

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:

December 26, 2019

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirtieth State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirtieth State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy a report covering

- Section 321-195
- Section 329-3
- Section 10 of Act 161 Sessions Law of Hawaii 2002
- Section 29 of Act 40 Sessions Laws of Hawaii 2004
- Section 329E-6

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

<https://health.hawaii.gov/opppd/department-of-health-reports-to-2020-legislature/>

Sincerely,

A handwritten signature in black ink that reads "Bruce S. Anderson".

Bruce S. Anderson, Ph.D.
Director of Health

Enclosures

**REPORT TO THE
THIRTIETH LEGISLATURE
STATE OF HAWAII**

2020

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**

**SECTION 329E-6, HAWAII REVISED STATUTES,
REQUIRING A REPORT ON UNINTENTIONAL OPIOID-RELATED DRUG OVERDOSE**

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

**DEPARTMENT OF HEALTH
STATE OF HAWAII
DECEMBER 2019**

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2018-19 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 2018-19, \$34,876,192 was appropriated by Act 53, Session Laws of Hawaii (SLH) 2018, to the Alcohol and Drug Abuse program (HTH 440) – \$20,246,936 general funds, \$750,000 special funds and \$13,877,256 federal funds (MOF N and P). Of the total appropriated, \$25,070,650 was allocated for substance abuse treatment services and \$7,256,791 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#122291) 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 \$46,035 (HTH440/HO); decreased the federal fund ceiling by \$121,582 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); and established the federal fund ceiling for the new Youth Implementation Treatment (YT-I) award totaling \$760,000 per year for four years.

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

\$8.85 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.

\$1.6 million over three years (9/30/17 – 9/29/20) 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).

\$4.0 million over two years (5/1/17 – 4/30/19) 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). A No Cost Extension was granted to extend the STR Project service period to April 30, 2020.

\$6.5 million over five years (9/30/16 – 9/29/21) 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.

\$3.1 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.

\$10.2 million over two years (9/30/18 – 9/29/20) for the SAMHSA/CSAT State Opioid Response (SOR) grant to provide opioid use disorder treatment and recovery support services to between 20 to 200 unduplicated clients annually based on the services utilized. The array of services includes the following: Outreach/Motivational Enhancement/Interim Care, Outpatient Services, Intensive Outpatient Services, Intensive Outpatient Services, Residential, Detox, Post Treatment/Continuing care, Health & Wellness Planning, Transportation, Care Coordination, Day treatment, Clean and sober housing, MAT Screenings, Testing Kits Purchase, Detox Beds Purchase, Peer Recovery Support Training, Provider Training. Through utilization of treatment and recovery services, ADAD intends to increase the number of clients in recovery and utilizing a recovery support system, as well as increase the number of physicians participating in the PDMP. ADAD also intends to increase the number of providers of MAT for opioid use disorders, thus decreasing the gaps in system of care.

\$1.8 million in each of five years (9/30/13 – 9/29/18) for the 2013 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.

\$2.0 million in each of five years (9/30/18 – 9/29/23) for the 2018 SAMHSA/CSAP SPF-PFS grant to provide further support for the SPF-PFS Project goals and objectives of strengthening and enhancing the prevention systems at the local and state level as well as to address the priority issue of alcohol use by minors in high need areas.

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 3,396 adults statewide in Fiscal Year 2018-19;

School- and community-based outpatient substance abuse treatment services were provided to 1,790 adolescents statewide in Fiscal Year 2018-19; and

Curriculum-based youth substance abuse prevention and parenting programs, underage

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.

drinking initiatives and the Hawaii Prevention Resource Center (HIPRC) served 37,993+ children, youth and adults directly and indirectly through individual-based and population-based prevention programs, strategies and activities² in Fiscal Year 2018-19.

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;

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

Section 329E-6, HRS, requiring a report on unintentional opioid-related drug overdose.

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. Examples of population-based strategies include the following: community health fairs and events, social media broadcasts, and public service announcements.

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ALCOHOL AND DRUG ABUSE DIVISION

This annual report covers Fiscal Year 2018-19 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; Section 29 of Act 40, SLH 2004, which requires a progress report on the substance abuse treatment monitoring program; and Section 329E-6, HRS, which requires a report on unintentional opioid-related drug overdose.

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 Strategic Prevention Framework (SPF) Project focuses on building community capacity to address substance use issues and sustain the substance abuse prevention system and infrastructure at the state, county and local community levels. The staff of the Food and Drug Administration (FDA) Tobacco Program within the Branch ensures that the Federal 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 drugs and illicit drugs, 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 use disorders. 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, 2018 to June 30, 2019

State and Federal Funding

Act 53, SLH 2018 appropriated \$34,876,192 to the Alcohol and Drug Abuse program (HTH 440) for Fiscal Year 2017-18:

General funds	\$20,246,936	(58.0%)	29.0 FTE
Special funds	750,000	(2.2%)	
Federal funds (N)	8,857,980	(25.4%)	6.5 FTE
Federal funds (P)	<u>5,019,276</u>	<u>(14.4%)</u>	
	\$34,876,192	(100.0%)	29.0 FTE ³

Allocations for the funds appropriated are as follows:

Substance abuse treatment services	\$25,070,650	(71.9%)
Substance abuse prevention services	7,256,797	(20.8%)
Division operating costs	0	(0%)
Division staffing costs	<u>2,548,751</u>	<u>(7.3%)</u>
	\$34,876,192	(100.0%)

For Fiscal Year 2018-19, \$34,876,192 was appropriated by Act 53, SLH 2018, to the Alcohol and Drug Abuse program (HTH 440) – \$20,246,936 general funds, \$750,000 special funds and \$13,877,256 federal funds (MOF N and P). Of the total appropriated, \$25,070,650 was allocated for substance abuse treatment services and \$7,256,791 was allocated for substance abuse prevention services. The Act also continued the general funds for the Clean and Sober Homes Registry Program Specialist IV (#122291) 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 \$46,035 (HTH440/HO); decreased the federal fund ceiling by \$121,582 for the Food and Drug Administration (FDA) Tobacco Enforcement contract (HTH440/HD); and established the federal fund ceiling for the new Youth Implementation Treatment (YT-I) award totaling \$760,000 per year for four years.

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 \$8.85 million in Fiscal Year 2019 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 \$1.6 million 3-year contract (9/30/17-9/29/20) 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.

Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant. Hawaii was awarded \$1.8 million in each of five years (9/30/13-9/29/18) 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 provided 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 utilized grant 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 2019, the SPF-PFS subrecipients had additional time to complete their planned actions and maintain involvement of community organizations and community members in SPF efforts. A second SPF-PFS grant of \$2.0 million in each of five years (9/30/18-9/29/23) was awarded to continue the Hawaii Project efforts and during the close of FY19 those funds were allocated to subrecipients to build on the progress made during the first grant period and further enhance efforts to address alcohol and related issues in communities of demonstrated high need.

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT is a five-year grant (project period 09/30/16-09/29/21) totaling \$6,513,812. 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 5/1/17-4/30/19) totaling \$4,000,000 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: 9/30/17-9/29/21) totaling \$3,090,000 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 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 3,396 adults statewide in Fiscal Year 2018-19; and school-based and community-based outpatient substance abuse treatment services were provided to 1,790 adolescents statewide in Fiscal Year 2018-19.

Prevention Services. Through a total of thirty-two (32) contracts, nineteen (19) public and community-based organizations supported statewide prevention efforts to reduce underage drinking and the use and abuse of other harmful substances during FY 2019. 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 and skills related to effective ways to avoid substance use 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 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

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.

collected for Fiscal Year 2018-2019, curriculum-based prevention strategies served a total of 5,785 children and youth and the community-based strategies touched a total of 32,208 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.

Hawai'i Coordinated Access Resource Entry System (CARES)

The Hawai'i Coordinated Access Resource Entry System (CARES) is the state's new multiple entry-point and coordinating center for substance use disorder (SUD) treatment services. This new initiative will improve coordination among providers and increase access to quality care for people who are living with substance use problems. Hawai'i CARES is a collaboration between the Alcohol and Drug Abuse Division and the University of Hawai'i at Mānoa (UH Mānoa) Myron B. Thompson School of Social Work. The project is funded through a combination of state and federal funds from the Substance Abuse and Mental Health Services Administration. The agreement over two years with UH Mānoa includes the development of a call center, service referral system, and processes for quality improvement. Hawai'i CARES staff, who are trained clinicians, facilitate entry into the system of care, transitions in care, and provide information and referrals to other treatment resources. Hawai'i CARES was soft-launched on October 1, 2019 with DOH partner agencies and contracted providers, and full implementation is anticipated in January 2020. In its first month as a pilot program, CARES handled more than 300 incoming calls and facilitated more than 400 referrals to and service authorizations for addiction treatment, with these number expected to grow upon full implementation. Within the next 12-18 months, we anticipate expansion of this project to include behavioral health services as well. We are striving toward a system where our community has a more direct and simplified process of gaining access to

behavioral health services across the state and that people can get those services help where they need it, when they need it and how they need it.

Take Back Boxes Promote Safe Medication Disposal

Appropriate disposal of prescription medications is essential in preventing diversion of medications and limited the environmental impact of improperly discarded drugs. In collaboration with the Attorney General's Office, Narcotics Enforcement Division and other key partners, DOH/ADAD has provided take back boxes to Police Departments statewide. Listed on www.hawaiiopioid.org website with maps and directions, there are now three (3) sites on Kauai, six (6) sites on Hawaii Island, nine (9) sites on Maui and ten (10) sites on O'ahu. These sites also include pharmacy-based take back sites that started after Act 183, SLH 2019 was signed by Governor Ige in July, 2019 which allows pharmacies to take back medications. Hawaii continues to participate in the twice-yearly DEA take back campaigns in addition to twenty-eight (28) sites statewide.

Studies and Surveys

Tobacco Sales to Minors. The 2019 annual statewide survey results for illegal tobacco sales to minors is 5.7% (weighted), a decrease from last year's rate of 6.6%. This year's 5.7% retailer violation rate is less than the 9.6% national weighted average for federal fiscal year 2013. 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 2019, 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. Nineteen stores (5.7%) sold to minors (ages 15-20). Of the four counties included in the statewide survey, the County of Kauai had zero sales, the County of Maui had five sales, and both the County of Hawaii and County of Honolulu had seven 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 2018-19, ADAD conducted training programs that accommodated staff development opportunities for 1,642 healthcare, human service, criminal justice and substance abuse prevention and treatment professionals through fifty-two (52) training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 28,217 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 (42) prevention service contracts and fifty-three (53) 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 2018-19, ADAD processed 462 (new and renewal) applications, administered-seventy-eight (78) computer-based written exams and certified-fifty-one (51) applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 1,328.

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 2018-19, 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

In Fiscal Year 2018-19, ADAD received twenty-nine (29) initial application for the clean and sober registry. ADAD reviewed and conducted twenty-two (22) clean and sober homes statewide, and in “Good Standing” as referred to by HAR Chapter 11-178. There are three (3) registrations pending home detail submissions, three (pending DOH review), and (1) one pending inspection. Currently there are two (2) homes that are “Not in Good Standing” pending further review. ADAD has received (1) one complaint that has been resolved.

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.

Law Enforcement Assisted Diversion (LEAD)

Act 5, SLH 2019 approved \$800,000 in general funds in the ADAD base budget for FY2020 to continue outreach counseling and law enforcement diversion services for the chronically homeless who suffer from severe substance abuse disorders on O’ahu. 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 for an arrest diversion pilot project 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 involves both HPD and the State Sheriffs from the Department of Public Safety. The first-year program evaluation report was released on Oct. 1, 2019.

In FY 2018-19, LEAD has:

- Received forty-seven (47) social contact referrals (individuals perceived as high risk for arrest);
- Of the social contact referrals, thirty-seven (37) participants were enrolled in and received services; with thirty-two (32) active in case management.

Through coordination with the Governor's Coordinator on Homelessness as well as the police departments and the county prosecutor on each island, LEAD was also expanded to Hawaii County, Maui County and Kauai County through three (3) contracts with mental health and substance use treatment providers serving those counties as a result of the Governor's Emergency Proclamation dated Dec. 14, 2018. The Proclamation recognized the need to divert homeless individuals and families away from frequent use of the healthcare and criminal justice systems by connecting them to mental health services or substance use treatment services. The contracts also used funds from Act 209, SLH 2018 which were intended to expand the LEAD pilot program to Maui and Hawaii. The one-year contracts were executed in Feb. 2019, and may be extended for two additional years.

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 2019 Legislative Session that addressed issues affecting the agency included:

Act 5, SLH 2019 (HB 2 SD2 CD1), relating to the state budget. This measure approved \$800,000 in general funds in the base budget for FY 2020 to continue to provide outreach counseling and law enforcement diversion services for the chronically homeless who suffer from severe substance abuse disorders on O'ahu. The Legislature also approved a Governor's Executive Budget 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.

Act 183, SLH 2019 (HB1272 HD1 SD1) relating to prescription drugs. This measure authorizes pharmacies to accept the return of any prescription drug for disposal via collection receptacles or mail-back programs; prohibits pharmacies from re-dispensing returned prescription drugs or accepting returned prescription drugs in exchange for cash or credit; requires the pharmacist-in-charge to ensure that only authorized reverse distributors acquire prescription drugs collected via collection receptacles or mail-back programs.

Act 230, SLH 2019 (SB1486 SD1 HD1 CD1) relating to the electronic prescription accountability system. DOH supported this Department of Public Safety measure which allows the Narcotics Enforcement Division Administrator to disclose confidential information from the Electronic Prescription Accountability System to the U.S. Department of Defense health agency prescription monitoring program and authorized employees of the State DOH Alcohol and Drug Abuse Division and the Emergency Medical Services and Injury Prevention Systems Branch.

Act 251, SLH 2019 (HB665 HD2 SD1 CD1) relating to the electronic prescription accountability system. DOH worked with Department of Public Safety to support this measure which specifies that a health care provider shall not be required to consult the electronic prescription accountability system for patients when the prescription will be directly administered under the supervision of a health care provider, provided that the system is consulted when the patients are initially admitted at a hospital, for patients in post-operative care with a prescription limited to a three-day supply, or for patients with a terminal disease receiving hospice or other palliative care.

Act 255, SLH 2019 (SB535 SD1 HD1 CD1) relating to pharmacists prescribing and dispensing of opioid antagonist. This measure authorizes pharmacists, acting in good faith and exercising reasonable care, to prescribe and dispense an opioid antagonist to patients at risk of overdose, and family members and caregivers of patients at risk of overdose. This measure also sunsets on 6/30/2024.

Act 263, SLH 2019 (SB1494 SD2 HD1 CD1) relating to health. This measure establishes and appropriates funds for a working group within DOH to evaluate current behavioral health care and related systems and identify steps to promote effective integration to respond to and coordinate care for persons experiencing substance abuse, mental health conditions, and homelessness.

NOTE: In the upcoming 2020 Supplemental Session ADAD will request to add 1.00 position to the Treatment and Recovery Branch to assist in the management of the Federal Grants. This position will be responsible to apply for new federal grants and implement the program. ADAD will also be requesting to change MOF P to A 2.00 positions in the SPF-PFS award that continues to be funded by SAMHSA/CSAP.

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 329E-6, Hawaii Revised Statutes, Requiring a Report on Unintentional Opioid-Related Drug Overdose.**

**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

<p>CARL BERGUIST Community and Business Affairs (Oahu) – 6/30/2020</p> <p>DIANA FELTON, M.D. Medical – 6/30/2019</p> <p>LORI FERREIRA, Ed.D. Education – 6/30/2019</p> <p>JODY JOHNSON Community and Business Affairs - 6/30/2022</p> <p>CHAD Y. KOYANAGI, M.D. Vice Chair Joint appointment to HACDACS and State Council on Mental Health – 6/30/2019</p>	<p>HEATHER LUSK Chairperson Education – 6/30/2019</p> <p>KENNETH TANO Enforcement – 6/30/2022</p> <p>ERIKA VARGAS Community and Business Affairs – 6/30/2021</p> <p>BRYAN WATKINS Youth Action – 6/30/2022</p>
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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 2018-2019:

- Coordinated Access Resource Entry System (CARES) and Coordinated Entry
- Withdrawal Management and Stabilization Beds for Homeless Substance Use Outreach
- Reducing Opioid Misuse, Opioid Overdose and Related Harms and Aligning with the Hawaii Opioid Initiative
- Substance Use Disorder (SUD) and Co-Morbidities

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 to 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.

HACDACS recognizes the data that establishes methamphetamine use as more prevalent than opioid use in the State of Hawaii. Methamphetamine is the primary substance reported by participants in ADAD treatment facilities. For example, 60.6% of ADAD-funded adults who were admitted to treatment facilities in FY2019 reported methamphetamine as the primary substance used.

Coordinated Access Resource Entry System (CARES) and Coordinated Entry

HACDACS supports the Alcohol and Drug Abuse Division's (ADAD) overarching goal to create a connected and coordinated continuum of care that provides people with the treatment they need, when they need it. Appropriate care is critical to successful recovery from SUD. As discussed in previous legislative reports, there have been systemic barriers to entering the continuum of care including time and resource management, lack of staff who can screen or assess patients for SUD, and lack of a simple system to provide referrals. To combat this deficit, ADAD and community providers have worked diligently to address these barriers.

Public health and public safety partnerships, such as Law Enforcement Assisted Diversion (LEAD) as well as the Health Efficiency and Long-term Partnerships (HELP), have strengthened this past year and are important access points into the continuum of care. LEAD, HELP, Outreach Workers, and other homeless outreach efforts have resulted in identifying people in need of pre-treatment, treatment, and recovery support services.

The system illustrated in Diagram 1 demonstrates a coordinated and responsive system of care providing clinically appropriate substance use treatment and recovery support services statewide. The specific services available under each treatment and recovery type are provided in Table 1. ADAD has contracted the University of Hawaii at Manoa School of Social Work to operate the system. On October 1st, 2019, ADAD launched the statewide Coordinated Access Resource Entry System (CARES) which will be the hub of the coordinated entry system. CARES provides SUD care coordination, screening, assessment, intake, placement determination, referral, and authorization management of services for all ADAD-funded clients. As people are identified in the Outreach process, CARES provides access into an array of treatment and support services. Currently, hours are similar to normal business hours, with the intention to eventually be a 24-hour facility. Further information can be found at: <http://manoa.hawaii.edu/cares/>. HACDACS supports eventually adding all behavioral health services to the coordinated entry system.

Diagram 1. Illustration of the CARES System.

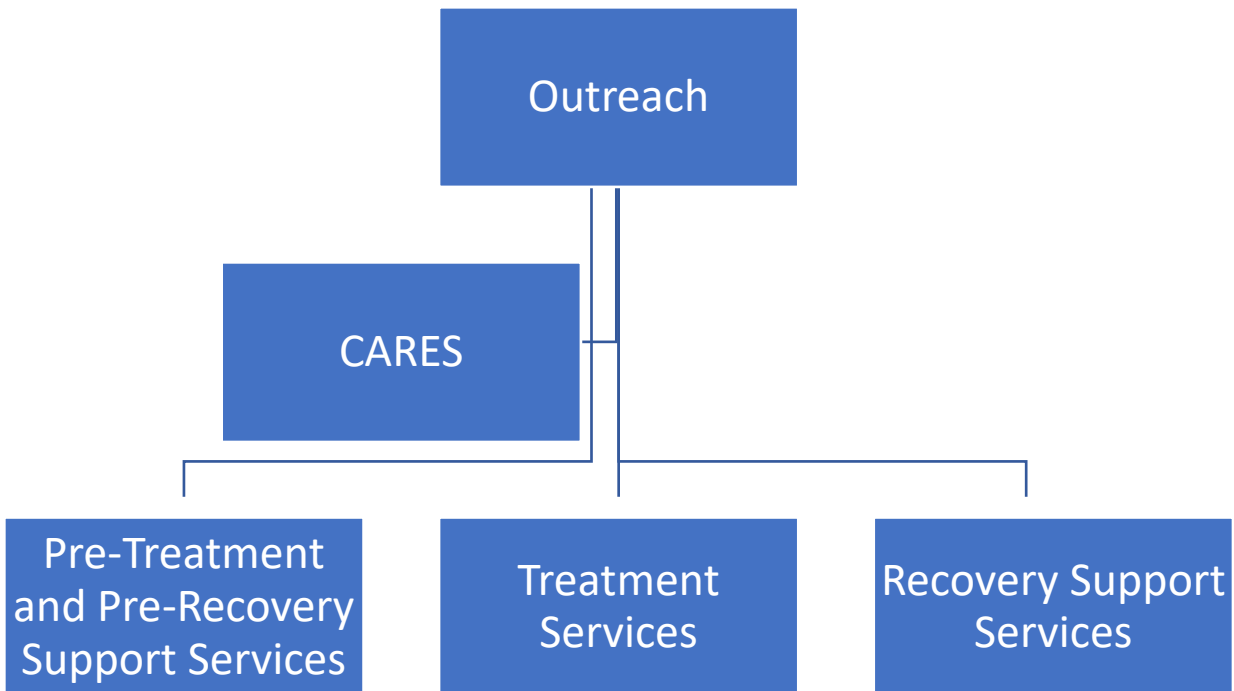


Table 1. Services Within Pre-Treatment, Treatment, and Recovery Support Services.

Pre-Treatment and Pre-Recovery Support Services	Treatment Services	Recovery Support Services
Addiction Care Coordination Interim Services Motivational Enhancement Outreach Screening Assessment Stability Bed Hold Clean and Sober Housing	Addiction Care Coordination Placement Determination Interim Services Withdrawal Management Residential Day Treatment Intensive Outpatient Outpatient Opioid Addiction Services Early Intervention Services Clean and Sober Housing	Addiction Care Coordination Therapeutic Living Stability Bed Hold Clean and Sober Housing Group Recovery Homes Continuing Care Services Transportation Translation Services

As the coordinated entry system continues to take shape, HACDACS encourages ADAD to review lessons learned from the Homeless Coordinated Entry System (CES). Jay King, administrator for the CES for Partners in Care, presented a series of best practices to HACDACS on CES implementation. Some of the notable lessons learned from the Homeless Coordinated Entry System three years of implementation are outlined on its website (www.coordinatedentrysystem.org), and include:

Ten Challenges: Service Coordination Barriers

1. Resistance to change
2. Limited understanding of HIPAA, PPI, PHI, and federal policy
3. Deficient data storage and case management system

4. Inaccurate, diluted, and missing measures of vulnerability: missing the greatest need
5. Limited resources and support
6. Data system not designed and operated with human factors engineering
7. Missing common communication and coordination platform
8. Limited reporting functions
9. Policies don't reflect regional reality
10. Resistance to new partnerships and methods of participation

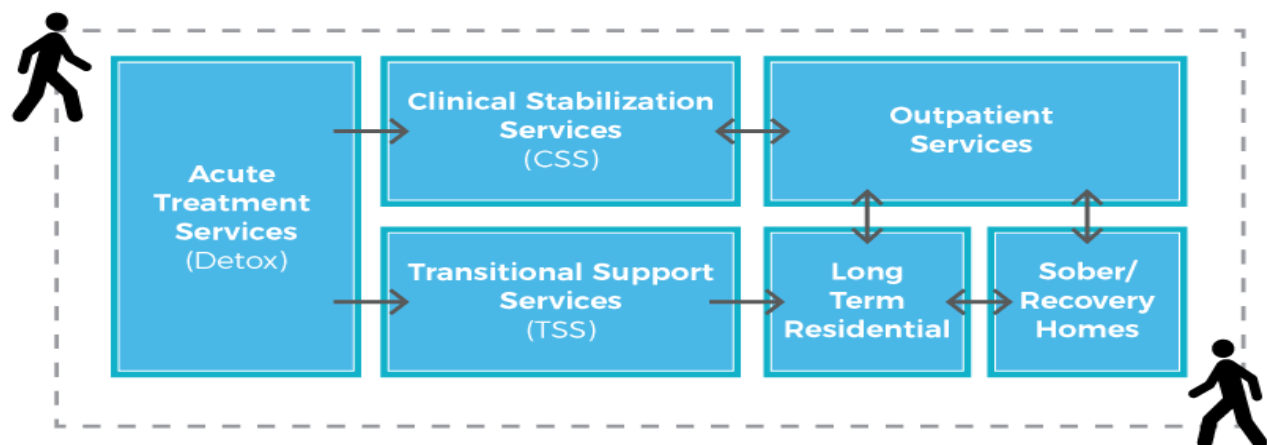
Ten Points of Progress:

1. Data that measures operational behaviors
2. Design that directs provider behavior
3. Empowerment of service staff with avenues to conference and contribute
4. Secure, accessible, and transparent data
5. Communication and referral platform: one place for all
6. Communication platform email and comment thread
7. Community resource collection
8. Inclusive case conferencing
9. Process for special requests
10. In person community presence

HACDACS members agree with adapting to a flexible system of care providing the appropriate level of care where, when, and how individuals need it is essential. HACDACS supports the concept of “treatment on demand,” allowing the consumer to access culturally appropriate services when ready, willing, and able. This is especially important during transitions of levels of care, including: from street into care, from residential to recovery homes, and support during relapse or changes in substance use that are a normal part of the cycle of SUD.

Diagram 2 illustrates the various ways an individual can travel within the system of care. A linear path is non-existent as an individual's recovery is unique to their circumstances and experiences. A system that is flexible enough to meet the needs and match the uniqueness of each individual will be paramount to the success of CARES.

Diagram 2. Illustration Services in the Treatment System of Care.



HACDACS recommends ongoing support of CARES with a focus on adapting best practices from other states and the Hawaii Homeless Coordinated Entry System to ensure a comprehensive, responsive and nimble system informed by consumer input, provider feedback, and a transparent

implementation process.

HACDACS recommends that CARES collaborate with coordinated street outreach efforts such as HELP and LEAD to build upon early successes of collaboration to streamline efforts to get consumers from the street into services.

Withdrawal Management and Stabilization Beds for Homeless Substance Use Outreach

A critical component in the homeless outreach effort is incorporating stabilization beds. The 2018 Homeless Point in Time Count found 4,453 homeless on Oahu and 1237 homeless on the Neighbor Islands. On Oahu, the homeless population is further broken down to 2401 unsheltered persons and 2052 sheltered, with 846 on Oahu indicating that substance use affects their daily activities.

During homeless outreach efforts over the past year, outreach workers encountered people with conditions such as dehydration, skin conditions (open infected wounds, sores, skin inflammation, scabies, lice), infectious diseases (tuberculosis, hepatitis A, B, C), chronic diseases (hypertension, diabetes), substance/alcohol intoxication, mental health disorders (active psychosis, depression, anxiety, post-traumatic stress disorder, schizophrenia), and seizures. In a 2006 study, 49.3% of people in the sample group were diagnosed with epilepsy and 40.7% with alcohol-related seizures. In the latter group, other factors like sleep deprivation, anxiety, and stress also contributed to the seizures⁵.

Substance use treatment is confronted with complex patients needing emergency supports and resources. Once a homeless individual agrees to engage with the outreach workers, a quick screening and triage is performed. Results from this screening often indicate that those with acute conditions need to be stabilized prior to admission into the appropriate level of formal treatment. A gap in the continuum of care is that most substance use residential facilities cannot provide the appropriate medical services needed for the acute care that many homeless individuals need.

The American Society of Addiction Medicine (ASAM) describes treatment as a continuum with five broad levels of care, including an early intervention level. Within the levels of care, decimal numbers differentiate degrees of intensity of services.⁶ Treatment services range from no care (0) to early intervention and outpatient care (0.5 – 2.5) to residential and detoxification (3 – 3.7) and hospitalization (4). The differences in levels correspond to the acuity of an individual's illness, see Diagram 3 for detailed information. ASAM best practices recommends that withdrawal management be integrated with other treatment services⁷ including: outpatient and residential services, stabilization beds, and in-patient hospital units. Due to the nature of habitual compulsive use and the difficulties inherent in overcoming them, the withdrawal management phase of

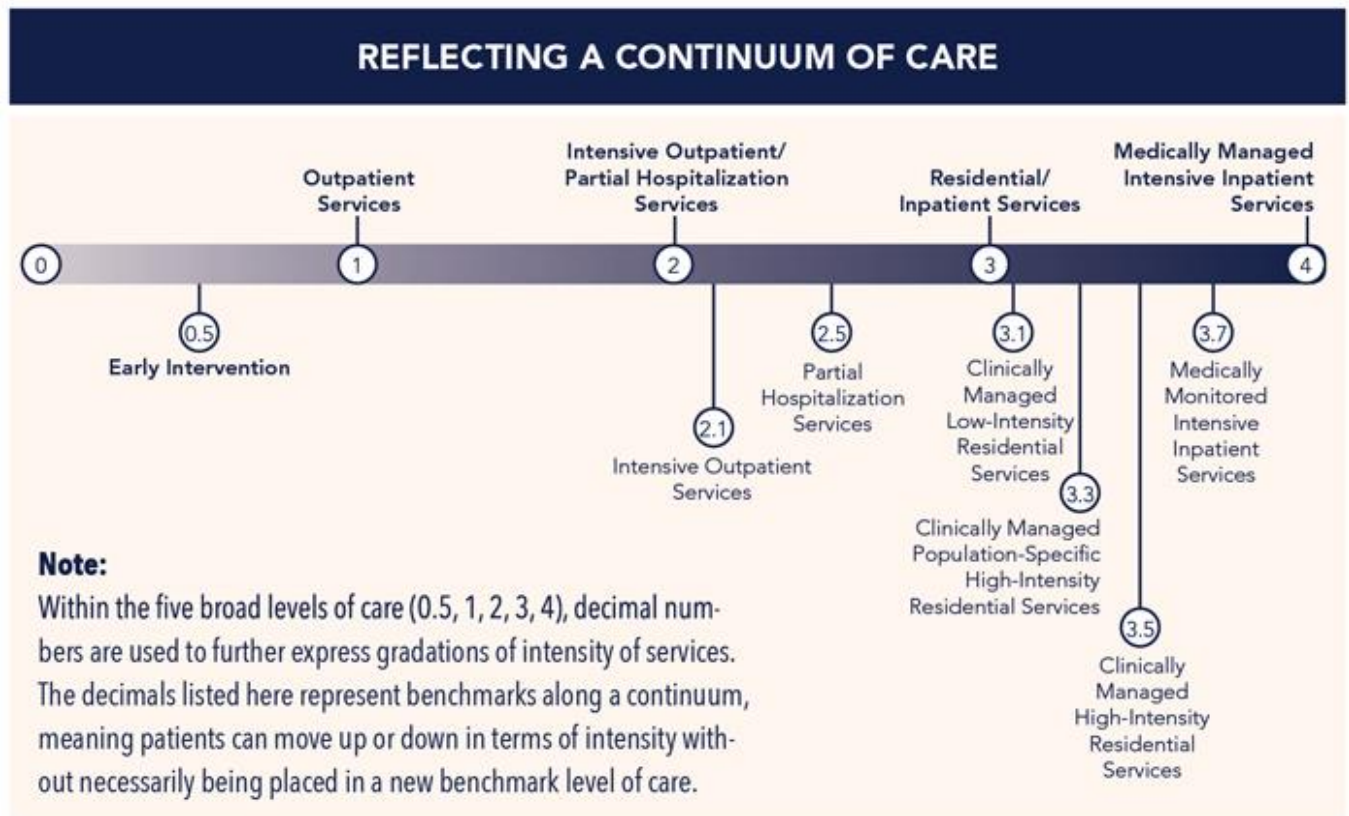
⁵ Anne Laporte, Anny Rouvel-Talleg, Etienne Grosdidier, Sandrine Carpentier, Chantal Benoît, Daniel Gérard, Xavier Emmanuelli, Epilepsy among the homeless: prevalence and characteristics, *European Journal of Public Health*, Volume 16, Issue 5, October 2006, Pages 484–486, <https://doi.org/10.1093/eurpub/ckl011>.

⁶ Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright by the American Society of Addiction Medicine.

⁷ Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright by the American Society of Addiction Medicine.

treatment often requires a greater intensity of services to establish initial treatment engagement and induction into formal treatment.

Diagram 3. The ASAM Treatment Continuum.⁸

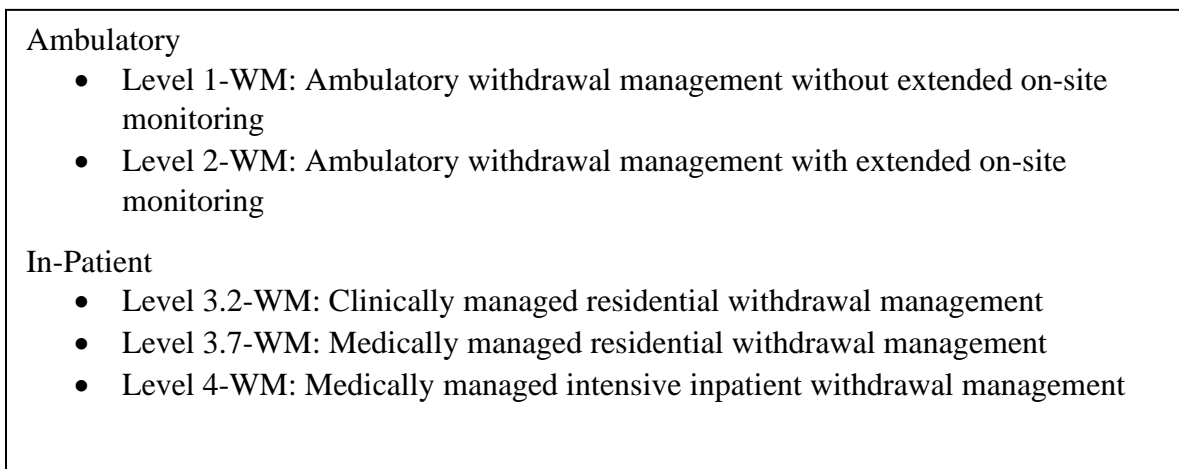


ASAM recommends the assessment of individuals for factors complicating withdrawal (including alcohol use) such as the use of other addictive substances, acute and/or destabilized medical or psychiatric problems, and/or a history of seizures or delirium tremens. An individual’s risk for complicated withdrawal increases with the presence of multiple risk factors. ASAM has criteria for different levels of withdrawal management based on the presence of risk factors as outlined below in Diagram 4:⁹

⁸ <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

⁹ Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright by the American Society of Addiction Medicine.

Diagram 4. ASAM Criteria for Different Levels of Withdrawal Management.



The Substance Abuse and Mental Health Administration (SAMHSA) suggests utilizing stabilization beds as a cost-effective alternative to in-patient hospitalization. This is outlined in SAMHSA’s publication *Crisis Services: Effectiveness, Cost-Effectiveness, Cost-Effectiveness, and Funding Strategies*, along with information regarding the types of crisis stabilization¹⁰. The purpose of stabilization beds is to promptly assess, provide acute care, and connect individuals to appropriate resources, ensuring the warm hand-off from the street to treatment. HACDACS is in support of the current request for information (RFI) for stabilization beds. The overall goal is to reduce repetitive emergency department visits and chronic homelessness. HACDACS would be in support of partnerships that encourage the development of stabilization units across the state.

It is HACDACS understanding that no hospitals in Hawaii provide inpatient withdrawal management (detoxification) in the absence of other acute psychiatric or medical conditions necessitating admission. The absence of such services presents great concern given that SAMHSA and ADAD recommend withdrawal management and stabilization beds as: 1) a cost reduction method, 2) crucial components in the continuum of service, and 3) part of an emergency response to the substance use and homeless crisis. At the time of this report, only two ADAD funded agencies are providing withdrawal management. After consultation with various treatment and outreach providers, it appears that our current services are insufficient to meet the needs of the community.

HACDACS recommends the development of a comprehensive SUD management plan to include emergency placement into detoxification and stabilization beds for those in need.

HACDACS recommends payment reform allowing providers to sustainably execute complex patient models of care that are needed and clinically indicated.

HACDACS recommends the development of more partnerships to provide withdrawal management and stabilization beds across the state.

¹⁰ Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

Reducing Opioid Misuse, Opioid Overdose and Related Harms and Aligning with the Hawaii Opioid Initiative

The State of Hawaii Department of Health reported that Hawaii had the third lowest rate of opioid poisoning fatality rates from 2013 through 2017. Despite these low rates, relative to the continental United States and Alaska, data from the State of Hawaii Department of Health (DOH) demonstrates that drug poisoning (drug overdoses) continue to be a leading cause of injury related death in Hawaii.

In 2016, Governor David Ige signed Act 68 granting immunity to individuals dispensing, carrying, or utilizing naloxone (Narcan®) to reverse an opioid-related drug overdose. Since the enactment of Act 68, more than 5,000 doses have been distributed statewide and over 230 overdose reversals were reported to the Hawaii Health and Harm Reduction Center (HHHRC), the overseer of the Overdose Prevention and Response Program. In 2019, Gov. Ige signed Act 255 which allows pharmacists to prescribe naloxone, increasing access to the medication and supports the CDC's recommendation that all persons with a prescription of morphine milligram equivalents greater than 50 milligrams per day should be prescribed naloxone.

In 2017, the Center for Disease Control reports that opioids contributed to 203 cases of fatal and non-fatal drug poisonings in Hawaii. To combat this, overdose prevention has been a major focus of the Hawaii Opioid Initiative (HOI). The Initiative was spearheaded by the Hawaii State Department of Health (DOH), Emergency Medical Services and Injury Prevention System Branch, Alcohol and Drug Abuse Division, and Harm Reduction Services Branch. Partners include the Department of Public Safety (DPS), Hawaii Narcotics Enforcement Division (NED), and community groups working collaboratively to develop a Hawaii-specific strategic plan to address opioid misuse and related harms.

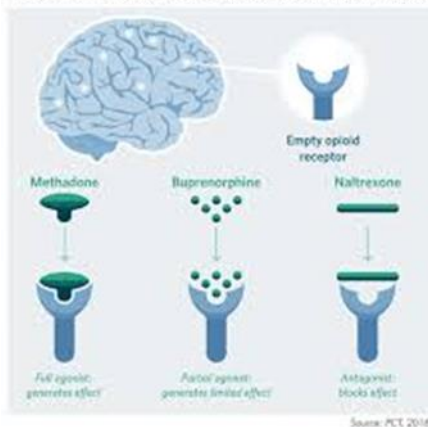
The HOI has supported collaboration among stakeholders across various disciplines to implement sustainable changes in preventing opioid misuse and increasing access to treatment for Opioid Use Disorder (OUD). The initiative has leveraged increased funding to make sustainable changes in Hawaii's substance use prevention and treatment continuum. 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.

The first HOI Plan was released in late 2017. The second (HOI 2.0) update was released in late 2018 and the third (HOI 3.0) update is anticipated by the end of 2019. The three primary themes guiding the workgroups and their recommendations include: 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. The seven working groups and executive steering committee meet regularly to coordinate efforts. In 2018, the HOI website was launched at www.hawaiiopioid.org and includes links to treatment options, places to dispose of unused prescription drugs, and information on naloxone access. In 2019, two HOI public awareness campaigns focused on the importance of disposing prescription drugs properly and learning about opioid use and misuse that are intended to drive the public to the website. The next campaign will focus on SUD treatment and the coordinated treatment referral system (CARES) launched in October 2019.

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
- FOCUS AREA 7 – SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT): Increase implementation of SBIRT in primary care settings.

How OUD Medications Work in the Brain



HACDACS members received monthly updates on HOI activities and a presentation on comprehensive treatment of OUD by an Addiction Certified Advanced Practice Registered Nurse, who is also a member of HACDACS. Highlights of the presentation included a review of FDA approved medications to treat OUD, an overview of mu-opioid receptor agonists (such as heroin or oxycodone), antagonists (such as naloxone) and partial agonists, such as buprenorphine. Buprenorphine is the only medication with partial agonist properties that is approved by the FDA to treat OUD and may be prescribed or dispensed by providers who have obtained a DEA X-Waiver (8 hours for physicians, 24 hours for Nurse Practitioners and Physician Assistants).

After the first dose or two, buprenorphine does not create a feeling of being “high,” nor does it lead to respiratory depression as do full opioid receptor agonists. There is a “ceiling effect (limit on receptor activation)” because doses greater than 32 mg per day will reduce pain, prevent euphoria from full opioid receptor agonists, and prevent withdrawal syndrome (“drug sickness”). While Hawaii only has two agencies certified to provide methadone (another FDA approved treatment for OUD) there are dozens of certified providers for buprenorphine, but not nearly enough to meet demand.

MEDICATION TO TREAT ADDICTION INVOLVING OPIOID USE 2018 FACT SHEET

3 FDA APPROVED MEDICATIONS

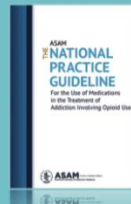
Three medications (methadone, buprenorphine, and naltrexone) are currently approved by the Food and Drug Administration (FDA) to treat addiction involving opioid use. When combined with psychosocial interventions, these medications help people recover.



There is significant evidence to support the safety, efficacy, and cost-effectiveness of all three medications, although methadone and buprenorphine have been studied most thoroughly. While all three medications are effective, they may not be equally effective for all patients.



The decision to use any medication should be made jointly by a patient and the treating provider. The provider should discuss the risks and benefits of the proposed and alternative treatment options with the patient before starting medication treatment.



There are clinical guidelines available to help clinicians make evidence-based clinical decisions when prescribing medications to patients with addiction involving opioid use: The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.

FACT

When used appropriately, medications used to treat addiction are not addicting, as they do not cause patients to use them compulsively or in an unhealthy way. Rather, these medications support patients in their recovery. Patients taking medications to treat addiction should be considered in recovery. Characterizing certain medications as “addictive” is confusing to people who don’t understand how these medications work and perpetuates stigma against patients with addiction.

HACDACS recommends the implementation of the Hawaii Opioid Initiative’s goals and objectives and encourages the Department of Health to provide workgroups with the resources they need to develop and sustain HOIs efforts.

HACDACS supports all HOI goals and recommends prioritizing specific efforts to help people struggling with chronic pain and opioid use disorder. This includes improved access to detoxification services, medication for OUD, evidence-based integrated pain management, and substance abuse treatment services.

HACDACS recommends the expansion of medication access for OUD be available statewide. Of particular concern is addressing pre-authorization barriers. Other important issues include methadone and buprenorphine access on Kauai and the west side of Hawaii Island, access in emergency departments, detention facilities, and other appropriate settings.

HACDACS recommends policies that promote utilizing these medications without exclusion from other treatment modalities or settings.

HACDACS recommends continued implementation of Act 68 (2016) that expands access to

naloxone through sufficient distribution throughout the state. Act 68 gives immunity to law enforcement, first responders and community members for the administration of naloxone. The focus on integration of naloxone into the continuum of care is imperative.

Substance Use Disorder (SUD) and Co-Morbidities

According to the US Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated forty-five percent of the 18.7 million American adults with a substance use disorder had a concurrent mental illness. Given the limitations in reporting and challenges of obtaining this kind of data, it is likely this is an underestimate. HACDACS is interested in the intersection of substance abuse with mental health and other comorbidities including homelessness and domestic abuse.

This past spring, Dr. Amy Curtis, an Epidemiologist with the Department of Health, presented an overview of the WITS database to HACDACS. The WITS database stores information on individuals serviced by ADAD funded programs. Data presented in Dr. Curtis' presentation confirms that methamphetamine use disorder remains the most common substance used by people in Hawaii seeking care through ADAD-funded programs. Dr. Curtis also presented data demonstrating that those suffering with methamphetamine use disorder are also high utilizers of mental health services in Hawaii. These services included (multiple) admissions to the Hawaii State Hospital system and enrollment in the Intensive Case Management program. Treatment modalities for methamphetamine use disorder including various behavioral therapies (ex. motivational interviewing, cognitive behavioral therapy, and contingency management therapy) were reviewed. Use of these treatment modalities can be resource intensive but may be very useful for certain patients.

Currently there are severe limitations in the database and imputing methods that impair the ability to identify the use of multiple substances as well as secondary diagnoses such as mental illness, domestic abuse, or homelessness. Co-occurring morbidities can contribute to the patient's status and impede treatment services. Improving reporting in the WITS would assist in identifying treatment gaps and help delineate the community's needs for resources.

HACDACS recommends aligning data collection and outcomes to improve the ability to report co-morbidities such as mental illness, homelessness, and domestic abuse.

HACDACS recommends additional and on-going support for re-introductory programs for patients being discharged from the Hawaii State Hospital or other state contracted inpatient facilities. On-going support and training should include recovery support services, continued engagement in care, and intensive SUD treatment focusing on prevention of relapse of methamphetamine use disorder.

HACDACS recommends increasing resources for stabilization programs and dual-diagnosis treatment programs that address SUD, co-morbid mental illness, and homelessness.

Prevention

Much of the focus in the SUD continuum of care has emphasized treatment, however, prevention

is critical in addressing health-related concerns and issues linked to alcohol and substance use. Prevention is imperative as it assists individuals in developing the knowledge, attitudes, and skills needed to change harmful behaviors, make helpful choices by promoting constructive lifestyles, and developing social environments facilitating drug free lifestyles. Methods in Prevention must remain dynamic due to changes in generational needs; SUD issues that were non-existent a decade ago may be prevalent now (ex. youth vaping and opioid use disorder).

Hawaii's SUD prevention programs have focused on youth, especially underage drinking (UAD). Since 2006, ADAD has partnered with prevention providers, community coalitions, and county governments to enhance the state's prevention infrastructure. In 2013, ADAD was awarded the Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant from SAMHSA with the goal of reducing and preventing underage drinking among youth and young adults ages 12-20 in the State of Hawaii. Components of the SPF include: assessment, capacity building, implementation, evaluation, sustainability, and cultural competency. Hawaii's efforts to address the priorities of UAD have made some significant achievements since October 2016 through the SPF.

HACDACS recommends focused data collection and research to guide decision making and planning in the area of SUD prevention.

HACDACS recommends prevention efforts be evidence-based and tailored to specific substances.

**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 thirty-two (32) substance abuse treatment agencies that provide services statewide.

During Fiscal year 2018-19, 1,690 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 1,954 offenders who received services, 375 were carryovers from the previous year. A breakdown of the numbers serviced in Fiscal Year 2018-19 is as follows in Tables 1-4:

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

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

Table 1. Total Referrals and Carryovers by Criminal Justice Agency: July 1, 2018 – June 30, 2019

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu	70	945	9	173	1,197
Maui	18	303		13	334
Hawaii	25	377	1	20	423
Total	113	1,625	10	206	1,954

Case management services providers: CARE Hawaii, The Queen's Medical Center, Big Island Substance Abuse Council, The Salvation Army—Addiction Treatment Services, Hina Mauka, Ka Hale Pomaika'i, Ohana Makamae

Table 2. Referrals by Criminal Justice Agency: July 1, 2018 – June 30, 2019

County	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
O'ahu ¹	59	828	8	158	1,053
Maui ²	7	274	0	7	288
Hawaii ³	20	316	1	12	349
Total	86	1,418	9	177	1,690

Case management services providers: CARE Hawaii, The Queen's Medical Center, Big Island Substance Abuse Council, The Salvation Army—Addiction Treatment Services, Hina Mauka, Ka Hale Pomaika'i, Ohana Makamae

Table 3. Carryover Cases 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
O'ahu	9	183	1	16	209
Maui	10	76	0	5	91
Hawaii	4	63	0	8	75
Total	23	322	1	29	375

Case management services providers: CARE Hawaii, The Queen's Medical Center, Big Island Substance Abuse Council, The Salvation Army—Addiction Treatment Services, Hina Mauka, Ka Hale Pomaika'i, 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 (the 2018 Recidivism Update was not yet available for this report) states 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 lower than the previous year's rate of 48.6%. The FY 2014 recidivism rate is 28.8% lower than the recidivism rate reported in the FY 1999 baseline year, remaining just 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, and indicates a 22.9% 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 26.9% 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 recidivism rate for FY 2014 is 45.1% (3.5 percentage points) lower than the FY 2013 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.

Table 4. Recidivism by Criminal Justice Agency: July 1, 2018 – June 30, 2019

	Supervised Release PSD/ISC	Judiciary Adult Client Services	PSD/ISC - Corrections Jail/Prison	Hawaii Paroling Authority	Total
Arrests/revocations	4	61	0	2	67
Total served	69	949	18	98	1,134
Recidivism rate	6%	6%	0%	2%	6%

**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 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 2016-19**
- B. ADAD-Funded Adolescent Services: Fiscal Years 2016-19**
- C. Performance Outcomes: Fiscal Years 2016-19**
- 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: 2009-19**

APPENDIX A

**ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2016-2019**

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Male	66.1%	67.4%	66.5%	67.5%
Female	33.9%	32.6%	33.5%	32.4%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Hawaiian	43.8%	44.7%	44.5%	44.4%
Caucasian	22.5%	23.0%	20.9%	21.3%
Filipino	8.0%	8.4%	7.9%	6.9%
Mixed - Not Hawaiian	3.0%	2.6%	2.1%	4.2%
Japanese	4.5%	3.9%	5.0%	3.2%
Black	4.0%	2.8%	3.2%	2.3%
Samoan	3.4%	3.1%	2.1%	3.1%
Portuguese	1.3%	1.2%	1.5%	1.5%
Other Pacific Islander	6.3%	3.3%	3.9%	3.9%
Other*	3.2%	7.1%	9.0%	9.3%
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 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Methamphetamine	50.5%	53.4%	54.7%	60.6%
Alcohol	22.2%	20.0%	16.8%	16.1%
Marijuana	13.8%	12.4%	10.9%	9.1%
Cocaine/Crack	2.6%	1.6%	3.3%	1.9%
Heroin	5.3%	6.4%	7.4%	6.9%
Other*	5.6%	6.2%	6.9%	5.4%
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 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
O'ahu	67.0%	65.6%	64.7%	57.8%
Hawaii	16.4%	18.1%	17.5%	27.2%
Maui	10.2%	11.5%	11.2%	8.0%
Molokai/Lanai	1.9%	1.8%	1.7%	1.4%
Kauai	3.1%	1.6%	2.9%	2.4%
Out of State	1.4%	1.4%	2.0%	3.2%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adult Admissions by Primary Substance for Fiscal Year 2015-16 through Fiscal Year 2018-19, methamphetamine use increased from 50.5% to 60.6%. Alcohol use decreased from 22.2% to 16.1%, and marijuana use decreased from 13.8% to 9.1%. Cocaine/Crack use decreased from 2.6% to 1.9%. Heroin use increased from 5.3% to 6.9% while all “Other” substances decreased slightly from 5.6% to 5.4%.

Also, among the 3,396 adult admissions for FY2019, 889 admissions (26.2%) were homeless when admitted to treatment.

APPENDIX B

**ADAD-FUNDED ADOLESCENT¹¹ SERVICES
FISCAL YEARS 2016-2019**

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Male	52.7%	53.4%	51.4%	48.7%
Female	47.3%	46.6%	48.6%	51.3%
TOTAL	100.0%	100.0%	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Hawaiian	46.0%	42.6%	44.7%	48.1%
Caucasian	10.8%	10.2%	7.8%	7.6%
Filipino	11.4%	10.5%	10.7%	9.3%
Mixed - Not Hawaiian	1.3%	1.9%	3.6%	2.7%
Japanese	3.6%	3.7%	4.4%	3.3%
Black	3.0%	2.9%	2.1%	2.1%
Samoan	4.3%	4.0%	4.0%	4.6%
Portuguese	0.4%	0.8%	0.9%	0.8%
Other Pacific Islander	15.3%	14.0%	15.2%	13.9%
Other*	3.9%	9.5%	6.5%	7.6%
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 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
Methamphetamine	0.6%	1.1%	1.0%	0.6%
Alcohol	21.5%	22.8%	22.2%	18.3%
Marijuana	66.8%	62.6%	61.6%	64.4%
Cocaine/Crack	0.3%	0.3%	0.3%	0.7%
Heroin	-0-	-0-	-0-	0.1%
Other	10.8%	13.2%	15.0%	16.0%
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 2015-2016	FY 2016-2017	FY 2017-2018	FY 2018-19
O'ahu	61.9%	60.0%	66.4%	66.9%
Hawaii	13.1%	12.8%	13.6%	18.0%
Maui	16.0%	18.7%	11.5%	9.3%
Molokai/Lanai	1.9%	0.6%	0.1%	-0-
Kauai	7.1%	8.0%	8.4%	5.7%
TOTAL	100.0%	100.0%	100.0%	100.0%

In the ADAD-Funded Adolescent Admissions by Primary Substance for Fiscal Year 2015-16 through Fiscal Year 2018-19, methamphetamine use remained steady at 0.6%. Alcohol use decreased from 21.5% to 18.3%, while marijuana used decreased slightly from 66.8% to 64.4%. Cocaine/Crack use increased slightly from 0.3% to 0.7%. Heroin use increased slightly from 0% to 0.1%, while use of “Other” substances increased from 10.8% to 16.0%.

¹¹ 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 2016 through 2019, 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 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Employment/School/Vocational Training	98.1%	97.4%	98.8%	98.3%
No arrests since discharge	93.5%	93.8%	93.4%	94.1%
No substance use in 30 days prior to follow-up	57.9%	53.8%	59.4%	56.7%
No new substance abuse treatment	77.1%	80.3%	85.5%	75.8%
No hospitalizations	95.4%	95.2%	95.5%	95.4%
No emergency room visits	93.5%	93.5%	92.1%	92.6%
No psychological distress since discharge	88.2%	84.8%	78.9%	76.3%
Stable living arrangements*	97.7%	97.8%	99.0%	97.1%

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

**PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT**

During State Fiscal Years 2016 through 2019, 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 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Employment/School/Vocational Training	58.7%	58.6%	58.2%	63.4%
No arrests since discharge	94.0%	92.9%	92.7%	90.1%
No substance use in 30 days prior to follow-up	60.3%	61.0%	56.6%	67.4%
No new substance abuse treatment	64.5%	61.8%	55.0%	63.6%
No hospitalizations	94.4%	90.9%	91.0%	91.9%
No emergency room visits	87.3%	86.2%	85.6%	88.1%
Participated in self-help group (NA, AA, etc.)	42.6%	36.5%	36.0%	40.3%
No psychological distress since discharge	71.7%	67.4%	63.7%	78.0%
Stable living arrangements*	79.6%	77.5%	76.1%	83.1%

**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 O'ahu 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 2015 to Fiscal Year 2019) average annual ADAD-funded admissions for adults is 3,027, which is 3.5% 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:

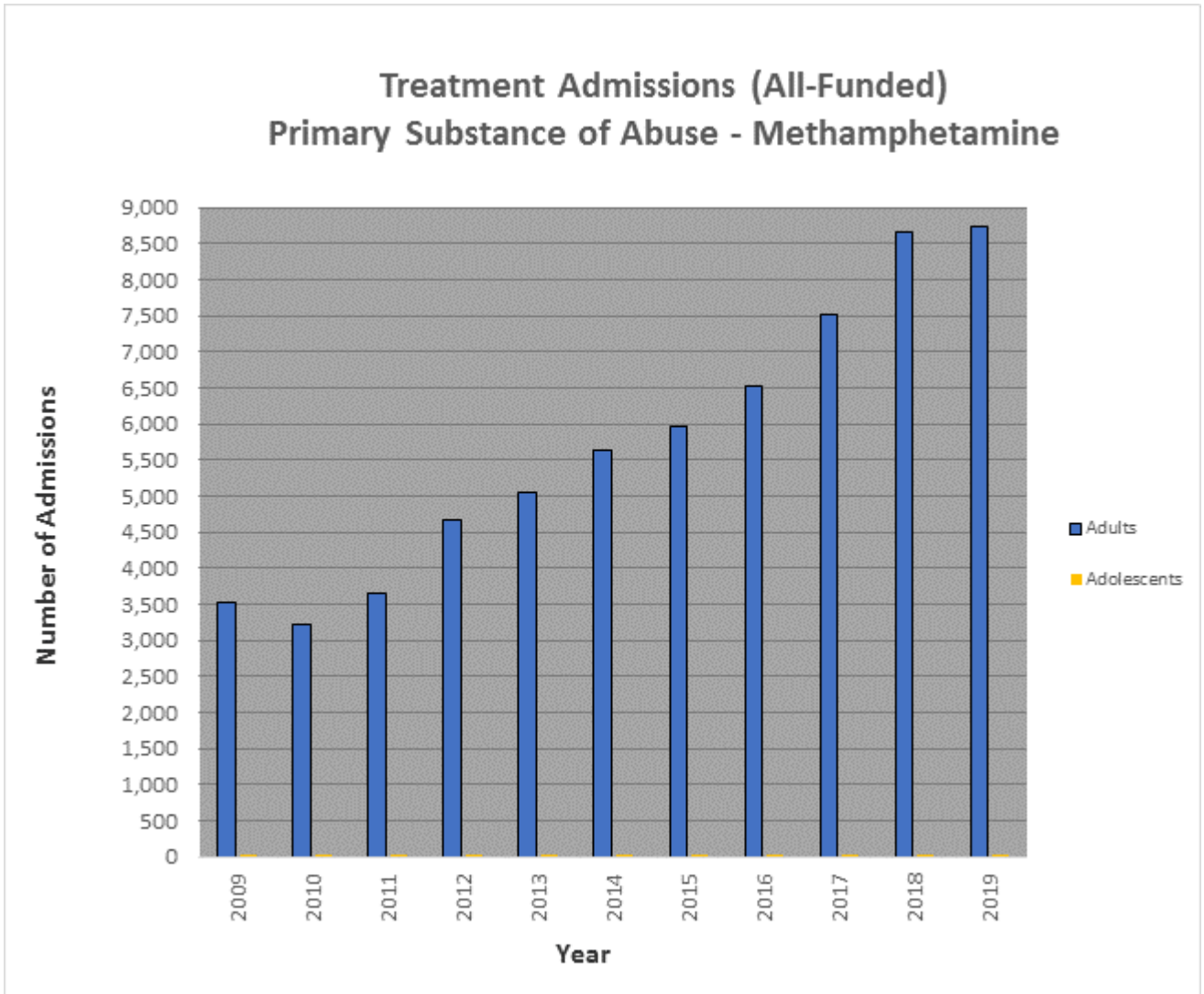
- For treatment needs by gender, more females (8.3%) than males (6.8%) met criteria for abuse or dependence for any substance use.
- For treatment needs by grade, 1.6% of 6th graders, 4.8% of 8th graders, 10.5% of 10th graders and 17.8% of 12th graders met criteria for substance abuse or dependence.
- 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 2015 to Fiscal Year 2019) average annual ADAD-funded admissions for adolescents is 1,908, which is 30.3% of the estimated need for adolescent alcohol and drug abuse treatment.

APPENDIX F

METHAMPHETAMINE ADMISSIONS 2009 - 2019

As reflected in the graph and table below, there was a 1.1% increase and a 16.0% increase in adult and adolescent crystal methamphetamine admissions to treatment, respectively, in Fiscal Year 2018-19.



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Adults	3,536	3,216	3,654	4,681	5,044	5,642	5,978	6,540	7,511	8,655	8,746
Adolescents	22	24	28	15	21	24	26	16	30	25	29
Total	3,558	3,240	3,682	4,696	5,065	5,666	6,004	6,556	7,541	8,680	8,775

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.

**REPORT PURSUANT TO
SECTION 329E-6, HAWAII REVISED STATUTES
REQUIRING A REPORT ON UNINTENTIONAL OPIOID-RELATED DRUG
OVERDOSE**

Section 2 of Act 68, SLH 2016, requires that the Department of Health ascertain, document, and publish an annual report on the number of, trends in, patterns in, and risk factors related to unintentional opioid-related drug overdose fatalities occurring each year within the State. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.

This report is the result of a collaboration between ADAD, the DOH Emergency Management Services and Injury Prevention Systems Branch (EMSIPSB), the University of Hawaii Office of Public Health Studies and the Hawaii Opioid Initiative (HOI).

Numbers, Trends, and Patterns

Data from the HOI website called <https://www.hawaiiopioid.org/opioid-dashboard/> shows a 5-year average of 59 opioid-related fatal overdoses from 2013-2017 according to the DOH death certificate database, a decrease from the previous 5-year average of 67 deaths a year from 2012-2016.

Recent data from the Centers for Disease Control's (CDC) WONDER system, a national public health dataset shows that Hawaii opioid poisoning fatality rates appear to be trending downward (5.2 in 2016 to 3.4 in 2017) (Figure 1) while the national rate appears to steadily increase (14.9 in 2017). When compared to overall drug poisonings, Hawaii's rate appears steady at 13.8 (Figure 2) which is still well below the national rate. And when compared to other states, Hawaii has the third *lowest* fatality rate of poisonings due to prescription opioids, methadone, heroin and opium (4.4) which is also well below the national rate (Figure 3).

Figure 1. Adjusted opioid poisoning fatality rates (per 100,000), Hawaii vs. U.S., 1999-2018 (includes poisonings due to heroin and opium.)

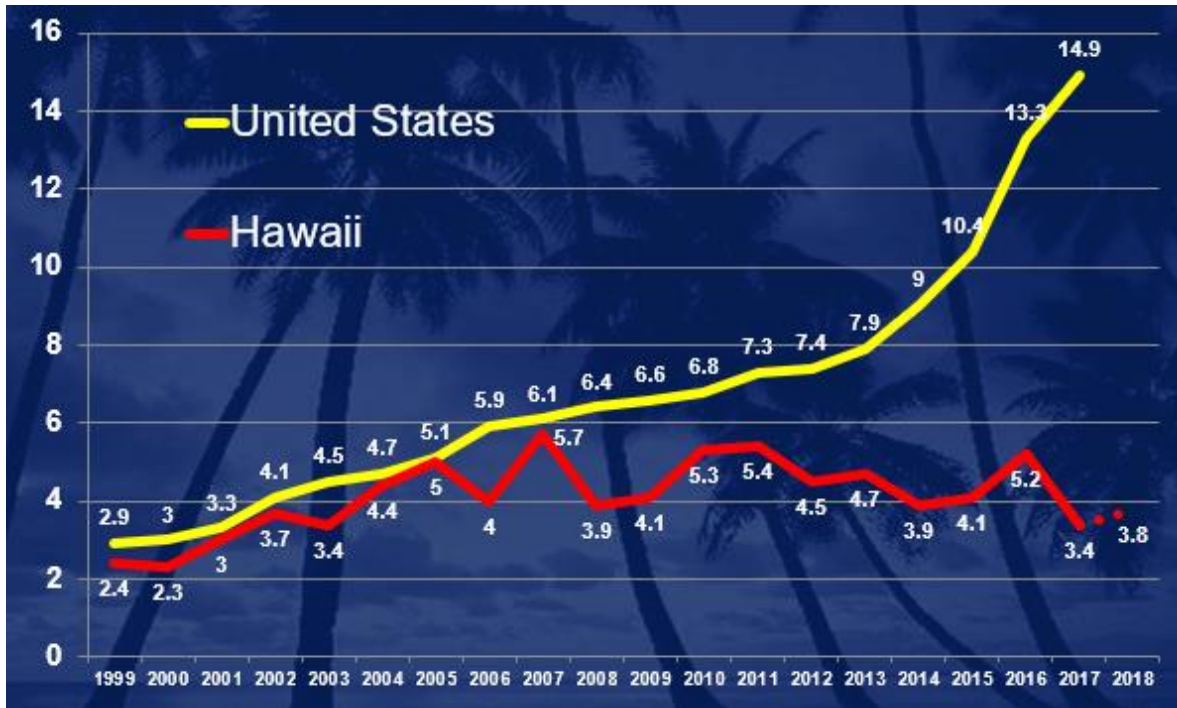


Figure 2. Adjusted drug poisoning fatality rates (per 100,000), Hawaii vs. U.S., 1999-2018.

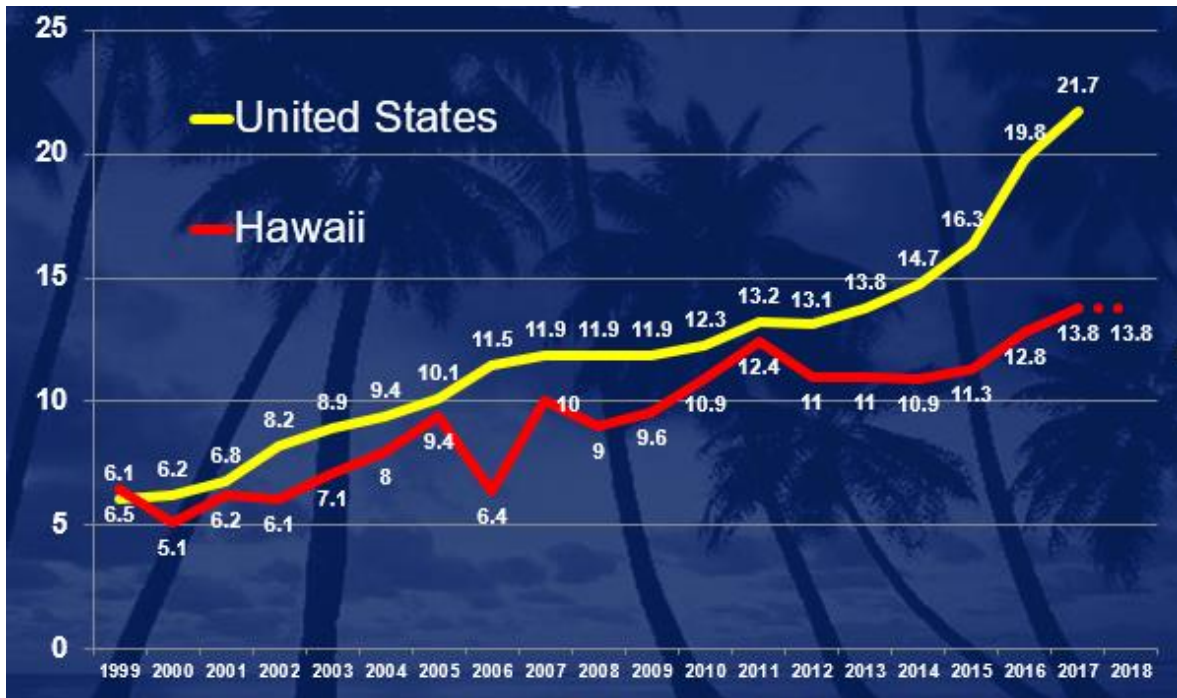
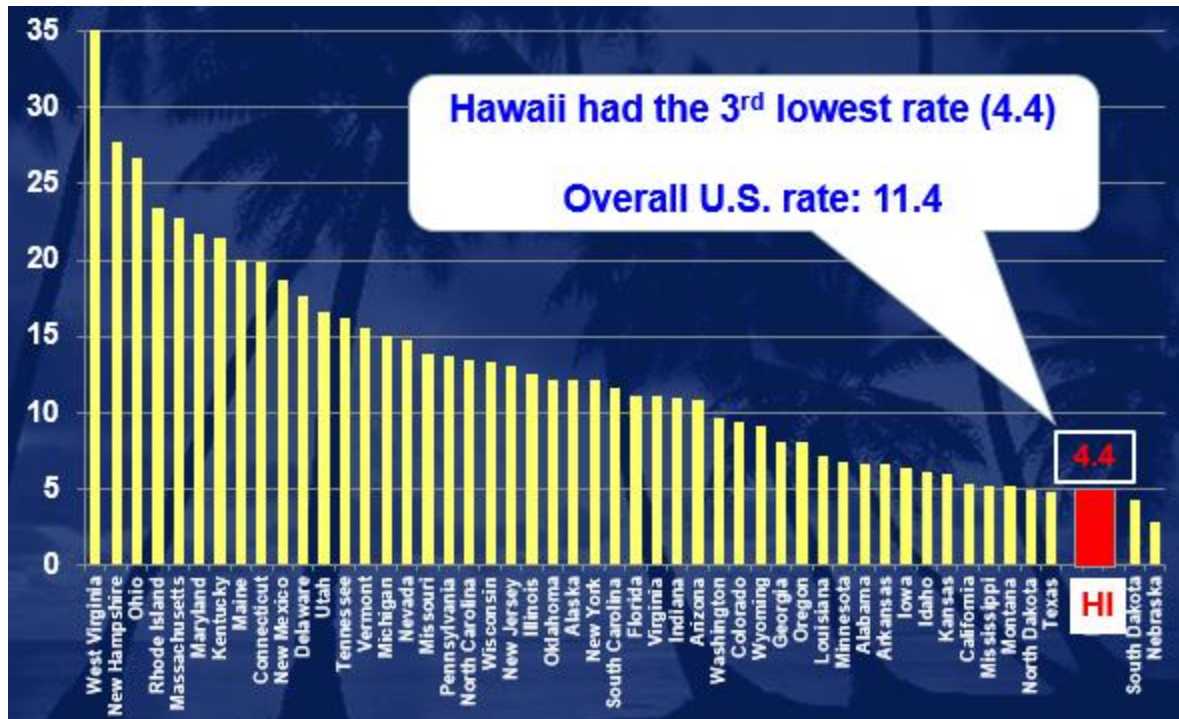


Figure 3. Adjusted opioid poisoning fatality rates (per 100,000), by state, 2013-2017 (includes poisonings due to heroin and opium).



When looking at poisoning fatality rates by type of drug, CDC WONDER data show that deaths due to synthetic drugs like fentanyl and tramadol have increased significantly (Figure 4). This picture contrasts with Hawaii death certificate data which show a greater prevalence of fatal opioid poisonings among Hawaii residents due to natural or semi-synthetic opioids like codeine, morphine, oxycodone and hydrocodone (Figure 5).

Figure 4. Adjusted opioid poisoning fatality rates, by type, U.S., 1999-2017.

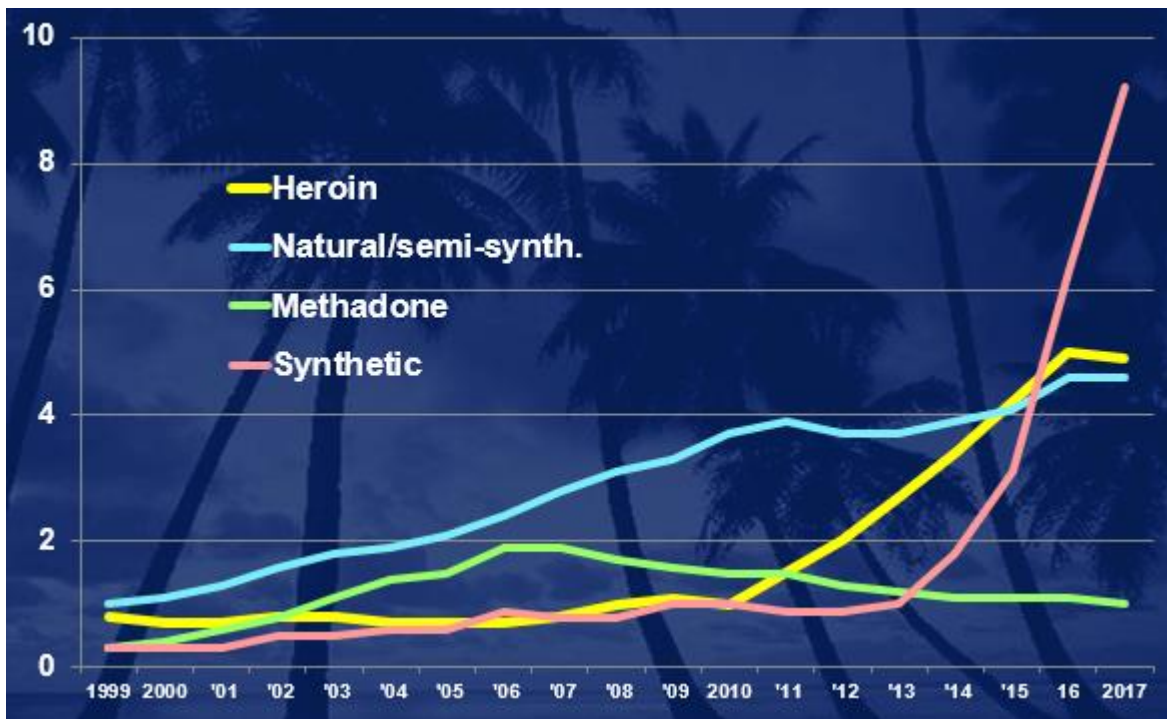
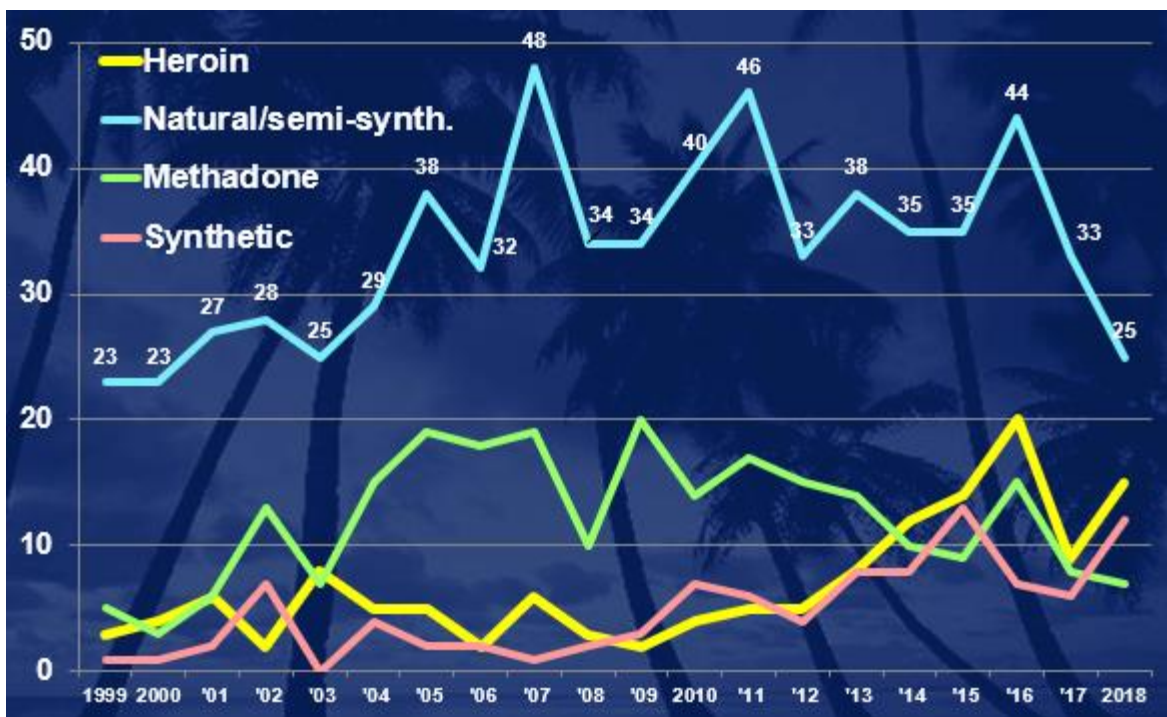


Figure 5. Annual number of fatal opioid poisonings among Hawaii residents, by type of opioid, 1999-2018.



A 2016 review of opioid-related fatal overdoses by the City & County of Honolulu then-Medical Examiner's Office (City MEO) upon request by the EMSIPSB found that:

- According to the MEO, 91% or 64 of the opioid-related fatal overdoses on Oahu in 2016 were unintentional;
- Only one victim was described as homeless;
- About two-thirds or 64% of the victims has a history of mental illness (e.g., depression, anxiety, bipolar);
- 43% were also positive for benzodiazepines which are also known as tranquilizers;
- More than half or 59% of victims tested positive for illicit substances (e.g., methamphetamine, heroin, THC, cocaine); and
- 39% of the victims had an opioid prescription.

Source: EMSIPSB

The EMSIPSB in prior work for the CDC linked the City MEO autopsy records with the Prescription Drug Monitoring Program (PDMP) which is operated by the Department of Public Safety. Of the 67 opioid-related fatal overdoses on Oahu in 2016, PDMP records matched for 76% or 51 decedents. The match found that:

- 73% or 49 of the decedents had prescriptions for opioid pain relievers (OPRs) like oxycodone, hydrocodone, tramadol, morphine, codeine and fentanyl;
 - About two thirds of them received their latest prescriptions within the last four months prior to death;
 - Nearly two-thirds or 63% of the 49 decedents with OPR prescriptions were not in compliance with CDC prescriber guidelines to guard against overlapping between OPR and benzodiazepine prescriptions.
- 24% had a single prescriber, whereas another 24% had 2-3 prescribers, another 27% had 4-5, and the last 24% had 6-18;
- Nearly half or 47% of the 51 matched decedents tested positive for benzodiazepines;
- Most or 71% of the 51 matched decedents had a benzodiazepine prescription filled within thirteen (13) days or sooner of their death;
- Of the 193 OPR prescribers:
 - 55% wrote only a single OPR prescription, and
 - 88% prescribed OPRs to a single victim.
- There were no significant differences between the matched decedent group and the unmatched group in terms of age, gender, residency, and testing positive for illicit substances.

Source: EMSIPSB

Risk Factors and Effective Interventions Against Opioid Overdose

The risk factors identified by the EMSIPSB in the 2016 consultations with the City Medical Examiner's Office and the PDMP include but are not limited to:

- Use of benzodiazepines
- Use of illicit substances (e.g., methamphetamine, heroin, THC, cocaine)
- Had recent (less than four months) prescription(s) for opioid pain relievers including methadone, codeine, morphine, oxycodone and hydrocodone
- History of mental illness (e.g., depression, anxiety, bipolar)

Other risk factors perhaps not considered in the 2016 autopsy record review that may also contribute towards opioid overdose includes:

- Male
- Caucasian
- Arrested more than 3 times in life
- Divorced
- Sleep apnea
- Positive drug screening test
- Liver disease
- Chronic obstructive pulmonary disease or asthma
- Past overdose
- Past intravenous drug use

Source: Wilder et al. J Addict Dis. 2016; 35(1): 42–51.

doi:10.1080/10550887.2016.1107264

According to the CDC, the best ways to prevent opioid overdose deaths are to improve opioid prescribing, reverse overdoses, prevent misuse, and treat opioid use disorder.

Improve Opioid Prescribing. CDC has issued the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for prescribing opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

Reverse Overdoses. CDC recommends expanded access to and use of naloxone – a non-addictive, life-saving drug that can reverse the effects of an opioid overdose when administered in time.

CDC also recommends expansion of Good Samaritan Laws, which already exist in Hawaii. In the event of an overdose, these types of policies protect the victim and the person seeking medical help for the victim from drug possession charges.

Prevent Misuse. CDC recommends:

- Expanded use of the PDMP;
- Prescription drug laws;
- Formulary management strategies in insurance programs, such as prior authorization, quantity limits, and drug utilization review
- Academic detailing to educate providers about opioid prescribing guidelines and

facilitating conversations with patients about the risks and benefits of pain treatment options

- Quality improvement programs in health care systems to increase implementation of recommended prescribing practices
- Patient education on the safe storage and disposal of prescription opioids
- Improve awareness and share resources about the risks of prescription opioids, and the cost of overdose on patients and families (like the [Rx Awareness](#) campaign website).

Opioid Use Disorder Treatment. CDC advocates expanded access to evidence-based treatments, including medication-assisted therapy (MAT) which is a comprehensive way to address the needs of individuals that combines the use of medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies (like the [SAMHSA Treatment Locator](#) and National Helpline).

ADAD continues to implement the collaborative and multidisciplinary stakeholder response currently known as the HOI. While a revision to the 2019 opioid plan is in process, ADAD wish to emphasize that the overarching goal of the collaborative is to also develop Action Plans for other substance misuse issues (like methamphetamine).

The HOI is currently working on the following objectives:

- Treatment Access:
 - Increase the number of prescribers licensed to prescribe and administer MAT such as buprenorphine and suboxone by 25%
 - Expand coordinated entry system pilot to a statewide system for all ADAD contracted providers by Dec. 2019;
- Prescriber Education & Pain Management
 - Establish a process within the Medical Review Board for professional or institutional review and engagement with prescribers who may be over-prescribing or who are engaged in prescribing practices that are of concern (separate from law enforcement).
 - By Dec. 2019 develop and recommend a plan for education for physicians specific to opioid prescribing and pain management practices that includes oversight to ensure that content remains relevant and current.
 - Identify and evaluate mechanisms to increase use of opioid/pain management education for prescribers upon relicensing or renewal of prescriptive authority.
 - Promote UH Project ECHO Series on Opioid and Pain management information.
 - Promote educational offerings that provide relevant opioid and pain management information. This will include development of a minimum of eight short video clips that can be distributed widely to enhance prescriber knowledge of relevant topics (“Mocha Minutes”).
- Data-Informed Decision Making
 - Support and recommend legislature that allows data sharing between the Narcotic Enforcement Division (NED) and DOH.

- Standardize a framework for collecting, synthesizing and disseminating data.
- Develop electronic health record (EHR) interface between hospital and primary care settings.
- Identify methods to optimize the completeness of PDMP data through additional software enhancements and personnel support.
- Develop an electronic health record (EHR) interface between hospitals and primary care settings.
- Increase prescriber education regarding access to and use of PMP, including delegates by an additional 20%.
- Increase capacity of the data dashboard through a standardized framework for data to be utilized by all workgroups and published on www.hawaiiopioid.org
- By Dec. 2019 increase data collection by pulling in additional data sets and continue to apply analytics to the data to describe, predict, and improve each of the workgroup's performance.
- Coordinate with all workgroups to develop a centralized system for naloxone distribution, utilization and tracking.
- By Dec. 2019 develop a data summary on medical cannabis statutes and patterns of utilization through a literature review.
- Prevention and Public Education
 - Continue developing and establishing a media campaign that encompasses themes and topics from all focus areas.
 - Continue to develop and disseminate an evidenced-based training module on opioid use, misuse, overdose and harms resources in Hawaii.
 - Create a comprehensive two-year marketing campaign that serves to develop, finalize, and disseminate branding and products (e.g. evidence-based training module on opioid use, misuse, overdose and related harms for non-prescribers) as the next stage in a multi-modal public awareness campaign to increase awareness of opioid issues, risks and centralize resources in Hawaii.
 - Expanding Drug Take-Back Options. Promote awareness of existing “take back” sites through www.hawaiiopioid.org and other channels (e.g. infographics), and increase access by implementing at least two additional year-round “take back” sites on Oahu.
 - By Dec. 2019, establish partnerships with at least ten new organizational allies (e.g. hepatitis coalitions, faith-based groups, environmental justice, hygiene centers, youth groups) to develop, implement, and evaluate at least two locally-based prevention projects that can be shared as successful models of care.
- Pharmacy-Based Interventions
 - Train pharmacists to screen for opioids users for SUD. This can be coordinated with implementation of SBIRT project activities.
 - Continue developing the Pharmacist Naloxone training program.
 - Create a marketing campaign to increase awareness about Act 154 (2019) and the availability of Naloxone. Group will identify their targeted audience for campaigns and will ensure there is agreement about

- messaging as to not confuse viewers.
- Review preauthorization requirements for Naloxone that may be potential barrier for pharmacists prescribing under Act 154 (2019) and provide an action plan to resolve.
- Support for Law Enforcement and First Responders
 - Establish LEAD in Maui and Hawaii Counties
 - Develop mechanism for real time reporting and data collection for opioid related incidents and emergencies.
 - Develop a resource card or an infographic about the availability and effectiveness of treatment options for both the opioid users and their families in healthcare settings. This resource card may also be a utilized for first responders (collaborating with HIDTA).
 - Collect data on implementation and utilization of ODOM Mapping pilot and discuss expansion project. Maui Police Department has piloted the ODOM Mapping system to disseminate real time data reporting of SUD related or crisis incidents for coordinated response efforts by available community resources.
 - Develop data needs and coordinate with the Department of the Medical Examiner on data resources, collection and reporting.
 - Continue providing support to NED for PDMP utilization and effectiveness.
 - Provide support for coordinated entry and related referral and access efforts such as LEAD implementation on Maui and Hawaii counties. Also provide coordination and leadership for community stakeholders and resources for implementing LEAD activities.