

*Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
National Advisory Council*

August 1, 2018

Open Session Minutes

*5600 Fishers Lane
Room 5E49
Rockville, Maryland 20857*

Open Session Minutes

Opening Remarks and Introductions

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Officer (DFO), Tracy Goss, called the CSAT NAC meeting to order at 9:00 a.m., E.D.T., on August 1, 2018. Ms. Goss conducted a roll call to establish the quorum, Dr. Chideha Ohuoha, who presided over the meeting, welcomed attendees and thanked staff, and guests who agreed to participate.

Dr. Ohuoha, the new CSAT Director, introduced himself and provided some information on his background and experience. Dr. Ohuoha is a Captain in the U.S. Public Health Service. Prior to his arrival at CSAT, he served as the Deputy and Director of Addiction Medicine at Fort Belvoir Community Hospital, implementing the Co-Occurring Partial Hospital Program. Before that, Dr. Ohuoha was Chief Psychiatrist for the Wounded Warrior Transition Brigade. He also served as Medical Director for the Mobile Community Outreach Treatment Team at St. Elizabeth's Hospital in Washington, DC, and held positions at the National Institute of Drug Abuse (NIDA), National Institute of Mental Health, and George Washington School of Medicine, among others.

Dr. Ohuoha also announced that Ms. Audra Stock is the new Deputy Director of CSAT.

Member Introductions and Updates

Council Members in attendance were: Bertrand Brown (by telephone); Kristen Harper, M.Ed., LCDC (by telephone); Jason Howell, MBA, PRS; Andre Johnson, M.A.; Sharon LeGore; Judith A. Martin, M.D.; Lawrence Medina, MBA; and Arthur Schut, M.A.

Also in attendance were: Audra Stock, LPC, MAC; Onaje Salim, Ed.D., LCPC; Anthony Campbell, RPH, D.O., FACP; Amy Smith, M.S., LPC, SAP; Steve Daviss, M.D., DFAPA; Darrick Cunningham, LCSW, BCD; Wilson Compton, M.D., M.P.E.; Arne Owens; Donna Hillman; Jamal Bankhead; Spencer Clark; Kim Thierry-English; and Monica Flores.

Dr. Ohuoha asked the Council Members to introduce themselves and provide some background information.

Ms. Kristen Harper introduced herself first. Ms. Harper is a consultant who recently launched her own company. Most of her work is in the field of collegiate recovery and she is also part-time, on-call staff at the Center for Social Innovation, working on the State Targeted Response to the Opioid Crisis (Opioid STR) grant. She and Andre Johnson are currently working together on a documentary covering the drug trade and recovery resources in Ghana.

Ms. Sharon LeGore, from Pennsylvania, founded the organization MOMSTELL after losing her daughter to a heroin overdose. She also has a son with a co-occurring disorder and a son who became addicted to opiates following a serious car accident and who is struggling with recovery today. Ms. LeGore started co-directing the National Family Dialogue for families of youth with substance use disorders. She expressed her concern about the effects of substance use disorders on other members of the family such as siblings and that the full continuum of care should deal with the entire family.

Mr. Lawrence Medina of Taos, New Mexico, is the executive director of the Rio Grande Treatment Program and recently participated in a project to begin a transitional living program for women in recovery, including those leaving prison, pregnant women, and women with children. He noted that he appreciates being able to take advantage of the networking and resource sharing as a NAC member.

Mr. Jason Howell introduced himself as a person in long-term recovery from both mental health and substance use issues. He is executive director of the nonprofit organization, RecoveryPeople, which is based in Texas and which focuses on peer- and family-led recovery support services. He also serves on the board of the National Alliance for Recovery Residences, which develops national standards for recovery housing. This organization is currently looking at ways to ensure that individuals on medication-assisted treatment (MAT) connect with the recovery support services they need.

Mr. Howell expressed concern over communications related to how technical assistance will be provided to RCSP Statewide Network grantees. He is also concerned that some funding streams are narrowly focused on opioids and this may be at the expense of building a larger infrastructure. Mr. Howell also asked about the potential wave of new funding for SAMHSA, wondering if SAMHSA has the staff to be able to handle the new responsibilities that will come with additional funding.

Mr. Andre Johnson is the president and chief executive officer of the Detroit Recovery Project and a person in long-term recovery for more than 30 years. He stated that Detroit Recovery Project has been in operation for 13 years and that a large part of its success is attributable to CSAT and the RCSP grant received in 2011. Mr. Johnson noted that Detroit has experienced an economic comeback but challenges remain, including lack of employment, education, and training opportunities for people who need it. More partnerships should be developed that help people be self-sufficient. Mr. Johnson described some of the initiatives he is working on, including reducing stigma faced by people who have substance use disorder.

Dr. Judith Martin introduced herself next. She is an addiction medicine specialist and the Medical Director of Substance Use Services for the City and County of San Francisco. Her agency is working on increasing the availability of MAT among patients who do not use

treatment services in clinics using a street medicine team. Dr. Martin discussed the increase in the percentage of overdoses due to fentanyl and the alarming finding that all types of drugs of abuse are contaminated with fentanyl. Also, there has been an increase in methamphetamine use that the agency is working to address as well as trying to increase the use of alcohol treatment medications. In addition, San Francisco is now a drug Medi-Cal organized delivery system health plan with requirements for care coordination. Privacy constraints with regard to substance use treatment make it difficult to coordinate care. The agency is looking for ways to better monitor treatment results over time.

Mr. Arthur Schut has been in the substance use disorder field for more than 45 years including 30 years as chief executive officer of comprehensive prevention and treatment organizations in Iowa and Colorado. He also had a faculty appointment at University of Iowa's graduate program in addictions. Mr. Schut currently serves on the board of directors of a behavioral health managed care company in Colorado. His concerns include the previously mentioned change in TA provision and how that will be evaluated, along with creating and improving the continuum of care. He also said that Colorado has been working on identifying gaps in the continuum of care in various regions and looking at how to have a continuum that includes prevention, treatment, and recovery support in all of their forms. Additionally, Mr. Schut noted the tremendous amount of inequity in access to substance use disorder treatment.

Bertrand Brown was not on the conference line for introductions.

Consideration of the February 14, 2018, Minutes

Dr. Ohuoha called for a motion for approval of the February 14, 2018, minutes for the 78th meeting of the CSAT NAC. Dr. Martin moved to approve the minutes and Mr. Schut seconded the motion. The motion passed without objections or abstentions and the February 14, 2018, minutes were then approved by the Council.

CSAT Division/Office Director's Update

Dr. Ohuoha invited Council Members to read the printed Director's Report at their leisure and turned to CSAT leadership to provide updates of activities since the last NAC meeting.

Ms. Audra Stock, Deputy Director CSAT, provided an update of the Division of Services Improvement (OSI), and its current and planned activities. The Quality Improvement and Workforce Development Branch is focusing on practitioner education in collaboration with other entities in SAMHSA and HHS. This branch is also working on establishing a stronger accessible continuum of recovery supports.

The Targeted Populations Branch is working with the National Association of Drug Court

Professionals and the Office of Equity and Inclusion on a grant program to pilot an equities and inclusions toolkit to help address racial disparities in drug court programs. Another initiative is a policy academy for SAMHSA grantees to identify effective prevention, treatment, and recovery service delivery models, along with quality care performance measures and financing. The branch is also working with three new pregnant and postpartum women pilot sites to provide more appropriate onboarding. This is an expansion of a residential-focused program to include outpatient continuum of care for pregnant and postpartum women.

The Health Systems Branch is focused on aligning activities with the National HIV/AIDS Strategy 2020 and the National Viral Hepatitis Action Plan and coordinating efforts across all federal agencies to learn how to integrate care for substance use disorders, co-occurring disorders, and HIV and hepatitis.

DSI is also working to enhance the adoption of MAT referrals and improving health information technology capabilities, using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) portfolio. Ms. Stock noted that SBIRT is increasingly being used in areas such as schools and that Massachusetts has implemented SBIRT as a requirement for schools screening youth for substance use disorders.

CSAT recently announced a new funding announcement related to the Medication-Assisted Treatment-Prescription Drug Opioid Addiction Program (MAT-PDOA) with grants going to organizations, nonprofits, and health plans rather than states.

Ms. Stock also related that more than 10,000 hard copies of Treatment Improvement Protocol (TIP) No. 63 have been distributed and almost 10,000 electronic versions have been downloaded from the SAMHSA online store.

Additional activities include:

- Working to implement the Protecting Our Infants Act, which addresses neonatal abstinence syndrome, also known as neonatal opioid withdrawal syndrome.
- Beginning to implement an alcohol screening brief intervention measure, in partnership with the Centers for Disease Control and Prevention (CDC), to increase screening in primary health care settings.
- Working on new TIPs on 1) relapse prevention and recovery promotion, and 2) behavioral health services for American Indian and Alaska Native populations.

Dr. Onaje Salim provided an update on the activities of the Division of State and Community Assistance (DSCA) of which he is Director. The division's Performance Measurement Branch is working on improving data collection related to grantees that comprises part of SAMHSA's Performance Accountability and Reporting System (SPARS). The branch is

refining data collection instruments to sharpen CSAT's understanding of grantee activities and, supporting SAMHSA's initiative to preserve and improve confidentiality without affecting the provision of quality and comprehensive care.

The Performance Partnership Grant Branch, which manages the substance abuse block grant, is working closely with the states to improve coordination and communication. DSCA is also managing the State Targeted Response grants. Compliance reviews are ongoing and state project officers visit almost state and territory to maintain good communications and understanding of how the block grant and other grant activities are functioning.

The Homeless Activities Branch awarded 89 service grants during this fiscal year as well as 35 off-the-shelf grants. Dr. Salim commented that they are seeing progress in reducing homelessness, particularly among veterans.

In addition, DSCA is operating a grantee review board, which uses SPARS data in discussions with project officers about how grantees are performing. It is implementing the new technical assistance strategies and improving coordination with tribes. DSCA is also conducting a tribal state policy academy, the first of three planned. Lastly, the division conducted a technical expert panel on recovery housing and MAT and is working to develop national standards.

Dr. Anthony Campbell, Medical Consultant Advisor for the Division of Pharmacologic Therapies (DPT), provided an update on the division's activities and priorities. DPT is responsible for Opioid Treatment Program (OTP) certification and regulation. To date, there are more than 1,600 OTPs serving more than 300,000 patients per year. This year, there have been 87 original applications for new OTPs.

The division also manages the process by which, under the Drug Addiction Treatment Act of 2000 (DATA), physicians may apply for a waiver of some requirements of the Controlled Substances Act in order to prescribe MAT. Around 50,000 DATA waivers have been issued to date—42,000 to physicians, more than 6,000 to nurse practitioners, and more than 1,700 to physician assistants.

Dr. Campbell also discussed the Providers' Clinical Support System (PCSS), which provides education and technical assistance to providers in the field. This program has been expanded and a three-year grant that is a hybrid of this program has been announced to universities. More than 115,000 practitioners have been trained under this program to date. The PCSS medication- assisted grant program is entering its second year with 5,000 practitioners being trained this year.

DPT released several products this year, including the opioid overdose prevention toolkit, the guideline Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use

Disorder and Their Infants, and the tobacco cessation toolkit. Future priorities include enhancing the OTP extranet system to improve data collection and analysis.

Dr. Campbell closed with additional information about the hybrid PCSS grants for universities, which he described as an attempt to get addiction treatment into medical and professional schools, including nursing schools and physician assistant programs. 24 three-year awards of \$150,000 each will be given under the program.

Ms. Amy Smith provided an update of activities in the Office of Consumer Affairs (OCA). OCA's priorities include strengthening the voice of consumers (people who are in recovery or who are seeking recovery) and their families. OCA also manages National Recovery Month and is working to expand beyond that activity by integrating its functions within CSAT among other CSAT divisions and being more engaged in their activities and programs. OCA has launched the 2018 National Recovery Month campaign and provides a toolkit and other resources on the campaign website, RecoveryMonth.org.

Other OCA activities include:

- Holding a BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy) policy academy. OCA supports this initiative with the Center for Mental Health Services Office of Consumer Affairs.
- Completing a successful pilot program that paired a peer mentor that is an established Recovery Community Organization (RCO) with an emerging RCO to help it build capacity.
- Conducting training for peer mentors to keep youth and young adults out of the criminal justice system and support those who need treatment and recovery to prevent re- incarceration. OCA held a successful leadership-training program for RCOs using the peer-to-peer recovery model.
- Conducting webcasts for health care professionals to look at the problem of discrimination against people with mental and substance use disorders, along with an all- Spanish webcast on behavioral health needs in the Latino community.
- Planning the National Recovery Month kickoff event at the Humphrey Building.
- Hosting a recovery and states' rights educational webinar covering rights in the states of Rhode Island, Georgia, Illinois, Kansas, Colorado, and California.

Ms. Smith finished her presentation by showing two Recovery Month public service announcements (PSAs), "Voices for Recovery" and "R Is for Recovery." She noted that the PSAs are available for use without the SAMHSA tagline so that organizations can tag them with their own logo and information.

Dr. Steve Daviss, CSAT Medical Director, updated the Council on activities of the Office of the Chief Medical Officer (OCMO). This office serves as a liaison between SAMHSA and

other organizations, particularly professional organizations. Dr. Daviss and other OCMO staff participate in regular meetings and calls with organizations such as the Academy of Psychosomatic Medicine and the American Society of Addiction Medicine. OCMO staff also review and comment on proposed legislation and regulations and convene meetings such as expert panels.

SAMHSA/CSAT Budget Update

Mr. Darrick Cunningham, Director of the Office of Program Analysis and Coordination, introduced himself and presented a budget update. Mr. Cunningham provided information on FY 2018 authorized spending for CSAT, which is \$3.7 billion and which is 65 percent of SAMHSA's total funding of \$5.7 billion. In 2018, SAMHSA will be funding 969 new grant awards, a huge increase from the 198 awarded in 2016 and 302 in 2017.

Presentation on Using Research to End the Opioid Crisis

Dr. Ohuoha introduced Dr. Wilson Compton, who gave a presentation on advancing addiction science to address the opioid crisis. Dr. Compton is the Deputy Director of NIDA at the National Institutes of Health (NIH).

Dr. Compton began his presentation by noting that, as mentioned by some of the Council Members, the opioid crisis does not exist in a vacuum and that opioid addiction is frequently accompanied by misuse of other substances including tobacco, which has long-term health effects. However, the attention received by the opioid crisis provides a vehicle to change the way addictions are addressed throughout the health care system.

Comparing maps showing rates of drug overdose deaths by county in the years 1999 and 2016 reveals that although increases are seen everywhere, these increases are not evenly distributed. Some areas of the country such as rural southwestern New Mexico and the Appalachian region showed signs of the coming opioid crisis in 1999. Overdose deaths are related to major shifts in population health in the U.S. For example, there has been an overall increase in deaths among 45- to 54-year-old, non-Hispanic whites while most developed countries have seen improvements in health for this same population. This trend seems to be driven by the overdose crisis, alcohol, and suicide.

Data also show a shift in focus from prescription opioids to heroin and then to fentanyl (and non-medical fentanyl-like compounds) over time. Fentanyl is hugely profitable-about \$1,000 worth of fentanyl ordered from overseas can be sold on the streets for around \$1 million.

Infectious disease is a major issue related to the opioid crisis. The incidence of hepatitis C has increased and there have been local outbreaks of human immunodeficiency virus (HIV). CDC estimates that there are around 200 U.S. counties that

have a similar risk profile as Scott County, Indiana, which experienced an HIV outbreak in 2015, making these counties hotbeds for potential HIV outbreaks. NIDA, in collaboration with CSAT and CDC, launched a series of grants to improve health care to rural areas. Admissions to neonatal intensive care units due to neonatal opioid withdrawal syndrome have increased markedly and are another focus for federal and state efforts to address the opioid crisis.

HHS' broad strategy therefore focuses on the upstream drivers in terms of understanding the public health data infrastructure, specifically addressing better access to prevention, treatment, and recovery services. Dr. Compton stated that researchers still have not decided on the key research questions; he looks forward to hearing results of the expert panel meeting also occurring in the building to help guide research efforts. Better pain management and better research on addiction and pain are also part of the HHS opioid strategy.

Dr. Compton turned to discussion of the National Drug Early Warning System (NDEWS), which identifies trends and emerging epidemics. NDEWS recently identified emerging fentanyl outbreaks in suburban areas. In a key study in New Hampshire, results showed that about one-third of drug users interviewed were actively seeking fentanyl. For a certain subgroup of opioid users, hearing of other drug users dying of overdose may influence them to seek out potent, powerful opioids.

In fighting the opioid crisis, naloxone has become more readily available including in nasal spray and auto-injector forms that may be administered by nonmedical personnel. However, with fentanyl becoming a major product, naloxone formulations may need to become more potent or longer lasting. Another research question is whether overdose treatments other than opioid antagonists may be effective.

A second research area concerns improving addiction treatment. There is still a shortage of clinicians with buprenorphine training and many clinicians who have completed training do not see many or any patients. Additionally, many programs do not offer access to MAT.

Dr. Compton continued his presentation with a review of NIDA's research as well as the activities of others in the research community. These activities include:

- Research to examine outcomes after administration of buprenorphine in the emergency room. Results to date indicate that this practice leads to less drug use, at least in the short term, and better engagement in care.
- A Rhode Island study that looked at the addition of long-acting naltrexone for persons on probation and parole. Study participants' behaviors and outcomes were better when long-acting naltrexone was added as part of their care; in fact, overdose deaths were reduced by 60 percent in this population and by 12 percent for the entire

state.

- Research comparing long-acting naltrexone and buprenorphine (the suboxone formulation) which showed that buprenorphine was superior in the intent-to-treat analysis but that individuals who were successfully induced onto long-acting naltrexone had similar outcomes.
- Approval of a promising new medication for withdrawal from opioids that, nonetheless, is just part of effective treatment.
- Launch of NIH's Helping to End Addiction Long-term (HEAL) initiative that is focused on improving research into pain in order to reduce reliance on opioids and improving treatment for opioid use disorder and rescue approaches. Congress allocated an additional \$500 million for FY 2018. Among the focus areas are neonatal opioid withdrawal, medication development including immunotherapies, criminal justice practices related to opioid use disorder, and the HEALing Communities Research Study.

This study will be a large-scale, community-based trial looking at how well evidence-based, integrated approaches address the opioid crisis. The HEALing Communities Research Study is being conducted in collaboration with SAMHSA.

Council Discussion: Using Research to End the Opioid Crisis

Following the presentation, Dr. Ohuoha opened the floor to questions and discussion. The following points and questions were raised:

- Mr. Howell asked if research had been done to better understand why there are so many physicians being trained and receiving a waiver, but not practicing. Anecdotally, he has heard that some clinicians feel they not fully equipped to support patients recovering from a substance use disorder. Dr. Compton responded that the reasons are not completely known, but that the PCSS program is helping to reduce barriers to adoption of buprenorphine treatment by reluctant clinicians. Barriers may also include concern about regulatory requirements. Dr. Ohuoha added that CSAT is actively looking at this issue.
- Ms. LeGore commented that programs such as initiating buprenorphine treatment in emergency departments and providing MAT to individuals being released or paroled from the criminal justice system must be accompanied by a continuum of care. She asked if the studies included aftercare, counseling, or other follow-up after leaving the criminal justice system. Dr. Compton said there was follow-up but that the typical duration of MAT was one to six months, which is not long enough.
- Ms. LeGore further noted that diversion is an issue. Dr. Compton agreed that diversion was a concern and replied that observational studies of people using opioids often use buprenorphine in a pseudo-medical fashion to help with

withdrawal symptoms.

- Mr. Schut stated that he has been involved in integrating clinicians into primary care offices but that payment is a challenge. He commented that providers tend to think that a person has to be admitted into a substance use disorder program before they can receive medication. He recommended that it would be worthwhile to look at the billing system for the necessary medications in order to receive discounts for larger orders. Dr. Compton discussed the importance of integrating addiction care into general medicine.
- Dr. Martin inquired about dose levels of buprenorphine that would be protective against fentanyl overdose. She said this question comes up frequently in emergency rooms. Dr. Compton was unsure if this question had been answered definitively and noted that patients often do not just use one substance when they overdose, which is a key issue. He also commented that opioids are not the only concern; alcohol, sedatives, methamphetamine, and fentanyl-contaminated illicit drugs are also serious issues.
- Mr. Medina noted the continuing lack of resources and attention faced by rural and frontier areas of the country in fighting the opioid crisis. He asked if the pharmaceutical industry might be a source of funds and if they are considered part of the problem. Dr. Compton responded that certainly these companies have been part of the problem but that it is not an either/or question. He suggested that it would be useful to see if local jurisdictions or states are participating in some of the major lawsuits against pharmaceutical companies, which may lead to funding availability.
- Dr. Martin described a program in Boston that provided a safe place for people to go when they are high. It is staffed by health professionals who monitor these individuals and can administer oxygen and naloxone if someone appears to be overdosing. Dr. Compton said it was important to study innovative programs such as this one to see if it is cost effective and could be replicated successfully.
- Ms. LeGore asked whether research has been conducted to see if drug courts implement and require treatment and drug screenings consistently and inconsistent drug courts had higher success rates. Dr. Compton replied that there was a well-established body of evidence regarding drug courts. The National Association of Drug Court Professionals has a great deal of information on its website. Ms. LeGore followed up by asking if there was research on family involvement in the recovery process. Dr. Compton said that there is some research, mostly focused on the adolescent age group. There is less information on family-based approaches for adult patients, but they should be included in future research. Ms. Stock added that CSAT has a robust drug court grant program including family treatment drug courts. Ms. LeGore stressed that families need to know how to help and participate effectively in family-based treatment.
- Mr. Schut suggested that it would be helpful to see drug use statistics reported by

age groups comprising persons under age 18 and individuals age 18 and above. He frequently sees a 12- to 24-year-old age group in Colorado but says the other breakdown would provide more meaningful data, particularly related to marijuana. He is also concerned that drug use may be underreported. He wondered if Dr. Compton saw this in the national statistics. Dr. Compton reported that around 15 percent of overdose deaths in 2016 were classified as "drug overdose," which is very general and not as helpful as more specific information would be. Regarding the age group breakdowns used in data reporting, because age is generally calculated using year of birth or similar, data analysts can group any set of ages together. There is typically a break between those under age 18 and those 18 and above because of the differences in consent requirements.

- Ms. Harper asked if Dr. Compton was familiar with the Journal of Recovery Sciences, which was just created. She stated that the editorial page indicated that several renowned recovery researchers were affiliated with the journal. She also asked what would be most impactful when it comes to recovery science and reaching the continuum of care. Dr. Compton replied that the importance of a long-term perspective has always been of interest to him in the recovery science arena. A system of care is needed that will help coach people in long-term recovery to support them and intervene quickly when people relapse. Dr. Compton believes this research area should be expanded. NIDA and another NIH institute have funded several studies looking at innovative approaches to supporting people in recovery.
- Mr. Howell continued this area of interest, commenting that merely focusing on abstinence or reducing overdose deaths does not fully measure recovery. Recovery support services need to be more thoroughly researched to determine best practices and establish standards and fidelity mechanisms. Dr. Compton agreed that clinical studies should maintain fidelity to the intervention so that elements of the intervention can be tested for effectiveness.
- Dr. Martin mentioned an article in The Journal of the American Medical Association (JAMA) about long-term elimination of addiction and wondered if adult-born neurons played a role. She also commented that having meaningful activities and ways to develop, as people might be important in preventing addiction. Dr. Compton responded that neuroscience research is helping scientists understand techniques for improving brain function even after major structural damage to the brain. He then noted that early childhood interventions could have positive impacts many years later. For example, the Good Behavior Game is a school intervention that can interrupt the trajectories into deviant behavior by the biggest impactor on acting-out little boys at ages 5, 6, and 7. By giving teachers, the tools to keep these children engaged in the classroom and not ostracized from their peers, the children are set on a positive life course trajectory with positive effects 20 to 30 years later. He reminded the group that using evidence-based programs was important; using the

drug education programs of the 1970s and 1980s as an example, he stated that many programs that seemed like a good idea at the time turned out to be ineffective or even had negative effects.

SAMHSA Leadership Discussion with CSAT Council Members

Following the lunch break, Dr. Ohuoha introduced Mr. Ame Owens, who is Principal Deputy Assistant Secretary for Mental Health and Substance Use at SAMHSA. Mr. Owens began by noting that while he is not a clinician or researcher, he has been in the behavioral health care management field for several years and was at SAMHA 10 years ago. As a Senate health care policy advisor, Mr. Owens helped craft the legislation that became the 21st Century Cures Act. Dr. McCance-Katz, who would normally attend the meeting, is currently participating in the Federal Commission on School Safety.

Speaking of the 21st Century Cures Act, Mr. Owens recounted some of the changes occurring at SAMHSA as the Act is being implemented. The position of SAMHSA Administrator has changed to Assistant Secretary for Mental Health and Substance Use and that of Deputy Administrator to Deputy Assistant Secretary for Mental Health and Substance Use. SAMHSA is undergoing reorganization, including creation of the Office of the Chief Medical Officer, led by a psychiatrist, and launch of the National Mental Health and Substance Use Policy Laboratory that will be used to promote evidence-based practices and service delivery models.

Also in progress is development of a SAMHSA strategic plan. It is to be a true strategic planning document with SAMHSA's mission and vision, overarching goals, priorities, and measurable objectives along with performance metrics.

SAMHSA is also leading the Interdepartmental Serious Mental Illness Coordinating Committee that was mandated by the 21st Century Cures Act. In addition to several parts of HHS, the Departments of Housing and Urban Development (HUD), Justice, Education, and Veterans Affairs (VA) are involved.

Mr. Owens turned to HHS' five-point opioid strategy, which includes 1) strengthening public health surveillance, 2) advancing the practice of pain management, 3) improving access to treatment and recovery services, 4) targeting availability and distribution of overdose-reversing drugs, and 5) supporting cutting-edge research. Accompanying this strategy is additional funding—an increase of more than \$1 billion from FY 2017.

Workforce development is another significant concern for SAMHSA. Dr. McCance-Katz is concerned about increasing the role of primary care practitioners in fighting substance use disorder. There are also efforts to encourage a national certification program for the peer workforce, establish training on recognition and treatment of substance misuse in health care

professional training programs, and encourage entry into the field through incentives.

SAMHSA is also working on criminal justice programs such as jail diversion program grants, funding for MAT and drug courts, and expansion of access to substance use treatment services for individuals who are reintegrating into communities after release from incarceration.

While opioid addiction remains a crisis, Mr. Owens said that progress is being made; for example, opioid prescribing has been declining since 2011 and naloxone dispensing has increased dramatically. Treatment facilities are increasing their use of MAT.

Mr. Owens closed by providing information on the changes in how technical assistance and training will be provided. SAMHSA is moving to a local and regional approach with regional prevention, addiction, and serious mental illness collaborating technology transfer centers. There will be a series of grants to support this effort.

Council Discussion: SAMHSA Leadership Discussion

The following points were raised and discussed during the Council's discussion:

- Dr. Martin asked about blending the funding streams for co-occurring disorders so that patients do not have to have two treatment plans. Mr. Owens remarked that SAMHSA has a good relationship with the Centers for Medicare and Medicaid Services (CMS) and the two agencies are looking at the problem. Dr. Martin also commented that the privacy rules for substance use were a barrier to treatment. Mr. Owens agreed this was an important issue that is being investigated. He invited Council Members to provide input on the issue. SAMHSA just released a funding opportunity announcement for a Center of Excellence for protected health information related to mental and substance use disorders.
- Mr. Schut asked whether NIATx has been involved in SAMHSA's process improvement efforts. NIATx has some resources that might be valuable in this process. He also asked Mr. Owens to clarify what the term "clinician" meant as it applied to the Addiction Technology Transfer Centers. Mr. Owens said that they were generally looking for medical doctors with a specialty in addiction medicine, which could mean an addiction psychiatrist.
- Mr. Johnson spoke about his work in Detroit and how his organization has incorporated mental health treatment into its recovery services and sees the need to integrate physical health care into their services as well. He also commented on the difficulty of maintaining funding and some of the barriers that people needing services face, including transportation, lack of job opportunities, and lack of recovery housing.

Presentation on the State Targeted Response to the Opioid Crisis Grants' (Opioid STR) Impact on the Opioid Crisis

Dr. Ohuoha introduced Ms. Donna Hillman, who delivered an overview of the funding and activities related to the Opioid STR grant. Ms. Hillman is the Assistant Lead Public Health Advisor and CSAT Opioid STR Project Lead.

The Opioid STR grant is a service grant with a focus on supplementing existing activities and programs within the states to expand access to treatment and recovery. A total of 57 state and territorial grantees received an initial \$485 million. Several activities are required, such as conducting a needs assessment; designing, implementing, enhancing, and evaluating primary and secondary prevention using evidence-based practices to reduce the number of persons with opioid use disorder and related deaths; and implementing or expanding access to clinically appropriate evidence-based practices, particularly MAT.

Ms. Hillman noted an improvement in surveillance data on drug poisoning deaths, which frequently did not contain specific information about the drug involved. States have requested more precise data from medical boards, coroners, and medical examiners that will provide valuable information.

Grantees are also required to provide assistance to patients who are uninsured or underinsured. Many states have applied for CMS 1115 waivers, which provide the state additional flexibility to design and improve programs to better serve their Medicaid populations.

Additional, allowable activities being conducted by grantees include training of physicians and other health practitioners to provide MAT, implementing innovative telehealth and social media programs, and training multiple audiences to administer naloxone. Many states have established governor's level task forces designed to bring individuals from all levels together and coordinate the efforts of multiple agencies and entities for a more comprehensive approach to the crisis. Grantees are also developing hub-and-spoke systems that connect MAT programs in rural areas with MAT specialists in a regional hub site for support and information.

Other state and territorial grantee activities include:

- Linking non-fatal overdose patients to community services.
- Expanding use of the Prescription Drug Monitoring Programs (PDMPs) to ensure that prescription medications are compatible, prescriptions are provided upon a doctor's order, and patients are not "doctor shopping." Originally state specific, some PDMPs now are connected from state to state.
- Developing practice guidelines for strength-based assessment.

- Increasing the number of peer recovery coaches.
- Setting prescription limits for the dispensing of opioids to limit firsthand exposure. Many state legislatures have set limits of a 7-day initial supply for acute pain and have implemented CDC's prescribing guidelines.
- Expanding prevention efforts in schools and communities. Research has indicated that many persons are not aware of the addictive potential of opioids.
- Expanding the numbers of DATA 2000-waivered physicians in opioid treatment programs.
- Expanding mobile outreach and street medicine techniques and implementing techniques to reduce exposure to communicable diseases such as HIV and hepatitis C.

Council Discussion: Opioid STR Grants' Impact on the Opioid Crisis

The following points were raised and discussed during the Council's discussion:

- Dr. Martin asked about an Arizona opioid treatment program using some of its funding to stay open 24 hours a day. Ms. Hillman and her colleague Ms. Kim Thierry-English replied that Arizona has two full-service programs operating 24/7. These programs have incorporated peer support within their local judicial systems and are providing comprehensive service. Dr. Martin also pointed out that different areas have different needs. For example, the San Francisco area is treatment rich but rural counties may need more doctors.
- Ms. Harper asked if there were any community-wide assessments that could be used as tools when the state or other grantees are trying to determine priorities. Ms. Hillman was not aware of any but Dr. Ohuoha said that CSAT would research the question and send the information to the Council. Ms. Harper remarked that determining priorities could be very overwhelming in the face of the epidemic. Furthermore, she is finding that some of the state offices are not familiar with how to incorporate recovery into a whole system.
- Mr. Howell asked if states are experiencing any barriers in being able to put the grant funds to use and if any states are requesting to carry over the funds to the next fiscal year. Ms. Hillman responded that some states may not fully understand the grant provisions and may have some misperceptions of what they can do with the funding. She has seen some states experience difficulty in increasing staff to manage and implement the grant, in some cases because of the 2-year time period. However, these states seem to be ramping up more quickly now. As time passes, she anticipates seeing increasing collaboration across agencies and across levels of government to address the opioid crisis.
- Mr. Medina commented that it would be helpful if SAMHSA could have some input on how funds are distributed within a state so that the funds are used efficiently and

equitably.

- Ms. LeGore asked if any of the states involve families or have looked at the fact that dealing with the opioid crisis and recovery process involves the family as well. She also noted that integrating behavioral health care with medical health care was very important. Ms. Hillman stated that several states have focused on ensuring that significant partners, families, and other relatives are involved in recovery.

Recap: Putting It All Together

Dr. Ohuoha opened the floor to a general discussion of the meeting and presentations.

- Dr. Martin said that avatar training was mentioned in the Director's Report and asked if the psychosocial avatar training for motivational interviewing developed at the VA could be made available. It would be valuable for treatment providers, medical assistants, nurses, and recovery coaches and in many different settings. Dr. Ohuoha agreed that it was a very good technique. He also stated that many medical professionals have not paid attention to addictions; all medical professionals should be trained on what addiction looks like.
- Ms. LeGore asked if dentists were included in the group of health professionals needing training as they frequently prescribe painkillers. Dr. Ohuoha said that the need for training was across the board noting that few schools of social work have addiction curricula.
- Mr. Johnson said that his organization has been working with the state university graduate nursing program in Detroit to improve training and provide internships. However, he still sees reluctance among service providers to work with persons with substance use disorders. He also emphasized the value of recovery coaches throughout the country. Half of Detroit's population of 700,000 lives below the poverty line and around 15,000 are in the treatment system on any given day. The issues are complex and there is no single solution. Dr. Ohuoha replied that the Assistant Secretary has asked CSAT to look at the role of employment and housing in recovery.
- Mr. Schut discussed his involvement in a housing program that has Section 8 vouchers attached to apartments for women in treatment who have children. He described another model using tax credits to provide housing for persons needing assistance. Mr. Schut also mentioned the website shifttheinfluence.org with an interactive avatar program for individuals and health professionals.
- Mr. Howell pointed out that HUD housing programs frequently do not meet the needs of people in recovery who need housing assistance. He requested that SAMHSA work with HUD to encourage them to offer programs specifically tailored for people in recovery. Mr. Howell also asked SAMHSA about developing standards for recovery housing and stressed that organizations with expertise in the issue

should have input into developing these standards.

- Mr. Medina remarked that the level of family involvement in treatment is very low and that there are many families who have lived in dysfunction all of their lives. He hoped that SAMHSA could look into interventions for highly dysfunctional families. He also sees the need for peer support providers and clinicians to work more collaboratively together. Dr. Martin agreed, noting that peers are very valuable to recovery support programs.
- Ms. Harper added that Medicaid reimbursement for peer support needs to be considered as well. Because Medicaid will reimburse costs for peers with only a few hours of training, this acts as a disincentive for states to require additional training for peer counselors.
- Dr. Ohuoha asked for the Council's assistance in providing recommendations on what products and publications SAMHSA should produce during the next year. Recommendations included the following:
 - Mr. Howell suggested a "buyer's guide" to help consumers, individuals, family members, and service providers understand the process of going through treatment and recovery services.
 - Mr. Johnson recommended a guide on how to develop an integrated health and wellness recovery resource center that would encompass mental health, physical health, and recovery support in a multi-service team.
 - Ms. Harper discussed the need for an explanatory guide for educators and administrators on the full continuum of care on a college campus. She has seen a sharp rise in community college recovery programs.
 - Dr. Martin commented that a guide for physicians and surgeons on treating persons with substance use disorders would be valuable. The guide could cover areas such as the effects of drugs on recovery from illness or surgery. Materials for neonatal nurses would also be helpful. Dr. Martin observed that neonatal nurses might be hostile to women who have infants with neonatal abstinence syndrome. Patient information for families and mothers on MAT on what to expect would also be useful.
- Ms. LeGore would like to see more information on family peer-to-peer support services.
- Mr. Schut mentioned that some of the TIPs need to be revised. He also noted the need for materials that differentiate levels of support needed by higher functioning versus lower-functioning people in recovery.
- Mr. Medina suggested more information for rural and frontier areas and a career exploration piece for people in recovery who are job seeking.

Public Comment

Dr. Ohuoha opened the floor for public comments. There were no public comments.

Adjournment

At the conclusion of the presentations and recap, Dr. Ohuoha requested a motion to adjourn. Mr. Johnson moved to adjourn the meeting and Ms. LeGore seconded the motion. Dr. Ohuoha adjourned the meeting at 4:07 p.m.

I certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

9/10/18
Date

/s/
Chideha M. Ohuoha, M.D., MPH, CAPT (USPHS)
Director
Center for Substance Abuse Treatment