ADVISORY COMMISSION ON DRUG ABUSE AND CONTROLLED SUBSTANCES (HACDACS)

Alcohol and Drug Abuse Division (ADAD), Department of Health (DOH), State of Hawai'i

Kākuhihewa Building, 601 Kamokila Boulevard, Room 360, Kapolei, Hawai'i
March 25, 2025
9:00 am – 11:00 am

Members Present: Ku ulei Salzer-Vitale, MSW Co-Chair, Lilinoe Kauahikaua, MSW, Co-Chair; Diana Felton, MD Vice Chair; Emily Andrade; Jon Fujii, MBA; John Paul Moses III, APRN-R; Jawanna Ready, MD; Greg Tjapkes.

Members Absent: Erika Vargas, LCSW.

Staff Present: John Valera, AICP; Robyn Loudermilk, AICP, Merrick Lambaco, Michaella Urial Abitz.

Guests Present Heather Lusk, LCSW.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS/ CONCLUSIONS	PERSON(S) RESPONSIBLE	DUE DATE
1. Call to Order:	The meeting was called to order at 9:02 am.			
2. Consideration and approval of meeting minutes of February 25, 2025.	**Motion by Co-Chair Salzer and seconded by Vice-Chair Felton to adopt minutes from the February 25, 2025, meeting. Motion approved.**	**Motion approved.**		
3. Community Input: [Pursuant to section 92-3, Hawaii Revised Statutes, all interested persons will have three (3) minutes to speak, i.e., per person, per item, or written testimony can be submitted on agenda items]	No community coments provided.			
4. Alcohol and Drug Abuse Division (ADAD) Report • Update on ADAD Staffing: Statistics Clerk and State Opioid Response Coordinator • Update on Activities of the Hawaii Overdose Initiative (HOI)	Mr. Valera reported on ADAD staffing and HOI activities. • Daniel Jeong is ADAD's new Statistics Clerk focusing on prevention related data. Sophia Santucci is ADAD's new State Opioid Response Coordinator.			

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	• Still reviewing and refining the Draft HOI Plan prepared by UH-West Oahu. Apologize for the delay, there were number of issues requiring ADADs immediate attention. Will send out another communiqué this week to HOI Launch participants. The release of the draft plan to participants will also include a survey to facilitate the formulation and operations of the working groups. Co-Chair Kauahikaua led the discussion on the ADAD Report focusing on HACDSCS advisory role for HOI. In response to a question, Mr. Valera relayed that this is an opportunity as the scope will be broader, focused on multiple substances, possibly help the co-occurring population, and incorporating the voices with lived experiences. It is a statewide approach with considerations to preferences within each county.			
5. Discussion on Commission Recruitment.		Deferred		
6. Discussion on Update to Bylaws	Co-Chair Kauahikaua led the discussion on updating by-laws which focused on how to fulfill duties and responsibilities while making an impact. Ms. Loudermilk provided a brief summary describing the mark-ups on the by-laws included in the meeting packet. Explaining that "HRS" stands for Hawaii Revised Statutes, which are state laws/statutes. Portions of the by-laws which reference HRS are taken directly from state law. Vice-Chair Felton explained that what is in the statute cannot be changed, but the by-laws can be changed as long as it doesn't violate the statute. While Co-Chair Salzer further explained that items in the by-laws			

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	taken from the statutes reflect the duties of the commission. Co-Chair Kauahikaua commented that there are a number of roles and responsibilities not being done by HACDACS. Does that mean that HACDACS needs to dig down into these roles and responsibilities to determine how HACDACS will/should respond? Feels like we are a commission that only does a legislative report. Based on by-laws, could be doing much more and having an impact. Preference is to have an impact. Commissioner Andrade commented that she agrees with Co-Chair Kauahikaua, How should this be done? What are next steps to move forward? She shared her experience submitting testimony to the Senate Committee on Health and Human Services supporting her nomination to HACDAC. The questions were very detailed questions, it felt like applying for a job. From that lens, it sounds like the Senate Committee takes nominations seriously. Need to educate the public about the good work being done by the government. Commissioner Tjapkes commented that he too also asks if anyone reads the report and thought it interesting that it is one of the last items listed. Not sure how advising the Director of Health and the Governor on research & development would functionally work. Pointed out that HACDACS does not have a budget and may not be able to do a number of things other than advise. Thinks it's good for HACDACS to be a more proactive, such as providing legislative testimony. In response to questions Mr. Valera noted that we can work with the DOH Communications Office to figure			

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	out their role in supporting us. They have been proactive in reaching out to the programs on what we would like to post on social media. ADAD previously provided them information on various campaigns such as National Recovery Month and Red Ribbon Week. He also noted that the Governor is surrounded by a number of advisers and has a policy team. The Director of Health does not have staff around him called "senior advisors". At a future meeting, ADAD can share all recommendations that have been acted upon, such as the recommendation to replace the WITS system. ADAD has been able to procure services and is currently developing a new system to replace WITS address identified issues. The State Council on Mental Health has developed a mechanism to submit legislative testimony. That it may be a tool that can be used. Ms. Loudermilk will contact the State Council on Mental Health to obtain a copy of their by-laws. if members have specific questions, send her an email.			
7. Identification of Date(s) for In-Person Commission Meetings in 2025.	An in-person meeting will be held on June 24, 2025, in Kapolei.			
8. Update on meeting topics and presentations for HACDACS meetings in: • June 2025 • July 2025 • August 2025 • September 2025	Co-Chair Kauahikaua led the discussion related to planning and any schedules or topics that the groups would like to discuss: • April 2025 Meeting: Findings from the Hawaii Opioid Initiative Needs Assessment • May 2025 Meeting: Primary Prevention Strategic Plan	Contact Mapuna Labs Contact ADAD	ADAD confirmed. ADAD confirmed	

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Potential topics include Medical Cannabis Safety and Testing Policies; Harm Reduction Review based on substance use; Status of Residential Treatment Programs and their trends and needs, Prevention Initiatives, Medication Assisted Treatment for Methamphetamine Use Disorder, the intersection of substance use treatment and the criminal justice system. New topic ideas are encouraged.	• June 2025 Meeting: Hawaii Opioid Settlement Program	Contact ADAD	ADAD confirmed	
9. Presentation on Providing an Overview of Harm Reduction and the Hawaii Health and Harm Reduction Center.	Ms. Heather Lusk, LCSW, Executive Director of the Hawaii Health and Harm Reduction Center (HHHRC) provided an overview on harm reduction and the HHHRC. • Harm reduction is public health. • Hawaii Health and Harm Reduction Center (HHHRC): Reduces harm, promoting health, creating wellness, and fighting stigma in Hawaii and the Pacific. Works at the intersection of the criminal legal system, chronic disease, mental health, substance use , and houselessness. Provides both street-based services and warm hand off referrals. Utilizes a "No Wrong Door" approach. Approximately 100+ syringe service participants accessing substance use services. • There is no "one" definition of harm reduction. HHHRC defines Harm Reduction as *a non-judgmental approach to public health that meets people where they are and celebrates positive change, with the goal of minimizing the harms of actions that pose adverse social and health outcomes.* Viewed as a public health approach Also shared a number of other definitions. • In response to a question co-Chair Kauahikaua shared that Papa Ola Lokahi's E Hui Ana Na Moku Harm Reduction Toolkit began with community listening sessions and continued to include the community throughout its development. • Harm reduction began in Europe during the 1980's in response hepatitis B, then HIV in people who inject drugs. Law enforcement, public health, and drug users came together and said that health risk is greater than substance use itself. Chose public health over criminalization. • Appeared in the US in the late 1980's with the first syringe exchange program established in 1988. Initial national harm reduction conference was held in 1996. In 2022, the Substance Abuse Mental Health Services Administration releases first harm reduction funding. • Appeared in Hawaii in 1983 when the Life Foundation started syringe exchanged before it was legal. The State of Hawaii's syringe exchange program (SEP) began in 1989 being one of the first in the nation. Hawaii's first harm			

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	reduction conference was held in 1995. The DOH has incorporated harm reduction as part of the substance use disorder continuum of care. • Harm reduction is trauma responsive care that may or may not include abstinence. One of the biggest challenges is how to balance individual level of harm and group or macro level of harm. Shared experience of operating a non-medical stabilization site in Waikiki during COVID. Knew how to do harm reduction on individuals, but was a much bigger challenge to manage in a setting with 36 individuals. Shared another story about an individual who had to leave a clean and sober home due smelling of marijuana from smoking off-site. Noted that there are no wet or damp houses available in Hawaii as an option for this individual. • In response to a question, Co-Chair Salzer commented on the need to expand housing options and not just focus on abstinence-based homes. That housing is a need that everyone has and is often hard to come by here in Hawaii. • In response to a question, Ms. Loudermilk relayed that ADAD is in the early stages of exploring regulatory frameworks for wet and damp houses. Preliminary indications are that there are a number of legal issues surrounding these types of housing • Examples of current harm reduction efforts in Hawaii include SEP and safer substance use efforts, overdose prevention, and low barrier substance use disorder (SUD) treatment [e.g. Medication for Opioid Use Disorder (MOUD)]. SEP requires one to one exchange. Seen dramatic decline in syringe distribution between 2023 and 2024, from 1.2 million to approximately 600,000, respectively. This decline is tied in with increased use of fentanyl. Injection clients have moved away from injections to fentanyl as it is easier not to overdose. Overdose prevention is through dissemination of Naloxone, fentanyl test strips, and xylazine test strips. Naloxone distribution machines are available statewide as well as training on how use Naloxone. A statewide map providing locations where Naloxone can be obtained is available on the HHHRC website. • There is not enough medical detox available in Hawaii to support low barrier SUD treatment. Nine beds are available at the Institute for Human Services facility for those experiencing homelessness. There are providers who provide Tele-detox. Medications support detox by addressing symptoms of detox such nausea. Challenge is that treatment centers will not take persons unless they have gone through medical detox, yet limited facilities. • There is no intersection for homeless persons between Hawaii CARES and the homeless system. At times a person needs both the bed and the treatment. The ideal system of care for homeless persons is the integration of Hawaii CARES with the Homeless Coordinated Entry System. • HHHRC services includes the previously mentioned SEP, overdose prevention, and low barrier SUD treatment. Additional services include clinic and behavioral health, HIV and HCV care coordination, STI, HIV/HCV testing and PrEP, street medicine, medical mobile unit, transgender services, homeless outreach, smoking cessation, Kauhale Ho`okahi Leo, and various trainings. • Some people think that harm reduction does not align with SUD treatment. When a person receiving harm reduction is ready for treatment, they can transition into SUD treatment. Can refer persons to the HHHRC website to get buprenorphine through in-person or tele-health.			

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	• A 2019 ADAD memo required all ADAD funded sites to accept people in MOUD treatment. However, HHHRC buprenorphine clients are declined access to treatment on a regular basis. Recently a HHHRC client was declined treatment because the buprenorphine dose was deemed too high, though the dosage is recommended by ASAM. Need to work with providers and community that MOUD is treatment and is not counter to abstinence. • MOUD has a much higher success rate than abstinence with 41% MOUD users managing their Opioid Use Disorder (OUD) compared to 7% abstinence-based treatment. Success percentage dropped from 49% to 7% when the medication was stopped. • Recommendations on potential harm reduction areas of growth: medical detox, wet and damp housing, more housing or therapeutic living communities (TLCs) for those who are experiencing homelessness and SUD, and contingency management. Co-Chair Kauahikaua led the group discussion on the presentation focusing on the recommendations. In response to questions Ms. Lusk relayed that setting up a medical detox facility is much harder than setting up social detox facility. There are liability and clinician costs with a medical detox facility and current rates do not cover these costs. HHHRC have put homeless clients in Pagoda for medical detox. Once finished, they can get the level of care needed. Some treatment programs take persons on medications for medical detox in outpatient treatment. However, major challenges are whether the program will allow the medicine(s) on-site and medication management. As treatment programs do not distribute medications. Ms. Lusk shared that there are wet and damp house models on the Continent. Some HHHRC staff have visited 1811 East Lake in Seattle. Other programs that she is aware of are similar to the Housing First model. Currently doing research on whether users and non-users in recovery need to be housed separately or can they be housed together. If housed together, will they activate each other? The challenge with TLC's residential treatment for the homeless community is that it is only for 30 days, and housing may not be available once treatment is done. Envision a model were people are living in a safe space with services being provided to them. Excited about the Medicaid's upcoming implementation of contingency management. Noted that contingency management has shown evidence of being an effective tool in the treatment for methamphetamines. Commissioner Fujii shared that Medicaid plane to roll out contingency management in early 2026. As part of program development and implementation, they are currently meeting with organizations implementing contingency management.			
10. Open Forum: Public comments on issues not on the agenda, for consideration for	No community comments provided.			

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Commissions agenda at its next meeting.				
11. Adjournment	The meeting was adjourned at 11:04 am			

Next Meeting: **April 22, 2025**
9:00 am to 11:00 am
Zoom Meeting