ALCOHOL AND DRUG ABUSE DIVISION

STATE OF HAWAII
DEPARTMENT OF HEALTH

STATE PLAN
1994 - 1997

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ADMINISTRATION (continued)

APPENDIX

STATE OF HAWAII
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH ADMINISTRATION
ALCOHOL AND DRUG ABUSE DIVISION
1994-1997 STATE PLAN

Background. The State of Hawaii, Department of Health's interest in programs and services to alcohol abusers dates back to 1955, when a part-time clinic was established and supported by ten percent of the liquor license fees collected on Oahu. It became a full-time clinic in 1959 and in 1965 was transferred to the Mental Health Division. In 1971, the Governor created and authorized the Governor's Ad Hoc Committee on Substance Abuse, which became the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) authorized by Chapter 321 Hawaii Revised Statutes in 1973. The State Substance Abuse Agency was attached to the Governor's Office until 1975, when its functions were transferred to the Department of Health. The Alcohol and Drug Abuse Branch (ADAB) was formally organized within the Mental Health Division in 1976. This Branch incorporated the former alcoholism clinic and the substance abuse agency.

As part of a separate reorganization of the Department of Health in 1989, three divisions were established and assigned to a newly-established administration headed by the Deputy Director for Behavioral Health Services. The three divisions, two of which were formerly branches subsumed within the Mental Health Division, are now the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Child and Adolescent Mental Health Division.

The duties and responsibilities of the Department of Health with respect to alcohol and drugs are delineated under Chapter 321-193, Hawaii Revised Statutes. The Alcohol and Drug Abuse Division (ADAD) is designated as the entity to carry out the following direct service and administrative activities in response to this mandate:

- Coordinate all substance abuse programs including rehabilitation, treatment, education, research and prevention activities.

- Prepare, administer and supervise the implementation of a State plan for substance abuse which may consist of a plan for alcohol abuse prevention and a plan for drug abuse prevention.

- Identify all funds, programs and resources available in the State, public and private, and from the Federal government which are being used or may be used to support substance abuse prevention, rehabilitation, treatment, education and research activities.

- Be the designated agency required by, and receive and administer all available substance abuse funds including but not limited to funds received from, the

federal government under Public Laws 92-255, 91-616, 91-211, and Title IVA and XVI of the Social Security Act or other subsequent acts of Congress which may amend or succeed such acts.

- Encourage and coordinate the involvement of private and public agencies in the assessment of substance abuse problems, needs and resources.

- Coordinate the delivery of available funding to public and private agencies for program implementation.

- Establish mechanisms and procedures for receiving and evaluating program proposals, providing technical assistance, monitoring programs and securing necessary information from public and private agencies for the purposes of planning, management and evaluation.

- Review the State plan for substance abuse annually for the purpose of evaluation and make necessary amendments to conform with the requirements of Federal or State laws.

- Do all things necessary to effectuate the purposes of this plan.

- Certify program administrators and counselors, and accredit programs related to substance abuse in accordance with rules to be promulgated by the Department.

The Alcohol and Drug Abuse Division is the designated single state agency to apply for and expend federal substance abuse funds administered under the Substance Abuse and Mental Health Services Administration.

The mission of the Alcohol and Drug Abuse Division is to provide the leadership necessary for the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of the State of Hawaii. The Division will plan, coordinate, provide technical assistance, and establish mechanisms for training, data collection, research and evaluation to ensure that statewide substance abuse resources are utilized in the most effective and efficient manner possible.

STATE DEMOGRAPHICS

The Hawaiian Island chain stretches for 1,523 miles from the tiny island of Kure Atoll to the easternmost point of the "Big Island" of Hawaii. The State of Hawaii consists of eight major islands (Hawaii, Kahoolawe, Kauai, Lanai, Maui, Molokai, Niihau and Oahu) and 129 minor islands with a total land area of 6,423.4 square miles (nationally ranked 47th in land area) and a general coastline of 750 miles. Of the eight major islands, one (Kahoolawe) is uninhabited.

According to the 1990 Census, Hawaii has a population of 1,108,229 people. As reported in the 1991 State of Hawaii Data Book, by ethnicity, the population is comprised of: 23.8% Caucasian, 21.8% Japanese, 19.8% Part Hawaiian, 12% Filipino, 4.6% Chinese, 1.8% Black, 1.1% Korean, .9% Hawaiian, .6% Samoan, .4% Puerto Rican and 13.1% other. By age, the population is comprised of: 19,834 0-11 year olds, 94,698 12-17 year olds, and 820,697 18 and over. The State's 1989 per capita personal income was $18,379. The per capita alcohol consumption for the State of Hawaii in 1989 was 2.76 gallons per year.

City and County of Honolulu

The City and County of Honolulu, which consists of the island of Oahu, has a total land area of 600.2 square miles and a population of 836,231 people. By ethnicity, the composition of the population is: 23.5% Caucasian, 22.4% Japanese, 17.9% Part Hawaiian, 11.5% Filipino, 5.8% Chinese, 2.4% Black, 1.3% Korean, 0.8% Samoan, 0.7% Hawaiian, .4% Puerto Rican, and 13.3 other. By age, the population is comprised of: 142,410 0-11 year olds, 62,203 12-17 year olds, and 631,618 18 and over. The County's 1989 per capita personal income was $19,171.

Hawaii County

The Hawaii County, which consists of the island of Hawaii, has a total land area of 4,028.2 square miles and a population of 120,317 people. By ethnicity, the population is comprised of: 26.2% Part Hawaiian, 25.4% Caucasian, 21.9% Japanese, 10.3% Filipino, 1.5% Chinese, 1.2% Hawaiian, 0.4% Korean, 0.4% Puerto Rican, 0.1% Samoan, and 12.6% other. By age, the population is comprised of: 23,802 0-11 year olds, 10,713 12-17 year olds, and 85,802 18 and over. The County's 1989 per capita personal income was $14,969.

Kauai County

Kauai County, which includes the islands of Kauai and Niihau, has a total land area of 622.5 square miles and a population of 51,177 people. By ethnicity, the population is comprised of: 23.6% Part Hawaiian, 21.8% Filipino, 20.6% Japanese, 18.3% Caucasian, 0.8% Hawaiian, 0.6% Chinese, 0.4% Korean, 0.3% Puerto Rican, and 13.6% other. By

age, the population is comprised of: 7,942 0-11 year olds, 13,579 12-17 year olds, and 29,656 18 and over. The County's 1989 per capita personal income was $15,585.

Maui County

Maui County, which includes the islands of Lanai and Molokai, has a total land area of 1,172.5 square miles and a population of 100,504 people. By ethnicity, the population is comprised of: 27.4% Caucasian, 25.7% Part Hawaiian, 17% Japanese, 13.7% Filipino, 2.5% Hawaiian, 0.6% Chinese, 0.5% Korean, 0.5% Puerto Rican, 0.3% Black, and 11.8% other. By age, the population is comprised of: 18,680 0-11 year olds, 8,203 12-17 year olds, and 73,621 18 and over. The County's 1989 per capita personal income was $17,121.

Population in Hawaii

	1990 Distribution	% of Total	Projected 2010 Distribution	% of Total
Statewide	1,108,229	100.0%	1,435,500	100.0%
City & County of Honolulu	836,231	75.4%	999,500	69.6%
Hawaii	120,317	10.9%	206,100	14.4%
Kauai	51,177	4.6%	84,600	5.9%
Maui	100,504	9.1%	145,300	10.1%

SOURCE: Department of Business, Economic Development and Tourism, State of Hawaii

ALCOHOL AND OTHER DRUGS
NATURE AND EXTENT
OF THE PROBLEM

NATURE AND EXTENT OF THE SUBSTANCE ABUSE PROBLEM
- THE NATION -

The newly-expanded 1991 National Household Survey on Drug Abuse released by the Health and Human Services Secretary Louis W. Sullivan, M.D. shows that the overall gains over the past several years in reducing Americans' use of illicit drugs have been maintained, but that specific gains in several areas are being challenged. The survey was carried out by the National Institute on Drug Abuse.

The 1991 Survey shows that several years of downward trends have generally levelled off. In the population 12 and older, 6.2% in 1991 responded that they had used illicit drugs within the last 30 days, not much different from the 6.4% of 1990. While the encouraging downward trends among adolescents (ages 12-17) continue, the picture among older Americans is more complex. It reflects, at least in part, the aging of an earlier high-use generation who began their drug-taking behavior in peak years of the late '70s and the early '80s, and have continued.

The Drug Abuse Warning Network (DAWN), which samples hospital emergency rooms for drug-related medical consequences, showed an increase of 12% in drug-related episodes during the first two quarters of 1991, though the estimates for the second quarter of 1991 are still 11% below the second quarter of 1989. The recent increase reflects in part the increasing medical consequences among those who continue their drug-taking behavior.

In releasing the findings from the two surveys, Secretary Sullivan has said, "Students have heard and responded to our message to stop using drugs, but the tougher job of reaching dropouts, the unemployed and other special populations remains. The new data emphasizes that our work is far from done. I hope that Congress will review and note these figures and decide to do more, as we've requested, to help us fight this important war."

Robert Martinez, Director of the Office of National Drug Control Policy, has said, "The data released . . . show that we are continuing to make progress. Most importantly there was a large drop in adolescent drug use since 1988. Among persons 12-17 years old, current use of any illicit drug . . . is down more than 25% over the three-year period, and went from 1.6 million in 1990 to 1.4 million in 1991. This is very good news: it means that we are shutting down the pipeline to drug addiction, especially among young Americans."

Highlights from the 1991 National Household Survey on Drug Abuse include:

- "Current" (in the past 30 days) illicit drug use among youth, 12-17 years old, declined by more than half between 1985 and 1991, dropping from 14.9% to 6.8%. The direction of the long term trend in this age group continued in this survey, going from 8.1% in 1990 to 6.8% in 1991.

- Approximately 0.9% of the total population 12 and older were past-month users of cocaine; up slightly, but not statistically significantly, from 1990. But the percentage remained well below 1980's levels, where it was three times higher in 1985 (3.1%) and nearly twice as high in 1988 (1.6%).

- The number of "past year" and "past month" cocaine users has decreased significantly since the peak year in 1985. However, frequent or more intense use showed no statistically significant change in the past year.

- According to the 1991 survey, 479,000 people (0.2%) used crack during the past month -- about the same as 1988 and 1990. The highest percentages of crack use were among those who were disproportionately represented in socio-economic groups that have historically faced increased health risks -- blacks (0.7%), the unemployed (1.8%), and the high school dropouts (0.6%) -- as well as by young adults age 18-34 (0.4%).

- Marijuana remained the most commonly used illicit drug in the United States. Past month use of marijuana declined about 6% (5.1% in 1990 to 4.8% in 1991). In the past year, 5.3 million used the drug once a week or more and 3.1 million used daily or almost daily.

In releasing the survey results, Secretary Sullivan stated that, "We have expanded the national sample for the Household Survey this year [1991] from approximately 9,000 to 32,000, which includes an oversampling of 12,000 individuals in six cities in order to have an even clearer picture than before of drug abuse in this country. The Household Survey was broadened to include college students in dormitories, homeless people in shelters, civilians in military installations and the special expanded sample of six major metropolitan areas. Data coming from this expanded data base becomes a guidepost to show us where we can make even stronger efforts to address drug problems. We see clearly that we need to put more effort into reaching high-risk groups, such as the unemployed and high school dropouts. We also must maintain our focus on women -- especially those in their child-bearing years for whom the consequences of addiction are especially tragic."

- Current illicit drug use was the highest among young adults (18-25) at 15.4% compared to youth (12-17) at 6.8%, and adults (26 and older) at 4.5%.

- Among unemployed 18-34 year olds, 21.5% used illicit drugs in the past month compared to 9.7% who are employed full time. Current cocaine use in this group was 4.9% among the unemployed and 1.8% among the employed. Current marijuana use was 18.5% among the unemployed and 7.9% among the employed.

- The survey showed that high school dropouts are more likely to use drugs than high school graduates. Among high school dropouts, 16.6% had used an illicit drug in the past month compared to 9.9% of high school graduates. Current marijuana use among dropouts was 14.1% compared to 7.9% of graduates. Current cocaine use was 3.6% for high school dropouts compared to 1.6% for graduates.

- While the survey does not provide data on drug use by pregnant women, it does show that over 4.5 million (7.7% of the nearly 59.2 million) women in the childbearing years of 15-44 had used an illicit drug in the past month. Of this group, 601,000 had used cocaine and 3.3 million had used marijuana.

Drug Abuse Warning Network (DAWN)

As earlier stated, the Drug Abuse Warning Network (DAWN) collects data on the consequences of drug abuse by measuring drug-related episodes in a nationally representative sample of hospital emergency rooms in the United States.

DAWN data from the first two quarters of 1991 show:

- Total drug-related emergency room episodes increased from 89,325 in the fourth quarter of 1990 to 100,381 in the second quarter of 1991, a 12% increase.

- Cocaine-related emergency room mentions increased 31% from 19,381 in the fourth quarter of 1990 to 25,370 in the second quarter of 1991.

- Heroin-related emergency room mentions increased 26% from 7,510 in the fourth quarter of 1990 to 9,432 in the second quarter of 1991.

- Trends in total episodes and mentions are similar for all ethnic groups.

These findings may reflect an increase in reports of medical consequences of drug use. The longer people use drugs, the more susceptible they become to severe medical consequences. Individuals whose drug problem is of several years' duration are more likely to use emergency rooms as their community clinic, and that is reflected in the data. In addition, changes in drug purity can result in more accidental or unintentional overdoses in this group, since users may be unaware of a drug's potency and impurity. Increased public awareness of the medical consequences of drug use could also contribute to greater utilization of emergency rooms.

NATURE AND EXTENT OF THE SUBSTANCE ABUSE PROBLEM
- HAWAII -

The Adult Population - 1991 Hawaii Behavioral Health Survey

In order to assess the prevalence of use and abuse of alcohol and other substances and aid in planning for statewide services, the Alcohol and Drug Abuse Division in 1991 contracted with the University of Hawaii School of Public Health to conduct a statewide household survey of adults (18 years and older).

The survey sample consisted of approximately 2,200 individuals -- 200 from each of 10 service areas and an additional 200 Hawaiian individuals. Women and Hawaiians were over-sampled to provide for a more detailed analysis of these populations.

The definitions used in the survey are:

Current Smoker: respondents who have smoked 100 cigarettes and smoke regularly now.

Current drug user: respondents who report having used an illicit drug at least once in the 12 months preceding the survey date.

Drinker: respondents who report having consumed at least one serving of an alcoholic beverage in the 30 days preceding the survey date.

Non-Drinker: respondents who report having not consumed any alcoholic beverage within the 30 days preceding the survey date.

Beer Drinker: respondents who report that they consumed beer on at least one day in the previous month.

Wine Drinker: respondents who report that they consumed wine on at least one day during the previous month.

Distilled Spirits Drinker: respondents who report that they consumed distilled spirits on at least one day during the previous month.

Within each of the categories of drinking behavior, further categorization, based on U.S. Center for Disease Control definitions, were applied:

Social Drinker: respondents who report they had consumed less than 60 drinks in the preceding month, and less than 5 drinks on any one occasion.

Heavy Drinker: respondents who were either "Binge" or "Chronic" drinkers of any alcoholic beverages.

Binge Drinker: respondents who consumed 5 or more drinks on an occasion, one or more times during the previous month, but less than 60 total drinks for the month.

Chronic Drinker: respondents who consumed 60 or more drinks during the past month.

Survey Limitations. The 1991 Hawaii Behavioral Health Survey has limitations which must be considered when reviewing the results. First, there is a lack of information on the homeless and institutionalized populations of the State which are known to include a disproportionately high percentage of substance abusers. Second, there is no information on the under age 18 population known to be among the most at-risk within the State. This was intentional in order to focus on the adult population in the State, since under age 18 data is available from the Department of Education's Student Use Survey. Also not included in the sample are individual residents on the islands of Lanai and Niihau. Further, preliminary analyses of the data suggest a systematic over-sampling of older females. The impact of this over-sample cannot be determined until detailed analyses of the 1990 Census are released.

Finally, the sample size of 200 per service area meant that a disproportionate sample design, with a different weighing factor needed for each service area, was required in order to adjust the results to reflect overall representation. Thus, the results of one service area cannot be compared to the results of another service area; valid comparisons must be drawn from within each of the service areas.

Findings of the statewide survey of the adult population include:

- 39.8% of the sampled population (equivalent to approximately 329,439 adults in Hawaii) are classified as drinkers. Of those, 32.5% (equivalent to 10,707 adults in Hawaii) are heavy drinkers.

- 28.9% of the sampled population (equivalent to approximately 239,216 adults in Hawaii) report having smoked marijuana at some time in their lives. 5.8% of the sampled population (equivalent to approximately 48,009 adults in Hawaii) report they currently use marijuana.

- Of the sampled population, 2.1% (equivalent to approximately 17,383 adults in Hawaii) report current use of drugs other than marijuana for non-medical purposes.

- 23.5% of the sampled population (equivalent to approximately 193,691 adults in Hawaii) are current smokers of tobacco. Smokers tend to be beer drinkers. Also, over 75% of the current marijuana smokers are tobacco smokers.

For the general population, the "Surveillance Report #20 - Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977-1989" prepared by the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Alcohol Epidemiologic Data System (AEDS) under the supervision of the Division of Biometry and Epidemiology, reports that in 1989, Hawaii's per capita consumption of alcohol was 1.54 gallons of beer, 0.43 gallons of wine, and 0.79 gallons of distilled spirits, resulting in a per capita consumption of 2.76 for all beverages. The U.S. total per capita consumption was 2.43 gallons for all beverages.

The following table contains the characteristics of the 1991 Hawaii Behavioral Health Survey statewide sample.

CHARACTERISTICS OF THE SAMPLE STATEWIDE

Census Population	1,108,229	
Census Population > 18	827,737	74.4%
Census Population - Males (All)	563,891	50.9%
Census Population - Females (All)	544,338	49.1%
Total Sample Size	1,984	<1.0%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	802	39.8	329,439
Non-Drinkers	1,182	60.2	498,298
Drinkers			
Social Drinkers	512	67.5	222,371
Heavy Drinkers (Binge + Chronic)	290	32.5	107,068
Binge Drinkers	101	10.8	35,579
Chronic Drinkers	189	21.7	71,488
SMAST (scores indicating alcoholism)	86	10.4	34,262
Marijuana Use			
Ever Used	634	28.9	239,216
Current Use (within the past year)	140	5.8	48,009
Drug Use - NOT Marijuana			
Ever Used	143	6.1	50,492
Current Use	51	2.1	17,383
Tobacco Smoking			
Ever Smoked	970	47.2	390,692
Current Smoker	508	23.4	193,691
Health Insurance			
Uninsured	113	5.4	44,698
Insured	1,871	94.6	783,039

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Based on the 1990 Census, the estimated number of adult chronic substance abusers by service areas is as follows:

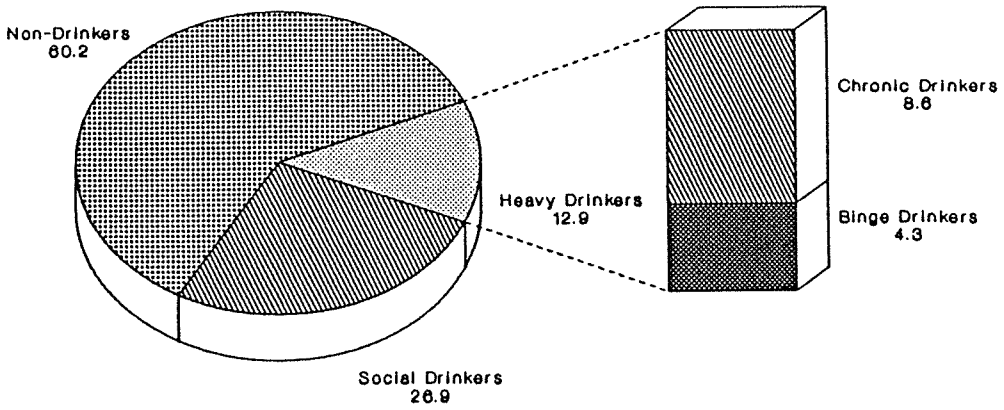
ESTIMATED NUMBER OF ADULT CHRONIC ABUSERS*

SERVICE AREA	ALCOHOL	DRUG
Central	12,418	773
Diamond Head	15,103	2,980
Windward	9,968	3,487
Leeward	4,864	1,021
Waianae	2,372	594
Kalihi-Palama	6,229	2,592
Maui	6,633	2,209
Kauai	2,979	371
East Hawaii	4,747	1,340
West Hawaii	6,079	2,262
TOTAL	71,488	17,383

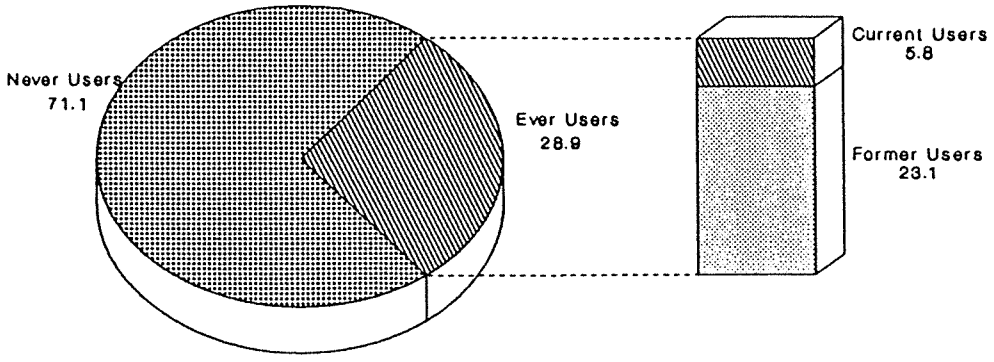
*Based on 1990 U.S. Census Data

Using the 1991 Hawaii Behavioral Health Survey data, the percentage of the adult population by drinking characteristics, use of marijuana and drugs other than marijuana, and use of tobacco are depicted in the following charts.

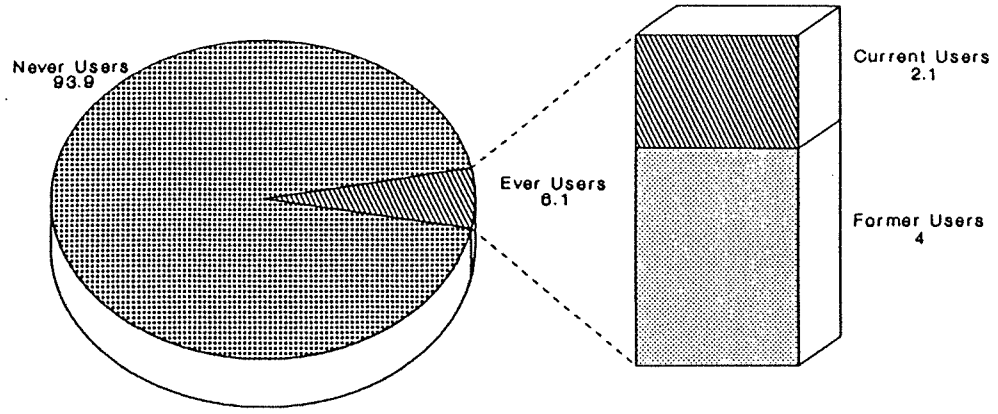
Percentage of State Population By Drinking Characteristics



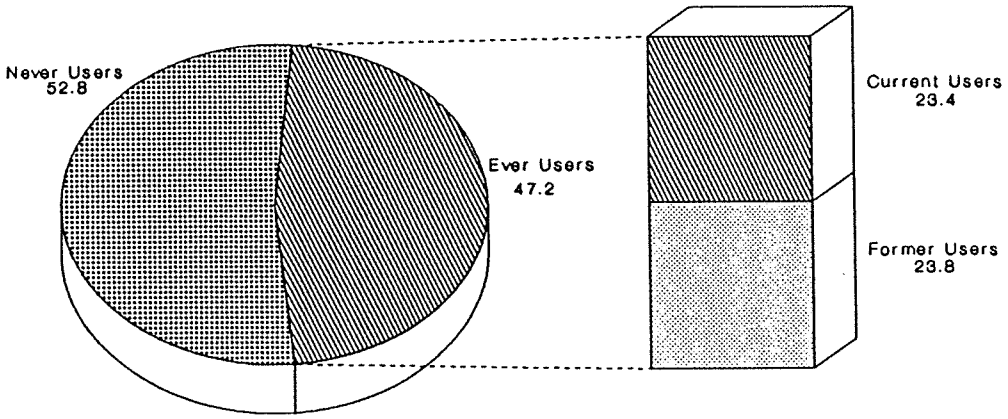
Percentage of State Population By Marijuana Use



Percentage of State Population By Drugs Other Than Marijuana/Smoking



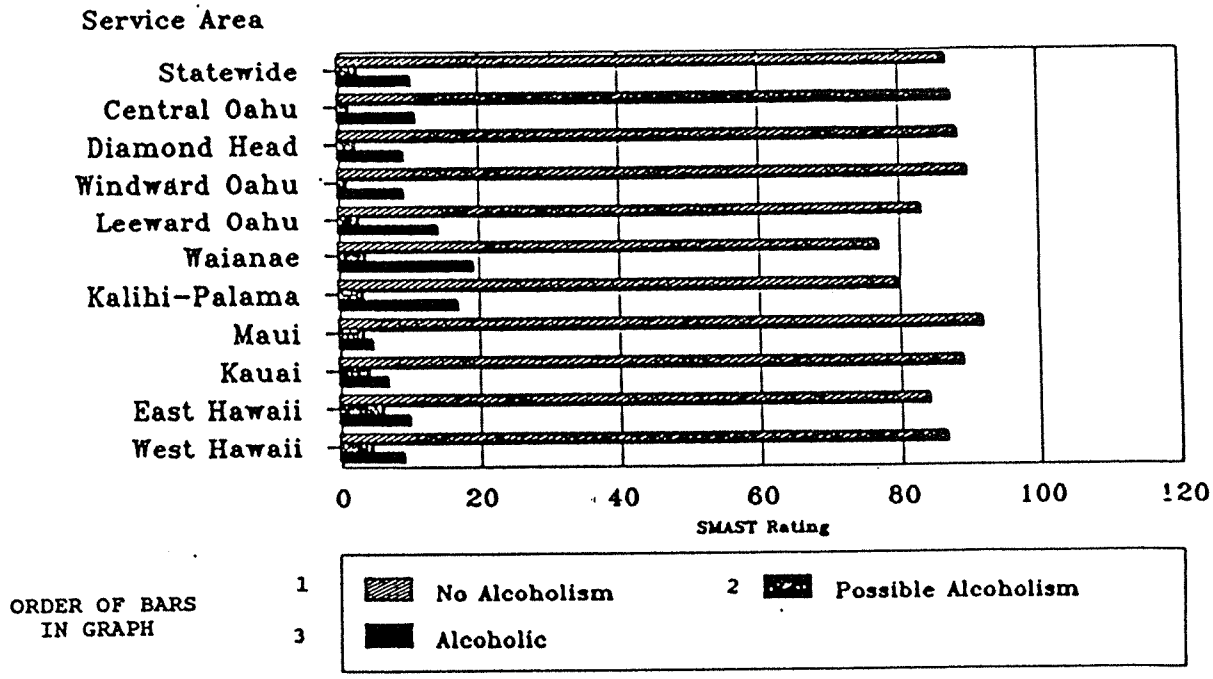
Percentage of State Population By Smoking



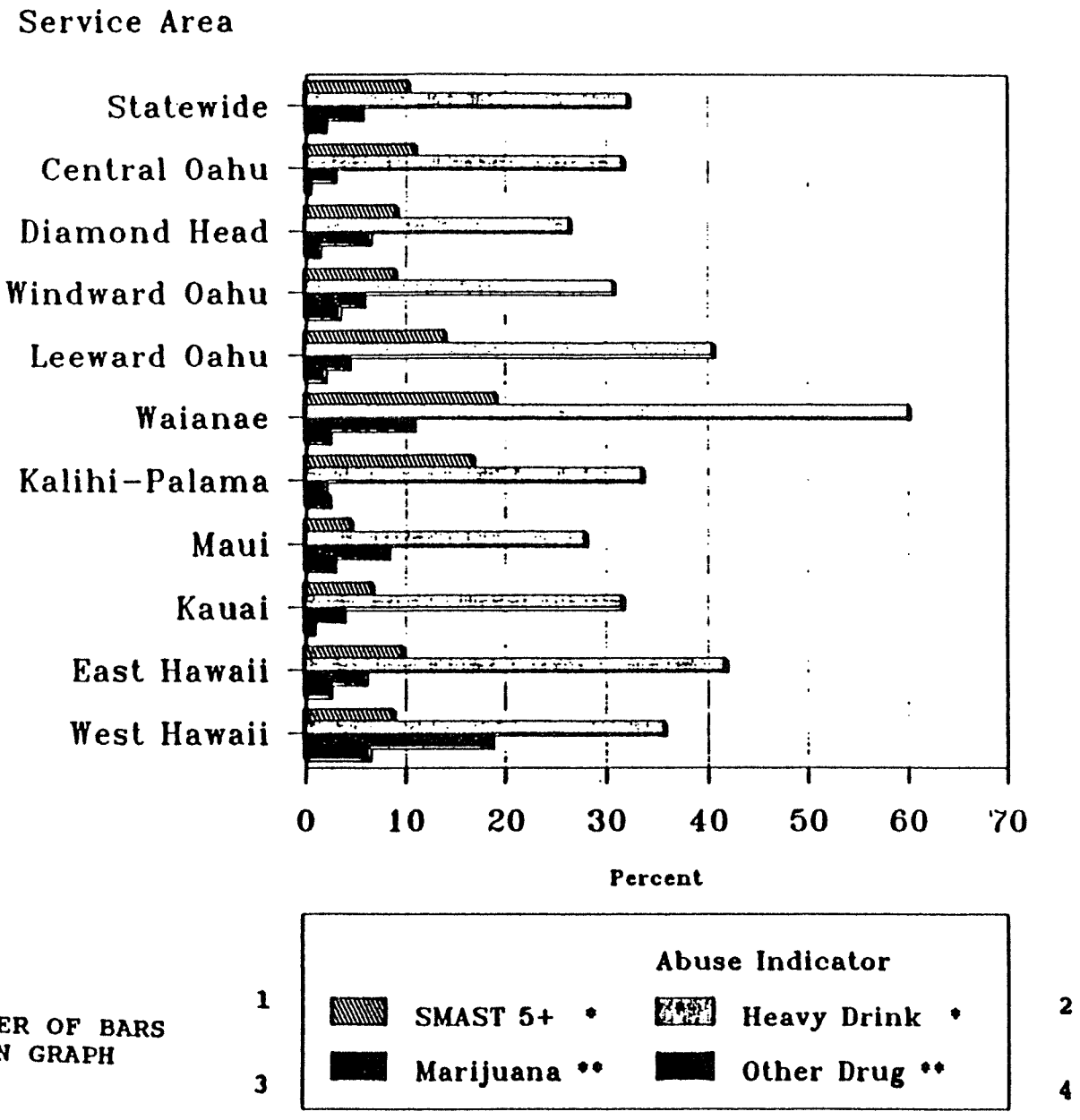
SMAST

A modified version of the Short Michigan Alcohol Screening Test (SMAST) was incorporated into the 1991 Survey. The SMAST scoring was applied in the data analysis to determine the extent of clinically relevant alcohol abuse in each service area. The following graph illustrates the SMAST scores of each service area. (A SMAST score of 5 or more is an indicator of alcoholism.) It is followed by a graph containing indicators of abuse for each service area.

Percent of Population with SMAST Scores of Five or More



SMAST
PERCENT OF POPULATION
BY INDICATORS OF ABUSE



* Of Drinkers
** Current Use

The Adult Population - Behavioral Risk Factor Surveillance System

Another source of data on adults is the Department of Health's Behavioral Risk Factor Surveillance System (BRFSS). Begun in 1986, the BRFSS is designed to collect information on health risk behaviors of adult residents. The report, "1989 Behavioral Risk Factor Survey" presents information on the prevalence of seven key factors associated with chronic disease and injury: cigarette smoking, hypertension, obesity, exercise, seatbelt nonuse, alcohol misuse, and preventive health practices.

On the positive side, Hawaii residents have a high use of seatbelts with only 6.15% of adult residents at risk for nonuse. And, although 22.31% of adult residents reported being current regular cigarette smokers, this is a decrease. On the negative side, Hawaii's drinking statistics are high. With 18.76% of adult residents categorized as binge drinkers (five or more drinks on one occasion, one or more times during the past month), Hawaii ranks as fourth highest in the country (out of the 40 participating states).

Also, 7.21% of adult residents are chronic drinkers (an average of two or more drinks per day during the past month), ranking Hawaii as the state with the highest percentage of chronic drinkers. Also, chronic drinking was found to be significantly associated with the following other risk factors: seatbelt use, smoking, acute drinking, and drinking and driving.

The Adult Population - Emergency Medical Services (EMS) Pick-ups

The impact of substance abuse in Hawaii is reflected in the number of emergency ambulance responses in 1990 classified as alcohol/drug/behavioral incidents. Shown below are the responses of the City and County of Honolulu Emergency Ambulance Service, the County of Hawaii Fire Department and the contractor for Kauai and Maui Counties.

	Total # of 1990 Emergency Ambulance Responses	Total # of 1990 Ambulance Responses Classified as Alcohol/Drug/ Behavioral Incidents
Hawaii	8,220	736 (8.9%)
Kauai	2,191	171 (7.8%)
Maui	5,308	378 (7.1%)
Honolulu	33,591	2,916 (8.68%)
Total	49,310	4,201 (8.5%)

SOURCE: Emergency Medical Services System Branch

The Adult Population - Hawaii Emergency Episode Data (HEED)

The Hawaii Emergency Episode Data project is a data collection system designed as an early indicator of the severity, scope, and nature of Hawaii's alcohol and other drug abuse problem. The project is designed to be similar to the national Drug Alert Warning Network (DAWN). However, the Hawaii HEED project incorporates alcohol as well as drug episodes and contains a database that is ethnically appropriate to Hawaii. HEED data, collected from selected Hawaii 24 hour emergency departments, includes:

- documentation of alcohol related emergency episodes in addition to other drug related visits;
- ethnic demographics to allow for a thorough study of alcohol and other drug abuse by and trends within Hawaii's many ethnic groups;
- documentation of emergency episodes of victims of alcohol or other drug related accidents or acts of violence, including both spouse and child abuse; and
- disposition of patient when discharged from the emergency department.

All emergency department records are screened for 100% of the alcohol and other drug-related episodes within the selected 24-hour emergency departments throughout Hawaii. Three sites were started in the 1991 pilot phase of the project, expanding to 12 sites statewide during FY 1993.

The four primary purposes of HEED are:

- To identify substances associated with episodes reported by Hawaii's emergency departments;
- To monitor alcohol and other drug abuse patterns and trends and to detect new abuse entities and new combinations of drugs;
- To assess health hazards associated with alcohol and other drug abuse; and
- To provide data for State and local drug abuse policy and program planning.

During the October through December 1991 quarter, 13,017 charts were reviewed; 998 (or 7.6%) cases identified substances associated with episodes. In the January through March 1992 quarter, 16,254 charts were reviewed; 1,177 (or 7.24%) identified substances associated with episodes.

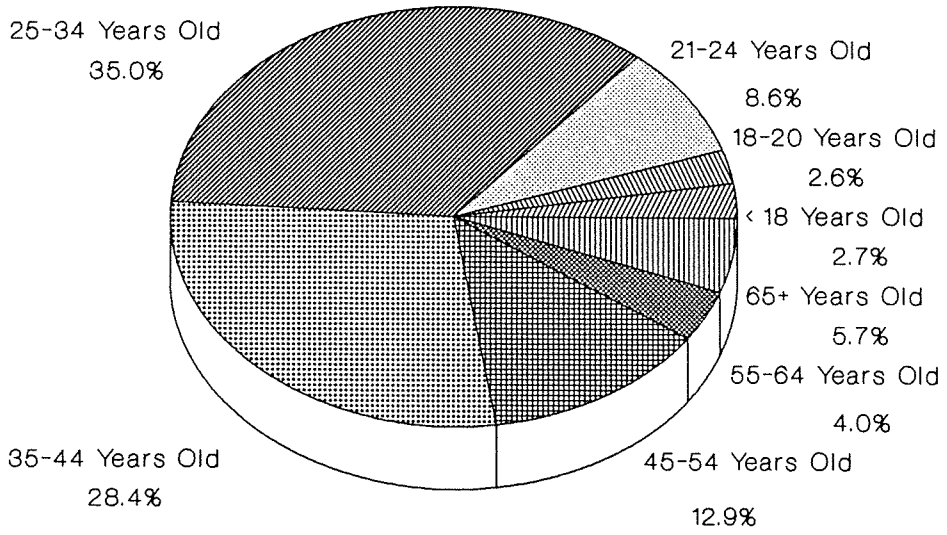
Of the substances associated episodes, the breakdown by alcohol, drug, etc. was as follows:

	OCT-DEC 1991	JAN-MAR 1992
Alcohol Only	582 (58%)	707 (60.07%)
Other Drug(s) Only	282 (28%)	312 (26.51%)
Alcohol & Drug	118 (12%)	151 (12.83%)
Unknown	15 (2%)	7 (00.59%)
TOTAL	998	1,177

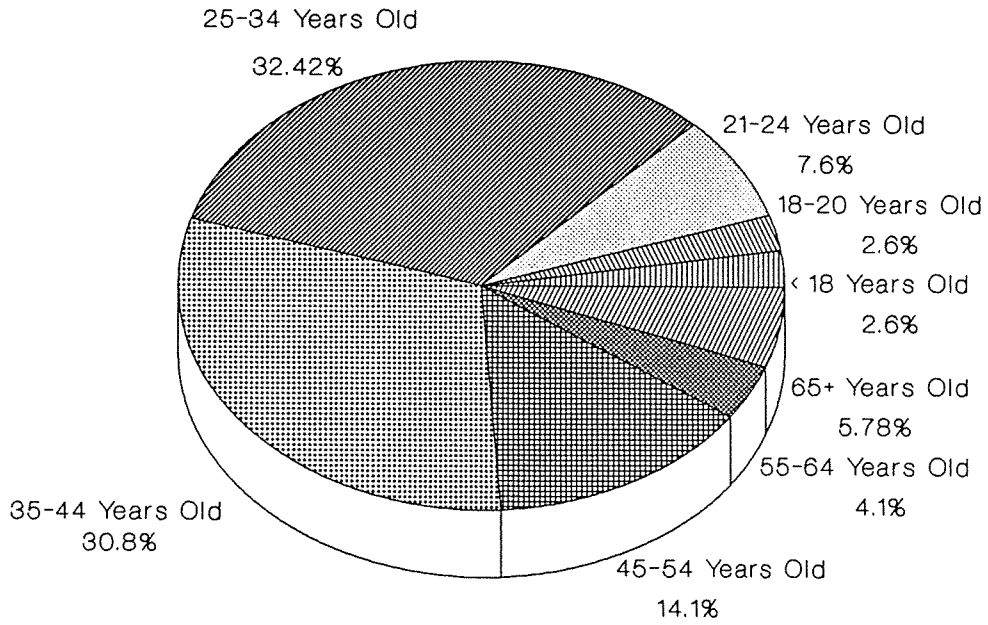
The charts on the following pages reflect Alcohol and Other Drug Emergency Episodes by age and by ethnicity for the six-month period between October 1, 1991 and March 31, 1992 for substances -- alcohol only, other drug(s) only, alcohol and drug combined.

HAWAII EMERGENCY EPISODE DATA
ALCOHOL AND OTHER DRUG EPISODES
BY AGE

10/1/91 - 12/31/91

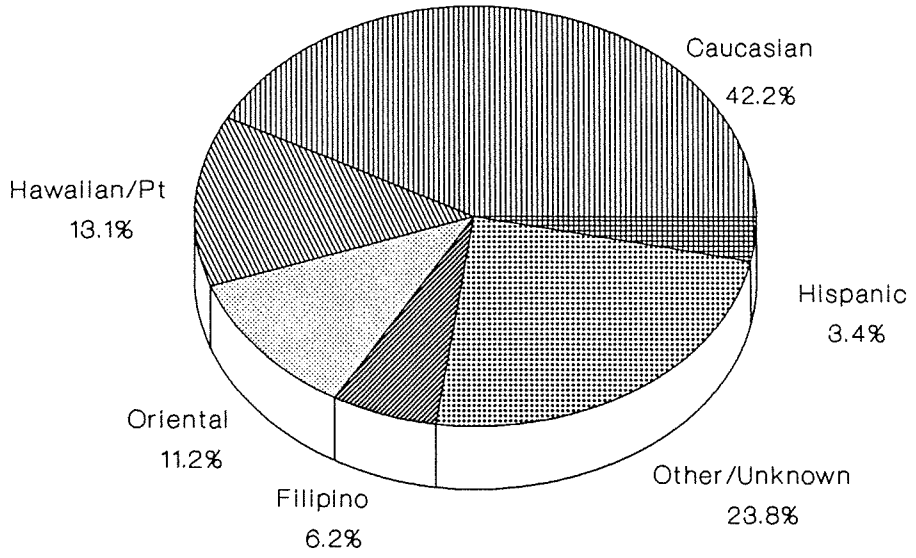


1/1/92 - 3/31/92

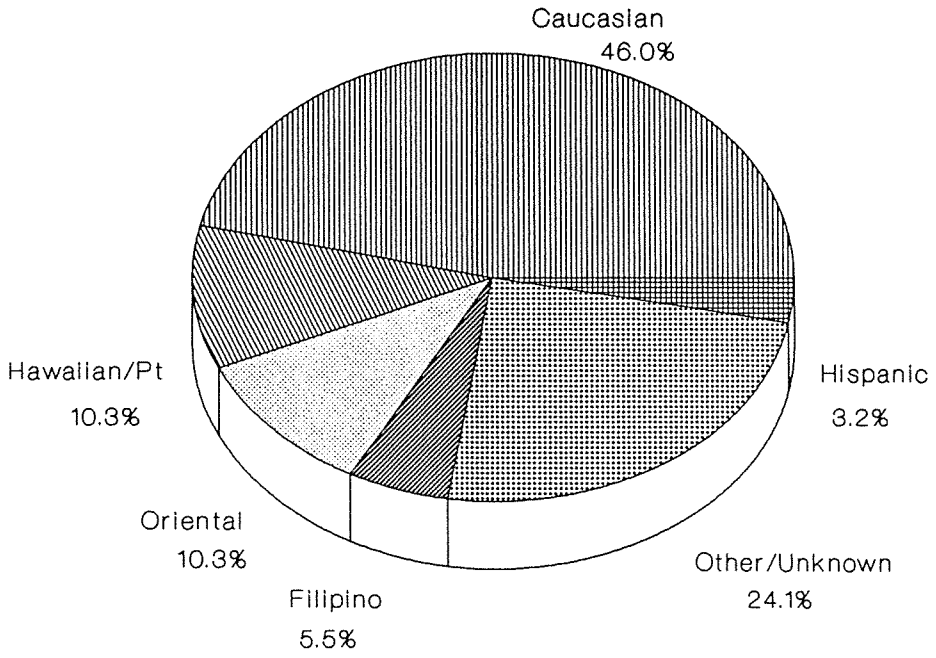


HAWAII EMERGENCY EPISODE DATA
ALCOHOL AND OTHER DRUG EPISODES
BY ETHNICITY

10/1/91 - 12/31/91



1/1/92 - 3/31/92



Student Population - The Nation

At the national level, the student alcohol and other drug use situation is much the similar to Hawaii. According to Surgeon General Antonia Novello, there are many "unrecognized consequences" of alcohol use. These consequences, based on the report *Youth and Alcohol: Laws and Enforcement* from the Office of the Inspector General, are:

Crime

- About one-third of all juvenile males who have been arrested said they had used alcohol in the previous 72 hours.
- Nearly 40% of young people in adult correctional facilities reported drinking before committing the crime.
- Over 50% of college students who had been arrested admitted drinking before they committed crimes.
- 50% of college students who were crime victims admitted using drugs and/or alcohol.

Rape and Sexual Assault

- At a southwestern university, 55% of perpetrators and 53% of sexual assault survivors were under the influence of alcohol at the time of the assault.
- At one university, administrators found that every sexual assault case was alcohol-related.
- 18% of high school females say that "it's okay to force sex if the girl is drunk."
- 39% of high school males say that "it's okay to force sex if the girl is drunk."

Suicide

- 70% of attempted suicides involve frequent drug and/or alcohol use.
- "A striking association" exists between alcohol use and using firearms to commit suicide by 10 to 19 year olds.

Water Activities and Drowning

- 40% to 50% of young males who drowned had consumed alcohol prior to drowning.
- 40% to 50% of youth injured while diving had consumed alcohol prior to diving.

Truancy, Vandalism, and School Performance in High School Seniors

- Twice as many frequent binge drinkers skipped school (55% vs. 25%).
- Nearly five times as many seniors who binged frequently damaged school property (36% vs. 8%).

Student Population - Hawaii

In order to assess the prevalence of substance use and abuse among students in Hawaii, the Hawaii State Department of Education and its Drug Free Education and Prevention Advisory committee authorized the 1991 statewide survey of substance abuse by students in Hawaii. The Department of Health is one of the co-sponsors and co-funders of this survey. The purpose of this survey is to develop an understanding of the nature and extent of illegal drug use among adolescents. The survey was administered to all public school students in grades 6, 8, 10, and 12 who were in attendance on the survey day in 1991. Participation was voluntary and responses were anonymous. A total of 33,570 students in 223 public schools participated in the survey. This survey is representative of only students in school and not all adolescents because the survey did not take into account those youths who have dropped out of school.

It is noted in the report that the survey results probably represent an underestimate of use. Substance abuse is usually highest among students with high absenteeism, so use is likely to be higher among the students who were absent when the survey was administered. Approximately 750 cases of truancy were reported in Maui, Kauai, and Hawaii counties and over 800 on Oahu in the 1989-1990 school year. This, however, is an underestimate of the problem since the number of reported cases represents only those cases in which court action was required. Also, according to the Department of Education, in the 1989-1990 school year, the state drop out rate for grades 9 through 12 was 5.5%. These students are not represented in this study, yet it is this population that is at higher risk of substance abuse as is pointed out nationally in the 1991 Household Survey.

The definitions used in the Department of Education Survey report are as follows:

No drug use refers to students who have never tried drugs in their lifetime.

Low drug use refers to students who have tried at least one drug but are not frequent users and may not be currently using any drugs. These students may be considered as experimental users.

Moderate drug use refers to students who use one or more drugs regularly (e.g., monthly or weekly use of marijuana) or experimenting with very addictive drugs like cocaine or opiates.

High drug use refers to students who use marijuana daily or cocaine weekly. These students are most at risk of becoming addicted or suffering from severe health and safety risks associated with heavy drug use.

No alcohol use refers to students who have not tried beer, wine, wine coolers, or distilled spirits in their lifetime.

Low alcohol use refers to students who have tried alcohol, but either drink no more than one drink at a time, once a month or less often, use small amounts no more than once a month, or are no longer using alcohol.

Moderate alcohol use refers to students who typically drink two to four drinks at a time monthly, one drink or less weekly, or binge drink (five or more at a time), but do so infrequently (less than six times in the last year).

High alcohol use refers to students who drink daily or binge regularly, drinking five or more drinks at any one time. Students who are heavy alcohol users or binge drinkers are most at risk of becoming alcoholics due to their daily use of alcohol or frequent binge drinking. For these heavy alcohol users, prevention programs are no longer appropriate. These students are definitely in need of intervention and treatment services for their substance abuse problems.

For purposes of planning, the student survey results have been extrapolated for the Department of Health Service Areas of Honolulu, Central Oahu, Leeward Oahu, Waianae, Kalihi-Palama, Diamond Head, Windward Oahu, Maui, Hawaii and Kauai.

An estimated number of low, moderate and high drug and low, moderate and high alcohol users 14 to 17 years of age, based on extrapolations of the percentage distributions to the total 14 to 17 year old population for each service area is reflected in the ensuing tables. The tables provide estimates of the number of high drug and high alcohol users, based on extrapolations from census total population data by age, and prevalence rates for the population of 17 year olds within each school district.

By averaging the 6th, 8th, 10th and 12th grades statewide percentages of alcohol and drug use stated in the 1991 survey, an approximate percentage for low, moderate and high alcohol and drug use can be calculated to the 12-17 year old population in the state. Using these approximate percentages, calculations based on extrapolations to the 12-17 year old population for each of the seven school districts.

DISTRIBUTION OF FREQUENCY OF USE EXTRAPOLATED TO DOH SERVICE AREAS FOR ALCOHOL AND OTHER DRUG USE AMONG THOSE 14-15 YEARS OLD IN THE STATE OF HAWAII

	LOW USE		MODERATE USE		HIGH USE	
	DRUG 19.7%	ALCOHOL 43.9%	DRUG 7.6%	ALCOHOL 17.9%	DRUG 6.2%	ALCOHOL 11.1%
Windward Oahu	706	1,573	272	641	222	398
Central Oahu	1,064	2,370	410	966	335	599
Leeward Oahu	397	885	153	361	125	224
Kalihi-Palama	732	1,632	283	666	231	413
Diamond Head	803	1,789	310	729	253	452
Waianae	284	633	110	258	89	160
Hawaii	686	1,529	265	623	216	387
Maui	535	1,191	206	486	168	301
Kauai	1,453	3,238	561	1,320	457	819
TOTAL	6,660	14,840	2,510	6,050	2,096	3,753

ADAPTED FROM: Substance Use Among Public School Students in Hawaii 1987-1991, Dept. of Education
ADAPTED FROM: The State of Hawaii Data Book 1991, Dept. of Business, Economic Development and Tourism

DISTRIBUTION OF FREQUENCY OF USE EXTRAPOLATED TO DOH SERVICE AREAS FOR ALCOHOL AND OTHER DRUG USE AMONG THOSE 16-17 YEARS OLD IN THE STATE OF HAWAII

	LOW USE		MODERATE USE		HIGH USE	
	DRUG 22.2%	ALCOHOL 37.7%	DRUG 9.9%	ALCOHOL 23.8%	DRUG 7.1%	ALCOHOL 18.3%
Windward Oahu	802	1,362	358	860	257	661
Central Oahu	1,196	2,031	533	1,282	382	986
Leeward Oahu	265	450	118	284	85	218
Kalihi-Palama	839	1,425	374	900	268	692
Diamond Head	984	1,672	439	1,055	315	811
Waianae	315	535	140	338	101	260
Hawaii	730	1,239	325	782	233	602
Maui	597	1,014	266	640	191	492
Kauai	1,237	2,101	552	1,326	396	1,020
TOTAL	6,965	11,829	3,105	7,467	2,228	5,742

ADAPTED FROM: Substance Use Among Public School Students in Hawaii 1987-1991, Dept. of Education
ADAPTED FROM: The State of Hawaii Data Book 1991, Dept. of Business, Economic Development And Tourism

DISTRIBUTION OF THE PREVALENCE OF HIGH DRUG AND HIGH ALCOHOL USE AMONG THOSE 17 YEARS OF AGE FOR THE SCHOOL DISTRICTS IN THE STATE OF HAWAII

	TOTAL POPULATION	DRUG	ALCOHOL
Honolulu	4,157	212 (5.1%)	570 (13.7%)
Central Oahu	1,739	92 (5.3%)	238 (13.7%)
Leeward Oahu	1,786	64 (3.6%)	298 (16.7%)
Windward Oahu	1,793	143 (8.0%)	402 (22.4%)
Hawaii	1,650	196 (11.9%)	399 (24.2%)
Maui	1,292	125 (9.7%)	314 (24.3%)
Kauai	1,996	152 (7.6%)	373 (18.7%)

SOURCE: Substance Use Among Public School Students in Hawaii 1987-1992, Dept. of Education
SOURCE: The State of Hawaii Data Book 1991, Dept. of Business, Economic Development And Tourism

Some highlights of the 1991 DOE Student Survey include:

- Alcohol is still by far the substance of choice for students at all grades. By the beginning of sixth grade, nearly one-third of the students (31 percent) have already tried some form of alcohol. By the beginning of eighth grade, this number has increased to nearly six out of ten students (56 percent).

- Smoking tobacco continues to follow alcohol as the next substance of choice. By tenth grade, nearly half of the students (45 percent) have tried smoking tobacco.

- By their senior year many students have also tried illicit drugs such as marijuana (34 percent), methamphetamine (9 percent) and cocaine (9 percent).

- When compared with a national mainland U.S. sample of high school seniors, a lower proportion of Hawaii's twelfth graders report regular use of alcohol, but a higher proportion report regular use of marijuana and cocaine. **This is of special concern because the steady decline in recent use of marijuana and cocaine among U.S. high school seniors is not being realized in Hawaii.**

- Nearly 4 percent of the eighth graders reported high use of alcohol while over 18 percent of the seniors reported high use. **At least 6,000 students (about 7.6 percent) in grades six through twelve in Hawaii may be considered heavy drinkers. This is slightly higher than the number reported in 1989 Department of Education Survey.**

- About 3 percent of the eighth graders reported high use of drugs, while nearly one in fourteen (7 percent) reported high use by their senior year. **Over 3,200 public school students (over 4 percent) in grades six through twelve can be considered heavy drug users. This is a decline from the number reported in 1989.**

- As in the previous 1989 Department of Education Survey, there continues to be a strong relationship between use of gateway substances of alcohol and tobacco with illicit drug use. **Among high school seniors, heavy drug users are three times as likely to be drinkers and ten times as likely to be smokers than are non-drug users.**

- Six of the seven school districts (all but Leeward) experienced a decline in the percent of seniors ever trying alcohol. This decline, however, was typically smaller than those observed from 1987 to 1989.

- Six of the seven school districts (all but Hawaii) experienced a decline in the percent of seniors ever trying illicit drugs. In general, declines in illicit drug use were greater than those observed for alcohol use.

- **Native Hawaiian/Part Native Hawaiian and Caucasian seniors report the highest rate of heavy drug and alcohol use. These results are similar to the 1989 findings.**

- Smoking one or more packs of cigarettes per day is seen as very risky by a higher proportion of high school seniors (63 percent) than occasional marijuana smoking (56 percent), trying heroin once or twice (60 percent), or trying cocaine once or twice (61 percent).

- A higher proportion of high school seniors consider smoking one or more packs of cigarettes per day (63 percent) riskier than binge drinking (36 percent).

- As students grow older, they perceive that drugs are increasingly easy to obtain. By the twelfth grade, about two-thirds (66 percent) of the students report that it would be easy to obtain marijuana and about one-third feel that methamphetamine (33 percent) and cocaine (32 percent) are easy to obtain.

- At all grades, school is the primary source of information about the dangers of drugs and alcohol. Three of the four grades surveyed (all but seniors) indicate their family as the next important source of information.

- **What continues to be troubling, however, is the apparently minimal effect of prevention and early intervention efforts targeting tobacco and alcohol use, especially at grades ten and twelve.** This may be observed from the sharp rise in experimentation with alcohol and cigarettes after the sixth grade. In the sixth grade, 31 percent have tried alcohol and 10 percent have tried cigarettes. By the twelfth grade, 80 percent have tried alcohol and 50 percent have tried cigarettes.

Recommendations made by the Drug Education and Prevention Committee. In viewing these results and assessing the progress of Hawaii's statewide prevention effort, the Drug Education and Prevention Advisory Committee of the Hawaii State Department of Education formulated eight programmatic recommendations. The are as follows:

- Continue substance abuse education efforts with increased emphasis on tobacco and alcohol.

- Continue to expand early intervention and referral services for students needing help. In addition, provide in-service trainings for school staff, counselors, and teachers to identify high-risk factors leading to substance use.

- Increase parent involvement in prevention education classes, early intervention support groups, and the referral process.

- Increase the number of alcohol- and drug-free alternative activities for middle schools that include drug awareness sessions for parents of children attending the activities.

- Peer programs should be encouraged so that positive anti-drug messages are given by youth (peer educators) to their peers.

- Expand and encourage interdepartmental and interagency efforts on education, law enforcement and treatment programs, and services at state, district and school levels.

- Continue to encourage anti-drug message by television and media.

College Students

According to the Center For Science in the Public Interest as printed in The Chemical People Newsletter, January/February 1992, alcohol is a serious problem for college students. One-half of college presidents surveyed in 1989 said that alcohol use is the single most serious campus life issue facing them. Alcohol use has remained constant among college students over the last ten years, despite a steady decline in marijuana and cocaine use.

According to campus administrators, alcohol is a factor in 34% of academic problems, 24% of dropouts, 69% of damage to college residence halls, and 64% of violent behavior on campus. Despite the fact that it is illegal to purchase alcohol if you're under 21, college students drink a lot:

- 93% of college students have tried alcohol in their lifetime.

- 89% of college student have consumed alcohol in the past year.

- 75% had alcohol in the last month.

- 42% had five or more drinks on one occasion in the past two weeks.

- Among freshman at 14 Massachusetts colleges, 50% of male and 33% of female students identified themselves as binge drinkers.

- Peak alcohol drinking behavior occurs in the 17-22 year old age group. Problem drinking, alcohol dependence, and drinking related consequences, occur most among 18-29 year olds.

- College students are more likely to drink than their same age non-college peers, 75% versus 71%, and college students are more likely to drink heavily, 41% versus 34%.

- Beer sales to college students account for approximately 10% of total brewery revenue.

- Brewers spend an estimated $15-20 million annually promoting their products to college youth.

WOMEN

Background. Since the early beginnings, alcoholism has been defined as a "man's disease." In the early 1940s, two middle class white males founded Alcoholics Anonymous (AA), the first attempt to deal with chemical dependency in an effective manner. The Big Book, the 12 Steps, and the AA meeting structure were written from the male needs' perspective. Even today, although AA membership is estimated at 30% female, AA policy is largely determined by men.

This focus on men most of the time has lead to an under-representation of women in treatment and an ignoring of research into women's etiology and disease progression.

Chronic alcohol and drug use has a greater psychological and physiological impact upon women. Women are more frequently incapacitated and for longer periods of time than men. Women experience greater physiological impairment than men early in their use. Women have more advanced liver disease, pancreatitis, ulcers, cardiovascular and circulatory disorders than men. One study found 85% of addicted women reported some kind of sexual dysfunction; other studies have found a positive correlation between female drinking levels and their report of gynecological problems.

Women are more likely than men to suffer from psychiatric symptoms, which contributes to a high rate of prescription drug abuse and dependency.

As with much of health care, there is a tremendous need for research and for immediate institutionalization of services specifically to serve chemically dependent women. There was some short-lived focus on women alcoholics and drug abusers in the 1970s by the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAA), but the resulting demonstration programs were short lived.

In 1985, 5% of the Alcohol Drug and Mental Health Services (ADMS) block grant was designated as a women's set aside. The set aside now is 10%, but Congress now has eliminated the broader set aside, and focuses only on pregnant women and women with dependent children. Much of the women's set aside nationally was used to supplement the existing treatment continuum, not to create gender specific treatment programs.

Hawaii. The 1991 Behavioral Health Survey obtained data on women and substance use and abuse in Hawaii. The following pages summarize the findings of that survey.

Women comprise approximately 49.1 percent of the population of the State (or approximately 544,338 individuals). The average age of the sample of 1,089 respondents is 47 years. Of these, 65.4 percent are married, 42.0 percent have one or two children, 39.5 percent have three or more children.

Nearly 20 percent of women over 18 years of age have not completed high school, 32.6 percent have completed high school and 46.1 percent have some college education.

The modal household income category for women is at $20,000 and $29,999, with 28.7 percent in the less than $20,000 per year income groups and 7.8 percent in the $75,000 or more group. About 54 percent of the women are currently employed.

Nearly 30 percent of the women drink alcohol. Of this group, 11.1 percent are "binge drinkers" and 13.6 percent are "chronic drinkers." Of women who drink, 24.7 percent are heavy drinkers, or 7.3 percent of the female population over age 18. Nearly 1.9 percent of the women sampled who drink are under 21 years of age and of these 50.0 percent are binge drinkers.

Women at higher risk for heavy drinking are separated (40.0%) and single (39.0%), are less educated and employed. Hawaiian (28.3%), Portuguese (30.4%) and Caucasian (52.5%) women are more likely to drink than other ethnic groups.

Of the women who drink, nearly 5 percent report driving after drinking and 4.5 percent of all women believe they have a drinking problem. Less than 3.0 percent report use of detoxification and other alcohol related service utilization which suggests a problem in access to or acceptability of services by women.

A least 6.0 percent of the women who drink report behavior ("blackouts") that indicates a need for clinical alcohol assessment services. In addition, 7.1 percent of the women drinkers (including 1.1 percent of the social drinkers) had SMAST scores strongly indicating alcoholism. Since the SMAST is based on one's history of alcohol use, these may include individuals who were problematic drinkers at one time, but not presently. Over, 1.6 percent of all women respondents are heavy wine drinkers, 2.5 percent are heavy distilled spirits drinkers, and 3.9 percent are heavy beer drinkers.

Over, 27.1 percent of women respondents have smoked marijuana at some time, and 4.9 percent currently smoke the drug. Of the women age 18 to 19 years, 45.5 percent have tried the drug and over nine percent within that age group are currently using it. Women marijuana users are more likely to be age 20 to 24, unmarried, more educated, and employed. Caucasians and Portuguese women are more likely to be current marijuana users than other groups. Native Hawaiian, Caucasian and Samoan women are more likely to have used it at least once in their lifetime.

Among the current marijuana smokers, 31.4 percent are heavy beer drinkers and 29.5 percent are current users of drugs other than marijuana and alcohol. In total, 6.0 percent of the women respondents indicate that they have used drugs, drugs other than marijuana for non-medical purposes, and 2.3 percent are currently using such substances. The modal group of current users of drugs other than marijuana are age 20 to 34 years.

Just over 23 percent of the women respondents currently smoke cigarettes (tobacco) and most started smoking at 18 years of age. Over 52 percent of the users of drugs other than marijuana currently smoke tobacco and of these, 40.0 percent smoke at least one pack of cigarettes per day.

Among the 4.4 percent of women who are uninsured, most are 20 to 24 years old, single, and with less than a high school education.

CHARACTERISTICS OF THE SAMPLE
WOMEN

Census Population > 18	827,737	74.4%
Census Population - Females (All)	544,388	49.1%
Total Sample Size	1,089	0.2%

Characteristic	n	%n
Alcohol		
Drinkers	324	29.8
Non-Drinkers	765	70.2
Drinkers		
Social Drinkers	244	75.3
Heavy Drinkers (Binge + Chronic)	80	24.7
Binge Drinkers	36	11.1
Chronic Drinkers	44	13.6
SMAST (scores indicating alcoholism)	23	7.1
Marijuana Use		
Ever Used	295	27.1
Current Use (within the past year)	53	4.9
Drug Use - NOT Marijuana		
Ever Used	65	6.0
Current Use	25	2.3
Tobacco Smoking		
Ever Smoked	446	41.0
Current Smoker	254	23.3
Health Insurance		
Uninsured	48	4.4
Insured	1,041	95.6

n = sample size
%n = % of the sample and/or % of given category - unweighted

According to Women & Infant Numbers in Hawaii, 1992 published by the Maternal and Child Health Branch of the Department of Health, there were 25,744 pregnancies resulting in 20,438 live births in Hawaii in 1990. According to "One Year in the Life of Hawaii's Families" compiled by Healthy Mothers, Healthy Babies Coalition of Hawaii in February 1991:

17,700 Families live in poverty
7,965 Of them are headed by women

1,460 Adults are arrested in cases of domestic violence
1,314 Women are victims in these cases

These are factors that become risk factors for substance abuse or are exacerbated by substance abuse.

Hawaii's Health Risk Behaviors 1989, published by the Hawaii State Department of Health, reports that: 57.6% of Hawaii's adult women have sedentary lifestyles; 18.5% are overweight; 24.5% smoke; and 9.4% have engaged in binge drinking in the past month while 2.8% have engaged in chronic drinking. Between 19.5% and 27.6% of women 18-44 have experienced binge drinking, while slightly over 9% of women 25-44 have experienced chronic drinking. Both binge and chronic drinking are associated with being overweight, smoking, leading a sedentary lifestyle, and driving under the influence.

Despite the growing numbers, Hawaii currently has fewer than 50 substance abuse treatment slots targeted specifically for women.

Pregnant Women and Infants. Smoking, excessive drinking, taking certain prescriptions or illegal drugs and failing to seek timely health care all harm a fetus. Alcohol can devastate a developing fetus causing mental retardation, schizophrenia in later life (1 out of 100); cigarette smoking reduces birth weight and can damage developing lungs; environmental and occupational hazards can and do damage the fetus.

Although economic research has not yet produced accurate estimates of the total cost of prenatal substance exposure, there is growing evidence that this exposure may result in large short-term expenditures for newborn medical intensive care and probably even larger long-term medical, social, and educational expenditures. The annual short-term economic costs due to maternal smoking are estimated to be from $332 million to $652 million (in 1986), long-term costs due to maternal smoking are estimated at $351 million to $852 million (in 1986). In 1980 over a billion dollars were spent caring for identified children and adults with fetal alcohol syndrome. This syndrome is one of the three leading cause of birth defects and is the only one that is 100% preventable. (Downs Syndrome and Spina-bifida are the other two leading causes of birth defects.) Babies born to alcoholic mothers are at increased risk for congenital heart defects which are among the most expensive Neonatal Intensive Care Unit cases as they often require care over a long period of time.

Drug-exposed infants often have neurological or other developmental problems, which lead to additional medical costs and costs for education. In some instances, drug-exposed infants are at risk for HIV/AIDS which will increase long-term costs. This population will require expansion of services and, as a result, this burden may be borne by other disadvantaged groups if not by society as a whole. The educational needs may divert already scarce funds from the public school system's general educational responsibilities. A 29% increase in the demand for foster care in 1986-1989 required an increase in the level of foster care payments to provide a sufficient supply of trained foster home parents. Foster parents often feel ill prepared to manage the unique needs of a drug-exposed infant.

The costs of treating cocaine and other drug-exposed infants vary widely, in part because accurate estimates of the number exposed are not available. "Aggregate costs in the first year of life of these infants appear large, at least $51 million per year." (Phibbs, '91). The future expenditures have been estimated to be even larger, since many costs, to date largely unmeasured, occur over a child's lifetime. Thus, educating women and men about the harm of substance use during pregnancy and treating maternal substance abuse through specialized treatment programs are extremely cost-effective.

Although data on the entire maternal-child drug-exposed population is not available, national estimates of the number of infants who are exposed at least one time prenatally to an illegal drug, or drugs in combination range from 350,000 to 739,200 per year.

In Hawaii, no statewide data collection systems exist which routinely gather and analyze information on the incidence of drug use at the time of delivery and/or the effects of drugs on the newborn. Recent recognition of the problem; inconsistent provider awareness; lack of consensus on how to measure the extent of maternal addiction and its effect on the infant; and the difficulty in identifying diagnostic indicators for drug exposure in infants, contribute to the lack of comprehensive data.

In studies conducted by Kapiolani Medical Center for Women and Children in 1989-1990, Kaiser Permanente in 1991, and Wilcox Hospital on Kauai in 1991, 1,579 pregnant women were screened through urine toxicologies. Seventy-one were positive for substance use: marijuana 73.2%, methamphetamine 15.5%, cocaine 15.5%, amphetamines 9.9%, and opiates 7.0%. These studies indicate an overall prevalence of 4.5% for drug exposed infants. However, it should be noted that on the island of Kauai the overall prevalence was 7.3%. If these percentages are applied to the number of live births recorded in 1990, the number of drug exposed infants in 1990 could total 946: 100 in Hawaii County; 69 in Kauai county, 85 in Maui County; and 692 in the City and County of Honolulu.

The following **characteristics of high risk women** were identified by the study:

Age	**18 - 34**
Ethnicity	Caucasian, Native Hawaiian
Residence	Oahu: Waianae Coast, East Honolulu and Windward Kauai: North Shore
Insurance	Medicaid
Primary Drug	Marijuana, methamphetamine, cocaine, amphetamines and opiates

Failure to access any treatment, prenatal care, or drug rehabilitation, is the major issue of the drug-exposed population. Of the identified substance abusing women who delivered at Kapiolani Medical Center for Women and Children, 69% received inadequate prenatal care and 20% received no prenatal care.

In Hawaii, preliminary data from the Hawaii Birth Defects Monitoring Program suggest a possible association between birth defects and maternal use of alcohol and drugs. Discharge records from one facility during an 8.5-month period in 1989 revealed 286 infants born with birth defects. Of these infants, 24 percent of the mothers had a history of alcohol and/or single drug use. However, the number of mothers with such a history may have been underestimated since substance abuse is frequently not diagnosed because of health care professionals lack of training in identification and assessment, patient and physician denial of substance abuse, chronic lack of treatment resources, and fear of legal action.

Other records indicate a dramatic increase in the number of drug-exposed infants. In 1988, the Child Protective Services Multi-disciplinary Team at Kapiolani Medical Center for Women and Children assessed 18 drug-exposed infants. In 1989, 108 drug-exposed infants were assessed by the Child Protective Services Team.

Barriers to the Delivery of Treatment Services. The female cultural and class experiences serve as barriers to treatment for women. Women are survivors of a culture where they are profoundly disrespected, as reflected in the amount of violence perpetrated against them. There is a greater stigma associated with women alcoholics and drug users; female addicts are more likely to be seen as deviant than male addicts. There is more social disapproval, shame, secrecy, family enabling and self-blaming of and by women. Alcoholic women have a higher suicide rate than men alcoholics. Several international studies have consistently shown women alcoholics have death rates from 50% to 100% higher than men alcoholics.

Women are more isolated in this culture than are men. Women have fewer social support groups, fewer informal networks of support, and suffer more financially-induced isolation and lack of contacts with the world. Isolation is a major barrier to women accessing treatment because it tends to prevent women from even knowing about available treatment resources. Isolation also induces fear and distrust of new experiences, which contributes to a woman's inability to access available treatment of any kind.

A study by the Association of Junior Leagues in 1988 identified the most serious barriers to women seeking treatment for alcohol problems as:

- Personal denial;
- Responsibility for child care (the most frequently cited barrier); and
- Family denial of the woman's alcohol problems or opposition to treatment.

In addition, another identified major barrier was the lack of awareness of women's alcohol problems on the part of key community gatekeepers (such as law enforcement, social service personnel, clergy, and health care providers). Even employee assistance programs may recognize problematic drinking in women at a later stage than that identified for men.

The following barriers to treatment have been identified in the literature, and by Hawaii's provider community:

- Fear of criminal prosecution
- Professional avoidance
- Lack of facilities for women & their infants
- Lack of treatment for women & their infants
- Inadequate access to prenatal care
- Insurance reimbursement issues
- Inadequate child care
- Lack of transportation
- Inadequate housing
- Lack of legal assistance
- Lack of residential treatment for women & children
- Inadequate aggressive aftercare
- Limited inpatient detoxification

Nationally, the majority of organizations and states support a public health, rather than a criminal, approach to the resolution of perinatal substance abuse. Further, most are concerned that perinatal substance abuse must be addressed with a comprehensive multi-strategy approach through the promotion of increased prevention, education, early identification and comprehensive treatment resources that include hospital detoxification, residential, out patient, postpartum and therapeutic nurseries.

Recommendations for Hawaii. In the past year, the Hawaii State Council on Chemical Dependency and Pregnancy developed twelve major positions which offer direction to future legislation. These positions have evolved from the continued study of maternal addiction and drug-exposed infants and are the foundation of the Baby S.A.F.E. (Substance Abuse Free Environment) action plan.

With respect to the concerns of Baby S.A.F.E. Hawaii, legislation in Hawaii should:

- Support pregnant women to receive prenatal care and education about the risk of using drugs, alcohol, and/or tobacco during pregnancy.

- Provide that a pregnant woman not be subjected to arrest, commitment, confinement, incarceration, or other detention or extension of detention, solely because of her pregnancy status.

- Provide that positive toxicologies taken of newborns at birth be used for medical intervention only. Removal of a child should be done only on the basis of evidence of parental unfitness which covers the entire home environment; not merely on the basis of a positive toxicology.

- Provide that child abuse reporting laws not be triggered solely on the basis of alcohol or other drug use or addiction without reason to believe that the child is a risk of harm because of parental unfitness. (Present Hawaii State child abuse laws are adequate for addressing this problem.)

- Prohibit the use of judicial authority to impose treatment regimens in order to protect the fetus. Health care workers shall refrain from performing procedures that are unwanted by a pregnant woman.

- Prohibit alcohol and drug treatment programs from excluding pregnant women. Appropriate indemnification measures should be adopted.

- Increase appropriations for comprehensive alcohol and drug treatment programs for women.

- Increase appropriations for alcohol and drug prevention education programs for women and men.

- Increase appropriations for treatment of drug- and alcohol-addicted incarcerated women.

- Increase appropriations for health and developmental assessments and follow-up treatment services for drug-exposed infants.

- In order to improve maternal and child health, provide for the coordination of alcohol and drug treatment programs, social services, educational and maternal and child health programs.

- Increase appropriations for research to determine (a) the prevalence of drug use among men and pregnant women; (b) the relationship between such use and birth and developmental outcomes, and (c) the effectiveness of drug treatment programs for pregnant women and parents with infants for their effectiveness in enabling participants to function as adequate caretakers of their children.

HOMELESSNESS

Nationally, homelessness is not a new phenomenon. Earlier manifestations were seen in such places as "poor farms," "children's homes," and "skid rows." Though not new, the homelessness that has emerged in the 1980s is distinct from previous periods because of its complex roots and perceived pervasiveness.

The actual incidence of homelessness remains unknown. Estimates range from one-quarter of a million to 3 million people. Conflicting counts of the homeless due to the varying methodologies used spark a lively debate; however, no consensus has been reached. The current focus has shifted from absolute numbers of the homeless to relative changes in homelessness, (e.g., percentage changes in homeless families or percentage changes in homeless substance abusers). In the absence of systematic data, most observers maintain that homelessness is increasing, particularly among families and "working poor."

Research suggests that substance abuse is common, but not pervasive among the homeless. Approximately 40% are estimated to be alcohol abusers. However, the overlap between chronic mental illness and substance abuse leads some observers to suggest that substance abuse, in some cases, may result as a coping response to the trauma of being homeless.

The research on homelessness makes it clear that problems such as mental illness, substance abuse, unemployment and familial estrangement do not necessarily occur in isolation. Typically, the homeless individual suffers from multiple problems: loss of employment may provoke family conflicts in addition to financial crisis, or substance abuse may impede the individual from working as well as estrange the individual from family members.

Research describes the long-term homeless (i.e., those who are homeless for more than 2 years) as those who are alcoholics, those with prison records and those who are mentally ill. The data also suggest that the long-term homeless are less likely to have ever been married, more likely to be white, more apt to be less educated and more frequently have less work experience.

In Hawaii, the SMS Research study entitled "Homelessness and Hunger in Hawaii," which was released in July 1992, reports that although the large majority of the homeless are people with limited economic resources who came to be homeless as a result of an economic, personal or family disaster, Hawaii's homeless population includes people with problems of substance abuse and mental illness.

The SMS study differentiates between housing situations. While the definition of homelessness is based on the federal McKinney Act provisions, the definitions of the hidden homeless are new.

Homeless: Persons who are without a regular place to sleep. There are two subtypes:

(1) McKinney homeless or persons who reside in homeless shelters or who sleep in non-standard sleeping places; and

(2) the institutionalized homeless -- homeless persons sheltered in residential treatment programs for problems other than homelessness. These types of shelters included those for runaway youth, for victims of spouse abuse and drug treatment programs. (Persons housed in prisons, mental institutions, hospitals, homes for senior citizens, college dormitories and other such institutions were not included. Persons housed in shelters for victims of family abuse, those in residential treatment programs for substance abuse and those for displaced youth were included in the definition.)

Hidden Homeless: There are two types of situations covered by this definition:

(1) Persons who share accommodations with other groups of people in the same household, (i.e., two or more families or groups related by birth, marriage, or adoption; or sharing by two or more families or groups who are not related by birth, marriage or adoption), and who would prefer to have their own homes; and

(2) Persons who depend upon public assistance for their shelter payments each month.

In both situations, if the public assistance and/or the generosity of relative and friends were withdrawn, there is a strong likelihood that at least some of the persons in this category would end up homeless.

At-Risk: Persons who are at risk of homelessness in the sense that they are three or fewer paychecks away from eviction. When asked, "If you or the head of household were to lose your job, how many rent or mortgage payments could you make before you became homeless?", these people answered none, one, two or three payments.

Other Households: All households that were not classified in one of the first three categories.

The homeless on the street and those who sleep in tents or cars are merely the most visible. They are the "tip of the iceberg" -- people whose current circumstances are the most depressing, whose resources are most limited, and whose support systems are non-existent. For every visible homeless person on the street, there are 18 others who would be homeless but for the kindness of relatives, friends and strangers. There are 65 more who are three or fewer paychecks away from being on the street.

There are over 5,000 people (0.5% of the total state population) without a place to call home. Another 96,000 (8%) are among the "hidden homeless," who share accommodations with other families or groups to deal with the housing situation. Another 344,000 (28%) in the "at-risk" group are three or four paychecks away from eviction.

The 1992 SMS study estimated that Hawaii's homeless number about 5,300 including just over 1,000 children. The majority of Hawaii's homeless people (3,240 or 61%) live on the island of Oahu. With a total population of approximately 920,000, the Oahu homeless rate is less than four per thousand. Given their lower total populations, the counties of Maui (with 506 homeless) and Kauai (with 363 homeless) have the fewest homeless persons in Hawaii, but have homeless rates near five per thousand. The Big Island has a higher homeless population than had been previously reported (about 1,200 persons), and also has the highest homeless rate (eight of every thousand) of any of the State's four counties.

The distribution of hidden homeless and at-risk households is relatively uniform across all of Hawaii's four counties. In terms of percentages, Hawaii, Honolulu and Kauai have roughly similar profiles. The County of Maui has the state's highest percentage of at-risk households -- 34% versus 28% for the other counties.

The homeless in Hawaii are more likely than others to be unmarried, living alone, Caucasian or part-Native Hawaiian, male, less educated and relatively recent arrivals to Hawaii. The findings are consistent with other homeless research across the nation and with past studies in Hawaii. Marriage tends to be a stabilizing factor in influencing economic impact, at least to the extent that it provides the possibility of double incomes.

The hidden homeless live in larger and more complex households; include a disproportionately larger number of divorced, separated or widowed persons; are more likely to be Filipino or of mixed ethnicity; and have been in Hawaii more than five years but less than a lifetime. Living in large households is part of the definition of this group. It is not surprising that we find them to be longer term residents (with more extensive support networks), and ethnically Filipino, Native Hawaiian or mixed. All three groups are usually thought of in Hawaii as more likely to be living in extended families.

At-risk households have profiles relatively similar to those found among the homeless. They are even more likely to be living alone, unmarried, Caucasian or Hawaiian. They have slightly longer histories in Hawaii, are a bit more likely to be Filipino, and have more education than the homeless.

Drug abuse, alcoholism, or mental illness was one primary reason that Hawaii's homeless felt they were homeless. Of those surveyed, 8.2% felt this to be the cause of their homelessness.

Of the 196 people who reported that they were homeless as a result of problems with drugs, alcohol or mental illness, 93% showed other evidence of drug or alcohol abuse. Evidence collected in the survey suggest that the causes of homelessness may not coincide accurately with the perceptions of homeless persons about why they are in their current condition.

COMMUNICABLE DISEASE AND SUBSTANCE ABUSE

INJECTION DRUG USE AND AIDS

Nationally, addressing drug abuse in the battle against human immunodeficiency virus (HIV) infection and the acquired immunodeficiency syndrome (AIDS) epidemic is critical. While education and prevention efforts appear to have been successful in slowing the transmission of HIV among gay and bisexual men, injection drug use is rapidly replacing sexual contact as the major cause of AIDS in newly diagnosed cases. Moreover, injection drug users represent the most likely route of transmission of HIV infection to the general heterosexual population.

The three primary ways in which HIV infection is transmitted are through unprotected sex, through the sharing of needles for injection drug use, and through an infected pregnant woman infecting her fetus. All of these modes of transmission are of concern in dealing with injection drug users. The virus can be transmitted by individuals who display no obvious symptoms. Usually within 10 years of an HIV infection, costly-to-treat full-blown AIDS occurs as the end stage of the disease.

According to the Centers for Disease Control, as of December 31, 1991, there have been 209,070 reported adult and adolescent cases and 3,579 children's cases of AIDS in the United States of whom 137,484 (65%) have died. Twenty-nine percent of these cases had a history of drug injection, while an additional 3% were infected by heterosexual contact with a drug injector.

Eighty-five percent (85%) of pediatric AIDS cases in the U.S. resulted from perinatal transmission by a mother infected with HIV. Sixty-nine percent (69%) of these are children of women who have injected drugs or whose sexual partners are or were drug injectors.

There are an estimated one-half to 1.5 million injection drug users (IDUs), including heroin, cocaine, and amphetamine users in the United States. The rate of HIV infection within the injection drug user population has increased rapidly over the past decade.

In Hawaii, estimates on the number of injection drug users have ranged from about 4,000 to 12,000 people. The population of injection drug users is a hidden population making it difficult to estimate.

871 AIDS cases have been diagnosed and reported in Hawaii as of March 31, 1992, of whom 564 (63%) have died. Thirteen percent (13%) of these Hawaii cases directly involved drug injection. Additionally, 7 of 16 heterosexually transmitted cases (44%) involved relations with drug injectors, while three of the seven pediatric AIDS cases (43%) were transmitted by mothers who had injected.

As of January 1993, Hawaii ranked 17th in the nation in terms of the annual rate per 100,000 population for new AIDS cases reported within a year's period. The statewide average rate is 12 cases per 100,000.

1992
NEW AIDS CASES

	NUMBER OF CASES	PER 100,000
STATEWIDE	138	12.0
OAHU	105	12.5
MAUI	7	7.0
KAUAI	10	19.5
HAWAII	16	13.0

The percentage of reported AIDS cases for each county appears to correlate to the county's percentage of the entire population of Hawaii. The percentage of Hawaii AIDS cases in which a history of drug injection was a risk factor ranges from 7.7% in Kauai County to 22% in Hawaii County as indicated in the table below.

CUMULATIVE AIDS CASES BY COUNTY
FROM 1982 TO MARCH 31, 1992

COUNTY	# OF CUMULATIVE REPORTED AIDS CASES	# AND % OF REPORTED AIDS CASES WITH INJECTION DRUG USE AS A FACTOR
HONOLULU	652	78 (12%)
HAWAII	118	26 (22%)
MAUI	62	10 (16%)
KAUAI	9	3 (7.7%)

SOURCE: Communicable Disease Division, Department of Health, May 1992

THE COMMUNITY HEALTH OUTREACH WORK (CHOW) PROJECT

In an effort to prevent the spread of AIDS, the Department of Health, with initial federal financial support, established the Community Health Outreach Work (CHOW) Project in 1989. The CHOW Project's main purpose is to provide outreach services to injection drug users not in substance abuse treatment and to the sexual partners of injection drug users, providing them with education, support for behavior change, advocacy, and referrals, as well as condoms and bleach. The CHOW Project currently serves the islands of Oahu, Maui, Kauai, and Hawaii.

A group of 818 current injection drug users not in treatment were recruited for interviews and HIV tests by the CHOW Project between June 1989 and February 1992. Of these, 6.6% tested positive for HIV.

HIV data on CHOW Project participants shows the highest infection rates among male injectors who have had sex with other men (19.6%), male daily injectors (10.1%), and female injectors (8.1%).

STERILE NEEDLE AND SYRINGE PROGRAM

Another initiative established by the Department of Health in 1990 to reduce the transmission of HIV by injection drug users and to promote the treatment and rehabilitation of injection drug users was a two year pilot sterile needle and syringe exchange program. This program's goal is to reduce the availability of contaminated needle and syringe units through a one-for-one exchange of used units for sterile units. It also provides a vital link with injection drug users by allowing routine contact with a public health worker who can provide education about HIV risks and make referrals to medical, social service, and drug treatment agencies.

The initial exchange site was opened in July, 1990. Because this one site was unable to fully meet the needs for service, additional sites were opened in the Kalakaua Avenue/Kapiolani Boulevard area in September, 1991 and at Iwilei in November, 1991.

As of May 1, 1992, 600 injection drug users have exchanged needles and received educational services. The number of needles exchanged per month has grown from 251 in July 1990 to 1,968 in October 1991.

In 1992, the pilot program was established as a permanent sterile needle and syringe exchange program by the Hawaii Legislature.

Both the CHOW Project and the Needle Exchange Program concentrate on current and former drug users and drug injectors who are not in treatment. The great majority of injection drug users are not treated for their drug abuse because of the lack of readily available treatment services or because they are unwilling to avail themselves of services. The rate in Hawaii and the nation of numbers and proportions of AIDS cases related to drug injection is on the rise. Without vigorous prevention, intervention, and treatment efforts these numbers will continue to increase.

INJECTION DRUG USE AND HEPATITIS B

Injection drug use is also a major risk factor for Hepatitis B, a serious and potentially fatal viral disease that can be transmitted through the sharing of contaminated needles. Across the nation, sharp increases in cases of Hepatitis B among injection drug users have been occurring. Transmission can also occur between sexual partners, from mother to newborn infant, and from exposure to infected blood products and other body fluids. Many carriers of the virus who can spread the disease experience little or no obvious symptoms. Hepatitis B can cause cirrhosis of the liver and is a major cause of liver cancer. Unlike HIV infection, Hepatitis B can be prevented in the unexposed by vaccination.

There are similarities between Hepatitis B and HIV. Specifically both:

- are spread mostly through having sex or sharing needles with an infected person which allows for direct contact with blood or other body fluids.
- can be transmitted from an infected mother to her unborn child.
- can be carried and passed on before signs of illness appear.
- do not yet have a cure.

Hawaii has the highest incidence of Hepatitis B in the country, standing at 10 times the national average. According to the Department of Health, as many as 33,000 people, or an estimated 2% - 3% of Hawaii's population are carriers. The following table reflects the number of new Hepatitis B cases for 1991.

NUMBER OF NEW HEPATITIS B CASES FOR 1991 BY ISLAND

	# OF REPORTED CASES	% OF TOTAL CASES REPORTED
OAHU	22	64.7%
MAUI	5	14.7%
KAUAI	4	11.8%
HAWAII	3	8.8%

SOURCE: Office Of Health Status Monitoring, Department Of Health, 1991.

Providing services to injection drug users is crucial if Hawaii is to reduce the spread of Hepatitis B.

ALCOHOL AND AIDS

Alcohol is often not thought of in connection with the HIV infection. However, the January 1992 issue of "Alcohol Alert," published by the U.S. Department of Health and Human Services, states:

There are, however, two reasons to investigate connections between alcohol, HIV infection, and AIDS: alcohol may adversely affect the immune system, and alcohol may influence high-risk sexual behavior.

Alcohol can impair normal immune responses that protect the body from disease. Chronic alcohol consumption has been shown to reduce the number of infection-fighting white blood cells in laboratory animals and in humans. Chronic alcohol ingestion or alcohol dependence can depress antibody production and other immune responses in animals and in humans. Alcohol can suppress activities of certain immune system cells, called macrophages, that help keep the lungs free from infection. In addition, alcoholics appear to be more susceptible to bacterial infections and cancer than are nonalcoholics. Studies in animals and in humans indicate that consuming alcohol during pregnancy can decrease immune resistance in the offspring.

Alcohol's generally immunosuppressive effects could mean that 1) drinking may increase vulnerability to HIV infection among people exposed to the virus, and that 2) among people who are already HIV infected, alcohol-induced immunosuppression might add to HIV-induced immunosuppression, and speed the onset or exacerbate the pathology of AIDS-related illness.

Alcohol's relationship to high-risk sexual behavior may be explained in two ways. First, alcohol use may be a marker for a risk-taking temperament: those who drink alcohol may also engage in a variety of high-risk activities, including unsafe sexual practices, as a part of a "problem behavior syndrome." Second, alcohol may influence high-risk behaviors at specific sexual encounters by affecting judgment and disinhibiting socially learned restraints. These are not mutually exclusive interpretations.

The correlation between alcohol and AIDS is a growing concern which is receiving increased attention.

SUBSTANCE ABUSE AND TUBERCULOSIS

Tuberculosis is an airborne infectious disease, which is spread when particles containing tuberculosis organisms are coughed into the air by a person with active pulmonary tuberculosis. People sharing the same air space with a tuberculosis-infected individual are at risk of inhaling the particles and contracting the disease. Indoor environments where large numbers of high-risk individuals come together have been the sites of tuberculosis outbreaks. These environments include hospitals, prisons, homeless shelters, residential care facilities for AIDS patients, nursing homes, and even crack houses.

Anyone can get tuberculosis, but those at higher risk include alcohol abusers and injection drug users; people who have contact with known cases; medically underserved, low-income populations, including high-risk racial and ethnic minorities; foreign-born persons from high prevalence areas; nursing home residents; prisoners; and especially persons with HIV infection.

According to the U.S. Department of Health and Human Services in a pamphlet entitled "What Drug Treatment Centers Can Do to Prevent Tuberculosis,"

> An estimated 10 to 15 million people (4 to 6% of the population) have inactive tuberculosis infection. . . Several conditions are associated with a higher risk that tuberculous infection will progress to active disease. Substance abuse (especially intravenous drug use) and infection with human immunodeficiency virus (HIV -- the virus that causes AIDS) are two of the strongest risk factors. When someone has both HIV infection and TB infection, the risk of developing active TB is extremely high.

Injection drug users are at very high risk for developing tuberculosis because of the high incidence of both tuberculous infection and HIV infection in this population. Substance abusers as a whole are more likely to experience poor health, reduced access to health care, and erratic compliance with medical treatment resulting in easier transmission of tuberculosis.

In **Hawaii**, between January 1, 1991 and December 31, 1991, 2,250 individuals in 8 correctional facilities statewide were tested for tuberculosis. 1 active and 317 inactive cases of tuberculosis were found. Overall in 1991, Hawaii had 17.2 cases per 100,000 people, the second highest per capita rate of Tuberculosis in the country. Hawaii reported a total of 201 new cases of tuberculosis in 1991 and anticipates 240 new cases in 1992. Hawaii has usually ranked as one of the top three states in reported cases. A breakdown by island of the new cases in 1991 is shown in the following table.

NUMBER, BY ISLAND, OF NEW TUBERCULOSIS CASES FROM JANUARY 1, 1991 TO DECEMBER 31, 1991

	# OF REPORTED CASES	% OF TOTAL CASES REPORTED
OAHU	165	82.1%
MAUI	15	7.5%
KAUAI	16	7.9%
HAWAII	5	2.5%

SOURCE: Tuberculosis Branch, Department Of Health

Persons who work in facilities that serve clients at high risk for tuberculosis are also at risk of becoming infected. Ongoing tuberculosis screening and prevention programs for workers includes yearly tuberculosis skin tests. Given the potential impact on public health, tuberculosis education, intervention and treatment needs to be made available to substance abusers.

NATIVE HAWAIIANS

As reported by the Office of Technology Assessment, an independent agency of Congress, the Native Hawaiian population in Hawaii is comprised of two groups, Native Hawaiians and part-Native Hawaiians. The groups are distinctly different in age distributions and mortality rate. Native Hawaiians comprise less than 5% of the total Native Hawaiian population and are much older than the young and growing part-Native Hawaiian population.

Overall, Native Hawaiians have a death rate that is 34% higher than the death rate for the United States. There is, however, a great difference in the death rate between Native Hawaiians and part-Native Hawaiians. Native Hawaiians have a death rate that is 146% higher than the U.S. rate. Part-Native Hawaiians also have a higher death rate, 17% higher than the U.S. rate.

The U.S. Congress determined that the reference to Indian tribes in the U.S. Constitution was intended to encompass all aboriginal, indigenous people of the United States, including Native Hawaiians. Accordingly, federal laws have been enacted for the benefit of Native Hawaiians. Of concern to the Alcohol and Drug Abuse Division is the Alcohol and Drug Abuse Amendments of 1983. This law designates Native Hawaiians as recipients of substance abuse funding from the National Institute on Alcohol Abuse and Alcoholism; establishes a National Commission on Alcohol and other Alcohol Related Problems, expressly identifying Native Hawaiians as requiring study; and specifies that applications from Native Hawaiians for funds from the National Institute on Drug Abuse are to be given special consideration.

The Substance Abuse and Mental Health Services Administration (SAMHSA) -- formerly called the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) -- of the federal government allots funds every fiscal year to each State. These federal funds are to be used for the purpose of planning, implementing, and evaluating activities to prevent and treat substance abuse and other related activities. The ADAMHA Reorganization Act of 1992 provides for the continued funding of substance abuse treatment services to Native Hawaiians in "an amount equal to the proportion of Native Hawaiians residing in the State to the total population." The Act further stipulates that the amount made available "may be expended only through contracts entered into by the State of Hawaii with public and private nonprofit organizations to enable such organizations to plan, conduct and administer comprehensive substance abuse and treatment programs for the benefit of Native Hawaiians. In entering into contracts under this section, the State of Hawaii shall give preference to Native Hawaiian organizations and Native Hawaiian health centers."

Based on the health care status and health care needs of Native Hawaiians, Congress enacted the Native Hawaiian Health Care Act in 1988 (reauthorized in 1992) "to improve the health status of Native Hawaiians through the continuation of a comprehensive health promotion and disease prevention effort that involves health education in Native Hawaiian communities, and the provision of primary care services using traditional Native Hawaiian

healers and health care providers trained in Western medicine." The term "traditional Native Hawaiian healer" has been defined as a practitioner who: is of Native Hawaiian ancestry; has the knowledge, skills and experience in direct personal health care of individuals; and whose knowledge, skills and experience are based on demonstrated learning of Native Hawaiian healing practices acquired by direct practical association with Native Hawaiian elders and oral traditions transmitted from generation to generation." Papa Ola Lokahi -- an organization composed of E Ola Mau, the Office of Hawaiian Affairs, Alu Like, Inc., the University of Hawaii, as well as representatives from the Native Hawaiian health care systems on each island -- was created to implement and update a comprehensive health care master plan. Federal planning funds first became available in July of 1990. However, Papa Ola Lokahi, incorporated in February 1989, was able to initiate its organizing activities in July 1989 with funds provided by the Hawaii State Legislature. Between July 1989 and December 1990, informational meetings and organizational activities took place throughout the state, resulting in the establishment or recognition of five Native Hawaiian health care systems which would take the responsibility for promoting services: Ho'ola Lahui Hawaii for Kauai and Niihau; Ke Ola Mamo for Oahu; Na Pu'uwai for Molokai and Lanai; Hui no Ke Ola Pono for Maui and Hui Malama Ola Na 'Oiwi for Hawaii.

In the initial stages, because the five health care systems need to gain experience in managing health services and because of limited funds, each health care system is concentrating on outreach, health assessments, case management and disease prevention and health promotion activities. Eventually, they intend to provide the full range of health and medical services that are available through a typical primary care health center, and are working with traditional healers so that their services will also be made readily available to Native Hawaiians.

According to the Native Hawaiian Health Data Book, in 1981-83, the five leading drug problems among Native Hawaiians identified by the agencies funded by the Alcohol and Drug Abuse Division of the State Health Department were: 1) alcohol (45.4%), 2) marijuana (32.8%), 3) heroin (9.3%), 4) inhalants (4.4%), and 5) barbiturates (2.2%).

In 1987, Native Hawaiians had the highest rates among all ethnic groups in the State for the following behavioral risk factors: a) smoking, b) acute drinking, c) heavier drinking, and d) drinking/driving. 27.8% of Native Hawaiians smoke compared to the State average of 22.3%. Native Hawaiians have an acute drinking rate of 30.4% compared to the State average of 22.6%. Native Hawaiians have a heavier drinking rate of 15.5% compared to the State average of 8.9%. Native Hawaiians have a drinking/driving rate of 7.5% compared to the State average of 3.9%.

In order to assess the prevalence of use and abuse of alcohol and other substances and aid in their program planning, the Alcohol and Drug Abuse Division's 1991 Hawaii Behavioral Health Survey of adults oversampled Native Hawaiians. The survey sample consisted of approximately 2,200 households -- 200 from each of the 10 service areas and an additional 200 Native Hawaiian/Part Native Hawaiian households. A total of 576 Native Hawaiian/Part Native Hawaiian households were sampled. (Note: because of the relatively small sample

size, generalization to the total population cannot be made.)

The following pages contain a summary and table of results of the survey:

The average age of the Native Hawaiian sample is 43.4 years, nearly four years younger than the general State sample. Slightly over five percent of Native Hawaiian respondents are under 21 years of age. Just over 35 percent of the Native Hawaiian group reported that they are alcohol drinkers, and 63.4 percent of the Native Hawaiian drinkers in the study are heavy drinkers, or 22.2 percent of the entire Native Hawaiian subset. We emphasize that the proportions for the Native Hawaiians are likely to underestimate the true proportions of heavy drinkers because of the possible sampling bias in age and gender for the entire sample.

As with the general population, Native Hawaiians drink beer in preference to almost any other alcoholic beverage, and nearly two-thirds of Native Hawaiian beer drinkers are heavy beer drinkers. Many more males than females are categorized into the Heavy Drinker groups (Binge and Chronic).

Nearly 7.5 percent of the Native Hawaiian sample who drink are under 21 years of age and illegally consume alcohol. Of those under age who say they drink, 80.0 percent are categorized as heavy drinkers and should be of major concern.

Of single Native Hawaiian drinkers, 76.1 percent are heavy drinkers.

Significant associations were found between drinking and education and drinking and employment. The highest proportion of drinkers is found among high school graduates and the employed. Among the unemployed, students are the most likely to drink. There is no significant association between income and drinking.

Of Native Hawaiian males that drink, more are categorized as heavy drinkers than not. In the male drinkers between age 18 and 44, the primary child-rearing years, as high as 89.4 percent and no less than 61.8 percent of the males who drink are heavy drinkers. Of the older Native Hawaiian men (na kupuna), age 45 and older who drink, between 50 and 100 percent are heavy drinkers.

Of the females in this survey who drink, over 35 percent are heavy drinkers. In the female drinkers between age 18 and 34, the primary child-bearing years, as high as 66.7 percent and no less than 50 percent are heavy drinkers. Of the older Native Hawaiian women (na kupuna), age 45 and older who drink, between 50 and 62 percent are heavy drinkers.

For 20-24 year olds, 65.5 percent of men drink alcohol, whereas only 29.6 percent of the Native Hawaiian women do. In this age group, men are more likely to be binge and chronic drinkers. Neither education, employment status, type of unemployment, nor income group are significantly related to heavy drinking patterns.

Of the Native Hawaiians that drink, two of every three had more than five drinks at any one occasion at least once during the month preceding the interview, or one of five of the total Native Hawaiian population. Nearly 15 percent drove their vehicles after drinking and 7.8 percent of the respondents believe they have a drinking problem. Some 3.2 percent of the drinkers report coming to work or school "high or a little drunk", 4.5 percent miss work due to hangovers, and 10.4 percent are afraid they might already be or become an alcoholic.

Nearly one in five Native Hawaiian drinkers have been told by their spouses to "cut down their consumption of alcohol" and nearly 17 percent continued to drink after they had promised not to do so. Nearly four percent stay drunk for more than one day (3.6%) and 9.0 percent state that once they start to drink it is "hard to stop". The behavior of "tossing back" drinks described previously occurs for 10.4 percent of Native Hawaiian drinkers although only 1.4 percent report that they "have a quick drink when nobody is looking". "Getting 'high' or drunk while alone" is reported by 15.4 percent of the drinkers in the Native Hawaiian sample. "Feeling aggressive or cross is an effect of alcohol" is reported by 12.7 percent of these drinkers and 13.6 percent get into arguments while drinking. Loss of memory after drinking is reported by 16.7 percent of this group and hand tremors are reported by 3.2 percent.

A total of 21.3 percent of those who drink report behaviors consistent with criteria used for a diagnosis of alcoholism and referral to treatment. Still, Native Hawaiian drinkers report less than half of the utilization of detoxification and other alcohol related service utilization as the general population (1.8% and 4.5% respectively) indicating problems in acceptability of or access to services for Native Hawaiians.

Examination of the association between drinking and marijuana use and between drinking and use of any drug is significant, and heavy beer drinkers are more likely to have smoked marijuana in the past year. Of the Native Hawaiians 40 percent report they have ever used marijuana. Based on the reports of those surveyed, 8.1 percent of all Native Hawaiian men and six percent of all Native Hawaiian women are currently using marijuana. Over half of the Native Hawaiians 18 to 19 years old have tried the drug and nearly 23 percent within that age group are currently using it. While this is the largest current marijuana using group in the categorization of age, when we regroup the sample into under and over 21 years we see a two-fold difference in the use rates.

Among those Native Hawaiian respondents who have used marijuana in the past, only 3.2 percent are currently using other drugs, compared to 19.1 percent of current marijuana smokers.

In total, 7.0 percent of the Native Hawaiian respondents indicate that they have used any drug other than marijuana for nonmedical purposes, and 2.6 percent are currently using such substances. A significant association exists between tobacco smoking and the use of drugs other than marijuana. Users of drugs other than marijuana all currently smoke tobacco.

Just under 36 percent of the Native Hawaiian respondents are currently smoking

cigarettes (tobacco). Another 20.7 percent have smoked more than 100 cigarettes in their lifetime, but they have since quit. Females tend to smoke less than males but more females than males smoke both in absolute and relative proportions to the population. In addition, fewer women than men are categorized as former smokers.

While 62.3 percent of the over 21-year-olds in the special sample who ever smoked smoke now, fully 90 percent of the under 21-year-olds who have smoked are current smokers.

Among the Native Hawaiian sample, 6.1 percent are uninsured. These individuals are described as more likely to be either single or divorced, 20 to 24 years old, with less than high school education. Unlike the statewide population, non-employed Native Hawaiians are more likely to be uninsured. Of the 6.1 percent uninsured Native Hawaiians, 32.6 percent smoke tobacco and 32.4 percent drink alcohol. Of those uninsured who drink, 28.6 are heavy drinkers.

CHARACTERISTICS OF THE SAMPLE
NATIVE HAWAIIANS

Characteristic	n	%n
Native Hawaiians	576	29.0
Alcohol		
Drinkers	202	35.1
Non-Drinkers	373	64.9
Drinkers		
Social Drinkers	74	36.6
Heavy Drinkers (Binge + Chronic)	128	36.4
Binge Drinkers	67	33.2
Chronic Drinkers	61	30.2
SMAST (scores indicating alcoholism)	43	21.3
Marijuana Use		
Ever Used	230	40.0
Current Use (within the past year)	51	8.9
Drug Use - NOT Marijuana		
Ever Used	40	7.0
Tobacco Smoking		
Ever Smoked	324	56.3
Current Smoker	205	35.6
Health Insurance		
Uninsured	35	6.1
Insured	541	93.9

n = sample size
%n = % of the sample and/or % of given category - unweighted

MENTALLY ILL SUBSTANCE ABUSERS (DUAL DIAGNOSIS)

Introduction. Many individuals have both psychiatric and substance abuse problems. Mental health professionals frequently construe substance abuse as a mere symptom of underlying psychopathology, while substance abuse counselors often see psychiatric problems as simply a reflection of drug use. Although these assertions are sometimes correct, all to often both problems need to be acknowledged and treated in their own right. It has been determined that large numbers of the psychiatric population have substance abuse problems, particularly in younger populations. Drug abuse is frequently not assessed during psychiatric hospitalization, much less treated. Known drug abusers with psychiatric problems are frequently excluded from drug treatment programs either because of the presence of severe psychiatric symptoms or as a result of the use of prescribed psychiatric medications. Moreover, those psychiatrically impaired clients who are self-medicating with alcohol and other drugs are not adequately treated if only their substance abuse is addressed.

The relationship between addictive behavior and an existing psychopathology is by no means clear cut. Drugs can mimic, initiate, exacerbate, or mask psychopathology. Moreover, psychopathology may serve as a risk factor for, modify the course of, or determine treatment outcome for addictive disorders. Staunch detective work is often necessary to determine causality and frequently cause and effect are so intertwined as to be impossible to sort out.

It is important to recognize that substance abuse can lie on a continuum from mild to severe as can psychiatric disability. This creates four broad possibilities. First, some individuals may have mild substance abuse problems and mild psychiatric dysfunction. These people are usually seen in either an outpatient counseling or a substance abuse program. Second, some individuals may have severe substance abuse and mild psychiatric dysfunction and are usually found in residential substance abuse treatment programs. Third, there are those who are mildly abusing substances, but with severe psychiatric disorder. These people may be seen in psychiatric hospitals or day programs for dual disorders. Fourth, some individuals are both severe substance abusers and severely psychiatrically impaired. They may be found in either psychiatric hospitals or residential programs for dual disorders.

Extent of the problem. Despite the growing appreciation of the frequent co-occurrence of these dual disorders, little information is available about the pattern of alcohol, drug abuse, and mental health services use by persons with dual diagnoses. In addition, to improve understanding of service use, better information is needed about the extent of unrecognized co-occurrence of these disorders in specific patient populations, about the interaction and coordination of ADM service systems, and about the most effective interventions to improve services provided for these co-occurring mental and alcohol and/or drug disorders.

As reported in the Spring 1991 issue of NIDA Notes, based on the findings of the Epidemiologic Catchment Area Study conducted by the National Institute of Mental Health (NIMH), researchers estimated that 22.5 percent of the adult American population has had at least one mental disorder, while 13.5 percent has had an alcohol abuse problem, and 6.1 percent has had a drug abuse problem.

The NIMH study provides some of the first data available on the magnitude of dual diagnosis in the United States. The study shows that:

- 30 percent of adults who have ever had a mental disorder also have had an alcohol or drug abuse problem, or both;

- 53 percent of adults who have had a drug abuse problem have also had one or more mental disorders; and

- 37 percent of adults who have ever been alcohol abusers have had one or more mental disorders.

The study also examined among two particular groups of adults: those who visited outpatient mental or substance abuse treatment centers and those institutionalized in long-term mental hospitals, nursing homes, and prisons. The researchers found that:

- 64 percent of those who sought outpatient treatment for a drug abuse problem had a mental disorder in the previous six months;

- 55 percent of those who sought treatment for an alcohol abuse problem had a mental disorder in the previous six months;

- 20 percent of those who visited a treatment center for a mental disorder had a substance abuse problem in the previous six months; and

- 72 percent of institutionalized adults had both mental and substance abuse disorders, a rate double that found in the rest of the population. The high prevalence was due largely to the rate of co-morbidity in prisons, where two-thirds of the inmates had a history of both a mental disorder and substance abuse problem.

In Hawaii, use of the national prevalence rate of nine chronically mentally ill individuals (CMI) per each 1000 adults produces an estimate of 7,025 CMI adults in the state. If 40 percent of these are substance abusers, the number of dual-diagnosed clients in the state would be estimated to be 2,810.

The Department of Health's Mental Health Division's on-line computer data system, the Mental Health Field Assessment and Statistical Information System (MFASIS), recorded 1,627 CMI clients currently receiving services through the public sector at The Community Mental Health Centers and Hawaii State Hospital. Using the same 40 percent estimate, potentially 650

dual diagnosis clients would have been receiving public mental health services.

In the private sector, another 680 CMI clients and 3,202 substance abuse clients were receiving services through contract agencies. 272 (40%) of the CMI clients and 640 (20%) of the substance abuse clients are estimated to be dual-diagnosed.

Estimates of the number of dual diagnosis clients vary across programs. A survey of four contracted programs providing services to the CMI clients estimates that 22% have dual diagnosis. The Crisis Response System Project estimates that 18% of the CMI clients have substance abuse problems and 27% of the substance abuse clients are CMI clients. These are somewhat conservative compared to the national estimates. However, health professionals at Hawaii State Hospital estimated 50 to 60 percent of their clients are dual diagnosis.

With these estimates, one might consider that staff are somewhat sensitized to dual diagnosis issues. However, a study conducted using MFASIS reported that of 1,629 CMI clients studied, only 137 or 8.5% had an identified substance abuse diagnosis. This indicates that although professionals estimate that dual diagnosis problems exist, professionals are not formally assessing, diagnosing or treating the substance abuse problem.

Noteworthy is not only the prevalence rate of 8.5%, but in the vast majority of cases, the substance use is categorized as "Non-Dependent Abuse of Drugs." Only ten of the clients had an alcohol or drug dependence diagnosis. This emphasizes that the problem of non-detection/underreporting dual diagnosis may be truly severe and to the detriment of effective treatment.

Presently, the true extent of the chronically mentally ill clients having a concurrent problem with substance abuse in the state of Hawaii is not known. However, it should be similar to the national estimate that indicates from 30% to 50% of this target population also have a problem with substance abuse. The following table reflects the number and percentage of dually diagnosed who were admitted to Community Mental Health Centers and the Hawaii State Hospital for the period July 1, 1990 through June 30, 1991.

HAWAII DATA
JULY 1, 1990 TO JUNE 30, 1991
NUMBER OF CLIENT ADMISSIONS AND PERCENTAGE OF DUAL DIAGNOSIS

	NUMBER OF ADMISSIONS		NUMBER DUALLY DIAGNOSED	
	ADULTS	CHILD/ADOL	ADULT	CHILD/ADOL
CENTRAL OAHU CMHC	166	76	18 (10.8%)	2 (2.6%)
KALIHI-PALAMA CMHC	277	65	43 (15.5%)	2 (3%)
DIAMOND HEAD CMHC	379	196	56 (14.8%)	9 (5%)
WINDWARD OAHU CMHC	154	164	17 (11%)	3 (1.8%)
LEEWARD OAHU CMHC	135	46	4 (3%)	0 (0%)
WAIANAE COAST CMHC	359		5 (1.4%)	
MAUI CMHC	195	51	13 (6.7%)	4 (7.8%)
KAUAI CMHC	65	80	1 (1.5%)	3 (3.8%)
HAWAII CMHC	355	78	51 (14.4%)	2 (2.6%)
HAWAII STATE HOSPITAL NEW ADMITS	311	45	68 (21.8%)	1 (2.2%)
HAWAII STATE HOSPITAL ACTIVE ADMITS	1002		103 (10.3%)	

*Of particular interest is the low numbers for children and adolescents. Very little research exists on dual-diagnosis in adolescents although the prevalence of use is thought to be much higher than these figures suggest.

Using the ADAD Client Data System Admission Reports for clients who were admitted to Department of Health funded substance abuse treatment programs from July 1991, to June 1992, it was found that excluding social detox, 10% of admissions admit to psychiatric problems while 20% of clients in a social detoxification program admit to psychiatric problems. The disparity between Hawaii data and national figures, however, may be attributable to the reliability of reporting by Community Mental Health Centers, the Hawaii State Hospital and ADAD non-profit service providers.

Finally, in a report presentation at the 1992 National Methadone Conference, Timothy Wilens, M.D. indicated that poly drug users may be at even higher risk for co-morbidity with the following comparison with the general population by psychiatric diagnoses.

	Depression	Anxiety	Attention Deficit Hyper-activity Disorder	Anti-Social Personality	Psychosis
General Population	15%	15%	6%	2%	1%
Poly Substance Use Disorder	35%	60%	15%	45%	7%

Characteristics of the Dual Diagnosed Individual. The growing magnitude of the dual diagnosis crisis has increasingly made its way into the literature. Individuals with coexisting substance abuse and psychiatric disorders have been shown to display many unique features. Studies and research findings have revealed that compared with either mentally ill or chemically abusing persons, dual diagnosed individuals demonstrate such programmatic characteristics as:

- increased rates of hospitalization;
- excessive utilization of acute care services;
- housing instability and homelessness;
- violent and criminal behavior;
- suicidal behavior;
- poor medication compliance;
- poor response to traditional substance abuse treatment;
- multiple psychiatric diagnosis received;

- poly-substance abuse;
- a lack of motivation;
- victimization and vulnerability;
- extremely low socialization skills; and
- need for employment, housing and skill development

State service delivery systems have had limited success in meeting the needs of persons with major mental illness and substance abuse problems. Systems' issues that create barriers or gaps in services include: rigid program boundaries, inflexible funding patterns, inadequate assessment and misdiagnosis, lack of trained staff, and limited array of special support services. The following are some of the needs of the dual diagnosed population which must be met if treatment is to be effective:

- accurate diagnosis;
- treatment by professionals who are educated in the specific needs for this population;
- access to innovative and individualized treatment programs which acknowledge the unique requirements of the population;
- a drug-free environment which promotes mental, physical and spiritual growth, and harmony;
- education regarding their mental illness and substance abuse disorders;
- vocational training and/or education;
- access to residential options;
- a holistic treatment program which includes family and significant others; and
- advocacy case management.

As is characteristic with many other states, Hawaii does not have a coordinated, comprehensive dual diagnosis diagnostic and treatment program. The following represent frequently cited problems with the current service system and providers in the care of these clients in many states. The problems have been found to be equally applicable to Hawaii.

- Separate services for the chronically mentally ill and substance abusers.

- Staff of both programs tend to be inadequately prepared to deal with problems that are the other's specialty.

- Dual-diagnosed clients are frequently not welcome in either program.

- Frequent under-reporting of secondary problem because of being undetected.

- If secondary problems are detected, staff, feeling incapable of addressing the problem, tolerate or ignored it.

- Communication and education gaps exist.

Treatment Approaches. According to an article by Patricia Parchem in the October 1988 issue of TIE Lines, four conditions for effective treatment should be taken into account.

1) Understanding the function that use of alcohol and/or drugs has in the life of the individual.

2) Setting realistic expectations, keeping goals modest and well defined; rapid change should not be expected.

3) Utilizing a therapy style that is non-threatening, promotes the abilities of the individual, fortifies self-esteem and provides practical education and information to enable an individual to manage his or her mental illness and chemical health.

4) Offering an array of services which encourages and assists individuals in achieving their optimum level of functioning.

Mental health and substance abuse programs generally take a variety of approaches in their attempts to serve the dual diagnosed client.
A summary includes:

- Taking a "wait-see" approach to the diagnosis of potential mental illness in patients entering treatment for drug and alcohol dependence. Many individuals entering drug treatment show symptoms of depression, anxiety, or psychosis. In many of these cases, symptoms disappear in a few weeks, and what looked like a dual disorder was in fact a case of drugs mimicking psychiatric symptoms.

- Exploring the possibility and extent of drug and alcohol use in every client, being prepared for denial (some clients use one disorder to explain away the legitimacy of the other disorder). Urine screening may be essential to get supporting documentation.

- Making a contract for a substantial period of abstinence to clarify what's wrong and what can be done about it. If such a contract cannot be achieved, inform the clients that accurate assessment and effective treatment become almost impossible.

- For those with two legitimate disorders the question is often raised: Which one should be treated first? Some possible answers:
  - Treating the most life threatening condition first;
  - Treating whichever condition blocks the treatment of the other first;
  - Treating whichever diagnosis you are certain about;
  - Not letting the client participate in a mental health program while intoxicated, but allowing the client ample opportunities to come back sober before excluding him/her from the program.
  - Working with collateral to support the goals of the program. They may have unique co-dependency issues to face e.g., life-long dysfunction, repeated relapses and alternative residential placements.
- Absolute abstinence, while ideal, may be unreachable for drug using chronically mentally ill individuals. Longer periods of abstinence (reduced rates of relapse) may be more achievable.
- Programs for the dual diagnosed usually need to be made smaller and more highly structured. Group therapy in particular needs to be more directive and less confrontational than might otherwise be the case. Moreover, drug education and mental illness education may need to be concrete, slow, and simple--with much repetition.
- Support groups such as AA/NA have an important role to play but they may need to be specialized to meet the particular needs of this population. Clients may also need to be prepared for how to function adequately in these groups.
- Staff competence and comfort in working with this population is essential. Some programs have one staff who is an expert in both areas. Some try to have an expert on psychiatric disorders and substance abuse as part of a team. Others have contracted out to several different agencies to provide different components of an overall program. Burn-out is a special risk with this group.
- Prescribing of medications might best be done by a psychiatrist with expertise with this population. The psychiatrist needs a smaller case load, a willingness to spend time educating clients about medications, knowledge of drug interactions, and an awareness of drug user scams, as well as a respect for the contributions of other professionals.
- Aggressive outreach may be essential, as well as innovative inducements to remain in treatment.

These approaches need to be evaluated and fine-tuned across different target groups. Much of what is thought to work in the treatment of the dual-diagnosed population is anecdotal and its success probably depends greatly on client, counselor, and environmental characteristics. Clearly, we are at the stage of trial and error and initial hypotheses testing rather than having a history of proven methods to fall back on.

In conclusion: Dual diagnosis is prevalent, clients with dual diagnosis have special needs and issues that often go unaddressed, a variety of treatment approaches are being explored with no one approach achieving a gold standard status. In spite of the difficulties, this is a target population in need and attention must be paid.

CRIMINAL JUSTICE SYSTEM

In FY 1990-91, there were 8,073 positions in the criminal justice system. The total expenditure for the system was $360 million. Both the number of positions and the amount spent increased from FY 1985-86, when the criminal justice system employed 6,346 staff and spent $212 million.

Police. Hawaii has no state police force; rather the police departments are under county jurisdiction. The four departments are the Hawaii County Police Department (HCPD), the Honolulu Police Department (HPD), the Kauai Police Department (KPD), and the Maui Police Department (MPD). Personnel consists of both sworn and civilian personnel.

The county is the primary funding source of the police departments, although all four police departments have received state and federal funding from the Hawaii State Department of the Attorney General, the U.S. Department of Justice through the formula grant programs authorized under the Anti-Drug Abuse Act, and asset forfeiture funds.

Prosecutors. The Attorney General is the State's chief legal officer who is statutorily charged with the responsibility of prosecuting criminal offenses. This responsibility has been delegated to the prosecuting attorneys at the county level.

The county is the major source of funding for all prosecutors. All four county offices receive state and federal funding from the Anti-Drug Abuse Act. They also receive state funds for Victim Witness Programs and Career Criminal Prosecution Programs and for gangs, as well as federal funds for their Victims of Crime Programs.

Courts. The Judiciary is a statewide system of courts consisting of four integrated court levels of appellate and trial courts: the Supreme Court, the Intermediate Court of Appeals, the Circuit Courts and the District Courts. In addition, there are three specialized courts of limited jurisdiction: the Land Court, the Tax Appeal Court and the Family Courts.

The Hawaii Supreme Court is composed of a chief justice and four associate justices. The Intermediate Court of Appeals is composed of a chief judge and two associate judges who hear all appeals assigned by the Hawaii Supreme Court.

Each of the four counties in Hawaii constitutes a separate judicial circuit: the First Judicial Circuit covers the City and County of Honolulu, the Second Circuit covers the County of Maui, the Third and Fifth Circuits cover the county of Hawaii and Kauai, respectively. (The Fourth Circuit was eliminated in 1943.)

The Family Courts specialize in cases involving children, family and domestic problems. They have exclusive jurisdiction over alleged juvenile law violators. In the First Circuit, both circuit and district family court judges hear cases; in all other circuits, circuit and district court judges are assigned family court cases in addition to their regular duties.

The Family Court of the First Circuit maintains a juvenile probation department; in all other circuits, a single probation department handles both adults and juveniles.

The Land Court and Tax Appeals Court are statewide courts of record and like the Courts of Appeal, are based in Honolulu.

More than 98% of the Judiciary's operating budget comes from the State general fund. Other funding sources include federal funds, trust funds and special revenue funds, such as assessments against insured motor vehicles.

Public Safety. The Department of Public Safety (PSD) is charged with the responsibility of administering eight correctional facilities, as well as the administratively attached Hawaii Paroling Authority. The Sheriff, Narcotics Enforcement Division, Criminal Injuries Compensation Commission and Maritime Law Enforcement are part of the Department as well.

The PSD manages and operates both the jails and prisons in the state. The inmate population in Hawaii is approximately 2,700. The capacities of each of the eight facilities range from 45 to 1,000 inmates. There are five community correctional facilities: two on Oahu (Oahu Community Correctional Center and the Women's Community Correctional Center) and three on the neighbor islands. The Kulani Correctional Facility on the Big Island and the Wahiawa Correctional Facility on Oahu are minimum security work camps. The Halawa Medium and the adjacent High Security Facilities are located on Oahu.

The Hawaii Paroling Authority is a quasi-judicial body which is attached to the Department of Public Safety for administrative purposes. It has one division, consisting of a branch with four parole sections, one for each county. The goal of the HPA is to aid parolees in their rehabilitation by conducting periodic testing of urine to discourage further abuse of drugs and alcohol. Early detection allows early intervention by parole officers.

Office of Youth Services. In 1989, the Legislature established the Office of Youth Services (OYS) in order that youth services be consolidated under one agency. On July 1, 1991, OYS assumed responsibility for juvenile corrections, including the Hawaii Youth Correctional Facility (HYCF) which had previously been administered by the Department of Public Safety. HYCF, which is located on Oahu, serves the entire state.

In conjunction with swapping sites with the women's prison, a new 30-bed facility is being planned for the most serious juvenile offenders. HYCF has the capacity to house approximately 72 males and 10 females. The current population of 49 (44 males and 5 females) will need to be reduced with the majority of youth going to community-based programs. HYCF staff includes 41 "uniform" staff and 37.5 other staff (administrative, maintenance, social workers). In addition, the Department of Education has teachers assigned from the HCYF, and one full-time mental health worker is assigned from the Department of Health.

DRUG TRAFFICKING AND DRUG AVAILABILITY

Police departments report that the amount of drug trafficking into and out of Hawaii is significant. Hawaii's marijuana, noted for its potency and high quality, is distributed throughout the islands, the nation, and the world. Marijuana grown in Hawaii has a higher content of tetrahydrocannabinol (THC), the intoxicating chemical, compared to marijuana grown on the continental United States or in foreign countries. Large amounts of marijuana are cultivated throughout the islands. The largest concentrated growth area for high potency marijuana is in the county of Hawaii.

Honolulu Police report that cocaine is very available in Hawaii. It is smuggled into the islands by air, postal, and marine carriers. Most of it comes from California and the most seizures are from Los Angeles. Couriers usually transport the cocaine by body or carry on luggage.

The most common heroin sold in Hawaii is white or "China white," with an increase in seizures of black tar heroin in Maui. Heroin has increased in popularity in Maui and Hawaii, but there has been no significant change in distribution or consumption in Honolulu or Kauai.

In contrast to other drugs, most agencies report virtually little activity in hallucinogens, barbiturates, other depressants, and stimulants. However, recent seizures by the Hawaii County Police Department include heroin, poppy plants, codeine, cocaine, marijuana, hash, crack, crystal methamphetamine, centrax, barbiturates (halcyon, valium), PCP, LSD, psilocybin, and percodan. The Honolulu Police Department reported 5,716 tabs of LSD, and 2,488 dosage units of unknown/other were seized during FY 1990-91.

DRUG CULTIVATION, PRODUCTION AND MANUFACTURE

Marijuana. Marijuana cultivation remains a significant problem and the major law enforcement problem in Hawaii. Hawaii's annual temperature of 77 degrees and annual precipitation of 23.5" are ideal for growing marijuana. The Hawaii State Department of Land and Natural Resources (DLNR) estimates that 10-20% of marijuana cultivation occurs on sugar cane land, 70-80% in forest areas, and 10% in private backyards. Neighbor Islands account for an estimated 82% of the marijuana grown in the state, with most of the cultivation on the island of Hawaii.

Crystal Methamphetamine. Although reports of clandestine labs have cropped up in every county except Maui, it was only in 1989 that the Hawaii County police found evidence of a dismantled laboratory in the Kona District of Hawaii.

Patterns of Drug Use. The use of crystal methamphetamine, "ice", "crystal", or "batu" (meaning rock in the Filipino language of Ilocano), moved from relative obscurity to widespread use within the past five years in Hawaii, especially Oahu.

The use of crystal meth cuts across all class and ethnic lines. All ages and both sexes are

reportedly affected. Users as young as 10 years of age and as old as 60 years have been reported. The Honolulu Police Department reports that most ice users range from the later teens to the early thirties. It is popular with young women and housewives because of the resulting weight loss.

Across the state, agencies reported an increase in the abuse of crystal meth, or "ice", particularly among the younger population during 1988 and 1989. The drugs of choice were marijuana and cocaine on the Neighbor Islands, with crystal meth rising in popularity. On Oahu, "ice" appeared to be the drug of choice.

In 1990 in Hawaii County, both prosecutors and police reported the drugs of choice to be cocaine and marijuana, with marijuana being more prevalent. Recently, the availability of marijuana has decreased while cocaine has increased.

The Kauai police report a decrease in popularity of "ice" and that the drug of choice is marijuana. Cocaine use has increased. Its availability and use remain high.

Maui police report that cocaine remains popular with all age groups, with the smokable form of "crack" still increasing in popularity. They also cite an increase in the popularity of heroin and an increase in seizures of the drug. Use of LSD has also increased. "Ice" use on Lanai is increasing.

On Oahu, the Honolulu prosecutor reports ice to be a problem. Multi-kilo seizures of cocaine, relatively rare in the past, are now routine. Heroin is still used among a core group. Large marijuana seizures appear to be declining as eradication efforts on the neighbor islands become more effective. No significant changes in drug usage over the past several years were seen; the most prevalent drugs continue to be "ice" and cocaine in powder form for all age groups.

CRIMINAL AND JUVENILE JUSTICE CLIENTELE

Probationers. In 1989, approximately 42% (1,300 of the 4,200) of adult offenders on probation in the First Circuit had court-ordered drug testing as a condition of probation.

As reported in A Report to the Governor on the Hawaii Statewide Drug Prevention and Control Strategy - January 1991, prepared by The Statewide Drug Prevention and Control Committee, the Adult Probation Division of the State Judiciary's First Circuit Court revealed that 2,139 (62%) of the 3,450 probationers comprising its caseload as of February 1, 1990, had a history of alcohol and/or other drug problems. In this identified group, 29% had alcohol problems; 24% had problems with drugs other than alcohol; and 48% had problems with both alcohol and other drugs.

Parolees. Currently there are 1,416 parolees under the control and supervision of the Hawaii Paroling Authority (HPA). HPA estimates that 80% of parolees have a history of moderate to serious substance abuse problems. Approximately 70% of the parolees have alcohol and/or drug testing as a special condition of parole. In 1990, 30% of parolees were returned to prison for parole violations which were directly related to positive drug tests. Another 25% were recommitted for

failure to complete drug treatment and for alcohol or drug use/possession.

Incarcerated. A limited survey by the Department of Public Safety in 1989 revealed that two-thirds of the incarcerated women reported substance abuse and that 51% perceived themselves as addicted. The percentages for incarcerated males were higher, with 90% and 72% reporting substance abuse and perceived addiction, respectively.

In 1989 and 1990 drug offenses ranked fourth (19.5%) as the offense for which a person was sentenced to prison (Table 21). Between 1985-86 and 1989-90, admissions for drug offenses increased by 8.4% while admissions for violent offenses decreased 17.3% and property offenses decreased by 5.1%.

Juveniles. The Family Court of the First Circuit reported 329 referrals for alcohol and drug offenses in FY 87-88. Family Court statistics for FY 87-88 reveal that 7% (329) of total law violation arrests were for substance abuse offenses. It is important to recognize, however, that this does not adequately describe the extent of the substance abuse problem among the youth of Hawaii. Based on an informal survey conducted in 1987, the Family Court suspects that the majority of the juveniles (ages 12 through 17) appearing before the Court has experimented or has had some contact with drugs or alcohol.

Of the 71 juveniles committed to the Hawaii Youth Correctional Facility (HYCF) and surveyed in December 1988, 91.5% (64) admitted using alcohol and/or drugs. Seventy-six percent of those respondents acknowledge consuming alcohol, and 71.8% admitted to using marijuana. In addition, 30.9% (22) of the youths confessed involvement with "hard" drugs.

DRUGS IN PUBLIC HOUSING

Drug sales in public housing are a serious problem. Although the Hawaii Housing Authority (HHA) has pursued efforts to shut down individual sellers at State housing complexes through STING operations and confidential informants, the lack of incriminating evidence as well as reluctance of tenants to testify against drug dealers have made the task difficult.

HHA's experience is that drug dealers within housing projects are "middlemen", not the drug kingpin. HHA feels that cutting off the supply of drugs will discourage these middlemen to continue their drug trafficking activities in public housing.

The Hawaii Housing Authority reports that marijuana remains a staple drug; that cocaine and crack use have escalated among the working class; and that crystal meth attracts the youths. Alcohol, however, remains the most overused and abused drug, and its use continues to grow.

Drug sales in public housing negatively impact the social structure. Children impressed with the dealers' materialistic benefits become tempted to go into the drug trade; children who inherit this lifestyle via parents or relatives often choose to incorporate criminal activity into their livelihood.

Other drug-related problems faced in public housing are: vandalism, rent delinquencies, theft, violent crimes, extortion, intimidation, and domestic disputes often leading to violence.

DRUG ARRESTS

A Hawaii Criminal Justice Data Center report indicates that drug arrests in Hawaii increased nearly 20% from 1982 to 1987.

Honolulu Police reported 613 arrests in 1989 for the possession and sale of crystal meth on Oahu and 472 arrests during 1990. During the first three months of 1991, 129 persons were arrested. Honolulu Police seized 5,647 grams of crystal meth during 1988 as compared to 7,391 grams during 1989 and 3,318 in 1990. In 1991, record amounts of 12 and 33 pounds were seized in Honolulu.

Overall, a total of 2,893 adults and 403 juveniles were arrested for drug offenses in 1991. As a percentage of total arrests, drug-related arrests accounted for 6.2% of adult arrests, and 2.4% of juvenile arrests.

DRIVING UNDER THE INFLUENCE

Nationally, drunk driving is the most committed crime. In **Hawaii**, there were 966 traffic fatalities between 1982 and 1988, 552 (47.1%) of which were alcohol-related. The national average was 52.4% (163,00 of 311,000) during the same period. In 1988, 58% (87 of the 149) of traffic fatalities were driving under the influence (DUI) fatalities compared to 50% nationally.

Although the highest concentration of licensed drivers in the state is in the 25-45 age group, the 15-25 year old age group accounts for most drinking drivers.

Of the 87 alcohol related traffic deaths in Hawaii in 1988, 41 were between the ages of 15 to 24 years of age (approximately 47%).

Between 1982 and 1988, arrests for drunk driving in Hawaii increased by over 140%, although DUI arrests nationwide have remained relatively static over the same period. There were 7,356 arrests for drunk driving in Hawaii in 1987 and 7,990 for 1991, nearly a 9% increase.

Adult arrests for driving under the influence increased from 16.2% of total arrests in 1989 to 17.7% of total arrests in 1990. Juvenile arrests for driving under the influence increased with such arrests accounting for 0.3% of total juvenile arrests in 1989 to 0.4% in 1990.

Most DUI arrests involve men. Ethnically, nearly half arrested for DUI are Caucasians. Caucasians, Koreans, and Samoans are over-represented in DUI arrests.

DUI ARRESTS BY ETHNIC GROUP, 1991

Ethnic Group	Representation Percent of Population 1991*	Percent of DUI Arrests in 1991	Percent of Ethnic Group: DUI Arrests (Under or Over Representation)
Caucasian	23.8%	44.6%	87.4% over
Japanese	21.8%	10.1%	53.6% under
Chinese	4.6%	1.9%	58.7% under
Filipino	12.0%	9.5%	20.8% under
Native Hawaiian/ Part Native Hawaiian	20.7%	13.7%	33.8% under
Korean	1.1%	2.7%	145.5% over
Samoan	.6%	3.4%	466.7% over
Other	13.5%	10.4%	23.0% under
Black	1.8%	3.6%	100.00% over

*Based on figures from the State of Hawaii Data Book 1991, Dept. of Business, Economic Development and Tourism.

KEY INFORMANT PERSPECTIVES

In the Spring of 1992, a series of meetings were held throughout the State to obtain perspectives on substance abuse service needs. Participants at the various meetings included community residents, recovering substance abusers, and members of regional Service Area Boards of the State Council on Mental Health and Substance Abuse. On the island of Hawaii, a special year-long community health needs assessment was conducted by the State Health Planning and Development Agency (SHPDA). SHPDA formed a subcommittee on mental health and substance abuse.

Consistently identified by all of the above participants was the need for expansion of the existing substance abuse services in each region, and the establishment and funding of a comprehensive substance abuse service delivery system.

For the Big Island of Hawaii, SHPDA's prioritized services were: 1) 24-hour crisis response system, 2) dual diagnosis treatment programs, 3) medical/non-medical detoxification for adults, 4) primary health care access for the mentally ill and substance abusers, 5) expanded children's mental health services, 6) expanded substance abuse programs for adolescents, 7) training for staff, health care providers, volunteers, families and clients, and 8) prevention programs/services to be integrated into the first seven priorities. The West Hawaii Kona Coast of the Big Island through the Kona Community Advisory Council conducted its own informal survey to learn what its community's priorities were regarding substance abuse services. The survey identified the five most pressing needs in Kona as: interim/transitional housing; adult day treatment; adolescent day treatment; elementary school age programs; and detoxification services.

On the island of Maui, the substance abuse service needs were priority ranked as follows: 1) medical detoxification facilities, 2) a staff coordinator of substance abuse services, 3) funding for adult residential beds, 4) transition living program and facility, 5) intervention services for adolescents, 6) decentralized outpatient treatment services (for rural areas such as Lahaina and Hana), 7) funding of treatment and treatment beds for intravenous drug users, 8) programs to address the needs of pregnant and post-partum women and their children, 9) programs for the dually diagnosed, and 10) migrant farm workers' programs.

For the island of Kauai, the Hawaii Advisory Commission on Drug Abuse and Controlled Substances convened a Community Planning Meeting on Kauai in 1991. Substance abuse service needs identified by community and provider agency representatives included: the need for different levels of training which would build on skill levels of substance abuse counselors, who range in scope and depth of experience, and the need to address the gap that exists in detoxification services. Like the other neighbor islands, the lack of detoxification services -- a basic component within the continuum of care -- is of particular concern, since the services on Oahu are unavailable when required.

On Oahu, Service Area Board meetings held in Central Oahu, Diamond Head, Kalihi-Palama and Waianae, focused on the need for expanded treatment services for both adults and adolescents, the need for long-term residential treatment for dual diagnosed clients, expansion of school-based treatment for adolescents and prevention programs.

Input into planning was also sought from substance abuse consumers. Residents of the 18 Oahu Oxford Houses for recovering substance abusers were consulted in April 1992 regarding their views on substance abuse service delivery needs. Residents identified medical detoxification as a primary need. They related how they needed to act suicidal or "psychiatric" in order to gain hospital admission. Also identified by these consumers were: 1) a need for a 'pre-Oxford House,' where consumers could get "cleaner longer" before entering an Oxford House; 2) the need for case management; 3) the need for more adult residential publicly-funded treatment beds; 4) the need for substance abuse treatment for the incarcerated; 5) the need for adolescent residential treatment that includes the whole family unit; and 6) the need for preventive training for parents on how to cope with their troubled adolescents.

A critical group of key informants on both the scope and nature of the substance abuse problem in Hawaii and the service delivery and client needs is the many private non-profit agencies that provide substance abuse services through contracts with the Alcohol and Drug Abuse Division (ADAD). ADAD convenes monthly meetings with contracted service providers for the purpose of communication, information sharing, and building and solidifying the public-private sector partnership.

In 1991, contracted provider agencies formed the Substance Abuse Coalition "to provide a forum for all individuals and agencies who are involved in the continuum of substance abuse services." The Coalition addresses members' concerns "relevant to the provision of quality substance abuse services for the State of Hawaii through direct advocacy, public policy development, information dissemination, professional development and other services deemed as priorities." The Substance Abuse Coalition, with its expertise and front-line day-to-day experience, generated a document of substance abuse service needs in early intervention, crisis counseling/referral, outreach, assessment and referral, temporary community shelter services, information/education, social policy and environmental change, education, primary prevention, community and professional mobilization, alternatives to substance abuse, community treatment including non-residential treatment, detoxification and continuing care.

In the Spring of 1992, the Coalition also identified and prioritized substance abuse support system needs beginning with training, coordinated planning, technical assistance in clinical and management areas, grantsmanship and resource development, advocacy, fiscal needs, quality assurance, monitoring and evaluation, administrative support, contract management, access to other health care services, case management and Hawaii-specific research and evaluation. The Coalition's complete listing of specific recommendations for both client service delivery and system needs is available at the ADAD. The Coalition

stressed the need for additional funding to maintain the current level of services, a comprehensive systematic approach to impacting on the problem of substance abuse in the State, and a need to focus on gaps in the service system for populations not covered by insurance or other resources and the ability to pay for services.

EMERGENT ISSUES AND NEEDS

EMERGING ISSUES AND TRENDS

Major trends affecting substance abuse in Hawaii continue to include: social and economic conditions which alter accustomed patterns of living, producing increased emotional stress on individuals and families with a resulting greater demand for substance abuse services; decreases in the availability of qualified substance abuse professionals and paraprofessionals; fiscal constraints at both the State and Federal level; increases in availability of drugs, including cocaine, marijuana and crystal methamphetamine; increased number of drug exposed infants; increased high-risk of HIV infection among substance abusing populations; increase in substance abuse education and employee assistance programs which highlight the increased need for other substance abuse services; increased State and Federal focus on accountability and outcome objective monitoring; and the Federal government's influence in shaping the direction of substance abuse programs and public policy.

The Department of Health's 1991 Adult Behavioral Health Survey and the Department of Education's 1991 Student Use Survey combined with data and information from the communicable disease field, the maternal and child health field, the law enforcement and criminal justice field, private non-profit substance abuse service providers, the Hawaii Advisory Commission on Drugs and Controlled Substances and key community groups and informants, all point to the need for increased resources to address the complex bio-psycho-social problems of addiction.

At the same time that the demand for substance abuse services is increasing, the country and Hawaii are faced with rising costs in the entire health care system and issues of accessibility, availability and extent of health care services. There is a need to strengthen the basic core services and expand the range of services throughout the state of Hawaii. In the long run, it will be far more dangerous and far more costly not to implement programs.

Some of the most pressing issues and emerging trends that will need to be addressed by the substance abuse field in the next four years include:

1. **The Public Sector Client Needs**. The 1991 monograph "The Alcoholism and Drug Abuse Field: Planning for the Year 2000," published by Education Training Publishing in Windsor, Connecticut, describes how the public system is faced with most of the severely ill substance abuse clients and fewer resources to deal with multi-problems faced. The clients seen in the public sector are more unhealthy with multiple and severe psychiatric and physical problems; have multiple drug use/abuse patterns; and experience more restricted access to care as the health care dollar shrinks. The public sector, in particular, is having to give the client more services with fewer resources.

2. **The Need For Increased Treatment Capacity**. Availability of residential treatment services for women and drug-exposed children, mentally ill substance abusers and adolescents is insufficient. There is a need to develop, improve and expand these programs as well as to increase non-residential treatment capacity.

3. **The Trend Toward Managed Care**. The need for cost-containment and managing care is among the most critical issues facing the United States. Congress has just begun to consider the role of substance abuse and managed care. Substance abuse service professionals and providers need to make sure that access to treatment is a function of the client's need and severity of addiction and not solely reimbursement opportunities.

4. **Greater Emphasis on the Linkage Between Substance Abuse, Primary Medical Care and Mental Health Care**. Continued emphasis on coordination and collaboration with the communicable disease health care system is vital.

5. **Lack of a Comprehensive System of Services**. The range of services available for treatment is severely limited in Hawaii in both numbers and types of service. The geographic isolation and relatively small population bases of the Neighbor Islands present additional challenges. A well integrated comprehensive system which facilitates client access to and movement between levels of services is needed.

6. **The Multi-Diagnoses Client**. It has been estimated that 30% to 60% of all mentally ill individuals also have problems with alcohol and other drugs. Unless both the mental illness and the drug abuse are addressed, it will be impossible to effectively treat either one. Currently there are only 5 residential beds and __ outpatient day treatment slots on Oahu dedicated to this population. Moreover, self-help groups such as AA and NA are not well suited for support of this population. There is a need to expand residential and outpatient programs as well as special self-help groups for this population.

7. **The Need for Qualified Substance Abuse Treatment Providers**. Systematic core education and training curricula are essential. Well-trained professionals and paraprofessionals who are sensitive to the cultural and ethnic diversity of the Hawaii population are the foundation for effective treatment delivery.

8. **A Substance Abuse Prevention Approach Founded on Community-Based Strategies and Designed with Promotion of Healthy Substance-Free Lifestyles as the Goal**. The strategies need to include all addictive substances -- alcohol, tobacco and other drugs.

9. **A Shift to Prevention and Treatment Rather Than Law Enforcement Focus to Impact the Problem of Substance Abuse**.

10. **An Increasing Emphasis on Outcome Evaluation and Quality Assurance**. More timely and rigorous monitoring to assure effective and efficient implementation of services with the public dollar is critical, especially as resources become more scarce. There is a need to develop coordinated monitoring across all government agencies purchasing services from the private substance abuse providers.

National health care priority issues for the substance abuse field have been advocated to Donna Shalala, the new Secretary for the United States Department of Health and Human Services by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), a non-profit organization composed exclusively of State and Territorial Administration of publicly funded alcohol and other drug treatment and prevention services. The priority issues are as follows:

PRIORITY ISSUES

1. INCLUSION OF BENEFITS FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT AND PREVENTION AS A CORE BENEFIT IN ANY HEALTH CARE PROPOSAL

A comprehensive coverage for alcohol and other drug dependency treatment and prevention should be included as a core benefit. The benefit should be separate from the mental health core benefit because of the different services, providers, funding, delivery systems, and populations served. The Legal Action Center has prepared a benefit that has been endorsed by NASADAD and many other national organizations. Other elements of managed care proposals must assure that "gatekeepers" are trained to identify and willing to actively refer children, youth, adults, and senior citizens with alcohol and other drug abuse problems to appropriate treatment services. Clinical and community-based prevention programs should also be included in any proposal. Model legislation proposed by the Legal Action Center follows the priority list.

2. INCREASED FUNDING FOR THE SUBSTANCE ABUSE BLOCK GRANT

Funding for the Substance Abuse Block Grant must be significantly increased. A 1990 Institute of Medicine Report, *Treating Drug Problems*, called for a one billion-dollar increase in the Block Grant to treat drug problems alone. Recommendations for public expansion of drug treatment included ending long lists of individuals waiting for treatment; improving treatment by raising the level of service intensity and providing necessary support services; expansion of treatment to pregnant women, young mothers and youth; and further expansion of community-based and institutionally based treatment for criminal justice clients. In another report, *Broadening the Base of Treatment for Alcohol*, also issued in 1990, the Institute of Medicine made similar recommendations for

alcohol treatment. In addition, adequate funding must be provided to State Alcohol and Drug Abuse Agencies to enable them to provide services to individuals suffering with HIV/AIDS/Tuberculosis without a diversion of funds for the primary treatment of alcohol and other drug problems.

3. COORDINATION OF FEDERAL PROGRAMS AND DOLLARS

There is currently no required coordination of Federal dollars at the State level for alcohol and other drug abuse treatment and prevention services. U.S. Department of Education, Department of Justice, Department of Transportation and even other Department of Health and Human Service programs and dollars are not currently coordinated by the State Alcohol and Drug Abuse Agency to assure maximum effectiveness and full State commitment. Perhaps most importantly, Center for Disease Control programs and dollars are not coordinated with State Alcohol and Drug Abuse Agencies. The current fragmented system results in a duplication of effort and a proliferation of conflicting policies. Federal coordination with State Alcohol and Drug Abuse Agencies should be required.

4. MEDICAID FUNDING

Problems exist with Medicaid regulations and funding for alcohol and other drug treatment. For example, the National Governors' Association has recommended that The Institution for Mental Disease (IMD) exclusion be amended so that alcohol and other drug treatment services provided by State-licensed residential programs can receive reimbursement. Currently, Medicaid rules specify that only hospital based treatment can be reimbursed - this results in a substantially higher cost to both Federal and State governments. These and other rules must be examined to determine whether or not appropriate treatment is being rendered in a cost-effective manner.

MODEL LEGISLATION MANDATING NATIONAL HEALTH INSURANCE BENEFIT FOR PREVENTION AND TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION (REVISED 2/12/93) AS PROPOSED BY THE LEGAL ACTION CENTER

I. INTRODUCTION AND PURPOSE

Alcoholism and drug dependencies can be prevented and treated effectively at low cost but, if they are left untreated, society will very quickly pay a much higher price. Though various national health care reform bills provide health benefits for the illnesses caused by alcoholism and rug dependencies, few cover drug and alcohol prevention and treatment itself.

The adverse social consequences of alcohol and other drug problems are associated with considerable economic costs. In the most recent comprehensive economic analysis, conducted in 1983, the cost of alcohol problems in America were estimated to exceed $70 billion per year, with the majority of these costs attributed to reduced productivity. An additional $44 billion in economic costs were attributed to drug problems. Prevention, early intervention and treatment will save billions of dollars each year.

The purpose of this proposal is to ensure that coverage of alcoholism and drug addictions prevention and treatment will be included in all proposals mandating private and/or public health insurance coverage for individuals and families. If coverage is not provided, our society will pay far more for the health care, social and economic problems that result from alcohol and drug problems.

This model outlines the necessary components for a comprehensive continuum of care. Individuals will be assessed for the severity of their addiction, and enter treatment at the level appropriate for their medical and psychosocial needs. This continuum of care is necessary for effective prevention and treatment whether it is provided through private or public sector programs.

All individuals should have access to the appropriate level of care for treatment of their addiction whether their payment source is private insurance, Medicaid, Medicare or federal and state dollars dedicated to treatment. Federal, state and local financing will continue to be needed to address larger issues related to poverty such as housing, unemployment and education.

It may become necessary to have substantial co-payments in order to limit excessive use of health care services. In that event, wealthier individuals should pay a higher proportion of their health care costs themselves. This could be achieved by having the co-payment percentage rise with income. The poor should not be deprived of health care because of their inability to pay. The lowest income members in society could be protected through an exemption from co-payment requirements for those below a certain income level. No co-payment should be required for preventive services.

II. SPECIFICATIONS OF PREVENTION AND TREATMENT FOR ALCOHOL AND DRUG ABUSE AND DEPENDENCE

Coverage for the prevention and treatment of alcohol and drug abuse and dependence shall be comprehensive and allow for services in the setting most appropriate for each individual. Individualized assessments should be based on clinical necessity and govern the intensity and duration of treatment.

The system of care must take into account that individuals entering treatment have diverse needs, some requiring prevention, some rehabilitation and others requiring more intensive habilitation efforts. While most individuals will not require all the services outlined in the model, the model should be flexible enough to accommodate individuals with diverse needs. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, will be provided for children.

At the minimum, benefits should allow for the following services, with appropriate applications of individualized services through case management:

1. **prevention** - clinical screening, health promotion and education on risks of drug alcohol use;

2. **intervention** - including assessment, diagnosis, and referral;

3. **detoxification** - 10 days of treatment in a hospital, non-hospital, or ambulatory detoxification program as medically necessary in any calendar year, unless medical complications require additional days;

4. **outpatient treatment** - a full continuum of outpatient services should be provided including:

    a. intensive day and evening treatment: 40 days in any calendar year;

    b. outpatient - 60 visits in any calendar year;

    c. continuing care - 60 visits in any calendar year;

    d. family outpatient care, including preventive services for children irrespective of treatment status of parent: 60 visits in any calendar year;

5. **residential treatment** -

   a. short-term: 30 days of treatment in a hospital or free-standing program in any calendar year;

   b. long-term: up to 18 months of treatment in a residential program (halfway and quarter-way houses, therapeutic communities);

6. **case management** - unlimited and determined as clinically appropriate; and

7. **pharmacotherapeutic intervention** - unlimited and determined as clinically appropriate.

III. RATIONALE

Alcoholism and drug addiction are among the leading health problems in our nation; therefore, any legislation mandating reform for the private and public health care financing systems should include comprehensive coverage for prevention and treatment of alcoholism and drug addictions.

Alcoholism and drug addictions are responsible for staggering economic loss, the deterioration of families, the spread of HIV/AIDS, and increased crime. These chronic illnesses cost billions of dollars each year and result in thousands of deaths.

Economic loss: Accidents at home and on the road resulting from drug and alcohol abuse cause a tremendous financial loss. Substance abuse results in huge economic losses in the work-place as well: employee productivity is greatly reduced, while absenteeism, health-related expenses, accidents and thefts all increase.

Social costs: Beyond the economic costs are the human costs. Individual lives are disrupted and entire families suffer when one member has an untreated alcohol or drug problem. Many families are destroyed as divorce rates increase and children are placed in foster care.

Increased crime: The proportion of offenders with alcohol or drug problems is overwhelming. By some estimates between 75% and 80% of offenders are substance abusers. Many offenses are directly alcohol and drug related, crimes committed to support continued drug use; other offenses are committed under the influence of alcohol or drugs. Numerous studies have established that treatment is far less expensive and far more effective in reducing crime than locking people up.

HIV/AIDS: Alcohol and drug abuse increase the spread of HIV/AIDS. Today, drug abusers account for 32% of those with AIDS, nationwide. Treatment for alcohol and drug

abuse in one of the few ways we know works to prevent the spread of HIV/AIDS.

Many individuals who need alcohol or drug treatment cannot get it because they cannot afford private treatment and publicly funded programs are full. The importance of mandating coverage is clear: Treatment is the best answer we have to decreasing the economic loses, social costs, crime rates, and health - care costs (including birth defects and the spread of HIV/AIDS) caused by alcohol and drug abuse.

A comprehensive alcoholism and drug dependencies prevention and treatment benefit will help reduce the stigma associated with these diseases; individuals and families will be encouraged to seek preventive services and early treatment; early treatment increases the likelihood of successful recovery.

Forty (40) states currently require private health insurers to make available some reimbursement for alcohol and drug treatment. Many states provide Medicaid support for detoxification, outpatient and case management services.

National leadership is needed now to address our nation's drug and alcohol crisis. Stable financing for the prevention and treatment network is crucial if we are to conquer this tragic problem.

IV. QUALIFIED SERVICE PROVIDERS

Alcoholism and drug dependencies treatment may be provided by any of the following licensed or certified professionals with a specialty in addictions: alcoholism and drug addictions counselor, physician, nurse, psychologist, social worker, mental health worker, marriage and family therapist, acupuncturist, professional counselor or prevention specialist and will include treatment provided in programs licensed by the single state alcohol and drug agency.

Alcoholism and Drug Dependencies Prevention and Treatment Benefit Definitions:

1. **Prevention** - patient education about the risks associated with alcohol and drug use.

2. **Intervention (including assessment, diagnosis and referral)** - a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral of the individual.

3. **Detoxification** - the medical and psychological management of an individual while he/she withdraws from alcohol and/or drugs.

4. **Outpatient Services:**

   a. Intensive outpatient/day treatment - an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of treatment consisting of regularly scheduled sessions of a minimum of nine (9) treatment hours per week within a structured program. Services are tailored to meet the individual's needs, and include detoxification, medical management and psychological support.

   b. Outpatient services - an organized non-residential service or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, treatment and recovery services to addicted patients. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

   c. Continuing care - a structured therapeutic involvement designed to enhance, facilitate, and promote the transition from primary care to ongoing recovery. The principle criterion for admission to continuing care is participation and satisfactory completion of a primary care treatment and intent to remain abstinent or alcohol and/or other nonmedical psychoactive substances.

   d. Family outpatient services - an organized, non-residential services or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, prevention, treatment and recovery services to the families of addicted individuals. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.

5. **Residential Treatment:**

   a. short-term -- an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care, and treatment for addicted patients in a residential setting. Clinical services includes: medical; educational; and individual, group and family therapy.

   b. long-term --

      Halfway house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual including educational and vocational rehabilitation and locating permanent housing.

Three-quarter-way house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides ongoing support and supervision for individuals who are resuming activity in the community.

Therapeutic community - an organized long-term residential service (up to 18 months) with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual, including educational and vocational rehabilitation and locating permanent housing.

6. **Case Management** - supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.

7. **Pharmacotherapeutic Intervention** - an organized medical intervention with a patient under the supervision of a licensed physician that utilizes approved medications such as methadone or Antabuse in conjunction with comprehensive medical, casework and counseling services.

PREVENTION

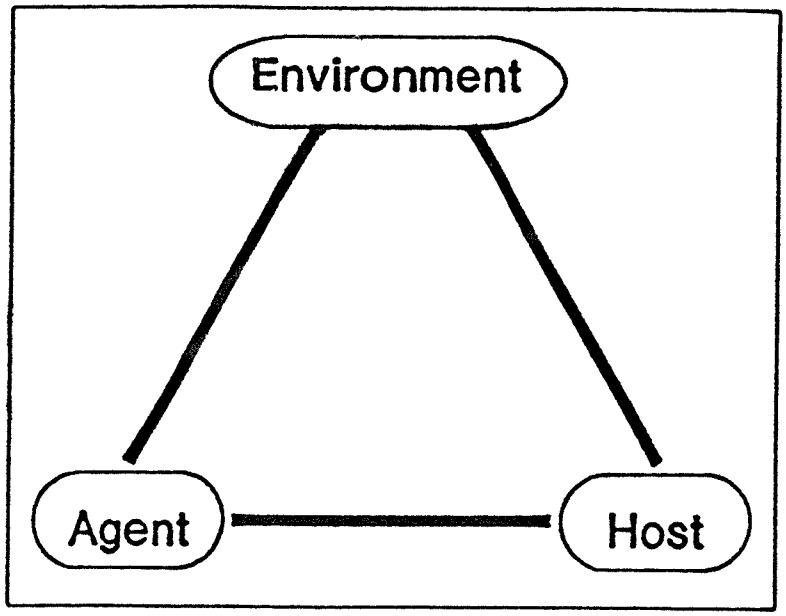
The Alcohol and Drug Abuse Division's prevention efforts are designed to prevent the onset of alcohol, tobacco and other drug use in both the general population and special high-risk populations, including youth, elderly and Native Hawaiians.

PREVENTION PHILOSOPHY

PREVENTION PHILOSOPHY

The Alcohol and Drug Abuse Division (ADAD) utilizes the public health model of prevention, which aims at the root causes of substance abuse. The public health model recognizes that prevention is a dynamic and proactive process that attempts to reduce the supply and demand for alcohol and other drugs by focusing attention on three of the following elements: the agent, the host, and the environment. Alcohol and other drug (AOD) problems in communities did not appear overnight; solutions will not come about quickly without the commitment of human and financial resources.

Public Health Model. In the public health model, the agent is defined as alcohol, tobacco, and other legal and illegal drugs. The host is defined as the individual and/or group, their particular susceptibilities to alcohol and other drug-related problems, and their knowledge and attitudes that influence their drinking, and other drug-using behavior. The environment is defined as the setting or context in which drinking and other drug-using behavior occurs or is influenced and includes specific institutions and systems; such as schools and religious institutions, the community in which they exist, and the larger society with its norms and mores. The challenge is to reduce the demand for alcohol and other drugs. Because the agent (drugs), the host (individual or group) and the environment (society) are interactive and interdependent, prevention efforts must deal with all three simultaneously.



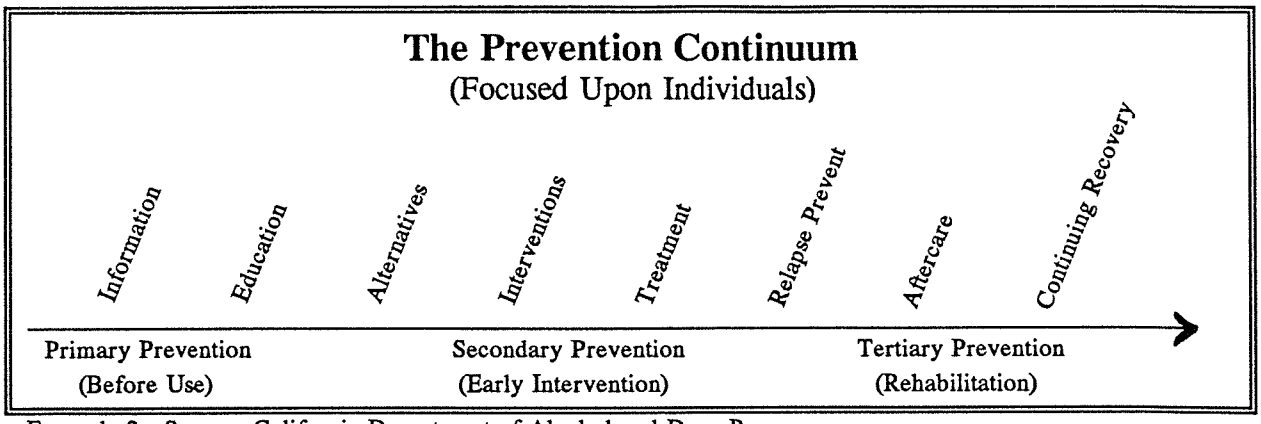
Alcohol and other drug misuse represents a major health problem, if not **the** major health challenge to public health and safety promotion today. Communities need to become aware of their critical role in the promotion of sober lifestyles through a wide array of activities and to be committed to zero tolerance of illicit drug production, distribution and use.

Prevention strategies that focus on the agent are aimed at reducing the supply and demand for alcohol and other drugs by addressing the following risk and resiliency factors: availability, advertising and promotion, pricing and taxation, enforcement, deterrence, content labeling, health and safety warning labeling, and other related issues. These social policy approaches aimed at supply and demand reduction are vital components of any comprehensive community, state or national prevention program.

Equally important are efforts aimed at reducing the demand for alcohol and other drugs by focusing on the host. Individuals use these substances for any number of complex biological, environmental or psychosocial reasons. In some instances, this use interferes with the constructive, pleasurable and meaningful benefits of life that are naturally derived from healthy development. According to the Prevention Plus II: Tools for Creating and Sustaining Drug-Free Communities manual prepared by the federal Office for Substance Abuse Prevention in 1989, studies have shown that the greater the number of risk factors to be found within the total system of school, family, peer group and community, the greater will be the tendency toward alcohol and drug-related problems.

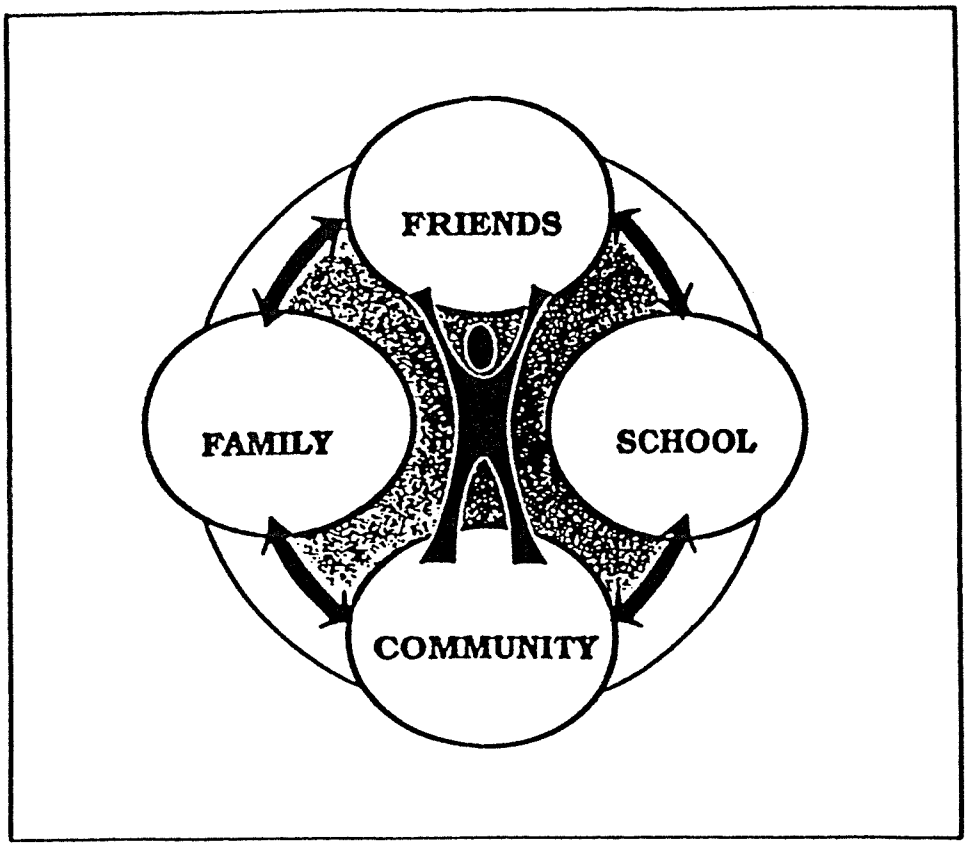
It is essential to recognize how individual behavior influences and is influenced by the larger systems of the family, and the social environment. To study any one of these systems in isolation is to inevitably obtain only a partial view of the problems related to alcohol and/or drugs. The systems approach provides a broad theoretical framework for organizing information and understanding relationships in real world settings. It focuses on understanding the "interconnectedness" between the host, agent, and environment.

Public health prevention strategies for alcohol and drug-related problems have been traditionally initiated at three stages of problem development. The first stage, primary prevention, involves pro-actively identifying factors which contribute to the possible development of problems, and making necessary changes in the agent, host and environment to avert their initial occurrence. Secondary prevention strategies are the next stage, and involve early identification of developing problems and appropriate corrective responses which forestall further development. The tertiary level of prevention is primarily concerned with reducing the prevalence of existing problems, preventing further deterioration, and preventing relapse. (Prevention Plus III, Office for Substance Abuse Prevention, 1991)



Example 2. Source: California Department of Alcohol and Drug Program

A new paradigm shift to the systems approach, however, emphasizes a way of looking at events or problems within the context of a larger whole, instead of as pieces existing in isolation. Prevention needs to be framed within the context of the settings, or the key systems that affect their lives each day.

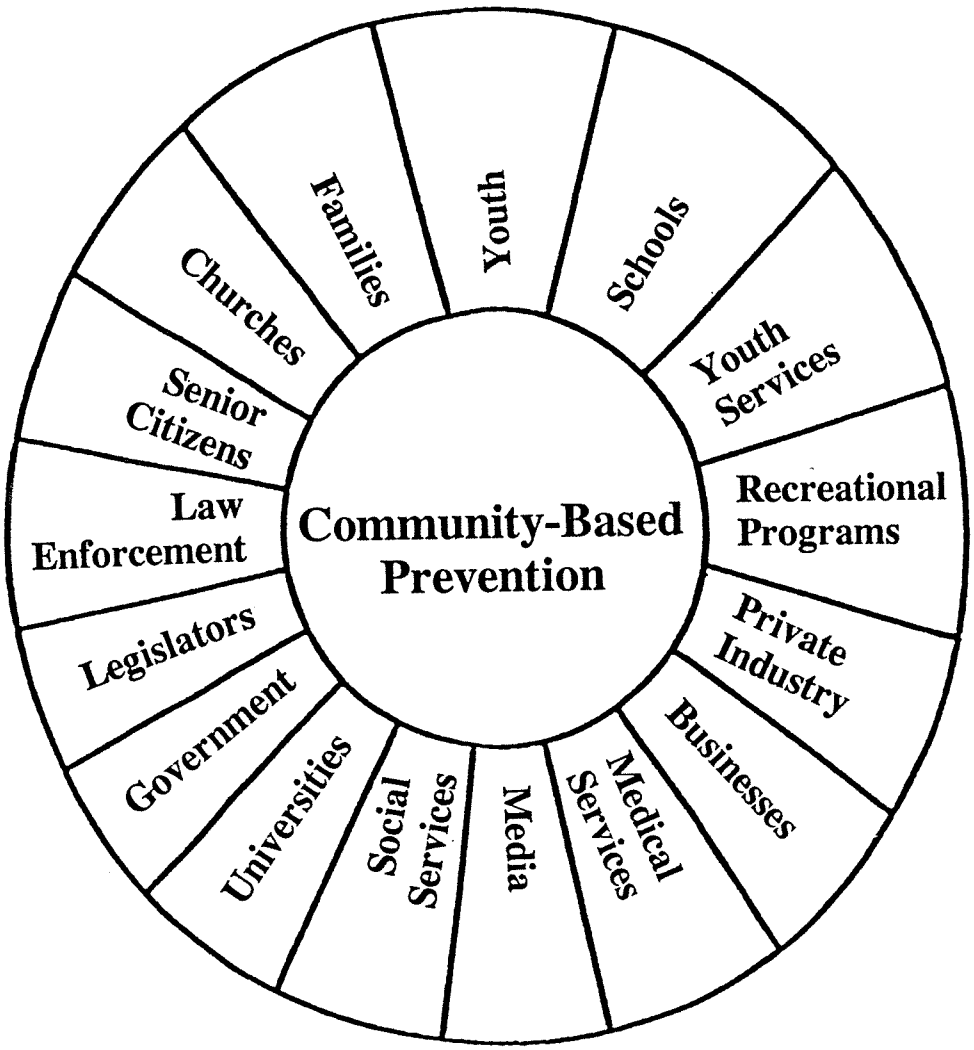


Example 3. Source: 1990 Together We Can

During the early years a young child is most influenced by the family environment. School and peer groups assume greater influence during the middle years. School, community and youth organizations which work together on anti-drinking/driving campaigns compound their influence upon the behavior of local teenagers. Individual behavior is a function of the interaction of a person with many systems and those systems with one other.

Multi-systems. ADAD's prevention approach reflects the understanding that prevention is a shared responsibility among all community groups, and state and national agencies. Organizational approaches must be developed, implemented and understood within a comprehensive system, a set of components that work together to achieve an overall objective.

COMMUNITY-BASED PREVENTION



Example 4. Source: Prevention Resource Center

Specific practical strategies, however, are best accomplished at the community level by recognizes and utilizing formal and informal leaders. Turning the work of prevention back to the community and encouraging "grassroots" community ownership are the key elements in prevention program success. The community is the expert where cooperation and collaboration are emphasized.

Research and experience in the field of education, behavioral science and community development provide valuable tools for development and implementing effective programs. No one system, agency, or organization can prevent alcohol and other drug problems. Public and private partnerships are vital components in this area.

Proactive Process. There is no such thing as a "quick fix" solution to the AOD problem. Instead, prevention is a proactive process which promotes the creation of conditions, opportunities, and experiences which encourage and develop healthy self-sufficient people, to reduce the incidence of substance abuse and related problems. The goal is a long-term process that integrates prevention, education and experiential activities with organizations, institutions and families to ensure consistent messages and strategies beginning early in life and continuing throughout the life cycle.

Prevention Programming. Nationally, research projects of the Prevention Resource Center have identified five characteristics contributing to successful and effective prevention programming. These characteristics include:

1) Targeting multiple systems (i.e., youth, families, schools, work-place, community organizations, and the media) and using multiple strategies (i.e., providing alternatives, training in developing life skills, creating positive alternatives and changing community standards and norms).

2) Targeting the whole community, (i.e., the school, the family, the community organizations, the work place, and the media, etc.) in prevention efforts.

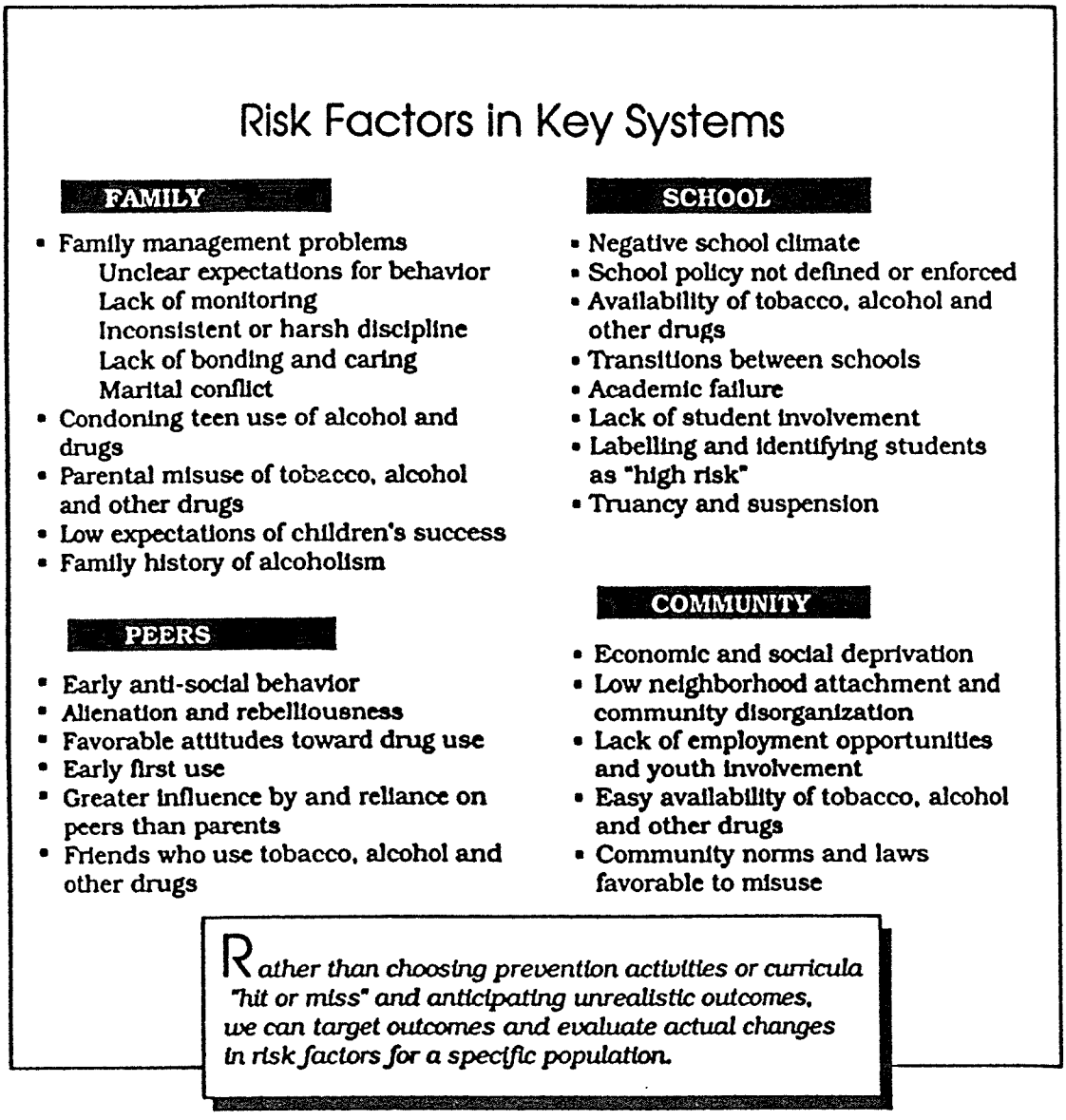
3) Using a broader comprehensive prevention effort focused on promoting health and life skills that will help motivate youth towards success. Focus should be on the whole health of the person; targeting risk factors and not people. The greater the number of risk factors, the greater the likelihood of problems.

4) Providing consistent and continuous prevention efforts (i.e., school and community interventions); one-shot prevention efforts are not successful.

5) Integrating prevention activities with individual, family, and community. The needs of women, children, ethnic groups, handicapped, and the elderly must be addressed in prevention efforts. Families, schools, peer groups and communities are, however, key system influences in a child's development of an overall moral/social framework. The very fabric of a child's values and belief system is

and indirect messages and interaction with family, school, peer group and community members. We must identify risk (problem) and protective factors (solutions) and provide prevention activities which minimize risk factors and strengthen protective factors.

The following chart identifies some of the most prominent risk factors inherent within the key systems of family, peers, school and community.



Example 5. Source: 1990 Together We Can

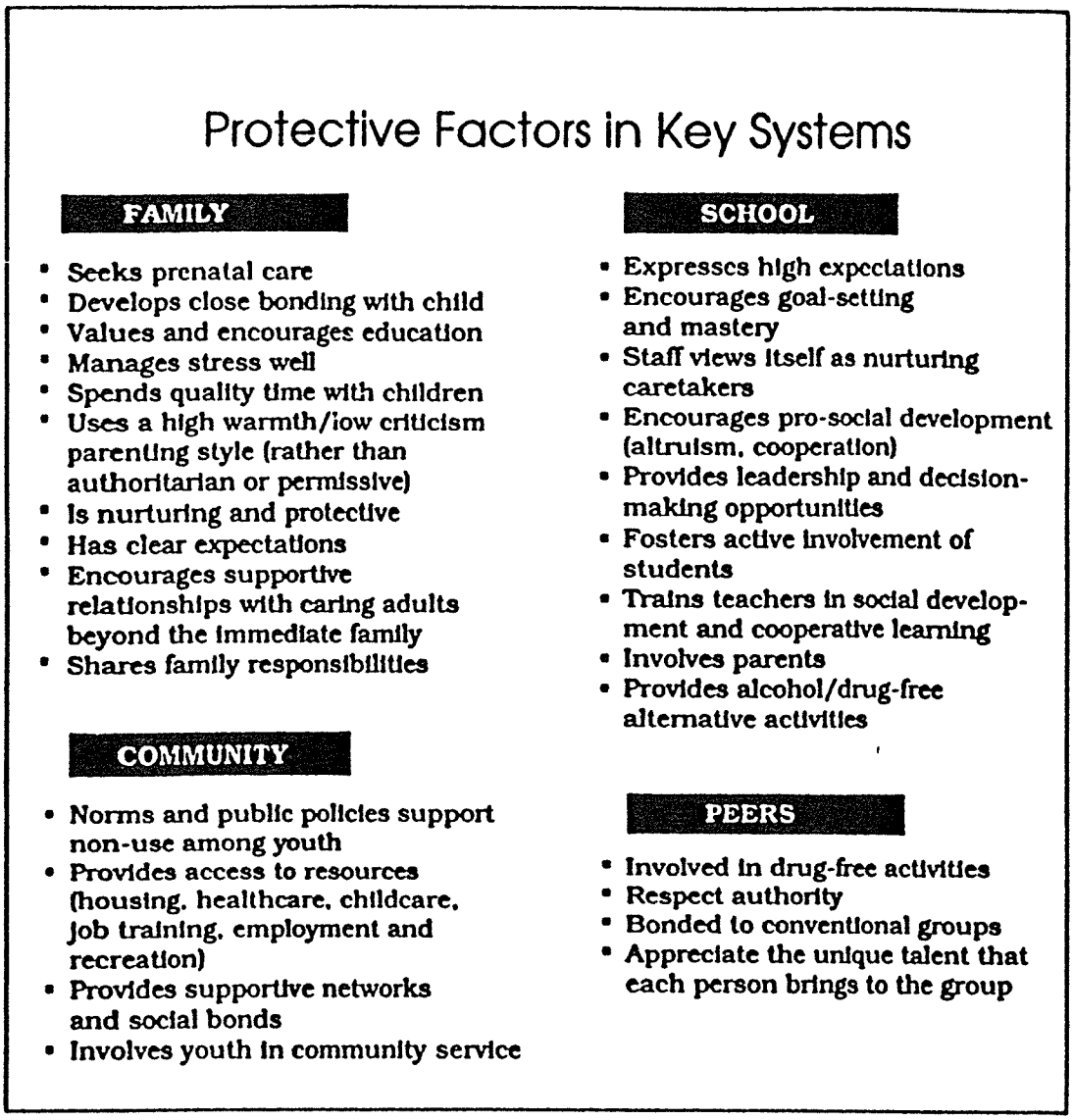
In addition to family, peers, school and community influences, a range of individual personality factors also place a young person at risk. For the most part, they are the same as those described as peer risk factors. Some studies indicate a genetic predisposition in some males toward alcoholism, but there still are not enough studies to link genetic factors to a predisposition to use of other drugs.

Once risk factors are identified for a given population, strategies (curricula and programs) can be chosen or designed to reduce specific factors. Rather than choosing prevention activities or curricula "hit or miss," outcomes and evaluate actual changes in risk factors for a specific population can be defined. When key risk factors are reduced within the school-community, fewer alcohol and drug-related problems will occur.

Therefore, prevention strategies must help individuals develop and maintain healthy lifestyles, behaviors, attitudes and knowledge. According to Prevention Plus II, when strengthening protective factors, a school-community needs to work together to strengthen known **protective factors** that reduce the likelihood of high risk behavior. Many of the protective factors are simply the translation of the negative risk factors into positive action strategies. Dr. J. David Hawkins, whose work has been published in the Journal of Children in Contemporary Society (Vol. 18, 1985), has given the prevention field one of the clearest ways to define protective strategies. Dr. Hawkins' social development model involves:

- **promoting bonding** to family, school, non-drug using peers and community;
- **defining a clear set of norms** about use;
- **teaching the skills** needed to create healthy relationships and take an active part in the community; and
- **providing recognition, rewards and reinforcement** for newly-learned skills and behaviors.

The stronger the social bond to conventional systems and people, the greater are the chances that children will not move into deviant behavior. Dr. Hawkins points out that a bond of attachment and commitment develops: (1) when youth have opportunities for active participation; (2) when they can develop the social, academic and interpersonal skills to perform with pride; and (3) when they receive consistent rewards. Formation of strong bonds to family and school decreases the likelihood of early attachments to drug-using peers.



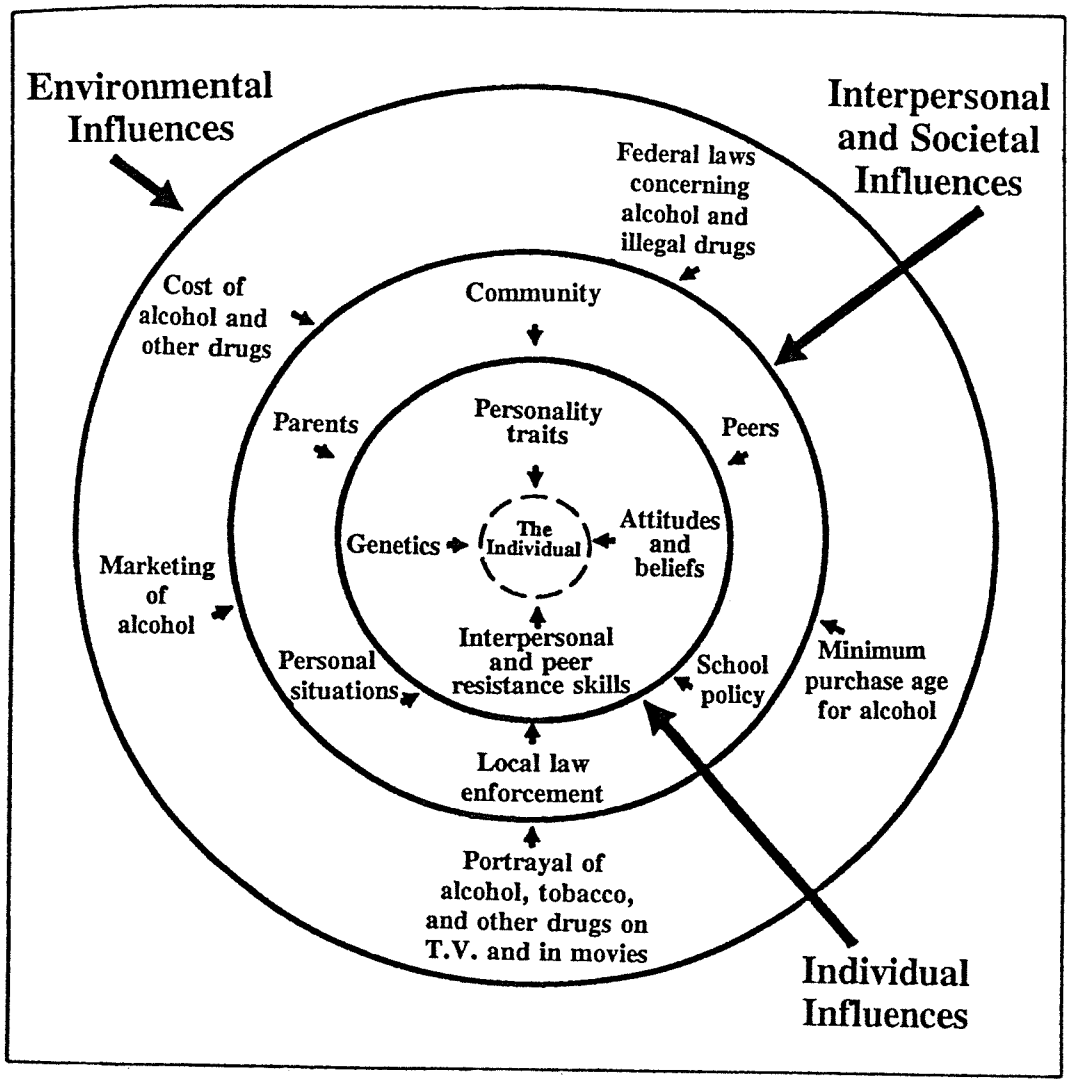
Example 6. Source: 1990 Together We Can

These efforts must help individuals improve their self-perceptions by teaching them that they are an important part of something larger than themselves, and that their actions affect the direction and events of their lives. Efforts impacting the host must also assist individuals in developing skills such as self-responsibility, judgment and decision-making, communications and self-discipline.

In order to achieve maximum effectiveness, prevention goals must cultivate the skills and self-perceptions that they are trying to prevent -- drug abuse, delinquency and unwanted pregnancy. By developing these personal resources, individuals can improve their chances of living satisfying and enriching lives.

Demand reduction goals must extend behind the individual and extend into the environment. Alcohol and other drug use within any society is influenced by many environmental factors: legal, economic, family, social, cultural, political, geographic, religious, ethnic and educational. Solutions lie in providing opportunities for all community segments to participate by exchanging ideas and setting priorities.

Prevention efforts focusing on the environment must empower and facilitate each community's capacity to mobilize organizational and legislative efforts to change these environmental risk factors (social problems). Through advocating appropriate actions, policies and procedures, prevention practitioners and public policy makers can shape the norms in a way that is supportive of healthier lifestyles.



Factors that Influence Alcohol and Other Drug Use

Example 7. Source: Prevention Plus II.

Prevention efforts work to:

- initiate a process among the general public that promotes overall health and wellness;

- deter the illegal use of alcohol and other drugs through the enforcement of appropriate sanctions:

- support abstinence as a legitimate choice;

- delay the age of onset of alcohol and other drug use or to prevent onset altogether; and

- avoid the development of problems related to the use of alcohol and other drugs.

The National Prevention Network (NPN) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) advocate the a community prevention system framework as provided by the public health mode of prevention. This comprehensive approach addresses problems related to the use of alcohol, tobacco and other drugs by focusing on the agent, the host and the environment. Agencies and professionals are no longer solely responsible for solving a community's substance abuse problems. The responsibility and power to prevent drug related problems lie **within** the communities. Prevention efforts must be directed toward the users, the source of the drugs and the social climate that encourages and supports the use of alcohol and other drugs. Prevention education and activities should not be limited to a focus solely substance abuse, but should also address the broader issue of community health. The key to the success of this prevention model is the involvement of members from all segments of the community in every phase of the effort. This inclusion ensures that plans and activities are appropriate to the communities and neighborhoods addressing the problem of substance abuse.

Recommendations: ADAD recommends using the Office of Substance Abuse Prevention's (OSAP) Community System Framework Model of prevention. Hence, ADAD recommends supporting and strengthening prevention efforts to:

- Increase community involvement in Hawaii's substance abuse prevention and control efforts.

- Ensure that all schools in Hawaii become alcohol and drug free.

- Develop a strong base of community, school, campus and work-place prevention activities that reach as many high risk groups in Hawaii as possible.

- Increase the public's awareness of substance abuse.

- Develop a systemic public health approach to substance abuse prevention. (An approach that can be evaluated.)
- Demonstrate strong leadership in the battle against substance abuse.
- Coordinate with groups and individuals who wish to become involved in preventing substance abuse.
- Empower communities to develop their own prevention strategies.

CURRENT LEVEL OF ALCOHOL AND OTHER DRUG ABUSE PREVENTION SERVICES

The Alcohol and Drug Abuse Division (ADAD), Department of Health funds prevention services which include Native Hawaiian ex-offender services for adults and their families and a Native Hawaiian agricultural-based program for elementary school age children, an information and resource center, a hot-line and alternative activities for high-risk youth. Services targeting elderly prescription use and abuse, college-age students and training and education focusing on pregnant women and women of child bearing age are also provided. All services are contracted out to private providers.

A. SCHOOL BASED PREVENTION SERVICES

Substance abuse prevention services in preschool settings are provided on a limited basis on Oahu and Kauai.

a. **Hawaii Counseling and Education Center, Inc.:** preschool prevention located on Oahu ($10,032 State funds).

b. **Kauai County YWCA:** preschool prevention located on Kauai ($14,046 State funds)

B. OTHER OAHU-WIDE PREVENTION EFFORTS

a. **Alu Like, Inc.:** Native Hawaiian Ex-offender Program. Services to build resiliency and protective coping skills in high risk Native Hawaiian individuals and families in an effort to reduce their vulnerability to their environment. Services are delivered through outreach by Kupuna (Native Hawaiian Elders) using their natural healing skills ($167,571 Federal funds).

b. **Pacific Institute of Chemical Dependency:** training/education. A total of $58,771 (Federal funds) provides training and education to the general public of all ages with a specific focus on pregnant women and women with childbearing ages and human service agency staff that work with these populations. This training also includes a statewide prevention conference.

C. STATEWIDE COMMUNITY-BASED PREVENTION SERVICES

a. **Alu Like, Inc.:** substance abuse prevention/treatment system development for Native Hawaiians for ex-offenders($322,002 Federal funds).

b. **Awareness House:** substance abuse prevention education for elementary and secondary students in Hilo and Kamakua on the Big Island of Hawaii ($11,500 State funds grant-in-aid).

c. **Coalition for a Drug-Free Hawaii (Prevention Resource Center):** a centralized information resource center for $131,000 (Federal funds) provides up-to-date information on alcohol and other drugs and on community resources. Linkage to national computerized data bases ensures that the latest research findings and program models are available to professional and the general community. The Prevention Resource Center serves the general population of all ages with specific focus on populations which may be at high risk for substance abuse, such as women, the elderly, and children of alcohol and other drug abusing families. It also focuses on professional and allied support staff of substance abuse prevention, intervention, treatment and aftercare programs.

d. **Coalition for a Drug-Free Hawaii (Youth Helping Youth):** comprehensive community based prevention, for $110,000 (Federal funds) provides: (1) A youth focused and youth-driven organization that plans and operates school and other drug prevention efforts which stresses positive alternative through a statewide youth advisory group, youth helping youth leadership training, and the development of drug free activities and public awareness presentations; (2) Training impactors to work with individual citizens, parents, families, civic groups, community organizations, agencies, systems and institutions; and (3) Community awareness campaign that disseminates information to youth, schools, parents, community organizations and the general public about alcohol and other drugs and prevention efforts.

e. **Department of Human Services:** staff development and training to use the "Michigan Model" of family preservation for the purpose of integrating family preservation & substance abuse services ($50,000 Federal funds).

f. **Department of Public Safety:** program and staff development to improve substance abuse prevention and treatment services to women in the criminal justice system ($51,953 Federal funds).

g. **Drug Addiction Services of Hawaii, Inc.:** drug and alcohol crisis line ($107,423 State funds).

h. **Hawaii Counseling and Education Center, Inc.:** preschool prevention located in Windward Oahu ($10,032 State funds).

i. **Hawaii Youth at Risk:** substance abuse prevention for adolescents through intensive camps ($100,000 Federal funds).

j. **Hawaii Youth at Risk:** substance abuse prevention for Waianae adolescents through intensive camps ($100,000 Federal funds).

k. **Kauai County YWCA:** preschool prevention located on Kauai ($14,036 State funds).

l. **Molokai Community Services Council:** substance abuse prevention community youth activity project services for youth in Molokai ($50,000 Federal funds).

m. **Susannah Wesley Community Center:** after school substance abuse prevention services for youth in Kahili-Palama. ($30,094 State funds + $26,725 Federal funds).

n. **University of Hawaii:** substance abuse prevention services for college-age students at the University of Hawaii-Manoa campus ($100,000 Federal funds).

o. **Waianae Coast Community Mental Health Center, Inc.:** substance abuse prevention agricultural project for students at Makaha Elementary ($36,133 Federal funds).

p. **Winners' Camp:** substance abuse prevention for adolescents through an intensive camping experience ($100,000 Federal funds).

PREVENTION GOALS

NATIVE HAWAIIAN EX-OFFENDER PREVENTION PROGRAM

GOAL:

Improvement of the quality of life of Native Hawaiian ex-offenders by the incorporation of a substance abuse prevention project that employs traditional Native Hawaiian methods of healing.

OBJECTIVE:

To provide culturally appropriate Native Hawaiian substance abuse prevention program for ex-offenders.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Native Hawaiians are more likely to live in rural areas, to be among the poor, and to lack medical insurance, thus they have limited access to health care. The health care that is accessed is generally based on Western medical principles and is not sensitive to Native Hawaiian cultural and communication needs and issues. Similar cultural and communication barriers apply to substance abuse prevention and treatment as well. A model which is responsive to Native Hawaiian culture and supports ex-offenders in their efforts to reintegrate into the work world and re-establish and stabilize their familial support network is needed.

The organizing principle of the Native Hawaiian ex-offender prevention program is "ka hana a ka makua, o ka hana no ia a keiki" (What parents do, children will do); thus the approach will be to focus on the adult (kupuna - grandparents and all relatives of the grandparent generation, and makua - parents and relatives of the parent generation, aunts and uncles), members of the ohana (family) as the role models and teachers for the keikis (children).

COLLEGE AGE POPULATION

GOAL:

Promotion and development of a drug-free lifestyle for the college age population.

OBJECTIVE:

To promote a drug-free lifestyle for college age students.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

College campuses and institutions of higher learning are often perceived by the young as places where "freedom" is finally achieved. No longer subject to the scrutiny of parents or teachers who see them every day, young people need to be reminded about what is acceptable behavior now that they are on their own.

Alcohol and drug use rates are high for college age students, exceeding even the high rate of alcohol use of similar age groups who do not go to college. Very heavy use of alcohol is often associated with the college years and is a frequent cause of premature termination of college education.

Currently there are small, fragmented educational efforts at the University of Hawaii. However, a comprehensive substance abuse prevention program is nonexistent.

Hawaii's institutions of higher education, while designed to encourage the growth and development of young adults, must carry out this mission within the laws of Hawaii regarding drug and alcohol use. College presidents and campus police should enter into cooperative agreements that clearly enforce student accountability.

ELDERLY PRESCRIPTION ABUSE PREVENTION PROGRAM

GOAL:

Reduction of prescription abuse and expansion of increased knowledge of interactive effects of medicine in the elderly.

OBJECTIVE:

Provision of a elderly prescription abuse prevention program.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Medication misuse exists among people of all ages, but the older person is more likely to experience problems resulting from inappropriate drug use. The high incidence of medication use among people over 65 (who represent 11% of the United States' population and take 25% of all prescription drugs), the physiological changes of aging, and lack of information about appropriate drug use increase the older adult's chances of experiencing adverse drug reactions.

While it has been found that most prescriptions are warranted, the likelihood of abuse - whether intended or inadvertent - increases significantly when the following factors are considered. The probability of an adverse drug reaction, even to a normal dose of medications, is double that of younger populations because of the lowered physical reserves of the elderly. Also, it has been shown that potential for adverse reactions swells in relation to the number of drugs an individual is taking and the complexity of the prescription directions. The elderly make a high degree of error in drug consumption as a result of lack of information and confusion arising from multiple prescriptions. This problem is further complicated by the fact that the aged are more likely to mix prescription drugs with over-the-counter remedies or alcohol. Added to this is a tendency to accumulate medications of all kinds - often long beyond their expiration date - and to share them freely with elderly friends and neighbors.

ALCOHOL, TOBACCO AND OTHER DRUGS COMMUNITY-BASED PRIMARY PREVENTION PROJECTS FOR YOUTH

GOAL:

Prevention of the onset of alcohol, tobacco and other drug use among high-risk youth.

OBJECTIVE:

A. To provide community-based alcohol, tobacco and other drug use projects targeting high-risk youth in geographic areas showing highest prevalence of substance abuse.

B. To provide community-based alcohol, tobacco and other drug use projects targeting Native Hawaiian high risk youth in geographic areas showing highest prevalence of substance abuse.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

In December 1991, the Hawaii State Department of Education's Student Use Survey found heavy alcohol and drug use among many of Hawaii's youth. Adolescents are at high risk of serious alcohol and other drug use. It is during these years when attitudes toward personal and peer use of substance are most likely to change. Adolescence is a period of unsettled identity and values. If prevention with high risk youths takes place at this time, attitudes can be changed and behaviors refocused.

NATIVE HAWAIIAN AGRICULTURAL PROJECT

GOAL:

Promotion of Native Hawaiian culturally appropriate prevention education to elementary school age children.

OBJECTIVE:

To provide an agriculture based primary prevention project utilizing Native Hawaiian principles of aloha aina.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Native Hawaiians are at particular risk for severe alcohol and other drug use and abuse. Early primary prevention targeting kindergarten through sixth grade provides a foundation for healthy substance-free lifestyles.

YOUTH LEADERSHIP SKILLS DEVELOPMENT

GOAL:

Empowerment of youth with the knowledge and skills necessary to implement alcohol and other drug free activities.

OBJECTIVE:

To provide a peer oriented youth leadership program.

IMPLEMENTATION STRATEGY:

FY 94 This program will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

One of the protective factors for youth is a bonding and sense of belonging with positive peers, school, family and community. Research has shown that the best messengers to carry the prevention message to youth are other youth themselves.

STATE RESOURCE CENTER

GOAL:

Assurance of the availability of the most up-to-date alcohol and other drug abuse services and information to the community.

OBJECTIVE:

To maintain a State Resource Center for compilation and dissemination of effective alcohol and other drug service models and programs.

IMPLEMENTATION STRATEGY:

FY 94 This will be funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

A vast amount of data exists that defines the horrible consequences of substance abuse in very specific ways, and many successful prevention and treatment programs have been developed that combat drug and alcohol abuse in innovative ways. Information needs to be gathered in one place, analyzed, and made available not only to local and state government policy makers, but to every citizen who needs or wants information on any aspect of prevention and/or treatment.

Information sharing is a critical component of any successful strategy. Too often local and state efforts exist in isolation. Local and state agencies must encourage interagency cooperation so that duplication of services can be eliminated and successful programs and services can be promoted through a collaboration of efforts. Agencies must share information if we are to be successful and efficient without resources, and a vehicle must be created that is a first step toward accomplishing this goal.

TARGETED EDUCATION/PREVENTION

GOAL:

Increase of professional and public awareness and knowledge of the health and safety risks associated with use and abuse of alcohol and other drugs.

OBJECTIVE:

A. To increase health care and human service professionals' knowledge of alcohol, tobacco and other drug use, addiction and their impact on major life functions.

B. To promote public policy development and implementation in order to reduce risk factors and strengthen protective factors for women at risk for substance abuse with special emphasis on pregnant women and women of childbearing age.

C. To increase substance abuse counselors' ability to implement HIV prevention strategies with their clients.

IMPLEMENTATION STRATEGY:

FY 94

1. Provide educational workshops for health care and human service professionals on substance abuse and addiction.

2. Develop and maintain a Women's Task Force on Alcohol, Tobacco and Other Drug Abuse to promote service and policy changes to meet women's needs more appropriately and to annually convene a "Women and Substance Abuse" conference.

3. Provide educational workshops on basic HIV/AIDS prevention targeting substance abuse counselors and focusing on women and gay, lesbian and bisexual clients.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Of growing concern is the use of alcohol and other drugs by pregnant women and women of childbearing age. Women have traditionally been less effective at accessing and availing themselves of substance abuse services. Health care and human service providers and the general public need to be fully informed on the signs of alcohol and other drug abuse. HIV/AIDS prevention efforts need to target women and others who are surfacing as a high prevalence risk group.

PUBLIC AWARENESS CAMPAIGN

GOAL:

Promotion of health enhancing behaviors and attitudes of the public regarding alcohol and other drugs.

OBJECTIVE:

To establish a comprehensive approach to coordinate public awareness programs on drug and alcohol abuse prevention.

IMPLEMENTATION STRATEGY:

Fiscal resources need to be secured for this goal. ACTION STEPS:

1. Secure the assistance of a public relations firm that will design a public awareness program.

2. Adopt a campaign model such as the "Census 90", or one of similar scope, which sends a message regarding the consequences of alcohol and other drug use.

3. Involve government and local communities in the design of the public awareness campaign so that the message is delivered as broadly as possible, and portraying a "local" image.

4. Tap the expertise and network of public information officers of the various state agencies and the Governor's Office.

RATIONALE:

Attitudes, images, and fantasies that glamorize alcohol and drug use are promoted through advertising and entertainment industries, even though it is clear that abuse is linked to the very things that tear our fantasies apart - depression, accidents, deaths, suicides, crimes, violence, and isolation. Images associated with alcohol and drug use falsely link "getting high" with happiness, success, sexual satisfaction, virility and maturity.

Advertising also promotes the idea of a quick fix to relieve pain, to help one sleep, to alleviate depression. Getting high buy using drugs and alcohol becomes the coping mechanism for dealing with life's problems.

The public largely denies the problems associated with using alcohol and illegal drugs. The messages permeating music, movies and television clearly make "recreational use" acceptable. While there are messages about the harmful effects of abuse, the linkage to recreational use is hardly ever made.

TREATMENT

The Alcohol and Drug Abuse Division's treatment efforts are designed to promote a statewide culturally appropriate comprehensive system of services to meet the treatment and recovery needs of individuals and families.

TREATMENT PHILOSOPHY

This section is a synthesis of concepts and approaches presented in a number of reports and studies on alcohol and other drug abuse. While the addiction models discussed in the various sources may differ, the rehabilitation/treatment processes are similar, and are adapted for applicability to all substances of abuse. Sources include: Broadening the Base of Treatment for Alcohol Problems, a report issued in 1990 by the Institute of Medicine; The Office of National Drug Control Policy white paper entitled "Understanding Drug Treatment" (June 1990); the Office for Treatment Improvement (OTI) 1992 "Annual Grantee Meeting Summary Report;" the February 1992 issue of Newswatch and the State of Oregon's Alcohol and Drug Review, Summer 1991. The Institute of Medicine (IOM) defines treatment as follows:

> **Treatment refers to the broad range of services, including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up, for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.**

The need for comprehensive treatment in the 1990's has been summarized by the Federal Center for Substance Abuse Treatment (CSAT - formerly OTI, The Office of Treatment Improvement), as follows:

- Addiction is a bio-psycho-social disease phenomenon - an interaction between biological vulnerability and the environment, such that a person's addictive disorder cannot be addressed in isolation from addressing his or her socioeconomic needs.

- Chemical dependency, at its most fundamental, is a neuro-biological disorder, one which may have irreversible consequences even for individuals who cease using alcohol or drugs.

- The incidence of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) is rising; injection drug users are the fastest growing vectors for transmission of HIV.

- The incidence of tuberculosis is rising markedly. According to the Centers for Disease Control, alcoholics, injection drug users, and HIV-positive individuals are especially at risk for tuberculosis; all drug and alcohol users are at risk for tuberculosis by virtue of the reduction in their immune system functioning; health care practitioners are also at great risk for acquiring tuberculosis.

- Data indicate a high positive correlation between cocaine use and female syphilis.

- Large numbers of individuals with a substance abuse problem also have a diagnosable mental illness. Treating one without addressing the other diminishes the likelihood of an effective outcome for either.

- Data clearly point to the correlation between drug/alcohol use and unemployment, school truancy, and misdemeanor and felonious crime.

- Alcohol and other drugs are associated with:

  - Up to 50 percent of spousal abuse cases
  - 49 percent of murders
  - 68 percent of manslaughter
  - 69 percent of drownings
  - 38 percent of child abuse incidents
  - 52 percent of rapes
  - 62 percent of assaults
  - 20 to 35 percent of suicides
  - 50 percent of traffic fatalities.

- Catchment area survey data indicate that minority populations do not abuse drugs more frequently than majority populations when measured as a proportion of the total U.S. population; however, minority individuals are dying at more than twice the proportional rate because of their higher exposure to socioeconomic dysfunction and reduced access to quality health and human services.

As a complex bio-psycho-social disorder, substance abuse tends to be chronic and relapsing by nature. From a clinical standpoint, it should be likened to hypertension or diabetes, diseases which require intervention, if the client is to attain and maintain recovery. CSAT recognizes that some clients, by virtue of the severity of their addiction, will require a lifetime of intervention in order to maintain recovery.

In order to address clients' needs adequately, CSAT has developed a framework for a comprehensive treatment model, recognizing that the method of service delivery is as important as the type of service rendered; that interventions should be delivered in a manner which is intimately appropriate to the racial, ethnic, cultural, or religious characteristics of the client; and as appropriate, that ancillary services required by clients should be provided within the treatment facility. "One stop shopping" is a phrase used to promote this substance abuse idea.

Issues surrounding the formulation of treatment programs and key elements that need to be considered in developing treatment models are reflected by the many approaches developed to help substance abusers permanently eliminate substance related problems. Not

all of these approaches work equally well for each type of drug user.

The type of treatment a client currently receives is still frequently determined by the first door knocked on. If a heroin addict knocks on the door of a therapeutic community program, that will be the treatment received. If a client knocks on the door of a methadone maintenance program and meets FDA requirements, methadone will be the treatment of choice.

Most addicts, though, stand a much better chance of success in treatment when aspects such as personality, background, mental condition, and duration, extent and type of drug use are evaluated during a pre-admission screening process that places an individual in a treatment program that is most likely to meet individual needs and produce the best outcomes. If a client isn't getting the right kind of treatment initially, then the chances for success are diminished without is redirection or transference to a more appropriate program. Clients who have a mental illness as well as addiction -- what psychiatrists call "dual diagnosis" -- may not be able to recover without proper attention to their psychiatric condition, regardless of what sort the treatment they receive.

Many treatment programs address the issues of trust, respect, and ethical behavior -- ideas that are essential for human civility but often alien to the world of drug addiction. Quality programs bring a group of recovering addicts together to create an atmosphere of support and friendship. Whether through the twelve steps of Alcoholics or Narcotics Anonymous, the tenets of a therapeutic community, or the behaviorally oriented programs, the effort to get addicts to abstain from alcohol and other drugs involves fostering their faith in something above and beyond themselves, and certainly beyond the self-absorbed euphoria of substance use.

Effective treatment programs are managed and staffed by competent people who have the capacity to be both tough and compassionate. Whatever the method, treatment relies heavily upon the leadership, skill, personality, and compassion of the men and women who work with alcohol and other drug users every day.

Successful treatment in the substance abuse arena involves a realistic grasp of related issues. An individual's addiction cannot be treated without addressing primary health, mental health, or socioeconomic realities. Those who suffer from extreme socioeconomic dislocation are at highest risk for addiction due to their exposure to crime, poverty, abuse, homelessness, and their lack of access to good primary health care and mental health services, social services, vocational training, and education.

Chemically dependent individuals must be provided with a series of interventions if they are to sustain harm reduction. CSAT espouses that treatment is most successful when clients can be provided with:

1) a continuum of comprehensive therapeutic services,
2) a readily accessible post-treatment continuing care program, and

3) that treatment outcomes will improve substantially for clients treated in comprehensive treatment programs.

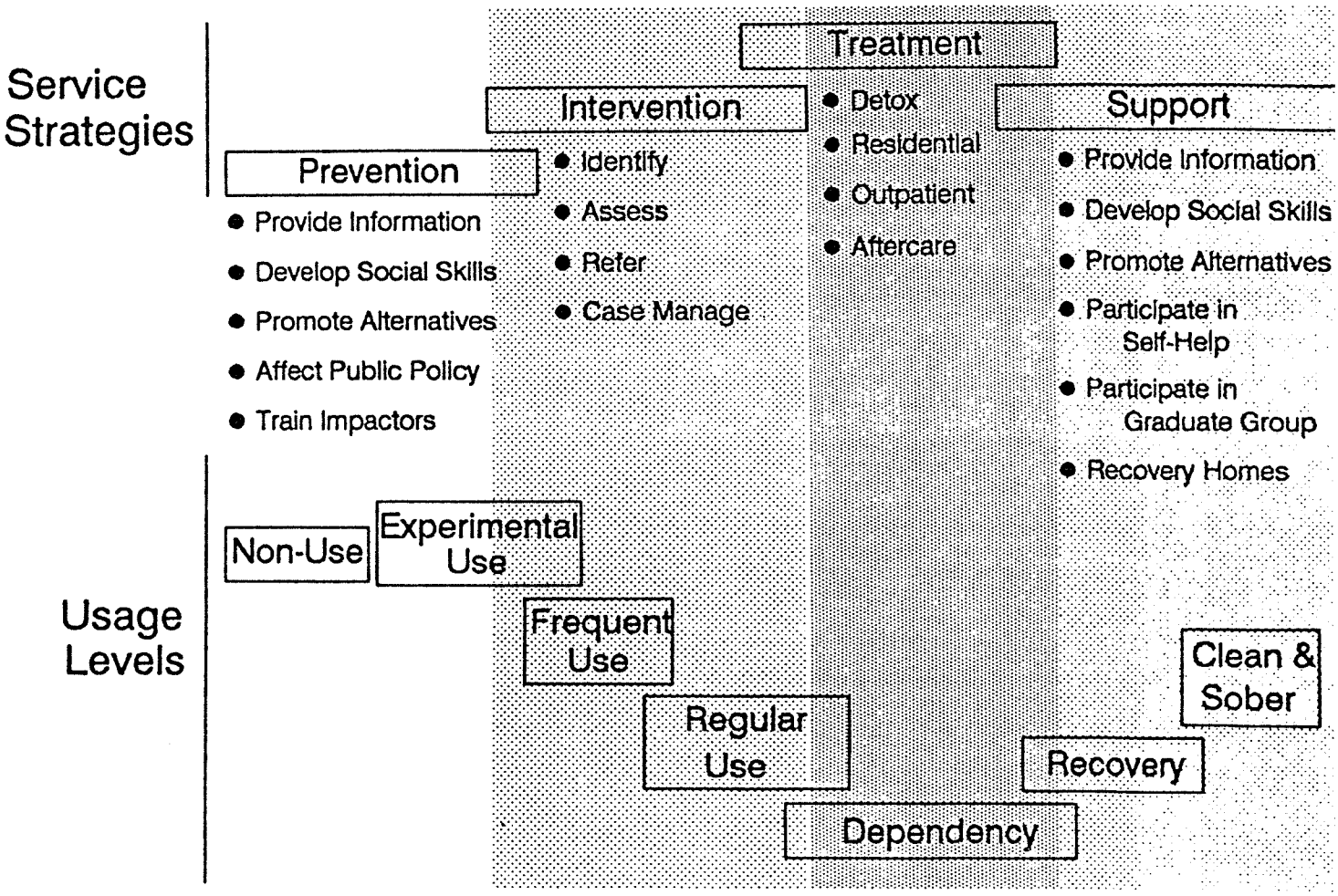
The CSAT Comprehensive Substance Abuse Treatment Model consists of early intervention, treatment and continuing care, which focuses on the client's specific needs. Ideally, the client receives treatment through a "one-stop" approach, which involves providing substance abuse treatment services in conjunction with other ancillary services.

Some of the major focus in the CSAT model are as follows:

- Treatment begins with an intake and assessment protocol for each patient, which includes:
    - medical examination
    - substance abuse history
    - psychosocial evaluation
    - psychiatric evaluation, when warranted
    - review of the patient's socioeconomic status, educational attainment level, family functioning, cultural/ethnic factors, peer influence, anti-social behavior, antisocial attitudes, mental and emotional distress, strengths and resources.
- Where intake cannot be accomplished at the time the client presents for treatment, limited intervention or pre-admission contact must be maintained.
- Emphasis is on providing appropriate pharmacotherapeutic interventions by qualified medical/psychiatric practitioners when needed.
- Other essential components of CSAT's Comprehensive Substance Abuse Treatment Model include:
    - Provision of preventive and primary medical care and/or referral linkages for these services.
    - Testing for communicable diseases -- Hepatitis, retro-virus, tuberculosis, HIV/AIDS, syphilis, gonorrhea and other STDs.
    - Initial and random urine testing, as appropriate.
    - Basic substance abuse counseling and psychological counseling (provided by certified professionals) that address families and significant others.
    - Practical life skills training.
    - Nutritional and general health education and counseling.
    - Peer/support group forums.
    - Family planning and contraception counseling and education.
    - Vocational and educational evaluation, counseling and training.
    - Social activities.
    - Transportation services.
    - Provision of child care at the treatment facility.

A full range of substance abuse services is needed which would include a continuum from prevention to continuing care. This is well illustrated by the State of Oregon's "Continuum of Alcohol and Drug Services," which identifies how service strategies for prevention, intervention, treatment, and support may correspond to clients' usage levels, within the range of non-use, experimental use, frequent use, regular use, dependency, recovery and sobriety.

Continuum of Alcohol and Drug Services



This model emphasizes the importance of matching treatment level to problem level and having an appropriate continuum of services available.

CURRENT LEVEL OF ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES
(State FY 1993, Federal FY 1992)

The Alcohol and Drug Abuse Division (ADAD), Department of Health funds treatment services mainly comprised of adult outpatient, adolescent outpatient, adult residential, adolescent residential, adult social detoxification, and methadone detoxification. Some services are specifically targeted to special populations such as Native Hawaiians, mentally ill substance abusers, injection drug users, and pregnant women and women with and without children. All treatment services funded by ADAD are contracted out to private providers.

A. SERVICES FOR ADOLESCENTS

1. Outpatient Treatment Services

ADAD contracts with private non-profit agencies to deliver adolescent outpatient services. Services are delivered primarily within public schools during school hours as well as after school. In State FY 93, approximately 1,273 adolescents received outpatient services on the islands of Hawaii, Maui, Kauai, and Oahu.

a. Oahu

Hina Mauka "Teen Care": school-based treatment at Kahuku High, Olomana High, Castle High, Kalani High and Pearl City High ($474,187 State funds + $65,471 Federal funds).

Waianae Coast Comprehensive Mental Health Center: general outpatient treatment services ($146,801 State funds).

Young Men's Christian Association of Honolulu: school and community based treatment in Diamond Head, Kalihi-Palama, Leeward, and Central Oahu areas ($422,907 State funds + $138,237 Federal funds). Schools include McKinley High, Kaimuki High, Roosevelt High, Moanalua High, Aiea High, Farrington High, Campbell High and Waipahu High.

b. Hawaii

Castle Medical Center: treatment at Pahoa High, Waiakea High, Ka'u High, and Konawaena High and Intermediate ($135,000 State funds).

c. Maui

Maui Youth and Family Services: general outpatient treatment services at Lahainaluna High, Baldwin High, Maui High, Kalama Intermediate and Mauiwaina Intermediate ($141,738 State funds).

d. Kauai

Kauai YWCA: school and community based outpatient treatment services at Kapaa High and Intermediate, Kauai High and Intermediate and Waimea High ($111,366 State funds).

2. Residential Treatment Services

ADAD contracts with private agencies to deliver adolescent residential treatment. For State FY 93, Oahu has only federally funded residential services targeted specifically for adolescents. State funded services are available on Hawaii, Maui, and Kauai. In FY 93, approximately 140 adolescents will receive services.

a. Oahu

Castle Medical Center: $273,750 Federal funds.

b. Hawaii

Big Island Substance Abuse Council: $430,000 State funds.

c. Maui

Aloha House: $246,375 State funds.

d. Kauai

Serenity House: $200,750 State funds. (Suspended pending re-establishment after Hurricane Iniki, funds being used for adolescent outpatient treatment on Kauai.)

B. SPECIAL POPULATION - ADDICTED WOMEN AND THEIR CHILDREN

1. Salvation Army - Hale O Ka Ohana: residential treatment for adolescent mothers and their children ($187,149 State funds + $100,000 Federal funds).

2. Salvation Army - Women's Way: residential treatment for adult mothers and their children ($299,975 State funds + $93,936 Federal funds).

C. SERVICES FOR ADULTS

1. Outpatient Treatment Services

Adult outpatient treatment services are available through contracts with private non-profit agencies on Hawaii, Maui, Molokai, Kauai, and Oahu.

a. Oahu

Castle Medical Center: outpatient treatment. Facilities are located in Leeward, Central, and Windward Oahu ($211,524 State funds + $15,933 Federal funds).

Drug Addiction Services of Hawaii, Inc.: outpatient methadone detoxification and maintenance with priority for pregnant women intravenous drug users ($470,112 State funds + $315,4000 Federal funds).

Drug Addiction Services of Hawaii, Inc.: outpatient treatment for intravenous drug users ($100,000 Federal funds).

Hale Ola Ho'opakolea: outpatient treatment specific for Native Hawaiians ($111,790 Federal funds).

Institute for Human Services: adult outpatient intervention for the homeless ($42,000 Federal funds).

Salvation Army ATS: outpatient treatment ($87,478 State funds + $49,772 Federal funds).

St. Francis Medical Center: outpatient treatment program ($4,462 State funds).

St. Francis Medical Center (W.I.S.H.): outreach to women: ($192,623 Federal funds).

Waianae Coast Community Mental Health Center, Inc.: outpatient treatment program ($85,000 State funds + $45,520 Federal funds).

b. Hawaii

Castle Medical Center: outpatient treatment. One facility is located in Hilo and one located in Kona ($141,014 State Funds + $10,626 Federal funds).

c. Maui

Aloha House: outpatient treatment ($75,660 State funds).

d. Molokai

Molokai Community Services Council: outpatient intervention/treatment ($180,000 Federal funds).

e. Kauai

Castle Medical Center: outpatient program ($56,146 State funds + $20,118 Federal funds).

2. Residential Treatment Services

Adult residential treatment is a 24-hour a day, 7-day a week alcohol and other drug free program. Treatment services are located on Hawaii, Maui, Kauai and Oahu.

a. Oahu

Hawaii Addiction Center: residential treatment for Native Hawaiians ($281,050 Federal funds).

Hawaii Alcoholism Foundation: residential treatment services for men ($149,569 State funds + $23,210 Federal funds).

Ohana Hale: residential treatment for men ($52,402 State funds).

Salvation Army - Eureka House: residential treatment for men ($71,856 State funds + $353,377 Federal funds).

Salvation Army - Alcohol Treatment Services (Coed): residential treatment ($79,362 State funds + $108,102 Federal funds).

St. Francis Medical Center - WATCH: residential treatment for women ($218,534 State funds + $71,901 Federal funds).

b. Hawaii

Big Island Substance Abuse Council: residential treatment ($243,752 State funds + $64,048 Federal funds).

Family Support Services of West Hawaii: (Bridge House) - adult interim supported living services ($60,000 Federal funds).

c. **Maui**

Aloha House: residential treatment ($110,467 State funds + $84,548 Federal funds).

d. **Kauai**

Serenity House: residential treatment ($98,175 State funds).

3. **Social Detoxification Services**

Social detoxification residential services are designed to safely withdraw people primarily from alcohol in a non-medical setting.

The Salvation Army Addiction Treatment Services, located on Oahu, operates the only social detoxification program in the state ($267,042 State funds + $102,299 Federal funds).

D. MENTALLY ILL/SUBSTANCE ABUSERS

1. **Po'ailani, Inc.:** residential treatment for clients who have a dual diagnosis of mental illness and substance abuse ($117,104 State funds).

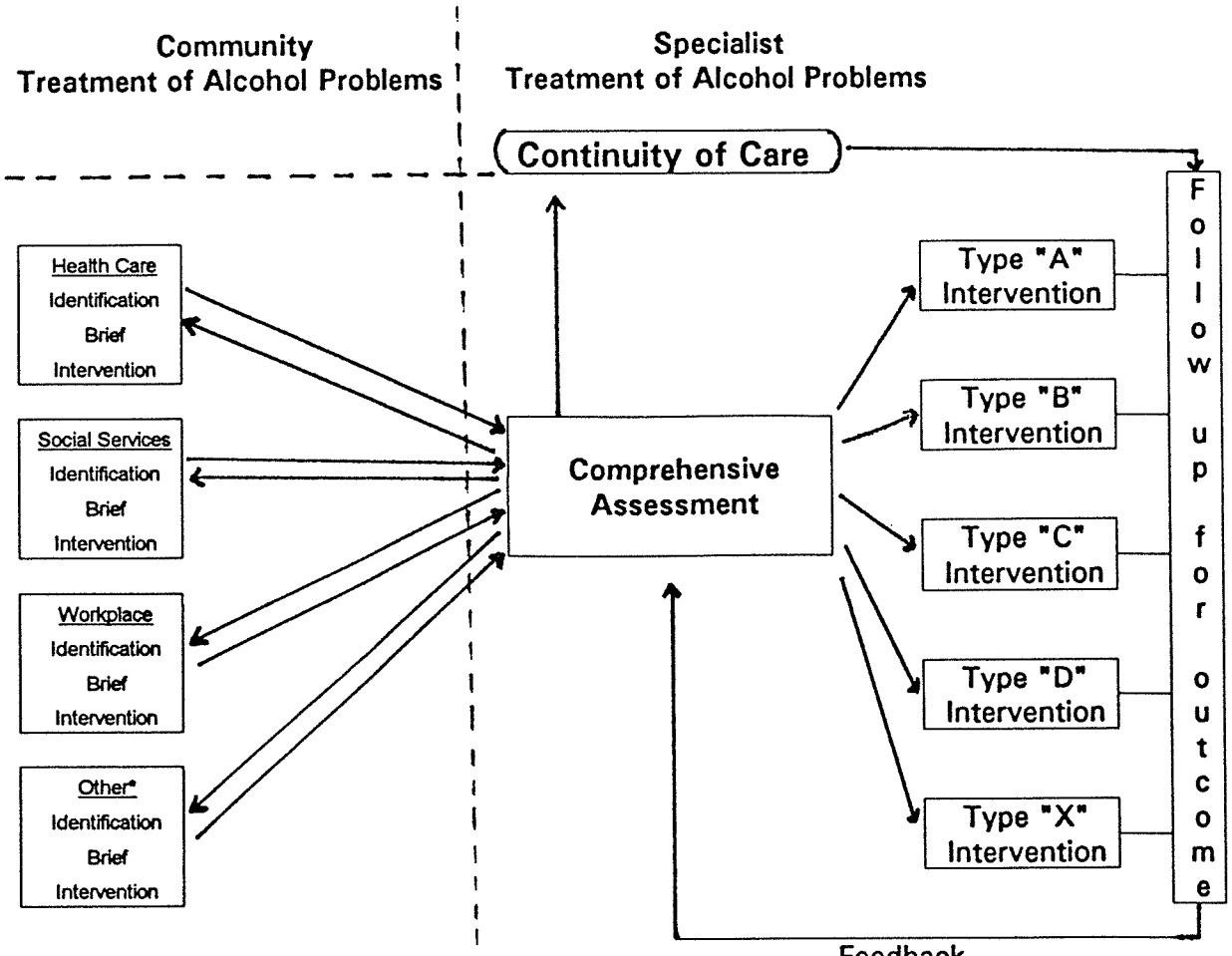
2. **Queen's Medical Center:** outpatient treatment for adults who have a dual diagnosis of mental illness and substance abuse ($127,857 State funds).

E. ANCILLARY SERVICES

Oxford House, Inc.: administration of the revolving loan fund for group recovery homes and technical assistance for these homes ($55,000 Federal funds).

The Ideal System

In designing a treatment system consisting of integrated parts, the Committee for the Study of Treatment and Rehabilitation Services for Alcoholism and Alcohol Abuse, which was commissioned by the Institute of Medicine, Division of Mental Health and Behavioral Medicine, issued its report -- Broadening the Base of Treatment for Alcohol Problems in 1990. The committee presents a "vision" of the system toward which treatment is evolving. Although the vision is limited to alcohol, it is also applicable to other drugs. This vision is depicted in the following illustration/schema:



*Other = Education, Criminal Justice, etc.

Figure 1-1 The committee's view of the evolving treatment system. All persons seeking services from community agencies are screened for alcohol problems. A brief intervention is provided by agency personnel for persons with mild or moderate problems. Persons with substantial or severe problems are referred for a specialized comprehensive assessment. Where treatment is indicated they are matched to the most appropriate specialized type of intervention. The outcome of treatment is determined, and feedback of outcome information is used to improve the matching guidelines. Continuity of care is provided as required to guide individuals through the treatment system.

On the left of the diagram appears that portion of the treatment system that is optimally located within various agencies and organizations in the community that provide general health, education and welfare functions. The task of this community services sector is to (a) identify those individuals within it who have substance abuse problems; (b) provide a brief intervention for persons who have mild or moderate substance abuse problems; and (c) refer to specialized treatment those persons with substantial or severe substance abuse problems, or for whom a brief intervention has proven insufficient. This model emphasizes that the operational location of the community role in treatment is diverse; it is partly in the health care sector, partly in the social services sector, and partly in the work-place, in educational settings, and in the criminal justice arena. Implementation of this aspect of the system broadens its base substantially and is more related to the training of personnel in relevant techniques than to the coalescence of treatment programs.

Specialized substance abuse treatment is shown on the right side of the diagram and is concerned with persons who have substantial or severe substance abuse problems, as well as other persons for whom a brief intervention has not proven sufficient. As the diagram indicates, all persons who are referred are first provided with comprehensive assessment and on that basis are matched to one or more of a variety of available specialized substance abuse programs.

As the arrows indicate, outcome determination and redirection of the individual are the result of a process of reassessment. After treatment, follow-up interviews are conducted to determine the outcome of treatment. If individuals have achieved a positive outcome, no further therapeutic attention may be necessary. If the outcome has not been satisfactory, further treatment may be indicated, perhaps of a different kind.

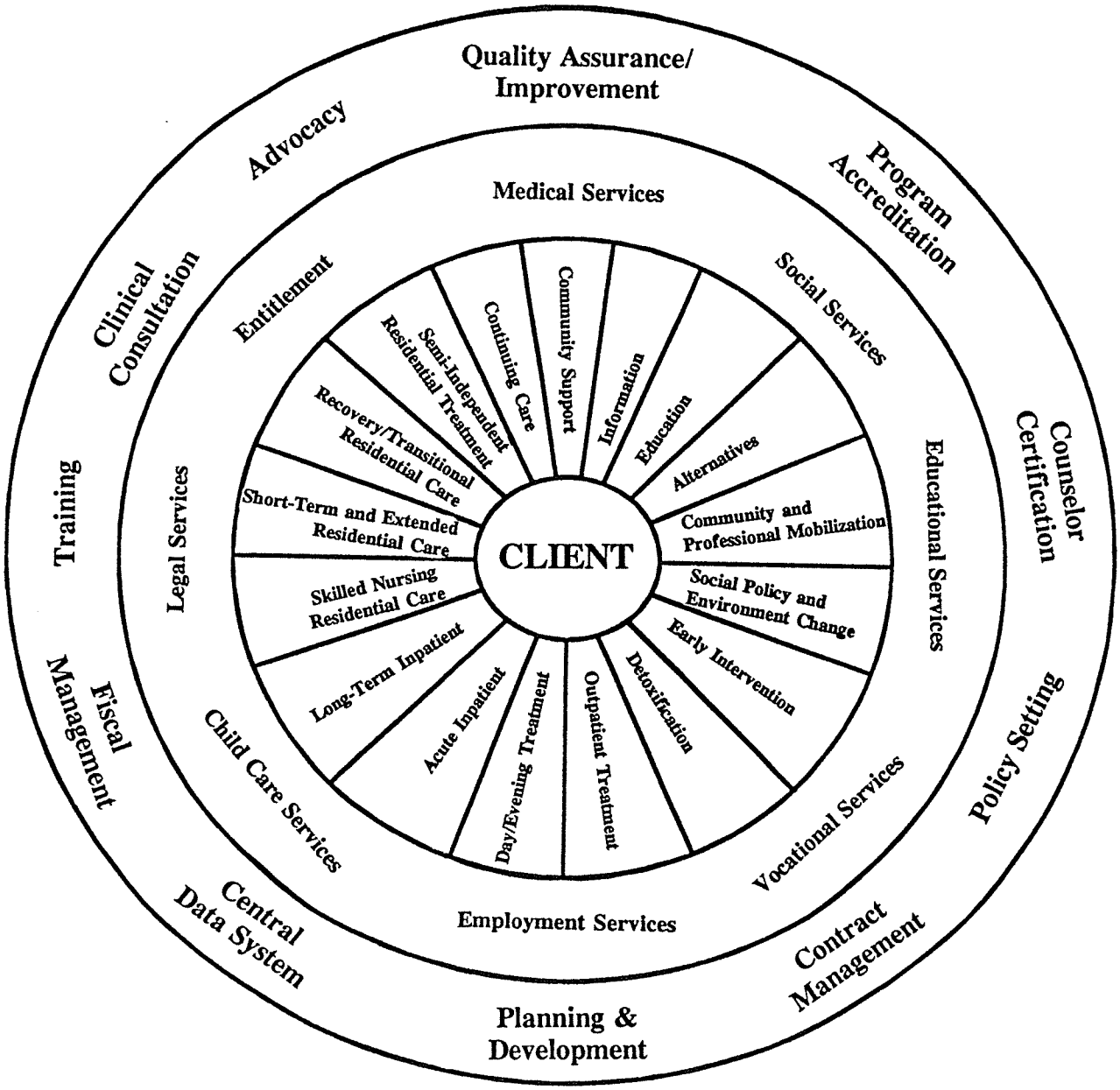
The determination of outcome provides a crucial feedback function of the treatment system. Feedback allows the system to correct for any lack of treatment success, perhaps its most obvious function. But it also provides, even in instances in which treatment is successful, an ongoing check on the matching guidelines used to select treatment so that the guidelines can be continually reexamined and confirmed or modified in the light of known outcomes.

One further function that becomes increasingly important when a relatively more complex system is approached by individuals with substantial to severe problems is **continuity of care.** Although some individuals may be quite capable of negotiating the system on their own, others will be unable to do so. This determination can be made as part of the pretreatment assessment, and appropriate steps can be taken to provide for continuity, either through the use of special personnel (expediters, case managers, ombudsmen, patient advocates, etc.) or by other methods. There is also a need to assure continuity of care between the treatment system and treatment in the community; for the most part this task can be undertaken by community providers.

CSAT and The Institute of Medicine emphasize the importance of comprehensive, individualized, cost efficient and effective services implemented by a wide range of well trained service providers. Furthermore, ongoing monitoring, peer review, evaluation and refinement of

services provide the linkage between clients and the comprehensive care needed to support recovery.

As depicted in the following diagram, the aforementioned conceptual frameworks have been synthesized in the formulation of the ADAD system of services, which is based on a holistic, client-centered approach to service delivery. The ADAD illustration consists of four concentric circles that represent the system support services needed, the various client support or ancillary services essential to successful treatment and recovery and the components of care including prevention, intervention and treatment services and the client him/herself.



The System Support Services are administrative functions which support operational or program entities and ensure service quality. The functions include: program accreditation, counselor certification, policy setting, contract management, planning and development, a centralized data collection system, fiscal management, training, clinical consultation, advocacy and quality assurance/improvement.

Client support or ancillary services provide clients with assistance in or access to a comprehensive range of support services: medical services, social services, educational services, vocational services, employment services, child care services, legal services, and information and/or application(s) assistance for entitlement programs. These services are intended to provide the client with the appropriate long- and short-term assistance for entry into treatment, as well as to ensure successful post-treatment transition. It is through the interaction between the clinician or case manager and client that appropriate referrals to other specialized provider agencies are made to facilitate recovery and subsequent transition.

Most directly impacting the client are some of the components of care that span the wide range of individual needs that must be addressed in substance abuse prevention and treatment: information, education, alternatives, community and professional mobilization, social policy and environmental change, early intervention, detoxification, outpatient treatment, day/evening treatment, acute inpatient, long-term inpatient, skilled nursing residential care, short-term and extended residential care, recovery/transitional residential care, semi-independent residential treatment, continuing care and community support. As earlier stated, "one size does not fit all." Thus, treatment services necessarily range between an unrestricted outpatient setting and long-term inpatient care.

The ADAD model, like the models discussed before it, is currently an ideal or blueprint for action. The hard work of implementation lies ahead. Although a limited range of specialized services currently exists, more effort needs to be placed on training individuals in health care, educational, human services, and judicial agencies to provide early identification, brief counseling, and appropriate referral. Moreover, primary health care services need to be more adequately integrated with specialized substance abuse services in order to deal with the emerging realities of TB, STD's, HIV, hepatitis, psychiatric problems, and pre-natal and post- partum addiction related difficulties. In addition, a centralized assessment function independent of those programs providing specialized substance abuse services needs to be piloted to determine whether matching clients to appropriate treatment and monitoring can be improved.

In conclusion, many state and federal organizations seem to be designing similar models of what a system of substance abuse services ought to look like. As we approach the year 2000 and the multifaceted problems and issues faced by substance abusers, the ADAD challenge will be to create the kind of system consistent with the proposed model.

TREATMENT GOALS

ADULT SUBSTANCE ABUSE TREATMENT

GOAL:

Reduction of the harm and restoration of life functioning for substance abusing and substance dependent adults by the provision of substance abuse treatment and support services for substance abusing adults and their families.

OBJECTIVE:

A. To provide intensive community based outpatient substance abuse treatment services to adults and their families statewide.

B. To provide substance abuse residential treatment to adults statewide.

C. To provide specialized substance abuse outpatient services to special adult populations including women and Native Hawaiians.

D. To provide specialized substance abuse residential services to special adult populations, including women and Native Hawaiians.

E. To provide adult early intervention substance abuse services on the island of Molokai.

F. To provide substance abuse assessment, referral and case management for homeless substance abusers.

G. To pilot interim community-based supported housing for West Hawaii.

IMPLEMENTATION STRATEGY:

FY 94

1. Maintain current level of adult substance abuse treatment services.

2. Maintain current level of adult early intervention substance abuse services on Molokai.

3. Maintain current level of substance abuse intervention services for the homeless.

4. Continue West Hawaii interim supported housing pilot project.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

There are an estimated minimum of 71,488 adult chronic alcohol and other drug abusers. Current publicly funded treatment is able to serve approximately 1,168 adults in outpatient or residential treatment plus approximately 700 adults in social detoxification. This accounts for less than 3% of those in need of treatment. For FY 94, it is critical to at least maintain current levels of treatment services and work toward treatment on demand.

It has been estimated by the National Association for State Alcohol and Drug Abuse Directors that for every $1 spent on treatment, $11 is saved in other health and human service and criminal justice costs.

ADOLESCENT SUBSTANCE ABUSE TREATMENT

GOAL:

Reduction of the harm and restoration of life functioning for substance abusing and substance dependent adolescents by the provision of substance abuse treatment services for substance abusing adolescents and their families.

OBJECTIVE:

A. To provide intensive community and school-based substance abuse treatment services to adolescents and their families statewide.

B. To provide substance abuse residential treatment services to adolescents statewide.

IMPLEMENTATION STRATEGY:

FY 94

1. At a minimum, maintain current level of adolescent school/community based substance abuse outpatient treatment services.

2. At a minimum, maintain current level of adolescent substance abuse residential treatment services.

3. If funding permits, provide adolescent school/community-based substance abuse treatment service to an additional 500 adolescents.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

There is presently limited capacity to treat substance abusing adolescents. Based on the Department of Education's 1991 Student Use Survey, there are 9,200 adolescents currently in school with severe alcohol and drug problems. With current levels of funding, 1,225 of these adolescents are presently able to be treated. A priority must be to reach and treat these adolescents before they drop out of school. Some adolescents will need intensive residential treatment in order to become alcohol and drug free.

Early treatment can disrupt the addiction process, reduce chronic relapse and preclude the need for more extensive treatment. Family inclusion in treatment can reduce costly placement in residential programs and family disintegration.

For FY 94, it is critical to at least maintain current levels of treatment services and work toward treatment on demand.

ADULT DETOXIFICATION AND FOLLOW THROUGH PROGRAMS

GOAL:

Assurance of availability of a safe, controlled environment to assist chemically intoxicated individuals in their effort to withdraw from the physiological effects of alcohol and other drugs.

OBJECTIVE:

To provide adult detoxification and follow through programs statewide.

IMPLEMENTATION STRATEGY:

FY 94 Provide psychosocial and/or medical detoxification services on at least one Neighbor Island. (This will require additional fiscal resources.)

FY 95 Provide psychosocial and/or medical detox services on additional two Neighbor Islands. (This will require additional fiscal resources.)

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Detoxification is an essential first step for most clients entering a comprehensive system of treatment services. Neighbor Islands have long expressed the need for detoxification services.

Detoxification forms the foundation for further treatment for many, if not most, individuals.

INJECTION DRUG USERS

GOAL:

Reduction of the spreading of AIDS and/or other communicable diseases in high risk substance abusing populations by the provision of treatment for injection drug users.

OBJECTIVE:

Ensure availability of pharmacological and drug free treatment services for injection drug users.

IMPLEMENTATION STRATEGY:

FY 94

1. Maintain current level of methadone services.

2. Maintain current level of drug-free outpatients.

3. Provide outreach to ensure accessibility to treatment services for injection drug users.

4. Provide interim services for injection drug users awaiting admission to treatment within 48 hours of seeking treatment. Interim services are designed to reduce adverse health effects of substance abuse, to promote the health of the individual and to reduce the risk of transmission of disease.

5. Develop and implement a model HIV early intervention service for injection drug users.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Injection drug users are at high risk of being exposed to and transmitting HIV as well as Tuberculosis, Hepatitis and Sexually Transmitted Diseases through needle sharing and risky sexual practices. Injection drug users are one of the fastest growing groups being infected with the HIV virus in Hawaii.

MENTALLY ILL SUBSTANCE ABUSERS

GOAL:

Assurance that substance abusers who also have a mental health problem are identified, supported and receive appropriate care.

OBJECTIVE:

To provide a basic range of services for mentally ill substance abusers.

IMPLEMENTATION STRATEGY:

FY 94

1. Maintain current level of residential treatment program.
2. Maintain current level of day treatment program.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

It has been estimated that there are at least between 3,000 and 5,000 mentally ill substance abusers in Hawaii. These clients frequently are undiagnosed, misdiagnosed and inadequately served. This results in high rates of recidivism for both substance abuse and/or mental health problems. The plan section on mentally ill substance abusers describes in detail programmatic needs of this population.

These services need to be closely collaborated with the Adult Mental Health Division, and the Child and Adolescent Mental Health Division.

PREGNANT ADDICTED WOMEN AND WOMEN WITH CHILDREN

GOAL:

Reduction of the impact of substance abuse on children and families by assuring availability of and access to appropriate treatment services for alcohol and other drug abusing women and their children.

OBJECTIVE:

To provide specialized residential services for addicted women and their children, with priority given to pregnant women.

IMPLEMENTATION STRATEGY:

FY 94

1. Provide residential treatment programs and support services to serve the special needs of alcohol and other drug abusing women and their children, with priority given to pregnant women.

2. Provide residential treatment programs and support services to serve the special needs of alcohol and other drug abusing adolescent women and their children.

3. To provide interim services for pregnant addicted women awaiting admission to treatment within 48 hours after requesting treatment. Interim services are designed to reduce adverse health effects of substance abuse, to promote the health of the individual and to reduce the risk of transmission of disease.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Without substance abuse treatment and parenting skills training for addicted women, in particular pregnant women and women with children, an entire segment of the next generation will be lost. Parenting skills will reduce the risk of child abuse. The human misery and fiscal expense resulting from the intensive needs of these women will be reduced.

Specialized residential treatment will provide homes for both substance using women and their children, thus allowing appropriate diagnosis and treatment for both the women and their children. Interim services will assure that pregnant women have access to primary health services.

RECOVERY GROUP HOMES

GOAL:

Support continuing recovery for substance abusers by assuring access to alcohol and drug free housing.

OBJECTIVE:

To provide special loans for alcohol and drug free housing for recovering individuals as a way to support their recovery process in conformance with Public Law 101-321, Section 1925.

IMPLEMENTATION STRATEGY:

FY 94 Maintain existing network of recovery homes. Expand number of homes, if deemed appropriate.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Many people who have alcohol and drug problems have difficulties maintaining clean and sober, stable living environments in the community. The lack of stable housing increases the risk of relapse into addiction. The recovery group home loan model required by federal statute is an effective way of supporting continued alcohol and drug-free functioning.

SUBSTANCE ABUSE HOTLINE

GOAL:

Improvement of access to the substance abuse treatment system.

OBJECTIVE:

To provide a referral linkage and follow-up service for persons experiencing problems related to injection drug use and/or use of crack, cocaine, crystal methemphetamines, or other addictive drugs.

IMPLEMENTATION STRATEGY:

FY 94 Implement referral and follow-up service.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

There is a need to provide services to facilitate access to treatment for injection drug users and others who are abusing other highly addictive drugs. Many of these kinds of drug abusers need assistance in seeking help for their substance abuse, which may be compounded by suicidal or homicidal thoughts or actual threats, delusional thinking, paranoia, panic, hallucinations, discussions of weapons, domestic violence and criminal problems.

ADMINISTRATION

The Alcohol and Drug Abuse Division's administrative efforts are designed to assure the infrastructure necessary for assessing the substance abuse services needs, developing policy and assuring access to quality community-based services.

ADMINISTRATION
ALCOHOL AND DRUG ABUSE DIVISION

CURRENT LEVEL OF ALCOHOL AND DRUG ABUSE ADMINISTRATION

The administrative sub-system is an essential component within the overall system of substance abuse services. The Alcohol and Drug Abuse Division is responsible for administrative functions in the implementation of all the elements of this sub-system, which include the development and implementation of the following:

1. **Policy Formulation** - Recommend principles, priorities and initiatives to be used by elected and appointed public officials, within the Departments and the Legislature to address the problems associated with substance abuse.

2. **Legislative Action** - Provide leadership in the legislative process to assure an integrated system and provide the necessary resources to plan, develop and implement such a system, which enhances and expands the full continuum of services.

3. **Community Relations and Participation** - Initiate and maintain contact with community groups interested in issues related to substance abuse and its consequences to establish on-going and open communication and encourage participation in order for public and private sector agencies to be responsive to community needs. As statutorily defined, areas where collaborative efforts are necessary include: (a) establishing of policy, (b) planning, (c) legislative activities, and (d) standard setting.

4. **Coordination** - As statutorily required, maintain an overview of all programs, services, research and educational activities related to substance abuse and promote cooperative working relationships among organizations, programs and/or groups.

5. **Planning** - Identification of needs, problem solving, and setting direction for action based on the consensus of common values, agreement upon planning assumptions and a commitment for follow-through. This is required by statute.

6. **Financing** - includes the following:

    a. **Budgeting** - Identification and justification of resources required to implement the plan for statewide substance abuse prevention and treatment services.

    b. **Grants/Contract Management** - Monitor and evaluate programs and services within the service delivery system of contracted providers to meet identified needs for flexible, quality service provision that no one agency can alone provide.

c. **Reimbursement Mechanisms** - Identify programs that are responsible for paying for substance abuse treatment services and assuring that the financial responsibilities are being fulfilled, improving the mechanisms and timing for reimbursements, and developing, assessing and implementing alternative methods of reimbursement.

7. Technical Assistance - Provide technical assistance and guidance required at the service delivery level to improve professional standards in the field of substance abuse treatment service delivery. This requires ADAD staff to maintain expertise in the latest developments in the continuum of service delivery, the findings in current research, new models of service delivery, and current political trends; as well as process skills, teaching skills, clinical supervision, clinical consultation, and administrative consultation to assist in the development and maintenance of an effective system.

8. Accreditation/Certification - Accreditation substance abuse prevention and treatment programs and the certification of substance abuse counselors and program administrators to assure the provision of appropriate, high quality services. This is required by statute.

9. Data and Information - Develop and maintain a high quality data and information system which is essential for planning, development and evaluation functions required by statute. The data system serves as a centralized data base for the purposes of: identifying clients and for demographic surveillance; an interactive system that will allow the tracking of service provision; and as a mechanism for evaluation of service utilization, client outcomes, and system functions.

10 Quality Assurance - Assure professional accountability in providing quality services based on the philosophy of education for and promotion of high quality services as the impetus for designing quality assurance programs. This includes developing standards in a cooperative effort by the service providers and the Alcohol and Drug Abuse Division, developing methods of monitoring and evaluation with the intent of: identifying areas for professional education, training, and technical assistance; and developing mechanisms for requesting technical assistance, education and training in order to improve quality of services.

CURRENT CAPACITY

To carry out its administrative functions and to meet its responsibilities, ADAD currently has 30.5 (28.5 permanent and 2.0 temporary) authorized positions divided into the Division staff, the Community and Consultative Services Branch (CCSB), and the Program Development Services Office (PDSO). Staffing costs are funded by a combination of state and federal sources.

Of the authorized positions, six are administration: Division Chief(EM 07), Public Health Administrative Officer (SR 24), Secretary III (SR 16), two Accountant III (SR 20) positions and an Account Clerk III (SR 10) position. In 1992, the Division Chief was classified at the EM 07 level, and was filled on a permanent basis. The Secretary III position, which supports the Division Chief, was also filled on a permanent basis.

As of March 1, 1993, 28.5 of the 30.5 authorized positions are filled. These include a Program Specialist V (SR 24) position to head the PDSO, and within the same office, a Secretary II (SR 14) and Clerk Typist II (SR 08). The Research and Statistics Unit is staffed by a Research Statistician IV (SR 22), a Research Statistician III (SR 20), and a Statistical Clerk I (SR 10) to implement and maintain the needed data and information system.

Other staff in the PDSO include six Program Specialists IV (SR 22), one of which is a temporary, federally-funded position. These positions are responsible for carrying out certification and accreditation activities, and developing treatment and prevention programs. The temporary Program Specialist IV serves as the sole statewide Prevention Coordinator. Also within the PDSO is a Planner V (SR 24) position.

The remaining positions are assigned to the CCSB. Positions include a Mental Health Supervisor III (SR 28), who is the CCSB Branch Chief; a Clinical Psychologist VII position which provides clinical consultation and training in addition to other planning, coordinating and contract management duties; a Clinical Psychologist VII (SR 28) position; and five Program Specialists IV (SR 22) positions. Two of the Program Specialist positions are federally funded and three are state funded. These positions are primarily responsible for all aspects of contract management. In addition, a Training Coordinator (SR 22) maintains a training network for substance abuse professionals, caregivers and community helpers. CCSB support staff positions include a Secretary II (SR 14) and two Clerk Typists II (SR 08).

ADMINISTRATION
GOALS

PLANNING

GOAL:

Establishment of a comprehensive statewide substance abuse plan including short and long range statewide treatment and prevention plans in accordance with the latest information, trends and identified needs.

OBJECTIVE:

To provide community-based planning for a system of alcohol and drug abuse prevention and treatment services.

IMPLEMENTATION STRATEGY:

FY 94 Maintain and improve community-based planning efforts statewide.

FY 95 Same as above.

FY 96 Same as above.

FY 97 Same as above.

RATIONALE:

There needs to be a systematic ongoing process for capturing and synthesizing information from a variety of sources in order to establish priorities and maintain a comprehensive, responsive, integrated array of services. Without adequate planning capacity, decisions will continue to be made on the basis of whim, fad and political expediency.

It is critical to develop and update the statewide plan for alcohol and other drug abuse; coordinate with other state and community agencies; assure the presence of necessary data and other information needed for decision making; analyze such data; conduct focus groups every year (including one on each neighbor island) to assure representation in the planning process; present information to managers responsible for decision making; assist managers in analyzing alternative solutions; review progress and update plan annually; and cooperate in the development of the Department of Health's functional state plan.

ACCREDITATION

GOAL:

Assurance of the provision of the highest quality substance abuse programs, including prevention and treatment.

OBJECTIVE:

To increase capacity to accredit substance abuse programs.

IMPLEMENTATION STRATEGY:

FY 94 Ensure that 50% of all agencies contracted by the State of Hawaii for substance abuse treatment services meet substance abuse accreditation standards.

FY 95 Ensure that 75% of all agencies contracted by the State of Hawaii for substance abuse treatment services meet substance abuse accreditation standards.

FY 96 Ensure that 90% of all agencies contracted by the State of Hawaii for substance abuse treatment services meet substance abuse accreditation standards.

FY 97 Ensure that 98% of all agencies contracted by the State of Hawaii for substance abuse treatment services meet substance abuse accreditation standards.

RATIONALE:

Accreditation standards and an accreditation process are essential mechanisms for ensuring that clients in state funded facilities are receiving quality services. This function is required by HRS 321-193.

This objective would result in a review and updated accreditation standards to keep abreast of current trends and technology; providing technical assistance to agencies to help them improve the quality of their programs; integrating with both planning and training in the improvement of substance abuse prevention and treatment programs; and providing the technical assistance needed by programs to accreditation standards.

CERTIFICATION

GOAL:

Assurance of the provision of the highest quality substance abuse services, including prevention and treatment.

OBJECTIVE:

To increase existing capacity to certify substance abuse counselors and administrators.

IMPLEMENTATION STRATEGY:

FY 94

1. Improve certification examination process.

2. Develop capacity to provide certification examination twice a year.

FY 95 Review and revise the certification process to incorporate new technologies and related standards.

FY 96 Same as above.

FY 97 Same as above.

RATIONALE:

Currently, certification examinations are administered once a year, which is inadequate given the numbers of people needing to be certified and the shortage of certified counselors and administrators. The Department is statutorily mandated by HRS 321-193 to do certification. Only certified counselors are eligible to perform DUI assessments. Growth in the numbers of programs and size of the substance abuse problem makes an increased counselor and administrator capacity necessary.

The Certification Unit is responsible for the ongoing processing of substance abuse counselor and program administrator certification; updating standards, rules, policies and procedures, including integration with developing national certification process; administering an application and testing process; developing reciprocity agreements with other states; integrating with training networks to assure that appropriate training is available; and integrating with accreditation staff to assure improved quality of programs.

CONTRACTS ACCOUNTABILITY

GOAL:

Assurance of the provision of the highest quality substance abuse services by managing and accounting for substance abuse purchase of services contracts which form the system of substance abuse services in Hawaii.

OBJECTIVE:

A. To manage and maintain accountability for ADAD contracted services.

B. To implement and maintain Independent Peer Review as stipulated in the federal Substance Abuse Prevention and Treatment Block Grant.

IMPLEMENTATION STRATEGY:

FY 94

1. Continue to maintain and improve the mechanism for contract management, including increased contract monitoring.

2. Continue to implement and refine Independent Peer Review.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Developing a competent management and accountability process can ensure that the Department of Health and programs become more accountable for the quantity and quality of services they deliver.

The volume of contracts and the amount of state and federal funds, has increased so that currently the Division is responsible for twice the amount of funds as in FY 1991.

Management and accountability for contracted services involves: (1) development of RFP's, (2) technical review of proposals, (3) contract development, (4) monitoring for compliance and performance indicators, (5) technical assistance as needed; and (6) assistance with integration with other state departments purchasing substance abuse and related services.

TRAINING

GOAL:

Assurance of an adequate supply of high quality professionals to deliver substance abuse services statewide.

OBJECTIVE:

To provide training activities for addiction counselors, potential counselors, collateral professionals and paraprofessionals.

IMPLEMENTATION STRATEGY:

FY 94 Maintain coordinated training activities statewide.

FY 95 Same as above.

FY 96 Same as above.

FY 97 Same as above.

RATIONALE:

There still remains a critical shortage of qualified professionals and paraprofessionals in the addictions field. This shortage is expected to become more critical in the next few years as a result of the growing severity of the substance abuse problems. There is a critical need to ensure that current professionals and paraprofessionals are kept abreast of the latest effective treatment methodologies and that efforts are made to attract additional well-trained manpower to the substance abuse field.

Provision of training activities involves developing a training network for addictions counselors, collateral professionals and para-professionals; completing a training needs assessment biannually; developing and updating a statewide training plan; developing training sites and curricula; providing a variety of workshops/classes for target populations; developing methods for evaluating training programs; and coordinating training offered by contracted agencies.

PREVENTION

GOAL:

Strengthen the state's prevention efforts by promoting cooperative relationships between organizations, programs or groups and leveraging of federal and other non-state funds.

OBJECTIVE:

To increase capacity in the area of both the coordination of prevention and the ability to access federal and other non-state prevention funds.

IMPLEMENTATION STRATEGY:

FY 94 Improve and expand mechanisms and networks for statewide substance abuse prevention coordination and prevention program development activities.

FY 95 Review strategy and revise as appropriate.

FY 96 Review strategy and revise as appropriate.

FY 97 Review strategy and revise as appropriate.

RATIONALE:

Supporting the continued development and coordination of a statewide, community based prevention effort which involves youth, parents, schools and community members is necessary in order to address the serious alcohol and other drug problems in Hawaii.

Coordination involves coordinating statewide substance abuse prevention services as per HRS Chapter 321; working with agencies and communities to forge alliances for the promotion of healthy social and physical environments; advocating for prevention-related legislation; evaluating statewide prevention programs annually; providing technical assistance and/or writing grants to access federal or other funding; providing input to communities on latest effective prevention strategies; collaborating with other statewide agencies including the Department of Education, the Office of Children and Youth, the Office of Youth Services, and the Office of Hawaiian Affairs to provide comprehensive integrated prevention strategy.

HIV/AIDS, TUBERCULOSIS AND OTHER COMMUNICABLE DISEASES

GOAL:

Assure that effective coordination and planning is established for treatment of substance abusers who are also at risk for HIV/AIDS, Tuberculosis and other communicable diseases.

OBJECTIVE:

To coordinate primary health care with appropriate state and private agencies.

IMPLEMENTATION STRATEGY:

FY 94 Establish a full-time Registered Professional Nurse IV at ADAD. (This will require additional funding).

FY 95 Maintain RPN IV position.

FY 96 Same as above.

FY 97 Same as above.

RATIONALE:

Access to primary health care, advocacy, education of substance abuse treatment providers and coordination with current state planning efforts to address the multi-health needs of the substance using and abusing population require one full time staff.

The RPN IV will coordinate TB education, HIV education and AIDS assessment and counseling for substance abuse programs; provide technical assistance related to HIV, TB and substance abuse to all agencies funded by ADAD; perform a needs assessment relative to need for services in this area; collaborate with Communicable Diseases Division, TB Branch, Governor's Committee on AIDS, and HIV Statewide Coordinators; and conduct research.

HAWAII EMERGENCY EPISODE DATA SYSTEM (HEED)

GOAL:

Identification of specific substance use and abuse in Hawaii.

OBJECTIVE:

To establish an alcohol and drug abuse data system in a minimum of twelve of Hawaii's hospital emergency rooms to provide information to be used for the identification of the nature, trends, scope and severity of current substance abuse problems.

IMPLEMENTATION STRATEGY:

FY 94 Maintain the Hawaii Emergency Episode Data System (HEED).

FY 95 Same as above.

FY 96 Same as above.

FY 97 Same as above.

RATIONALE:

Drug abuse is a major national and international problem. There is a need for consistent, accurate data that can be used to monitor drug abuse trends and to identify new drugs of abuse and new combinations of drugs so that effective intervention and prevention programs can be developed. The ability to compare data over time and from various communities is vital if the drug abuse problem is to be addressed successfully.

HEED is particularly valuable because it:

Is ongoing and thus continually provides current and consistent information;

Identifies specific drug(s), including alcohol, being used;

Will enable us to monitor alcohol and other drug abuse patterns and trends and to detect new abuse entities and new combinations;

Will enable us to assess health hazards associated with alcohol and other drug abuse; and

Will enable us to provide data for State and local alcohol and other drug abuse policy and program planning and evaluation.

RESEARCH AND EVALUATION

GOAL:

Identification of the impact that alcohol and other drug abuse services are having on persons and communities, and determination of the costs/benefits of funds spent on activities to ameliorate alcohol and other drug problems.

OBJECTIVE:

To improve the completeness, accuracy, usefulness and accessibility of data about alcohol and other drug abuse and related social problems for use in assessing program needs and efficiency, and making management, policy, and planning decisions.

IMPLEMENTATION STRATEGY:

Conduct epidemiological studies on prevalence, demographics, trends, risk/protective factors and consequences of abuse, and outcome studies on the effectiveness of services for individuals and communities, cost effectiveness of state programs; disseminate results through a variety of mechanisms, and make recommendations for improving current strategies.

FY 94 Conduct Community Epidemiology Work Group (CEWG) sessions; supporting the Department of Education (DOE) survey; key informant surveys; and Program Effectiveness and Efficiency evaluations.

FY 95 Conduct CEWG, key informant, Program Evaluation.

FY 96 Conduct CEWG, Key Informant, Program Evaluation, support the DOE survey.

FY 97 Conduct CEWG, Key Informant, Household survey, Program Evaluation.

RATIONALE:

In order to provide coordinated, efficient and effective alcohol and other drug services that are appropriate to needs, adequate, timely information regarding existing services, need for services, and service effectiveness is essential

APPENDIX

1991 BEHAVIORAL HEALTH SURVEY HIGHLIGHTS BY SERVICE AREA

CENTRAL OAHU SERVICE AREA

DIAMOND HEAD SERVICE AREA

KALIHI-PALAMA SERVICE AREA

WINDWARD OAHU SERVICE AREA

LEEWARD OAHU SERVICE AREA

WAIANAE SERVICE AREA

MAUI SERVICE AREA

KAUAI SERVICE AREA

EAST HAWAII SERVICE AREA

WEST HAWAII SERVICE AREA

Central Oahu Service Area

For a significant portion of the sampled population, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, were somewhat over-represented in the Central Oahu Service Area sample, and still over 36 percent of all adults surveyed in this area are alcohol drinkers. Of these drinkers, 68.1 percent are social drinkers and 31.9 percent are heavy drinkers, or over 11 percent of the district's population.

Of individuals between the ages of 18 and 21 years, 28.0 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, all are heavy drinkers which suggests a group at serious risk.

Females are more likely to be social drinkers (88.0%), with the exception of the age 45 to 54 group of which 50.0 percent are heavy drinkers. More males are problematic drinkers and males age 25 to 34 and age 55 to 64 are at greater risk for heavy drinking. Heavy drinking is associated with single or divorced individuals, with the less educated, and those in the $12,000 to $39,999 income groups. Groups at lower risk for heavy drinking include: Okinawan, Filipino, and Puerto Rican. Those at higher risk include Hawaiians and Koreans.

In total, 12.5 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 11.1 percent of the adult drinking population meet screening criteria for alcoholism. The characteristics of those most likely to score "alcoholic" on the SMAST group are males, persons aged 20 to 24, or 55 to 64 years of age, divorced or single, with high school or some college to post graduate education, in the $12,000 to $29,000 income groups, and of Portuguese or Korean ethnicity.

Of the respondents, 24.6 percent smoked marijuana at some time and 12.2 percent of those smoke currently, or 3.0 percent of the population. The reported mean age for beginning use of marijuana is 14.9 years among those age 25 and younger and 17.1 years among the age 26 to 45 group.

Of the respondents sampled in this service area, 3.0 percent have used drugs, drugs other than marijuana for non-medical purposes, and 0.5 percent are currently using such substances.

In total, 23.6 percent of the sample are current smokers of tobacco. Of those who smoke now, 53.2 percent are males. Smokers tend to be beer drinkers and social wine drinkers. Over three-quarters of the current marijuana users are current smokers.

Among the 2.5 percent who are uninsured, 60.0 percent both smoke and 60.0 percent drink alcohol. Of the uninsured who drink, all are heavy drinkers.

CHARACTERISTICS OF THE SAMPLE
CENTRAL OAHU SERVICE AREA

Census Population > 18	154,523	72.8%
Census Population - Males (All)	113,017	53.3%
Census Population - Females (All)	99,362	46.8%
Total Sample Size	197	0.1%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	72	36.2	55,937
Non-Drinkers	127	63.8	98,586
Drinkers			
Social Drinkers	49	68.1	38,093
Heavy Drinkers (Binge + Chronic)	23	31.9	17,844
Binge Drinkers	7	9.7	5,426
Chronic Drinkers	16	22.2	12,418
SMAST (scores indicating alcoholism)	8	11.1	6,209
Marijuana Use			
Ever Used	49	24.6	38,013
Current Use (within the past year)	6	3.0	4,636
Drug Use - NOT Marijuana			
Ever Used	6	3.0	4,636
Current Use	1	0.5	773
Tobacco Smoking			
Ever Smoked	95	47.1	72,780
Current Smoker	47	2.6	36,467
Health Insurance			
Uninsured	5	2.5	3,863
Insured	194	97.5	150,660

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Diamond Head Service Area

For a significant portion of the population of the Diamond Head Service Area, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol were somewhat over-represented in this sample, and still nearly 44 percent of all the adults surveyed were alcohol drinkers. Of these, 73.3 percent are social drinkers and nearly 26.7 percent are heavy drinkers.

Forty percent of the individuals between the ages of 18 and 21 years said they had consumed alcohol in the past 30 days. Of those young adults who drink, one half are heavy drinkers which suggests a group at serious risk.

Females are more likely to be social drinkers (85.0%) with the exception of those age 20 to 24 who are more likely to be heavy drinkers. More males are problematic drinkers and males under 35 years of age are at greater risk for heavy drinking. Heavy drinking is associated with single or divorced individuals, with the less educated, and those in the $12,000 to $39,999 income group. Those at higher risk include Caucasians, Hawaiians, Chinese and Japanese.

In total, 7.4 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 9.3 percent of the drinkers meet screening criteria for alcoholism and are in need of treatment services. The most likely to score "alcoholic" on the SMAST are males, persons age 20 to 24 or age 45 to 54, single, with a high school education, in the $40,000 to $49,000 income group, and of Caucasian or Portuguese ethnicity.

Of the respondents to this survey, 28.9 percent smoked marijuana at some time and 22.8 percent of those who have ever used marijuana smoke currently (6.6% of the population).

Of the respondents sampled in this service area, 5.6 percent have used drugs, drugs other than marijuana for non-medical purposes, and 1.5 percent are currently using such substances.

In total, 21.3 percent of the population are current smokers of tobacco.

Among the 7.6 percent who are uninsured, 46.0 percent smoke tobacco and 46.0 percent drink alcohol. Of the uninsured who drink, 28.6 percent are heavy drinkers.

CHARACTERISTICS OF THE SAMPLE
DIAMOND HEAD SERVICE AREA

Census Population > 18	198,630	83.9%
Census Population - Males (All)	115,900	49.0%
Census Population - Females (All)	120,867	51.0%
Total Sample Size	198	0.1%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	86	43.7	86,801
Non-Drinkers	111	56.3	111,819
Drinkers			
Social Drinkers	63	73.3	63,625
Heavy Drinkers (Binge + Chronic)	23	26.7	23,176
Binge Drinkers	8	9.3	8,073
Chronic Drinkers	15	11.4	15,103
SMAST (scores indicating alcoholism)	8	9.3	8,073
Marijuana Use			
Ever Used	57	28.9	57,404
Current Use (within the past year)	13	6.6	13,110
Drug Use - NOT Marijuana			
Ever Used	11	5.6	11,123
Current Use	3	1.5	2,980
Tobacco Smoking			
Ever Smoked	93	47.2	93,308
Current Smoker	42	21.3	42,308
Health Insurance			
Uninsured	15	7.6	15,096
Insured	182	92.4	183,534

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Kalihi-Palama Oahu Service Area

For a significant portion of the population, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, were somewhat over-represented in the Kalihi-Palama Service Area sample, still, nearly 30 percent of those surveyed drink alcohol. Of these, 66.1 percent are social drinkers and nearly 34 percent are heavy drinkers (14.5% of the district's adult population).

Of the individuals age 18 to 20, 33.3 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, all are heavy drinkers which suggests a group at serious risk.

In Kalihi-Palama, females are more likely to be social drinkers (78.9%), except in the age 18 to 34 and age 45 to 54 groups where they are heavy drinkers. All males and females age 18 to 19 were heavy drinkers and males are more likely to be problematic drinkers after age 35. Male chronic drinkers are most likely to be 65 or older. Heavy drinking is associated with single or divorced individuals, with those less educated, and those in the $12,000 to $39,999 income groups. Ethnic groups at lower risk for heavy drinking are Okinawans, Caucasians, Chinese, and Puerto Ricans. Those at higher risk are Hawaiians and Portuguese.

In total, at least 14.5 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. Of the respondents in this survey, 11.3 percent of the males and 2.0 percent of the females, or 16.9 percent of the adult drinking population, meet screening criteria for alcoholism.

Of the respondents to this survey, 19.1 percent smoked marijuana at some time and 10.5 percent of those smoke currently, (2.0% of the population). The reported mean age of the beginning of marijuana use is 14.9 years among those age 25 years and younger and is 18.4 years among the age 25 to 45 group.

Of the respondents sampled in this service area, 4.5 percent have used drugs, drugs other than marijuana for non-medical purposes, and 2.5 percent are currently using such substances.

In total, 21.1 percent of the population are current smokers of tobacco.

Among the 6.5 percent who are uninsured, 30.8 percent both smoke and drink alcohol. Of the uninsured who drink, 16.7 percent are chronic beer drinkers. None of the uninsured report current use any type of drugs including marijuana.

CHARACTERISTICS OF THE SAMPLE
KALIHI-PALAMA SERVICE AREA

Census Population > 18	103,663	73.9%
Census Population - Males (All)	70,471	50.2%
Census Population - Females (All)	69,471	49.8%
Total Sample Size	199	0.2%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	59	29.6	30,684
Non-Drinkers	140	70.6	72,979
Drinkers			
Social Drinkers	39	66.1	20,282
Heavy Drinkers (Binge + Chronic)	20	33.9	10,402
Binge Drinkers	8	13.6	4,173
Chronic Drinkers	12	20.3	6,229
SMAST (scores indicating alcoholism)	10	16.9	5,187
Marijuana Use			
Ever Used	38	19.1	19,800
Current Use (within the past year)	4	2.0	2,073
Drug Use - NOT Marijuana			
Ever Used	9	4.5	4,665
Current Use	5	2.5	2,592
Tobacco Smoking			
Ever Smoked	76	38.2	39,599
Current Smoked	42	21.1	21,873
Health Insurance			
Uninsured	13	6.5	6,738
Insured	186	93.5	96,925

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Windward Oahu Service Area

For a significant portion of the Windward Oahu Service Area population, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol were somewhat over-represented, and still 43.5 percent of those surveyed drank alcohol in the month preceding the survey. Of these drinkers, 69.0 percent are social drinkers, and over 13 percent of the district's population (31.0% of those surveyed who drink alcohol) are heavy drinkers.

One of the individuals in the age 18 to 21 group said he consumed alcohol in the past 30 days. Females are more likely to be social drinkers (81%). However, 25.0 percent of the females over age 65 are heavy drinkers, and 33.3 percent of the females age 25 to 34 are heavy drinkers. More males are problematic drinkers. Males between ages 25 and 34 are at greater risk for heavy drinking. Heavy drinking is associated with single or divorced individuals, with the less educated, and those in the $40,000 to $49,999 income groups.

In total, nearly 9 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 11.4 percent of the males and 3.1 percent of the women in the area, or 9.2 percent of the area's adult drinking population, meet screening criteria for alcoholism. Those groups at lower risk for heavy drinking are Portuguese and Okinawan. Those at higher risk include Japanese, Hawaiian and Chinese.

Of the respondents to this survey, 34.5 percent smoked marijuana at some time and 6.0 percent of the population use the drug currently. The reported mean age for beginning use of marijuana is 15.1 among those age 25 and younger and 17.1 years among the age 26 to 45 group.

Of the respondents sampled in this service area, 7.5 percent have used drugs, drugs other than marijuana for non-medical purposes, and 3.5 percent are currently using such substances.

Of the current drug users, 57.1 percent currently smoke cigarettes, 33.3 percent are heavy beer drinkers and 71.4 percent are current marijuana users.

In total, 18.5 percent of the population are current smokers of tobacco. Among the 4.5 percent of the population without health insurance, 33.3 percent smoke tobacco and another 33.3 percent drink alcohol. Of the uninsured who drink, 66.7 percent are heavy drinkers.

CHARACTERISTICS OF THE SAMPLE
WINDWARD OAHU SERVICE AREA

Census Population > 18	99,632	73.2%
Census Population - Males (All)	70,220	51.6%
Census Population - Females (All)	65,917	48.4%
Total Sample Size	200	0.2%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	87	43.5	43,340
Non-Drinkers	113	56.5	56,292
Drinkers			
Social Drinkers	60	69.0	29,905
Heavy Drinkers (Binge + Chronic)	27	31.0	13,345
Binge Drinkers	7	8.0	3,467
Chronic Drinkers	20	23.0	9,968
SMAST (scores indicating alcoholism)	8	9.2	3,987
Marijuana Use			
Ever Used	69	34.5	34,373
Current Use (within the past year)	12	6.0	5,978
Drug Use - NOT Marijuana			
Ever Used	15	7.5	1,412
Current Use	7	3.5	3,487
Tobacco Smoking			
Ever Smoked	92	45.6	45,432
Current Smoker	37	18.5	18,432
Health Insurance			
Uninsured	9	4.5	4,483
Insured	191	95.5	95,149

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Leeward Oahu Service Area

For a significant portion of the population of the Leeward Oahu Service Area, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, are somewhat over-represented in the Leeward Oahu Service Area sample, and still nearly 36 percent of those surveyed report they use alcohol. Of these, 59.2 percent are social drinkers and over 14 percent of the district's population, (40.8% of all drinkers) are heavy drinkers.

Of the individuals in the sample age 18 and 21, 25.0 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, 50.0 percent are heavy drinkers which suggests a group at serious risk.

Females are more likely to be social drinkers (85.0%), however, 28.6 percent of the female drinkers age 25 to 24 are heavy drinkers. This is significant as this is the child bearing and child rearing age group. More males are problematic drinkers. Males age 25 to 34 and those age 65 and older are at greater risk for heavy drinking. Heavy drinkers are more likely to be single or divorced, with less education, and in the $12,000 to $39,999 income range. The group at lowest risk for heavy drinking appears to be Caucasian, which is not the case statewide. Those at higher risk are Koreans, and Okinawans, which again is not the case statewide.

In total, at least 20.8 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 10.9 percent of the males and 2.8 percent of the females, or 14.1 percent of the adult drinking population in this area meet the screening criteria for alcoholism. The characteristics of those most likely to score "alcoholic" on the SMAST group are males, persons aged 20 to 24, divorced or single, with a high school education, in the $30,000 to $39,999 income groups, and of Korean ethnicity.

Of the respondents sampled, 28.1 percent smoked marijuana at some time and 4.5 percent of those smoke currently. The reported mean age for beginning use of marijuana is 16.4 years among those age 25 and younger and 16.8 years among the age 26 to 45 group.

Of the respondents sampled in this service area, 6.0 percent have used drugs, drugs other than marijuana for non-medical purposes, and 2.0 percent are currently using such substances.

In total, 26.6 percent of the population are current smokers of tobacco.

Among the 2.5 percent who are uninsured, 40.0 percent smoke tobacco and 40.0 percent drink alcohol.

CHARACTERISTICS OF THE SAMPLE
LEEWARD OAHU SERVICE AREA

Census Population > 18	51,023	69.7%
Census Population - Males (All)	37,511	51.2%
Census Population - Females (All)	35,734	48.8%
Total Sample Size	199	0.4%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	71	35.7	18,215
Non-Drinkers	128	64.3	32,808
Drinkers			
Social Drinkers	42	59.2	10,783
Heavy Drinkers (Binge + Chronic)	29	40.8	7,432
Binge Drinkers	10	14.1	2,568
Chronic Drinkers	19	26.8	4,864
SMAST (scores indicating alcoholism)	10	14.1	2,568
Marijuana Use			
Ever Used	56	28.1	14,338
Current Use (within the past year)	9	4.5	2,296
Drug Use - NOT Marijuana			
Ever Used	12	6.0	3,061
Current Use	6	2.0	1,021
Tobacco Smoking			
Ever Smoked	83	41.7	21,277
Current Smoker	53	26.6	13,572
Health Insurance			
Uninsured	5	2.5	1,276
Insured	194	917.5	49,747

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Waianae Oahu Service Area

For a significant portion of the population, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, were somewhat over-represented in the Waianae Service Area sample, and still 39.0 percent of those surveyed were drinkers. Of these drinkers, 39.7 percent are social drinkers and 60.3 percent are heavy drinkers (over 23% of the district's population).

Of the individuals age 18 and 21, 33.3 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, 75.0 percent are heavy drinkers which indicates a group at serious risk.

Both males and females are more likely to be heavy drinkers in nearly every age group category. Males between age 20 and 24 are at greater risk for binge drinking. Heavy drinking is associated with those who are less educated, and those in the higher income groups. Groups at lower risk for heavy drinking include Japanese and Caucasian. Those at higher risk include Hawaiian and Samoan with all others in an average risk group.

In total, at least 18.8 percent of the drinkers in the sample report behaviors ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 16.3 percent of the males and 6.7 percent of the females, or 19.2 percent of the adult drinking population in this area meet the screening criteria for alcoholism.

Of the respondents to this survey, 45.5 percent smoked marijuana at some time and 24.0 percent of those smoke currently (11.0% of the population of the district).

Of the respondents sampled in this service area, 6.5 percent have used drugs, drugs other than marijuana for non-medical purposes, and 2.5 percent are currently using such substances.

In total, 41.0 percent of the population age 18 or older are current smokers of tobacco and among the 10.0 percent who are uninsured, 30.0 percent smoke and another 30.0 percent drink alcohol. Of the uninsured who drink, 33.0 percent are chronic beer drinkers.

CHARACTERISTICS OF THE SAMPLE
WAIANAE SERVICE AREA

Census Population > 18	23,761	63.5%
Census Population - Males (All)	18,875	50.5%
Census Population - Females (All)	18,536	49.5%
Total Sample Size	200	0.8%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	78	39.0	9,267
Non-Drinkers	122	61.0	14,494
Drinkers			
Social Drinkers	31	39.7	3,619
Heavy Drinkers (Binge + Chronic)	47	60.3	5,588
Binge Drinkers	27	34.7	3,216
Chronic Drinkers	20	25.6	2,372
SMAST (scores indicating alcoholism)	15	19.2	1,119
Marijuana Use			
Ever Used	91	45.5	10,811
Current Use (within the past year)	22	11.0	2,614
Drug Use - NOT Marijuana			
Ever Used	13	6.5	1,545
Current Use	5	2.5	594
Tobacco Smoking			
Ever Smoked	115	57.5	13,663
Current Smoker	82	41.0	9,142
Health Insurance			
Uninsured	20	10.0	2,376
Insured	180	90.0	21,385

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Maui Service Area

For a significant portion of the sampled population of the Maui Service Area, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol were somewhat over-represented, still nearly 43 percent of all adults are alcohol drinkers. Of these, 71.8 percent are social drinkers, and over 12.1 percent of the area's population (28.2% of those surveyed who drink) are heavy drinkers.

Of the individuals surveyed between ages 18 and 21, over 50 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, 50.0 percent are heavy drinkers which suggests a group at serious risk.

Females are more likely to be social drinkers (84.8%). However, it is notable that of the female drinkers, 15.2 percent are heavy drinkers. It is also notable that 22.0 percent of the women drinkers in the child-bearing and child-rearing years (ages 25 to 34) and 40.0 percent of the women drinkers age 65 years and older are heavy drinkers. More males are problematic drinkers. Males between 18 and 19 are at greater risk for binge drinking. Male chronic drinkers are most likely to be 35 to 44 years of age. Heavy drinking is associated with individuals who are divorced, who have less education, and those in the under $12,000 and $40,000 to $49,000 income groups. Ethnic groups at lower risk for heavy drinking include Portuguese and Okinawans. Those at higher risk include Hawaiians and Filipinos.

Responses to questions regarding drinking behaviors show that, at least 6.7 percent of the drinkers in this sample report behavior ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 5.4 percent of the males and 5.6 percent of the females, or 4.7 percent of the population meet screening criteria for alcoholism.

Of the respondents, 30.7 percent smoked marijuana at some time and 8.5 percent of the population smoked the drug currently. The reported mean age for beginning use of marijuana is 13.9 years among those age 25 and younger and 17.2 years among the age 26 to 45 group.

Of the respondents sampled in this service area, 11.1 percent have used drugs, drugs other than marijuana for non-medical purposes, and 3.0 percent are currently using such substances.

In total, 28.1 percent of the population are current smokers of tobacco.

Among the 4.5 percent who are uninsured, 77.8 percent smoke tobacco and 45.0 percent drink alcohol. Of the uninsured who drink, 40.0 percent are chronic beer drinkers.

CHARACTERISTICS OF THE SAMPLE
MAUI SERVICE AREA

Census Population > 18	73,621	73.3%
Census Population - Males (All)	51,281	51.0%
Census Population - Females (All)	49,223	48.0%
Total Sample Size	199	0.3%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	85	42.7	31,436
Non-Drinkers	114	57.3	42,182
Drinkers			
Social Drinkers	61	71.8	22,571
Heavy Drinkers (Binge + Chronic)	24	28.2	8,865
Binge Drinkers	6	7.1	2,232
Chronic Drinkers	48	21.2	6,633
SMAST (scores indicating alcoholism)	4	4.7	1,478
Marijuana Use			
Ever Used	61	30.7	22,602
Current Use (within the past year)	17	8.5	6,258
Drug Use - NOT Marijuana			
Ever Used	22	11.1	8,172
Current Use	6	3.0	2,209
Tobacco Smoking			
Ever Smoked	107	53.8	39,608
Current Smoker	56	28.1	20,688
Health Insurance			
Uninsured	9	4.5	3,313
Insured	190	95.5	70,308

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

Kauai Service Area

For a significant portion of the sampled population of the Kauai Service Area, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, were somewhat over-represented, and still over 36 percent of all adults surveyed in this area are alcohol drinkers. Of these drinkers, 68.1 percent are social drinkers and 31.9 are heavy drinkers, (over 11% of Kauai's adult population).

Of the individuals between age 18 and 21, 40.0 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, 50.0 percent are binge or chronic drinkers which suggests a group at serious risk.

Females are more likely to be social drinkers (75.0%). However, 25.0 percent of female drinkers are heavy drinkers, being primarily those in the childbearing and child-rearing age group and those age 65 and older. More males are problematic drinkers. Males between 35 and 54 are at greater risk for heavy drinking. Heavy drinking is associated with divorced individuals, those with less education, and those in the $40,000 to $49,000 income groups. Japanese appear to be at lower risk for heavy drinking and those at higher risk are Puerto Ricans and Hawaiians.

In total, nearly 8 percent of the drinkers in this sample report behavior ("blackouts") that indicates a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 6.3 percent of the males and nearly 3 percent of the females, or 6.9 percent of the adult drinking population meet screening criteria for alcoholism.

Of the respondents, 30.2 percent smoked marijuana at some time, and 13.3 percent of those report they smoke currently (4.0 percent of Kauai's adult population). The reported mean age for beginning use of marijuana is 15.0 years among those age 25 and younger and 17.2 years among the 26 to 45 age group.

Of the respondents sampled in this service area, 6.5 percent have used drugs, drugs other than marijuana for non-medical purposes, and 1.0 percent are currently using such substances.

Among the 3.0 percent who are uninsured, 16.7 percent smoke tobacco and 50.0 percent drink alcohol. Of the uninsured who drink, 66.7 percent are heavy drinkers.

CHARACTERISTICS OF THE SAMPLE
KAUAI SERVICE AREA

Census Population > 18	37,062	72.4%
Census Population - Males (All)	25,951	50.7%
Census Population - Females (All)	25,226	49.3%
Total Sample Size	199	0.5%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	72	36.2	13,416
Non-Drinkers	127	63.8	23,646
Drinkers			
Social Drinkers	49	68.1	9,136
Heavy Drinkers (Binge + Chronic)	23	31.9	4,280
Binge Drinkers	7	9.7	1,301
Chronic Drinkers	16	22.2	2,979
SMAST (scores indicating alcoholism)	5	6.9	926
Marijuana Use			
Ever Used	60	30.2	11,193
Current Use (within the past year)	8	4.0	1,483
Drug Use - NOT Marijuana			
Ever Used	13	6.5	2,409
Current Use	2	1.0	371
Tobacco Smoking			
Ever Smoked	89	43.0	15,937
Current Smoker	40	20.1	7,449
Health Insurance			
Uninsured	6	3.0	1,112
Insured	193	97.0	35,950

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

East Hawaii Service Area

For a significant portion of the population, the consumption of alcohol is a problem. Older individuals, who as a group tend less often to drink alcohol, were somewhat overrepresented in the East Hawaii Service Area sample, and still 41.5 percent of those surveyed were drinkers. Of these drinkers, 58.0 percent are social drinkers and 42.0 percent are heavy drinkers (or 17.4% of the district's population).

Of the individuals between the ages of 18 and 21 years, 50.0 percent said they had consumed alcohol in the past 30 days. Of those young adults who drink, 100.0 percent are heavy drinkers which indicates a group at serious risk.

Females are more likely to be social drinkers (66.7%), however, 33.0 percent are heavy drinkers. More males are problematic drinkers. Males between 18 and 34 are at great risk for binge drinking. Male chronic drinkers are most likely to be 55 years of age and older. Heavy drinking is associated with single or divorced individuals, with those less educated, and with those in the $12,000 to $19,000 and $50,000 to $74,000 income groups. Groups at higher risk include: Portuguese, Hawaiian and Filipino with all others in an average risk group.

In total, at least 9.1 percent of the drinkers in the sample report behaviors ("blackouts") that indicate a need for clinical alcohol assessment services. The scoring of the SMAST reveals that 9.9 percent of the adult drinking population meet the screening criteria for alcoholism.

Of the respondents, 24.1 percent smoked marijuana at some time and 25.0 percent of those smoke currently, or 6.2 percent of the population. The reported mean age for beginning marijuana use is 13.3 years among those age 25 and younger and 16.7 years among the age 26 to 45 group.

Of the respondents in this survey, 6.6 percent have used drugs, drugs other than marijuana for non-medical purposes and 2.6 percent are currently using such substances. In total, 27.2 percent of the population are current smokers of tobacco.

Among the 7.7 percent who are uninsured, 60.0 percent smoke and 53.0 percent drink alcohol. Of the uninsured who drink, 37.5 percent are binge beer drinkers.

CHARACTERISTICS OF THE SAMPLE
EAST HAWAII SERVICE AREA

Census Population > 18	51,525	71.1%
Census Population - Males (All)	36,290	50.1%
Census Population - Females (All)	36,216	49.9%
Total Sample Size	195	0.4%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	81	41.5	21,383
Non-Drinkers	114	58.5	30,142
Drinkers			
Social Drinkers	47	58.0	12,402
Heavy Drinkers (Binge + Chronic)	34	42.0	8,981
Binge Drinkers	16	19.8	4,234
Chronic Drinkers	18	22.2	4,747
SMAST (scores indicating alcoholism)	8	9.9	2,117
Marijuana Use			
Ever Used	47	24.1	12,418
Current Use (within the past year)	12	6.2	3,195
Drug Use - NOT Marijuana			
Ever Used	9	4.6	2,310
Current Use	5	2.6	1,340
Tobacco Smoking			
Ever Smoked	100	51.3	26,432
Current Smoker	53	27.2	14,015
Health Insurance			
Uninsured	15	7.7	3,967
Insured	180	92.3	47,558

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

CHARACTERISTICS OF THE SAMPLE
WEST HAWAII SERVICE AREA

Census Population > 18	34,277	71.7%
Census Population - Males (All)	24,375	50.0%
Census Population - Females (All)	23,463	49.0%
Total Sample Size	197	.6%

Characteristic	n	$\%n_w$	n_w
Alcohol			
Drinkers	111	56.3	19,298
Non-Drinkers	86	43.7	14,979
Drinkers			
Social Drinkers	71	64.0	12,351
Heavy Drinkers (Binge + Chronic)	40	36.0	6,947
Binge Drinkers	5	4.5	868
Chronic Drinkers	35	31.5	6,079
SMAST (scores indicating alcoholism)	10	9.0	1,737
Marijuana Use			
Ever Used	106	53.8	18,441
Current Use (within the past year)	37	18.8	6,444
Drug Use - NOT Marijuana			
Ever Used	33	16.8	5,759
Current Use	13	6.6	2,262
Tobacco Smoking			
Ever Smoked	120	60.1	20,601
Current Smoker	56	28.4	9,735
Health Insurance			
Uninsured	16	8.1	2,776
Insured	181	91.9	31,501

n = sample size
$\%n_w$ = percent weighted to census estimates
n_w = sample size weighted to census estimates

HRS §321-193

[HRS §321-192] Substance abuse program. The department shall establish a substance abuse program in the State under this part. [L 1975, c 190, pt of §2]

§321-193 Duties and responsibilities of department. The department shall:

(1) Coordinate all substance abuse programs including rehabilitation, treatment, education, research, and prevention activities.

(2) Prepare, administer, and supervise the implementation of a state plan for substance abuse which may consist of a plan for alcohol abuse prevention and a plan for drug abuse prevention.

(3) Identify all funds, programs, and resources available in the State, public and private, and from the federal government which are being used or may be used to support substance abuse prevention, rehabilitation, treatment, education, and research activities.

(4) Be the designated agency required by, and receive and administer all available substance abuse funds including but not limited to funds received from, the federal government under Public Law 92-255, Public Law 91-616, Public Law 91-211, and Title IVA and XVI of the Social Security Act or other subsequent acts of Congress which may amend or succeed such acts.

(5) Encourage and coordinate the involvement of private and public agencies in the assessment of substance abuse problems, needs, and resources.

(6) Coordinate the delivery of available funding to public and private agencies for program implementation.

(7) Establish mechanisms and procedures for receiving and evaluating program proposals, providing technical assistance, monitoring programs and securing necessary information from public and private agencies for the purposes of planning, management, and evaluation.

(8) Review the state plan for substance abuse annually for the purpose of evaluation and make necessary amendments to conform with the requirements of federal or state laws.

(9) Do all things necessary to effectuate the purposes of this part.

(10) Certify program administrators, counselors and accredit programs related to substance abuse programs in accordance with rules to be promulgated by the department. [L 1975, c 190, pt of §2; am L 1977, c 108, pt of §1]