

# Hawaii

## UNIFORM APPLICATION

FY 2026/2027 SUPTRS BG Only Application Behavioral Health  
Assessment and Plan

## SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028  
(generated on 02/12/2026 4.56.14 PM)

Center for Substance Abuse Prevention  
Division of Primary Prevention

Center for Substance Abuse Treatment  
Division of State and Community Systems (DSCS)

# State Information

## State Information

### Plan Year

Start Year 2026  
End Year 2027

### State Unique Entity Identification

Unique Entity ID NL2YKJLUFY5

### 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 9/30/2025 8:28:47 PM  
Revision Date 2/12/2026 2:24:59 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: 05/28/2025 Expires: 01/31/2028

#### Footnotes:

# State Information

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

### Fiscal Year 2026

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  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
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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.
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8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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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](http://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<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_  
<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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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](http://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: Kenneth S. Fink, MD, MGA, MPH

Signature of CEO or Designee<sup>1</sup>: 

Title: Director of Health

Date Signed: 09/30/2015

mm/dd/yyyy

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.  
OMB No. 0930-0168 | Approved: 05/28/2025 | Expires: 01/31/2028



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,

A handwritten signature in black ink that reads "Josh Green M.D." in a cursive style.

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



STATE OF HAWAII  
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 \(click here\)](#)

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Name

Title

Organization

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Signature:

Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

**Footnotes:**

1. The State of Hawaii does not lobby the federal government.

# Planning Steps

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

### Narrative Question

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Provide an overview of the state's prevention system (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 behavioral health 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 mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. 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."

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1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

The Hawaii State Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is the Single State Authority (SSA) that manages the Substance Use Prevention, Treatment and Recovery Support Services Block Grant (SUPTRS BG) for Hawaii. ADAD is located within the DOH Behavioral Health Administration (BHA). Also located within the BHA umbrella are the Adult Mental Health Division (AMHD), the Developmental Disabilities Division (DDD), and the Child and Adolescent Mental Health Division (AMHD).

ADAD's functions include grants and contract management, monitoring implementation of substance use services, clinical consultation, accreditation of substance use treatment programs, certification of clean and sober homes, training and certification of substance use counselors and program administrators, needs assessment, planning and coordination of services, policy development, and information systems management.

While both substance use and mental health services are under the BHA umbrella, ADAD's operations are not fully integrated with AMHD and CAMHD. ADAD oversees, and funds substance use services for both adults and youth. Adult and children mental health services are provided by AMHD and CAMHD, respectively.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

ADAD is the primary source of public substance use treatment funds in Hawaii. Its efforts are designed to promote a statewide, comprehensive, evidence-based system of substance use services to meet the treatment, recovery, lifesaving overdose prevention and response needs of individuals and families, and primary prevention needs of the community

To plan for the delivery of substance use services, ADAD has divided the state into four planning areas. These planning areas are consistent with Hawaii's four counties: Kauai County (Island of Kauai), City and County of Honolulu (Island of Oahu), Maui County (Islands of Lanai, Maui, and Molokai), and Hawaii County (Island of Hawaii). The 2024 U.S. Census Bureau population estimates reported the State of Hawaii's population at 1,446,146. With the majority of the population residing in the City and County of Honolulu at 69%, followed by Hawaii County at 15%, Maui County at 11%, and Kauai County at 5%.

Block Grant funds, State general funds, State Opioid Response (Hawaii SOR) grant funds, Partnership for Success (PFS) grant funds, and Opioid Settlement funds (Settlement funds) are expended to support ADAD contracts with service providers to deliver evidence-based prevention, treatment, recovery, and lifesaving overdose prevention and response services statewide. ADAD is required to use the State procurement process to contract for these 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, which is then finalized and issued. All RFPs issued include the following elements: 1) SUPTRS BG requirements for services to specified target populations; 2) reflects existing needs assessment data along with other pertinent data sources; and 3) requires applicants to substantiate the need for their proposed program and/or services as well as identifying their target populations for which services will be provided. All proposals submitted by community-based organization are reviewed, evaluated based upon established criteria, and scored by ADAD. Resulting in awarding of service contracts based upon the evaluation criteria.

Procurement and contracting cycles vary depending on funding availability and service type. A typical service contract approximately covers a period from two to four years. The contract initially covers a one-year period. Its continuation is subject to funding availability, satisfactory performance of services, and a determination by the State that the services are still needed.

Some substance use treatment services are funded through the Hawaii Medicaid 1115 waiver program Med-QUEST, administered by the Hawaii State Department of Human Services. Most Medicaid services in Hawaii are delivered through Managed Care Organizations (MCOs). Each MCO sets criteria for enrollment of and determines the substance use 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 use services, after the benefits have been exhausted and up to the limit of the ADAD substance use benefits. The current 1115 waiver expands the range of behavioral health services including transportation and are looking to expand to include peer recovery services. Qualifying individuals who are also diagnosed with SUD are eligible for these services. Med-QUEST plans to seek a 1115 waiver to further expand MAT coverage and substance use services.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Supported by Block Grant funds, State general funds, Hawaii SOR funds, and Settlement funds, ADAD facilitates access to a well-rounded system of evidence-based substance use disorder (SUD) treatment and recovery services through a statewide continuum of care (COC.) Funded services include pre-treatment (outreach, motivational enhancement, screening, care coordination), social detoxification, partial hospitalization, residential treatment, motivational enhancement services, intensive outpatient, outpatient, therapeutic living programs, opioid addiction recovery services, group recovery homes, clean and sober housing, HIV early intervention services and continuing care services. For a whole-person approach, additional supportive treatment services offered include motivational enhancement, activities, stabilization beds, individual/family counseling, peer support/coaching, vocational rehabilitation support, transportation and translation/interpretation

ADAD continues to support the implementation of the Hawaii Coordinated Access Resource Entry System (Hawaii CARES), a statewide 24/7 coordination center that connects community members to substance use, mental health, and crisis intervention services. This system of care increases access to all ADAD contracted treatment service providers within the State. Since its establishment in 2019, the Hawaii CARES line has reduced barriers to substance use treatment programs by emphasizing rapid connection to treatment and recovery support services to promote long-term health outcomes and reduction in overdose risk, homelessness, and recidivism.

ADAD contracted treatment providers are required to implement policies and procedures that prioritize at-risk populations in the following order pregnant injecting drug users, pregnant substance users, person who inject drugs (PWID), and all others. Additionally, individuals with co-occurring disorders, pregnant women and women with dependent children (PWWDC), individuals on supervised release, furlough, probation or parole, and unhoused individuals receive specialized services supported by either Block Grant, State general funds, Hawaii SOR funds, or Settlement funds. Thus, ensuring a robust SUD system that enhances access to treatment

ADAD service providers are contractually obligated to demonstrate a clear commitment to prioritizing PWWDC in the delivery of SUD services. In addition to admission priority, programs are required to publicize both the availability of services and the prioritization of admission for the PWWDC population. If a treatment provider is unable to immediately admit a pregnant woman, or if the placement is deemed clinically inappropriate, the provider must promptly refer the individual to Hawaii CARES to coordinate placement within the SUD COC. In such cases, the program must also provide interim services within forty-eight (48) hours of the treatment request.

Providers must comply with childcare regulations under Chapter 346, HRS, Part VIII, specifically §§ 346-151 and 346-161, when delivering services to PWWDC. Required interim services for pregnant women include counseling and education on HIV, tuberculosis (TB), and communicable diseases; education on needle sharing and disease transmission risks; steps for prevention of disease transmission; referrals for HIV and TB services as needed; prenatal care referrals; and counseling on the effects of alcohol and drug use on the fetus. Federally authorized methadone services may also be included as part of interim care.

PWWDC treatment programs providers who use Block Grant funds, must offer or coordinate access to comprehensive services, including primary medical and pediatric care, SUD treatment and therapeutic interventions specific for women, therapeutic services for children in the mother's custody, childcare during treatment, and sufficient case management and transportation to ensure access to these services. Additionally, programs must adopt a family-centered approach, recognizing that approximately 70% of women entering treatment are mothers. Treating the family as a unit reduces barriers to care and has been shown to improve outcomes for both the mother and her children. Research further supports that including children in treatment, particularly in residential settings, is essential to a mother's recovery process.

PWIDs are provided with specialized services through ADAD's contracted opioid addiction recovery services, that targets outreach ,assessment, and connections to appropriate community-based treatment services. PWID must be admitted to a treatment program within fourteen (14) days of requesting services. Pregnant injecting drug users are given the highest priority for admission. If a treatment program lacks the capacity to immediately admit a PWID client or if the program is not clinically appropriate, the client must be referred to Hawaii CARES (<https://hicare.hawaii.gov/>) to facilitate placement with an alternative available service provider in the SUD COC network. While Hawaii CARES coordinates this placement, the referring program is required to provide interim services within forty-eight (48) hours of the request. If no treatment program can admit the individual

within the fourteen-day window, interim services must be initiated within forty-eight(48) hours, and the individual must be admitted to a treatment program no later than one hundred twenty (120) days from the initial request for services.

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

The most recent Substance Abuse and Mental Health Services (SAMHSA) Center for Substance Abuse Treatment's (CSAT) available list of "designated states" is for the Federal Fiscal Year 2026 (FFY 2026) SUPTRS BG application. According to the CSAT list, 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 Block Grant 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.

To support people in recovery, ADAD treatment contracts provide for a variety of recovery support services, including transportation, translation, stabilization beds, group recovery homes, and clean and sober homes. Hawaii established a voluntary Clean and Sober Home Registry (Registry), administered by ADAD, to ensure that persons in recovery have access to a safe, clean, and sober environment. Only clean and sober homes listed on the Registry are eligible to bill ADAD for services.

State general funds are currently used to support access to SUD COC treatment services for adolescents up to 24 years of age. These services are delivered through the Hawaii Youth Correctional Facility and a network of contracted school and community-based treatment programs. School-based treatment services are available in forty (40) middle and high schools across the state, offering one (1) to six (6) hours per week of outpatient care. Community-based treatment services provide six (6) to nine (9) hours per week of intensive outpatient treatment and one (1) to six (6) hours per week of standard outpatient care.

#### Prevention Services

The goal of the substance use disorder prevention system is to reduce the prevalence, incidence, and consequences of alcohol, tobacco, and other drugs (ATOD) by addressing community conditions that promote substance use by enhancing conditions in the community that buffer individuals from the consequences of SUDs. The State Prevention system establishes evidence-based and cost-effective models, programs, and policies to prevent substance use in the community. The Strategic Prevention Framework (SPF) is central to ADAD's approach to prevention. It provides a structured planning process, using a public health and data driven approach, to selecting and delivering evidence-based programs that meets the needs of the community. ADAD along with the State Epidemiological Outcomes Workgroups (SEOW) and the SPF Evaluation Team to identify substance use disorder prevention priorities to be implemented

SPF has been used effectively by ADAD contracted prevention programs to mobilize and create community-level change. Including 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.

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 in vulnerable communities that experience a cluster of high-risk factors that make them especially susceptible to substance use.

Block Grant funds, Partnership for Success grant funds, State general funds, Hawaii SOR funds and Settlement funds are awarded through service contracts with community based non-profit organizations and public agencies to provide services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Funded prevention programs, for youth and their families, are primarily focus on the provision of evidence-based curricula and practices categorized in at least one of the following CSAP strategies: information dissemination, education, alternatives, environmental, community-based process, and problem identification and referral. Prevention services are comprehensive and appropriate for universal, selected and/or indicated populations and strive to produce sustainable positive outcomes

During this application planning period, ADAD plans Hawai'i to expand prevention services within the IOM Categories, especially the selective and indicated categories, among different populations, and within the behavioral health continuum of care. Populations identified for services are youth, ages 9-17 and their families, and young adults ages 18-24, schools, communities, military personnel and their families, and rural areas.

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 risk factors, increase protective factors, expand innovation prevention approaches, 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. 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. Parents are provided with background information on the survey and allow their child to participate. 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 Synar Amendment compliance requirement for the Block Grant 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.

#### Opioid Related Initiatives

The State Opioid Response Grant (Hawaii SOR) addresses the opioid and stimulant crisis by increasing access to evidence-based 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) and stimulant use disorder. The Hawaii Opioid Initiative (HOI) was launched in 2017 and provided the framework for Hawaii to address the opioid and stimulant crisis. In 2025, the HOI was relaunched as the Hawaii Overdose Initiative, reflecting the increase in poly-substance use with synthetic opioid and associated increase in overdoses.

The Hawaii SOR funds support a variety of programs which are targeted to build capacity to prevent and address opioid and stimulant misuse. Including funding to support ADAD services providers contracted to provide evidence-based SUD COC and primary prevention program.

The DOH established the Opioid Settlement Project (OSP) to manage the States share of Settlement funds from the various national opioid settlements. These national settlement agreements requires that the settlement funds be used to conduct statewide abatement and remediation from the harm's illicit fentanyl, misused opioids, and other substances have caused to our communities.

A Memorandum of Agreement between the State of Hawaii and its counties sets forth the allocation of funds to each entity, identifies allowable expenditures, and establishes the Hawaii Opioid Settlement Advisory Committee (HOSAC). The OSP is responsible for the allocation of settlement funds to support treatment, recovery, prevention, and life-saving overdose prevention and response services. Including funding to support ADAD service providers contracted to provide evidence-based SUD COC and primary prevention programs.

#### Certification for Substance Abuse Professionals and Workforce Development

ADAD certifies substance abuse counselors and program administrators pursuant to State law [HRS §321-197 (10)] and regulations (Hawaii Administrative Rules (HAR), 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. ADAD is amending their HAR to include Peer Recovery Support Specialist.

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 49 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 evidence-based trainings to include asynchronous 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 evidence-based and capacity training which have been approved for contact hours that may be applied towards meeting the educational requirements for certification and renewal.

**Footnotes:**

## Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

#### Narrative Question

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This narrative should describe your state's needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of 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 should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the [National Survey on Drug Use and Health \(NSDUH\)](#), [Treatment Episode Data Set \(TEDS\)](#), [National Substance Use and Mental Health Services Survey \(N-SUMHSS\)](#), the [Behavioral Health Barometer](#), [Behavioral Risk Factor Surveillance System \(BRFSS\)](#), [Youth Risk Behavior Surveillance System \(YRBSS\)](#), the CDC mortality data, 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, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

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1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

ADAD conducted a number of statewide assessments to identify needs for substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services. The Hawaii Substance Use State Plan, 2022 (Revised 2023) provides a statewide assessment. Additional reports and studies are conducted to provide additional data on an as needed basis.

#### Statewide

The Hawaii Substance Use State Plan, 2022 (Revised 2023) (State Plan) is a comprehensive, statewide, data-driven strategy to guide the State Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) actions over the next five years to promote a comprehensive, continuum of care for substance use services that meets the needs of the community. This plan builds upon the framework of previous statewide plans.

The priority of the State Plan was to collect and compile and assess a variety of data on the current system of care. This involved compiling quantitative and qualitative data, reviewing previous plans, existing planning and policy documents, and specific subject matter reports and documents.

A quantitative data analytics infrastructure was developed resulting in the "Hawaii State Plan on Substance Use: 2022 Statistical Report", an appendix to the State Plan. Data used included National Survey on Drug Use and Health (NSDUH), Hawaii Behavioral Risk Factor Surveillance System (BRFSS), Hawaii Youth Risk Behavioral Survey, (YRBS), Pregnancy Risk Assessment Monitoring System

(Hawaii PRAMS), Treatment Episode Data Set (TEDS), Web Infrastructure for Treatment Services (WITS) (data that provides information on clients receiving substance use treatment services from ADAD), Fatal Analysis Reporting System, and National Vital.

Corresponding white papers, prepared by local subject matter experts, were prepared and incorporated in the State Plan. Each white paper included literature highlights, State of Hawaii specific data, expert insights about the current system of care from practice-based knowledge, evidence-based interventions, along with observations and recommendations. Corresponding chapters in the State Plan provides an overview of Hawaii data, ADAD activities, and identified gaps in the system of care.

#### Treatment and Recovery Services

In January 2025, ADAD contracted with Recovery Innovations, Inc, to conduct a study of current adult and adolescent substance use care continuum. It was also used to complete a comparative analysis against best practices and proposed recommendations to current system to align to best practices, within allowed State regulations. This report has not been finalized and is still in the draft form. Once finalized, the needs assessment will assist ADAD with their future Request for Proposals (RFP) and planning efforts so that they know what services are needed for a client to be successful in their recovery.

The ADAD Treatment Services Report for State Fiscal Year (SFY) 2024 provides data on individuals who received ADAD contracted substance use treatment and recovery services. Data comes from the Web Infrastructure for Treatment Services (WITS), an electronic health and billing system for ADAD-contracted substance use treatment and recovery service providers.

#### 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 service is documented and tracked by ADAD's electronic data management systems. ADAD recognizes that the local information gathered and reported through its data management systems 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 SAMHSA' Center for Substance Abuse Prevention to ADAD in 2013, 2018 and 2023. The SEOW is comprised of an epidemiologist, data analysts, and graduate assistants.

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. The recently released The State Epidemiological Profile 2024: Substance Use Trends in Hawaii. updates community profiles that provide an insight and basis for potential prevention program design and direction. The original data sources for the profiles include the Hawaii Behavioral Risk Factor Surveillance System (BRFSS) and the Hawaii Youth Risk Behavior Survey (YRBS). Indicators in the profile helps to address the issues of SUD on a broader scale, all substances, age groups and indicators are taken into consideration in the developing priorities.

#### Opioid Related Initiatives

To obtain a better understanding on issues surrounding opioid use, both the State Opioid Response Grant (Hawaii SOR) and Opioid Settlement Project (OSP) conducted informal statewide needs assessments. Meetings with stakeholders across government and private sectors, the community, and service providers.

The OSP continuously receives input from the Hawaii Opioid Settlement Advisory Committee (HOSAC), established through a memorandum of agreement (MOA) between the State of Hawaii and its counties. HOSACS was established to guide the State and the counties in the use of opioid settlement funds and to do so in a manner consistent with the terms and conditions of the MOA. HOSACS is comprised of the mayor, or the mayor's designee from the City and County of Honolulu, Hawaii County, Kauai County, and Maui County; a designee from the Director of the Department of Health; the Director of the Department of Corrections and Rehabilitation, or designee; the Superintendent of the Department of Education, or designee; and the President

of the University of Hawaii John A. Burns School of Medicine, or designee

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

#### Statewide

Several findings emerged from the State Plan, identifying 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.

**Services.** 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 the community are limited or non-existent. For example, there is limited availability of services for pregnant and parenting women. Lastly, there is perceived stigma and/or discriminating those seeking out services.

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 individual's access to a full continuum of care (COC).

**Workforce Development.** There is a need for increased recruitment and retention of a qualified substance use workforce. Service providers have difficulty in finding and retaining qualified workers resulting in high vacancies and turnovers. Hawaii's unique geography affects the availability of substance use workforce amongst the various islands with a majority of the workforce on Oahu. Over the past two years, ADAD has observed that the substance use workforce has remain steady.

ADAD provides evidence-based 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 activities and to do case management

**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. Lastly, funding requirements and restrictions can reduce collaboration amongst service providers.

Many community-based substance use prevention and treatment agencies are contracted by ADAD to provide statewide substance use prevention and treatment services to adults and adolescents. To explore reimbursement rates, ADAD recently completed rate studies to analyze and compare service rates for substance use services. ADAD would like to explore ways to develop technical assistance for service providers to build and expand their business, so they are less dependent on ADAD funding.

**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.

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, even though the prevalence estimated offered by the NSDUH have been helpful. The number of Hawaii residents sampled in national surveys may be 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

ADAD's electronic management system, Web Infrastructure Treatment Services (WITS) system has several deficiencies that impacts ease from third-party payors. Additionally, the WITS system is also not able to receive or share data with other systems. From 2019 through 2021, ADAD completed 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. ADAD recently launched Phase I of INSPIRE PLUS to replace WITS. Once all phases are completed, INSPIRE PLUS will provide tools for case management, billing, fiscal management, credentialing of professionals, and accreditation of substance use facilities. Lastly, the State Plan identified areas in which ADAD needs take the lead to update administrative rules to add credentials for peer recovery support specialists and establish and maintain partnerships to expand options in the SUD system of care particularly in the field of recovery.

#### Treatment and Recovery Services

According to WITS data, in State Fiscal Year (SFY) 2024, there were 16,036 services delivered by ADAD's thirty-four (34) contracted providers, statewide. The most common source of referral was self-referral, followed by referrals from the criminal justice system. Methamphetamine was the substance most frequently reported at the time of service with 48% of young adults 18 to 24 years old, 61% of adults 18-64 years old, and 50% of older adults 65 years and older, followed by alcohol.

Among adolescents 17 years and younger, marijuana (59%) was the primary substance reported, followed by tobacco (18%) and alcohol (17%). These data indicate that the need for substance use treatment exists throughout the State. These data further suggest that methamphetamine remains the primary substance of use. However, substantial numbers of persons exhibit addiction to both alcohol and other drugs.

In SFY 2024 4.2% of pregnant women and women with dependent children entered a residential treatment program while 3.8% entered a therapeutic living program. Their primary substance upon admission was methamphetamine, followed by alcohol. Women in the 25-64-year age group were the highest users of therapeutic living services and residential treatment services.

ADAD provides people who inject drugs (PWID) with specialized services through contracted opioid addiction recovery services program that target outreach to encourage PWIDs to utilize their treatment services and accept referrals to connect with appropriate service providers. In SFY 2024, 256 individuals received services with methamphetamine being the primary substance, followed by heroin. Hawaii SOR funds are also used to treat PWID. Instead of WITS, a separate system is used to collect data on clients who services are paid by Hawaii SOR funds. For Federal Fiscal Year 2024-25, a total of 25 clients received opioid use disorder treatment. Number of clients per treatment are as follows: twenty-three clients received buprenorphine, three clients received methadone, and one client received injectable Naltrexone.

In SFY 2024, 878 (19.7%) clients reported being unhoused either alone, with parents, or with partners at the time of admission into a treatment program. ADAD also supports services for substance use disorders through recovery housing. Given the lack of affordable housing in Hawaii is, 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. ADAD contracted recovery homes (clean and sober homes, therapeutic living programs, and group homes) are often supported using Block Grant funds to allow the client to remain in the home if they are unable to afford housing on their own.

#### Prevention Services

Alcohol continues to be one of the most widely used substances among Hawaii youth. According to the 2023 Youth Risk Behavior Survey, Hawaii, Maui, and Kauai Counties continue to report higher rates of alcohol use indicators such as lifetime use, current use, binge drinking, and early initiation (before age 13).

E-cigarette use (vaping) has surpassed alcohol as the most commonly reported substance used by Hawaii's youth. The 2024 Epidemiological Profile shows that approximately 1 in 10 middle school students and 2 in 10 high school students currently use e-cigarettes. Rates are even higher on neighbor islands compared to Oahu. Youth often perceive vaping as less harmful than smoking cigarettes, but nicotine dependence and co-use with cannabis vaping products are growing concerns.

Cannabis is another substance of concern statewide. The 2024 Epidemiological Profile highlights that use of cannabis among middle and high school students remains higher than national averages, particularly on neighbor islands. Early initiation is also concerning, with notable proportions of youth trying cannabis before age 13. Cannabis use is often normalized in certain community settings, raising concerns about long-term impacts on adolescent brain development, school performance, and co-use with other substances.

The 2024 Profile emphasizes poly-use—the concurrent use of multiple substances (e.g., alcohol, cannabis, and e-cigarettes)—as an increasing public health concern. Poly-use is especially prevalent among homeless/runaway adolescents. These groups show higher likelihood of using more than one substance in the past 30 days, which compounds health risks and complicates prevention and intervention efforts. For example, youth who vape are more likely to also report cannabis and alcohol use, highlighting the need for integrated prevention strategies.

Hawaii continues to face readiness and capacity gaps in delivering responsive prevention services that meets the needs of the community. Community-based organizations often lack sufficient resources to implement needed evidence-based programs. Locally developed, evidence-based, grounded prevention curricula, that meets the needs of the community, remain limited. Smaller agencies, while trusted in their communities, struggle with the administrative and fiscal demands of state and federal contracts.

Workforce development is also a pressing need, with communities calling for more certified prevention specialists and greater

training reflective of community needs and values as well as poly-use-focused prevention approaches. Data gaps persist in key areas including cannabis use patterns, vaping-related harms, prescription drug misuse, and mental health comorbidities.

#### Opioid Related Initiatives

Separate informal assessments were conducted for Hawaii SOR and OSP. The result of these assessments identified a number of unmet needs, gaps, and challenges within the current system of care to address those in need of services statewide, with an emphasis on those with opioid misuse.

The Hawaii SOR assessment identified service gaps and challenges within the SUD continuum of care. There are transportation barriers, especially in rural areas and neighbor islands. Housing, withdrawal management, residential treatment, and crisis management services are in high demand for target populations, including the houseless, PWWDC, PWID, persons in need of recovery support services for substance use disorder, criminal justice-involved, and in rural areas.

There are stigma and biases about opioid use disorder treatment, creating barriers to serving focused populations. Including perinatal and parents with substance use disorders. There is on-going biases, stigma, and shame for perinatal substance use and people with children who have substance use disorders, particularly in emergency departments and hospitals.

Lastly, Hawaii has a workforce shortage. A major barrier in the state is the shortage of SUD treatment professionals and addiction medicine providers, resulting in a limited addiction medicine workforce

The assessment conducted by the OSP identified gaps and challenges covering the spectrum of substance use treatment and prevention services, and real time surveillance data. There is limited, timely access to residential addiction treatment, especially on neighbor islands. Community access to opioid overdose reversal supplies and substance test kits, including fentanyl test strips, is uneven. At schools, an ability to response to an opioid overdose is inconsistent.

There is a need to increase prevention efforts that target youths. Availability and access to evidence-based prevention strategies that meets the needs of Hawaii's youth is not sufficient. Also, prevention campaigns developed by and for Hawaii youth are few. Lastly, there is a need to have timely access to surveillance data to monitor emerging trends.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

ADAD has embarked on a number of initiatives to address unmet service needs and gaps.

#### Funding

Rate studies have recently been completed for both treatment and recovery services as well as primary prevention services. In the fall of 2023, ADAD contracted with Milliman, Inc to perform a rate study to evaluate the reimbursement rate for services provided. The purpose of the study was to provide independent rates which used a set of assumptions to produce rates to cover reasonable and necessary costs related to the delivery of evidence-based substance use disorder (SUD) services. ADAD also wanted to use these rates for comparison with Medicaid reimbursement, given that ADAD is often the sole source of public funds for SUD treatment.

Additionally, ADAD's contracted providers that specialize in PWWDC services participated in the Milliman Rate study. It was in these meetings that these providers were able to share their need for increase funding and the justification on why their population is not the same as treating a single adult.

In the Spring of 2025, Milliman, Inc. completed a rate study to evaluate the reimbursement rate for many of ADAD services provided. The purpose of the study was to provide independent rates which used a set of assumptions to produce rates to cover reasonable and necessary costs related to the delivery of evidence-based primary prevention services.

#### Treatment and Recovery Services

Treatment and recovery initiatives include new contracts for SUD services statewide, a new contract for Hawaii CARES, exploring ways to increase evidence-based services statewide, especially on the neighbor islands, and continue build capacity and increase the number of peer recovery specialists.

ADAD has contracts with 30 treatment and recovery service providers statewide, covering the period from October 1, 2024, to September 30, 2026. The scope of services for the PWWDC, PWID, and adult contracts provide a wide range of recovery and support services as well as supporting the reduction of infectious disease transmission associated with substance misuse by connecting individuals to services for TB and HIV.

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 Request for Information (RFI) in 2023. ADAD utilized the information from the RFI to identify unmet needs and critical gaps within the Hawaii treatment infrastructure. In March 2024, ADAD incorporated rates from Milliman Raste study into their

Request for Proposal (RFP) for new contracts which began on October 1, 2024. In addition to the new rates, ADAD also included additional services to fill in service gaps, such as peer recovery specialist, to provide more support to the clients under clinical supervision with fidelity monitoring to ensure evidence-based practices and measurable outcomes.

Collaborations with the OSP and Hawaii SOR has provided additional funding for these contracts to support the SUD continuum of care to serve Hawai'i's population, including treatment services for PWWDC, PWID, and people in recovery. According to ADAD provider reports, these funds strengthened the continuum of care by increasing opioid education to clients, referrals to lower levels of care after residential treatment, and faster admission and intake times for medicated opioid use disorder treatment.

Hawaii CARES continues to play an important role to improve access to and coordination of evidence-based treatment and recovery services. ADAD's current contractor for Hawaii CARES SUD treatment and referral hotline is CARE Hawaii. Under a separate contract CARE Hawaii also services a hotline for those who are inquiring services for mental health and co-occurring mental health and SUD services and receiving crisis services. Having one contractor handling SUD, mental health, and co-occurring mental health ensures timely assessment and connection to appropriate evidence-based services.

ADAD continually explores ways to expand recovery support services. To increase the number of Peer Recovery Specialist, ADAD will provide Peer Recovery Specialist training to interested contracted PWWDC and PWID service providers. Hawaii SOR is developing a statewide contingency management (CM) program for persons with stimulant use disorder. CM integration for all ADAD contracted treatment providers would allow them to bill for CM and utilize evidence-based practices for the target populations.

Collaborations with OSP and Hawaii SOR will provide additional funding to expand resources and evidence-based services, especially on the neighbor island and rural areas. Currently, there are no detox centers on the neighbor islands. Requiring persons to fly to Oahu to obtain detox services. ADAD plans to establish additional detox centers in Hawai'i County and the City and County of Honolulu.

ADAD is currently developing a request for proposals (RFP) to fund organizations who are interested in creating more clean and sober beds to expand the Clean and Sober Home Registry (Registry). More than half of Registry homes are on Oahu Island, with the remaining homes on Hawaii and Maui islands. Additional homes are needed on Oahu, Hawaii Island, and Maui Island. And a need to establish clean and sober homes on the islands of Kauai, Lanai, and Molokai.

#### Prevention Services

Primary prevention initiatives include new contracts with community-based organizations to provide evidence-based primary prevention services, providing new contracted providers technical support to implement Strategic Prevention Framework (SPF), expand access to prevention programs, and development of statewide strategic plan for prevention.

ADAD will continue to contract with community organizations and coalitions to develop and implement evidence-based prevention strategies using SPF. ADAD is nearing completion of the State procurement process for primary prevention services. Once completed, awards will be offered and new contracts executing. ADAD incorporated rates from the Milliman Rate Study in the procurement process and will be incorporated into new contracts.

ADAD utilizes SPF framework which requires prevention service providers to assess the needs of their individual community, conduct ongoing assessment of program implementation, and effectiveness. This allows the data to inform the development and implementation of prevention interventions appropriate to the needs of that community. With the execution of new contracts, technical assistance will be provided to ensure the implementation of SPF framework.

Collaborations with the OSP and Hawaii SOR has provided additional contract funding to increase evidence-based prevention programs in Kauai County, Hawai'i County, and Maui County.

In May 2025, ADAD released the Hawaii Statewide Strategic Plan for Prevention, also known as the "Skeleton Plan 2025-2026 (Skeleton Plan)". It was developed in coordination with providers, stakeholders, and community partners as an initial framework for the Hawaii Statewide Strategic Plan for Prevention. The Skeleton Plan outlines priority areas and objectives and is a working draft to guide the completion of the strategic plan. This document was also incorporated into the procurement process.

#### Workforce

ADAD is currently updating its administrative rules to add Peer Recovery Specialist certification and remove Co-Occurring Disorder Professional Diplomat certification. Updated rules have been drafted and are undergoing internal review. When the internal review is completed, they will be sent to the Governor's Office for approval to initiate and complete the public engagement process.

In the meantime, ADAD has initiated Peer Recovery Specialist training. To date, three cohorts have completed training, while one cohort is currently in training. Once the administrative rules have been approved, those who completed the Peer Recovery Specialist training will automatically become certified.

#### Data

In the Spring of 2024, ADAD contracted with RSM to develop and implement a new IT system, INSPIRE PLUS, to replace the

outdated WITS with a more integrated and user-friendly platform. Known as Project Alaka'i, the vision is to create a nimble and improved IT system dedicated to enhancing the delivery of substance use prevention, treatment, and recovery support services across Hawaii.

The implementation of INSPIRE PLUS is intended to increase operational efficiency, enhance compliance, and improve data accessibility for employees. By modernizing systems, it will create a more streamlined and effective

INSPIRE PLUS will improve workflow efficiency, reduce manual processes, promote data accuracy, and provide a more intuitive user experience. The system will support better reporting, compliance, and overall organizational effectiveness of ADAD contracted service providers. It will also increase operational efficiency, improved data accessibility, enhanced compliance with state and agency policies, and a smoother and provide users experience for ADAD. The initial phase went "live" in late October.

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**Footnotes:**

# Planning Tables

**Table 1: Priority Area and Annual Performance Indicators**

**Priority #:** 1

**Priority Area:** To have Alcohol and Drug Abuse Division (ADAD) contracted treatment and recovery service programs for pregnant women and women with dependent children (PWWDC) and persons who inject drugs (PWID) provide peer recovery support services.

**Priority Type:** SUT, SUR

**Population(s):** PWWDC, PWID

**Goal of the priority area:**

To provide peer recovery support specialist training to ADAD contracted PWWDC and PWID treatment and recovery service programs.

**Strategies to attain the goal:**

To provide training once a year to interested ADAD contracted treatment and recovery programs to build capacity and support to the clients within their agency as Certified Peer Recovery Specialist

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Identify ADAD contracted PWWDC programs that are interested in having staff become Certified Peer Recovery Support Specialist.

**Baseline measurement (Initial data collected prior to and during 2026):** Beginning October 1, 2025, identify at least one PWWDC program who is interested in having staff attend an ADAD Peer Recovery Support Specialist training.

**First-year target/outcome measurement (Progress to the end of 2026):** Certify at least two (2) staff from a PWWDC program by end of FFY 2026.

**Second-year target/outcome measurement (Final to the end of 2027):** Certify at least two (2) staff from a PWWDC program by end of FFY 2027.

**Data Source:**

Copies of sign in/out sheets during the training sessions (to identify the staff that are enrolled in the training).

**Description of Data:**

ADAD's Quality Assurance Improvement Office (QAIO) manages all ADAD sponsored trainings. Each training offering Continuing Education Units (CEU) requires attendees to sign an in/out sheet. ADAD has contracts with many treatment and recovery service programs statewide, that allows them to invoice ADAD for Peer Recovery Support services. Data collected by ADAD includes the name of the program providing the peer support to clients, cost spent on peer recovery support specialists, and the length of time that a client will need a peer recovery support specialist.

**Data issues/caveats that affect outcome measures:**

The contracted programs will need to have a plan in the event that a Peer Recovery Support Specialist relapses.

**Indicator #:** 2

**Indicator:** Identify ADAD contracted PWID programs that are interested in having staff become Certified Peer Recovery Support Specialist.

**Baseline measurement (Initial data collected prior to and during 2026):** Beginning October 1, 2025, identify at least one PWID program who is interested in having staff attend an ADAD Certified Peer Recovery Specialist training.

**First-year target/outcome measurement (Progress to the end of 2026):** Certify at least two (2) staff from a PWID program by end of FFY 2026.

**Second-year target/outcome measurement (Final to the end of 2027):** Certify at least two (2) staff from a PWID program by end of FFY 2027.

**Data Source:**

Copies of sign in/out sheets during the training sessions (to identify the staff that are enrolled in the training).

**Description of Data:**

ADAD’s Quality Assurance Improvement Office (QAIO) manages all ADAD sponsored trainings. Each training offering Continuing Education Units (CEU) requires attendees to sign an in/out sheet. ADAD has contracts with many treatment and recovery service programs statewide, that allows them to invoice ADAD for Peer Recovery Support services. Data collected by ADAD includes the name of the program providing the peer support to clients, cost spent on peer recovery support specialists, and the length of time that a client will need a peer recovery support specialist.

**Data issues/caveats that affect outcome measures:**

The contract programs will need to have a plan in the event that a Peer Recovery Specialist relapses.

**Priority #:** 2

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

**Priority Type:** SUT, SUR

**Population(s):** PRSUD

**Goal of the priority area:**

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

**Strategies to attain the goal:**

Scope of services for recovery support services for the next two-year (October 1, 2025-September 30, 2027) contract period to include transportation, translation, stabilization beds, group recovery homes, clean and sober housing, therapeutic living programs, and groups for adults, PWWDC, and PWIDs with substance use treatment and recovery 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, translation, stabilization beds, group recovery homes, clean and sober housing therapeutic living programs, and groups for adults, PWWDC, and PWIDs with substance use treatment and recovery needs.

**Baseline measurement (Initial data collected prior to and during 2026):** Continue contracting with the target populations, i.e., adults, PWWDC, PWID; to provide recovery and support services including transportation and translation, stabilization beds, group recovery homes, clean and sober living, therapeutic living homes, and groups for adults prior to FFY 2026

**First-year target/outcome measurement (Progress to the end of 2026):** Maintain a minimum of one (1) contract to provide recovery support services including transportation, translation, stabilization beds, group recovery homes, clean and sober living, therapeutic living programs, and groups for adults each for each target population by end of FFY 2026

**Second-year target/outcome measurement (Final to the end of 2027):** Maintain a minimum of one (1) contract to provide recovery support services including transportation, translation, stabilization beds, group recovery homes, clean and sober living, therapeutic living programs, and groups for adults for each target population by end of FFY 2027.

**Data Source:**

Executed contract and contract modifications.

**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 and 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 Modifications. In accordance with HRS 103F (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 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 TB services for individuals receiving SUD treatment services.

**Strategies to attain the goal:**

Scope of services for SUD contracts for the next two-years (October 1, 2025 – September 30, 2027) contract period to include the availability of TB services for individuals needing SUD services

**Annual Performance Indicators to measure goal success**

<b>Indicator #:</b>	1
<b>Indicator:</b>	Execution of SUD contracts with scope of services to include provisions for the availability of TB services for individuals receiving SUD treatment services.
<b>Baseline measurement (Initial data collected prior to and during 2026):</b>	Effective October 1, 2025, there was at least one contract executed in each of Hawaii's four counties (Hawaii, Honolulu, Kauai, and Maui) to make available TB services for individuals seeking SUD treatment services in FFY 2026
<b>First-year target/outcome measurement (Progress to the end of 2026):</b>	Effective October 1, 2025, there was at least one contract executed in each of Hawaii's four counties (Hawaii, Honolulu, Kauai, and Maui) to make available TB services for individuals

seeking SUD treatment services in FY 2026.

**Second-year target/outcome measurement (Fiscal year 2027):**

Effective October 1, 2025, there was at least one contract executed in each of Hawaii's four counties (Hawaii, Honolulu, Kauai, and Maui) to make available TB services for individuals seeking SUD treatment services in FFY 2027.

**Data Source:**

Executed contract and contract modifications.

**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 and 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:

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 #:** 4

**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 in affected 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 in



**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 (Initial data collected prior to and during 2026):** Five (5) opportunities provided in FFY2025.

**First-year target/outcome measurement (Progress to the end of 2026):** Seven (7) opportunities for technical assistance and training by end of FFY2026.

**Second-year target/outcome measurement (Final target the end of 2027):** Ten (10) opportunities for technical assistance and training by end of FFY2027.

**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.

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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 2026-27 SUPTRS BG application. 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 SUPTRS BG 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 the SUPTRS BG Report submitted annually to SAMHSA by December 1.

**Planning Tables**

**Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)**

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Use Disorder Prevention <sup>a</sup> and Treatment	\$4,480,000.00		\$0.00	\$5,935,579.00	\$9,200,000.00	\$0.00	\$7,250,000.00
a. Pregnant Women and Women with Dependent Children (PWWDC) <sup>b</sup>	\$0.00				\$1,800,000.00		\$250,000.00
b. All Other	\$4,480,000.00			\$5,935,579.00	\$7,400,000.00		\$7,000,000.00
2. Recovery Support Services <sup>c</sup>	\$520,000.00			\$450,000.00	\$2,800,000.00		\$2,500,000.00
3. Primary Prevention <sup>d</sup>	\$1,900,000.00			\$1,666,544.00	\$1,500,000.00		\$3,300,000.00
4. Early Intervention Services for HIV <sup>e</sup>	\$0.00			\$0.00	\$0.00		\$0.00
5. Tuberculosis	\$0.00			\$0.00	\$0.00		\$0.00
6. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
7. State Hospital							
8. Other Psychiatric Inpatient Care							
9. Other 24-Hour Care (Residential Care)							
10. Ambulatory/Community Non-24 Hour Care							
11. Crisis Services (5 percent set-aside) Set Aside							
12. Other Capacity Building/Systems Development <sup>f</sup>	\$1,636,763.00			\$0.00	\$4,610,154.00		\$0.00
13. Administration <sup>g</sup>	\$251,261.00			\$861,702.00	\$2,285,559.00		\$13,050,000.00
<b>14. Total</b>	<b>\$8,788,024.00</b>		<b>\$0.00</b>	<b>\$8,913,825.00</b>	<b>\$20,395,713.00</b>	<b>\$0.00</b>	<b>\$26,100,000.00</b>

<sup>a</sup> Prevention other than primary prevention.

<sup>b</sup> Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women’s Maintenance of Effort (MOE) over the two-year planning period.

<sup>c</sup> This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, “Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG.” Only plan RSS for those in need of RSS from substance use disorder.

<sup>d</sup> Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

<sup>e</sup> 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.

<sup>f</sup> Other Capacity Building/Systems development include those activities relating to substance use per [45 CFR 996.122 \(f\)\(1\)\(v\)](#)

<sup>g</sup> Per [45 CFR 96.135](#) Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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**Footnotes:**

1. Amounts in Column A are based upon the Federal Fiscal Year (FFY) 2025 SUPTRS BG Continuing Resolution allotment for Hawaii.
2. Source of funding for Column G “Others” is Hawaii State Opioid Settlement Funds.
3. Estimates for other columns are based on upon the same period as Column A. This provides a consistent basis on which to compare planned expenditures of Block Grant funds with funds from other sources during the same period.
4. 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 the availability of TB services.
5. According to CSAT’s list of “designated states” for the FFY 2026-2027 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 at substance use treatment programs.

# Planning Tables

**Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only**

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the [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 B), please refer to the most recent edition of the [Treatment Episode Data Set \(TEDS\)](#) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	740	12
Women with Dependent Children	0	147
Individuals with a co-occurring M/SUD	75000	328
Persons who inject drugs	16753	253
Persons experiencing homelessness	6389	449

**Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is**

### Footnotes:

1. Data from Column B is from SAMHSA's TEDS-A2022. The exception is Row 2, Women with Dependent Children. This estimate is from billing data, pulled from ADAD's Web Infrastructure for Treatment data, of admissions between 1/1/2022 – 12/31/2022. Specifically, billing data to PWWDC payor group that did not indicate pregnant during admission.
2. For Column A, SAMHSA's 2022-2023 NSDUH is the most recent data available at the state level. This only available state level data for Row 3, Individuals with Co-occurring mental health and substance use disorder.
3. Data for Column A, Row 1, Pregnant Women, was estimated using the national prevalence of SUD amongst women and the number of births as a proxy for pregnant woman. "5% of pregnant women aged 15–44 reported current illicit drug use." Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice*, 3(1), 2. <https://doi.org/10.1186/s40352-015-0015-5>.
4. Column A, Row 2, Women with Dependent Children is blank as unable to find good proxy data.
5. Data for Column A, Row 4, Persons who Inject Drugs, was estimated based on the US census on those 18 and older time the national prevalence rate for PWID. Assuming that those who inject drugs are 18 and older and reflect the national trend. "There were an estimated 3 694 500 (95% confidence interval [CI], 1 872 700–7 273 300) PWID in the United States in 2018, representing 1.46% (95% CI, .74–2.87) of the adult population" <https://pmc.ncbi.nlm.nih.gov/articles/PMC10202436/>  
Bradley H, Hall EW, Asher A, Furukawa NW, Jones CM, Shealey J, Buchacz K, Handanagic S, Crepez N, Rosenberg ES. Estimated Number of People Who Inject Drugs in the United States. *Clin Infect Dis*. 2023 Jan 6;76(1):96-102. doi: 10.1093/cid/ciac543. PMID: 35791261; PMCID: PMC10202436.  
"On July 1, 2024, the resident population for the State of Hawaii was 1,446,146." <https://census.hawaii.gov/main/2024-state-pe/>  
18 years and older, both sexes 1,147,468  
<https://files.hawaii.gov/dbedt/census/popestimate/2024/state-county-char/sc-est2024-agesex-15.pdf>
6. Data for Column A, Row 5, Persons Experiencing Homelessness, was estimated based on aggregate of homeless counts in 2024 times 2020 ratio of homeless with SUD. Partners In Care Oahu's Continuum of Care Point in Time Count 2024 Comprehensive Report (Updated 5/14/2024) <https://www.partnersincareoahu.org/pitc>. Bridging The Gap CoC Homeless Point-in-Time Count Jan 22, 2024 (Neighbor Islands) <https://www.btghawaii.org/reports/hic-&-pit/>  
"Data from Hawai'i's 2020 Point in Time Count shows that on a single night in 2020, there were approximately 4448 individuals experiencing homelessness on O'ahu and 2010 individuals on the neighbor islands.1 Of those counted, 683 (18%) indicated harmful substance use on O'ahu and 460 (28%) on the neighbor islands. Compared to neighboring islands, substance use was slightly higher among both sheltered (350, 24%) and unsheltered (333, 27%) populations on O'ahu." Lusk HM, Shaku D, Hemrajani A, Leverenz N, Moefu-Kaleopa J, Staley AF.

Housing First: Harm Reduction at the Intersection of Homelessness and Substance Use. Hawaii J Health Soc Welf. 2022 Dec;81(12 Suppl 3):6-11. PMID: 36660275; PMCID: PMC9783810

# Planning Tables

**Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year**

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

**Note:** The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025      Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention <sup>a</sup> and Treatment	\$4,480,000.00
2 . Recovery Support Services <sup>b</sup>	\$520,000.00
3 . Substance Use Primary Prevention <sup>c</sup>	\$1,900,000.00
4 . Early Intervention Services for HIV <sup>d</sup>	\$0.00
5 . Tuberculosis Services	\$0.00
6 . Other Capacity Building/Systems Development <sup>e</sup>	\$1,636,763.00
7 . Administration <sup>f</sup>	\$251,261.00
8. Total	\$8,788,024.00

<sup>a</sup>Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

<sup>b</sup>This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

<sup>c</sup>This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

<sup>d</sup>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.

<sup>e</sup>Other Capacity Building/System Development include those activities relating to substance use per [45 CFR §96.122 \(f\)\(1\)\(v\)](#). The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

<sup>f</sup>Per [45 CFR §96.135](#) Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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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. The most recent CSAT's list of "designated states" is for the FFY 2024-2025 SUPTRS BG. According to this list 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 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories**

Planning Period Start Date: 10/1/2025      Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
7. Section 1926 (Synar)-Tobacco	Universal	\$0
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
<b>Total Prevention Budget</b>		<b>\$0</b>
<b>Total Award <sup>a</sup></b>		<b>\$8,788,024</b>
<b>Planned Primary Prevention Percentage</b>		<b>0.00%</b>

<sup>a</sup> Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year  
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**Footnotes:**

1. Page 23 of the FFY 2026/2027 SUPTRS BG Application Instructions states "In presenting their primary prevention planned budget, states must complete either Plan Table 5a or Plan Table 5b or may choose to complete both. If Table 5b is completed, the state must also complete Section 1926 - Tobacco on Table 5a. If both Tables 5a and 5b are completed, then totals should be the same for both." ADAD does not plan to expend SUPTRS BG funds for Section 1926-Tobacco (Synar) activities, therefore Table 5a will not be used. Table 5b will be used for the primary prevention planned budget.

## Planning Tables

**Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories**

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025      Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	\$724,000
2. Universal Indirect	\$453,300
3. Selective	\$722,700
4. Indicated	
<b>5. Column Total</b>	<b>\$1,900,000</b>
<b>6. Total SUPTRS Award<sup>a</sup></b>	<b>\$8,788,024</b>
<b>7. Primary Prevention Percentage</b>	<b>21.62%</b>

<sup>a</sup> Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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**Footnotes:**

# Planning Tables

**Table 5c: SUPTRS BG Planned Primary Prevention Priorities**

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025    Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	<input checked="" type="checkbox"/>
Tobacco/Nicotine-Containing Products	<input checked="" type="checkbox"/>
Cannabis/Cannabinoids	<input checked="" type="checkbox"/>
Prescription Medications	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Fentanyl or Other Synthetic Opioids	<input type="checkbox"/>
Other	<input type="checkbox"/>
Priority Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
American Indian/Alaska Native	<input type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>
Persons Experiencing Homelessness	<input checked="" type="checkbox"/>
Native Hawaiian/Pacific Islander	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>

**Footnotes:**

1. Aside from the Native Hawaiian target population, please note that ADAD does not track prevention funds by specific substances and specific populations.

## Planning Tables

**Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities**

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025    Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	\$240,000.00	\$0.00	\$240,000.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$240,000.00	\$0.00	\$240,000.00
2. Infrastructure Support	\$28,000.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$28,000.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$0.00	\$0.00	\$515,000.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$515,000.00
4. Planning Council Activities	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$2,500.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$2,500.00	\$0.00	\$0.00
6. Research and Evaluation	\$0.00	\$0.00	\$0.00

a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00
7. Training and Education	\$611,263.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$4,345.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$606,918.00	\$0.00	\$0.00
<b>8. Total</b>	<b>\$881,763.00</b>	<b>\$0.00</b>	<b>\$755,000.00</b>

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**Footnotes:**

# Environmental Factors and Plan

## 1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

### Narrative Question

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Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **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 health 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: [The Essential Aspects of Parity: A Training Tool for Policymakers](#); [Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States](#).

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.<sup>1</sup> 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 an efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity 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.

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<sup>1</sup>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. Available at: [https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding\\_Excess\\_Mortality\\_in\\_Persons\\_With.11.aspx](https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx)

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1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:
  - a) Adults with serious mental illness (SMI)
  - b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
  - c) Pregnant women with substance use disorders
  - d) Women with substance use disorders who have dependent children
  - e) Persons who inject drugs
  - f) Persons with substance use disorders who have, or are at risk for, HIV or TB
  - g) Persons with substance use disorders in the justice system
  - h) Persons using substances who are at risk for overdose or suicide

- i) Other adults with substance use disorders
- j) Children and youth with serious emotional disturbances (SED) or substance use disorders
- k) Children and youth with SED and a co-occurring I/DD
- l) Individuals with co-occurring mental and substance use disorders

In 2019, the Department of Health, Alcohol and Drug Abuse Division (ADAD), launched the substance use disorder (SUD) component of the Hawaii Coordinated Access Resource Entry System, or Hawaii CARES, to coordinate a responsive system of care for SUD treatment and recovery support services. Hawaii CARES provides a universal intake, screening, care coordination, referral, and linkages to the appropriate service providers and resources across the state. Hawaii CARES is modeled after the American Society of Addiction Medicine (ASAM) 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 Hawaii CARES contractor for SUD treatment and referrals, is CARE Hawaii. Under a separate contract administered by the Adult Mental Health Division, CARE Hawaii also operates a hotline for those who are inquiring about services for mental health and co-occurring mental health and crisis services. The ADAD also separately contracts with Care Hawaii for SUD services resulting from a recent 2025 RFP award (transitioning from the previous contractor, Aloha United Way). Having one contractor now handling SUD, mental health, crisis and co-occurring mental health ensures timely assessment and connection to appropriate evidence-based services.

Some of ADAD's current treatment providers assist with the continuity of care with non-violent clients who are transitioning out of the Hawaii State Hospital with evidence-based treatment (residential or outpatient) and basic life skills (transportation, budgeting, medication management), to assist the client with adjusting to life out in the community.

For pregnant women and women who have dependent children (PWWDC) with substance use disorders, ADAD currently has contracted providers to provide evidence-based treatment specifically for this population. PWWDC are listed in ADAD's contract as a priority admission and are placed on the top of the list for admission into a treatment program. Priority admission into treatment services is also provided to people who inject drugs (PWID).

To support the reduction of infectious disease transmission associated with substance misuse, for clients with HIV or tuberculosis (TB), ADAD has several contracted providers that provide education, testing, counseling, and case management to clients that are enrolled in ADAD's contracted treatment programs. In addition, it is a requirement for the ADAD contracted treatment providers to receive training on HIV services and resources available in the community.

All ADAD contracted providers provide services to those involved in the criminal justice system, whether it's outreach, various modalities of treatment, assessments, screenings, housing, peer recovery, etc. If a client is released from jail or prison, needs SUD treatment or housing, and does not have medical insurance, ADAD contracted providers will admit the client utilizing ADAD funds until he/she has medical insurance. ADAD also has providers who go into the jail/prison to conduct SUD assessments, so those who are incarcerated know what level of care they qualify for when they are released.

Several ADAD contracted providers provide outreach services to those who are unhoused, in high unhoused areas, for SUD treatment, life-saving overdose prevention and response services, and resources to mental health agencies, including suicide prevention. When the providers conduct outreach services, they include peer recovery specialist to encourage those who are unhoused to seek services that are available to them.

For adults with SUD or co-occurring mental and SUD, ADAD has contracted agencies that provide services to adults with SUD and co-occurring disorders. These agencies usually have a medical director as part of their staff to educate the client and staff on their mental health problems.

Children and youth with SUD or co-occurring intellectual and developmental disabilities may seek treatment through ADAD's adolescent treatment programs, who also have contracts with other state programs. If the child or youth enters one of ADAD's contracted adolescent programs and begins to display serious emotional disturbances that maybe inappropriate to the current level of care, the providers can easily refer the client to their staff, within their agency for the appropriate level of care, utilizing another state agency funds that specializes in severe emotional and/or behavioral challenges.

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, overseen by the Department of Human Services Med-Quest Division (Med-QUEST), helps to fund a large percentage of treatment clients. Most Medicaid services in Hawaii are delivered through Managed Care Organizations (MCOs), which include Aloha Care, Hawaii Medical Service Association, Kaiser Permanente, Ohana Health Plan, and United Healthcare Community Plan. Each MCO sets criteria for enrollment, determines the substance use 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 use services, after the benefits have been exhausted and up to the limit of the ADAD substance use benefits. The

current 1115 waiver expands the range of behavioral health services including transportation and are looking to expand to include peer recovery services. Qualifying individuals who are also diagnosed with SUD are eligible for these services. Med-QUEST 1115 waiver was recently approved, allowing for the expansion of SUD services.

3. 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.

ADAD recognizes the need for integrating services and support for individuals with co-occurring mental and substance use disorders, since more individuals are entering treatment with these issues. ADAD contracted treatment programs also recognize the need to provide services for these individuals, thus, many of the programs utilizes a cognitive-behavioral approach with motivational interviewing techniques to the clients in their program. ADAD also includes other services that the providers may be able to invoice ADAD, such as contingency management.

- a. Please describe how this system differs for youth and adults.

This system is different for youths, especially those who have severe mental health disorders. For youths that have severe mental health disorders, services such as case management and funding for treatment, are provided by the Department of Health, Child and Adolescent Mental Health Division (CAMHD).

- b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

For adults who have severe mental health issues, services such as case management and funding for housing, are provided by the Department of Health, Adult Mental Health Division (AMHD). However, for those who have co-occurring disorders and their mental health issues are not severe, they may be enrolled in an ADAD contracted treatment program

- c. How many IT-COD teams do you have? Please explain.

ADAD currently has about twelve contracted treatment agencies that accepts clients that have co-occurring and SUD problems. These agencies usually have a doctor as part of their staff or work closely with a doctor in the community.

- d. Do you monitor fidelity for IT-COD? Please explain.

Yes. A contract requirement for all contracted providers is to submit a quarterly report on various client information (admissions, discharges, success stories, wait list, etc). ADAD's electronic management information system also receives client's information (receive clinical discharge with or without substance use, six-month follow-ups, drug test results, etc) that can provide fidelity of the treatment programs.

- e. Do you have a statewide COD coordinator?

Yes  No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. 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
- d) How the state provides integrated treatment for individuals with co-occurring disorders

The Hawaii Opioid Initiative (HOI) was a community-based initiative launched in 2017 to combat the opioid crisis. It was grounded in a framework that emphasized collaboration, adaptability, and was wide-ranging. Key focus areas included screening and referral for treatment and treatment access. In 2025, the Hawaii Overdose Initiative was relaunched to address the full spectrum of substance use issues from opioids to the rising prevalence of fentanyl, psychostimulants, and co-occurring mental health conditions. The initiative will continue to prioritize cross-disciplinary collaboration, community-driven strategies, and a comprehensive response to today's drug epidemic building on the lessons learned from past successes and challenges.

Through the HOI, one of the action items are to ensure a prompt system of care that is accessible, meets the needs of the community, and reduces stigma to increase engagement and coordination among stakeholders and consumers. One of their objectives are to provide individuals that are high utilizers of the emergency room with SUD treatment, medically assisted treatment (MAT), and case management

Another HOI objective is to focus on people who have co-occurring disorders, medically focused SUD treatment, and the flexibility of referrals (a "no wrong door" approach), to expand access using an approach that meets the needs of the community. This is to ensure that clients will not be transitioned between different programs due to acuity. The "hopes" is to have all residential programs have a Medical Director and Registered Nurse staff. Through this working group, one of the tasks is to increase funding rates to support medical staff, access to medications before, during, and after each level of care.

All ADAD's contracted providers are required to utilize the client's medical insurance prior to using ADAD funds. Prior to admission into treatment, a client's medical record is reviewed so that the program is aware of any health issue(s). Any findings in the client's medical record (i.e., high blood pressure, diabetes, heart disease, etc.) is addressed while the client is in treatment.

ADAD is currently contracts with several providers that accepts clients who have co-occurring disorders. For the programs that accept this clientele, there is usually a doctor that is part of the staff, and the programs will incorporate addressing their mental health issues as part of their treatment plan.

5. 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 (SMI)
- b) Adults with substance use disorders
- c) Adults with SMI and I/DD
- d) Children and youth with serious emotional disturbances (SED) or substance use disorders
- e) Children and youth with SED and I/DD

Adults who have a serious mental illness receive care coordination services funded through the Department of Health, Adult Mental Health Division (AMHD). Through AMHD, the client is provided with a case manager, may receive funding for their housing (24-hour housing and then 8-16 housing) upon release from the Hawaii State Hospital. The clients are also provided crisis support and resources for those experience mental health challenges. Should the client have a crisis or need emergency housing, a case manager will be involved with care coordination to either transport the client to a hospital or an alternative housing

Adults with substance use disorders receive various types of care coordination throughout their treatment episode. An example of a care coordination that is often utilized within ADAD's contracted treatment providers is when a client is admitted into a program (such as an intensive outpatient program) and continues to relapse. The client is then reassessed and transferred to the appropriate level of care. If the program does not service that level of care the client is appropriate to, then care coordination is utilized to a program that is able to accept the client into that level of care. Funding for care coordination for ADAD's contracted treatment providers are able available through ADAD.

For adults with SMI and I/DD, they are funded and serviced through another State of Hawaii Behavioral Health agency, the Development Disabilities Division (DDD) within the Department of Health. The clients receive care coordination through their case manager to assist the individual, and their families navigate all resources and support systems. The clients are also provided an individualized service planning, tailored to the client's needs. All care coordination services for the clients are from the case manager to the desired program.

Children and youth with SED or SUD are serviced and funded through another State of Hawaii Behavioral Health agency, Child and Adolescent Mental Health Division (CAMHD). The clients receive assessment and case management services, therapeutic supports (in the home or community), and child and family services. The clients receive care coordination services through their assigned case manager.

Children and youth with SED and I/DD may be serviced (depending on the severity of the problem) through one of ADAD's contracted treatment providers that services adolescent. However, if the client needs a higher level of care, they may be referred to CAMHD for more intensive case management services to provide the care coordination services for the client. If the client is receiving services through an ADAD contracted treatment provider, then care coordination services will be funded through ADAD. If the client is overseen by CAMHD, then funding for care coordination will be through CAMHD.

6. 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.

ADAD supports the provision of integrated services with clients with co-occurring mental and substance use disorders by providing funding for contracted SUD treatment programs that provides services to clients who have SUD and/or co-occurring mental and SUD. The ADAD contracted treatment providers are funded for the following services, motivational enhancement, screening, assessments, housing (clean and sober, therapeutic living, group homes), care coordination, various treatment levels (detox, residential, partial hospitalization, intensive outpatient, outpatient, and continuing care), peer recovery, medicated assisted treatment (MAT), and contingency management.

ADAD's system may differ from youth to adults if the youth is overseen by another Department of Health agency housed within the Behavioral Health Administration, Child and Adolescent Mental Health Division (CAMHD) or Developmental Disabilities Division (DDD). If the client is overseen by CAMHD or DDD, then they are provided integrated services and funding through that agency.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Clients (adult and youth) with co-occurring mental and I/DD are funded and supported through other state agencies, AMHD and CAMHD for services.

8. Please indicate areas of **technical assistance needs** related to this section.

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**Footnotes:**

# Environmental Factors and Plan

## 3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

### Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from <https://acl.gov/news-and-events/announcements/person-centered-practices-resources>

1. Does your state have policies related to person centered planning?  Yes  No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.  
Clients who have SMI are supported by another state agency within the Behavioral Health Administration, Adult Mental Health Division or Child and Adolescent Mental Health Division. (depending on the client's age).
4. Describe the person-centered planning process in your state.  
All ADAD contracted treatment providers create a treatment plan that includes the client's input and feedback. In the client's individual counseling session(s), it is required in the program's contract that these sessions are a collaborative process where the client participates in the development of their treatment goals and services to the greatest extent as possible. The treatment plans should be strength based and focuses on the individual capacity, preference, and goals. ADAD's Request for Proposals (RFP) state that "Effective individual care planning strengthens the voice of the individual, builds resiliency, and fosters recovery."  
For group counseling, the client's Stages of Change should dictate which group model and methods are appropriate at a particular time. A Skill Building group shall consider the individual variation of the client's needs, characteristics, abilities, and background.
5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as [A Practical Guide to Psychiatric Advance Directives](#))?  
The methods that the SMHA uses falls under a different section under the Behavioral Health Administration, Adult Mental Health and not ADAD.
6. Please indicate areas of technical assistance needs related to this section.

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**Footnotes:**

# Environmental Factors and Plan

## 4. Program Integrity – Required for MHBG & SUPTRS BG

### Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in [42 U.S.C. § 300x-5](#) and [42 U.S.C § 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\(g\)](#), there are periodic 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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 behavioral health 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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.

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### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No

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

With respect to Section 4, 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 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.
- e. 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 4, 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.

ADAD's Prevention Branch also provide technical support to its contract providers to ensure consistent and accurate data reporting in alignment with federal requirements.

**4.** Please indicate areas of technical assistance needs related to this section.

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**Footnotes:**

## Environmental Factors and Plan

### 5. Primary Prevention – Required for SUPTRS BG

#### Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use 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 serve 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)?  Yes  No
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)  Rural communities

i)  Other (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)  Other (please list)

Fatal Analysis Reporting System (FAR) and Pregnancy Risk Assessment Monitoring System (PRAMS)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds?  Yes  No

a) If yes, (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. This allows the data to inform the development and implementation of prevention interventions appropriate to the unique needs of that community.

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

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?  Yes  No
  - 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 <https://health.hawaii.gov/substance-abuse/home/counselor-certification/>
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?  Yes  No
  - 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 and Treatment 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?  Yes  No
  - a) If yes, please describe mechanism used.

## Narrative Question

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## 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 WebBGAS
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  
 Not applicable (no prevention strategic plan)
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)  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
  - a) Does the composition of the Advisory Council represent the demographics of the State?  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, which include either a) Inclusion in a registry for substance misuse prevention programs and policy; b) reported in a peer-reviewed journal with positive effects on the primary target outcome; or Community-Defined Evidence Practices (CDEP) that do not meet either of the two criteria (registry or peer-reviewed journal) shall work towards documenting effectiveness by the end of the contract period through consensus judgement of ADAD and the Evidence-Based Workgroup. The Evidence-Based Workgroup 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 and innovative interventions that meets the needs of the community, to determine effectiveness. Adaptations to evidence-based programs and policies are documented through the Adaptation Form to monitor the level of fidelity and adherence to the principles underlying core components.

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## 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  
Botvin LifeSkills

**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) Yes (if so, 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.

## Narrative Question

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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 use 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 serve 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 WebBGAS

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 prioritized benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes 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 describe):
- 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 alcohol use
- c)  Binge alcohol 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, 2021, and 2023. 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.

**Footnotes:**

# Environmental Factors and Plan

## 7. Substance Use Disorder Treatment – Required for 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 (with medications for addiction treatment included in v-x):

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief intervention  Yes  No
- iv) Assessment  Yes  No
- v) Withdrawal Management (inpatient/residential)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive outpatient  Yes  No
- viii) Inpatient/residential  Yes  No
- ix) Aftercare/Continuing Care  Yes  No
- x) 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. Does your state 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.

ADAD identifies compliance issues and corrective actions through contract monitoring and through corrective action plans.

**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 Request for Proposals, 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. ADAD will create and send a PO to ASO to encumber 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 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 desktop review of a few open and closed charts is reviewed prior to the on-site monitor. At the on-site monitoring, the TRB review the program's policies and procedures, interviews staff and clients, and observe a group session.

After the protocol is completed, it is sent to the provider, along with a cover letter, signed by the TRB Chief, informing them of the results of the on-site 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, ADAD conducts periodic reviews, by either Contract Managers or the TRB Chief, as well as following up on any previous POC's for quality control.

Treatment Contract Managers are assigned several 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, to minimize lapsing funds. Increasing or decreasing contract amounts require a contract modification. The TRB Chief is responsible for monitoring 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) 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, older adults)?  Yes  No
3. States are required to monitor program compliance related to activities 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 through corrective action plans. ADAD utilizes the same procedures and strategies, used to monitor compliance for PWWDC, to monitor compliance for PWID. 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.
- As part of the state procurement process, the Request for Proposal requires all providers to adopt a policy which states that it provides for TB and Hepatitis C screening, referral, and education as appropriate.
- ADAD does annual monitoring of treatment contracted providers for TB screening and when appropriate, referral for TB services. ADAD utilizes the same procedures and strategies used by PWWDC and PWID, 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

**Hypodermic Needle Prohibition**

- 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 for the purpose of injecting illicit substances [\(42 U.S.C. § 300x-31\(a\)\(1\)\(F\)\)](#)?  Yes  No

## 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 members, veterans, tribal entities, older adults, persons experiencing homelessness)?  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations?  Yes  No

### Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered 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 system, adult criminal justice system, 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

### 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
- If the answer is No to any of the above, please explain the reason.
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<sup>[1]</sup> (TTCs)?
- a) Prevention TTC?  Yes  No
- b) SMI Adviser  Yes  No
- c) Addiction TTC?  Yes  No
- d) State Opioid Response Network?  Yes  No
- e) Strategic Prevention Technical Assistance Center (SPTAC)  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections [42 U.S.C. § 300x-22\(b\)](#), [300x-23](#), [300x-24](#), and [300x-28](#) ([42 U.S.C. § 300x-32\(e\)](#)).*

1. Is your state considering requesting a waiver of any requirements related to:
- a) Allocations regarding women (300x-22(b))  Yes  No

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

a) Intravenous substance use (300x-23)  Yes  No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis  Yes  No

b) Early Intervention Services Regarding HIV  Yes  No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (42 U.S.C. § 300x-28)

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 the Mental Health are not covered here because those regulations apply only to the Mental Health Block Grant (MHBG) application. MHBG provides funds for the DOH Adult Mental Health Division and Child and Adolescent Mental Health Division. Please refer to their 2026-2027 MHBG Application for information on this section.

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

The following statutes governs the state's substance use program.

Hawaii Revised Statutes, Sections 321-191 to 198

[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0191.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0191.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0192.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0192\\_0005.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0192_0005.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0193.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0193\\_0005.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0005.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0193\\_0007.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0193_0007.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0194.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0194.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0195.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0195.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0196.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0196.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0197.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0197.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0321/HRS\\_0321-0198.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0321/HRS_0321-0198.htm)

Hawaii Revised Statutes, Sections 329-1 to 4

[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0329/HRS\\_0329-0001.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0001.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0329/HRS\\_0329-0002.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0002.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0329/HRS\\_0329-0003.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0003.htm)  
[https://www.capitol.hawaii.gov/hrscurrent/Vol06\\_Ch0321-0344/HRS0329/HRS\\_0329-0004.htm](https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0329/HRS_0329-0004.htm)

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[1] <https://www.samhsa.gov/technology-transfer-centers-ttc-program>

**Footnotes:**

## Environmental Factors and Plan

### 9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

#### Narrative Question

There is a mandatory 5 percent set-aside within 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 evidence-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 fund 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 expending 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 has 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. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include [Crisis Services: Meeting Needs, Saving Lives](#), which consists of the [National Guidelines for Behavioral Health Coordinated System of Crisis Care](#) as well as an [Advisory: Peer Support Services in Crisis Care](#). There is also the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#) which offers best practices, 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 the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

**Crisis Contact Center.** In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

**Mobile Crisis Response Team.** Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

**Crisis Receiving and Stabilization Facilities.** In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

**988 – 3-Digit behavioral health crisis number.** The National Suicide Hotline Designation Act ([P.L. 116-172](#)) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

**Building Crisis Services Systems.** Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis 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 published 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 published 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.

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 contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone to respond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe place to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Briefly explain your stages of implementation selections here.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#), explain how the state will develop the crisis system.

5. Other program implementation data that characterizes crisis services system development.

**Someone to contact: Crisis Contact 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
  - i. In the 988 Suicide and Crisis lifeline network:
  - ii. Not in the suicide lifeline network:
- c. Estimated percent of 911 calls that are coded out as BH related:

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

- a. Independent of public safety first responder structures (police, paramedic, fire):
- b. Integrated with public safety first responder structures (police, paramedic, fire):
- c. Number that utilizes peer recovery services as a core component of the model:

**Safe place 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):

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

7. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

**Footnotes:**  
 1. The Hawaii SSA provided no response because the Crisis Services section is requested, not required, for SUPTRS BG per the FFY2026-2027 SUPTRS BG application instructions

# Environmental Factors and Plan

## 10. Recovery – Required for MHBG & SUPTRS BG

### Narrative Question

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Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 [Working Definition of Recovery](#).

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the [Recovery Support Services Table](#).

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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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 funds for recovery support services?  Yes  No
  - d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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 (RSS) for adults with SMI and children with SED in Hawaii are provided by the Department of Health through the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Divisions (CAMHD), respectively. AMHD has a certified peer specialist program modeled after the Georgia's Certified Peer Specialist Project. However, ADAD contracts with a few treatment programs that provide services for adults with SMI. There is 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 Alcoholics Anonymous (AA)/Narcotics Anonymous (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 SUD are provided through ADAD-contracted treatment services include the following: Continuing Care, Clean and Sober Housing, Therapeutic Living Programs, Group Recovery Homes, Transportation, Translation Service, Peer Support, and Childcare.

5. Does the state have any activities that it would like to highlight?  
 With respect to Section 10, 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. ADAD is working to establish certification and adopt Hawaii Administrative Rules (HAR) for peer recovery specialist and incorporate training methods for increasing peer recovery specialist for specific groups.

6. Please indicate areas of technical assistance needs related to this section.

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**Footnotes:**

## Environmental Factors and Plan

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

#### Narrative Question

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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 disorder 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.<sup>[1]</sup> 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.<sup>[2]</sup> 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.<sup>[3]</sup>

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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.<sup>[4]</sup>

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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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.<sup>[5]</sup>

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

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

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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

<sup>[2]</sup>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.

<sup>[3]</sup>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](http://www.cdc.gov/injury/wisqars/index.html).

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

<sup>[5]</sup>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-CMH10608SUM>

**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 use 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 Early Serious Mental Illness (ESMI) services?  Yes  No
- d) Is the state providing trauma informed care?  Yes  No

6. Describe how the state provides 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 Understanding (MOU) 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.

Within ADAD's contracted adolescent treatment providers, they have multiple contracts with the juvenile justice services (Girl's Court, Juvenile Drug Court, Family Drug Court, etc.), which may also involve the Child Welfare System.

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

The ADAD's Prevention Branch, contracts with 21 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.

**8.** Please indicate areas of technical assistance needs related to this section.

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<b>Footnotes:</b>
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## Environmental Factors and Plan

### 12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

#### Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted?  Yes  No
2. Describe activities intended to reduce incidents of suicide in your state.
3. Have you incorporated any strategies supportive of the Zero Suicide Initiative?  Yes  No
4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments?  Yes  No  
If yes, please describe how barriers are eliminated.
5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted?  Yes  No  
If so, please describe the population of focus?
6. Please indicate areas of technical assistance needs related to this section.

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#### Footnotes:

1. The Hawaii SSA provided no response because the Suicide Prevention section is requested, not required for SUPTRS BG per the FFY2026-2027 SUPTRS BG application instructions.

## Environmental Factors and Plan

### 13. Support of State Partners – Required for MHBG & SUPTRS BG

#### Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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**Please respond to the following items:**

- 1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
- 2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

None

- 3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Alcohol and Drug Abuse Division (ADAD) partners with governmental, private, non-profit, and community organizations, to address needed substance use treatment and prevention services and programs. Though the response for Section 13, item2, was "No", ADAD is always looking for opportunities to build new partnerships. The various partnerships are described

There are a number of partnerships with the Department of Health. Adult Mental Health Division (AMHD) for treatment access to needed services. Some ADAD treatment providers assist with the continuity of care with non-violent clients who are transitioning out of the Hawaii State Hospital by providing treatment and basic life skills to assist the client with adjusting to life out in the community.

Another partnership is with Hawaii CARES. In April 2025, ADAD contracted with a new vendor for Hawaii CARES, CARE Hawaii, who also has a contract with AMHD to provides mental health and crisis services through Hawaii CARES. Having one provider manage two different lines for these services makes it effective to collaborate and coordinate behavioral health services for SUD, mental health, and development disability services. 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.

Partnership with the Department of Human Services, Med-Quest Division (Med QUEST) supports those who require treatment and recovery services. Med-QUEST is the Hawaii Medicaid 1115 waiver program who services, including SUD treatment services, are delivered through Managed Care Organizations. ADAD funds may be used to supplement Med-QUEST should there be a clinical need. Currently ADAD and Med-QUEST are consulting with each other on the development of their respective contingency management (CM) program.

Partnerships with the Department of Education (DOE) provides access to treatment services as well as primary prevention activities through ADAD treatment and prevention services providers. ADAD supplies opioid overdose prevention supplies, naloxone, public middle and high schools. Lastly, we are in discussions with the DOE on a Memorandum of Agreement to assist with the development of a youth summit and council designed to give youth a voice in the substance use prevention system. The youth summit will be a forum for students to discuss topics and work with adults to find solutions. While the youth council will provide an ongoing platform for student leaders to advise on prevention programs.

Partnerships with the Hawaii Department of Transportation (DOT), Department of the Attorney General (AG), Hawaii High Intensity Drug Trafficking Area (HITDA), and the University of Hawaii (UH) were recently established through the ADAD initiated prevention advisory council (Council). This Council provides a mechanism to better coordinate primary prevention efforts statewide. It meets regularly to share information, identify systemic barriers, and develop joint projects to enhance prevention services. For instance, the collaboration with the DOT has helped address impaired driving issues. Input from the AG and HITDA provides critical insights into substance use and other issues, which informs our prevention strategies. The UH lends its research and academic expertise to ensure prevention programs are evidence-based.

ADAD is also partnering with some of the labor unions to build a peer recovery group that creates a safe space that the workers can go to and to reduce the stigma of receiving help for SUD services. These labor unions have been provided training on suicide prevention, peer mentoring, and motivational interviewing.

- 4. Please indicate areas of technical assistance needs related to this section.  
Continue receiving technical assistance from the Prevention Technology Transfer Center and the Strategic Prevention Technical Assistance Center regarding ADADs prevention advisory council.

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**Footnotes:**

## Environmental Factors and Plan

### 14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in [42 U.S.C. §300x-3](#) for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the [State Behavioral Health Planning Councils: An Introductory Manual](#).

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

#### Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan  Yes  No

b. State Report  Yes  No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?)  Yes  No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

7. Please indicate areas of technical assistance needs related to this section.

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#### Footnotes:

1, The Hawaii SSA does not fall under the purview of the Hawaii State Council on Mental Health.

# Environmental Factors and Plan

## Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

- State Mental Health Agency
- State Education Agency
- State Vocational Rehabilitation Agency
- State Criminal Justice Agency
- State Housing Agency
- State Social Services Agency
- State Medicaid Agency

Start Year: 2026      End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

\*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	0	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	0	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	0	
<b>5. Total individuals in recovery, family members, and parents of children with SED</b>	<b>0</b>	<b>0.00%</b>
6. State Employees	0	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
<b>9. Total State Employees &amp; Providers</b>	<b>0</b>	<b>0.00%</b>
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
<b>15. Total non-required but encouraged members</b>	<b>0</b>	<b>0.00%</b>
<b>16. Total membership (all members of the council)</b>	<b>0</b>	

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**Footnotes:**

# Environmental Factors and Plan

## 15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. §300x-51\)](#) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

### 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 2026-2027 SUPTRS BG 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 for SAMHSA 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

d) Please indicate areas of technical assistance needs related to this section.

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**Footnotes:**

## Environmental Factors and Plan

### 16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:

Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

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 SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG 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 SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the [HIV.gov website](#).

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

**Step 1** - Request a **Determination of Need** from the CDC

**Step 2** - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

**Step 3** - Obtain SUPTRS BG State Project Officer Approval

**Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.**

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
<b>Totals:</b>		\$0.00		0	

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**Footnotes:**  
 1. FFY 2026-2027 SUPTRS BG funding will not be used for a Syringe Services Program.