REPORT TO THE

TWENTY-NINTH LEGISLATURE

STATE OF HAWAII

2018

PURSUANT TO:

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

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

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

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

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAII**

DECEMBER 2017

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2016-17 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS).

For Fiscal Year 2016-17, $31,436,129 was appropriated by Act 119 Session Laws of Hawaii (SLH) 2015, as amended by Act 124, SLH 2016, to the Alcohol and Drug Abuse program (HTH 440) – $18,996,527 general funds, $750,000 special funds and $11,689,602 federal funds (MOF N and P). Of the total appropriated, $25,103,847 was allocated for substance abuse treatment services and $5,139,472 was allocated for substance abuse prevention services. The Act also increased the general funds for the Clean and Sober Homes Registry by $252,000 including one Program Specialist V (#97606H) that was later classified as Program Specialist IV; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $350,000 (HTH440/HO); increased the federal fund ceiling by $100,000 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); increased the federal fund ceiling for the Hawaii Pathways Project by $499,185 (HTH440/HR); decreased the federal fund ceiling by $59,639 in the State of Hawaii Enforcing Underage Drinking Laws Grant by $59,639 (HTH440/HD); decreased the federal fund ceiling for the Strategic Prevention Framework – State Incentive Grant (SPF-SIG) by $2,941,131(HTH440/HR/HO) and removed four positions and decreased the federal fund ceiling by $2,750,961 for the Access to Recovery (ATR) Grant (Temporary ATR Project Director, SR24, #99855H; Temporary ATR QA Monitor, SR22, #99856H; Temporary ATR Service Developer, SR22, #99857H; and Temporary ATR Accountant, SR22, #99858H) (HTH440/HR).

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

$8.4 million for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

$1.0 million over three years (9/30/2014 – 9/29/2017) 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).

$3.1 million over three years (9/30/2013 – 9/29/2017) for the Hawaii Pathways Project funded by SAMHSA/CSAT/Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States, assists chronically homeless individuals with substance abuse or co-occurring substance use and mental health disorders through assertive outreach, case management and treatment services. The project will strengthen the infrastructure, partnerships and system of services to provide permanent housing to individuals and families living on Oahu. Project services assist the target population in securing permanent housing, maintaining that housing through wrap-around support services (e.g., housing, vocational, and mental health support), as well as case management and peer navigators. The project is based on the Pathways Housing First model, the only evidence-based program recognized by the National Registry of Evidence-Based Programs and Practices that provides

comprehensive housing and treatment services without preconditions of the individual's alcohol or drug use. In July 2016, ADAD began procedures for requesting a No Cost Extension from SAMHSA. The Notice of Award was granted on September 14, 2016. The service period was extended from October 1, 2016 to September 30, 2017, a total of twelve (12) months. This period was provided in order to transition enrolled clients towards sustainable permanent supportive housing resources.

$1.8 million in each of five years (9/30/2013 – 9/29/2018) for the SAMHSA/CSAP SPF-PFS grant provides resources to implement the Strategic Prevention Framework process at the state and community levels and to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. The project will engage public, private, state and community level stakeholders to ensure the program uses data- driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure to address underage drinking among persons aged twelve to twenty and other substance abuse prevention priorities as determined by assessments.

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

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,970 adults statewide in Fiscal Year 2016-17;

Assertive outreach, case management (e.g. wrap-around support services that include housing, vocational, and mental health support) and treatment services were made available to 136 participants enrolled in the Cooperative Agreements to Benefit Homeless Individuals (CABHI) project in Fiscal Year 2016-17.

School- and community-based outpatient substance abuse treatment services were provided to 2,123 adolescents statewide in Fiscal Year 2016-17; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, underage drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 30,902 children, youth and adults directly through individual-based prevention programs and strategies[2] in Fiscal Year 2016-17.

Also included are reports that are required pursuant to:

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

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

[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.

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

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2016-17 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) and is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS). Also included are reports that are required pursuant to: Section 329-3, HRS, which requires a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS); Section 10 of Act 161, SLH 2002, which requires a status report on the coordination of offender substance abuse treatment programs; and Section 29 of Act 40, SLH 2004, which requires a progress report on the substance abuse treatment monitoring program.

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

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

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

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

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

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

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

The Prevention Branch (PB) provides a focal point and priority in the Division for the development and management of a statewide prevention system which includes the development and monitoring of substance abuse prevention services contracts and the implementation of substance abuse prevention discretionary grants.

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

Health promotion and substance abuse prevention are essential to an effective, comprehensive continuum of care. The promotion of constructive lifestyles and norms includes discouraging alcohol, tobacco and other drug use, encouraging health-enhancing choices regarding the use of alcohol, prescription drug misuse and abuse and illicit drug use, 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 abuse. In addition, prevention efforts seek to enhance protective factors in the individual/peer, family, school and community domains. Protective factors are those psychological, behavioral, family and social characteristics and conditions that can reduce risks and insulate children and youth from the adverse effects of risk factors that maybe present in their environment.

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

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2016 to June 30, 2017

State and Federal Funding

Act 124, SLH 2016 appropriated $31,436,129 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2016-17:

General funds	$18,996,527	(60.4%)	25.0 FTE
Special funds	750,000	(2.4%)	
Federal funds (N)	8,346,657	(26.6%)	3.0 FTE
Federal funds (P)	3,342,945	(10.6%)	
	$31,436,129	(100.0%)	28.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$22,290,850	(61.7%)
Substance abuse prevention services	6,068,413	(16.8%)
Division operating costs	5,075,969	(14.1%)
Division staffing costs	2,686,632	(7.4%)
	$31,436,129	(100.0%)

For Fiscal Year 2016-17, $31,436,129 was appropriated by Act 124, SLH 2016, to the Alcohol and Drug Abuse program (HTH 440) – $18,996,527 general funds, $750,000 special funds and $11,689,602 federal funds (MOF N and P). Of the total appropriated, $25,103,847 was allocated for substance abuse treatment services and $5,139,472 was allocated for substance abuse prevention services. The Act also increased the general funds for the Clean and Sober Homes Registry by $252,000 including one Program Specialist V (#97606H) that was later classified as Program Specialist IV; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $350,000 (HTH440/HO); increased the federal fund ceiling by $100,000 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); increased the federal fund ceiling for the Hawaii Pathways Project by $499,185 (HTH440/HR); decreased the federal fund ceiling by $59,639 in the State of Hawaii Enforcing Underage Drinking Laws Grant by $59,639 (HTH440/HD); decreased the federal fund ceiling for the Strategic Prevention Framework – State Incentive Grant (SPF-SIG) by $2,941,131 (HTH440/HR/HO) and removed four positions and decreased the federal fund ceiling by $2,750,961 for the Access to Recovery (ATR) Grant (Temporary ATR Project Director, SR24, #99855H; Temporary ATR QA Monitor, SR22, #99856H; Temporary ATR Service Developer, SR22, #99857H; and Temporary ATR Accountant, SR22, #99858H) (HTH440/HR).

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

Federal Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. ADAD received $8.2 million in Fiscal Year 2016-17 of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

U.S. Food and Drug Administration (FDA) Tobacco Inspections. The award of $1.0 million over three years (9/30/2014 – 9/29/2017) by the FDA supports tobacco inspections on retail outlets that sell or advertise cigarettes or smokeless tobacco products to determine whether they are complying with the Tobacco Control Act (Public Law 111-31) and the implementing regulations (21 Code of Federal Regulations Part 1140, et seq.). Two types of tobacco compliance inspections are conducted: undercover buys, to determine a retailer's compliance with age and photo identification requirements; and product advertising and labeling to address other provisions of the Tobacco Control Act.

Hawaii Pathways Project. The $3.1 million over three years (9/30/2013 – 9/29/2016) for the Hawaii Pathways Project funded by the SAMHSA/CSAT/Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States assists chronically homeless individuals with substance abuse or co-occurring substance use and mental health disorders through assertive outreach, case management and treatment services. Project services assist the target population in securing permanent housing, maintaining that housing through wrap-around support services that include housing, vocational, and mental health support, as well as case management and peer navigators. During the original service period (9/30/2013 – 9/29/2016), the project has enrolled 136 clients. 74 housing vouchers were obtained from various federal, state, and city housing resources as well as other non-profit housing resources. 61 clients have been matched with permanent supportive housing and have received tenancy support services. The extension period will focus on transitioning clients to sustainable tenancy support services.

The project collaborated with the Hawaii Interagency Council on Homelessness, the Hawaii Public Housing Authority, State Dept. of Human Services, and other state and county affiliates, in developing and implementing a project transition and state sustainability plan for resolving homelessness. The goal has been to identify alternative, permanent financial resources while connecting clients to local resources of sustainable tenancy support services and permanent supportive housing. As the federal support ends, clients were connected to case management services that were connected to the original housing voucher used by the client. Those clients not housed were connected to case management services covered by client's insurance coverage.

The Hawaii Pathways Project contracted with Corporation for Supportive Housing (CSH) for technical consultation. CSH collaborated with the Governor's Coordinator for Homelessness and MedQuest Division (MQD) Administrator in developing Hawaii's Medicaid waiver request to include coverage for billable Tenancy Support services designed to pay for those services conducted by ICM providers that support individuals requiring housing support. ADAD has created funding to support Helping Hands Hawaii from October 1, 2017 to March 31, 2018.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant. The $1.8 million in each of five years (9/30/2013 – 9/29/2018) for the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) SPF-PFS grant award provides additional resources to implement the Strategic Prevention Framework process at the state and community levels to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. The project has engaged public, private, state and community level stakeholders to set the foundation for the effective gathering and analysis of local data to support data-driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure as determined by assessments. Five (5) community coalitions have been awarded resources to conduct assessments and plan for the implementation and evaluation of environmental strategies to address underage drinking among persons aged twelve to twenty in their communities. Environmental strategies have a broader focus than individual or curriculum-based strategies, so they have the potential to change community norms and population behaviors. Additionally, SPF-PFS resources were awarded to each County for infrastructure and capacity support to assess, plan and implement a sustainable prevention system at the county level to support substance abuse prevention efforts needed or currently being conducted in communities. During the FY 2017, the SPF-PFS contracted services involved approximately thirty-seven (37) community organizations and 4,335 community members in SPF efforts to enhance community health across the state.

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT is a five-year grant (project period 09/30/2016-09/29/2021) totaling $8,291,875. Funding is to implement screening, brief intervention, and referral to treatment (SBIRT) services for adults in primary care and community health settings for substance misuse and substance use disorders (SUD). Project services are designed to develop, expand, and enhance infrastructure to fully integrate SBIRT in six Federally Qualified Health Centers (FQHC) in Hawaii and up to twenty-five small group primary care practices (PCP) over five years and to establish the SBIRT model as a standard of care statewide. The SBIRT program seeks to address behavioral health disparities by encouraging the implementation of strategies, such as SBIRT, to decrease the differences in access, service use, and outcomes among the populations served. Implementing the SBIRT will aid in improving overall health outcomes, reducing the negative impact on health, and reducing healthcare costs. The grant has three goals: 1) Implement SBIRT in six FQHCs and twenty-five small group primary care practices; 2) Develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers; and, 3) Expand existing behavioral health integration efforts which includes a plan to disseminate SBIRT to small primary care practices throughout the State.

State Targeted Response to the Opioid Crisis (STR). The Hawai‘i STR grant (project period 5/1/2017-4/30/2019) totaling $2,000,000 is an initiative awarded jointly through SAMHSA’s Center for Substance Abuse Treatment (CSAT) and CSAP. The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The STR grant will address these concerns through three key activity tracks: (1) **education and awareness**, which will promote public awareness of the dangers of opioid use and provide training to health professionals to better identify and assist persons at risk or suffering from opioid use disorders; (2) **care coordination and integration** which will target more efficient and effective ways to integrate primary and behavioral health care to reduce risk and better treat

persons affected by opioid misuse and abuse; and (3) **policy shaping** which targets policies and protocols aimed at improving access and expanding proven interventions and prevention strategies such Medication Assisted Treatment (MAT).

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. Twenty-six (26) agencies, which resulted in thirty-two (32) contracts were established to provide a continuum of services to seven different populations which are, Adult Substance Abuse Treatment, Dual Diagnosis Substance Abuse Treatment, Opioid Addiction Recovery Services, Specialized Substance Abuse Treatment for Pregnant Women and Women with Dependent Children, Intensive Addiction Care Coordination and Substance Abuse Treatment for Offenders, Group Recovery Homes, Early Intervention Service for HIV, Homeless Outpatient Substance Abuse Treatment, and Adolescent Substance Abuse Treatment Services which consist of School-Based and Community-Based services. Treatment providers are able to provide all or part of the treatment continuum, which includes pre- treatment service such as motivational enhancement services, outreach, and interim; treatment services such as non-medical social detoxification, residential, intensive outpatient, outpatient; and recovery support services such as therapeutic living, clean and sober housing, continuing care, transportation, translation, and childcare. All client admissions, treatment service, including treatment progress notes, and discharges are tracked on the Web-Based Infrastructure for Treatment Services (WITS) system. Services were provided to 2,970 adults statewide in Fiscal Year 2016-17; and school-based and community-based outpatient substance abuse treatment services were provided to 2,123 adolescents statewide in Fiscal Year 2016-17.

Prevention Services. Sixteen (16) public and community-based organizations were awarded a total of twenty-five (25) contracts to support statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2017. In efforts to best utilize resources to fund what works, the contracted services are to implement evidence-based programs, policies, and practices that include: information dissemination; education; problem identification and referral; community-based programming; environmental strategies; and alternative activities that decrease alcohol, tobacco, and other drug use. The funded programs engage schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models to prevent substance abuse in young people in a variety of community settings, and promoting programs and policies to improve knowledge about alcohol and other drug

[4] Details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions are appended at pages 27-33.

problems, including effective ways to address the 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 the Hawaii Information System for Substance Abuse Prevention (HISSAP). The HISSAP is a comprehensive web-based data collection and management system for the processing of data transmitted by contracted providers at the state and community levels; the system accommodates a broad range of reporting entities and added capacity for reporting of substance abuse prevention program output measures and participant demographics. Additionally, the 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 2016-17, curriculum-based youth substance abuse prevention strategies and the HIPRC served a total of 30,902 children, youth and adults across the state.

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

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

Studies and Surveys

Tobacco Sales to Minors. The 2017 annual statewide survey results for illegal tobacco sales to minors is 5.3% (weighted), an increase from last year's rate of 4.6%. While the 5.3% is still significantly less than the 9.6% national weighted average for federal fiscal year 2013, it represents a slight increase from the 4.6% in overall retailer violation rates for 2016. The annual survey, which is a joint effort between the Alcohol and Drug Abuse Division and the University of Hawaii, monitors the State's compliance with the "Synar" (tobacco) regulations for the federal Substance Abuse Prevention and Treatment Block Grant. It is important to note that on

January 1, 2016, it became unlawful to sell both tobacco products and electronic smoking devices to persons under 21 years of age. With the enactment of Act 122, SLH 2015, which increased the minimum age from eighteen (18) to twenty-one (21), youth between the ages of 18-20 were also included in the annual survey. In the Spring of 2017, teams made up of youth volunteers (ages fifteen to twenty) and adult observers visited a random sample of 157 stores statewide in which the youth attempted to buy cigarettes to determine how well retailers were complying with state tobacco laws. Eight stores (5.3%) sold to minors (ages fifteen to twenty). Of the four counties included in the statewide survey, the County of Kauai and the County of Maui had one sale each, the County of Hawaii had two sales, and the County of Honolulu had four 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 twenty-one (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 2016-17, ADAD conducted training programs that accommodated staff development opportunities for 1,245 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through 105 training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 15,350 Continuing Education Units (CEU's) towards their professional certification and/or re-certification as certified substance abuse professionals in the following: Certified Substance Abuse Counselor (CSAC), Certified Prevention Specialist (CPS), Certified Criminal Justice Professional (CCJP), Certified Clinical Supervisor (CCS), Certified Co-occurring Disorders Professional-Diplomate (CCDP-D), or Certified Substance Abuse Program Administrator (CSAPA).

Topics covered during the reporting period included: opioid prevention and response; screening, brief, treatment, referral (SBIRT); motivational interviewing; group counseling; criminal conduct and substance abuse; drug use during pregnancy; confidentiality of alcohol and drug abuse client records (42 CFR, Part 2); Health Insurance Portability and Accountability Act of 1996 (HIPAA); certification and examination processes; data input and its usefulness; prevention specialist training; identifying/implementing environmental trainings; evaluation capacity building; evidence-based practices; Code of Ethical Conduct for substance abuse professionals; mental health and substance use; denial and resistance in addiction treatment; critical thinking for substance addiction professionals; understanding sexually transmitted diseases; HIV/AIDS in the substance abusing population; cultural diversity; and understanding the addiction process and how families are affected by addiction.

Programmatic and Fiscal Monitoring

Through desk audits of providers' program and fiscal reports, ADAD staff examined contractors' compliance with federal SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance abuse prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of forty (40) prevention service contracts and thirty-two (32) treatment service contracts.

Technical assistance and follow-up and site visits related to program development and implementation, reporting and contract compliance provided as needed.

Certification of Professionals and Accreditation of Programs

Certification of Substance Abuse Counselors. In Fiscal Year 2016-17, ADAD processed 648 (new and renewal) applications, administered forty-nine (49) computer-based written exams and certified forty-five (45) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,229.

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

Accreditation of programs. In Fiscal Year 2016-17, ADAD conducted a total of twenty-two (22) accreditation reviews and accredited thirteen (13) organizations, some of which have multiple (residential treatment and therapeutic living) programs.

Clean and Sober Homes Registry

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

The voluntary registry of clean and sober homes is a product of a two-year process during which the knowledge and expertise of public (i.e., State and County) as well as private agencies' perspectives were elicited. The registry will help residents to access a stable, alcohol-free and drug-free home-like living environment by establishing procedures and standards by which homes will be allowed to be listed on the registry, including but not limited to: organizational and administrative standards; fiscal management standards; operation standards; recovery support standards; property standards; and good neighbor standards.

Act 124, SLH 2016 also increased the general funds for the Clean and Sober Homes Registry by $252,000 including one Program Specialist V (#97606H) that was later classified as a Program Specialist IV.

Act 49, SLH 2017 also increased the general funds for the Clean and Sober Homes Registry by $28,584 in FY18 and $28,584 in FY19 for the same Program Specialist V (#97606H) that was classified as a Program Specialist IV.

Concerning the status of the plan for establishing and operating the registry of clean and sober homes, at the time of report preparation (December 2017), the status of establishing and operationalizing the registry of clean and sober homes is as follows:

> The web-based registry of clean and sober homes has been developed through a contract with the Hawaii Information Consortium and is undergoing the internal testing phase.
>
> The process of drafting administrative rules to operationalize the registry of clean and sober homes is in progress. It is anticipated that by the end of December 2017, a draft will be completed for internal (i.e., Department of Health) and external (i.e., Department of the Attorney General, Legislative Reference Bureau, etc.) review and mark-up.
>
> NOTE: In the upcoming 2018 Regular Session ADAD as part of the Governor's Executive Budget will request to convert 1.00 position from temporary to permanent and address variance of the position (#97606H) from Program Specialist V to Program Specialist IV to fulfill mandates pursuant to Act 193, SLH 2014.

It is anticipated that:

- By Fiscal Year 2018, rules will be adopted;
- By Fiscal Year 2018, the web-based registry of clean and sober homes will be operational; and
- By Fiscal Year 2019, ADAD-funded substance abuse treatment providers whose clients are assisted with housing referrals shall only refer clients to residences that are on the registry.

Law Enforcement Assisted Diversion (LEAD)

Act 49, HSL 2017 approved an $800,000 general fund appropriation for FY 2018, $200,000 of which is to implement a pilot program (LEAD) that provides pre-arrest diversion services working with local law enforcement (e.g., local police departments) for the chronically homeless who suffer from severe substance abuse disorders. The pilot also includes training for local law enforcement to detect the signs of SUD addiction (versus mental health disorders) in the field and how to fast-track low-level offenders to SUD treatment programs. With LEAD, low-level offenders for whom probable cause for arrest or citation exists are provided the choice of arrest/citation or active engagement in services by local law enforcement.

On their own, the homeless will have no benefit of a care coordination safety net, and are at risk of wandering from one provider that requires multiple assessments and services completed with previous providers that were not effective, leading to increased waste of treatment provider time and effort. A segment of the homeless population may qualify for LEAD which fast-tracks them to receive appropriate care in a SUD treatment program if they have committed low-level, non-violent offenses due to drug and/or alcohol addiction. Sustained outreach and quick referrals to SUD treatment services coupled with wrap-around services such as care coordination will expand

the system of care to help the homeless overcome addiction which will improve their ability to secure housing, reduce crime and qualify for employment. This intervention is targeted to move resistant individuals into care and increase the overall safety of the community. The project is currently being piloted and the general fund appropriation will be utilized to expand implementation of the project. It is anticipated that the FY 2018 one-year pilot will serve up to 300 individuals.

NOTE: In the upcoming 2018 Regular Session ADAD as part of the Governor's Executive Budget will request another $800,000 in general funds for FY19 to continue intensive outreach based counseling and law enforcement diversion services through a continuation of the LEAD program for the chronically homeless who suffer from severe substance abuse disorders, in coordination with the Governor's Coordinator on Homelessness.

Legislation

ADAD prepared informational briefs, testimonies and/or recommendations on legislation addressing substance abuse related policies. Legislation enacted during the 2017 Legislative Session that addressed issues affecting the agency included:

Act 49, HSL 2017 (H.B. 100 HD1 SD1 CD1), relating to the state budget. This measure approved $800,000 in general funds for FY18 to provide outreach counseling and law enforcement diversion services for the chronically homeless who suffer from severe substance abuse disorders. Of this amount, $600,000 was added to existing contracts with substance abuse treatment providers to expand their outreach ability to serve the chronically homeless in coordination with the Governor's Coordinator on Homelessness. The remaining $200,000 is intended to implement a pilot program for arrest diversion working with local law enforcement who intervene with individuals who are visibly and chronically homeless due primarily to substance abuse disorders.

NOTE: In the upcoming 2018 Regular Session ADAD as part of the Governor's Executive Budget will request another $800,000 in general funds for FY19 to continue intensive outreach based counseling and law enforcement diversion services through a continuation of the LEAD program for the chronically homeless who suffer from severe substance abuse disorders, in coordination with the Governor's Coordinator on Homelessness.

Act 66, HSL 2017 (**S.B 505 SD1 HD2 CD1), relating to health.** Requires prescribing healthcare providers to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency. Establishes limits for concurrent opioid and benzodiazepine prescriptions. Clarifies Board of Nursing authority to enforce compliance with Uniform Controlled Substances Act, with repeal scheduled for 6/30/2023.

A measure to appropriate funds to the Department of Health and Department of Human Services to provide homeless outreach services and rental subsidies to reduce and prevent homelessness (HB1195) was heard but not enacted.

NOTE: In the upcoming 2018 Regular Session ADAD as part of the Governor's Executive Budget will request to convert 1.00 position from temporary to permanent and address variance of the position (#97606H) from Program Specialist V to Program Specialist IV to fulfill mandates pursuant to Act 193, SLH 2014, relating to group homes.

OTHER REQUIRED REPORTS

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

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

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

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

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

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

MEMBERS BY CATEGORY OF APPOINTMENT AND TERM OF OFFICE

CARL BERGQUIST Community and Business Affairs(Oahu) - 6/30/2020 **LORI FERREIRA, Ed.D.** Education (Oahu) - 6/30/2019 **JODY JOHNSON** Community and Business Affairs (Oahu) - 6/30/2019 **CHAD Y. KOYANAGI, M.D.** Vice Chair Joint appointment to HACDACS and State Council on Mental Health (Oahu) - 6/30/2019	**CASHMIRE LOPEZ** Medical (Hawaii) - 6/30/2019 **HEATHER LUSK** Chairperson Education (Oahu) - 6/30/2019 **KENNETH TANO** Enforcement (Oahu) - 6/30/2018

On March 28, 2013, members elected Heather Lusk as Chairperson and on August 22, 2017 elected Chad Koyanagi as Vice-Chairperson. Meetings were scheduled on the fourth Tuesday of each month.

Priorities discussed during FY 2016-17:

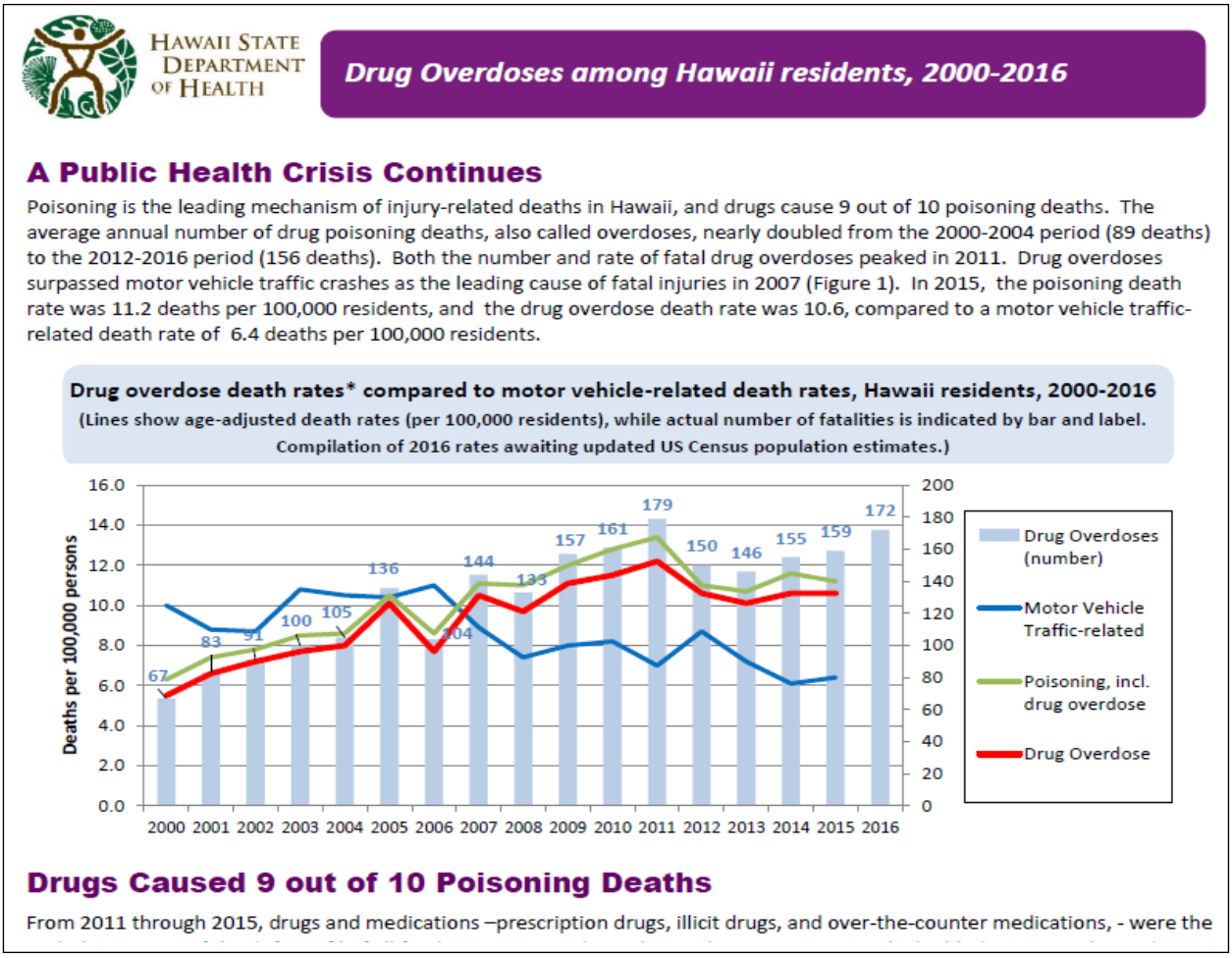
- Opioid use/misuse and related harms
- Homeless individuals struggling with substance use
- Public health/public safety partnerships
- Pregnancy and substance use
- Increased access to substance abuse treatment

The members of HACDACS gathered research, best practices and invited knowledgeable

speakers on these topics to form the following policy recommendations for prevention and treatment of substance use in Hawaii. The overarching themes of our recommendations are: support evidence and data-driven culturally appropriate services by integrating systems, policies and programs to create a comprehensive continuum of substance abuse prevention and treatment services in Hawaii.

Opioid Use/Misuse and Related Harms

Drug poisoning (drug overdose) is the leading mechanism of injury-related deaths in Hawaii, and drugs cause 9 out of 10 poisoning deaths. The average annual number of drug poisoning deaths, also called overdoses, nearly doubled from the 1999-2003 period (78 deaths) to the 2010-2014 period (156 deaths). Drug overdoses surpassed motor vehicle traffic crashes as the leading cause of fatal injuries in 2008. In 2014, the poisoning death rate was 11.6 deaths per 100,000 residents, and the drug overdose death rate was 10.6, compared to a motor vehicle traffic-related death rate of 6.5 deaths per 100,000 residents.



In an effort to improve understanding of prescription drug use, misuse and the opioid epidemic in Hawaii, the Hawaii State Department of Health (DOH), Emergency Medical Services and Injury Prevention System Branch, the Alcohol and Drug Abuse Division and the Harm Reduction Services Branch partnered with the Department of Public Safety (DPS), Hawaii

Narcotics Enforcement Division (NED) and community partners to develop a Hawaii-specific strategic plan to address opioid misuse and related harms.

The Opioid Strategic Planning Group has six work groups to develop recommendations and have the following goals:

1. Improve and modernize healthcare strategies and access for opioid and other substance abuse treatment and recovery services.
2. Improve prescribing practices by working with healthcare providers and payers.
3. Improve use of data (i.e., PDMP, EMS, hospitalizations) to improve prescribing, conduct public health surveillance and reduce related harms, and assist law enforcement.
4. Improve community-based programs and public education to prevent substance abuse and related harms.
5. Increase consumer education and management through pharmacy-based strategies.
6. Support law enforcement and first responders by coordinating operations, supporting specialized training, and strengthening existing laws.

Several HACDACS members are participating in the strategic planning process and will collaborate to align HACDACS' and the strategic plan's goals, objectives and activities. One of the main concerns of HACDACS' assessment of the research and evidence-based practices to reduce opioid misuse and related harms are the potential unintended consequences of policy changes.

Hawai'i needs to be cautious, creative and compassionate in preemptively tackling the opioid epidemic. We are fortunate in that we are not reacting to what is already a crisis on the scale witnessed in many communities on the mainland. First, this allows employing caution that should lessen the temptation of adopting unproven solutions with possible negative unintended consequences. Second, as Hawai'i moves away from the failed enforcement heavy approach that characterizes the War on Drugs, it must encourage creativity to flourish as we address demand and not just supply. Lastly, compassion in the form of harm reduction must be the guiding principle of how we work with the impacted individuals and communities. As we acknowledge that pain is real, addiction is a disease and that the opioid epidemic is a public health matter, we must continually move towards the destigmatization of drug users in crafting a holistic solution. This is not only humane, but it is smart public policy.

Caution is Warranted on Arbitrary Limits on Prescriptions

Decision makers around the country, from state legislators to pharmacy chain executives, are proposing and passing limits to opioid prescriptions. These restrictions have their genesis in the Centers for Disease Control and Prevention (CDC). In 2016, the CDC published new *guidelines* for prescribing opioids for "chronic pain outside of active cancer treatment, palliative care and end-of-life care".[1] The guidelines provide *recommendations* for primary care physicians (PCP) treating chronic pain yet have been used to justify the mandating of restrictions, often ones stricter than the guidelines themselves. Further, the state laws tends to apply to all physicians and not just PCPs as well as to conditions aside from chronic pain, including acute pain.

Research

New research highlights the issue with blanket solutions like dosage and time restrictions. A

large scale study of eight common surgical procedures found that at least 20% of patients needed one or more refills to deal with their pain.[2] Within certain musculoskeletal and women's health procedures, the ideal prescription length could be up to fifteen days. This and other research highlights that the limits in state laws are arbitrary and not based on reliable data. A 2016 study of 81 state laws published in the New England Journal of Medicine found that:

> *Adoption of controlled-substance laws was not associated with reductions in potentially hazardous use of opioids or overdose among disabled Medicare beneficiaries, a population particularly at risk.*[3]

Further, these restrictions do not address the issue of street opioids, from heroin to the far more potent fentanyl and carfentanyl. By limiting a supply for patients, either the physician may become less inclined to prescribe in the first place or the patient will instead turn elsewhere for pain relief, e.g. to the aforementioned street drugs. Similarly, even if initially treated by a physician, at the end of the limit a patient may look for pain relief in the unregulated and far more dangerous market. This, in turn, can exacerbate the spread of communicable diseases like Hepatitis C and HIV. The former U.S. Surgeon-General Vivek Murthy emphasized the role of holistic approaches to the opioid epidemic, and he certainly did not shy away from addressing his colleagues in the medical profession. Pointedly, in a first-of-its-kind letter sent to the nation's 2.3 million doctors, nurses, dentists and other clinicians, instead of calling for arbitrary limits Murthy emphasized the roles of education, reassessing practices and being honest about pain.[4]

Act 68 (2016)
On June 7, 2016, Governor Ige signed SB2392 (Act 68) into law. Relating to opioid antagonists, it creates immunity for health care professionals and pharmacists who prescribe, dispense, distribute, or administer an opioid antagonist such as naloxone hydrochloride to persons who are at risk of experiencing or who are experiencing an opioid-related drug overdose. It provides immunity for any person who administers an opioid antagonist to a person suffering from an opioid-related drug overdose. It authorizes emergency personnel and first responders to administer opioid antagonists. It requires Medicaid coverage for opioid antagonists; and allows harm reduction organizations to store and distribute opioid antagonists.

Act 72 (2017)
Requires prescribing healthcare providers to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency. Establishes limits for concurrent opioid and benzodiazepine prescriptions. Clarifies Board of Nursing authority to enforce compliance with Uniform Controlled Substances Act.

HACDACS recommends the adoption of evidence-based best practices in combating opioid use, misuse and prevention of related harms in relation and supports the Opioid Strategic Working Group's recommendations and recommends close evaluation of the impact of Act 72 and to make policy changes to avoid unintended harms and consequences.

HACDACS recommends specific efforts to help people struggling with chronic pain and opioid use disorder have access to evidence-based pain management and substance abuse treatment services including Medication Assisted Treatment,

HACDACS recommends the implementation of Act 68 which expands access to naloxone and

gives immunity to law enforcement, first responders and community members for the administration of naloxone.

HACDACS recommends public education on the application of the medical model and language use (American Medical Association Journal) to reduce the stigmatization of substance use and encourage treatment seeking behaviors. This public education campaign should be aligned with the Statewide Opioid Strategic Plan's recommendations on public education.

Homeless Individuals Struggling with Substance Use

The 2017 Homeless Point in Time Count for the State of Hawaii found of 7,220 homeless individuals of which 3,800 were unsheltered. On Oahu, of the 4,959 homeless individuals identified 1,088 were identified as having a serious mental illness and 933 were identified as having a substance use disorder.

Hawaii has adopted the Comprehensive Assessment and Housing Placement System (CAHP or Hale O Malama) which replaces the system of linking the homeless to housing. Using a single assessment tool, the VISPDAT, people are assessed and ranked to determine the level of services needed. A score of 10-20 means the person would benefit from Permanent Supportive Housing (PSH). For a score of 5-10, the person would qualify for rapid re-housing and for those with a score of 4 and below, they would need to utilize existing housing services. The system uses a "housing first" model which separates program requirements from tenancy requirements. There are currently three "housing first" programs—all of which are using the VI-SPDAT, one of which is funded through ADAD.

The Cooperative Agreement to Benefit Homeless Individuals (CABHI) Grant awarded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for the Hawaii Pathways Project provides a three-year grant (9/30/13-9/29/16) totaling $2.1 million. Funding provides for housing support services to the chronic homeless individuals on Oahu who suffer from substance abuse or co-occurring substance abuse and mental health disorders. The project served a minimum of 120 chronically homeless individuals. Project services will assist the target population in finding and securing permanent housing, then maintaining that housing through support services that will include housing, vocational and mental health support, as well as case management and peer navigators.

The project is based on the Pathways Housing First model, the only evidence-based program recognized by the National Registry of Evidence-based Programs and Practices that provides comprehensive housing and treatment services without preconditions of the individual's alcohol or drug use. The Housing First model seeks to transform individual lives by ending homelessness and supporting recovery by: providing immediate access to permanent independent apartments, without preconditions; setting the standard for services driven by consumer choice that support recovery and community integration; and conducting research to find innovative solutions and best practices for those who are homeless and suffer from substance abuse and mental illness.

Due to the success of Housing First Models, where individuals are significantly less likely to engage in substance use as compared to their "Treatment First" counterparts, we continue to support "Housing First" Models. However, we acknowledge that due to strict requirements many individuals continue to fall out of housing. There is an opportunity to improve follow-up,

coordinated entry and referral processes, particularly for people who use substances after they are housed. Increased representation of homeless services on substance use committees would be beneficial in addressing the intersection of substance use and homelessness. Lastly, through the medical model, relapse is recognized as a characteristic of substance use disorder which therefore logically precludes the implementation of mandated sobriety.

HACDACS recommends the continued funding of "Housing First" models that include low threshold requirements (such as not requiring sobriety) and wraparound services for those who are homeless and also struggling with addiction and mental health challenges. HACDACs notes that the substance use management and substance abuse treatment services need to be prioritized for persons once housed and recommends on-going collaboration between homeless service providers and substance abuse treatment providers to ensure wrap-around services.

HACDACS recommends ongoing collaboration and integration of substance use and homeless services and that HACDACS participate and/or have a liaison on the Hawaii Interagency Council on Homelessness

HACDACS recommends that Substance Use Disorder be included in DHS's Med QUEST Community Care Services eligibility criteria so that people struggling with both mental health challenges and substance abuse may have access to these much-needed services.

Public Health/Public Safety Partnerships

Law Enforcement Assisted Diversion or LEAD is a nationally recognized promising best practice diversion program, primarily used for those charged with low-level offences. Individuals arrested for eligible offenses, such as low-level drug offenses and prostitution, can be referred to LEAD. Individuals with certain violent offenses in criminal history are not eligible for the program. The program allows law enforcement officers to exercise discretion in redirecting these offenders towards social services, rather than jail and prosecution. Instead of falling into the normal criminal justice cycle, those participating in LEAD programs are referred into intensive case-management programs where they can receive various support services, including housing, healthcare, job training, and substance abuse treatment. LEAD began as a privately funded pilot program, first administered in the Belltown and Skyway neighborhoods of Seattle, Washington, in 2011. There are currently LEAD programs in areas as diverse as Albany, New York, Santa Fe, New Mexico, and Huntington, West Virginia, with many other cities launching their own pilot programs, developing programs for their upcoming legislative sessions, or in the early stage of exploring programs.

LEAD Efforts in Hawaii

In mid-2016, The CHOW Project started to convene the LEAD Hui, a group of more than twenty-five agencies dedicated to bringing a LEAD pilot to Hawaii. Hawaii LEAD Hui members include:

- ACLU – Hawaii Chapter
- ALEA Bridge
- CARE Hawaii
- City and County of Honolulu
- Community Alliance on Prisons
- Hina Mauka
- Institute for Human Services
- Ku Aloha ola Mau
- Mental Health America of Hawaii
- Mental Health Kokua

- CHOW Project
- Drug Policy Forum of Hawaii
- Harm Reduction Hawaii
- Harm Reduction Services Branch, Hawaii State Dept. of Health
- Hawaii Appleseed
- Hawaii Substance Abuse Coalition
- Helping Hands Hawaii
- Partners in Care
- PHOCUSED
- State Office of the Public Defender
- The Salvation Army ATS-FTS
- Susannah Wesley Community Center
- UH Office of Public Health Studies
- We are Oceania
- Waikiki Health

The LEAD Hui implemented four committees to develop a Hawaii-specific pilot: program and evaluation, policy, communications, and the link and sync committee. Through their efforts, the following progress has been made on supporting a LEAD pilot in Honolulu:

- Testified and supported 200,000 in Governors Budget for LEAD pilot through ADAD;
- Developed potential list of included and excluded offenses;
- Developed draft evaluation plan and clinical work flow;
- Conducted over a dozen public presentations on LEAD to Neighborhood Boards, policy makers, business owners, social service providers and law enforcement and judiciary staff;
- Worked with Councilmember Carol Fukunaga to get a Honolulu City Council Resolution unanimously passed to expedite a pilot in Chinatown;
- Worked with Chinatown Neighborhood Board to pass unanimous resolution supporting a pilot project in Chinatown;
- Collaborated with HPD to conduct dual outreach (police officers and outreach workers) to start to build public health/public safety partnerships;
- Trained HPD officers on LEAD and how to work with people who are homeless and/or struggling with substance use ; and
- Met with State and City officials including the Public Defender, the Prosecutor's Office, the Office of the Attorney General and the Governor's Office on Homelessness to coordinate LEAD efforts within the existing systems of care.

LEAD has been conclusively shown to cut down recidivism rates for participants. Participants were 58% less likely to be arrested after enrollment in the LEAD program. Compared to a control group, LEAD participants also showed a significant reduction in the number of days spent in jail after entering the program. In addition, participants were 87% less likely to be incarcerated in Washington State Prison than a control group after taking part in the program. Lower recidivism rates lead to safer communities and cities. Ineffective crime control methods, such as "broken windows" policing, have shown to be largely ineffective at reducing recidivism. Programs like LEAD focus on the idea of harm reduction, which states that efforts to reduce negative behaviors, while helpful, cannot be the only goal of criminal justice policy. According to LEAD, drug crimes should be seen as more of a public health issue than a criminal one, and that it will be more beneficial to society to connect petty criminals with services, rather than involving them in the criminal justice system.

HACDACS recommends support of the LEAD pilot in Chinatown on Oahu and additional pilots on the Neighbor Islands for low-level drug offenders and other low-level offenders. HACDACS recommends on-going public health/public safety partnerships to address substance use, homelessness and other complex social issues.

HACDACS recommends support of a LEAD pilot on the Neighbor Islands.

Pregnancy and Substance Use

Pregnancy is a point of high motivation for women using substances to quit. Research indicates that pregnant women have lower rates of substance use compared to non-pregnant women in the same age group and surveillance data in Hawai‘i confirms that for all substances (smoking, alcohol, illicit drugs), use declines during pregnancy. [5]

The Perinatal Addiction, Treatment and Health (PATH Clinic) is one of the nation's only clinics which specializes in women's reproductive health care, pre-natal care and other services for women with a current or former history of substance use and is a collaboration between the JABSOM, Waikiki Health and Salvation Army Family Treatment Services. PATH Clinic and SAFTS collaborate seamlessly to ensure pregnant and parenting women receive access to medical care that also addresses their addictions and social service needs. Our programs target women with a history of substance abuse, including women who are homeless, or experiencing socioeconomic, language, cultural or other barriers to accessing care, to promote addiction cessation, reduce perinatal substance exposure, and promote healthy birth outcomes. SAFTS provides substance abuse treatment in a residential setting specifically designed for women with children.

The State of Hawai‘i Healthcare Innovation Project and the Hawai‘i Maternal and Infant Health Collaborative (HMIHC) promotes routine screening, brief intervention, and referral to treatment (SBIRT) for prevention and treatment associated with pregnancy and substance use. The Hawai'i Screening, Brief Intervention and Referral to Treatment (HI-SBIRT) project incorporates SBIRT services into medical practices throughout Hawai'i. SBIRT is an evidence-based collaborative effort between Substance Abuse and Mental Health Administration (SAMHSA), Hawai'i state agencies, community organizations and health care providers developed to reduce substance use and increase positive health outcomes. Over a period of five years 65,000 adults will be screened for alcohol, drug, and mental health disorders. SBIRT will be implemented at federally qualified health centers and primary care providers. A strategic 6 month follow up survey administered to 10% of the sample will illuminate the impact of SBIRT practices and implementation. [6]

The "One Key Question" which asks women, "Would you like to become pregnant in the next year?" is a critical tool for shaping prevention and public education related to substance misuse in women and mothers. The one key question approach illicit critical information needed to tailor intervention. Women who answer "Yes" can best health practices. Women who answer "No" can be provided support with remaining not pregnant. [7]

Although universal screening for substance use is already a recommendation of the American College of Obstetricians and Gynecologists (ACOG), the quality of screening and implementation is not believed to be consistent across providers. The environmental scan of treatment resources sponsored by the Hawai‘i Maternal and Infant Health Collaborative will provide a more extensive and systematic review of capacity than is possible within the scope of this paper.[8] It may identify other concerns in addition to the problems highlighted here; provider shortages, lack of local investment, and limited capacity of appropriate gender-specific treatment for pregnant women with SUDs. Continued focus and integrated efforts to address the problem of substance

use in pregnancy are essential to meet the current demand and help to prevent substance exposed pregnancies in the future.

HACDACS recommends that SBIRT and the "One Key Question" be integrated into services for women of child-bearing age throughout Hawaii and that pregnant women struggling with substance use be offered evidence-based services without stigma, including medication assisted treatment as appropriate.

HACDACS recommends support of the State of Hawai'i Healthcare Innovation Project and the Hawai'i Maternal and Infant Health Collaborative (HMIHC) emphasis on routine screening, brief intervention, and referral to treatment (SBIRT) as a strategy for preventing and treating prenatal substance use.

HACDACS recommends that evidence-based harm reduction programs such as the PATH clinic be available to all women of child-bearing age to reduce the harms associated with substance use during pregnancy. HACDACs strongly recommends that the services offered to pregnant women who are using drugs further engagement and prenatal care and do not criminalize them and that these services be expanded to the Neighbor Islands.

Increase Access to Substance Abuse Treatment

Stigma associated with substance misuse remains the number one barrier to treatment, and therefore a key component to prevention and intervention planning. The language used to speak about substance use is critical to decreasing the negative impact of stigma. The Mental Health Parity and Addiction Equity Act of 2008 paired with the Affordable Care Act in 2010 emphasize parity in primary care and require an increased emphasis on substance use disorder in general health care.[4] Further, the SBIRT model which advocates enhanced relationships between behavioral health, women's health, and primary care, is an essential tool for building the connectedness necessary to increase resilience, informed decision making, and transitional skills needed to prevent relapse.

In order to facilitate access to treatment, communities or seeking to implement or strengthen coordinated entry processes, which creates opportunities for providers who may not have communicated as regularly in the past to collaborate in new ways and simultaneously promote the standardization of assessment and referrals, improve targeting, and more quickly connect people to appropriate and tailored services. This process also encourages communities collectively to prioritize individuals with the highest need. As innovative approaches develop through coordinated efforts, relationships with new partners are solidified, stakeholders grow in number and involvement, and access to services greatly improves.

Based on other states' innovative coordinated approaches, several variables would impact Hawai'i's coordinated entry implementation such as what are the various motivations of the different agencies, what are the politics of each region, how developed is the existing infrastructure and how easily can the infrastructure evolve, what are the historical factors that could contribute or impede coordinated efforts, what resources are available, and many other variables. Coordinated entry efforts has the added benefit of allowing communities to bring services directly to people who otherwise might not seek out services and to connect them to necessary supports. Often the biggest barrier is an inherent distrust of public systems that may

take significant time and effort involving creative and proactive engagements.

Key elements of a coordinated entry approach include:

1. Connecting as quickly as possible to services that attend to immediate needs to reduce the likelihood of reoccurrences. Essential for such connectivity is the availability of services that goes beyond just basic needs to establishing meaningful pathways to healthiness;
2. Systematical documenting to target priorities, avoid duplication, improve greater participation, and evolve access systems to become faster;
3. Collaboration with partners that includes law enforcement, jails, prisons, hospitals, and other health care providers, as well as other nontraditional partners;
4. Targeting. Assessments help to identify those with highest needs who are frequent users of shelter, emergency health services, and the criminal justice system. Targeting individuals based on vulnerability and high utilization increases the probability of accessing comprehensive services and motivates more stakeholders to participate in the coordinated approach;
5. Data sharing across multiple systems and programs is essential to coordinate effective services among various partners and must also address privacy and confidentiality issues, particularly the Code of Federal Regulations—Title 42;
7. Identify hot spots that are concentrations of high-need individuals geographically so that the community can periodically mobilization intensive, comprehensive services;
8. Coordinated efforts for institutional offenders to help to form pre- and post-incarceration services to meet the needs of chronic conditions for people who have repeatedly been involved with the criminal justice system to ensure that they have adequate supports for employment and family reunification upon reentry;
9. Ensure a warm hand-off between stakeholders and partners to reinforce transitions and to provide support to the individual and their providers;
10. Training on evidence-based practices such as Trauma-Informed Care, Motivational Interviewing, and Critical Time to increase the effectiveness of the community's coordinated efforts; and
11. Engagement efforts must be diverse and robust. For example, using social media can be particularly effective in reaching youth.

As Hawai'i's coordinated entry approach is developed in a particular community, the successful elements must be shared with other communities as well as other states. Curricula should be adopted or developed to teach staff essential skills, such as open communication, ethics, cultural competency, mental health first aid, staff care, strength based and person-centered approaches, recognizing patterns of interaction, and accessing coordinated entry. Supplemental training on preferred or best practices in case management and on using data is also recommended. Creatively resolving funding issues will be a priority. It's important to promote clear messages about the benefits of coordinated approaches and what various resources are available. Inclusiveness is the most important aspect because coordinated entry is not a fixed success, it is an evolving provision of multiple services. As part of the planning, recognize that what will be the most challenging is developing data sharing parameters that can navigate different provider experiences. The goal, however, is worth the challenge to develop systems that produce good outcomes for individuals and families as well as a key secondary outcome will be that providers and stakeholders develop and share best practices as well as "how-to's" based on community experiences.

HACDACS recommends increased access to substance abuse treatment through a "Coordinated Entry" system that facilitates access to treatment through coordinated assessments, intake and referrals processes and which provides de facto "treatment on demand" by matching open treatment slots with appropriate clients based on acuity and clinical necessity.

HACDACS recommends a public education campaign designed to lower the stigma associated with substance use with particular emphasis on language and the medical model to increase access to culturally competent substance abuse treatment services.

HACDACS recommends continue implementation of the integration of behavioral health into primary care and to support parity of the coverage of behavioral health services by both public and private health insurance entities.

HACDACS recommends expansion of SBIRT trainings for primary care providers.

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[1] https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[2] Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures; JAMA Surgery; September 27, 2017; https://jamanetwork.com/journals/jamasurgery/article-abstract/2654949

[3] State Legal Restrictions and Prescription-Opioid Use among Disabled Adults; New England Journal of Medicine; July 7, 2016, http://www.nejm.org/doi/full/10.1056/NEJMsa1514387

[4] Ending the Opioid Epidemic — A Call to Action; New England Journal of Medicine; December 22, 2016; http://www.nejm.org/doi/full/10.1056/NEJMp1612578#t=article[i]

[5] https://waikikihc.org/wp-content/uploads/2016-Annual-Report-efile.pdf

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5125361/?report=classic

[7] http://hmhb-hawaii.org/images/featured/Linda_Chock_WIC_OKQ_Presentation.pdf

[8] https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf

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

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

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

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

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

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

The following tables indicate the number of offenders served, criminal justice agency referral source and the geographic distribution of the offenders served. The Alcohol and Drug Abuse Division (ADAD) has contracts with eight (8) out of the twenty-six (26) substance abuse treatment agencies that provide services statewide.

During Fiscal year 2016-17, 434, offenders were referred by criminal justice agencies for substance abuse treatment, case management and clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Of the 711 offenders who received services, 228 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2016-17 is as follows:

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

** Act 152-98, Criminal Offender Treatment Act.

Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2016 – June 30, 2017

	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu	7	341	0	29	**377**
Maui	51	122	0	18	**191**
Hawaii	1	132	0	1	**134**
Total	**59**	**595**	**0**	**48**	**702**

Case management services providers:
CARE Hawaii
Mental Health Kokua
Institute for Human Services

Referrals by Criminal Justice Agency: July 1, 2016 – June 30, 2017

	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu[1]	2	251	0	14	**267**
Maui[2]	43	88	0	15	**146**
Hawaii[3]	1	115	0	1	**117**
Total	**46**	**454**	**0**	**30**	**530**

Substance abuse treatment providers:
[1] Salvation Army – Addiction Treatment Services; Hina Mauka and Queen's Medical Center
[2] Aloha House and Hina Mauka
[3] Big Island Substance Abuse Council (BISAC)

Carryover Cases by Criminal Justice Agency: July 1, 2015 – June 30, 2016

	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu	5	90	0	15	**110**
Maui	8	34	0	3	**45**
Hawaii	0	17	0	0	**17**
Total	**13**	**141**	**0**	**18**	**172**

Case management services providers:
CARE Hawaii
Mental Health Kokua
Institute for Human Services

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) 2016 Recidivism Update (dated June 2017) for the Fiscal Year 2013 cohort reports that the overall recidivism rate is 50.5% 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 45.5% recidivism rate for probationers; a 56.1% recidivism rate for offenders released to parole; and a 65.1% recidivism rate for offenders released from prison (maximum-term release).

The 48.6% recidivism rate for FY 2013 probationers and parolees was slightly higher than the previous year's rate of 47.3%. The FY 2013 recidivism rate is 23.2% lower than the recidivism rate reported in the FY 1999 baseline year, but remains short of the primary goal of reducing recidivism in Hawaii by 30%. Felony probationers in the FY 2013 cohort had a 45.5% recidivism rate, which is 1.9 percentage points lower than the recidivism rate for the previous year's cohort, but indicates only a 15.3% decline in recidivism since the baseline year. Parolees in the FY 2013 cohort had a 56.1% recidivism rate, which is 9.0 percentage points higher than the previous year's rate, and signifies a 23.0% decline in recidivism from the baseline year. The recidivism rate for maximum-term released prisoners declined from 76.1% for the FY 2005 cohort to 65.1% for the FY 2013 cohort. The FY 2013 recidivism rate was 3.2 percentage points higher than the previous year's (FY 2012) recidivism rate. Additionally, maximum-term released prisoners had the highest recidivism rates in the entire FY 2013 offender cohort for criminal reconvictions (41.3%), and criminal rearrests (51.2%).

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

Recidivism by Criminal Justice Agency: July 1, 2016 – June 30, 2017

	Supervised Release PSD/ISC	**Judiciary Adult Client Services**	**PSD/ISC - Corrections Jail/Prison**	**Hawaii Paroling Authority**	**Total**
Arrests/revocations	9	193	0	13	**215**
Total served	46	457	0	30	**533**
Recidivism rate	**20%**	**42%**	**0%**	**43%**	**40%**

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

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

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

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

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

Since Fiscal Year 2008-09, WITS has been used as a data collection and billing system for all ADAD contracted substance abuse treatment providers. The data collected was used to annually report admission and discharge information to the Legislature. While WITS has always had the capability to collect substance abuse treatment information about all clients served by its contracted providers, only clients whose services were paid through ADAD contracts were reported. In Fiscal Year 2011-12, some of ADAD contracted providers began collecting

* Established under Part III (Sections 23-28) of Act 40, SLH 2004.

information from the Judiciary, followed in Fiscal Year 2013-14 with the Hawaii Paroling Authority; and in Fiscal Year 2015-2016, the Department of Public Safety. ADAD continues to strengthen collaboration with the Office of Youth Services, the Department of Public Safety and the Judiciary to use WITS as their substance abuse treatment data collecting and monitoring system.

APPENDICES

A. ADAD-Funded Adult Services: Fiscal Years 2014-17

B. ADAD-Funded Adolescent Services: Fiscal Years 2014-17

C. Performance Outcomes: Fiscal Years 2014-17

D. 2004 Estimated Need for Adult Alcohol and Drug Abuse Treatment in Hawaii

E. 2007-08 Hawaii Student Alcohol, Tobacco and Other Drug Use Study (Grades 6-12)

F. Methamphetamine Admissions: 2007-17

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS –2014-17

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Male	71.0%	71.0%	66.1%	67.4%
Female	29.0%	29.0%	33.9%	32.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Hawaiian	43.6%	44.6%	43.8%	44.7%
Caucasian	24.3%	24.2%	22.5%	23.0%
Filipino	7.3%	7.3%	8.0%	8.4%
Mixed - Not Hawaiian	2.3%	1.8%	3.0%	2.6%
Japanese	3.9%	4.6%	4.5%	3.9%
Black	2.5%	3.0%	4.0%	2.8%
Samoan	3.2%	2.5%	3.4%	3.1%
Portuguese	1.6%	1.3%	1.3%	1.2%
Other Pacific Islander	6.5%	6.4%	6.3%	3.3%
Other*	4.8%	4.3%	3.2%	7.1%
TOTAL	100.0%	100.0%	100.0%	100%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Methamphetamine	48.6%	51.5%	50.5%	53.4%
Alcohol	24.8%	22.9%	22.2%	20.0%
Marijuana	15.0%	14.1%	13.8%	12.4%
Cocaine/Crack	2.8%	2.7%	2.6%	1.6%
Heroin	3.4%	3.9%	5.3%	6.4%
Other*	5.4%	4.9%	5.6%	6.2%
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 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Oahu	63.7%	65.4%	67.0%	65.6%
Hawaii	18.2%	17.8%	16.4%	18.1%
Maui	11.8%	9.6%	10.2%	11.5%
Molokai/Lanai	1.9%	2.3%	1.9%	1.8%
Kauai	2.7%	3.7%	3.1%	1.6%
Out of State	1.7%	1.2%	1.4%	1.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2013-14 through Fiscal Year 2016-17, methamphetamine use increased from 48.6% to 53.4%. Alcohol use decreased from 24.8% to 20.0%, and marijuana use decreased from 15.0% to 12.4%. Cocaine/Crack use decreased from 2.8% to 1.6%. Heroin use increased from 3.4% to 6.4% while all "Other" substances increase only slightly from 5.4% to 6.2%.

Also, among the 2,764 adult admissions for FY2017, 761 admissions (27.5%) were homeless when admitted to treatment.

APPENDIX B

ADAD-FUNDED ADOLESCENT[5] SERVICES FISCAL YEARS –2014-17

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Male	52.5%	52.3%	52.7%	53.4%
Female	47.5%	47.7%	47.3%	46.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Hawaiian	39.5%	43.7%	46.0%	42.6%
Caucasian	8.5%	10.8%	10.8%	10.2%
Filipino	12.4%	12.2%	11.4%	10.5%
Mixed - Not Hawaiian	1.8%	1.7%	1.3%	1.9%
Japanese	3.2%	3.2%	3.6%	3.7%
Black	2.5%	2.6%	3.0%	2.9%
Samoan	5.1%	4.3%	4.3%	4.0%
Portuguese	0.7%	0.9%	0.4%	0.8%
Other Pacific Islander	20.5%	16.3%	15.3%	14.0%
Other*	5.8%	4.3%	3.9%	9.5%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Methamphetamine	0.5%	0.7%	0.6%	1.1%
Alcohol	28.1%	24.7%	21.5%	22.8%
Marijuana	61.3%	63.5%	66.8%	62.6%
Cocaine/Crack	0.1%	0.1%	0.3%	0.3%
Heroin	-0-	0.1%	-0-	-0-
Other	10.0%	10.9%	10.8%	13.2%
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 2013-14	FY 2014-15	FY 2015-2016	FY 2016-2017
Oahu	66.2%	64.4%	61.9%	60.0%
Hawaii	15.4%	11.8%	13.1%	12.8%
Maui	11.2%	15.5%	16.0%	18.7%
Molokai/Lanai	1.0%	2.0%	1.9%	0.6%
Kauai	6.2%	6.3%	7.1%	8.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2013-14 through Fiscal Year 2016-17, methamphetamine use increased from 0.6% to 1.1%. Alcohol use decreased from 28.1% to 22.8%, while marijuana used increased slightly from 61.3% to 62.6%. Cocaine/Crack use increased slightly, from 0.1% to 0.3%. Heroin use remained at 0%, while use of "Other" substances increased from 10.0% to 13.2%.

[5] Adolescent: Grades 6 through 12

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

APPENDIX C

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2014 through 2017, six-month follow-ups were completed for samples of adolescents discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Employment/School/Vocational Training	97.8%	97.9%	98.1%	97.4%
No arrests since discharge	92.6%	95.2%	93.5%	93.8%
No substance use in 30 days prior to follow-up	60.6%	64.3%	57.9%	53.8%
No new substance abuse treatment	84.6%	86.2%	77.1%	80.3%
No hospitalizations	96.0%	96.8%	95.4%	95.2%
No emergency room visits	93.5%	95.4%	93.5%	93.5%
No psychological distress since discharge	85.3%	85.6%	88.2%	84.8%
Stable living arrangements*	97.8%	98.7%	97.7%	97.8%

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

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2014 through 2017, 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 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Employment/School/Vocational Training	55.2%	57.8%	58.7%	58.6%
No arrests since discharge	81.2%	91.3%	94.0%	92.9%
No substance use in 30 days prior to follow-up	70.2%	72.7%	60.3%	61.0%
No new substance abuse treatment	68.8%	71.0%	64.5%	61.8%
No hospitalizations	90.4%	94.3%	94.4%	90.9%
No emergency room visits	82.5%	86.9%	87.3%	86.2%
Participated in self-help group (NA, AA, etc.)	46.4%	47.7%	42.6%	36.5%
No psychological distress since discharge	75.2%	80.7%	71.7%	67.4%
Stable living arrangements*	79.3%	78.5%	79.6%	77.5%

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

APPENDIX D

2004 ESTIMATED NEED*
FOR ADULT ALCOHOL AND DRUG ABUSE
TREATMENT IN HAWAII

ESTIMATE OF DEPENDENCE AND ABUSE (NEEDING TREATMENT)					
	COUNTY				
	HONOLULU	MAUI	KAUAI	HAWAII	TOTAL
Population (18 Years and Over)	628,853	98,042	47,346	102,849	877,090
NEEDING TREATMENT					
Alcohol Only	57,228	8,935	8,121	7,094	81,377
Drugs Only	10,070	1,981	1,573	1,562	15,186
Alcohol and/or Drugs	59,459	9,699	8,121	8,189	85,468

Findings of the State of Hawaii 2004 Treatment Needs Assessment* revealed that of the state's total 877,090 adult population over the age of 18, a total of 85,468 (9.74%) are in need of treatment for alcohol and/or other drugs. Comparable figures by county are as follows:

For the *City and County of Honolulu*, 59,459 (9.46%) of the total 628,853 adults on Oahu are in need of treatment for alcohol and/or other drugs.

For *Maui County*, 9,699 (9.89%) of the 98,042 adults on Maui, Lanai and Molokai are in need of treatment for alcohol and/or other drugs.

For *Kauai County*, 8,121 (17.15%) of the total 47,346 adults on Kauai are in need of treatment for alcohol and/or other drugs.**

For *Hawaii County*, 8,189 (7.96%) of the total 102,849 adults on the Big Island are in need of treatment for alcohol and/or other drugs.

The five-year (Fiscal Year 2013 to Fiscal Year 2017) average annual ADAD-funded admissions for adults is 2,970, which is 3.6% of the estimated need for adult alcohol and drug abuse treatment.

* "State of Hawaii 2004 Treatment Needs Assessment," Department of Health, Alcohol and Drug Abuse Division, 2007.
** The 2004 Kauai County data present a unique pattern of use, abuse and dependence that makes the data difficult to analyze and compare to other counties within the State. The results of the Kauai County data need to be further investigated in order to reconfirm the accuracy of the information. Other statewide studies may also provide information on the county drug/alcohol problem. One data source, the Department of Health's 2007 Behavioral Risk Factor Surveillance System (BRFSS) data, provides county data on alcohol which are comparable.

APPENDIX E

2007-08 ESTIMATED NEED*
FOR ADOLESCENT (GRADES 6-12)
ALCOHOL AND DRUG ABUSE TREATMENT
IN HAWAII

Diagnosis for Abuse or Dependence of any Substance, Based on DSM-IV Criteria, for Gender, Grade Level, and Ethnicity (weighted percents)					
	No		Yes		Total
	n	%	n	%	
Overall Total	5,753	92.3	553	7.7	6,306
Gender					
Male	2,478	93.2	210	6.8	2,688
Female	3,023	91.7	316	8.3	3,339
Grade					
6th Grade	1,807	98.4	33	1.6	1,840
8th Grade	1,555	95.2	88	4.8	1,643
10th Grade	1,150	89.5	150	10.5	1,300
12th Grade	1,241	82.2	282	17.8	1,523
Ethnicity					
Japanese	778	94.6	49	5.4	827
Caucasian	1,040	88.5	153	11.5	1,193
Filipino	1,451	95.3	89	4.7	1,540
Native Hawaiian	999	88.9	132	11.1	1,131
Other Asian	426	96.4	17	3.6	443
Other Pacific Islander	481	93.0	39	7.0	520
2 or more ethnicities	129	86.8	20	13.2	149
Other	346	88.9	49	11.1	395

The Hawaii Student Alcohol, Tobacco, and Other Drug Use Study: 2007-2008 Comprehensive Report.

NOTE: Data was collected from students in grades 6, 8, 10 and 12 across the State, using a risk and protective factors approach, to report levels of substance use and treatment needs in Hawaii. Specifically, data illustrate the prevalence rates of alcohol, tobacco and other drug use among Hawaii's adolescents and provides information on risk and protective factors associated with adolescent substance use. Analyses were conducted to determine the number of students who met the American Psychiatric Association DSM-IV criteria for any substance abuse or dependence by gender, grade level and ethnicity. For the purposes of this study, abuse and dependence variables were combined such that students who qualified would meet criteria for any substance abuse or dependence as a single variable. In addition, all substances were combined into a single category. Therefore, students who met criteria for abuse or dependence for any substance are identified as individuals in need of treatment.

The table above provides the percentages of students meeting criteria for substance use disorders overall by gender, grade and ethnicity:

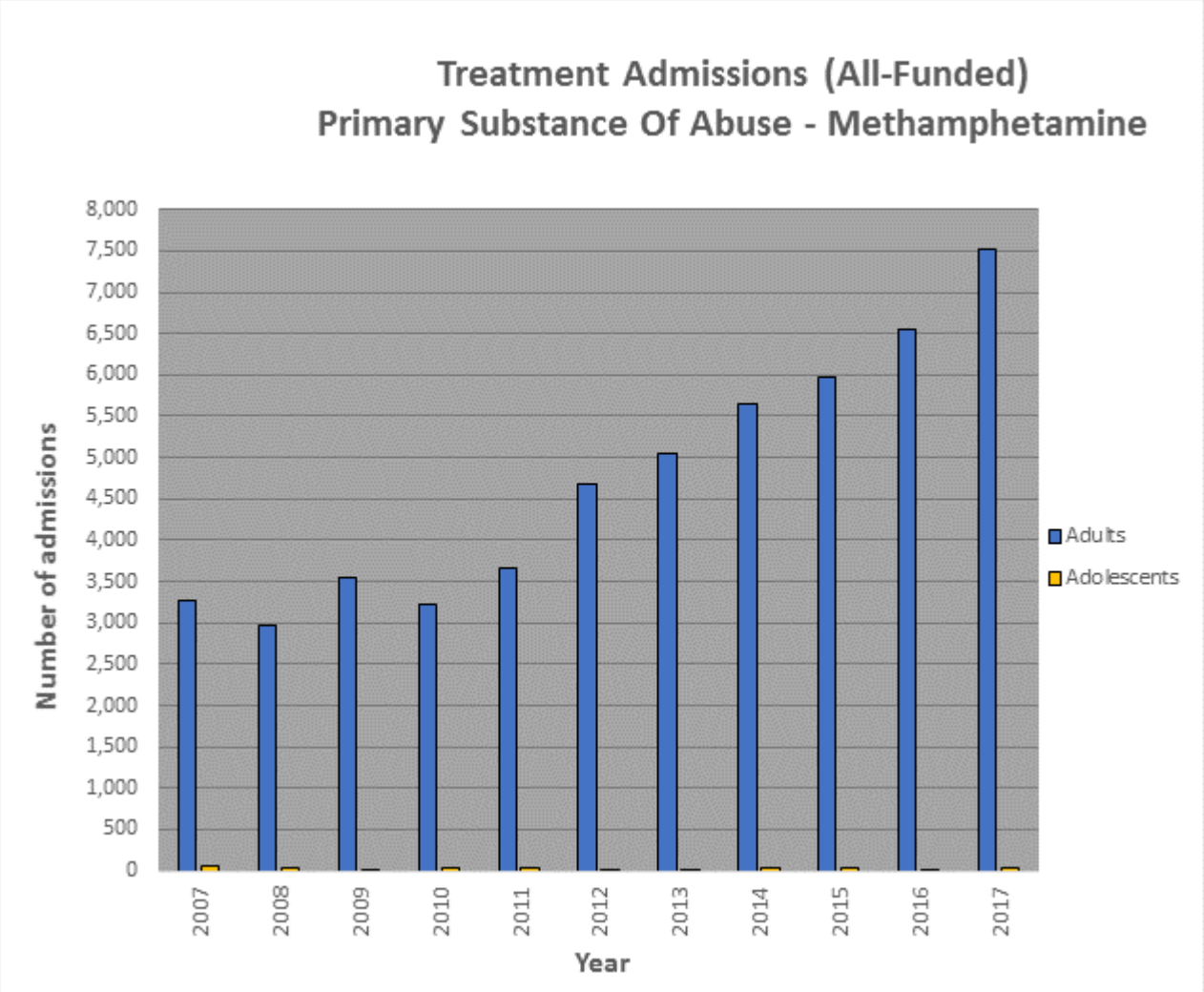
- For treatment needs by gender, more females (8.3%) than males (6.8%) met criteria for abuse or dependence for any substance use.
- For treatment needs by grade, 1.6% of 6th graders, 4.8% of 8th graders, 10.5% of 10th graders and 17.8% of 12th graders met criteria for substance abuse or dependence.
- Adolescents most likely to meet criteria for substance abuse or dependence were Caucasians (11.5%) and Native Hawaiians (11.1%). Students identified as Other ethnicities (11.1 %) had higher rates as well, but it should be noted that the sample size for Other ethnicities was not as large as that of Caucasians and Native Hawaiians. In addition, 7% of students of Other Pacific Islander ancestry also met criteria. Japanese (5.4%) and Filipino (4.7%) students had the lowest rates of needing treatment for substance use.

The five-year (Fiscal Year 2013 to Fiscal Year 2017) average annual ADAD-funded admissions for adolescents is 2,123, which is 32.5% of the estimated need for adolescent alcohol and drug abuse treatment.

APPENDIX F

METHAMPHETAMINE ADMISSIONS
2007 – 2017

As reflected in the graph and table below, there was a 14.8% increase and 87.5% increase in adult and adolescent crystal methamphetamine admissions to treatment, respectively, in Fiscal Year 2016-17.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Adults	3,270	2,967	3,536	3,216	3,654	4,681	5,044	5,642	5,978	6,540	7,511
Adolescents	53	33	22	24	28	15	21	24	26	16	30
Total	3,323	3,000	3,558	3,240	3,682	4,696	5,065	5,666	6,004	6,556	7,541

As reported by contracted substance abuse treatment providers, the above data encompass "ice" admissions that are funded by all sources of funds which includes clients whose services are ADAD-funded, as well as coverage by Medicaid (i.e., QUEST) and health

insurance coverage under Chapter 431M, HRS, relating to mental health and alcohol and drug abuse treatment insurance benefits. Data reported on Appendices A, B and C are for ADAD-funded admissions only.