
# Hawai'i's Strategic Prevention Framework State Incentive Grant

# Underage Drinking Prevention Plan

***Focusing on the reduction and prevention of underage alcohol consumption for youth 12-17 years old.***

***MOVE THE NEEDLE***

## October 2008

# INTRODUCTION

Hawai'i, the 50th State, is one of the most remote places in the world. Located in the middle of the North Pacific Ocean, Hawai'i's closest neighbor is 2,400 miles away. The Hawaiian Archipelago is made up of hundreds of islands that stretch 1,523 miles across the Pacific. Collectively, these islands have a total landmass of 6,450+ square miles, and are the only State in the U.S. that is continuously growing due to active lava flows. The eight main islands of the Hawaiian Archipelago include: Hawai'i, Maui, O'ahu, Kaua'i, Moloka'i, Lana'i, Ni'ihau and Kaho'olawe (listed in order of size). Seven of the eight most southerly islands in the chain are inhabited (Kaho'olawe is not). The State's 1,283,388 population (U.S. Census Bureau, 2007 Population Estimates, Census 2000, 1990 Census) is unevenly distributed among its four Counties, with the majority (70.6%) of the residents in the City & County of Honolulu, 13.5% in Hawai'i County, 11.1% in the tri-island populated County of Maui (Maui, Moloka'i, and Lana'i), and 4.9% in Kaua'i County.

Hawai'i is composed of a rich blend of races, ethnicities, languages and cultures-Native Hawaiians, Pacific Islanders, Japanese, Filipino, Chinese, Vietnamese, Caucasian, African American, American Indian, Alaska Native, Hispanic, and people of many other heritages. Of the 1.3 million residents, Hawai'i unlike other States in the nation, does not have a majority ethnic group. Ethnically, Hawai'i is a State which Caucasians do not represent a majority, and has the largest percentage of Asian Americans. Hawai'i also has the largest percentage of persons of 2 or more races, who constitute 20% of the total population.

Hawai'i is geographically and culturally interconnected with other islands in the South Pacific. As Hawai'i was first populated by Polynesians some time around the 4th century, there is a strong cultural connection to other islands in the South Pacific.

Hawai'i's unique geography, demography and culture present special challenges in developing a comprehensive approach to prevention. Dependence upon air travel between geographically isolated islands presents a challenge to statewide project coordination, and lack of transportation in rural areas on all islands presents a challenge to accessibility of services. Multiple languages, adherence to traditional Hawaiian culture, and influences from the mainland majority culture result in unique situations that require appropriate, differentiated substance abuse prevention processes and responses. Moreover, many national prevention models and programs, based on research and practices reflecting different cultures and life experiences, are not a good fit for Hawai'i's diverse local populations.

As background to the Hawai'i Strategic Prevention Framework State Incentive Grant (SPF-SIG), the State of Hawai'i's Department of Health was awarded funding for the establishment of a State Epidemiological Outcomes Workgroup (SEOW) in March, 2006 for the purpose of collecting and reporting substance abuse prevention data. Building on existing efforts, the SEOW was formed from the Hawai'i Drug Information Network (HDIN). The University of Hawai'i, Center of the Family (UH-COF), in conjunction with the HDIN, led SEOW efforts to compile the *Hawai'i Epidemiological Profile for Substance Abuse Prevention, Spring, 2007*. In anticipation of the Strategic Prevention Framework State Incentive Grant, the SEOW developed this document for the purpose of improving prevention assessment and facilitating the use of data in prevention planning, implementation, monitoring, and evaluation. This work laid the foundation for and informs all five steps of SAMHSA's Prevention Platform.

Hawai'i's Governor, as the chief executive of the State of Hawai'i, is in charge of Executive Branch State agencies, establishes the goals of the State, and outlines ways to reach those goals. Hawai'i's Department of Health, Alcohol and Drug Abuse Division (ADAD) is the SAMHSA Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant and the Office Juvenile Justice and Delinquency Prevention (OJJDP) Enforcing Underage Drinking Laws (EUDL) Block Grant. ADAD is responsible for overseeing and managing adult and adolescent substance abuse prevention, intervention, and treatment services statewide including oversight of the SPF-SIG project.

The SPF-SIG supports the implementation of SAMHSA's Strategic Prevention Framework to 1) assess community needs and capacity, 2) mobilize and/or build capacity for effective prevention, 3) develop a comprehensive strategic prevention plan, 4) implement capacity building activities and evidence-based prevention programs, practices and policies, and 5) evaluate effectiveness of implemented programs,

practices and policies, and monitor process and outcomes. The SPF-SIG approach supports the President's vision of a Healthy U.S.

In October, 2006 the Hawai'i Department of Health, ADAD received the SPF-SIG from the Hawai'i Governor's Office, and embarked on the effort to implement the SPF-SIG.

In 2007, a SPF-SIG Project Manager was hired to direct the overall project, and a SPF-SIG Project Specialist was hired to coordinate the project at the Community level. Also in 2007, the State Epidemiology Workgroup (SEW) was formed to update the *Hawai'i Epidemiological Profile for Substance Abuse Prevention* (revised March, 2008), address some of the data gaps identified in the Spring, 2006 edition, and to meet the data requirements of the SPF-SIG. During 2007, the SPF-SIG Project Manager built an infrastructure to support the implementation of the SPF-SIG in Hawai'i. The State Advisory Council (SAC) was convened, with representatives from the Lieutenant Governor's Office, other State agencies including, among others, the Department of Education, the Coalition for a Drug-Free Hawai'i, the Hawai'i National Guard and the Salvation Army. The Community Advisory Council Chairperson, one from each of Hawai'i's four counties, also sit on the SAC, that advises the SPF-SIG. A State Drug Liaison, identified by the Lieutenant Governor, serves as chair of the SAC. During 2007, the SPF-SIG Project Manager and Project Specialist traveled to each of Hawai'i's four island Counties to meet individually with each SAC member in order to build commitment and capacity at the County and State levels. They educated SAC members about the SPF-SIG, and gained their support for the process. In December of 2007, an Assessment Workgroup was formed as a subcommittee of the SAC to identify a survey tool to collect capacity assessment data at the State and County levels.

In January, 2008 the SPF-SIG Project Manager and Project Specialist, working with the SAC, formed Community Advisory Councils (CAC) in each of Hawai'i's four island counties, Hawai'i County, City and County of Honolulu, Kaua'i County and the tri-island Maui County (includes the islands of Maui, Moloka'i and Lana'i). A CAC chairperson was appointed by the Mayor of each county to coordinate the CAC, serve as the county point of contact, and to represent the county on the SAC. Initial meetings, facilitated by the SPF-SIG Project Specialist, focused on assisting the State to complete the capacity and infrastructure assessment at both the State and County levels. This document presents the State Strategic Plan for implementing the Strategic Prevention Framework State Incentive Grant.

## Guiding Principles

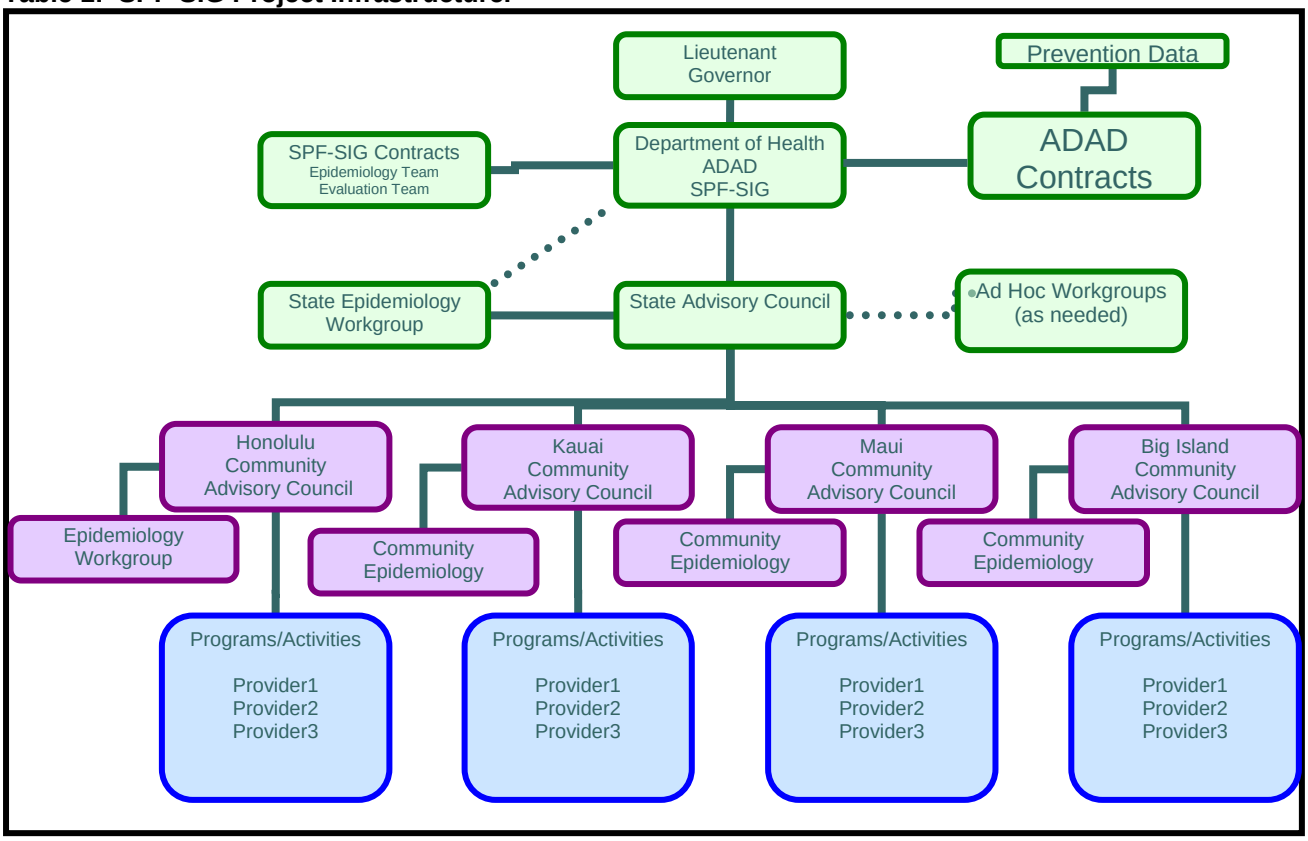
Underage Drinking Prevention in Hawai'i is guided by the following principles:

- Decision-making will be driven by the best available data.
- Data will be used, in as much as possible; to identify disparities in substance-use and plans will be made to reduce those disparities.
- Coordination and collaboration are essential to achieving all phases of the SPF-SIG. By working together, more can be done to reduce the burden of underage drinking than could be accomplished if we continue our individual efforts.
- Cultural competency will be integrated into all phases of the SPF-SIG as a key ingredient for the success of this plan.
- The implementation of evidence based programs will be foremost considered and all efforts will be made to tailor those programs to fit the unique needs of Hawai'i's population.
- This underage drinking prevention plan will be a road map of efforts in Hawai'i to reduce the burden of underage drinking. The plan establishes goals and priorities, and will work with Counties to act on the greatest needs and the most achievable, realistic strategies and actions.
- Many worthwhile and effective underage drinking prevention efforts are currently underway in Hawai'i and throughout the nation. The SPF-SIG process will identify existing efforts and strive not to duplicate those efforts, but rather, where appropriate, to build, enhance and expand on them for the benefit of all citizens of Hawai'i.

# SPF-SIG PROJECT INFRASTRUCTURE

Critical to any project is its infrastructure and all related elements such as communication processes, structure, tools, techniques and trainings. These elements assure the delivery of project goals. The SPF-SIG staff dedicated their first several months of the project assessing, planning, strategizing and building a solid project infrastructure. The Hawai'i SPF-SIG multi-level project infrastructure promises an inclusive process and support throughout the life of the SPF-SIG to assure Community sustainability long after the life of the project. The infrastructure consists of three levels (Table 1): State/Government (green), Community (purple), and Programs/Activities (blue). A brief description of each level and pertinent sections follow.

**Table 1: SPF-SIG Project Infrastructure.**




**State/Government Level.** Critical to this level is (1) the Department of Health, Alcohol and Drug-Abuse Division, (2) the State Epidemiological Workgroup, and (3) the State Advisory Council.

**Department of Health-Alcohol and Drug-Abuse Division (ADAD)**. ADAD is the Single State Authority (SSA) designated to receive Federal and State funding for substance abuse prevention and treatment. ADAD oversees Statewide substance abuse prevention and treatment grants throughout Hawai'i. ADAD is the primary and often sole source of public funds for substance abuse prevention and treatment services. ADAD houses the SPF-SIG project and employs a full-time SPF-SIG Project Manager Project Specialist to handle the day to day operations of the Hawai'i SPF-SIG project including meeting the federal grant requirements and managing the contracts of the Project Epidemiological and Evaluation Teams.

**Project Epidemiological Team**. Through a contract with the University of Hawai'i, Department of Public Health Sciences, this team comprised of two epidemiologists and one graduate assistant, will provide epidemiological support to the project. Specific duties include overseeing data collection, conducting data analysis and interpretation, coordinating activities with the chair of the SEW and acting as liaison to the Project Evaluation Team. The Project Epidemiological Team will also develop a comprehensive inventory of data sets and sources on substance use in Hawai'i and produce and

disseminate annual reports on substance use in Hawai'i that includes State and community-level data.

**State Epidemiological Workgroup (SEW)**. The 13-member SEW is chaired by the State Epidemiologist of the Department of Health and is comprised of data managers, epidemiologists, and community based individuals from around the State. SEW members (Table 3) were asked to be a part of the SEW due to their knowledge and/or access to data sources. The purpose of the SEW is to act in an advisory capacity to the Project Epidemiological Team. It is expected that the primary responsibility of the SEW is to assure the science and methodology as it relates to data collection, analysis and interpretation.

**State Advisory Council (SAC)**. The SAC was formed in 2006 in anticipation of the SPF-SIG. The primary purpose of the SAC is to:

1. Participate in making evidence based decisions and recommendations for the project; and,
2. To assure support and communication at all three levels of the project infrastructure.

The 15, Lieutenant Governor appointed, members were selected based on their experience in the drug prevention field and overall commitment to drug prevention. The selection process resulted in a membership not only with prevention expertise but one that is both culturally and ethnically diverse reflecting the unique demographics of our State. The membership includes representation from all four counties including the Community Advisory Council Chair from each Community. This assures communication between the State and Community Councils. In addition, one SAC member, whose expertise is in cultural competency, will work with the SPF-SIG Project staff to assure cultural competency at all phases of the project.

**Community Level.** Critical to this level is (1) the County Mayor's Office and (2) The Community Advisory Councils.

**County Mayor's Offices.** Each of the four Mayor's offices has designated a representative to manage and coordinate SPF-SIG activities at the community level. Traditionally, State projects, such as previous State incentive grant projects, have funded prevention programs and activities directly to providers however, for the purpose of the SPF-SIG; the project will be coordinating community level efforts through the mayor's office within each Community. In addition, the named office will manage the fiscal operations of the project including the administration of the SPF-SIG grants in their respective Counties. Below lists each County and the designated department assigned to the SPF-SIG project.

- Hawai'i County – Office of the Prosecuting Attorney
- City and County of Honolulu – Department of Community Services
- Kauai County – Mayor's Office, County Drug-Liaison
- Maui County – Department of Community Services

**Community Advisory Council** (CAC). Each of the four offices/departments noted above convened a CAC. Each CAC is comprised of 8-16 members (for a full listing of CAC members by Community refer to tables 4-7). Similar to the SAC, the members of the CAC were selected based on their experience in the drug-prevention/treatment field and overall commitment to drug-prevention. The membership of each CAC is both culturally and ethnically diverse and reflects the unique demographics of the Community which they represent. The CAC Chairperson convenes the CAC, keeps in communication with the SPF-SIG Project Specialist and acts as Community liaison to the SAC.

**Communication.** To assure clear communication between the SAC and CAC (State and Community), Community chairpersons were strategically placed on the SAC. This will assure that information and decisions made at the State level are communicated to the members of each CAC via their Community chairperson. The chairperson will also be responsible for sharing the concerns of their specific

Community to the SAC.

**Decision Making**. The Community Chairperson will act as the "voice" for each Community on the SAC during the decision making process. This assures an inclusive decision making process allowing for input from all levels of the project.

**Table 2: State Advisory Council***

| Name | Title | Organization |
|---|---|---|
| James R. Aiona, Jr. | Lieutenant Governor | State of Hawai'i |
| Kimo Alameda | Office of Multicultural Services | Hawai'i Department of Health-Adult Mental Health Division |
| Paul Ban | Director of Special Education | Department of Education |
| Ernest Martin | Deputy Director | City & County of Honolulu, Dept of Community Services |
| Karl P. Espaldon | State Drug Control Liaison | Office of the Lieutenant Governor |
| Cheryl Kameoka | Program Director | Coalition for a Drug-Free Hawai'i |
| Theresa Koki | Community Drug Liaison | Kauai County |
| Gabe Naeole | Director, Na Hoa Hoola | Pacific Resources for Education and Learning |
| Tamah-Lani Noh | Lieutenant Colonel | Hawai'i National Guard, Counter Drug Unit |
| Kevin Pang | Demand Reduction Coordinator | Drug Enforcement Administration |
| Pauline Pavao | Administrator | Salvation Army Family Services |
| Damaris Richardson | State Project Officer | Substance Abuse and Mental Health Services Administration – Center for Substance Abuse Prevention |
| Dixie Thompson | Children & Youth Specialist | Office of Youth Services |
| Lori Tsuhako | Community Drug Liaison | Maui County |
| Lisa Faulkner- Inouye | Special Projects Coordinator | County of Hawai'i Office of the Prosecuting Attorney |
| Leinaala Nakamura** | Assistant Administrator | City and County of Honolulu |

*Membership as of October 2008, subject to change.
**Non-voting member.

**Table 3: State Epidemiological Workgroup***

| Name | Title | Organization |
|---|---|---|
| Kathleen Baker | Research Statistician | Hawai'i Department of Health, Office of Health Status Monitoring |
| Larry Burnett | Director | Hawai'i High Intensity Drug Trafficking Areas |
| Michael Casey | Project Specialist | Pacific Resources for Education and Learning |
| Rochelle Cup Choy | Program Support Analyst | Hawai'i High Intensity Drug Trafficking Areas |
| Dan Galanis | Epidemiologist | Hawai'i Department of Health, Injury Prevention Program |
| Deborah Goebert | Associate Professor | University of Hawai'i, School of Medicine, Department of Psychiatry |
| Robert Hirokawa | Epidemiologist | Hawai'i Department of Health, Science & Research Group |

| | | |
|---|---|---|
| Alvin Onaka | Research & Statistics Officer, Director | Hawai'i Department of Health, Office of Health Status Monitoring |
| Alan Shinn | Executive Director | Coalition for a Drug-Free Hawai'i |
| Ken Tano | Hawai'i Regional Coordinator | Hawai'i High Intensity Drug Trafficking Areas – Western States Information Network |
| Jennifer Wise | Program. Analyst | Hawai'i High Intensity Drug Trafficking Areas |
| Sylvia Yuen | Director | University of Hawai'i, Center on the Family |

*Membership as of October 2008, subject to change.

**Table 3: Hawai'i Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Chief Lawrence Mahuna | Chief of Police | Hawai'i County Police Dept. |
| Napua Brown | Hawaii County Drug Liaison | Mayor's Office |
| Joe Fichter | Associate Director | Family Support Services of West Hawaii |
| Wally Lau | Executive Director | Neighborhood Place of Kona |
| Lisa Faulkner-Inouye | Special Projects Coordinator | Prosecutor's Office |
| Leonard Feliciano, Sr. | Director of Adolescent Services | Big Island Substance Abuse Council (BISAC) |
| Frecia Basilio | Resource Center Specialist | Hawai'i County Research and Development |
| Nancy Kelly | Business Manager | Prosecutor's Office |
| Jason Cortez | Lieutenant | Hawai'i County Police Dept. |
| Heidemarie Koop | Director | Child and Family Service |
| Rita Miller | Staff Sgt. | Hawaii National Guard-Counterdrug Support |
| Lance Niimi | Unit Manager | Queen Lili'uokalani Children's Center |
| Jan Pakele | Director | Department of Liquor Control |
| Pauline Pavao | Administrator | The Salvation Army |
| Jan Yokoyama | Public Health Nurse | Hawaii Department Of Health / Hawaii Island District Health Office |

*Membership as of October 2008, subject to change.

**Table 4: City and County of Honolulu Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Peter Carlisle | Prosecuting Attorney | City & County of Honolulu, Prosecuting Attorney Department |
| Lester Chang | Director | City & County of Honolulu, Dept. Of Parks & Recreation |
| Libby Char | Director | City & County of Honolulu, Emergency Medical Services |
| Cliff Cisco | Sr. V.P. | Hawaii Medical Service Association |
| William Haning III | Director | University of Hawaii at Manoa, John A. Burns School Of Medicine |
| Mason Henderson | CEO | Kline-Welsh Behavioral Health Foundation |
| Ed Kubo | US Attorney | Department Of Justice |
| Ernie Martin | Deputy Director | City & County of Honolulu, Department of Community Services |
| Debbie Kim Morikawa | Director | City & County of Honolulu, Community Services Department |

| | | |
|---|---|---|
| Kenneth Nakamatsu | Director | City & County of Honolulu, Department of Human Resources |
| Carrie Okinaga | Corp. Counsel | City & County of Honolulu |
| Paul Putzulu | Deputy Chief | City & County of Honolulu, Honolulu Police Department |
| Alan Shinn | Executive Director | Coalition for a Drug Free Hawaii |
| Kenneth Silva | Chief | City & County of Honolulu, Honolulu Fire Department |

*Membership as of October 2008, subject to change.

**Table 5: Kauaʻi Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Bridget Arume | PCNC Program Coordinator | Department of Education |
| Fran Becker | Executive Director | Na Lei Wili Area Health Education Center |
| Kaui Castillo | Unit Manager - Kaua'i | Queen Lili'uokalani Children's Center |
| Miguel Graham | Acting President | Wave Riders Against Drugs |
| Eric Honma | Director | County Of Kauaʻi, Department of Liquor Control |
| Theresa Koki | Anti-Drug Coordinator | County of Kaua'i, Office of the Mayor |
| Sandra Kouchi | East Kaua'i Manager | Hawaiʻi Public Housing |
| Tori Ann Laranio | Probation Officer | Drug Court |
| Al Nebre | After School Director | Kauaʻi Economic Opportunity |
| Jan Pascua | Public Health Educator | Department of Health-Chronic Disease |
| Moana Ta'a | KKIPC Coordinator | Kauaʻi Keiki Injury Prevention Center -Shattered Dreams |
| Dan Miyamoto | Lt. Research & Development | County Of Kauaʻi, Kaua'i Police Department |
| Ann Wooton | Grants Program Mgr., COK Finance | County Of Kauaʻi, West Kauaʻi Community Coalition |

*Membership as of October 2008, subject to change.

**Table 6: Maui Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Debbi Amaral | MEO Director of Early Childhood Services | Maui Economic Opportunity, Inc. |
| Jud Cunningham | CEO | Aloha House/Malama |
| Christina Fisher | Consultant | For State Advisory Council/County Advisory Council -Maui Contract Professional |
| Butch Gima | Social Worker | Hawaii Department of Health, Adult Mental Health Division |
| Ray Henderson | Executive Director | Ohana Makamae |
| Mary Santa Maria | Public Health Educator | Hawaii Department of Health, Maui District Health Office |
| Lori Tsuhako | Deputy Director | Maui County, Department of Housing and Human Concerns |
| Marlene Young | Executive Assistant | Maui County, Department of Housing and Human Concerns |

*Membership as of October 2008, subject to change.

**Table 6: Kauaʻi Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Bridget Arume | Program Coordinator | Department of Education/Parent Community Networking Center |
| Fran Becker | Executive Director | Na Lei Wili Area Health Education Center |
| Kaui Castillo | Unit Manager - Kauai | QLCC |
| Miguel Graham | Acting President | Wave Riders Against Drugs (WRAD) |
| Eric Honma | Director | County Liquor Department |
| Theresa Koki | County Drug Liaison | Kauai County |
| Sandra Kouchi | East Kauaʻi Manager | Hawaiʻi Public Housing Authority (HPHA) |
| Tori Ann Laranio | Probation Officer | Kauai Drug Court |
| Al Nebre, Jr. | After School Director | Kauai Economic Opportunity (KEO) |
| Jan Pascua | Public Health Educator | Kauai District Health Office |
| Moana Taʻa | K-KIPC Coordinator | KKIPC-Shattered Dreams |
| Jon Takamura | Lieutenant, Youth Services Section | Kauai Police Department (KPD) |
| Ann M. K. Wooton | Grants Program Manager | COK-Finance |
| Diane Zachary | President/CEO | Kauai Planning and Action Alliance (KPAA) |

*Membership as of October 2008, subject to change.

**Table 7: Maui Community Advisory Council***

| Name | Title | Organization |
|---|---|---|
| Debbi Amaral | MEO Director of Early Childhood Services | Maui Economic Opportunity, Inc. |
| Jud Cunningham | CEO | Aloha House/Malama |
| Christina Fisher | Consultant | For SAC/CAC-Maui Contract Professional |
| Butch Gima | SW | AMHD |
| Ray Henderson | ED | Ohana Makamae |
| Mary Santa Maria | PH Educator | Maui DHO |
| Lori Tsuhako | Deputy Director-DHHC | Maui County |
| Marlene Young | Executive Assistant DHHC | Maui County |

*Membership as of October 2008, subject to change.

# STEP I: ASSESSMENT

The purpose of SPF-SIG **Step 1: Assessment** is to profile population needs, resources and readiness to address the problems identified in the assessment. This step involves the following:

1) Assessing the nature and extent of the substance abuse problem and its contributing factors (producing an Epidemiological Profile).
2) Assessing the prevention system's infrastructure and capacity to address the problems (Infrastructure and Capacity Assessment Survey).
3) Selecting SPF-SIG priorities, documenting rationale and baseline data.

## 1. ASSESSING SUBSTANCE ABUSE AND RELATED CONSEQUENCES

### ASSESSING THE PROBLEM

In preparation for the SPF-SIG, Hawai'i engaged in a year-long epidemiological study of the available substance abuse data in the State, through the State Epidemiological Outcomes Workgroup (SEOW). The *Hawai'i Epidemiological Profile for Substance Abuse Prevention, Spring, 2007* is the result of this work. Following the award of the SPF-SIG, the State Epidemiological Workgroup (SEW) revised the document (March, 2008) to address some of the data gaps identified in the Spring, 2007 edition, to expand and update the data assessment, and to meet the data requirements of the SPF-SIG.

The profile was developed using both population-based data and information from the Hawai'i Drug Information Network (HDIN) and State Advisory Council (SAC). The data analysis began with a comprehensive review of data sources that had national and/or Hawai'i alcohol, tobacco, and other drug constructs and indicators. A total of 29 data sources were identified (Appendix A: Data Sources Reviewed for Assessment), and 197 data indicators were reviewed. The constructs and indicators were categorized into two groups—consequences and consumption—within each of the three major substances: alcohol, tobacco, and other drugs. These were screened using five criteria—availability, validity, consistency, periodic collection, and sensitivity—to yield a smaller set of 7 constructs and 46 indicators (Appendix B: Seven Constructs and 46 Indicators Used in Priority Assessment), which were distributed among four *consequences* constructs—mortality (4), crime/public safety (4), antisocial behavior (2), and morbidity (4), and three *consumption* constructs—current use (21), lifetime use (8), and early initiation (3).

For each of these 46 indicators, Hawai'i data was gathered and compared with trend data for the nation, each of the 50 States, and the District of Columbia for the years 1990 through 2005, whenever possible. In order to understand the differential use of substances within the State and to provide insights on the geographic areas and subpopulations that are most in need of prevention services, a detailed analysis was conducted on the selected focus area using the latest Hawai'i-specific data with county and subpopulation (e.g., sex, age/grade, and ethnicity) information. To inform prevention decisions and develop strategies that yield the greatest impact, the analysis of each focus area consisted of the following: prevalence rates, consumption patterns of current users, access and perceptions of availability, and risk and protective factors. Across substances, alcohol, tobacco, and other drug constructs and their related indicators were assessed in respect to prevalence in the population affected, rate of change, and relative comparison with national and other States' prevalence rates.

### PRIORITIZATION PROCESS

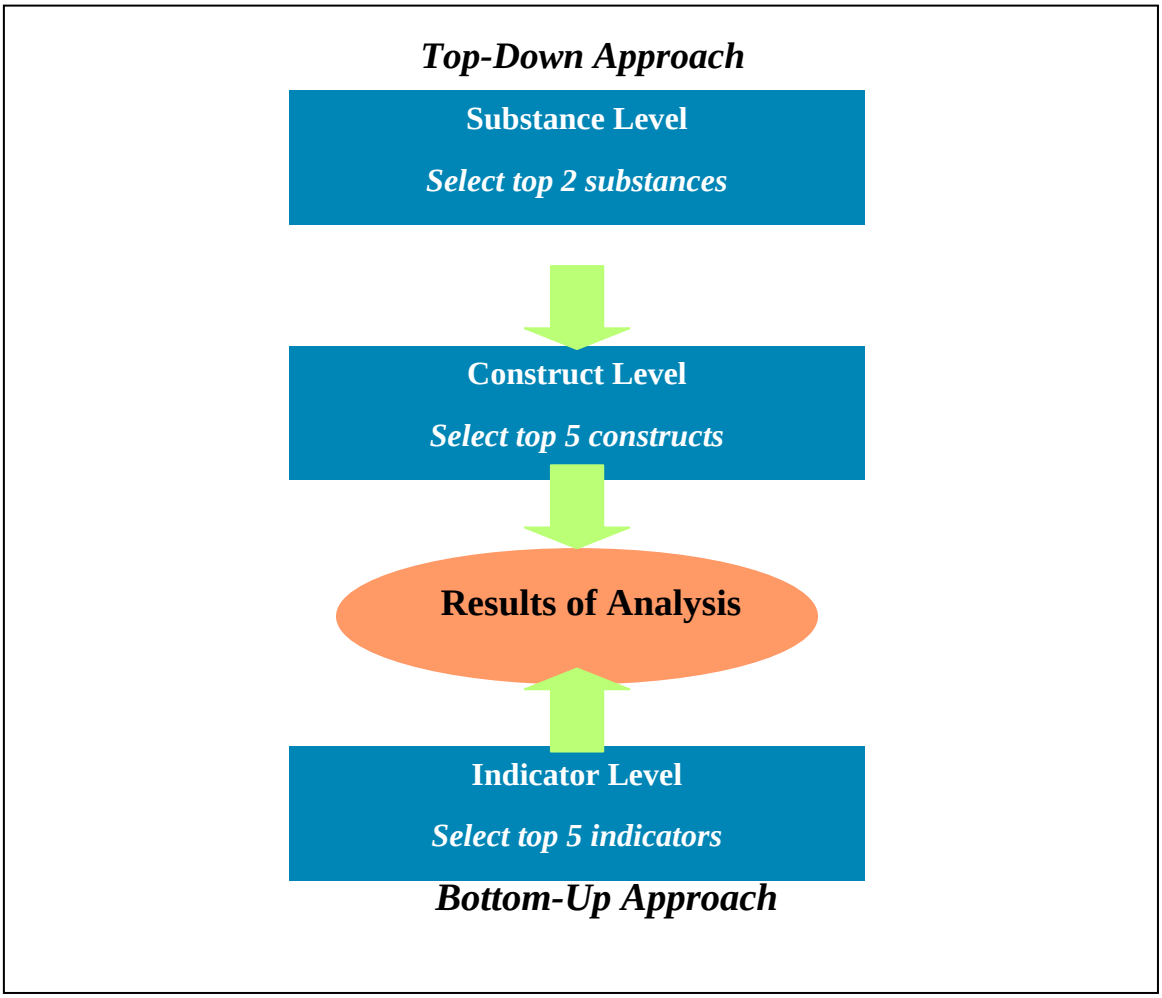
To systematically evaluate the priority of indicators for the SPF-SIG initiative, the SEW employed *three criteria* and *two approaches* to process the population-based data.

Two levels of assessment were conducted, the first to determine the priority of indicators and second to

identify specific problems and population subgroups for the SPF-SIG focus area. First, the scores from the assessments of the 46 indicators described above were entered into a general formula (prevalence score × rate of change × relative comparisons) that yielded a priority score for each construct and indicator. This analysis resulted in a short list of 10 priority indicators (Appendix C: Summary of Population-Based Data Assessment 10 Priority Indicators) six for alcohol, three for illicit drugs, and one for tobacco. Six of the ten indicators related to consumption and four to consequences.

Two approaches were used to identify the group of indicators with the highest priorities. The "top-down" approach screened substance type to select two of the three substances with the highest priority scores for construct-level analysis, and then selected a set of five constructs and their indicators based on the total score of constructs. The "bottom-up" approach selected the top 5 among the 46 indicators to ensure no high-priority areas were inadvertently left out during the screening process in the "top-down" approach. Figure 1 illustrates the two data analysis approaches.

**Figure 1: Two Approaches of Data Analysis**




For the "top-down" approach, at the first level of analysis—substance type—the 46 indicators were examined to identify a balanced and comparable set of indicators for each of the three substances. This review resulted in the selection of nine indicators: one consequence and two consumption indicators for each of the ATOD substances (Table 8). The total score for each substance type was calculated by adding together the scores of the three indicators within each substance.

**Table 8. Indicators Selected for Substance Type-Level Analysis**

| Substance | Domain | Construct | Indicator |
|---|---|---|---|
| **Alcohol** | Consequences | Mortality | Alcohol-Related Death Rate |
| | Consumption | Age of initial use | Early Initiation of Alcohol Use by High School Students |
| | | Current use | Current Use of Alcohol by Persons Aged 12 and Older |
| **Illicit Drugs** | Consequences | Mortality | Deaths From Illicit Drug Use |
| | Consumption | Age of initial use | Early Initiation of Marijuana Use by High School Students |
| | | Current use | Current Use of Any Illicit Drug by Persons Aged 12 and Older |
| **Tobacco** | Consequences | Mortality | Deaths From Lung Cancer |
| | Consumption | Age of initial use | Early Initiation of Cigarette Use by High School Students |
| | | Current use | Current Cigarette Smoking by Persons Aged 12 and Older |

Sources: See Appendix D.

At the second levels of analysis—construct—the 46 indicators were reviewed to select indicators that best represented each construct. Two composite indicators were created at the construct-level to summarize (1) alcohol-related deaths (chronic liver disease deaths and alcohol-related vehicle deaths) and (2) alcohol-related arrests (arrests due to DUI, liquor law violations, alcohol-related disorderly conduct, and public drunkenness). A total of 19 indicators were identified, each associated with a construct of a substance, except for the construct "current use" for all substances where two indicators were identified. The total score of a construct equals the total score of its indicator or the average score of the two indicators that it represents.

For the "bottom-up" approach, the total score for each of the 46 indicators was calculated and compared.

The indicators scored from both "top-down" and "bottom-up" approaches were then re-examined using the following three criteria: urgency, readiness for change, and change potential. This analysis was conducted using data collected from HDIN members. The indicators that received the highest scores on the aforementioned criteria were selected as the focus area for the SPF-SIG initiative.

## SUBSTANCE USE IN HAWAI'I

Table 9 shows the prevalence of current use of alcohol, illicit drugs, and tobacco in the State of Hawai'i. Nearly half (48.9%) of the people in Hawai'i who are 12 years of age and older, reported using alcohol in the past 30 days. The highest prevalence rate for alcohol use—over 62.0%—is found among people 21 to 34 years old, and the rate gradually drops with age so that for those 65 years and older, the prevalence rate is 33.0%. At the other end of the age continuum, one in every four 9th graders (27.2%) reported monthly alcohol use, and the percentage of users increases to 42.8% among high school seniors.

More students use alcohol than marijuana, the most heavily used illicit drug among young people. Among 9th and 10th graders, approximately 15.0% reported using marijuana monthly, and the percentage increased to 22.4% among 12th graders. Nearly one fifth (19.1%) of those aged 18-25 reported using illicit drugs, predominantly marijuana. Marijuana use is less prevalent among individuals 26 years and older: Overall illicit drug use is only 5.7% among this cohort.

**Table 9. Prevalence Rate of Current Substance Use, by Substance Type and Age/Grade, 2004-2005**

| Age/Grade | Alcohol[a] | Illicit Drugs[b] | Tobacco[c] |
|---|---|---|---|
| **12 and Over** | 48.9 | 8.0 | n.s. |
| **9th Grader** | 27.2 | 14.3 | 14.4 |
| **10th Grader** | 33.4 | 15.7 | 16.7 |
| **11th Grader** | 39.5 | 18.7 | 12.5 |
| **12th Grader** | 42.8 | 22.4 | 22.6 |
| **18-20** | 40.8 | 19.1[d] | 11.8 |
| **21-29** | 62.8 | | 23.8 |
| **30-34** | 62.1 | 5.7[e] | 16.0 |
| **35-54** | 55.5 | | 19.5 |
| **55-64** | 47.6 | | 18.1 |
| **65-99** | 33.0 | | 7.2 |

[a] Prevalence of alcohol use in the past 30 days.
[b] Prevalence of marijuana use among high school students (9th to 12th grades) and illicit drug use among 12 years and older in the past 30 days.
[c] Prevalence of cigarette use in the past 30 days among high school students (9th to 12th grades) and among adults (18 and over).
[d] Prevalence rate among people aged 18-25.
[e] Prevalence rate among people aged 26 and over.

Sources: NSDUH 2003-2004 for alcohol use among persons aged 12 or older, and illicit drug use for persons aged 12 or older, 18-25, and 26 or older; YRBS 2005 for alcohol, marijuana, and cigarette use among 9th to 12th graders; BRFSS 2005 for alcohol and cigarette use among persons aged 18 or older.

The prevalence of cigarette smoking is highest among young adults ages 21-29 at 23.8%, followed by high school seniors at 22.6%. Smoking is least prevalent among adults who are 65 years and over. By the age of 13, over one fourth (27.3%) of high school students had used alcohol, the same proportion as those who had smoked cigarettes (27.1%), and more than twice those who reported using marijuana (12.5%) (Table 10). There are gender differences in the early use of alcohol and illicit drugs, with males more likely than females to use these substances before age 13.

**Table 10: Percentage of High School Students Who Reported ATOD Use by Age 13, 2005**

| Gender | Alcohol | Illicit Drugs | Tobacco |
|---|---|---|---|
| **Total** | 27.3 | 12.5 | 27.1 |
| **Male** | 29.6 | 14.6 | 27.5 |
| **Female** | 24.9 | 10.1 | 26.6 |

Source: YRBS 2005.

Regarding patterns of alcohol use, one in ten teenagers in Hawai'i reported binge drinking at least once in the past 30 days (Table 11). Among young adults ages 18-25, 44.3% reported binge drinking, and 12.1% reported heavy alcohol use (individuals from 21-29 years). Among illicit drugs, inhalants have the highest prevalence of lifetime use (13.0%) among teenagers in Hawai'i, followed by cocaine (6.5%), and MDMA or ecstasy (6.1%). About one twentieth (4.8%) of the teenagers in Hawai'i smoke cigarettes daily.

**Table 11: Patterns of Substance Use, 2004-2005**

| Substance Use | Age | Percent |
|---|---|---|
| **Alcohol** | | |
| Binge Alcohol Use | 12-17 | 10.9 |
| | 18-25 | 44.3 |
| | 26 and over | 21.1 |
| Current Heavy Alcohol Use | 18-19 | 7.4 |
| | 21-29 | 12.1 |
| | 30-34 | 10.5 |
| | 35-54 | 5.8 |
| | 55-64 | 7.7 |
| | 65 and over | 4.8 |
| **Illicit Drugs** | | |
| Current Marijuana Use | 14-18 | 17.2 |
| Lifetime Inhalant Use | 14-18 | 13.0 |
| Lifetime Cocaine Use | 14-18 | 6.5 |
| Lifetime MDMA Use | 14-18 | 6.1 |
| Lifetime Methamphetamine Use | 14-18 | 4.3 |
| Lifetime Steroid Use | 14-18 | 2.9 |
| Lifetime Heroin Use | 14-18 | 2.5 |
| Lifetime Injection Drug Use | 14-18 | 2.2 |
| **Tobacco** | | |
| Daily Cigarette Use | 14-18 | 4.8 |

Sources: NSDUH 2003-2004 for binge alcohol use; BRFSS 2005 for current heavy alcohol use; YRBS 2005 for illicit drugs and tobacco use.

In Hawai'i, 7.2 % of our young adults are alcohol dependent, and 5.6% are dependent on illicit drugs (Table 12). The substance dependence rates among people 12-17 years old, 18-25 years old, and 26 years and older represent a reverse U-shaped curve where rates are lower for the age cohorts at both ends. The rate of reduction in substance dependence after ages 18-25 is greater for illicit drugs (2.5) compared to alcohol (4.7).

**Table 12: Percentage of People Dependent on Substances by Age, 2003-2004**

| Age | Alcohol | Illicit Drugs |
|---|---|---|
| **12-17** | 2.9 | 2.7 |
| **18-25** | 7.2 | 5.6 |
| **26 and over** | 2.9 | 1.2 |

Source: NSDUH 2003-2004.

**DATA LIMITATIONS AND GAPS**

Like every data-based report, there are data limitations and gaps that should be taken into consideration when interpreting and using the information in this profile. One of the limitations relates to Hawai'i's small population—approximately 1.2 million people—which has implications for the available data pool. Because of its small size, Hawai'i is often left out of national surveys, or when it is included, the number of cases sampled is too small to yield meaningful data, particularly at the Community level. As a result, it is difficult to compare Hawai'i to other States that generally have a larger and more comprehensive pool of valid and reliable ATOD data to draw upon. Small numbers also affect the accuracy, stability, and reliability of survey estimates, which has implications for the measurement of the underlying construct over time. Small sample size was addressed in two ways: (a) survey data with small numbers (e.g., fewer than 20 cases) were not included in the analyses, and (b) multi-year averages were used to generate more stable estimates.

There are also areas of importance (e.g., ATOD abuse among pregnant women) for which data is lacking, only anecdotal data exist, or the data available did not meet specified criteria. Such information is, therefore, absent from the analyses and the prioritization of indicators that led to the identification of the Hawai'i SPF-SIG target area.

## 2. ASSESSING CAPACITY AND INFRASTRUCTURE

**STATE-LEVEL PREVENTION INFRASTRUCTURE**

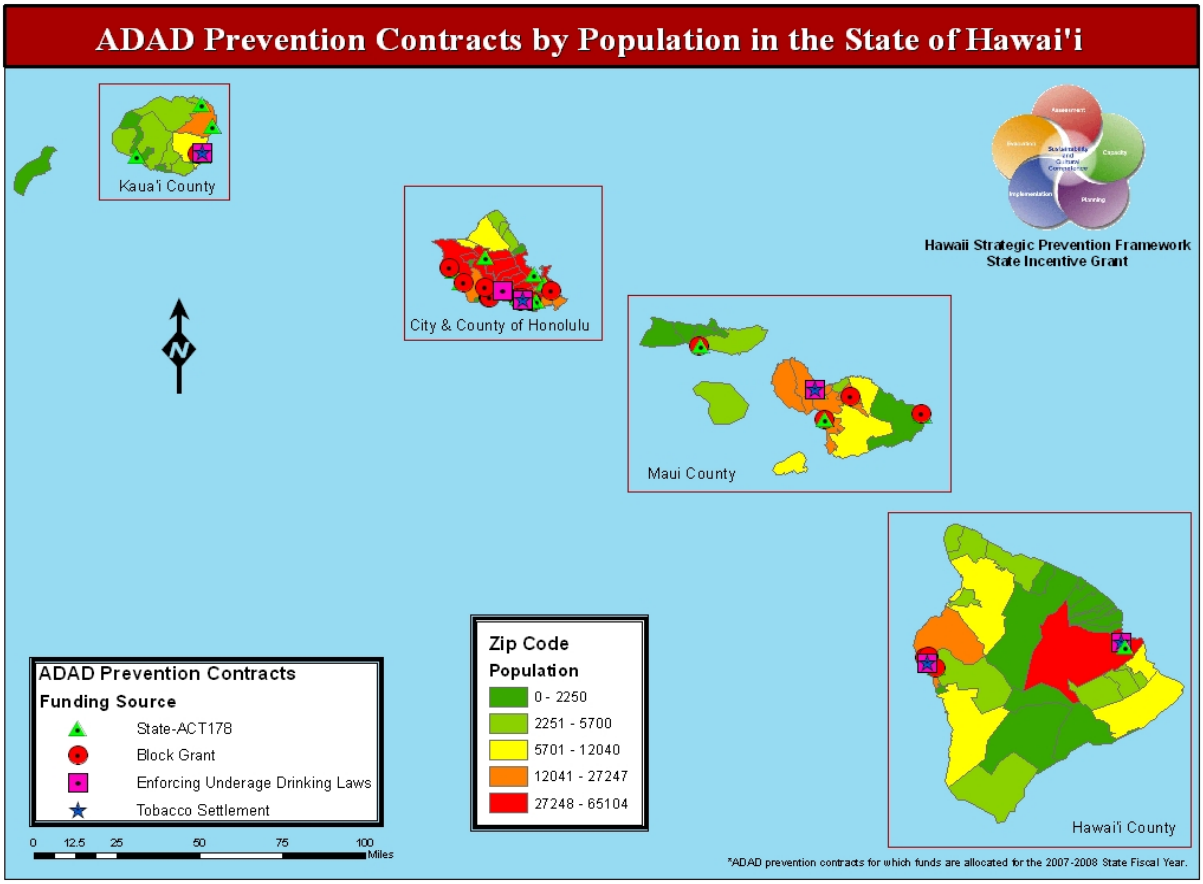
The Alcohol and Drug Abuse Division (ADAD) of the Hawai'i State Department of Health (DOH) is the Single State Authority (SSA) designated to receive federal and State funding for substance abuse prevention and treatment. ADAD oversees Statewide, Community, and individual provider substance abuse prevention and treatment grants throughout Hawai'i. ADAD is the primary and often sole source of public funds for substance abuse prevention and treatment services. ADAD's prevention funding comes primarily from the Substance Abuse Prevention and Treatment (SAPT) Block Grant, discretionary federal grants (e.g., Strategic Prevention Framework State Incentive Grant (SPF-SIG) and Enforcing Underage Drinking Laws (EUDL) Program), and State general funds (Table 13 and Figure 2).

ADAD's mission is to provide the leadership necessary for the development and delivery of quality substance abuse prevention and treatment services for Hawai'i residents. ADAD's efforts are designed to promote a Statewide, culturally appropriate, comprehensive system of services to meet the needs of individuals and families.

**Table 13: 2007-2008 State Fiscal Year (SFY) prevention funds (non-age specific) allocated through ADAD.**

| ***Funding Source*** | ***Allocated*** |
|---|---|
| State (Act 178) | $2,000,000 |
| SAPT Block Grant | $1,836,450 |
| Office of Juvenile Justice Delinquency Program (OJJDP) Enforcement of Underage Drinking Law (EUDL) | $341,400 |
| Tobacco Settlement | $267,373 |
| Total | $4,445,223 |

**Figure 2: ADAD Prevention Contracts by Population in the State of Hawai'i.**




**EFFECTIVENESS OF STATE-LEVEL PREVENTION INFRASTRUCTURE**

ADAD has developed a strong collaborative relationship with the Office of the Lieutenant Governor. The Lieutenant Governor was assigned by the Governor to chair the SPF-SIG State Advisory Council (SAC). This partnership creates significant opportunities to advocate for prevention, which has made substance abuse a more visible, active component of all State-level initiatives. The Lieutenant Governor has provided leadership and engaged State agencies and local partners through a series of press releases and town hall meetings. These events provide a solid foundation for ongoing collaboration and planning for substance abuse prevention efforts.

The SAC membership includes a diverse group of 15 members with representation from each Community in the State of Hawai'i. The SAC members bring to the table a strong background in prevention and leadership and reflect the unique demographics of Hawai'i. The SAC includes the Chairperson from each Community Advisory Council as a link between the State and Community (county) levels.

Another integral part of the SPF-SIG team is the State Epidemiological Workgroup (SEW). In addition to the credentials of the SAC listed above, the SEW brings experience and knowledge of substance abuse data to the table. SEW members are often referred to as "gate-keepers" to this data, due to their knowledge or and access to data sources. The SEW is chaired by the State Epidemiologist of the Department of Health.

ADAD employs a full-time SPF-SIG Project Manager and Project Specialist to handle the day to day operations of the Hawai'i SPF-SIG project. ADAD contracts SPF-SIG epidemiological services with the University of Hawai'i's Department of Public Health Sciences and, SPF-SIG evaluation services with the University of Hawai'i's Center on the Family.

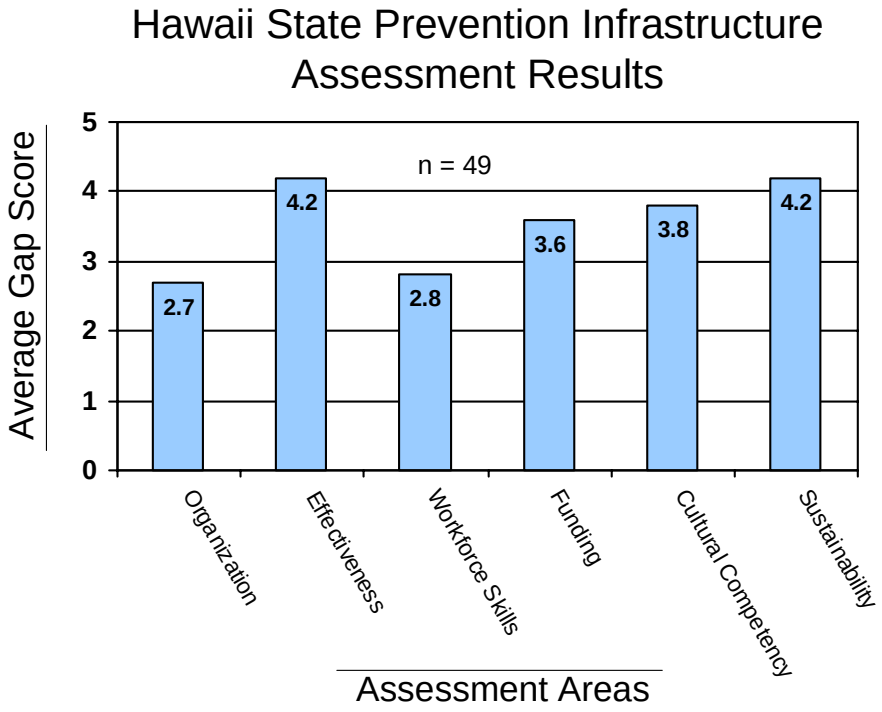
**SIGNIFICANT GAPS IN STATE-LEVEL PREVENTION INFRASTRUCTURE & CAPACITY TO IMPLEMENT THE SPF-SIG AT THE STATE-LEVEL**

The Assessment Workgroup of the SAC developed the State Capacity Assessment Survey (Appendix E) from a tool created by Nebraska Partners for Prevention, Southwest CAPT, and CSAP. The survey was administered to members of the SAC, SEW and each CAC as a method of collecting information from

prevention key stakeholders at the State and community levels regarding the strengths and challenges of the State prevention system for SPF-SIG assessment purposes.

The State survey measures 6 areas (with a total of 24 indicators) of the prevention system. The areas are (1) Organization; (2) Effectiveness; (3) Workforce Skills, (4) Funding; (5) Cultural Competence; and (6) Sustainability. Respondents rated the State's current capacity relative to each of the 24 indicators (the current score) as well as their perceived importance of each indicator relative to capacity for effective prevention (the importance score). Gap scores were calculated by subtracting the current score from the importance score. High gap scores indicate areas that may need capacity improvement, and low gap scores indicate strengths in the current State prevention system. A total of 49 surveys were completed by key prevention stakeholders. Areas with elevated average gap scores (Figure 3) were Sustainability (4.2%), Effectiveness (4.2%), Cultural Competency (3.8%) and Funding (3.6%). Conversely, Organization (2.7%) and Workforce Skills (2.8%) represented strengths in the State prevention system.

**Figure 3: Hawai'i State Capacity Assessment Results**



Deeper analysis of individual indicator gap scores within each Assessment Area revealed both strengths and weaknesses in the State's prevention infrastructure. Hawai'i's State-level capacity strengths include:

(1) Established State agencies who allocate financial and other prevention resources.
(2) Good State-level data collection.
(3) Good workforce knowledge of evidence based prevention strategies.
(4) Good workforce knowledge of prevention risk/protective factors.

Hawai'i would benefit from building capacity at the State-level to:

(1) Develop a State plan to achieve sustainable outcomes.
(2) Provide language assistance services and translated material, at no cost, to beneficiaries with limited English proficiency.
(3) Strengthen interagency communication and collaboration to produce maximum impact with unduplicated services.
(4) Increase involvement of the State Advisory Council (SAC) with prevention issues.

**STATE LEVEL CAPACITY TO COLLECT, ANALYZE, AND REPORT DATA FOR SPF-SIG**

ADAD is at a pivotal crossroads when it comes to prevention data collection systems. Currently, ADAD uses the Minimum Data Set (MDS) to collect basic demographic information on prevention services to meet federal reporting requirements. In 2009, ADAD will transition to a new, more robust, web-based data collection system called Knowledge-based Information Technologies (KIT) Solutions. ADAD is in the process of customizing KIT Solutions to include the National Outcome Measures (NOMs) for SPF-SIG and the SAPT Block Grant, State General Fund reports, and other prevention contract reporting requirements. The system allows data to be collected at the State, community, and program levels. The goal of KIT Solutions is to make reporting easier for our providers and to create one central data collection point for prevention in Hawai'i. The result will be a more complete picture of prevention efforts in Hawai'i.

In October, 2007 KIT Solutions was pilot tested with seven prevention providers funded by SAPT Block Grant or State Funds with representation from each of Hawai'i's four counties. Each provider was tasked with inputting program data from the previous three months, and reporting services in KIT Solutions for the next three months (6 months total). Feedback from the pilot testers was extremely positive, and useful to the customization process. The providers were able to quickly learn to use KIT Solutions and meet their individual data collection needs. Overall providers preferred using KIT Solutions over MDS because it was easy to use and had the ability to meet their individual program needs.

The Project Epidemiological Team with support from the SEW supports the SPF-SIG in analyzing, and interpreting data and utilizing data to guide decision making. In addition, the University of Hawai'i, Center on the Family is contracted to help develop KIT Solutions and provide evaluation services for SPF-SIG. ADAD also has a contract with the University of Hawai'i, Department of Public Health to provide epidemiological services for the SPF-SIG Project.

**COMMUNITY-LEVEL PREVENTION INFRASTRUCTURE**

For the Hawai'i SPF-SIG, Community have been defined as the four Counties of the State. Letters of support for SPF-SIG have been submitted by Mayors of Kauai County, City & County of Honolulu, Maui County, and Hawai'i County. Each county has different political structures, demographic composition, and geographical landscape (e.g., Maui County has a tri-island population; Honolulu County contains 71% of the entire State population, etc.). Despite these differences, County Advisory Councils (CAC) have been formed in each Community. Mayors' Offices will serve as the SPF-SIG fiscal agent at the County level.

ADAD has prevention contracts totaling $4.4 Million (allocated for SFY 2007-2008) distributed in each of the four counties (see Table 14). As mentioned above, prevention funding comes from SAPT Block Grant, federal discretionary grants, and State funds. This breakdown does not include SPF-SIG funds as monies have not yet been allocated to Counties/Programs (as per our grant requirements) for the 2008 fiscal year. As per Hawai'i procurement statutes, contracts are awarded through a competitive RFP process. Awarded contracts may provide services to the entire population or only to a specific geographical area (i.e.: Kaua'i county only). Contracted agencies serve target populations identified through the application process as areas of high need (contribution to burden) or low service (magnitude).

**Table 14: 2008 prevention funds allocated through ADAD by County (non-age specific).**

| *County* | *2007 Population (estimate)* | *Percentage of State Population* | *2008 ADAD Prevention Funding* | *Percentage of ADAD Funding* | *Funding per capita* |
|---|---|---|---|---|---|
| Kauai | 62,828 | 4.9 | $812,659 | 18.3 | $12.93 |
| Honolulu | 905,601 | 70.6 | $2,012,797 | 45.3 | $2.22 |
| Maui | 141,902 | 11.1 | $984,157 | 22.1 | $6.94 |
| Hawai'i | 173,057 | 13.5 | $635,610 | 14.3 | $3.67 |
| State | 1,283,388 | 100.0 | $4,445,223 | 100.0 | $3.46 |

Note: Population data from 2007 US Census Population Estimate

For maps of prevention services funded by ADAD, see Figures 4-7.

**Figure 4: ADAD Prevention Contracts by Population in Kaua'i County.**

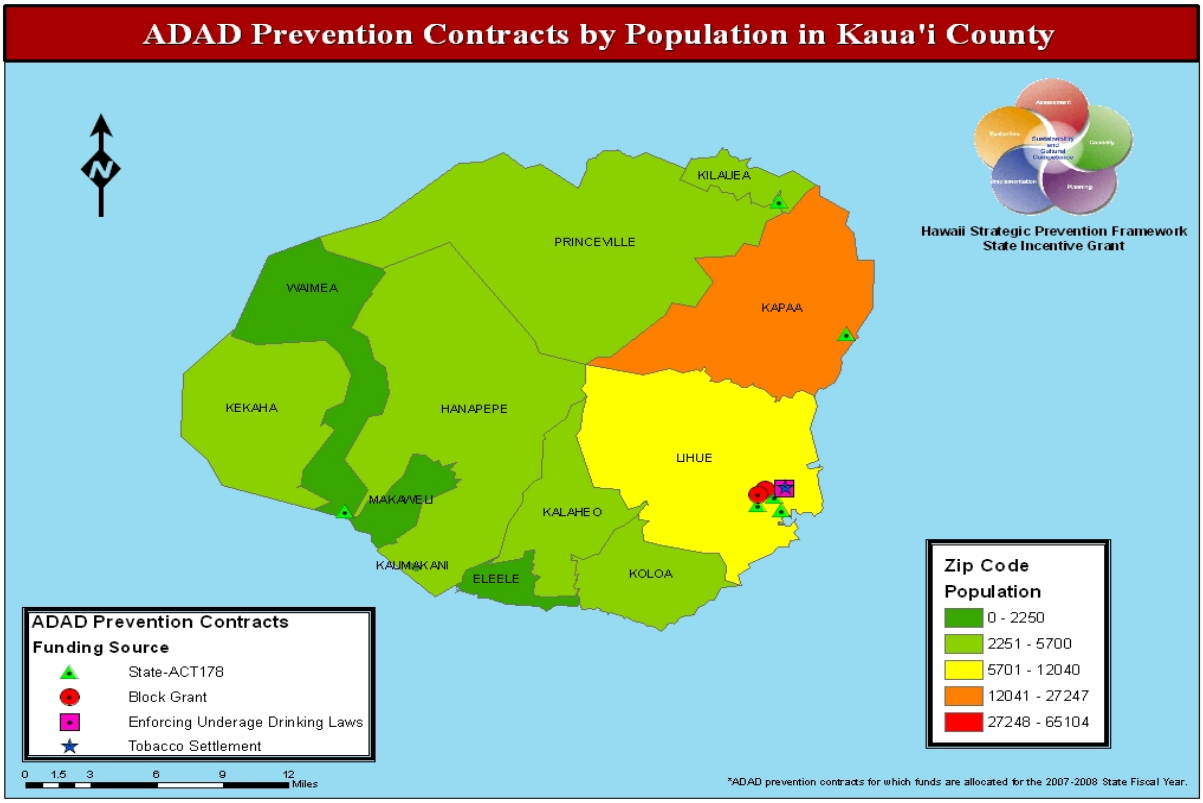


**Figure 5: ADAD Prevention Contracts by Population in the City and County of Honolulu.**

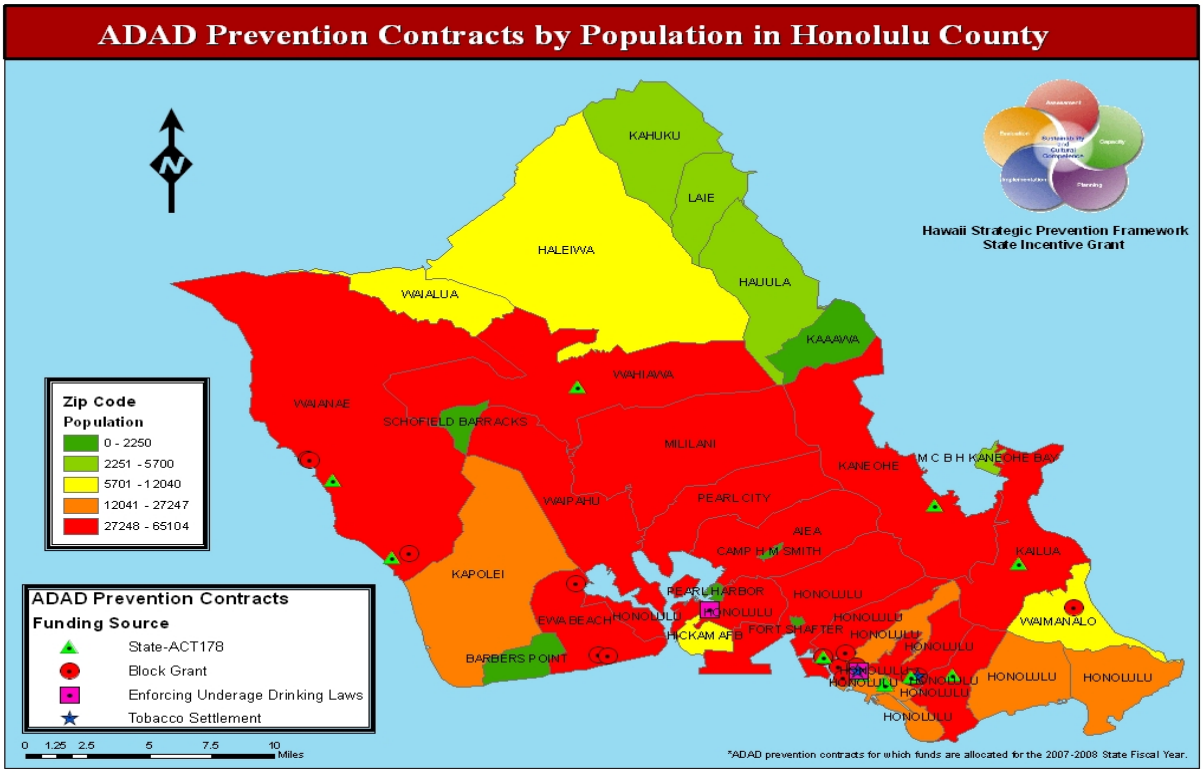



**Figure 6: ADAD Prevention Contracts by Population in the County of Maui.**

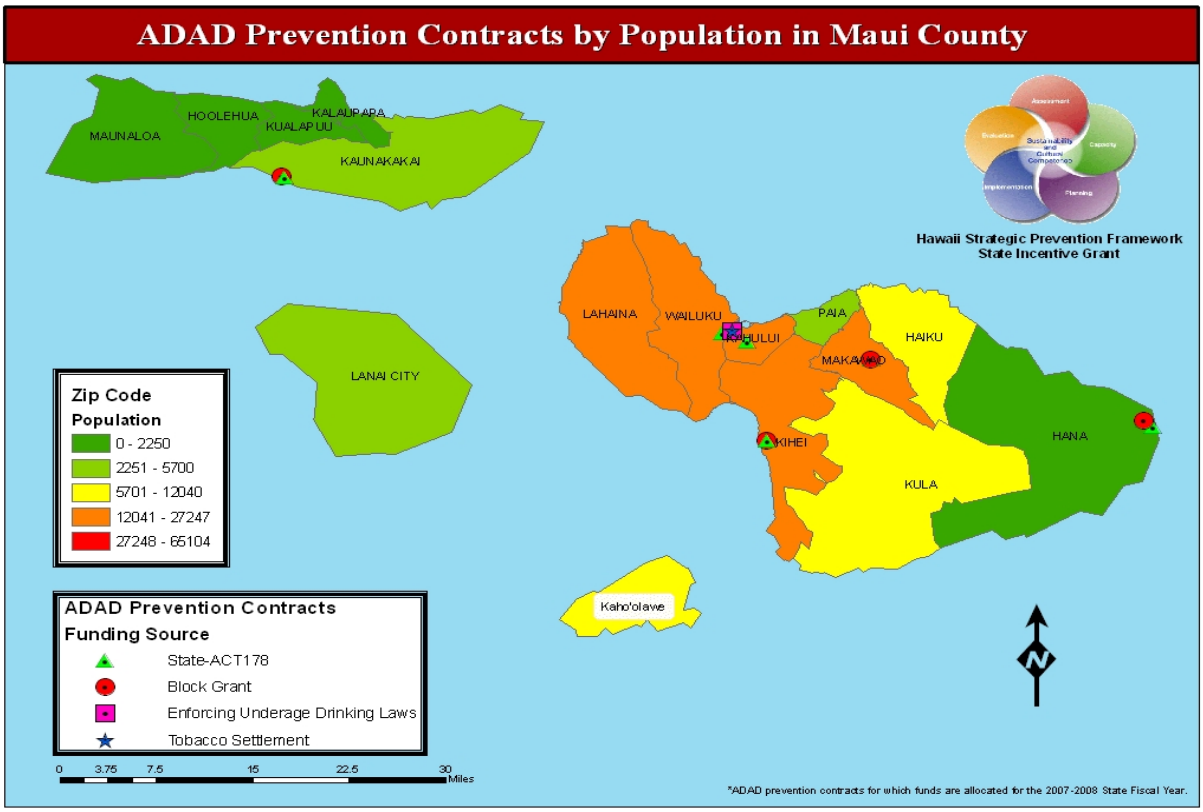
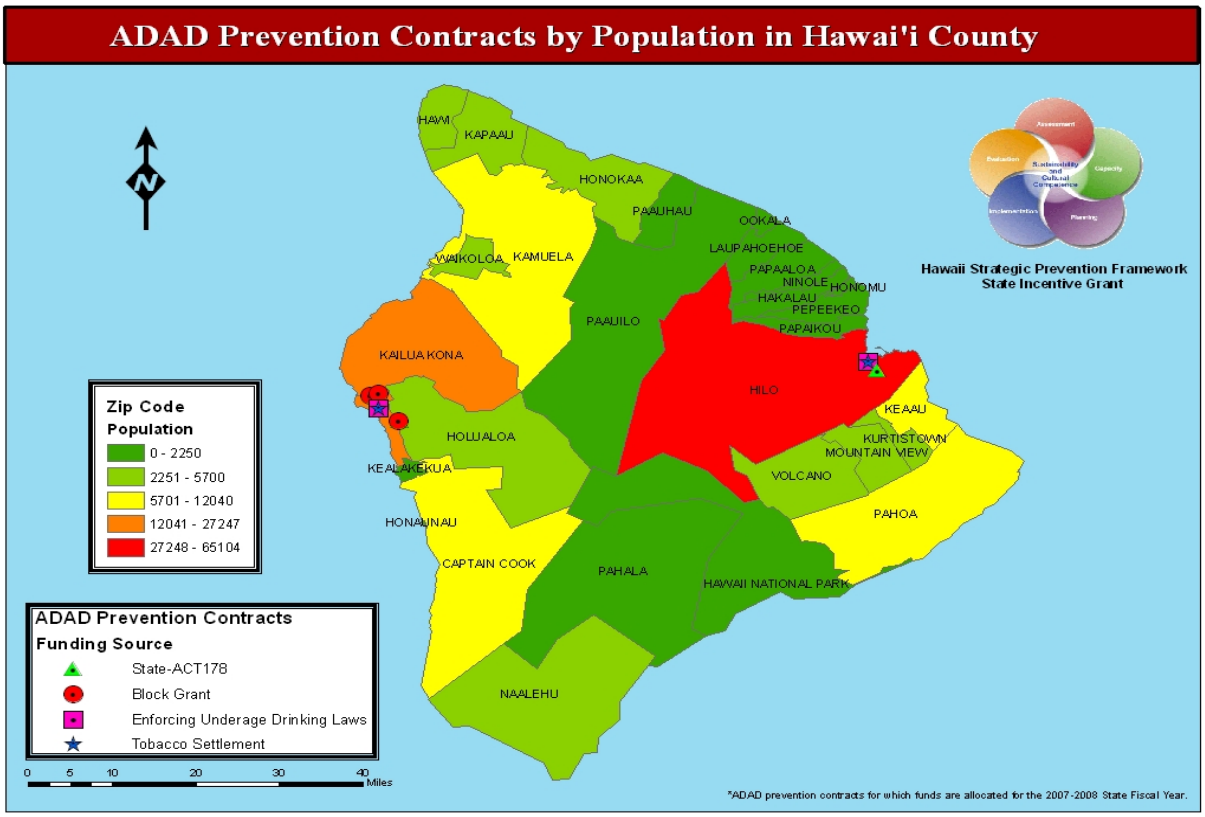


**Figure 7: ADAD Prevention Contracts by Population in Hawai'i County.**




## EFFECTIVENESS OF COMMUNITY PREVENTION INFRASTRUCTURE

As described earlier, there are SPF-SIG Community Advisory Councils (CAC) in each of Hawai'i's four counties. Mayors' Offices serve as the SPF-SIG fiscal agent for each Community. Each CAC is chaired by a Mayor appointed Chairperson, who also sits on the SAC. The role of the Chairperson is to act as liaison to the SAC and to represent the "voice" of their specific community during SAC meetings. The CAC membership includes a diverse group of members who represent their Community. The CAC members bring to the table a strong background in community prevention and leadership in their Community. Each Neighbor Island (Kaua'i, Maui, and Hawai'i) CAC membership also includes a representative from the State District Health Office (DHO) as a link between the State Department of Health and the Community.

Another important part of the SPF-SIG team will be the Community Epidemiological Workgroup (CEW). The CAC are in the process of identifying membership of the CEW. CEW members will have the experience and knowledge of substance abuse data and access to various data sources. Each CEW will have the support of the SEW, SPF-SIG contracted Epidemiologist, and DHOs to identify and analyze local substance abuse data. In addition, the SPF-SIG Project Manager and Specialist will assist with coordinating meetings and technical assistance requested by CAC.

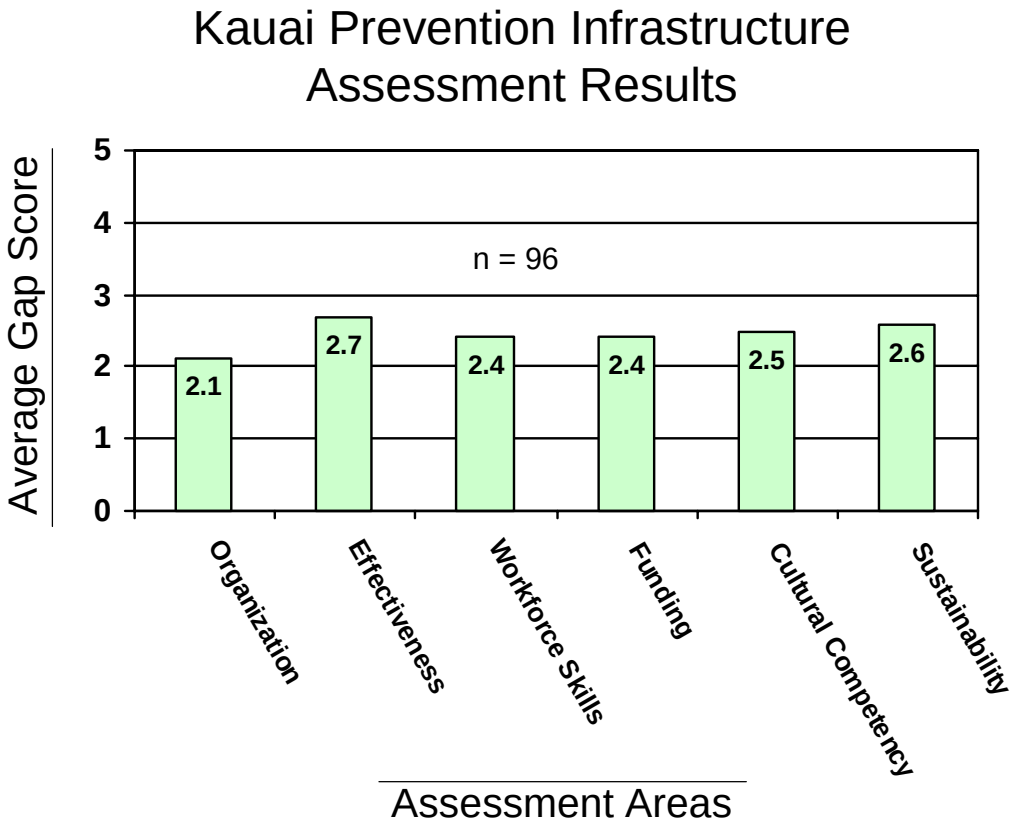
## SIGNIFICANT GAPS IN CURRENT COMMUNITY PREVENTION SYSTEMS & CAPACITY TO IMPLEMENT THE SPF-SIG AT THE COMMUNITY-LEVEL

As mentioned earlier, the Assessment Workgroup of the SAC developed the Community Capacity Assessment Survey (Appendix F) from a tool created by Nebraska Partners for Prevention, Southwest CAPT, and CSAP. The survey was administered to members of each CAC as a method of collecting information from key prevention stakeholders at the community level regarding the strengths and challenges of the community (County) prevention system for SPF-SIG assessment purposes. Each CAC member was then asked to identify approximately 10 community key stakeholders who were familiar with the Community prevention system. The goal was to engage key community stakeholders and provide a more comprehensive picture of each Community's prevention infrastructure.

The community survey measures 6 areas (with a total of 23 indicators) of the prevention system. The areas are (1) Organization; (2) Effectiveness; (3) Workforce Skills; (4) Funding; (5) Cultural

Competence; and (6) Sustainability. A total of 96 surveys were completed in Kaua'i County, 46 in the City and County of Honolulu, 61 in Maui County, and 68 in Hawai'i County. Respondents rated the Community's current capacity relative to each of the 23 indicators (the current score) as well as their perceived importance of each indicator relative to capacity for effective prevention (the importance score). Gap scores were calculated by subtracting the current score from the importance score. High gap scores indicate areas that may need capacity improvement, and low gap scores indicate strengths in the current Community prevention system. Average gap scores for each Community are presented in Figures 8-11, below. Deeper analysis of individual indicator gap scores within each Assessment Area revealed both strengths and weaknesses in each Community's prevention infrastructure.

**Figure 8: Kaua'i Community Capacity Assessment Results.**




Kaua'i Community's capacity strengths include:

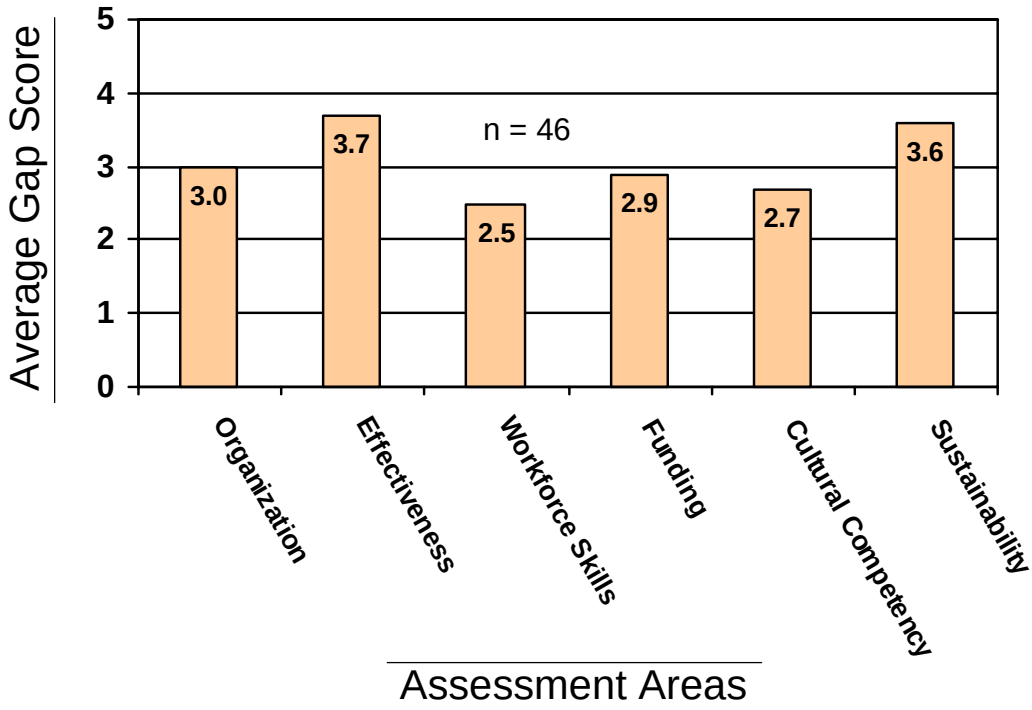
(1) Active and coordinated Community substance abuse prevention agencies, departments, and stakeholders who allocate financial and other resources;
(2) Workforce knowledge of prevention risk/protective factors;
(3) Workforce members who participate and contribute resources toward collaborative community prevention efforts; and
(4) Workforce ability to effectively share prevention knowledge with others.

Kaua'i Community would benefit from building capacity at the community level to:

(1) Ensure that all age groups are being served by prevention services;
(2) Acquire and allocate resources to sustain key prevention initiatives;
(3) Coordinate funding streams across prevention agencies and organizations to maximize the impact and provide unduplicated services;
(4) Provide language assistance services and translated material, at no cost to beneficiaries with limited English proficiency.

**Figure 9: City and Community of Honolulu Capacity Assessment Results**

# Honolulu Prevention Infrastructure Assessment Results



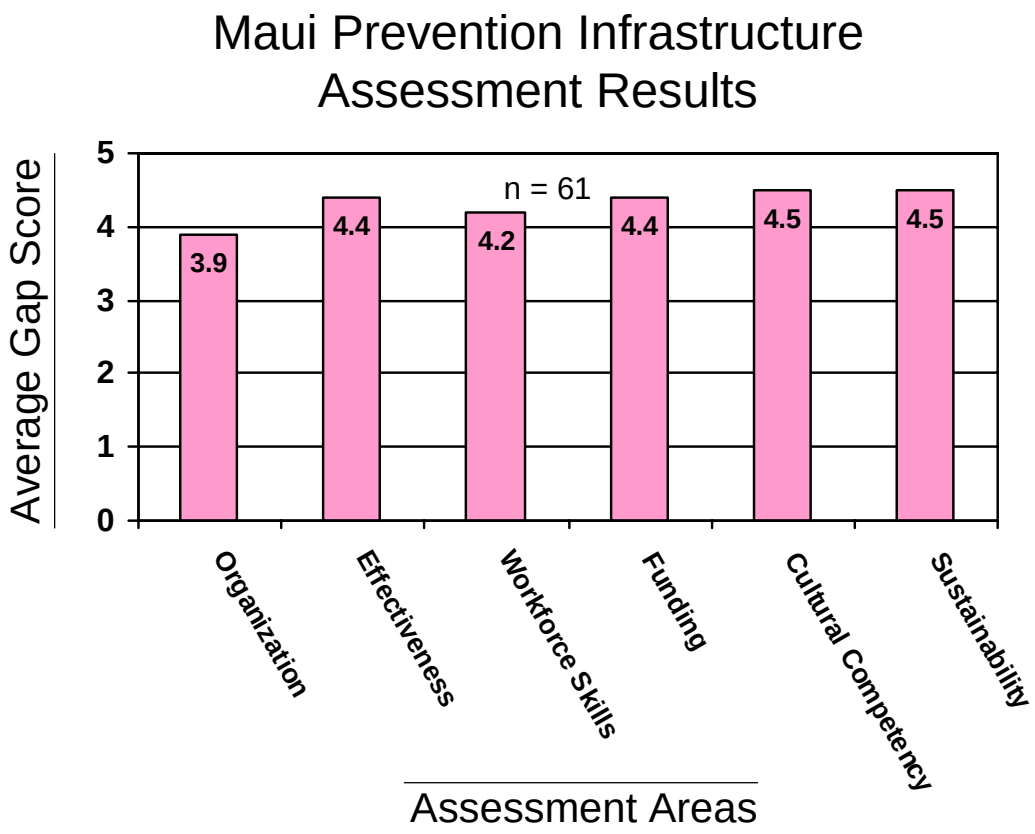

City and County of Honolulu capacity strengths include:

(1) Workforce knowledge of prevention risk/protective factors;
(2) Workforce skills using Community/program data for planning and decision making;
(3) Integration of participant demographic data into management information systems; and
(4) Workforce knowledge of evidence-based prevention strategies and ability to effectively share prevention information with others.

City and County of Honolulu would benefit from building capacity at the community level to:

(1) Develop a written plan to achieve sustainable outcomes;
(2) Increase interagency collaboration to meet goals and provide unduplicated services;
(3) Promote strong working relationships through better interagency communication; and
(4) Acquire and allocate resources to sustain key prevention initiatives.

**Figure 10: Maui County Capacity Assessment Results**



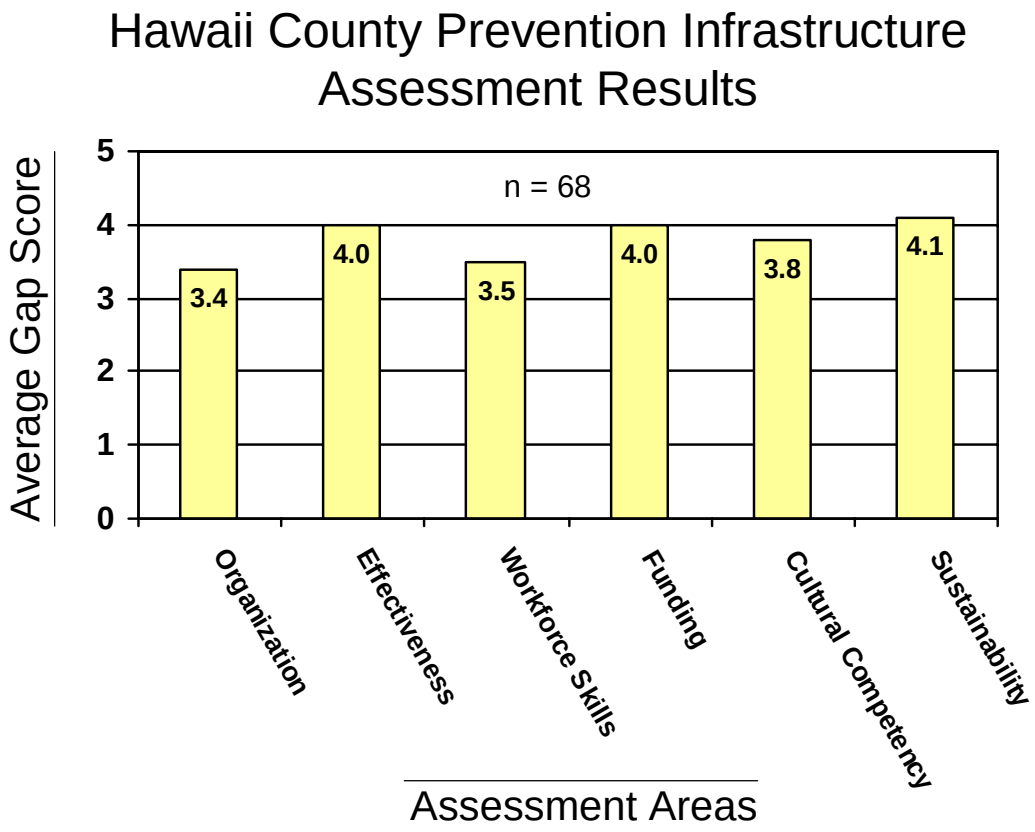

Maui County capacity strengths include:

(1) The existence of key substance abuse agencies;
(2) Support (resources, staffing, in-kind, etc.) from prevention members;
(3) Workforce knowledge and skill using Community and program-level data as the basis for prevention planning and decision-making;
(4) Workforce knowledge of prevention risk and protective factors and ability to effectively share this information.

Maui Community would benefit from building capacity at the County level to:

(1) Provide understandable and respectful language assistance services and translated material, at no cost to beneficiaries;
(2) Coordinate funding streams across prevention agencies and organizations to maximize the impact of prevention efforts and provide unduplicated services;
(3) Acquire and allocate resources to sustain key prevention initiatives; and
(4) Increase workforce knowledge and skill to use a combination of strategies (policy, enforcement, media, etc.) to influence the environment, as well as to change the behavior of individuals.

**Figure 11: Hawai'i County Capacity Assessment Results**




Hawai'i County's capacity strengths include:

(1) The existence of key substance abuse agencies that allocate financial resources;
(2) Workforce knowledge of prevention risk and protective factors;
(3) Integration of participant demographic data into management information systems; and
(4) Workforce knowledge of evidence-based prevention strategies.

Hawai'i County would benefit from building capacity at the County level to:

(1) Coordinate and leverage funding streams across prevention agencies and organizations to maximize the impact of prevention efforts;
(2) Develop a written plan to acquire and allocate resources to sustain key prevention initiatives;
(3) Ensure that all age groups are being served with prevention services; and
(4) Provide language assistance services and translated material, at no cost to beneficiaries.

**COUNTY-LEVEL CAPACITY TO COLLECT, ANALYZE, AND REPORT DATA FOR SPF-SIG**

ADAD is at a pivotal crossroads when it comes to prevention data collection systems. As described earlier, ADAD currently uses Minimum Data Set (MDS) to collect basic demographic information on prevention services in order to meet federal reporting requirements. In 2009, ADAD will transition to a new, more robust, web-based data collection system called Knowledge-based Information Technologies (KIT) Solutions. ADAD is in the process of customizing KIT Solutions to include the National Outcome Measures (NOMs) for SPF-SIG and the SAPT Block Grant, State Fund reports, and other prevention contract reporting requirements. The system allows data to be collected at the State, County, and program levels. The goal of KIT Solutions is to make reporting easier for our providers and to create one central data collection point for prevention in Hawai'i. The result will be a more complete picture of prevention efforts at each level in Hawai'i.

In accordance with the Health Insurance Portability and Accountability Act 1996 security measures have been built into KIT Solutions with regards to levels of access.

The CEW will support the SPF-SIG in analyzing, and interpreting County data to guide decision making.

In addition, the University of Hawai'i, Center on the Family is contracted to help develop KIT Solutions and provide evaluation services for SPF-SIG at each level. ADAD also has a contract with the University of Hawai'i, Department of Public Health to provide epidemiological services at each level.

### 3. HAWAI'I SPF-SIG STATE PRIORITIES

As detailed earlier, the results of the *Hawai'i Epidemiological Profile for Substance Abuse Prevention (Spring 2007)* lead the SEOW to recommend a priority focus area for the SPF-SIG. The SEW confirmed this recommendation in March 2008 and suggested that the Hawai'i SPF-SIG focus on the reduction and prevention of underage alcohol consumption for youth 12-17 years old. The data tables in Appendix D summarize the priority indicator data leading to this finding. The results of the analyses of population-based data from National and State sources led to the conclusion that reducing consumption by increasing the age of initial use of alcohol and reducing the current use of alcohol, should lead to a reduction in negative consequences, such as antisocial behaviors related to alcohol use. Table 15 describes Hawai'i's Statewide priority and related indicators, baseline data, and desired outcomes.

**TABLE 15: SPF-SIG GOAL – REDUCTION AND PREVENTION OF UNDERAGE ALCOHOL CONSUMPTION BY YOUTH 12-17 YEARS OLD (SUBJECT TO FINALIZING UPON SELECTION OF OUTCOME MEASURES BY SEW).**

| Consumption Pattern | Indicator | Data Source | Baseline Data | Desired Outcomes |
|---|---|---|---|---|
| Current alcohol use | (1) 30-day alcohol use, ages 12-17 | (1.a.) Hawai'i Student Alcohol, Tobacco, and Other Drug Use Study (ATOD 2003) | (1.a.a) 20.2% of 6th to 12th grade students report alcohol use in past 30 days<br>Secondary data:<br>(1.a.b) 3.9% of 6th graders report alcohol use in past 30 days<br>(1.a.c) 17.4% of 8th graders report alcohol use in past 30 days<br>(1.a.d) 27.1% of 10th graders report alcohol use in past 30 days<br>(1.a.e) 36.6% of 12th graders report alcohol use in past 30 days | (1.a.) Decrease current alcohol use by 12-17 years olds, as measured by 30-day alcohol use, from 20.2% to 16.0% by 2011. |
| | | (1b) National Survey on Drug Use and Health (NSDUH 2004-2005) | (1.b.a) 14.1% of youth ages 12-17 reporting have used alcohol in the past 30 days | (1.b.) Decrease current alcohol use by 12-17 year olds, as measured by 30-day use, from 14.1% to 11.0% by 2011. |
| | (2) 30-day binge drinking, ages 12-17 | (2) NSDUH 2004-2005 | (2) 9.3% of 12-17 year olds reported binge drinking at least once in the past 30 days | (2) Decrease current alcohol use by 12-17 year olds, as measured by 30-day binge drinking, from 9.3% to 7.0%, by 2011. |

| | | | | |
|---|---|---|---|---|
| Early initial use of alcohol | (1) Mean age at first use of alcohol by intermediate and high school students | (1) ATOD 2003 | (1) Average age at initial alcohol use is 12.2 years | (1) Decrease early initial use of alcohol, as measured by average age at initial use, by increasing this age from 12.2 years to 13.0 years, by 2011. |
| | (2) Percent of students in grades 6-12 reporting first use of alcohol before age 13 | (2) Youth Risk Behavior Survey (YRBS 2005) | (2) 27.3% of students report first use of alcohol before age 13 | (2) Decrease early initial use of alcohol, as measured by percent of students in grades 6-12 reporting first use of alcohol before age 13, by decreasing this percent from 27.3% to 23.0%, by 2011. |
| | (3) Age of initial use of alcohol | (3) NSDUH 2004-2005 | (3) The average age of initial alcohol use is 13.2 years | (3) Decrease early initial use of alcohol, as measured by age of initial use of alcohol, by raising the age of initial use from 13.2 years to 14.0 years, by 2011. |
| Antisocial behavior | (1) Percent of high school students reporting they drank on school property in the past 30 days | (1) YRBS 2005 | (1) 8.8% of high school students report having used alcohol on school property in the past 30 days | (1) Decrease antisocial behavior, as measured by the percent of high school students drinking on school property in the past 30 days, by reducing this percent from 8.8% to 7.0%, by 2011. |
| | (2) Percent of current alcohol users grades 6-12 reporting they have been drunk or high at school. | (2) ATOD 2003 | (2) 39% of $6^{th}$-$12^{th}$ graders who are current alcohol users (have used alcohol in past 30 days) report having been drunk or high on alcohol at school. | (2) Decrease antisocial behavior, as measured by the percent of current alcohol users grades 6-12 reporting they have been drunk or high (on alcohol) at school, by reducing this percent from 39% to 32.0%, by 2011. |

| | | | | |
|---|---|---|---|---|
| Low perception of risk of using alcohol | (1) Percent of students 12-17 reporting they perceive "great risk" of drinking 5 or more drinks once or twice a week | (1) NSDUH 2004-2005 | (1) 39.38% ages 12-17 perceive "great risk" of drinking 5 or more drinks once or twice a week. | (1) Increase perception of risk of use of alcohol, as measured by percent of students ages 12-17 reporting they perceive "great risk" of drinking 5 or more drinks once or twice a week from 39.28 % to 45.28 % in 2011. |
| | (2) Percent of students ages 12-17 reporting they perceive "great risk" of drinking 5 or more drinks once or twice a week. | | (2) 75.8% of students ages 12-17 report they perceive "great risk" of drinking 5 or more drinks once or twice a week. | (2) Increase perception of risk of use of alcohol, as measured by percent of students ages 12-17 reporting they perceive "great risk" of drinking 5 or more drinks once or twice a week from 75.8% to 81.1%, by 2011. |

# STEP 2: CAPACITY BUILDING

The purpose of the **Capacity Building Step** is to build State and County capacity based on the priorities established in the assessment phase of the Strategic Prevention Framework. This component includes three elements:

1) Areas Needing Strengthening – identify and describe areas in which the State/County needs to strengthen its capacity in order to effectively implement the SPF-SIG.
2) State and County Level Activities – describe SPF-SIG capacity building activities that will be conducted at the Statewide and local County levels.
3) Role of the SEW – describe the expected role of the SEW in the remaining years of the grant, and how the State plans to strengthen this Workgroup. Describe how the State will continue to collect and analyze data in order to identify emerging priority areas and monitor substance abuse consequences and consumption patterns over time.

**1. AREAS THAT NEED STRENGTHENING**

When the Hawai'i Department of Health, ADAD received the SPF-SIG from the Hawai'i Governor's Office in October, 2006, the State needed to develop and strengthen its capacity to implement the SPF-SIG. Since the award, much progress has been made in building State capacity to implement the SPF-SIG. A SPF-SIG Project Manager was hired to direct the project at the State level, and a SPF-SIG Project Specialist was hired to direct the project at the county level. The SEW was formed and the *Hawai'i Epidemiological Profile for Substance Abuse Prevention* (revised March, 2008) was produced to meet the data requirements of the SPF-SIG. The SPF-SIG Project Manager also built an infrastructure to support the implementation of the SPF-SIG in Hawai'i at the State and County levels. A State Advisory Council (SAC) was formed to oversee the SPF-SIG. The County Advisory Council (CAC) were formed in each of Hawai'i's four island counties, Kaua'i County, Honolulu County, Maui County and Hawai'i County.

Currently the State would benefit from building capacity at the State level to (1) develop a State plan to achieve sustainable outcomes; (2) provide language assistance services and translated material, at no cost, to beneficiaries with limited English proficiency; (3) strengthen interagency communication and collaboration to produce maximum impact with unduplicated services; and (4) increase involvement of the State Advisory Council (SAC) with prevention issues.

Currently the counties would benefit from building capacity at the county level to (1) improve communication, coordination, and resource leveraging among prevention agencies to maximize the impact of prevention efforts and reduce duplication of services; (2) develop a written sustainability plan to acquire and allocate resources to sustain key prevention initiatives; (3) provide no-cost language assistance services to beneficiaries; (4) ensure that all age groups are being served with prevention services; and, in Hawai'i county (5) to increase workforce knowledge and skills to use a combination of strategies (policy, enforcement, media, etc.) to influence the environment, as well as to change the behavior of individuals.

**2. STATE AND COUNTY LEVEL ACTIVITIES**

Capacity to implement the SPF-SIG at the State and County levels will be enhanced by providing technical assistance and support to the members of the SAC, SEW and CAC; and, to key prevention stakeholders. The SPF-SIG project staff, the Project Evaluation Team and the Project Epidemiological Team will collaborate to meet the identified needs in one-to-one technical assistance sessions or large group trainings and workshops. The capacity building needs will be identified through the capacity and infrastructure assessment and through other surveys as identified by SPF-SIG staff.

**Technical Assistance**. These sessions will provided upon request and will be tailored to meet a specific need of a stakeholder. Sessions are delivered either in a one-to-one session or in a small group setting. Such topics may include:

- Data Collection.
- Identifying Sub-County Data.
- Fiscal Management.
- Outcome Instruments (i.e.: National Outcome Measures, Hawai'i Alcohol, Tobacco and Other Drug Survey – *Ka Leo O Na Keiki*).
- Translating Research and Adapt Evidence-Based Practices into County Based Interventions.
- Meeting Facilitation and Strategic Planning.

**Training/Workshops**. Trainings and workshops will be provided as a result of intermittent surveys. The resulting sessions will be provided in a large group setting and attendees may include general public health providers not specifically connected to the SPF-SIG Project. Such topics may include:

- SAMHSA's 5-Step Prevention Platform (Assessment, Capacity Building, Planning, Implementation and Evaluation).
- Identifying and Selecting Evidence-Based Interventions.
- Process and Outcome Evaluation.
- Developing Sustainability Plans.
- Grant writing.
- Cultural Competency.
- Providing No-Cost Language Assistance Services.
- Coalition Capacity Building.
- Translating Research and Adapt Evidence-Based Practices into County Based Interventions.

**3. ROLE OF THE SEW**

The *Hawai'i Epidemiological Profile for Substance Abuse Prevention*, *March, 2008* was revised by the SEW and focuses on presenting State and county level substance abuse data and illuminating substance use and consequence issues and trends at the State level. Throughout the life of the SPF-SIG the SEW will be convened by the Project Epidemiological Team primarily in a consultative capacity; to assure the science and methodology as it relates to data collection, analysis and interpretation. The SEW will assist

the Epidemiological Team to update the County Epidemiological Profiles at least every two years (depending on the availability of data), address existing data gaps, identify emerging priority issues, and monitor substance abuse consequences and consumption patterns over time.

The project epidemiologist will solicit input from the SEW, on an as needed basis, when working with the State level evaluator to develop recommendations for data sets to be collected at the County and sub-County level for each priority. The SEW will also support State level work to create collection strategies where possible for all Counties. Several Statewide workshops will be held during the first month after funding to initiate this process.

# STEP 3: PLANNING

The purpose of the **Planning Step** is to allow States to describe the proposed approach to developing and deploying SPF-SIG grant resources and the programmatic mechanisms to address SPF-SIG priorities. This component must including at least four (4) elements:

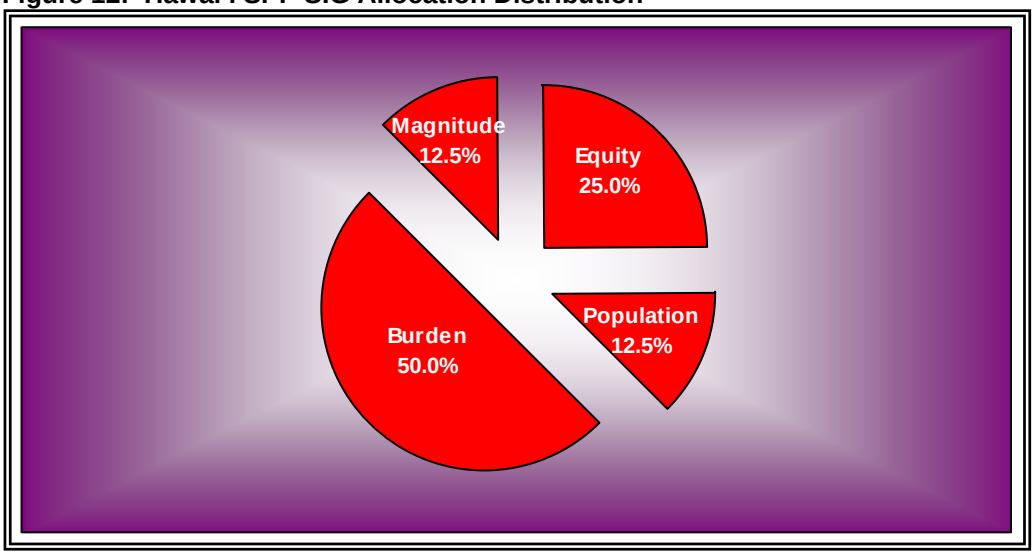
1) State planning model;
2) Description of County-based activities;
3) Allocation approach; and
4) Implications of allocation approach.

## 1. STATE PLANNING MODEL

The State of Hawai'i will use a hybrid equity planning model (Figure 12), combining both non-competitive and competitive allocation mechanisms.

- **Non-competitive**:
  - Equity-25.0%: Non-competitive funds amounting to 25.0% of the total available County SPF-SIG grant resources will be awarded as an equity allocation to each of the four counties.
  - Population-12.5%: Will be awarded as non-competitive allocations based on county population for the targeted age group of youth ages 12-17 years old.
- **Competitive:**
  - Contribution to Burden-50.0%: Competitive allocations totaling 50% of the available County SPF-SIG grant resources will be allocated to counties based on documentation of their contributions to the burden of underage drinking in the State.
  - Magnitude-12.5%: The remaining 12.5% on documentation of the magnitude of resource gaps identified in the County assessment. For the purpose of this project, magnitude is defined as the counties ability to illustrate its lack of availability and/or access to prevention activities and resources.

**Figure 12: Hawai'i SPF-SIG Allocation Distribution**




All funding will be made available to Mayors' Office, or their designee, within each of the four counties. A total of 37.5% of the funds will be allocated in a non-competitive process based on equity (25.0%) and population size (12.5%). Such funds will be awarded upon completion of pre-assessment activities as determined by the SPF-SIG- SIG project and includes but is not limited to the collection of data specific to pre-populated epidemiological data, sub-county data, and capacity and infrastructure activities. It is anticipated that non-competitive funding will be used to assist the counties with completing the

assessment and capacity building phases of the framework to develop their county specific underage drinking prevention plan that aligns with SPF-SIG goals. Timeline and deliverables are noted below.

The remaining 62.5% of the funds will be allocated in a competitive process based on each county's contribution to the overall State burden (50.0%) and their ability to demonstrate (with the use of sub-county data) the magnitude (12.5%) of the problem within their county. While it is anticipated that the funding will be available to the four counties, it is unclear at this time as to how it will be disseminated within each county. Distribution of these funds will be determined by each county based on the data collected and will be outlined in their plan. Table 16 summarizes the type of funding, timeline and deliverables.

**Table 16: Funding Distribution. Type of Funding, Timeline and Deliverables**.

| Type of Funding | Timeline | Deliverables |
|---|---|---|
| Non-Competitive (Equity) | By December 31, 2008 | Submission of application for funding including, but not limited to:<br>• Completion of County Epidemiological Profile<br>o Set of sub-county data (TBD)<br>• Completion of 100 capacity infrastructure surveys<br>• Completion of Resource Directory<br>• Completion of Pre-Assessment Report |
| Non-Competitive (Population) and Competitive Funding (Burden and Magnitude) | By April 30, 2009 | • Completion of County Underage Drinking Prevention Plan |
| Competitive Funding (Burden and Magnitude) | TBD through September 2011 | • Implementation of County Underage Drinking Prevention Plan |

**2. APPLICATION AND REVIEW PROCESS**

The announcement of availability of funds will be made by SPF-SIG to the members of the SAC. The announcement will include application requirements as well as the scoring tool. Post receipt of applications, a review panel of at least 5 members (two of which will be a team member of both the Epidemiological and Evaluation team) will be convened to review and score the proposals to determine whether a competitive allocation will be awarded, and if so, the amount of the allocation. Criteria related to the severity of the problem, the magnitude of gaps identified, selection of evidence-based programs/policies/practices to address gaps, cultural responsiveness, and sustainability of plans will be utilized in the scoring process to determine competitive allocation awards.

Competitive allocations will be used to focus resources on those areas with the greatest need and the greatest resource gaps relative to these indicators, with the goal of showing change in factors contributing to underage drinking, ages 12-17 at the State level. Equity is a strong value imbedded in Island culture, so providing some equity funding to all counties is vital. As in many States, larger metropolitan areas often secure the lion's share of available funding, while small, isolated Counties suffer chronic funding shortages. Hawai'i's allocation approach assures that each county receives adequate funding to implement effective prevention strategies.

**3. IMPLICATIONS OF ALLOCATION APPROACH (STATE TO COUNTY)**

Hawai'i Revised Statutes exempts the SPF-SIG from adhering to a formal RFP process, since County allocations represent a "Government to Government" transaction. Therefore, the application approach described above assures that Hawai'i remains in compliance with State procurement laws and ensures that Counties have the opportunity to apply for funding through an open application process.

After receiving funding, Counties will have to adhere to the “Request for Proposal” process as required by law. Programs within a specific County may apply independently or together with other programs within the County in an attempt to meet the competitive allocation criteria. This allows for programs to collaborate and also to apply independently. Collaborative applications will contribute to demonstrating desired changes (achieving desired outcomes) at the State level. The Project Epidemiological Team will provide data analysis support to applicants. Applicants can apply, and must document their use of, any or all of the three criteria for selecting evidence-based programs/practices/policies included in the SAMHSA/CSAP publication, *Identifying and Selecting Evidence-Based Interventions*. Technical assistance will be available to applicants from the SPF-SIG Project Manager, Project Specialist, the Project Epidemiological Team and the SPF-SIG evaluator as they prepare their applications for competitive funding. The Statewide infrastructure for prevention will, as a result, be strengthened. Strengthening prevention infrastructure is a capacity building goal at the State and county levels in Hawai‘i.

# STEP 4: IMPLEMENTATION

The **Implementation Step** focuses on the approach the State will take in implementing State level capacity and infrastructure activities as well as County level SPF-SIG policies, programs and practices. This includes:

1) The mechanisms that will be put in place to determine training and technical assistance needs of Counties.
2) The procedures that will be put in place to ensure that needed training is provided to Counties and is successful.

The State of Hawai'i has not yet reached the implementation phase of the SPF-SIG process. When the State Strategic Plan is approved by CSAP, Hawai'i will allocate a portion of the non-competitive funds to counties according to the formula described in the Planning section. The State will provide counties with a list of indicators on which counties should collect and analyze data. Epidemiological technical assistance will be provided to counties by the SPF-SIG epidemiologist to assist with data collection and analysis.

At the same time, Hawai'i will create the Application Process and criteria for the competitive portion of grant funding. The State will review applications and allocate funding to Counties and will approve all County strategic plans and logic models prior to implementation at the program level. The SPF-SIG staff will use the information provided by the Counties in their strategic plans to ensure that the selection of policies, programs, strategies, and practices are evidence-based. County and program implementers must also ensure that programs and practices are culturally responsive, adaptations are made without sacrificing the core elements of the program, and fidelity is maintained.

The SPF-SIG Project Manager and Project Specialist will utilize the SAC to build State level capacity to create a State sustainability plan, to explore resources for language assistance services at the State and County levels, and to strengthen interagency collaboration and State prevention leadership.

During the life of the project the Project Manager, the Project Epidemiologist and the Evaluator will review the status of implementation on a regular basis, in addition to the required annual compliance monitors to determine ongoing capacity, training, and technical assistance needs.

## 1. DETERMINING TRAINING AND TECHNICAL ASSISTANCE NEEDS OF COUNTIES

The State, in collaboration with other public health agencies, will conduct a Training Needs Assessment with the membership of the SAC and CAC to determine what kinds of training and technical assistance is needed by State prevention stakeholders relative to implementing the SPF-SIG. The SPF-SIG encourages States and Counties to build on existing infrastructure and activity where appropriate. Therefore, existing prevention training opportunities provided by ADAD and other State agencies will be offered to all SAC members. These training opportunities might include Substance Abuse Prevention Specialist Training (SAPST), Stages of Change training, and Geographic Information System (GIS) training.

## 2. TRAINING AND TECHNICAL ASSISTANCE TO COUNTIES

Through the SPF-SIG, ADAD will provide the leadership, technical assistance, and monitoring to ensure that Counties are successful in implementing the five steps of the strategic prevention framework. Based on the outcome of the Training Needs Assessment, tailored training opportunities will be made available to the members of the CAC and sub-recipients. It is anticipated that training and technical assistance will be needed by all Counties in the application of the third category of evidence-based programs/practices/policies included in the SAMHSA/CSAP publication, *Identifying and Selecting Evidence-Based Interventions*.

In order to minimize duplication and increase the effectiveness and quality of efforts, ADAD is encouraging Counties to collaborate with a diverse and comprehensive range of prevention

stakeholders. For instance, collaborative relationships will be expected with Drug Free Communities grantees, local departments of education, law enforcement agencies, policy makers, and other government and non-government entities that have a stake in the prevention of substance abuse.

# STEP 5: EVALUATION

The purpose of the **Evaluation Step** is to describe preliminary activities addressing evaluation and monitoring of the SPF-SIG. Please include the following considerations:

1) Discuss the State-level surveillance, monitoring, and evaluation activities you anticipate implementing.
2) Describe what you are expecting to track and how you plan to do the tracking.
3) Discuss what you are expecting to change.
4) Describe how you will ensure that your sub recipients will collect required SAMHSA/CSAP National Outcome Measures data, and how the data will be then submitted both to the State and to CSAP.

This section outlines the general evaluation activities for the Hawai'i SPF-SIG project in broad terms. At the State level ADAD has contracted with the University of Hawai'i, Center of the Family, to oversee SPF-SIG Evaluation; and will be referred to as the Project Evaluation Team lead by the Project Evaluator. The evaluation approach will be both multi-level and multi-method, including process and outcome components for the State- and County-level projects. At a minimum, we anticipate tracking demographic information, the number of people reached with the strategy or program, process information (difficulties encountered and how was it delivered), and the immediate impact on the population served.

**1. ANTICIPATED STATE-LEVEL MONITORING AND EVALUATION ACTIVITIES**

The evaluation will have three main areas of focus:

- State-level evaluation – process and outcome measures.
- County/sub-County evaluation – process and outcome measures.
- Training and technical assistance evaluation.

The Hawai'i SPF-SIG Evaluation Team will provide evaluation training and/or technical assistance to and gather ongoing monitoring and evaluation data from the State and County SPF-SIG projects. Project Manager and Project Specialist will receive regular status updates from the Project Evaluator on the appropriateness and timeliness of evaluation data submitted by county projects. Data will be collected on county program process, fidelity of implementation, and effectiveness. The Project Evaluator will identify successes, recommend improvements, and provide evaluation information to the Project Manager and Specialist for the purpose of adjusting implementation plans as needed. The Project Manager and Specialist will ensure that the counties address any problems and that data is submitted as required. Hawai'i SPF-SIG also will report to CSAP through the quarterly reporting process.

**2. TRACKING CHANGES**

The Hawai'i SPF-SIG will track, at the State level, the following indicators:

1. 30-day alcohol use by youth ages 12-17;
2. 30-day binge drinking by youth ages 12-17;
3. age of initiation of alcohol use; percent of students ages 12-17 who report drinking alcohol on school property in the past 30 days;
4. Percent of students ages 12-17 who report having been drunk or high on alcohol at school; and,
5. Percent of students ages 12-17 who report they perceive "great risk" of use of alcohol.

In order to track these changes, a number of methodologies will be used to track expected changes in indicators and underage drinking, ages 12-17. First, "case studies" will be completed for the State and for each county over the course of the SPF-SIG project. The purpose of the "case studies" is to fully describe and explain the project and resulting changes at the State and County levels. These studies are dependent upon a sound theory of change, the SPF-SIG process itself. Hawai'i will use "case studies" to determine the success with which counties implement the SPF-SIG process, and evaluators will use

this information to compare successful processes with successful outcomes. Second, State level data indicators will be tracked over time using longitudinal analysis and compared to national changes. Third, the *Hawai'i Epidemiological Profile for Substance Abuse Prevention* will be updated and revised by the SEW in the third year of the project or as data is made available.

**3. CHANGES EXPECTED**

We expect the numbers of current alcohol users, ages 12-17 in Hawai'i to decrease, due to the efforts of the State and County SPF-SIG. At the State level, we predict a decrease in the following priority factors contributing to underage drinking by youth ages 12-17: current alcohol use; early initiation of alcohol; antisocial behavior; and low perception of risk of using alcohol.

**4. REPORTING ON NOMs**

Hawai'i State and funded Counties will be required to participate in evaluation activities. This includes collecting all data required for the SAMHSA Prevention NOMs. Process data will also be collected; State evaluators will assist the State and Counties to create "case studies" of their SPF-SIG process. All required reports will be completed.

# CROSS-CUTTING PRINCIPLES

In this section, plans should include a discussion of the following three areas of focus that cut across all steps of the Strategic Prevention Framework:

1) Cultural competence in SPF-SIG steps.
2) Sustainability of SPF-SIG efforts.
3) Challenges you expect during implementation of the State Strategic Plan.

## 1. CULTURAL COMPETENCE

All SPF-SIG funded activities will be evidence-based, as defined in the SAMHSA/CSAP publication, *Identifying and Selecting Evidence-Based Interventions*. The Hawai'i SPF-SIG will ensure cultural competence at all steps of the SPF-SIG at both the State and County levels by considering the cultural landscape of each County; realizing that each County have different cultural issues and challenges. If an area requires additional training in cultural competence, the SPF-SIG will provide training through existing resources.

Many national prevention models and programs, based on research and practices reflecting different cultures and life experiences, are not a good fit for Hawai'i's diverse population. Therefore, Hawai'i's challenge is to integrate and/or tailor evidence-based programs for her diverse populations, and to provide evidence that innovative Hawaiian prevention programs and practices are effective.

## 2. SUSTAINABILITY

The 5-step Strategic Prevention Framework simplifies the 10-step public health strategic planning process currently utilized by Hawai'i's Department of Health. The SPF-SIG also strengthens the assessment process and the data-driven approach to strategic planning. Over the life of the SPF-SIG, the SPF-SIG will be adopted as the primary strategic planning process by the Department of Health and integrated into the requirements of the SAPT Block Grant.

Sustainability at the County level will be strengthened through the CAC. The hope is that the CAC will be able to generate enough capacity in the years of the grant that efforts to address underage drinking, ages 12-17 in the State will be sustained. Representatives from the Hawai'i Partnership to Prevent Underage Drinking (HPPUD), the Coalition for a Drug-Free Hawai'i, who operates the prevention resource center for the State, and other island coalitions serve on the SAC and CAC. It is hoped that these groups will build on the efforts of the SPF-SIG and continue using the SPF-SIG to address underage drinking in the State when the SPF-SIG is completed. Dedicated, committed citizens at the State and county levels will coalesce around current and future funding resources to continue the work.

The epidemiological work begun with the SPF-SIG is sustainable in Hawai'i. The State has engaged KIT Solutions to build a State data collection and reporting system that integrates data reporting requirements of the Block Grant, the SPF-SIG, NOMs, and other requirements at the program, County and State levels. This system will be sustained through the Block Grant. In addition, the SEW Chairperson is the Epidemiologist for the Hawai'i Department of Health and is developing a data warehouse to accumulate cross-agency State data. ADAD is also currently undergoing reorganization which may result in a permanent Epidemiologist position within ADAD. Finally, the Public Health Department is applying to become a School of Public Health within the University of Hawai'i, housing a Department of Epidemiology.

## 3. CHALLENGES

Initially during implementation, we expect the CAC may feel overwhelmed at the beginning of the process. We also expect both Counties and programs to struggle with data collection and analysis tasks. For these reasons we have committed to provide technical assistance to Counties and are working with the Project Evaluator to address data issues. We also acknowledge that there are political issues that will impact certain areas and the implementation of the grant. These may include uncertain County support for adherence to the SPF-SIG process, resistance from some agencies to share data, inability of the prevention services to reach the selected populations, or competing agendas. We are prepared to provide support and assistance to the CAC in areas that encounter such challenges.

A challenge may occur with linking the current State data reporting system (MDS) to the KIT Solutions data reporting system. KIT Solutions and State data staff will collaborate to solve issues related to the transition from one system to the other. A data challenge exists in that it is unlikely that the ADAD ATOD student survey, last administered in 2007, will not be administered again until 2011. In this case, the data may be too late for the purposes of the SPF-SIG evaluation. To address this potential challenge, alternative data sources have been identified for all indicators utilizing ADAD ATOD student survey data such as the National Survey on Drug Use and Health (NSDUH) and the Youth Risk Behavior Survey (YRBS). Some of these data are not reportable at the sub-state level, and none are reportable at the sub-County level.

An unwieldy State procurement system may present a challenge in the flow of funds and may complicate contract management.

Finally, the concept of using evidence-based interventions is a challenging concept to many Hawai‘i Counties. As has been mentioned, many national prevention models and programs, based on research and practices reflecting different cultures and life experiences, are not a good fit for Hawai‘i’s diverse population. Hawai‘i’s challenge is to define the third category of evidence-based interventions included in the SAMHSA/CSAP publication, *Identifying and Selecting Evidence-Based Interventions*. Defining theory base, what constitutes evidence of effectiveness, and defining and identifying “leaders,” are difficult for Hawai‘i’s Counties to do, and may vary among and between Counties.

## APPENDIX A: DATA SOURCES REVIEWED FOR ASSESSMENT

| Data Source | Sponsor Agency |
|---|---|
| 2004 Household Survey of Alcohol and Drug Abuse in Hawai‘i | Hawai‘i State Department of Health |
| 2005 Survey of Retail Alcohol Sales to Underage Persons: A Report | Hawai‘i State Department of Health & MADD Hawai‘i |
| ADAD treatment admission data | Hawai‘i State Department of Health |
| Alcohol Epidemiologic Data System (AEDS) | National Institute on Alcohol Abuse and Alcoholism (NIAAA) |
| Arrestee Drug Abuse Monitoring (ADAM) Program | National Institute of Justice (NIJ) |
| Behavioral Risk Factor Surveillance System (BRFSS) | Centers for Disease Control and Prevention (CDC) |
| Birth Certificate Data from National Vital Statistics System | National Center for Health Statistics (NCHS) |
| Census data for population estimates | U.S. Census Bureau |
| Diagnostic Laboratory Service statistics, Honolulu | Diagnostic Laboratory Service, Honolulu |
| Drug-related death data from Medical Examiners Office | City and County of Honolulu |
| Drug-related data from Honolulu Police Department | Honolulu Police Department |
| DUI in the City and County of Honolulu – Report | Crime Prevention and Justice Assistance Division, Department of the Attorney General |
| Fatality Analysis Reporting System (FARS) | National Traffic Highway Safety Administration (NTHSA) |
| Federal drug seizure statistics from Drug Enforcement Administration (DEA) Web page | Drug Enforcement Administration (DEA) |
| Hawai‘i Student Alcohol, Tobacco, and Other Drug Use (ATOD) Survey | Hawai‘i State Department of Health |
| Hawai‘i Health Information Corporation (HHIC) online data | Hawai‘i Health Information Corporation (HHIC) |
| Hawai‘i Health Survey | Hawai‘i State Department of Health |
| HIDTA Annual Report | Office of National Drug Control Policy (ONDCP) |
| Household Drug Survey | Center on the Family, University of Hawai‘i |
| Illicit Drug Use in Honolulu and the State of Hawai‘i - Proceedings of the Community Epidemiology Working Group (CEWG), 2006 | National Institute on Drug Abuse (NIDA |
| National Survey on Drug Use and Health (NSDUH) | Substance Abuse and Mental Health Services Administration (SAMHSA) |
| National Survey on Substance Abuse | Substance Abuse and Mental Health Services |
| Treatment Services (NSSATS) | Administration (SAMHSA) |
| National Vital Statistics System (NVSS) | National Center for Health Statistics (NCHS) |

| Data Source | Sponsor Agency |
|---|---|
| Reducing Minors Access to Tobacco in Hawai‘i – Report on Annual Compliance Inspection and Law Enforcement Operation 2005-2006 | Cancer Research of Hawai‘i/University of Hawai‘i |
| The Tax Burden on Tobacco. Historical Compilation, Vol. 37, 2002 (State Excise Tax Data) | Private; data were downloaded from the University of California at San Diego (UCSD) Social Sciences and Humanities Library Web site |
| Treatment Episode Data Set (TEDS) | Substance Abuse and Mental Health Services Administration (SAMHSA) |
| Uniform Crime Report (UCR) | Federal Bureau of Investigation (FBI)<br>CPJAD, Department of the Attorney General |
| Youth Risk Behavior Survey (YRBS) | Centers for Disease Control and Prevention (CDC) |
| Youth Tobacco Survey (YTS) | Centers for Disease Control and Prevention (CDC) |

## APPENDIX B: SEVEN CONSTRUCTS AND 46 INDICATORS USED IN PRIORITY ASSESSMENT

| Construct | Indicator | Definition | Data Source |
|---|---|---|---|
| **Alcohol Consequences** | | | |
| **Antisocial behaviors** | Drank on School Property by High School Students in Past 30 Days | Percent of students in grades 9 through 12 reporting use of at least one drink of alcohol ≥1 of the 30 days preceding the survey | YRBS |
| **Crime/Public safety** | DUI Arrest Rate | Number of drivers driving or operating any vehicle or common carrier while drunk or under the influence of intoxicants reported to the police per 1,000 population | UCR |
| | Arrest Rate for Liquor Law Violation | Number of arrests for unlawful manufacture, sale, transporting, furnishing, or possessing intoxicating liquor; maintaining unlawful drinking places; bootlegging; operating a still; furnishing liquor to a minor; and drinking on a train or public conveyance per 1,000 population | UCR |
| | Arrest Rate for Alcohol-Related Disorderly Conduct | Annual number of arrests due to committing a breach of the peace, including affray; unlawful assembly; disturbing the peace; disturbing meetings; and blasphemy, profanity, and obscene language per 1,000 population. | UCR |
| **Morbidity** | Alcohol Dependence of Persons Aged 12 and Older | Percent of persons aged 12 and older meeting DSM-IV criteria for alcohol dependence | NSDUH |
| | Alcohol Abuse or Dependence of Persons Aged 12 and Older | Percent of persons aged 12 and older meeting DSM-IV criteria for alcohol abuse or dependence | NSDUH |
| **Mortality** | Chronic Liver Disease Death Rate | Number of deaths from chronic liver disease per 1,000 population | NVSS |
| | Alcohol-Related Vehicle Death Rate | Number of vehicle deaths in which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.00) per 1,000 population | FARS |
| | **Indicator** | Definition | Data Source |
| **Alcohol Consumption** | | | |
| **Age of initial use** | Early Initiation of Alcohol Use by High School Students | Percent of students in grades 9 through 12 reporting first use of alcohol before age 13 (more than just a few sips) | YRBS |

| | | | |
|---|---|---|---|
| **Current use** | Current Use of Alcohol by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting any use of alcohol within the past 30 days | NSDUH |
| | Current Use of Alcohol by High School Students | Percent of students in grades 9 through 12 reporting any use of alcohol within the past 30 days | YRBS |
| | Current Use of Alcohol by Persons Aged 18 and Older | Percent of persons aged 18 and older reporting any use of alcohol within the past 30 days | BRFSS |
| | Alcohol Use in Past 30 Days Among Persons Aged 12 to 20 | Percent of persons aged 12 to 20 reporting any use of alcohol within the past 30 days | NSDUH |
| | Binge Alcohol Use in Past 30 Days Among Persons Aged 12 to 20 | Percent of persons aged 12 to 20 reporting having five or more drinks on at least one occasion within the past 30 days | NSDUH |
| | Current Binge Drinking by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting having five or more drinks on at least one occasion within the past 30 days | NSDUH |
| | Current Binge Drinking by Adults Aged 18 and Older | Percent of persons aged 18 and older reporting having five or more drinks on at least one occasion within the past 30 days | BRFSS |
| | Current Binge Drinking by High School Students | Percent of students in grades 9 through 12 reporting having five or more drinks in a row (i.e., within a couple of hours) on at least one occasion within the past 30 days | YRBS |
| | Current Heavy Use of Alcohol by Adults Aged 18 and Older | Percent of women aged 18 and older reporting an average daily alcohol consumption of greater than one drink per day or men aged 18 and older reporting an average daily alcohol consumption of greater than two drinks per day. | BRFSS |
| | **Indicator** | Definition | Data Source |
| **Drug Consequences** | | | |
| **Antisocial behaviors** | Offered/Sold/Given Illegal Drugs on School Property by High School Students in Past 12 Months | Percent of students in grades 9 through 12 reporting being offered/sold/given any illegal drug by anyone in school in past year | YRBS |
| **Crime/Public safety** | Drug-Related Arrest Rate | Number of drug-related arrests (drug manufacturing/sale or drug possession) per 1,000 population | UCR |
| **Morbidity** | Drug Abuse or Dependence of Persons Aged 12 and Older | Percent of persons aged 12 and older meeting DSM-IV criteria for drug abuse or dependence | NSDUH |
| | Drug Dependence of Persons Aged 12 and Older | Percent of persons aged 12 and older meeting DSM-IV criteria for drug dependence | NSDUH |
| **Mortality** | Deaths From Illicit Drug Use | Number of deaths directly attributable to illicit drug use per 1,000 population | NVSS |

| Drug Consumption | | | |
|---|---|---|---|
| **Age of initial use** | Early Initiation of Marijuana Use by High School Students | Percent of students in grades 9 through 12 reporting first use of marijuana before age 13 | YRBS |
| **Current use** | Current Use of Marijuana by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting any use of marijuana within the past 30 days | NSDUH |
| | Current Use of Marijuana by High School Students | Percent of students in grades 9 through 12 reporting any use of marijuana within the past 30 days | YRBS |
| | Current Use of Illicit Drugs Other Than Marijuana by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting use of any illicit drug other than marijuana, or of an abusable product that may be obtained legally, on one or more days within the past 30 days. Other illicit drugs include cocaine, heroin, and hallucinogens (LSD, PCP, peyote, mescaline, mushrooms, and ecstasy). Abusable legal products include prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) and inhalants (amyl nitrate, cleaning fluids, gasoline, paint, and glue). | NSDUH |
| | Current Use of Cocaine by High School Students | Percent of students in grades 9 through 12 reporting any use of cocaine within the past 30 days | YRBS |
| | **Indicator** | Definition | Data Source |
| **Drug Consumption (continued)** | | | |
| **Current use (continued)** | Current Use of Any Illicit Drug by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting any illicit drug within the past 30 days. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. | NSDUH |
| **Lifetime use** | Lifetime Use of Marijuana by High School Students | Percent of students in grades 9 through 12 reporting ever using marijuana in their lifetime | YRBS |
| | Lifetime Use of Cocaine by High School Students | Percent of students in grades 9 through 12 reporting ever using cocaine in their lifetime | YRBS |
| | Lifetime Use of Inhalants by High School Students | Percent of students in grades 9 through 12 reporting ever using inhalants in their lifetime | YRBS |
| | Lifetime Use of Steroids by High School Students | Percent of students in grades 9 through 12 reporting ever using steroids in their lifetime | YRBS |
| | Lifetime Use of Methamphetamine by High School Students | Percent of students in grades 9 through 12 reporting ever using methamphetamine in their lifetime | YRBS |

| | | | |
|---|---|---|---|
| | Lifetime Use of Ecstasy (MDMA) by High School Students | Percent of students in grades 9 through 12 reporting ever using ecstasy/MDMA in their lifetime | YRBS |
| | Lifetime Use of Heroin by High School Students | Percent of students in grades 9 through 12 reporting ever using heroin in their lifetime | YRBS |
| | Lifetime Use of Any Drug via Injection by High School Students | Percent of students in grades 9 through 12 reporting ever using any drug via injection in their lifetime | YRBS |
| | **Indicator** | Definition | Data Source |
| **Tobacco Consequences** | | | |
| **Mortality** | Deaths From Lung Cancer | Number of deaths from lung cancer per 1,000 population | NVSS |
| **Tobacco Consumption** | | | |
| **Age of initial use** | Early Initiation of Cigarette Use by High School Students | Percent of students in grades 9 through 12 reporting that they smoked a whole cigarette for the first time before age 13 | YRBS |
| **Current use** | Current Tobacco Use by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting tobacco use on one or more days within the past 30 days. Tobacco products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco). | NSDUH |
| | Current Cigarette Smoking by Persons Aged 12 and Older | Percent of persons aged 12 and older reporting smoking a cigarette on one or more days within the past 30 days | NSDUH |
| | Current Use of Cigarettes by High School Students | Percent of students in grades 9 through 12 reporting smoking a cigarette on one or more days within the past 30 days | YRBS |
| | Current Use of Cigarettes by Adults Aged 18 and Older | Percent of persons aged 18 and older reporting smoking 100 or more cigarettes in their lifetime and also now smoking cigarettes either every day or on "some days" | BRFSS |
| | Current Use of Smokeless Tobacco by High School Students | Percent of students in grades 9 through 12 reporting use of "chewing tobacco, snuff, or dip" on one or more days within the past 30 days | YRBS |
| | Current Daily Use of Cigarettes Among Adults | Percent of adults aged 18 and older reporting smoking 100 or more cigarettes in their lifetime and also now smoking cigarettes every day | BRFSS |
| | Current Daily Use of Cigarettes Among High School Students | Percent of students in grades 9 through 12 reporting smoking cigarettes on 20 days or more within the past 30 days | YRBS |

## APPENDIX C: SUMMARY OF POPULATION-BASED DATA ASSESSMENT (10 PRIORITY INDICATORS)

| Construct | Indicator | Year | HI | Estimated Number of People Affected |
|---|---|---|---|---|
| **Alcohol** | | | | |
| Antisocial behaviors | Drank on School Property by High School Students in Past 30 Days | 2005 | 8.8 | 5,951 |
| Current use | Current Use of Alcohol by Persons Aged 12 and Older | 2004 | 48.9 | 520,204 |
| Current use | Current Use of Alcohol by Persons Aged 18 and Older | 2005 | 51.4 | 501,326 |
| Current use | Current Binge Drinking by Persons Aged 12 and Older | 2004 | 22.8 | 243,117 |
| Current use | Current Binge Drinking by Adults Aged 18 and Older | 2005 | 16.5 | 160,931 |
| Current use | Current Heavy Use of Alcohol by Adults Aged 18 and Older | 2005 | 7.4 | 72,175 |
| **Illicit Drugs** | | | | |
| Antisocial behaviors | Offered/Sold/Given Illegal Drugs on School Property by High School Students in Past 12 Months | 2005 | 32.7 | 22,114 |
| Mortality | Deaths From Illicit Drug Use | 2003 | 0.7 | 9 |
| Age of initial use | Early Initiation of Marijuana Use by High School Students | 2005 | 12.5 | 8,453 |
| **Tobacco** | | | | |
| Mortality | Deaths From Lung Cancer | 2003 | 40.7 | 508 |

## APPENDIX D: DATA TABLES

**Monthly (30-Day) use of alcohol among intermediate and high school students in Hawai'i by grade, race, and county, 2003**

| Demographic Characteristics | State % | County % | | | |
|---|---|---|---|---|---|
| | | Maui | Kauai | Hawai'i | Honolulu |
| All 6th to 12th Graders | 20.2 | 23.1 | 19.0 | 27.9 | 18.1 |
| **Grade** | | | | | |
| 6th Grade | 3.9 | 4.3 | 6.6 | 6.2 | 3.1 |
| 7th Grade | 7.4 | 7.3 | 7.4 | 9.0 | 6.9 |
| 8th Grade | 14.7 | 16.3 | 19.4 | 17.1 | 13.2 |
| 9th Grade | 19.2 | 21.7 | 20.9 | 27.9 | 16.7 |
| 10th Grade | 27.1 | 30.7 | 25.8 | 35.7 | 24.9 |
| 11th Grade | 32.3 | 37.8 | 26.2 | 44.5 | 28.8 |
| 12th Grade | 36.3 | 42.5 | 26.2 | 49.8 | 33.0 |
| **Ethnicity** | | | | | |
| Chinese | 11.6 | 18.5 | 5.3 | 11.3 | 11.6 |
| Filipino | 17.9 | 18.4 | 14.3 | 24.1 | 17.3 |
| Japanese | 13.7 | 15.8 | 16.0 | 20.1 | 12.3 |
| Hawaiian | 25.6 | 25.1 | 22.0 | 33.6 | 23.7 |
| White | 24.4 | 26.8 | 22.6 | 29.1 | 21.6 |
| Other | 19.0 | 24.5 | 25.2 | 27.7 | 17.3 |
| Multi-Racial | 26.8 | 28.2 | 23.1 | 31.8 | 25.1 |

Source: Hawai'i State Department of Health. 2003 Student ATOD Survey.

**Monthly (30-day) use of alcohol among 12-17 year olds in Hawai'i**

| % students ages 12-17 who have used alcohol in the past 30 days | Data source |
|---|---|
| 17.2% | NSDUH 2003-2004 |
| 14.1% | NSDUH 2004-2005 |

**Monthly (30-day) binge use of alcohol (5 or more drinks in a single occasion) among 12-17 year olds in Hawai'i**

| % students ages 12-17 who have consumed 5 or more drinks in a single occasion in the past 30 days | Data source |
|---|---|
| 10.9% | NSDUH (OAS) 2003-2004 |
| 9.3% | NSDUH (OAS) 2004-2005 |

**Mean age at first use of alcohol among intermediate and high school current users in Hawai‘i by sex, ethnicity, and county, 2003**

| Demographic Characteristics | State | County | | | |
|---|---|---|---|---|---|
| | | Maui | Kauai | Hawai‘i | Honolulu |
| All 6th- to 12th-Grade Current Users | 12.2 | 12.1 | 11.9 | 12.0 | 12.3 |
| **Sex** | | | | | |
| Male | 12.1 | 12.0 | 11.9 | 11.9 | 12.3 |
| Female | 12.2 | 12.2 | 12.1 | 12.1 | 12.3 |
| **Ethnicity** | | | | | |
| Chinese | 12.7 | 12.6 | 14.0 | 11.6 | 12.7 |
| Filipino | 12.3 | 12.6 | 12.1 | 11.8 | 12.4 |
| Japanese | 12.6 | 12.6 | 12.2 | 12.3 | 12.7 |
| Hawaiian | 11.8 | 11.9 | 11.3 | 11.7 | 11.8 |
| White | 12.3 | 11.8 | 12.5 | 12.4 | 12.4 |
| Other | 12.2 | 12.4 | 11.7 | 12.3 | 12.2 |
| Multi-Racial | 11.7 | 11.9 | 11.2 | 11.1 | 12.0 |

Source: Hawai‘i State Department of Health. 2003 Student ATOD Survey.

**Percent of students grades 6-12 reporting first use of alcohol before age 13**

| % students ages 12-17 who have used alcohol in the past 30 days | Data source |
|---|---|
| **27.3%** | **YRBS 2005** |

**Reported age of first use of alcohol (Hawai‘i)**

| Age of first use of alcohol | Data source |
|---|---|
| **13.2** | **NSDUH 2003-2004** |
| **13.2** | **NSDUH 2004-2005** |

**Use patterns of current users in intermediate and high school in Hawai‘i by sex and county, 2003**

| Behavior Characteristics | State % | County % | | | |
|---|---|---|---|---|---|
| | | Maui | Kauai | Hawai‘i | Honolulu |
| **All 6th- to 12th-Grade Current Users** | | | | | |
| Daily use of any alcohol | 9.1 | 9.8 | 7.6 | 10.6 | 8.5 |
| Drink regularly | 66.5 | 68.4 | 68.8 | 72.4 | 63.8 |
| Been drunk or high at school | 39.0 | 39.9 | 37.7 | 44.5 | 36.7 |
| Mean age at first drunkenness | 13.5 | 13.4 | 13.3 | 13.4 | 13.6 |
| Mean age at starting to drink regularly | 14.1 | 14.1 | 14.1 | 14.1 | 14.2 |
| **Male** | | | | | |
| Daily use of any alcohol | 10.3 | 11.6 | 10.7 | 10.1 | 9.9 |
| Drink regularly | 66.4 | 68.8 | 72.8 | 74.4 | 62.6 |
| Been drunk or high at school | 40.9 | 40.2 | 39.3 | 46.5 | 39.1 |

| | | | | | |
|---|---|---|---|---|---|
| Mean age at first drunkenness | 13.5 | 13.2 | 13.0 | 13.2 | 13.7 |
| Mean age at starting to drink regularly | 14.2 | 14.1 | 14.1 | 14.1 | 14.4 |
| **Female** | | | | | |
| Daily use of any alcohol | 7.9 | 8.6 | 5.0 | 10.5 | 7.2 |
| Drink regularly | 66.7 | 68.5 | 64.7 | 71.5 | 64.7 |
| Been drunk or high at school | 37.2 | 40.4 | 35.5 | 43.3 | 33.8 |
| Mean age at first drunkenness | 13.5 | 13.5 | 13.4 | 13.6 | 13.5 |
| Mean age at starting to drink regularly | 14.1 | 14.1 | 14.0 | 14.0 | 14.1 |

Source: Hawai'i State Department of Health. 2003 Student ATOD Survey.

### Percent of high school students who drank on school property in the past 30 days (YRBS, 2005)

| Percent of high school students who drank on school property in the past 30 days | Data source |
|---|---|
| **8.8%** | **YRBS 2005** |

Note: Hawai'i rates are the highest of all 40 States reporting this data on the YRBS.

### Perceived risk of weekend drinking by intermediate and high school students in Hawai'i by current use status, grade, sex, ethnicity, and county, 2003

| Demographic Characteristics | State % | County % | | | |
|---|---|---|---|---|---|
| | | Maui | Kauai | Hawai'i | Honolulu |
| All 6th to 12th Graders | 55.2 | 51.0 | 54.3 | 48.9 | 57.6 |
| **Current Use Status** | | | | | |
| Current Users | 36.7 | 35.1 | 34.5 | 32.7 | 38.7 |
| Non-Current Users | 60.0 | 55.8 | 58.9 | 55.1 | 61.9 |
| **Grade** | | | | | |
| 6th Grade | 60.5 | 53.0 | 55.3 | 57.3 | 63.1 |
| 7th Grade | 60.4 | 55.2 | 58.7 | 55.0 | 62.9 |
| 8th Grade | 56.4 | 51.8 | 50.9 | 53.7 | 58.3 |
| 9th Grade | 52.9 | 50.8 | 53.1 | 47.3 | 54.8 |
| 10th Grade | 51.6 | 49.6 | 50.1 | 44.0 | 54.4 |
| 11th Grade | 53.4 | 48.3 | 58.8 | 43.0 | 56.1 |
| 12th Grade | 51.6 | 48.4 | 53.4 | 44.1 | 53.8 |
| **Sex** | | | | | |
| Male | 52.0 | 46.3 | 48.8 | 47.7 | 54.2 |
| Female | 58.7 | 54.5 | 61.2 | 50.1 | 61.5 |
| **Ethnicity** | | | | | |
| Chinese | 65.7 | 50.6 | 77.9 | 56.7 | 66.4 |
| Filipino | 57.9 | 55.5 | 62.4 | 50.2 | 59.3 |
| Japanese | 60.3 | 58.8 | 53.5 | 52.3 | 62.3 |
| Hawaiian | 52.2 | 46.8 | 49.3 | 52.7 | 53.8 |
| White | 50.0 | 47.4 | 49.8 | 45.0 | 53.3 |
| Other | 55.8 | 53.7 | 52.4 | 47.9 | 57.4 |

| | | | | | |
|---|---|---|---|---|---|
| Multi-Racial | 49.9 | 41.3 | 51.9 | 48.7 | 51.7 |

Source: Hawai‘i State Department of Health. 2003 Student ATOD Survey.

**Percent of students ages 12-17 reporting that they perceive “great risk” of use of alcohol**

| Percent of students ages 12-17 reporting that they perceive “great risk” of use of alcohol | Data source |
|---|---|
| **76.5%** | **NSDUH 2003-2004** |
| **75.8%** | **NSDUH 2004-2005** |

**Parental Attitudes of Intermediate and High School Students in Hawai‘i by Current Use Status, Sex, and County, 2003**

| Parental Attitudes | State % | County % | | | |
|---|---|---|---|---|---|
| | | Maui | Kauai | Hawai‘i | Honolulu |
| **All 6th to 12th Graders** | | | | | |
| Parents think it’s very wrong to drink | 85.1 | 84.3 | 85.5 | 77.6 | 86.9 |
| Lack of parental sanctions for ATOD use | 24.6 | 28.0 | 26.6 | 32.2 | 22.0 |
| Parental attitudes favorable toward ATOD use | 17.9 | 19.1 | 17.6 | 25.9 | 16.0 |
| **Current User** | | | | | |
| Parents think it’s very wrong to drink | 61.9 | 60.9 | 67.4 | 54.5 | 64.4 |
| Lack of parental sanctions for ATOD use | 51.9 | 56.2 | 51.9 | 54.8 | 49.5 |
| Parental attitudes favorable toward ATOD use | 44.3 | 46.1 | 40.8 | 51.7 | 41.4 |
| **Non-Current User** | | | | | |
| Parents think it’s very wrong to drink | 91.2 | 91.5 | 90.2 | 86.7 | 92.0 |
| Lack of parental sanctions for ATOD use | 17.5 | 19.2 | 20.0 | 23.0 | 15.8 |
| Parental attitudes favorable toward ATOD use | 11.1 | 10.8 | 11.9 | 15.6 | 10.2 |
| **Male** | | | | | |
| Parents think it’s very wrong to drink | 85.3 | 85.2 | 84.6 | 77.1 | 87.2 |
| Lack of parental sanctions for ATOD use | 23.9 | 25.4 | 25.7 | 31.0 | 21.5 |
| Parental attitudes favorable toward ATOD use | 17.5 | 17.2 | 19.0 | 25.6 | 15.5 |
| **Female** | | | | | |
| Parents think it’s very wrong to drink | 85.3 | 83.2 | 85.6 | 78.0 | 87.2 |
| Lack of parental sanctions for ATOD use | 24.9 | 28.9 | 26.8 | 33.2 | 22.0 |
| Parental attitudes favorable toward ATOD use | 18.0 | 20.7 | 17.7 | 26.0 | 15.8 |

Source: Hawai‘i State Department of Health. 2003 Student ATOD Survey.

# APPENDIX E: SPF-SIG (CAPACITY) ASSESSMENT SURVEY (STATE LEVEL-FRONT)

## SPF-SIG Capacity Assessment Survey (State of Hawai'i)

*Rev. 1/14/2008*

**Overview:**
You have been identified as a key stakeholder of the State Prevention System of Hawai'i (SPSH). The attached Capacity Assessment Survey was designed to assess the SPSH. The SPSH consists of agencies that provide statewide substance abuse prevention services, including but not limited to: Alcohol & Drug Abuse Division (ADAD), Office of Attorney General (AG), ALU Like, Coalition for a Drug Free Hawai'i (CDFH), Hawai'i Drug Abuse Resistance Education (DARE) Officers' Association, Department of Education (DOE), Office of Youth Services (OYS), Pacific Resources for Education and Learning (PREL), REAL Youth Movement Against Tobacco, etc. (see Prevention Directory for further examples). The goal of this form is to recognize strengths and identify areas that need improvement. These areas will be used for planning purposes of the Strategic Prevention Framework State Incentive Grant (SPF-SIG).

**Instructions:**
Please answer all questions based on your current knowledge of the SPSH. The information you provide on this form is confidential. No individual information will be shared; only aggregate results will be available for public access. Again, this information will only be used for SPF-SIG planning purposes. There are no correct or incorrect answers to the questions on this form. Fill out each section to the best of your knowledge. If you have a question, please ask your administrator for help. For each indicator, rate how the SPSH scores currently by circling a number on a scale of 1 (Strongly **Disagree**) to 10 (Strongly **Agree**). Then rate how important this indicator is by circling a number on a scale of 1 (**Not** Very Important) to 10 (**Very** Important). Finally, subtract the two scores (Importance Score *minus* Current Score) to get a Gap Score. High Gap Scores represent gaps, or areas that need improvement, and Low Gap Scores represent strengths of the State Prevention System of Hawai'i.

**Date Completed:** ____ / ____ / ____ (Month (mm) / Day (dd) / Year (yyyy))

**Participant ID (Provided by Administrator):** H | 0 | 8 | X | X | X | X

**These questions ask for general information about you. Please mark the response that best describes you.**

1. What is your sex? (Check one)
   ☐ Male ☐ Female
2. Which ethnicity(s) do you identify with most? (Write in one or more) _____
3. What is your date of birth? ____ / ____ / ____ (Month (mm) / Day (dd) / Year (yyyy))

| CAPACITY ASSESSMENT AREA | | INDICATORS (State Prevention System of Hawai'i consists of agencies that provide statewide substance abuse prevention services. Examples: Alcohol & Drug Abuse Division (ADAD), Office of Attorney General, ALU Like, Dept. of Education (DOE), Hawai'i DARE Officers' Association, etc.) | RATE THE STATE OF HAWAI'I CURRENTLY (Strongly Disagree ← → Strongly Agree) | HOW IMPORTANT IS THIS INDICATOR? (Not Very Important ← → Very Important) | GAP (Importance Score *Minus* Current Score) |
|---|---|---|---|---|---|
| A | Organizational Structure | 1) There are departments for substance abuse prevention within key state agencies in Hawai'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) An active, coordinated state-wide prevention system of stakeholders exists in Hawai'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) Prevention agencies allocate and control financial and other (e.g. in-kind, etc) resources. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4) The state collects state-level data on substance abuse. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 5) The state collects county-level data on substance abuse. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| B | Effectiveness | 1) Agencies within the state prevention system communicate with each other to promote positive interagency working relationships. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) Agencies within the state prevention system collaborate to address similar goals and objectives (reduce substance abuse, increase protective factors, etc.) with unduplicated services. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) The state prevention system has generated beneficial outcomes across the lifespan for the people of Hawai'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |

The Capacity Assessment Survey was adapted for the Hawai'i Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the Capacity Assessment Matrix, a Prevention System Assessment Tool developed by Nebraska Partners in Prevention, the Southwest Center for the Application of Prevention Technologies, and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention.

## APPENDIX E (CONTINUED): SPF-SIG (CAPACITY) ASSESSMENT SURVEY (STATE LEVEL-BACK)

### SPF-SIG Capacity Assessment Survey (State of Hawai'i)

*Rev. 1/14/2008*

| CAPACITY ASSESSMENT AREA | | INDICATORS (Hawai'i State Prevention System consists of agencies that provide statewide substance abuse prevention services. Examples: Alcohol & Drug Abuse Division (ADAD), Office of Attorney General, ALU Like, Dept. of Education (DOE), Hawai'i DARE Officers' Association, etc.) | RATE THE STATE OF HAWAI'I CURRENTLY (Strongly Disagree ← → Strongly Agree) | HOW IMPORTANT IS THIS INDICATOR? (Not Very Important ← → Very Important) | GAP (Importance Score *Minus* Current Score) |
|---|---|---|---|---|---|
| C | Knowledge, Skills and Abilities | **Hawai'i State prevention system members have…** | | | |
| | | 1)…knowledge of evidence-based prevention strategies. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2)…the necessary knowledge and skills to use state, county, and program-level data as the basis for prevention planning and decision-making. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3)…the knowledge and skills to use a data-driven strategic planning process for prevention assessment, capacity, planning, implementing and evaluating prevention strategies. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4)…knowledge about risk and protective factors that affect youth substance abuse in Hawai'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 5)…the knowledge and skills to use a combination of strategies (policy, enforcement, media, etc.) to influence the environment, as well as to change the behavior of individuals. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 6)…the necessary knowledge and skills to use formal evaluation to help achieve desired substance abuse prevention outcomes. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 7)…the skills and ability to effectively share their prevention knowledge with others. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| D | Funding and Other Resources | 1) The state prevention system is able to leverage funds and other resources from multiple sources in order to support priority prevention initiatives. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) State prevention system members participate and contribute resources toward collaborative community prevention efforts. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) Funding streams are coordinated across prevention agencies and organizations at the state level to maximize the impact of prevention efforts. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4) State prevention system members are aware of and access various prevention funding streams that are available for the areas/regions they serve. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| E | Cultural Competency | 1) State prevention system members ensure that beneficiaries receive understandable and respectful services provided in a manner compatible with their cultural health beliefs, practices, and preferred language. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) State prevention system members offer and provide language assistance services and translated material, at no cost to beneficiaries with limited English proficiency at all points of contact and in a timely manner. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) State prevention system members ensure that data on the beneficiary's race, ethnicity, and spoken language are collected in intake or health records, integrated into the organization's management information systems, and periodically updated | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| F | Sustainability | 1) The state prevention system has developed a written plan to achieve sustainable outcomes (e.g., legislature backing, secured funding from traditional (grants) and non-traditional sources (insurance companies/banks), leveraging funds, etc.) over time. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) The prevention system is able to acquire and allocate resources to sustain key prevention initiatives. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |

The Capacity Assessment Survey was adapted for the Hawai'i Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the Capacity Assessment Matrix, a Prevention System Assessment Tool developed by Nebraska Partners in Prevention, the Southwest Center for the Application of Prevention Technologies, and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention.

## APPENDIX F: SPF-SIG CAPACITY ASSESSMENT SURVEY (SAMPLE COMMUNITY LEVEL-FRONT)

# SPF-SIG Capacity Assessment Survey (Kaua'i County)

*Rev. 1/16/2008*

**Overview:**
You have been identified as a key stakeholder of the County Prevention System of Kaua'i (CPSK). The attached Capacity Assessment Survey was designed to assess the CPSK. The CPSK consists of agencies that provide county substance abuse prevention services, including but not limited to: ALU Like, Inc. (Island Center), American Lung Association, Boys & Girls Club, Central/East/West Kaua'i Coalitions, Child & Family Services (Baby Safe), Kaua'i Economic Opportunity (KEO,) Kaua'i Police Department, Liquor Control Commission, Mayor's Office, etc. (see Prevention Directory for further examples). The goal of this form is to recognize strengths and identify areas that need improvement. These areas will be used for planning purposes of the Strategic Prevention Framework State Incentive Grant (SPF-SIG).

**Instructions:**
Please answer all questions based on your current knowledge of the CPSK. The information you provide on this form is confidential. No individual information will be shared; only aggregate results will be available for public access. Again, this information will only be used for SPF-SIG planning purposes. There are no correct or incorrect answers to the questions on this form. Fill out each section to the best of your knowledge. If you have a question, please ask your administrator for help. For each indicator, rate how the CPSK scores currently by circling a number on a scale of 1 (Strongly **Disagree**) to 10 (Strongly **Agree**). Then rate how important this indicator is by circling a number on a scale of 1 (**Not** Very Important) to 10 (**Very** Important). Finally, subtract the two scores (Importance Score *minus* Current Score) to get a Gap Score. High Gap Scores represent gaps, or areas that need improvement, and Low Gap Scores represent strengths of the County Prevention System of Kaua'i.

**Date Completed:** _____ / _____ / _____ Month (mm) / Day (dd) / Year (yyyy)

**Participant ID (Provided by Administrator):** _____

**These questions ask for general information about you. Please mark the response that best describes you.**

1. What is your sex? (Check one)
   ☐ Male ☐ Female
2. Which ethnicity(s) do you identify with most? (Write in one or more) _____
3. What is your date of birth? _____ / _____ / _____ Month (mm) / Day (dd) / Year (yyyy

| Capacity Assessment Area | | Indicators (The County Prevention System of Kaua'i is made up of agencies that provide county substance abuse prevention services. Examples: ALU Like, Inc. (Island Center), American Lung Association, Boys & Girls Club, Kaua'i Economic Opportunity (KEO,) Kaua'i Police Department, Liquor Control Commission, Mayor's Office, etc.) | Rate the County of Kaua'i Currently (Strongly Disagree ← → Strongly Agree) | How Important is This Indicator? (Not Very Important ← → Very Important) | Gap (Importance Score *Minus* Current Score) |
|---|---|---|---|---|---|
| A | Organizational Structure | 1) There are departments for substance abuse prevention within key county agencies in Kaua'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) An active, coordinated county-wide prevention system of stakeholders exists in Kaua'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) Prevention agencies allocate and control financial and other (e.g. in-kind, etc) resources. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4) The prevention system receives tangible support (resources, staffing, in-kind, etc.) from its members. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| B | Effectiveness | 1) Agencies within the county prevention system communicate with each other to promote positive interagency working relationships. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) Agencies within the county prevention system collaborate to address similar goals and objectives (reduce substance abuse, increase protective factors, etc.) with unduplicated services. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) The county prevention system has generated beneficial outcomes across the lifespan for the people of Kaua'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |

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## APPENDIX F (CONTINUED): SPF-SIG CAPACITY ASSESSMENT SURVEY (SAMPLE COMMUNITY LEVEL-BACK)

### SPF-SIG Capacity Assessment Survey (Kaua'i County)

*Rev. 1/16/2008*

| CAPACITY ASSESSMENT AREA | | INDICATORS (The County Prevention System of Kaua'i is made up of agencies that provide county substance abuse prevention services. Examples: ALU Like, Inc. (Island Center), American Lung Association, Boys & Girls Club, Kaua'i Economic Opportunity (KEO,) Kaua'i Police Department, Liquor Control Commission, Mayor's Office, etc.) | RATE THE COUNTY OF KAUA'I CURRENTLY (Strongly Disagree ← → Strongly Agree) | HOW IMPORTANT IS THIS INDICATOR? (Not Very Important ← → Very Important) | GAP (Importance Score *Minus* Current Score) |
|---|---|---|---|---|---|
| C | Knowledge, Skills and Abilities | **Kaua'i County Prevention System members have…** | | | |
| | | 1)…knowledge of evidence-based prevention strategies. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2)…the necessary knowledge and skills to use county and program-level data as the basis for prevention planning and decision-making. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3)…the knowledge and skills to use a data-driven strategic planning process for prevention assessment, capacity, planning, implementing and evaluating prevention strategies. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4)…knowledge about risk and protective factors that affect youth substance abuse in Kaua'i. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 5)…the knowledge and skills to use a combination of strategies (policy, enforcement, media, etc.) to influence the environment, as well as to change the behavior of individuals. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 6)…the necessary knowledge and skills to use formal evaluation to help achieve desired substance abuse prevention outcomes. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 7)…the skills and ability to effectively share their prevention knowledge with others. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| D | Funding and Other Resources | 1) The Kaua'i County Prevention System is able to leverage funds and other resources from multiple sources in order to support priority prevention initiatives. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) Kaua'i County Prevention System members participate and contribute resources toward collaborative community prevention efforts. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) Funding streams are coordinated across prevention agencies and organizations to maximize the impact of prevention efforts. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 4) Kaua'i County Prevention System members are aware of and access various prevention funding streams that are available for the area(s)/region(s) they serve. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| E | Cultural Competency | 1) Kaua'i County Prevention System members ensure that beneficiaries receive understandable and respectful services provided in a manner compatible with their cultural health beliefs, practices, and preferred language. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) Kaua'i County Prevention System members offer and provide language assistance services and translated material, at no cost to beneficiaries with limited English proficiency at all points of contact and in a timely manner. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 3) Kaua'i County Prevention System members ensure that data on the beneficiary's race, ethnicity, and spoken language are collected in intake or health records, integrated into the organization's management information systems, and periodically updated | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| F | Sustainability | 1) The Kaua'i County Prevention System has developed a written plan to achieve sustainable outcomes (e.g., legislature backing, secured funding from traditional (grants) and non-traditional sources (insurance companies/banks), leveraging funds, etc.) over time. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |
| | | 2) The prevention system is able to acquire and allocate resources to sustain key prevention initiatives. | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | |

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