U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minutes of the

Interdepartmental Substance Use Disorders Coordinating Committee

Full Committee Meeting

December 6, 2023

9:00 a.m. to 11:40 a.m. (Eastern Time Zone)

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane

Rockville, MD 20857

(Via Zoom)

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Call to Order, Committee Roll Call, and Consideration of Minutes

Tracy Goss – Designated Federal Officer (DFO), Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC) – called the meeting to order on December 6, 2023, at 9:00 a.m. via Zoom. She established a quorum following the roll call.

Federal ISUDCC Members or Designees Present

- Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Yngvild K. Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment (CSAT), SAMHSA
- Ruth Ryder, Deputy Assistant Secretary for the Office of Policy and Programs – Formula Grants, Office of Elementary and Secondary Education, Department of Education (ED)
- Dominick DePhilippis, Ph.D., Office of Mental Health and Suicide Prevention, Department of Veterans Affairs (VA)
- June Sivilli, Senior Advisor, Office of Public Health, Office of National Drug Control Policy (ONDCP)
- Wilson Compton, M.D., National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH)
- Patricia Powell, Ph.D., Deputy Director, National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIH
- Marta Sokolowska, Ph.D., Associate Director for Controlled Substances, Office of the Center Director/ Center for Drug Evaluation and Research (CDER), Food and Drug Administration (FDA)*[1]
- Dele Solaru, PharmD, MBA, Chief Pharmacy Officer, Office of Personnel Management (OPM)*
- Kellie Kubena, Deputy Innovation Officer, Rural Development, Department of Agriculture (USDA)

Federal ISUDCC Members Not Present

- U.S. Department of Justice (DOJ)
- U.S. Department of Labor (DOL)
- U.S. Department of Housing and Urban Development (HUD)
- Social Security Administration (SSA)
- Centers for Disease Control and Prevention (CDC)

Non-Federal ISUDCC Members Present

- Chad Audi, Ph.D., President and CEO, Detroit Rescue Mission Ministries*
- Caleb Banta-Green, Ph.D., MPH, MSW, Principal Research Scientist, Alcohol & Drug Abuse Institute, University of Washington*
- Honorable Nancy L. Butts, President Judge, Lycoming County Court of Common Pleas, Williamsport, PA
- Meredith Canada, MSW, MPA, LCSW, Public Health Analyst, Indiana High-Intensity Drug Trafficking Area Overdose Response Strategy

[1] *Joined after roll call

- Jamie Chrisman Low, M.Ed., NCC, Recovery Consultant, Statewide Recovery Community, Network Weaver, Certified Peer Support Specialist
- Judy Goforth Parker, Ph.D., A.P.R.N., F.A.C.H.E., Commissioner of Health Policy, Chickasaw Nation
- Sheryl Ryan, M.D., FAAP, Division Chief, Professor of Pediatrics, Adolescent Medicine and Eating Disorders, Penn State Health
- Amanda S., Patient and Advocate
- Cynthia Seivwright, MA, CQIA
- Daniel Sledge, BA, LP, Lead Outreach Paramedic, Wilco EMS-MOT
- Richard Spoth, Ph.D., Director, Partnerships in Prevention Science Institute, Iowa State University
- Luis R. Torres, Ph.D., Founding Dean and Professor, School of Social Work, The University of Texas Rio Grande Valley

Non-Federal ISUDCC Members Not Present

- Susan Dawson, Ed.D., PMHNP-BC, Psychiatric Nurse Practitioner, Assisted Recovery Center of America, and State Targeted Response Team for the Opioid Crisis Trainer for Professionals
- Nicholas Estabrook, Addictive Disease Recovery Support Specialist, Department of Behavioral Health and Development Disabilities
- Sara A. Goldsby, MSW, MPH, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
- Erik P. Hess, M.D. MSc, Professor and Vice Chair for Research, Department of Emergency Medicine, the University of Alabama at Birmingham School of Medicine

Upon determining that a quorum had been established, the DFO entertained a motion to adopt the minutes from the ISUDCC meeting held on June 5, 2023. These minutes had been forwarded electronically in advance to each member. She noted that the minutes were certified in accordance with the Federal Advisory Committee Act (FACA) regulations. June Sivilli moved to adopt the minutes, after which the DFO called for discussion. There being none, the DFO called for a vote to adopt the minutes, and they were adopted unanimously. She turned the meeting over to Dr. Delphin-Rittmon.

Welcome and Opening Remarks

Dr. Miriam E. Delphin-Rittmon, Ph.D., ISUDCC Chair, Assistant Secretary for Mental Health and Substance Use, opened the meeting by acknowledging that the workgroups have been working diligently to develop recommendations to the federal government, particularly SAMHSA, on how to further integrate and coordinate harm reduction strategies across the full continuum of prevention, treatment, and recovery. She stated that the agenda would be devoted primarily to presentations and report-outs from the three ISUDCC workgroups on their recommendations for vote by the full ISUDCC at the end of the meeting. She underscored the significance of this work given that more than 107,000 deaths were caused by overdose in 2022 – a tragic milestone that coincided with increasingly complex polysubstance use in the nation. She stated that the efforts of the ISUDCC workgroups will inform the policies, programs, and approaches that the federal government adopts across the continuum of care. After

acknowledging the expertise of all members and expressing her appreciation for their hard work, she turned the meeting over to Dr. Olsen.

Dr. Yngvild K. Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment (CSAT), SAMHSA, said that the day's work would focus on the consolidated draft report on workgroup recommendations that had been sent electronically to each ISUDCC member in the week before the meeting. The draft report contains the proposed recommendations from each workgroup on the topic of interest. She stated that the document represents collaborative work from the federal- and non-federal partners who are part of the ISUDCC with support from SAMHSA staff who served as facilitators.

She also highlighted the presence of tension within the broader substance use field between prevention and harm reduction, recovery and harm reduction, as well as treatment and harm reduction. These conflicting perspectives must be openly discussed and addressed to find common ground. Such discussions are essential for the well-being of individuals and communities impacted by substance use and substance use disorders (SUD). She explained that the meeting agenda would be consolidated into an extended block of time dedicated to presentations, discussions, and addressing any clarifying questions arising from the workgroup report-outs and the comprehensive draft document. She stated that the goal of the meeting is to end with a vote on whether to accept the draft document and recommendations from the workgroups and move it onto finalization. Furthermore, she expressed her expectation that an additional meeting of the full ISUDCC in 2024 would be necessary to review and approve the final recommendations report. She introduced ISUDCC member and patient advocate Amanda S., who addressed the ISUDCC body.

Rules and Resilience: The Road to Recovery

Amanda S. relayed her gripping story of "struggle, resilience, and [her] personal, persistent fight for dignity and care" as a person with lived experience and in recovery. She shared this story because she wants to increase understanding of how difficult it can be for people who genuinely want to stop using substances to do so within a health care system that is fractured and that imposes many barriers amid ongoing stigma regarding substance use. Additionally, sharing her story with the ISUDCC underscores the importance of coordinating policies, practices, and services related to treatment of mental illness and SUD. In her journey, there were many missed opportunities for intervention through harm reduction and other strategies and constant interruptions in care attributed to a lack of coordination and system failures.

ISUDCC Workgroups Report-Outs

Dr. Olsen turned the floor over to the members of the three ISUDCC workgroups, each of whom reported on their proposed final recommendations for consideration by the full ISUDCC.

<u>ISUDCC Prevention Workgroup Report-Out</u>

Dr. Sheryl Ryan and Dr. Richard Spoth delivered this ISUDCC prevention workgroup report. The members of this workgroup are as follows:

Prevention – ISUDCC Non-Federal Members

1. Judy Goforth Parker, Ph.D., A.P.R.N, F.A.C.H.E.
2. Sheryl Ryan, M.D., FAAP
3. Richard Spoth, Ph.D.
4. Sara Goldsby, MSW, MPH
5. Amanda S.

Prevention – ISUDCC Federal Members

1. Marta Sokolowska, Ph.D. (FDA)
2. Wilson Compton, M.D., M.P.E. (NIDA, NIH)
3. Ruth Ryder (ED)
4. June Sivilli (ONDCP)

Prevention – ISUDCC Workgroup Facilitators

1. Lauren Barnes, CSAP, SAMHSA
2. Chase Holleman, CSAP, SAMHSA

Dr. Spoth commended Amanda S. for sharing her impactful story. He expressed confidence that it would have staying power with the ISUDCC and further inspire members to engage in their efforts to prevent similar occurrences. He provided a contextual background for the prevention workgroup's presentation by describing the numerous challenges inherent in prevention when considered alongside harm reduction, based on a preliminary literature review and dialogues with prevention workgroup members. Dr. Spoth acknowledged the tension associated with harm reduction, as highlighted earlier by Dr. Olsen. He emphasized that the field of prevention is all about non-drug users and early users and aims to prevent the initiation of substance use and the development of substance use disorders. He reported the following information on behalf of the workgroup.

Fundamental Challenges

- Reconcile implications of different populations of focus: Non-drug users (or early users).
- Address how prevention's focus on avoiding initiation or regular drug use integrates with harm reduction's focus on safer drug use.
- Generate a more explicit, scientifically sound conceptual framework for integration.

Consensus: There is a need for further groundwork before optimizing integration to fill critical knowledge and conceptualization gaps.

Suggested Groundwork

- Conducting a comprehensive harm reduction literature review paralleling another conducted for prevention.
- Mapping the prevention recommendations onto the SAMHSA Harm Reduction Framework.
- Facilitating ongoing dialogue between thought leaders in the fields of prevention and harm reduction.

Main Recommendations

- Systematically review the scientific literature (theoretical and empirical) on harm reduction interventions/systems for relevance to evidence-based prevention.
- Address the critical need for more robust prevention infrastructure, including coalitions/partnerships for scaling up evidence-based prevention, and development of a stronger prevention workforce integrating with harm reduction.
- Address the related recommendations concerning proven service delivery models, key research, and federal programs.

Dr. Spoth stressed the importance of the framework to be generated, which should not only be grounded in science but also informed by those with lived experience, scientists, and practitioners. He pointed out that currently there is no system to effectively deliver evidence-based prevention—it is fragmented and delivered in various ways through many existing systems (e.g., education, public health, juvenile justice).

Dr. Ryan continued the workgroup report-out by presenting data indicating a dramatic increase of more than 100 percent in mortality rates among youth aged 15 to 19 from 2015 to 2020 specifically related to fentanyl overdose. She emphasized that a significant portion of these cases involved young people who unknowingly consumed fentanyl through counterfeit pills. This data underscores the intersection of prevention with the realm of harm reduction and necessitates discussion and resolution. Dr. Ryan noted that in two-thirds of these overdoses, there was a bystander present who failed to recognize the need to administer naloxone or seek help. This information reinforces Dr. Olsen's earlier statement on finding common ground between prevention and harm reduction. Dr. Ryan then reported the key recommendations put forth by the ISUDCC prevention workgroup.

Key Points on Recommendations Across the Five Issue Areas

Systems Development

(1) Substantially increase investments in infrastructure for evidence-based prevention scale-up.

(2) Enhance collaboration/coordination among prevention stakeholders.

Service Delivery Models

(1) Improve access through proven service delivery models.

(2) Address social determinants of substance use, cultural competency, and diversity.

Workforce Development

(1) Devise workforce development strategies for practitioners in health/human services.

(2) Develop more formalized training/certification.

(3) Support state service reimbursement policies.

Research

(1) Improve research infrastructure for translation of science into practice.

(2) Prioritize key research questions to be addressed.

(3) Implement guiding community monitoring/evaluation tools.

(4) Support research addressing opportunities/barriers/outcomes related to the integration of harm reduction.

Federal Programs

(1) Strengthen federal funding policy/programs to scale up evidence-based preventive interventions.

(2) Enhance federal agency programs for developing and disseminating training materials and educational resources.

The prevention workgroup provided a list of primary references and resources for their background work.

Council Discussion

Christopher M. Jones, Pharm.D., Dr.P.H., M.P.H., the Director of SAMHSA's Center for Substance Abuse Prevention (CSAP), thanked the prevention workgroup for recognizing the inherent tension between prevention and harm reduction, identifying the need to address this challenge as a crucial next step. He pointed out that many of the workgroup's recommendations are already prominently featured in SAMHSA's strategic priorities and signal a positive trajectory. He underscored the importance of focusing on the period between substance initiation and diagnosis/treatment – emphasizing the creation of a culture, especially in schools, that facilitates connecting individuals to preventive interventions. Dr. Jones emphasized the need to dispel a misconception that those who initiate substance use are on their own until they require treatment, stressing, "There are opportunities to reduce harm, but there is also opportunity to connect it back to preventive interventions."

Dr. Ryan added that there are often opportunities for secondary and tertiary prevention in addressing adolescents' progression through preventive interventions and harm reduction. She cautioned against equating prevention solely with abstinence, acknowledging the potential for such thinking to derail prevention efforts.

Dr. Compton called attention to the critical gap in evidence-based prevention approaches for individuals already using substances. He emphasized the urgency of new research and intervention ideas in the space between early use and diagnosable disorders. He also highlighted the need to strengthen the prevention workforce, community organizations, and coalitions, acknowledging the field's existing challenges in meeting the country's current demand to prevent substance use initiation.

Dr. Spoth noted the opportunity for cultural change in evidence-based prevention through enhanced infrastructure and systems development focusing on harm reduction. He stated the prevention workgroup is committed to continuing its literature review on systems and infrastructure development before finalizing its recommendations.

Dr. Banta-Green called for a clear signal from the federal government that prevention and harm reduction are not conflicting goals, urging demonstration in the forms of federal guidance, funding, and mandates. Dr. Delphin-Rittmon concurred, emphasizing the potential benefits of increased awareness and understanding of the complementary nature of prevention and harm reduction.

Dr. Jones advised that SAMHSA's Harm Reduction Framework, submitted in draft form for public comment, is in the finalization stage. Many of the public comments pertained to operationalization. The next stage of SAMHSA's work will entail engaging with people across the care continuum to infuse harm reduction principles and practices in prevention, treatment, and recovery. He echoed the sentiments of so many others in the meeting that this is an urgent matter.

Dr. Powell drew parallels from the alcohol field, describing collaborations between the NIAAA and the FDA on medication development. She emphasized the importance of individual improvement in feeling and function instead of strictly focusing on the number of drinks consumed to determine the success in harm reduction. NIAAA's *Healthcare Professional's Core Resource on Alcohol* was also mentioned for its role in cultural change by addressing stigma and normalizing conversations around alcohol use.

Dr. Spoth urged thoughtful consideration of the following steps, inquiring about the goals for the next six months and the following year and how to articulate and implement the recommendations effectively. Dr. Delphin-Rittmon supported establishing a timeline for fleshing out and acting on the range of recommendations in the workgroup reports.

Dr. DePhilippis addressed the challenge of introducing harm reduction into a public perception that may view it negatively. He proposed normalizing and gaining broader acceptance by highlighting everyday behaviors, such as using seat belts or sunscreen, as examples of harm reduction. Drawing parallels to medical practices, he noted the inconsistency of withholding essential medications based on strict enforcement of behavioral conditions or changes (e.g., losing weight or restricting caloric intake).

ISUDCC Treatment Workgroup Report-Out

Daniel Sledge delivered the ISUDCC treatment workgroup presentation. The workgroup members are listed below.

Treatment – ISUDCC Non-Federal Members

1. Chad Audi, Ph.D.
2. Caleb Banta-Green, Ph.D., MPH, MSW
3. Meredith Canada, MSW, MPA, LCSW
4. Amanda S.
5. Daniel Sledge, BA, LP

Treatment – ISUDCC Federal Members

1. Joseph Liberto, M.D. (VA)

2. June Sivilli (ONDCP)
3. Dele Solaru, PharmD, MBA (OPM)
4. Kellie Kubena (USDA)
5. Karran Phillips, M.D., M.Sc. (CSAT, SAMHSA)
6. Amanda Sharp, Ph.D., MPH (CSAT, SAMHSA)
7. Capt. Emily Williams, LCSW-PIP, BCD (OPIA, SAMHSA)

The Incorporation of Harm Reduction Within Treatment

Daniel Sledge gave a forward-thinking presentation centered on the workgroup's efforts to develop recommendations for an optimal future state for engaging and treating individuals with SUD that incorporates harm reduction principles and practices. The workgroup embraced a person-centered approach recognizing and meeting individuals where they currently stand and not where others think they should be.

The Traditional Treatment Model vs. The Person-Centered Model

To illustrate the concept of the ideal future state, Daniel, a person with lived experience and in recovery, shared a compelling real-life story. Drawing from his experiences as a paramedic and outreach worker, he described the challenges faced by an individual with SUD. He vividly highlighted numerous existing barriers that prevent access to lifesaving approaches, essential practices, and medications for those with SUD. The story left a lasting impression and underscored the urgency of addressing these barriers.

Elements of Success in an Ideal Future State

Daniel stated that underlying the treatment workgroup's recommendations is the critical need to meet people with SUD where they are. This includes developing practices and policies that are supportive and not punitive. He presented the information below culminating in the proposed set of recommendations.

- Meeting others where they are goes beyond the usual intervention mindset, focusing on empowerment and balance. It might involve helping someone in a crisis, during a police interaction, amid an overdose, or in the emergency department.
- Empower individuals to set their own goals; grant them complete autonomy and decision-making authority.
- Establish Trust: Utilize the innate connection and empathy of peers to form initial bonds, create pathways to resources, deliver dependable referrals, assist in accessing reliable services, and offer human connection throughout.
- Unleash Access: Provide on-site & off-site telemedicine, eliminate drug tests, develop transportation networks, create no-cost/low-cost services, provide HR-inclusive insurance coverage, access to physician prescribing and pharmacy pickup for all MOUD.

Supportive actions include:

- Promoting partnerships with criminal-legal systems, hospitals, and EDs.
- Removing abstinence requirements as an outcome for everyone treated in SUD treatment programs.
- Establishing harm reduction service delivery in treatment settings.

- Supporting training and education for harm reduction and person-centered skills.
- Prioritizing and providing additional funding for programs that offer peer support.
- Mandating equitable pay and benefits for peer support specialists.
- Limiting restrictions for background check requirements for peers.
- Providing training and education on harm reduction for providers at all levels.
- Promoting accountability on the programmatic level for fidelity to EBPs.
- Having flexible standards for take-home medication.
- Eliminating urine drug-screening requirements.
- Removing MOUD dosage limits.
- Allowing for individualized treatment plans (removal of pre-set counseling, predetermined tapering, etc.)
- Encouraging CMS coverage for harm reduction services across states.

Challenges: State and Federal Differences

Examples of treatment policy variability by state:

- Drug screenings to participate in MOUD programs.
- Peer specialist background checks.
- Medicaid prior approval for MOUD.
- Termination of care due to continued use.
- MOUD participation is dependent on a set counseling schedule.
- MOUD discontinuation vs. maintenance.
- MOUD dose maximums.

Top-Level Treatment Recommendations for Federal Stakeholders

- Clear the Path. Develop and publish guidance for states on integrating harm reduction into the continuum of care for SUD.
- Lead the way. Establish clear federal policies that support harm reduction approaches and services for states to model.
- Put your money where your mouth is. Establish new and expand existing funding opportunities that explicitly support harm reduction services and person-centered workforce development.

Harm Reduction is Health Care

- Harm reduction tools, services, and principles can all be effectively integrated within treatment settings, given permission, funding, and buy-in.
- The longer we talk, the more lives we lose.
- It's time for action.

Council Discussion

Dr. Delphin-Rittmon remarked that the presentation was "excellent" and contained substantial information and questions to act upon. She thanked Daniel and the treatment workgroup for their efforts. Similar high accolades were expressed by Dr. Olsen, June, and Dr. Banta-Green on the presentation and stories shared by Daniel and Amanda S. that set the tone for remembering why we are all here and demonstrated the valuable voices of persons with lived experiences.

June zeroed in on the workgroup's expression that "harm reduction is health care." She advised that the more we can message it that way, the more we will begin to normalize and change how people think about it. She recalled a document developed in 2014 on the language of stigma that influenced many federal activities, suggesting that it is time to develop a similar document that draws analogies between harm reduction and health care. She agreed that the notion of a model state, as put forth in the treatment workgroup presentation, is needed – one that states and communities can follow. Although the notion of harm reduction is not a new concept, June said, SAMHSA is a trailblazer in doing all it can to bring it into the current landscape and to increase its visibility in a non-threatening way.

Dr. Banta-Green also expressed support for the idea of the model state. He said the only reason for a person with opioid use disorder (OUD) to not be on medication should be because they were offered it but made an informed decision not to take it. Getting to that point, he said, is a massive mind shift. He reminded the group that harm reduction's goal is infectious disease prevention, overdose prevention, and mortality prevention. He warned against measures that deem a harm reduction intervention effective only when a person starts treatment or begins medication. Additionally, he reminds us to keep our outcomes, goals, and intentions clear as we consider the integration of harm reduction.

Dr. Olsen concluded the discussion on a future state by informing the ISUDCC of a recent article shared internally at CSAT that rethinks treatment in a way that meets people where they are. It encourages a person-centered approach with shared decision-making and informed consent. It helps to ensure that harm reduction and medical care are linked whenever and wherever a patient presents for care.

ISUDCC Recovery Workgroup Report-Out

Kristen Harper delivered the ISUDCC recovery workgroup report, which was enhanced by her impactful insights from lived experience and contributed meaningfully to the group's recommendations. The members of this workgroup are listed below.

Recovery – ISUDCC Non-Federal Members

1. Honorable Nancy L. Butts
2. Jamie Chrisman Low, M.Ed., NCC
3. Cynthia Seivwright, LCMHC, CQIA (ret)

Recovery – ISUDCC Federal Members

1. Leola Brooks, (SSA)
2. Dele Solaru, PharmD, MBA (OPM)
3. Patricia A. Powell, Ph.D. (NIAAA, NIH)

Recovery – ISUDCC Workgroup Facilitators

1. David Awadalla (OoR, SAMHSA)
2. Kimberly Freese, LAC, M.P.A.
3. Kristen Harper, (OR, SAMHSA)
4. Enid Osborne, Ph.D., (CSAT, SAMHSA)

Recovery Workgroup Overall Objectives

- Propose recommendations on how the federal government, in particular SAMHSA, can further the integration and coordination of harm reduction approaches and strategies across the spectrum of prevention, treatment, and recovery – focusing on systems and workforce development.
- Foster a better understanding of harm reduction across members of ISUDCC.

Recovery Workgroup Objectives for Issue Areas

Systems Development

- Identification of gaps, including pressing needs at the local level.
- Identify barriers to integration/coordination/interdigitation of recovery and harm reduction at federal, state, and local levels.
- Identification of best practices and resources.

Service Delivery Models

- Identify barriers to integration/coordination/interdigitation at federal, state, and local levels.
- Identification of best practices and resources.
- Relational components of harm reduction and how they can integrate the expertise and autonomy of people with lived experience.
- Reimbursement for harm reduction services.

Workforce Development

- Identification of gaps, including training needs for integrated recovery/harm reduction.
- Identification of best practices and resources.

Research

- Developing systems and best practices for care under real-world conditions.
- Health care providers and patients are provided with evidence-based clinical practices.

Federal Programs

- Practice and policy recommendations integrate the expertise and autonomy of people with lived experience.
- Identify barriers to integration/coordination/interdigitation of recovery and harm reduction at federal, state, and local levels.

Recovery Workgroup Recommendations

Systems

- Prevent the exclusion of people who use drugs (PWUDs) from the peer workforce. Refer to SAMHSA's National Model Standards for Peer Support Certification for guidance.
- Make an intentional effort to shift the culture in the workplace regarding PWUD.
- Include those with RECENT use in the living experience of staff.

- Staff should be reflective of the communities served. Ex.: Veterans, formerly incarcerated, parents, and so forth.
- Grow the community-based workforce.
- SAMHSA's National Model Standards for Peer Support Certification are meant to guide the state certification process. States' policies and procedures are a barrier for many, and they should better align with the model standards.
- Adopt SAMHSA's Harm Reduction Framework at all systemic levels.
- Increase funding at all levels for braiding and building systems of care with an awareness of local and organizational capacity.

Workforce Development

- Peers need authentic supervision, as well as mentorship programs.
- Mentors should have a strong harm reduction background when mentoring those working in the recovery space who integrate harm reduction into their work.
- Establish digital and virtual platforms for networking and sharing best practices among harm reductionists and peer professionals.
- Harm reduction calls for peer leadership at all levels; it is a perspective and an approach, not just services.
- Recommend not capping the career pipeline. Peers want to advance professionally.
- Provide role clarity and ongoing guidance to supervisors and organizational leadership.
- Use technology to deliver harm reduction services, including via mobile apps, or telehealth platforms. (Including texting). Train providers on the benefits of digital support and how to utilize technology to build the workforce.

Service Delivery

- Offer culturally tailored and region-specific harm reduction solutions based on feedback and direction for those working in local areas.
- Conduct provider education sessions monthly and provide ongoing support. This could include harm reduction specialists being detailed to mid- or large-scale provider organizations to assist with implementing harm reduction and recovery strategies.
- Create organizational campaigns that raise awareness and reduce stigma (e.g., "What is harm reduction/recovery?")
- Include considerations for those with significant experience or for career harm reductionists or senior harm reduction peer mentors/trainers, to participate in state or local regulatory processes.
- Develop trainings and materials that clarify the role of recovery in harm reduction settings.
- Encourage pharmacies to distribute information about local harm reduction and recovery resources.
- Provide more information on sobering centers and their impact on various populations, with special attention paid to emergency centers and crisis centers.
- Develop training and material that clarify the harm reduction approach vs. harm reduction services related to service setting and population served.

Research

- Adopt SAMHSA's National Model Standards for Peer Support Certification into research proposals.
- Encourage collaborative research involving universities, NGOs, governmental bodies, etc.
- Study the effectiveness of new interventions or technologies in harm reduction and recovery.
- Conduct longitudinal studies tracking the outcomes of different harm reduction strategies.
- Mine publicly released health records to look for trends or patterns.
- Consider legality in harm reduction interventions when proposing research projects.
- Create a recovery support lexicon with examples of each service type.
- Provide funding for research on harm reduction and recovery.

Federal Programs

- Encourage a continuum of lived/living experience from PWUD who have never had a substance use disorder diagnosis, PWUD who also consider themselves in recovery, and PWUD with SUD who have benefited or are benefiting from harm reduction services.
- Enforce parity reimbursement for mental health and substance use services.
- Recommend specializations for the peer workforce, so states could create specialized pathways and allow for PWUD to be certified.
- Update the Institute of Medicine's IOM classifications of prevention to include current terminology for recovery and harm reduction.
- Create a process for veterans agencies and organizations to ensure the fidelity and authenticity of harm reduction services.
- Host a SAMHSA policy academy on current and future state financing options for SUD (including Centers for Medicare & Medicaid Services).
- Develop a model for a syndemic approach to care.
- Create campaigns to reduce stigma and misinformation within harm reduction and recovery communities.
- Fund collaborative efforts between Harm Reduction Organizations and Recovery Community Organizations.

Council Discussion

Dr. Compton commended Kristin Harper on a "terrific" presentation, although he said the recommendation regarding substance use by peer recovery support workers raised some concerns. As a treating clinician, he said, he recognized that people often relapse and that a hard-and-fast rule of "if you use, you're fired" is not a helpful approach. He asked if there was any research that could provide guidance in this area in understanding the role of abstinence in the recovery support workforce. He stated that NIDA might be interested in conducting studies on the topic. Kristin concurred that more studies were needed. She mentioned that SAMHSA's Office of Recovery and ONDCP had begun a literature review on the characteristics of and criteria for a recovery-ready workforce and workplace. She will share those citations with Dr. Compton and with others who express interest. Dr. Compton pointed out that the Drug-Free

Workplace federal regulations may also play a role in what we, as federal entities, can allow our funds to be used for. She gave an example of how these regulations can play out in workforce situations where an employee who tests positive for cannabis during a randomized drug test can be fired.

David Awadalla clarified the distinction between a peer support specialist who is working in a recovery community organization—especially one that is abstinence-based—and a peer supporter who is working in a harm reduction setting. He said that, within the framework of Harm Reduction Standards, the decision regarding abstinence or adherence to a particular recovery pathway should be at the discretion of a hiring organization rather than a mandatory requirement imposed by state certification entities. This flexibility is essential, he said, because peer support varies based on the diverse lived experiences of individuals and the setting in which it is applied. The nature of lived experiences and peer support encompasses many nuances that necessitate a tailored approach.

Dr. Olsen asked if stigma related to medications an individual may be taking in the workplace came up in the recovery workgroup discussions, be it a recovery-ready workplace or another work setting.

David confirmed that the topic was discussed. One person shared a story about a family member who is facing workplace discrimination for being on buprenorphine. He pointed out that stigma still exists, although it has improved over the past 10 years and it appears to be more prevalent in rural communities and the South than elsewhere. As a person in recovery himself for opioid use disorder, he recalled how, in 2012, people were being actively terminated from diversion court programs or sent to jail and prison if they tried to take buprenorphine legally or illegally. He finds that it all comes down to communication. That is what reduces stigma and misinformation.

Kristin agreed with David. She thinks that the problem can be addressed through a three-pronged approach: 1) conducting more research on MOUD, 2) providing results or guidance in plain language and user-friendly formats that the public can understand, and 3) focusing more on multiple pathways for recovery and its nuances, including lexicon.

Kimberly Freese addressed points made about supervision and support of the peer support workforce. The recovery workgroup members discussed the importance of providing appropriate trauma-informed supervision and support of the peer support workforce.

At the end of this discussion, Dr. Delphin-Rittmon turned the session over to Dr. Olsen, who set the stage for the remaining tasks.

ISUDCC Recommendations and Next Steps

Council Discussion

As explained at the top of the meeting, Dr. Olsen reiterated to the ISUDCC members that the goal of today's session was to deliberate and vote on whether to approve the recommendations put forth by the three ISUDCC workgroups and to move these recommendations and the summary document toward finalization. Furthermore, she sought the members' input regarding a

timeline and procedural approach for finalizing and prioritizing the recommendations. This includes identifying specific recommendations with a pressing need for rapid implementation to mitigate the impact of SUD on people's lives. In the forthcoming process stages, SAMHSA will collaborate with its contractor to assimilate insights garnered from today's dialogue and compile a definitive document version.

Dr. Olsen also inquired about the potential interest in having the workgroups continue to meet to refine or adjust their final recommendations. She articulated that the final document should ideally encompass recurring themes about integrating harm reduction across the three key domains – prevention, treatment, and recovery.

Dr. Compton asked about the intended utilization of the end product. For example, would it be a white paper accessible on a website or a product accompanying SAMHSA's Harm Reduction Framework in the finalization stage, or would it be a guiding document for Dr. Delphin-Rittmon's leadership on this issue?

Dr. Olsen explained that the initial objective was to develop a document with recommendations that would be shared with SAMHSA, HHS, and other federal partners, including ONDCP, on integrating harm reduction across the continuum of care. However, owing to the richness of the workgroup report-outs, new possibilities have emerged for consideration in many different areas encompassing policy, programming, and research. Such outcomes could lead to further federal initiatives and expedited adoption of specific recommendations.

Dr. Delphin-Rittmon suggested that, in terms of a timeline, it may be helpful to flesh out timeframes that categorize the recommendations as short-term, intermediate, or long-term – with the workgroups determing the duration of each segment. In terms of utilization of the document, she envisions multiple uses across the board, from contributing to SAMHSA's strategic planning and overdose prevention strategy to influencing related initiatives and critical areas.

Dr. Banta-Green recommended that the final document feature an abstract or brief summary of the ISUDCC workgroups' work on the selected topic, facilitating immediate action by states and other entities. Drawing on Daniel's earlier presentation, Dr. Banta-Green stressed the importance of explicitly stating in the document the importance of not co-opting harm reduction and harm reduction organizations, acknowledging them as true experts. He advocated for collaboration with these organizations and individuals with lived experience, emphasizing the need for explicit guidance on working with and supporting harm reduction agencies and clear guidance on the flow of funds.

Dr. Jones proposed a dual-track approach for the finalization process. First, he suggested swift finalization and the inclusion of an abstract and executive summary outlining recommendations, particularly emphasizing key short-term priorities for immediate implementation. Second, he indicated leveraging the workgroups for additional insights or next steps. The final document, developed by a federal advisory committee and external experts on harm reduction integration, will play a crucial role in helping SAMHSA operationalize its strategic plan and bolster budget requests, among many other applications.

Dr. Delphin-Rittmon agreed with Dr. Jones, emphasizing the practicality of the parallel-track approach. This strategy ensures the dissemination of critical information to government bodies, states, the field, and other stakeholders while concurrently advancing the work through collaborative efforts. Dr. Olsen noted Daniel's suggestion to identify, within each recommendation, the entities (federal, state, local, or other organizations) involved beyond SAMHSA. This aligns with one of the ISUDCC's mandates to underscore the coordination needed across federal, state, and local systems. Dr. Delphin-Rittmon highlighted that this approach emphasizes the multi-sector, multisystem involvement required for the recommended integration of harm reduction.

June endorsed the inclusion of an executive summary and supported the two-pronged approach mentioned earlier. She added that aligning priorities and recommendations with two upcoming federal budget cycles could enhance the funding potential.

Dr. Olsen added that besides the budget considerations, legislative and policy changes might be required based on the recommendations. This comprehensive approach ensures a holistic and impactful implementation of the proposed harm reduction strategies.

The DFO informed the group that the meeting was running ahead of schedule, and that a few ISUDCC members had joined the session after the DFO took a roll call and should be added to the list of members present. These individuals are Dr. Chad Audi, Dr. Caleb Banta-Green, and colleagues from FDA and OPM.

Dr. Delphin-Rittmon asked if there was any other discussion or feedback on the recommendations and report before putting them to a vote.

Amanda S. echoed Dr. Banta-Green's suggestion for the ISUDCC to swiftly develop concise guidance for immediate publication, focusing on recommendations that demand prompt implementation. Drawing on her lived experience, she underscored the crucial need for timeliness. Additionally, she agreed with Daniel's observations regarding the variations in norms and policies surrounding harm reduction and the disparities in clinical practices among different states.

Dr. Delphin-Rittmon proposed considering a shorter document, akin to a policy brief, alongside the comprehensive report (with an executive summary and a conclusion), with a quicker turnaround time for publication. Dr. Banta-Green supported Dr. Delphin-Rittmon's suggestion and reiterated the importance of involving individuals with lived experience in developing comprehensive and abbreviated publications. Dr. Delphin-Rittmon mentioned that substantial portions of the proposed policy brief are essentially "already written" based on the workgroup presentations.

Judge Butts, a drug court judge for 25 years, expressed support for the creation of a condensed document that could be utilized not only by health care professionals but also by public servants like herself on the frontline of the legal system. She emphasized that data indicates judges are pivotal in influencing individuals' success in treatment court and long-term recovery. Serving on the ISUDCC recovery workgroup enhanced her understanding of harm reduction and its

applicability, she said, even in resource-constrained states and counties. She discovered that there are numerous cost-effective opportunities to implement harm reduction strategies.

Final Vote on the Workgroup Process and Recommendations

Dr. Delphin-Rittmon summarized the preceding ISUDCC discussion to outline the course of action and set the stage for the impending vote as follows:

- The comprehensive document will be finalized, incorporating an executive summary that outlines workgroup recommendations and specifies the responsible governmental sectors/agencies and other organizations for leading and implementing each recommendation. A conclusion will also be incorporated into the larger document, and recommendations will be prioritized, focusing on those achievable within the next 12 months.
- A second, more concise document (e.g., a policy brief) will be developed, summarizing strategically key areas and messages derived from the comprehensive document on integrating harm reduction across the care continuum. The intention is to expedite the production and dissemination of this shorter document, potentially building upon the executive summary.
- The three ISUDCC workgroups will continue to meet until the end of 2024, refining timelines and approaches for recommendations that warrant more implementation time. They will also elaborate on specific recommendations within their purview as needed.

Dr. Delphin-Rittmon then called for a motion to vote on this proposed process and these decisions, which passed unanimously. She expressed gratitude to the ISUDCC for their diligent efforts and valuable contributions.

Public Comment

Dr. Delphin-Rittmon turned the meeting over to the DFO, who informed the ISUDCC that no requests for public comments had been received**.**

Final Comments/Adjourn

Dr. Delphin-Rittmon thanked the ISUDCC members for joining the meeting and participating in the dialogue to continue the important work regarding the integration of harm reduction across the continuum of care. Dr. Olsen echoed those sentiments and thanked Amanda S., Daniel, and Kristin for sharing their impactful stories of lived experience and recovery that contributed meaningfully to the workgroup discussions and recommendations.

The DFO asked for a motion to adjourn the meeting because there were no further comments or questions from the ISUDCC members. Dr. Torres and Dr. Compton so moved, and all were in favor.

The meeting was officially adjourned at 11:40 a.m.

Certification
I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete. Minutes will be formally considered by the ISUDCC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting

Date: __February 27, 2024__

___/Miriam E. Delphin-Rittmon, Ph.D./___
Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use