CALIFORNIA

Health Care Almanac

CHCF

SEPTEMBER 2025

Substance Use in California:
2025 Edition

Executive Summary

Substance use in California is widespread. Almost half of Californians age 12 and older reported using alcohol in the past month, and about one in four reported using marijuana in the past year. While many people use substances safely, the overuse or misuse of alcohol and other drugs, including illicit drugs, can lead to immediate or long-term health problems. Approximately 5.6 million Californians age 12 and older (17%) reported meeting the criteria for a substance use disorder (SUD) in 2022 to 2023.

Substance Use in California uses the most recent data available to provide an overview of substance use and addiction in California. Topics include prevalence of substance use, treatment, emergency department visits, and deaths.

KEY FINDINGS INCLUDE:

- The average annual rate of substance use disorder for young adults (age 18 to 25) was over three times the rate for adolescents (age 12 to 17).
- Between 2019 and 2023, the number of emergency department visits for non-heroin opioid use tripled.
- In 2023, 7,560 Californians died from an opioid-related overdose. The death rate per 100,000 population from fentanyl increased from 0.2 deaths in 2013 to 18.3 deaths in 2023.
- California's Drug Medi-Cal Organized Delivery System (DMC-ODS) provides organized SUD treatment to eligible Medi-Cal members. As of August 2024, 39 counties, representing 96% of the state's Medi-Cal population, had implemented DMC-ODS.
- Almost two in five people with commercial HMO and PPO health plans who had an alcohol or other drug dependence diagnosis had an initial treatment visit within 14 days of diagnosis, meeting the national quality recommendation.

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About Substance Use Disorders

Substance use can have far-reaching impacts on individuals, families, and communities. For some people, the repeated use of alcohol or drugs can lead to substance use disorders. Substance use disorders can cause health problems, disability, and failure to meet major responsibilities at work, school, or home. Frequent, long-term use of substances can result in physical changes in the brain that may increase the likelihood of compulsive and destructive behaviors, and can make recovery more difficult.

Like many other chronic conditions, substance use disorders can be prevented, treated, and managed. Behavioral therapy, which seeks to identify and help change potentially self-destructive or unhealthy behaviors, can benefit people with a wide range of disorders. For some substances, including alcohol and opioids, behavioral therapy is often most effective when combined with medications that can manage withdrawal, reduce cravings, and decrease the physical "reward" from substance use. Peer support is another highly valued component of substance use disorder recovery.

Substance use disorders are common, recurrent, and often serious illnesses. However, they can be prevented, treated, and managed.

Sources: "Drug Misuse and Addiction," National Institute on Drug Abuse (NIDA), July 6, 2020; "Drugs and the Brain," NIDA; "Treatment and Recovery," NIDA, July 6, 2020; and Sharon Reif et al., "Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence," *Psychiatric Services* 65, no. 7 (July 2014): 853–61.

Definitions

Substance use disorder* is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least 2 of 11 symptoms occurring in a 12-month period. Presence of 2 to 3 symptoms is considered mild, presence of 4 to 5 symptoms is considered moderate, and presence of 6 or more symptoms is considered severe. (See Appendix D for the full definition.)

Alcohol use disorder is a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 symptoms occurring within a 12-month period. Presence of 2 to 3 symptoms is considered mild, presence of 4 to 5 symptoms is considered moderate, and presence of 6 or more symptoms is considered severe. (See Appendix D for the full definition.)

Drug use disorder is a problematic use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives.

Binge alcohol use is drinking five or more drinks for males, or four or more drinks for females, on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.

Illicit drugs are marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, methamphetamine, or prescription-type drugs used nonmedically.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* provides the standard definitions of substance use disorder for the United States.

* *Substance use disorder* replaced the terms substance dependency, substance addiction, and substance abuse disorder in the diagnostic lexicon.

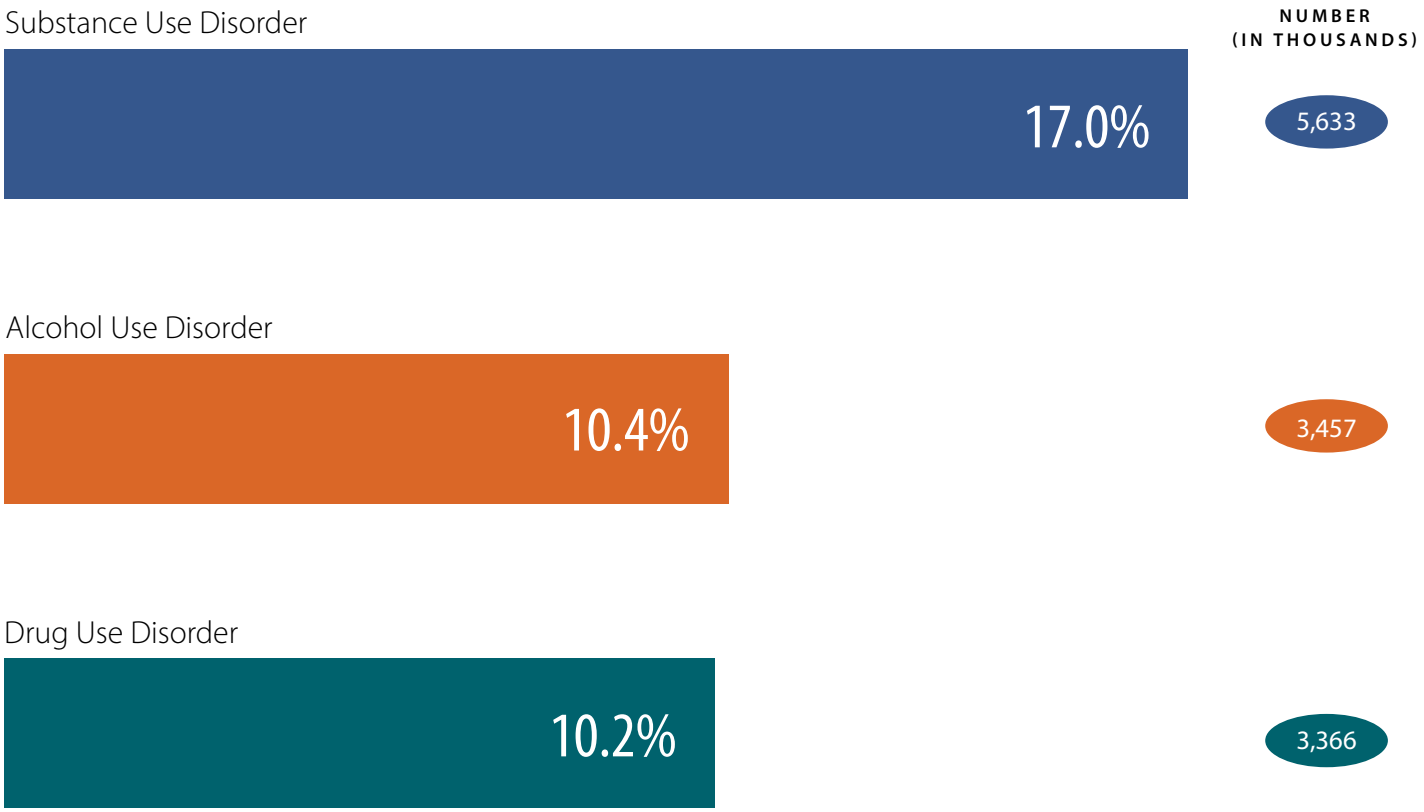
Notes: *DSM* is Diagnostic and Statistical Manual of Mental Disorders. Some of the measures for prevalence presented in this document reflect the diagnostic terminology in use at the time of data collection (DSM-IV-TR). The definition for illicit drugs includes marijuana, which was legalized for adults age 21 and older in California effective January 1, 2018.

Sources: *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5* (Washington, DC: American Psychiatric Association, 2013); *National Survey on Drug Use and Health* (2022–23), Substance Abuse and Mental Health Services Administration, table 19B; and *Behavioral Health Barometer: California, Volume 6*, Substance Abuse and Mental Health Services Administration, 2020.

Substance Use Disorder Prevalence, by Type

California, Annual Average, 2022 to 2023

PERCENTAGE OF POPULATION AGE 12 AND OLDER



Notes: Substance use disorder estimates are based on *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) criteria. *Substance use disorder* is defined as meeting the criteria for drug or alcohol use disorder. *Drug use disorder* includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

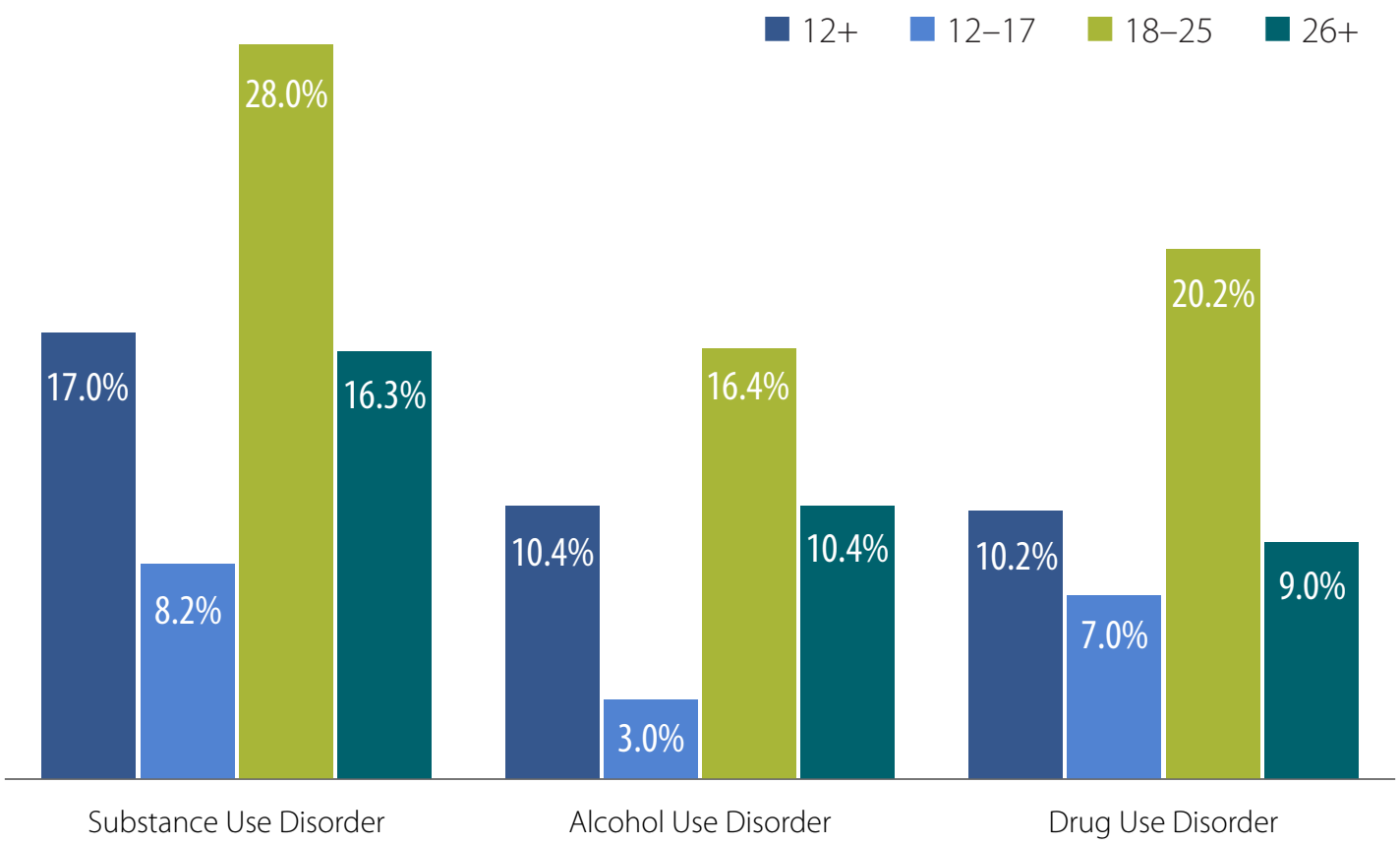
Source: *National Survey on Drug Use and Health* (2022–23), Substance Abuse and Mental Health Services Administration, table 19B and 20B.

Approximately 5.6 million Californians age 12 and older (17%) met the criteria for substance use disorder in the past year. Ten percent reported meeting criteria for alcohol use disorder, and 10% reported meeting criteria for drug use disorder.

Substance Use Disorder in the Past Year, by Type and Age Group

California, Annual Average, 2022 to 2023

PERCENTAGE OF POPULATION



Notes: *Substance use disorder* is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Substance use disorder estimates are based on *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) criteria. *Drug use disorder* includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

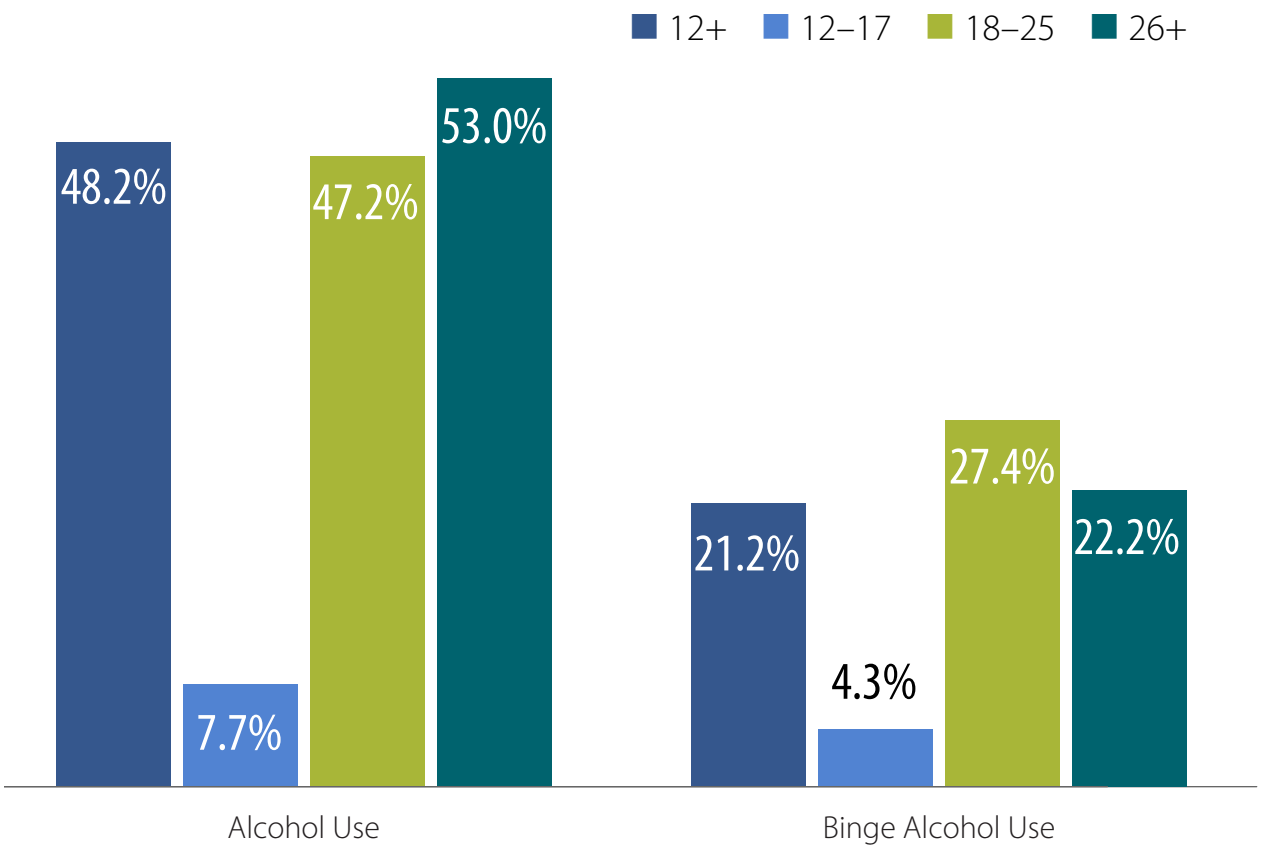
Source: *National Survey on Drug Use and Health* (2022–23), Substance Abuse and Mental Health Services Administration, table 20B.

The average annual rate of substance use disorder for young adults (age 18 to 25) was more than three times the rate for adolescents (age 12 to 17).

Alcohol Use in the Past Month, by Age Group

California, Annual Average, 2022 to 2023

PERCENTAGE OF POPULATION



Note: *Binge alcohol use* is defined as drinking five or more drinks for males or four or more drinks for females on the same occasion (i.e., at the same time or within a couple hours of each other) on at least one day in the past 30 days.

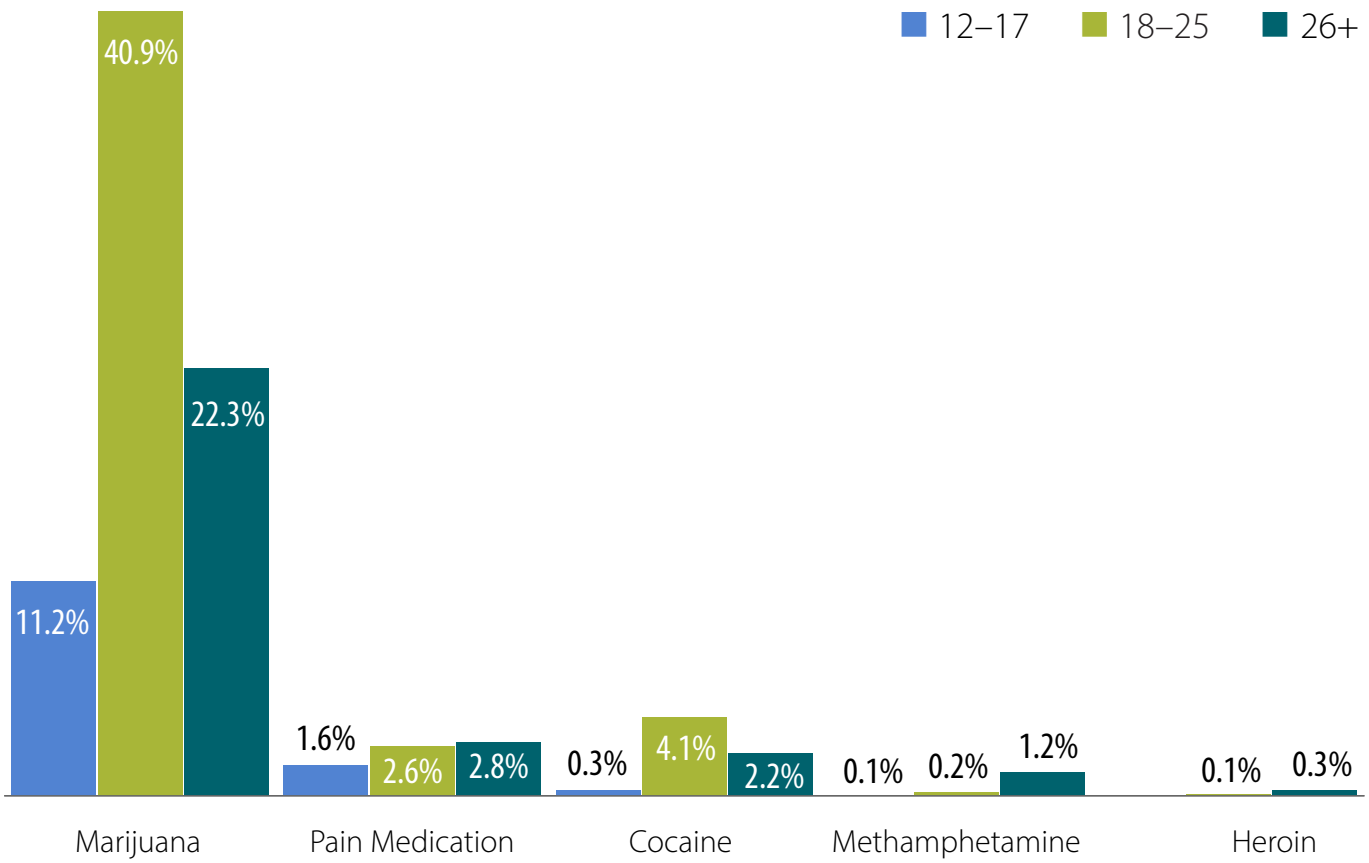
Source: *National Survey on Drug Use and Health* (2022–23), Substance Abuse and Mental Health Services Administration, table 20A.

Less than half of Californians 12 or older reported using alcohol in the past month. Almost thirty percent of young adults (age 18 to 25) reported binge alcohol use in the past month.

Drug Use in the Past Year, by Selected Type and Age Group

California, Annual Average, 2022 to 2023

PERCENTAGE OF POPULATION



Notes: *Pain medication* is prescription pain reliever misuse in the source. *Cocaine* includes crack. See page 4 for further definitions. Data are not available for heroin use among those age 12 to 17.

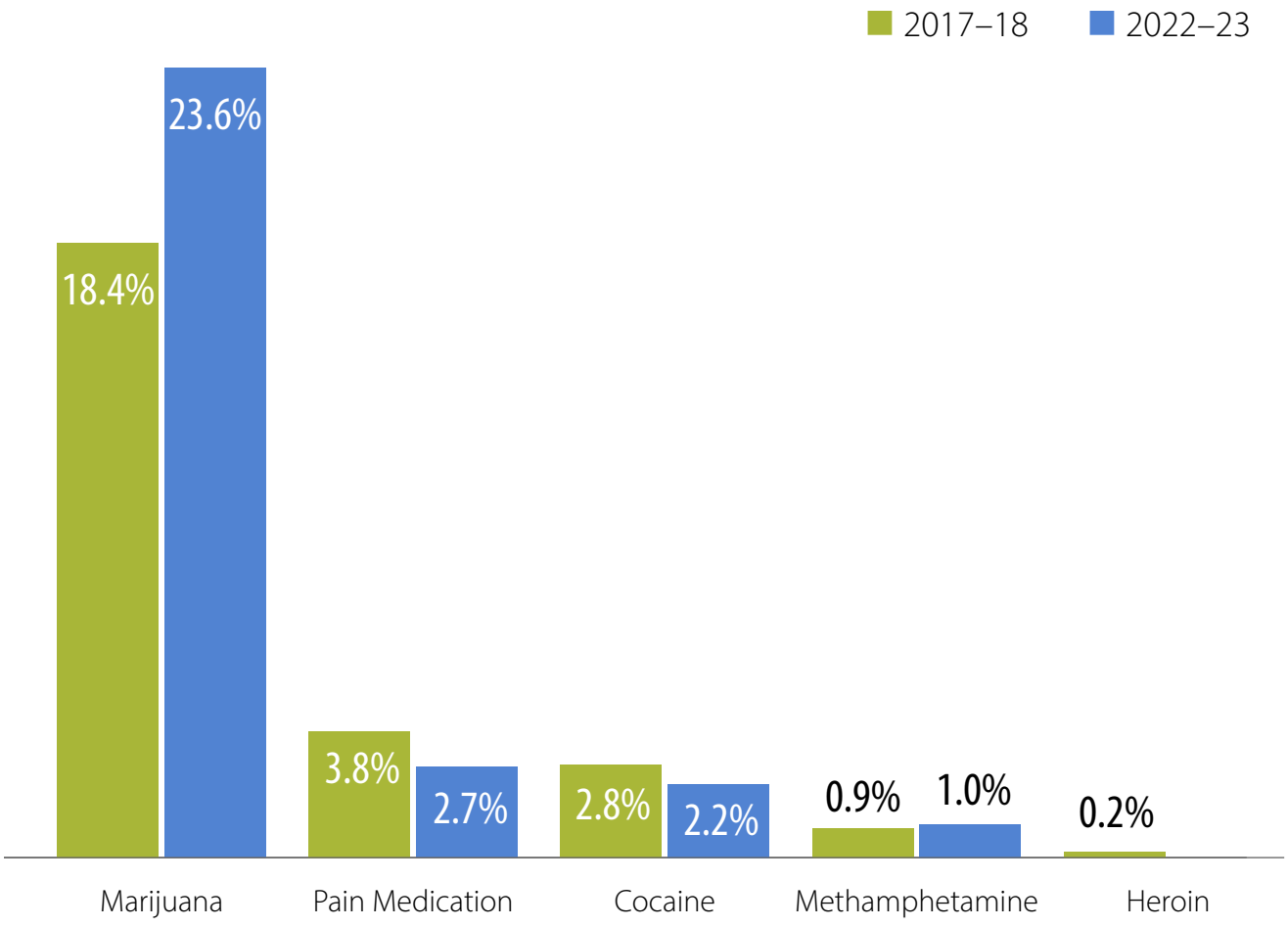
Source: *National Survey on Drug Use and Health* (2022–23), Substance Abuse and Mental Health Services Administration, table 20A.

Marijuana was the most commonly used drug among all age groups. Young adults age 18 to 25 reported marijuana use in the past year at nearly twice the rate of adults age 26 and older. The rate for cocaine use in the past year by young adults was also almost twice the rate of older adults.

Drug Use in the Past Year, by Selected Type

California, 2017–18 and 2022–23

PERCENTAGE OF POPULATION AGE 12 AND OLDER

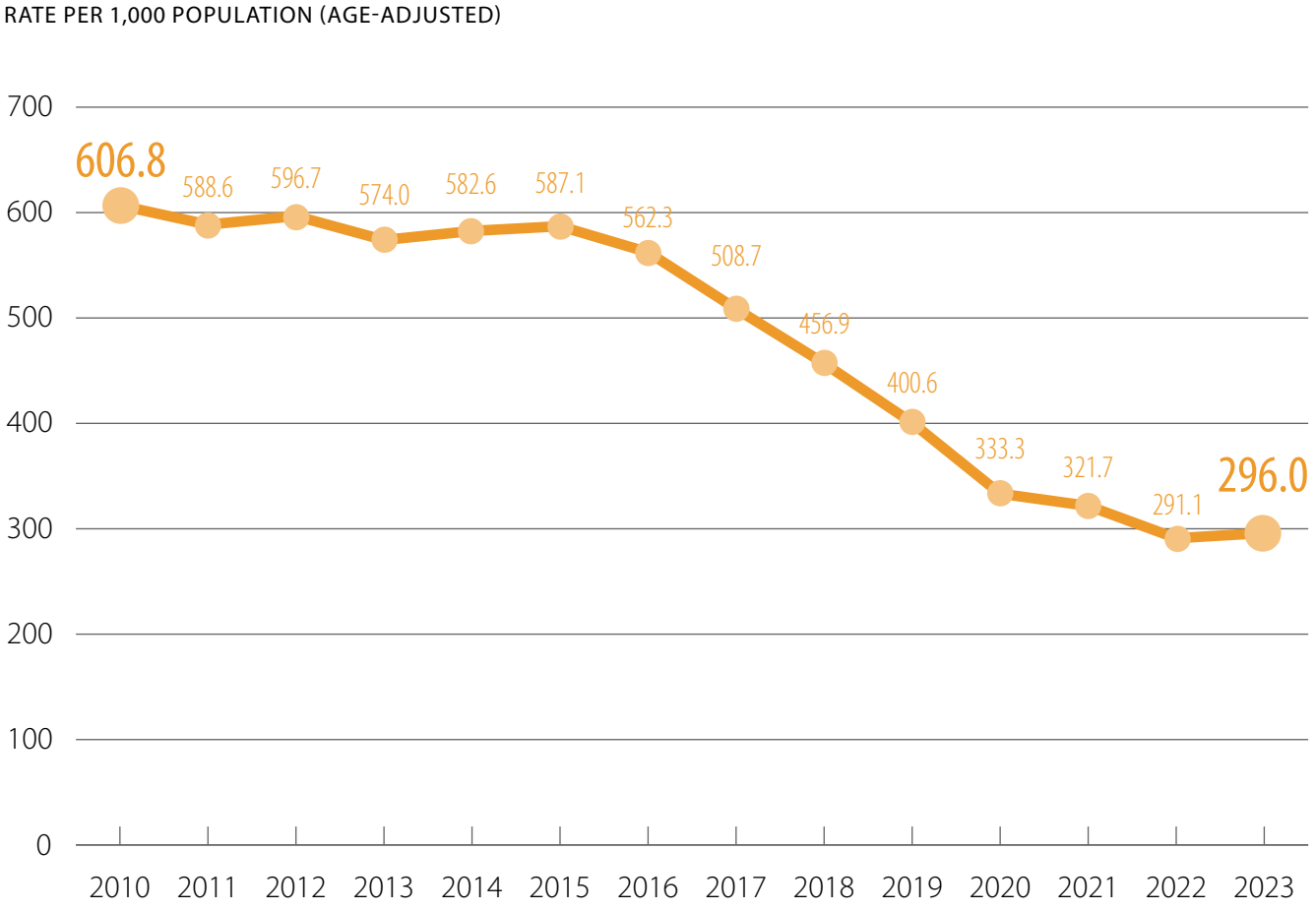


Notes: Data are annual averages. *Pain medication* is *prescription pain reliever misuse* in the source. *Cocaine* includes crack. Data are not available for heroin use among those age 12 and older for 2022–23.

Source: *National Survey on Drug Use and Health* (2017–18, 2022–23), Substance Abuse and Mental Health Services Administration.

Past-year marijuana use increased from 18% in 2018 to 24% in 2023. Marijuana use became legal for Californians age 21 and older in 2018.

Opioid Prescriptions
California, 2010 to 2023



Notes: Relative number of all opioid prescriptions (any quantity) filled at a pharmacy. Based on Q4 12-month rolling rate of each year. Data are limited to Schedule II, III, and IV prescription opioids dispensed to patients and excludes drugs not critical for calculating dosages into morphine milligram equivalents (e.g., decongestants, antitussives, and expectorants) as well as medications for opioid use disorders.

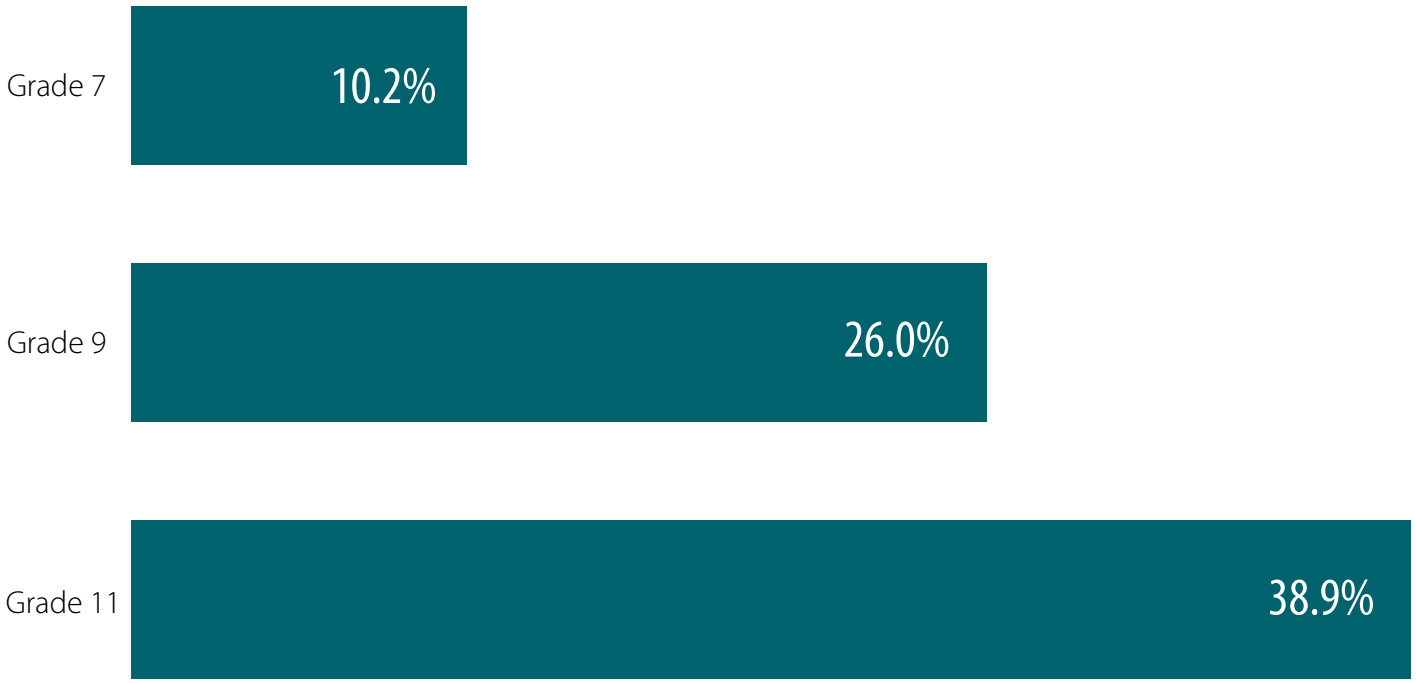
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

The rate of opioid prescriptions in California decreased by 51% between 2010 and 2023. The state has implemented several efforts aimed at reducing the use of prescription opioids, including a prescription drug monitoring program and guidelines for opioid prescribing.

Adolescent Lifetime Alcohol or Drug Use by Grade

California, 2019 to 2021

PERCENTAGE OF PUBLIC SCHOOL STUDENTS WHO USED ALCOHOL OR DRUGS AT LEAST ONCE



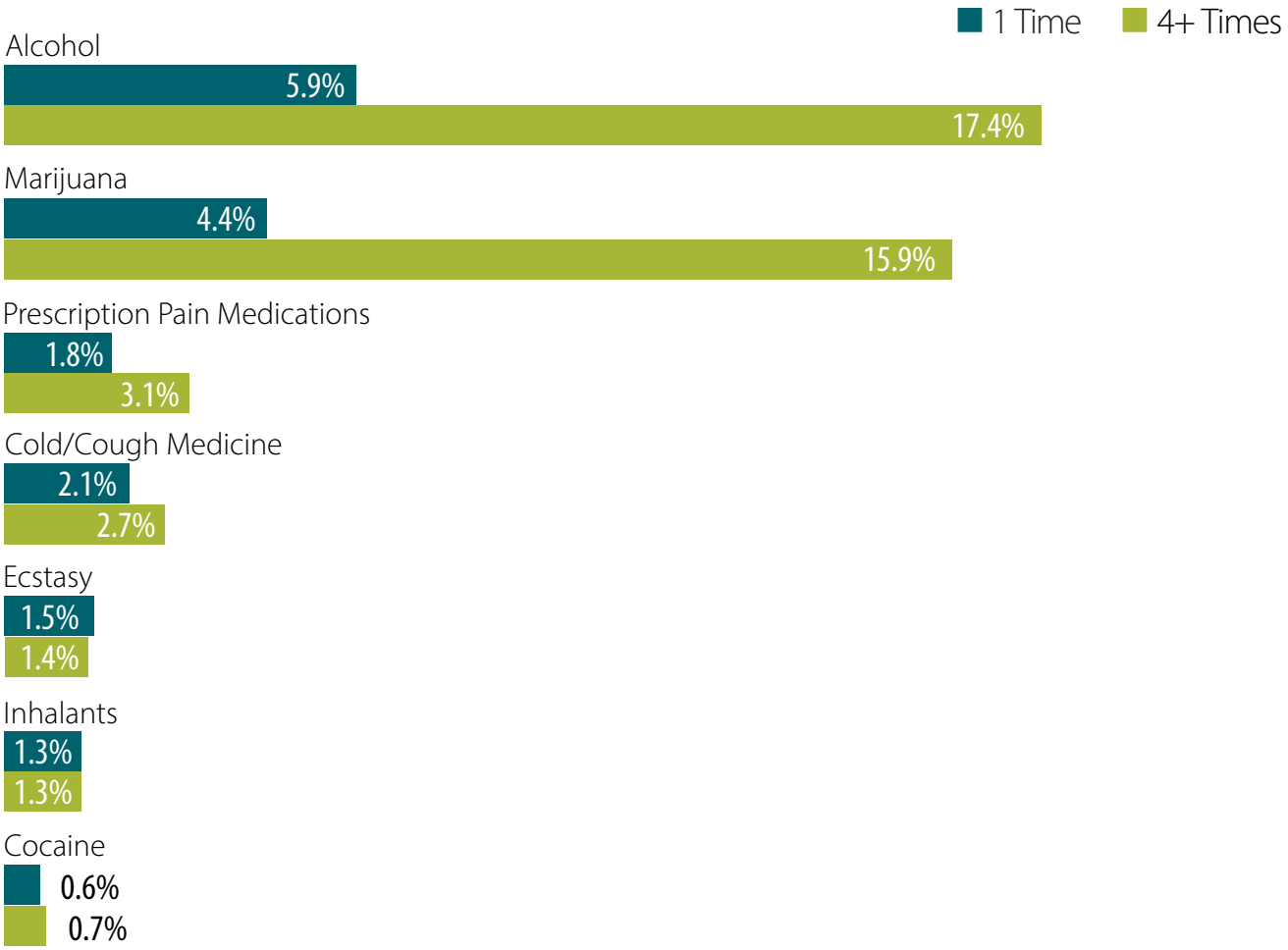
Self-reported use by California students of alcohol or drugs to get high increased dramatically from grade 7 to grade 11. Nearly 40% of high school juniors reported having used alcohol or drugs at least once in their lifetimes.

Note: Includes alcohol; marijuana; inhalants; cocaine, methamphetamines or any other amphetamines; heroin; ecstasy, LSD, or other psychedelics; prescription pain medication, opioids, tranquilizers, or sedatives; diet pills, or other prescription stimulants; cold/cough medicines or other over-the counter medicines to get high; and any other drug, pill, or medicine to get high.

Source: Gregory Austin et al., *School Climate and Student Engagement and Well-Being in California, 2019–21: Results of the Eighteenth Biennial State California Healthy Kids Survey, Grades 7, 9, and 11* (PDF), WestEd, 2023, table A6.1.

Lifetime Use of Substances, 11th Grade Students by Number of Times Used, California, 2019 to 2021

PERCENTAGE OF 11TH GRADE PUBLIC SCHOOL STUDENTS



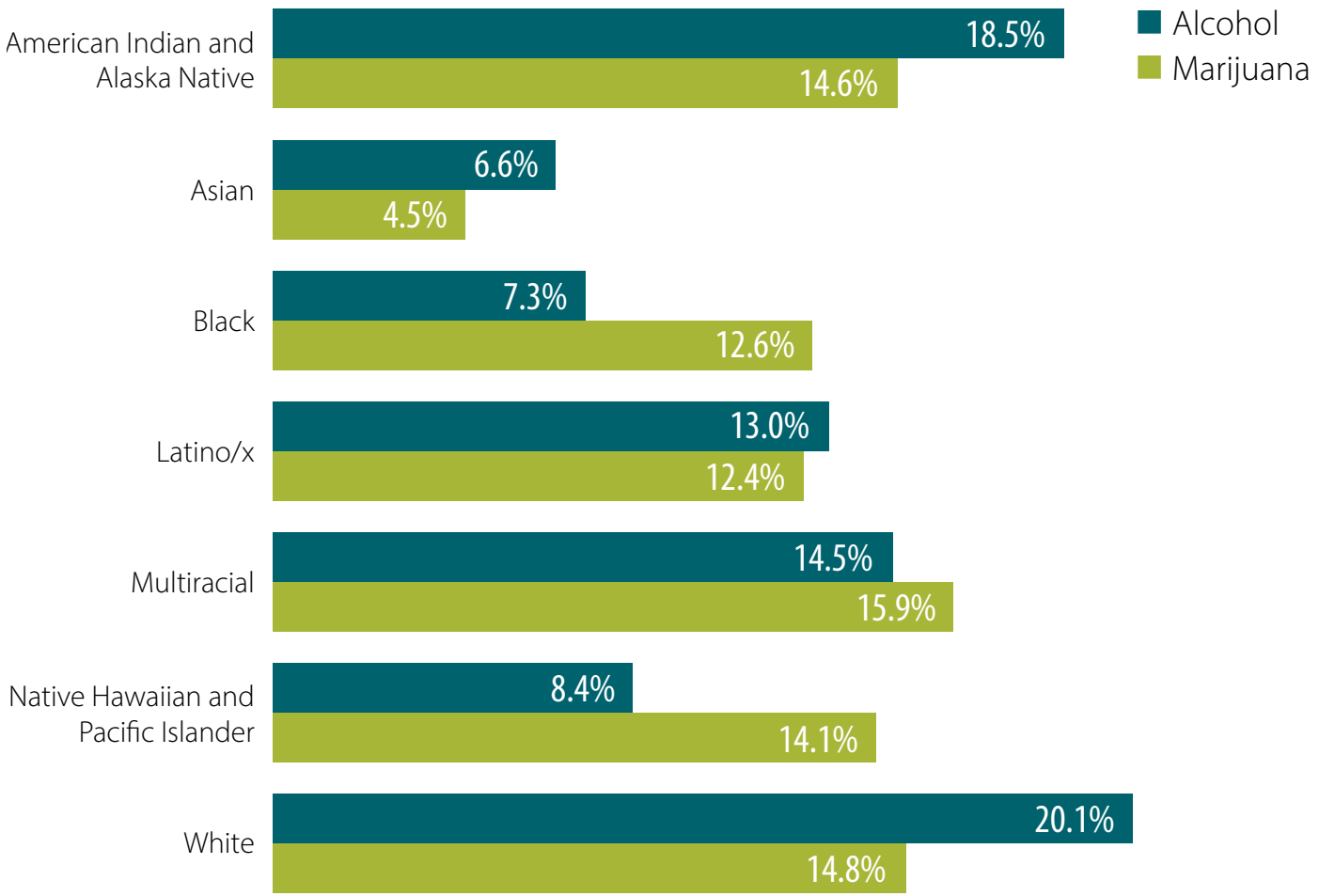
Notes: *Cold/cough medicine* and *prescription pain medications* are percentage of students who indicated they used substances to get high or for other-than-medical reasons. *Prescription pain medications* includes opioids, tranquilizers, and sedatives. *Cold/cough medicine* includes other over-the-counter medicines. *Ecstasy* includes LSD and other psychedelics. *Cocaine* includes methamphetamines or any other amphetamines.

Source: Gregory Austin et al., *School Climate and Student Engagement and Well-Being in California, 2019–21: Results of the Eighteenth Biennial State California Healthy Kids Survey, Grades 7, 9, and 11* (PDF), WestEd, 2023, table A6.3.

Alcohol and marijuana were the most frequently used substances among 11th graders in California. One in six reported having used alcohol or marijuana four or more times.

Alcohol and Marijuana Use in Past 30 Days, 11th Grade Students, by Race/Ethnicity, California, 2019 to 2021

PERCENTAGE OF 11TH GRADE PUBLIC SCHOOL STUDENTS WHO USED ALCOHOL AND MARIJUANA IN THE PAST 30 DAYS



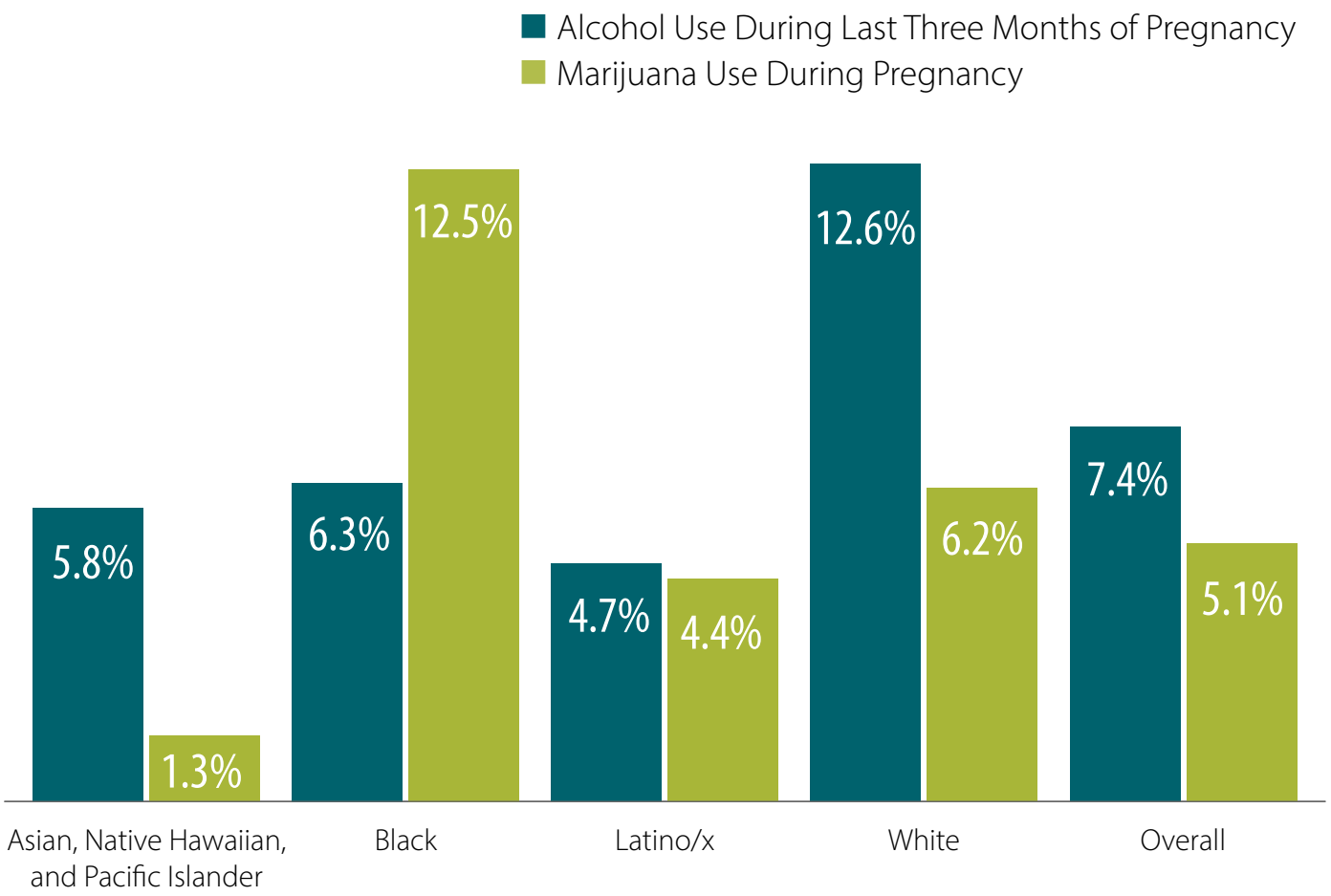
Note: Source uses *Black or African American*, *Hispanic or Latino*, and *Mixed (two or more races)*.

Source: Gregory Austin et al., *School Climate and Student Engagement and Well-Being in California, 2019–21: Results of the Eighteenth Biennial State California Healthy Kids Survey, Grades 7, 9, and 11* (PDF), WestEd, 2023, tables A9.3 and A9.4.

In California, one in five White high school juniors reported drinking alcohol in the last 30 days. With the exception of Asian students, at least 12% of students of all other racial/ethnic groups reported past-month use of marijuana.

Alcohol and Marijuana Use During Pregnancy by Race/Ethnicity, California, 2019 to 2021

PERCENTAGE OF BIRTHING PEOPLE WITH A LIVE BIRTH



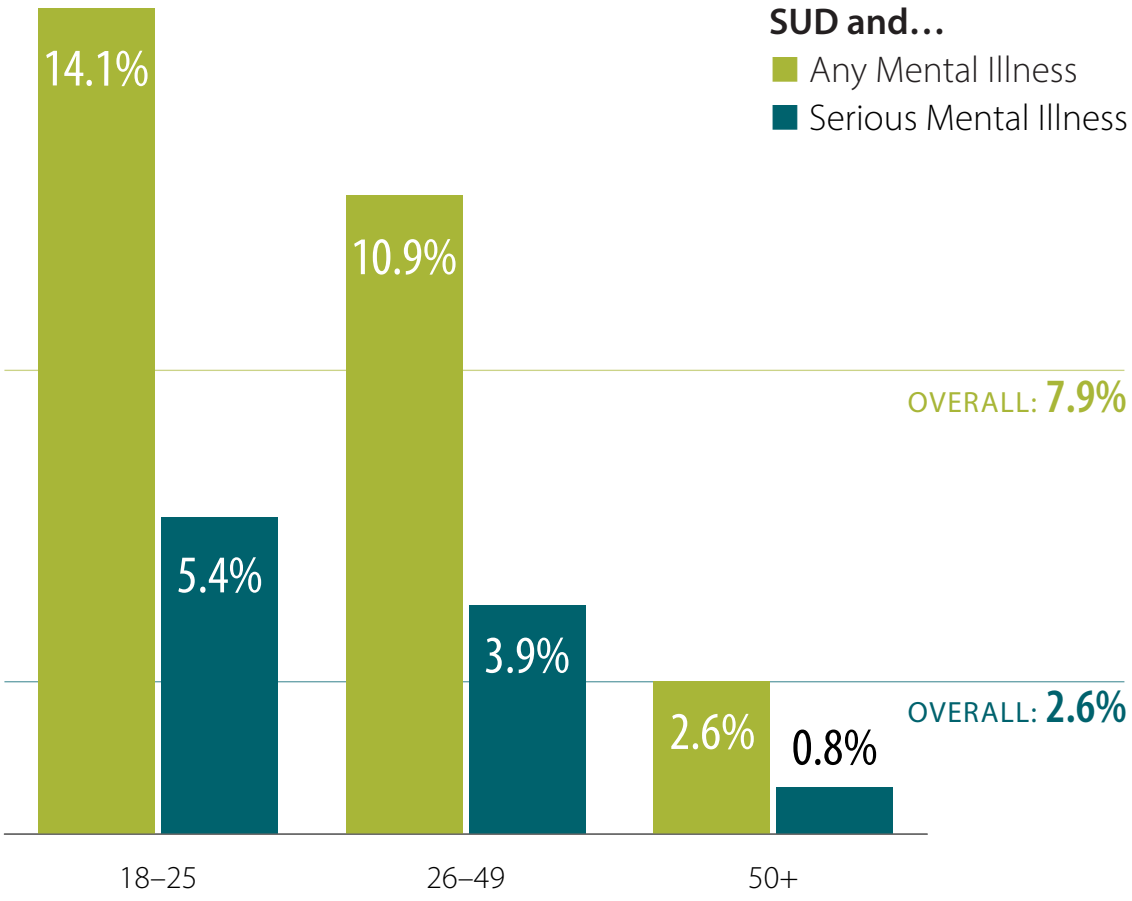
Notes: *Birthing people* is used to recognize that not all people who become pregnant and give birth identify as women or mothers. Data from a population-based survey of 18,533 California residents with a live birth in 2019 to 2021. Data are weighted to represent all California residents with a live birth in California. Source uses *Asian / Pacific Islander* and *Hispanic*.

Source: Maternal and Infant Health Assessment (2019–21), California Department of Public Health, 2024.

One in eight White birthing people reported alcohol use during the last three months of pregnancy, while one in eight Black birthing people reported marijuana use during pregnancy.

Substance Use Disorder and Mental Illness in Adults by Age Group, United States, 2023

PERCENTAGE OF POPULATION WITH A CO-OCCURRING SUBSTANCE USE DISORDER IN THE PAST YEAR



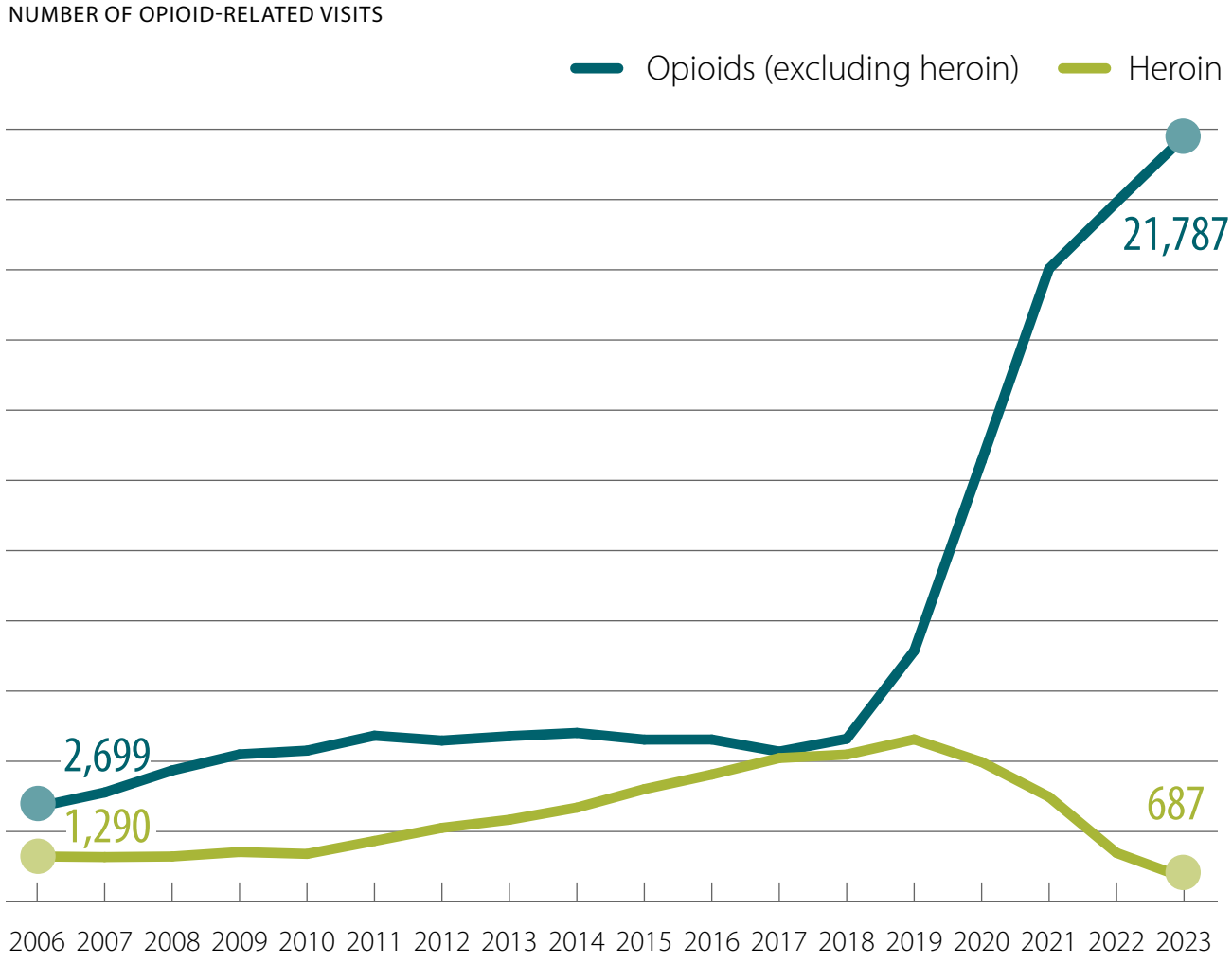
Notes: *SUD* is substance use disorder. *Any mental illness* is defined as adults 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder, regardless of the level of impairment in carrying out major life activities. *Serious mental illness* is defined as adults 18 or older who currently or at any time in the past year have had a mental illness that resulted in substantial impairment in carrying out major life activities.

Source: *National Survey on Drug Use and Health Detailed Tables* (2023), Substance Abuse and Mental Health Services Administration, tables 6.10B and 6.13B.

In the US, 8% of adults had both a substance use disorder and any mental illness during the past year, and 3% had both a substance use disorder and a serious mental illness. Adults age 18 to 25 had higher rates of these co-occurring conditions than adults in other age groups.

Nonfatal ED Visits for Opioids

California, 2006 to 2023



Note: Based on the Q4 12-month rolling rate of each year. *Nonfatal ED visits* are emergency department visits caused by nonfatal acute poisonings due to the effects of opioid drugs regardless of intent (e.g., suicide, unintentional, or undetermined).

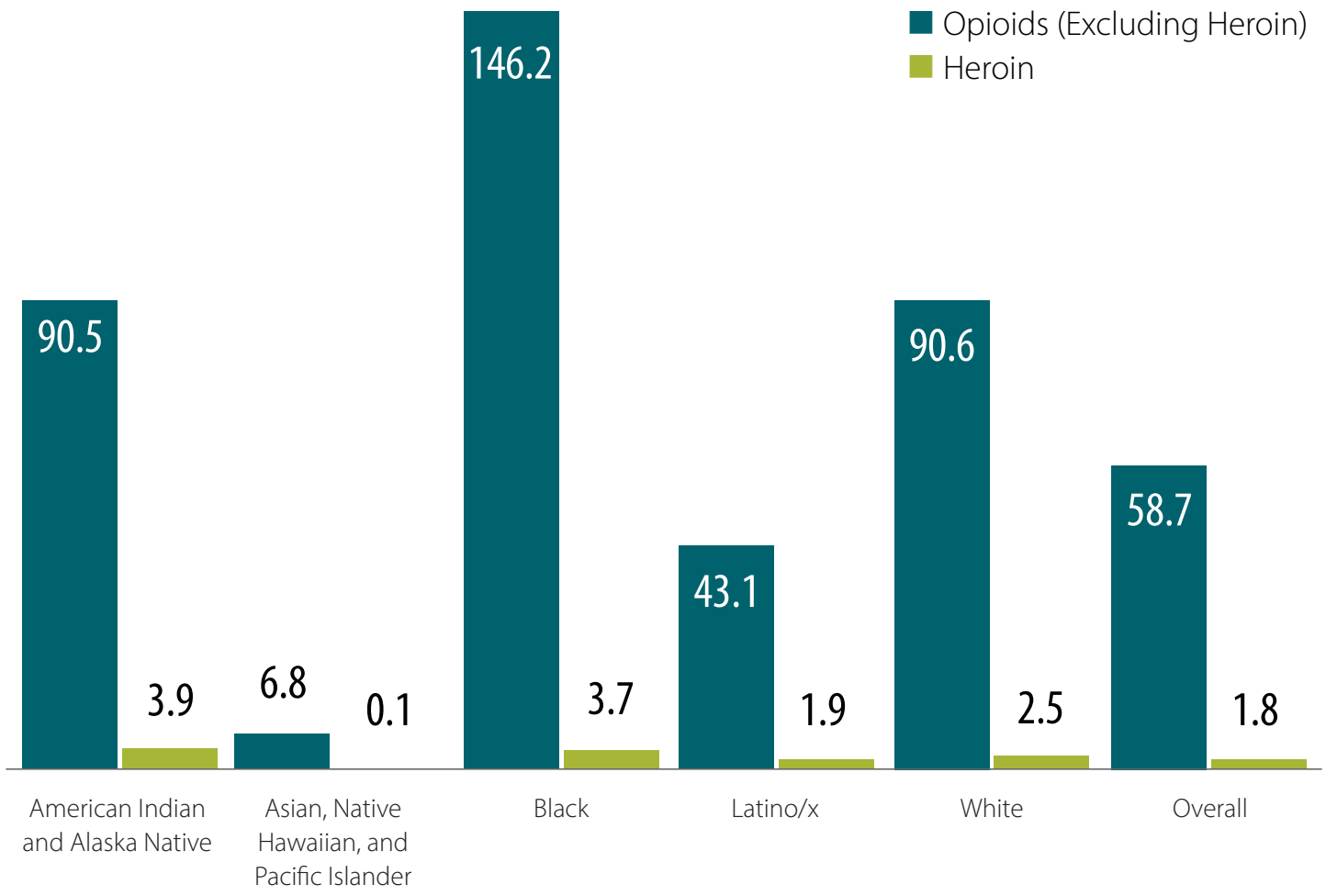
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Substance Use
Emergency Department Visits

Opioid emergency department (ED) visits were relatively stable from 2006 to 2018. Between 2019 and 2023 the number of heroin-related ED visits in California decreased by 85%, while non-heroin opioid ED visits tripled. Much of this increase may be due to fentanyl-related ED visits, which rose by over 70% from 2021 to 2023 (not shown).

Nonfatal ED Visits for Opioids
by Race/Ethnicity, California, 2023

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



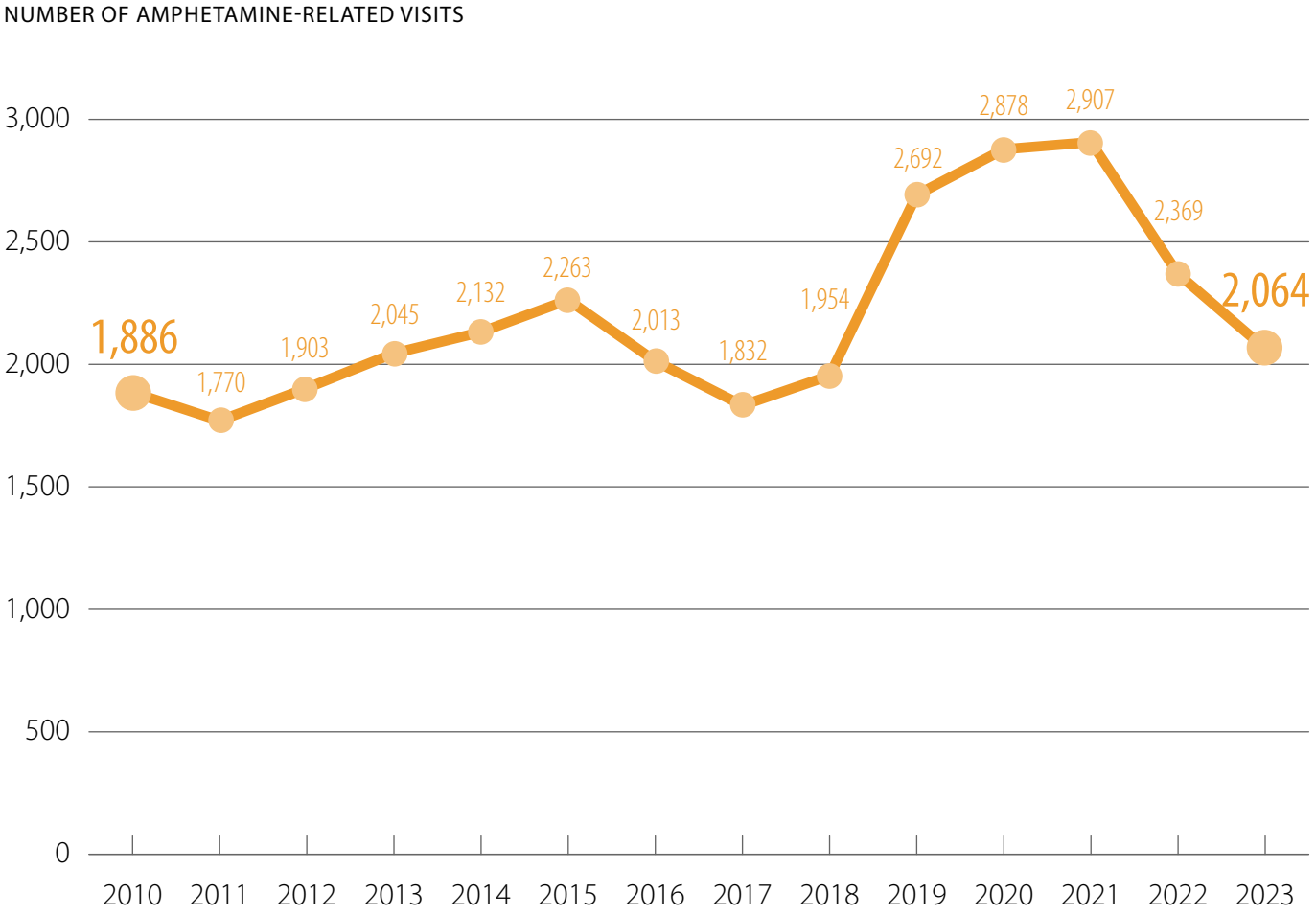
Notes: *Nonfatal ED visits* are emergency department visits caused by nonfatal acute poisonings due to the effects of opioid drugs regardless of intent (e.g., suicide, unintentional, or undetermined). Source uses *Asian / Pacific Islander, Black / African American, Hispanic,* and *Native American / Alaska Native*.

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Black Californians had the highest rate of nonfatal emergency department visits for opioids excluding heroin. American Indian and Alaska Native and Black Californians had the highest rates of nonfatal emergency department visits for heroin.

Nonfatal ED Visits for Amphetamines

California, 2010 to 2023



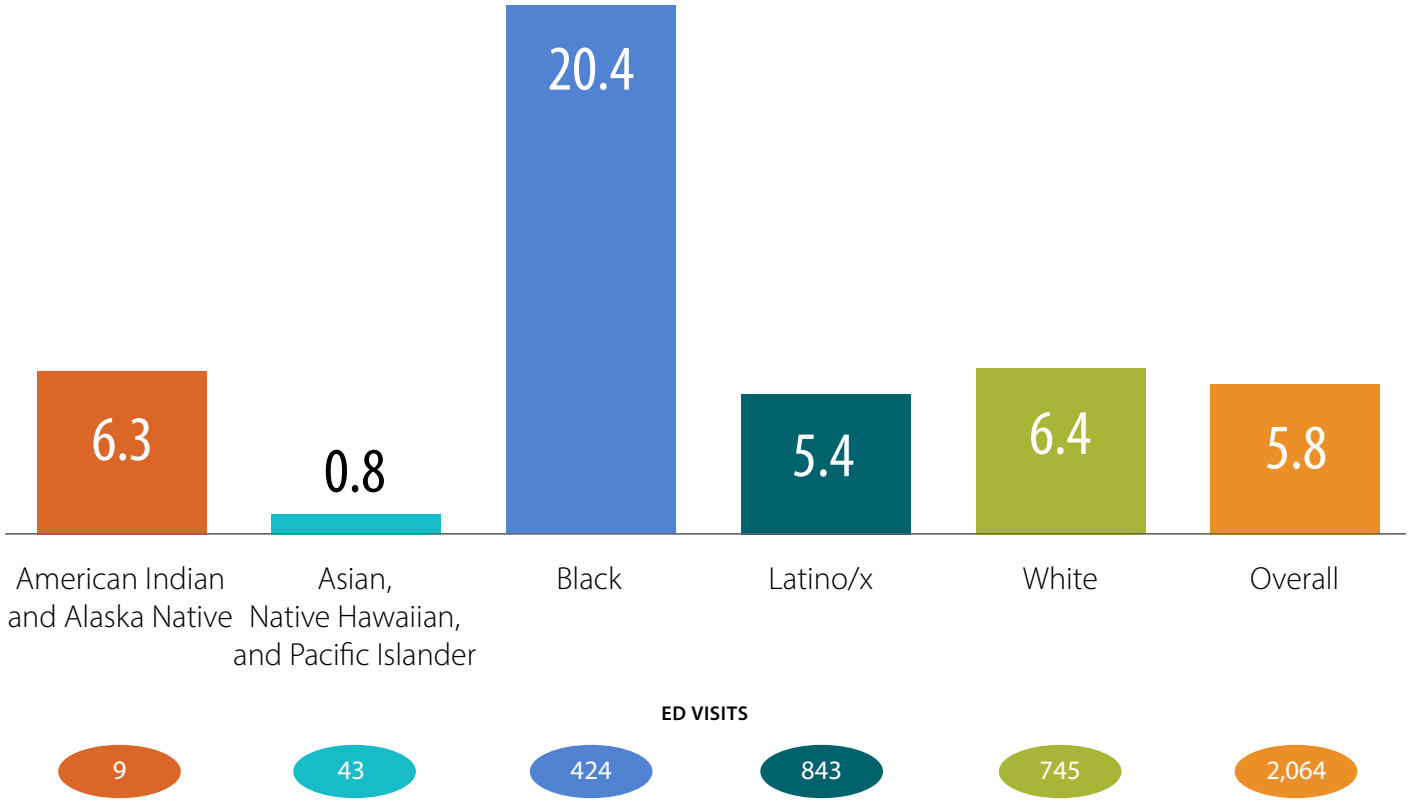
Notes: Based on the Q4 12-month rolling rate of each year. *Nonfatal ED visits* are emergency department visits caused by nonfatal acute poisonings due to the effects of amphetamines (such as methamphetamine), regardless of intent (e.g., suicide, unintentional, or undetermined).

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

The number of nonfatal amphetamine-related emergency department visits in California rose between 2018 and 2021 before decreasing 29% between 2021 and 2023.

Nonfatal ED Visits for Amphetamines by Race/Ethnicity
California, 2023

PER 100,000 POPULATION (AGE-ADJUSTED)

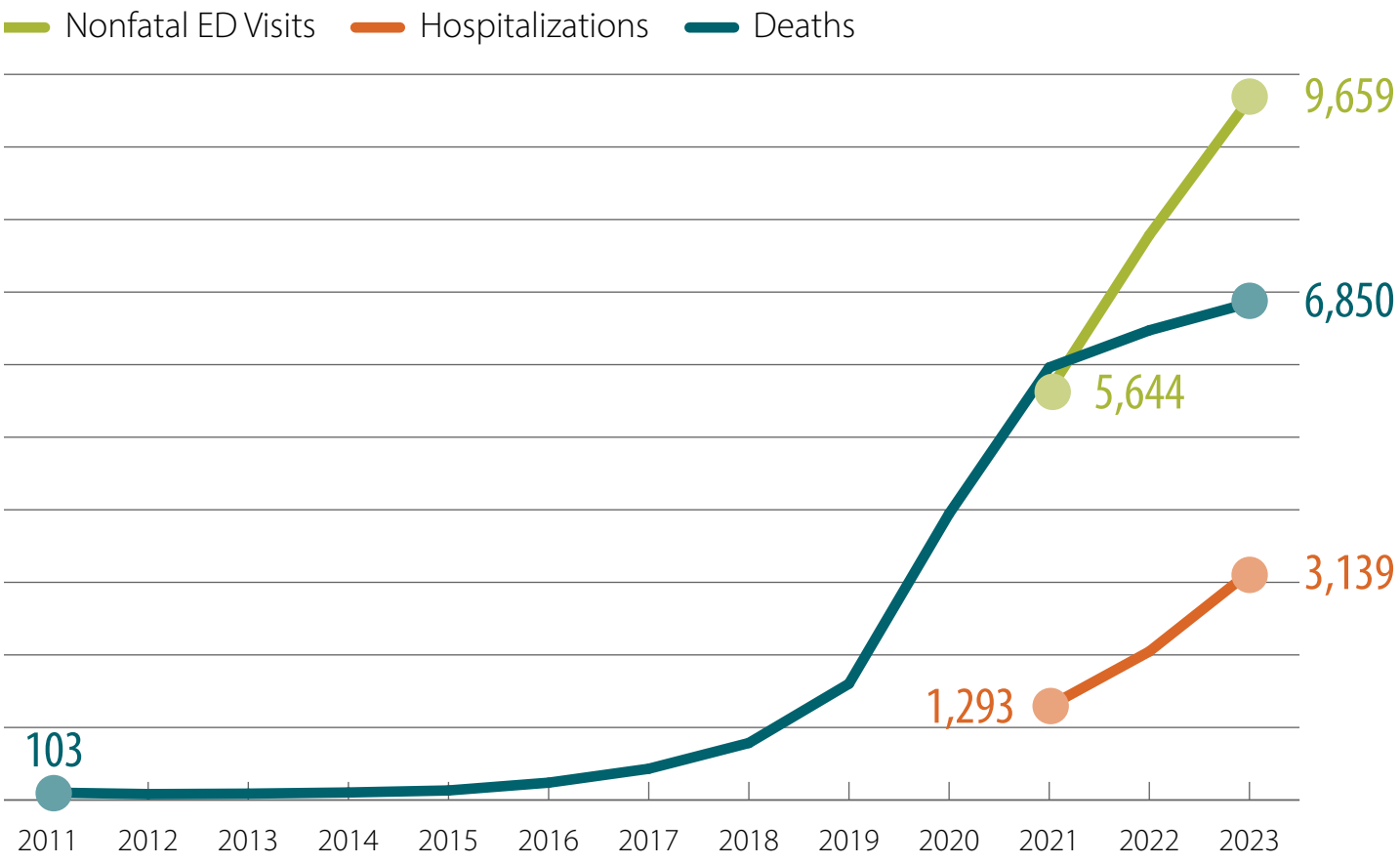


Notes: *Nonfatal ED visits* are emergency department visits caused by nonfatal acute poisonings due to the effects of amphetamines regardless of intent (e.g., suicide, unintentional, or undetermined). Source uses *Asian / Pacific Islander, Black / African American, Hispanic*, and *Native American / Alaska Native.*

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

While the rate of amphetamine-related nonfatal emergency department visits for Black Californians was nearly four times the rate for the state, Latino/x Californians accounted for 41% of all visits and White Californians accounted for 36%.

Fentanyl-Related Nonfatal ED Visits, Hospitalizations, and Deaths, California, 2011 to 2023



Notes: Based on the Q4 12-month rolling rate of each year. *Deaths* are acute poisoning deaths with fentanyl or fentanyl analogs listed as a contributing cause of death. *Nonfatal ED visits* are emergency department visits, and *hospitalizations* are hospitalizations caused by nonfatal acute poisonings due to the effects of fentanyl or fentanyl analogues regardless of intent (e.g., suicide, unintentional, or undetermined). Data for fentanyl-related hospitalizations and nonfatal ED visits became available starting in 2021.

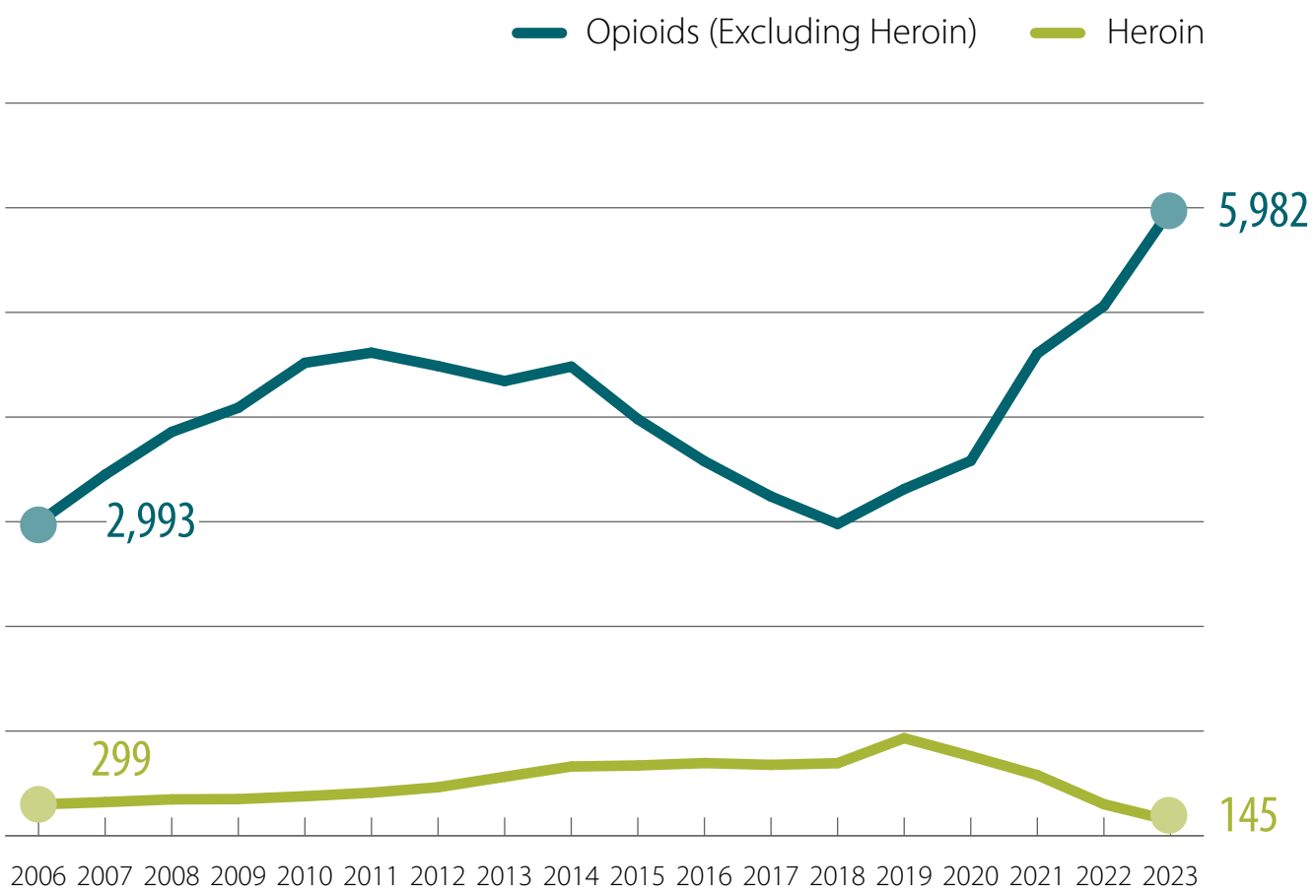
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Between 2019 and 2023, fentanyl-related overdose deaths in California quadrupled. Hospitalizations and ED visits related to fentanyl and fentanyl analogues have increased since 2021.

Opioid Hospitalizations

California, 2006 to 2023

NUMBER OF OPIOID HOSPITALIZATIONS



The number of hospitalizations caused by nonfatal acute poisonings due to the effects of opioids (excluding heroin) doubled between 2006 and 2023. The increase is likely driven by an increase in fentanyl use (not shown).

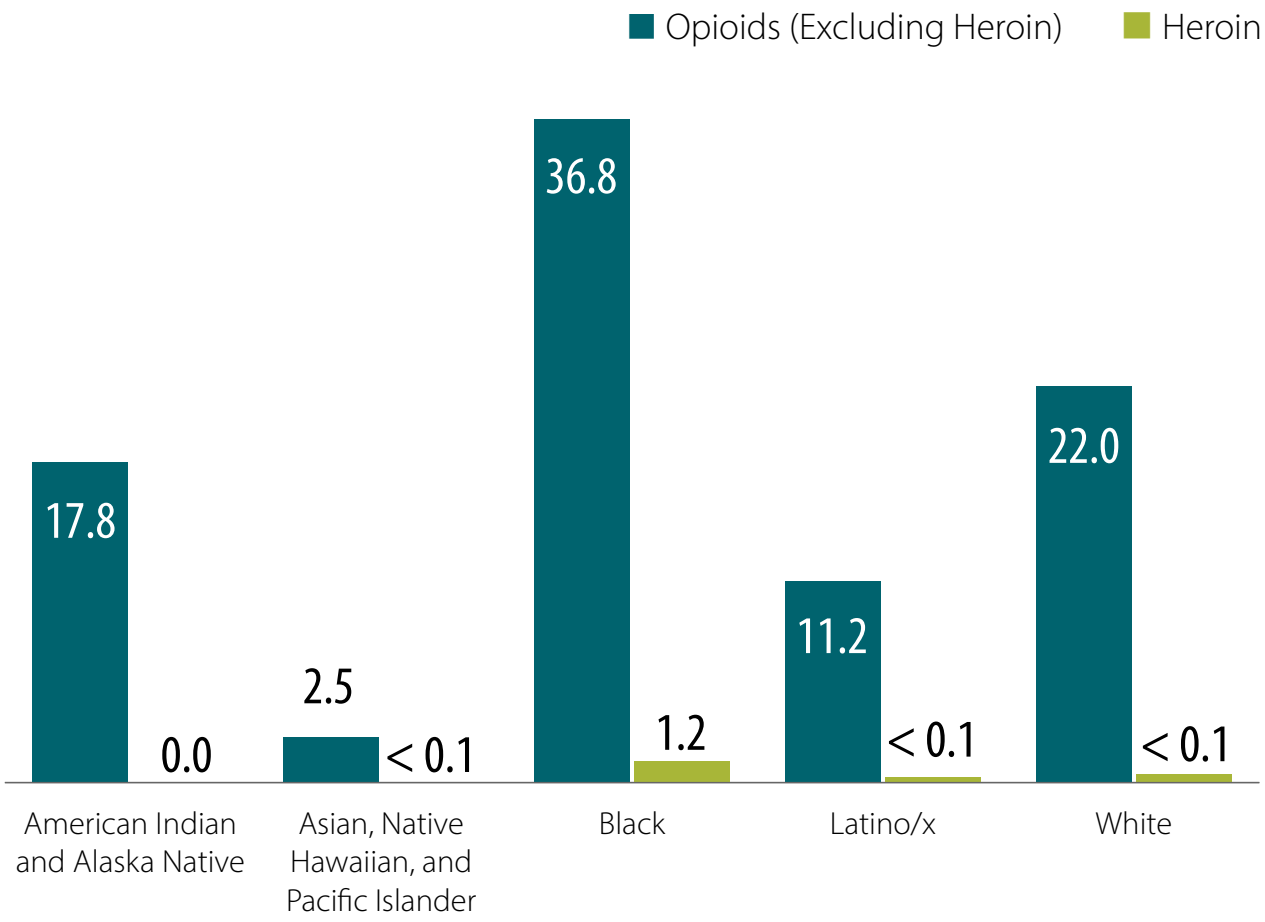
Notes: *Hospitalizations* are hospitalizations caused by nonfatal acute poisonings due to the effects of all opioid drugs regardless of intent (e.g., suicide, unintentional, or undetermined). Hospitalizations related to late effects, adverse effects, and chronic poisonings due to the effects of drugs (e.g., damage to organs from long-term drug use) are excluded.

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Opioid Hospitalizations by Race/Ethnicity

California, 2023

AGE-ADJUSTED RATE PER 100,000 POPULATION



Notes: *Hospitalizations* are hospitalizations caused by nonfatal acute poisonings due to the effects of all opioid drugs regardless of intent (e.g., suicide, unintentional, or undetermined). Hospitalizations related to late effects, adverse effects, and chronic poisonings due to the effects of drugs (e.g., damage to organs from long-term drug use) are excluded. Source uses *Asian / Pacific Islander, Black / African American, Hispanic,* and *Native American / Alaska Native.*

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

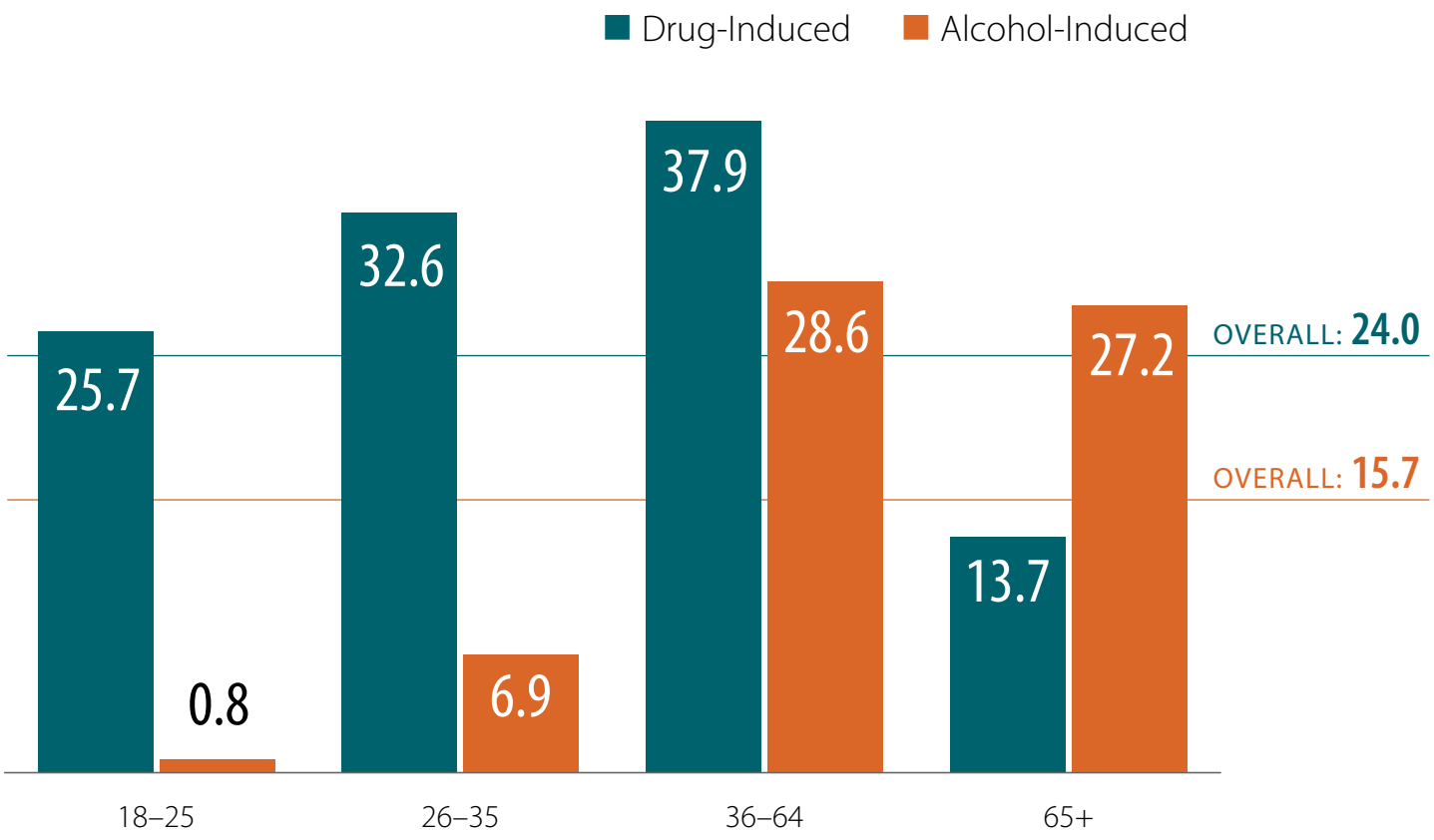
Black Californians had the highest rate of opioid-related hospitalizations in 2023 and experienced the highest percentage increase of all groups from 2018 to 2023 (222%, not shown).

Drug- and Alcohol-Induced Deaths by Age Group

California, 2020

In 2020, both drug- and alcohol-induced death rates were highest for adults age 36 to 64.

RATE PER 100,000 POPULATION

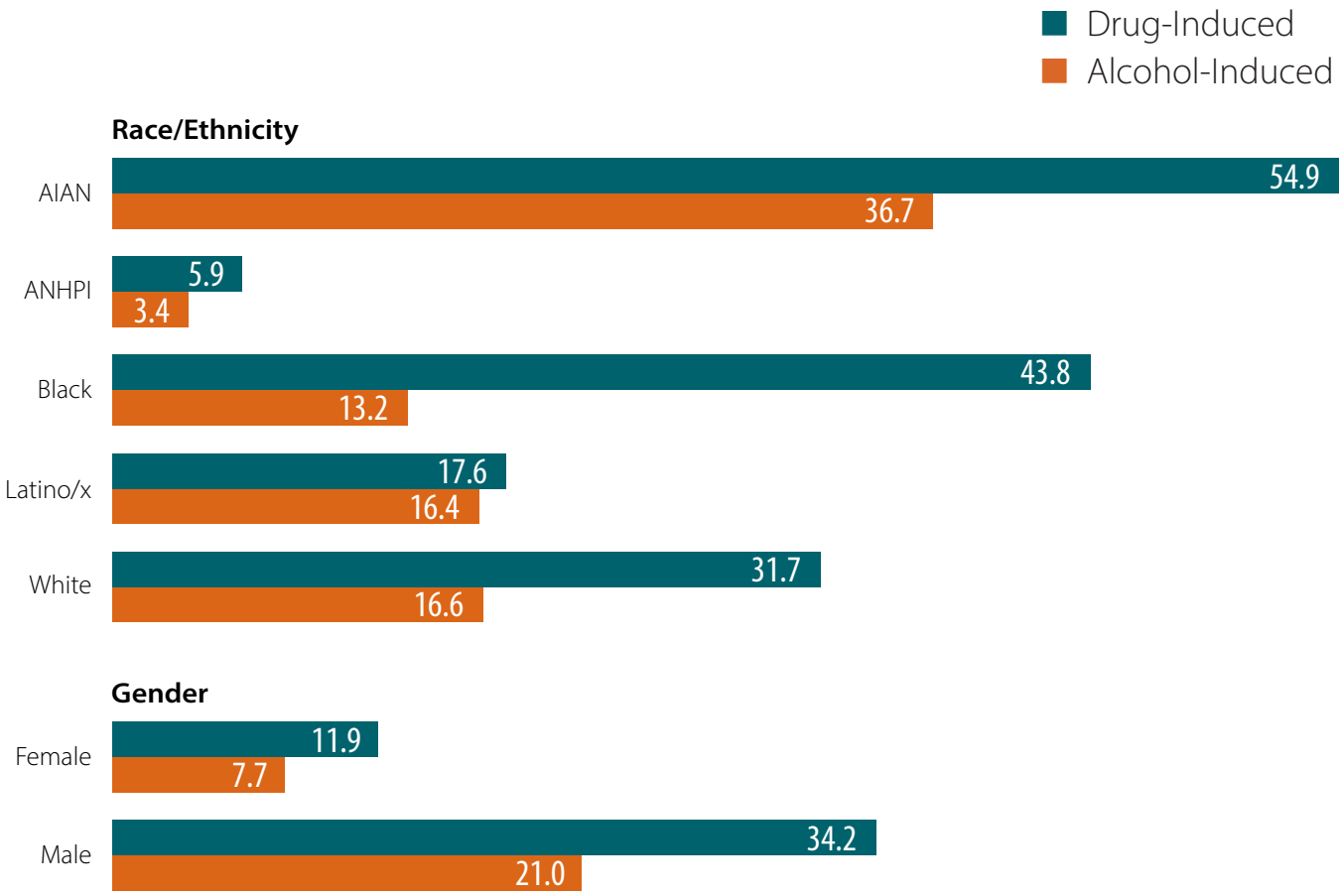


Notes: Data come from registered death certificates. Excludes deaths when age not indicated. *Drug-induced* includes drug poisonings (overdoses) with ICD-10 codes that cover unintentional, suicide, homicide, and undetermined poisoning. *Alcohol-induced* includes accidental or intended poisoning, in addition to other conditions directly induced by use of alcohol.

Source: "Underlying Cause of Death, 1999–2020," US Centers for Disease Control and Prevention.

Drug- and Alcohol-Induced Deaths by Race/Ethnicity and Gender, California, 2020

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



Notes: Includes all ages. Excludes deaths when age not indicated. *AIAN* is American Indian and Alaska Native; *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. *Latino/x* data include those who selected any of the race/ethnicity categories. Source used *Asian or Pacific Islander, Black or African American, Hispanic or Latino*. All other race/ethnicity categories are those who selected "Not Hispanic or Latino." Data come from registered death certificates. *Drug-induced* includes all drug overdoses under ICD-10 codes for unintentional deaths, suicide, homicide, and undetermined poisonings. *Alcohol-induced* includes accidental or intended poisoning in addition to other conditions directly induced by use of alcohol.

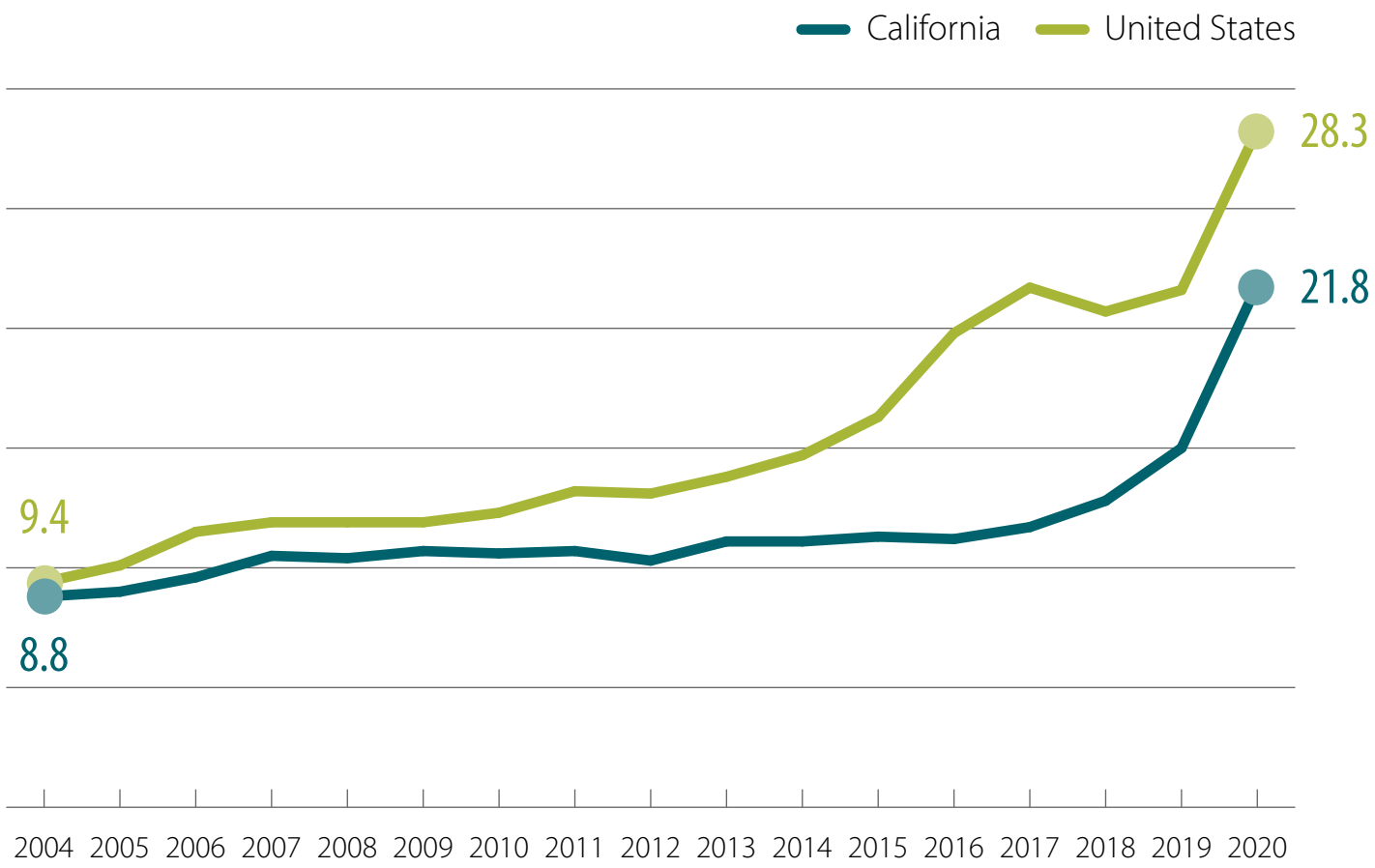
Source: "Underlying Cause of Death, 1999-2020," US Centers for Disease Control and Prevention.

The rates of both alcohol- and drug-induced deaths were nearly three times higher among males than females. Drug- and alcohol-induced death rates differed considerably by race/ethnicity, with American Indian and Alaska Native Californians having the highest rates and Asian, Native Hawaiian, and Pacific Islander Californians having the lowest.

Drug Overdose Deaths

California vs. United States, 2004 to 2020

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



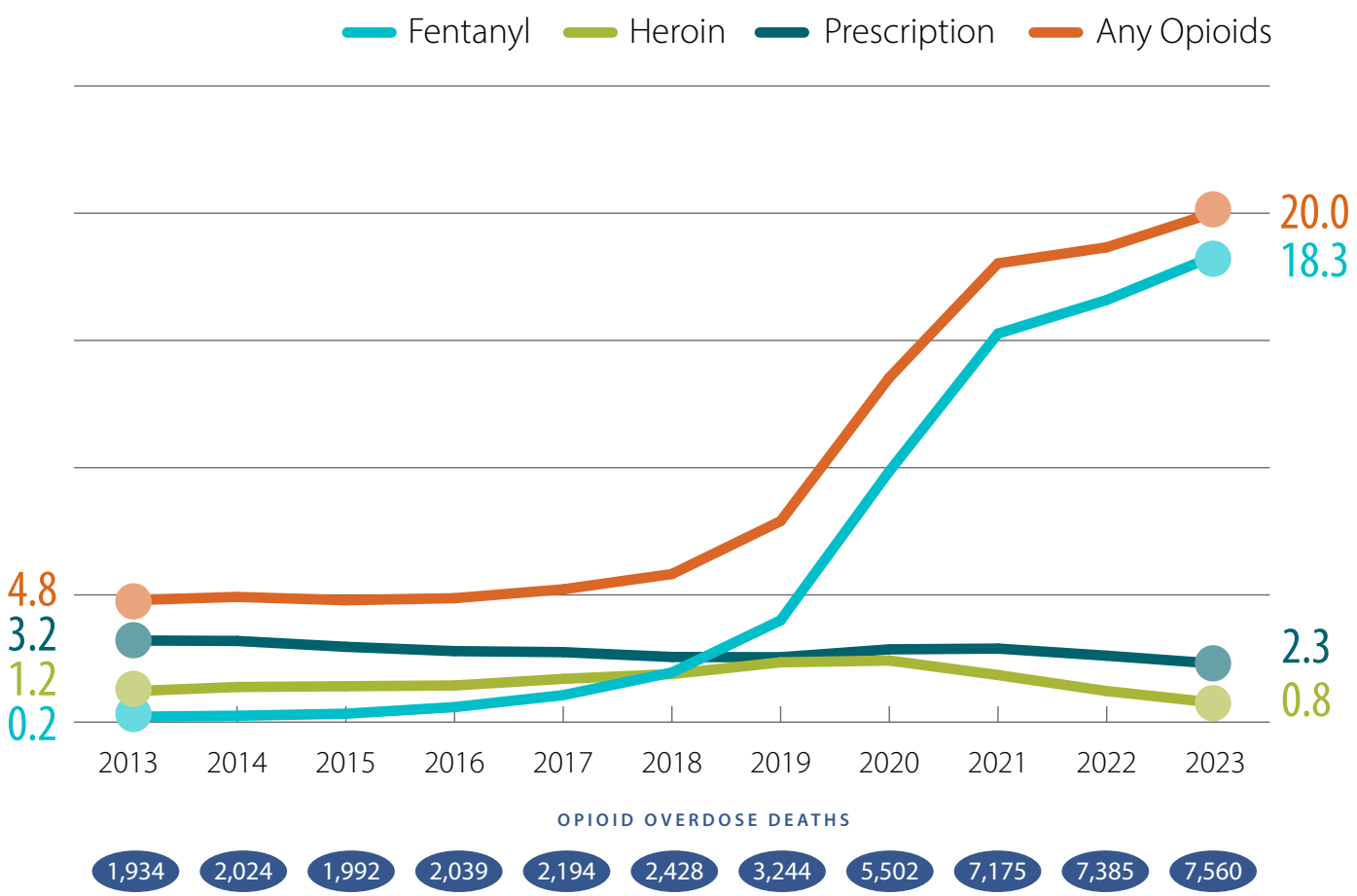
In California and nationally, the drug overdose death rate has more than doubled since 2004. In California, there were 8,908 drug overdose deaths in 2020, up from 3,125 in 2004 (not shown). California's drug overdose death rate has been lower than the national rate since 2004.

Notes: Deaths are classified using the International Classification of Diseases, 10th Revision (ICD–10). *Drug overdose deaths* are defined as having ICD–10 underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent).

Source: "Underlying Cause of Death, 1999–2020," US Centers for Disease Control and Prevention.

Opioid Overdose Deaths by Opioid Type
California, 2013 to 2023

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



Notes: Deaths are acute poisoning deaths regardless of intent (e.g., unintentional, suicide, assault, or undetermined) and exclude deaths related to chronic use of drugs. Fentanyl is a strong synthetic opioid that may be prescribed or obtained illegally. *Fentanyl* is acute poisoning deaths involving fentanyl or fentanyl analogs. *Heroin* is acute poisoning deaths involving heroin. *Prescription* is acute poisoning deaths involving prescribed opioid pain relievers such as hydrocodone, oxycodone, and morphine; it includes methadone and excludes synthetic opioids such as fentanyl. *Any opioids* is acute poisonings deaths involving opioids such as prescription opioid pain relievers, heroin, and opium.

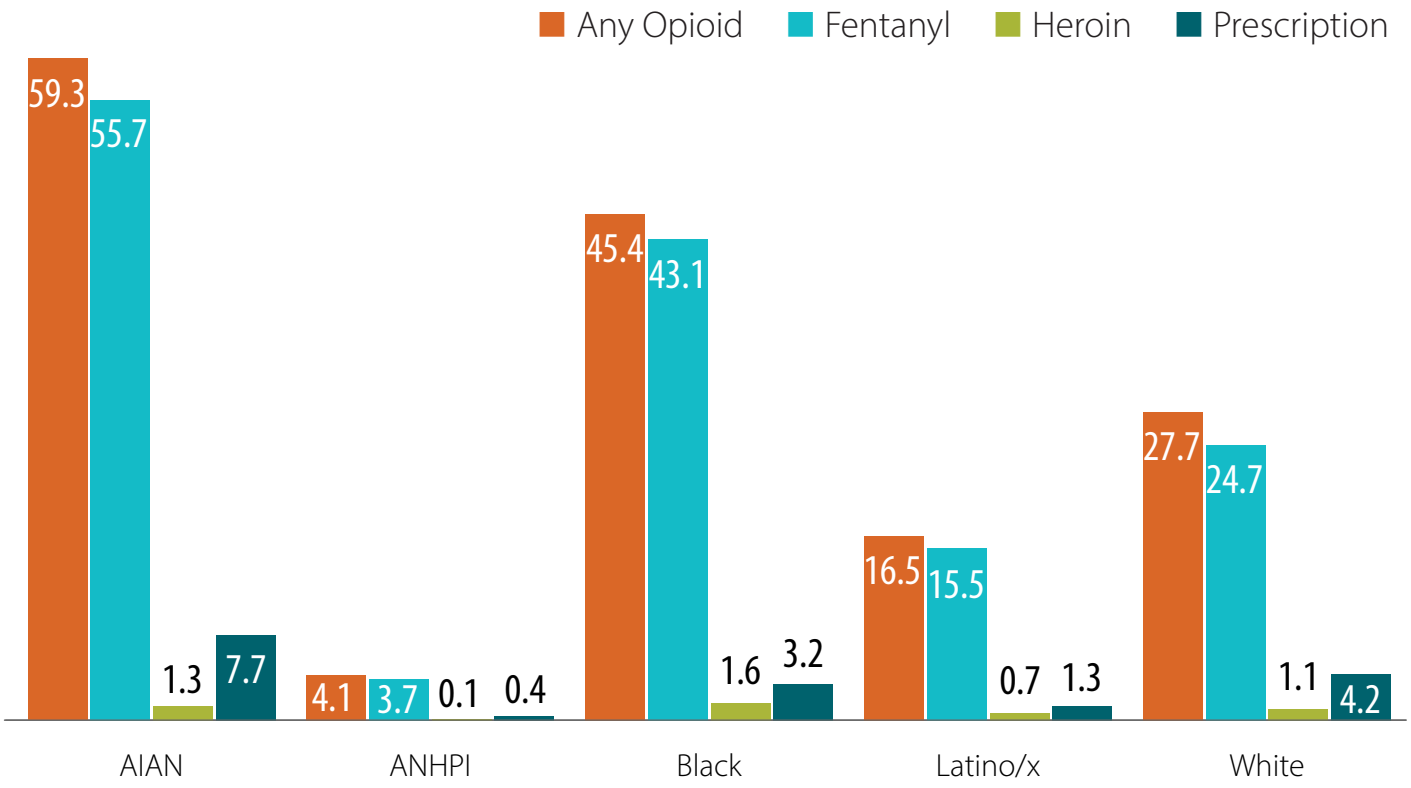
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

In 2023, 7,560 Californians died from an opioid-related overdose. The death rate per 100,000 population from fentanyl increased from 0.2 deaths in 2013 to 18.3 deaths in 2023. The rate of deaths from heroin and prescriptions have remained relatively steady across these years.

Opioid Overdose Deaths by Race/Ethnicity

California, 2023

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



Notes: Deaths are acute poisoning deaths, regardless of intent (e.g., unintentional, suicide, assault, or undetermined) and exclude deaths related to chronic use of drugs. *Fentanyl* is acute poisoning deaths involving fentanyl or fentanyl analogs. *Heroin* is acute poisoning deaths involving heroin. *Prescription* is acute poisoning deaths involving prescribed opioid pain relievers such as hydrocodone, oxycodone, and morphine; it includes methadone and excludes synthetic opioids such as fentanyl. *Any opioid* is acute poisonings deaths involving opioids such as prescription opioid pain relievers, heroin, and opium. *AIAN* is American Indian and Alaska Native; *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. Source uses *Asian / Pacific Islander, Black / African American, Hispanic,* and *Native American / Alaska Native*.

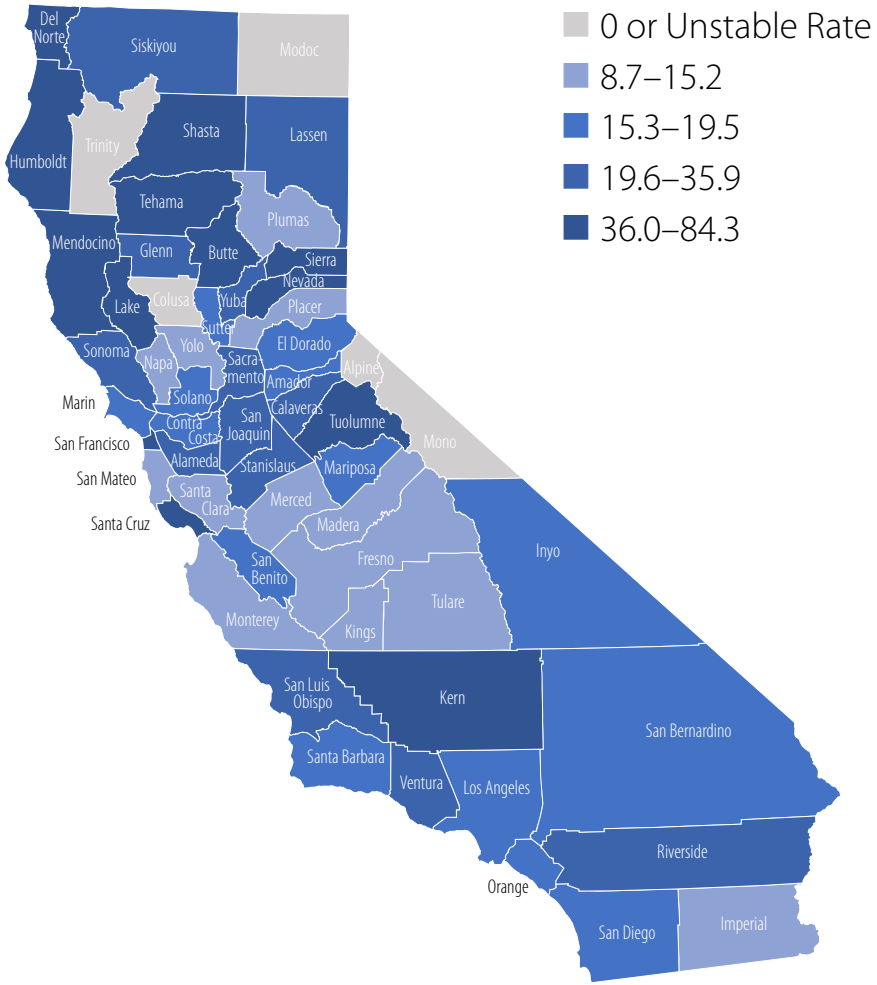
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Substance Use
Deaths

In 2023, American Indian and Alaska Native Californians had the highest rate of opioid overdose deaths followed by Black Californians. The overdose death rate for fentanyl was higher than the rate for heroin and prescription opioids for all racial and ethnic groups.

Opioid Overdose Deaths by County
California, 2023

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



Notes: Deaths related to chronic use of drugs are excluded. *Opioid* is overdose deaths caused by acute poisonings that involve any opioid as a contributing cause of death regardless of intent and includes prescription opioids as well as heroin and opium.

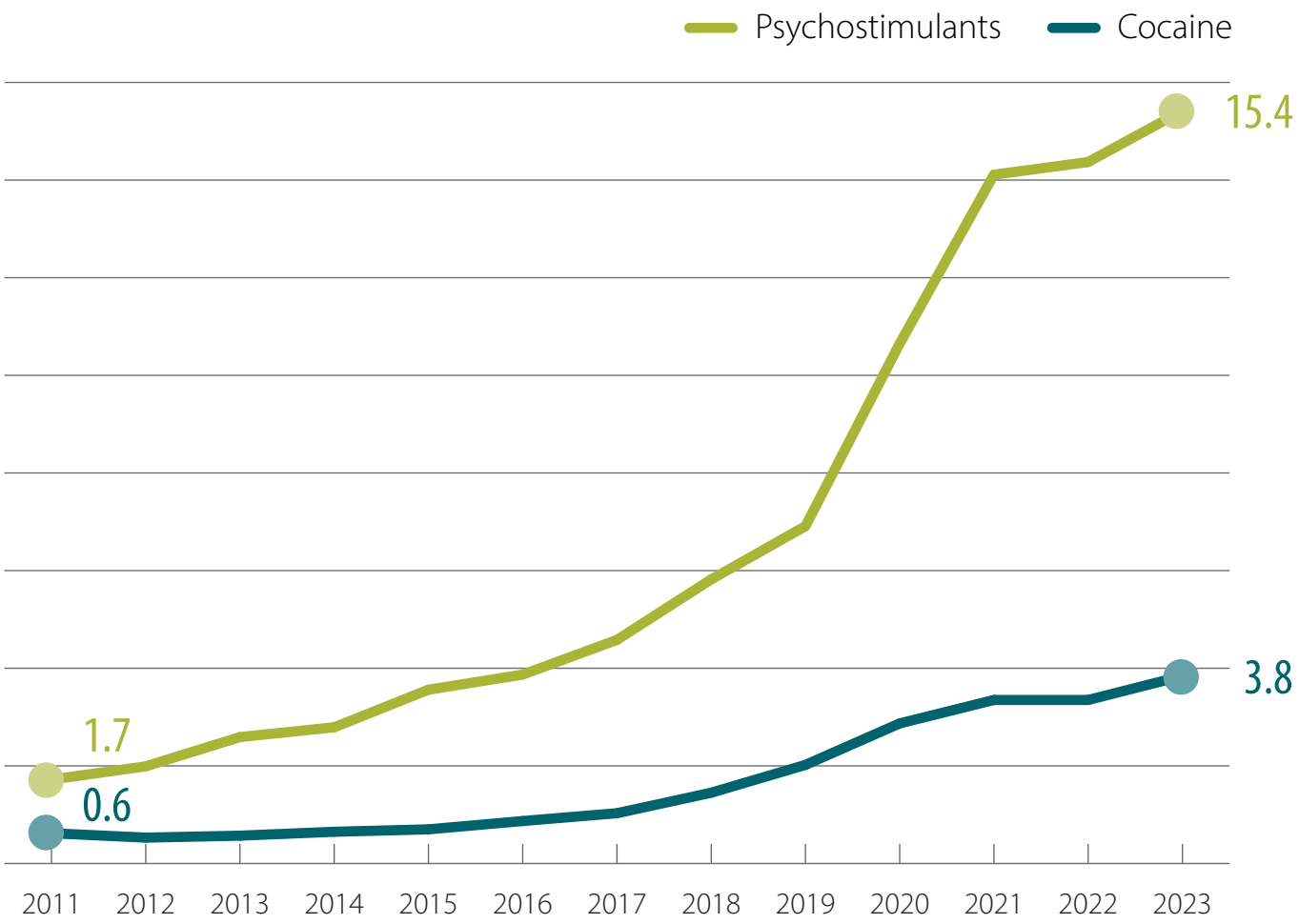
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Substance Use
Deaths

In 2023, Northern California counties had some of the highest rates of opioid overdose deaths. Sierra County had the highest rate, followed by San Francisco County.

Psychostimulant and Cocaine Overdose Deaths
California, 2011 to 2023

RATE PER 100,000 POPULATION (AGE-ADJUSTED)



Notes: Deaths related to chronic use of drugs are excluded. *Psychostimulants* is acute poisoning deaths involving psychostimulants with abuse potential excluding cocaine (such as methamphetamine, MDMA, dextroamphetamine, levoamphetamine, or Ritalin). *Cocaine* is acute poisoning deaths involving cocaine.

Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

Psychostimulant and cocaine overdose death rates increased between 2011 and 2023. Some of this increase may be due to cross contamination with opioids such as fentanyl.*

* Source: "Charting the Stimulant Overdose Crisis & the Influence of Fentanyl," National Institute for Health Care Management Foundation.

About Substance Use Disorder Treatment

Treatment for substance use disorders comprises multiple service components. Some of these, which may be provided in outpatient or inpatient settings, include the following:

Behavioral Interventions

Motivational enhancement therapy helps people resolve their ambivalence about engaging in treatment and stopping drug use, in order to evoke internally motivated change.

Cognitive behavioral therapy teaches skills to identify and change problem behaviors and to address other life challenges that may influence use of substances.

Family therapy addresses a youth's substance use problems while considering family dynamics that may influence the youth's substance use and other risky behaviors.

Contingency management is often used to treat stimulant use disorder. Positive reinforcement — prizes, privileges, or cash — is provided for completing desired behaviors including remaining drug-free, attending counseling sessions, or taking medications as prescribed.

Medications

Medications are often used in combination with counseling and behavioral therapies to treat opioid or alcohol use disorder. Methadone and buprenorphine are two commonly used medications for opioid use disorder. Naltrexone is used to treat alcohol and opioid use disorder.

Numerous approaches are used to treat substance use disorders, depending on the primary substance being used and the severity of the substance use disorder, as well as the preferences and needs of the person in treatment.

Sources: "Drugs, Brains, and Behavior: The Science of Addiction — Treatment and Recovery," National Institute on Drug Abuse, July 6, 2020; A. Thomas McLellan et al., "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation," *JAMA* 284, no. 13 (2000): 1689–95; "Substance Use Disorder Treatment Options: Medications for Substance Use Disorders," Substance Abuse and Mental Health Services Administration (SAMHSA), last updated April 11, 2024; and *Treatment of Stimulant Use Disorders*, SAMHSA, June 2020.

Substance Use Treatment by Substance Type
California, 2023

SINGLE-DAY COUNT

Notes: Includes all ages. Single-day counts reflect the number of clients in substance use treatment on March 31, 2023. Figures may not sum due to rounding.

Source: *National Substance Use and Mental Health Services Survey (N-SUMHSS) State Profiles 2023: National and State Highlights* (PDF), Substance Abuse and Mental Health Services Administration, 2024.

Of the 87,000 clients in treatment for a substance use disorder in California on March 31, 2023, more than half were receiving treatment for substances other than alcohol.

DHCS Opioid Response

The California Department of Health Care Services (DHCS) Opioid Response refers to the collective efforts and initiatives that DHCS has undertaken to address the opioid crisis. It encompasses a wide range of projects and activities in prevention, harm reduction, treatment, and recovery that aim to reduce opioid-related overdose deaths, reduce unmet treatment need for opioid use disorder, and expand access to medications for opioid use disorder. DHCS Opioid Response receives funding through the State Opioid Response grant under the Substance Abuse and Mental Health Services Administration, California's opioid settlements, and California State General Funds.

DHCS Opioid Response impact as of August 2024:

- More than 30 projects funded
- More than 500 organizations participating as access points for opioid use disorder
- Medications for opioid use disorder provided to 211,000 patients
- Peer support or recovery coaching services provided to more than 258,000 patients
- Distributed more than 3,110,000 units of naloxone through the Naloxone Distribution Project, which resulted in more than 203,000 overdose reversals

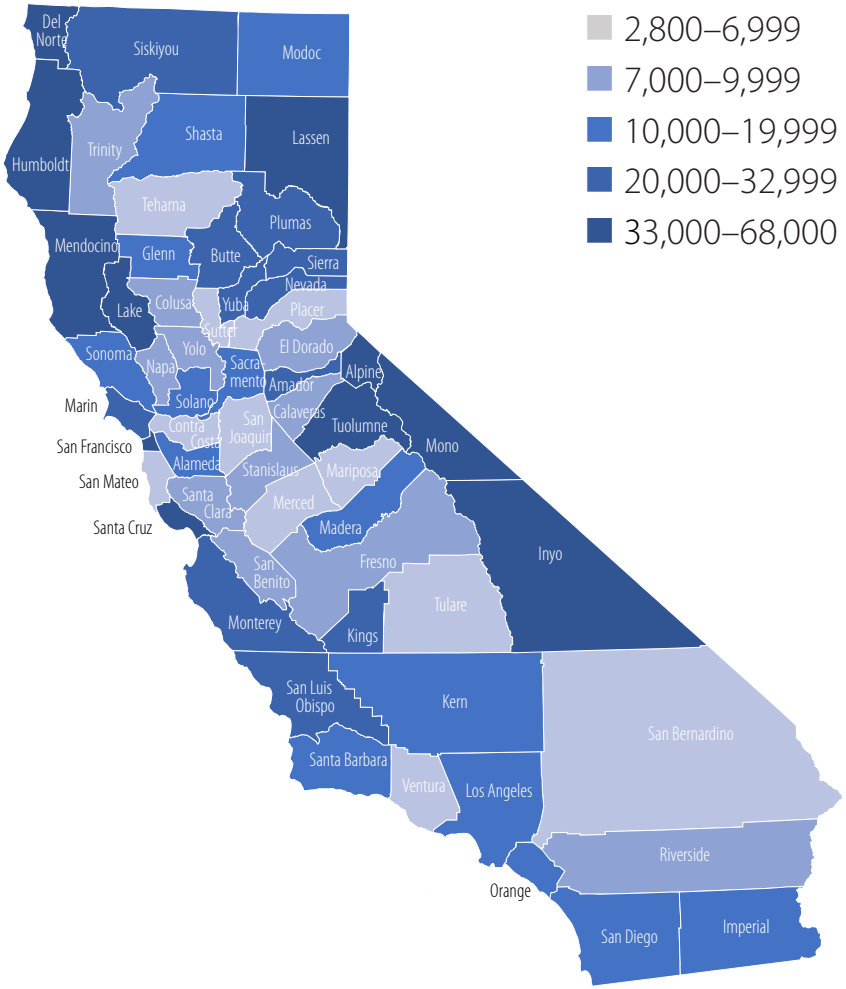
California's Department of Health Care Services, through its DHCS Opioid Response, aims to expand access to medications for opioid use disorder, reduce unmet treatment need, and reduce opioid-related overdose deaths.

Source: "DHCS Opioid Response," California Department of Health Care Services, accessed August 1, 2024.

Naloxone Kits by County

California, 2018 to 2024

PER 100,000 RESIDENTS



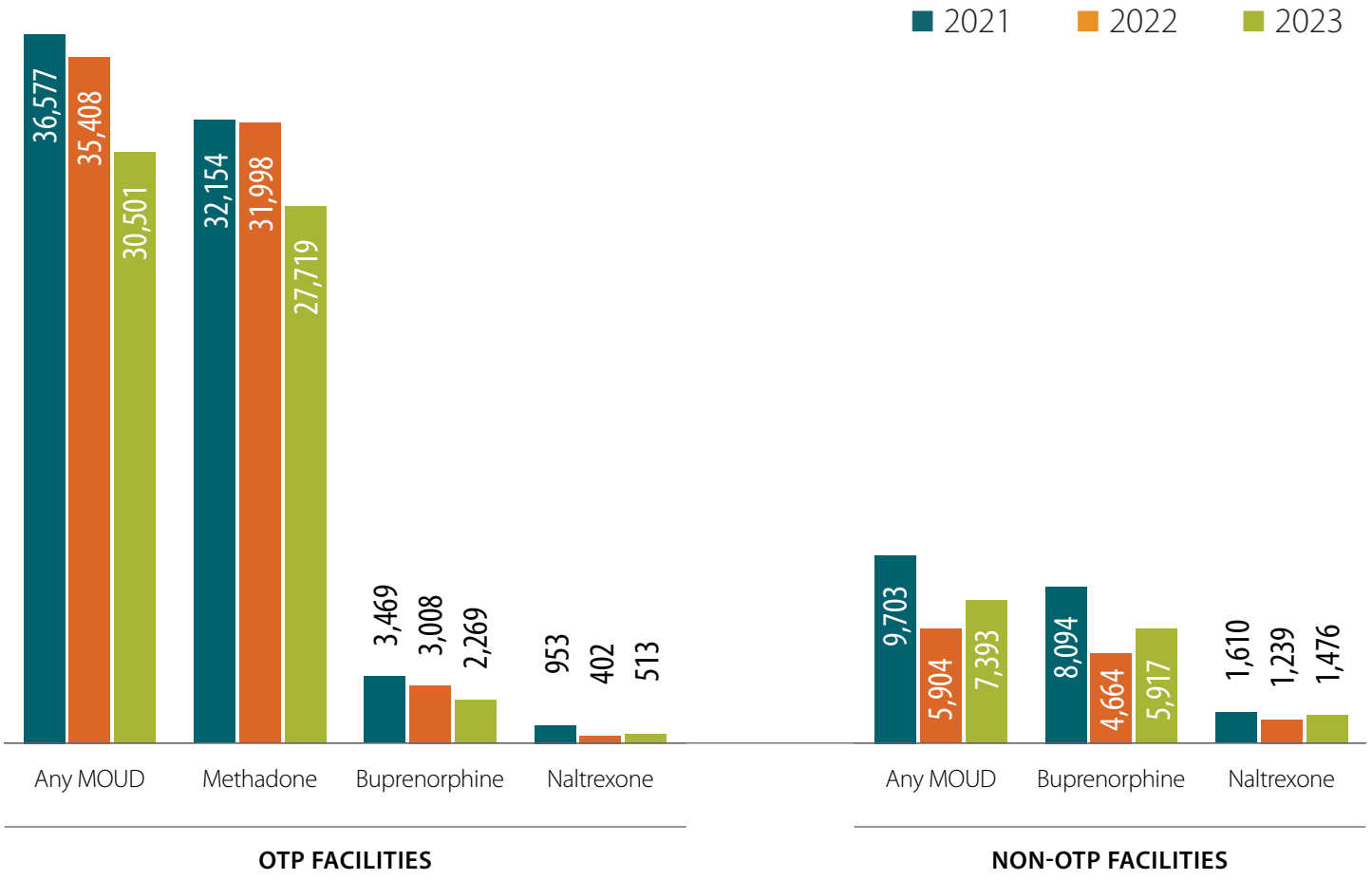
Notes: *Naloxone* is a medication designed to reverse opioid overdoses. See the most up-to-date map.

Source: "Opioid Overdoses and Approved Naloxone by County," California Department of Health Care Services, accessed December 20, 2024.

All California counties receive naloxone kits through the California Department of Health Care Services's Naloxone Distribution Project. As of December 2024 the project has distributed more than five million kits.

Medications for Opioid Use Disorder, by Type
California, 2021 to 2023

SINGLE-DAY COUNT

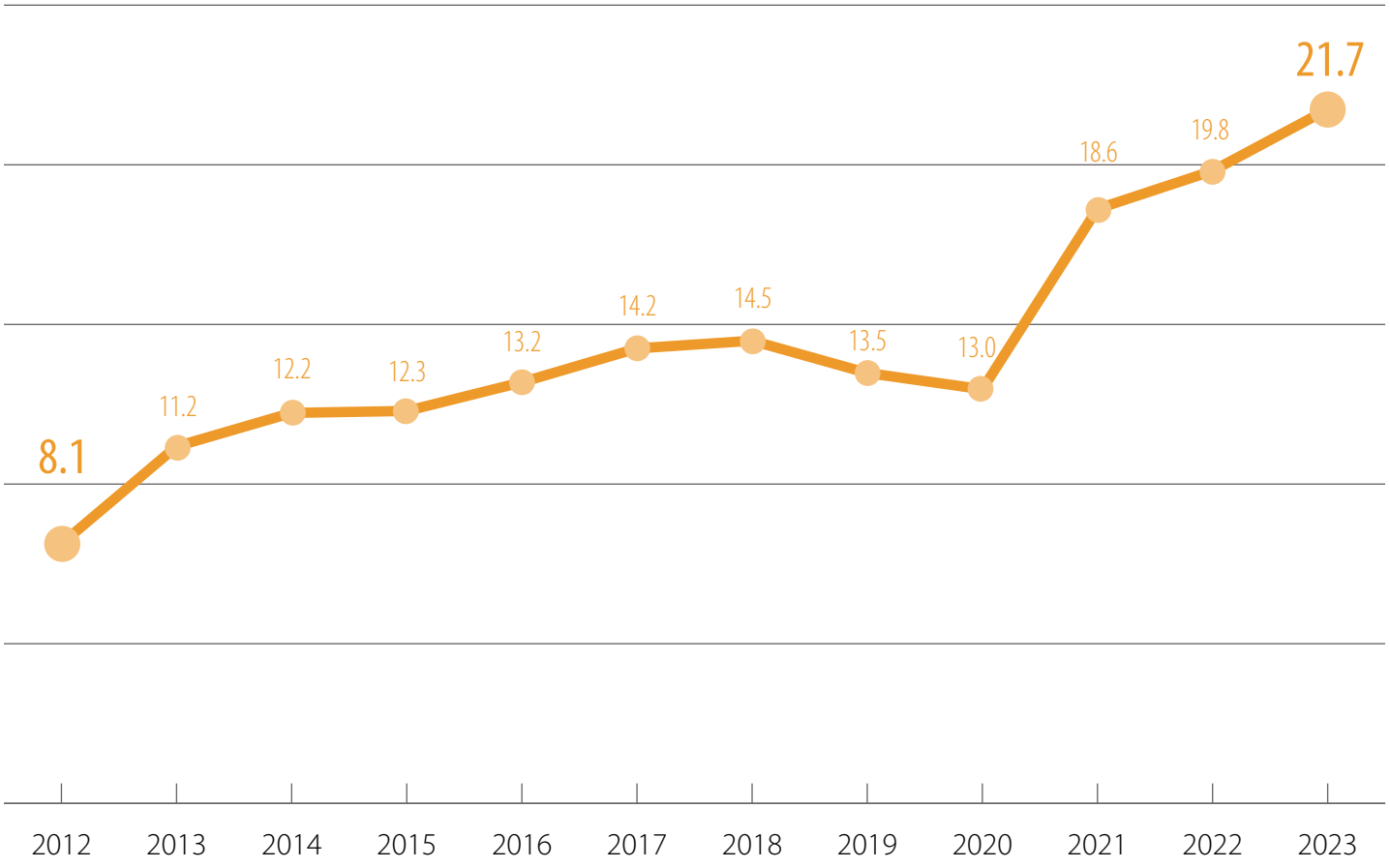


Notes: *MOUD* is medication for opioid use disorder. Methadone, buprenorphine, and naltrexone are FDA-approved medications commonly used to treat those with opioid use disorders. Data reflect the number of clients in substance use treatment on March 31 in 2021, 2022, and 2023 at Certified Opioid Treatment Program (OTP) Facilities and non-OTP Facilities. Single-day counts include the number of people prescribed these medications through substance use treatment programs and do not include those who may have been prescribed these medications by physicians in a private practice. An OTP is an accredited and certified facility authorized to administer and dispense FDA-approved medications, such as methadone and buprenorphine, for the treatment of opioid use disorder. Source uses *medication for addiction treatment*.

Sources: National Substance Use and Mental Health Services Survey (N-SUMHSS) State Profiles (2021, 2022, and 2023) (PDF), Substance Abuse and Mental Health Services Administration.

Methadone was used much more frequently than other medications to treat opioid use disorder. Between 2021 and 2023, the number of clients receiving buprenorphine, naltrexone, and methadone at certified opioid treatment program facilities decreased.

Buprenorphine Prescriptions
California, 2012 to 2023



Note: Buprenorphine is a medication for opioid use disorder.

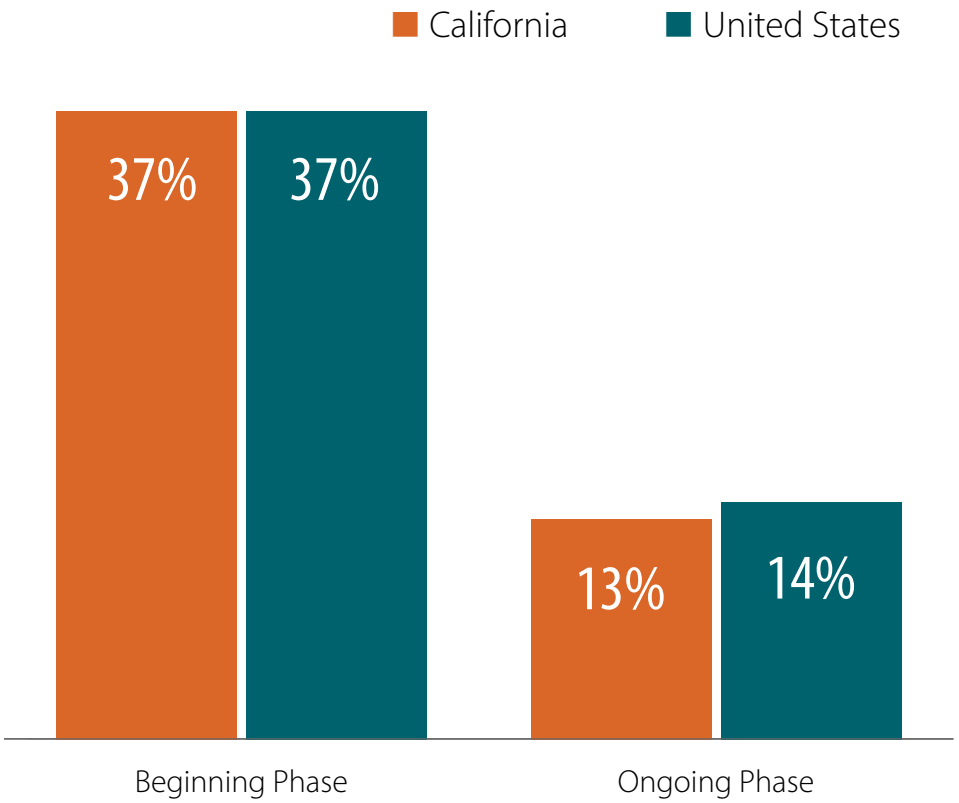
Source: "California Overdose Surveillance Dashboard," California Department of Public Health.

The rate of buprenorphine prescriptions in California has increased since 2012, in line with statewide efforts to increase access to treatment for opioid use disorder. In 2023, the Drug Enforcement Administration removed the requirement for physicians to receive special authorization (an "X-waiver") to prescribe buprenorphine to treat people with opioid use disorder.

Alcohol and Drug Dependence Treatment

Commercial HMO and PPO Plans, California vs. United States, 2022

PERCENTAGE OF MEMBERS WITH A NEW EPISODE OF ALCOHOL OR DRUG DEPENDENCE WHO RECEIVED TREATMENT



Few commercial HMO and PPO health plan members received alcohol or drug dependence treatment consistent with National Committee for Quality Assurance recommendations. In California, nearly two in five health plan members with an alcohol or other drug dependence diagnosis had an initial treatment visit within two weeks of diagnosis, and only one in eight had at least two follow-up visits within a month of initial treatment.

Notes: *Beginning phase* shows the percentage of patients 13 years or older with a substance use disorder diagnosis who started treatment services within 14 days of being diagnosed. *Ongoing phase* shows the percentage of patients with a substance use disorder diagnosis that had their first treatment within two weeks of diagnosis and had at least two follow-up treatment services within 30 days of their first treatment. Health plan scores include PPO plans as well as HMO plans. Source uses *alcohol and drug dependence*.

Source: "Compare Clinical Performance for HMO and PPO Plans Nationwide," California Office of the Patient Advocate, accessed July 24, 2025.

Treatment Facilities and Programs

- **Detoxification** includes clinical management of the withdrawal process in a 24-hour residential or hospital setting (ASAM level 3.2-WM).
- **Hospital inpatient** includes substance use disorder (SUD) treatment or detoxification services in general acute care hospitals, psychiatric acute care hospitals, and chemical dependency recovery hospitals.
- **Narcotic treatment programs** provide narcotic replacement therapy and administer methadone. Narcotic replacement therapy is administered as part of a comprehensive treatment program including medical evaluation and counseling for medical, alcohol, criminal, and psychological problems. The Substance Abuse and Mental Health Services Administration refers to these programs as opioid treatment programs.
- **Outpatient** SUD treatment and recovery services are provided in primary care offices, community clinics, substance use treatment clinics, and other settings for patients who do not require hospitalization.
- **Residential programs** (nonhospital) provide clinically managed SUD treatment and recovery services in a 24-hour supportive living setting (ASAM levels 3.1, 3.3, and 3.5).

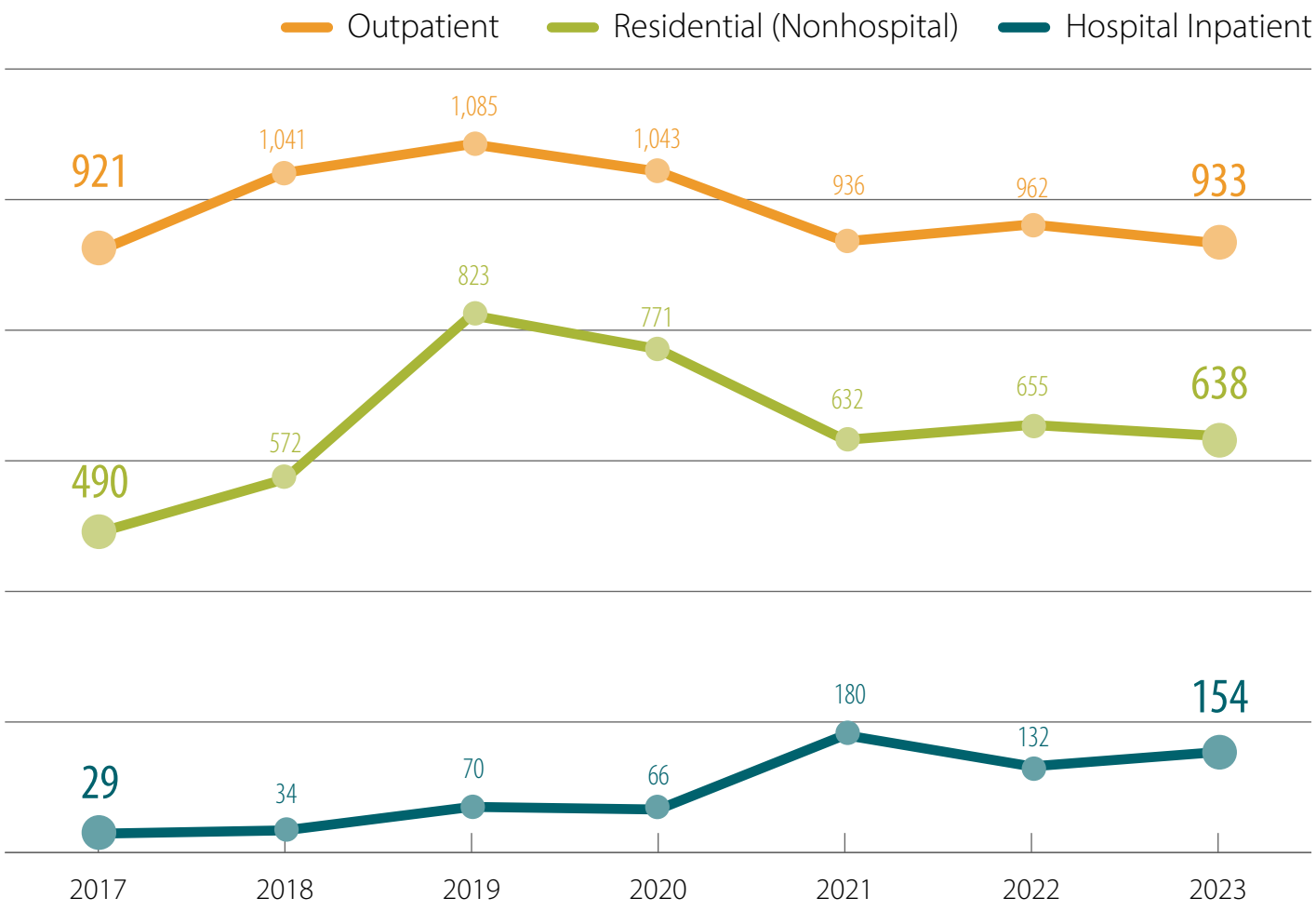
Substance use disorder (SUD) treatment services are provided in inpatient, outpatient, and residential settings, spanning the continuum of care for SUD treatment as defined by the American Society for Addiction Medicine.

Notes: American Society for Addiction Medicine (ASAM) levels are based on 3rd Edition criteria. See Appendix A for ASAM levels of care.

Substance Use Disorder Treatment Facilities, by Type of Care

California, 2017 to 2023

NUMBER OF FACILITIES

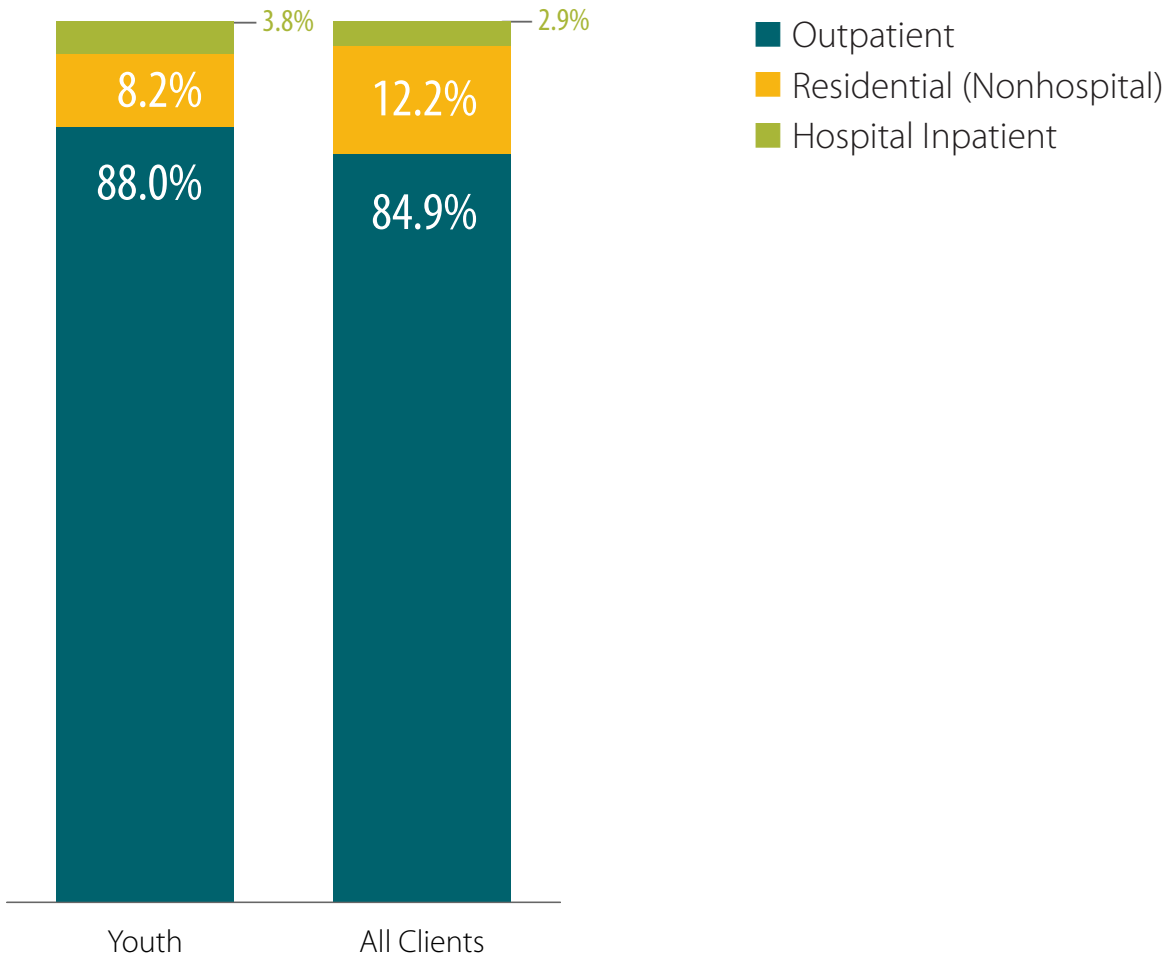


Notes: Data are number of treatment facilities on March 31 of each year. A facility may provide more than one type of care. See Appendix E for a description of California substance use disorder treatment programs and services.

Sources: *National Survey of Substance Abuse Treatment Services (N-SSATS) — Data on Substance Abuse Treatment Facilities* (2017, 2018, 2019, and 2020) (PDF), Substance Abuse and Mental Health Services Administration (SAMHSA); and *National Substance Use And Mental Health Services Survey (N-SUMHSS): State Profiles* (2021 2022, and 2023) (PDF), SAMHSA.

The number of California substance use disorder treatment facilities offering outpatient, residential, and hospital inpatient care each increased from 2017 to 2023. The number of facilities offering residential care increased by 30%, and the number of facilities offering hospital inpatient care increased by 431%.

Clients in Substance Use Disorder Treatment by Type of Care
California, 2023

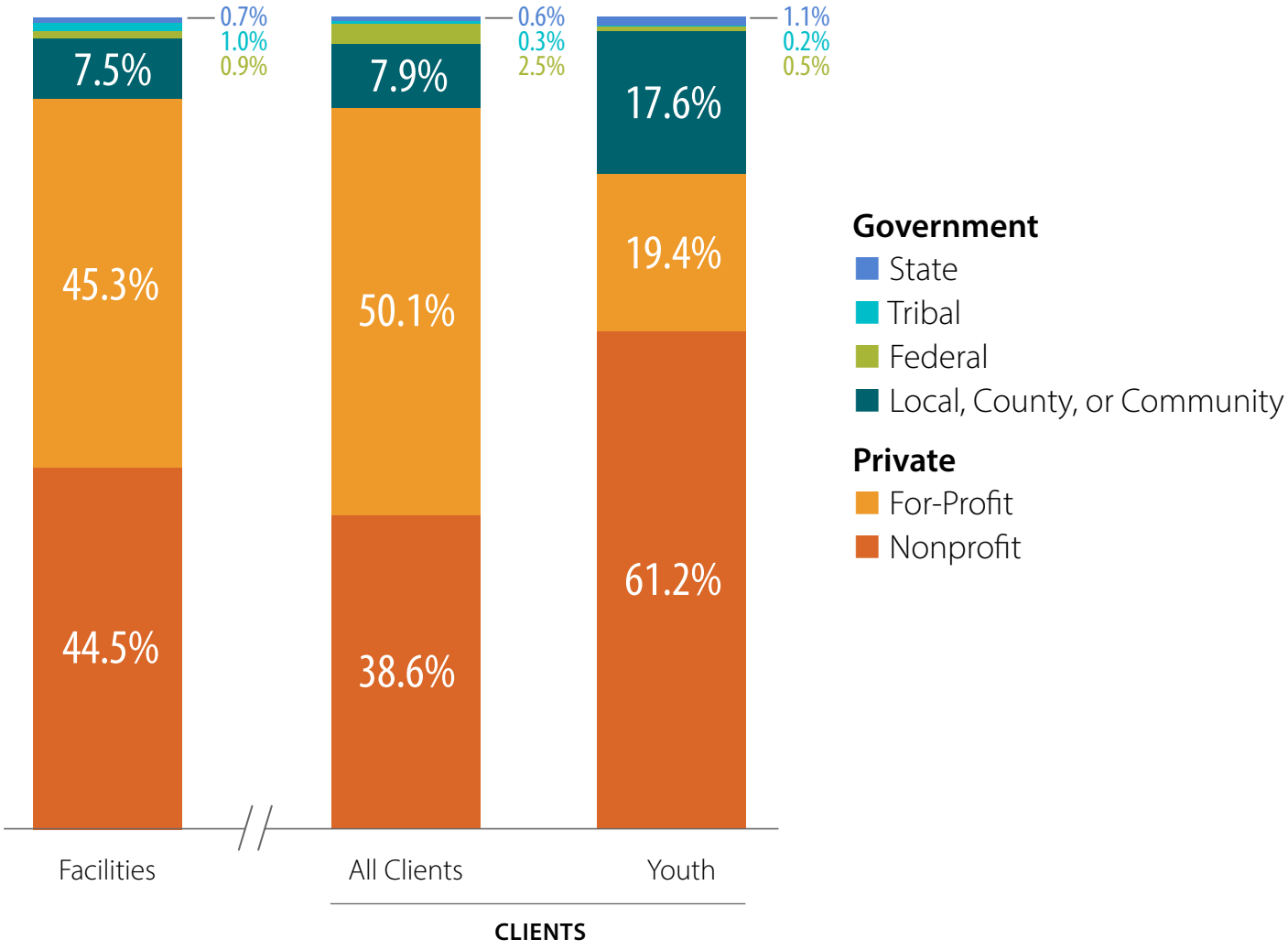


In California, the majority of clients in substance use disorder treatment received outpatient care.

Notes: Percentages are based on clients in treatment on March 31, 2023. *Youth* is under age 18. Figures may not sum due to rounding.

Source: *National Substance Use and Mental Health Services Survey (N-SUMHSS): State Profiles 2023* (PDF), Substance Abuse and Mental Health Services Administration, 2024.

Substance Use Disorder Treatment Facilities and Clients in Treatment, by Owner Type, California, 2023

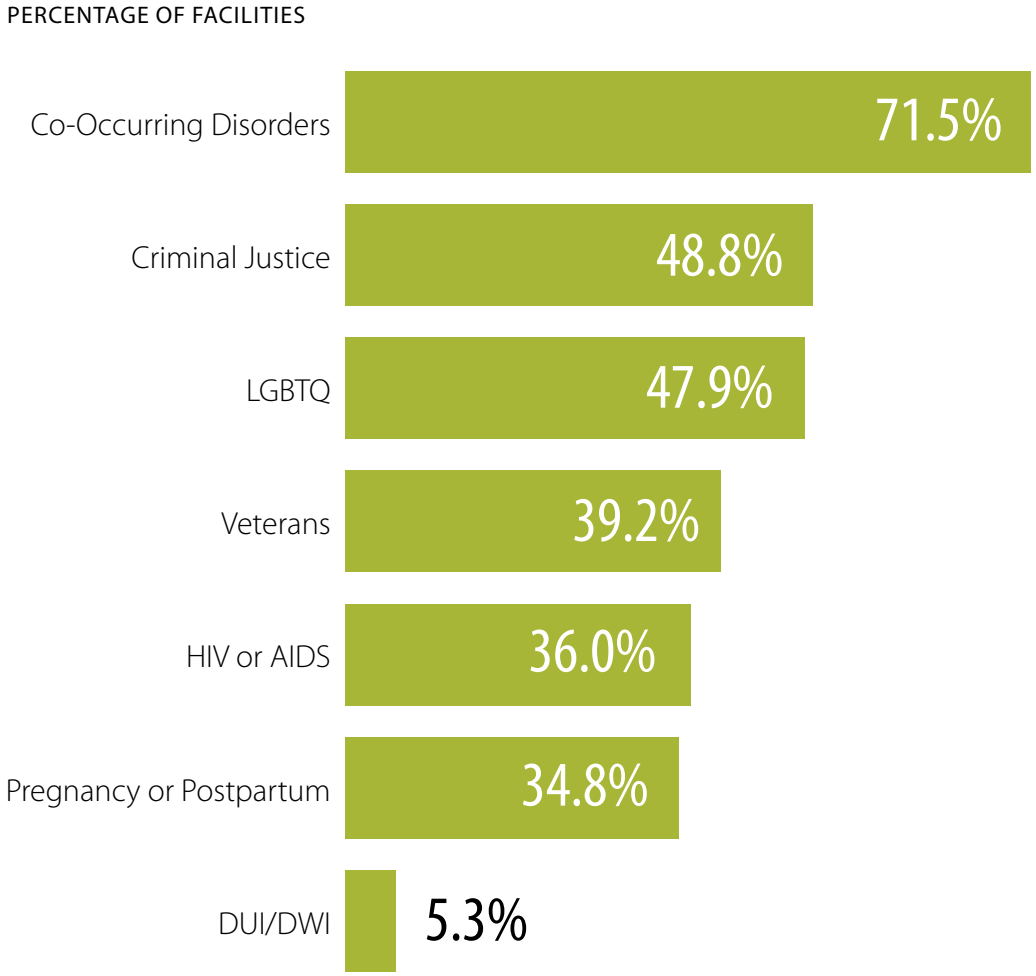


Notes: Data are facilities and clients in treatment on March 31, 2023. *Youth* is under age 18. Figures may not sum due to rounding.

Source: *National Substance Use and Mental Health Services Survey (N-SUMHSS): State Profiles 2023* (PDF), Substance Abuse and Mental Health Services Administration, 2024.

In 2023, the majority of California substance use disorder treatment facilities (90%) were privately owned. Local, county, and community government–operated facilities accounted for 8% of total facilities, 8% of all clients, and 18% of youth clients. A higher percentage of youth clients were treated in nonprofit private facilities than clients overall.

Substance Use Disorder Treatment Facilities, Selected Programs and Groups, California, 2023



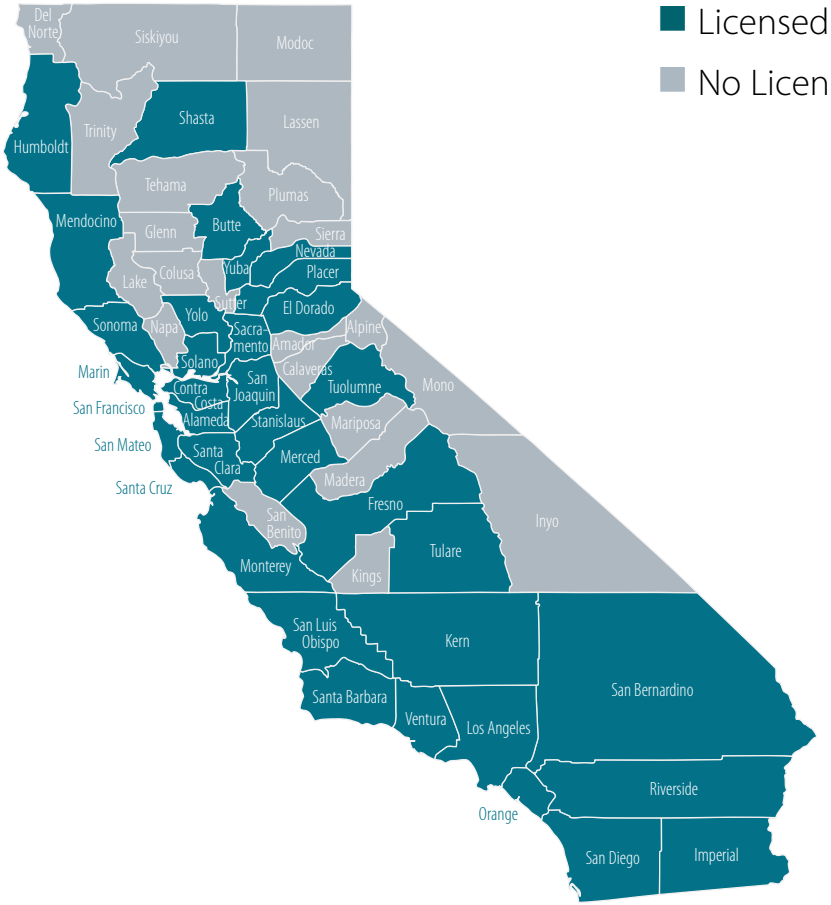
Notes: Facilities with programs or groups on March 31, 2023. A facility may provide more than one specifically tailored program or group. *Co-occurring disorders* refers to co-occurring mental and substance use disorders. *LGBTQ* is lesbian, gay, bisexual, transgender, and queer or questioning. *DUI/DWI* is driving under the influence, driving while intoxicated or impaired. *Criminal justice* is other than DUI/DWI.

Source: *National Substance Use and Mental Health Services Survey (N-SUMHSS): State Profiles 2023* (PDF), Substance Abuse and Mental Health Services Administration, 2024.

About 72% of California's substance use disorder treatment facilities had programs tailored for clients diagnosed with co-occurring mental illness and substance use disorders, and 49% had programs for clients involved in the criminal justice system.

Licensed Narcotic Treatment Programs by County

California, 2022



Notes: Only narcotic treatment programs (NTPs) licensed by the California Department of Health Care Services, with approval from the US Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration may provide narcotic replacement therapy (NRT) to administer methadone. To receive NRT medications, all patients are required to participate in a comprehensive treatment program, which includes a medical evaluation and counseling for medical, alcohol, criminal, and psychological problems. Patients are required to undergo regular urinalysis to ensure that illicit drugs are not being used during treatment. See Appendix C for number of narcotic treatment program slots by county.

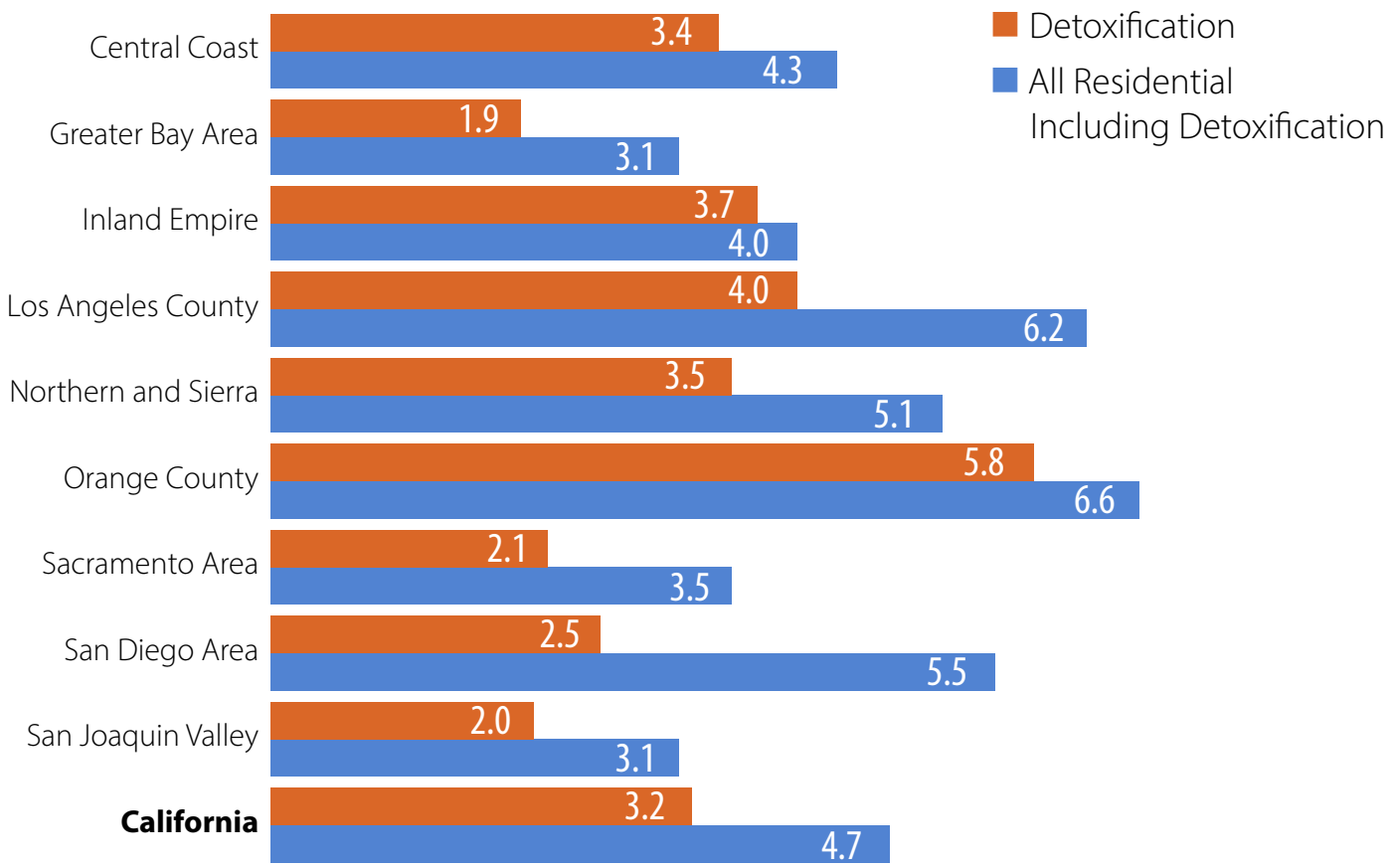
Sources: State of California Narcotic Treatment Program Directory, California Department of Health Care Services, June 11, 2024.

People who receive methadone treatment typically attend narcotic treatment programs (NTPs) daily — making proximity and access critical. NTP capacity varied considerably by county. NTP services were not available in 22 of 58 California counties. In 2024, California NTP regulations aligned with new federal flexibilities permitting more take-home dosing and mobile NTP services, intended to increase patient access to NTP services.

Residential Treatment Facility Beds by Region

California, 2022

BEDS PER 10,000 POPULATION



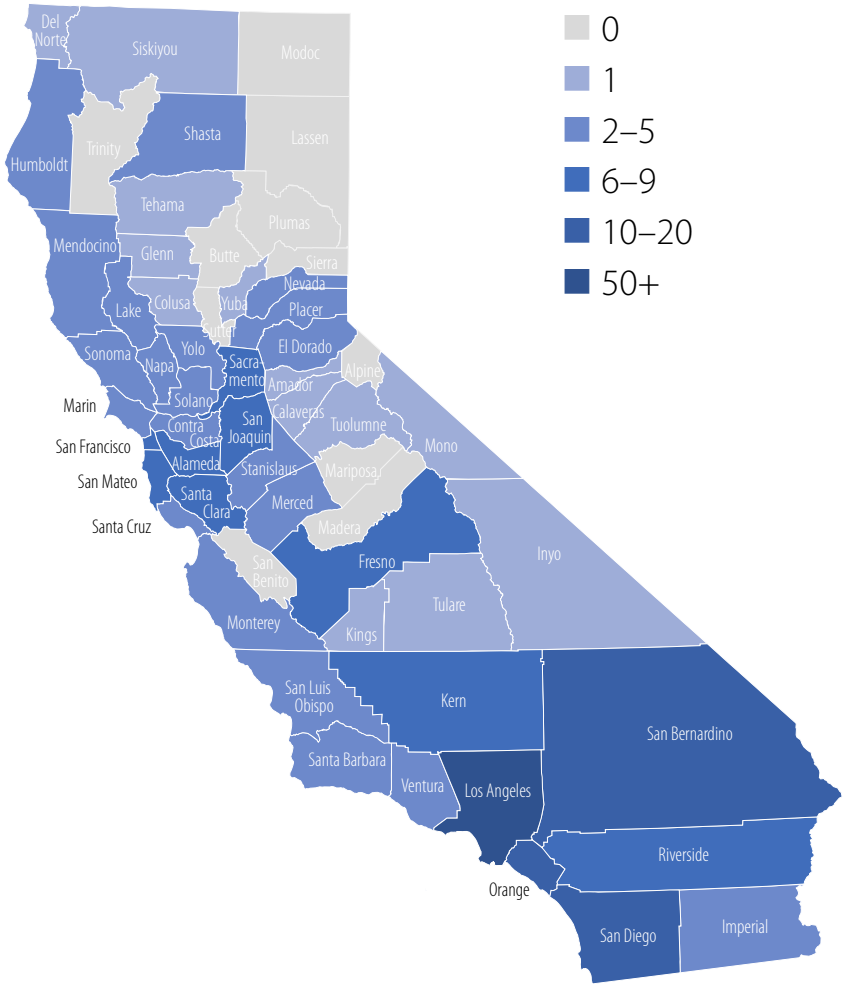
The number of residential and detoxification beds per population varied considerably. Orange County, Los Angeles County, and the San Diego area had the most residential treatment beds per population.

Notes: Includes nonmedical recovery or treatment facilities for substance use disorder and alcohol use disorder licensed and/or certified by the California Department of Health Care Services (DHCS). *Residential* beds provide recovery services corresponding to 3rd Edition ASAM levels 3.1, 3.3, and 3.5. *Detoxification* beds correspond to 3rd Edition ASAM level 3.2-WM and provide clinical management of the withdrawal process. See Appendix A for more detail on ASAM levels. As of 2018, residential facilities, with approval from DHCS, may provide incidental medical services (medical services associated with detoxification, treatment, or recovery services). See Appendix B for a list of counties in each region.

Sources: Author calculations based on *SUD Recovery Treatment Facilities*, DHCS, accessed July 2024; and *Report P-2B: Population Projections by Individual Year of Age, California Counties, 2020–2060*, California Department of Finance, March 2024.

California Bridge Program Facilities by County
2024

NUMBER OF CALIFORNIA BRIDGE FACILITIES PER COUNTY



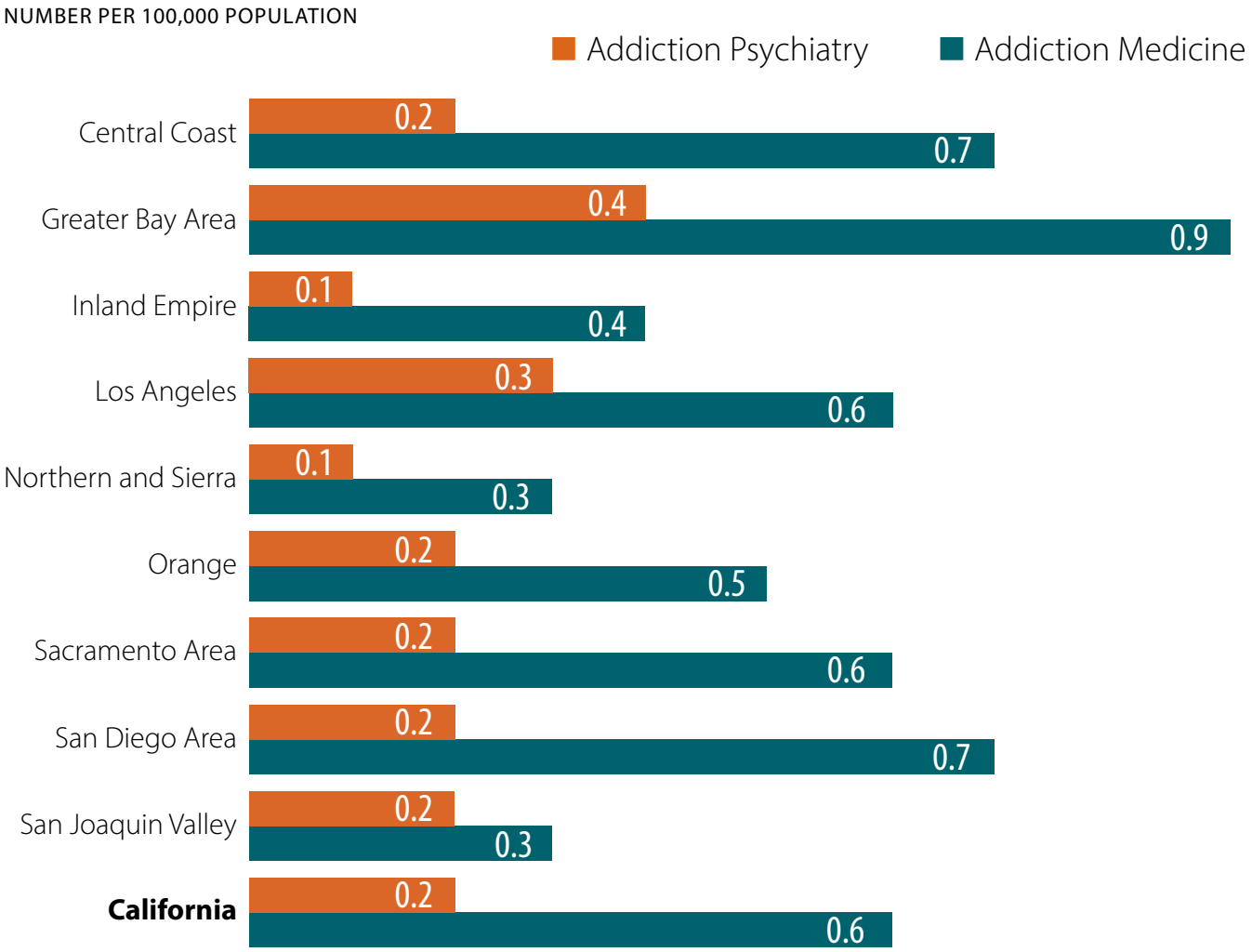
Notes: Facilities participating in the California Bridge Program. The program aims to increase access to medication for opioid use disorder in California emergency departments and hospitals.

Source: *CalBridge Navigator Program Hospitals as of 10/31/24* (Excel), Bridge to Treatment, 2024.

Most counties in California have at least one hospital facility that participates in the California Bridge Program. The program enables people with opioid use disorder to receive medication for it in emergency departments and provides a connection to continued care in the community.

Physicians Specializing in Addiction Treatment by Region

California, 2023



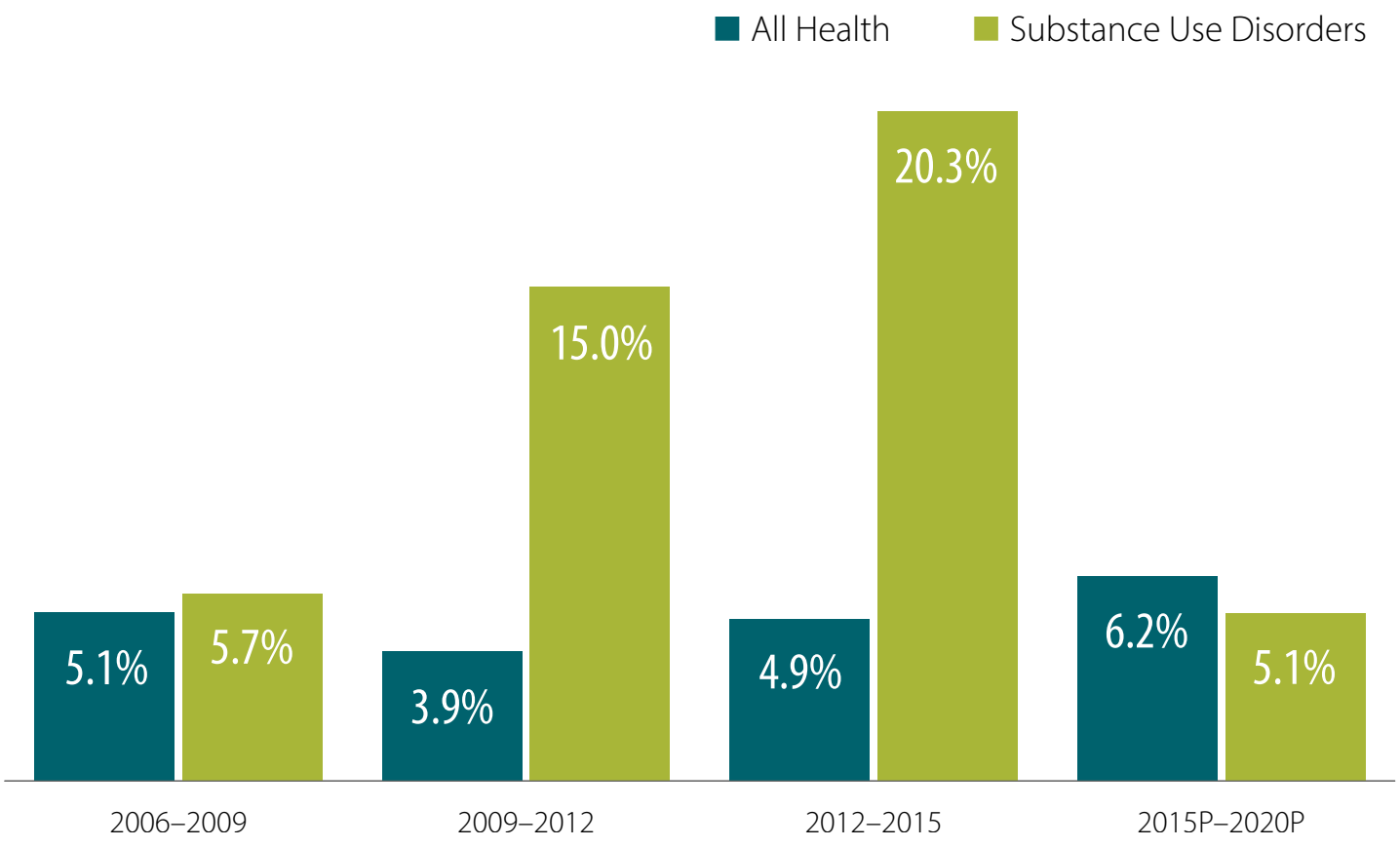
Notes: Includes MDs with an active California license who had a California address, provided patient care at least 20 hours per week, and indicated they are board-certified in addiction medicine or addiction psychiatry. Residents, fellows, and nonrespondents are excluded. See Appendix B for a map of counties in each region.

Source: Janet Coffman and Margaret Fix, UCSF, Survey of Licensees (private tabulation), Medical Board of California, December 2023.

In 2023, 203 patient care physicians (less than one per 100,000 population) were board-certified in addiction medicine or addiction psychiatry in California.

All Health and Substance Use Disorder Treatment Expenditure Growth, United States, 2006 to 2020

AVERAGE ANNUAL GROWTH



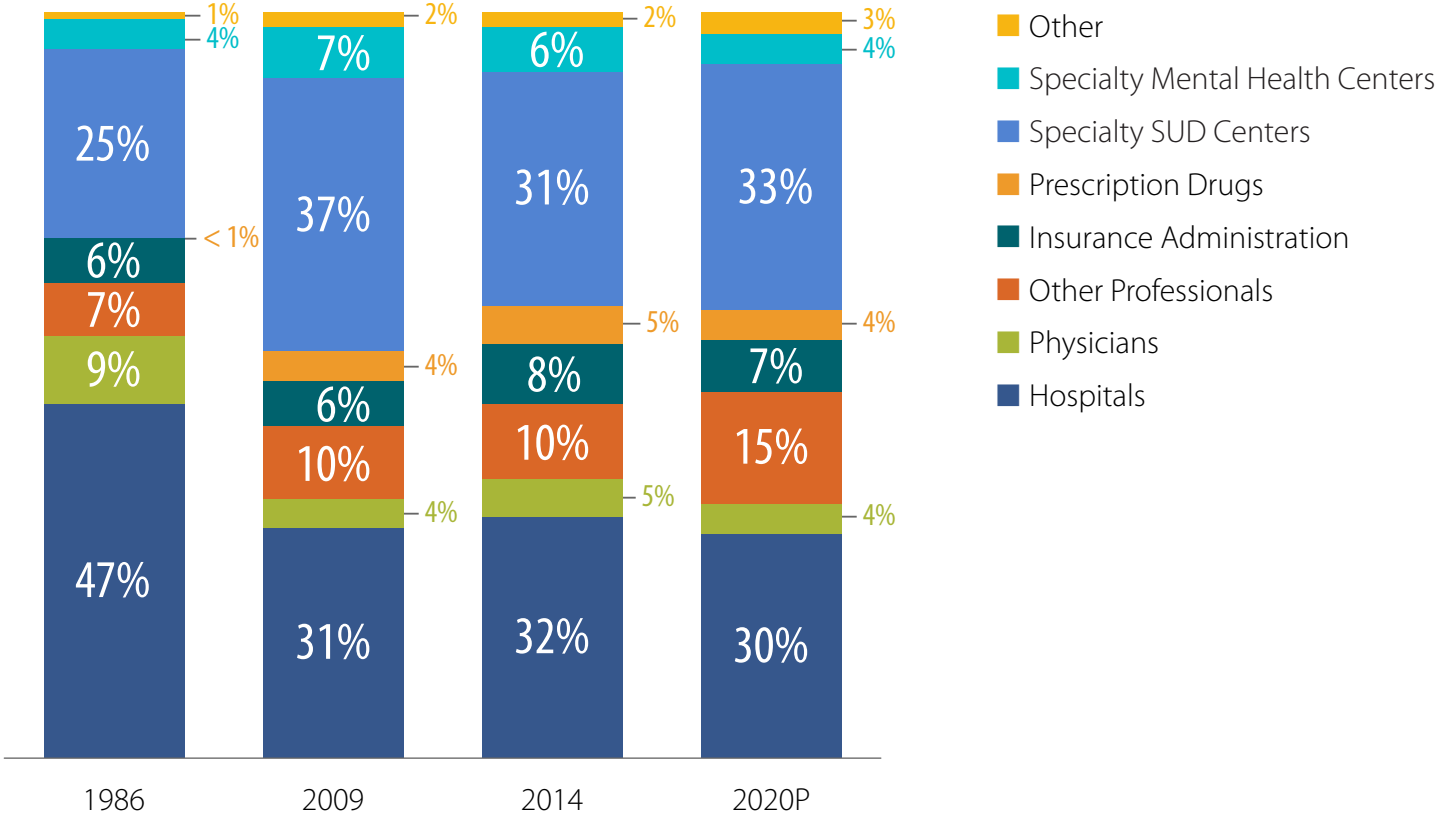
From 2006 to 2015, the average annual growth rate for substance use disorder treatment more than tripled. However, annual expenditure growth for substance use disorder was projected to slow considerably from 2015 to 2020.

Notes: Projections (2015P–2020P) were calculated by authors. Expenditures on substance use disorder treatment includes clinical treatment and rehabilitative services and medications, and exclude activities to prevent substance use disorders and peer support services for which there is no cost. Projections incorporate expansion of coverage through the Affordable Care Act, implementation of the provisions of behavioral health parity regulations, and expectations about the expiration of patents for certain psychotropic medications.

Sources: *Behavioral Health Spending and Use Accounts, 2006–2015* (PDF), Substance Abuse and Mental Health Services Administration (SAMHSA), HHS Pub. No. (SMA) 9-5095, 2019, table A.8; and *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020,* SAMHSA, 2014, table A.4.

SUD Treatment Expenditures, by Service Category

United States, 1986 to 2020, Selected Years



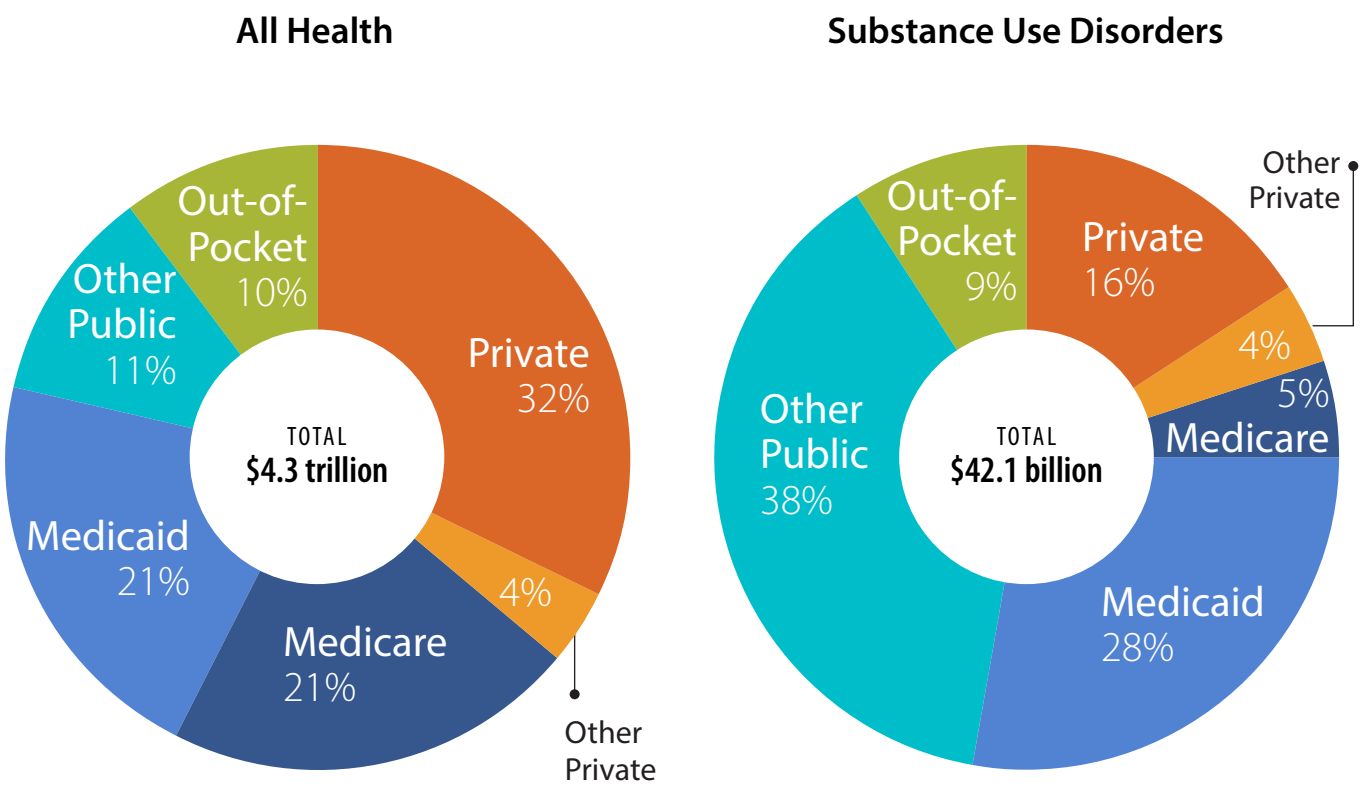
The distribution of spending on substance use disorder (SUD) treatment changed between 1986 and 2009. Hospital expenditures dropped from 47% of total SUD spending in 1986 to 31% in 2009. During the same time, the share of expenditures for specialty SUD centers increased from 25% to 37%. Spending by service category was projected to be relatively stable in 2020.

Notes: Projections shown with *P.* Estimates of treatment expenditures for substance use disorder include expenditures for clinical treatment and rehabilitative services and medications, and exclude both peer support services and activities to prevent substance abuse. *Other professionals* includes psychologists, counselors, and social workers. *Other* includes freestanding nursing homes and freestanding home health. Figures may not sum due to rounding.

Sources: *Behavioral Health Spending and Use Accounts, 1986–2014,* Substance Abuse and Mental Health Services Administration (SAMHSA), HHS Publication No. SMA-16-4975, and *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020,* SAMHSA, 2014, table A.4.

All Health and Substance Use Disorder Treatment Expenditures, by Payer, United States, 2020

PERCENTAGE OF TOTAL PROJECTED SPENDING



Notes: Expenditures are projections. *Other public* includes *other federal* and *other state and local*. Spending includes clinical treatment and rehabilitative services and medications, and excludes both activities to prevent SUDs and peer support services for which there is no cost. Projections incorporate expansion of coverage through the Affordable Care Act, implementation of the provisions of behavioral health parity regulations, and expectations about the expiration of patents for certain psychotropic medications. Figures may not sum due to rounding.

Source: *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*, Substance Abuse and Mental Health Services Administration, 2014, table A.7.

Based on projections, substance use disorder (SUD) treatment accounted for 1% of all health care expenditures in the United States in 2020 (not shown). Medicaid paid for 28% of SUD treatment. Other public payers, which includes federal and state grants, accounted for 38% of SUD treatment spending. Although new health plan standards and parity laws have expanded SUD coverage, Medicare and private payers were still projected to provide a smaller share of SUD expenditures than of overall health care services.

California's Public Substance Use Disorder Treatment System

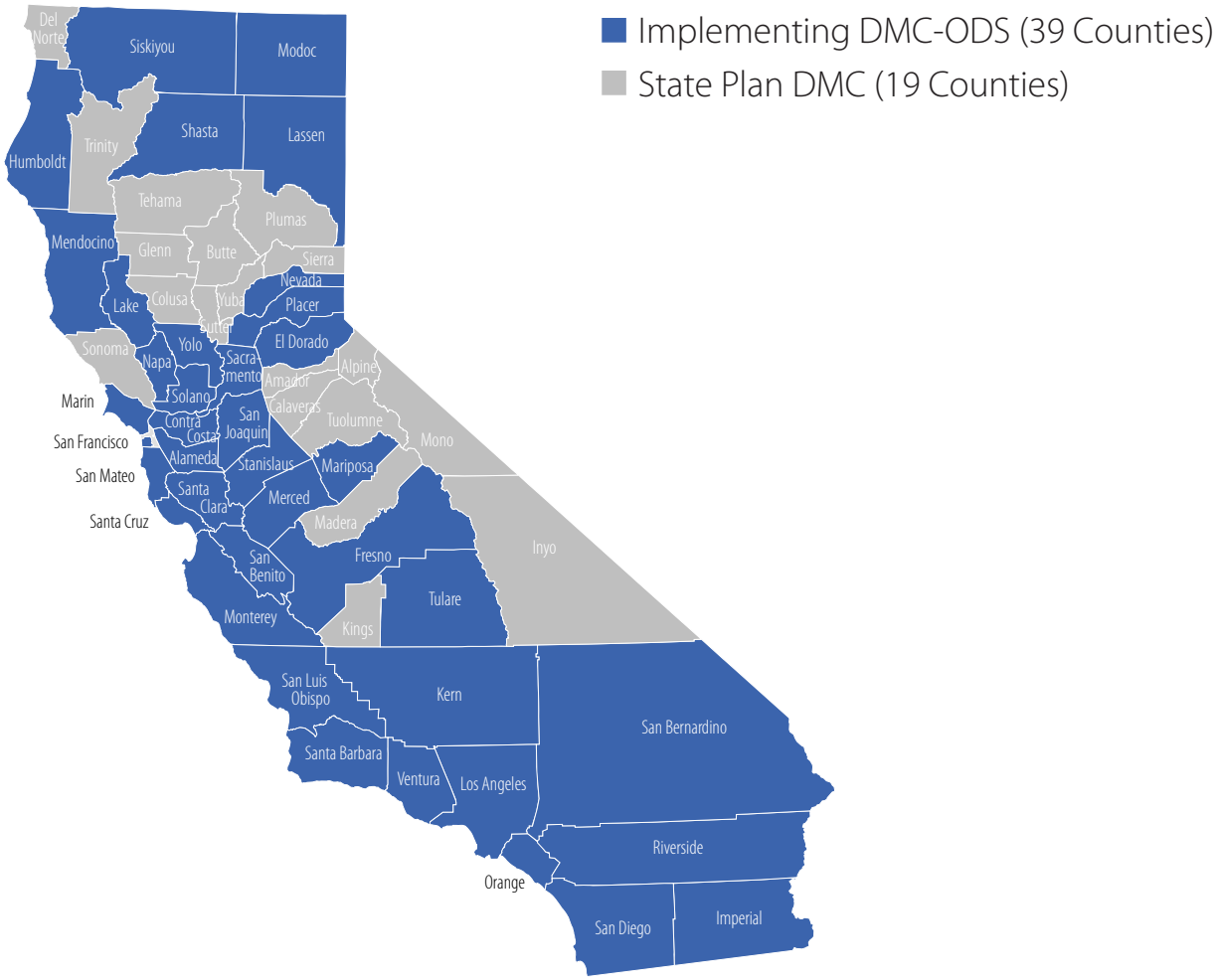
Counties provide the majority of substance use disorder treatment services to Medi-Cal enrollees and Californians who are uninsured. Medi-Cal managed health care plans have more limited responsibility for substance use disorder services.

	Primary Public Programs for SUD Treatment			
	COUNTY SUD PROGRAMS			
	STANDARD DRUG MEDI-CAL STATE PLAN	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)	PROGRAMS FUNDED THROUGH SUBSTANCE USE BLOCK GRANT	MEDI-CAL MANAGED CARE AND FEE-FOR-SERVICE
Payer	Medi-Cal (federal and state/local)	Medi-Cal (federal and state/local)	Substance Abuse and Mental Health Services Administration	Medi-Cal (federal and state/local)
People Served	Medi-Cal enrollees with SUD	Medi-Cal enrollees with SUD	Uninsured people with SUD, Medi-Cal enrollees (for services not covered by Medi-Cal)	Medi-Cal enrollees needing preventive services, addiction medication management, or inpatient withdrawal management
Services Provided	Outpatient and intensive outpatient SUD services, perinatal residential SUD treatment, narcotic treatment programs	Standard Drug Medi-Cal benefit plus residential and inpatient SUD treatment (not limited to perinatal), withdrawal management continuum, recovery services, clinician consultation, narcotic treatment programs expanded to include buprenorphine, disulfiram, and naloxone, care coordination, early intervention services for members under age 21, and at county option, partial hospitalization, peer support services, and contingency management	Nonresidential treatment, residential treatment, ancillary services, and recovery support services	Prevention and early intervention; Screening, Brief Intervention, and Referral to Treatment; medication-assisted treatment provided in medical settings; inpatient withdrawal management in general and freestanding facilities

Note: *SUD* is substance use disorder.

Sources: Cal. Welf. & Inst. Code § 5600–5623.5; *California Mental Health and Substance Use System Needs Assessment and Service Plan — Volume 2: Service Plan* (PDF), California Department of Health Care Services, September 30, 2013; Allison Valentine, Patricia Violett, and Molly Brassil, *How Medi-Cal Expanded Substance Use Treatment and Access to Care*, California Health Care Foundation, August 2020, and Ivan Bhardwaj (division chief, Medi-Cal Behavioral Health, Policy Division) and Michele Wong (division chief, Medi-Cal Behavioral Health, Oversight & Monitoring Division) to California Alliance of Child and Family Services et al., "Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026" (PDF), Behavioral Health Information Notice No: 24-001, December 21, 2023.

California's Drug Medi-Cal Organized Delivery System by County, California, 2024



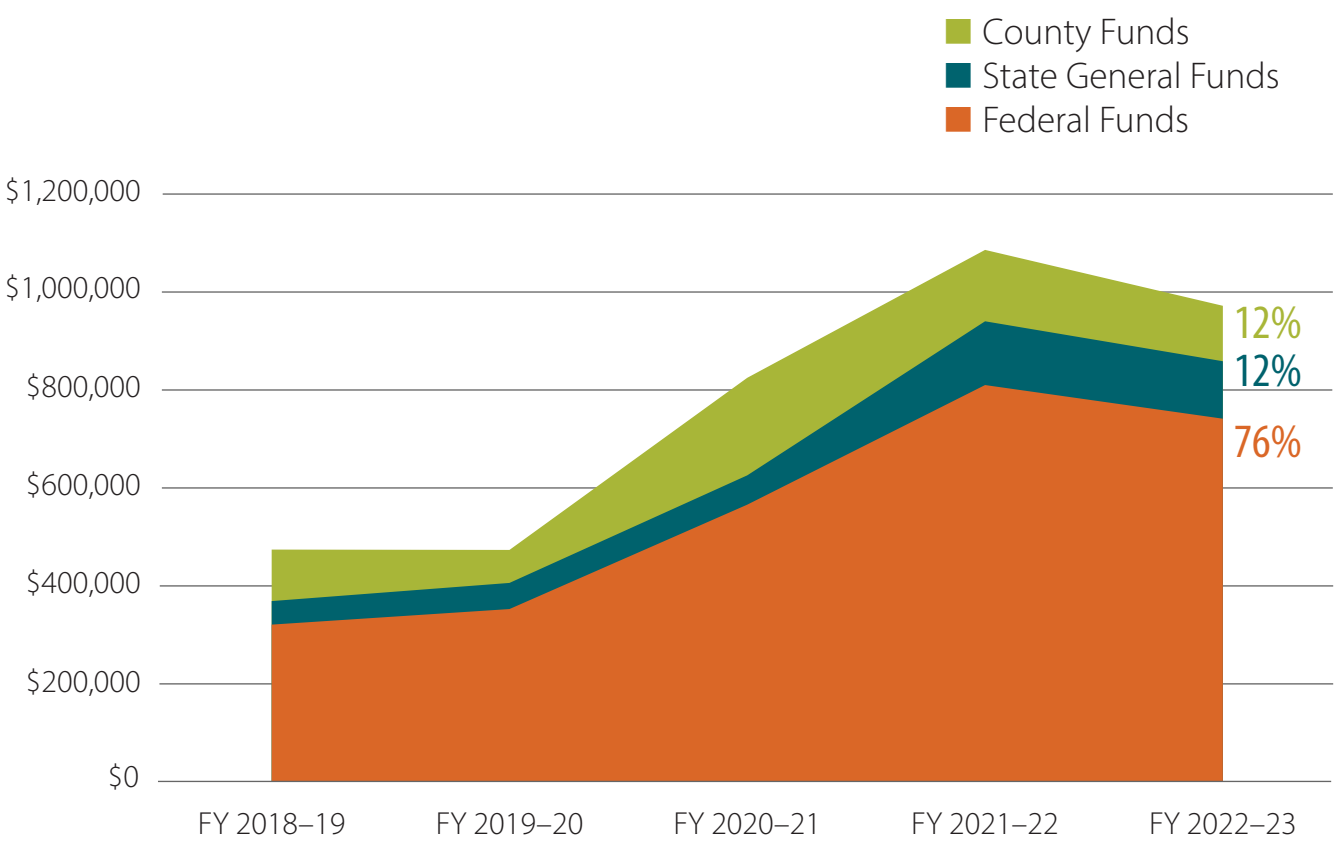
Note: *DMC-ODS* is Drug Medi-Cal Organized Delivery System.

Source: "Counties Participating in DMC-ODS," California Department of Health Care Services, accessed August 2024.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) enables participating counties to expand the services provided under the standard Drug Medi-Cal state plan to provide a continuum of care for substance use disorder treatment services. As of August 2024, 39 counties, representing 96% of the state's Medi-Cal population, had implemented DMC-ODS.

Drug Medi-Cal Program Financing
California, FY 2018–19 to FY 2022–23

DOLLARS (IN THOUSANDS)



Notes: All numbers are estimates. In FY 2021–22 and FY 2022–23, *State general funds* includes the estimated cost of adding Contingency Management as an optional evidence-based service under the Drug Medi-Cal Organized Delivery System waiver program, including the Home and Community-Based Services American Rescue Plan Fund.

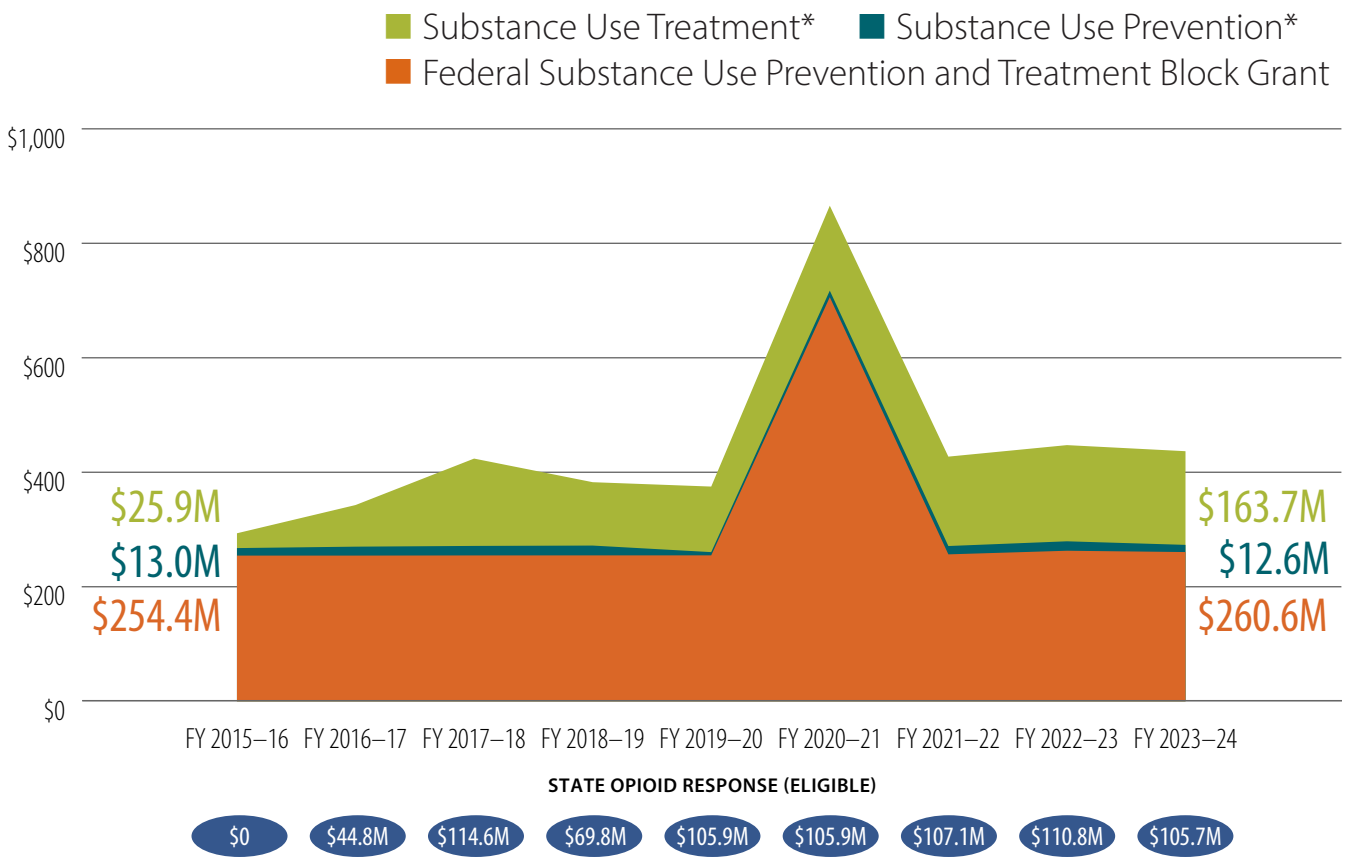
Source: *Drug Medi-Cal Supplemental Charts* (May 2019–May 2023), California Department of Health Care Services.

The Drug Medi-Cal program is jointly funded by federal, state, and county government. In fiscal year 2022–23, the federal government financed 76% of the program.

SAMHSA Substance Use Disorder Grants

California, FY 2015–16 to FY 2023–24

IN MILLIONS



* Discretionary funding

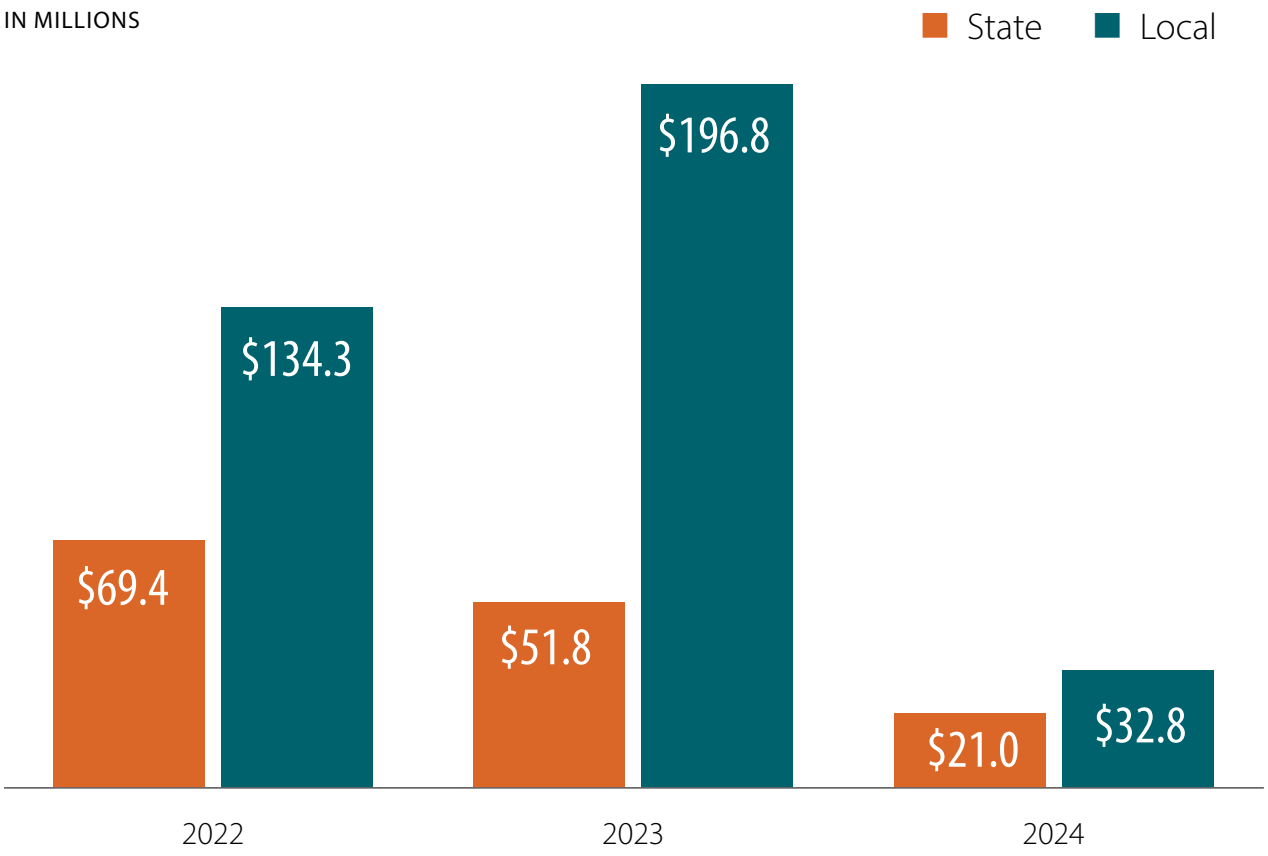
Notes: *SAMHSA* is Substance Abuse and Mental Health Services Administration. California is also eligible to apply for State Opioid Response (SOR). The SOR numbers are the maximum dollar amounts per year for which California was eligible to apply. FY 2016–17 SOR numbers are State Targeted Response to the Opioid Crisis (STR) grants awarded and funded. FY 2017–18 SOR numbers include STR awarded and funded ($49.8 million) and SOR awarded.

Source: "SAMHSA Grants Dashboard," SAMHSA, accessed December 20, 2024.

In fiscal year 2023–24, California was awarded grants totaling $437 million for the prevention and treatment of substance use. In addition, California was eligible to apply for $106 million in state opioid response grant funding.

Opioid Settlement and Bankruptcy Funds by Recipient

California, 2022 to 2024



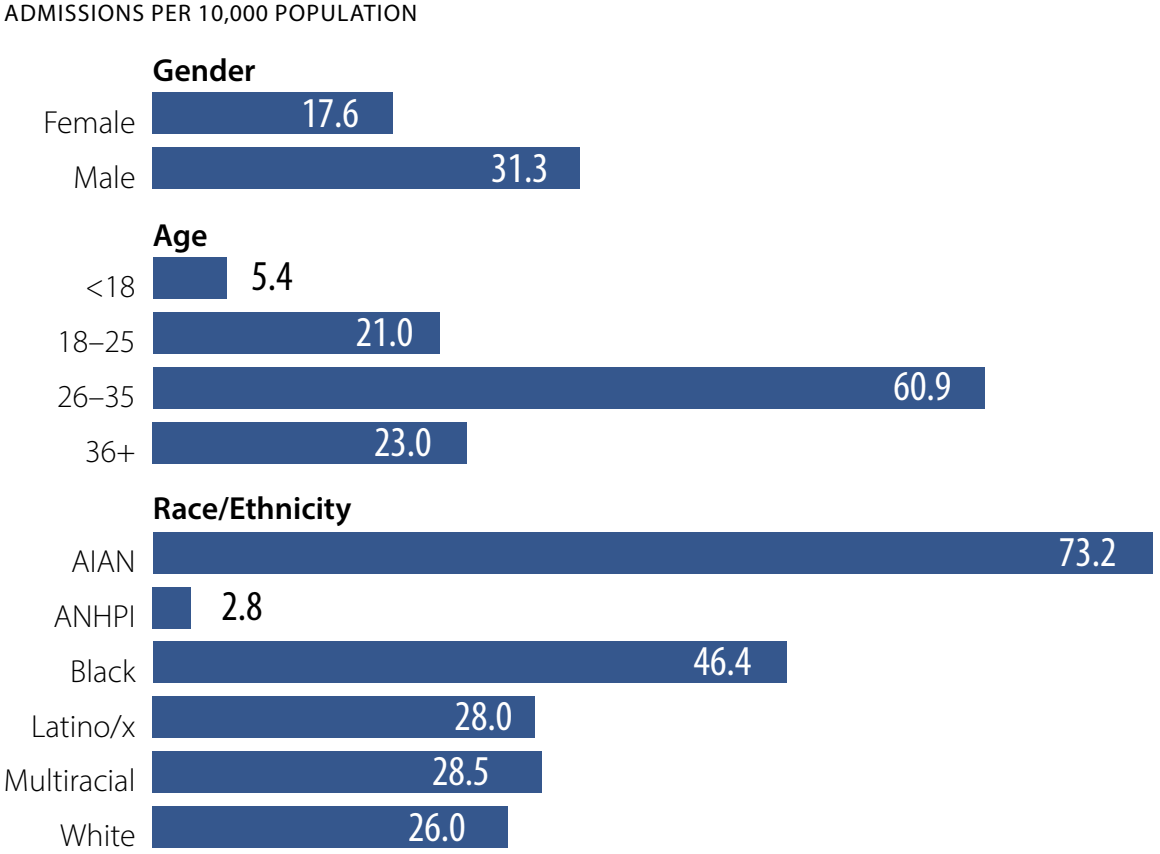
California joined national lawsuits against opioid manufacturers and distributors in an effort to abate the opioid epidemic. The state, and its cities and counties, began receiving funds in 2022 and are expected to receive additional funds through 2038.

Notes: Data include monies from settlements and bankruptcies distributed to California pursuant to the relevant National Opioid Settlement Agreements, National Mallinckrodt Bankruptcy Plan, and Endo Public Opioid Trust Agreement. The California opioid settlements are allocated to cities and counties through the California Abatement Accounts Fund and the California Subdivision Fund. The California State Fund is allocated to the state for opioid remediation. Funds received from the Mallinckrodt bankruptcy are allocated to participating cities and counties (National Opioid Abatement Trust [NOAT] II - Local Government Share) and to the state (NOAT II - State Share) for state use. For more information, see California Opioid Settlements.

Sources: *List of California Janssen and Distributors Settlement Payments (as of June 30, 2024)*, California Department of Health Care Services (DHCS); and *List of California Mallinckrodt Bankruptcy Payments (as of October 2024)*, DHCS.

Admission to State- or County-Contracted SUD Programs by Gender, Age, and Race/Ethnicity

California, SFY 2022–23

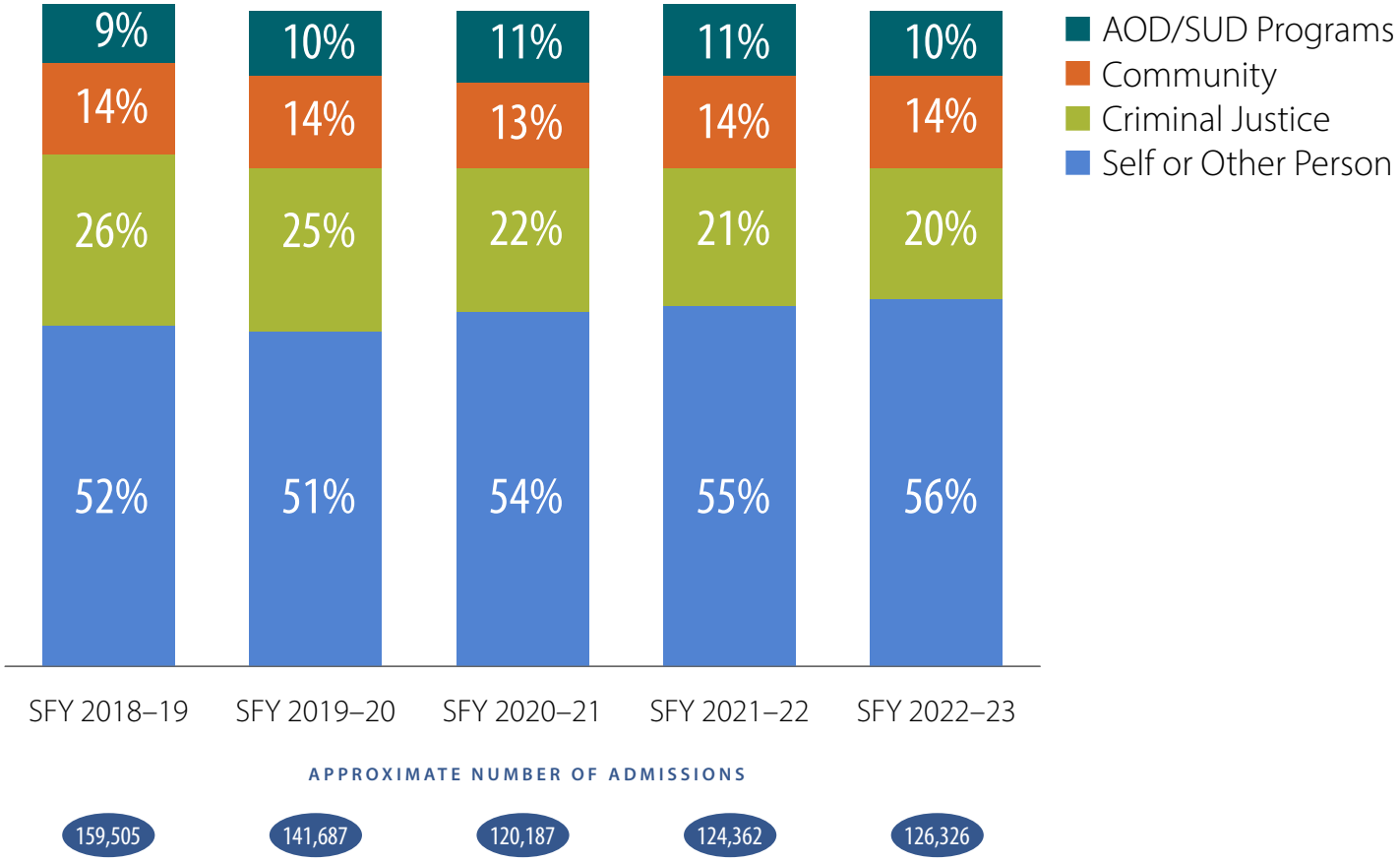


About 95,000 people were admitted to state- and county-contracted substance use disorder programs in state fiscal year 2023. The admission rate for males was higher than the rate for females. Adults age 26 to 35 had the highest rates of admission of any age group. American Indian and Alaska Native Californians had the highest rates of admission per population.

Notes: Unduplicated count of people for their most recent admission for substance use disorder (SUD) treatment during state fiscal year (SFY) 2022–23. *AIAN* is American Indian and Alaska Native. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. Source uses *Asian / Pacific Islander*, *Latino*, and *Native American / Alaska Native*.

Sources: Author calculations based on custom data request to the California Department of Health Care Services for CalOMS Treatment data, received May 2025; and *Report P-1A: Total Population Projections, California, 2020–2060*, California Department of Finance, April 2025.

Admissions to State- or County-Contracted SUD Programs by Referral Source, California, SFY 2018–19 to SFY 2022–23

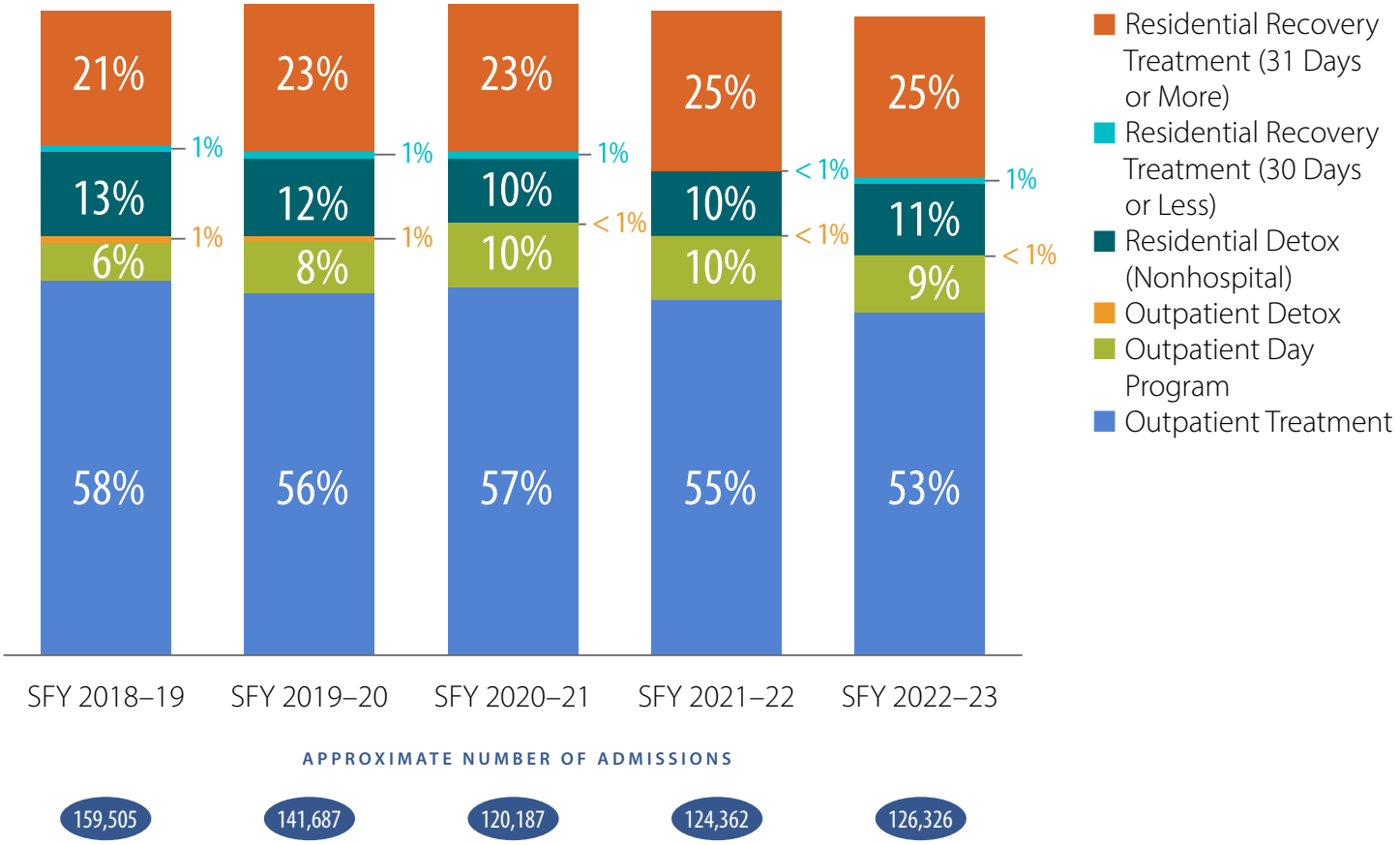


Between state fiscal year (SFY) 2018–19 and SFY 2022–23, an increasing share of admissions to state- or county-contracted substance use disorder services were self-referrals or referrals from other people. Referrals from criminal justice organizations decreased during the five-year period shown.

Notes: Data are based on client admissions, not unique client counts. Admissions are for residential and outpatient only. Detox services are not included. *AOD* is alcohol and other drug. *SUD* is substance use disorder. *Community* includes referrals from other health care providers, schools, employers or employee assistance programs, Alcoholics Anonymous or Al-Anon, and other community and religious organizations. *SFY* is state fiscal year. Figures may not sum due to rounding.

Source: Custom data request for CalOMS Treatment data, California Department of Health Care Services, received May 2025.

Admissions to State- or County-Contracted SUD Programs by Facility Type, California, SFY 2018–19 to SFY 2022–23



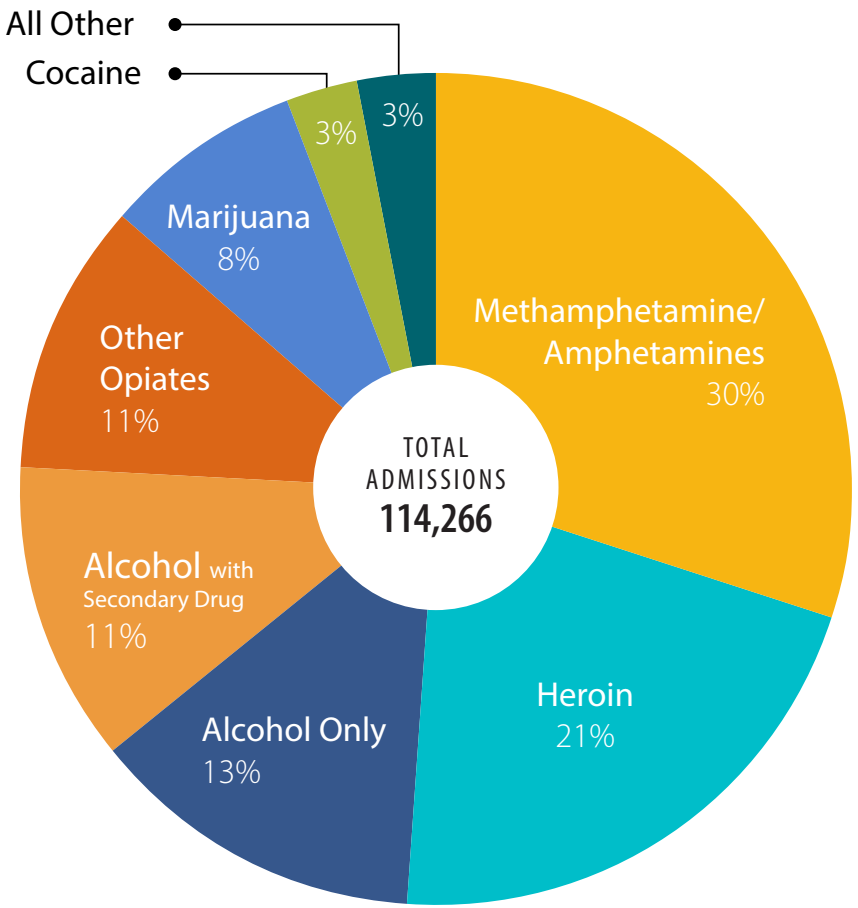
Notes: Data are based on client admissions, not unique client counts. *SUD* is substance use disorder. *Outpatient treatment* includes outpatient treatment, recovery use for outpatient drug free and narcotic treatment program (NTP) facilities. *Outpatient day program* includes outpatient day program intensive, day care rehabilitative use for intensive outpatient, and day care rehabilitative facilities. *Outpatient detox* includes NTP detox facilities. *SFY* is state fiscal year. Figures may not sum due to rounding. See Appendix D for detail by gender, age, and race/ethnicity.

Source: Custom data request for CalOMS Treatment data, California Department of Health Care Services, received May 2025.

The number of admissions to state- or county-contracted substance use disorder programs decreased by 20% between state fiscal year (SFY) 2018–19 and SFY 2022–23. During that time the share of admissions to residential recovery treatment programs (31 days or more) increased, while the share of admissions to outpatient treatment programs decreased.

Admissions to State- or County-Contracted Substance Use Disorder Programs, by Primary Substance Use, California, 2021

PERCENTAGE OF UNIQUE CLIENTS



Notes: Clients age 12 and older admitted to substance use disorder programs. *Cocaine* includes both smoked and other routes. *All other* includes tranquilizers, sedatives, hallucinogens, PCP, inhalants, and other / none specified. Although California Proposition 64 (2016) legalized recreational use of marijuana for adults over age 21 (effective January 1, 2018), marijuana is still considered an illicit substance at the federal level. Figures may not sum due to rounding.

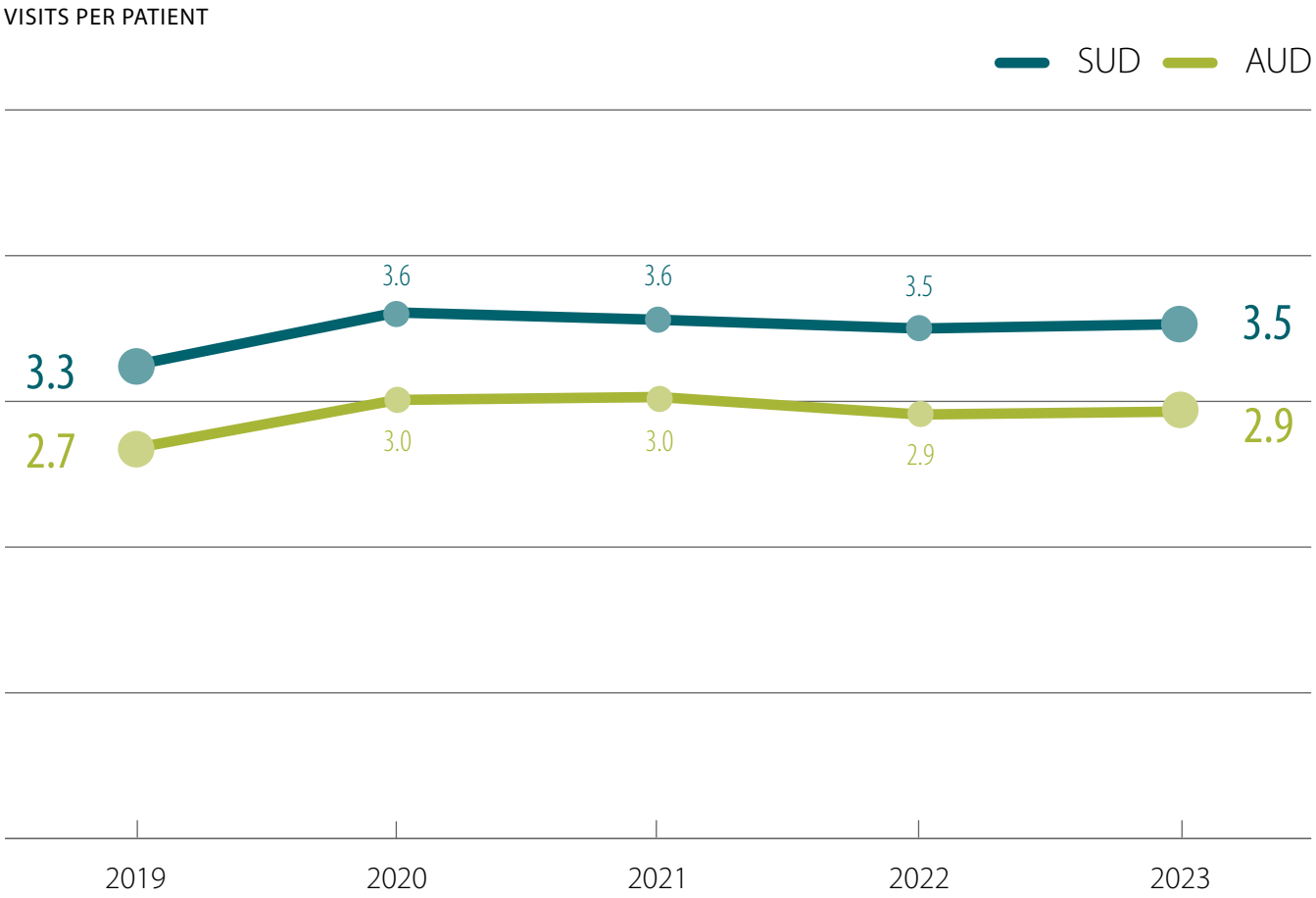
Source: *Treatment Episode Data Set (TEDS) 2021: Annual Detailed Tables* (PDF), Substance Abuse and Mental Health Services Administration, 2023, table 7.5a.

Methamphetamine/amphetamines were the primary substances used by 30% of people admitted to state- and county-contracted substance use disorder treatment programs. Heroin was the primary substance for 21% of admissions. Although alcohol use disorder is the most common substance use disorder in California,* alcohol (either alone or with a secondary drug) represented 24% of admissions.

* *2021–2022 National Survey on Drug Use and Health: State-Specific Tables*, Substance Abuse and Mental Health Services Administration, table 20.

FQHC Visits, Substance Use Disorder and Alcohol Use Disorder

California, 2019 to 2023



From 2019 to 2023, California's Federally Qualified Health Centers provided roughly 3.5 substance use disorder-related and 3.0 alcohol use disorder-related visits per patient annually.

Notes: Source uses *other substance-related disorders* (SUD), which includes ICD-10-CM code or Value Set Object Identifier (OID) F11- through F19- (except F17-), G62.0, and O99.32 and *alcohol-related disorders* (AUD) which includes ICD-10-CM code or Value Set OID F10-, G62.1, and O99.31. Substance use disorder visits do not include alcohol or tobacco use disorder–related visits. Visits are number of visits by diagnosis regardless of primacy.

Source: Custom data request, Capitol Link, received December 10, 2024.

Methodology

The charts were developed through review of numerous public sources of data on substance use disorder prevalence, treatment resources, use of treatment, and state and national expenditures. In some cases, the author calculated rates per population using estimates and projections of the California Department of Finance. Data not publicly available were acquired through custom data requests to California state agencies.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

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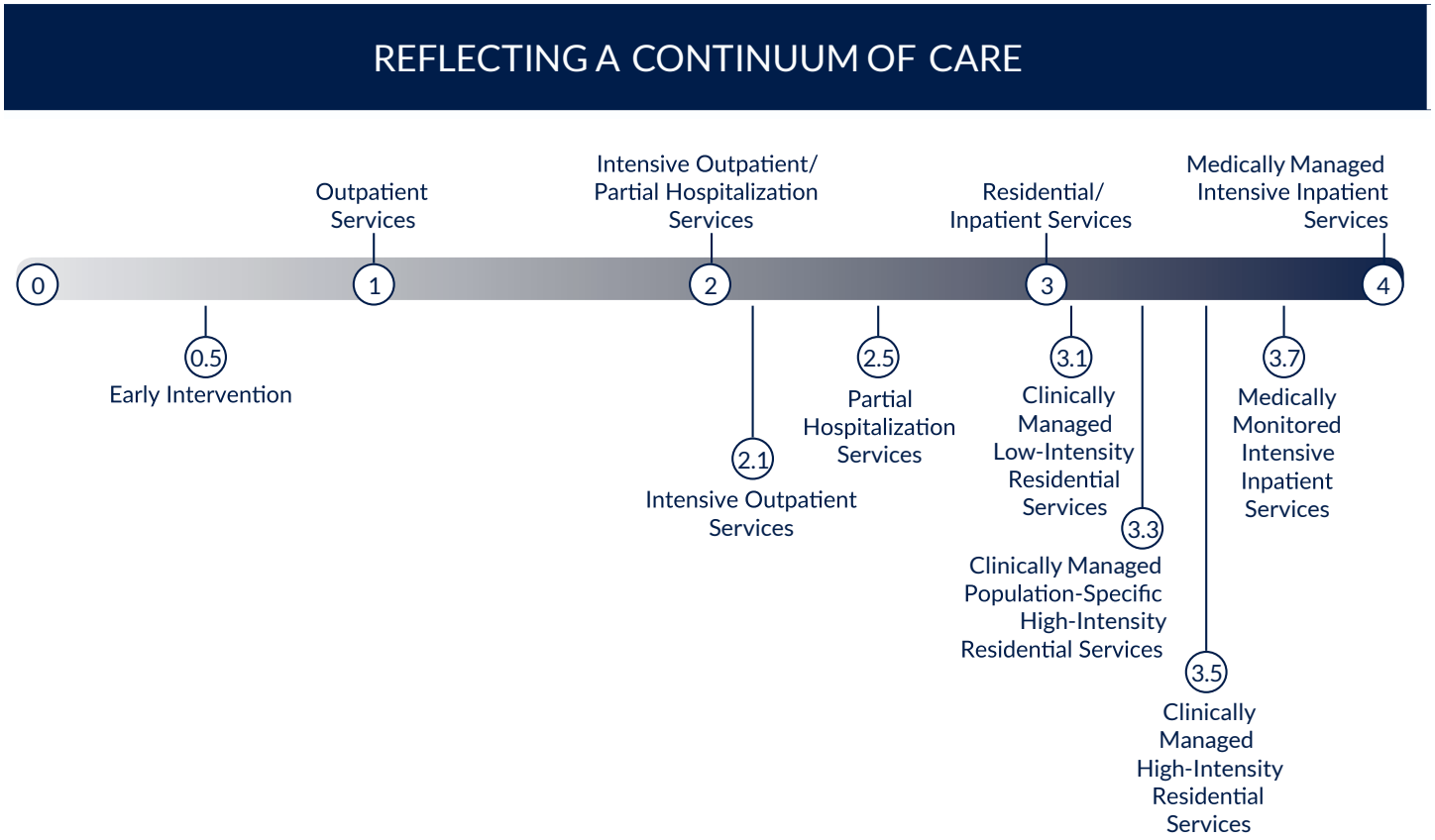
Appendix A. ASAM Levels of Care

The ASAM Criteria is a comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co-occurring conditions. Level of care recommendations and treatment plans are developed based on multidimensional patient assessments that consider the patient's biomedical, psychological, and social needs.



Notes: Within the five broad levels of care (0.5, 1, 2, 3, and 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in intensity without necessarily being placed in a new benchmark level of care.

These levels reflect ASAM 3rd Edition criteria, which were updated to 4th Edition in 2024. However, as of July 2025, updated DHCS guidance and tools utilizing the ASAM Criteria 4th Edition were not available.

Source: "What Are the ASAM Levels of Care?," American Society of Addiction Medicine, May 13, 2015.

Appendix B. California Counties Included in Regions

REGION	COUNTIES
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Greater Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Inland Empire	Riverside, San Bernardino
Los Angeles County	Los Angeles
Northern and Sierra	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Orange County	Orange
Sacramento Area	El Dorado, Placer, Sacramento, Yolo
San Diego Area	Imperial, San Diego
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare

Appendix C. Licensed Narcotic Treatment Programs, by California County, 2020

COUNTY	SLOTS PER 100,000 POPULATION
Alameda	16.9
Alpine	0.0
Amador	0.0
Butte	30.2
Calaveras	0.0
Colusa	0.0
Contra Costa	17.6
Del Norte	0.0
El Dorado	7.4
Fresno	28.3
Glenn	0.0
Humboldt	26.0
Imperial	27.9
Inyo	0.0
Kern	24.4
Kings	0.0
Lake	0.0
Lassen	0.0
Los Angeles	10.2
Madera	0.0

COUNTY	SLOTS PER 100,000 POPULATION
Marin	13.7
Mariposa	0.0
Mendocino	22.3
Merced	17.7
Modoc	0.0
Mono	0.0
Monterey	9.6
Napa	0.0
Nevada	15.4
Orange	7.6
Placer	22.5
Plumas	0.0
Riverside	10.4
Sacramento	27.1
San Benito	0.0
San Bernardino	9.5
San Diego	13.5
San Francisco	45.9
San Joaquin	35.2
San Luis Obispo	17.0

COUNTY	SLOTS PER 100,000 POPULATION
San Mateo	9.5
Santa Barbara	21.4
Santa Clara	5.6
Santa Cruz	29.3
Shasta	38.6
Sierra	0.0
Siskiyou	0.0
Solano	19.8
Sonoma	13.5
Stanislaus	5.5
Sutter	0.0
Tehama	0.0
Trinity	0.0
Tulare	22.2
Tuolumne	9.3
Ventura	22.5
Yolo	10.3
Yuba	106.6

Notes: Only narcotic treatment programs licensed by the California Department of Health Care Services, with approval from the US Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration may provide narcotic replacement therapy (NRT) to administer methadone. To receive NRT medications, all patients are required to participate in a comprehensive treatment program, which includes a medical evaluation and counseling for medical, alcohol, criminal, and psychological problems. Patients are required to undergo regular urinalysis to ensure that illicit drugs are not being used during treatment.

Sources: Author calculations based on *Narcotic Treatment Program Directory* (PDF), California Department of Health Care Services, June 11, 2024; and *Report P-1A: Total Estimated and Projected Population for California: July 1, 2020 to July 1, 2060 in 1-Year Increments* (2023), California Department of Finance, March 2024.

Appendix D. Admissions to State- or County-Contracted SUD Programs by Facility Type and Gender, Age Group, Race/Ethnicity California, SFY 2022–23

		FACILITY TYPE				
		OUTPATIENT TREATMENT	OUTPATIENT DAY PROGRAM	RESIDENTIAL DETOX (NON-HOSPITAL)	RESIDENTIAL RECOVERY TREATMENT (30 DAYS OR LESS)	RESIDENTIAL RECOVERY TREATMENT (31 DAYS OR MORE)
Gender	**Female**	12.6	2.6	2.2	0.3	6.0
	Male	22.0	3.4	5.1	0.5	10.1
Age	**Under 18**	5.4	0.2	NA	0.1	0.2
	18 to 25	14.8	2.6	2.8	0.4	7.5
	26 to 35	42.4	8.5	9.1	1.0	22.8
	36+	15.9	2.7	3.9	0.4	7.4
Race/Ethnicity	**AIAN**	49.3	7.0	14.3	2.1	24.4
	ANHPI	2.0	0.4	0.4	0.1	0.8
	Black	28.0	6.7	8.3	0.5	18.7
	Latino/x	20.1	3.5	3.2	0.5	9.1
	Multiracial	20.2	3.5	4.3	0.5	9.6
	White	18.9	3.0	4.7	0.4	8.2

Notes: Data are based on client admissions, not unique client counts. *SUD* is substance use disorder. *Outpatient treatment* includes outpatient treatment, recovery use for outpatient drug free and narcotic treatment program (NTP) facilities. *Outpatient day program* includes outpatient day program intensive, day care rehabilitative use for intensive outpatient, and day care rehabilitative facilities. *Outpatient detox* includes NTP detox facilities. *AIAN* is American Indian and Alaska Native. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. *SFY* is state fiscal year. Source uses *Asian / Pacific Islander*, *Latino*, and *Native American / Alaska Native*. Insufficient data were available for outpatient detox facilities.

Sources: Author calculations based on custom data request for CalOMS Treatment data, California Dept. of Health Care Services, received May 2025; and *Report P-1A: Total Population Projections, California, 2020–2060*, California Department of Finance, April 2025.

Appendix E. Diagnostic Criteria for Substance Use Disorder and Alcohol Use Disorder, *DSM-5*

The *DSM-5* describes problematic use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    - **a.** A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - **b.** A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
    - **a.** The characteristic withdrawal syndrome for that substance (as specified in the DSM-5 for each substance).
    - **b.** The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Source: *DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5* (American Psychiatric Association, 2013).

Appendix E. Diagnostic Criteria for Substance Use Disorder and Alcohol Use Disorder, *DSM-5* (continued)

The *DSM-5* describes a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.

1. Craving, or a strong desire or urge to use alcohol.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. Alcohol is often taken in larger amounts or over a longer period than was intended.
4. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
5. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
6. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
7. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
8. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
9. Tolerance, as defined by either of the following:
   - **a.** A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   - **b.** A markedly diminished effect with continued use of the same amount of alcohol.
10. Withdrawal, as manifested by either of the following:
    - **a.** The characteristic withdrawal syndrome for alcohol.
    - **b.** Alcohol (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
11. Recurrent alcohol use in situations in which it is physically hazardous.

Source: *DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5* (American Psychiatric Association, 2013).

Appendix F. California SUD Treatment Programs and Services

	DESCRIPTION	LICENSING AUTHORITY	DHCS SUD COMPLIANCE DIVISION PROGRAM CERTIFICATION
Driving Under the Influence (DUI) Programs	Providing court-mandated educational sessions to those convicted of driving under the influence	Department of Health Care Services (DHCS) Substance Use Disorder Compliance Division	N/A
Emergency Medical Services	Hospital emergency medical services for people experiencing substance use disorder (SUD) issues	Department of Public Health	Voluntary
Narcotic Treatment Programs	Providing replacement narcotic therapy to people overcoming opioid dependency	DHCS Substance Use Disorder Compliance Division	Voluntary
Outpatient SUD Services	Any outpatient medical facility licensed by the Department of Public Health may also provide SUD outpatient services	Department of Public Health	Voluntary
	Nonhospital outpatient SUD providers offering nonmedical SUD care	No licensure required or available	Voluntary
Residential Medical Services	Medical services in a hospital residential setting to people overcoming alcohol or other drug issues	Department of Public Health	Voluntary
Residential Nonmedical Services	Nonmedical care, recovery services, or both to adults for the treatment of alcohol and other drug issues in a residential setting, including alcohol or drug detoxification; group, individual, or educational sessions; recovery or treatment planning; or some combination of these	DHCS Substance Use Disorder Compliance Division	Voluntary for DHCS SUD Compliance Division licensed facilities, and DSS or other state agency licensed residential nonmedical facilities with an SUD treatment component

Notes: *SUD* is substance use disorder. *N/A* is not applicable.

Source: Cal. Code Regs. tit. 9, § 9000 et seq