JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

DEPT. COMM. No. 225

KENNETH S. FINK, M.D., M.P.H., M.G.A.
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

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

In reply, please refer to:
File:

December 30, 2025

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

The Honorable Nadine K. Nakamura,
Speaker
and Members of the House of
Representatives
Thirty-Third State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

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

For your information and consideration, I am transmitting a copy of the required Annual Reports on Various Alcohol and Drug Abuse Division Activities and Special Funds to the Legislature, pursuant to Chapter 321, Section 195, Hawaii Revised Statutes; Chapter 329, Section 3, Hawaii Revised Statutes; Chapter 321, Section 193.5, Hawaii Revised Statutes; Chapter 321, Section 192.5, Hawaii Revised Statutes; and Chapter 329E, Section 6, Hawaii Revised Statutes.

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

https://health.hawaii.gov/opppd/department-of-health-reports-to-2026-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

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

REPORT TO THE

THIRTY-THIRD LEGISLATURE

STATE OF HAWAIʻI

2026

PURSUANT TO:

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

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

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

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

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

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAIʻI
DECEMBER 2025**

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2024-25 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawai‘i Revised Statutes (HRS).

For Fiscal Year 2024-25, $34,159,042 was appropriated by Act 230, Session Laws of Hawai‘i (SLH) 2024, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds, and $13,013,329 federal funds (MOF N and P). Of the total appropriated, $26,168,548 was allocated for substance abuse treatment services and $8,327,105 was allocated for substance use prevention services. The funding was inclusive of 33.00 FTE positions.

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

$8.9 million for the Substance Use Prevention, Treatment and Recovery Support Services Block Grant (SUPTRS BG or SUBG) funds (10/1/23-9/30/25) administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

$3.8 million over five years (9/30/24-9/29/29) 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).

$12.5 million over three years (9/30/24-9/29/27) for the SAMHSA Center for Substance Abuse Treatment (CSAT) State Opioid Response (SOR) SOR 4 grant that enhances and expands the services from the SOR 3 grant and aims to improve access to opioid and other substance misuse prevention, treatment, and recovery support services while expanding harm reduction, increase the inclusion of Native Hawaiian cultural intervention treatment programs, wellness plans, and holistic living systems of care, increase system-wide routine data collection, sharing, and dissemination, and expand community-based programs and public education to prevent opioid and other substance misuse and improve harm reduction systems.

$6.25 million over five years (9/30/23-9/29/28) for the 2023 SAMHSA Center for Substance Abuse Prevention (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).

$13.7 million over five years (9/1/23-8/31/28) for the Centers for Disease Control and Prevention (CDC) Overdose Data to Action in States (OD2A-S) grant. The OD2A-S cooperative agreement is to expand drug overdose surveillance and prevention efforts. Surveillance activities help track overdoses, emerging drug threats, associated risk factors. Prevention activities promote evidence-based strategies aligned with the rapid shifts in overdose trends, including changes in the illegal drug supply and rise in stimulant and polysubstance use.

Other funds for substance abuse prevention and treatment services include the Opioid Litigation Settlement Funds.

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 saw 1,193 adult admissions statewide in Fiscal Year 2024-25;
>
> School-based and community-based outpatient substance abuse treatment services saw 554 adolescent admissions statewide in Fiscal Year 2024-25; and
>
> Curriculum-based youth substance use prevention and parenting programs, and underage drinking initiatives served 403,398 children, youth, and adults directly and indirectly through individual-based and population-based prevention programs, strategies, and activities[2] in Fiscal Year 2024-25.

Also included are reports that are required pursuant to:

- Section 321-195, HRS, requiring a report on implementation of the state plan for substance abuse;
- Section 329-3, HRS, requiring a report by the Hawai‘i 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; and
- Section 329E-6, HRS, requiring a report on unintentional opioid-related drug overdose.

[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; treatment monitoring program; and public service announcements.

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2024-2025 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD or Division) and is submitted pursuant to Section 321-195, Hawai‘i Revised Statutes (HRS). Also included are reports that are required pursuant to: Section 329-3, HRS, which requires a report by the Hawai‘i 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 Hawai‘i residents. ADAD's primary functions include: grants and contracts management; clinical consultation; quality assurance, which encompasses training, accreditation of substance abuse treatment programs, and 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, and 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 use prevention services contracts and the implementation of substance abuse prevention discretionary grants. The Strategic Prevention Framework – Partnerships for Success 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 Hawai‘i.

The Treatment and Recovery Branch (TRB) develop and manages a statewide treatment and recovery system, which includes program and clinical oversight of substance use treatment, opioid treatment programs (OTP), early intervention services, recovery support service contracts, and the implementation of substance use 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 may be 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, persons who inject drugs, Native Hawaiians, and adult offenders.

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2024 to June 30, 2025

State and Federal Funding

Act 230, SLH 2024 appropriated $34,159,042 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year2024-25:

General funds	$20,395,713	(59.71%)	28.0 FTE
Special funds	$750,000	(2.20%)	
Federal funds (N)	$9,038,656	(26.46%)	1.0 FTE
Federal funds (P)	3,974,673	(11.64%)	4.0 FTE
	$34,159,042	(100.0%)	33.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$26,168,548	(71.0%)
Substance abuse prevention services	8,327,105	(22.6%)
Division operating costs	0	(0.0%)
Division staffing costs	2,343,092	(6.3%)
	$36,838,745*	(100.0%)

*Total allocation is higher than appropriated funds because it is inclusive of grant funding that is not legislatively appropriated.

For Fiscal Year 2024-25, $34,159,042 was appropriated by Act 230, SLH 2024, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds and $13,013,329 federal funds (MOF N and P). Of the total appropriated, $26,168,548 was allocated for substance use treatment services and $8,327,105 was allocated for substance use prevention services.

[3] Position count does not include temporary grant-funded exempt positions that are not included in the State budget.

Federal Grants and Contracts

Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG or SUBG). ADAD received $8.79 million in Fiscal Year 2025 (10/1/24-9/30/26) of SUPTRS BG funds administered by SAMHSA to plan, implement and evaluate substance abuse prevention and treatment activities.

U.S. Food and Drug Administration (FDA) Tobacco Inspections. The award of a $3.8 million 5-year contract (9/30/24-9/29/29) was received from the FDA. Since September 2011, Hawai‘i has been awarded $6.3 million by the FDA to support 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.). In September 2024, Hawai‘i was awarded an additional $3.8 million 5-year contract from the FDA for continued services for the period of September 30, 2024, through September 29, 2029. 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 2023. In September 2023, Hawai‘i was awarded a new SPF-PFS grant of $1.25 million in each of five years (9/30/23-9/29/28) to work in collaboration with state and community level stakeholders to continue the Hawai‘i Project's efforts to address prevalent substance use issues in communities of demonstrated high need use. The project prevents the initiation and escalation of substance use by promoting comprehensive, data-driven processes and strengthening prevention infrastructure at both community and state levels. It emphasizes evidence-based approaches that address local priorities, enhance protective factors, reduce risk factors, and builds capacity for sustainable, community-driven prevention efforts.

State Opioid Response (SOR) 3.0 The Hawai‘i SOR 3.0 grant (project period: 9/30/2022 – 9/29/2024) totaling $8 million was an initiative awarded through SAMHSA's Center for Substance Abuse Treatment (CSAT). A no-cost extension was approved for one year (9/30/24 – 9/29/25). The extension allowed the grant to continue to address opioid and stimulant use disorder by increasing access to treatment and recovery support services, increasing access to primary prevention for families and children, and expanding naloxone distribution throughout the State. The SOR 3.0 grant ended on 9/29/25.

State Opioid Response (SOR) 4.0 The Hawai‘i SOR 4.0 grant (project period: 9/30/2024-9/29/2027) totaling $12 million is an initiative awarded through SAMHSA's Center for Substance Abuse Treatment (CSAT). The SOR 4.0 grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose related deaths by further expansion of naloxone nasal spray distributions, funding prevention, treatment, and recovery activities for those with opioid use disorder (OUD). SOR grant funds also support efforts to address opioid and stimulant use disorder by increasing access to primary prevention for families and children, providing Hepatitis C Virus (HCV) care coordination, increasing the availability of telehealth services for rural communities, expanding opioid and stimulant use training for nurses, providing workforce training, developing a new contingency management program, and providing peer support for pregnant women with dependent children

(PWWDC). An application for continuation of the grant was approved for year two (9/30/25 – 9/29/26).

SUPTRS BG COVID-19 Supplement. The SUPTRS BG 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 SUPTRS grantees in response to the COVID-19 pandemic. The funds were 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. (An extension of time was approved for one year (3/15/23 – 3/14/24) and an additional extension of time for one year was approved (3/15/24 – 3/14/25)). The Grant ended on 3/14/25.

SUPTRS BG American Rescue Plan Act (ARPA) Supplement. The SUPTRB BG ARPA supplemental funds (project period 9/1/21- 9/30/25) totaling $7 million. These supplemental funds awarded May 17, 2021, were to address the effects of the COVID-19 pandemic and improve and enhance the substance use service array that serves the community. The funds were 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. The grant ended on 9/30/25.

SUPTRS BG ARPA Mitigation Supplement. The SUPTRS BG ARPA Mitigation supplemental funds (project period 9/1/21-9/30/25) that were transferred to ADAD was $155,979.05. 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 were 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 rurally remote and/or provide outpatient or intensive outpatient services, and for other SUD treatment and primary prevention facilities.

Overdose Data to Action in States (OD2A-S). Hawai‘i was awarded a $2.7 million per year for five years (9/1/23 – 8/31/28) to continue the progress of the surveillance and prevention activities of the previous Hawai‘i OD2A project (conducted by the Adult Mental Health Division) to address the ongoing issues of the drug overdose epidemic in Hawai‘i by working collaboratively and strategically with key partners from various sectors to implement and evaluate evidence-based strategies to achieve measurable improvements in the prevention, management, and reduction of opioid use with a focus on priority populations. The project will expand and build on key interventions currently being conducted and efforts will be carried out

at the State, regional, and local levels to reach multiple settings and communities to maximize health improvement throughout Hawai‘i’s diverse populations. The project also aims to enhance surveillance efforts by improving infrastructure, morbidity surveillance, mortality surveillance, and data linkage. As part of these enhanced surveillance efforts, Hawai‘i is also in the process of updating the Behavioral Health Dashboard (https://bh808.hawaii.gov) to improve data transparency and streamline timely dissemination of actionable information to partners and the public. Hawai‘i has also developed activities for four key prevention strategies: Clinician/Health System Engagement and Health/IT Prescription Drug Monitoring Program (PDMP) Enhancement; Public Safety Partnerships/Interventions; Harm Reduction; and Community-Based Linkage to Care. Some short-term outcomes of this project include: actionable surveillance data that is more timely, detailed, and comprehensive; increased data sharing and data availability; and an increased collaboration, coordination, and communication among community partners. Some long-term outcomes of this project are decreases in illicit opioid and stimulant use, including co-use with other substances, and decreases in nonfatal and fatal drug overdoses, especially among those that are disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall.

Other funds for substance use prevention and treatment services include the Opioid Litigation Settlement Funds.

Substance Abuse Prevention and Treatment Services

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

Treatment Services. ADAD’s overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse, and dependence by assuring an effective, accessible public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Thirty-one (31) agencies were contracted with the Treatment and Recovery Branch (TRB) within ADAD to provide Substance Use Disorder Continuum of Care Service Array for Adults and Adolescents. Treatment providers may provide all or part of the pre-treatment continuum, such as motivational enhancement, outreach, care coordination, and interim services. In addition to pre-treatment services, some treatment providers may also provide clinical treatment services such as medically monitored inpatient withdrawal management, clinically managed residential withdrawal management, clinically managed high intensity residential services, partial hospitalization, intensive outpatient, and outpatient services. Lastly, TRB also contracts with providers on recovery support services such as therapeutic living, clean and sober housing, continuing care, transportation, translation services, peer support specialist, and childcare.

Other contracted continuum of care services includes early intervention services such as Human Immunodeficiency Virus (HIV) and Hepatitis-C (HCV) testing and counseling services and opioid recovery support services such as providing medications for opiate use disorder

[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.

(MOUD) dosing. All client's admissions, treatment services, including treatment progress notes, and discharges are tracked on the Web-Based Infrastructure for Treatment Services (WITS) system.

Services were provided to 1,193 adults statewide in Fiscal Year 2024-25; and school-based and community-based outpatient substance use treatment services were provided to 554 adolescents statewide in Fiscal Year 2024-25. [5]

In June 2024, the TRB participated in building a new electronic health records system, Inspire Plus, through the procured contracted vendor, RSM US LLP. The entire ADAD staff participated in this effort, along with TRB's contracted providers to provide information that would assist with building a robust database system.

October 1, 2024 was the start date to TRB's thirty-one (31) treatment and recovery support services contracts. The types of services that are provided are listed in the beginning of this section. These contracts end on September 30, 2026.

In Fiscal Year 2024-25, the ADAD and Adult Mental Health Division (AMHD) contracted with Recovery Innovations (RI), to conduct a needs assessment with TRB's contracted providers. This was a statewide effort where RI met with several contracted treatment providers on each island to learn about their programs, listen to their struggles, and understand the need for substance use treatment. RI also met with other stakeholders, such as probation and parole, to gain awareness of their clientele. The report presents a comparative analysis of change costs against potential system-wide economic benefits, providing decision-makers with a holistic understanding of the financial and operational dynamics. The report also provides a guide to the State of Hawai‘i in establishing and maintaining a resilient, responsive, and efficient substance use care ecosystem that meets the highest standards of intervention and support. This report has not been finalized as of this date.

Prevention Services. Through a total of twenty-seven (27) contracts, twenty-two (22) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2025. To best utilize resources, the contracted services implement evidence-based and promising programs, policies, and practices in addition to the SAMHSA/CSAP 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 use in young people in a variety of community settings and promoting programs and policies to improve knowledge and skills related to effective ways to avoid substance use problems and enhance resiliency.

Program implementation is tracked according to the number of times (cycles) curricula and strategies were implemented as collected and reported using WITS, the data management system described above and expanded to collect prevention service data. Additionally, quarterly

[5] For ADAD annual reports prior to FY2024, each treatment episode – regardless of service type or level – was counted separately, even for the same client. Beginning in FY2024, admissions to each service that a client needs is viewed as part of a single episode of care to better reflect a client's full treatment journey.

progress reports, plans and progress notes submitted capture information related to community partnerships, problems, priorities, resources, readiness, and implementation status of identified evidence-based programs. According to the data collected for Fiscal Year 2024-2025, curriculum-based prevention strategies served a total of 5,458 individuals and the community-based strategies benefited a total of 397,940 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 promising 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 Hawai‘i.

To address the rising youth cannabis use that was identified as a key priority in the 2023 Substance Use State Plan, the ADAD contracted services to launch a statewide prevention campaign for individuals under 21. The campaign aims to prevent cannabis use disorder by increasing awareness of its effects on youth.

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; SPF Application for Prevention Success Training, SPF model principles and steps; community organizing; evidence-based strategies; environmental strategies; and youth engagement.

Hawai'i Coordinated Access Resource Entry System (CARES)

On September 26, 2024, a Request for Proposal (RFP) was posted on the Hawai‘i Awards and Notices Data System (HANDS) website. The contract with Aloha United Way (AUW) ended on March 31, 2025, and a new provider was selected through the RFP process. CARE Hawai‘i was awarded the Hawai‘i CARES contract. This contract began on April 1, 2025. Funding for this contract is a combination of state and federal funds from SAMHSA. CARE Hawai‘i also has a contract with AMHD, providing crisis management and mental health services. This collaboration, having one provider assisting with crisis management and mental health services, along with substance use resources makes this an effective partnership where care for individuals can be easily transferred from one department to another.

Aside from a call center, CARE Hawai‘i also provides a talk and text feature to allow more flexibility to those who need SUD services/information. ADAD is striving toward a system

where the community has a more direct and simplified process of gaining access to SUD treatment across the state and that people can get those services where they need it, when they need it, and how they need it.

Hawai‘i Opioid Settlement Project

The Department of the Attorney General (AG) secured a Master Settlement Agreement (MSA) as part of a set of multi-state lawsuits against manufacturers and distributors of opioids due to their roles in the nationwide opioid crisis. Hawai‘i stands to receive about $150 million over a period of approximately 18 years, through 2038, as part of the larger $50 billion in national settlements. Pursuant to the terms of the MSA, a portion of Hawai‘i’s opioid settlement funds are distributed annually to Honolulu, Maui, Kaua‘i, and Hawai‘i counties based on total deposits.

ADAD works with counties to ensure that all settlement funds go to support treatment, recovery, harm reduction programs, and other strategies to remediate and address the opioid epidemic. Approximately $44 million has been received as of June 30, 2025.

The Hawai‘i Opioid Settlement Project has made significant progress over the last two years by developing and expanding statewide programs to improve surveillance, naloxone distribution, youth prevention strategies, community engagement, and access to treatment. Key activities supported and funded by the Opioid Settlement Project include:

- A significant expansion of the State’s naloxone nasal spray distribution program to approximately 65,000 units in 2024. Naloxone continues to be distributed for free to the public, first responders, and non-profit organization in an effort to reduce the number of opioid and fentanyl overdose deaths in our State. Naloxone has continued to be distributed to the public at near the same pace in 2025, and will expand further in 2026, using more than 100 newly procured, free standing, naloxone distribution boxes. The Opioid Settlement Project has also offered free naloxone to the administrators of all public, charter, and private schools in the State.

- A dedicated Hawai‘i Opioid Settlement Project website was launched in 2025 that provides the public with access to data dashboards, spending updates, reports, and educational resources. The public can also utilize the website to submit opioid remediation funding suggestions, learn where to obtain free naloxone nasal sprays, and free fentanyl test strips.

- Opioid settlement funds have also been used to purchase airtime for public service announcements that inform the public about the dangers for illicit fentanyl and to sponsor new opioid and substance use public service announcement categories in ‘Ōlelo Community Media’s high school student audio/visual program contest.

- In early 2026, a statewide addiction medicine telehealth warmline program called UTelehealth, will launch using settlement funds. The addiction medicine warmline will be operated by the University of Hawai‘i John A. Burns School of Medicine and will provide expedited access to addiction care for those in need, regardless of insurance status, offer post emergency services overdose follow-ups, and facilitate warm handoffs

of patients between providers and emergency services. The program also intends to expand pharmacist training to help UTelehealth providers administer prescribed medications in the community to support patients in recovery. UTelehealth will open in phases by island, beginning with Maui.

Studies and Surveys

Tobacco Sales to Minors. In March 2025, teams made up of youth volunteers (ages 16-20) and adult observers visited a random sample of 327 stores in which the youth attempted to buy tobacco products to determine how well retailers were complying with state tobacco laws. Eighteen (18) stores sold to younger volunteers (ages 16-17) resulting in a weighted violation rate of 5.5%. Three out of the four counties included in the statewide survey had sales. The County of Kauaʻi had one sale, the City and County of Honolulu had twelve sales, and the County of Hawaiʻi had five sales. Only the County of Maui had zero 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 2024-25, ADAD conducted eighty-four (84) Zoom and on-site training activities for 2,589 participants from the field of healthcare, Department of Education, University of Hawaiʻi John A Burns School of Medicine, social services, criminal justice, and substance abuse prevention and treatment professionals. Participants received a total of 5,480 Continuing Education Units (CEU's) for use towards professional certification 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); or Certified Substance Abuse Program Administrator (CSAPA).

During this fiscal year, ADAD in partnership with the University of Hawaiʻi Thompson School of Social Work & Public Health School provided thirty-seven (37) asynchronous training activities for 362 participants and awarded 300 CEUs.

ADAD delivered its first specialized training in Peer Recovery to eighteen (18) individuals that will now qualify as peer recovery specialists. ADAD is currently working on amending the Hawaiʻi Administrative Rule 11.177.1 to adopt this certification.

Topics covered during the reporting period included: Hawaiʻi Substance Use Professional Development Advocacy training; judiciary – resiliency training; drug court conference; probation/judge training; prevention conference; prevention/Inspire+ training; substance use and misuse; self-care practices; boundaries with aloha; positive psychology; suicide prevention; a detailed review of 12-step communities for providers; ethical decision making; introduction to substance use disorder ethics; fentanyl – community resource development; client centered therapy; ethics in prevention; stages of change; de-escalation, Narcan, and suicide prevention awareness; introduction to medication assisted treatment; case management; alcohol misuse and prevention; the soul of counseling; surveying the landscape – working with LGBTQIA + teens with substance use disorders; case conceptualization; reporting and record keeping; introduction of the 12 core functions; updates on sexual and gender minority people in Hawaiʻi; supportive

supervision; crisis intervention – an overview; helping children and teens so they are in control; HIV, hepatitis, Sexually Transmitted Infections 101; loving yourself/self-care; introduction and application of the 12 Core Functions; level of service inventory – revised and adult substance use survey; motivational interviewing; Malama project – University of Hawai‘i at Manoa’s collegiate recovery program; fetal alcohol spectrum disorder (FASD); harm reduction 101; Hawai‘i SBIRT manual overview; Hawai‘i healthcare workforce summit; mental health first aid; virtual summer training series – Hanai Ahu: anchoring culture in substance use treatment and prevention models; addictions conference; international summit preventing, assessing and treating trauma across the lifespan; End Meth summit; a providers guide to legislative advocacy; a harm reduction toolkit for Native Hawaiian communities; Native Hawaiian cultural intervention training series; fundamentals of domestic violence webinar series; and social media workshop – influencers, metrics and engagement: communicating prevention on Instagram.

Programmatic and Fiscal Monitoring

Through site visits and desk audits of providers’ program and fiscal reports, ADAD staff examined contractors’ compliance with federal SUPTRS BG restrictions, State General Fund expenditure guidelines, and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance use prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of twenty (20) prevention service contracts and three (3) treatment service contracts. The focus for contracted treatment and prevention providers this past year was technical assistance and site visits related to program development and implementation, reporting, and contract compliance due to the shortage of workforce employees.

Certification of Professionals and Accreditation of Programs

Certification of Substance Use Professionals. In Fiscal Year 2024-25, ADAD processed 584 (new and renewed) applications, administered thirty (30) computer-based exams and certified twenty-seven (27) applicants as substance use professionals, bringing the current number of certified substances use professionals to 1,248.

ADAD is in the process of amending the Hawai‘i Administrative Rule 11.177.1 to adopt a Peer Recovery Specialist certification and remove the Co-Occurring Disorder Professional Diplomate certification.

The shortest amount of time it takes to become a Certified Substance Abuse Counselor is approximately thirteen (13) months. An applicant with a master’s degree in a human service field is credited with 4,000 work hours in the substance abuse field. The applicant must still obtain 2,000 supervised work experience hours, which equates to approximately twelve (12) months of working full-time in the substance abuse profession, and an additional month to schedule and take the required written exam. If an applicant is a licensed Clinical Social Worker, Mental Health Counselor, Marriage and Family Therapist, Clinical Psychologist, or Psychiatrist, the requirement of supervised work experience is 1,000 hours (approximately six (6) months of working full-time) with an additional month to schedule and take the written exam. If an applicant has no applicable college degree, the work experience requirement is 6,000 hours (approximately 3 (three) years of working full-time) with an additional month to schedule and take the written exam.

Accreditation of Programs. In Fiscal Year 2024-25, ADAD conducted a total of thirteen (13) accreditation site reviews and accredited twenty-three (23) organizations, some of which have multiple (residential treatment and therapeutic living) programs.

In the same fiscal year, there are two (2) special treatment facility programs that are working on obtaining accreditation. This will potentially bring the total programs accredited to twenty-five (25).

ADAD is currently drafting Hawai‘i Administrative Rules (HAR) for outpatient services accreditation.

Clean and Sober Homes Registry

In Fiscal Year 2024-25, ADAD received five (5) initial applications for the Clean and Sober Registry. The five (5) were inspected, determined to meet the registry standards, and were issued a Certificate “In Good Standing” as referenced in HAR Chapter 11-178. In Fiscal Year 2024-25, twenty-eight (28) clean and sober homes in the registry were renewed. To date, there are a total of eight-seven (87) clean and sober homes that are registered and “In Good Standing.”

Currently, there are four (4) new applications for registration that are in review and pending approval.

A tracking and numbering system was developed in 2024 to identify and summarize concerns about the registry, which is used along with the formal concern form found on the ADAD website. ADAD also has a toll-free number for public concerns or questions. In 2025, ADAD received four (4) concerns – two (2) that were related to registered clean and sober homes (and were solved); and two (2) that related to clean and sober homes that were not on the registry.

ADAD has regular quarterly meetings with the operators of its registered clean and sober homes to build and strengthen the community of operators through networking, exchange of organizational information, and providing technical assistance and access to training opportunities and other resources. A process to elicit available bed space from clean and sober home operators has been developed, and weekly reports on space availability reported back to the registry community for the purpose of potential referrals between homes.

Act 193, SLH 2014, 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 helps individuals seeking a clean and sober home access stable, alcohol-free, and drug-free home-like living environments. The registry established procedures and standards by which homes are listed, such as 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 Hawai‘i Advisory Commission on Drugs and Controlled Substances. ADAD coordinated with stakeholders to develop and plan the launch of the Hawai‘i Overdose Initiative in January, 2025. Legislation enacted during the 2025 Legislative Session that addressed issues affecting the agency included:

- **Act 299, SLH 2025 (HB 943 CD1), relating to homelessness.** This measure appropriated $500,000 in general funds to establish a homeless triage and treatment center program.

OTHER REQUIRED REPORTS

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

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

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

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

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

The Hawaiʻi 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, Hawaiʻi 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

EMILY ANDRADE Community and Business Affairs – 7/1/2024 – 6/30/28 **KUNANE DRIER** Community and Business Affairs – Interim Appointment **JON FUJII** Joint appointment to HACDACS and State Council on Mental Health – 7/1/2024 – 6/30/28 **DAVE FIELDS** Co-Chair Pharmacological – Interim Appointment	**LILINOE KAUAHIKAUA** Co-Chair Education – 7/1/2024 – 6/30/2028 **JOHN PAUL MOSES III** Pharmacological – 7/1/2024 – 6/30/2028 **JAWANA READY, M.D.** Medical – 7/1/2024 – 6/30/2028 **KUʻULEI SALZER-VITALE** Youth Action – 7/1/2022 – 6/30/2026

On July 22, 2025, members elected Lilinoe Kauahikaua and Dave Fields as Co-chairs as well as John Paul Moses III as Vice-Chair. Meetings were scheduled on the fourth Tuesday of each month.

The members of HACDACS gathered research, reviewed best practices, and invited knowledgeable speakers to form the following policy recommendations.

Priorities discussed during the past year included:

1. Department of Health Syringe Exchange Program and Data on Hepatitis C in Hawaiʻi
2. U.S. Department of Veteran Affairs Pacific Islands Health Care System Substance Treatment and Recovery Program

3. Harm Reduction and the Hawai‘i Health and Harm Reduction Center
4. Findings from the Hawai‘i Opioid Initiative Need Assessment
5. Development of the Hawai‘i State Strategic Plan for Primary Prevention
6. Hawai‘i Opioid Settlement Project, the Hawai‘i Opioid Settlement Advisory Commission, and Opioid Settlement Trust Spending
7. Med-QUEST Approved 1115 Waiver for Contingency Management
8. Summary of Recent Changes to the Department of Health Syringe Exchange Program and Data on the Syringe Exchange Program.
9. Addiction Medicine-Psychological Needs of Substance Use Disorder Clients in Inpatient Setting

Department of Health Syringe Exchange Program and Data on Hepatitis C in Hawaii

At the January 2025 meeting of the Hawai‘i Advisory Commission on Drug Abuse and Controlled Substances (HACDACS), Mr. Thaddeus Pham from the Hawai‘i Department of Health's (DOH) Harm Reduction Services Branch delivered a comprehensive presentation on the ongoing efforts to address hepatitis C (HCV) in the state and the role of the DOH Syringe Exchange Program (SEP) in supporting individuals who use drugs. His findings underscored the urgent public health implications of hepatitis C in Hawai‘i. Approximately 88 percent of Hawai‘i residents living with hepatitis C die earlier than the general population, and nearly 40 percent pass away before reaching retirement age. Among syringe service program (SSP) participants, more than half had been exposed to HCV, yet six out of ten had not engaged in treatment. These data highlight a critical gap between diagnosis, interest in care, and actual access to curative treatment.

Mr. Pham presented results from a 2023 qualitative study titled "I Wanna Live a Full Life," which examined how SSP participants perceive hepatitis C, the care system, and the possibility of treatment. He emphasized that the study intentionally centered the voices of people who use drugs, voices that are often absent from policy, planning, and prevention conversations. Using a culturally grounded "talk story" approach, researchers interviewed 15 adults receiving services in Honolulu's Chinatown. Participants shared deeply personal reflections on their experiences with hepatitis C, revealing mixed levels of disease knowledge, strong emotional ties to family or peers affected by the illness, and significant concerns about their long-term health.

The study exposed major misconceptions rooted in memories of older, harsher HCV treatment regimens. Many participants were unaware that newer medications are short, well-tolerated, and highly effective. They described meaningful barriers to seeking treatment, including intense stigma from the healthcare system, the challenges of navigating care while actively using substances, and the practical difficulties of transportation and appointment scheduling. One participant articulated a common sentiment: "I just want to live a full life," expressing both desire for wellness and frustration with systemic obstacles.

Importantly, the study highlighted the role of syringe exchanges as trusted spaces where individuals feel safe, respected, and connected. Participants expressed appreciation for SSP staff and suggested co-locating hepatitis C education, testing, and treatment within syringe service programs. They recommended simple, direct, urgent messaging for HCV print materials placed where they already receive services. Participants also identified a need for programs that address basic needs, such as food, hygiene, and transportation, before individuals can meaningfully

engage in care.

Mr. Pham detailed how the study findings have already influenced policy and practice. The results have been incorporated into HepFree 2030, the statewide hepatitis elimination framework, and have contributed to new community-facing reports, data dashboards, and health communication campaigns designed alongside SSP participants. This research also helped secure funding for a pilot program that provides HCV testing, treatment initiation, and peer navigation directly in syringe exchange settings. Plans include exploring mobile health vans to extend these services to rural areas, recognizing that many individuals are geographically isolated from traditional clinics.

During the discussion, Mr. Pham noted that no additional HCV-specific barriers were unique to Native Hawaiian or Pacific Islander participants, though culturally congruent care remains essential, and transportation challenges were significant. He noted that language barriers were minimal, but interviewers needed familiarity with pidgin and māhū pidgin to build trust and conduct interviews effectively. Commissioners and co-chairs highlighted the strong value of qualitative research in guiding statewide solutions, noting that rich insights from small samples can illuminate pathways to improving health outcomes that larger quantitative studies may overlook. Mr. Pham also highlighted the supportive role of Med-QUEST in enabling treatment to occur outside clinic settings. This practice aligns with the needs of people who use drugs and supports flexible, patient-centered approaches.

Altogether, the presentation demonstrated that people who use drugs are both motivated and capable of engaging in hepatitis C treatment when services are accessible, culturally appropriate, and provided in trusted environments. The reported findings reinforce the need for continued investment in harm reduction, community-based care, and approaches that center the experiences of disproportionately affected communities.

> ***HACDACS recommends*** **an expansion of low-barrier hepatitis C testing and treatment** at syringe service programs, mobile health vans, and other trusted community spaces.
>
> ***HACDACS recommends*** **supporting a culturally grounded, community-driven research and messaging,** including youth voices and talk-story methodologies.
>
> ***HACDACS recommends*** **an increase in logistical supports**, such as transportation assistance, flexible scheduling, and peer navigation, to reduce barriers to treatment completion.

U.S. Department of Veteran Affairs Pacific Islands Health Care System Substance Treatment and Recovery Program

This report summarizes a presentation delivered to the Hawai‘i Advisory Commission on Drug and Controlled Substances (HACDACS) on February 25, 2025, by Dr. Natalie Crommett, Psychologist and Clinic Lead for the Veteran Affairs (VA) Pacific Islands Health Care System (PIHCS) Substance Treatment and Recovery (STAR) Program. Dr. Crommett highlighted the STAR program's comprehensive, evidence-based, and individualized treatment approach for Veterans with substance use disorders (SUDs) and co-occurring mental health concerns across the vast Pacific region, including Hawai‘i, Guam, American Samoa, and Saipan. The presentation underscored opportunities for strengthening collaboration between the Hawai‘i VA

and Community SUD care sector, particularly focusing on improved communication and resource sharing.

The STAR program operates on a hub-and-spoke model, leveraging virtual platforms to overcome geographical barriers and dramatically expand access to specialized SUD care, particularly Intensive Outpatient Programming (IOP). STAR embraces a harm reduction approach, aligning with person-centered goals and reflecting a significant shift from traditional, abstinence-only programs. The program emphasizes shared decision making, expedited access to care, and a stepped-care model matched to individual needs and severity, guided by American Society of Addiction Medicine criteria. Unique aspects of the STAR program include a robust virtual IOP, innovative contingency management, dual diagnosis treatment, peer support services (both in-person and virtual), and a long-standing partnership with Hina Mauka for residential treatment.

> ***HACDACS Recommends Increased Partnership Potential:*** Opportunities exist for enhanced collaboration between the VA STAR program and Hawai‘i community SUD care sector, particularly in sharing expertise and addressing the evolving landscape of SUD treatment.
>
> ***HACDACS recommends*** **Harm Reduction Initiatives:** Dr. Crommett specifically encouraged VA and Hawai‘i community SUD care sector networking around harm reduction initiatives to foster shared learning.
>
> ***HACDACS recommends*** **the Peer Support Model:** The STAR program's use of Veteran Peer Specialists offers a promising model for expanding access to peer-based recovery support across the state.
>
> ***HACDACS recommends*** **Community Engagement:** The VA is committed to increasing its presence and outreach within the Hawai‘i community SUD care sector.
>
> ***HACDACS recommends*** **Virtual SUD Care Innovation:** Utilization of virtual platforms to expand SUD care availability and access.

<u>Harm Reduction and the Hawai‘i Health and Harm Reduction Center</u>

At the March 25, 2025, Hawai‘i Advisory Commission on Drug and Controlled Substances (HACDACS) meeting, Heather Lusk, executive director at the Hawai‘i Health & Harm Reduction Center (HHHRC) provided insight and training on harm reduction and what that look likes in practice. The HHHRC serves Hawai’i communities by reducing the harm and fighting the stigma of HIV, hepatitis, homelessness, substance use, mental illness, and poverty in our community. Their efforts are focused on those disproportionately affected by social determinants of health, including but not limited to people living with and/or affected by HIV, hepatitis, substance use, and the transgender, LGBQ, and the Native Hawaiian communities. The HHHRC fosters health, wellness, and systemic change in Hawai‘i and the Pacific through care services, advocacy, training, prevention, education, and capacity building. Harm reduction can be defined in many ways depending on who you ask. Harm reduction is not a new term nor is it a radical term. People sometimes associate harm reduction as being radical because it’s tied to substance use. A few definitions of harm reduction include:

Pupukahi I Holomua, Harm Reduction Conference Planning: Harm reduction is a

philosophy and set of strategies for working with individuals engaged in potentially harmful behaviors. The main objective is to reduce the potential dangers and health risks associated with such behaviors, even for those who are not willing or able to completely stop. Harm reduction uses a non-judgmental, holistic and individualized approach to support incremental change and increase the health and well-being of individuals and communities.

Harm Reduction Coalition: Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

HHHRC: A non-judgmental approach to public health that meets people where they are and celebrates positive change, with the goal of minimizing the harms of actions that pose adverse social and health outcomes.

First Nations Health Authority: Harm reduction is a public health approach that saves lives by minimizing harm and potential danger. A harm reduction approach meets people where they are at with open arms, acceptance, and compassion – not judgment or shame. A harm reduction approach recognizes that every life is valuable, and that substance use, and addiction are complex and challenging.

Along with the definitions of harm reduction, Ms. Lusk pointed out Papa Ola Lokahi's E Hui Ana Na Moku Harm Reduction Toolkit as a resource to approaching harm reduction from a native Hawaiian lens. Co-Chair Kauahikaua shared the process to create the toolkit and the community engagement that assisted with the development of toolkit. Noting that harm reduction is part of our native Hawaiian culture.

To better understand harm reduction, Ms. Lusk outlined the tenants of harm reduction. These tenants include

- Meet people where they are
- Non-judgment and respect
- Low barrier services
- Any positive change
- Options, not directives
- Consumer involvement
- Transparency and consistency
- Social justice: harms are disproportionate

Ms. Lusk noted if we can incorporate these tenants into our work and daily lives, we will have a greater chance of reaching the people that need support. She also talked about the importance of language and our words. It is key to de-stigmatizing language. What we hear vs. what we want to say. A good example of this are the words "addict", "user", and "clean/sober." What we want to

say is “people who use…,” “people who drink,” or “healing journey.”

A few harm reduction theories and models were highlighted, including the Transtheoretical Model of Behavior Change, Motivational Interviewing, and Harm Reduction as Trauma Responsive Care. Ms. Lusk made it a point to emphasize that harm reduction may or may not include abstinence.

The HHHRC harm reduction efforts include the statewide Syringe Exchange Program (SEP), and safer substance use outreach. This outreach program provides access to new syringes and exchanged more than 600,000 syringes last year. These programs also provide low barrier substance use disorder (SUD) treatment in the community allowing people to access treatment for one substance while still using another. Low barrier SUD treatment includes medication management, relapse, and/or focused abstinence and recovery support. Lastly, HHHRC also provides overdose prevention services with monthly training and distribution of naloxone and test strips in the community. Ms. Lusk introduced the HHHRC clinical providers to the group, including Commissioner Moses.

Ms. Lusk presented ideas for potential growth in the harm reduction arena in Hawai‘i. These include medical detox, “wet and damp” housing, increased housing or therapeutic living communities (TLC) for those experiencing homelessness and SUD, and contingency management.

Ms. Lusk ended her presentation highlighting additional HHHRC programs and encouraged people to make referrals to the agency utilizing the referral form at www.hhhrc.org.

> ***HACDACS recommends*** **expanding harm reduction efforts** through medical detox, wet/damp housing, TLC, and contingency management.
>
> ***HACDACS recommends*** **expanding harm reduction services across Hawai’i** through low-barrier, non-judgmental harm reduction programs such as syringe exchange, overdose prevention, and community-based substance use treatment.
>
> ***HACDACS recommends*** **integrating culturally responsive and trauma-informed practices** through incorporating Native Hawaiian values, culturally grounded approaches, and trauma-responsive care into harm reduction initiatives.

Findings from the Hawai‘i Opioid Initiative Needs Assessment

During its April 22, 2025, meeting, the Hawai‘i Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) received a presentation from the Mapuna Lab on findings from the Hawai‘i Opioid Initiative Needs Assessment and the transition to the Hawai‘i Overdose Initiative. The presentation underscored the importance of harm reduction as a culturally resonant and life-affirming approach to substance use in Hawai‘i, particularly for Native Hawaiian and other priority populations who are disproportionately impacted by overdose.

The Needs Assessment highlighted the limitations of a system of care that relies primarily on short-term, clinical, and one-size-fits-all treatment models. While Western approaches offer important tools such as medication-assisted treatment and acute care, they often fall short in addressing the social, cultural, and intergenerational conditions that shape substance use. In contrast, Indigenous approaches to healing align closely with harm reduction principles by

prioritizing relationship, dignity, belonging, and long-term wellness. These approaches meet people where they are, reduce risk without requiring abstinence as a precondition, and emphasize connection to ʻāina, ʻohana, and community as protective factors.

Stakeholders emphasized that culturally grounded harm reduction practices are difficult to access and remain underutilized due to narrow definitions of evidence and outcomes. The presentation affirmed that incorporating cultural practices does not compromise clinical standards, including American Society of Addiction Medicine criteria, and instead strengthens engagement, retention, and safety within the system of care. The relaunch of the Hawaiʻi Opioid Initiative as the Hawaiʻi Overdose Initiative reflects this shift, centering harm reduction through themes of wellness, trauma responsiveness, lived experience, and culturally responsive systems

> ***HACDACS Recommends Advancing Harm Reduction Through Culturally Grounded Funding and Policy*:** That the Legislature support harm reduction strategies that are culturally grounded and community led. This includes recognizing ʻāina based, relationship-centered, and Indigenous healing approaches as legitimate and necessary components of Hawaiʻi's overdose prevention and substance use continuum. Funding and policy frameworks should allow these approaches to demonstrate impact using measures that reflect long-term wellness, safety, and connection, rather than relying solely on short-term clinical indicators.
>
> ***HACDACS Recommends Strengthening Harm Reduction Pathways Across Systems of Care:*** Investing in partnerships that bridge licensed treatment providers with culturally based organizations and practitioners. These partnerships support harm reduction by creating warm handoffs, reducing barriers to care, and expanding non-punitive pathways for individuals at different stages of recovery. Workforce development and technical assistance should be funded to help providers implement harm reduction practices in culturally safe ways, without fear of regulatory conflict or cultural misuse.
>
> ***HACDACS Recommends Ensuring Harm Reduction Efforts Are Guided by Data Equity and Community Voice:*** Improving race and ethnicity data practices to accurately reflect Native Hawaiians and other Pacific Islanders, including those who identify in combination with other races, to ensure harm reduction strategies reach those most impacted by overdose. Continued investment in geographic and systems-level analysis should prioritize communities experiencing the greatest harm, including Native Hawaiians, rural and remote populations, people experiencing houselessness, pregnant and parenting individuals, and those involved in the justice system. Harm reduction efforts must be informed by lived experience and community knowledge, not solely administrative data.

Update on the Hawaiʻi Statewide Strategic Plan for Primary Prevention

Mr. Trevor Lee of the Department of Health, Alcohol and Drug Abuse Division Prevention Branch (ADAD), provided an update on the development of the Hawaiʻi Statewide Strategic Plan for Primary Prevention (Plan), a comprehensive framework aimed at fostering a healthier Hawaiʻi free from the challenges of substance misuse. The Plan is being prepared collaboratively with prevention providers, community stakeholders, and technical experts, with guidance informed by local data, community input, and national best practices.

Its development began with the 2022 ADAD Hawai‘i Prevention Conference, which convened stakeholders from across the state, and has continued through the ADAD Prevention Advisory Council, with technical assistance from the Substance Abuse and Mental Health Services Partnership for Success program. Local data has been used to identify strategies that address the specific needs of communities with higher prevalence of substance use, and feedback from ADAD's recent Request for Information sessions has further shaped the Plan's priorities. The initial framework, referred to as the "Skeleton Plan," will be released soon and is designed to provide a flexible structure while leaving space for additional community input over the next year, with a final Plan targeted for release by October 2026.

The Plan will identify priority substances, target populations, risk factors, and protective factors. Substances of concern include alcohol, nicotine, and cannabis, while populations disproportionately affected include underage youth, emerging adults aged 18–25, Native Hawaiians, LGBTQ+ individuals, and residents of rural communities. Key risk factors include peer pressure, family rejection, access to substances, and past trauma, while protective factors include supportive policies, strong family bonds, positive parenting, and life skills development. During discussions, it was noted that culture is a significant protective factor for all communities and should be incorporated into the framework to ensure the Plan reflects the diverse population and values of Hawai‘i.

Statewide agency prevention goals focus on reducing underage drinking through education curricula, preventing intoxicated driving via policy promotion and media campaigns, preventing youth vaping by increasing risk perception and teaching decision-making and social skills, and reducing marijuana use through awareness campaigns and provision of data to policymakers.

The prevention provider community has identified goals related to workforce development, data proficiency, and community networks. Initiatives include exploring workforce incentives, reviewing and streamlining the prevention specialist certification process, developing a data training framework to strengthen analytic skills and infrastructure, and leveraging community networks to engage youth, cultural leaders, and broader community sectors. Statewide and county-level gatherings are also planned to promote collaboration and training among providers.

Community engagement will be central to finalizing the Plan. The release of the Skeleton Plan will be followed by statewide listening sessions, which will include youth voices and culminate in a summary report by June 2026. This feedback will help shape the final Plan, ensuring it incorporates a wide range of community perspectives and aligns with state and federal prevention goals. A Prevention Summit may also be convened in 2026 to further facilitate input and collaboration. ADAD welcomes HACDACS' review of the Skeleton Plan and the submission of recommendations to inform the final version.

Efforts to streamline the prevention specialist certification process are underway, led by the Coalition for Drug-Free Hawai‘i and the University of Hawai‘i under contract with ADAD. These efforts aim to provide a clear roadmap for individuals entering the field, including required credits, class availability, and guidance for career progression in prevention services.

Overall, preparation of the Hawai‘i Statewide Strategic Plan for Primary Prevention represents a coordinated, evidence-informed approach to reducing substance misuse across the state. Its flexible design allows for continuous community input, integration of cultural protective factors, and alignment with statewide and national prevention objectives. Legislative support for these

initiatives, including workforce development, data infrastructure, and community engagement, will strengthen prevention efforts, improve public health outcomes, and ensure the completed Plan effectively addresses the evolving needs of Hawai‘i communities.

> ***HACDACS recommends*** **Incorporating Cultural Protective Factors**: Support programs that integrate cultural practices and values to strengthen resilience and reduce substance use risk.
>
> ***HACDACS recommends*** **Strengthening the Prevention Workforce**: Fund training, certification, and career pathways for prevention specialists to ensure a skilled workforce statewide.
>
> ***HACDACS recommends*** **Promoting Community Engagement and Data-Driven Planning**: Support listening sessions, data collection, and community partnerships to guide effective prevention strategies.

Hawai‘i Opioid Settlement Project, the Hawai‘i Opioid Settlement Advisory Commission, and Opioid Settlement Trust Spending

At the June 24, 2025, meeting of the Hawai‘i Advisory Commission on Substance Use and Controlled Substances (HACDACS), Mr. Grant Giventer of the Hawai‘i Opioid Settlement Project (OSP) provided an overview of the OSP, the Hawai‘i Opioid Settlement Advisory Commission (HOSAC), and Opioid Settlement Trust spending. The OSP is part of the Department of Health, Alcohol and Drug Abuse Division (ADAD) that supports the implementation of the national opioid settlement agreement in Hawai‘i as well as overseeing the federal State Opioid Response (SOR) 4 Grant.

Approximately $150M in opioid settlement funds will be distributed to Hawai‘i through 2038 and will likely increase as settlement talks are occurring with other companies. As of June 1, 2025, $43,207,304.73 has been received in settlement funds with $6,671,575.82 expended , resulting in a current balance of $37,276,571.12. Project expenditures will increase significantly in the next few years for new projects and treatment services. Hawai‘i will receive approximately $8M annually for the next few years then slowly taper off.

A Memorandum of Agreement (MOA) between the state and counties outlines the distribution and spending of funds as well as establishes the HOSAC. Fund distribution is 85 percent to the State and 15 percent to the Counties (combined) with the amount distributed to each county based upon population size. Expenditure requirements are that 85 percent of the funds be used for opioid-related remediation while 15 percent can be used for other substances. HOSAC members are comprised of the Mayor’s designee for each county, the Department of Education, the Department of Corrections and Rehabilitation, and the John A. Burns School of Medicine (JABSOM). HOSAC members serve two-year terms and meet on the 2nd Monday of each month. The current term began in November 2024.

There are a number of harm reduction, prevention, and treatment activities and initiatives. Harm reduction efforts are focused on naloxone and fentanyl test strips distribution in the community along with naloxone readiness in schools. The amount of naloxone kits distributed has grown significantly between 2020 through 2024, from 3,029 kits to 67,328 kits respectively. Naloxone kits distribution is starting to decrease and could indicate naloxone saturation in the state. SOR 4 grant funds are currently being used to purchase these items as these funds have an expenditure

deadline. To increase naloxone availability, in addition to naloxone vending machines, naloxone distribution boxes will be established statewide.

Prevention related proposals submitted to and being reviewed by ADADs Prevention Branch include an Oahu Fentanyl Summit, microgrants, and a culturally anchored youth program. Prevention initiatives include collaboration with Olelo on their annual Youth Challenge Public Service Announcement contest; to include subjects such as naloxone, fentanyl test strips, and counterfeit pills. Treatment and recovery projects include establishing a new Education Research Center of Addiction Medicine and an Addiction Medicine Telehealth Program, both with JABSOM. Other projects include expansion of clean and sober homes and providing supplemental funding to ADADs Treatment and Recovery Branch for opioid use disorder services.

Additionally, the SOR 4 grant has a number of ongoing initiatives including the expansion of the University of Hawai‘i (UH) Mānoa Summer Youth Prevention Program, targeting middle and high school students, to the UH Maui and UH Hilo campuses. Other initiatives include UH Nursing Residency Program with opioid training and the UH Addiction Medicine and U-Telehealth Second Responder Pilot Program. The U-Telehealth Second Responder Pilot Program will target opioid overdose on neighbor islands and rural areas. The pilot program will occur on Maui in partnership with Maui Emergency Medical Services (EMS) and Maui Memorial Hospital. This pilot program will provide multiple pathways for those recovering from an opioid overdose to receive information on or referral to treatment via U-Telehealth. If the pilot goes well it could expand to include Moloka‘i and Lāna‘i, and then go statewide.

Mr. Giventer noted that all information on the OSP can be found on its website; including how to request naloxone and fentanyl test strips. A link is also provided to a map showing the location of existing naloxone vending machines. A similar link will be provided for the naloxone distribution boxes. A form is also available for members of the community to submit proposed projects using settlement funds.

> ***HACDACS recommends*** **strengthening** transparency, reporting, and community awareness of opioid settlement fund use.
>
> ***HACDACS recommends*** **prioritizing** data-driven harm reduction and prevention strategies, especially in rural and neighbor island communities.
>
> ***HACDACS recommends*** **sustaining and expanding** treatment, recovery, and workforce development initiatives supported by settlement and SOR funds.

Med-QUEST Approved 1115 Waiver for Contingency Management

At the July 22, 2025, Hawai‘i Advisory Commission on Substance Use and Controlled Substances (HACDACS) meeting, Ms. Lorna Green of the Hawai‘i Med-QUEST Division (MQD) provided an overview of the MQD and the recently approved 1115 Demonstration Renewal which allows for contingency management (CM) benefits.

The MQD is a division of the Department of Human Services that administers the Hawai‘i Medicaid program through its Section 1115 Demonstration known as the QUEST Integration (QI) program. The program provides comprehensive and specialty services to the 99.9% of Medicaid beneficiaries who are enrolled in managed care. The divisions mission is to “Empower

Hawai‘i residents to improve and sustain wellbeing by developing, promoting, and administering innovative and high-quality health care programs with aloha.”

On January 8, 2025, the Centers for Medicare and Medicaid Services approved a five-year extension for the Hawai‘i QI Section 1115 Demonstration. Enabling the state to support a whole-person approach to care through the implementation of new initiatives to support healthy families and communities focusing on health-related social needs and expanded services for specific populations and providing CM benefits for substance use disorder (SUD) treatment. This new CM benefit implements a HACDACS 2024 Annual Report recommendation to expand access to CM and encourage reimbursement by Medicaid.

Medicaid beneficiaries aged 18 years and older, diagnosed with a stimulant or opioid use disorder for which CM is medically necessary and appropriate, are eligible. Contingency management benefits will be provided as part of a 24-week treatment program for stimulant and opioid use disorders. Motivational incentives distributed will be in the form of cash equivalents such as gift cards. All Hawai‘i Medicaid and certified providers are available to participate. Providers will be required to participate in CM training and undergo a readiness review. This benefit is expected to be rolled out in mid-2026.

The MQD is exploring the use of a Third-Party Administrator (TPA) to implement the program. In April 2025, MQD released a Request for Information (RFI) for TPA services, thus beginning stakeholder conversations. Highlighted feedback on the TPA RFI included that they can help reduce provider burden, continue to provide input on incentive design by managed care plans, and align with the CM program being developed by Alcohol and Drug Abuse Division (ADAD).

During the discussion, Ms. Green noted that MQD is looking to have one TPA to administer the program, with a preference for a TPA experienced in CM. This will simplify administrative challenges encountered by Medicaid and participating providers during implementation. They are aware of potential conflicts of interest with this type of program. Use of a TPA to administer the program will separate incentive distribution duties from treatment duties by providers and minimize potential conflict of interest. The MQD continues to learn about services that can be provided through a TPA and are currently having conversations with those TPAs who responded to the RFI, are currently providing CM services, and have a system in place.

Ms. Green also noted that MQD and ADAD are having ongoing conversations on the development of the respective CM programs, sharing tentative plans to provide greater alignment between the two programs. There are differences between the two programs. As previously noted, MQD's CM program is for stimulant and opioid use disorders, while ADADs' CM program is focused solely on stimulant use. The MQD is currently working on a crosswalk to identify differences between the two programs to focus future conversations on further alignments. There are also different eligibility requirements between the two programs. ADAD only pays for a person’s treatment if they do not have insurance and are receiving treatment from one of their contracted service providers, while Med-QUEST providers must bill Med-QUEST.

The five-year extension of the Hawai‘i QI Section 1115 Demonstration allows for CM benefits for persons with a stimulant or opioid use disorder. Implementing a HACDACS recommendation to expand access to CM and encourage reimbursement by Medicaid. Contingency management is an evidence-based substance use disorder (SUD) treatment that provides a highly effective behavioral intervention proven to support substance non-use and SUD treatment awareness.

Program implementation will provide an additional tool to support SUD treatment awareness.

> ***HACDACS recommends*** **minimizing provider confusion** between the ADAD and MQD contingency management programs, through provider communication, outreach & technical assistance.

Summary of Recent Changes to the Department of Health Syringe Exchange Program and Data on the Syringe Exchange Program.

The Hawai‘i Department of Health (DOH) Syringe Exchange Program (SEP) is a vital public health initiative designed to reduce the harms associated with injection drug use while providing pathways to treatment and other supportive services. Established as a pilot program in 1990 and made permanent in 1992, the Hawai‘i SEP was the first state-funded syringe exchange program in the United States. The program is overseen by the DOH Harm Reduction Services Branch, which is also responsible for HIV prevention, sexually transmitted infection control, and adult viral hepatitis care. SEP is a highly researched intervention, with decades of evidence demonstrating that it reduces infections, promotes safe disposal of used syringes, is cost-effective, and serves as an entry point into treatment. Importantly, research consistently shows that SEPs do not increase drug use or crime in the community.

In response to evolving best practices and changes in the drug use landscape, Hawai‘i recently updated its SEP through Act 106, Session Laws Hawaii (SLH) 2025, which became effective on May 29, 2025. This legislation modernizes the program by allowing needs-based distribution of syringes rather than the previously required one-to-one exchange. Act 106 also permits the provision of additional “Authorized objects” and services to non-injection drug users, reflecting national guidance that items used in the preparation and consumption of drugs beyond syringes and needles can contribute to infection risk. The law also introduced liability protections for SEP staff, participants, and law enforcement officers acting in good faith, including protection for the residue in used syringes, which allows participants to safely bring used equipment to the program for proper disposal.

Data from the Hawai‘i Health and Harm Reduction Center (HHHRC) 2023 Annual Report highlights several important trends within the SEP. Between 2021 and 2024, the number of syringes exchanged declined by 61 percent from the 2021 peak of 1,234,623 exchanges, while the number of SEP visits increased by 110 percent, reaching 19,732 visits in 2023. This reflects changing patterns of substance use among participants. Heroin use among SEP participants declined by 58 percent, while methamphetamine use increased by 7 percent. Injection use decreased by 17 percent, and smoking increased by 5 percent. These trends indicate that non-injection drug use is rising, and services such as safer smoking supplies are increasingly needed. SEP participants also access first aid supplies to address xylazine-related wounds, hygiene kits, food, condoms, test strips for fentanyl and xylazine, and overdose prevention training, including naloxone distribution. Feedback from participants consistently emphasizes the life-saving impact of these services, with many reporting that naloxone kits have been used to reverse overdoses among peers.

SEP also functions as a critical community hub, connecting participants to broader social and healthcare services. In 2024, approximately 72.5 percent of new SEP participants had medical insurance, many through Medicaid. This high rate of coverage has allowed the program to expand access to low-threshold hepatitis C treatment and medications for opioid use disorder.

Additionally, SEP staff assist with document readiness, enrollment in Supplemental Nutrition Assistance Program, Electronic Benefit Transfer Program, and housing resources. These services address participants' immediate needs and support long-term engagement with public health interventions.

Given the evolving needs of SEP participants and the demonstrated effectiveness of harm reduction strategies, there are several areas where legislative support is recommended. First, decriminalizing drug paraphernalia beyond syringes, such as pipes for safer smoking, would help maintain participant engagement, reduce infection risks, and support public health goals. Second, continued support for needs-based distribution and expanded SEP services, including naloxone, safer smoking supplies, hygiene kits, and testing resources, is essential to meet the changing needs of the population. Finally, enhancing access to health insurance and treatment services through partnerships with Medicaid and other programs would ensure low-threshold access to hepatitis C treatment, medications for opioid use disorder, and essential social services, improving overall health outcomes for participants.

In conclusion, the Hawai‘i SEP continues to be a critical public health intervention that effectively reduces harm, provides life-saving services, and connects participants to treatment and social support. Updates under Act 106, SLH, 2025 reflect national best practices and respond to changes in substance use patterns and participant needs. Legislative support to expand protections for paraphernalia, maintain funding for needs-based distribution, and strengthen access to healthcare will ensure that the program continues to protect public health and improve

> ***HACDACS recommends*** **decriminalizing drug paraphernalia beyond syringes** (e.g., pipes) to support harm reduction for non-injection drug users and maintain engagement with SEP services.
>
> ***HACDACS recommends*** **supporting the needs-based distribution and expanded SEP services** to provide naloxone, safer smoking supplies, hygiene kits, and testing resources, reflecting evolving participant needs.
>
> ***HACDACS recommends*** **enhancing access to health insurance and treatment** by strengthening partnerships with Medicaid and other programs, enabling low-threshold access to hepatitis C treatment, medications for opioid use disorder, and essential social services.

Addiction Medicine-Psychological Needs of Substance Use Disorder Clients in Inpatient Setting

On September 23, 2025, Dr. Miki Kiyokawa and Dr. Treena Becker presented to the Hawai‘i Advisory Commission on Substance Use and Controlled Substances (HACDAC) on the "Psychological Needs of Substance Use disorder (SUD) in inpatient Settings." Dr. Kiyokawa is the Director of the Addiction Medicine Fellowship Program Director at the University of Hawai‘i John A. Burns School of Medicine as well as an Addiction Medicine Physician at Queens Medical Center (QMC). Dr. Treena Becker is the Assistance Professor at the UH Thompson School of Social Work and Public Health and provided an overview of data associated with the needs of inpatient SUD and mental health patients at the Queens Medical Center. The HACDACS requested to receive this presentation to 1) understand the current landscape of opportunities and challenges of inpatient psychiatric settings in relationship to the need and desire for substance abuse treatment and 2) determine how HACDACS may inform the

legislature of the inpatient and potential outpatient SUD treatment can influence and impact inpatient settings, ideally to reduce overall healthcare costs.

Dr. Kiyokawa oversees a team that provides consultation to psychiatry patients who have requested substance abuse assessments to determine treatment options. From March 2024 – February 2025, the team received 366 consultations from ages 18 – 87. Twenty-five percent of these consultations were not directly with patients, but medical providers, physicians, community members that were affiliated with QC, and limited detail is known regarding their specific clientele.

Overall, the data shared during this presentation informed the Commission that older adults (age 65+), white males, continue to be the largest demographic served, which is consistent with other data sources across the County. Alcohol and Opioid Use disorders were the two most seen substance use disorders found from this group of patients. Follow up care was able to be provided to most patients. The older adult population can demonstrate challenges with follow up care because those exiting a medical setting (medical or psychiatric inpatient services) may require other activity of daily living support that may often become the primary discharge service needed. In addition to the discharge challenges there are also issues that may arise for patients who identify as people experiencing homelessness. Twenty-five percent of the participants reported houselessness which will also impact the complexity of the older adult population access to services and discharges from the hospital.

This presentation demonstrated that Hawaii continues to have a need for ongoing support through outpatient detox centers that can provide medication assistance and can manage complex patients. A need for additional skilled nursing facility and Independent Care Facility beds and rooms is needed across the community and those that can specialize in medical, mental health, and substance abuse treatment services, and may offer harm reduction services for the older population. This program does not operate 7 days a week and thus referrals could increase should additional funding be provided to build out a more robust program.

Finally, this data demonstrates a need for larger systems of care to provide more consolidated outreach to the Hawaiian community, ʻāina based programming, and other substance-focused services that may serve the Native Hawaiian community as desired.

Ensuring that there is more extensive coordination among all substance use programs across the state of Hawaiʻi that can collect data, build programs, and focus on native Hawaiian culture continues to be a need. This presentation provided a snapshot into one project, however further data around a larger data set surround medical care and outpatient (or inpatient) substance use treatment is needed to review in order to consider further recommendations.

> ***HACDACS recommends more specific services for older adults*** discharged from inpatient settings with complex medical, mental health, and substance use issues.
>
> ***HACDACS recommends ensuring ongoing cultural practices*** are incorporated into accessing inpatient services and during inpatient hospital stays.
>
> ***HACDACS recommends strengthening coordination*** between inpatient hospital settings and outpatient substance use settings.

REPORT PURSUANT TO
SECTION 10 OF ACT 161, SESSION LAWS OF HAWAIʻI 2002,
ON THE IMPLEMENTATION OF SECTION 321-193.5, HAWAIʻI
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, Hawaiʻi 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 over thirty substance abuse treatment agencies that provide services statewide.

During Fiscal year 2024-25, 1,514 individuals 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 Hawaiʻi. Of the 1,438 offenders who received services, 357 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2024-25 is as follows in Tables 1-3:

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

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

Table 1. Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2024 – June 30, 2025

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawai'i Paroling Authority	Total
O'ahu	86	665	74	825
Maui	58	124	22	204
Hawai'i	47	372	30	449
Kauai	7	25	4	36
Total	198	1186	130	1514

Case management services providers: Alcoholic Rehabilitation Services of Hawaii (Hina Mauka), Aloha House, Big Island Substance Abuse Council, Bobby Benson, Bridge House, CARE Hawai'i, Child and Family Service, Hawaii Health and Harm Reduction Center, Institute for Human Services, Ka Hale Pomaika'i, Kline-Welsh Behavioral Health Facility, Kokua Support Services, Malama Family Recovery Center, Poailani, Queens Medical Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Service

Table 2. Referrals by Criminal Justice Agency: July 1, 2024 – June 30, 2025

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawai'i Paroling Authority	Total
O'ahu	88	630	65	783
Maui	45	126	24	195
Hawai'i	59	324	35	418
Kauai	5	30	7	42
Total	197	1110	131	1438

Case management services providers: Alcoholic Rehabilitation Services of Hawaii (Hina Mauka), Aloha House, Big Island Substance Abuse Council, Bobby Benson, Bridge House, CARE Hawai'i, Child and Family Service, Hawaii Health and Harm Reduction Center, Institute for Human Services, Ka Hale Pomaika'i, Kline-Welsh Behavioral Health Facility, Kokua Support Services, Malama Family Recovery Center, Poailani, Queens Medical Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Service

Table 3. Carryover Cases by Criminal Justice Agency: July 1, 2024 – June 30, 2025

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawai'i Paroling Authority	Total
O'ahu	6	185	31	222
Maui	8	23	7	38
Hawai'i	16	58	7	81
Kauai	3	9	4	16
Total	33	275	49	357

Case management services providers: Alcoholic Rehabilitation Services of Hawaii (Hina Mauka), Aloha House, Big Island Substance Abuse Council, Bobby Benson, Bridge House, CARE Hawai'i, Child and Family Service, Hawaii Health and Harm Reduction Center, Institute for Human Services, Ka Hale Pomaika'i, Kline-Welse Behavioral Health Facility, Kokua Support Services, Malama Family Recovery Center, Poailani, Queens Medical Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Service

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 lower 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 Hawai‘i by 30%. Felony probationers in the FY 2016 cohort had a 54.6% recidivism rate, which is 10.1 percentage points lower 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 did not met the goal of reducing recidivism in Hawai‘i 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%).

REPORT PURSUANT TO
SECTION 29 OF ACT 40, SESSION LAWS OF HAWAIʻI 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 Corrections and Rehabilitation, 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 Hawaiʻi Paroling Authority; and in Fiscal Year 2015-16, the Department of Public Safety (now the Department of Corrections and Rehabilitation. For Fiscal Year 2024-25, ADAD worked with the Department

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

APPENDICES

A. ADAD-Funded Adult Services: Fiscal Years 2022-2025

B. ADAD-Funded Adolescent Services: Fiscal Years 2022-2025

C. Performance Outcomes Adolescent and Adult Substance Abuse Treatment: Fiscal Year 2022-2025

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 Hawai‘i

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2022-2025

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Male	67.3%	67.0%	69.9%	68.0%
Female	32.7%	33.0%	30.1%	32.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Hawaiian	44.9%	47.0%	44.0%	45.9%
Caucasian	21.0%	16.1%	20.7%	16.1%
Filipino	7.1%	6.0%	4.6%	6.0%
Mixed - Not Hawaiian	6.8%	8.2%	6.0%	7.3%
Japanese	2.7%	3.8%	3.7%	4.6%
Black	3.4%	1.7%	2.1%	2.5%
Samoan	2.6%	2.4%	2.5%	3.2%
Portuguese	1.0%	2.2%	1.7%	1.3%
Other Pacific Islander	5.2%	6.5%	7.1%	6.5%
Other*	5.3%	6.1%	7.5%	6.8%
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 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Methamphetamine	53.5%	61.2%	57.3%	61.4%
Alcohol	19.5%	16.6%	20.9%	17.6%
Marijuana	12.3%	8.6%	8.1%	7.5%
Cocaine/Crack	1.5%	2.5%	2.8%	3.9%
Heroin	8.9%	6.9%	5.0%	3.1%
Other*	4.3%	4.1%	6.0%	6.5%
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 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
O'ahu	49.6%	56.2%	53.0%	63.0%
Hawai'i	34.3%	28.7%	35.9%	22.2%
Maui	6.7%	7.1%	4.4%	4.9%
Molokai/Lanai	0.6%	0%	0.2%	0.3%
Kauai	2.7%	3.0%	2.5%	4.6%
Out of State	6.1%	5.1%	4.1%	4.9%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2021-22 through Fiscal Year 2024-25, for the latest year, methamphetamine admissions saw an increase in the most recent year – from 57.3% to 61.4%. Conversely, alcohol admissions saw a decrease to 17.6% from previous year's 20.9%. Marijuana continued to decrease, going from 8.1% down to 7.5% of admissions. Cocaine/Crack admissions have increase from 2.8% last year to 3.9% this year. Heroin has continued to trend downwards across the previous 4 years. Admissions for all "Other" substances saw an increase to 6.5% last year.

Among the adult admissions for Fiscal Year 2025, 280 (31.8%) were homeless when admitted to treatment. This proportion is consistent with previous year rates. ('incarcerated' and 'unknown' were not included in the denominator)

APPENDIX B

ADAD-FUNDED ADOLESCENT[6] SERVICES FISCAL YEARS 2022-2025

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Male	45.2%	38.9%	31.6%	37.4%
Female	54.8%	61.0%	68.4%	62.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Hawaiian	44.4%	42.1%	47.2%	46.2%
Caucasian	9.0%	7.7%	10.5%	11.2%
Filipino	8.9%	11.3%	11.3%	9.6%
Mixed - Not Hawaiian	7.0%	6.1%	5.1%	5.1%
Japanese	2.8%	1.7%	1.2%	2.0%
Black	1.5%	1.2%	2.8%	2.3%
Samoan	3.5%	4.2%	4.2%	4.7%
Portuguese	0.7%	0.5%	0.4%	0.5%
Other Pacific Islander	17.6%	21.5%	13.0%	12.1%
Other*	4.5%	3.8%	4.3%	6.3%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Methamphetamine	0.8%	2.0%	1.1%	0.4%
Alcohol	15.9%	21.0%	17.9%	11.0%
Marijuana	71.0%	76.2%	59.5%	70.6%
Cocaine/Crack	0.7%	0.0%	0.1%	0.2%
Heroin	0.0%	0.0%	0.0%	0.0%
Tobacco	-	-	20.3%	16.8%
Other	11.6%	0.8%	1.1%	1.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

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

ADAD-FUNDED ADOLESCENT ADMISSIONS BY RESIDENCY

	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
O'ahu	32.5%	76.9%	81.2%	74.9%
Hawai'i	38.7%	1.0%	0.9%	0.7%
Maui	17.3%	22.1%	17.9%	23.3%
Molokai/Lanai	5.2%	0.0%	0.0%	0.0%
Kauai	6.4%	0.0%	0.0%	1.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

[6] Adolescent: Grades 6 through 12

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2021-22 through Fiscal Year 2024-25, in the most recent year, methamphetamine decreased from 1.1% to 0.4%. Alcohol also decreased starting at 17.9% and ending at 11.0%. Marijuana based admissions increased considerably from 59.5% to 70.6%. Cocaine/Crack increased from 0.1% to 0.2%. Tobacco decreased from 20.3% to 16.8%. All "Other" substances maintained steady at 1.1%

Community profiles by the State Epidemiological Outcomes Workgroup (SEOW) and the results of Student Health Surveys administered in 2013, 2015, 2017, 2019, 2021, and 2024 are consistent with the ADAD-Funded Adolescent Treatment Admissions by primary substance in that Marijuana and Alcohol are the primary substances of choice for use by person in Hawai‘i, ages 12-25. (Tobacco was not evaluated in the Hawai‘i State Epidemiological Profile). 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 2024 through 2025, six-month follow-ups were completed for adolescents discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Employment/School/Vocational Training	99.20%	99.70%	98.80%	98.96%
No arrests since discharge	99.20%	96.30%	99.40%	98.73%
No substance use in 30 days prior to follow-up	39.40%	37.10%	35.70%	34.93%
No new substance abuse treatment	89.70%	80.10%	84.60%	82.20%
No hospitalizations	98.40%	96.30%	94.20%	98.27%
No emergency room visits	96.90%	91.20%	91.40%	97.01%
No psychological distress since discharge	89.00%	77.00%	77.80%	84.14%
Stable living arrangements*	97.60%	99.70%	99.80%	100.00%

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

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2024 through 2025, 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 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Employment/School/Vocational Training	46.70%	73.30%	83.40%	63.55%
No arrests since discharge	98.00%	97.50%	96.90%	98.10%
No substance use in 30 days prior to follow-up	57.00%	30.60%	47.20%	40.74%
No new substance abuse treatment	76.80%	71.30%	60.20%	62.83%
No hospitalizations	86.40%	94.40%	96.60%	96.93%
No emergency room visits	94.40%	86.40%	93.80%	93.27%
Participated in self-help group (NA, AA, etc.)	28.10%	32.30%	49.40%	50.22%
No psychological distress since discharge	82.10%	70.70%	78.80%	81.57%
Stable living arrangements*	90.40%	73.60%	97.60%	96.54%

**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 2021 to Fiscal Year 2025) average annual ADAD-funded admissions for adults is 1,832, which is 0.87% 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.

[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.

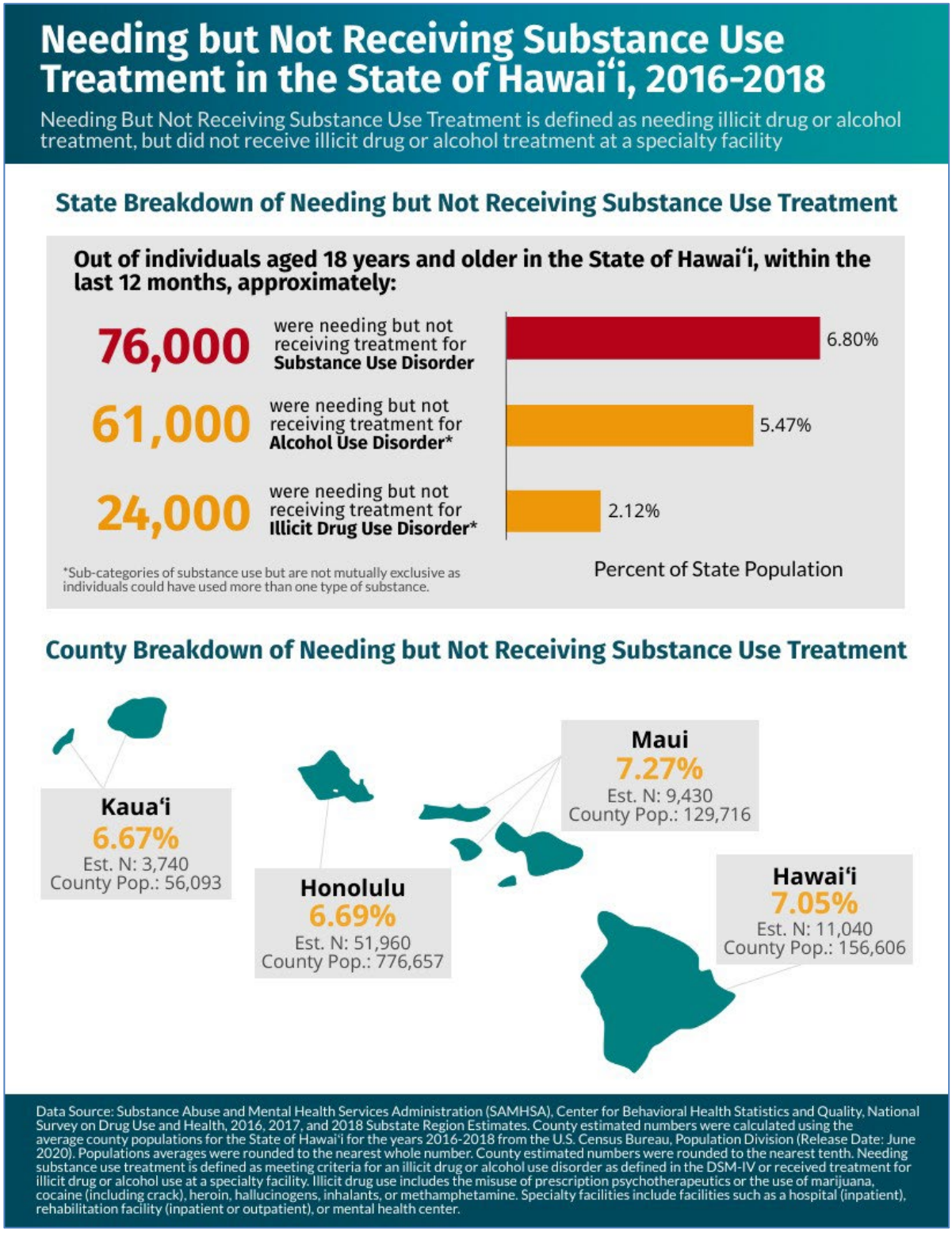


Table D2: Substance Use Disorder in the Past Year among Individuals Aged 18 or Older, by State and Substate Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs										
	Percent of State Population (County Population)									
	Kaua‘i		Honolulu		Maui		Hawai‘i		State	
Population (18 Years and 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.

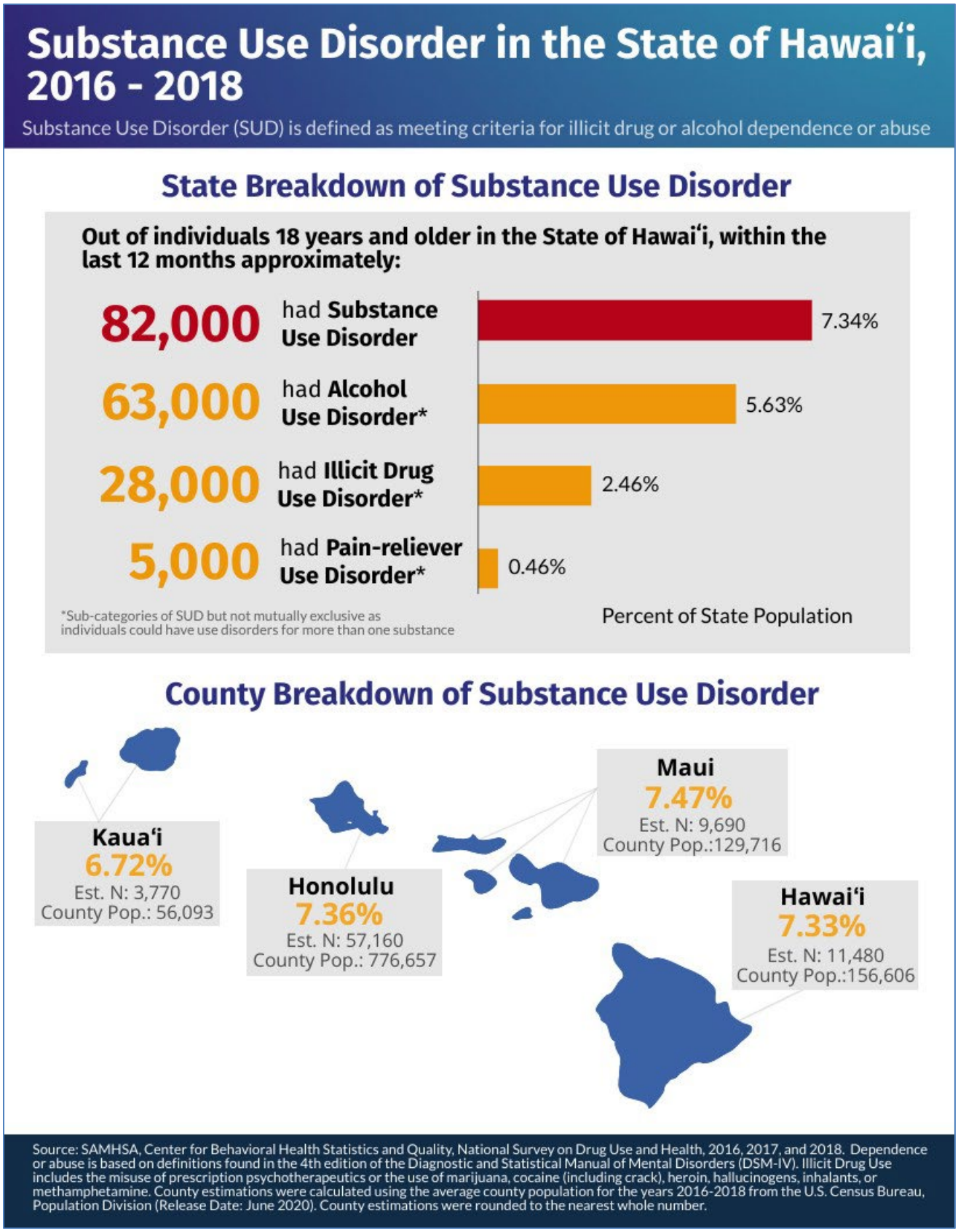
For *Hawai‘i County*, 11,480 (7.33%) of individuals aged 18 and older on the Big Island had substance use disorder in the past year.

[1] Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016, 2017, and 2018.

[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 HAWAI'I

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 Hawai'i 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 Hawai'i. *Estimated need* for alcohol or substance use treatment among Hawai'i'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.

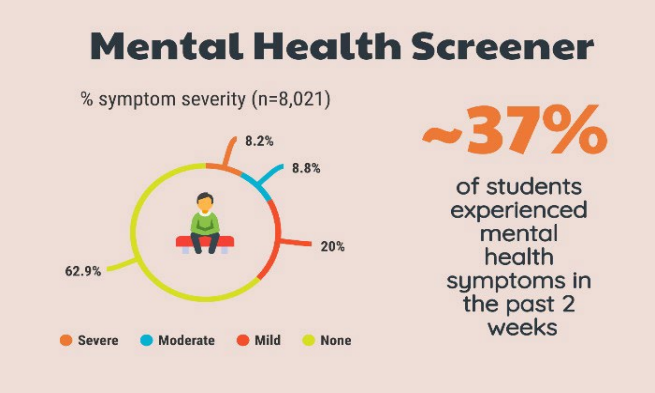
The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade, and primary race/ethnicity:

[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 Hawai'i 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.

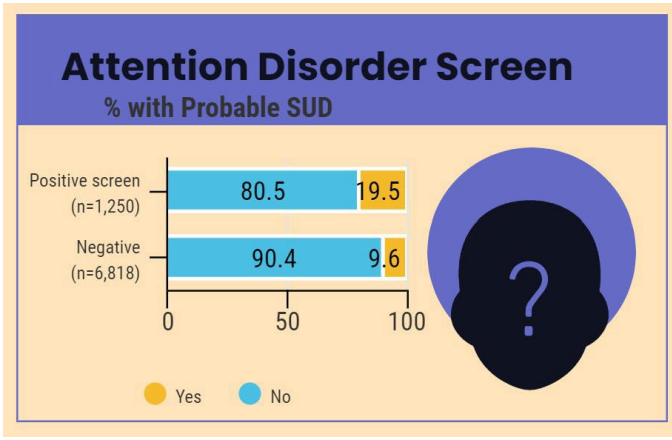
[2] While the survey asks students to select a group with which they primarily identify, a large proportion reported primarily identifying with multiple (2 or more) ethnic/racial groups. Among those who selected two or more ethnic/racial groups in the state sample, Native Hawaiian was among the highest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

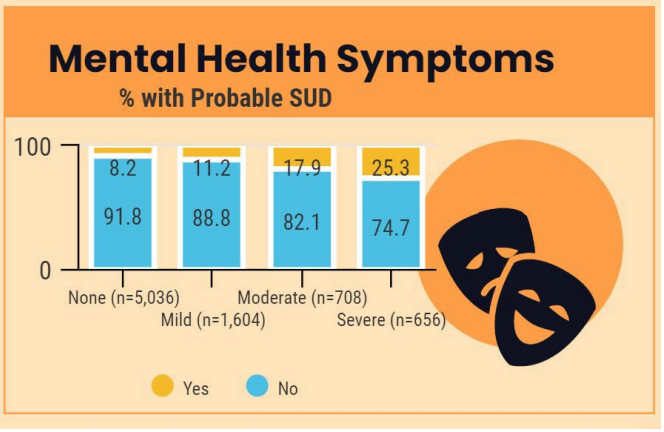
- The overall total estimated treatment needs across the state ***increased*** to 11.1% compared to 7.7% reported from the 2007-2008 Hawai‘i Student Alcohol, Tobacco, and Other Drug Use Study.
- ***Transgender and Other Gender Minority*** students make up the smallest proportion of the state sample but 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 Hawai‘i 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 Hawai‘i 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 Hawai‘i 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 2021 to Fiscal Year 2025) average annual ADAD-funded admissions for adolescents is 718 which is 6.53% of the estimated need for adolescent alcohol and drug use treatment.

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

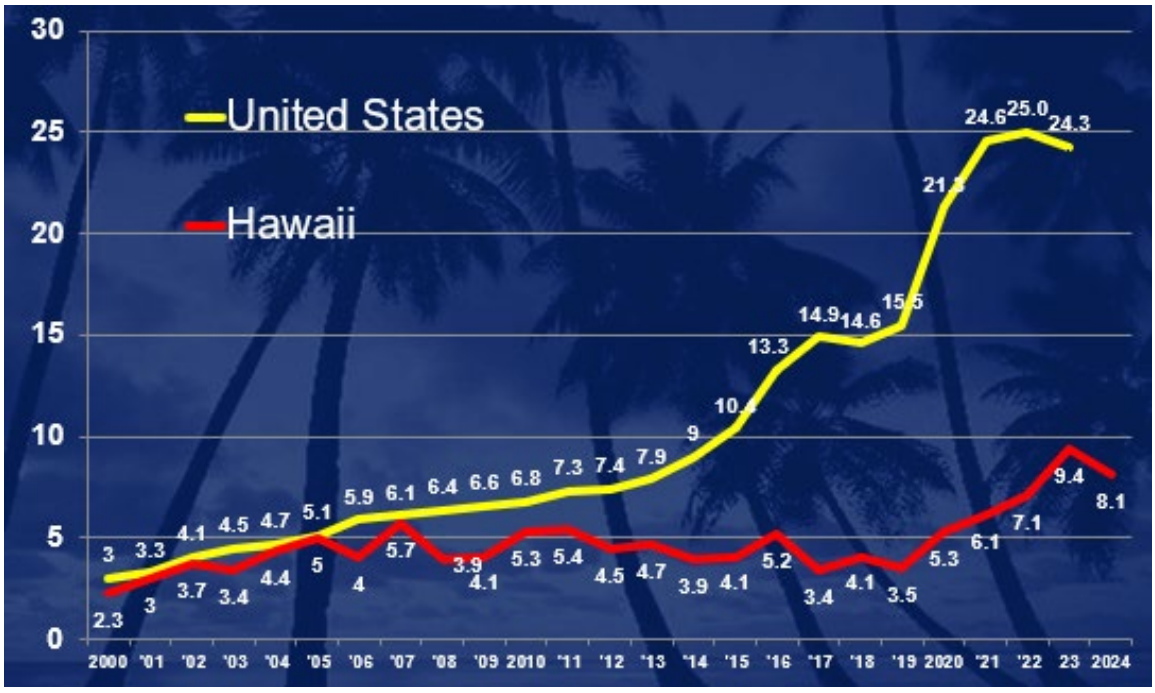
Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also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

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 Hawaiʻi opioid poisoning fatality rates appear to be trending slightly downward (from 9.4 in 2023 to 8.1 in 2024), still an increase from the 2016 rate of 5.2 (Figure 1) while the national rate has increased since 2000 but has showing a slight decrease (24.3 in 2023 down from 25.0 in 2022). Please note that the 2024 national rate is provisional and therefore not included.

Figure 1. Adjusted opioid poisoning fatality rates (per 100,000), Hawaiʻi vs. U.S., 2000-2023, (2024 Hawaii only).



When compared to other states, Hawai‘i has the third *lowest* fatality rate of poisonings due to opioids (6.3) which is also well below the national rate of 22.2 (Figure 2).

Figure 2. Average annual opioid-related overdose fatality rates (per 100,000), by state, 2019-2023.

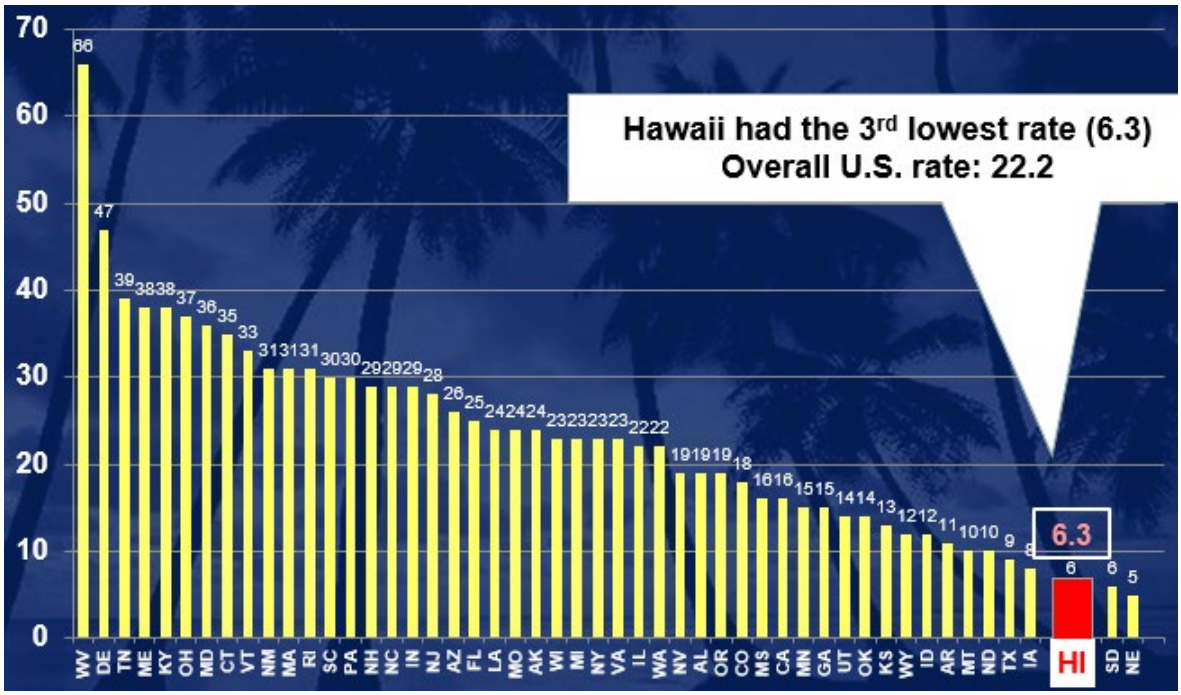
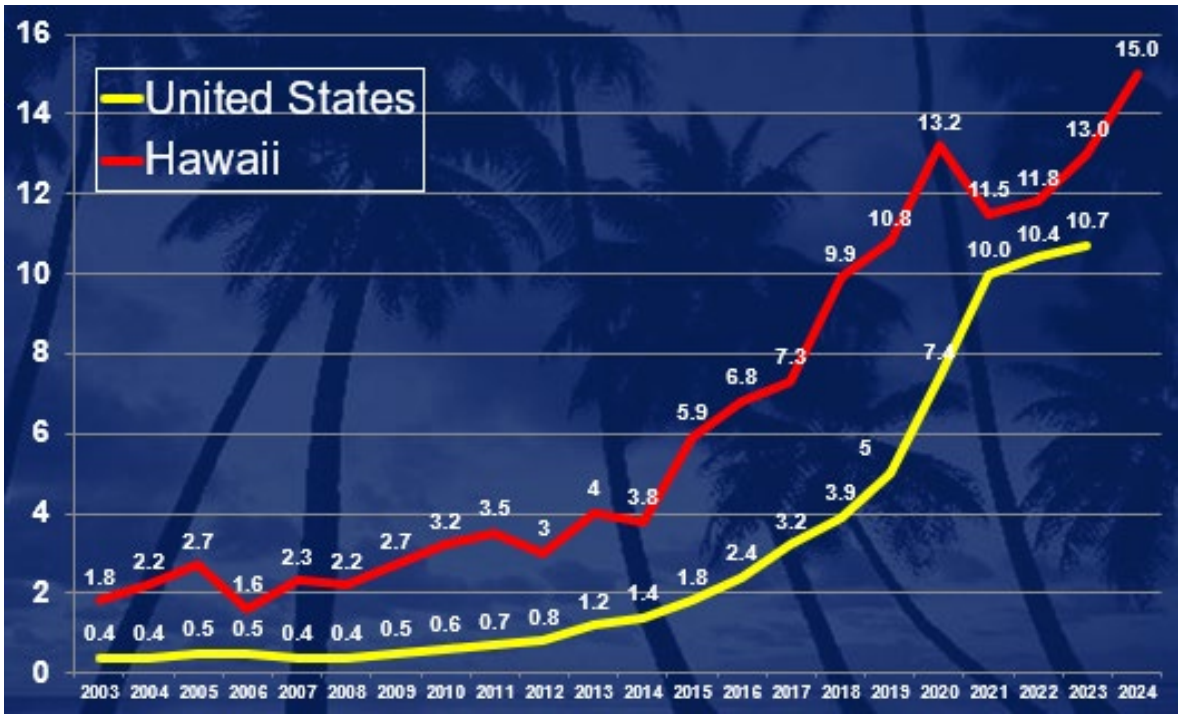


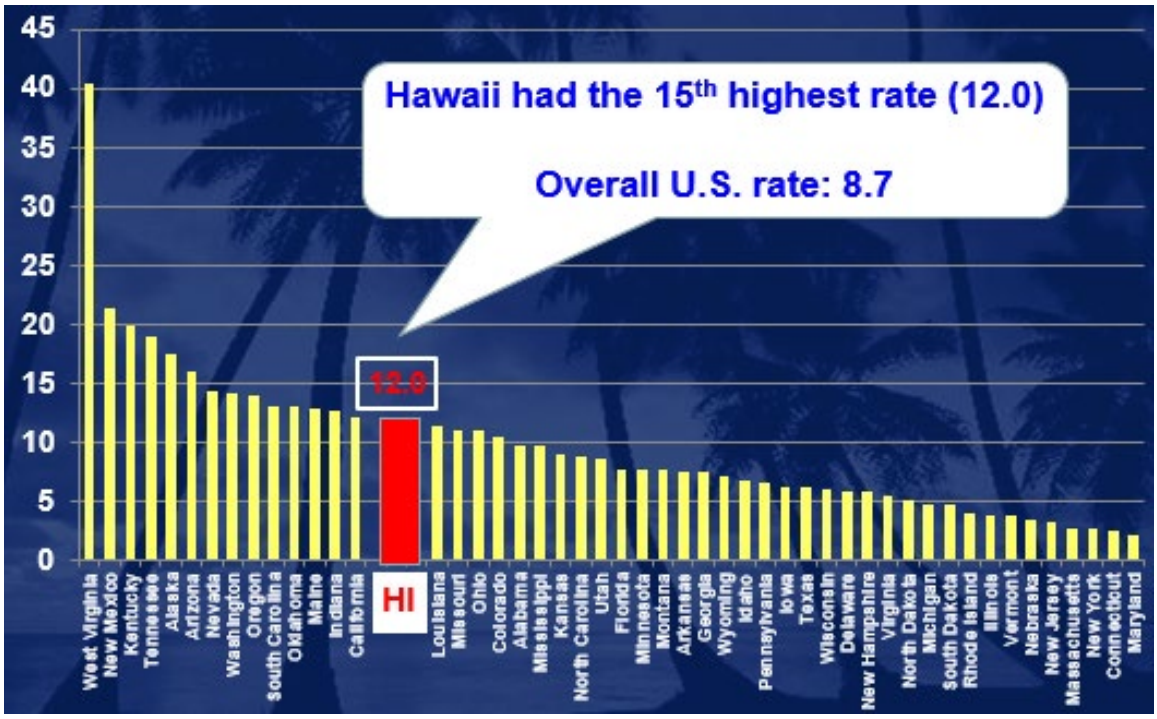
Figure 3. Annual adjusted poisoning fatality rates involving psychostimulants (per 100,000), Hawai‘i vs. U.S., 2003-2023, (2024 Hawaii only).



* Code indicating psychostimulants with abuse potential.

However, Hawai‘i by comparison has a higher adjusted rate of fatalities involving psychostimulants (13.0 in 2023 and 15.0 in 2024), higher than the national average of 10.7 (Figure 3). Hawai‘i also ranks 15th in the fatality rate of poisonings involving psychostimulants, again higher than the national rate of 8.7 (Figure 4).

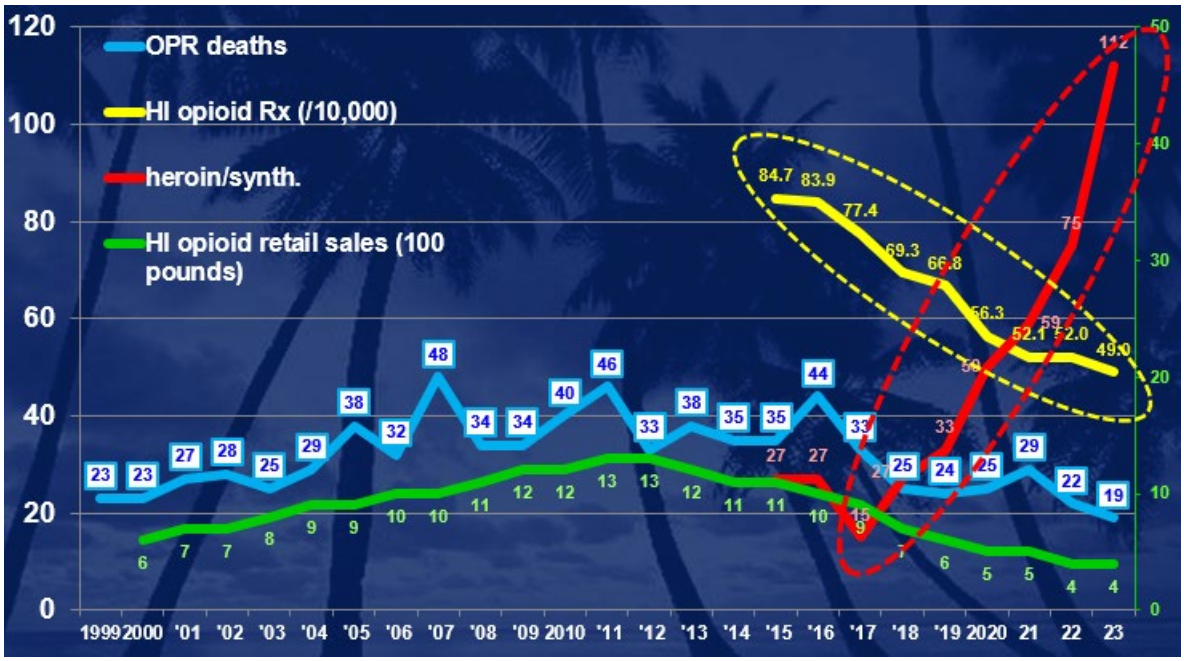
Figure 4. Average adjusted poisoning fatality rates involving psychostimulants (per 100,000), by state, 2019-2023.



* Code indicating psychostimulants with abuse potential.

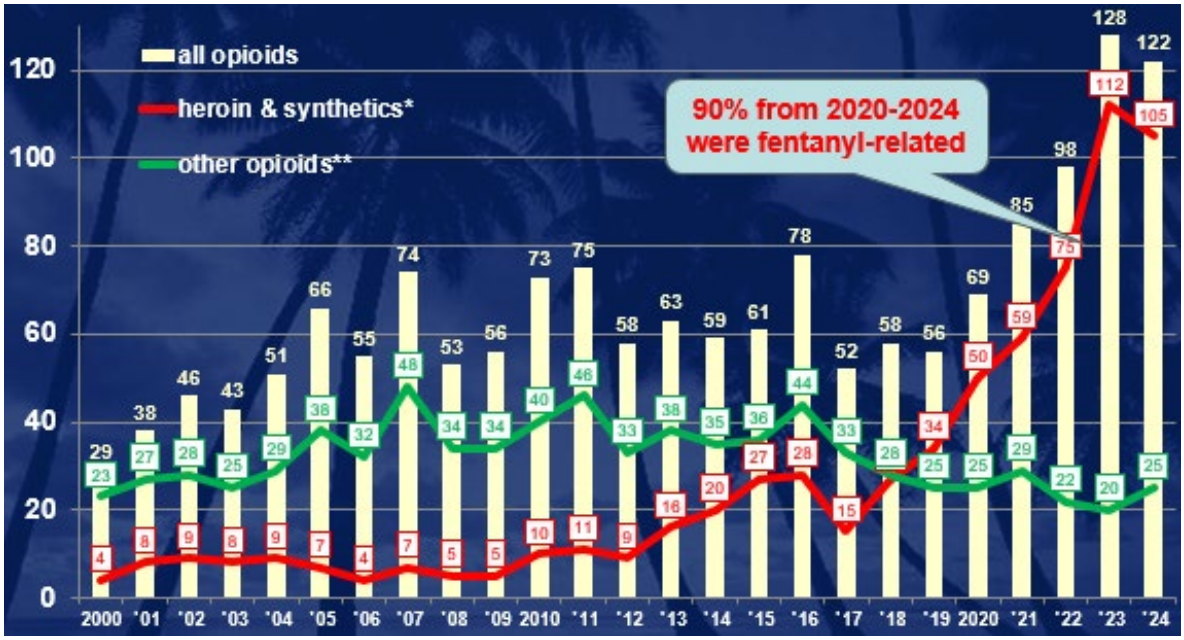
When looking at poisoning fatality rates among Hawai‘i residents compared to national opioid consumption, EMSIPSB data show that deaths due to opioid pain relievers are decreasing (Figure 5). However, Hawai‘i death certificate data show a greater prevalence of fatal opioid poisonings among Hawai‘i residents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

Figure 5. Annual trends of fatal opioid poisonings* among Hawai'i residents: Opioid consumption, and opioid prescriptions in Hawai'i (2015-2023).



* 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. However, EMSIPSB no longer has access to the PDMP data.

Figure 6. Annual number of fatal opioid poisonings among Hawai'i residents, by type of opioid, 2000-2024.



* 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, Hawai‘i has a very low rate of opioid-related poisonings but a high rate by comparison for poisonings involving psychostimulants, which includes methamphetamines (Figures 3 and 4). Also, while fatal poisonings involving opioid pain relievers are decreasing since 2015, there was 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 opioid poisonings remain steady for all counties, however total nonfatal opioid poisonings are decreasing (355 in 2024 vs. 434 in 2016) (Figure 7). And over the last twelve years, naloxone administrations continue to remain steady for each county except Honolulu which has seen a noted rise in administrations for EMS patients since the last spike which occurred in 2016 (Figure 8).

Figure 7. Trends in nonfatal opioid poisonings treated in Hawai‘i hospitals, by patient county of residence, 2016-2024.

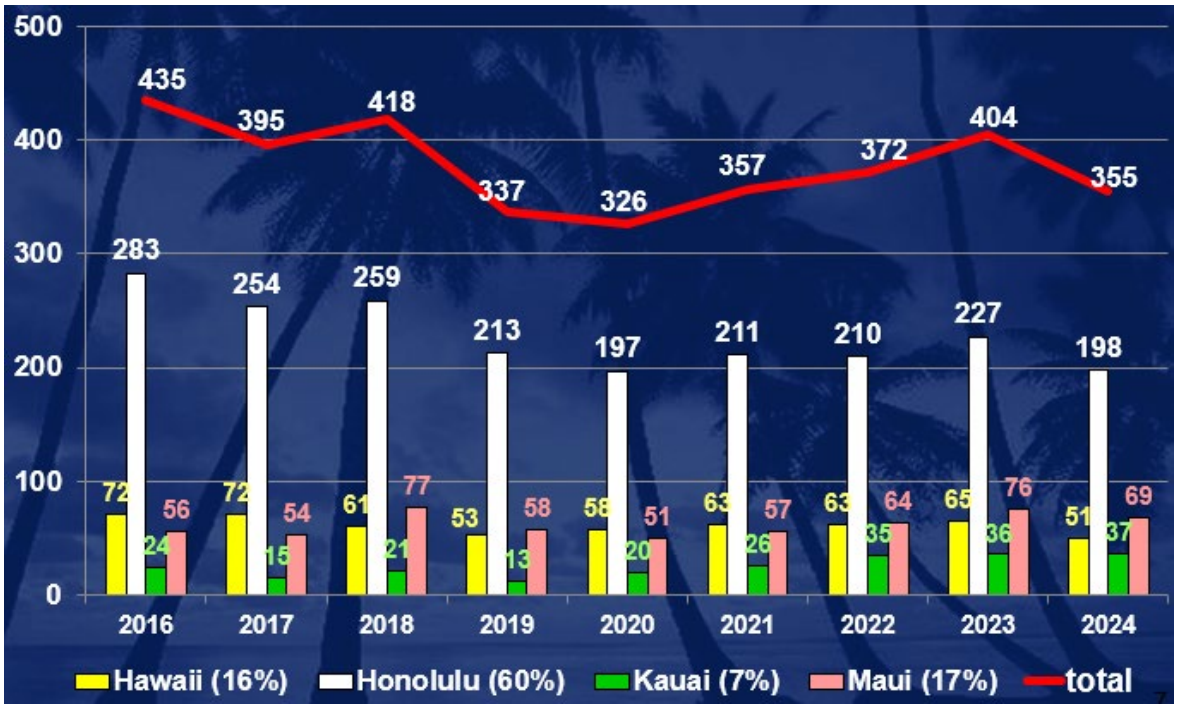
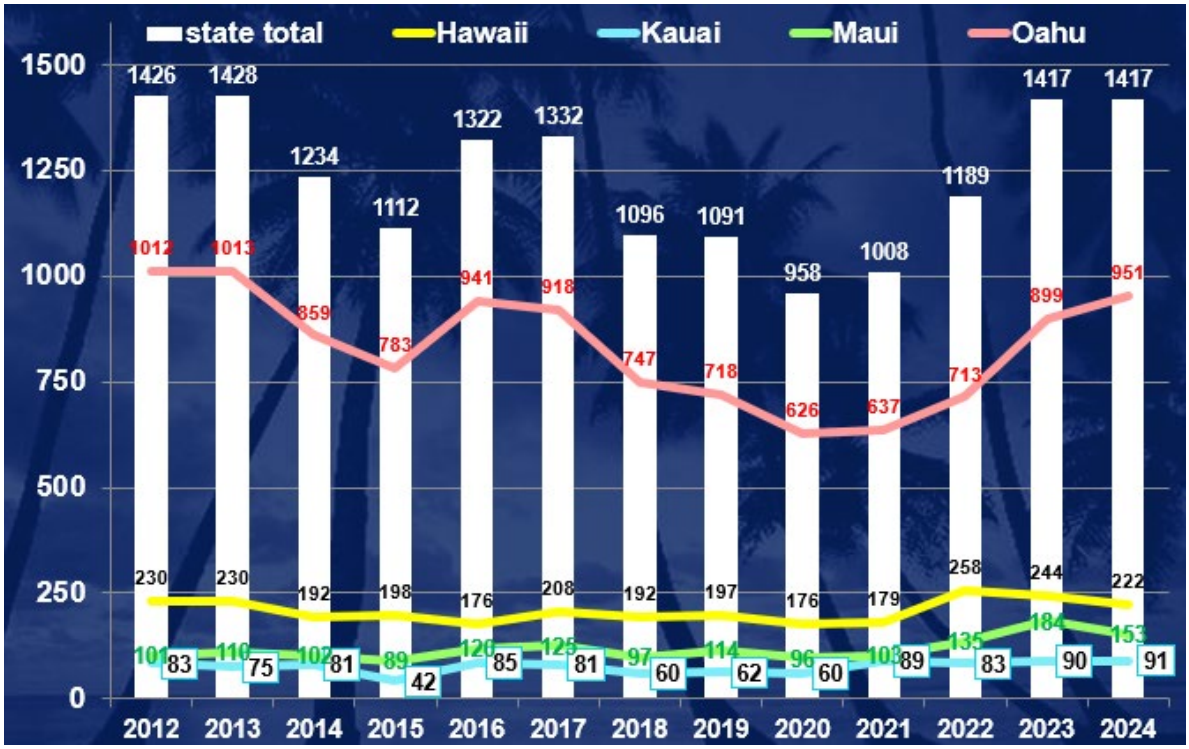


Figure 8. Annual number of EMS patients receiving naloxone, by county, 2012-2024.



According to recent EMS data for the 2022-2024, over 44.6 percent of 4,023 who received naloxone showed improvement. And for instances characterized as overdoses, about 77 percent improved in response, with an 87 percent improvement rate for opioid overdoses (Figure 9). EMS also attended to 446 overdoses from fentanyl from late 2021 to mid-2024, where 20 percent received naloxone from bystanders before EMS arrived (Figure 10).

Figure 9. EMS administrations of naloxone, 2022-2024.

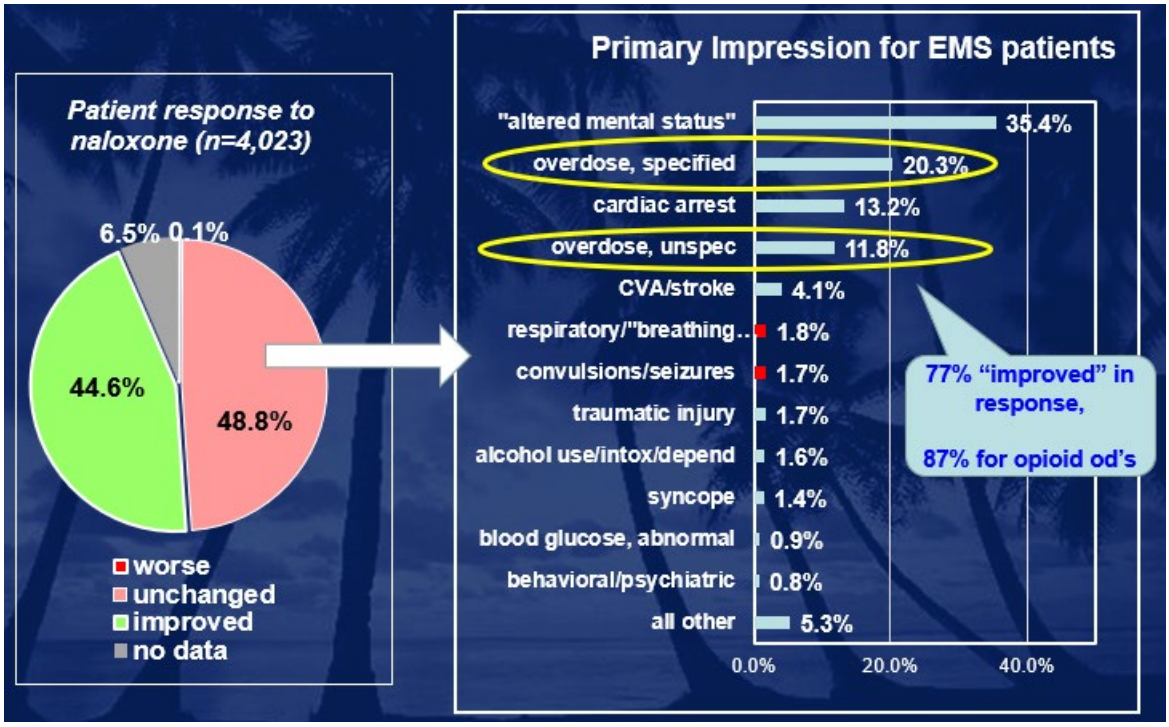
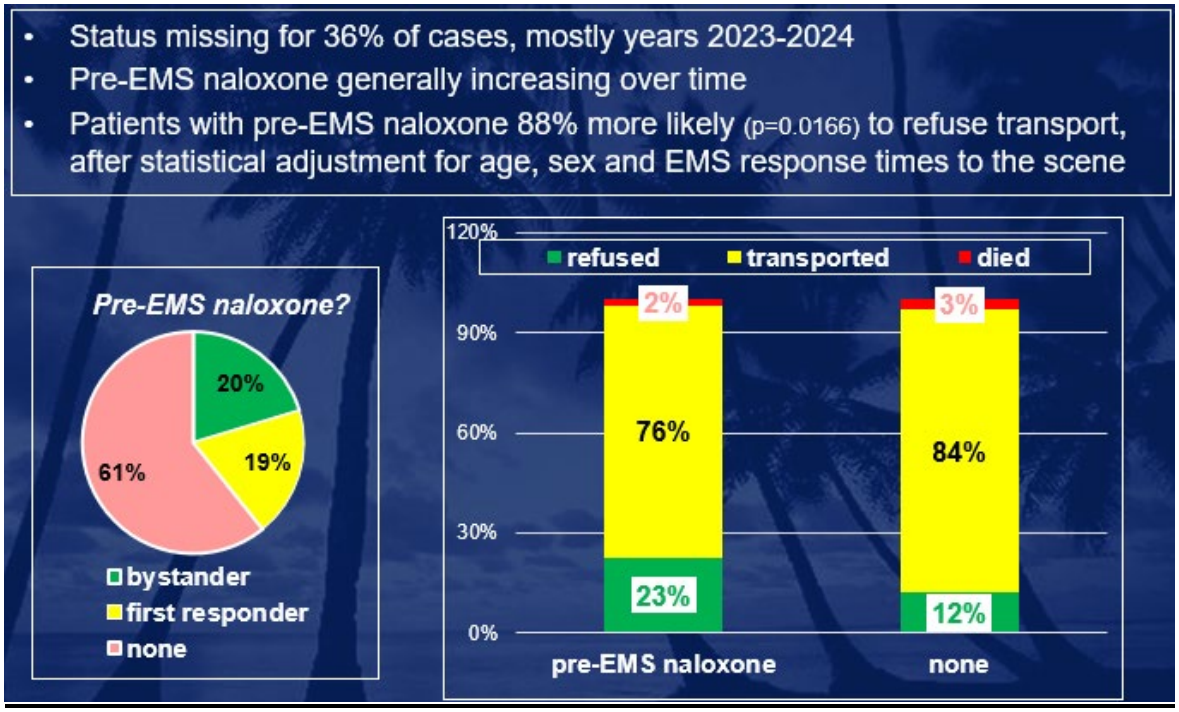


Figure 10. Discharge disposition for EMS patients with fentanyl overdoses, by pre-EMS naloxone status, 10/2021 –7/2024.



Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified in a December 2020 literature review conducted by the University of Hawai‘i 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 (Hawai‘i 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 following programs and interventions identified in a December 2020 rapid literature review conducted by the University of Hawai‘i 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).