DAVID Y. IGE
GOVERNOR OF HAWAII

.ELIZABETH A. CHAR, M.D
DIRECTOR OF HEALTH

DEPT. COMM. NO. 276

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:

December 28, 2020

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-first State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirty-first State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Annual Report pursuant to:

- Section 321-195, Hawaii Revised Statues (HRS), Implementation of the State Plan for Substance Abuse,
- Section 329-3, HRS, Hawaii Advisory Commission on Drug Abuse and Controlled Substances,
- Section 10 of Act 161 Sessions Laws of Hawaii 2002, Coordinating of Offender Substance Abuse Treatment Program;
- Section 29 of Act 40, Session Laws Hawaii 2004, Progress Report on the Substance Abuse Treatment Monitoring Program; and
- Section 329E-6, Unintentional Opioid-Related Drug Overdose

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

https://health.hawaii.gov/opppd/department-of-health-reports-to-2021-legislature/

Sincerely,

Elizabeth A. Char, M.D.
Director of Health

Enclosures

c: Legislative Reference Bureau
Hawaii State Library (2)
Hamilton Library

REPORT TO THE

THIRTY-FIRST LEGISLATURE

STATE OF HAWAII

2021

PURSUANT TO:

**SECTION 321-195, HAWAII REVISED STATUTES,
REQUIRING A REPORT ON IMPLEMENTATION OF THE STATE PLAN FOR SUBSTANCE ABUSE;**

**SECTION 329-3, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE HAWAII ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES;**

**SECTION 10 OF ACT 161, SESSION LAWS OF HAWAII 2002,
REQUIRING A STATUS REPORT ON THE COORDINATION OF OFFENDER SUBSTANCE ABUSE TREATMENT PROGRAMS; AND**

**SECTION 29 OF ACT 40, SESSION LAWS OF HAWAII 2004,
REQUIRING A PROGRESS REPORT ON THE SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM**

**SECTION 329E-6, HAWAII REVISED STATUTES,
REQUIRING A REPORT ON UNINTENTIONAL OPIOID-RELATED DRUG OVERDOSE**

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAII**

DECEMBER 2020

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2019-20 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS).

For Fiscal Year 2019-20, $34,874,192 was appropriated by Act 5, Session Laws of Hawaii (SLH) 2019, to the Alcohol and Drug Abuse program (HTH 440) – $20,246,936 general funds, $750,000 special funds and $13,877,256 federal funds (MOF N and P). Of the total appropriated, $26,810,707 was allocated for substance abuse treatment services and $5,490,603 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#122291) by $28,584; increased the general fund by $800,000 for Homeless Outreach; increased the general funds by $300,000 for Clean and Sober Housing; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $322,088 (HTH440/HO); decreased the federal fund ceiling by $1,209,203 for the Hawaii Pathway Project (HTH440/HT); increased the federal fund ceiling by $25,000 for the Youth Treatment Implementation (HTH440/HT); increased the federal fund ceiling by $152,495 for the Screening, Brief Intervention, & Referral to Treatment grant; increased the federal fund ceiling by $183,707 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HU); increased by federal fund ceiling by $60,363 for the SPF-PFS grant; and transferred funds within each organizational code to align the budget with current expenses.

Federal funds for substance abuse prevention and treatment services include the following:

$8.58 million for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

$1.6 million over three years (9/30/17 – 9/29/20) for the contract awarded by the U.S. Food and Drug Administration (FDA) for tobacco inspections of retail outlets on behalf of the FDA for compliance with the Tobacco Control Act (Public Law 111-31).

$4.0 million over two years (5/1/17 – 4/30/19) for the SAMHSA/CSAT Opioid State Targeted Response (STR) grant to reduce opioid overdose deaths and that provides expanded program capacity to serve those with opioid use disorders (OUD), including prescription opioids as well as illicit drugs such as heroin, expand education and awareness, expand care coordination and integration of behavioral health care with primary care, and to improve access to proven interventions and prevention strategies such as Medication Assisted Treatment (MAT). A No Cost Extension was granted to extend the STR Project service period to April 30, 2020.

$6.5 million over five years (9/30/16 – 9/29/21) for the SAMHSA/CSAT Screening, Brief Intervention, & Referral to Treatment (SBIRT) grant that provides screenings, early intervention and referral to treatment for adults in primary care and community health settings for substance misuse and substance use disorders (SUD), as well as develop and

expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers.

$3.1 million over four years (9/30/17 – 9/29/21) for the SAMHSA/CSAT Youth Treatment Implementation (YT-I) grant that provides expanded screening, brief interventions and brief referrals to treatment services for SUD/co-occurring mental illness treatment, prevention, and care.

$10.2 million over two years (9/30/18 – 9/29/20) for the SAMHSA/CSAT State Opioid Response (SOR) grant to provide opioid use disorder treatment and recovery support services to between 20 to 200 unduplicated clients annually based on the services utilized. The array of services includes the following: Outreach/Motivational Enhancement/Interim Care, Outpatient Services, Intensive Outpatient Services, Intensive Outpatient Services, Residential, Detox, Post Treatment/Continuing care, Health & Wellness Planning, Transportation, Care Coordination, Day treatment, Clean and sober housing, MAT Screenings, Testing Kits Purchase, Detox Beds Purchase, Peer Recovery Support Training, Provider Training. Through utilization of treatment and recovery services, ADAD intends to increase the number of clients in recovery and utilizing a recovery support system, as well as increase the number of physicians participating in the PDMP. ADAD also intends to increase the number of providers of MAT for opioid use disorders, thus decreasing the gaps in system of care.

$1.8 million in each of five years (9/30/13 – 9/29/18) for the 2013 SAMHSA/CSAP SPF-PFS grant provides resources to implement the Strategic Prevention Framework process at the state and community levels and to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. The project engages public, private, state and community level stakeholders to ensure the program uses data- driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure to address underage drinking among persons aged twelve to twenty and other substance abuse prevention priorities as determined by assessments. A No Cost Extension was granted to extend the SPF-PFS Project service period to September 29, 2019.

$2.0 million in each of five years (9/30/18 – 9/29/23) for the 2018 SAMHSA/CSAP SPF-PFS grant to provide further support for the SPF-PFS Project goals and objectives of strengthening and enhancing the prevention systems at the local and state level as well as to address the priority issue of alcohol use by minors in high need areas.

Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided substance abuse prevention and treatment services to adults and adolescents as follows:[1]

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,867 adults statewide in Fiscal Year 2019-20;

[1] See Appendices A through F for details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions.

School- and community-based outpatient substance abuse treatment services were provided to 1,323 adolescents statewide in Fiscal Year 2019-20; and

Curriculum-based youth substance abuse prevention and parenting programs, underage drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 41,033+ children, youth and adults directly and indirectly through individual-based and population-based prevention programs, strategies and activities[2] in Fiscal Year 2019-20.

Also included are reports that are required pursuant to:

Section 329-3, HRS, requiring a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS);

Section 10 of Act 161 SLH 2002, requiring a status report on the coordination of offender substance abuse treatment programs;

Section 29 of Act 40 SLH 2004, requiring a progress report on the substance abuse treatment monitoring program; and

Section 329E-6, HRS, requiring a report on unintentional opioid-related drug overdose.

[2] Examples of individual-based strategies include the following: school and community-based curricula; after-school programs; community service activities; and parent education classes and workshops. Examples of population-based strategies include the following: community health fairs and events, social media broadcasts, and public service announcements.

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2019-20 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) and is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS). Also included are reports that are required pursuant to: Section 329-3, HRS, which requires a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS); Section 10 of Act 161, SLH 2002, which requires a status report on the coordination of offender substance abuse treatment programs; Section 29 of Act 40, SLH 2004, which requires a progress report on the substance abuse treatment monitoring program; and Section 329E-6, HRS, which requires a report on unintentional opioid-related drug overdose.

ADAD's mission is to provide the leadership necessary for the development and delivery of quality substance abuse prevention and treatment services for Hawaii residents. ADAD's primary functions include: grants and contracts management; clinical consultation; quality assurance, which encompasses training, accreditation of substance abuse treatment programs, certification of substance abuse counselors and program administrators, monitoring implementation of prevention activities and treatment services; policy development; planning and coordination of services; and information systems management (i.e., treatment client data system, prevention minimum data set, and needs assessments for substance abuse prevention and treatment services).

The reorganization of the Alcohol and Drug Abuse Division (approved on March 29, 2011) provides the framework to implement and maintain the core public health functions of assessment (i.e., monitoring trends and needs), policy development on substance abuse issues and assurance of appropriate substance abuse services.

Assessment. Data related functions and positions are organized within the Planning, Evaluation, Research and Data (PERD) Office so that data functions and activities support planning, policy, program development and reporting needs of the Division.

Policy development. The PERD Office is charged with strategic planning, organizational development, program development, evaluation, identification of community needs, knowledge of best practices, policy research and development.

Assurance. The core public health function of assurance is encompassed within four components, each of which are assigned the following functions.

The Administrative Management Services (AMS) Office is responsible for budgeting, accounting, human resource and contracting functions to ensure Division-wide consistency, accuracy and timeliness of actions assigned to the Division.

The Quality Assurance and Improvement (QAI) Office is responsible for quality assurance and improvement functions (i.e., certification of substance abuse counselors, program accreditation and training).

The Prevention Branch (PB) provides a focal point and priority in the Division for the development and management of a statewide prevention system which includes the development and monitoring of substance abuse prevention services contracts and the implementation of substance abuse prevention discretionary grants. The Strategic Prevention Framework (SPF) Project focuses on building community capacity to address substance use issues and sustain the substance abuse prevention system and infrastructure at the state, county and local community levels. The staff of the Food and Drug Administration (FDA) Tobacco Program within the Branch ensures that the Federal Tobacco Control Act is enforced in Hawaii.

The Treatment and Recovery Branch (TRB) develops and manages a statewide treatment and recovery system which includes program and clinical oversight of substance abuse treatment services contracts and the implementation of substance abuse treatment discretionary grants.

Health promotion and substance abuse prevention are essential to an effective, comprehensive continuum of care. The promotion of constructive lifestyles and norms includes discouraging alcohol, tobacco and other drug use, encouraging health-enhancing choices regarding the use of alcohol, prescription drugs and illicit drugs, and supporting the development of social and physical environments that facilitate drug-free lifestyles. Prevention is achieved through the application of multiple interventions (e.g., evidence-based curricula, strategies and practices, and/or environmental strategies) that impact social norms and empower people to increase control over, and to improve, their health. Substance abuse prevention focuses on interventions to occur prior to the onset of a disorder and is intended to prevent the occurrence of the disorder or reduce the risk for the disorder. Risk factors are those characteristics or attributes of an individual, his or her family and peers, school or environment that have been associated with a higher susceptibility to problem behaviors such as alcohol and other drug use disorders. In addition, prevention efforts seek to enhance protective factors in the individual/peer, family, school and community domains. Protective factors are those psychological, behavioral, family and social characteristics and conditions that can reduce risks and insulate children and youth from the adverse effects of risk factors that maybe present in their environment.

Substance abuse treatment refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological and social dysfunction and to arrest, retard or reverse the progress of any associated problems. Treatment services have, as a requirement, priority admission for pregnant women, injection drug users, native Hawaiians and adult offenders.

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2019 to June 30, 2020

State and Federal Funding

Act 5, SLH 2019 appropriated $34,874,192 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2019-20:

General funds	$20,246,936	(58.0%)	29.0 FTE
Special funds	750,000	(2.2%)	
Federal funds (N)	8,857,980	(25.4%)	7.5 FTE
Federal funds (P)	5,019,276	(14.4%)	
	$34,874,192	(100.0%)	29.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$26,810,707	(76.9%)
Substance abuse prevention services	5,490,603	(15.7%)
Division operating costs	0	(0%)
Division staffing costs	2,572,882	(7.4%)
	$34,874,192	(100.0%)

For Fiscal Year 2019-20, $34,874,192 was appropriated by Act 5, SLH 2019, to the Alcohol and Drug Abuse program (HTH 440) – $20,246,936 general funds, $750,000 special funds and $13,877,256 federal funds (MOF N and P). Of the total appropriated, $26,810,707 was allocated for substance abuse treatment services and $5,490,603 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#122291) by $28,584; increased the general fund by $800,000 for Homeless Outreach; increased the general funds by $300,000 for Clean and Sober Housing; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $322,088 (HTH440/HO); decreased the federal fund ceiling by $1,209,203 for the Hawaii Pathway Project (HTH440/HT); increased the federal fund ceiling by $25,000 for the Youth Treatment Implementation (HTH440/HT); increased the federal fund ceiling by $152,495 for the Screening, Brief Intervention, & Referral to Treatment grant; increased the federal fund ceiling by $183,707 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HU); increased by federal fund ceiling by $60,363 for the SPF-PFS grant; and transferred funds within each organizational code to align the budget with current expenses.

[3] Position count does not include grant-funded exempt positions: Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant (2.0 FTE), U.S. Food and Drug Administration (FDA) contract (1.5 FTE), Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States (1.0 FTE), and Hawaii Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grant (2.0 FTE). The position count also does not include the general funded temporary Program Specialist for the Clean and Sober Homes Registry (1.0 FTE).

Federal Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. ADAD received $8.58 million in Fiscal Year 2019 of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

U.S. Food and Drug Administration (FDA) Tobacco Inspections. The award of a $1.6 million 3-year contract (9/30/17-9/29/20) by the FDA supports tobacco inspections on retail outlets that sell or advertise cigarettes or smokeless tobacco products to determine whether they are complying with the Tobacco Control Act (Public Law 111-31) and the implementing regulations (21 Code of Federal Regulations Part 1140, et seq.). Two types of tobacco compliance inspections are conducted: undercover buys, to determine a retailer's compliance with federal age and photo identification requirements; and product advertising and labeling to address other provisions of the Tobacco Control Act.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant. Hawaii was awarded $1.8 million in each of five years (9/30/13-9/29/18) from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) to implement the Strategic Prevention Framework process at the state and community levels to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. A No Cost Extension, effective September 30, 2018 through September 29, 2019 provided additional time to achieve project goals and complete activities initiated during the 5-year grant period. The project has engaged public, private, state and community level stakeholders to set the foundation for the effective gathering and analysis of local data to support data-driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure as determined by assessments. Five (5) community coalitions utilized grant resources to conduct assessments and plan for the implementation and evaluation of environmental strategies to address underage drinking among persons aged twelve to twenty in their communities. Environmental strategies have a broader focus than individual or curriculum-based strategies, so they have the potential to change community norms and population behaviors. Additionally, SPF-PFS resources awarded to each County have assisted in strengthening infrastructure and providing capacity support to assess, plan and implement a sustainable prevention system at the county level to support substance abuse prevention efforts needed or currently being conducted in communities. During the FY 2019, the SPF-PFS subrecipients had additional time to complete their planned actions and maintain involvement of community organizations and community members in SPF efforts. A second SPF-PFS grant of $2.0 million in each of five years (9/30/18-9/29/23) was awarded to continue the Hawaii Project efforts and during the close of FY19 those funds were allocated to subrecipients to build on the progress made during the first grant period and further enhance efforts to address alcohol and related issues in communities of demonstrated high need.

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT is a five-year grant (project period 09/30/16-09/29/21) totaling $6,513,812. Funding is to implement screening, brief intervention, and referral to treatment (SBIRT) services for adults in primary care and community health settings for substance misuse and substance use disorders (SUD). Project

services are designed to develop, expand, and enhance infrastructure to fully integrate SBIRT in six Federally Qualified Health Centers (FQHC) in Hawaii and up to twenty-five small group primary care practices (PCP) over five years and to establish the SBIRT model as a standard of care statewide. The SBIRT program seeks to address behavioral health disparities by encouraging the implementation of strategies, such as SBIRT, to decrease the differences in access, service use, and outcomes among the populations served. Implementing the SBIRT will aid in improving overall health outcomes, reducing the negative impact on health, and reducing healthcare costs. The grant has three goals: 1) Implement SBIRT in six FQHCs and twenty-five small group primary care practices; 2) Develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers; and, 3) Expand existing behavioral health integration efforts which includes a plan to disseminate SBIRT to small primary care practices throughout the State.

State Targeted Response to the Opioid Crisis (STR). The Hawai‘i STR grant (project period 5/1/17-4/30/19) totaling $4 million is an initiative awarded jointly through SAMHSA’s Center for Substance Abuse Treatment (CSAT) and CSAP. The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The STR grant will address these concerns through three key activity tracks: (1) **education and awareness**, which will promote public awareness of the dangers of opioid use and provide training to health professionals to better identify and assist persons at risk or suffering from opioid use disorders; (2) **care coordination and integration** which will target more efficient and effective ways to integrate primary and behavioral health care to reduce risk and better treat persons affected by opioid misuse and abuse; and (3) **policy shaping** which targets policies and protocols aimed at improving access and expanding proven interventions and prevention strategies such Medication Assisted Treatment (MAT).

State Opioid Response (SOR). The Hawai‘i SOR grant (project period: 10/1/2020-9/30/2022) totaling $10 million is an initiative awarded jointly through SAMHSA’s Center for Substance Abuse Treatment (CSAT) and CSAP. The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The SOR grant will address these concerns through three key activity tracks: (1) **education and awareness**, which will promote public awareness of the dangers of opioid use and provide training to health professionals to better identify and assist persons at risk or suffering from opioid use disorders; (2) **care coordination and integration** which will target more efficient and effective ways to integrate primary and behavioral health care to reduce risk and better treat persons affected by opioid misuse and abuse; and (3) **policy shaping** which targets policies and protocols aimed at improving access and expanding proven interventions and prevention strategies such Medication Assisted Treatment (MAT).

State Youth Treatment-Implementation (YTI). The Hawai‘i YTI grant (project period: 9/30/17-9/29/21) totaling $3 million is an initiative awarded by SAMHSA’s CSAT. The grant aims to improve treatment for adolescents and/or transitional aged youth with substance use disorders (SUD) and/or co-occurring substance use and mental disorders by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. It intends to bring together stakeholders

across the systems serving the populations of focus to strengthen an existing coordinated network that will enhance/expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices (EBPs), and implement financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment, and recovery support system. The YTI grant will address these concerns by increasing the number of multi-systemic therapists (MST) at select treatment providers, expanding eligibility criteria for services, and including treatment services for criminal justice adolescents within the Hawai‘i Youth Correctional Facility, and adolescents aged 12-25 who present for care or are directed for care through the Child and Adolescent Mental Health Division and the Hawai‘i Youth Criminal Justice Division.

Substance Abuse Prevention and Treatment Services

Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided substance abuse prevention and treatment services to adults and adolescents as follows:[4]

> **Treatment Services.** ADAD's overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse and dependence by assuring an effective, accessible, public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Thirty-two (32) agencies, which resulted in fifty (50) contracts were established to provide a continuum of services to seven different populations which are, Adult Substance Abuse Treatment, Dual Diagnosis Substance Abuse Treatment, Opioid Addiction Recovery Services, Specialized Substance Abuse Treatment for Pregnant Women and Women with Dependent Children, Intensive Addiction Care Coordination and Substance Abuse Treatment for Offenders, Group Recovery Homes, Early Intervention Service for HIV, Homeless Outpatient Substance Abuse Treatment, and Adolescent Substance Abuse Treatment Services which consist of School-Based and Community-Based services. Treatment providers can provide all or part of the treatment continuum, which includes pre-treatment service such as motivational enhancement services, outreach, and interim; treatment services such as non-medical social detoxification, residential, intensive outpatient, outpatient; and recovery support services such as therapeutic living, clean and sober housing, continuing care, transportation, translation, and childcare. All client admissions, treatment service, including treatment progress notes, and discharges are tracked on the Web-Based Infrastructure for Treatment Services (WITS) system. Services were provided to 2,867 adults statewide in Fiscal Year 2019-20; and school-based and community-based outpatient substance abuse treatment services were provided to 1,323 adolescents statewide in Fiscal Year 2019-20.
>
> **Prevention Services**. Through a total of forty-seven (47) contracts, twenty (20) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2019. In efforts to best utilize resources to fund what works, the contracted services implement evidence-based programs, policies, and practices that include: information dissemination;

[4] Details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions are appended at pages 35-46.

education; problem identification and referral; community-based programming; environmental strategies; and alternative activities that decrease alcohol, tobacco, and other drug use. The funded programs engage schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models to prevent substance abuse in young people in a variety of community settings and promoting programs and policies to improve knowledge and skills related to effective ways to avoid substance use problems and enhance resiliency.

Program implementation is tracked according to the number of times (cycles) curricula and strategies were implemented as collected and reported using WITS, the data management system described above and expanded to collect prevention service data. Additionally, quarterly progress reports, plans and progress notes submitted capture information related to community partnerships, problems, priorities, resources, readiness and implementation status of identified evidence-based programs. According to the data collected for Fiscal Year 2019-20, curriculum-based prevention strategies served a total of 4,165 children and youth and the community-based strategies touched a total of 36,868 children, youth and adults across the state.

The funded services impact the contracted community-based agencies' ability to mobilize support and build capacity and readiness in identified service areas to ensure that the community is aware of the substance abuse issues and is prepared to support the implementation of interventions that have proven effective in preventing the occurrence or escalation of such problems. Agencies use the State and Federal prevention resources to secure materials, training, and technical assistance to implement substance abuse prevention evidence-based interventions (EBI) and strategies with fidelity, as designed and adhering to the core components, as intended by the developer. If evaluation findings are not what was anticipated, mid-course corrections and adaptations to the implementation of the strategy are made with guidance from the developer to increase the effectiveness of the EBI and the substance abuse prevention efforts. An emphasis on implementing evidence-based practices and determining what works should result in quality, effective prevention services that will benefit youth and their families and contribute to an enhanced substance abuse prevention system for Hawaii.

Substance Abuse Prevention resources are also used to positively impact and develop the prevention workforce. Prevention staff from contracted community-based agencies are required to attend annual prevention related trainings to gain new knowledge and skills to improve implementation efforts and effectively address the prevention of the use of alcohol, tobacco and other drugs in the community. Trainings or conferences attended may include but are not limited to the Overview of the fundamentals of substance abuse prevention; Substance Abuse Prevention Skills Training (SAPST), SPF model principles and steps; community organizing; evidence-based strategies; environmental strategies; and youth engagement.

Hawai'i Coordinated Access Resource Entry System (CARES)

The Hawai'i Coordinated Access Resource Entry System (CARES) is the state's new multiple entry-point and coordinating center for substance use disorder (SUD) treatment services (https://hicares.hawaii.gov/). This new initiative will improve coordination among providers and

increase access to quality care for people who are living with substance use problems. Hawai'i CARES is a collaboration between the Alcohol and Drug Abuse Division and the University of Hawai'i at Mānoa (UH Mānoa) Myron B. Thompson School of Social Work. The project is funded through a combination of state and federal funds from the Substance Abuse and Mental Health Services Administration. The agreement over two years with UH Mānoa includes the development of a call center, service referral system, and processes for quality improvement. Hawai'i CARES staff, who are trained clinicians, facilitate entry into the system of care, transitions in care, and provide information and referrals to other treatment resources. Hawai'i CARES was soft-launched on October 1, 2019 with DOH partner agencies and contracted providers, and full implementation is anticipated in January 2020. Crisis services from the Adult Mental Health Division were also added on July 1, 2020. Since November 2019, CARES handled a monthly average of over 460 incoming calls and facilitated a monthly average of over 620 referrals to and service authorizations for addiction treatment, with these number expected to grow upon full implementation. We anticipate a continued expansion of this project to include behavioral health services as well. We are striving toward a system where our community has a more direct and simplified process of gaining access to behavioral health services across the state and that people can get those services help where they need it, when they need it and how they need it.

Take Back Boxes Promote Safe Medication Disposal

Appropriate disposal of prescription medications is essential in preventing diversion of medications and limited the environmental impact of improperly discarded drugs. In collaboration with the Attorney General's Office, Narcotics Enforcement Division and other key partners, DOH/ADAD has provided take back boxes to Police Departments statewide. Listed on the www.hawaiiopioid.org website with maps and directions, there are three (3) sites on Kauai, eleven (11) sites on Hawaii Island, nine (9) sites on Maui and ten (10) sites on O'ahu, not including seven (7) locations for the military. These sites also include pharmacy-based take back sites that started after Act 183, SLH 2019 was signed by Governor Ige in July, 2019 which allows pharmacies to take back medications. Hawaii also continues to participate in the twice-yearly DEA take back campaigns in addition to forty (40) sites statewide.

Studies and Surveys

Tobacco Sales to Minors. The 2020 annual statewide survey results for illegal tobacco sales to minors is not available because the University of Hawaii retailer sampling study in March 2020 was cancelled due to the start of the COVID-19 pandemic. The University of Hawaii will resume the study in March 2021 (last year's 2019 rate was 5.7%). The 2019 5.7% retailer violation rate is less than the 9.6% national weighted average for federal fiscal year 2013. The annual survey, which is a joint effort between the Alcohol and Drug Abuse Division and the University of Hawaii, monitors the State's compliance with the "Synar" (tobacco) regulations for the federal Substance Abuse Prevention and Treatment Block Grant. It is important to note that on January 1, 2016, it became unlawful to sell both tobacco products and electronic smoking devices to persons under twenty-one (21) years of age. With the enactment of Act 122 SLH 2015, which increased the minimum age from 18 to 21, youth between the ages of 18-20 were also included in the annual survey. In March 2019, teams made up of youth volunteers (ages 15-20) and adult observers visited a random sample of 335 stores statewide in which the youth attempted to buy

cigarettes to determine how well retailers were complying with state tobacco laws. Nineteen stores (5.7%) sold to minors (ages 15-20). Of the four counties included in the statewide survey, the County of Kauai had zero sales, the County of Maui had five sales, and both the County of Hawaii and County of Honolulu had seven sales each. Due to the small sample size, rates for individual counties are not considered statistically reliable. Fines assessed for selling tobacco to anyone under the age of 21 are $500 for the first offense and a fine of up to $2,000 for subsequent offenses.

Provision of Contracted or Sponsored Training

In Fiscal Year 2019-20, ADAD conducted training programs that accommodated staff development opportunities for 1,642 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through fifty-six (56) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 16,965 Continuing Education Units (CEU's) towards their professional certification and/or re-certification as certified substance abuse professionals in the following: Certified Substance Abuse Counselor (CSAC), Certified Prevention Specialist (CPS), Certified Criminal Justice Professional (CCJP), Certified Clinical Supervisor (CCS), Certified Co-occurring Disorders Professional-Diplomate (CCDP-D), or Certified Substance Abuse Program Administrator (CSAPA).

Topics covered during the reporting period included: opioid prevention and response; SBIRT; The American Society of Addiction Medicine (ASAM) Criteria; suicide prevention; workplace satisfaction; supportive supervision; group processing and treatment; providers instruction to substance abuse treatment for LGBTQ; street drugs and surviving through crisis; motivational interviewing; group counseling; criminal conduct and substance abuse; drug use during pregnancy; confidentiality of alcohol and drug abuse client records (42 CFR; Part 2); Health Insurance Portability and Accountability Act of 1996 (HIPAA); certification and examination processes; data input and its usefulness; prevention specialist training; identifying/implementing environmental trainings; evaluation capacity building; evidence-based practices; Code of Ethical Conduct for substance abuse professionals, mental health and substance use; denial and resistance in addiction treatment; critical thinking for substance addiction professionals; understanding sexually transmitted diseases; HIV/AIDS in the substance abusing population; cultural diversity; and understanding the addiction process and how families are affected by addiction.

Programmatic and Fiscal Monitoring

Through desk audits of providers' program and fiscal reports, ADAD staff examined contractors' compliance with federal SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance abuse prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of forty-seven (47) prevention service contracts and fifty (50) treatment service contracts. Technical assistance and follow-up and site visits related to program development and implementation, reporting and contract compliance provided as needed.

Certification of Professionals and Accreditation of Programs

Certification of Substance Abuse Counselors. In Fiscal Year 2019-20, ADAD processed 360 (new and renewal) applications, administered fifty-two (52) computer-based written exams and certified thirty-five (35) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,363.

On average, the shortest amount of time to become a certified substance abuse counselor is approximately thirteen (13) months. A Master's degree in a human service field credits the applicant with 4,000 hours working in the substance abuse field. The applicant must still obtain 2,000 supervised work experience hours which is approximately twelve (12) months of working full-time. The remaining month is to schedule and take the required written exam. If a person also licensed as a Clinical Social Worker, Mental Health Counselor, Marriage and Family Therapist, Clinical Psychologist, or Psychiatrist, the required supervised work experience is 1,000 hours (or approximately six (6) months of full-time work) in the substance abuse profession. The person would also need a month to schedule and take the written exam. If an applicant has no applicable college degree to substitute for education and supervision hours, the total time to become certified is approximately three (3) years (i.e., 6,000 hours of work experience), plus one month to schedule and take the exam.

Accreditation of programs. In Fiscal Year 2019-2020, ADAD conducted a total of seventeen (17) accreditation site reviews and accredited thirteen (17) organizations, some of which have multiple (residential treatment and therapeutic living) programs. ADAD conducted four (4) preliminary accreditation desk reviews, due to limited ability to travel due to COVID-19. Preliminary accreditation is six (6) months and ADAD will review after six (6) months if travel has been allowed. A total of twenty-one (21) accreditations were conducted.

Clean and Sober Homes Registry

In Fiscal Year 2019-20 ADAD received twenty-nine (32) initial application for the clean and sober registry. ADAD reviewed and conducted fourteen (14) clean and sober homes statewide, and in "Good Standing" as referred to by HAR Chapter 11-178. There are three (3) registrations pending home detail submissions, three (pending DOH review), and eleven (11) pending inspection. Currently there are no homes that are "Not in Good Standing" pending further review. ADAD has received (6) one complaint that has been resolved. High numbers in pending inspections is due to COVID-19 restrictions and will resume upon conditions.

Act 193, SLH 2014 (HB 2224 HD2 SD2 CD1), relating to group homes, establishes a registry for clean and sober homes within the Department of Health; appropriates funds for staffing and operating costs to plan, establish and operate the registry of clean and sober homes; and amends the county zoning statute to better align functions of state and county jurisdictions with federal law.

The voluntary registry of clean and sober homes is a product of a two-year process during which the knowledge and expertise of public (i.e., State and County) as well as private agencies' perspectives were elicited. The registry will help residents to access a stable, alcohol-free and

drug-free home-like living environment by establishing procedures and standards by which homes will be allowed to be listed on the registry, including but not limited to: organizational and administrative standards; fiscal management standards; operation standards; recovery support standards; property standards; and good neighbor standards.

Law Enforcement Assisted Diversion (LEAD)

Act 5, SLH 2019 approved $800,000 in general funds in the ADAD base budget for FY2020 to continue outreach counseling and law enforcement diversion services for the chronically homeless who suffer from severe substance abuse disorders on O'ahu. Of this amount, $600,000 was added to existing contracts with substance abuse treatment providers to expand their outreach ability to serve the chronically homeless in coordination with the Governor's Coordinator on Homelessness. The remaining $200,000 is intended for an arrest diversion pilot project working with local law enforcement (e.g., local police departments) for the chronically homeless who suffer from severe substance abuse disorders. The pilot also includes training for local law enforcement to detect the signs of SUD addiction (versus mental health disorders) in the field and how to fast-track low-level offenders to SUD treatment programs. With LEAD, low-level offenders for whom probable cause for arrest or citation exists are provided the choice of arrest/citation or active engagement in services by local law enforcement.

On their own, the homeless will have no benefit of a care coordination safety net and are at risk of wandering from one provider that requires multiple assessments and services completed with previous providers that were not effective, leading to increased waste of treatment provider time and effort. A segment of the homeless population may qualify for LEAD which fast-tracks them to receive appropriate care in a SUD treatment program if they have committed low-level, non-violent offenses due to drug and/or alcohol addiction. Sustained outreach and quick referrals to SUD treatment services coupled with wrap-around services such as care coordination will expand the system of care to help the homeless overcome addiction which will improve their ability to secure housing, reduce crime and qualify for employment. This intervention is targeted to move resistant individuals into care and increase the overall safety of the community. The project is currently being piloted and the general fund appropriation will be utilized to expand implementation of the project.

The Honolulu LEAD pilot began in Chinatown in mid-2018 and involves both HPD and the State Sheriffs from the Department of Public Safety. The second-year program evaluation report was released on Oct. 1, 2020.

In FY 2019-20, LEAD has:

- Received fifty-seven (57) social contact referrals (individuals perceived as high risk for arrest);
- Of the social contact referrals, fifty (50) participants were enrolled in and received services; with forty-four (44) triaged and referred to other service providers.

Through coordination with the Governor's Coordinator on Homelessness as well as the police departments and the county prosecutor on each island, LEAD was also expanded to Hawaii County, Maui County and Kauai County through three (3) contracts with mental health and

substance use treatment providers serving those counties as a result of the Governor's Emergency Proclamation dated Dec. 14, 2018. The Proclamation recognized the need to divert homeless individuals and families away from frequent use of the healthcare and criminal justice systems by connecting them to mental health services or substance use treatment services. The contracts also used funds from Act 209, SLH 2018 which were intended to expand the LEAD pilot program to Maui and Hawaii. The one-year contracts were executed in Feb. 2019 and may be extended for two additional years.

Legislation

ADAD prepared informational briefs, testimonies and/or recommendations on legislation addressing substance abuse related policies, and often in coordination with the stakeholders of the Hawaii Opioid Initiative. Legislation enacted during the 2020 Legislative Session that addressed issues affecting the agency included:

> **Act 9, SLH 2020 (SB 126 CD1), relating to the state budget.** This measure reduced $133,512 in general funds in the base budget for FY 2021 to decrease the salaries for 2.00 positions (119205 Admin Specialist III and 43883 Program Specialist Substance Abuse IV).

NOTE: In the upcoming 2021 Regular Session ADAD will request to:

- Change the means of finance from general to special funds for 2.00 FTE positions 119205 Administrative Specialist III and 43883 Program Specialist Substance Abuse IV; and
- Increase the federal fund ceiling to align the anticipated Substance Abuse Prevention and Treatment Block Grant (SABG) award.

OTHER REQUIRED REPORTS

- **Report Pursuant to Section 329-3, Hawaii Revised Statutes, Requiring a Report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS)**

- **Report Pursuant to Section 10 of Act 161, Session Laws of Hawaii 2002, on the Implementation of Section 321-193.5, Hawaii Revised Statutes**

- **Report Pursuant to Section 29 of Act 40, Session Laws of Hawaii 2004, Requiring a Progress Report on the Substance Abuse Treatment Monitoring Program**

- **Report Pursuant to Section 329E-6, Hawaii Revised Statutes, Requiring a Report on Unintentional Opioid-Related Drug Overdose.**

REPORT PURSUANT TO
SECTION 329-3, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE HAWAII ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES

The Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) is required to submit a report on its actions during the preceding fiscal year pursuant to Section 329-3, Hawaii Revised Statutes (HRS).

Pursuant to Section 329-2, HRS, commission members are "selected on the basis of their ability to contribute to the solution of problems arising from the abuse of controlled substances, and to the extent possible, shall represent the pharmacological, medical, community and business affairs, youth action, educational, legal defense, enforcement, and corrections segments of the community." The commission is attached to the Department of Health for administrative purposes.

MEMBERS BY CATEGORY OF APPOINTMENT AND TERM OF OFFICE

ANITA CIARLEGLIO, Pharm.D Pharmacological– 6/30/2020	**KATHI FUJII** – Corrections- 7/1/2020 -6/30/2020
DIANA FELTON, M.D. Vice Chair Medical – Interim – 6/30/2021	**HEATHER LUSK** Education – Interim
LORI FERREIRA, Ed.D. Co-Chair Education – Interim	**KUULEI SALZER-VITALE, MSW, MPA** Youth Action – 7/1/2020– 6/30/2022
JODY JOHNSON Community and Business Affairs – 6/30/2022	**JOHN PAUL MOSES, III, APRN** Medical – 3/20/2022
CHAD Y. KOYANAGI, M.D. Joint appointment to HACDACS and State Council on Mental Health – Interim	**KENNETH TANO** Enforcement – 6/30/2022
JON FUJII, MBA Joint appointment to HACDACS and State Council on Mental Health – Interim	**GREG TJAPKES** – Community and Business Affairs – 7/1/2020 - 6/30/2022
	ERIKA VARGAS, LCSW Co-Chair Community and Business Affairs – 6/30/2021

On June 25th, 2019 members elected Erika Vargas and Lori Ferreira as Co-Chairpersons and Dr. Diana Felton as Vice-Chairperson. Meetings were scheduled on the fourth Tuesday of each month.

Priorities discussed during FY 2019-2020:

1. **Prevention Programming in School-Based Settings**
2. **Methamphetamine Use in Hawaii**
3. **Substance Use Treatment in the Criminal Justice System**
4. **Coordinated Access Resource Entry System (CARES)**
5. **Workforce Development**

The members of HACDACS gathered research, reviewed best practices and invited knowledgeable speakers to form the following policy recommendations for prevention and treatment of substance use in Hawaii. The overarching themes of our recommendations are to support evidence and data driven, culturally appropriate services by integrating systems, policies and programs to create a comprehensive continuum of substance abuse prevention and treatment services in Hawaii.

Substance Use Prevention Programming in School-Based Settings

Prevention is a complex yet critical component in the continuum of strategies to reduce drug and alcohol abuse, especially in adolescents. This begs for a well-designed strategy requiring a multi-layered and coordinated approach to address the range of factors contributing to alcohol and drug use. Prevention benefits communities when school, family, and community components are used in a coordinated and mutually supporting manner.

Classroom-based primary prevention programs are effective in inhibiting the onset of drug use, while secondary prevention strategies and programs are designed to address the unique needs of adolescents at higher risk of use or already using alcohol and other drugs. In their 2013 National Survey on Drug Use and Health, the Substance Abuse and Mental Health Services Administration (SAMHSA) noted that 73.5 percent of youths aged 12 to 17, who were enrolled in school in the past year, reported having seen or heard drug or alcohol prevention messages at school. In addition, the survey found that the prevalence of past month use of illicit drugs or marijuana was lower among those who reported having exposure to prevention programming in school (8.4 and 6.7 percent for illicit drugs and marijuana, respectively) versus those were enrolled in school but reported having no exposure (10.2 and 8.7 percent).[5] The key point is that school based prevention is effective when implemented.

There is currently no strategic plan for the Prevention Branch of the State of Hawaii Department of Health's Alcohol and Drug Abuse Division (ADAD). The lack of a strategic plan has led to a lack of consistent application of substance use prevention strategies across Hawaii's school complexes. This has left many young people without substance use prevention programming and potentially at higher risk for substance use. ADAD is currently working with Susana Helm, PhD, Professor, Department of Psychiatry, John A. Burns School of Medicine at the University of Hawai`i at Manoa to develop a strategic plan for substance use prevention which should be ready in 2022. Incorporating broad school-based prevention programming into this strategic plan will

[5] 2013 National Survey on Drug Use and Health, https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

help ensure Hawaii's youth are exposed to prevention programming and help reduce substance abuse and its sequelae.

Increasing protective factors with a comprehensive prevention strategy that is integrated, coordinated, and fully disseminated, will have a greater overall effect on reducing adolescent drug use, under-age drinking, and related harms in Hawaii.

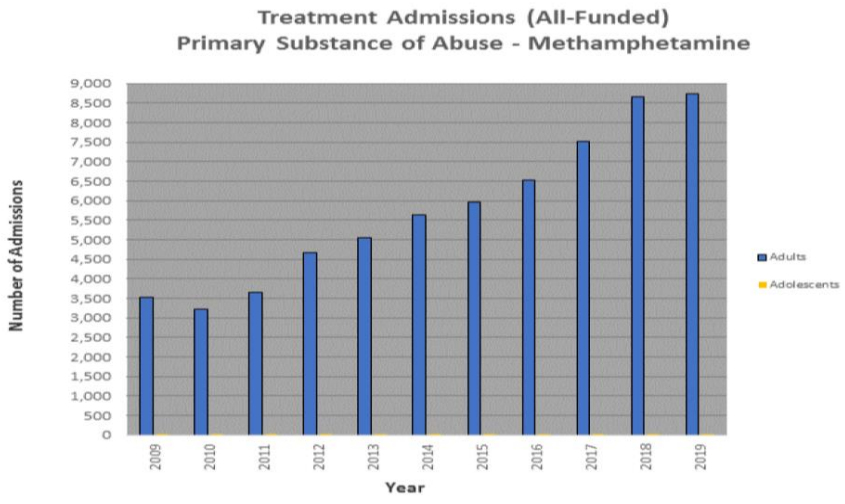
HACDACS recommends that ADAD Prevention Branch's strategic plan include implementing prevention programming using Evidence Based Interventions in all public middle and high schools as part of the health curriculum.

HACDACS recommends collaboration between the State of Hawaii Department of Health and State of Hawaii Department of Education in order to implement Evidence Based prevention programming in Hawaii's public schools.

Addressing Methamphetamine Use in Hawaii

Methamphetamine use in Hawaii remains widespread, and its negative effects are broad and severe. Data collected by the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrates that Hawaii consistently ranks among the highest in the nation in need for substance use treatment for methamphetamine.[6] In addition, data from the State of Hawaii Department of Health's Alcohol and Drug Abuse Division (ADAD) has shown a steady increase in admissions to treatment for methamphetamine from 2009-2019.[7]

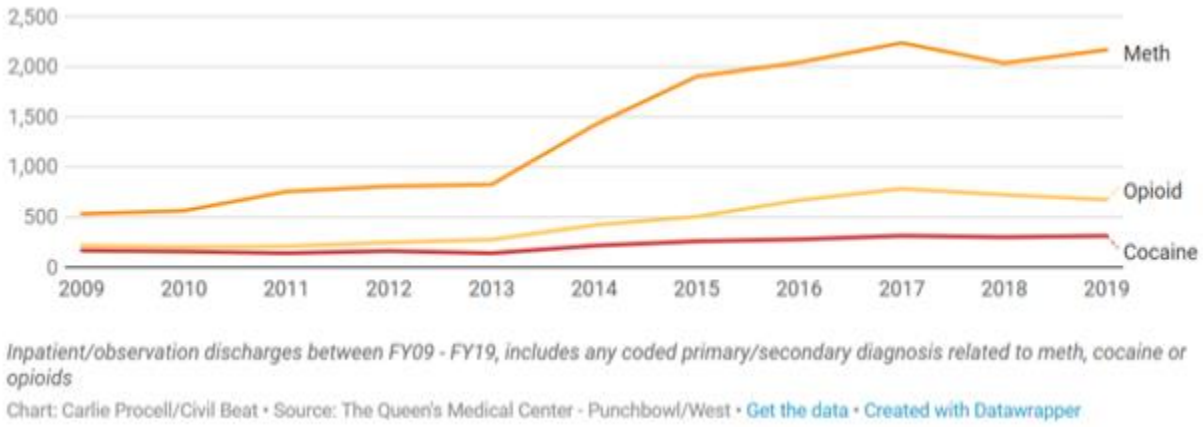
Figure 1. Treatment Admissions from ADAD's 2020 Report to the Legislature.[8]



[6] Treatment Episode Data Set (TEDS) 2017, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. www.samhsa.gov/data/sites/default/files/cbhsq-reports/TEDS-2017.pdf
[7] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 39.
[8] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 39.

Acute adverse impacts from methamphetamine use include severe effects such as increased heart rate and blood pressure, leading to strokes and heart attacks, as well as psychosis and other neurological problems. People on Methamphetamines are at very high risk for traumatic accidents from impaired judgement while under the influence. Long term effects of methamphetamine use include damage to the heart, leading to heart failure, as well as permanent neurologic and psychological impairment.[9] These sequelae from methamphetamine use pose an immense burden on Hawaii's resource limited health care system. Some of the most affected units of the health care system include emergency rooms, intensive care units, as well as mental health and substance use treatment facilities. Data from the Queens Health System shows Methamphetamine-related hospitalizations have quadrupled between 2009 and 2019 and far exceed opioid-related hospitalizations.[10]

Figure 2. Annual Hospitalizations for Methamphetamines, Cocaine, and Opioids at the Queen's Health System, from Hawaii Civil Beat's "*Queen's Medical Center on 'Losing End' of Battle with Meth*" by Eleni Avendano, published November 12, 2019.



Methamphetamine use affects people of all ages, ethnicities, cultures, and socioeconomic strata. Groups at higher risk for use and negative health impacts include men aged 40-60, pregnant women, and youth. The prevalence of methamphetamine use changes over time and there may be critical points at which prevention is most effective. For example, the primary substance for ADAD funded treatment in high-school aged kids is Marijuana, with over 64% of ADAD funding directed toward Marijuana efforts. By the time people reach adulthood, more than 60% of ADAD funded treatment is for methamphetamine use.[11] This implies that the transition from high school to young adulthood is when many people begin using methamphetamine and is a critical timeframe for intervention.

[9] Jang DH Amphetamines Goldfrank's Toxicologic Emergencies, 11th edition c. 2019
[10] www.civilbeat.org/2019/11/queens-medical-center-at-losing-end-of-battle-with-meth/
[11] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 32-34.

Table 1. ADAD Funded Adolescent Admissions by Primary Substance, from ADAD's 2020 Report to Legislature for Adolescents aged under 18.[12]

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Methamphetamine	0.6%	1.1%	1.0%	0.6%
Alcohol	21.5%	22.8%	22.2%	18.3%
Marijuana	66.8%	62.6%	61.6%	64.4%
Cocaine/Crack	0.3%	0.3%	0.3%	0.7%
Heroin	-0-	-0-	-0-	0.1%
Other	10.8%	13.2%	15.0%	16.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.

Table 2. ADAD-Funded Adult Admissions by Primary Substance, from the ADAD 2020 Report to Legislature for Adults Aged 18 and Older.[13]

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Methamphetamine	50.5%	53.4%	54.7%	60.6%
Alcohol	22.2%	20.0%	16.8%	16.1%
Marijuana	13.8%	12.4%	10.9%	9.1%
Cocaine/Crack	2.6%	1.6%	3.3%	1.9%
Heroin	5.3%	6.4%	7.4%	6.9%
Other*	5.6%	6.2%	6.9%	5.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.

Prevention efforts should be aimed at high-risk groups including youth transitioning to adulthood, pregnant women, and those aged 40-60. Certain ethnic populations are also disproportionately represented in substance use treatment programs, indicating that use and the burden of consequences is higher in specific communities.[14] It is critical that prevention and education efforts be available in multiple languages, in addition to utilizing appropriate cultural practices and norms, to address the overrepresentation of methamphetamine use in specific ethnic populations.

[12] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 32-34.
[13] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 32-34.
[14] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 32-34.

Table 3. ADAD-Funded Adult Admissions by Ethnicity, from ADAD's 2020 Report to Legislature for Adults aged 18 and older.[15]

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Hawaiian	43.8%	44.7%	44.5%	44.4%
Caucasian	22.5%	23.0%	20.9%	21.3%
Filipino	8.0%	8.4%	7.9%	6.9%
Mixed - Not Hawaiian	3.0%	2.6%	2.1%	4.2%
Japanese	4.5%	3.9%	5.0%	3.2%
Black	4.0%	2.8%	3.2%	2.3%
Samoan	3.4%	3.1%	2.1%	3.1%
Portuguese	1.3%	1.2%	1.5%	1.5%
Other Pacific Islander	6.3%	3.3%	3.9%	3.9%
Other*	3.2%	7.1%	9.0%	9.3%
TOTAL	100.0%	100.0%	100.0%	100%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

Methamphetamine use disorder is notoriously difficult to treat which emphasizes the importance of prevention. There are several challenges that contribute to treatment difficulties as methamphetamine is highly addictive physiologically and psychologically. Currently, there are no effective pharmacological mechanisms that can be used to treat methamphetamine addiction. Relapse is a significant problem for people in recovery from methamphetamine addiction and most people relapse multiple times before reaching terminal recovery. There is also significant interplay with methamphetamine use and mental illness and effective treatment requires addressing addiction and mental health.

Treatments proven to be effective in treating methamphetamine addiction including cognitive-behavioral therapy[16] are time intensive, expensive, and difficult to access. Despite this, there is growing recognition of success with peer-supported recovery programs such as Crystal Meth Anonymous and Refuge Recovery. Relapse prevention and other specialized recovery programs are gaining notice as being effective in helping people with methamphetamine use disorder. An example of a specialized recovery program is Wellbriety[17] which emphasizes culturally based healing for indigenous people and is available on-line globally.

Hawaii Opioid Initiative (HOI) has worked effectively to make sustainable changes in Hawaii's substance use prevention and treatment continuum since 2017, however, the focus has been primarily on Opioid misuse. While it is important to continue working to prevent and treat Opioid misuse, methamphetamine continues to have a larger negative impact on life in Hawaii. The HOI model can be adapted and broadened to address methamphetamine use to create a coordinated and well-funded prevention and treatment effort to combat the devastating effects of methamphetamine use on individuals, families, and communities in Hawaii.

HACDACS recommends directing of increased funds and attention to methamphetamine

[15] State of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Report to the Thirtieth Legislature 2020 December 2019, p 32-34.
[16] National Institute on Drug Abuse (NIDA) Methamphetamine DrugFacts www.drugabuse.gov/publications/drugfacts/methamphetamine
[17] https://wellbriety.com/

prevention and treatment to decrease the long-term physical, mental, and societal impacts of methamphetamine use. This includes utilizing newly awarded federal funding from SAMHSA as part of the 2020 State Opioid Response grant.

HACDACS recommends utilizing and applying existing organizational systems and lessons learned from the Hawaii Opioid Initiative (HOI) to the methamphetamine epidemic in Hawaii. This includes recalibrating the goals of the HOI to create a statewide initiative that also addresses methamphetamine and engages stakeholders involved in prevention, outreach, and treatment.

HACDACS recommends promoting and preserving funding of methamphetamine prevention programs including public outreach and public service campaigns. These programs should be aimed at high-risk groups of all ages and emphasize multicultural and multi-language materials and efforts.

HACDACS recommends preserving funding and support dedicated to recovery and relapse prevention including peer-support based recovery programs and programs that focus on specialized and high-risk populations.

HACDACS recommends the legislature indefinitely delay the legalization of marijuana (cannabis) until the data supports that it is clearly in best interest of the public health, medical, economic, and social interests of the people and state of Hawaii.

Substance Use Treatment in the Criminal Justice System

In April 2020, Courtny Tanigawa, APRN-Rx, CSAC, presented to HACDACs on a System of Care that comprehensively addresses the complex intersections of substance use, mental health, and the criminal justice system in Hawaii. Ms. Tanigawa is a community psychiatric and family nurse practitioner who was previously the intake provider at Oahu Community Correctional Center (OCCC) and currently works at the Honolulu Police Department (HPD) Cellblock, as well as the Hawaii Health & Harm Reduction Center.

According to HPD, of the 21,564 arrests in Honolulu County in 2018, 56 percent or 12,076 had symptoms of serious mental illness or severe substance intoxication. Most detainees do not get regular medical care while in the community and only receive assessments prior to cellblock entry and when entering OCCC. The current process does not adequately provide the acute medical care that is needed urgently, such as managing withdrawal syndromes.

The Department of Public Safety (DPS) utilizes a proprietary electronic medical record and is responsible for all medical care while an individual is incarcerated. During incarceration, an individual's insurance is often terminated or placed in suspension until release. Transition from incarceration back into the community is severely compromised when people are released without insurance or medical records to maintain continuity of care with community providers. This abrupt shift severely compromises the ability to fill medically necessary prescriptions and receive timely treatment. Care cannot be safely coordinated when medical records from community providers are unavailable to DPS providers and vice versa. Communication between

DPS and community providers about release dates is often unclear, further complicating the planning of appointments and follow-up while people are incarcerated.

HACDACS recommends DPS implement an evidence-based Reentry Program to support those leaving incarceration, with transition planning initiated 60 days prior to release. The program must address medical/behavioral health, insurance, housing, and case management as addressing these factors reduces recidivism. Reactivation of an inmate's MedQuest health insurance, if eligible, will occur 7 days prior to release, coordinating with community medical providers to ensure continuity of medical care and access to required medications.

HACDACS recommends linking inmates to community medical providers while incarcerated via telehealth. DPS can share medical records with community providers and vice-versa through a HIPAA Business Associate Agreement (BAA) or similar agreement.

HACDACS recommends medications for Substance Use Disorders, such as buprenorphine, naltrexone, and varenicline, be available for people while incarcerated. Linkage to community treatment providers should be initiated prior to release with an appointment made for re-evaluation within 14 days of release. Coordination with Adult Client Services is encouraged.

Coordinated Access Resource Entry System (CARES)

Appropriate care is critical to successful recovery from Substance Use Disorder (SUD). The system in which the continuum of care is embedded in should be coordinated, clinically appropriate, and responsive. The Alcohol and Drug Abuse Division (ADAD), community providers, and the University of Hawaii School of Social Work have worked diligently to address systemic barriers to entering substance use care which have been mentioned in previous legislative reports. A large component of this effort is the development of the Coordinated Access Resource Entry System (CARES), a statewide coordinated entry system into the continuum of care. CARES was launched on October 1, 2019 to provide individuals with access to treatment and community resources, as needed. In April 2020, the Crisis Line of Hawaii merged responsibilities with CARES to enable the expansion of services such as crisis stabilization and mental health services. Having one number to call removes barriers to care and provides increased access to resources for consumers, families, and providers.

CARES has attempted to improve mechanisms regarding service referrals and coordination across a continuum of care but has also uncovered the need for further standardization in the screening, assessment, and placement process. Hawaii CARES has been especially helpful in bridging public health and public safety partnerships, such as Law Enforcement Assisted Diversion (LEAD) and the Health Efficiency and Long-term Partnerships (HELP), which are important access points into the continuum of care. Providers and homeless outreach efforts have also assisted in identifying people in need of pre-treatment, treatment, and recovery support services.

Hawaii CARES provides SUD care coordination, screening, assessment, intake, placement determination, referral, and authorization management of services for all clients, in addition to

serving as the 24/7 crisis line of Hawaii. The specific services available under each treatment and recovery type are provided in Table 4.

Table 4. Services within Pre-Treatment, Treatment, and Recovery Support Services.

Pre-treatment and pre-recovery support services	Treatment Services	Recovery Support Services
Addiction Care Coordination Assessments Clean and Sober Housing Crisis Response Interim Service Motivational Enhancement Outreach Screening Stability Bed Hold	Addiction Care Coordinator Day Treatment Clean and Sober Home Early Intervention Services Interim Services Placement Determination Intensive Outpatient Opioid Addiction Services Outpatient Residential Withdrawal Management	Addiction Care Coordinator Case Management Clean and Sober Housing Continuous Support Services Recovery Housing Relapse Prevention Therapeutic Living Transportation Stability Bed

Hawaii CARES also provides a medium for public and provider education and is currently informing the public about their resources through various efforts such as television commercials and referral services at hospitals, recovery homes, and treatment centers. A gap in services noted by CARES staff to HACDACS members included the need for clinical detox beds. HACDACS members agree that there is a great need for available clinical detox beds in Hawaii.

Assessment of performance has been an important aspect of Hawaii CARES as it develops. Metrics were implemented to measure successes and areas for improvement by collecting quantitative and qualitative data. This data includes the total number of calls received per month from November 2019 through July 2020, as well as the average number of calls per day (see Table 5).

Table 5. Daily total and averages of calls received by Hawaii CARES.

	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Number of Calls Received	304	428	438	369	359	316	320	354	377
Average Calls Per Day (in/out)	19.3	75.5	76	69.1	44	25	31.7	29.4	24

Additional qualitative data gathered by Hawaii CARES also includes perceived barriers, as well as successes, found through the implementation of CARES, as outlined in Table 4. These successes and barriers were shared by CARES Primary Investigator Dr. Clifford Bersamira during a presentation given to HACDACS members on May 28, 2020.

Table 6. Hawaii CARES Successes and Barriers in 2020.

Successes	Barriers
• Merger with the Crisis Line • Connection with treatment agencies • Increased resources and support • Increased public awareness through commercial ads • Consistent, publicly available, monthly reporting. • In-person community presence • Secure, accessible, and transparent data	• Low provider response rate to satisfaction survey • Rejection of referrals to treatment • Lack of stabilization beds • Limited resources and support • Lack of clinical detox services in Hawaii • Lack of standardized training for all CARES employees • Lack of bilingual speakers at the call center

In January 2020, ADAD distributed a user satisfaction survey to providers utilizing Hawaii CARES services for treatment referral, which remained open until March 2, 2020. A total of 27 respondents participated. HACDACS members agree that there is a need for more robust client feedback as customer satisfaction is an important component in improving CARES. Some of the feedback obtained is displayed in Figures 3-5.

Figure 3. How satisfied were you in the INFORMATION you were provided about CARES? (15 responses)

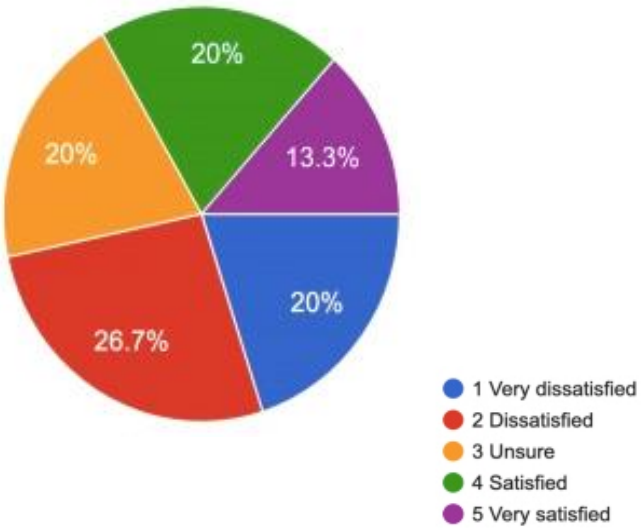


Figure 4. How satisfied were you with the TIMELINESS of your service response? (15 responses)

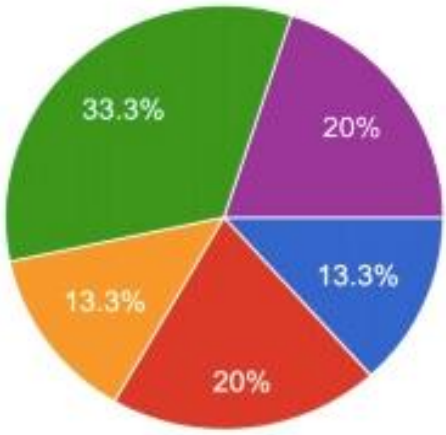
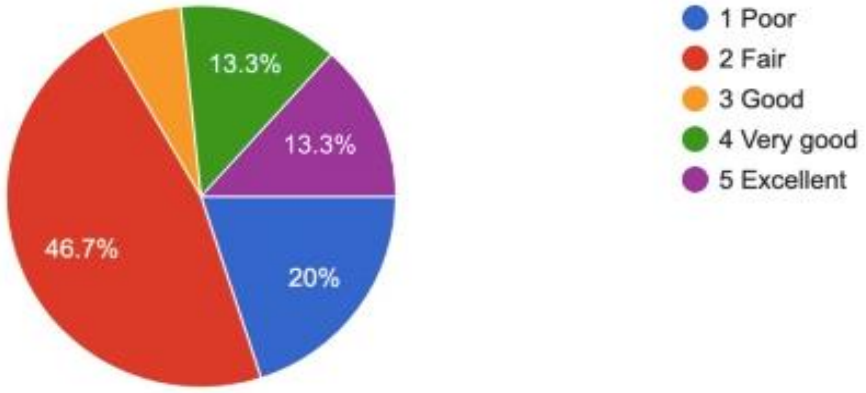


Figure 5. How would you rate your overall experience calling CARES? (15 responses)



This information demonstrates that while CARES is useful, there is still some improvement needed to increase its effectiveness and ease of use.

HACDACS recommends supporting expanding linkages to increase services including and beyond SUD and behavioral health services, including the installation of clinical detox beds in hospitals and treatment centers within Hawaii.

HACDACS recommends that CARES initiates user satisfaction surveys on an annual or biannual basis. More responses will provide a greater understanding of consumer feedback and drive policy and programmatic decisions to leverage funding.

HACDACS recommends that CARES initiate a provider survey to allow an opportunity for provides to give CARES feedback for improvement on an annual or biannual basis.

HACDACS recommends ongoing support of CARES with a focus on adapting best practices from other states and the Hawaii Homeless Coordinated Entry System to ensure a comprehensive, responsive and nimble system informed by consumer input, provider feedback, and a transparent implementation process.

Workforce Development

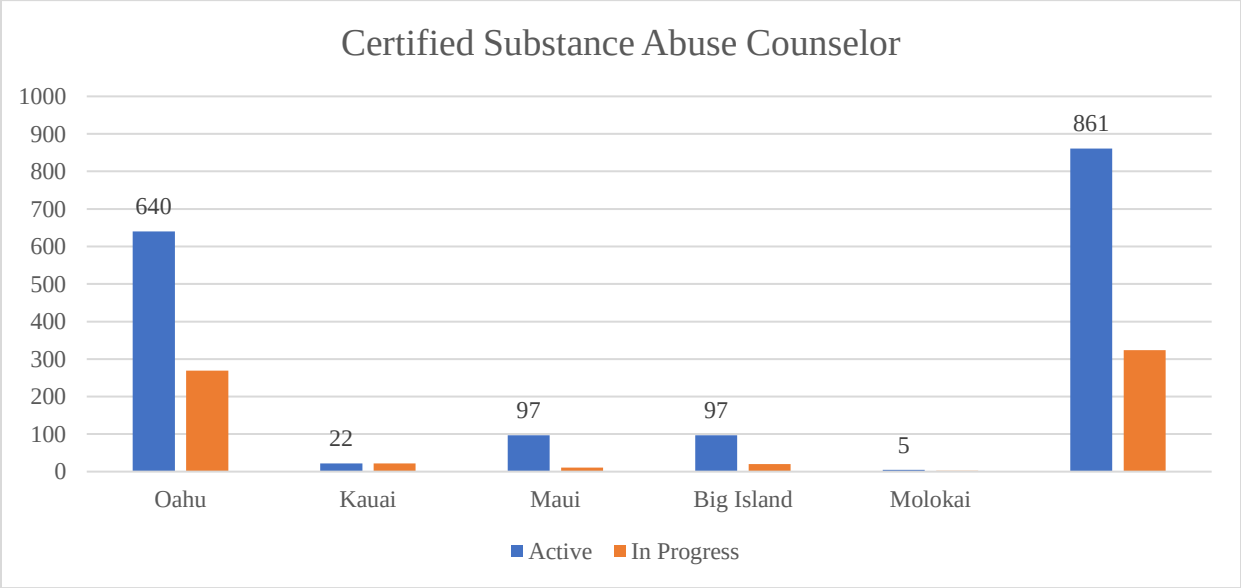
At the March 24th, 2020 HACDACS meeting, Angela Bolan from the Quality Assurance and Improvement (QAI) office at the Alcohol and Drug Abuse Division (ADAD) presented on Workforce Development in the substance use treatment and prevention sector. The QAI office is responsible for quality assurance and improvement functions such as certification of substance abuse counselors, program accreditation, and training. ADAD offers 5 certifications:

1) Certified Substance Abuse Counselor (CSAC)
2) Certified Prevention Specialist (CPS)
3) Certified Clinical Supervisor (CCS)
4) Certified Criminal Justice Professional (CCJP)
5) Certified Substance Abuse Program Administrator (CSAPA).

Figure 6 illustrates the number of active and in-progress CSACs to date. There are currently 324

CSAC applicants in progress while 69 applicants passed the examination in 2019. The high number of applicants in progress, and the low number of those who obtain their CSAC, is concerning and raises questions regarding recruitment, the application process, training, and exam preparation.

Figure 6. Number of Active and In-Progress CSACs Statewide, 8/10/2020.

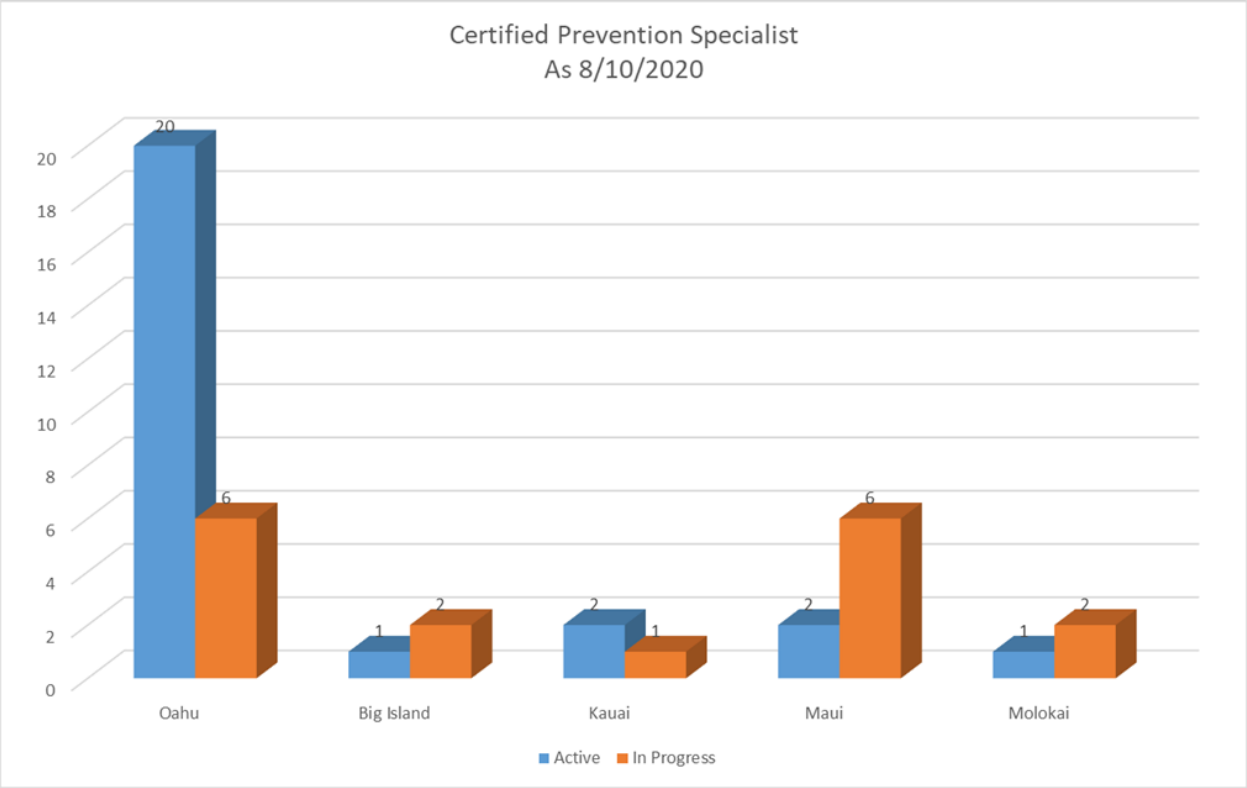


The certification process, particularly for CSAC and CPS, is long and cumbersome especially for those without a secondary education. For instance, it can take 6 years or longer for an applicant who holds a High School diploma to acquire all the required hours before becoming eligible to take the CSAC certification test. The result of having a long certification process is that many who apply do not finish the entire process. Anecdotally, applicants have reported delays in communication and poor follow through from the QAI office which may indicate a need for more ADAD staff to support this process.

While it is important to have safeguards and standards in a certification process, an evaluation of the application process would help ascertain whether there is alignment amongst the type of candidate and the criteria for certification. Ms. Bolan indicated that the QAI office is considering different levels of certification. As it stands, anyone with a high school diploma to a higher-level degree (i.e. Masters) and licensure (i.e. LCSW) can apply for certification, with varying numbers of hours needed to obtain certification. Ms. Bolan noted that those who have a higher degree are more likely to see the process through and achieve certification due to the lesser time need to complete all requirements.

Figure 7 illustrates the number of active and in-progress CPSs to date. There are currently 17 CPS applicants in progress. This number is significantly lower than the number of active and in progress CSACs. HACDACS notes the importance and value that prevention plays in addressing public health issues relating to substance use disorders and feels a robust prevention workforce is essential. Effective prevention services require an adequately staffed, highly skilled, diverse, and interdisciplinary workforce to address barriers, challenges, gaps, and strengths within the prevention system. More attention is needed in the promotion of CPS as a career choice and recruitment of strong candidates.

Figure 7. Number of Active and In Progress CPSs Statewide, 8/10/2020.

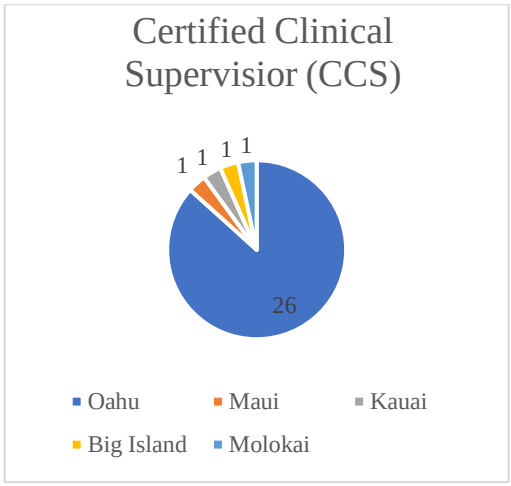


Just as promotion and recruitment are vital to the certification system, so is training and preparation. To become either a CSAC or CPS, one must be supervised by a Licensed Clinician (i.e., LCSW, LMHC). To become a CSAC, one must be supervised by a Licensed Clinician (i.e., LCSW, LMHC) and a portion of hours (Practical Training) must be supervised by a CSAC, and hours regarding the 12 Core Functions training must be signed-off by a CSAC. To become a CPS, one must be supervised by a CPS, or an individual who has a secondary degree in a substance use oriented field with one year of related work experience.

However, there is no guidance on supervising the Practical Training hours that would lead to a uniformity in evaluation. In addition, there are no minimum number of years required as a CSAC before being able to supervise another candidate. Having guidance or education provided by ADAD will ensure consistency and effectiveness amongst those responsible for overseeing the preparation of CSAC candidates.

ADAD does provide a Certified Clinical Supervisor (CCS) certification in Substance Use and Prevention. The candidates must have a CSAC or CCJP, previous work experience, and education specific to supervision in order to be eligible. Figure 1.3 illustrates the number of active (30) and in progress (8) CCSs to date. This certification appears to be underutilized and needs more recruitment. It should be noted that one does not need to be a CCS in order to supervise a CSAC candidate.

Figure 8. Number of Active and In Progress CCS Statewide, 8/10/2020.



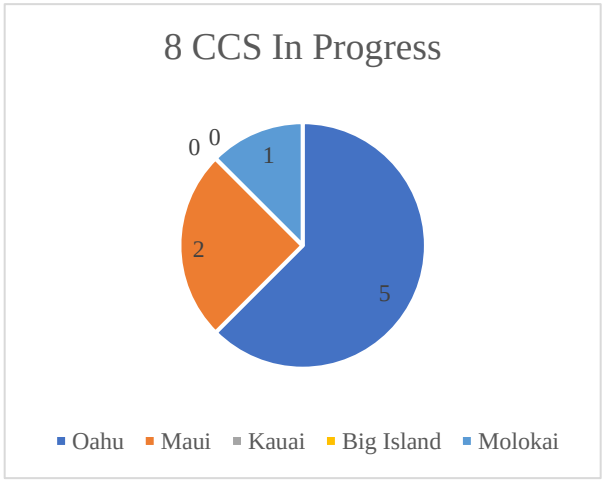
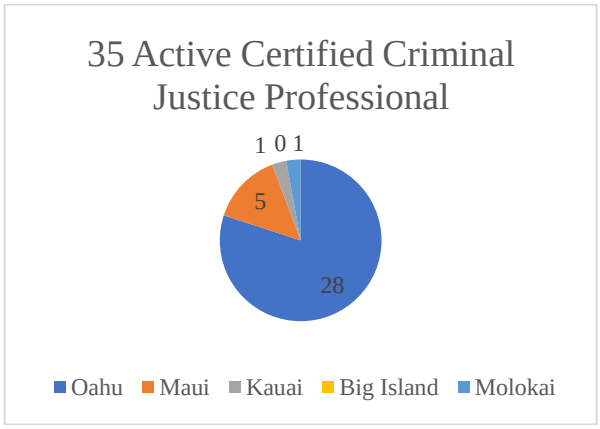
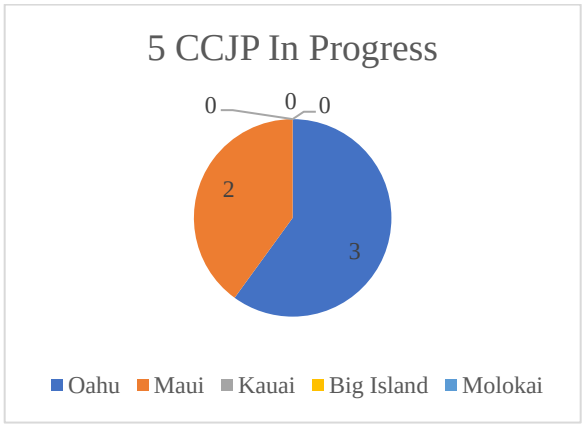


Figure 8 identifies 861 current CSACs and Figure 9 identifies 35 current CCJP. Cumulatively, there is a small pool of candidates (896) for the CCS. Since ADAD's certification system builds upon itself, having a strong base of CSAC, CPS, and CCJP candidates is critical.

Figure 9. Number of Active and In Progress CCJPs, 8/10/2020.





Recruitment and retention need to be a strong component of any certification system. There are currently 1317 certified counselors in the state of Hawaii with fewer than 140 holding CPS, CCJP, and CCS certifications. In addition, the majority of the certified counselors are on Oahu, leaving the neighbor islands in significant need of providers who specialize in substance use counseling. Ms. Bolan noted a growing concern that the CSAC workforce is aging/retiring at a greater rate than is achieving certification. ADAD is challenged with finding ways to recruit candidates for certification. While some educational institutes (Leeward Community College, University of Hawaii Medical School, Chaminade University, University of Hawaii, West Oahu, and University of Hawaii, School of Social Work) provide training for potential CSAC candidates, greater outreach and recruitment is needed to increase the chances that students will follow through with the certification process and take the exam.

ADAD has identified several trainers that provide trainings to providers in topics such as Ethics, Cultural Competency, and Self Care. Typically, one to five trainings are offered in-person each month, however, due to the COVID-19 pandemic, ADAD has expanded distance learning by

making their trainings available via Zoom. Although ADAD provides a variety of trainings, it is insufficient in meeting the needs of complex patients and treatment facilities. HACDACS recognizes that treatment is encountering increasingly complex patients who exhibit severe substance use disorders, in addition to co-occurring physical health and mental health disorders. Additional training and education beyond substance use is needed to service complex patients with co-morbid conditions, in addition to, more consistent application of the 12 Core Functions and evidence-based practices for mental health disorders.

The current model for certification places the burden of training and developing counselors on the treatment facilities. Those interested in getting certified need to work in the field for a certain number of hours commensurate with their education level. Anecdotally, treatment facilities report that staff work in the treatment facility to gain work hours, and then leave once they have obtained their certification. The treatment facility then becomes the training ground for CSAC certification resulting in frequent staff turnover.

Enhancing the certification process for substance use treatment and prevention providers and developing the workforce for this important sector will have long-term benefits to the people of Hawaii.

HACDACS recommends a committee be formed to evaluate the current substance use treatment and prevention workforce development structure to include each certification offered and processes. The committee should focus on determining the benefits of a tiered certification model, evaluating qualifications for obtaining certification, and developing standards and processes for the monitoring of training and supervision.

HACDACS recommends providing support for recruitment and retention. ADAD should develop a collaboration with the Department of Education and University system to caste a broad search for applicants. ADAD should develop an incentive program for the retention of certified counselors.

HACDACS recommends providing support for tracking applicants and renewals. Support should address the delays in communication with applicants and develop a tracking system for easier follow-up. Reasons why applicants do not complete the application process or pass the certification exam should also be evaluated.

REPORT PURSUANT TO
SECTION 10 OF ACT 161, SESSION LAWS OF HAWAII 2002,
ON THE IMPLEMENTATION OF SECTION 321-193.5, HAWAII REVISED STATUTES

Act 161, SLH 2002, was enacted "to require first time non-violent drug offenders, including probation and parole violators, to be sentenced to undergo and complete drug treatment instead of incarceration." Section 2* of the Act specifies that:

> The Department of Public Safety, Hawaii Paroling Authority, Judiciary, Department of Health, Department of Human Services, and any other agencies assigned oversight responsibilities for offender substance abuse treatment by law or administrative order, shall establish a coordinating body through an interagency cooperative agreement to oversee the development and implementation of offender substance abuse treatment programs in the State to ensure compliance with the intent of the master plan developed under Chapter 353G, HRS.

Section 10 of Act 161, SLH 2002, specifies that:

> The Department of Health shall submit an annual report to the Legislature before the convening of each Regular Session, beginning with the Regular Session of 2004, on the status and progress of the interagency cooperative agreement required under Section 2 of this Act and the effectiveness of the delivery of services thereto, and expenditures made under this Act.

It should be noted that there are caveats to Act 161, SLH 2002, implementation. There is no mention of a "master plan" in Chapter 353G** as cited in Section 2 of Act 161, SLH 2002; and no funds were appropriated in Act 161. The interagency initiative to implement offender substance abuse treatment services, however, has been an on-going collaborative activity.

The following tables indicate the number of offenders served, criminal justice agency referral source and the geographic distribution of the offenders served. The Alcohol and Drug Abuse Division (ADAD) has contracts with thirty-two (32) substance abuse treatment agencies that provide services statewide.

During Fiscal year 2019-20, 1,690 offenders were referred by criminal justice agencies for substance abuse treatment, case management and clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Of the 1,954 offenders who received services, 375 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2019-20 is as follows in Tables 1-4:

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* Codified as §321-193.5, Hawaii Revised Statutes.

** Act 152, SLH 1998, Criminal Offender Treatment Act.

Table 1. Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2019 – June 30, 2020

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu	221	1,206	63	530	**2,020**
Maui	44	114	0	0	**158**
Hawaii	31	250	22	25	**328**
Total	**296**	**1,570**	**85**	**555**	**2,506**

Case management services providers: Action with Aloha LLC, Big Island Substance Abuse Council, Bridge House, Inc., Child and Family Service, Hope Treatment Services, Institute for Humans Services, Kokua Support Services, Malama Family Recovery Center, Maui Youth & Family Services Inc., Po'ailani Inc., Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, Waianae Coast Comprehensive Health Center MRS

Table 2. Referrals by Criminal Justice Agency: July 1, 2019 – June 30, 2020

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu[1]	115	928	54	515	**1,612**
Maui[2]	42	114			**156**
Hawaii[3]	28	216	14	23	**281**
Total	**185**	**1,258**	**68**	**538**	**2,049**

Case management services providers: Action with Aloha LLC, Big Island Substance Abuse Council, Bridge House, Inc., Child and Family Service, Hope Treatment Services, Institute for Humans Services, Kokua Support Services, Malama Family Recovery Center, Maui Youth & Family Services Inc., Po'ailani Inc., Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, Waianae Coast Comprehensive Health Center MRS

Table 3. Carryover Cases by Criminal Justice Agency: July 1, 2018 – June 30, 2019

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu	42	314	17	16	**389**
Maui	2				**2**
Hawaii	3	39		2	**44**
Total	**47**	**353**	**17**	**18**	**435**

Case management services providers: Action with Aloha LLC, Big Island Substance Abuse Council, Bridge House, Inc., Child and Family Service, Hope Treatment Services, Institute for Humans Services, Kokua Support Services, Malama Family Recovery Center, Maui Youth & Family Services Inc., Po'ailani Inc., Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, Waianae Coast Comprehensive Health Center MRS

Recidivism. The major outcome for services to offenders is recidivism, or the proportion of offenders who have been rearrested. The Interagency Council on Intermediate Sanctions (ICIS) 2018 Recidivism Update (dated June 2020) for the Fiscal Year 2015 cohort states that the overall recidivism rate is 61.3% for probation, parole and Department of Public Safety (PSD) maximum-term released prisoners. (ICIS defines recidivism as criminal rearrests, criminal

contempt of court and revocations/violations). The data reveal a 64.7% recidivism rate for probationers; a 50.3% recidivism rate for offenders released to parole; and a 64.0% recidivism rate for offenders released from prison (maximum-term release).

The 61.4% recidivism rate for FY 2015 probationers and parolees was higher than the previous year's rate of 45.1%. The FY 2015 recidivism rate is 1.9% lower than the recidivism rate reported in the FY 1999 baseline year, far from the goal of reducing recidivism in Hawaii by 30%. Felony probationers in the FY 2015 cohort had a 64.7% recidivism rate, which is 23.3 percentage points higher than the recidivism rate for the previous year's cohort, and indicates a 11.0% increase in recidivism since the baseline year. Parolees in the FY 2015 cohort had a 50.3% recidivism rate, which is 3.0 percentage points lower than the previous year's rate, and signifies a 31.0% decline in recidivism from the baseline year, which has met the goal of reducing recidivism in Hawaii by 30%. The recidivism rate for maximum-term released prisoners increased from 61.5% for the FY 2006 cohort to 64.0% for the FY 2015 cohort. The recidivism rate for FY 2015 is 64.0% (0.6 percentage points) higher than the FY 2014 rate. Additionally, probationers had the highest recidivism rates in the entire FY 2015 offender cohort for criminal reconvictions (40.0%), while maximum-term released prisoners had the highest recidivism rate in the entire FY 2015 offender cohort for criminal rearrests (49.3%).

The table below summarizes data for clients (i.e., non-violent offenders) from various segments of the overall offender population who are referred and are provided substance abuse treatment and case management services. It should be noted that clients who are referred for services may also drop out before or after admission.

Table 4. Recidivism by Criminal Justice Agency: July 1, 2019 – June 30, 2020

	Supervised Release PSD/ISC	**Judiciary Adult Client Services**	**PSD/ISC - Corrections Jail/Prison**	**Hawaii Paroling Authority**	**Total**
Arrests/revocations	2	34	10	27	**73**
Total served	207	1236	92	156	**1691**
Recidivism rate	**1.0%**	**2.8%**	**10.9%**	**17.3%**	**4.3%**

REPORT PURSUANT TO
SECTION 29 OF ACT 40, SESSION LAWS OF HAWAII 2004,
REQUIRING A PROGRESS REPORT ON THE SUBSTANCE
ABUSE TREATMENT MONITORING PROGRAM

Section 29 of Act 40, SLH 2004, requires that the Department of Health submit a progress report on the Substance Abuse Treatment Monitoring Program.* The Substance Abuse Treatment Monitoring Program requires the Department of Health, the Office of Youth Services, the Department of Public Safety and the Judiciary to collect data from private providers of substance abuse treatment services that receive public funds and state agencies that provide direct treatment services. Treatment providers are required to report admission and discharge data, as determined by the Department of Health.

During the Fiscal Year 2005-06, site visits to substance abuse treatment provider agencies were conducted to assess contractors' data collection procedures. During Fiscal Year 2006-07, activities of the interagency group included: training State agencies' staff on admission, discharge and follow-up data collection; making adjustments to accommodate criminal justice agencies' data needs; training for substance abuse treatment providers; and assistance in installing software onto providers' computers and providing "hands-on" training.

Throughout Fiscal Year 2007-08, progress in data entry included orientation and training of providers' staff in the Web-based Infrastructure for Treatment Services (WITS) system. During Fiscal Year 2008-09, agencies were to have strengthened communication and collaboration for data collection, however, challenges in staff recruitment and retention stymied continuity in program implementation. Similarly, during Fiscal Years 2009-10 and 2010-11, restrictions on hiring, the reduction in force which deleted one of the three positions, and furloughing of staff exacerbated progress in program implementation.

Act 164, SLH 2011, converted two positions, Information Technology Specialist (ITS) IV and Program Specialist - Substance Abuse (PSSA) IV, from temporary to permanent. The ITS IV position was filled on June 18, 2014. The PSSA IV position was reclassified into a Program Specialist VI position and was filled on April 1, 2016. The position supervises the Division Planning, Evaluation, Research and Data (PERD) Office that is responsible for strategic planning; organizational development; program development and evaluation; policy research and development; coordination and development of the Division's legislative responses, reports, and testimonies; and management of the Division's data systems.

Since Fiscal Year 2008-09, WITS has been used as a data collection and billing system for all ADAD contracted substance abuse treatment providers. The data collected was used to annually report admission and discharge information to the Legislature. While WITS has always had the capability to collect substance abuse treatment information about all clients served by its contracted providers, only clients whose services were paid through ADAD contracts were reported. In Fiscal Year 2011-12, some of ADAD contracted providers began collecting information from the Judiciary, followed in Fiscal Year 2013-14 with the Hawaii Paroling Authority; and in Fiscal Year 2015-16, the Department of Public Safety. ADAD continues to strengthen collaboration with the Office of Youth Services, the Department of Public Safety and

the Judiciary to use WITS as their substance abuse treatment data collecting and monitoring system.

APPENDICES

A. ADAD-Funded Adult Services: Fiscal Years 2017-20

B. ADAD-Funded Adolescent Services: Fiscal Years 2017-20

C. Performance Outcomes: Fiscal Years 2017-20

D. Treatment Related to Substance Use - County Estimates

E. 2019-2020 Preliminary Estimated Need for Adolescent (Grades 8-12) Alcohol and Drug Abuse Treatment in Hawaii

F. Methamphetamine Admissions: 2010-20

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2017-2020

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Male	67.4%	66.5%	67.5%	63.4%
Female	32.6%	33.5%	32.4%	36.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
Hawaiian	44.7%	44.5%	44.4%	48.9%
Caucasian	23.0%	20.9%	21.3%	21.6%
Filipino	8.4%	7.9%	6.9%	5.4%
Mixed - Not Hawaiian	2.6%	2.1%	4.2%	4.8%
Japanese	3.9%	5.0%	3.2%	3.0%
Black	2.8%	3.2%	2.3%	1.0%
Samoan	3.1%	2.1%	3.1%	2.0%
Portuguese	1.2%	1.5%	1.5%	1.7%
Other Pacific Islander	3.3%	3.9%	3.9%	3.5%
Other*	7.1%	9.0%	9.3%	8.0%
TOTAL	100.0%	100.0%	100.0%	100%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
Methamphetamine	53.4%	54.7%	60.6%	60.3%
Alcohol	20.0%	16.8%	16.1%	14.5%
Marijuana	12.4%	10.9%	9.1%	8.9%
Cocaine/Crack	1.6%	3.3%	1.9%	2.6%
Heroin	6.4%	7.4%	6.9%	7.9%
Other*	6.2%	6.9%	5.4%	5.7%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.				

ADAD-FUNDED ADULT ADMISSIONS BY RESIDENCY

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
O'ahu	65.6%	64.7%	57.8%	46.6%
Hawaii	18.1%	17.5%	27.2%	35.3%
Maui	11.5%	11.2%	8.0%	8.2%
Molokai/Lanai	1.8%	1.7%	1.4%	2.3%
Kauai	1.6%	2.9%	2.4%	3.6%
Out of State	1.4%	2.0%	3.2%	4.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2016-17 through Fiscal Year 2019-20, methamphetamine use increased from 53.4% to 60.3%. Alcohol use decreased from 20.0% to 14.5%, and marijuana use decreased from 12.4% to 8.9%. Cocaine/Crack use increased from 1.6% to 2.6%. Heroin use increased from 6.4% to 7.9% while all "Other" substances decreased slightly from 6.2% to 5.7%.

Also, among the 2,867 adult admissions for FY2020, 643 admissions (22.4%) were homeless when admitted to treatment.

APPENDIX B

ADAD-FUNDED ADOLESCENT[18] SERVICES FISCAL YEARS 2017-2020

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Male	53.4%	51.4%	48.7%	47.7%
Female	46.6%	48.6%	51.3%	52.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
Hawaiian	42.6%	44.7%	48.1%	48.0%
Caucasian	10.2%	7.8%	7.6%	7.1%
Filipino	10.5%	10.7%	9.3%	9.1%
Mixed - Not Hawaiian	1.9%	3.6%	2.7%	5.7%
Japanese	3.7%	4.4%	3.3%	3.1%
Black	2.9%	2.1%	2.1%	1.7%
Samoan	4.0%	4.0%	4.6%	4.2%
Portuguese	0.8%	0.9%	0.8%	0.8%
Other Pacific Islander	14.0%	15.2%	13.9%	15.1%
Other*	9.5%	6.5%	7.6%	5.2%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
Methamphetamine	1.1%	1.0%	0.6%	0.8%
Alcohol	22.8%	22.2%	18.3%	18.6%
Marijuana	62.6%	61.6%	64.4%	64.7%
Cocaine/Crack	0.3%	0.3%	0.7%	-0-.5%
Heroin	-0-	-0-	0.1%	0
Other	13.2%	15.0%	16.0%	15.3%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY RESIDENCY

	FY 2016-2017	FY 2017-2018	FY 2018-19	FY 2019-20
O'ahu	60.0%	66.4%	66.9%	71.8%
Hawaii	12.8%	13.6%	18.0%	12.6%
Maui	18.7%	11.5%	9.3%	10.3%
Molokai/Lanai	0.6%	0.1%	-0-	0.6%-
Kauai	8.0%	8.4%	5.7%	4.7%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2016-17 through Fiscal Year 2019-20, methamphetamine use descreased slightly from 1.1% to 0.8%. Alcohol use decreased from 22.8% to 18.6%, while marijuana used increased slightly from 62.6% to 64.7%. Cocaine/Crack use increased slightly from 0.3% to 0.5%. Heroin use remained steady at 0%, while use of "Other" substances increased from 13.2% to 15.3%.

[18] Adolescent: Grades 6 through 12

Community profiles by the State Epidemiological Outcomes Workgroup (SEOW) and the results of Student Health Surveys administered in 2013, 2015 and 2017 are consistent with the ADAD-Funded Adolescent Treatment Admissions by primary substance in that Alcohol and Marijuana are the primary substances of choice for use by person in Hawaii, ages 12-25. Community-based programs report similar trends based on qualitative data informally gathered at the local community level and therefore, are directing prevention education and strategies and social norm activities to younger ages and families as well as youth ages 12-17 and young adults.

APPENDIX C

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2017 through 2020, six-month follow-ups were completed for samples of adolescents discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Employment/School/Vocational Training	97.4%	98.8%	98.3%	97.7%
No arrests since discharge	93.8%	93.4%	94.1%	94.3%
No substance use in 30 days prior to follow-up	53.8%	59.4%	56.7%	51.8%
No new substance abuse treatment	80.3%	85.5%	75.8%	80.5%
No hospitalizations	95.2%	95.5%	95.4%	94.8%
No emergency room visits	93.5%	92.1%	92.6%	92.1%
No psychological distress since discharge	84.8%	78.9%	76.3%	81.1%
Stable living arrangements*	97.8%	99.0%	97.1%	97.9%

**defined as client indicating living arrangements as "not homeless"*

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2017 through 2020, six-month follow-ups were completed for samples of adults discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Employment/School/Vocational Training	58.6%	58.2%	63.4%	61.9%
No arrests since discharge	92.9%	92.7%	90.1%	94.0%
No substance use in 30 days prior to follow-up	61.0%	56.6%	67.4%	72.5%
No new substance abuse treatment	61.8%	55.0%	63.6%	72.2%
No hospitalizations	90.9%	91.0%	91.9%	93.0%
No emergency room visits	86.2%	85.6%	88.1%	90.6%
Participated in self-help group (NA, AA, etc.)	36.5%	36.0%	40.3%	31.8%
No psychological distress since discharge	67.4%	63.7%	78.0%	81.1%
Stable living arrangements*	77.5%	76.1%	83.1%	77.3%

**defined as client indicating living arrangements as "not homeless"*

APPENDIX D

TREATMENT RELATED TO SUBSTANCE USE - COUNTY ESTIMATES

Table D1: Needing But Not Receiving Substance Use Treatment at a Specialty Facility in the Past Year among Individuals Aged 18 or Older, by State and Sub- state Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs

	Percent of State Population (County Population)									
	Kaua'i		Honolulu		Maui		Hawai'i		State	
Population (18 Years and Over)	5.01	(56,093)	69.4	(776,657)	11.59	(129,716)	13.99	(156,606)	100	(1,119,159)
	Percentage (Estimated N)									
Illicit Drug	2.07	(1,160)	2.03	(15,770)	2.35	(3,050)	2.43	(3,810)	2.12	(23,730)
Alcohol	5.74	(3,220)	5.43	(42,170)	5.59	(7,250)	5.51	(8,630)	5.47	(61,220)
Alcohol or Illicit Drug	6.67	(3,740)	6.69	(51,960)	7.27	(9,430)	7.05	(11,040)	6.80	(76,100)

Findings of the National Survey on Drug Use and Health (NSDUH)[1] revealed that of the state's total 1,119,159 population over the age of 18, a total of 76,100[2] (6.80%) individuals were needing[3] but not receiving treatment for substance use[4] in the past year. Comparable figures by county are as follows:

For *Kaua'i County*, 3,740 (6.67%) of individuals aged 18 and older on Kaua'i were needing but not receiving treatment for substance use in the past year.

For the *City and County of Honolulu*, 51,960 (6.69%) of individuals aged 18 and older on O'ahu were needing but not receiving treatment for substance use in the past year.

For *Maui County*, 9,430 (7.27%) of individuals aged 18 and older on Maui, Lana'i and Moloka'i were needing but not receiving treatment for substance use in the past year.

For *Hawai'i County*, 11,040 (7.05%) of individuals aged 18 and older on the Big Island were needing but not receiving treatment for substance use in the past year.

The five-year (Fiscal Year 2016 to Fiscal Year 2020) average annual ADAD-funded admissions for adults is 3,013, which is 3.6% of the estimated need for adult alcohol & drug abuse treatment.

[1] Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018. The NSDUH 2016-2018 substate reports can be found at https://www.samhsa.gov/data/nsduh/2016-2018-substate-reports.

[2] Estimated numbers were calculated using the average county populations for the State of Hawai'i for the years 2016-2018 from the U.S. Census Bureau, Population Division (Release Date: June 2020). Estimated numbers were rounded to the nearest tenth.

[3] Respondents were classified as needing substance use treatment if they met the criteria for an illicit drug or alcohol use disorder as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). 4Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility. Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use

of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Figure D1: Substance Use Treatment Gap - Needing but Not Receiving Substance Use Treatment in the State of Hawai'i, 2016-2018.

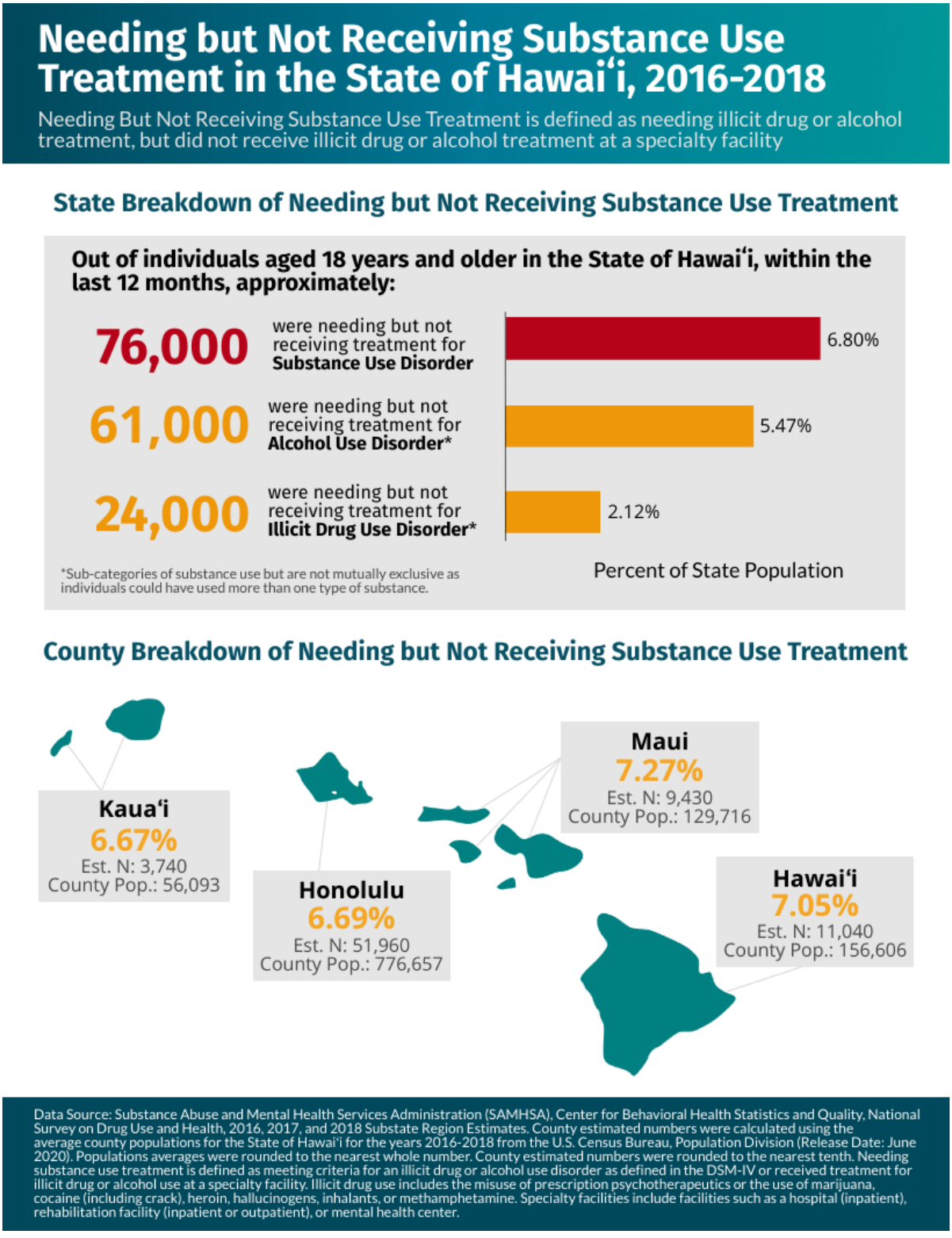


Table D2: Substance Use Disorder in the Past Year among Individuals Aged 18 or Older, by State and Substate Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs										
	Percent of State Population (County Population)									
	Kaua‘i		Honolulu		Maui		Hawai‘i		State	
Population (18 Years and Over)	5.01	(56,093)	69.4	(776,657)	11.59	(129,716)	13.99	(156,606)	100	(1,119,159)
	Percentage (Estimated N)									
Illicit Drug	2.32	(1,300)	2.45	(19,030)	2.53	(3,280)	2.62	(4,100)	2.48	(27,760)
Pain Reliever	0.50	(280)	0.44	(3,420)	0.53	(690)	0.52	(810)	0.46	(5,150)
Alcohol	5.87	(3,290)	5.63	(43,730)	5.70	(7,390)	5.44	(8,520)	5.63	(63,010)
Alcohol or Illicit Drug	6.72	(3,770)	7.36	(57,160)	7.47	(9,690)	7.33	(11,480)	7.34	(82,150)

Findings of the National Survey on Drug Use and Health (NSDUH)[1] revealed that of the state's total 1,119,159 population over the age of 18, a total of 82,150[2] (7.34%) individuals had substance use disorder[3] in the past year. Comparable figures by county are as follows:

For *Kaua‘i County*, 3,770 (6.72%) of individuals aged 18 and older on Kaua‘i had substance use disorder in the past year.

For the *City and County of Honolulu*, 57,160 (7.36%) of individuals aged 18 and older on O‘ahu had substance use disorder in the past year.

For *Maui County*, 9,690 (7.47%) of individuals aged 18 and older on Maui, Lana‘i and Moloka‘i had substance use disorder in the past year.

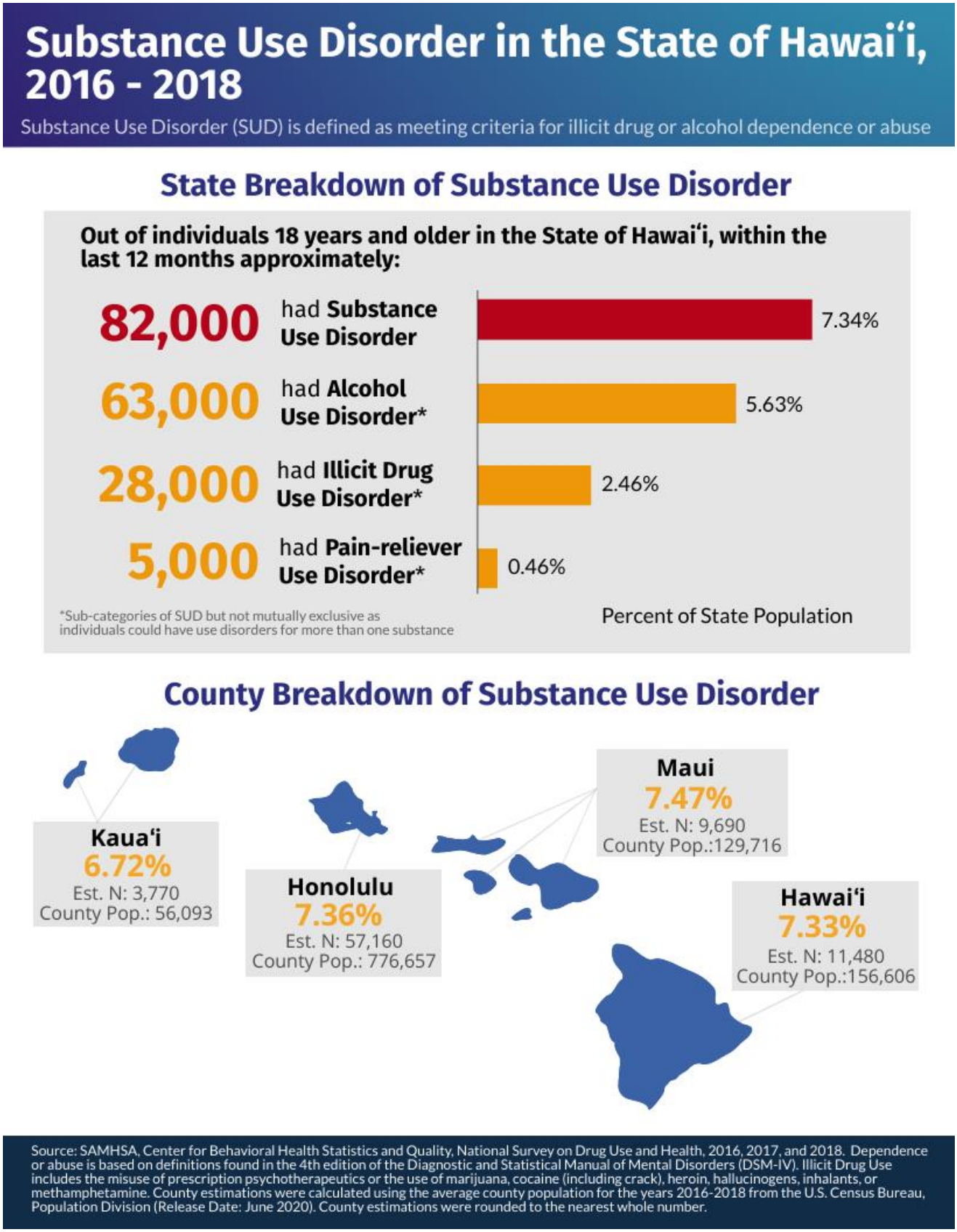
For *Hawai‘i County*, 11,480 (7.33%) of individuals aged 18 and older on the Big Island had substance use disorder in the past year.

[1] Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018. The NSDUH 2016-2018 substate reports can be found at https://www.samhsa.gov/data/nsduh/2016-2018-substate-reports.

[2] Estimated numbers were calculated using the average county populations for the State of Hawai‘i for the years 2016-2018 from the U.S. Census Bureau, Population Division (Release Date: June 2020). Estimated numbers were rounded to the nearest tenth.

[3] Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Figure D2: Substance Use Disorders in the State of Hawai‘i, 2016 – 2018.



APPENDIX E

2019-2020 PRELIMINARY ESTIMATED NEED* FOR ADOLESCENT (GRADES 8-12) ALCOHOL AND DRUG ABUSE TREATMENT IN HAWAII

Probable Abuse or Dependence of any Substance, Based on the CRAFFT[19] for Gender, Grade Level, and Ethnicity (weighted percents)					
	No		Yes		Total
	n	%	n	%	
Overall Total	6,970	**88.9%**	871	**11.1%**	7,841
Gender					
Male	3,889	**89.3%**	466	**10.7%**	4,355
Female	3,045	**86.7%**	466	**13.3%**	3,511
Transgender & Other Gender Minority	127	**75.6%**	41	**24.4%**	168
Grade					
8th Grade	2,437	**93.4%**	173	**6.6%**	2,610
10th Grade	2,474	**88.1%**	335	**11.9%**	2,809
12th Grade	2,058	**85.0%**	362	**15.0%**	2,420
Self-Identified[20] Primary Ethnicity/Race					
Native Hawaiian	655	**85.1%**	115	**14.9%**	770
Other Pacific Islander	358	**81.4%**	82	**18.6%**	440
Japanese	663	**93.9%**	43	**6.1%**	706
Filipino	1,228	**92.4%**	101	**7.6%**	1,329
Other Asian	299	**94.6%**	17	**5.4%**	316
Hispanic/Latino	195	**83.7%**	38	**16.3%**	233
White/Caucasian	591	**90.9%**	59	**9.1%**	650
Other	99	**86.1%**	16	**13.9%**	115
2 or more ethnicities[21]	2780	**87.6%**	394	**12.4%**	3,173

The 2019-2020 Hawaii Student Alcohol, Tobacco, and Other Drug Use (ATOD) Survey Preliminary Findings

*NOTE: Data were collected from students in grades 8, 10 and 12 across the State, using a risk and protective factors approach, to report levels of substance use and treatment needs in Hawaii. Preliminary estimated need for alcohol or substance use treatment among Hawaii's adolescents were based on the cutoff score of 4 or higher on the well-validated CRAFFT instrument (Knight et al, 1999, 2002; Shenoi et al 2019), indicating probable substance use disorder (abuse/dependence, American Psychiatric Association DSM-IV and DSM-5) by gender, grade level and ethnicity.

The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade and ethnicity:

- The overall total estimated treatment need across the state ***increased*** to 11.1% compared to 7.7% reported from the 2007-2008 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study.

- Both males (10.7%) and females (13.3%) also showed an ***increase*** in estimated treatment need compared to 2007-2008 (males 6.8%, females 8.3%). The inclusion of Gender Minorities additionally indicates an elevated proportion of probable substance use disorder (24.4%).

[19] The CRAFFT (https://crafft.org/about-the-crafft) is an efficient and effective health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. It is used widely as a universal screener in clinical, community and research settings for detection of substance use and problematic substance use for early intervention and patient-centered counseling, including the Hawaii State Department of Health Alcohol and Drug Abuse Division and its network providers. The CRAFFT is shown to be valid for adolescents from diverse socioeconomic and racial/ethnic backgrounds, and is recommended by the American Academy of Pediatrics' Bright Futures Guidelines for preventive care screenings and well-visits, the Center for Medicaid and CHIP Services' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) Youth Screening Guide.

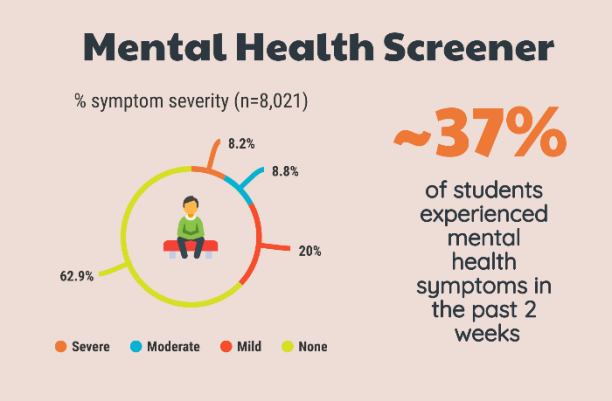
[20] While the survey asks students to select a group with which they primarily identify, a large proportion reported primarily identifying with multiple (2 or more) ethnic/racial groups.

[21] Note that among the 2 or more ethnicities category, over half identified as being Native Hawaiian.

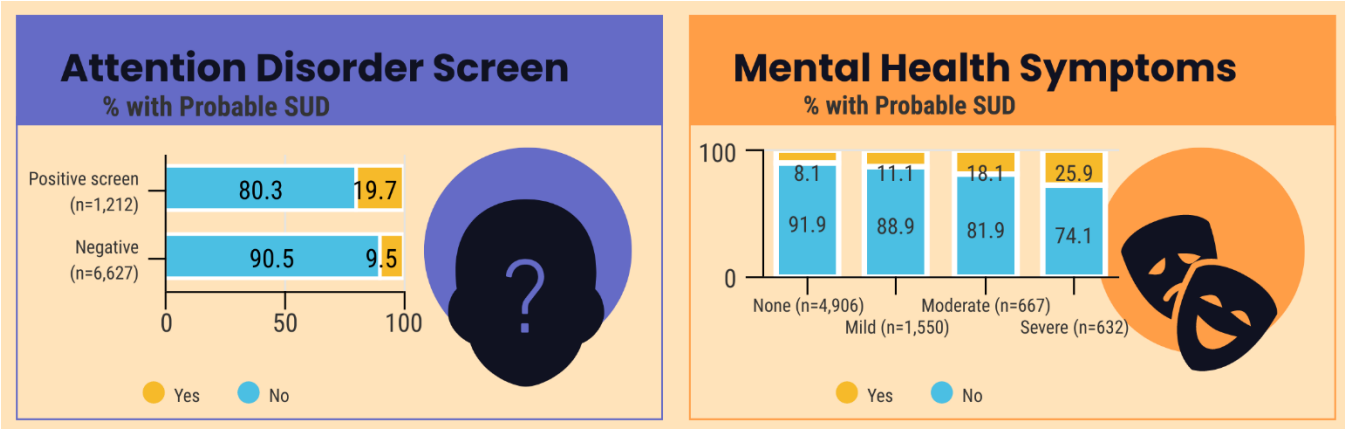
- For treatment needs by grade, 6.6% of 8th graders, 11.9% of 10th graders, and 15.0% of 12th graders had a probable substance use disorder.

- Adolescents most likely to have a probable substance use disorder primarily identified themselves as **Other Pacific Islander (18.6%), Native Hawaiian or part Native Hawaiian (14.9%), Hispanic or Latino (16.3%), and of Mixed (2 or more) ethnicities (12.4%)**. Students identified as Other ethnicities (13.9 %) had higher rates as well, but it should be noted that the sample size was smaller than for other groups.

- ***New items in*** the Hawaii ATOD Survey related to **Mental Health** (PHQ-4 screener for anxiety and depressive symptoms; Kroenke et al, 2009) showed that with about ***37%*** of student reported experiencing mild to severe mental health symptoms in the past two weeks. Furthermore, along the continuum of increasing symptom severity, the percentage of probable substance use disorder (as measured by the CRAFFT) is about ***two-fold from mild (8.1%) to severe (25.9%)*** mental health symptoms.



- From the Hawaii ATOD Survey ***new items*** related to screening for **attention related disorders** (Pediatric Symptom Checklist, Attention subscale; Gardner et al, 1999), youth with a ***positive screen*** (which indicates further assessment for attentional disorders) also had a percentage (19.7%) of probable substance use disorder ***about twice that of those with a negative screen*** (9.5%).



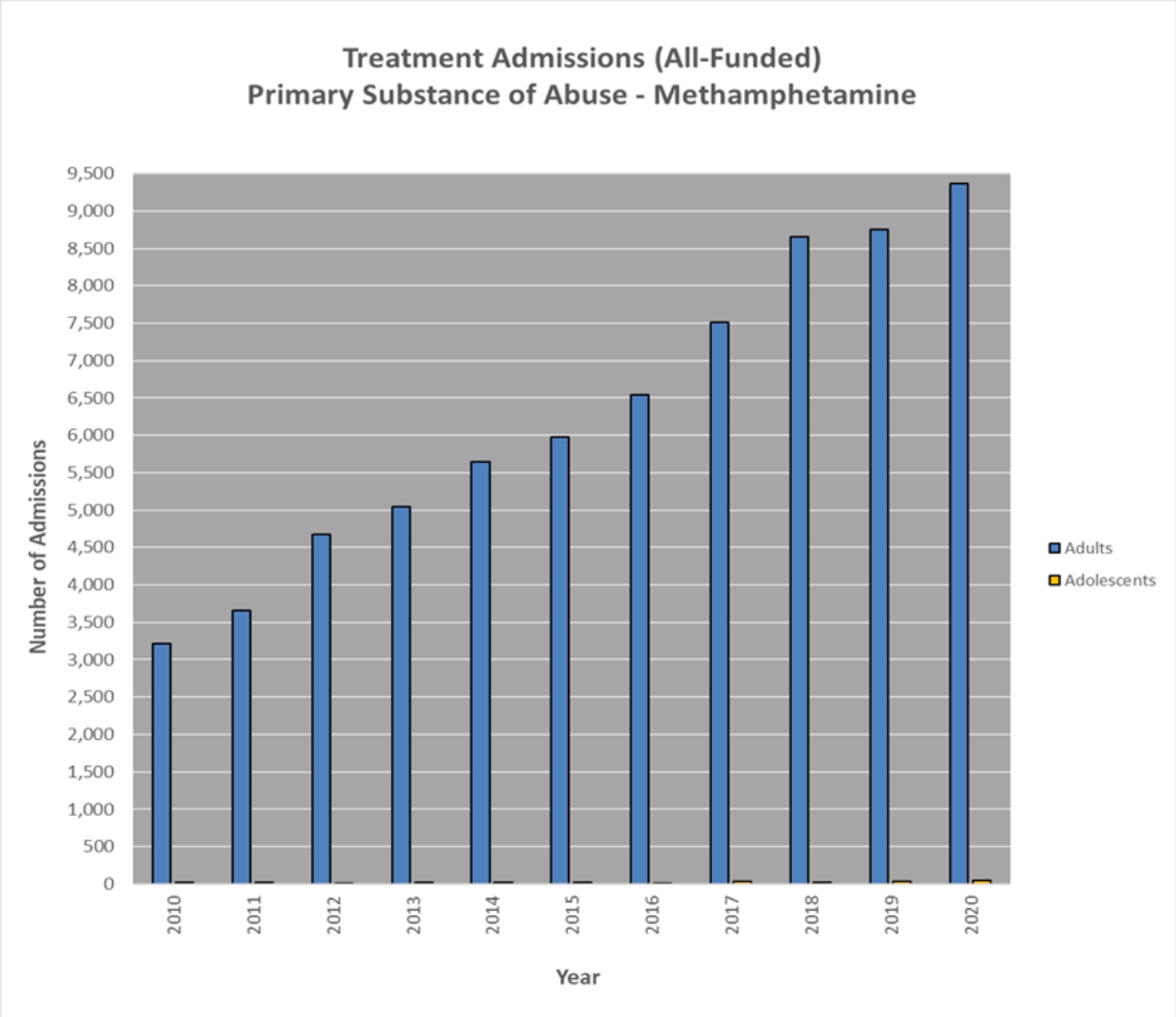
The 2019-2020 Hawaii Student Alcohol, Tobacco, and Other Drug Use Survey Comprehensive Report is expected to be released in 2021, and will include updated and more detailed findings in domains of risk and protective factors related to alcohol and substance use for state and regional level results.

The five-year (Fiscal Year 2016 to Fiscal Year 2020) average annual ADAD-funded admissions for adolescents is 1,743, which is 32.5% of the estimated need for adolescent alcohol and drug abuse treatment.

APPENDIX F

METHAMPHETAMINE ADMISSIONS 2010 - 2020

As reflected in the graph and table below, there was a 7.0% increase and a 44.8% increase in adult and adolescent crystal methamphetamine admissions to treatment, respectively, in Fiscal Year 2019-20.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Adults	**3,216**	**3,654**	**4,681**	**5,044**	**5,642**	**5,978**	**6,540**	**7,511**	**8,655**	**8,746**	**9,361**
Adolescents	**24**	**28**	**15**	**21**	**24**	**26**	**16**	**30**	**25**	**29**	**42**
Total	**3,240**	**3,682**	**4,696**	**5,065**	**5,666**	**6,004**	**6,556**	**7,541**	**8,680**	**8,775**	**9,403**

As reported by contracted substance abuse treatment providers, the above data encompass "ice" admissions that are funded by all sources of funds which includes clients whose services are ADAD-funded, as well as coverage by Medicaid (i.e., QUEST) and health insurance coverage under Chapter 431M, HRS, relating to mental health and alcohol and drug abuse treatment insurance benefits. Data reported on Appendices A, B and C are for ADAD-funded admissions only.

REPORT PURSUANT TO
SECTION 329E-6, HAWAII REVISED STATUTES
REQUIRING A REPORT ON UNINTENTIONAL OPIOID-RELATED DRUG OVERDOSE

Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.

This report is the result of a collaboration between ADAD, the DOH Emergency Medical Services and Injury Prevention Systems Branch (EMSIPSB), the University of Hawaii Pacific Health Analytics Collaborative and the Hawaii Opioid Initiative (HOI).

Numbers, Trends, and Patterns: Fatal Opioid-Related Poisonings

Recent data shows a 5-year average of 59 opioid-related fatal overdoses from 2015-2019 according to the DOH death certificate database, a decrease from the previous 5-year average of 73 deaths a year from 2010-2014.

Recent data from the Centers for Disease Control's (CDC) WONDER system, a national public health dataset shows that Hawaii opioid poisoning fatality rates appear to be trending slightly upward (4.1 in 2018) but still below the 2016 rate of 5.2 (Figure 1) while the national rate has generally increased since 2000 (14.6 in 2018). When compared to overall drug poisonings, Hawaii's rate shows a slight increase at 14.3 (Figure 2) which is still well below the national rate of 20.7.

Figure 1. Adjusted opioid poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2000-2019 (includes poisonings due to heroin and opium.)

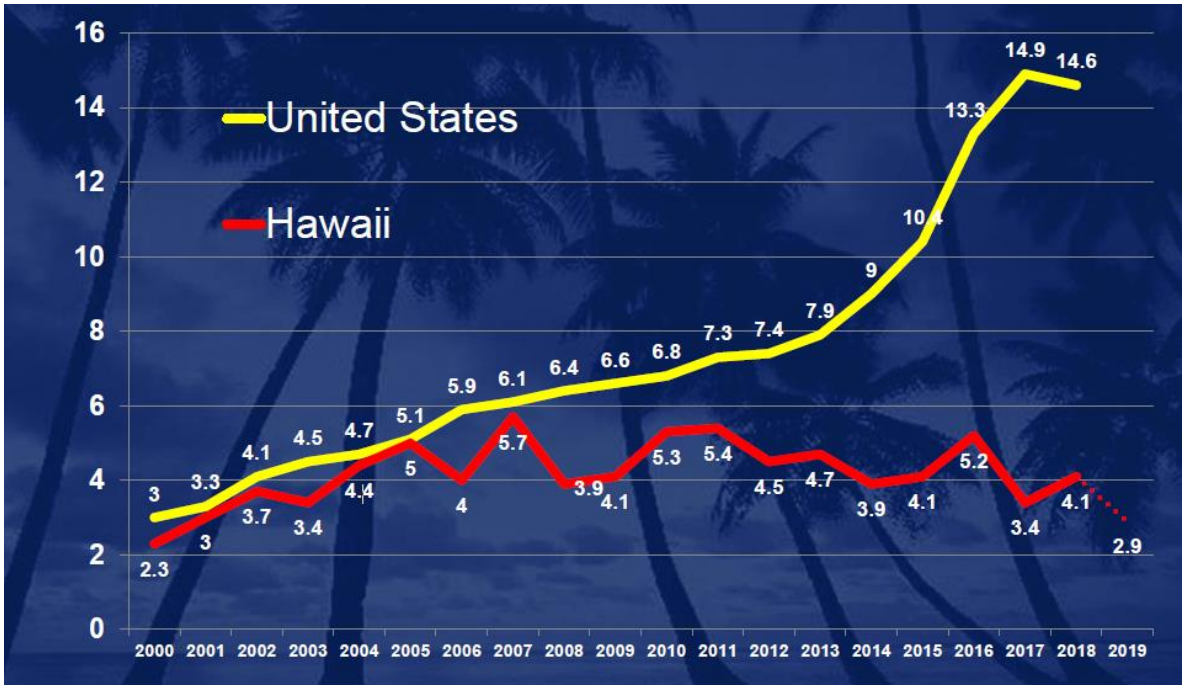
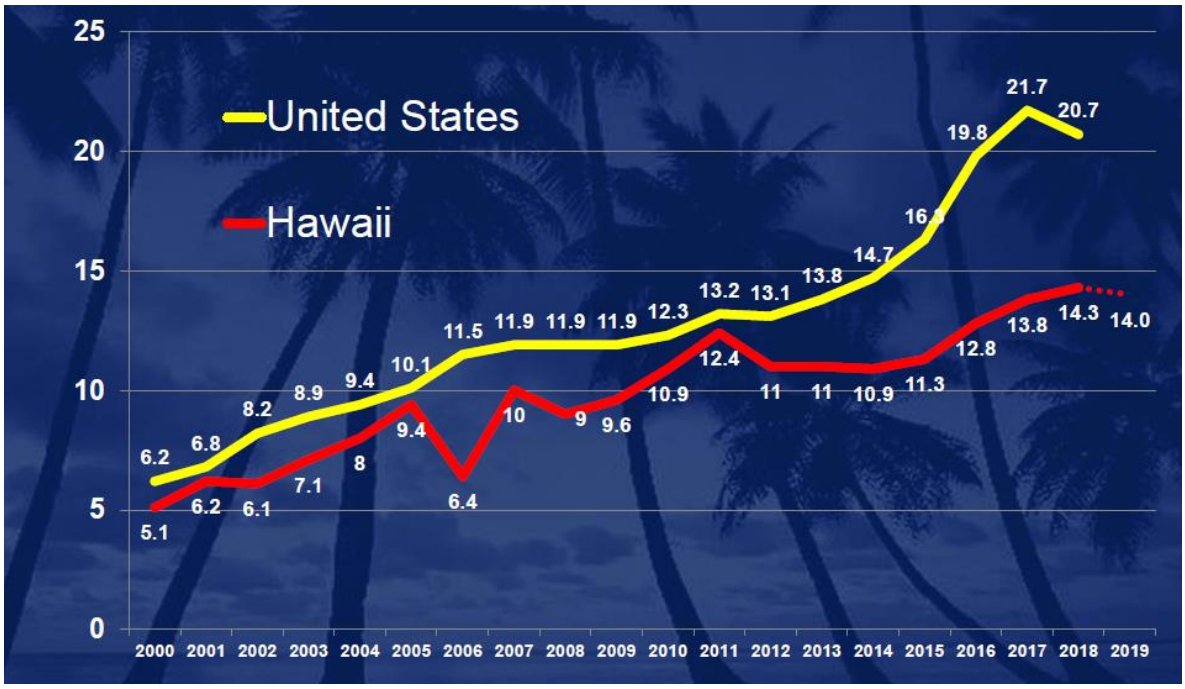
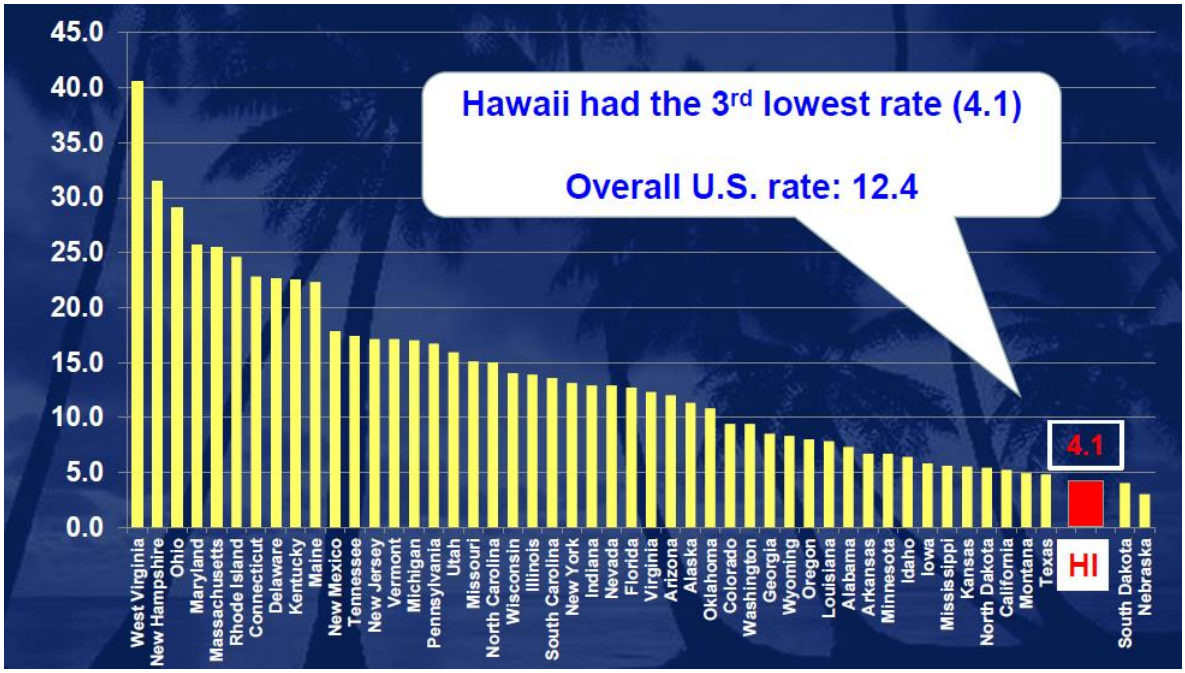


Figure 2. Adjusted drug poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2000-2019.



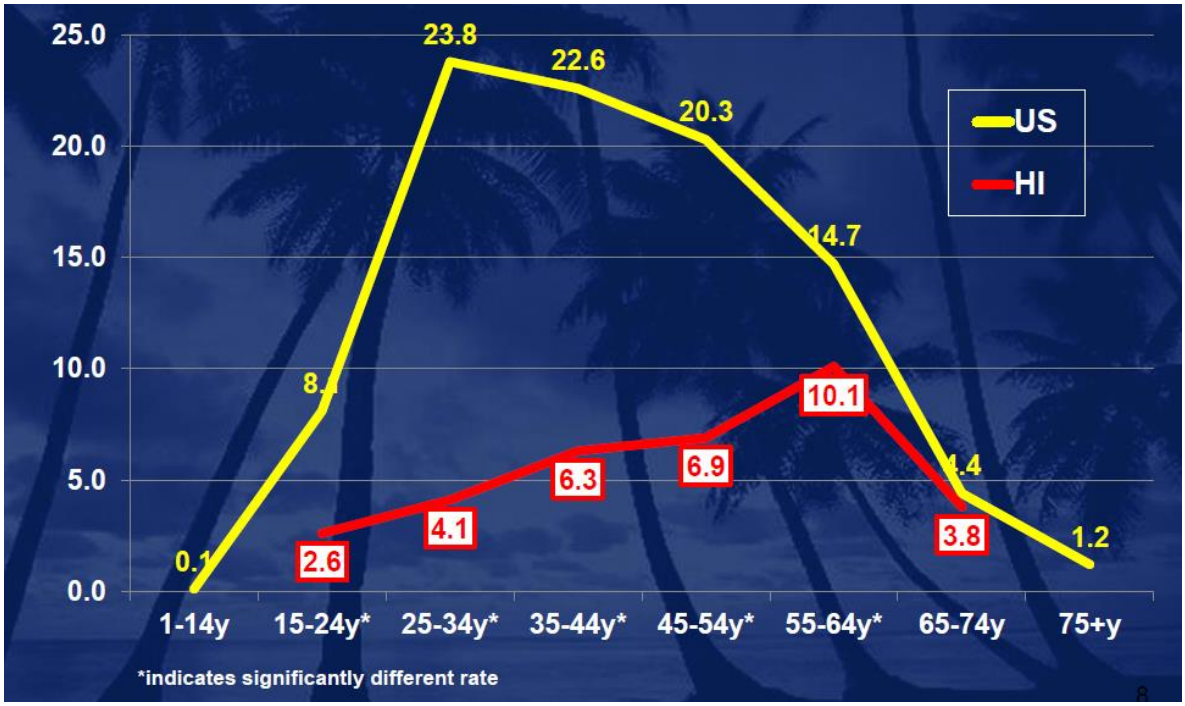
And when compared to other states, Hawaii has the third *lowest* fatality rate of poisonings due to prescription opioids, methadone, heroin and opium (4.1) which is also well below the national rate of 12.4 (Figure 3).

Figure 3. Adjusted opioid poisoning fatality rates (per 100,000), by state, 2014-2018 (includes poisonings due to heroin and opium).



Looking at drug poisoning fatalities by age group averaged from 2014-2018, Hawaii remains well below the national rates for the 15-64 year age brackets, but is only slightly below the national rate for the 65-74 year bracket (3.8 for Hawaii vs. 4.4 nationally) (Figure 4).

Figure 4. Average annual drug poisoning fatality rates (per 100,000) involving opioid pain relievers, by age group, Hawaii vs. US, 2014 2018



When looking at poisoning fatality rates by type of drug, CDC WONDER data show that deaths due to synthetic drugs like fentanyl and tramadol have increased significantly (Figure 5). This picture contrasts with Hawaii death certificate data which show a greater prevalence of fatal opioid poisonings among Hawaii residents due to natural or semi-synthetic opioids like codeine, morphine, oxycodone and hydrocodone (Figure 6).

Figure 5. Adjusted opioid poisoning fatality rates, by type, U.S., 2000-2018.

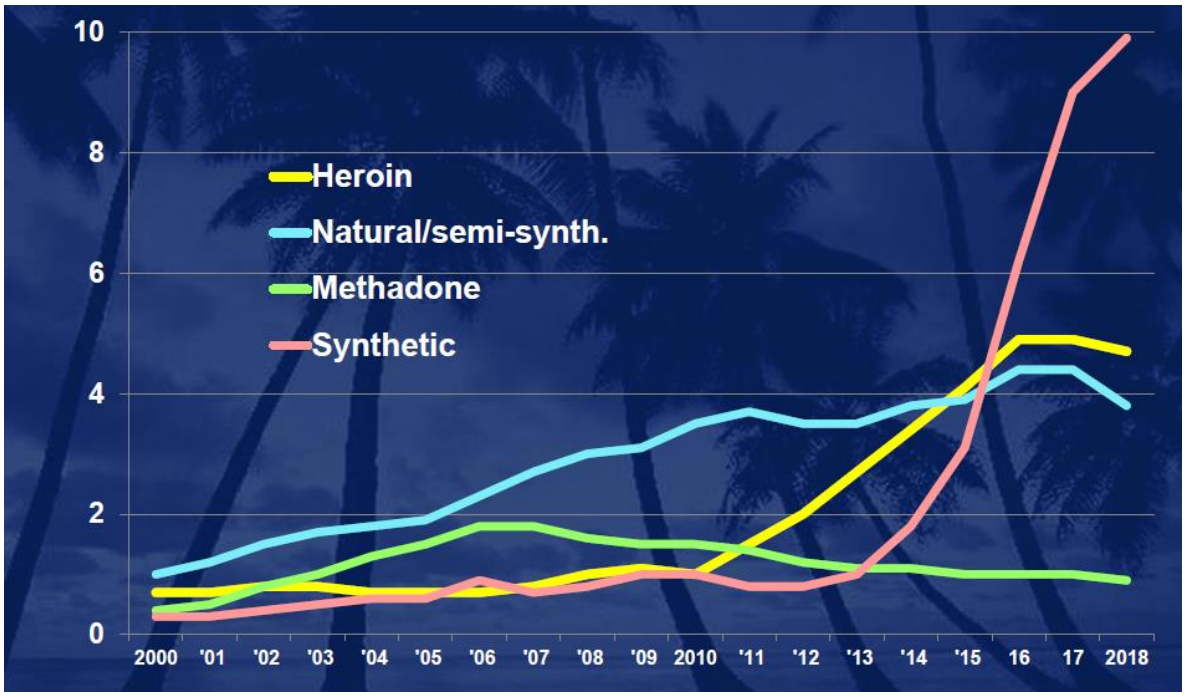
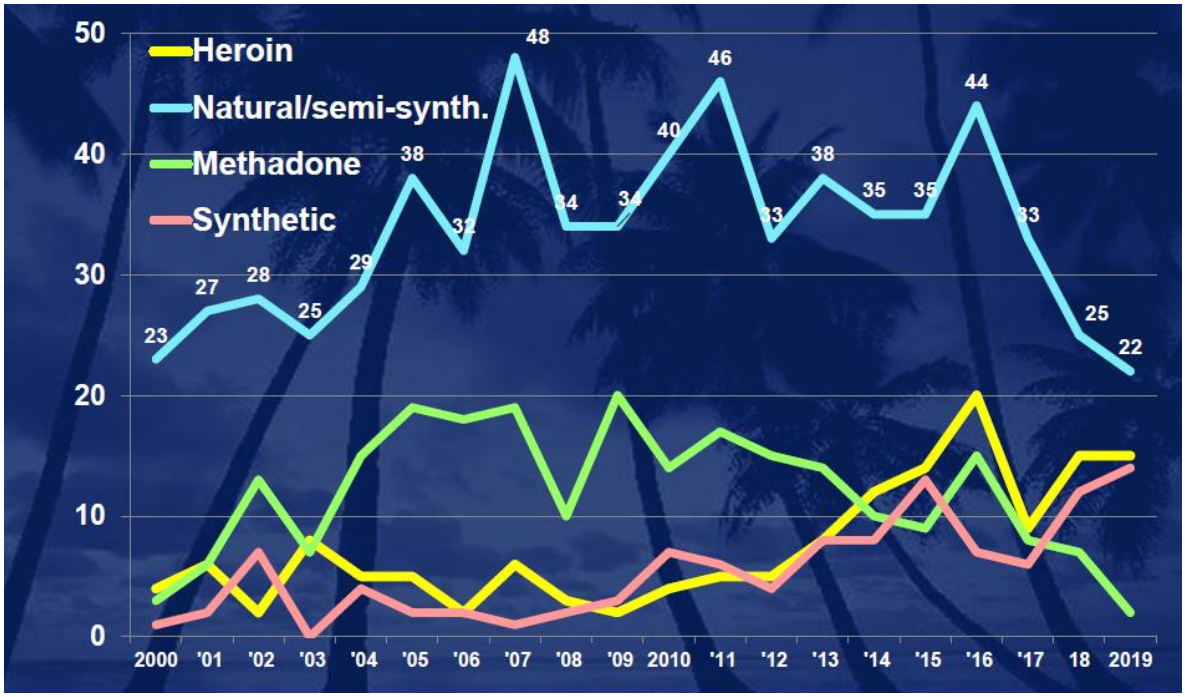


Figure 6. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 2000-2019.



Numbers, Trends, and Patterns: Non-Fatal Opioid-Related Poisonings

Recent data from the EMSIPSB poison center dataset shows that nonfatal non-heroin opioid poisonings remain significantly higher compared to heroin, however total nonfatal opioid poisonings appears to be decreasing (370 in 2019 vs. 432 in 2018) (Figure 7). For the same time period, naloxone administrations have remained steady for each county except Honolulu where fewer EMS patients are receiving naloxone since 2012 (Figure 8).

Figure 7. Annual number of hospital treated nonfatal opioid poisonings among Hawaii residents, by type of opioid, 2012 2019.

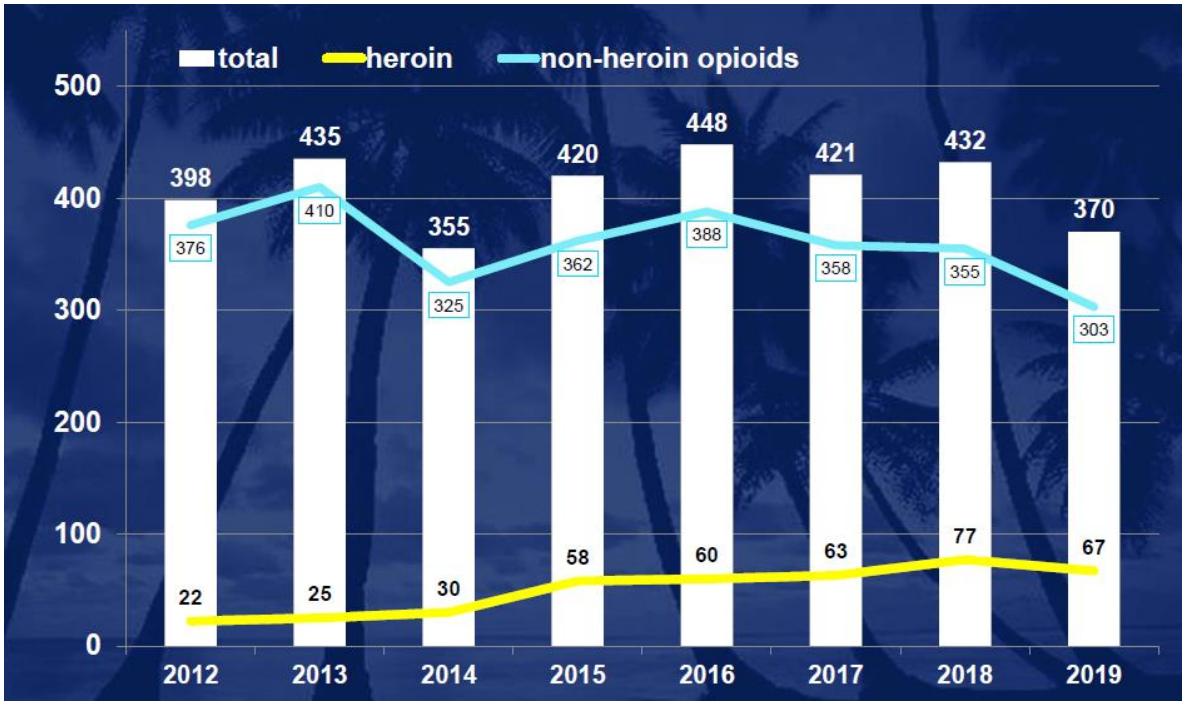
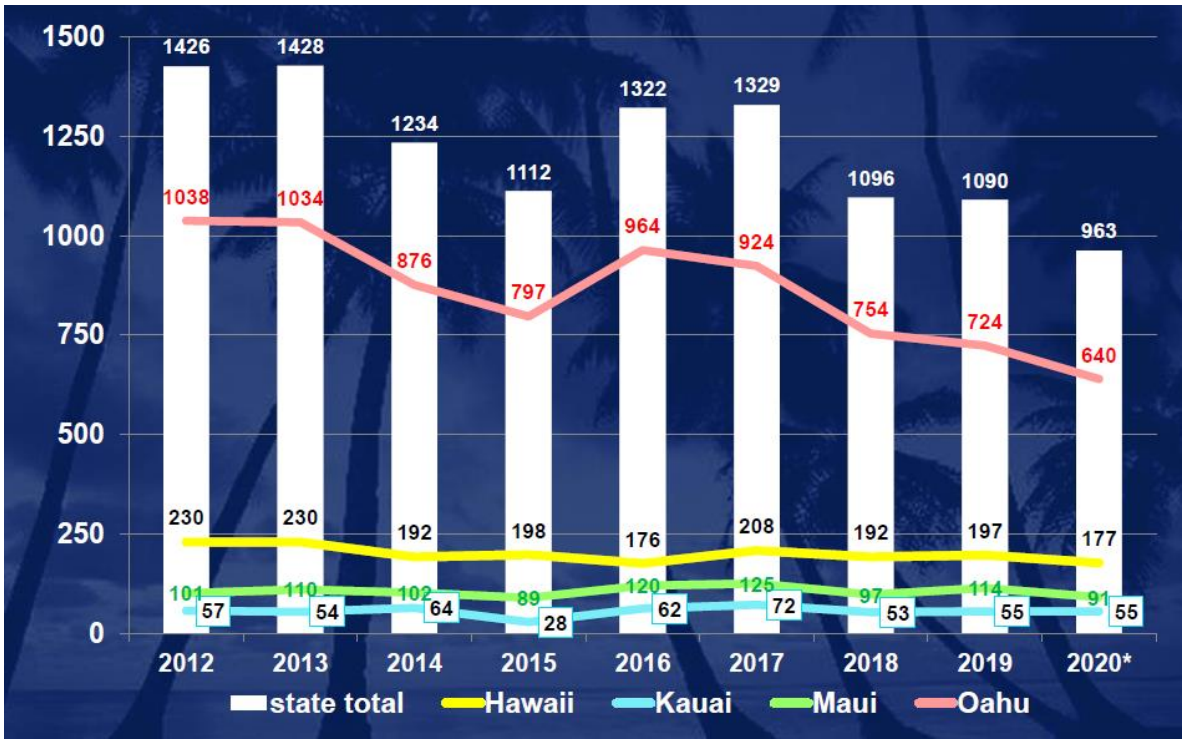


Figure 8. Annual number of EMS patients receiving naloxone, by county, 2012 Sept. 2020.



Recent data from the Prescription Drug Monitoring Program (PDMP) administered by the Department of Public Safety also suggest that a July 2018 law mandating prescriber usage of the PDMP is having positive effects such as the gradual reduction in the number of opioid prescriptions in Hawaii (Figure 9), significant boosts in PDMP prescriber registrations (Figure 10), increased PDMP usage prior to issuing new opioid or benzodiazepine prescriptions (Figure 11), and significant increases in patient usage history checkups among both prescribers and pharmacists (Figure 12).

Figure 9. PDMP data: Quarterly number of dispensed opioid prescriptions in Hawaii, 2015 Sept. 2020.

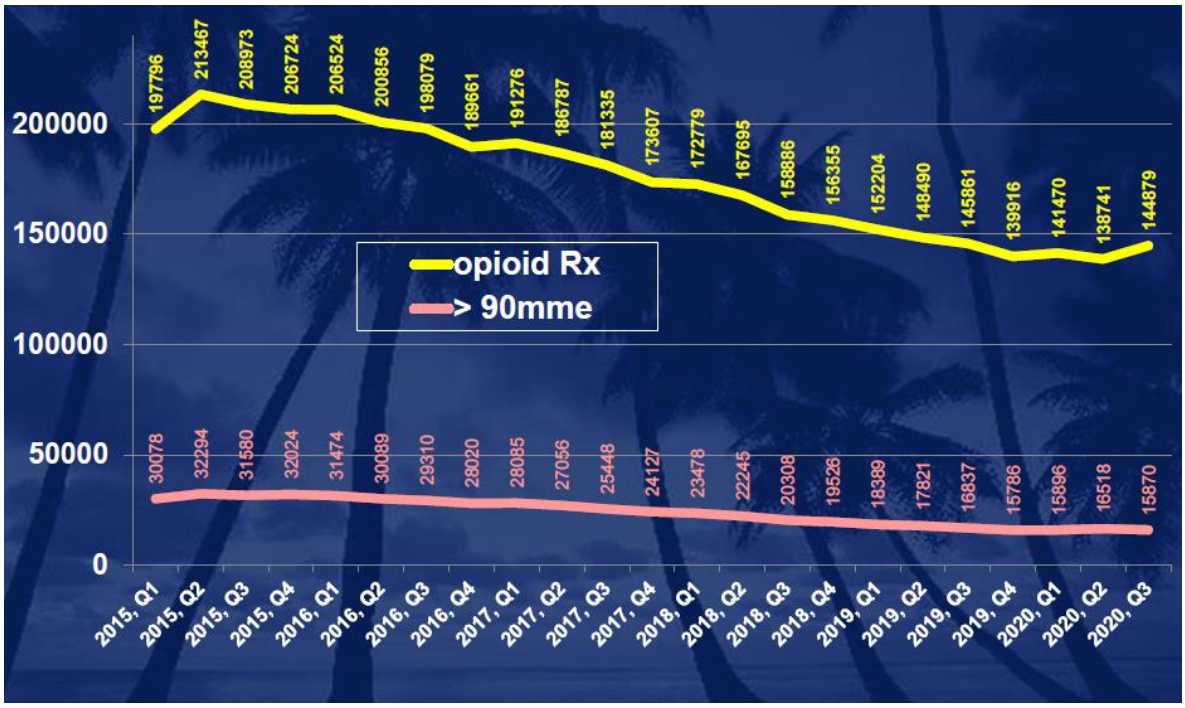


Figure 10. PDMP data: Monthly number of prescribers registered for the Hawaii PDMP, 2017 Sept. 2020.

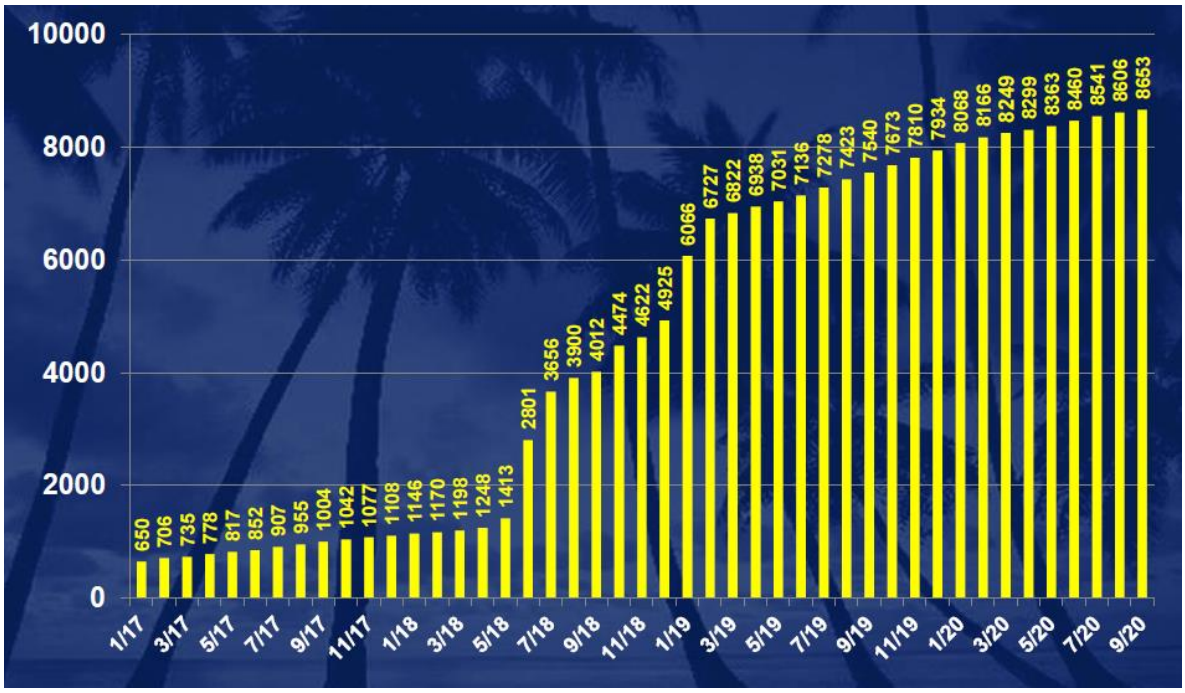


Figure 11. Quarterly number of prescriber PDMP inquiries before new opioid or benzodiazepine prescription is issued, July 2017 Sept. 2020.

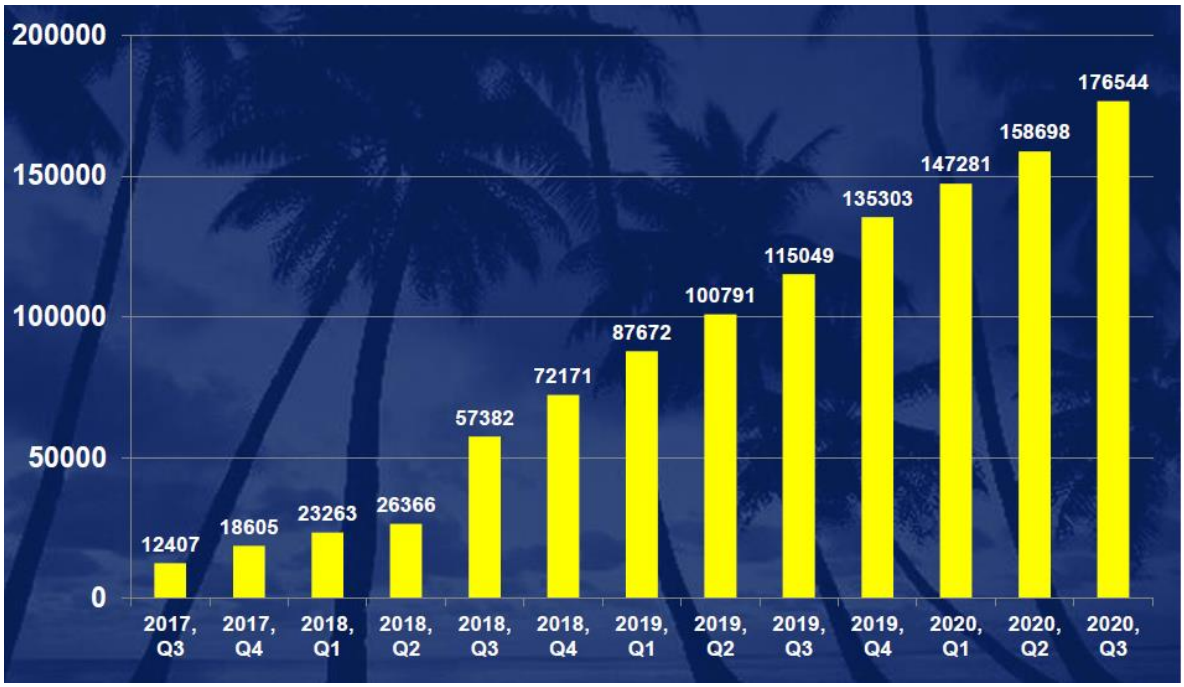
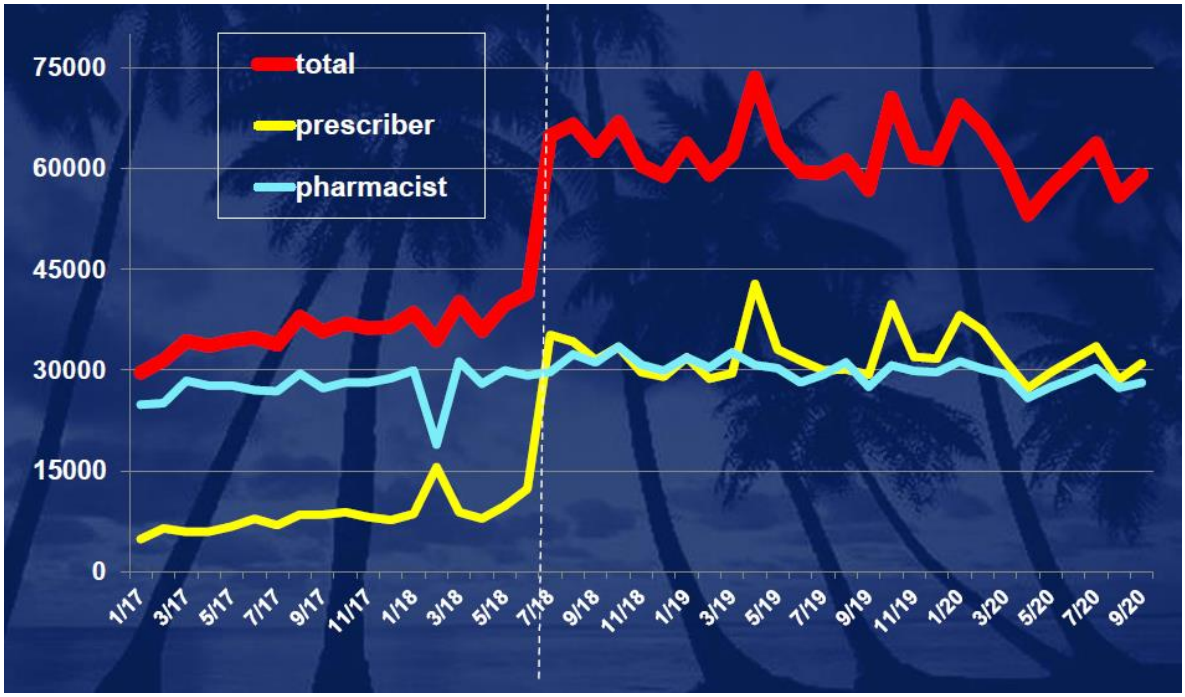


Figure 12. Monthly number of patient searches in the Hawaii PDMP, by provider role, 2017-Sept. 2020 (Evaluation of Act 153(18) requiring prescriber use of PDMP).



Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified in a December 2020 literature review conducted by the Pacific Health Analytics Collaborative include:

Evidence from Outside Hawai‘i

- Opioid dependence (emergency department visits and hospital admissions between 2009 and 2014 show that opioid dependence is linked with a heightened risk of premature mortality, almost 6 times higher than that of the general population);
- Nonfatal opioid overdose experiences (a longitudinal study of Medicaid beneficiaries between 18 and 24 years of age who experienced nonfatal opioid overdose shows that those who survive an opioid overdose are 24 times more likely than others to die the following year from circulatory or respiratory disease, cancer, or suicide);
- Prisoner re-entry (another study found former prisoners were extremely vulnerable to unintentional opioid overdose deaths during post release, with women having a higher risk of opioid-related death compared to men);
- Limited access to behavioral health among Medicaid beneficiaries (Medicaid expansion may be important to promote opioid agonist therapy for those receiving opioid treatment that would otherwise receive only non-medication therapies like counseling or group therapy);
- Comorbid mental illness (Medicaid expansion also plays a significant role in providing other needed behavioral health services for those with mental illnesses and other substance use disorders); and
- Behavioral health impacts due to COVID-19 (2 out of 5 U.S. adults struggled with mental health, substance use, and suicidal ideation during June 2020 possibly due to increased anxiety and reduced access to healthcare due to physical distancing).

Evidence from Hawai‘i

- Relative risk of opioid overdose differs across demographics (Hawaii EMS data shows Native Hawaiians have the highest seven-year fatal and nonfatal rates of opioid poisonings, followed by Caucasians, African Americans, Japanese, Filipinos and Chinese);
- Pre-existing behavioral health conditions (a 2013 needs assessment found that a history of mental illness was associated with 64% of opioid related deaths in 2016, 47% of whom reported symptoms of depression, and 23% other behavioral health symptoms); and
- Access to treatment in rural areas (Census average age-adjusted rates per 100,000 residents of fatal and nonfatal opioid-related poisonings between 2014-2018 were higher in Hawai‘i County and Maui County compared to O‘ahu).

The EMSIPBSB data shows both similarities and slight differences in the epidemiologic profiles of fatal and nonfatal opioid-related poisonings in Hawaii (Figure 13). The main

differences are proportionally more of the nonfatal poisonings were self-inflicted (i.e., suicidal) and 45% of the patients were females (compared to 35% of the victims of fatal poisonings).

Figure 13. Summary: opioid poisonings in Hawaii, 2014 2019.

	Fatal	Nonfatal
Number/year	60 no trend	378 no trend
Intent	83% unintentional, 13% suicide	68% unintentional, 26% suicide
Gender	65% male	55% male
Age	45 to 64 years: 50%	45 to 64 years: 40%
Geography	62% Oahu Maui sig. higher rate	62% Oahu Hawaii sig. higher rate
Type	79% OPR 23% heroin	59% OPR 15% heroin

The following programs and interventions identified in a December 2020 rapid literature review conducted by the Pacific Health Analytics Collaborative were acknowledged by SAMHSA or the CDC to reduce risk of opioid overdoses, including but not limited to:

- Opioid Stewardship and Implementation of Opioid Prescribing Guidelines (a set of 12 recommendations that discuss when to initiate or continue opioids for chronic pain; which opioid to select, the dosage, duration, follow-up, and discontinuation; and how to assess the potential risk/harm of opioid use for the patient, including checking the prescription drug monitoring program or PDMP);
- Risk Reduction Messaging and Prescribing Naloxone (includes educating those with high risk of opioid overdose on potential risk factors, prescribing naloxone for those with history of opioid overdose or substance use disorder or who use benzodiazepines with opioids, and naloxone distribution for treatment centers and criminal justice settings);
- Treating OUD with Medication-Assisted Therapy (approved medications for OUD treatment include methadone, buprenorphine (with or without naloxone), and naltrexone);
- Academic Detailing (a practice that consists of structured visits to healthcare providers that can provide tailored training and assistance to help providers utilize

best practices or evidence-based practices, which has been shown to prompt behavioral change among providers than traditional education resources);

- Random Testing for Fentanyl (fentanyl is an opioid highly associated with overdoses, and random testing of an at-risk population may help to identify people at an unknown increased risk of opioid overdose; pilot studies show that fentanyl test strips may help to decrease illicit opioid and substance use in active drug users, any may decrease opioid-related overdoses due to knowledge of fentanyl contamination);
- 911 Good Samaritan Laws (legislation that provides limited immunity to drug-related criminal charges and other consequences that may result from calling first responders because of an opioid overdose, since not all opioid overdoses are reported); and
- Syringe Services programs (those in a syringe exchange program which are also places to provide naloxone and overdose education may be 5 times more likely to enter drug treatment, and 3.5 times more likely to stop injection drug use).