

SUBSTANCE USE STATE PLAN

MAY 2023

HAWAII STATE DEPARTMENT OF HEALTH
ALCOHOL AND DRUG ABUSE DIVISION

REVIEW COPY ONLY

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1. EXECUTIVE SUMMARY

The Substance Use State Plan 2022 is a comprehensive statewide, data-driven strategy to guide the Hawai'i State Department of Health, Alcohol and Drug Abuse Division actions over the next five years to promote a culturally appropriate, comprehensive, continuum of care for substance use services. ADAD is tasked with coordinating all substance use programs for the State of Hawai'i. In addition, ADAD is the designated single state agency to receive and administer all substance use funds provided by the state and federal government.

Substance use continues to be a significant public health issue in Hawai'i. Approximately 62.3% of the population over the age of 12 consumed or used illicit drugs or alcohol within the past year (UH PHAC 10). Methamphetamine and cocaine use, abuse, and dependence were higher in Hawai'i than the United States average. Alcohol, marijuana, and prescription drugs without a doctor's prescription had the highest estimated percentage of lifetime use for Hawai'i public high school students.

Methamphetamine and marijuana are the most widely available drugs, with methamphetamine considered the greatest overall threat to the State. Both drugs account for the highest percentage of treatment admissions compared to any other drug for both adults and adolescents. In addition, the threat from fentanyl, an opioid, is rapidly increasing. Since 2019, law enforcement has seen an increased number of drug seizures and emergency room cases involving fentanyl in Hawai'i. Fatal drug related poisonings continue to rise with most of the increase due to methamphetamines, while opioids remain steady. However, since 2016, the composition of opioid-involved deaths has changed from prescription opioids to heroin and synthetics, such as fentanyl.

The priority of the Substance Use State Plan 2022 is to collect and compile a variety of data on the current system of care covering areas of primary care integration and treatment access as well as the intersection of substance use on specific sectors and special populations. Specific sectors covered are mental health, homelessness, criminal justice, juvenile justice, and violence. Special populations covered are pregnant women and women with dependent children, Native Hawaiians, rural communities, and sexual and gender minorities.

Several findings emerged highlighting the gaps and challenges within the existing system of care. Findings by themes are:

- **Data:** There is a need for additional and improved data collection, sharing, and usage.
- **Services:** There is a need for increased collaboration, coordination, and referrals within and across agencies, service providers, and other community partners.
- **Funding:** There is a need for shifts in funding priorities towards programs that improve primary prevention capacity and service delivery to meet the needs of priority populations.
- **Workforce Development:** There is a need for increased recruitment and retention of qualified substance use workforce.

These findings provide the basis for the Substance Use State Plan 2022 Priority Action Items. The Priority Action Items are organized by themes: Data, Administration, Services, Funding, and Workforce Development. Each theme details objectives, activities to address gaps, ADAD's proposed priority actions over the next five years, and potential partnerships.

2. INTRODUCTION

2.1 Purpose

The Substance Use State Plan 2022 is a comprehensive statewide, data driven strategy to guide the Hawai'i State Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) actions over the next five years to promote a culturally appropriate, comprehensive, continuum of care for substance use services.

2.2 State Profile

The State of Hawai'i is an archipelago of 137 islands, with a land area of 6,422.6 square miles, located in the north central Pacific Ocean, approximately 2,400 miles from the continental United States (U.S.). The islands stretch northwest to southeast, from Kure Atoll to the north to Hawai'i Island (Big Island) to the south. There are 8 major islands (Figure 1). Except for Kaho'olawe, the remaining major islands of Ni'i'hau, Kaua'i, O'ahu, Moloka'i, Maui, Lāna'i, and Hawai'i are inhabited.

There are four counties: Kaua'i County (Islands of Kaua'i and Ni'i'hau), City and County of Honolulu (Island of O'ahu and the Northwest Hawaiian Islands, excluding Midway), Maui County (Islands of Lāna'i, Maui, and Moloka'i), and Hawai'i County (Hawai'i Island). The State's Capital, Honolulu, is located on O'ahu.



Figure 1. Map of the Hawaiian Islands (<https://geology.com/county-map/Hawaii.shtml>).

The 2020 Decennial Census reported the State of Hawai'i's resident population of 1,455,271 (Hawaii: 2020 Census). As shown in Table 1, almost three quarters of the State's population resides in the City and County of Honolulu, followed by Hawai'i County, Maui County, and Kaua'i County. As shown in Table 2, the largest percentage racial group, alone or in combination is Asian (56.6%) followed by White (41.9%), Native Hawaiian and Other Pacific Islanders (27.1%), Other (4.4%), Black or African American (3.2%), and American Indians & Alaska Native (2.9%).

Table 1. 2020 Decennial Population and Land Area by State and County.

County	Population	Percentage of Total Population	Land Area (Square miles)
City and County of Honolulu	1,016,508	70%	600.7
Hawai'i County	200,629	14%	4,028.4
Maui County	164,836	11%	1,161.5
Kalawao County*	-	-	12
Kaua'i County	73,298	5%	620
Statewide Total	1,455,271	100%	6,422.6

* Located on the island of Moloka'i, population included in Maui County

Table 2. 2020 Decennial Census Population by Major Race Alone or in Combination by State and County.

Race Alone or In Combination	State	County			
		Honolulu	Hawai'i	Kaua'i	Maui
White	41.9%	36.8%	56.1%	52.5%	51.2%
Black or African American	3.2%	3.8%	2.0%	1.5%	1.8%
American Indian & Alaska Native	2.9%	2.5%	4.2%	3.4%	3.2%
Asian	56.6%	62.2%	41.1%	45.5%	44.4%
Native Hawaiian & Other Pacific Islanders	27.1%	25.6%	34.1%	27.2	28.8
Other	4.4%	4.1%	5.0%	4.5%	5.6%

2.3 The Alcohol and Drug Abuse Division Mission and Overarching Goal

Mission

“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 Hawai'i.”

Overarching Goal

“To prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse, and dependence by assuring an effective, accessible, public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs.”

ADAD is tasked with coordinating all substance use programs including research, treatment, recovery, and prevention activities for the State of Hawai'i. Its efforts are designed to promote a statewide culturally appropriate, comprehensive system of substance use services to meet the treatment and recovery needs of individuals and families, as well as prevention needs of the community.

ADAD is the designated agency to receive and administer all available substance use funds provided by the state and federal government. ADAD is also the Single State Agency to receive and administer the Substance Abuse Prevention and Treatment Block Grant (SABG) funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

2.4 Policy Framework

The Substance Use State Plan 2022 aligns with the overall Hawai'i State Plan, Hawai'i Revised Statutes (HRS) §321, Part XVI, Substance Abuse, the Department's mission and goals, the Department's Strategic Plan, the action plans of the Hawai'i Opioid Initiative (HOI), and the Strategic Plan for Workforce Development.

HRS §226, The Hawai'i State Plan Act

The Hawai'i State Plan is a long-range comprehensive plan that sets forth the goals, objectives, policies, priorities, and implementation measures for the long-term development of the State of Hawai'i. The Substance Use State Plan 2022 is consistent with the following objectives and policies:

HRS §226-20 Objectives and Policies for Socio-Cultural Advancement--Health.

(a) *Planning for the State's socio-cultural advancement with regard to health shall be directed towards achievement of the following objectives:*

(3) *Eliminate health disparities by identifying and addressing social determinants of health.*

(b) *To achieve the health objectives, it shall be the policy of the State to:*

(1) *Provide adequate and accessible services and facilities for the prevention and treatment of physical and mental health problems, including substance abuse.*

HRS §321, Part XVI, Substance Abuse

The Substance Abuse program is codified in HRS §321-191 through §321-198. The Substance Use State Plan 2022 is prepared pursuant to HRS §321-193(2) which requires the preparation of a state plan for substance abuse which may consist of a plan for alcohol abuse prevention and a plan for drug abuse. Additionally, HRS §321-194 requires the Hawai'i Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) to advise the Director of Health on all matters relating to substance abuse including but not limited to the preparation of the state plan for substance abuse. The Substance Use State Plan 2022 implements HRS §321-193(2) in consultation with the HACDACS.

The Hawai'i State Department of Health

The mission of the Hawai'i State Department of Health is "to protect and improve the health and environment for all people in Hawai'i." The goals are to:

- Promote health and well being
- Prevent injury and disease
- Promote healthy lifestyles and workplaces
- Promote the strength and integrity of families and communities

The Hawai'i State Department of Health Strategic Plan: 2015-2018

The Substance Use State Plan 2022 is consistent with the following priorities and objectives from The Hawai'i State Department of Health Strategic Plan: 2015-2018 (now expired):

- *Strategic Priority A: Invest in Healthy Babies and Families*
 - *Objective 1: Reduce substance use and exposure for pregnant mothers.*
 - *Objective 7: Plan for a system of care for children that addresses physical and emotional health.*

- *Strategic Priority B: Take Health to Where People Live, Work, Learn, and Play*
 - *Objective 3: Improve connections between primary care and behavioral health.*
 - *Objective 4: Improve life trajectories for vulnerable persons.*
 - *Objective 5: Partner with communities to identify their needs.*
- *Strategic Priority C: Create a Culture of Health Throughout Hawai'i*
 - *Objective 1: Invest in better mental health.*
 - *Objective 6: Enhance public health communication to influence, educate, and motivate.*
- *Strategic Priority D: Address the Social Determinants of Health*
- *Strategic Priority E: Use Evidence-based Practices and Make Data-Driven Decisions*
- *Strategic Priority F: Improve Core Business Services and Customer Satisfaction*

Hawai'i Opioid Initiative: A Statewide Response for Misuse and Abuse Issues Related to Opioids and Other Substances

The HOI Action Plan provides a roadmap for a focused and sustainable response to opioid and other substances misuse in Hawai'i. The Substance Use State Plan 2022 is consistent with the following focus areas:

Focus Area 1: Treatment Access - Improve and modernize healthcare strategies and access for opioid and other substances misuse treatment and recovery services.

Focus Area 2: Prescriber Education - Improve opioid and related prescribing practices by working with healthcare providers and payers.

Focus Area 3: Data-Informed Decision Making and Evaluation - Implement system-wide routine data collection, sharing and dissemination to increase knowledge and inform practice.

Focus Area 4: Prevention and Public Education - Improve community-based programs and public education to prevent opioid misuse and related harms.

Focus Area 5: Pharmacy-Based Interventions: Increase consumer education and prescription harm management through pharmacy-based strategies.

Focus Area 6: Support for Law Enforcement and First Responders: Coordinate operations and services, support specialized training for first responders and ensure effective laws and policies.

Focus Area 7: Screening, Brief Intervention, and Referral to Treatment (SBIRT): Integrate substance use disorder screening in primary care settings and develop referral and entry system into a continuum of care.

A Strategic Plan for Workforce Development

The Strategic Plan for Workforce Development provides a foundation for workforce development that meets the unique needs of the State (CDFH 5-8).

Goal 1: Align the state with national initiatives to strengthen and expand the behavioral health workforce in order to enhance the availability of prevention and treatment for substance abuse, strengthen the capabilities of the workforce, and promote an infrastructure to support delivery of competent organized services.

Goal 2: To identify and implement workforce development strategies that support the transfer of knowledge, skills, resources, and mana within the context of meaningful, self-reflective, culturally grounded, place-based, collaborative, reciprocal, trauma-informed and accessible approaches.

Goal 3: Build a foundation for sustaining a competent, responsive workforce by acknowledging and engaging the people and relationships that can contribute to ongoing workforce development including service providers, community partners, kupuna, funders, administrators, systems, those being served, and others who share the common purpose of promoting and supporting health and well-being.

Objective 1: Increase the number of technical assistance and training opportunities for prevention specialists, treatment providers and communities, as well as support learning approaches such as field supervision, mentoring, course practicum, field placements, and other learning experiences.

Objective 2: Build the state's resource capacity to support substance abuse prevention and treatment, public health, and behavioral health practitioners to provide quality substance abuse prevention and treatment services.

2.5 Plan Framework

The Substance Use State Plan 2022 aims to build upon the framework of previous substance abuse plans. The initial substance abuse plan, *Comprehensive Plan for Substance Abuse 1976-1977*, focused on public and private agencies and coordination with the respective counties. A *Framework for a Comprehensive Substance Abuse System for the State of Hawai'i 1989* established a comprehensive framework comprised of administration, delivery, data, and quality assurance. Plans covering the 1991-1993 and 1994-1997 periods continued to implement the comprehensive framework set forth in the 1989 plan. The 1994-1997 plan was split in two: the *Alcohol and Drug Abuse Division State Plan* and the *Substance Abuse Prevention Plan*. A subsequent plan, *Statewide Substance Abuse Treatment Plan 2000*, shifted focus to treatment.

Information Collection

The collection and compilation of information on the current state of substance use in the State of Hawai'i began with a four-part protocol to develop and implement a data driven system of care. Protocol areas included:

1. Developing a data analytics infrastructure;
2. Gathering corresponding white papers by subject matter experts on implications for a data-driven system of care;
3. Conducting an emerging adult treatment system of care needs assessment; and
4. Conducting a cultural case study among youth in the Native Hawaiian community.

The data analytics infrastructure and subject matter white papers focused on areas of primary care integration and treatment access as well as the intersection of substance use on specific sectors and special populations (Figure 2). Specific sectors covered are mental health, homelessness, criminal justice, juvenile justice, and family violence. Special populations covered are pregnant and parenting women, Native Hawaiians, rural communities, and sexual and gender minorities.



Figure 2. Intersection Among Substance Use and Treatment Access-(yellow), Sectoral-(brown), and Community-(green) Focused Chapters.

The data analytics infrastructure led to the preparation of the “Hawai‘i State Plan on Substance Use: 2022 Statistical Report.” This data provides broad information on the prevalence of substance use and treatment access. The infrastructure allows for new data to be added in the future.

The corresponding white papers have been compiled into the volume “Intersections of Substance Use Among Public Sectors and Health Disparities Populations: Implications for a System of Care.” Each chapter includes 1) literature highlights, 2) State of Hawai‘i specific data, 3) expert insights about the current system of care from practice-based knowledge, 4) evidence-based interventions or relevant innovative approaches, and 5) observations and recommendations.

ADAD conducted further research by reviewing previous plans, existing planning and policy documents, and specific subject matter reports and documents.

Community Engagement

An initial series of community dissemination webinars hosted by the University of Hawai‘i at Mānoa Pacific Health Analytics Collaborative (UH PHAC) and ADAD focused on the “Hawai‘i State Plan on Substance Use: 2022 Statistical Report.” Six webinars were held from May to July 2022 disseminating information and receiving feedback on the chapters depicted in Figure 2.

A second series of community dissemination webinars hosted by the University of Hawai‘i at Mānoa, John A. Burns School of Medicine, Department of Psychiatry focused on the “Intersections of Substance Use Among Public Sectors and Health Disparities Populations: Implications for a System of Care.” Ten webinars were held during September 2022 highlighting the intersection among substance use and corresponding chapters (Figure 2) that were authored by subject matter experts from both academia and practice.

A webpage for the State Plan on Substance Abuse - 2022 Revision was established in August 2022 and was made available for public review and comment on October 25, 2022. The State Plan can be accessed at <https://health.hawaii.gov/substance-abuse/state-plan/>.

3. ASSESSMENT

The assessment provides a statewide overview of substance use and treatment access in the State of Hawai'i, as well as assessments on the intersection between substance use and the ten chapters identified in Figure 2. Each chapter provides an overview, current Hawai'i data, ADAD activities, and identified gaps in the system of care. The identified gaps are listed under specific themes: Data (D), Services (S), Funding (F) and Workforce Development (W). When applicable, the identified gaps are referenced to one or more ADAD priority action items.

Prevalence of Substance Use in Hawai'i and Treatment Need

Between 2015 to 2018, an estimated 62.3% of all people over the age of 12 consumed or used illicit drugs or alcohol in the past year in the State of Hawai'i (UH PHAC 10). Alcohol (59.10%), tobacco (20.70%), and marijuana (14.20%) accounted for the most used substances in the past year (UH PHAC 10). During this same period methamphetamine and cocaine use, abuse, and dependence were higher in Hawai'i than the U.S. average (UH PHAC 11-12). Tobacco, Alcohol, and marijuana were the most common substance use for the past year substance use among emerging adults aged 18-25 (UH PHAC 13).

According to the Hawai'i State Plan on Substance Use: 2022 Statistical Report, the National Survey of Drug Use and Health estimated that from 2015 to 2018, 17,000 individuals annually in the State of Hawai'i received treatment for illicit drugs or alcohol use (UH PHAC 63). However, this is only a small fraction of those who were needing treatment in the past year from 2015 to 2018, which is estimated to be 91,000 individuals annually (UH PHAC 80). Methamphetamine, alcohol, and marijuana were the top major substance groups among primary groups reported for substance use treatment admissions statewide (UH PHAC 73). Emerging adults had the highest annual percentage for needing and receiving treatment for alcohol and illicit drugs.

Substance Use Among Youth

Between 2011 to 2017 alcohol, marijuana, and prescription drugs without a doctor's prescription had the highest estimated percentage for lifetime use for the State of Hawai'i public high school students (UH PHAC 10). In 2017, Hawai'i public high school students had higher rates than the U.S. average for trying marijuana before the age of 13 (SEOW 22). They also had higher rates than the U.S. average for ever using illicit drugs such as cocaine, ecstasy, heroin, methamphetamine, and injection drugs (SEOW 65, 67-70). They also had higher rates than the U.S. average on whether one was offered, given, or sold illegal drugs during the past 30 days.

The 2019-2020 Alcohol, Tobacco, and Other Drug Use (ATOD) Survey estimated that 11.1% of Hawai'i public school students in grades 8, 10, and 12 likely have a substance use disorder (SUD) and need treatment (ADAD, *Annual Report to the Thirty-First Legislature State of Hawaii 2022* 45). The risk for probable substance use disorder increases by grade level; 6.6% of 8th graders, 12% of 10th graders, and 15% of 12th graders (ADAD, *Annual Report to the Thirty-First Legislature State of Hawaii 2022* 45). Transgender and other gender minority students have the highest risk for probable substance use disorder (ADAD, *Annual Report to the Thirty-First Legislature State of Hawaii 2022* 45).

Alcohol, e-cigarettes/vaping products, marijuana, and tobacco are the most frequently used substances by public school students in grades 8, 10, and 12 (Onoye et al. *ATOD Survey Executive Summary* 9). The overall percentage of current use in the past 30 days are alcohol (27.3%), vaping (25.9%), marijuana (20.3%), and tobacco cigarettes (8.4%) (Onoye et al. *ATOD Survey Executive Summary* 10). There is an across-the-board increase in use of these substances from grade 8 to grade 12.

New ATOD Survey items on mental health and attention disorders identifies the percentage of probable co-occurring disorders among public school students. An estimated 37% of students reported experiencing mild to severe mental health symptoms within the past two weeks (Onoye et al. *ATOD Survey Executive Summary 7*). The estimated percentage of probable SUD among students ranges from 8.2 % for mild symptoms to 25.3% for severe symptoms. The estimated percentage of probable SUD among students screened for attention disorder ranges from 9.6% with a negative screening to 19.5% of students with a positive screening.

Substance Use Among Adults

Between 2016 to 2018, an estimated 7.34% of all individuals 18 years or older in the State, had a SUD within the last 12 months (ADAD, *Annual Report to the Thirty-First Legislature State of Hawai'i 2022 42*). The estimated percentage of SUD by county, from highest to lowest are Maui County (7.47%), City and County of Honolulu (7.36%), Hawai'i County (7.33%), and Kaua'i County (6.72%). Alcohol was the most used substance, followed by illicit drugs and pain relievers.

During this same period, an estimated 6.8% of all individuals 18 years or older were needing but not receiving treatment for substance use in the past year (ADAD, *Annual Report to the Thirty-First Legislature State of Hawai'i 2022 40*). The estimated percentages of people needing treatment but not receiving treatment by county, from highest to lowest are Maui County (7.27%), Hawai'i County (7.05%), City and County of Honolulu (6.69%), and Kaua'i County (6.67%). Treatment for alcohol was most needed, followed by illicit drugs.

Greatest Threat to Public Health and Substance Use-Related Deaths

The Hawai'i High Intensity Drug Trafficking Area (Hawai'i HIDTA) 2022 Drug Assessment Report identifies methamphetamine and marijuana as the most widely available drugs, with methamphetamine considered the greatest overall threat to the State (Hawai'i HIDTA *Threat Assessment 1*). As previously noted, methamphetamines and marijuana account for the highest percentage of treatment admissions compared to any other drug for adults and adolescents, respectively (UH PHAC 73; ADAD, *Annual Report to the Thirtieth Legislature 2022 36-37*). Methamphetamine posed the greatest public health threat due to drug related deaths, with methampetamine-related overdoses on the rise in recent years (Onoye et al. 33; *Drug Overdose: Other Drugs*).

Overdose deaths in Hawai'i, per 100,000 residents, were lower than the U.S. average from 2015 to 2021 (UH PHAC 15). Psychostimulants with abuse potential, including methamphetamines, were the leading cause of overdose deaths per 100,000 residents between 2018 to 2021 (UH PHAC 15). Cannabis was the most common substance, from drug toxicology results, of drivers involved in fatal crashes in 2018 and 2019 (UH PHAC 16).

Fentanyl on the Rise

Illicit fentanyl is the second most dangerous drug threat to the State after methamphetamine (Hawai'i HIDTA *Threat Assessment 3*). Since 2019, the Hawai'i HIDTA has seen an increased amount of fentanyl seizures as well as emergency room cases involving fentanyl in the State of Hawai'i (Hawai'i HIDTA *Fentanyl 1*). Fentanyl's potency is 50-100 times stronger than morphine and 25-40 times stronger than heroin (Hawai'i HIDTA *Fentanyl 1*). There has been increased use in new synthetic opioids derived from fentanyl, also known as "designer fentanyl", whose potency is greater than regular fentanyl (Hawai'i HIDTA *Fentanyl 2*).

Between 1999 to 2021 fatal drug poisonings among State's residents continued to increase, mainly due to methamphetamines, while opioid involved deaths remained steady (Galanis 1). Beginning in 2016 the composition of opioid-involved deaths in the State of Hawai'i has changed from prescription opioids to heroin and synthetics, other than methadone, such as fentanyl (Galanis 3). Between 2020 to 2021 there

was a tremendous increase in fentanyl-related deaths, with 26 fentanyl-related deaths in 2020 compared to 48 fentanyl-related deaths in 2021 (Hawai'i HIDTA *Threat Assessment* 14).

A recent development in the composition of synthetic opioids is the addition of xylazine to extend the effect of the opioid high (Hawai'i HIDTA *Threat Assessment* 4). Xylazine is a non-opioid veterinary tranquilizer, affecting the central nervous system, that is added to illicit opioids including fentanyl (NIDA 2). As xylazine is a non-opioid there is concern that the effectiveness of naloxone, to treat overdoses, will be reduced (NIDA 3).

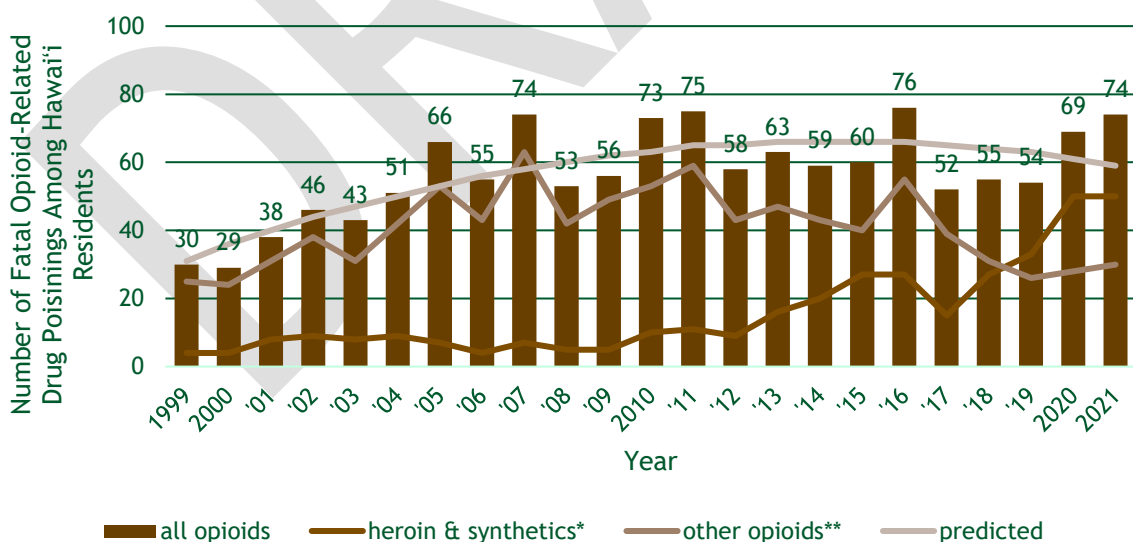
Potential Legalization of Cannabis for Non-Medical Use

Potential legalization of cannabis for non-medical use continues to be explored by the Hawai'i State Legislature. Act 169, Session Laws Hawaii 2021 established a task force within the DOH Office of Medical Cannabis Control and Regulation to explore the development of a dual system of legalization of cannabis, for both medical and non-medical use. A report of the task force findings and recommendations will be submitted to the Hawaii State Legislature 20 days prior to the convening of the 2023 Legislative Session.

There are concerns about the public health impact of legalization of cannabis for non-medical use. During SFY 2021, 10.6% of adults and 71.1% of adolescents were admitted to ADAD-funded treatment services for marijuana (ADAD, *Annual Report to the Thirtieth Legislature 2022* 36-37). Between 2015-2018, approximately 2.1% of females aged 12-44 years old who were pregnant used marijuana within the past month (UH PHAC 320). During this same time, approximately 20.1% of females aged 12-44 years old who were pregnant used marijuana within the past year (UH PHAC 326). Cannabis was the most common substance, from drug toxicology results, of drivers involved in fatal crashes in 2018 and 2019 (UH PHAC 16).

Opioid Overdose Deaths

As shown in Figure 3, deaths from heroin and synthetic opioids, other than methadone (i.e., fentanyl) have increased in the State since 2012 while deaths from commonly prescribed opioids have mostly declined since 2016 (Galanis, Daniel email 8/9/2022). Over the past three years, deaths from synthetic opioids, other than methadone, have outnumbered those from commonly prescribed opioids.



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

Figure 3. Annual Number of Fatal Opioid-Related Drug Poisonings Among Hawai'i Residents by Type of Opioid, 1999 through 2021.

Governor’s Ige’s remarks of August 9, 2022, on the Opioid Settlement included this startling fact: Between 2017 to 2021, fatalities from drug poisoning outnumbered those from traffic crashes and account for 24% of all fatal injuries in the State of Hawai‘i.

Between 2000 to 2018, Hawai‘i’s adjusted opioid poisoning fatality rates (per 100,000) was 4.1, below the U.S average of 14.6 (ADAD, *Annual Report to the Thirty-First Legislature State of Hawai‘i 2022* 50). During this same period Hawai‘i’s adjusted drug poisoning fatality rates (per 100,000) was 14.3, below the U.S average of 20.7. In a state-by-state comparison, covering the period between 2014 to 2018, Hawai‘i had the third lowest fatality rate of poisonings due to prescription opioids, methadone, heroin, and opium (ADAD, *Annual Report to the Thirty-First Legislature State of Hawai‘i 2022* 51).

Primary Prevention

The goal of the substance use disorder prevention system is to reduce the prevalence, incidence, and consequences of alcohol, tobacco, and other drugs by addressing community conditions that promote substance misuse and by enhancing community conditions that buffer individuals from the consequences of substance use disorder. Prevention services engage schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models, programs, and policies to prevent substance use in young people. These services address risk and protective factors that influence the likelihood of substance use, misuse, or abuse and related behaviors.

The SMAHSA Center for Substance Abuse Prevention (CSAP) has identified six strategies to decrease alcohol, tobacco, and other drug use: information dissemination, education, problem identification and referral, community-based programming, environmental strategies, and alternative activities. Additionally, the Strategic Prevention Framework (SPF) provides a cost effective, structured planning process that can be applied to prevention systems. It is focused on systems development reflecting a public health, or community-based, data driven approach to selecting and delivering effective and appropriate intervention for the community and identified target population.

Programs provided by ADAD-contracted service providers incorporate at least one of the six CSAP prevention strategies and the SPF for universal, selected and/or indicated populations. In FFY 2020-2021, ADAD-contracted prevention providers served a total of 895,933 children, youth, and adults statewide.

3.1 Treatment Access

In order to implement and maintain a coordinated and responsive system of care that provides SUD services statewide, the Hawai‘i State DOH created The Hawai‘i Coordinated Access Resource Entry System (Hawai‘i CARES). It is a statewide 24/7 coordination center for support with substance use, mental health, and crisis intervention services. In 2021, the Hawai‘i CARES received 101,151 calls related to mental health, substance use and crisis services. Beginning in early 2022, the Hawai‘i State DOH contracted with two community-based agencies to support the Hawai‘i CARES. The Adult Mental Health Division contracts with Care Hawai‘i, Inc. to provide the mental health and crisis services component of the Hawai‘i CARES. ADAD contracts with Aloha United Way to provide the substance use services component of the Hawai‘i CARES. On July 16, 2022, as part of a nationwide commitment to transform the mental health and crisis care system in America, the State of Hawai‘i adopted the new 988 dialing code. Calling the simple three-digit number, 988, directs an individual to the Hawai‘i CARES line. The implementation of 988 allows for expanded access and an easier-to-remember contact number to the Hawai‘i CARES.

Alcohol is the most prevalent substance used among individuals aged 12 years or older in Hawai‘i, with approximately 6 in 10 individuals reporting alcohol use in the past year (UH PHAC 21). This is much greater than the prevalence of methamphetamine use among individuals aged 12 years or older in Hawai‘i, estimated to be 1.5% (UH PHAC 21). According to the Hawai‘i State Plan on Substance Use: 2022 Statistical Report, the National Survey of Drug Use and Health estimated that from 2015 to 2018, 17,000 individuals annually in Hawai‘i received treatment for illicit drugs or alcohol use (UH PHAC 63). However, this is only a small fraction of those who were actually needing treatment in the past year, which is

estimated to be 91,000 individuals annually. In addition, despite alcohol use being most prevalent, of individuals admitted to treatment between 2015 to 2019, 47.38% were admitted for methamphetamine whereas 23.55% were admitted for alcohol as the primary substance (UH PHAC 122). ADAD-funded adult admissions in State Fiscal Year (SFY) 2020-2021 reported 60.6% of individuals admitted for methamphetamine as the primary substance, a slight increase from previous SFY 2019-2020 of 60.3% (ADAD, *Annual Report to the Thirtieth Legislature 2022* 36).

Treatment admissions have also declined. A recent study published in *JAMA Network Open* in September 2022, found that treatment program admissions per 10,000 population fell significantly, by 55%, during the first year of the COVID-19 pandemic in Hawai'i (Cantor et al.). Hawai'i was ranked second in the U.S. to experience the largest state-level per 10,000 population decrease in treatment admissions.

Table 3. Gaps in Treatment Access.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Need to establish a learning management system for new continuing education of substance use professionals 	<ul style="list-style-type: none"> D-1, D-2
Services	<ul style="list-style-type: none"> Lack of addiction treatment resources for primary care providers to refer to, especially on neighbor islands and in rural areas. SBIRT services are not extensively used Statewide through primary care settings. <ul style="list-style-type: none"> Ex. Smaller private offices typically opt out of providing SBIRT services due to lack of capacity and training. Many primary care offices still tend to use the traditional care model rather than the Collaborative Care Model. 	<ul style="list-style-type: none"> S-2, S-3
Funding	<ul style="list-style-type: none"> Low reimbursement for higher complexity patients. Inadequate funding for mobile clinics for medication assisted treatment so that patients can easily access methadone. Lack of incentives for primary care physicians to work in Hawai'i. <ul style="list-style-type: none"> Ex. Lower salary, loan repayment programs, scholarships Insufficient funding for training primary care workforce. 	<ul style="list-style-type: none"> F-1, F-2
Workforce	<ul style="list-style-type: none"> Lack of education, training, and support on addiction medicine for physicians. Lack of addiction treatment resources and overall physician shortage, especially in rural areas. Perceived stigma and discrimination of patients with SUD. Further need for training for prescribers to overcome reservations on issuing suboxone prescriptions. Lack of implementable policies and procedures for hospitals and other primary care settings to implement SBIRT. Inadequate number of clinicians licensed to prescribe buprenorphine. Less than 5% or 159 of 3,290 physicians actively practicing in the state (Onoye et al. 224). 	<ul style="list-style-type: none"> W-1, W-2

3.2 Primary Care Integration

According to SAMHSA, as of October 2022, the number of practitioners waived to provide buprenorphine for the treatment of opiate use disorders in the State of Hawai'i is 159 (*Buprenorphine Practitioner Locator*). This only takes into account practitioners who consent to have their information listed and may not include all waived practitioners. 101 of the 159 (64%) practitioners waived are located on O'ahu. The remaining practitioners waived to provide buprenorphine are more limited in rural areas with 36 (23%) in Hawai'i County, 16 (10%) in Maui County, and 6 (4%) in Kauai County.

HRS §329-101(b) and Act 153(18) requires practitioners be registered to and utilize the electronic prescription accountability system, also known as the Hawai'i Prescription Drug Monitoring Program (HI-PDMP). Practitioners are required to consult the HI-PDMP before prescribing a schedule II-IV controlled substance. This helps to prevent prescription misuse, reduce the risk of abuse of addiction to controlled substances, avoid harmful drug interactions, and ultimately helps to improve patient care.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been found to be an effective public health approach in primary care settings. Despite high interest in a collaborative care approach and

substance use as a significant issue presented in the primary setting, one study found that only 25% of primary care offices implemented universal screening for alcohol and illicit drug use (Onoye et al. 220). In September 2016, ADAD received a five-year discretionary grant from the SAMHSA to implement SBIRT for substance use in the State of Hawai'i (Figure 4). ADAD focused primarily on primary care settings to administer SBIRT services. Various independent physician associations, community health centers and pharmacies were involved in providing SBIRT in this project.



Figure 4. From 2016 to 2022, SBIRT services were provided in primary care settings in Hawai'i.

Despite the SBIRT grant ending September 2022, participating providers, the DOH, the Med-QUEST Division, and other key stakeholders are working to sustain SBIRT within primary practice and in hospitals. ADAD is interested in continuing SBIRT beyond the grant expiration.

Table 4. Gaps in Primary Care Integration.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Need to establish a learning management system for new continuing education of substance use professionals 	<ul style="list-style-type: none"> D-1, D-2
Services	<ul style="list-style-type: none"> Lack of addiction treatment resources for primary care providers to refer to, especially on neighbor islands and in rural areas. SBIRT services not extensively used Statewide through primary care settings. <ul style="list-style-type: none"> Ex. Smaller private offices typically opt out of providing SBIRT services due to lack of capacity and training. Many primary care offices still tend to use the traditional care model rather than the Collaborative Care Model. 	<ul style="list-style-type: none"> S-2, S-3
Funding	<ul style="list-style-type: none"> Low reimbursement for higher complexity patients. Inadequate funding for mobile clinics for medication assisted treatment so that patients can easily access methadone. Lack of incentives for primary care physicians to work in Hawai'i. <ul style="list-style-type: none"> Ex. Lower salary, loan repayment programs, scholarships Insufficient funding for training primary care workforce. 	<ul style="list-style-type: none"> F-1, F-2
Workforce	<ul style="list-style-type: none"> Lack of education, training, and support on addiction medicine for physicians. Lack of addiction treatment resources and overall physician shortage, especially in rural areas. Perceived stigma and discrimination of patients with SUD. Further need for trainings for prescribers to overcome reservations on issuing suboxone prescriptions. Lack of implementable policies and procedures for hospitals and other primary care settings to implement SBIRT. Inadequate number of clinicians licensed to prescribe buprenorphine. Less than 5% or 159 of 3,290 physicians actively practicing in the state (Onoye et al. 224). 	<ul style="list-style-type: none"> W-1, W-2

3.3 Mental Health

Dual disorders, also known as co-occurring disorders, describes the co-occurrence of a mental health disorder and a SUD in an individual. Between 2018 to 2019, an estimated 17 million Americans had dual disorders. Of individuals with a mental health disorder, 47% have a co-occurring substance use disorder. Of individuals with a substance use disorder, 80% have a co-occurring mental health disorder (Onoye et al. 5). Individuals with dual disorders are often underdiagnosed and undertreated as a result of the “wrong door syndrome.” Rather than being diagnosed and obtaining treatment for the dual disorder, the individual is placed into treatment based upon the diagnosis of one disorder (Onoye et al. 6).

Between 2018 to 2019, the State of Hawai'i had an estimated 40,000 individuals, 18 years and older, who had a dual diagnosis of mental illness with drug or alcohol dependence in the past year (UH PHAC, 131). During this same time, among individuals 18 years and older, Hawai'i saw a higher average percentage for mild or moderate mental illness with drug or alcohol dependence or abuse and a higher average percentage for any mental illness with drug or alcohol dependence or abuse compared to the U.S. (UH PHAC, 134).

Between 2018 to 2019, among individuals 12 years and older, marijuana, cocaine, methamphetamine, and pain relievers being problematic with emotions, nerves, or mental health in the past year, showed slightly higher rates in Hawai'i compared to the U.S. (UH PHAC, 137). Continued use of substances, specifically marijuana and methamphetamine, was higher for Hawai'i than the U.S.

Between 2015 to 2019, the highest number of treatment admissions among all Diagnostic and Statistical Manual of Mental Disorders diagnoses came from other substance abuse or dependence followed by specific substance use disorder diagnoses, such as cannabis abuse or dependence and alcohol abuse or dependence (UH PHAC, 135). Other mental health conditions, along with specific mental health disorder diagnoses, such as anxiety disorders and depressive disorders generally accounted for less treatment admissions in the State of Hawai'i. In contrast to the downward trend from 2015 to 2018, from 2018 to 2019 the number of treatment admissions with dual disorders increased by 208 (UH PHAC, 135).

There are no long-term treatment options for dual disorders on the neighbor islands (Onoye et al. 10). Individuals requiring long-term treatment must go to O'ahu. Treatment for individuals with severe and refractory dual disorders is only available on O'ahu through the Queens Medical Center Psychiatric Emergency Room or as a pre-trial detainee at the O'ahu Community Correctional Center (Onoye et al. 11).

During SFY 2018-2019, HACDACS was interested in the intersection of substance abuse with mental health and other comorbidities. Methamphetamine was the most common substance used by individuals serviced by ADAD-funded programs. Additionally, they were also high utilizers of mental health services (HACDACS, *Annual Report to the Thirtieth Legislature State of Hawai'i 2020 24*).

Per the Report to the Legislature on Act 263, Session Laws of Hawai'i 2019, Relating to Health, data on the Hawai'i State Hospital shows “the average number of patients that have a substance use disorder is 85%, 75% of which have a co-occurring disorder” (DOH 30). Additionally, the majority of recidivists at the Hawai'i State Hospital have a co-occurring disorder, with 36% of all patients returning within 6 months of being discharged (DOH 30).

ADAD has closed out the Hawai'i Youth Treatment and Implementation (HI YT-I) project. The HI YT-I grant allowed the State the opportunity to expand access for SUD continuum of care (COC) treatment services and mental health services to youth ages 12-26. Additionally, it expanded access to multisystemic therapists and eligibility criteria for services. ADAD is interested in continuing these services beyond the grant expiration.

Table 5. Gaps in Mental Health.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Lack of a uniform data system or governance exists for data collection, prevention, identification, and/or management of dual disorders in the state. The National Survey on Drug Use and Health is the only survey data available for dual disorders and has limitations as it does not include certain groups of people such as the homeless. Lack of data sharing to coordinate care for users in different systems. <ul style="list-style-type: none"> Ex. Coordinating care for an individual who is an ADAD client but also an Adult Mental Health Division (AMHD) consumer. 	<ul style="list-style-type: none"> D-1, D-2
Services	<ul style="list-style-type: none"> No long-term treatment for severe and refractory dual disorders on neighbor islands. Need for case management for clients with dual disorders is essential as it provides a lifeline for continuity of care, treatment engagement and adherence. Need to institute a “no wrong door” policy to prevent the negative impact of “wrong door syndrome” on dual disorder. Need for long-term integrated treatment. Insufficient resources and services for dual disorders at the community level, leading to overburden at hospitals and emergency rooms. 	<ul style="list-style-type: none"> S-2, S-3
Funding	<ul style="list-style-type: none"> Insufficient funding for dual disorder treatment. Low reimbursement for higher complexity patients. 	<ul style="list-style-type: none"> F-1, F-2
Workforce	<ul style="list-style-type: none"> Lack of education and training of providers on dual disorders often leads to clients being underdiagnosed and undertreated. Lack of providers who specialize in treating clients with dual disorders. Perceived stigma and discrimination of clients with dual disorders. 	<ul style="list-style-type: none"> W-1, W-2

3.4 Homelessness

Homelessness in Hawai'i is a widespread public health issue. A nationwide Point-in-Time Count ranked Hawai'i as second highest in the U.S. for per capita rates of homelessness at 45.6 per 10,000 people, only behind New York (*State of Homelessness: 2021 Edition*). The count indicated a total of 6,458 individuals (4,448 on O'ahu and 2,010 on the neighbor islands) in Hawai'i experienced homelessness on a single night in January 2020. Additionally, problematic substance use is third highest in self-reported cause of homelessness on O'ahu, affecting one in five homeless individuals (Onoye et al. 19)

Although services for individuals experiencing homelessness and substance use exist, they are often siloed and offered through separate systems of care. For housing, the system of care is the Coordinated Entry System, whereas for behavioral health services the system of care is the Hawai'i CARES. These systems of care have little coordination and integration creating barriers for those who need it. Generally speaking, a person seeking housing may be disqualified from services due to their substance use and vice versa.

Data from the Treatment Episode Data Set - Admissions reports that in 2019, at substance use treatment admission 25.56% of individuals reported being homeless, 40.62% reported dependent living, and 31.44% reported independent living (UH PHAC 169). Of the total individuals, methamphetamine/speed (47.38%) and alcohol (23.55%) were the highest primary substances used. Additionally, of the 635 individuals who reported homelessness at treatment admission, 58% (n = 369) reported methamphetamine/speed and 24.88% (n = 158) reported alcohol as their primary substance used. The percentage of homeless individuals and primary substance used are higher when looking specifically at ADAD-funded adult admissions for Federal Fiscal Year (FFY) 2021. Among ADAD-funded client admissions, 30.2% reported being homeless and 60.6% reported methamphetamine as the primary substance used (ADAD, *Annual Report to the Thirtieth Legislature 2022* 36).

Currently, ADAD contracts with agencies to provide an array of substance use treatment and recovery services, that also provide housing resources. These services include residential treatment, clean and sober homes, group recovery homes and therapeutic living program. Residential treatment provides 24/7 non-medical, non-acute care in facilities that provides support for individuals with SUD. Therapeutic living programs provide structured residential living to individuals who are currently receiving, are in transition to, or who have been clinically discharged from a substance abuse program. The focus of therapeutic living programs is to provide structure and support as individuals complete treatment and navigate activities of daily living to eventually transition to independent housing. Group homes are for unrelated individuals who completed substance use treatment and are in recovery, offering peer-assisted living arrangements before transitioning to independent living.

Similarly, clean and sober homes provide living arrangements for individuals who are in or have completed substance use treatment. Of note, pursuant to HRS §321-193.7 and as described in Chapter 11-178 Hawaii Administrative Rules, ADAD launched the Clean and Sober Homes Registry, a voluntary registry to assist individuals in finding a safe living environment to support their recovery (ADAD, *Clean and Sober Homes*). To date, there are 64 homes registered and in good standing on the Clean and Sober Homes Registry. The Clean and Sober Homes Registry website offers various services including allowing: 1) the general public to search for and find information about registered Clean and Sober homes that are “in good standing” in Hawai‘i, 2) operators to submit applications and check status of their registration application, and 3) registry staff to access information and track complaints about clean and sober homes.

Table 6. Gaps in Homelessness.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Lack of data integration between the two systems of care, the Coordinated Entry System and the Hawai‘i CARES Insufficient data collection on homelessness within the Hawai‘i CARES and substance use disorder within the Coordinated Entry System. 	<ul style="list-style-type: none"> D-1, D-2, D-3
Services	<ul style="list-style-type: none"> Little coordination between the Coordinated Entry System and the Hawai‘i CARES for clients to access services. Contradictions among the two systems. <ul style="list-style-type: none"> Ex. Completing 90 days or longer in residential may disqualify an individual of their chronic homelessness status which is essential for housing programs. Harm reduction-based services are limited within housing programs. Housing options as well as treatment facilities including residential programs, therapeutic living programs, registered clean and sober homes and group recovery homes are concentrated in O‘ahu, with limited on neighbor islands especially in rural areas. Limited resources for housing after clinical discharge from substance treatment program. Need for case management and other housing services. Access to the Hawai‘i CARES is via telephone only, therefore individuals requiring treatment need a working phone or way to be contacted. 	<ul style="list-style-type: none"> S-2, S-3
Funding	<ul style="list-style-type: none"> Insufficient funding for Housing First programs to be able to house more individuals experiencing homelessness. Currently only HUD funding goes to Hawai‘i for Housing First programs. Pg 9 of chapter. Individuals seeking housing may not have security deposit or first month’s rent often needed when finding housing placement. 	<ul style="list-style-type: none"> F-2
Workforce	<ul style="list-style-type: none"> Perceived stigma and discrimination of homeless clients. 	<ul style="list-style-type: none"> W-2

3.5 Criminal Justice (Adults)

The criminal justice system is comprised of laws, rules, and agencies devised to hold criminals accountable for their misdeeds and help them to restore their victims as much as possible (Onoye et al. 33). Hawai‘i’s adult criminal justice system is comprised of law enforcement, the courts, and the corrections system. Entrance into the criminal justice systems occurs at the time of arrest by law enforcement.

Between the time of arrest and when a case reaches the court, there are opportunities to divert individuals into needed treatment during bail, through drug treatment courts, or use of specialized probation. This is crucial as a significant portion of the criminal justice population have substance use disorders. When entering the Hawai'i corrections system, an individual is assessed and has access to an array of substance use services including outpatient, intensive outpatient, residential, reintegration services, and continuing care.

In 2019, 11,059 adults were arrested for substance-related offenses (UH PHAC 172). Between 2010 to 2019, more adults were arrested for alcohol related offenses than drug possession and manufacturing or sale offenses. Between 2010 to 2019, the most common substance-related Part II offense was drinking and driving under the influence for adult arrests.

Between 2015 to 2018, an estimated 4,000 people annually received substance abuse treatment at a prison or jail. Between 2015 to 2019, referrals from probation or parole had the highest number of treatment admissions among criminal justice referrals. Substance abuse treatment providers are required to prioritize the admissions for several groups, including adult offenders. In 2018 and 2019, ADAD-funded substance abuse treatment was provided to 822 and 838 adult offenders, respectively (UH PHAC 339). This represents 9.53% and 7.40%, respectively, of all individuals receiving ADAD-funded substance abuse treatment.

An April 2020 presentation to the HACDACS highlighted gaps in substance use treatment in the criminal justice system and continuum of care in general. Gaps highlighted include limited access to needed medical care for withdrawal management, and challenges to continuing treatment upon release. Challenges include lack of medical insurance as it is often suspended or terminated while incarcerated, as well as the difficulty of transferring electronic medical records due to the Department of Public Safety's use of proprietary software (HACDACS, *Annual Report to the Thirty-First Legislature State of Hawai'i 2021 20-21*).

ADAD funds several programs to support diversion into treatment: the Driving While Impaired Court Program, the Drug Court, and the Law Enforcement Assisted Diversion (LEAD) program now known as Letting Everyone Advance with Dignity program.

Located in Honolulu, the Driving While Impaired Court provides a comprehensive treatment program for impaired driving offenders on O'ahu (Hawai'i State Judiciary 29). Drug Courts are established on Kaua'i, O'ahu, Maui, Moloka'i, and Hawai'i islands (Hawai'i State Judiciary 16). These courts provide an 18-month intensive treatment program that also helps in obtaining employment and housing.

A Memorandum of Agreement between ADAD and the Hawai'i State Judiciary coordinates implementation and sustainment of the Hawai'i Drug Court Program and the Adult Client Services Branch of the First Circuit, offering an effective and less costly alternative to incarceration. Funding provided through the Agreement will coordinate access and integration of treatment services of the Hawai'i Drug Court Program and Adult Client Services Branch drug testing compliance.

The Honolulu LEAD pilot program targeting the chronically homeless in Chinatown was established in 2018. The LEAD program is a tool that can be used to divert individuals who commit low-level, non-violent offenses into needed treatment. An important component of the pilot program included training law enforcement to detect signs of SUD addiction in the field and how to fast-track low-level offenders to SUD treatment programs. All county police departments and the State Sheriff Division were participants (ADAD, *Annual Report to the Thirty-First Legislature 2021 11-12*). This pilot program was expanded to Hawai'i, Kaua'i, and Maui Counties the following year. In addition, all ADAD-contracted treatment providers can administer LEAD in current contracts.

Table 7. Gaps in Criminal Justice.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> • Lack of research and data on the role continuity of care plays in recidivism. <ul style="list-style-type: none"> ○ Ex. Does continuity of care before, during or after involvement in the criminal justice system contribute to lower rates of recidivism. ○ 	<ul style="list-style-type: none"> • D-1
Theme	Identified Gaps	Action Item Reference
Services	<ul style="list-style-type: none"> • Need for criminal justice discretion process to increase diversion and connect people with treatment, where applicable/appropriate. • Limited to no substance abuse treatment in pretrial jail. • Lack of continuity of care as criminal justice-involved individuals move throughout the criminal justice system. <ul style="list-style-type: none"> ○ Ex. Defendants who start substance abuse treatment may be at risk for failure as they bail out of pretrial detention. ○ Ex. Persons convicted and sent to prison and who also have a SUD cannot be forced into correctional drug treatment, or for those in treatment, it is not finished once prison sentence is complete. • Lack of incentives to motivate individuals to participate in treatment programs while incarcerated. 	<ul style="list-style-type: none"> • S-2, S-3
Funding	<ul style="list-style-type: none"> • None identified. 	
Workforce	<ul style="list-style-type: none"> • Lack of education and training for police and courts on resources available to refer individuals who never enter or are filtered out of or away from the criminal justice system. • Need for law enforcement and first responders to access naloxone. 	<ul style="list-style-type: none"> • W-2

3.6 Juvenile Justice

The components and processes of the juvenile justice system generally mirror those of the adult criminal justice system. However, it is the Hawai'i State Judiciary Family Court and the Department of Human Services Office of Youth Services that adjudicate and incarcerate. Act 201, SLH 2014 initiated the juvenile justice reform system and appropriated \$1.26 million for implementation, including for substance abuse treatment. Both the Judiciary and the Office of Youth Services continue to transform the juvenile justice system including diversion to substance abuse treatments. ADAD plans to increase collaboration with the Office of Youth Services.

Between 2000 to 2010, a random sample of youths adjudicated in the City and County of Honolulu for any law violation, revealed that 71.8 % had a history of substance use. For youths detained at the Hawai'i Youth Correctional Facility between 1999 to 2000, approximately three-fourths were diagnosed with substance abuse or dependency. Marijuana was the most used substance (91%) followed by alcohol (80%), cigarettes (71%) and methamphetamines (54%). In an updated profile, the percentage of youths diagnosed with substance abuse or dependency increased to 83.6%.

From 2010 to 2019, drug possession offenses accounted for the highest number of juvenile arrests compared to alcohol-related and drug manufacturing/sales offenses (UH PHAC 215). Marijuana possession was the most common substance-related Part II offense among juveniles arrested (UH PHAC 211). It was significantly higher than the next two offenses, alcohol-related liquor laws and disorderly conduct.

For youth with a qualifying diagnosis for mental health services, integrated substance abuse treatment is available through the Department of Health Child and Adolescent Mental Health Division contracted services.

ADAD closed out the Hawai'i Youth Treatment and Implementation project. This grant allowed the State the opportunity to expand access for SUD COC treatment services and mental health services to youth ages 12-26, including youth at the Hawai'i Youth Correctional Facility. Additionally, it expanded access to multisystemic therapists and eligibility criteria for services.

Table 8. Gaps in Juvenile Justice.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Locally, data on sex or gender identity have not been systematically collected for justice-involved youth. 	<ul style="list-style-type: none"> D-1
Themes	<ul style="list-style-type: none"> Identified Gaps 	Action Item Reference
Services	<ul style="list-style-type: none"> Student access to services at a school level is highly dependent on individual school administrators' awareness of student needs. Lack of a systematic approach to implementing and sustaining prevention programs. A youth's access to youth services usually requires adult support for participation. Lack of sufficient culturally responsive programs. Care upon release from detention is neither required nor well-coordinated. Misalignment between available programs and community acceptance and trust. Cost of substance abuse at early stages of the justice-system involvement are often placed on families, with public support available only for those who can navigate the eligibility process and meet criteria. Access to substance use services for youth who are not court-ordered, detained, or incarcerated is limited by a number of factors, including space, awareness of services, and alignment or cultural fit of available services for the youth and family. Lack of services for criminal justice youth who are pregnancy and/or parenting. Lack of residential options for youth on neighbor islands. 	S-1, S-2, S-3
Funding	<ul style="list-style-type: none"> Need for increased funding of prevention and treatment programs for justice-involved youth. 	<ul style="list-style-type: none"> F-2
Workforce	<ul style="list-style-type: none"> Inadequate peer supports within the workforce. Need for further training for peer specialists to reach youth. Lack of naloxone availability for all Department of Education campuses and staff statewide. 	<ul style="list-style-type: none"> W-3

3.7 Family Violence

Family violence in the context of this report includes intimate partner violence (IPV) and child abuse and neglect (CAN). Research has shown the extensive and interconnected nature of intimate partner violence, child abuse and neglect, and substance use. In fact, alcohol and drugs are involved in 46% of IPV cases and approximately 80% of CAN cases, and 60% of cases include both IPV and CAN (Onoye et al. 73). Although the data shows the interconnectedness between IPV, CAN and substance use, services offered to address these issues are often dealt with individually through different systems rather than simultaneously. Treating these issues holistically is correlated with better outcomes, while treating these issues separately can actually be ineffective.

Very little data exists on the intersection between substance use and family violence specific to Hawai'i. Data from 2019 shows that drug abuse as a caregiver risk factor for children who have experienced maltreatment was approximately 20% higher in Hawai'i (49.3%) when compared to the U.S. (29.4%) (UH PHAC 228). Additionally, unacceptable child rearing methods, the inability to cope with parenting responsibilities, and drug abuse were the three highest risk factors precipitating confirmed child victims in Hawai'i in 2020.

Currently, the majority of ADAD's contracted providers primarily address substance use disorder, with none specifically specializing in family violence. However, some do exist that provide gender-specific treatment, including for pregnant women and women with dependent children (PWWDC). These programs which primarily focus on treatment and recovery from substance use disorders, such as Salvation Army

Family Treatment Services - Women’s Way program, Malama Family Recovery Center, and the Big Island Substance Abuse Council - Moms and Babies Program, also concurrently provide trauma-informed services and help to address intimate partner violence among the PWWDC population.

Table 9. Gaps in Family Violence.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Inaccurate and insufficient data on intimate partner violence and child abuse and neglect within and across systems in Hawai‘i. No centralized system for family violence for tracking and reporting. No common data collection or terminology used among family violence agencies for IPV and CAN. Lack of information sharing within and across systems. 	<ul style="list-style-type: none"> D-1, D-2, D-3
Services	<ul style="list-style-type: none"> Perceived stigma and discrimination associated with seeking help for services. No centralized and integrated system for substance use, IPV, and CAN. Little coordination between systems for clients to access services. No single-entry point for IPV services. Few gender-specific residential SUD treatment models for both mothers and children and none for fathers and children to provide holistic family support, especially on neighbor islands and in rural areas. Inadequate resources to support families dealing with SUD and family violence. Difficult to navigate through system of care. Time limitation for services based on statutory time frames, contracts requirements, and/or funding. Lack of trust across systems, which can reduce collaboration. Systems may not screen for family violence. 	<ul style="list-style-type: none"> S-1, S-2, S-3
Funding	<ul style="list-style-type: none"> Funding is heavily used for intervention and treatment, with little focus on prevention. Funding requirements and restrictions, which can reduce collaboration. 	<ul style="list-style-type: none"> F-2
Workforce	<ul style="list-style-type: none"> Lack of knowledge and training on family violence. Difficulty finding and retaining qualified workforce - high vacancies and turnover. High client to staff caseloads. 	<ul style="list-style-type: none"> W-1, W-2

3.8 Native Hawaiians

Native Hawaiians have a higher prevalence for substance abuse than other ethnic groups in the state. A Native Hawaiian is defined as “any descendent of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai‘i” (Office of Hawaiian Affairs).

Between 2015 to 2018, the Native Hawaiian population had the highest lifetime methamphetamine use compared to other races (UH PHAC 245). Between 2015 to 2017, the percentages of prescription drug overuse and 30-day binge drinking among Native Hawaiians were higher than the Hawai‘i State average (UH PHAC 252-254).

In 2017, the Native Hawaiian population had the highest percentage of public high school students who ever used marijuana, cocaine, heroin, and methamphetamines (UH PHAC 258-261). Alcohol consumption and marijuana use before the age of 13 were also highest compared to other races (UH PHAC 256, 258). The percentage who ever used injection drugs, ecstasy, or used prescription drugs without a doctor’s prescription was the second highest compared to other races (UH PHAC 260-262). The percentage of use for injection drugs and ecstasy were higher than the U.S. average (SEOW Profile 67, 70).

Native Hawaiians are a priority population to receive ADAD-funded treatment. Pursuant to Section 1953 of P.L. 102-321, the SABG requires ADAD to set-aside a portion of funds for the Native Hawaiian population that is equivalent to the proportion of Native Hawaiians residing in the State. ADAD tracks the allocation and utilization of the Native Hawaiian set-aside, and information is then reported to SAMHSA and available upon request.

From 2018 to 2020, 40% of ADAD-funded treatment admissions for the Native Hawaiian population were for methamphetamine (UH PHAC 268). This was followed by marijuana, hashish, and tetrahydrocannabinol (UH PHAC 268). Treatment admissions were highest for self-referrals followed by the criminal justice system (UH PHAC 231).

ADAD believes that services for Native Hawaiians must be holistic and culturally appropriate in approach and must be well integrated into community practices to reach the majority of those in need or at risk. ADAD currently allows cultural activities (i.e., groups, counseling) within any modality of services in its treatment contracts. However, these services are often not reimbursable in the system of care. Some ADAD-funded agencies provide cultural-based treatment with a focus on Native Hawaiian values including Ho'omau Ke Ola and Queen's Medical Center on O'ahu: and Bridge House, Ka Hale Pomaika'i, and Ku Aloha Ola Mau on the neighbor islands.

Senate Concurrent Resolution No. 103, SLH 2019 *Urging the Inclusion of Native Hawaiian Cultural Intervention Treatment Programs, Wellness Plans and Holistic Living Systems of Care in the State of Hawaii's Response to the Rise of Misuse and Abuse of Opioids or Illicit Substances in Hawaii*, has been incorporated into the HOI. In its third year of implementation, the HOI seeks to develop strategies for inclusion of Native Hawaiian cultural intervention treatment programs, wellness plans and holistic living into the system of care.

ADAD plans to provide more training from Native Hawaiian perspectives and build a system of care that minimizes risk factors and builds upon protective factors of the Native Hawaiian community. Additionally, ADAD will work with Med-QUEST to explore peer supports and cultural awareness trainings, as well as a reimbursable model for cultural practitioners. ADAD is motivated to improve the current data system and revise how funds for Native Hawaiians are currently distributed as part of the SABG set-aside requirements.

Table 10. Gaps in Native Hawaiian Communities.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Need to create mechanisms that identify culturally relevant data collection. 	<ul style="list-style-type: none"> D-1, D-2
Services	<ul style="list-style-type: none"> Lack of culturally relevant substance use programs to support Native Hawaiian communities. Lack of substance abuse treatment services on the neighbor islands. 	<ul style="list-style-type: none"> S-3
Funding	<ul style="list-style-type: none"> Cultural services are not offered as a separate billable rate within treatment contracts. Cultural services are only included as part of intensive outpatient program or outpatient program billable rates, requiring documentation as a non-billable encounter note. Service providers are dependent on outside funding to cover costs of cultural practitioners to provide culturally-based healing and other related services not reimbursable by ADAD and other payors. 	<ul style="list-style-type: none"> F-1
Workforce	<ul style="list-style-type: none"> Need for culturally grounded peer support specialists. Lack of cultural knowledge and training. Difficulty finding and retaining qualified, culturally competent workforce. 	<ul style="list-style-type: none"> W-1, W-2, W-3

3.9 Rural Communities

Rural communities often face barriers to treatment and prevention of substance use, including accessibility and availability of resources. Rural areas of Hawai'i which include Kaua'i County, Maui County, and Hawai'i County have fewer available health services, including substance abuse services (Onoye et al. 142). Most treatment services and prevention efforts are provided in the City and County of Honolulu. Additionally, a lack of transportation in rural areas adds an additional layer to obtaining services.

Services for opioid dependence are very limited if not nonexistent in rural areas. Currently, there are only 4 opioid treatment programs statewide, which provide medication assisted treatment, offered at Ku Aloha Ola Mau, Inc. and the Comprehensive Health and Attitude Program. Two of these programs are outside of the City and County of Honolulu - one in Hilo (Hawai'i County) at Ku Aloha Ola Mau, Inc. and one in Wailuku (Maui County) at CHAMP Clinic of Maui. Additionally, as of October 2022, 101 of the 159 (64%) practitioners waived to provide buprenorphine for the treatment of opiate use disorder in Hawai'i are located on O'ahu (*Buprenorphine Practitioner Locator*). The remaining practitioners waived to provide buprenorphine are more limited in rural areas with 36 (23%) in Hawai'i County, 16 (10%) in Maui County, and 6 (4%) in Kauai County.

Syringe service programs, a harm reduction strategy used to reduce the spread of human immunodeficiency virus and other blood-borne infections among people who inject drugs, began on O'ahu, and has since expanded to neighbor islands operating via fixed sites, syringe exchange appointments and mobile sites. The 2020 Syringe Exchange Annual Report by Hawai'i Health and Harm Reduction Center, reports that some rural areas of Hawai'i including in Maui County and in Hilo, do not have fixed sites for syringe service programs and operate solely through mobile sites (Gralapp 4). Although mobile sites allow for increased reach and flexibility, some services can be limited including outreach, testing, and linkage.

Rural communities also have a limited number of clean and sober homes. To date, there are 64 clean and sober homes registered and in good standing on ADAD's Clean and Sober Homes Registry (ADAD, *Clean and Sober Homes*). However, the majority of clean and sober homes (47 of 64 homes) are located on Oahu, 8 on Maui, 8 on Hawai'i island and 1 on Kaua'i. The high cost of housing in Hawai'i makes it difficult to fund recovery resources such as clean and sober homes and group recovery homes, especially on neighbor islands.

The annual average percentage of individuals 18 years or older in the State of Hawai'i with either a substance use disorder, illicit drug use disorder or alcohol use disorder are slightly higher in rural counties (i.e., Kaua'i County, Maui County, and Hawai'i County) compared to the City and County of Honolulu (UH PHAC 273). Maui County had the highest percentage for past year substance use disorder at 7.47% compared to the State average of 7.34%. Hawai'i County had the highest percentage for past year illicit drug use disorder at 2.62% compared to the State average of 2.48%. Kaua'i County had the highest percentage for past year alcohol use disorder at 5.87% compared to the State average of 5.63%. Although percentages are slightly higher in rural counties, it is known that certain areas of the State, especially rural areas, have inequities in service need compared to service capacity.

In 2017, the Hawai'i Youth Risk Behavior Survey, which surveys public high school students in Hawai'i discovered that rural counties have higher current alcohol use and binge drinking compared to Honolulu County (UH PHAC 295). Additionally, youth consumed alcohol before age 13, at a higher rate in rural counties (17.8-20.5%) compared to the City and County of Honolulu (15.4%) and the state overall average (16.8%) (UH PHAC 296). Public high school students engaged in risky behaviors at a higher rate in rural counties (23.6-25.6%) compared to the City and County of Honolulu (18.8%), including riding in a car with someone who was high or had been using alcohol or drugs.

ADAD currently contracts with six providers, indicated in Table 11 below, to offer substance use disorder services in rural remote areas. In recent years, as a result of the Coronavirus Disease 2019 (COVID-19) pandemic, ADAD also allowed service providers to provide treatment services via telehealth. This has allowed residents who reside in rural and underserved areas to access needed services more readily.

ADAD criteria in determining rural remote status for ADAD-contracted treatment providers includes:

1. Limited provider capacity within a defined area;
2. Limited specialized workforce within a defined area;
3. Limited accessibility to services;
4. Areas where the need outweighs the current capacity; and

5. Populations of defined area are less than 2,500 inhabitants.

Table 11. ADAD-Contracted Treatment Providers Providing Rural Services.

Agency	Island	Rural Services
Big Island Substance Abuse Council	Hawai'i	Hawai'i Island School-Based Services
Alcoholic Rehabilitation Services of Hawai'i dba Hina Mauka	Kaua'i	Kaua'i School-Based Services
Child and Family Service	Kaua'i	Kaua'i Pregnant Women and Women with Dependent Children Services
Ohana Makamae, Inc.	Maui	Hana, Maui Services
Agency	Island	Rural Services
Young Men's Christian Association of Honolulu dba YMCA of Honolulu	Lāna'i and Moloka'i	Lāna'i and Moloka'i School-Based Services
Ka Hale Pomaika'i	Moloka'i	Moloka'i Services

Table 12. Gaps in Rural Communities.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Data is often limited to the county, state, and federal levels, and not at the rural level. 	<ul style="list-style-type: none"> D-1, D-2
Services	<ul style="list-style-type: none"> Inadequate access and availability of SUD programs and services in rural areas, including for individuals with opioid dependence, recovery housing, and residential treatment (PWWDC) Lack of transportation to get to and from available SUD programs and services. Distance and travel to available services, which are often in more urban areas, can be extensive. Programs and services are mainly on O'ahu. <ul style="list-style-type: none"> Ex. Hawai'i County and Honolulu County have about equal number of facilities for outpatient programs and transitional housing; however, Hawai'i County area is much larger. Lack of housing resources such as clean and sober homes and group recovery homes in rural areas. Perceived stigma associated with seeking SUD services, especially in small rural areas where anonymity and confidentiality can be challenging. 	<ul style="list-style-type: none"> S-1, S-3
Funding	<ul style="list-style-type: none"> Different insurers reimburse differently. <ul style="list-style-type: none"> Ex. Services may be covered by some and not by others. High cost of housing in Hawai'i makes it difficult to fund recovery resources such as clean and sober homes and group recovery homes. Need for long term funding and sustainability. 	<ul style="list-style-type: none"> F-1, F-2
Workforce	<ul style="list-style-type: none"> Difficulty finding and retaining qualified workforce - high vacancies and turnover. 	<ul style="list-style-type: none"> W-1

3.10 Pregnant Women and Women with Dependent Children

Pregnant women and women with dependent children (PWWDC) are a priority population of focus when it comes to substance use disorder prevention, treatment, and recovery. Substance abuse among pregnant and parenting women continues to be a significant public health issue, with multigenerational

impacts affecting not only the mother, but her children and family as well. Additionally, substance use during

pregnancy is associated with many adverse implications during and after birth and from adolescence to adulthood, including low birthweight, birth defects, and preterm birth, as well as increased risks of cognitive and behavioral challenges (Onoye et al. 114).

Maternal characteristics related to perinatal substance use include being under 35 years of age, less educated, not married, and individuals insured by Medicaid/Med-QUEST or having no insurance prior to pregnancy (Schempf et al. 2). Substance use during pregnancy is one the most preventable causes of adverse birth outcomes, and thus increased abstinence in pregnancy should be addressed.

In a survey conducted from 2015 to 2018, of females aged 12-44 years old who were pregnant in the State of Hawai'i, the most common substances used in the past month included alcohol (15.6%), tobacco (12.8%), and marijuana (2.1%) (UH PHAC 321). Additionally, of those individuals who used illicit drugs or alcohol, 7.2% reportedly needed substance use treatment. However, results from the survey suggest that the percentage of females who needed treatment but actually received it was suppressed.

Data from the Pregnancy Risk Assessment Monitoring System, shows that from 2011 to 2015 alcohol use before and during pregnancy were generally higher in rural counties (UH PHAC 329-334). Kaua'i County reported 61.2% of individuals drank alcohol 3 months before pregnancy compared to an average of 54.5% in the State of Hawai'i. Maui County and Hawai'i County reported 11.5% and 11.4% of individuals drank during the last 3 months of pregnancy, respectively, compared to an average of 8.7% in the State of Hawai'i. Similarly, illicit drug use before pregnancy was higher in rural counties (6.9%-9.6%) compared to the City and County of Honolulu County (4.4%).

Pregnant women and women with dependent children, who have a substance use disorder often face barriers to treatment including lack of access, transportation, childcare, housing, and other resources (Onoye et al. 118). In the State of Hawai'i, there is a lack of availability and insufficient programs to serve the PWWDC population. Currently, only 5 of the 35 ADAD-contracted substance abuse agencies statewide have programs and services with evidence-based programs specific to the PWWDC population. As shown in Table 13, services offered are limited by geographic location, further adding to the inadequate access to gender-responsive treatment for the PWWDC population (Onoye et al. 119). For instance, an individual living on a neighbor island who is seeking PWWDC residential services would be required to fly to O'ahu to receive these services.

Table 13. ADAD-Contracted Treatment Providers Providing PWWDC Services.

Agency	Island	Services
Big Island Substance Abuse Council	Hawai'i	Day Treatment, Intensive Outpatient, Outpatient, Continuing Care, Clean & Sober Housing (Mom & Child), Therapeutic Living Program (Mom & Child), Child Care PWWDC
Child and Family Service	Kaua'i	Outpatient, Continuing Care, Child Care
Ka Hale Pomaika'i	Moloka'i	Intensive Outpatient, Outpatient, Continuing Care, Clean & Sober Housing
Malama Na Makua A Keiki dba Malama Family Recovery Center	Maui	Intensive Outpatient, Outpatient, Continuing Care, Clean & Sober Housing (Mom & Child), Therapeutic Living Program (Mom & Child), Child Care
Salvation Army Family Treatment Services	O'ahu	Residential PWWDC, Therapeutic Living Program PWWDC, Day Treatment, Intensive Outpatient, Outpatient, Continuing Care, Clean & Sober Housing PWWDC

ADAD continues to prioritize PWWDC for treatment services as part of the SABG requirements. The SABG requires various special services for PWWDC such as access to primary medical care and pediatric care, gender-specific substance use disorder treatment, childcare while women are receiving services, and treating the family as a unit.

The most current data from 2020 shows that of the 5,961 ADAD-funded clients in the State of Hawai'i, 272 (4.56%) were served under specialized programs for the PWWDC population (UH PHAC 339). This amounted to \$1,337,656 (11%) of ADAD funds expended for the PWWDC population (UH PHAC 340).

Table 14. Gaps in PWWDC Communities.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Lack of information sharing within and across systems. Insufficient data on intersection between PWWDC and SUD services. 	<ul style="list-style-type: none"> D-1, D-2, D-3
Services	<ul style="list-style-type: none"> Insufficient availability of gender-specific and gender-responsive programs and services. Perceived stigma and discrimination associated with PWWDC seeking SUD services. Lack of access to services and providers, especially on neighbor islands and in rural areas. Issues with coordination of services and fragmented delivery system. Lack of continuum of care services specific to PWWDC. Difficult to navigate through system of care. Few gender-specific residential SUD treatment models for both mothers and children and none for fathers and children to provide holistic family support, especially on neighbor islands and in rural areas. Time limitation for services based on contracts requirements and/or funding. Inadequate treatment length of stays. Challenges with balancing direct service and administrative expectations. <ul style="list-style-type: none"> Ex. Authorization processes and benefit exceptions Housing options as well as treatment facilities including residential programs, therapeutic living programs, registered clean and sober homes and group recovery homes are concentrated in O'ahu, with limited on neighbor islands especially in rural areas. Limited resources for housing after clinical discharge from substance treatment program. Lack of trust by clients and providers within and across systems, which can reduce collaboration and care. Lack of resources and services specific to teen mothers. 	<ul style="list-style-type: none"> S-1, S-2, S-3
Funding	<ul style="list-style-type: none"> Insufficient funding for gender-specific and gender-responsive treatment, including for children. Low reimbursement for higher complexity patients. Providers are only reimbursed for specific services, limiting provider in treating client holistically. Insurance reimbursement is limited and does not account for child's treatment. 	<ul style="list-style-type: none"> F-1, F-2
Workforce	<ul style="list-style-type: none"> Lack of knowledge and training on PWWDC-focused topics especially for providers who do not generally service the PWWDC population. <ul style="list-style-type: none"> Ex. Gender-specific and gender-responsive care for women Ex. Trauma-informed care Difficulty finding and retaining qualified workforce - high vacancies and turnover. Inadequate peer supports within the workforce. 	<ul style="list-style-type: none"> W-1, W-2, W-3

3.11 Sexual and Gender Minorities

Sexual and gender minorities (SGM) include individuals who identify as lesbian, gay, bisexual, and transgender (LGBT) as well as people of other sexual orientations and gender identities. When looking at research regarding SGM, it is worth noting that these individuals are disproportionately affected in many aspects including health risk behaviors, well-being issues, and mental health challenges. SGM communities are more likely to have mental health diagnoses such as depression and anxiety, internalized stigma, and be exposed to anti-LGBT bullying in schools all which contribute to increased substance use among these communities (Onoye et al. 194).

From 2015 to 2018, the current, past year and lifetime average annual percentages for alcohol use in the State of Hawai'i were highest among individuals aged 18 and above who identified as bisexual (UH PHAC 311). Additionally, the current, past year and lifetime average annual percentages for methamphetamine use were significantly higher among individuals aged 18 and above who identified as gay, lesbian, or bisexual, compared to the Hawai'i population and individuals who identified as straight. Although the need for treatment of alcohol or illicit drug use was highest among SGM communities (16.2-20.6% compared to 7.8% Hawai'i population average), treatment received did not correspond accordingly, with only a small percentage actually receiving treatment (2.5% among individuals who identified as bisexual).

The prevalence of current substance use among middle and high school students in Hawai'i who identify as transgender and gender non-conforming was significantly higher than their cisgender counterparts, as indicated in Table 15 below (Onoye et al. 193). Additionally, public high school students who identified as lesbian, gay, or bisexual were more likely to engage in risky behaviors including using injectables and using prescription drugs without a doctor's prescription compared to individuals who identified as heterosexual.

Table 15. Current Substance Use Amongst Transgender and Gender Non-Conforming Middle and High School Students in Hawai'i.

Substance	Percentage			
	Overall	Female	Male	Transgender/ Gender Non- Conforming
Alcohol	27.3	31.1	23.6	37.4
Cigarettes	8.4	8.4	7.6	30.2
E Cigarettes	25.9	29.7	22.3	35.4
Marijuana	20.3	22.3	17.7	42

Currently, ADAD collects data on gender in its Universal Standardized Intake and Screening form, which is used when a client enters into an episode of care for treatment and recovery services. No data is collected on other SGM demographics, including sexual identity or sex assigned at birth. Other data collection on SGM communities is also limited, including effectiveness of interventions and other treatment outcomes. Agencies may not have adequate training and workforce development focused on culturally competent care specific to SGM communities. Additionally, some stakeholders who have sought services in the past have mentioned that they are sometimes deterred or not accepted into programs due to a lack of SGM-specific services. For instance, agencies that offer residential, clean and sober, and/or group recovery housing may not have policies in place for accepting clients who identify as LGBT.

Table 16. Gaps in SGM Communities.

Theme	Identified Gaps	Action Item Reference
Data	<ul style="list-style-type: none"> Lack of data and literature on substance use treatment among SGM communities. No common data collection or tracking specific to SGM and SGM sub-populations. <ul style="list-style-type: none"> Ex. Pronouns, gender and sexual orientation as separate demographic fields on USIS and other intake forms Lack of information sharing within and across systems. 	<ul style="list-style-type: none"> D-1, D-2, D-3
Services	<ul style="list-style-type: none"> Perceived stigma and discrimination of SGM communities and with seeking SUD services. Need for more SGM-affirming care techniques and prevention efforts. Fragmented system of referral and service delivery for SGM communities. Lack of culturally competent care at existing programs. Insufficient SGM-specific programs and services. <ul style="list-style-type: none"> Ex. Residential, outpatient, clean and sober homes, and group recovery homes 	<ul style="list-style-type: none"> S-1, S-2, S-3
Funding	<ul style="list-style-type: none"> Insufficient funding for SGM-specific treatment. Insurance reimbursement is low and limited to specific services. 	<ul style="list-style-type: none"> F-1, F-2

<p>Workforce</p>	<ul style="list-style-type: none"> • Insufficient workforce that addresses SUD among SGM communities. • Lack of knowledge and training on SGM-focused issues in order to provide culturally competent care. • SGM training is not a requirement for certification of or continuing education for Certified Substance Abuse Counselors and Certified Prevention Specialists. • Difficulty finding and retaining qualified workforce - high vacancies and turnover. • Inadequate peer supports within the workforce. 	<ul style="list-style-type: none"> • W-1, W-2, W-3
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4. DATA

4.1 Overview

Compilation, analysis, and exchange of data is integral to creating and implementing a data driven system for substance use prevention and treatment. The priority of the Substance Use State Plan 2022 is to collect and compile a variety of data on the current state of substance use in Hawai'i. Development of the Hawai'i State Plan on Substance Use: 2022 Statistical Report is a key piece of this effort. Another key piece of data is ADAD's Web Infrastructure for Treatment Services (WITS) system. The compilation of the statistical report and implementation of WITS highlights several challenges to compile, analyze, and exchange substance use data. A continuing data project funded by the Overdose Data to Action cooperative agreement from the Centers for Disease Control and Prevention (CDC) is State of Hawai'i Behavioral Health Dashboard - BETA website. The Dashboard helps understand Hawai'i's current behavioral health trends and needs, with a focus on drug overdose, polysubstance, co-occurring substance use, and mental health, including crisis care. The State of Hawai'i Behavioral Dashboard summarizes the related number of hospitalizations and overdose deaths and can be found online at bh808.hawaii.gov

4.2 Hawai'i State Plan on Substance Use: 2022 Statistical Report

The Hawai'i State Plan on Substance Use: 2022 Statistical Report provides broad information on the prevalence of substance use and extent of treatment access within the state. Areas covered included a statewide overview on substance use and treatment access, mental health, homelessness, criminal justice, juvenile justice, violence, Native Hawaiians, rural communities, pregnant & parenting women with dependent children, and sexual & gender minorities.

The University of Hawai'i at Mānoa Pacific Health Analytics Collaborative developed and implemented the data analytic infrastructure utilizing eighteen existing accessible data sets from the following categories: survey, clinical, and administrative data resources. The central principals throughout this process were standardization, automation, and reproducibility. Standardization minimizes human error and increases efficiency. Automating the analysis minimizes the risk of error. Lastly, reproducibility allows for new data to be included in the future.

4.3 Web Infrastructure for Treatment Services System

The WITS system was established by ADAD in SFY 2008-2009 to implement HRS §321-192.5 Substance Abuse Treatment Monitoring Program and is one of the data sets utilized by the statistical report. Treatment providers are required to transmit information, such as demographics, on individuals receiving ADAD funded treatment. This information is included in ADAD's annual report to the Hawai'i State Legislature.

4.4 Challenges

There are two major challenges to compile, analyze, and exchange data: 1) gaps in data collection and 2) issues with information sharing especially around health outcomes.

Gaps in data collection can occur for various reasons, such as data not being in line with the intended purpose and need or data not able to be gathered from clients. An example of this is data collection required for the Substance Abuse Treatment Monitoring Program. Treatment providers are required to provide ADAD with six-month follow up data on individuals who were discharged due to successful

completion of treatment. However, not all these individuals complete the follow up survey because treatment providers are not able to reach them. Also, WITS is not fully mapped to current reporting software, resulting in limited utility in analysis of specific priority populations, such as the PWWDC population.

Substance use data is stored in multiple data sources, by multiple agencies, and may not be easily accessed or used as each set of data is being collected for a specific purpose and need. Proposed additions or revisions to data fields of an existing data set must be approved by the developer. In addition, it is time-consuming to wait for new releases depending on the complexity of the coding involved. Data collection can be hampered due to lack of access to an existing data source, often requiring the execution of a data access and data use agreement. The Hawai'i State Plan on Substance Use: 2022 Statistical Report encountered these challenges associated with gaps in data collection.

ADAD is also part of the DOH Behavioral Health Administration's workgroup to improve data sharing across the Behavioral Health Administration Divisions. The key consideration is navigation of legal issues (i.e., HIPAA and 42 CFR Part 2) on who has access to the data and for what purpose.

Information sharing can be difficult or not available if data systems cannot easily export data or talk to each other. Since its launch in SFY 2008-2009, ADAD uses the WITS system for purposes such as client enrollment, provider enrollment, utilization management, prior authorization, claims processing, and provider payment. There are several deficiencies that impact ease of use such as difficulty in generating reports, modifying data collection, and processing payments from third-party payors. The WITS system is also not able to receive or share data with the medical and judicial system. To address these deficiencies and meet ADAD's needs, during SFY 2020-2021, HACDACS recommended a replacement to the WITS system (ADAD, *Annual Report to the Thirtieth Legislature 2022 19-20*).

5. ADMINISTRATION

5.1 ADAD Offices and Branches

The ADAD's five offices and branches help to maintain the core public health functions of assessment, policy development, and assurance of substance abuse services (Figure 5).



Figure 5. The Alcohol and Drug Abuse Division Offices and Branches.

5.2 Hawai'i Advisory Commission on Drug Abuse and Controlled Substances

The Hawai'i Advisory Commission on Drug Abuse and Controlled Substances is part of the State of Hawai'i Department of Health for administrative purposes. The HRS §329-4 requires the HACDACS to assist the DOH with coordinating action programs of community agencies and carrying out educational programs, creating public awareness, and sitting and acting in an advisory capacity to the Governor, other State departments, and the Director of Health on substance abuse matters. The HRS §329-3 also requires the HACDACS to provide annual reports on actions during the previous fiscal year. Priorities discussed during SFY 2021, as noted in the DOH ADAD's *Annual Report to the Thirtieth Legislature 2022* included:

1. Medical Cannabis and the Legalization of Recreational Cannabis;
2. ADAD Strategic Plan and Public Health Data;
3. Culture as a Basis for Substance Use Treatment and Recovery Programs;
4. Hawai'i Coordinated Access Resource Entry System; and
5. Peer Specialists for Mental Health and Substance Use Treatment.

5.3 Hawai'i Opioid Initiative

With support from Governor Ige and collaboration with over 100 stakeholders and community representatives, ADAD has implemented the Hawai'i Opioid Initiative. The HOI initiates activities in seven (7) focus areas all targeted to reduce risk factors and increase protective factors throughout the state for opioid and other substance misuse. The HOI in its second year of implementation achieved several objectives which include expanded registration in the Patient-Driven Payment Model, broadened naloxone training and distribution, and coordination of state-wide installation of medication drop boxes. The HOI in its third year of implementation seeks to develop strategies for inclusion of Native Hawaiian cultural intervention treatment programs, wellness plans and holistic living into the system of care.

5.4 Opioid Settlement

In August 2022, Governor David Ige announced \$78 million in opioid settlement funds for the State of Hawai'i. The funds will be distributed to the State and all four major counties, following recommendations made by an Advisory Committee who will determine proper use of funds. Of the \$78 million, 85% of funds will be used for opioid-related treatment, prevention and education, while the remaining funds will be used for other substances. The settlement will be disbursed over a span of 18 years. The DOH and ADAD will play a major role in ensuring efficient, effective, and proper use of funds for treatment, prevention and education of the opioid crisis and the devastating and lasting impacts it has on our communities.

5.5 Interagency Collaboration

The HRS §321-193.5 requires the establishment of "a coordinating body through an interagency cooperative agreement to oversee the development and implementation of offender substance abuse treatment programs in the State." The coordinating body is comprised of at minimum, the Department of Public Safety, Hawai'i Paroling Authority, Judiciary, DOH, the Department of Human Services, and any other agencies assigned oversight responsibilities for offender substance abuse treatment by law or administrative order. The DOH ADAD is tasked with leading, facilitating and providing administrative support to the coordinating body. ADAD seeks to increase collaboration of the coordinating body to ensure offender substance use treatment is adequately and effectively provided.

ADAD currently collaborates with other agencies to provide substance abuse treatment and recovery services for adults, children, and families. These include, but are not limited to, the Judiciary, the Department of Public Safety, Child Welfare Services, Department of Human Services, AMHD, and the Child and Adolescent Mental Health Division.

6. SERVICES

Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provides substance abuse prevention and treatment services to adults and adolescents Statewide.

6.1 Prevention

The goal of the substance use disorder prevention system is to reduce the prevalence, incidence, and consequences of alcohol, tobacco, and other drugs by addressing community conditions that promote substance misuse and by enhancing community conditions that buffer individuals from the consequences of substance use disorder. Past prevention-funded programs engaged schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models, programs, and policies to prevent substance abuse in young people.

The Prevention Branch, as of October 01, 2022, contracts with fifteen non-profit organizations and community-based agencies Statewide to provide Substance Misuse Prevention Services. These services are to prevent substance use disorders by addressing risk and protective factors that influence the likelihood of substance use, misuse, or abuse and related behaviors. Under these contracts, prevention programs incorporate at least one of the six Center for Substance Abuse Prevention strategies and the Strategic Prevention Framework for universal, selected and/or indicated populations. The SPF is a community-based, data driven five step process that can be applied to prevention systems at both the state and local levels and that are appropriate for the community and identified target populations (Figure 6).

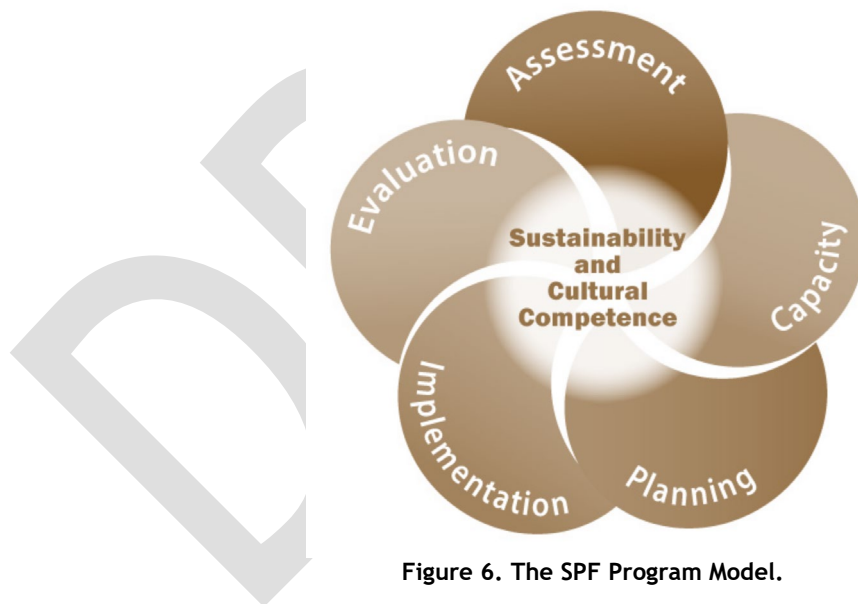


Figure 6. The SPF Program Model.

In SFY 2020-2021, ADAD contracted with fourteen agencies and community coalitions funded by the Strategic Prevention Framework - Partnerships for Success Grant and ten agencies funded by the Substance Abuse Prevention and Treatment Block Grant and State General funds to serve a total of 895,933 children, youth, and adults statewide through individual-and population-based prevention services, activities, and programs. These included curriculum-based substance use prevention programs and underage drinking initiatives.

The Food and Drug Administration (FDA) Tobacco Program

The Food and Drug Administration Tobacco Program within the Prevention Branch ensures that the Tobacco Control Act (Public Law 111-31) is enforced in Hawai'i. The current 4-year FDA contract, which runs from 09/30/2020 to 09/30/2024, funds tobacco inspections to ensure compliance with the Tobacco Control Act at retail outlets that sell or advertise tobacco products. In the last 12 months ending 06/30/2022, 571 inspection results were returned in the State of Hawai'i. Of the inspection results returned, 23 were in violation - 14 on O'ahu, 4 on Maui, 4 on Kaua'i, and 1 on the Big Island (*Compliance Check Inspections of Tobacco Product Retailers*). Charges included violations due to failure to verify age, sale to a minor under 18, and sale to a person under 21.

6.2 Treatment

The goal of treatment services is to reduce the severity and disabling effects related to alcohol and other drug use by coordinating services in a broad and comprehensive behavioral health continuum of care. The ADAD uses the American Society for Addiction Patient Placement Criteria, better known as The American Society for Addiction Medicine (ASAM) Criteria as the foundation and guideline for admission, continuance, and discharge for clients with substance use disorder or co-occurring disorders. Treatment plans are developed using the six dimensions of a multidimensional assessment and over five levels of treatment within a continuum of care (Figure 7) (*ASAM Criteria*).

The six dimensions of The ASAM Criteria are:

- Dimension 1 - Acute Intoxication and/or Withdrawal Potential
- Dimension 2 - Biomedical Conditions and Complications
- Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4 - Readiness to Change
- Dimension 5 - Relapse, Continued Use or Continued Problem Potential
- Dimension 6 - Recovering/Living Environment

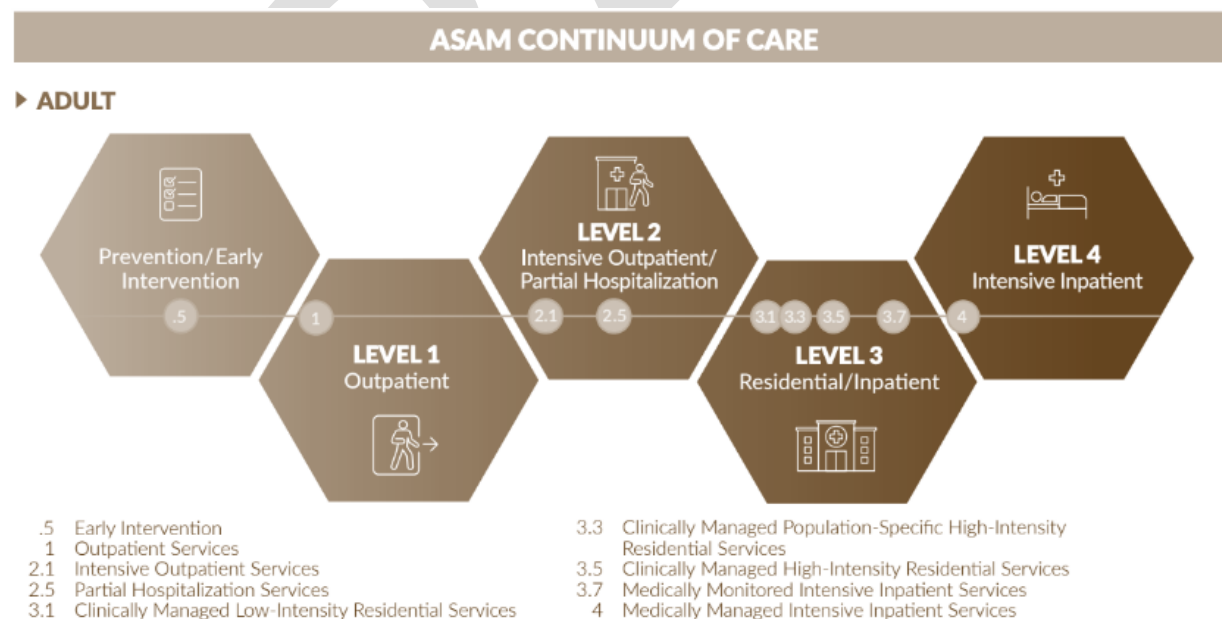


Figure 7. Five Broad Levels of Treatment within the Continuum of Care for the Adult Population.

The Treatment and Recovery Branch currently contracts with thirty-five (35) agencies Statewide to provide the Behavioral Health Substance Use Disorder Continuum of Care Service Array for Adults and

Adolescents. Treatment providers can provide all or part of the SUD Continuum of Care Service Array. All client admissions, treatment service, including treatment progress notes, and discharges are tracked on the ADAD-designated electronic management information system, currently known as the WITS system.

In FFY 2020-2021, 2,331 adults and 557 adolescents Statewide were served through the SUD COC. Compared to FFY 2018-2019, this was a 31% and 69% reduction of adults and adolescents served, respectively, and can be attributed in large part to the COVID-19 pandemic. The SUD Continuum of Care Service Array, outlined below in Figure 8, includes services in pre-treatment, treatment, and recovery for adults and adolescents:



Figure 8. DOH ADAD’s Behavioral Health Substance Use Disorder Continuum of Care Services for Adults and Adolescents.

6.3 Recovery

Key components of recovery services include therapeutic living programs, clean and sober homes, and group recovery homes.

Pursuant to HRS §321-193.7 and as described in Chapter 11-178 Hawai’i Administrative Rules, ADAD launched the Clean and Sober Homes Registry, a voluntary registry to assist individuals in finding a safe living environment to support their recovery (ADAD, *Clean and Sober Homes*). To date, there are 64 homes registered and in good standing on the Clean and Sober Homes Registry. The Clean and Sober Homes Registry website offers various services including allowing: 1) the general public to search for and find information about registered Clean and Sober homes that are “in good standing” in Hawai’i, 2) operators to submit applications and check status of their registration application, and 3) registry staff to access information and track complaints about clean and sober homes.

ADAD also supports peer recovery support specialists and persons with lived experiences in the workforce to provide peer support in treatment and recovery programs. In the coming years, ADAD will look to establish certification and adopt Hawai’i Administrative Rules for peer recovery support specialists, incorporate training methods for increasing peer recovery support specialists for specific groups, and consider ways to offer peer recovery support as part of the SUD COC with reimbursement and payment strategies for this service.

6.4 Harm Reduction

In November 2021, the Alcohol and Drug Abuse Division released an official announcement on Harm Reduction as a distinctly recognized component to the comprehensive continuum of care services, along with Prevention, Treatment and Recovery. As such, ADAD supports and is working to integrate Harm Reduction as a key pillar in its current COC in Hawai'i to "meet people where they are." Any policies, funding, and planning going forward will take into consideration this fourth component.

Harm Reduction is well recognized and supported by the Biden-Harris Administration and the Office of National Drug Control Policy, Department of Health and Human Services, The National Harm Reduction Coalition and The Substance Abuse and Mental Health Services Administration (Office of National Drug Control Policy; *Overdose Prevention Strategy*; *Principles of Harm Reduction*; *Harm Reduction at SAMHSA*). These resources provide background on and principles of Harm Reduction, as well as current evidence-based efforts to address the alarming rise of drug overdose deaths.

6.5 Hawai'i Coordinated Access Resource Entry System

Contracted agencies are responsible for participating in the SUD COC network of providers and interacting with the Hawai'i CARES. The Hawai'i CARES, administered by Hawai'i State DOH, is a statewide 24/7 coordination center for support with substance use, mental health, and crisis intervention services. In 2021, the Hawai'i CARES received 101,151 calls related to mental health, substance use and crisis services. Beginning in early 2022, the Hawai'i State DOH contracted with two community-based agencies to support the Hawai'i CARES. The Adult Mental Health Division contracts with Care Hawai'i, Inc. to provide the mental health and crisis services component of the Hawai'i CARES. The Alcohol and Drug Abuse Division contracts with Aloha United Way to provide the substance use services component of the Hawai'i CARES.

On July 16, 2022, as part of a nationwide commitment to transform the mental health and crisis care system in America, Hawai'i adopted the new 988 dialing code. Calling the simple three-digit number, 988, directs an individual to the Hawai'i CARES line. Individuals are still able to call the original 808-832-3100 or 1-800-753-6879 numbers to reach the Hawai'i CARES. The implementation of 988 allows for expanded access and an easier-to-remember contact number to the Hawai'i CARES. Individuals who may be in the precontemplative or contemplative stages of change can take their first step by reaching out to the Hawai'i CARES to inquire about services.

7. FUNDING

ADAD is the primary source of public substance use funds in the State of Hawai'i. During SFY 2020-2021, \$36,291,947 was appropriated by Act 9, Session Laws of Hawai'i 2020 to ADAD's programs - \$20,113,424 general funds, \$750,000 special funds, and \$15,428,523 federal funds. Of the total appropriated, \$27,158,498 was allocated for substance abuse treatment services and \$6,694,079 was allocated for substance abuse prevention services. Moving forward, ADAD is committed to increasing the share of prevention funding from the current share of approximately 20% to 30% or more.

ADAD allows for and encourages the use of braided funding for providers to weave multiple sources of funding together. These include federal, special, state, discretionary and other funding sources (i.e., Managed Care Organizations and third-party payors) to fund substance abuse treatment and recovery services. Providers first maximize reimbursement of benefits through any Medicaid, Medicare, and other third-party payors. Provided there is clinical need and no other payors available, ADAD funds may be used to supplement Medicaid, Medicare, and other third-party payors for substance abuse services, after the benefits have been exhausted and up to the limit of the ADAD substance abuse benefits. ADAD is the payor of last resort for all services. ADAD hopes to be able to use other sources of funding, including funds from the Opioid Settlement, on future projects.

ADAD intends to embark on a rate study to analyze and compare service rates for substance use services, as well as look into value-based purchasing strategies. In recent years, Medicaid and the Hawaii Medical Service Association have implemented value-based purchasing models. ADAD would also like to explore ways to develop technical assistance for service providers to build and expand their business, so they are less dependent on ADAD funding.

7.1 State – Special Funds

Drug Demand Reduction Assessments

In addition to State general funds, the Drug Demand Reduction Assessments special fund (HRS §706-650) administered by the Department of Health is used to supplement substance abuse treatment and other substance abuse demand reduction programs.

7.2 Federal – Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse and Mental Health Services Administration administers two block grants, the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant. The Block Grants are offered annually on a noncompetitive basis, to all states, territories, and tribes for the planning, implementation, and evaluation of prevention and treatment of SUD and mental health, respectively. The allocation of Block Grant funds to each of the states, territories and tribes are based on a SAMHSA formula and requirements. In the Federal Fiscal Year (FFY) 2022, the State of Hawai'i was awarded \$8,654,757.00 in SABG funds. The Alcohol and Drug Abuse Division is the Single State Agency that manages the SABG for Hawai'i.

ADAD's efforts are designed to promote a statewide culturally appropriate, comprehensive system of substance abuse services to meet the treatment and recovery needs of individuals and families and to address the prevention needs of communities. ADAD utilizes the State procurement process to direct available SABG and State funds to support the provision of services for the substance abuse continuum of care. Of note, as an SABG requirement, the prevention set aside requires that a minimum of 20% of all SABG funds must be expended annually for primary prevention services. Similarly, the SABG

maintenance of effort and set aside requirements for the PWWDC and Native Hawaiian population must also be met.

In FFY 2021 and 2022, ADAD also received supplemental funds in response to the COVID-19 pandemic. The supplemental funds include:

COVID-19 Supplemental

The SABG COVID-19 supplemental funds are a total of \$8 million over 2 years (03/15/2021-03/14/2023). The funds will be used to enable workforce supports for peer recovery specialists, credential substance use counselors among physicians, provide systematic training and a pilot project on warm lines for SUD professionals, and expand SUD stabilization bed capacity for pregnant and parenting women with dependent children in rural areas.

American Rescue Plan Act (ARPA) Supplemental

The SABG ARPA supplemental funds are a total of \$7 million over 4 years (09/01/2021-09/30/2025). These supplemental funds will be used to address the effects of the COVID-19 pandemic and improve and enhance the substance use service array that serves the community. The funds will be used to expand peer-based recovery support services and training for peer recovery specialists, advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas, improve health information technology interoperability and a consent registry, workforce supports to increase physicians who wish to obtain the substance use counselor credential, improve primary prevention programs to educate children, adolescents and youth under 21 on cannabis, and to expand SUD stabilization bed capacity combined with medication assisted treatment and withdrawal management services.

ARPA Mitigation

The SABG ARPA Mitigation supplemental funds are a total of \$250,000.00 over 4 years (09/01/2021-09/30/2025). These funds will provide resources and flexibility for states to prevent, prepare for, and respond to the COVID-19 public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system. The funds will be used to conduct substance use professional training on COVID-19 testing and mitigation strategies based on guidance from the Centers for Disease Control and Prevention, and contract with a mobile testing provider to relieve SUD provider cost burden on the administrative and operating costs of conducting onsite testing services for SUD staff and clients in housing-related programs, for facilities that are rural remote and/or provide outpatient or intensive outpatient services, and for other SUD treatment and primary prevention facilities.

7.3 Federal – Discretionary Funds

Current

Strategic Prevention Framework - Partnerships for Success Grant

The Strategic Prevention Framework - Partnerships for Success grant is \$2.0 million in each of five years (09/30/2018-09/29/2023). This grant provides further support for the project goals and objectives of strengthening and enhancing the prevention system at the local and state level. It also addresses the priority issue of alcohol use by minors in high need areas through community anti-drug coalition work and evidence-based programs.

State Opioid Response Project (SOR) Grants (SOR 2.0 and SOR 3.0)

The SOR 2.0 Grant for \$8 million over 3 years (09/30/2020-09/29/2023) expands on the SOR 1.0 Grant aiming to address the opioid crisis by increasing prevention, treatment and recovery services and programs for opioid use disorder and/or stimulant use disorders, including for cocaine and methamphetamine.

The SOR 3.0 Grant for \$8 million over 2 years (09/30/2022-09/29/2024) expands on SOR 2.0 and aims to enhance and expand the State's SUD continuum of care for prevention, treatment, harm reduction, and recovery support services and increases culturally anchored intervention treatment programs, wellness plans, and holistic living systems of care throughout the continuum of care.

Recently CompletedState Opioid Response Project Grant (SOR 1.0)

The SOR 1.0 Grant for \$10 million over 3 years (09/30/2018-09/29/2021) aimed to address the opioid crisis by increasing prevention, treatment, and recovery services and programs for opioid use disorder. From FFY 2019-2021, 1,154 clients received treatment and recovery services, 1,067 clients received medication-assisted treatment, 1,154 overdoses were reversed, and 21,510 naloxone kits were distributed (ADAD, "Towards a Population Health Model", Slide 16).

Screening, Brief Intervention, and Referral to Treatment Grant

The SBIRT grant for \$6.5 million over six years (09/30/2016-09/29/2022) provided screenings, early intervention, and referral to treatment for adults in primary care and community health settings for substance misuse and substance use disorders. The SBIRT grant also helped develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers. Despite the SBIRT grant ending in September 2022, participating providers, the Department of Health, the Med-QUEST Division, and other key stakeholders are working to sustain SBIRT within primary practice and in hospitals. ADAD is interested in continuing SBIRT beyond the grant expiration, especially for priority populations such as pregnant and parenting women with children.

Youth Treatment and Implementation Grant

The HI YT-I grant for \$3.1 million over 5 years (09/30/2017-09/29/2022) provided the State the opportunity to expand access for SUD COC treatment services and mental health services to youth ages 12-26. ADAD collaborated with the Child and Adolescent Mental Health Division on expansion and coordination for multiple systems to allow for additional access to services including multisystem therapy. This grant presented the opportunity to create a direct referral process between SUD and mental health service providers. In response to the COVID-19 pandemic, and in collaboration with the Child and Adolescent Mental Health Division and the Office of Youth Services, HI YT-I contracted with a provider to offer a residential crisis shelter and other behavioral health services for youth. ADAD is committed to continuing services for youth treatment and recovery services and looking at the intersection of substance use as it relates to issues such as youth pregnancies and services that are offered to this population.

Disaster Response State Project (DRS) Grant

The Disaster Response State Project grant for \$7.0 million over 2 years (09/30/2020-09/29/2022) provided support for addressing the behavioral health impacts of natural disasters. The DRS grant allowed for various activities including dissemination of disaster preparedness and response resources, development of an emergency preparedness toolkit, a disaster response cultural training series, and a media campaign to spread awareness about the importance of preparing for natural disasters. ADAD is

committed to continuing partnerships with Office of Public Health Preparedness, the Family Health Services Division, the Adult Mental Health Division, and the UH School of Social Work and Public Health on future projects including but not limited to emergency preparedness and trainings.

7.4 Federal - Other Funds

Food and Drug Administration Contract

The Food and Drug Administration Contract for \$3 million over four years (09/30/2020-09/29/2024) assists with compliance check inspections of retail outlets, on behalf of the FDA, for compliance with the Tobacco Control Act (Public Law 111-31).

7.5 Med-QUEST 1115 Waiver

The Hawai'i Medicaid 1115 waiver program overseen by the Department of Human Services Med-Quest Division (Med-QUEST), helps to fund a large percentage of treatment clients. Most Medicaid services in Hawai'i are delivered through Managed Care Organizations (MCOs), which include AlohaCare, Hawai'i Medical Service Association, Kaiser Permanente, Ohana Health Plan and United Healthcare Community Plan. Each MCO sets criteria for enrollment of and determines the substance abuse treatment providers it contracts with and has its own process for credentialing. Treatment services are provided to clients within the limits of the benefits in the Med-QUEST plan. Provided there is clinical need, ADAD funds may be used to supplement Med-QUEST for substance abuse services, after the benefits have been exhausted and up to the limit of the ADAD substance abuse benefits.

The current 1115 waiver expands the range of behavioral health services including supportive housing. Qualifying individuals who are also diagnosed with SUD are eligible for supportive housing services. Med-QUEST plans to seek a 1115 waiver to further expand MAT coverage and substance use services.

8. WORKFORCE DEVELOPMENT

Workforce development of qualified, culturally competent staff in the prevention and treatment of substance use disorders is one of ADAD’s current priorities. Pursuant to HRS §321-193(10), ADAD certifies substance abuse counselors and program administrators in Hawai’i through the five certifications identified in Figure 9.



Figure 9. Certifications through the Alcohol and Drug Abuse Division.

Hawai’i is a member board of the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC/AODA). This is a voluntary international organization comprised of substance abuse credentialing boards representing 41 states, the U.S. military, various Indian Health Service Organizations, and a range of countries. Hawai’i Administrative Rules Title 11 Chapter 177.1 includes a provision allowing substance use professionals credentialed and in good standing with an IC&RC member board to apply for reciprocity to work in Hawai’i. ADAD will be adding a sixth certification for a Peer Recovery Support Specialist.

From August 2020 to July 2022, Hawai’i has seen a significant and across the board decrease in substance use workforce. As shown in Table 17, on the next page, these decreases occurred in those who are currently active with certification and those who are in progress to certification. Factors likely associated with this decrease are the COVID-19 pandemic, updating records on file with ADAD, individuals on sabbatical, or individuals leaving the State using reciprocity through IC&RC.

There are also geographic disparities in the substance use workforce amongst the various islands. As the state’s largest urban area, O’ahu has the highest number of individuals with active or in progress certifications.

Table 17. Number of Workforce by Certification Type Statewide, August 2020 and July 2022.

Certification Type	August 2020			July 2022			Active % Change	In Progress % Change
	Active	In Progress	Total	Active	In Progress	Total		
CSAC	861	-	-	562	979	1,541	-35%	N/A
CPS	26	17	43	26	13	39	0%	-23%
CCS	40	8	48	26	4	30	-35%	-50%
CCJP	35	5	40	28	4	32	-20%	-20%
CSAPA	16	2	18	18	0	18	12%	-100%

In addition to substance use certification, ADAD also provides training programs that provide Continuing Education Units for professional certification and/or recertification for healthcare, human services, criminal justice, and substance abuse treatment and prevention professionals. During 2020-2021, ADAD conducted 59 training sessions, courses and workshops on various topics related to substance use treatment and prevention. Participants earned a total of 17,813 Continuing Education Units.

There is a need to develop technical assistance materials for providers in several areas to supplement current training. ADAD's priority is to develop technical assistance material to properly document cultural activities and do case management as part of aiding in a client's recovery.

The increase in workforce training and development of primary care professionals is particularly important as they often serve as the first entry point to healthcare and can be a significant referral source for an individual to access and be referred to substance use treatment (Onoye et al. 218). Increased workforce in primary care and particularly to treat individuals with substance use disorder, as well as more workforce development in the form of training and continuing education regarding substance use disorders is necessary for primary care providers. Hawai'i is currently facing workforce shortages in both primary care and substance treatment settings, making it more difficult to access treatment for substance use. Additionally, among primary care providers, very few actually have sufficient training and education in addiction medicine.

The HACDACS at its March 2020 meeting provided recommendations to evaluate the current substance abuse treatment and workforce development structure. This evaluation should cover each certification offered and its processes; support recruitment and retention through collaborations with educational institutions as well as develop incentives for retention; develop an application tracking system providing easier and timely follow to applicants; and evaluate reasons why applicant do not complete certification process or pass certification exam.

ADAD has several initiatives to support workforce development: collaboration with higher education institutions, staff certificate exemption in treatment and recovery contracts, and development of a workforce training plan. Current collaborations are with the Leeward Community College, University of Hawai'i at Mānoa, John A. Burns School of Medicine and Thompson School of Social Work and Public Health, University of Hawai'i West O'ahu, and Chaminade University to improve recruitment of CSAC certification. ADAD currently does not place CSAC applicants with organizations for experience and hours. Instead, the community colleges and universities often have agreements with substance use treatment agencies and community organizations to place students for experience and hours.

To monitor workforce recruitment and retention, ADAD incorporated staff certification exemptions in Treatment and Recovery Branch contracts, effective October 01, 2021. These staff certification exemptions only apply to staff who are currently working towards CSAC, CCS, or Peer Recovery Support Specialist certification. Updates documenting progress for each staff member with an approved staff certification exemption request are made to ADAD on a quarterly basis at minimum. With the inclusion of this new contract provision, the Quality Assurance and Improvement Office has seen an influx of CSAC applications and those interested in pursuing certification.

To build upon the 2018 Strategic Plan for Workforce Development, ADAD has contracted with the University of Hawai'i at Mānoa to develop a new workforce training plan, known as the Hawai'i Substance Use Professional Development (Hawai'i SUPD) project. The Hawai'i SUPD will address the State's workforce development needs. A workforce development committee, consisting of a variety of stakeholders, will be established to guide the successful implementation of the training plan. In addition to the plan, various training opportunities and resources for professional development will also be developed. The Hawai'i SUPD contract activities are shown below in Figure 10.

Additionally, other workforce recruitment and retention initiatives are in progress, including through a \$2.2 million grant awarded to the University of Hawai'i at Mānoa and the Leeward Community College to train students in substance abuse counseling, treatment, and aftercare. The grant will expand the

behavioral health workforce and enable 88 students to become trained as substance abuse counselors. In partnership with community organizations for on-the-job training, and ADAD, these students can also work towards becoming Certified Substance Abuse Counselors.

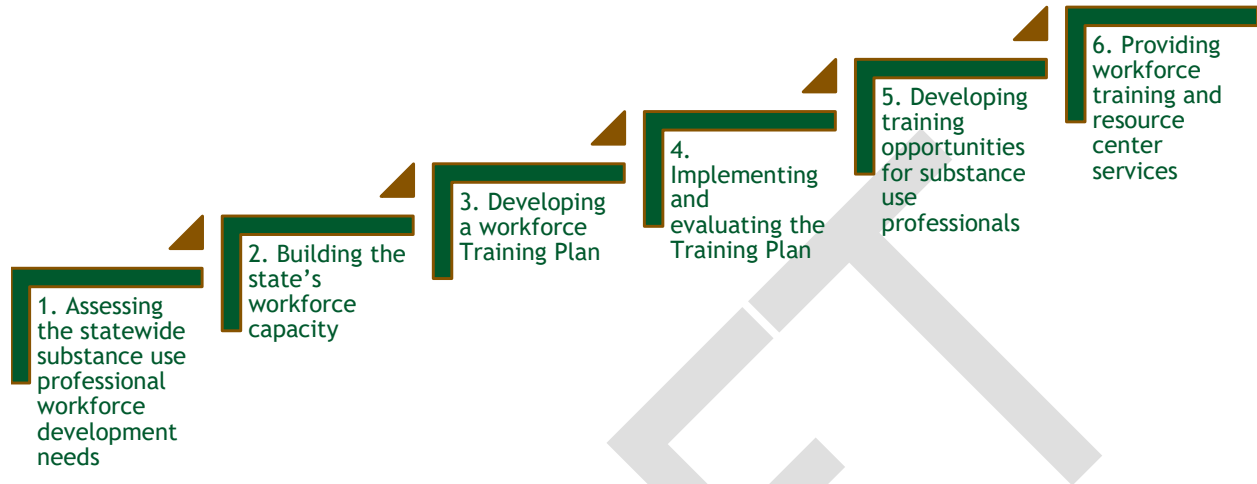


Figure 10. Activities to be Completed as Part of the State's Substance Use Training and Workforce Development Contract with the University of Hawai'i.

9. FINDINGS

Several findings emerged highlighting the gaps and challenges, across themes, within the existing system of care and the intersection between substance use and various sectors and communities in Hawai'i. There is a need for:

- improved data collection, sharing, and usage;
- increased collaboration, coordination, and referrals within and across agencies, service providers and other community partners;
- shifts in funding priorities towards programs that improve primary prevention capacity and service delivery to meet the needs of priority populations; and
- increased recruitment and retention of qualified substance use workforce.

These findings provide the basis for the Substance Use State Plan 2022 Priority Action Items. The Priority Action Items are organized by themes: Data, Administration, Services, Funding, and Workforce. Each theme details objectives, activities to address gaps, ADAD's priority actions over the next five years, and potential partnerships.

DATA. There is a need for additional and improved data collection, sharing, and usage.

Substance use data is collected and used for a specific purpose, need, and geographic region. The Substance Use State Plan 2022 provided ADAD the opportunity to develop and implement a data driven system for substance use prevention and treatment. The compilation of the Hawai'i State Plan for a Data Driven System of Care on Substance Use: 2022 Statistical Report and implementation of WITS highlights the gaps in current data collection and challenges with information sharing especially around health outcomes. Data gaps and challenges were also identified qualitatively in the volume "Intersections of Substance Use Among Public Sectors and Health Disparities Populations: Implications for a System of Care."

Identified data gaps can be categorized as demographic, geographic, or non-existent. Additional demographic data required for the SGM community includes pronouns, gender, and sexual orientation. Needs for rural communities require that data be collected and broken down into a variety of geographic regions, not just at the County or State level.

Information sharing is difficult or not available as existing data systems cannot easily export data or talk to one another. This lack of access to data or information sharing impacts coordination of care for individuals in different systems. For example, an individual who is an ADAD client but also an AMHD consumer, or an individual utilizing both the Coordinated Entry System for housing and the Hawai'i CARES for behavioral health services. Primary care physicians have identified the need to standardize electronic health records to implement SBIRT.

ADAD's WITS system has several deficiencies that impact ease of use such as difficulty in generating reports, modifying data collection, and processing payments from third-party payors. Additionally, the WITS system is also not able to receive or share data with other systems.

SERVICES. There is a need for increased collaboration, coordination, and referrals within and across agencies, service providers, and other community partners.

The existing system of care for SUD services is fragmented amongst public and private service providers. For those living in rural O'ahu and on the neighbor islands, access to SUD services is either limited or simply not available. Lack of transportation on neighbor islands can further hamper access to an on-island SUD service. Availability of SUD services to meet the needs of specific sectors and special

populations are limited or non-existent. For example, services that are culturally appropriate for Native Hawaiians, are gender responsive for pregnant and parenting women, and specific to sexual and gender minorities. Lastly, there is perceived stigma and/or discrimination for those seeking out services.

ADAD recognizes Harm Reduction as a distinct component to the comprehensive continuum of care services, along with Prevention, Treatment and Recovery. Currently, ADAD is working to integrate Harm Reduction as a key pillar in its current continuum of care in Hawai'i.

FUNDING. There is a need for shifts in funding priorities towards programs that improve primary prevention capacity and service delivery to meet the needs of priority populations.

Funding for service providers is an ongoing challenge. Existing reimbursement rates do not consider additional time and services required to treat higher complexity patients such as pregnant women and women with dependent children. These rates also differ among insurance providers. Not all services provided qualify for reimbursement. For example, ADAD does not offer cultural services as a billable rate, though there are limited circumstances where cultural services can be billed as part of a different service. Lastly, funding requirements and restrictions can reduce collaboration amongst service providers.

ADAD is the primary source of public substance use funds in Hawai'i. During SFY 2020-2021, approximately \$33.9 million of federal and state funds were allocated for substance use services. Substance use treatment services were allocated \$27,158,498 and substance abuse prevention services were allocated \$6,694,079. ADAD is committed to increasing the share of prevention funding from the current share of approximately 20% to 30% or more. ADAD also allows for and encourages the use of braided funding for service providers to weave multiple sources of funding together. These include federal, special, state, discretionary and other funding sources (i.e., from managed care organizations and third-party payors) to fund substance use treatment and recovery services. Additionally, ADAD is currently working with Med-QUEST to expand the 1115 waiver to include more services within the SUD continuum of care.

Many community-based substance use prevention and treatment agencies are contracted by ADAD to provide statewide substance use prevention and treatment services to adults and adolescents. To explore reimbursement rates, ADAD intends to embark on a rate study to analyze and compare service rates for substance use services, as well as look into value-based purchasing strategies. In recent years, Medicaid and the Hawaii Medical Service Association have implemented value-based purchasing models. ADAD would also like to explore ways to develop technical assistance for service providers to build and expand their business, so they are less dependent on ADAD funding.

WORKFORCE DEVELOPMENT. There is a need for increased recruitment and retention of qualified substance use workforce.

SUD service providers have difficulty in finding and retaining qualified workers resulting in high vacancies and turnovers. There are geographic disparities in substance use workforce amongst the various islands with a majority of the workforce on O'ahu. Requiring individuals to fly to O'ahu to receive needed treatment. Over the past two years, ADAD has seen an across the board decrease in substance use workforce which further exacerbates the current shortage.

ADAD provides training programs that provide Continuing Education Units for professional certification and/or recertification for healthcare, human services, criminal justice, and substance abuse treatment and prevention professionals. There is a need to develop technical assistance materials for providers in several areas to supplement current training. There is a need to develop and provide technical assistance to properly document cultural activities and do case management. ADAD has contracted with the University of Hawai'i to develop and support a workforce training plan that addresses the State's workforce development needs.

10. PRIORITY ACTION ITEMS

The State Plan 2022 priority action items fall under five theme areas: Data, Administration, Services, Funding, and Workforce Development. Each theme has three objectives, number of potential ADAD activities to address gaps, ADAD priority actions, and potential partners.

Theme	Objectives	Activities to Address Gaps	Priority Actions	Potential Partners
D-1. Data - Limitations	Minimize data gaps due to limitations that different data sets present	<ul style="list-style-type: none"> Engage with providers to optimize data collection and reporting of performance measures for quality assurance and improvement. Expand data collection including different types of data. Collect and analyze data at various geographic regions. <ul style="list-style-type: none"> Ex. Neighborhood, Zip Code, State, County 	<ul style="list-style-type: none"> Within 1-2 years, meet with stakeholders to identify data collection needs. 	<ul style="list-style-type: none"> Judiciary Department of Public Safety Substance use agencies and community organizations Other DOH Behavioral Health Administration (BHA) Divisions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Human Services, Judiciary, Department of Public Safety Healthcare providers
D-2. Data - Standardization	Maximize quality and utility of data collection and analysis	<ul style="list-style-type: none"> Develop a data-driven system of care that allows for reproducible analytical frameworks and data analysis. Develop a robust data system that intersects with other data points, captures data from as many sources, and standardizes data collection whenever possible. 	<ul style="list-style-type: none"> Within 2-5 years, transition to improved ADAD-designated electronic management information system. 	<ul style="list-style-type: none"> Med-QUEST Managed Care Organizations Substance use agencies and community organizations Other DOH BHA Divisions Other government agencies/systems
D-3. Data - Information Sharing	Improve data sharing across providers and systems.	<ul style="list-style-type: none"> Improve upon current ADAD-designated electronic management information system. Develop and/or update multiagency consent form. Establish coordination with County Medical Examiners to obtain data on poisoning cases. 	<ul style="list-style-type: none"> Within 2-5 years, execute Memorandum of Agreements to allow for data information sharing. Within 1-2 years, execute a data sharing Memorandum of Agreement between Department of Health and a medical examiner/coroner. 	<ul style="list-style-type: none"> Med-QUEST Managed Care Organizations Substance use agencies and community organizations Other DOH BHA Divisions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Human Services, Judiciary, Department of Public Safety

		<ul style="list-style-type: none">• Establish coordination with DOH and medical examiners on poisoning cases		
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PRIORITY ACTION ITEMS

Theme	Objectives	Activities to Address Gaps	Priority Actions	Potential Partners
A-1. Administration - Hawai'i Administrative Rules	Establish and/or update Hawai'i Administrative Rules	<ul style="list-style-type: none"> Amend existing rules to credential Peer Recovery Support Specialist. 	<ul style="list-style-type: none"> Within 1-2 years, complete approval of Hawai'i Administrative Rules for Peer Recovery Support Specialist. 	<ul style="list-style-type: none"> Office of Planning Policy and Program Development Hawaii Substance Abuse Coalition
A-2. Administration - Harm Reduction	Add Harm Reduction as distinct component within SUD COC	<ul style="list-style-type: none"> Update SUD system of care to include Harm Reduction Services. 	<ul style="list-style-type: none"> Within 1-2 years, ADAD to establish standards to implement Harm Reduction Services. 	<ul style="list-style-type: none"> Substance use agencies and community organizations
A-3. Administration - Partnerships	Establish and maintain partnerships to expand options in the SUD System of Care	<ul style="list-style-type: none"> Increase Interagency Collaboration. Collaborate with the Opioid Settlement Advisory Committee to implement services. 	<ul style="list-style-type: none"> Within 1-2 years, evaluate the continuing role of ADAD to develop and implement the offender substance abuse treatment programs pursuant to HRS §321-193.5. Within 2-5 years, establish a coordinating body through an interagency cooperative agreement to oversee offender substance abuse treatment programs pursuant to HRS §321-193.5. Within 1-2 years, establish positions needed to support implementation of the Opioid Settlement. Within 1-3 years, work with the DOH Adult Mental Health Division to expand SUD services at Community Mental Health Centers. 	<ul style="list-style-type: none"> Other DOH BHA Divisions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Human Services, Judiciary, Department of Public Safety Opioid Settlement Advisory Committee HACDACS

Theme	Objectives	Activities to Address Gaps	Priority Actions	Potential Partners
S-1. Services - Public Awareness	Increase public awareness regarding substance use prevention	<ul style="list-style-type: none"> • Work with providers to develop and implement prevention strategies. • Develop and disseminate material informing the public of substance use and misuse. • Expand the directory of all resources including agencies in various sectors. • Strengthen partnerships at the local, state, and federal level to maximize reach. • Address perceived stigma associated with seeking SUD services within communities. • Expand prevention service array to include tutoring, peer-to-peer mentoring, family support for at-risk youth. • Expand prevention services and media campaign messaging on cannabis use disorder. 	<ul style="list-style-type: none"> • By October 2023, execute new prevention contracts. • By September 2023, convene first prevention provider conference. • By December 2023, support Prevention Teams to implement at least one action step in their SMART Action Plan from the Hawai'i Prevention Conference. • By June 2024, convene second prevention provider conference. • By October 2023, have at least two contract pilots in place. • Within 1-2 years, partner with a media outlet to provide ad/commercial campaigns to promote awareness on the risks of cannabis use for anyone under the age of 21. 	<ul style="list-style-type: none"> • Substance use agencies and community organizations • Media outlets • Other DOH BHA Divisions • Other government agencies/systems <ul style="list-style-type: none"> ○ Ex. Department of Education • Hawai'i CARES • County governments
S-2. Services - Collaboration	Increase collaboration, coordination, and referrals within and across various agencies and systems	<ul style="list-style-type: none"> • Continue to evaluate and refine Hawai'i CARES. • Coordinate SUD services between various systems including primary care, homelessness, and family violence. • Integrate Law Enforcement Assisted Diversion with Adult Mental Health Division's Jail Diversion 	<ul style="list-style-type: none"> • Continue promotion of Hawai'i CARES as a free call center for mental health and substance use • By December 2023, decide on startup of additional CARES hotline for substance use. • Within 1-2 years, develop SBIRT procedures for use in hospital settings. • By year 3, implement SBIRT procedures in at least two hospitals. • Within 1 year, collaborate with Adult Mental Health Division to secure new federal grant and develop joint triage procedure. 	<ul style="list-style-type: none"> • Other DOH BHA Divisions • Other government agencies/systems <ul style="list-style-type: none"> ○ Ex. Department of Public Safety, Judiciary, Department of Human Services, Police Departments • Hawai'i CARES • Hospitals and health systems • Healthcare providers

			<ul style="list-style-type: none"> • Within 1-2 years, collaborate with Adult Mental Health Division to implement joint triage for at least two community or criminal justice settings (e.g., cellblock) 	
S-3. Services - Resources	Increase substance use resources and services for prevention, treatment and recovery, and harm reduction	<ul style="list-style-type: none"> • Expand resources and services, especially on neighbor islands and rural areas. • Expand harm reduction services. <ul style="list-style-type: none"> ○ Ex. Syringe exchange programs • Expand access of HAWAII CARES communication support channels for those who need help with alcohol or substance use. • Collaborate with AMHD to establish Certified Community Behavioral Health Clinics to increase convenient SU service access in at least two counties. • Expand the number of Stabilization Beds on the neighbor islands for Substance Use clients experiencing crisis. • Establish Opioid Medication Mobile Clinics • Expand the number of recovery homes on clean and sober home registry. 	<ul style="list-style-type: none"> • Within 1-2 years, ADAD to establish policies and procedures to implement Harm Reduction Services. • Within 2-5 years, implement harm reduction strategies within SUD COC contracts. • Within 1-2 years, expand the number of stabilization beds on Maui and on the Big Island in Hilo. • In 1 year, add an AUW TEXT option where anyone privately connect with a care coordinator for assistance, • In 2 years, expand the HAWAII cares website with an AUW CHAT feature where anyone can privately connect with a care coordinator for assistance. • Within 1-2 years, have at least one contract with a Substance Use provider who can support Certified Community Behavioral Health Clinics on Maui. • Within 2-5 years, have at least one contract with a Substance Use provider who can support Certified Community Behavioral Health Clinics in another county. • Within 1-2 years, have at least one contract to add additional capacity at one Certified Community Behavioral Health Clinic. 	<ul style="list-style-type: none"> • Substance use agencies and community organizations • Other DOH BHA Divisions • Other government agencies/systems • Hawai'i CARES • County governments

			<ul style="list-style-type: none"> • Within 1-3 years, identify at least one more suitable facility for stabilization beds. • Within 1 year, procure and establish at least one contract to establish a mobile clinic in one county. • Within 2-3 years, establish a mobile clinic on Oahu and another on the neighbor island. • Within 1 year reach out to various organizations and encourage them to sign up for the clean and sober home registry • Within 3 years increase registered clean and sober homes to 120, and double the homes on Hawaii, Maui, and Kauai. 	
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Theme	Objectives	Activities to Address Gaps	Priority Actions	Potential Partners
F-1. Funding - Rates	Reimbursement rates	<ul style="list-style-type: none"> Explore reimbursement rates and max units, especially for high need and complex populations such as PWWDC and co-occurring. Work with Med-QUEST and managed care organizations to look at current reimbursement rates, max units, expand billable services, and adjust rates as appropriate. 	<ul style="list-style-type: none"> By year 1, complete feasibility analysis of increasing current rates to accommodate new minimum wage increases. Within 2-3 years, complete rate study to analyze and compare service rates for treatment and prevention services and provide technical assistance. By year 3, assist Med-QUEST to obtain an expanded 1115 Waiver for MAT services. 	<ul style="list-style-type: none"> Substance use agencies and community organizations Med-QUEST Managed Care Organizations Other DOH BHA Divisions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Human Services, Judiciary, Department of Public Safety
F-2. Funding - Technical Assistance	Develop targeted technical assistance	<ul style="list-style-type: none"> Check feasibility of developing technical assistance on use of billing codes for cultural services. 	<ul style="list-style-type: none"> Within 2-5 years, explore ways to develop targeted technical assistance to service providers to build and expand their business so that they are less dependent on ADAD funding. Within 2-5 years, explore ways to develop technical assistance to properly document cultural activities and do case management as part of aiding in client recovery. 	<ul style="list-style-type: none"> Other DOH BHA Divisions SMAHSA Technology Transfer Center
F-3. Funding - Application	Apply for additional funding	<ul style="list-style-type: none"> Explore and apply to other sources of funding. 	<ul style="list-style-type: none"> Continue to explore funding opportunities (i.e., future State Opioid Response grants). 	<ul style="list-style-type: none"> None

Theme	Objectives	Activities to Address Gaps	Priority Actions	Potential Partners
W-1. Workforce - Recruitment and Retention	Increase recruitment and retention of qualified and culturally competent professionals	<ul style="list-style-type: none"> Explore the use of monetary incentives for recruitment. <ul style="list-style-type: none"> Ex. Loan repayment, scholarships Provide electronic tracking system for credentialing to allow support for tracking applicants and renewals. 	<ul style="list-style-type: none"> Within 1-2 years, a committee will be formed to evaluate the current substance use workforce and workforce development structure. Within 2-5 years, implement electronic tracking system for credentialing. 	<ul style="list-style-type: none"> Hawai'i Substance Abuse Coalition Managed Care Organizations Hospitals and health systems Higher education institutions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Education Professional Organizations <ul style="list-style-type: none"> Ex. Social workers, psychologists, psychiatrists, therapists, addiction professionals
W-2. Workforce - Professional Development	Increase technical assistance, training opportunities and education, as well as support learning approaches (i.e., field supervision, mentoring, practicum)	<ul style="list-style-type: none"> Offer training, continuing education, and resources especially on neighbor islands. <ul style="list-style-type: none"> Ex. SBIRT Training to primary care and hospital providers Develop culturally appropriate and competent trainings focusing on special populations including Native Hawaiians, SGM, co-occurring disorders, and PWWDC. Increase capacity of existing providers and services (such as for gender-specific and responsive treatment options, therapeutic living programs). 	<ul style="list-style-type: none"> Within 2-5 years, create a learning management system to host trainings, continuing education, and resources. 	<ul style="list-style-type: none"> Substance use agencies and community organizations Hospitals and health systems Higher education institutions Other government agencies/systems <ul style="list-style-type: none"> Ex. Department of Education Professional Organizations <ul style="list-style-type: none"> Ex. Social workers, psychologists, psychiatrists, therapists, addiction professionals
W-3. Workforce - Peer Recovery Support	Support peer recovery support specialists and persons with lived experiences in the workforce	<ul style="list-style-type: none"> Offer peer support as part of the SUD COC with reimbursement and payment strategies for this service. Incorporate persons with lived experiences in the workforce to provide peer support in treatment programs. Incorporate training methods for increasing peer specialists for specific groups, such as forensics, veterans, college students, teenagers, etc. 	<ul style="list-style-type: none"> Within 1-2 years, pass Hawai'i Administrative Rules to credential Peer Support Specialist. Convene a working group to development relationships between providers and educators that employ substance use professionals. 	<ul style="list-style-type: none"> Substance use agencies and community organizations Other DOH BHA Divisions <ul style="list-style-type: none"> Adult Mental Health Division

11. LIST OF ACRONYMS

Abbreviation	Definition
ADAD	Alcohol and Drug Abuse Division
AMHD	Adult Mental Health Division
ARPA	American Rescue Plan Act
ASAM	American Society of Addiction Medicine
ATOD	Alcohol, Tobacco, and Other Drug Use
BHA	Behavioral Health Administration
CAN	Child Abuse and Neglect
COC	Continuum of Care
COVID-19	Coronavirus Disease 2019
CCJP	Certified Clinical Justice Professional
CCS	Certified Clinical Supervisor
CPS	Certified Prevention Specialist
CSAC	Certified Substance Abuse Counselor
CSAP	Center for Substance Abuse Prevention
CSAPA	Certified Substance Abuse Program Administrator
DOH	Department of Health
DRS	Disaster Response State Project
FDA	The Food and Drug Administration
FFY	Federal Fiscal Year
HACDACs	Hawai'i Advisory Commission on Drug Abuse and Controlled Substances
Hawai'i CARES	Hawai'i Coordinated Access Resource Entry System
Hawai'i SUPD	Hawai'i Substance Use Professional Development
Hawai'i HIDTA	Hawai'i High Intensity Drug Trafficking Area
HI YT-I	Hawai'i Youth Treatment and Implementation Project
HOI	Hawai'i Opioid Initiative
HRS	Hawai'i Revised Statutes
IC&RC/AODA	International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.
IPV	Intimate Partner Violence
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual and Transgender
MCOs	Managed Care Organizations
UH PHAC	University of Hawai'i at Mānoa Pacific Health Analytics Collaborative
PWWDC	Pregnant Women and Women with Dependent Children
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFY	State Fiscal Year
SGM	Sexual and Gender Minorities
SOR	State Opioid Response Project
SPF	Strategic Prevention Framework
SUD	Substance Use Disorder
U.S.	United States
WITS	Web Infrastructure for Treatment Services

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