REPORT TO THE

THIRTIETH LEGISLATURE

STATE OF HAWAIʻI

2024

PURSUANT TO:

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

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

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

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

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

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAIʻI**
DECEMBER 2023

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2022-23 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawai‘i Revised Statutes (HRS).

For Fiscal Year 2022-23, $36,574,236 was appropriated by Act 248, Session Laws of Hawai‘i (SLH) 2023, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds and $15,428,523 federal funds (MOF N and P). Of the total appropriated, $26,536,681 was allocated for substance abuse treatment services and $7,171,221 was allocated for substance abuse prevention services. The Act also did not fund 2.00 FTE positions totaling $133,512 as a Legislative Adjustment for personnel savings.

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

$8.65 million for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds (10/1/21 – 9/30/23) administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

$3 million over four years (9/30/20 – 9/29/24) for the contract awarded by the U.S. Food and Drug Administration (FDA) for tobacco inspections of retail outlets on behalf of the FDA for compliance with the Tobacco Control Act (Public Law 111-31).

$8.03 million over three years (9/30/20 – 9/29/23) for the SAMHSA/CSAT State Opioid Response (SOR) 2 grant that provides an array of opioid and stimulant use disorder treatment, recovery support, prevention, and harm reduction services which includes: increasing telehealth services in rural communities, providing culturally anchored training for the workforce, purchasing, and disseminating naloxone to reduce opioid overdose deaths, providing opioid related training to nurses across the state, reducing opioid use disorder through Hepatitis care coordination, and increase culturally anchored primary prevention for children and families. The grant ended on September 29, 2023.

$8.06 million over two years (9/30/23 – 9/29/25) for the SAMHSA/CSAT State Opioid Response (SOR) SOR 3 grant that enhances and expands the services from the SOR 2 grant and aims to improve access to opioid and other substance misuse prevention, treatment, and recovery support services while expanding harm reduction, increase the inclusion of Native Hawaiian cultural intervention treatment programs, wellness plans, and holistic living systems of care, increase system-wide routine data collection, sharing, and dissemination, and expand community-based programs and public education to prevent opioid and other substance misuse and improve harm reduction systems.

$2.0 million in each of five years (9/30/18 – 9/29/23) for the 2018 SAMHSA/CSAP SPF-PFS grant to provide further support for the SPF-PFS Project goals and objectives of strengthening and enhancing the prevention system at the local and state level as well as to address the priority issue of alcohol use by minors in high need areas through community anti-drug coalition work and evidence-based programs (EBP). A no-cost extension was approved for six months (9/30/23 – 3/29/24). The grant will end on March 29, 2024

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

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

> A continuum of residential, outpatient, day treatment and therapeutic living services saw 3,303 adult admissions statewide in Fiscal Year 2022-23;
> School- and community-based outpatient substance abuse treatment services saw 1,188 adolescent admissions statewide in Fiscal Year 2022-23; and
>
> Curriculum-based youth substance abuse prevention and parenting programs, underage drinking initiatives and the Hawai‘i Prevention Resource Center (HIPRC) served 643,013 children, youth, and adults directly and indirectly through individual-based and population-based prevention programs, strategies and activities[2] in Fiscal Year 2022-23.

Also included are reports that are required pursuant to:

- Section 329-3, HRS, requiring a report by the Hawai‘i Advisory Commission on Drug Abuse and Controlled Substances (HACDACS);
- Section 10 of Act 161 SLH 2002, requiring a status report on the coordination of offender substance abuse treatment programs;
- Section 29 of Act 40 SLH 2004, requiring a progress report on the substance abuse; and
- Section 329E-6, HRS, requiring a report on unintentional opioid-related drug overdose.

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

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

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2022-23 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) and is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS). Also included are reports that are required pursuant to: Section 329-3, HRS, which requires a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS); Section 10 of Act 161, SLH 2002, which requires a status report on the coordination of offender substance abuse treatment programs; Section 29 of Act 40, SLH 2004, which requires a progress report on the substance abuse treatment monitoring program; and Section 329E-6, HRS, which requires a report on unintentional opioid-related drug overdose.

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

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

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

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

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

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

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

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

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

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

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

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2022 to June 30, 2023

State and Federal Funding

Act 248, SLH 2022 appropriated $36,5740,236 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2022-23:

General funds	$20,395,713	(55.7%)	29.0 FTE
Special funds	750,000	(2.1%)	
Federal funds (N)	8,857,980	(24.2%)	7.5 FTE
Federal funds (P)	6.570,543	(18.0%)	
	$36,574,236	(100.0%)	29.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$26,536,713	(72.6%)
Substance abuse prevention services	7,171,221	(19.6%)
Division operating costs	275,000	(.8%)
Division staffing costs	2,591,334	(7.1%)
	$36,574,236	(100.0%)

For Fiscal Year 2022-23, $36,574,551 was appropriated by Act 248, SLH 2022, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds and $15,428,523 federal funds (MOF N and P). Of the total appropriated, $26,536,713 was allocated for substance abuse treatment services and $7,171,221 was allocated for substance abuse prevention services.

The Act 248, SLH 2022, did not fund 2.00 FTE positions totaling $133,512 as a Legislative Adjustment for personnel savings.

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

Federal Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. ADAD received $8.65 million in Fiscal Year 2023 (10/1/21 – 9/30/23) of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

U.S. Food and Drug Administration (FDA) Tobacco Inspections. The award of a $3 million 4-year contract (9/30/20-9/29/24) by the FDA supports tobacco inspections on retail outlets that sell or advertise cigarettes or smokeless tobacco products to determine whether they are complying with the Tobacco Control Act (Public Law 111-31) and the implementing regulations (21 Code of Federal Regulations Part 1140, et seq.). Two types of tobacco compliance inspections are conducted: undercover buys, to determine a retailer's compliance with federal age and photo identification requirements; and product advertising and labeling to address other provisions of the Tobacco Control Act.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant. Hawai‘i was awarded a SPF-PFS grant of $2.0 million in each of five years (9/30/18-9/29/23) to continue the Hawai‘i Project efforts and funds were allocated to subrecipients to build on the progress made during the first grant period and further enhance efforts to address alcohol and related issues in communities of demonstrated high need. A no-cost extension was approved for six months (9/30/23 – 3/29/24). The grant will end on March 29, 2024.

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT is a five-year grant plus a one-year extension (project period 09/30/16-09/29/22) totaling $6,513,812. Funding is to implement screening, brief intervention, and referral to treatment (SBIRT) services for adults in primary care and community health settings for substance misuse and substance use disorders (SUD). Project services are designed to develop, expand, and enhance infrastructure to fully integrate SBIRT in six Federally Qualified Health Centers (FQHC) in Hawaii and up to twenty-five small group primary care practices (PCP) over five years and to establish the SBIRT model as a standard of care statewide. The SBIRT program seeks to address behavioral health disparities by encouraging the implementation of strategies, such as SBIRT, to decrease the differences in access, service use, and outcomes among the populations served. Implementing the SBIRT will aid in improving overall health outcomes, reducing the negative impact on health, and reducing healthcare costs. The grant has three goals: 1) Implement SBIRT in six FQHCs and twenty-five small group primary care practices; 2) Develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers; and 3) Expand existing behavioral health integration efforts which includes a plan to disseminate SBIRT to small primary care practices throughout the State. The grant ended on September 29, 2022. During the last quarter of the grant (7/1/22-9/29/22), ADAD reached 142% of the targeted number served. A total of 50,617 patients were screened for substance misuse. The Brief Intervention was provided to over 4,000 patients and Brief Treatment was offered to 184 patients.

State Opioid Response (SOR) 2.0 The Hawai‘i SOR 2.0 grant (project period: 09/30/2020-9/29/2022) totaling $8,003,294.00 are initiatives awarded through SAMHSA's Center for Substance Abuse Treatment (CSAT). A No Cost Extension effective 9/30/22 was approved to extend the Hawaii SOR 2 grant service period. The extension provided additional time to

achieve project goals and complete activities initiated during the two-year grant period. The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (OUD), including prescription opioids as well as illicit drugs such as heroin, and synthetic drugs such as fentanyl. The implementation of SOR 2 funds in September 2020 opened the criteria to include stimulant use disorders (e.g., methamphetamine treatment, prevention, recovery, and harm reduction activities). The SOR grant will address these concerns through three key activity tracks: (1) **education and awareness**, which will promote public awareness of the dangers of opioid use and provide training to health professionals to better identify and assist persons at risk or suffering from opioid use disorders; (2) **care coordination and integration** which will target more efficient and effective ways to integrate primary and behavioral health care to reduce risk and better treat persons affected by opioid misuse and abuse; and (3) **policy shaping** which targets policies and protocols aimed at improving access and expanding proven interventions and prevention strategies such medications for opioid use disorder (MOUD). The Grant ended on 9/29/23.

State Opioid Response (SOR) 3.0 The Hawai‘i SOR 3.0 grant (project period: 9/30/2022 – 9/29/2024) totaling $8 million are initiatives awarded jointly through SAMHSA’s Center for Substance Abuse Treatment (CSAT). The grant continues to address opioid and stimulant use disorder by: increasing access to treatment and recovery support services, increasing access to Native Hawaiian culturally anchored primary prevention for families and children, providing Hepatitis C Virus (HCV) care coordination to reduce opioid use disorder, increasing telehealth services for rural communities, expanding opioid and stimulant use training for nurses, enhancing and increasing naloxone purchasing and distribution, providing culturally anchored training for the workforce, and providing peer support for pregnant women with dependent children (PWWDC).

State Youth Treatment-Implementation (YTI). The Hawai‘i YTI grant (project period: 9/30/17-9/29/22) totaling $3 million was an initiative awarded by SAMHSA’s CSAT. A No Cost Extension effective September 30, 2021 was approved to extend the YT-I grant service period which ended September 29, 2022. The extension provided additional time to achieve project goals and complete activities initiated during the four-year grant period. The project has improved treatment for adolescents and/or transitional aged youth with substance use disorders (SUD) and/or co-occurring substance use and mental disorders by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. Stakeholders across the systems serving the populations of focus collaborated to strengthen the existing coordinated network. The coordinated network enhanced and expanded SUD treatment services, developed policies, expanded workforce capacity, disseminated evidence-based practices (EBPs), and implemented financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment and recovery support systems. The YTI grant also helped by increasing the number of multi-systemic therapists (MST) at select treatment providers, expanding eligibility criteria for services, and including treatment services for criminal justice adolescents within the Hawai‘i Youth Correctional Facility, and adolescents aged 12-25 who presented for care or were directed for care through the Child and Adolescent Mental Health Division and the Hawai‘i Youth Criminal Justice Division. In the last quarter (7/1/22-9/29/22), through the YTI grant, ADAD was able to expand and enhance behavioral health and SUD treatment primarily for unaccompanied homeless youth. The services included emergency shelter, housing, medical services, education and

employment, outreach and engagement, and care coordination. During the last fiscal year, the service providers were able to use grant funds for incentives for follow-up Government Performance and Results Act (GPRA) interviews. The project had collected 89 six-month follow-up interviews. Analysis on alcohol and illicit drug use showed that, of the baseline substance users, 65% reduced or stopped using at the six-month follow-up. The probability of reduced use or abstinence is higher for females (0.86) vs. males (0.58), youth aged 18-24 (0.89) vs. younger clients (0.52), and those who self-identified as Asian (0.8) vs. Hawaiian and Pacific Islander (0.57) and White (0.57). As expected, those who completed the treatment program are more likely to achieve better outcomes (0.75) than those terminated (0.44). The total number of youth served through this grant is 244 youth.

Substance Abuse Prevention and Treatment (SAPT) Block Grant COVID-19. The SAPT Block Grant COVID-19 supplemental funds (project period 3/15/21-3/14/23) totaling $8 million. These supplemental funds awarded March 11, 2021, are to assist SAPT grantees in response to the COVID-19 pandemic. The funds will be used to enable workforce supports for peer recovery specialists, addiction medicine fellowships, substance use counselor credentialing for physicians, systematic training on the American Society for Addiction Medicine (ASAM) placement criteria and on warm lines for SUD professionals, the development of a warm line pilot for primary prevention providers, and to expand SUD stabilization bed capacity for pregnant and parenting women with dependent children in rural areas. (An extension of time was approved for one year (3/15/23 – 3/14/24). The Grant ended on 3/14/24.

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

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

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

Settlement Funds.

Substance Abuse Prevention and Treatment Services

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

Treatment Services. ADAD's overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse, and dependence by assuring an effective, accessible public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Thirty-six (36) agencies were contracted to provide Substance Use Disorder Continuum of Care Service Array for Adults and Adolescents. Treatment providers can provide all or part of the treatment continuum, which includes pre-treatment service such as motivational enhancement services, outreach, and interim; treatment services such as non-medical social detoxification, residential, intensive outpatient, outpatient; and recovery support services such as therapeutic living, clean and sober housing, continuing care, transportation, translation, and childcare. All client admissions, treatment services, including treatment progress notes, and discharges are tracked on the Web-Based Infrastructure for Treatment Services (WITS) system. Services were provided to 3,303 adults statewide in Fiscal Year 2022-23; and school-based and community-based outpatient substance abuse treatment services were provided to 1,188 adolescents statewide in Fiscal Year 2022-23.

Prevention Services. Through a total of forty-three (43) contracts, twenty (20) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2022-2023. In efforts to best utilize resources to fund what works, the contracted services implement evidence-based programs, policies, and practices to the Center for Substance Abuse Prevention Strategies: information dissemination; education; problem identification and referral; community-based programming; environmental strategies; and alternative activities that decrease alcohol, tobacco, and other drug use. The funded programs engage schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models to prevent substance use in young people in a variety of community settings and promoting programs and policies to improve knowledge and skills related to effective ways to avoid substance use problems and promote resiliency.

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

Program implementation is tracked according to the number of times (cycles) curricula and strategies were implemented as collected and reported using WITS, the data management system described above and expanded to collect prevention service data. Prevention services under the SPF-PFS project are recorded in the Performance Based Prevention System. Additionally, quarterly progress reports, plans and progress notes submitted capture information related to community partnerships, problems, priorities, resources, readiness, and implementation status of identified evidence-based and innovative programs. According to the data collected for Fiscal Year 2022-23, curriculum-based prevention strategies served a total of 2,850 children and youth and the community-based strategies touched a total of 643,013 children, youth, and adults across the state.

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

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

Hawai'i Coordinated Access Resource Entry System (CARES)

Since April 2022, the Alcohol and Drug Abuse Division (ADAD) has contracted with Aloha United Way (AUW) utilizing a combination of state and federal funds from the Substance Abuse and Mental Health Services Administration.

Within this past fiscal year, AUW has accomplished so much with promoting their AUW 211 SUD services. AUW received 7,219 phone calls for those inquiring about SUD services. AUW received 3,318 client referrals from the contracted treatment providers and 3,814 clients referred from AUW and accepted by the treatment providers.

AUW also collaborates with CARE Hawai‘i, Inc, who is the contracted agency to provide crisis management and mental health services. Within this past year, there were 263 clients referred to the CARES Mental Health Crisis Line from AUW. To expand Hawai‘i CARES, AUW provided

30 presentations to various groups around the state (Adult Client Services Branch, Department of Public Defenders, 2022 Hawai‘i Health Workforce Summit, etc.) and 30 “Meet and Greet” sessions (Department of Human Services, Department of Health-Child and Adolescent Mental Health Division, Homeland Security Investigation, United Health Care, etc.) ADAD is striving toward a system where the community has a more direct and simplified process of gaining access to SUD treatment across the state and that people can get those services where they need it, when they need it, and how they need it.

Studies and Surveys

Tobacco Sales to Minors. In March 2023, teams made up of youth volunteers (ages 15-17) and adult observers visited a random sample of 330 stores in which the youth attempted to buy tobacco products to determine how well retailers were complying with state tobacco laws. Two stores sold to minors (age 15) resulting in a weighted violation rate of 0.6%. Of the four counties included in the statewide survey, the County of Kauai had zero sales, the County of Maui had one sale, the County of Hawai‘i had zero sales and the County of Honolulu had one sale. Due to the small sample size, rates for individual counties are not considered statistically reliable. Fines assessed for selling tobacco to anyone under the age of 21 are $500 for the first offense and a fine of up to $2,000 for subsequent offenses.

Provision of Contracted or Sponsored Training

In Fiscal Year 2022-23, ADAD conducted zoom and on-site training programs that accommodated staff development opportunities for 2,397 healthcare, Department of Education, human service, criminal justice and substance abuse prevention and treatment professional through sixty-five (65) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 6,010 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), or Certified Substance Abuse Program Administrator (CSAPA).

Topics covered during the reporting period included: Hawai‘i Substance Use Professional Development Advocacy training; judiciary – resiliency training; drug court conference; probation/judge training; prevention conference; prevention/WITS training; substance use and misuse; self-care practices; boundaries with aloha; positive psychology; suicide prevention; a detailed review of 12-step communities for providers; ethical decision making; introduction to substance use disorder ethics; fentanyl – community resource development; client centered therapy; ethics in prevention; stages of change; de-escalation, Narcan, suicide prevention awareness; introduction to medication assisted treatment; case management; alcohol misuse and prevention; the soul of counseling; surveying the landscape – working with LGBTQIA + teens with substance use disorders; case conceptualization; reporting and record keeping; introduction of the 12 core functions; updates on sexual and gender minority people in Hawai‘i; supportive supervision; crisis intervention – an overview; helping children and teens so they’re in control; HIV, hepatitis, Sexually Transmitted Infections 101; loving yourself/self-care; introduction and application of the 12 core functions; level of service inventory – revised and adult substance use survey; motivational interviewing; Malama project – University of Hawai‘i at Manoa’s collegiate recovery program; FASD; harm reduction 101; Hawai‘i SBIRT manual overview; Hawai‘i

healthcare workforce summit; mental health first aid; virtual summer training series – Hanai Ahu: anchoring culture in substance use treatment and prevention models; addictions conference; international summit preventing, assessing and treating trauma across the lifespan; Endmeth summit; a providers guide to legislative advocacy; a harm reduction toolkit for Native Hawaiian communities; Native Hawaiian cultural intervention training series; fundamentals of domestic violence webinar series; social media workshop – influencers, metrics and engagement: communicating prevention on Instagram.

Programmatic and Fiscal Monitoring

Through desk audits of providers' program and fiscal reports, ADAD staff examined contractors' compliance with federal SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance abuse prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of thirty-six (36) prevention service contracts and seventy-six (76) 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 2022-23, ADAD processed 427 (new and renewal) applications, administered twenty-one (21) computer-based written exams and certified sixteen (16) applicants as substance abuse counselors, bringing the current number of certified substance abuse counselors to 1,430.

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 is already 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 an additional month to schedule and take the exam.

Accreditation of programs. In Fiscal Year 2022-23, ADAD conducted a total of thirteen (13) accreditation site reviews and accredited twelve (12) organizations, some of which have multiple (residential treatment and therapeutic living) programs. One (1) of the thirteen (13) residential treatment services will submit a corrective action plan due by the end of this fiscal year for consideration of accreditation.

In the same fiscal year, one (1) residential site and two (2) therapeutic living programs closed operations. Currently, there are three (3) residential treatment facilities working on renewing accreditation. In addition, there are two (2) residential treatment facilities, and two (2) therapeutic living programs that are working on obtaining accreditation. This will potentially

bring the total programs accredited to twenty-one (21).

Clean and Sober Homes Registry

In Fiscal Year 2022-23 ADAD received eleven (11) initial applications for the Clean and Sober Registry and renewed thirty-one (31) clean and sober homes statewide, all of which were inspected and determined to meet the registry standards and were each issued a Certificate of Registration "In Good Standing" as referred to by Hawai'i Administrative Rules (HAR) Chapter 11-178.

In the current Fiscal Year 2023-2024, ADAD has received thirteen (13) initial applications for the Clean and Sober Homes Registry and renewed five (5) clean In the current Fiscal Year 2023-2024, ADAD has received thirteen (13) initial applications for the Clean and Sober Homes Registry and renewed five (5) clean and sober homes statewide. To date, there are a total of sixty-nine (69) registered clean and sober homes, with nine (9) pending a renewal inspection. Currently, there are four (4) new registration applications that are under DOH review and no homes that are "Not In Good Standing" and pending further review.

In calendar year 2023, ADAD has developed a tracking and numbering system, that is used alongside the formal concern form that was developed and can be found on the ADAD website, that identifies and summarizes concerns that are received. ADAD has received a total of fourteen (14) concerns filed, four (4) of which were related to registered clean and sober homes. One (1) of the four (4) concerns related to clean and sober homes is still in the process of being resolved. ADAD is also currently utilizing a toll-free number in which stakeholders and the public can call to report any concerns or questions they may have.

ADAD has established recurring quarterly meetings with the clean and sober home operators, conducting two (2) meetings, one each in June 2023 and September 2023, with the goal of building and strengthening the community of operators through networking, sharing about each one's organization and their unique approaches to recovery, information sharing, providing technical assistance to support recovery efforts in the homes, and provide operators with access to training opportunities and other resources. A process for eliciting bed space availabilities from the clean and sober homes operators has been developed, and weekly bed space availabilities are reported back to the sober home operator community for the purpose of potential referrals between home operators and to support and enhance information sharing to the benefit and support of recovery efforts.

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 individuals seeking a clean and sober home access to stable, alcohol-free, and drug-free home-like living environments. The registry established procedures and standards by which homes are listed, such as organizational and administrative standards, fiscal management standards, operation standards, recovery support standards, property standards, and good neighbor standards.

Legislation

ADAD prepared informational briefs, testimonies and/or recommendations on legislation addressing substance abuse related policies, appointments to the Hawai‘i Advisory Commission on Drugs and Controlled Substances, coordinated with the stakeholders of the Hawai‘i Opioid Initiative.

OTHER REQUIRED REPORTS

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

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

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

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

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

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

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

MEMBERS BY CATEGORY OF APPOINTMENT AND TERM OF OFFICE

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

On August 23, 2022, members elected Ku‘ulei Salzer-Vitale as Chairperson and Greg Tjapkes as Vice-Chairperson. Meetings were scheduled on the fourth Tuesday of each month.

The members of HACDACS gathered research, reviewed best practices, and invited knowledgeable speakers to form the following policy recommendations for the prevention and treatment of substance use in Hawai‘i.

Priorities discussed during FY 2022-2023 included:

- Stimulant Use Disorder and Treatment Options including Medication Assisted Treatment
- The Importance of Incorporating Cultural Beliefs, Traditions, and Practices into Treatment and Recovery
- Substance Use in Native Hawaiian Communities and Cultural Healing
- Recovery Communities and Organizations
- Law Enforcement Perspective on fentanyl and other drugs of abuse
- Trauma-Informed Recovery-Oriented System of Care
- Legalization of Cannabis and Findings of the Cannabis Dual-Use Taskforce

The overarching theme of our recommendations is to follow the SAMHSA's Working Definition of Recovery Guiding Principles. In 2010 SAMHSA convened a working group to develop a standard, unified working definition of Recovery from mental disorders and/or substance use disorders to help advance recovery opportunities for all Americans, and help to clarify these concepts for peers, families, funders, providers, and others. HACDACS believes that widely available and accessible, robust recovery services are essential to the health and well-being of individuals with substance use disorders and their communities.

The unified working definition of recovery created by the SAMHSA group is:
"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." In addition, the 4 major dimensions that support a life in recovery:

- Health
- Home
- Purpose
- Community

Additionally, the group identified 10 Guiding Principles of Recovery:

Hope	Person-Driven
Many Pathways	Holistic
Peer Support	Relational
Culture	Addresses Trauma
Strengths/Responsibility	Respect

Every HACDACS recommendation will have a guiding principle. HACDACS believes that it is vital to indicate that there is a pathway of wellness after an individual's involvement with substances. A single recovery pathway will not work for everyone. Therefore, it is essential that HACDACS' overall theme for this legislative report is Recovery.

Medication Assisted Treatment

SAMHSA's Working Definition of Recovery Guiding Principles: Holistic, many pathways, person-driven, respect.

Hawai‘i experiences high rates of substance use disorders, with overdose deaths now outpacing auto-accident fatalities.[1] In particular, Hawai‘i has high rates of methamphetamine use disorders—the most prevalent SUD among adults aside from alcohol—which is responsible for three-quarters of the State's overdose deaths and over five times the emergency department admissions than opioids.[6,7] This is a disquieting trend that has persisted over time. For example, State data from the State of Hawai‘i Department of Health Alcohol and Drug Abuse Division (ADAD) indicate that in 2016, methamphetamine was the most frequently reported primary substance at the time of SUD treatment admission (51.6 percent among adults 18 to 49 years), followed by alcohol (19.8 percent among adults 18 to 49 years). This trend held from 2010 through 2016 (most current state data), with methamphetamine continuing to outpace alcohol and other substances as the most frequently reported primary substance at the time of SUD treatment admission (44.3 percent - 51.6 percent).[2]

Treatment for stimulant use disorder (StUD) has been focused on behavioral therapies, with varying degrees of success. For example, Contingency Management (CM) is one of the most effective behavioral interventions for the treatment of SUDs, with decades of research indicating its ability to increase substance non-use and SUD treatment adherence.[3]

Over 30 years of evidence indicates that CM is an effective behavioral intervention for a wide range of SUDs, promoting non-use of substances, including cocaine, methamphetamines, tobacco, alcohol, opioids, cannabis, and benzodiazepines.[1] While CM has been used most commonly to address StUDs, numerous meta-analyses of CM clinical research indicate that CM's combination of SUD treatment and motivational incentives is highly effective at addressing SUDs across diverse populations, above and beyond the treatment effects of other evidence-based treatments like cognitive-behavioral therapy or 12-step programs. In a 2021 meta-analysis of the long-term efficacy of CM treatments, CM participants were 1.22 times as likely to maintain non-use of substances at the one-year mark compared to those receiving therapies or treatments without motivational incentives.[4] Further, the Veteran's Affairs (VA) health system has embraced CM as a critical means of addressing SUDs: as of 2019, over 100 VA Medical Centers offer CM for various SUDs, with a negative drug screening success rate of 92.6 percent for the target substance during the intervention period.[5] [6] [7] However, there are systemic challenges that result in limitations on the use of CM in certain populations and for certain individuals.

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics CDC Wonder, Detailed Mortality Adjusted pharmaceutical/synthetic opioid poisoning fatality rates., by state, 2012-2015. https://wonder.cdc.gov/ucd-icd10.html

[2] "The Hawai‘i Opioid Initiative A Statewide Response." The Hawai‘i Department of Health. 2017. https://health.hawaii.gov/substance-abuse/files/2019/06/THE-HAWAII-OPIOID-INITIATIVE-1.0-A-Statewide-Response-to-Opioid-Use-and-Other-Substance-Misuse.pdf

[3] McPherson, Sterling M., Sara Parent, Andre Miguel, Michael McDonell, and John M. Roll. "Contingency Management Is a Powerful Clinical Tool for Treating Substance Use Research Evidence and New Practice Guidelines for Use." *Psychiatric Times 39*, no. 9 (2022). [1] https://www.psychiatrictimes.com/view/contingency-management-is-a-powerful-clinical-tool-for-treating-substance-use-research-evidence-and-new-practice-guidelines-for-use

[4] Ginley, M K., R A. Pfund, C J. Rash, and K Zajac. "Long-term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence from Illicit Substance Use up to 1 Year following Treatment: A Meta-analysis." Journal of Consulting and Clinical Psychology 89, no. 1 (2021). https://doi.org/10.1037/ccp0000552.

[5] DePhilippis, D., "How VA Uses Contingency Management to Help Veterans Stay Drug F." *VA News*, August 22, 2019. https://news.va.gov/64870/how-va-uses-contingency-management-help-veterans-stay-drug-free/

[6] "Contingency Management for Supporting Substance Use Treatment and Recovery: An Innovative Practice in VHA Homeless Program Operations." VHA National Homeless Program Office. https://www.va.gov/HOMELESS/docs/White-Paper-Contingenc-Management-with-Homeless-Veterans-508.pdf

[7] "State of Hawai‘i Behavioral Health Dashboard." State of Hawai‘i, Department of Health. https://bh808.hawaii.gov/

Because of the challenges involved in successful treatment for Stimulant Use Disorder, there is growing interest in finding medications that can augment behavioral therapies to treat stimulant use disorder. Medication Assisted Therapy for opioid use disorder is well-established with medications such as buprenorphine and naltrexone. These medications are safe and effective and their use in treating opioid use disorder is now the standard of care. Finding similar medications to treat stimulant disorder is of high priority to help large numbers of people suffering from the ill effects of methamphetamine, cocaine, and other stimulants.

In January 2022, HACDACS received a presentation from Dr. Daryll Shorter, an addiction Psychiatrist with expertise in medication-assisted treatment for stimulant use disorder. He reviewed current behavioral treatment regimens and medications that may augment these treatment strategies such as bupropion, mirtazapine, methylphenidate, topiramate, naltrexone, and modafinil (See Table 1). While none of these medications are FDA-approved for this use, research and off-label use show promise.

Table 1: A summary of medication options for methamphetamine use disorder.

	FDA	MOA	Target Effects
Bupropion (300mg/day)	No	Dopamine/Norepinephrine reuptake inhibition	Reduce meth use in LOW severity users
Mirtazapine (30mg/day)	No	Enhance dopamine/norepinephrine via blocking presynaptic A2 adrenergic and/or 5HT2C receptors	Reduce meth use; HIV risk behaviors
Methylphenidate (54mg/day)	No	Enhance dopamine and norepinephrine via reuptake inhibition at DAT/NET	Craving reduction?; better in heavy users?
Naltrexone (50mg/day)	No	Opioid Antagonist	Reduce meth use; craving reduction
Naltrexone IM (380mg monthly) + Bupropion (300mg/day)	No	Combination Therapy	Reduce meth use; low attrition for treatment?

Credit: Dr. Daryl Shorter MD.

HACDACS encourages further research and investigation into the use of these medications to help treat people with stimulant use disorder.

In January of 2021, the Hawai‘i Medicaid Med-QUEST program (MQD) requested an exemption from the Centers for Medicare and Medicaid Services (CMS) from the requirement to provide the medication assisted-treatment (MAT) benefit. This exemption request was based on the shortage of qualified providers or facilities that will furnish one or more of the required MAT benefit components. CMS concurred with this assessment and subsequently granted this exemption through September 30, 2025.

The MQD determined that the state is experiencing a shortage of facilities providing MAT and qualified providers of MAT. Alcohol and Drug Abuse Division (ADAD) provides substance

abuse treatment statewide and manages the accreditation of substance abuse treatment programs. ADAD has accredited Ku Aloha Ola Mau (KAOM) and CHAMP Clinic, LLC, which has Opioid Treatment Program (OTP) sites in Honolulu, Wailuku, and Hilo. The following table is a summary of these accredited MAT providers:

Program Name	DBA	Street	City	State	Zip code
Ku Aloha Ola Mau, Inc	Ku Aloha Ola Mau-East Hawaii Treatment Clinic	900 Leilani St.	Hilo	HI	96720
Comprehensive Health and Attitude Management Program		173 South Kukui St.	Honolulu	HI	96813
Ku Aloha Ola Mau	Ku Aloha Ola Mau	1130 North Nimitz Hwy., C-302	Honolulu	HI	96817
CHAMP Clinic of Maui (Comprehensive Health and Attitude Management Program)		270 Waiehu Beach Rd, #115	Wailuku, Maui	HI	96793

Overall, the number of OTPs are limited in the State of Hawaii. There are only two OTP facilities in our State and currently, the facilities only cover three of the seven islands (Oahu, Maui, and Hawai‘i) for the State of Hawai‘i. However, the demand for MAT services is on all islands. The lack of adequate resources for OTPs on the outer islands makes it very challenging to provide access to MAT services. In addition, the travel time can be up to one hour each way to get to the clinic for those who reside on the other side of the island.

Although there are other MAT providers in the state, MQD was unable to confirm at this time that these providers are available to provide MAT services based on updated MAT requirements or that there is a sufficient network for all who need MAT. There are providers who can prescribe medications on some but not all of the seven islands. There are providers who perform the counseling and therapy services, but it is not clear which of these providers can specifically perform the counseling and therapy services for MAT.

MQD in partnership with ADAD believes there is an unmet need for our state population who could benefit from MAT. Preliminary data indicates that treatment is initiated (related to opioid abuse or dependence) for only 35% of Medicaid individuals who needed assistance and of that group, only 14% with actual treatment. Evaluation reveals that Hawai‘i lacks appropriate qualified providers and facilities for both the identification of individuals who need MAT, as well as continued treatment and follow-up of those who are identified and prescribed MAT. Again, an OTP facility is only available on three islands out of seven in our state.

- **HACDACS recommends** supporting the availability and access of Contingency Management (CM) behavioral therapy for substance use disorders. This includes encouraging reimbursement of CM by Medicaid as well as State Opioid Response grants.
- **HACDACS recommends** supporting the availability and access to medication-assisted treatment for all substance use disorders. This includes decreasing barriers for patients and providers as well as enhancing public understanding of the utility of these treatment modalities.
- **HACDACS recommends** investment in increasing medical addiction services such as medication-assisted treatment. This may involve increased training requirements, loan forgiveness, and incentives for healthcare providers delivering addiction medicine services, particularly in rural areas.

Native Hawaiian Community and Cultural Healing

SAMHSA's Working Definition of Recovery Guiding Principles: Culture, relational, peer support, holistic, many pathways, person-driven, hope, respect, strengths/responsibility, addresses trauma

In March of 2023, HACDACS received a presentation by Papa Ola Lōkahi's Culture & Addictions Advisory Council who shared some of the work they have advised coming out of Papa Ola Lōkahi regarding cultural approaches to healing from substance use for Native Hawaiians. Of special note Papa Ola Lōkahi's chapter in the 2022 ADAD state plan. Excerpts that specifically highlight the alignment with SAMHSA's working definition of recovery are shared below.

Native Hawaiians of all age groups tend to show a higher prevalence of substance use than other ethnic groups in the state. Research shows that this inequitable health status results from several complex and interconnected social determinants of health, including historical trauma, discrimination, and lifestyle changes.

Before European contact, Native Hawaiians understood that balanced nutrition, physical activity, social relationships, and spirituality were fundamental to maintaining optimal health. Western influences triggered an imbalance in Native Hawaiian society, shifting the paradigm of Native Hawaiian family systems.

Historical and cultural trauma affects multiple generations and is linked to Native Hawaiian health disparities. Cultural trauma is defined as "the loss of identity and meaning that negatively affects group consciousness. It marks and changes them in fundamental and irreversible ways, often resulting in the loss of language, lifestyles, and values."[8] The remedy for cultural trauma is cultural reclamation (identified by Lynette Paglinawan).[9] Historical trauma is defined as psychosocial trauma experienced by Indigenous groups as a result of colonization, war, genocide, or cultural, social, and political subjugation.[10] These historical and cultural aspects have impacted and reached across generations of Native Hawaiians. The outcomes of these

[8] Paglinawan L, Paglinawan R, Kaulukukui M, Krief T, Kim JK. Cultural and Historical Trauma, Created for SW 774: Cultural Factors in Work with Hawaiians: Module

[9] Paglinawan LL, Paglinawan RL, Kauahi D, Kanuha VK. Nānā I Ke Kumu Vol. III. Vol III: Lili'uokalani Trust; 2020.

[10] Robin RW, Chester B, Goldman D. Cumulative trauma and PTSD in American Indian communities. In: A. J. Marsella MJF, E. T. Gerrity, & R. M. Scurfield (Eds.), ed. American Psychological Association.1996:239–253. https://psycnet.apa.org/record/1996-97494-009

traumas are reflected in higher rates of health disparities, including mental health and addiction, which have affected the social determinants of health. Current access to recovery support is extremely limited in Hawai‘i.

In 2019, the Hawai‘i State Senate passed Senate Concurrent Resolution 103 “Urging the Inclusion of Native Hawaiian Cultural Intervention Treatment Programs, Wellness Plans, and Holistic Living Systems of Care in the State of Hawaii's Response to the Rise of Misuse and Abuse of Opioids or Illicit Substances in Hawaii.”

The Native Hawaiian Health Care System through Papa Ola Lōkahi has worked throughout Hawai‘i to support the coordination of existing Native Hawaiian services, which have included those related to substance use outreach and education through the regular convening of local leaders, community organizations, and their Culture & Addictions Advisory Council. In 2007, Papa Ola Lōkahi & ‘Imi Ke Ola Mau developed a strategic plan for the improvement of substance use and mental health outcomes for Native Hawaiians, their families, and communities. In 2021-2022, Papa Ola Lōkahi held community listening sessions throughout the pae ‘āina regarding substance use in Native Hawaiian communities and cultural healing. The reports from these listening sessions can be found here. Across all islands, ‘ike kūpuna (ancestral knowledge) and ‘āina (land) were discussed as core to a Native Hawaiian system of care. This system of care also needs to reflect the values of a pu‘uhonua (place of refuge) and ahupua‘a (land division usually extending from the uplands to the sea), allowing Native Hawaiians to thrive in spaces of ancestral healing and abundance. These spaces allow clients, ‘ohana (family), community, providers, and others to forge needed pilina (connections) to integrate services and collaborate across stakeholders. Two main areas of focus for increasing recovery support services included:

- Train culturally focused peer recovery specialists & mentors
- Develop Hawaiian-based: 12-step recovery programs, all-recovery programs, and recovery community organizations.

“Conceptualizing a New System of Care in Hawai‘i for Native Hawaiians and Substance Use,” released in 2022 and their published a peer-reviewed article by the same name, a summarized version, in the Hawai‘i Journal of Health and Social Welfare include the presentation of an ‘āina-based systems model for cultural healing through the Ahupua‘a system. The ahupua‘a model (**figure 1**) shows the impact of cultural reclamation and healing on intergenerational, cultural, and historical traumas, as shown through symbolic representation in a land-based system. This model provides a framework to implement cultural interventions at various places within the ahupua‘a to effectively provide healing that impacts not only the individual but their ‘ohana and community as well. Interventions within the metaphorical and physical framework would aim to effectively decrease the intergenerational transmission of risk factors (intergenerational/historical/ cultural trauma, colonization, poverty, oppression, loss of traditional healing practices, criminalization of Native identity, loss of land, and family/community history of use/incarceration), and increase the intergenerational transmission of protective/ resiliency factors (‘ohana relationships, cultural wisdom, traditional healing, community connection, mo‘okū‘auhau (genealogy), ‘āina (land), respect for kupuna, and culture).

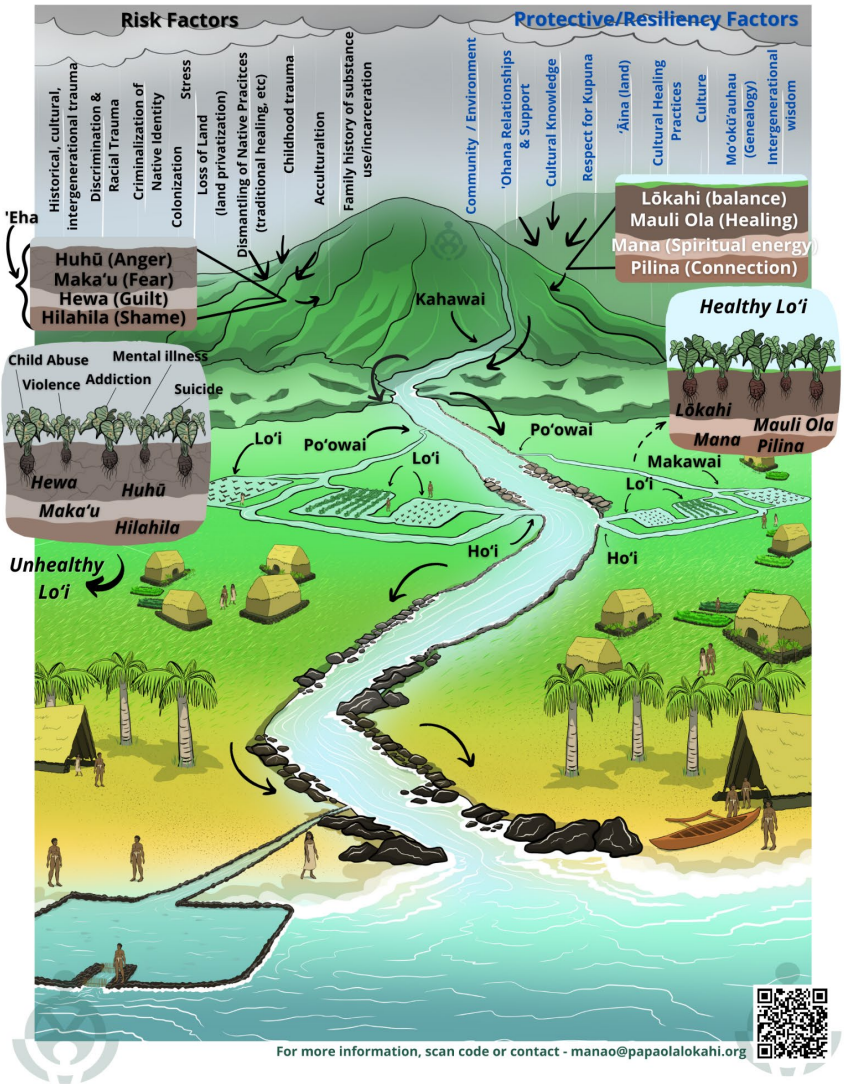

Figure 1. The impact of cultural reclamation and healing on intergenerational, cultural, and historical trauma as shown through the Ahupua‘a. Original copyrighted figure created by Kimo Apaka and edited by the authors with permission.

On a traditional continuum of care, recovery is viewed as the phase after treatment. The depth of the recovery field often overlaps within the treatment area, as there are many pathways toward healing and recovery, and not all individuals in recovery have followed a path that involves clinical treatment. The linkages between recovery and prevention lie in using one to inform the other through the feedback of successful outcomes, promoting mauli ola (well-being), and educating clients about making healthy, informed choices.[11] From a culturally informed or holistic perspective, systems thinking can help us understand whether the purpose of the existing system is being accomplished and look for ways to create more equitable and resonating systems

[11] Papa Ola Lōkahi & ‘Imi ke Ola Mau. A strategic plan for improvement of substance abuse and mental health outcomes for Native Hawaiian, their families and communities. Phoenix, Arizona.: Published 2007. https://health.hawaii.gov/amhd/files/2013/06/2007-PolicyAcademy-Strategic-Plan.pdf

of care, thereby achieving better results with fewer resources in lasting ways.[12]

For Kānaka Maoli, the cultural perception of self is anchored in relationships to ʻāina, spirituality, and one another, ʻohana and community. At the center, the piko, is the depiction of self, of ʻohana, and community: three interrelated, interconnected healing targets. You cannot heal just one; all must be healthy for each to flourish. SAMHSA explains that the resiliency- and recovery-oriented care system "is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health and wellness outcomes for those at risk or experiencing issues with substance misuse."[13] A recovery-oriented system of care (ROSC) supports the understanding that there are many pathways to recovery and healing. Native Hawaiian approaches to overcoming substance misuse and embracing Mauli ola are more closely aligned with the values and approaches of resiliency and recovery-oriented systems of care, than existing care systems in Hawaiʻi. The Recovery Ready Ecosystems Model (RREM) provides a model to increase the prevalence of recovery and focus on supporting and building recovery-informed infrastructure within communities. Collective healing of our communities is needed to combat intergenerational traumas that lead to stigma and NIMBYism (not in my backyard), which inhibit the healing of our Native people and their communities.

The Recovery-informed infrastructure allows for a backward mapping approach to building a culturally resonant system, beginning with what is working. Recovery through an RREM lens encompasses the many pathways to healing, including harm reduction, behavioral/mental health, reentry, peer recovery services, diversion courts, and many more. It provides an emphasis on healing within the community, building recovery capital (resources connected to the individual human traits with which persons are born, the individual qualities that they have acquired over time, and the environmental and social structural spaces that they occupy in the world), and assessment of the recovery readiness of the community.[14] RREM provides an avenue of alignment with Indigenous, collective healing approaches.

Peer recovery specialists can be invaluable for our Native people, who often struggle with Western recovery spaces and language. There are many ways one may obtain a peer certification, including federal certifications. Culturally grounded peer support services help address that dichotomy of individualism on the Western spectrum, with a more collectivist or holistic approach toward healing, ola, and the well-being of the whole environment. Recovery for many may even take the place of clinical treatment. A newly conceptualized healing journey for Native Hawaiians should utilize and uplift stories of resilience to resonate with, inform, educate, and empower those impacted, those who help navigate these systems, and those who choose to walk alongside the healing journey.

The development of culturally grounded recovery community organizations (RCO) across the paeʻāina (Hawaiian Archipelago) would provide safe spaces anchored in the community for collective healing. RCOs are independent, non-profit organizations led and governed by

[12] Arnold RD, Wade JP. A Definition of Systems Thinking: A Systems Approach. Procedia Comput Sci. 2015(44):669-678.
[13] Substance Abuse and Mental Health Services Administration. Recovery-Oriented Systems of Care (ROSC) Resource Guide. Published 2010. Accessed July 7, 2021. https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf
[14] Ashford RD, Brown, Austin M., Ryding, Rachel & Curtis, Brenda,. Building recovery ready communities: the recovery ready ecosystem model and community framework. Addict Res Theory. 2020;Volume 28, 2020 (1):10. doi:10.1080/16066359.2019.1571191

representatives of local communities of recovery, primarily peers. An overarching initiative to guide the cultivation of these RCOs, built through a culturally grounded framework, could extend its reach statewide, providing an ʻupena (net) across all services on each island, like an interconnected network.

It is important to note that a culturally-focused approach to recovery engages all 10 of SAMHSA's guiding principles of recovery. Therefore, HACDACS recommends the following:

- **HACDACS recommends:** The expansion and promotion of the Ahupuaʻa Model for cultural healing as a way to support the growth of culturally-based treatment and recovery programs and policy.
- **HACDACS recommends:** Supporting the development of culturally-focused recovery programs and groups.
- **HACDACS recommends:** Financially & infrastructurally supporting the development of Recovery Community Organizations throughout Hawaiʻi or one Recovery Community Organization Hub (which will support the growth of many statewide).
- **HACDACS recommends*:*** Shifting the state's current system of care to a recovery-oriented system of care.

Māpuna Lab

SAMHSA's Working Definition of Recovery Guiding Principles: Culture, Many Pathways, Holistic

The Māpuna Lab is part of the Thompson School of Social Work and Public Health at the University of Hawaiʻi at Mānoa. The Māpuna Lab is guided by five core values: 1) Collective Wisdom, 2) Culturally Grounded, 3) Community-centered, 4) Truth Seekers, and 5) Service Leadership. The Māpuna Lab developed training and programs to address the findings in the 2020 Hawaiʻi Opioid Initiative Program Evaluation report. These findings include areas: 1) Linguistic ability in ʻōlelo hawaiʻi, 2) Awareness of Hawaiian Cultural Practices, and Understanding of Hawaiian history. Three trainings were created based on cultural frameworks, the ʻUlu Fractal Framework, the Kanilehua Framework, and the Pilinaha Framework. The ʻUlu Fractal Framework involves a cultural response to disaster preparedness. Given the known increases in mental distress and substance use after disasters[15], using a culturally driven framework to train disaster response workers may help persons affected by the disaster receive culturally appropriate services that enhance well-being and decrease morbidity. The Kanilehua Framework involves HOI working groups that were developed with the ʻOhia Lehua tree as a guide. The Pilinaha Framework involves a primary prevention mode for substance use disorders. This includes a sixteen-day culturally anchored program for middle and high school students.

- **HACDACS recommends** the State of Hawaiʻi continue support of Māpuna Lab and expand training and services to other state departments and agencies.
- **HACDACS recommends** expansion and promotion of the ʻUlu Fractal Framework for disaster preparedness to provide training for Hawaii Emergency Management Agency Staff and other Emergency responders within Hawaii. In addition, create a response plan

[15] Gamze Zengin İspir , Mustafa Danışman & Kübra Sezer Katar (2023) Substance use disorders after natural disasters: a narrative review, Journal of Addictive Diseases, DOI: 10.1080/10550887.2023.2242073

for rapid delivery of the ʻUlu Fractal Framework for emergency response teams arriving from the continent or other agencies.

Hawaiʻi High-Intensity Drug Trafficking Area (HIDTA)

SAMHSA's Working Definition of Recovery Guiding Principles: Strengths/Responsibilities

The May 2023 HACDACS meeting included a presentation from representatives from law enforcement describing recent information about the Hawaiʻi High-Intensity Drug Trafficking Area. The speakers provided an overview of drug overdose death trends in the US and Hawaiʻi. Since 2000, there have been over 1 million overdose deaths in the U.S. with over 107,000 fatal opioid overdose deaths in the U.S. in 2021 alone. The trend of opioid overdose deaths is thought to be related to three waves that have occurred due to behavior and policy changes.
1) overprescription of opioids,
2) obtaining opioids from the street if cut off from prescription opioids, and
3) illicit drug supply tainted with other synthetics.

Hawaiʻi is currently entering an increasingly concerning fourth wave of substance use combining opioids and psychostimulants. In Hawaiʻi, an estimated $28.5M worth of drugs; including methamphetamine (Meth), cocaine, heroin, and fentanyl were seized in 2021. Meth continues to be the greatest threat to the State and the leading cause of death from 2017 to 2021. Mexico is the main source of meth in Hawaiʻi. Of high concern is the street price of meth in Hawaiʻi and therefore the profit is much greater in Hawaiʻi compared to other states such as California. This has led to powerful incentives for manufacturers to transport their products to Hawaiʻi and an increase in methamphetamine use and overdose. In addition, following US trends, Fentanyl related deaths continue to rise in Hawaiʻi with 79 deaths in 2022 and data shows an increase in polydrug overdoses. Increasingly, there is growing concern related to novel, more potent opioids such as xylazine. The ability of people who use drugs to use tools to decrease their risk of a fatal overdose is essential to prevent these horrifying overdose deaths. Currently, many harm-reduction tools that can decrease overdose deaths are classified as "drug paraphernalia" and are illegal. Fentanyl test strips were legalized in the 2023 legislative session but test strips for newer novel drugs such as xylazine will need to be made available. In addition, to decrease the risk of overdose deaths, many people who use drugs have switched from injecting to smoking. However, water pipes and other smoking equipment are illegal under drug paraphernalia statutes. Decriminalizing these materials will prevent deaths. The threats and deaths are increasing faster than legislative changes can go into effect, and the current piecemeal approach to preventing overdoses is not keeping up, with devastating consequences to individuals, families, and communities. A comprehensive, harm reduction-based strategy is needed to prevent overdose deaths in Hawaii.

- **HACDACS recommends** increasing the availability and accessibility of naloxone to reverse the deadly effects of opioid overdoses.
- **HACDACS recommends** eliminating penalties and prohibitions on drug paraphernalia to enhance the use of harm reduction strategies such as point-of-use drug testing supplies (test strips), smoking devices to transition from injection use, and other tools that may prevent overdose deaths.

- **HACDACS recommends** supporting efforts to decrease the availability of psychostimulants and other harmful substances in Hawaii through the use of the opioid settlement funds.
- **HACDACS recommends** increasing treatment and recovery options.

Office of Wellness and Resilience

SAMHSA's Working Definition (OWR) of Recovery Guiding Principles: Person-Driven, Many Pathways. Address Trauma

The Office of Wellness and Resilience was established due to Act 291, Session Laws Hawai'i 2022. The Office of Wellness and Resilience is housed in the Office of the Governor and was created as a result of the trauma-informed framework developed by the State of Hawai'i Trauma Informed Taskforce. The OWR is the only office nationwide housed in the Governor's Office with jurisdiction over state departments. The OWR Utilizes SAMHSA's Six Principles of Trauma-Informed Care. The OWR's current focus is strengthening communities in three areas: 1) workforce wellness for professionals in the helping fields, 2) training and technical assistance, and 3) trauma-informed programs and policies. Other initiatives include establishing a working group on psilocybin and collaborating with the University of Hawaii (UH) on racial healing and equity. The working group is anticipated to launch in August 2023. The UH is leading the racial healing and equity initiative as they are the recipient of a large grant to be used for this purpose. Beginning July 2025, OWR will be attached to the Department of Human Services for administrative purposes.

- **HACDACS recommends** that the Office of the Governor increase personnel to assist with the growing need of the OWR due to the Maui Fires.
- **HACDACS recommends** the OWR expand their training of trauma-informed care to other departments and agencies to ensure a cross-trained workforce.

Recovery Community Organizations and Recovery Services

SAMHSA's Working Definition of Recovery Guiding Principles: Person-Driven, Many Pathways, Hope, Relational

Faces and Voices of Recovery was established in 2001 to advocate for those who are in recovery from substance misuse. The Alliance for Recovery Centered Organizations (ARCO), Council on Accreditation of Peer Recovery Support Services (CAPRSS), National Recovery Institute (NRI), and Recovery Data Platform (RDP) are programs of Faces & Voices of Recovery. Faces and Voices of Recovery are also the national sponsors for Recovery Month. Faces and Voices of Recovery utilizes SAMHSA's definition of recovery as well as SAMHSA's four dimensions that support recovery: health, home, purpose, and community. The Recovery Ready Ecosystem Model identifies four levels to support recovery communities: policy, institutional, community, and individual/interpersonal. In 2010, national and statewide attention to recovery community organizations (RCO) began to increase. Recovery community organizations were part of the U.S. Surgeon General's Report on Alcohol, Drugs, and Health (2016) and the President's Commission on Combating Drug Addiction and the Opioid Crisis (2017). A RCO is an independent non-profit organization led and governed by representatives of local communities of recovery. They work with the community to find out what recovery support services are needed.

Also, the RCO national network for local, statewide, and national can provide an overall framework, standards, linkages, training, technical assistance, and advocacy. For example, an ARCO National Standard for RCOs states "more than 50% of the Board of Directors or Advisory Board self-identify as people in personal recovery from their own substance use disorder."

- **HACDACS recommends** that the State of Hawai'i increase its awareness of recovery and then increase visibility of recovery communities through coordinated public outreach activities and communications such as a celebrated Recovery Day or month.
- **HACDACS recommends** the expansion of the recovery communities be supported by a braided funding approach, which also includes opioid settlement funds.
- **HACDACS recommends** outreach and education at neighborhood board meetings to increase the number of recovery homes.

Cannabis Use Task Force

SAMHSA's Working Definition of Recovery Guiding Principles: Person-Driven, Many Pathways

Considerations and Recommendations Regarding Legalization of Recreational Marijuana

Recreational cannabis legalization will undoubtedly be a legislative consideration in the 2024 legislative session. As legislative efforts work towards the legalization of cannabis and the associated regulatory structure, it is important to consider public health impacts and how they may be minimized as part of legislation to legalize these substances. Public health should continue to be the primary lens through which these issues are viewed with special attention to protecting youth. There are concerns about the public health impact of legal recreational cannabis. For example, cannabis continues to be the number one substance for the Department of Health's Alcohol and Drug Abuse Division (ADAD) funded adolescent substance abuse treatment admissions at 64.7%, with alcohol a distant second place at 18.6%.[1] Legalization of recreational cannabis runs counter to ADAD's mission and Department of Health goals for prenatal health.[2] Should the Hawaii legislature decide to pursue the legalization of recreational cannabis, it is imperative that effective oversight be built into the statute. Similar to medical cannabis, alcohol, and tobacco, this should be done with oversight that minimizes harm and protects public health and safety. As described in the American Society for Addiction Medicine's 2021 Public Policy Statement on Cannabis[3], these measures should include:

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

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

define uses for tax revenues that are directed to mitigate and address related health harms and expenses.

HACDACS has significant reservations about the potential negative effects of the legalization of recreational cannabis. Many of these concerns are detailed in the Dual Use Task Force reports, especially the *Public Health and Safety Working Group* recommendations.

As legalization is pursued, the following recommendations may decrease negative public health impacts.

- **HACDACS *recommends*** that evidence-based prevention programs for youth funding be increased to meet the challenge of legal recreational cannabis.
- **HACDACS *recommends*** development and implementation of a public health education and prevention campaign in advance of the implementation of legalization.
- **HACDACS *recommends*** product safety measures including impaired driving; accidental poisoning of children & pets; youth access; use during pregnancy & while breastfeeding; young adult use; drug-drug interactions; second-hand smoke; substance use & psychiatric disorders, and protection from predatory practices
- **HACDACS *recommends*** establishing potency limits to minimize adverse effects, creating labeling standards, and strengthening THC testing guidelines.
- **HACDACS *recommends*** a substantial proportion of cannabis tax revenue be earmarked to fund the prevention and mitigation of cannabis-related harm, substance use disorder prevention and treatment programs, public safety programs to reduce impaired driving and monitor black market activity, public awareness campaigns about the risks of cannabis use, including cannabis use disorder.
- **HACDACS *recommends*** including safety protection language in the content of any bills establishing legalization. Public health safety measures are necessary and should be codified in the wording of the law.

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 over thirty substance abuse treatment agencies that provide services statewide.

During Fiscal year 2022-23, 1,302 were referred by criminal justice agencies for substance abuse treatment, case management and clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Of the 1,041 offenders who received services, 382 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2022-23 is as follows in Tables 1-3:

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

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

Table 1. Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2022 – June 30, 2023

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
Oʻahu	35	486	43	564
Maui	36	235	2	293
Hawaii	14	127	10	151
Kauai	8	3	0	33
Total	93	851	55	1,041

Case management services providers: Aloha House, Bobby Benson, Bridge House, CARE Hawaii, Ka Hale Pomaikaʻi, Kokua Support Services, Malama Family Recovery Center, Queen's Medical Center, RYSE, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka

Table 2. Referrals by Criminal Justice Agency: July 1, 2022 – June 30, 2023

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
Oʻahu	81	820	51	952
Maui	33	51	5	89
Hawaii	15	225	11	251
Kauai	8	2	0	10
Total	137	1,098	67	1,302

Case management services providers: Aloha House, Bobby Benson, Bridge House, CARE Hawaii, Ka Hale Pomaikaʻi, Kokua Support Services, Malama Family Recovery Center, Queen's Medical Center, RYSE, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka

Table 3. Carryover Cases by Criminal Justice Agency: July 1, 2021 – June 30, 2022

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
Oʻahu	2	92	8	102
Maui	3	205	3	211
Hawaii	4	50	13	67
Kauai	0	2	0	2
Total	9	349	24	382

Case management services providers: Aloha House, Bobby Benson, Bridge House, CARE Hawaii, Ka Hale Pomaikaʻi, Kokua Support Services, Malama Family Recovery Center, Queen's Medical Center, RYSE, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Services, The Alcoholic Rehabilitation Services of Hawaii, Inc., dba Hina Mauka

Recidivism. The major outcome for services to offenders is recidivism, or the proportion of offenders who have been rearrested. The Interagency Council on Intermediate Sanctions (ICIS) 2019 Recidivism Update (dated March 2021) for the Fiscal Year 2016 cohort states that the overall recidivism rate is 61.3% for probation, parole, and Department of Public Safety (PSD) maximum-term released prisoners. (ICIS defines recidivism as criminal rearrests, criminal contempt of court and revocations/violations). The data reveal a 54.6% recidivism rate for probationers; a 50.1% recidivism rate for offenders released to parole; and a 57.1% recidivism

rate for offenders released from prison (maximum-term release).

The 53.8% recidivism rate for FY 2016 probationers and parolees was lower than the previous year's rate of 61.7%. The FY 2016 recidivism rate is 19.1% lower than the recidivism rate reported in the FY 1999 baseline year, far from the goal of reducing recidivism in Hawaii by 30%. Felony probationers in the FY 2016 cohort had a 54.6% recidivism rate, which is 10.1 percentage points higher than the recidivism rate for the previous year's cohort and indicates a 0.9% increase in recidivism since the baseline year. Parolees in the FY 2016 cohort had a 50.1% recidivism rate, which is 0.2 percentage points lower than the previous year's rate and signifies a 22.8% decline in recidivism from the baseline year, which has not met the goal of reducing recidivism in Hawaii by 30%. The recidivism rate for maximum term released prisoners decreased from 76.1% for the FY 2005 cohort to 57.1% for the FY 2016 cohort. The recidivism rate for FY 2016 is 57.1% (6.9 percentage points) lower than the FY 2015 rate. Additionally, probationers had the highest recidivism rates in the entire FY 2016 offender cohort for criminal reconvictions (38.4%), while maximum term released prisoners had the highest recidivism rate in the entire FY 2016 offender cohort for criminal rearrests (43.8%).

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

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

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

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

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

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

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

APPENDICES

A. ADAD-Funded Adult Services: Fiscal Years 2020-23

B. ADAD-Funded Adolescent Services: Fiscal Years 2020-23

C. Performance Outcomes: Fiscal Years 2020-23

D. Treatment Related to Substance Use - County Estimates

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

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2020-2023

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Male	63.4%	67.3%	67.3%	67.0%
Female	36.6%	32.7%	32.7%	33.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Hawaiian	48.9%	48.0%	44.9%	47.0%
Caucasian	21.6%	20.6%	21.0%	16.1%
Filipino	5.4%	7.0%	7.1%	6.0%
Mixed - Not	4.8%	5.4%	6.8%	8.2%
Japanese	3.0%	2.8%	2.7%	3.8%
Black	1.0%	1.4%	3.4%	1.7%
Samoan	2.0%	2.2%	2.6%	2.4%
Portuguese	1.7%	1.5%	1.0%	2.2%
Other Pacific	3.5%	4.6%	5.2%	6.5%
Other*	8.0%	6.5%	5.3%	6.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Methamphetamin	60.3%	60.6%	53.5%	61.2%
Alcohol	14.5%	12.1%	19.5%	16.6%
Marijuana	8.9%	10.6%	12.3%	8.6%
Cocaine/Crack	2.6%	1.6%	1.5%	2.5%
Heroin	7.9%	10.0%	8.9%	6.9%
Other*	5.7%	5.1%	4.3%	4.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

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

ADAD-FUNDED ADULT ADMISSIONS BY RESIDENCY

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
O'ahu	46.6%	53.7%	49.6%	56.2%
Hawaii	35.3%	27.0%	34.3%	28.7%
Maui	8.2%	10.8%	6.7%	7.1%
Molokai/Lanai	2.3%	1.2%	0.6%	0%
Kauai	3.6%	3.1%	2.7%	3.0%
Out of State	4.0%	4.2%	6.1%	5.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2019-20 through Fiscal year 2022-23, methamphetamine admissions saw a drop in FY22 to 53.5% before returning to a similar proportion of usage as previous years at 61.2%. Conversely, alcohol admissions saw a spike in FY22 at 19.5% before returning to a lower 16.6%. Marijuana admissions saw an increasing trend in FY20 from 8.9% to 12.3% in FY22 before coming back down in FY23 to 8.6%. Cocaine/Crack admissions saw a temporary 1% depression from FY20's 2.6% before returning to 2.5% in FY23. Heroin admissions had spiked at 10% FY21 before trending down to FY23's 6.9%. All "Other" substances saw a

decreasing trend from 5.7% to 4.1%.

Several Primary Substance rates may have been influenced by circumstances arising from COVID. Although COVID began in FY20, its more significant ramifications did not manifest until late in the 3rd fiscal quarter. FY21 and FY22 probably encapsulate the majority of the effects of COVID. Consequently, we observe substance use returning to pre-COVID levels in FY23.

Also, among the 3,303 adult admissions for FY2022, 1,053 admissions (31.9%) were homeless when admitted to treatment. This proportion is consistent with previous year rates.

APPENDIX B

ADAD-FUNDED ADOLESCENT[6] SERVICES FISCAL YEARS 2020-2023

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Male	47.7%	55.5%	45.2%	38.9%
Female	52.6%	44.5%	54.8%	61.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Hawaiian	48.0%	45.6%	44.4%	42.1%
Caucasian	7.1%	8.1%	9.0%	7.7%
Filipino	9.1%	5.6%	8.9%	11.3%
Mixed - Not Hawaiian	5.7%	5.4%	7.0%	6.1%
Japanese	3.1%	1.8%	2.8%	1.7%
Black	1.7%	1.4%	1.5%	1.2%
Samoan	4.2%	4.7%	3.5%	4.2%
Portuguese	0.8%	0%	0.7%	0.5%
Other Pacific Islander	15.1%	24.2%	17.6%	21.5%
Other*	5.2%	3.2%	4.5%	3.8%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Methamphetamine	0.8%	1.8%	0.8%	2.0%
Alcohol	18.6%	17.1%	15.9%	21.0%
Marijuana	64.7%	71.1%	71.0%	76.2%
Cocaine/Crack	0.5%	0.2%	0.7%	0%
Heroin	0%	0%	0%	0%
Other	15.3%	9.9%	11.6%	0.8%
TOT	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 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
O'ahu	71.8%	84.4%	32.5%	76.9%
Hawaii	12.6%	2.9%	38.7%	1.0%
Maui	10.3%	12.2%	17.3%	22.1%
Molokai/Lanai	0.6%	0%	5.2%	0%
Kauai	4.7%	0.5%	6.4%	0%
TOTAL	100.0%	100.0%	100.0%	100.0%

[6] Adolescent: Grades 6 through 12

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2019-20 through Fiscal Year 2022-23, methamphetamine has fluctuated yearly with a low at 0.8% in FY20 and FY22 with a high at 2.0% in FY23. Alcohol admissions temporarily trended down from 18.6% in FY20 to 15.9% in FY22 before reaching a four year high in FY23 at 21.0%. Marijuana admission has trended upwards from 64.7% in FY20 to 76.2% in FY23. Cocaine/Crack had no admissions for FY23. All "Other" substances went from 15.3% in FY20 to 0.8% in FY23.

Community profiles by the State Epidemiological Outcomes Workgroup (SEOW) and the results of Student Health Surveys administered in 2013, 2015, 2017, and 2019 and 2021 are consistent with the ADAD-Funded Adolescent Treatment Admissions by primary substance in that Alcohol and Marijuana are the primary substances of choice for use by person in Hawaii, ages 12-25. Community-based programs report similar trends based on qualitative data informally gathered at the local community level and therefore, are directing prevention education and strategies and social norm activities to younger ages and families as well as youth ages 12-17 and young adults.

APPENDIX C

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2020 through 2023, 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 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Employment/School/Vocational Training	97.7%	98.6%	99.2%	99.7%
No arrests since discharge	94.3%	98.0%	99.2%	96.3%
No substance use in 30 days prior to follow-up	51.8%	47.1%	39.4%	37.1%
No new substance abuse treatment	80.5%	89.2%	89.7%	80.1%
No hospitalizations	94.8%	96.3%	98.4%	96.3%
No emergency room visits	92.1%	94.2%	96.9%	91.2%
No psychological distress since discharge	81.1%	79.7%	89.0%	77.0%
Stable living arrangements*	97.9%	96.9%	97.6%	99.7%

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

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2020 through 2023, 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 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Employment/School/Vocational Training	61.9%	51.6%	46.7%	73.3%
No arrests since discharge	94.0%	96.5%	98.0%	97.5%
No substance use in 30 days prior to follow-up	72.5%	61.9%	57.0%	30.6%
No new substance abuse treatment	72.2%	69.1%	76.8%	71.3%
No hospitalizations	93.0%	94.8%	86.4%	94.4%
No emergency room visits	90.6%	90.2%	94.4%	86.4%
Participated in self-help group (NA, AA, etc.)	31.8%	27.4%	28.1%	32.3%
No psychological distress since discharge	81.1%	75.1%	82.1%	70.7%
Stable living arrangements*	77.3%	73.6%	90.4%	73.6%

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

APPENDIX D

TREATMENT RELATED TO SUBSTANCE USE - COUNTY ESTIMATES

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

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

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

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

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

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

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

The five-year (Fiscal Year 2019 to Fiscal Year 2023) average annual ADAD-funded admissions for adults is 2,725, which is 3.6% of the estimated need for adult alcohol and drug abuse treatment.

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

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

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

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

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

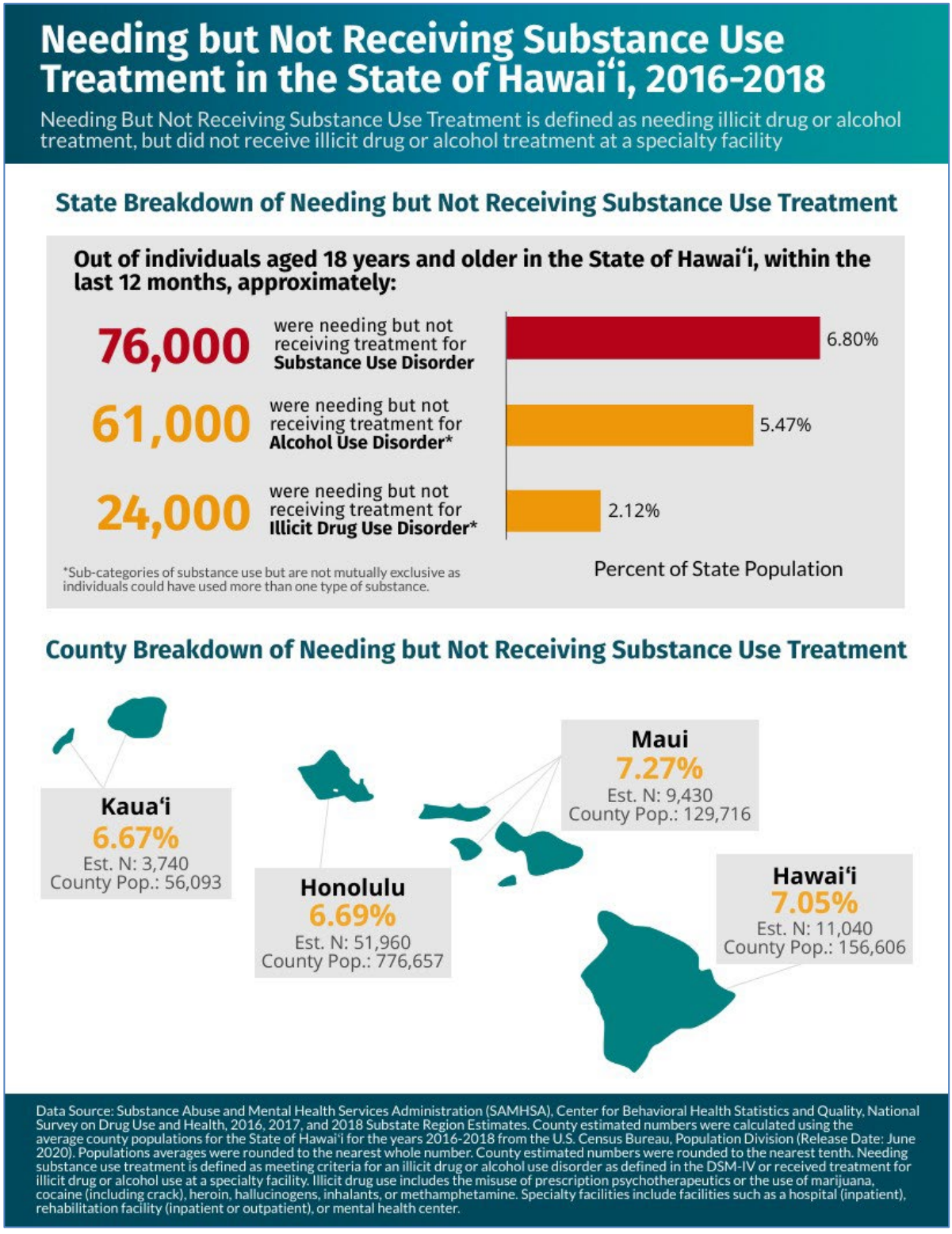


Table D2: Substance Use Disorder in the Past Year among Individuals Aged 18 or Older, by State and Substate Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs										
	Percent of State Population (County Population)									
	Kaua‘i		Honolulu		Maui		Hawai‘i		State	
Population (18 Years and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

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

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

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

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

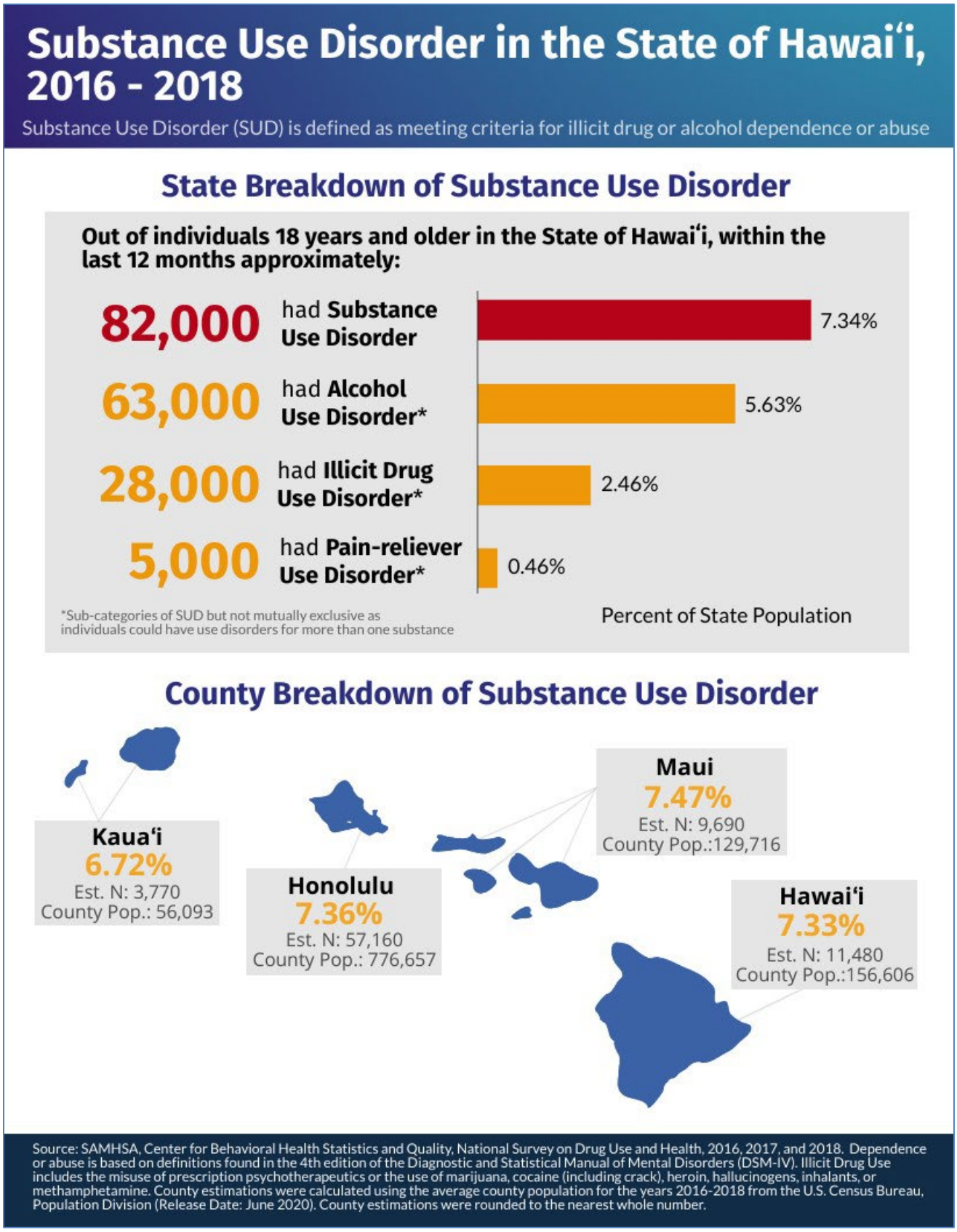
For *Hawai‘i County*, 11,480 (7.33%) of individuals aged 18 and older on the Big Island had substance use disorder in the past year.

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

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

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

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



APPENDIX E

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

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

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

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

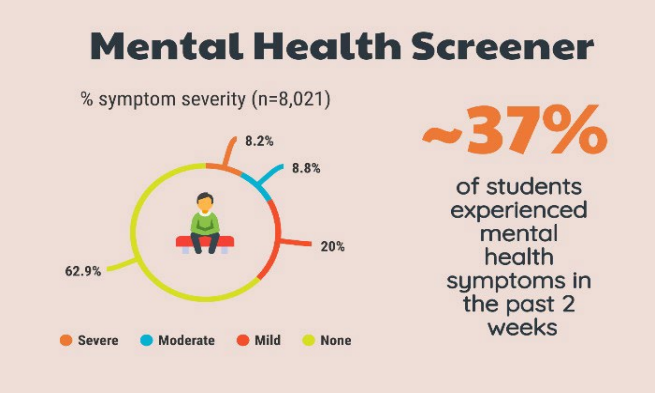
The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade, and primary race/ethnicity:

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

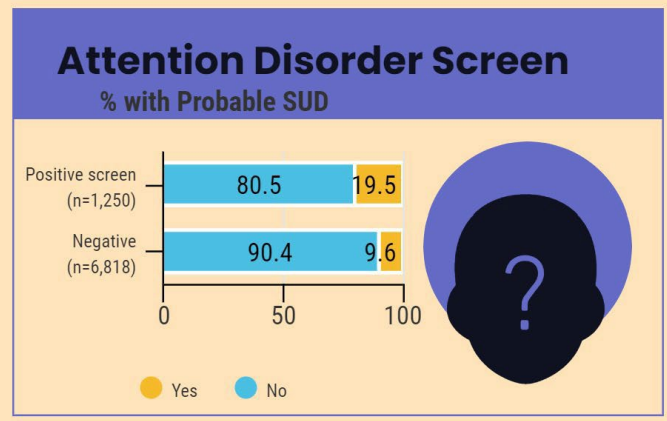
[2] While the survey asks students to select a group with which they primarily identify, a large proportion reported primarily identifying with multiple (2 or more) ethnic/racial groups. Among those who selected two or more ethnic/racial groups in the state sample, Native Hawaiian was among the highest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

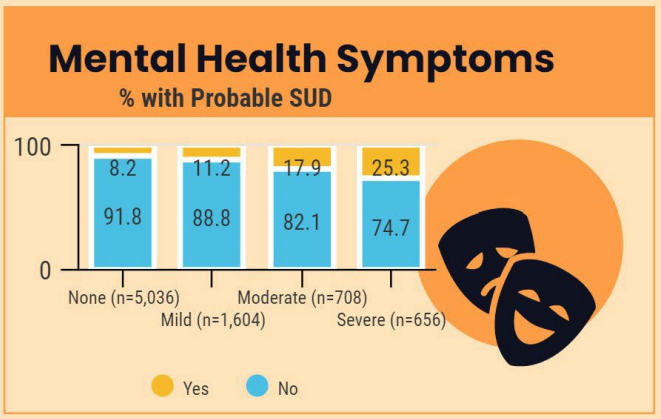
- The overall total estimated treatment needs across the state ***increased*** to 11.1% compared to 7.7% reported from the 2007-2008 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study.
- ***Transgender and Other Gender Minority*** students make up the smallest proportion of the state sample but show the ***highest risk for a probable substance use disorder*** (24.4%) compared to their cisgender counterparts (females 13.1%, males 8.8%).
- Treatment need ***increased by grade level***, (6.6% of 8th graders, 11.9% of 10th graders, and 15.0% of 12th graders) ***more than doubling from middle school to high school***.
- Adolescents most likely to have a probable substance use disorder primarily identified themselves as ***Other Pacific Islander (19.7%), Native Hawaiian (15.2%), Hispanic or Latino (16.2%), and of two or more ethnicities with Native Hawaiian (13.5%)***. Students identified as Other ethnicities (13.7%) had higher rates as well, but it should be noted that the sample size was smaller than for other groups.

- ***New items in*** the Hawaii ATOD Survey related to **Mental Health** (PHQ-4 screener for anxiety and depressive symptoms; Kroenke et al, 2009) showed that about ***37% of students reported experiencing mild to severe mental health symptoms in the past two weeks***. Furthermore, along the continuum of increasing symptom severity, the ***percentage of probable substance use disorder*** (as measured by the CRAFFT) ***was more than two-fold from mild (8.2%) to severe (25.3%) mental health symptoms***.



- From the Hawaii ATOD Survey ***new items*** related to screening for **attention related disorders** (Pediatric Symptom Checklist, Attention subscale; Gardner et al, 1999), youth with a ***positive screen*** (which indicates further assessment for attentional disorders) ***had a percentage (19.5%) of probable substance use disorder, about twice that of those with a negative screen*** (9.6%).





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

The five-year (Fiscal Year 2019 to Fiscal Year 2023) average annual ADAD-funded admissions for adolescents is 1,091, which is 12.4% of the estimated need for adolescent alcohol and drug abuse treatment.

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

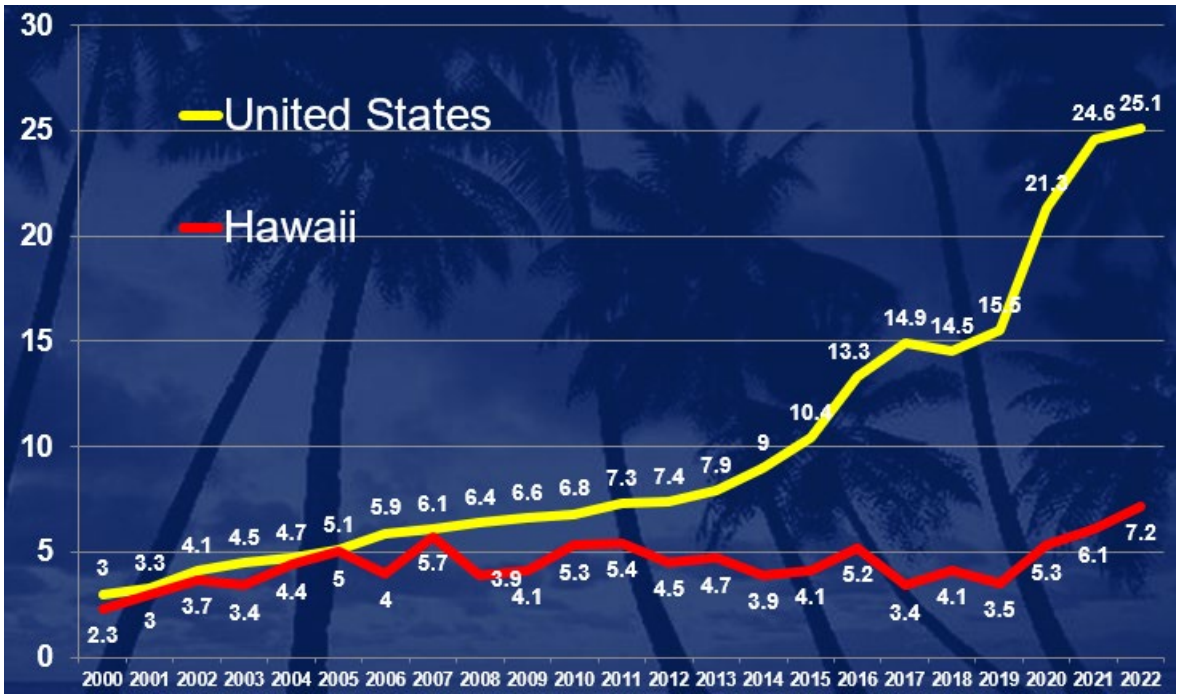
Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also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

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

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

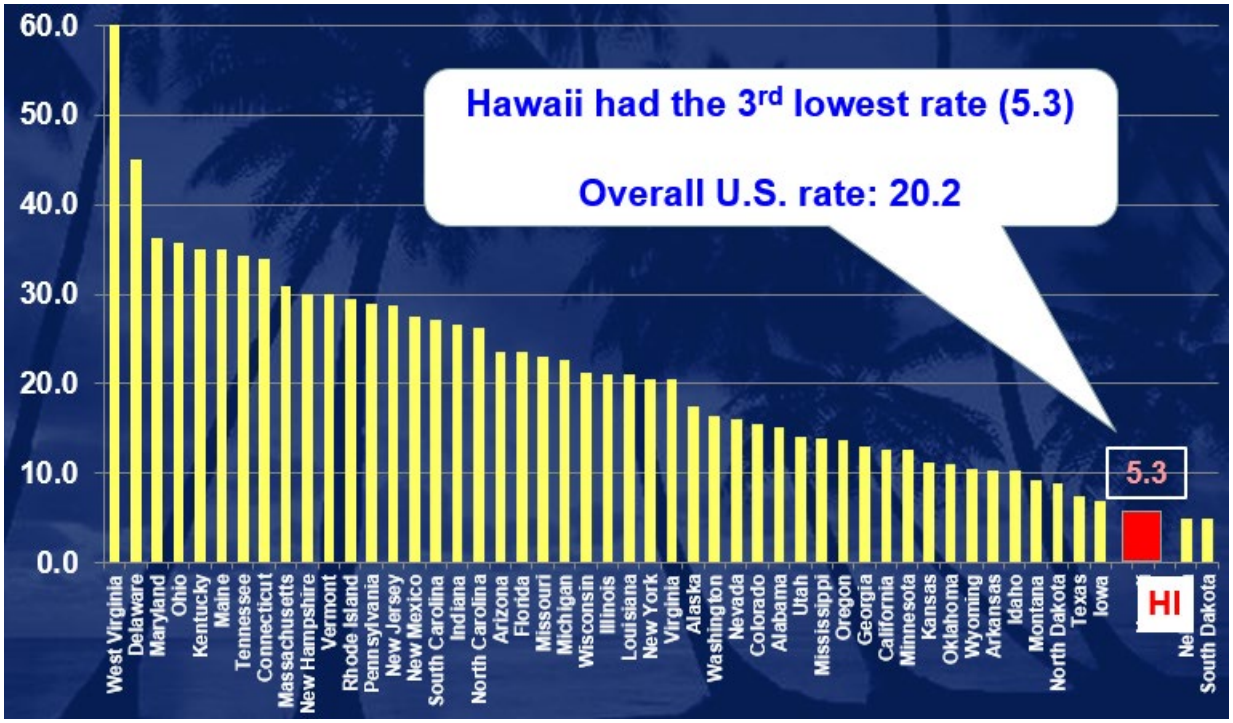
Data from the Centers for Disease Control's (CDC) WONDER system, a national public health dataset shows that Hawaii opioid poisoning fatality rates appear to be trending slightly upward (7.2 in 2022), a slight increase from the 2016 rate of 5.2 (Figure 1) while the national rate has increased since 2000 (25.1 in 2022).

Figure 1. Adjusted opioid poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2000-2022.



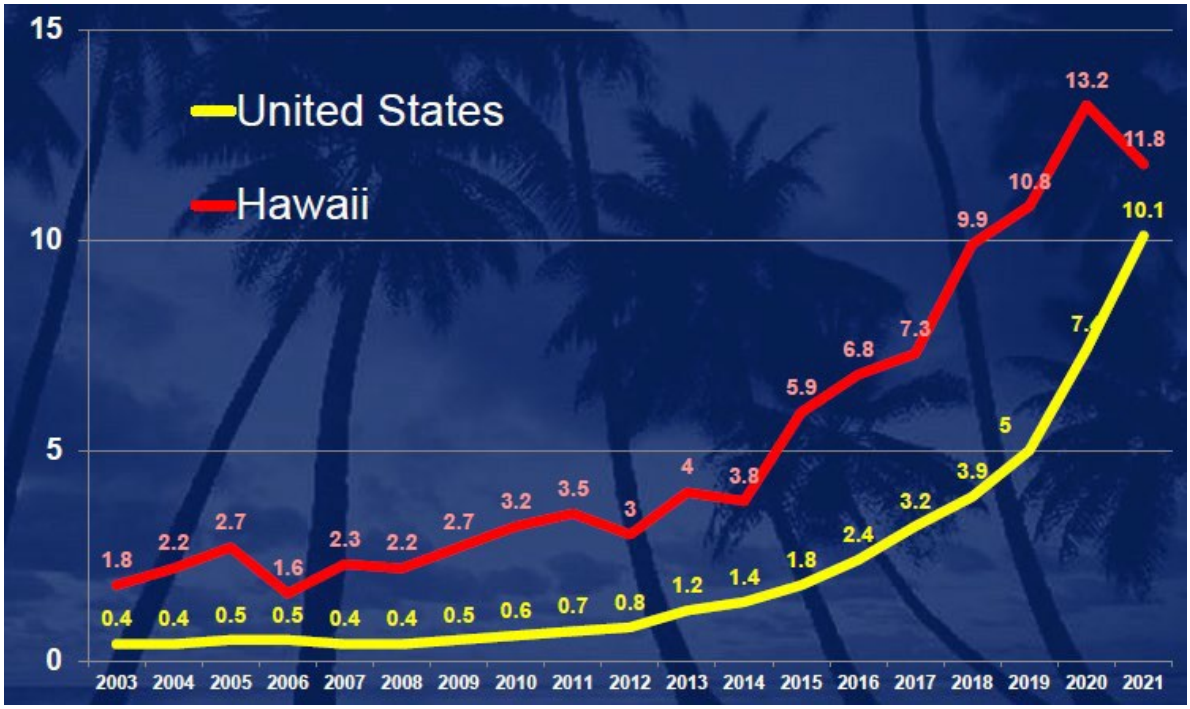
And when compared to other states, Hawaii now has the third *lowest* fatality rate of poisonings due to prescription opioids, methadone, and heroin (5.3) which is also well below the national rate of 20.2 (Figure 2).

Figure 2. Adjusted opioid poisoning fatality rates (per 100,000), by state, 2018-2022*



*Data for 2021 is provisional.

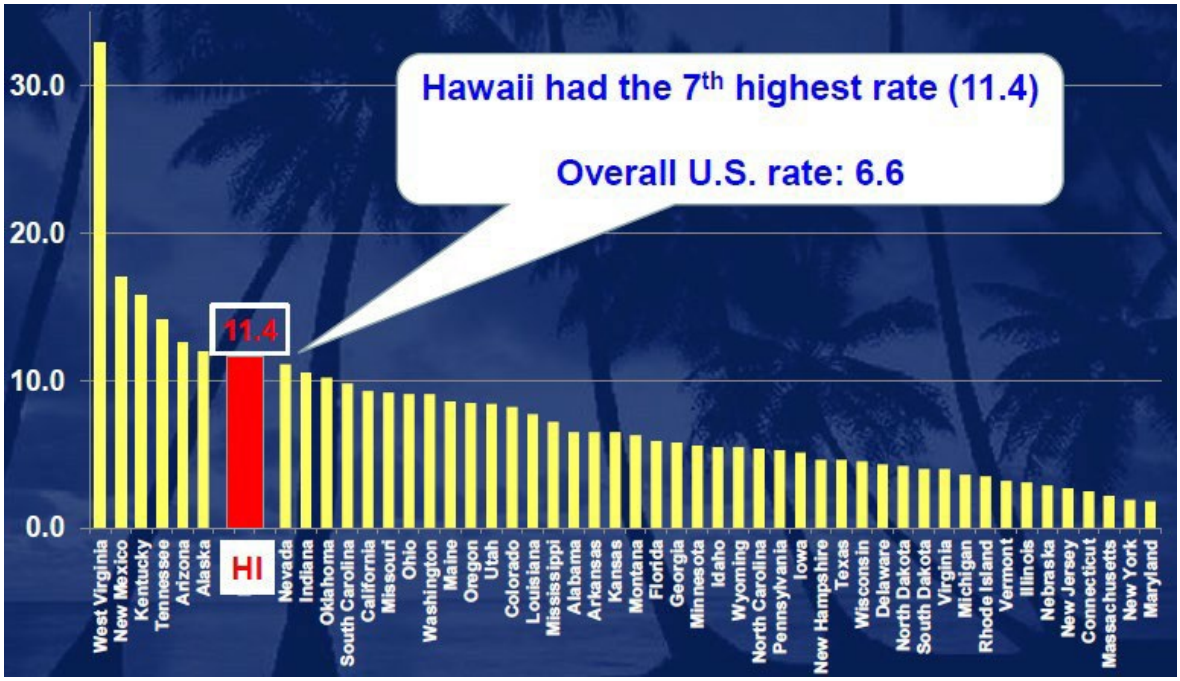
Figure 3. Annual adjusted "meth" poisoning fatality rates (per 100,000), Hawaii vs. U.S., 2003-2021*



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

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

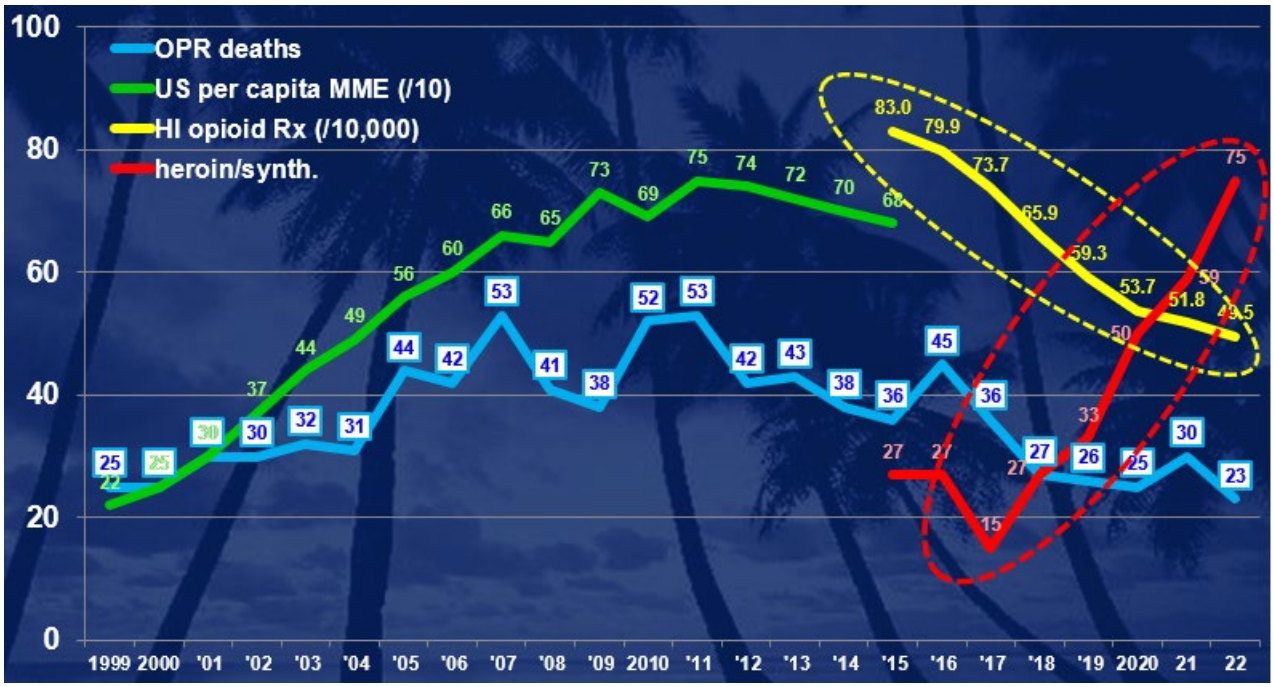
Figure 4. Average adjusted "meth" poisoning fatality rates (per 100,000), by state, 2018-2021*



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

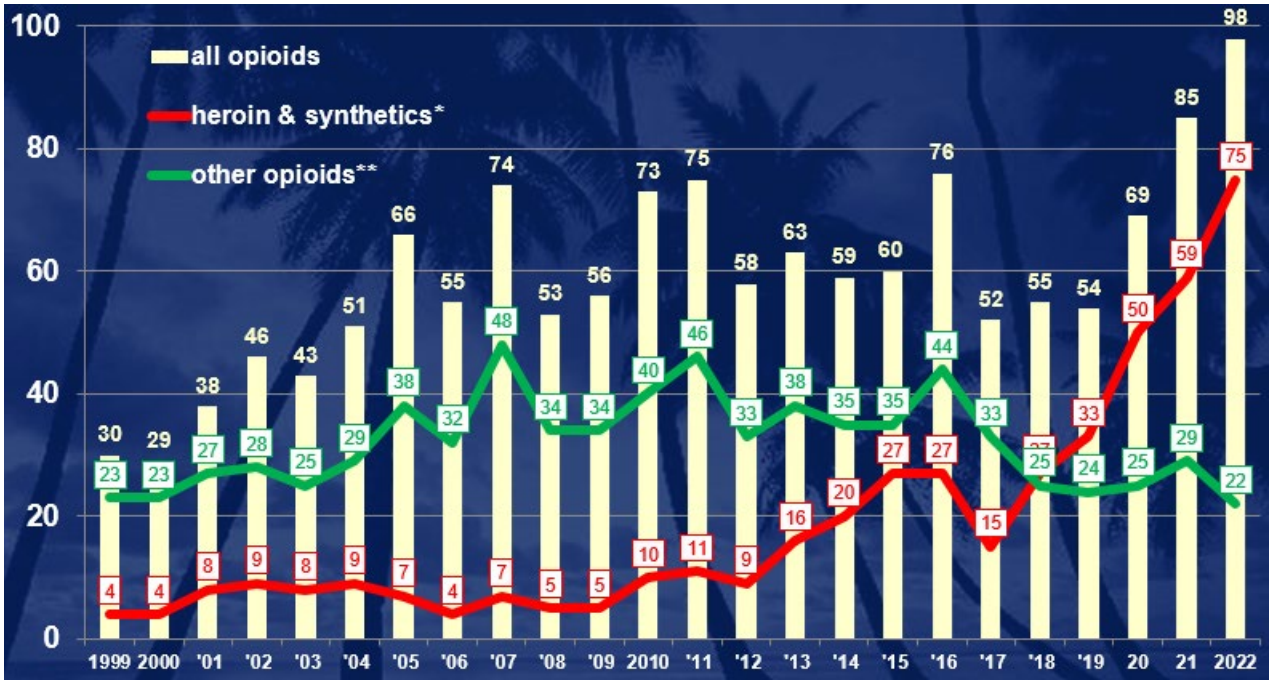
When looking at poisoning fatality rates among Hawaii residents compared to national opioid consumption, EMSIPSB data show that deaths due to opioid pain relievers are decreasing (Figure 5). However, Hawaii death certificate data show a greater prevalence of fatal opioid poisonings among Hawaii residents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

Figure 5. Annual trends of fatal opioid poisonings* among Hawaii residents: national opioid consumption (through 2015), and opioid prescriptions in Hawaii (2015-2022).



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

Figure 6. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 1999-2022.



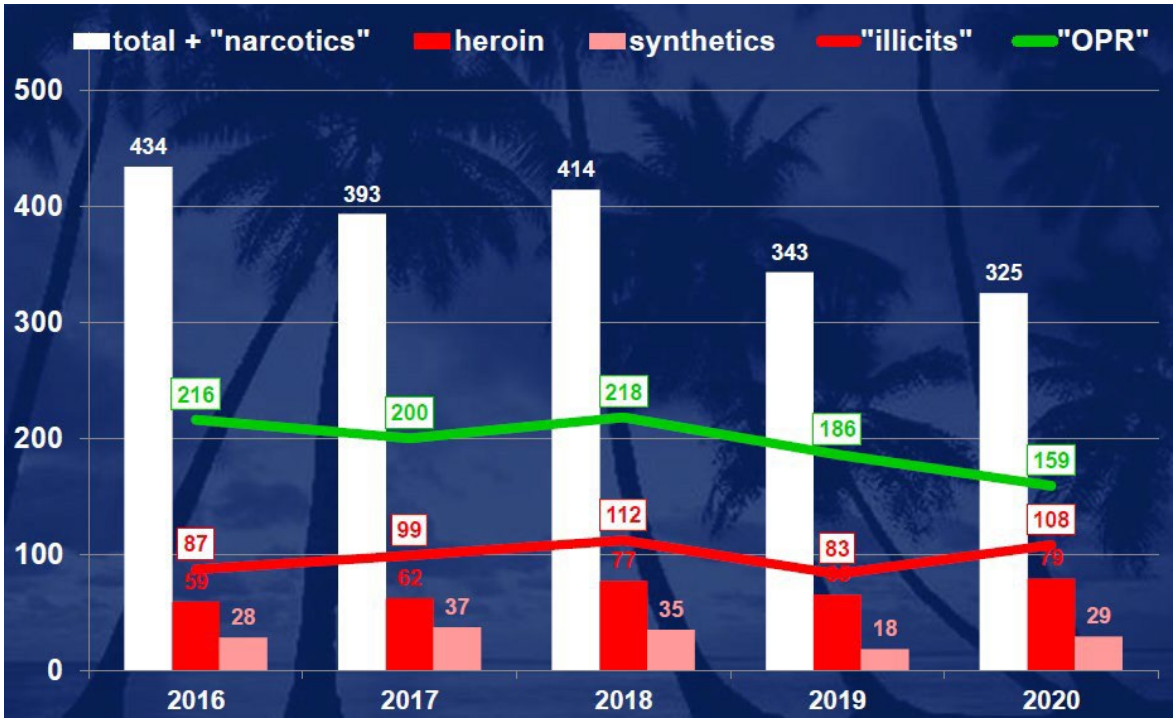
* Includes heroin and synthetic opioids other than methadone (e.g., fentanyl, tramadol)
** Includes naturally derived opioids (e.g., codeine, morphine), semi-synthetics (e.g., oxycodone, hydrocodone) and other narcotics.

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

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

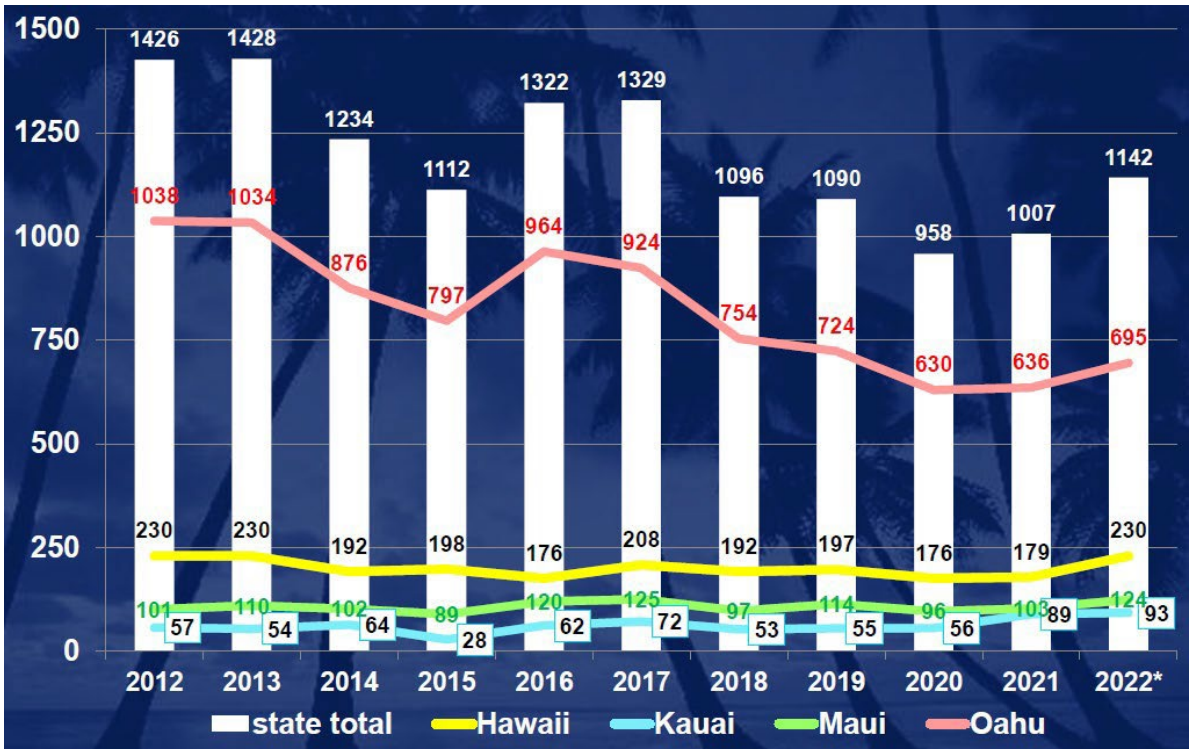
Recent data from the EMSIPSB poison center dataset shows that nonfatal non-heroin opioid poisonings remain significantly higher compared to heroin, however total nonfatal opioid poisonings appear to be decreasing (325 in 2020 vs. 434 in 2016) (Figure 7). And over the last ten years, naloxone administrations continue to remain steady for each county except Honolulu where fewer EMS patients are receiving naloxone since the last spike which occurred in 2016 (Figure 8).

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



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

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



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

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

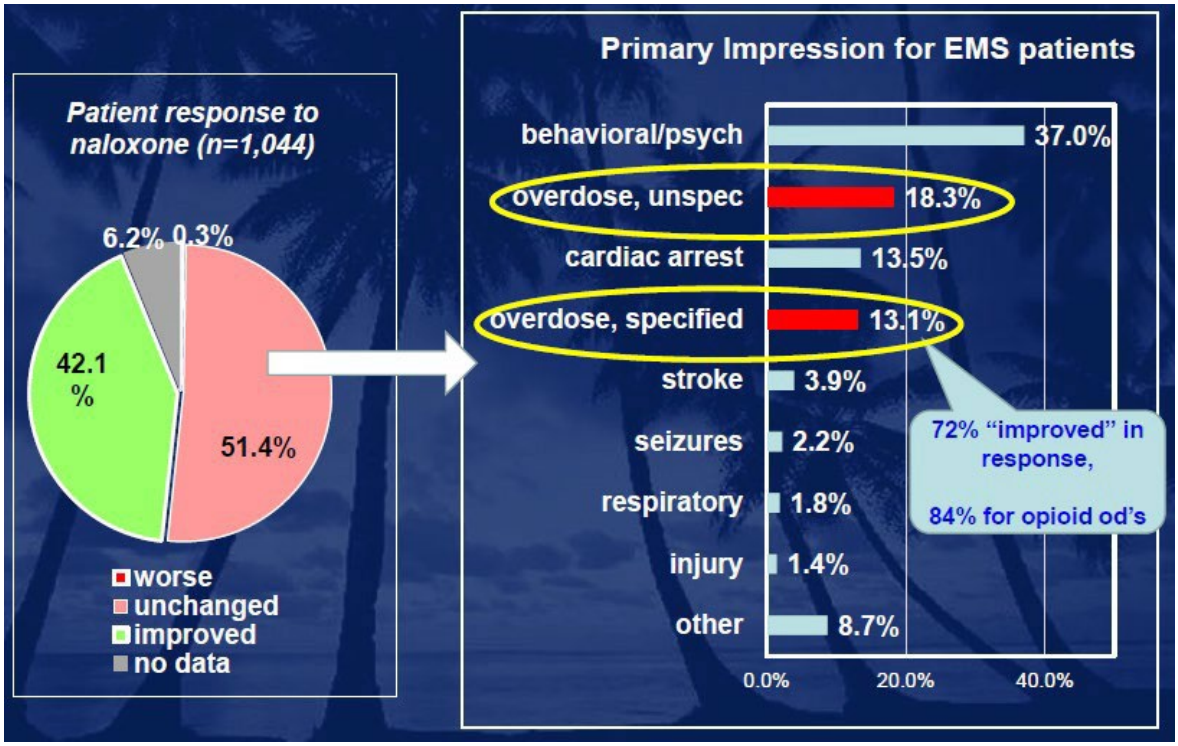
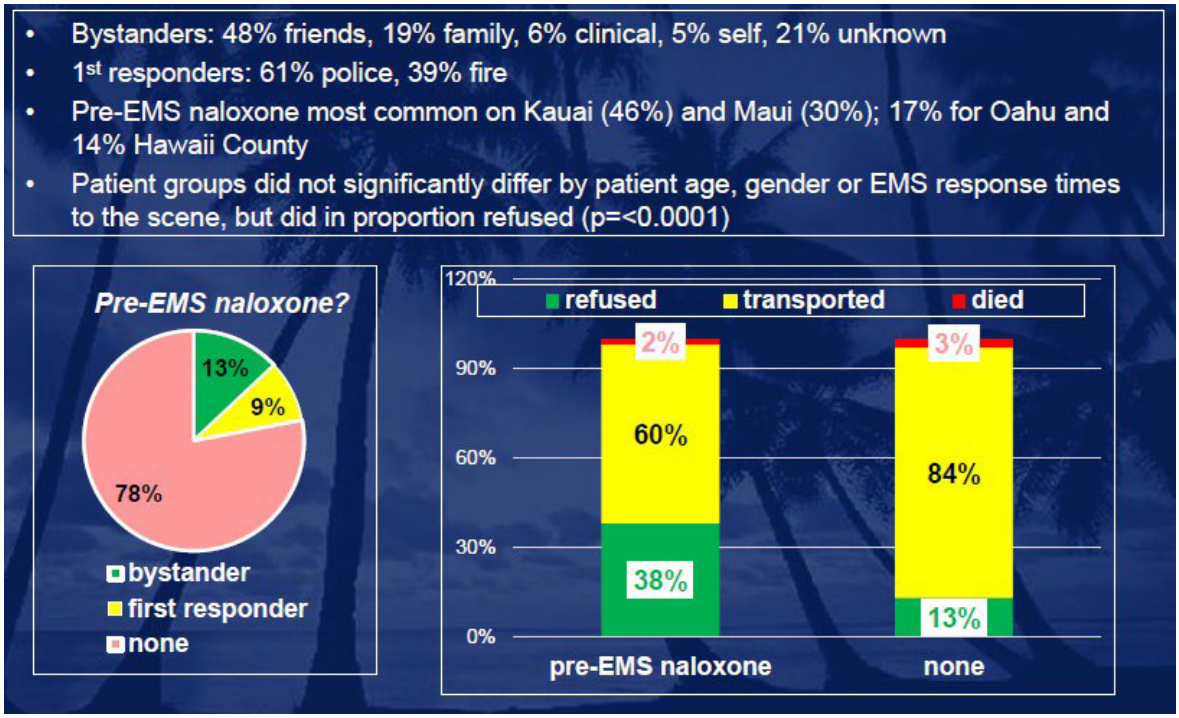


Figure 10. Discharge disposition for EMS patients with fentanyl or heroin overdoses, by pre-EMS naloxone status, 10/2021 – 9/2022.



Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified in a December 2020 literature review conducted by the University of Hawaii include:

Evidence from Outside Hawai‘i

- Opioid dependence (emergency department visits and hospital admissions between 2009 and 2014 show that opioid dependence is linked with a heightened risk of premature mortality, almost 6 times higher than that of the general population);
- Nonfatal opioid overdose experiences (a longitudinal study of Medicaid beneficiaries between 18 and 24 years of age who experienced nonfatal opioid overdose shows that those who survive an opioid overdose are 24 times more likely than others to die the following year from circulatory or respiratory disease, cancer, or suicide);
- Prisoner re-entry (another study found former prisoners were extremely vulnerable to unintentional opioid overdose deaths during post release, with women having a higher risk of opioid-related death compared to men);
- Limited access to behavioral health among Medicaid beneficiaries (Medicaid expansion may be important to promote opioid agonist therapy for those receiving opioid treatment that would otherwise receive only non-medication therapies like counseling or group therapy);
- Comorbid mental illness (Medicaid expansion also plays a significant role in

providing other needed behavioral health services for those with mental illnesses and other substance use disorders); and
- Behavioral health impacts due to COVID-19 (2 out of 5 U.S. adults struggled with mental health, substance use, and suicidal ideation during June 2020 possibly due to increased anxiety and reduced access to healthcare due to physical distancing).

Evidence from Hawai‘i

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

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

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

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

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