REPORT TO THE

THIRTY-THIRD LEGISLATURE

STATE OF HAWAIʻI

2025

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 2024

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2023-24 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 2023-24, $34,159,042 was appropriated by Act 230, Session Laws of Hawai‘i (SLH) 2024, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds and $13,013,329 federal funds (MOF N and P). Of the total appropriated, $24,019,720 was allocated for substance abuse treatment services and $7,355,910 was allocated for substance use prevention services. The Act also funded 2.00 FTE positions, abolished an 1.00 FTE position, and removed 4.00 positions associated with two federally funded programs that ended.

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

> $8.9 million for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds (10/1/22 – 9/30/24) 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.
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> $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).
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> $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.
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> $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 ended 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 1,265 adult admissions statewide in Fiscal Year 2023-24;

School- and community-based outpatient substance abuse treatment services saw 744 adolescent admissions statewide in Fiscal Year 2023-24; and

Curriculum-based youth substance use prevention and parenting programs, and underage drinking initiatives served 1,331,871 children, youth, and adults directly and indirectly through individual-based and population-based prevention programs, strategies, and activities[2] in Fiscal Year 2023-24.

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.

TABLE OF CONTENTS

ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2023-24 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 use prevention services contracts and the implementation of substance abuse prevention discretionary grants. The Strategic Prevention Framework – Partnerships for Success Project focuses on building community capacity to address substance use issues and sustain the substance abuse prevention system and infrastructure at the state, county, and local community levels. The staff of the Food and Drug Administration (FDA) Tobacco Program within the Branch ensures that the Federal Tobacco Control Act is enforced in Hawai‘i.

The Treatment and Recovery Branch (TRB) develops and manages a statewide treatment and recovery system which includes program and clinical oversight of substance use treatment, opioid treatment programs (OTP), early intervention services, and recovery support service contracts and the implementation of substance use treatment discretionary grants.

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

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

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2023 to June 30, 2024

State and Federal Funding

Act 230, SLH 2024 appropriated $34,159,042 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2023-24:

General funds	$20,395,713	(59.7%)	28.0 FTE
Special funds	750,000	(2.1%)	
Federal funds (N)	9,038,656	(26.6%)	1.0 FTE
Federal funds (P)	3,974,673	(11.6%)	
	$34,159,042	(100.0%)	29.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$24,294,566	(71.1%)
Substance abuse prevention services	7,355,910	(21.5%)
Division operating costs	268,633	(0.8%)
Division staffing costs	2,239,933	(6.6%)
	$34,159,042	(100.0%)

For Fiscal Year 2023-24, $34,159,042 was appropriated by Act 230, SLH 2024, to the Alcohol and Drug Abuse program (HTH 440) – $20,395,713 general funds, $750,000 special funds and $13,013,329 federal funds (MOF N and P). Of the total appropriated, $24,294,566 was allocated for substance use treatment services and $7,355,910 was allocated for substance use prevention services.

Act 230, 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 3.0) Grant (2.0 FTE).

Federal Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. ADAD received $8.65 million in Fiscal Year 2024 (10/1/22 – 9/30/24) 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 to support tobacco inspections on retail outlets that sell or advertise cigarettes or smokeless tobacco products to determine whether they are complying with the Tobacco Control Act (Public Law 111-31) and the implementing regulations (21 Code of Federal Regulations Part 1140, et seq.). In September 2024, Hawaii was awarded a $3.8 million 5-year contract from the FDA for continued services for the period, September 30, 2024 through September 29, 2029. Two types of tobacco compliance inspections are conducted: undercover buys, to determine a retailer's compliance with federal age and photo identification requirements; and product advertising and labeling to address other provisions of the Tobacco Control Act.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant 2018. Hawai‘i was awarded a SPF-PFS grant of $2.0 million in each of five years (9/30/18-9/29/23). 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 ended on March 29, 2024.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant 2023. In September 2023, Hawai‘i was awarded a new SPF-PFS grant of $1.25 million in each of five years (9/30/23-9/29/28) to work in collaboration with state and community level stakeholders to continue the Hawai‘i Project's efforts to address prevalent substance use issues in communities of demonstrated high need use. The project uses data-driven processes to develop and implement effective prevention strategies and sustainable prevention infrastructures in communities that demonstrate a need for programming in their selected prevention priorities.

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 addressed 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, increase telehealth services for rural communities, expand opioid and stimulant use training for nurses, increase naloxone distribution, provide culturally anchored training for the workforce, and provide peer support for pregnant women with dependent children (PWWDC). A no-cost extension is approved for one year (9/30/24 – 9/29/25). The grant will end on 9/29/25.

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). An additional extension of time was approved for one year (3/15/24 – 3/14/25). The Grant will end on 3/14/25.

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.

Overdose Data to Action in States (OD2A-S). Hawai'i was awarded a $2.7 million per year for five years (9/1/23 – 8/31/28) to continue the progress of the surveillance and prevention activities of the previous Hawaii OD2A project (conducted by the Adult Mental Health Division) to address the ongoing issues of the drug overdose epidemic in Hawai'i by working collaboratively and strategically with key partners from various sectors to implement and evaluate evidence-based strategies to achieve measurable improvements in the prevention, management, and reduction of opioid use with a focus on priority populations. The project will expand and build on key interventions currently being conducted and efforts will be carried out at the state, regional, and local levels to reach multiple settings and communities to maximize health improvement throughout Hawai'i's diverse populations. The project also aims to enhance surveillance efforts by improving infrastructure, morbidity surveillance, mortality surveillance, and data linkage. Hawai'i has also developed activities for four key prevention strategies: Clinician/Health System Engagement and Health/IT Prescription Drug Monitoring Program (PDMP) Enhancement, Public Safety Partnerships/Interventions, Harm Reduction, and Community-Based Linkage to Care. Some short-term outcomes of this project include more timely, detailed, comprehensive, and actionable surveillance data, increased data sharing and data availability, and increased collaboration, coordination, and communication among community partners. Some long-term outcomes of this project are decreases in illicit opioid and stimulant use, including co-use with other substances, and decreases in nonfatal and fatal drug overdoses, especially those disproportionately affected by the overdose epidemic and those previously underserved by overdose prevention programs and the healthcare system overall.

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

Substance Abuse Prevention and Treatment Services

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

Treatment Services. ADAD's overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse, and dependence by assuring an effective, accessible public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Thirty-three (33) 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 services such as motivational enhancement services, outreach, and

[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.

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 services, and childcare. Also, under the Continuum of Care Services includes early intervention services such as Human Immunodeficiency Virus (HIV) and Hepatitis-C (HCV) testing and counseling services and opioid recovery support services such as providing medications for opiate use disorder (MOUD) dosing. 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 1,265 adults statewide in Fiscal Year 2023-24; and school-based and community-based outpatient substance abuse treatment services were provided to 744 adolescents statewide in Fiscal Year 2023-24.

In the fall of 2023/winter of 2024, ADAD contracted with Milliman, Inc. to perform a rate study to evaluate the reimbursement rates for many of the treatment services. The purpose of the study is to provide independent rates (also known as comparison rates) to cover reasonable and necessary costs related to the delivery of substance use disorder services. This study was a joined effort between ADAD and the contracted treatment programs. In addition, it was used for the treatment's upcoming Request for Proposals (RFP).

In April of 2024, the RFP was posted statewide for substance use prevention, treatment, and recovery services to adults and adolescents.

In May of 2024, a Notice of Award were sent to thirty-one (31) substance use programs. The start date of the contract is October 1, 2024, and will be for two (2) years.

Prevention Services. Through a total of thirty-two (32) contracts, twenty-eight (28) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2024. In efforts to best utilize resources to fund what works, the contracted services implement evidence-based and promising programs, policies, and practices in addition to the Center for Substance Abuse Prevention Strategies: information dissemination; education; problem identification and referral; community-based programming; environmental strategies; and alternative activities that decrease alcohol, tobacco, and other drug use. The funded programs engage schools, and communities across the state in establishing evidence-based and cost-effective models to prevent substance use in young people in a variety of community settings and promoting programs and policies to improve knowledge and skills related to effective ways to avoid substance use problems and enhance resiliency.

Program implementation is tracked according to the number of times (cycles) curricula and strategies were implemented as collected and reported using WITS, the data management system described above and expanded to collect prevention service data. Additionally, quarterly progress reports, plans and progress notes submitted capture information related to community partnerships, problems, priorities, resources, readiness, and implementation status of identified evidence-based programs. According to the data collected for Fiscal Year 2023-24, curriculum-based prevention strategies served a total of 3,399 children and youth and the community-based strategies touched a total of 1,331,871 children, youth, and adults across the state.

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

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

Hawai'i Coordinated Access Resource Entry System (CARES)

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

Within this past fiscal year, AUW has accomplished so much with promoting their AUW 211 SUD services. AUW received 5,153 phone calls for those inquiring about SUD services. AUW received 4,532 client referrals from the contracted treatment providers and 4,138 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 327 clients referred to the CARES Mental Health Crisis Line from AUW. To expand Hawai‘i CARES, AUW provided several presentations to various groups around the state (Adult Client Services Branch Resource Fair, 2023 Hawai‘i Health Workforce Summit, Institute on Violence, Abuse, and Trauma-Hawaii Summit etc.). In January 2024, AUW expanded their SUD call center by including talk and text features to allow more flexibility to those who need SUD services/information. ADAD is striving toward a system where the community has a more direct and simplified process of gaining access to SUD treatment across the state and that people can get those services where they need it, when they need it, and how they need it.

Hawaii Opioid Settlement Project

The Department of the Attorney General (AG) secured a Master Settlement Agreement (MSA) as part of a multi-state suit against manufacturers and distributors of opioids due to their roles in

the nationwide opioid crisis. Hawai‘i stands to receive about $100 million over a period of 19 years, starting in 2022, as part of the larger $26 billion settlement with various manufacturers and distributors. A share of the Hawaii opioid settlement funds will go to the Hawaii and Kauai, Honolulu, Maui, and Hawaii counties, which signed onto the MSA.

The ADAD is responsible to work with counties to ensure that settlement funds will go to support treatment, recovery, and harm reduction programs, and other strategies to remediate and address the opioid epidemic. Approximately $33.2 million was received as of June 30, 2024. Current efforts are geared towards the following:

Harm Reduction activities including increased access to free naloxone for those in need; expanded statewide syringe exchange program; purchase of fentanyl test strips; and greater outreach for those with OUD and other substance use disorders who need treatment services.

Support Community Coordination including county grassroots efforts to reduce substance use demand and prevent overdose deaths; and participation in county fentanyl task force events.

Expand Substance Use Treatment activities to increase access to treatment by expanding capacity of residential treatment services; improve community re-entry from jails; work with University of Hawaii to maximize telehealth; and establish mobile medication units for rural populations.

Expand Substance Use Prevention activities including development of a statewide awareness campaign; establish a dedicated website for Hawaii opioid settlement activities; expand DOE naloxone education and distribution; and support after-school prevention programs.

Through regular communication with the AG and counties and interested community stakeholders, the ADAD intends to expand treatment, recovery and prevention services and opportunities for those who need but are not receiving assistance).

Studies and Surveys

Tobacco Sales to Minors. In March 2024, teams made up of youth volunteers (ages 15-20) and adult observers visited a random sample of 328 stores in which the youth attempted to buy tobacco products to determine how well retailers were complying with state tobacco laws. Twenty-four (24) stores sold to the older volunteers (aged 18-20) resulting in a weighted violation rate of 7.3%. All four counties included in the statewide survey had sales. The County of Kauai had two sales, the County of Maui had seven sales, the County of Hawai‘i had three sales, and the County of Honolulu had twelve sales. Due to the small sample size, rates for individual counties are not considered statistically reliable. Fines assessed for selling tobacco to anyone under the age of 21 are $500 for the first offense and a fine of up to $2,000 for subsequent offenses.

Provision of Contracted or Sponsored Training

In Fiscal Year 2023-24, ADAD conducted zoom and on-site training programs that accommodated staff development opportunities for 1,566 healthcare, Department of Education, human service, criminal justice and substance abuse prevention and treatment professionals

through sixty-eight (68) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 5,480 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).

In addition, there was one training for Peer Recovery Specialist that trained twenty-five (25) individuals in completion of the specialization areas for peer recovery specialist. ADAD is currently working on amending the Hawaii Administrative Rule 11.177.1 to adopt this certification.

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; fetal alcohol spectrum disorder (FASD); harm reduction 101; Hawai‘i SBIRT manual overview; Hawai‘i healthcare workforce summit; mental health first aid; virtual summer training series – Hanai Ahu: anchoring culture in substance use treatment and prevention models; addictions conference; international summit preventing, assessing and treating trauma across the lifespan; End Meth summit; a providers guide to legislative advocacy; a harm reduction toolkit for Native Hawaiian communities; Native Hawaiian cultural intervention training series; fundamentals of domestic violence webinar series; 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 use prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of thirty-two (32) prevention service contracts and five (5) treatment service contracts. The focus for contracted treatment and prevention providers this past year was technical assistance and site visits related to program development and implementation, reporting and contract compliance due to the shortage of workforce employees.

Certification of Professionals and Accreditation of Programs

Certification of Substance Use Professionals. In Fiscal Year 2023-24, ADAD processed 404 (new and renewal) applications, administered seventy-four (74) computer-based exams and certified forty-five (45) applicants as substance use professionals, bringing the current number of certified substances use professionals to 1,221.

ADAD is currently working on amending the Hawaii Administrative Rule 11.177.1 to adopt Peer Recovery Specialist certification and remove Co-Occurring Disorder Professional Diplomate certification.

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 2023-24, 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, there are two (2) therapeutic living programs that are working on obtaining accreditation. This will potentially bring the total programs accredited to twenty-three (23).

Clean and Sober Homes Registry

In Fiscal Year 2023-24 ADAD received twenty-five (25) initial applications for the Clean and Sober Registry. Twenty-three (23) were inspected and determined to meet the registry standards and each were issued a Certificate "In Good Standing" as referred to by Hawai‘i Administrative Rules (HAR) Chapter 11-178. Two (2) homes were denied as not meeting the registry standards.

In Fiscal Year 2023-24, there were nine (9) renewals of clean and sober homes statewide, which remain "In Good Standing." To date, there are a total of seventy-nine (79) registered clean and sober homes. There are no homes that are "Not in Good Standing."

Currently, there are twelve (12) new registration applications that are pending further review.

In calendar year 2024, 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, one (1) of which were related to registered clean and sober homes. One (1) of the) 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, 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. ADAD coordinated with stakeholders to develop and plan the launch of the Hawai‘i Overdose Initiative in January, 2025. Legislation enacted during the 2024 Legislative Session that addressed issues affecting the agency included:

- **Act 230, SLH 2024 (HB 1800 CD1), relating to the state budget.** This measure appropriated $58,296 in general funds for 2.00 FTE positions (119205 Admin Specialist III and 95400H Epidemiologist II) as Personal Services and Legislative Adjustments respectively for FY 2025.

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

EMILY ANDRADE Community and Business Affairs – Interim Appointment **DIANA FELTON, M.D.** Medical – 7/1/2021 – 6/30/2025 Vice-Chair **JON FUJII, MBA** Joint appointment to HACDACS and State Council on Mental Health – Interim Appointment **LILINOE KAUAHIKAUA, MSW** Co-Chair Education – Interim Appointment	**JOHN PAUL MOSES, III, APRN-Rx** Pharmacological – Interim Appointment **JAWANA READY, M.D.** Medical – Interim Appointment **KU‘ULEI SALZER, MSW, MPA** Co-Chair Youth Action – 7/1/2022– 6/30/2026 **GREG TJAPKES** Community and Business Affairs – 7/1/2021 - 6/30/2025 **ERIKA VARGAS, LCSW** Community and Business Affairs – 6/30/2021– 6/30/2025

On September 24, 2024, members elected Ku`ulei Salzer-Vitale and Lilinoe Kauahikaua as Co-Chairs as well as Diana Felton as Vice-Chair. Meetings were scheduled for the fourth Tuesday of each month.

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

Priorities discussed during FY 2023-2024 included:

1. **Hawaii Opioid Settlement Advisory Committee (HOSAC)**
2. **Hawaii CARES/988**
3. **Ka Hale Pomaika`i**
4. **Cannabis**
5. **Overdose Prevention Centers**

Overarching Theme: Prevention

The Hawaii Advisory Commission for Drug Abuse and Controlled Substances (HACDACS) is honored to present its annual report, centered on the critical theme of *prevention*. In our ongoing commitment to safeguard the health and well-being of communities across Hawaii, we recognize that prevention is not merely a component of substance use response—it is the foundation of long-term resilience and health for individuals, families, and communities.

Prevention efforts aim to proactively reduce the onset of substance use disorders, mitigate risk factors, and strengthen protective factors that promote healthy behaviors. By investing in preventive education, awareness campaigns, and community-based initiatives, HACDACS seeks to foster a culture where people are equipped with the tools and knowledge to make informed choices. This report highlights efforts to increase access to prevention resources, support community-based coalitions, and engage youth and families in early intervention strategies.

We acknowledge that a successful approach to prevention must be multifaceted, integrating education, access to services, and culturally grounded strategies that resonate with Hawaii's diverse populations. Our partnerships with community organizations, healthcare providers, and governmental agencies ensure that prevention efforts are tailored to meet the unique needs of Hawaii's communities, particularly in underserved areas.

In this year's report, HACDACS reinforces its dedication to a holistic prevention model that not only addresses the immediate risks associated with drug abuse and controlled substances but also supports the broader goal of community resilience. As we continue to tackle the challenges associated with substance use, prevention remains at the heart of our strategy to build a healthier, safer Hawaii for all.

Hawai‘i Opioid Settlement Advisory Committee

This report outlines recent updates presented to HACDACS, covering achievements, challenges, and future topics under discussion. The Hawaii Opioid Settlement Advisory Committee (HOSAC) was established through a Memorandum of Agreement (MOA) between the State of Hawaii and its counties to implement the National Settlement Agreement, specifying committee membership and outlining allowable expenditures.

Program Achievements and Funding Allocation
HOSAC remains optimistic about the potential impact of Opioid Settlement Funds, anticipating progress in opioid and substance use remediation within the next 12 to 36 months. The committee has used these funds to advance numerous programs addressing opioid abuse and harm reduction, including statewide Narcan distribution, fentanyl test strip provision, and the Department of Health's Syringe Exchange and Hepatitis C initiatives.

The Narcan distribution program, originally funded by the State Opioid Response grant, has transitioned to using Opioid Settlement Funds. In 2023, $1,630,473 was allocated to purchase and distribute 35,488 Narcan kits, and in early 2024, an additional $790,303 funded 18,420 kits. For the remainder of 2024, it is projected that $2,365,660 will support the purchase and distribution of 55,260 kits. Currently, Narcan distribution focuses on partnerships with public and nonprofit entities, including the Hawaii Health and Harm Reduction Center, the Hawaii Island Fentanyl Task Force, and the Department of Education, with efforts underway to expand access through vending machines and outreach to college campuses.

In addition, the Hawaii Island Fentanyl Task Force has conducted training for various grassroots organizations, attracting diverse groups across the state, including government agencies, nonprofits, and first responders. The task force model is set to expand, with each county at different stages of establishing similar initiatives.

Key Challenges
Several challenges were identified, with the primary obstacle being access to treatment resources. HOSAC noted a critical need to expand residential and outpatient treatment capacity, especially for Neighbor Island clients who may require transportation to facilities on other islands. Rural area clients also face transportation barriers, and criminal justice stakeholders report wait times of several months for individuals seeking residential treatment. Another unique challenge is continuity of care for incarcerated individuals post-release, where delays in activating Med QUEST insurance impact the ability to continue substance use treatment.

Workforce limitations present additional challenges, as there is an insufficient number of medical providers treating substance use statewide. Preventative initiatives, particularly for middle school students, are also under review. HOSAC is reaching out to educational institutions to assess available after-school programs and collaborating with the City and County of Honolulu's Department of Parks and Recreation to examine the integration of substance use prevention strategies within the Summer Fun Program.

Discussion Points
HOSAC is exploring strategies to increase public access to information on overdose rates and to support grassroots organizations. Staff are scheduled to meet with the Overdose Detection Mapping Application Program (ODMAP) to discuss the feasibility of implementing a program in Hawaii that would make overdose data more accessible.

Cultural Representation and Community Engagement
During the meeting, commissioners highlighted the importance of incorporating cultural approaches within the program. One commissioner mentioned the availability of culturally rooted harm reduction resources, such as Papa Ola Lokahi's cultural resource guide, and suggested a review of ADAD treatment demographics to confirm whether Native Hawaiians remain the largest ethnic group in treatment. Concerns were also raised regarding the absence of cultural representatives on HOSAC, leading to a broader discussion on how cultural values and perspectives could be integrated into HOSAC's mission.

The chair facilitated a discussion on cultural representation, Narcan distribution, and program priorities. Acknowledging the need for greater cultural insight, the MOA allows for subject matter experts to present before HOSAC, and the committee expressed support for exploring

cultural approaches to substance use treatment. Additionally, efforts are underway to improve public access to HOSAC's work through a new website featuring meeting schedules and materials.

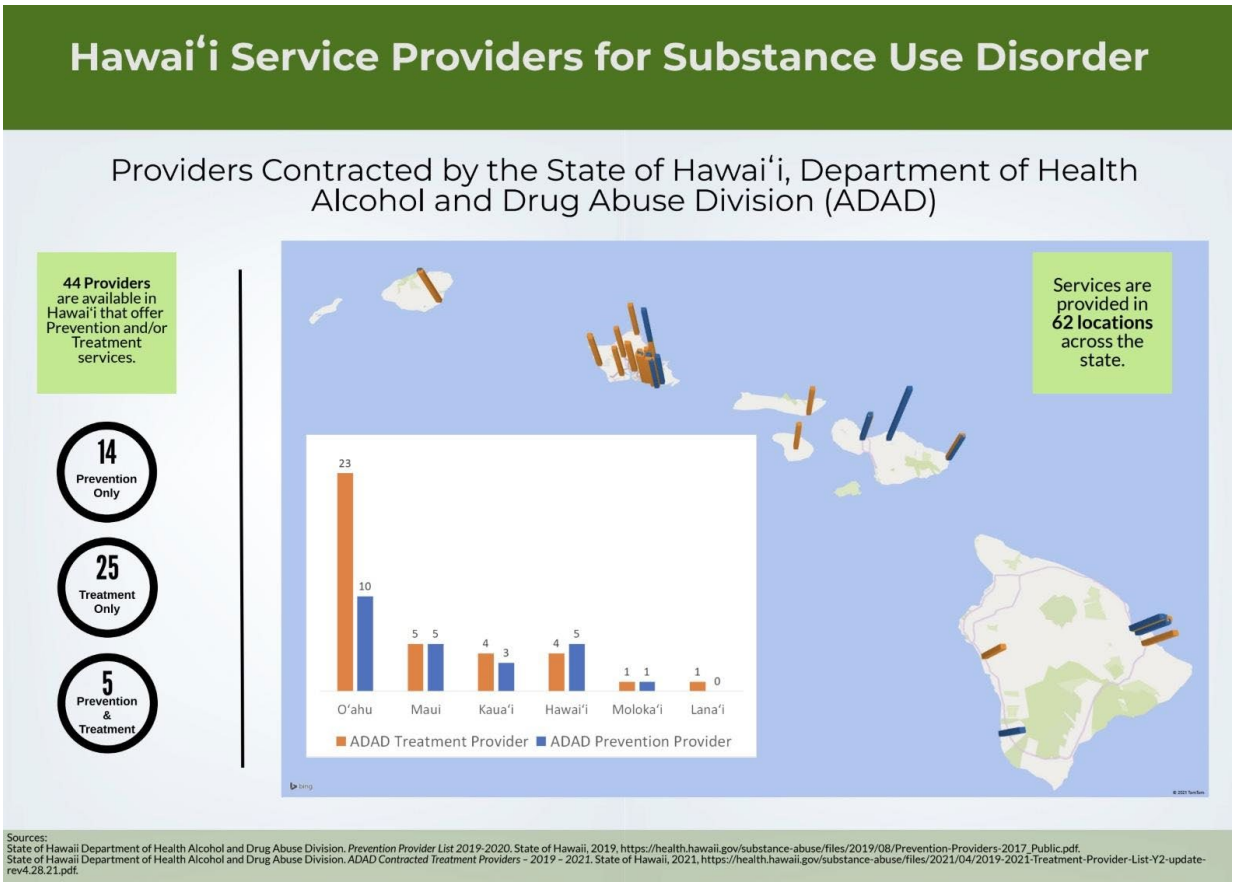
Upcoming Initiatives

HOSAC is preparing a Request for Proposal (RFP) to expand treatment capacity through mobile medication units. A renewed Hawaii Opioid Initiative (HOI) will be relaunched in January 2025, with a new contractor engaged to oversee operations. Listening sessions with HOI participants are in progress to gather insights on past successes and areas for improvement. HOSAC is also finalizing its long- and short-term priorities.

> ***HACDACS recommends*** enhancing the availability of treatment options by expanding the network of providers using mobile units to deliver medication-assisted treatment (MAT) to underserved areas.
>
> ***HACDACS recommends*** that HOSAC include a Cultural Specialist, Practitioner, or Expert on any advisory or planning councils, to ensure culturally relevant practices and perspectives are embedded within its initiatives.
>
> ***HACDACS recommends*** launching a comprehensive public messaging effort to increase awareness of prevention strategies, naloxone use, Xylazine and Fentanyl test strips, and medication-assisted treatment (MAT) options.
>
> ***HACDACS recommends*** that HOSAC build cohesive collaborations with the Hawaii Opioid Initiative and county-level fentanyl task forces to streamline resources and strategies.
>
> ***HACDACS recommends*** equipping Emergency Department personnel with the necessary training to initiate buprenorphine treatment for patients experiencing opioid use disorder.

Hawaii CARES/988

The Hawaii Coordinated Access Resource Entry System (CARES) plays a vital role in providing mental health and substance use disorder (SUD) services throughout Hawaii and American Samoa. The system includes Hawaii CARES 988, a 24/7 crisis and suicide call center that offers culturally competent services to both adults and children. These services are available via call, text, and chat, providing immediate crisis intervention, risk assessments, and follow-up care.



Counselors are trained in specialized areas such as suicide intervention and crisis management, ensuring that callers receive appropriate care based on the severity of their needs. The service has been particularly beneficial for hearing-impaired individuals and teenagers who may be experiencing triggers related to family dynamics. Additionally, crisis stabilization beds, available on Oahu, Maui, and the Big Island, provide short-term (3-10 days) sub-acute care for individuals in crisis. From July 2022 to June 2023, 31.3% of these beds were utilized by individuals with co-occurring mental health and substance use disorders.

In 2023, Hawaii CARES received 98,703 inbound calls, with approximately 32.45% related to mental health, substance use, or co-occurring conditions. The highest number of calls came from Oahu, followed by Hilo, Kona, Maui, Kauai, Molokai, and Lanai, with some calls also originating from American Samoa and other states. The Aloha United Way (AUW) 211 call center, which handles substance use disorder referrals, is available daily but not 24/7. When AUW is unavailable, Hawaii CARES refers SUD-related calls to AUW, which follows up with clients the following day. Crisis support services include Crisis Mobile Outreach, Crisis Support Management, and Certified Peer Specialist Support Services, with additional community outreach efforts aimed at expanding service awareness and engagement.

Between April 2022 and May 2024, AUW received 8,795 calls, with 4,711 callers undergoing Universal Standardized and Intake Screening (USIS), resulting in 3,196 clients being referred to ADAD service providers. In addition, 8,386 clients were referred to AUW for review by ADAD service providers, and AUW made 13,132 outgoing calls to coordinate care between clients and

providers. In December 2023, data indicated that 47% of clients were using prescription or over-the-counter medications, and 90% of clients had health insurance, with 85% covered by Medicaid. Substance misuse, including alcohol, methamphetamine, marijuana, and other sedatives, was common among clients, with the highest numbers of clients coming from Honolulu, followed by Maui, Hawaii, and Kauai. Hawaii has the 12th lowest suicide rate nationwide, with Honolulu, Hawaii County, Maui County, and Kauai County having the highest suicide rates

While Hawaii CARES has made significant progress in crisis response and mental health services, several areas need improvement. One key area is cultural awareness, particularly in identifying and developing culturally appropriate service providers and practitioners. There is a need to create a more robust network of culturally competent providers to ensure that the services offered are in alignment with the cultural values of Hawaii's diverse populations. Malu I Ka ʻulu, an organization that specializes in culturally responsive crisis response, could be a valuable partner in expanding these services. Additionally, there is a need to support the development and expansion of youth warm-line services, which provide peer-supported, culturally sensitive care for young people experiencing mental health or substance use challenges. Expanding the network of treatment and prevention providers is also a priority to improve the referral process and ensure that clients receive timely care. Lastly, resources on the neighbor islands must be strengthened to address service gaps, particularly in crisis stabilization and peer support services.

> ***HACDACS recommends*** strengthening collaboration with culturally focused providers by streamlining referral processes to ensure timely connections to culturally appropriate care. This includes partnering with organizations like Malu I Ka ʻUlu to train staff and develop a comprehensive directory of cultural practitioners.
>
> ***HACDACS recommends*** expanding culturally responsive care training and tools by focusing on Native Hawaiian and Pacific Islander communities. This includes utilizing findings from the needs assessment to create a screening tool for Hawaii CARES that enhances referrals to Native Hawaiian culture-based treatment and prevention services.
>
> ***HACDACS recommends*** supporting the development and expansion of youth warm-line services to provide peer-supported, culturally sensitive care for young people experiencing mental health or substance use challenges. This initiative should address youth-specific needs and incorporate cultural identity and values into service delivery.
>
> ***HACDACS recommends*** expanding the network of treatment and prevention providers to improve referral pathways and ensure timely access to culturally appropriate care. This includes increasing collaboration with community-based organizations and enhancing provider capacity to meet diverse client needs.
>
> ***HACDACS recommends*** expanding resources on neighbor islands to address service gaps in crisis stabilization, peer support, and treatment access. Investments should prioritize culturally responsive services and infrastructure to better serve rural and underserved communities.

Ka Hale Pomaika’i

Ms. Shari Lynn presented an insightful overview of the cultural perspectives of recovery communities, with a specific focus on Ka Hale Pomaika'i, an all-volunteer recovery community organization (RCO) established in 1996 on Moloka'i to meet the unique needs of the local community. The organization began with a focus on initiatives such as a clean and sober house, 12-step support groups, and a farm, all driven by volunteers in recovery. The shared passion for recovery was the cornerstone of the community's engagement, which included activities like sharing recovery stories at community events, participating in Recovery Month with sign holding, and partnering with other agencies to support initiatives like food distribution.

Despite facing early funding challenges, Ka Hale Pomaika'i initially received a modest $2,000 from Papa Ola Lokahi. However, the organization's efforts were significantly bolstered when the late Senator Dan Inouye secured $200,000 in federal funding after observing the services provided to the community during his visit to Moloka'i. This funding enabled the organization to expand its services, and in 2009, Ka Hale Pomaika'i transitioned to providing formal treatment services. As a proactive RCO, it supported former recovery participants in pursuing education and certifications, such as becoming Certified Substance Abuse Counselors (CSACs), who now play a key role in delivering treatment services. Today, Ka Hale Pomaika'i is the only treatment facility on Moloka'i, offering wraparound services that support recovery and teach social skills. The organization continues to hire peers from the program who have since become CSACs, further strengthening the community's recovery network.

The vision of Ka Hale Pomaika'i is rooted in a deep respect for life and community, embracing the belief that life is a gift from Akua, and it is meant to be cherished and sustained in harmony with oneself, one's family, and the broader community. The organization’s restorative agency goals focus on embracing anti-racist approaches that recognize the intersection of race, gender, and class oppression. They also aim to restore access to traditional food cultivation, honor Hawaiian culture, and build a workforce reflective of Moloka'i's community.

Ka Hale Pomaika'i has seen positive outcomes through its culturally grounded recovery initiatives. Native Hawaiian individuals have engaged with the organization's services, addressing both sobriety and food security. Alumni peers continue to assist in supported community activities, and many former participants have become educated, empowered, and employed as CSACs. While treatment providers are often required to implement evidence-based practices, Ka Hale Pomaika'i has found that practice-based evidence, grounded in Hawaiian cultural values and teachings, yields more sustained positive outcomes. The organization recognizes that isolation is a hallmark of addiction and works to end this isolation by fostering strong relationships, or pilina, which play a crucial role in the recovery process. By maintaining close ties to the community, Ka Hale Pomaika'i helps combat the stigma associated with addiction and promotes a positive public image that encourages respect for those in recovery.

The programs offered by Ka Hale Pomaika'i have a strong cultural focus because they align with the needs of the local community. One of the key elements of this focus is Mala Farm, which not only aids in the healing process but also provides organic food to the community. The farm's produce stand serves the community by offering fresh, locally grown food. The farm's practice of providing participants with three bags of produce—one for themselves, one for the community, and one to share with someone who has helped them—strengthens the tradition of giving first,

rather than just giving back. Recovery Ambassadors, individuals who have transitioned out of the program, serve as peers who welcome and support newcomers. These ambassadors play a vital role in helping individuals reintegrate into the community and find their footing in recovery.

Ka Hale Pomaika'i's work has been recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA), which visited Moloka'i to observe the organization's operations. Following the visit, the organization presented on its successes, challenges, and future goals. Among the successes highlighted were the use of an 'aina-based cultural approach to recovery, the provision of the only safe and sober living program addressing homelessness on the island, and efforts to address food insecurity through farming and traditional resources. However, the organization also faces challenges, particularly related to the limited resources available in rural communities. There are difficulties in hiring and retaining employees who are familiar with and committed to Moloka'i's unique ways, and the normalization of alcohol and drug (AOD) use, as well as gambling, within the family structure, poses additional barriers.

Looking to the future, Ka Hale Pomaika'i plans to offer scholarships as incentives for local individuals in recovery to pursue education and give back to their community. Reducing stigma through community events and honoring the past are also key goals for the organization. A video presentation featured a personal story of one individual who shared their journey to recovery through the program, further illustrating the powerful impact of Ka Hale Pomaika'i's work.

During the discussion, several challenges were noted regarding outpatient treatment. Specifically, there is a shortage of medical providers on Moloka'i to prescribe medications like buprenorphine, Vivitrol, and Sublocade, which are essential for medication-assisted treatment (MAT). Recently, fentanyl was detected in methamphetamine drug tests on Moloka'i, indicating a new and alarming trend. The island's lack of local providers for MAT raises concerns about the proper management of clients' medications, especially for those prescribed a 30-day supply. The Commission recommended exploring partnerships with the Hawai'i Health and Harm Reduction Center to address this issue and suggested including recommendations for medically monitored stabilization beds in the HACDACS annual report. The lack of consistent air transportation to and from Moloka'i also presents a barrier, particularly when clients need to travel off-island for treatment.

In conclusion, Ka Hale Pomaika'i represents a model of culturally responsive recovery services that emphasizes community, cultural values, and peer support. Despite facing significant challenges, particularly related to funding, staffing, and access to medication-assisted treatment, the organization has had a profound and positive impact on the Moloka'i community. Moving forward, increasing resources, expanding access to treatment, and addressing transportation and staffing issues will be key to sustaining and enhancing the organization's success.

> ***HACDACS recommends*** prioritizing rural and remote communities in the allocation of substance use funding to ensure that underserved areas receive the necessary resources and support for recovery services.
>
> ***HACDACS recommends*** expanding culturally based recovery models that operate independently of traditional treatment services, recognizing the importance of culturally relevant approaches in supporting long-term recovery.

HACDACS recommends developing peer-led support networks with livable wages, recognizing peer support as a cornerstone of the recovery process. While private insurance reimbursement for peer specialists (e.g., Medicaid at $15.19 per 15-minute session as outlined by the Peer Recovery Center of Excellence) is one pathway to sustain these networks, it also poses a burden on many smaller healing centers. We proposed emphasizing the inclusion of Peer Recovery Support Services (PRSS) funding in funding applications. Such funding should reflect livable wages and prioritize equitable financial support for remote and rural communities. These communities heavily depend on the cultural expertise and lived experience of recovering peers, who serve as mentors and outreach providers. By pursuing funding over insurance billing, we can ensure a more equitable access and culturally grounded services in areas where they are most needed.

HACDACS recommends building the capacity of culturally based recovery community organizations to strengthen local support systems and provide a more personalized approach to recovery that aligns with community values and traditions.

HACDACS recommends supporting the development of supportive housing to provide stable living environments for individuals in recovery, which is essential for ensuring long-term success and stability in the recovery process.

HACDACS recommends increasing transparency and flexibility in funding processes for treatment facilities better to support culturally grounded approaches in treatment and recovery. Organizations like Ka Hale Pomaikaʻi, which utilize practice-based evidence rooted in Hawaiian cultural values, should not be required to conform to rigid funding criteria that prioritize Western evidence-based practices. Instead, ADAD should adapt its application and reporting requirements to recognize and uplift Indigenous and cultural approaches that demonstrate sustained positive outcomes, including pilina (relationships), community engagement, and ʻāina-based healing practices. This approach will ensure that funding aligns with the unique needs and strengths of Hawaii's diverse communities.

Cannabis

In September 2024, HACDACS received an update from The Department of Health's Office of Medical Cannabis Control and Regulation and their preparations for the possible legalization of recreational cannabis in Hawaii.

Recreational cannabis legalization will be a legislative consideration in the 2025 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 any foundational legislation. 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, and increasing yearly, for the Department of Health's Alcohol and Drug Abuse Division (ADAD) funded adolescent substance use treatment admissions at 76%, with alcohol a distant second place at 21%. Legalization of recreational cannabis runs counter to ADAD's mission and Department of Health goals for prenatal health. 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 well as current medical cannabis patient's access to treatment. As described in the American Society for Addiction Medicine's 2021 Public Policy Statement on Cannabis, 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 including funding substance use disorder prevention and treatment programs, public safety programs to reduce impaired driving and monitor black market activity, and public awareness campaigns about the risks of cannabis use, including cannabis use disorder.

HACDACS has significant reservations about the potential negative effects of the legalization of recreational cannabis. 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*** the development and implementation of a public health education and prevention campaign in advance of the implementation of legalization.
>
> ***HACDACS recommends*** consideration for the protection of current patient access to medicinal cannabis products.
>
> ***HACDACS recommends*** incorporating safety measures into legalization legislation 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*** 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.

Overdose Prevention Centers

Overdose Prevention Centers (OPC) are also referred to as drug consumption rooms, safe injecting sites, supervised injecting facilities, supervised consumption sites, and other similar terms. These are facilities where persons can consume drugs they have obtained elsewhere, under the supervision of trained staff, without fear of arrest, and out of public view.

The first OPC opened in 1986 and sites have operated for decades in Europe, Australia, and Canada and there are currently 200 OPCs in 14 countries across the world. In the United States, Rhode Island, Minnesota, Vermont, and NYC have authorized OPCs. Fifteen additional states are considering legislation to authorize OPCs.

According to data from the Hawaii Department of Health, there were 916 unintentional overdose deaths in Hawaii from 2020-2022. OPCs can prevent drug-related overdose deaths especially those caused by fentanyl and other potent opioids. OPCs can also reduce transmission of blood borne infections due to sharing of injection equipment and connect persons who use drugs with drug treatment and other health and social services. Additionally, OPCs are valuable because they have ancillary benefits such as:

- Reduced public drug use
- Community reduction of improperly discarded used syringes
- Less Emergency Room visits and ambulance transports
- Cost savings
- Cost-Benefit Analyses show OPCs can save governments millions of dollars in healthcare costs, based on averted overdose deaths, decreased Emergency Department visits, infectious disease transmission, reduced skin and soft tissue infections, and increased uptake of medication-assisted opioid use disorder.
- Economic models show that an OPC in San Francisco would cost $1.5M while saving $3.5M in healthcare costs and an OPC in Baltimore costing $1.8M would save $7.8M annually in healthcare costs.

There is extensive peer-reviewed scientific and economic evidence demonstrating the benefits of OPCs including but not limited to:

- The American Medical Association, the American Public Health Association, and the American Society of Addiction Medicine endorse OPCs.
- A 2022 survey by Data for Progress of 1,260 likely voters founds that 64% support OPCs.
- Brown University: http://opcinfo.org/ with fact sheets OPC Health Impacts, OPC Treatment Uptake, OPC Cost effectiveness, OPC Community Impacts.
- Dozens of peer-reviewed articles have examined the effect of OPCs on overdose prevention, treatment referrals, and cost-effectiveness:

- Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. Overdose Prevention Centers. https://nida.nih.gov/sites/default/files/NIH-RTC-Overdose-Prevention-Centers.pdf
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The creation of Overdose Prevention Centers in Hawaii would save lives and health costs and have lasting benefits to the community.

> ***HACDACS recommends*** consideration of legislative policy change to enable the creation of overdose prevention centers in Hawaii.

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 2023-24, 1,150 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 1,651 offenders who received services, 275 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2023-24 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, 2023 – June 30, 2024

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
O'ahu	131	1028	96	1255
Maui	32	87	10	129
Hawaii	32	174	11	217
Kauai	8	40	2	50
Total	203	1329	119	1,651

Case management services providers: Action with Aloha, Bobby Benson, CARE Hawaii, Child and Family Service, Ka Hale Pomaika'i, Malama Family Recovery Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Services

Table 2. Referrals by Criminal Justice Agency: July 1, 2023 – June 30, 2024

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
O'ahu	107	662	74	843
Maui	24	40	6	70
Hawaii	26	135	10	171
Kauai	5	55	6	66
Total	162	892	96	1150

Case management services providers: Action with Aloha, Bobby Benson, CARE Hawaii, Child and Family Service, Ka Hale Pomaika'i, Malama Family Recovery Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Service

Table 3. Carryover Cases by Criminal Justice Agency: July 1, 2023 – June 30, 2024

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	Hawaii Paroling Authority	Total
O'ahu	21	157	10	188
Maui	3	28	4	35
Hawaii	1	41	1	43
Kauai	2	7	0	7
Total	27	233	15	275

Case management services providers: Action with Aloha, Bobby Benson, CARE Hawaii, Child and Family Service, Ka Hale Pomaika'i, Malama Family Recovery Center, Salvation Army- Addiction Treatment Services, Salvation Army-Family Treatment Service

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

The 53.8% recidivism rate for FY 2016 probationers and parolees was lower than the previous

year's rate of 61.7%. The FY 2016 recidivism rate is 19.1% lower than the recidivism rate reported in the FY 1999 baseline year, far from the goal of reducing recidivism in 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 2021-24

B. ADAD-Funded Adolescent Services: Fiscal Years 2021-24

C. Performance Outcomes: Fiscal Years 2021-24

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 2021-2024

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Male	67.3%	67.3%	67.0%	69.9%
Female	32.7%	32.7%	33.0%	30.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Hawaiian	48.0%	44.9%	47.0%	44.0%
Caucasian	20.6%	21.0%	16.1%	20.7%
Filipino	7.0%	7.1%	6.0%	4.6%
Mixed - Not Hawaiian	5.4%	6.8%	8.2%	6.0%
Japanese	2.8%	2.7%	3.8%	3.7%
Black	1.4%	3.4%	1.7%	2.1%
Samoan	2.2%	2.6%	2.4%	2.5%
Portuguese	1.5%	1.0%	2.2%	1.7%
Other Pacific Islander	4.6%	5.2%	6.5%	7.1%
Other*	6.5%	5.3%	6.1%	7.5%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Methamphetamine	60.6%	53.5%	61.2%	57.3%
Alcohol	12.1%	19.5%	16.6%	20.9%
Marijuana	10.6%	12.3%	8.6%	8.1%
Cocaine/Crack	1.6%	1.5%	2.5%	2.8%
Heroin	10.0%	8.9%	6.9%	5.0%
Other*	5.1%	4.3%	4.1%	6.0%
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 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
O'ahu	53.7%	49.6%	56.2%	53.0%
Hawaii	27.0%	34.3%	28.7%	35.9%
Maui	10.8%	6.7%	7.1%	4.4%
Molokai/Lanai	1.2%	0.6%	0%	0.2%
Kauai	3.1%	2.7%	3.0%	2.5%
Out of State	4.2%	6.1%	5.1%	4.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2020-21 through Fiscal year 2023-24, methamphetamine admissions saw a slight drop in proportion in the most recent year – from 61.2% to 57.3%. Conversely, alcohol admissions saw an increase to 20.9% from previous year's 16.6%. Marijuana continued to be about the same as the previous year, going from 8.6% down to 8.1% of admissions. Cocaine/Crack admissions have also held mostly constant in comparison to previous year, going slightly up from 2.5% last year to 2.8% this year. Heroin has continued to trend downwards across the previous four years. Admissions for all "Other" substances saw an increase to 6% last year.

Also, among the adult admissions for FY 24, 31.6% were homeless when admitted to treatment. This proportion is consistent with previous year rates.

APPENDIX B

ADAD-FUNDED ADOLESCENT[5] SERVICES FISCAL YEARS 2021-2024

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Male	55.5%	45.2%	38.9%	31.6%
Female	44.5%	54.8%	61.0%	68.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Hawaiian	45.6%	44.4%	42.1%	47.2%
Caucasian	8.1%	9.0%	7.7%	10.5%
Filipino	5.6%	8.9%	11.3%	11.3%
Mixed - Not Hawaiian	5.4%	7.0%	6.1%	5.1%
Japanese	1.8%	2.8%	1.7%	1.2%
Black	1.4%	1.5%	1.2%	2.8%
Samoan	4.7%	3.5%	4.2%	4.2%
Portuguese	0.0%	0.7%	0.5%	0.4%
Other Pacific Islander	24.2%	17.6%	21.5%	13.0%
Other*	3.2%	4.5%	3.8%	4.3%
TOTAL	100.0%	100.0%	100.0%	100.0%

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

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Methamphetamine	1.8%	0.8%	2.0%	1.1%
Alcohol	17.1%	15.9%	21.0%	17.9%
Marijuana	71.1%	71.0%	76.2%	59.5%
Cocaine/Crack	0.2%	0.7%	0.0%	0.1%
Heroin	0.0%	0.0%	0.0%	0.0%
Tobacco	-	-	-	20.3%
Other	9.9%	11.6%	0.8%	1.1%
TOTAL	100.0%	100.0%	100.0%	100.0%

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

ADAD-FUNDED ADOLESCENT ADMISSIONS BY RESIDENCY

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
O'ahu	84.4%	32.5%	76.9%	81.2%
Hawaii	2.9%	38.7%	1.0%	0.9%
Maui	12.2%	17.3%	22.1%	17.9%
Molokai/Lanai	0.0%	5.2%	0.0%	0.0%
Kauai	0.5%	6.4%	0.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

[5] Adolescent: Grades 6 through 12

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2020-21 through Fiscal Year 2023-24, methamphetamine decreased from 1.8% to 1.1%. Alcohol was approximately steady starting at 17.1% and ending at 17.9%. Marijuana decreased considerably from 71.1% to 59.5%. Cocaine/Crack decreased from 0.2% to 0.1%. Tobacco was introduced as a Primary Substance; previous data did not exist. All "Other" substances decreased from 9.9% to 1.1%.

Community profiles by the State Epidemiological Outcomes Workgroup (SEOW) and the results of Student Health Surveys administered in 2013, 2015, 2017, 2019 and 2021 are consistent with the ADAD-Funded Adolescent Treatment Admissions by primary substance in that Marijuana and Alcohol are the primary substances of choice for use by person in Hawaii, ages 12-25. (Tobacco was not evaluated in the Hawaii State Epidemiological Profile). Community-based programs report similar trends based on qualitative data informally gathered at the local community level and therefore, are directing prevention education and strategies and social norm activities to younger ages and families as well as youth ages 12-17 and young adults.

APPENDIX C

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2023 through 2024, 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 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Employment/School/Vocational Training	98.6%	99.2%	99.7%	98.8%
No arrests since discharge	98.0%	99.2%	96.3%	99.4%
No substance use in 30 days prior to follow-up	47.1%	39.4%	37.1%	35.7%
No new substance abuse treatment	89.2%	89.7%	80.1%	84.6%
No hospitalizations	96.3%	98.4%	96.3%	94.2%
No emergency room visits	94.2%	96.9%	91.2%	91.4%
No psychological distress since discharge	79.7%	89.0%	77.0%	77.8%
Stable living arrangements*	96.9%	97.6%	99.7%	99.8%

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

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2023 through 2024, 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 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Employment/School/Vocational Training	51.6%	46.7%	73.3%	83.4%
No arrests since discharge	96.5%	98.0%	97.5%	96.9%
No substance use in 30 days prior to follow-up	61.9%	57.0%	30.6%	47.2%
No new substance abuse treatment	69.1%	76.8%	71.3%	60.2%
No hospitalizations	94.8%	86.4%	94.4%	96.6%
No emergency room visits	90.2%	94.4%	86.4%	93.8%
Participated in self-help group (NA, AA, etc.)	27.4%	28.1%	32.3%	49.4%
No psychological distress since discharge	75.1%	82.1%	70.7%	78.8%
Stable living arrangements*	73.6%	90.4%	73.6%	97.6%

**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 2020 to Fiscal Year 2024) average annual ADAD-funded admissions for adults is 1,992, which is 2.6% 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.

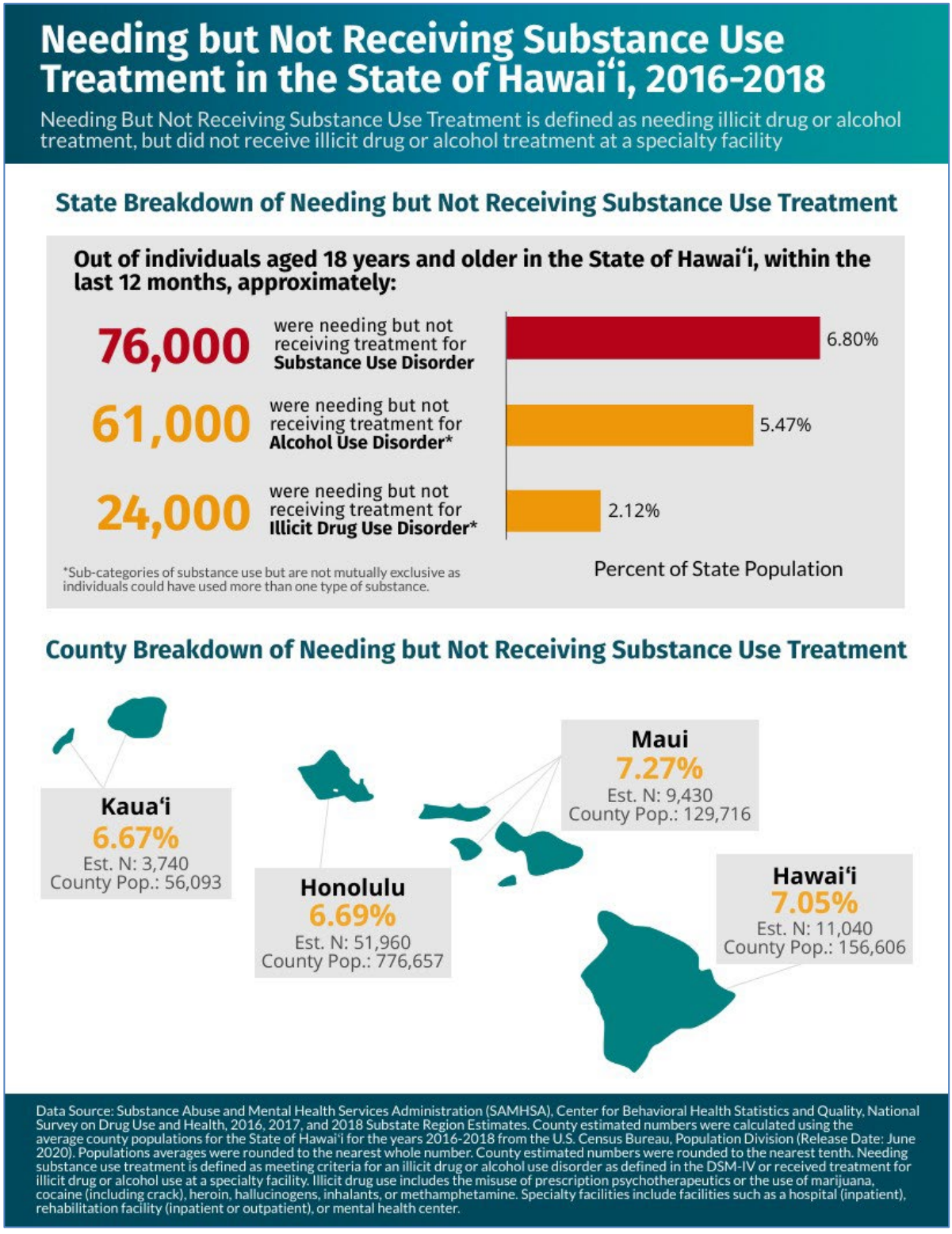


Table D2: Substance Use Disorder in the Past Year among Individuals Aged 18 or Older, by State and Substate Region: Annual Averages Based on 2016, 2017, and 2018 NSDUHs										
	Percent of State Population (County Population)									
	Kaua‘i		Honolulu		Maui		Hawai‘i		State	
Population (18 Years and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

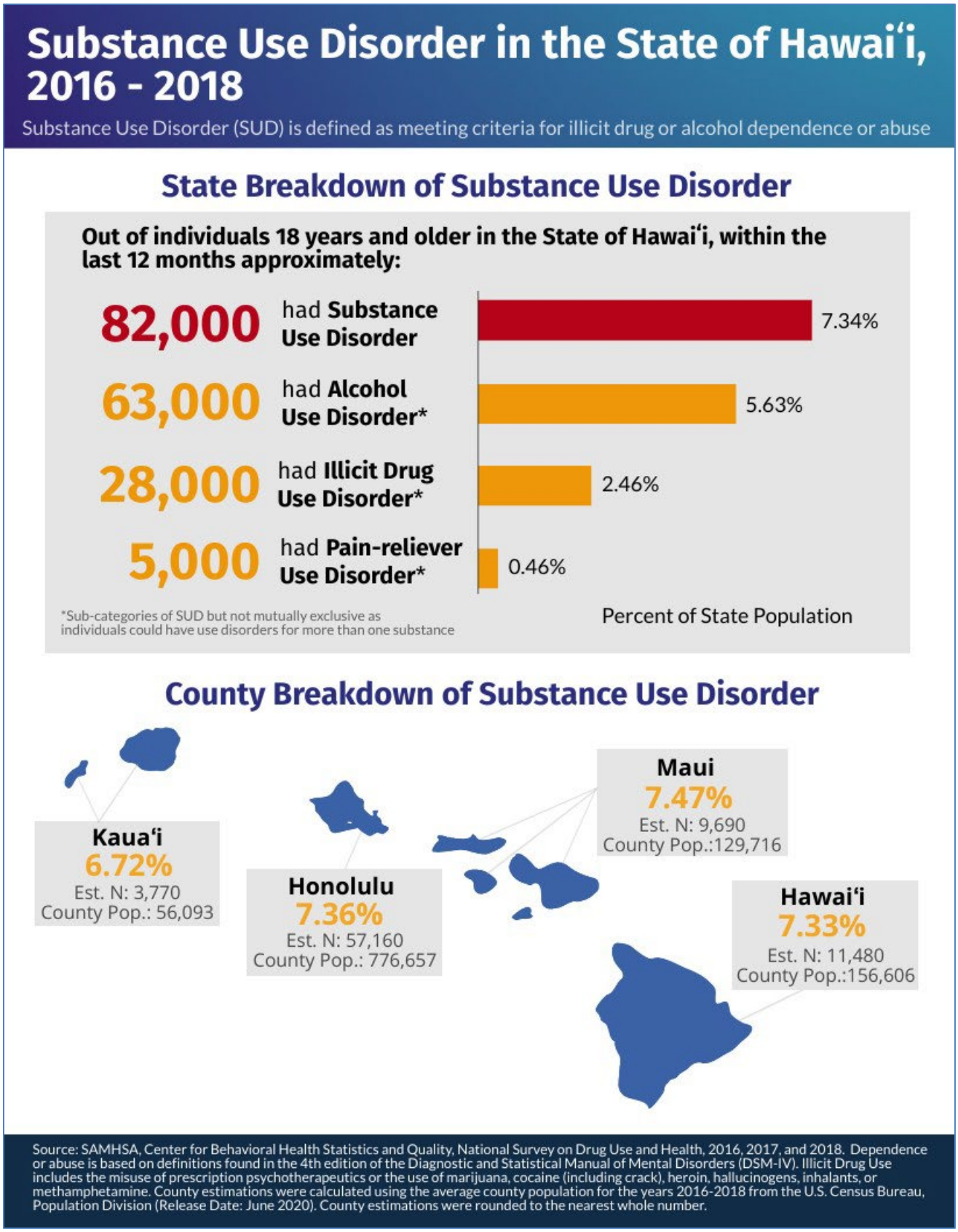
For *Hawai‘i County*, 11,480 (7.33%) of individuals aged 18 and older on the Big Island had substance use disorder in the past year.

[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.

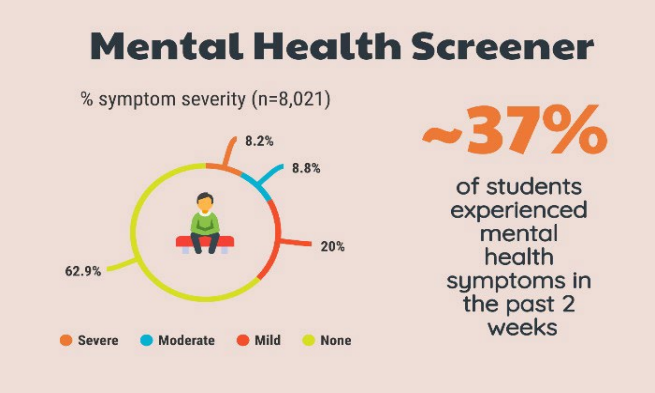
The table above provides the estimated percentages of students with probable substance use disorders overall by gender, grade, and primary race/ethnicity:

[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.

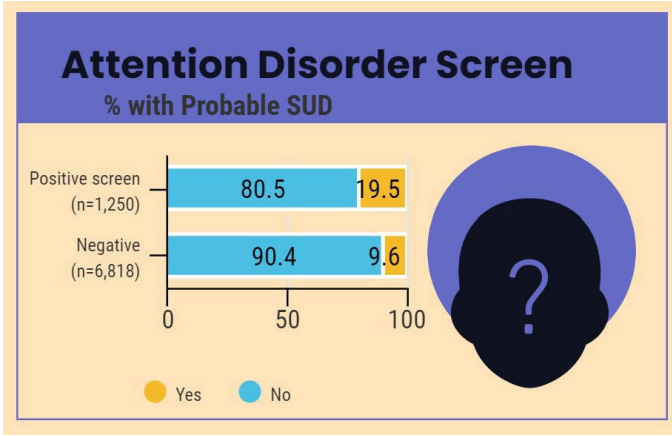
[2] While the survey asks students to select a group with which they primarily identify, a large proportion reported primarily identifying with multiple (2 or more) ethnic/racial groups. Among those who selected two or more ethnic/racial groups in the state sample, Native Hawaiian was among the highest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

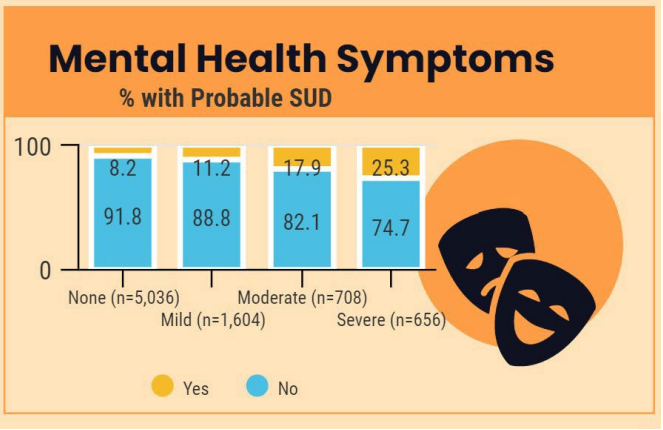
- The overall total estimated treatment needs across the state ***increased*** to 11.1% compared to 7.7% reported from the 2007-2008 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study.
- ***Transgender and Other Gender Minority*** students make up the smallest proportion of the state sample but 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 2020 to Fiscal Year 2024) average annual ADAD-funded admissions for adolescents is 759 which is 8.43% of the estimated need for adolescent alcohol and drug use treatment.

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

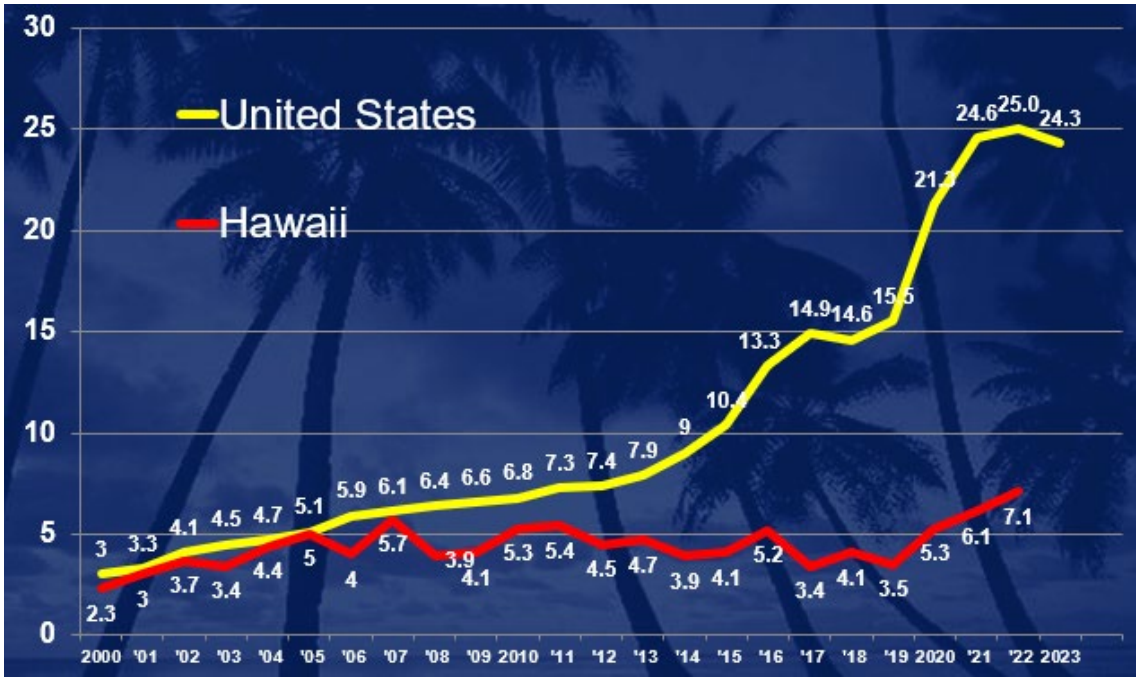
Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also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

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

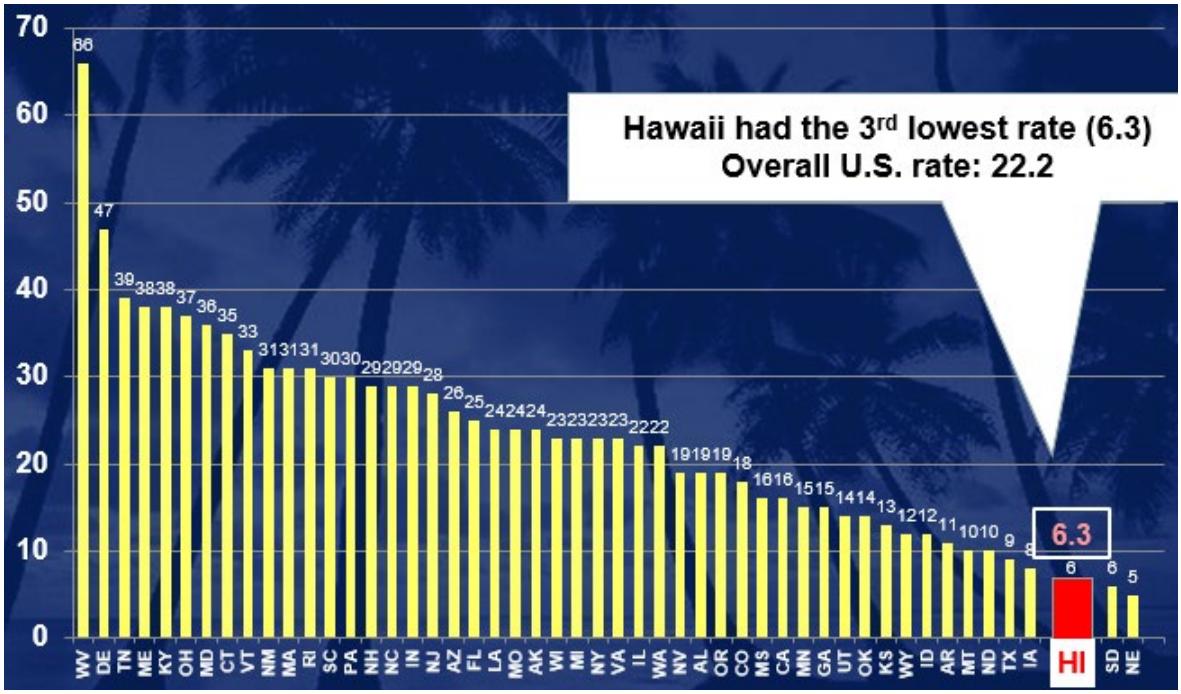
Data from the Centers for Disease Control's (CDC) WONDER system, a national public health dataset shows that Hawaii opioid poisoning fatality rates appear to be trending slightly upward (7.1 in 2022), a slight increase from the 2016 rate of 5.2 (Figure 1) while the national rate has increased since 2000 but has showing a slight decrease (24.3 in 2023 down from 25.0 in 2022).

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



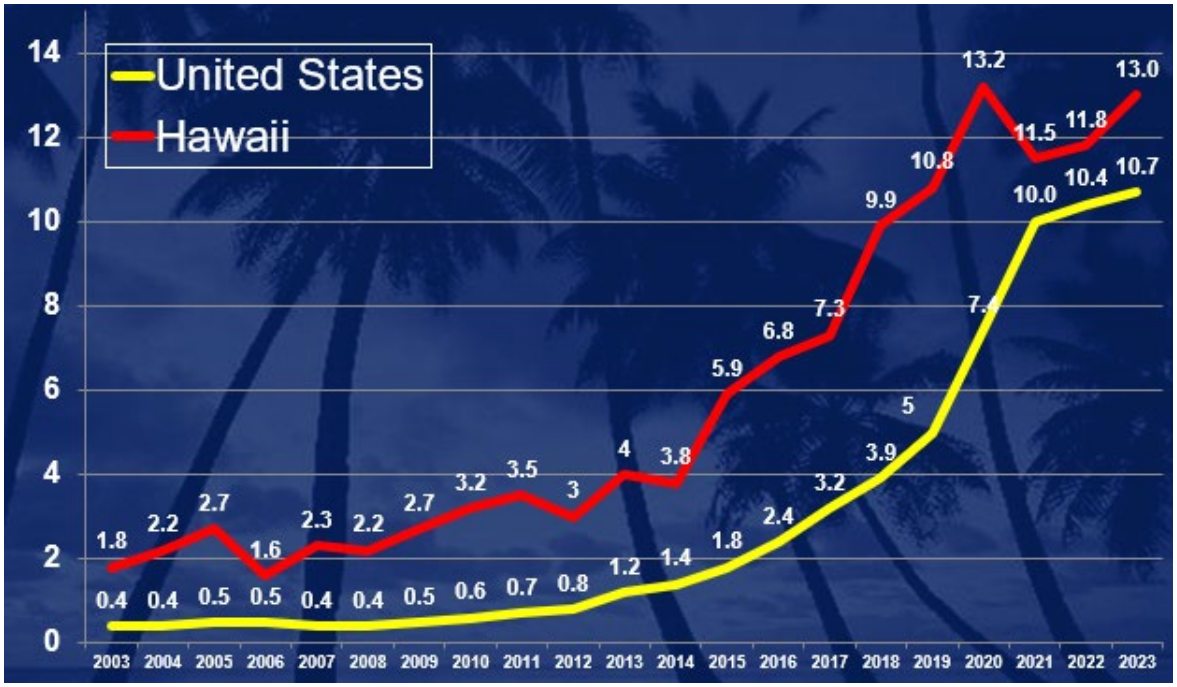
And when compared to other states, Hawaii now has the third *lowest* fatality rate of poisonings due to opioids (6.3) which is also well below the national rate of 22.2 (Figure 2).

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



*Data for 2023 is provisional.

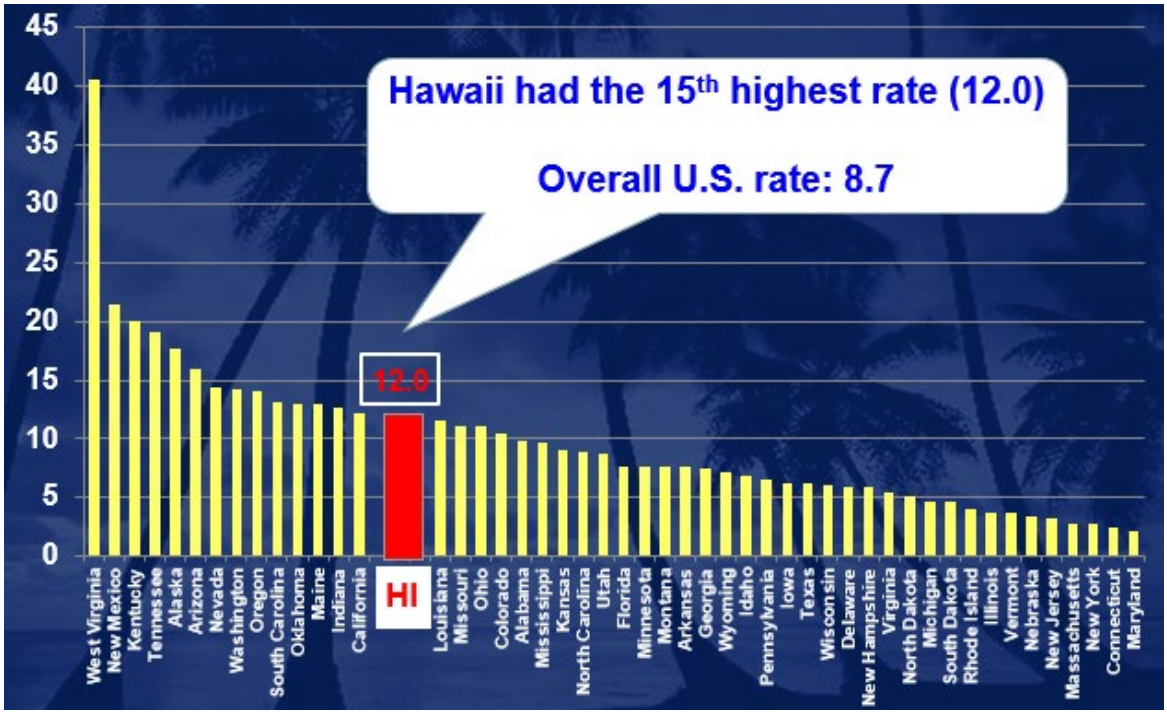
Figure 3. Annual adjusted poisoning fatality rates involving psychostimulants (per 100,000), Hawaii vs. U.S., 2003-2023.



* Code indicating psychostimulants with abuse potential.

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

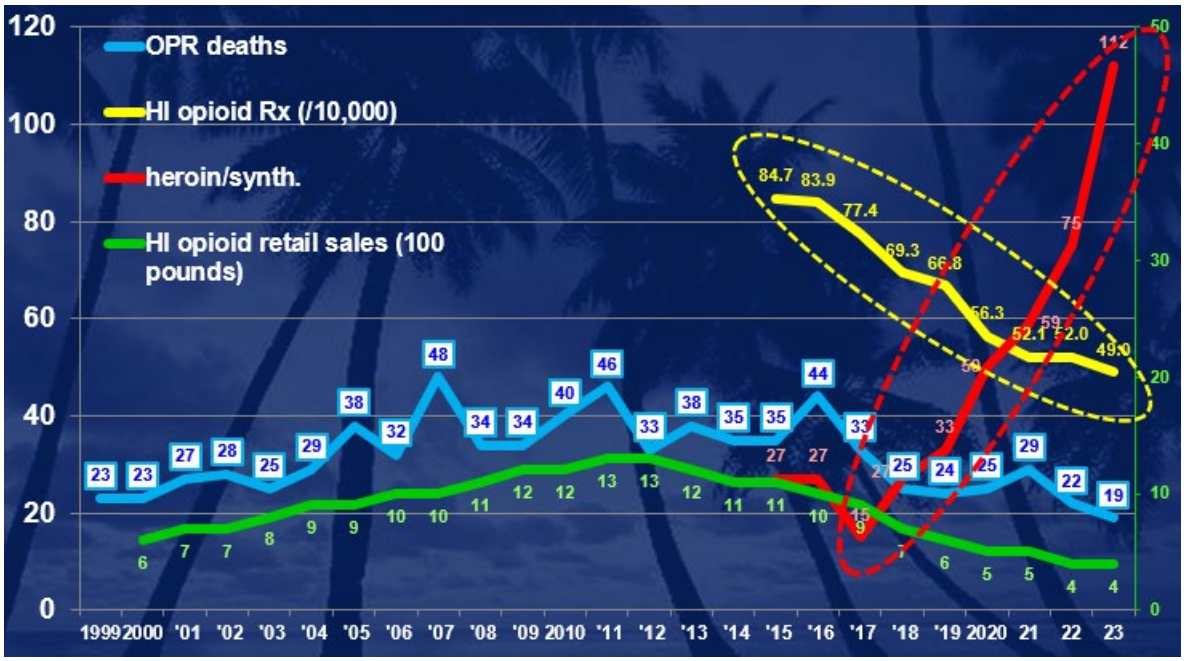
Figure 4. Average adjusted poisoning fatality rates involving psychostimulants (per 100,000), by state, 2019-2023.



* Code indicating psychostimulants with abuse potential.

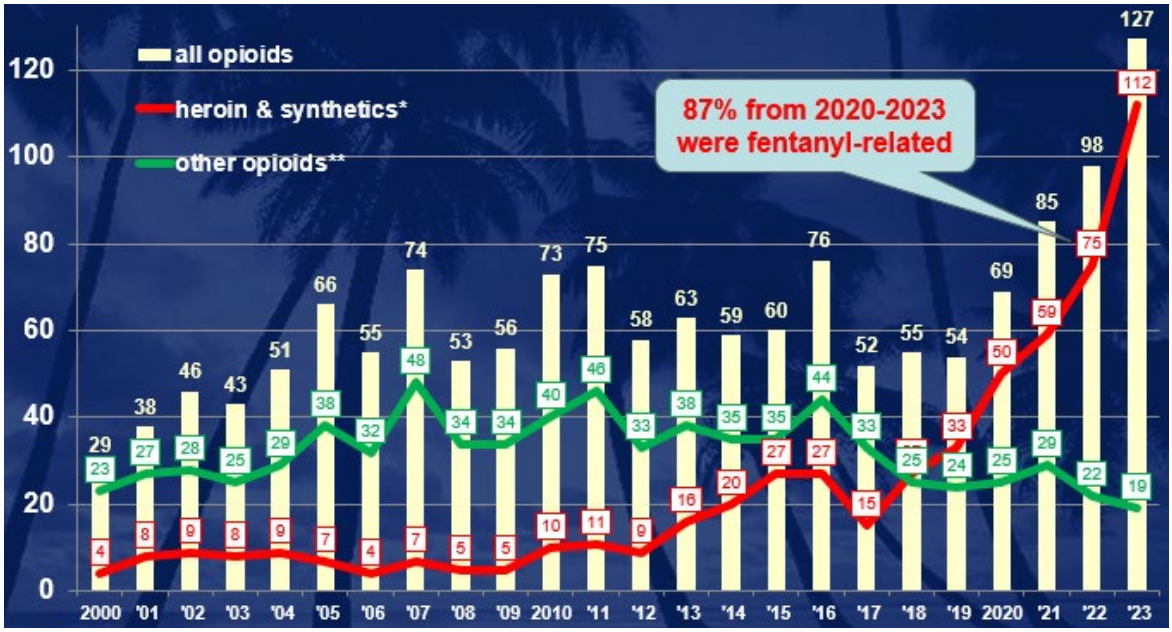
When looking at poisoning fatality rates among Hawaii residents compared to national opioid consumption, EMSIPSB data show that deaths due to opioid pain relievers are decreasing (Figure 5). However, Hawaii death certificate data show a greater prevalence of fatal opioid poisonings among Hawaii residents 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: Opioid consumption, and opioid prescriptions in Hawaii (2015-2023).



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

Figure 6. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 2000-2023.



* 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 poisonings involving psychostimulants, which includes methamphetamines (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 opioid poisonings remain steady for all counties, however total nonfatal opioid poisonings appear to be decreasing (398 in 2023 vs. 434 in 2016) (Figure 7). And over the last twelve years, naloxone administrations continue to remain steady for each county except Honolulu which has seen a rise in administrations for EMS patients since the last spike which occurred in 2016 (Figure 8).

Figure 7. Trends in nonfatal opioid poisonings treated in Hawaii hospitals, by patient county of residence, 2016-2023.

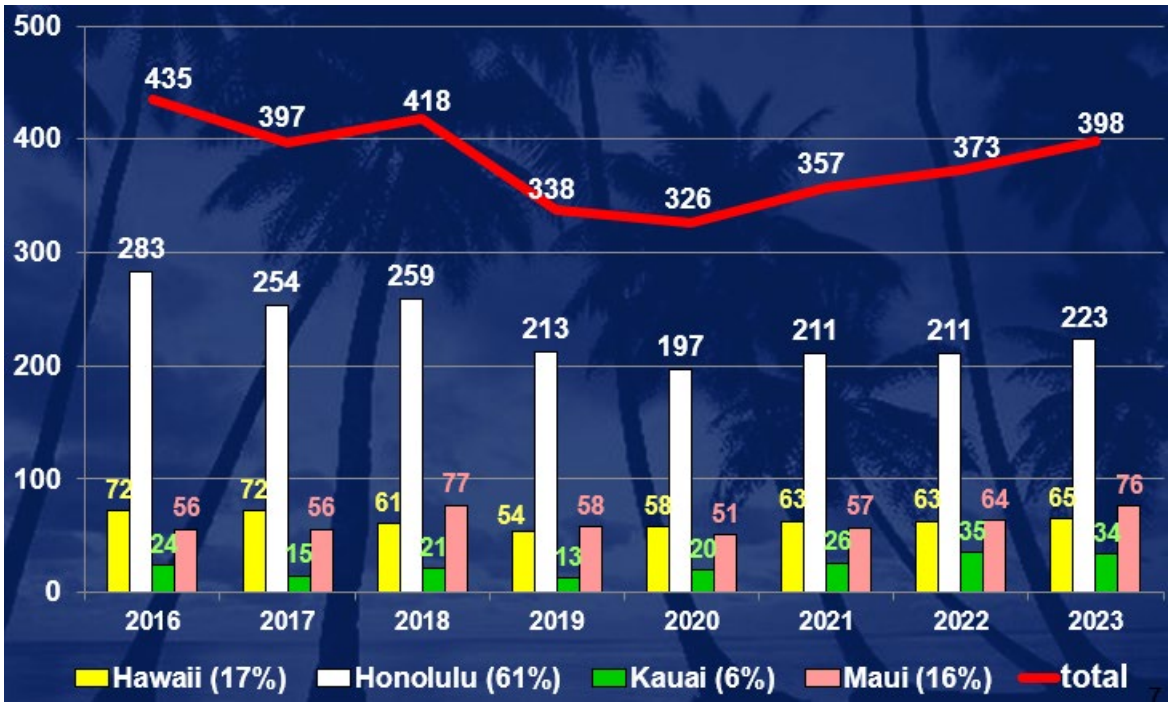
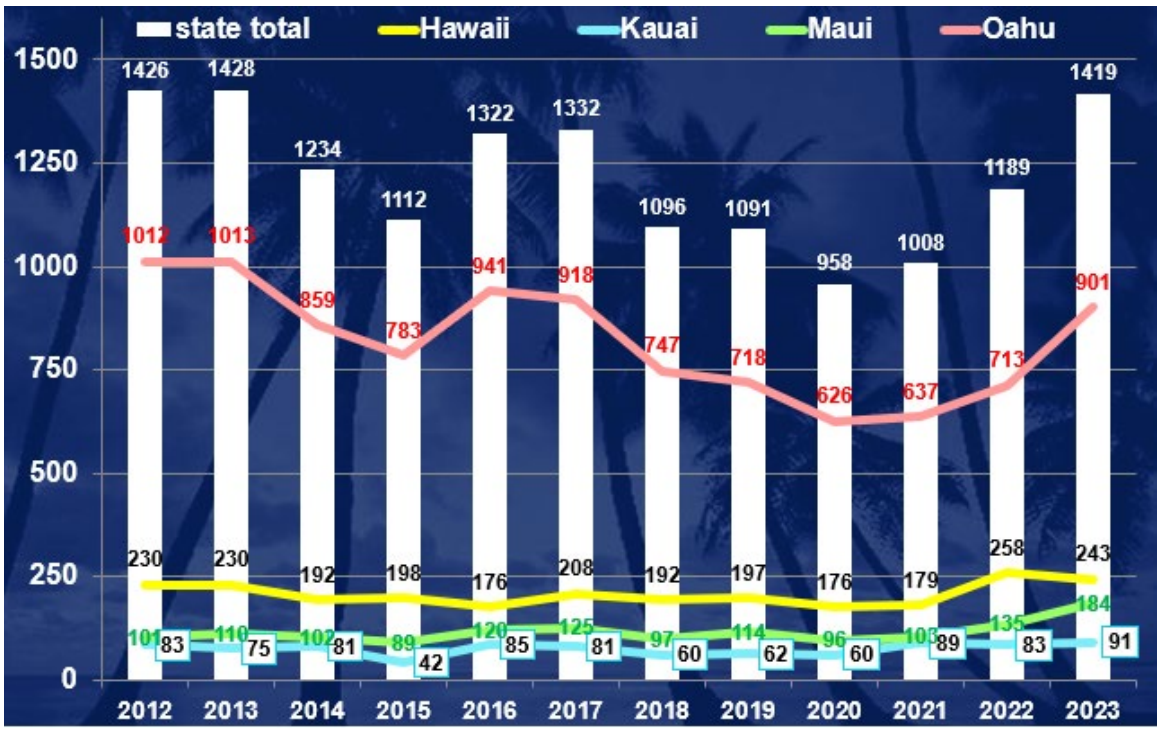


Figure 8. Annual number of EMS patients receiving naloxone, by county, 2012-2023.



According to recent EMS data for the 2022-2023, over 44 percent of 2,608 who received naloxone showed improvement. And for instances characterized as overdoses, about 77 percent improved in response, with an 88 percent improvement rate for opioid overdoses (Figure 9). EMS also attended to at least 440 overdoses from fentanyl from late 2021 to mid-2024, where 39 percent received naloxone from bystanders before EMS arrived (Figure 10).

Figure 9. EMS administrations of naloxone, 2022-2023.

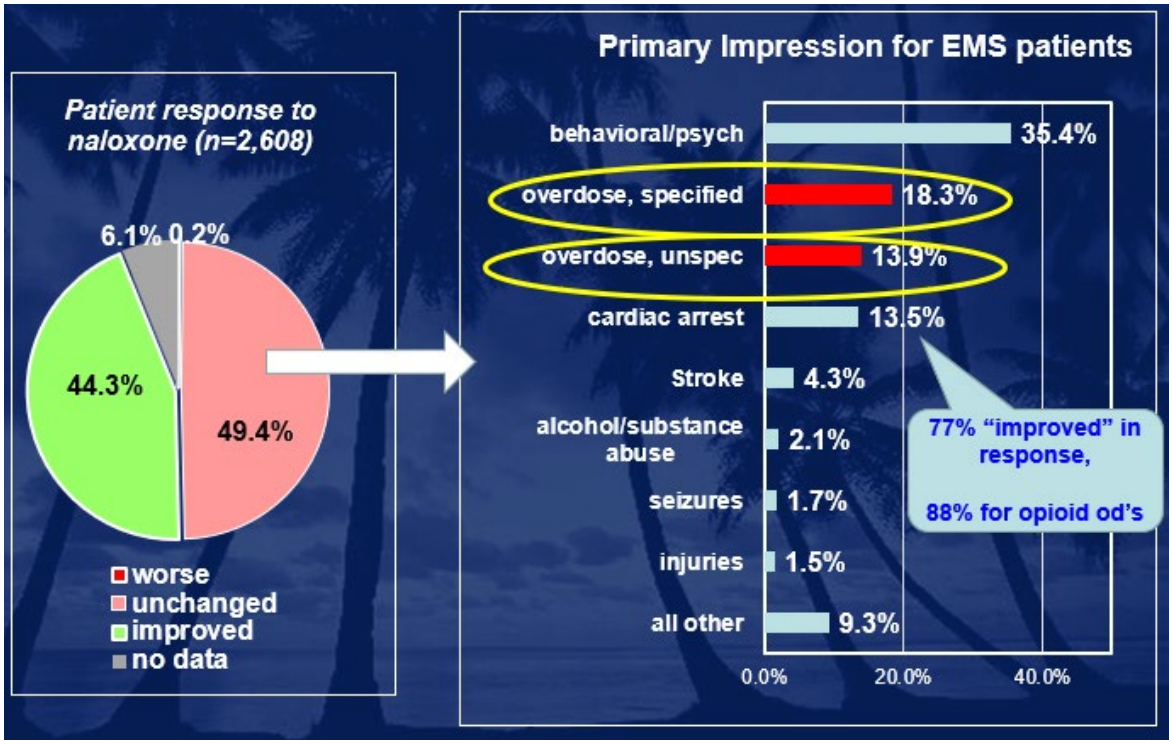
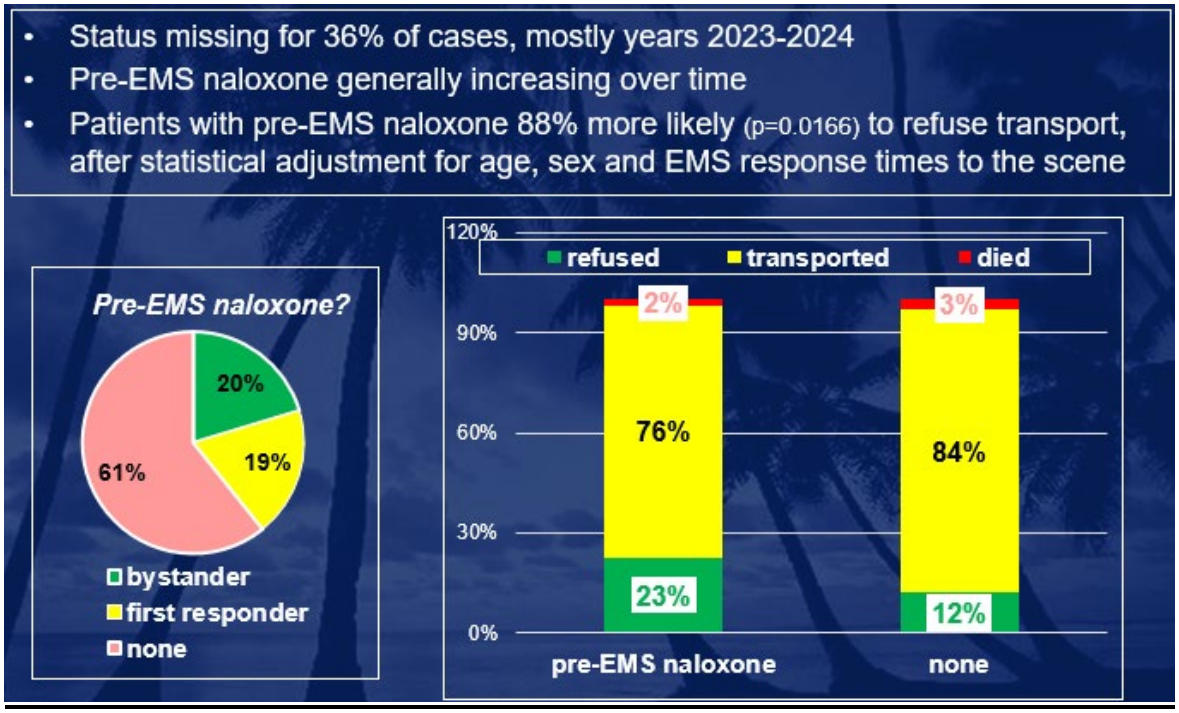


Figure 10. Discharge disposition for EMS patients with fentanyl overdoses, by pre-EMS naloxone status, 10/2021 –7/2024.



Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified in a December 2020 literature review conducted by the University of 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).