JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

DEPT. COMM. NO. 219

ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

January 4, 2023

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

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirty-second 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 "2023 ADAD Annual Report containing the following Sections: Section 321-195, 329-3, Section 10 of Act 161, Section 29 of Act 40, Section 329E-6.

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

https://health.hawaii.gov/opppd/department-of-health-reports-to-2023-legislature/

Sincerely,

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

2023

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 2022

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2021-22 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 2021-22, $36,400,551 was appropriated by Act 088, Session Laws of Hawaii (SLH) 2021, to the Alcohol and Drug Abuse program (HTH 440) – $20,222,028 general funds, $750,000 special funds and $15,428,523 federal funds (MOF N and P). Of the total appropriated, $27,654,186 was allocated for substance abuse treatment services and $6,198,391 was allocated for substance abuse prevention services. The Act also did not fund 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 (10/1/20 – 9/30/22) 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.

In FY23, under appropriation S-19-581-H (SAMHSA Substance Abuse Prevention and Treatment Block Grant) program was notified of a refund. The refund will be returned to SAMHSA and a revised federal financial report will be submitted for FY20.

$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. The grant ended on 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. The grant ended on September 29, 2022.

$8 million over two years (9/30/20 – 9/29/22) for the SAMHSA/CSAT State Opioid Response (SOR) grant SOR 2.0 Grant project period 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, Medications for Opioid Use Disorder 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 providers who give medications for opioid use disorder and improve the system of care.

$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).

$7.0 million over two years (9/30/20-9/29/22) for the SAMHSA Disaster Response State grant to conduct outreach, screening, and referral services to those who have the behavioral health signs and symptoms resulting from natural disasters, as well as expand coordination and training for substance use and mental health professionals. The grant ended on September 29, 2022.

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

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 3,521 adults statewide in Fiscal Year 2021-22;

School- and community-based outpatient substance abuse treatment services were provided to 938 adolescents statewide in Fiscal Year 2021-22; and

Curriculum-based youth substance abuse prevention and parenting programs, underage drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 553,405 children, youth and adults directly and indirectly through individual-based and population-based prevention programs, strategies and activities[2] in Fiscal Year 2021-22.

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

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

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

treatment monitoring program; and

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

TABLE OF CONTENTS

Alcohol and Drug Abuse Division 1
Highlights of Accomplishments and Activities
- State and Federal Funding 3
- Federal Grants and Contracts 4
- Substance Abuse Prevention and Treatment Services 6
- Coordinated Access Resource Entry System (CARES) 8
- Studies and Surveys 9
- Provision of Contracted or Sponsored Training 9
- Programmatic and Fiscal Monitoring 10
- Certification of Professionals and Accreditation of Programs 10
- Clean and Sober Homes Registry 11
- Legislation 11

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) 13
- Report Pursuant to Section 10 of Act 161, Session Laws of Hawaii 2002, on the Implementation of Section 321-193.5, Hawaii Revised Statutes 26
- Report Pursuant to Section 29 of Act 40, Session Laws of Hawaii 2004, Requiring a Progress Report on the Substance Abuse Treatment Monitoring Program 29

Appendices
- A. ADAD-Funded Adult Services: Fiscal Year 2019-22 32
- B. ADAD-Funded Adolescent Services: Fiscal Year 2019-22 33
- C. Performance Outcomes: Fiscal Year 2019-22 35
- D. Treatment Related to Substance Use - County Estimates 36
- E. 2019-2020 Preliminary Estimated Need for Adolescent (Grades 8-12) Alcohol and Drug Abuse Treatment in Hawaii 40

- Report Pursuant to Section 329E-6, Hawaii Revised Statutes, Requiring a Report on Unintentional Opioid-Related Drug Overdose 43

ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2021-22 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, 2021 to June 30, 2022

State and Federal Funding

Act 088, SLH 2021 appropriated $36,400,551 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2021-22:

General funds	$20,222,028	(55.6%)	29.0 FTE
Special funds	750,000	(2.0%)	
Federal funds (N)	8,857,980	(24.3%)	7.5 FTE
Federal funds (P)	6.570,543	(18.1%)	
	$36,400,551	(100.0%)	29.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$27,654,186	(76.0%)
Substance abuse prevention services	6,198,391	(17.0%)
Division operating costs	0	(0%)
Division staffing costs	2,547,984	(7.0%)
	$36,400,551	(100.0%)

For Fiscal Year 2021-22, $36,400,551 was appropriated by Act 088, SLH 2021, to the Alcohol and Drug Abuse program (HTH 440) – $20,222,028 general funds, $750,000 special funds and $15,428,523 federal funds (MOF N and P). Of the total appropriated, $27,654,186 was allocated for substance abuse treatment services and $6,198,391 was allocated for substance abuse prevention services.

The Act 088, SLH 2021, did not fund 2.00 FTE positions totaling $133,512 as a Legislative Adjustment for personnel savings.

[3] 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 2022 (10/1/20 – 9/30/21) 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.

In FY23, under appropriation S-19-581-H (SAMHSA Substance Abuse Prevention and Treatment Block Grant) program was notified of a refund. The refund will be returned to SAMHSA and a revised federal financial report will be submitted for FY20.

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 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. The grant ended on September 29, 2022.

State Opioid Response (SOR). The Hawai‘i 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 was 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 which ended September 29, 2022. The extension provided 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 enhanced and expanded SUD treatment services, developed policies, expanded workforce capacity, disseminated evidence-based practices (EBPs), and implemented 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 presented for care or were 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 which ended on 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:[4]

[4] 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.

Treatment Services. ADAD's overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse, and dependence by assuring an effective, accessible, public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Thirty-six (36) 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 3,521 adults statewide in Fiscal Year 2021-22; and school-based and community-based outpatient substance abuse treatment services were provided to 938 adolescents statewide in Fiscal Year 2021-22.

Prevention Services. Through a total of twenty-six (26) contracts, nineteen (19) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2021-22. In efforts to best utilize resources to fund what works, the contracted services were guided by the Strategic Prevention Framework to implement and evaluate Evidence-Based Programs and Practices and Innovative Interventions in addition to implementing 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 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 and innovative programs. According to the data collected for Fiscal Year 2021-22, curriculum-based prevention strategies served a total of 3,719 children and youth and the community-based strategies touched a total of 553,405 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 and innovative practices 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 effectiveness. 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://hicares.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 (ADAD) and. Aloha United Way (AUW), with whom ADAD contracted in April, 2022. The project is funded through a combination of state and federal funds from the Substance Abuse and Mental Health Services Administration. The agreement over one year, with an option to renew each year up to five years with AUW, includes the continued operation of a call center, service referral system, and processes for quality improvement.

Hawai'i CARES staff, who are trained in behavioral health, 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 (AMHD) were also added on July 1, 2020. In March 2022, AMHD contracted crisis services with CARE Hawaii (HI), Inc., a private local vendor. Both AUW and CARE HI work in coordination with one another to provide CARES services. Incoming calls are routed to CARE HI, which screens all crisis calls. CARE HI addresses calls requiring crisis mental health services or transfers calls to AUW for those requiring substance use disorder treatment services. AUW also receives referrals from providers. Since April 2022, Hawai'i CARES through AUW has handled 2,022 inbound calls from multiple sources for a monthly average of 289 calls. AUW received 5,230 referrals from ADAD providers

resulting in 4,462 ADAD authorization for services. AUW also provided 1,433 referrals out to providers for services. . We anticipate a continued expansion of this project to include other health, behavioral health and non-clinical (wraparound) 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.

Studies and Surveys

Tobacco Sales to Minors. In March/April 2022, teams made up of youth volunteers (ages 15-20) and adult observers visited a random sample of 328 stores in which the youth attempted to buy cigarettes to determine how well retailers were complying with state tobacco laws. Twenty stores sold to minors (ages 15-20). The weighted retailer violation rate is 6.0%. Of the four counties included in the statewide survey, the County of Kauai had zero sales, the County of Maui had one sale, the County of Hawaii had four sales and the County of Honolulu had fifteen sales. 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 2021-22, ADAD conducted zoom and on-site training programs that accommodated staff development opportunities for 2,366 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through seventy-four (74) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 52,242 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; Pacific mental health awareness; disaster response cultural training series; impact of COVID-19 on mental health and substance use disorder; how to end meth and collaboration in tacking the meth epidemic in Hawaii; FASD: integrating trends and application; and SUD peer recovery cohort.

Programmatic and Fiscal Monitoring

Through desk audits of providers' program and fiscal reports, ADAD staff examined contractors' compliance with federal SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance abuse prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of forty (40) prevention service contracts and seventy-seven (77) 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 2021-22, ADAD processed 542 (new and renewal) applications, administered thirty-two (32) computer-based written exams and certified twenty-seven (27) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,414.

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 2021-22, ADAD conducted a total of fifteen (15) accreditation site reviews and accredited fifteen(15) organizations, some of which have multiple (residential treatment and therapeutic living) programs. ADAD conducted four (6) preliminary accreditation desk reviews, due to limited ability to travel due to COVID-19 and staffing resources.

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. Currently, there is one (1) residential treatment facility working on obtaining accreditation.

Clean and Sober Homes Registry

In Fiscal Year 2021-22 ADAD received four (4) initial application for the clean and sober registry. ADAD renewed and conducted thirty (30) virtual site visits of clean and sober homes statewide, and in "Good Standing" as referred to by HAR Chapter 11-178, with two (2) registration pending DOH review, and twenty (20) pending renewal inspection. Currently there are no homes that are "Not in Good Standing" pending further review. ADAD has received ten (10) complaints that have been resolved. In addition, ADAD has developed a formal concern form that can be found on the ADAD website for stakeholders and public to send any concerns for clean and sober homes. ADAD also has a toll-free number for any concerns or questions stakeholders and public can call.

ADAD conducted a meeting with the clean and sober home operators to support future meetings and training regarding more information on clean and sober process and to assist with reducing stigma. Meeting will be quarterly for home operators to address any concerns or technical assistance needed to support recovery efforts in the homes.

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, appointments to the Hawaii Advisory Commission on Drugs and Controlled Substances, and also in coordination with the stakeholders of the Hawaii Opioid Initiative. Legislation enacted during the 2022 Legislative Session that addressed issues affecting the agency included:

> **Act 248, SLH 2022 (HB 1600 CD1), relating to the state budget.** This measure added .50 FTE to existing .50 FTE position 122752 Program Specialist IV as required by contract for the U.S. Food and Drug Administration (FDA) Tobacco Inspections award.

OTHER REQUIRED REPORTS

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

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

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

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

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

The Hawai‘i 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, Hawai‘i 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

KATHI CALLES Corrections - 7/1/2020 - 6/30/2024 **DIANA FELTON, M.D.** Medical – 7/1/2021 – 6/30/2025 **JON FUJII, MBA** Joint appointment to HACDACS and State Council on Mental Health – 7/1/2020 – 6/30/2023 **ADAM GRATZ, D.O.** Pharmacological – 7/1/2021 – 6/30/2024 **LILINOE KAUAHIKAUA, MSW** Education– 7/1/2022 – 6/30/2023	**JOHN PAUL MOSES, III, APRN-Rx** Medical – 7/1/2019 – 6/30/2023 **KUULEI SALZER-VITALE, MSW, MPA** Chair Youth Action – 7/1/2022– 6/30/2026 **GREG TJAPKES** Vice Chair Community and Business Affairs – 7/1/2021 - 6/30/2025 **ERIKA VARGAS, LCSW** Community and Business Affairs – 6/30/2021– 6/30/2025

On August 24, 2021, 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 2021-2022:

1. **Emerging Adults**
2. **Workforce Development**
3. **Hawaii CARES Aloha United Way**
4. **Formation of a Behavior Health Council**
5. **Law Enforcement Assisted Diversion/ Let Everyone Advance with Dignity (LEAD)**
6. **Intersection of Substance Use Treatment and the Criminal Justice System**

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 Hawai‘i. 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 Hawai‘i.

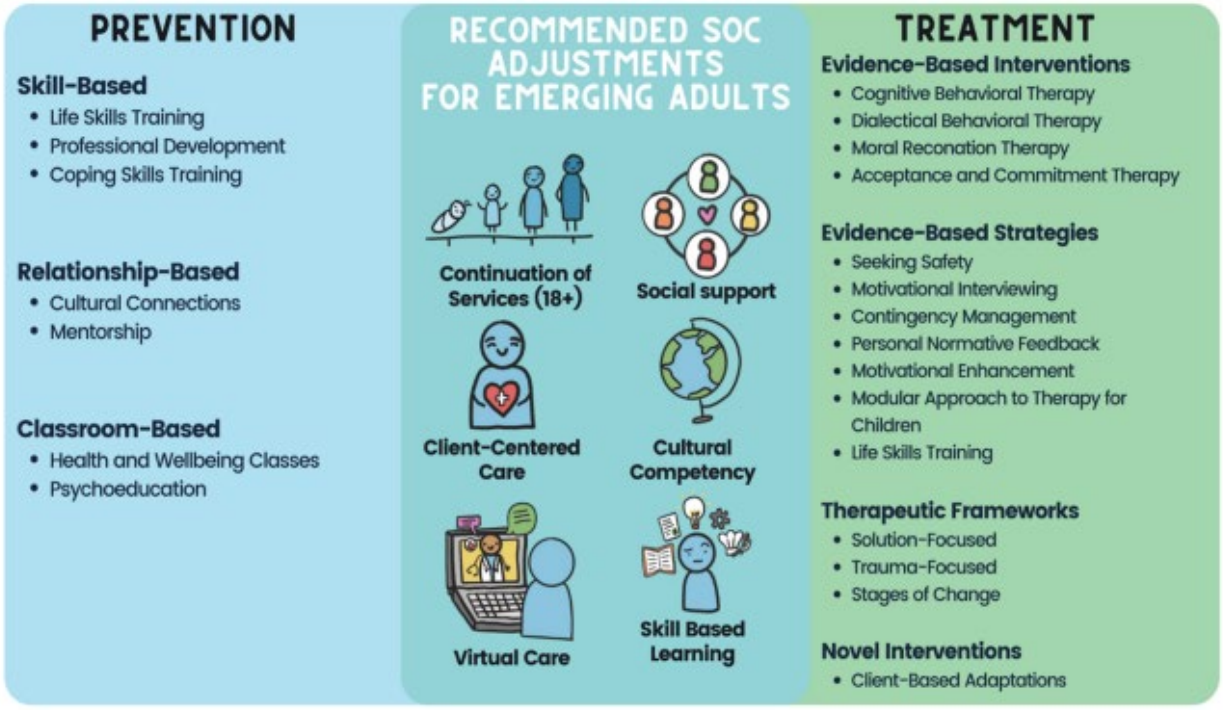
Emerging Adults

Emerging adults, ages ~18-25, are a gap group in terms of substance use disorder prevention and treatment. This age group is at high risk for substance use disorders due to their distinct developmental period and the continuing development of their brain's frontal cortex. Emerging adults often experience instability due to identity exploration, changing life circumstances, geographical moves, and feeling in-between childhood and adulthood. Factors such as a large prevalence of substance use in social situations, pronounced feelings of racial and ethnic discrimination and poor mental health in this age group increase the risk for substance abuse disorder (SUD). In addition, Medicaid, and other support, including that received from family, often drop off completely at age 18, leaving these emerging adults to need to address multiple life stressors. The combination of these factors leads to a high risk of SUD in this age group and emphasizes the need for increased prevention and treatment resources for emerging adults.

Dr. Susana Helm of the University of Hawaii John A. Burns Schools of Medicine, Department of Psychiatry spoke to HACDACS on March 22, 2022 reviewing an ongoing needs assessment for emerging adults conducted in conjunction with a 2022 revision to the State Plan on Substance Use. Dr. Helm's presentation highlighted the above risk factors for substance abuse in emerging adults and outlined some of the major areas for improvement in the treatment sector. A July 2022 report "State of Hawai`i Substance Use System of Care for Emerging Adults. Recommendations for Improvements from Professionals in the Field" outlines specific challenges for this age group as perceived by providers. The report states "There was an emphasis on the importance of social support and client-centered care, especially for skill-based learning to aid the transition into adulthood; paired with cultural competence in the system and among professionals for both prevention and health promotion as well as treatment and recovery. In fact, professionals acknowledged that while there is a high value on prevention, it is underfunded and therefore underutilized among professionals who may work with emerging adults."[5]

[5] S. Helm et al. State of Hawai`i Substance Use System of Care for Emerging Adults. Recommendations for Improvements from Professionals in the Field. July 2022. https://health.hawaii.gov/substance-abuse/files/2022/07/State-of-Hawaii-Substance-Use-System-of-Care-for-Emerging-Adults.-Recommendations-from-Professionals_2022-July.pdf accessed November 15, 2022

Figure 4 from the report describes Interventions identified by Professionals for the System of Care and is shown below.



1. ***HACDACS recommends*** that ADAD and other service providers and funders recognize that emerging adults are a unique demographic with specific needs that differ from "adults" or adolescents.

2. ***HACDACS recommends*** that ADAD and other policy makers promote programs that create healthy social and community activities targeted at this age group.

3. ***HACDACS recommends*** that ADAD develop easier access to counseling, therapy, substance use disorder outpatient treatment and self-care options for this age group through workplace psychoeducation programs. Programs should be culturally competent and specific to this age group.

Workforce Development

At the July 26, 2022, HACDACS meeting, committee members were given a presentation from ADAD about efforts related to workforce development. The primary focus was on the shortage of certified substance use professionals and efforts to recruit, train, and retain these types of professions.

The table below shows the numbers of certified SUD professionals in Hawai‘i as of September 2022 and the decrease in active workers from 2020 to 2022.

Type of Certified	2020 Active	2022 Active	2022 Workers in

Professional	Workers	Workers	Training
Certified Substance Abuse Counselor (CSAC)	861	624	897
Certified Prevention Specialist	40	26	14
Certified Clinical Supervisor	30	26	9
Certified Criminal Justice Addictions Professional	n/a	28	7

There were many challenges identified that hamper recruitment, training, and retention of certified workers in these fields. Some of the most prominent challenges included difficulties with finding mentors and locations for trainee clinical hours, overly complex or restrictive requirements for who can oversee trainee clinical hours, and difficulty connecting workers in training or certified workers with prospective employers. Other challenges faced by these certified professionals include over-work, low pay, burnout, and lack of support for continuing education.

Policy changes have the opportunity to rectify some of these challenges and improve the working conditions for certified substance use professionals, leading to a larger, more qualified and happier workforce. An improved and larger workforce will be able to provide more much needed services to people with substance use disorder.

1. ***HACDACS recommends*** enhanced funding for training programs to increase the numbers of CSACs, Certified Prevention Specialists, Certified Clinical Supervisors and Certified Criminal Justice Professionals.

2. ***HACDACS recommends*** that CSAC training organizations work to improve connections between organizations that need providers and CSACs.

3. ***HACDACS recommends*** that ADAD and other agencies improve recruitment and retention strategies by enhancing or creating programs that do outreach.
   a. Outreach programs would target people early in their career path, provide continuing education, and other career development options.
   b. Outreach programs could also work with employers to improve training programs, placements, and retention.

4. ***HACDACS recommends*** that ADAD support educational institutions to have more clinical hours for trainees.

5. ***HACDACS recommends*** support for ADAD‘s rate study to increase reimbursements for substance use professionals and services.

Hawai‘i CARES Aloha United Way 211 Call Center

On June 28, 2022, Ms. Jennifer Pecher, Mr. Joshua Osegueda, and Mr. Elliot Plourde presented to the HACDACS their Aloha United Way (AUW) 211 Hawai‘i Cares SUD Referral and Treatment Call Center, which began in April 2022.

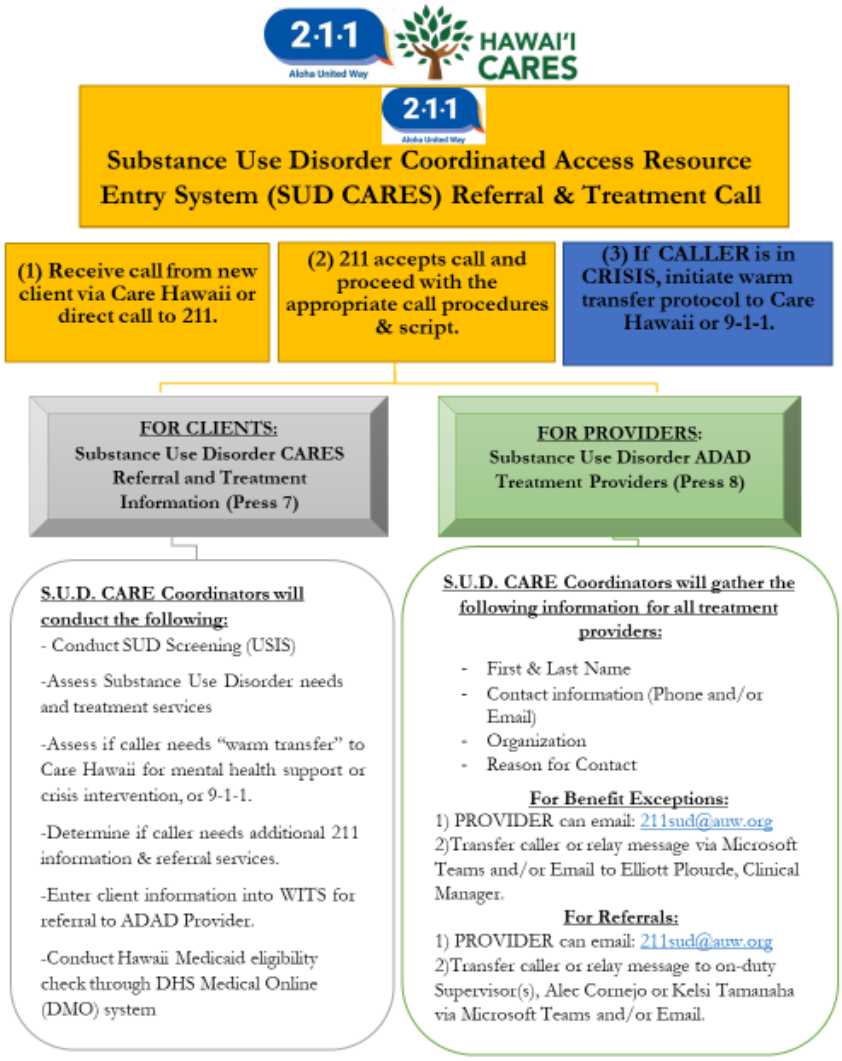
The AUW 211 SUD CARES call center is Hawaii's only comprehensive, community information, and referral helpline with a database of over 4,000 community resources statewide. The AUW's goal is to provide information and screening for Hawai‘i residents seeking SUD treatment and recovery services. This program supplements and connects with what they are currently doing with treatment and recovery services SUD. The call center is open seven days a week, from 7:00 am-10:00 pm.

The AUW frequently solicits informal and formal feedback from providers, ADAD, and stakeholders to inform best practices and program improvements. This includes meeting with the Adult Client Services Branch (statewide), Office of the Public Defender, Po'ailani, and Integrated Health Hawaii.

Data driven tools, ongoing evaluations, and continuous learning activities are utilized to increase the quality of referrals, overall program quality, and effectiveness. The AUW continues to improve technology and systems to provide real-time data and information sharing between AUW and ADAD providers, such as a secure portal for uploading client forms and residential bed availability which enhances their security with confidential information.

SUD clients are also provided with wrap-around support with AUW's 211 information and referral services for those in need of food, housing, healthcare, COVID-19 assistance, and other public programs/community resources for keiki, kupuna, and others in need.

Below is the referral process for the AUW 211 SUD CARES call center:



1. ***HACDACS recommends*** that ADAD assist AUW in community response surveys, which will include a client satisfaction survey.

2. ***HACDACS recommends*** that AUW attend cultural sensitivity and bias training and review the screening tool: *Referrals to Native Hawaiian Culture-Based Treatment and Prevention Services.*
3. ***HACDACS recommends*** that AUW and treatment facilities collaborate to help provide transportation or a voucher to a treatment facility when the client is not able to transport themselves.

Behavioral Health Advisory Council

Discussion on Setting up a Hawai‘i Behavioral Health Advisory Council

Hawai‘i State Council on Mental Health

The Hawaii State Council on Mental Health (SCMH) is an appointed council consisting of island service area board representatives, state agency representatives, a HACDACS representative, parents and family members of mental health service recipients, youth and consumer advocates, and mental health providers. The SCMH takes input from its members, topical speakers, and guests that address mental health issues in Hawaii, and then formulates policy recommendations on various mental health issues. Each member of the council is appointed by the governor and serves a three-year term. Currently the SCMH meets on the second Tuesday of each month at nine a.m.

Behavioral Health Advisory Council

The SCMH brought up the issue, in late 2021, of Hawaii possibly setting up a Behavioral Health Advisory Council (BHAC). These councils address both mental health and SUD issues. It was acknowledged that many other states have successful BHACs, and the establishment of a Hawaii BHAC may similarly consolidate and coordinate mental health and SUD efforts statewide as well as focusing and targeting available funding to promote state goals. The SCMH used a joint member of HACDACS and SCMH to float the proposal to HACDACS in early 2022. Since then, there have not been any formal discussions between the two groups on the set up of a BHAC.

Throughout 2022, HACDACS engaged in multiple discussions on the possibility of setting up a BHAC in Hawaii where many questions and uncertainties arose. Some of the concerns included questions around benefits and drawbacks, the importance of maintaining a focus on SUD issues, the role of HACDACS and SCMH in the setting of a BHAC, and coordination needs amongst the different advisory groups.

In the interest of gathering more information on a BHAC, Public Health Service Captain Emily Williams from the Substance Abuse and Mental Health Services Administration Region IX was invited to present at the September 27, 2022, HACDACS meeting. She shared her background and experience working with BHACs in other states and territories, as well as answered questions from the HACDACS members. Key takeaways from CAPT Williams' presentation include:

- Typical membership in BHACs include representation from mental health, substance abuse, and intellectual/developmental disability services; across provider, consumer, community advocate, & state agency roles; and often include local indigenous population representation.
- BHACs can be a forum to collect input from consumers, providers, advocates, and agencies, and then make informed decisions and policy recommendations based on this input.
- BHACs experience challenges when they become solely a sounding board for all of the things wrong with the behavioral health system. This can lead to a lack of focus on solutions, reducing their impact and effectiveness.
- California and Connecticut are examples of high-functioning BHACs. Collaboration with members from these BHACs may be useful during the exploration process.
- Setting up a BHAC in Hawai‘i would not supplant the HACDACS and SCMH, and the groups could work in tandem with each other.

- Hawaii could begin with an informal behavioral health advisory council planning committee and expand to a more formal model in the future.

The creation of a Behavioral Health Advisory Council could help Hawai‘i further address issues related to substance use and mental health, but more work needs to be done to understand the potential effectiveness and barriers associated with the formation of this council.

1. ***HACDACS recommends*** engaging directly with SCMH in exploratory talks around how Hawaii might move forward with a BHAC, to possibly include the formation of an ‘informal’ behavioral health advisory council planning committee.

2. ***HACDACS recommends*** corresponding directly with high-functioning existing BHACs in other states with the goal of gathering information on BHAC structure and protocols, if/how the BHAC interfaces with other existing state councils and advisory committees related to behavioral health, and real-world pros and cons of a BHAC.

3. ***HACDACS recommends*** passing legislation creating a Behavioral Health Advisory Council Planning Committee to explore the feasibility of a BHAC. This committee shall include a broad spectrum of representation across mental health, SUD, & I/DD services; across providers, consumers, advocates, & state agency roles; and to include Papa Ola Lokahi representation.

Law Enforcement Assisted Diversion/ Let Everyone Advance with Dignity (LEAD)

Public Health/Public Safety Partnerships

Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) is a nationally recognized diversion program model. The system of care continues to be refined to reduce client recidivism for minor offenses by diverting individuals prior to arrest into social services. LEAD programs facilitate delivery of intensive case management and by consistently partnering with community stakeholders and law enforcement officials, clients receive support to access housing, substance use treatment, and other social services. LEAD efforts in Hawaii have been under continuous evaluation by the University of Hawai‘i at Manoa (UH) Department of Psychology since their implementation in 2018 and 2019. LEAD efforts in Hawaii have received technical assistance from the LEAD National Support Bureau since 2017.

LEAD Efforts in Hawaii

The Honolulu LEAD Pilot project began in 2018, supported by funding in the Governor’s budget allocated to ADAD. Additional funding became available in 2019 through Act 209, Session Laws of Hawaii, 2018 (aka Ohana Zones). Additional ADAD funding is allocated for pilot programs on the islands of Maui, Hawaii, and Kauai.

In 2020, funding for LEAD-specific contracts through ADAD was discontinued. Remaining funding for programs on Kauai and the Island of Hawai‘i were diverted to support COVID-19 pandemic response efforts. LEAD programs on Kauai and the Island of Hawai‘i are no longer under evaluation in coordination with UH Manoa. More information available in the LEAD 2-Year Program Evaluation Report (https://www.hhhrc.org/lead).

LEAD Maui

LEAD Maui was launched on May 1, 2019, by Mental Health Kokua (MHK) and is ongoing. LEAD Maui has successfully coordinated diversion efforts directly with the Maui Police Department and local service providers to provide direct services to clients in their community. The MHK was able to sustain the LEAD Maui program beyond 2020 through supplemental grants and private donations.

LEAD Honolulu

LEAD Honolulu was launched on July 1, 2018, by the Hawai'i Health & Harm Reduction Center and is ongoing. LEAD Honolulu transitioned from a law enforcement diversion approach to a community diversion model in early 2022. This program was able to sustain its program efforts through ADAD contracts targeting populations in the SUD Continuum of Care, grants from the Harry and Jeannette Weinberg Foundation, and private donations. An Open Society Foundation grant allowed LEAD Honolulu to obtain technical assistance through the LEAD National Support Bureau.

According to the Evaluation Report, 53 percent of clients who received intensive case management services from LEAD Honolulu in the first two years reported receiving no case management services. 98 percent of those clients previously mentioned reported that they are currently experiencing homelessness.

In its third year, despite the COVID-19 pandemic, LEAD Honolulu was able to coordinate housing for twenty percent of the clients referred. Throughout the third year, 100 percent of those clients sustained their housing placement, many moving on to more stable housing options soon after.

LEAD Honolulu has excelled at closing service gaps throughout its four years providing intensive case management and triage to individuals in need.

1. ***HACDACS recommends*** support of the LEAD programs operating in Maui and Honolulu.

2. ***HACDACS recommends*** support of a State Administering Agency in Hawaii applying for the next available Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program through the U.S. Department of Justice Bureau of Justice Assistance. The current LEAD programs operating in Maui and Honolulu qualify under previous grant allowances under Category One. Additional funding will allow programs to further develop capacity and expand service delivery.

Intersection of Substance Use Treatment and the Criminal Justice System

According to the House Concurrent Resolution (HCR) 85 Task Force report Creating Better Outcomes, Safer Community, Hawai'i's combined jail and prison population has increased by 670 percent in the past 40 plus years, and its incarceration rate has increased by 400 percent. Hawai'i's jail population is extremely high given our relatively small population. To put things in perspective, Hawai'i has about the same number of persons incarcerated as Sweden, even though

Sweden's population is more than six times larger than Hawai'i. Around the mid-1990s, Hawai'i's prisons had become so overcrowded, and community resistance to the building of new facilities was overwhelming, that the state began sending Hawai'i's incarcerated population to privately owned and operated prisons on the US continent. The practice of shipping our pa'ahao (person who is incarcerated) to the continent continues today. Hawai'i is one of only five states in the country that houses 20 percent or more of their pa'ahao in private prisons. However, even with shipping our pa'ahao to the continent, our jails and prisons remain overcrowded and in very poor condition.

In a recent 2022 report by the Hawai'i Correctional Oversight Commission (HCOC), the coordinator and commission members candidly commented on severe overcrowding, safety, and security concerns. The report also commented on the lack of programs and basic services, including several pa'ahao being housed in shipping containers. The Department of Public Safety (DPS) has also been under fire recently for the growing number of deaths while in custody and the lack of working video cameras which make investigations of abuse extremely difficult.

Hawai‘i ranks third in the nation for drug crime sentencing, with half of all prison sentences being drug related. Nearly all (98 percent) drug offenses charged in the state are being served in prison, meaning those charged have received a sentence of one year or longer (Security.org Team, 2019). According to the HCR 85 Task Force report, Native Hawaiians make up 24 percent of the overall population of Hawai‘i yet make up a staggering 37 percent of the incarcerated population and 44 percent of incarcerated women. Further, many criminal justice advocates argue that the circumstances are far worse, proposing that Native Hawaiians make up an estimated 80 percent of the incarcerated population (webinar, Pu‘uhonua Prison Program, 2021). This data discrepancy is largely due to the problematic way ethnicity data is collected upon intake, asking justice-involved persons to "choose one" ethnicity.

Native Hawaiians are sentenced to prison more often for drug offenses than any other ethnic group (Kī‘aha, 2016). In 2020, Native Hawaiians made up 38 percent of adult persons incarcerated in Hawai‘i for which "serious drug offenses" was their lead charge, and thirty-nine percent were listed as "drug paraphernalia". In 2018, over 30 percent of all Native Hawaiian admissions to ADAD treatment were referred via the criminal justice system, increasing to over 40 percent in 2020. Of those Native Hawaiians accessing services, over 40 percent indicated methamphetamine addiction as their primary substance of issue (reported with permission from ADAD).

HACDACS invited the following speakers to elaborate on the issues impacting how the Department of Health, ADAD and the DPS, Corrections Division, maybe be able to decrease recidivism related to drug offenses and improve outcomes for justice-involved persons.

Mr. Ted Sakai was a previous director of the DPS and probation officer, who now sits on the Hawai‘i Correctional Oversight Commission (HCOC), spoke to HACDACS on August 23, 2022, about the HCOCs focus on population management control within correctional facilities due to extreme overcrowding. They are also focused on the Reentry Coordination Office which aims to improve the process of helping previously incarcerated persons reenter the community as those released are often released with no resources or support. He stated that "corrections really need additional programs in this area as about 60 percent of incarcerated persons have a diagnosable SUD which may contribute to their criminality, even if they are not currently incarcerated for a drug charge."

In 1995, Hawai‘i began to contract with private prison companies on the continent to hold Hawai‘i‘s incarcerated population, which was supposed to be temporary, to relieve overcrowding. Today, we still incarcerate more than 1,000 Hawai‘i residents in Arizona’s Saguaro Correctional Center. To free up beds, those incarcerated are often sent to Arizona even before they have completed their SUD programming.

Many may also face challenges with housing and mental illnesses in addition to SUD, this can cause additional challenges and consume a lot of resources. Every person that comes into corrections must visit medical staff within hours of intake. During his time, between thirty and forty percent of new intakes were homeless, mentally ill, or had a SUD. Too often, our jails are being used when the police are out of options for this population. A high percentage of intakes are those that were already on probation or parole, indicating that those who are released are not set up for success in the community.

There is a real need to find alternatives to incarceration within the community to reduce the jail population, help the Hawai‘i state hospital, and reduce overall costs to the state. There is also a need to build partnerships between state services, including the DOH, the DPS, law enforcement, and the community. Building partnerships are essential as 95 percent of those incarcerated will return to the community at some point. We should want these individuals as prepared as possible

Behind the closed doors of a facility, it is a totally different and insulated world, and often at the discretion of the warden for each facility. Security is paramount, which makes most administration and staff distrustful of anything new. We need to look even at the language when someone is sentenced to prison. When sentenced, they are “remanded to the care and custody of the director of the department of public safety”; this includes all their basic needs; food, clothing, healthcare, etc. The DPS has control over everything, and all the systems are insular, meaning SUD treatment in a facility does not connect with, have contact with, or share files with any SUD treatment or recovery service provider in the community. There is a disconnect between care and data sharing.

The DPS also determines what kind of medications, for those who are incarcerated, can take. They have a formula of medications that are allowed for use in facilities and those which are not. When we think about medications for opioid use disorder (MOUD) such as Vivitrol, buprenorphine, etc. the DPS has a concern with liability and will be cautious. It may be very difficult to get these medications approved, despite their evidence-base.

HACDACS reached out to the, Mr. Dwayne Kojima, Substance Abuse (SA) Program Manager with the DPS, to speak at HACDACS August 23, 2022, meeting, as part of a panel discussion on the intersection of substance use treatment in corrections with services once a person is released. Mr. Kojima was unable to attend, however, provided the following written answers to questions included in the HACDACS invitation to speak.

Upon intake, individuals complete various assessments to identify criminogenic needs which can then be matched to support and services. Once assessed, a recommended level of treatment is determined. SUD treatment is only offered to individuals who are assessed in need of SUD treatment. Currently, SA offers outpatient, intensive outpatient, and residential service treatment programs; with participation being voluntary. In general, each treatment program, at each facility follows a set of evidence-based tenets to promote a standardized approach to maintain

consistency and quality. The exceptions are Residential and Intensive Residential treatment which are unique to specific facilities: Women's Community Correctional Center, Waiawa Correctional Facility, and Saguaro Correctional Center. SUD treatment works best when it involves evidence-based practices that account for risk, need, responsivity of the individual, and the fidelity of which the program is administered. While evidence-based practices provide a framework for what is to be done and have been shown to work, it takes consistency, persistency, and fidelity to reach desired outcomes.

If there is a need for continued support post-treatment after release, that recommendation will be noted in the institutional discharge documentation. When "released" to another jurisdiction (i.e., parole), the receiving agency will reassess the individual to design a case plan. When individuals are "released" they may not be under the jurisdiction of PSD. However, Mr. Kojima stated that "every effort to inform the receiving agency or family is made to offer support services." The DPS website also offers a PSD Community Resource Guide.

Ms. Renee Rivera, who is in long-term recovery and has lived experience with being justice-involved, spoke to HACDACS at it August 23, 2022, meeting as part of a panel discussion. She now teaches and serves as a mentor with Going Home Hawai'i, a nonprofit organization on Hawai'i Island, that provides transitional housing services to those coming out of incarceration. Ms. Rivera was able to share, from the perspective of a person interacting with the carceral system, her struggles with both substance use and mental health issues, which played a large part in her justice involvement.

Ms. Rivera described the struggles in Hawai'i, especially for someone experiencing severe mental health issues, encountering the carceral system. Of being transferred to the Hawaii State Hospital, not being offered any evaluations for mental health, and having to explain her situation and advocate for an evaluation and appropriate mental health care. With no residential treatment for mental health in Hawai'i, jails and prisons are being used to house those with severe mental health issues, SUD, and houselessness. Without the appropriate care both in the facility and in the community, these individuals are released more often into the same unhealthy environment they came from.

Ms. Rivera expressed the difficulty for someone with severe mental health issues and SUD to navigate the system, making it essential to provide a navigator for these individuals. This navigator can be that bridge to help someone navigate the terms of their probation/parole, find housing when released, reinstate health care, dental care, and get connected with resources and support services in the community. She also shared the importance of being reconnected with culture and learning along her healing journey, which allowed her to really learn more about why she was using substances and making the choices in her life that led to her justice involvement.

A key recommendation from Ms. Rivera centered on providing mentorship to those both in incarceration and those leaving. Mentorship by those with lived experience would provide a unique lived perspective and approach that would be more resonant for those in incarceration and returning to the community. Helping them to navigate the difficult systems they are required to interact with after release, as well as providing peer support to help them with the journey of introspection, looking at why they made the choices they had made along the way.

1. ***HACDACS recommends*** a partnership between the DPS and ADAD to coordinate services to ensure there is continuity of care while justice-involved people with SUD move through incarceration and re-enter the community.

2. ***HACDACS recommends*** performing and evaluation and needs assessment of substance use care services in correctional facilities to determine long-term effectiveness, cultural safety, and continuity of care with substance use services outside of the facility.

3. ***HACDACS recommends*** standardizing data collection across correctional facilities and all state systems
    a. Development of a centralized data system, accessible by the DPS, the DOH, and the Department of Human Services.
        i. Behavioral health data should be collected and accessible throughout all interactions with state services and include information on hospitalizations, medical records, referrals, treatment, medications, etc.
        ii. Collect ethnically disaggregated data.
            1. PSD currently has a problematic ethnic data collection process. Justice-involved persons are asked to "choose one" ethnicity.

4. ***HACDACS recommends*** development of a coordinated network of state & community-based services and supports aimed at justice-involved persons re-entering the community that are culturally safe, person-centered and build on the strengths and resiliencies of individuals, families, and communities.

5. ***HACDACS recommends*** enhancing Trauma-Informed processes that recognize the signs and symptoms of trauma in those incarcerated and accessing services, their 'ohana, correctional facility staff, and others involved with the system. Aspects of these trauma-informed processes would include:
    a. Recognition of the impact of trauma, and its connection to addiction
    b. Integration of knowledge about trauma into policies, procedures, and practices with special effort to actively resist re-traumatization.
    c. Uplifting of voices of lived experience and provision of mentorship that helps to bridge the re-entry processes.

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-six (32) substance abuse treatment agencies that provide services statewide.

During Fiscal year 2021-22, 1,235 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 1,445 offenders who received services, 210 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2021-22 is as follows in Tables 1-4:

---

* 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, 2021 – June 30, 2022

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu	24	552	257	155	988
Maui	21	77	0	10	108
Hawaii	23	290	0	36	349
Total	68	919	257	201	1,445
Case management services providers: Big Island Substance Abuse Council, Bridge House, CARE Hawaii, Ho'omau Ke Ola, Ka Hale Pomaika`i, Kokua Support Services, Malama Family Recovery Center, Salvation Army-Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, United Self Help, Women in Need					

Table 2. Referrals by Criminal Justice Agency: July 1, 2021 – June 30, 2022

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu[1]	14	497	239	123	873
Maui[2]	20	68		8	96
Hawaii[3]	15	230		21	266
Total	49	795	239	152	1,235
Case management services providers: Big Island Substance Abuse Council, Bridge House, CARE Hawaii, Ho'omau Ke Ola, Ka Hale Pomaika`i, Kokua Support Services, Malama Family Recovery Center, Salvation Army-Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, United Self Help, Women in Need					

Table 3. Carryover Cases 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	10	55	18	32	115
Maui	1	9		2	12
Hawaii	8	60		15	83
Total	19	124	18	49	210
Case management services providers: Big Island Substance Abuse Council, Bridge House, CARE Hawaii, Ho'omau Ke Ola, Ka Hale Pomaika`i, Kokua Support Services, Malama Family Recovery Center, Salvation Army-Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka, United Self Help, Women in Need					

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, 2021 – June 30, 2022

	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Arrests/revocations	5	38	0	14	57
Total served	54	616	34	140	844
Recidivism rate	9.26%	6.17%	0	10.00%	6.75%

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 2019-22

B. ADAD-Funded Adolescent Services: Fiscal Years 2019-22

C. Performance Outcomes: Fiscal Years 2019-22

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

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2019-2022

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Male	67.5%	63.4%	67.3%	67.3%
Female	32.4%	36.6%	32.7%	32.7%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Hawaiian	44.4%	48.9%	48.0%	44.9%
Caucasian	21.3%	21.6%	20.6%	21.0%
Filipino	6.9%	5.4%	7.0%	7.1%
Mixed - Not Hawaiian	4.2%	4.8%	5.4%	6.8%
Japanese	3.2%	3.0%	2.8%	2.7%
Black	2.3%	1.0%	1.4%	3.4%
Samoan	3.1%	2.0%	2.2%	2.6%
Portuguese	1.5%	1.7%	1.5%	1.0%
Other Pacific Islander	3.9%	3.5%	4.6%	5.2%
Other*	9.3%	8.0%	6.5%	5.3%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Methamphetamine	60.6%	60.3%	60.6%	53.5%
Alcohol	16.1%	14.5%	12.1%	19.5%
Marijuana	9.1%	8.9%	10.6%	12.3%
Cocaine/Crack	1.9%	2.6%	1.6%	1.5%
Heroin	6.9%	7.9%	10.0%	8.9%
Other*	5.4%	5.7%	5.1%	4.3%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over the counter.				

ADAD-FUNDED ADULT ADMISSIONS BY RESIDENCY

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
O'ahu	57.8%	46.6%	53.7%	49.6%
Hawaii	27.2%	35.3%	27.0%	34.3%
Maui	8.0%	8.2%	10.8%	6.7%
Molokai/Lanai	1.4%	2.3%	1.2%	0.6%
Kauai	2.4%	3.6%	3.1%	2.7%
Out of State	3.2%	4.0%	4.2%	6.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2018-19 through Fiscal year 2021-22, methamphetamine use decreased from 60.6% to 53.5%. Alcohol use increased from 12.1% to 19.5%. Marijuana use increased from 10.6% to 12.3%. Cocaine/Crack use decreased from 1.6% to 1.5%. Heroin use decreased from 5.1% to 4.3%. All "Other" substances decreased from 5.1% to 4.3%.

Also, among the 1,727 adult admissions for FY2022, 567 admissions (32.8%) were homeless when admitted to treatment.

APPENDIX B

ADAD-FUNDED ADOLESCENT[6] SERVICES FISCAL YEARS 2019-2022

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Male	48.7%	47.7%	55.5%	45.2%
Female	51.3%	52.6%	44.5%	54.8%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Hawaiian	48.1%	48.0%	45.6%	44.4%
Caucasian	7.6%	7.1%	8.1%	9.0%
Filipino	9.3%	9.1%	5.6%	8.9%
Mixed - Not Hawaiian	2.7%	5.7%	5.4%	7.0%
Japanese	3.3%	3.1%	1.8%	2.8%
Black	2.1%	1.7%	1.4%	1.5%
Samoan	4.6%	4.2%	4.7%	3.5%
Portuguese	0.8%	0.8%	-0-	0.7%
Other Pacific Islander	13.9%	15.1%	24.2%	17.6%
Other*	7.6%	5.2%	3.2%	4.5%
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 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Methamphetamine	0.6%	0.8%	1.8%	0.8%
Alcohol	18.3%	18.6%	17.1%	15.9%
Marijuana	64.4%	64.7%	71.1%	71.0%
Cocaine/Crack	0.7%	0.5%	0.2%	0.7%
Heroin	0.1%	-0-	-0-	-0-
Other	16.0%	15.3%	9.9%	11.6%
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 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
O'ahu	66.9%	71.8%	84.4%	32.5%
Hawaii	18.0%	12.6%	2.9%	38.7%
Maui	9.3%	10.3%	12.2%	17.3%
Molokai/Lanai	-0-	0.6%	-0-	5.2%
Kauai	5.7%	4.7%	0.5%	6.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2018-19 through Fiscal Year 2021-22, methamphetamine decreased from 1.8% to 0.8%. Alcohol decreased from 17.1% to 15.9%. Marijuana decreased slightly from 71.1% to 71.0%. Cocaine/Crack increased slightly from 0.2% to 0.7%. All "Other" substances increased from 9.9% to 11.6%.

[6] 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 and 2021 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 2019 through 2022, 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 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Employment/School/Vocational Training	98.3%	97.7%	98.6%	99.2%
No arrests since discharge	94.1%	94.3%	98.0%	99.2%
No substance use in 30 days prior to follow-up	56.7%	51.8%	47.1%	39.4%
No new substance abuse treatment	75.8%	80.5%	89.2%	89.7%
No hospitalizations	95.4%	94.8%	96.3%	98.4%
No emergency room visits	92.6%	92.1%	94.2%	96.9%
No psychological distress since discharge	76.3%	81.1%	79.7%	89.0%
Stable living arrangements*	97.1%	97.9%	96.9%	97.6%

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

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2019 through 2022, 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	63.4%	61.9%	51.6%	46.7%
No arrests since discharge	90.1%	94.0%	96.5%	98.0%
No substance use in 30 days prior to follow-up	67.4%	72.5%	61.9%	57.0%
No new substance abuse treatment	63.6%	72.2%	69.1%	76.8%
No hospitalizations	91.9%	93.0%	94.8%	86.4%
No emergency room visits	88.1%	90.6%	90.2%	94.4%
Participated in self-help group (NA, AA, etc.)	40.3%	31.8%	27.4%	28.1%
No psychological distress since discharge	78.0%	81.1%	75.1%	82.1%
Stable living arrangements*	83.1%	77.3%	73.6%	90.4%

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

APPENDIX D

TREATMENT RELATED TO SUBSTANCE USE - COUNTY ESTIMATES

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

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

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

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

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

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

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

The five-year (Fiscal Year 2018 to Fiscal Year 2022) average annual ADAD-funded admissions for adults is 2,706, which is 3.6% of the estimated need for adult alcohol and drug abuse treatment.

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

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

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

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

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

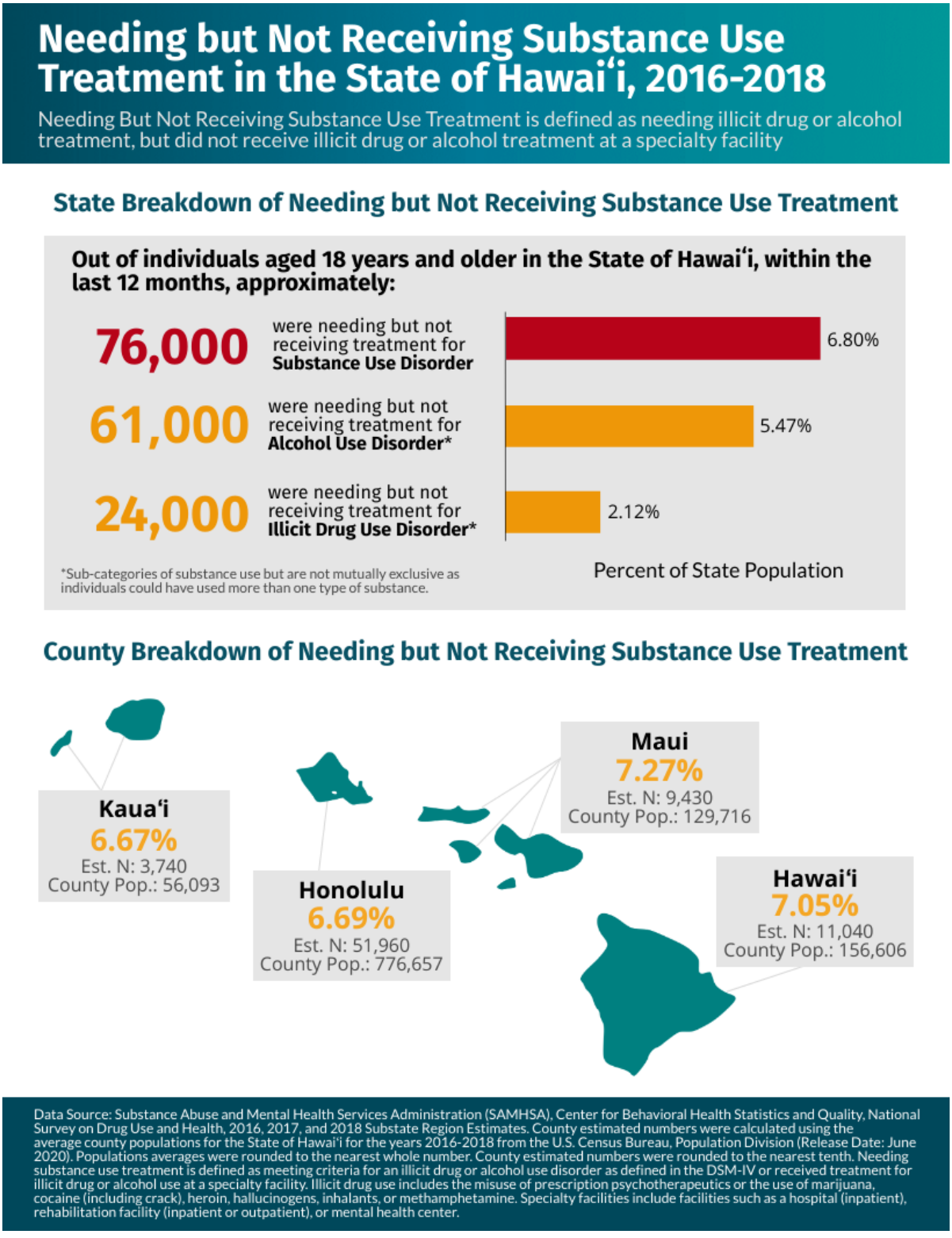


Table D2: Substance Use Disorder in the Past Year among Individuals Aged 18 or Older, by State and Substate Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs										
	Percent of State Population (County Population)									
	Kaua‘i		Honolulu		Maui		Hawai‘i		State	
Population (18 Years and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

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

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

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

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

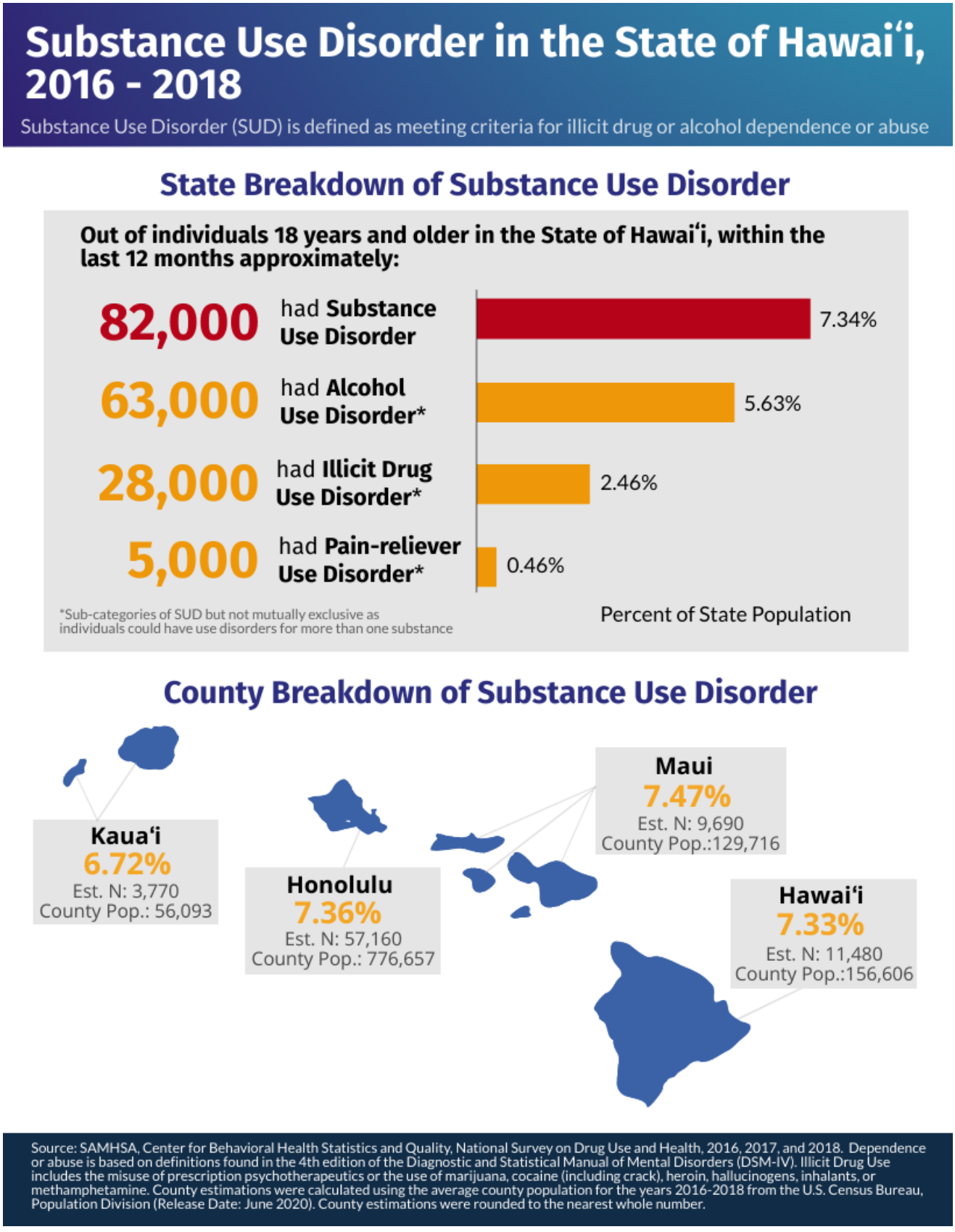
For *Hawai‘i County*, 11,480 (7.33%) of individuals aged 18 and older on the Big Island had substance use disorder in the past year.

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

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

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

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



APPENDIX E

2019-2020 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[1], for Gender, Grade Level, and Race/Ethnicity (weighted counts and percents)					
	No		Yes		Total
	n	% (CI95%)	n	% (CI95%)	
Overall Total	7,172	**88.9 (88.2, 89.6)**	896	**11.1 (10.4, 11.8)**	8,068
Gender					
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
Grade					
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
Self-Identified[8] Primary Race/Ethnicity					
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.

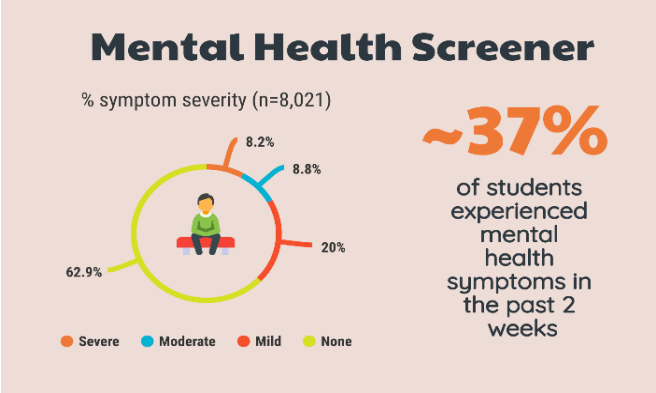
The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade, and primary race/ethnicity:

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

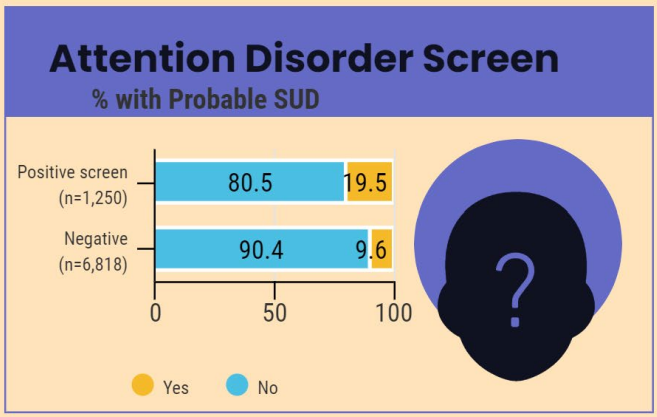
[2] While the survey asks students to select a group with which they primarily identify, a large proportion reported primarily identifying with multiple (2 or more) ethnic/racial groups. Among those who selected two or more ethnic/racial groups in the state sample, Native Hawaiian was among the highest therefore, the table shows the percentage of students that selected Native Hawaiian and those that did not.

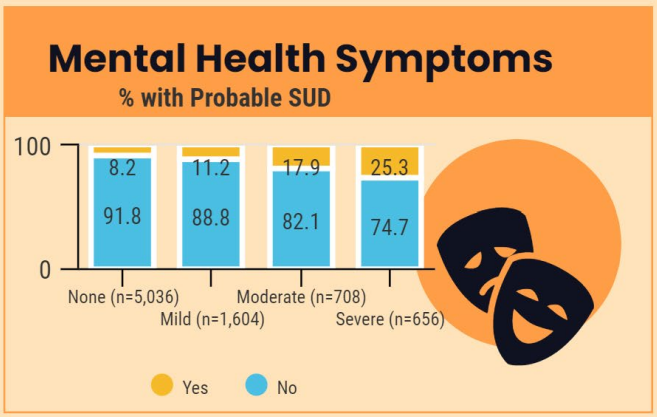
- The overall total estimated treatment need across the state ***increased*** to 11.1% compared to 7.7% reported from the 2007-2008 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study.
- ***Transgender and Other Gender Minority*** students make up the smallest proportion of the state sample but 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 8th graders, 11.9% of 10th graders, and 15.0% of 12th 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 2018 to Fiscal Year 2022) average annual ADAD-funded admissions for adolescents is 1,249, which is 14.1% of the estimated need for adolescent alcohol and drug abuse treatment.

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

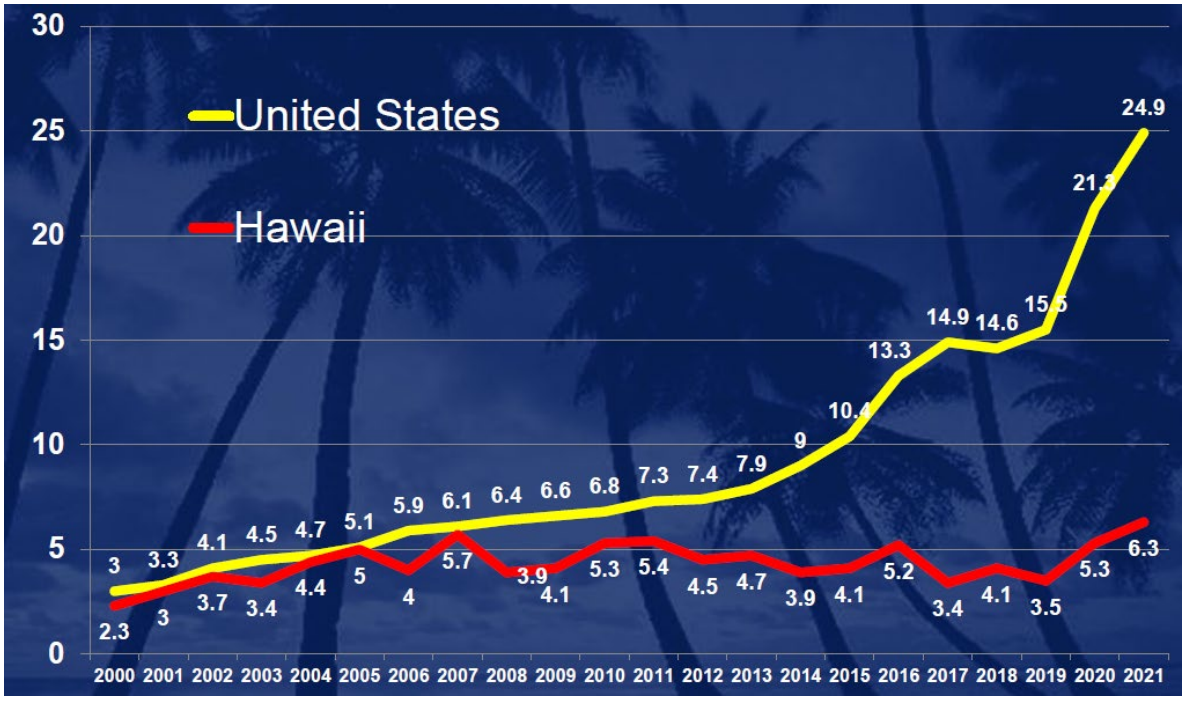
Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also 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 and the Hawaii Opioid Initiative (HOI).

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

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 (6.3 in 2021), a slight increase from the 2016 rate of 5.2 (Figure 1) while the national rate has increased since 2000 (24.9 in 2021).

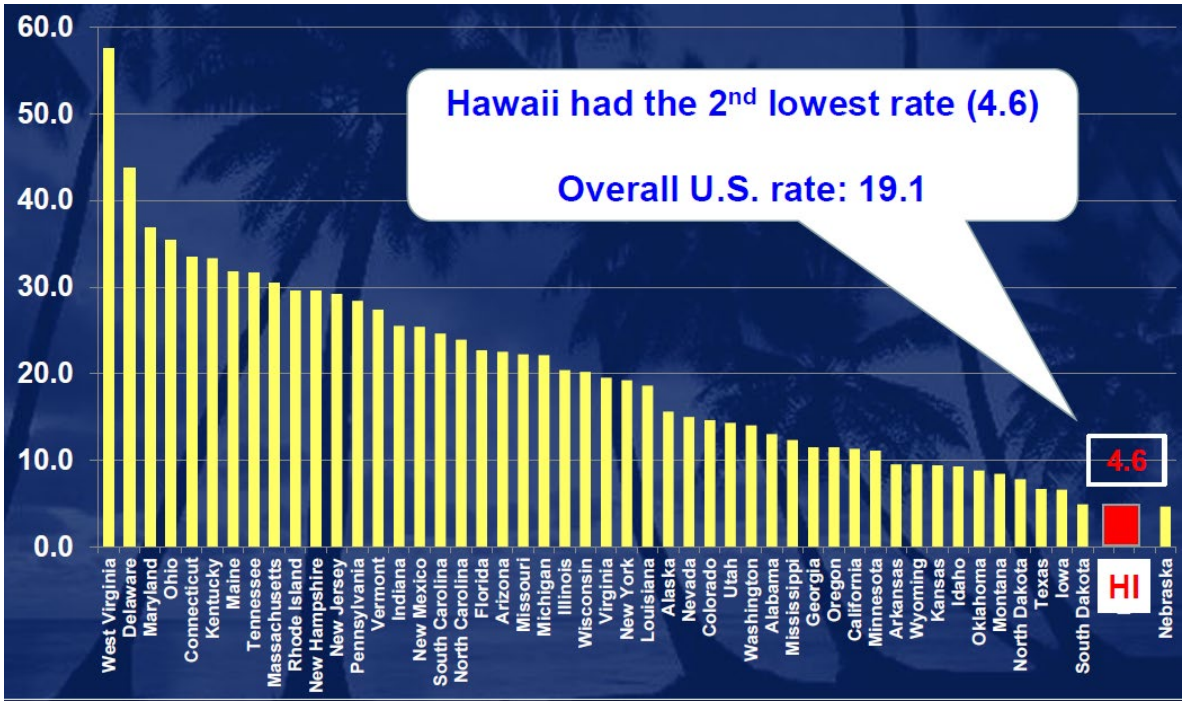
Figure 1. Adjusted opioid poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2000-2021.



And when compared to other states, Hawaii now has the second *lowest* fatality rate of poisonings due to prescription opioids, methadone, heroin and opium (4.6) which is also

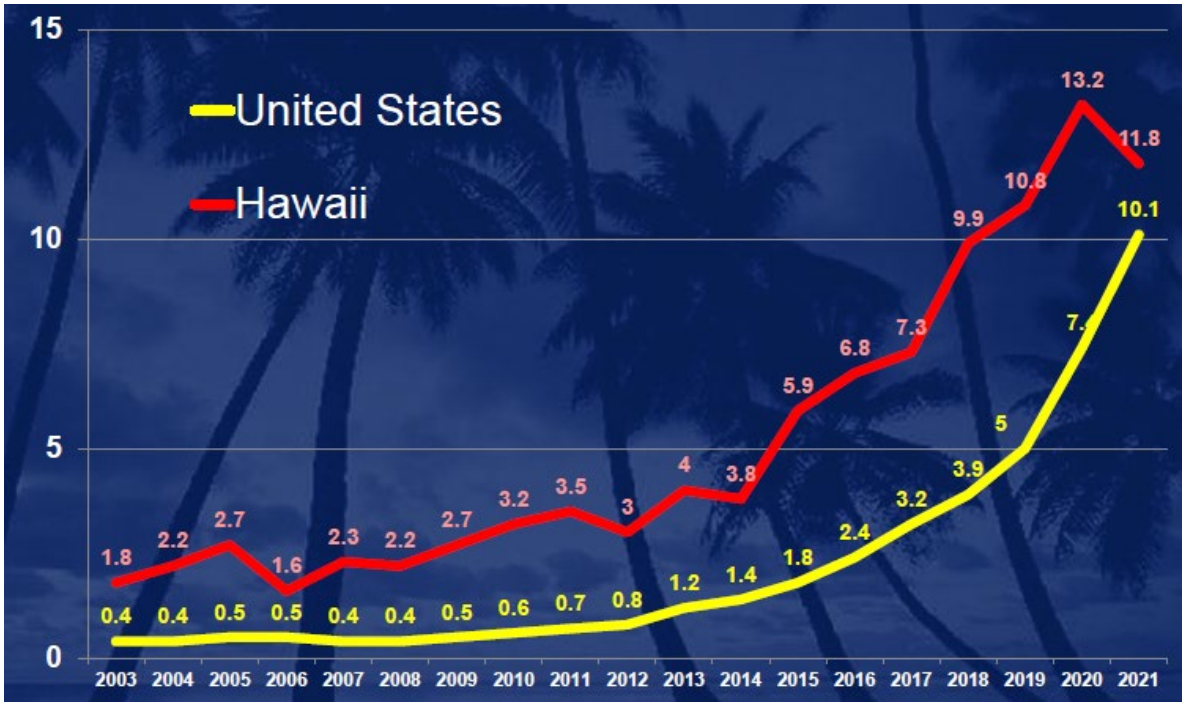
well below the national rate of 19.1 (Figure 2).

Figure 2. Adjusted opioid poisoning fatality rates (per 100,000), by state, 2018-2021*



*Data for 2021 is provisional.

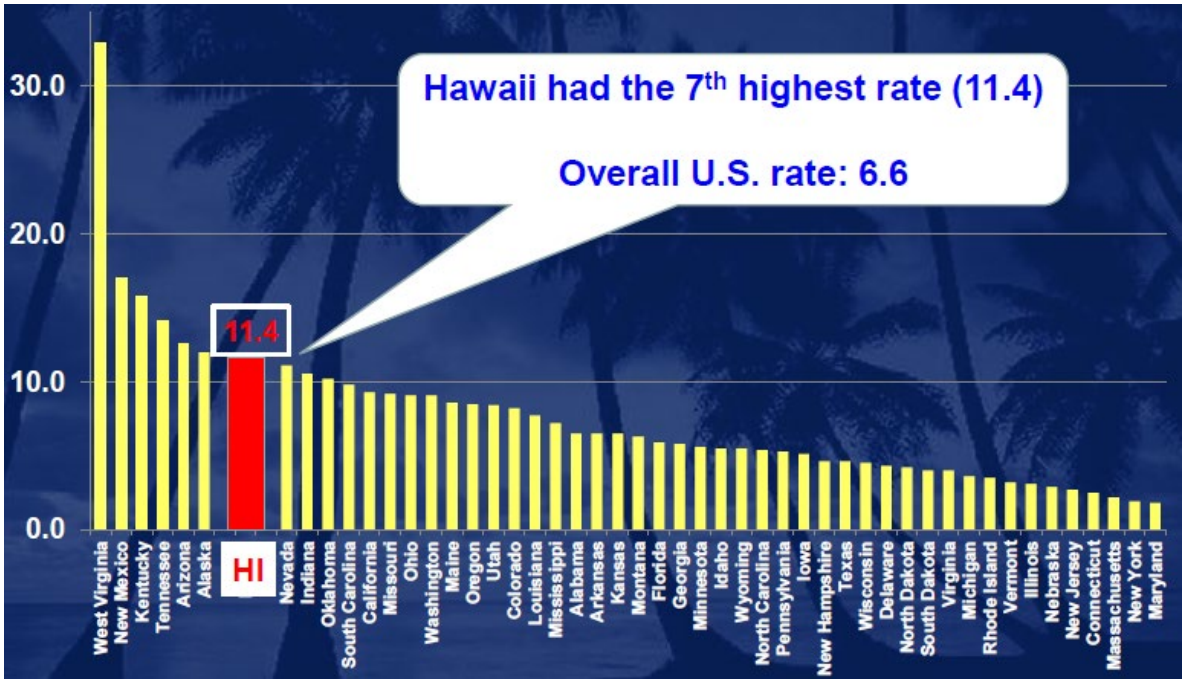
Figure 3. Annual adjusted "meth" poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2003-2021*



* Code indicating "Psychostimulants with abuse potential. Data for 2021 is provisional.

However, Hawaii by comparison has a higher rate of meth-related fatalities (11.8 in 2021), slightly higher than the national average of 10.1 (Figure 3). Hawaii also ranks 7th in the fatality rate of poisonings due to "meth," higher than the national rate of 6.6 (Figure 4).

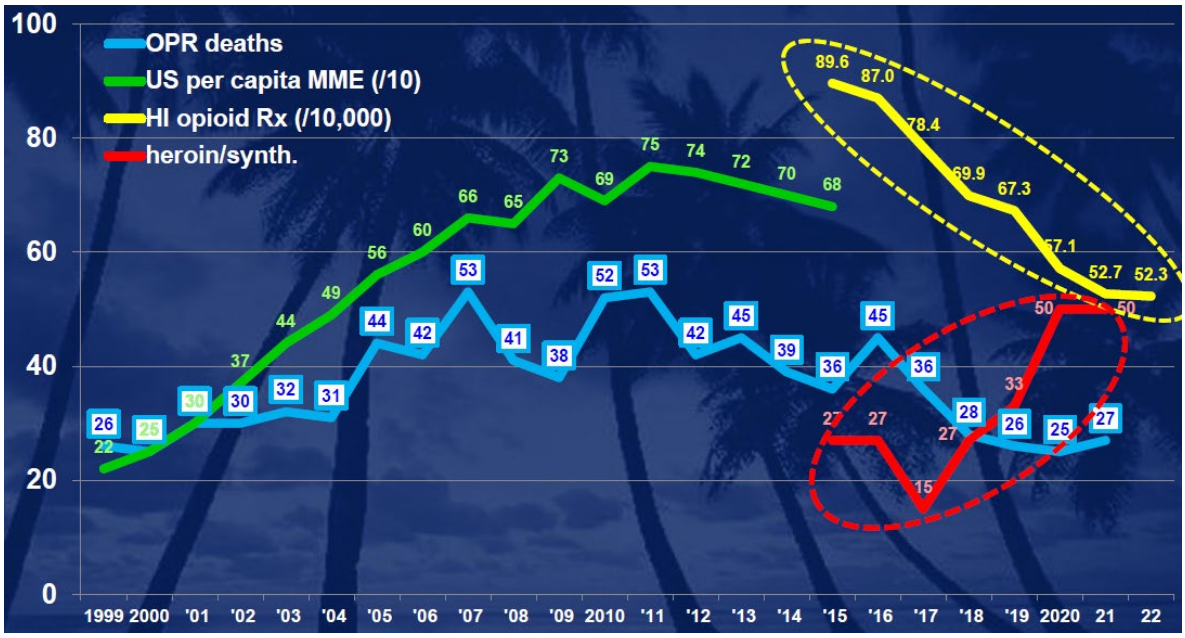
Figure 4. Average adjusted "meth" poisoning fatality rates (per 100,000), by state, 2018-2021*



* Code indicating "Psychostimulants with abuse potential. Data for 2021 is provisional.

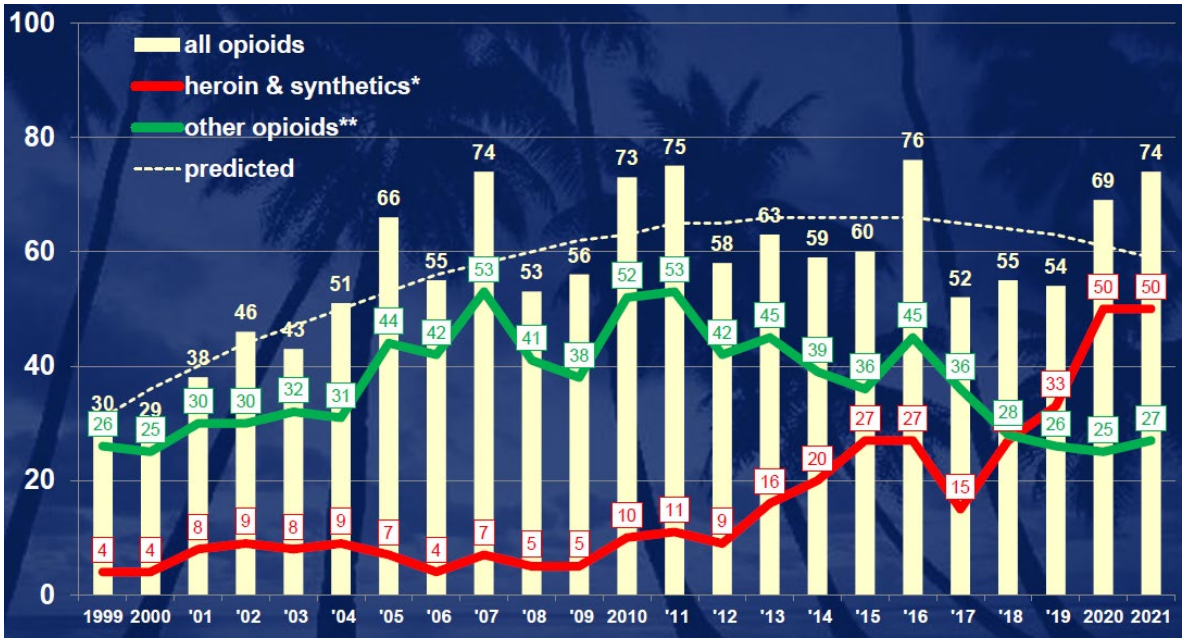
When looking at poisoning fatality rates among Hawaii residents compared to national opioid consumption, EMSIPSB data show that deaths due to opioid pain relievers are decreasing (Figure 5). However, Hawaii death certificate data show a greater prevalence of fatal opioid poisonings among Hawaii residents 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 (2015-2022).



* OPR includes naturally derived opioids (e.g., codeine, morphine), semi-synthetics (e.g., oxycodone, hydrocodone) and other narcotics. Prescription data for 2022 is projected from PDMP data through September.

Figure 6. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 1999-2021.



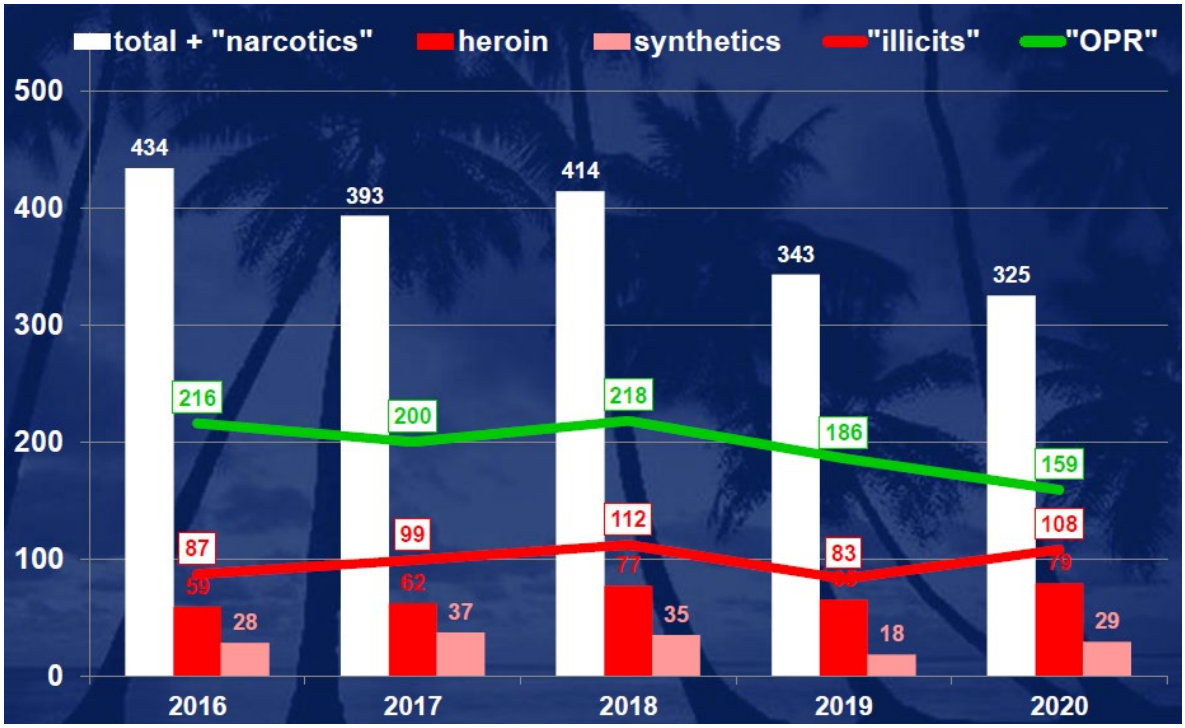
* Includes heroin and synthetic opioids other than methadone (e.g., fentanyl, tramadol)
** Includes naturally derived opioids (e.g., codeine, morphine), semi-synthetics (e.g., oxycodone, hydrocodone) and other narcotics.

To summarize, Hawaii has a very low rate of opioid-related poisonings but a high rate by comparison for meth-related poisonings (Figures 3 and 4). Also, while fatal poisonings involving opioid pain relievers are decreasing since 2015, there is a rise in poisoning due to use of illicit substances over the same timeframe.

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

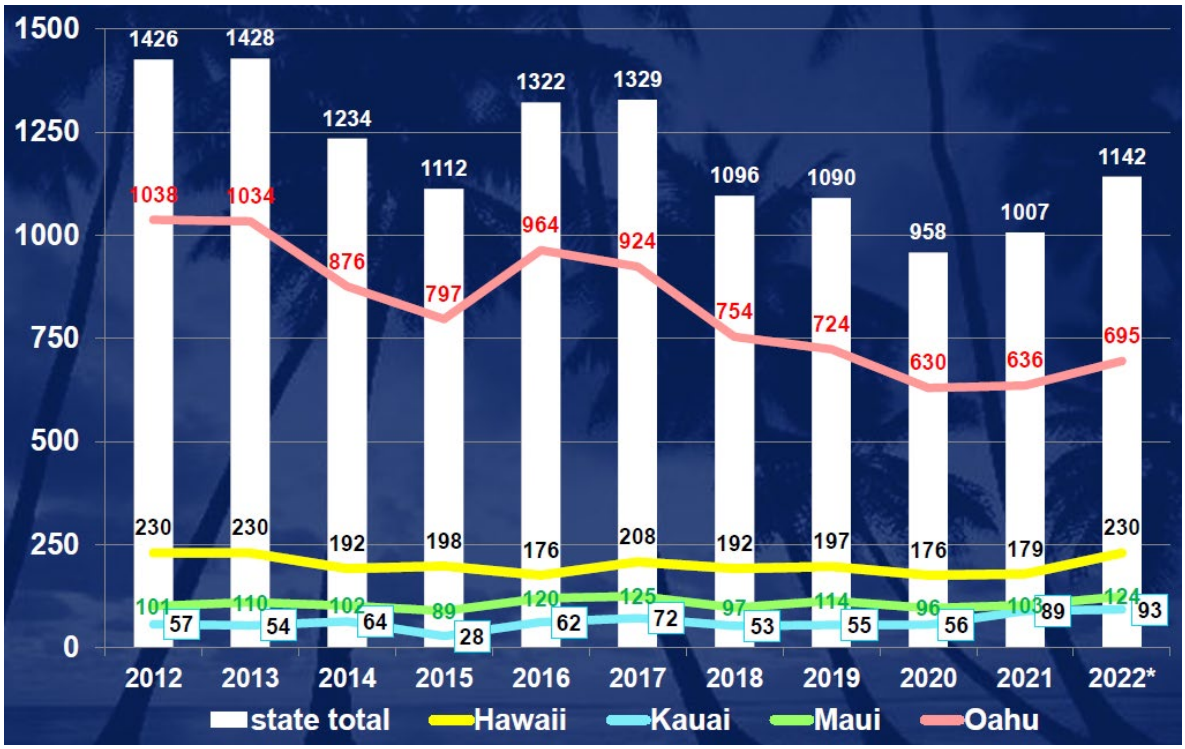
Recent data from the EMSIPSB poison center dataset shows that nonfatal non-heroin opioid poisonings remain significantly higher compared to heroin, however total nonfatal opioid poisonings appear to be decreasing (325 in 2020 vs. 434 in 2016) (Figure 7). And over the last ten years, naloxone administrations continue to remain 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.



According to recent EMS data over a twelve-month period thru Sept. 2022, about 42 percent of 1,044 who received naloxone showed improvement. And for instances characterized as overdoses, at least 72 percent improved in response (Figure 9). EMS also attended to at least 490 overdoses from fentanyl or heroin over the same twelve-month period, where about 22 percent received naloxone from bystanders before EMS arrived (Figure 10).

Figure 8. Annual number of EMS patients receiving naloxone, by county, 2012 to 2022.*



* Total for 2022 projected from data through 9/30/2022

Figure 9. EMS administrations of naloxone, 10/2021 through 9/2022.

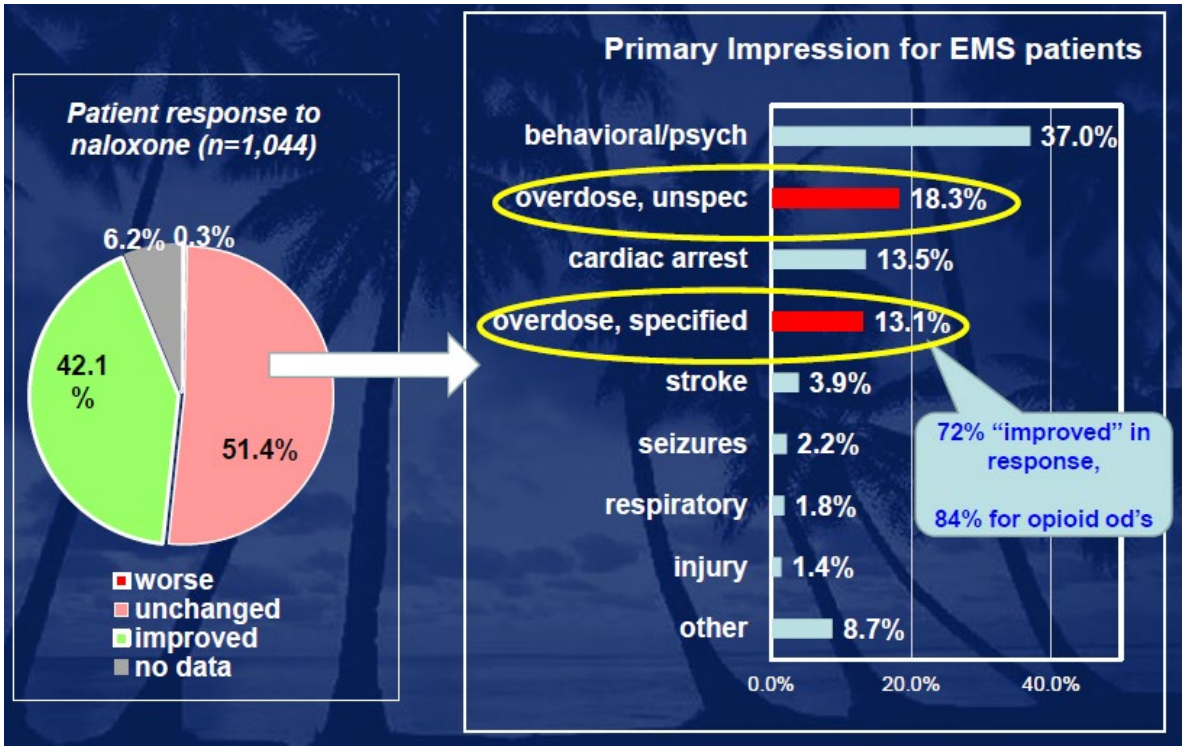
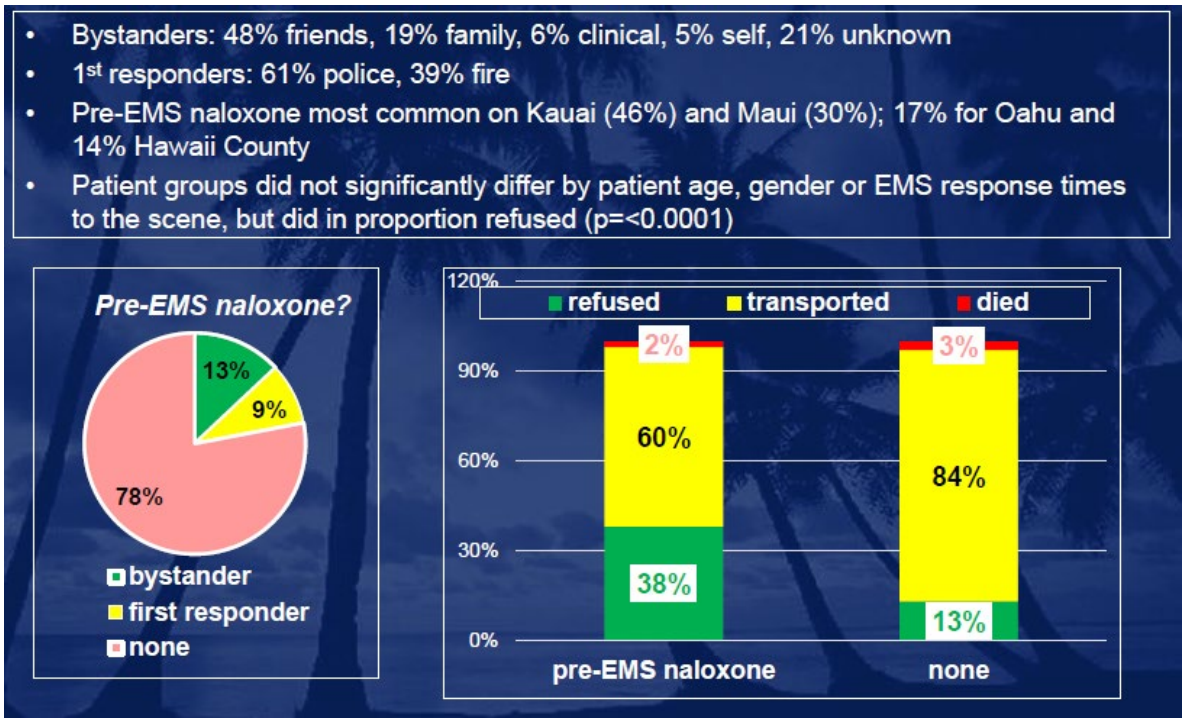


Figure 10. Discharge disposition for EMS patients with fentanyl or heroin overdoses, by pre-EMS naloxone status, 10/2021 – 9/2022.



Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified in a December 2020 literature review conducted by the University of Hawaii 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 11). 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 11. Summary: opioid poisonings in Hawaii, 2014 to 2019.

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

The following programs and interventions identified in a December 2020 rapid literature review conducted by the University of Hawaii 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).