Hawaii

UNIFORM APPLICATION
FY 2024/2025 SUPTRS BG Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 09/28/2023 6.50.27 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State Unique Entity Identification

Unique Entity ID	NL2YKJJLUFY5

I. State Agency to be the Grantee for the Block Grant

Agency Name	Department of Health
Organizational Unit	Alcohol and Drug Abuse Division
Mailing Address	Kakuhihewa Building, 601 Kamokila Boulevard, Room 360
City	Kapolei
Zip Code	96707

II. Contact Person for the Grantee of the Block Grant

First Name	John
Last Name	Valera
Agency Name	Department of Health, Behavioral Health Administration
Mailing Address	Kakuhihewa Building, 601 Kamokila Blvd., Room 360
City	Kapolei
Zip Code	96707
Telephone	8086927529
Fax	
Email Address	john.valera@doh.hawaii.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/28/2023 6:47:22 PM
Revision Date	9/28/2023 6:47:49 PM

V. Contact Person Responsible for Application Submission

First Name	Robyn
Last Name	Loudermilk
Telephone	8086928198
Fax	
Email Address	robyn.loudermilk@doh.hawaii.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

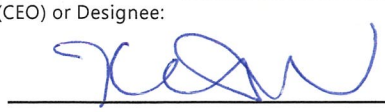
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Hawaii

Name of Chief Executive Officer (CEO) or Designee: Kenneth S. Fink, MD, MGA, MPH

Signature of CEO or Designee[1]: 

Title: Director of Health

Date Signed: 9/28/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

EXECUTIVE CHAMBERS
KE KE'ENA O KE KIA'ĀINA

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

August 23, 2023

TO: Kenneth S. Fink, MD, MGA, MPH
Director of Health

SUBJECT: Designation of Signature Authority to the Current Director of Health or Director's Designee for the Substance Use Prevention, Treatment, and Recovery Services Block Grant Application, Synar Report and Related Documents

The Director of the Department of Health is hereby designated as the State of Hawai'i's signature of authority for the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG or SUPTRS BG) Application, Annual Synar Report and related documents submitted to the Substance Abuse and Mental Health Services Administration. The Director of Health is hereby authorized to sign all Funding Agreements, Certifications and Assurances that must be signed and submitted for the SUBG Application, Annual Synar Report and related documents. This designation will remain in effect until such time as it may be rescinded.

Mahalo,

Josh Green M.D.

Josh Green, M.D.
Governor, State of Hawai'i

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

August 27, 2023

MEMORANDUM

TO: Valerie Kato
Deputy Director of Health

Marian E. Tsuji
Deputy Director, Behavioral Health Administration

FROM: Kenneth S. Fink, MD, MGA, MPH
Director of Health

SUBJECT: Designation of Alternate Signature Authority for the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG or SUPTRS BG) Application, Annual Synar Report and Related Documents, and Related Documents for Other Substance Abuse and Mental Health Services Administration Grants (SAMHSA)

Governor Josh Green has designated signature authority to me, as the Director of the Department of Health (DOH), for the SUBG Application, Synar Report and related documents, and other SAMHSA grants. In case of my absence and unavailability, the Deputy Director of Health, who is the DOH second in command, is authorized to sign all Funding Agreements, Certifications and Assurances for the SABG Application, Synar Report and related documents and other SAMHSA grants. If the Deputy Director and I are both absent and unavailable, then the Deputy Director of Behavioral Health Administration (BHA) is authorized to sign all Funding Agreements, Certifications and Assurances for the SUBG Application, Synar Report and related documents, and documents for other SAMHSA grants to be submitted to the SAMHSA because the Alcohol and Drug Abuse Division is directly under the BHA Deputy Director.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Step 1: Assess the Strengths and Organizational Capacity of the Service Systems to Address the Specific Population

Description of Substance Use Service Systems

The Hawaii State Alcohol and Drug Abuse Division (ADAD) is the Single State Agency (SSA) that manages the Substance Use Prevention, Treatment and Recovery Support Services Block Grant (SUBG or SUPTRS BG) for Hawaii. ADAD's 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; and to address the prevention needs of the communities.

ADAD is under the Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA). BHA also includes the Adult Mental Health Division (AMHD), Developmental Disabilities Division (DDD) and the Child and Adolescent Mental Health Division (CAMHD). While mental health and substance use services are organizationally under the BHA umbrella, ADAD's operations are not fully integrated with AMHD and CAMHD. ADAD is physically sited in a separate and distant location from the mental health divisions. While mental health services for adults and children are administered by separate divisions, ADAD oversees, and funds substance use services for both adults and youth.

ADAD is the primary source of public substance use treatment funds in Hawaii. Some substance use treatment services are publicly funded through the Hawaii Medicaid 1115 waiver program called QUEST, which is administered by the Department of Human Services. Each QUEST managed care plan determines the substance use treatment providers with which it will contract. Treatment services are provided to QUEST clients within the limits of the benefits in the plan.

ADAD's major functions include grants and contracts management, monitoring implementation of treatment services and prevention activities; clinical consultation; accreditation of substance use treatment programs; training and certification of substance abuse counselors and program administrators; policy development; planning and coordination of services; needs assessment for substance use services; and information systems management.

Hawaii continues to recover from the COVID- 19 pandemic, with an average unemployment rate of 2.9 percent for the first seven months of 2023. However, this continued statewide recovery is impacted by the August 2023 fire disasters on the islands of Maui and Hawaii. On August 8, 2023, a fire disaster destroyed a large swath of Lahaina Town; located in West Maui; killing at least 97 people and destroying more than 2,000 residences. Devastating the West Maui economy by destroying over 800 businesses employing approximately 7,000 persons generating approximately $2.7M a day. Since August 9, 2023, island wide losses from business closures and visitor expenditures are estimated to be $11M a day. Rebuilding Lahaina Town, and its businesses, will be a long-term endeavor.

The long-term impact to the state's economy is unknown at this time. There is the immediate loss of State and County tax revenue generated by businesses and visitors. In the short term, the State forecasts continued growth, albeit less than forecasted prior to the wildfires. However,

economic conditions can change rapidly and are influenced by internal factors (i.e., changes in state procurement and contracting policy and procedures) as well as external factors (i.e., availability of federal and state funding). Within ADAD, staff turnover and attrition pose challenges to ADAD's operations and may be related to the State's current low unemployment rate.

ADAD utilizes the State procurement process to direct Block Grant and State funds to support the provision of prevention, treatment, and recovery support services. In planning for these services, ADAD focuses on four planning areas that are consistent with the four State's counties: City and County of Honolulu (island of Oahu), Hawaii County (island of Hawaii), Maui County (islands of Lanai, Maui, and Molokai) and Kauai County (island of Kauai).

The 2020 Decennial Census reported the State of Hawaii's population at 1,455,271. Most of the population resides in the City and County of Honolulu, 70 %, followed by Hawaii County 14%, Maui County 11%, and Kauai County 5%. 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%, Black or African American 3.2%, and American Indian & Alaska Native.

The U.S. Census Bureau introduced a new set of tools to measure the racial and ethnic diversity of the US, replacing "majority" and "minority" measures (see Racial and Ethnic Diversity in the U.S.: 2010 Census and 2020 Census). Hawaii is ranked number one, nationwide, by the Diversity Index.

As a division of a state agency, ADAD is required to utilize the State procurement process to contract for prevention, treatment, and recovery support services. This is a two-step process consisting of one or more Requests for Information (RFI) followed by a Request for Proposal (RFP). The RFI is used to obtain community input on services that ADAD intends to procure. Information acquired through the RFI is incorporated into the RFP that is developed and issued in accordance with State procurement procedures. The RFP also: 1) include SUPTRS BG requirements for services for specified target groups; 2) reflect existing needs assessment data along with other pertinent data sources; and 3) require applicants to substantiate the need for their proposed programs and services as well as identify their target populations for which services will be provided. ADAD reviews, evaluates, and scores the proposals submitted by community-based organizations, and awards services contracts based upon the evaluation criteria.

While the procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is approximately two to four years. This would generally commit the State to these services for the entire contract period. However, after the first contract year, continuation of contract is subject to funding availability, satisfactory performance of contracted services, and a determination by the State that the services are still needed.

Substance Use Treatment Services

Supported by Block Grant and/or State general funds, ADAD provides access to substance use disorder (SUD) continuum of care (COC) treatment services to include residential services

(including nonmedical residential detoxification), motivational enhancement services, intensive outpatient, outpatient, therapeutic living programs; opioid addiction recovery services, group recovery homes, continuing care services, clean and sober housing, transportation, child care, translation/interpretation services, and HIV early intervention services for persons in substance use treatment programs. Adult populations receiving specialized services supported by Block Grant and/or State general funds include dual diagnosed, pregnant women and women with dependent children (PWWDC), people who inject drugs (PWID), offenders on supervised release, furlough, probation or parole, and homeless.

In 2019, ADAD implemented the Hawaii Coordinated Access Resource Entry System (Hawaii CARES), a statewide 24/7 coordination center for support with substance use, mental health, and crisis intervention services. This provides a system of care that includes all SUD COC treatment service providers, those contracted and not contracted with the State, that lowers the barriers to access and treatment by offering referrals to on-demand SUD treatment services. Another Hawaii CARES objective is to reduce the need of a waitlist for all clients who enter into the SUD COC network by referral to either a state contracted service provider or non-network provider.

On July 16, 2022, as part of a nationwide commitment to transform the mental health and crisis care system in America, Hawaii adopted the new 988 dialing code. Calling the 988 code directs an individual to the Hawaii CARES line. The implementation of 988 allows for expanded access and an easier-to-remember contact number to the Hawaii CARES. Individuals who may be in the pre-contemplative or contemplative stages of change can take their first step by reaching out to the Hawaii CARES to inquire about services. The Hawaii CARES line has been on several television and radio commercials to promote access to these services. In addition, the contracted agencies who provide Hawaii CARES services for SUD and mental health conduct trainings to anyone who is interested in learning about their services.

For information on specialized services for PWWDC please see Section 10, Criterion 3: Pregnant Women and Women with Dependent Children.

People Who Inject Drugs (PWIDs) are provided with specialized services through ADAD's contracted opioid addiction recovery services program that includes outreach service to encourage PWIDs to utilize the program's treatment services and to accept referral and linkages to appropriate service providers in the community. All ADAD-funded treatment programs are contractually obliged to comply with ADAD's Wait List Management and Interim Services Policy and Procedures that include service provisions for PWIDs. If an ADAD-funded treatment program does not have the capacity to admit PWID to treatment within 14 days of the initial request for treatment, the program must refer the individual to Hawaii CARES to be linked and referred to another treatment program that can admit the wait-listed individuals to treatment within 14 days. If no treatment program has the capacity to admit the PWID within 14 days, then the program must provide interim services within 48 hours of refer the PWID to the ADAD designated Opioid Therapy Outpatient Treatment Program to receive interim services. PWID clients in interim services must be admitted to treatment within 120 days of the initial request for treatment.

All ADAD-funded treatment programs are contractually required to comply with Sec. 1924(a) of Public Law (P.L.) 102-321, to routinely make available tuberculosis (TB) services to all their clients either directly or through arrangements with public or nonprofit agencies. If the substance use treatment program is unable to accept a person requesting TB services, the program shall refer the person to a provider of TB services. These services include but are not limited to the following: counseling; testing to determine whether the individual has contracted TB and to determine the appropriate form of treatment; and treatment. The DOH's Communicable Disease Division, Tuberculosis Control Branch provides needed TB services to ADAD clients in treatment for substance use.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment's (CSAT) list of "designated states" for the Federal fiscal year (FFY 2024) SUPTRS BG, Hawaii is not a 'designated state" whose AIDS case rate is equal to or greater than 10 per 100,000 population. (See 42 USC §300x-24(b) and 45 CFR §96.128). Since 2002, SAMHSA has prohibited non-designated States from expending any Block Grant funds for HIV early intervention services. In September 2011, SAMHSA made a program policy change to allow States that were "designated" within the last three years the option to continue to set aside 5% of their SUPTRS BG award for HIV early intervention services. This option does not apply to Hawaii since Hawaii was not "designated" within the last three years. Thus, no SUPTRS BG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance use treatment programs.

ADAD uses State general funds to ensure access to SUD COC treatment services for adolescents through contracted school- and community-based substance use treatment programs. School-based treatment services are provided at nearly all the public middle and high schools statewide. School-based treatment allows for 1-8 hours per week of outpatient treatment while community-based treatment allows for 1-9 hours per week of intensive outpatient and 1-8 hours per week of outpatient treatment services.

The State Opioid Response Grant (SOR) addresses the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The goal is to develop and provide opioid use crisis response services within the state of Hawaii and based on needs identified in the State's strategic plan. Initiated by former Governor Ige in collaboration with over 100 stakeholders and community representatives, ADAD has implemented the Hawaii Opioid Initiative (HOI). The HOI initiated activities in seven (7) focus areas to reduce risk factors and increase protective factors throughout the State for opioid and other substance misuse.

Substance Use Disorder Prevention Services

The goal of the substance use disorder prevention services is to reduce the prevalence, incidence, and consequences of alcohol, tobacco, and other drugs (ATOD) by addressing community

conditions that promote alcohol and other substance use by enhancing community conditions that buffer individuals from the consequences of SUDs. ADAD supports the implementation of the Strategic Prevention Framework (SPF), a cost-effective, structured planning process that can be applied to prevention systems at both the state and local level. Focused on systems development, the SPF reflects a public health, or community-based, data-driven approach to selecting and delivering effective prevention interventions appropriate for the community. The SPF has been used effectively by community-based organizations and community coalitions to mobilize and create community-level change. Mobilization has included the implementation of evidence-based environmental strategies which establish or change written and unwritten standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. Partnership for Success (PFS) grant funds from the Center for Substance Abuse Prevention (CSAP) have contributed to further enhancing the prevention system infrastructure and supporting efforts to implement the SPF and building capacity of community coalitions and organizations to address alcohol and other substances (Please see Home - Strategic Prevention Hawaii | SPF Hawaii)

Guided by the SPF process, ADAD awards available resources that align prevention priorities, leverage resources, build capacity and enhance community-level infrastructure to reduce and prevent the use of ATOD among at risk persons in high needs areas. Federal and State dollars are allocated through service contracts with community based non-profit organizations and public agencies to provide an effective, accessible community-based system of prevention services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Funded prevention programs primarily focus on the provision of evidence-based curricula and practices categorized in at least one of the CSAP strategies for youth and their families. Prevention interventions are comprehensive and culturally appropriate for universal, selected and/or indicated populations and strive to produce sustainable positive outcomes.

Prior to making decisions regarding funding allocations, ADAD utilizes the previously described state procurement process to obtain feedback from public agencies and non-profit community-based organizations on gaps to services, populations, substances, collaborations, and capacity in the current prevention system. ADAD is implementing the SPF process with the State Epidemiological Outcomes Workgroup (SEOW) and the SPF Evaluation Team to identify substance use disorder prevention priorities. The most recent State Epidemiological Profile for Alcohol and Drug 2021 Hawai`i State Epidemiologic Profile for the updated 2021 profile (modified Sept. 29, 2022). It is anticipated that, the next State Epidemiological Profile for Alcohol and Drug with 2023 data, will be released in the fall of 2024.

During this application planning period, ADAD plans to use the SUPTRS BG along with State general funds and PFS grant funds to expand prevention services within the IOM Categories, especially the selective and indicated categories, among disparate populations, and within the behavioral health continuum of care.

The general target populations identified for services are at-risk youth, ages 9-17 and young adults ages 18-24 and their families, schools, and communities. Additionally, depending on the

geographic area or community where prevention services are delivered, providers may target and include for prevention services populations identified below:

- Children and youth whose parents are experiencing substance use disorders;
- Children and youth who have experienced academic difficulties or chronic failure in school:
- Children, youth, and families who are economically disadvantaged
- Children, youth, and families who have committed or are at risk of committing a violent or delinquent act;
- Children, youth, and families who have experienced mental health problems;
- Youth at risk for suicide;
- Lesbian, Gay, Bisexual, Transgender, Questioning, and In transition individuals (LGBTQI);
- Homeless children, youth, and families;
- Military personnel and dependents; and
- Native Hawaiians and Pacific Islanders.

ADAD promotes the coordination of resources to further support and strengthen the prevention service system. State and local government agencies and community-based organizations coordinate to leverage resources and services to address rick factors, increase protective factors, expand innovation prevention approaches and, and improve the quality of comprehensive community-based prevention efforts to prevent SUD and its related issues. ADAD funds the Substance Use Prevention and Treatment Resource Center which houses the State's most comprehensive resource on prevention of alcohol, tobacco , and other substance use and related issues available through its lending library, resource clearinghouse, and technical assistance services, as well as the Hawaii Prevention Resource Center website at the Hawaii Prevention Resource Center. Further, ADAD collaborates with other DOH programs, the Hawaii Department of Education, and the University of Hawaii to develop and administer an integrated Hawaii School Health Survey in selected public high and middle school classrooms across the State. The analyzed survey data is helpful in guiding ADAD planning activities for prevention services.

Programs and service activities overseen by ADAD that are related to reducing use of and access to tobacco and alcohol by minors include compliance support activities and public education and policy development focusing on limiting youth access to alcohol, strictly enforcing underage drinking laws, and promoting zero tolerance for underage drinking while creating positive outlets for youth. In addition to support the required Synar Amendment Compliance and Enforcement activities, ADAD maintains a cost-reimbursement contract with the U.S. Food and Drug Administration (FDA) for field enforcement of FDA regulations [21 CFR 897014 (a) and (b)] prohibiting tobacco and tobacco product sales to minors and carrying out inspection of retail outlets throughout the State using FDA Commissioned Officers and underage volunteers in controlled, observed undercover by operations.

Certifications for Substance Abuse Professionals

ADAD certifies substance abuse counselors and program administrators pursuant to State law [HRS §321-197 (10)] and regulations (Hawaii Administrative Rules, Title 11, Department of Health, Chapter 177.1. In efforts towards advancing workforce development of substance use professionals, ADAD expanded its certification services. In July 2011, ADAD began offering certification services for Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified-Co-Occurring Disorders Professional-Diplomate. Information on the certification process and requirements are available here.

Hawaii is a member of the International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC/AOAO). The IC&RC is a voluntary international organization comprised of substance abuse credentialing boards representing 43 states, the U.S. military, various Indian Health Service Organizations, U.S. territories, and a range of countries. As a member board, Hawaii subscribes to the international standards prescribed by the IC&RC and published in the IC&RC guidelines.

Counselors certified in Hawaii have reciprocity with other IC&RC member boards, providing the other member board offers similar credential.

ADAD provides numerous training and educational opportunities annually for those obtaining an initial credential, and for those renewing their credentials, required bi-annually. ADAD also collaborates with other organizations and service professionals to provide training which have been approved for contact hours that may be applied towards meeting the educational requirements for certification and renewal.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Current Unmet Needs and Critical Gaps

There are a number of issues affecting unmet needs and service gaps. The recently Revised Substance Use State Plan 2022 (State Plan) collected and assessed data on the current system of care (SOC) in the state. The State Plan covered areas of primary care integration and treatment access as well as the intersection of substance use with 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. Findings identified the unmet needs, gaps, and challenges within the existing system of care in the areas of substance use disorder (SUD) services, workforce development, data, and funding. The State Plan and technical studies are available here.

Services. The 2022 State Plan revealed a need for increased collaboration, coordination, and referrals within and across agencies, service providers, and other community partners across both the behavioral health and primary healthcare continuum. The existing system of care for SUD services is challenged by Hawaii's unique geography and is fragmented amongst public and private service providers. For those living in rural Oahu and on the neighbor islands, access to SUD services is limited or simply not available, making it necessary to fly individuals to another island to receive specialty services. For example, individuals requiring inpatient psychiatric treatment on neighbor islands are flown to Oahu. This is a significant cost to the State and a disruption to the individual and their family. Lack of transportation on neighbor islands can further hamper access to 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 discriminating 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 into its current continuum of care in Hawai‘i.

A lack of coordinated entry to SUD services among Hawaii treatment providers continues to result in fragmented collaboration among providers and results in barriers for an individuala access to a full continuum of care (COC). In order to implement and maintain a coordinated and responsive system of care that provides SUD services statewide, the Hawaii State DOH created The Hawaii Coordinated Access Resource Entry System (Hawaii CARES) in 2019. Hawaii CARES is a statewide 24/7 coordination center for support with substance use, mental health, and crisis intervention services. The FY2021-2023 treatment contracts utilize Hawaii CARES, with the objectives of reducing treatment access barriers and creating a system that provides a COC that delivers SUD treatment and is modeled after the American Society for Addiction Medicine (ASAM) criteria for SUD services. ADAD intends to continue to utilize Hawaii

CARES in future treatment contracts, especially after the expansion of Hawaii CARES in 2022 to include 988 services, with accompanying text and chat features.

Workforce Development. There is a need for increased recruitment and retention of a qualified substance use workforce. SU 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 Oahu. Over the past two years, ADAD has seen an across the board decrease in the substance use workforce. Therefore ADAD hopes to increase the number of applicants seeking CSAC certification, as well as support the credentialing of more prevention specialist and peer recovery support specialists through expanded in-person and on-demand training opportunities, including train-the-trainer sessions.

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 also a need to develop and provide technical assistance to properly document cultural activities and to do case management. ADAD has partnered with the University of Hawaii to develop and support a training plan that addresses the State's workforce development needs.

Funding. There is a need to shift 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 committed to increasing the share of prevention funding beyond the current minimum of approximately 20%.

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. ADAD seeks data from various information resources in planning for the provision of substance use services, identifying service needs and critical gaps, and developing priorities and goals. These information resources include surveys, groups and agencies engaged in data collection, alcohol and drug service providers, community forums, and officially appointed advisory bodies in operation.

Identified data gaps can be categorized as demographic, geographic, or non-existent. For example, 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.

There are limitations in utilizing national surveys such as the National Survey on Drug Use and Health (NSDUH) and Monitoring the Future survey to obtain information on Hawaii's population. The number of Hawaii residents sampled in national surveys is often too small to yield meaningful data, particularly at the state or community level. In addition, Hawaii may be totally excluded from a survey due to its relatively small population size, distance from the mainland U.S., and the high cost of survey implementation in a multi-island state.

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 a client of another organization, or an individual utilizing both the Coordinated Entry System for housing and the Hawaii CARES for behavioral health services.

ADAD's WITS system has several deficiencies that impacts 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. ADAD also completed from 2019 through 2021 an internal review of all its current business processes to capture both "as is" and "to be" scenarios in order to better improve its entire business functions. Therefore the ADAD will conduct a procurement with a systems integrator to find an IT system that functions not just as a case management tool, and a contracts management and billing tool, but serves the rest of the division's business functions including but not limited to fiscal management, credentialing of professionals, and accreditation of substance use facilities.

As previously described under Step 1 of this application, ADAD utilizes the State procurement process to direct Block Grant and State funds to support the provision of prevention, treatment, and recovery support services. This is a two-step process consisting of a Request for Information (RFI) and then a Request for Proposal (RFP). The RFI is used to obtain community input on services that ADAD intends to procure. It is an opportunity for service providers to express what they perceive as gap areas in the current system. Information acquired through the RFI is incorporated into the RFP that is developed and issued in accordance with State procurement procedures. The RFP also: 1) include SUPTRS BG requirements for services for specified target groups; 2) reflect existing needs assessment data along with other pertinent data sources; and 3) require applicants to substantiate the need for their proposed programs and services as well as identify their target populations for which services will be provided. ADAD then reviews, evaluates, and scores the proposals submitted by community-based organizations, and awards services contracts based upon the evaluation criteria.

While the procurement and contracting cycles vary depending on the type of service and funding availability, the typical service contract is approximately two to four years. Generally, this committed the State to these services for the entire contract period. However, after the first year, continuation of the contract is subject to funding availability, satisfactory performance of contracted services, and a determination by the State that the services are still needed.

Substance Use Treatment Services

ADAD is currently processing contract modifications, in accordance with the State procurement process, to extend current two-year treatment contracts (October 1, 2021, to September 30, 2023)

for one year to September 30, 2024. Federal Fiscal Year (FFY) 2023 SUPTRS BG award is being used to support the year three of the current contract. The FFY 2024 SUPTRS BG will be used for year one of the new two-year contract covering the period from October 30, 2024, to September 30, 2026.

The planning process used for the current contract period followed State procurement requirements and procedures which preceded the first year of the contract period. Planning activities for ADAD's two-year contract period included publishing an electronic RFI in 2020. ADAD utilized information from the RFI to identify unmet needs and critical gaps within the Hawaii treatment infrastructure.

The following is a description of data sources used in planning for substance abuse treatment and recovery services by types of service populations funded by the SUPTRS BG and/or State funds for the contact period from October 1, 2021, to September 30, 2024.

Adult Population. In planning for substance abuse treatment and recovery support services for the adult population, ADAD reviewed state fiscal year (SFY) 2022 data from ADAD's Web Infrastructure for Treatment Services (WITS) system, an electronic health record and billing system for ADAD-contracted substance abuse treatment and recovery service providers. For the population 18 years of age and older, 19.5% received treatment for alcohol as the primary substance while 53.5% received treatment for methamphetamines and 12.3% for marijuana. Another 8.9% received treatment for heroin. Other opiates as primary substance accounted for 4.3% for adults. These data indicate that the need for substance abuse treatment exists throughout the State. These data further suggest that methamphetamine remains the primary substance of abuse. However, substantial numbers of persons exhibit addiction to both alcohol and other drugs.

ADAD released the "Alcohol and Drug Treatment Services in Hawai`i, 2018" data brief produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at Alcohol and Drug Treatment Services in Hawaii 2018. These data briefs which were temporarily on hold due to the COVID pandemic and the retirement of an ADAD employee responsible for statistics. This position has been filled and the University hopes to resume this data brief.

Pregnant Women and Women with Dependent Children. In planning for specialized substance abuse treatment and recovery support services for pregnant women and women with dependent children, ADAD reviewed the National Survey on Drug Use and Health (NSDUH) data, the Treatment Episode Data Set (TEDS) Admissions to and Discharges from Publicly Funded Substance Use Treatment Report, and Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) data from the Department of Health, Family Health Services Division.

NSDUH national data focused on substance use treatment among women of childbearing age for whom substance use poses risks to vulnerable offspring. According to 2021 NSDUH data for the U.S., 9.8% of pregnant women aged 15 to 44 used alcohol in the past month, and 4.3% of pregnant women ages 15-44 were binge drinking in the last month. The 2019 TEDS data indicates that 67.9% of female admissions aged 12-17 were admitted with marijuana/ hashish as the primary substance, followed by methamphetamines at 11.5%. For pregnant females aged 18 and older, 31% of admissions listed heroin as the primary substance, followed by methamphetamines at 22.4%.

Local contributors to a chapter of the 2022 ADAD State Plan on the PWWDC population noted that NSDUH estimates for pregnant people in Hawaii are not very precise due to the small sample sizes (i.e., they have wide confidence intervals), which complicates comparison of state data to the national sample. For example, NSDUH data from 2015-2018 estimate that 15.6% of pregnant people in Hawaii were currently using alcohol, but the true proportion (with 95% confidence) may be anywhere between 5.0% and 39.6%. NSDUH 2015-2018 estimates of current tobacco and marijuana use among pregnant people in Hawaii were 12.8% and 2.1%, respectively, with similarly wide confidence intervals.

The PRAMS Report showed that an estimated 6.8% of mothers in 2019 reported alcohol use in the last three months of pregnancy; about 50.3% drank alcohol three months before pregnancy, and an estimated 5.8% reported cigarette smoking in the last three months of pregnancy. From 2019 there was an average annual estimate of 8,500 resident births.

Opioid Addiction (encompasses services for intravenous drug users). In planning for opioid addiction treatment and recovery services, ADAD reviewed data from the WITS system. The data indicated, by primary substance of abuse, that heroin accounted for 8.9% of SFY 2022 treatment admissions for adults, down from 10% in SFY 2021. Other opiates as primary substance accounted for 4.3% for individuals aged 18 and older, a slight decrease from 5.1% in SFY 2021. Based on WITS data for SFY 2022, ADAD's contracted providers reported total admissions of 3,500 ADAD-funded clients, of which 8.9% had heroin as the primary substance.

In July 2017, then Governor David Ige officially launched the State Opioid Action Initiative. This initiative brought together stakeholders from the public and private sector and adopted both a public health and public safety focus. The overarching goal was to develop and implement a coordinated statewide Action Plan on opioid and other substance misuse issues. The stakeholders produced the Hawaii Opioid Action Plan (Dec. 2017) that serves as a roadmap for a proactive and sustainable response to the opioid crisis as seen in other states, a significant accomplishment but only a beginning. Now adopted as the Hawaii Opioid Initiative (the HOI) the State is in its third year of implementation. The second version (HOI 2.0) are available here. The 2020 HOI Evaluation Report along with the third version's (HOI 3.0) goals and objectives may be found here. Participation by the HOI membership has suffered from reduced due to the COVID pandemic. ADAD hopes over the next two years to work with a contractor to rebuild membership in each of its workgroups, streamline the HOI workgroup structure, migrate HOI content to a permanent DOH website, and update its annual action plan.

Treatment Services/Groups Supported by State Funds Only. The services described above will continue to be supported by both SUPTRS BG and State funds. ADAD's upcoming two-

year substance use treatment contracts (with the possibility of two-year extensions) also cover services supported only by State funds for certain populations. These State-funded services include school-based and community-based substance abuse treatment services for adolescents, integrated addiction care coordination and substance abuse treatment services for offenders on supervised release, furlough, probation or parole, substance abuse treatment and recovery support services for the homeless, group recovery homes, and HIV early intervention services for persons in substance abuse treatment programs. In planning for services for these populations, data sources utilized (in addition to those described above) included ADAD's WITS treatment program admissions and discharge data, data from the new Behavioral Health Dashboard (https://bh808.hawaii.gov/) which is to be maintained by a separate CDC grant, and the Hawaii Health Data Warehouse.

Another way ADAD supports services for substance use disorders is through recovery housing. The Homelessness and Housing Solutions Point in Time Count, conducted by Partners In Care (PIC) for Oahu and Bridging the Gap (BTG) for Hawaii, Maui and Kauai counties, found 6,223 homeless individuals. Given the lack of affordable housing in Hawaii, encouraging the startup of more recovery houses is key to providing a stable living environment that supports progress achieved through treatment services and serve as a transition towards independent living.

According to CSAT's list of "designated states" for the Federal fiscal year (FFY 2024-2025) SUPTRS BG, Hawaii is not a 'designated state" as its AIDS case rate is not equal to or greater than 10 per 100,000 population. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SUPTRS BG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance use treatment programs.

Tuberculosis. Effective October 1, 2017, ADAD-funded substance use treatment providers are required to adopt a policy regarding tuberculosis (TB) and Hepatitis C which states that it provides for TB and Hepatitis C screening, referral, and education as appropriate. The provider shall routinely make available to TB services to all clients either directly or through arrangements with public or nonprofit agencies. If the provider is unable to accept a person requesting TB services, the provider shall refer the person to another provider. TB services shall include, but not be limited to counseling and testing to determine whether the individual has contracted the disease and to determine the appropriate form of treatment. Providers shall also maintain documentation for each employee of an initial and annual TB skin test or chest X-ray. Providers shall also give training to staff on the risks of TB and Hepatitis C for those using substances. Providers shall also submit, in the format specified by ADAD, TB screening/test results as part of their client's health record whenever applicable. For contractors who provide clean and sober housing, their policies and procedures must specify that all clients admitted are required to have a current TB clearance. As part of the requirements for therapeutic living programs, providers shall also have on file, documented evidence that every direct care staff or any individuals having contact with residents has an initial and annual TB clearance following current DOH policy. Providers are also to adopt an interim service policy for Pregnant Women and PWID until they are admitted to the treatment program. At a minimum, such interim services shall include counseling and education about (a) HIV, Hepatitis C, and TB; (b) the risk of needle sharing; (c) the risk of transmission to sexual partners and infants, (d) steps to be taken to ensure

that HIV and TB transmission does not occur; and (e) referral for HIV or TB treatment services if necessary.

The planning and procurement process for the next two-year contract period, from October 1, 2024, to September 30, 2026, will begin shortly. The most recent data and pertinent information available from local, state, and national sources will be used to inform the RFP to address community needs and gaps for treatment and recovery support services.

Substance Use Disorder Prevention Services

National and local data sources are used to inform the process to identify service needs and develop priorities and goals for substance use disorder prevention services in Hawaii. ADAD relies heavily on community-based service providers, contracted consultants and experts, and trained epidemiologists for assessments, data collection, and data analysis to identify primary prevention program needs and gaps. Representatives from community-based organizations and other stakeholders participate in formal and informal discussions and meetings to provide insights and feedback regarding local conditions, behaviors and trends related to substance use disorder issues. The implementation of prevention program services funded by SUPTRS BG, State general funds, and PFS funds is documented and tracked in the Hawaii-Web Infrastructure for Treatment Services (HI-WITS). ADAD recognizes that the local information gathered and reported through HI-WITS may be flawed or biased relative to the contracted service providers' depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and interpretation. The University of Hawaii is contracted to provide technical assistance and training to contracted service providers to ensure more effective and reliable primary prevention program data collection and reporting.

The State Epidemiological Outcomes Workgroup (SEOW) led by the University of Hawaii Office of Public Health Studies Epidemiology Team has been instrumental in assisting ADAD in making data informed decisions regarding plans and resource allocations that enhance the prevention system. The functions and membership of the SEOW have been sustained through the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) five-year grants awarded by CSAP to ADAD in 2013, 2018 and 2023. The workgroup is comprised of voluntary members, primarily directors, epidemiologists, or data managers, from government, educational and community agencies involved in research or data collection. The SEOW provides additional support to sustain SPF efforts, fill knowledge gaps, and develop a platform for data sharing and a data sharing protocol that enables timely and efficient sharing of epidemiological data relating substance use disorder and its consequences. Quarterly meetings, training workshops and conferences are organized by the SEOW to share and review different data sources and reports in efforts to apply the lessons learned in substance use disorder data collection and reporting to broader behavioral health issues.

Compiling and analyzing various data sources, the SEOW created and periodically updates community profiles that provide an insight and basis for potential prevention program design and direction. Please see 2021 Hawaii State Epidemiologic Profile for the updated 2021 profile (modified Sept. 29, 2022). It is anticipated that the next profile, with 2023 data, will be released in fall 2024. The original data sources for the profiles include the Hawaii Behavioral Risk Factor Surveillance System (Hawaii BRFSS), Hawaii Youth Risk Behavior Survey (Hawaii YRBS), and

Pregnancy Risk Assessment Monitoring System (PRAMS). To address the issues of SUD on a broader scale, all substances, age groups and indicators are taken into consideration in the priority selection process and the following are some of the indicators identified and highlighted in the State and County Epidemiological Profiles:

- Youth consumption within past30 days (alcohol, marijuana, cocaine, any illicit drug)
- Adult consumption within past 30 days (alcohol, marijuana, any illicit drug)
- Consumption before the age of 13 (alcohol, marijuana)
- Adult binge use (alcohol)
- Consumption within last 3 months of pregnancy (alcohol)
- Youth substance use disorder or dependence (alcohol, any illicit drug)
- Adult substance use disorder or dependence (alcohol, any illicit drug)
- Youth perceived risk from marijuana use
- Drivers in fatal crash that were alcohol positive
- Youth driving after alcohol consumption
- Adult driving after alcohol consumption
- Deaths by drug overdose
- Mental health admissions reporting any use of alcohol

As first identified during the State Incentive Grant (SIG) period and further supported by more recent survey results and data analysis of the SEOW, alcohol use is more prevalent among youth ages 9-17 and young adults ages 18-20 than any other substance, so therefore, underage drinking (UAD) remains a prevention priority focus statewide. Although the prevalence of UAD has been in decline overall in Hawaii, neighbor islands, Native Hawaiians, sexual and gender minorities, and homeless and runaway youth are disproportionately impacted. The Youth Risk Behavior Survey (YRBS 2019) data shows that youth living in counties outside of the highly urbanized City and County of Honolulu are more likely to consume alcohol. Hawaii, Maui and Kauai Counties have higher prevalence rates in alcohol indicators for middle and high school students. These indicators include: ever having a drink of alcohol; current drinkers; first drink before the age of 13, and; binge drinking for both girls and boys. Hawaii County ranks the highest for all indicators except binge drinking.

Data also shows that Native Hawaiian youth have a greater risk of alcohol use compared to other racial groups. Among the major racial groups where data were available, Native Hawaiian high school students consistently showed the highest prevalence in all alcohol-use indicators, according to the 2019 YRBS: 56.2% reported they had ever used alcohol, 29.9% were current drinkers, 11.6% of boys and 18.5% of girls participated in binge drinking and 19.8% of alcohol users had their first drink before 13 years of age. UAD also disproportionately affects gender and sexual minority youth. According to the Department of Health (DOH) 2017 Hawaii Sexual and Gender Minority Health Report, over 1 in 10 high school students self-identified as lesbian, gay, bisexual and questioning (LGBQ). Using YRBS multi-year high school data (2011 – 2015), the report found that 45% of LGBQ youth were current alcohol users, compared to 25% of heterosexual youth. Moreover, LGBQ youth were twice as likely to participate in binge drinking compared to heterosexual youth (20% versus 10%).

Homelessness is another major public health problem within the State. The 2018 Street Youth Study, released by the University of Hawaii, surveyed 151 homeless and runaway youth aged 12-24 in the City and County of Honolulu. The study found that street youth are about five times more likely to report “fair” or “poor” overall health compared to the general population. When looking specifically at youth drinking, 53% of youth in the study reported drinking within the 30 days prior to the interview; among younger youth (aged 12-17) the prevalence of current drinkers was 44.4%.

Needs and gaps related to readiness, capacity, and resources to provide services to identified high need areas and special populations in order to sustain an effective prevention service system for Hawaii continue to exist. Often community-based organizations are challenged to select and deliver effective programs for specific populations such as homeless adolescent, LGBTQ+, and Native Hawaiian populations. Though a commitment continues to incorporate cultural values and traditions without compromising the integrity of identified evidence-based programs, there is a lack of locally developed and evaluated evidenced-based, culturally appropriate SUD prevention programs and curricula. Additionally, the limited capacity and financial resources of community-based organizations to manage and maintain compliance with the fiscal reporting, management requirements and special conditions of state and federal contract agreements, provide challenges for the substance use disorder prevention system at the community level. Even though prevention services may be delivered more effectively by local, small agencies or individuals in certain communities or for specific populations, the smaller organizations often lack the business plan and infrastructure necessary for billing and reporting processes. A related gap to be addressed is the workforce capacity, expertise and staff required to conduct the financial or programmatic aspects of government contracts and sustain operations. Communities have expressed the need for attention to workforce development and further support for increasing the skills and numbers of certified prevention specialists.

According to the Hawaii SEOW, Hawaii has data limitations and gaps in SUD and mental health areas, specifically prescription drug misuse, SUD by ethnic sub-groups, specific populations, and mental health related comorbidities. If addressed the following list of data gaps, identified by the SEOW, could expand the knowledge base of specific populations, substances, risk, and protective factors and assist in mores effective allocation of substance use disorder prevention resources.

Data by Ethnicity. The ethnic make-up of Hawaii is unique compared to the rest of the states. The majority of individuals are Asian by race. In addition, a substantial proportion of the population consists of Native Hawaiians and Pacific Islanders. Since each ethnicity has different culture, history, traditions, and social characteristics, it would be more useful if data was segregated by ethnic sub-groups (Native Hawaiians, Micronesian, Samoan, Vietnamese, Japanese, Chinese, etc.).

Special Populations. Current data sources do not identify current college enrollment, resulting in the need to collect data specific to college students and individuals above and below 21 years of age. Limited data available for youth drug use indicate that sexual minority youth may be using certain substances at higher rates than their heterosexual peers. Based on the few findings regarding ethnic differences, groups with consistently higher use, specifically Native Hawaiian and Caucasian youth, have been seen over several years.

Consistent Indicators. A consistent set of indicators to measure each substance is useful for comparing the priorities by substance. However, certain substances, such as alcohol are thoroughly measured whereas others, such as heroin, are not. Further, certain indicators for alcohol use are not consistently available every year. For example, the indicators for youth disapproval of alcohol use, youth driving while under the influence of alcohol, family communication around substance use, and percentage of youth seeing a prevention message were canvassed in previous years' questionnaires but are no longer available. Continued data collection for all indicators would allow for better cross-year comparisons.

Adult Indicators. Although youth substance use patterns may predict the substance use behaviors in the adult phase of an individual, a set of summary statistics is still more accurate than estimated data. Currently there are more indicators measured for youth than adults. Consistent indicators should be used to track prevalence.

Mental Health Related Indicators. Additional mental health related indicators other than mental health admission records will be useful in examining the association between mental health and substance use disorder.

Additional Substances. Additional data is needed on other substances such as methamphetamine, heroin, synthetics, and prescription drugs. Although prescription drug misuse is designated as a national epidemic, Hawaii has limited data on this topic. Currently the only indicator available is "use of any prescription drug within a lifetime."

Under the lead of the SEOW, community partners, and other stakeholders, ADAD plans to address the needs and gaps identified above and enhance the substance use disorder prevention system and services in Hawaii during the FFY2024 and FFY2025. ADAD will allocate available resources to community-based agencies to implement evidence-based programs, practices and policies that will impact the highest need communities and special populations. Funded prevention strategies and programs will be culturally appropriate and tailored to target populations and behaviors. Evaluation practices will be used to understand whether and how programs should be altered for specific ages or population characteristics. ADAD also plans to focus technical assistance efforts toward building capacity at the local level to enhance the potential for agencies to diversify funding as to sustain substance use disorder prevention efforts and promote healthy communities across Hawaii.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: To provide services for children of pregnant women and women with dependent children (PWWDC) with substance use trwatment needs up to twelve (12) years of age.

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

To provide services for children of pregnant women and women with dependent children (PWWDC) with substance use treatment needs up to twelve (12) years of age.

Strategies to attain the goal:

Scope of services for PWWDC contracts for the next two-year (October 1, 2024 - September 30, 2026) contract period to include treatment and supportive services for children up to twelve (12) years of age with substance use treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of PWWDC contracts with a scope of service to include a provision for treatment and supportive services for children up to twelve (12) .

Baseline Measurement: Effective October 1, 2021, there was at least one (1) contract executed in each of Hawaii's four counties (Honolulu, Maui, Kauai, and Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance use treatment needs.

First-year target/outcome measurement: Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Honolulu, Maui, Kauai, Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance use treatment needs in FFY 2024.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract per county in each of Hawaii's four counties (Honolulu, Maui, Kauai, Hawaii) to provide treatment and supportive services for PWWDC children up to 12 years of age with substance use treatment needs in FFY 2025.

Data Source:

Executed contract and contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance

17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 2

Priority Area: To maintain enhanced services for people who inject drugs (PWIDs), namely opioid injection/intravenous drug users. Enhanced services include a broad spectrum of treatment options for opioid addiction.

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

To maintain enhanced services for people who inject drugs (PWIDs), namely opioid injection/intravenous drug users. Enhanced services include a broad spectrum of treatment options for opioid addiction.

Strategies to attain the goal:

Scope of services for opioid service contracts for the next two-year (October 1, 2024 - September 30, 2026) contract period to include motivational enhancements, transportation, translation, and cultural activities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of opioid contracts with a scope of service to inlcude a provision which expands services to PWIDs by reducing severity and disabling effects related to opioid addiction services by broadening the spectrum of treatment options to best meet the needs of the opioid users.

Baseline Measurement: Effective October 1, 2021, there as at least one (1) contract executed to provide statewide enhanced services for PWIDs.

First-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for PWIDs in FFY24.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract to provide enhanced services for PWIDs in FFY24.

Data Source:

Executed contract and contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification

5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
1. Contract Modification Checklist (ASO-C005 3/2012)
2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 3

Priority Area: To provide recovery support services to include transportation and translation for adults, PWWDC, and IDUs with substance use treatment needs.

Priority Type: SUR

Population(s): Other

Goal of the priority area:

To provide recovery support services to include transportation and translation for adults, PWWDC, and IDUs with substance use treatment needs.

Strategies to attain the goal:

Scope of services for recovery supports for the next two-year (October 1, 2024 - September 30, 2026) contract period to include transportation, translation, stabilization beds, groups recovery homes, clean and sober living, and therapeutic living programs for adults, PWWDC, and PWIDs with substance use treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of PWWDC, PWIDs, and adult contracts with a scope of service to include transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs.

Baseline Measurement: Effective October 1, 2021, there was at least one (1) contract executed for the of the target populations, i.e.; adults, PWWDC, and PWIDs; to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs.

First-year target/outcome measurement: Maintain a minimum of one (1) contract to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober

living, and therapeutic living programs for each of the target populations, i.e., adults, PWWDC, and PWIDs with substance use needs in FFY 2024.

Second-year target/outcome measurement: Maintain a minimum of one (1) contract to provide recovery support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, and therapeutic living programs for each of the target populations, i.e., adults, PWWDC, and PWIDs with substance use needs in FFY 2025.

Data Source:

Executed contract and contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
3. Hawaii Compliance Express
4. Request for Taxpayer Identification Number and Certification
5. AG Form 103F1 (10/08)- Recitals
6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
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2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

Priority #: 4

Priority Area: To prevent and reduce the use and misuse of alcohol, tobacco and tobacco products, marijuana, and presecription drugs by youth and young adults, especially underserved populations (i.e., students in college, military families, LGBTQ+, homeless, Native Hawaiians/other Pacific Islanders, Asian, rural and ethnic minorities) in communities statewide.

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To prevent and reduce the use and misuse of alcohol, tobacco and tobacco products, marijuana, and prescription drugs by youth and young adults, especially underserved populations (i.e., students in college, military families, LGBTQ+, homeless, Native Hawaiians/other Pacific Islanders, Asian, rural

and ethnic minorities) in communities statewide.

Strategies to attain the goal:

a. Provide communities with resources, technical assistance and specific training directed to build capacity for data collection and the use of data, planning, evaluation, cultural competencies, and other prevention topics identified to support the implementation of the Strategic Prevention Framework (SPF) to sustain local efforts.
b. Allocate available resources to community organizations and coalitions to implement individual and/or community-based prevention strategies to reduce risk factors and address local conditions associated with substance use by youth and young adults.
c. Provide technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco and other drugs, including, educating community members and law enforcement officials about the benefits of enforcing alcohol, tobacco and drug policies and laws.
d. Allocate available resources to support programs that increase knowledge about tobacco and tobacco products, alcohol, prescription drug misuse, marijuana use and other drug problems as to establish policies to address negative consequences of use and to promote protective factors and resilience.
e. Built capacity and increase competencies of the prevention workforce by promoting the Prevention Specialist Certification and providing opportunities for professional development.
f. Obtain data from funded prevention programs on types of services and activities conducted and information on service populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of contracted community-based organizations utilizing data driven decision making, capacity building and planning (SPF) to address local conditions and prevent substance use disorders (i.e. alcohol, tobacco and tobacco products, and marijuana) in their communities of underserved populations as demonstrated by completed, or in progress, logic models, Comprehensive Strategic Plans, and evaluation reports.

Baseline Measurement: 75% of the funded community organizations have initiated components of the SPF and have chosen effective prevention programs for implementation based on completed assessment and planning steps (FFY2023)

First-year target/outcome measurement: 80% of the funded community organizations, have completed, or have in progress, assessment, comprehensive strategic plans, and evaluation of prevention programs and interventions by end of FFY 2024.

Second-year target/outcome measurement: 85% of the funded community organizations have evaluated the implementation of prevention programs to determine effectiveness and plan for sustainability of outcomes by end of FFY 2025

Data Source:

Program Quarterly Reports: Monitoring Comprehensive Strategic Plans and evaluation reports submitted by contracted agencies; Surveys questionnaires completed by contracted agencies.

Description of Data:

Review of status and evaluation progress as provided through written program reports and updated comprehensive strategic plans submitted by contracted organizations; Dates content details training technical assistance to agencies enhance SPF implementation efforts.

Data issues/caveats that affect outcome measures:

Delayed implementation of the various components SPF due to inability of the state to provide sufficient training and technical assistance to communities; Delays in procurement process procedures may shorten time for services proceed; development consistent evaluation tool prevention organizations affect degree increased capacity utilize tool; local information gathered presented may be flawed or biased relative service organizations' depth of experience, knowledge and understanding of needs assessment, evaluation and data collection and implementation; inadequate resources and capacity to engage assistance and service evaluators.

Indicator #: 2

Indicator: Number of technical assistance and training opportunities relates to implementing the SPF, including identifying, implementing, and evaluating evidence-based prevention programs and strategies, information on alcohol, tobacco, marijuana, and prescription drug use; and related topics provided to prevention specialists and community organizations.

Baseline Measurement: Five (5) opportunities provided in FFY2023.

First-year target/outcome measurement: Seven (7) opportunities for technical assistance and traning by end of FFY2024.

Second-year target/outcome measurement: Ten (10) opportunities for technical assistance and traning by end of FFY2025.

Data Source:

Registration flyers, Agendas, Sign In Sheets, Handouts and materials distributed. Participant Evaluation/Comment Forms. Number of certification units CEs); Assessment completed by workforce development coordinator.

Description of Data:

Summary reports with participant information and details of content delivered during training and/or technical assistance; registry of Certified Prevention Specialist; follow-up surveys and interviews with participants.

Data issues/caveats that affect outcome measures:

Limited relevant and ongoing opportunities for onsite training and mentoring for trainees and prevention specialist seeking certification due to prohibitive costs or limited funds may affect outcome measures.

Priority #: 5

Priority Area: To make available tuberculosis (TB) services for individuals receiving substance use disorder (SUD) treatment services.

Priority Type: SUT

Population(s): TB

Goal of the priority area:

To make available tuberculosis services for individuals receiving substance use disorder (SUD) treatment services.

Strategies to attain the goal:

Scope of services for SUD contracts for the next two-year (October 1, 2024 - September 30, 2026) contract period to include availability of TB services for individuals receiving SUD treatment services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Execution of SUD contracts with scope of services to include provisions for the availability of TB services for individuals receiving SUD treatment services.

Baseline Measurement: Effective October 1, 2021, there was at least one (1) contract executed in each of Hawaii's four counties (Honolulu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving SUD treatment services.

First-year target/outcome measurement: Effective October 1, 2021, there was at least one (1) contract executed in each of Hawaii's four counties (Honolulu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving SUD treatment services in FFY 2024.

Second-year target/outcome measurement: Effective October 1, 2021, there was at least one (1) contract executed in each of Hawaii's four counties (Honolulu, Maui, Kauai, and Hawaii) to make available TB services for individuals receiving SUD treatment services in FFY 2025.

Data Source:

Executed contract and contract modification.

Description of Data:

Executed Contract. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete meet state compliance standards:
1. Contract Checklist for 103F Health and Human Services
2. FAMIS- Vendor Confirmation
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4. Request for Taxpayer Identification Number and Certification
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6. AG Form 103F7 (10/08)- Providers Acknowledgment
7. Scope of Services
8. AG Form 103F11 (10/08)- Time of Performance
9. AG Form 103F12 (10/08)- Compensation and Payment Schedule
10. AG Form 103F8 (9/08)- Certificate of Exemption from Civil Service
11. AG Form 103F9 (10/08) - Provider's Standards of Conduct Declaration
12. AG Form 103F (10/08) - General Conditions for Health & Human Services Contracts
13. Special Conditions
14. Allocation Schedule
15. Rate Schedule and/or Budget
16. Certification of Insurance
17. Proof of other related documents:
a. Statement of Attestation
b. Printout of Solicitation
c. Retro Memo (when applicable)
Contract Modification. In accordance with HRS 103F (the procurement of Health and Human Services), all documents listed below are required. Documents must be complete and meet state compliance standards:
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2. Contract Modification Summary Sheet (ASO C-002)
3. Contract Modification (ASO C-003)
4. Contractor's/Provider's Acknowledgment (AF-103F7)
5. Attachments (when applicable)
6. Exhibits (when applicable)
7. Retroactive Contract Approval (when applicable) (Comptroller's Memo 2009-14)
8. Debarment of Suspension
9. Availability of Funds
10. Certificate of Insurance (General and/or Professional, and Automobile Liability)

Data issues/caveats that affect outcome measures:

Any unanticipated delay may affect the timely execution of contracts and contract modifications.

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Footnotes:

1. All ADAD-funded treatment programs will continue to be contractually required to comply with Sec. 1924(a) of P.L. 102-321, to routinely make available tuberculosis (TB) services to all clients either directly or through arrangements with public or nonprofit agencies. The Department of Health's Communicable Disease & Public Health Nursing Division, Tuberculosis Control Branch will continue to provide needed TB services to ADAD clients in treatment for substance use disorders. ADAD's contract compliance monitoring protocol for treatment programs will continue to include the review of a program's policy and procedures and documentation on TB screening and testing of clients.

2. Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse are not identified as a priority for Table 1 because Hawaii is not a "designated State" according to CSAT's list of "designated states" for the FFY 2024-25 SUBG. Since 2002, SAMHSA has prohibited non-designated States from expending any Block Grant funds for HIV early intervention services. But in September 2011, SAMHSA made a program policy change to allow States that were "designated" within the last three years the option to continue to set aside 5% of their SUBG award for HIV early intervention services. This option does not apply to Hawaii since Hawaii was not "designated" within the last three years. However, ADAD will continue to allocate State general funds to provide HIV early intervention services at substance use treatment programs.

3. Although Native Hawaiians are not identified as a specific priority for Table 1, ADAD makes available a proportion of the SUBG funds for substance use programs for Native Hawaiians, pursuant to Sec. 1953 of P.L. 102-321. The description of Block Grant expenditures and services for Native Hawaiians is included in Hawaii's SUBG Report submitted annually to SAMHSA by December 1.5.

4. For Priority 3 (Recovery Support Services), ADAD selected "Other" but did not specify a subcategory of "Other" such as Adolescents or Homeless because ADAD intended to say that its recovery support contracts were also meant to serve "Other Adults" as well as PWWDC and PWIDs.

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$6,854,854.00		$0.00	$6,419,645.00	$20,385,592.00	$0.00	$0.00		$6,344,078.00	$5,078,226.00
a. Pregnant Women and Women with Dependent Children[c]	$1,800,000.00				$100,000.00				$1,800,000.00	$1,800,000.00
b. Recovery Support Services										
c. All Other	$5,054,854.00			$6,419,645.00	$20,285,592.00				$4,544,078.00	$3,278,226.00
2. Primary Prevention[d]	$1,900,000.00		$0.00	$561,000.00	$2,180,000.00	$0.00	$0.00		$1,700,000.00	$1,869,023.00
a. Substance Use Primary Prevention	$1,900,000.00			$561,000.00	$2,180,000.00				$1,700,000.00	$1,869,023.00
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$15,000.00			$583,636.00	$1,520,000.00				$105.00	
11. Crisis Services (5 percent set-aside)										
12. Total	**$8,769,854.00**	**$0.00**	**$0.00**	**$7,564,281.00**	**$24,085,592.00**	**$0.00**	**$0.00**	**$0.00**	**$8,044,183.00**	**$6,947,249.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

1. Amounts in Column A are based upon the Federal Fiscal Year (FFY) 2023 SUPTRS BG allotment for Hawaii.

2. Estimates for other columns are based on the same period as Column A. This provides a consistent basis on which to compare planned expenditures of Block Grant funds with funds that may be available from other sources during the same period.

3.Although no separate funds are shown for TB services, all ADAD funded treatment providers are contractually required to comply with Sec. 1924(a) of P.L. 102-321, regarding availability of TB services.

4. According to CATS's list of "designated states" for the FFY 2024-2025 SUPTRS BG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000 (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SUPTRS BG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance use treatment programs.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	868	62
2. Women with Dependent Children	15,866	85
3. Individuals with a co-occurring M/SUD	86,868	1,777
4. Persons who inject drugs	1,829	507
5. Persons experiencing homelessness	1,186	967

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$6,854,845.00	$6,344,078.00	$5,078,226.00
2 . Substance Use Primary Prevention	$1,900,000.00	$1,700,000.00	$1,869,023.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]			
6 . Administration (SSA Level Only)	$15,000.00	$105.00	$0.00
7. Total	**$8,769,845.00**	**$8,044,183.00**	**$6,947,249.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

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Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

1. Although no separate funds are shown for TB services, all ADAD-funded treatment programs are contractually required to comply with Sec.1924(a) of P.L. 102-321, regarding availability of TB services.

2. According to CSAT's list of "designated states" for the FFY 2024-2025 SUPTRS BG, Hawaii is not a "designated state" whose AIDS case rate is equal to or greater than 10 per 100,000. (See 42 USC §300x-24(b) and 45 CFR §96.128). Thus, no SUBG funds are allocated for HIV early intervention services. However, ADAD will continue to allocate State general funds to continue the availability of HIV early intervention services at substance abuse treatment programs.

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$125,000		
	Selected			
	Indicated			
	Unspecified			
	Total	**$125,000**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$125,000**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$8,769,845**	**$8,044,183**	**$6,947,249**
Planned Primary Prevention Percentage		**1.43 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

1. Table 5a reflects only the portion of primary prevention planned expenditures related to Sec. 1926 of the Public Health Services Act (USC §300x-26) regarding the Synar program. Primary prevention planned expenditures, including planned expenditures related to the Synar program are reported in Table 5b which is based upon the Institute of Medicine prevention categories. According to the 2024-2025 SUBG Behavioral Health Assessment and Plan Preparation Instructions, States have the option of completing either Table 5a or 5b. If the State completes Table 5a, then planned expenditures for the Synar program must be reported in Table 5a, Sec. 1926 (Synar) Tobacco.

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$724,000	$338,000	
Universal Indirect	$453,300		
Selected	$722,700	$346,800	
Indicated			
Column Total	**$1,900,000**	**$684,800**	**$0**
Total SUPTRS BG Award[3]	**$8,769,845**	**$8,044,183**	**$6,947,249**
Planned Primary Prevention Percentage	**21.67 %**	**8.51 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☐
Marijuana	☑	☑	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐

Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

1. Aside from the Native Hawaiian target population, please note that ADAD does not track prevention funds allocated to or expected for specific substances or populations.

Planning Tables

Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$415,732.00	$415,732.00			
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					$350,000.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement	$148,380.00	$150,880.00			
6. Research and Evaluation					
7. Training and Education	$452,990.00	$457,990.00		$509,500.00	$552,500.00
8. Total	**$1,017,102.00**	**$1,024,602.00**	**$0.00**	**$509,500.00**	**$902,500.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

In 2019, the Department of Health, Alcohol and Drug Abuse Division (ADAD), launched their Hawaii Coordinated Access Resource Entry System, or Hawaii CARES, which is a coordinated and responsive system of care for substance use disorder (SUD) treatment and recovery support services. Hawaii CARES provides universal intake, screening, assessment, care coordination, referral, placement determination, and linkages to appropriate service modalities and resources across the state. Hawaii CARES is modeled after the American Society of Addiction Medicine criteria for SUD services and provides on-demand care to those who need it, when they need it, and where they need it. ADAD's current contractor for Hawaii CARES SUD treatment and referrals, Aloha United Way, also assist with food, shelter, financial assistance, childcare, parenting supporting, disability services, and job training.

In April 2022, the Hawaii CARES hotline expanded to include mental health disorders and co-occurring mental and SUD. When a caller calls the Hawaii CARES hotline, they can receive crisis services. In addition, depending on the situation(s), there is also a local crisis therapist that can be sent out through their Crisis Mobile Outreach program. For individuals who are not in crisis, but just need someone to talk to, the Hawaii CARES line is able to provide support and resources.

ADAD is also in the procuring process to contract with a community treatment provider(s) to assist in the continuity of care with non-violent clients who are transitioning out of the Hawaii State Hospital. This treatment provider would provide basic life skills (budgeting, transportation, employment, etc), along with outpatient treatment, to assist the client with adjusting to life out in the community.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Hawaii Medicaid 1115 waiver program over seen by the Department of Human Services Med-Quest Division (Med-QUEST), helps to fund a large percentage of treatment clients. Most Medicaid services in Hawaii are delivered through Managed Care Organizations (MCOs), which include AlohaCare, Hawaii 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 a 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.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

In 2019, the Department of Health created The Hawaii Coordinated Access Resource Entry System (Hawaii CARES), which is a statewide 24/7 coordination center for support with substance use, mental health, and crisis intervention services. On July 16, 2022, as part of a nationwide commitment to transform the mental health and crisis care system in America, Hawaii adopted the new 988 dialing code. Calling the 988 code directs an individual to the Hawaii CARES line. The implementation of 988 allows for expanded access and an easier-to-remember contact number to the Hawaii CARES. Individuals who may be in the pre-contemplative or contemplative stages of change can take their first step by reaching out to the Hawaii CARES to inquire about services. The Hawaii CARES line has been on several television and radio commercials to promote access to these services. In addition, the contracted agencies who provide Hawaii CARES services for SUD and mental health conduct trainings to anyone who is interested in learning about their services.

In the Alcohol and Drug Abuse Division's (ADAD) State Plan, there are some efforts to improve behavioral health care provided by primary care providers. One effort is to provide short webinars for useful tools to treat SUD and provide some continuing education hours. This will help educate the physicians on SUD and receive their mandatory education hours at the same time. Developing culturally appropriate and competent trainings while focusing on special populations including Native Hawaiians, co-occurring disorders, and the Pregnant Women and Women with Dependent Children (PWWDC) will provide a better understanding to the physicians are the target populations.

ADAD is making efforts to integrate primary care into behavioral health settings by providing more Screening, Brief Interventions, and Referral to Treatment (SBIRT) procedures in at least two (2) hospitals. This will assist the physicians to provide a brief screening and a possible referral to treatment quicker than sending a patient to a treatment provider for possible substance use needs. In addition, the SBIRT will also be utilized as an effective tool for physicians to recognize the issues immediately, which will be time-effective for an already busy work environment. ADAD recognizes the need to increase collaboration, coordination, and referrals within and across various agencies and systems. ADAD will continue to evaluate and refine Hawaii CARES by continuing to promote Hawaii CARES as a free call center for mental health and substance use. This will expand the types of calls the Hawaii CARES will be receiving.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care

coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

As part of ADAD's Treatment and Recovery Branch contracts, all treatment providers utilize the Hawaii CARES hotline to collaborate and coordinate behavioral health services for SUD, mental health, and developmental disability services. ADAD's addiction care coordination is funded through their state funds, which actively assists and supports client's access to needed health, behavioral health and other community support. It is a service that is coordinated with and coordinates on behalf of, treatment and recovery support services for the client. This coordination can occur at any time during the client's episode of care. The Hawaii CARES hotline provides various referral linkage, depending on the caller's needs. The Hawaii CARES referral line works closely with the treatment providers to ensure that there is a "warm hand-off" between referrals.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

With the launch of Hawaii CARES in 2019 and the expansion to include mental health services and crisis intervention services in 2022, it provides a coordinated and responsive system of care that provides SUD and mental health services statewide. Having the public using the call center for services, it also provides data to ADAD on the types of calls, referral source, types of drugs, etc. Also, within Hawaii CARES, there is a one-page universal screening form which provides the initial detail on what services the caller is needing. The Hawaii CARES staff provides a warm hand-off to a treatment provider to complete the assessment and determines the level of care. ADAD also has contracts with treatment providers who accepts and treats clients with co-occurring disorders. ADAD also contracts with treatment agencies who work with adolescents. The system may be a little different for youth and adults by the way how they reach the clients. Most of today's youths communicate via texting and not by speaking to a "live" person. The Hawaii CARES staff had to learn and upkeep the "youth terminology" since they appear to communicate with abbreviations and different terminology.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race

Yes No

b) Ethnicity

Yes No

c) Gender

Yes No

d) Sexual orientation

Yes No

e) Gender identity

Yes No

f) Age

Yes No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

Yes No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

Yes No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

Yes No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

Yes No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?

Yes No

7. Does the state have any activities related to this section that you would like to highlight?

With respect to Section 2, item 1, ADAD's substance use disorder treatment providers are contractually required to utilize the Web-Based Infrastructure for Treatment Service (WITS) system, an electronic health record and billing system to report to ADAD client data and types of services provided in order to receive payment for services. WITS is also used to collect treatment episode data set (TEDS) information required by SAMHSA. WITS can generate information on race, ethnicity, gender and age of clients, as well as admissions, program enrollments and disenrollments, discharges, follow-up and waitlist information. WITS does not currently collect data on sexual orientation or gender identity.

The DOH Surveillance, Evaluation & Epidemiology Office (SEEO) of the Chronic Disease Prevention & Health Promotion Division (CDPHPD) in 2017 released its inaugural health report on Hawai'i's Sexual and Gender Minority communities. Hawai'i's sexual and gender minorities—including, but not limited to, transgender people, bisexual persons, lesbian women, and gay men—have unique health experiences and needs, and the report highlights some of the disparities in health outcomes affecting these communities, and shares opportunities to reduce these gaps in health equity. The report is found at https://health.hawaii.gov/surveillance/files/2017/05/SexualandGenderMinorityHealthReport. A 2018 report was also released that focused on transgender youth.

ADAD released the "Alcohol and Drug Treatment Services in Hawaii, 2018" report produced by the University of Hawaii Center on the Family under a contract with ADAD. The report focuses on substance use disorder treatment services provided by agencies that were funded by ADAD during State fiscal years 2015, 2016 and 2017. The report presents information on characteristics (e.g., age, county of residence, gender, ethnicity, employment status, and special conditions) of the adolescents and adults who were admitted to treatment programs. The report also includes information on the use of different modalities of services and data relating to treatment service outcomes. The report is available on the ADAD website at https://health.hawaii.gov/substance-abuse/files/2018/12/TREATMENT_2018_WEB.pdf.

Enrollment in substance use disorder prevention services is tracked through ADAD's prevention data collection and monitoring system which is used to collect data from ADAD-funded prevention programs on types of prevention services provided and clients

served. ADAD tracks enrollment in substance use disorder prevention services by each prevention provider and contract. The type of prevention services and/or objectives is different for each curriculum. ADAD does not track outcomes by race, gender, or age.

With respect to Section 2, item 2, ADAD-funded substance use disorder treatment providers are required to submit quarterly reports that include information on treatment units provided, number of clients served, number of individuals followed up on, client participation in self-help groups, staffing information, as well as accomplishments and challenges. Also, providers are required to report annually on various outcome measures.

Regarding substance use disorder prevention services, ADAD tracks services that address disparities based on the contracted providers' assessment of the individual communities. ADAD works with community-based agencies, the SEOW and service providers to assess the existence of disparities and develop plans to address and eventually reduce disparities in access, service use, and outcomes for the disparity-vulnerable subpopulations in the individual communities.

With respect to Section 2, item 3, for ADAD's substance use disorder treatment and recovery services contracts, the contracts' scope of work now includes translation or interpreter services as a reimbursable recovery support service. Services for language needs can be tracked through the WITS system. Many providers try to employ a multi-ethnic, multi-cultural staff to help meet the service needs of their clients.
Prevention service providers assess the needs of their individual communities and conduct ongoing assessment of program implementation and effectiveness to determine if identified needs change during the course of the service period.

With respect to Section 2, item 4, ADAD partners with other State, county, and community-based agencies to provide training and educational opportunities to address cultural competence for providers.

With respect to Section 2, item 5 ADAD's training plans to incorporate Culturally Linguistically Appropriate Service (CLAS) Standards. ADAD's plan is to increase cultural awareness, knowledge, and skills, coordinate with traditional healers, work with community health workers, and provide culture-specific attitudes and values in training that promote healthy life skills and tools. The Substance and Prevention resource center will include resources in diverse language access that support substance prevention, treatment, and recovery information. ADAD currently provides trainings on community cultural diversity needs of population groups such as native Hawaiian, Micronesians, the LGBTQ community, and those affected by HIV/STDs.

With respect to Section 2, item 6, as described above, ADAD makes available translation or interpreter services as a reimbursable recovery support service provided by ADAD's contracted substance use disorder treatment and recovery providers.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

1. The Hawaii SSA provided no response because the Innovation in Purchasing Decisions section is not required for SUPTRS BG per the FF24-25 SUPTRS BG instructions.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

3. Does the state have any activities related to this section that you would like to highlight?

With respect to Section 6, item 1, in planning and contracting for services to be funded by SUPTRS BG and State funds, ADAD follows State laws and procedures established in the Hawaii Revised Statutes (HRS), Chapter 103F and implementing regulations in the Hawaii Administrative Rules (HAR) that govern for fairness and quality, the basic planning, procuring, and contracting of health and human services by executive branch departments and agencies. The objective of the HRS and HAR is to ensure the fair and equitable treatment of and opportunity for all service providers delivering health and human services on behalf of the State and federal government by using a standardized procurement process and by optimizing information sharing and coordinating, planning, and service delivery efforts. The Department of Accounting and General Services (DAGS), State Procurement Office (SPO) serves as the central authority on State procurement requirements, policies, and procedures.

Federal program requirements are conveyed to intermediaries and providers through the narrative and description included in the Request for Proposals (RFP) procurement method and 103F contract awards. ADAD also employs the following program integrity activities for monitoring the appropriate use of block grant funds and oversight practices:

a. Budget review: Providers are required to submit a budget with each proposal or contract. All budgets are reviewed by ADAD's fiscal staff to ensure that they are reasonable, appropriate, feasible, and in compliance with State and federal requirements and guidelines.

b. Claims/payment adjudication: Electronically submitted claims to ADAD are adjudicated and reviewed for completeness, accuracy, and meeting required payment criteria for the contracted service. Electronic invoices are reviewed for completeness, accuracy, and appropriateness before processing for payment.

c. Expenditure report analysis: Invoices, expenditure reports and supporting documents are submitted to ADAD with hard invoices summarizing the expenditures by budgeted line items. Before and after each payment is made, ADAD's fiscal staff reviews and updates expenditure report information to ensure expenditures are appropriate, reasonable, and stay within the approved budget.

d. Compliance reviews: Program compliance reviews are conducted through desktop and onsite monitoring of contracts. The annual close-out process for every ADAD contract requires contracted agencies to submit compliance documents such as an inventory report with invoices of purchases, Hawaii State and federal tax clearances, and single audit report. If there are findings in the single audit report, the provider is required to submit a corrective action plan for approval. The corrective action plan is reviewed the following year for compliance.

f. Audits: ADAD's fiscal audits include a close-out report, subsidiary ledger of expenditures for the year, sampling of transactions for allowability, appropriateness and allocability. Indirect cost rate, allocation policies and procedures, and lease rent agreements are also reviewed. ADAD also complies with the OMB Circular A-133, Single Audit Report.

ADAD also uses Cost Principles established by the Hawaii State Procurement Office to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered. The Cost Principles for HRS, Chapter 103F are available at http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/.

With respect to Section 6, item 2, ADAD assists substance abuse treatment and prevention providers in adopting practices that promote compliance with program requirements, including quality and safety standards in a variety of ways. ADAD provides accreditation to substance abuse facilities that provide services 24 hours a day (designated as Residential Treatment Programs, aka Special Treatment Facilities and Therapeutic Living Programs) and are required to be licensed by the Department of Health's Office of Health Care Assurance (OHCA). The accreditation standards are based on HAR, Title 11, Department of Health, Chapter 98 (Special Treatment Facility). The program requirements include quality and safety standards.

ADAD certifies substance abuse counselors and program administrators. Certification services are also provided for the Certified Prevention Specialist, Certified Clinical Supervisor, Certified Criminal Justice Addictions Professional, and Certified Co-Occurring Disorders Professional-Diplomate. In collaboration with community-based organizations, other State agencies, and federal agencies and organizations, ADAD provides training opportunities for in-service and professional development for service providers. ADAD staff conduct desktop and onsite monitoring of compliance with State and federal requirements identified in contract agreements for treatment and prevention services. ADAD's prevention staff periodically review prevention providers' Community Action Plans (CAP) and provide assistance with CAP development and implementation.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

1. No federally recognized tribes or tribal lands exist within Hawaii's border.

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)

b) ☑ Youth (ages 12-17)

c) ☐ Young adults/college age (ages 18-26)

d) ☐ Adults (ages 27-54)

e) ☐ Older adults (age 55 and above)

f) ☑ Cultural/ethnic minorities

g) ☑ Sexual/gender minorities

h) ☐ Rural communities

i) ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☐ State - developed survey instrument

h) ☑ Others (please list)

Uniform Crime Reporting (UCR)
Fatal Analysis Reporting System (FARS)
Pregnancy Risk Assessment Monitoring System (PRAMS)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The Evidence-Based Workgroup (EBW) has established criteria and is consulted for implementation of programs and policies but not specific to SUPTRS BG funds. The intent is to utilize the EBW for assistance in evaluating locally developed, culturally appropriate and innovative interventions to determine effectiveness.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step?

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

ADAD utilizes the Strategic Prevention Framework (SPF) framework which requires prevention service providers to assess the needs of their individual community, conduct ongoing assessment of program implementation, and effectiveness. A community's cultures, beliefs, and languages are an integral component of this process. Allowing for the development and implementation of prevention interventions appropriate to the unique needs of that community.

7. Does your state integrate sustainability into the assessment step?

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

The ADAD plans to integrate sustainability into the assessment step and has the tools to do so as state staff has attended an enhanced prevention learning series on sustainability.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

a) If yes, please describe.

ADAD approves credentials for Certified Prevention Specialist (CPS). Applicants complete the International Certification and Reciprocity Consortium (IC & RC) International Written Prevention Specialist Examination and submit an application including documentation of hours and signed code of ethics for review. Information on the certification process and requirements is available at http://health.hawaii.gov/substance-abuse/counselorcertification/.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?

a) If yes, please describe mechanism used.

Existing service contracts and collaborative partnerships facilitate the logistics of utilizing consultants, trainers, and venues to conduct relevant training workshops and courses approved for continuing education/contact hours (CEs) that may be applied toward meeting the education requirements for certification and/or renewal of certification. Additionally, ADAD continues to allocate SUPTRS BG funds to maintain the Hawaii Prevention Resource Center to ensure prevention practitioners and the general public have access to up-to-date research, substance use disorder treatment and prevention resources, and evidence-based curriculum models. The https://www.hiprc808.org/ links to a lending library, resource clearinghouse, and technical assistance services. A website specific to the Strategic Prevention Framework and prevention efforts is available for the workforce and prevention system at https://www.spfhawaii.org/.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

a) If yes, please describe mechanism used.

4. Does your state integrate the National CLAS Standards into the capacity building step?

a) If yes, please explain in the box below.

5. Does your state integrate sustainability into the capacity building step?

 Yes  No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

The ADAD plans to integrate sustainability into the capacity step and has the tools to do so as state staff has attended an enhanced prevention learning series on sustainability.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?

○ Yes ○ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

○ Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds

b) ☐ Timelines

c) ☐ Roles and responsibilities

d) ☐ Process indicators

e) ☐ Outcome indicators

f) ☐ Cultural competence component (i.e., National CLAS Standards)

g) ☐ Sustainability component

h) ☐ Other (please list):

i) ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds?

○ Yes ◉ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

○ Yes ◉ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Evidence-Based Workgroup (EBW) has established criteria and is consulted for implementation of programs and policies but not specific to SUPTRS BG funds. The intent is to utilize the EBW for assistance in evaluating locally developed, culturally appropriate and innovative interventions to determine effectiveness.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds?

○ Yes ◉ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

○ Yes ◉ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The Evidence-Based Workgroup (EBW) and ADAD collaborated on the criteria for evidence-based programs, policies and strategies but specific to SUPTRS BG funds. The intent is to utilize the EBW for assistance in evaluating locally developed, culturally appropriate and innovative interventions to determine effectiveness.

8. Does your state integrate the National CLAS Standards into the planning step?

○ Yes ◉ No

a) If yes, please explain in the box below.

Not applicable.

b) If no, please explain in the box below.

ADAD utilizes the SPF framework which requires prevention service providers to assess the needs of their individual community, conduct ongoing assessment of program implementation, and effectiveness. A community's cultures, beliefs, and languages are an integral component of this process. Allowing for the development and implementation of prevention interventions appropriate to the unique needs of that community.

9. Does your state integrate sustainability into the planning step?

○ Yes ◉ No

a) If yes, please explain in the box below.

Not applicable.

b) If no, please explain in the box below.

The ADAD plans to integrate sustainability into the planning step and has the tools to do so as state staff has attended an enhanced prevention learning series on sustainability.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars

in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health/Community Fairs
Speaking Engagements/Presentations
Social Media
Prevention-Focused Websites and Email Blasts
Public Service Announcements

b) Education:

Positive Action
Project Alert
Why Try
Prevention Plus Wellness

c) Alternatives:

Substance-Free Social/Recreational Activities
Community Service Activities
Mentoring, Youth/Adult Leadership Activities

d) Problem Identification and Referral:

Providers identify individuals from program sessions or school presentations and refer them for screening.

e) Community-Based Processes:

Substance- and Prevention-Related Trainings
Partnership Meetings
Community Coalition and Inter-Agency Meetings

f) Environmental:

Synar Activities
Community Coalition involvement and inter-agency collaboration to address local conditions and policies.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?


Yes


No

a) If yes, please describe.

Applicants for funding provide information related to agency-wide budget and sources of funds, planned expenditures, and actual expenditures for program services. Budgets and expenditures are approved and tracked by State fiscal and program staff.

4. Does your state integrate National CLAS Standards into the implementation step?


Yes


No

a) If yes, please describe in the box below.

b) If no, please explain in the box below.

ADAD utilizes the SPF framework which requires prevention service providers to assess the needs of their individual community, conduct ongoing assessment of program implementation, and effectiveness. A community's cultures, beliefs, and languages are an integral component of this process. Allowing for the development and implementation of prevention interventions appropriate to the unique needs of that community.

5. Does your state integrate sustainability into the implementation step?


Yes


No

a) If yes, please describe in the box below.

b) If no, please explain in the box below

The ADAD plans to integrate sustainability into the implementation step and has the tools to do so as state staff has attended an enhanced prevention learning series on sustainability.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?

○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served

b) ☑ Implementation fidelity

c) ☑ Participant satisfaction

d) ☑ Number of evidence based programs/practices/policies implemented

e) ☑ Attendance

f) ☑ Demographic information

g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

c) ☐ Binge use

d) ☐ Perception of harm

e) ☐ Disapproval of use

f) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☑ Other (please describe):

ADAD intends to track the select indicators from SAMHSA's NOMs related to youth such as 30-day marijuana and alcohol use; age of first use; perceived harm of use; lifetime prescription drug use without doctor's prescription; 30-day binge drinking; and family communication around substance use.

Further outcomes and impact of funded services will be determined by the SEOW, SPF Evaluation Team, and the analysis and comparison of the Hawaii Youth Risk Behavior Survey results from 2017, 2019, and 2021. ADAD intends to work with an evaluator to enhance our ability to collect and report on outcome data from ADAD-funded providers as well as evaluate the prevention system as a whole.

5. Does your state integrate the National CLAS Standards into the evaluation step?

○ Yes ◉ No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

ADAD utilizes the SPF framework which requires prevention service providers to assess the needs of their individual community, conduct ongoing assessment of program implementation, and effectiveness. A community's cultures, beliefs, and languages are an integral component of this process. Allowing for the development and implementation of prevention interventions appropriate to the unique needs of that community.

6. Does your state integrate sustainability into the evaluation step?

○ Yes ◉ No

a) If yes, please describe in the box below.

b) If no, please explain in the box below.

The ADAD plans to integrate sustainability into the evaluation step and has the tools to do so as state staff has attended an enhanced prevention learning series on sustainability.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	● Yes	○ No
ii)	Education	● Yes	○ No
iii)	Brief Intervention	● Yes	○ No
iv)	Assessment	● Yes	○ No
v)	Detox (inpatient/residential)	● Yes	○ No
vi)	Outpatient	● Yes	○ No
vii)	Intensive Outpatient	● Yes	○ No
viii)	Inpatient/Residential	● Yes	○ No
ix)	Aftercare; Recovery support	● Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	● No
ii)	Adolescents?	● Yes	○ No
iii)	Older Adults?	○ Yes	● No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ● Yes ○ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ● Yes ○ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ● Yes ○ No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ● Yes ○ No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ● Yes ○ No

b) Establishment of an electronic system to identify available treatment slots ● Yes ○ No

c) Expanded community network for supportive services and healthcare ● Yes ○ No

d) Inclusion of recovery support services ● Yes ○ No

e) Health navigators to assist clients with community linkages ○ Yes ● No

f) Expanded capability for family services, relationship restoration, and custody issues? ● Yes ○ No

g) Providing employment assistance ● Yes ○ No

h) Providing transportation to and from services ● Yes ○ No

i) Educational assistance ● Yes ○ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In general, ADAD identifies compliance issues and corrective actions through contract monitoring and also through corrective action plans. The wait-list is also generated weekly via web-based infrastructure (WITS) for Treatment Services. action plans. The wait-list is also generated weekly via web-based infrastructure (WITS) for Treatment Services.

Award identification
The sub-recipient (in this case the PWWDC Provider) is informed of their initial contract award by the Competitive Purchases of Services Statement of Findings and Decision which informs the sub-recipient of the amount awarded, identifies other applicants who were selected for this RFP, and the technical review committee comments, which includes general comments and conditions of acceptance for proposals that are recommended for funding. The reviews of proposals are conducted by the Treatment and Recovery Branch (TRB) for substance abuse treatment programs. Once the Statement of Findings and Decision are completed, the contracts for each award are completed by the TRB Program Specialists.

During-the-Award Monitoring
After the contract is awarded, the accountants and Administrative Officer (AO) III in ADAD will monitor the agencies reported use of funds for the contracts on an annual basis. When the contract is finalized and executed at the Administrative Services Office (ASO), a copy of the contract is forwarded to ADAD. ADAD will create and send a purchase order (PO) to ASO to encumber funds for the contract. The pink copy of the PO is sent back to ADAD once the fund is encumbered and it is kept in the fiscal contract folder with the accountant or AO III. If the contract is a multiple year contract, ADAD will create and send a PO to ASO to encumbered funds accordingly for the contracted amount at the beginning of each subsequent year.

On Site Monitoring/Desktop Review (Treatment)
In the first year of a new contract, ADAD conducts on-site contract orientations. During this visit, ADAD requests a tour of the facility in order to understand and visualize how services will be implemented. An orientation of the contract is conducted with key staff. This orientation reviews the scope and terms of the contract, policy and procedure monitoring process, funding, WITS (the management information system utilized by ADAD), clinical requirements and any questions that the provider may have.

A desk top review of the providers Policies and Procedure is also scheduled within the first year of the contract. During the desk top review, the Contract Manager will complete the Treatment and Recovery Branch (TRB) Contract Compliance Monitoring Protocol to evaluate compliance with policies and procedures in the following areas: general, personnel, other administrative personnel files, and other administrative wait list capacity management. After the protocol is completed, it is sent to the provider, along with a cover letter, signed TRB Chief, informing them of the results of the desk top review. If the report has findings, ADAD will indicate that a Plan of Correction (POC) will need to be submitted within 30 days. After the POC is submitted, the TRB monitor will then evaluate the POC for effectiveness of the corrective action measures. Once the POC is deemed acceptable, a final letter of acceptance will be sent to the provider.

In the second year of the contract, desk top reviews are completed at ADAD by either Contract Managers and or Clinical Psychologist. The Program Specialist protocols evaluate administrative requirements and scope of work requirements. The Clinical Psychologist protocols evaluate clinical services, treatment curriculum review, and facility standards which include interviews of staff and consumers. Random test sampling is performed to ensure compliance with the scope of the contract and work requirements. The desk top review consists of reviewing programs and clinical notes and billing information that are submitted by the providers. Prior to viewing the client information, which is considered to be protected Health Information (PHI), the TRB staff must obtain approval to view the information and request proper log-on authorization in order to review WITS data, for the safe of monitoring. A follow-up site visit may or may not be scheduled depending on the additional information that would need to be verified. The site visit for these monitoring years, would be to verify client sign-in sheets, interview with staff, and interviews with client to verify services satisfaction and appropriateness of treatment services, as well as to follow up on any previous POCs for quality control.

Treatment Contract Managers are assigned a number of contracts, which are tracked on the "Contract Caseload" schedule. They are responsible for conducting the reviews for their assigned contracts each quarter, of each year. The contracts are constantly being reviewed and monitored, in conjunction with Fiscal section, for optimal utilization review, in order to minimize lapsing funds. Increasing or decreasing contract amounts require a contract modification. The Clinical Psychologist is responsible for monitoring all clinical aspects of all the contracts.
all clinical aspects of all the contracts.

On-site monitoring for the fourth year is mainly for those contracts with previous findings which required a POC. The priority for selection of on-site monitoring for the fourth year depends on the severity of the findings or correction action plan in the previous year.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a) 90 percent capacity reporting requirement — ● Yes ○ No

b) 14-120 day performance requirement with provision of interim services — ● Yes ○ No

c) Outreach activities — ● Yes ○ No

d) Syringe services programs, if applicable — ○ Yes ● No

e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — ● Yes ○ No

2. Has your state identified a need for any of the following:

a) Electronic system with alert when 90 percent capacity is reached — ○ Yes ● No

b) Automatic reminder system associated with 14-120 day performance requirement — ○ Yes ● No

c) Use of peer recovery supports to maintain contact and support — ● Yes ○ No

d) Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)? — ○ Yes ● No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

ADAD identifies compliance issues and corrective actions through contract monitoring and the use of corrective action plans. ADAD utilizes the same procedures and strategies to monitor program compliance for PWID activities and services. Please see response to Criterion 3, item 6.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Business agreement/MOU with primary healthcare providers — ○ Yes ● No

b) Cooperative agreement/MOU with public health entity for testing and treatment — ○ Yes ● No

c) Established co-located SUD professionals within FQHCs — ○ Yes ● No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Additional Response to 1.
With regards to 1,the RFP requires all providers to adopt a policy which states that it provides for TB and Hepatitis C screening, referral, and education as appropriate.

Monitoring Program Compliance
ADAD does annual monitoring of SSA-contracted providers for TB screening and when appropriate, referral for TB services. ADAD utilizes the same procedures and strategies to monitor program compliance for SUD activities and services. Please see response to Criterion 3, item 6.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

Yes No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas

Yes No

b) Establishment or expansion of tele-health and social media support services

Yes No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?

Yes No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

Yes No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program?

Yes No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access — ● Yes ○ No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ● Yes ○ No

c) Establish a peer recovery support network to assist in filling the gaps — ● Yes ○ No

d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ○ Yes ● No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ● No

f) Explore expansion of services for:

i) MOUD — ● Yes ○ No

ii) Tele-Health — ● Yes ○ No

iii) Social Media Outreach — ● Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ● Yes ○ No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ● Yes ○ No

b) Establish a program to provide trauma-informed care — ○ Yes ● No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ● Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ● Yes ○ No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries — Yes / No

b) An organized referral system to identify alternative providers? — Yes / No

c) A system to maintain a list of referrals made by religious organizations? — Yes / No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes / No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments — Yes / No

b) Review of current levels of care to determine changes or additions — Yes / No

c) Identify workforce needs to expand service capabilities — Yes / No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes / No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes / No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — Yes / No

b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes / No

c) Updating written procedures which regulate and control access to records — Yes / No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — Yes / No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes / No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Two sub-recipients will be identified for the fiscal years involved.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan

○ Yes ○ No

b) Establishment of policies and procedures related to independent peer review

○ Yes ○ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

○ Yes ○ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

○ Yes ○ No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ● Yes ○ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ● Yes ○ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ● Yes ○ No

c) Performance-based accountability: ● Yes ○ No

d) Data collection and reporting requirements ● Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ● Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ● Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ● Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) Mental Health TTC? ● Yes ○ No

c) Addiction TTC? ● Yes ○ No

d) State Targeted Response TTC? ○ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ○ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ○ No

b) Early Intervention Services Regarding HIV ○ Yes ○ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ○ No

b) Professional Development ○ Yes ○ No

c) Coordination of Various Activities and Services ○ Yes ○ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Hawaii State administrative regulations which govern Mental Health are not covered here because such regulations apply only to the MHBG application. SAMHSA's MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2024-2025 MHBG Application Plan for information on this section.

For the SUPTRS BG Application Plan, current state administrative regulations administered by ADAD are contained in Hawaii Administrative Rules (HAR) Chapter 177.1, "Certification Standards for Substance Abuse Counselors, Program Administrators, Prevention Specialists, Clinical Supervisors, Criminal Justice Addictions Professionals, and Co-Occurring Disorders Professional Diplomate." http://health.hawaii.gov/opppd/files/2015/06/11-177.1.pdf

Hawaii Revised Statutes, Sections 321-191 to 198:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0191.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0005.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0007.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0194.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0195.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0196.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0197.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0198.htm

Hawaii Revised Statutes, Sections 329-1 to 4:

- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0001.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0002.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0003.htm
- http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0004.htm

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023?


Yes


No

Please indicate areas of technical assistance needed related to this section.

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12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? ○ Yes ○ No

4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No

6. Does the state use an evidence-based intervention to treat trauma? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight.

ADAD has initiated their first peer support services training and are hoping to have another round of peer support training.

ADAD recognizes the need for having additional peer support specialist in the field and the likelihood of a client's recovery being successful if the client had a peer support specialist supporting them in their recovery process.

ADAD has conducted and sponsored several trauma-informed care trainings and is mindful of those who attend these trainings. ADAD also understands how important trauma-informed care is introduced/presented to the client while attending a treatment program. Having the treatment programs provide a safe and non-judgemental setting for the client to discuss their past and/or present trauma will increase their success in recovery.

Please indicate areas of technical assistance needed related to this section.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [ ] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [ ] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [ ] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [ ] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

◉ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

ADAD is represented in the Interagency Council on Intermediate Sanctions (ICIS), which is a committee that consist of the Department of Attorney General, Department of Public Safety, Hawaii Paroling Authority, and the Judiciary. The goal of ICIS is to implement a system-wide application of standardized assessment protocols; establish a continuum of services that match the risk and needs of adult offenders, collaborate with communities in developing and implementing the continuum of services, create a management information system capable of communicating among agencies to facilitate sharing of offender information, and evaluate the effectiveness of intermediate sanctions in reducing recidivism.

Since April 2022, ADAD and the Adult Client Services Branch (ACSB) created a Memorandum of Agreement (MOA) to support different sections within ACSB. Some of the sections and support that ADAD has provided to ACSB are updated equipment to the Division of Driver Education (DDE). The DDE provides classes to those who have been arrested for Driving While Intoxicated (DWI). ADAD has supported some of their IT equipment so that they would be able to continue providing DWI classes, statewide. The MOA also supported ACSB with their Community Outreach Court. ADAD supported this court by providing bus passes for homeless clients who are supervised by ACSB so that they will have transportation to and from court, treatment, employment, etc. ADAD also supports ACSB's Adult Drug Court program by providing art supplies to the clients who attend the Adult Drug Court Intensive Outpatient Program. The art supplies are used in conjunction with the Adult Drug Court's curriculum. Lastly, the ADAD MOA provides workforce development training for any ACSB staff on substance use related matters.

Please indicate areas of technical assistance needed related to this section.

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders?

(●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women?

(●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?


Yes


No

5. Does the state have any activities related to this section that you would like to highlight?

ADAD has co-sponsored conferences and educational workshops which provide sessions on medication-assisted treatment for substance use disorders. ADAD has collaborative partnerships with other departments of Human Services, Attorney General, and Public Safety; first responders, pharmacies, primary care providers, the University of Hawaii, as well as community-based organizations like the Hawaii Health & Harm Reduction Center to sponsor and promote training sessions in evidence-based practices, naloxone, and overdose prevention.

ADAD has also received State Opioid Response (SOR) grants. These are two-year grants awarded through the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP). This grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). Once of ADAD's objectives is to increase MAT services through its treatment provider contracts. Beginning with new contracts starting on October 1, 2019, service providers are eligible to bill for MAT services in both outpatient and inpatient settings by 1) hiring qualified staff to provide MAT services on site or 2) developing a partnership with a pre-existing opioid treatment program to provide on-site MAT services to enrolled client..

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☐
Someone to respond	☐	☐	☐	☐	☐	☐
Safe place to go or to be	☐	☐	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Please indicate areas of technical assistance needed related to this section.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ○ Yes ○ No

b) Required peer accreditation or certification? ○ Yes ○ No

c) Use Block grant funding of recovery support services? ○ Yes ○ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ○ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ○ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI and children with SED in Hawaii are provided through Adult Mental Health Division and the Child and Adolescent Mental Health Divisions of the Department of Health, respectively. However, ADAD contracts with a few treatment programs that provide services for adults with SMI. There are peer support, and the state Clubhouse programs where the clients are taught daily living skills such as answering the phones, cooking, and computer education. While the client is enrolled in a treatment program, they have the option to attend an AA/NA meeting to build their support network and find a sponsor to possibly work the 12-steps.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery and recovery support services for substance use disorders in Hawaii are provided through ADAD-contracted treatment services and include the following: Continuing Care, Clean and Sober Housing, Therapeutic Living Programs, Transportation, Translation Service, and Childcare.

5. Does the state have any activities that it would like to highlight?

With respect to Section 16, item 1a., ADAD has contracted with the University of Hawaii to develop a statewide workforce to prevent and reduce substance use to protect health, safety and quality of life in Hawaii. This contract will support assessment, planning, training, and evaluation. The University of Hawaii will execute a statewide needs assessment of current substance use professional and workforce development needs, create and implement a state workforce plan, and provide training relevant to advance the professional workforce while meeting the prevention, treatment and recovery needs of the community.

With respect to Section 16, item 1 b., ADAD supports peer recovery support specialists and persons with lived experience in the workforce to provide peer support in treatment and recovery programs. In the near future, ADAD will be working to establish certification and adopt Hawaii Administrative Rules (HAR) for peer recovery support specialist, incorporate training methods for increasing peer recovery support specialist for specific groups, and consider ways to offer peer recovery in support as part of the SUD COC with reimbursement and payment strategies for this service.

With respect to Section 16, item 1c, $898,111 of SUPTRS BG funds were expended during State Fiscal Year (SFY) 2022-2023 for recovery support services. During (SFY) 2022-2023 $1,267,731 of federal funds were expended for recovery support services. In addition to SUPTRS BG funds, the following federal funds and amounts were expended:
COVID-19: $146,596
Disaster Response Grant: $33,121
State Opioid Response Grant: $189,703

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

- Housing services provided — Yes / No
- Home and community-based services — Yes / No
- Peer support services — Yes / No
- Employment services. — Yes / No

2. Does the state have a plan to transition individuals from hospital to community settings? — Yes / No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ○ Yes ○ No

b) The resilience of children and youth with SED? ○ Yes ○ No

c) The recovery of children and youth with SUD? ○ Yes ○ No

d) The resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ○ Yes ○ No

b) Health care? ○ Yes ○ No

c) Juvenile justice? ○ Yes ○ No

d) Education? ○ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ○ Yes ○ No

b) Costs? ○ Yes ○ No

c) Outcomes for children and youth services? ○ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ○ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ● No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ● Yes ○ No

b) for youth in foster care? ● Yes ○ No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ○ Yes ● No

d) Does the state have an established FEP program? ○ Yes ● No

Does the state have an established CHRP program? ○ Yes ● No

e) Is the state providing trauma informed care? ● Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

In accordance with the State procurement process, ADAD contracts with substance use treatment and recovery service providers to provide school-based outpatient substance use treatment to middle school and high school age adolescents statewide. During ADAD's Request for Proposal (RFP) planning process, communication is shared with the Hawaii State Department of Education (DOE) administration. Prior to submitting a proposal to ADAD, prospective service providers must obtain a Memorandum of Agreement (MOA) that is signed by the principal of the specific school at which the substance use treatment services will be provided. The agreement specifies that the provider will have administrative and logistical support, and also specifies the responsibilities of both parties. The school-based treatment counselor becomes a part of the team established by the DOE to look at the individual needs of the adolescent.

7. Does the state have any activities related to this section that you would like to highlight?

The ADAD's Prevention Branch, 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, and 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 (SPF) for universal, selected and/or indicated populations.

In SFY 2020-2021, ADAD contracted with fourteen agencies and community coalitions funded by the SPF-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.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

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22. Public Comment on the State Plan - Required

Narrative Question

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings?


Yes


No

b) Posting of the plan on the web for public comment?


Yes


No

If yes, provide URL:

This 2024-2025 Application and Plan was made available for public review and comment at ADAD's website where, as needed, it will be updated to reflect any revisions that may be required by SAMHSA for approval.

https://health.hawaii.gov/substance-abuse/survey/

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media)


Yes


No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: