REPORT TO THE

THIRTIETH LEGISLATURE

STATE OF HAWAII

2019

PURSUANT TO:

**SECTION 321-195, HAWAII REVISED STATUTES,
REQUIRING A REPORT ON IMPLEMENTATION OF THE STATE PLAN FOR SUBSTANCE ABUSE;**

**SECTION 329-3, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE HAWAII ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES;**

**SECTION 10 OF ACT 161, SESSION LAWS OF HAWAII 2002,
REQUIRING A STATUS REPORT ON THE COORDINATION OF OFFENDER SUBSTANCE ABUSE TREATMENT PROGRAMS; AND**

**SECTION 29 OF ACT 40, SESSION LAWS OF HAWAII 2004,
REQUIRING A PROGRESS REPORT ON THE SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM**

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAII
DECEMBER 2018**

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2017-18 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS).

For Fiscal Year 2017-18, $$41,702,101 was appropriated by Act 49, Session Laws of Hawaii (SLH) 2017, to the Alcohol and Drug Abuse program (HTH 440) – $20,660,248 general funds, $750,000 special funds and $20,291,853 federal funds (MOF N and P). Of the total appropriated, $33,768,692 was allocated for substance abuse treatment services and $6,016,957 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#97606H) by $28,584; increased the general fund by $800,000 for Homeless Outreach; increased the general funds by $300,000 for Clean and Sober Housing; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $560,472 (HTH440/HO); increased the federal fund ceiling by $131,438 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); established the federal fund ceiling for the new Hawaii Screening, Brief Intervention, and Referral to Treatment (SBIRT) award totaling $8,291,875; decreased the federal fund ceiling by $1,800 for the Hawaii Pathways Project; established the federal fund ceiling for the Drug and Alcohol Services Information System (DASIS) by $37,538; changed the means of financing from federal funds to general funds for 3.00 FTE Program Specialists (#31668, #26644, #27863); removed three positions (#108768, #99852H, #116269) and decreased the federal fund ceiling by $136,520 for federal projects that ended; established the Prevention Branch and Treatment and Recovery Branch as approved in ADAD's reorganization acknowledged on March 29, 2011; and corrected the negative balance in MOF N, HTH440/HT by $19,991.

Federal funds for substance abuse prevention and treatment services include the following:

> $8.45 million for the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.
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> $1.6 million over three years (9/30/2017 – 9/29/2020) for the contract awarded by the U.S. Food and Drug Administration (FDA) for tobacco inspections of retail outlets on behalf of the FDA for compliance with the Tobacco Control Act (Public Law 111-31).
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> $3.1 million over three years (9/30/2013 – 9/29/2017) for the Hawaii Pathways Project funded by SAMHSA/CSAT/Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States, assists chronically homeless individuals with substance abuse or co-occurring substance use and mental health disorders through assertive outreach, case management and treatment services. The project will strengthen the infrastructure, partnerships and system of services to provide permanent housing to individuals and families living on Oahu. Project services assist the target population in securing permanent housing, maintaining that housing through wrap-around support services (e.g., housing, vocational, and mental health support), as well as case management and peer navigators. The project is based on the Pathways Housing First model, the only evidence-based program recognized by

the National Registry of Evidence-Based Programs and Practices that provides comprehensive housing and treatment services without preconditions of the individual's alcohol or drug use. In July 2016, ADAD began procedures for requesting a No Cost Extension from SAMHSA. The Notice of Award was granted on September 14, 2016. The service period was extended from October 1, 2016 to September 30, 2017, a total of twelve (12) months. This period was provided in order to transition enrolled clients towards sustainable permanent supportive housing resources.

$4.0 million over two years for the SAMHSA/CSAT Opioid State Targeted Response (STR) grant to reduce opioid overdose deaths and that provides expanded program capacity to serve those with opioid use disorders (OUD), including prescription opioids as well as illicit drugs such as heroin, expand education and awareness, expand care coordination and integration of behavioral health care with primary care, and to improve access to proven interventions and prevention strategies such as Medication Assisted Treatment (MAT).

$8.3 million over five years (9/30/17 – 9/29/23) for the SAMHSA/CSAT Screening, Brief Intervention, & Referral to Treatment (SBIRT) grant that provides screenings, early intervention and referral to treatment for adults in primary care and community health settings for substance misuse and substance use disorders (SUD), as well as develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers.

$3.0 million over four years (9/30/17 – 9/29/21) for the SAMHSA/CSAT Youth Treatment Implementation (YT-I) grant that provides expanded screening, brief interventions and brief referrals to treatment services for SUD/co-occurring mental illness treatment, prevention, and care.

$1.8 million in each of five years (9/30/2013 – 9/29/2018) for the SAMHSA/CSAP SPF-PFS grant provides resources to implement the Strategic Prevention Framework process at the state and community levels and to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. The project engages public, private, state and community level stakeholders to ensure the program uses data- driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure to address underage drinking among persons aged twelve to twenty and other substance abuse prevention priorities as determined by assessments. A No Cost Extension was granted to extend the SPF-PFS Project service period to September 29, 2019.

Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided substance abuse prevention and treatment services to adults and adolescents as follows:[1]

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 3,210 adults statewide in Fiscal Year 2017-18;

[1] See Appendices A through F for details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions.

School- and community-based outpatient substance abuse treatment services were provided to 1,977 adolescents statewide in Fiscal Year 2017-18; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, underage drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 30,865+ children, youth and adults directly through individual-based prevention programs and strategies[2] in Fiscal Year 2017-18.

Also included are reports that are required pursuant to:

Section 329-3, HRS, requiring a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS);

Section 10 of Act 161 SLH 2002, requiring a status report on the coordination of offender substance abuse treatment programs; and

Section 29 of Act 40 SLH 2004, requiring a progress report on the substance abuse treatment monitoring program.

[2] Examples of individual-based strategies include the following: school and community-based curricula; after-school programs; community service activities; and parent education classes and workshops.

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2017-18 for the Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) and is submitted pursuant to Section 321-195, Hawaii Revised Statutes (HRS). Also included are reports that are required pursuant to: Section 329-3, HRS, which requires a report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS); Section 10 of Act 161, SLH 2002, which requires a status report on the coordination of offender substance abuse treatment programs; and Section 29 of Act 40, SLH 2004, which requires a progress report on the substance abuse treatment monitoring program.

ADAD's mission is to provide the leadership necessary for the development and delivery of quality substance abuse prevention and treatment services for Hawaii residents. ADAD's primary functions include: grants and contracts management; clinical consultation; quality assurance, which encompasses training, accreditation of substance abuse treatment programs, certification of substance abuse counselors and program administrators, monitoring implementation of prevention activities and treatment services; policy development; planning and coordination of services; and information systems management (i.e., treatment client data system, prevention minimum data set, and needs assessments for substance abuse prevention and treatment services).

The reorganization of the Alcohol and Drug Abuse Division (approved on March 29, 2011) provides the framework to implement and maintain the core public health functions of assessment (i.e., monitoring trends and needs), policy development on substance abuse issues and assurance of appropriate substance abuse services.

Assessment. Data related functions and positions are organized within the Planning, Evaluation, Research and Data (PERD) Office so that data functions and activities support planning, policy, program development and reporting needs of the Division.

Policy development. The PERD Office is charged with strategic planning, organizational development, program development, evaluation, identification of community needs, knowledge of best practices, policy research and development.

Assurance. The core public health function of assurance is encompassed within four components, each of which are assigned the following functions.

The Administrative Management Services (AMS) Office is responsible for budgeting, accounting, human resource and contracting functions to ensure Division-wide consistency, accuracy and timeliness of actions assigned to the Division.

The Quality Assurance and Improvement (QAI) Office is responsible for quality assurance and improvement functions (i.e., certification of substance abuse counselors, program accreditation and training).

The Prevention Branch (PB) provides a focal point and priority in the Division for the development and management of a statewide prevention system which includes the development and monitoring of substance abuse prevention services contracts and the implementation of substance abuse prevention discretionary grants. The reorganization of the Branch (approved on August 29, 2018) established the Strategic Prevention Framework (SPF) Project and the Food and Drug Administration (FDA) Tobacco Program organizational segments within the Branch. The SPF Project will build the capacity for the delivery of prevention services and sustain the substance abuse prevention system and infrastructure at the state, county and local community levels. The staff of the FDA Program will ensure that Compliance Cheek Inspections are conducted, and the Tobacco Control Act is enforced in Hawaii.

The Treatment and Recovery Branch (TRB) develops and manages a statewide treatment and recovery system which includes program and clinical oversight of substance abuse treatment services contracts and the implementation of substance abuse treatment discretionary grants.

Health promotion and substance abuse prevention are essential to an effective, comprehensive continuum of care. The promotion of constructive lifestyles and norms includes discouraging alcohol, tobacco and other drug use, encouraging health-enhancing choices regarding the use of alcohol, prescription drug misuse and abuse and illicit drug use, and supporting the development of social and physical environments that facilitate drug-free lifestyles. Prevention is achieved through the application of multiple interventions (e.g., evidence-based curricula, strategies and practices, and/or environmental strategies) that impact social norms and empower people to increase control over, and to improve, their health. Substance abuse prevention focuses on interventions to occur prior to the onset of a disorder and is intended to prevent the occurrence of the disorder or reduce the risk for the disorder. Risk factors are those characteristics or attributes of an individual, his or her family and peers, school or environment that have been associated with a higher susceptibility to problem behaviors such as alcohol and other drug abuse. In addition, prevention efforts seek to enhance protective factors in the individual/peer, family, school and community domains. Protective factors are those psychological, behavioral, family and social characteristics and conditions that can reduce risks and insulate children and youth from the adverse effects of risk factors that maybe present in their environment.

Substance abuse treatment refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological and social dysfunction and to arrest, retard or reverse the progress of any associated problems. Treatment services have, as a requirement, priority admission for pregnant women, injection drug users, native Hawaiians and adult offenders.

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2017 to June 30, 2018

State and Federal Funding

Act 49, SLH 2017 appropriated $41,702,101 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2017-18:

General funds	$20,660,248	(49.6%)	29.0 FTE
Special funds	750,000	(1.8%)	
Federal funds (N)	8,489,857	(20.3%)	6.5 FTE
Federal funds (P)	11,801,996	(28.3%)	
	$41,702,101	(100.0%)	28.0 FTE[3]

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	$33,768,692	(81.0%)
Substance abuse prevention services	6,016,957	(14.4%)
Division operating costs	0	(0%)
Division staffing costs	1,916,452	(4.6%)
	$41,702,101	(100.0%)

For Fiscal Year 2017-18, $41,702,101 was appropriated by Act 49, SLH 2017, to the Alcohol and Drug Abuse program (HTH 440) – $20,660,248 general funds, $750,000 special funds and $20,291,853 federal funds (MOF N and P). Of the total appropriated, $33,768,692 was allocated for substance abuse treatment services and $6,016,957 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#97606H) by $28,584; increased the general fund by $800,000 for Homeless Outreach; increased the General funds by $300,000 for Clean and Sober Housing; increased the federal fund ceiling for the Substance Abuse Prevention and Treatment Block Grant by $560,472 (HTH440/HO); increased the federal fund ceiling by $131,438 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); established the federal fund ceiling for the new Hawaii Screening, Brief Intervention, and Referral to Treatment (SBIRT) award totaling $8,291,875; decreased the federal fund ceiling by $1,800 for the Hawaii Pathways Project; established the federal fund ceiling for the Drug and Alcohol Services Information System (DASIS) by $37,538; changed the means of financing from federal funds to general funds for 3.00 FTE Program Specialists (#s 31668, 26644, 27863); removed three positions (#s 108,768, 99852H, 116269) and decreased the federal fund ceiling by $136,520 for federal projects that ended; established the Prevention Branch and Treatment and Recovery Branch as approved in ADAD's reorganization acknowledged on March 29, 2011; and corrected the negative balance in MOF N, HTH440/HT by $19,991.

[3] Position count does not include grant-funded exempt positions: Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant (2.0 FTE), U.S. Food and Drug Administration (FDA) contract (1.5 FTE), Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States (1.0 FTE), and Hawaii Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grant (2.0 FTE). The position count also does not include the general funded temporary Program Specialist for the Clean and Sober Homes Registry (1.0 FTE).

Federal Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. ADAD received $8.5 million in Fiscal Year 2017-18 of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and evaluate substance abuse prevention and treatment activities.

U.S. Food and Drug Administration (FDA) Tobacco Inspections. The award of a $1.5 million 3-year contract (9/30/2017 – 9/29/2020) by the FDA supports tobacco inspections on retail outlets that sell or advertise cigarettes or smokeless tobacco products to determine whether they are complying with the Tobacco Control Act (Public Law 111-31) and the implementing regulations (21 Code of Federal Regulations Part 1140, et seq.). Two types of tobacco compliance inspections are conducted: undercover buys, to determine a retailer's compliance with federal age and photo identification requirements; and product advertising and labeling to address other provisions of the Tobacco Control Act.

Hawaii Pathways Project. The $3.1 million over three years (9/30/2013 – 9/29/2017) for the Hawaii Pathways Project funded by the SAMHSA/CSAT/Cooperative Agreements to Benefit Homeless Individuals (CABHI) for States assists chronically homeless individuals with substance abuse or co-occurring substance use and mental health disorders through assertive outreach, case management and treatment services. Project services assist the target population in securing permanent housing, maintaining that housing through wrap-around support services that include housing, vocational, and mental health support, as well as case management and peer navigators. During the original service period (9/30/2013 – 9/29/2016), the project has enrolled 136 clients. 74 housing vouchers were obtained from various federal, state, and city housing resources as well as other non-profit housing resources. 61 clients have been matched with permanent supportive housing and have received tenancy support services. The extension period will focus on transitioning clients to sustainable tenancy support services.

The project collaborated with the Hawaii Interagency Council on Homelessness, the Hawaii Public Housing Authority, State Dept. of Human Services, and other state and county affiliates, in developing and implementing a project transition and state sustainability plan for resolving homelessness. The goal has been to identify alternative, permanent financial resources while connecting clients to local resources of sustainable tenancy support services and permanent supportive housing. As the federal support ends, clients were connected to case management services that were connected to the original housing voucher used by the client. Those clients not housed were connected to case management services covered by client's insurance coverage.

The Hawaii Pathways Project contracted with Corporation for Supportive Housing (CSH) for technical consultation. CSH collaborated with the Governor's Coordinator for Homelessness and MedQUEST Division (MQD) Administrator in developing Hawaii's Medicaid waiver request to include coverage for billable Tenancy Support services designed to pay for those services conducted by ICM providers that support individuals requiring housing support. ADAD has created funding to support Helping Hands Hawaii from October 1, 2017 to March 31, 2018.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant. Hawaii was awarded $1.8 million in each of five years (9/30/2013 – 9/29/2018) from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) to implement the Strategic Prevention Framework process at the state and community levels to promote the alignment and leveraging of prevention resources and priorities at the federal, state and community levels. A No Cost Extension, effective September 30, 2018 through September 29, 2019 has been provided to allow additional time to achieve project goals and complete activities initiated during the 5-year grant period. The project has engaged public, private, state and community level stakeholders to set the foundation for the effective gathering and analysis of local data to support data-driven decision-making processes in the development and implementation of effective prevention strategies and sustainable prevention infrastructure as determined by assessments. Five (5) community coalitions have been awarded resources to conduct assessments and plan for the implementation and evaluation of environmental strategies to address underage drinking among persons aged twelve to twenty in their communities. Environmental strategies have a broader focus than individual or curriculum-based strategies, so they have the potential to change community norms and population behaviors. Additionally, SPF-PFS resources awarded to each County have assisted in strengthening infrastructure and providing capacity support to assess, plan and implement a sustainable prevention system at the county level to support substance abuse prevention efforts needed or currently being conducted in communities. During the FY 2018, the SPF-PFS contracted services involved approximately thirty-seven (37) community organizations and 4,335 community members in SPF efforts to enhance community health across the state.

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT is a five-year grant (project period 09/30/2016-09/29/2021) totaling $8,291,875. Funding is to implement screening, brief intervention, and referral to treatment (SBIRT) services for adults in primary care and community health settings for substance misuse and substance use disorders (SUD). Project services are designed to develop, expand, and enhance infrastructure to fully integrate SBIRT in six Federally Qualified Health Centers (FQHC) in Hawaii and up to twenty-five small group primary care practices (PCP) over five years and to establish the SBIRT model as a standard of care statewide. The SBIRT program seeks to address behavioral health disparities by encouraging the implementation of strategies, such as SBIRT, to decrease the differences in access, service use, and outcomes among the populations served. Implementing the SBIRT will aid in improving overall health outcomes, reducing the negative impact on health, and reducing healthcare costs. The grant has three goals: 1) Implement SBIRT in six FQHCs and twenty-five small group primary care practices; 2) Develop and expand State and community infrastructure to improve linkages and coordination between primary care and SUD treatment providers; and, 3) Expand existing behavioral health integration efforts which includes a plan to disseminate SBIRT to small primary care practices throughout the State.

State Targeted Response to the Opioid Crisis (STR). The Hawai‘i STR grant (project period 5/1/2017-4/30/2019) totaling $2,000,000 is an initiative awarded jointly through SAMHSA’s Center for Substance Abuse Treatment (CSAT) and CSAP. The grant aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin). The STR grant will address these concerns through three key activity tracks: (1) **education and awareness**, which will promote public awareness of the dangers of opioid use and provide training to health professionals to better identify and assist persons at risk or suffering from

opioid use disorders; (2) **care coordination and integration** which will target more efficient and effective ways to integrate primary and behavioral health care to reduce risk and better treat persons affected by opioid misuse and abuse; and (3) **policy shaping** which targets policies and protocols aimed at improving access and expanding proven interventions and prevention strategies such Medication Assisted Treatment (MAT).

State Youth Treatment-Implementation (YTI). The Hawai‘i YTI grant (project period: 9/30/2017–9/29/2021) totaling $3,040,000 is an initiative awarded by SAMHSA’s CSAT. The grant aims to improve treatment for adolescents and/or transitional aged youth with substance use disorders (SUD) and/or co-occurring substance use and mental disorders by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. It intends to bring together stakeholders across the systems serving the populations of focus to strengthen an existing coordinated network that will enhance/expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices (EBPs), and implement financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment, and recovery support system. The YTI grant will address these concerns by increasing the number of multi-systemic therapists (MST) at select treatment providers, expanding eligibility criteria for services, and including treatment services for criminal justice adolescents within the Hawai‘i Youth Correctional Facility, and adolescents aged 12-25 who present for care or are directed for care through the Child and Adolescent Mental Health Division and the Hawai‘i Youth Criminal Justice Division.

Substance Abuse Prevention and Treatment Services

Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided substance abuse prevention and treatment services to adults and adolescents as follows:[4]

> **Treatment Services.** ADAD’s overarching goal is to prevent or reduce the severity and disabling effects related to alcohol and other drug use, abuse and dependence by assuring an effective, accessible, public and private community-based system of prevention strategies and treatment services designed to empower individuals and communities to make health-enhancing choices regarding the use of alcohol and other drugs. Twenty-six (26) agencies, which resulted in thirty-two (32) contracts were established to provide a continuum of services to seven different populations which are, Adult Substance Abuse Treatment, Dual Diagnosis Substance Abuse Treatment, Opioid Addiction Recovery Services, Specialized Substance Abuse Treatment for Pregnant Women and Women with Dependent Children, Intensive Addiction Care Coordination and Substance Abuse Treatment for Offenders, Group Recovery Homes, Early Intervention Service for HIV, Homeless Outpatient Substance Abuse Treatment, and Adolescent Substance Abuse Treatment Services which consist of School-Based and Community-Based services. Treatment providers can provide all or part of the treatment continuum, which includes pre-treatment service such as motivational enhancement services, outreach, and interim; treatment services such as non-medical social detoxification, residential, intensive outpatient, outpatient; and recovery support services such as therapeutic living, clean and

[4] Details on adult and adolescent treatment admissions, outcomes for six-month follow-ups, needs assessments and methamphetamine admissions are appended at pages 34-43.

sober housing, continuing care, transportation, translation, and childcare. All client admissions, treatment service, including treatment progress notes, and discharges are tracked on the Web-Based Infrastructure for Treatment Services (WITS) system. Services were provided to 3,210 adults statewide in Fiscal Year 2017-18; and school-based and community-based outpatient substance abuse treatment services were provided to 1,977 adolescents statewide in Fiscal Year 2017-18.

Prevention Services. Through a total of twenty-five (25) contracts, sixteen (16) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2018. In efforts to best utilize resources to fund what works, the contracted services implement evidence-based programs, policies, and practices that include: information dissemination; education; problem identification and referral; community-based programming; environmental strategies; and alternative activities that decrease alcohol, tobacco, and other drug use. The funded programs engage schools, workplaces, and communities across the state in establishing evidence-based and cost-effective models to prevent substance abuse in young people in a variety of community settings and promoting programs and policies to improve knowledge about alcohol and other drug problems, including effective ways to address the problems and enhance resiliency.

Program implementation is tracked according to the number of times (cycles) curricula and strategies were implemented as collected and reported using WITS, the data management system described above and recently expanded to collect prevention service data. Additionally, quarterly progress reports, plans and progress notes submitted capture information related to community partnerships, problems, priorities, resources, readiness and implementation status of identified evidence-based programs. According to the data collected for Fiscal Year 2017-18, curriculum-based youth substance abuse prevention strategies and the HIPRC served a total of 30,865+ children, youth and adults across the state.

The funded services impact the contracted community-based agencies' ability to mobilize support and build capacity and readiness in identified service areas to ensure that the community is aware of the substance abuse issues and is prepared to support the implementation of interventions that have proven effective in preventing the occurrence or escalation of such problems. Agencies use the State and Federal prevention resources to secure materials, training, and technical assistance to implement substance abuse prevention evidence-based interventions (EBI) and strategies with fidelity, as designed and adhering to the core components, as intended by the developer. If evaluation findings are not what was anticipated, mid-course corrections and adaptations to the implementation of the strategy are made with guidance from the developer to increase the effectiveness of the EBI and the substance abuse prevention efforts. An emphasis on implementing evidence-based practices and determining what works should result in quality, effective prevention services that will benefit youth and their families and contribute to an enhanced substance abuse prevention system for Hawaii.

Substance Abuse Prevention resources are also used to positively impact and develop the prevention workforce. Prevention staff from contracted community-based agencies are required to attend annual prevention related trainings to gain new knowledge and skills to

improve implementation efforts and effectively address the prevention of the use of alcohol, tobacco and other drugs in the community. Trainings or conferences attended may include but are not limited to the Overview of the fundamentals of substance abuse prevention; Substance Abuse Prevention Skills Training (SAPST), SPF model principles and steps; community organizing; evidence-based strategies; environmental strategies; and youth engagement.

Studies and Surveys

Tobacco Sales to Minors. The 2018 annual statewide survey results for illegal tobacco sales to minors is 6.6% (weighted), an increase from last year's rate of 5.3%. While the 6.6% is still less than the 9.6% national weighted average for federal fiscal year 2013, it represents an increase from the 5.3% in overall retailer violation rates for 2017. The annual survey, which is a joint effort between the Alcohol and Drug Abuse Division and the University of Hawaii, monitors the State's compliance with the "Synar" (tobacco) regulations for the federal Substance Abuse Prevention and Treatment Block Grant. It is important to note that on January 1, 2016, it became unlawful to sell both tobacco products and electronic smoking devices to persons under twenty-one (21) years of age. With the enactment of Act 122, which increased the minimum age from 18 to 21, youth between the ages of 18-20 were also included in the annual survey. In the Spring of 2018, teams made up of youth volunteers (ages 15-20) and adult observers visited a random sample of 335 stores statewide in which the youth attempted to buy cigarettes to determine how well retailers were complying with state tobacco laws. Twenty-two stores (6.6%) sold to minors (ages 15-20). Of the four counties included in the statewide survey, the County of Kauai had one sale, the County of Hawaii had five sales, and both the County of Honolulu and County of Maui had eight sales each. Due to the small sample size, rates for individual counties are not considered statistically reliable. Fines assessed for selling tobacco to anyone under the age of 21 are $500 for the first offense and a fine of up to $2,000 for subsequent offenses

Provision of Contracted or Sponsored Training

In Fiscal Year 2017-18, ADAD conducted training programs that accommodated staff development opportunities for 1,325 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through forty-six (46) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 25,856 Continuing Education Units (CEU's) towards their professional certification and/or re-certification as certified substance abuse professionals in the following: Certified Substance Abuse Counselor (CSAC), Certified Prevention Specialist (CPS), Certified Criminal Justice Professional (CCJP), Certified Clinical Supervisor (CCS), Certified Co-occurring Disorders Professional-Diplomate (CCDP-D), or Certified Substance Abuse Program Administrator (CSAPA).

Topics covered during the reporting period included: opioid prevention and response; SBIRT; The American Society of Addiction Medicine (ASAM) Criteria, suicide prevention, workplace satisfaction, supportive supervision, group processing and treatment, providers instruction to substance abuse treatment for LGBTQ, street drugs and surviving through crisis , motivational interviewing; group counseling; criminal conduct and substance abuse; drug use during pregnancy; confidentiality of alcohol and drug abuse client records (42 CFR,

Part 2); Health Insurance Portability and Accountability Act of 1996 (HIPAA); certification and examination processes; data input and its usefulness; prevention specialist training; identifying/implementing environmental trainings; evaluation capacity building; evidence-based practices; Code of Ethical Conduct for substance abuse professionals; mental health and substance use; denial and resistance in addiction treatment; critical thinking for substance addiction professionals; understanding sexually transmitted diseases; HIV/AIDS in the substance abusing population; cultural diversity; and understanding the addiction process and how families are affected by addiction.

Programmatic and Fiscal Monitoring

Through desk audits of providers' program and fiscal reports, ADAD staff examined contractors' compliance with federal SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions for grants-in-aid and purchases of service. ADAD also provided technical assistance to substance abuse prevention and treatment programs statewide. Staff conducted ongoing desktop program and fiscal monitoring of forty (40) prevention service contracts forty-four (44) treatment service contracts. Technical assistance and follow-up and site visits related to program development and implementation, reporting and contract compliance provided as needed.

Certification of Professionals and Accreditation of Programs

Certification of Substance Abuse Counselors. In Fiscal Year 2017-18, ADAD processed 462 (new and renewal) applications, administered sixty-one (61) computer-based written exams and certified forty-eight (48) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,277.

On average, the shortest amount of time to become a certified substance abuse counselor is approximately thirteen (13) months. A Master's degree in a human service field credits the applicant with 4,000 hours working in the substance abuse field. The applicant must still obtain 2,000 supervised work experience hours which is approximately twelve (12) months of working full-time. The remaining month is to schedule and take the required written exam. If a person also licensed as a Clinical Social Worker, Mental Health Counselor, Marriage and Family Therapist, Clinical Psychologist, or Psychiatrist, the required supervised work experience is 1,000 hours (or approximately six (6) months of full-time work) in the substance abuse profession. The person would also need a month to schedule and take the written exam. If an applicant has no applicable college degree to substitute for education and supervision hours, the total time to become certified is approximately three (3) years (i.e., 6,000 hours of work experience), plus one month to schedule and take the exam.

Accreditation of programs. In Fiscal Year 2017-18, ADAD conducted a total of twenty-one (21) accreditation reviews and accredited thirteen (13) organizations, some of which have multiple (residential treatment and therapeutic living) programs.

Clean and Sober Homes Registry

Act 193, SLH 2014 (HB 2224 HD2 SD2 CD1), relating to group homes, establishes a registry for clean and sober homes within the Department of Health; appropriates funds for staffing and operating costs to plan, establish and operate the registry of clean and sober homes; and amends the county zoning statute to better align functions of state and county jurisdictions with federal law.

The voluntary registry of clean and sober homes is a product of a two-year process during which the knowledge and expertise of public (i.e., State and County) as well as private agencies' perspectives were elicited. The registry will help residents to access a stable, alcohol-free and drug-free home-like living environment by establishing procedures and standards by which homes will be allowed to be listed on the registry, including but not limited to: organizational and administrative standards; fiscal management standards; operation standards; recovery support standards; property standards; and good neighbor standards.

Act 124, SLH 2016 also increased the general funds for the Clean and Sober Homes Registry by $252,000 including one Program Specialist V (#97606H) that was later classified as a Program Specialist IV.

Act 49, SLH 2017 also increased the general funds for the Clean and Sober Homes Registry by $28,584 in FY18 and $28,584 in FY19 for the same Program Specialist V (#97606H) that was classified as a Program Specialist IV.

Concerning the status of the plan for establishing and operating the registry of clean and sober homes, at the time of report preparation (December 2018), the status of establishing and operationalizing the registry of clean and sober homes is as follows:

> The web-based registry of clean and sober homes has been developed through a contract with the Hawaii Information Consortium and is undergoing the internal testing phase.
>
> The process of drafting administrative rules to operationalize the registry of clean and sober homes is in progress. It is anticipated that by the end of December 2018, a draft will be completed for internal (i.e., Department of Health) and external (i.e., Department of the Attorney General, Legislative Reference Bureau, etc.) review and mark-up.
>
> NOTE: In the upcoming 2019 Regular Session ADAD as part of the Governor's Executive Budget will request to convert 1.00 position from temporary to permanent and address variance of the position (#97606H) from Program Specialist V to Program Specialist IV to fulfill mandates pursuant to Act 193, SLH 2014.

It is anticipated that:

- By early 2019, rules will be adopted;
- By the end of Fiscal Year 2019, the web-based registry of clean and sober homes will be operational; and
- By early Fiscal Year 2020, ADAD-funded substance abuse treatment providers whose clients are assisted with housing referrals shall only refer clients to residences that are on the registry.

Law Enforcement Assisted Diversion (LEAD)

Act 53, HSL 2018 approved an $800,000 general fund appropriation for FY 2019, $200,000 of which continues implementation of the LEAD pilot program that provides pre-arrest diversion services working with local law enforcement (e.g., local police departments) for the chronically homeless who suffer from severe substance abuse disorders. The pilot also includes training for local law enforcement to detect the signs of SUD addiction (versus mental health disorders) in the field and how to fast-track low-level offenders to SUD treatment programs. With LEAD, low-level offenders for whom probable cause for arrest or citation exists are provided the choice of arrest/citation or active engagement in services by local law enforcement.

On their own, the homeless will have no benefit of a care coordination safety net and are at risk of wandering from one provider that requires multiple assessments and services completed with previous providers that were not effective, leading to increased waste of treatment provider time and effort. A segment of the homeless population may qualify for LEAD which fast-tracks them to receive appropriate care in a SUD treatment program if they have committed low-level, non-violent offenses due to drug and/or alcohol addiction. Sustained outreach and quick referrals to SUD treatment services coupled with wrap-around services such as care coordination will expand the system of care to help the homeless overcome addiction which will improve their ability to secure housing, reduce crime and qualify for employment. This intervention is targeted to move resistant individuals into care and increase the overall safety of the community. The project is currently being piloted and the general fund appropriation will be utilized to expand implementation of the project.

The Honolulu LEAD pilot began in Chinatown in mid-2018 and will have its first evaluation available by the end of 2018 and involves both HPD and the State Sheriffs from the Department of Public Safety.

In 2018, LEAD has:

- Enrolled thirty-eight (38) participants with twenty-six (26) active in case management (14 have treatment plans);
- Four (4) completed residential substance abuse treatment;
- Ten (10) were linked to shelter; and
- Twelve (12) were supported with document readiness, bus passes, Supplemental Nutrition Assistance Program (SNAP) and food assistance and legal services.

Act 209, HSL 2018 approved an $400,000 general fund appropriation for FY 2019, $200,000 for the DOH to expand the LEAD pilot program by establishing one site on the island of Maui and another site on the island of Hawaii. ADAD is working to establish these sites in coordination with the Governor's Coordinator on Homelessness as well as the police departments and the county prosecutor on each island.

Legislation

ADAD prepared informational briefs, testimonies and/or recommendations on legislation addressing substance abuse related policies, and often in coordination with the stakeholders of the Hawaii Opioid Initiative. Legislation enacted during the 2018 Legislative Session that addressed issues affecting the agency included:

Act 53, HSL 2018 (H.B. 1900 HD1 SD1 CD1), relating to the state budget. This measure approved $800,000 in general funds for FY 2019 to provide outreach counseling and law enforcement diversion services for the chronically homeless who suffer from severe substance abuse disorders. Of this amount, $600,000 was added to existing contracts with substance abuse treatment providers to expand their outreach ability to serve the chronically homeless in coordination with the Governor's Coordinator on Homelessness. The remaining $200,000 is intended to implement a pilot program for arrest diversion working with local law enforcement who intervene with individuals who are visibly and chronically homeless due primarily to substance abuse disorders.

Act 209, HSL 2018 (S.B. 2401 SD2 HD1 CD1) relating to homelessness. This measure approved an $400,000 general fund appropriation for FY 2019, $200,000 for the DOH to expand the LEAD pilot program by establishing one site on the island of Maui and another site on the island of Hawaii. ADAD is working to establish these sites in coordination with the Governor's Coordinator on Homelessness as well as the police departments and the county prosecutor on each island.

Act 151, HSL 2018 (H.B. 1602 HD2 SD1 CD1) relating to opioids. This measure requires the inclusion of a label warning of the risks of addiction and death on the packaging of any opioid drug dispensed by a health care professional or pharmacist.

Act 152, HSL 2018 (H.B. 2384 HD1 SD1) relating to the uniform controlled substances act. This measure updates the Uniform Controlled Substances Act for consistency with federal law, and allows prescription of drugs to patients undergoing medically managed withdrawal, also known as detoxification treatment and maintenance treatment, by practitioners who are properly registered.

Act 153, HSL 2018 (S.B. 2646 SD1 HD3 CD1) relating to prescription drugs. This measure requires prescribers of certain controlled substances to consult the State's Electronic Prescription Accountability System before issuing a prescription for the controlled substance, under certain circumstances, and provides that a violation by a prescriber shall not be subject to criminal penalty provisions but that a violation may be grounds for professional discipline. This measure repeals on 6/30/2023.

Act 154, HSL 2018 (S.B. 2247 SD1 HD2 CD1) relating to opioid antagonists. This measure authorizes pharmacists to prescribe, dispense, and provide related education on opioid antagonists to individuals at risk of opioid overdose and to family members and caregivers of individuals at risk of opioid overdose without the need for a written, approved collaborative agreement; subject to certain conditions.

Act 155, HSL 2018 (S.B. 2244 SD1 HD2 CD1) relating to workers compensation. This measure requires health care providers in the workers' compensation system who are authorized to prescribe opioids to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency, and establishes limits for concurrent opioid and benzodiazepine prescriptions.

Several appropriation measures to appropriate funds to the Department of Health to provide funds for chronic conditions such as substance use, including coordinated treatment, centralized referral, case managers, and peer mentors (H.B. 2611 and S.B. 3107) were heard but not enacted.

NOTE: In the upcoming 2019 Regular Session ADAD as part of the Governor's Executive Budget will request to convert 1.00 position from temporary to permanent and address variance of the position (#97606H) from Program Specialist V to Program Specialist IV to fulfill mandates pursuant to Act 193, SLH 2014, relating to group homes.

OTHER REQUIRED REPORTS

- **Report Pursuant to Section 329-3, Hawaii Revised Statutes, Requiring a Report by the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS)**

- **Report Pursuant to Section 10 of Act 161, Session Laws of Hawaii 2002, on the Implementation of Section 321-193.5, Hawaii Revised Statutes**

- **Report Pursuant to Section 29 of Act 40, Session Laws of Hawaii 2004, Requiring a Progress Report on the Substance Abuse Treatment Monitoring Program**

REPORT PURSUANT TO
SECTION 329-3, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE HAWAII ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES

The Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) is required to submit a report on its actions during the preceding fiscal year pursuant to Section 329-3, Hawaii Revised Statutes (HRS).

Pursuant to Section 329-2, HRS, commission members are "selected on the basis of their ability to contribute to the solution of problems arising from the abuse of controlled substances, and to the extent possible, shall represent the pharmacological, medical, community and business affairs, youth action, educational, legal defense, enforcement, and corrections segments of the community." The commission is attached to the Department of Health for administrative purposes.

MEMBERS BY CATEGORY OF APPOINTMENT AND TERM OF OFFICE

CARL BERGQUIST Community and Business Affairs (Oahu) - 6/30/2020 **DIANA FELTON, M.D.** Medical (Hawaii) - 6/30/2019 **LORI FERREIRA, Ed.D.** Education (Oahu) - 6/30/2019 **JODY JOHNSON** Community and Business Affairs (Oahu) - Interim **CHAD Y. KOYANAGI, M.D.** Vice Chair Joint appointment to HACDACS and State Council on Mental Health (Oahu) - 6/30/2019	**HEATHER LUSK** Chairperson Education (Oahu) - 6/30/2019 **KENNETH TANO** Enforcement (Oahu) - 6/30/2022 **ERIKA VARGAS** Community and Business Affairs (Oahu) - 6/30/2021 **BRYAN WATKINS** Youth Action (Oahu) - 6/30/2022

On March 28, 2013, members elected Heather Lusk as Chairperson and on August 22, 2017 elected Chad Koyanagi as Vice-Chairperson. Meetings were scheduled on the fourth Tuesday of each month.

Priorities discussed during FY 2017-18:

- Reducing Opioid Misuse, Opioid Overdose and Related Harms
- Coordinated Entry and Care Coordination
- Public Health-Public Safety Partnerships
- Medical Cannabis

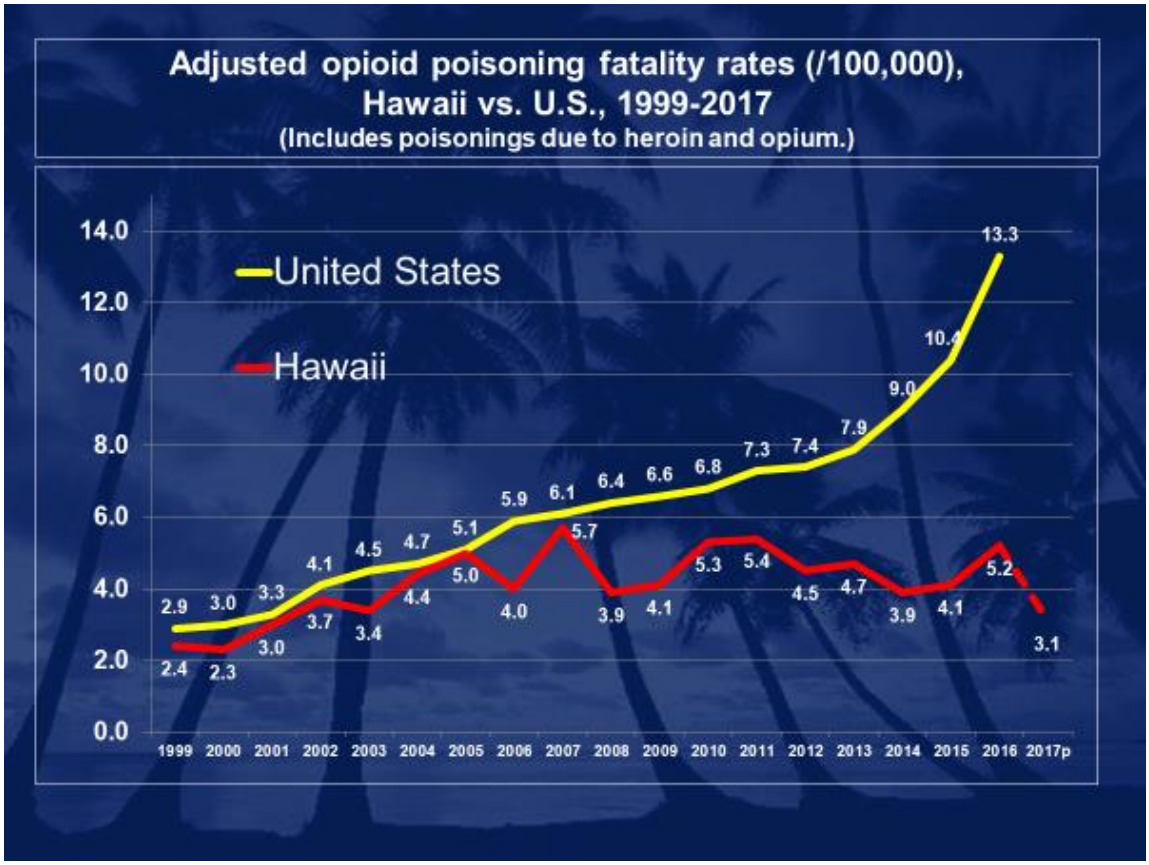
The members of HACDACS gathered research, best practices and invited knowledgeable speakers on these topics to form the following policy recommendations for prevention and treatment of substance use in Hawaii. The overarching themes of our recommendations are: support evidence and data-driven culturally appropriate services by integrating systems, policies and programs to create a comprehensive continuum of substance abuse prevention and treatment services in Hawaii.

Reducing Opioid Misuse, Opioid Overdose and Related Harms

Drug poisoning (drug overdose) continues to be leading mechanism of injury-related death in Hawaii, and drugs cause 9 out of 10 poisoning deaths. According to the Hawaii Department of Health (DOH), Hawaii averages 59 deaths a year from drug overdose, with an average of 186 non-fatal hospitalizations, 198 non-fatal emergency department visits and 205 calls to the Hawaii Poison Control line.

In 2017, Hawaii saw the first decline in fatal opioid deaths in a decade.

Figure 1. Adjusted Opioid Poisoning Fatality Rates (per 100,000), Hawaii vs. U.S., 1999-2017.



Despite this recent decline, opioids continue to be a major contributor to both fatal and non-fatal drug poisonings in Hawaii and overdose prevention has been a major focus of the Hawaii Opioid Initiative (HOI). The HOI was spearheaded byDOH), Emergency Medical Services and Injury Prevention System Branch, the Alcohol and Drug Abuse Division and the Harm Reduction Services Branch partnered with the Department of Public Safety (DPS), Hawaii Narcotics

Enforcement Division (NED) and community partners to develop a Hawaii-specific strategic plan to address opioid misuse and related harms. The HOI plan was released in late 2017, with an update expected in late 2018. The three primary themes are the foundation of the work and recommendations: system improvement through a collaborative response by identifying and fostering key systems-level coordination; a balanced public health-public safety approach; and supporting healthcare integration through enhanced behavioral health integration into primary care.

While Hawaii has not seen the increasing rates of fatal opioid overdoses as many states on the continent, the Hawaii Opioid Initiative (HOI) has been effective at bringing together stakeholders across disciplines to implement sustainable changes in not only the preventing opioid misuse and increasing access to treatment for Opioid Use Disorder, but leveraging the increased funding and priority of the opioids to make sustainable changes in the substance use prevention and treatment continuum in Hawaii. This broad focus acknowledges the ongoing challenges of methamphetamines, which is still the number one substance reported by people accessing DOH-funded treatment programs in Hawaii. Several members of HACDACs participated in HOI activities, and HACDACs supports the ongoing efforts of the HOI.

The HOI has seven workgroups with the following priorities:

- FOCUS AREA 1, TREATMENT ACCESS: Improve and modernize healthcare strategies and access for opioid and other substance misuse treatment and recovery services;
- FOCUS AREA 2, PRESCRIBER EDUCATION: Improve opioid and related prescribing practices by working with healthcare providers and payers;
- FOCUS AREA 3, DATA INFORMED DECISION MAKING: Implement system-wide routine data collection, sharing and dissemination to increase knowledge and inform practice;
- FOCUS AREA 4 – PREVENTION AND PUBLIC EDUCATION: Improve community-based programs and public education to prevent opioid misuse and related harms;
- FOCUS AREA 5 – PHARMACY-BASED INTERVENTIONS: Increase consumer education and prescription harm management through pharmacy-based strategies;
- FOCUS AREA 6 – SUPPORT LAW ENFORCEMENT AND FIRST RESPONDERS: Coordinate operations and services, support specialized training for first responders and assure effective laws and policies; and
- FOCUS AREA 7 – SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT): Increase implementation of SBIRT in primary care settings.

In mid-2018, The Centers for Disease Control and Prevention released *Evidence-based Strategies for Prevention Opioid Overdose – What's Working in the United States* which details the following evidence-based strategies for reducing opioid-related overdoses:

- Targeted naloxone distribution;
- Medication Assisted Treatment (MAT);
- Eliminating pre-authorizations for medications for Opioid Use Disorder;
- Screening for fentanyl;
- 911 Good Samaritan laws;
- Naloxone distribution in treatment centers and criminal justice settings;
- MAT in criminal justice settings and upon release;
- Initiating buprenorphine-based MAT in emergency departments; and

- Syringe services programs.

The strategies widely implemented in Hawaii are: targeted naloxone distribution; MAT; 911 Good Samaritan laws; and the syringe services program.

HACDACS received data and a presentation from the Drug Enforcement Agency on the increase of fentanyl being confiscated in Hawaii and from the DOH on the most recent overdose-related data and received monthly updated on the HOI. While there has been much good work through the HOI, HACDACs offers the following recommendations:

HACDACS recommends the implementation of the Hawaii Opioid Initiative's goals and objectives and encourages the DOH to provide workgroups with the resources they need to develop and sustain HOI's efforts.

HACDACS recommends specific efforts to help people struggling with chronic pain and opioid use disorder have access to evidence-based interdisciplinary and integrated pain management and substance abuse treatment services including increased access to detoxification services and Medication Assisted Treatment.

HACDACS recommends the expansion of MAT statewide including methadone access on Kauai and the west side of Hawaii Island and Buprenorphine access in emergency departments, criminal justice and other appropriate settings.

HACDACS recommends continued implementation of Act 68 (Session Laws of Hawaii, 2016) which expands access to naloxone and gives immunity to law enforcement, first responders and community members for the administration of naloxone, with a focus on integration of naloxone into treatment and criminal justice settings.

HACDACS recommends monitoring the prevalence of fentanyl as well as its analogues and derivatives, particularly in methamphetamine, in Hawaii through increased data-sharing with public safety as well as through pilot fentanyl testing projects.

HACDACS recommends ongoing assessment of the impact, particularly of "unintended consequences" including effects on prescriber and user behaviors, of the implementation of Act 153 (Session Laws of Hawaii, 2018) that requires use of that state's Electronic Prescription Accountability System (a.k.a. Prescription Drug Monitoring Program, PDMP) by certain prescribers.

Coordinated Entry and Care Coordination

In last year's report, issues around stigma as a barrier to treatment were discussed. Suggestions to increase coordination of care and to change the language used to speak about substance misuse were made. In addition, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model was highlighted as an essential tool for breaking down barriers and building connectedness. In the past year, efforts to increase coordination of care and reduce stigma have been noted and seem to be effective.

SBIRT advocates enhanced relationships between behavioral health and primary care. Over the

past year, it has been noted that primary care has not generated many referrals through the SBIRT model. The screenings conducted in primary care revealed low level problems in patients and a quick intervention by primary care was sufficient to address patients' needs. Continued use of SBIRT in primary care will help to prevent little problems from becoming big problems, as well as, continue to reduce the stigma of substance use by making it common practice to discuss substance use issues with one's primary care.

One avenue that will greatly enhance coordination efforts is the expansion of SBIRT into hospital emergency departments. Hospital emergency departments and detoxification units continue to report a high number of substance users in need of services; however, due to barriers, few patients are connected to treatment. Support is needed to address the following barriers: 1) time and resource management, 2) lack of staff who can screen or assess patients for substance use disorders, and 3) lack of a simple system to provide referrals. Emergency departments are often inundated and do not have the resources or time to screen for substance use problems. Training on SBIRT will provide a systematic way of interacting, engaging, and screening patients. Once patients are identified, hospital staff will need a simple system through which they can make referrals to treatment and enhance avenues for a warm hand-off. A coordinated entry system would increase confidence in screening patients in need of services resulting in a decrease of stigma and an increase in the access of services through an established referral process.

The SBIRT Care Coordinator, along with multiple agencies, has also been involved in homeless outreach and coordinated entry efforts which has provided quick screening and triage resulting in easier access to services. These mini coordinated entry efforts have uncovered new barriers, primarily concerning access to treatment and capacity.

There are approximately twenty-six (26) ADAD-funded substance use treatment providers on the island of O'ahu, each having their own entry process and with varying waitlists. Commonly, an individual seeking treatment calls each treatment center, applies to as many as possible, and waits to hear which one can accept the individual. During that waiting period, individuals can feel discouraged and lose motivation due to long, repetitive processes putting them at greater risk for continued use, relapse, and recidivism. In addition, multiple individuals applying at multiple treatment centers floods the system and taxes limited resources by creating a duplication of services across a multitude of agencies. The SBIRT Care Coordinator becomes the funneling point for a more coordinated entry process. Coordinated entry facilitates access to treatment, connects people to appropriate and tailored services, and reduces the duplication of services across agencies. Coordinated entry can also prioritize individuals with the highest needs. The overarching goal is to get more people into treatment and connected to services in a shorter amount of time.

With LEAD, SBIRT, and monthly night outreach, the referral stream has been created. The coordination into treatment poses the following challenges:

1) Limited number of stabilization beds – once an individual agrees to engage with treatment, they will need to be stabilized prior to being admitted into the next level of treatment. Utilization of stabilization beds will ensure the warm hand-off from the street to treatment.
2) Limited number of case managers and outreach workers – there is an enormous amount of care coordination that occurs when agencies work together to engage individuals in treatment. Currently agencies do not have the resources to expand their workforce. While

current efforts have been successful, it is not a sustainable practice without added resources.

3) Complex entry system into treatment – the entry process could be more efficient. Multiple agencies have started exploring the possibility of developing a more streamlined process that involves all substance use treatment facilities; however, more resources and supports are needed to develop a universal screening form, increase communication systems, and increase capacity to share records within the current electronic system.
4) Safety issues – when working with vulnerable populations, care coordinators/outreach workers are at risk of encountering unsafe conditions. Many substance using individuals have been marked by trauma, violence, and mental health problems. Untreated individuals need to be approached with caution. More training and protective services are needed to create the most possible safe environment for care coordinators/outreach workers and consumers.

In last year's report, several variables were identified that could impact Hawai'i's coordinated entry implementation. With the implementation of coordinated entry over the past year, it has been observed that agencies are motivated to coordinate with each other, to promote the standardization of a screening tool and referral process, and to improve identification of individuals needing treatment. It has also been observed and reported that there is a great need to expand current efforts, increase resources, and further develop processes in communication and coordination. There are many communities that are interested in expanding and acquiring these services, including neighbor islands. Through a coordinated entry system, communities have capitalized on the opportunity to bring services directly to people who otherwise might not seek out services and to connect them to necessary supports.

As Hawai'i's coordinated entry approach is being developed in a particular community, the successful elements must be shared with other communities, as well as, other states. Curricula should be adopted or developed to teach staff essential skills, such as open communication, ethics, cultural competency, mental health first aid, staff care, strength based and person-centered approaches, recognizing patterns of interaction, and accessing coordinated entry. Supplemental training on preferred or best practices in case management and on using data is also recommended. Creatively resolving funding issues will be a priority. It's important to promote clear messages about the benefits of coordinated approaches and what various resources are available. Inclusiveness is the most important aspect because coordinated entry is not a fixed success, it is an evolving provision of multiple services. As part of the planning, recognize that what will be the most challenging is developing data sharing parameters that can navigate different provider experiences. The goal, however, is worth the challenge to develop systems that produce good outcomes for individuals and families. In addition, a key secondary outcome will be that providers and stakeholders develop and share best practices as well as "how-to's" based on community experiences.

HACDACS recommends expansion of coordinated entry services and staff to develop a universal screening form, provide twenty-four-hour screening (i.e., substance use disorder 911), triage, resource matching, and referral which will simplify the referral process for providers, encourage providers to utilize a streamlined system, and provide providers access to a network of care based on need.

HACDACS recommends expansion of safety measures and procedures to ensure the safety of care coordination/outreach workers, as well as, consumers.

HACDACS recommends increase the capacity for stabilization beds by collaborating with shelters and other services that can keep individuals engaged throughout the coordinated entry process.

HACDACS recommends continued implementation of the integration and training of SBIRT within hospital systems to support providers in conducting universal screening and utilization of a coordinated entry system to make referrals to treatment services.

HACDACS recommends the maximization of available funding in order to better coordinate resources.

HACDACS recommends establishing a communication system to identify openings for stabilization beds and treatment beds.

Public Health-Public Safety Partnerships

Public health and public safety partnerships are forming across Hawaii to more effectively address homelessness, substance abuse and mental illness in a collaborative approach. This theme is reflected in the Hawaii Opioid Initiative's goals and objectives, the overwhelming support for Law Enforcement Assisted Diversion (LEAD) pilot in the legislature, and through the creation of community/law enforcement partnerships such as Health, Efficiency & Long-term Partnerships (HELP) Honolulu and the Crisis Intervention Training (CIT) efforts underway in Maui and soon to be implemented in Honolulu. HACDACS strongly supports this balanced approach to complex social issues as evidence indicates the cycle of incarceration is not effective at resolving substance use disorder or mental health challenges.

According to the Honolulu Police Department, more than forty percent (40%) of those arrested in 2017 were homeless, and more than sixty percent (60%) had substance abuse and/or mental illness which contributed to their offenses. In 2018, the Honolulu Police Department (HPD) launched the Community Outreach Division, which will include HELP Honolulu, LEAD, CIT and other community collaborations to support the diversion of people with behavioral health issues to health and social services instead of jail and/or prison. HACDACS received a presentation on both LEAD and HELP Honolulu from HPD in 2018 and recommends the continuation and expansion of these efforts.

HELP Honolulu
HELP Honolulu partners plain-clothes police officers with outreach workers in Honolulu to give officers more tools and resources to link people to services as well as to provide safety for outreach workers conducting night and other outreach efforts. HELP Honolulu started with outreach worker focusing on those experiencing homelessness with monthly night outreach efforts scheduled in Chinatown and Waikiki. In addition to partnering officers with outreach workers so they can learn from each other, the HELP outreach efforts also have a "hub" that provides food and linkage to other services, transportation to shelters and the identification of available shelter beds prior to outreach. More recently, substance abuse treatment providers and the Hawaii Substance Abuse Coalition has joined the effort and agencies such as Hina Mauka and Salvation Army Detox has saved beds for the HELP outreach efforts so that people who are interested in treatment identified during the outreach effort can be directly linked to the available

bed if clinically appropriate. This has been very successful and linking the SBIRT/Coordinated Entry for Substance Abuse Treatment to the HELP outreach efforts.

In 2018, HELP Honolulu has:

- Identified 363 homeless individuals;
- Conducted 1070 meaningful interactions;
- Supported 154 in getting shelter; and
- Linked ten (10) individuals directly to either detox or residential substance abuse beds.

Law Enforcement Assisted Diversion (LEAD)
LEAD is a nationally recognized promising best practice diversion program, primarily used for those charged with low-level offences. Individuals arrested for eligible offenses, such as low-level drug offenses and prostitution, can be referred to LEAD. Individuals with certain violent offenses in criminal history are not eligible for the program. The program allows law enforcement officers to exercise discretion in redirecting these offenders towards social services, rather than jail and prosecution. Instead of falling into the normal criminal justice cycle, those participating in LEAD programs are referred into intensive case-management programs where they can receive various support services, including housing, healthcare, job training, and substance abuse treatment. LEAD has been conclusively shown to cut down recidivism rates for participants. Participants were 58% less likely to be arrested after enrollment in the LEAD program In mid-2016, Hawaii Health and Harm Reduction Center convened the LEAD Hui, a group of more than thirty agencies including substance abuse treatment providers, homeless providers, and mental health service providers. The Honolulu LEAD pilot began in Chinatown in mid-2018 and will have its first evaluation available by the end of 2018 and involves both HPD and the State Sheriffs from the Department of Public Safety.

In 2018, LEAD has:

- Enrolled thirty-eight (38) participants with twenty-six (26) active in case management (14 have treatment plans);
- Four (4) completed residential substance abuse treatment;
- Ten (10) were linked to shelter; and
- Twelve (12) were supported with document readiness, bus passes, Supplemental Nutrition Assistance Program (SNAP) and food assistance and legal services.

In May 2018, the Hawaii Legislature allocated $400,000 for LEAD pilots on Maui and Hawaii Island, and initial meetings have commenced to support these pilots and link the evaluation of the Honolulu pilot with evaluation of the Neighbor Island LEAD projects. The Honolulu LEAD program is now part of the base funding for ADAD.

Additional Collaborations
Additional partnerships discussed by HACDACs include the Community Outreach Court and the Adult Mental Health Division (AMHD) Jail Diversion program. The Community Outreach Court is in Honolulu and is a partnership between the Honolulu Prosecutor's Office, the Public Defender and the Judiciary and allows people who are homeless to consolidate and get rid of homeless-related warrants and cases through community service. The AMHD program works with people who have multiple encounters with law enforcement that result in an MH1

(involuntary hold and assessment) to divert people to the Institute for Human Services for intensive case management instead of jail or the hospital. HACDACs strongly recommends the continued support and evaluation of these public health – public safety partnerships.

HACDACS recommends continued support of the LEAD pilot in Chinatown on Oahu, the additional pilots in the Counties of Maui and Hawai'i as well as an appropriation of funding for to the County ofKauai for low-level drug offenders and other low-level offenders.

HACDACS recommends that felony personal use drug possession offenses (HRS §712-1243 & §712-1246) be included as eligible offenses for LEAD participation.

HACDACS recommends integration of all DOH-funded substance abuse prevention and treatment providers into appropriate public health – public safety projects such as HELP Honolulu, CIT and other jail diversion projects.

Medical Cannabis

At the March 27, 2018 HACDACS meeting, two informative presentations on medical cannabis were given.[5] The first was by Tamara Whitney, a Program Specialist with Department of Health (DOH), Harm Reduction Services Branch and the second was by Wendy Gibson, RN, field organizer for the Drug Policy Forum of Hawai'i and the Medical Cannabis Coalition of Hawai'i. Ms. Whitney, who oversees the medical cannabis patient registry, focused on the mechanics and objectives of the program. Ms. Gibson addressed the history and pharmacology of cannabis as a medicine.[6]

1) The Department of Health's Medical Cannabis Program

Cannabis has long been used in health care, with reports of its use dating back thousands of years in among places China, India and Egypt.[7] In 2000, Hawai'i became the first state to legalize medical cannabis via a state legislature, occurring just a few years after California and Oregon did so via statewide referenda.

a) The Medical Cannabis Registry Program

After being housed in the Department of Public Safety and administered by the state Narcotics Enforcement Division since its inception, the medical cannabis registry was transferred to the Department of Health in 2015. The Medical Cannabis Registry Program is currently being administered by the Harm Reduction Services Branch in the Department of Health. Since that time, Hawai'i has added several new medical conditions for which a

[5] NOTE: Cannabis ("marijuana") remains a Schedule I controlled substance under both state and federal law. While it has not taken any action versus Hawai'i or any other state with legal medical cannabis, the federal government reserves the right to do so.

[6] Pursuant to Act 170 (Session Laws of 2017), "medical cannabis" is the official term, replacing "medical marijuana." All Hawai'i Revised Statutes (HRS) references have been updated, Hawai'i Administrative Rules (HAR) are being updated currently, most DOH printed and electronic references are now to "medical cannabis."

[7] In a 2017 comprehensive summary of the findings in over 10,000 peer-reviewed studies, the National Academies of Science, Medicine and Engineering found considerable evidence to back this proposition. http://nationalacademies.org/hmd/Reports/2017/health-effects-of-cannabis-and-cannabinoids.aspx

person can be treated with medical cannabis. New qualifying conditions have been added by the legislature and through the DOH's petition process.

Figure 2. Number of Registered Patients, Their Caregivers and Physician/Advanced Practice Registered Nurses.

Registered Patient Totals	
23,468	Patients have a valid medical cannabis registration.
Caregiver Totals	
1,723	Caregivers are caring for registered patients.
Physician/Advanced Practice Registered Nurse (APRN) Totals	
148	Physician's/APRN have recommended/certified medical cannabis for one or more patients.
223	Physician's/APRN's are registered to recommend/certify patients in Hawaii

Demographic Information

Table 1. Registered Patients by Age and Gender.

Gender	Average Age	Percentage on Registry
Male	50.4	61.32%
Female	50.6	38.63%
Transgender*	48.6	0.06%

***Transgender includes both Male to Female and Female to Male.

Table 2. Frequency of Conditions.

Reported Condition	Number of Patients Reporting Condition	Percentage of Patients Reporting Condition**
Severe Pain	20,026	85.33%
Persistent Muscle Spasms	3,118	13.29%
PTSD***	2,800	11.93%
Malignant Neoplasm (Cancer)	1,552	6.61%
Severe Nausea	1,492	6.36%
Cachexia/Wasting Syndrome	473	2.02%
Glaucoma	437	1.86%
Seizures	331	1.41%
Rheumatoid Arthritis****	285	1.21%
HIV or AIDS	156	0.66%
Epilepsy****	98	0.42%
Lupus****	63	0.27%
Multiple Sclerosis****	48	0.20%
ALS******	NA*	0.00%

* ALS data is not reportable; *
** Does not add to 100% as some patients report more than one debilitating condition.
*** Added via Act 241 (Session Laws of 2015).
**** Added via Act 041 (Session Laws of 2017).
***** Added via DOH's Petition Process in 2017 (in accordance with HAR 11-160-7).

Table 3. Registered Patient Total and the Top 3 Reported Conditions by Age.

Age Group	Patient Total and Percentage by Age	1st Reported Condition	2nd Reported Condition	3rd Reported Condition
0-10	17 (0.07)	Seizures (12)	* Epilepsy	*Malignant Neoplasm (Cancer) & *Persistent Muscle Spasms
11-17	24 (0.10)	Seizures (9)	PTSD (6)	*Severe Pain
18-25	1,151 (4.90)	Severe Pain (839)	PTSD (271)	Persistent Muscle Spasms (118)
26-35	3,857 (16.44)	Severe Pain (3,236)	PTSD (659)	Persistent Muscle Spasms (468)
36-45	4,333 (18.46)	Severe Pain (3,761)	PTSD (633)	Persistent Muscle Spasms (581)
46-55	3,940 (16.79)	Severe Pain (3,418)	Persistent Muscle Spasms (552)	PTSD (435)
56-65	5,407 (23.04)	Severe Pain (4,770)	Persistent Muscle Spasms (780)	Malignant Neoplasm (Cancer) (469)
66-75	4,026 (17.16)	Severe Pain (3,430)	Persistent Muscle Spasms (544)	Malignant Neoplasm (Cancer) (521)
76 and Older	713 (3.04)	Severe Pain (567)	Malignant Neoplasm (Cancer) (148)	Persistent Muscle Spasms (70)

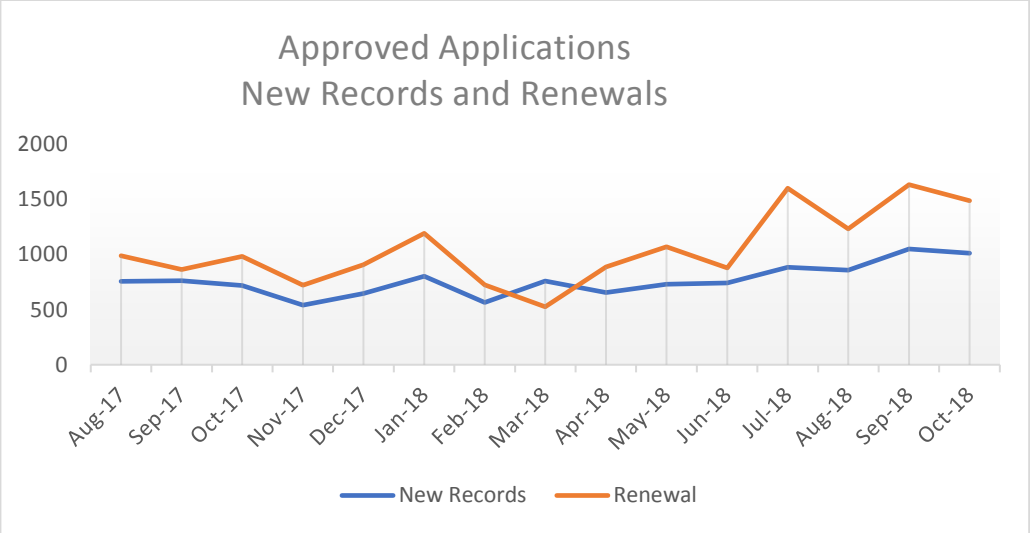
*Patient count is not reportable

Table 4. Registered Patients, Caregivers, and Top 3 Reported Conditions by County.

County	Number of Patients	Number of Caregivers	1st Reported Condition	2nd Reported Condition	3rd Reported Condition
Oahu	9,488	782	Severe Pain (7,737)	PTSD (1,535)	Malignant Neoplasm (Cancer) (813)
Maui	*5,275	405	Severe Pain (4,579)	PTSD (623)	Persistent Muscle Spasms (577)
Hawaii	6,727	388	Severe Pain (5,962)	Persistent Muscle Spasms (1,852)	PTSD (518)
Kauai	1,977	148	Severe Pain (1,748)	Severe Nausea (205)	Persistent Muscle Spasms (164)

*Patient registered using an out of state address is not included in the count.

Figure 3. Number of Approved Applications: New Records and Renewals, Aug. 2017 – Oct. 2018.



On January 1, 2015 when DOH took over the registry responsibilities there were 11,402 patients. By October 2018, the number had risen to 23,468 unique patients listed.[8] This number has steadily increased over the course of the last few years at a rate of 3-4% per month. Following an initial in person medical examination by a physician or an advance practice registered nurse (APRN), a patient can become certified for the use of medical cannabis given 1) the physician/APRN has diagnosed the patient as having one or more of the qualifying debilitating medical conditions approved under state law, 2) the physician/APRN has explained the potential risks and benefits of medical cannabis use, and 3) the physician/APRN maintains a bona fide relationship with their qualifying patient. The qualifying patient may then submit an online application to the department and can expect to wait a couple of days to a few weeks for a completed application to be processed.[9] Current DOH policy, based on interpretation of state law, is that a patient must have their physical medical cannabis registry card in hand in order to legally grow, purchase, possess or use medical cannabis. The same applies for a registered caregiver who grows medical cannabis or otherwise assists a registered patient.

b) The Medical Cannabis Dispensary Program

Patients and their caregivers currently have two options for securing their access to medical cannabis. One is to grow it oneself, or to have a caregiver do so for them. The other is purchase medical cannabis from one of six medical cannabis dispensaries operating in Hawai'i. Dispensaries are currently open on Oahu (3), Maui (2), and Kauai (1); the two Hawai'i Island dispensaries are progressing toward becoming operational. The Medical Cannabis Dispensary Licensing Program is also overseen by DOH, currently by the Office of Health Care Assurance.[10]

[8] https://health.hawaii.gov/medicalcannabisregistry/files/2018/11/2018-October-23468-Valid-posted-11.15.18.pdf.
[9] The wait time was 6 days on 10/21/18, see http://health.hawaii.gov/medicalcannabis/.
[10] See Act 159 below for information on the ongoing consolidation of both medical cannabis programs.

2) Medical Cannabis and the Opioid Epidemic

The Hawai'i Opioid Initiative – a Statewide Response was launched in December 2017.[11] It does not mention medical cannabis. Yet medical cannabis can have a role to play in combating the opioid epidemic, and it is likely already doing so. Data from the mainland shows that both opioid overdose death rates and opioid prescriptions have decreased in states with regulated cannabis available from dispensaries.[12] While further research is needed to establish correlations, the data is promising. This prevention and front-end use of medical cannabis as a substitute or complement to opioids is not to be confused with the use of medical cannabis to treat substance use disorders (including opioids) or associated symptoms. The research in this area is far less developed, but there are promising signs here as well.[13] In 2017 & 2018, New Jersey, New York and Pennsylvania added opioid use disorder as a qualifying condition for medical cannabis use. Following suit, the Hawai'i State Legislature sent to the Governor Senate Bill 2407. The measure added opioid use disorder (opioid addiction), substance use disorder (substance abuse), or withdrawal symptoms resulting from the treatment of these conditions as a qualifying condition for the medical use of cannabis. The bill was vetoed by the Governor who pointed to the existence of a petition process run by DOH as the more appropriate vehicle for adding new conditions.[14]

Act 116 (Session Laws of 2018)
The broad omnibus bill (HB2729, HD2, SD2, CD1) included numerous provisions to improve the medical cannabis program, including the use of telehealth to maintain the health care professional-patient relationship, an extension of certifications for up to three years, the authorization for sale of pulmonary devices and single use cartridges at dispensaries and guidelines for out-of-state patients' use of medical cannabis.[15] Further, a working group has been convened to explore a) adding employment protections for medical cannabis patients and b) authorize the sale of edible medical cannabis products at dispensaries. Together, these provisions aim to benefit both Hawai'i resident patients, and as of early 2019 (projected), out of state patients visiting Hawai'i.

Act 159 (Session Laws of 2018)
This law consolidates the two DOH medical cannabis programs (Registry and Dispensary) into one office, the Office of Medical Cannabis Control and Regulation. Aside from existing responsibilities, with new dispensaries opening and out of state patients becoming eligible to use them, this office will play an increasingly important role.

[11] https://www.hawaiiopioid.org/the-plan/
[12] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2676999?redirect=true (decreased opioid prescription rates for Medicare Part D patients); https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2677000 (decreased opioid prescription rate for Medicaid patients); https://www.rand.org/pubs/external_publications/EP67480.html (decreased admissions to addiction programs and decreased death rates).
[13] https://www.liebertpub.com/doi/pdf/10.1089/can.2018.0022 ("The compelling nature of these data and the relative safety profile of cannabis warrant further exploration of cannabis as an adjunct or alternative treatment for [opioid use disorder].")
[14] The reason for the veto was a preference expressed for DOH's existing petition process to add qualifying conditions, see https://www.capitol.hawaii.gov/session2018/bills/GM1254_.PDF.
[15] DOH is currently updating the Hawai'i Administrative Rules, Chapter 11-160, to reflect some of these changes.

Act 161 (Session Laws of 2018)
This act establishes the Medical Cannabis Insurance Reimbursement Working Group to address the complexities surrounding the topic of making medical cannabis reimbursable by health insurance. In order to make medical cannabis as affordable an alternative as possible. The group explores reimbursement via health insurance and workers' compensation.

HACDACS recommends that the Legislature continue to support the nascent Office of Medical Cannabis Control and Regulation in order to ensure that Hawai'i medical cannabis patients and Hawai'i dispensaries are properly served. With the advent of out-of-state patients to Hawai'i, it is imperative that both the patient registration process and dispensary operations function safely and smoothly.

HACDACS recommends that DOH, as required by HRS §329D-26, conduct more public education, including for substance use treatment providers, regarding the use of medical cannabis, and if necessary, that the Legislature appropriate funds to this effect.

HACDACS recommends that the Legislature continue to pursue solutions, including adopting related legislation, to the employment discrimination, edible medical cannabis and insurance reimbursement issues discussed in the working groups established by Acts 116 and 161 (Session Laws of 2018).

HACDACS recommends that the Hawai'i Opioid Initiative include medical cannabis as part of the action plan going forward. The nature and extent of this should be determined by DOH and its partner stakeholders.

REPORT PURSUANT TO
SECTION 10 OF ACT 161, SESSION LAWS OF HAWAII 2002,
ON THE IMPLEMENTATION OF SECTION 321-193.5, HAWAII REVISED STATUTES

Act 161, SLH 2002, was enacted "to require first time non-violent drug offenders, including probation and parole violators, to be sentenced to undergo and complete drug treatment instead of incarceration." Section 2* of the Act specifies that:

> The Department of Public Safety, Hawaii Paroling Authority, Judiciary, Department of Health, Department of Human Services, and any other agencies assigned oversight responsibilities for offender substance abuse treatment by law or administrative order, shall establish a coordinating body through an interagency cooperative agreement to oversee the development and implementation of offender substance abuse treatment programs in the State to ensure compliance with the intent of the master plan developed under Chapter 353G, HRS.

Section 10 of Act 161, SLH 2002, specifies that:

> The Department of Health shall submit an annual report to the Legislature before the convening of each Regular Session, beginning with the Regular Session of 2004, on the status and progress of the interagency cooperative agreement required under Section 2 of this Act and the effectiveness of the delivery of services thereto, and expenditures made under this Act.

It should be noted that there are caveats to Act 161, SLH 2002, implementation. There is no mention of a "master plan" in Chapter 353G** as cited in Section 2 of Act 161, SLH 2002; and no funds were appropriated in Act 161. The interagency initiative to implement offender substance abuse treatment services, however, has been an on-going collaborative activity.

The following tables indicate the number of offenders served, criminal justice agency referral source and the geographic distribution of the offenders served. The Alcohol and Drug Abuse Division (ADAD) has contracts with ten (10) out of the twenty-six (26) substance abuse treatment agencies that provide services statewide.

During Fiscal year 2017-18, 801 offenders were referred by criminal justice agencies for substance abuse treatment, case management and clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Of the 1,242 offenders who received services, 140 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2017-18 is as follows:

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* Codified as §321-193.5, Hawaii Revised Statutes.

** Act 152, SLH 1998, Criminal Offender Treatment Act.

Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2017 – June 30, 2018

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu	150	572	54	114	**890**
Maui	31	158	0	49	**238**
Hawaii	0	114	0	0	**114**
Total	**181**	**844**	**54**	**163**	**1,242**
Case management services providers: CARE Hawaii, Institute for Human Services, The Salvation Army—Addiction Treatment Services, Hina Mauka, Ka Hale Pomaikaʻi, Ohana Makamae					

Referrals by Criminal Justice Agency: July 1, 2017 – June 30, 2018

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu[1]	4	350	45	110	**509**
Maui[2]	25	126	0	48	**199**
Hawaii[3]	0	93	0	0	**93**
Total	**29**	**569**	**45**	**158**	**801**

Carryover Cases by Criminal Justice Agency: July 1, 2016 – June 30, 2017

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Oahu	0	76	0	4	**80**
Maui	5	33	0	1	**39**
Hawaii	0	21	0	0	**21**
Total	**5**	**130**	**0**	**5**	**140**
Case management services providers: CARE Hawaii, Institute for Human Services, The Salvation Army—Addiction Treatment Services, Ohana Makamae					

Recidivism. The major outcome for services to offenders is recidivism, or the proportion of offenders who have been rearrested. The Interagency Council on Intermediate Sanctions (ICIS) 2017 Recidivism Update (dated June 2018) for the Fiscal Year 2014 cohort reports that the overall recidivism rate is 47.3% for probation, parole and Department of Public Safety (PSD) maximum-term released prisoners. (ICIS defines recidivism as criminal rearrests, criminal contempt of court and revocations/violations.) The data reveal a 41.4% recidivism rate for probationers; a 53.3% recidivism rate for offenders released to parole; and a 66.0% recidivism rate for offenders released from prison (maximum-term release).

The 45.1% recidivism rate for FY 2014 probationers and parolees was slightly higher than the previous year's rate of 48.6%. The FY 2014 recidivism rate is 18.2% lower than the recidivism rate reported in the FY 1999 baseline year, but remains short of the primary goal of reducing recidivism in Hawaii by 30%. Felony probationers in the FY 2014 cohort had a 41.4% recidivism rate, which is 4.1 percentage points lower than the recidivism rate for the previous year's cohort, but indicates only a 15.9% decline in recidivism since the baseline year. Parolees in the FY 2014 cohort had a 53.3% recidivism rate, which is 2.8 percentage points lower than the previous year's rate, and signifies a 19.6% decline in recidivism from the baseline year. The recidivism rate for maximum-term released prisoners declined from 76.1% for the FY 2005 cohort to 63.4% for the FY 2014 cohort. The FY 2014 recidivism rate was 4.1 percentage points higher than the previous year's (FY 2013) recidivism rate. Additionally, probationers had the highest recidivism rates in the entire FY 2014 offender cohort for criminal reconvictions (35.4%), while maximum-term released prisoners had the highest recidivism rate in the entire FY 2014 offender cohort for criminal rearrests (48.5%).

The table below summarizes data for clients (i.e., non-violent offenders) from various segments of the overall offender population who are referred and are provided substance abuse treatment and case management services. It should be noted that clients who are referred for services may also drop out before or after admission.

Recidivism by Criminal Justice Agency: July 1, 2017 – June 30, 2018

	Supervised Release PSD/ISC	**Judiciary Adult Client Services**	**PSD/ISC - Corrections Jail/Prison**	**Hawaii Paroling Authority**	**Total**
Arrests/revocations	7	157	0	21	**185**
Total served	28	339	0	56	**423**
Recidivism rate	**25%**	**46%**	**0%**	**38%**	**44%**

REPORT PURSUANT TO
SECTION 29 OF ACT 40, SESSION LAWS OF HAWAII 2004,
REQUIRING A PROGRESS REPORT ON THE SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM

Section 29 of Act 40, SLH 2004, requires that the Department of Health submit a progress report on the Substance Abuse Treatment Monitoring Program.* The Substance Abuse Treatment Monitoring Program requires the Department of Health, the Office of Youth Services, the Department of Public Safety and the Judiciary to collect data from private providers of substance abuse treatment services that receive public funds and state agencies that provide direct treatment services. Treatment providers are required to report admission and discharge data, as determined by the Department of Health.

During the Fiscal Year 2005-06, site visits to substance abuse treatment provider agencies were conducted to assess contractors' data collection procedures. During Fiscal Year 2006-07, activities of the interagency group included: training State agencies' staff on admission, discharge and follow-up data collection; making adjustments to accommodate criminal justice agencies' data needs; training for substance abuse treatment providers; and assistance in installing software onto providers' computers and providing "hands-on" training.

Throughout Fiscal Year 2007-08, progress in data entry included orientation and training of providers' staff in the Web-based Infrastructure for Treatment Services (WITS) system. During Fiscal Year 2008-09, agencies were to have strengthened communication and collaboration for data collection, however, challenges in staff recruitment and retention stymied continuity in program implementation. Similarly, during Fiscal Years 2009-10 and 2010-11, restrictions on hiring, the reduction in force which deleted one of the three positions, and furloughing of staff exacerbated progress in program implementation.

Act 164, SLH 2011, converted two positions, Information Technology Specialist (ITS) IV and Program Specialist - Substance Abuse (PSSA) IV, from temporary to permanent. The ITS IV position was filled on June 18, 2014. The PSSA IV position was reclassified into a Program Specialist VI position and was filled on April 1, 2016. The position supervises the Division Planning, Evaluation, Research and Data (PERD) Office that is responsible for strategic planning; organizational development; program development and evaluation; policy research and development; coordination and development of the Division's legislative responses, reports, and testimonies; and management of the Division's data systems.

Since Fiscal Year 2008-09, WITS has been used as a data collection and billing system for all ADAD contracted substance abuse treatment providers. The data collected was used to annually report admission and discharge information to the Legislature. While WITS has always had the capability to collect substance abuse treatment information about all clients served by its contracted providers, only clients whose services were paid through ADAD contracts were reported. In Fiscal Year 2011-12, some of ADAD contracted providers began collecting

* Established under Part III (Sections 23-28) of Act 40, SLH 2004.

information from the Judiciary, followed in Fiscal Year 2013-14 with the Hawaii Paroling Authority; and in Fiscal Year 2015-16, the Department of Public Safety. ADAD continues to strengthen collaboration with the Office of Youth Services, the Department of Public Safety and the Judiciary to use WITS as their substance abuse treatment data collecting and monitoring system.

APPENDICES

A. ADAD-Funded Adult Services: Fiscal Years 2015-18

B. ADAD-Funded Adolescent Services: Fiscal Years 2015-18

C. Performance Outcomes: Fiscal Years 2015-18

D. 2004 Estimated Need for Adult Alcohol and Drug Abuse Treatment in Hawaii

E. 2007-08 Hawaii Student Alcohol, Tobacco and Other Drug Use Study (Grades 6-12)

F. Methamphetamine Admissions: 2008-18

APPENDIX A

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2015-2018

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Male	71.0%	66.1%	67.4%	66.5%
Female	29.0%	33.9%	32.6%	33.5%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Hawaiian	44.6%	43.8%	44.7%	44.5%
Caucasian	24.2%	22.5%	23.0%	20.9%
Filipino	7.3%	8.0%	8.4%	7.9%
Mixed - Not Hawaiian	1.8%	3.0%	2.6%	2.1%
Japanese	4.6%	4.5%	3.9%	5.0%
Black	3.0%	4.0%	2.8%	3.2%
Samoan	2.5%	3.4%	3.1%	2.1%
Portuguese	1.3%	1.3%	1.2%	1.5%
Other Pacific Islander	6.4%	6.3%	3.3%	3.9%
Other*	4.3%	3.2%	7.1%	9.0%
TOTAL	100.0%	100.0%	100.0%	100%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Methamphetamine	51.5%	50.5%	53.4%	54.7%
Alcohol	22.9%	22.2%	20.0%	16.8%
Marijuana	14.1%	13.8%	12.4%	10.9%
Cocaine/Crack	2.7%	2.6%	1.6%	3.3%
Heroin	3.9%	5.3%	6.4%	7.4%
Other*	4.9%	5.6%	6.2%	6.9%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.				

ADAD-FUNDED ADULT ADMISSIONS BY RESIDENCY

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Oahu	65.4%	67.0%	65.6%	64.7%
Hawaii	17.8%	16.4%	18.1%	17.5%
Maui	9.6%	10.2%	11.5%	11.2%
Molokai/Lanai	2.3%	1.9%	1.8%	1.7%
Kauai	3.7%	3.1%	1.6%	2.9%
Out of State	1.2%	1.4%	1.4%	2.0%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2014-15 through Fiscal Year 2017-18, methamphetamine use increased from 51.5% to 54.7%. Alcohol use decreased from 22.9% to 16.8%, and marijuana use decreased from 14.1% to 10.9%. Cocaine/Crack use increased slightly from 2.7% to 3.3%. Heroin use increased from 3.9% to 7.4% while all "Other" substances increased from 4.9% to 6.9%.

Also, among the 3,210 adult admissions for FY2018, 895 admissions (27.9%) were homeless when admitted to treatment.

APPENDIX B

ADAD-FUNDED ADOLESCENT[16] SERVICES FISCAL YEARS 2015-2018

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2014-15	FY 2015-	FY 2016-2017	FY 2017-2018
Male	52.3%	52.7%	53.4%	51.4%
Female	47.7%	47.3%	46.6%	48.6%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Hawaiian	43.7%	46.0%	42.6%	44.7%
Caucasian	10.8%	10.8%	10.2%	7.8%
Filipino	12.2%	11.4%	10.5%	10.7%
Mixed - Not Hawaiian	1.7%	1.3%	1.9%	3.6%
Japanese	3.2%	3.6%	3.7%	4.4%
Black	2.6%	3.0%	2.9%	2.1%
Samoan	4.3%	4.3%	4.0%	4.0%
Portuguese	0.9%	0.4%	0.8%	0.9%
Other Pacific Islander	16.3%	15.3%	14.0%	15.2%
Other*	4.3%	3.9%	9.5%	6.5%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other ethnicity includes: (1) other (not specified), (2) other Asian and (3) unknown.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Methamphetamine	0.7%	0.6%	1.1%	1.0%
Alcohol	24.7%	21.5%	22.8%	22.2%
Marijuana	63.5%	66.8%	62.6%	61.6%
Cocaine/Crack	0.1%	0.3%	0.3%	0.3%
Heroin	0.1%	-0-	-0-	-0-
Other	10.9%	10.8%	13.2%	15.0%
TOTAL	100.0%	100.0%	100.0%	100.0%
*Other substances include: (1) other (not specified), (2) other hallucinogens, (3) other stimulants, (4) other opiates/synthetics, (5) other amphetamines, (6) benzodiazepines, (7) none and (8) over-the-counter.				

ADAD-FUNDED ADOLESCENT ADMISSIONS BY RESIDENCY

	FY 2014-15	FY 2015-2016	FY 2016-2017	FY 2017-2018
Oahu	64.4%	61.9%	60.0%	66.4%
Hawaii	11.8%	13.1%	12.8%	13.6%
Maui	15.5%	16.0%	18.7%	11.5%
Molokai/Lanai	2.0%	1.9%	0.6%	0.1%
Kauai	6.3%	7.1%	8.0%	8.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2014-15 through Fiscal Year 2017-18, methamphetamine use increased slightly from 0.7% to 1.0%. Alcohol use decreased from 24.7% to 22.2%, while marijuana used decreased slightly from 63.5% to 61.6%. Cocaine/Crack use increased slightly, from 0.1% to 0.3%. Heroin use decreased slightly from 0.1% to 0%, while use of "Other" substances increased from 10.9% to 15.0%.

[16] Adolescent: Grades 6 through 12

Community profiles by the State Epidemiological Outcomes Workgroup (SEOW) and the results of Student Health Surveys administered in 2013, 2015 and 2017 are consistent with the ADAD-Funded Adolescent Treatment Admissions by primary substance in that Alcohol and Marijuana are the primary substances of choice for use by person in Hawaii, ages 12-25. Community-based programs report similar trends based on qualitative data informally gathered at the local community level and therefore, are directing prevention education and strategies and social norm activities to younger ages and families as well as youth ages 12-17 and young adults.

APPENDIX C

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2015 through 2018, six-month follow-ups were completed for samples of adolescents discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Employment/School/Vocational Training	97.9%	98.1%	97.4%	98.8%
No arrests since discharge	95.2%	93.5%	93.8%	93.4%
No substance use in 30 days prior to follow-up	64.3%	57.9%	53.8%	59.4%
No new substance abuse treatment	86.2%	77.1%	80.3%	85.5%
No hospitalizations	96.8%	95.4%	95.2%	95.5%
No emergency room visits	95.4%	93.5%	93.5%	92.1%
No psychological distress since discharge	85.6%	88.2%	84.8%	78.9%
Stable living arrangements*	98.7%	97.7%	97.8%	99.0%

**defined as client indicating living arrangements as "not homeless"*

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2015 through 2018, six-month follow-ups were completed for samples of adults discharged from treatment. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOMES ACHIEVED			
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Employment/School/Vocational Training	57.8%	58.7%	58.6%	58.2%
No arrests since discharge	91.3%	94.0%	92.9%	92.7%
No substance use in 30 days prior to follow-up	72.7%	60.3%	61.0%	56.6%
No new substance abuse treatment	71.0%	64.5%	61.8%	55.0%
No hospitalizations	94.3%	94.4%	90.9%	91.0%
No emergency room visits	86.9%	87.3%	86.2%	85.6%
Participated in self-help group (NA, AA, etc.)	47.7%	42.6%	36.5%	36.0%
No psychological distress since discharge	80.7%	71.7%	67.4%	63.7%
Stable living arrangements*	78.5%	79.6%	77.5%	76.1%

**defined as client indicating living arrangements as "not homeless"*

APPENDIX D

2004 ESTIMATED NEED*
FOR ADULT ALCOHOL AND DRUG ABUSE
TREATMENT IN HAWAII

ESTIMATE OF DEPENDENCE AND ABUSE (NEEDING TREATMENT)					
	COUNTY				
	HONOLULU	MAUI	KAUAI	HAWAII	TOTAL
Population (18 Years and Over)	628,853	98,042	47,346	102,849	877,090
NEEDING TREATMENT					
Alcohol Only	57,228	8,935	8,121	7,094	81,377
Drugs Only	10,070	1,981	1,573	1,562	15,186
Alcohol and/or Drugs	59,459	9,699	8,121	8,189	85,468

Findings of the State of Hawaii 2004 Treatment Needs Assessment* revealed that of the state's total 877,090 adult population over the age of 18, a total of 85,468 (9.74%) are in need of treatment for alcohol and/or other drugs. Comparable figures by county are as follows:

For the *City and County of Honolulu*, 59,459 (9.46%) of the total 628,853 adults on Oahu are in need of treatment for alcohol and/or other drugs.

For *Maui County*, 9,699 (9.89%) of the 98,042 adults on Maui, Lanai and Molokai are in need of treatment for alcohol and/or other drugs.

For *Kauai County*, 8,121 (17.15%) of the total 47,346 adults on Kauai are in need of treatment for alcohol and/or other drugs.**

For *Hawaii County*, 8,189 (7.96%) of the total 102,849 adults on the Big Island are in need of treatment for alcohol and/or other drugs.

The five-year (Fiscal Year 2014 to Fiscal Year 2018) average annual ADAD-funded admissions for adults is 2,970, which is 3.6% of the estimated need for adult alcohol and drug abuse treatment.

* "State of Hawaii 2004 Treatment Needs Assessment," Department of Health, Alcohol and Drug Abuse Division, 2007.
** The 2004 Kauai County data present a unique pattern of use, abuse and dependence that makes the data difficult to analyze and compare to other counties within the State. The results of the Kauai County data need to be further investigated in order to reconfirm the accuracy of the information. Other statewide studies may also provide information on the county drug/alcohol problem. One data source, the Department of Health's 2007 Behavioral Risk Factor Surveillance System (BRFSS) data, provides county data on alcohol which are comparable.

APPENDIX E

2007-08 ESTIMATED NEED* FOR ADOLESCENT (GRADES 6-12) ALCOHOL AND DRUG ABUSE TREATMENT IN HAWAII

Diagnosis for Abuse or Dependence of any Substance, Based on DSM-IV Criteria, for Gender, Grade Level, and Ethnicity (weighted percents)					
	No		Yes		Total
	n	%	n	%	
Overall Total	5,753	92.3	553	7.7	6,306
Gender					
Male	2,478	93.2	210	6.8	2,688
Female	3,023	91.7	316	8.3	3,339
Grade					
6th Grade	1,807	98.4	33	1.6	1,840
8th Grade	1,555	95.2	88	4.8	1,643
10th Grade	1,150	89.5	150	10.5	1,300
12th Grade	1,241	82.2	282	17.8	1,523
Ethnicity					
Japanese	778	94.6	49	5.4	827
Caucasian	1,040	88.5	153	11.5	1,193
Filipino	1,451	95.3	89	4.7	1,540
Native Hawaiian	999	88.9	132	11.1	1,131
Other Asian	426	96.4	17	3.6	443
Other Pacific Islander	481	93.0	39	7.0	520
2 or more ethnicities	129	86.8	20	13.2	149
Other	346	88.9	49	11.1	395

The Hawaii Student Alcohol, Tobacco, and Other Drug Use Study: 2007-2008 Comprehensive Report.

NOTE: Data was collected from students in grades 6, 8, 10 and 12 across the State, using a risk and protective factors approach, to report levels of substance use and treatment needs in Hawaii. Specifically, data illustrate the prevalence rates of alcohol, tobacco and other drug use among Hawaii's adolescents and provides information on risk and protective factors associated with adolescent substance use. Analyses were conducted to determine the number of students who met the American Psychiatric Association DSM-IV criteria for any substance abuse or dependence by gender, grade level and ethnicity. For the purposes of this study, abuse and dependence variables were combined such that students who qualified would meet criteria for any substance abuse or dependence as a single variable. In addition, all substances were combined into a single category. Therefore, students who met criteria for abuse or dependence for any substance are identified as individuals in need of treatment.

The table above provides the percentages of students meeting criteria for substance use disorders overall by gender, grade and ethnicity:

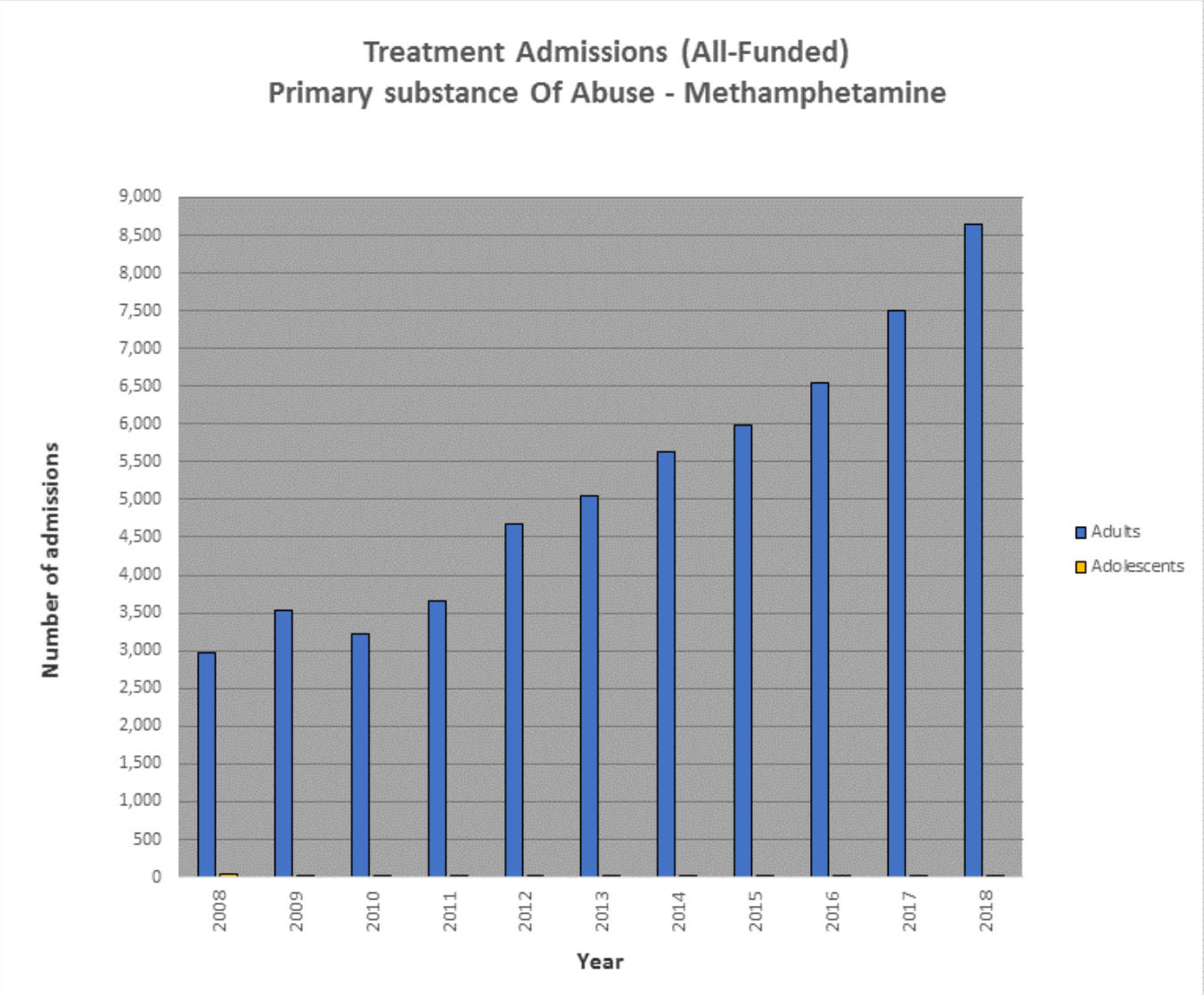
- For treatment needs by gender, more females (8.3%) than males (6.8%) met criteria for abuse or dependence for any substance use.
- For treatment needs by grade, 1.6% of 6th graders, 4.8% of 8th graders, 10.5% of 10th graders and 17.8% of 12th graders met criteria for substance abuse or dependence.
- Adolescents most likely to meet criteria for substance abuse or dependence were Caucasians (11.5%) and Native Hawaiians (11.1%). Students identified as Other ethnicities (11.1 %) had higher rates as well, but it should be noted that the sample size for Other ethnicities was not as large as that of Caucasians and Native Hawaiians. In addition, 7% of students of Other Pacific Islander ancestry also met criteria. Japanese (5.4%) and Filipino (4.7%) students had the lowest rates of needing treatment for substance use.

The five-year (Fiscal Year 2014 to Fiscal Year 2018) average annual ADAD-funded admissions for adolescents is 2,060, which is 32.5% of the estimated need for adolescent alcohol and drug abuse treatment.

APPENDIX F

METHAMPHETAMINE ADMISSIONS
2008 - 2018

As reflected in the graph and table below, there was a 15.2% increase and a 16.7% decrease in adult and adolescent crystal methamphetamine admissions to treatment, respectively, in Fiscal Year 2017-18.



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Adults	**2,967**	**3,536**	**3,216**	**3,654**	**4,681**	**5,044**	**5,642**	**5,978**	**6,540**	**7,511**	**8,655**
Adolescents	**33**	**22**	**24**	**28**	**15**	**21**	**24**	**26**	**16**	**30**	**25**
Total	**3,000**	**3,558**	**3,240**	**3,682**	**4,696**	**5,065**	**5,666**	**6,004**	**6,556**	**7,541**	**8,680**

As reported by contracted substance abuse treatment providers, the above data encompass "ice" admissions that are funded by all sources of funds which includes clients whose services are ADAD-funded, as well as coverage by Medicaid (i.e., QUEST) and health

insurance coverage under Chapter 431M, HRS, relating to mental health and alcohol and drug abuse treatment insurance benefits. Data reported on Appendices A, B and C are for ADAD-funded admissions only.