

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

In reply, please refer to:

December 31, 2021

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 combined Annual Report on the following:

1. Section 321-95, Report on the Implementation of the State Plan for Substance Abuse;
2. Section 329-3, Report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances;
3. 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, Sessions Laws of Hawaii 2004, Requiring a Progress Report on the Substance Abuse Treatment Program
4. Section 329E-6 Requiring a report on Unintentional Opioid-Related 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/departments-of-health-reports-to-2022-legislature/>

Sincerely,

A handwritten signature in dark ink, appearing to read "Elizabeth A. Char", followed by a small flourish.

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

Enclosures

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

**REPORT TO THE  
THIRTIETH LEGISLATURE  
STATE OF HAWAII  
2022**

**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 2021**

## EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2020-21 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 2020-21, \$36,291,947 was appropriated by Act 9, Session Laws of Hawaii (SLH) 2020, to the Alcohol and Drug Abuse program (HTH 440) – \$20,113,424 general funds, \$750,000 special funds and \$15,428,523 federal funds (MOF N and P). Of the total appropriated, \$27,158,498 was allocated for substance abuse treatment services and \$6,694,079 was allocated for substance abuse prevention services. The Act also reduced funds for 2.00 FTE positions totaling \$133,512 as a Legislative Adjustment for personnel savings.

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

\$8.98 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.

\$3 million over four years (9/30/20 – 9/29/24) 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).

\$6.5 million over six years (9/30/16 – 9/29/22) 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. An extension was approved to extend the SBIRT grant service period to September 29, 2022.

\$3.1 million over five years (9/30/17 – 9/29/22) 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. An extension was approved to extend the YT-I grant service period to September 29, 2022.

\$18 million over four years (9/30/18 – 9/29/22) for the SAMHSA/CSAT State Opioid Response (SOR) grants (Hawai'i SOR 1.0 grant project period: 10/1/18-9/30/21 totaling \$10 million and SOR 2.0 Grant project period: 09/30/20-9/29/22 totaling \$8 million) to provide an array of opioid use disorder and stimulant use disorder treatment and recovery support services which 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. An extension was approved to extend the SOR 1.0 grant service period to September 29, 2021.

\$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 system at the local and state level as well as to address the priority issue of alcohol use by minors in high need areas through community anti-drug coalition work and evidence-based programs (EBP).

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:<sup>1</sup>

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,331 adults statewide in Fiscal Year 2020-21;

School- and community-based outpatient substance abuse treatment services were provided to 557 adolescents statewide in Fiscal Year 2020-21; and

Curriculum-based youth substance abuse prevention and parenting programs, underage drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 895,933 children, youth and adults directly and indirectly through individual-based and population-based prevention programs, strategies and activities<sup>2</sup> in Fiscal Year 2020-21.

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.

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

<sup>2</sup> 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 2020-21 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 resources, 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, 2020 to June 30, 2021**

**State and Federal Funding**

Act 9, SLH 2020 appropriated \$36,291,947 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2020-21:

General funds	\$20,113,424	(55.0%)	29.0 FTE
Special funds	750,000	(2.5%)	
Federal funds (N)	8,857,980	(24.4%)	7.5 FTE
Federal funds (P)	<u>6,570,543</u>	<u>(18.1%)</u>	
	\$36,291,947	(100.0%)	29.0 FTE <sup>3</sup>

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	\$27,158,498	(74.8%)
Substance abuse prevention services	6,694,079	(18.5%)
Division operating costs	0	(0%)
Division staffing costs	<u>2,439,370</u>	<u>(6.7%)</u>
	\$36,291,947	(100.0%)

For Fiscal Year 2020-21, \$36,291,947 was appropriated by Act 9, SLH 2020, to the Alcohol and Drug Abuse program (HTH 440) – \$20,113,424 general funds, \$750,000 special funds and \$15,428,523 federal funds (MOF N and P). Of the total appropriated, \$27,158,498 was allocated for substance abuse treatment services and \$6,694,079 was allocated for substance abuse prevention services.

The Act also reduced funds for 2.00 FTE positions totaling \$133,512 as a Legislative Adjustment for personnel savings.

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<sup>3</sup> Position count does not include grant-funded exempt positions for the SAMHSA/CSAT State Opioid Response (SOR 1.0) Grant (2.0 FTE).



## **Federal Grants and Contracts**

**Substance Abuse Prevention and Treatment (SAPT) Block Grant.** ADAD received \$8.98 million in Fiscal Year 2020 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 \$3 million 4-year contract (9/30/20-9/29/24) 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 a second SPF-PFS grant of \$2.0 million in each of five years (9/30/18-9/29/23) to continue the Hawaii Project efforts and 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 plus a one-year extension (project period 09/30/16-09/29/22) 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. A No Cost Extension was approved to extend the SBIRT grant service period to September 29, 2022.

**State Opioid Response (SOR).** The Hawai'i SOR 1.0 grant (project period: 10/1/2018-9/30/2021) totaling \$10 million and SOR 2.0 grant (project period: 09/30/2020-9/29/2022) totaling \$8 million are initiatives 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, and synthetic drugs such as fentanyl. The implementation of SOR 2 funds in September 2020 opened the criteria to include stimulant use disorder (e.g., methamphetamine) treatment, prevention, recovery, and harm reduction activities). 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: 9/30/17-9/29/22) totaling \$3 million is an initiative awarded by SAMHSA’s CSAT. A No Cost Extension, effective September 30, 2021 was approved to extend the YT-I grant service period to September 29, 2022. The extension provides additional time to achieve project goals and complete activities initiated during the four-year grant period. The project has improved 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. Stakeholders across the systems serving the populations of focus collaborated to strengthen the existing coordinated network. The coordinated network enhances and expands SUD treatment services, develops policies, expands workforce capacity, disseminates evidence-based practices (EBPs), and implements financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment and recovery support systems. The YTI grant also helped 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.

**Disaster Response State (DRS) Project.** The Hawaii DRS Project (project period 9/30/20-9/29/21) totaling \$7 million is an initiative awarded by SAMHSA. A No Cost Extension effective September 30, 2021 was approved to extend the DRS grant service period to September 29, 2022. The extension provides additional time to achieve project goals and complete activities initiated during the one-year grant period. The extension gives additional time to conduct outreach, screening, and referral services to those who have the behavioral health signs and symptoms resulting from natural disasters. ADAD has worked with Hawaii CARES to augment its intake, encounter and health and wellness planning procedures and is also working with the Child and Adolescent Mental Health Division (CAMHD) to expand its crisis mobile outreach services to young mental health clients. The project also promoted the availability and coordination of statewide SUD, mental health, crisis support services and Hawaii CARES through television and radio public service announcements (PSAs) that message COVID-related mental health supports and substance use treatment. The project also seeks to develop and infuse professional training along with a resource website for providers, clinicians, and cultural practitioners that provides culturally relevant connection to mental health and substance use disorder support services in response to disaster relief.

**Substance Abuse Prevention and Treatment (SAPT) Block Grant COVID-19.** The SAPT Block Grant COVID-19 supplemental funds (project period 3/15/21-3/14/23) totaling \$8 million. These supplemental funds awarded March 11, 2021 are to assist SAPT grantees in response to the COVID-19 pandemic. The funds will be used to enable workforce supports for peer recovery specialists, addiction medicine fellowships, substance use counselor credentialing for physicians, systematic training on the American Society for Addiction Medicine (ASAM) placement criteria and on warm lines for SUD professionals, the development of a warm line pilot for primary prevention providers, and to expand SUD stabilization bed capacity for pregnant and parenting women with dependent children in rural areas.

**Substance Abuse Prevention and Treatment (SAPT) Block Grant, American Rescue Plan Act of 2021(ARPA).** The SAPT Block Grant ARPA supplemental funds (project period 9/1/21-9/30/25) totaling \$7 million. These supplemental funds awarded May 17, 2021 are to address the effects of the COVID-19 pandemic and improve and enhance the substance use service array that serves the community. The funds will be used to expand peer-based recovery support services and training for peer recovery specialists, advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas, improve health information technology interoperability and a consent registry, workforce supports to increase physicians who wish to obtain the substance use counselor credential, improve primary prevention programs to educate children, adolescents and youth under 21 on cannabis, and to expand SUD stabilization bed capacity combined with medication assisted treatment and withdrawal management services.

**Substance Abuse Prevention and Treatment (SAPT) Block Grant ARPA Mitigation.** The SAPT Block Grant ARPA Mitigation supplemental funds (project period 9/1/21-9/30/25) total \$0.25 million. These supplemental funds awarded August 10, 2021 provide resources and flexibility for states to prevent, prepare for, and respond to the COVID-19 public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system. The funds will be used to conduct substance use professional training on COVID testing and mitigation strategies based on guidance from the Centers for Disease Control and Prevention (CDC), and contract with a mobile testing provider to relieve SUD provider cost burden on the administrative and operating costs of conducting onsite testing services for SUD staff and clients in housing-related programs, for facilities that are rural remote and/or provide outpatient or intensive outpatient services, and for other SUD treatment and primary prevention facilities.

### **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:<sup>4</sup>

**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

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<sup>4</sup> Please see Appendices A through F for details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions.

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-five (35) agencies were contracted to provide Substance Use Disorder Continuum of care Service Array for Adults and Adolescents. 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-eight (48) contracts, seventeen (17) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2021. In efforts to best utilize resources to fund what works, the contracted services implement evidence-based programs, policies, and practices in addition to the Center for Substance Abuse Prevention Strategies: information dissemination; 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. Prevention services under the SPF-PFS project are recorded in the Performance Based Prevention System. 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 2020-21, curriculum-based prevention strategies served a total of 3,087 children and youth and the community-based strategies touched a total of 892,827 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 practices (EBP) 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, their evaluator, and the Evidence-Based Workgroup to increase the effectiveness of the EBP 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 (Hawai'i CARES) is the state's multiple entry-point and coordinating center for substance use disorder (SUD) treatment services (<https://hicare.hawaii.gov/>). Hawai'i CARES provides 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 launched on October 1, 2019 with DOH partner agencies and contracted providers. Crisis services from the Adult Mental Health Division were also added on July 1, 2020. During the COVID pandemic from March 2020 till September 2021 Hawai'i CARES also managed taking calls to conduct screening and intakes for the Department of Health's Isolation and Quarantine sites. Hawai'i CARES has been handling a monthly average of 9,000 calls a month and facilitates a monthly average of over 600+ referrals to and service authorizations for SUD treatment. 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 Hawai'i Opioid website ([www.hawaiiopioid.org](http://www.hawaiiopioid.org)) with maps and directions, there are three (3) sites on Kauai County, eleven (11) sites on Hawaii County, nine (9) sites on Maui County 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.** In March 2021, teams made up of youth volunteers (ages 15-20) and adult observers visited a random sample of 194 stores in which the youth attempted to buy cigarettes to determine how well retailers were complying with state tobacco laws. Only the County of Honolulu was able to be surveyed. Twenty-four stores (12.4%) in the County of Honolulu sold to minors (ages 15-20). These results are not weighted and 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 2020-21, ADAD conducted training programs that accommodated staff development opportunities for 1,653 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through fifty-nine (59) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 17,813 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); trauma informed care, medicated assisted treatment (MAT), MAT waiver training for tribal providers, medical aspects related to drug of abuse, adapting youth services for COVID-19 restrictions, helping with emotional intelligence, Enhanced Prevention Learning series, client centered therapy, opioid overdose prevention and response, cultured of smoking, ice, cannabis use disorder and the opioid crisis , cyber bullying and the law, COVID-19 mental

health and substance abuse, peer recovery specialist training, Hawaii Leadership Academy for Coalitions, native Hawaiian resilience to natural disasters and healing, 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 thirty-four (34) prevention service contracts and sixty-six (66) 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 2020-21, ADAD processed 400 (new and renewal) applications, administered fifty-two (52) computer-based written exams and certified twenty-four (24) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,387.

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 2020-21, ADAD conducted a total of seventeen (17) accreditation site reviews and accredited seventeen (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 2020-21 ADAD received five (5) initial application for the clean and sober registry. ADAD renewed and conducted sixty-two (62) virtual site visits of clean and sober homes statewide, and in “Good Standing” as referred to by HAR Chapter 11-178, with one registration pending DOH review, and one pending renewal inspection. Currently there are no homes that are “Not in Good Standing” pending further review. ADAD has received four (4) complaints that have been resolved.

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.

### **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 2021 Legislative Session that addressed issues affecting the agency included:

**Act 88, SLH 2021 (HB 200 CD1), relating to the state budget.** This measure reduced \$133,512 in general funds for 2.00 positions (119205 Admin Specialist III and 43883 Program Specialist Substance Abuse IV) as a Legislative Adjustment for personnel savings for FY 2022 .

NOTE: In the upcoming 2022 Regular Session ADAD will request to:

- Restore the means of finance of general funds for 2.00 FTE positions 119205 Administrative Specialist III and 43883 Program Specialist Substance Abuse IV; and
- Increase the FTE from .50 to 1.00 in the U.S. Food and Drug Administration (FDA) Tobacco Inspections as approved in the contract



## **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**

<b>KATHI CALLES</b> Corrections - 7/1/2020 - 6/30/2024  <b>DIANA FELTON, M.D.</b> Co-Chair Medical – 6/30/2021 – 6/30/2025  <b>JON FUJII, MBA</b> Joint appointment to HACDACS and State Council on Mental Health – 7/1/2020 – 6/30/2023  <b>ADAM GRATZ, D.O.</b> Pharmacological – 7/1/2021 – 6/30/2024  <b>JODY JOHNSON, CSAC</b> Community and Business Affairs – 6/30/2018 – 6/30/2022	<b>JOHN PAUL MOSES, III, APRN-Rx</b> Medical – 7/1/2019 – 6/20/2023  <b>KUULEI SALZER-VITALE, MSW, MPA</b> Youth Action – 7/1/2020– 6/30/2022  <b>GREG TJAPKES</b> Vice Chair Community and Business Affairs – 7/1/2021 - 6/30/2025  <b>ERIKA VARGAS, LCSW</b> Co-Chair Community and Business Affairs – 6/30/2021– 6/30/2025
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On August 25, 2020 members elected Erika Vargas and Dr. Diana Felton as Co-Chairpersons and Greg Tjapkes as Vice-Chairperson. Meetings were scheduled on the fourth Tuesday of each month.

Priorities discussed during FY 2020-2021:

- 1. Medical Cannabis and the Legalization of Recreational Cannabis**
- 2. ADAD Strategic Plan and Public Health Data**
- 3. Culture as a Basis for Substance Use Treatment and Recovery Programs**
- 4. Hawaii Coordinated Access Resource Entry System (CARES)**
- 5. Peer Specialists for Mental Health and Substance Use Treatment**

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.

### **Medical Cannabis and the Legalization of Recreational Cannabis**

In 2021, HACDACS spent significant time exploring issues related to cannabis in Hawaii including health, legal and economic issues related to medical cannabis, legalization of recreational cannabis, and the development of the American Society of Addiction Medicine (ASAM) Public Policy Statement on Cannabis.

HACDACS committee members were informed on these topics by multiple presentations from local experts including:

- April 2021: Dr. Clifton Otto, Cannabinoid Medical Specialist, Akamai Cannabis Clinic
- May 2021: Dr. William Haning, ASAM President 2021-2023
- July 2021: Tamara Whitney, Hawaii Department of Health Office of Medical Cannabis Control and Regulation
- September 2021: Jared Redulla, Hawaii Department of Public Safety, Narcotics Enforcement Division

## The Medicalization of Medical Cannabis

The access to medical cannabis is essential for the health and well-being of many people in Hawaii. Because of the current format of laws and regulations regarding medical cannabis, many patients and providers experience challenges in accessing these products. Some of the challenges faced by medical cannabis patients and providers include:

- The lack of science-based guidelines for providers and patients regarding the best available strains and dosages for an individual indication.
- Paucity of scientific research related to medical cannabis and specific therapeutic effects, dosages, and adverse effects.
- The discrepancy between federal and state law regarding the legality of medical cannabis which creates potential legal repercussions related to the use of this therapy. Some of these legal issues include risks related to loss of employment, custody problems, loss of federally subsidized housing, problems with interisland transport and the inability to legally possess a firearm.
- The lack of insurance coverage for these medications.
- Minimal oversight of the quality, potency, and safety of individual products due to a lack of FDA inclusion.

One method for addressing some of these barriers involves an overall “medical-ization” of cannabis products and the medical cannabis industry. This would involve the development of science-based usage guidelines for providers and patients, more scientific research on medical cannabis as a therapeutic entity and more comprehensive quality assurance programs for products. This may include the addition of a state regulated process for medical grade manufacturing of medical cannabis products.

As part of the “medical-ization” of cannabis, indications for cannabis used to treat medical or mental health conditions should not be specified by legislatures or public referenda but directed by health specialists and medical research as described in ASAM’s 2021 Public Policy Statement.<sup>5</sup>

In addition to trying to align medical cannabis with current medical therapeutics, efforts need to be made to protect Hawaii’s medical cannabis patients from the legal repercussions of cannabis as a Federal schedule 1 drug. These efforts may be somewhat limited until cannabis is rescheduled at the Federal level, but whatever protections are possible should be implemented.

Recommendations to protect Hawaii’s medical cannabis patients and improve access to high quality therapeutic options are listed below.

***HACDACS recommends*** the scientifically rigorous development of Provider Guidelines for clinicians to help advise patients on therapeutic use of medical cannabis by indication, strain and dosage. This includes designation of medical cannabis indications driven by medical research and medical experts. In addition, all available avenues for increasing research related to medical cannabis should be used to broaden the understanding of therapeutic use, dosage

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<sup>5</sup> [www.asam.org/docs/default-source/public-policy-statements/2020-public-policy-statement-on-cannabis.pdf](http://www.asam.org/docs/default-source/public-policy-statements/2020-public-policy-statement-on-cannabis.pdf)

and adverse effects.

***HACDACS recommends*** pursuing all available options for protecting Hawaii’s medical cannabis patients from legal repercussions related to the federal prohibition and current Federal scheduling of Cannabis as a schedule 1 drug. An advisory group consisting of representatives from involved state and local agencies, the medical community, the medical cannabis industry and community groups may provide added resources and expertise to help solve this difficult problem.

***HACDACS recommends*** establishing a formal system for reporting legal repercussions related to the Federal prohibition on cannabis use.

***HACDACS recommends*** an exploration of feasibility of state regulated process for manufacturing of medical grade cannabis products in Hawaii.

#### Strengthening the Department of Health’s Medical Cannabis Program

Improving the access to and safe use of medical cannabis for Hawaii’s citizens requires continuous efforts and improvement of the Department of Health’s Office of Medical Cannabis Control and Regulation (DOH MedCan). The regulation and administration of the Hawaii medical cannabis program is complex and ever changing. DOH MedCan requires support and tools to effectively maintain the program and help it advance to best support patients and providers.

DOH MedCan does not currently have a formal system of reporting for adverse effects from medical cannabis use. Because of this lack of a reporting system, the prevalence of adverse effects from these medications, including problematic individual products, is lacking. In addition, there is a lack of information related to the number of medical cannabis patients that require treatment for substance use disorders related to their medical cannabis use. Data acquired from a comprehensive reporting system of these adverse effects would be useful for preventing direct harm to patients and directing policy and resource allocation.

In addition, expanded oversight and monitoring of the potency, content and potentially harmful contaminants in medical cannabis products would be beneficial in enhancing patient safety and health. Because the market and manufacturing of these products changes rapidly, more resources need to be dedicated to direct oversight including independent testing of products for potency and contaminants and inspections of manufacturing locations and dispensaries.

In order for DOH MedCan to perform its base functions and add health protective and supportive measures, it is essential that DOH-MedCan’s staff positions remain intact and able to grow.

***HACDACS recommends*** avoiding budget or position cuts for the DOH MedCan Program.

***HACDACS recommends*** the establishment of a formal process for reporting adverse health effects including need for substance use disorder treatment from medical cannabis.

***HACDACS recommends*** expanding the DOH-MedCan’s oversight program including testing of more products and dispensary inspections.

## Considerations and Recommendations Regarding Legalization of Recreational Marijuana

Recreational cannabis legalization will undoubtedly be a legislative consideration this year as the cannabis industry and normalization of the drug continue their rise. Public and youth perceptions of harm from cannabis use are decreasing while cannabis flower and product potencies increase. Public health should continue to be the primary lens through which these issues are viewed with special attention to protecting youth.

There are general concerns about the public health impact of legal recreational cannabis. For example, cannabis continues to be the number one substance for the Department of Health's Alcohol and Drug Abuse Division (ADAD) funded adolescent substance abuse treatment admissions at 64.7%, with alcohol a distant second place at 18.6%.<sup>6</sup> Legalization of recreational cannabis runs counter to ADAD's mission and Department of Health goals for pre-natal health.<sup>7</sup>

Should the Hawaii legislature decide to pursue legalization of recreational cannabis, it is imperative that effective oversight be built into the statute. Similar to medical cannabis, alcohol, and tobacco, this should be done with oversight that minimizes harm, and protects public health and safety. As described in the American Society for Addiction Medicine's 2021 Public Policy Statement on Cannabis<sup>8</sup>, these measures should include:

- Health warnings against cannabis use by persons with a history of mental illness or substance use disorder
- Health warnings against use by persons under age 21
- Health warnings against use by pregnant women
- Limitations on potency given the correlation between cannabis potency and adverse effects, particularly cannabis-induced psychosis
- Warnings about the risk of impaired driving.

One of the driving forces for legalization of cannabis is the potential financial gain from market and tax revenues. The use of cannabis related tax revenues could create financial incentives that run counter to the mission and goals of the Department of Health, ADAD, and the Department of Public Safety. Legislation legalizing recreational cannabis use should clearly define uses for tax revenues that are directed to mitigate and address related harms and expenses.

HACDACS has significant reservations about the potential negative effects of legalization of recreational cannabis. However, if legalization is pursued, the following recommendations may decrease negative public health impacts:

***HACDACS recommends*** that evidence-based prevention programs for youth be increased.

***HACDACS recommends*** mandatory health warnings for packaging, promotional materials, and public health messages.

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<sup>6</sup> <https://health.hawaii.gov/opppd/files/2020/12/2021-ADAD-Leg-Report.pdf>

<sup>7</sup> <https://health.hawaii.gov/opppd/files/2013/04/Hawaii-Department-of-Health-Strategic-Plan-2015-2018-081616.pdf>

<sup>8</sup> <https://www.asam.org/docs/default-source/public-policy-statements/2020-public-policy-statement-on-cannabis.pdf>

**HACDACS recommends** establishing and strengthening THC testing guidelines, labeling and potency limits to minimize adverse effects.

**HACDACS recommends** a substantial proportion of cannabis tax revenue be earmarked to fund prevention and mitigation of cannabis-related harm, substance use disorder prevention and treatment programs, public safety programs to reduce impaired driving and monitor black market activity, and public awareness campaigns about the risks of cannabis use, including cannabis use disorder.

### **Alcohol and Drug Abuse Division (ADAD) Strategic Plan and Public Health Data**

Rethinking public-facing substance use disorder (SUD) data for the Alcohol and Drug Abuse Division (ADAD), Dr. Dev Talagi and Joshua DeCamp of the University of Hawaii’s Pacific Health Analytics Collaborative presented to HACDACS, on January 26, 2021, the public dashboard on the “Hawaii State Plan on Substance Use 2021.” Their research and assembly of a database and a public facing dashboard revolved around the following factors:

- Identifying the number of people requiring treatment who are not receiving it.
- Focusing on special populations (ex. people in the criminal justice system) and those in specific populations such as Native Hawaiians and the LGBTQI Community.
- Creating a data-driven system of care and leveraging reproducible analytical frameworks.

The steps involved in this project were discovery phase, cleaning phase, analysis, and communication. Dr. Talagi demonstrated the features of the Hawai’i Behavioral Health Dashboard (screenshot below). The dashboard displays data from the following sources:

- National Survey on Drug Use and Health,<sup>9</sup>
- Laulima inpatient hospital data from the Healthcare Association of Hawaii,<sup>10</sup>
- Hawai’i CARES call line,<sup>11</sup> and
- Hawaii Prescription Drug Monitoring Program.<sup>12</sup>

The combined data set includes survey data, call data, and some encounter-based inpatient hospital data. Dr. Talagi shared that the current database used by ADAD and substance use treatment practitioners in Hawai’i (Web Infrastructure for Treatment Services (WITS)) is very large, complicated to use and has inherent features that do not lend to easy data analysis. Dr. Talagi’s recommendations for maximizing the quality and utility of data include:

- Standardized data collection whenever possible,
- Creating data that intersects with other data points,
- Minimizing free text data fields that are difficult to analyze, and

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<sup>9</sup> <https://nsduhweb.rti.org/respweb/homepage.cfm>

<sup>10</sup> <https://www.hah.org/>

<sup>11</sup> <https://hicares.hawaii.gov/>

<sup>12</sup> [https://dps.hawaii.gov/wp-content/uploads/2018/08/HAWAII-PDMP-FREQUENTLY-ASKED-QUESTIONS\\_updated-2018-FOR-WEB.pdf](https://dps.hawaii.gov/wp-content/uploads/2018/08/HAWAII-PDMP-FREQUENTLY-ASKED-QUESTIONS_updated-2018-FOR-WEB.pdf)

- The importance of capturing data from as many sources as possible (i.e. the current dashboard does not contain any data from Medicaid).

**Figure 1. Hawai'i Behavioral Health Dashboard Home Page.**



***HACDACS recommends*** ADAD consult with outside stakeholders to gather input on community needs, gaps in services and coverage, and equity disparities. This input should drive future changes and modifications to the SUD dashboards and SUD data in general.

***HACDACS recommends*** increased transparency in how SUD data is acquired, processed, shared, reported, and utilized. Transparency should be increased to promote public trust and improve accountability. Public access to de-identified SUD data sets for research purposes should be encouraged and supported.

***HACDACS recommends*** ADAD look to other state partners' data sources -- for instance the justice system and the Medicaid program -- to enhance the scope, variety and utility of the SUD dashboards.

***HACDACS recommends*** ADAD continue to collaborate directly with the Med-QUEST Division's Medicaid program to design future SUD dashboards around Medicaid encounter data. These two programs share many of the same members, and their data intersections can provide an enhanced view of the impact and overall cost of SUD in our communities.

### **Replacement of the ADAD Electronic Health Records System**

The Hawaii Web Infrastructure for Treatment Services (WITS) system was put into production in 2009, and has served as the member enrollment, provider enrollment, utilization management, prior authorization, claims processing & provider payment system for the DOH-ADAD. Identified deficiencies in the WITS system include an interface that is not user-friendly, restricted data field options for gender identity, poor ability to intake documents and data sets from an external source, difficulty in creating reports using the WITS data, poor ability to transact claims that have a third-party biller, and the inability to strategically share information with other parts of medical and justice system. A WITS replacement system should be considered by ADAD over



the next few years to close these functional gaps and improve functionality.

***HACDACS recommends*** ADAD conduct a complete business process redesign prior to establishing the requirements for the new system. If there are business processes within ADAD that need to be redesigned or reconsidered, these steps should occur early in the process and currently acceptable business processes can be refined and streamlined. The new system should ultimately meet the needs of ADAD, not require ADAD to amend their best practices to fit the new system.

***HACDACS recommends*** stakeholders outside of ADAD should also be consulted to further identify gaps in system functionality. These stakeholders can include providers, members, community partners, and other DOH divisions with the DOH Behavioral Health Administration.

***HACDACS recommends*** the new system's requirements support data sharing between other agency information systems and account for audit controls, data integrity, data standardization, data sensitivity and privacy such as personal health information.

### **Culture as a Basis for Substance Use Treatment and Recovery Programs**

To support individuals in maintaining their sobriety through the recovery process, substance use programs must be intentional. They should be designed to meet the needs of participating individuals as opposed to requiring members mold themselves to conform to what the program makes available. An example of this is Wellbriety,<sup>13</sup> a program that provides these types of services to those belonging to an indigenous community, with the purpose of assisting with sobriety maintenance through a culturally focused model. Wellbriety was developed by Mr. Don Coyhis, a member of the Mohican Nation, because of the lack of indigenous forms of recovery and wellbeing. Mr. Coyhis also founded White Bison in 1988, which is the organization that houses the Wellbriety model of wellness and recovery. Wellbriety encompasses sober lifestyles, wellness (mental, physical, spiritual, and emotional balance), and the reference and application of the concept of a "Healing Forest."

Wellbriety recognizes the wounds caused by the colonization of indigenous people. Instead of using western approaches to wholeness, Wellbriety utilizes perspectives and healing aspects of the indigenous people that were practiced, shared, and passed down from elders and previous generations of that particular community. One of these teachings is the idea of the "Healing Forest", a metaphor that depicts traditional communities of men, women, youth, elders, warriors, and leaders being rooted in healing, language, cultural values, elder's teachings, and overall interconnectedness.

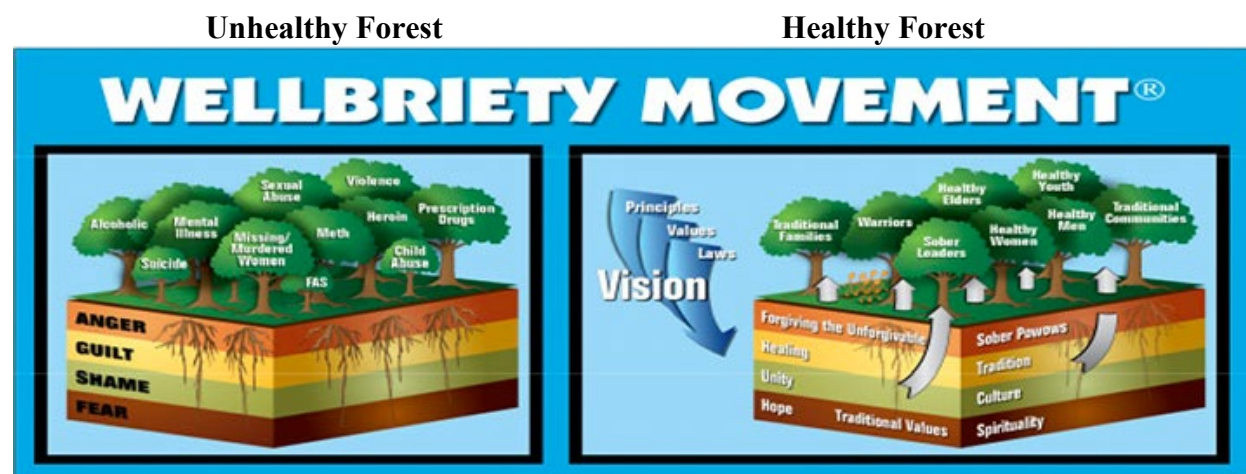
Due to colonization, the forest soil of today is infected by family separation, alcoholism, family violence, drug use, suicides, etc. People are now a part of the legal process and court system, some are in treatment, and others have overdosed. This is a representation of an infection that is spreading and not healing. However, for the forest to thrive and be healthy again, where we are all connected, then the soil must go through the process of healing. Figure 2 shows a conceptual

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<sup>13</sup> <https://wellbriety.com/>

model of this approach by comparing what grows from an unhealthy forest, and the kind of results the Wellbriety Movement aims to produce.

**Figure 2. Wellbriety Movement, Unhealthy and Healthy Forest** <sup>14</sup>



Wellbriety has a variety of culturally significant methods for indigenous wellness, such as the Sacred Hoop of 100 Eagle Feathers. The Sacred Hoop has immense *mana* (divine power) to indigenous people overcoming trauma. The Sacred Hoop was assembled in a sweat lodge after one hundred eagle feathers were gifted from different places across the continent. Elders blessed the Hoop with four gifts: hope, unity, healing, and forgiving the unforgivable. From 1999-2021, the Sacred Hoop has traveled over 25,000 miles to share the message of Wellbriety.<sup>15</sup>

Wellbriety understands the needs of the indigenous communities they serve and has been successful in implementing many initiatives and programs to sustain individuals' recovery.<sup>16</sup> Wellbriety currently provides online meetings, annual conferences, Warrior Down Recovery Coaching, daily meditations, and other indigenous focused programs to enhance wellness.

Identifying and overcoming trauma can play an important role in maintaining recovery. Not all programs acknowledge the wrongful outcomes of colonization and how indigenous methods can help heal trauma. Hope, healing, forgiveness, and unity plays a substantial role in having a successful Wellbriety program.

<sup>14</sup> Moore, D. (2020) The Healing Forest Environmental Prevention Process: Community Effectiveness through Coalition Program Evaluation. <http://wellbriety.com/wellbriety/wp-content/uploads/2019/06/FinalS2SPProgramEvaluationReport-2010.pdf>. Accessed on September 20, 2021.

<sup>15</sup> "Culturally-Based Healing to Indigenous People." whitebison. Accessed September 16, 2021. <http://whitebison.org/>

<sup>16</sup> "Culturally-Based Healing to Indigenous People." whitebison. Accessed September 16, 2021. <http://whitebison.org/>

### Adapting the Healing Forest to Healing ‘Ahupua‘a

Before the introduction of westerners in 1778, indigenous Hawaiians were sustained by an ‘ahupua‘a system that was connected from the peak of a mountain to the base of the sea. The ‘ahupua‘a system was interconnected, if there was an issue in the uplands then the issue could negatively impact everything below. The community shared resources and worked together to maintain wellness in the ‘ahupua‘a. Using the Ahupua‘a system as a metaphor, once colonization contaminated the soils of the upland, it caused similar issues as the sick forest such as family separation, alcoholism, family violence, drug use, suicides. However, once the contaminated soil is removed and replaced with nutrient rich soil, the healing ‘ahupua‘a will flourish. Nutrient rich soil is acknowledging wrongdoings and supporting indigenous methods of recovery, wellness, and prevention.

**Figure 3. ‘Ahupua‘a System.**



The State of Hawaii should acknowledge the trauma of indigenous Hawaiians that was caused by colonization and the illegal overthrow of the Hawaiian Kingdom in 1893. By acknowledging the wrongdoings of the past, the State of Hawaii will have a responsibility to support healing trauma and support indigenous lead efforts to wellness.

***HACDACS recommends*** that the State of Hawaii recognizes that the outcome of colonization and the illegal overthrow of the Hawaiian Kingdom has caused immense trauma that leads to health disparities, poverty, homelessness, and substance misuse of indigenous Hawaiians.

***HACDACS recommends*** that the State of Hawaii provide stronger support of indigenous methods of wellbeing by promoting core integration of one’s culture-driven client health outcomes.

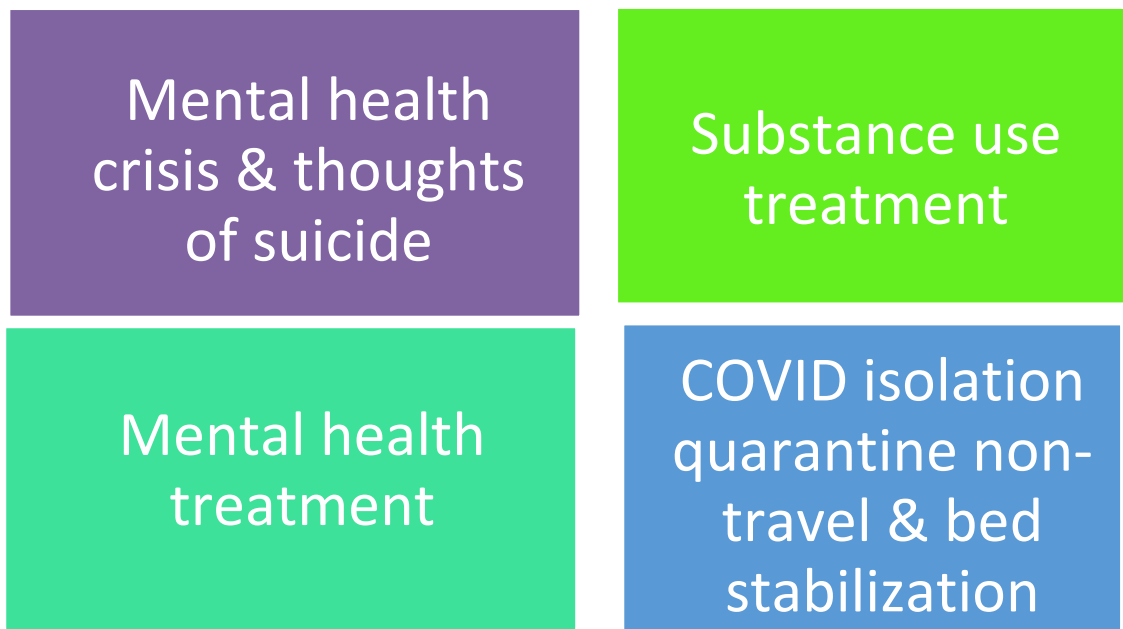
***HACDACS recommends*** that the State of Hawaii establish a Native Hawaiian and Indigenous Advisory Board to ADAD to enhance the role of culture in primary prevention, treatment and recovery programs.

### **Hawai’i Coordinated Access Resource Entry System (CARES) and Substance Use**

On June 22, 2021, Leocadia Conlon, Clinical Director for the Hawai’i Coordinated Access Resource Entry System (CARES) presented her program to HACDACS.

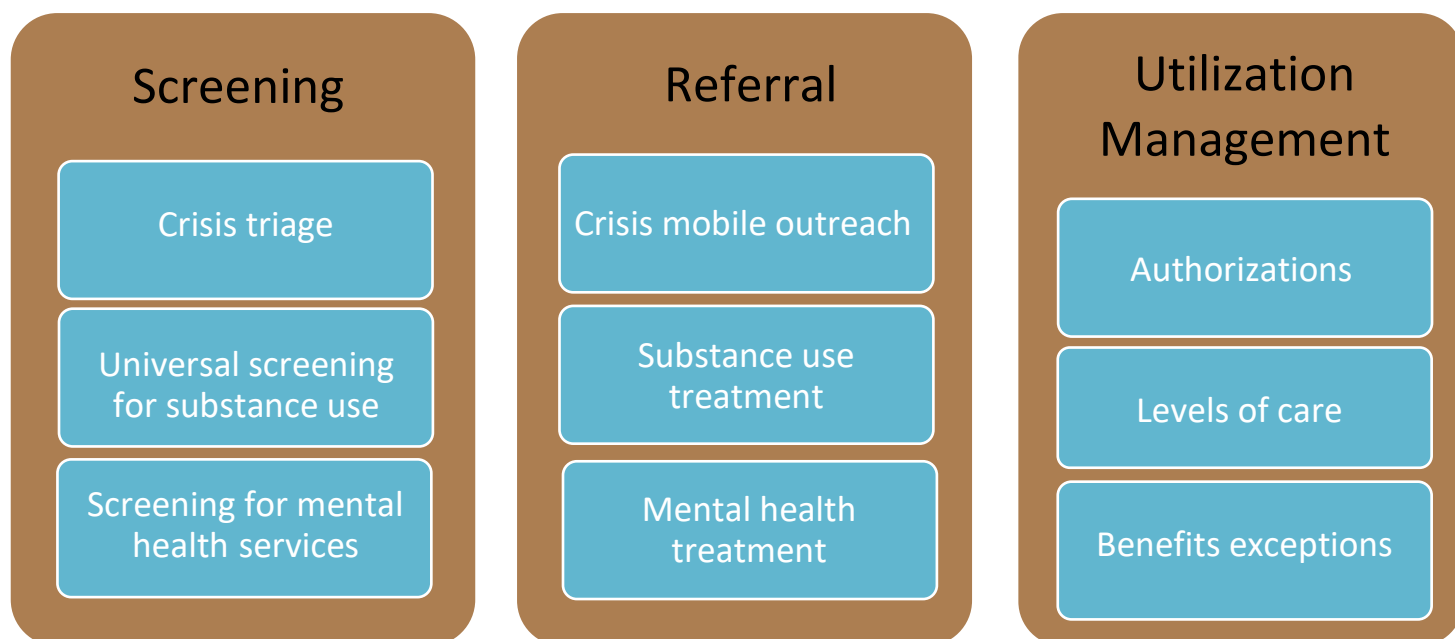
Hawai'i CARES is a 24/7 help line for crisis support, as well as access to treatment, and recovery (Figure 4). It is a collaboration between the Hawaii State Department of Health Behavioral Health Administration (BHA) and the University of Hawai'i (UH). There is also collaboration among BHA, UH, service providers, and key partners in behavioral health, criminal justice, and homelessness sectors.

**Figure 4. Hawai'i CARES Call Routing.**



Hawaii CARES also participates in a network of behavioral health services statewide (Figure 5).

**Figure 5. Hawai'i CARES Behavioral Health Services.**



Hawai'i CARES provides a therapeutic support and de-escalation techniques to active suicidal callers. They also provide resources to community networking agencies to assist with caller's needs.

When Hawai'i CARES was initially established in October 2019, they only received calls for substance use disorders and/or referrals. Over time, they have expanded to multiple services statewide including receiving phone calls from people requiring mental health assistance including suicidal ideation. In the middle of 2020, Hawai'i CARES developed a system for COVID-19 isolation and quarantine matters which has since been transferred to another agency. With the rapid changes and expansion of services, communication among CARES' community partners was stressed. Many stakeholders and community members felt the ever-changing information was not being communicated and their needs were not being met. There has been confusion as to how Hawai'i CARES is providing the services they stated would be provided. If an agency required clarification of the Hawai'i CARES system or processes, the communication lines were very unclear and not readily available.

Although Hawai'i CARES has suffered from poor communication with partners, there is still potential for them to be a great resource for the community.

***HACDACS recommends*** that Hawai'i CARES be more transparent with the community and improve the lines of communication.

***HACDACS recommends*** that Hawai'i CARES improve outreach and feedback methods to users of this program. An External Advisory Committee from different agencies (hospitals, treatment programs, mental health agencies, criminal justice, legal, etc.) will provide

community feedback on the pros and cons of Hawai'i CARES and how the system and services can be improved.

***HACDACS recommends*** that Hawai'i CARES provide continuous quality improvement of each section as well as consumer satisfaction and share this information with their community partners via robust public outreach and regular updates.

### **Peer Specialists for Mental Health and Substance Use Treatment**

On March 23, 2021, Mr. Jacob McPherson, Consumer Affairs Chief for the Department of Health, Adult Mental Health Division (AMHD), presented the Hawaii Certified Peer Specialist Program to HACDACS. Mr. McPherson defined a Certified Peer Specialist as a person who lives with mental illness, has achieved mental stability, and can transfer recovery skills so that others can reach that milestone in their lives as well.

Peer Support Specialists strive to empower individuals to achieve their hopes, dreams, and goals, through connection with their personal recovery journey. A Peer Support Specialist is a person who has walked the path of recovery from mental illness and is employed to assist others in their journeys of recovery.

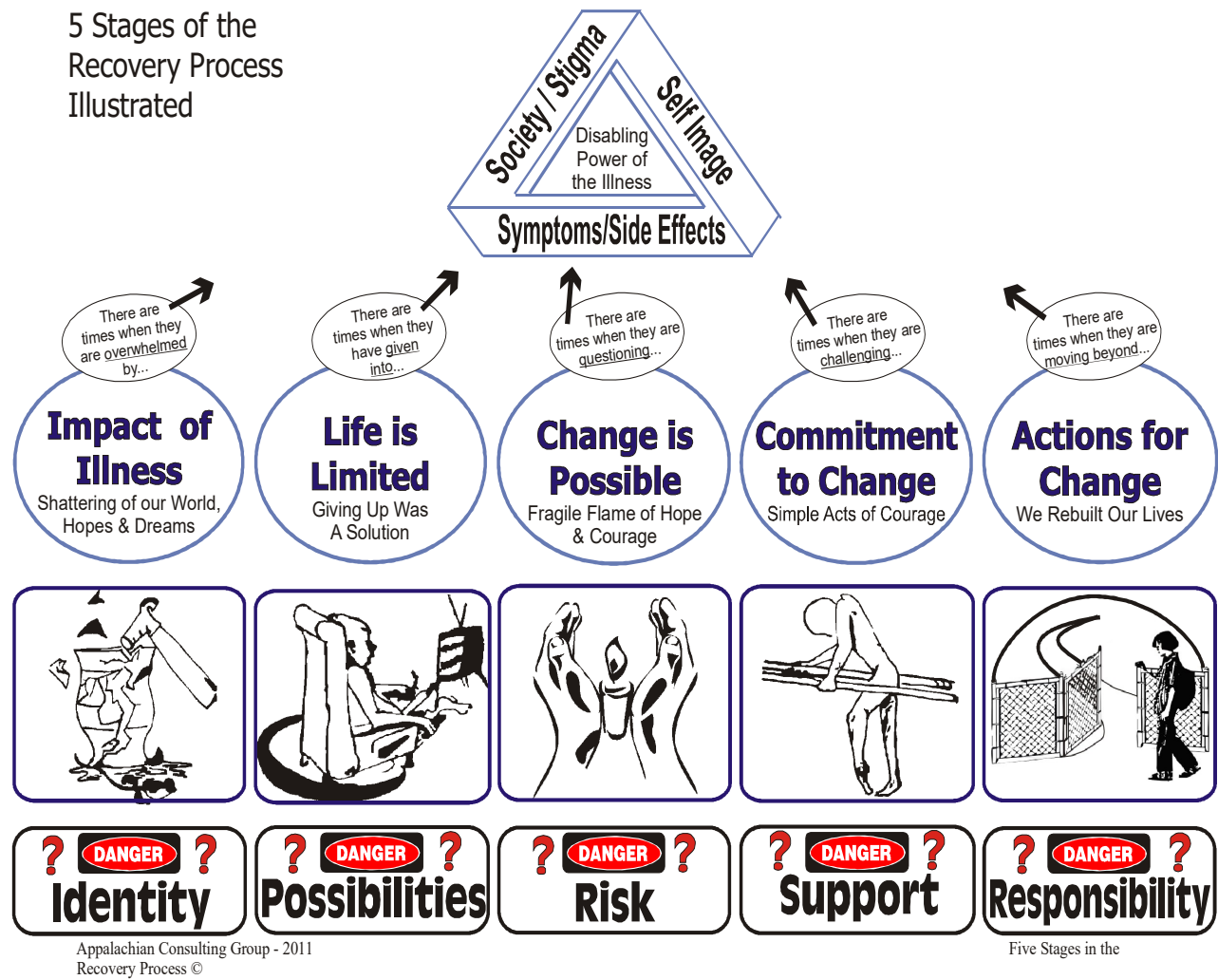
Hawai'i received a grant to hire peer specialists in the early 1990s. Through this grant, they were able to employ peer specialists from 1990-1992; however, these peer specialists were laid off when the grant expired. In 2003, selected staff at DOH's AMHD were trained as Peer Specialists and in 2005, the Department of Health developed a Peer Specialist Training program. In 2006, a class of 30 people were trained as Peer Specialist, but only 18 graduated from the training. In 2012, the Department of Health restarted the Peer Specialist program. Mr. McPherson was trained in 2013 and was hired to oversee the program in 2015. In 2021, AMHD completed 2 rounds of training with around 10 graduates from each training cohort.

It is important to note that throughout the years, there has been a shift in training approaches to include a recovery-oriented aspect in the Peer Specialist training. A recovery-oriented approach emphasizes wellness and strengths, is more client-centered, and takes a holistic view of recovery. Rather than focusing on the deficits, a recovery-oriented approach encourages more social integration and developing support networks that help clients feel more engaged and in the driver's seat of their recovery. See Figure 6 and 7 for more information regarding the current recovery-oriented approach.

**Figure 6. Shift to Recovery-Oriented Approach.**

<i>PRIOR APPROACH</i>	<i>CURRENT RECOVERY-ORIENTED APPROACH</i>
Stabilization and Maintenance	Recovery and Resiliency
Disease/Disability	Wellness/Strengths
What's wrong?	What's strong?
Staff Driven	Client driven
Staff-Client Hierarchy	Staff-Client Partnership
Mental Health	Whole Health
Social Separation	Social Integration
Compliance to a plan	Engagement in a process
Dependence	Interdependence

**Figure 7. Stages in the Recovery Process.**



Recovering from mental illness is full of challenges. As illustrated above, there are 5 stages to the recovery process. First, clients identify the impact that mental illness has had on their world,

hopes, and dreams. Clients often focus on the realization that life is limited and at times it feels like giving up is the only solution. At this point, recovery focus shifts towards finding the possibilities of change and shifting towards a belief that change is possible. From here the flame of hope and courage is lit which illuminates path towards a commitment to change. Through connection to the proper supports, the client is ready to take action steps towards change and accept responsibility for rebuilding their life. Under AMHD's training program, Peer Specialists are trained on the 5 stages of recovery and are given tools for assisting the client through the process. After the training, Peer Specialists are required to complete an internship before they can become fully certified.

As illustrated above, Peer Specialists play a vital role in the consumer's recovery process. Unfortunately, the need for Peer Specialists outnumbers the availability, utilization and employment of Peer Specialists. The lack of Peer Specialists in the field leaves a significant service gap.

***HACDACS recommends*** that the AMHD Certified Peer Specialist Program develop a sustainability plan so that there is a continuity of care with no gaps in services for the consumer.

***HACDACS recommends*** an increase of support for training of peer specialists and to increase the number of peer specialist trainings per year. This would be beneficial to consumers and the community in preventing mental health relapse. Peer Specialists should be a part of consumers' treatment planning.

During the same meeting on March 23, 2021, Ms. Angela Bolan, Manager of Quality Assurance and Improvement (QAI) Office Certification Board from the Alcohol and Drug Abuse Division (ADAD), presented to the HACDAC members on the certification process of Peer Recovery Support Specialists. Ms. Bolan provided HACDAC members information on an International Certification and Reciprocity Consortium (IC&RC) Peer Recovery Credential Standards. The standards consist of four domains: Advocacy, Ethical Responsibility; Mentoring and Education, and Recovery/Wellness Support. Ms. Bolan reported ADAD was implementing this new certification for Peer Recovery Support and is in the process of finalizing training requirements.

In substance use, a peer support model has been in practice for many years dating back to 1935 when Alcoholics Anonymous (AA) was created in Akron, Ohio. Later in 1953, Narcotics Anonymous (NA) was created in Los Angeles, California. One of the cornerstones of AA and NA is working through the 12 steps with a Sponsor who has many years of sobriety. The Sponsor assists participants in their journey of recovery and self-actualization. While a Sponsor and a Peer Recovery Support Specialist may have similar functions, Ms. Bolan stated that there is a difference between a non-certified Peer and an IC&RC Certified Peer. Mainly, an IC&RC certified Peer Recovery Support is equipped with expertise via a scope of practice and core competencies. They are also bound by ethical guidelines which protect the Peer, the individual, and the public.

IC&RC Certified Peers are required to:

1. Participate in peer specific training in the competency areas of:



- a. Advocacy
  - b. Recovery and Wellness
  - c. Mentoring and Education
  - d. Ethical Responsibility
2. Apply for certification through a formal application process
3. Sign and adhere to a peer-specific code of ethics
4. Take and pass the IC&RC Peer Recovery examination
5. Pursue continuing education credits to stay current on emerging trends and best practices.

On July 26-30, 2021 ADAD conducted a training with the first cohort of Peer Recovery Support Specialists. This training introduced the Peer Recovery Support Model of Mentoring, Professional Responsibility, Recovery Support, and Advocacy. All participants received 40 hours of continuing education for this training.

While HACDACS recognizes the importance and vital role that a trained peer plays in someone's recovery from mental health and substance use, the development of two separate training programs raises some questions. While many evidence-based practices (i.e., Integrated Dual Disorder Treatment, Assertive Community Treatment, and many others) are moving towards a more integrated treatment approach, the two training tracks seems to be moving in a more siloed direction. Clients with co-occurring disorders account for greater than twenty-five percent (25%) of those seeking treatment from Hawaii's substance use treatment facilities. Should Peer Specialists be trained in both mental health and substance use? Will those who are certified through AMHD have reciprocity with ADAD's certification and vice versa? How can we get more qualified peer specialists working in the field? What kind of support will be provided to agencies as these peer specialists seek internships and employment?

There are specific communities with high rates of mental illness that may be particularly amenable to Peer Recovery Specialists. These communities often include people who feel disconnected and marginalized, and receiving support from a PEER Specialist is likely to enhance their recovery. One example is the community of veterans with mental health concerns, but the Department of Veterans Affairs (VA) and the peer support communities are not connected. A fellow veteran peer support specialist would be able to use their disability and shared experiences in the military as a source of strength for their clients. Another example is adolescents. During the high school years, peers play a very important role in determining a teenager's success or termination in treatment. Bridging this gap by providing the teenager a peer mentor to walk beside him/her through their recovery is likely to increase their success with recovery.

***HACDACS recommends*** that ADAD integrate Peer Recovery Specialists into the substance use program and incorporate peer recovery as part of treatment plans. This includes increasing the number of trained Peer Recovery Specialists and providing consistent support for the program.

***HACDACS recommends*** that broader training methods be developed for increasing peer specialists for specific groups, such as forensics, veterans, college students, teenagers, etc.

***HACDACS recommends*** increasing the availability of peer specialists where there are gaps in peer support options and incorporating broader training methods for increasing peer specialists for specific groups, such as forensics, veterans, college students, teenagers, etc.

**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 2020-21, 892 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 1,132 offenders who received services, 240 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2020-21 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, 2020 – June 30, 2021**

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu	53	711	5	154	923
Maui	36	54	23	8	121
Hawaii	9	74	0	5	88
<b>Total</b>	<b>98</b>	<b>839</b>	<b>28</b>	<b>167</b>	<b>1,132</b>
Case management services providers: CARE Hawaii, Malama Family Recovery Center, Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka					

**Table 2. Referrals by Criminal Justice Agency: July 1, 2020 – June 30, 2021**

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu <sup>1</sup>	48	572	5	113	738
Maui <sup>2</sup>	22	45	22	4	93
Hawaii <sup>3</sup>	7	49		5	61
<b>Total</b>	<b>77</b>	<b>666</b>	<b>27</b>	<b>122</b>	<b>892</b>
Case management services providers: CARE Hawaii, Malama Family Recovery Center, Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka					

**Table 3. Carryover Cases 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	5	139	0	41	185
Maui	14	9	1	4	28
Hawaii	2	25			27
<b>Total</b>	<b>21</b>	<b>173</b>	<b>1</b>	<b>45</b>	<b>240</b>
Case management services providers: CARE Hawaii, Malama Family Recovery Center, Salvation Army, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka					

*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) 2019 Recidivism Update (dated March 2021) for the Fiscal Year 2016 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 54.6% recidivism rate for probationers; a 50.1% recidivism rate for offenders released to parole; and a 57.1% recidivism rate for offenders released from prison (maximum-term release).

The 53.8% recidivism rate for FY 2016 probationers and parolees was higher than the previous year's rate of 61.7%. The FY 2016 recidivism rate is 19.1% 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 2016 cohort had a 54.6% recidivism rate, which is 10.1 percentage points higher than the recidivism rate for the previous year's cohort and indicates a 0.9% increase in recidivism since the baseline year. Parolees in the FY 2016 cohort had a 50.1%

recidivism rate, which is 0.2 percentage points lower than the previous year's rate and signifies a 22.8% decline in recidivism from the baseline year, which has not met the goal of reducing recidivism in Hawaii by 30%. The recidivism rate for maximum term released prisoners decreased from 76.1% for the FY 2005 cohort to 57.1% for the FY 2016 cohort. The recidivism rate for FY 2016 is 57.1% (6.9 percentage points) lower than the FY 2015 rate. Additionally, probationers had the highest recidivism rates in the entire FY 2016 offender cohort for criminal reconvictions (38.4%), while maximum term released prisoners had the highest recidivism rate in the entire FY 2016 offender cohort for criminal rearrests (43.8%).

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, 2020 – June 30, 2021**

	<b>Supervised Release PSD/ISC</b>	<b>Judiciary Adult Client Services</b>	<b>PSD/ISC - Corrections Jail/Prison</b>	<b>Hawaii Paroling Authority</b>	<b>Total</b>
<b>Arrests/revocations</b>	19	112	15	6	152
<b>Total served</b>	80	207	60	226	573
<b>Recidivism rate</b>	23.75%	54.11%	25%	2.65%	26.53%

**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 2018-21**
- B. ADAD-Funded Adolescent Services: Fiscal Years 2018-21**
- C. Performance Outcomes: Fiscal Years 2018-21**
- 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: 2011-21**



## APPENDIX A

### ADAD-FUNDED ADULT SERVICES FISCAL YEARS 2018-2021

#### ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Male	66.5%	67.5%	63.4%	67.3%
Female	33.5%	32.4%	36.6%	32.7%
TOTAL	100.0%	100.0%	100.0%	100.0%

#### ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
Hawaiian	44.5%	44.4%	48.9%	48.0%
Caucasian	20.9%	21.3%	21.6%	20.6%
Filipino	7.9%	6.9%	5.4%	7.0%
Mixed - Not Hawaiian	2.1%	4.2%	4.8%	5.4%
Japanese	5.0%	3.2%	3.0%	2.8%
Black	3.2%	2.3%	1.0%	1.4%
Samoan	2.1%	3.1%	2.0%	2.2%
Portuguese	1.5%	1.5%	1.7%	1.5%
Other Pacific Islander	3.9%	3.9%	3.5%	4.6%
Other*	9.0%	9.3%	8.0%	6.5%
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 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
Methamphetamine	54.7%	60.6%	60.3%	60.6%
Alcohol	16.8%	16.1%	14.5%	12.1%
Marijuana	10.9%	9.1%	8.9%	10.6%
Cocaine/Crack	3.3%	1.9%	2.6%	1.6%
Heroin	7.4%	6.9%	7.9%	10.0%
Other*	6.9%	5.4%	5.7%	5.1%
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 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
O'ahu	64.7%	57.8%	46.6%	53.7%
Hawaii	17.5%	27.2%	35.3%	27.0%
Maui	11.2%	8.0%	8.2%	10.8%
Molokai/Lanai	1.7%	1.4%	2.3%	1.2%
Kauai	2.9%	2.4%	3.6%	3.1%
Out of State	2.0%	3.2%	4.0%	4.2%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2017-18 through Fiscal Year 2020-21, methamphetamine use increased slightly from 60.3% to 60.6%. Alcohol use decreased from 14.5% to 12.1%, and marijuana use increased from 8.9% to 10.6%. Cocaine/Crack use decreased from 2.6% to 1.6%. Heroin use increased from 7.9% to 10% while all “Other” substances decreased slightly from 5.7% to 5.1%.

Also, among the 2,331 adult admissions for FY2021, 703 admissions (30.2%) were homeless when admitted to treatment.

## APPENDIX B

### ADAD-FUNDED ADOLESCENT<sup>17</sup> SERVICES FISCAL YEARS 2018-2021

#### ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Male	51.4%	48.7%	47.7%	55.5%
Female	48.6%	51.3%	52.6%	44.5%
TOTAL	100.0%	100.0%	100.0%	100.0%

#### ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
Hawaiian	44.7%	48.1%	48.0%	45.6%
Caucasian	7.8%	7.6%	7.1%	8.1%
Filipino	10.7%	9.3%	9.1%	5.6%
Mixed - Not Hawaiian	3.6%	2.7%	5.7%	5.4%
Japanese	4.4%	3.3%	3.1%	1.8%
Black	2.1%	2.1%	1.7%	1.4%
Samoan	4.0%	4.6%	4.2%	4.7%
Portuguese	0.9%	0.8%	0.8%	-0-
Other Pacific Islander	15.2%	13.9%	15.1%	24.2%
Other*	6.5%	7.6%	5.2%	3.2%
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 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
Methamphetamine	1.0%	0.6%	0.8%	1.8%
Alcohol	22.2%	18.3%	18.6%	17.1%
Marijuana	61.6%	64.4%	64.7%	71.1%
Cocaine/Crack	0.3%	0.7%	-0-	0.2%
Heroin	-0-	0.1%	0	-0-
Other	15.0%	16.0%	15.3%	9.9%
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 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
O'ahu	66.4%	66.9%	71.8%	84.4%
Hawaii	13.6%	18.0%	12.6%	2.9%
Maui	11.5%	9.3%	10.3%	12.2%
Molokai/Lanai	0.1%	-0-	0.6%-	-0-
Kauai	8.4%	5.7%	4.7%	0.5%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2017-18 through Fiscal Year 2020-21, methamphetamine use increased slightly from 0.8% to 1.8%. Alcohol use decreased from 18.6% to 17.1%, while marijuana used increased from 64.7% to 71.1%. Cocaine/Crack use decreased slightly from 0.5% to 0.2%. Heroin use remained steady at 0%, while use of “Other” substances decreased from 15.3% to 9.9%.

<sup>17</sup> 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, 2017 and 2019 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 2018 through 2021, 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 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Employment/School/Vocational Training	98.8%	98.3%	97.7%	98.6%
No arrests since discharge	93.4%	94.1%	94.3%	98.0%
No substance use in 30 days prior to follow-up	59.4%	56.7%	51.8%	47.1%
No new substance abuse treatment	85.5%	75.8%	80.5%	89.2%
No hospitalizations	95.5%	95.4%	94.8%	96.3%
No emergency room visits	92.1%	92.6%	92.1%	94.2%
No psychological distress since discharge	78.9%	76.3%	81.1%	79.7%
Stable living arrangements*	99.0%	97.1%	97.9%	96.9%

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

### PERFORMANCE OUTCOMES ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2018 through 2021, 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 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Employment/School/Vocational Training	58.2%	63.4%	61.9%	51.6%
No arrests since discharge	92.7%	90.1%	94.0%	96.5%
No substance use in 30 days prior to follow-up	56.6%	67.4%	72.5%	61.9%
No new substance abuse treatment	55.0%	63.6%	72.2%	69.1%
No hospitalizations	91.0%	91.9%	93.0%	94.8%
No emergency room visits	85.6%	88.1%	90.6%	90.2%
Participated in self-help group (NA, AA, etc.)	36.0%	40.3%	31.8%	27.4%
No psychological distress since discharge	63.7%	78.0%	81.1%	75.1%
Stable living arrangements*	76.1%	83.1%	77.3%	73.6%

*\*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)<sup>1</sup> revealed that of the state's total 1,119,159 population over the age of 18, a total of 76,100<sup>2</sup> (6.80%) individuals were needing<sup>3</sup> but not receiving treatment for substance use<sup>4</sup> 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 2017 to Fiscal Year 2021) average annual ADAD-funded admissions for adults is 2,914, which is 3.6% of the estimated need for adult alcohol and drug abuse treatment.

<sup>1</sup> 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>.

<sup>2</sup> 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.

<sup>3</sup> 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). <sup>4</sup>Needing 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.**

## Needing but Not Receiving Substance Use Treatment in the State of Hawai'i, 2016-2018

Needing But Not Receiving Substance Use Treatment is defined as needing illicit drug or alcohol treatment, but did not receive illicit drug or alcohol treatment at a specialty facility

### State Breakdown of Needing but Not Receiving Substance Use Treatment

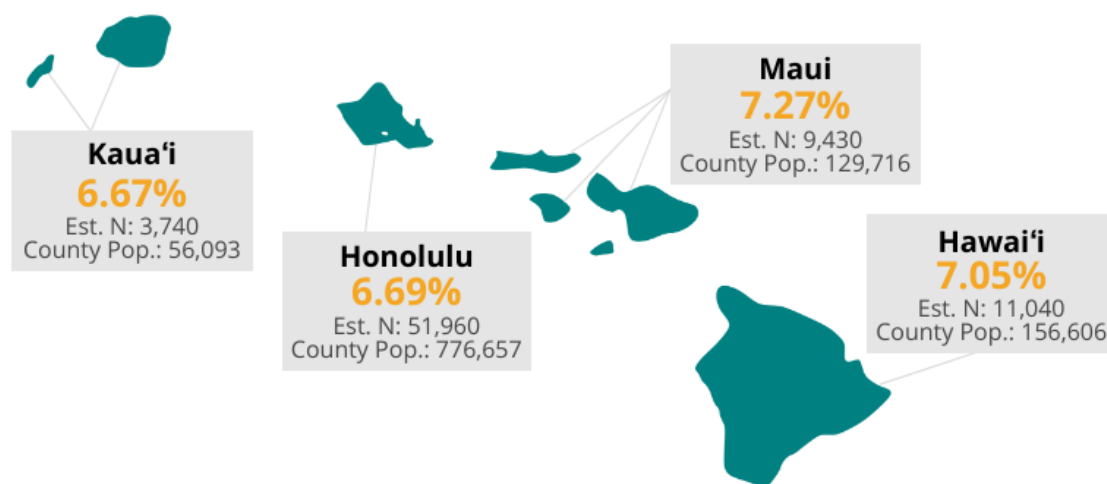
Out of individuals aged 18 years and older in the State of Hawai'i, within the last 12 months, approximately:



\*Sub-categories of substance use but are not mutually exclusive as individuals could have used more than one type of substance.

Percent of State Population

### County Breakdown of Needing but Not Receiving Substance Use Treatment



Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018 Substate Region Estimates. County 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). Populations averages were rounded to the nearest whole number. County estimated numbers were rounded to the nearest tenth. Needing substance use treatment is defined as meeting criteria for an illicit drug or alcohol use disorder as defined in the DSM-IV or received treatment for illicit drug or alcohol use 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. Specialty facilities include facilities such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center.

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)<sup>1</sup> revealed that of the state's total 1,119,159 population over the age of 18, a total of 82,150<sup>2</sup> (7.34%) individuals had substance use disorder<sup>3</sup> 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.

<sup>1</sup> 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>.

<sup>2</sup> 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.

<sup>3</sup> 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.

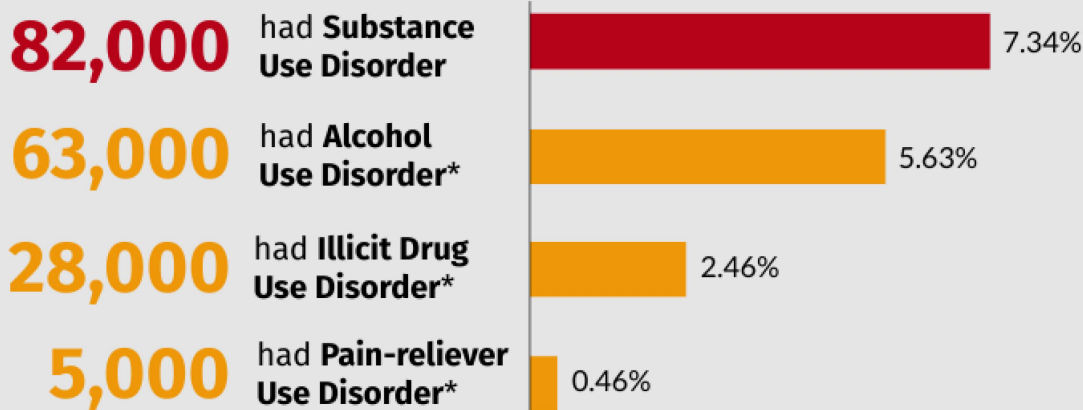
**Figure D2: Substance Use Disorders in the State of Hawai‘i, 2016 – 2018.**

## Substance Use Disorder in the State of Hawai‘i, 2016 - 2018

Substance Use Disorder (SUD) is defined as meeting criteria for illicit drug or alcohol dependence or abuse

### State Breakdown of Substance Use Disorder

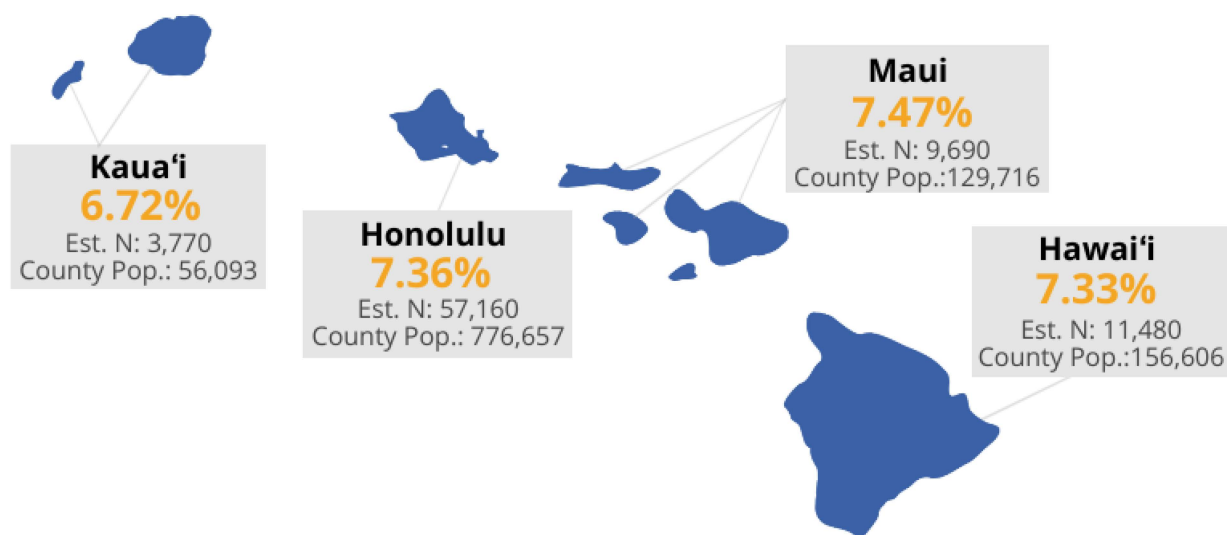
Out of individuals 18 years and older in the State of Hawai‘i, within the last 12 months approximately:



\*Sub-categories of SUD but not mutually exclusive as individuals could have use disorders for more than one substance

Percent of State Population

### County Breakdown of Substance Use Disorder



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018. 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. County estimations were calculated using the average county population for the years 2016-2018 from the U.S. Census Bureau, Population Division (Release Date: June 2020). County estimations were rounded to the nearest whole number.



## APPENDIX E

### 2019-2020 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 <sup>1</sup> , for Gender, Grade Level, and Race/Ethnicity (weighted counts and percents)					
	No		Yes		Total
	n	% (CI95%)	n	% (CI95%)	
<b>Overall Total</b>	7,172	88.9 (88.2, 89.6)	896	11.1 (10.4, 11.8)	8,068
<b>Gender</b>					
Male	3,902	91.2 (90.4, 92.0)	377	8.8 (8.0, 9.6)	4,279
Female	3,116	86.9 (85.8, 88.0)	471	13.1 (12.0, 14.2)	3,587
Transgender & Other Gender Minority	133	75.6 (69.3, 81.9)	43	24.4 (18.1, 30.7)	176
<b>Grade</b>					
8th Grade	2,527	93.4 (92.5, 94.3)	179	6.6 (5.7, 7.5)	2,706
10th Grade	2,531	88.0 (86.8, 89.2)	346	12.0 (10.8, 13.2)	2,877
12th Grade	2,113	85.0 (83.6, 86.4)	373	15.0 (13.6, 16.4)	2,486
<b>Self-Identified<sup>19</sup> Primary Race/Ethnicity</b>					
Native Hawaiian	671	84.8 (82.3, 87.3)	120	15.2 (12.7, 17.7)	791
Other Pacific Islander	372	80.3 (76.7, 83.9)	91	19.7 (16.1, 23.3)	463
Japanese	681	94.1 (92.4, 95.8)	43	5.9 (4.2, 7.6)	724
Filipino	1,261	92.4 (91.0, 93.8)	103	7.6 (6.2, 9.0)	1,364
Other Asian	316	95.2 (92.9, 97.5)	16	4.8 (2.5, 7.1)	332
Hispanic/Latino	197	83.8 (79.1, 88.5)	38	16.2 (11.5, 20.9)	235
White/Caucasian	600	90.8 (88.6, 93.0)	61	9.2 (7.0, 11.4)	661
Other	101	86.3 (80.1, 92.5)	16	13.7 (7.5, 19.9)	117
2 or more ethnicities with Native Hawaiian	1,589	86.5 (84.9, 88.1)	248	13.5 (11.9, 15.1)	1,837
2 or more ethnicities not Native Hawaiian	1,269	89.3 (87.7, 90.9)	152	10.7 (9.1, 12.3)	1,421

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

\*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. *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 primary race/ethnicity.

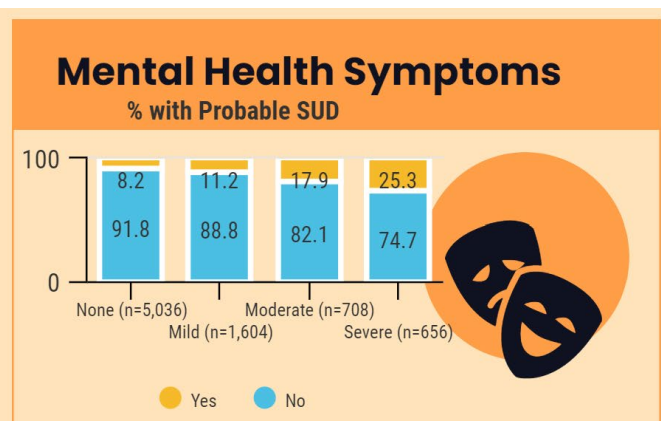
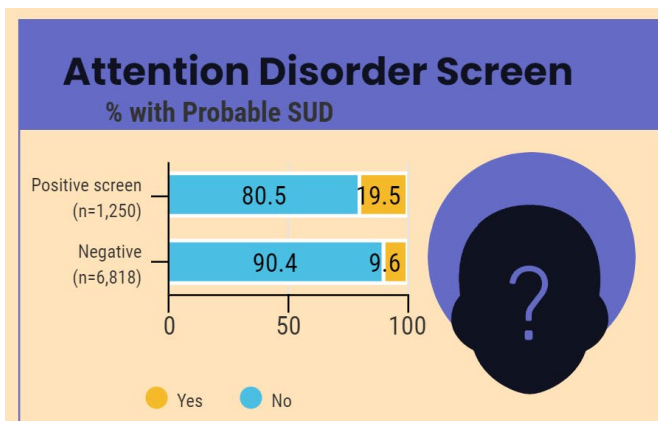
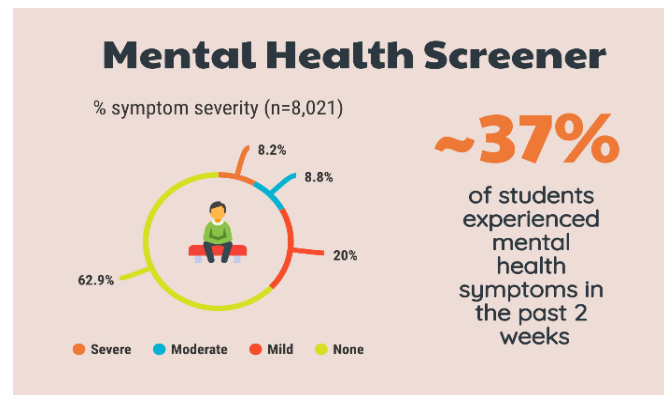
The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade, and primary race/ethnicity:

<sup>1</sup> The CRAFFT ( <https://craftt.org/about-the-craftt>) 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.

<sup>2</sup> 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. Among those who selected two or more ethnic/racial groups in the state sample, Native Hawaiian was among the highest therefore, the table shows the percentage of students that selected Native Hawaiian and those that did not.

- 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.
- **Transgender and Other Gender Minority** students make up the smallest proportion of the state sample but show the **highest risk for a probable substance use disorder** (24.4%) compared to their cisgender counterparts (females 13.1%, males 8.8%).
- Treatment need **increased by grade level**, (6.6% of 8<sup>th</sup> graders, 11.9% of 10<sup>th</sup> graders, and 15.0% of 12<sup>th</sup> graders) **more than doubling from middle school to high school**.
- Adolescents most likely to have a probable substance use disorder primarily identified themselves as **Other Pacific Islander (19.7%), Native Hawaiian (15.2%), Hispanic or Latino (16.2%), and of two or more ethnicities with Native Hawaiian (13.5%)**. Students identified as Other ethnicities (13.7%) 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 about **37% of students 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) **was more than two-fold from mild (8.2%) to severe (25.3%) 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) **had a percentage (19.5%) of probable substance use disorder, about twice that of those with a negative screen (9.6%)**.



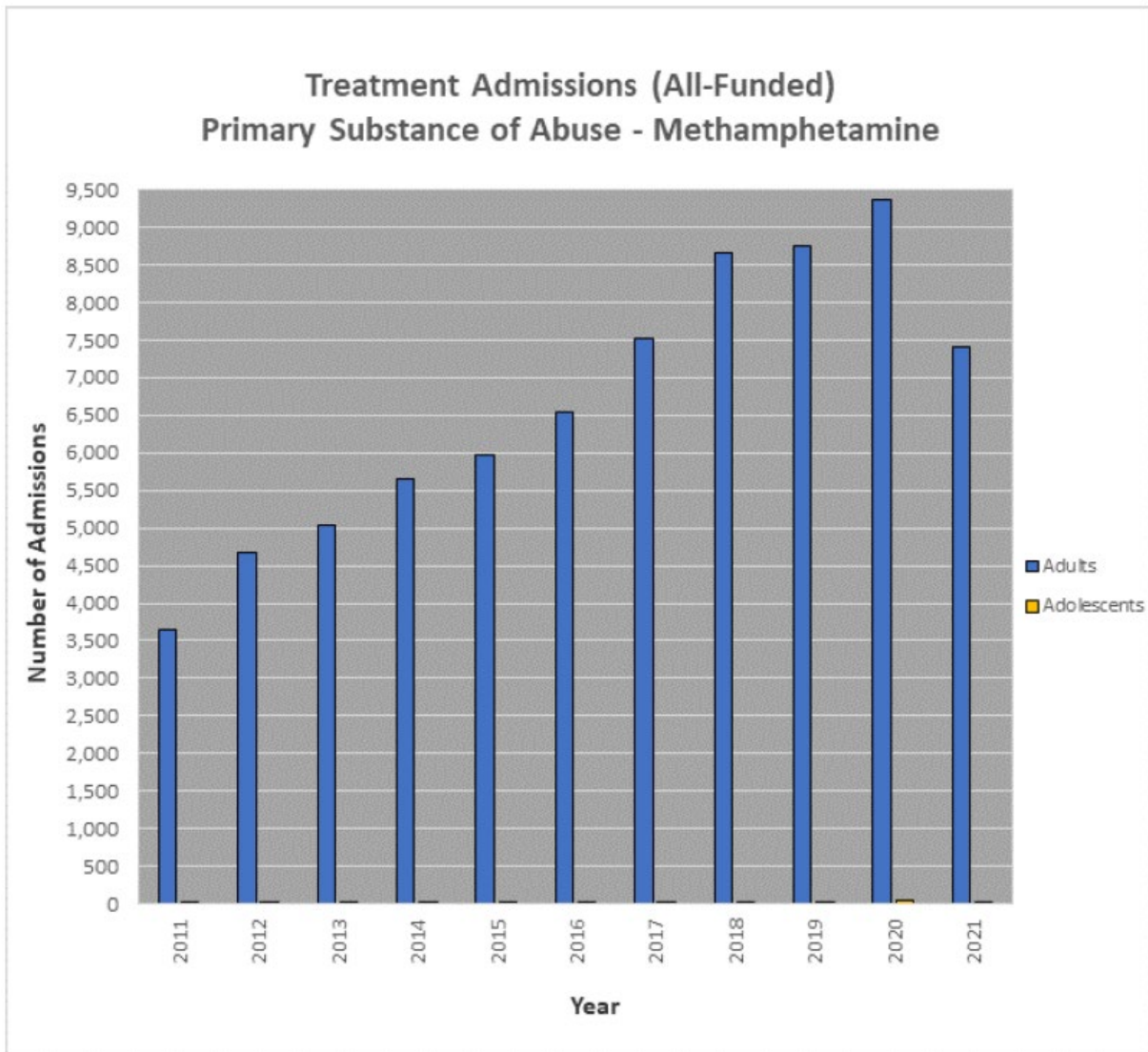
**The 2019-2020 Hawaii Student Alcohol, Tobacco, and Other Drug Use Survey Comprehensive Report includes more detailed findings for alcohol and substance use prevalence indicators and domains of risk and protective factors.**

The five-year (Fiscal Year 2017 to Fiscal Year 2021) average annual ADAD-funded admissions for adolescents is 1,477, which is 32.5% of the estimated need for adolescent alcohol and drug abuse treatment.

## APPENDIX F

### METHAMPHETAMINE ADMISSIONS 2011 - 2021

As reflected in the graph and table below, there was a 21.0% decrease and a 9.5% decrease in adult and adolescent crystal methamphetamine admissions to treatment, respectively, in Fiscal Year 2020-21.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Adults	3,654	4,681	5,044	5,642	5,978	6,540	7,511	8,655	8,746	9,361	7,399
Adolescents	28	15	21	24	26	16	30	25	29	42	38
Total	3,682	4,696	5,065	5,666	6,004	6,556	7,541	8,680	8,775	9,403	7,437

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).

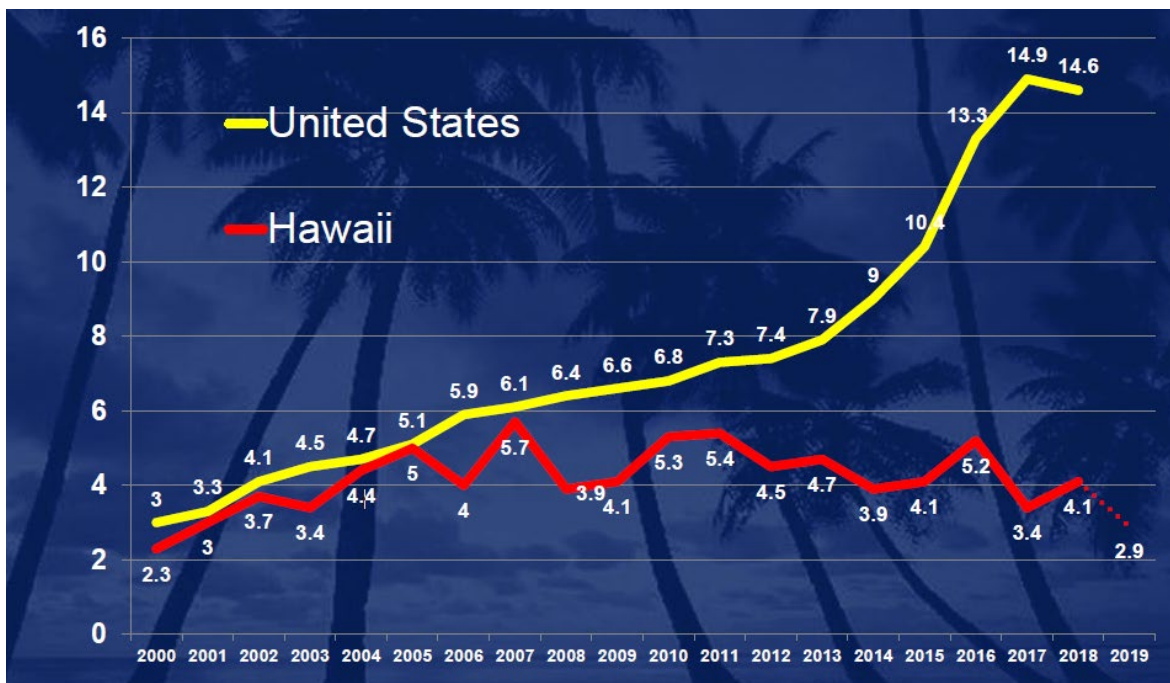
**Numbers, Trends, and Patterns: Fatal Opioid-Related Poisonings**

Recent data shows a 5-year average of 58 opioid-related fatal overdoses from 2015-2019 according to the DOH death certificate database, a decrease from the previous 5-year average of 66 deaths a year from 2010-2014.

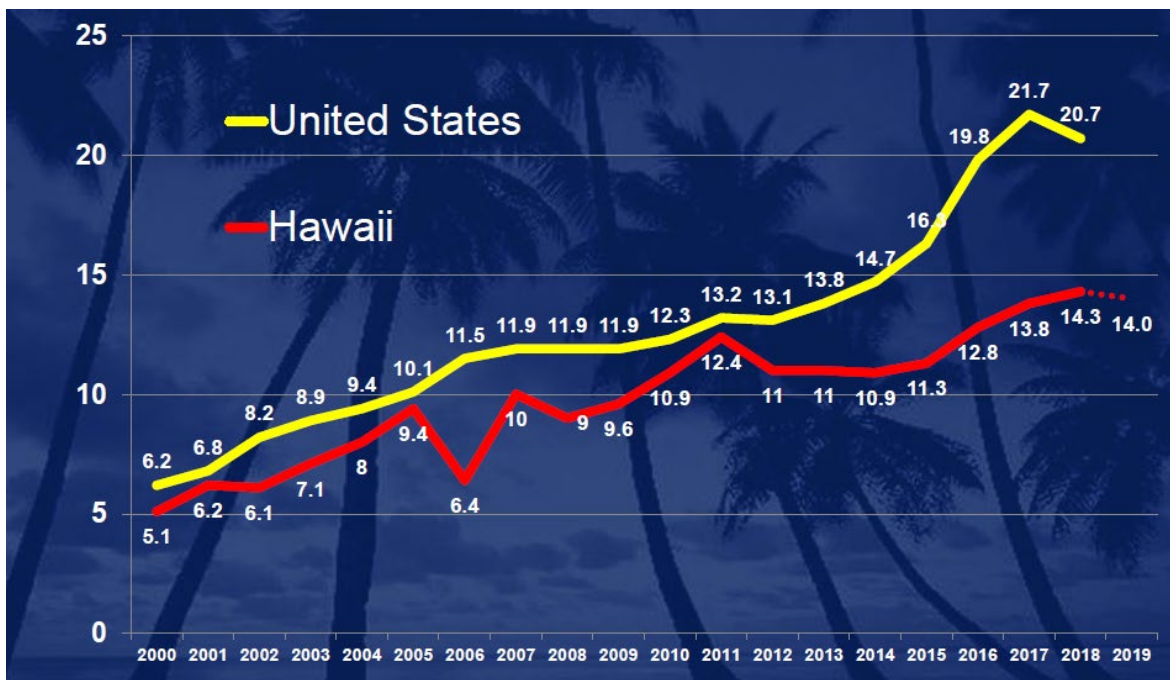
Data from the Centers for Disease Control's (CDC) WONDER system, a national public health dataset shows that Hawaii opioid poisoning fatality rates appear to be trending slightly upward (4.1 in 2018) but still below the 2016 rate of 5.2 (Figure 1) while the national rate has generally increased since 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.)**

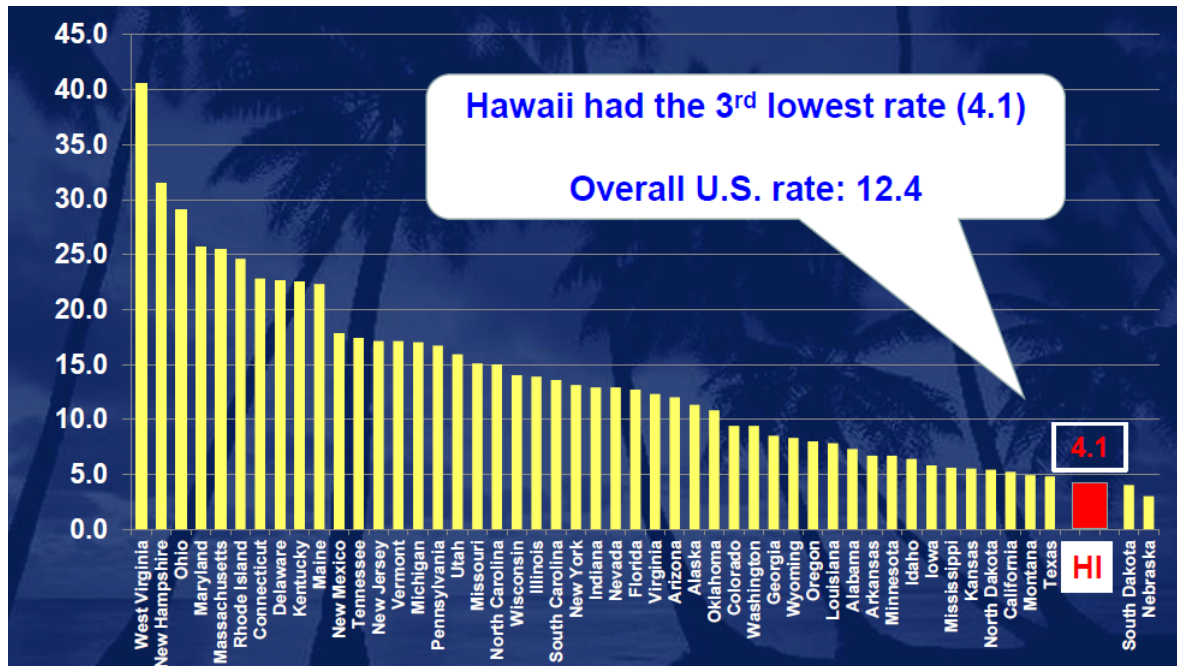


**Figure 2. Adjusted drug poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2000-2019.**



And when compared to other states, Hawaii seems to have 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).

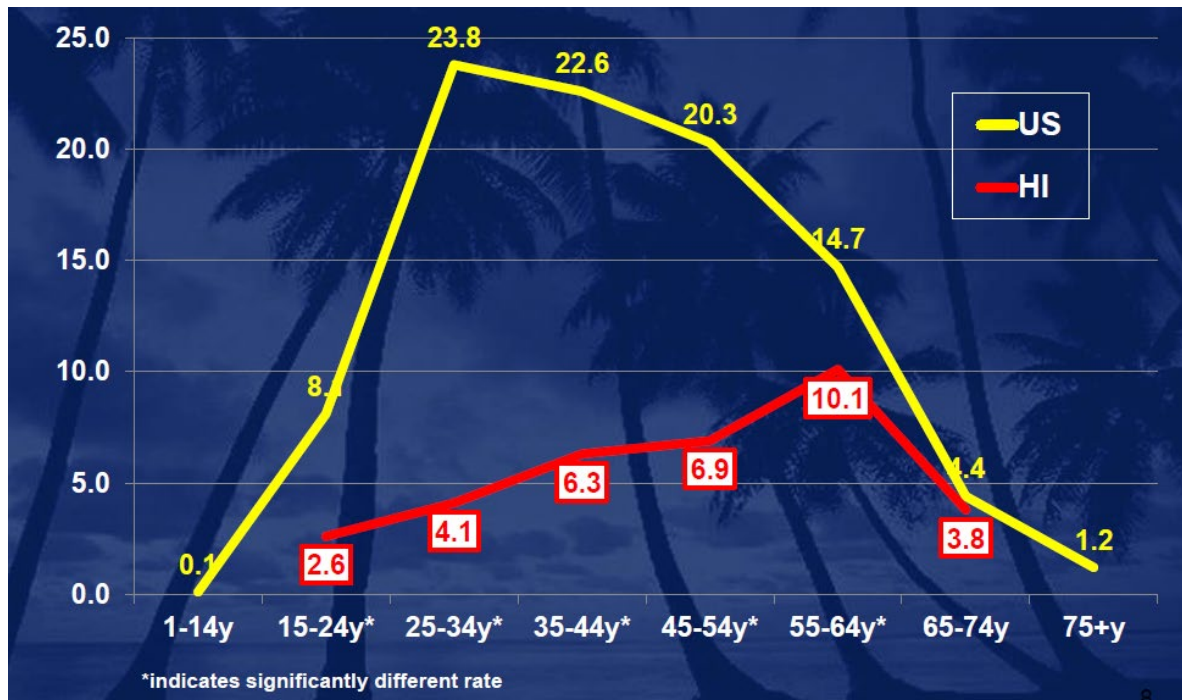
**Figure 3. Adjusted opioid poisoning fatality rates (per 100,000), by state, 2014-2018 (includes poisonings due to heroin and opium).**





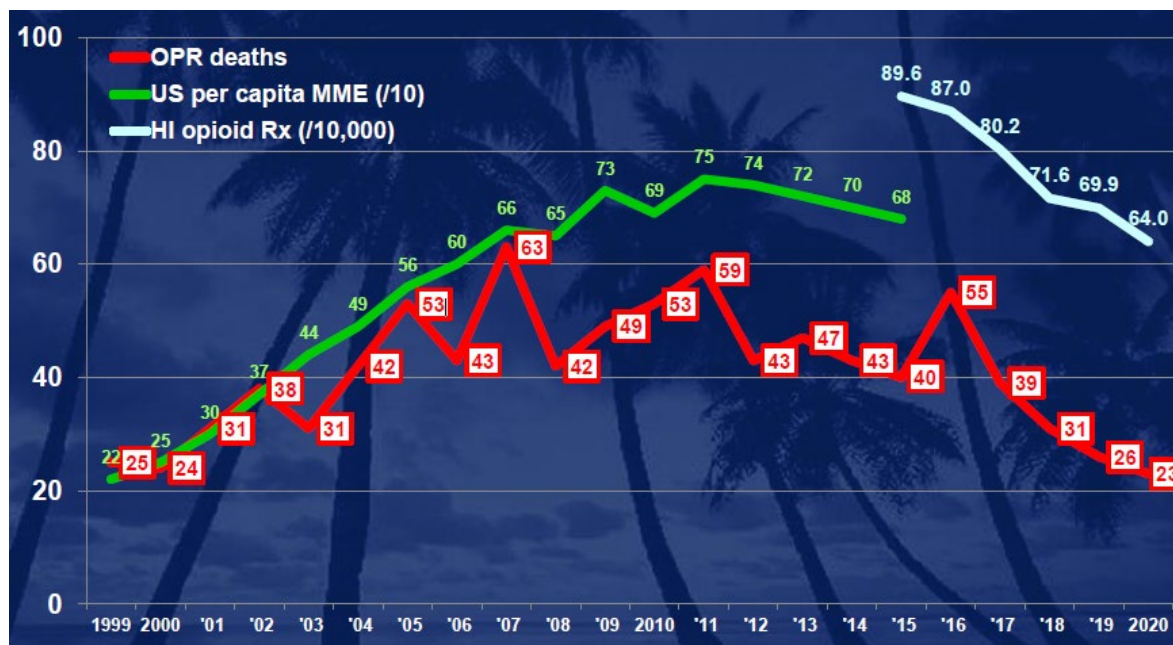
Looking at drug poisoning fatalities by age group averaged from 2014-2018, Hawaii remains well below the national rates for the 15-64 year age brackets, but is only slightly below the national rate for the 65-74 year bracket (3.8 for Hawaii vs. 4.4 nationally) (Figure 4).

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



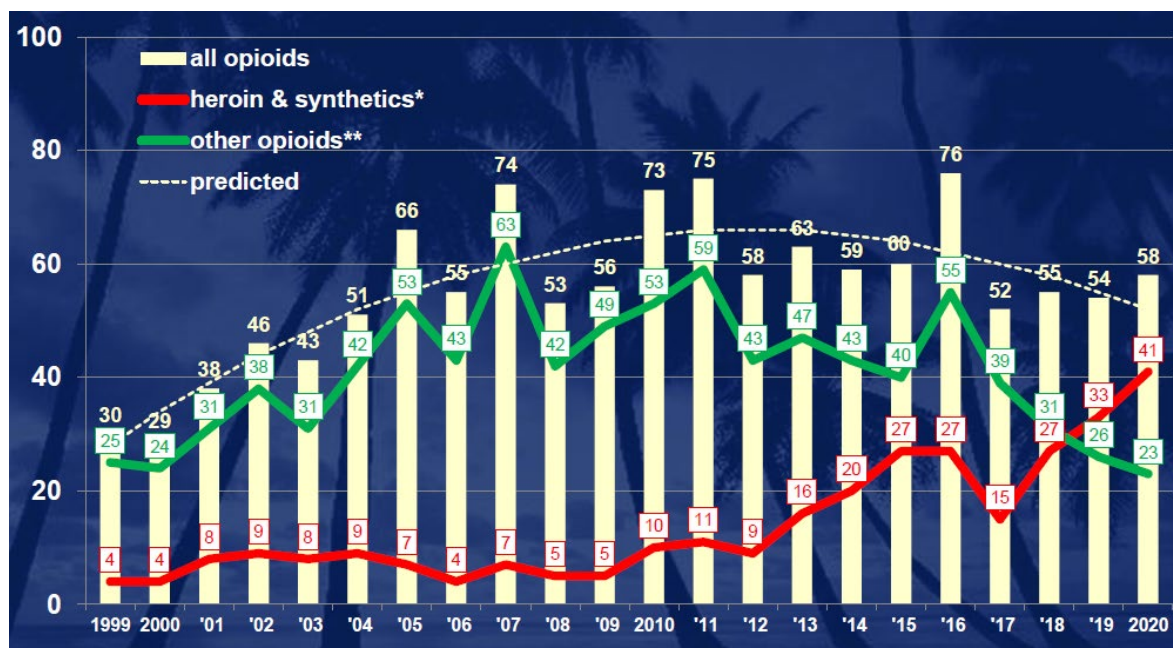
When looking at poisoning fatality rates among Hawaii residents compared to national opioid consumption, EMSIPSB data show that deaths due to opioid pain relievers have decreased recently (Figure 5). However, Hawaii death certificate data show a greater prevalence of fatal opioid poisonings among Hawaii residents due to heroin and-synthetic opioids other than methadone like fentanyl and tramadol (Figure 6).

**Figure 5. Annual trends of fatal opioid poisonings\* among Hawaii residents, national opioid consumption (through 2015), and opioid prescriptions in Hawaii (2015-2020).**



\* Includes naturally derived opioids (e.g., codeine, morphine), semi-synthetics (e.g., oxycodone, hydrocodone) and methadone. Data for 2020 is preliminary.

**Figure 6. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 1999-2020 (Preliminary data for 2020).**



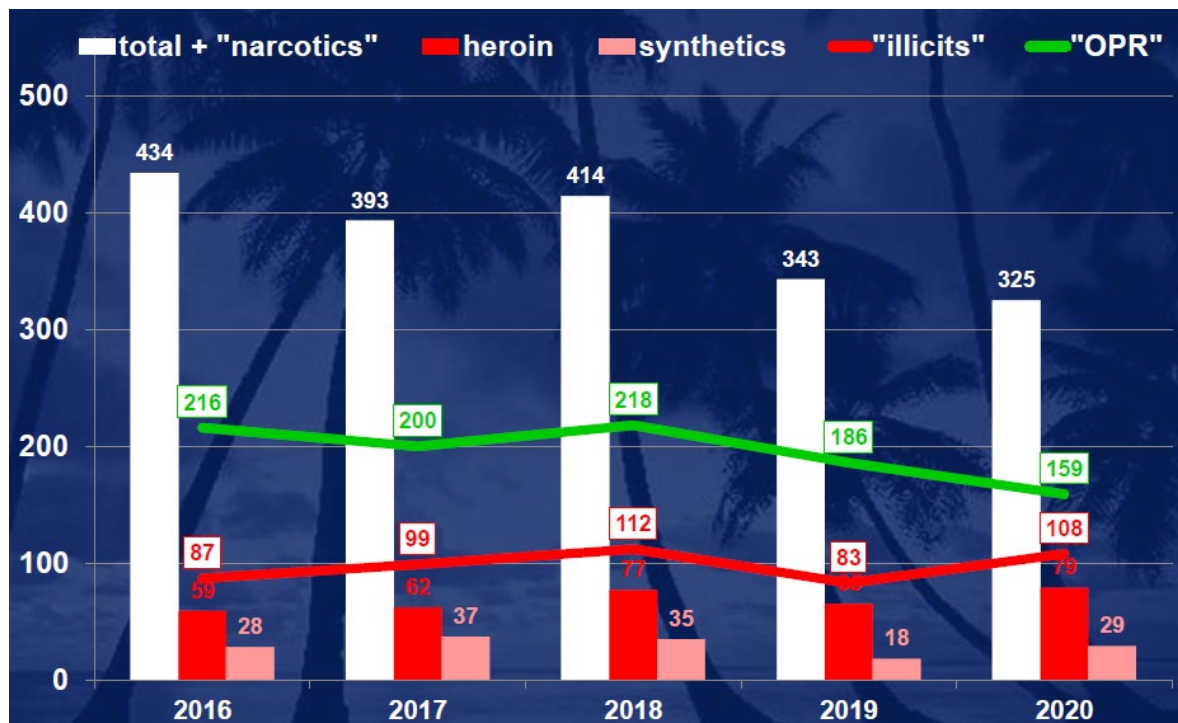
\* Includes heroin and synthetic opioids other than methadone (e.g., fentanyl, tramadol)

\*\* Includes naturally derived opioids (e.g., codeine, morphine), semi-synthetics (e.g., oxycodone, hydrocodone) and methadone.

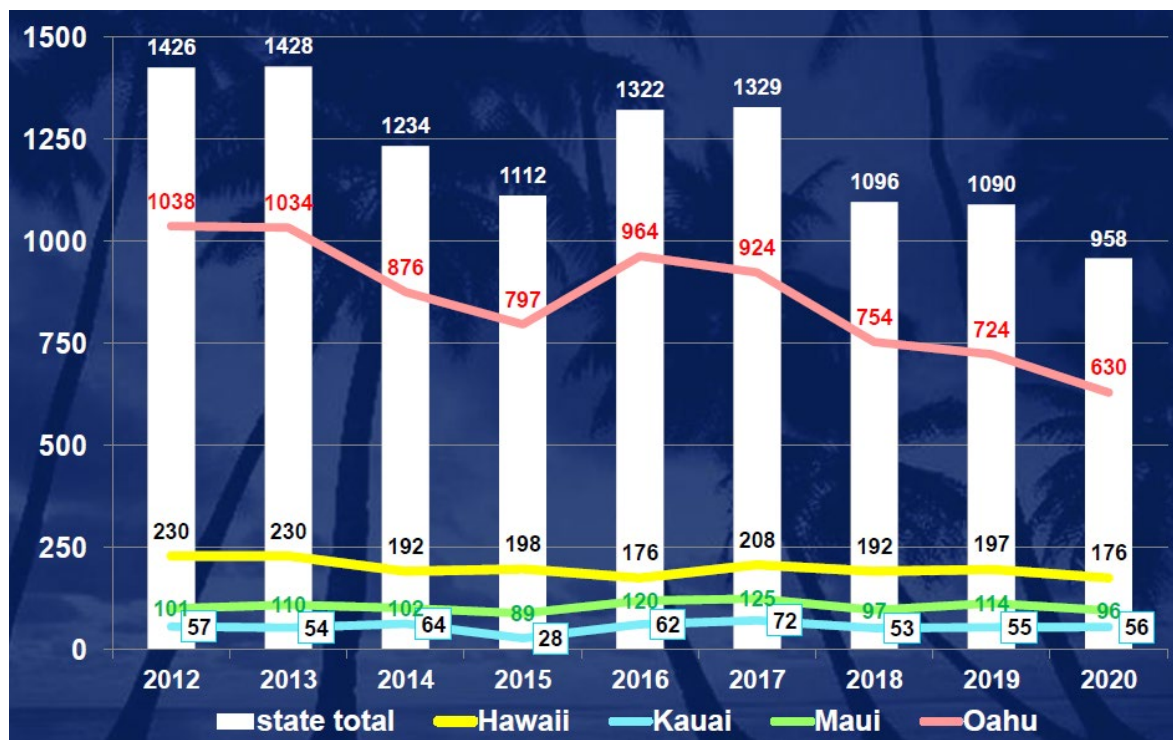
### **Numbers, Trends, and Patterns: Non-Fatal Opioid-Related Poisonings**

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 (325 in 2020 vs. 343 in 2019) (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 the last spike which occurred in 2016 (Figure 8).

**Figure 7. Annual number of hospital treated nonfatal opioid poisonings among Hawaii residents, by type of opioid, 2016 to 2020.**



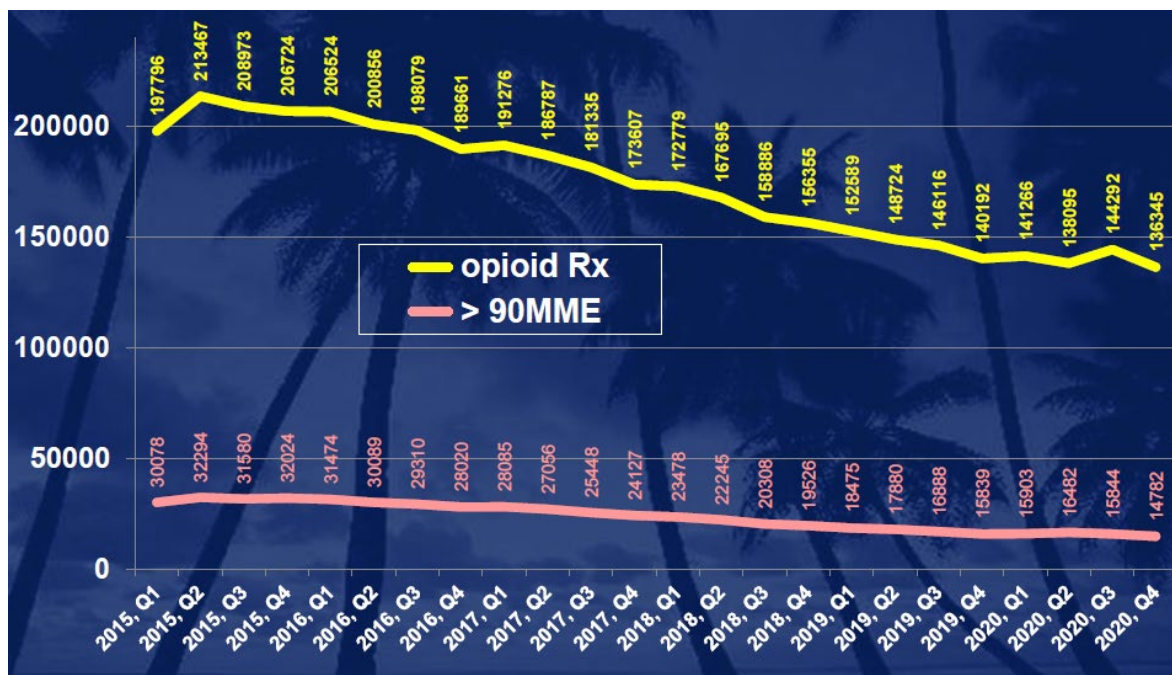
**Figure 8. Annual number of EMS patients receiving naloxone, by county, 2012 to 2020.**



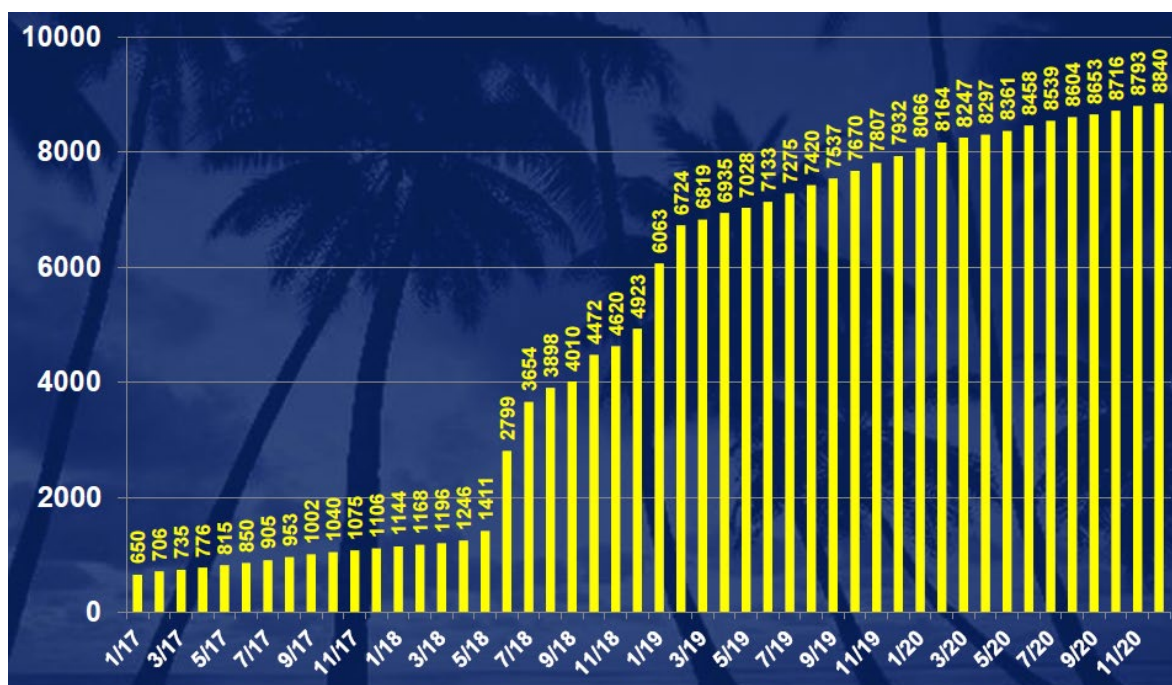
Recent data from the Prescription Drug Monitoring Program (PDMP) administered by the Department of Public Safety also suggest that a July 2018 law mandating prescriber usage of the PDMP is having positive effects such as the gradual reduction in the number of opioid prescriptions in Hawaii (Figure 9),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



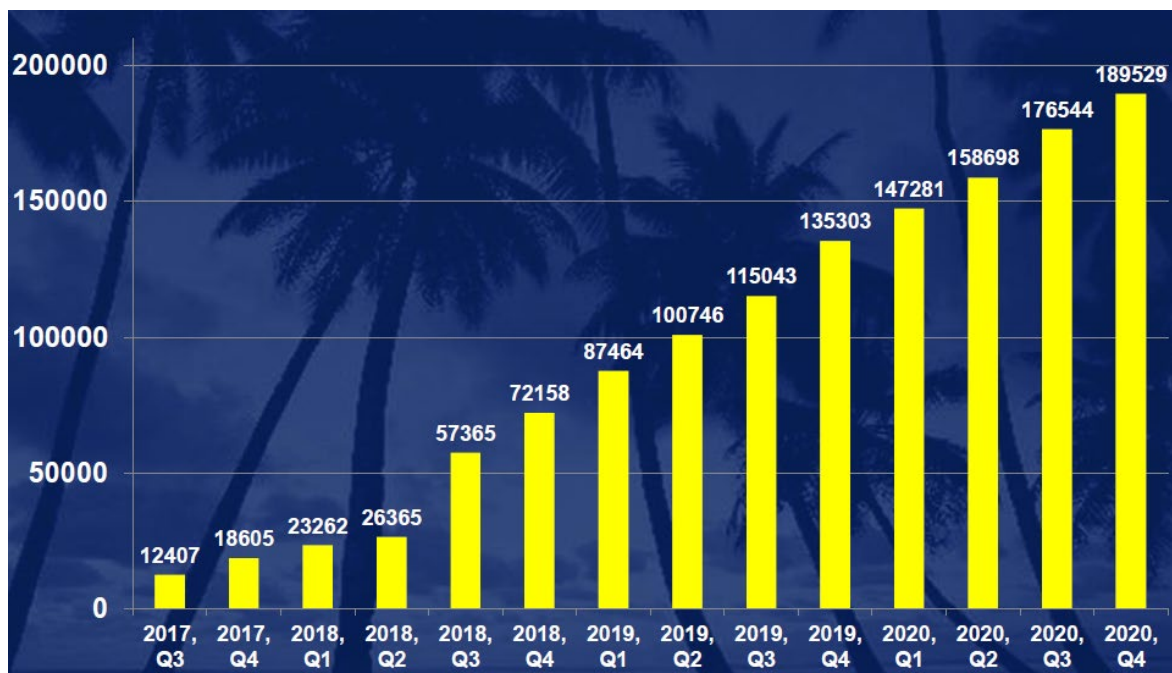
**Figure 9. PDMP data: Quarterly number of dispensed opioid prescriptions in Hawaii, 2015 to Dec. 2020.**



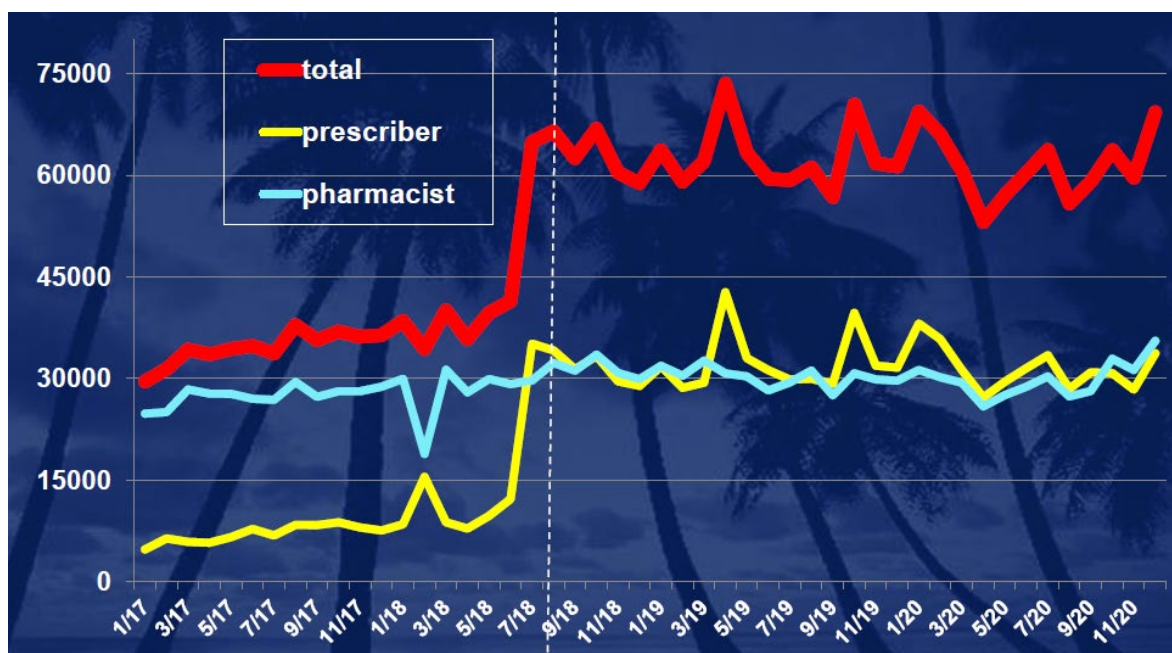
**Figure 10. PDMP data: Monthly number of prescribers registered for the Hawaii PDMP, 2017 to Nov. 2020.**



**Figure 11. Quarterly number of prescribers PDMP inquiries before new opioid or benzodiazepine prescription is issued, July 2017 to Dec. 2020.**



**Figure 12. Monthly number of patient searches in the Hawaii PDMP, by provider role, 2017 to Nov. 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 EMSIPSB 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 to 2019.**

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

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).