

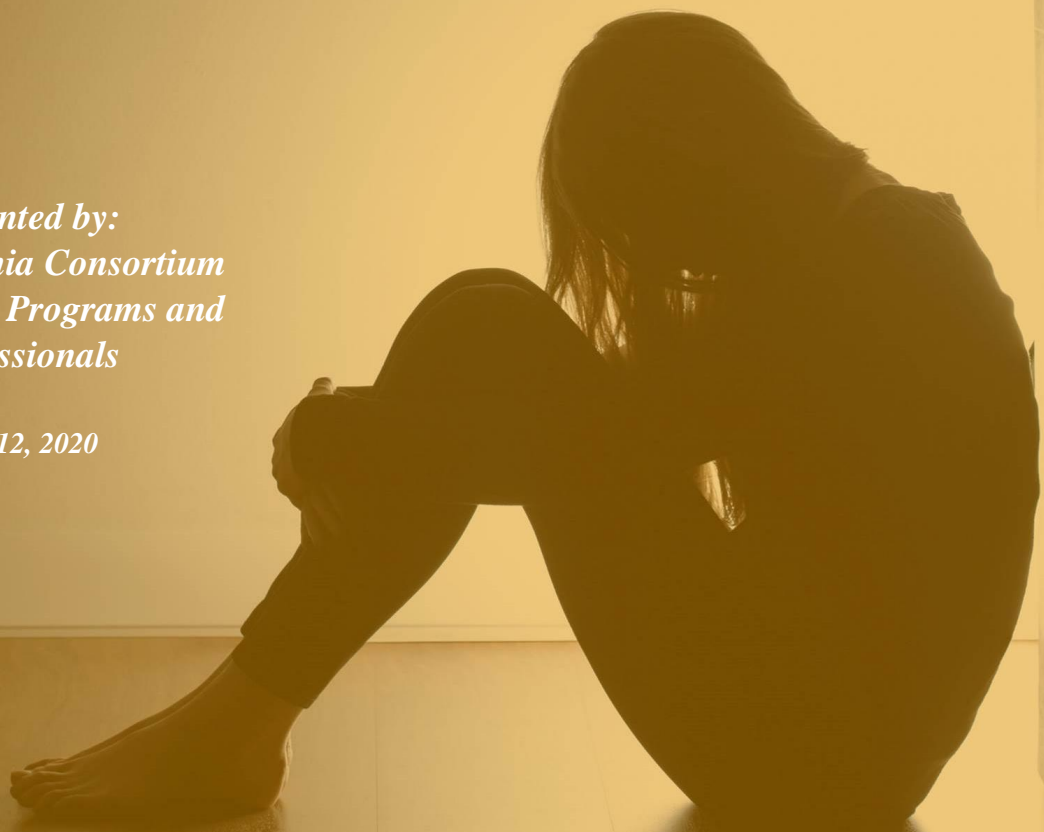
The Disease of Addiction Thrives on Isolation

*A Report to Governor Gavin Newsom
and the California Legislature*

**The Impact of COVID-19 on the State's Fragile
Substance Use Disorder Treatment System**

*Presented by:
The California Consortium
of Addiction Programs and
Professionals*

May 12, 2020



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California Legislature on the Impact of COVID-19 on the
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Sacramento, California

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In coordination with:



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California Council of Community
Behavioral Health Agencies

The Parallel Epidemic

*An Urgent Plea from CCAPP Chief Executive Officer
Pete Nielsen*

Prior to February 2020, Californians faced a deadly force killing thousands of citizens each year: the opioid epidemic. Regardless of race, education, wealth, or social standing, the disease of addiction has ravaged this state and the nation. Pre-COVID-19, deaths from alcohol, drugs and suicide were on track to break records in the number of victims in our state this year. Those who survive this year will face a second wave of death due to tobacco related diseases and or relapse to drug of choice unless tobacco is routinely treated in Substance Use Disorder. Sadly, the pandemic we now face portends an upward spike in deaths from untreated addiction that may rival deaths from COVID-19.

Economic despair, psychiatric trauma, an inability to access services, and a constricting treatment system in the face of rapid increases in demand for services paints a picture that resembles the familiar graphics which depicted a growing number of COVID patients and a limited number of hospital beds and ventilators, yet no plan is yet in place to lessen the impact of California's "parallel epidemic."

This report gives insight to policy makers about what our families, communities, and people with addiction are now facing. Based on historic trends and contemporary data gathered over just the past month, *The Disease of Addiction Thrives on Isolation*, can serve as an important tool in preparing the state to lessen the devastating impact of addiction as we move through this crisis. It also provides policy direction from leaders and experts in the field of addiction who are grappling with the historic events we are now experiencing.

Saving lives endangered by addiction in the era of COVID-19 will take concerted leadership and a cross-systems approach. Addiction responses must come from multiple agencies and jurisdictions. Because a successful response to the parallel epidemic will involve action from the Governor to suspend or waive certain regulations and statute; action from budget committees to ensure that resources are put into place; and strategies from various committees to enact legislation that can quickly address systematic hurdles, the information in *The Disease of Addiction Thrives on Isolation* is presented from a comprehensive standpoint so that policy makers can see the relationships between systems that must be fortified to create an effective response. The *Table of Contents* provides a breakdown of where information may be found by subject.

CCAPP commends the Governor and Legislature for their heroic efforts to save Californians from COVID-19 infection and death. Having witnessed the leadership harnessed to address this crisis in our state, we are confident that California will become the model for addressing the parallel epidemic as well. It is with that spirit that our profession pledges to do all that we can to assist decision makers in designing a response our citizens will be grateful for and our nation will take pride in.

United States Pre COVID-19 Substance Use Disorder Conditions:

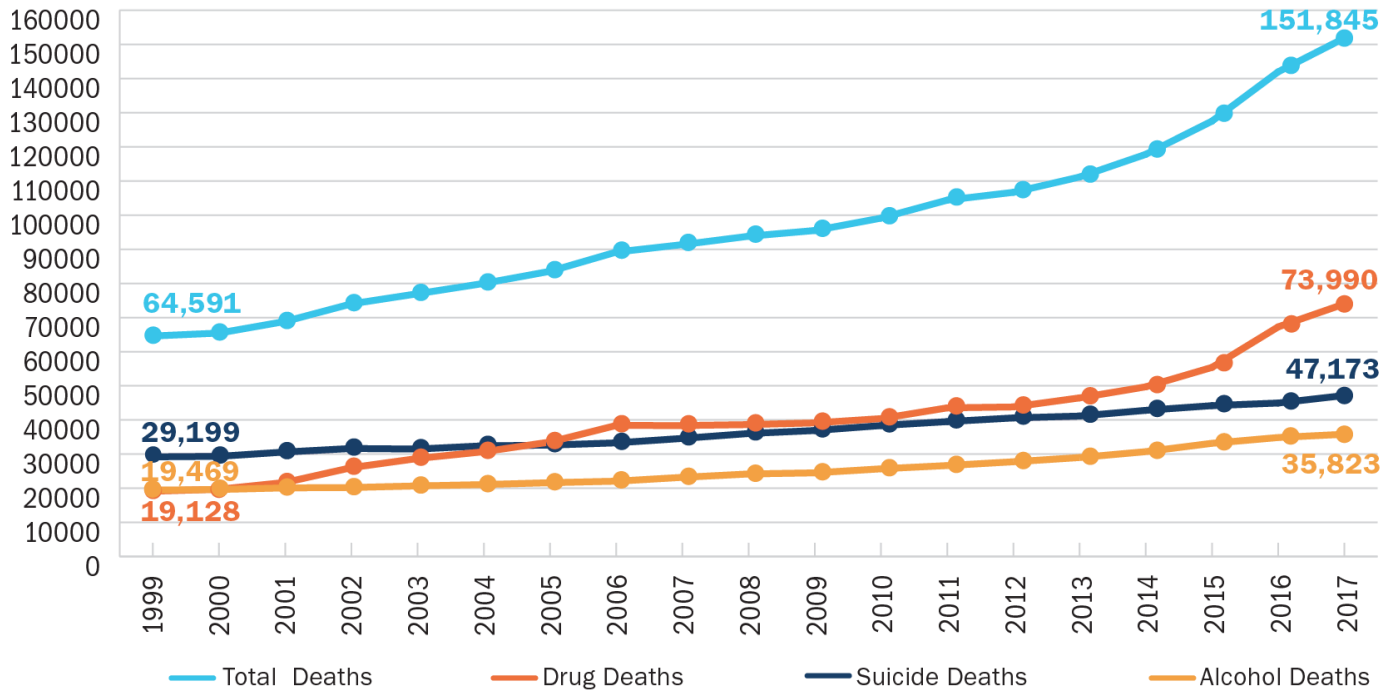
Prior to January 1, 2020, the nation faced a growing opioid epidemic, rising addiction rates, and an exponential growth in deaths caused by alcohol abuse, drug overdose, and suicide. More than 1 million Americans have died in the past decade from drug overdoses, alcohol, and suicides (2006 to 2015) and life expectancy in the country decreased in 2017 for the first time in two decades.ⁱ From 2016 to 2017, the combined death rate for alcohol, drug, and suicide increased 6 percent, from 43.9 to 46.6 deaths per 100,000 people.ⁱⁱ

The current addiction crisis is evidenced by the following:

- More than 150,000 Americans died from alcohol- and drug-induced causes and suicide in 2017—more than twice as many as in 1999—according to a new analysis by Trust for America’s Health (TFAH) and Well Being Trust (WBT) of mortality data from the U.S. Centers for Disease Control and Prevention (CDC).ⁱⁱⁱ
- Among those age 35-54, the rate of death by alcohol, drug, and suicide was 72.4 per 100,000, highest among all age groups.^{iv}
- Synthetic-opioid deaths increased 10-fold over the prior five years, including a 45 percent climb between 2016 and 2017.^v
- In 2017, life expectancy decreased in the United States for the third year in a row.^{vi} This was, in part, due to increases in death rates for alcohol, drugs, and suicide. The increases in deaths from synthetic-opioid overdoses and suicide in 2017 were particularly alarming.
- A recent analysis conducted by the Berkeley Research Group (BRG) found that if the current rise in drug, alcohol and suicide death trends continue — over the next decade, these three epidemics would be expected to result in more than 1.6 million deaths (by 2025). This would represent a 60 percent increase over the current level.
- Life expectancy rates declined 20 percent among middle-class Whites with less than a college education during this time period, with deaths from drug overdoses, alcohol poisoning, liver disease and suicide all tripling among this cohort. These trends have not been seen within other racial and ethnic groups.^{vii}
- 15.7 million Americans (5.9 percent) have an alcohol use disorder.^{viii}
- Alcohol-induced deaths have reached a 35-year high, growing by 37 percent from 2000 to 2014, with 33,200 Americans dying from liver diseases, alcohol poisoning and other diseases as of 2015.^{ix}

- Healthcare spending for individuals who have a diagnosis related to drugs, alcohol or individuals at risk for suicide are 2.5 times higher than the average American adult, at \$20,113 per patient per year.^x

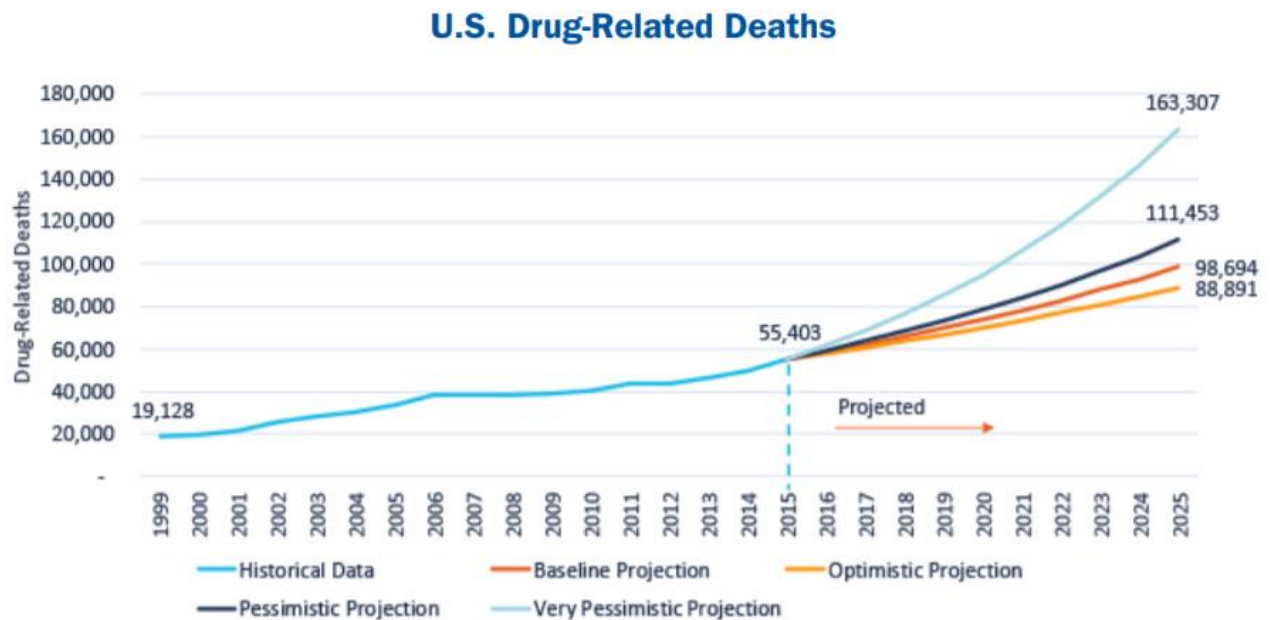
Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2017



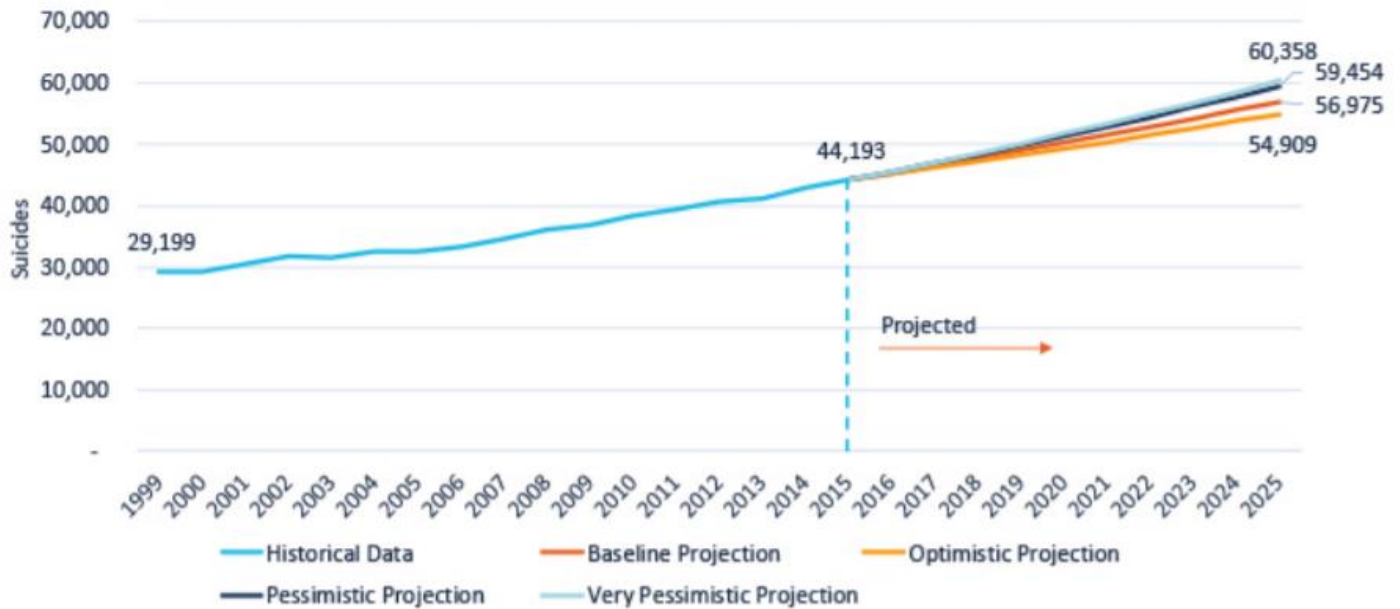
Source: Trust for America's Health and Well Being Trust analysis of data from National Center For Health Statistics, CDC

Projected Substance Use Disorder Conditions (without COVID-19 Impact)

The Berkeley Research Group produced modeling, based on historic trends, optimistic, and pessimistic estimates for alcohol, drug, and suicide rates as follows^{xi}:



U.S. Suicide-Related Deaths



California Specific Substance Use Disorder Conditions (without COVID-19 Impact)

Over the past five years, California has focused efforts on reducing increases in deaths attributed to alcohol, drug, and suicide factors by reducing the commercial availability of opioids (CURES 2.0), reforming the state's addiction treatment system (1115 Waiver to create the Drug Medi-Cal Organized Delivery System/DMC-ODS), addressing Adverse Childhood Experiences ACEs by allocating Proposition 64 funding to interventions in early childhood development, and multiple other significant projects and strategies. Although these programs are beginning to make an impact, data predicted a need for additional resources (before COVID arrived):

- The Berkeley Research Group compiled historic and trend data specific to each state regarding alcohol, drug, and suicide rates. California's forecast predicts a need for continued focus to arrest increasing rates.^{xii}

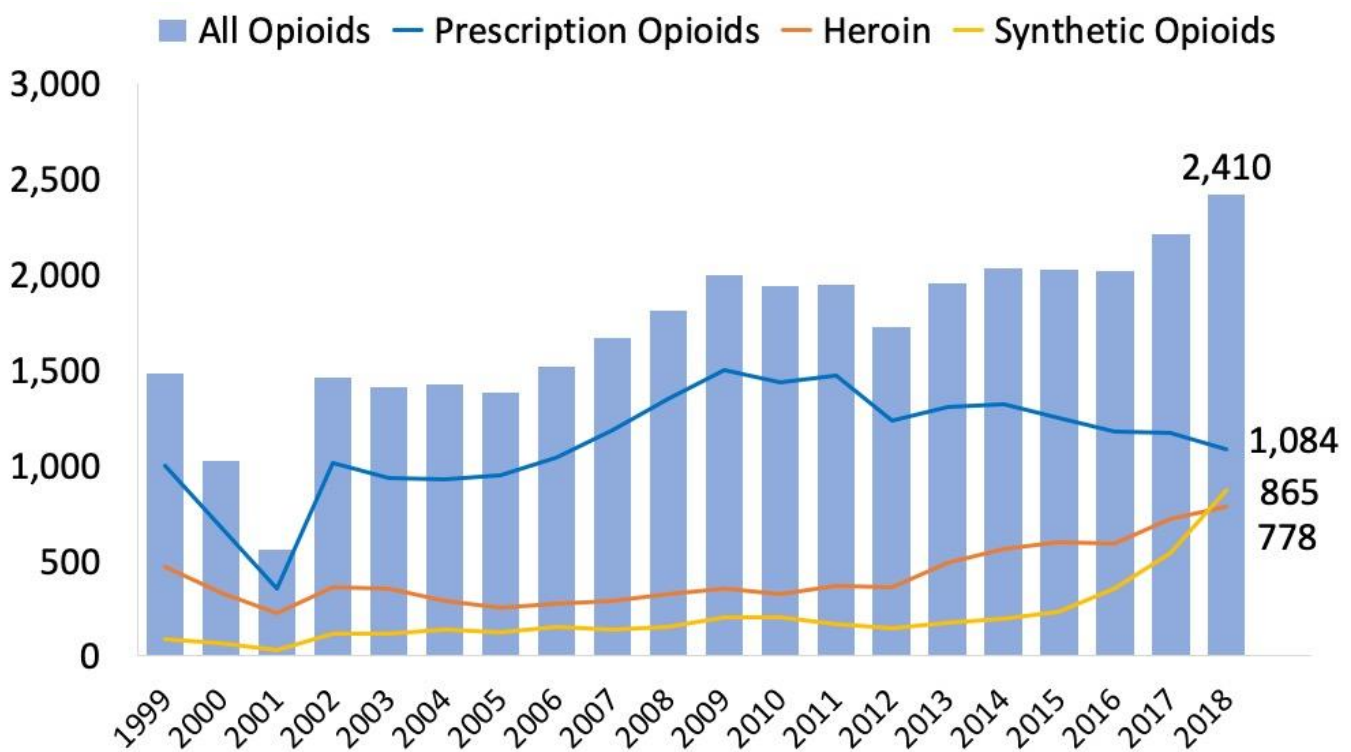
ALCOHOL, DRUG AND SUICIDE DEATH RATES PER 100,000 IN 1999 AND 2015 AND 2025 PROJECTIONS (CDC WONDER)

	Alcohol Deaths				Drug Deaths			
	1999	2015	2025	Change 1999-2025	1999	2015	2025	Change 1999-2025
California	9.8	13.2	16.6	69%	9.2	11.9	21.2	130%

- In 2014 the yearly health care cost for the average Californian was \$7,549, while the cost of health care for individuals with alcohol, drug, or suicide diagnoses, the cost was

\$18,873 (2.5 times the rate of the general population), making these three factors one of the predominant accelerators of costs to the healthcare system.^{xiii}

- In California, an estimated 45% of drug overdose deaths involved opioids in 2018; a total of more than 2,400 fatalities (a rate of 5.8 per 100,00 adjusted for age).^{xiv}
- Among opioid-involved deaths, the largest increase involved synthetic opioids other than methadone (mainly fentanyl and fentanyl analogs) with a more than 60% increase from 536 in 2017 to 865 in 2018.^{xv}



- Deaths involving heroin also continued to rise to 778 reported in 2018. Deaths involving prescription opioids continued a downward trend and totaled 1,084 in 2018 (primarily due to a decrease in deaths caused by prescription opioids).^{xvi}
- In 2018, 2,487,000 Californians met criteria for illicit drug or alcohol dependence or abuse based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

- In 2018, individuals needing but not receiving substance use disorder services as defined as meeting criteria for illicit drug or alcohol dependence or abuse as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), was 2,339,000.
- As of April 2020, there are 1,742 (only 17 more than in 2008) residential treatment beds in California; if each bed is used for a treatment duration of 30 days, yearly capacity is 20,904 unique clients.
- As of April 2020, there are 832 certified outpatient programs in California, with a current unknown capacity (DHCS does not track this capacity).
- As of April 2020, there are 9,038 certified addiction counselors and 10,108 registered alcohol drug technicians in California.

Historical Context of Demand Spikes for Substance Use Disorder Services:

There are two multipliers that can be reasonably expected to increase substance use disorder cases: unemployment and traumatic events. Each has been studied for their impact on substance use disorder rates.

The Impact of Recession and Unemployment on Substance Use Disorder

- A number of peer reviewed studies suggest that unemployment increases alcohol, cannabis, and other drug use.^{xvii xviii xix xx xxi xxii xxiii xxiv xxv xxvi xxvii}
- People with a history of substance use may be at higher risk: Unfavorable employment changes were found to predict increased heavy drinking among former heavy drinkers.^{xxviii}
- Countercyclical results also emerge from work focused on clinically significant alcohol abuse rather than on utilization. The Christchurch Health and Development Study (CDHS) reported that the variation in unemployment among young people accounted for 8%–17% of substance abuse risk and that those who had been unemployed for >6 months had increased rates of disorder.^{xxix}
- Using panel data from the Epidemiologic Catchment Area Study (ECA), Catalano et al. found that involuntary job loss increased risk of meeting standards of “caseness” by six fold.^{xxx}
- A study using World Health Organization (WHO) and International Labor Organization (ILO) data showed that increases in unemployment contributed to excess alcohol-related deaths among those <65 years.^{xxxi} This paper also indicated that dips in employment may significantly increase alcohol-related deaths among working-age people.

Substance Use Disorder and the Great Recession: A Snapshot in Time

Studies following the Great Recession, show that rates of abstinence from alcohol increased among US adults. However, total alcohol consumption also increased, driven by a rise in the number of moderate and heavy drinkers and a decline in the number of light drinkers. In other words, a recession polarizes alcohol use rates whereby economic impact and fear of job loss encourages some light drinkers to abstain, while others become heavy drinkers and binge drinking dramatically increases.

Table 1. Changes in alcohol use, levels and frequency during the Great Recession, between 2006–2007 and 2008–2009

Outcomes: drinking behaviors	Group	N	Mean in 2006–2007	Difference 2008/2009–2006/2007 ^a	Percent change	Estimated change in number of drinkers, in '000s, (95% CI)
Prevalence rates						
Abstinence from drinking	All	1,570,597	48.0%	0.39%* (0.17%)	0.8	880 (140–1620)
Light drinking ^b	All	1,542,309	29.2%	–0.87%** (0.16%)	–3.0	–1990 (–2700 to –1290)
Moderate drinking ^b	All	1,542,309	16.7%	0.39%** (0.13%)	2.3	900 (320–1480)
Heavy drinking ^b	All	1,542,309	5.1%	0.20%* (0.08%)	3.9	450 (90–810)
Any binge drinking	All	1,553,192	15.3%	0.01% (0.13%)	0.1	20 (–600–560)
Frequent binge drinking ^b	All	1,553,192	4.8%	0.34%** (0.09%)	7.1	770 (390–1140)
Consumption levels						
Drinks per month	All	1,542,309	11.1	0.27* (0.11)	2.5	
Drinks per month	Drinkers	731,225	21.8	0.79** (0.21)	3.6	
Drinking days per month	Drinkers	743,422	8.1	0.25** (0.04)	3.1	
Average number of drinks on days drank	Drinkers	740,982	2.5	0.01 (0.02)	0.4	
Binging episodes	Drinkers	742,108	1.2	0.06** (0.02)	5.2	

- Moderate and heavy drinking both increase during recession.
- Drinks per month and binge episodes also increased during the Great Recession.

The Impact of National Trauma on Substance Use Disorder

Consensus is emerging among disaster researchers that psychological disorders and substance abuse increases in the aftermath of both man-made and natural disasters. Exposure to a disaster can entail physical threats to life and post-disaster behavior and readjustment problems (eg, dealing with loss of home, friends, or family). These events can increase the risk of substance abuse, such as extensive drinking or drug use, as a coping mechanism.^{xxxii}

- For the period one year following the World Trade Center Disaster, drinks per day and drinks per month both increased for New Yorkers, leading to a 75% increase in alcohol dependence.^{xxxiii}
- The period between six to nine months following the September 11th attacks New Yorkers reported a 9.9% increase in smoking, 17.5% an increase in alcohol use, and 2.7% an increase in marijuana use compared to the month before September 11.^{xxxiv}
- The number of persons reporting problem drinking before 911 as opposed to six months after increased from 2% to 4.2%, a 110% increase.^{xxxv}

- 2.2% of over six million adults living in NYC reported drinking problems in the 6 months after September 11 that were not present before September 11; this corresponds to approximately 130,000 adults.^{xxxvi}
- A study of African American drug users evacuated from New Orleans, Louisiana, during Hurricane Katrina of August 2005, revealed that where alcohol and drug abuse is already high, increases in use rise dramatically in post disaster periods.

Table 1 Prevalence (%) of substance use and changes in use before and after Hurricane Katrina (n = 200)

Substance	30 days before Katrina* n (%)	Percentage increased use after Katrina** n (%)
Tobacco	141 (71)	58 (29)
Alcohol	135 (68)	58 (29)
Marijuana	148 (74)	68 (34)
Tranquilisers/barbiturates/sedatives	31 (16)	14 (7)
Ecstasy	25 (13)	23 (12)
Crack	25 (13)	12 (6)
Cocaine	19 (10)	8 (4)

Notes:

* Number and percentage of respondents who used the substance 'within 30 days' before Katrina.

** Percentage of respondents who increased substance use 30 days prior to being interviewed compared with 30 days before Katrina. This percentage includes respondents who used the substance 30 days before Katrina and increased their frequency of use 30 days prior to the interview and those who were not using the substance before Katrina and reported use after Katrina (new users).

Column one depicts the number of respondents indicating use prior to the event and the percent of the population that number is. Column two shows the increase as an individual count and the percent increase this represents.

Historical Context of Supply Constraints for Substance Use Disorder Services

The outlook for SUD capacity is further complicated by historic factors that have limited growth in this sector for decades. Constant shortages in workforce, combined with dramatic increases in NIMBY (not in my backyard) activity has resulted in little growth in treatment capacity with residential facilities now at about the same level as 2008.

Workforce Criticality

- About 8% of Californians, or 2.7 million people, met the criteria for substance use disorder (SUD) in the past year; of those only 1 in 10 received treatment.^{xxxvii} Despite

these statistics, California lags the nation in its percentage of qualified counselors and other addiction treatment providers.

- There are less than 20,000 alcoholism and drug abuse counselors currently certified in California, and fewer than 700 of the nearly 140,000 physicians who hold a California license maintain an addiction specialty certification.^{xxxviii}
- Addiction programs have cited the “lack of qualified staff” as a primary reason that they are unable to expand provision of services to clients.
- There are a multitude of factors contributing to workforce shortages. Examples are:
 - Retirement: Workforce in the addiction recovery field is older on average than in other healthcare areas.
 - Compassion fatigue: Exhaustion is common, so workers move on.
 - Salary: The average salary for social workers in the addiction field is \$38,600 compared with \$47,230 in the rest of the healthcare fields (Bureau of Labor Statistics).
 - Overall need for a myriad of behavioral health professionals, each impacting the capacity of the others: Psychiatrists, psychologists, social workers, advanced practice nurses, marriage and family therapists, certified prevention specialists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides, para-professionals, peer support specialists, recovery coaches and certified medical assistants.
- Cultural Disparities Within the Workforce
 - The Department of Health Care Services, White Paper on California Substance Use Disorder Treatment Workforce Development, set workforce goals for the substance use disorder profession, including: “DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce. Fewer members of these groups are involved, and generally it is preferable for clients to receive treatment from individuals who are of similar age, gender, and racial/ethnic background.”
 - Vulnerable populations that could benefit from support in order to bolster their presence in the workforce. Namely, people who identify as lesbian, gay, bisexual, or transgender (LGBT), people who have been diagnosed with Hepatitis C or HIV, and those who have been involved in the criminal justice system often face social stigma, discrimination, harassment and other challenges not encountered by people who identify opposite of these categories.
 - The mental health and substance use workforce in California is comprised of predominately English-only speakers. According to the 2010 US Census almost 38% of the population of California is of Hispanic/Latino origin. In Los Angeles

County alone, it is reported that 36% of residents are foreign born and 57% speak a language other than English.

NIMBY Impact

- Local ordinances have proliferated throughout California, making investment in treatment programs and recovery residences less appealing and siting extremely cumbersome and difficult.
- There are several ongoing lawsuits in multiple jurisdictions that are consuming years of time and millions of dollars in litigation fees, although local ordinances that prohibit treatment and recovery residence operations are clearly contradictory to state and federal disability law.
- Mentor/leaders in recovery residences are being recruited by Private Attorney Generals to sue recovery residence owners for salary and benefits for “work” performed even though the activities of the mentor/leader are part of group recovery activities shared by the recovering household (not employment). This has a dampening effect on investment in recovery residence housing.

Post-COVID-19 Substance Use Disorder Forecasts

Mounting economic pressures and health concerns, coupled with social isolation during the COVID-19 public health emergency, have led to a rise in individuals self-medicating with drugs and alcohol and increases in persons seeking assistance for addiction. Factors impacting substance use disorder rates include:

- Isolation
- Reduction of protective factors (community, structure and activities, supervision, coping mechanisms)
- Unemployment
- Increased anxiety
- Despair / depression
- Strain on the healthcare system
- Risk of relapse / break in treatment for those in recovery

COVID-19 is the catalyst to an influx of new patients that will flood the system and require care. Isolation, physical distancing, mortality, and economic hardship all are stressors that have proven relationships to initial onset of addictive behavior and relapse.

Early Indicators of Surge in Demand and Risk Factors

- Calls to the Substance Abuse and Mental Health Services Administration's disaster distress hotline increased 891 percent from March 2019 to March 2020, according to a spokesperson.
- A survey released by Kaiser Family Foundation found that 45 percent of individuals say stress related to COVID-19 is affecting their mental health.^{xxxix}
- Alcohol purchases spiked last month with U.S. sales rising 55 percent in the week ending March 21.
- A study on Macroeconomic Conditions and Opioid Abuse in 2017 found that when an unemployment rate increases by one percentage point, the opioid death rate per 100,000 rises by 0.19 (3.6%) and the opioid overdose ED visit rate per 100,000 increases by 0.95 (7.0%).^{xl*}¹
- Montgomery County, Ohio - which is home to Dayton and was considered the country's overdose capital in 2017 - is reporting a 50 percent jump in overdoses over last year.
- Comorbid chronic obstructive pulmonary disease, cardiovascular disease, and other respiratory diseases, which are more frequent among chronic smokers and persons with other SUDs, have been shown to worsen prognosis with other coronaviruses, including those causing severe acute respiratory syndrome and Middle East respiratory syndrome.^{xli}
- Persons with SUD are already marginalized and underserved by health care services, largely because of stigma. When hospitals are pushed to their capacity, there is added danger of persons with SUD being deprioritized for care if they present with COVID-19 symptoms.^{xlii}
- Workers in some of California's largest employment categories, Accommodations and Food Services, and Arts, Entertainment, and Recreation, have some of the highest rates of heavy drinking (11.8 and 11.5 respectively). These workers stand the greatest chance to have the longest periods of unemployment which is a factor leading to increased substance use disorder.^{xliii}
- Childhood trauma is linked with future substance use disorders and other negative mental health effects. COVID-19 may increase exposure to potentially traumatic childhood experiences, including harassment, abuse, loss, disasters, and even medical trauma, which can be caused when children or their families experience single or multiple medical events.

¹ Alex Hollingsworth Christopher J. Ruhm Kosali Simon Working Paper 23192, <http://www.nber.org/papers/w23192>.

Post-COVID-19 Onset Substance Use Disorder Preparedness

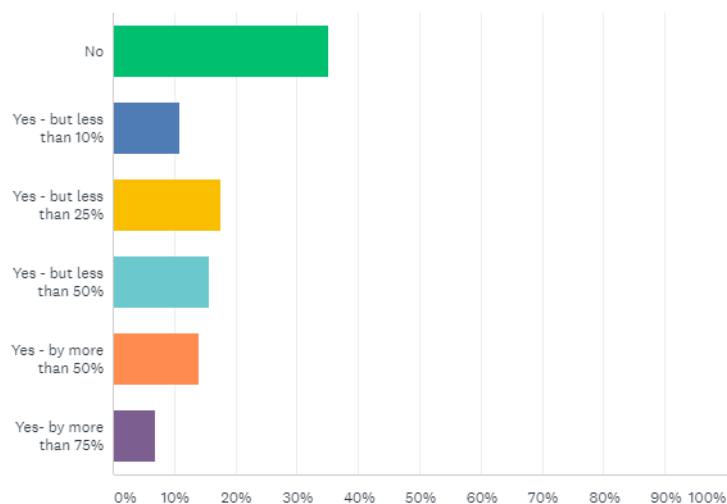
The California Consortium of Addiction Programs and Professionals (CCAPP) represents more than 20,000 addiction focused professionals and over 500 substance use disorder treatment programs and recovery residences that form the largest statewide consortium of community-based for profit and nonprofit substance use disorder treatment agencies and addiction-focused professionals in California. Following the Governor's statewide Safer at Home Order, CCAPP began hosting weekly conference calls to gather input regarding the impact of the disease and the stay at home order. It also distributed a questionnaire through the California Behavioral Health Directors Association (CBHDA) to gain insight into data concerning COVID-19 impact. The results of these information gathering activities have shown that many programs are suffering short term consequences of the pandemic and many are ill-prepared to staff up for the oncoming increase in cases.

COVID-19 Treatment Program Impact at a Glance

- 65% of programs report that the pandemic has reduced capacity, with 21% reporting it has reduced capacity by more than 50%.

Has the COVID-19 virus reduced your capacity?

Answered: 250 Skipped: 5

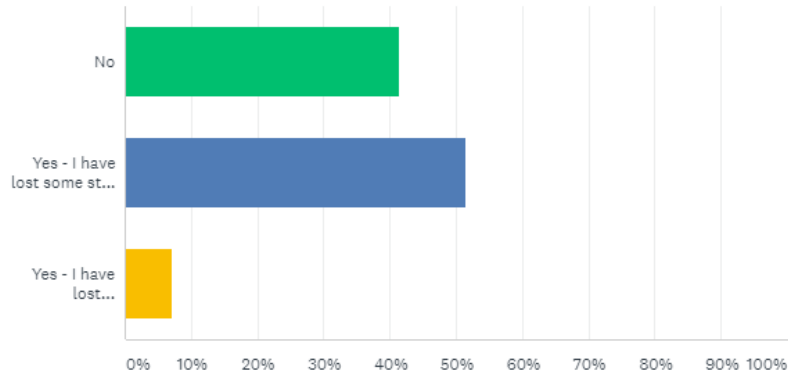


ANSWER CHOICES	RESPONSES
No	35.20% 88
Yes - but less than 10%	10.80% 27
Yes - but less than 25%	17.60% 44
Yes - but less than 50%	15.60% 39
Yes - by more than 50%	14.00% 35
Yes- by more than 75%	6.80% 17
TOTAL	250

- 58% of programs have lost staff, with 7% unable to provide all necessary services.

Have there been changes to your staff due to the virus?

Answered: 253 Skipped: 2

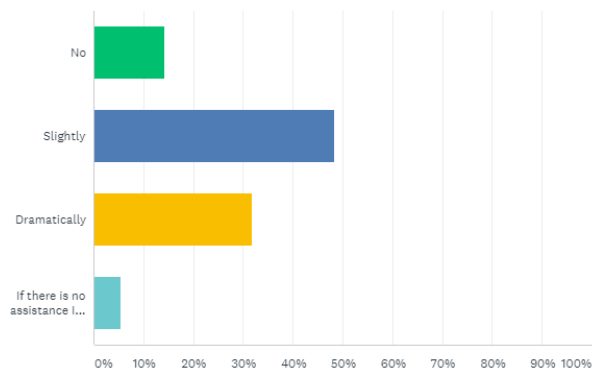


ANSWER CHOICES	RESPONSES	
▼ No	41.50%	105
▼ Yes - I have lost some staff but am able to provide all services	51.38%	130
▼ Yes - I have lost significant staff making it not possible to provide all necessary services	7.11%	18
TOTAL	253	

- 86% of programs have been financially impacted (37% reporting drastic impact or threat of closure); estimates of losses range from thousands of dollars to hundreds of thousands in losses.

Has the virus impacted the financial health of your organization?

Answered: 254 Skipped: 1

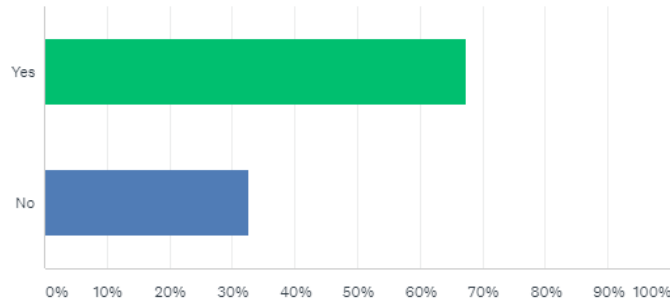


ANSWER CHOICES	RESPONSES	
▼ No	14.17%	36
▼ Slightly	48.43%	123
▼ Dramatically	31.89%	81
▼ If there is no assistance I will need to discontinue operations.	5.51%	14
TOTAL	254	

- Lack of PPE puts clients and workers at risk.

Should a client test positive for COVID-19, do you presently have personal protective devices (gowns, masks, gloves) to protect staff members from contracting the disease?

Answered: 248 Skipped: 7



ANSWER CHOICES	RESPONSES	
Yes	67.34%	167
No	32.66%	81
TOTAL		248

Insurance Disparities

- As workers transition from workplaces where they have access to insurance benefits that may have covered a significant portion of the cost of treatment, in order to gain coverage, they may access Medi-Cal or Covered California. This has tremendous implications for the publicly funded treatment system.
- Silver Plans for Covered California for a couple with less than \$50,000 income have deductibles of 1,400 per individual and copays are 15% of total costs of substance use disorder inpatient services. This cost will make access to addiction treatment services unattainable for many families with one income or low income.
- Programs are reporting that even where potential clients are still employed and insured they are reluctant to put forth deductibles and copays due to financial insecurity generated by the pandemic and the faltering economy.

COVID-19 Recovery Residence Impact at a Glance

CCAPP has also conducted weekly calls with recovery residence (sober living) home operators to determine the impact to this part of California's continuum of care. CCAPP also conducted a

recovery residence survey, however the low number of respondents makes it not statistically significant. It does yield some insightful anecdotal evidence concerning the outlook for this important resource.

- Recovery residence operators report difficulties in obtaining basic cleaning supplies, masks, and protective equipment.
 - Recovery residences live as families so infection poses a high risk to the members of these “families” who often do not have elsewhere to live.
 - A certain portion of recovery residence participants are coming from homeless shelters where incidence of infection is higher and the ability to quarantine is lower.
 - Persons early in recovery are often re-entering the job market. They often have low paying, retail jobs that are subject to stay at home closures.
 - Many in early recovery have spotty work histories which make them ineligible for unemployment benefits.
 - Most recovery residence owners are extending bed fee payments by asking residents to sign loan agreements to pay bed fees at a later time; it is unknown how long these entities can delay collection of these fees and still operate.
 - Recovery residence participants are at the highest risk for homelessness and relapse given a downturn in the economy and no practical way to pay bed fees.
- Economic Impact on Insurance and Willingness to pay

COVID-19 ACEs Impact

California’s recently appointed Surgeon General, Dr. Nadine Burke Harris, has been a leader in bringing to the forefront the impact that Adverse Childhood Experiences (ACEs) have on lifelong health and mental health of Californians. Governor Newsom allocated a \$10 million one-time General Fund expenditure for the development of an Adverse Childhood Experiences (ACEs) public awareness campaign and cross-sector training and the California Surgeon General has set a bold goal of cutting ACEs and toxic stress in half in a generation through raising awareness and strengthening response networks.

Stresses that California families face due to the effects of prolonged stress from unemployment, uncertainty, increased domestic violence, and swings in mood brought on by increased alcohol and drug use will have significant, long term consequences for today’s youth. Children of all ages are without typical screening channels at schools, after school programs, and workplaces where suspected exposure to trauma would have been recognized and perhaps addressed by caring adults.

- ACEs consistently happen within the context of homes where parents are abusing substances (alcohol, tobacco and other drugs). Dr. Burke-Harris' vision CANNOT be realized without addressing addiction in parents, particularly in the context of prolonged, close personal contact with an adult with substance use disorder.
- Findings on the linkages between intimate partner violence (IPV), emotional health and substance use among adults ages 18-65 in California show that among the 3.5 million Californians who have ever been victimized by IPV as adults, over half a million report serious psychological distress (SPD) in the past year.^{xliv}
- Almost half of all adult IPV victims indicate that their partner was under the influence of alcohol or other drugs during the most recent incident, and two-fifths of adult IPV victims report past-year binge drinking and 7% report daily or weekly binge drinking. One in three IPV victims expressed a need for mental health, alcohol or other drug (AOD) services and almost one-fourth used mental health or AOD services during the past year.^{xlv}
- The number of cases of children entering the foster care system due to parental drug use has more than doubled since 2000, according to research published last July in *JAMA Pediatrics*.^{xlvi}
- In the United States, about 1 in 8 children ages 17 or younger are living in households with at least one parent who has a substance use disorder. While these 8.7 million children will not all experience abuse or neglect, they are at increased risk for child maltreatment and child welfare involvement compared to other children.^{xlvi}

Stigma and Discrimination Will Impact Death Rate

According to American Society of Addiction Medicine, Dr. Cory Waller, an expert on ACEs, Addiction, and Medicated Assisted Treatment (MAT), "We have moved beyond stigma as a society as it pertains to addiction. It is now blatant discrimination. We have, and continue to systematically deny evidenced based treatment to people with addiction and have allowed them to suffer and die in droves. This happens inside and outside the profession."

Deaths from untreated addiction are no less tragic than death from COVID-19.

- While the exact form of discrimination may vary across different substances and social groups, research indicates that substance misuse appears to be at least as stigmatized as psychological disorders such as depression, schizophrenia, or borderline personality disorder.^{xlvi}

- The medical community has worse attitudes toward individuals with substance use disorders (SUDs), whom they frequently treat, than toward individuals with other medical or psychiatric conditions. This is concerning, as when clinicians have negative attitudes toward these patients, quality of care declines substantially.^{xlix}
- Persons Who Inject Drugs/PWIDs (especially Latino/a vs. White PWIDs) believe they are more deserving of punishment, as opposed to help.¹
- Behavior analysts have significantly more negative attitudes toward people with SUDs than toward people with other mental disorders. Analysts report a greater desire for social distance and greater acceptability of discrimination for people with SUDs than for people with mental disorders.^{li}
- Some mental health professionals still believe there is less potential for recovery and provide lower support for policies to improve equity in insurance coverage for persons with substance use disorder.^{lii}
- Others were less supportive of using government funding to improve treatment, housing, and job support for people with SUDs.^{liii}

Endnotes

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