FINAL REPORT

of the
Joint House-Senate Task Force
on
Ice and Drug Abatement

January 2004

Submitted by:

Representative Eric G. Hamakawa, Co-Chair
Senator Colleen Hanabusa, Co-Chair
Senator Melodie Williams Aduja, Co-Chair

TABLE OF CONTENTS

DESCRIPTION OF TASK FORCE

At the close of the 2003 Regular Session of the State Legislature, the Speaker of the House of Representatives, Calvin K. Y. Say and the Senate President, Robert Bunda, recognized the need to address issues relating to the manufacture, sale and use of the drug crystal methamphetamine, commonly known as "ice."

Communities throughout the State are crying for help to eliminate the drug from the marketplace, treat the individuals addicted to the drug and the families torn apart by the effects of this addiction and ensure that our youth and adults do not start down the road to addiction.

The leaders of the House and Senate heard the cries from the communities and named 18 legislators to the Joint House-Senate Task Force on Ice and Drug Abatement (Task Force). The Task Force was charged with this mission:

- **GO OUT INTO THE COMMUNITIES.**
- **LISTEN TO THE PEOPLE.**
- **SEARCH FOR NEW IDEAS AND FRESH SOLUTIONS.**
- **RULE NOTHING OUT.**

The ultimate goal of the Task Force is to bring forth legislation with a comprehensive approach to the myriad of problems associated with the ice epidemic.

The members of the Task Force are:

House of Representatives

Rep. Eric G. Hamakawa, Co-Chair
Rep. Thomas Waters, Vice-Chair
Rep. Cindy Evans
Rep. Robert N. Herkes
Rep. Michael Y. Magaoay
Rep. Romy M. Mindo
Rep. Maile S.L. Shimabukuro
Rep. Colleen R. Meyer
Rep. Bud Stonebraker

Senate

Sen. Colleen Hanabusa, Co-Chair
Sen. Melodie Williams Aduja, Co-Chair
Sen. Suzanne Chun Oakland
Sen. Willie C. Espero
Sen. Lorraine R. Inouye
Sen. Norman Sakamoto
Sen. Shan Tsutsui
Sen. Fred Hemmings
Sen. Bob Hogue

EXECUTIVE SUMMARY

The Task Force spent nearly 80 hours collecting information and listening to over 400 persons. In addition, members of the Task Force attended community and town hall meetings sponsored by groups organized to find solutions to the ice problems within their communities. In conclusion, the Task Force finds:

THE SOLUTION TO THE ICE EPIDEMIC IS TO PREVENT THE FUTURE GENERATION FROM SUBSTANCE ABUSE AND CURE THE PRESENT GENERATION OF ICE ABUSERS.

Accordingly, the Task Force recommends a comprehensive funding and legislative package consistent with its overall conclusion. The most important findings and recommendations are:

- Ice usage has reached epidemic proportions. The ice epidemic is a public health crisis that must be cured.

- Safety of Hawai`i's residents is the most important objective. This means that the ice epidemic must be cured by treating the addicted and protecting against the spread of the disease of drug addiction. Enhanced criminal penalties are required to protect the public and send a strong message to drug traffickers who profit from the spread of the ice epidemic.

- Early intervention and treatment of adolescents is the highest funding priority. School based treatment programs should be expanded to the middle school level and efforts should be made to identify and treat adolescents who drop out of school. Treatment of adolescents will prevent the present epidemic from spreading into its third wave. Recommended funding: $4.5 million.

- Substance abuse prevention is the second funding priority, focusing on youth programs within and outside of the schools and families with children. Preventing the spread of substance abuse is a sound investment in the future. Recommended funding: $3.6 million.

- Coordination of community, government and law enforcement efforts to fight the ice epidemic is needed. The Task Force recommends that this coordination function be assigned to the Office of Community Services. Recommended funding: $200,000 per year for five years.

- Substance abuse treatment for adults is the third funding priority to close the gap between those who need publicly funded treatment and current resources available. The Task Force finds that treatment is effective to combat ice addiction. Curing the present generation of ice addicts will reduce future costs for public services in health care, welfare, child care and child welfare services. The Task Force recommends that women of childbearing age, pregnant women, parents of young children in the home and Hawai`ians receive priority for treatment. Recommended funding: $10.7 million.

- Protection of the family is an important objective. In addition to its recommendation for funding for treatment and counseling services for the family (under adult treatment), the Task Force recommends legislation to (1) amend the civil commitment statutes to provide an expedited civil process for involuntary commitment to outpatient substance abuse treatment and (2) establish a task force to develop a drug endangered child protection program.

- Treatment for the first time, nonviolent drug offender as an alternative to incarceration is an

important objective, provided the offender does not pose a public safety risk or has a lengthy criminal history and can benefit from treatment. The Task Force recommends amending existing laws to permit court discretion in granting probation and the terms and conditions of probation, with referral to Drug Court for those who can benefit from supervision by Drug Court in order to maximize successful outcome in treatment. Avoiding incarceration for nonviolent offenders whose addiction drives their criminal activities can save millions of dollars. Recommended funding: $850,000.

- Expansion of Drug Court for the adult and juvenile drug offender and for families. The Task Force finds that Drug Court is an effective method of intervention and a good use of resources in lieu of incarceration. Recommended funding: $1.2 million.

- Partnerships with the business community are necessary to fight the ice epidemic. Since about 20 percent of the known admissions for substance abuse treatment are employed, employers are big stakeholders to ensure that the disease does not spread throughout the workplace. The Task Force recommends that employers offer mandatory drug education and awareness training for their employees and receive a tax credit for doing so. The Task Force also recommends that employers, in limited circumstances, be required to continue health insurance for employees who are terminated due to their addiction.

- Hawai`i's sensitive environment must be protected from the toxic chemicals produced by the manufacture or conversion of methamphetamine. The Task Force recommends that a study be conducted on the environmental effects of methamphetamine laboratories. Recommended funding: $300,000.

A complete summary of the Task Force's findings and recommendations is included in this report.[1] The recommended funding totals nearly $21.6 million. A detailed analysis of the facts and information considered by the Task Force in support of its findings and conclusions follows the summary. The report includes appendices that summarize the testimonies of speakers, the community recommendations and a list of recommendations from individual Task Force members.

The Task Force commends all the persons in recovery, community members, community organizations, treatment providers, law enforcement officers, state, local and federal government administrators and employees for their commitment to finding a solution to the ice epidemic. Mahalo to everyone who took time out of their busy schedules to talk to the Task Force and share their ideas and information.

[1] Each of the findings and recommendations in this report reflect the views of at least half of the Task Force members. Whenever the term "Task Force" is used, it may or may not indicate a consensus of all the Task Force members.

SUMMARY OF FINDINGS BY SUBJECT

FINDINGS RELATING TO THE ICE EPIDEMIC

- The ice epidemic is a serious public health crisis that must be immediately abated to protect Hawai`i's future generations and its resources.

- An epidemic is that which affects a disproportionately large number of individuals within a population, community or region. (Webster's) An epidemic is a pervasive condition affecting the well being of the population and reoccurs. (Wood)

- An ice epidemic exists in Hawai`i, which probably began in 1997. (Wolkoff, "Methamphetamine Abuse: An Overview for Health Care Professionals," Hawai`i Medical Journal, Vol. 56, February 1997) The use and abuse of this powerful drug has permeated all facets of our community, workplace, prisons and law enforcement activities. The data below overwhelmingly suggests a problem that is growing, and if left unchecked, it will consume government resources and further destroy lives and families.

- Ice usage and drug interdiction efforts related to ice manufacture and distribution were first reported in the 1980's and have continued to the present.

- Hawai`i has been experiencing a second wave of the disease in the last few years, as the longer term effects of the early onset of the disease now manifests itself in the addicted population. (Wood) For example, based on testimony from treatment agencies and in discussions with persons in treatment, most recovering addicts report long-term use of ice, five to ten years or longer. Trends in State adult arrests for drug possession for the past ten years reflect this second wave. Arrests for possession of ice (reported as a "nonnarcotic" drug) peaked in 1997, then declined for two years. Starting in 2000 arrests for ice possession began to dramatically increase. In 2002, ice possession arrests had nearly tripled since 1999 and more than doubled over the peak in 1997. (Office of the Attorney General of the State of Hawai`i, Crime in Hawai`i 2002, p. 110) Similarly, although less dramatic, the drug offenses of manufacture/sale of ice over the past ten years reflect the same peak in 1997 followed by a one year decline, then a steady increase since 1999 to its highest level in 2002. (Id.)

- Between 1998 and 2002, admissions into treatment for ice increased by approximately 80 percent (DOH/ADAD). In 2002, ice was the number one substance abused for which treatment was sought. (DOH/ADAD) Nearly every adult in recovery who spoke to the Task Force reported ice as the primary drug of choice. Every agency testifying before this Task Force that provided adult drug treatment services reported ice as the primary drug of choice among its treatment population.

- O`ahu deaths associated with ice usage rose from 11 in 1991, to 27 in 1998 to 62 in 2002. (Wood) Similarly, on the neighbor islands, deaths associated with methamphetamine usage rose from 1 in 1998 to 20 in 2002. (Wong)

- Among adult men arrested who tested positive for drug use, 37.4 percent tested positive for ice in 2001. Hawai`i's ice usage among the male arrested population is the highest in the nation. Among adult women arrested who tested positive for drug

use, 36.1 percent tested positive for ice in 2001. Hawai`i's ice usage among female arrestees is among the highest across the nation. (ADAM, NDCS Report February 2003)

- Comparison of Hawai`i federal drug cases with the national percentage of drug cases indicates 51 percent of Hawai`i's cases involved ice, in comparison with 14.2 percent ice-related cases across the nation. (HIDTA 2004 Report)

- In the period November 2002 to May 2003, among Hawai`i's prison population, out of 7,456 drug tests, approximately 5 percent tested positive. Of those positive tests, 69 percent tested positive for ice. (Peyton)

- Ice and drug paraphernalia are readily available, as reported by users and those in recovery. (National Drug Threat Assessment January 2003)

- While marijuana is the drug of choice in Hawai`i's workplace, the use of methamphetamine in Hawai`i has increased by 25 percent (Diagnostic Laboratory Services) and 67 percent (Clinical Labs of Hawai`i) over the past five years, as indicated by Hawai`i's largest drug testing laboratories. Hawai`i's methamphetamine use in the workplace is 4 to 5 times higher than the national average. (Linden) This is significant because nationally, while drug use in the workplace has declined, methamphetamine use increased by 70 percent in the past five years. (Quest Diagnostics Drug Testing Index 2003)

FINDINGS RELATING TO THE EFFECTS OF ICE ON THE USER

- Ice is a bad drug. Ice cannot be used recreationally without detrimental effects on the body and psyche.

- Ice addiction drives a compulsive need to seek out and take the drug, to the exclusion of awareness of other bodily needs and life responsibilities.

- Ice addiction is a chronic disease, with frequent relapses.

FINDINGS RELATING TO THE EFFECTS OF ICE USAGE ON FAMILIES AND CHILDREN

Fetal Exposure to Ice

- Drug use by a pregnant woman may pose dangers to the fetus. However, tobacco and alcohol use by a pregnant woman is far more dangerous to the fetus than ice. No laws exist that impose criminal sanctions on the woman for fetal exposure due to alcohol or tobacco use. Therefore, the Task Force makes no recommendations about laws to protect the unborn fetus from ice use.

- The Task Force strongly supports education and awareness programs directed toward women of childbearing age regarding the effects of ice. As discussed in more detail under Section G. Adult Treatment, the Legislature has provided funding for treatment programs directed toward pregnant women and supports continued funding. As discussed in more detail under Section E. Prevention, the Task Force recommends funding priority for programs directed to women of childbearing age.

Civil Commitment Process

- Families should not have to resort to filing criminal charges against a family member who is abusing ice simply to

force a “wake up call” on the user. A civil commitment process that allows the family to expeditiously commit a family member to involuntary drug treatment is needed. This avoids stigmatizing a person as a criminal because of his or her addiction to illicit drugs.

Protecting Children Exposed to Ice in the Home

- The effects of ice abuse in the home that affects children cost Hawai`i's taxpayers between $75 to $84 million dollars annually.

- No apparent coordinated plan exists between various governmental departments, such as the Department of Health, Department of Human Services, law enforcement, prosecutor’s offices, Judiciary and community agencies to respond to the effects on the child due to ice usage in the home. A multidisciplinary approach to problem solving must be enacted.

Family Counseling and Support Services

- Family counseling and support services should be part of the continuum of care needed to heal the drug addict and the families affected by the addiction. This appears to be a service gap.

FINDINGS RELATING TO SUBSTANCE ABUSE TREATMENT SERVICES FOR ADOLESCENTS

- Hawai`i’s youth must receive substance abuse treatment. Early intervention is the key to divert young adults away from drug use. The treatment gap of adolescents who need treatment and do not receive it is over 5,000, based on both state and federal estimates.

- Marijuana and alcohol use poses the greatest threat of substance abuse for Hawai`i's adolescents who are in school. However, ice and ecstasy use levels remain problematic. Ice usage is the drug of choice for those adolescents who have entered the juvenile justice system.

- School based treatment programs appear to be successful in returning students to a drug free lifestyle. Family and Juvenile Drug Court programs also report success rates.

- Current levels of funding for adolescent treatment are woefully inadequate to protect our investment in Hawai`i’s youth.

- The Task Force is concerned about the adolescents who drop out of school and have no access to school based treatment programs. Except for the Courts and juvenile justice system or privately paid treatment, these youths have no where to turn to for help with drug addiction.

FINDINGS RELATING TO SUBSTANCE ABUSE PREVENTION

- Substance abuse prevention is a high priority for the State of Hawai`i. The State has relied on federal funding to support prevention programs in the past. While such efforts have paid off in terms of the decline in use of hard drugs among Hawai`i's youths, the State must be vigilant in prevention efforts.

- The State's limited financial resources are better-spent on treatment and prevention programs for adolescents than on mandatory drug testing.

FINDINGS RELATING TO DRUG INTERDICTION

- Safety of the people of Hawai`i is the most important objective in the fight against ice. Criminals who manufacture, distribute and push illicit drugs to victimize others must be punished. Accordingly, the Task Force recommends changes in the laws as detailed below under "Recommendations for Legislation."

- The majority of the Task Force does not recommend a constitutional amendment to permit "walk and talk" at this time. Changes in the law to permit "walk and talk" approaches by law enforcement officers would require an amendment to the Hawai`i Constitution regarding the privacy protections afforded to the citizens of the State. Constitutional privacy protections were enhanced by the 1978 Constitutional Convention, not to protect the criminals but rather to protect the citizens from unreasonable intrusions by government. Federal agents and State and local law enforcement officials deputized as federal agents, already possess the ability to conduct "walk and talk" approaches as part of the drug interdiction efforts. Major drug interdiction efforts are primarily in the hands of federal law enforcement officers because of the federal law violations resulting from transportation of drugs through federal venues, such as mail, freight and interstate commerce. Moreover, the intrusion of innocent persons that may result from curtailing the privacy protections may lead to more erosion into the private lives of Hawai`i's citizens.

- The Task Force is concerned about properly balancing the interests of its citizens to be protected against unreasonable government intrusions with the needs of law enforcement to ensure that drug traffickers are caught and punished. Wiretaps are considered to be the most intrusive of all investigation tools used by law enforcement because the number of communications intercepted regarding private matters are substantially disproportionate to the communications that tend to reveal criminal activities. Prior to issuing this report, the Task Force asked local and federal prosecutors for additional information, which was not provided. The Task Force is willing to consider changes to the wiretap laws. However, further information is required about examples of where law enforcement has lost prosecution opportunities, both in federal "down line" cases and other criminal activities under state or local investigation.

- The use of canine drug interdiction appears to be helpful in detecting drugs in freight and possibly other areas, although odor transference is a problem in accurately detecting drugs on humans and in mail. The cost for canine drug interdiction appears to be modest in relationship to the benefit provided.

- Drug interdiction efforts by the law enforcement community will not solve the ice epidemic in Hawai`i. Such efforts are properly directed to organized criminal activities in drug trafficking and money laundering, not the small time abusers who sell small quantities of drugs and steal to support their addiction.

- While drug interdiction is an important weapon in the war against drugs and necessary to deter drug traffickers from importing ice into Hawai`i, the ice epidemic is a public health crisis and must be fought on that basis.

FINDINGS RELATING TO ADULT SUBSTANCE ABUSE TREATMENT SERVICES

Treatment Gap

- A significant treatment gap exists. The Federal government estimates nearly 17,000 persons need treatment for illicit drug use. State estimates based on the 1998 "Substance Abuse in Hawai`i Adult Population Household Telephone Survey," (1998 Survey) indicate 7,000 adults need treatment for drug use, and over 82,000 need treatment for all substances abused.

- A treatment gap exists for ice addicts. Based on the 1998 Survey over 6,000 ice users require treatment. In 2002, 2,730 were admitted to treatment. Since the ice epidemic began in 1997 in Hawai`i, it is likely that the number of ice abusers requiring treatment has increased. Less certain, however, is whether ice abusers have sufficient awareness of their addiction to seek treatment in the absence of legal sanctions or family pressure.

- 3,162 adults need publicly funded substance abuse treatment services and are not receiving such services. It is not clear whether the adult need includes the 1,500 pregnant and parenting women, but the Task Force assumes it does since the adult treatment need is based on the 1998 Survey that included the needs assessment of pregnant and parenting women.

- Even though the Task Force's mission is to specifically address the ice problem, we note that alcohol addiction continues to pose a serious problem in Hawai`i and few efforts have been made to address this problem.

- A needs assessment and new survey should be funded to determine the characteristics of the population in need of treatment and whether any specific segment of the population is substantially under served.

Treatment Services

- Publicly funded treatment programs cover all the levels of severity of addiction and offer the continuum of care necessary for recovery. In general, Hawai`i's breadth of services to treat drug addiction is adequate and appropriate. The Task Force declines to second-guess treatment providers as to whether one type of service should be preferred over another, such as residential over outpatient services. Instead, treatment plans should be tailored to meet the individual's needs.

- Current information is necessary to determine whether gaps exist in services to specific subgroups. A new needs assessment should be conducted and funding for programs should be based on the areas of greatest need. The new assessment should cover the treatment service needs for the neighbor islands, the dual diagnosed population and other subgroups as appropriate. In the absence of current information regarding the needs on the neighbor islands and of the dual diagnosed population, the Task Force cannot determine whether these groups are substantially under served.

- Recovering addicts need clean and sober housing or therapeutic living homes in order to sustain recovery. The need for housing-related programs stems from the concern that the ice addict in recovery needs to be physically removed from the environment that led to the addiction, placed in a structured environment where behaviors can be challenged and abstinence is rewarded. While

O`ahu has numerous clean and sober homes, the same is not true for the neighbor islands. Clean and sober homes are independently operated, with little financial support from public resources. Residents of the homes pay rent and provide for their own needs. However, communities raise barriers to clean and sober homes operating in residential areas, such as zoning, concern about the conduct of the residents and increase in criminal activity. The Task Force finds that efforts should be made to facilitate the ability of organizations to establish clean and sober homes.

Funding for Adult Substance Abuse Treatment

- Based on the treatment gap of 3,162, including pregnant and parenting women, additional funding of $10,750,800 is needed to close the gap. This estimate is based on a cost of $3,400 per admission.

- Approximately 8,000 admissions to adult treatment are served annually in the non-offender population for drug and alcohol substance abuses from all payment sources. This accounts for less than 1 percent of Hawai`i's adult population.

- The cost of treatment will result in institutional savings in other areas and is money well spent. For example, the savings are illustrated in the table below

Adult Treatment	Incarceration	Child Welfare
3,162 additional admissions at $3,400 per admission	If 50 percent of those who need treatment are diverted into treatment who might otherwise enter criminal justice system: 1,581 persons at $30,000 per person	Approximately 1,500 parenting women treated who might otherwise lose their children: 1,500 women at $14,740 per child removed from home
TOTAL COST: $10.7 million	SAVINGS: $47 million	SAVINGS: $22 million

FINDINGS RELATING TO TREATMENT SERVICES FOR ADULT OFFENDERS

- Act 161 was intended to remove a nonviolent first time offender from the prison system and provide treatment for the addiction that motivated the criminal conduct. This is a laudable objective that should be retained.

- Treatment through Drug Court programs is more cost effective than incarceration. Graduates of Drug Court treatment programs have low rates of recidivism. While the number of offenders terminated from Drug Court is high, the program successfully graduates more than 50 percent of its admissions. The Task Force is impressed with the judges, and their dedication, who supervise these Drug Court programs. Drug Court should be expanded as a diversionary program and challenged to take on the most difficult cases.

- Diversion to treatment will result in cost savings for incarceration. For example, 39 offenders who are on probation and in treatment could result in savings of $400,000 if incarceration is avoided for six months.

- While the Family and Juvenile Drug Courts are in their early stages in the First Circuit and in the developmental stages in other Circuits, the success of the criminal offender Drug Courts may be reliable indicators of the success of

these new programs. These programs should be supported.

- The Task Force supports treatment for the offender population because it will reduce costs for incarceration over the long run and provide positive social value for the community if the offender is able to become a contributing member of the community. For example, the $2.2 million allotment for Integrated Case Management is expected to serve 241 offenders. The cost saving to avoid incarceration for one year is $5 million. However, the Task Force will await additional reports and information regarding the implementation of the Integrated Case Management Plan before considering further funding.

FINDINGS RELATING TO COORDINATION OF EFFORTS TO FIGHT THE ICE EPIDEMIC

- Law enforcement efforts directed at drug interdiction are being coordinated through HIDTA and this appears to be operating efficiently.

- The Office of Community Services is appropriate to coordinate the State, local and community efforts to fight the ice epidemic. The State Department of Health Alcohol and Drug Abuse Division will maintain jurisdiction over distribution of state and federal funds for treatment and prevention programs since it has the expertise to do so.

FINDINGS RELATING TO PARITY FOR SUBSTANCE ABUSE TREATMENT

- The lifetime cap should be removed because only a small number of members reach it for substance abuse treatment under private insurance. However, those who reach the lifetime cap are likely to need services the most. The same lifetime cap does not apply to mental illness, creating a disparity between mental illness and substance abuse treatment.

- At a minimum, serious substance abuse should be afforded parity with serious mental illness. Ideally, full parity should be afforded to substance abuse since the Legislature has already concluded that substance abuse is an illness.

- For the privately insured population, low utilization of substance abuse treatment services suggests that costs for parity will be insubstantial. Low utilization in private plans is due primarily to job loss resulting in the loss of insurance coverage, but also due to stigmas associated with illegal drug use. Thus, for private plans, parity is not expected to increase the utilization resulting in substantial cost increases for private employers.

- For the Quest plans, utilization is higher than that of private plans, but is still low, relative to the Quest population. Costs for substance abuse treatment is also low relative to the total costs of benefits provided. Hence, parity is not expected to cause a significant increase in this state-funded program.

- The Task Force makes no findings on the effect of managed care on determinations of medically necessary treatment insofar as this issue is outside the scope of the Task Force's mission.

FINDINGS RELATING TO WORKPLACE DRUG USE

- Employers are required to provide a safe workplace and need to operate under conditions to maximize business objectives. Employee drug use in the workplace undermines business objectives and should not be tolerated.

- The Task Force is concerned that employers who simply eliminate the problem employee from the workplace ultimately shift the problem to the taxpayers to bear the societal consequences of an unemployed drug user, such as increased criminal activity, burden on public resources for welfare, health care and treatment and impact on the family. The Task Force finds that employers must partner with government and the community in solving the ice epidemic.

- While employers have policies to deal with punishment for drug use by employees, and some even have policies that encourage employees to seek treatment, few employers have prevention or early intervention programs. The Task Force has previously found that prevention and early intervention programs are the key to abating the ice epidemic.

- Hawai`i's limited job market requires special attention to ensure that Hawai`i's residents are fully employed while still meeting the staffing needs of Hawai`i's businesses. A growing unemployed population who are victims of the ice epidemic does not serve the public interest.

FINDINGS RELATING TO ENVIRONMENTAL EFFECTS OF METHAMPHETAMINE

- Toxic materials that are the byproducts of the manufacture or conversion of methamphetamine pose a danger and risk of harm to the public and environment. The site of the clandestine laboratory itself may pose a danger to the environment and public.

- Little information is available about the impact of toxic materials produced by the clandestine laboratories in Hawai`i.

- No apparent action plan exists for systematic handling of hazardous materials found at laboratory sites, including the site itself. While there appears to be a process for disposal of the materials located at the site, there does not appear to be a process to determine whether the site itself poses an environmental hazard.

- Hawai`i's sensitive aquifer system is particularly at risk due to toxic chemicals that leach into the groundwater.

SUMMARY OF RECOMMENDATIONS FOR LEGISLATION, FUNDING AND POLICIES BY SUBJECT

RECOMMENDATIONS FOR LEGISLATION

Enhanced Criminal Penalties to Protect the Public

- The Task Force recommends changes in the law to provide enhanced criminal penalties for harm caused to children exposed to ice in the home, dangers caused by methamphetamine labs (meth labs), operating meth labs near schools and public parks where people are likely to be injured if the lab explodes and distributing drugs to pregnant women. The Task Force also recommends enhanced criminal fines and penalties for drug traffickers and amending the drug paraphernalia laws.

Substance Abuse Treatment for First Time Offenders

- The Task Force recommends that Act 161 be amended to clear up the ambiguities in statutory language relating to repeat offenders, criteria for eligibility for drug treatment as diversion from incarceration and to permit more discretion by the court in sentencing, including setting the terms of probation. To the extent that Track 3 first time offenders eligible under Section 706-622.5, HRS, can be appropriately diverted to Drug Court programs, Drug Court should be the first option for the most difficult cases who need more supervision to maximize success in drug treatment. Since Drug Court appears to have both the ability and experience to handle difficult cases, this should be the first recourse.

Child Protection

- The Task Force recommends that a multiagency task force be convened to prepare a drug endangered child protection program to be submitted to the Legislature 20 days before the commencement of the 2005 Legislative Session.

Civil Commitment

- The Task Force recommends that Section 334-121 et seq., HRS, be revised to permit family members to expeditiously seek civil court intervention when private sources to pay for treatment are available. This would relieve the criminal justice system of drug abusers who would not otherwise become involved in the system but for the illegal drug use.

Student Discipline for Drug Offenses

- The Task Force recommends that the zero tolerance policy (§302A-1134.6, HRS) be amended to require referral to treatment before student disciplinary action is taken.

Insurance Parity for Substance Abuse Treatment

- The Task Force recommends that the Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits, Section 431M et seq., HRS, be amended to remove the benefit restrictions and lifetime cap on the number of treatment episodes for substance abuse treatment. This will eliminate the current disparity between substance abuse treatment benefits and mental illness treatment benefits created when the Legislature passed Act 197, SLH 2003.

Workplace

- The Task Force recommends that employers with more than 15 employees be required to provide three hours of mandatory drug

education and awareness each year to its employees.

- The Task Force recommends a tax credit of $250 for employers who institute drug prevention and education programs for their employees.

- The Task Force recommends a tax credit for employers who partner with community based treatment organizations to provide jobs for those in recovery who maintain a clean and sober lifestyle.

- The Task Force recommends that private sector employers be required to maintain health insurance benefits for three months that provide substance abuse treatment for an employee who is terminated for impairment of performance due to substance abuse or working under the influence of drugs, provided that the employee is otherwise eligible for health insurance benefits under the employer's policies. Excluded from this requirement are employees who are terminated for sale, distribution or manufacture of illegal drugs at the workplace, who are terminated due to the inability to work because of arrest or conviction for criminal activity relating to the sale, distribution or manufacture of illegal drugs or who are terminated for theft, violence or safety reasons, even if such actions are related to the drug use. This requirement would apply to employers with workforces of 25 or more employees. Employees eligible for continued benefits would have to be employed for more than one year or have completed the probationary period. Excluded from this requirement are employees who are subject to federally mandated drug testing programs and those who hold management, safety-sensitive or trust positions.

RECOMMENDATIONS FOR FUNDING PRIORITIES

Adolescent Substance Abuse Treatment

- The Task Force recommends allocation of $4.5 million in new money to fund school based treatment programs commencing at the middle schools.

Substance Abuse Prevention

- The Task Force recommends that $3 be spent on every resident of Hawai`i in new State funding for substance abuse prevention. This amounts to $3.6 million. Every effort should be made to obtain federal funding using State matching funds if necessary. The programs to be funded should be consistent with the policy guidelines adopted by the Legislature (see policy recommendations below). The Task Force supports school based prevention programs but does not recommend separate funding for school based prevention programs at this time. The Task Force will await more information from the Department of Education about its use of existing federal funding and its recommendations.

- The Task Force recommends stable funding for prevention programs, with an earmarked revenue stream in order to ensure long-term funding. Possible revenue streams may include a special tax, a portion of taxes levied on certain consumer items such as alcohol or tobacco or estate taxes. Alternatively, some of the cost savings from government services that are expected to decline due to the effectiveness of treatment and prevention efforts may be dedicated to prevention programs.

Adult Substance Abuse Treatment

- The Task Force recommends allocation of $10.7 million for adult treatment services in new state money. The Task Force recommends that women of childbearing age, pregnant women, parents of young children in the home and Hawai`ians receive priority for treatment.

- The Task Force recommends $150,000 be appropriated to conduct a new needs assessment for adult substance abuse treatment services.

Women of Child-bearing Age, Parents with Children

- The Task Force recommends increased funding for prevention programs directed toward at-risk women of child-bearing ages, increased funding for treatment programs for pregnant women, women with young children and that parents with children in the home who are not involved in the criminal justice system receive a higher priority for public funded treatment programs. The Task Force requests that Departments of Human Services and Health explore the use of TANF funds and other federal funds for these purposes.

Drug Interdiction

- The Task Force recommends expansion of the canine drug interdiction program and recommends additional funding of $75,000 for the Sheriff's Department.

Substance Abuse Treatment for First Time Offenders

- The Task Force recommends that treatment services for offenders eligible under Act 161 should be funded. Using the Drug Court costs for treatment and case management as a benchmark, even if treatment costs were $8,000, this is far less costly than incarceration of $30,000 per offender per year. To the extent that offenders pose no public safety risk and can benefit from drug treatment, every effort should be made to divert such offenders into treatment rather than incarceration. The Task Force recommends allocation of $850,000 based on 250 offenders at a cost of $3,400 per offender.

Drug Courts

- The Task Force recommends that $1.2 million be allocated to the various Drug Courts to expand their programs, including Family and Juvenile Drug Courts and Track 3 offenders eligible for treatment diversion under Act 161. This treatment diversion could result in savings of over $1 million if incarceration is avoided for six months.

Environment

- The Task Force recommends that $300,000 be allocated to the State Department of Health to conduct a study and analysis of the effects of methamphetamine clandestine laboratories on our environment, particularly the ground water, the disposal of toxic waste materials found at the site, the disposal of the site and provide recommendations for action.

Community Mobilization

- The Task Force strongly supports modest funding for grassroots community efforts to sustain their work. Since police and communities need to work together to identify and dismantle drug houses, use of up to 25 percent of federal forfeiture funds for community mobilization efforts, to be distributed by local government, is appropriate.

Family Counseling and Support Services

- The Task Force recommends modest funds for family counseling and support services to be allocated from either adult treatment or prevention funding sources, but requires that evaluation criteria be established to determine the successful outcomes of the programs.

Coordination by Office of Community Services

- The Task Force recommends allocation of funding to the Office of Community Services to perform the coordination role of $200,000 per year for five years.

Sources of Funding

- The Task Force recommends that all possible sources of funding be explored, including the following: TANF, other federal, partnership with the Office of Hawai`ian Affairs to serve the Native Hawai`ian population that is disproportionately affected by ice addiction, Rainy Day Fund, increase in alcohol tax, increase in General Excise Tax either statewide or permit the Counties to levy and fund their own programs, state estate tax and forfeitures. The federal government announced a voucher program for treatment. The effect of the voucher program on the funding for treatment should be analyzed. An alternative source of funding is the savings resulting from reductions in government services as a result of diminished needs as the addicted population is cured or reduced.

RECOMMENDATIONS FOR POLICIES OR ADMINISTRATIVE ACTION

Establish Goals and Criteria to Measure Success of Treatment and Prevention Programs

- The Task Force recommends that State administrative agencies responsible for purchase of services contracts establish baseline evaluation criteria for adult and adolescent treatment and prevention programs. Although some community agencies appear to set their own goals, there should be some objective measurement to determine the significance of the “successful outcomes” data collected. State agencies should also require contractors to compile data, implement standards for evaluation and performance goals. If a contractor fails to provide reports or data to the administrative agencies, the contract should be terminated or not renewed.

- As to ongoing funding for offender treatment programs, the Task Force strongly recommends that supervising agencies develop objective criteria for measurement of a treatment program's effectiveness. Such data should be required for inclusion with budget requests to the Legislature.

- The Task Force recommends that the Office of Youth Services establish reporting and evaluation criteria for the treatment programs offered in the juvenile justice system.

- As a condition of funding from the Legislature, state agencies should be required to compile data, establish evaluation criteria and performance goals. State agencies should be required to report to the Legislature on a periodic basis, at least prior to the commencement of the biennial legislature, the population served, the goals and objectives of the programs,

the evaluation criteria used to assess whether the goals and objectives were met and recommendations.

- The Legislature should consider adopting performance goals to guide future funding decisions. Shifting funding priorities to substance abuse treatment and prevention programs should result in savings in other government service areas in three years. If the Legislature adopted performance goals for those areas that are likely to be affected by reductions in the needs for public services, then state agencies would be able to plan for reductions. In expectation of reduced funding in certain areas, a plan for personnel reduction, redirection and retraining could be developed based on future growth areas in government services.

Alternative Schools and Youth Drop Out Centers

- The Task Force recommends that the Department of Education explore the feasibility of establishing alternative schools or drop out centers for adolescents who suffer from drug addiction. The Department of Education shall report to the Legislature its recommendations and cost analysis no later than 20 days before the commencement of the 2005 Legislative Session.

Policy Guidelines on Funding Substance Abuse Prevention Programs

- The Task Force recommends that the following policies guide funding for substance abuse prevention programs:
  - ❖ Drug education in the schools, school partnerships with community and parents;
  - ❖ Youth activities in the communities;
  - ❖ Families and parenting women; and
  - ❖ Community mobilization.

Substance Abuse Training for Credentialed School Employees

- The Task Force recommends that the Department of Education require all credentialed school personnel to undergo training in identifying risk factors and symptoms of substance abuse, and such training be completed within two years for current employees. All new credentialed school employees should receive training within their first year of employment.

Consider Actions to Encourage Development of Clean and Sober Homes

- The Task Force recommends the following actions to encourage the development of clean and sober homes or therapeutic living centers: (1) Urge county governments to amend zoning ordinances to permit up to 10 unrelated persons to reside in a household. This will increase the capacities of clean and sober homes. (2) Consider tax credit or tax deduction for landlords who enter into long-term leases with community organizations that provide housing related services for recovering substance abusers. (3) Enhance existing loan program to provide start-up costs for housing-related programs for recovering substance abusers. (4) Explore incentive programs for private, nonprofit, or for profit organizations to develop housing facilities. (5) Explore conversion or expansion of existing facilities and surplus properties.

Reallocation of Resources for Office of Community Services

- The Task Force encourages the Governor to review the Office of Community Services functions to determine whether additional resources may be allocated within the existing budget for the purpose of coordinating the fight against ice.

(This page intentionally left blank)

SUMMARY OF ACTIVITIES

The first phase of the Task Force's activities was to gather information by listening to the community. The Task Force wanted to know: Is there an ice epidemic? And if so, what is causing the epidemic, who is being affected, how are communities affected, what is currently being done to deal with the epidemic and what needs to be done to cure the disease. The Task Force collected information through the following activities:

(1) Informational briefings. The Task Force invited representatives from government, law enforcement, education, nonprofit community organizations, the private sector and the community to present factual information about the illegal trafficking of ice, its use and the effects ice usage has on the community and to solicit ideas and recommendations for possible legislation. **Seven (7) informational briefings were held on O`ahu, approximately 29 hours of testimony from 70 speakers.**

(2) Public hearings. The Task Force held public hearings on all islands to learn about the activities in the communities, identify community needs, listen to personal experiences of families affected by ice addiction and hear the views from members of the public. **Four (4) public hearings or community meetings were held on neighbor islands, approximately 18 hours of testimony from over 103 speakers. Three (3) public hearings were held on O`ahu, approximately 8 hours of testimony from over 25 speakers.**

(3) Site visits. The Task Force visited facilities or agencies that are involved in the treatment and/or prevention of drug addiction to find out first hand the experiences of participants in treatment or in recovery. This allowed direct, candid communication in a sheltered, private environment. At the same time, the Task Force observed the treatment programs and facilities available. **Fourteen (14) site visits to community agencies or organizations with residential, therapeutic and outpatient drug treatment programs on five islands, over 24 hours of discussion with more than 170 persons in recovery and staff who work in recovery.**

(4) Extensive written materials were submitted by speakers, stacking 40 inches high. Supplemental materials were submitted by government agencies and community based treatment providers in response to follow up requests from the Task Force. Substantive research was conducted into the subject areas addressed in this report.

In addition to these information-gathering activities, members of the Task Force attended community and town hall meetings.

The second phase is the preparation of this report for the Legislature and public distribution. This report includes lengthy analysis regarding the ice epidemic, factual findings and recommendations.

The final action by the Task Force is to present legislation consistent with its recommendations.

(This page intentionally left blank)

FACTUAL FINDINGS

INTRODUCTION

The Task Force went out into the communities and listened to the people. Many people shared their experiences and offered hundreds of ideas for us to consider. We collected technical, anecdotal and statistical information from everyone who offered facts or recommendations. At the end of the information gathering process, we came away from these experiences convinced that the ice epidemic can be stopped.

Ice is a scourge in our communities that must be treated as any infectious disease. Ice is a public health crisis that must be fought by identifying the sources of the infection, preventing the spread of the disease and treating those who are sick. At all times, the safety of the people of Hawai`i must be protected. Those who reap profit from the spread of the ice epidemic and the misfortune of the afflicted must be punished.

The people of Hawai`i are prepared to invest in the solution to the ice epidemic. They ask the Legislature for leadership in the fight against ice. The Task Force is prepared to recommend a comprehensive legislative and funding package to the Legislature as the first step toward a solution. The fight against ice will not be won by legislative action alone. Parents, community members, all branches of government, law enforcement, treatment providers and the business community must all work together against this disease. Together, the ice epidemic can be stopped.

The Task Force, having collected nearly 80 hours of testimony from hundreds of concerned citizens and written materials that stack 40 inches high, presents its findings and recommendations to the Twenty-second State Legislature. The overall conclusion of the Task Force is:

THE SOLUTION TO THE ICE EPIDEMIC IS TO PREVENT THE FUTURE GENERATION FROM SUBSTANCE ABUSE AND CURE THE PRESENT GENERATION OF ICE ABUSERS.

(This page intentionally left blank)

A. HAWAI`I'S ICE EPIDEMIC BEGAN IN 1997

ISSUE: The first step of the Task Force was to determine whether a problem exists. When the Task Force began its hearings in June 2003, the groundswell of community and media attention was just gaining momentum. The Task Force sought information to determine whether an ice epidemic exists and if so, the scope of the use and abuse of ice in Hawai`i.

BACKGROUND INFORMATION

Eleven years ago, in March 1992, representatives from government, higher education, community agencies and community members, met for two days to discuss "The Culture of Addiction." This conference was heralded as a historic event for Hawai`i because it brought together, for the first time, a diverse group of professionals and community members from across the State to talk about the use and abuse of alcohol and other substances. Then, the primary concern was alcohol abuse. At this conference, University of Hawai`i Professor D. William Wood reported that of the illicit drugs, marijuana was the most widely used, followed by cocaine. He stated that methamphetamine indicators showed a leveling off but no marked decline. (Report on "The Culture of Addiction," March 5-6, 1992, p. 24)

By 1997, the story of ice usage was different. For the first time, Hawai`i reported methamphetamine use as a major problem to the Office of National Drug Control Policy (ONDCP). "Sources in Hawai`i report the greatest prevalence of methamphetamine use and the widest range in types of users of all the states surveyed… 'ice' [use]…is reported among whites, Asians, males and females, students, blue collar workers and professionals…. 40 percent of prisoners…had used methamphetamine…69 percent of treatment providers…felt that methamphetamine use had increased over the past year and 25 percent felt it was stabilizing. It is the primary drug of abuse at entry for 38 percent of programs interviewed, second only to alcohol (44 percent)…An average of 55 percent of the clients at entry use methamphetamine." Also noted was the relationship between ice usage and violent episodes, the difficulty of treatment due to the need for extended treatment for those who have used the drug for over a year and the practice of not revealing ice usage unless specifically asked. (Office of National Drug Control Policy, Pulse Check National Trends, Summer 1997)[2]

Two years later, Dr. Wood reported on the "emerging epidemic" of crystal methamphetamine, the primary illicit drug of choice, following the legal substances of alcohol and tobacco. Dr. Wood noted that an identifiable methamphetamine culture in Hawai`i has evolved but that law enforcement officials disputed that ice users originated from the same groupings as long-term marijuana users. He noted that the first clandestine conversion laboratory was seized in 1996. Treatment admissions for the first six months of 1999 indicated that 27.5 percent sought treatment for ice, lagging behind alcohol as the primary substance of abuse. Dr. Wood also reported that law enforcement estimated 30,000 ice users. (Wood, "Illicit Drug Use in Honolulu and the State of Hawai`i," , CEWG Journal, Vol. II, December 1999) During his testimony to the Task Force, Dr. Wood admitted that he knew of no hard data to back up this number. (Wood)

In December 1999, the first ever Hawai`i Regional Methamphetamine Conference was convened to discuss the "ice epidemic" in Hawai`i. Dr. Wood and

[2] Subsequent reports to the ONDCP in 1998, 1999, 2000, 2001, 2002 indicate that methamphetamine continued to be the most prevalent illicit abused drug. In 2001, an increase in women users was reported. (ONDCP, Pulse Check National Trends, Winter 1998, 1999, Mid Year 2000, November 2001, April 2002, November 2002)

Thomas Feucht, deputy director of the National Institute of Justice, reportedly stated that increased interdiction efforts would not solve the problem. (Honolulu Advertiser, December 7, 1999)

Since 1999, treatment admissions with ice as the primary illicit drug being abused has nearly doubled. (DOH/ADAD, SAMHSA Substance Abuse Treatment Admissions by Primary Substance of Abuse 1998, 2002) In 2002, adult treatment admissions for ice surpassed alcohol for the first time, as 43 percent of adults sought treatment for ice in comparison to 32 percent for alcohol. (DOH/ADAD)

RESPONSES FROM THE LEGISLATURE TO DATE

The Legislature first responded to the growing concern over ice usage in December 1999. A Town Hall meeting was called by the House Committee on Health and Senate Committee on Health and Human Services to receive testimony from law enforcement, government, providers, scientists and the public about the effects ice. Four years later, a second hearing was convened on January 25, 2003 by House Committees on Health and Judiciary and the Senate Committees on Health and Judiciary and Hawai`ian Affairs, to obtain information about the scope and gravity of ice usage and seek possible solutions to this "epic problem." Both hearings discussed numerous issues ranging from law enforcement, the characteristics of the ice addiction, insurance parity and inadequacy of treatment and prevention. Both efforts resulted in various proposals for legislation.

Over the past few years, the Legislature has passed numerous laws to address ice-related issues. The legislation and financial appropriations include: (1) mandatory minimum sentences for methamphetamine possession and distribution, (2) probation and drug treatment for first time nonviolent drug offenders, (3) nuisance abatement program to close down drug houses, (4) allocation of $2.2 million to provide a continuum of substance abuse treatment for the offender population, (5) penalty and fines for procurement of precursor drugs or any controlled substance through fraud or misrepresentation and (6) continued funding for various substance abuse programs.

ACTIONS BY STATE AND LOCAL GOVERNMENTS

Neighbor islands have mobilized communities to address issues relating to ice usage. The Big Island held its first "Meth Summit" in August 2002, followed by a second "Meth Summit" in August 2003. Kaua`i held five drug summits throughout the island in May 2003. County governments on Hawai`i, Maui and Kaua`i established specific administrative coordinators to implement a comprehensive strategy to solving the ice problem in their respective counties.

In 2003, on O`ahu, communities in Kahaluu, Kailua, Waimanalo, Palolo, Nuuanu, Waipahu, North Shore, Ewa, Wai`anae, Makiki, Mililani and others met to share information and come up with solutions to deal with ice-related issues.

In September 2003, the Lieutenant Governor convened a Hawai`i Drug Control Strategy Summit to address the issues of underage drinking and substance abuse. That Summit resulted in an action plan.

FINDINGS

- The ice epidemic is a serious public health crisis that must be immediately abated to protect Hawai`i's future generations and its resources.

- An epidemic is that which affects a disproportionately large number of individuals within a population, community or region. (Webster's) An epidemic is a pervasive condition affecting the well being of the population and reoccurs. (Wood)

- An ice epidemic exists in Hawai`i, which probably began in 1997. (Wolkoff, "Methamphetamine Abuse: An Overview for Health Care Professionals," Hawai`i Medical Journal, Vol. 56, February 1997) The use and abuse of this powerful drug has permeated all facets of our community, workplace, prisons and law enforcement activities. The data below overwhelmingly suggests a problem that is growing, and if left unchecked, will consume government resources and further destroy lives and families.

- Ice usage and drug interdiction efforts related to ice manufacture and distribution were first reported in the 1980's and have continued to the present.

- Hawai`i has been experiencing a second wave of the disease in the last few years, as the longer term effects of the early onset of the disease now manifests itself in the addicted population. (Wood) For example, based on testimony from treatment agencies and in discussions with persons in treatment, most recovering addicts report long-term use of ice, five to ten years or longer. Trends in State adult arrests for drug possession for the past ten years reflect this second wave. Arrests for possession of ice (reported as a "nonnarcotic" drug) peaked in 1997, then declined for two years. Starting in 2000, arrests for ice possession began to dramatically increase. In 2002, ice possession arrests had nearly tripled since 1999 and more than doubled over the peak in 1997. (Office of the Attorney General of the State of Hawai`i, Crime in Hawai`i 2002, p. 110) Similarly, although less dramatic, the drug offenses of manufacture/sale of ice over the past ten years reflect the same peak in 1997 followed by a one year decline, then a steady increase since 1999 to its highest level in 2002. (Id.)

- Between 1998 and 2002, admissions into treatment for ice increased by approximately 80 percent (DOH/ADAD). In 2002, ice was the number one substance abused for which treatment was sought. (DOH/ADAD) Nearly every adult in recovery who spoke to the Task Force reported ice as the primary drug of choice. Every agency testifying before this Task Force that provided adult drug treatment services, reported ice as the primary drug of choice among its treatment population.

- O`ahu deaths associated with ice usage rose from 11 in 1991 to 27 in 1998 to 62 in 2002. (Wood) Similarly, on the neighbor islands, deaths associated with methamphetamine usage rose from 1 in 1998 to 20 in 2002. (Wong)

- Among adult men arrested who tested positive for drug use, 37.4 percent tested positive for ice in 2001. Hawai`i's ice usage among the male arrested population is the highest in the nation. Among adult women arrested who tested positive for drug use, 36.1 percent tested positive for ice in 2001. Hawai`i's ice usage among female arrestees is among the highest across the nation. (ADAM, NDCS Report February 2003)

- Comparison of Hawai`i federal drug cases with the national percentage of drug cases indicates 51 percent of Hawai`i's cases involved ice, in comparison with 14.2 percent ice-related cases across the nation. (HIDTA 2004 Report)

- In the period November 2002 to May 2003, among Hawai`i's prison population, out of 7,456 drug tests, approximately 5 percent tested positive. Of those positive tests, 69 percent tested positive for ice. (Peyton)

- Ice and drug paraphernalia are readily available, as reported by users and those in recovery. (National Drug Threat Assessment January 2003)

- While marijuana is the drug of choice in Hawai`i's workplace, the use of methamphetamine in Hawai`i has increased by 25 percent (Diagnostic Laboratory Services) and 67 percent (Clinical Labs of Hawai`i) over the past five years, as indicated by Hawai`i's largest drug testing laboratories. Hawai`i's methamphetamine use in the workplace is 4 to 5 times higher than the national average. (Linden) This is significant because nationally, while drug use in the workplace has declined, methamphetamine use increased by 70 percent in the past five years. (Quest Diagnostics Drug Testing Index 2003)

B. ICE IS A POTENT, ADDICTIVE DRUG THAT HAS SERIOUS, HARMFUL EFFECTS ON THE USER

ISSUE: Treatment providers, law enforcement and government officials report that crystal methamphetamine causes behavior and addiction that is unique to the drug and unlike anything that society has experienced with other substance abuse addictions such as alcohol, cocaine and marijuana. Law enforcement officers, child welfare workers and others report concerns about dealing with the violent behavior of the user when coupled with the user's heightened sense of strength.

BACKGROUND INFORMATION

Much literature exists on the use and effects of crystal methamphetamine. This report will not attempt to summarize the vast research literature on the subject.

In 1997, David Wolkoff, M.D., of the John A. Burns School of Medicine observed that the "Hawai`ian epidemic of smokable crystal methamphetamine presents a serious public health and public safety threat." He noted that ice was gaining in popularity because of its more potent and longer high. Dr. Wolkoff wrote that ice affects the central nervous system, resulting in increased energy, perception, self-confidence, sexuality and sense of euphoria. Users also experience irritability, impulsivity, impaired judgment, insomnia, nausea, dizziness and anorexia. Psychotic behavior such as hallucinations and paranoia are potentially dangerous manifestations of acute toxicity. After time, the user develops a tolerance for the drug and needs higher doses to achieve the desired high. At the same time, chronic abusers experience a "kindling" or "reverse tolerance" effect, which means very low doses of ice or even any psychostimulant such as caffeine or nicotine can trigger psychosis or self-destructive behavior. (Wolkoff, "Methamphetamine Abuse: An Overview for Health Care Professionals," Hawai`i Medical Journal, Vol. 56, February 1997)

In 2001, the first studies of the abuse of methamphetamine on the brain were reported. The first study concluded that the drug significantly reduced dopamine transporters to the section of the brain that controls movement, attention, motivation and other higher functions. This impaired memory and slowed motor function. Dopamine is a neurotransmitter that sends messages to the brain that communicates feelings of well being. The second study found that methamphetamine inflamed the brain, suggesting physical insult to the brain. These findings appeared even in abusers who had stopped using the drug for a year or more. This brain injury was much greater than that observed by heroin, alcohol or cocaine abuse. (Volkow, "Association of Dopamine Reduction with Psychomotor Impairment in Methamphetamine Abusers," "Higher Cortical and Lower Subcortical Metabolism in Detoxified Methamphetamine Abusers," American Journal of Psychiatry, 158:377-389, March 2001)

The general effects of smoking ice is an intense rush, extremely pleasurable feeling that lasts a few minutes, but the effects of the euphoria or high can continue for 12 hours or more. (NIDA Research Report) Unlike cocaine's high that lasts 20-30 minutes and 50 percent of the cocaine is removed from the body within an hour, methamphetamine's high can last as long as 24 hours and 50 percent of the drug is removed from the body in 12 hours. ("Comparing Methamphetamine and Cocaine," NIDA Notes, Vol. 13, No. 1, June 1998).

According to a UCLA study, methamphetamine abusers typically use the drug throughout the day. The abuser

typically uses the drug in the morning when he or she awakes, then throughout the waking day every 2 to 4 hours. This pattern resembles that of taking a medication, in contrast to the recreational pattern of cocaine that is used in the evening, continuously over a period of several hours. (Zickler, "Methamphetamine, Cocaine Abusers Have Different Patterns of Drug Use, Suffer Different Cognitive Impairments," NIDA Notes, Vol. 16, No. 5, December 2001, citing Journal of Addictive Diseases, Vol. 21, No. 1, 2002)

The short-term effects include: increased attention and decreased fatigue, increased activity, decreased appetite, euphoria and rush, increased respiration and hyperthermia. Long-term effects include: dependence and addiction psychoses, i.e. paranoia, hallucinations, mood disturbances, repetitive motor activity, stroke and weight loss. In animal research, long-term effects of prolonged exposure to small doses can lead to damage of 50 percent of the dopamine producing cells in the brain. (Koch Crime Institute, "Methamphetamine Frequently Asked Questions," hereafter cited as KCI)

Ice is a highly addictive stimulant that dramatically affects the central nervous system. Ice usage falls into three levels: small dose, abuse and addiction. Even a small dose can produce short-term effects, such as rush, euphoria and increased activity. (NIDA Research Report Series, "Methamphetamine Abuse and Addiction," hereafter cited as NIDA) However, a single high dose use can damage the brain. (Carlton) Fifteen percent of first time users become addicted to the drug. (Holschuh) Ice abusers use higher dosages of the drug. Chronic abusers suffer addiction, characterized by compulsive drug seeking, violent behavior, anxiety, confusion and insomnia. (NIDA) Chronic use builds up a tolerance for the drug, requiring higher doses and more frequent use. In some cases, abusers forego food and sleep while "bingeing" or using a gram of the drug every 2-3 hours over several days. Some paranoia effects leads to suicidal or homicidal thoughts. (NIDA)

Ice is addictive because it produces a pleasurable effect, followed by depression when the dopamine is suppressed, causing a chemical imbalance. The user then needs to seek out the drug to restore their sense of well-being. (KCI) This cycle is an addiction. When the chronic user stops taking the drug, the user suffers from symptoms of depression, anxiety, fatigue, paranoia, aggression and intense craving. (NIDA)

FINDINGS

- Ice is a bad drug. Ice cannot be used recreationally without detrimental effects on the body and psyche.

- Ice addiction drives a compulsive need to seek out and take the drug, to the exclusion of awareness of other bodily needs and life responsibilities.

- Ice addiction is a chronic disease, with frequent relapses.

C. ICE USAGE IS DESTROYING FAMILIES AND HARMING CHILDREN

ISSUE: Concerns are raised by all segments of the community about the effects of ice on the family, the home, children and the unborn fetus of a pregnant woman who is an ice user. These concerns run the gamut of protecting family members from being victimized by the ice user to providing resources and support to family members in order to assist the recovering ice addict.

BACKGROUND INFORMATION

The following discussion is divided into the four main concerns raised by persons testifying before the Task Force: fetal exposure to ice, the process to involuntarily commit a substance abuser to treatment, efforts to protect children exposed to ice in the home and the need for family counseling and support services.

Fetal Exposure to Ice

Law enforcement and others raise concerns about fetal exposure to ice taken by a pregnant woman. This subject is controversial and emotional. Little scientific research exists to reach conclusions about the effects of prenatal use. Many treatment providers warn that over reaction to protect the fetus by punishing the pregnant woman will result in avoidance of health care by the pregnant woman, premature removal of a newborn from the mother and retrenchment of civil liberties. Proponents favoring actions to protect the fetus express fear that newborns will be born addicted, have physical problems that will result in expensive State funded long-term medical care needs, or may have a greater propensity toward drug addiction. Finally, public policy concerns revolve around whether the current controversy regarding fetal exposure to ice will extend to punish women who consume alcohol or use tobacco while pregnant, since scientific evidence exists that both alcohol and tobacco have severe effects on the fetus.

Despite the usage of the term “ice baby,” there is no long-term scientific evidence to prove that a baby born to an ice user mother is adversely affected by ice at birth. The only consistent finding is that ice use may increase the risk of premature birth and decreased size of the fetus for gestational age. No studies have concluded that ice affects the fetus the same way that alcohol does. Specifically, alcohol exposure causes life long permanent disorders of memory function, impulse control and judgment and is the leading cause of preventable mental retardation. In contrast, fetal exposure to cocaine does not have similar effects on children up to age six, although subtle developmental effects on intelligence levels may result. (DeRauf) Similarly, little scientific research exists regarding the long-term effects of a newborn that tests positive for ice due to the mother’s use of the drug near the time of birth, although anecdotal information suggests the newborn is harmed.

The danger of prenatal exposure to methamphetamine is substantially less than that of tobacco and alcohol and few protections exist against those known and harmful substances. Dr. DeRauf reports that a Child Welfare Services Study in 2000 reported prevalence of methamphetamine exposed births was 1.2 percent and a study of births between 1986-1999 indicated 39.9 prenatal exposures per 10,000 births.

Findings Relating to Fetal Exposure

- Drug use by a pregnant woman may pose dangers to the fetus. However, tobacco and alcohol use by a pregnant woman is far more dangerous to the fetus than ice. No laws exist that impose criminal sanctions on the

woman for fetal exposure due to alcohol or tobacco use. Therefore, the Task Force makes no recommendations about laws to protect the unborn fetus from ice use.

- The Task Force strongly supports education and awareness programs directed toward women of childbearing age regarding the effects of ice. As discussed in more detail under section G. Adult Treatment, the Legislature has provided funding for treatment programs directed toward pregnant women and supports continued funding. As discussed in more detail under section E. Prevention, the Task Force recommends funding priority for treatment programs directed to women of childbearing age.

Civil Commitment

Many family members of drug users reported that as a last resort they turned in their family member to the police in the hope that the user would be required to obtain treatment under the threat of the criminal justice system. Family members asked for some mechanism that they could "commit" the user to treatment.

Section 334-121 et seq., HRS, provides a legal mechanism to compel a person to obtain outpatient treatment for substance abuse. It is a complicated process that has not been used in recent history, according to Family Court judges.

Findings Relating to Civil Commitment

- Families should not have to resort to filing criminal charges against a family member who is abusing ice simply to force a "wake up call" on the user. A civil commitment process that allows the family to expeditiously commit a family member to involuntary drug treatment is needed. This avoids stigmatizing a person as a criminal because of his or her addiction to illicit drugs.

Recommendations Relating to Civil Commitment

- The Task Force recommends that Section 334-121 et seq., HRS, be revised to permit family members to expeditiously seek civil court intervention when private sources to pay for treatment are available. This would relieve the criminal justice system of drug abusers who would not otherwise become involved in the criminal justice system but for the illegal drug use.

Protecting Children Exposed to Ice in the Home

Law enforcement officials reported dangers for children residing in drug houses, clandestine meth labs and in households where the parent is so addicted that the child is neglected or abused. Drug abusers told the Task Force about losing their children to Child Welfare Services (CWS), although some complained that their children should not have been taken from them. Family members of drug abusers appealed for treatment for the abusing parent, advocated to keep the child within the family and asked for family support counseling. Community organizations, government employees who work directly with families affected by ice, Family Court judges and attorneys representing families and the State spoke about the inadequate resources to respond to the needs of families, the children and the lack of coordination between government offices.

Director Koller reported that in FY2002, CWS had 7,000 active cases, of which 4,827 children were placed in foster care. CWS does not collect data on the number of children removed from the home because of safety concerns relating to ice usage in the home. However, anecdotally, CWS estimates that 85-90 percent of its cases involved parents addicted to ice or other drugs. Other witnesses estimate that 95 percent of the cases involving removal of the child are

related to ice usage in the home. The financial consequences of the ice epidemic that affects children in the home are staggering, as shown in Table 1 below.

Table 1 Child Welfare Services Costs

Estimates of cost for foster care for nondifficult care	4,827 children in foster care x $14,740/year	$71,149,980
Estimates of cost for caseload services, child remains in family	Approx. 2,200 cases x $7,840/year	$17,248,000
TOTAL COST for child welfare services due to ice abusers in the home	85-95% of cases due to ice abuse x $88,397,980	**$75,138,283 to $83,978,081**

Source: Koller Testimony, September 22, 2003

The Task Force is extremely concerned that this very serious problem does not appear to be adequately addressed through any type of coordinated plan and that no data has been collected documenting the apparent severity of the problem. The Task Force notes that in neither the presentation before the Task Force nor the FY2002 Report from the Department of Human Services (DHS) was there any discussion of a plan or approach to address the escalating number of child maltreatment cases resulting from ice abuse in the home. The FY2002 Report noted the rise in cases but failed to identify the cause for the caseload increase or a plan to assess the factors that account for the increase. This confirms the concerns raised in the community about the apparent lack of coordinated efforts by the Department of Human Services to deal with the substance abuse issues of the parent to ensure the safety of the child in the home.

A study conducted by The National Center on Addiction and Substance Abuse at Columbia University (CASA) is a comprehensive analysis of the effect of substance abuse on the child welfare system. (Reid, et. al. "No Safe Haven: Children of Substance Abusing Parents," CASA, January 1999). The study concluded that substance abusing parents affected 3 million children in 1997 and cost the taxpayer over $10 billion per year. Children of parents who abuse drugs are three times more likely to be abused and four times more likely to be neglected.

The study found that child welfare agencies devoted most of their resources to investigation, foster care and permanent custody decisions while the provision of services to prevent the recurrence of child abuse/neglect was a lower budget priority. Child welfare workers were inadequately trained and most systems did not have protocols to document and assess substance abuse by the parent. The study found six critical weaknesses that hobble child welfare officials' efforts to protect the child: (1) lack of effective substance abuse screening and assessment practices, (2) lack of timely access to appropriate treatment and related services, (3) lack of strategies to motivate addicted parents, (4) lack of criteria or knowledge to inform decisions on when to return children to their families, (5) few efforts to prevent relapse and (6) difficulty of determining when to permanently remove the child from the parents. (Id. p. 7) The study praised family drug court efforts to impose accountability on the parents and a fragmented and uncoordinated child welfare system. The study noted that the child's developmental needs should take precedence over the timing of parental recovery.

The study concluded with five recommendations: (1) Prevent substance abuse, focus on treatment for pregnant women, conduct home visits before and after birth to reduce incidence of maltreatment, (2) dramatically reform the child welfare system by adopting protocols to address the weaknesses outlined above, (3) fund treatment for

parents, (4) provide training to all professionals involved in the system, (5) collect better data and invest in research to evaluate outcomes of the efforts. (Id. pp. 8-10)

The Task Force appreciates that Hawai`i's child welfare system may be stretched beyond its resources and that problem solving efforts may be ongoing but not reported to the Task Force. However, the solution to the problem is not removal of the child and placement in foster care. The solution must lie in preventing the addiction and treating the parent before child maltreatment happens. No one disagrees that protection of the intact family is in the best interests of the child.

A final concern is the coordination between law enforcement and CWS workers to respond to the discovery of the child in the home where ice is being manufactured, distributed and used by household residents or guests. While anecdotal stories indicate that this is happening in Hawai`i, the magnitude of the problem is unclear. A recent study by the Office for Victims of Crime portrays a growing and frightening problem across the country. Children are not just subject to maltreatment from substance abusing adults, but suffer injury and health risks due to exposure to the toxic chemicals, caused by the equipment and process used to manufacture crystal methamphetamine. Many of the meth labs are in isolated areas, are poorly ventilated and in run down condition. Children who are present in clandestine labs or drug houses are unsupervised, subject to hazardous lifestyles such as weapons on the premises or household food and items contaminated by poisonous substances and unhygienic conditions. The study found proactive efforts by multiagency emergency response teams to be most effective in assessing the danger to the child, making a decision on temporary removal, providing intervention and medical services and documenting the conditions in order to assist the prosecutor's office in evaluating whether to file criminal charges relating to the child. (Swetlow, Karen, "Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims," U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crimes, June 2003) Various states have adopted drug endangered child protection acts that provide for enhanced criminal penalties for harm to children exposed to drugs, create multiagency response teams and fund the programs. (Id. pp. 7-10) The Task Force supports these types of efforts.

Despite its concerns, the Task Force recognizes and supports the efforts made by DHS, the Judiciary and county prosecutor's offices to coordinate services for families affected by ice. The Family Court in the First Circuit instituted a Family Drug court last year, with a maximum caseload of 30 participants. Other circuit courts indicate an interest in developing a Family Drug court. This program is a bright light in an otherwise dark problem and is a small first step toward a solution.

Findings Relating to Protecting Children

- The effects of ice abuse in the home that affects children cost Hawai`i's taxpayers between $75 to $84 million dollars annually.

- No apparent coordinated plan exists between various governmental departments, such as the DOH, DHS, law enforcement, prosecutor's offices, Judiciary and community agencies to respond to the effects on the child due to ice usage in the home. A multidisciplinary approach to problem solving must be enacted.

Recommendations Relating to Protecting Children

- The Task Force recommends that a multiagency task force be convened to prepare a drug endangered child

protection program to be submitted to the Legislature 20 days before the commencement of the 2005 Legislative Session.

- The Task Force recommends increased funding for prevention programs directed toward at-risk women of child-bearing ages, increased funding for treatment programs for pregnant women, women with young children and that parents with children in the home who are not involved in the criminal justice system receive a higher priority for public funded treatment programs. The Task Force requests that DOH/ADAD and DHS explore the use of TANF funds and other federal funds for these purposes.

- The Task Force recommends legislation for enhanced criminal penalties for persons who expose children to drug houses or meth labs.

Family Counseling and Support Services

Testimony from the community overwhelmingly advocated for counseling services for family members to deal with the drug user's addiction, provide a support mechanism for the recovering addict and reduce the relapse rate. Research on addiction confirms the need for such services as part of the continuum of care. Many community based groups currently provide such services and they claim it to be effective. No current publicly funded dollars are earmarked for these services. No data exists on the successful outcomes of such programs, except through anecdotal statements.

Findings Relating to Family Counseling and Support Services

- Family counseling and support services are needed as part of the continuum of care to heal the drug addict and the families affected by the addiction. This appears to be a service gap.

Recommendations Relating to Family Counseling and Support Services

- The Task Force recommends modest funds for family counseling and support services to be allocated from either adult treatment or prevention funding sources, but requires that evaluation criteria be established to determine the successful outcomes of the programs.

(This page intentionally left blank)

D. EXPANSION OF ADOLESCENT TREATMENT SERVICES IS NECESSARY TO PROTECT AGAINST FUTURE DRUG EPIDEMICS

ISSUE: Nearly all members of the community advocated for increased treatment services for adolescents, as indicated by the number of recommendations relating to adolescent treatment.

BACKGROUND INFORMATION

Drug Use by Adolescents

Based on the 2002 Hawai`i Student Alcohol, Tobacco and Other Drug Use Study (2002 Schools Survey), which does not include adolescents who have dropped out of school, 7 percent or 7,519 students need drug treatment. When alcohol is included, the need for treatment rises to 10.6 percent or 11,319 students. (p. 17) Tobacco, alcohol and marijuana are the most prevalent substances used by students in the survey.

The good news is that that lifetime use of ice declined for all grades, which means that fewer students were experimenting with the drug. Only 5.3 percent of 12th graders reported any lifetime use of ice, down from 7.7 percent in 1998. Even at the 6th grade level, lifetime ice use was .4 percent, down from 1.8 percent in 1998. Ice use within 30 days also declined since 1998, but was slightly higher in 2002 than it was in 2000 for older adolescents. For example, 1.8 percent of 12th graders reported use within 30 days, up from 1.6 percent in 2000, but down from 2.3 percent in 1998.

Table 2 summarizes the use of alcohol, marijuana, ice and the newest "trendy" drug, ecstasy in 2002. As indicated in Table 2, alcohol and marijuana are the most frequently used substances.

Table 2 Summary of Alcohol, Marijuana, Ice, Ecstasy Use and Adolescent Treatment Needs in Grades 6, 8, 10, 12

2002	Lifetime Use	30 Day Use	Daily Use	Percent Need treatment
Alcohol				**Alcohol**
6th grade	20.0%	7.8%	0.5%	0.6%
8th grade	42.5	20.4	1.8	4.0
10th grade	64.7	33.9	2.5	10.9
12th grade	75.4	43.0	3.3	16.3
Marijuana				**Marijuana**
6th grade	2.6	1.3	0.2	0.4
8th grade	15.9	9.1	1.6	3.3
10th grade	35.8	18.4	4.4	10.2
12th grade	46.2	21.2	4.8	12.8
Methamphetamine				**Stimulants**
6th grade	0.4	0.2	0.1	0.2
8th grade	2.0	1.2	0.1	0.8
10th grade	4.2	1.8	0.2	1.2
12th grade	5.3	1.8	0.3	1.7
Ecstasy				**Club drugs**
6th grade	0.2	0.1	0	0.2
8th grade	3.0	1.7	0.2	1.0
10th grade	7.2	2.3	0.2	1.3
12th grade	10.6	2.5	0.2	1.8

Source: 2002 Hawai`i Alcohol, Tobacco and Other Drug Use Study, Table 1, 23 (excerpts)

State juvenile arrest data confirms that marijuana is the illegal drug of choice for juveniles. In 2002, over 90 percent of drug possession offenses were for marijuana. While marijuana possession arrests dropped by about 17 percent in 2002, the arrests for manufacture/sale of marijuana substantially increased by six-

fold over the prior year. (Office of the Attorney General State of Hawai`i, Crime in Hawai`i 2002, p. 111)

Estimating the Need for Adolescent Treatment Services

The data in Table 3 estimates the total number of adolescents who need treatment for abuse or dependency. Over 4,000 adolescents need treatment for illicit drug use. When combined with any abused substance, 6,457 adolescents need treatment. More than half the students who need treatment, need help for both alcohol and drug abuse. Less than 15 percent of students diagnosed with substance abuse have used treatment services. Unfortunately, less than 5 percent of the students who perceive they have a problem have been told to get help.

Table 3 Adolescent Treatment Needs (DSM III-R), Grades 6, 8, 10, 12

Treatment Needs	6th grade	8th grade	10th grade	12th grade	Total
Alcohol only	104	643	1,726	2,166	4,639
Illicit Drug only	104	611	1,742	1,833	4,290
Any substance	173	933	2,534	2,817	6,457

Source: 2002 Hawai`i Alcohol, Tobacco and Other Drug Use Study, p. 242

Treatment for adolescent substance abuse requires a comprehensive, integrated approach to address co-occurring mental disorders, school failure, health and medical needs, family problems, peer pressure and juvenile justice problems. The treatment should include the family, if feasible, and be developmentally appropriate for the adolescent. Treatment providers are challenged to keep the adolescent involved in the program and to develop trust relationships.

Only two types of adolescent treatment programs are offered through public funds: school based outpatient treatment and two residential treatment programs. In 2002, approximately 1,552 adolescent admissions were reported to DOH/ADAD, most of which were through school based outpatient treatment programs. In 2002, 158 adolescents were admitted to treatment for ice. This indicated a decline from 1998 when 189 adolescents were admitted to treatment for ice. The decline is attributed to several factors: decline in ice use as indicated by the 2002 Schools Survey and the severity of the addiction which meant more public funds were needed to support fewer adolescents. However, this decline is noted only for the school based programs. No data tracks the ice addicted adolescents who have dropped out of school, although the juvenile justice system reports high rate of addiction to ice (see discussion below).

Public Funding for Existing Adolescent Treatment Services

Publicly funded adolescent treatment admissions for FY2003 and FY2004 were paid by state and federal sources and were administered by DOH/ADAD, as described in Table 4.

Table 4 Funding for Adolescent Treatment

Adolescent Treatment	FY2003	FY2004
School based Treatment	$2,019,122	$2,321,470
Admissions	1,233	--
Av. Cost per school	$54,571	$62,742
Residential Treatment	$721,336	$489,997
Admissions	35	--
Av. Cost per admission	$20,609	
Total Public Funding	$2,740,458	$2,811,467

Source: Wilson testimony, September 8, 2003

The school based outpatient treatment program reaches 34 out of 45 public high schools and three out of 57 middle schools throughout the State. Since nearly all drug treatment is school based, adolescents who are out of the school system have limited access to publicly funded treatment services, primarily through the family courts and juvenile justice system.

Assessing the Effectiveness of Existing Programs

Outcomes from school based treatment indicate positive results. On O`ahu, two community based treatment organizations provide adolescent treatment services to high school students. Each organization submitted statistics of successful outcomes resulting from the treatment program. Between 64 and 82 percent of the students completed the treatment program. Around 80-85 percent of the students were in school, employed or in vocational training within six months after completion of treatment. Between 56 and 76 percent remained abstinent at six months after discharge. The Big Island school based adolescent treatment programs did not fare as well as the programs on O`ahu. Fifty-four percent completed the program, 46 percent were employed, in school or attending vocational programs six months after completion of treatment and 66 percent of the students were abstinent at six months after discharge. See Appendix A, testimony summaries of Wilson, Malott, Pacheco and Margheim for additional details on treatment outcomes.

Chart 1 indicates the composite results of successful outcomes for all school based adolescent treatment programs in the State for the last three years. The greatest challenge for adolescents who completed treatment appears to be refraining from using drugs or alcohol.

Residential treatment services at Bobby Benson also indicate positive outcomes at the six month follow up. Fifty-nine percent completed treatment, 71 percent were clean and sober, 85 percent missed no school or work due to drugs and nearly all were in a stable living arrangement. See Appendix A, testimony summary of Bruns.

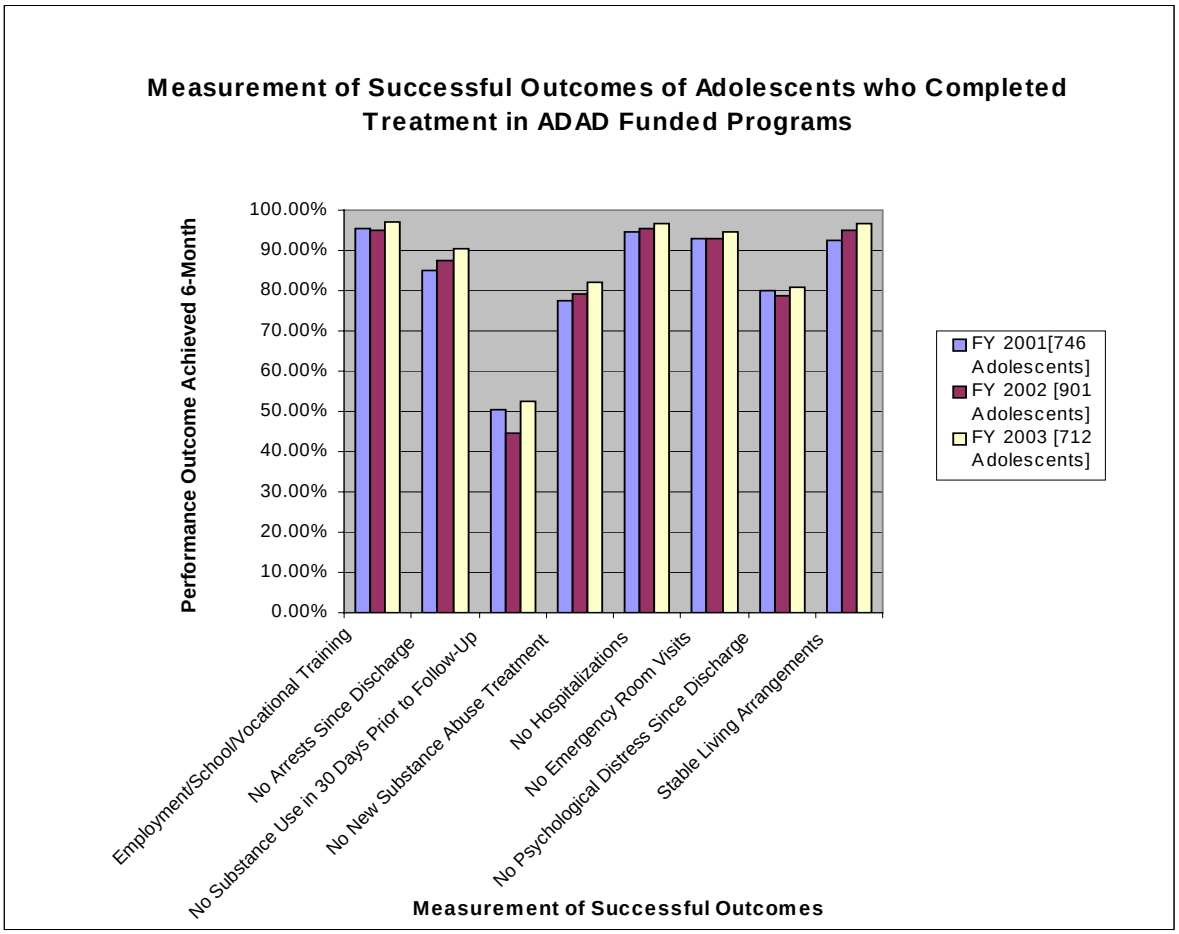
Juvenile Justice System Treatment Programs

The juvenile justice system and Family Courts also provide treatment to adolescents. These programs report positive outcomes, indicating effectiveness. The First Circuit Court has a Juvenile Drug Court that has enrolled 65 participants in a program that runs 12-15 months. State funding of $746,178 supported this program in FY2002. Thirteen have graduated and only one graduate was arrested. Kalihi YMCA provides the treatment services through the Juvenile Drug Court. It reports 81 percent completion rate and 77 percent of the participants were not re-arrested at three months. Sixty-two percent were abstinent at three months follow up. The Family Court of the First Circuit also provides adolescent treatment services. Federal funding of $87,037 supported this program in FY2002. Sixty-two percent completed the program and 59 percent had no additional criminal justice violations at three month follow up. See Appendix A, testimony summary of Malott, Uale, Browning.

The Hawai`i Youth Correctional Facility provides treatment to youth offenders through a community based provider. In FY2003, 59 percent acknowledged ice usage. Seventy-seven percent completed the treatment program. About 59 percent indicated no drug use at three month follow up. Youth offenders are also referred to Bobby Benson Center, funded through DOH/ADAD. In FY2003, 20 young adults 18-20 years of age under the jurisdiction of the correctional facility were sent to Sand Island Treatment. Seventy percent of those persons admitted ice usage. Fifteen completed the program. The Office of Youth Services

does not compile outcome data on the adolescents under their jurisdiction who are in treatment. This data was compiled for this report. See Appendix A, testimony summary of Yamamoto.

CHART 1:



Source: DOH/ADAD Data, Wilson testimony, August 27, 2003, supplemented 10/20/03.

Treatment Gap

The Task Force recognizes that ice is not a problem for adolescents in school. Rather, alcohol and marijuana are the primary substances of abuse. While the scope of this inquiry does not focus on alcohol, research confirms that adolescent addiction is typically based on both alcohol and drugs. Further, while the issue of marijuana as a gateway to more harmful drugs is controversial, the Task Force cannot ignore the fact that such a high percent of Hawai`i's youth are recreational users of marijuana, as demonstrated by the 30 day usage data in the 2002 Schools Survey. Indeed the gateway theory suggests that marijuana users are many times more likely to progress to hard drug use, that almost all who have used both hard drugs and marijuana used marijuana first and the greater the frequency of marijuana use, the greater the likelihood of hard drug use later. In a recent study conducted by Drug Policy Research Center of Rand, it concluded that the gateway effect can be explained by other factors, such as when youths had a first opportunity to use drugs and the individual's propensity to

use drugs. However, the study specifically did not disprove the gateway theory. ("Using Marijuana May Not Raise the Risk of Harder Drugs," Drug Policy Research Center, Rand, 2002)

DOH/ADAD estimates, based on the 2002 Schools Survey, that 7,519 public school students need treatment for illicit drug abuse. The gap of over 5,000 adolescents, i.e. the difference between the 7,519 who need treatment and the less than 2,000 adolescents who received treatment, is shocking. The federal estimates of the treatment gap in Hawai`i for the age group 12 to 17 is generally consistent with the 2002 Schools Survey. The federal government estimates that 5,034 adolescents or 5.29 percent of the estimated population in that age group need treatment for illicit drug use and did not receive it. (SAMHSA "Estimates of Treatment Gap by State," 2000 NHSDA, Tables 6, 7, 8)

Nearly all adolescent treatment providers urged more school based treatment programs extending to the middle schools and more residential treatment. DOH/ADAD recommends extension of counselors to all high schools and into the middle schools. DOH/ADAD estimated the cost for two counselors at each of 15 high schools and 54 middle schools, at $90,000 per school is $6,210,000.

Based on historical data of funding for 37 schools, the average cost per school runs between $54,000 and $62,000. Thus, at an average cost of $65,000 per school, the cost to extend school based treatment to all high schools and middle schools is $4,485,000.

While adolescent residential treatment facilities are limited, the Big Island will be opening up a facility soon. The Task Force agrees with DOH/ADAD's wait and see approach to determine whether additional residential treatment is needed. The Task force notes that the per admission cost for adolescent residential treatment is very high, at $20,000 per admission.

FINDINGS

- Hawai`i's youth must receive substance abuse treatment. Early intervention is the key to divert young adults away from drug use. The treatment gap of adolescents who need treatment and do not receive it, is over 5,000, based on both state and federal estimates.

- Marijuana and alcohol use poses the greatest threat of substance abuse for Hawai`i's adolescents who are in school. However, ice and ecstasy use levels remain problematic. Ice usage is the drug of choice for those adolescents who have entered the juvenile justice system.

- School based treatment programs appear to be successful in returning students to a drug free lifestyle. Family and Juvenile Drug Court programs also report success rates.

- Current levels of funding for adolescent treatment are woefully inadequate to protect our investment in Hawai`i's youth.

- The Task Force is concerned about the adolescents who drop out of school and have no access to school based treatment programs. Except for the courts and juvenile justice system or privately paid treatment, these youths have no where to turn to for help with drug addiction.

RECOMMENDATIONS

- The Task Force recommends allocation of $4.5 million in new money to fund school based treatment programs commencing at the middle schools.

- The Task Force recommends that baseline evaluation criteria be developed for treatment programs. Although some agencies appear to set their own goals, there should be some objective measurement to determine the significance of the "successful outcomes" data collected. (See further discussion on evaluations in section G. Adult Treatment)

- The Task Force recommends that the Office of Youth Services establish reporting and evaluation criteria for the treatment programs offered in the juvenile justice system.

- The Task Force recommends that the DOE explore the feasibility of establishing alternative schools or drop out centers for adolescents who suffer from drug addiction. The DOE shall report to the Legislature its recommendations and cost analysis not later than 20 days before the commencement of the 2005 Legislative Session.

E. PREVENTION OF ADDICTION TO ICE AND OTHER ILLEGAL DRUGS IS CRITICAL TO STOP THE EPIDEMIC AND PROTECT FUTURE GENERATIONS

ISSUE: Without exception, testimony received urged that drug education and prevention is absolutely necessary to end the ice epidemic and protect against future epidemics. Overwhelming testimony advocated for drug education programs in the schools, starting at a young age.

BACKGROUND INFORMATION

Prevention Programs Are Effective Tools Against Drug Use

Hawai`i has compiled data identifying risk factors of youth and communities that can lead to drug addiction. Dr. Sylvia Yuen of the University of Hawai`i Center on the Family has current and comprehensive community profiles that outline both risk and protective factors essential for developing effective prevention strategies. The 2002 Schools Survey identifies student behaviors that can lead to addiction, and the data is broken down by geographical districts. This data is critical to establishing substance abuse prevention programs throughout the State. With this information, nothing prevents Hawai`i and its communities from adopting best practices prevention programs. Nothing, except that the State has shamefully failed to fund prevention programs for over a decade.

Prevention programs, based on scientifically researched "best practices," are effective. These programs are the first lines of defense against drug addiction. Prevention programs that focus on youth are critical because the youth ice users in the mid 1990's are the adult addicts today. Early onset of illicit drug use generally predicts adult abuse. (See research cited in the 2002 Schools Survey, p. 3) Hawai`i's youth experimentation with ice peaked in the mid-1990's. However, marijuana use remained static for older adolescents, as nearly half of all adolescents age 15 or older have experimented with marijuana, as indicated in Table 5 below.

Table 5 Trends in Illicit Drug Use by Adolescents

Lifetime Use of Substance	1996	1998	2002	Comments
Methamphetamine				
6th grade	1.4	1.8	0.4	Decline
8th grade	4.4	4.6	2.0	Decline
10th grade	5.9	6.7	4.2	Decline
12th grade	7.5	7.7	5.3	Decline
Any illicit drug				
6th grade	13.4	13.7	9.5	Decline
8th grade	29.6	26.3	22.0	Decline
10th grade	41.3	42.9	40.4	Decline
12th grade	47.7	50.3	49.4	Static
Marijuana				
6th grade	5.1	4.9	2.6	Decline
8th grade	21.5	19.2	15.9	Decline
10th grade	36.5	39.2	35.8	Decline
12th grade	44.7	47.7	46.2	Static
Alcohol				
6th grade	29.8	31.6	20.0	Decline
8th grade	54.0	52.6	42.5	Decline
10th grade	73.4	72.3	64.7	Decline
12th grade	79.7	81.2	75.4	Decline

Source: 2002 Hawai`i Alcohol, Tobacco and Other Drug Use Study, Table 17 (excerpts)

The onset of marijuana usage and drunkenness due to alcohol are the best overall predictors of use and abuse of illicit drugs. (2002 Schools Survey, p. 320) The survey found that most students initiate marijuana use between ages 13-16, but can start as early as age nine or younger. One out of 100 students begins marijuana use before age 10. This suggests that prevention programs must begin before age nine, with the strongest efforts in the 8th grade. Alcohol usage begins before age nine for about 10 percent of students, with more than 50 percent of 8th graders reporting drunkenness at age 13. Alcohol education needs to begin before age nine since one in ten has used alcohol by that age. (Id. pp. 310, 311, 314)

Effectiveness of Existing Prevention Programs

Existing publicly funded prevention programs administered through DOH/ADAD center around youth and family and are based on "best practices" within a culturally and gender appropriate approach. Descriptions of these programs are included in the testimonies of Elaine Wilson, Boys & Girls Club of Hawai`i and Maui, Coalition for a Drug Free Hawai`i, Susannah Wesley Community Center, Maui Youth & Family Services, Kaua`i Economic Opportunity Inc., Seventh Day Adventist, Wai`anae Coast Comprehensive Health Center, Alu Like and others. Some programs included successful outcomes data.

The prevention programs instituted with federal money clearly have been successful because of the decline in use as indicated above. However, those numbers do not tell a complete story and should not lead to complacency about prevention efforts. The 2002 Schools Survey is based on a statistical sampling model that primarily reaches the “good kids” who remain in school and whose parents consented to participate in the survey. The survey does not reach the school drop outs or the students that may already be using drugs who declined to participate in the survey or who have parents who refused to consent to participation in the survey. For the 2002 Schools Survey, eight public schools declined to participate in the survey, including Kahuku High School, Benjamin Parker Elementary School and Laie Elementary School, all of which are in the Windward community that led the anti-drug community mobilization efforts on O`ahu. Thus, the true picture of adolescent drug use as predictors of adult abuse may never be known given the inherent limitations of research data.

What is known is that the youth ice users of the mid-1990’s are part of the epidemic affecting young adults today, that ice is a highly addictive drug that can create addiction with one use, and that brain injury occurs with one use. We also know that other harmful drugs will emerge, such as the upward trend of experimentation with the club drug ecstasy, unless the State remains vigilant about prevention programs.

Prevention Strategies that Work

The general philosophy of drug prevention is to reduce the demand for the drug by focusing on the individual susceptible to drug use and the social environment that may influence the individual to take drugs. Prevention strategies generally include: community mobilization, information dissemination, prevention education by raising awareness, strengthening families, role models and parenting skills, support for community and school activities that promote healthy lifestyles and positive life decisions and problem identification and assessment. DOH/ADAD has a current prevention plan in place that has guided funding decisions. Those goals include youth leadership development, primary prevention for high risk youth, promoting drug free lifestyles for the college age population, Native Hawai`ian agriculture project for elementary school age

children, Native Hawai`ian ex-offender prevention, resource and technical assistance to communities, targeted education and public awareness. (2002 Report to the Twenty-First Legislature on Implementation of the State Plan for Substance Abuse, January 2002)

Existing Funding for Prevention Programs

No public agency collects comprehensive data on funding for and types of prevention programs in Hawai`i. Prevention programs administered by DOH/ADAD have been funded by federal dollars as described in Table 6 below. Twenty percent of the State's federal Substance Abuse Prevention and Treatment (SAPT) block grant goes to prevention programs. In addition, in 2001, the State was awarded a 3-year $8.4 million dollar State Incentive Grant (SIG) to reduce drug, alcohol and tobacco use among Hawai`i's youth and coordinate and leverage community resources toward substance abuse prevention programs at the community level. The SIG funding will soon run out and must be replaced by either new federal or state funds. Most importantly, the SIG funded pilot programs that have proven to be effective need to have stable funding to continue its work until the epidemic wanes.

Table 6 Funding for Youth Prevention Programs, by Island

Prevention FY2004	TOTAL Federal	SAPT	SIG
O`ahu	$1,788,337	549,037	1,239,300
Maui	395,500	210,000	185,500
Moloka`i	198,100	75,000	123,100
Lana`i	150,000	--	150,000
Hawai`i	513,100	150,000	363,100
Kaua`i	294,000	75,000	219,000
Statewide	952,946	952,946	--
Total	4,291,983	2,011,983	2,280,000

Source: Wilson testimony, September 8, 2003

The DOE received federal funding for drug free schools for two years, about $600,000. The DOE requires all schools to include drug education in its health curriculum and each school is permitted to design its own approach to this. Obviously, state funding supports the drug education curriculum, but the only earmarked state funded program is Lion's Quest (a teacher training program designed to reduce gang and drug involvement). (Kawaguchi)

Community nonprofit organizations raise money and seek funding for prevention programs directly from the private sources, faith based organizations and the federal government. Federal funding is obtained through a competitive application and selection process. Local government agencies also receive federal funding for prevention programs through a competitive process. For example, in the last fiscal year, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded approximately $3 million in discretionary funding for prevention programs to various nonprofit agencies. Weed and Seed and DARE programs also are funded by federal dollars. Federal funds are awarded for programs dealing with juvenile delinquency that may be closely tied to the same risk factors that affect adolescent drug abuse.

Setting Policies for Expansion of Prevention Programs

Many suggestions for prevention programs were presented to the Task Force, including nonschool activities to keep children involved in positive activities, education and prevention in the schools starting as young as the 4th grade,

mentoring programs, drug testing, media campaigns and family support.

Unlike treatment needs that can be documented through estimates of use and historical admission data, the need for prevention programs is based more on anecdotal information and public policy decisions. The Task Force supports the prevention goals adopted by DOH/ADAD. However, the Task Force also recommends four cornerstone policies in the funding and development of prevention programs.

- **Drug education and awareness in the schools and community partnerships**

Every public school student from kindergarten to high school should be required to attend a drug education curriculum, as appropriate to the development of the student. A more directive educational program should begin at the 4th grade level when experimentation with drugs is likely to begin. Schools should have the ability to assess and refer a student to school based treatment programs. Finally, the schools should partner with parents and the community to solve drug-related problems. These partnerships can be integrated into the DOE's parent-community networking centers.

The Task Force strongly supports school based prevention programs. Research indicates that model school based programs make small, incremental progress in managing a mature drug epidemic, such as Hawai`i now faces. Such programs primarily increase public health awareness of the effects of illicit drugs rather than dramatically diminish the demand for illicit drugs. (Rand Drug Policy Research Center, "What are the True Benefits of School-Based Drug Prevention Programs," 2002) The estimated cost for school based prevention program is $150 per student. The cost benefit to society equals $840 per student. A hidden cost, however, is the lost learning opportunity as a result of diverting instructional time away from traditional academic classes. (Id.) School based prevention programs also have a corollary benefit, a spillover effect on the nonparticipants, resulting in reduced consumption of drugs. (Rand Drug Policy Research Center, "The Benefits and Costs of Drug Use Prevention," 1999) By the time the public realizes that drug abuse has reached epidemic proportions, it is too late to run a maximally effective prevention program because those who could have benefited from prevention efforts as young adolescents are now addicted adults. Thus, sustaining prevention programs regardless of current drug use trends can ameliorate the effects of future epidemics. (Id.)

Some organizations conduct drug education programs in the school, such as the police department's DARE program. However, the Task Force was not sufficiently informed by the DOE about the drug education programs currently offered by the DOE or in partnership with the DOE. In its presentation, the DOE stated drug education is part of its health curriculum. The DOE has not evaluated its drug education programs and stated that any evaluation should be part of a redesign of the educational system. Based on anecdotal information received from the communities[3], it does not appear that the DOE's programs, to the extent such programs may exist in various communities, are well known to the communities. However, the $600,000 in federal funds awarded to the DOE may well have supported school based prevention programs. The Task Force further notes that the DOE did not recommend funding for school based prevention programs.

[3] Several speakers offered suggestions on model programs for schools, claiming no education program was offered in their communities' schools. Two principals reported that they did not have any prevention programs in their schools and had no resources for such programs.

❖ **Non school youth activities that promote healthy lifestyles, positive decisions**

Communities with the greatest need should be identified and supported by programs that provide youth activities based on best practices models. While these activities are not likely to reduce the demand for ice or other illegal drugs, such programs will reduce the propensity to use drugs that may be influenced by peer pressure and social environmental factors.

❖ **Education and support for families and parenting women**

Government alone cannot fight the ice epidemic. Families must be supported and educated to prevent children from using and abusing drugs. Programs are currently in existence for this purpose and those programs should be supported and expanded to communities with the greatest needs. The societal benefits and cost savings for this prevention effort includes reduced health and medical care for children and parents, reduced costs on the child welfare system and family courts, increased nurturing, positive role models and development of the child into a contributing member of society.

❖ **Community mobilization**

Communities throughout the state have mobilized to battle the ice epidemic and raise awareness about this potent drug. The Task Force is impressed with the involvement of numerous segments of the community, such as health care, community action, local government and treatment providers. The Task Force finds that community action is one of the keys to fighting the ice epidemic. Public education about the effects of crystal methamphetamine and the treatment for this addiction, coupled with ongoing community prevention and youth programs are required to divert users and potential users away from the drug and the criminal justice system.

Law enforcement plays a key role in community mobilization efforts. Community policing and community prosecution models appear to be successful partnerships between law enforcement and the community. During hearings, representatives of law enforcement encouraged multidisciplinary approaches to solve the ice epidemic, advocated for more treatment and prevention programs and testified about strengthening community mobilization.

The Task Force strongly supports modest funding for grassroots community efforts to sustain their work. Because of the strong ties between communities and local police, an appropriate source of funding is the forfeiture money received by local police from federal forfeitures. Since police and communities need to work together to identify and dismantle drug houses, use of up to 25 percent of federal forfeiture funds for community mobilization efforts, to be distributed by local government, is appropriate.

Public Education

Three related issues to preventing drug use among students are specific to public education: drug testing, the zero tolerance policy for student drug offenses and training for school personnel.

The current law is zero tolerance for certain types of drug related offenses committed by public school students. Schools may suspend a student up to 92 days for drug related offenses. The community complains that it makes no sense to suspend a child from school for drugs, thereby affording the student more unsupervised time to engage in improper activities. The Task Force agrees that the zero tolerance policy should be revised. The first response to a student drug offense should be to have the student assessed for substance abuse and then referred to treatment as appropriate. The suspension should be held in abeyance during the time the student undergoes

treatment, and rescinded upon completion of treatment.

Some members of law enforcement advocate for mandatory school drug testing, not to punish students but to identify and deter drug users. Studies of the effectiveness of drug testing cut both ways. Some conclude that drug testing deters drug use, others do not. A recent study conducted by the University of Michigan found that drug testing was not a predictor of prevalence or frequency of drug use. Instead, policies that focus on values, attitudes and perceptions were more important in drug prevention than drug testing. (Yamaguchi, "Relationship Between Student Illicit Drug Use and School Drug Testing Policies," Journal of School Health, April 2003)

In Hawai`i, we already know that nearly 50 percent of students have tried marijuana by age 15. We know that an estimated 7,500 students out of 106,861 need treatment for illegal drug abuse or dependency. We also know that treatment reaches less than 2,000 adolescents. One time annual drug testing is not likely to deter drug use or provide any more information in order to conclude that prevention and treatment programs must be provided for adolescents.

Moreover, drug testing is costly. If 25 percent of the student population are tested, the cost will run $37-64 per urinalysis or $50-250 per hair analysis. At a minimum, the cost to run one test for 25 percent of the student population is nearly $1 million. That cost does not include school administration time necessary to obtain parental consent for students under 14 and student consent for those over 14[4], lost school time for testing and training for school officials. Funds are better used for treatment rather than drug testing.

Finally, school personnel must be trained to identify a child who is leaning toward drug use and detect the early warning signs. The 2002 Schools Survey reported that few students who perceive they may have a problem were told to get help. Some witnesses complained that school personnel are not sufficiently trained to recognize these symptoms and refer the student to be assessed. Several testified that the curriculum at the University of Hawai`i does not include sufficient course requirements in substance abuse and addiction for those seeking degrees in education.

FINDINGS

- Substance abuse prevention is a high priority for Hawai`i.

- The State has relied on federal funding to support prevention programs in the past. While such efforts have paid off in terms of the decline in use of hard drugs among Hawai`i's youths, the State must be vigilant in prevention efforts.

- The State's limited financial resources are better spent on treatment and prevention programs for adolescents than mandatory drug testing in the schools.

RECOMMENDATIONS

- The Task Force recommends that the following policies guide funding for substance abuse prevention programs:
  - ❖ Drug education in the schools, school partnerships with community and parents;
  - ❖ Youth activities in the communities;
  - ❖ Families and parenting women; and
  - ❖ Community mobilization.

[4] See, testimony of Jon Van Dyke, September 22, 2003 in which he clarifies the requirements for consent for voluntary drug testing. In summary, Dr. Van Dyke stated that a parent may consent to drug testing of the student who is under age 14 but that parental consent to test students over age 14 is not sufficient.

- The Task Force recommends that $3 be spent on every resident of Hawai`i in new state funding for substance abuse prevention. This is $3.6 million. Every effort should be made to obtain federal funding using state matching funds if necessary.

- The Task Force supports school based prevention programs but does not recommend separate funding for school based prevention programs at this time. The Task Force will await more information from the DOE about its use of existing federal funding and its recommendations.

- The Task Force recommends stable funding for prevention programs, with an earmarked revenue stream in order to ensure long-term funding. Possible revenue streams may include a special tax, a portion of taxes levied on certain consumer items such as alcohol or tobacco or estate taxes. Alternatively, some of the cost savings from government services that are expected to decline due to the effectiveness of treatment and prevention efforts, may be dedicated to prevention programs.

- The Task Force recommends that the zero tolerance policy (Section 302A-1134.6, HRS) be amended to require referral to treatment before student disciplinary action is taken.

- The Task Force recommends that the DOE require all credentialed school personnel to undergo training in identifying risk factors and symptoms of substance abuse and such training be completed within two years for current employees. All new credentialed school employees should receive training within their first year of employment.

- The Task Force strongly supports modest funding for grassroots community efforts to sustain their work. Since police and communities necessarily work together to identify and dismantle drug houses, use of up to 25 percent of federal forfeiture funds for community mobilization efforts, to be distributed by local government, is appropriate.

(This page intentionally left blank)

F. DRUG INTERDICTION IS NECESSARY TO SEND A STRONG NO TOLERANCE MESSAGE TO DRUG TRAFFICKERS, BUT IS INEFFECTIVE TO ABATE THE ICE EPIDEMIC

ISSUE: Law enforcement officials present a united front in asking for specific legislation to assist them in drug interdiction efforts. They argue that Hawai`i must be able to prosecute drug offenders under the same standards as federal prosecutors. They urge changes in the Hawai`i Constitution to permit "walk and talk" approaches to inbound passengers arriving from the Mainland and abroad to determine whether the passenger is carrying drugs on the body. They ask for changes in the laws to ease the process to obtain a search warrant for electronic eavesdropping. Opponents argue that privacy rights must be protected, not to protect the guilty, but rather to protect the innocent. Opponents claim that easing privacy protections to put more people in jail will not stop the ice epidemic because drug organizations will simply find other ways to bring drugs into Hawai`i.

BACKGROUND INFORMATION

Methamphetamine is primarily imported into Hawai`i from foreign countries where it is manufactured, such as Mexico (through California), China, Philippines and Korea. It arrives in powdered form and is converted into crystal form that is smoked through pipes.

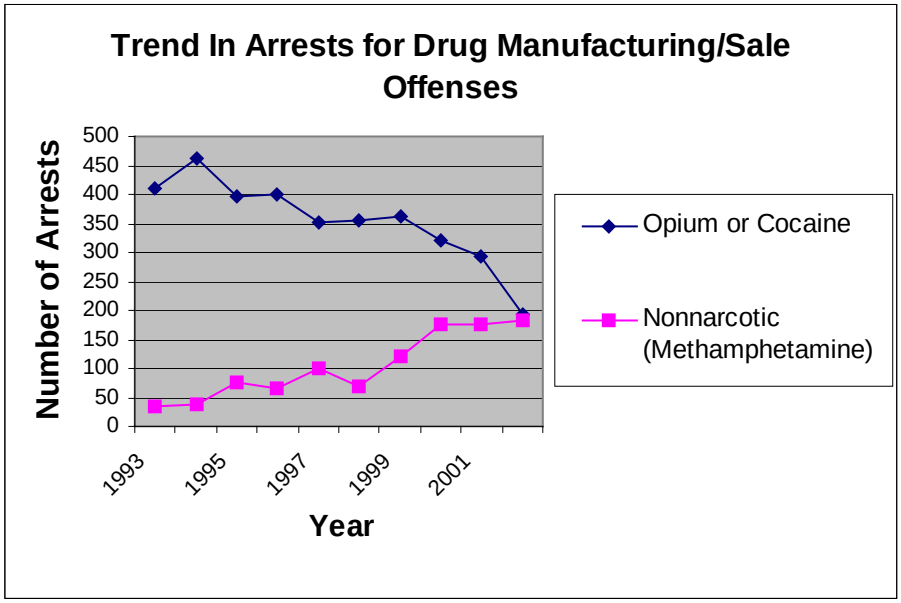
Most of the clandestine meth labs, which have been discovered in Hawai`i, are conversion laboratories that modify powered methamphetamine into crystal methamphetamine. Ice may be manufactured using over the counter, using raw materials and recipes that are readily available over the Internet. In 2001, Honolulu police found seven meth labs, 15 in 2002 and nine in the first six months of 2003. (Lima) Recent newspaper accounts indicate that several meth labs and drug houses have been uncovered in the last few months.

During the period May to December 2002, drug interdiction activities of local, state and federal law enforcement indicated that 70 percent of the activities (i.e. drug buys, buy-busts, search warrants, arrests, surveillance, other field operations) were related to ice. (HIDTA 2004 Report)

Statistics compiled on State adult arrests for drug offenses[5] indicate that ice dominates the drug offenses in Hawai`i. While ice is reported in the broader category of "nonnarcotic" drugs, the significant upward trend in nonnarcotic drug offenses is generally attributable to ice possession. Importantly, as shown on Charts 2 and 3, drug offenses related to heroin and opium have significantly declined over the past ten years, in contrast with ice that is at the highest level in ten years. (Office of the Attorney General State of Hawai`i, Crime in Hawai`i 2002, p. 110) Notably, this trend is primarily influenced by the activities on O`ahu.

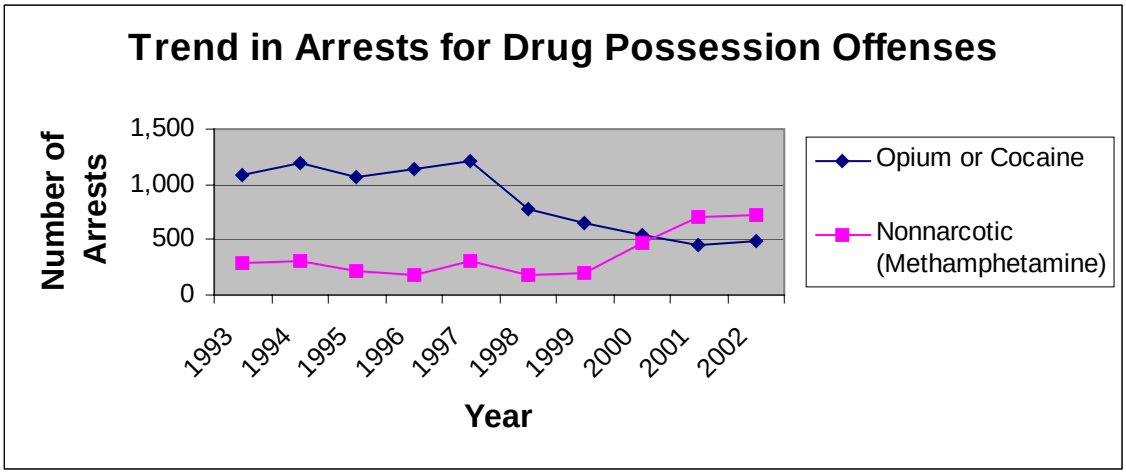
[5] Federal statistics on drug offenses for Hawai`i were not available for this report. State statistics are compiled based on a criminal hierarchy formula, which means that only the most serious offense, when multiple offenses are charged, is reported for the person arrested. Thus, if the arrestee committed a more serious offense such as aggravated assault and was also charged with the lesser offense of possession of ice, only the aggravated assault charge would be reported. Hence, aggregate numbers of arrests for drug offenses are unreliable for a complete picture of the incidences of arrests for drug crimes.

CHART 2:



Source: Crime in Hawai`i 2002, p. 110.

Chart 3:



Source: Crime in Hawai`i 2002, p. 110.

Neighbor island adult arrest statistics indicate dramatic increases of arrests for ice possession commencing in 2000. Prior to that, ice possession was nonexistent or insignificant. (Id. pp. 135, 147, 159)

Since Hawai`i does not compile statistics of drug related crimes, criminal activities that may be related to drug use can only be estimated. For example, law enforcement estimates that 90 percent of the property crimes committed in Hawai`i are due to ice. (HIDTA 2004 Report) Law enforcement officials attribute the high property crime rate to ice abusers trying to find a revenue source to support their drug addiction. (Boylan, "O`ahu Crime Rate Up 16 Percent in 2002, Honolulu Advertiser, October 30, 2003; see also Appendix A, testimony summaries of Kamita, Kubo)

Ice is an expensive and profitable drug for drug dealers and distributors. Prices currently in Hawai`i range from $50-250 per ¼ gram. The price for one pound of

ice ranges from $20,000 to $45,000. Drug prices in Maui appear to be the highest in the state, with Honolulu and Hawai`i County as the least expensive market. (HIDTA 2004 Report) Daily ice consumption in Hawai`i is estimated to be worth at least $5.1 million. (Carlisle, Kubo)

The primary point of entry of ice is Honolulu International Airport. Approximately 80-90 percent of the ice seized in Hawai`i enters the state via Honolulu International Airport through mailed packages and on commercial flights through body carriers. (HIDTA 2004 Report) Since the events of September 11 and the passage of strict laws relating to terrorist activities, including enhanced security measures at airports, the use of body carriers of drugs has declined. (Hayakawa) Federal law enforcement officers have jurisdiction over the airport. Local and State law enforcement officers are deputized as federal agents to assist in drug interdiction efforts at the airport and in joint operations.

Federal law enforcement use a tactic called "walk and talk" at the airports to confront inbound passengers. "Walk and talk" does not require probable cause before an officer may stop a person. Instead, an officer may approach a person without any tangible basis for suspicion that the person may be carrying drugs. Evidence obtained through this tactic is inadmissible for cases tried in state courts. Hawai`i's courts, relying on the State Constitution's privacy protections, have ruled that a "walk and talk" stop is sufficiently intimidating that consent to a search cannot be given voluntarily.

Inbound passengers who may be carrying drugs look like any other inbound passenger. Generally, nothing stands out that would raise suspicion of illegal drug activity. Thus, "walk and talk" stops are truly random, affecting more innocent persons than being used as an effective tool to catch drug carriers. Law enforcement officials argue that this tactic is a tool to deter entry of drugs through body carriers. If so, then this tool which is already available to federal agents who have jurisdiction over airports, has been unsuccessful in preventing ice from entering Hawai`i.

"Walk and talk" will not stop drugs from entering Hawai`i because Hawai`i has so many points of entry that cannot be sufficiently monitored by any reasonable use of law enforcement manpower. Drugs can enter from boats, ships, mail, packages and freight. Sheer volume of mail and cargo that enters the islands makes drug interdiction efforts difficult. (Lima, Derwey) Ice can be manufactured in clandestine labs. While diligent and aggressive law enforcement efforts can discourage drug importation, it will not cut off the flow of drugs into Hawai`i as long as drugs are in demand and highly lucrative to manufacture.

Federal prosecutors also use evidence obtained through wiretaps in drug prosecution. The federal law does not require that a federal judge conduct an adversarial hearing to determine whether probable cause exists to issue a search warrant. Instead, wiretap search warrants are issued based on affidavits. Hawai`i's wiretap law requires an adversarial hearing in addition to affidavits. Thus, arguably, evidence obtained through a federal wiretap could be challenged in State court. State and local prosecutor's seek change in this law so that "down line" drug offenders may be prosecuted in state court if the federal prosecutor declines to take the case. State law enforcement officials also argue that they need to use wiretap for their own investigations. State and local law enforcement officials contend that the adversarial proceeding required for wiretap warrants in Hawai`i is burdensome because of the risk that confidential information or informants may be revealed and this procedural hurdle is not necessary to ensure that a warrant is based on probable cause.

Wiretap search warrants are intended to be used as a last resort when other less intrusive searches or investigation tools are ineffective. 44 states have wiretap laws, including Hawai`i. Six states, Arkansas, Alabama, Kentucky, Michigan, Montana and Vermont have no laws that permit electronic surveillance. (US Courts Wiretap Reports) Wiretaps are very intrusive, not routinely used as an investigation tool and expensive to conduct. In 2002, the average cost of a federal wiretap was $54,000. Wiretaps are used primarily for organized criminal activities related to drugs and money laundering. Over the past five years, federal prosecutors have reported 32 wiretap warrants in Hawai`i, mostly for drug activities or related money laundering. The most extensive wiretap was reported in 2000 that intercepted over 10,000 telephone conversations with 77 persons over 86 days. Of the 10,000 conversations, only 1224 contained incriminating information. The wiretap resulted in 66 arrests, but as of the 2002 report, no convictions had been reported. That wiretap operation cost the taxpayers $456,016. (US Courts Wiretap Report)

The only wiretap warrant reportedly sought by local prosecutors in Hawai`i was in 1997 in an investigation into gambling activities. That wiretap cost $29,000 and intercepted over 600 conversations with 28 persons. Fourteen persons were arrested but only two have been convicted to date. (US Courts Wiretap Report) No person has complained that in the 1997 case, it was unduly burdensome to obtain the warrant or that confidential information was revealed as a result of the adversarial proceeding. A second wiretap warrant was issued in 2003 under Hawai`i's laws but no information is available on that warrant because of the ongoing investigation.

Nationally, federal law enforcement efforts in the drug war cost over $12 billion last year. In Hawai`i, federal and local law enforcement has devoted substantial resources to fight the ice epidemic. The U.S. Attorney's Office conducts most drug prosecutions. Ice-related crimes account for 65 percent of that office's workload. (Kubo) Law enforcement estimates that annual ice consumption ranges from 1,520 pounds to over 47,000 pounds. The annual street value of ice ranges from $30 million to $940 million. Yet, the average annual amount of ice seized by law enforcement is 100-200 pounds annually. (Kubo) Thus, despite the resources allocated to fight the ice epidemic, law enforcement has been unable to curb the appetite for ice in Hawai`i.

In a survey conducted by the Lieutenant Governor's Office, "Hawai`i Drug Control Strategy Summit Pre-Summit Report," out of 224 persons who responded to the survey, 12.5 percent identified issues relating to law enforcement and criminal justice as significant barriers to solving the drug and alcohol problem. However, only one respondent identified search and seizure laws as a barrier to solving the drug problem and no one identified the need to change wiretap laws to solve the drug problem. When asked what laws hinder illicit drug initiatives, only 45 percent of the respondents answered this question. Of those respondents, 4.9 percent identified wiretap laws and 3.6 percent identified search and seizure laws. Thus, it appears that outside of the law enforcement community, public perception does not focus on changes in wiretap and search and seizure laws as the means to solving the drug problem in Hawai`i.

The battle against ice will not be won based on law enforcement efforts, no matter how diligent the effort. It must be attacked on the demand side of the equation. Ice users who create the demand for the drug, do not expect to get caught. They are not deterred by fear of police officers or prisons. They are driven by their addiction. That is not to say that drug distributors and manufacturers who become wealthy off the plight of the addicted should go unpunished.

FINDINGS

- Safety of the people of Hawai`i is the most important objective in the fight against ice. Criminals who manufacture, distribute and push illicit drugs to victimize others must be punished.

- The majority of the Task Force does not recommend a constitutional amendment to permit "walk and talk" at this time. Changes in the law to permit "walk and talk" approaches by law enforcement officers would require an amendment to the Hawai`i Constitution regarding the privacy protections afforded to the citizens of the State. Constitutional privacy protections were enhanced by the 1978 Constitutional Convention, not to protect the criminals but rather to protect the citizens from unreasonable intrusions by government. Federal agents and State and local law enforcement officials deputized as federal agents, already possess the ability to conduct "walk and talk" approaches as part of the drug interdiction efforts. Major drug interdiction efforts are primarily in the hands of federal law enforcement officers because of the federal law violations resulting from transportation of drugs through federal venues, such as mail, freight and interstate commerce. Moreover, the intrusion of innocent persons that may result from curtailing the privacy protections may lead to more erosion into the private lives of Hawai`i's citizens.

- The Task Force is concerned about properly balancing the interests of its citizens to be protected against unreasonable government intrusions with the needs of law enforcement to ensure that drug traffickers are caught and punished. Wiretaps are considered to be the most intrusive of all investigation tools used by law enforcement because the number of communications intercepted regarding private matters are substantially disproportionate to the communications that tend to reveal criminal activities. Prior to issuing this report, the Task Force asked local and federal prosecutors for additional information, which was not provided. The Task Force is willing to consider changes to the wiretap laws. However, further information is required about examples of where law enforcement has lost prosecution opportunities, both in federal "down line" cases and other criminal activities under state or local investigation.

- The use of canine drug interdiction appears to be helpful in detecting drugs in freight and possibly other areas, although odor transference is a problem in accurately detecting drugs on humans and in mail. The cost for canine drug interdiction appears to be modest in relationship to the benefit provided.

- Drug interdiction efforts of the law enforcement community will not solve the ice epidemic in Hawai`i. Such efforts are properly directed to organized criminal activities in drug trafficking and money laundering, not the small time abusers who sell small quantities of drugs and steal to support their addiction.

- While drug interdiction is an important weapon in the war against drugs and necessary to deter drug traffickers from importing ice into and distributing ice throughout Hawai`i, the ice epidemic is a public health crisis and must be fought on that basis.

RECOMMENDATIONS

- The Task Force recommends changes in the law to provide enhanced criminal penalties for harm caused to children exposed to ice in the home, dangers caused by meth labs, operating meth labs near schools and public parks where people are likely to be injured if the lab explodes and distributing drugs to pregnant women. The Task Force also recommends enhanced criminal fines and penalties for drug traffickers and amending the drug paraphernalia laws.
- The Task Force recommends expansion of canine drug interdiction program and recommends additional funding of $75,000 for the Sheriff's Department.

G. THE NEED FOR MORE ADULT SUBSTANCE ABUSE TREATMENT HAS REACHED A CRISIS POINT

ISSUE: Nearly all persons presenting information to the Task Force urged for more funding for treatment services. Many spoke about the specific needs of their communities. Others advocated for specific types of treatment services, such as residential and therapeutic living centers. Some asked for specific programs to meet the needs of women, pregnant women and to be culturally sensitive to Hawai`ians. A few called for more drastic changes in treatment approaches, such as legalization of marijuana or establishment of European drug clinic models. The challenge to the Legislature is to determine priorities for funding with limited resources.

BACKGROUND INFORMATION

An ice epidemic exists. It is a public health crisis. In order to make recommendations for funding additional substance abuse treatment, the Task Force must (1) identify whether a treatment gap for adults exists, (2) determine the services that are currently available, (3) assess what types of treatment services are needed and (4) review current funding sources and future options.

Treatment Gap

Current, credible data on the number of persons needing treatment for ice use and abuse does not exist. Two data sources address treatment needs: State data compiled by DOH/ADAD and federal studies conducted by the SAMHSA of the U.S. Department of Health and Human Services. Both data sources provide some insight but few definite answers, as discussed in detail below. The Task Force echoes the observation made in the 1998 National Drug Control Strategy report which stated that estimates of user populations are imprecise because the illicit drug user is difficult to locate for interviews and hence surveys tend to undercount this population.

SAMHSA recently conducted a first time ever analysis of the "treatment gap" for each state based on the 2000 National Household Survey on Drug Abuse (NHSDA). The report looked only at treatment needs for illicit drug users, but did not break down the users by drug type. In Hawai`i, ***1.73 percent of the population*** who are 12 years or older ***need treatment for illicit drug use and did not receive treatment***. (NHSDA, Table 7) Hawai`i's treatment gap falls slightly lower than the national average of 1.74 percent of the population. Among 50 states, Hawai`i ranks 23rd. This treatment gap means an estimated 16,838 persons who take illicit drugs need treatment and did not receive it, as broken down by the following age groups as described in Table 7 below:

Table 7 Federal Estimates of Hawai`i's Substance Abuse Treatment Gap by Age

Hawai`i Treatment Gap	Total Population	12-17 years old	18-25 years old	26 years, older
Percent of population	1.73%	5.29%	3.80%	0.97%
Estimated population	16,838	5,034	4,375	7,429

Source: SAMHSA "Estimates of Treatment Gap by State," 2000 NHSDA, Tables 6, 7, 8

Although the SAMHSA Treatment Gap report did not break down the affected population by choice of drug, the NHSDA separates users into broad categories of illicit drugs. Unfortunately, methamphetamine is not included as a separate drug category. Hawai`i's drug user population age 12 and older is

estimated to be 75,000 persons. Marijuana is the predominant drug, used by an estimated 59,000 persons. (National Drug Control Strategy, Update 2003, Table 57) Thus, about 1 in 13 persons over age 12 uses an illegal drug in Hawai`i.

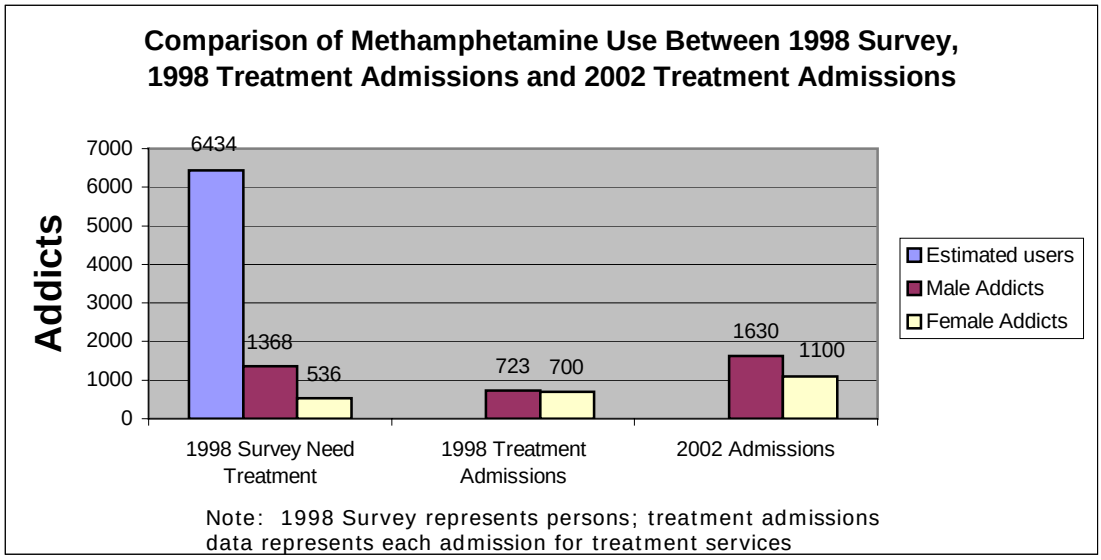
Of significance, in terms of setting funding priorities, the largest substance abuse treatment need exists for the adolescent and young adult population. Not surprisingly, as discussed in more detail below, the young adult population is the most vulnerable to ice addiction. The adolescent population, as discussed under section D. Adolescent Treatment, uses marijuana as the drug of choice.

The most recent state estimates on substance abuse treatment needs are based on the 1998 "Substance Abuse in Hawai`i Adult Population Household Telephone Survey" (hereafter "1998 Survey"). The 1998 Survey warns about undercounting leading to estimates that are lower than actual numbers of persons in need of treatment.

The 1998 Survey estimates that over 82,000 persons over age 18 need treatment for alcohol, illegal drugs or both. About 7,000 need treatment for drug abuse or dependence. Alcohol posed the greatest need for treatment in Hawai`i. Of the illegal drugs, marijuana was the most used drug, followed distantly by crystal methamphetamine. However, the report noted that ice was emerging as a dominant drug of choice, particularly by young male adults, 18-34 years old. The 1998 Survey divided substance abuse into two major categories, i.e. those who used the substance within the last 18 months ("user population"), and those who met the diagnosis of addiction under the DSM-III-R criteria ("addicted population"). The estimates of treatment needs were based on those who met the DSM-III-R criteria for addiction. An estimated 1900 adults were addicted to methamphetamine and in need of treatment. The larger, methamphetamine user population, was estimated at 6,434. Interestingly, the user population was predominantly young men between 18-34 years of age in contrast to the addicted population, which was predominantly men over 35 years of age. Caucasians were estimated to be 38 percent of the user population but 78 percent of the addicted population. Hawai`ians were 22 percent of the user population but none were estimated as part of the addicted population. (1998 Survey, pp. 57-60, Tables 7.2a, 7.2b, pp. 68-69, Table 12.2, p.125)

While the 1998 Survey data is all that is available, it is out of date and inadequate to determine whether any treatment needs of specific segments of the population are under served. Regarding ice addiction, we can assume that the estimated 6,434 ice users for whom publicly funded treatment services were not available in 1998 have now become part of the ice addicted population today. That assumption is based on the scientific research that has evolved since 1998 and anecdotal testimony that ice is not a drug that may be used recreationally without serious physical and psychological effects. This assumption is further supported by the jump in treatment admissions for ice addiction that doubled between 1998 and 2002. See, Chart 4. Both in 1998 and 2002, Hawai`ians dominate the ice addicted population in publicly funded treatment programs. See, Table 8.

CHART 4:



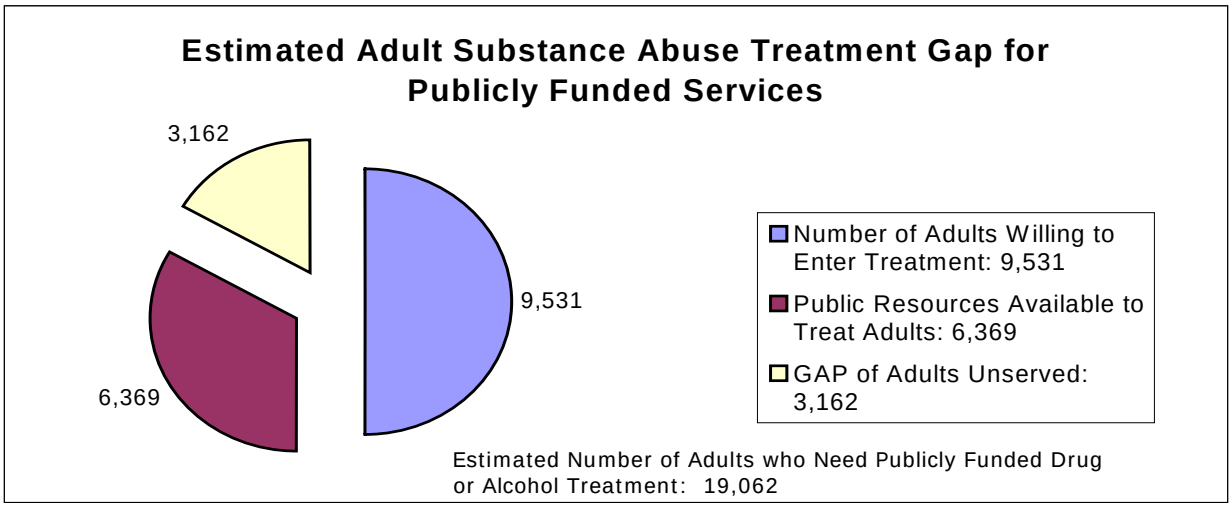
Source: 1998 Survey, Tables 7.2a, 7.2b; DOH/ADAD Admissions Data

Table 8 Comparison of Ice use between 1998 and 2002, by gender and major ethnic categories

Comparison of Methamphetamine use	1998 Survey,est. Need Treatment	1998 treatment Admissions	2002 treatment Admissions
Estimated users	6,434	--	--
Men users	5,137 (80%)	--	--
Women users	1,297 (20%)	--	--
Caucasian users	2,508 (38%)	--	--
Hawai`ian users	1,421 (22%)	--	
Estimated addicts	**1,904**	**1,423**	**2,730**
Men addicts	1,368 (72%)	723 (51%)	1,630 (60%)
Women addicts	536 (28%)	700 (49%)	1,100 (40%)
Caucasian addicts	1,413 (73%)	159 (11%)	369 (14%)
Hawai`ian addicts	0	727 (51%)	1,351 (49%)

Source: 1998 Survey, Tables 7.2a, 7.2b, DOH/ADAD Admissions Data

Chart 5:



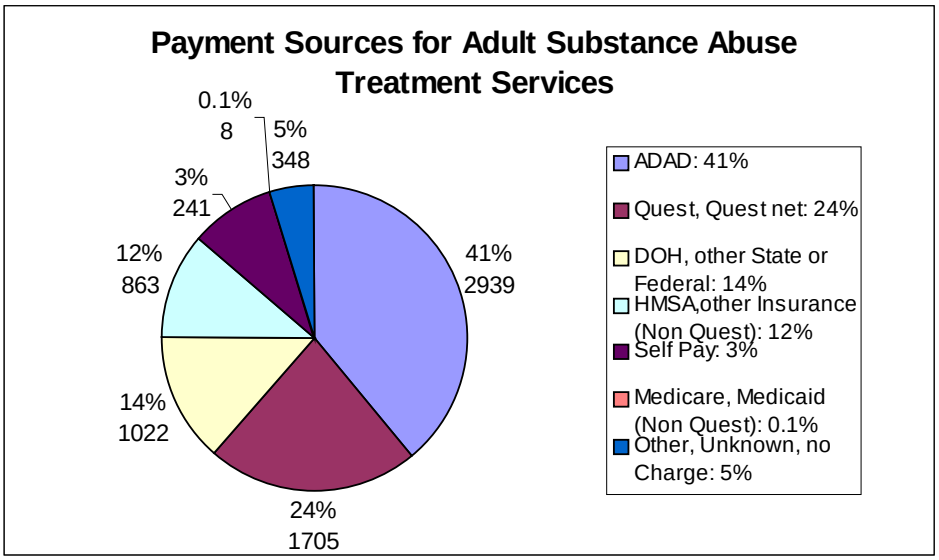
Source: Wilson Testimony, August 27, 2003

DOH/ADAD estimates that the treatment gap for publicly funded services is 3,162 adults per year for alcohol, drug or any substance abuse. DOH/ADAD's estimates are described in Chart 5 above.

Given the low utilization of treatment services paid by private insurance and QUEST, as discussed more fully under section J. Parity for Substance Abuse, there does not appear to be any unmet needs for treatment services from those who have access to private insurance and Quest. Further, based on treatment admissions for FY2002 reported to DOH/ADAD[6], the source of payment for treatment falls disproportionately on state and federal funding through DOH/ADAD. Chart 6 illustrates the sources of payment for adult substance abuse treatment.

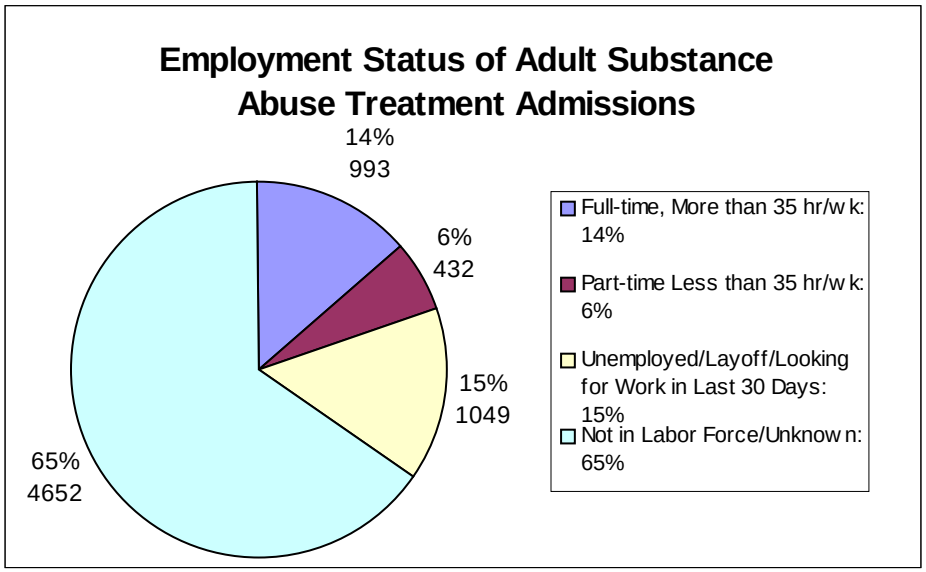
[6] Treatment admission data reported to DOH/ADAD by DOH/ADAD-funded treatment providers includes admissions that are publicly funded as well as privately or self-paid admissions. All of these treatment providers are community based organizations. This data does not include persons who sought treatment exclusively through private practice treatment providers who do not receive DOH/ADAD funding and thus have no obligation to report treatment admissions statistics.

Chart 6:



Based on treatment admissions for FY2002 reported to DOH/ADAD by ADAD-funded treatment providers.
Source: Wilson Testimony, August 27, 2003

Chart 7:



Based on treatment admission for FY2002 reported to DOH/ADAD by ADAD-funded treatment providers.
Source: Wilson Testimony, August 27, 2003

The employment status of those who were admitted to treatment in FY2002 confirms that most persons in treatment require public funding for such services. See, Chart 7. Sixty-five percent of those persons are not in the labor force, and only 20 percent are employed. Most of those who are employed are eligible for treatment through private insurance.

Therefore, DOH/ADAD's estimate of the treatment gap that requires publicly funded services appears to be well founded and corroborated by other data.

In order to respond to various advocates who urge that additional treatment programs should be directed to specific segments of the population, such as pregnant women, mothers with children and Hawai`ians, it is necessary to determine whether such needs exist. Numerous programs already exist and are funded through DOH/ADAD and federal sources to serve these populations. No data exists on the ice user population to suggest that any one group's needs are not being met. However, two segments of the user population, pregnant women and parenting mothers and Hawai`ians stand out as needing more treatment services, as discussed more fully below.

According to the U.S. Census 2000, Hawai`ian and Hawai`ian mixed persons accounts for 23.3 percent of the adult population. (Table DP-1) The 1998 Survey found statistically significant increases in the Hawai`ian use and abuse of alcohol and all illegal substances except cocaine between 1995 and 1998, and dramatic increase in the use of ice. (1998 Survey, Executive Summary, pp. 9,11,14,15,18,21) Ice treatment admissions for Hawai`ians nearly doubled between 1998 and 2002 and accounts for approximately 50 percent of ice admissions during the past five years. Thus, the numbers of Hawai`ians who are affected by substance abuse is disproportionate to their population. In all likelihood this population is under served and, based on undisputed anecdotal testimony, requires culturally sensitive programs in order to achieve successful outcomes from treatment.

The concern for prevention and treatment of pregnant women is not new because the scientific research of the dangers of tobacco and alcohol to the fetus is well known. In 1996, the Hawai`i Department of Health conducted a study of substance abuse and treatment needs of women of childbearing age. The study revealed that most women had used substances that could be harmful to the fetus at some point in their lives, i.e. 84.5 percent of women reported use of alcohol, 67.2 percent used tobacco, 54.9 percent used marijuana and 18 percent used methamphetamine. However, the numbers declined for those whose use met the DSM-III-R criteria for dependency, i.e. 14 percent of women were diagnosed for dependency on tobacco, 3.5 percent for alcohol and 3.9 percent for marijuana. Urine testing of the pregnant women in the study revealed that 12.7 percent tested positive for illegal drugs. ("1996 Blind Study of Substance Abuse and Need for Treatment Among Women of Child-bearing Age in Hawai`i") Based on this study, DOH/ADAD recommended a comprehensive statewide screening and early identification program as part of prenatal care provided to pregnant women. (Statewide Substance Abuse Treatment Plan, January 2000, p. 23)

Dr. DeRauf reported that the prenatal exposure to ice in Hawai`i was 39.9 births per 10,000 births based on a study for the period 1986-1999. In contrast, tobacco exposure was 997 in 10,000 births and alcohol was 138 in 10,000 births. Dr. DeRauf estimates that 170 to 510 births are potentially affected by ice out of 17,000 live births annually.

Also in 2000, DOH/ADAD reported that an estimated 1,539 women with young children in the child welfare system would benefit from specialized substance abuse treatment. The report noted that services were extremely limited. This estimate was based on 3,800 active child welfare cases, of which approximately 45 percent had children under five years of age. DOH/ADAD recommended specialized treatment services for the mother-child dyad at a cost of $6,000 per year for each dyad. (Statewide Substance Abuse Treatment Plan, p. 24)

The DHS reported that currently, over $1 million is allocated to substance abuse treatment for TANF/TAONF mothers and fathers, and more could be made available. While the program is still new, DHS reports that the resources are underutilized. Only 15 persons elected to receive treatment, of which eight report methamphetamine as the primary addiction, and over half of the recipients are Hawai`ian or part Hawai`ian. A possible explanation for the underutilization is the TANF/TAONF program requirements that put the recipient at risk of losing welfare benefits for failure in treatment.

The Task Force recognizes that pregnant and parenting women who are substance abusers pose a particular danger to society. Long-term effects of the mother's ice use and affect on the fetus and newborn have yet to be identified through scientific research. The societal impact of a mother's substance abuse is substantial, such as neglect and child abuse, poor role model and destruction of the intact family. In FY2004, approximately 27 percent of the funding for adult treatment services administered through DOH/ADAD are allocated to pregnant and parenting women's programs. Women account for about 40 percent of the admissions for ice addiction and 33 percent of the admissions for addiction to alcohol or drugs. Many treatment providers report that pregnant and parenting women are given a higher priority for publicly funded treatment services. While the Task Force recognizes that funding for treatment services to this group may be insufficient, it cannot say that the needs of this group have been ignored or unserved within the limited resources allocated to date.

Finally, advocates demand additional treatment services on the neighbor islands. The criminal statistics indicate dramatic and substantial increases in arrests for ice possession since 2000, while arrests for possession of other types of drugs declined. (Office of the Attorney General of the State of Hawai`i, Crime in Hawai`i 2002, pp. 135, 147, 159) Those statistics may indicate a growing treatment need on the neighbor islands. However, most advocates call for certain types of services that are lacking on the specific island rather than for services to a specific characteristic of the gap population. This will be addressed below under Treatment Services.

Findings Relating to the Treatment Gap

- A significant treatment gap exists. The Federal government estimates nearly 17,000 persons need treatment for illicit drug use. State estimates based on the 1998 Survey indicate 7,000 adults need treatment for drug use and over 82,000 need treatment for all substances abused.

- A treatment gap exists for ice addicts. Based on the 1998 Survey, over 6,000 ice users require treatment. In 2002, 2,730 were admitted to treatment. Since the ice epidemic began in 1997 in Hawai`i, it is likely that the numbers of ice abusers requiring treatment has increased. Less certain, however, is whether ice abusers have sufficient awareness of their addiction to seek treatment in the absence of legal sanctions or family pressure.

- 3,162 adults need publicly funded substance abuse treatment services and are not receiving such services. It is not clear whether the adult treatment need includes the 1,500 pregnant and parenting women, but the Task Force assumes it does since the adult treatment need is based on the 1998 Survey that included the needs assessment of pregnant and parenting women.

- Even though the Task Force's mission is to specifically address the ice problem, we note that alcohol addiction continues to pose a serious

problem in Hawai`i and few efforts have been made to address this problem.

- A needs assessment and new survey should be funded to determine the characteristics of the population in need of treatment and whether any specific segment of the population is substantially under served.

Treatment Services

This section focuses on the addiction of crystal methamphetamine, the services provided and identifies the gaps in services, unique to ice addiction.

Treatment for ice addiction

Treatment providers report that ice addicts are the hardest to treat because they are resistant to any form of intervention after the acute effects of drug use have abated. Addicts recover from the acute effects of withdrawal quickly. However, the "wall" period lasts 6-8 months for less severe users and 2-3 years for chronic users. The "wall" is a period where the brain recovers from the changes resulting from ice usage. Some will never recover from the brain damage. Will power alone will not cure ice addiction. Relapse is common. (KCI) DOH/ADAD suggests that effective treatment requires at least three months to one year and should include all aspects of a person's life, medical, psychological, social, vocational, educational, legal and a support system.

The general assumption is that addicts cannot be treated until they are ready to accept treatment. While treatment is most effective when entered into voluntarily, involuntary treatment can also be successful. Indeed, forced treatment, such as Drug Court, is very effective. Most of the recovering addicts reported a series of treatment, relapse and treatment episodes. Those who were involved in the criminal justice system report going through treatment because they would "do whatever it takes" to avoid incarceration, and often followed a cycle of incarceration, treatment, relapse and treatment. Despite the high tendency to relapse, treatment providers and the research conclude that ice addiction is treatable.

There is no one comprehensive treatment program that works for everyone. But many experts conclude that the most effective treatment for methamphetamine is cognitive behavioral interventions to modify thinking, expectancies, behavior and increase life coping skills. No pharmacological treatments for methamphetamine is currently in use, although emergency room protocols call for use of anticonvulsant or antianxiety drugs to deal with symptoms of overdose. Antidepressant drugs may be used for the recovering abstinent addict to help with depression. (Carlton, NIDA)

A continuum of care from prevention, through treatment, to aftercare is needed. Without exception, recovering persons and treatment providers all agree that aftercare and access to clean and sober living situation maximizes successful treatment outcomes. Relapse is highly probable if a recovering addict returns to the same societal environment that led the person to use and abuse ice. Table 9 below describes the drug usage levels and the treatment strategies for each level of use.

Table 9 Treatment Strategies at Different Levels of Drug Use

Usage Levels	Service Strategies
Non Use	Prevention: ➢ Provide information ➢ Develop social skills ➢ Promote alternatives ➢ Affect public policy Train impactors
Experimental use	Intervention: ➢ Identify ➢ Assess ➢ Refer ➢ Case management
Use: Frequent Regular Dependency	Treatment: ➢ Detoxification ➢ Residential treatment ➢ Day treatment ➢ Intensive outpatient ➢ Outpatient ➢ Therapeutic living program ➢ Continuing treatment
Recovery Clean and Sober	Support: ➢ Provide information ➢ Develop social skills ➢ Promote alternatives ➢ Participate in self-help groups ➢ Participate in graduate group ➢ Recovery homes

Source: DOH/ADAD Report to the Twenty-First Legislature 2002, citing Oregon State Office of Alcohol and Drug Abuse Programs, Alcohol & Drug Review, Vol. XI, No. 2, Summer 1991.

Hawai`i's publicly funded drug treatment programs offer the full range of services to meet the severity levels of drug addiction. To the extent service gaps may exist, those gaps appear to be in the availability of services by geographical location and the capacity of treatment programs and whether those who seek services can afford to access such services.

Neighbor island treatment services

The Task Force received extensive testimony from neighbor island residents about the need for certain types of services on their islands, which is summarized in Appendix B of this report. The Task Force recognizes that the neighbor islands do not have the same range of services as offered on O`ahu. For example, Kaua`i, Moloka`i, Lana`i and Hawai`i do not have residential treatment programs. Moloka`i has no detoxification service. Maui needs more residential treatment services and homes for recovering addicts. Big Island needs more therapeutic living services. Many groups advocated for specific resources in their communities. On O`ahu, groups primarily advocated for increased funding to increase capacity in order to meet the demand for publicly funded services.

The Task Force recognizes, that based on the 1998 Survey, Hawai`i and Maui Counties had the largest jump in estimated population needs for treatment for drug abuse between 1995 and 1998. See Table 10 below.

Table 10 Trend in Illicit Drug Treatment Needs by County between 1995 and 1998

Statewide		C&C Honolulu		Hawai`i County		Kaua`i County		Maui County	
1995	1998	1995	1998	1995	1998	1995	1998	1995	1998
1.1%	1.6%	1.0%	1.2%	1.2%	2.5%	1.5%	1.9%	1.8%	2.7%
9,735	13,954	6,635	8,338	1,206	2,494	619	796	1,498	2,326
Treatment needs increased 30%		Treatment needs increased 20%		Treatment needs increased 52%		Treatment needs increased 22%		Treatment needs increased 36%	

Source: Substance Abuse and Treatment Needs: Survey Estimates for Hawai`i (1998), Executive Summary Table 2 (Corrected)

In terms of services, funding and admissions, the Task Force recognizes that neighbor islands need more treatment resources. However, no county has been substantially under served as Table 11 below indicates. Table 11 indicates a comparison of funding by county for FY2004 and the number of ADAD-funded admissions for each county.

Table 11 Comparison of Funded Services and Substance Abuse Treatment Admissions by Neighbor Islands/County

Treatment program Adults (excl. offenders)	State Funds FY2004	Federal Funds FY2004	Total Funds FY2004	Treatment Admissions FY2003
O`AHU				1,242(56.5%)
General	$1,245,628	$ 871,053	$2,116,681	
Nonmedical residential detox	100,000	269,340	369,340	
Homeless treatment		42,000	42,000	
Injection drug user treatment	166,316	119,934	286,250	
Dual Diagnosis	256,091	20,000	276,091	
Pregnant & parenting women & children	862,150	870,119	1,732,269	
Total O`AHU	2,630,185	2,192,446	4,822,631	
MAUI				141(6.4%)
General	152,065	140,543	292,608	
Pregnant & parenting women & children	200,000		200,000	
Total MAUI	352,065	140,543	492,608	
MOLOKA`I				Incl. w/Maui
General	54,547	90,453	145,000	
Total MOLOKA`I	54,547	90,453	145,000	
KAUA`I				115(5.2%)
General	150,278	16,160	166,438	
Pregnant & parenting women & children		140,524	140,524	
Total KAUA`I	150,278	156,684	306,962	
HAWAI`I				698(31.8%)
General	750,695	571,153	1,321,848	
Injection drug user treatment	110,750	79,000	189,750	
Total HAWAI`I	861,445	650,153	1,511,598	
Total STATEWIDE	$4,048,520	$3,230,279	$7,278,799	2,196

Source: Wilson testimony, August 27, 2003, supplemented 10/20/03

A comparison of estimated need versus treatment admissions and funding in Table 12 indicates that no county is substantially under served, although Maui county appears to be served with less funding and admissions in comparison to the estimated need in 1998. Hawai`i County serves a higher number of admissions with fewer funds, probably due to the use of therapeutic living homes rather than residential treatment facilities. O`ahu has the greatest level of services and funding, primarily because of the residential treatment facilities that also serve neighbor island residents. This comparison also highlights the need for better and current data on treatment needs by counties.

Table 12 Comparison of Drug Treatment Needs, Treatment Admissions, Percent of Funding by County

County	Est. % of total who need treatment in 1998 Survey	% of treatment admissions FY2003	% of funding FY2004
Honolulu	59.7%	56.5%	66.1%
Maui	16.7	6.4	8.7%
Kaua`i	5.7	5.2	4.2%
Hawai`i	17.8	31.8	20.7%
Total	100% (13,954)	100% (2,196)	100% ($7,278,799)

Source: Wilson testimony, August 27, 2003, supplemented 10/20/03

The Task Force notes that substantial testimony was received from the neighbor islands regarding the need for two types of services, transportation and clean and sober or therapeutic living homes. These two needs are unique to the neighbor island communities. The Task Force has not conducted an independent assessment on the validity of the need for transportation, but includes findings and recommendations relating to the need for housing below.

Treatment for substance abusers with mental illness disorders

Persons who are diagnosed as substance abusers or addicts often are diagnosed with having a mental illness as well. Some treatment providers report that every addict under treatment is dual diagnosed with a mental disorder. The Task Force primarily received testimony from substance abuse treatment providers, some of which had the medical capacity to also treat persons with co-occurring disorders. The Task Force did not focus on mental health treatment providers who also had the ability to treat substance abuse.

In the Statewide Substance Abuse Treatment Plan, January 2000, DOH/ADAD reports that the co-occurring disorder population is under served. It estimates that about 12,000 persons have serious mental illness and substance abuse disorders. Of that, about 2,000 would need publicly funded treatment, of which 1,200 would be funded through the DOH Adult Mental Health Division. DOH/ADAD concluded that 842 adults with serious mental illness and substance abuse disorders need publicly funded treatment at an estimated cost of $10,000 per person per year.

As indicated in Table 11 above, funding for FY2004 includes approximately $276,000 earmarked for treatment services for the dual diagnosed population. Based on DOH/ADAD's estimated $10,000 per person treatment cost, this means 27 persons are served. However, we assume that those with dual-diagnosis are also served through funding for general treatment services.

The Task Force did not solicit information from DOH Adult Mental Health Division to determine whether any part of the dual diagnosed population is being served through their funding sources. Accordingly, the Task Force is unable to determine whether the dual diagnosed population remains under served. A new needs assessment should include the treatment needs for this group.

Private insurance paid treatment services

Private insurance appears to offer a full range of services to its members, with the exception of residential treatment that is not offered by Kaiser. Advocates complain about Kaiser's decision to treat substance abuse through outpatient sessions. Community advocates also urge extension of private insurance to cover the full continuum of care, including services to meet social, vocational, life coping and housing needs. However, health care insurance is designed on a

medical model and is not intended to cover the full range of social services that a recovering addict may need. For those types of services, the recovering addict must rely on private sources for payment or compete for public resources and meet stringent eligibility requirements. The same holds true for persons eligible for Quest health care benefits, which is based on the medical model. However, Quest members may be eligible for public resources that pay for non-medical services.

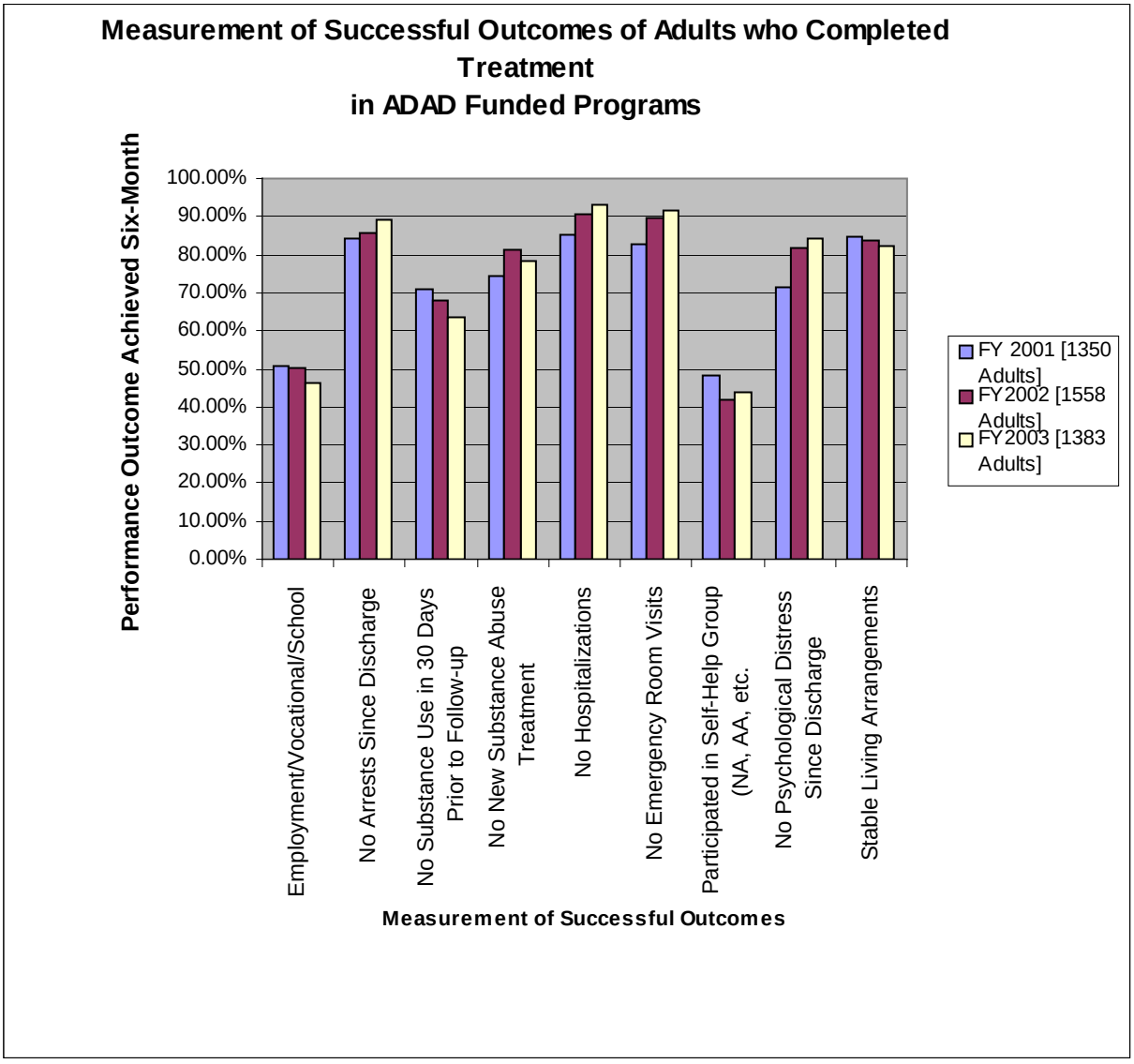
Based on the information available, the Task Force declines to make findings on whether insurance carriers should offer specific treatment services. Moreover, deference must be given to professionals who assess the addict and set the treatment plan. Simply stated, the Task Force cannot determine that where residential treatment is not available, the recovery cannot be accomplished through services that are available, such as outpatient treatment.

Evaluation of treatment outcomes

One major barrier to assess whether one type of service is more effective than others is the lack of consistent evaluation criteria. Few treatment providers maintain consistent and long-term follow up data on patients who complete treatment and leave the program. For example, relapse rate is one criteria that may have a bearing on the effectiveness of a treatment program, although a relapse rate is not the definitive measure of success. However, relapse data is often not available. Even when available, the significance of the relapse rate is questionable because no benchmark is established as indicia for success for any given type of treatment service. For example, would a relapse rate of 30 percent for a residential treatment program mean that this type of treatment is more effective than an outpatient treatment provider who reports a relapse rate of 40 percent?

DOH/ADAD identified nine outcomes that indicate success of treatment. In order to gather this information, DOH/ADAD relies on reports from DOH/ADAD funded treatment providers and surveys of those who have completed treatment in an DOH/ADAD funded program. However, not all DOH/ADAD funded programs compile and maintain this data because some were not able to provide this information to the Task Force. The survey seeks self reported responses to nine questions based on a recovering person's status six months after completion of treatment. Chart 8 below summarizes the responses of those surveyed who completed treatment offered by ADAD funded treatment providers.

Chart 8:



Source: DOH/ADAD Data, Wilson testimony, August 27, 2003, supplemented 10/20/03.

While the data measuring successful outcomes appears to indicate treatment is effective, it is difficult to assess the significance of some of the numbers in the absence of a benchmark goal. For example, less than 50 percent of the respondents reported participation in a self-help group after they completed treatment. Is that a good or bad indicator of success?

Several of the largest community based treatment providers provided the Task Force with data regarding outcomes of persons who successfully completed their respective programs. Outcomes data are included in Appendix A, testimony summaries of Hina Mauka, Sand Island Treatment Center, Ho'omau Ke Ola, Hale `Opio, Big Island Substance Abuse Council, Salvation Army Family Treatment Services, Salvation Army Addiction Treatment Services and Drug Addiction Services of Hawai`i, Inc. The only treatment provider that provided the Task Force with benchmark goal for its adult services programs was Salvation Army Addiction Treatment Services (Salvation Army ATS). The Salvation Army ATS has target goals for each of the outcomes and appears to achieve the targets for every outcome measured. However, the DOH/ADAD composite data reflected in Chart 8 does not contain benchmark goals. It does not appear that DOH/ADAD imposes benchmark goals on each of its contractors, but rather allows each contractor to set their own goals.

One revealing statistic is the number of adults who completed treatment. While the reasons participants fail to complete treatment may vary, the fact remains that a high noncompletion rate exists for most treatment programs. A sample of programs and completion rates is listed below in Table 13. Comparable data is also included in sections D. Adolescent Treatment and H. Offender Treatment.

Table 13 Statistics of Persons who Completed Treatment by Treatment Provider

Provider	Completed treatment	Discharged for noncompliance	Left treatment
Hina Mauka Residential Treatment	60% first time		
BISAC Adult programs	51%		
Ho`omau Ke Ola Residential	41%	30%	14%
Ho`omau Ke Ola Outpatient	45%	36%	19%
Sand Island Treatment, residential	About 50%	25%	25%
Salvation Army Family Treatment	60%		
Salvation Army ATS	46%		

Source: Testimonies of Treatment providers or site visits, as supplemented.

Findings Relating to Treatment Services

- Publicly funded treatment programs cover all the levels of severity of addiction and offer the continuum of care necessary for recovery. In general, Hawai`i's breadth of services to treat drug addiction is adequate and appropriate. The Task Force declines to second-guess treatment providers as to whether one type of service should be preferred over another, such as residential over outpatient services. Instead, treatment plans should be tailored to meet the individual's needs.

- More current information is necessary to determine whether gaps exist in services to specific subgroups. A new needs assessment should be conducted and funding for programs

should be based on the areas of greatest need. The new assessment should cover the treatment service needs for the neighbor islands, the dual diagnosed population and other subgroups as appropriate. In the absence of current information regarding the needs on the neighbor islands and of the dual diagnosed population, the Task Force cannot determine whether these groups are substantially under served.

- The Task Force finds that recovering addicts need clean and sober housing or therapeutic living homes in order to sustain recovery. The need for housing-related programs stems from the concern that the ice addict in recovery needs to be physically removed from the environment that led to the addiction, placed in a structured environment where behaviors can be challenged and abstinence is rewarded. While O`ahu has numerous clean and sober homes, the same is not true for the neighbor islands. Clean and sober homes are independently operated, with little financial support from public resources. Residents of the homes pay rent and provide for their own needs. However, communities raise barriers to clean and sober homes operating in residential areas, such as zoning, concerns about the conduct of the residents and increase in criminal activity. The Task Force finds that efforts should be made to facilitate the ability of organizations to establish clean and sober homes.

- The Task Force finds that insufficient data is collected on the success of treatment programs and recommends that baseline evaluation criteria be developed for treatment programs. Although some agencies appear to set their own goals, there should be some objective measurement to determine the significance of the “successful outcomes” data collected.

Recommendations Relating to Treatment Services

- The Task Force recommends the following actions to encourage the development of clean and sober homes or therapeutic living centers: (1) Urge county governments to amend zoning ordinances to permit up to 10 unrelated persons to reside in a household. This will increase the capacities of clean and sober homes; (2) Consider tax credit or tax deduction for landlords who enter into long-term leases with community organizations that provide housing related services for recovering substance abusers; (3) Enhance existing loan program to provide start up costs for housing-related programs for recovering substance abusers; (4) Explore incentive program for private, nonprofit or for profit organizations to develop housing facilities; (5) Explore conversion or expansion of existing facilities and surplus properties.

Funding for Adult Treatment

DOH/ADAD administers the public funding for substance abuse treatment programs. A comprehensive description of the current services provided through DOH/ADAD is described in the "Report to the Twenty-first Legislature State of Hawai`i 2002 Pursuant to Section 321-195 Hawai`i Revised Statutes Requiring a Report by the Department of Health on Implementation of the State Plan for Substance Abuse" dated January 2002. The types of programs funded through DOH/ADAD for FY2004 are described above.

Over the past five years, state funding for adult treatment services has remained relatively static, around $4 million. Over $4 million of new state money for substance abuse treatment has been earmarked for the offender population, as discussed in section H. Offender Treatment. Federal Substance Abuse Block Grant funds for adult treatment has

increased over the past few years, to $3.2 million for FY2004. Total public funding for community based adult treatment services for FY2004 is $7,278,799. Based on the average cost per admission for the FY2001, 2002 and 2003, the three year historical average cost per admission is about $3,400. (DOH/ADAD data 10/20/03)

While data provided to the Task Force is incomplete, a rough comparison of treatment costs by payment source indicates that DOH/ADAD funded treatment is the most costly, primarily because persons admitted require higher levels of care and longer treatment periods. Table 14 describes the admissions and costs by payment source. Chart 9 graphically compares the average costs for substance abuse treatment by payment source.

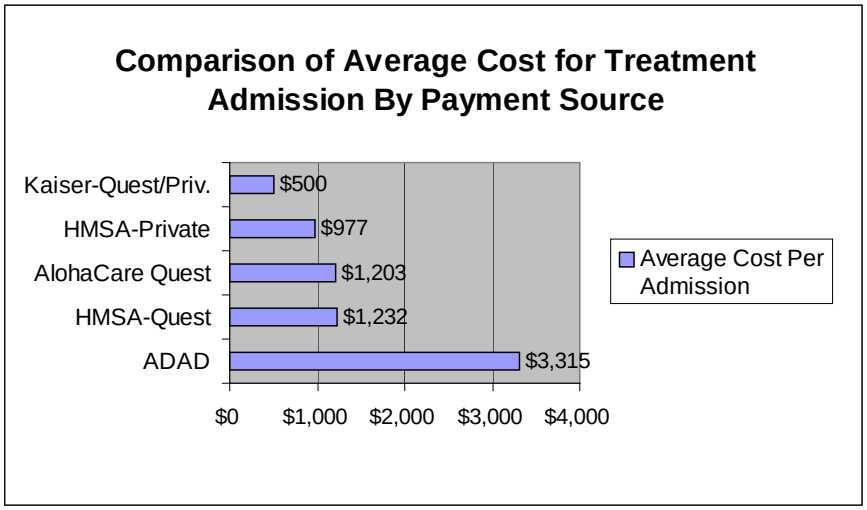
In its Substance Abuse Treatment Plan, January 2000, DOH/ADAD estimated that the per admission cost for adults is $7,000 and $6,000 for parenting women. The Task Force acknowledges that DOH/ADAD's estimates may reflect an ideal approach to treatment services. However, the Task Force finds that based on the comparisons below, a historical basis for treatment costs is reasonable.

Table 14 Comparison of Costs for Substance Abuse Treatment by Payment Source

Comparison of average cost for treatment	HMSA-Private	HSMA-Quest	AlohaCare Quest	Kaiser-Quest/Priv.	DOH/ADAD FY2003
Admissions	2,047	2,029	929	1,000+	2,196
Total dollars for treatment	2 million	2.5 million	1,117,519	500,000	7,278,799
Average per admission	$977	$1,232	$1,203	$500	$3,315

Source: Testimonies of Jennifer Diesman, Doug Althauser, Robert McClay on October 6, 2003, as supplemented; Wilson testimony, August 27, 2003, supplemented 10/20/03.

CHART 9



Source: Testimonies of Jennifer Diesman, Doug Althauser, Robert McClay on October 6, 2003, as supplemented; Wilson testimony, August 27, 2003, supplemented 10/20/03.

Findings Relating to Funding

- Based on the treatment gap of 3,162, including pregnant and parenting women, additional funding of $10,750,800 is needed to close the gap. This estimate is based on a cost of $3,400 per admission.

- Approximately 8,000 admissions to adult treatment are served annually in the nonoffender population for drug and alcohol substance abuses from all payment sources. This accounts for less than 1 percent of Hawai`i's adult population.

- The Task Force finds that the cost of treatment will result in institutional savings in other areas and is money well spent. For example, the savings may be illustrated in the table below.

Adult Treatment	Incarceration	Child Welfare
3,162 additional admissions at $3,400 per admission	If 50 percent diverted from the criminal justice system: 1,581 persons at $30,000 per person	Parenting women treated who might otherwise lose their children: 1,500 women at $14,740 per child
TOTAL COST: $10.7 million	SAVINGS: $47 million	SAVINGS: $22 million

Recommendations Relating to Funding

- The Task Force recommends allocation of $10.7 million for adult treatment services in new state money. The Task Force recommends that women of childbearing age, pregnant women, parents of young children in the home and Hawai`ians receive priority for treatment.

- The Task Force recommends allocation of $150,000 to conduct a new survey and needs assessment of the substance abuse treatment needs of the adult population.

- The Task Force recommends that all possible sources of funding be explored, including the following: TANF, other federal, partnership with Office of Hawai`ian Affairs to serve the Native Hawai`ian population that is disproportionately affected by ice addiction, Rainy Day Fund, increase in alcohol tax, increase in General Excise Tax either statewide or permit the counties to levy and fund their own programs, state estate tax and forfeitures. The federal government announced a voucher program for treatment. The effect of the voucher program on the funding for treatment should be analyzed. An alternative source of funding is the savings resulting from reductions in government services as the addicted population is cured or reduced.

(This page intentionally left blank)

H. TREATMENT SERVICES FOR ADULT OFFENDERS ARE MORE COST EFFECTIVE THAN INCARCERATION

ISSUE: The "treatment versus incarceration" debate produced substantial testimony before the Task Force. At the forefront of the debate was the controversy over the implementation of Act 161, passed by the Legislature in 2002, which diverted nonviolent first time offenders convicted of drug offenses to treatment rather than prison. Less controversial but just as emotional were the community voices that urged expanded treatment programs and aftercare programs for those in prison as a means to reduce recidivism. The discussion below separately addresses the need for treatment for the first time drug offender and the treatment needs for the offender population.

BACKGROUND INFORMATION

After two decades of research, the conclusion is that drug abuse treatment not only reduces drug use but also reduces criminal activity. Treatment works. Even Hawai`i's law enforcement and corrections officials agree and strongly support treatment programs.

One of the most persuasive studies was completed by the State of California, referred to as CALDATA that examined 150,000 participants with follow up for two years. (California Department of Alcohol and Drug Programs, 1994) The study found that the level of crime declined by two-thirds in the year following treatment and continued into the second year. Further, the study concluded that the longer the person remained in treatment, the greater the likelihood of reduced criminal activity. The greatest long-term benefit from treatment came from the most expensive type of treatment, residential treatment. Most significantly, the CALDATA study is widely quoted for its conclusion on the cost benefit of treatment: for each dollar spent on treatment, the savings were $7.14 in future costs, primarily costs avoided due to the reduction in crimes.

To be clear, treatment is not a substitute for punishment. Nor should the focus on treatment be at the cost of public safety. Public support for offender treatment is often at odds with the public's desire to remove the offender from society. However, this desire generally stems not from the need to punish the offender, but rather concerns for safety and to be free from criminal activities. Treatment is a long-term solution for controlling crime. (National Institute of Justice, "The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision," 1995) Treatment is an alternative to incarceration for a large segment of the offender population whose addiction drives their criminal activities, who can benefit from treatment and whose criminal history does not pose a risk to public safety.

Treatment focuses on changing behavior, particularly the cognitive behavior approach. Incarceration does not change behavior and illegal drug use and abuse in prison continues without treatment. Even though treatment in the criminal justice system is not entered into voluntarily, studies show that coerced treatment can be just as effective as voluntary treatment and promotes retention in treatment. (SAMHSA, "Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System," TIP 17, 1995, p. 9, citing research.)

Description of Hawai`i's Offender Population, Overview of Sources of Funding for Treatment of Offender Population

The offender population is divided into four categories based on the agency with supervision responsibilities for offenders at various points within the criminal

justice system, as described in Table 15. First time nonviolent offenders eligible for diversion to treatment under Act 161, SLH 2002 are identified by supervision responsibilities.

Table 15 Categories of Offender Population

Supervising Agency	Description of Offender	Estimated Population
Public Safety, Intake Service Center	Pre-trial offender on **supervised release** pending adjudication.	600
Judiciary, Adult Probation	Sentenced to **probation**, under supervision of the courts, including Act 161 eligible offenders.	15,500
Public Safety, Corrections	**Incarcerated** in jails or prisons	5,500
Hawai`i Paroling Authority	**Paroled** from prison, including Act 161 eligible offenders.	2,600

Source: Statewide Substance Abuse Treatment Plan January 2000 (DOH/ADAD), 2002 Annual Report Edward Byrne Memorial (Dept. Attorney General), Peyton testimony, Hawai`i Paroling Authority information.

No comprehensive data exists on the sources of treatment funding for the offender population. Public, community and faith based organizations and private treatment resources are sources for treatment services. Table 16 below summarizes generally the known sources of public funding for substance abuse treatment services for the offender population.

Each supervising agency has access to funding for substance abuse treatment for the offenders under their supervision. These funds may come from the agency's budget allocation, federal grants, other state or county agencies or community resources, such as faith based organizations. In addition, the offender may access treatment through private insurance, if available, or Quest, if eligible.

Commencing in 1999, a working group of various public agencies developed a comprehensive plan to address the substance abuse treatment needs of the offender population. This plan was presented to the Legislature, referred to as the "Integrated Case Management and Substance Abuse Treatment for Offenders" (ICM) plan. The Legislature responded by initially funding approximately $2.2 million in Act 259, SLH 2001 for the fiscal biennium 2001-2003. Due to budget constraints, only a modest part of the funds were allocated in FY2002, with the full allocation for FY2003. In the ICM plan, the responsibility for assessment, treatment and monitoring of the offender is placed in the hands of the integrated case manager rather than the supervising agency. The integrated concept was intended to provide case management continuity for the offender, regardless of the division of supervision responsibilities between various agencies. The expected target population to be served by ICM is any nonviolent offender over 18 years of age, who is indigent and can benefit from treatment to reduce the likelihood of recidivism.

When the Legislature passed Act 161, SLH 2002, commonly referred to as the "First Time Offender Treatment" bill, it did not allocate funding for substance abuse treatment for those eligible for diversion to treatment. Some of the offenders eligible for treatment received state funded treatment through Drug Courts, ICM and other funding sources.

Table 16	**Funding for Substance Abuse Treatment by**	**Supervising Agencies**	
AGENCY	TARGET POPULATION	SOURCES	FUNDING FY2003
DOH	Any adult, less than 300% of poverty.	State Match, SAPT	Approx. $7 million
DOH	ICM: Supervised release (60), probation (75), furlough (18), parole (88)	State	$2,192,698
JUD/Probation	200 adult felons under supervision	State	1,424,521
JUD/Drug Court – 5th Circuit	10-20 pretrial and post conviction offenders, Track 1, 2, 3	State	235,205
JUD/Drug Court – 1st Circuit	150 pretrial and post conviction offenders, Track 1, 2, 3	State	930,849
		Federal/State match	208,000/52,000
JUD/Drug Court – 2nd Circuit	Pretrial and post conviction offenders, Track 1, 2, 3 and 4	State	283,602
		Federal/State match	57,561/43,171
JUD/Drug Court – 3rd Circuit	50 pretrial and post conviction offenders, Track 1, 2, 3	State	440,832
PSD/Corrections	Kashbox TLC, felons w/in 2 years of release	State	934,000
PSD/Corrections	Crossroads: Parole violators	State	128,000
PSD/Corrections	Incarcerated; contract w/Salvation Army	State	260,000
PSD/Corrections	26 Incarcerated on Kaua`i; contract w/Salvation Army	State	172,207
PSD/Corrections	50 Incarcerated Women WCCC; contract w/Hina Mauka;	State	320,000
PSD/Corrections	TJ Mahoney: 89 incarcerated women, work release; 36 bed transitional	State	900,090
PSD/Corrections	Bridge: 32 beds; Laumaka Work Furlough: 32 beds; WCCC: 15 beds	Federal/State match	443,900/332,900
PSD/Corrections	8 incarcerated women at HCCC; contract w/BISAC	State	248,400
PSD/Corrections	Hawai`i reentry project for serious and violent offenders; 225 adult offenders released from MCCC	Federal	2 million over 3 years
HPA	36 neighbor island parolees	State	170,100
HPA	5 bed supportive living for female parolees on Maui	Federal/State match	83,250/27,750
Offenders	On supervised release or parole who have access to private insurance or Quest	--	--

Source: DOH/ADAD Draft report May 5, 2003

First Time Nonviolent Offenders

Community members, judges and prosecuting attorneys recommend that Act 161 be repealed and that appropriate criminal offenders be referred to the Drug Court for treatment. The objections to Act 161 include concerns about the vagueness of the language, whether the repeat offender is eligible for probation due to prior criminal history and the fact that the Legislature has not funded drug treatment services for those eligible for probation or parole under Act 161. In opposition to the repeal of Act 161, community members advocate for full funding of treatment for nonviolent first time offenders eligible under Act 161. Some express concern that offenders may be incarcerated due to lack of treatment resources.

Act 161

Act 161, SLH 2002 affects three types of offenders:
(1) First time nonviolent offender convicted of drug or paraphernalia possession or use. (§706-622.5, HRS) The offender is placed on probation, contingent on participation in drug treatment. If the offender fails to complete treatment, the offender is returned to the court for sentencing. If the probationer completes treatment, the charges are expunged.
(2) Probationer who is a first time violator of a term or condition of probation involving possession or use of drugs or paraphernalia. The probation shall not be revoked and the probationer shall undergo drug treatment as a condition of continued probation. (§706-625, HRS)
(3) Parolee who is a first time violator of the terms of parole involving possession or use of drugs or paraphernalia. The parole shall not be revoked and the parolee shall undergo drug treatment as a condition of continued parole.

Since Act 161 was not funded, the state agencies responsible for its implementation have scrambled to find resources to pay for drug treatment for those eligible for the program. Some ICM funds were used if the offender was eligible under the ICM criteria.

The Adult Probation Department reports that from July 1, 2002 to October 31, 2003, 190 offenders have been identified as Act 161 sentenced probationers in all circuits. Status information on 181 offenders is described in Table 17 below.

Table 17 Status of Act 161 Offenders in Probation

Known Status of Offenders	Number of clients	Percent of total
Assessed, no treatment	21	11.6
Assessed, in treatment	39	21.5
Assessed, awaiting treatment	14	7.7
Assessed, completed treatment	12	6.6
Pending assessment, processing	21	11.6
Probation revoked, sentenced to prison, missing, new arrest, jail, deported, other legal action	74	40.9

Source: Judiciary, State of Hawai`i, November 2003

The Adult Probation Department's ability to fund treatment services was limited to using existing budgetary resources because Act 161 was not funded. No person who has been placed on probation awaiting treatment has been incarcerated.

Tommy Johnson, Administrator, Hawai`i Paroling Authority, reports that 48 inmates were identified initially as Act 161 eligible and about one-third of those inmates were released contingent on participation in drug treatment. Another third served out their sentences and are out of the system. The final group had their paroles revoked either for new charges or parole violations. Drug treatment services were paid by either the parolee, through DOH/ADAD funds, or from funds allocated by the Department of

Public Safety (PSD). PSD allocated approximately $617,000 for drug treatment and job development services through contracts with Salvation Army, Goodwill Industries, Aloha House, Alu Like, BISAC and Hina Mauka. No person is incarcerated who is eligible for parole under Act 161 due to lack of funding for drug treatment. Johnson estimates that out of 2,600 parolees, about 60 percent have substance abuse problems but the number of parolees eligible for Act 161 ranges between 80-100.

No state agency has data about the cost to provide drug treatment services to Act 161 offenders, the recidivism rates of those who have avoided incarceration due to Act 161 or whether this diversion effort is successful.

Officials in supervising agencies, prosecutors and public defenders note that diversion through Act 161 is an "easier" alternative for the offender than participation in Drug Court because Drug Court has stringent supervision and imposes the sanction of incarceration for failure in treatment.

Act 161 requires a report to the Legislature by the Interagency Coordinating group prior to the 2004 Legislature.

Adult Offender Drug Courts

Drug Courts in Hawai`i appear to be successful in providing alternatives to incarceration. Drug Court is a voluntary program. Table 18 explains the categories of adult offenders served by the Drug Courts.

Table 18 Categories of Offenders in Adult Offender Drug Courts

Category of offender served	O`ahu Drug Court	Maui Drug Court	Kaua`i Drug Court	Hawai`i Drug Court
Pre-trial, arrested; charges dropped for successful completion of treatment; if fails, prosecuted (Track 1, 2)	Yes	Yes	Yes	Yes
Convicted, referred to drug court as alternative to incarceration; successful completion means sentence served; if fails, returns to prison to serve sentence. (Track 3)	Yes	Yes	Yes	Not yet
Act 161: Convicted of first time possession offense, nonviolent, sentenced to probation to undergo treatment if resource available; if successful, record expunged; if fail or decline treatment, court imposes sentence.	No	No	No	No
Paroled, referred to drug court in lieu of return to prison for parole violation. (Track 4)	No	Yes	No	No
Act 161: Probationer or parolee whose probation/parole not revoked for possession/use as first time violation of probation/parole conditions if attends drug treatment.	No	No	No	No

Source: Summarized from testimonies of Judges Marcia Waldorf, Shackley Raffetto, Ronald Ibarra and Administrator Elton Amimoto.

According to the Judiciary, the cost to provide treatment and administer the drug court program is $8,000/year per adult offender, in comparison to $32,000/year for incarceration. (Source: News Release, 8/19/03) In the Judiciary's Annual Report to the Legislature on the Drug Courts, December 2002, the Judiciary reported the information contained in Table 19 below. The cost figures have been revised to reflect current data.

Table 19 Costs and Outcomes for Adult Offender Drug Courts

Circuit	Outcomes	Expenditure	Cost/client
First (O`ahu)	Began 1996. Admitted 551 clients. 315 or 57% graduated. 120 or 22% terminated from program. 16 or 5% of graduates convicted of crimes after graduation. 13 or 10% of those terminated were convicted of new crimes. 160 participants were arrested.	FY02: State: $851,835 Fed: 247,752 Total: 1,099,587	160 clients Cost est. per client= $6,872
Second (Maui)	Began 2000. 183 clients admitted, 144 retained in program, 39 terminated. 58 graduates, 3 were re-arrested. [See Judge Raffetto's testimony for updated enrollment]	FY02: State: $195,686 Fed: 290,862 Total: 486,548 Note: treatment services paid directly by Maui County not included	60 clients Cost est. per client = $8,109 plus unk. Costs
Third (Hawai`i)	Began 2002. Funded for 50, four enrolled. [see Judge Ibarra's testimony for updated enrollment]	FY02: $116,971 State funds	Est. of $8,816/yr per client based on 50 clients, projected $440,832 State funding
Fifth (Kaua`i)	Developmental stage, operational in August 2003	FY02: $28,666 State funds; lapsed funds	Not applicable

Source: Annual Report of Judiciary, December 2002, Supplemented by Judiciary October, 2003.

Findings Relating to Drug Court and Act 161

- Act 161 was intended to remove a nonviolent first time offender from the prison system and provide treatment for the addiction that motivated the criminal conduct. This is a laudable objective that should be retained.

- Diversion to treatment will result in cost savings for incarceration. For example, 39 offenders who are on probation and in treatment could result in savings of $400,000 if incarceration is avoided for six months.[7]

- Treatment through Drug Court programs is more cost effective than incarceration. Graduates of Drug Court treatment programs have low rates of recidivism. While the number of offenders terminated from Drug Court is high, the program successfully graduates more than 50 percent of its admissions. The Task Force is impressed with the judges and their dedication, who supervise these Drug Court programs. Drug Court should be expanded as a diversionary program and challenged to take on the most difficult cases.

- Since the adoption of Act 161, Drug Court has lost some referrals as those offenders opt for diversion under Act 161 rather than the supervision under Drug Court. Since Drug Court appears to have both the ability and experience to handle difficult cases, this should be the first recourse for Track 3 offenders eligible under Act 161.

- While the Family and Juvenile Drug Courts are in their early stages in the First Circuit and in the developmental stages in other Circuits, the success of the criminal offender Drug Courts may be reliable indicators of the success of these new programs. These programs should be supported.

[7] This calculation based on a conservative estimated cost of $15,000 per offender for six months incarceration and $3400 per offender for treatment.

- The Task Force may revise its findings and recommendations pending additional information from the Interagency Coordinating group regarding the implementation of Act 161.

Recommendations Relating to Drug Court and Act 161

- Act 161 should be amended to clear up the ambiguities in statutory language relating to repeat offenders, criteria for eligibility for drug treatment as diversion from incarceration and to permit more discretion by the court in sentencing, including setting the terms of probation.

- Treatment services for offenders eligible under Act 161 should be funded. Using the Drug Court costs for treatment and case management as a benchmark, even if treatment costs were $8,000, this is far less costly than incarceration of $30,000 per offender per year. To the extent that Act 161 offenders pose no public safety risk and can benefit from drug treatment, every effort should be made to divert such offenders into treatment rather than incarceration. The Task Force recommends allocation of $850,000 based on 250 offenders at a cost of $3,400 per offender.

- To the extent that Track 3 first time offenders eligible under Section 706-622.5, HRS, can be appropriately diverted to Drug Court programs, Drug Court should be the first option for the most difficult cases who need more supervision to maximize success in drug treatment. On the other hand, the Drug Court judge may also exercise discretion to refuse the referral.

- The Task Force recommends allocation of $1.2 million to the various Drug Courts to expand their programs, including Family and Juvenile Drug Courts and Track 3 offenders eligible for diversion to treatment under Act 161. This treatment diversion could result in savings of over $1 million if incarceration is avoided for six months.[8]

Treatment Services for Offenders

Drug use and addiction is a significant problem for the offender population. For the probation population, out of 8,723 drug tests administered over a two-year period (1998-99), 28 percent tested positive, of which ice was the most common on O`ahu and marijuana was the most common on the neighbor islands. (2002 Annual Report on Byrne Funds, Department of Attorney General). The PSD reported that, upon entry, 88 percent of the offenders test positive for drug use. Each month, 5 percent of the population is randomly tested, and about 20 percent test positive for drug use. During a recent seven-month period, 373 of 7,456 drug tests were positive, of which 69 percent tested positive for ice. (Peyton) This means that drug use continues even during incarceration.

DOH/ADAD reported statistics on drug use in support of the ICM proposal as follows:

Supervised release: of 600 offenders, 150 (25%) had release status revoked, of which 120 (80%) were drug related.
Probation: of 15,000+, 595 (4%) were incarcerated for probation violations, of which 150 (25%) were drug related.
Corrections/furloughed: no data reported.
Parole: of 1,300, 433 (33%) incarcerated for parole violations, of which 175 (40%) were drug related.
(Report to the Twenty-First Legislature, 2002 Pursuant to Section 32 of Part III, Act 259)

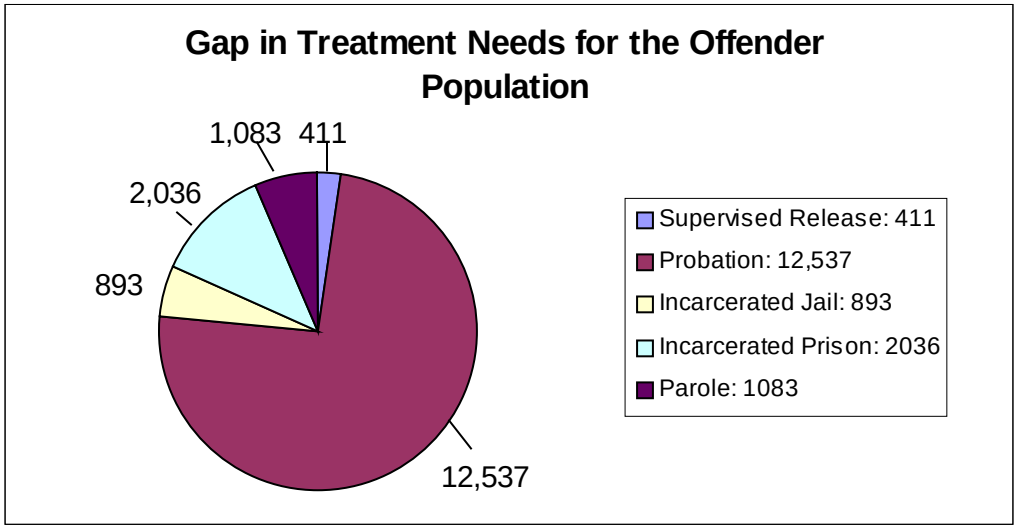
[8] This calculation is based on a conservative estimated cost of $15,000 per offender for six months of incarceration, $1.2 million cost to provide treatment services to 150 offenders in Drug Court.

Table 20 Treatment Gap in Offender Population

	Supervised Release	Probation	Incarcerated		Parole	Total
			Jail	Prison		
Est. Population	600	16,000	1,050	3,234	1,350	22,234
Est. need treatment	420	13,600	893	2,749	1,148	18,810
Treatment services	9	1,063	0	713	65	1,850
Gap	411	12,537	893	2,036	1,083	16,960

Source: Statewide Substance Abuse Treatment Plan, January 2000

CHART 10:



DOH/ADAD's Statewide Substance Abuse Treatment Plan, January 2000 estimated the gap in treatment needs for the offender population as described in Table 20 above.

Chart 10 graphically describes the treatment gap for the offender population by category of the offender.

In 2000, DOH/ADAD and the supervising agencies responsible for the offender population proposed the ICM Plan, described above, and requested $4.4 million to fund the new program. Although this would not meet all the treatment needs, it was proposed as a strong beginning toward solving the problem. The Legislature funded this program in FY2003.

Treatment for offenders is cost effective and reduces infractions of prison rules, violence and criminal activities. Savings produced from reduction of criminal activities and health care costs pay for the cost of treatment programs in two to three years. The higher the investment in rehabilitating the most severe addicts, the greater the probable effects. (National Institute of Justice, "The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision," U.S. Department of Justice, 1995)

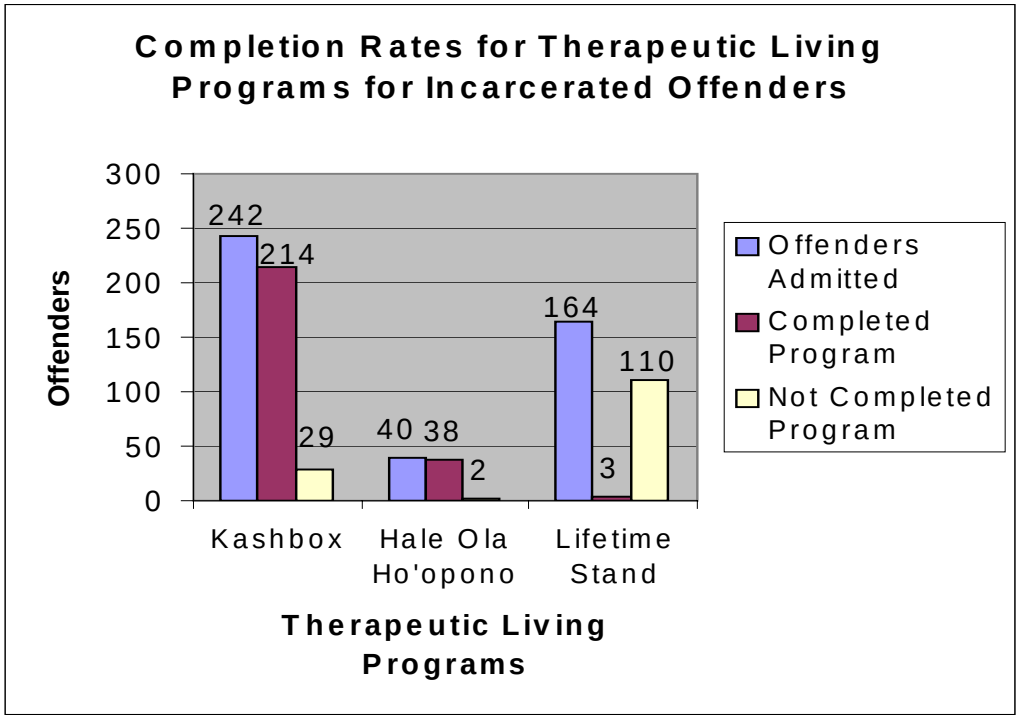
The types of treatment services offered to the offender population who are incarcerated are described in detail in Appendix A, testimony summary of John Peyton and DOH/ADAD's Statewide Substance Abuse Treatment Plan, January 2000.

The Task Force is unable to evaluate the effectiveness of current treatment programs, except for the Drug Court, which is discussed above. For the ongoing treatment programs supported by state funds in Judiciary/Adult Probation, PSD/Corrections and Hawai`i Paroling Authority, no data was provided to the Task Force on the recidivism or successful outcomes of such programs. PSD generally estimates the recidivism rate for the incarcerated population to be 65 percent, but offers no data specific to the offenders who receive treatment while in prison. The Task Force recognizes that recidivism data is difficult to compile on a regular basis when the offender leaves the jurisdiction of the supervising agency.

However, it does not appear that supervising agencies routinely collect data on treatment outcomes in the same way as done by the Drug Courts.

PSD reported that they use a process evaluation of their in-house treatment programs rather than objective measurements. The data for FY2003 in Chart 11 indicates the completion rates for the three therapeutic living programs run by PSD. The completion rates for Kashbox and Hale Ola Ho`opono are high, indicating effectiveness, but that should be expected for such programs with a captive population.

CHART 11:



Source: PSD data 10/21/03

Since the ICM plan has just been implemented, no data has been submitted to the Legislature or this Task Force regarding the success of the program. In DOH/ADAD's 2002 report, it described the objectives of the program. However, the report indicated no baseline criteria upon which the program would be evaluated.

For example, a significant objective is abstinence from drug use, even though relapse frequently occurs. Performance outcomes for that objective is stated as "percent and number of clients reporting use thirty days prior to follow up." There is no established goal to measure at what level this outcome is deemed successful,

such as 100 percent of those completing the treatment would be drug free and 90 percent would be abstinent at 30-day follow up.

In the Drug Court, the goal is stated objectively, i.e. 25 percent of clients who complete treatment will remain drug free at three months after discharge. Except for the goals stated for the Drug Court, the Task Force has not been provided with any other specific evaluation criteria to gauge the success of offender treatment programs. Unfortunately, this vacuum of information casts suspicion on the effectiveness of offender treatment programs.

Recommendations Relating to Offender Population

- As to ongoing funding for treatment programs, the Task Force strongly recommends that supervising agencies develop objective criteria for measurement of a treatment program's effectiveness. Such data should be required for inclusion with budget requests to the Legislature.

- The Task Force supports treatment for the offender population because it will reduce costs for incarceration over the long run and provide positive social value for the community if the offender is able to become a contributing member of the community. For example, the $2.2 million allotment for ICM is expected to serve 241 offenders. The cost saving to avoid incarceration for one year is $5 million.[9] However, the Task Force will await additional reports and information regarding the implementation of the ICM Plan before considering further funding.

[9] Calculation based on estimated cost for incarceration for one year is $30,000. One year incarceration for 241 offenders diverted to treatment is $7.2 million.

I. THE OFFICE OF COMMUNITY SERVICES SHOULD COORDINATE STATE, LOCAL AND COMMUNITY EFFORTS TO FIGHT THE ICE EPIDEMIC

ISSUE: Representatives of community groups, treatment providers, prevention programs, youth activities, local and state government and law enforcement spoke about the need to coordinate services and share information and resources. No one government agency currently performs this function. Some advocate for the creation of a new public office, others for a working group. Last year, the House of Representatives introduced a bill calling for a "drug czar" to lead the effort. Law enforcement officials and the Governor's Office did not support the "drug czar" concept and the concept was removed from the legislation.

COORDINATION IS NEEDED

The Task Force has reviewed a variety of options for coordinating community, government and law enforcement efforts. The Task Force is satisfied with the work undertaken by HIDTA to coordinate federal, local, state and other law enforcement efforts in drug interdiction. This federally funded program cannot be duplicated or replaced by the limited state resources nor has any state or local government agency stepped up to request such responsibility.

The Task Force finds that there is a need to share resources, information and provide technical support to permit communities to maximize resources available. At the local level, the counties of Maui, Kaua`i and Hawai`i have designated point persons to coordinate their efforts at drug abatement. The same coordination is needed at the State level to interface with all government, community and private organizations.

The Task Force recommends that this coordinating responsibility be placed in the Office of Community Services. The purpose of this office is to "facilitate and enhance the development, delivery and coordination of effective programs for those in need and to provide advice and assistance to the agencies of the executive branch, other private agencies in the human services field, and the legislature." (§371K-1, HRS) Among the duties of the Office is to "Assist and coordinate the efforts of all public and private agencies providing services, which affect the disadvantaged,…including…the department of health, the department of human services, the department of labor and industrial relations, and the department of education." The office is also responsible for "maintain[ing] contacts with local, state and federal officials and public and private agencies concerned with planning for the disadvantaged…" (§371K-4, HRS)

The purpose and duties of the Office is well suited to perform the coordination role in the drug abatement efforts because the Office has similar responsibilities. The law mandates state agencies work with this Office (§371K-7, HRS) and encourages county, public and private agencies to work with it as well. In addition, an advisory council for community services is already established to assist with policy and program development. An ad hoc group specializing in addressing problems relating to the ice epidemic may enhance the composition of that council. This ad hoc group would include stakeholders from the community, government health and human services offices, public and private treatment and prevention agencies, corrections, law enforcement, judiciary, employer and employee groups. Thus, since the Office of Community Services already exists within the current infrastructure of the executive branch, there is no need to create a new office.

FINDINGS

- Law enforcement efforts directed at drug interdiction are being coordinated through HIDTA and this appears to be operating efficiently.

- The Office of Community Services is appropriate to coordinate the State, local and community efforts to fight the ice epidemic. DOH/ADAD will maintain jurisdiction over distribution of state and federal funds for treatment and prevention programs since it has the expertise to do so.

RECOMMENDATIONS

- The Task Force recommends allocation of funding to the Office of Community Services to perform the coordination role of $200,000 per year for five years.

- The Task Force also encourages the Governor to review the Office of Community Services' functions to determine whether additional resources may be allocated within the existing budget for the purpose of coordinating the fight against ice.

J. PARITY FOR SUBSTANCE ABUSE TREATMENT DOES NOT CREATE AN UNREASONABLE OR UNACCEPTABLE COST BURDEN ON THE PUBLIC OR PRIVATE SECTORS

ISSUE: Community organizations, treatment providers, employee organizations, state and local government administrators and individuals urge the Legislature to mandate parity for substance abuse health care benefits in insurance coverage. These advocates argue that current coverage is insufficient for the length of treatment needed for recovery of serious ice addiction and for the relapses typically associated with ice addiction. Health plans urge caution, arguing that plan benefits required under existing law are sufficient. Employers are silent on this issue, primarily because most employers elect to prevent or eliminate those with drug addiction from their workforce at the earliest opportunity.

BACKGROUND INFORMATION

Myth and misconception cloud this emotionally charged subject. This report attempts to address the following aspects of the issue: (1) current law regarding substance abuse benefits, (2) the perception that current substance abuse coverage is inadequate versus facts of actual use of substance abuse benefits provided by health plans, (3) what parity means and how other states have addressed the parity issue and (4) the myth that parity will add significant costs to private insurance.[10]

Current Law on Substance Abuse Benefits

In 1974, Hawai`i passed the "Hawai`i Prepaid Health Care Act" (§393-1 et seq., HRS) (hereafter referred to as HPHCA) which, except for minor administrative amendments, has been unchanged since its passage. HPHCA generally requires employers to provide prepaid health care plans to permanent employees who work in excess of 20 hours per week and establishes a formula for the maximum premium contribution an employee is required to pay. State, local and federal government employers are exempt from HPHCA and covered for health benefits under separate laws. In 1976, HPHCA was amended to require substance abuse treatment benefits in prepaid health care plans. However, those provisions were held to be preempted by ERISA.[11]

In 1984, the Legislature passed Act 202, the Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits Act, (§431M et seq., HRS) (hereafter referred to as MHADA) that required insurance health care plans to include mental health and substance abuse benefits in all plans. MHADA established minimum benefits of not less than (1) 30 days inpatient hospital services per year that may be exchanged for two days of nonhospital residential services or partial hospitalization service, day treatment services or outpatient visits and (2) 30 visits per year for day treatment or partial

[10] The 2003 Legislature passed Senate Concurrent Resolution 116 that requires the Auditor to prepare a report on the parity issue, particularly as it applies to mental health but also including substance abuse. That report is due prior to the commencement of the 2004 Session of the Legislature. The Auditor may have more detailed data than that provided to the Task Force. The Task Force reserves the right to amend its report upon review of the Auditor's report.

[11] The Federal Employee Retirement Income Security Act of 1974 (ERISA) preempted HPHCA. Standard Oil Co. v. Agsalud, 442 F.Supp.695 (N.D.Cal. 1977), aff'd, 633 F.2d 760 (9th Cir. 1980), aff'd 454 U.S. 801 (1981). Subsequently, Congress amended ERISA to provide a limited exception from the preemption provisions for HPHCA. However, that exception applies only to the original enactment of the HPHCA in 1974, and minor administrative amendments. Council of Hawai`i Hotels v. Agsalud, 594 F.Supp. 449 (D.Hawai`i, Sep.17, 1984) The provisions relating to substance abuse were amendments to the HPHCA passed two years after its original enactment. Accordingly, the original version of HPHCA as passed in 1974 remains in effect today. Any substantive amendment to HPHCA is subject to legal challenge as being preempted by ERISA.

hospitalization services by a mental health provider. Total benefits for outpatient visits shall be not less than 12 visits per year for substance dependence and 12 visits for mental illness.

MHADA permits the insurer to limit the treatment episodes for substance abuse to two per lifetime, but the same limitation does not apply for mental illness. Further, serious mental illnesses have no benefit restrictions because this condition was afforded parity with medical conditions (Act 197, SLH 2003). Detoxification benefits are not counted as part of a treatment episode but may be counted as inpatient hospital benefits.

The MHADA sets a floor for benefits, not a ceiling. Nevertheless, none of the major insurers provide for substance abuse treatment benefits that exceed the MHADA minimum levels. The MHADA minimum substance abuse treatment benefits apply to private insurance plans.

Of note, the self-funded programs, such as health plans offered by some unions, are not subject to the MHADA but must comply with the HPHCA.

State funds administered through DOH/ADAD provide substance abuse treatment as a last resort for uninsured indigent persons who are not eligible for Quest or subject to a waiting period before Quest benefits are available. DOH/ADAD pays for approximately 41 percent of all treatment rendered by community based treatment providers that serve the uninsured population. Treatment services for this uninsured population are based on contracts between DOH/ADAD and the treatment provider and subject to limitations on service. However, the service limitations far exceed the minimum requirements under a health care plan regulated by MHADA.

Adequacy of Coverage for Substance Abuse Benefits

HMSA interprets the MHADA to mean 30 days of inpatient hospitalization that may be exchanged for two days of outpatient visits for each inpatient day and 12 days of outpatient visits, assuming the patient is not also diagnosed as having a mental illness. The total benefits per treatment episode for substance abuse is 72 outpatient visits. For commercial insurance plans, the member is limited to two treatment episodes per lifetime for substance abuse.

Kaiser interprets the MHADA slightly differently, and reports 84 visits as the maximum outpatient visits if the inpatient hospitalization is exchanged for outpatient visits. For commercial insurance, Kaiser limits the member to two treatment episodes per lifetime for substance abuse.

Kaiser, HMSA and AlohaCare contract with the State to provide health care to Quest eligible members. Under the contract, Quest members are afforded the minimum coverage required under the MHADA for substance abuse. However, there is no lifetime limitation on the number of treatment episodes for Quest members, although Quest members are limited to one treatment episode per year.

The issues raised relating to adequacy of coverage are: length of treatment and residential treatment and the lifetime cap for private insureds.

Health care insurance plans are not required by law to provide residential treatment. The State does not require residential treatment benefits under the Quest contracts. Kaiser decided recently that it would not contract with and refer its members to residential treatment. Instead, Kaiser concluded that outpatient treatment would be effective in treating substance abuse. AlohaCare provides residential treatment to Quest members only when medically necessary and if alternative funding is available. But

AlohaCare limits residential treatment to 1-5 days. HMSA provides medically necessary residential treatment. Health care insurers disagree with community treatment providers on whether residential treatment is a "medical" model or "medical-social" model. Yet, treatment providers and research indicates that for the seriously addicted person, residential treatment increases the chances of success in treatment.

The limitation of two treatment episodes per lifetime does not appear to be a substantial problem for those receiving substance abuse benefits under private insurance. As indicated in Table 21 below, few members reach the lifetime cap and those members represent an insignificant percent of the member population of the health plans. Nevertheless, even though such numbers are small, for those who need treatment, they are likely to be denied access under their private insurance plan. The ice addict in particular, with high relapse occurrences, may be foreclosed from treatment under a private plan.

Table 21 Comparison of Costs to Provide Members with Substance Abuse Treatment under Private Health Plans and Quest

	HMSA	KAISER	ALOHACARE
Private Plan			
Total number of members	552,992	200,000	Not applicable
Total benefits paid for all members	$805 million		Not applicable
Number of members provided substance abuse benefits	2047 (.37%)	250+	Not applicable
Total benefits paid for substance abuse treatment	$2 million	$500,000 (private and Quest)	Not applicable
Number of members who reached lifetime cap	167 since 1998	40	Not applicable
Number of members who reached maximum benefits per treatment episode	None in last 15 months	Information not available; average length is 36 sessions over 5 months	Not applicable
Substance for which treatment sought	34% alcohol; 15% dual diagnosis; 14% tobacco, 11.5% misc. drugs; 10.6% amphetamine.	O`ahu: 75% ice Maui: 50% ice	Not applicable
QUEST			
Total number of members	72,051		43,000
Total benefits paid for all members	$94 million		
Number of members provided substance abuse benefits	2029 (2.82%)	750+	926
Total benefits paid for substance abuse treatment	$2.5 million	$500,000 (private and Quest)	$1,117,519 (1.5% of all benefits paid)
Number of members who reached maximum benefits per treatment episode	None in last 15 months	Information not available; average length is 36 sessions over 5 months	4
Substance for which treatment sought	29% alcohol; 23.4% amphetamine, 10% misc. drug.	See above.	

Source: Testimonies of Jennifer Diesman, Doug Althauser, Robert McClay, October 6, 2003, as supplemented.

The issue of length of treatment is controversial because many community based treatment providers insist that ice addiction is difficult to treat within the coverage limits of 72 or 84 sessions, or for 30 days of residential treatment followed by 12-24 outpatient visits. DOH/ADAD claims that ice addiction, depending on

the severity, requires at least 90 days in treatment.

However, as indicated in the chart above, HMSA claims that no private plan or Quest member reached the maximum benefits per treatment episode. Kaiser claims that its treatment is effective under the current coverage limits, with the average length of treatment being 36 sessions over five months. This data is consistent with the data reported to the DOH in 1998 by the two largest health plans in the State, i.e. a very small percentage of members utilize the maximum benefits allowed. (A Report to the Governor and the Legislature of the State of Hawai`i, "Evaluation of Mental Health, Alcohol, and Drug Abuse Treatment Insurance Benefits Under Chapter 431M, HRS," January 1998, p. 78, 83)

Since the two largest insurers that provide both private and Quest benefits insist that coverage limits are reached by only a small percentage of members, then it would appear that current laws do not impose barriers to substance abuse treatment. Indeed, the Legislative Auditor reached that conclusion in her 1997 report, "Current utilization of mental health and substance abuse services is low and even fewer employees using services up to the maximum allowed benefits....In light of the low demand...and low utilization under the coverage currently available, we conclude that mandating parity in coverage for all mental health and substance abuse services is not warranted at this time." (Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits, Report No. 97-19, December 1997, pp. 15-16)

However, low utilization does not end the parity discussion. Compelling and troublesome reasons explain why only 8,000 persons are treated under the State's largest health care plans when an estimated 80,000 persons need treatment for alcohol or illegal drug abuse.

In private plans, low utilization and length of treatment is generally attributed to the fact that employees who are the most seriously affected by substance abuse lose health care coverage when they lose employment. Job loss causes private plan members to terminate treatment prematurely. Parity will not cure this problem. (Sturm, Roland, Testimony on "Effects of Substance Abuse Parity in Private Insurance Plans Under Managed Care," Rand Health, October 1999) Other explanations for why health plan data indicates low numbers of members are treated for substance abuse: employees with illegal drug abuse problems tend not to seek treatment under their insurance for fear of disclosure and having a record of illegal drug use, treatment is sought from self help groups such as NarcoAnon, treatment providers code services as medical rather than substance abuse, and treatment providers fail to diagnose the condition as substance abuse due to a patient's denial of illegal drug use. Low use of benefits by those who seek substance abuse treatment tends to be attributed to inability to participate in cost sharing or co-payments. (Stein, Bradley, "Drug and Alcohol Treatment Services Among Privately Insured Individuals in Managed Behavioral Health Care," Rand Graduate School Dissertation, December 2002)

Even though utilization in private plans is low, the numbers are not expected to substantially increase, even with parity. Based on a survey conducted by the DOH in 1998, only 7 percent of the respondents reported that any family member ever used substance abuse or mental health treatment services under their health care plans. (A Report to the Governor and the Legislature of the State of Hawai`i, "Evaluation of Mental Health, Alcohol, and Drug Abuse Treatment Insurance Benefits Under Chapter 431M, HRS," January 1998, p. 102)

Some of these reasons may also explain the low utilization for the Quest plans, i.e. fear of disclosure, self help groups,

provider coding, and failure to disclose illegal drug use.

Finally, proponents of parity contend that the reason that maximum benefits are not reached has to do with managed care by the health plans. Health plans disagree, and argue that all medically necessary services are provided. While managed care could explain in part why few members reach maximum benefits or the lifetime cap on treatment episodes, it would not explain the low numbers who seek treatment.

Defining Parity and Parity Laws of Other States

Generally, parity means that substance abuse is treated equally with any other medical condition under health care plans. (SAMHSA, "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits," 1998, Executive Summary, p. 1) In Hawai`i, health care plans generally provide the minimum level of substance abuse benefits required by law as discussed above. The Quest plan follows the same minimum requirements except for the lifetime caps on treatment episodes. Substance abuse treatment benefits are not on parity with medical services benefits under any plan in Hawai`i. Further, substance abuse treatment benefits are not on parity with serious mental illness that has no benefit restrictions nor any mental illness that has no lifetime cap on treatment episodes.

Some treatment providers report that most, if not all, persons with substance abuse problems are dual diagnosed with a mental disorder as well. Thus, as a practical matter, if a person with a co-occurring disorder that meets the definition of serious mental illness and substance abuse, then the benefit minimums in health plans should not restrict treatment. Nevertheless, some confusion and ambiguity may exist on this point and should be cleared up through changes in the Section 431M, HRS.

The National Conference of State Legislatures reports that only six states require substance abuse to be on full parity with other physical care services in terms of scope of inpatient and outpatient treatment, residential treatment, co-payments, lifetime and dollar limitations. Those states are Connecticut, Delaware, Minnesota, Vermont, Virginia and West Virginia. ("Substance Abuse Parity: State Actions, National Conference of State Legislatures, December 2002) Indiana passed a bill affording full parity for substance abuse treatment that was signed into law in May 2003. North Carolina and South Carolina have parity for substance abuse in the state employee's health plan only. Fifteen other states require minimum mandated benefits for substance abuse, as does Hawai`i. The Federal Employees Health Benefit Program implemented full parity for substance abuse benefits in 2001.

Costs for Parity are Insignificant

A study conducted by SAMHSA in 1998 effectively dispelled the notion that parity will mean unreasonable or unacceptable increases in insurance premiums. (SAMHSA, "The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits") The study concluded that (1) state parity laws have small effect on premiums, especially in tightly managed care systems, (2) costs have not shifted to the private sector because most people who receive public funded services are not privately insured and (3) **full parity for substance abuse benefits will increase premiums an average of 0.2 percent**.

The cost implications for parity in private insurance for the major health care plans in Hawai`i are minimal. A detailed analysis is not possible because each of the plans provided different and limited information. Kaiser expects the loss of revenue that would have to be recovered due to parity is $100,000. If allocated among its 200,000 members, this would represent 50 cents per member per year.

HMSA, which provides health insurance for over 600,000 members, nearly 50 percent of the population of the State, indicates that less than 1 percent of its members received substance abuse benefits during a recent 12-month period. Out of almost $900 million in benefits paid, only $4.5 million or 0.5 percent was paid out for substance abuse treatment during the same 12-month period.

AlohaCare provides Quest benefits to 43,000 members, of whom 2 percent were treated for substance abuse in the last benefit year. The costs paid for substance abuse treatment services equaled 1.5 percent of the total costs paid for all benefits for its members. Notably, 60-70 percent of this population is diagnosed as having co-occurring mental illness, and if seriously mentally ill, may not be subject to benefit limitations.

Thus, the effect of parity on the insured population, particularly those under private insurance is expected to be insubstantial due to low utilization. The effect of parity on the Quest plans is expected to be higher, but not at an unreasonable or unacceptable level.

FINDINGS

- The lifetime cap should be removed because only a small number of members reach it for substance abuse treatment under private insurance. However, those who reach the lifetime cap are likely to need services the most. The same lifetime cap does not apply to mental illness, creating a disparity between mental illness and substance abuse treatment.

- At a minimum, serious substance abuse should be afforded parity with serious mental illness. Ideally, full parity should be afforded to substance abuse since the Legislature has already concluded that substance abuse is an illness.

- For the private plans, low utilization of substance abuse treatment services suggests that costs for parity will be insubstantial. Low utilization is due primarily to job loss resulting in the loss of insurance coverage, but also due to stigmas associated with illegal drug use. Parity is not expected to increase the utilization resulting in substantial cost increases for private employers.

- For the Quest plans, utilization is higher than that of private plans, but is still low, relative to the Quest population. Costs for substance abuse treatment is also low relative to the total costs of benefits provided. Hence, parity is not expected to cause a significant increase in this state-funded program.

- The Task Force makes no findings on the effect of managed care on determinations of medically necessary treatment.

RECOMMENDATIONS

- The Task Force recommends that the Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits, Section 431M et seq., HRS, be amended to remove the benefit restrictions and lifetime cap on the number of treatment episodes for substance abuse treatment. This will eliminate the current disparity between substance abuse treatment benefits and mental illness treatment benefits created when the Legislature passed Act 197, SLH 2003.

K. WORKPLACE DRUG USE SHOULD NOT BE TOLERATED AND EMPLOYERS SHOULD INSTITUTE PREVENTION AND EARLY INTERVENTION PROGRAMS FOR EMPLOYEES

ISSUE: Employers and unions agree that drug use in the workplace is a problem. It has a detrimental effect on productivity, employee morale, safety and trust. They disagree on the method to ensure a drug free workplace. Employers adopt a zero tolerance policy with termination of employees who test positive for illegal drug use. Unions urge that employees should be permitted to enter treatment before faced with job loss.

BACKGROUND INFORMATION

According to the 2002 National Survey on Drug Use and Health sponsored by the SAMHSA, 74.6 percent of illicit drug users are employed either full-time or part-time. However, the rate of illicit drug use is higher among those who are unemployed than those who are employed. There are no statistics for illicit drug use broken down by employment status for Hawai`i. Thus, no specific conclusions can be reached about the magnitude of illegal drug use among Hawai`i's employed population. However, the Task Force received factual information from two sources, DOH/ADAD and the two largest drug testing laboratories in Hawai`i that shed light on workplace drug use.

Admissions data provided to DOH/ADAD by ADAD funded treatment providers[12] for eleven months in FY2002, indicates that 20 percent of treatment admissions for alcohol or drug abuse are employed. This number could be significantly higher because the admissions data reported tends to be skewed by the unemployed population who qualify for Quest or ADAD funded treatment services based on indigence status.

According to data provided by Diagnostic Laboratory Services, of the 40,000 drug tests administered to employees or applicants during an 18-month period, about 4.2 percent tested positive for marijuana and 3 percent tested positive for methamphetamine. Clinical Labs of Hawai`i reports that of 60,000 tests administered to employees or applicants during an 18-month period, 2 percent tested positive for methamphetamine[13].

Compared to national test results data, Hawai`i's workplace drug use is higher. Based on 7 million tests for calendar year 2002, 4.4 percent tested positive for illicit drugs. Of the general U.S. workforce, 0.34 percent tested positive for amphetamines and 2.96 percent tested positive for marijuana. Nationally, methamphetamine positive test results increased by 70 percent over the past five years. (Quest Diagnostics Inc. Drug Testing Index 2003)

Therefore, based on this limited data and anecdotal testimony, it appears that illegal drug use exists, probably at higher rates than the national rates, among Hawai`i's employed population. While marijuana is the drug of choice for Hawai`i's employed users, methamphetamine use is significantly higher in Hawai`i than national use.

The employers' response to drugs in the workplace appears to be primarily punitive and zero tolerance. Testimony from employers and unions indicate that preemployment drug testing is widely used to screen illegal drug users from

[12] DOH/ADAD funded treatment providers may report on treatment services that are paid by a health insurance carrier and private sources, in addition to Quest, Medicare/Medicaid and DOH/ADAD funds. Since DOH/ADAD funded treatment providers tend to serve persons who are eligible for Quest or DOH/ADAD funded treatment, we can expect that most admissions would be unemployed in order to meet the income eligibility requirements for those treatment payment sources.

[13] Clinical Labs did not provide data on positive tests for other illegal drugs.

employment. Employers believe that this tactic is necessary to reduce drug use in the workplace. No testimony was received suggesting that legislation should be enacted to control or limit the employer's ability to conduct preemployment drug testing.

Under a zero tolerance policy, employers terminate an employee who tests positive on a drug test or is found to be impaired by or under the influence of drugs. Some employers have a "two strikes" policy that permits an employee to seek treatment through an employee assistance program for the first violation of the zero tolerance policy, provided the employee submits to random testing. If the employee tests positive for a second time, the employee is terminated. Unions complain that a "two strikes" policy is too harsh, especially for the ice abuser because of the tendency for relapse. One union testified that no employee had ever successfully completed treatment under a "two strikes" policy. As a result, the terminated employee is unable to continue treatment because of loss of financial support, which in turn pushes the person back into the spiral of drug dependency.

Employers urge for the unrestricted ability to conduct drug testing and to terminate an employee upon a positive test result. Employers claim that drug testing improves safety and productivity and leads to fewer workers' compensation claims.

One employer group asks for legislation to permit hair testing because hair testing is less intrusive. However, it is not authorized for use for workplace drug testing by the federal government in mandated testing programs. Hawai`i laws only permit urinalysis testing.

Hair testing is helpful to an employer who has a policy of terminating an employee for any illegal drug use, regardless of whether such use results in job impairment or affects the workplace. Hair testing, which can indicate drug use at any time over several months, does not tell how much of an illegal drug a person has used or how long ago the drug was used. Hair testing can report a false positive if the hair sample is touched by something that contains a drug or if the person inhales second hand smoke of a person who smoked marijuana or cocaine. (Quest Diagnostics Hair Analysis, November 27, 2002) Thus, hair testing will reveal illegal drug use but may not be sufficient to demonstrate current impairment or being under the influence of drugs. Hair testing has one other drawback. Recent studies indicate that hair testing has a disproportionate impact on black-haired persons, such as Asians, because dark hair more readily stores up drugs for longer periods of time. The black hair contains higher concentrations of melanin pigment that is particularly attractive to chemicals. Thus, persons with blonde or red hair are more likely to avoid detection through hair testing and Asians are more likely to be caught. (Marcus, "Fair Tresses Hide Drug Excesses," HealthSCOUT, March 17, 2000)

Unions urge for more employer compassion, more treatment resources through health plans and more intervention and prevention programs in the workplace.

Community organizations and persons testified about the difficulty of recovering addicts to find employment in order to put their lives back on track. One business testified about its program, in partnership with a community treatment program, to hire persons in treatment and recovery. That business did not terminate the employee upon relapse because they understood that relapse can and does occur as part of the recovery process.

FINDINGS

- Employers are required to provide a safe workplace and need to operate under conditions to maximize business objectives. Employee drug use in the

workplace undermines business objectives and should not be tolerated.

- The Task Force is concerned that employers who simply eliminate the problem employee from the workplace ultimately shift the problem to the taxpayers to bear the societal consequences of an unemployed drug user, such as increased criminal activity, burden on public resources for welfare, health care and treatment and impact on the family. The Task Force finds that employers must partner with government and the community in solving the ice epidemic.

- While employers have policies to deal with punishment for drug use by employees, and some even have policies that encourage employees to seek treatment, few employers have prevention or early intervention programs. The Task Force has previously found that prevention and early intervention programs are the key to abating the ice epidemic.

- Hawai`i's limited job market requires special attention to ensure that Hawai`i's residents are fully employed while still meeting the staffing needs of Hawai`i's businesses. A growing unemployed population who are victims of the ice epidemic does not serve the public interest.

RECOMMENDATIONS

- The Task Force recommends that employers with more than 15 employees be required to provide three hours of mandatory drug education and awareness each year to its employees.

- The Task Force recommends a tax credit of $250 for employers who institute drug prevention and education programs for their employees.

- The Task Force recommends a tax credit for employers who partner with community based treatment organizations to provide jobs for those in recovery who maintain a clean and sober lifestyle.

- The Task Force recommends that private sector employers be required to maintain health insurance benefits for three months that provide substance abuse treatment for an employee who is terminated for impairment of performance due to substance abuse or working under the influence of drugs, provided that the employee is otherwise eligible for health insurance benefits under the employer's policies. Excluded from this requirement are employees who are terminated for sale, distribution or manufacture of illegal drugs at the workplace, who are terminated due to the inability to work because of arrest or conviction for criminal activity relating to the sale, distribution or manufacture of illegal drugs or who are terminated for theft, violence or safety reasons, even if such actions are related to the drug use. This requirement would apply to employers with workforces of 25 or more employees. Employees eligible for continued benefits would have to be employed for more than one year or who have completed the probationary period. Excluded from this requirement are employees who are subject to federally mandated drug testing programs and those who hold management, safety-sensitive or trust positions.

(This page intentionally left blank)

L. THE ENVIRONMENTAL EFFECTS OF THE MANUFACTURE OR CONVERSION OF METHAMPHETAMINE ARE UNKNOWN AND SHOULD BE STUDIED AND ANALYZED

ISSUE: The nature and extent of the impact of the manufacture of crystal methamphetamine on Hawai`i's environment is unknown.

BACKGROUND INFORMATION

In the last three years, the Honolulu Police Department uncovered at least 31 clandestine laboratories. Hawai`i and Maui County police also discovered several clandestine laboratories. HIDTA reports that the number of clandestine laboratories operating in Hawai`i is significantly undercounted due to the lack of training as to what constitutes a clandestine laboratory. While some of the clandestine laboratories are involved in the production of methamphetamine, most labs are conversion labs that convert the powdered form of methamphetamine to crystal form. HIDTA reports that production labs are believed to be less prevalent in Hawai`i because of the difficulty of obtaining the precursor chemicals needed to manufacture methamphetamine.

When the Task Force attempted to ascertain what, if any, information was being collected or maintained about the hazardous and toxic materials from clandestine laboratory sites and the disposal of such materials, it discovered that little information existed. Apparently, no data or analysis has been conducted by any state, federal or local government office about the effects of the toxic materials on the environment.

Waste materials produced from clandestine production laboratories contain 70 hazardous byproducts, some of which are heavy metals that never degrade. For every pound of methamphetamine manufactured, five pounds of toxic mixed waste is produced. (Li, Kamita) This waste is not controlled and is disposed by dumping in the ground or flushing into the sewer system. Toxic vapors are also produced, affecting air quality. Meth labs have been discovered everywhere, in hotel rooms, vehicles, residences, open areas and any structure. (Kamita) Contamination exists at the site, in the air, the ground, nearby physical structures and watercourses.

The danger of exposure to toxic materials exists not just for the manufacturers and persons present at the laboratory, but also for the first responders who uncover the clandestine laboratory and wildlife populations.

The leaching of toxic chemicals into Hawai`i's sensitive aquifer system poses an unknown risk. Toxic chemicals can reach the groundwater in one day.

Disposal of hazardous materials involves shipment to mainland sites. The cost to ship and dispose one 55 gallon drum ranges from $200-500 per drum.

FINDINGS

- Toxic materials that are the byproducts of the manufacture or conversion of methamphetamine pose a danger and risk of harm to the public and environment. The site of the clandestine laboratory itself may pose a danger to the environment and public.

- Little information is available about the impact of toxic materials produced by the clandestine laboratories in Hawai`i.

- No apparent action plan exists for systematic handling of hazardous materials found at laboratory sites, including the site itself. While there appears to be a process for disposal of

the materials located at the site, there does not appear to be a process to determine whether the site itself poses an environmental hazard.

- Hawai`i's sensitive aquifer system is particularly at risk due to toxic chemicals that leach into the groundwater.

RECOMMENDATIONS

- The Task Force recommends that $300,000 be allocated to the DOH to conduct a study and analysis of the effects of methamphetamine clandestine laboratories on our environment particularly the groundwater, the disposal of toxic waste materials found at the site, the disposal of the site and provide recommendations for action.

CONCLUSION

In addition to the specific factual findings and recommendations by subject areas, the Task Force makes the following observations:

1. Current statistics on the drug user population in Hawai`i are incomplete because no recent assessment of the adult population in need of substance abuse treatment is available. The Task Force relied on estimates and best data available.

2. An accurate count of the number of persons treated for ice addiction in Hawai`i is not available because there is no reporting mechanism for this data. Data on admissions to treatment are generally available, but this does not represent an unduplicated count of persons treated. The Task Force does not contend that such data should be reported, but the absence of the data meant that the Task Force relied primarily on best estimates and anecdotal information.

3. State agencies who provide treatment or social services to those with drug abuse problems do not routinely collect data on the number of persons served, the type of drug abuse and the successful outcomes of treatment services provided. Most state agencies responded to requests for data with "no information available" or the information had to be manually compiled for the Task Force. The two exceptions are Drug Courts and DOH/ADAD. Many community treatment providers who receive funding from DOH/ADAD routinely compile such information, as required by DOH/ADAD. Nonprofit organizations that receive federal funding also compile data as required by the federal grant. Accordingly, because data collection practices differ widely between treatment providers and government agencies, the Task Force had difficulty assessing whether gaps exist in types of services that are state funded and whether state funding for services was well spent.

4. Public funds spent on treatment and prevention services could not be determined with any reasonable accuracy because no centralized source collects this information. Even more difficult to determine are the private sources of funding for treatment and prevention services.

5. Coordination of efforts and resources are critically necessary to avoid duplication of efforts, increase efficiency and share information and resources.

The Task Force makes the following general recommendations relating to funding substance abuse treatment and prevention programs:

1. As a condition of funding, state agencies should be required to compile data, establish evaluation criteria and performance goals for programs under their supervision. The information submitted to the Legislature as part of the budget process, while generally informative about the use of the funds, is not adequate to assess whether the objectives for funding certain services have been met or to justify continued funding.

2. As a condition of funding, state agencies should be required to report to the Legislature on a periodic basis, at least prior to the commencement of the biennial Legislature. These reports should contain specific information about the population served, the goals and objectives for the program, the evaluation criteria used to assess whether the goals and objectives were met and recommendations.

3. State agencies should require purchase of services contractors to compile data, implement standard evaluation criteria

and performance goals and make reports to the state agency. If a contractor fails to provide such reports to a state agency, the contract should be terminated or not renewed.

4. The Legislature should consider adopting performance goals to guide future funding decisions. For example, the rationale for recommending funding for substance abuse prevention and treatment services is to reduce costs in other areas. Research shows that such reductions are probable if treatment and prevention dollars are available to address the substance abuse problems. If this research conclusion is correct, i.e. that for every dollar spent in treatment saves $7.14 in other areas, then these projected savings should become evident in three years. The Task Force has identified several areas where costs should decline, if prevention and treatment services are effective in reducing drug addiction:

- Offender population
- Child welfare services, foster care
- Health care and welfare costs
- Criminal activities
- Law enforcement

Thus, if the Legislature adopted performance goals reflecting an expectation that services would no longer be necessary in certain areas, then state agencies affected would be able to plan for such reductions. In expectation of reduced funding in certain areas, a plan for personnel reduction, redirection and retraining could be developed based on future growth areas in government services.

APPENDIX A - SUMMARY OF TESTIMONY RECEIVED

Informational Briefings on O`ahu

The Task Force held seven informational briefings on O`ahu and invited persons from a cross section of the community. Information provided to the Task Force is summarized below.[14] Recommendations made by speakers are included in Appendix B, "Summary of Community Recommendations."

June 30, 2003

Gary Shimabukuro, Laulima Hawai`i

TOPIC: Overview of the effects of crystal methamphetamine on the body and mental condition of users. Key points:

- In contrast to other drugs, ice affects the user by a more intense and sustained period of euphoria, followed by a period of dysphoria. Highs can last 14-16 hours or, for those users who have built up a tolerance, highs can last 4-5 hours. Severe depression sets in after the high.
- Other physiological effects from ice use may include brain damage, sleeplessness followed by long periods of sleep, body odor, bad breath, weight loss, binge eating, heightened sex drive and heightened sense of strength.
- Psychological effects from ice use include hallucinations, paranoia, psychotic behavior, violent behavior in part due to hallucinations, paranoia and impaired judgment.
- Brain damage due to ice use takes a long period to recover. Thus, the user requires a longer period to recover after ice use to be mentally responsive to treatment, in comparison to the effects of other illicit drugs.
- Self-treatment is not possible.
- Treatment resources are inadequate for those who need it.
- Drug babies require long-term medical attention.
- Insurance coverage is inadequate for treatment of ice addiction. Ice addiction requires longer period of treatment and since the addict tends to relapse several times before treatment begins to work, insurance coverage is exhausted before treatment becomes effective.
- Seven in ten drug users are employed, based on national data.

Keith Kamita, Narcotics Enforcement Division of the Dept. of Public Safety

TOPIC: State law enforcement efforts to deter entry and manufacture of crystal methamphetamine in Hawai`i. Key points:

- China and Mexico are major producers of methamphetamine and crystal methamphetamine.
- Most violent crimes are due to ice use, and most property crimes are due to ice addicts' need for cash to purchase the drug.
- Cost of addiction is estimated at $170/day.
- Identity theft is prevalent because users go through trash to obtain information to sell.
- In Hawai`i, a pound of ice is worth about $20,000.

[14] Characterization of key points is not intended to be inclusive. Summaries are not intended to transcribe testimony but to indicate the information heard by the Task Force members.

- Clandestine laboratories that either manufacture ice or convert powdered methamphetamine to its crystal form operate everywhere, in cars, hotel rooms, private homes, sheds or open areas.
- Ice is produced with over the counter chemicals, such as ephedrine, red phosphorus, solvent, salt and acid.
- The manufacture or conversion process produces noxious odors, hazardous waste and illegal dumping into the sewer or water system. For every pound of ice made, there is five pounds of waste.

July 11, 2003

Peter Carlisle, Prosecuting Attorney

TOPIC: City and County of Honolulu's response to ice. Key points:

- Hawai`i leads the nation in percentage per capita of arrested adults who test positive for ice usage.
- Ice replaces alcohol as the drug of choice in adult treatment programs.
- Deaths related to ice has almost doubled in the last two years.
- 51 percent of drug traffickers sentenced in Hawai`i were involved with ice, in contrast to 14 percent nationally.
- Ice enters Hawai`i from the Philippines, Korea and Mexico.
- Daily ice usage in Hawai`i is 105 pounds at net value of $5.1 million.
- The phases of the effects of ice are: (1) The high which can last 4-16 hours. A continuation of the high is maintained through bingeing over 3-15 days. (2) The crash, which is profound sleep that can last 1-3 days. (3) Tweaking, which occurs at the end of the binge, during which the user experiences dysphoria, poses the greatest risk of violent behavior by the user.
- Mental symptoms of chronic ice usage include: motor problems, depression, irritability, fatigue, exhaustion, delusions of insects crawling on the skin, flashbacks, paranoid schizophrenic symptoms, disorganized lifestyle, persistent delusions and irresponsibility.
- Physical symptoms of chronic ice usage include: fatal liver, heart, kidney and lung disorders, brain injury and lowered immunity to disease.
- Mandatory and random drug testing in private schools have been successful in deterring drug use. See recommendations on drug testing.
- Laws governing wiretaps should be changed to eliminate the adversarial hearing process requirement.
- Law enforcement focus should be shifted away from marijuana eradication to theft crimes and hard drug use.

Capt. Kevin Lima, Honolulu Police Department, Narcotics/Vice Division

TOPIC: Overview of HPD efforts in curbing crystal methamphetamine. Key points:

- Narco/Vice division is responsible for all investigations of drug related activities on O`ahu.
- Hawai`i participates with the federal High Intensity Drug Trafficking Area Task Force (HIDTA) that coordinates State, federal and local law enforcement efforts. HPD partners with numerous federal, State and military law enforcement organizations.
- In 2003, HPD received $210,000 from HIDTA.
- HPD officers are deputized under the federal system in order to investigate and make arrests that are prosecuted under the federal system.
- HPD prefers to use the federal system to prosecute drug offenders because prosecution is swifter, punishment is more severe, law enforcement activities are paid for by the

federal government and federal wiretaps do not require adversarial hearing or release of confidential information to opposing attorneys as is required by State law.

- In 2002, the number of drug law offenses was 3,204, compared to 3,033 in 2001. The number of drug related arrests in 2002 were 1,905, compared to 1,466 in 2001.
- In 2002, 41,513 grams of ice were seized, compared to 27,205 in 2001. In the first six months of 2003, 29,298 grams of ice were seized.
- In 2002, 143 search warrants were served, compared to 135 in 2001. In the first six months of 2003, 105 search warrants were served.
- In 2002, 15 clandestine laboratories were found, compared to 7 in 2001. As of June 2003, 9 labs were found. Most of the laboratories were involved in converting powdered methamphetamine to crystal.
- HPD supports increase in drug treatment programs for citizens and prisoners.
- More attention should be given to drug smuggling into the prisons.
- More attention should be given to prevent entry of drugs into Hawai`i. Technology exists to scan cargo and increase the use of dogs. However, the sheer volume of cargo into Hawai`i makes drug interdiction efforts difficult.

Lt. Connie Shaw-Fujii, Drug Abuse Resistance Education, Honolulu Police Department

TOPIC: HPD participation in the federal DARE program. Key points:

- DARE is a school based, officer instructed drug education and prevention program. HPD assigns 2 sergeants and 9 officers to this program.
- On O`ahu, DARE reaches 15,000 3rd, 5th, 8th and 10th grade students in 165 schools each year.
- HPD has instituted a new DARE curriculum of 10 weeks with a focus on middle schools. The major change is in the educational delivery, from the lecture format to facilitation of group discussions on topics.
- For every $1 spent in prevention, $5 will be saved in treatment.

August 4, 2003

Ed Kubo, U.S. Attorney

TOPIC: Overview of federal prosecution activities related to crystal methamphetamine. Key points:

- Ice is a serious health problem that affects adults, adolescents and families of those addicted to ice. According to the Honolulu Medical Examiner, deaths among ice users quadrupled in the past decade; last year, 62 deaths were associated with ice; in the first four months of 2003, 20 deaths were related to ice. Ice users display violent tendencies, which in turn results in abuse, domestic violence and violent crimes.
- Hawai`i is recognized as the number one ice-consuming State in the country.
- Ice addiction drives users to criminal activity in order to raise money to support their addiction. The rise in theft crimes, such as burglaries, shoplifting, robberies, purse snatching and car thefts is attributable to ice use. Similarly, the rise in serious crimes such as rape and assault, is linked to ice usage. In 2002, 45 percent of persons arrested in Hawai`i tested positive for ice.
- U.S. Attorney's Office in Hawai`i has 10 full time prosecutors and ice-related crimes account for 65 percent of the workload.
- There are an estimated 30,000 hard core ice users in Hawai`i.
- It is estimated that each hard core ice user consumes in the range of 1/16 gram to 1/16 ounce per day; daily cost to the user ranges from $50-170 to support the habit.

- It is estimated that in one year, ice consumption ranges from 1,520.83 to 42,773.4375 pounds.
- It is estimated that the daily cost for all ice users statewide ranges from $1.5-5.1 million, depending on consumption. Annual cost for ice ranges from one-half billion dollars to over $1.8 billion, depending on consumption.
- Hawai`i law enforcement seizes only 100-200 pounds of crystal methamphetamine each year.
- Eighty percent of ice comes in through airports, packaging services and mail.
- Law enforcement must be able to cut off the flow of ice into Hawai`i by amending Hawai`i's laws to permit "walk and talk" at airports and wiretapping. A 1992 decision by the State Supreme Court, striking down the "walk and talk" program, is primarily responsible for the substantial level of drug flow into Hawai`i.
- Nuisance abatement efforts must be increased, more police officers are needed, stronger restrictions on the purchase of ice precursors should be adopted and landlords should be allowed to evict tenants engaged in drug activities.

Larry Burnett, HIDTA; Briane Grey, Special Assistant Agent, DEA; Charles Goodwin, Special Agent in Charge, FBI; Ken Tano, Western States Information Network

TOPIC: Overview of federal law enforcement activities related to ice and drugs. Key points:

- A strong coordinated effort to investigate drug trafficking activities into Honolulu is needed. The neighbor islands do not have a permanent interdiction group responsible for drug interdiction at the airports, although some federal agents have been temporarily assigned.
- All counties in Hawai`i are tied into the ISC information network.
- Investigations into suspected drug trafficking within the United States require probable cause to search and seize.
- Federal prosecution focuses on more serious drug crimes, with higher thresholds of drugs involved. Less serious activities are referred to local law enforcement.
- Decision to prosecute in Federal or State courts depends on who has the best strategy. If the case begins at the state level, it can be switched to federal. However, if the case starts at the federal level, it cannot be switched to the State because of the difference in evidentiary standards.

Mark Bennett, State of Hawai`i Attorney General

TOPIC: Overview of abatement activities at the State level, recommendations for legislative action. Key points:

- Letters from attorney generals of 10 states commenting on Hawai`i's wiretapping law, that requires an adversary proceeding, were presented.
- Electronic surveillance is a necessary tool for law enforcement that is not being used in Hawai`i due to the burden of the adversary proceeding and concern that confidentiality will be breached. Several state attorney generals noted that if confidential informants or undercover police are required to participate in an adversary hearing, their identities will be revealed by their mere presence at the court house, thus jeopardizing their safety and the investigation.
- Act 161 is a get out of jail card that permits hardened offenders to avoid sentencing. It must be limited to true first time nonviolent offenders.
- The nuisance abatement program is being implemented and public education on this program has begun.
- The Attorney General's office is working with the department of health to identify toxic waste dump due to clandestine methamphetamine laboratories.

- Community members express concern for their personal safety if they report drug activity, therefore, there is a need to allow anonymous information to be used to establish probable cause.
- There should be an amendment to Hawai`i's Constitution to include language similar to the Patriot Act.

Lt. Patrick Lee, Department of Public Safety, Sheriff's Division, Warrants Section

TOPIC: Overview of Sheriff's Division activities relating to grand jury process, service of arrest warrants and arrest warrants related to drugs. Key Points:

- Persons arrested must be charged with the offense within 48 hours or be released pending further investigation. For drug related offenses, the person is often released because of the inability to obtain laboratory test results on the drugs within 48 hours.
- Hawai`i uses the grand jury process to determine whether sufficient evidence exists to issue an arrest warrant. The Sheriff's Warrants section serves all grand jury warrants.
- A survey conducted in June 2003 indicated that there were 1,200 criminal warrants outstanding, including grand jury warrants and parole and probation revocation warrants. Of the 1,200 warrants, about 40 percent were for drug-related offenses or where the defendant tested positive for drugs or left a drug treatment facility. Another 40 percent were indirectly related to drugs, i.e. the defendant was charged with a property crime but had a history of drug offenses.
- Drug related warrants have steadily increased over the years and the Sheriff's Division is unable to handle the volume of warrants, which results in an increasing backlog.
- Sheriffs face increased dangers serving warrants due to the rise in violent behavior by drug offenders, which necessitates more officer coverage in order to serve the warrants. This in turn reduces the number of warrants that can be served due to limited manpower.

Department of Public Safety, Sheriff's Division, Canine Unit (Charles Lacaden)

TOPIC: Demonstration of use of dogs for drug detection. Key points:

- Dogs are used at the airports, harbors and ports. Twelve dog/handler teams are used at the airports.
- A trained dog costs $4,000-5,000 and costs approximately $6,000 per year to maintain.
- Dogs are used for drug detection as well as handler protection.
- Dogs have highly sensitive olfactory senses and are trained to detect a range of drugs.
- The use of a dog to establish probable cause for further search and arrest is limited due to odor transference. For example, an innocent person may have drug odors attached to clothing without violation of any laws.

Paul Ciccarelli, Special Agent in charge, Naval Criminal Investigative Services (NCIS)

TOPIC: Overview of Navy's and Marine Corp's response to illegal drug activities. Key points:

- The military has a zero tolerance for drugs, so the drug offender is discharged from the military as well as required to serve criminal penalties. Military dependants involved in drug use/trafficking are removed from military housing and the active duty family member is recalled from deployment.
- Military conducts random drug tests. Over the past four years, the number of positive tests decreased for Navy and increased for Marine Corps. In 2003, the number of positive tests declined for both services.

- Marijuana is the most commonly used illegal drug, followed by cocaine, then methamphetamine.
- Methamphetamine is considered to be the greatest threat to personnel, particularly in the Pacific Fleet command; use of this drug has doubled over the past five years, which is a higher rate of increase than the national average. Currently, ice use accounts for one third of the drug use in the Pacific Fleet command.
- NCIS works cooperatively with federal and local law enforcement and shares intelligence collected on drug traffickers.
- Drugs are brought into military housing areas or property by civilians, with only a few instances of military personnel bringing in drugs for sale.

Sgt. Lane Martin, Sheriff's Division; Sidney Hayakawa, Federal Security Director, Honolulu International Airport, Transportation Security Administration; Gary Moniz, Administrator, Dept. of Land and Natural Resources, Officer Robert Rushford, Conservation and Resources Enforcement, DLNR; Kathryn Derwey, Inspector, U.S. Postal Service

TOPIC: Panel presentation on the points of entry of drugs into the State. Key points:

- Federal security at the airport is primarily concerned with searches for weapons and explosive devices of outbound passengers, as permitted by federal law. Agricultural inspections of outbound passengers are also conducted as permitted by federal law.
- There is concern that there is insufficient law enforcement coverage of inbound passengers at the neighbor island airports where flights originate from mainland cities.
- Since September 11, the number of body carriers of drugs coming into Hawai`i through the airports has decreased due to collateral effects of heightened security at mainland cities for outbound passengers.
- State and federal law enforcement work cooperatively at airports on drug interdiction. Inbound passengers are not routinely searched for drugs; probable cause is required for such searches. Federal agents may use "walk and talk" but State officers who are not deputized as federal agents may not. Evidence obtained from "walk and talk" may only be used in federal prosecutions.
- State harbors' officials work with local law enforcement and U.S. Customs on drug interdiction at harbors and ports. However, there is little known drug trafficking at this point of entry.
- There is significant inbound drug traffic through the mail and parcel services. Federal and local law enforcement work cooperatively on drug interdiction at this point of entry.
- The U.S. Postal Service has such a tremendous volume of mail that it is unable to monitor drug movement; search of mail must be based on probable cause. There is no routine drug screening permitted of mail or parcels.
- Federal agents engage in daily drug interdiction at central mail and parcel services offices in Honolulu.
- DLNR works with local law enforcement on clandestine laboratories that may be on State property, but there are few incidents of this. Marijuana is the illegal drug most often found on State lands.

August 27, 2003

Elaine Wilson, Chief, Alcohol and Drug Abuse Division, Department of Health

TOPIC: Overview of adult treatment and prevention programs funded through DOH/ADAD, overview of treatment philosophies. Key points of testimony, as supplemented by written information submitted after the informational briefing:

- Drug addiction is a bio-psycho-social disease that requires ongoing treatment and intervention. It is a brain disease expressed as compulsive behavior.
- Drug addiction is preventable and treatable. Effective treatment addresses medical, psychological, social, vocational and legal problems.
- Effective treatment does not have to be voluntary. Outcomes are similar whether treatment is entered into voluntarily or under legal pressure. A court order is required to force a person into involuntary treatment.
- Treatment reduces drug use by 40-60 percent, reduces crime by 40-60 percent and increases employment prospects by 40 percent.
- Every $1 invested in treatment yields up to $7 in reduced crime related costs.
- Effective treatment must last three months to one year, depending on the severity of addiction.
- Assessment of drug addiction is based on criteria established in the Diagnostic and Statistical Manual IV (DSM IV) and Addiction Severity Index (ASI).
- Placement of a patient in treatment is based on criteria established by the American Society of Addiction Medicine (ASAM), which essentially matches the patient to services based on clinical severity and level of functioning.
- Treatment modalities and level of care are:

  Early intervention service
  Opiate maintenance therapy
  Detoxification service
  Level I Outpatient service
  Level II Intensive outpatient service, partial hospitalization
  Level III Residential/inpatient service
  Level IV Medically managed intensive inpatient service

- Treatment models for ice require a stay of at least 90 days, with follow up of at least one year. Models include: Cognitive behavior approach, contingency management, matrix model and self help group support. A medications model is in development.

- The need for publicly funded adult treatment services is described in the table below.

1998 Household Survey: Estimate of adults Needing Treatment	State Total	Hawai`i	Honolulu	Kaua`i	Maui
Population over 18 yrs.	895,414	99,941	668,524	41,304	85,645
Population needing treatment for drugs	13,954	2,494	8,338	796	2,326
Percent of population needing treatment for drugs	1.6%	2.5%	1.2%	1.9%	2.7%
Population needing treatment for drugs and/or alcohol	82,880	12,176	57,623	3,259	9,822
Percent of population needing treatment for drugs and/or alcohol	9.26%	12.18%	8.62%	7.89%	11.47%

- The gap between those who need publicly funded treatment, those who are willing to enter treatment and publicly funded treatment resources is described in the table below.

Est. adults need public funded drug/alcohol treatment	Adults willing to enter treatment	Public Resources available to treat adults	GAP of adults unserved
19,062	9,531	6,369	3,162

- The number of pregnant women in need of substance abuse treatment, based on 1996 DOH study of “Blind Study of Substance Abuse and Need for Treatment among Women

of Child-bearing Age in Hawai`i" and infants exposed to drugs prenatally is described in the table below.

Non-pregnant women testing positive for illegal drugs	15.7%
Pregnant women testing positive for illegal drugs	12.7%
New born children exposed to illegal drugs prenatally, based on 18,552 births in 1995	2,356

- Students in need of substance abuse treatment based on the 2002 Student Alcohol, Tobacco and Other Drug Use survey: 11,319 (10.6 percent) meet the criteria for needing substance abuse treatment.
- Treatment admissions reported to DOH/ADAD is described in the table below.

Drug	Adult/Adolescent	1998	2000	2002
Methamphetamine	Adult	1,423	2,136	2,730
Methamphetamine	Adolescent	189	143	158
Methamphetamine	**Total**	**1,612**	**2,279**	**2,888**
Any drug & alcohol	Adult	5,518	6,500	6,369
Any drug & alcohol	Adolescent	1,821	1,633	1,552
Any drug & alcohol	**Total**	**7,339**	**8,133**	**7,921**

- Available adult residential treatment resources are described in the table below.

Type of service	Resources available	Public funded	Comments
Licensed residential treatment beds	390 beds	85 beds	No residential treatment beds available on Big Island, Kaua`i, Lana`i, Moloka`i.
Licensed Detoxification Beds	26 beds	Part of 85 beds	Salvation Army on O`ahu and Aloha House on Maui are the only providers
Therapeutic living homes	9 homes on Big Island		Bridge House and BISAC operate homes

- In terms of cost, hospitalization is the most expensive, followed by residential treatment, then therapeutic living homes supplemented with outpatient counseling, the outpatient treatment. A therapeutic living home that serves 8 persons costs $300,000 per year, including outpatient treatment.
- Funding for substance abuse treatment and prevention for adults and adolescents, as administered through DOH/ADAD, is described in the table below. Notably, there is no State funding for prevention programs.

Fiscal Year	State General funds	Federal Prevention & Treatment	Comments
1992	$5,104,244	$6,078,000	
1997	5,319,979	5,867,429	
2000	5,633,837	6,810,019	
2001	5,666,740	6,983,864	
2002	5,779,949	7,070,824	Incl.$192,692 ICM funds
2003	7,783,598	7,164,579	Incl.$2.2m ICM funds
2004	7,790,900	[award not received yet]	Incl.$2.2m ICM funds

- Funding for adult substance abuse treatment, as administered through DOH/ADAD, by island and type of programs for FY2004 is described in the table below.

Treatment program	State Funds	Federal Funds	Total Funds
O`AHU			
General	$1,245,628	$ 871,053	$2,116,681
Nonmedical residential detox	100,000	269,340	369,340
Homeless treatment		42,000	42,000
Injection drug user treatment	166,316	119,934	286,250
Dual Diagnosis	256,091	20,000	276,091
Pregnant & parenting women & children	862,150	870,119	1,732,269
Total O`AHU	$2,630,185	$2,192,446	$4,822,631
MAUI			
General	152,065	140,543	292,608
Pregnant & parenting women & children	200,000		200,000
Total MAUI	352,065	140,543	492,608
MOLOKA`I			
General	54,547	90,453	145,000
Total MOLOKA`I	54,547	90,453	145,000
LANA`I			
None			
KAUA`I			
General	150,278	16,160	166,438
Pregnant & parenting women & children		140,524	140,524
Total KAUA`I	150,278	156,684	306,962
HAWAI`I			
General	750,695	571,153	1,321,848
Injection drug user treatment	110,750	79,000	189,750
Total HAWAI`I	861,445	650,153	1,511,598
Total STATEWIDE	4,048,520	3,230,279	7,278,799

- Funding administered through DOH/ADAD for integrated case management for criminal justice population for FY2004, including all State funded programs on the islands of O`ahu, Kaua`i, Maui and Hawai`i is $2.2 million.
- Funding administered through DOH/ADAD for adult treatment system support services, all from federal funds is $539,662.
- No State office maintains data on all sources of state and federal funds for substance abuse treatment and prevention programs in Hawai`i.
- ADULT SUBSTANCE ABUSE TREATMENT PERFORMANCE OUTCOMES, Fiscal Year 2001 and 2002 are described in the table below. The outcomes are based on samples of adults who received treatment from DOH/ADAD funded programs.

MEASURE	PERFORMANCE OUTCOME ACHIEVED AT SIX-MONTH	
	FY2001 [1,350 adults]	FY2002 [1,558 adults]
Employment/School/Vocational Training	50.7%	50.2%
No arrests since discharge	84.0%	85.6%
No substance use in 30 days prior to follow-up	70.8%	67.9%
No new substance abuse treatment	74.4%	81.5%
No hospitalizations	85.2%	90.4%
No emergency room visits	83.0%	89.8%
Participated in self-help group (NA, AA, etc.)	48.4%	41.7%
No psychological distress since discharge	71.6%	81.8%
Stable living arrangements	84.6%	83.7%

- Demographics of persons admitted for treatment based upon data submitted to DOH/ADAD by all ADAD funded programs, regardless of source of payment for treatment are described in the table below. Note that these treatment admissions may

not reflect unduplicated counts of individuals who receive treatment from various agencies because there is no data collection system that tracks individuals who seek treatment from providers.

Adult Admissions, primary substance treated	1998 count/%	1999 count/%	2000 count/%	2001 count/%	2002 count/%
Methamphetamine	1423/**26**	1517/**26**	2136/**33**	2332/**36**	2730/**43**
Alcohol	2231/40	2337/41	2469/38	2435/38	2051/32
Marijuana	343/6	404/7	495/8	552/9	558/9
Other substances	1521/28	1487/26	1400/21	1135/17	1030/16
Total	5518/100	5745/100	6500/100	6454/100	6369/100

Adult Admissions, Methamphetamine	1998 count/%	1999 count/%	2000 count/%	2001 count/%	2002 count/%
Gender					
Men	723/51	821/54	1254/59	1343/58	1630/60
Women	700/49	696/46	882/41	989/42	1100/40
Ethnicity [highest 5]					
Hawai`ian	727/51	736/49	1060/50	1192/51	1351/49
Caucasian	159/11	184/12	271/13	257/11	369/14
Filipino	140/10	141/9	201/9	250/11	238/9
Mixed, not Hawai`ian	120/8	131/9	197/9	229/10	246/9
Japanese	104/7	129/9	191/9	154/7	190/7
Other ethnic groups	173/12	196/13	216/10	250/11	336/12

Adolescent Admissions, primary substance treated	1998 count/%	1999 count/%	2000 count/%	2001 count/%	2002 count/%
Methamphetamine	189/10	126/8	143/9	150/9	158/10
Alcohol	429/24	379/25	432/26	442/27	378/24
Marijuana	1158/64	961/63	956/59	979/60	949/61
Other substances	45/2	59/4	102/6	70/4	67/4
Total	1821/100	1525/100	1633/100	1641/100	1552/100

Adolescent Admissions, Methamphetamine	1998 count/%	1999 count/%	2000 count/%	2001 count/%	2002 count/%
Gender					
Men	101/53	53/42	57/40	65/43	71/45
Women	88/47	73/58	86/60	85/57	87/55
Ethnicity [highest 6]					
Hawai`ian	98/52	60/48	67/47	60/40	80/51
Caucasian	12/6	6/5	4/3	9/6	11/7
Filipino	24/13	26/21	40/28	36/24	29/18
Mixed, not Hawai`ian	13/7	12/9	8/6	16/11	12/8
Hispanic	12/6	5/4	10/7	5/3	6/4
Japanese	9/5	6/5	6/4	13/9	8/5
Other ethnic groups	21/11	11/9	8/6	11/7	12/8

Barry S. Carlton, M.D., John A. Burns School of Medicine, The Queen's Medical Center

TOPIC: Methamphetamine abuse, treatment and research. Key points:

- In contrast to alcohol addiction, ice addiction is different because a single use of ice can result in brain injury. Brain injury can continue 90 days to years later, even if a person is sober and in recovery. Often, the ice user who is in recovery has little to return to, such as family and a job, because ice addiction starts earlier and brain injury occurs quicker than alcoholic addiction.
- Withdrawal from ice use is rapid but there is sustained mood and cognitive and perceptual disturbance, during which time the user expresses anger and has auditory hallucinations.

- Dispute in the scientific studies as to whether a person can be permanently impaired by effects of ice addiction even after abstinence from use.
- Cognitive behavioral treatment is effective in managing the craving and conditioned response. Life skills, job skills and interpersonal skills need to be taught and developed. Family situation and peer group must change in order to support the client's sobriety.
- Currently, there is research into the epidemiology of the disease, genetic and psychosocial vulnerabilities, effect on the brain, heart, muscle, kidney, fetus and family. Research is ongoing into medications that will block the high and prevent DOPA release, block the mood change and prevent the crash and block the craving for ice.
- Medicines are available to stabilize mood swings and to deal with hallucinations and delusions.
- Many programs view the family as an integral part of treatment.
- Use of a contingency contract works as motivation for success in treatment, i.e. drug court and continued employment.
- There should be community based transition programs for users who complete treatment in order to reinforce change and provide positive experiences from not using ice.
- There is never normal experimentation with ice because of brain change after single use.

Chris Derauf, M.D., Department of Pediatrics, John A. Burns School of Medicine

TOPIC: Prenatal Methamphetamine Use and Child Development: What We Know and What We Don't. Key points:

- Based on the 1998 DOH/ADAD Household Survey, methamphetamine was used by 0.7 percent of the adult population.
- Prenatal methamphetamine exposure in Hawai`i was 39.9 per 10,000 births in a study for the period 1986-1999. In contrast, tobacco exposure was 997 per 10,000 births and alcohol was 138 per 10,000 births.
- A 1996 Blind Study of Substance Abuse and Treatment Need among Women of Child-bearing Age indicated 7.9 percent prevalence of methamphetamine use among pregnant women in Honolulu County.
- A CWS Report for 2000 indicated prevalence of methamphetamine exposed births on O`ahu was 1.2 percent.
- It is estimated that out of 17,000 live births in Hawai`i annually, 170 to 510 births are potentially affected by methamphetamine.
- According to a 1985 study, a toxic response to drugs depend on the dose, genetic susceptibility and the stage of development
- Fetal exposure to drugs is not the only factor that affects child development. Child development is affected by many factors, such as exposure to drugs, prenatal conditions, environmental, genetics, mother's substance abuse, lifestyle, personality and cultural background.
- Intimate and caring relationships are the fundamental mediators of successful human adaptation.
- There are no prospective, blinded or controlled studies on health and development consequences of in utero exposure to ice. In contrast, there are blinded, controlled studies of effects of alcohol, tobacco and cocaine on health and development of newborns and infants. Alcohol produces the most serious effects on the fetus, resulting in life-long permanent disorders of memory function, impulse control and judgment. Fetal exposure to alcohol is the leading preventable cause of mental retardation. However, cocaine exposure does not indicate any distinct clinical malformations or effect on physical growth or consistent effects on language and behavior and motor functions in children up to six years of age. There could be subtle effects that appear

developmentally, such as long-term IQ changes in the population, with less gifted children and more mental retardation.

- Studies funded by NIDA in progress now on the effects of ice are looking for potential effects on the mother, such as hypertension, premature labor, placental bleeding and irregular heartbeat. The studies are reviewing potential effects on the child, such as malformations, transient systemic effects and cognitive and behavioral effects.
- Reported malformations that are *possibly associated* with ice use during pregnancy include: cleft lip, cardiac defects, low birth weight, growth reduction, premature birth, still birth, cerebral hemorrhage, brain metabolites and other conditions.
- Reported cognitive and behavioral effects *possibly associated* with use of ice during pregnancy include learning disabilities, aggression, school failure and attention deficit hyperactivity disorder.
- The only consistent finding of the effect of ice on pregnancy is increased rates of shortened gestational period and decreased size for gestational age.
- Community perceptions regarding prenatal ice exposure may be unfounded because any health or developmental characteristics of an infant or child may be due to many factors, such as labeling and stigmatizing women and children (i.e. use of term "ice babies") affected by substance abuse.
- A physician may not intervene to protect the unborn fetus even if the mother is a known drug user and there is no imminent risk to the fetus.

Alice Dickow, Principal Investigator, MATRIX model study, Honolulu Site

TOPIC: Update on MATRIX model used for methamphetamine treatment. Key points:

- 140 women addicted to ice participated in the MATRIX treatment program, which was part of a national study. The Matrix model consisted of a two hour per day, three times a week drug education for 16 weeks.
- The average age of women entering treatment was 33 years old, with average 11.5 years of ice use. This means that the women's first use of ice occurred at 21 years of age, which suggests that prevention efforts for women should focus on early adult years.
- Hawai`i women indicated multiple problems that required ancillary services in order for treatment to succeed, such as unemployment, social and psychological disorders.
- The matrix model indicated an ability to retain clients in treatment for longer periods of time and improve in-treatment outcomes. While there was a significant reduction in ice use, the clients showed changes in positive behavior even though complete abstinence was not achieved.

William Wood, Professor, Sociology, University of Hawai`i

TOPIC: Statistics on ice epidemic in Hawai`i. Key points, as supplemented by written information submitted after the informational briefing:

- An ice epidemic exists in Hawai`i. An epidemic is defined as a pervasive condition affecting the well being of a population and is recurring. An ice epidemic exists because ice usage began in the late 1980's and has continued to the present. Reported data on the effects of ice show generally upward trends without let up.
- Limited sources of data exist on the use and affects of ice in Hawai`i. Known data sources are: Community Epidemiology Work Group (CEWG) reports deaths with positive toxicology screen for ice, numbers of persons entering treatment with ice as the drug of choice and numbers of cases for ice-related crimes. Arrestee Drug Abuse Monitoring (ADAM) report shows positive toxicology screens for ice among arrestees on O`ahu. School survey data showed a leveling of numbers of students who have used ice. Local and federal law enforcement collects data on arrests by types of crime and seizures of ice and also monitors price and purity of the drug.

- Indicators of the magnitude of Hawai`i's ice problem are shocking.
- Honolulu coroner's office reports deaths with positive screen for ice dramatically increased over the last two years. Similarly, the admissions to treatment with ice as the primary drug have nearly doubled in the last four years, from 1,450 in 1998 to 2,677 in 2002[15]. See, table below for specific data.

Reported	1991	2000	2001	2002
O`ahu deaths, positive for ice	11	35	54	62
Admissions, ice primary drug	152	2,419	2,644	2,677

- Ice continues to be the drug of choice among men and women arrested who test positive for drug use. In 2002, of the arrested men who tested positive, 43.5 percent indicated ice; of the women arrested who tested positive, 49.3 percent indicated ice.
- As typical with an epidemic, the major social effects follow the epidemic. Hawai`i is experiencing a second wave of the ice epidemic.
- Law enforcement is not sufficient to solve the problem. More treatment is necessary to ensure that the same users are not part of the third wave of the epidemic. Based on the statistics known, only 25 percent of those who need treatment receive treatment.
- The 1998 Household survey (See chart in Wilson's testimony) was based on a statistical weighted sampling of 5500 persons. No other survey or study exists that counts the number of ice users. A report in 1999 stated that certain members of law enforcement estimated 30,000 ice users but there is no hard data to back up that number.

Judge Marcia Waldorf, Criminal Drug Court

TOPIC: Activities of the criminal drug court. Key points:

- The Drug Court program began in January of 1996 and has admitted 551 clients. The clients represent a broad cross section of the population. The primary drug of choice is ice.
- The program consists of intensive outpatient treatment, 12-24 months in duration. Relapse does not result in automatic termination for the program; the client works on relapse prevention.
- 315 participants have graduated and 122 were terminated. Of the 315 that graduated, only 16 of them, or 5 percent, were convicted of crimes after graduation. Ten percent, or 13 participants, that were terminated from the program have since been convicted.

John Peyton, Director of Department of Public Safety, Frank Lopez, Deputy Director of Corrections Division, Miles Murakami, Acting Corrections Program Services Administrator

TOPIC: Drug treatment programs in the Corrections Division of the Department of Public Safety. Key points:

- Criteria for intensive treatment services are: the inmate must be within 24 months of release date and classified for minimum security and bed space must be available. Those inmates who are not classified as minimum security do not receive intensive substance abuse treatment in preparation for re-entry into the community.
- There is a waiting list for bed space and a serious lack of bed space to meet the needs of the prison population in need of treatment. The Department believes that resources should be spent on those who can most benefit from treatment and estimates that 60 percent of those in need of treatment fall into that category.

[15] Admissions data based on calendar year.

- There are five types of treatment: education, intensive treatment, specialized services, transition and aftercare. The inmate is assessed for the level of treatment needed.
- Three levels of education treatment: (1) 12 hour education program, (2) 144 hour program that includes group sessions twice a week and (3) 144 hour program in a secure, controlled environment at Halawa for those who are not eligible for minimum security treatment programs.
- Three therapeutic communities for intensive treatment: KASHBOX at Waiawa, Ke Alaula at Women's Community Correctional Center and Hale Ola Ho'opono at Kulani. Therapeutic communities work on changing psychosocial characteristics under positive peer pressure in a highly structured social environment. KASHBOX is a program for men, lasting 9-15 months. Ke Alaula is a program for women that incorporates native Hawai`ian culture.
- Specialized services include psychological counseling for those inmates with co-occurring mental health disorders and a parole violator program. Crossroads is a 4-6 month program for parolees who return to prison due to substance abuse relapses.
- Transition services programs are offered to those inmates who complete either the therapeutic community program or the 144-hour education program. Two in-facility transition programs: Project Bridge at OCCC and Olomana Bridge at WCCC. Two in-community programs: Matlock Hale and BISAC.
- Aftercare service is a personal support system after prison to maintain sobriety. It is often a condition of parole to attend a treatment or intervention program upon release from prison.
- There are 5,500 inmates in Hawai`i's prisons. Upon entry, 88 percent test positive for drug use. Each month, 5 percent of the prison population are randomly tested for drug use and 20 percent of the population in treatment are tested for drug use.
- In the seven-month period from November 2002 to May 2003, 7,456 tests were given and 373 tested positive. Of positive tests, 69 percent tested positive for ice.
- Annual costs to fund the substance abuse treatment programs in the correctional facilities: $3,535,000.
- The overall recidivism rate is 65 percent.

Claire Woods, Director, Salvation Army Family Treatment Services

- The Salvation Army in America was founded in 1879. The Salvation Army Family Treatment Services (SAFTS) has provided chemical dependency treatment and therapeutic living services for pregnant and parenting women and children since the mid 1970's. The Therapeutic Nursery and Therapeutic Living Program works with other agencies to stabilize and support the reunification of families where addiction has been a problem. The programs have been developed to address the gender-specific issues of women in treatment, the problems of drug exposed infants, mental health services for children and infant/child development services.
- Funding for SAFTS is provided by the DOH/ADAD, Department of Public Safety, the Judiciary, Office of the Attorney General, Dept. of Human Services, the City and County of Honolulu, Aloha United Way, private foundations and donations. The budget for 2004 is $4.1 million.
- Of the 52 new admissions this year, 45 admissions were for ice addiction. Half of the women admitted were part Hawai`ian, 90 percent under the age of 34. Seventy-one percent of the admissions were covered by Quest, the rest had no insurance coverage.
- The SAFTS treatment program was designed to allow women with children the necessary time to stabilize their recovery and to provide the comprehensive range of services required to address their needs including, treatment that addresses parenting, life skills, trauma and mental health issues as well as substance abuse. Programs are designed to provide 6 to 12 months of treatment. Issues of particular importance in relapse prevention, include financial and emotional dependency, family and cultural

expectations, domestic violence, sexual abuse, stress related to single parenting, self-esteem and body image and mood and anxiety disorders are addressed.

- To provide comprehensive treatment, collateral relationships with a wide range of agencies in the community is necessary. Each counselor or case manager provides individualized family support coordination in the areas of legal, financial and medical assistance, child welfare services, medical and dental services, nutrition, education and vocational education, transportation and developmental services.
- The effectiveness of SAFTS programs are measured through follow-up with discharged families. The majority, 60 percent, of all served complete treatment. Medical homes are established for all families at the time of discharge. At the six-month follow-up, 66 percent have remained sober, with no new arrests and there were few new cases of Child Welfare involvement.

Lisa Cook, Drug Addiction Services of Hawai`i, Inc.

- Drug Addiction Services of Hawai`i provides outreach in the downtown Honolulu area. Of the 109 drug free outpatient clients, 80 percent were being treated for ice addiction, with 90 percent of the population comprised of Native Hawai`ians, Filipinos, Japanese and Koreans. Approximately, 300-400 people per day are served in the opioid treatment program, called Hui Ho`omaika`i Ika Poe O Hawai`i. Twenty percent of applicants to the opioid treatment program also now use ice, which was very rare in the past. There is evidence that ice is now being injected, which raises a number of health related issues including Hepatitis C, exposure to MRSA (methicillin-resistant staphylococcus, staph bacteria that has become resistant to various antibiotics) and HIV/AIDS. With ice use comes unpredictable behavior, psychosis and a propensity towards violence. Without adequate staffing, outpatient programs are faced with discharging patients to preserve the safety of the staff.
- Intensive outpatient programs are run through Cornerstone on O`ahu and Hui Ho`ola o Na Nahulu O Hawai`i in Puna. Hui Ho`ola's approach is to enforce healthy every day living skills that have been passed on from their ancestors and kupuna. The focus is on restoration of self-identity, discovering the purpose for one's life and creating a healthy family. Acupuncture and lomilomi massage are utilized to heal the mind and spirit.
- Statistics taken 6 months after discharge have shown that 77 percent of those discharged report abstinence, 85 percent report no new arrests, 58 percent report that they are employed, 85 percent report they have had stable living arrangements and 97 percent were not hospitalized for medical problems or used emergency room services. These statistics include those who completed treatment, dropped out, or were discharged for noncompliance.
- All the programs have aftercare of at least one year. The focus is to mainstream the clients, not allow them to associate only with other persons in recovery. Traditional cultural healing modalities and resources are used and culturally relevant programs that strengthen families and communities are stressed, not only programs that help people to stop using drugs. Vocational education programs and assistance with education and employment are offered.
- Concern was expressed over the growing use of oxycontin. Ice users take heroin and oxycontin, often together to deal with the effects of ice as it wears off; ice users also take benzodiazepines for the same purpose.

Dr. Robert Young, Director of Behavioral Health, Wai`anae Coast Comprehensive Health Center

- Wai`anae Coast Comprehensive Health Center is the largest community health center in the State of Hawai`i and the fourth largest nonprofit agency in the State. In 2002, the Health Center served 22,400 patients. Over half treated were Native Hawai`ians, 48 percent were covered by QUEST and 17 percent were uninsured.

- The Malama Recovery program is an adult outpatient program that provides low intensive treatment and aftercare substance abuse treatment services to QUEST patients. The Leeward Kokua Program is funded by the Department of Human Services and provides eligible women and children with education and support for substance abuse. The Baby S.A.F.E. program provides early identification of pregnant women who are at high risk for substance use.
- Minimal treatment is available for substance abuse patients, while their numbers are rapidly increasing and more violent crimes are being committed. Referrals to child welfare services are increasing. Services are also limited for prisoners who are released in to the community. More ex-prisoner and outpatient services are needed at the community level to assist these people in the transition to family life. Additional treatment is needed for adolescents. Stronger connections need to be built between primary care doctors and mental health providers to identify and address problems earlier.

Hans Bochentin, Clinical Director, Institute for Human Services

- The Institute for Human Services (IHS) has been providing assistance to the homeless for 25 years. It is a $4 million operation that includes two separate shelters, one for men and one for women and families. In addition to sheltering up to 400 men, women and children nightly, the Institute provides 1,000 meals a day. Funding is received from the State of Hawai`i Housing and Community Development's Homeless Assistance branch and the Department of Health Adult Mental Health division to provide outreach and intensive case management.
- IHS partners with two treatment agencies to provide substance abuse treatment, Hina Mauka and the Salvation Army. Hina Mauka provides on site group counseling and education and possible referral to their outpatient treatment services. The Salvation Army provides detoxification services to the IHS population.
- There are challenges when working with the homeless. Because they are transient and difficult to find, services need to be delivered on the spot, or may be handled as an emergency intervention where clients can be placed in detox or inpatient treatment. The second challenge is that a number of the homeless are dually diagnosed with both substance abuse and mental health problems.
- Fifty percent of the family populations are from the Federated States of Micronesia, the Marshall Islands and Samoa. Local families make up the other 50 percent, and of those, an estimated 90 percent are involved with ice. A major problem for IHS is providing adequate care for the dually diagnosed. The State needs to have an appropriate medical detoxification program instead of relying on IHS.

Joe Chavez, Technical Outreach Coordinator, Oxford House

- Oxford House is a nonprofit organization established in 1975, that provides charters and technical assistance for democratically run and self-supported houses for men and women in recovery from substance abuse. In Hawai`i there are 20 houses, 17 for men and 3 for women, with a total of 180 available beds.
- The average stay in the house is 18 months in Hawai`i. More than 1,900 individuals have been in the program, which opened in Hawai`i in 1991. Nearly 64 percent, or 1,200 individuals have stayed clean and sober. The average age of a resident is 35 (in 2000), with the racial breakdown of 29 percent white, 9 percent black, 8 percent Hispanic, 23 percent Asian, 32 percent Pacific Islander.
- The average cost paid by each resident is $83.35 a week. 75 percent of the residents have served time in jail. Individuals must be admitted alcoholics or drug addicts. Oxford House provides an environment where a substance abuser helps another abuser to stay sober.

- The Outreach Coordinator will sign a lease on behalf of Oxford House. Houses leased are from the rental pages of the newspaper. Individual rents are calculated based on the number of beds, and fixed expenses like cable, phones, house supplies and possibly electricity and water. Each house is run by the residents and has elected officers. There is no time limit on an individual's stay, as long as they remain clean and sober, pay their rent and do not disrupt the house.

September 8, 2003

David Bettencourt, Criminal Defense Attorney, Richard S. Miller, Professor of Law, Emeritus

TOPIC: Protection of privacy rights against searches and seizures through "walk and talk" and electronic surveillance (wiretap). Key points:

Legal Standards and Comments (Mr. Bettencourt)

- "Walk and talk" was held to be unconstitutional by the Hawai`i Supreme Court in a series of cases in the early 1990s. The rationale for the court's ruling is that when a police officer approaches a traveler without a basis for suspecting wrongdoing, that approach is considered to be threatening and the traveler is incapable of providing consent to the questioning.
- Currently, walk and talk is used by federal officers and requires that they inform the stopped person that they do not need to consent to the search. Very few federal judges find that a person did not voluntarily consent to the search.
- There is no correlation between high ice use in Hawai`i and Constitutional rights that protect Hawai`i's residents and visitors from "walk and talk." Federal agents and local police deputized for federal law enforcement use "walk and talk" now and this has not deterred the movement of ice into Hawai`i. The demand for ice is based on social and economic issues in Hawai`i, not the Constitutional protections. Ice enters Hawai`i through many points, containers, shipped vehicles and courier packages. Body carriers through the airports is only one method that has dropped since September 11 due to enhanced airport security.
- A person who is carrying drugs on their body will not stand out. Even if one in ten persons who are stopped under walk and talk is carrying drugs, that means nine innocent persons have been stopped. Subjective facts are created by law enforcement after the person is caught with drugs in order to support their decision to stop the courier. Wiretapping is permitted under State law, but only after a court has conducted an adversarial hearing. The adversarial hearing does not slow down the search warrant process, and few investigations are so fast breaking that a wiretap is needed immediately. It is highly unlikely that there would be a breach of confidentiality by the adversarial attorney because of that attorney's desire to avoid being blamed for any breach. The grand jury counsel is in the same situation and no one has accused those attorneys of leaks.
- Wiretaps are generally sought as part of a lengthy investigation where the police want to identify co-conspirators and they already know the identity of the core conspirators. Police usually do not rely on wiretaps because it is costly to conduct, requiring six full-time agents to monitor the communications. Police usually have ability to obtain search warrants based on neighbor or witness observations of drug activity rather than rely on wiretaps to obtain a search warrant. Delays between neighbors complaints about drug activity and the police action has more to do with limited manpower than the burden of obtaining a wiretap or search warrant. Police should use their limited resources to investigate and prosecute known drug offenders.

Policy Reasons Against Sacrificing Civil Liberties for Drug enforcement (Prof. Miller)

- The Patriot Act subjects innocent people to invasions of privacy in the name of national security. While the dangers of drug use and harm to the community and families are considerable, such danger does not rise to the same level as the dangers posed by terrorism that would justify the dilution of Hawai`i's privacy rights under the Constitution.
- Hawai`i's Constitution, Article 1, section 7 differs from the Fourth Amendment of the United States Constitution. The Hawai`i constitutional convention specifically added protection against "invasions of privacy" and required warrants be based on probable cause for "communications sought to be intercepted."
- There are no facts to support law enforcement's claimed need for "walk and talk" as a significant tool for drug interdiction. There should be facts that the use of such tactics will be successful in stopping drugs from entering Hawai`i.
- Drug law enforcement does not work; it has no significant impact on reducing drug use in the United States based on a survey conducted by the U.S. Department of Human Services.
- The adversarial process used to determine whether probable cause exists for a wiretap warrant is a reasonable protection of privacy.
- A better use of limited resources is on drug education and treatment.

Darlene Hein, Coordinator of Harm Reduction Hawai`i

TOPIC: Harm reduction policies to reduce harms associated with drug use. Key points:

- Harm Reduction examines research in public health and what has worked and what does not. It also looks at the socio-economic and racial factors that have created inequalities in society due to a lack of access.
- When crafting policy, both positive and negative consequences are examined. Policies that address harm created must be non-judgmental, realistic and practical. See recommendations for harm reductions associated with drug use.

Kat Brady, Coordinator, Community Alliance on Prisons

TOPIC: Retain and Fund Act 161. Key points:

- Act 161, SLH 2001, allows for those first time nonviolent drug offenders convicted under Section 712, HRS, to receive treatment instead of incarceration. It excludes offenders that refuse treatment, failed drug treatment two or more times and those convicted in the same criminal proceeding of a non-drug use misdemeanor or felony.
- According to the Department of Public Safety, number of convictions under Section 712, HRS, is listed on the table below.

Statute	Total	Male	Female
§712-1241 – Class A	86	74	12
§712-1242 – Class B	242	202	40
§712-1243 – Class C	309	254	55
Total convictions	637	530	107

The lowest cost estimate of an inmate is $76 per day. The average time served under these statutes is 39-40 months. With these estimates, the State would be spending $56,642,040 to incarcerate the total number of people convicted under these statutes.

- Mandatory minimum sentencing is not effective. It has only filled prisons and increased the amount of separated families. They also do not receive any rehabilitation or treatment in prison and will return to the community without any restorative care that may be necessary.

- Prisons create a negative environment where evil triumphs. This was proven by a Stanford University study in which students were asked to become guards or prisoners. After six days, the students acting as guards became sadistic and the prisoners became depressed and showed signs of extreme stress.
- Treatment is a more cost effective and successful means of helping drug addicts recover. It would also decrease societal costs, such as welfare and unemployment. However, there is a lack of adequate funding, and access and treatment options are limited.
- Since July 2002, 182 people have been sentenced under Act 161, and the Department of Public Safety found 45 inmates that it could apply to.
- Act 161 can be improved in the following ways: increase funding for treatment, clearly delineate who is eligible for sentencing under Act 161, and define drug treatment to include vocational training and support services, such as employment, counseling, housing and education opportunities.

Dr. Sylvia Yuen, Director/Professor, Center on the Family, University of Hawai`i

TOPIC: Community profiles for development of prevention programs. Key points:

- The general feeling and safety of a community is directly related to the amount of drug use and success of its teens.
- In order to better serve the youth, there needs to be a turn around in the community to reinforce positive behaviors and activities.
- The UH Center on the Family has created community profiles that are useful to identify the risk and protective factors for purposes of planning prevention programs. Its website has all of their community profiles at http://uhfamily.Hawai`i.edu.

Elaine Wilson, Chief, Alcohol and Drug Abuse Division, Department of Health

TOPIC: Overview of drug prevention and treatment programs for adolescents. Key points, as supplemented by written information submitted after the informational briefing:

- The prevalence of ice use among 6th, 8th, 10th and 12th grade students in school has generally declined. The schools survey does not track adolescents who have dropped out of school.
- The State has not funded prevention programs. The State received $8 million from the federal government for three years to combat youth alcohol and drug abuse, known as the State Incentive Grant (SIG). The State also receives Federal Substance Abuse Prevention & Treatment Block Grant funds. The table below lists federal funds for youth drug and alcohol prevention programs by island for FY2004.

Island	TOTAL Federal	SAPT	SIG
O`ahu	$1,788,337	549,037	1,239,300
Maui	495,500	210,000	185,500
Moloka`i	198,100	75,000	123,100
Lana`i	150,000	--	150,000
Hawai`i	513,100	150,000	363,100
Kaua`i	294,000	75,000	219,000
Statewide	952,946	952,946	--
Total	4,391,983	2,011,983	2,280,000

- The state has a comprehensive Youth Substance Abuse Prevention Strategy that focuses on coordinating resources, forming partnerships, using best practices, using risk and protective factors as a framework for planning and supporting programs that are effective and reflective of Hawai`i's cultural diversity.

- Risk factors are characteristics of people, family, school and community environment that are associated with increase in drug use. There are 17 identified factors, such as availability of drugs, extreme poverty, mobile community, families with drug abuse, family conflicts, academic failure in school, and a peer group that uses drugs and feelings of alienation or rebellion.
- Protective factors are associated with reduced potential for drug use, such as policies that encourage non-use of drugs, make resources available, foster close family relationships, provide leadership and decision making opportunities in school, encourage school activities that foster involvement of school, parents, community, students and involve a peer group that discourages drug use.
- In 2002, treatment needs for students in grades 6 through 12 indicates that 7,519 students in public and private schools need drug treatment; and 11,319 students are in need of any substance abuse treatment, as described in the table below.

County		Any drug abuse treatment needs		Any substance abuse treatment needs	
	Total	%	Number	%	Number
Honolulu	58,645	6.1	3,591	9.3	5,458
Hawai`i	13,077	8.8	1,150	13.7	1,787
Kaua`i	5,268	9.0	476	12.7	671
Maui	10,813	10.3	1,115	14.4	1,558
All public schools	87,803	7.2	6,332	10.8	9,474
Private schools	19,058	6.2	1,187	9.7	1,845
Total State	106,861	7.0	7,519	10.6	11,319

- In 2002, there were 1,552 adolescent treatment admissions for drug and alcohol abuse, almost all were publicly funded. This number is lower than in previous years due to the severity of the addiction that required longer stays in treatment. Thus, based upon the needs outlined in the table above, a significant gap exists between currently available publicly funded adolescent treatment resources and the need for adolescent treatment for substance abuse.
- State and federal funds for public school based substance abuse treatment programs were provided in the following number of schools for 2003-04 as described in the table below.

Schools	Total Number of schools	State funded	Federal funded	No funds, no program
High schools	45	30	4	11
Middle schools	57	3	0	54

- State and federal funding for adolescent substance abuse treatment for FY2004 is described in the table below.

Program/island	State	Federal	Total
School based treatment	$1,602,383	$719,087	$2,321,470
O`ahu	1,189,656	529,380	1,719,036
Maui	152,446	82,554	235,000
Kaua`i	113,927	36,073	150,000
Hawai`i	146,354	71,080	217,434
Lana`i (see Maui)			
Moloka`i	0	0	
Residential Treatment	289,997	200,000	489,997
O`ahu	145,000	100,000	245,000
Maui	144,997	100,000	244,997
Total all treatment	1,892,380	919,087	2,811,467

- Since nearly all state and federal funded adolescent treatment programs are school based, there are no treatment programs for youth who are not in school.

- ADOLESCENT SUBSTANCE ABUSE TREATMENT PERFORMANCE OUTCOMES for FY2001 and FY2002 based on six-month follow-ups are described in the table below.

MEASUREMENT	PERFORMANCE OUTCOME ACHIEVED AT SIX-MONTH FOLLOW UP	
	FY2001 [746 sample]	FY2002 [901 sample]
Employment/School/Vocational Training	95.3%	95.2%
No arrests since discharge	84.9%	87.3%
No substance use in 30 days prior to follow-up	50.4%	44.4%
No new substance abuse treatment	77.6%	79.2%
No hospitalizations	94.6%	95.4%
No emergency room visits	93.0%	93.1%
No psychological distress since discharge	79.9%	78.8%
Stable living arrangements	92.5%	94.8%

Judge R. Mark Browning, Juvenile Drug Court

TOPIC: Update on activities in Juvenile Drug Court. Key points:

- The Juvenile Drug Court program conducts hearings once a week and requires participants to maintain daily curfew and school attendance, and participate in community service and submit to drug tests 2-3 times per week. There is also a program of punishments and incentives to reinforce positive behaviors.
- Since its inception in August 2001, the program has received 165 referrals and accepted 65 participants. Of those 65, 13 have graduated and 39 are still currently in the program. Only one of the graduates has been arrested since completing the program.
- The program requires at least 8 months participation, however, most participants take 12-15 months to graduate. After graduation, there is six months of aftercare.
- Juvenile Drug Court does not accept applicants who are violent or sex offenders.

Judge Bode Uale, Family Drug Court

TOPIC: Update on activities in Family Drug Court. Key points:

- Family Drug Court was established in May 2002 to help alleviate Child Welfare Services cases. It was formed by a partnership between the Department of Health, Department of Human Services and the Judiciary.
- The program has a maximum caseload of 30 and there are currently 20 participants, all of whom are ice users. Thus far, there has been one graduate; however, five more are expected to graduate in two weeks.
- Participants must attend weekly hearings in which the case manager, social worker and guardian ad-litem inform the judge of the participant's progress.

Alan Shinn, Executive Director, Coalition For a Drug-Free Hawai`i

TOPIC: Description of programs. Key points:

- Since 1987, the goal for The Coalition For a Drug-Free Hawai`i has been to find permanent solutions to substance abuse in Hawai`i through education and prevention

with the support of schools, businesses and the community. Among the many programs offered by CDFH, two are discussed below.

- The Strengthening Hawai`i Families program emphasizes family values, defines family relationships, and helps to develop communication between family members. This model family program combines a team of four facilitators with a group of 6-10 families to assist them with goal setting, problem-solving, making choices, anger and stress management, and creating a healthy lifestyle. Participants in the program reported better relationships among family members, improved behavior by children, and clearer communication skills.
- The Strengthening Families program works because its starting point is based upon traditional Hawai`ian cultural values, and the entire family is empowered to find out what works best for them. Facilitators encourage parents and children to discover family skills that are consistent with their own values, rather than "teaching" them particular beliefs. The Strengthening Hawai`i Families brings together families, schools, businesses and community resources to build a healthier society.
- The R.A.D.A.R. Network Center lends out resource materials through their lending library; disseminates free informational brochures and materials through the clearinghouse and various information booths at community events, health fairs and meetings; and provides factual information upon request through telephone service, email, website, walk-ins and mailouts. There were approximately 30,000 patrons served this past year, materials were provided to over 30 community events across the State, and approximately 40,000 pieces of informational literature were provided to youth, educators and service providers.

Stan Inkyo, Program Director, Susannah Wesley Community Center

TOPIC: Description of programs. Key points:

- Susannah Wesley Community Center began its mission to help children and families in 1903. In 1968, the agency was incorporated as a nonprofit community center providing a range of social services including, senior meal services, family court diversion programs, immigrant services, substance abuse, and gang prevention services.
- Funded through the DOH/ADAD, the Center has partnered with Parents and Children Together, Kokua Kalihi Valley, the Housing and Community Development Corporation of Hawai`i, and the Department of Education to operate Parenting Adolescents Wisely. This program tries to provide outreach and parent education services to targeted families utilizing the "best practices" prevention strategy.
- The Hui Malama Ohana Youth Services Center is a collaboration of Kualoa-Heeia Ecumenical Youth, Hale Kipa, Parents and Children Together and Susannah Wesley that is funded through the Office of Youth Services. The Youth Services Center provides a safe environment where at-risk youth can access a continuum of services to assist them in developing a positive self-image and to reduce delinquency and recidivism. While Susannah Wesley does not provide direct substance abuse treatment programs, their goals are to strengthen the community and to provide alternative activities for our young people.
- Although Mr. Inkyo was not able to attend the hearing, the Susannah Wesley Community Center presented results from a survey of youth ages 16-21 in their Youth Employment Program about drug use. The survey was completed by 37 youths, of whom 27 responded that they had experimented with drugs. The following table lists the type of drugs with which the youths have experimented. Marijuana is the primary drug of experimentation.

	Number who experimented
Marijuana	25
Crystal Meth	6
Alcohol	5
Cocaine	4
Acid	3
Ecstasy	3
Inhalants	2
Heroin	1

- The following table lists the reasons given for experimenting with drugs, including the number of times the reason was given, and number of times that it was the only reason given. Peer pressure is the primary reason given for drug experimentation.

	Number of occurrences	Occurrences where only reason given
Peer pressure	9	4
Curiosity	8	4
Stress	6	1
Wanted to	5	5
To get high	4	2
Just for fun	2	

Charles Braden, Executive Director, Waimanalo Health Center

TOPIC: Description of programs. Key points:

- The Waimanalo Health Center, founded in 1992, is a federally qualified primary health care center for the residents of Waimanalo, serving over 3,500 patients annually. The annual budget is $3.6 million dollars consisting of federal grants, State of Hawai`i purchase of service contracts, private and public medical insurance dollars, and fees for services. The staff is comprised of 55 physicians, clinical psychologists, physical therapists, nurses, nurse practitioners, medical assistants, outreach workers, a social worker, a cultural healer, youth mentors, and administrative personnel.
- Ice use is a prevalent problem in Waimanalo. The Waimanalo Health Center runs a mentoring program at the Waimanalo Elementary and Intermediate School, and would like to expand the program to the Blanche Pope Elementary School and Kailua High School, but is hampered by funding issues. The State purchase of service contracts have not allocated any increases to cover inflationary costs. While intervention and treatment are key, the best means for addressing the ice issue is through prevention and education, and more resources are necessary to achieve that end.

Greig Gaspar, Marketing Specialist, Waimanalo Heath Center

TOPIC: Description of programs. Key points:

- The Waimanalo Heath Center is one of 10 federally qualified health centers under Section 330 of the Social Security Act, in the State of Hawai`i. It serves the underinsured and the uninsured, often the sickest of the sick. No one is ever turned away from the Center. Ice is the number one drug of choice for the population served, and is a major problem in the Waimanalo community.
- The Ku I Ka Mana Native Hawai`ian Youth Mentoring Program, funded through DOH/ADAD, has been in the Waimanalo Elementary & Intermediate School for six years. It provides a culturally sensitive support system for our community's young people.

- The `Ai Kupele, or Cultural Healing Center, combines cultural knowledge with modern substance abuse information to assist patients in beating substance abuse. In partnership with Tripler Army Hospital, the Center has a mental health program that provides patients with twice a week visits to address substance abuse issues like relapse, recovery and depression/anxiety.
- Treatment dollars are inadequate for the current problem. Limiting treatment services means that our prisons will become increasingly crowded and the likelihood of recidivism increases. The State has acted only when a crisis hits. Had more funds been allocated for treatment and prevention programs years ago, Hawai`i would not be facing such a huge problem today.

David Nakada, Executive Director, Boys & Girls Club

TOPIC: Description of programs. Key points:

- Funded through the Office of Youth Services, the DOH/ADAD, and the Department of Education, the Boys & Girls Club provides after-school activities and services in at-risk communities. Total membership for 2001 was 5,420. The program is based on providing youth a safe place to learn and grow, providing long-term relationships with caring adult professionals, and working on character and leadership development.

Lynn Akana, Family Service Center, Palama Settlement

TOPIC: Description of programs. Key points:

- Established 100 years ago, the Palama Settlement has helped immigrants adjust to Hawai`i, giving their children a place to learn and to have fun. The Settlement has provided medical and dental care, social service, boarding houses, sports activities, classes, and cultural and recreational activities. For adolescents, it has provided an after-school program, specialized day residential treatment services, and behavioral management classes. It also provides drug outreach and family preservation services for the low-income housing areas surrounding the Settlement, and has assisted 700 families.

September 22, 2003

Keith Yamamoto, Program Development Officer, Office of Youth Services, Department of Human Services

TOPIC: Drug prevention and treatment programs in Youth Services Correctional facilities. Key points, as supplemented by information submitted after the informational briefing:

- Office of Youth Services (OYS) refers adolescents in need of residential treatment to Bobby Benson and Ho`omaka Hou (Maui Youth & Family Services). DOH/ADAD pays for these referrals. Last year, 35 adolescents were referred to residential treatment.
- In FY2003, OYS had 365 adolescents in its correctional facility. In FY2003, OYS contracted with Kalihi YMCA for $94,000 to provide education, assessment, screening and counseling for these adolescents. 55 adolescents required counseling for drug abuse, of which 59 percent acknowledged ice usage. In a follow-up of 27 adolescents who completed the program in FY2003, 16 adolescents or 59 percent indicated no drug-use for 90 days after leaving the facility.
- Last year, OYS referred 20 persons over 18 years old to the Hawai`i Alcohol Foundation (Sand Island Treatment) for residential treatment. The FY2003 contract for these services was $139,000. These individuals had an average stay of 102 days, at an average cost of $135/per bed per day. Of those 20 persons, 70 percent acknowledged

ice use. In FY2002, of the 15 persons who completed the treatment, only 7 were located for follow up after 90 days. Of the 7 persons located, 5 persons or 71 percent reported no drug-use within 90 days of completion of treatment.[16]

- Adolescents who are referred to residential treatment as part of their short-term commitment to the correctional facility (less than 365 days) may be furloughed home after completion of residential treatment, and remain on probation under the supervision of the Family Court.
- Adolescents who are referred to residential treatment as part of their commitment to the correctional facility until the age of 18, may be paroled subject to the jurisdiction of OYS upon successful completion of residential treatment. Those who do not complete residential treatment are returned to the correctional facility.

Lillian Koller, Director, Department of Human Services

TOPIC: Protecting children affected by ice, placement and services through the Department. Key points:

- Child Welfare Services Branch (CWS) of the Department of Human Services may recommend that a child be removed from an unsafe home, but has no authority to do so. Only the police and courts are authorized to remove a child from a home.
- Police are authorized to remove a child without a court order and without the consent of the family if the police officer finds that the child's continuation in the custody or care of the family or legal guardian presents an imminent harm to the child. Police may take protective custody of the child if there is no legal custodian willing or able to provide a safe home for the child, or if the parent or legal guardian has subjected the child to harm or threatened harm and is likely to flee the court's jurisdiction with the child.
- CWS conducts a safety and risk assessment before recommending that a child be removed from the home. CWS may assess a child as being harmed, but this does not automatically result in removal from the parent(s). CWS follows the federal government guideline that states that a drug-exposed newborn or newborns born to parents who are using drugs are not automatically removed from the home. A child of parents who are using drugs is not automatically removed from the home.
- CWS operates with the premise that the child should remain with the family and tries to keep the family intact. CWS tries to divert the family to family strengthening services and ohana conferencing before considering removal of the child
- CWS uses the "Safe Family Home Guidelines" (§587-25, HRS) to determine whether a family is willing and able to provide a safe family environment for the child. After the assessment is made, CWS will recommend to the Family Court whether the child should be returned to the home.
- One million dollars in TANF funds administered through the Benefits Division is earmarked for contracts with Hina Mauka and the Salvation Army to provide drug treatment services to eligible clients. Clients participate in a treatment program as an alternative to placement in the work program. The client's benefits are contingent on continued participation in treatment. To date, 20 persons are participating in this new program.
- CWS arranges for counseling for children removed from the home through available resources, such as purchase of services contracts, through DOH, DOE, Family or Juvenile Drug Courts, or private health insurance.
- Child welfare services are activated for a person born alive and who is less than 18 years of age. Thus, CWS does not provide services to an unborn fetus of a mother who is addicted to ice. Prenatal care and substance abuse services may be available under

[16] OYS does not routinely maintain outcome data on those persons referred into residential treatment. Data provided was compiled at the request of the Task Force.

QUEST, if the mother is eligible. Notably, alcohol and tobacco are more harmful to the fetus than ice, and CWS does not step-in to protect the fetus of a mother who uses those substances.

- CWS does not collect data on the number of children removed from the home because of safety concerns relating to the use of ice in the home. In FY2002, CWS had approximately 7,000 active case, of which 4,827 children were in foster care. Anecdotally, CWS estimates that 85-90 percent of its cases involved parents addicted to ice or other drugs, but not all of these cases result in the removal of the child from the home. As of the date of the presentation, CWS had exhausted all foster care resources.
- Placement costs are described in the table below:

Level of Service	Annual cost
Child remains in home, CWS and court involvement, treatment/counseling services to the family	$7,840
Child placed in foster care, CWS and court involvement, treatment/counseling services to the family, monthly board payments for foster care of $529	$14,740
Child placed in foster care, CWS and court involvement, treatment/counseling services to the family, monthly board payments for foster care of $529, maximum difficulty of care payment of $570/month	$21,740

- Persons may qualify for federal disability benefits if a physician certifies them as having a "chemical dependency" disability. This benefit should not be overlooked by professionals who deal with persons who are addicted to drugs.

Kathy Kawaguchi, Assistant Superintendent, Office of Curriculum, Instruction and Student Support, Department of Education (DOE) (Superintendent Patricia Hamamoto responded to questions).

TOPIC: Drug usage, drug prevention and treatment programs in public schools, and drug testing. Key Points:

- According to the 2002 Hawai`i Student Alcohol, Tobacco and Other Drug Use Study, which surveyed with parental consent 27,995 students in grades 6, 8, 10, and 12 attending 181 public and 34 private schools, the trend in lifetime prevalence of illicit drugs, including methamphetamine is declining, except for ecstasy. The survey indicates ecstasy use by 11 percent of 12th graders, 7 percent of 10th graders, and 3 percent of 8th graders.
- DOE does not offer drug treatment programs. It refers students to treatment programs funded by other state agencies and private treatment organizations.
- DOE includes drug education in its health curriculum requirements. Each school may select a health program that includes drug education. The majority of programs offered in the schools are federally funded. DOE received approximately $600,000 in federal funding for two years. Lions Quest is the only State funded program. DOE has not evaluated the success of their drug education programs and any program evaluation should be part of a redesign of the educational system.
- DOE takes no position on drug testing in the schools.
- DOE has a zero tolerance policy for drug offenses. If a student commits a drug offense, the student is referred to counseling and information about drug treatment, and counseling is provided to the parents. However, the student is primarily responsible to seek assistance and resolve any drug abuse problem. (Substance Abuse Regulations 4200.5)
- In school year 2001-2002, student disciplinary action taken for drug-related offenses were predominantly due to marijuana and tobacco use as described in the table below.

Drug related offense	Number
Marijuana	675

Smoking	673
Drug paraphernalia	240
Alcohol	211
Other Illicit substances	60

- DOE may exclude a student from attending school for up to 92 days for possessing, selling, consuming, or using illicit drugs while attending school or a school activity, or if the student reasonably appears to have consumed or used illicit drugs prior to attending school or a school activity. If the student is excluded for more than 10 days, the school should refer the student to appropriate intervention and treatment. (§302A-1134.6, HRS)

Jon M. Van Dyke, Professor, William S. Richardson School of Law, University of Hawai`i at Manoa

TOPIC: Drug testing in schools under the State of Hawai`i and United States Constitution. Key points, as supplemented by written information submitted after the informational briefing:

- Under the United States Constitution, students have an expectation of privacy at school, but school officials do not have to obtain a search warrant based on probable cause to search a student. Instead, school officials may search a student if they have a reasonable suspicion that the search will produce evidence of violation of a law or school rule.
- In 2002, in Board of Education v. Earls, the United States Supreme Court upheld a policy that required urine testing for drug usage for all middle and high school students who engage in extracurricular activities. The Supreme Court has struck blanket suspicionless drug testing programs.
- The Hawai`i Constitution, as amended by the Constitutional Convention in 1978, established privacy as a fundamental right subject to interference only upon a compelling State interest. Since the amendment, the Hawai`i Supreme Court has given greater protection to privacy interests than the United States Supreme Court.
- The Hawai`i courts have upheld mandatory drug testing of police officers and fire fighters on the grounds that public safety concern was a compelling State interest that outweighed the diminished privacy expectations of such public employees. Further, the Hawai`i Supreme Court ruled that drug testing of persons serving on probation was permissible without a warrant if the probation officer had a reasonable suspicion that the probationer was using illegal drugs.
- It is difficult to predict how the Hawai`i Supreme Court would rule if the question on mandatory drug testing in the schools were before the Court. However, based on its past rulings, the Court would likely find that blanket suspicionless testing would violate the Hawai`i Constitution unless the State can establish a compelling State interest to justify the intrusion, and that the testing method be the least drastic alternative to meet the State's objectives. A student has at least as much privacy rights as a probationer, and a court may require reasonable suspicion to justify drug testing.
- While the government has a compelling State interest in ensuring the safety of students, this interest may not be sufficient to conduct drug testing on all the students for the sake of identifying some of the students who use drugs.
- A voluntary drug-testing program where a student consents to be tested for drugs would not be unconstitutional. Parental consent to conduct drug testing on a minor child under 14 would be a valid waiver of the child's privacy. However, a parent may not waive the privacy rights of a minor child between 14 and 16 years of age, except in limited circumstances. A student over age 16 must consent to drug testing and parental consent is not sufficient. (Testimony clarified by letter dated October 7, 2003)

Harvey Lee, Program Specialist, Pacific Comprehensive Regional Assistance Center, Pacific Resources for Education and Learning

TOPIC: Overview of drug testing in schools across the nation. Key points, supplemented by written materials submitted by speaker:

- Some schools that have implemented a drug-testing program have found that drug testing deters drug use.
- According to a pilot study of 9 schools that implemented a drug-testing program for students who participated in athletics or extracurricular activities, the study found that the testing program resulted in less positive test results, but lowered the level of disciplinary problems. The elements of a successful drug-testing program included a well written publicized policy, procedures to prevent fraud and protect confidentiality of test results, policy against reporting the results to the police, referral to counseling and treatment for students who test positive, and involvement of stakeholders in the planning process. (DuPont, et. al., "Report of a Preliminary Study: Elements of a Successful School-Based Student Drug Testing Program," U.S. Department of Education, July 22, 2002)
- Some schools have abandoned drug-testing programs because testing did not appear to deter drug use, funding for testing was switched to drug prevention programs or the school changed to using drug-sniffing dogs. Miami Dade County public schools abandoned a voluntary drug-testing program that required consent of parent and student because of poor response and results. Out of 83,000 eligible high school students, only 37 consented to testing, and of those tested, 2 tested positive. The Guymon school district ended its three-year random drug-testing program for athletes and students engaged in competitive extracurricular activities because it found that students who participated in such activities were less likely to use drugs. Testing also deterred students from participating in such activities thereby pushing them out on the streets where they were more likely to become involved in drugs. See, "Challenges to Drug Testing Programs," prepared by Drug Policy Alliance for examples of schools approaches to drug testing.
- A study conducted by researchers from the University of Michigan, funded by National Institute on Drug Abuse and the Robert Wood Johnson Foundation (Yamaguchi, Johnston, O'Malley, "Relationship Between Student Illicit Drug Use and School Drug-Testing Policies, Journal of School Health, April 2003, Vol. 73, No. 4), concluded that drug testing was not a predictor of either the prevalence or frequency of illegal drug use. As a deterrent, the study found that school policies that focus on values, attitudes, and perceptions were more important in drug prevention than drug testing.
- The Office of National Drug Control Policy recommends that schools that implement a drug-testing program include the following components: use substance abuse specialists to assess drug use, provide comprehensive treatment services for students with potentially serious drug problems, keep test results confidential, and refrain from releasing the test results to police.
- A five-year study of the use of student assistance programs in residential facilities for high risk, multi-problem, inner city, minority youth found that such programs were successful in preventing or reducing alcohol and illegal drug use. (Morehouse and Tobler, "Preventing and Reducing Substance use Among Institutionalized Adolescents," Adolescence, Vol. 35, No. 137, Spring 2000)

Carl Linden, Scientific Director, Toxicology, Diagnostic Laboratory Services, Inc.

TOPIC: Drug testing statistics in Hawai`i, Urinalysis testing methodology. Key points, as supplemented by written information submitted after the informational briefing:

- Diagnostic Laboratory Services, Inc. (DLS) and Clinical Labs of Hawai`i (CLH) contract with public and private employers in the State to perform urinalysis drug testing of applicants and employees referred to testing as a condition of continued employment. Both laboratories combined their workplace drug testing data to provide the Task Force with a picture of drug use by Hawai`i's workforce subject to testing. The table below describes the samples used for this analysis.

DATA SAMPLE of persons tested for five year trends	Sample size
DOT: Employees subject to federal Department of Transportation regulations [mandatory, random drug testing]	26,327
Non-DOT: Employees subject to employer's policy on testing [random or for cause], includes persons tested under court ordered program	106,327
CLH: primarily employees subject to employer's policy on testing, may include others	60,000

- Of those applicants/employees tested over an 18-month period of time who tested positive for illegal drug use, marijuana is the drug of choice, with methamphetamine as the next most prevalent drug used. The table below describes the percent of positive test results in DLS and CLH data for marijuana and methamphetamine.

Applicant/employees who tested positive	Marijuana	Methamphetamine
DOT (DLS)	1.5%	1.0%
Non-DOT (DLS)	1.4%	1.2%
DOT, Non-DOT, Court ordered (DLS)	4.2%	3.0%
CLH	Not provided	2.0%

- Nationally and in Hawai`i, marijuana is the drug of choice in the workplace. However, methamphetamine use in Hawai`i is 4-5 times higher than the national average. (National data source: Quest Laboratories)
- The trend over the last four years indicates an increase in use of methamphetamine among the workforce in Hawai`i and across the nation. DLS data indicates an increase of 25 percent and CLH data indicates an increase of 67 percent over five years. Nationally, while methamphetamine use is low, the increase over five years is 70 percent. Marijuana use in the workplace in Hawai`i also appears to be trending upward.
- Hawai`i conducts drug testing through urinalysis only. All drug testing follows the industry and national standards. Urinalysis can detect drug use between 1 to 14 days prior to collection. Urine can be adulterated through ingestion of chemicals that mask the drug.
- The urine specimen (30-45 ml) must be collected under controlled procedures, kept confidential and sealed, through a chain of custody between collection and testing. After the initial screen, a positive test result is subject to a second test for confirmation. The final report is then reviewed by a medical review officer.
- The range of cost for urine testing is described in the table below:

Collection	$15-25
Test	$15-25
Medical review officer	$ 7-14
TOTAL	$37-64

- Costs for urine testing is established by contract. The cost for testing is due, in part, to the State law that requires confirmatory retesting and the lower thresholds than that required under federal law, which tends to result in more false positives.

- National statistics of drug testing in the workplace indicates that testing is a deterrent to drug use in the workplace because the number of positive test results have been declining over the years.
- Voluntary drug testing will produce typically 100 percent negative test results because only those who are drug free will volunteer.

Clifford Wong, Toxicology Director, Clinical Labs of Hawai`i

TOPIC: Workplace and other drug testing statistics, use of hair and saliva as a predictor of drug use. Key points:

- Clinical Labs of Hawai`i (CLH) conducts drug testing of persons arrested for Driving Under the Influence. Over the past five years, marijuana use by drivers occurred twice more often than methamphetamine use, on a statewide basis.
- CLH conducts postmortem analysis for coroners on the neighbor islands. Deaths associated with methamphetamine use do not appear to be dramatically on the rise, as described in the table below.

County	1998	1999	2000	2001	2002	2003 (7 mos.)
Maui	0	4	10	6	9	5
Hawai`i	1	3	5	12	9	7
Kaua`i	0	0	3	1	2	2
Total	1	7	18	19	20	14

- Hair testing for drug use is not authorized under current State law. Drugs may be detected in hair samples due to transfer from blood capillaries to hair follicle, absorption of oil gland secretions by the hair follicle, and absorption of sweat gland secretions by the hair follicle. Hair follicles may also absorb airborne drugs, which requires a higher cut-off limit for a positive test result. Hair samples are taken from behind the head and should include a 1.5" root strand. A 1.5" strand provides detection for drugs over a 3-month period of time. The estimated cost for hair testing is $50-250 and only a limited number of laboratories offer this service.
- Hair testing does not detect drug use within 1-2 days prior to collection of the sample. Hair testing provides long-term assessment of drug use, is noninvasive, easy to resample, and has a low potential for adulteration. On the other hand, hair testing has the potential for environmental contamination and is subject to ethnic bias because drugs attach more readily to dark hair that contains more melanin than light hair.
- Saliva, or oral fluid testing, is not authorized under current State law. Drugs may be detected in saliva due to transfer from blood capillaries to salivary glands. Drug concentrations in saliva are comparable to blood levels. Saliva is taken from the mouth after prewash. The estimated cost for saliva testing is $25-30 and only a limited number of laboratories offer this service.
- Saliva testing detects drug use within 10-24 hours before collection. Saliva testing is noninvasive, provides immediate link between drug use and behavior, saliva concentration correlates to free drug concentration in blood, and has a low potential for adulteration. However, saliva testing has the potential for oral drug contamination, measures only short-term drug use, and requires careful collection methods.

Pamela Lichty, President, Drug Policy Forum

TOPIC: Policy issues relating to student drug testing. Key points:

- The United States Supreme Court has upheld student drug testing for students involved in extracurricular activities. About 5 percent of 15,000 school districts test athletes and

3 percent test extracurricular participants. Suspicionless blanket drug testing is not a standard practice in schools across the country.

- Participation in extracurricular activities should not be contingent on drug testing because such activities serve as a protective factor to prevent substance abuse.
- Suspicionless testing creates an atmosphere of mistrust, and could adversely affect school morale.
- Better use of resources would be for programs that prevent harmful student behaviors, attitudes and perceptions. This type of prevention program is more effective as a deterrent to drug use than drug testing.
- Treatment programs must be in place before drug testing is undertaken.
- The California State PTA in May 2003 adopted a resolution advocating for alternatives to a zero tolerance policy for students who are caught using drugs. It concluded that punishment through suspension or expulsion, without any intervention services, is ineffective and unsuccessful in deterring substance abuse. Instead, school connectedness programs, such as positive behavior mentoring, student assistance counseling and education, and extracurricular activities, were more effective as a deterrent to substance abuse than a zero tolerance punishment policy.

Debbie Hornsby, Academy of the Pacific.

TOPIC: Private school's response to drug prevention. Key points:

- The school rejected the drug-testing program, and instead brought in Custer, a golden retriever, to sniff lockers, cars and backpacks to identify drugs. The dog does not sniff students. The dog will appear unannounced twice a month to perform his sniffing task. Custer is provided by Interquest Detection Canines of Hawai`i, the only private company that provides this service in Hawai`i.
- The school has 140 students who have fallen through the cracks of public or private education. Last year, drug presence on campus was a problem. In response, the school adopted a practice to assess and refer the student and his or her family to counseling or more intensive treatment. The student must participate in treatment while continuing in school. The school works with the treatment provider. The school uses a referral form that may be completed by family, school staff, or friends to identify the behavior of the student that suggests a substance abuse or other problems.

Rich Schaffer, Principal, Mid Pacific Institute

TOPIC: A private school's response to drug prevention. Key points:

- Mid Pacific Institute is a college preparatory school that enrolls 1100 students. The school had a zero tolerance policy resulting in immediate dismissal for a student caught using drugs. Last year, the school reviewed that policy and switched to a treatment assistance approach. They now look at the student as a whole and refer the student to treatment with random testing while in treatment. They implemented a curriculum that covers the societal issues, including drug abuse.

Charlotte Malott, co-Executive Director, YMCA Outreach Services, Kalihi YMCA

TOPIC: Adolescent treatment programs. Key points:

- The Kalihi YMCA Outreach Services provides two outpatient substance abuse treatment programs for youth aged 12 to 18, school based and court ordered. The programs assess the client, develop an appropriate treatment plan utilizing individual and group interventions, relapse prevention, and family sessions. As the youth move toward completion of the treatment plan, a self-recovery post treatment plan is developed.

Treatment interventions are developed based on age and gender, and are culturally appropriate.

- The school-based program is funded through DOH/ADAD ($975,837 for FY2003) and provides treatment services at 12 public high schools on O`ahu. In FY 2002-2003, 526 youths were served. Outcomes from treatment are described in the table below:

School Based Program Outcomes	Percent
Youths admitted who completed program	82%
Youths discharged, abstinent at 6 month follow up	56%
Youths discharged, abstinent or reduced usage at 6 month follow up	67%
Youths discharged, improved school performance or attendance or employed in vocational program at 6 month follow up	78%

- The Kalihi YMCA contracts with Family Court, First Circuit Judiciary Outpatient Substance Abuse Treatment Program to provide outpatient treatment and assessment services to adjudicated youths to age 18 ($239,000 for FY2003). Youths are court order to treatment and remain in the program until clinically discharged. YMCA provides assessment and treatment services under this program. In FY2002-03, 197 youths were served in the treatment program, and 214 were assessed. Outcomes from the treatment program are described in the table below:

Family Court Program Treatment Outcomes	Percent
Youths admitted who completed treatment	62%
Youths discharged who abstained at 3 month follow up	41%
Youths discharged who abstained or reduced usage at 3 month follow up	54%
Youths discharged who had no additional criminal law violations at 3 month follow up	59%

- The Kalihi YMCA contracts with the Family Court, First Circuit Juvenile Drug Court to provide assessment and outpatient treatment services to families and nonviolent juveniles under age 18. Most juveniles in this program are addicted to drugs. Treatment time runs four to six months and juveniles are drug tested by the court. The court may sanction or reward the juvenile, depending on the test result. In FY2003, 28 juveniles and 68 families were served with treatment. Outcomes from the treatment program for juveniles served are described in the table below:

Juvenile Drug Court Treatment Outcomes	Percent
Juveniles successfully completed treatment	81%
Juveniles completed program, no re-arrest at 3 month follow up	77%
Juveniles completed program, abstain at 3 month follow up	62%

- The Kalihi YMCA provides assessment and substance abuse counseling and educational services to youths committed to Hawai`i Youth Correctional Facility. The youths receive between one to eight hours of individual and group counseling sessions each week, covering the subjects relating to substance abuse and life skills. In FY2002-03, 219 youths received counseling and educational services. The outcomes of the program are described in the table below:

HYCF Counseling Program Outcomes	Percent
Youths completed counseling program	77%
Youths remained abstinent at 3 month follow up	55%
Youths avoid further involvement in criminal justice system for 3 months after discharge	55%

Tony Pfaltzgraff, co-Executive Director, Kalihi YMCA

TOPIC: Drug testing in public schools. Key points:

- Students in school who participate in the school based treatment programs meet the criteria for substance abuse, but they do not meet the criteria for drug addiction. This means that their drug use has progressed to the point where it negatively impacts school performance and their relationships with friends and family. Often, the parents or family members regularly abuse drugs or alcohol.
- Drug testing means that information will be shared with parents. This could lead to more deterioration in the relationship between the student and parent. Insufficient resources exist for parents to learn how to deal with their child's drug use.
- Drug testing would create an atmosphere of suspicion. The school-based counselors have positive relationships with the students and testing would undermine those relationships.
- Money for drug testing would be better used for treatment and prevention programs that actually make a difference.

Mary Elizabeth Pacheco, Clinical Supervisor, Andy Anderson, Chief Executive Officer, Hina Mauka Adolescent Programs

TOPIC: Adolescent Treatment programs. Key points:

- Hina Mauka's Teen-C.A.R.E. program provides a continuum of school based substance abuse treatment services to adolescents and their families. It includes individual and group processing, counseling, education, peer and adult role modeling, crisis intervention, and clean and sober recreational activities. Teen-C.A.R.E. staff and school faculty work together to educate students about taking responsibility for their choices and finding solutions. Since some students come from families that abuse drugs or alcohol, the student participation in the program is confidential until it is feasible to involve the families. The program provided treatment services to 500 public high school students in 12 schools on O`ahu, Kaua`i, and Lana`i in FY2002. Outcomes of the treatment program for FY2001-2002 are described in the table below:

School based treatment outcomes	O`ahu	King	Kaua`i	Lana`i
Completed program	64%	68%	76%	100%
Completed program, abstinent or reduced usage at 6 month follow up	76%	75%	60%	60%
Completed program, employed, in school or vocational at 6 month follow up	85%	93%	91%	58%
Completed program, improved social relations	60%	68%	55%	58%

Catherine Bruns, Executive Director, Bobby Benson Center

TOPIC: Adolescent residential treatment. Key points:

- Bobby Benson Center provides chemical dependency treatment for up to 24 girls and boys, ages 13-17 in a residential setting. Family cabins are available for families participating in the care of the child. The center emphasizes its work with families. The program is highly structured, uses cognitive behavioral methods within a 12-step recovery model. A DOE supported school operates on site to provide clients with education while they are in treatment. Sources of funding include DOH/CAMHD, DOH/ADAD, Judiciary, HMSA, Kaiser and other.
- The program served 98 youth in FY2002-03, with 75 admissions and discharges. 45 percent of the youth identified as part Hawai`ian. 37 percent of the clients identify ice

as the primary drug of choice and 75 percent report use of ice. The average length of stay runs 4-6 months. The outcomes for FY2002-03 are described in the table below:

Treatment Outcomes	Percent
Completed program, clinically discharged	59%
Clean and sober at 6 month FU	71%
Working or attending school at 6 month FU	71%
Living in stable arrangement at 6 month FU	94%
Missed no work/school due to drugs for six months after discharge	85%
No new arrests for 6 months after discharge	76%

- The program has a long waiting list because it is the only residential treatment center-serving adolescents. No step down resources are available for those who are discharged from the program. Funding restrictions from private insurance creates challenges to providing treatment because youth who are high on ice require two to four weeks before they can participate in treatment, and private insurance is generally exhausted by that time.

OCTOBER 6, 2003

Jennifer Diesman, Manager, Governmental Relations, HMSA

TOPIC: Insurance coverage and insurance parity for substance abuse treatment, Quest coverage for substance abuse. Key points, as supplemented by written information submitted after the informational briefing:

- HMSA plans have no barriers to care. HMSA does not require referrals, prior authorizations, or notifications. HMSA does not control how or when members use substance abuse benefits.
- HMSA covers substance abuse treatment through a provider network that includes: 94 percent of all SAMHSA-recognized providers that accept private health insurance; 100 percent of all public and private hospitals that provide substance abuse services; contracts with any provider that meets credentialing criteria; and 90 percent of eligible residential care programs who participate in HMSA.
- HMSA pays full benefits, as required by State law for substance abuse benefits and for medically necessary substance abuse services. Members also receive case management services through the Behavioral Care Connection.
- Private insurance and Quest members can access 30 hospital days or 72 outpatient visits, including residential treatment, per treatment episode. This benefit is provided twice over the lifetime of the commercial plan member. Under the Quest plan, these benefits are provided per treatment episode per year, although treatment episodes spill over into the next calendar year.
- In the last 15 months, no member under either the commercial or Quest plan has reached their maximum benefits or been denied the treatment they need.
- Since 1998, only 167 commercial plan members incurred a second lifetime episode for treatment. Of that group, 12 received treatment beyond their second episode and were extended coverage.
- The table below describes the increase in costs for substance abuse services, both on a per person basis, as well as overall for all substance abuse services due to increase in utilization. This increase reflects payments to providers and insured's co-payments.

Feb. 2002-March 2003, average costs per commercial member increased for substance abuse benefits	20%
Feb. 2002-March 2003, costs for all commercial members increased for substance abuse benefits	30%

- The nonweighted average fees for categories of service per member per day for substance abuse benefits are described in the table below:

Average HMSA Fees paid to providers	Commercial Plan	Quest
Adult intensive outpatient	$120/session	$75/session
Adolescent intensive outpatient	$77/session	$73/session
Residential care	$172/day	$137/day
Partial hospitalization	$129/day	$101/day

- The number of commercial plan members with substance abuse diagnosis is small, 2047 members out of 552,922 average monthly enrollment or 0.37 percent. Out of approximately $805 million in benefits paid, $2 million was paid for substance abuse benefits or 0.25 percent. The most prevalent substance or condition for which members sought treatment is alcohol (34 percent), followed by dual diagnosis disorders (15 percent), tobacco (14 percent), miscellaneous drugs (11.5 percent) and amphetamine (10.6 percent). Of the 2,047 members diagnosed with substance abuse, two-thirds were treated for medical conditions related to substance abuse but did not seek therapeutic substance abuse treatment. (Time period: April 2002 to March 2003)
- The number of QUEST members with substance abuse diagnosis is comparable to commercial plan members, 2029 out of 72,051 average monthly enrollment or 2.82 percent. Out of approximately $94 million in benefits paid, $2.5 million was paid for substance abuse benefits, or 2.65 percent. As with commercial plan members, the most prevalent substance for which treatment was sought by Quest members was alcohol (29 percent), followed by amphetamine (23.4 percent), and miscellaneous drugs (10 percent). (Time period: July 2002-June 2003)
- The types of treatment provided to Quest members who sought substance abuse treatment for the period July 2002-June 2003 falls into three basic categories: (1) professional services, such as a physician's office, (2) inpatient facility, such as an acute care hospital with emergency room services and overnight stay, and (3) outpatient facility, such as a residential treatment center, multidisciplinary services clinic, skilled nursing home. Notably, few members were treated by inpatient hospitalization. The table below indicates the number of Quest members who received services by service category and the aggregate cost for each service category.

Quest Members	Professional Services	Inpatient Facility	Outpatient Facility
Unique members	1403	125	1274
Amount paid	$466,675	$406,554	$1,618,998

- HMSA is working proactively to identify and refer members to substance abuse treatment, participating and sponsoring drug awareness and education activities in the community, and by developing a Statewide data set and standards for measuring outcomes for substance abuse treatment.

Doug Althauser, MEd, CSAC, MAC, Chemical Dependency Program Coordinator, Kaiser Permanente Department of Behavioral Health Services

TOPIC: Insurance coverage and insurance parity for substance abuse treatment, Quest coverage for substance abuse. Key points:

- Kaiser's philosophy of treatment for chemical dependency is to educate their members about their recovery so the member can pursue his or her recovery at the time of discharge.

- Kaiser provides outpatient treatment services only and believes that this method is as effective as residential treatment. Since not all addicts require the same type of treatment, Kaiser provides a spectrum of services, including assessment, education, intensive outpatient (9 hours/week), day treatment (15 hours/week), aftercare, relapse prevention, and ongoing recovery support.
- Chemical dependency services are estimated at $500,000 per year for members.
- Kaiser provides substance abuse treatment under both its commercial plan and the State Quest program for the medically indigent. Both programs offer up to 84 sessions of clinically necessary outpatient treatment and do not cover residential treatment. The commercial plan limits substance abuse treatment benefits to two treatment episodes per lifetime and requires co-payment up to 20 percent. The Quest plan does not have these limitations.
- The average treatment for members is 36 sessions over five months.
- 1200 – 1400 members are evaluated per year. More than 1000 are referred to treatment, primarily outpatient treatment services. Of those referred to treatment, more than 75 percent are QUEST members.
- On O`ahu, nearly 75 percent are addicted to ice, and on Maui, 50 percent are addicted to ice.
- Kaiser is not concerned that parity will affect its practice because its treatment is effective under the present level of coverage. Of the 200,000 members, less than 40 commercial plan members reached their second lifetime episode. The Kaiser treatment philosophy works with members to avoid relapse.
- Kaiser expects that parity will result in the loss of $100,000 in revenue that will have to be recovered. If residential treatment or longer lengths of treatment are required, then Kaiser would need to recover increased revenues. Two days of residential treatment costs more than one month of Quest premium capitation.
- Kaiser is concerned that parity will remove its ability to exercise clinical judgment to authorize appropriate services. Persons with chemical dependency do not require identical treatment and forced treatment can be counter-therapeutic.

Robert McClay, Executive Consultant, AlohaCare

TOPIC: Insurance coverage and insurance parity for substance abuse treatment, Quest coverage for substance abuse. Key points, as supplemented by written information submitted after the informational briefing:

- AlohaCare is governed by the Community Health Centers of Hawai`i and provides Quest benefits to 43,000 members on all islands except Moloka`i and Lana`i.
- AlohaCare contracts with hospitals and medical providers to provide behavioral health services through 250 independent providers. It uses a data system that monitors services through providers and members to avoid provider hopping.
- Behavioral health benefits are 30 days inpatient days for hospital care and 24 hours of professional outpatient care. Inpatient days may be converted 2:1 for outpatient sessions. Residential care is not a covered benefit. Based on medical necessity and availability of alternative funding, AlohaCare will pay for 1-5 days of residential treatment.
- Approximately 60-70 percent of requests for treatment have a co-occurring diagnosis of substance abuse and a mental health disorder.
- 1.5 to 2 days of residential care exhausts the entire capitation that AlohaCare receives from Quest to cover all the members health care needs for a month. Residential care costs approximately $4,500 for 30 days, excluding medications, physicals for admission to treatment, and lab work. This equals the per member capitation from Quest for two years. Intensive Outpatient Care costs approximately $75 per session.

- The table below indicates the number of Quest members who received substance abuse treatment by service category and the aggregate cost for each service category in benefit year 2002-2003.

Level of care	Number of members	Cost
Acute hospital	202	$577,652
Intensive outpatient	598	$484,754
Residential type care	126	$55,113
Total	929	$1,117,519

- The total dollars paid for substance abuse treatment services represents 1.5 percent of medical care expenses incurred in 2002-2003. This does not reflect the medical, laboratory, and pharmacy costs that may be provided to the same member diagnosed with substance abuse.
- In benefit year 2002-03, four members exhausted benefits for the year, of which 2 were provided expanded benefits under another State program.
- Although not required under the Quest contract, AlohaCare makes administrative exceptions for members who exhaust benefits, pays for residential care that is medically necessary, and waives waiting periods for acutely ill members.
- Generally, more focused and coordinated care leads to quality outcomes and less cost. Mandated benefits will not necessarily lead to better outcomes but it will lead to more cost.
- Coordination between Child Welfare Services, the court system, parole authorities, treating providers and health plans leads to better care at less cost.
- Under the current Quest model, social services, vocational counseling, and housing are not part of the medical model. If a social services model is mandated, then cost for Quest will rise.
- Treatment on demand also departs from the medical model and need for diagnostic assessments. If a client centered theoretical approach to care is adopted as opposed to cognitive behavior for the treatment of ice addiction, then the current benefit structure needs to be revisited.
- AlohaCare has no position on parity because its services are defined by the Quest contract. However, AlohaCare opposes any language that would prohibit the health plan from performing utilization management and care management functions.

Harold Dias, Business Manager, IBEW Local 1357 (Verizon Hourly Employees)

TOPIC: Drugs in the workplace, union perspective. Key points:

- The drug and alcohol policy negotiated with the employer many years ago provides for termination after two strikes, i.e. two positive test results for drug or alcohol use. This policy is archaic, unrealistic, and punitive. It predetermines the employee to failure. The first positive test leads to referral to the Employee Assistance Program (EAP). EAP may refer the employee to outpatient treatment, subject to random testing. Ice is such a highly addictive drug that an employee cannot stop "cold turkey." The employee inevitably tests positive again and is terminated. Not a single employee has successfully completed the treatment program and returned to work. Employees are not encouraged to voluntarily get help for drug addiction because of fear of termination.
- There is a high cost to the employer if the employee's fear of seeking treatment leads to loss of productivity, then there are the costs to recruit and retrain new employees.
- The union has attempted to negotiate changes to the policy but the employer has been unwilling to change this policy.

Eric Gill, Financial Secretary-Treasurer, Hotel Employees & Restaurant Employees, Local 5

TOPIC: Drugs in the workplace, union perspective. Key points:

- Local 5 represents 11,000 members statewide and works proactively to bring a drug prevention and treatment program to its members. The Local 5 Trust Fund, joint labor-management, is the largest self-funded medical provider in the State.
- The Employee Assistance Program (EAP) is a voluntary program dedicated to counseling for personal crisis, including substance abuse. The program is limited to 6 counseling sessions and an additional 4 sessions per eligible dependent per calendar year.
- Local 5 is developing a pilot program that all workers would be required to attend with pay. It would be comprised of an hour-long program, run by EAP staff to recognize signs of abuse and receive information on referral services. This pilot program has been proposed to four hotel employers.
- The union is revising substance abuse policies to include peer counseling to be considered by employers.
- The self-insured health plan limits treatment to two treatment episodes per lifetime. This is inadequate. While the union can negotiate changes to the health plan, the industry standards should change to provide parity for substance abuse to be treated as any other medical disease.
- Local 5 is considering a special fund to support those employees who are in treatment and cannot sustain the loss of wages.
- Local 5 has no drug-testing program in any of its collective bargaining agreements. Many hotels use pre-employment drug testing to screen out applicants. Local 5 may consider "reasonable suspicion" testing if a positive test results in referral to treatment and not termination.

Carey Brown, President, Hawai`i Chapter of the Employee Assistance Professionals Association

TOPIC: Employee Assistance Programs. Key points:

- Employee assistance programs began 40 years ago in response to the problem of alcohol in the workplace. It now includes assistance for a range of psychosocial and mental health issues affecting health, safety and productivity in the workplace.
- EAP is a work-based program, interacting w/ employees and families. EAP counselors are certified in substance abuse training and have degrees in the mental health field.
- Insurance parity is needed to treat drug addiction on par with other medical diseases. Drug dependence has much in common with chronic illnesses such as diabetes, hypertension and asthma. (Journal of American Medical Association, October 4, 2002).
- Drug and alcohol addiction costs this country more than $165 billion. Adequate treatment can save taxpayers $7 for every $1 spent on treatment in one year. ("Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment")
- A Rand Corporation study found that unlimited substance abuse benefits costs employers 43 cents per month. (Journal of Behavioral Health Services & Research, May 1999)

Charles Kelley, MD, MPH, MBA, Outrigger Enterprises, Inc.

TOPIC: Employer's response to drug use in the workplace. Key points:

- Outrigger owns or manages 35 properties in the State with 1800 employees, mostly non-union properties.

- Company conducts post-offer testing, and for-cause or reasonable suspicion testing. Random testing is permitted under the policy but they are not doing this type of testing. A policy of substance free workplace through drug testing is the key to protect the workplace. But, as with any public health disease, it is important to identify who is affected and get them treated.
- Company is proactive about training employees on the negative consequences of drug use. It holds informational round tables for employees about drug use, offers EAP services, and medical benefits through the health plan.
- Outrigger has a two-strike policy, unless the employee is stealing, intimidating co-workers or drug dealing. The employer has seen very few cases in the last year.
- Drug users are often tolerated by co-workers, resulting in intimidation of co-workers and destruction of morale. They create serious liability and safety concerns for fellow employees and the public. Unfortunately, drug users have to bottom out before they seek help, usually by losing their job and destroying family relationships and financial support.

Lloyd Kishi, ISI Health Enhancement Services; Carole Tao, HPM Builders

TOPIC: Developing a Drug Free Workplace Program. Key points:

- Drug Free Workplace involves: active support of the employer, clear written policies uniformly applied, involvement with union, a method to identify abusers, and access to treatment.
- The impact on employers due to drug use at the workplace includes unhealthy employees, unsafe working conditions, reduced productivity, higher absenteeism, more accidents and higher medical costs.
- Employers should implement a drug free workplace policy, but often do not because they are in denial that a problem exists in their workplace. Reasons why employers do not conduct drug testing are the cost of testing, business priorities, fear of adverse impact on morale of the organization and drug testing services are not conveniently available.
- KTA Super Stores has a zero tolerance program and includes pre-employment and random drug testing. Security sensitive positions are tested annually. Employees who transfer and are involved in accidents are also tested. It is a costly program that interrupts work, inconveniences employees and prolongs the hiring process. Yet, drug testing has resulted in reduced accidents and absenteeism, screened out drug users from applying and reduced employee theft.
- HPM Builders experienced a 30 percent increase in workers' compensation claims. It implemented a drug-testing program for employees. Of 26 employees tested, 2 walked off the job, 2 did not show up for work, 2-tested positive for marijuana and ice and 1 refused to retest. The company instituted a random testing policy and zero tolerance. Employees who test positive are referred to EAP and reimbursed up to $500 for drug rehabilitation. Employees who are terminated for a positive drug test are permitted to reapply once after completion of substance abuse program and are subject to drug testing annually. Since instituting the drug testing policy, their workers' compensation claims have dropped and employee morale has improved.

Professor Qing Li, Department of Molecular Biosciences and Engineering, University of Hawai`i

TOPIC: Environmental Effects of Methamphetamine Production. Key points:

- Waste produced by methamphetamine laboratories pose an international problem. The raw materials are easily accessible and instructions on how to manufacture the drug can be readily obtained on the Internet.

- Labs can be anywhere, many with unskilled cooks and unsafe equipment. Little quality control exists and hazardous waste and toxic vapors are produced.
- For one pound of ice, five pounds of toxic mixed waste is produced.
- 70 hazardous chemicals are created as byproducts of lab sites; some of the hazardous chemicals are heavy metals that never disappear.
- The Hawai`i aquifer system is very sensitive. Toxic chemicals can reach the ground water in one day. The toxic chemicals usually contaminate the laboratory site and sewage treatment plants.
- Toxicity to the ecosystem and to persons other than the drug manufacturers, such as first responders, need to be studied.
- More information is needed on the effects of disposal of toxic wastes on the groundwater, land, and wildlife populations.

Dr. Katherine Irwin, Assistant Professor, Dept. of Sociology, University of Hawai`i

TOPIC: Treatment versus incarceration. Key points, supplemented by written materials:

- Prevention works, and costs less than crime intervention techniques.
- 2002 Bureau of Justice Statistics for 272,000 former inmates in 15 states indicated that recidivism rates have increased despite more use of incarceration over past 10 years. Incarceration incapacitates offenders and prevents them from committing crimes while they are incarcerated. However, when offenders are released back into the community, 70 to 80 percent of ex-convicts return to a life of crime.
- Drug treatment programs in prisons with six months of aftercare can reduce re-arrest rates by 70 percent, according to a study conducted by UCLA. But such programs remain experimental, and to produce positive outcomes, the program must adhere to rigid components. An effective drug treatment prison should be based on the premise that treatment should be the goal, not incarceration. It should have inmates housed separately from other inmates. The staff should be outsiders to the prison system and be well trained. Aftercare must be provided for a minimum of six months, and treatment intervention must be specific to target the causes of addiction for that population.
- In 2002, over 2 million people were incarcerated in the United States. (Bureau of Justice statistics) The average cost of incarceration is $25,000 per year (Bureau of Justice). In Hawai`i, the Department of Public Safety reports that incarceration costs between $76 and $91 per day or $27,740 to $33,215 per person per year.
- In 2001, 42 percent of the prison population was incarcerated for drug offenses (U.S. Sentencing Commission, 2001).
- From 1980 to 1996, the proportion of persons incarcerated for drug offenses rose from 1 in 10 to 1 in 3. (The Economist, June 8, 1996)
- In 2002, the Department of Public Safety reported that between 77.6 and 80.9 percent of Hawai`i's inmates were re-arrested.

O`AHU PUBLIC HEARINGS

The Task Force held three public hearings on O`ahu. Many speakers offered recommendations that are included in Appendix B "Summary of Community Recommendations."

Paliku Theater, Windward Community College, September 26, 2003

Robert Nakata, John Reppun, Community Works in 96744

- Spoke about the activities of the group to improve treatment services, and advocated for better treatment facilities and health insurance to cover costs of treatment.

Sunny Greer, Maryanne Long, Ardi Maioho, Max Purcell, Hans Taala, Working Together as a Community

- Described their four point plan, "LATE", which stands for legislation, awareness, treatment and education. Supports suggestions made by law enforcement community.
- Believes that improved community organization improves awareness of drugs; advocates for education campaign materials that are age and gender appropriate.
- Suggests that mothers in treatment should have the opportunity to visit with their children.

Andrew Jamila, Rocky Like, Waimanalo Ice Town Hall

- Reported on the issues and activities of Waimanalo.
- Asked for technical assistance in organizing their community.
- Suggested that welfare recipients undergo drug testing.

Numerous concerned citizens testified about their experiences with ice and its affects, availability of funding for treatment, drug testing and health insurance. Their recommendations are included in Appendix B.

State Capitol, September 27, 2003

James Hall

- Commented on funding for substance abuse treatment in Hawai`i, citing a 1998 Study, "Shoveling Up: The Impact of Substance Abuse on State Budgets" which states that Hawai`i spent 8.6 percent on prevention and treatment programs.

Hawai`i Youth Services Network (written)

- Opposes drug testing of students in public schools because drug testing is not a deterrent to drug use, is not intended to detect alcohol which is the predominant drug used by students, promotes distrust and deters students from seeking help, deters participation in extracurricular activities if testing is made a condition of participation and confidentiality cannot be assured. The State has not provided sufficient resources for treatment and thus should not identify persons who need treatment without having treatment available for those identified.

Kat Brady, Community Alliance on Prisons

- According to a study by Columbia University, Hawai`i spends $368.13 per capita on substance abuse but, of that amount, only $7.31 is spent on prevention and treatment.
- In contrast, the State is committed to spend $56,642,040 to incarcerate 637 persons who were sentenced under Section 712-1241-1243, HRS, mandatory minimum sentencing for ice. These persons will likely return to the community, without being treated for the addiction that caused the criminal conduct.

Robert Nakata

- Began community mobilization efforts in Kahaluu. This was the catalyst for other community efforts in the State. Faith based organizations need to work with all parts of the community. Need to support community efforts.
- Treatment, prevention and education is a more effective response to addiction than incarceration.
- Do not reallocate funds. Rather, increase funding for services.

Duke Bainum

- Encouraged legislators to work with public and government officials to find solutions; avoid partisan conflicts.
- Priority for funding should be for rehabilitation and treatment, especially directed toward youth.
- Adjust funding for law enforcement where needed, maintaining county home rule.
- Focus on prevention programs for children.

Kahele Porter, Kalihi Valley Collaborative

- Kalihi community is mobilizing for drug awareness. Ice is a big problem especially in the housing projects.
- Problem of unsupervised children, youth who make negative choices.
- Inadequate services in Kalihi Valley to protect youth.

Dancetta Feary

- Drug testing does not work.
- Law enforcement officers should be drug tested, including prison guards.
- Opposes changes in law relating to wiretap, walk and talk.
- Parole violators who test positive should have an alternative to prison, such as treatment.
- Media and advertising suggests drugs solve all problems, it doesn't.

Lydia Hardie, Executive Director, Blueprint for Change

- Keep families in the community and treat addiction through community based programs.
- Pregnant women should receive treatment for addiction to stay clean and sober during pregnancy. Focus on preventing adverse effect on fetus rather than the child welfare services's response of removal of the child at birth. Do not enact laws that will discourage pregnant women from seeking medical treatment or treatment for drug addiction for fear of losing the child.
- Explore funding from non-State programs for treatment services, like the faith based First Lap program.

Wai`anae District Park, October 11, 2003

Recommendations, which are included in Appendix B, "Summary of Community Recommendations," were received from the following individuals: Melinda Anderson, Lucy Gay, Heather George, Teresa Gonsalves, Roland Lee, Sarah Lindsey, Maysana Lopez, Bill Mouser, Chris Noa, Doreen Redford, Mike Sarmiento, Sonya Sarmiento and Betty Waller.

NEIGHBOR ISLAND PUBLIC HEARINGS

The Task Force visited four neighbor islands and held public hearings on Maui, Kaua`i, Moloka`i, and in Hilo and Kona on the Big Island. The Task Force invited speakers to provide specific information and received public comment from the following groups or individuals. The recommendations from speakers are included in Appendix B, "Summary of Community Recommendations."

Maui Public Hearing: August 6, 2003

Davelyn Tengan, Maui County Prosecuting Attorney

- Act 161 should be repealed. The State has not adequately funded treatment services under this program for the nonviolent first time offender. Offenders are placed on waiting lists, return to crime and drug use while on probation, and receive neither treatment nor removal from society.
- Drug court is more effective and should replace Act 161.

Chief Thomas Phillips, Maui County Police Department

- Difficult to do drug interdiction at the Maui airport without being deputized as a federal agent because of the inability to prosecute in State court for arrests based on "walk and talk".
- Wiretap laws should be revised to conform to the federal standard.
- 130 drug dealers were not prosecuted because they fell below the federal threshold and the evidence obtained for prosecution did not meet the State standards.
- Drug paraphernalia laws should be changed.

Judge Shackley Raffetto, Maui Drug Court

- In his experience with over 700 criminal cases, 70 percent of the drug related cases involve ice. He has seen persons as young as 13 years old addicted to ice and those who have a history of being addicted to ice for 10-15 years.
- 84 persons have graduated from drug court. The recidivism rate is 24 percent.
- Maui Drug court is the only one with a track 4 re-entry program for offenders on parole. 67 percent of those on parole returned to prison within 3 years, not because of a new crime but because they tested positive for ice. The court established a re-entry program to handle those types of parole violators. They sent parolees to a dorm for up to 90 days of inpatient treatment, then released them to 15 months of outpatient treatment. Thus far, this program has served only men but they hope to open a dorm for 5 women.
- Drug court works, Act 161 does not.
- Funding should be given for treatment, not incarceration. The cost for treatment is $50 per day; incarceration is $91 per day.

Alice Lee, Director, Maui County Housing and Human Concerns

- Maui County has supported the drug court program, opened up facilities for incarcerated men and women, and plans to start a juvenile drug court. The State must begin funding these programs.
- Maui needs more funding for treatment services, to provide a medical response to treat drug addiction as a disease, like any chronic illness.

Christina Fisher, Coordinator of Ice Breakers, Maui County

- Ice is a major problem on Maui.
- Maui formed an organization of county government, law enforcement, judiciary and prevention and treatment organizations to respond to ice addiction problems. This county department is focused only on substance abuse.
- Cost $250,000 to coordinate the response to ice.
- Strategy includes starting prevention at the pre-school level, providing aftercare and using kupunas for healing.

Gail Gnazzo, Chief Executive Officer, Rick Engelman, Program Director, Maui Youth and Family Services

- Maui Youth and Family Services started in 1978 as an emergency youth shelter. It offers a broad range of services aimed at providing physical safety, personal growth, mental and emotional stability, and rehabilitation to youth. The first adolescent substance abuse treatment program in Hawai`i was begun in 1985. A residential component in 1993 was added, named Ho`omaka Hou.
- School and Community Based Adolescent Substance Abuse Program consists of 12 weeks of individual and group sessions, followed by eight weeks of one day a week aftercare sessions. The target population is youth ages 11-17, with priority admissions for pregnant teens and young mothers. Demographic data and outcomes are described in the table below.

Outpatient Services 7/02-6/03	Total participants: 61
Gender	Male: 54%; Female: 46%
Ethnicity	Hawai`ian/part Hawai`ian: 54%; API: 24%; Caucasian: 13%
Completed program	67%
Abstinence or reduced use at six month	66%
Enrolled in school or employed at six months	83%
No new arrests at six months	100%
Payment source	Maui County, Judiciary, Maui United Way

- I Mua Mau `Ohana is an experimental adolescent treatment approach to substance abuse and mental health, in partnership with Marimed Foundation. This federally funded enhancement program is designed for youth who are discharged from residential treatment and offers therapeutic sessions, case management, life skills and vocational training. Family members are encouraged to participate in the program. Activities aboard the sailing school vessel are part of the program.
- Ho`omaka Hou is only one of two adolescent residential treatment programs for substance abuse in the State. The target populations are young men and women, ages 12-17, with priority admissions for pregnant teens or young mothers. Close to 80 percent of the adolescents admit to multiple drug abuse. Demographic data and outcomes are described in the table below.

Residential Services 7/02-6/03	Total participants: 45
Gender	Male: 57%; Female: 43%
Ethnicity	Hawai`ian/part Hawai`ian: 60%; API: 13%; Caucasian: 11%
Completed program	22%
Abstinence or reduced use at six months	76%
Enrolled in school or employed at six months	83%
No new arrests at six months	76%
Payment source	CAMHD, DOH/ADAD, Judiciary, SAMHSA

- According to the 2002 Hawai`i Student Alcohol, Tobacco and Substance Abuse study, Maui school district has the highest need for treatment, at 14.4 percent of the students surveyed. However, the study may be deficient because only students in school were counted, leaving out the homeless, truant, and de facto emancipated. Based on the study, 2,264 youths in Hawai`i need residential treatment. Yet, the funded capacity is for 40 individuals. With the average stays of 160 days, only 91 youth can be treated in ADAD funded programs for the year.
- Yale University study found that adolescents are more vulnerable to developing addictions. Substance use changes regions in their brain that govern impulse and motivation, which are not fully formed. This makes adolescents even more vulnerable to addiction.
- Adolescents can have dual disorders w/ chemical dependency, such as conduct disorder, anxiety disorder, depression, and post-traumatic stress disorder. The State has insufficient treatment services for dual diagnosed disordered youth and insufficient funding for a multidisciplinary approach to treatment. Government agencies responsible for mental health treatment, substance abuse treatment and education do not coordinate with each other to provide services.

Jud Cunningham, Administrator, Aloha House, Inc. and Malama Family Recovery Center

- Aloha House, Inc. is a nonprofit founded in 1977, offering assessments, education, counseling, medically monitored detoxification, residential and outpatient treatment and aftercare for substance abuse. It operates school based outpatient treatment programs for adolescents, therapeutic living and clean and sober homes. The Malama Family Recovery Center provides gender specific treatment for pregnant, parenting and other women. Over the past few years, ice has replaced alcohol and other drugs as the primary drug of choice for its admissions. Communities need to reclaim neighborhoods and develop drug free zones. See, Site Visit for additional information.

Ray Henderson, Director, Ohana Makamae

- Ohana Makamae (OMI) is a private nonprofit family resource agency in Hana that provides substance abuse counseling and prevention services to residents of Hana. OMI is funded by Maui County, private foundations and donors. It operates several programs that focus on substance abuse treatment or prevention which are sensitive to the Hawai`ian culture: Keiki Makamae (counseling and support activities for pregnant women and mothers with children under 5), Saving Babies Together (support and services to pregnant women and women of child-bearing age to avoid substance addicted babies), and Alternative Community Training (education about adverse consequences of drug use).
- Ice is a huge problem because it is manufactured and sold for economic survival since job opportunities are scarce in the community. Hana is such a small community that

neighbors all know each other and ice activities go unreported for fear of disruption of family life. The agency works with the kupunas to educate families on the dangers of ice and tries to raise their consciousness about its effects.

Dana Alonzo-Howeth, Executive Director, Community Clinic of Maui

- The Community Clinic of Maui is a nonprofit community health center founded in 1993 to provide comprehensive primary care medical services for the poor, uninsured and homeless. Substance abuse treatment is one of the services provided. The Clinic employs 61 staff members and provides services in Kahului, Wailuku, and at the Lahaina Comprehensive Health Center. It has an annual budget of $3.9 million, excluding capital projects, of which 51 percent comes from federal funds, 11 percent from State grants, 4 percent from county and foundation funds, and 34 percent from patient fees.
- In response to the ice problem, the Clinic designated a position, Ice Program Service Coordinator, to work with therapists and clients on treatment needs, to provide follow up referral services such as housing and employment, and to provide general case management services. The Clinic has implemented an integrated primary care/behavioral health model in addition to individualized chemical dependency treatment. This method intervenes with high-risk clients at an early stage, thereby maximizing the chance of recovery. The Clinic is the only agency on Maui that delivers on-site chemical dependency treatment in addition to mental health and comprehensive medical care regardless of insurance status or ability to pay. The Clinic turns no one away.
- The Clinic measures outcomes based on the number of clients discharged who reported abstinence from drugs and alcohol as described in the table below.

Outcomes 7/02-6/03	Discharged/completed treatment	Abstinence from drugs and alcohol at time of discharge
Persons treated	66	42 or 64%

- Tobacco is a huge trigger for substance abuse relapse. The same behaviors associated with tobacco are also associated with drug and alcohol abuse. ("Programs Including Nicotine Addiction as Part of Treatment," Alcoholism & Drug Abuse Weekly, May 2003)

Shawnee Tuivai, Coordinator, SMART Moves, Boys & Girls Club of Maui

- The SMART Moves program is designed for kids 6-17 years of age to inspire young people from disadvantaged areas to gain character and leadership skills, develop education and career goals, gain health and life skills, and develop arts, sports and fitness skills. SMART stands for skills, mastery and resistance training. Using a team of 2 youth facilitators, 2 community members and staff, the group sends a message that youth should not be involved in alcohol, tobacco or illegal substances and should postpone sexual involvement.
- Demographic data for one year is described in the table below:

Gender	Number	Percent
Male	32	41%
Female	46	59%

Ethnicity/Race	Hawai`ian/Pacific Islander	Caucasian	Asian	Other
Number	44	21	6	7
Percent	56%	27%	8%	9%

- This prevention program measures success based on responses to 10 multiple choice and fill-in the blank questions posed at the beginning of attendance and after a period of participation in the program. 78 participants were tested. The pre-test mean score was

7.19 and the post-test mean score was 9.35, which indicates that the youth were responding to the messages of the program.

Larry Koss, Empowering Maui Teen Project

- This organization sponsors the Teen Challenge day in high schools throughout the country. The organization seeks broad-based social change by identifying the root causes of violence in the schools. The group hopes to bring the Teen Challenge Day program to sixth through twelfth graders in Maui and seeks funding for this program.

Debbie Revilla, Maui Comprehensive Strategy for Juvenile Justice

- The Maui Comprehensive Strategy for Juvenile Justice is funded through the U. S. Dept. of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP). It is a data and research based effort to coordinate government, education, law enforcement, business and faith-based organizations to develop a comprehensive strategy for youth centered on prevention, intervention and juvenile justice responses to juvenile offenders.
- Drugs are not the issue. The problem is that families are disconnected.

Terry Lock, Maui County Childhood Resource Coordinator.

- Prevention programs that start with preschoolers and their families need to be expanded. The foundation for healthy habits develop from birth to age 8. Children depend on their parents to teach and guide them. Parents need support and education on the factors that are shown to prevent substance abuse. The State should support expansion of programs that strengthen parenting skills to guide children toward drug free lives.

Verdine Kong, Director, BEST Community Reintegration Program, Maui Economic Opportunity, Inc.

- The BEST program, in collaboration with the Department of Public Safety has been in operation since January 2003. The program assists persons who are released from prison with services needed to re-acclimate them to the community.
- Ice is robbing our community of healthy families. A client who started using ice at age 9 because her parents were ice users, was an addict by age 15, and was murdered at age 17 by a person high on ice. A solution to this epidemic must be found. Longer prison terms do not change the face of a drug addict because inevitably the offender will return to the community and to the same environment that caused the addiction. Instead, for first time offenders, send them to a diversionary program. For repeat offenders who have not been through drug treatment, send them to Drug Court and establish an intensive treatment program at MCCC Dorm 3. Prevention is key to eliminating the ice epidemic. Education from the elementary school level is necessary.

Thelma Akita-Kealoha, Community Advocate Specialist, Free to Grow, Maui Economic Opportunity, Head Start

- The Free to Grow program is funded by Head Start, Maui Economic Opportunity, Robert Wood Johnson Foundation and Doris Duke charities and focuses on prevention of substance abuse and child abuse through family strengthening.
- A second program, funded by Housing And Community Development Corp. of Hawai`i (HUD), targets drug elimination in public housing. This program operates in the low-income areas of Wailuku, which is home for a high number of Hawai`ian and part-Hawai`ian families. The statistics for drug use and related criminal activities are high in this area. The program provides education, treatment, and aftercare to high-risk families. This program is ending because of the loss of federal funds.

Lee Stein, Certified Substance Abuse Counselor and teacher at Maui Community College

- Ice is a devastating problem that is taking over our community. The "war on drugs" to crack down on the criminals who bring drugs into the community is a criminal justice approach that overlooks the people who are affected by the drug problems. Prevention and treatment programs must be expanded to prevent future generations from becoming trapped in the cycle of ice abuse.

Other testimony: two Drug Court graduates and one concerned citizen.

Kaua`i Public Hearing: August 11, 2003

Roy Nishida, Anti-Drug Coordinator, Mayor's Office, County of Kaua`i

- Kaua`i held five Drug Summits around the island. Needs identified at the Summits included: (1) residential treatment facilities for adults and adolescents, (2) a transitional residential facility, (3) diversified recreational activities for youth, (4) transportation for youth to drug-free activities, (5) In/Out of school prevention activities, and (6) federal drug enforcement presence. The Summits also identified the need for community involvement and education.
- In response to the Summits, the County has identified its resources for treatment and prevention. In addition it is working with two private nonprofit organizations to establish two residential treatment centers with a total of 48 beds; is working on plans for an adolescent treatment center; and is looking for facilities to house youth activities and recreational programs.
- The Mayor's Office will be developing a five-year drug plan with the Kaua`i Planning Action Alliance, to coordinate activities in the areas of prevention, treatment, enforcement and integration.
- Maui County received a grant from the Community Anti-Drug Coalition of America Greenhouse to attend a training session on the development of prevention programs.
- Based on their statistics, Kaua`i estimates that methamphetamine use rose ten-fold between 1995 and 1998 and the need for treatment more than doubled over the same period of time. Kaua`i estimates that ice usage by its population is nearly twice that of the State on a per capita basis.

Deputy Chief William Ihu, Police Department

- Ice arrests of adults have almost doubled from 55 arrests in 2000 to 93 in 2002. Statistics of adults and juveniles arrested for drug related offenses are described in the table below.

Drug Arrests	Juveniles		Adults		Total	
	Ice	All drugs	Ice	All drugs	Ice	All drugs
2000	2	67	55	129	57	196
2001	3	79	63	103	66	182
2002	4	93	93	109	97	202

- Ice as an adult consumer drug of choice has increased from 14 percent in 1998 to 40 percent in 2002. Marijuana remains the predominant drug for juveniles.
- The DARE program reaches children in the kindergarten, third, fifth and eighth grades.

Michael Soong, Prosecuting Attorney, Kaua`i County

- Act 161 should be repealed because it takes away court discretion on sentencing and permits judges to inconsistently interpret Act 161.

- Supports constitutional amendment to permit walk and talk; supports amendment to make the wiretap law consistent with federal law, and to permit the State to prosecute those offenders who are not prosecuted under the federal system.

Elton Amimoto, Coordinator, Drug Court Fifth Circuit

- Kaua`i is the last island to start its Drug Court. It became operational in August 2003 and is staffed with a substance abuse counselor and three professional staff.
- Expects to handle 20 clients per year.
- Drug court will be an intensive program, with judges supervising the clients on a regular basis. Drug testing will be conducted.
- Intended to be an alternative to prosecution of non-violent offenders 18 years or older who are charged or arrested for felony drug or drug related offenses. Successful completion of the program results in charges being dismissed. Failure to complete the program results in conviction and possible incarceration.

Joann Yukimura, Council member, member of Kaua`i Drug Prevention Team

- Effective prevention programs are the most cost-effective solution to the drug problem. It is cheaper than treatment or incarceration ($300,000 to imprison a person for 10 years). Successful prevention programs empower individuals to turn away from drugs, regardless of what drug is readily available at the time.
- The "best practices" for prevention program tailors itself to the community and the individuals in it. Kaua`i is looking at the Communities that Care approach to identify the best practices for their communities, including Ropes Course, Life Skills, Challenge Day, Standing Strong Together, Winners Camp, Wave Riders Against Drugs and Kupuna program.
- A public transportation system is needed for Kaua`i to provide young people access to drug free programs.
- Counties should be given flexibility to determine how to allocate funds for drug interdiction efforts, rather than earmarking resources for specific drugs.

Nancy Golden, Child and Family Service-Kaua`i

- Child and Family Service (CFS) is a private nonprofit social service agency that delivers prevention and treatment programs to Kaua`i residents through community locations. The CFS statewide budget is over $31 million, of which $3 million is spent on the Kaua`i operation. CFS funding is primarily through state and federal contracts. CFS Kaua`i provided free direct services to more than 3,000 persons in FY2003.
- The prevention programs include: Nana's House, Hale Ho`omalu, Healthy Start, Baby SAFE, Employee Assistance Program, Kaua`i Adoption Support Group, Head Start and Child Protective Diversion. Treatment services include: early intervention and intensive instruction services for special needs children, general counseling, intensive home and community based intervention services for school children and independent living services for foster children.

Jimmy Trujillo, Kaua`i Drug Prevention Team

- Kaua`i Drug Prevention Team is a coalition of nonprofit agencies, government agencies, community members and faith-based organizations whose purpose is to utilize the “Communities that Care” model to increase community resiliency and decrease risk factors for Kaua`i families. This group has been selected for a federally funded incubator program, the Community Anti-Drug Coalition of America and to participate in the Greenhouse Project to support and monitor local anti-drug coalition building.
- Do not reduce funding for treatment and prevention; must find new sources of funding to expand services.

Elaine Albertson, Therapeutic Group Homes, Hale `Opio Kaua`i, and Robin McCarthy, Kaua`i Teen Court

- Hale `Opio Kaua`i provides residential and community programs for youth and their families. It operates long-term therapeutic group homes for males and females ages 11-20. The group homes are supported in part by the Harry and Jeanette Weinberg Endowment Fund. Other programs offered include emergency shelter for males and females up to age 21 who are in need of sanctuary or counseling in a home setting, Therapeutic Foster Home Program, a juvenile diversion program in collaboration with Office of Youth Services and the police department and Teen Line.
- The Therapeutic Group Home program served 21 youths between the ages of 10-19 in FY2003. The average consumer stayed 2,928 hours in the program. At the six months post-discharge period, more than 80 percent of the consumers who completed the program were enrolled in an educational/vocational/employment program, reported no new arrests and maintained stable living arrangements.
- Ice addiction affects families. Youths are removed from the home due to drug use in the home, but treatment needs to focus on the family or else the child cannot be returned to the same environment.
- Kaua`i Teen Court works with Hale `Opio, the Kaua`i Prosecutor, Police Department, Family Court, Queen Lili`uokalani Children's Center and other agencies to provide programs for first time offenders between the age of 10-18. This diversionary program operates through the use of peer attorneys, judges, and jurors. Sentences may include a letter of apology, counseling or skill building sessions, conflict resolution, and anger management classes. Youth serving sentences also serve on juries. Teen Court is successful, with a low recidivism rate of 2-3 percent repeat offenders on the same charge within one year, although they could be offending on another charge.
- All the teens prosecuted through Teen Court are ice users. Alcohol, tobacco, and marijuana are gateway drugs and used in conjunction with ice. Drugs are a family business for youth drug users.

Orianna Skomoroch, Kathleen Lorenz, The Samuel Mahelona Medical Center and Memorial Hospital

- The Hospital provides inpatient psychiatric services with 9 beds. In 2000, total inpatients were 40, 33 for alcohol abuse and 7 for substance abuse. In 2003, inpatients were 26, 12 for alcohol abuse and 14 for substance abuse. Outpatient services are provided through Hina Mauka, Ke Ala Pono Recovery Center. The Hospital's mission is to provide safe, medically supervised inpatient detoxification; to encourage and refer patients to appropriate treatment; and to provide follow up support programs for further recovery after discharge from the program.

Dr. Gerald McKenna, Medical Director, Ke Ala Pono

- Ke Ala Pono was the first comprehensive outpatient treatment facility on Kaua`i to offer chemical dependency treatment for adults and adolescents. It is the only program with a full-time medical director board certified in psychiatry and addictive medicine. It has a full range of services, including group and family therapy, chemical dependency counseling and acupuncture. Private insurance, the insured's co-payments and Quest pays for treatment for its clients.
- Ice epidemic began in 1985 in Hawai`i. Adolescents are using ice at an earlier age. Over the past 10 years, about 300 adults and adolescents with ice dependency have been treated. The most prevalent addiction is marijuana.
- Success rate with any form of addiction is based on an individual's commitment to recovery and the external controls that can be placed on them. Low and mid-range addiction can be salvaged. The highest level of addiction cannot be saved.

- Overall recovery rate is about 25 percent for ice, which is identical to the recovery rate of people afflicted with any major, chronic, relapsing medical illness.
- When motivation is high and external controls are available, recovery rate is 90 percent.
- There is a myth that residential treatment for adolescents produces better results than outpatient treatment. This is not borne out by research. The critical factor is the length of time in treatment, particularly outpatient treatment. The longer a person is connected with the treatment program, the better the outcome.
- Methamphetamine dependence is treatable using a variety of treatment techniques including, individual and group therapy, family therapy for adolescents, application of external controls, appropriate use of medication and commitment of resources to solving the problem.

Phil McLaughlin and Alan Johnson, Hina Mauka

- Hina Mauka operates an adult intensive outpatient and day treatment clinic in Lihue and runs three adolescent school based outpatient treatment programs in Waimea and Kapa`a High Schools and Kapa`a Middle School.
- The adult day treatment program consists of three months of formalized care and three months of aftercare. The average cost for the three month formalized care averages $3,780 per client. Currently, treatment services are paid through private and Quest insurance, DOH/ADAD and the Judiciary.
- Hina Mauka offers residential treatment through its facility on O`ahu. Residential costs average $165 per day, with an average stay of 30-40 days. Thus, the average treatment episode runs $5,000 to $7,000. Funds for residential treatment includes commercial and Quest insurance and DOH/ADAD. Outcomes for adult treatment indicate that about 60 percent complete treatment the first time and over 90 percent report abstinence in the six-month follow up. Outcomes improve for clients who undergo second or third treatments, even though the treatment episode is less intensive and for a shorter time period.
- The adolescent school based treatment program is funded by DOH/ADAD at $50,000 per school, which provides one counselor per school. Approximately 12-15 students are treated each semester at each school and the treatment episode generally runs for one semester. This translates to approximately $1,800 per student per semester. Outcomes for the school-based program are excellent. 74 percent of the adolescents completed the treatment, with about 60 percent reporting abstinence or reduced usage. 91 percent remain in school and 89 percent report no new arrests.
- In 1998, 12 percent of 1,500 residential adults reported ice as the drug of choice. In 2003, 52 percent of adults reported ice as the primary drug.
- In 2000, two adolescents out of 200 in treatment reported they had experimented with ice. In 2003, 30 percent report having tried ice. However, for adolescents, alcohol and marijuana continue to be predominant drugs of choice.

Julie Ann Beck, Kaua`i Economic Opportunity Inc.

- This organization receives federal funding through DOH/ADAD to operate an after school prevention program for adolescents at the middle school level, ages 11-14. The program focuses on teaching youth life skills, awareness, self-image, anger management and education about alcohol and drugs. The program also provides culturally sensitive approaches to Native Hawai`ian youth.

Deborah Burnham, Challenge Day

- Challenge Day is a nonprofit organization that provides life changing programs for youth. It focuses on the real problems teens' face through interactive processes and discussions. The group seeks funding support to bring Challenge Days to Kaua`i schools, grades 7 – 12.

Bill Arakaki, Principal, Waimea High School

- Drug prevention education is provided through the health curriculum. The program is federally funded through the Safe and Drug Free Schools grant.
- Supports drug testing to prove that its students are drug free. Supports a voluntary program where students can participate, especially at the request of the parent.

Kaipo Asing, Chair, Kaua`i County Council

- Supports more stringent drug interdiction efforts at the airports to reduce the in-flow of drugs.
- Fund expanded treatment programs on Kaua`i.

Other testimony: at least three concerned citizens

Moloka`i Public Hearing: August 18, 2003

Officer Ronald Sagario, DARE, Capt. Milton Matsuoka, Police Department, Moloka`i, Maui County

- DARE program operates for 17 weeks in the 7th grade classrooms. The officer is involved with students outside of school. Students attend the Youth Camp, sponsored by the Office of Youth Services Maui County, which is a federally funded program.
- Ice and marijuana are the primary drugs of choice on Moloka`i. Ice users often grow marijuana for sale and use the profits to buy ice because marijuana is more expensive than ice.
- All drug investigations are conducted by the school and community officer. Moloka`i has no narcotic/vice officers and Moloka`i based officers do not conduct drug interdiction. Maui County brings in officers, deputized by the federal law enforcement agencies, to conduct drug interdiction.
- Moloka`i community is too small for Moloka`i based officers to conduct drug interdiction because all police officers are known.
- Law enforcement needs help on Moloka`i.
- Moloka`i public parks are exempt from the laws prohibiting alcohol consumption. Parks are the gathering places where alcohol and drugs are used. There is a strong public outcry if the laws are enforced on Moloka`i public parks.

Ted Takamiya, Queen Lili`uokalani Trust

- Prevention services are provided by DARE, Alu Like, Inc., and a program will be started by the Seventh Day Adventist Church through a State incentive grant.
- The only treatment services offered on Moloka`i is by Hale Ho`okupa`a.
- Moloka`i has no detoxification services, no residential treatment facility, no transition home or aftercare programs. Alcoholic Anonymous, Narco Anonymous, and Lanaku`ikahi support groups are available.

Wayde Lee, Alu Like

- Alu Like provides prevention programs to the 4th and 6th grades in every elementary school on Moloka`i under a DOH/ADAD contract for $75,000 per year. This contract amount has been unchanged for ten years. While their contract is limited to prevention programs, Alu Like brings in Kupunas once a week to counsel the youth in the old fashioned Hawai`ian way (Ho`oponopono) to heal themselves. It plans to open a wellness center in partnership with the Department of Education. This center will serve youth aged 14-21 in a 90 day program that focuses on Ho`oponopono and family treatment. The youth will live at the center for three weeks to get sober and then return to the community. This wellness center is a more affordable approach to treatment because residential treatment is not available.

Shari Lin, Executive Director, Auntie Luana Hamakua, Kupuna advisor, Ka Hale Pomaika`I

- Ka Hale Pomaika`I is a new start up organization that plans to develop a clean and sober living facility for recovering alcohol and substance abuse addicts. The group has land and desires to build a transition residential facility with a grant from CBDG funds. This facility will serve persons who have received treatment off island and are returning home to their community. The group intends to use Hawai`ian healing practices to restore the mind, body and spirit, teach independent living skills and work with the community.

Mary Jane Brown Willis, Executive Director, Hale Ho`okupa`a

- Moloka`i needs transportation to bring people to treatment services. Outreach services were funded for a period of time by Maui County, but those funds ended.
- School based treatment programs are needed. Suspending the student for 90 days is not the best approach to drug use. Alcohol is the biggest problem in the high school.
- Aftercare and transition homes are needed for those who are in recovery.
- Pregnant women using drugs need a program since Moloka`i has no physicians to provide obstetric care.

Wendy Brooks, Moloka`i Youth Incentive Grant, Seventh Day Adventist

- The organization received a State incentive grant to develop a strategic plan for youth substance abuse prevention, and to implement a prevention program serving 14-17 year old youth. It is a three-year grant for $360,000, and is in its first year.

Mahealani Davis, Community Association of East Moloka`i

- This community is mobilizing to deal with ice issues. Families are coming together to support those who are affected by ice addiction. Ice dealers are Hawai`ian, which creates an internal problem in the Hawai`ian community.

Moloka`i High School Principal, Vice Principal and Counselor (Phone conversation)

- Moloka`i High and Intermediate School is the only high school on the island of Moloka`i. The school currently has no prevention programs in place, however, there is a counselor on staff that can talk to students that have been referred by other counselors, teachers or staff. Hale Ho`okupa`a runs support groups on campus and after school programs. Maui Youth and Family Services also provide counseling services.
- In recent years, the staff has seen an increase in ice usage and behaviors. Ice is more difficult to detect because it has no odor. Despite the rise in ice usage, the school views marijuana and alcohol as its primary problems because those drugs are not viewed as serious drugs. Parents are not usually involved in the treatment of a student because the parents are usually users themselves.
- Another tool used to deter drugs is having a police officer on campus. This officer serves as a resource officer and provides not only security, but also trains teachers in spotting criminal behavior, establishes relationships with students and follows up and provides counseling for students after they have been caught.

Hilo, Hawai`i Public Hearing: September 3, 2003

Lawrence Mahuna, Police Chief, Hawai`i County

- The use of ice is higher on the Big Island than elsewhere in State.
- In FY2003, Hawai`i County police initiated 398 cases involving ice, made a total of 97 ice-related arrests, and confiscated 12-½ pounds of ice.
- From January to July 2003, officers executed search warrants on 37 homes, 49 vehicles and 41 body searches.

- The community works with police on curtailing ice usage. 25 search warrants resulted from crime stoppers tips and 44 through the ice hotline.
- Two special police task forces were formed for East Hawai`i and West Hawai`i to concentrate exclusively on the ice problem.
- The Big Island has received financial assistance from federal government to purchase specialized lab equipment for analysis and to station additional DEA agents on the Big Island.
- Recommends reviving "walk and talk" and amending the wiretap statutes to remove the adversarial hearing.
- Recent search of an ice house found weapons and a pregnant woman who was addicted to ice. Need to protect the unborn fetus.
- Families with children addicted to ice turn to the police to arrest their children as the only way to avoid being abused, or having their household valuables stolen, or as a way to get treatment for the child.

Jay Kimura, Hawai`i County Prosecuting Attorney

- Drug abuse is not a victimless crime. Drug users steal, can become physically abusive and violent. Need to balance rights of offender against crimes committed against community (victims and property).
- There is a need to balance education and prevention with law enforcement, rehabilitation and treatment.

William Smith, Deputy Prosecutor, Juvenile Division of Prosecuting Attorney's Office

- We must look at the broader issues relating to the ice epidemic. Based on his experiences in Family Court and Juvenile Court, the first line of defense is the family. Must address the issues in the family.
- Ice usage creates mental health issues as well. Hawai`i Youth Correctional Facility needs to address both drug use and mental health problems.
- There is a great need for residential treatment centers for adolescents.

Steve Morrison, MD, Hilo Medical Center Emergency Room

- Expressed concerns over the high number of persons who seek emergency treatment for conditions related to ice usage. Methamphetamine has harsh effects on the body and brain, and has tragic consequences for the individual and the family.
- We need to stop the drug at the source, before it comes to the State.

Billy Kenoi, Executive Assistant to the Mayor, Mayor's Office

- Ice is a big problem on the Big Island. The Mayor has declared a war on ice and is working with the community, law enforcement, government agencies and nonprofit agencies to address its many problems.
- We must mobilize the community to work together to solve this problem.
- Big Island held the second meth summit to further identify problems and come up with solutions. They will provide the Legislature with recommendations.
- Three components for a healthy and safe community are: enforcement to take care of supply and demand for ice; make treatment available for those who need it; and prevention and education. Need additional resources and commitment to fund these components.

Michael Ebesugawa, Deputy Public Defender, Office of the Public Defender

- There are 8 deputy public defenders in Hilo and 4 in Kona. No numbers on exact caseloads, but ice-related cases appear to be the prevalent hard drug in felony cases in the office.

- Disagrees that the increase in ice cases means that ice has become the drug of choice in the community. Instead, increases in the ice caseload may be attributed to other factors such as targeting of ice offenses and increased allocation of law enforcement resources to investigate and prosecute ice users and dealers.
- Defendants charged with ice-related offenses do not fit a "profile." They are a cross-section of the community. Many have no prior criminal records, are educated, have families, have work histories and hold current employment.
- Violence is not necessarily involved in ice-related offenses. The majority of cases involve possession of ice and property offenses driven by ice addiction where violence is not present.
- Under current law, a person charged with an ice-related offense is subject to mandatory minimum sentencing, except if the person falls under Act 161 as a first time drug possessor who is eligible for probation and drug treatment. Mandatory sentencing laws hamper courts from exercising discretion to look at critical therapeutic responses needed for rehabilitation services. Often the offender is the head of the household and primary income earner so his/her incarceration has an effect on the family. Act 161 is not sufficient to address the need for treatment for offenders whose criminal activity is driven by ice addiction, and are subject to mandatory sentencing.
- Overreaction to the ice problem can do damage by suspending civil liberties and eroding personal rights. Opposes constitutional change that compromises right to privacy and use of federal standards for wiretap orders.
- Supports Big Island Drug Court. There is a need to allow the court discretion to find solutions, without the restriction of minimum mandatory sentencing.

Judge Ronald Ibarra, Judge Greg Nakamura, Drug Court Third Circuit

- Drug Court opened in Fall 2002 and has had some success to date. It focuses on problem solving and therapeutic intervention.
- Some of the participants have used drugs for a long time, as early as age 14. The first priority is to get the participant off drugs, to attend treatment, and then to return them back into the community, stabilizing their living and employment situations.
- The participants are tested 2-3 times per week and are seen by the judge every week. If the participant tests positive, the person is returned to jail or sent to intensive treatment. The Court uses sanctions and incentives for motivation.
- The hope is to expand to include juvenile drug court.
- The Friends of Drug Court are doing fundraising to pay for treatment for participants.
- Drug Court cannot take violent offenders and under federal funding, cannot accept domestic violence offenders. The State should consider resources to permit Drug Courts to take such cases at the court's discretion.

Ray Dangaran, Program Coordinator, Salvation Army Youth Service Center

- Salvation Army is a private nonprofit agency that provides residential, prevention and intervention services to adolescents. The Smart Moves program provides an in-school program with limited after school services for ages 7 – 19. It also provides youth gang prevention, outreach, monitoring of law violators, and drug elimination programs. The program has served over 1,500 youth per year. Services are funded through the Office of Youth Services, Department of Health and Hawai`i County.
- Hawai`i Kids Count Data Book for 1995, statistics for the Big Island, indicates the highest rate of poverty (20 percent), highest single parent rate (22 percent), highest teen birth rate (56 per 1000 teens), highest rate of class B offenses (4.8 percent), highest number enrolled in Free/Reduced lunch program (49 percent), and highest child abuse and neglect referrals in State.

- Several youth from the program expressed their concern that prevention programs be offered at the elementary school level. They asked for expanded after school activities to keep kids drug free, and for summer work programs for youth.

Fred Holschuh, MD, Hawaii County Council Member

- Has 30 years of emergency room medical experience in Hilo. His experiences with ice users indicate an increase in the severity and brutality of injuries in cases of domestic abuse or stranger violence. He has seen numerous examples of victims injured by ice users, and ice users who are so addicted that they cannot control themselves. He has seen a 13 year old who prostitutes to support her addiction, an 11 year old user and dealer who attempted suicide, and a 12 year old who tried to kill another person and had no remorse about his action.
- Programs for treatment and recovery are important, but prevention is vital for kids, starting before the age of 11 and pregnant women.
- Non-violent addicts must be separated in concept and treatment from non-addicted dealers.
- There is a need for meaningful employment for those in recovery. They need positive role models, and more thorough drug testing in certain jobs and maybe schools. The goal is not to punish, but to ensure treatment. Must have treatment resources available.
- Disagrees that ice use can be recreational; 15 percent of first time users become addicted. Addiction is a medical condition and should be treated as such.
- The solution is to reduce demand through prevention and education for families and to reinstate public health nurses as in the Vermont model. Need to prevent fetal exposure to ice to prevent babies from suffering the effects of the drug.
- He disagrees that marijuana is a gateway drug. Alcohol and early childhood tobacco use is far more dangerous. Legislature should rethink public policy on marijuana.

Wes Margheim, Deputy Director, Big Island Substance Abuse Council (presenting for Gloria Egle, Chief Executive Officer)

- BISAC began operations in 1964, and from 1997 to the present, has expanded from two outpatient treatment sites to 21. BISAC operates the following programs: 8 school based programs in high schools, 8 therapeutic living programs in Hilo and North Kohala, 3 outpatient adolescent facilities in Hilo, Kealakekua, and Waimea, and 2 Baby SAFE programs in East and West Hawai`i. It provides transportation services within a 50-mile radius of each facility. The types of services offered include: transition out of prison programs, mental health and dual diagnosis care, employment rehab, relapse prevention, community reintegration, nursery services, and family counseling and education. BISAC programs are funded by DOH/ADAD, PSD, DOH, DHS, County of Hawai`i, United Way Hawai`i Community Foundation, Hawai`i Hotel Industry, Wal-Mart and other private trusts and foundations. Demographic and outcome data are described in the table below.

Adult Program Services 2001/2003	Total admissions: 938
Gender:	Male: 63%; Female: 37%
Ethnicity	Hawai`ian: 49%; Caucasian: 33%
Age	Age 18-35: 54%; age 36-45: 30%; age 46+: 16%
Referral	Judiciary: 36% DUI: 18% Self: 17% CPS: 15%
Payment sources	DOH/ADAD: 43% Quest: 33% Private insurance: 12% Self: 10%
Drug of choice	Ice: 45%; alcohol, marijuana: 21%
Outcomes 2001-2002	
Completed treatment	51%
Remained abstinent at six months	61%
Reduced use at six months	82%
Employed/ school/ vocational at six months	70%
No new arrests six months post discharge	75%
No new treatment episodes at six months	90%
Involved in self help groups post discharge	35%
Stable living arrangement at six months	80%
No hospitalizations six months	99%
No significant psychological distress at six months	84%

School based Adolescent Programs 2001-2002 (Waiakea, Pahoa, Ka`u, Konawaena)	Total admissions: 119	
Gender	Male: 63%; Female: 37%	
Ethnicity	Hawai`ian/part Haw'n: 40%; Caucasian: 12%	
Drug of choice	Marijuana: 76%; alcohol: 15%; ice: 10%	
Referrals	Judiciary: 54% CPS: 21% Self: 19%	
Payment sources; Hawai`i county and United Way provide funds when insurance benefits exhausted.	Quest: 36% Private insurance: 28% County: 22% United Way: 11%	
Outcome Objectives at six months	Objective threshold	Percent achieved
Abstinent six months post discharge	50%	66%
Completed treatment	50%	54%
Reduced frequency of use	40%	81%
Employed, school, vocational	35%	46%
New arrests post discharge	65%	85%
Improved grades, attendance	70%	95%
Improved social relationships	70%	96%
No new treatment episodes	65%	84%
Involved in self help groups post discharge	30%	39%

- A substance abuse epidemic exists if epidemic is defined as an increase in need for services. In 1997, treatment was provided to 815 consumers, in 2002, 1729 consumers were treated for substance abuse.
- In 1997, BISAC closed its residential treatment facility due to earthquake damage. Since then, it has operated through the therapeutic living and outpatient model facilities. Based on its analysis of successful outcomes in its residential facility versus its intensive outpatient (IOP) and therapeutic living programs (TLP), BISAC concludes that its present models are more successful. For example, about 25 percent completed residential treatment in comparison to 45-55 percent completion rates for IOP/TLP. About 45 percent of residential treatment clients reduced the frequency of drug use in comparison to 65-90 percent of IOP/TLP clients who reduced usage. Improvement in social skills was the most successful outcome for 70 percent of clients in residential treatment; 80-90 percent of clients in IOP/TLP showed improvement in social skills. Even the least successful outcome, employment, showed improvement under the IOP/TLP model: 15 percent of clients in residential treatment were employed, in comparison to 35-60 percent of those in IOP/TLP.
- Between 1998 and 2002, methamphetamine as the drug of choice among BISAC consumers rose from less than 15 percent to 45 percent. In the same period, cocaine dropped from 24 percent to 6 percent, marijuana remained relatively stable around 21-25 percent use, and alcohol dropped from 31 percent to 23 percent.

Melissa Moniz, Probation Officer and Hawai`ian Homesteader

- As a member of Keaukaha homestead, the community bulldozed areas that were havens for drug users, founded a Parents Against Drugs group and Keaukaha Neighborhood Watch, and held drug informational meetings.
- As a probation officer in Family Court for 13 years, she has seen the types of offenses become more serious. Back in 1990, the worst crimes were shoplifting, running away, and promotion of detrimental drugs 3rd degree; now it's assault in the 1st degree, terroristic threatening, 1st degree robbery, firearms charges, negligent homicide and prostitution by children as young as age 10.
- Children get lost in the bureaucracy. There is a long waiting list for programs, a lack of coordination in DOE, so children get no services, and no consistency in care coordination. If a child has no insurance, he/she receives no treatment. Grant funded programs are only selecting kids to assure a success rate, so some children get left out. There is great cultural insensitivity in the programs that do exist.

Matthew Brittain, Clinical Forensic Social Worker

- Drug use is more of a public health/social service issue, not one of law enforcement.
- The law enforcement approach does not work to solve the drug problem. This approach creates higher costs because those arrested become dependent on government social services. It increases Medicaid utilization by users who don't get proper substance abuse treatment. This results in a loss of workforce tax base, decreased employability, and increased poverty and violent crime rates.
- The public health approach to treating the medical, social and economic causes of drug abuse is more effective. First, crack down on illicit drug dealers, and develop government-sponsored clinics to dispense the drugs to addicts. When the profit is removed from the dealers, the attendant law enforcement demands will decrease. Legalize marijuana, which will reduce exposure to hard drugs by new users and reduce the incidents of new addicts.

John Santangelo, former Hawaii County Council member

- We must treat families and individuals addicted to ice. Need to provide services to address all three stages, i.e. potential user, the user, and the user in recovery.

- We need to have programs that partner with business to help the recovering user become a contributing part of the community. His business operates a sod farm that partners with BISAC, North Kohala Therapeutic Living Home, to have clients in recovery work on the farm. This helps with their recovery, and provides them with financial support. Three clients have successfully completed work and two have remained with the company.
- We must not be discouraged with those who relapse. It is part of the recovering process. Instead, be encouraged by at those who have made it.
- Do not substitute a drug with another drug.

Roger Christie, Hawai`i Cannabis Ministry

- Proposes that the eradication of marijuana has made ice more popular because it is cheaper and more available.

Other testimony from at least eight concerned citizens expressed the following types of concerns: the impact of ice addiction on families, the loss of jobs and financial support due to ice addiction, the loss of children by parents using ice, the lack of treatment options and advocacy for decriminalizing marijuana.

Meeting with North Hawai`i Drug Free Coalition: September 4, 2003

Members of the Task Force met with 15 representatives from five community groups to listen to their concerns relating to the ice epidemic in their communities. Recommendations are included in Appendix B, "Summary of Community Recommendations."

- Patti Cook, Power of Choice, Waimea. This group of volunteers formed in 2001 to coordinate with Neighborhood Watch, schools, local businesses and law enforcement. They have held numerous activities, including a Community Dinner attended by over 350 people, parent education nights, teacher workshops and public awareness activities. They are working on Substance Abuse Advocacy Training Program, Clean and Sober housing and other education workshops.
- Doug Andrews, Power of Choice, Hamakua. This group of volunteers formed in 1999. They meet monthly, and created Hamakua Health Center Drug Treatment Advisory Committee. They sponsored the play "Breaking Ice", and held a Relay for Life, Western Weekend and Hugs Not Drugs sign waving events.
- Doug Connors, North Hawai`i Drug Free Coalition. This volunteer organization was formed to reduce substance abuse and acts as a resource for individuals in the community who need assistance.
- Pete Hoffman, Waikoloa Community Action Group. This volunteer organization formed in 2002, is comprised of medical and mental health professionals, law enforcement and the recovery community. They meet monthly. They promote Teen Intern Program for mentoring, have helped revitalize the Neighborhood Watch and Community Help Line, and sponsored public events to create drug awareness.
- Charlotte Donat, Team Kohala. This volunteer organization formed in 1997; has sponsored all district meetings on ice, drug forums and workshops. A significant achievement was in raising $600,000 for a men's Therapeutic Living Center in North Kohala.

Kona, Hawai`i Public Hearing: September 4, 2003

Judge Ronald Ibarra, Drug Court Third Circuit

- Drug Court accepts offenders who are referred before trial (tracks 1 and 2) and those who have been convicted but seek drug treatment as an alternative to going to prison (track 3).

- For the period October 2002 through September 1, 2003, 103 offenders were referred to Drug Court. 32 of those referred were rejected by the Prosecuting Attorney as being ineligible for the program. The court rejected 33 and accepted 36 into the program. Of the 36, nearly all offenders had drug charges and most had theft charges as well.
- The demographics for the 36 persons accepted into drug court are:

Males	Females
21	15

Race/ethnicity	Hawai`ian/Mix	Caucasian	Filipino	Japanese	Other
Number	12	14	4	2	4
Percent	39%	33%	11%	6%	11%

- The program will graduate its first client in November. As of September 2003, 33 of the 36 remain in the program and 5 are expected to successfully complete the program by January 2004. 2 participants were re-arrested. 13 of the participants found jobs or entered a vocational program. 19 participants were drug free 30 days after discharge.
- Since the inception of the program, 952 drug tests have been given, of which only 20 resulted in positive results. 13 of the positive tests were for ice.

Deputy Chief Harry Kubojiri, Police Department

- Hawai`i County leads the State in the number of students who are involved with drugs, according to the 2002 Hawai`i Student Alcohol, Tobacco and Other Drug Study.
- He supports the U.S. Attorney's recommendations regarding walk and talk and wiretap laws.

Jay Kimura, Prosecuting Attorney

- The Prosecuting Attorney's Office is proactive with the community through a number of programs. For example, it receives federal funding for Youth Builders through the Juvenile Accountability Block Grant that works to build a comprehensive strategy in dealing with juvenile crimes and early prevention of criminal activity. They also have a community empowerment project that works on community mobilization efforts.
- Another grant-funded program is the gun prosecution grant. The ice user poses a particular threat if he/she has a gun.
- They also use forfeiture funds for training, drug education, neighborhood watch programs and law enforcement training.

Mel Fujino, Deputy Prosecutor, Community Oriented Prosecution

- This office works in partnership with law enforcement, and public and private organizations to help identify community problems, improve public safety and enhance quality of life. The goal of this federally funded project is to increase community involvement in the criminal justice system in order to reduce crime.
- There are 2 prosecutors, an investigator and a clerk who are assigned to the community oriented prosecution unit. They educate communities, expedite drug case screening, and assist with drug nuisance abatement.

Kevin Kunz, MD, private practice

- The current methods used to fight ice include prevention, treatment, government leadership and criminal justice system. But these four areas need the support of the family and community to keep the programs going.
- We should treat addiction like any other disease, and receiving insurance parity is necessary. Like any other repetitive illness, we should not give up when a client relapses. Insurance coverage should be provided and not limited.
- Ice requires longer periods of treatment, often the user fails treatment twice.

- W must switch the point of entry for treatment away from the hospital emergency room to the treatment providers who are in the business of addiction treatment.

Don Bebee, Family Support Services of West Hawai`i

- Family Support Services is a private nonprofit created in 1979 to prevent child abuse/neglect. It operates with a budget of $3.5 million from federal, State and county contracts and foundation funding. The services provided range from prenatal programs to youth outreach. It runs two State incentive grants in North Kohala and South Kona designed to be model drug/alcohol prevention programs.
- West Hawai`i Child Welfare Services Advisory is a group of human service providers who meet on a monthly basis. The ice epidemic has seriously overloaded the child welfare system, including the number of drug-exposed infants in foster care. 95 percent of the children removed from their home is due to ice usage. The child welfare system needs better-trained foster parents. Child Welfare Services needs to streamline resources to local community based programs.

Jamar Wassan, MD, Waikoloa Rehabilitation

- This organization began in the late 1990's to deal with crack cocaine addicts. Ice is now the more prevalent drug. Waikoloa Rehab identified the need for services in the area and opened up a clinic. Since then, it has opened up community clinics in Honokaa, Kohala, Hamakua and plans to open clinics in Keeau and Kau.
- The community needs transportation to get to treatment services. It needs a program for mothers and babies, a women's program, and an adolescent program. An aftercare program for adolescents who complete residential treatment, and a vocational rehabilitation program for recovering addicts who complete treatment are also needed.

Wally Lau, Jackie Kalani, Community Response to Ice Coalition

- This group of Kona volunteers was organized in 2001. They held their first ice forum and have held three public meetings since then. They are active in strategic planning to deal with ice problems. They created a Speakers Bureau, and a Tutu Hui for grandparents. A play, "Breaking Ice" was developed and performed by recovering addicts and taken to all high schools on the Big Island.
- Families need as much help as the addicted person.
- If the State decides to conduct drug testing in the schools, make sure there are sufficient services provided to those who test positive. The community is not currently prepared for this.

Mary Jo Westmorland, Branch Administrator, Kapiolani Child Protection Center

- The child welfare system is overloaded by the number of ice-related cases. The transportation needs of the community is a problem due to the distances on the Big Island. The staff is at risk due to the violent behavior of ice users. Need for more resources in West Hawai`i.

Other testimony was received from at least 7 concerned citizens who spoke about the following concerns: Hawai`ian cultural issues are being overlooked in treatment services; the need for stronger law enforcement efforts to eliminate drug traffickers; addicts being involuntarily confined; insurance coverage expanded to cover unlimited treatment; finding the funds for community projects such as the "Breaking Ice"; the need to fund prevention programs for children that are outside of the school system; the need for transportation; the need for a homeless shelter; legalizing marijuana; the need to find a better solution for families who end up turning in their family member to the police in order to obtain assistance.

Site Visits

The Task Force visited a number of treatment facilities on O`ahu, Maui, Kaua`i, Moloka`i and Hawai`i. A description of those facilities and visitation dates follows below. Some organizations provided demographic and successful outcome data about the clients served. Recommendations made by staff and persons in recovery are included in Appendix B, "Summary of Community Recommendations."

June 19, 2003 – **Hina Mauka**, Kane`ohe, O`ahu

- Hina Mauka is a private nonprofit organization that offers various treatment programs including: residential, day and outpatient treatment, family education sessions and aftercare. In addition, Hina Mauka operates a therapeutic community in the women's prison and is the only agency in the State that is CARF certified for our criminal justice treatment programs. It provides a statewide urine analysis monitoring and assessment program to both the federal government and DHS/CWS. It runs a school-based adolescent treatment program in 12 public high schools in the State. Residential services are centralized in Kane`ohe on O`ahu, but Hina Mauka provides outpatient services throughout the State. The predominant drug of choice among those receiving adult treatment is ice, see data below. Hina Mauka receives state, federal, and private funding. The tables below describe the demographic data regarding the clients served.

Demographic data for all programs based on admissions between July 1, 2000 and May 31, 2003 as follows.

Age	Under 17	18-20	21-24	25-34	35-44	45-54	Over 55
Number	43	255	554	1548	1723	793	145
Percent	1%	5%	11%	31%	34%	16%	3%

Gender	Number	Percent
Female	1640	32%
Male	3421	68%

Ethnicity	Hawai`ian /mix Haw'n	Caucasian	Filipino	Mix, not Hawai`ian	Japanese	Hispanic	Other
Number	1655	1547	476	388	335	169	491
Percent	33%	31%	9%	8%	7%	3%	9%

Primary substance	Methamphetamine	Alcohol	Marijuana	Other
Number	2383	1597	450	631
Percent	47%	32%	9%	12%

Age of First Use of Ice	By age 15	Age 16-20	Age 21-25	Over age 26
Percent	15%	32%	17%	36%

Employment Status	Full-time (over 35hr/wk)	Part-time (less than 35hr/wk)	Unemployed	Not in labor force
Number	1378	422	807	2454
Percent	27%	8%	16%	49%

Source of payment for treatment	Quest	DOH/ADAD	HMSA NonQuest	Other Health Ins.	Other Govt.	Self Pay	Other
Number	1581	958	769	774	471	261	247
Percent	31%	19%	15%	15%	9%	5%	5%

- The residential treatment facility houses 42 recovering addicts of both sexes. The program is intensive, including medical-based treatment, counseling, and education that adhere to the 12-step philosophy. All treatment programs use a highly individualized therapeutic approach that focuses upon the bio-psycho-social needs of the consumer, i.e. physical, mental, social, emotional, familial, and spiritual. Treatment activities incorporate a cognitive/behavioral approach with extensive relapse prevention and life skills training to provide a strong foundation for treatment and recovery. Activities included are individual counseling, group therapy, education of the disease process including family roles and dynamics, medication education, skill building, anger management, cognitive restructuring, development of a spiritual base, relapse prevention, recreation, education, some vocational rehabilitation services, application of AA or NA to their life, including the completion of step work, obtaining and using a sponsor, and developing a strong support system within the recovering community. Hina Mauka also provides extensive linkage to other community resources. Preference in admission to treatment goes to 1) pregnant IV drug users, 2) pregnant women, and 3) IV drug users in accordance with established Alcohol and Drug Abuse Division Policy.

- The Therapeutic Community (TC) at the Women's Community Correctional Center houses 50 inmates, with length of stays from 12 to 18 months. Following TC treatment, women are released to TJ Mahoney's for structured living or participate in Bridge for Vocational Rehabilitation. Aftercare at Hina Mauka is available for six months. The program is not quite two years old. Outcome data is described in the table below.

Completed all phases of treatment	11
Completed all phases, substance free	100%
Completed all phases, employed or in school	100%
Completed all phases, no new arrests	100%
Completed TC phase	43
Completed TC phase, in follow up treatment	26
Completed TC phase, still serving sentence	6
Not completed TC treatment due to transfer, parole, court orders	17
Not completed TC due to unstable medical or mental health conditions	18
Not completed TC due to transfer to lockdown for violence	14
Discharge from TC due to noncompliant behavior	9

- Outcome data for adult treatment on Kaua`i, see McLaughlin/Johnson testimony in Kaua`i public hearing testimony summaries. Outcome data for Teen C.A.R.E., see Pacheco testimony on September 22, 2003.

July 18, 2003 – **Sand Island Treatment Center**, Honolulu, O`ahu

- Sand Island Treatment Center of the Hawai`i Alcoholism Foundation is a private nonprofit agency that operates intensive long-term residential and supportive living facilities to men and women with alcohol and drug abuse addiction. It was the first residential facility to open in Hawai`i. The residential facility has 53 beds and the supportive living unit has 70 beds.
- The demographics of the Sand Island population for FY 2002-03 based on 264 admissions are described in the table below.

Gender	Males: 69%; Females: 31%
Age	Age 18-29: 36%; Age 30-39: 32%; Age 40+: 32%
Race	90% are Hawai`ian or part Hawai`ian
Drug of choice	Crystal meth: 52%; crack cocaine: 20%; alcohol: 15%
Referral source	CJS: 33%; Public referrals: 33%; Self referral: 17%
Payment source	90% from DOH/ADAD and AMHD
Successful outcomes	Full-time employment: 47 (18%) Vocational readiness: 67 (25%) Client left the program: 25% Terminated from program due to noncompliance: 25%

- Admission priorities are pregnant women, homeless, and dual diagnosis men. Under the original treatment program, primarily for alcohol, the duration of treatment was 60 days. Ice addiction takes longer, six to nine months to ensure a good rate of recovery. Sand Island treats the individual for as long as it takes, regardless of funding source. 52 percent of the population have dual diagnosis at the time of admission. By the end of the program, 80 percent of those in treatment are diagnosed with co-occurring disorders of mental illness and substance abuse. The facility has their own equipment to conduct urine testing. Sand Island receives State, federal and private funding.

August 6, 2003 – **Aloha House**, Paia, Maui

- Aloha House is a private, nonprofit agency that operates various treatment programs: residential, day, intensive outpatient, family services counseling, prevention, adolescent outpatient, and school based treatment. For 75 percent of its population, ice is part of their addiction. Aloha House receives state, local, federal, and private funding.
- The residential treatment program provides 32 beds and includes medical detoxification. Many of the consumers in residential treatment have co-occurring disorders of mental illness and substance addiction. Generally, residential treatment runs 30-40 days, which is insufficient for the ice addict who needs three to four weeks to recover enough cognitive function to respond to treatment. DOH/ADAD funds 4-5 beds at $161/per day. HMSA/Quest will pay for 25-30 days of residential treatment, and AlohaCare pays for 4 days. Kaiser does not cover residential treatment. The occupancy is generally 90 percent with a waiting list for publicly funded beds. The facility has the capacity for more beds but no source of funding. Most of its residents are Hawai`ian or part Hawai`ian so they are using an immersion program to deal with cultural issues.
- **Malama Family Recovery Center** is part of Aloha House. It operates two therapeutic living centers for pregnant women and women with children, and offers intensive outpatient and aftercare programs. It also offers Baby SAFE, an early intervention and outreach program for pregnant women at risk for substance abuse.

August 11, 2003 – **Lifetime Stand**, Kaua`i Community Correction Center, Lihue, Kaua`i

- Lifetime Stand provides a minimum security, residential treatment facility for men and women serving out their sentences at KCCC. It is activity based and paramilitary, with focus on music, farming, and sensitivity to Hawai`ian culture. Ice is the most prevalent drug addiction. In FY2003, 164 inmates were admitted to the program; 3 completed the program; 110 did not complete the program.

August 18, 2003 – **Hale Ho`okupa`a**, Kaunakakai, Moloka`i

- Hale Ho`okupa`a serves all residents of Moloka`i, provides individual and group counseling and therapy, family education and counseling, urinalysis reporting, and transportation services for clients needing to get to treatment. It operates with State

insurance and private funds. Filipino immigrants have difficulty adapting to the culture and require services. Moloka`i residents cannot participate in the Maui Drug Court program because they can't find jobs on Maui while participating in the Drug Court program. 30 percent of the drug offenders turn to drug dealing to support themselves while participating in the Drug Court. Ice addiction is a serious problem with the adult population served; alcohol is the most serious problem with adolescents.

September 3, 2003 – **Hui Ho`ola O Na Nahulu O Hawai`i**, Paradise Park, Hawai`i

- Hui Ho`ola, which is operated by DASH, provides culturally based long-term outpatient treatment for substance abuse. It integrates the Hawai`ian culture and practices as part of treatment. It uses lomilomi, hula, Ho`oponopono, acupuncture, Hawai`ian values, and group activities. Their program runs for three months with aftercare once a week for as long as the client feels it to be necessary. They also include family counseling twice a week. Patients are either referred through the criminal justice system, parole and probation only (not through Drug Court), or self-referral. Currently, there are 45 adults in treatment and an adolescent program (ages 12-17) is just beginning. For most of its participants, ice is the primary drug of choice. Based on a six-month evaluation of a small sample of women, the program indicates a positive trend toward reaching its program goals. This program received federal funds, which is ending.

September 4, 2003 – **North Kohala Therapeutic Living Center**, Hawi, Hawai`i

- A Big Island Substance Abuse Council program, the North Kohala Therapeutic Living Center houses up to seven males. The program is geared towards integrating the men back into the community and re-teaching them life skills that they may have lost through their addiction. This program was initiated through community efforts and seed money from community organizations. Ice is the primary drug of choice for its residents. It receives State, local and private funding.

September 4, 2003 – **Bridge House**, Holualoa, Hawai`i

- Bridge House is a therapeutic living facility, where about 30 men and women are helped to integrate back into society. Residents are released after 130 days if they have everything necessary to lead normal, clean lives. This includes housing and employment. This program uses acupuncture to treat addicts. Many of them believe that it helps to ease the cravings and helps them relax. The Task Force observed a demonstration on acupuncture and spoke to participants about its usefulness. They all feel that the acupuncture helps them greatly and lessens withdrawal symptoms. Ice is a part of the addiction for most of its residents. Bridge House receives State and private funding.

October 2, 2003 – **Ho`omau Ke Ola**, Wai`anae, O`ahu

- Ho`omau Ke Ola is a private nonprofit organization that provides substance abuse day treatment, outpatient treatment, case management, residential treatment, outreach, housing, vocational and employment services and family support counseling to adult men and women in an environment based on Hawai`ian spiritual values. The treatment goals are to restore lokahi (balance, harmony, unity), pono (peace or balance within oneself), and maluhia (safe from harm). Demographic data for the period January 1, 2001-December 31, 2001 is described in the table below.

	Residential	Day Treatment	Outpatient
Total admissions	71	12	69
Gender	M: 56%; F: 44%	M: 66%; F: 33%	M: 52%; F: 48%
Age: 18-35 36-45 46+	49% 41% 10%	92% 8%	55% 32% 13%
Ethnicity	82% Hawai`ian/part-Hawai`ian	83% Hawai`ian/part-Hawai`ian	75% Hawai`ian/part-Hawai`ian
Drug of choice; multiple uses	Ice: 82%; alcohol: 49%; Marijuana: 52%	Ice: 100%; alcohol and marijuana: 67%	Ice: 68%; alcohol: 56%; marijuana: 59%
Referral source	CJS: 49%; self: 30%; CPS: 17%	CJS: 25%; self: 42%; CPS: 33%	CJS: 39%; Self: 17%; CPS: 35%
Payment source	DOH/ADAD: 51%, HUD: 49%	DOH/ADAD: 67%; Quest: 25%	Quest: 83%
Successful outcomes			
Completed treatment	41%	67%	45%
Discharge for noncompliance	30%	8%	36%
Client left before completion	14%	17%	19%
Referred to another agency for services	13%	8%	--

October 2, 2003 – **KASHBOX**, Waiawa Correctional Facility, Waipahu, O`ahu

- The KASHBOX compound currently houses approximately 200 inmates. There is a nine-month minimum stay consisting of three phases that last for roughly three months each. In the first stage, orientation, the inmates learn what their responsibilities will be and the pecking order of the program. The second stage addresses criminal behavior and helps the inmates to understand why they did what they did. The final stage is transitional, in which they set goals, receive job training and further their education, either by getting a GED or taking college courses.
- In FY03, 242 inmates were admitted into the program, 213 completed it and 29 did not complete the program.

October 20, 2003 – **Marimed Foundation**, Kane`ohe, O`ahu

- The Marimed Foundation runs a program that centers around the ocean and sailing for males ages 14-18, who do not need to be incarcerated or hospitalized, but face difficult emotional challenges requiring something more structured and restrictive than school or home-based services. Most of the youths have been referred directly by the Child and Adolescent Mental Health Division of the State Department of Health. Youths are also indirectly referred by Family Court, the Office of Youth Services or the Department of Education.
- There are four stages, or houses, to the program. The first is the Hale Ho`omaak`ana Intake House where youth spend 1-3 months being introduced to the program, assessed for treatment needs and further interventions and prepared for the ship voyages. The second house is Hale Ho`ohua Voyaging House where the youth work toward period "voyages" in canoes and sailing vessels. The third house is Hale Olelo Pai Pai Voyaging House, which is closer to the water and youth are reminded of their connection with the

community. The final house is Hale Huli`au Voyaging House where the youth work together toward reintegration into the community at large.

October 20, 2003 – **Habilitat**, Kane`ohe, O`ahu

- Habilitat is a long-term residential program based on the principals of the therapeutic community, which emphasizes the individual's responsibility to the community and effective teamwork. Senior residents and staff serve as role models for the newer residents. Habilitat receives referrals from friends, family, courts and other outside agencies.
- Habilitat's program consists of three phases. The first is the treatment phase in which the concept of `ohana and the practice of ho`oponopono are integrated. The next phase, re-entry, includes on-the-job training in one of Habilitat's departments (i.e.- construction, sales, public relations, computer training, landscaping, food service, etc.). The final phase is post re-entry where residents begin to integrate back into society in small groups then on their own. They get involved in the community by attending support groups such as AA and are given more freedom regarding their futures.

November 6, 2003 – **Salvation Army Detoxification Program**, Honolulu, O`ahu

- The Salvation Army Addiction Treatment Services (ATS), which is funded through the DOH/ADAD, Housing and Urban Development, Department of Human Services, the Judiciary, Department of Public Safety and insurance and Quest plans, offers both in and out patient services.
- The levels of services are as follows:
    - Detoxification: ATS provides social model detox services to alcoholic and drug dependent (heroin, cocaine or ice) clients, funded primarily by DOH/ADAD or through insurance. Clients receive 1-7 days of clean, safe and sober support, which includes around the clock monitoring by trained professionals, a well-balanced diet, counseling, education and referral to treatment if possible.
    - Residential Services: The program's primary focus is relapse prevention, which is achieved through the use of cognitive re-structuring and behavior management. The initial phase includes an extensive orientation to treatment and a slower pace to allow for clients to adapt to their environment. The main facets of the program are individual counseling, therapeutic goals, women's and men's issues, addiction education, recovery building skills, case management services, recreational activities, vocational skills, family services, chaplain's services, aftercare, community 12-step support groups and support services.
    - Day Treatment Services: This includes 4-6 hours of therapeutic activities five days a week, with additional time spent to support clients in a clean and sober atmosphere. The day treatment clients participate in many of the same activities as those in residential services. They are also required to participate in 12-step community programs.
    - Outpatient Services: These clients attend three-hour sessions 1-4 times a week, which includes therapeutic goals, relapse prevention classes, cognitive re-structuring, addiction education, anger management and family education/couples class. Individual counseling and aftercare are also available. Outpatient clients are also required to participate in 12-step programs.
- During 2003, ice was the most prevalent primary drug problem for clients, with 63 percent listing it as their primary drug. A trend shows the continuing increase in the percentage of clients admitted with chronic or long-term (10 years or longer) ice dependency with increased severity of neurological impairment that may last for six months or more.
- Alcohol was still the primary drug of choice for detox clients, however, by a much smaller margin, only 59 percent, compared with 70 percent the prior year.

- The following statistics were provided through the ATS Annual Management Report for the Program Year 2003, which runs from July 1, 2002 – June 30, 2003:
    - 1,595 adults were admitted in the following treatment modalities:

Level of Care	Unduplicated clients	Duplicated clients	Service units
Detoxification	489	734	3667 bed days
Residential	210	237	13,878 bed days
Outpatient	228	440	6677 days/sessions
In-prison	668	750	6110 staff hours
Total	1595	2161	

(Duplicated count includes multiple admissions for detox unit, transfers between modalities for residential and outpatient levels of care and carry-overs from prior year for in-prison treatment program):

- The following demographics include multiple admissions and transfers between treatment modalities as admissions:

Descriptor	Treatment Continuum		Social Detox		All Programs	
	N=681		N=734		N=1415	
Sex	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Female	141	20.7%	126	17.2%	267	18.9%
Male	540	79.3%	608	82.8%	1148	81.1%
Age						
18-24	114	16.7%	77	10.5%	191	13.5%
25-34	248	36.4%	207	28.2%	455	32.2%
35-44	231	33.9%	274	37.3%	505	35.76%
45-64	87	12.8%	174	23.7%	261	18.4%
65+	1	0.2%	2	0.3%	3	0.2%
Ethnicity						
Caucasian	132	19.4%	309	42.1%	441	31.2%
Hawai`ian	297	43.6%	221	30.1%	518	36.6%
Descriptor						
Alcohol	95	14.0%	430	58.6%	525	37.1%
Marijuana/THC	61	9.0%	7	1.0%	68	4.8%
Methamphetamine	430	63.0%	234	31.9%	664	46.9%

(Treatment continuum includes residential & day/outpatient treatment)

- Treatment effectiveness outcomes at six months following discharge is described in the table below:

	Population: Total clients served	Target Outcome	All Clients	Completes Only	Non-completes
			432	197	235
1. Maximize completion of treatment program	% of clients who complete the treatment of program	50%	46%	100%	0%
	Follow-up population				
	Total Clients Serviced from 01/01/02 – 12/31/02 who were followed-up 6 mos. After discharge		464	242	222
	No. of clients actually contacted		300	195	105
	Percent of clients actually contacted		65%	81%	47%

Objective	Measure				
2. Achieve and maintain abstinence	% of clients maintaining total abstinence for 30 days prior to follow-up	75%	79%	87%	64%
3. Maximize employment	% of clients employed, in school or in a vocational training program	45%	43%	54%	21%
4. Maximize participation in employment/school /vocational training	% of clients not missing any days of work/school/training due to substance use during the past 30 days	80%	100%	100%	100%
5. Maximize stable living environment	% of clients with stable living situation during the prior 30 days	80%	82%	91%	63%
6. Minimize need for further drug treatment	% of clients requiring no additional drug treatment following completion of ATS treatment	80%	74%	84%	55%
7. Minimize need for further drug treatment	% of clients completing treatment who are not in drug treatment as a follow-up	80%	82%	87%	71%
8. Minimize injection drug use	% of clients who have not injected drugs intravenously during 30 days prior to follow-up	90%	100%	100%	100%
9. Minimize legal involvement	% of clients with no new arrests since discharge	80%	98%	98%	98%
10. Minimize utilization of hospital emergency rooms	% of clients who have not been treated in hospital ER since discharge	85%	98%	98%	97%
11. Minimize hospital admissions for medical problems.	% of clients not needing hospitalization due to medical problems since discharge	90%	98%	98%	98%
12. Minimize psychological distress	% of clients who have not experienced significant periods of psychological distress during the past 30 days	70%	99%	100%	98%

- Measurements of effectiveness for the detoxification unit are described in the table below.

Measure of effectiveness	Target percent	Actual percent
1. The percentage of clients who have achieved their detoxification objectives and successfully complete the program	70%	83%
2. The percentage of clients who have been successfully referred	70%	91%
3. The percentage of clients not needing medical detoxification	90%	99%
4. The percentage of clients not requiring additional detoxification services within 6 months following discharge	50%	66%

November 6, 2003 – **First LAP**, Palolo, O`ahu

- First LAP stands for Life After Prison and is a faith-based program for males who have been released from prison. In the program, they are taught basic life skills and are responsible for paying their own "rent" and staying gainfully employed. They currently can house 20 men.
- The program has only been in existence for a year and therefore has not had any measure of either success or failure.

APPENDIX B - SUMMARY OF COMMUNITY RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS RELATING TO TREATMENT FOR SUBSTANCE ABUSE [FUNDING REQUIRED]

More treatment programs; treatment is more cost effective than incarceration; need to close the gap in treatment capacity.
Early treatment programs.
Treat the families of the addict, even if addict refuses treatment.
Fund research into the effects of ice.
Fund treatment for youth, students; current resources inadequate to meet need, need to provide continuum of care for youth and case management services.
Stabilize funding for treatment programs by providing long-term funding for programs. This leads to better data, consistent approaches, ensures staffing quality.
Review costs of ice on all government spending to see total effect, then prioritize funding.
Need more affordable treatment programs.
Fund adult treatment programs for persons with co-occurring mental disorders.
Increase treatment options for homeless with co-occurring disorders.
Provide more treatment for incarcerated drug addicts since they are a captive audience.
Refocus funds for treatment on those persons who can be helped at early stages; money spent for treatment of those on probation, parole, or in jail will less likely result in rehabilitation.
Fund outreach by geographic districts, to identify substance users and divert them into early intervention programs as well as to assist recovery persons transition back into community. Cost: $150,000 for three person team of two outreach workers and one certified substance abuse counselor per district.
Give tax credits for taxpayers that pay for private treatment.
Increase funding for drug courts.
Expand and increase funding for juvenile drug court.
Fund treatment for first time offenders under Act 161; expand treatment alternatives.
Establish a drug diversion program, sentencing suspended while in diversion, with dismissal of charges for successful completion of diversion program.
Require mandatory treatment for those admitted to a hospital emergency room for drug-related symptoms.
Require referral to treatment at point of entry into hospital.
Establish "hui's" on each island, designed by the community as an alternative to incarceration and resource for those in recovery and their families. Cost: About $400,00 per year to provide transportation, staffing, treatment and support services to 50 families, cultural modalities.
Set reimbursement rates to cover reasonable costs of providing the care.
Ensure appropriate assessment, referral and treatment for all those who need treatment based on a continuum of care; ice addiction requires longer treatment and aftercare to prevent relapses; fund community based programs that can provide treatment and support services to assist recovering person transition back into community.
Adopt treatment models based on best scientific evidence.
Fund evaluations for programs; encourage new treatment ideas.
Establish treatment programs that include culturally sensitive approaches.
Need medical response to substance abuse treatment to emphasize that it is a disease.
Define treatment to include life skills, support services in order to treat the whole person.
Fund alternative treatment approaches to addiction, such as acupuncture, nutritional

supplementation in addition to traditional psychosocial modalities.
Require compulsory, long-term treatment and confinement to program.
Fund more treatment programs for families involved in child welfare, family drug court, probation, parole and homeless.
Assess offenders to determine which person would benefit from community-based treatment and which person would benefit from treatment while incarcerated. Move women into community treatment as soon as possible.
Establish motivational enhancement groups, integrated with the criminal justice system.
Fund more community based outpatient and aftercare programs for offenders coming out of therapeutic communities in prison.
Increase number of detox programs with longer stays so that a person is ready for residential treatment.
Fund detox program within homeless shelter by adding medical service.
Implement voucher system for treatment; consumers make own choice for treatment with voucher payment.
Use alcohol and tobacco taxes to fund treatment and prevention; use tobacco settlement money for drug treatment and prevention.
Fund adolescent substance abuse counselors in the schools to provide transition services to students.
Fund treatment programs that support self esteem building and resilience training.
Establish alternative schools for students addicted to drugs, with emphasis on treatment.
Provide counseling in every high school for students with drug problems or with family drug programs.
Fund treatment program starting at the 5th and 6th grade level, using a prevention and treatment approach. Few middle schools have outpatient treatment and the need for such services exists.
Fund more adolescent residential beds in the State.
Fund a seamless continuum of care for adolescents, from day treatment, intensive outpatient treatment, independent living and recovery houses for older teens.
Do not fund more residential beds for adolescents until after the Big Island center opens and we see what the needs are. Fund the gap in treatment programs between residential and school based outpatient treatment. Need for intensive outpatient, high school outpatient treatment.
Fund treatment programs for adolescents who are not in school and are out of the system.
Facilities where drug users can safely use drugs should be established. These areas, known as "tolerance zones," "injection rooms" or "health rooms" create an environment where drug users can obtain clean injection equipment, condoms, advice and/or medical attention. Such programs currently operate in several European cities and Vancouver, Canada. They also provide access to treatment and other social services while better controlling the unhygienic public places used by drug addicts.
Improve and build stronger communication between behavioral health provider and primary care physicians to identify and address substance abuse.
Do not mandate parity without addressing increased costs.
Clinical judgement should prevail in deciding treatment plans (length of stay, discharge).
Adequately fund all state agencies that provide ancillary support to recovering addicts and treatment programs, i.e. Judiciary, Public Safety, DOH, DHS, ADAD.
Consider incarceration based treatment facility under the Department of Public Safety.
Amend forfeiture laws to use funds from forfeiture to fund treatment.
Increase the number and availability of clean and sober housing. Cost for clean and sober housing with outpatient treatment and child care is about $350,000 to serve 12 families.
Long-term housing is much needed to unite families, stabilize and reenter community. Focus on public-private efforts.

Expand the number of clean and sober homes to the neighbor islands by funding modest loans for start up costs.
Establish treatment or rehabilitation programs for recovering persons who are released from residential treatment or prison to stop the revolving door into prison.
Increase funds to Maui for mental health treatment of co-occurring disorders in adolescents.
Maui needs additional residential treatment beds to meet demand of those unable to pay.
Fund additional treatment for incarcerated adolescents in Maui; current resources are inadequate.
Expand residential treatment programs for women at Salvation Army because space is available. Cost: $600,000 per year to serve 48 singles and 15 families. Need to expand program for pregnant female offenders. Provide similar programs on neighbor islands.
Fund treatment programs that are gender-specific; women affected by domestic violence have different treatment needs.
Fund Maui Drug Court. Maui County currently funds this program; need to expand drug court to juveniles.
Convert MCCC Dorm 3 into an intensive treatment program.
Fund transitional residential treatment facility on Kaua`i for ex-offenders in recovery; match $250,000 to Kaua`i county funds.
Establish "one stop" support facility for ex-offenders on Kaua`i, including recreational services and mental health.
Expand substance abuse outreach, early intervention and treatment programs serving Kaua`i.
Establish a residential treatment facility for mothers and children on Kaua`i.
Establish an adolescent residential treatment facility on Kaua`i that is culturally sensitive and includes family support services.
Establish a residential treatment facility for adults in Kaua`i.
Expand school-based treatment programs on Kaua`i, into the middle schools. Add two counselors per school, at a cost of $100,000 per year. Design a comprehensive outpatient treatment program for intermediate schools.
Establish clean and sober living homes on Kaua`i.
Fund therapeutic living homes on Kaua`i; residential homes have not been economically viable on Kaua`i.
Fund detoxification program, residential facility and transition homes on Moloka`i. No transition homes for those who received treatment off-island.
Fund school-based adolescent outpatient treatment program on Moloka`i.
Need residential treatment home on Big Island for juveniles; address mental health problems as well as drug addiction.
Fund inpatient drug treatment program on Big Island.
Fund youth transition programs on Big Island to support child and family after release from juvenile justice system or a residential treatment program.
Add Certified Substance Abuse Counselor to Waimea Middle School.
Fund mother/infant treatment program for Waikoloa, West Hawai`i.
Fund Homeless Shelter for West Hawai`i and provide treatment.

SUMMARY OF RECOMMENDATIONS RELATING TO PREVENTION OF SUBSTANCE ABUSE [FUNDING REQUIRED]

Conduct studies, do long-term planning for Statewide substance abuse, routinely consult with communities and make funding decisions based on the plan.
Establish a statewide, coordinated prevention strategy, using risk and protective factors for needs assessment, best practices to fill gaps in prevention programming, develop

community partnerships.
Prevention focus should be in the workplace for identification and early intervention.
Prevention should start in schools, at 5th-6th grade level and continue every year, deal with peer pressure.
Prevention in schools should start at the middle schools.
Prevention in school should begin at 4th grade level and continue through high school.
Mandatory drug education curriculum in schools, K-12; elective credits at high school.
Prevention programs should start with preschoolers and their families.
Add drug prevention and education in school curriculum; drug education program should be for each grade.
Maintain and expand extracurricular activities through the schools.
School drug prevention curriculum should include discussions about media glamorization of alcohol and drugs and be honest, reality based.
Schools should monitor attendance and performance to identify troubled students.
Expand youth mentoring programs in the schools.
Fund prevention programs for juvenile offenders.
Expand after school activities for middle school and older youth.
Develop a drug prevention curriculum using Kamehameha Schools materials, especially for Waikoloa elementary.
Drug education and prevention programs in schools should include persons with real life stories about addiction and recovery, adults and youth.
Drug testing in schools through hair analysis; no criminalization, identify students using drugs at early stage for intervention and treatment; reduce peer pressure; test results will not be used for disciplinary purposes.
Schools should be authorized to force student into treatment when counseling fails.
Schools should provide programs that strengthen students personal skills and enhance peer support systems.
Schools should foster mentoring programs to discourage substance abuse.
Stabilize funding for prevention programs by State funding of programs initiated under federal funds that prove to be effective and culturally competent.
Fund prevention programs.
Increase funding for prevention, but not by reducing intervention and treatment.
Adopt prevention programs based on best practices and science based programs.
Partner with community and state agencies for prevention system.
Support prevention programs that are effective and reflective of Hawai`i's cultural diversity.
Establish crisis lines, chat room web sites for youth.
Educate children on signs of parental drug use.
Make substance abuse prevention a priority in every community, including reducing availability through merchant compliance (such as drug paraphernalia).
Fund public health nursing visits to home of families with drug users.
Educate youth and women on dangers of drugs on fetus.
Increase media coverage of abuse and prevention programs, educate parents, increase public awareness, workplace education.
Make available free or inexpensive, non legally binding drug and alcohol testing for families and friends.
Fund grassroots programs, such as "Breaking Ice" a play.
Fund outreach and referral programs for families in public housing on Maui most of whom are affected by ice epidemic.
Fund teen challenge days in schools, targeting sixth to twelfth grades on Maui.
Fund teen challenge days in seventh to twelfth grades on Kaua`i.

Fund outreach program on Kaua`i; need $240,000.
Fund prevention program for youth on Moloka`i.
Need more after school activities on the Big Island for youth to keep them out of trouble.
Fund mentoring programs, with elders and youth, Big Brothers/Big Sisters on Big Island.
Fund coordinator for Waikoloa Action Plan.
Develop a community center in Waikoloa.
Fund more youth services programs in Kalihi Valley.

SUMMARY OF RECOMMENDATIONS FOR POLICIES OR CHANGES IN THE LAWS RELATING TO ELIMINATION OF ICE EPIDEMIC [MAY AFFECT FUNDING]

Coordinate efforts of law enforcement, treatment, prevention, government re abatement efforts.
Coordinate efforts of agencies responsible for funding or providing treatment and prevention services through a council.
Require insurance parity, provide coverage for drug addiction treatment as any other disease.
Expand insurance coverage for treatment; longer coverage for treatment needed because treatment for ice addiction requires a longer period of time.
Mandate that insurance programs cover drug treatment and for adequate periods of time, i.e. Kaiser does not cover.
Quest coverage for drug treatment must be expanded; should include residential treatment.
Insurance coverage for drug treatment should be separated from coverage for psychiatric disorders.
Require insurance carriers to refer the insured to community services in addition to treatment, as the model used by Aloha Care.
Require managed care decisionmakers to be educated and experienced with substance abuse treatment services, the need for long-term care and to make decisions based on successful treatment outcomes rather than treatment costs.
Review Quest program to eliminate barriers to service and utilization of services.
Schools: create drug free schools, safe environment for students, mandatory testing at the beginning of each school year.
Schools: voluntary drug testing for parents who want their children tested.
Schools: require drug testing as part of the physical examination required for entry into school.
Instead of using funds for mandatory drug testing in the schools, use them for adolescent treatment; don't do drug testing until services are in place for treatment.
Provide resources for community involvement programs, which partner with schools to address the drug problem.
Provides resources for the redesign of secondary education to create smaller learning communities within middle and high schools.
Provide resources for the establishment or expansion of transition programs in the secondary schools.
Develop an adolescent substance abuse counselor certification program at the University of Hawai`i.
Require UH to reinstate the health certification in the College of Education so that teachers can be trained in substance abuse issues and properly implement a prevention curriculum.
Counselors should be better trained and educated.
A vehicle to compel parental involvement in their child's treatment for drug abuse in order to ensure the child attends treatment would be helpful.
More police needed, look for additional funding such as federal.

Employers should be encouraged to refer employees to treatment and that treatment is made a condition of continued employment; 70% of users have jobs.
Increase funding for nuisance abatement efforts to eliminate drug houses and meth labs.
Permit school counselors to report to the police those students who are abusing drugs, without fear of privacy law violations; these reports will be for the purpose of investigation into drug distribution networks, not prosecution of the student user.
Establish an effective system of monitoring drug use and abuse to include hospitals, poison control centers, child protection agencies, schools. This data necessary for decision making.
Establish tax incentives, government sponsored loans for employers to hire persons in recovery or for persons in recovery to start small businesses.
Establish and provide resources and staff to community action groups; establish drug free zones; more effort to collaborate between law enforcement, government, service providers, insurance; provide planning grants for communities to develop strategy for dealing with substance abuse.
Fund volunteer community action groups a nominal amount, such as $2,000, to pay for basic administrative expenses such as postage, printing, travel costs.
Fund a grant writer to go after private foundation and federal dollars; coordinate funding strategies.
Funds for marijuana eradication should not be earmarked, but local jurisdiction should be permitted to use the funds for drug interdiction as needed.
Restore Career Criminal Program funding to address career criminal impact on State.
Use alcohol tax to fund law enforcement activities.
Encourage business partnership with treating agencies to provide jobs for persons in recovery.
Fund a study on drug policies in other countries, such as government sponsored clinics to dispense controlled substances as done in Switzerland.
CWS is overloaded; need to improve the placement system; training for foster parents.
Need to strengthen Section 587, HRS, to make it a higher priority to provide services to prevent child abuse and to provide diversion alternatives from the CWS; current system is reactive to harm without focus on preventing child abuse.
Amend Section 587, HRS, to implement a differential response system in compliance with CAPTA, which requires states to have policies/procedures for referring newborns and their families to services. Need triage system to assess and treat pregnant women instead of removing baby after birth if test positive for drugs.
Fund planning grants for community programs for prevention of child abuse.
Make support and diversion services mandatory for families at risk for child abuse, especially where chemical dependency is present.
Partner with organizations, trusts, businesses, Dept. of Hawai`ian Homelands to provide land for new treatment facilities.
Provide childcare for parents attending vocational or general education programs.
Permit faster changes in administrative rules relating to the substance abuse testing requirements in order to be consistent with the federal standards.
Create incentives for drug testing by employers by reducing the worker's compensation rates.
Lower cost of urinalysis testing by modifying State law on the requirements for substance abuse testing to permit more flexibility.
Fund a study on substance abuse in the hospitality industry.
Create peer counseling program for workplace; train management and union members for program; would then have job site expertise before an individual reaches crisis stage.
Change laws to mandate a worker's ability to use sick leave and/or TDI while enrolled in a qualified program.

Use Washington State Labor Council's "Working Drugfree" program.
Need to develop protocols and train personnel to carry out environmental risk assessments, define cleanup goals, evaluate process and handle remediation for lab site cleanup.
Provide funding for additional training for first responders.
Create medical monitoring program to evaluate on-going health and environmental risks.
Review Quest administrative rules that pertain to "Carve out" for mental health care services to provide more clarity to health care providers.
Treatment providers must work collaboratively with probation officers and CWS workers, but must be permitted to exercise clinical judgment about the treatment necessary for the patient without pressure that the patient will suffer adverse consequences, such as being incarcerated or having parental rights revoked.
Reduce the cost for drug testing.
Increase the availability of Employee Assistance Programs.
Permit employers to use the urine sample cup for reasonable suspicion or random testing, not just for pre-employment post offer testing. This would be a faster test that would reduce an employer's liability especially where safety concerns exist.
Permit employers to obtain a two-year drug history on applicants for safety sensitive positions.
Make youth full partners in the fight against drug use.
Recognize that substance abuse is a public health issue and not a criminal justice issue; acknowledge that no balance exists between funding of law enforcement and treatment.
Fund drop in centers for the homeless.
Utilize research done by UH criminologists as the basis for sound public policy.
Conduct drug testing on prison guards to prevent drugs from coming into prisons.

SUMMARY OF RECOMMENDATIONS RELATING TO CHANGES IN LAWS RELATING TO ELIMINATION OF ICE EPIDEMIC [INDIRECT AFFECT ON FUNDING]

Change Hawai`i search and seizure laws to be consistent with federal laws in order to permit evidence that is admissible in federal court, obtained through wiretap and walk and talk, to be admissible in state court.
Amend Hawai`i Constitution to revive “walk and talk” at airports to prevent drugs from entering.
Eliminate the State laws requiring advocacy hearing for wiretaps.
Make Hawai`i laws re threshold levels for classification of drug offenses consistent with federal law.
Permit searches for traffic violation stops to be based on "reasonable grounds."
Change law to permit trash searches from the curb.
Elevate the level of drug offense, starting with misdemeanor instead of petty misdemeanor. Marijuana is gateway drug.
Repeal the mandatory minimum law for ice and use savings to fund treatment.
Review child endangerment laws for children subjected to clandestine laboratories.
Review rights of mothers and child for removal of the child from the mother due to drug use; removal of newborn.
Enact law to protect the unborn fetus from a woman using ice while pregnant; allow CPS to intervene early in the best interest of the unborn.
Tighten laws governing criminal standards for possession or sale of drug paraphernalia; possession of drug paraphernalia should be stand alone charge.
Process to "commit" an addict into treatment by family members; process to permit family members to involuntarily commit a minor to treatment.
Sentencing reforms for habitual criminals, i.e. elevate multiple misdemeanors to felony.

Modify mandatory sentencing law as it hampers implementation of treatment alternatives for ice addicts who are a minimal risk to public safety.
Mandatory sentences of 20-25 years without parole for drug dealers and distributors.
Incapacitate drug offenders through incarceration.
Repeal Act 161 that refers first time drug offender to treatment programs; instead, should permit court discretion on sentencing and referral to Drug Court; dealers should be incarcerated.
Establish bounty for drug dealers, with hotline to report suspected activities.
Implement direct filing for criminal arrests.
Decriminalize marijuana, cease spending money on marijuana eradication.
Legalize and tax marijuana, use funds for drug treatment and prevention.
Shift law enforcement away from marijuana eradication to property theft, car theft and hard drug usage.
Adopt law that restricts unlimited access to ice precursors and tracks purchases.
Educate landlords of forfeiture and nuisance abatement laws, train them on responsibility prevent illegal drug activities at their property.
Amend landlord tenant laws to permit landlord to evict tenant where the landlord can prove drug distribution or manufacture on the site.
Change zoning laws to ease use of private residences for clean and sober living; restrictions on the number of unrelated adults that may live in one house limit availability of clean and sober houses. Maui limits 5 unrelated adults.
Enact law that permits expedited zoning change process for substance abuse treatment homes, at risk youth. Current State law permits 8 beds. Cut red tape on approval process so that facilities may be approved faster, deal with NIMBY issues.
Enact a public intoxication law.
Ban alcohol in public parks on Moloka`i; Moloka`i is exempt from the county law.
Share information about juveniles, between DOE, DOH, CPS to provide drug treatment and case management services.
Require parents to enter treatment under the juvenile justice system where juvenile is found responsible for a crime and a parent or guardian is contributing the juvenile drug use.
Criminalize intent to distribute law.
Change law for holding suspects while under the influence of ice; extend time for holding in custody to 96 hours; this would allow for assessment and referral to treatment before a charging decision is made or as a condition of release.
Medical marijuana: provide affirmative defense that the drug user bears the burden of proving medical need.
Legalize drugs, remove the profit incentive, redirect resources from law enforcement.
Workplace: amend drug testing law to permit less intrusive hair testing for preemployment, random and for cause testing.

APPENDIX C – SUMMARY OF RECOMMENDATIONS BY INDIVIDUAL TASK FORCE MEMBERS

Amend Act 161
Amend wiretap laws to conform to federal law
Use tobacco fund money to establish new drug prevention programs for middle school and high school
Establish office of a Drug Czar within Lieutenant Governor's office
Tax credits for businesses that pay for private drug treatment for employees
Drug counselors in every middle and high school
Medium security facility with the emphasis on treatment and rehabilitation for convicted drug dealers and users who have committed crimes.
Change zoning laws to allow more unrelated persons to live in clean and sober houses.
Establish alternative schools with emphasis on treatment for students addicted to drugs and alcohol.
Use forfeiture funds for treatment services.
Random drug tests on ACOs at all prisons.
Random drug tests in schools for early identification and early intervention.
Establish more after school activities for teenagers.
Voluntary drug testing of children at parent's request.
Use alcohol tax to fund prevention and treatment programs.
Direct filing for criminal arrests.
Strengthen laws dealing with criminal standards for possession and sale of drug paraphernalia.
Reinstate "walk and talk."
Extend suspects' time in custody to 96 hours to allow time for assessment and referral to treatment.
Make the whole state a weed and seed site.
Give select squad of trained police officers under the authority of the Attorney General or Department of Public Safety the authority to do "knock and talk" and "walk and walk."
Wiretap
Give expanded role to sheriffs at airport security stations to stop neighbor island outbound drug traffic.
Concentrate on cultural based rehab, education, information, etc.
Treat adult family members.
Put pregnant women on drugs in treatment without compromising prenatal care and hospital delivery.
Increase support for PCNC's.
Support efforts such as the Parent Project, which is a specific program that helps parents with "strong willed" children.
Support after-school programs.
Provide for additional after school transportation by revising bus schedules or by other means.
Encourage community activities on school campuses creating a strong sense of community and collective responsibility, while also nourishing student, parent and community ownership of the school and its grounds.
Complete memorandum of agreement for increase information sharing with Judiciary, DOH, DHS and the DOE.

Create avenues to encourage businesses and community groups to support school complexes by supporting the creation of information and communication networks using school complexes as the base.
Minimum of $3M for new prevention efforts and programs to target middle/intermediate school students
Minimum of $7M for treatment and rehabilitation.
Two year pilot project for drug testing in two high schools with the intent to help at-risk students. Drug testing would need to follow these guidelines: parental consent required, voluntary, random, in-house counseling of student and family for positive results, results not given to law enforcement, no automatic suspension from extra-curricular activities, appropriation of $80-100K and the schools participating are chosen based on student population vote.
Incentives/tax breaks for businesses that hire ex-cons.
Raise taxes on ice pipes and drug paraphernalia.
Pilot project of one year to change wiretap laws to federal standards.
More school funding for Youth Challenge Academy and expansion of programs for at-risk students.
Reinstate "walk and talk" and "knock and talk" with the condition that people are allowed to remain silent and there is no profiling.
$10M per year funding for non-school hour programs for children and youth.
Funding for treatment programs for all high schools and middle schools.
Seed funding for community-based, culturally-based rehabilitation programs.
Full parity for substance abuse.
Expand and increase funding for juvenile drug courts.
Fund more community based outpatient and aftercare programs for offenders coming out of therapeutic communities in prison.
Use alcohol and tobacco taxes and tobacco settlement money for drug treatment and prevention.
Allow law enforcement agencies and school principals to exchange student truancy and disciplinary records.
Need counselors in all middle and high schools that are trained to counsel students with drug problems or with family drug problems.
Fund more adolescent residential beds in the State.
Fund treatment programs for adolescents who are not in school and are out of the system.
Require insurance coverage for drug addiction treatment for youth.
Fund mother/infant treatment programs.
Mandatory drug education curriculum, age appropriate, in schools beginning in 4th grade.
Fund more after school activities for middle school.
Require health care providers to educate pregnant women on dangers of drugs on fetus.
Establish vocational rehabilitation programs for recovering persons who are released from residential treatment or prison.
Provide resources for the redesign of secondary education to create smaller learning communities within middle and high schools.
Require teachers to get training in substance abuse issues.
Review child endangerment laws for children subjected to clandestine laboratories.
Sentencing reforms for habitual criminals, i.e., elevate multiple misdemeanors to felony.
Shorten the timeline for prosecution.
Amend landlord tenant laws to permit landlord to evict tenant where landlord can prove drug distribution or manufacture on site.
Create permission waivers allowing state agencies to share information about juveniles to improve drug treatment and case management services.

Change law for holding suspects while under the influence of ice; extend time for holding in custody to 96 hours.
Provide funding for improved island-wide transportation system or grant-funded shuttles for patients in treatment.
Regulate chemical purchases.
Fund a youth summit.
Random drug searches at school using dogs.
Require training for emergency rooms and intervention when drugs are involved.
Expand resource centers in middle and high schools that serve as source of state and community-based services for families.
Law that allows parent to commit a child to drug treatment, similar to that which a parent may commit a child for psychiatric care.
Establish a four-year advisory council to review and recommend procedures and/or process for coordination of efforts of agencies responsible for funding or providing treatment and prevention services.

(This page intentionally left blank)

INDEX OF SUMMARIZED TESTIMONY

Mr.	Carlisle	Peter	Prosecuting Attorney	City and County of Honolulu Prosecutor's Office	99
Dr.	Carlton	Barry	Professor	John A. Burns School of Medicine, UH	107
Mr.	Chavez	Joe	Director	Oxford House	113
Rev.	Christie	Roger		Hawaii Cannabis Ministry	156
Mr.	Ciccarelli	Paul	Special Agent in Charge	Naval Criminal Investigative Services	102
Ms.	Cook	Lisa	Director	Drug Addiction Services of Hawai`i, Inc.	112
Mr.	Cunningham	Jud	Administrator	Aloha House	142
Mr.	Dangaran	Ray	Program Coordinator	Salvation Army	152
Ms.	Davis	Mahealani		Community Association of East Moloka`i	150
Dr.	Derauf	Chris	Professor	John A. Burns School of Medicine, UH	108
Ms.	Derwey	Kathryn	Inspector	U.S. Postal Service	103
Mr.	Dias	Harold	Business Manager	IBEW Local 1357 (Verizon Hourly Employees)	134
Ms.	Dickow	Alice	Principal Investigator	MATRIX model study, Honolulu Site	109
Ms.	Diesman	Jennifer	Governmental Relations Manager	HMSA	131
Mr.	Ebesugawa	Michael	Public Defender	County of Hawai`i	151
Mr.	Engelman	Rick	Program Director	Substance Abuse Division, Maui Youth and Family Services	141
Ms.	Fisher	Christina	Coordinator	Ice Breakers	141
Ms.	Fraser	Judy	Co-Chair	Kaua`i County Drug Prevention Team	146
Mr.	Fujino	Mel	Deputy Prosecutor	Community Oriented Prosecution	157
Mr.	Gaspar	Greig	Marketing Specialist	Waimanalo Health Center	120
Mr.	Gill	Eric	Financial Secretary-Treasurer	Hotel Employees & Restaurant Employees, Local 5	135
Ms.	Gnazzo	Gail	Chief Executive Officer	Maui Youth and Family Services	141
Ms.	Golden	Nancy		Child and Family Service	146
Mr.	Goodwin	Charles	Special Agent in Charge	Federal Bureau of Investigations	101
Mr.	Grey	Briane	Special Assistance Agent	Drug Enforcement Agency	101
Mr.	Hayakawa	Sidney	Federal Security Director, Honolulu International Airport	Transportation Security Administration	103
Ms.	Hein	Darlene	Coordinator	Harm Reduction Hawai`I	115
Mr.	Henderson	Ray	Director	Ohana Makamae	142
Dr.	Holschuh	Fred	Councilman	Hawai`i County Council	153

Ms.	Hornsby	Debbie	Assistant to the Head	Academy of the Pacific	128
Judge	Ibarra	Ronald	Judge	Third Judicial Circuit, State of Hawai`i	152, 156
Mr.	Ihu	William	Deputy Chief	Kaua`i County Police Department	145
Mr.	Inkyo	Stan	Program Director	Susannah Wesley Community Center	119
Ms.	Irwin	Katherine	Assistant Professor	University of Hawai`i, Sociology	137
Mr.	Johnson	Alan	Chief Financial Officer	Hina Mauka	148
Mr.	Kamita	Keith	Administrator	Narcotics Enforcement Division	98
Ms.	Kawaguchi	Kathy	Assistant Superintendent	Department of Education	123
Dr.	Kelley	Chuck	Director of Sales, Special Markets	Outrigger Hotels	135
Mr.	Kenoi	Billy	Executive Assistant	Mayor's Office, County of Hawai`I	151
Mr.	Kimura	Jay	Prosecuting Attorney	County of Hawai`i	151, 157
Mr.	Kishi	Lloyd		ISI-Health Enhancement Services	136
Ms.	Koller	Lillian	Director	Department of Human Services	122
Ms.	Kong	Verdine	Director	BEST Community Reintegration Program, Maui Economic Opportunity, Inc.	144
Mr.	Koss	Larry		Empowering Maui Teens Project	144
Mr.	Kubo	Ed	U.S. Attorney	Office of the Attorney General	100
Deputy Chief	Kubojiri	Harry	Deputy Chief	Hawai`i Police Department	157
Dr.	Kunz	Kevin	Physician	Substance Abuse private practice	157
	Lacaden	Charles	Trainer	Sheriff's Division, PSD	102
Mr.	Lau	Wally		Community Response to Ice Coalition	158
Lt.	Lee	Patrick	Sheriff's Division, Warrants Section	Department of Public Safety	102
Ms.	Lee	Alice	Director	Housing and Human Concerns, County of Maui	140
Mr.	Lee	Wayde		Alu Like	149
Mr.	Lee	Harvey	Program Specialist	Pacific Resources for Education and Learning	125
Mr.	Li	Qing	Professor	University of Hawai`i, Molecular Biosciences	136
Ms.	Lichty	Pamela	President	Drug Policy Forum	127
Capt.	Lima	Kevin	Narcotics/Vice Division	Honolulu Police Department	99
Ms.	Lin	Shari	Exeutive Director	Ka Hale Pomaikai	150
Dr.	Linden	Carl	Certified Toxicologist	Diagnostic Laboratory Services	125

Ms.	Lock	Terry	Early Childhood Resource Coordinator	Good Beginnings	144
Mr.	Lopez	Frank	Deputy Director	Corrections, Department of Public Safety	110
Ms.	Lorenz	Kathleen		Samuel Mahelona Medical Center	147
Chief	Mahuna	Lawrence	Chief	Hawai`i County Police Department	150
Ms.	Malott	Charlotte	Co-Executive Director	YMCA of Honolulu, Kalihi Branch	128
Mr.	Margheim	Wes	Deputy Director	Big Island Substance Abuse Council	153
Sgt.	Martin	Lane	Sheriff's Division	Department of Public Safety	103
Capt.	Matsuoka	Milton	Captain	Maui County Police Department	149
Ms.	McCarthy	Robin	Teen Court Coordinator	Hale `Opio	147
Mr.	McClay	Robert	Executive Consultant	AlohaCare	133
Dr.	McKenna	Gerald	Exeutive Director	Ke Ala Pono	147
Mr.	McLaughlin	Phil	Managing Director, Kaua`i	Hina Mauka	148
Mr.	Miller	Richard	Professor Emeritus	William S. Richardson School of Law	114
Mr.	Moniz	Gary	Administrator	Department of Land and Natural Resources	103
Ms.	Moniz	Melissa	Probation Officer		155
Dr.	Morrison	Steve	Emergency Room Physician	Hilo Medical Center	151
Mr.	Murakami	Miles	Acting Corrections Program Services Administrator	Department of Public Safety	110
Mr.	Nakada	David	Executive Director	Boys and Girls Club	121
Judge	Nakamura	Greg	Judge	Third Judicial Circuit, State of Hawai`i	152
Mr.	Nishida	Roy	Anti-Drug Coordinator	County of Kaua`i	145
Ms.	Pacheco	Mary Elizabeth	Clinical Supervisor	Hina Mauka Adolescent Programs	130
Mr.	Peyton	John	Director	Department of Public Safety	110
Mr.	Pfaltzgraff	Tony	Co-Executive Director	YMCA of Honolulu, Kalihi Branch	130
Chief	Phillips	Thomas	Chief	Maui County Police Department	140
Judge	Raffetto	Shackley	Judge	Second Judicial Circuit, Judiciary	140
Ms.	Revilla	Debbie		Maui Comprehensive Strategy Coordinator for Juvenile Justice	144
Mr.	Rushford	Robert	Conservation and Resources Enforcement	Department of Land and Natural Resources	103
Officer	Sagario	Ronald	Officer	Maui County Police Department, DARE	149
Mr.	Santangelo	John		Business	155
Mr.	Schaffer	Rich	Principal	Mid Pacific Institute	128

Lt.	Shaw-Fujii	Connie	Drug Abuse Resistance Education	Honolulu Police Department	100
Mr.	Shimabukuro	Gary	President	Laulima Hawai`i	98
Mr.	Shinn	Alan	Executive Director	Coalition for a Drug Free Hawai`i	118
Ms.	Skomoroch	Orianna	Chief Executive Officer	Samuel Mahelona Medical Center	147
Mr.	Smith	William	Deputy Prosecutor	County of Hawai`i	151
Mr.	Soong	Michael	Prosecuting Attorney	County of Kaua`i	145
Mr.	Stein	Lee	Certified Substance Abuse Counselor	Maui Community College	145
Mr.	Takamiya	Ted		Queen Liliuokalani Children's Center	149
Mr.	Tano	Ken		Western States Information Network	101
Ms.	Tao	Carol	Human Resources	HPM Builders	136
Ms.	Tengan	Davelyn	Prosecuting Attorney	County of Maui Prosecutor's Office	140
Lt.	Tom	Wallace	Lieutenant	Maui County Police Department	140
Mr.	Trujillo	Jimmy	Co-Chair	Kaua`i County Drug Prevention Team	146
Ms.	Tuivai	Shawnee	Smart Moves Program Coordinator	Boys and Girls Club of Maui	143
Judge	Uale	Bode	Judge	First Judicial Circuit, State of Hawai`i	118
Mr.	Van Dyke	Jon	Professor	UH Richardson Law School	124
Judge	Waldorf	Marcia	Judge	First Judicial Circuit, Judiciary	110
Dr.	Wassan	Jamar	Director, Physician	Waikoloa Rehabilitation	158
Ms.	Westmorland	Mary Jo	Branch Administrator	Kapiolani Child Protection Center	158
Ms.	Wilson	Elaine	Chief	Alcohol and Drug Abuse Division, DOH	103,116
Dr.	Wong	Clifford	Toxicology Director	Clinical Laboratories	127
Dr.	Wood	William	Professor	University of Hawai`i, Department of Sociology	109
Ms.	Woods	Claire	Director	Salvation Army Family Treatment	111
Mr.	Yamamoto	Keith	Program Development Officer	Office of Youth Services, DHS	121
Dr.	Young	Robert	Director of Behavioral Health	Waiana`e Coast Comprehensive Health Center	112
Dr.	Yuen	Sylvia	Director	Center on the Family, University of Hawai`i	116
Councilwoman	Yukimura	Joann	Co-Chair	Kaua`i County Drug Prevention Team	146

(This page intentionally left blank)

INDEX OF SITE VISITS

(This page intentionally left blank)

INDEX OF TABLES AND CHARTS

Tables

Charts