Goal: Decrease Prescription Drug Misuse or Abuse Among Youth and Adults
Problem Statement: Excessive prescribing among adults, lack of community awareness of proper disposal methods, lack of resiliency skills around prescription drug use among youth, and the use of prescription drugs prior to sexual intercourse among youth contribute to an increase of the misuse and abuse of prescription drugs.

CAPACITY ASSESSMENT

Current Capacity

County Staff: The DPH-SAPC prevention programs team (12 staff) from the Community Youth and Engagement Unit provide administrative support, technical assistance, and provider support to subcontracted agencies within the prevention portfolio; County staff are funded by SABG. Staff that are funded by SABG include: Intermediate Typist Clerk (1), Management Analyst (1), Senior Community Worker (1), Prevention Program Specialists (7), Chief of Community and Youth Engagement (1), and Assistant Medical Director (1).

While the data team is not funded by SABG, 5 staff within the Community Youth and Engagement Unit and Health Outcomes and Data Analytics (HODA) Unit support data reporting for prevention services. Along with the data team, the programs team collaborates with DPH-SAPC Finance and Contracts teams to ensure successful provision of substance use prevention-based services.

County Providers, Services, and Programs: From July 2020 to July 2021, the current contracts will remain in effect: Adolescent Prevention Services (APS), Comprehensive Prevention Services (CPS), and Environmental Prevention Services (EPS).

LAC is in the process of resoliciting new prevention contracts which will start in July 2021. More information will be provided as the new contracts are being finalized and the updated list of County providers will be added by July 2021.

Currently, all Student Well-Being Center staff are funded by SABG through subcontractors. The intention is for the staff to be hired as permanent County items when applicable.

County Coalitions/Groups: DPH-SAPC's substance use contracted prevention program providers are required to develop a process to consistently engage community members and key stake holders in the identification of local substance use problems and contributing risk factors to guide the development and implementation of prevention activities and services.

DPH-SAPC's SPA-Based Coalitions

The overall mission of DPH-SAPC's SPA-Based Coalition is to actively engage communities in addressing the four priority areas described in the assessment process. Prevention providers have the capacity to mobilize and organize community residents including youth, business, and representatives of other community-based organizations (education, law enforcement, and public social services), as appropriate, to address local and county substance use problems.

Prevention Community Council (PCC)

The overall mission of the PCC is to establish a formal mechanism to obtain community feedback to guide the development of its prevention services and effectively and efficiently adjust to changing community needs. The size and structure of the PCC may vary depending on the scope of services provided. For example, a school-based program may involve primarily students, parents, teachers; whereas a policy-focused program may involve a wide array of individuals and more closely resemble a coalition structure.

In addition, agencies also participate on the SPA Coalition meetings in the SPA(s) to effectively inform, engage, and mobilize community support; particularly in its target area(s), around the PCC's prevention efforts.

DPH-SAPC's SafeMed Los Angeles Coalition

SafeMed LA is a broad, cross-sector coalition that will take a coordinated and multipronged approach to comprehensively address the prescription drug abuse epidemic in LAC, guided by its five-year strategic plan. DPH-SAPC developed a five-year strategic plan that will be carried out through the broad, cross-sector SafeMed LA coalition. The SafeMed LA strategic plan utilizes a "9-6-10" approach, with 9 Action Teams focusing on 6 priority areas with 10 key objectives, each tackling a specific component of the prescription drug abuse problem.[20] DPH-SAPC prevention providers are members of the SafeMed LA's Community Education Action Team, which focuses on community outreach and engagement.

Rethinking Access to Marijuana (RAM)

RAM is a collaboration of public health professionals seeking to prevent marijuana-related harms by limiting youth access to marijuana. This group was established with the vision of educating communities about the

[20] http://nebula.wsimg.com/2a21dd5aed40dea75ab50c994af7dd7a?AccessKeyId=5647EEC704480FB09069&disposition=0&alloworigin=1

potential harms of marijuana use; implementing and evaluating environmental strategies formulated to limit youth accessibility and availability of marijuana; and influencing policy actions that support flourishing youth and communities free from marijuana-related harms. RAM neither supports nor opposes any specific legislation. RAM utilizes a prevention-oriented public health approach by educating policymakers and communities about ways to protect youth from the potential harms of marijuana use, misuse, and abuse.

Workforce Development: The County provides technical assistance and training to all contracted prevention providers in order to ensure quality service provision and contract compliance. Currently, County DPH-SAPC Prevention staff are assigned to providers in order to provide at minimum monthly check-in calls, quarterly visits, and regular communication through email, phone, and in person. Per contract, the County also ensures that new prevention contracted staff receive training through multiple sources, including the Prevention Technology Transfer Center (PTTC) online trainings and educational resources. The County also collaborates with Community Prevention Initiative (CPI) and a local contracted training agency to ensure all staff are trained appropriately in prevention topics, depending on the need and request of agencies.

Beginning July 1, 2020, DPH-SAPC will coordinate quarterly CPI training sessions for substance use prevention providers. Training sessions will be designed to assist providers in implementing LAC's SPP. All training and technical assistance will be tailored to assist providers with strengthening their program efforts to meet County goals and objectives.

Resource and Community Readiness

MJ: Marijuana Al: Alcohol Me: Methamphetamine Rx: Prescription Drugs

		Priority Areas			
	Enter (+), (n/a), or (-) to measure resources for each priority area.	Al	Mj	Me	Rx
Community Resources	Community awareness	-	-	-	-
	Specialized knowledge about Pv research, theory, and practice	+	+	+	+
	Practical experience	+	+	_	+
	Political/policy knowledge	+	-	_	_
Fiscal Resources	Funding	+	+	+	+
	Equipment: computers, Xerox, etc.	+	+	+	+
	Promotion and advertising	_	_	_	+
Human Resources	Competent staff	-	-	-	+
	Training	+	+	+	+
	Consultants	+	+	+	+
	Volunteers	+	+	+	+
	Stakeholders	+	+	+	+
	Other agency partners	+	+	+	+
	Community leaders	_	_	_	+
Organizational Resources	Vision and mission statement	+	+	+	+
	Clear and consistent organizational patterns and policies	+	+	+	+
	Adequate fiscal resources for implementation	_	_	_	_
	Technological resources	+	+	+	+
	Specialized knowledge about Pv research, theory, and practice	+	+	_	+

<u>Target Priority Area 1: Alcohol Use</u>

The county is in Stage 8: Confirmation/Expansion. The community has already implemented efforts to address alcohol availability and accessibility. Agencies in SPA 2, 5 and SPA 8 have long implemented environmental approaches (i.e., retail/social host ordinances) towards alcohol prevention. Provider participation in LA DAPA and the California Alcohol Policy Alliance (CAPA) coupled with decades or more of experience on youth drinking and prevention have made LAC strong leaders in this field.

<u>Target Priority Area 2: Marijuana Use</u>

The county is in Stage 8: Confirmation/Expansion. According to the capacity assessment, it was determined that the community has already implemented efforts to decrease marijuana use among youth. Strong collaborative relationships such as RAM have led this effort and due to high provider participation, RAM continues to fully support and champion this cause. DPH-SAPC substance use prevention providers are also very active in the LA DAPA, whose mission is to advocate for safe and healthy communities by reducing AOD-related harm through public awareness and policy change.

Target Priority Area 3: Methamphetamine Use

The county is in Stage 4: Preplanning. Although data shows a rise in meth treatment admissions in LAC, the community recognizes a problem exists, leading to some discussion among local leaders and community members, but there is still a need to increase community awareness around the risk and harms associated with meth use among youth.

Target Priority Area 4: Prescription Drugs

The county is in Stage 6: Initiation. With the implementation of DPH-SAPC's Opioid media campaign and Safe Med LA, the community is aware there is a problem. However, DPH-SAPC's substance use prevention network of providers needs to focus and outreach to build more awareness of Rx use and its consequences.

Capacity Challenges/Gaps

Priority Areas:	Alcohol Use	Marijuana Use	Methamphetamine Use	Prescription Drugs
Community Readiness	Stage 8 – Confirmation/ Expansion Efforts and activities are in place and programs have been evaluated and modified. Community has detailed knowledge of prevalence and risk and protective factors.	Stage 8 – Confirmation /Expansion Efforts and activities are in place and community members are participating. Data is being collected regularly and used to drive planning.	Stage 4 – Preplanning Community recognizes there is a local problem and something needs to be done. There have been some discussions to address the problem, but no real recent planning on how to progress.	Stage 6 – Initiation Data has been collected to justify a Pv program. Action has begun and staff is being trained.
Community Resources	Community has specialized knowledge and theory, including political and practical experience. Community is lacking positive youth development strategies and leadership opportunities targeting community youth. Community can benefit from increased community engagement strategies as opportunities to improve community	Community has specialized knowledge and theory, including practical experience, but could benefit from more political/policy knowledge, especially due to new legislation. Community is lacking positive youth development strategies and leadership opportunities	Community has specialized knowledge and theory, including political and practical experience. Community lacks education on how to properly address meth from a prevention perspective. Community also lacks political/policy knowledge on meth prevention strategies. Community is lacking positive youth	Community has specialized knowledge and theory, including practical experience, but could benefit from more political/policy knowledge. Community is lacking positive youth development strategies and leadership opportunities targeting community youth. Community can benefit from increased community engagement strategies as opportunities to improve community capacity and resource building.

	capacity and resource building.	targeting community youth. Community can benefit from increased community engagement strategies as opportunities to improve community capacity and resource building.	development strategies and leadership opportunities targeting community youth. Community can benefit from increased community engagement strategies as opportunities to improve community capacity and resource building.	
Fiscal Resources	Community could benefit from additional funding geared towards advertising the harmful effects of underage drinking.	Community could benefit from additional funding geared towards advertising the harmful effects of marijuana (specifically vaping) and the legal ramifications.	Community could benefit from additional funding geared towards advertising the harmful effects of meth use.	n/a (no negatives in TABLE: Resource Readiness Assessment)
Human Resources	Due to high staff turnover, Pv providers face staff retention issues. More support from community leaders such as city council/assembly members is also needed.	Due to high staff turnover, Pv providers face staff retention issues. More support from community leaders such as city council or assembly members is also needed.	Due to high staff turnover, Pv providers face staff retention issues. More support from community leaders such as city council or assembly members is also needed.	n/a (no negatives in TABLE: Resource Readiness Assessment)
Organizational Resources	Additional funding could be used towards program and policy implementation.	Additional funding could be used towards program and policy implementation.	Additional funding could be used towards program and policy implementation. Staff, stakeholders, and community leaders need to be trained in order to help drive efforts further.	Additional funding could be used towards program and policy implementation.

Cultural Competence and Sustainability

Contractors and special projects must provide programs that are culturally competent and sustainable. Culture includes beliefs, communications, actions, customs, and values across racial, ethnic, religious, or social groups.[21] Cultural competency is the convergence of these behaviors, attitudes, and policies in a system, agency, or among professionals to enable effective work in cross-cultural situations. Consideration for culturally competent programming that is responsive to the health beliefs, practices, cultural, and linguistic needs of diverse populations is more likely to bring about positive change. In LAC, the culture of substance use differs by gender, age group, race, and ethnic origin. For example, alcohol binge consumption is usually highest among college age men and certain ethnic groups[22] where binge drinking is culturally acceptable.

[21] https://store.samhsa.gov/system/files/sma16-4932.pdf
[22] http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/Binge_Drinking_2014_FinalS.pdf

Methamphetamine use is highest among certain sexual minorities,[23] who may believe meth use enhances their sexual experiences.

Sustainability contributes to long term program success and includes continued community support and engagement, stable infrastructure, and available resources and training to keep abreast of emerging cultural nuances and obtain the required skills to address these trends within at-risk populations.

DPH-SAPC's prevention principles are consistent with the following Community and Anti-Drug Coalitions of America (CADCA) principles:

1. Each group has unique cultural needs. Coalitions acknowledge that several paths lead to the same goal.

2. Coalitions must recognize that what works well for one cultural group may not work for members of another cultural group.

3. Culture is ever-present, dynamic, and complex. Acknowledge culture as a predominant force in shaping behaviors, values, and institutions.

4. Cultural competence is not limited to ethnicity, but includes age, gender, disability, sexual identity and other variables. DPH-SAPC is in the process of finalizing the Culturally and Linguistically Appropriate Services (CLAS) Cultural Competence Strategic Plan. It will be used to ensure cultural competence across all systems of services.

The above CADCA guiding principles enable programs and coalitions to have positive interactions in culturally diverse environments.

Additionally, DPH-SAPC has the resources and readiness to support priority areas identified during the assessment process. SPA-Based Coalitions engage community residents, law enforcement, educational representatives, elected officials, faith-based and other community organizations to learn about common community concerns. Collectively, they learn how to change community conditions and advocate for community improvement projects. Teaching the community how to organize and mobilize is key for sustaining resources after a contract ends.

[23] https://www.cdc.gov/msmhealth/substance-abuse.htm

Phase:	Sustainability	Cultural Competence
Assessment	Utilized data collection as an opportunity to identify providers. Conducted interviews with community leaders to understand how data trends are impacting overall capacity, such as community resource availability and funding.	Used data to target populations with specific disparities. Collaborated with the community throughout the assessment. Created a process for identifying culturally relevant risk and protective factors and other underlying conditions. Utilized existing provider network to better understand how the aggregated data relates to their specific at-risk communities.

SPA-Based Coalition Guidelines

To ensure the coalition establishes a coherent purpose and committed membership, the following activities must be included in the Prevention Work Plan and formalized through documents establishing the coalition's structure and expectations of members:

1. Vision and Mission: Each of the SPA-Based Coalitions creates a vision and mission designed to drive and address substance use prevention and coalition work.
2. Data Handouts: How will findings from the county assessment be presented to community stakeholders?
3. Structure: How will the coalition be structured to ensure an action oriented and community responsive process? This includes:
    a. Who will develop the agenda and facilitate meetings (e.g., elected position, staff)?
    b. Who will complete administrative duties such as drafting agendas, meeting notifications, inter-meeting communication, and meeting minutes (e.g., elected position, staff)?
    c. If there are elected positions, what are the respective roles and responsibilities?
    d. What is the process for determining actionable items/efforts of the coalition?
    e. What is the process for establishing a Steering Committee and/or Subcommittee(s)?
4. Membership: How will recruitment and membership be addressed including defining roles and responsibilities?
    a. What key community sectors will be recruited for membership?
    b. How will active and continued membership of the identified sectors be maintained?
    c. How is membership established and the membership list developed/maintained?
    d. What is the orientation process for new members?
    e. What are the responsibilities of members? How does this vary, for Steering Committee and/or Subcommittee members (if applicable)?

5. Frequency: What is the frequency of meetings (minimum quarterly)? If applicable, are there any subcommittee, steering committee, or contractor specific meeting?
6. Deliverables: What materials will be provided at each meeting and in what format (meeting announcement, agenda, and meeting minutes)?

In addition, CPS contractors are required to actively participate with the SPA-based coalition led by the EPS contractors in the SPA(s) where they provide services. This coalition focuses on addressing local substance use related problems and contributing factors, in particular reducing availability and accessibility to underage youth. CPS contractors will further work with their target population(s) and communities to build capacity and strategically address substance use associated risk factors that contribute to problems.

Guidelines for Establishing Membership and Participation Expectations

To ensure that the PCC establishes a coherent purpose and committed membership, the following activities must be included on the Prevention Work Plan and formalized through documents establishing the PCC's structure and expectations of members:

1. Purpose: What is the purpose and goals of the PCC and its membership in guiding development and implementation of comprehensive prevention services and how will efforts of the SPA-Based Coalition be incorporated to promote local support?
2. Membership: How will recruitment and membership be addressed including defining roles and responsibilities?
    a. What sectors/type of representatives will be recruited to best support implementation of the CPS services and why? A minimum of five non-agency participants are required.
    b. How will active and continued membership of the identified sectors/representative types be maintained?
    c. What is the orientation process for new members and what are member roles/responsibilities?
3. Frequency: What is the frequency of meetings (minimum quarterly)?
4. Deliverables: What materials will be provided at each meeting and in what format (meeting announcement, agenda, and meeting minutes.

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Chapter 3: Capacity Building

CAPACITY BUILDING PLAN

Priority Area: Alcohol Use	
Community Readiness Stage: 8	
Course of Action	**Proposed Timeline**
Community Resources 1. Develop a positive youth development plan and provide leadership opportunities to the community youth. 2. Increase community engagement to improve community capacity and resource building.	Years 1-5 Years 1-5
Organization Resources 1. Ensure adequate fiscal resources for implementation.	Year 1
Human Resources 1. Providers to implement a professional and career development plan that provides employees with advancement opportunities and competitive salaries and benefits. 2. Engage community leaders to garner more support.	Year 1 Years 1-5
Fiscal Resources Increase funding for advertising/marketing.	Years 1-2

Priority Area: Marijuana Use	
Community Readiness Stage: 8	
Course of Action	**Proposed Timeline**
Community Resources 1. Increase political knowledge of new legislation. 2. Develop a positive youth development plan and provide leadership opportunities to the community youth. 3. Increase community engagement to improve community capacity and resource building.	Years 1-5 Years 1-5 Years 1-5
Organization Resources 1. Ensure adequate fiscal resources for implementation.	Year 1
Human Resources	Year 1

1. Providers to implement a professional and career development plan that provides employees with advancement opportunities and competitive salaries and benefits. 2. Engage community leaders to garner more support.	Years 1-5
Fiscal Resources 1. Increase funding for advertising/marketing.	Years 1-2

Priority Area: Methamphetamine Use	
Community Readiness Stage: 4	
Course of Action	**Proposed Timeline**
Community Resources 1. Increase educational resources to improve community knowledge of meth prevention efforts. 2. Increase political/policy knowledge. 3. Develop a positive youth development plan and provide leadership opportunities to the community youth. 4. Increase community engagement to improve community capacity and resource building.	Years 1-5 Years 1-5 Years 1-5 Years 1-5
Organization Resources 1. Increase training opportunities for staff, stakeholders, and community champions, in order to acquire knowledge on research, theory, and practice relating to methamphetamine prevention strategies and solutions.	Years 1-2
Human Resources 1. Providers to implement a professional and career development plan that provides employees with advancement opportunities and competitive salaries and benefits. 2. Engage community leaders to garner more support.	Year 1 Years 1-5
Fiscal Resources 1. Increase funding for advertising/marketing.	Year 1-2

Priority Area: Prescription Drugs	
Community Readiness Stage: 6	
Course of Action	**Proposed Timeline**
Community Resources 1. Increase political/policy knowledge. 2. Develop a positive youth development plan and provide leadership opportunities to the community youth. 3. Increase community engagement to improve community capacity and resource building.	 Years 1-5 Years 1-5 Years 1-5
Organization Resources 1. Ensure adequate fiscal resources for program and policy implementation.	Year 1
Human Resources n/a (no negatives in Table 2.3 Resource Readiness Assessment)	n/a
Fiscal Resources n/a (no negatives in Table 2.3 Resource Readiness Assessment)	n/a

Cultural Competence and Sustainability

Phase:	Sustainability	Cultural Competence
Capacity Building	Conducted interviews with community leaders to understand how current capacity can be improved to meet the needs of individual communities, such as community resource availability and funding. Analyzed fiscal data from previous contracts to better understand incentives to increase employee retention and workforce development strategies to sustain prevention programming efforts.	Collaborated with the community throughout the capacity building phase such as key informant interviews with providers who understand the capacity challenges and gaps within their communities. Created a process for identifying culturally relevant risk and protective factors and other underlying conditions. Utilized existing provider network to better understand how improvements to employee retention interventions and additional funding for marketing and advertising impacts specific at-risk communities.

Chapter 4: Planning

DATA-BASED STRATEGIES

Priority Area	Risk Factor	Protective Factor	Strategy
Alcohol Use	Low perception of harm among youth	Awareness of alcohol associated harms	Information Dissemination Education
	Availability of alcohol to teens by retailers	Effective laws enforcing policies to restrict availability to teens	Environmental Community-Based
	Youth lack the life skills to develop resiliency around their own health and wellness	Youth develop resiliency around their own health and wellness Self-efficacy to assert personal limits and manage risky situations	Information Dissemination Education Community-Based Alternative
	Use of alcohol prior to sexual intercourse among youth	Peer norms encourage sober safer sex practices among youth	Information Dissemination Education Community-Based Alternative
Marijuana Use	Low perception of harm among youth and adults	Awareness of risks and harms	Information Dissemination Education
	Availability of marijuana to teens by retailers	Effective laws enforcing policies to restrict availability to teens	Environmental Community-Based
	Youth lack the life skills to develop resiliency around their own health and wellness	Youth develop resiliency around their own health and wellness	Information Dissemination Education Community-Based Alternative
	Use of marijuana prior to sexual intercourse among youth	Peer norms encourage sober safer sex practices among youth	Information Dissemination Education Community-Based Alternative

Methamphetamine Use	Lack of community awareness of methamphetamine use	Enhanced community awareness of emerging drug trends	Information Dissemination Education Community-Based
		Effective community partnerships to assess and advocate for appropriate interventions to reduce meth usage	Environmental Community-Based
	Youth lack the life skills to develop resiliency around their own health and wellness	Youth develop resiliency around their own health and wellness	Information Dissemination Education Community-Based Alternative
	Use of methamphetamines prior to sexual intercourse among youth	Peer norms encourage sober safer sex practices	Information Dissemination Education Community-Based Alternative
Prescription Drug Misuse	Excessive prescribing of prescription drugs among adults	Collaborating with physicians, pharmacists, law enforcement and judicial system on enforcing proper prescribing practices	Information Dissemination Education Environmental Community-Based
	Community is unaware of proper disposal methods	Community is aware of proper disposal methods	Information Dissemination Education Environmental Community-Based
	Youth lack the life skills to develop resiliency around their own health and wellness	Youth develop resiliency around their own health and wellness Self-efficacy to assert personal limits and manage risky situations	Information Dissemination Education Community-Based Alternative
	Use of prescription drugs prior to sexual intercourse among youth	Peer norms encourage sober safer sex practices among youth	Information Dissemination Education Community-Based Alternative

The selected strategies will increase the protective factors and decrease the risk factors identified above. The selection of strategies was determined to address the criteria of effectiveness, conceptual fit, and practical fit. All strategies demonstrate evidence or effectiveness, are capable of producing positive outcomes, able to influence the selected risk and/or protective factor, and target a relevant population. Strategies ensure that interventions are feasible, capable of adequately addressing the readiness of the community, and supported by the community to secure stakeholder and community involvement in its planning and implementation, leading to successful program sustainability.

LOGIC MODEL

Priority Area 1: Alcohol Use

Problem Statement: Alcohol consumption rates among youth are high due to low perception of harm, availability of alcohol to teens by retailers, lack of life skills to develop resiliency around their own health and wellness, and the use of alcohol prior to sexual intercourse.

Goal (Behavioral Change): Decrease Alcohol Use Among Youth

Objective What do we want to accomplish?	**Strategies** What CSAP strategies will the county implement to accomplish the objective?	**What is going to happen as a result of implemented strategies?**			**Indicators** How will the County measure what happened?
		Short Term Outcomes Immediate implementation: measures process change.	**Intermediate Outcomes** Measures change in contributing factors and/or change in knowledge or skills.	**Long Term Outcomes** Match the objective as if it was accomplished.	
Objective 1.1: By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS[24] or other survey.	Information Dissemination Education	By 2022, the number of youth who perceive underage alcohol use as harmful will increase by 1% as measured by CHKS compared to baseline.	By 2024, the number of youth who perceive underage alcohol use as harmful will increase by 2% as measured by CHKS compared to baseline.	By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline.	CHKS or other survey
Objective 1.2: By 2025, reduce retail availability of alcohol to teens by 3% as measured by Alcohol Beverage Control infractions.	Environmental Community-Based	By 2022, reduce retail availability of alcohol to teens by 1% as measured by Alcohol Beverage Control infractions.	By 2024, reduce retail availability of alcohol to teens by 2% as measured by Alcohol Beverage Control infractions.	By 2025, retail availability of alcohol to minors will have decreased by 3% as measured by Alcohol Beverage Control infractions.	Alcohol Beverage Control data
Objective 1.3: By 2025, youth resiliency for underage drinking will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys

[24] https://data.calschls.org/resources/Los_Angeles_County_1517_Sec_CHKS.pdf

Objective 1.4: By 2025, there will be a 3% decrease in high school students who report having consumed alcohol before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will be a 30% increase in knowledge about the impact of alcohol use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 2% as measured by pre/post surveys.	By 2025, there will be a 3% decrease in students who report having consumed alcohol before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

Priority Area 2: Marijuana Use

Problem Statement: Marijuana use is a priority in LAC following legalization. The low perception of harm by youth, increased availability of marijuana by retailers, lack of resiliency skills, and use of marijuana prior to sexual intercourse among youth contribute to increased marijuana use among youth.

Goal (Behavioral Change): Decrease Marijuana Use Among Youth

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 2.1: By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data or other survey.	Information Dissemination Education	By 2022, youth will have increased their perception of the harms of underage marijuana use by 1% as measured by CHKS data, compared with baseline	By 2024, youth will have increased their perception of the harms of underage marijuana use by 2% as measured by CHKS data, compared with baseline	By 2025, youth will have increased their perception of the harms of underage marijuana use by 3% as measured by CHKS data, compared with baseline	CHKS or other survey
Objective 2.2: By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys.	Environmental Community-Based	By 2022, reduce retail availability of marijuana to teens by 1% as measured by pre-post surveys.	By 2024, reduce retail availability of marijuana to teens by 2% as measured by pre-post surveys.	By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys.	Pre/Post Surveys
Objective 2.3: By 2025, youth resiliency for marijuana use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys

Objective 2.4: By 2025, there will be a 3% decrease in high school students who report having used marijuana before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experiences.	By 2025, there will be a 3% decrease in students who report having used marijuana before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

Priority Area 3: Methamphetamine Use

Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines prior to sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lack the life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth.

Goal (Behavioral Change): Decrease Methamphetamine Use Among Youth

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 3.1: By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Environmental	By 2022, increase community awareness of methamphetamine use by 1%, as measured by pre/post surveys.	By 2024, increase community awareness of methamphetamine use by 2%, as measured by pre/post surveys.	By 2025, increase community awareness of methamphetamine use by 3%, as measured by pre/post surveys.	Pre/Post Surveys
Objective 3.2: By 2025, youth resiliency for methamphetamine use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 3.3: By 2025, there will be a 3% decrease in high school students who report having used methamphetamine before last intercourse.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experience as measured by pre/post test surveys.	By 2025, there will be a 2% decrease in the number of youth who report having used methamphetamine at last intercourse as measured by pre/post test surveys.	Pre/Post Surveys

Priority Area 4: Prescription Drug Misuse

Problem Statement: Excessive prescribing among adults, lack of community awareness of proper disposal methods, lack of resiliency skills around prescription drug use among youth, and the use of prescription drugs prior to sexual intercourse among youth contribute to an increase of the misuse and abuse of prescription drugs.

Goal (Behavioral Change): Decrease Prescription Drug Misuse or Abuse Among Youth and Adults

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 4.1: By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP[25].	Information Dissemination Education Environmental Community-Based	By 2022, there will be a 1% decrease in prescribing of opioid drugs as measured by PDMP.	By 2024, there will be a 3% decrease in prescribing of opioid drugs as measured by PDMP.	By 2025, there will be a 5% decrease in prescribing of opioid drugs as measured by PDMP.	PDMP, CHKS or other survey, CNA
Objective 4.2: By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	Information Dissemination Education Environmental Community-Based	Objective 4.2: By 2021, there will be a 1% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	Objective 4.2: By 2023, there will be a 2% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	CHKS or other survey
Objective 4.3: By 2025, youth resiliency for prescription drug use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 4.4: By 2025, there will be a 3% decrease in high school students who report having consumed prescription drugs before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 3% as measured by pre/post surveys.	By 2025, there will be a 3% decrease in high school students who report having consumed prescription drugs before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

[25] https://insight.livestories.com/s/v2/prescriptions-opioid-abuse-in-la-county/c153ae4e-020d-4833-ace7-b8ceb7775467

PLANNING PROCESS

Prevention Contractors: SPA-based Coalitions and other coalitions (e.g. Safe Med LA, RAM) were engaged in order to discuss whether the logic model objectives are realistic and attainable for each community represented. Prevention contractors provided feedback to identify resources and verify planning steps as identified. Previous data sources were identified to verify goals and objectives as outlined in the logic model so that they are attainable and realistic.

Special Projects: Youth and staff from special projects were engaged to determine crucial aspects of the planning process, ensuring that programs are culturally relevant within each school campus, public park setting, etc. Faculty and staff from school administration were contacted to verify that program planning efforts meet the cultural, social, and economic needs of the target population(s). A primary focus of these special projects is to provide programs in settings (school, park, community center) that serve low-income and under-resourced segments of LAC. For example, prevention media campaigns utilized key informant interviews and formal focus groups to identify planning components and launch successful campaigns that are culturally relevant and data-driven.

Cultural Competence and Sustainability

Phase:	Sustainability	Cultural Competence
Planning	Conducted interviews with community leaders, students, and community partners to understand how current capacity can be improved to meet the needs of individual communities, such as ranking of risk and protective factors and suggested planning strategies to identify interventions in substance use prevention.	Collaborated with the community throughout the planning phase, such as key informant interviews with providers who understand application challenges to suggested aligned prevention strategies as they fit within their communities. Created a process for ranking culturally relevant risk and protective factors and other underlying conditions. Utilized existing provider network to better understand how improvements to strategies and community impact outcomes impact specific at-risk communities. Utilized special projects to ensure community members are engaged in similar ways that best relate to the program (i.e. students, faculty, healthcare partners, Parks and Recreation partners).

Chapter 5: Implementation

IMPLEMENTATION PLANS

In accordance with contract requirements, all substance use prevention efforts implemented through DPH-SAPC service providers must clearly align with the SPP and substance use prevention priorities. Selection of services, service populations, and service locations are based on the data presented in the SPP and is in accordance with the county goals and objectives. The Substance Abuse Prevention Services Program Manual serves as a reference to the SPP, highlighting current county priorities, goals, and objectives.

Service providers are required to identify focus populations and communities based on SPP priorities. Prevention strategies depend on the service delivery method and the targeted population as established by the Institute of Medicine (IOM).

In participating in substance use-related outreach and education, service providers will address the community and systems-level factors that directly and indirectly impact substance use and misuse within communities. Through the use of evidence-based and local innovative programs, service providers will identify, implement, and sustain effective prevention strategies to address substance use prevention issues within the different communities within LAC.

Table 5.1: Implementation Plan for Adolescent Prevention Services (APS)

Program/Intervention: Adolescent Prevention Services (APS)	
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.	
Objective(s): By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.	
IOM Category(ies): Universal, Selective, and Indicated	Population(s): Youth and Young Adults

Major Tasks	Timeline	Responsible Party	Strategy
1. Implement strategies from the Center for Substance Abuse Prevention (CSAP) through a range of evidence-based practices to deliver age appropriate services to at-risk youth	Ongoing	Providers	CBP EDU ALT ENV
2. Provide prevention-based services to at-risk youth, such as outreach, brief screening, educational sessions, and alternative activities	Ongoing	Providers	EDU ALT PIDR ID
3. Submit annual work plan reports	April Annually	Providers	CBP
4. Annual evaluation report	Jul Annually	Providers	CBP

Table 5.2: Implementation Plan for Environmental Prevention Services (EPS)

Program/Intervention: Environmental Prevention Services (EPS)			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.			
Objective(s): By 2025, reduce retail availability of alcohol to teens by 3% as measured by Alcohol Beverage Control infractions. By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys. By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys. By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Execute culturally competent and evidence-based prevention environmental efforts and initiatives that change the policies, ordinances, and practices which facilitate substance use; Develop methods to ensure efforts are enforced and sustained once implemented	Ongoing	Providers	ENV
2. Provide active and sustained involvement and collaboration of local community residents (youth and adults), leaders, non-substance use focused businesses, substance use services providers, and other stakeholders who are knowledgeable of the local substance use-related issues and who are committed to engaging in evidence-based solutions	Ongoing	Providers	ENV
3. Develop SPA-Based Coalitions to consistently engage community members, key stakeholders, and other substance use prevention providers in the identification of local substance use problems	Ongoing	Providers	ENV

and contributing risk factors that guide the development and implementation of prevention activities and services within their SPA			
4. Submit annual work plan reports	April Annually	Providers	CBP
5. Annual evaluation report	Jul Annually	Providers	CBP

Table 5.3: Implementation Plan for Comprehensive Prevention Services (CPS)

Program/Intervention: Comprehensive Prevention Services (CPS)			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.			
Objective(s): By 2025, reduce retail availability of alcohol to teens by 3% as measured by Alcohol Beverage Control infractions. By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys. By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys. By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Offer culturally competent evidence-based prevention programs/services that focus on both community and individual-level efforts to reduce the availability of alcohol, marijuana, and other substances in the community	Ongoing	Providers	
2. Ensure that the selection of programs/services is data-driven and designed to specifically address the highest priority substance use problems and	Ongoing	Providers	CBP

contributing factors within specific populations and communities			
3. Continued active and sustained involvement and collaboration of local community residents (youth and adults), leaders, non-substance use focused businesses, substance use services providers, and others who are knowledgeable of the local substance use related issues and who are committed to engaging in evidence-based solutions	Ongoing	Providers	CBP
4. Submit annual work plan reports	April Annually	Providers	CBP
5. Annual evaluation report	Jul Annually	Providers	CBP

Table 5.4 Implementation Plan for Friday Night Live (FNL)

Program/Intervention: Friday Night Live (FNL)			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.			
Objective(s): By 2023, youth participants will increase their perception that underage drinking is harmful by 3% as measured by the FNL Youth Survey.			
IOM Category(ies): Indicated, Universal	Population(s): Youth, High School Students		
Major Tasks	Timeline	Responsible Party	Strategy
1. Attend CFNLP annual training	Jul Annually	Provider	CBP
2. Provide FNL implementation for selected school site chapters	7/1/2020-6/30/2025	Provider	ALT
3. Execute FNL Youth Evaluation Report	Jul Annually	State	CBP
4. Submit annual work plan reports	April Annually	Providers	CBP
5. Annual evaluation report	Jul Annually	Providers	CBP

Table 5.5: Implementation Plan for LA County Our SPOT Program

Program/Intervention: LA County Our SPOT Program			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.			
Objective(s): By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.			
IOM Category(ies): Universal, Selective	Population(s): Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Implement programs utilizing community-based youth organizations and activities to enhance youth participation and community buy-in	Ongoing	Providers	CBP
2. Conduct trainings to Department of Parks and Recreation frontline staff to increase their knowledge and expertise about positive youth development in the areas of health, empowerment, leadership, and resilience, program administration and evaluation	Ongoing	Providers	CBP
3. Collaborate with County departments including the Probation Department, LAC Department of Mental Health, and Workforce Development, Aging and Community Services (WDACS) to support existing Our SPOT programming efforts	Ongoing	Providers	CBP
4. Provide an annual Our SPOT Youth Summit to increase youth participation and engagement	Spring 2021	Provider	ALT
4. Annual evaluation report	Jul Annually	Provider	CBP

Table 5.6: Implementation Plan for Prevention Media Campaigns

Program/Intervention: Prevention Media Campaigns			
Goal(s): Decrease underage alcohol and methamphetamine use among youth and young adults.			
Objective(s): By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Utilize local media Communication Provider, LAC Department of Public Health Communications, and community-based organizations to drive media campaign implementation efforts	Ongoing	County & Providers	ENV
2. Plan, implement, and evaluate three (3) countywide media and public awareness campaigns targeting youth, young adults, and/or parents/guardians and active users	Ongoing	County & Providers	ENV CBP
3. Draft campaign earned media report including social media activity and campaign evaluation results	Jul Annually	Provider	ENV

Table 5.7: Implementation Plan for Prevention Advisory Committee

Program/Intervention: Prevention Advisory Committee			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth and young adults.			
Objective(s): By 2025, reduce retail availability of alcohol to teens by 3% as measured by Alcohol Beverage Control infractions. By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline. By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys. By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys. By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.			
IOM Category(ies): Universal	Population(s): Providers and County Prevention Staff		
Major Tasks	Timeline	Responsible Party	Strategy
1. Meet regularly with other agencies and coalitions to collaborate efforts on planning and implementation efforts in Countywide substance use prevention program initiatives	7/1/2020-6/30/2023	County & Providers	CBP
2. Secure a location, presenters, agenda, etc.	Ongoing	County & Providers	CBP

Table 5.8: Implementation Plan for Rethinking Access to Marijuana (RAM) Coalition

Program/Intervention: Rethinking Access to Marijuana (RAM) Coalition			
Goal(s): Decrease underage marijuana use among youth and young adults.			
Objective(s): By 2025, youth will increase their perception of the harms of underage marijuana use by 3% as measured by CHKS data compared to baseline. By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Educate local communities about the potential harms of marijuana use	Ongoing	Providers	ED
2. Implement and evaluate environmental strategies formulated to limit youth accessibility and availability of marijuana	Ongoing	Providers	ENV
3. Influence policy actions that support flourishing youth and communities free from marijuana-related harms	Ongoing	Providers	ENV
4. Create and execute a strategic plan focusing on environmental and educational strategies to target youth marijuana education efforts and initiatives across LA County.	Ongoing	Providers	CBP

Table 5.9: Implementation Plan for SafeMed LA Community Education Action Team

Program/Intervention: SafeMed LA Community Education Action Team (CEAT)			
Goal(s): Decrease prescription drug misuse among youth and young adults.			
Objective(s): By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP. By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS or other survey.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
1. Provide community education to increase public awareness of the risks of prescription drug abuse, safe use/storage/disposal, and available resources for help	Ongoing	Providers	ID EDU
2. Support convenient, safe, and environmentally responsible prescription drug collection and disposal programs in LAC	Ongoing	Providers	ENV
3. Promote the bi-annual DEA National Prescription Drug Take-back Day, which are free to the public to help decrease the supply and navigate the interface between public health and law enforcement	October and April Annually	Providers	ENV
4. Provide training and education to help the community (e.g., parents, youth, educators, law enforcement, residents, merchants, etc.) better understand prescription drug abuse and navigate the interface between public health and law enforcement	Ongoing	Providers	CBP

Table 5.10: Implementation Plan for DPH-SAPC's Student Well-Being Centers

Program/Intervention: DPH-SAPC's Student Well-Being Centers			
Goal(s): Decrease underage alcohol, marijuana, and methamphetamine use and prescription drug misuse among youth.			
Objective(s): By 2025, youth resiliency for alcohol use will increase by 3% as measured by pre/post surveys. By 2025, youth resiliency for marijuana use will increase by 3% as measured by pre/post surveys. By 2025, youth resiliency for methamphetamine use will increase by 3% as measured by pre/post surveys. By 2025, youth resiliency for prescription drug use will increase by 3% as measured by pre/post surveys. By 2025, there will be a decrease of 3% among high school students reporting alcohol use prior to last intercourse. By 2025, there will be a decrease of 3% among high school students reporting marijuana use prior to last intercourse. By 2025, there will be a decrease of 3% among high school students reporting methamphetamine use prior to last intercourse. By 2025, there will be a decrease of 3% among high school students reporting prescription drug misuse prior to last intercourse.			
IOM Category(ies): Selective	Population(s): High School students		
Major Tasks	Timeline	Responsible Party	Strategy
1. Provide classroom education on impact of alcohol/substance use on safer sex practices	Ongoing	County	EDU
2. Provide individual and group consultation and education in the Well-Being Centers	Ongoing	County	EDU
3. Train youth leaders and facilitate youth leadership program to execute school-wide prevention education campaigns	Ongoing	County	ALT

Cultural Competence and Sustainability

Contractors and special projects must provide programs that are culturally competent and sustainable. Culture includes beliefs, communications, actions, customs, and values across racial, ethnic, religious, or social groups.[26] Cultural competency is the convergence of these behaviors, attitudes, and policies in a system, agency, or among professionals to enable effective work in cross-cultural situations. Consideration for culturally competent programming that is responsive to, the health beliefs, practices, cultural, and linguistic needs of diverse populations is more likely to bring about positive change. In LAC, the culture of substance use differs by gender, age group, race, and ethnic origin. For example, alcohol binge consumption is usually highest among college age men and certain ethnic groups[27] where binge drinking is culturally acceptable. Methamphetamine use is highest among certain sexual minorities,[28] which may believe meth use enhances their sexual experiences.

Sustainability contributes to long term program success and includes continued community support and engagement, stable infrastructure, and available resources and training to keep abreast of emerging cultural nuances and obtain the required skills to address these trends within at-risk populations.

[26] https://store.samhsa.gov/system/files/sma16-4932.pdf
[27] http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/Binge_Drinking_2014_FinalS.pdf
[28] https://www.cdc.gov/msmhealth/substance-abuse.htm

Chapter 6: Evaluation

EVALUATION PLAN SUMMARY

The LAC evaluation plan to conduct prevention process and outcome evaluation will begin by engaging stakeholders (e.g., LAC prevention program directors/coordinators, their program evaluators, and DPH-SAPC Community and Youth Engagement prevention specialists) as members of the prevention evaluation team. DPH-SAPC's prevention evaluation team within the Health Outcomes and Data Analytics (HODA) Unit will continue working collaboratively with prevention evaluation team members throughout the evaluation process to evaluate shared program goals, objectives, activities, and performance measures. The evaluation plan will include the following steps: evaluation design, gathering and analyzing data/evidence, justifying conclusions, and reporting evaluation results (dissemination plan). Indicators corresponding to each priority area reported in the logic models of the planning chapter will be references to assess process and outcome evaluation. The overall purpose of the evaluation is to monitor progress toward program goals, determine whether program strategies are progressing toward the desired outcomes, and ensure the sustainability of effective strategies/programs.

Table 6.1: Evaluation Plan

Outcomes	Performance Measures	Method of Data Collection	Indicators/Data Source	Roles and Responsibilities	Timeframe
Short term: By 2022, there will be a 1% decrease in prescribing of opioid drugs as measured by PDMP. **Intermediate:** By 2024, there will be a 3% decrease in prescribing of opioid drugs as measured by PDMP. **Long term:** By 2025, there will be a 5% decrease in prescribing of opioid drugs as measured by PDMP.	Prescription Medication Misuse Prevalence	Survey/ Pharmacy reporting data	Prescription Drug Monitoring Program (PDMP), California Health Kids Survey (CHKS) or other survey, Community Needs Assessment (CNA)	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short term: By 2022, there will be a 1% reduction in youth access to Rx drugs, as measured by CHKS. **Intermediate:** By 2024, there will be a 2% reduction in youth access to Rx drugs, as measured by CHKS. **Long Term:** By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS.	Prescription Medication Access and Availability	Survey	CHKS or other survey	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short term: By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	Prescription Medication Resiliency	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics,	Before and After program

Intermediate: By 2024, youth resiliency will increase by 2% as measured by pre/post surveys. **Long Term:** By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.				Prevention evaluation team as well as surveillance data team	
Short Term: By 2022, there will a 30% increase in knowledge about the impact of prescription drug use on one's ability to practice safer sex as measured by pre/post surveys. **Intermediate:** By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 3% as measured by pre/post surveys. **Long Term:** By 2025, there will be a 3% decrease in high school students who report having consumed prescription drugs before last intercourse as measured by pre/post surveys.	Prescription Drug Use before Intercourse	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, increase community awareness of methamphetamine use by 1%, as measured by pre/post surveys. **Intermediate**: By 2024, increase community awareness of methamphetamine use by 2%, as measured by pre/post surveys. **Long Term:** By 2025, increase community awareness of methamphetamine use by 3%, as measured by pre/post surveys.	Methamphetamine Use – Increase Community Awareness	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, youth resiliency will increase by 1% as measured by pre/post surveys. **Intermediate:** By 2024, youth resiliency will increase by 2% as measured by pre/post surveys. **Long Term:** By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Methamphetamine Resiliency	Survey	Pre/Post- Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, there will a 30% increase in knowledge about the impact of methamphetamine use on one's ability to practice safer sex as measured by pre/post surveys. **Intermediate**: By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experience as measured by pre/post test surveys. **Long Term:** By 2025, there will be a 2% decrease in the number of youth who report having used methamphetamine at last intercourse as measured by pre/post test surveys.	Methamphetamine Use before Intercourse	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program

Short Term: By 2022, youth will have increased their perception of the harms of underage marijuana use by 1% as measured by CHKS data, compared with baseline. **Intermediate:** By 2024, youth will have increased their perception of the harms of underage marijuana use by 2% as measured by CHKS data, compared with baseline. **Long Term:** By 2025, youth will have increased their perception of the harms of underage marijuana use by 3% as measured by CHKS data, compared with baseline	Marijuana Use – Harms Perception	Survey	CHKS or other survey	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, reduce retail availability of marijuana to teens by 1% as measured by pre-post surveys. **Intermediate:** By 2024, reduce retail availability of marijuana to teens by 2% as measured by pre-post surveys. **Long Term**: By 2025, reduce retail availability of marijuana to teens by 3% as measured by pre-post surveys.	Marijuana Availability	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, youth resiliency will increase by 1% as measured by pre/post surveys. **Intermediate:** By 2024, youth resiliency will increase by 2% as measured by pre/post surveys. **Long Term**: By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Marijuana Resiliency	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, there will a 30% increase in knowledge about the impact of marijuana use on one's ability to practice safer sex as measured by pre/post surveys. **Intermediate:** By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experiences. **Long Term:** By 2025, there will be a 3% decrease in students who report having used marijuana before last intercourse as measured by pre/post surveys.	Marijuana Use before Intercourse	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, the number of youth who perceive underage alcohol use as harmful will increase by 1% as measured by CHKS compared to baseline. **Intermediate:** By 2024, the number of youth who perceive underage alcohol use as harmful will increase by 2% as measured by CHKS compared to baseline.	Alcohol Harms Perception	Survey	CHKS or other survey	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program

Long Term: By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline.					
Short Term: By 2022, reduce retail availability of alcohol to teens by 1% as measured by Alcohol Beverage Control infractions. **Intermediate**: By 2024, reduce retail availability of alcohol to teens by 2% as measured by Alcohol Beverage Control infractions. **Long Term**: By 2025, retail availability of alcohol to minors will have decreased by 3% as measured by Alcohol Beverage Control infractions.	Alcohol Availability	Survey	Alcohol Beverage Control data	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, youth resiliency will increase by 1% as measured by pre/post surveys. **Intermediate:** By 2024, youth resiliency will increase by 2% as measured by pre/post surveys. **Long Term:** By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Alcohol Resiliency	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program
Short Term: By 2022, there will be a 30% increase in knowledge about the impact of alcohol use on one's ability to practice safer sex as measured by pre/post surveys. **Intermediate:** By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 2% as measured by pre/post surveys. **Long Term**: By 2025, there will be a 3% decrease in students who report having consumed alcohol before last intercourse as measured by pre/post surveys.	Alcohol Consumption before Intercourse	Survey	Pre/Post Surveys	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	Before and After program

DISSEMINATION PLAN

Evaluation findings will be disseminated to enhance prevention efforts and share lessons learned. This step is needed to turn the data collected into meaningful, useful, and accessible information. Program evaluation meetings will address topics related to dissemination including:

1. Sharing preliminary and final evaluation results
2. Eliciting feedback on interpretation of results
3. Recommendations on how to modify strategies based on results
4. Integrating traditional prevention practices with new/innovative approaches
5. Dissemination of evidenced-based and innovative practices and curricula

Program evaluation meetings will be utilized to present preliminary findings on topics such as:

1. The fidelity of prevention service implementation
2. Progress updates about priority areas
3. Clarification and interpretation of findings
4. Justification of conclusions
5. Determination of media formats for distribution of findings
6. Determination of target audiences (e.g., current and potential funders, administrators, board members, and community-based groups and organizations)

Evaluation findings will be disseminated in annual progress reports to state, county, local funders, stakeholders, coalitions, and LAC residents in oral and written formats as results become available.

Briefing Stakeholders

DPH-SAPC HODA prevention evaluation team will host on-going prevention program evaluation meetings to provide a forum for a reciprocal exchange of ideas about prevention program evaluation activities such as refining logic models and SMART objectives (specific, measurable, attainable, results-focused, and timely), survey development, data collection, identifying data sources, analyzing data, disseminating outcome findings. The HODA prevention evaluation team will convene these meetings and ensure a clear explanation of the goals and objectives of LAC Evaluation Plan. Meetings will discuss prevention program strategies, address concerns and challenges regarding program evaluation activities, and provide technical assistance if necessary. The HODA prevention evaluation team will take minutes, summarize discussion points, and share findings/deliverables with stakeholders when appropriate.

Cultural Competence and Sustainability

Cultural competence evaluation activities will explore providers' ability to consider culture when delivering prevention services. To be relevant in the community and obtain buy-in from stakeholders, providers need to address a range of issues, many of which stem from equity concerns. To be relevant to youth, prevention efforts need to be appealing, fun, engaging to youth, promote healthy environments/messages/activities, and oppose norms that encourage or accept substance use.

The DPH-SAPC HODA prevention evaluation team will work collaboratively with prevention providers continuously to assess community needs and resources and identify the most pressing SUD problems and contributing factors, thereby developing and improving effective and culturally responsive prevention strategies. As noted in the Assessment chapter, evaluation activities will continuously involve:

1. Consumption data to target disparities. Equity concerns will be addressed in evaluation activities such as exploring providers' efforts to take culture into account when delivering prevention services.
2. Community engagement. Including a diverse range of partners will expand the base of prevention stakeholders, engaging community members in assessment activities, and effectively disseminating evaluation findings throughout local communities in LAC will further facilitate sustainability.
3. Collect and assess cultural competence-related information/data. Culturally competent data will be used to improve prevention services and increase mutual respect and understanding between providers and DPH-SAPC. This will promote the inclusion of all provider/community members. The goal is to incorporate different perspectives, ideas, and strategies that will improve prevention services.

4. Development of learning communities. The DPH-SAPC HODA prevention evaluation team will establish learning communities designed to provide a forum for providers/communities to exchange effective approaches and projects to learn from each other, in order to identify culturally relevant risk and protective factors and other underlying conditions pertaining to substance use. These learning communities will help prevention providers develop new knowledge and skills, allowing the field to capitalize on new prevention strategies.
5. Hiring of culturally competent staff and evaluators. Culturally competent staff and evaluators who are familiar with the diversity of LAC residents in terms of religion, traditions, language, race/ethnicity, sexual orientation, social determinants of health, and other factors will be hired, and ongoing related training will be provided in order to build rapport and credibility at the local level.

Los Angeles County
Prevention SPP Addendum: Priority 3 – Methamphetamine

Submitted: March 23, 2021

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Prevention SPP Addendum: Priority 3 – Methamphetamine
Submitted: March 23, 2021

Include Adults as a population of focus (see below, highlighted in yellow):

Priority 3: Methamphetamine Use

Goal: Decrease Methamphetamine Use Among Youth and Adults

Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines priorto sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lack the life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth and adults.

Assessment

In 2018, an estimated 1.9 million (0.7%) Americans aged 12 or older had used methamphetamine in the past year, of which about 205,000 were new users (approximately 560 each day). Among recurrent users of methamphetamine aged 12 or older, 0.4% developed methamphetamine use disorder for dependence and abuse (NSDUH, 2018). The average age of new methamphetamine users in 2016 was 23.3 years old. In 2018, there were 25,327 methamphetamine-related emergency department visits (a 367% increase from 2005) and 20,141meth related hospitalizations (a 174% increase from 2005). The number of methamphetamine- involved deaths increased from 125 in 2008 to 661 in 2018, resulting in a 417% increase in age- adjusted death rate. In 2018, methamphetamine surpassed opioids as the most common cause of overdose death in LA County. Percent of total admissions at publicly funded SUD treatment programs with a primary methamphetamine problem increased 41% from 22% of total admissions in FY1617 to 31% of total admissions in FY1819.

Capacity-Building

Los Angeles County Methamphetamine Task Force works collaboratively with community partners to develop a framework to address methamphetamine prevention across the provider network and other participating County and non-County community partners. Based on a reviewof data collection and feedback from community members, the Task Force develops and implements coordinated and effective prevention strategies to provide community awareness, education, and policy advocacy for individuals who are most at risk for methamphetamine use and abuse.

[1] https://insight.livestories.com/s/v2/meth---hospitalizations/773899a2-6c2f-4527-806e-adfdfb5efc1e

Planning

Added Risk Factor (see below, highlighted in yellow):

Priority Area	Risk Factor	Protective Factor	Strategy
Methamphetamine Use	Lack of community awareness of methamphetamine use	Enhanced community awareness of emerging drug trends	Information Dissemination Education Community-Based
		Effective community partnerships to assess and advocate for appropriate interventions to reduce meth usage	Environmental Community-Based
	Adult abuse of methamphetamine use	Awareness of risks and harms through education and effective community partnerships	Alternative Education Community-Based Environmental
	Youth lack the life skillsto develop resiliency around their own healthand wellness	Youth develop resiliency around their own health and wellness	Information Dissemination Education Community-Based Alternative
	Use of methamphetamines prior to sexual intercourse among youth	Peer norms encourage sober safer sex practices	Information Dissemination Education Community-Based Alternative

Add/Edit to Logic Model:

Priority Area 3: Methamphetamine Use

Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines prior to sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lackthe life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth and adults.

Goal (Behavioral Change): Decrease Methamphetamine Use Among Youth and Adults

Objective	Strategies	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	Indicators
Objective 3.4: By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data	Alternative Education Community-Based Environmental	By 2022, decrease adult abuse of methamphetamine by 1% as measured by SUD treatment admission data	By 2023, decrease adult abuse of methamphetamine by 2% as measured by SUD treatment admission data	By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data	SUD treatment admission data

Implementation:

Add to Implementation Plan:

Table 5.11 Methamphetamine Task Force

Program/Intervention: Methamphetamine Task Force			
Goal(s): Decrease methamphetamine use among youth and adults.			
Objective(s): By 2025, increase community awareness of methamphetamine by 3% as measured by Pre/Post Surveys. By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data.			
IOM Category(ies): Universal	Population(s): Adults, Parents, Youth		
Major Tasks	Timeline	Responsible Party	Strategy
Obtain and gather data and feedback fromcommunity members regarding action steps to address the impact of methamphetamine	Ongoing	County & Providers	CBP
Provide community education to increasepublic awareness of the risks of methamphetamine use and abuse, and available resources for help	Ongoing	County & Providers	EDU
Build capacity around best practices in methamphetamine prevention programsand policy recommendations	Ongoing	County & Providers	ENVCBP

Evaluation

Add to Evaluation Table:

Outcomes	Performance Measures	Method of Data Collection	Indicators/Data Source	Roles and Responsibilities	Timeframe
Short Term: By 2022, decrease adult abuse of methamphetamine by 1% as measured by SUD treatment admission data **Intermediate**: By 2023,decrease adult abuse of methamphetamine by 2% as measured by SUD treatment admission data **Long Term:** By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data	Methamphetamine Use – Decrease Adult Abuse	Survey	SUD treatment admission data	Health Outcomes and Data Analytics, Prevention evaluation team as well as surveillance data team	SUD treatment admission data