

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
National Advisory Council**

Open Session

April 15, 2015

**1 Choke Cherry Drive
Great Falls Conference Room
Rockville, Maryland 20857**

**Transcribed by:
Transcription, Etc., LLC
Washington, D.C.**

Table of Contents

Agenda Item: Welcome, Opening Remarks, Consideration of April 2, 2014 Minutes.....	2
Agenda Item: Members Introductions and Updates.....	4
Agenda Item: Director's Report	12
Agenda Item: SAMHSA/CSAT Budget Update	16
Agenda Item: Joint Session with SAMHSA Advisory Committee for Women's Services (ACWS): CSAT's Pregnant and Postpartum Women (PPW) Grant Program - Future Direction.....	41
Agenda Item: SAMHSA Administrator's Discussion with Council Members.....	64
Agenda Item: Expanding Access to Medication-Assisted Treatment Panel Discussion	94
Agenda Item: Council Discussion	106
Agenda Item: Public Comments	109
Agenda Item: Council Discussion	110

PROCEEDINGS

Agenda Item: Welcome, Opening Remarks, Consideration of April 2, 2014 Minutes

LT. CDR. HOLLY BERILLA: Thank you. Yes, good morning. We are about to begin the meeting for the CSAT NAC. And my name is Lieutenant Commander Holly Berilla; I'm the Acting Designated Federal Officer for this meeting and for the NAC, and I'm ready to turn the meeting over to the Chair, Daryl Kade.

Thank you.

MS. DARYL KADE: Thank you. This is the 72nd meeting of the CSAT Advisory Council. So thank you all. And thank you, Holly. As you may know, Cynthia Graham had been our DFO, and has retired. It's very difficult to replace Cynthia, and we're looking for a replacement, but Holly has graciously stepped in to help us out for this meeting. I'd also like to welcome back those members and staff who participated in the closed session and our extended break and who reviewed earlier this morning. And welcome to those who are joining us for this open session.

We put together a full schedule and I hope that you will find it informative. And, of course, we look forward to an insightful discussion regarding the challenges facing us in the behavioral health field and suggestions for meeting those challenges.

Our first item of business on the agenda is to vote on the April 2, 2014 minutes, which were forwarded to you, electronically, for your review and comment. They have been certified in accordance with the Federal Advisory Committee Act regulations and include your edits. I will now entertain a motion to adopt the minutes.

MS. CHRIS WENDEL: So moved.

MS. DARYL KADE: Is there any discussion of the minutes?

DR. JEANNE MIRANDA: Second.

MR. ARTHUR SCHUT: Is there a way I can make a correction? It reflects that I was not present in person, and I was present on the phone.

MS. DARYL KADE: Uh-huh.

MR. ARTHUR SCHUT: But I was locked out and unable to speak because apparently, the technology will not allow one person to speak and not everyone else who's in. So if there's a way to correct that part, that'd be great.

MS. DARYL KADE: Yes, we will attend to that. Thank you.

MR. ARTHUR SCHUT: Thank you.

MS. DARYL KADE: So is there a second?

DR. LEIGHTON HUEY: Second.

MS. DARYL KADE: Very good. A second to adopt the minutes as presented. And then those in favor?

(Council Members collectively vote "aye.")

MS. DARYL KADE: Those opposed?

(No response.)

And the minutes have been adopted and we're rolling. Before I begin, I want to thank our four retiring members for agreeing to extend their terms: Christine Wendel, Dr. Victor Capoccia, Dr. Leighton Huey, and Dr. Jeanne Miranda. Thank you. I appreciate your willingness to continue to serve for this extended period and making this meeting possible. I also want to, again, give my thanks to all of the Council Members for taking the time from your demanding schedules to be here today. Your dedication to improving the behavioral health of the nation and our experience on the frontlines are invaluable to us as we develop programs and policies to enhance the behavioral health of the nation.

It has been a number of months since the Council Members convened. So even though we don't have any new members, I'd like to take a couple of minutes to allow the members to introduce themselves and to update us on any new projects or programs they have been working on since we last met. We can begin, perhaps, with Arthur Schut.

Agenda Item: Members Introductions and Updates

MS. CHRIS WENDEL: Schut.

MS. DARYL KADE: Schut.

MR. ARTHUR SCHUT: Schut.

MS. DARYL KADE: Schut. I'm sorry.

MR. ARTHUR SCHUT: Think -- I hate to say this, but think scuttlebutt, just always leave off the last two syllables.

MS. DARYL KADE: All right. Will do.

MR. ARTHUR SCHUT: So I'm from Denver. I'm at an organization that serves the metropolitan Denver and provides a broad range of services that range from detox to intensive 24-hour services to specialty services for pregnant women and the women with their children in treatment together, as well as we have clinicians in integrated primary care practices and we provide a broad range of services. One of my interests right now is medication-assisted treatment and spreading that. And so this afternoon, I'll talk a little bit about that and I'll save that for then.

MS. DARYL KADE: Thank you.

MR. ARTHUR SCHUT: Thank you.

MS. DARYL KADE: Thank you. Paul Molloy.

MR. PAUL MOLLOY: Hi, I'm Paul Molloy and I'm with Oxford House, Inc. Oxford House continues to roll along. We have 1,867 houses. Last year, 34,820 people went through Oxford Houses. About 5,000 were asked to leave because they relapsed. That was about a 16 percent relapse rate. We continued to be studied by DePaul University and other places and we encourage all kinds of third-party researchers to look at the recovery process.

Oxford House has sort of been a leader since 1988 and saying come study us and figure out how it is we're staying clean and sober. And researchers, I think, have been relieved because they were sort of scared off by the anonymity of AA and NA. And so we continue to encourage researchers to look at us. We continue to grow. There's now about 22 states that have contracts with us where we send outreach workers into the state to open new houses. And our latest annual report is on our webpage. And so please, go to our webpage and click on it. You can learn as much about Oxford House as I know. Thanks.

MS. DARYL KADE: Great. Thank you so much. Lori Simon.

DR. LORI SIMON: Hi. Lori Simon, I'm a psychiatrist in Northern New Jersey and Manhattan. I have a private practice in both areas for about 15 years now, which I can't believe. And prior to that, though, I'm also on the volunteer faculty at Cornell because I trained there. But prior to that, actually, I had a career in computers. I used to work for IBM for a long time and so I'm increasingly getting back into that with regard to healthcare and doing that via several mechanisms; one is I am on the American Psychiatric Association that has a mental health information technology committee. I'm a member of that.

And I've also, through them, gotten involved with -- there's another organization of computers in healthcare called HL7. And interestingly enough, the HIT, the Health Information Technology Group from SAMHSA actually is heavily involved with HL7, and so we're working together. And what I want to do is actually expand some of the requirements work that I've done because there's been a huge ongoing problem in healthcare where what's being developed by vendors does not match what the providers need and so I'm trying to bridge that gap through work that I'm going to be doing with HL7.

MS. DARYL KADE: All right. Thank you. Christine Wendel.

MS. CHRIS WENDEL: Good morning, everybody. This is Chris Wendel. I have decided to, for the most part, walk away from the advocacy work I've been doing with our state in New Mexico. I am a person in long-term recovery, and what that means for me is that I have not had a drink or a drug since the summer of 1985.

So I have chosen, instead, to get involved with something that we've just started called Recovery Santa Fe. I did put together some handouts so you can have a sense of what

we're doing. Doug, if you can pass them your way. And here you go for you guys. And here you go for you guys. So what we're trying to do is, and this will sound very familiar to some of you, we're trying to bring forth the Face of Recovery versus the Face of Addiction. And my partner in crime, my main partner in crime is a gentleman by the name of Dr. Tom Stark. And Tom is -- get this, this is terrific -- Tom is a retired physicist from Los Alamos, who is a community activist. And to say he brings a different perspective to the table would be an understatement. So we're having a blast.

We had our first recovery celebration last September. We had a cookout. We had about 250 people there for the first time. We had a fair, kind of trade show kind of thing with about 20 exhibitors. We showed the movie, "Anonymous People," continually, for the day. We had some workshops. We had a fabulous art show. Many people. We had about 60 artists, many of whom have never exhibited. They are people in recovery and they've never exhibited their artwork prior to that. So the mayor was there. We have a city councilwoman in Santa Fe who is in long-term recovery.

So it was just fun. We just had fun and we're going to do it again this coming year. This coming September, we're going to do it again and invite anybody who wants to have a vacation in Santa Fe, come see us. It's a lovely time of year to be in Santa Fe. We're doing a couple of other things. One of the things I've started doing is what we're calling Tables and Talks. So the other morning I had breakfast at the Rotary and I told them about the Face of Recovery and Recovery Santa Fe and what we're trying to do, just to start to get the word out more and more and more. So we're doing those kinds of things.

When I get back next Saturday, a week from Saturday, I'll take a table to the Women's Health Fair in Santa Fe and talk about recovery. And I'm going to have a table at Gay Pride, and we're just trying to do it, trying to do it, trying to do it. It's slow, and I gotta tell ya, it's grassroots at its best. I think our budget for last year was about \$1,200, so it's all volunteer and a great group of people. We're including mental health. We're including

family members. We're just trying to reach out and include as many people as we possibly can and it's all about the Face of Recovery. So thank you.

MS. DARYL KADE: Thank you very much. Leighton Huey.

DR. LEIGHTON HUEY: I'm Leighton Huey; I'm Associate Dean and Professor of Psychiatry at the University of Connecticut. The latest project that I'm working on is heading a consortium of people to address America's opioid overdose epidemic through retraining and work force development, breaking the cycle through medical and community education, best practice, and prescribing guidance while meeting legitimate pain needs. And this is taking the argument and the concerns about the opioid overdoses to education and training, informing clinical practice in using pain medications.

Are we ready for curricular changes in medical schools, in residencies, and among established physicians at state and federal levels? That's the focus of the work that I am doing now, with a proposed presentation to the American Association of Medical Colleges in November about this.

MS. DARYL KADE: Thank you. Jeanne Miranda.

DR. JEANNE MIRANDA: So Jeanne Miranda from UCLA. I long have worked in the area of bringing mental healthcare to low-income minority individuals. Working on a big project in LA. Also, I have a project working with family cohesion and actually improving care for families adopting older kids from foster care and I am increasingly bringing our depression treatments to international states. So we're working in South Vietnam. We're working in India and this summer we'll start a big project in Africa.

MS. DARYL KADE: Great. Thank you. Indira Pahlaria.

DR. INDIRA PAHARIA: Indira Pahlaria. I'm with an organization that provides a community health worker model. We are based in Maryland and we have operations in eight states, and we focus on the most vulnerable populations. So folks who are on Medicare and Medicaid are dually eligible, have severe and persistent mental illness, substance use disorders, homelessness, and disability. And what we do is provide these vulnerable citizens to needed healthcare services, social services and community services. And what we're finding is that there are a lot of people who are difficult to reach, don't understand the benefits that they have, and really do need a lot of help navigating the healthcare system. And so that's the work that we're doing.

MS. DARYL KADE: Great. Thank you. Sadé Ali.

MS. OMISADÉ ALI: I'm Sadé Ali. I presently live in Delaware. Who knows tomorrow where the wind might take me, but I work and I had to get advice about conflict of interest before I came here on the ATR issue because I know all of those grantees, but we don't get money directly from them. I work for Altarum Institute and we do the training and technical assistance for the grantees around the country, and I focus primarily on tribal grantees. Until now, we have one. So I'm presently doing work force development and integrated care training and technical assistance packages for Altarum Institute and the ATR grantees.

I also work with First Nations, LLC, which is a training and technical assistance organization designed to look at intergenerational trauma and its impact on Native American and First Nations people around North America. And as a first generation survivor myself of the residential schools, this is very important work for me.

Recently, we started the east coast Two Spirit Society. Two Spirits is a term that was created at a gathering in 1990 in Winnipeg, Canada by Native American and First Nations people, formerly known as Lesbian, Gay, Bisexual, Transgender and all of the other letters. So we are now Two Spirit people and we just started the east coast Two

Spirit Society based in New York City, where most of the 78 percent of those of us who live off of tribal lands reside.

So if you are interested in the issue ec2, the number two, ss.net is our website, and we do phenomenal work. Since we last met, my social healing words, using language to promote recovery resilience and resilience in people, families, and communities is in its second publication with some revisions. And hopefully, SAMHSA will pick up on that revision as well as they did the first. Thank you.

MS. DARYL KADE: Thank you. Andre Johnson.

MR. ANDRE JOHNSON: Hi. My name is Andre Johnson. I'm a person in long-term recovery, and what that means is I have not used no drugs and alcohol since July of -- early July of 1988. And it also means that I wouldn't be able to be a father to my lovely 16-year-old daughter. Whoo. Hallelujah.

And I also wouldn't be able to lead the Detroit Recovery Project, which is an organization that I was fortunate to found just nearly 10 years ago. And the Detroit Recovery Project was an initiative of the RCSP funding out of CSAT in 2001. It was an initiative of the City of Detroit Health Department, and it began to take a life of its own and we started a non-profit, entitled Detroit Recovery Project. And in July, we'll be celebrating 10 years. So that's a huge milestone for the organization and also, just to have this continuing relationship with SAMHSA.

And since the start of the organization, we've continuously expanded and we are in the process of acquiring two properties to provide and create a new program entitled, Adolescent Recovery Center. And what we'll be doing, it'll be a 10-bed facility for boys between the ages of 13 and 17 years old and a 10-bed facility of girls between the same ages, and so I'm excited.

We currently don't have no residential treatment program for adolescents in our state. Our agency works with Wayne County Third Circuit Court. And that's juvenile drug court. And so we've been really instrumental in helping to provide treatment and recovery support services for the adolescents in Wayne County.

Wayne County is probably one of the 10th largest counties in our country, so I'm really excited about that endeavor. I'm excited about just being able to sustain and start an organization from two people to have in several properties, providing housing. We just added another home for men who are in recovery. We provide transition living. We've also recently partnered with Wayne State University Graduate School of Nursing. And giving all the talk about how we're going to become more a -- we've renamed our centers. It's now called, instead of recovery center, it's Health and Wellness Recovery Resource Center. We have on the east side and one of the west side of Detroit. Those are the dividers of Detroit.

And so we've now infused some mindfulness activities, some yoga activities, and we've partnered with Wayne State University Graduate School of Nursing where we'll have a team of nurse practitioners that will be on our site on a daily basis, providing full comprehensive health screenings. Also assisting our recovery culture and training our coaches in areas of hepatitis, A and B education, as well as HIV and AIDS education and training. So I'd like to think that we are on a cutting edge of becoming a highly respectable recovery community organization in the country and I certainly attribute it to meeting the great minds of people like Tom Coderre over the years, who've witnessed it firsthand, But it's a lot of synergy in Detroit, Michigan.

I'm sure you've heard of all the wonderful renaissance that's coming to downtown Detroit. And the Detroit Recovery Project is right in the midst of it all. And I think just this whole movement has really elevated, and as we all know, we can put a face on recovery and it's friendly. We still have the pink elephant in the living room there,

though, okay, but we got to continuously get the message out and I certainly, again, thank you guys for your support over the years. Thank you very much.

MS. DARYL KADE: Thank you very much. Mohammad Yunus on the phone?

MR. MOHAMMAD YUNUS: Yes. Hi, everyone. My name is Mohammad Yunus, I'm a retired CEO. I have been in the mental health and the substance abuse field for more than 30 years. Currently, I'm working (inaudible) focusing on new ideas involving (inaudible), innovation, motivation, pride and (inaudible). The social group has continued to (inaudible) right now and continuing with classes. They seem to know what they are doing. They have the qualified clinicians, selective gadgets, and the workers. But they don't seem to have a man that can plan for the next horizon and next goals/opportunity, a man and a leader who can inspire people. They have the knowledge, they have the skill, but they seem to be lacking motivation to put everything together. These (inaudible) are very susceptible to our ideas and have made extensive progress. That is my story right now. This is what I'm working on.

MS. DARYL KADE: Great. Thank you very much. Is there any other member on the phone? Terrance, are you there?

(No response.)

LT. CDR. HOLLY BERILLA: I don't think he has dialed in yet.

Agenda Item: Director's Report

MS. DARYL KADE: Okay. Well, thank you. I'm really in awe and very honored to be part of this group today. I read your bios, and just hearing what you're working on now makes your participation in the CSAT Council very special, not only for SAMHSA, but personally for me.

I wanted to direct your attention to the Director's Report in your folders. The report includes all the details pertaining to CSAT activities during the period of time since the last report. I wanted to take a moment to focus on a few highlights regarding personnel changes, planning efforts, new programs and collaborations across SAMHSA.

With regard to personnel changes, the obvious change is that Dr. Clark retired and I was asked to fill in for a while as the agency searched for a replacement. As I mentioned in our closed session, as some of you know, this is not my area of expertise, but I am the Director of the Office of Financial Resources and the CFO, but I do have expertise to share with the CSAT line staff and senior management on budget, grants, contracts, and day-to-day business processes.

To balance out the CSAT executive team, Tom Coderre was also detailed to CSAT to help cover many political and policy-related issues, opportunities, and challenges that face CSAT. And Tom and I are very fortunate to be working with Kimberly Jeffries-Leonard, who assumed her role as Deputy Director, only three months before Dr. Clark resigned. It has been an exciting time at CSAT, especially for me, as I've had to close out the 2014 budget for SAMHSA and start the 2015 budget for CSAT. I appreciate all the support I've received from the CSAT staff and the IOA leadership and hope that the CSAT Council will bear with me as we all await a new leader.

Second, regarding planning efforts, I wanted to discuss two efforts that have started since I began my detail. CSAT, a division of pharmacotherapies, in conjunction with the Office of Planning and Innovation, policy-planning innovation and with CSAT, is developing a medication-assisted treatment action plan. The purpose of this plan is to expand access to medication-assisted treatment for the full array of FDA-approved medications, not just the ones that we regulate. The plan will work with providers, prescribers, and clients to try to identify and fill gaps. And you will be hearing more about some of our in-house efforts later in the agenda.

CSAT is also working on an action plan to increase access to family-centered treatment for pregnant and postpartum women. We plan to hold focus groups, review sustained programs and investigate various models for treatment and barriers to treatment. And this is in preparation for proposals for 2017. Again, you will be hearing more about our plans later in the agenda. Both plans should help inform SAMHSA's road ahead. Again, not only for 2017, but also for 2016.

Third, regarding new programs, you may know that SAMHSA has announced a new program in 2015, titled, Targeted Capacity Expansion Medication-Assisted Treatment; Prescription, Drug, and Opioid Addiction that we refer to as PDOA. This grant is limited to states that are experiencing the highest rates of primary treatment admissions for heroin opioids per capita and targeting those states that have experienced a dramatic increase in admission in recent years for both heroin and prescription analgesics. Based on these criteria, 39 states have been identified as eligible, with 18 states identified as priority states. CSAT will be able to make 11 state awards this year and the FY 2016 President's Budget expands this program to another 12 states. This program is part of the Secretary's opioid initiative.

Finally, regarding collaborations, I want to acknowledge the work that Office of Policy Planning and Innovation has done in collaboration with CSAT and CSAP to update the 2016/2017 Block Grant application. The overall format has been changed to integrate the environmental factors throughout the behavioral health assessment and plan narrative. This has reduced the length of the application by 10 pages and has reduced the redundancy and narrative. There are also proposed revisions that reflect changes within the planning section of the application.

The most significant of these changes relate to evidence-based practice for early intervention for the Mental Health Block Grant, participant-directed care, medication-assisted treatment for the substance Abuse Block Grant, crisis services, pregnant and

postpartum women with dependent -- women with dependent children, community living homestead and quality and data readiness collection. The 60-day notice was published in the Federal Register on January 8th and expired on March 8th. A 30-day notice was published in the Federal Register on March 26th and will expire soon, April 27th.

In addition, I want to acknowledge the work that CBHSQ has done, the Center for Behavioral Health of Statistics and Quality has done to migrate to the new common data platform. CBHSQ has spent years planning for CDP and we are finally about to see their hard efforts realized. The new system was launched to CSAT grantees and staff in March. The goal of the CDP is to merge the individual data collection systems used by each of the three centers into one system. The result should be a more consistent set of data that can be used agency-wide to assess program effectiveness and better track grantee progress.

There have been significant challenges in implementing the system and CSAT staff continue to work closely with CBHSQ and the CDP team to address those challenges. CSAT staff are also working with OFR, my home office, Office of Financial Resources and OMTO, Office of Management and Technology, to develop a new grant's enterprise management system that we call GEMs. It's designed to move SAMHSA toward a more efficient grant process. GEMs will incorporate grant announcements, review management, closeout functions to reduce the process steps and system logins, increase information reuse and analytic insight and increase grantee interaction and internal collaboration and enable reporting that allows performance measurement and improve decision-making. It is a task for which I am the executive sponsor as the executive lead for the business operation internal strategy.

GEMs will start with a pilot next year and will proceed to a new conversion implementation the following year. The team hopes to make a selection in August after review of both the ACF and NIH proposals and then again pilot. Through these and

other innovative projects within the agency, SAMHSA continues to work toward improving efficiencies while more effectively meeting the needs of our grantees.

So I don't want to steal Tom's thunder, but I do want to mention that this September will mark the 26th year of recovery month. This year's theme is Join the Voices for Recovery: visible, vocal, and valuable. The 2015 Recovery Month Toolkit and Public Service Announcements are currently under development and will be available. And we can give you the site, but it's www.recoverymonth.gov, at the end of May. The PSAs will also be distributed to TV and radio networks across the country in early June. As of April 6th, there are 96 Recovery Month community events posted on the website.

So at this point, that was a brief overview of some of the things that I've been working with at CSAT and I'd like to shift attention to Dr. Leonard, who will give you a budget update, my favorite part of the program.

Agenda Item: SAMHSA/CSAT Budget Update

DR. KIMBERLY JEFFRIES-LEONARD: Thank you, Daryl. I'd like to bring your attention to the left side of your binder. And in it you have an innovation of our acting director, Daryl Kade, a pocket budget for the Center for Substance Abuse Treatment. I think this is the first of its kind that we've ever had. It's a wonderful tool to be able to look at our budget, significant changes in a snapshot.

This pocket budget provides an overview of the appropriations and the significant changes in the FY 2016 President's Budget. It describes new initiatives and details numbers of FY 2016 new grants and contracts. So it's very useful and we're very pleased to have it. There have been some significant changes in the FY 2016 President's Budget when you compare it to the 2015 inactive budget. There have been increases, as you can see, in our TCE-General Program. There have been increases

proposed in the Primary and Addiction Services Integration, PCASI Program, and also in the Crisis Systems Program.

We have had some decreases also, that have been impactful. There have been decreases to the Screening Brief Intervention and Referral to Treatment, SBIRT Program. Access to Recovery was decreased significantly, as you can see. Our minority AIDS Program was decreased. The criminal justice activities were decreased and the Addiction Technology Transfer Centers were decreased. So you can see that there was a net change of \$40 million -- \$40,762,000 in the budget. But there have been some highlights. There are some highlights that I'd like to present. Daryl mentioned some, and I'll go into a little more detail.

The first one is our Medication-Assisted Treatment for Prescription Drug and Opioid Addiction, which we love our acronyms; this is our MAT-PDOA Grant. And many of you may have heard about this or seen it and been on conference calls regarding it, but for this particular grant program, we requested \$25.1 million in the FY 2016 budget to continue, which is an increase of \$13 million of our FY 2015 budget.

Funding is a part of a joint effort by SAMHSA and the Agency for Healthcare Research and Quality (AHRQ) to improve access to MAT Services, Medication-Assisted Treatment Services, with a focus on heroin and prescription opioids. Our FY 2016 funding will increase the number of states receiving funding from the current 11 to 22, and we are expected to serve an additional 24 high-risk communities. We also have money set aside for technical assistance to these programs and our partnership with the Agency for Healthcare Research and Quality (AHRQ) will do the evaluation to ensure effectiveness and improve outcomes.

Our crisis systems, increasing crisis access response efforts, iCARE, \$10 million was requested in the FY 2016 budget, \$5 million in the mental health appropriation and \$5 million in the substance abuse treatment appropriation. There was an increase of \$10

million from the FY 2015 enacted level. iCARE is a demonstration activity to help communities build, fund, and sustain crisis systems. These grants will help mitigate the demand for inpatient beds by those with serious mental illness and substance use disorders by coordinated effective crisis response with ongoing outpatient services and support, so this is another important program.

Our PCASI Program, the Primary Care and Addiction Services Integration, \$20 million was requested in the FY 2016 budget. This program will provide grants to behavioral health and primary care providers to integrate substance abuse treatment services and primary care, which is very important in our behavioral health approach. We expect that PCASI will complement the successful Primary and Behavioral Healthcare Integration grant Program, the PBHCI Program, by promoting integrated services for individuals with substance use disorders and using lessons learned from our PBHCI Program. We had a very in-depth evaluation of that program by RAND and got some excellent lessons learned and next steps in outcome information.

This slide just shows you some of the other new grant programs from our FY 2016 budget. You can see that we have, for our opioid treatment programs and regulatory activities, there's one grant that will be funded 13 SBIRT grants, and this will be funded through our PHS evaluation funds. TCE-General, 40 new grants, 11 of which are the MAT-PDOA that I just described; 22 PCASI grants, nine treatment systems for the homeless, up to 24 Minority AIDS Initiative grants, 39 grants for the criminal justice activities, and three grants for our crisis systems, a total of 151 new grants to impact integration and substance use disorders and behavioral health in our communities at need.

So that's a quick overview. We have more in-depth information in our pocket budget. And so I am happy to answer any questions that you may have at this point.

Agenda Item: Council Discussion

MS. DARYL KADE: Actually, now, if you have any questions about the budget or any of the initiatives that I talked about, it's an open discussion at this point.

MR. ANDRE JOHNSON: Yeah. I had a couple of questions around -- I noticed you talked about -- when you talked earlier about the increase and the decreases. And I noticed significant funding was decreased in the areas of recovery support and access to recovery. It seemed like that particular area took a major hit and I'm just wondering, you know, why and what was the justification behind that.

MS. DARYL KADE: So very good question. Being cut by \$78 million wasn't that comfortable, coming in as a DTO and rolling out the 2016 budget, but if you look in your pocket budget, on the overview of significant changes -- so it would be this page, Andre.

MR. ANDRE JOHNSON: Okay.

MS. DARYL KADE: So when you get down to Access to Recovery, what we say is that many of the services are expected to be covered by public and private insurance and SAMHSA's plan in 2016 is to bring the key elements of ATR to scale.

MR. ANDRE JOHNSON: That's good.

MS. DARYL KADE: Now, we'll see whether or not that happens. In our closed session, we approved the ATR grants. They will be multi-year funded, which means there are fewer grants because we have to use all of 2015 funds to fully fund them because the President's budget, the cut of \$38 million basically eliminates all funding for ATR. So we will see how the Hill addresses that. The reason why we had funding this year was because the House restored the cut in the President's budget. So we're trying to see where the Hill is coming from, but we felt that we can bring this to scale, based on the other changes in the healthcare financing system in the states.

MR. ANDRE JOHNSON: Okay.

MS. DARYL KADE: Did you have another question?

MR. ANDRE JOHNSON: Yeah. I was just curious if you could maybe elaborate. This is my first hearing about the Primary Care and Addiction Service Integration, which I know is important, but I'm just wondering like, this particular funding, because it seems like it's been a slight shift where non-profit, a lot of funding have been earmarked towards universities and hospitals versus your non-profit organizations. And I'm just wondering, like, this particular initiative, it is targeting non-profits or is it targeting hospitals? You know, what's the target?

DR. KIMBERLY JEFFRIES-LEONARD: This particular grant program is, you know, the standard eligibility programs, so non-profits are able to apply. The purpose of this program, one of the things that we see very often when we are working with those who have substance use disorders, mental and substance use disorders, there are other issues also.

MR. ANDRE JOHNSON: Sure.

DR. KIMBERLY JEFFRIES-LEONARD: And so this is another opportunity to provide funding to implement programs that look at these issues comprehensively. And so it really it moving towards treating and having integrated teams of professionals, collaborative teams, comprehensive teams to treat the whole individual, which we know leads to better recovery outcomes.

MR. ANDRE JOHNSON: Okay.

DR. KIMBERLY JEFFRIES-LEONARD: So certainly, a non-profit can apply if its eligible. So this is not targeted to anything particular, other than the current eligibility that we typically have.

MR. ANDRE JOHNSON: Okay.

MS. DARYL KADE: And I would add, it's based on the PBHCI model, so it is comparable to CBOs, as well as states could apply.

MR. ANDRE JOHNSON: Okay. All right. Thank you very much.

I'm a little confused and I'd like clarification, please, in this Primary Care and Addiction Services Integration. It's not a true behavioral health integration; is that true?

MS. DARYL KADE: What do you mean by true behavioral health integration?

MS. OMISADÉ ALI: Mental health substance use challenges and primary care.

DR. KIMBERLY JEFFRIES-LEONARD: This is specific to substance -- those who have substance use disorders and other co-occurring, along with primary care. So it is a behavioral health integration program.

MS. OMISADÉ ALI: Okay. By the name, I can't get that.

DR. KIMBERLY JEFFRIES-LEONARD: Oh, I understand. I see what you're saying.

MS. OMISADÉ ALI: Okay. Thank you.

MR. ANDRE JOHNSON: Mental health and --

MS. DARYL KADE: What we can do, Sadé, is provide the excerpt from the actual 2016 President's budget that would give you more information. Okay? Lori.

DR. LORI SIMON: Just an additional question about that program, the Primary Care and Addiction Services Integration. You mentioned that it complements the other program, Primary and Behavioral Healthcare Integration, so I'm not that familiar with that program, so I just wanted to get a better sense of what the differences are between this new program and the one that's in existence.

MS. DARYL KADE: I can start, but the description is rather comparable by PBHCI as funded within the mental health appropriation. Our appropriation is divided now into four components for separate appropriations. And so the emphasis there, the target population is on people with mental health conditions, but also on co-occurring and that was the idea that then generated maybe we need a PCASI program that focuses on substance abuse and co-occurring. But we could also get you a more robust description of that program, not only from the President's budget, we actually have an RFA that we can show in terms of how it's developed because we would use that RFA, the PBHCI RFA to then inform the PCASI RFA if we actually got the money. So we can do that for you.

DR. LORI SIMON: Thank you.

MS. DARYL KADE: Any other questions?

MR. ANDRE JOHNSON: I have more like a comment. First of all, I want to thank you all for, you know, the presentation. Very helpful. And I'm just wondering, as it relates to us and our body, how can you guys better utilize us, if that's possible, as it relates to some of these new emerging initiatives so that we can become a little more apprised of it and maybe offer some of our expertise, if that's okay.

MS. DARYL KADE: Many of these proposals, PCASI in particular, was proposed in the 2015 President's budget and was not funded and it's now proposed in the 2016 President's budget. So we'll see how that plays out for medication-assisted treatment that was actually proposed in the 2016 President's budget, but funded by the Hill in 2015. So that actually was a unique situation in that we're building upon something that Congress has recognized and supported.

But to answer your question, I would focus on what the Administrator is asking us to do in terms of how to leverage SAMHSA investments. I think in our session, our working lunch, there will be three questions that we'll be reviewing and providing her information so that she will have a better sense as to how to better leverage not only what she's promoting in 2016, but what she hopes to promote in 2017. So I don't think it's so much about this budget is already on the Hill -- what will be, will be -- as much as the larger path forward, especially the input that this Council can provide at the joint session tomorrow. Kim, would you like to add?

DR. KIMBERLY JEFFRIES-LEONARD: Tomorrow at the Joint Session and today, we're going to go through these questions. We will service facilitators. We will breakout in different like groups and really come up with some brainstorming ideas on how to take back information and how SAMHSA can utilize your collective expertise around how to address some of these issues. And so that's what we'll do today. That's what we'll be doing tomorrow. And not only us, but the Administrator in how to move forward in representing SAMHSA's needs.

MS. DARYL KADE: Thank you. Tom, would you like to add?

MR. TOM CODERRE: Sure. I think your question was how can you help, right? We've advanced some of the things in addition to some of the things Daryl and Kim already said. We, of course, as feds, can't be involved in telling you whether or not to go to Congress or not, but if you think that some things in the budget are helpful, are

important the communities that we all serve, then we think you should let them know that. That's a way you can clearly get out in front and assist by letting the people that represent you on the Hill know what your feelings are.

MS. DARYL KADE: Well, with that, I'd like to refer to Tom Coderre, who joined the CSAT Leadership Team during this transition. Those of you who know Tom are aware of his commitment, his substance use disorder treatment and recovery services. His experience and insights are invaluable to me, and a great benefit to CSAT. We've asked Tom to share with you the work that SAMHSA has been doing on the recovery support strategic initiative.

Agenda Item: SAMHSA's Leading Change - Recovery Support Strategic Initiative

MR. TOM CODERRE: Thank you, Acting Director Kade. And welcome, to everybody, to this National Advisory Council meeting for CSAT. My name is Tom Coderre, and I'm a person in long-term recovery. For me, that means that I haven't used alcohol or drugs since May 15th of 2003. So I'm coming up on an anniversary of a dozen years in recovery, so it's really that lens that I come to this work with and that I'm constantly referring back to when I do a lot of this work.

Many of you know my background; I'm a former State Senator from Rhode Island, who ended up losing everything as a result of my addiction. I found recovery and then came back to work in this field, first, doing advocacy work with Faces and Voices of Recovery for a couple of years as their National Field Director. I was involved in a local recovery community organization in Rhode Island called RHI Cares. And then I went back to the state senate to serve as the chief of staff to the Senate president there. I did that for five or six years before receiving this appointment.

This is a political appointment for me, so I'm here for a couple of year, working with the administrator and with the staff here at CSAT and throughout the agency on a variety of different initiatives that include prevention treatment and recovery, and representing SAMHSA at HHS, through the other operational divisions and the White House. So it's really an honor for me and it's a gift of my recovery that I'm able to do this work, just as many of you mentioned when you introduced yourselves.

And I know many of you, fortunately, through that work. And thanks for the shout out, Andre, but truly, you've been a teacher -- each of you have been teachers to me about this work and how important it is. And what I'm going to talk about, as Daryl said, is the strategic initiative, but I thought was maybe a little too narrow of a focus just to talk about the strategic initiative. So I decided to encompass a little bit more about recovery support and how it's a key component to SAMHSA's programs.

We all know that recovery touches everyone. And the slide that you see before you now is a quote from the National Recovery Month proclamation, and I think President Obama said it best that every day, millions of Americans with substance use disorders commit to managing their health by maintaining their recovery from drug and alcohol addiction and that people in recovery are not strangers, they are our family members, friends, colleagues, neighbors; they're all of us. So that when we support their recovery, we support them.

We believe at SAMHSA that there are many pathways to recovery. And you'll see on this slide, the definition that came out of Leading Change 1.0, SAMHSA's strategic initiative, the first iteration of the strategic initiative, the four-year plan from 2011 to 2014, which describes recovery as a process of change through which individuals improve their health, wellness, and live a self-directed life and strive to reach their full potential.

On the next slide, many of you may be familiar with the Healthy People 2020 Project, which has this circle of health determinates, the social determinates of health. And examples of social determinates include availability of resources to meet daily needs: safe housing. Paul is very aware of the importance of that and providing that to folks in recovery to help them sustain their recovery; access to educational, economic, and job opportunities, access to healthcare, quality of education and job training and on and on. Each of these fits in one of the social determinates of health. And we, at SAMHSA, look at this and use social determinates of health of part of our guiding principles, which also came out of Leading Change 1.0.

So we had the definition and the guiding principles, where we see recovery really as this circle of different things that people in recovery rely on to sustain their recovery for the long-term, and you'll see the examples there. When we talk about many pathways, we talk about it being holistic. We talk about peer support being a key element of it. It's relational, it's cultural, it addresses trauma. These are the things that we've learned over the years, where we used to look at recovery more as maybe remaining abstinent from a particular substance. Now we know that it's a lot more in helping people sustain their recovery that involves a lot of these things.

The central tenets to recovery as SAMHSA defines it, is health, home, purpose and community. And you'll hear that talked about through all of our grant programs. And you'll hear the Administrator talk about and Senate Directors. You'll hear everyone really share this. And when we're talking about recovery and the Recovery Support Strategic Initiative, too, we are talking about behavioral health recovery. We're not just talking about addiction from substances, but also recovery from mental illness. And the recovery, the strategic initiative, the RSSI, the Recovery Support Strategic Initiative focuses on many of the different elements that really will advance recovery into the future.

Many of you are aware that there are six strategic initiatives that are included in Leading Change 2.0, which just kicked off in January. The next section of our four-year plan, I wanted to share specifically with you what the Recovery Support Strategic Initiative encompasses. There's four basic strategic goals in this strategic initiative: improve the physical and behavioral health of individuals with mental illness and substance use disorders and their families, increased access to permanent housing for individuals with mental illness, substance use disorders and their families, increased competitive employment and educational attainment and promote community living for individuals with mental health and substance use disorders.

So you'll see, when we saw the social determinates of health or you saw the tenets of recovery support, these are the -- this is exactly what went into creating the strategic initiative around this. So it was really informed by that work that was done in science and then that was done in Leading Change 1.0.

SAMHSA's recovery efforts are person-centered and evidence-based. So we are integrating recovery support into all of our grant programs and treatment protocols and recovery support is really becoming something that we're trying to bring to scale through a variety of different activities that we do at SAMHSA. It's a public health approach to support recovery from all substances. It's person-centered and evidence-based and it includes, as I said, the integration of all of this.

This is an example of how we're including recovery-oriented systems of care in some of our publications. This is a new Federal Guideline; it was only released a week ago, just prior to the AATOD meeting. And you'll see recovery-oriented systems of care featured prominently. And this is new for us. This isn't something that we've traditionally done, and so finding ways through the different products that we have to include recovery-oriented systems of care is going to be a continued priority. And thankfully, the strategic initiative is helping us to remind us how important that is and it's helping us to redirect us in this way.

So you see recovery-oriented systems of care is directed by the individual. Recovery services comprised of clinically-based structured processes that coordinate and facilitate recovery after the acute treatment stage and it talks about OTPs really need to include recovery support services in their clients treatment plan. We know that that medication-assisted treatment is the most effective treatment for opioid abuse disorders. And not to think about the recovery part of it would be foolish, right? It would be treating the individual for that issue and not thinking about their needs post treatment.

Just a few more examples of the things that are included in the guidelines, key components, recovery individuals who experience challenges, as well as the successive treatments. Peers often have more credibility and impact than non-peer clinicians. So including peers into the equation is something that we're encouraging these programs to do as well.

We have a recovery web hub. I don't know how many of you have been on SAMHSA's newly launched website, but SAMHSA went through a process called Project Evolve, where we overhauled our entire website and everything that's on it. So everything has been updated with new pages, new links, a new look, and new search engines, which I hear is the most popular part of our new website so that when you actually type something into the search engine, now you can find what you're looking for.

MS. DARYL KADE: I had no idea.

MR. TOM CODERRE: Because before, there was such as collection of materials. So you know how these websites grow and you start going onto them and at the end of the day you can't find anything that you're looking for. So those functions was a particular pet peeve of the Administrator and I think those functions have been significantly improved, but the recovery hub is a great place to go to for all things recovery.

We also have some examples of online resources in the SAMHSA store. There are a couple of selected publications that I put on this slide, one regarding LGBT populations and dialogue on advancing opportunities for recovery from addiction and mental health problems from the dialogues. So this is a recap of a meeting that was held, but there's a lot of these publications online. We also have a lot of Web videos that you can access through SAMHSA's YouTube channel. There are two examples here: "The Power of Youth Development and Recovery Support, A Girl's Matter" webinar and "Recovery and Health Echoing through Community" webcast that features one of our regional administrators, Michael Duffy.

We also have other online resources through the ATTC networks. There's a couple that have been included here. The behavioral health webinars have been extremely popular and have focused a great deal on recovery and also products and resources like addiction recovery and intimate violence was an example that I found through our website. It's important to note that these are not just ideas that SAMHSA has. That these programs are focused on outcomes; they're evidence-based and focused on outcomes. So how do we do that? Well, we have our Block Grant, which you all know about, but we also have discretionary grant programs, which are on the next slide.

SAMHSA's Discretionary Grant Program Support Recovery Services in a whole host of ways, you all know about the Access to Recovery Program, which was talked about earlier. Support services to reach the homeless, statewide peer networks, peer-to-peer grants; we have that in our targeted capacity expansion. The ROSC Grants, the pregnant and postpartum women, RCSP that Andre and others mentioned, and we have, obviously, drug courts offender reentry programs and more. I'm glad I included that because Ken's here. He probably been all over for not.

We have just a few examples of some of the outcomes that have been achieved through Access to Recovery, which was a presidential initiative. Everyone knows this

provides vouchers for clients to use for their treatment and recovery support services. Since 2004, there's been more than 650,000 clients who have received services that previously were not reimbursable by insurance. In FY 2013, there were 261,000 vouchers that were redeemed for a total of \$68 million, so it's been a big, big program and extremely successful. This has also been a major entrée for faith-based organizations who receive 24 percent of the total dollar amount for ATR vouchers. And they previously really weren't eligible for any other types of funding.

These are some of the outcomes in 2013 of the clients that were measured. So again, this data that's included here isn't of the entire program, but this is the -- we picked some outcome data that we had through our program profile index in 2014, and you'll see the types of outcomes here: 27 percent increase in abstinence, 30 percent increase in housing, 54 percent increase in employment and education as a result of ATR.

We also talked about home as being one of the major tenets. We have our co-occurring and homeless activities branch, CABHI -- CHAB, I'm sorry, that promotes a public health approach to recovery and treatment systems of care for persons who are experiencing homelessness and for persons with co-occurring disorders since 2001. The CHAB Program has funded 252 homeless treatment service grants and helped more than 60,000 clients. In 2014, there's 98 active service grants and including grants for the benefits of the homeless individuals, which is CABHI, and cooperative agreements to benefit homeless individuals.

Looking at some of the data from CABHI, you'll see that clients were reporting, obviously, huge increases in stability in housing and also, you'll see the similar type of increase in employment and education, as you saw in the ATR grants.

DR. LORI SIMON: I heard you just say compared to one. Is that compared to where they were before?

MR. TOM CODERRE: Yes. So this is a six-month -- so they measure them at intake and then there's a six-month follow-up. Exactly. Next slide. Statewide peer networks for recovery and resiliency. This is to create an enhanced statewide networks that represent mental health and substance use disorder recovery communities, to improve access to and quality of the behavioral health systems and services, including treatment or recovery support services. These are statewide programs. This grant is on the street right now and it closes on June 23, 2015. And then Block Grant funding. We just included some of the NAMS data for Block Grants as well.

Many of you know this figure already, but this 1.7 million American who receive some type of service through the Substance Abuse Block Grant, which is a huge, huge number. And that includes recovery and overdose prevention, and rescue as well, which are two things that SAMHSA has given guidance to the states that these are allowable costs out of the Block Grant. So you'll see some of the numbers there, 31 percent abstinence from alcohol, 43 from drugs, and 61 percent of the people through NAMS, reported increased social support, which we know is critical for improving recovery.

And then just to talk a little bit about SAMHSA's BRSS TACS Program -- are many of you aware of the Bringing Recovery Support Services to Scale Program? So BRSS TACS is a technical assistance center strategy, whereas, before, SAMHSA was giving direct grants to community-based organizations and others. To do recovery support, we thought one strategy to bring this to scale so that so many more organizations would have the opportunity take advantage of these was to develop the Technical Assistance Center.

So this Technical Assistance Center really helps these community-based organizations with the wide scale adoption of recovery oriented support services and systems. It builds on the accomplishments of the existing mental health recovery movements and community stakeholders. So we've looked at what has worked in these other grant

programs and made sure that the Technical Assistance Center had the ability to share that so that more of these programs could be adopted around our country.

I wanted to just mention to folks, again, as feds, we can't tell you how to feel about any particular piece of legislation that's before Congress, but we wanted to make you aware that the Comprehensive Addiction and Recovery Act of 2015 has been reintroduced. There was a version of this last year by Senators Whitehouse and Portman. It's back before Congress this year and there's a companion House Bill this year, H.R.93. And there are many sections in the Bill that asks SAMHSA to provide grant support for these various activities: the National Youth Recovery Initiative, the National Task Force on Recovery and Collateral Consequences, and State Demonstration Grants for Comprehensive Opioid Abuse and Response. SAMHSA has a direct role in these bills, as in these programs as the Bill is currently written and could see, as this Bill moves through Congress, even more -- be included in even more sections of the Bill. So we're watching for that.

Many of you know about Recovery Month, and Daryl mentioned Recovery Month, but the Office of Consumer Affairs provided me with a couple of slides to get you involved in the Recovery Month activities. You know you can organize Recovery Month events just like Chris is doing in Santa Fe. Did you post it yet, Chris?

MS. CHRIS WENDEL: Not yet.

MR. TOM CODERRE: If that is going to be down here, I'm sure at some point, asking why not.

MS. CHRIS WENDEL: Mea culpa.

MR. TOM CODERRE: In 2014, there are over 1,000 Recovery Month events held across the country, and based on the numbers that people provided on our website, we

saw that they reached over 1.5 million individuals and they can take all forms and sizes. These are anything from the kind of events that Chris described to we have a walk here at SAMHSA that we do as part of Recovery Month. There are health fairs, picnics, dinners and you can visit www.recoverymonth.gov for ideas. And if you hosted an event in 2014, you can actually receive an award for these events, but the deadline is fast approaching, it's only in two days. So if you hosted an event in 2014 and you want to apply to receive this year's award, you have to get your application in, in the next two days and there's a link for where that happens.

Also, the Voices for Recovery on the Recovery Month website enable you to share your story. In 2014, we had 27 Voices for Recovery posted. In 2015, we went to blow that out of the water. So you can help us by getting your stories up on the website. People know that proclamations are an important way that we get Government leaders involved in Recovery Month and that helps with the awareness about how important Recovery Month is, from the President, to members of Congress, to governors, to state legislatures. These Recovery Month proclamations roll in every year. We had 80 of them last year and they're really helpful to get the word out about Recovery Month. And you can also, if you're so inclined and you're in the new social medial realm, you can blog, post, or tweet about Recovery Month. And we have a hashtag and a Twitter handle and you can see them there for Recovery Month and for SAMHSA.

And then finally, my very last -- second to the last slide is I wanted to let you know about this event that's going to be taking place on the National Mall as a follow-up to Recovery Month. So this is going to be on October 4 on the National Mall; it's called Unite to Face Addiction. It's not a SAMHSA event; it is being coordinated out in the community. I've been asked to asked to serve as a federal liaison to the event and been given permission to do that. So I'm bringing information from SAMHSA to the event to help inform it and bring information back to SAMHSA from the event to help inform us about our activities.

You can find out more information at facingaddiction.org about what their plans are, but obviously, they want addiction and recovery to be known as the public health crisis that it is, you know, as it impacts more than 85 million Americans. And so we want people to know that, and if we unite together to face it, that we can have a significant impact.

And finally, Daryl mentioned this, but the theme this year is visible, vocal, and valuable and that's what we consider you guys here at the CSAT NAC: visible, vocal, and valuable. So thanks for letting me present on recovery this morning and I hope you learned something from the slides. Thanks.

MS. DARYL KADE: Thank you very much. You get a round of applause.

MR. TOM CODERRE: Look at that.

MS. DARYL KADE: Excellent. I did want to open up the floor for any Council discussion, but I also wanted to check on the phone and just check on Mohammad Yunus and see whether or not he would also like to participate in the discussion.

MR. MOHAMMAD YUNUS: I'm here.

MS. DARYL KADE: I'm here. Any questions, comments, et cetera?

MS. OMISADÉ ALI: Thank you, Tom.

MR. TOM CODERRE: Thank you, Sadé.

MS. OMISADÉ ALI: I just had a couple of -- not questions, but observations.

MR. TOM CODERRE: Sure. Sure.

MS. OMISADÉ ALI: Language is hugely important to me and I'm all about changing language, and we have, in the 45 years I've been doing this, thank goodness. Could you please look at the language in BRSS TACS and use that across the board in SAMHSA publications?

I thought that it was extremely affirming. It took the stigma out of it, and if we really believe that this is a public health approach, the way we present our information and the way we talk about the work that we are doing, it will engage more people if people look at health and wellness instead of addiction. And the language used in BRSS TACS really resonated with me.

The other thing I wanted to say is it seems kind of paradoxical that you presented these wonderful statistics about ATR --

MR. TOM CODERRE: ATR.

MS. OMISADÉ ALI: I'm sorry. I have to say this, and they are really wonderful statistics, and it seems paradoxical that this is going away. The other thing I wanted to say is that --

MR. TOM CODERRE: Can I say something on that before I lose the thought?

MS. OMISADÉ ALI: Yes.

MR. TOM CODERRE: So on BRSS TACS, first, thank you for that comment and we'll go back and look through some of that and see if we can spread that across SAMHSA in the other programs that we're working on. And language is incredibly important for me too, and we're trying as hard as we can and it's not easy, as you know, because we're dealing with multiple stakeholders and populations and there's not really good science around what words are the best and how the language should be portrayed.

ONDCP just released a chart, you may have seen it, where they said instead of using this word, use this word. Instead of using "addiction" or "addict," use "A person with a substance use disorder," which is great, but one of the things that we struggle with at SAMHSA here is where's the science behind that? Has it been tested? Have these words been tested and do we know if one word is more effective than another word when we're using it? And so SAMHSA has something called the Science of Changing Social Norms, and this is a project we're doing with the national academies. And the national academies are helping us look at the science of how do you change the way people, you know, this is all about negative public attitudes around people who have mental health conditions or addiction. And how do you change that so that more people feel that they can come out and talk about it; that they can get help for it. And we know one of the largest reasons why people don't seek help is because they're afraid of what people will think of them. So we'll working on that, I promise.

MS. OMISADÉ ALI: Okay.

MR. TOM CODERRE: Second thing is on the ATR, it's a proposed -- the decision hasn't been made that it's going away yet. It's proposed in our budget and in the present budget. So I can't say anything more than that, but I just want to clarify that it's not necessarily going away yet. That decision hasn't been made yet. It's proposed to go away.

MS. OMISADÉ ALI: Because a lot of the interventions -- and you talked about the faith-based, the numbers of faith-based providers, who the 28 percent who never was involved in the treatment of folks, families and communities and individuals with substance use challenges are all of a sudden becoming part of the team, which they should've been all along. But in the case of indigenous people, we even found a way to pay for sweat lodge. You're not going to get that paid in a Block Grant. You're just not.

MR. TOM CODERRE: Right.

MS. OMISADÉ ALI: So the innovation that ATR has created in our field and the opportunities for people to actually choose, this is what I need for my path. It might be different than yours and it probably is, but it's still okay.

MR. TOM CODERRE: Right.

MS. OMISADÉ ALI: But it's still okay. It's not a question, it's just a --

MR. TOM CODERRE: Yeah. It's a great statement and I hope you let others know that.

MS. OMISADÉ ALI: Oh, I do.

MR. TOM CODERRE: And you had one more point before I cut you off. Okay. Good. Great.

MS. DARYL KADE: Chris.

MS. CHRIS WENDEL: Thanks, Daryl. Tom, I just want to say thank you for your presentation and welcome. Welcome to the playground, you know?

MR. TOM CODERRE: It's good to be here.

MS. CHRIS WENDEL: It's always good to have another person in long-term recovery at the table. I was doing some quick math. I think there's about 150 years sitting here, just at this table. So welcome. That's all.

MR. TOM CODERRE: Thank you. Thanks.

MR. PAUL MOLLOY: Yeah. I didn't mention I was in recovery. Make sure you add my 42 years.

MS. OMISADÉ ALI: And my 45.

MS. CHRIS WENDELL: I did the math.

MS. DARYL KADE: That was Paul Molloy with 40 -- how many?

MR. PAUL MOLLOY: Forty-two.

MS. DARYL KADE: Forty-two.

MR. TOM CODERRE: And it makes me feel like a baby. Thank you, Paul.

MS. CHRIS WENDEL: She's got 45.

MR. TOM CODERRE: I know. I'm the recovery baby, clearly, here.

MS. DARYL KADE: Well, thank you. You can see why the Administrator was strategic to place Tom with me as we went through this transition. It is an honor and a joy to be working with him and he obviously influences a lot of what CSAT is doing and SAMHSA is doing right now. So thank you, Tom.

MR. TOM CODERRE: Thank you. And I should've said this when I presented but I didn't, but Daryl sells herself short when she says she doesn't have the -- I mean, I know she indicated that the experience she does have, but she has brought a wealth of experience to SAMHSA; her 30 years in the Federal Government, her experience with grants and contracts, asking all the right questions and really, getting to work with Daryl and Kim, who is a professional in her right, from her SSA here in D.C., who has a

wealth of experience in this area, has been a great learning experience for me, an experience I would not have received had I remained up on the 8th floor. So I'm happy to be with you guys for however long they allow me to.

MS. DARYL KADE: It's nice being part of a team.

MR. TOM CODERRE: Okay. I'm reading these comments. Because of our full agenda today, we planned a working lunch. Had I known that the beginning session could've been cut short, we could've had a freer lunchtime. So I apologize for that, but since that was not the case, we do need to have a working lunch because we do need to discuss the three questions that the Administrator asked us to focus on and that will be discussed in the joint NAC session tomorrow.

So rather than a discussion with the entire group, we're going to divide into three groups, each taking one question and Kim, Tom and I will lead each of the groups. A representative from each group will then report out to the Council. So if you look inside your tent card, you'll see the question that you've been asked to discussed. So once you pick up your lunches at the side table, if you could --

MS. JEANNE MIRANDA: There is no side table.

MS. DARYL KADE: All right.

MS. JEANNE MIRANDA: Julie is hawking outside the --

MS. DARYL KADE: So there's a secret path to the lunches and Linda will show you that path.

UNIDENTIFIED SPEAKER: This is the path.

MS. CHRIS WENDEL: Daryl, I'd like to say something before we break, if I may.

MS. DARYL KADE: Yes. If we could just settle just for a minute, please.

MS. CHRIS WENDEL: This is Chris. Did we discuss this in February that we were going to break? And here's the reason I ask the question, because I did take this -- thank you -- I did take this extensively to different organizations within the State of New Mexico. I got a bunch of responses and I asked them all three questions. So I am now placed to the situation and I have not looked at that card. I am placed to the situation where I'm only basically going to get to say a third of what I heard. Point taken?

MS. DARYL KADE: So Chris, I don't see why we have to be so limited. I suspect that you should walk around all three groups.

MS. CHRIS WENDEL: Deal. Sold.

MR. ARTHUR SCHUT: Yeah. I think other people may have addressed all three questions as well. So I don't think that, personally, I would want to be confined to a particular question.

MS. DARYL KADE: Okay. So I think that maybe we should reconsider. Why don't you follow the secret path or follow the boxes and we'll get back to you in five, ten minutes on maybe a different approach.

MS. CHRIS WENDEL: Great.

MR. ARTHUR SCHUT: Is it possible to donate a half-an-hour for each topic, since there's an hour-and-a-half?

MS. DARYL WADE: That's what -- we'll get back to you.

MR. TOM CODERRE: That's fine.

(Whereupon, from 12:30 p.m. to 2:00 p.m., a working luncheon commenced.)

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Agenda Item: Joint Session with SAMHSA Advisory Committee for Women's Services (ACWS): CSAT's Pregnant and Postpartum Women (PPW) Grant Program - Future Direction

MS. SHARON AMATETTI: Welcome to CSAT NAC, to the Advisory Committee for Women's Services NAC, and it's nice to do this together. I'm Sharon Amatetti from CSAT, and I wanted to introduce Andrea Kopstein, who's the Director of the Division of Systems Improvement in CSAT, who is going to be walking us through our program on pregnant and postpartum women, our grant program.

The Women's Advisory Committee got some background material about this presentation in advance. What we really want to do is to tell you about the program but also tell you about some of our ideas for moving forward, and more importantly, get your ideas for moving forward. So with that, Andrea, I turn it over to you.

DR. ANDREA KOPSTEIN: Okay. Good afternoon. Hopefully, I did make a lot of copies of this presentation, so hopefully, if you wanted it, you got a copy of it. There will be a brief overview of the PPW Program, which is basically the PPW Program is authorized, under Section 508 of the Public Health Service Act, and that is one of things that I think the Women's Council did get in advance. It basically states what the requirements are and absolutely, you know, it's always been providing residential

treatment care for these women, ensuring that their minor children, those 17 and under, can be with them in these facilities if they want them. Also to provide services for those extended family members who are not in the residential care with them, and a lot of other requirements.

Since 2014, with ACA and everything, some of the requirements for this initiative also includes screening for things like depression. The RFA was also included for the Women's Council in your package when you got it. And basically, it has a lot of requirements, this initiative. First of all, you're offering comprehensive, coordinated and integrated gender-specific, trauma-informed services, individual and family service plans, screening and assessments. Recently, we've also added SBIRT practices, Screening Brief Intervention Referral to Treatment (SBIRT) for alcohol use disorders, screening for fatal alcohol spectrum disorder, and use of -- we're also interested in allowing the use of medication-assisted treatment for women in this being treated.

Let me look for a second when we talk about this. So basically, a lot of what we want for these women and their children are the pretty basic things. We want to improve their physical and mental health. We want them to have healthy pregnancies and have good birth outcomes. We also want improvements in the mental and physical health of their minor children. The PPW Program also wants to improve their parenting skills, the family functioning. Basically, PPW wants reunification of families and to maintain those families that are still united. And, of course, so many of the outcomes that we want in this initiative are the same ones we want in many of our grant initiatives, which is decreased involvement in crime and violence and neglect.

PPW has been in existence since 1993. And I just want to introduce over here, Linda White-Young, who works -- she's worked with PPW since its inception in 1993, and she has been the lead on this initiative for all these years and seeing it evolve. And basically, has done a lot. So that basically, from 2003 to 2014, we founded 101 three-year PPW grants. These grants are generally about a half-a-million dollars a year,

depending on what they requested in their budgets. And in 2015, we'll be funding six new PPW programs. And you can see from the map, basically, the states where these PPW grants have been have sort of clustered. There are quite a few in California, quite a few in Florida, a lot of them up in the northeast, but in the center of the country, there isn't much. And that's one of the things we're thinking about and that's why this is called Future Directions.

We basically, this has been an initiative that doesn't fund a lot of grants every year. We generally fund somewhere between like, six grants and maybe up to 16 or 19 in the bigger years when we've gotten more funding, but that's a very small amount that we are funding. We want a greater uptake at like a state level or like a territory level because this is a very successful initiative. Although it's evolved over time, it has terrific outcomes, always. What we're doing in this program has helped many, many women over these years.

Although we are doing more now to look at more recent cohorts, I have information that we have done for a previous presentation that actually Dr. Clark had done, where they actually looked at some of the previous cohorts to see who was still providing some of these women's residential services. And basically, our 2003 cohort had six programs and five of those six are still providing many of the services that were funded by PPW, subsequent to having that grant.

For the 2006 cohort, where we had eight PPW grants, all eight are doing that. We will be reviewing more recent cohorts. We actually have a new contract this year, an analysis contract which will allow us to look into what these grants are doing, these previous PPW grantees and seeing what they're doing and how they -- we're very interested in how they're financing what they're doing. Residential care, which PPW has required, is a very expensive treatment, but also, we know that many of the things that are important in PPW programs can also be provided through outpatient and other recovery support services.

So here's just some statistics on the PPW women that we serve. So we served \$7,500 women since 1993. Over 40 percent were pregnant, but actually, almost 60 percent were postpartum. The biggest age group of these women is obviously the childbearing years, 26 to 44. Very few are older than 45. Basically, half are white, but there are very large proportions that are -- 20 percent were African American and 10 percent American Indian and Alaska Native, and about 3 percent other. The most frequently used substances were alcohol, marijuana, cocaine, methamphetamine, and heroin, which I think is increasing everywhere, at this point in time.

Treatment duration, the interesting thing about this is PPW has had tremendous success with this. About half of these women were in treatment 121 days or longer, which can only be a better thing for them. The next few slides are going to be talking about some our ideas for future directions, but as Sharon said, we also want to hear from you about what we're talking about, in terms of expanding this program. We call it a family-centered model that we use in PPW. And basically, we want to expand it to states and we want to expand it using evidence-based practices and also finding out how can we leverage the financing that's out there to provide the services that make a difference for this group.

So these are some of our questions. So basically, we're going to use this analysis contract I mentioned previously to do a state-by-state environmental scan, in terms of trying to figure out what kind of family-centered programs are out there already. How are they being financed? What sources of funds are being used by state territories and tribes? How do they use the Block Grant? What other funds do they leverage for this?

Basically, we also want to know what are some of the needs that the states and territories would say are needed by this population. What kind of disparities are out there that should be addressed? We also want to look at the current cost in the various locations.

Here in SAMHSA, we've developed for PPW in particular, a two-year work plan heading towards 2017. And basically, that work plan has three phases. So it basically has a lot of steps that we're trying to take between now and then that will help guide and develop that new RFA that we put out for the 2017 cohort. So Phase I of the work plan, that's where we're looking at the existing PPW grant programs. We're using the analysis contract, looking back to see what is out there, how is it being funded, how is it working, what are the varieties of family-centered models that are out there. We will also be doing a financial analysis on a sample of states. Clearly, we're not going to do every states, and states are different, but we're going to try to come up with some kind of scientifically meaningful way of sampling these states and looking at seeing what they're doing and we're also going to try to get input from those states we contact to find out what they think a family-centered approach should be.

Phase II, one of the things we're doing -- you know, also in the Division of Services Improvement, we have an initiative that many of you probably are familiar with, the Addiction Technology and Transfer Centers. And what we've done, there's an RFA right now out there to establish a Center of Excellence for pregnant and postpartum women. And the responses to that are due, I think, it was May 11th. But basically, only the ATTCs are eligible applicants for this. And what they'll be doing is -- one of the things for sure they'll be doing in the first year, they're going to look and see what's out there already. What are the evidence-based practices? What is available? And they are going to actually create a clearing house for these PPW-related materials that hopefully will be able, you know, it's going to be available online and hopefully, they're going to also do some training face-to-face, like they always do. They do a lot online, but not everything's online.

They will also be creating toolkits for these evidence-based practices that can be disseminated so that they can be larger, much larger, you know, part of the U.S. population. Phase II also includes convening of a policy academy, which we'll develop

a blueprint for adopting a PPW family-centered approach at the state, territory, or tribal level.

Activities in Phase III of the work plan is to develop new or strength in existing collaborative partnerships of federal agencies to assist in the implementation of family-centered approaches at the macro level. But basically, that's where we're heading. And hopefully, when we get finished with this, I know Kana will be coming in very soon. But we definitely want some input on what we're thinking about this and how we might best go about it. Have we not included something that we should be including? So please, you know, listen to the questions and help us with this because like I said, this is terrific program and we want to share it with more women and their families. Thank you.

MS. SHARON AMATETTI: Thanks very much, Andrea. And until Kana gets back, I'll help with the discussion question. So if you could put the first text slide up. But first, I wanted to ask this audience, how many of you are familiar with the PPW Program?

(Participants raise their hands)

Okay. So a few of you, essentially. And how many people have had a PPW grant program that they have been connected with in some way?

(Participants raise their hands.)

So two. Okay. So maybe you could also help us with this discussion somewhat, more robustly as well. So Andrea gave you a quick run-through, for those of you who aren't so familiar with the program about what the expectations are. You know, I'm not sure we actually said, but it's a residential treatment program. It's a comprehensive residential, long-term treatment program for women and their children, where children can come into residence with the women. And I'm not sure if we actually included that

in the slides, it might've gotten left out. So it's very intensive and expensive, expensive program. And it serves the women that are participating in it very well, we think. We've had very, very good outcomes from most of the programs that have been funded.

So for the Advisory Committee for Women Services, we've been talking about how do you reach more people with what you -- how do you spread what you're trying to do so that more people can benefit from it and from what we've learned. And now, here we are, 22 years into this and we're asking, you know, are there things that we could change that would enable us to really transfer this knowledge more broadly? Are there things that we could change so that states would be in a better position to pick up the programs after they've been supported by us so that they have a longer reach? What are the things that we need to learn from the states about their needs? Financing is changing. Do we need to change this program to respond to financing changes? These are the types of questions that we are really struggling with and we want to use our dollars most wisely.

You know, Pam talked about our dollars are really just a drop in the bucket, but we have other roles, in terms of transferring knowledge. Andrea talked about the Center for Excellence. How can we use that to transfer knowledge so that more states, communities, programs can benefit, and ultimately women and families can benefit. So that's really where we are in our center; we're trying to get our head around that. And because you all have roles different than ours, you know, here we are in the federal agency, we want to hear from you about what your experiences are, if there things that you can recommend to us to look at. We're going to be talking to other audiences as well with the same similar types of questions. Help us. Help us figure this out so that the next iteration of this program is where it should be going, the direction we should be going in.

So the Advisory Committee for Women's Services got these questions in advance and I hope that you've had a chance to look at the RFA, to look at the authorizing legislation

because there are very clear things that we need to do. This is not just what we want to do, only, but there are things that we need to do and that relates to what's authorized. And then what can we do and how can we build on it. So I'm going to open it up. I don't know if any of the two of you who have had PPW programs wanted to start by saying something about your experience with the program, reflections, what would've made it easier, better, keep it exactly the way it is, anything to that effect. I'd invite those you, perhaps, to start.

THE REPORTER: Could everyone say their name, please, so I can have it for the transcript?

MS. SHARON AMATETTI: So could everyone state your name before you speak? Do we need them to go up to the mic?

THE REPORTER: That would be ideal. And if they could spell their name.

MS. SHARON AMATETTI: And Dan, do we have any -- or Josh, do we have any portable mics at all in this room? No, we don't. So, I'm sorry, but if you could go up to a --

DR. ANDREA KOPSTEIN: Well, there's an empty seat next to a microphone.

MS. SHARON AMATETTI: Oh, there's right there. Doug has got one. Okay. Thank you, Doug.

MR. ARTHUR SCHUT: Hi. I'm Arthur Schut from Denver. And really, Karen Mooney can tell you everything about what we do.

MS. SHARON AMATETTI: Please speak real loudly.

MR. ARTHUR SCHUT: Yeah. I think since 1996 --

MS. KAREN MOONEY: '93.

MR. ARTHUR SCHUT: '93. It predated me. We had a PPW grant. We had an additional one that ended, I believe, in 2014, and we currently have another one right now. And I think that it has sustained itself. That we have sustained it as an organization. We have space for 16 families, so 16 women and their children. We have a Qualistar Childcare Center in our facility that we operate. So we operate a school for the kids. And I think my current concern is what happens to our ability to sustain it, as more and more payments are perceived to be provided by Medicaid because it is a residential treatment program that fits the IMD exclusion and so therefore, Medicaid cannot pay for it.

And currently, we receive funding from TANF and county funds and in some instances, actually commercial payment, although that's somewhat limited because of our length of stay. And we have lots of private donations; we actually have an organization that has a foundation as well as the service delivery portion and the foundation raises money. It's a lot easier to raise money for women and children than it is for men, frankly, and particularly children in particular. So that helpful, but my long-term sustainability issue is if counties currently pay for it out of county dollars because Medicaid was not paying for that kind of thing, as the perception is that Medicaid pays for more, and more, and more. I think our concern is that we will lose the county general funds support because they're anxious to offload their obligation into Medicaid. I'd be glad to answer questions if anybody has them and Karen can add to my comments.

MS. CAROLE WARSHAW: Can anybody change the Medicaid ability to fund this kind of a thing?

MR. ARTHUR SCHUT: Changing the Medicaid would actually take an act of God. I would say it requires a congress united in their focus and function.

MS. CAROLE WARSHAW: Okay. It's not at the rule level, I'd say.

MR. ARTHUR SCHUT: It's at the rule -- when Medicaid was passed, there was a concern that states would use Medicaid dollars to fund their state hospitals, and so they stuck this provision in the law itself and changing it actually involves opening the law and redoing. And I think no one has the will nor stomach for doing that and has concerns about what happens there, to be candid. And for decades, we have tried to find multiple ways to get around this and that effort is not ending. And maybe someday we'll have a way to get around it, but right now it doesn't exist.

MS. SHARON AMATETTI: So I have a follow-up question for you then. So in light of this question, do outcomes matter?

Does it matter if you're able to demonstrate that you have certain types of outcomes or is that really a moot point because Medicaid is not going to pay for it?

MR. ARTHUR SCHUT: I think outcomes matter in general and are particular in the context of the ACA. You know, you have health outcomes that are tied to a variety of pieces of the healthcare system. So the fact that we enhance health outcomes, I think is to our advantage and we clearly do it not only for the moms but also for the children. So there's a huge difference and we connect folks to primary care that didn't have primary care connections before. We do a variety of things like that. So the outcomes, I think matter. Clearly, the people who receive the services think matter and there is a variety of other entities that think it matters. It probably matters to Medicaid, but Medicaid is on the spot where they really can't change it.

MS. KAREN MOONEY: It's almost as if they -- this is Karen Mooney. It's almost as if the PPW Program serves up the ball in a game of tennis. It serves it across the net and if the state is going to smack it and hit it back, we have to figure out how we're going to get funding from the state general fund, other funding sources, to maintain and continue the game of tennis. Unfortunately, it's been kind of an ace a lot of times and we haven't been able to hit it back because either we haven't had the political will to sustain a program like that. It's not glamorous and sexy in the eyes of the public, it's much fun to focus on scary things like the methamphetamine and that kind of stuff.

When you've got a good, solid program that has 16 beds, it doesn't benefit a huge number of people that, you know, just in terms of numbers, so it's been very difficult to get the backing from the legislature to actually even write a decision item to request the kind of funding that it takes to sustain a program that's not cheap, over time. So I think we will eventually be in the position of being able to hit the ball back because we're getting enough data, over time, from this program, but it really takes a lot longer than the term of a politician to see the kinds of outcomes that we get to make this actually work.

MS. CAROLE WARSHAW: Are you getting long-term outcome data for kids that could, over time, make a difference, in terms of trajectories?

MS. KAREN MOONEY: Their problem?

MS. CAROLE WARSHAW: Yeah. And the other question was would the ACA start to pay for some of these programs?

MS. KAREN MOONEY: Perhaps. Perhaps not. It all depends on individual -- like if we were talking about private insurance, then it depends on what the private insurance will pay for, which as Art has said, you know, it's typically not the life of the program for somebody for an entire episode of care. We also don't have enough children that are

served to be able to look like a robust children's program, although, now since, you know, 1993, a number of kids have gone through that program. Our state data system is also not such that information on families is collected.

So we have admission and discharge data on individual people who receive treatment as the identified patients, but there is no electronic record that goes along with the services that are delivered to the children. So they're essentially invisible to us at the state, trying to make a case for the funding for this program. So that's part of the reason that I get all excited about data and finance stuff because you can have the most glamorous program in the world with the coolest programming, but if it's not captured in the data and you don't have a way to bill for it and track the services that way, then you're stuck. And I think we're getting there, but we're not there yet.

MR. DAN LUSTIG: Thank you. I'm an old PPW grantee, and I just want to briefly mention that as a program, it is truly the most comprehensive approach to addictions and mental health treatment for women. I think outcomes is really, really critical because that's what's going to help shape the argument on policy. I do think, though, when reviewing the outcomes, it's not just taking a look at family-based outcomes, but also tying it to children, how the recovery of women has improved the lives of children. And I think that's a huge argument to make and an important argument to make.

I think the cost of the program is something that has to be looked at over time with the data, by quantifying what parts and pieces of this program is the cost behind it because that appears to be the number one question that funders have, politicians have, is cost. I took all these notes, I'm sorry. I think it's also trying to ask the question about why is it that residential treatment is so important for not just women, but women and children. And it's hard to get your arms around that because a lot of the data in the PPW Program is geared towards the women and women's outcomes and it's linked to the children, but I think it's important to look at that.

I think another discussion around the PPW model, as an evidence-based model, would go a long way. I think right now it is not on NREPP, but there are miscommunications around other family-based models. Like, if you look on NREPP, HRSA has a model for family-based treatment and I think it's going to be important to be able to package this. Over the last 22 years or 20 years, there's been lessons learned and there's a real core group of principles that make up the PPW Program and I think that really needs to be packaged and educated around.

DR. ANDREA KOPSTEIN: Well, hopefully, the Center of Excellence is going to do some of that, you know, to help head in that direction because you end up also including promising -- you know, not everything is EBP. Some of the things that are in NREPP are promising practices and those might be important, but I think one of the things, you know, I'm looking at this Question 1, thinking, and you started to address it, but I think one of the things that would be interesting for us is we are going to look back and say, you know, the ones that have sustained it that don't have existing PPW grants, what have they sustained and why. What have they valued enough to keep it going? And basically, I think, you know, we're thinking we also need to identify what are some of the critical components? If you can't have the Cadillac --

MR. DAN LUSTIG: Exactly.

DR. ANDREA KOPSTEIN: -- what can you have that would make a difference?

MR. DAN LUSTIG: And my last comment is honestly, I have never in my 25 years of working this field, have ever worked with someone who is more passionate around this than Linda White-Young.

DR. ANDREA KOPSTEIN: Yes.

MR. DAN LUSTIG: I mean, I just have to say that.

DR. ANDREA KOPSTEIN: Absolutely. That is -- that has actually made a huge difference for SAMHSA and for this initiative.

MS. SHARON AMATETTI: She has a question. If you could state your name first, please?

MS. INDIRA PAHARIA: Sure. Indira Pahlaria with CSAT. I just want to make a comment about an outcome you could measure that would become also a financial justification. And you have to do it at a population level, but it would really be the avoidance of NICU cost. And those are the huge dollar costs for babies who are born to others who are addicted because babies go right into the NICU. And this is a huge medical cost and oftentimes it's a million dollars a child. But you would have to look at a population, pre, post control. You know, it's a little complicated because I know you're talking about small sample sizes here, but I think what you're doing in this program has amazing potential, but you just have to look at the medical side where you could really have huge dollars.

DR. ANDREA KOPSTEIN: That does make sense. I know sometimes we've -- you know, we work sometimes in conjunction with NIDA or other NIH institutes, and sometimes, you know, they will also work on things. It's not a quick answer, but you're right, I mean, there could be, like you say, the negative side. Like, you're avoiding not just the positive things, but what are you trying to avoid?

MS. CAROLE WARSHAW: Like, the class of child welfare, incarceration, you know, the people being in the system. If you have an economist who could do that kind of analysis, then you might be able to show the potential impact in many ways.

MS. JEANNETTE PAI-ESPINOSA: The other data point -- and my agencies work primarily with girls in the child welfare system, juvenile justice, homeless and runaway,

substance use disorders who are young moms. Many who aren't, but many who are, and we run residential programs and I would love to have this kind of -- we don't have anything like this in terms of guidance or legislation.

One of my thoughts is, I don't know if you are already or if you can collect data on sort of generational, you know, are you breaking generational cycles for families? So was the two generations before, same situation as the mom that's in the PPW Program, you know, where are her kids going to be? Since the program is so old, I'd imagine you might be able to, I don't know, collect some of that, but that's something that we've been asked, where it shows the money, right. Not really show us the money, but show us what's the measureable impact and it's really difficult, especially with the small numbers, but I think that's one place where, if you have any level of data about how these are breaking generational cycles, I think that would be pretty significant.

The other thing that strikes me is the same conversations is going on in child welfare and juvenile justice about residential placements and residential treatment. And so in our -- I don't know if it's possible, I don't know what the barriers are in terms of rules and legislation, but it would be interesting to see whether there's a way to do a pilot or something where PPW has a cite that's working in cooperation with child welfare on a state level so that you have blending funding to support young moms and their kids who are in care.

Right now, you know, young moms and their children staying together is obviously preferred, but doesn't always happen, so that's a possibility. And juvenile justice, too, in terms of young -- young moms in both those systems are really invisible and don't have any support, or if there's a way that you could get them as they're older. So maybe they're 17 and then they come out when they're 18 and they can move into a longer-term program. So I mean, that's really where we see the highest instances of their kids ending up in the system and addiction and poverty and the whole thing, so that, for what it's worth.

And then lastly, there are a lot of philanthropists and now the Federal Government is getting involved in this conversation about two generation approaches to ending poverty, but it also includes health. It also includes all the things that are in PPW. It's a two generation. You can say it's a whole family, but they might even be interested in supporting, filling the data gaps, particularly, you know, whatever you find after the team comes in to do the things that you said on slides, I can't remember specifically. There's just a lot of momentum around it and it really is how do you equally support two or more generations to end these ongoing cycles of poor health, poverty and violence.

MS. SHARON AMATETTI: Andrea, could you put the next slide up?

DR. ANDREA KOPSTEIN: Sure.

MS. SHARON AMATETTI: Thank you, Jeannette. Those were really good insights. So one of the questions that we're asking ourselves is without a PPW grant, how are states, communities providing these services or what could they do to implement them? Your thoughts there?

So over 23 years -- or not 23 years, but we didn't go back quite that far, but since 2003, we've had 101 grant programs. And if you remember that slide, about a third of them are in California and Florida, and maybe a New England state. So all of the rest of the communities and states, what can they do? What have they done? We know there is residential care for women and children without our funds, but we don't know that much about them.

MS. KAREN MOONEY: Well, for us, there really just isn't. The funds that we have available through the Block Grant, for the women set aside have funded -- funds have funded two of the residential programs for women and children. And then there's one

that's funded primarily with a county contract and another one that's funded primarily with a criminal justice contract and that's it.

MS. SHARON AMATETTI: Okay.

MS. KAREN MOONEY: So we have a total of five.

MS. SHARON AMATETTI: Great. And if you could state your name too.

MR. ANDRE JOHNSON: Sure. My name is Andre Johnson. I can speak from being a provider rather than Detroit. We really don't have any residential drugs programs. I know there was once funding through CSAT; one agency was funded many years ago, and currently, what happens in our area is our state has a specified money for women specifically, and those dollars are targeting those who do not have health insurance. And so in most cases, the women are insured through the Affordable Care Act. And so when I talk to my colleagues, a lot of them want to stay away from women and children programs because of the liability costs that are associated. And it's just a huge cost to really provide a strong program that's going to hurt this program in the future. I think the services that they get, the services need to be strongly considered. And historically, the funding stream just hasn't been able to really sustain the services.

MS. SHARON AMATETTI: Thank you.

MR. ARTHUR SCHUT: There are a couple of things that I think -- so if I think about our organization opening another one, we have sustainable, at this point, sustainable funding for service delivery and continuing it. I think one of the biggest issues under financial challenges is actually capital. I mean, the capital to create the beginning that the space and all those kinds of things. And frankly, what Medicaid provides, if Medicaid would ever fund it, what they provide in reimbursement is not enough to create

the capital to set up the space and hire people to begin with, and do those kinds of things.

Venture capital now has entered into substance use disorder treatment services, but clearly, venture capital is in there because they believe that they're going to make a lot of money on a certain population that has to do with reducing several hospital costs and those kinds of things. I'm not aware of anything that's capitalized, in terms of this kind of program with venture capital. And then work force is a huge issue, there's just not qualified work force. Specifically, where we are right now, there was a recent funding of mental health crisis centers, behavioral health crisis centers, and they hired 800 new clinicians -- well, they're trying to, this one year alone. And if you look at that and you look in the marketplace, it's very difficult to hire qualified people who are dually credentialed in both substance use disorder and mental health services.

DR. ANDREA KOPSTEIN: Yeah, I know. Like I said, the Center of Excellence, that is work force training, but also I know we have another initiative in my division that is new this year, they call it the Minority Fellowship Program, which is providing stipends. But you know what the issue was, is how many universities actually have advanced training in this field? It was kind of not exactly good news to find out about. It's not really as available as you'd like to think it is. So that's part of it. Do you want to go to the next question or do you want to stay on this one?

MS. SHARON AMATETTI: Yeah. Well, just one more comment from Anita.

MS. ANITA FINEDAY: Just one comment. This is Anita Fineday. So everybody knows that Section 4(e) of the Social Security Act is what funds child welfare in the country. And what you may not know is that more than 30 states have waivers of 4(e) and that there is a move afoot to have permanent federal finance reform of 4(e), and a lot of people that I know think it can really happen in this current legislative climate that we have. They do think that permanent federal finance reform is going to happen. And the

big push is for 4(e) to fund prevention. And so it seems like this would really fall in the prevention of placing children in foster care. So it could, conceivably, if the numbers stayed the same, you know, qualify for 50 percent funding under 4(e). Don't know what that permanent federal finance reform is going to look like, but the waivers are the laboratories for showing the kinds of things that are successful. So that should be on your radar.

MS. SHARON AMATETTI: And a couple of people have mentioned important collaborators and has opportunities for financing and that's helpful to us and we need to think about that broadly. Exactly. We haven't really spoken about whether it makes sense for us to look at a mixed model of residential and then outpatient programming, somehow connected. Did you want to speak to that?

MR. ARTHUR SCHUT: Yeah, I didn't mention that. We connect people to outpatient and provide outpatient services subsequent to the residential portion.

MS. SHARON AMATETTI: Has it impacted the length of stay that was planned for residential care in any way?

MR. ARTHUR SCHUT: Well, our length of stay shortened a little bit. I mean, one of the realities, which I'm sure you all know, is we all ration care because there's just more people than there are resources. So one of the ways you ration care is you shorten the length of stay and then you can serve more people because you've shortened the length of stay. If you do everything ideally, there are just huge numbers of people who get no services at all. Is that the way I'd like to do business? No, but I've done this for decades and it's pretty much the same now than it has been. So rationing is part of our normal existence and it's what we do and there's no public policy about rationing, it's clearly pushed down to the level of providers. But we do outpatient, we continue to do outpatient and we've done a number of things around connection to primary care, using navigators. We actually had some assistance in our last PPW grant.

MS. SHARON AMATETTI: And have you looked at any differences in outcomes as a result?

MR. ARTHUR SCHUT: Not that I'm aware of. We did when we had the grant because it paid for research base, and we have a research department in our organization that does, you know, evaluations of SAMHSA grants and it's part of the clinical trials network for NIDA. Those kinds of things. But good research is expensive. Doing it right.

MS. SHARON AMATETTI: Did anyone else want to comment before we go to the third question?

(No response.)

So this question basically says understanding that we have legislative requirements, if there were no requirements, will you recommend any changes, alternatives to the model as it presently is outlined?

MS. KAREN MOONEY: I think I would look at a more robust connection to primary health as having being a requirement of the program so that women are really set up to be able to care for their own health and for the health of their children and they're fluent with being consumers of healthcare services.

MS. SHARON AMATETTI: Linda, I know that's been a passion of yours. Do you want to comment on that at all?

MS. LINDA WHITE-YOUNG: No. She said it all.

MS. SHARON AMATETTI: Okay.

MR. DAN LUSTIG: Well, one thing I want to kind of piggyback on what Karen was saying is that I don't think the model does a good job at understanding the addiction as a chronic relapsing condition.

MS. SHARON AMATETTI: Okay.

MR. DAN LUSTIG: Because once the client moves from this into the community, as the gentleman over there said, you know, having treatment extenders, recovery coaches, those people working in the community is something that I think would be really, really an important piece to add to the model.

MS. SHARON AMATETTI: Okay. That's good.

MR. DAN LUSTIG: And you can look at this as recovery check-ups. So just like people are required -- or not required, but should have a physical done once a year, it's this constant kind of recovery check-up once they're in the community that really prolongs recovery.

MS. SHARON AMATETTI: Good point.

MR. DAN LUSTIG: And we have strong evidence to show that. We have outcome data for that.

MS. SHARON AMATETTI: You do. Okay.

MR. DAN LUSTIG: Seventeen years of outcome data on that topic.

MR. ARTHUR SCHUT: If I might comment just about that model, and I don't know if this is true in every state, but most states have a system that's actually somewhat related to the TEDS that you all collect. That when people aren't in for a certain period

of time they get discharged and they get readmitted and then they get discharged. And so having a primary care kind of model where you check in with people is really onerous, in terms of the data collection and all the kinds of things that you have to do with people that makes it very difficult, clinically, to operate like the rest of the health system. And as does some of the prescriptive pieces of state licensure in most states for the amount of information, psychosocial history information and all sorts of things that you gather for which they are, frankly, as far as I'm aware of, is little evidence that it is useful or helpful.

And one of the challenges is being efficient in a system where everybody else has their own problems, in terms of the rest of the healthcare system, but frankly, they don't have the kinds of problems that we do in terms of how much our professional activity is prescribed, externally. And I think it largely dates to when most of the work force was paraprofessional and we had generated enough information that it could be reviewed by a professional and we could become much more professionalized and the challenges were saddled with a huge amount of bureaucracy and administrative tasks that make it very difficult to do this kind of check-in that you would do in a primary care practice because you have to reinstitute admission if it's been a certain number of days, et cetera.

So I know it sounds odd for me to ask for regulation relief, but regulation relief and data relief, I mean, there are a lot of things that would be nice to know. It would be nice to have a conversation about what the essential database should be and then how we get high quality data that you have for each of them, on a few measures, as opposed to -- I believe, Colorado now has 90 questions, depending on which tree you go down, in terms of collecting information.

MR. DAN LUSTIG: I agree that there is a lot of mechanics in doing recovery check-up, but NIDA has done a really good research project with recovery management check-ups, and has a model that's already been built and that comes out of Chestnut Health

Systems. But it will take a different look at how to do systems. It's not -- I mean, I think this is what is critical right now is that we are in a time of change and I think this model certainly does not have to be reinvented, since it's already done. I do think it can be tweaked. And NIDA has done a lot of publishing on recovery management check-ups, so there is a clear model to use with that and we've used that model in my agency for a little over 13 years. So it takes a different kind of approach to it.

MS. SHARON AMATETTI: Very good. Okay. Kana, you've joined us. We're happy to have you here. We're coming towards the end of this session and I just want to give you an opportunity to comment.

MS. KANA ENOMOTO: Yes. I apologize for being late, I had gone over to meet with our SAMHSA Tribal Advisory Committee, and so as one does with tribal years, you stay until the session is over. And so that was a very robust and interesting conversation about historical trauma and what SAMHSA could be doing better to address the needs of tribes and it went a little bit over time, so I apologize.

This was a topic that I wanted on the agenda, so it was a little bit of an unfortunate pairing of agenda items because this is an important issue for SAMHSA. It is a big program, but the PPW Program is a storied and important part of our portfolio, but as we were talking with the ACWS earlier today, the opportunity to influence what is funded out of the women set-aside, I think is an important one with the Block Grant. And to understand what pieces of PPW can or should be transported elsewhere and where are their opportunities for more of a multiplier effect so that we can ensure that every woman who is struggling with substance use disorder can have a safe and healthy pregnancy and have a healthy baby, healthy birth outcomes. That is our goal to save lives across the country, not just for the people who are in the PPW Program.

Obviously, we want that, but we also want to -- SAMHSA has an obligation and a role to improve birth outcomes for all women who are struggling with substance use disorder and are pregnant and that's where the genesis for this conversation came from and

some work in the Senate for substance use treatment to do sort of a two-year look forward, in terms of what are the pieces that we need to do.

Dan raised earlier that PPW is not on NREPP, so what are the steps that need to happen? Should it be on NREPP and how do you do that and what are the steps to go through? And that ball is in our court, and so on. And you know, I think there's a lot that can be done and that we're going to do as we have supported this really great model for so many years. So I will definitely catch up with Sharon and with the rest of the members and the leaders that are here to get the nuggets of wisdom that you guys have provided to us. So I'm sorry. But thank you.

DR. ANDREA KOPSTEIN: Okay.

MS. SHARON AMATETTI: Andrea, thank you. Thank you, everybody for your good, thoughtful comments. Appreciate it.

(Brief recess.)

Agenda Item: SAMHSA Administrator's Discussion with Council Members

MS. PAM HYDE: So also let me just start by saying that -- giving a big thanks to Daryl for being Acting CSAT Director for a while. Yeah, she is a terrific federal employee, who really knows the Federal Government. And while she may not have known substance abuse treatment, there's lots of great people in CSAT who knows substance abuse treatment. What she knew how to do is keep the ships running and I really appreciate that for her. We pulled her out of an area of her comfort zone and threw her in an area of non-comfort zone, and I think she's become a major advocate for CSAT, so I really appreciate her doing that.

What I have learned in the Federal Government is that everything takes a long time and you wonder why. So we are in the process. The process is unfolding and we will try to keep you apprised, but we are ways away yet from having a permanent CSAT director. So again, I appreciate Daryl's willingness to continue to hold things together. And also, thanks to Kim for being a great deputy. She was what, three months on the job when this happened?

DR. KIMBERLY JEFFRIES-LEONARD: Two.

MS. PAM HYDE: Two months. She jumped right in. And then Tom, who was here all of two or three months, when he was supposed to be kind of advising the Administrator's Office and we said nope, he's got to go help Daryl. He's been running around everywhere, so Tom is playing two or three roles at the moment. Our alleged director is also out for surgery for a few weeks, so he's doing that job and this job and advising me and taking on marijuana and 50 hundred other things that he's doing. So if you want to know anything about marijuana, ask Tom. I just set you up, didn't I?

Yeah. So, anyway, I don't want to do a lot of talking. I want to just say that there's a lot going on, and as you know, we decided this time to focus on treatment. And I know that there has been maybe some concern that we haven't focused as much on treatment and I'll probably say a little bit more about this. Kana and I will both say a little bit more about it tomorrow when we meet. But I think you all know, but just in context, I was asked in a couple of other Advisory Committees to put some context to this meeting, the way we did this because we've had some criticism, but part of the criticism is a lack of understanding about the roles that we play. So SAMHSA's treatment dollars are literally a blip in the screen, in terms of the larger treatment dollars that are happening in the country. So behavioral health RIT large, so both mental health and substance abuse RIT large is the treatment dollars are primarily about two-thirds for Medicaid and Medicare and private insurance.

So what our role is with those three funding streams is trying to influence them. We do a lot of that work, but it's behind the scenes. We're trying to struggle with somebody over a reg or a rule. Or we're working on the parity issues. Or we're working on things that other people own or control, but we are trying to influence. So part of our role there is influencing. And so it's not quite as obvious or as evident. The other funding streams for treatment are state and local dollars and then we're part of a 5 percent that also includes the VA and IHS and a bunch of other players that are bigger than we are. So even inside the 5 percent, we're a small piece of the overall funding for treatment RIT large.

We're a little bit larger in the substance abuse treatment world, but not a lot. And in fact, the substance abuse treatment, for good reasons, is becoming more funded by Medicaid and private insurance now. So I think our role will continue to be and maybe even grow to be more of a how do we influence treatment more than fund it. And then the other thing you're going to hear tomorrow -- so we won't do it today -- is we're going to try to tell you a little updates on some of the things we're doing by the roles we play. So people often immediately think of our budget or our grants as a primary thing that we do and there's no question, it is a primary thing that we do. But it's only one of six major roles that we have.

So we're going to kind of explain to you some of the things that we're doing. We won't have time to do a lot of that, but we'll do just little highlights tomorrow on each of those roles. And part of the reason we're doing that is for you to be able to advise us well about what we can do. It is not as simple as saying well, have a grant program on X. Yeah, well, tell Congress that because we have to have money from Congress. The other resources we have are our human beings, our people and where we spend our time and what we try to make a difference in and where we try to raise up an issue in public education or other things. So you'll hear more about that tomorrow, but anyhow.

So we've spent so much time on prevention and recovery because frankly, we are bigger funders in those areas, but also because we've understood that in order to address treatment issues, we're going to have to do some prevention and in order to do good treatment, we're going to support recovery and how those things relate in the circle, if you will, of health and wellness as part of the way we think about this. But we've definitely spent more time talking about prevention and recovery in the last few years, so we decided it was time that we just stepped back and spend three whole days with all of you smart people, talking a little bit more about how can we be better about influencing treatment in this country, even if we don't directly fund it because we probably don't. We do a little, and certainly, CSAT is a big player in certain parts of treatment, but not in the overall scheme of things, so that's where we've got to figure out how to do more of.

So with that, I'm going to stop and let you either make comments or tell me what you've been talking about. We're going to have -- which one of you gets to be the person -- who's going to be the --

MS. DARYL KADE: Actually, we have one for each question.

MS. PAM HYDE: Oh, dear. That probably won't work.

MS. DARYL KADE: But we are so agile, we can work this out.

MS. PAM HYDE: Okay. Well, tomorrow's panel will be a conversation, not a report-out. So whoever it is that sits on the panel for you, and that needs to be one person, will have to sort of reflect the conversation RIT large, as we have that conversation.

MS. DARYL KADE: That will be done.

MS. PAM HYDE: All right. So you will have to adjust just a teeny tad. But anyway, having said that, what's on your minds and what would you like to know from me and how can we jump in here? By the way, I should thank Holly; this is your first time through, right?

LT. CDR. HOLLY BERILLA: Yes.

MS. DARYL KADE: Good job.

MS. PAM HYDE: Holly has looked like a deer in headlights a few times when I've said do this, do that. No, do it this way. No, it's changed, do it that way. She's adjusting quite quickly, so it's great. So thoughts? Andre.

MR. ANDRE JOHNSON: I'll jump in. Just coming back from this last workshop, the cuffs of conversation around postpartum and women, I was just thinking about the huge need for recovery services for women and children as well as youth, which is a huge gap in the metro Detroit area. I mentioned earlier, there are currently no residential drug treatment programs for teenagers in our entire state. And not to mention, I don't know if you all heard about the very, very unfortunate situation that happened about three weeks ago, where we had a 31-year-old who had -- she had murdered two of her children and stuck them inside of a freezer. It was very clear that she had co-occurring issues. And her children were in a freezer for two years, and this is a 32-year-old woman. And so for me, I constantly wonder if we're doing enough work in our community on the frontline, working with the downtrodden and really getting the message out that recovery is truly possible. That treatment really works and making sure people access these services.

So now, I mean, you know, the young lady is probably going to spend the rest of her life incarcerated and two other children who had witnessed this. So they survived that traumatic issue, and, you know, it just becomes a cycle. So I think for me, the

conversation is how do we take this conversation to our communities because there's still a cadre of people who never really understand what addiction is, never really understand what mental health is and how do we continue to dispel the myths and really get in the heart of the community where it's needed. But I think, you know, overall, the conversations we've had, I think has been very fruitful, in my humble opinion. Thank you.

MS. PAM HYDE: Yeah. Thanks. These kinds of really tragic situations that are occurring, whether it's in the substance abuse area or the mental health area or just domestic violence or women's issues, I mean, you pick the issue. I think I am seeing -- maybe it's just my age, but I've been around long enough now that I'm seeing, actually, a change in the conversation, and in some ways, the conversation is going kind of in a - - you're scratching your head and going, "Are those late night ads about addiction services in some big fancy resort, is that getting us the right message?" And yet, at the same time, I'm going, my God, it's on T.V. as addiction can be treated and come on down and we've got a place for you. Now, that's if you're rich and can pay for it, but still, it's a change in the conversation and I'm very curious to see how some of that conversation is going to change. I think kids are talking about it differently. And there's a lot of work going on around the country.

There's hundreds of conversations that have been going on in communities about youth and mental health and substance use issues. I don't know if you've seen the Text, Talk, Act process that's out there, it's reaching hundreds of thousands of people. They may be up to a million. Their goal was to get a million people engaged in the conversation across the country because I think it's going to take that kind of change in the conversation. You have to wonder, in a situation like you described, it's like, how could a woman be so isolated that her two kids were not even visible for a year or two years without anybody saying hey, where's your kids? I mean, so there's some major issues going on there, I think.

MR. ANDRE JOHNSON: And just to add, we're talking about, you know, the school system, you know, in my mind, is at fault because they had to know these kids should've been in school. Even in our state, we have a law that was recently passed where if you're receiving assistance from the Government, you are subjected to drug testing. And obviously, if you test positive, you will no longer receive benefits.

And so I'm wondering like, you know, in our Department of Health and Human Services Division, not really communicating to our state substance, our Office of Drug Control Policy on the state level, you know, which is no communication with the whole Department of Corrections, because, see, our Department of Corrections budget is \$3 billion. And that \$3 billion was once the City of Detroit budget for a million+ people. And so, you know, our incarceration rates are steadily increasing, but I certainly appreciate the piece you talked about around the text and the whole social media, but sometimes I wonder if these messages are really filtering down to urban America. You know, our kids have Metro PCS phones. You know, I have kids that say we can't text; we don't have the data. And so how do we be creative, even if it's on the radio, you know, are we pushing the envelope to really kind of, you know, focus on our urban American issue as well? So that's just something I would love to, you know, be involved in if you have -- or I'm sure you probably have some endeavors that's involved in it, but just to push the envelope on another level.

MS. PAM HYDE: We'll go onto some other folks, but you might want to touch base with Marla tomorrow or some of our communications folks because they'd probably love your input about social media and whether it works for youth and other kinds of things.

MS. OMISADÉ ALI: Pam, I have two things. We talked about culture today and what SAMHSA could do to change or redirect some of the messages around culture, and there's two things that I want to ask you; one of them I asked you on the call, which is around the trauma initiative with indigenous people here in this country. And I know that

the focus is on my wonderful brothers and sisters on the Tribal Council, but what about the 78 percent of us who don't live on our tribal lands?

I mean, I'm from Canada, from Nova Scotia. My nation is in Nova Scotia. I don't have the access to that kind of important services that SAMHSA is probably going to be crafting with the tribal governments. There's 78 percent of us who don't live and are not connected to our tribal land, so the impact of intergenerational trauma, especially around the boarding schools, runs deep. And if you look deeply at those of us with alcohol or other drug use challenges or other mental health challenges, you will find somewhere in there that intergenerational trauma. So that's number one.

Number two is two weeks ago, it was about two weeks ago, the White House held a hearing for transgender individuals. It was really well attended and many of my friends were on that panel, talking about the challenges of transgender individuals here in this country. I would love to see SAMHSA pay more or pay special attention to the various layers that create behavioral health challenges in transgender communities so that the stigma is removed. That people get the correct information about who transgender people are, and they're not men trying to be women or women trying to be men, but these are individuals who understand quite clearly who they are and should be treated with the dignity and respect that any human being deserves. So just a suggestion.

MS. PAM HYDE: Yeah. I know it's a great suggestion and I'm really pleased to say that we have a person now who's our special expert on LGBT populations, who is transgender and he will be -- I don't know if he'll be down here tomorrow or not, but could you make sure she gets connected to Elliot?

He has just added a wealth of -- he's a young lawyer. We stole him from --

MR. TOM CODERRE: Trevor.

MS. PAM HYDE: Trevor. I just blanked. Thank you. He's been great. And he and I, along with my special assistant, were working with the White House this last week on their position against conversion therapy, which is not a transgender issue, per se, but an LGBT, more broadly, issue. The White House took a positive position against it and we are actually going to do an expert panel. Elliot is going to pull together an expert panel to look at that issue, but anyway, he's very much brought a lot of information and helped us to think through those issues. And he's actually -- we've loaned a quarter of his time, actually, to the Department's LGBT Committee, and they're doing a lot to transgender work around policies, about coverage for care and other kinds of issues. So he would be a great connection for you, and you for him. So it would be terrific.

On the tribal issue, we just literally came from -- Kana and I just came from a great conversation with the tribal leaders about intergenerational and historical trauma, and we have some sort of some next step action steps. That particular group doesn't have an urban Indian focus because of the way it's constructed by law, it's tribal leaders. But we do a lot of work with urban Indian groups who are in some of our interactions around tribal issues and AIAN issues. So your ideas about that would be welcome as well. So Murtha, who should be here tomorrow, make sure you connect up with her because we've created this new Office to Tribal Affairs and Policy and we now have four whole people who actually are working on that issue, so we're excited about that. We're kind of growing our capacity about tribal issues. So yeah, we'd like to hear more about that. Leighton.

DR. LEIGHTON HUEY: Well, going back to Andre's comments about the example that he used, I wonder if there is a societal blind spot when it comes to those issues. And what I mean by that is that in a way, society has a free pass because it's those crazies who have done it again. Okay.

MS. PAM HYDE: Yeah.

DR. LEIGHTON HUEY: Because what happens is that, you know, what we do is not mainstreamed, okay. So you take the war on cancer 40, 50 years ago and an army was mounted around cancer and so it was taboo to discuss cancer back then, but now it's more acceptable and we don't have that at this point. And I think a lot of it comes into how people are trained, going back to the training and education piece.

So one example is that -- one little known fact is that most North American medical schools provide little or limited substantive training in pain management, including the safe and effective use of opioids. In fact, in Canada, veterinary schools provide more training in pain management than the medical schools in Canada and U.S. medical schools. Only 30 percent of U.S. and Canadian medical schools require instruction in opioid prescribing, and only 10 percent require instruction about opioid abuse and addiction. So how can things change unless those very root causes of the problem are tackled directly? So that's an example of our blind spot.

MS. PAM HYDE: Yeah, I think you're right, Leighton. And I hold out hope because when I see these weird, different messages happening, I see the late night ads about addiction and I think that is a weird message and on the other hand, it's kind of good that people are talking about and then on the other hand, I've seen more use of the term "the" mentally ill in the last two years than I've seen in 20 years, I think because we kind of got over that. So we kind of got over of saying you're all the diagnosis and nothing else. And we've kind of come back to that, so there's language out there that needs to be addressed. And we've actually been working with the Entertainment Industry Council and with the Carter Center, who does a whole journalism program, developing some guidelines for press about how to talk about these issues. So just trying to take advantage of the people, the fact that people are talking about them, but getting to talk about them more accurately is one thing that we're trying to do.

On the training issue, I had to smile when you said that because I have gotten from my dentist and from my vet the very same pain medication and the very same dosage, with

neither one of them telling me anything about being careful about the use of this medication. It's just because the dog was in pain after surgery or because I was in pain after a tooth thing. We didn't give them to either the dog or me, but nevertheless --

MR. ARTHUR SCHUT: Never too early to do both.

MS. PAM HYDE: Yeah, I know. But I was fascinated when I saw that. It's like, it's the very same medication and it's an exact same dosage. But anyhow, we actually are doing some conversation, and I can't say much more about it than that, but there is some conversation going on as part of the Secretary's Prescription Drug and Opioid Plan to look at the issue of provider education. That is hugely touchy, as you might imagine, issue because some people, even within the Administration will say, look, medical school is medical school and you can give 50 medications, why are you picking out one medication and saying it's not okay and you should have education but the other one you shouldn't.

So there's a lot of stuff about that and it involves DEA and it involves HHS, it involves Congress, a lot of things. But just know there's some conversation going on about that. It actually went on a couple of years ago and then stalled and didn't get anywhere, but we're going to try it again with more interest in the prescription drug and opioid issue. We, of course, provide training for pain management and opioid prescribing, but relatively speaking, touches a small number of physicians, but we offer it; we offer the education.

And then CDC, as part of the Secretary's plan, CDC is taking the lead on prescriber practices. So they've developed a work group on putting prescribing guidelines together and the hope is that if we have some federal prescribing guidelines that we can get the states and others to do, to match to that, and then sometimes when you do that, you can get medical schools to train to that because you train to the standard. So it's a long-term process, but at least it's on people's radar and there is something happening

about it. I was just telling a couple of people, I have learned the Federal Government takes a very long time.

So slowly but surely, I think we're -- at least the issue has been raised and people are aware of it. So I think it's a good point. I think you know we've taken on work force initiative in a little more straightforward way as a strategic initiative, working with HRSA and CDC and others around work force development, so it's a big issue for behavioral health. And we don't look at our role as just behavioral health practitioners, but also primary care practitioners and others. I don't think anybody has taken on the vet or dentist issue yet, which we need to because that's yet another issue.

DR. LORI SIMON: You just made a comment a few minutes ago about how actually, SAMHSA --

MS. DARYL KADE: Turn on your mic.

DR. LORI SIMON: You actually made a comment just a while ago that SAMHSA actually funds only a small portion of mental health and substance abuse treatment. That's actually very scary to me because the reality of what's happening in this country is that it is very quickly becoming a two-tier system of healthcare because you've got the commercial insurance companies, who -- and the Affordable Care Act, the intent was terrific, tried to get more people, you know, insured. The reality, though, has been the insurance companies are implementing it and so it becomes a game of Whac-A-Mole, where wherever they're required to spend more money in one area, they look to ways to save in other areas and so they're limiting the networks. Out-of-network benefits are becoming less and less, to the point of being almost non-existent. If they do pay anything, it's much less than what the doctor is charging.

So the care through that vehicle is becoming less, unless you can afford to go to pay what you want. Medicare, I don't know how much there's an awareness in the

Government, but doctors are leaving Medicare in droves. And in behavioral health, it's never been great. I think, probably, for example, for psychiatrists, it's probably about 50 percent. I'm in it, but I know very few colleagues that are. And what's happening is it's not so much the money, I think what's happening is CMS -- because the money, it's always been known that there's a difference between what CMS -- what Medicare reimburses and what others do, but what's pushing them over, I think, is now the requirements from both the computer-related, meaningless/meaningful use, exception of primary care --

DR. JEANNE MIRANDA: I'll let them know you think that.

DR. LORI SIMON: I'm not the only one. And the PQRS quality indicators, which, again, for behavioral health, it's really pulling teeth to try to find something that's relevant. And so I think doctors have just said I'm done. And, you know, what's happening, it used to be an incentive that okay, if you did this, that and the other thing, you would get a little bit of additional money. Now it's turning into a punitive system. As of this year, now percentages are being deducted off of your puny reimbursement to begin with, if you don't comply. And so what's happening is that doctors are saying I'm done. I've had it, you know. And so what you're left with are less and less. When you talk about manpower problems, there's less and less providers out there that are going to be available unless you can afford it, which is terrible and it's going to be leaving out a lot of people who need it. And then with Medicaid, Medicaid has always been a disaster because they reimburse so little that the only way anybody can get treatment is through the clinics and the wait list can be actually, six weeks. It's not unusual. So, you know, I don't know if anybody is listening, but that's the reality of what's happening and it's very scary.

MS. PAM HYDE: Yeah, I appreciate that. This is a good example of where try to influence. And your advice about where we use our limited resourcing to do the influencing would be a good conversation as we go through the next couple of days.

A couple of things. I'm sure you're watching the Senate struggle through the SGR. Did they just pass it?

MS. DARYL KADE: They just passed it.

MS. PAM HYDE: Oh, good. Good for them.

MS. DARYL KADE: Except, there's also some exceptions in there, but yes, they --

MS. PAM HYDE: So they still have to go back and connect it up with the House?

MS. DARYL KADE: No. The Senate -- yeah, the House passed it. The Senate just passed it today.

MS. PAM HYDE: The same one?

MS. DARYL KADE: Yes. Well, I'm not sure if it's the same.

MS. PAM HYDE: I was on a plane yesterday and I've been in here all day long.

MS. DARYL KADE: I don't know if it's the same or if they have to go back and look at it.

MS. PAM HYDE: Okay. All right.

MS. DARYL KADE: But there's still things, I was just looking this morning, that it was a little bit of a --

MS. PAM HYDE: Well, that's better than nothing, though.

MS. DARYL KADE: Yeah. Exactly.

MS. PAM HYDE: For the first time, they actually have a long-term fix to this issue because if I were a practitioner, I'd say every year I got to know whether or not Congress is going to do it or not. And even our Medicare people were withholding payments until -- 'cause to pay everybody the \$10 and then have to go back and pay the \$15 is just a nightmare. So they were trying to hold back a little bit. So if I were a practitioner, I also probably would've said, you know, screw this. But nevertheless, we've been sort of watching that and sort of play in that game and be helpful in that game. And you know the Section 223 of the demonstration that's actually being lead out of the Center for Mental Health Services, but it includes substance abuse treatment as well. It's a demonstration to try improve the quality of community behavioral health services. That was actually in last year's SGR Bill, but it continues and so we're about to implement that. It's a demonstration that's going to take all the way to 2021. See, I told you in the Federal Government, things take time. But nevertheless, this is a fairly major tow in the water at getting behavioral health paid at a level that's comparable to primary care and so that's really exciting. We're getting to work on it with CMS and with ASBI, who's going to do the evaluation on the process. So we're doing that and then the other thing that we're doing about Medicare is -- Medicare is kind of the last bastion of lack of parity. You can that parity hasn't been implemented fully. No question. But at least with the Parity Bill, in 2008, we have commercial insurance pretty much covered by parity. There's a compliance issue. There's an implementation issue, but legally, it is there. And then the President directed VA and DoD and TRICARE to equal up benefits, so they've done a lot of work in those two systems. And then Medicaid, just last week, just produced their reg for public comment about Medicaid parity.

So we've been involved in all of those efforts behind the scene. You won't see SAMHSA's name much of anyplace, except for helping to education and stuff, but we've been behind the scenes being part of the expertise in helping that process. The next

thing we're doing, because in 2016, the President proposed eliminating the legal barrier to inpatient psychiatric care and Medicare.

So Medicare pays only a certain number of lifetimes, limited numbers of days for psychiatric inpatient care. It's in law, and the President's budget proposed to change that. Whether Congress passes it or not, I don't know, but it's a tow in the water. And then what we are doing, and I will mention this is brief passing tomorrow, but what we are doing is an analysis of Medicare to see where the other differences are. And one of the big differences is in substance abuse treatment. So it doesn't cover methadone; it doesn't cover some of the other services for substance abuse treatment and Medicare.

So if your addiction emerges, if you will, or it's identified when you're Medicare eligible, you've been pretty much out of luck. So it's kind of the last bastion of parity and we're trying to identify where is it a legal barrier that would take Congress to change and where is it an executive barrier that we could change, but it might cost money, and therefore, it would be a budget issue. So we're looking at those issues right now. Those are great examples of ways that SAMHSA plays a role, but people don't see us playing that role very much.

MS. DARYL KADE: Yeah. Yeah.

MS. PAM HYDE: So that's a good example. You'll see more of those examples tomorrow.

MR. TOM CODERRE: Going back to the SGR, just so you know, the Senate did pass the House version. It's going to the President, who is indicated he will sign it.

MS. PAM HYDE: Great. See, Tom's playing the legislation role right now. He's playing six roles at the moment. Chris.

MS. CHRIS WENDEL: Thanks, Pam. Just a quick anecdote. I was reminded, when you were talking about your recent prescription issue with your animals and your teeth that about 10 years ago, I had a dog that had some surgery and the vet handed me a prescription to take to the pharmacy for something narcotic. And within two-and-a-half seconds, I had calculated the difference between the dog's weight and mine, so I knew exactly how many to take to get off. And I was probably 20 years sober at the time. So that behavior never really goes away, it just goes by. I didn't do it, by the way.

MS. OMISADÉ ALI: Good for you.

MS. CHRIS WENDEL: Yeah.

MS. PAM HYDE: So in a case like that, do you feel saying to the vet --

MS. CHRIS WENDEL: I gave it to my wife and said, you know, here, you take care of filling this because I'm not going to fill it.

MS. PAM HYDE: Yeah, that's good. That's hard. Yeah.

MS. CHRIS WENDEL: Yeah. I mean, I just know where my boundaries are. And I also sat on a task force for the State of New Mexico around this issue and I brought it up more than once that the Veterinary Association, you know, the docs were there, the nurses were there, the chiropractors were there, the DOMs were there, but the vets weren't there. And I said why aren't the vets here? And they looked at me like I was nuts. And I looked at them like they were nuts. You know, why aren't the vets here? Anyway, that's not what I wanted to say.

I have gotten away from policy work. God bless you. Honest to God. So I'm not really doing much for the state at all anymore; I just can't do it. I'm way too product-oriented. And one of the things I've gotten into, and I've talked a little bit about that today, is I was

struck a couple of years ago, I guess, when I heard someone say, and I don't know what the statistics were or where he got them, but there were roughly an equal number of people in recovery as people who are active in addiction right now. And that struck me. I thought, wow. And then I started to think about the work I was doing.

I'm sorry; active addiction is an incredibly depressing subject. It's just depressing.

Recovery, there's not a thing depressing about recovery. And so that whole paradigm shift, if you will, that at least I've done personally in that I want to focus on recovery. I'm tired of talking about addiction. Let's talk about the other half of the people involved in this subject who are miracles and have wonderful quality of life. Let focus on that. And so that's what I'm doing in Santa Fe. And so my suggestion to you is yes, you know, you can't quite walk away the way I did. And that said, I think there's a place for the miracles to get some press in the biggest possible way you can do because I think the face of recovery is an astonishing thing. And that's where the miracles happen and that's where families recover and the whole ripple effect of all of that. So that's kind of my two cents, is the face of recovery.

MS. PAM HYDE: That's great. And I know Tom may want to add something here, but I think that several of the advisory committees I've been to today, because I kind of go from one to one this day and then meet with all of you tomorrow, have asked, sort of what's the context of having this conversation about treatment. And I say, partly what I just said to you, which is we haven't focused as much on it in these advisory committees, so let's do that. But also, it's because we're sitting in the middle of a lot of criticism at the moment about why we don't pay more attention to treatment. And some of the people who are critics about that are poo-pooing recovery. And not so much poo-pooing recovery in the sense of if they see a person like you or like Tom, or like somebody else who is an example of a productive person in recovery, but this concept that that should be where our focus is, is not something they're grabbing. Their focus is, you know, those people who are winding up in jail; those people who are creating havoc

out there. Those women who are struggling with issues and ending up harming their children. I mean, those are things that they're focusing on.

So I think we're trying to figure out what's the balance between celebrating and holding out the hope of recovery 'cause why do treatment if you don't have the hope of recovery? And actually, Tom is our liaison to a national group that's working on -- are we allowed to say this?

MR. TOM CODERRE: Yes. We have slides on it.

MS. PAM HYDE: Oh, good. So the October 4th rally for recovery, the first one, that's going to be really cool, on the White House -- or on the Mall. And we also have to talk about the issue of recovery on the mental health side. It might look or feel a little differently, but it's still the idea that you can move through that diagnosis and that illness with treatment, with supports and get to a life. And so I think this is part of what we're struggling with is how do we talk about these things and how do we hold out the hope of recovery is, in fact, the reason we're doing all this other stuff. I think at one point I said, and I'll say it again here just 'cause you are all friends, but I think I said something once that may have been taken wrong. I said on some levels, treatment is a failure of prevention and a prior state for recovery. And it got sort of taken as I don't like treatment, and that wasn't it. It was that we have to focus on those other two pieces. We have to focus on prevention and recovery and understand that treatment is critical to them. And then we've also been trying to connect the dot or the circle between recovery and the focus on wellness and keeping oneself and the lifestyle that's well and healthy. And prevention, I mean, there's a lot of connection there. So we've been trying to pull some of those ideas out as well.

DR. JEANNE MIRANDA: I think it's part of our culture, too, because our culture looks at any kind of mental illness, the way they look at homelessness. You know, there's something wrong with you. There's something that needs to be fixed. And so the

treatment affect is okay, well, there's these people that they've got a problem, just fix them and let's just get on with it. They don't look at this as a continuum and then it's a whole, you know, it's an ongoing support thing.

MS. PAM HYDE: You're reminding me to come back to Leighton's point about there was a period of time where you didn't talk about breast cancer or prostate cancer or any kind of cancer because people thought it was catching or you weren't going to get over it or whatever it was. And there is a lot more understanding that sometimes with cancer, it's not a matter of fixing the cancer, it's a matter of living with the cancer.

We have people in SAMHSA and the staff who are living with cancer and it's not going to go away. It's going to get managed and it's going to be dealt with. And the same thing is true with diabetes or other kinds of chronic conditions, if you want to call them that, that are going to continue to require monitoring and attention to a person's health and wellness. So I think that's this issue you were raising about people don't think about this right and we've got to shift our thinking about these conditions and the diseases and not make them a moral issue and not make them, somehow, to blame kind of issue, but rather, it's an issue that can be treated and can be recovered from. Even if that means ongoing treatment, it still can be in recovery.

Okay. This is great. Other comments? I told them that we saw each other on the plane yesterday while you were out of the room and I said, "I know that guy, but I can't remember where." I was out of context, you know.

Other thoughts? It's late in the day here.

DR. INDIRA PAHIRIA: Pam?

MS. PAM HYDE: Who said Pam? Yes.

DR. INDIRA PAHARIA: Hi, it's Indira. I wanted to just mention that we had talked a little bit about health system integration and how there are really good models for integrating into primary care, but not so many empirically validated models of bringing primary care to the settings that people who are in recovery for substance use disorders are living with severe and persistent mental health see as their medical homes or their health homes. So we were talking about the importance of that to really not expect people to go to primary care, but to bring primary care to them. And I know you guys have done a lot around integration; you have a whole separate section on your website. I don't know if you are starting to see some good models for that sort of reverse integration.

MS. PAM HYDE: Well, we, of course, have a grant program, but it's about people with serious mental illness. It's about primary care in programs that serve people with serious mental illness. We have proposed a similar program for people in addiction treatment that are going to an addiction specialty organization --

DR. INDIRA PAHARIA: Right.

MS. PAM HYDE: -- that would put primary care there. One of the things we're finding about that is while we can do things in that context about hypertension and heart disease issues and weight and other kinds of things, it goes away after the grant goes away. So there's something fundamental to the way the program is designed that we're struggling with. I mean, we're working through it and we're doing it with our colleagues at AHRQ, the Administration for Healthcare Research and Quality because they're developing the models the other way.

DR. INDIRA PAHARIA: Okay.

MS. PAM HYDE: And then HRSA, who is co-funding with us what we call Bidirectional Technical Assistance Center, so putting behavioral health into primary care settings and

the other direction for us, for our PBHCl grants. And then we also have CMS, which has got some innovation models that they have funded about integration that they're using some of RTA and some of our measures. And so we're sort of collaborating across agencies, which is really cool. So we've got four agencies in HHS that are sort of collaborating on this issue.

DR. INDIRA PAHARIA: Yeah.

MS. PAM HYDE: And then we're also starting to go beyond primary care. So we're starting to think about people who use their specialists as their primary care. So some women use their OB/GYN as their primary care.

DR. INDIRA PAHARIA: Or oncologist.

MS. PAM HYDE: Or oncologist or people dealing with pretty severe diabetes, for example, may use that person who's the specialty in diabetes, but if that person doesn't know about untreated alcoholism, or untreated depression, then they're going to not have as good an outcome on the diabetes care. So when we think about specialty care, we think about primary care and then behavioral health as the specialty care. But we're trying to think about specialty as all these other kinds of care that need to know about behavioral health also.

So our thinking about this is evolving. We have a paper that we've been working on. In fact, our National Council on Friday, we'll hear about it. So if you're interested, either call in or stay and listen. That, and we have two really incredible people coming at 11:00 on Friday to talk to our National Advisory Council about something called Delivery System Reform. It's really moving from fee-based services to value-based payment for models. And struggling to how to put behavioral health in that context is not easy, but these two people are just wonderful. They're both docs; one is the head of our Office of National -- "our," meaning HHS -- Office of National Coordinator for HIT, Health and

Information Technology and the other one is now deputy administrator in CMS, and he's head of the quality and innovations and now he's the deputy. So these are both really great people who understand behavioral health and really get it and one is them is, I think Patrick is a pediatrician. And Karen is an internist, but they both bring this understanding of behavioral health. It's really profound. So it'll be a great conversation on Friday. If you have an opportunity, I really encourage you to listen in or stay and come and participate, it'll be in that room down there.

DR. INDIRA PAHARIA: Thank you.

DR. LEIGHTON HUEY: I had one comment on physician reimbursement. And I know, Lori, you don't fit into this camp because you take people in your practice that are poor people, so I know that about you. But, you know, psychiatrists have the lowest rate of acceptance of people who are on Medicare, relative to other areas of medicine. And I think that there are a number of us who feel that that's a shameful statistic. There are psychiatrists who pride themselves on not accepting any insurance whatsoever because what they refer to as a hassle or the low reimbursement. I think a number of us feel that it's shameful and that it is in violation of our ethics, in terms of professionalism. And I'm not saying that people should just flood their practices with people who have low reimbursement, but I do think it is part of an obligation when you become a professional to take on people who are less well-off and cannot afford care. I think that's a fundamental issue, and so the people in Connecticut that pride themselves on not accepting insurance, I think that, you know, shame on them, from my perspective.

MS. CHRIS WENDEL: It's interesting because since I live in D.C. but I have a house and a family and stuff in Santa Fe, I am mostly out of network when I go to healthcare; it doesn't matter what it is, dentist, skin doctor, whatever it is. So I appreciate this issue of the fact that physicians don't take it and how hard that is even for a fairly sophisticated consumer of how much hassle it is to go through the paperwork and try to get it covered

and half the time they say no, and you have to give them more information. And it's just a pain in the bazoo, but I also, in New Mexico, tried to get -- our governor supported it, we tried to put a law through that said anybody who got licensed in New Mexico -- and this was both physical and behavioral health physicians. Actually, I think we were going to do this for all practitioners.

Anyway, we said they had to accept all kinds of insurance, all insurance and that way we thought we'd spread it. Oh, my God. Even the people that agreed with me of what you just said, still said it should be voluntary, not that it should be forced.

DR. LEIGHTON HUEY: Well, if were 10 percent or 20 percent of one's practice, that might be okay. Manageable.

MS. CHRIS WENDEL: Yeah. And that's kind of what we said, well, if you take all forms of insurance, then you can kind of spread it a little bit. We didn't say you had to have your whole practice be Medicare or your whole practice be Medicaid, but you had to take -- some portion of your practice had to be those individuals. We didn't very far with that, as you might imagine.

DR. LORI SIMON: I see kind of both sides because yeah, I do take Medicare, but I'm one of the few around. And the -- and, you know, I don't take everybody, you know, who walks in. I mean, I kind of keep it manageable. And do I have some people who are pro bono? Yes, because some of them are the homeless patients I used to treat. And I think if everybody just took just a few, you know, you can still make lots of money.

So I agree with Leighton on that side of things, but I do see the other side too because the reimbursements are so low. I mean, I just had hand surgery, just to give you -- two hand surgeries. Doctor is out of network. I've been seeing him for 28 years. I pay \$940 a month premium for my insurance. One surgery was \$7,300. I got back \$1,000. So they forgo \$3,500, but I still had to pay \$3,500 out-of-pocket. This surgery is now

\$9,100; I've gotten back \$1,200. So there's so much of a disparity. So I think it's got to come from both sides to make it work.

MS. PAM HYDE: No, I think that's absolutely fair. And in fact, in our strategic initiative on work force, the fourth goal, we have goals into that and the fourth one is looking at fairness of reimbursement because we think that, again, one of the things that may be our role is not to pay these things because we don't control that, but we might be able to influence it.

And I'll tell ya, just putting that down on paper, I have learned so much. And I'm a relatively sophisticated person about behavioral health financing. In fact, about healthcare financing just because of the roles I've played. I have learned so much about the disparities and where these things happen. The Medicaid bump -- do you know about the Medicaid bump? I learned about this. It's all kinds of interesting things that I've learned from some physician friends and our meetings with the APA and others about these disparities that I'm not even -- I wasn't even aware of. So we decided, we're going to try to pick one or two and just try to hammer at them and see if we can make a difference.

The good news is, and again, I have learned, Chris, in my role here that I have to even more patient than I have to be at the state level about how long it takes, but we just have majorly wonderful colleagues who get this. Karen and Patrick are a couple of them you will meet if you get to listen on Friday. But we're all sort of trying to figure out how to do this, how to get this done. And even in the value-based purchasing of ACOs and that kind of stuff, they are starting to work with us on what the measures for behavioral health would look like in that context. And, of course, the pushback we get there is not the payment, but it's how many things you're making us measure kind of stuff. So we're struggling through those issues, but knowing them, if you know some of these differences, we'd like to know what they are because we want to keep a list and then pick off one or two that we can go after. Yeah?

MR. PAUL MOLLOY: Well, I guess, as I'm sitting here listening, I'm thinking to myself, back in the '60s, we considered unit pricing. You used to go to the grocery store and there would be 67 different sizes of toothpaste tubes and you never knew how much was in each tube, so you never knew what you were being charged, and the same with coffee and everything else.

And today, I probably oppose putting in unit pricing, but today, we automatically take it for granted that we're able to figure out how much something is per ounce or per pound or whatever. If you look at the forms at Blue Cross/Blue Shield will send you after a doctor's visit and you see all of the phony charges and the silliness that's there, it's time for a unit pricing kind of concept in the health insurance industry. And it's going to require, first, a strong good idea.

I mean, Mike Pertschuk, I think is probably still alive and out in Santa Fe now, was my adversary in those days, but he would at least come up with a good, simple concept. He hired a guy who came up with the barcode and the unit pricing. The same sort of good idea has to happen with respect to how you are going to quantify how much doctors are going to charge for whatever practice or procedure, but once that's done, then it just requires the political guts to do it. And until you have the political guts to do it, it's not going to happen and all the rest of this stuff is going to be fooling around, around the edges and there will be good professors and bad professors and good psychiatrists and bad psychiatrists, and good lawyers and bad lawyers. But until somebody sets the rules of the road, it's not going to happen. And when you think about whether or not that can be done, if you're old enough to remember the days before unit pricing, which most aren't these days, just thinking about what was done with unit pricing and when you go to a store and things are pretty simple, if you really care how much the coffee is per ounce or the toothpaste is per gram or whatever.

MS. PAM HYDE: Yeah. Actually, it's a great analogy and it plays out in this way. And you'll probably be glad to know, and Chris will be glad to know this because she and I have had conversations about capitalism before, but I think in the healthcare arena, they're trying to bring a uniquely American approach to healthcare and part of that is having the consumer be more sophisticated about healthcare costs.

Now, just like ketchup, that only works if there's choices. So if you only have one hospital or one healthcare system in town, like in Santa Fe, New Mexico, you either got to go to another town and have the ability to do that or you've got to sort of take what they give you and what they offer. Same thing is true as if you're in a small town and there's only one grocery store and they only offer two ketchups, you don't really have much to compare, especially, some of them only offer one. So there's still some disparity, even though unit pricing did add, if you have some competition, you can see what costs .27 cents an ounce and what costs .32 cents an ounce. And then you can decide would you rather have the label, the person you want or the thing you want or would you rather pay less money? And so you can kind of see that.

MR. PAUL MOLLOY: Yeah.

MS. PAM HYDE: The part that HHS is into now, and we're actually a part of this, is trying to help people understand what their healthcare -- now that they've got this card, what's their choices? How do they make good choices? When do they go for healthcare? Those kind of choices. But who do they choose to go to? And the theory is, again, it will take time, but the theory is to build the pressure to have more consistent kinds of costs in pricing. And God knows, we've pulled down the cost of insurance big time, but we haven't pulled down yet the cost of the doctor or the healthcare because of all the reasons we've been talking about because people are able to opt out of taking insurance, et cetera.

So the good news is those conversations are going. The good news is SAMHSA is part of those conversations. It's not something that we get very much attention or support for doing because people sometimes think we just go give your grants and leave all that other stuff alone. But we know we have to be at those tables on behalf of all of us.

MR. PAUL MOLLOY: One other thing, another thing to keep in mind is the railroad industry, which was around for 150 years and it mastered regulation with the ICC and they had rate bureaus and they fixed prices and they behaved very much like insurance companies behave today. And in the late 1970s, two-thirds of all railroads in America were bankrupt. And in 1980, the Staggers Act deregulated railroads and said behave like normal businesses. And since 1980, not only has no railroad gone bankrupt, but every railroad has made money. So when you're talking in these circles of how to solve the problem, remind folks about the railroads.

MS. PAM HYDE: Yeah. We could have long conversations about this, we're going to run out of time, but what's happening to behavioral health providers, specialty providers right now is kind of what happened during the DRG era for hospitals, which is the shift of the way funding is happening for hospitals. There's no such thing as a freestanding hospital anymore; it's a healthcare system, which inpatient beds are a part of, but not all on its own. And we're seeing that happening with behavioral health now. The National Council, the behavioral provider group for the country is really watching and struggling and trying to help their members with this issue of being gobbled up or competition from really big health systems who are developing their own behavioral health infrastructure and then taking away the psychiatrist or the nurse practitioners or the case managers or whatever. So I think there is some shifting going on there and you can say it's good or bad, the fact is I think the small freestanding substance abuse treatment providers are going to really struggle to survive. And I think more and more you're going to see substance abuse treatment and mental health treatment be part of larger healthcare delivery systems for good or ill. So that shift is happening a little bit.

MR. PAUL MOLLOY: Of course, with an Oxford House around every corner.

MS. PAM HYDE: Yeah, there you go. Well, see that's the thing, is are they going to be willing to fund Oxford Houses? That's the question. Did I see a hand over here? Then we got to probably go.

MR. ARTHUR SCHUT: I just have one quick comment. What Leighton talked about in psychiatry, in terms of folks cherry-picking, or refusing to serve Medicaid, the same things happens at organizational levels, in terms of substance use disorders. So the late night ads that you see for the California programs, clearly, they're not recruiting Medicaid clients.

MS. PAM HYDE: Yes. Malibu Treatment Center.

MR. ARTHUR SCHUT: That's right. All those folks. We have one in Denver that takes cash only, upfront. Like, \$22,500 for admission.

MS. PAM HYDE: Do you notice -- I know I'm digressing on you, but do you notice what they say? I find it interesting and I'd be interested from Tom, Chris, and others who have personal experience with this, they say, "I was an addict, now I'm not."

MS. CHRIS WENDEL: Good for you.

MS. PAM HYDE: And it's not a 12-step program. I mean --

MS. CHRIS WENDEL: God forbid.

MS. PAM HYDE: -- so, okay.

MR. ARTHUR SCHUT: Well, that would be an indication of that, yes. But I think the problem is that it's sort of devised along the lines of attritional safety net programs and then the traditional "for profit" folks have come in. And they're more for profit and more venture capital funded substance use chains.

MS. PAM HYDE: Yes.

MR. ARTHUR SCHUT: And my concern with the Medicaid funding is it is very difficult, if you take -- what's happening is you can't create a payer mix if you take Medicaid people. You end up with largely Medicaid people and you end up without the commercial payment and you can't balance the fact that Medicaid pays cost or less. And ultimately, that creates -- it's not a good business model.

MS. PAM HYDE: Well, I think the interesting thing is, you're absolutely right, that's what's happening. I think if you look at it from a systems point of view, generally speaking, except in a couple of states where they're really obnoxious about not wanting to expand Medicaid and other kinds of things, but generally speaking the public sector Medicaid behavioral health benefits are better than the private insurance benefits for substance abuse and for mental health, and it's particularly true for mental health. It's getting to be more true for substance abuse. So they're more likely to be willing. They're really sort of stepping their toe in the water of substance abuse residential and other kinds of support services for people in recovery, et cetera.

So I think it's going to be interesting to see it from a systems point of view. You're actually kind of better off, in a Medicaid system. From a provider point of view, that's not necessarily the case, unless you're connected to a larger system that can do your billing, that can do your electronic health records, that you can get the meaningful use and it makes a difference to them and all that kind of stuff.

Interesting financing issues; so treatment is about financing sometimes. Sometimes that is the issue, so I appreciate this conversation. We will have more of it tomorrow and I appreciate you hanging in there until late in the day. I don't know if you have more to today, but --

MS. DARYL KADE: We have one more presentation.

MS. PAM HYDE: Just a little. All right. I'll let you go. Thanks. Tom and I are going to see a congressman.

MS. DARYL KADE: That was great. Thank you, Pam. We have another presentation on medication-assisted treatment, and then before we have public comment, I think I'd like to go over how we're going to handle the three questions tomorrow, having heard some or received some guidance from the Administrator. And then I'd like to hand out some materials that we promised you, as a result of the deliberations earlier and anything else that you need to be addressed as a cleanup.

So at this point, even though we're running a little late, I'm going to ask Bob Lubran to join me here. How's that?

MR. ROBERT LUBRAN: Okay.

MS. DARYL KADE: To start the presentation on medication-assisted treatment, and Art will join him as well.

Agenda Item: Expanding Access to Medication-Assisted Treatment Panel Discussion

MR. ROBERT LUBRAN: Good afternoon. Bob Lubran, the Director of the Division of Pharmacologic Therapies, and I'm going to do a little abbreviated presentation so Art can get up and talk about what it's like being on the ground floor, so to speak. Okay. You want to go ahead?

MS. DARYL KADE: You go first.

MR. ROBERT LUBRAN: Yeah. So just a quick background, in early December, Congress put into the Appropriations Bill a provision for medication-assisted treatment for addressing the heroin and prescription opioid problem. We then developed this grant announcement, and as you can see, the purpose was to provide funding to states to enhance or expand their treatment service systems to increase capacity, provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based medication-assisted treatment (MAT) and other recovery support services to people with an opioid use disorder, seeking or receiving medication therapy.

So as a result of the program, SAMHSA seek to increase the number of people who are receiving medication-assisted treatment services with pharmaco therapies that are approved by FDA for treatment of opioid use disorders or relapse to opioid use, increase the number of individuals receiving integrated care and decrease illicit drug use at six months follow-up. Now, just quickly to mention, medications, there are three approved medication by FDA: methadone, buprenorphine, buprenorphine naloxone, and naltrexone, both oral and injectable formulations.

So we identified 39 states that were eligible based on the language in the Appropriations Bill. Paul might've written that Bill if he was around, but essentially, the criterion in the Bill language was to identify states with the highest rates of primary treatment admissions for heroin and opioids per capita. We used the TEDS data, and I've heard people mention the TEDS, and the applicant in this case is the state government, the single state agency. And we've had some questions about whether or

not somebody else can be the applicant, but the answer is no, it must be the single state agency. And they can contract with other provider organizations to collect data, provide services, et cetera, et cetera.

So on the left-hand slide are the 39 states that are eligible. On the right-hand side are 18 states that received a little bonus in their application, by virtue of the fact that they had the most dramatic increase in admission for heroin or opioid during a period of time that we looked at through the TEDS data. So again, left-hand state, you can see New Mexico is not one of the states, Colorado is. And it's strictly a function of the data. We were asked questions of why isn't my state in the mix and that's because they didn't make the cutoff.

So \$11 million in grant funding, \$1 million per state, if the providers are using a qualified/certified EHR system and about \$50,000 less if you're not using or you don't plan to have a certified EHR. The grant period is up to three years. There would be a million dollars set aside for technical assistance to support the grantees. And the annual continuation is kind of the standard language that it would continue, provided that the grantee is in compliance with the terms and condition of the awards in the contract and that Congress allocates the funding, et cetera, et cetera.

Future funding: Well, in the President's budget for 2016, I think you heard this earlier that there is a request for, I believe it's an additional \$12 million for 2016 to fund an additional 12 states. And if there are sufficient applications this year, applications that are scored high enough, we may not have a new announcement next year, but we could, in fact, fund from the pool of eligible states that have submitted an application.

So we've been getting questions from states and providers, both to our grants office, that's Eileen Bermudez, and Tony Campbell is the subject matter expert on this project. I might add, this is a collaboration between two divisions at CSAT. We have my division, which is mainly involved in regulatory type of services, and then Andrea

Kopstein's division, which is more running grants, they're actually going to manage these grants once the awards are made. Our job was to help write the conditions and stipulations in the grant announcement, provide technical assistance, and then hand it over to Andrea because she's got more expertise and ability to manage these grants than we do.

I think that was the end. Are there any more slides? Okay. So what we wanted to do now is to ask Art to come up and talk about it from the standpoint of a provider who is in a state, in this, Colorado. And he and I chatted a little bit about whether or not Colorado is going to apply for the grant. Hopefully, they are and hopefully, it will be a part of that, but he's going to talk about what does it mean, from a provider's standpoint, to look at the increased admissions for heroin, prescription opioids. Art.

MR. PAUL MOLLOY: Bob, while Art is coming up, before I forget it, we have four deaths from heroin overdoses since the first of the year.

MR. ROBERT LUBRAN: Oxford residents?

MR. PAUL MOLLOY: Yeah. Two in New Jersey, one in South Carolina, one in Eastern Pennsylvania. But we have had seven saves, whatever you call it, when you --

ROBERT LUBRAN: Yeah, residents.

MR. PAUL MOLLOY: When you apply whatever it is --

MR. ARTHUR SCHUT: Naloxone.

MR. PAUL MOLLOY: Naloxone. And so we lost four, but saved seven. And the outreach workers in New Jersey have worked with the state to go train a bunch EMS workers, emergency service folks, because it's not good enough just to give the relapse

prevention drug or savior drug, but to also immediately call 9-1-1 and say to EMS, get your ass over here and get this person to the hospital. So anyway, that's -- we're watching it as we go along, and we also found that of those seven folks who were saved, three of them were in Texas and no one has been lost in Texas.

MR. ROBERT LUBRAN: Well, I don't want to go any further, but we have issued a toolkit, an overdose prevention toolkit, which is available on our website that talks about strategies, as well as the medication, naloxone, and so we would encourage you and everybody else to download the toolkit. We can provide technical assistance to do that.

MR. PAUL MOLLOY: That's been helpful to us, yes.

MR. ROBERT LUBRAN: And Art is actually going to talk about strategy for addressing that from a treatment standpoint, too, and recovery.

MR. ARTHUR SCHUT: We'll hope I do that, right? Just real quick, where I work provides a broad range of services and we see about 15,000 people a year at 13 different locations. I'm going to talk largely about Vivitrol, which is the extended release naltrexone, and not talk very much about methadone or methadone. I can never figure out whether it's the south of New England. I know they say methadone in Chicago too. At any rate, next slide.

So when I think about expanding access, we've been trying to expand access to medication-assisted treatment beyond opioid replacement because we think there's a lot of potential there, in terms of assisting people and I'm going to look at that, but there are real issues around you need to have providers who prescribe. We have prescribers in Colorado that are both physicians and nurse practitioners. So one of the issues is you need a provider. You need substance use treatment clinicians that buy-in to using medication and think it's a good thing to do, in terms of adding to that treatment as usual. You need client perception that there's benefit from medications in addition to

the treatment. So there are some clients that are hesitant to do that. You need infrastructure and efficient clinical workflow, and you're really providing treatment, not as usual in many respects, in terms of substance use disorder treatment, and you need a commitment to quality.

So there are a shortage of addiction trained PCPs, and/or they see that as a limit of their scope of practice. So both, in terms of physicians and nurse practitioners, there's a deficit of providers. So there is not only a shortage, but there are not a lot of providers and clinician that are enthused about medication-assisted treatment. And you need the right prescriber, the right nurse, and the right clinician. And I am grateful and overjoyed to have those at the organization where I work.

I have a physician who thinks this is a mission in life to do it, a nurse who's committed to the same piece of it. And we have clinicians who -- we had a conversation about seven years ago where I said if there's a treatment that's effective and works well and has a strong evidence base to it, and at the time, it was opioid replacement, and we don't use it and we don't recommend it for people, then as far as I'm concerned, that's malpractice and we're not going to engage in that. So you need to do this and you need to do it to the extent that it's appropriate. And then there needs to be a clear understanding of the therapeutic benefits of medication-assisted treatment by everyone.

So the majority of the treatment capacity and the traditional safety net, and I talked about this briefly, is undercapitalized. There's some discussion right now about repurposing the grant, the Block Grant, and so there's a hesitancy in some states to fund anything new. There are attempts to move it out of treatment, which reduces capital. So you have an undercapitalized system, you're reducing capital, and frankly, capital is necessary to expand services. You can't bill for things that you have not created the ability to bill for. It's a little bit of a chicken and egg, but if you have -- if you're undercapitalized, your future capital is under it being reduced. It's a little hard to go out and get a loan to new construction or an increase in your capacity. And then we

have the belief that Medicaid and all the insurance plans have solved all our problems and are going to pay for everything, which isn't true.

So financial resources, the cost of the medication. Vivitrol in particular, which is injectable, costs about \$1,000 a dose. Oral naltrexone, you can do for about \$100 a month, but all of us know, in healthcare in general, people that take a medication daily, no matter what it is, if it's for high blood pressure or it's for any kind of other illness, they tend to miss doses; they tend to not do it on a regular basis. And so one of the elegant things about the injectable extended release naltrexone is that you only have to show up once a month. And we actually have clients who think that's great and like that compared to naltrexone, oral naltrexone. We've tried oral doses. We tried doing oral doses in residential programs and then doing something else in naltrexone, and Vivitrol on outpatient, it's just very difficult to do that. We have a specialty care work force shortage that's extensive. And then you have to be licensed and credentialed, clearly, with not only at Medicaid and everybody else, but every pair in the world to do this, and there are some that require little different kinds of things that you do with naltrexone or Vivitrol.

So you need provider and clinician availability: hours, weekends, evenings, geographic location. You know, you need childcare, you need transportation. How many bus transfers does it take to get to the clinic that's doing this and how do you do that? And we've actually -- I'll talk a little bit later, we're going to go out to -- we're largely metro Denver. We're going to go out to some other rural areas to provide services just because there's no one there that will provide the service.

So no challenge, I think in general, if you're going to get clients out of primary care setting where they're seen by someone else, addiction generally occurs gradually, it doesn't occur instantly, both the patient and the provider don't really notice it lots of times until it becomes extremely severe. And so you tend not to get referrals of folks early on. And then the other challenge is what comes first, medication or substance use

disorder treatment enrollment. There is a belief among some providers, especially providers of substance use disorder treatment that they have to enroll people in treatment before they do medication. And I, frankly, of the opinion, at this point, that in many instances, you need to do the medication first because that actually engages people in coming into the treatment. It's a little bit like if you had diabetes and you went into your provider and they said you know, I know you need insulin right now, but we're not going to give you any because you're not enrolled in controlling your diet, and your behavior, and your wellness, but once you get that done, we're going to give you some insulin. This doesn't make sense to me in providing healthcare. And then there's just the bureaucracy of how you enroll people, which I've referenced, I think, previously. And we clearly have wait lists. There are wait lists for treatment, so you also have a wait list for medicating people and how do you maintain people in that interim.

In-reach to correctional facilities, you know, a lot of the people come out on parole are people who are in institutions for drug-related crime and alcohol-related crimes. We're using naltrexone, both for helping to assist and prevent relapse for both alcohol problems and for opioid issues. So how do you do that? We discovered that if you are a behavioral health provider, you can't order Vivitrol from Medicaid on the pharmacy; you have to have a MPI number as a physical medicine provider, not just the behavioral health provider. So we had to get an MPI number. I can't tell you how long it took, but anyway. But you have to have MPI numbers, both for behavioral health and for medical care because Vivitrol is not on the formulary for behavioral health. The only thing that's on the formulary in Colorado is methadone/methadone.

MR. ROBERT LUBRAN: Is it state-by-state?

MR. ARTHUR SCHUT: It's state-by-state, as far as I can tell, but Vivitrol is not. So there's a lack of understanding how Vivitrol works. We continue, I believe, nationwide, to have this resistance to replacement therapy and this concept of using drugs to cure drug addiction. There's still folks who think that's a bad idea; you shouldn't do it. It

dates largely to the time when physicians thought alcoholism was a Valium deficiency. And so, you know, all alcoholism was an anxiety reaction and so we gave alcoholics Valium, and then they thought they'd died and gone to heaven because they could drink -- okay.

We, as a few, need to get over this, by the way. It persists, and so there are clinicians that are resistant to medication as part of treatment. I think SBIRT has had challenges in getting people to treatment and we've had challenges with that, in terms of SBIRT referrals. And there's been a lot work done around that, around effective handoffs from SBIRT, and I think SBIRT is a blessing, but it needs that piece, which we've worked very hard on and we're expanding at how do you actually get people to go to treatment once they have a referral. So effective handoffs both to and from SUD treatment and medical care providers because the primary care folks should have folks back, in terms of providing continuing aftercare. And then we're blessed in Colorado to have Medicaid expansion and increased access to MAT. And actually, the movement to pay for healthcare outcomes and the ACAs has really increased emphasis upon the need for early intervention and SUD consults and services. And four years ago, five years ago when we went to medical systems and medical plans and talked to them about our services and how we could help reduce costs, we didn't get return calls. And we're now actually having folks call us and it includes primary care practices, but it also includes health plans, saying we want to make sure you're on our provider panel because we'll really concerned about it. So I think that's a major success. And part of it, frankly, includes medication-assisted treatment. Next.

DR. JEANNE MIRANDA: What is the stand of AA and NA on medication-assisted treatment?

MR. ARTHUR SCHUT: I don't know that AA and NA have stands on it, but I could be wrong.

MS. CHRIS WENDEL: I can actually answer that --

MR. ARTHUR SCHUT: Go ahead.

MS. CHRIS WENDEL: -- because I looked it up. Individual groups can basically do a group conscience and decide what they want. Overarching, what the NA site says, if it's medication-assisted treatment, it is accepted.

DR. JEANNE MIRANDA: Oh, really?

MS. CHRIS WENDEL: Yeah.

DR. JEANNE MIRANDA: That's a change, correct?

MS. CHRIS WENDEL: Oh, it's a huge change, yeah.

MR. ARTHUR SCHUT: So we also have Department of Corrections in Colorado is enrolling everyone in Medicaid prior to their reentry into the community, which is a huge difference. And actually, we had our jails in Colorado, for the most part, were reporting to the Medicaid authority when people went into jail so that Medicaid could de-enroll them, and I believe we've stopped doing that as well, which is helpful. Just to give you an example, though, remember, a dose is about \$1,000. A year ago, the total amount of money that we had available to do medication-assisted treatment was \$37,000. I mean, it gives you an idea of how many people you could dose. That has increased substantially. And really, the folks that are increasing it are the Department of Corrections is making sure no one gets missed who doesn't have Medicaid because they're in a status where they can't get it, but then also, Medicaid has made -- it's a huge opportunity for us to do medication-assisted treatment.

We then had the commercial plans do a little bit as well, which is good. We did a MAT pilot with the Department of Correction parolees, and we have a little research here that does research and parolee returns went from 56.5 percent to 26 percent when folks were receiving Vivitrol. So huge reduction in returns to prison when people are paroled and there is a real commitment to parole --

MR. PAUL MOLLOY: What was your number?

MR. ARTHUR SCHUT: Oh, it was a very small end. It was like, 23. And we can do a larger number, but we didn't have enough money to do enough. This helped us expand available funds.

MR. PAUL MOLLOY: Can the price come down if there's greater use or does the drug company got an interest in keeping the price up?

MR. ARTHUR SCHUT: I would wish the price would come down. The price just went up a little bit for us. The commercial pharmacy price is about \$1,200 to \$1,500 a dose and we're currently getting it for \$1,000.

MR. PAUL MOLLOY: That's a huge profit.

MR. ARTHUR SCHUT: They have a lot --

MR. PAUL MOLLOY: And it's only costing them about \$50.

MR. ARTHUR SCHUT: Well, they have a lot invested in their research, I think, and development right now.

MR. PAUL MOLLOY: What's the cost in Canada?

MR. ARTHUR SCHUT: I have no idea. It would be interesting to know.

So our lessons: There really needs to be a review of regulatory barriers for consultation, brief treatment by us for primary care clinics because right now there's no real good mechanism for us to get reimbursed for that. There needs to be increased training and pain management and I'm just glad to hear that, which is wonderful. And access to treatment options. There has been some talk about taking on the Block Grant on our state Block Grant side, taking money from medication-assisted treatment out of the regular treatment fund, so reducing the basic treatment support. And I think the idea is you're supposed to get both at the same time. So that's a concern, in terms of doing that.

Increased early intervention: There needs to be more provider education and brief treatment options. We need to change the health plan accounting, I mentioned that before, to look at dollars saved and dollars reinvested. And clearly, a positive relationship with providers, prescribers are extremely valuable for us and identifying those people, finding them so that the private delivery system can do that with us.

And then I think identifying and supporting early adopters is extremely important. And one of the things in my career that I think we've tried to do is we've tried to bring everyone along and tried to get everyone to do it. A number of years ago, I decided that wasn't the world's best plan. I think the best plan is to find early adopters, support them, have them produce it and then other providers look at them and say ooh, that's a good idea, I need to do what they're doing because I'm going to get caught and get behind.

Medication first, I mentioned. Clients do engage in treatment. We've had a number of clients who are just -- have now coming to us and talking to us about wanting to get treatment because they've heard about it. And there needs to be a modification of clinical flow requirements that hinder innovation and integration with primary care, and therefore, an ability to increase access to medication.

And there needs to be expert consults. There needs to be enhanced payment for behavior health professionals in primary care so we can do more of this in a primary care setting, and the power of word-of-mouth is substantial. I think that's the end.

MS. DARYL KADE: Thank you, Bob and Art. Actually, even though we're running a little late, this is really a hot topic and I've checked with Holly and we can go. If you would like to have a conversation or some Q's and A's on this topic, I think we can take 15 minutes if you would like to do so. Is that something you'd like to do?

Okay, then. If you have questions for Bob or Art, please. Chris.

Agenda Item: Council Discussion

MS. CHRIS WENDEL: Thank you. Great job, guys. I was just thinking, when you were mentioning about expanding outside of the metropolitan Denver area, and the point I made earlier about rural and frontier, and I don't know a ton about what I'm talking about, but there's a project out of Albuquerque called Project Echo, and I think it's expanded around the country. I'm not 100 percent sure of that, but it's very active in Albuquerque and in New Mexico. And what it basically is, is a way to put local clinics together via sort of tele-health with Echo in Albuquerque, and it allows then access to people in the rural and frontier areas that wouldn't otherwise have access. Sort of addressing some of your challenge questions.

MR. ARTHUR SCHUT: Yeah.

MS. CHRIS WENDEL: So do you know about those guys?

MR. ARTHUR SCHUT: I don't know about them specifically, I know about tele-health, clearly. And there are a number of places in Colorado doing it. We are not, specifically.

MS. CHRIS WENDEL: Okay. Like I said, I don't know a ton about it, but I know it's gotten some interesting press. Bob, do you want to jump on that?

MR. ROBERT LUBRAN: Oh, just quickly. Yes, University of New Mexico has a collaborative learning model where they are reaching out to underserved and rural areas where specialty care does not exist. I learned about them years ago through hepatitis. New Mexico has a huge hepatitis C problem. Hepatologists don't exist outside of the urban areas, and so they created this learning collaborative so that you've got people sitting around the table like we are, we're the experts. And on the screen are the folks out in the rural communities who bring a case up and they do a case review, sometimes very complicated cases, as you can imagine and it's a very interesting model. I know SAMHSA has been looking at it and evaluating it. And maybe in the future there will be some work together with that group.

MS. CHRIS WENDEL: Yeah, I mean, again, that rural and frontier issue is enormous. I mean, it's just enormous. So anything that we can come up with that innovative to address that. So as you move forward, I'll throw that out to you.

MS. DARYL KADE: Any other questions?

DR. LEIGHTON HUEY: I have a question about whether you've connected with the University of Colorado Medical School on your program and tried to enlist the power of their addiction specialist there? Has that been done or considered?

MR. ARTHUR SCHUT: We have a relationship with them and we have not explicitly talked about this part of it. They have an addiction specialty program in psychiatry.

DR. LEIGHTON HUEY: Maybe we should talk.

MR. ARTHUR SCHUT: That would be great.

MS. DARYL KADE: Sadé.

MS. OMISADÉ ALI: You talked about mobile services, and I love that, especially for communities that without transportation, without any way to access services. I'm thinking about places like Vermont, where they have to travel three or four hours and some places in Pennsylvania, too, there's nothing there. And to get medication, they have to travel enormous distances. So when you're talking about providing mobile services for medication, would that also include therapy?

MR. ARTHUR SCHUT: Right now, what we're looking at is actually providing mobile services to jails that have large numbers of parolees who are pending revocation because of their substance use disorder and they tend not to be in the metropolitan area, although many of the people are from the metropolitan area.

DR. LORI SIMON: Just to add on with the therapy part of it, I mean, tele-psychiatry is becoming an increasingly important way of providing that. And I think for rural areas, it's absolutely key.

MS. DARYL KADE: Any other questions or comments?

(No response.)

Well, thank you very much. We're doing a lot in this area, not only this new MAT Program, but in our RFAs, we are adding language to clarify that MAT is an allowable cost. In our letters to our continuation grantees, we are clarifying that, again, it's an allowable cost and we are providing a stricter requirement for our drug court, new drug court grantees. So we are trying to focus on this in a very consolidated way.

At this point, I would like to ask whether or not we have any members of the public with us today that would like to address the council?

UNIDENTIFIED SPEAKER: I do have a question.

MS. DARYL KADE: Yes, ma'am.

Agenda Item: Public Comments

UNIDENTIFIED SPEAKER: Thank you. I've been hearing about a naltrexone implant that has been very effective. Are you looking into any kind of study on that or is there any movement or are you looking to fund any studies?

MS. DARYL KADE: Usually, with the public comment period, we listen to your comments, not necessarily answer your questions.

UNIDENTIFIED SPEAKER: Oh, okay.

MS. DARYL KADE: But I would just point out that there is, in the President's budget, a proposal in the CSAT budget to fund a prevention program to prevent a drug overdose, which includes up to 20 percent funding for naloxone.

UNIDENTIFIED SPEAKER: No, no. I'm not talking about naloxone, I'm talking about naltrexone.

MS. DARYL KADE: Oh, I'm sorry, naltrexone. I'm sorry. So in the MAT PDOA RFA, there's a strict reference to all FDA-approved medications and that would clearly include naltrexone. I can't comment on the other studies.

UNIDENTIFIED SPEAKER: Okay. Thank you.

MS. DARYL KADE: Any other members of the public who like to comment? If not, I would like to, before we adjourn, I would like Kim to hand out some of the materials that we talked about today and also go over the three questions or three answers and then we're going to need, based on the input from the Administrator, of the three people who volunteered to represent each of the three questions, I think we'll need one. So if you could review the summary of our discussion, that would be terrific. Maybe give it a quick glance.

Agenda Item: Council Discussion

DR. KIMBERLY JEFFRIES-LEONARD: So the three questions that we had, the first one was, "Which investments would best leverage SAMHSA's limited resources to help bridge the treatment gap?"

We had identified Dr. Huey to report, but some of those high-level items, which I thought encompassed our very robust conversation was work force development, resources dissemination to rural and small communities, case management, limiting SAMHSA's activities to select high-profile projects, addressing social service areas, leveraging integration and bringing primary care to the behavioral healthcare settings. That should be behavioral health. Curriculum integration into specific health specialties.

Do those high-level categories capture, from your perspective, what we discussed?

DR. INDIRA PAHARIA: That's fine. Peers are missing.

DR. KIMBERLY JEFFRIES-LEONARD: Peers. Okay.

MS. CHRIS WENDEL: Peers, yeah.

DR. KIMBERLY JEFFRIES-LEONARD: Let's add peers. Peer support/peer programs. Okay. So I'll add that. So the next question was, "How can the prevention and treatment systems maximize each system's strengths while forging stronger connections?"

And we had identified Indira to report, and again, we'll address these. So from our conversations, again, I solidified them into some high-level categories: breaking down the silos. I didn't put down here that, you know, for SAMHSA, in addition to how we address our categories of treatment, prevention treatment and recovery, integrate SAMHSA Council meetings, focusing on recovery and resilience, prevention focus for children of those in treatment, implementing from a pharmacogenetic approach, understanding how to truly diagnose, which in doing this, then we will have relevant prevention and treatment approaches.

MS. CHRIS WENDEL: Kimberly, I have one thing. The fourth one, prevention focus for children of those in treatment, I don't know that we specifically said "in treatment."

DR. KIMBERLY JEFFRIES-LEONARD: Okay. I know that --

MS. CHRIS WENDEL: Did we? I don't know.

DR. KIMBERLY JEFFRIES-LEONARD: I can go back to my notes. I think that's what Andre was saying that for those -- for his population in treatment, he thought that it would be very helpful to start prevention with those children.

MS. CHRIS WENDEL: Okay.

DR. KIMBERLY JEFFRIES-LEONARD: That in term -- but I know we had some other conversation around that topic.

MS. CHRIS WENDEL: Speak of the devil.

DR. KIMBERLY JEFFRIES-LEONARD: Amazing.

MS. CHRIS WENDEL: Well, then I would add this. This is Question No. 2, it's about kids and whether -- this says kids of people who are in treatment. I would like to expand that and not just people in treatment, but it could be people in recovery. It can people who are not in recovery, not in treatment.

DR. JEANNE MIRANDA: How about just high-risk kids.

MS. CHRIS WENDEL: High-risk kids. That works for me.

DR. KIMBERLY JEFFRIES-LEONARD: That sounds great. Okay.

DR. INDIRA PAHARIA: And there's one thing that's missing. One thing that's missing is designing systems around consumers rather than consumers having to fit existing systems.

DR. KIMBERLY JEFFRIES-LEONARD: Okay.

MR. ARTHUR SCHUT: Could we go back to high-risk kids? And Andre is here now, but clearly, there's a huge genetic component to alcoholism, for example, as well as some other addictions. And if you're going to focus -- when you get healthcare, you focus on -- if you're a family that has a lot of diabetes in it, for example, or you have a hereditary illness, there is prevention done with those kids very early on, in terms of the kinds of things that you want to look for. You talk about that as a family, right?

Or if breast cancer runs in your family, you have a conversation with your kids about that. For the most part, you don't have a conversation with your kids about addiction.

So I'm a little bit concerned just about the general at-risk category because it's not as specific to that risk for substance use disorder, due to that sort of intergenerational kind of stuff that goes on, if that makes sense.

DR. LORI SIMON: But high-risk can be anything. High-risk is very general.

MR. ARTHUR SCHUT: Right. Yeah, it is.

DR. LORI SIMON: It can be either those who have a genetic predisposition. It could be those who are living in a socioeconomic environment which is shaky and it could lean them towards that as a way of coping. So it's very generic.

MR. ARTHUR SCHUT: Which is --

DR. LORI SIMON: The problem.

MR. ARTHUR SCHUT: Which is my problem.

DR. LEIGHTON HUEY: I just have one technical change. It says, "Implement from a pharmacogenetic approach." The newer terms is pharmacogenomic approach.

DR. JEANNE MIRANDA: So I wonder if we could do something like say high-risk children, and then particularly those -- you know, just because trauma people are pretty high risk.

DR. LORI SIMON: But what is the --

DR. JEANNE MIRANDA: I hate to leave it all out.

DR. LORI SIMON: What your concern about high-risk kids?

MR. ARTHUR SCHUT: I don't really have any concern about it because most of -- actually, most of what CSAP does, in many respects, is focused on high-risk kids. And there's a lot of high-risk kids' stuff. I think the part that's missing is focusing, from a health perspective. There's been this sort of divide between -- there's prevention and then there's not this continuum to treatment. There is this sort of firewall between the two, but there's also a gap between the two. And so if you look at what happens in healthcare, there are not a lot of conversations with people that have substance use disorders about what they're going to do with their kids and how they're going to work with their kids going forward, and those kinds of things.

I have no objection to doing high-risk kid prevention services; I think it's a good idea, but there's a piece missing because we have had this --

DR. KIMBERLY JEFFRIES-LEONARD: I think that's what Andre was trying to convey in his statement that those parents who were in treatment, those are the high-risk -- we need to have those conversations with that and we need to start efforts with those children so we could stop the trajectory.

MR. ANDRE JOHNSON: Correct. And just to add, I really think a lot of the young people need some intervention, in some cases, not necessarily treatment. Just to give you an example, in our juvenile drug court, we have about 70 kids, and out of those kids, again, Wayne County is a really big county that is comprised of an urban and a rural area and we have, probably 70 percent of those kids are from the urban environment, where a lot of them come from, you know, homes with high poverty levels and the same happens in the rural.

So I see where the disconnect is, not only the kids. If we treat the kids, it is the environmental factors that is going to have an impact. So I'm wondering if we can have some type of maybe tip or some type of written documentation that really just helps

providers on a national level to provide some direction and some support because again, we don't have no treatment programs. Our program kids, in most cases, they end up in juvenile or lock-up before their SUD is ever treated or acknowledged.

DR. JEANNE MIRANDA: So we're saying the same thing. I mean, because some of these kids don't even have functional parents. So it's not the parents who are -- so you can maybe say focus on prevention, including children at high-risk for substance abuse. Is that okay?

DR. KIMBERLY JEFFRIES-LEONARD: So how do you all want to phrase this?

DR. JEANNE MIRANDA: Is that okay?

MR. ANDRE JOHNSON: I'm tired. I'll roll with anything. I don't know if this is more CSAT or --

DR. JEANNE MIRANDA: I think you guys made a really good case. I think all high-risk kids should ultimately be treated, but there is this opportunity that we're kind of throwing away, those who were in treatment that we're not paying attention to other kids, and we should say something about that. I mean, I think you guys are making a good case for that.

MR. ANDRE JOHNSON: So two summers ago I got charged with -- I got some grant money from my local health department. And they said we want to give you some grant money to work with kids. So I said well -- I challenged my staff and I said well, let's do a summer program for these kids and then we found that once we started circulating flyers, the adults of our program were sending their kids our program. And then we had a cadre of about 35 kids, a lot of them had STDs, sexually, you know, active, poor GPAs, you know, doing very poor in school, molestation, trauma of mother and dad in

and out of their lives, grief was prevalent, and obviously, the use of cigarettes, alcohol and tobacco and other drugs was prevalent.

So we put together this six-week program of activities, and embraced and integrated some strength in the family components and yada, yada, yada. And after the six weeks, we found the kids had really began to embrace what we had taught them. And so I said well, I felt like we couldn't just abandon them after six weeks, so I said well, we got to do something for these kids for the entire school year and we'll just create an afterschool program. And so after school, we had an afterschool program from 4:00 to 7:00, where we help kids with their homework and we continued to teach them about ATLD prevention and we also was obviously still working with their mothers and fathers, in some cases. And I said this is a missed opportunity. We already have a cadre. We don't need to go out in the community and look for a cadre of kids, we have a cadre of kids.

We're always talking about family reintegration and family unification, but I think a lot of times as providers, we get so caught up on just the adults and the kids are still lost in the cycle and then that attributes to this generation thing that we're always talking about, but I don't want to beat the dead horse.

DR. KIMBERLY JEFFRIES-LEONARD: Well, how about this: Prevention is

DR. JEANNE MIRANDA: So how would you want to say it because it's exactly -- I totally understand what you're saying.

MR. ANDRE JOHNSON: So I guess, in a way, you know, I don't want to exclude no kids at all. I think any kids that meet the criteria of "at risk" should be able to get involved in the program, but I also think we missed the opportunity of really targeting kids of the parents that we service in our community.

DR. KIMBERLY JEFFRIES-LEONARD: So perhaps it could say, "Prevention focus for high-risk children, specifically for those whose parents are in treatment," with a specific focus, with an emphasis.

DR. LORI SIMON: No. Not including. It's not just -- that's a great program. It absolutely is need, but it's also other kids who are at high risk, not only those who are the children of parents currently have substance abuse problems.

DR. KIMBERLY JEFFRIES-LEONARD: Okay.

DR. LEIGHTON HUEY: What a task.

DR. KIMBERLY JEFFRIES-LEONARD: I do want to say, as Art said, that prevention does have a lot of focus on high-risk kids. And I'm not sure if they are focused on those whose parents are in treatment.

DR. LORI SIMON: I agree, but that's what it said here and that's what we're trying to change.

DR. KIMBERLY JEFFRIES-LEONARD: So we're going to say including those whose parents are in treatment?

DR. LORI SIMON: Forget it. I can't anymore.

MS. DARYL KADE: I actually think that's good enough because what we're going to be asked to do tomorrow --

DR. LORI SIMON: I don't think it's good enough because it's only focusing on -- right now, all it says here is prevention for children of those in treatment. So what this says is all you're going to focus on --

DR. KIMBERLY JEFFRIES-LEONARD: We've changed it to prevention focus for high-risk children, including those whose parents are in treatment.

DR. LORI SIMON: Right. That's what I said 10 minutes ago.

DR. KIMBERLY JEFFRIES-LEONARD: Oh, okay.

MS. DARYL KADE: That's what I thought was good enough.

DR. LORI SIMON: No, but then people were upset about that.

DR. JEANNE MIRANDA: Well, I don't think so.

MS. DARYL KADE: I think you reached consensus.

DR. KIMBERLY JEFFRIES-LEONARD: I think so.

MS. DARYL KADE: And what I was going to say is that from what I gather from Pam and double-checking with others now, is although we're not going to be asked to report out, the person representing CSAT will have this as a framework, in terms of the additional discussions. So you can fine-tune it, add to it, and depart from it if you feel the need.

DR. LEIGHTON HUEY: I just have a couple of comments. One, in Question No. 2, breaking down silos and integrated SAMHSA Council meetings, those two issues have been discussed for years. So the fact that these are coming up again makes me wonder, well, why. Okay, so that's a question and a comment.

The other issue in Question No. 1, "Address social services areas," what does that mean? Of course, we would address social service areas, but why would that be something, you know, that would be a departure from what already should be going on?

MR. ARTHUR SCHUT: Could it have meant social determinates of health? How's that?

MS. CHRIS WENDEL: Is it -- 'cause I did talk about being of service. And could it have been from that? I talked about the importance of being in service.

DR. KIMBERLY JEFFRIES-LEONARD: It incorporates --

MS. CHRIS WENDEL: Incorporating service --

DR. KIMBERLY JEFFRIES-LEONARD: And incorporating service into programming.

MS. CHRIS WENDEL: Right. The concept of being of service. Give it away. To keep it, you've gotta give it away.

DR. KIMBERLY JEFFRIES-LEONARD: And that was one of the things that -- I thought that was a high level capture of that.

MR. PAUL MOLLOY: That's like apple pie.

DR. LORI SIMON: Yeah. I think the problem is, this has all been so broad that it's hard to go back and capture the specifics that we were all talking about earlier.

DR. KIMBERLY JEFFRIES-LEONARD: We could certainly change it and add more.

MR. PAUL MOLLOY: Or less.

DR. KIMBERLY JEFFRIES-LEONARD: Or less. However you all want to do it. It really was just a starting point to pull together the talking points that you will need for the conversation tomorrow.

MS. DARYL KADE: But remember, these are not talking points. This is just a framework. And to the extent that you remember more of the specifics that's on this paper, it will be up to whoever's representing CSAT to put it together. So I just want to emphasize that.

DR. INDIRA PAHARIA: So we have to choose one person?

MS. DARYL KADE: Apparently. I did not realize that, but apparently that is the case and I think Pam was very clear, one person and it's not a report-out; this is just context.

DR. KIMBERLY JEFFRIES-LEONARD: Just a conversation.

MS. DARYL KADE: That's right. Do you want to finish Question No. 3 and then we can talk about the representation.

DR. KIMBERLY JEFFRIES-LEONARD: Number 3, "How can SAMHSA best influence the cultural/gender-specific provision of behavioral health treatment in healthcare?" Sadé was going to report. Some of the things that came out of that discussion from a high level capture was looking at each person as an individual, really understanding what culture is, looking at the recovery community for models of cultural tolerance, letting communities adapt treatment programs to fit their treatment needs, developing evaluation models based on client needs as proposed to provider input and create systems based on listening and understanding needs. Yes, Chris.

MS. CHRIS WENDEL: Thank you, Kimberly. I just have one comment and that is, is it possible, under, "Let communities adapt treatment programs to fit their treatment needs," so that we could do treatment and prevention programs to fit their treatment and prevention needs? Is that possible?

DR. KIMBERLY JEFFRIES-LEONARD: Sure. Other comments.

MS. CHRIS WENDEL: I have one more and then I'm done.

DR. KIMBERLY JEFFRIES-LEONARD: Okay.

MS. CHRIS WENDEL: I was just going back through my notes. I would like somewhere, and maybe it's number one, but I would somewhere very much to address the difference between rural and frontier needs versus urban or suburban needs. And I don't know where we put that, but that's part of bridging the gap, so it may be number one because the needs of rural and frontier communities are very different than metropolitan areas. So if we could add that, I'd appreciate it.

DR. KIMBERLY JEFFRIES-LEONARD: Okay.

MS. CHRIS WENDEL: Thank you.

DR. KIMBERLY JEFFRIES-LEONARD: So I'm going to put differentiate the needs between rural and frontier communities versus urban communities: urban and suburban.

MS. CHRIS WENDEL: Right.

DR. KIMBERLY JEFFRIES-LEONARD: Any other comments on No. 3?

(No response.)

So I guess at this point, we need to decide who's going to lead the discussion or represent this group.

MS. DARYL KADE: And as I mentioned, these are, maybe, if not talking point, memory points to help jog your memory on the conversation. We have three representatives who would feel most comfortable in representing the council on all three questions.

DR. INDIRA PAHARIA: I nominate Leighton.

DR. JEANNE MIRANDA: Me too.

MS. CHRIS WENDEL: All in favor of Leighton? There you go, well --

MS. DARYL KADE: As I say, motion accepted, huh? Okay. Very good. But as you know, you'll be part of the Joint Council and feel free to participate tomorrow. Very good. But then one more thing. Could you share the materials that we have as a result of our deliberation?

DR. KIMBERLY JEFFRIES-LEONARD: So I passed out for you all, you already have in your hand the request for applications for the Primary Behavioral Healthcare Integration Grant, the PBHCI. And then you also have a copy of the description of the Primary Care and Addiction Services Integration Program, the PCASI program from the 2016 budget, President's budget, so that you can see what those look like.

MS. DARYL KADE: Very good.

DR. INDIRA PAHARIA: Can we leave our folders here?

MS. CHRIS WENDEL: We usually leave them here and you guys take care of it.

MS. DARYL KADE: We're new.

MS. CHRIS WENDEL: I know. That's why I'm telling you. That's why I'm asking.

MR. PAUL MOLLOY: How long are you going to use that for?

MS. CHRIS WENDEL: You've had eight hours, guys. Come on.

MS. DARYL KADE: Then Holly will take care of it.

MS. DAISY KIM: Leave all your folders and everything right there and I will take them and make sure they're all arranged for the Joint Session.

MS. DARYL KADE: Oh. So you'll put them on the tables?

MS. DAISY KIM: Yeah. I'll pass them out. Also, the shuttle will be here for the hotel at 5:15.

MS. DARYL KADE: Okay. So --

MR. MOHAMMAD YUNUS: I'll be there. Will you make a folder for me?

MS. DARYL KADE: Of course, I will. I sure will.

MR. MOHAMMAD YUNUS: Okay. Thank you.

MS. DARYL KADE: So now, again, thank you for making this a very enjoyable day for me. And I hope it was enjoyable for you. And thank you for your comments, and participating, and staying a little bit later. I think we were very fortunate to have the Administrator stay longer than she had planned, so I think there was a cost benefit to

that, but I thank you for your patience. And so at this time, do I have a motion to adjourn?

MS. CHRIS WENDEL: So moved.

MR. ANDRE JOHNSON: I make a motion, yes. Second.

MS. DARYL KADE: And second?

DR. LEIGHTON HUEY: Second.

MS. DARYL KADE: All right. Meeting is adjourned.

[Whereupon, at 5:00 p.m., the meeting was adjourned.]