



RACIAL/ETHNIC DISPARITIES –

A DATA- INFORMED PERSPECTIVE

California Department of Alcohol and Drug Programs
June 2013

A Message From the Director's Office

I am pleased to present the Racial/Ethnic Disparities – A Data-Informed Perspective report, intended to support local planning efforts in achieving improved outcomes for community members of varied racial/ethnic backgrounds.

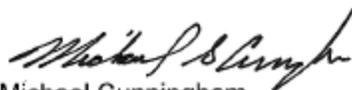
The existence of disparities is well documented and understood in relation to physical health but not as clearly understood related to substance use. While there are certain health conditions (e.g., hypertension, certain cancers, etc.) that are more prevalent in persons from certain racial/ethnic groups, the same is not true for substance use when controlling for environmental factors. Although substance use is an equal opportunity condition, we do know that certain racial/ethnic groups are disproportionately impacted (i.e., the high rate of people of color incarcerated when the data indicates no difference in the rate of drug crimes committed). This report provides data and the context for a clearer understanding of the existence of disparities in relation to alcohol and other drug (AOD) use from a social determinants and social justice perspective. This broad view is critical in assembling the necessary local planning partners to comprehensively address the many factors involved in the occurrence of AOD disparities.

The Department of Alcohol and Drug Programs (ADP) is, and has been, committed to public policy that supports cultural competency principles that can be actualized in business practices and service provision. By promoting the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards (strategies for organizations to become culturally responsive in the provision of services), a critical first step has been achieved in moving toward an AOD system that is equitable for all – in which everyone coming through our doors has the same chance to achieve a positive outcome.

Concurrently with the implementation of CLAS standards within our field, the Department has implemented an ADP staff capacity building program to increase the Department's level of cultural competency. An investment in our staff was deemed an important component in building our system's capacity in this area.

A third component of our commitment to reducing disparities is the production of this report as a catalyst in broadening the discussion of AOD disparities to the impact on individual communities and the potential for positive change.

I recognize that this will not be an easy task, but it will be a worthwhile challenge to undertake. For the health of our communities and our state, I encourage you to take up this challenge, assemble your local partners and commit for the long term.



Michael Cunningham
Acting Director

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Introduction

This report is a continuation and expansion of the *Unique Needs Populations* chapter of the 2012 California Needs Assessment report. It will specifically focus on the existence and prevalence of racial/ethnic disparities in relation to alcohol and drug use from a socioeconomic and social determinants perspective. The objective of the report is to articulate the benefits of: reevaluating current philosophies in operating Alcohol and Other Drug (AOD) programs that may contribute to the occurrence of AOD disparities; moving to an integrated culturally competent whole-person approach; and partnering across systems in new and innovative ways that result in better overall health outcomes for individuals and communities. It is intended that the reader gain a better understanding of the underlying causes of racial/ethnic disparities in order to establish programs that will foster success for clients of color.

It is well documented that when services are culturally sensitive/competent better outcomes follow. In an environment of added scrutiny over government investments and use of public funds, finding pathways to better outcomes for clients must be a goal for all state and local government leaders. One such pathway instituted within the publicly-funded AOD service system is the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards (strategies for organizations to become culturally responsive in the provision of services). For the AOD service system, this is a step toward ensuring equity for all clients to obtain a positive outcome.

The following sections of this report will detail, through data, “a case for disparities” from a socioeconomic perspective – that poverty drives many inequities. Simply put, when we follow the trail of data, we see that more persons of color live in high poverty neighborhoods which results in no or limited access to resources, which often leads to deficits in education, which means lower paying or no jobs, which means lower income, which leads to the continuing cycle of poverty. This oftentimes generational poverty cycle is a great contributor to the disparities we see today.

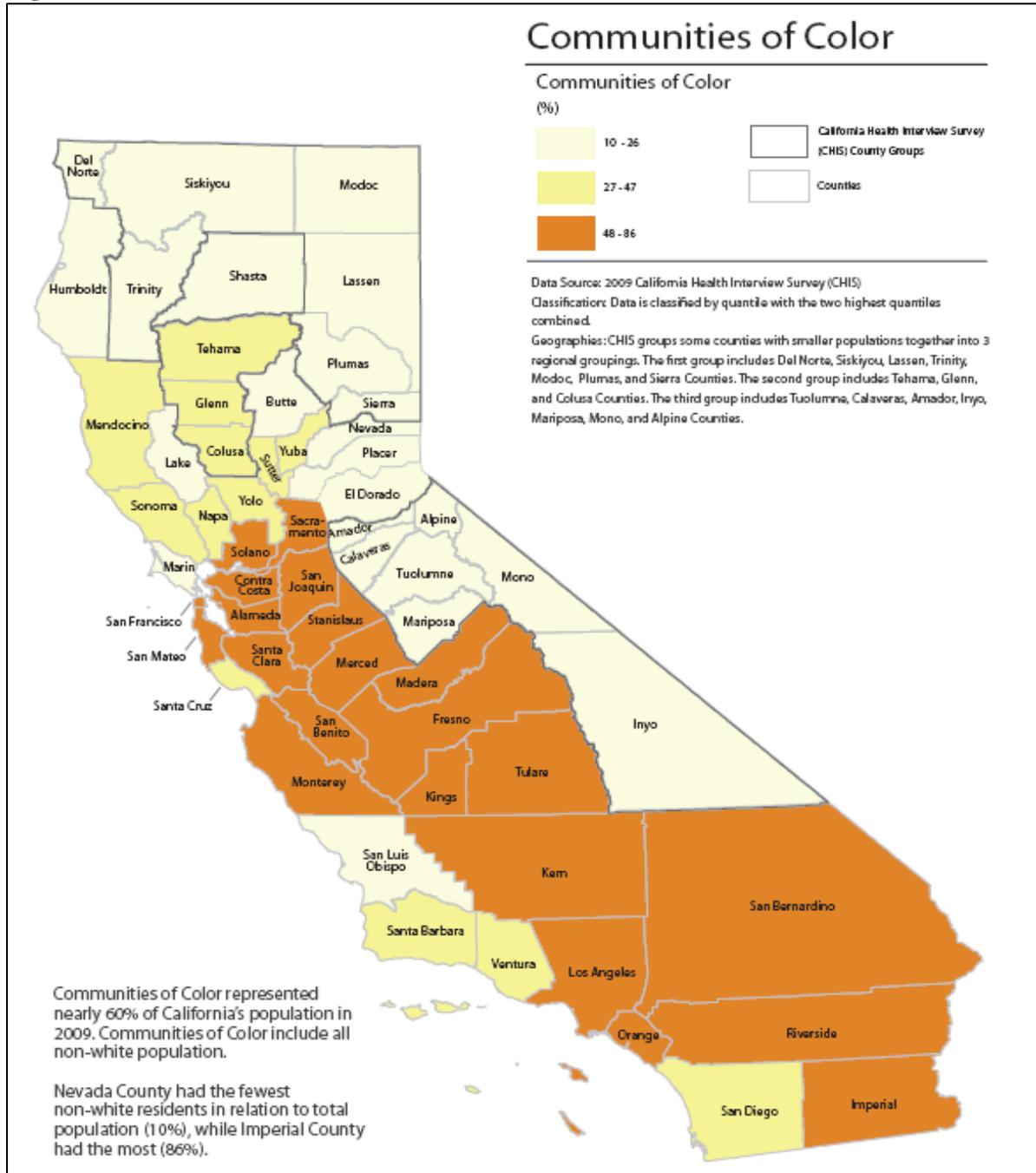
This report also details, through data and discussion, the impact of AOD use and the racial/ethnic disparities that exist within the *larger* AOD system that encompasses: The criminal justice system which arrests, judges, and incarcerates individuals for drug and alcohol related crimes; the child welfare system which removes children from homes oftentimes for substance abuse related issues; and the health care system which treats the substance-related health conditions of individuals.

This is a complex issue with no easy solutions, but there are many steps that can be taken toward building culturally competent programs, engaging individuals, communities and partners in new ways, and building innovative initiatives that includes equity for all as an overarching goal.

California's Demographics

California's unique population diversity is one of its greatest strengths. Our neighborhoods are filled with the sounds of numerous languages and display many different, vibrant cultures. The 2010 Census confirmed that communities of color are now the majority in California, representing close to 60% of all Californians. The map below identifies the statewide diversity distribution.

Figure 1: California Communities of Color

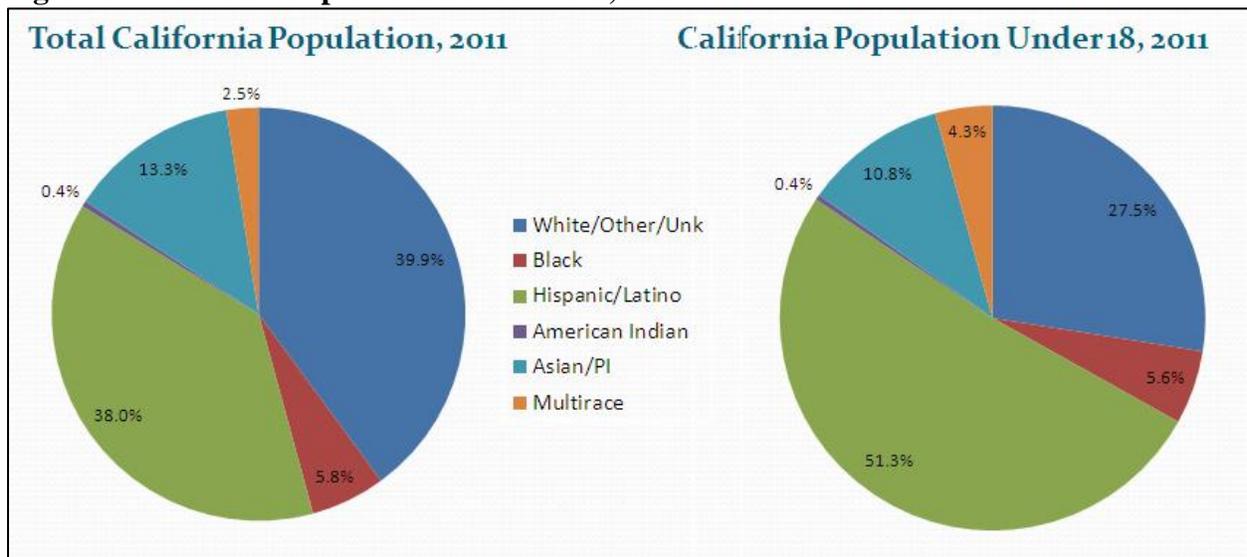


Source: <http://www.cpehn.org/pdfs/LandscapeofOpportunity2012.pdf>

The counties with the lowest percent (10-26%) of communities of color show less diversity, whereas the counties with the highest percent (48-86%) show greater diversity.¹

Figure 2 shows the distribution of California’s total population, compared to the “Under age 18” population. Overall, Hispanics under age 18 are a majority in California, 72.6% of California’s youth are people of color, and White youth make up 27.4%, as seen in Figure 2 below.

Figure 2: California Population Distribution, 2010



Source: 2010-2015: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

Prepared by: California Department of Public Health, Safe and Active Communities Branch Report generated from <http://epicenter.cdph.ca.gov> on: May 27, 2013.

Along with this dynamic and increasingly diverse California population has come some challenges. Prosperity and scarcity are not distributed evenly across society. The communities in which people are born, go to school, live, work, worship, and age, as well as the levels of poverty, employment/income education, and overall health that each person experiences throughout their lifetime all contribute to and impact their long-term outcomes. It is well documented that, in general, better education leads to better jobs, and better jobs leads to higher income. Lower education and income impact overall health by reducing access to health care, increasing chronic stress from poverty, and living in environments that are not conducive to a healthy diet and physical activity. Subsequently, health disparities disproportionately harm certain groups and threaten the well-being of our entire society.

Public health data confirm the reality that all across American cities, suburbs and rural areas, the zip code in which you live is the best predictor of your overall health status and life expectancy. For example, in Alameda County “an African American child born today in Oakland’s flatlands will live an average of 15 years less than a White child born in the Oakland hills neighborhood.”² Many have argued that these disparities in the social determinants of health have persisted over time and across the life course and continue to have serious effects on the health and well-being of low income families and people of color. Howard Koh, Assistant Secretary for Health, U.S. Department of Health and Human Services, reported³ that analyses of progress on the Healthy

People 2010 indicators showed “no significant change in disparities had occurred for at least 70% of the leading health indicator objectives.”

Race/ethnicity and socioeconomic status are not interchangeable systems of inequality and it is essential to look at both of them together.⁴⁵ The long-term effects of the experiences of racism, for example, are an added burden that is linked to health status. Patterns of geographic isolation, residential segregation, and socioeconomic disadvantage have played a major role in creating and maintaining these health disparities across generations as well. Using a “dissimilarity index”, a measure of the percentage of people in a defined geographic area who would have to move to create integration in that area, demonstrated that African American and Latino families are much more likely to live in communities with highly concentrated poverty (defined as 40% or more of the population living below the federal poverty level).⁶ In 2000, African American families were 36 times and Latino families were 22 times more likely than white families to live in communities with highly concentrated poverty. Although the majority of people living in poverty in the U.S. are white, poor African American and Latino families were 11 and 7 times, respectively, more likely than poor white families to live in high-poverty neighborhoods.⁷

Making the Case for Disparities

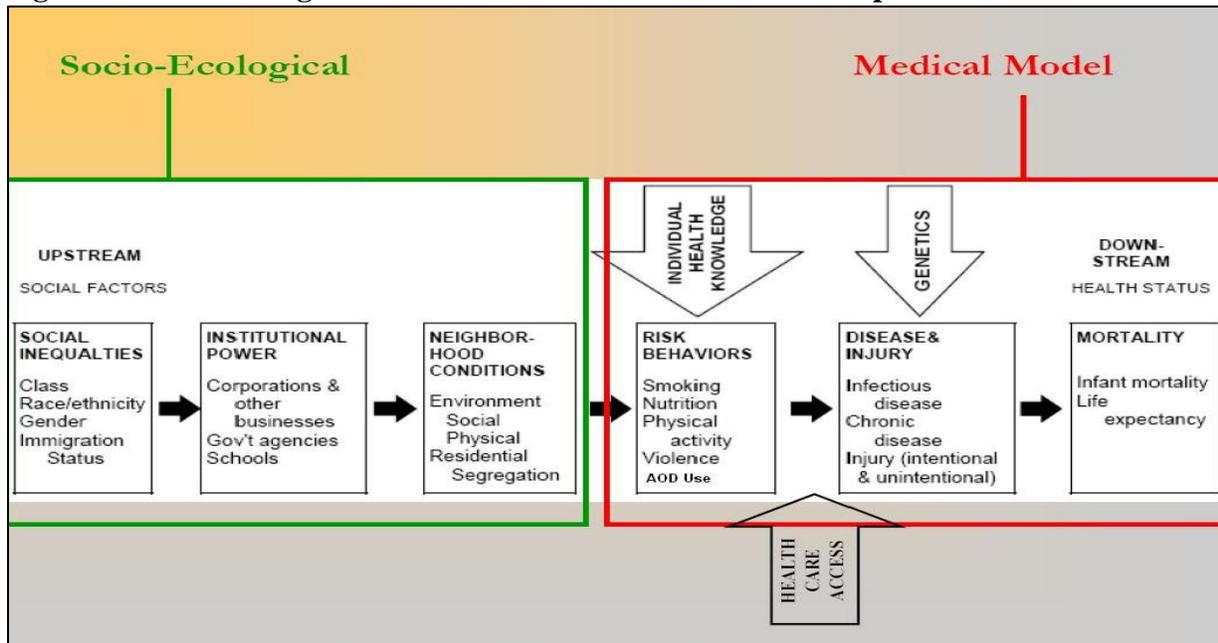
What the Data Tell Us

Research shows that social conditions (neighborhoods where we live, jobs we hold, and schools we attend) play a vital role in our overall health. Additionally, research supports the concept that social factors and inequalities that individuals experience in their lifetime have a direct correlation to overall health status. Reducing or eliminating negative or harmful social factors can, and does, improve outcomes (e.g., reduced risky behaviors and associated consequences, and improved overall health). The levels of poverty, education, employment/income, and overall health that each person experiences throughout their lifetime all contribute to and impact their long-term outcomes.

Disparities exist when the resources and access are limited for a specific group or population disproportionately from other groups. Segregation, social exclusion, encounters with prejudice, differential access and treatment and the overall accumulating disadvantage experienced by certain racial/ethnic groups in society all contribute to systematic disparate treatment, and therefore worse overall outcomes, for these populations. In selected social systems (Child Welfare, Criminal Justice, and Health Care) identified later in this report, the data will show how these disparities contribute to the disproportionate negative impact on society as a whole.

Social determinants of health shape the choices that people make every day, as well as the opportunities and resources for health available to them. People in less affluent communities often have fewer opportunities and resources for health, which is reflected in significantly worse health outcomes. Created by the local Bay Area Regional Health Inequalities Initiative (BARHII), the model below provides a useful framework for understanding the broader social context in which long-term health outcomes arise and continue over time.

Figure 3: Socio-Ecological and Medical Model: Factors That Impact and Determine Risk



Source: Bay Area Regional Health Inequalities Initiative, A Proposed Framework, The Context of Health: What Are We Really Doing To Change It?, Iton, Witt, Siegel & Raya 5-07. Retrieved 9-2012 from <http://www.barhii.org/programs/download/framework-in-action.pdf>

Socioeconomic Status

SES is an economic and sociological combined total measure of a person's social position in relation to others, based on income, education, and occupation. Low income and little education have shown to be strong predictors of a range of physical and mental health problems. Disparities in socioeconomic status lead to social inequalities. SES has a profound impact on each and every Californian's life course directly influencing:

- Access to fundamental social and economic resources
- Ability to benefit from resources
- Differential exposures, vulnerabilities & consequences

Studies have found that adolescents with low SES have a greater propensity toward substance use during adolescence. Numerous problems are associated with substance use in young adults, including problems in school, decreased employment, increases in convictions of driving under the influence (DUI) and accidental deaths.⁸ Literature has shown a divergence by age in the relationship between SES and substance use: adolescents with low SES are more likely to engage in substance use, as are adults with high SES.

SES is often measured in terms of three intertwined components - education, employment and income. In general, better education leads to better jobs, and better jobs leads to higher income. However, as documented in the California Pan Ethnic Health Network 2012 report, *The Landscape of Opportunity: Cultivating Health Equity in California*:

“Inequities in employment, education, and income have created a society in which the places we live and work not only determine our success, but also how healthy we will be and how long we will live. Low-income communities, which often have higher numbers of people of color, have seen opportunities diminish and disparities grow. Institutional racism—in the form of housing segregation, employment discrimination, unequal wages, and other discriminatory practices—has created persistent inequalities that limit opportunities for communities of color.”

There is increasing interest from epidemiologists on the subject of economic inequality and its relation to the health of populations. A strong correlation exists between socioeconomic status and health that suggests that it is not only the poor who tend to be sick when everyone else is healthy, but that there is a continual gradient, from the top to the bottom of the socioeconomic ladder, relating status to health. This phenomenon is often called the "SES Gradient". Lower socioeconomic status has been linked to chronic stress, heart disease, ulcers, type 2 diabetes, rheumatoid arthritis, certain types of cancer, and premature aging.⁹ It has been noted that no amount of medical attention will help decrease the likelihood of someone getting type 2 diabetes or rheumatoid arthritis - yet both are more common among populations with lower socioeconomic status. Examinations of SES often reveal inequities in access to resources and issues related to privilege, power and control.

Poverty

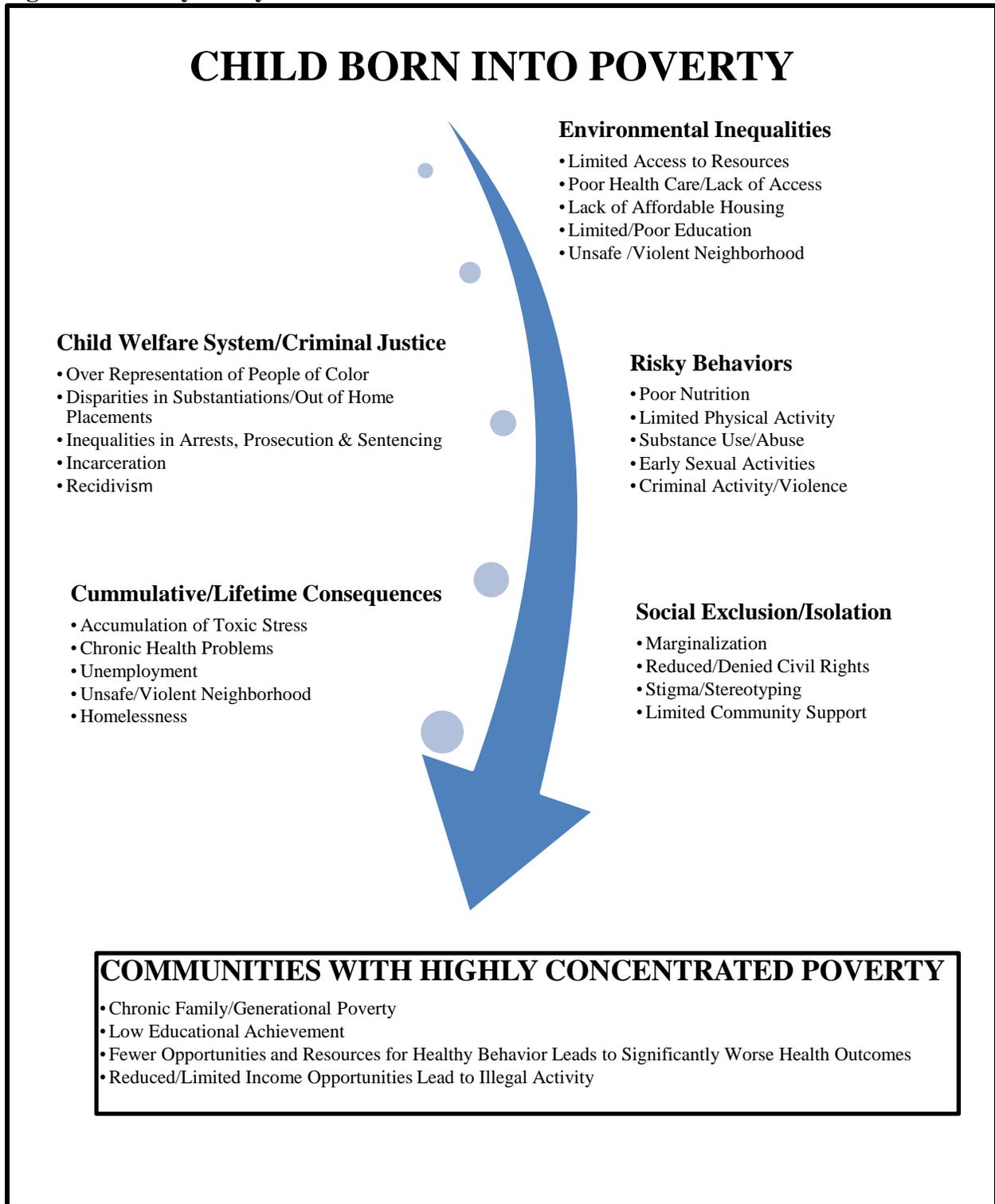
Around the world, poverty drives poor health outcomes. Poverty levels vary greatly among the 58 California counties, from a low of 6.6% in San Mateo County, to a staggering 27.1% in Fresno County. California has the highest number of people living in poverty of any state in the nation (and is ranked 20th among all states in terms of the percentage of its population living in poverty). Using the Supplementary Poverty Measure (SPM) developed by the Census Bureau, the poverty rate in California vaults to *first* in the nation at 23.5% (when adjusting for government assistance paid).¹⁰

President Lyndon Johnson, the architect of the War on Poverty, stated in his Message to Congress speech in 1964,

“Unfortunately, many Americans live on the outskirts of hope--some because of their poverty, and some because of their color, and all too many because of both...Poverty is a national problem, requiring improved national organization and support. But...to be effective...[it] must be supported and directed by State and local efforts...Very often a lack of jobs and money is not the cause of poverty, but the symptom. The cause may lie deeper in our failure to give our fellow citizens a fair chance to develop their own capacities, in a lack of education and training, in a lack of medical care and housing, in a lack of decent communities in which to live and bring up their children...”¹¹

Figure 4 below shows how the impact of poverty, from birth throughout the lifecycle, can positively or negatively influence long-term outcomes.

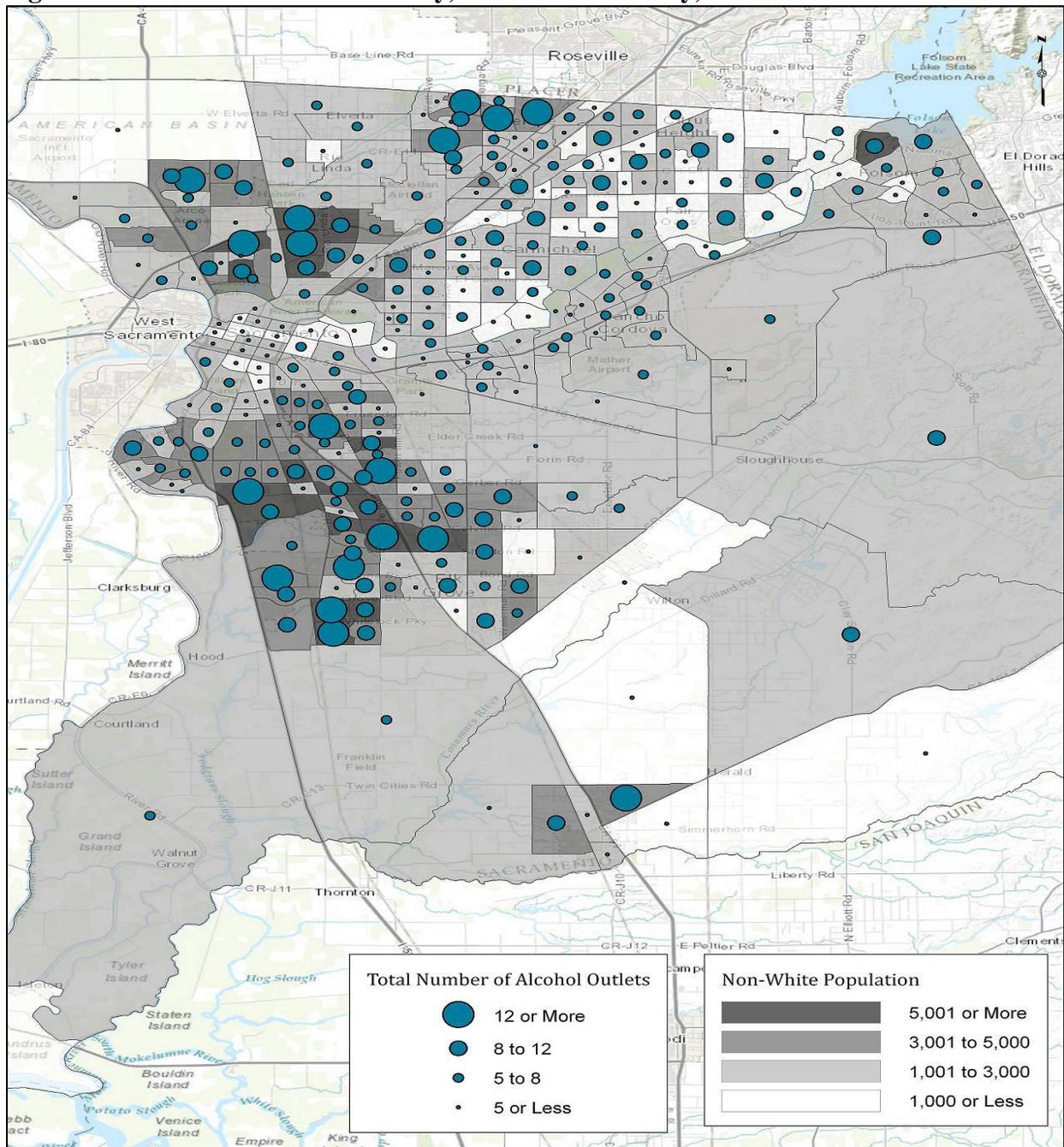
Figure 4: Poverty Lifecycle



Source: Department of Alcohol and Drug Programs, Racial/Ethnic Disparities – A Data-Informed Perspective, June 2013.

Additionally, low-income and minority neighborhoods are less likely to have access to recreational facilities and full-service grocery stores and more likely to have higher concentrations of stores selling tobacco, fast food and alcohol. For example, the density of alcohol sale outlets in Sacramento County (overlaid onto non-white (minority) neighborhoods), is shown in Figure 5 below. This visual depiction shows a higher prevalence of alcohol sales outlets in communities of color, which also correlates to the less affluent neighborhoods in Sacramento County if income were depicted as well.

Figure 5: Alcohol Sales Outlet Density, Sacramento County, 2010



Source: Alcoholic Beverage Control (ABC) Retail Authorization for both On-Sale and Off-Sale outlets, Retrieved June 2013, <http://www.abc.ca.gov/permits/permits.html>

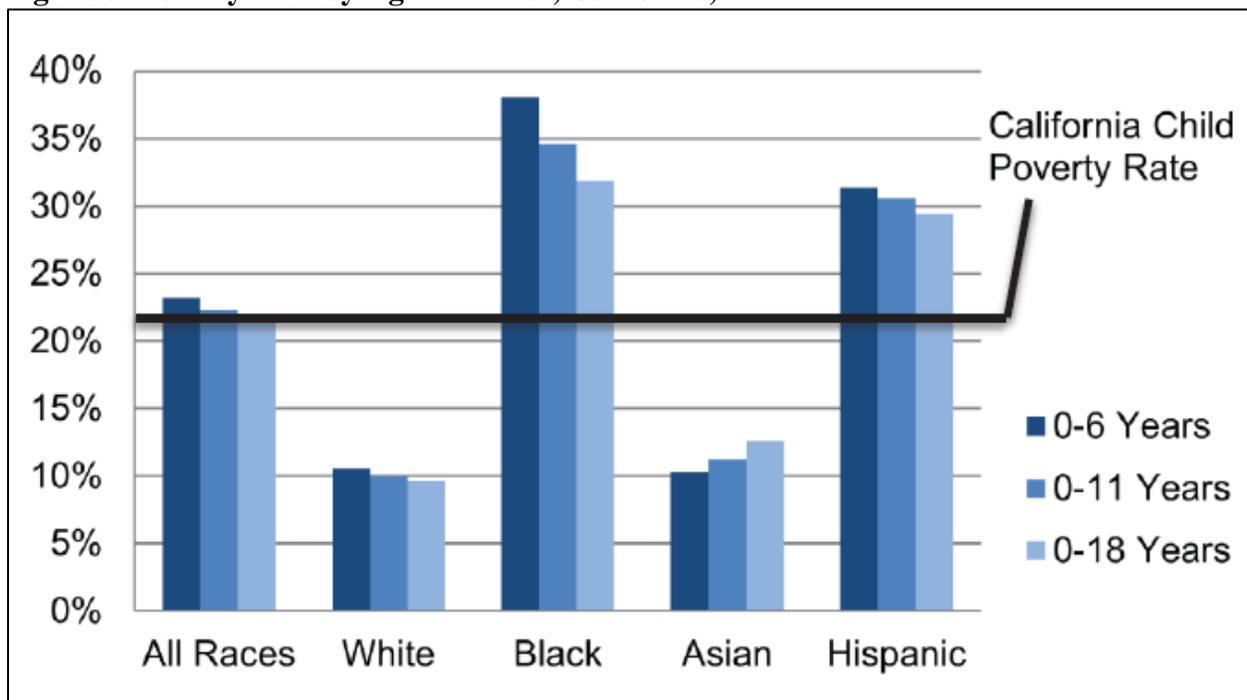
Source: U.S. Census Bureau, Retrieved June 2013, <http://www.census.gov/geo/maps-data/data/tiger-data.html>

Where you live is a larger determinant of your health than accessing health care, and experts agree that health care contributes only about 10–15% to health outcomes and life span.¹² Adolescents who grow up in neighborhoods characterized by concentrated poverty are more likely to be victims of violence; use tobacco, alcohol, and other substances; and become obese.¹³ It is almost impossible to maintain good health in a neighborhood without:

- Safe streets and transportation (including safe intersections, traffic lights, crosswalks, sidewalks, and bike lanes);
- Opportunities for physical activity (including safe playgrounds, parks, and other walkable areas);
- Access to conveniently located nutritious, affordable food;
- Quality schools;
- Safe and affordable housing; and
- Equitable employment opportunities.

As Figure 6 below shows, among children who live in poverty, the largest percentage tend to be the youngest, and by definition, most vulnerable members of society. Black children, ages zero to six, experience a poverty rate of 38.1%, which is 14.9 percentage points higher than the state-wide figure for all children zero to six (at 23.2%). California’s youngest Hispanic children, ages zero to six, see poverty rates that are over eight percentage points higher than the state total.

Figure 6: Poverty Rate by Age and Race, California, 2011



Source: American Community Survey, 3-year estimates 2009-11. Retrieved May 2013 from: Rey Fuentes, Ann O’Leary, and James Barba, *Prosperity Threatened: Perspectives on Childhood Poverty in California January 2013*.

California’s children have the highest rates of poverty. More than one in five children in California lives in poverty; nearly *half* live either in poverty or perilously close to it.¹⁴ This is of concern due to the immediate effects of income deprivation, such as decreased health outcomes,

and also because poverty is mobile across generations. According to a recent study from Columbia University’s National Center for Children in poverty, 45% of people who spent half their childhoods in poverty were also poor as adults.¹⁵ A 2010 county breakdown of poverty rates is provided below in Table 1. Thirty-two California counties (55%) ranked above the National poverty rate of 14.9%.

Table 1: Poverty Rates by California County, 2010

County or County Group	Poverty Rate (%)	Rank in CA	County or County Group	Poverty Rate (%)	Rank in CA
Alameda	13.3	29	Placer	9.4	40
Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne	12.6	30	Riverside	16.6	21
Butte	20.9	7	Sacramento	17.3	20
Colusa, Glenn, Tehama, Trinity	17.3	18	San Bernardino	17.8	17
Contra Costa	9.4	39	San Diego	14.7	24
Del Norte, Lassen, Modoc, Siskiyou	21.9	4	San Francisco	12.6	31
El Dorado	9.8	37	San Joaquin	20.1	10
Fresno	27.1	1	San Luis Obispo	14.6	25
Humboldt	15.0	23	San Mateo	6.7	41
Imperial	20.8	8	Santa Barbara	19.0	13
Kern	21.4	6	Santa Clara	10.4	36
Kings	21.7	5	Santa Cruz	14.0	26
Lake, Mendocino	20.2	9	Shasta	17.9	15
Los Angeles	17.3	19	Solano	11.8	33
Madera	19.5	12	Sonoma	13.5	27
Marin	9.6	38	Stanislaus	19.8	11
Merced	24.3	2	Sutter, Yuba	18.3	14
Monterey, San Benito	16.5	22	Tulare	23.5	3
Napa	11.1	34	Ventura	10.6	35
Nevada, Plumas, Sierra	13.4	28	Yolo	17.9	16
Orange	12.0	32	California Total	16.1	

Note: Counties with poverty rate % above the National poverty rate of **14.9%** are shown in **bold numbers**.

Note: For some counties, poverty rates cannot be calculated individually and are grouped with nearby counties.

Source: American Community Survey, 2010.

A December 2011 report from the Public Policy Institute of California (PPIC)¹⁶ also shows California typically has a higher poverty rate than the rest of the nation, and for most of the past two decades, California’s poverty rate (16.1%)¹⁷ has exceeded that of the rest of the country (14.9%). Latinos (22.8%) and African Americans (22.1%) have much higher poverty rates than Asians (11.8%) and whites (9.5%) in California.

The PPIC report also shows that poverty varies widely in accordance with educational level. In 2010, the poverty rate among families without any adult high school graduates was 31.3%. On the other hand, in families headed by at least one college degree holder, the poverty rate was

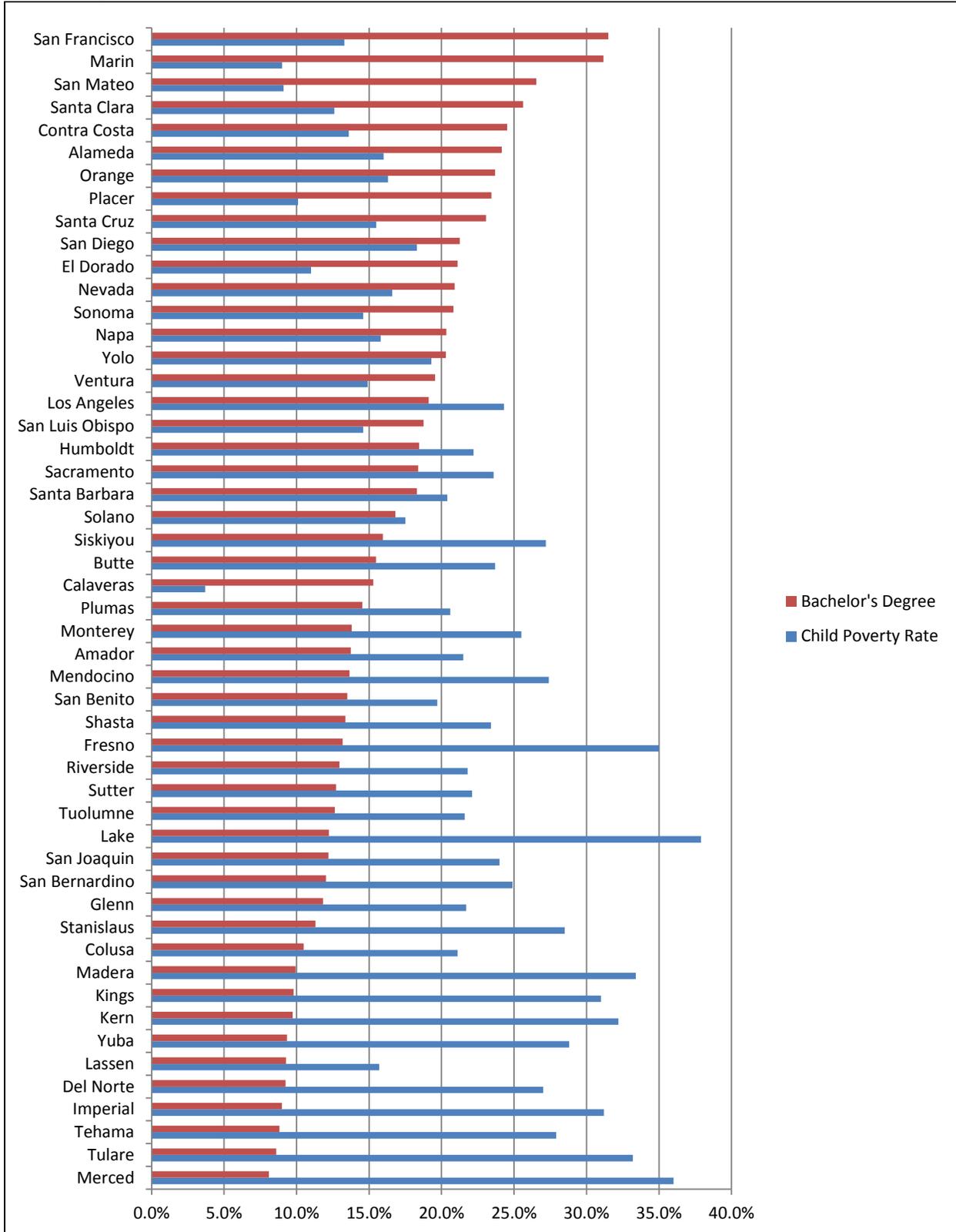
5.2%. For families in which the highest level of education is a high school diploma, the poverty rate was 19.2%. Additionally, the majority (63.4%) of poor people in California are in working families. In 38.3% of poor families, a family member is working full-time, and in another 25.1% someone is working part-time. Workforce participation among the poor in California has increased over the past three decades and remains higher than in the rest of the nation.

Education

Education is at least nominally correlated with the poverty outcomes in each county. The counties with the highest number of college graduates have the lowest rates of childhood poverty and vice versa. And while this trend is largely acknowledged in the field of poverty research, there are wide differences between counties.¹⁸ There are a substantial number of individuals in every county, particularly in low income, high poverty counties, in which many residents hold less than a 9th grade education.

In ten counties in California, among adults twenty-five years and older, the percentage of residents with less than a 9th grade education tops 15% – a figure that translates into over 280,000 residents. Statewide, the number of residents 25 years and older who lack more than a 9th grade education is more than 2.5 million.¹⁹ Figure 7 below shows the percentage of people 25 and over who have a bachelor's degree plotted against the child poverty rate for each California County, indicating a correlation between poverty and the lack of higher education.

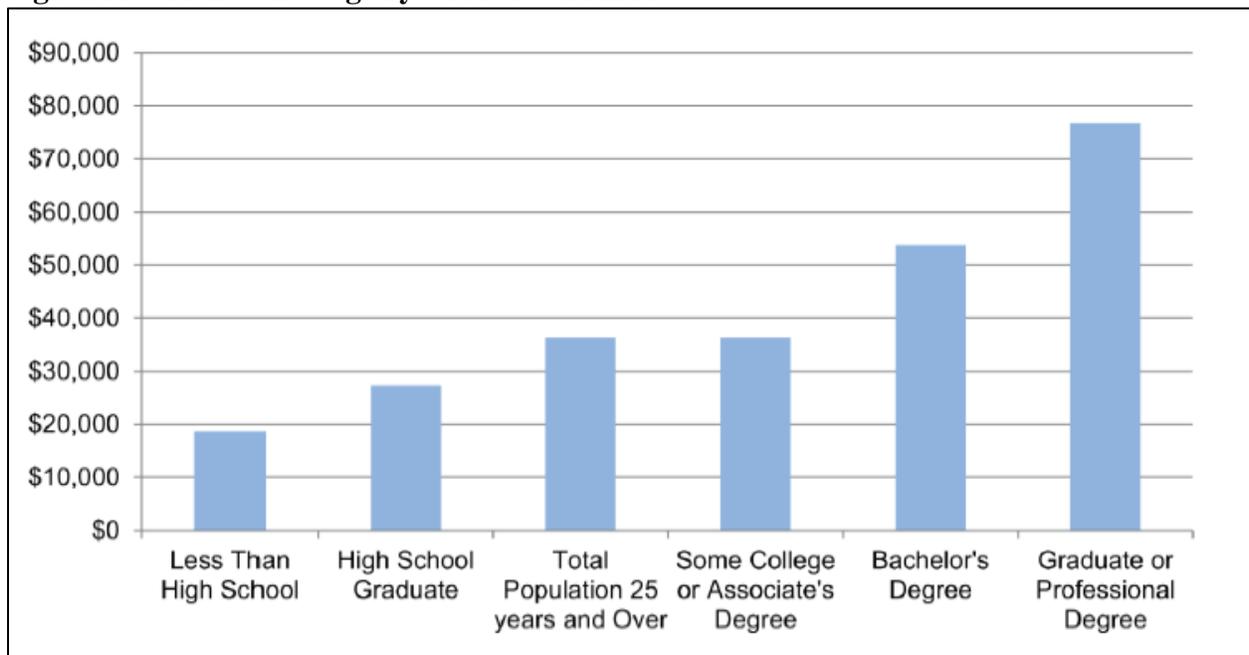
Figure 7: Percentage of Child Poverty and Bachelor Degrees, by California County, (3-year estimates, 2009-11)



Source: American Community Survey, 3-year estimates (2009-11). Retrieved May 2013 from: Rey Fuentes, Ann O’Leary, and James Barba, *Prosperity Threatened: Perspectives on Childhood Poverty in California January 2013*.

Education has a significant impact on the statewide rate of poverty, given the observed relationship between earnings and education. The American Community Survey (ACS) quantifies this impact in California by assessing the median earnings of individuals by the type of education they have received. Education facilitates economic mobility and is an especially important tool for lifting children of the next generation out of poverty. Higher education is crucial to boost the economic status of children from low-income families. Children with a college education are more likely to exceed their parents' income compared to their peers without a college education.²⁰ There is a significant increase in median incomes by level of education, as shown in Figure 8 below.

Figure 8: Median Earnings by Level of Education



Source: American Community Survey, 3-year estimates 2009-11. Retrieved May 2013 from: Rey Fuentes, Ann O'Leary, and James Barba, *Prosperity Threatened: Perspectives on Childhood Poverty in California January 2013*.

Schools play a key role in promoting equal opportunity for Californians, supporting civic engagement and critical thinking. The 2013-14 state budget increases funding for districts and makes targeted investments in districts serving students with the greatest level of needs — recognizing that this approach will help the state reduce disparities, maximize student achievement, and strengthen the foundation for sustainable growth.

The California Longitudinal Pupil Achievement Data System (CALPADS) report is used by schools, districts, policymakers, researchers, parents, and the public for purposes of identifying and understanding trends, causal relationships, early warning indicators, and potential points of intervention to address the high rate of dropouts in California. The rate is calculated by following the cohort (i.e., the group of students) over a period of time.

Table 2 provides a summary of four-year statewide 9th to 12th grade cohort graduation rates overall, and by racial/ethnic subgroup, as well as a side-by-side comparison to higher education graduation rates for the same demographic subgroups.

Table 2: Graduation Rates by Racial Subgroup, Grade 9-12 (2006-10) and Grade 12 Graduates (2009-10) Completing All Courses Required for UC and/or CSU Entrance

Demographic Subgroup	Four Year Cohort Graduation Rate	Percentage of UC/CSU Graduates
Overall	74.4%	35.6%
Female	78.5%	39.7%
Male	70.5%	31.4%
Black or African American – not Hispanic	59.0%	28.5%
American Indian/Alaska Native - not Hispanic	67.1%	24.9%
Asian – not Hispanic	89.4%	60.3%
Filipino – not Hispanic	87.5%	47.6%
Hispanic or Latino of any Race	67.7%	26.5%
Pacific Islander – not Hispanic	72.6%	30.7%
White – not Hispanic	83.4%	40.9%
Two or More Races – not Hispanic	84.8%	42.0%
Socioeconomically Disadvantaged	67.9%	25.1%

Note: See <http://www.cde.ca.gov/ds/sd/fa/> for rate calculation method.

Source: California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS)

Highlights:

- The Black demographic group had the lowest high school graduation rate at 59%, well below the overall rate of 74.4%.
- The American Indian group had the lowest UC/CSU graduation rate at 24.9%, compared to the overall rate of 35.6%.

Nearly three out of four students who started high school in 2006 graduated with their class in 2010. However, the graduation rates show a significant attainment gap between students of certain groups (African American, American Indian/Alaskan Native, Hispanic and Socioeconomically Disadvantaged) and their peers. This trend continues into the realm of higher education, as seen in the disparate graduation outcomes for these same groups.

Employment

According to the 2013 National Drug Control Strategy, extensive research suggests that problematic substance use is both a cause and a result of unemployment. Individuals can get caught in a cycle of substance use and unemployment that can be difficult to break without treatment and job counseling. Studies indicate that alcohol use disorders double the risk of becoming unemployed;²¹ heavy alcohol users are 6 times more likely to be unemployed than low use drinkers; and cocaine use tends to lower the likelihood of being employed by 23 to 32 percentage points while marijuana use lowers it by 15 to 17 points.²²

The California statewide unemployment figure of 8.5% masks the high levels of unemployment in some counties — 4 of which are double that of the Federal rate of 7.5%, and 44 that exceed the state average.²³ The Bureau of Labor Statistics provides measures of unemployment that show California unemployment figures (as shown in Table 3) are high in state-by-state comparisons, having the third highest rate of unemployed and underemployed in the country.²⁴

This means that not only do individuals in California experience a higher than average rate of unemployment, when they do find employment, they tend to enter jobs that are part-time or pay a much lower wage than they would expect.

Table 3: Unemployment Rank, Number, and Rate, by California County, as of May 2013

COUNTY	RANK BY RATE	UNEMPLOYMENT N	RATE
ALAMEDA	11	54,500	7.0%
ALPINE	29	50	9.8%
AMADOR	29	1,590	9.8%
BUTTE	32	10,200	10.0%
CALAVERAS	34	1,980	10.5%
COLUSA	57	2,260	19.9%
CONTRA COSTA	11	37,800	7.0%
DEL NORTE	37	1,260	11.3%
EL DORADO	22	7,800	8.6%
FRESNO	47	58,800	13.4%
GLENN	42	1,570	12.4%
HUMBOLDT	21	5,000	8.4%
IMPERIAL	58	18,200	24.0%
INYO	16	700	7.5%
KERN	39	46,700	12.1%
KINGS	53	8,400	13.8%
LAKE	44	3,150	12.8%
LASSEN	35	1,340	10.8%
LOS ANGELES	23	453,900	9.3%
MADERA	42	8,100	12.4%
MARIN	1	6,600	4.6%
MARIPOSA	23	860	9.3%
MENDOCINO	18	3,370	8.0%
MERCED	55	17,200	15.5%
MODOC	40	460	12.2%
MONO	15	620	7.3%
MONTEREY	32	22,400	10.0%
NAPA	5	4,700	5.9%
NEVADA	17	3,810	7.6%
ORANGE	4	92,500	5.7%
PLACER	14	12,900	7.2%
PLUMAS	49	1,250	13.6%
RIVERSIDE	27	90,200	9.6%
SACRAMENTO	20	56,500	8.3%
SAN BENITO	41	3,300	12.3%
SAN BERNARDINO	27	82,600	9.6%
SAN DIEGO	11	111,900	7.0%
SAN FRANCISCO	3	25,800	5.4%
SAN JOAQUIN	45	38,200	12.9%
SAN LUIS OBISPO	7	8,800	6.1%
SAN MATEO	2	20,200	5.1%
SANTA BARBARA	6	14,100	6.0%
SANTA CLARA	8	59,600	6.5%
SANTA CRUZ	31	15,100	9.9%
SHASTA	36	8,900	11.1%
SIERRA	54	210	14.0%
SISKIYOU	45	2,410	12.9%
SOLANO	19	17,700	8.1%
SONOMA	8	16,800	6.5%
STANISLAUS	47	31,600	13.4%
SUTTER	56	7,000	16.4%
TEHAMA	38	2,920	11.8%
TRINITY	51	650	13.7%
TULARE	51	28,400	13.7%

COUNTY	RANK BY RATE	UNEMPLOYMENT N	RATE
TUOLUMNE	26	2,420	9.5%
VENTURA	10	30,900	6.9%
YOLO	25	9,200	9.4%
YUBA	49	3,700	13.6%
STATE TOTAL		1,579,000	8.5%

Note: Counties are ranked from lowest unemployment rate (1) to highest unemployment rate (58).

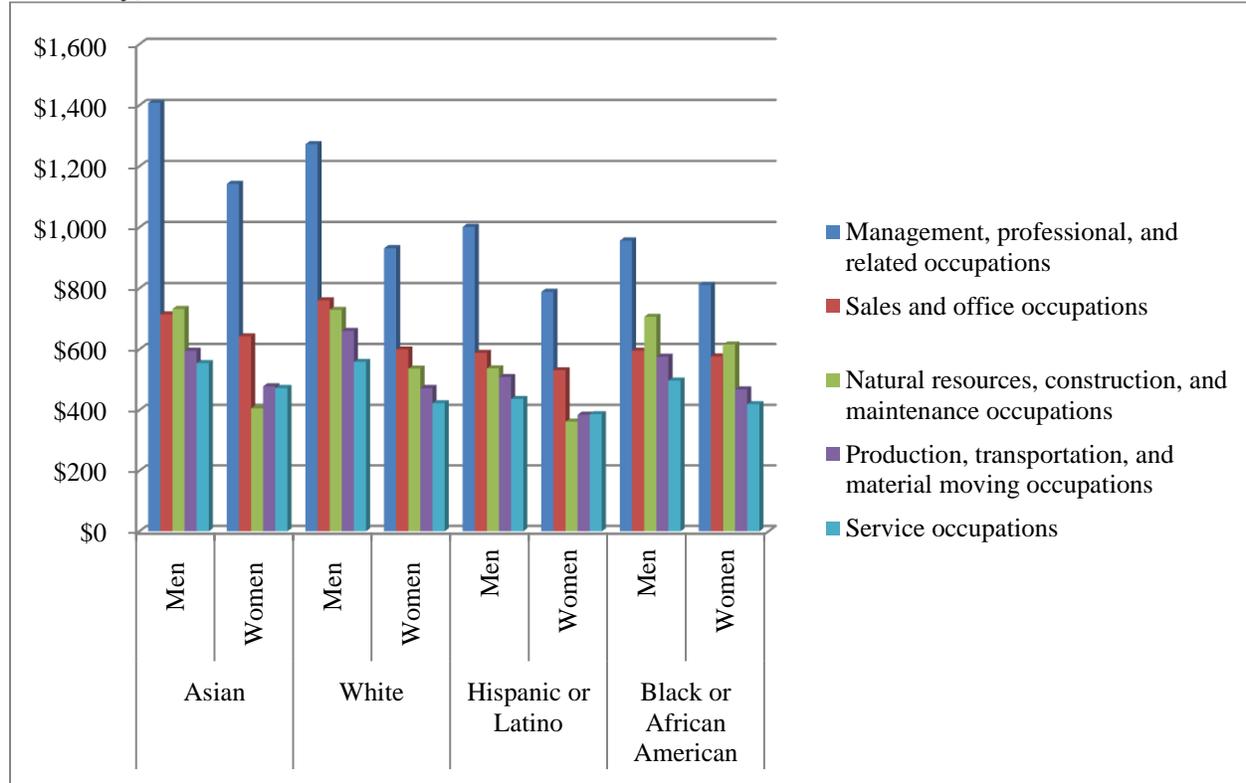
Note: Data may not add due to rounding. The unemployment rate is calculated using unrounded data.

Source: Employment Development Department, Labor Market Information Division. Retrieved May 2013 from <http://www.calmis.ca.gov/file/1fmonth/countyur-400c.pdf>

Research also suggests that unemployment results in increases in substance use (alcohol, illicit drugs, and abuse of prescription drugs) and substance use disorders. For example, a longitudinal study of U.S. workers reported that those workers who lost their jobs sometime between their first and second survey interviews were 9 times more likely to develop a substance use disorder compared to workers who did not lose their jobs.²⁵

According to a report from the Economic Policy Institute (EPI),²⁶ Hispanic and black communities in metropolitan areas generally experience greater hardship from unemployment than whites. Generally, the more educated a population, the lower their unemployment rate. As a result, many people assume that racial disparities in unemployment rates are due only to differences in educational attainment, but in reality, the story of race and unemployment is more complicated. Nationally, in 2010, median usual weekly earnings of Asian men (\$1,408) and White men (\$1,273) working full time in management, professional, and related occupations (the highest paying major occupation group) were well above the earnings of Hispanic men (\$1,002) and Black men (\$957) in the same occupation group, as shown in Figure 9 below.

Figure 9: Median Weekly Earnings by Occupation, Sex, Race, and Hispanic/Latino Ethnicity, 2010



Source: Bureau of Labor Statistics, U.S. Department of Labor, The Editor's Desk, Earnings and Employment by Occupation, Race, Ethnicity, and Sex, 2010. Retrieved May 2013 from http://www.bls.gov/opub/ted/2011/ted_20110914.htm

The median income of White households (\$69,224) is roughly 50% greater than the median income of African American (\$46,320), American Indian/Alaska Native (\$44,620), and Latino (\$43,856) households. African Americans, Latinos, and Native Americans/Alaska Natives are more than twice as likely as Whites to have an income below the poverty level. African American (29%), Latino (26%), and Native American (27%) children are more than three times as likely to live in poverty as White children (8%).²⁷

Communities as a whole suffer from high unemployment. High rates of unemployment cause immediate harm to families and communities, and they also cause long-term social and economic damage that cannot be easily fixed even when the economy finally recovers.²⁸ Economic health is essential to overall community health.

Health

Health is more than just the absence of sickness: It is a state of complete physical, mental, and social well-being. The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. It is commonly acknowledged, and well documented in the health care field, that significant health disparities exist for racial and ethnic minority populations in this country. Health disparities defined are differences in health outcomes between groups that reflect social inequalities.²⁹

Differences in health follow a strong social gradient which reflects an individual or population group's position and treatment in society. This translates in differential access to, and security of, resources such as education, employment, and housing.³⁰ The health of Californians is significantly influenced by the social, physical, and economic environments in which they live, work, learn, and play. These influences, in contrast to genetic factors, are called "social determinants of health." Social determinants of health are the conditions in which people are born; grow up, live, work and age. These conditions influence a person's opportunity to be healthy, risk of illness and life expectancy.

Social determinants of health shape the choices that people make every day, as well as the opportunities and resources for health available to them, as indicated in the example cited below. People in less affluent communities often have fewer opportunities and resources for health, which is reflected in significantly worse health outcomes.

Disparities also exist in access to quality healthcare. There is a broad array of social, political and economic structures and policies that shape access to resources and have a tremendous impact on health outcomes. People of color make up 74% of California's uninsured population. More than half of these uninsured are Latino. Over 50% of Californians who do not speak English well or at all were uninsured for all or part of 2005, compared to 24% of those who speak English very well. Almost 64% of noncitizen adults without Green Cards are uninsured for all or part of the year, and 37% of noncitizen adults with Green Cards are uninsured for all or part of the year. Even for those Californians with access to care, disparities exist in access to quality care.³¹

Consider, for example, a woman with diabetes. In addition to the health care she receives, she also will be counseled to modify her diet to include more fruit and vegetables, or to exercise more.

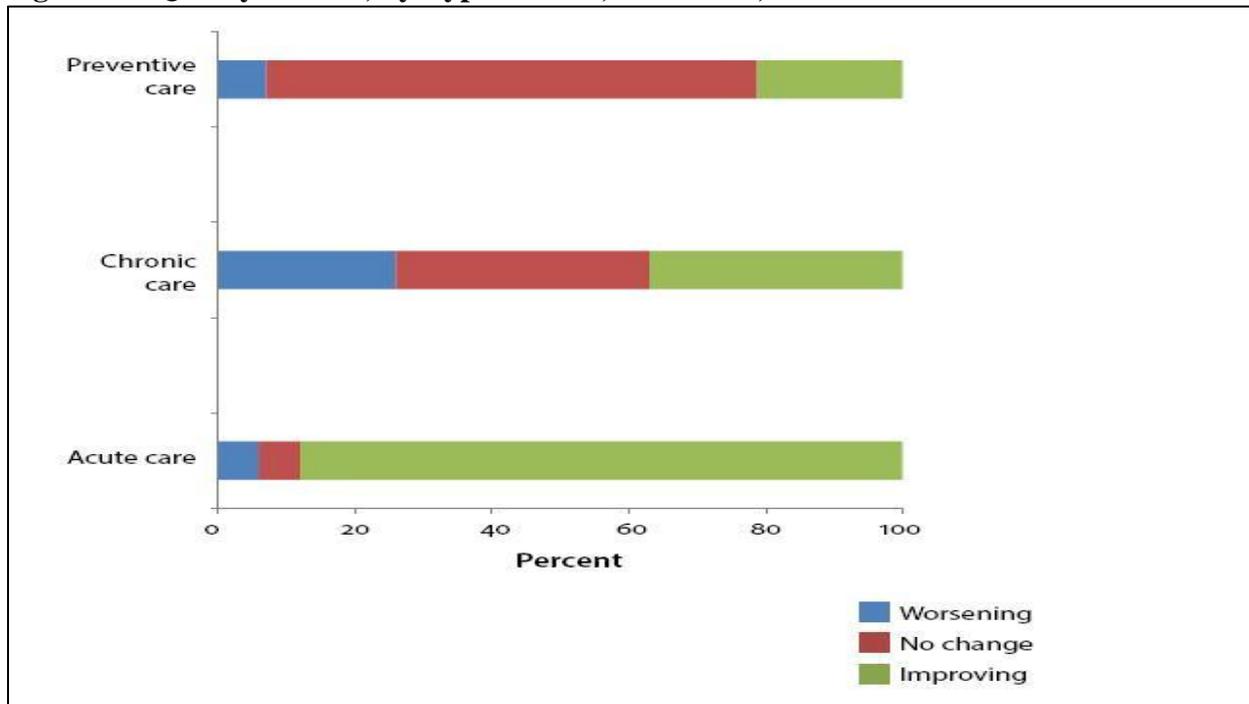
But if this woman is poor, there is no accessible supermarket, and her neighborhood is unsafe, she will be much less likely to follow these recommendations.

Her diabetes will likely not be abated, her health will deteriorate faster, hospitalizations will be required sooner and more often, and complications will come earlier. All of these are affected by factors outside the medical care system.

Robert Wood Johnson Foundation, Lavizzo-Mourey, Risa, Why Health, Poverty, and Community Development are inseparable. Retrieved May 2013 from, <http://www.whatworksforamerica.org/pdf/lavizzo-mourey.pdf>

As shown in Figure 10, the quality of chronic care (the most prevalently utilized type of care for the majority of uninsured/under-insured populations) has worsened over time.

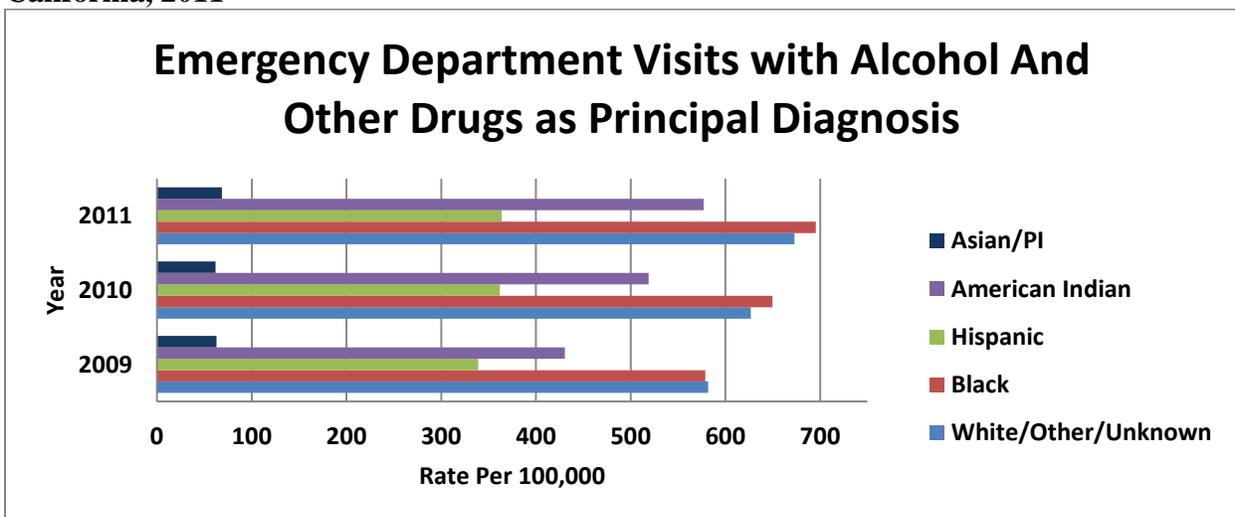
Figure 10: Quality of Care, by Type of Care, California, 2011



Source: California Department of Public Health, *The Burden of Chronic Disease and Injury, California*, 2013.

Additionally, fundamental causes of systematic limitations in access to resources – money, power, influence, racial/ethnic inequality – can be seen through data available in Figure 11, which suggests that certain minority groups have increasingly utilized the Emergency Department as their primary healthcare modality, likely due to a lack of health insurance.

Figure 11: AOD-Related Emergency Department (E.D.) Visits, by Race/Ethnicity, California, 2011



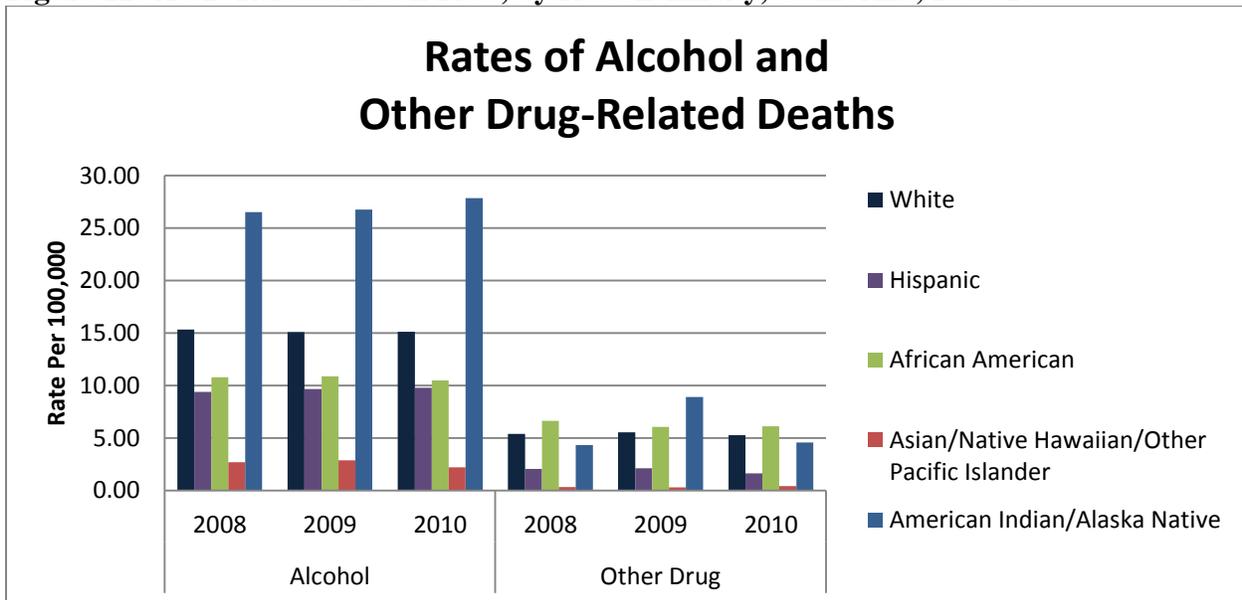
Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by: California Department of Public Health, Safe and Active Communities Branch with assistance from California Department of Alcohol and Drug Programs, Office of Applied Research and Analysis. Report generated from <http://epicenter.cdph.ca.gov/ReportMenu/AlcoholDrugTable.aspx> on: June 06, 2013

Highlight:

- In 2011, Blacks had the highest rate of AOD-related E.D. visits for all substances (695.6 per 100,000 population) - over ten times that of the Asian group, which had the lowest rate, at 68.4 per 100,000 population.

Moreover, the California Department of Public Health Vital Statistics Death Master Files contain data for AOD-related Death rates for 2008-10. Figure 12 displays a 3-year trend of all AOD-related deaths, by racial/ethnic breakdown.

Figure 12: AOD-Related Death Rate, by Race/Ethnicity, California, 2008-10



Note: AOD-related deaths are defined as deaths due to an ICD-10 Underlying Cause of Death (UCOD) code considered to be 100%)

Source: California Department of Public Health (CDPH) Vital Statistics, Death Statistical Master Files, 2008-10. <http://www.cdph.ca.gov/data/statistics/Pages/DeathStatisticalDataTables.aspx>

Highlight:

- American Indian/Alaskan Natives died from AOD-related issues at an increasing rate (when combined and averaged over the 3-year period) for both alcohol and other drugs

It is also well-documented that “minority” groups experience chronically higher levels of “toxic” stress due to their under-privileged status. This toxic stress is considered another factor that increases risk for negative health outcomes for certain racial and ethnic populations. It is likely caused by a number of factors, including poor social support and low socioeconomic status, but the primary factors are interpersonal and institutional prejudice, discrimination and racism. Numerous scientific studies support claims that individuals of non-dominant racial and ethnic groups experience a high degree of prejudice, which causes stress responses (e.g., high blood pressure, anxiety) that accrue over time, eventually leading to poor mental and physical health outcomes.³²

The cumulative impact of toxic stress on a person’s overall health is seen in children who experience strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.³³ A Centers For Disease Control and Prevention study on Adverse Childhood Experiences (ACEs, which is explained in greater detail below) suggests that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life.³⁴

Each health-related influence is intricately linked and cannot be considered in isolation. It is the interrelationships among these factors that determine individual and population health. Because of this, interventions that target multiple determinants of health are most likely to be effective.³⁵ Social and economic conditions and their effects on people’s lives determine their risk of illness and the actions taken to prevent them becoming ill or treating illness when it occurs. The evidence shows that in general, the lower an individual’s socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone.

Adverse Childhood Experiences (ACE) Study

There is a growing consensus that childhood abuse, neglect, and exposure to other traumatic stressors, termed adverse childhood experiences (ACEs), increase the risk for unhealthy behaviors, the most deadly chronic diseases, and both unintentional and intentional injuries. Learning how to cope with adversity is an important part of healthy child development. Adverse Childhood Experiences have been linked to a wide range of health outcomes in adulthood including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality.

A 5-state Behavioral Risk Factor Surveillance System (BRFSS) survey³⁶ examined whether a history of ACEs was different among racial/ethnic groups. Eight categories of ACEs (verbal abuse, physical abuse, sexual abuse, household mental illness, household substance abuse, domestic violence, parental separation/divorce and incarcerated family members) were identified, and the following demographic breakdowns were revealed:

Figure 13: Cumulative Adverse Childhood Experiences, By Race/Ethnicity

	0 ACEs	1 ACEs	2 ACEs	3 ACEs	4 ACEs	≥5 ACEs
White, non-Hispanic	41.7%	22.0%	12.7%	8.7%	6.0%	8.9%
Black, non-Hispanic	37.3%	27.0%	13.8%	8.9%	8.0%	4.9%
Hispanic	35.7%	23.5%	12.9%	10.3%	8.6%	9.1%
Other, non-Hispanic^	37.8%	18.2%	16.4%	8.4%	7.6%	11.7%

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2009, <http://www.cdc.gov/Features/dsACEs/>

For specific ACE categories, differences by race/ethnicity can be seen among respondents, as shown in Figure 14 below:

Figure 14: Percent of Prevalence of Exposure to Select ACEs, By Race/Ethnicity



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2009, <http://www.cdc.gov/Features/dsACEs/>

Highlights:

- Black, non-Hispanic respondents reported higher prevalence of having had an incarcerated family member (12.9%), compared to Hispanics (9.5%) and Whites (6.2%).
- Compared to Whites, Hispanics more frequently reported physical abuse (14.6% for Whites, 19.8% for Hispanics), and witnessing domestic violence (15.1% for Whites, 21.7% for Hispanics).

Increased awareness of the frequency and long-term consequences of adverse childhood experiences may lead to improvements in health promotion and disease prevention programs. The magnitude of the difficulty of introducing the requisite changes into medical and public health research, education, and practice can be offset only by the magnitude of the implications that these changes have for improving the health of the nation.

Impact of Racial/Ethnic Disparities on Other Systems

Many systems are directly or indirectly impacted by substance use and abuse, which also contribute to the prevalence of racial/ethnic disparities, due to the over-lapping and cumulative impact of inequity in access and delivery of publicly-funded services. Most individuals act in the context of their families, neighborhoods, workplaces, social networks and communities. These environments in turn are influenced by regional, national and global policies in which policies and other actions can be applied to improve the health of Californians. Public systems that shape our environments such as child welfare, criminal justice, and healthcare all contribute to the disproportionate negative impact from the disparate treatment and outcomes of certain racial/ethnic groups. The Domain data presented earlier in this report suggest a direct correlation between racial/ethnic groups where resources and access are limited, higher levels of “toxic” stress exist due to under-privileged status, the over-representation of cumulative risk factors exacerbate current adverse experience, and worse overall outcomes.

The following sections will discuss disparities that exist within the child welfare, criminal justice and health care systems - three systems highly impacted by the consequences of AOD use.

Child Welfare

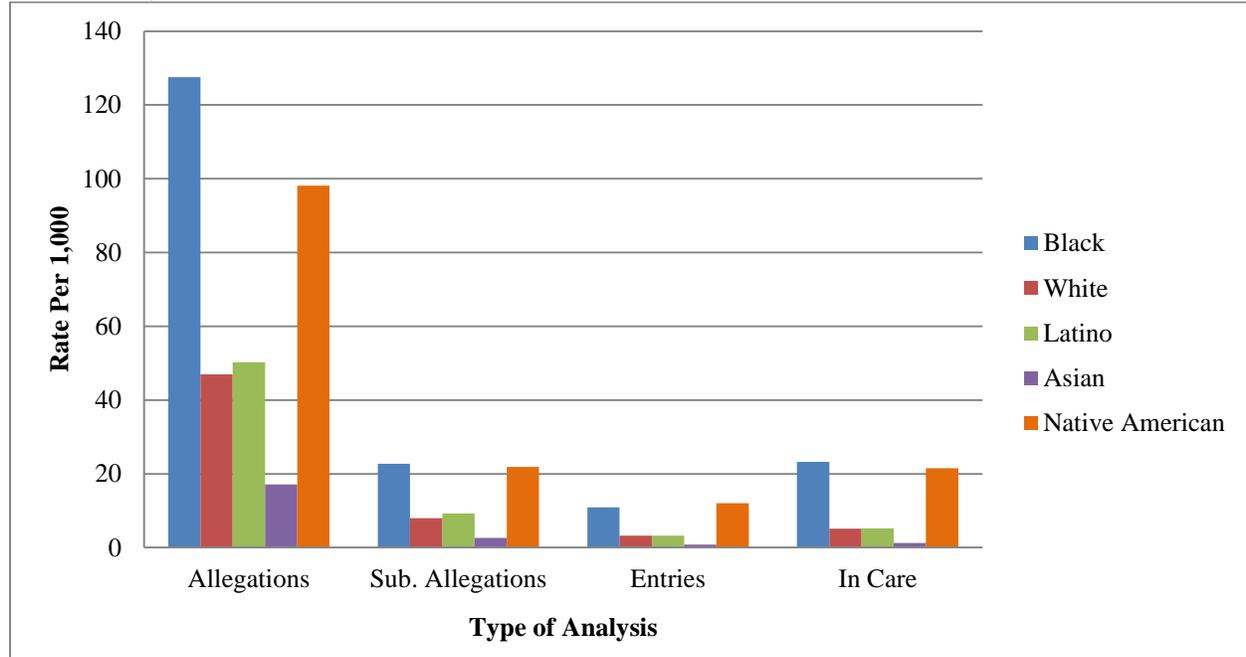
In California, there were 475,580 child maltreatment referrals to Child Protective Services (CPS) in 2011, with a total of 87,491 children substantiated as victims of child maltreatment.³⁷ Most of the children who become part of the child welfare system do so primarily because of confirmed physical abuse, sexual abuse, neglect or emotional abuse by their caregivers, oftentimes due to parental substance abuse.

As of July 1, 2012, California had 52,170 children in foster care, the majority being Hispanic (47.6 %). White and African American children represented the next highest race/ethnicity groups at 25.2 % and 22.8 %, respectively. African Americans and Native Americans had the highest rates of children in foster care, based on their overall state population (23.9 per 1,000 and 22.1 per 1,000 children, respectively).

A large amount of research has documented the overrepresentation³⁸ of certain racial and ethnic groups in the child welfare system, when compared with their representation in the general population.³⁹ While the extent of this overrepresentation varies significantly across different regions of the country, it exists at some level in virtually every locality.

Figure 15 below shows the degree to which groups of children have contact with the child welfare system at higher or lower rates than their presence in the general population. Black and Native American children had the highest rates of contact with the system across all categories: Allegations, Substantiated Allegations, Entries and In Care as of July 1, 2012.

Figure 15: Rates of Child Abuse and Neglect, by System Contact Level and Race/Ethnicity, California, 2012



Source: Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Yee, H., Hightower, L., Lou, C., Peng, C., King, B., & Henry, C. (2012) *Child Welfare Services Reports for California*. Retrieved [month day, year], from University of California at Berkeley Center for Social Services Retrieved May 2013 from: http://cssr.berkeley.edu/ucb_childwelfare/DisparityIndices.aspx

Research from the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4) 2010 report found race differences partly due to the enlarged gap between Black and White children in economic well-being. Income, or socioeconomic status, is the strongest predictor of maltreatment rates, but since the time of the NIS-3, incomes of Black families have not kept pace with the incomes of White families. Race correlates with a number of predictors of maltreatment, and did have effects on risk in certain maltreatment categories, even after the effects of other important predictors were considered.⁴⁰

Black children were at significantly greater risk than White children of experiencing physical abuse under both the Harm and Endangerment Standards, but in both cases, this race difference depended on SES. Furthermore white children had significantly higher risk for Endangerment Standard physical neglect, but this race difference appeared only among children in low SES households.⁴¹

The race difference was small or nonexistent among children living in low SES households, but it was notably larger for children in not-low SES households. Black children were also at comparatively elevated risk when living with unmarried parents or a single parent with a partner in the household, whereas the risk for White

While most people in financial need do not maltreat their children, poverty can increase the likelihood of maltreatment, particularly when poverty is combined with other risk factors such as depression, substance abuse, and social isolation.

*U.S Department of Health and Human Services, Administration for Children & Families,
<https://www.childwelfare.gov/can/factors/environmental/poverty.cfm>*

children in those circumstances was considerably lower. At the same time, White children appeared to have somewhat higher risk than Black children when living with married parents who were not both biologically related to them and when living with a single parent who had no cohabiting partner.⁴²

Criminal Justice

As stated in the 2013 National Drug Control Strategy, “While smart law enforcement efforts will always play a vital role in protecting communities from drug-related crime and violence, we cannot arrest our way out of the drug problem.”⁴³

There is a strong social gradient in imprisonment, with people of lower class, income and education much more likely to be sent to prison than people higher up the social scale. Blacks and Hispanics represented 39% of California’s adult population in 2010, but accounted for 68% of adults sentenced to state prison and 58% of adults sentenced to county jail, probation, or both. Black and Hispanic juveniles represented 56% of California’s under-age-18 population in 2010, but accounted for 87% of Division of Juvenile Justice youth and 74% of county commitments.⁴⁴

In 2010, California’s total inmate population of 162,976 had a total of 15% who were drug offenders while the federal inmate population of 190,641 had over 50% who were drug offenders.⁴⁵ The most recent 2012 data show that the vast majority of the state prison population is male. Blacks and Hispanics comprise 71% of inmates. Most prisoners are between 20 and 39 years of age. During the past 20 years, the percentage of inmates who are Hispanic has increased by 27%, while the percentage of white and black inmates has decreased. The percentage of inmates who are 50 or older is nearly four times larger than it was 20 years ago. The gender distribution of inmates has remained stable.⁴⁶

Racial disparities in convictions and sentencing in the United States criminal justice system have been widely documented.⁴⁷ Experts and analysts have debated the relative importance of different factors that have led to these disparities. Minority defendants are charged with crimes requiring a mandatory minimum prison sentence more often, leading to large racial disparities in incarceration. The impact the “War on Drugs” has had on the prison population (particularly, who gets incarcerated), with strict drug law violations and California’s three strikes law (recently modified), is a prison population with a large number of individuals with substance dependence and abuse receiving inordinately lengthy sentences, and in many cases, for minor drug law infractions (i.e., possession for personal use).

In an ideal world, persons involved with the various levels of criminal justice would receive needed

How are imprisoning people for drug use and race interconnected?

While we know that there has been a "war on drugs" since the 1980s, in fact this has been a two-tiered "war." Drug use and abuse cuts across lines of race and class, but drug law enforcement has primarily targeted low-income communities of color.

When parents in well-off suburbs find out that their teenage son or daughter has a drug problem they don't call the police to demand that their teenager be arrested, but instead consult with their friends who can recommend a high-quality treatment program.

In contrast, in disadvantaged communities with limited resources, the primary response is far more likely to be one involving law enforcement and incarceration.

*How the Prison-Industrial Complex Destroys Lives, Friday, 26 April 2013 00:00
By Mark Karlin, Truthout Interview*

effective substance use disorder and mental health treatment while incarcerated, and continued recovery support services that assist with employment, housing, medical care, and other social supports to ensure their successful reentry into the community.⁴⁸ However, the scarcity of inmate rehabilitation programs and the complexity of operating large institutions have turned the nation's prison systems into revolving doors with high recidivism rates.

California, with one of the nation's highest recidivism rates, had a parole system that had been overwhelmed by high caseloads. Consequently, parolees were receiving neither the services nor supports they need to find jobs, deal with substance abuse or resolve psychological issues.⁴⁹ With limited options at the community level for engagement in substance abuse treatment, released offenders often times failed to successfully negotiate the multiple challenges of re-entry into society. This situation has been helped by Realignment and the shifting of a portion of state prison inmates and resources to local control and community supervision. This group of returning community members, with complex public safety and health care needs, creates new challenges for county alcohol and drug service providers, as the resources to treat these individuals' substance use is not guaranteed.

Racial inequality in sentencing still exists in the justice system. Members of minority groups are more likely to be incarcerated for drug offenses, and punished with longer sentences, than their White counterparts. State prison data show that African American and Hispanic-American individuals who commit drug offenses are consistently incarcerated at higher proportions than White drug offenders. In 2009 alone, there were nearly 60% more African Americans in state prison for drug offenses than Whites.⁵⁰

Research confirms that the inequalities in rates of incarceration for people of color are not a function of higher rates of crimes committed by those groups. For example, 25% of White youth in the U.S. have committed one violent offense by age 17, compared to 36% of African Americans. Ethnic rates of property crime are the same and African American youth commit fewer drug crimes, but African American youth are overwhelmingly more likely to be arrested, detained, charged, charged as if an adult, and imprisoned. The same pattern is true for African American and Hispanic adults, who are treated more harshly than Whites at every stage of judicial proceedings. Facing the same charges, White defendants are far more likely to have the charges against them reduced, or to be offered diversion (a deferment or suspension of prosecution) if the offender agrees to certain conditions, such as completing a drug treatment program.⁵¹

Another group which has been incarcerated at high rates is veterans. Research shows that among the greatest predictive factors for the incarceration of veterans are substance misuse and addiction. Suffering from a mental health condition, especially Post Traumatic Stress Disorder (PTSD) is also highly associated with increased risk of incarceration. Incarcerated veterans with PTSD report more serious legal problems, higher lifetime use of alcohol and other drugs, and poorer overall health than those without PTSD.⁵² Additionally, 46% of veterans in federal prison were incarcerated for drug law violations; 15% of veterans in state prison were incarcerated for drug law violations (including 5.6% for simple possession); 61% of incarcerated veterans met the DSM-IV criteria for substance dependence or abuse; 38% of veterans in state prison received less than an honorable discharge (which may disqualify them for VA benefits). The incarceration of veterans tracks the general rates of incarceration in an important and unfortunate way: African

American and Latino veterans are much more likely to be incarcerated than are White veterans – exemplifying the same racial disparities inherent in the war on drugs.⁵³

Jarvious Cotton cannot vote. Like his father, grandfather, great-grandfather, and great-great-grandfather, he has been denied the right to participate in our electoral democracy. Cotton's family tree tells the story of several generations of black men who were born in the United States but who were denied the most basic freedom that democracy promises—the freedom to vote for those who will make the rules and laws that govern one's life.

Cotton's great-great-grandfather could not vote as a slave. His great-grandfather was beaten to death by the Ku Klux Klan for attempting to vote. His grandfather was prevented from voting by Klan intimidation. His father was barred from voting by poll taxes and literacy tests. Today, Jarvious Cotton cannot vote because he, like many black men in the United States, has been labeled a felon and is currently on parole.

Michelle Alexander, The New Jim Crow, Mass Incarceration in the age of Colorblindness, <http://newjimcrow.com/about/excerpt-from-the-introduction>

More than half of California's adult male population is Latino or nonwhite (55%), but three of every four men in prison are Latino or nonwhite: 41% are Latino, 29% are African American, and 6% are of another race. Among adult men in 2010, African Americans were incarcerated at a rate of 5,525 per 100,000, compared to 1,146 for Latinos, 671 for non-Latino whites, and 43 for Asians. Among women, African Americans were incarcerated at a rate of 342 per 100,000, compared to 57 for Latinas, 66 for non-Latina whites, and 5 for Asian women.⁵⁴

According to a national study, within three years of release, almost 7 in 10 will have been rearrested. Many released prisoners have difficulty transitioning back into societies and communities from state and federal prisons because the social environment of peers, family, community, and state level policies all impact prison reentry; the process of leaving prison or jail and returning to society. Men released from prison will most likely return to

their same communities, putting additional strain on already scarce resources as they attempt to garner the assistance they need to successfully reenter society. Due to the lack of resources, these same men will continue along this perpetuating cycle.⁵⁵

Individuals with criminal conviction records face barriers that extend beyond their sentences. State and Federal laws and rules restrict their access to many government benefits and opportunities, making it difficult for them to successfully return to society. These restrictions and sanctions are known as collateral consequences. Though some collateral consequences serve an important and legitimate public safety or regulatory function, many do not and rather serve as additional punishment without due process protections.

The disenfranchisement of felons continues upon release, through the loss of basic rights (i.e., voting, jury service), public benefits (i.e., food stamps, housing assistance, etc.) and discrimination in employment, housing, etc. This creates an underclass of individuals with few options, who oftentimes find themselves back in prison, homeless or staying with friends or relatives while they try to re-enter society.

Health Care

A basic principle of public health is that all people have a right to health. Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as health disparities. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health. Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical conditions.⁵⁶ Health equity, then, as understood in public health literature and practice, is when everyone has the opportunity to “attain their full health potential” and no one is “disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”⁵⁷

Certain racial/ethnic groups live in social and/or economic environments that adversely affect health. For example, neighborhoods without easy access to stores, recreation, and jobs limit the options for making the healthy choice the easy choice.⁵⁸ Lower education and income impact overall health by reducing access to health care, chronic stress from poverty, and living in environments that are not conducive to a healthy diet and physical activity. Many diseases can be prevented through common medical screenings and early detection, regular exercise, healthy eating, and maintaining a healthy weight.

Studies have shown that diagnoses, treatments, and quality of care can vary greatly depending on a number of factors that affect minority communities including language barriers, lack of insurance coverage, and differential treatments based on the population group.⁵⁹ The differences in health outcomes are not always attributable to providers' delivering a different quality or quantity of care for certain patients with the same health conditions as others. Health inequities can also result when the exact same medical treatment is provided to all patients who have the same health condition without regard to the patient's cultural norms. People who are not optimally treated have an increased risk of severe disease and subsequent poor quality of life.

Thirty-eight percent of California's residents (fourteen million) are living with at least one chronic condition, and many Californians have multiple chronic conditions; this puts them at greater risk for other chronic conditions, limits their ability to exercise or be a member of the workforce, and can portend an early death.⁶⁰ Californians with chronic disease report more days of poor health. Poor health can affect a person's mental wellbeing and productivity in school or at work. People with chronic conditions account for approximately 80% of health care costs, 80% of hospital admissions, 90% of all prescriptions filled, and 75% of all doctor's visits. Almost 60%, or \$51 billion, of California's health care expenditures were for people with multiple chronic conditions.

The way most medicine comes about is that you have various treatments and you test them and see if it's effective and then you implement it... If one thing doesn't work, they don't keep doing the same thing over and over again, they modify the treatment. That tends not to happen in traditional rehab. You keep going back, but the treatment is not modified much at all the third, fourth, and fifth times that you go back—and you're blamed if the treatment fails.

SALON, What Really Goes On Inside Rehab? by Chrisanne Grise.

In 2010, over 187,000 deaths (80%) in California were caused by chronic disease and injury. Chronic diseases are largely preventable. Up to 80% of heart disease, stroke, and type 2 diabetes and over 30% of cancers could be prevented by eliminating tobacco use, unhealthful diet, physical inactivity, and the harmful use of alcohol. Many of these health risks are largely shaped by community environments and neighborhood design, which influence whether healthful, accessible and affordable food, safe housing, and opportunities for exercise and transportation are a part of everyday life.⁶¹

California ranks third in the United States in terms of life expectancy. At birth, the average Californian is expected to live 81 years. However, life expectancy is not the same for all racial/ethnic groups. Asian Americans are expected to live the longest (86 years), and African Americans the shortest (73 years) number of years. Native Americans have a life expectancy of 78 years. Women live longer than men (83 years versus 78 years). Life expectancy depends on where you live, and overall, educational attainment is the most important predictor of life expectancy.⁶²

A number of chronic health conditions (like cancer, diabetes and heart disease) occur at a greater rate among minority populations, which research links to the cumulative impact affect. For example, socioeconomic status is an important predictor of heart disease in California: As education increases, the risk of heart disease falls. A similar relationship exists between lower income and heart disease.⁶³ Chronic disease not only impacts life expectancy (how long we live), but quality of life. As measured in Disability Adjusted Life Years (DALYs), the overall disease burden, expressed as the cumulative number of years lost due to ill health, disability, and early death paints a grim picture for those with chronic diseases.

Poor health is costly and increases direct medical costs (such as emergency room visits and hospitalizations) and indirect costs (lost productivity due to absenteeism). Costs have rapidly increased over the past decade. People with chronic conditions account for approximately 80% of health care costs, 80% of hospital admissions, 90% of all prescriptions filled, and 75% of all doctor's visits.⁶⁴ Many chronic diseases have causes in common, so creating healthy environments and adopting healthy behaviors will have a positive impact on the one in five Californians who have more than one chronic disease.

California spends more money on health care than does any other country in the world.⁶⁵ We also spend more on health care than we do on housing or food: \$2.2 trillion in 2007, or \$7,421 per person.⁶⁶ Health disparities add to this cost. One study found that disproportionate rates of several common preventable chronic diseases among African Americans and Latinos cost the nation's health-care system \$23.9 billion in 2009, including \$6 billion in California alone.⁶⁷ The indirect cost of disparities is even higher — an estimated \$1 trillion in lost work time and lower productivity from 2003 to 2006.⁶⁸ And that does not include the personal toll on individuals.

Conclusions

AOD leaders are in a unique position to garner support and initiate local planning efforts to take this broader social determinants view of AOD use and its consequences. Due to the large fiscal impact that AOD use has on numerous systems and the cascading negative effect it has on communities of color that can perpetuate for generations, far-sighted investments in prevention

are critical for the long-term health of all of our communities. Research has long told us that thoughtful investments of public funds would reap long-term benefits through healthier communities. We now have local examples of movement in this direction with the Bay Area Regional Health Initiative and the Magnolia Place Initiative, and federal investments through Promise Neighborhoods and Choice Neighborhoods Initiatives. These initiatives tell us that it is possible to garner the local support needed to impact the outcomes for communities of color.

More than 40 years after President Johnson's *War on Poverty* speech to Congress, then Senator and now President Obama made his famous race speech in 2008 saying that:

“ . . . The fact is that the comments that have been made and the issues that have surfaced over the last few weeks reflect the complexities of race in this country that we've never really worked through – a part of our union that we have yet to perfect. And if we walk away now, if we simply retreat into our respective corners, we will never be able to come together and solve challenges like health care, or education or the need to find good jobs for every American. . . . This union may never be perfect, but generation after generation has shown that it can always be perfected. . . ”

Any overhaul of our health care system will be incomplete as long as segments of our population experience more limited access to, and poorer outcomes from, systems of care than the rest of America. No single entity/agency/department can provide a full-spectrum solution to reducing long-term consequences of lifetime disparities. However, working collaboratively, with coordinated community-level cooperation and participation, improvements in overall attitudes, beliefs, practices and treatment of racial/ethnic populations can be the beginning of positive change in local communities.

ENDNOTES

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- ¹⁴ While great care was taken to normalize the data available for analysis, the official poverty level recorded by the American Community Survey’s 3-year estimates does differ slightly from the Supplemental Poverty Measure breakdown. For further context, compare Census Table S1701 to see differences in measures of poverty broken down by age, race, gender, etc.
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