

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Substance Abuse and Mental Health Services Administration**

**Center for Substance Abuse Treatment**

**National Advisory Council**

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# PROCEEDINGS

## Open Session

### **Agenda Item: Call Meeting to Order**

MS. TRACY GOSS: Good morning. This is Ms. Goss, calling into order the 74th meeting of the Center for Substance Abuse Treatment, National Advisory Council is hereby called to order. Tom Hill, the Acting Chair.

### **Agenda Item: Welcome, Opening Remarks**

MR. TOM HILL: Thank you, Tracy. Good morning and welcome. This is my first CSAT National Advisory Council Meeting, and I look forward to a very interesting and insightful day. Before we proceed, I would like to introduce CSAT's new center director, Dr. Kim Johnson, who is also attending her first NAC meeting.

Some of you may already know Kim from her work at the ATTC and NIATx, and a former SSA for the State of Maine. And needless to say, the CSAT staff and I are extremely excited to have Kim join us, and we look forward to working with her. I'll now introduce you to Kim.

DR. KIMBERLY JOHNSON: So this is the unscripted part of the day. Thank you. Thanks, Tom. Thanks, everybody. This is my third day on the job. So it's actually a good week to start to have the three days of the National Advisory Committee meetings because I get to hear from people across the country about what they think is important. So I really appreciate that. I welcome you here, and I'm very excited about being in here and being in this room. Thanks.

MR. TOM HILL: Great, Kim. Thanks, and welcome again. We are fortunate today to have two guests join us, Dr. Doreen Cavanaugh, who is a research professor at Health Policy Institute, McCourt School of Public Policy at Georgetown University. I think Doreen is in the room.

DR. DOREEN CAVANAUGH: Right here.

MR. TOM HILL: And Carolyn Hardin of the National Association of Drug Court Professionals will also be joining us. Dr. Cavanaugh will be joined later this morning by Council member OmiSadé Ali to discuss the impact of the opioid epidemic on specific demographic groups. And then following that segment, Carolyn Hardin, along with Council member Andre Johnson, will discuss the challenges of integrating medication- assisted treatment and peer support programs into drug courts.

Our final panel discussion of the day will focus on peer support services and medication-assisted treatment and medication-assisted recovery. Council member John Paul Molloy of Oxford House will be joined by Wilma Townsend, one of our CSAT staff members from the Division of Pharmacologic Therapies, DPT staff member.

So I'd like to thank them all in advance for taking time to participate today and look forward to a robust exchange of ideas and perspectives.

### **Agenda Item: Consideration of August 26, 2015, Minutes**

MR. TOM HILL: Our first item of business on the agenda is to vote on the August 26, 2015, 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. So I will now entertain a motion to adopt the minutes.

MS. OMISADÉ ALI: So moved.

MR. TOM HILL: So moved by OmiSadé Ali. Is there any discussion on the minutes, including the members on the phone?

(No response.)

Thank you. May I get a vote to adopt the minutes as presented?

MR. ANDRE JOHNSON: I second.

MR. TOM HILL: Seconded by Andre Johnson. Those in favor will let it be known by signifying aye.

**(Council members collectively vote "aye.")**

MR. TOM HILL: Thank you. And any opposed, say nay.

(No response.)

So hereby, the minutes are adopted. Thank you very much.

### **Agenda Item: Member Introductions and Updates**

MR. TOM HILL: So it's been about six months since we last met, really since you last met. And since this is a first NAC meeting for Kim and me, I'd like to take a couple of minutes to allow members to introduce themselves and to update us on any new projects or programs you've been working on since that last meeting. We'll begin with our two members who are joining us on the phone and then proceed to those in the room. Mohammad, would you like to begin?

MR. MOHAMMAD YUNUS: Yes. Sure. First, I want to congratulate Kimberly on your new assignment. I wish you well. My name is Mohammad Yunus.

(Due to technical difficulties, comments were not transcribed.)

DR. KIMBERLY JOHNSON: Are you there?

MR. TOM HILL: Mohammad, did you drop off?

(No response.)

MS. TRACY GOSS: He may have dropped off.

MR. MOHAMMAD YUNUS: Hello?

MS. TRACY GOSS: We can hear you now.

MR. MOHAMMAD YUNUS: I have been --

(Due to technical difficulties, comments were not transcribed.)

DR. KIMBERLY JOHNSON: He may be on a cell phone.

MR. TOM HILL: Mohammad, are you speaking on a cell phone?

MR. MOHAMMAD YUNUS: Hello? Not much is happening in my neck of the woods to report.

MR. TOM HILL: Aside from some minor technological problems.

MR. MOHAMMAD YUNUS: I am having problems. I don't know why.

MR. TOM HILL: Well, we appreciate you chiming in. Thank you so much, Mohammad. Terrance, would you like to share something about yourself?

MR. TERRANCE RANGE: Yeah. Sure. I'm Terrance Range. Good morning, everyone. I am the Higher Education Administrator, and also current Lifelong Student at Michigan State. So I'm here in Michigan currently, and we're preparing for a winter storm; so that will be starting my day, as I look outside. My experience and expertise really revolves around working with college youth, adult students and students at large, around different substance abuse and opioid issues. I spent some time at the University of California, Berkeley, working on issues with courts and attorneys and the analysts, and with our health counseling health services experts. Now I'm here at Michigan doing the same thing, but in a different capacity, working specifically with our student athletes. So that's my current role at the moment, attempting to address, interrogate and investigate those issues.

MR. TOM HILL: Thank you so much, Terrance. Now we're going to go around the room. We'll go around clockwise, and, I guess, start with Andre Johnson.

MR. ANDRE JOHNSON: Good morning, everyone. My name is Andre Johnson. I'm the President and Chief Executive Officer of the Detroit Recovery Project, which is a peer-led, peer-driven, peer-ran organization and operation in the City of Detroit.

Our organization works with people of pretty much all facets of human services, so to speak. What I mean by that is we found ourselves evolving over the years and working with individuals coming out of the criminal justice system and working with individuals who are actively part of drug courts, working with people coming out of mental health systems. We've seen a huge spike in expanding recovery support services to other populations. So we've had a huge shift in the City of Detroit over the last 18 months as it relates to providing peer services, which is basically billable services through our block grant and Medicaid dollars in our program, versus when we first launched, we were heavily grant driven. So we've had a shift, in terms of fee for services.

We also have experienced some challenges around this whole integration. In Wayne County, Michigan, there has been this push for integration of behavioral health and physical healthcare organizations, and there hasn't been any money to follow that paradigm shift. And there really hasn't been a lot of direction and support for your community-based recovery organizations. But nevertheless, we are in conversations with our Detroit Medical Center, which is one of the largest hospital systems in the Detroit area, and we're looking and working hard to really make sure we bring that health component to our recovery community.

I've seen firsthand many, many people dying over the years. Just to share one brief story, one guy, 64 years old, IV drug user. His hands and legs have all the IV marks, and he shared with me that even after years clean, he has this inferiority and insecurity as it relates to going to see a doctor; and he doesn't have a primary care physician. And I'm like, you're retired and you have health insurance, but that stigma of addiction is very sad because he now has an enlarged prostate. It's been enlarged over the years because he didn't feel comfortable going to a physician.

So I'm really seeing the value and importance of integrations. And that's just one of many, many stories. I don't want to hold you hostage, but it's something that really needs to be thought out and needs to be discussed. Really, we have to really be strategic on how we're going to be effective with helping people as it relates to a holistic perspective. Thank you all for allowing me to share that with you.

MR. TOM HILL: Thank you, Andre. Next is Arthur Schut.

MR. ARTHUR SCHUT: And it's Schut.

MR. TOM HILL: Thank you.

MR. ARTHUR SCHUT: That's fine. Everybody has trouble with it because of all the Germans. My family hails from the Netherlands, originally. I've been in the field about

100 years, slightly less. I've been an executive for several community-based organizations. I was in Iowa for programs involving addictions. I've been involved in a variety of quality treatment, including the National Quality Forum and NIATx. I'm currently on the board of a couple of Medicaid/Medicare organizations that are not for profits. I've been involved in a variety of both state and national provider associations. I have an interest in research to practice how you facilitate that and improve upon that.

In general, overall, I've had a career that has served people who are medically underserved and who are indigent. So I've been part of a safety net. So I have concerns about where that goes, in terms of health reform. I've most recently been involved in projects that integrate substance use disorder treatment into primary care practices and medicine in general. I have an interest in that as well.

MR. TOM HILL: Excellent. Thank you, Arthur. Next, we're going to hear from OmiSadé Ali.

MS. OMISADÉ ALI: Good morning, and welcome. My name is Sadé Ali. I am a person in long-term recovery. For me, that means that I haven't used drugs for 46 years. I celebrated 46 years on Sunday, as a matter of fact. Well, Saturday. I've been in the field that long. I was offered a job a month into recovery. So I've been in the field that same amount of time. I was in this building -- not this building. I was in this area in 1974. This is the first time I'm coming back. So this is like a coming back for me.

Presently, I am a senior associate with Altarum Institute. We have the responsibility of the Access to Recovery Project and the technical assistance going around in the country. I get to work with some of our tribal nations, especially our Intertribal Council of Michigan, who is our shining star in the area. I am presently managing the CBO, FBO --

DR. KIMBERLY JOHNSON: What does that mean, though?

MS. OMISADÉ ALI: Community-based organization, faith-based organization. Creating coalitions across the country. One of the exciting things I'm doing is creating a white paper on working in Native America and creating coalitions or creating synergy between what we call traditional behavioral practices are, like indigenous healers and our healing medicines, along with western behavioral health medicine and bringing those two together and creating spiritual coalitions. So that's something very exciting that we're doing.

I'm also president of First Nation's, LLC, which is an organization that provides training and technical assistance around intergenerational and historical trauma, which we really can't talk about the use of alcohol or other drugs or any other mental health or behavioral health challenge without talking about what happened to our people. So that's very exciting for me.

I have a bunch of faculty positions, which really isn't important, except in academic social situation, so I'm not going to even talk about them. I'm also a competitive pow-wow dancer. I'm on the circuit in the golden age category, whenever they have a golden age category. And I just got back from a very large pow-wow in San Francisco this weekend, and I'm still jetlagged.

MR. TOM HILL: Thank you. Next, we'll hear from Lori Simon. Welcome, Lori. Nice to see you.

DR. LORI SIMON: Thank you. So I actually have a dual career. I started out in the computer field and worked there for 18 years, including 13 with IBM. I did software and getting involved in IBM's health accounts, and then decided to go to medical school. I have a degree and then went on to specialize in psychiatry. So I have been practicing for 15 years. From the clinical side of things, I've always had the private practice, but I've also done other things part-time, including working for a homeless organization in New York City. My practice is in the northern New York City area. I work with an

organization that supports the homeless for eight years. I actually went into family shelters. I've actually met people on the street as part of the ACT Team, which I think is a great model.

Also, I'm board certified in psychosomatic medicine. So that means that's the border between physical and emotional. I've worked in hospitals and in psychiatry ER, dealing with patients on a consult service, an inpatient consult service, who have psychiatric problems and a consult is needed. And also in the psych ER when the patients come in and have to determine whether they need admission or not and treat them.

So I've been doing all that kind of stuff for 15 years, and now I just have the private practice. I'm at the volunteer faculty at Cornell because that's where I trained, so I teach there. I've also been trying to get back into the computer field because I think there's a lot going on with computers and healthcare, as everybody knows. So I've gotten active in the American Psychiatric Association, Mental Health Information Technology Committee, and from there, I've gotten involved in the HL7 organization, which SAMHSA actually has a tie-in to. There is a work group in particular, CBCC, which SAMHSA is actually -- in fact, Jim Kretz is one of the co-chairs from SAMHSA. I'm trying to also do all that because I think it's really important, and I like it.

MR. TOM HILL: Thank you, Lori. We have two local members, Paul Molloy and Indira Paharia. They are not present yet. I assume that they're coming and will be here sometime this morning, and we'll fold them into the discussion.

DR. LORI SIMON: The parking is a huge issue. That's probably why they're not here because I ran into that.

MR. TOM HILL: And traffic on a pea soup morning is also sometimes an issue. So thank you, everybody, for those introductions. As Kim said, it is her third day as the permanent director of CSAT. Part of what I would like to do in this meeting is start

passing the torch over to Kim. And so I asked her to do some highlights from the director's report. Even though she is three days in, it's a learning for all of us. So I'm going to turn it over to Kim.

## **Agenda Item: Director's Report**

DR. KIMBERLY JOHNSON: Thanks, Tom. You all have the full report in your packets. I'm only going to cover a few things. The first one is the 42 CFR Part 2. The revisions of the regulations are out for public comment. They were put out on February 1st, and are open for public comment through March 29th. My impression is that we are getting lots of feedback. Hopefully, you all will read them and give us feedback as well.

The next step in the process is we'll take that feedback and, as much as we can, incorporate it into the final rules and then if everything goes smoothly, then we should have the final rules published before the end of this Administration. So the other rulemaking activity that we're doing is the Division of Pharmacological Therapies is working on expanding access to medication-assisted treatment.

Secretary Burwell has announced to the Department that she will be drafting a regulation to increase the patient limit for physicians for a waiver to prescribe buprenorphine. That is an expedited review process. We are currently reviewing comments from the Office of Management and Budget. I was just looking at those yesterday, actually, and we probably will be having a meeting during our NAC meetings about those to figure out how to proceed with their comments. I can't share anything because of where it is in the process, but it is a process; and that will eventually also go up for public comment.

Another thing that we're doing that is around expanding access to medication-assisted treatment is that we asked for \$10 million in the FY 2017 budget to fund a demonstration program to explore the safety and effectiveness of prescribing

buprenorphine by a non-physician, such as advanced practice providers, so nurse practitioners or PAs. So we just did a demonstration. I'm excited about that. And of course, it would have to be in accordance with a provider's prescribing authority under state law. State laws are all different about who can prescribe and who can't in those categories. So we would provide training, and that would be part of the demonstration to advise conversion risk. So hopefully, that's in the budget, and we'll see what happens.

Another thing that I'm also personally excited about and knew about before I came here is the PEPFAR program. And you know what, I don't know what that acronym stands for. Do you know what it stands for?

MR. TOM HILL: President's Emergency Plan for AIDS Relief.

DR. KIMBERLY JOHNSON: I know what it does. So we have PEPFAR activities in Vietnam for some time. CSAT has been located there. We're also providing technical assistance to Africa and Eastern Europe on substance abuse treatment, particularly medication-assisted treatment. Heroin is a major risk factor in the epidemic in all of those regions. So this year we're going to deploy a substance abuse treatment expert in the Ukraine and establish an international ATTC. So I was excited about that when I worked at ATTC, and I'm excited about it now that I'm here.

In addition, we've established a new position, a regional substance abuse expert for Southeast Asia. And by the end of the year, the SAMHSA PEPFAR program expects to expand the capacity of the international ATTCs in both Hanoi and Ho Chi Minh City in Vietnam, with a new regional ATTC somewhere else in Southeast Asia. We're also planning to add a fourth substance abuse expert in Africa, with a primary focus on alcohol as an HIV risk factor.

The other thing that I think is exciting is we're planning more collaboration between the international and the domestic ATTCs so that they will work together more and figuring out ways of enhancing the communication between the international ATTCs and the domestic ATTCs.

The last thing I'm going to focus on is CSAT received an additional \$25 million in the FY16 budget for medication-assisted treatment, prescription drug and opioid addiction and MAT-PDOA, which will allow us to fund an additional 11 grantees.

One of our themes today for the meeting today is the integration of medication-assisted treatment and support programs and opioid treatment programs. The MAT-PDOA program is playing a key role in that effort. So we're excited that we're able to expand that to additional states. So those are the quick, brief highlights. There is a lot more detail in the report, so I do urge you to go ahead and read that.

Tom, back to you.

MR. TOM HILL: Thanks, Kim. Now, it's time to introduce our director of CSAT's Office of Program Analysis and Coordination (OPAC), Ms. Stephanie Weaver. Stephanie will provide us a short budget update.

### **Agenda Item: SAMHSA/CSAT Budget Update**

MS. STEPHANIE WEAVER: By far the most exciting part of this day, I assure you.

DR. KIMBERLY JOHNSON: For some of us it is.

MS. STEPHANIE WEAVER: I'm a numbers person, so I actually meant that. So I'm going to go over some highlights from FY16 and then talk about some of the highlights from FY17, which was just released the other day. I'm sure there are a lot of questions. I'm going to try to go through this quickly so that we have time to answer some questions that you might have.

Overall, the CSAT budget for FY 2016 is \$2.2 billion, an increase of about \$10.5 million. We received the equal level funding as FY15 for opioid treatment programs for SBIRT, PPW, RCSP. I think you all are familiar with those terms, but I can certainly expand on what the acronyms are. Children and Families, Minority AIDS, Criminal Justice and ATTCs, we received increased funding of \$13 million in what we call TCE general. That brings the total for MAT-PDOA to \$25 million, which does increase the numbers of grants that we'll be providing.

The other increase was in the Substance Abuse Prevention Treatment Block Grant. That increased about \$38 million. Reduced funding for treatment systems for homeless by about \$82,000. We received no funding for three different programs. One of them probably isn't a big surprise. Access to Recovery lost \$38 million. The other two were Strengthening Treatment and Access and Retention. That was funded at \$1 million, and we received no funding there.

MR. TOM HILL: Stephanie, just a quick interruption. If folks want to follow what Stephanie is reading, the budget is in the director's report on page 5. So the tab is the director's report, and go to tab 5. There is the table of the budget.

MS. STEPHANIE WEAVER: No problem. I appreciate that. Thank you. I should've mentioned that. And finally, no funding in FY16 for Special Initiatives and Outreach. For FY17, this is where it gets exciting. The overall budget is \$2.6 billion. That's the budget request. This is an increase of about \$469 million. Five programs received level funding from FY16, and that's opioid treatment programs: PPW, RCSP, Children and Families, and the block grant. I should've said didn't receive, but we are requesting level funding. We're also requesting an increase funding for TCE general, which will be an additional \$25 million, bring MAT-PDOA to \$50 million and providing grants to nearly every state eligible for accessing or increasing MAT services.

Reduced funding in FY17 is recommended for SBIRT, which will see a reduction of \$16.9 million. Treatment Systems for Homeless is \$4.9 million. Reduction in Minority AIDS is equal to \$6.7 million. Criminal Justice is \$16 million, and the ATTCs would see a \$965,000 reduction. That bad news brings good news. So that is that we are recommending some new programs; one of them being a cohort monitoring and evaluation of MAT outcomes. And that really piggybacks along with the state-targeted response cooperative agreements which we are recommending for mandatory funding, which is \$460 million. Those would go to states in response to opioid crisis in the nation, focused on treatment and prevention. Recommending a new program crisis system, which would equate to \$5 million.

And finally, buprenorphine prescribing authority demonstration, which Kim mentioned earlier, an increase of \$10 million. So hopefully I went through those quickly enough so if you guys have some questions, you can ask. I think I was pretty thorough, and the numbers are clear; so that shouldn't be a problem.

## **Council Discussion**

MR. ANDRE JOHNSON: I have one question.

MS. STEPHANIE WEAVER: Sure.

MR. ANDRE JOHNSON: I know I read something about the President had recommended a \$1 billion increase for revenue to target opioid users or something. I was curious of how much of that was earmarked for SAMHSA and/or CSAT.

MS. STEPHANIE WEAVER: For SAMHSA, overall, and CSAT got the vast majority of that. We got about a half-a-billion of that.

MR. ANDRE JOHNSON: Okay. Because I heard you say \$469 million. I was curious, do you know, by chance, how that money was being targeted?

MS. STEPHANIE WEAVER: You know, I'm not confident, but I believe some of it went to other places within HHS, like CDC. Some of it may have gone to the Justice Department, but I'm not exactly sure. I know there is a document. I can certainly find that and share that.

MR. ANDRE JOHNSON: Well, no. I'm just glad to hear that we got at least half of that.

MS. STEPHANIE WEAVER: Oh, yeah. So it's the \$460 million and then the \$15 million for the evaluations. So \$475 million of that came directly to CSAT, which is pretty impressive.

MR. ANDRE JOHNSON: Okay.

MR. TOM HILL: And that's just for the first year of two years, correct?

MS. STEPHANIE WEAVER: That's correct. The intent is to have level funding for two years for both of those programs. Not to go beyond that, but to keep that funding for two years.

MR. TOM HILL: So 450 for '17 and 450 for '18, right?

MS. STEPHANIE WEAVER: Well, 460.

MR. TOM HILL: And those are for the cooperative agreements?

MS. STEPHANIE WEAVER: Correct.

MR. TOM HILL: And then there's some smaller pieces about monitoring OTPs, opioid treatment programs. I think there is a piece for prevention and a piece for HRSA, I believe.

MS. STEPHANIE WEAVER: I believe so. I think the preventative piece is about medication and intervention and overdose prevention.

MR. ANDRE JOHNSON: Okay.

MR. TOM HILL: We can get you those figures. Any other questions?

MR. MOHAMMAD YUNUS: Yes. This is Mohammad Yunus. Can I get a copy of the budget? Is it available on the website?

MR. TOM HILL: Yes. It's on the website.

MR. MOHAMMAD YUNUS: Okay. Thanks.

MR. TOM HILL: Thank you, Stephanie.

MS. STEPHANIE WEAVER: All right. Thank you.

**Agenda Item: TOPIC: The Opioid Epidemic: Impact on Demographic Groups**

MR. TOM HILL: So we're ready to move onto our first topic area with presentations and discussion. Our first panel discussion today is on the opioid epidemic and its impact on particular demographic groups. We have expertise on this in the room. We have chosen Native Americans as well as adolescent and young people.

Dr. Melinda Campopiano von Klimo from our Division of Pharmacologic Therapies

(DPT) is the moderator for this discussion. She is joined by OmiSadé Ali, President of First Nations, and Dr. Doreen Cavanaugh of Georgetown University. So I'm going to turn it over to Melinda.

DR. MELINDA CAMPOPIANO VON KLIMO: Thank you. So the speakers want to come up here or just remain where you are?

DR. DOREEN CAVANAUGH: We'll come up.

DR. MELINDA CAMPOPIANO VON KLIMO: What I'd like to do, just briefly, if it's okay with both of you, as the presenters, is give a brief overview of both bios of our presenters, and then they can proceed through their presentations and then we can have our discussion. Hopefully, that will accommodate the most possible time for discussion.

I'll start with Ms. Ali. Ms. Ali is the retired deputy commissioner of Philadelphia's Deputy Department of Behavioral Health and Intellectual Disabilities Services. She is now the president of First Nations, LLC, a behavioral health training and consulting organization in Delaware and a senior associate with the Altarum Institute in Washington, D.C., where they provide training and technical assistance to tribal governments and other providers engaged in SAMHSA's Access to Recovery (ATR) initiative.

Ms. Ali holds faculty positions at Brown University, Temple University's College of Health Professions, and Drexel University's School of Public Health. Ms. Ali has traveled the U.S. and Canada extensively, providing culturally appropriate recovery management and resilience, promoting training in both the mental health and addictions field. She has many other accomplishments. I guarantee you, they are quite impressive, but for the sake of time, I'll proceed to Dr. Cavanaugh's bio to give you a

brief overview.

Doreen Cavanaugh is a research professor at the Health Policy Institute, McCourt School of Public Policy, Georgetown University. Dr. Cavanaugh has worked with the Substance Abuse and Mental Health Services Administration and its grantees, which include the Office of National Drug Control Policy, U.S. Department of Education, the Office of Juvenile Justice and Delinquency Prevention, and other federal agencies on access, quality, financing, implementation, and organization of treatment recovery services for adolescents and young adults with substance use, mental health, or co-occurring disorders, and their families, for 20 years. Prior to that, Dr. Cavanaugh worked on youth behavioral health and child welfare issues at both the regional and state levels for the Commonwealth of Massachusetts.

So with no further ado, we'll start with the presentation, please. Ms. Cavanaugh.

MS. OMISADÉ ALI: Quickly. (Spoke in Native American dialect.) Good morning. My name is Heart of the Hawk. My second name is Sadé Ali. My roots are in the Pictou Landing Reserve in Nova Scotia, Canada. My presentation is entitled, "We Shall Remain." Because for me, I can't talk about the use of any alcohol or other drug without talking about recovery. So it's not only opioid use, but it's also recovery that we're going to be talking about. I know you want some numbers, so here are some numbers.

Right now, there are 566 federally-recognized tribes in the United States. We call this Turtle Island. So in this part of the United States, 16 of our states recognize 62 tribes. Our census figures are grossly under-reported. Why? Because 75 percent of us live in the United States off our tribal lands. So they're only talking about reporting the folks who actually are enrolled members of those federally-recognized tribes. There are

many more of us. Many of us live in cities like New York. In fact, there is a huge native population living in New York City.

DR. LORI SIMON: Really?

MS. OMISADÉ ALI: Yes. We have, unfortunately, the highest use rates of any ethnicity in the country. The 984 percent increase in opioid use is a staggering figure for us, but it's absolutely true. There is a 3,695 percent increase in the use of opioids and heroin that has been reported since 2011. Last year, there was 16,000 overdose death due to overdose in our community. There are some social factors that go along with some of these things. In some of our reserves around the United States, if you have worked with any of our people in some of our tribal nations around the country, there is up to 96 percent unemployment rate. So people are experiencing symptoms of hopelessness. The poverty in some of our reserves is grinding. There are lack of resources.

We know about what's happening in Flint, but what they don't publicize is what's happening on some of our reserves with the lack of water that is drinkable or useable at all that's been happening. But it doesn't get the same press that some of the other areas do. There is very poor access to services, even if they're available. If you go to the Pine Ridge Reserve right now, the weather is not great. So even if there are services, they are inaccessible. There is no transportation system in some of our tribal nations. Many of our tribal nations, the areas are remote; they're inaccessible. And if there are services, those are not accessible. But I don't think that, as a person in long-term recovery and as what we call a first-generation survivor, I don't think we can talk about the use of alcohol or other drug, or any other symptom that we are experiencing without talking about some of the major impacts to our system.

One of the major impacts -- and I know if you've been on the National Advisory Council, you heard the Tribal Advisory Council talking about we really need to talk intergenerational and historical trauma and that impact on us. I've been in the field for 46 years, and I think, as a person in long-term recovery and as a person who has worked in every major service you can think of in our field, that we have been focusing on the wrong thing. I believe that the impact of trauma on the lives of people is specifically and critically important to focus on. For indigenous people in this country, historical and intergenerational trauma is one of the major reasons why we see so much devastation in our communities. That devastation is not always talked about, except by people like me and by the people who are here today to talk about indigenous people and the issues. I'd like to focus a little bit on that today.

This picture is from the Carlyle Indian School. It was the very first one in this country. It's located not so far from here in Carlyle, Pennsylvania. And it was a prototype for all of the other schools that sprung up across Turtle Island, in the United States and in Canada. And there were over 300 of them. These were not really schools; they were a place that the "Cry Killed the Indian to Save the Man" was born. So our people, these children sometimes as young as three or four years old were taken from their nations and put into these institutions where they were designed to integrate people or to assimilate people into the dominant culture. I have an elder up in the Saginaw Chippewa Nation in Michigan who says he is a failed assimilation Indian. I am too.

What happened in these schools, and many people don't even know that they existed, left deep and lasting scars. My mother, and I just learned this in the past 15 years, what she went through in a school called Shubenacadie in Nova Scotia, where she was forced into labor, had her hair cut, had her language taken from her, was beaten, raped, along with other children. Her whole personality, from the age of 6 to 16 was formed around this abuse. So you can image what kind of mother she was.

I also found out recently, within the last couple of years that the children in Shubenacadie were used in an experiment for a drug company, a vitamin company here in the United States. They starved these children. Those of you who understand child development know how important good nutrition is to the brain development. So a lot of these children grew up impacted severely by what happened. It was a genocidal tactic, along with sterilizing our young girls. They forced relocation of our people to areas that are often remote and inaccessible and that no one else would want to live on.

So we have all of these challenges. I think as a behavioral health service in this country, we need to focus on healing that before we can talk about ending the use of alcohol or other drugs, or other things that impact people's lives in negative ways. I know SAMHSA, Ann Matthews especially, is focusing on trauma and trauma-informed care. And treating people and asking people not what's wrong with you, but what happened to you. Many of us used opiates. It's a good numbing agent, along with alcohol. I, myself, used opiates. I was medicating my trauma that happened to me in childhood because unfortunately, when we talk about intergenerational trauma, these things are passed on, generationally.

So what I went through, and hopefully I've broken the cycle with my own children, if you're not in touch with that, if you don't understand that or you don't understand how it's passed on, we are creating a cycle. So what we're seeing right now, especially in our reservations, is this cycle being recreated over and over and over again. SAMHSA has brought in some tribal experts. There was a young man here last year who I met, Leon Leader from the Rosebud Reserve. He was brought in by CMHS to talk about the suicide pacts that our young children are engaging in. Sometimes there are up to 10 and 15 children at one time committing suicide in our communities. It's scary for us,

especially those of us who are elders. We need our traditions and our healing ways, and our songs, and our dances passed on because if you have a good sense of who you are as an individual from a cultural perspective, you're less likely to harm yourself with alcohol or other drugs.

Some of the work that's being done around this country, and I have to applaud Andre, my fellow council member, for working with the Intertribal Council of Michigan, the 12 tribes there, and bringing peer recovery support to those tribal organizations. What they did with that work was to create a peer program that is culturally specific. So of course, we use the foundational things in any good peer program, but we also add our own traditional medicines into that. So there are ceremonies, and there are healing ways; and there are songs that may not be in a peer program, but we have incorporated that and created something that is actually relevant across Native America and is being used by other nations to create peer services because it is so important to have people who have actually been there, done that, got the T-shirt, the mug, and the lanyard to actually work with others because you speak that language, that language of the heart and the spirit.

Also Don Coyhis -- I love Don; that man is one of my major mentors -- has created, according to the grandmothers, he created a sacred hoop with 100 eagle feathers and took it to the site of every single residential school on Turtle Island. That means the United States and Canada. So that the people who are survivors of those schools. That healing is so important to us. Just a little bit about medication-assisted care in our communities, we barely have substance use treatment in many of the tribal organizations. You find a lot of medication-assisted programs off reserve. Those are available to our people, and many of them are culturally appropriate, including a lot of them in California, but not so much on the reserves. And again, if you go up to North or South Dakota or to Montana right now to where some of the reserves are, a lot of the

Ojibwe Reserves in Wisconsin, if they have services, you're not going to be able to get to them. They're very difficult to get to. There's no transportation system at all. So those things are barriers to us accessing care if we are indeed enrolled members on tribal reservations.

These are just some quotes from a recent conference. It just talks about the need to heal in a cultural context. Western medicine is great, but Western medicine doesn't work for indigenous people. We need to heal in our own ways. We need to heal with our tribal medicines, with our healers, and with people who understand intergenerational and historical trauma. Recently, I was up on the Saginaw Chippewa Nation on their reserve. They have a casino there, and they finance their behavior health totally with casino money. So they put all of their casino money back into the infrastructure of the tribe. Their substance use program is one of my dreams. I wish that we had this all across the country. They can stay as long as they want. So it's totally person directed.

So if Andre comes in and he only needs three months and I need a year and-a-half, I can stay the year and-a-half. Not only do they use the Western medicine, but they also have several traditional healers that work with them with sweat lodges, with longhouses, and doing the healing in the traditional manner. I think that it is really important to recognize that we need to go beyond what we see as a symptom. And as a person in long-term recovery, I can tell you it's a symptom; it's not the be all and end all. And if we don't look at what happened to you instead of what's wrong with you, we're doing a disservice to the people, especially people of native and ancestry with historical trauma.

So I just wanted to show a little six-minute clip, if you could pull up that YouTube video for me. This is done by some children from the Fond du Lac Reserve. I saw it for the first time last summer. It was extremely powerful. It was a group of indigenous people

up in the Seneca Reserve. It was very emotional for us. It's a story of healing, and it's a story of enlightenment.

(Technical difficulties.)

MR. TOM HILL: Should we move on?

DR. MELINDA CAMPOPIANO VON KLIMO: Maybe it will be better if we end the whole segment with that. So we'll come back to the video segment when we have some IT, and then we'll proceed with Dr. Cavanaugh's presentation. Dr. Cavanaugh, I'll give you the mic now.

DR. DOREEN CAVANAUGH: Well, good morning, everybody. I'm delighted to be here. I want to thank Tom very, very much for the invitation to spend some time with you this morning and talk about this really important population that we're going to discuss.

So we're looking at the opioid epidemic and its impact on adolescents and young adults. We are going to look at the extent of the problem. The extent of the problem is - - I realize that the slides don't change on the screen the way they change up there. So we're going to talk a little bit about the extent of the problem, the effect of opiates on our youth. We're going to address the impact of this situation and to talk a little bit about moving forward in an agenda for the future.

Of course, we know that this population is critical to us because the younger a person begins using alcohol or drugs, the more likely they are to develop a substance use disorder later in life. So this is truly a population of opportunity. This is a population that if we cannot prevent folks from using substances, then the sooner we can address

their issues, the better off they will be and we will all be. We wanted to talk a little bit about the extent of this problem. There are a lot of metrics that we can use to do that. I chose the metric of disorder because I find that when you put a lot of metrics on the screen, we can all get lost in the data. I do have the metrics of use with me, if anybody wants to talk about that in the discussion.

I think with substance abuse treatment, we're looking at our key population as youth who have disorders need our services and need treatment. So we are looking for ages 12 to 17, which is approximately 168,000 adolescents who currently have pain-reliever use disorders. So non-medication use of pain relievers. So 168,000 youths. This, of course, is the National Health Survey on Drug Use and Health. And then we have approximately 430,000 young adults, 18 to 25 who have a pain reliever disorder. So just those statistics really understand why this discussion is so compelling.

So there is about 168,000 adolescents with this issue and about 430,000 young adults with the pain reliever issue. When we turn to heroin, we see that we have about 18,000 adolescents with the problem in 2014 and about 168,000 young adults. Again, I stress that these are disorders. So these are the number of folks who actually have a disorder today.

We'll talk a little bit about pathways to getting into this problem. I think we know that nearly half of the people who inject heroin started with prescription opioids before they went to heroin. Sometimes they report that it's because it's cheaper. Sometimes it's easier to obtain. Sometimes it's easier to administer, but whatever the case, a lot of the time, they're starting with opiates. There is a study that just came out in 2016 that I thought had a few interesting facts. This is a study of high school seniors from Monitoring the Future. It is a very large sample size, as you can see, of about 67,822. So that's a pretty good sample size. Most of the students who said that they had used

opiates or heroin said they had done it through experimentation. However, clearly, there is a subset of students that reported non-medical use of opiates. They were, of course, at increased odds for using heroin.

I think a really important point here is the dose response. There is a clear dose response dose observed for those youth who moved from opiates into heroin. Looking at a frequency of equal to or greater than 40 times use of opiate that was associated with an increase of reporting heroin use by 8,700 percent. That is not a typo. So clearly, what we can see if we can't prevent it, if we reduce the frequency, it's going to make a huge difference because there is a high correlation between the frequency of opiate use and then moving onto heroin.

Also, females were less likely to use opiates and heroin. We know that the increased risk of heroin was distinct for whites and for males, which might break a stereotype. I think sometimes we think it's more of our black and Hispanic youth, but it's our white youth. Also, we find that there's another difference because for black and Hispanic youth who don't use heroin as much as white youth, but for those who do, the study found that their pathway was different. Not as many of them started with opiates. They came to heroin by a different route. So that's another important piece of information for us looking and working with this population. Also, it's students who are in smaller populations. So it's not just our big cities. Another myth, sometimes, is that we believe that they're in the inner cities of our big cities in the country, but really, we have a rural and urban problem. This is a major issue when we look at policy later, when we talk about the delivery of treatment and we're talking about delivery of treatment to this population in rural settings.

Also, income was correlated with the use of using opiates. Rather than moving onto heroin, youth who could afford the prescription pain killers stayed with them more than

those who had lower incomes. So what are some of the effects of opiates? Well, we know that. I mean, you know that much better even than I do because some of you are working with these people every day. We have sleepiness. We have confusion. We have nausea. We have breathing problems. We have interfering with the functions of the brain, so we have all kinds of critical functions that are affected, such as our blood pressure, such as respiration, and of course, such as breathing. We know that. We have long-term effects as well. Youth can build a tolerance. Some more of the drug is needed to keep them at the same level. They have dependence, you know, the need to continue to use the drug. Some studies are showing in some cases that it is affecting the white matter of the brain overtime as well, so that we're affecting decision-making capabilities, the ability to regulate behavior, responses to stressful situations. So you add that to adolescent and young adult development, and you see that we have a compounded problem.

I was thinking, well, how else can we talk about the effects of this problem? So I said I'll look at just the general literature. I literally went in, and I scanned the general literature and up popped *Sports Illustrated*. And I said well, you know, if you see your problem in *Sports Illustrated*, you've got a real problem. Here we have what I would call, unfortunately, a typical article. This is an article about a youth who started on a baseball team and had a baseball injury. He started using opiates to take care of the pain from that injury and then, unfortunately, died from overdosing as a young adult in his early 20s. He, of course, hid his problem from his parents and his relapse from his parents. I was looking in this small town in Massachusetts, Brockton, you know, and I just kind of looked at this; and the headline takes your breath away. "Wasted Youth: Our Ongoing Coverage of the Region's Drug Epidemic. State Sees Surge in Suspected Heroin Overdose Deaths." These words just grabbed me when I read them.

So here is Dr. Joseph Strand, the medical director at the Brockton-based Castle

Treatment Program, says he's seen heroin addicts as young as 13 or 14. He said, "Most of the kids using Percocet and heroin who come in to see us are not getting high from heroin any more. They're using it so they don't go into withdrawal." So these youths are deep in the weeds of the opiate problem. Then I saw this little article from Lowell, Massachusetts that said, you know, opiates, heroin, OxyContin are the leading cause of death for youth in the State of Massachusetts. I said yeah, absolutely. We know that. All of New England is really having a serious problem. And then I looked at the data and I went, "Oh, it's from 2002 to 2007." So I said, "I really can't use that." So I disregarded it. You know, I threw it away. I just deleted it.

So I said, "Well, you know, maybe I should have a journal article. It's always good to have like a published peer-reviewed article, so let's go see what we can find." So I went into the data for that, and I found this article that said, "Major increases in Opiate Analgesic Abuse of the United States, Concerns and Strategies." I said perfect. This is great. And then it was written by Wilson Compton and Nora Volkow, so I said can it be any better? You know, this is going to be a great article to use. So I went in, and I started to look at the words; and the words said, you know, though this problem is not new, the scale, range, and growth of the problem are expanding and that's new. The Epi Survey shows that it is the second most-used drug after marijuana. True. We've seen a marked increase over the past few years. True. The upsurge in use and problems is very concerning because it seems to represent an expanded pathway to opiate addiction. True. So this is true; I can use this article. And then you know what I'm going to say. I looked at the data, and the data in this article is from 2003, and the article was published in 2006.

So a lightbulb went off over my head and I said, "No, not only can you not use this data, you must use this data." Because the point of the conversation here today is to make sure that nobody can ever do what I just did. To make sure that nobody can ever use

an article that's 10 years old and say that it's still relevant. So we hope that from our conversation today and everything that we're going to do moving forward that nobody will be sitting here in a room like this in 2026, talking about the way that life is today for youth with opiate addiction.

One of our big issues with these youths is treatment resistance. Needless to say, youth that want to go to treatment, they're not receiving treatment. They don't perceive the need for treatment. Another piece of this study was another factor that is reinforcing something that we already knew, but it's the importance of adults in youth's lives, particularly, the importance of parents. So this talks to our parent involvement that we talk about all the time. Youth reported that if they talk to their parents about the dangers of substance abuse, they were 56 percent more likely to have received some services than those who did not. So keep that in mind when we talk about the policy issues in a minute when we get to that.

Needless to say, we have very little treatment for youth with opioid disorders. We're having problems with psychosocial treatments for youth who are abusing other drugs, never mind youth who are abusing opiates. So this is another huge issue for us to look at. So a lot of times we get to this part of the presentation and we say, "Gee, if we only had some ideas of what to do, you know, if we only have some clues." But today we do because SAMHSA had the foresight to have a meeting back in December of 2011, where they brought in 24 of the best known researchers around the country and ran a technical expert consensus panel. Consensus is important because it was done rigorously. It was done with a modified Delphi approach. So it means that everything this panel said reaches the lowest rung of evidence for science. I mean, it's the lowest rung. There are five rungs. This is the lowest rung. But at least it reaches evidence for science, which we very often don't do.

So we discussed 10 questions at that meeting, but two of them are really germane to our conversation. One is what do we know from neuroscience? And the other is what is the state of pharmacotherapy for use with substance use disorders? So isn't that perfect? We actually had this conversation in December of 2011, and we're able to bring it to you today. So what are some of the things that our nation's best researchers said about this? One thing they said was that you can pretty much take buprenorphine to the bank. In other words, bupre works. Bupre and I are friendly, so I call it "bupre." Bupre works for youth 16 and older, and it is approved for youth 16 and older. So a big piece of this is getting it to youth who are 16 and older, but that part we've put away.

Also, we know that it works better in conjunction with psychosocial treatments, and we know that's part of the federal definition of MAT, is that it has to be accompanied by psychosocial treatment. But keep in mind, parenthetically, that we're having a hard enough time getting evidence-based psychosocial treatments to youth across the country using any drug. And now we need to do that. We need to put it in combination with MAT and put it together. So there are some challenges.

We also know that youth with co-occurring disorders are a very special population that we need to also address. Maybe there is a greater need of medication-assisted treatment. Needless to say, we have to make this treatment appropriate for the youth's age. We really need to think about what's happening to youth under 16 because bupre is only 16 and older. So what are we doing about them? And we have to understand that even though we know this, science knows this thanks to NIDA and all the great work that's been done out there, there is still a huge lag in adopting evidence-based treatment, science-based practice into the field.

So to that end, what are some of the things that we could think about to getting this and moving this out? Well, one, of course, is engaging providers on the evidence and value

of pharmacotherapy for youth with substance use disorders. Well, that's great. We want to encourage practitioners to use medication-assisted treatment that we have available. And in order to do that, we have to really improve the competency and awareness and appreciation of MAT with providers who work primarily with youth. So there's a challenge there. There's also a need to explain this to parents and help parents understand that medication can really be helpful for their youth. And then, of course, we have to develop treatment and reimbursement of pain methods so that we can reimburse, at the appropriate rates, the practitioners who will be delivering these services. So this we know.

We have a piece of good news here today because we can say that CSAT has already started down this road. That's really terrific. CSAT took up the recommendations of the expert panel. We all know because we've all been on a lot of them that sometimes that doesn't happen. Sometimes we write a report, and then the report doesn't get used. But this time it actually got used. The information from this research panel went right into the RFA, so that in 2015 and 2016, the Center for Substance Abuse Treatment put into its adolescent portfolio and its young adult portfolio that states may now use some of the money coming from CSAT to introduce medication-assisted treatment for youths 16 and older, as well as psychosocial treatment. So that was really a step forward.

What are some of the issues that this brings up for us that we need to talk about going forward? Well, one is, remember what we said about the importance of parents? We know the importance of family-based treatment for youth, but we have the issue of parental consent. So it's just an interesting conversation to have about the role of parental consent when we talked about it for psychosocial treatment and youth being able to access treatment without parental consent. Now we're talking about youth using medication-assisted treatment without parental consent, and knowing what we know

from the past slide, the role of the family and the need for that to help the youth. So it's just a nice policy piece to talk about.

Another piece of provider risk. We are now asking providers who went to school and thought they would take care of babies and bruises on six-year-olds, and helping youth into puberty, and now you're saying, "Gee, we'd really like you to administer medication-assisted treatment to the youth that you're working with." So we have a whole other challenge in trying to get our pediatricians, our nurse practitioners, when we get the ancillary services that Kim talked about, comfortable and ready to work with medication-assisted treatment for this population.

We know that we have huge issues in youth engagement, and then we have issues in youth compliance because this is medication. You have to do something proactively on a regular basis. So we know that we have to work on that. I think we have to get in front of the backlash that we could expect from the issues around the child psychotropic medication issues. You know the discussions that we've had for the past 10 years about overuse of prescription medications for youth with mental health disorders. So we need to anticipate that and be ready to talk about that.

Workforce and training, again, our medical staff out there, our behavioral counseling staff -- well, SAMHSA has been working for 15 years to introduce evidence-based practices and take what NIH develops and get it out to the field. We are still having significant struggles just getting evidence-based talk therapy out there used, reimbursed, trained, with fidelity to the program. We're still working very hard on that. So given that, we now have to also introduce our behavioral counseling staff to the understanding that they will be working in collaboration with the medical community, which, for many people, will be a first. So that's another big issue to look at.

We also need appropriate and available recovery services and support specific to this particular population. I say "population," but there are two populations because when we're talking about adolescents, what they need and what recovery looks like for them can be very different from recovery for young adults. And different, again, for recovery for older adults, so we have to split that out. We have financing and organization of care. There is a lot going on. I happen to be recently in a state meeting with the substance abuse people in the state, and they said to me, "Oh, look, across the hall. That's the meeting where they are designing the health homes for our state for kids." It was like a pause, and I looked around and I said, "Well, you're everybody who is anybody in the state here for substance abuse for youth." I said, "So if you're here with me, who is across the hall talking about substance abuse in the health homes?" It's just a dead stop. And of course, nobody was. The help home was being designed strictly for mental health. So it's just something that needs to happen. This was within the last few months.

We have major changes in the way we're funding things with certified community behavioral health clinics and different ways that we are organizing and providing both penalties and incentives to providers, and we need to think about that. Finally, we need a lot more research and a lot more evaluation. Research is NIDA's job. We know that, but we need them to help us with genetic predisposition and going further with a lot of the material that we talked about this morning. Looking at combination therapies. We don't know. We have almost no idea of medication-assisted plus what? Do I add ACCRA? Do I add contingency management? Do I add seven challenges? And will it make a difference if I pick one over the other? We haven't had any of the research yet.

And finally, effective implementation. I think that's a role where SAMHSA can really step in by making sure that our evaluations are really good, strong evaluations that will stand up to scrutiny and making sure that we're evaluating the implementation of the

evidence-based practices out there in the field. So we too can contribute to the literature. We're not doing the research, but we are doing evaluation that, from 1995 to 2005, SAMHSA was the leader in putting evaluation information out into the scientific research. We can do that. We can do that again.

So those are just some of the major pieces that I think we can think about for this population. I want to thank everybody that helped me because Tom invited me and then, of course, what do you do? You pick up the phone and call your friends and say, "Ah, I have to do this talk. Talk to me." And all these people were generous with their time. They talked to me and helped me prepare for this presentation. So thanks very much. I really look forward to the discussion. Thank you.

### **Agenda Item: Council Discussion**

DR. MELINDA CAMPOPIANO VON KLIMO: Thank you very much. I think we can just open up to questions in the room and then in a minute, give an opportunity to folks on the phone. Since we only have two mics up at the front of the room, I'm going to say as little as possible so that our speakers can communicate more effectively.

Questions?

MR. ARTHUR SCHUT: I don't have any questions. I have lots of comments. We can actually probably have a two-hour or three-hour discussion and briefly touch on what the issues are from my perspective. I'd like to talk just a little bit about the idea of resistance to treatment. I really don't think anybody resists treatment. I think that there are people who have a difficult time seeing the difficulty that they're in. There is a lot of ambivalence. There is a part of them that knows that they need assistance, and there is part of them that thinks that they don't. I think conceptualizing that as a resistance is

something that ends up with us making interventions that are not appropriate for folks. I would encourage us to think about it as ambivalent, as opposed to resistance, in terms of what's going on.

The other issue we have, frankly, is access. You alluded to the issue of access, but if you want treatment and you're an adolescent or an adult and you want to get in, you have difficulty doing that in a timely fashion. I'll hit all my high points, and I promise not to take more than an hour. I think there are issues around medication-assisted treatment. In the rest of healthcare, there is no discussion about medication-assisted treatment being an evidence-based practice. We don't need to have that discussion. We seem to need to have that discussion in our field because we have had, traditionally, beliefs that medication is bad or that medication is bad because it "substitutes a substance for something else," et cetera. And we really have ignored the evidence.

There are issues around prescribers about having access to prescribers. There are issues around sophisticated prescribers. There are many prescribers that have no interest in participating because they perceive themselves as having a great deal of liability, and that includes primary care health homes. Prescribers don't really see themselves of being able to do this and wanting to do this. There are some limits, in terms of who the prescribers can be. In some cases, nurse practitioners who are prescribers, are not permitted to prescribe certain drugs. It has to be only MDs or DOs. And that's a problem right now.

There was an example of 10 percent of a grant being allocated to medication-assisted treatment, which was \$52,000. If you're talking about antagonists like Vivitrol, extended release, that's going to buy you 52 doses. So the whole issue of financing, rates, where you get the money, and how you access that. In Colorado, for example, the only

Medicaid-managed care companies that manage the behavioral health benefit, the only medication in the behavioral health benefit is methadone. So if you wanted buprenorphine or Suboxone, or Vivitrol, that's in the physical health. The pharmacy benefit is not in the behavioral health benefits. And you can't draw down on that if you don't have an MPI number that is a physical medicine MPI number, not a behavioral MPI number. And then you have to find the Medicaid formula where it pays for that. You got some issues around getting access to payment for medication. When the medication is expensive and you have no prescribers to prescribe it and administer it, access becomes a huge issue.

We do have pockets, I think, in the field, who continue to resist. Resistance is an appropriate word for this point. They resist using medications or see medications as bad. My perspective is if you refuse to use something that is evidence-based and is efficacious, then you're engaging in malpractice. We ought to just define it as that nationally. If you don't want to do medication-assisted treatment, you're engaging in malpractice, and you shouldn't be allowed to practice, whether you're a counselor or a community-based substance use disorder program, or any other kind of entity. It's just simply inappropriate, and we ought to talk about it that way.

Integration is an issue. Integration of healthcare is an issue. There are two cultures involved, and both cultures have issues, both in terms of the fern and lamp people who need to have an hour to talk to somebody. On the behavioral health treatment side, they can't figure out how to do an intervention in 15 minutes in a primary care. That's possible, and we can do that. On the medical medicine side, they have sort of a hard time around how to address these things. We have a continuing issue around fidelity and workforce, but we don't reward anyone for performing fidelity checks. Fidelity is not an easy thing to do correctly and to monitor correctly. It requires resources, but we tend to underfund that piece of it or have no interest in funding it. So basically, we don't

get fidelity, in terms of what we do. I'd be glad to talk more about any one of those items, but I don't want to make you suffer through anymore.

DR. LORI SIMON: I also have a lot of comments, but I'll try to keep it to under three hours. The first thing is that when I was, as I mentioned earlier, I was working with homeless organizations in New York City and, of course, came across a lot of substance abuse issues. My experience has been that upwards of 95 percent and higher of patients who were having a substance abuse issue were also self-medicating. This was not, "Oh, wow! Gee, isn't it great," feeling good and stuff. They were self-medicating. And what they were self-medicating is a combination of psychosocial. It was either circumstances that they grew up with, circumstances as an adult, an emotional area, and also the social services.

I mean, if somebody is homeless, you know, sometimes the biggest thing I can write on my prescription pad is how to help them get services for their living condition or how to help them get furniture, for example. So I echo the comments I made earlier that this absolutely has to be a multi-pronged attack. I'm a physician, and so, of course, I am a believer in the need for medication. But that's only part of it. When I'm treating a patient, I'm one of the psychiatrists who actually does therapy too. So I always tell them that a medication is not a panacea. It can help. It can help you function better. In the case of an actual addiction, it can help you get past that. You know, but that's only the start. It's got to be a multi-pronged attack. It's the underlying issues that have got the person being there. As I said, I was working, at the time, with the homeless and underserved, but you see this also in affluent areas because there are other issues that are particularly on adolescents. They have the financial assets to get some of this stuff. That is extremely important.

The talk about evidence-based, I know that's been a big -- I don't want to use the word

"buzz word" because I want it to mean evidence-based. I think it's extremely important. But you also have to be careful about only funding evidence-based because there are a lot of good treatments out there that need the funding to show that they are evidence-based. So you don't want to bypass programs and things that we kind of know are working and we see it's working, but they haven't gotten that evidence-based status. So it's extremely important not to forget those types of treatments as well.

The collaborative ability with primary care folks is absolutely critical because --

DR. MELINDA CAMPOPIANO VON KLIMO: Lori? I'm sorry to interrupt you, but we'd like to take a moment and finish Ms. Ali's presentation of the video that we weren't able to share earlier.

DR. LORI SIMON: Okay. Can I just make one more comment for two minutes?

DR. MELINDA CAMPOPIANO VON KLIMO: Sure.

DR. LORI SIMON: One minute. The insurance company issue is a huge, huge problem. What's happened in this country is -- well, I'm talking more about the commercial insurance companies, you know, Medicaid and Medicare are other issues. They are running rampant right now. They are for-profit companies, and they do not care about patient care. So trying to get prescriptions for patients that we know are needed is becoming an increasing problem, and it needs to be addressed.

DR. MELINDA CAMPOPIANO VON KLIMO: Thank you. I'm sorry about that.

DR. LORI SIMON: That's okay.

**(Whereupon, a video was played.)**

DR. MELINDA CAMPOPIANO VON KLIMO: In the time that's remaining, Ms. Ali, did you have anything you wish to say about the video that you weren't able to do because we didn't close your talk the way we planned?

MS. OMISADÉ ALI: Not really. It's just that, again, we can talk about the use of alcohol or other drugs as a healing way, but we also need to talk about the resilience of our people. We have a surprisingly devastating impact in our native communities of the use of alcohol and other drugs for medicating. I think that people need to understand that we've got the highest rate of abstinence in any ethnicity in this country as well. So we do have warrior spirits. I really believe that if we focus on healing, as some of the folks as Don Coyhis has done, that we can heal our communities and to focus on what happened to us rather than what's wrong with us is the key. Thank you.

DR. MELINDA CAMPOPIANO VON KLIMO: In the remaining few minutes, I wonder if there are any comments or questions, either in the room or on the phone, pertaining to the populations that were discussed by the presenters.

MR. MOHAMMAD YUNUS: Hello, this is Mohammad Yunus. I have a question for OmiSadé Ali. You said that there was 695,000 persons who are users of painkillers and heroin in 13 years. What was the reasons for the sudden increase in the use of drugs? Is there any change in the socioeconomic or family situation?

Number two, the question is that the intervention strategies that we are using for that population, are they considered responsive and competent?

MS. OMISADÉ ALI: To respond to your first question, Mohammad, I believe that we

are getting better at recognizing that data needs to be collected. It hasn't always been collected. I will say that there are still massive problems, socioeconomic problems in our native communities and our tribal nations that the data collection has become better. There are still challenges with sharing of data in tribal communities around things like incidence of HIV. The CDC does not have any of our data. The data is not shared between government organizations and tribal organizations. So I think just the data collection -- I don't think anything has really changed, for myself, knowing that the problems and the challenges have always existed in our communities, but I think that sharing is better.

We are also recognizing that in order to heal, we have to reach back into our root system and do what works for us. So you can't take a Western medicine into a tribal organization and expect evidence-based practices that have never been normalized on indigenous populations to work with those populations. We're often told well, you know, you can adopt them or change them. But once that's adopted or changed, it also decreases the validity of that practice.

MR. MOHAMMAD YUNUS: The evidence-based practices are not particularly in demand to get published.

MS. OMISADÉ ALI: Exactly. Exactly. So people like Don Coyhis and White Bison and the Wellbriety Movement have brought to the forefront that people need to heal in a cultural context. There is nothing wrong with that. Myself, I got clean sitting in a talking circle and talking with other people. I didn't have to explain intergenerational trauma to them. We all had that root experience. So it's very healing to be with others and to be able to connect on a cultural context. Absolutely. Thank you for those questions.

MR. MOHAMMAD YUNUS: Thank you.

DR. MELINDA CAMPOPIANO VON KLIMO: Mr. Hill, do we have more time for questions, or do we need to conclude this session?

MR. TOM HILL: You need to conclude.

DR. MELINDA CAMPOPIANO VON KLIMO: Okay. Well, please accept our thanks for your very informative presentations.

MR. TOM HILL: Thanks, Melinda. Thank you to Doreen and to Sadé for their presentations. We will have ongoing discussions throughout the day. So if you have some ideas or comments, jot them down because we'll have time at the end of the day as well. We're up to break time. It's 10:45. We'd like to come back at 11:00.

**(Whereupon, at 10:45 a.m., a brief recess was taken.)**

**Agenda Item: TOPIC: Substance Use Disorders and Criminal Justice Reform**

MR. TOM HILL: Please take your seats. Welcome back. We're on a fairly tight time schedule because we want to get this session done by noon for lunch, and then at 1:00, Acting Administrator, Kana Enomoto and Acting Deputy Administrator, Amy Haseltine will be here at 1:00 to 2:00 to talk with us. That's why we're adhering to a nice, tight schedule.

Welcome back. We're going to continue our theme of integrating medication-assisted treatment and peer support. This time it's focusing on Criminal Justice Reform.

Carolyn Hardin from the National Association of Drug Court Professionals joins Andre Johnson, President and CEO of the Detroit Recovery Project for this discussion. Shannon Taitt of CSAT's Division of Services Improvement (DSI) will be the moderator. So I'll turn it over to Shannon.

MS. SHANNON TAITT: Thank you, Tom. I appreciate that. I'm excited to be a moderator today because this really carries over from the presentation that we just had and how important it is for us to get a better understanding of trauma as it relates to people with substance use disorders. So no population can really shed light on our need for reform or in the criminal justice population and their history of trauma.

According to the Psychiatric Rehabilitation Journal, research consistently demonstrates that substance use disorders are more common among persons in jails and prisons and other criminal justice settings than among the general population. They get arrested more, and they end up spending more time in jails and prisons. So we have a great group with us today that will help us to shed some light on this subject and really talk about the increases that Congress is having with funds related to Criminal Justice Reform and how their programs really impact what we're doing.

So I'm going to start with Carolyn first, and then we'll turn it over to Andre from there. If you are interested in their bios, they are on the table over there on the corner. So at this time, I'm going to turn it over to Carolyn.

MS. CAROLYN HARDIN: Good morning. As she said, my name is Carolyn Hardin. I am the Chief of Training and Research for the National Association of Drug Court Professionals. In that role, I oversee all of our curriculum development, as well as what we do out in the field in training, and our research initiatives for the three divisions that operate under NADCP.

So under NADCP, there are three different training divisions, the National Drug Court Institute, the National Center for DWI Courts, and Justice for Vets. I'm going to talk to you today about drug courts and part of our work in Criminal Justice Reform. When we heard this whole big wave, as many of you all have heard today about Criminal Justice Reform, oh, my goodness, it's a new thing. It's really not a new thing. Criminal Justice Reform, as we like to say, is drug courts in action. So when you think about what we've seen -- I have a PowerPoint and I'm going to ask you all to indulge me because I'm going to fly through it to get to some basic big points because I know we have a time constraint.

Over the past 25 years, we've learned some things in this country. One of those is that drugs drives about 80 percent of crime that we see. As a former probation officer and as a former person who did evaluations for drug court, one of the things that I've seen over the years is that no matter who we bring in to, you look back and connect where they came from and what they did. Instead of asking what did you get arrested for, and we start to really get down to it, a lot of our folks have been using drugs and alcohol. Not only that, a number of the folks we see in the criminal justice system, it's not just drugs and alcohol, but mental health issues. So what you look at what we are seeing, a lot of folks with co-occurring disorders coming into the system, requires us to operate in a different way.

The drug court model kind of does that. It brings together a multi-disciplinary team. So you have a judge, prosecution, defense. You have treatment providers, probation, law enforcement, court coordinators, case management, clinical as well, coming together as a group to determine how do we help this individual make behavior modification change?

One of the things, too, that we are pushing, as we go out and we train with our courts, is that we do not want them to just be focused on getting sober. What we talk about is we need to make sure our people are getting into recovery. So that's a whole different set of things that they need to have as considerations, as opposed to folks just walking out of your program a year from now. Many drug courts are about 18 to 24 months. They walk out, and they say, "Okay, he's sober." But if he ends up back in the system, it means we didn't help him or assist that individual with making long-term behavioral modification changes. So those are the big focuses of what we do.

So one of the things that we talk about in this model is that if we just put people in prison, one of the things that we've learned over time is this: when you put them in prison and you don't address what the main issues are, when they come out of prison, guess what? They will end up back in prison. So one of the biggest focus for us in drug courts, and especially at NADCP, we believe our role is from entry to reentry. So one of the things is that we have to provide and assist communities.

There are specific populations because we have now over 26 years of research of who drug courts actually work with. Everybody doesn't need drug court. So we have to help communities identify what are the different intercepts in this model, in the continuum of criminal justice that they need to build in their community because we know that if we just put people in treatment in prison, we don't get the same impact. It's the same as if, for our populations that we see, if we just give them treatment and we don't address some of their other issues. What we talk about in the criminal justice system is folks come in with what we refer to as RNR: risk, need, responsivity.

So when folks come in, they have substance abuse and mental health issues. Let's put that up there. Many of our folks that come in, they are homeless. They need teeth. They need shoes. They need some basic things. It's very hard for you to sit in a room

and tell somebody you got to go to treatment. And I'm trying to figure out where I'm going to sleep tonight and what I'm going to do with my kids. So we have to teach our folks, our court personnel and everybody on that team, you've got to address all the issues when they walk in the door. We can't say no, no, we're just going to -- that's not an option. It's integrated care across the board even addressing those other things. Because if we don't, what we know from the research is that those are criminogenic needs, and folks will go back to doing what they used to do. So we have to address all of those.

One of the things that we try to get across is that it's beyond a philosophical base of punishment or rehabilitation. When we are working with the courts, and especially with a lot of our attorneys, we have to help them move through this process of, "Well, why can't they just change?" We provide them with a lot of training on psychopharmacology. What's going on with the drugs in the brain? It's not just a real issue; it's a disease issue. So once we get them there, they're like, "Oh, okay." So then we have to get over the other hurdle of -- for many of the many folks that we see in some of our programs, it's not rehabilitation, it's habilitation. We have a lot of folks who come to us with nondaree (phonetic); there ain't nothing to work with. You're talking about "re" and they're just looking at you like, what's that? So we really have to get our folks to the basic principles for many of our folks; it's habilitation.

So I like this quote that was authored by one of the judges. He wrote this book and he said, "We need to punish the offenders we are afraid of and treat the ones we are mad at." I'd like to take that a step further. When folks come to us, we have to look beyond what the offense is that they have done and look at the need. Because there is an opportunity for us to address all of the needs when they come into our system. And the great news is what many of you are doing around this table. Some of you are doing some great work, but they'll never get to me in the system. So that's a piece that we

hope to see also as we go forward.

So what we talk about is courts being a problem solver. People come to us and it has not worked. We have years and years, where if it worked and I said, "Hey, I'm going to take your kids away if you don't stop." And we took your kids away, and you just magically stop; that doesn't happen. We know that this is a disease issue. We know that it is chronic. It is ongoing. I always say this. I was in Alabama yesterday doing their statewide association training. I told them, "You don't have conversations with folks about when you're going to stop your diabetic medication? You've been on that for years." We don't have those conversations. Doctors don't have those conversations. Courts don't have those conversations, and that's not your role; and that is not a conversation you need to have. Our job is to address the needs that folks come with and connecting them with community services.

One of the things that we talk about in our training is you can't be the messenger for everything because there are other people out there who have that message and can bring that message in a more appropriate way. The other thing is, we have to make sure that the folks who come to our programs get connected in the communities so that they have those natural supports. That they don't feel like that life ends when they complete these programs. They, again, have been in these programs for a period of time. So we believe drug courts work. We've got bumper stickers. We've got a number of MAT analysis that we can show you and say, "Hey, this works." But if you don't believe me, check out the research.

There are a lot of studies here, but I'm going to kind of skip through those because there are a couple of places I want to get to. I want to let you know that back in 1997, the 10 key components were work-related, and they were basically the outline of what drug courts should do. They are different iterations of these components because

there are different models to that. So we started out with the adult courts when they first began in 1989. Today, we stand with almost 3,000 drug courts in existence. A number of those courts are DUI courts. We have family dependency treatment courts, juvenile drug courts. We also have our newest ladle of drug courts, our veteran treatment courts. We also have tribal healing to wellness courts. So it was really great to sit here and hear her talk about all the tribal work because I do all the tribal work in our office.

So we have all these different iterations of us being able to take this model. The great thing about these 10 key components is that they were built so that any community could get them and adapt them. One of the things that I find interesting is that from my research, back in 1997, a group of folks got in a room. There were a bunch of judges, prosecution, defense. They had a couple of treatment providers, and they all sat around the table and they made these up. After the research, I'm like, "No, you need a hypothesis. We need to tell you what we're looking at. We need to go study it. You made up some stuff," and then we find out years later, they actually got many of it right.

So one of the things at the National Association of Drug Court Professionals that we came out with in 2013 and just released in 2015, are national standards for adult drug courts. No longer can our courts go in or come around to folks and tell you adult information and bring up to your graduates. "Let me tell you my story about how great it was." Because somebody is going to ask you at the end of the day, what has your drug court done for me? We want them to be able to answer those questions. Drug courts need to have a criminal justice impact, as well we see now so much of a bigger intersection with public health, and we also should have an impact on public health. One of the things we've come up with is what we call our Adult Drug Court Best Practice Standards. Volume I came out in 2013. These are the first five standards. It talks about target population, historically disadvantaged groups, the roles and

responsibilities of the judge, incentive sanctions and therapeutic adjustments and substance abuse treatment.

One of the things I just want to highlight real quick is that when we talk about who is appropriate for drug court, it is high-risk, high-need folks. What do we mean by that? High risk are folks that have multiple interactions in the criminal justice systems. These are folks who when you do a risk assessment on them -- and this is not necessarily propensity for violence. That's not what we're talking about. We're talking about folks who would otherwise return and come back in your system over and over and over again. These folks meet what we call high risk. There is a whole elaborate evaluation thing I can get into, but I'm going to forego that.

One of the things I want you to know about risk and what the research tells us, which is real critical, so I want you to repeat it after me. Risk is contagious.

(Audience members comply.)

MS. CAROLYN HARDIN: I need y'all to say that one more time. Risk is contagious.

(Audience members comply.)

MS. CAROLYN HARDIN: Risk is contagious, and that's important because if you take low risk offenders and mix them with high risk offenders, you will make them worse. The only time I recommend that is if you have a shortage of crime. Most of the cities we go to do not have a shortage of crime. So that is not a behavior they need to engage in. When we talk about high need, what we're talking about, oftentimes, if you think about it this way, when we talk about need, we're looking at clinical issues. So we're talking about the severity of the substance use or the mental health. We want

them to be looking at -- and what the research shows, folks at that high end who are at the severe end, do extremely well in these programs, and that's who you should be focusing your resources on. So we talked about that.

I want to get to Volume II. It's called Complimentary Treatment and Social Services, Drug and Alcohol Testing, Multi-Disciplinary Team, Census and Caseload, and Monitoring Evaluation. Our goal is to hopefully have additional volumes to come out, but these are the ones where we had research. We pulled together the best researchers and said what's out there? And we searched, and we searched. Basically, it had to meet statistical research criteria to actually make it into the volume. There were a lot of things that we wanted to include, but we did not have research on. We actually held a research roundtable last year at our conference. We brought in NIDA. We brought in BJA. We brought in NIJ. We brought in all the federal heads to say here's what we learned where the gaps in the research were that need to be hopefully further funded someday down the line.

What I'd like to spend some time talking about is our Standard 5 and our Substance Treatment Standard. We talk about medically-assisted treatment. If you've seen the *Huffington Post* or any articles lately, there has been lots of attacks that drug courts don't take people with MAT. Our goal at NADCP is to make that basically an untruth. I will talk to you about what the issues are for many courts that don't have MAT. Number 1 is access.

In a lot of our communities, our courts are located in rural communities. There is no doctor. If you're living in a large city, yep, there might be a methadone clinic, but if you live in a town of 400 or 4,000, that doesn't happen. So access is a big issue. The other issue is cost. Cost is a major issue. It is great when I do the training, and I talk to them about, "Well, you can write these to SAMHSA," and, "You can do such-and-such." Our

folks don't have grant writers. Our folks aren't getting those grants.

So there's a whole other set of issues that we see on that end for our populations in which we are working with. So we talk about medication-assisted treatment in that it can improve outcomes and that it should be a part of the regimen. We also had a board resolution that was passed on the availability of medication-assisted treatment. Basically, what our Board said was that everybody should be using MAT. That it is an evidence-based modality that should be included.

So there are a couple of things I want to focus on that we're doing. We have an online training tool that is coming out, and I passed out to you guys a little handout that says, "Educating Drug Courts on MAT." What we did was we partnered with triple AP, the American Academy of Addiction Psychiatrists to help develop for us our online course. We have been providing at our statewides, our national conferences, and trainings for drug courts for many, many years on medication-assisted treatment. What we now have done is put online a course that we hope to have launched. Everything is almost done. I watched all the videos this past weekend, making edits. So we're hoping to have this up and out and available to the community by the end of May, right before our NADCP conference.

What this does, it breaks it down to you. There are a couple of issues that we went into developing this curriculum that we needed to address. So if you can imagine, I work with a lot of lawyers. When you're training lawyers, they like to get real wordy. So it's really fun because when we did this curriculum and we sat down, we have a senior judicial fellow; his name is Judge Bill Meyer. Judge Meyer is retired, but one of things he does for us is he tracks all case law as it relates to drug court. So on our website, we actually have a tab that says "Law." You can go in there and find all case law as it relates to drug court and drug court practices.

What we have been doing for the past couple of years is we've collected questions that have come from our field about medication-assisted treatment. So at the end of every one of these webinars that people will see, there are frequently asked questions that we got from the field. We ask the doctors to answer those questions. We gave the doctors some very specific requirements. One, you need to explain to our folks how you, as a medical doctor, go about your process of trying to figure out which medication folks need to be on. Now, when I asked them that, they were like, "Oh, no, no, no. We can't tell you that." I said, "Well, if you want these folks to buy in, you're going to have to tell them something. And you can say in clarification that these are general practices. These are different things, but they need to know what folks are giving consideration to so that they have an understanding of it."

So we asked them to do that, and they did that. The other thing we did was when the course goes online, each one of our folks will be able to take a quiz in order to get a certificate and their little hours if they want to pass. What we also did was at the end, we will have on their website, you can download the frequently asked questions and be able to use those in your program to answer other questions. The other biggest issue that we hear from drug courts about why they don't want to do it beyond access is diversion. We have a lot of those folks. It's always fun when they call me and they tell me, "Well, we got folks coming in who are addicted to Suboxone." So I say to them, "I bet you they're not addicted to Suboxone. I bet you they're using that Suboxone so they don't have to go through withdrawals. There's a difference."

So we made sure that we included in our online website to address their questions, such as strategies to reduce diversion. We talk about that. We give them the pros and cons for all of the medications so that they have an understanding of that. The other great part was we had our own judicial fellow to do a presentation on the legal

landscape. We address and talk about you cannot have blanket prohibitions. If you have blanket prohibitions, we explain the case law. We explain all this to them. So it's quite interesting to see when they hear that presentation because we've tested it out numerous times and they're like, what? Yeah, you're not a doctor. You can't do it. So we make sure that's very clear.

The other thing, along with this curriculum, is we're going to have what's called a how-to guide. How I met Dr. Johnson was at the triple AP conference, and I was talking about how we're going to develop this how-to guide. And she emails me this document by NIATx that is basically a how-to guide. And I was thinking, I was like, "Oh, dear God, bless her," because it saved us a lot of work. We're going to put in specific pieces that relate to drug courts, but there's a lot of work done. For our population, we can't say to them go out and do MAT. They don't understand that. We have to tell them here is the steps you've got to do. So we're doing Step 1, Step 2, Step 3, Step 4. That will be how you do it. The great part about it for us is we receive funding from the Office of National Drug Control Policy to develop this curriculum. And we do 180 training events a year. We provide training for between 28 to 30 statewide association meetings. So we are providing MAT at all of those trainings that is available for them.

I think that I'm out of time. Thank you all for listening.

MS. SHANNON TAITT: Thank you, Carolyn, for that very informative presentation. At this time, I want to turn it over to Andre Johnson, who will discuss "We Are One: Our Collective Responsibility." Andre.

MR. ANDRE JOHNSON: Sure. Thank you. Thank you for your presentation, too, Carolyn. I came up with this title, "We Are One" because I realized that running a recovery community organization, just let me say for you all who don't know, I am a

person in long-term recovery. That means that I haven't used any drugs or alcohol since July 13, 1988. And if it had not been for recovery --

MR. JOHN PAUL MOLLOY: A baby. A newcomer.

MR. ANDRE JOHNSON: Right. You guys are at 50 years. If it had not been for recovery, I certainly wouldn't be here today because when I was using, I was stuck in a three-block radius. And I certainly wouldn't be able to lead a recovery community in Detroit. I've been leading this organization for over 10 years now. Every year I'm always embarked with something new. Particularly, a couple of years ago I was approached by a juvenile drug court, and they said, "We need a little help writing this SAMHSA grant." I was thinking, "Sure, I'll help you write the grant." Consequently, our Third Circuit Juvenile Drug Court had received the grant. I think that was a three or a four-year grant.

One of the things I realized is I had previously done some training for about a year for the National Drug Court Institute. So I had a lot of familiarity and exposure to the whole drug court concept and the process. In fact, I was part of some of the teams that first started in the City of Detroit. One was the adult drug court. When it was created -- we don't have the history of the Detroit Recovery Project. I think Fresh Start was the program that was targeting prostitutes in the City of Detroit. As you know, most women who are prostituting and walking throughout the belly of the beast, they're not just doing that for the money; they're ultimately doing it to support their drug habit. So it only made sense that a recovery community organization would partner with the drug court to assist these women who need recovery.

The Wayne County Jail Code Program was a funded program targeting individuals who have co-occurring issues. There are very high recidivism rates as it relates to people

who have dual disorders. In the State of Michigan, our mental health institutions were closed down several years ago. So our county jail system is now warehousing the co-occurring individuals in the City of Detroit.

So some would ask why involve peers? Why involve peers? The true question would be why not involve peers? Because when we talk about at-risk youth, we know that at-risk youth are the children of people who are in recovery. So I found that it is very, very important to work with children. Most of these children have been displaced in the foster care system. Some of these young people have high recidivism rate, in and out of the juvenile justice system, and consequently, failing in the school system.

So when we talk about peers, we know the value of peers is the fact that peers have lived experiences. Peers tend to be nonjudgmental when we see individuals who need services and/or help. One of the beautiful parts is it is a cost-efficient component. Next slide, Aisha. I like her name because it goes to one of my favorite songs. Don't ask me to sing it.

So this just gives you some demographics as it relates to Wayne County. I think we are one of the top seven counties in our country. We have a population of 1.9 million. Approximately 15 percent of the population is between 13 and 17 years old. The Third Circuit Court is one of the largest circuit courts in our state. And in 2010, there were 9,530 delinquent complaints in the juvenile division. This is a picture of the S.T.A.N.D Juvenile Drug Court team. Obviously, you can't have a drug court without having a judge. So we have three referees, a drug court program coordinator, and we have three probation officers, tutors. We have recovery peers and one administrative assistant.

The characteristics of the youth, 93 of the youth at 84 percent males, 16 percent

females. Approximately, 61 percent African American, 28 percent Caucasian, 1 percent Hispanic and other, and mixed. The other characteristics consisted of 99 percent. Most of them indicated they had been smoking marijuana recently. Ninety-five percent of the drug court enrollees scored a Level II on the gangs. These are some of the goals and objectives of the actual S.T.A.N.D juvenile grant that we have with SAMHSA. Goal Number 1 is to enhance support services to meet the needs of the S.T.A.N.D participants and their families offering many of the services to meet the assessed needs of the participant and his or her family, including co-occurring disorders, academic tutoring, life skills, smoking cessation and HIV testing.

We're going to go through the goals, and then I just want to just kind of keep moving as quickly as possible so I can stay on target with the time. Enhance substance abuse treatment services and its effectiveness, and improve the wellness, health, and quality of life of participants. These are some of the evidence-based best practice curriculums that our peers are using, particularly as it relates to servicing the young people that is part of the drug court, which is motivation enhancement and adolescent community reinforcement, and the family supporting their work.

These are some of the early identification upon placements of the eligible participants. First of all, it is a volunteer program and basically, if the youth indicates that they want to be part of this program, their records will be sealed. So there are four phases that exist in the drug court. Phase I is a very, very intense program. There are lots of requirements. Meaning, the juveniles appear before the jurors. They have to take at least two or three drug screenings per week. And then obviously, they receive recovery support services from the Detroit Recovery Project. Our agency is very excited to be an exclusive agency to be responsible for these young people throughout our entire county.

Also, there are behavioral assessments that are done, mental health assessments that are done. Case management assessments are done as well. All these things happen weekly. So as they transition from Phase I to Phase II, some of their participation levels begin to decrease with progress. A lot of that is dependent on 1) passing a drug test, and 2) their progress in school, and 3) their progress at home. What is reached through this phase is obviously the frequency of appearance continues to reduce week-to-week, the more we get from Phase 1, 2, 3, and then the fourth phase is the aftercare phase, which is the contact with the S.T.A.N.D team is reduced significantly.

Sometimes it can be a bit overwhelming because our county is very, very big. It's comprised of rural kids, suburban kids, and urban kids. Obviously, people have different means. Some people have transportation. I have seen several kids who are part of this juvenile drug court were children of parents that we were serving at the same time. So there are lots of challenges around, you know, case management services are actually needed for these young people. You know, meeting kids in the wintertime who may not have winter boots, may not have a winter coat. When they go outside, it's based on if their sibling is home because they're trading coats and trading shoes and trading gloves. We have very, very harsh winters in Detroit.

I'm excited about our team. As you've seen, the five peers are people in recovery. And the people in recovery are very, very passionate as it relates to helping these young people accomplish and achieve recovery. Drug free is the way to be. Judge Lloyd is probably one of the most phenomenal judges I've met in Detroit. She runs the adult drug court. Their drug court team was once identified as the number one drug court in the nation. She is very adamant. And that's putting it lightly. She understands recovery. There is nothing like being in the presence of a judge that really understands what recovery is and what it's not. She is very passionate. She will call, text me anytime of the day, anytime of the night, and I can do the same to her. What I

appreciate about her is that she will call and say, "Give me the information on this individual who is a part of your program. Is that person actively participating, and what do you think?" She will tell you very candidly, "If you don't do what I say, you will go to my hotel, and you will wear my cufflinks."

So the 36th District Court is one of the largest district courts in the City of Detroit as well. That court has been highly respected to assist people with sustaining long-term recovery. And obviously, she was the lead judge who expressed an interest in working with the women who were walking the streets of Detroit to sell their body to support drugs. That is what we refer to as the drug court Fresh Start Program. That program involved our county sheriffs, and it involved our local Detroit Police Department. It involved our prosecutor's office and obviously, the entire court system. So again, same situation. Voluntarily, if the women complied. We were averaging about two years per program and if they complied, the judge would -- a lot of these women had a lot of tickets, a lot of warrants, but the judge would basically wipe them all out.

This was a cute cartoon. "Stop sending nonviolent criminals to prison. It's either buy new prisons or release 10,000 inmates. What's the alternative?" Let me think about that. Current estimates suggest that as many as 700,000 adults in jail each year have active symptoms of serious mental health illness and three-quarters of these individuals meet the criteria for co-occurring disorders. And I know we still have a whole lot of jails and prisons that haven't really caught onto the recovery model and recovery-oriented systems of care and peer programs can really help to reduce some of the recidivism that exists in our community. Luckily for us, we've been able to leverage and have relationships with our sheriffs because most of our peers have had a formidable criminal background. But because of our relationships, our sheriffs will give our peers access into the jail and work with the people to help the people transition from jail to the community.

Why do we need peers at the forefront of criminal reform? Those are jails, and inmates with co-occurring mental illness, substance use disorders will leave the correctional setting and return to the community and don't have a solid plan on where they're going to be living or how they're going to eat and how they're going to access their mental health medicine and psychiatric treatment. There is no psychiatric treatment plan, so they're using in and out of jail within five to seven days.

So consequently, we had an advocate who was a mental health peer, who actually had gone to the medical director at the time of our mental health system in Wayne County. He actually advocated and he said, "Hey, we need more programs to go into our county jail to provide some intervention for the co-occurring people who actually went in the Wayne County jail." Then consequently, his avocation had resulted in our agency receiving a grant to go into the jails. Part of the condition was to go ahead and use this model, the APIC model. I don't know if you all have heard of the APIC model, which is Assess, Plan, Integrate -- what's the next one? I'm missing something.

So it's Assess, Plan, Identify and Coordinate. Basically, that means you meet with the individuals. So that's an evidence-based practice model because we all know you can't get no funding unless you use an evidence-based practice. So we'll use the model. But we use it using our peers. We had four, on average. We have 244 peers in our county jail. We have three jail systems in Detroit. Our peer program supervisor will enter the jails and sit down with the individuals who have a co-occurring disorder and help them transition back home. We're making sure we transition them back into a friendly living environment and to make sure we link them with their psychiatrist and make sure they have their medication upon exiting the jail system. Part of the problem was people were being released from jail, and they didn't have access to their medication. And then obviously, I'm linking them up with the recovery community,

which was huge.

All right. So I think it's really, really important that we -- and I'm glad this is on our agenda for today because this is important. A couple of months ago I was attending the conference that Shannon was leading, which was great. It was the Atlanta Mental Health Conference. Now, you all see that I'm 6'4", and I weigh almost 300 pounds. So when I fly, I need some recovery when I get off the airplane. So I'm getting on the plane, flying to Charlotte. It was a small plane, so I cringe when I see a small plane because I have to walk on the plane like this, like I got a mental health illness or something. I get on this little plane and I'm like, okay, I'm the only black guy on this plane. So one other black guy gets on this plane. And he is as big as me with dreadlocks. Guess where he sits, Tom? Right next to me.

DR. KIMBERLY JOHNSON: Shocking.

MR. ANDRE JOHNSON: And I'm saying, "Oh, shit" to myself. It's painful enough sitting on the little plane. Then I got another big guy sitting right next to me.

So consequently, I'm flying and I fall asleep and wake up in an hour and-an-half. You ever just be restless and you can't go back to sleep? So I got to get up to use the bathroom. He has to get up to use the bathroom. So he uses the bathroom and he comes out the bathroom with this air spray, "Shooosss-shooosss." So I'm like, "Oh, my God." I just got to go use the bathroom, but now I got to encounter this. So now my thought process is getting worse. Nonetheless, I go use the bathroom.

I come back and sit down. I said, "Where are you from?" And he said, "I'm from Charlotte." And he begins to talk and he says, "Man, I just got released from prison last night after serving 10 years in prison because of the new Obama law to allow

nonviolent offenders to return home." He said, "It was totally unexpected. My mother was crying all night, and I'm just so happy." I mean, he was talking like, real loud. Like, everybody on the airplane could hear him. And I immediately had some gratitude and appreciation for the fact that people are taking a conscious look at criminal reform.

This guy is 29 years old. He spent some of his best years behind a jail system. And I'm really interested in knowing what was his support system like and what was his home life like. I'm hoping and praying that he stays out of this penal system because we know many people have been arrested. The real issue is hardly ever treated, in terms of the behavioral component. So I've talked to the DA. I've talked to law officials of all walks in our community, and now they are all singing the same song. And that song is we can't lock our way out of this problem. We cannot lock our way out of this problem. We have to treat this problem, and we have to make sure that we bring this behavioral health component to the people who need it the most; and we can only do this together. That's why I said we are one. And it is our collective responsibility to work together. I'm very fortunate to have spoken at the Drug Court Conference this past July. And I think it's important that we continue to speak to these entities because I think, historically, we haven't had this conversation with the National Drug Court Professionals.

So I'm excited. Criminal Reform, I think there are so many layers that need to be discussed, whether it's from your local county jail or whether it the prison system as well. Thank you very much.

MS. SHANNON TAITT: Thank you very much, Andre Johnson. I appreciate that. What a wonderful panel we've had to really talk about the Criminal Justice Reform issues. We started with Ms. Hardin and her discussion around Criminal Justice Reform: Is Drug Court in Action. And I think that that was something really powerful for

her to say. And to really end with her topic, focusing on medication-assisted treatment and what we can do to make sure that drug courts are equipped to be able to handle the people that need medication-assisted treatment with the 3,000 drug courts that we already have.

Another great point that Ms. Hardin made was also around how do we encourage long-term behavior change and get people who are reentering the community into long-term recovery. That was another great point that she mentioned. And then, of course, turning over to Andre and his focus really on peers and the importance of peers and other appropriate people at the table to really help facilitate this collaborative approach to Criminal Justice Reform.

So at this time, I'd like to open it up for questions of Ms. Hardin. If you can come back up here to the microphone, please speak into the mics. If you have questions, we'll get people around the table and also in the back of the room, and then we will open it up to the people on the phone. Yes, Sadé?

MS. OMISADÉ ALI: I have three quick questions, Andre. Number 1, what is a referee?

MR. ANDRE JOHNSON: A referee has some of the responsibilities that a judge has. However, I think what happens is the referee writes up the stuff, and then the judge has to sign it. So in the case of like, you violated a sanction and you're going to jail, the judge would have to sign off on it.

MS. OMISADÉ ALI: Okay. As far as the children who you're working with, do you do an ACE evaluation on them?

MR. ANDRE JOHNSON: I'm not familiar with that particular evaluation.

MS. OMISADÉ ALI: The Adverse Childhood Experience screening.

MR. ANDRE JOHNSON: Okay. No, I'm not familiar with that particular screening. Our focus is really the gang assessment to see where they are, in terms of looking at what type of substance they use and why they're using it. Most of the kids have a lot of family issues is what we've seen.

MR. TOM HILL: It's pretty simple. For the folks you're working with, it would be really good to look at.

MR. ANDRE JOHNSON: Sure. Well, thank you. I need to take a look at that.

MS. OMISADÉ ALI: And the third question is you talked about having peers on the team in the drug courts. Are these kids?

MR. ANDRE JOHNSON: No, they are adult peers. I mean, that's a good question and a good thought process. In fact, we are looking at creating a youth component within our agency. That is a youth component of peers in recovery. So we're hashing out some areas right now. When I say peers, I'm talking about adult recovery peers. Peers who are adults who have been in long-term recovery. I think an average person probably has at least 20 years of long-term recovery. And they look very youthful.

MR. TOM HILL: Have you used drug court alumni?

MR. ANDRE JOHNSON: I would say they are prison alumni. Not literally, but, you know, one guy in particular, Rodney, he has a master's in social work from the

University of Illinois, Chicago. Robert Shakan, a long-term person in recovery, he brings a lot of that. So we've trained them on our models because those models that I've shared were the models that were written into the SAMHSA grant.

MS. OMISADÉ ALI: Okay. Thank you.

MR. TOM HILL: Thank you.

MS. SHANNON TAITT: Any other questions? Yes. Could you push your button, please?

MR. JOHN PAUL MOLLOY: Let me make a comment just because I'm getting old. I was on the National Association of Drug Court Professionals Board for its first five years, and it's come a long way. One of the motivations for many of us getting the drug court program going was that in the other field of the CSAT SAMHSA field, the state directors, for example, for block grants, in 1988, only four of the 50 state directors were in recovery. And our feeling was that most were very unsympathetic to the whole business of recovery and very pro pushing the slogan, "treatment works." And the only problem with treatment works, as it was pushed in 1988, was the fact that for people who were afflicted by that, either because they were addicted to alcohol or drugs or they were family members, they simply didn't believe it because relapse was such a part of the recovery process.

So one of the things that Dr. Clark's long stay at CSAT contributed to was changing the terminology. He was not alone. Lots of other people pushed the notion of talking about recovery and recovery works. That's a big step forwards. Most of the judges then -- now, there's probably what, 2,200 drug courts or 2,500?

MS. CAROLYN HARDIN: Almost 3,000.

MR. JOHN PAUL MOLLOY: Okay. Most of the drug court judges were in 12-Step programs, and we recruited them through lawyer's programs. We started the first helping lawyers program in D.C. in 1980. A few years ago when I checked, more than 5,000 lawyers had gotten into treatment and recovery because of an aggressive intervention program. The nice thing about lawyers, doctors, and airline pilots is you really have leverage. We simply say that lawyers, by going into a firm, you've got a member of your firm who has a booze or a drug problem. You got a choice. You get them into treatment now and get them shaped up, or we're going to move to take away his license. And it really works fine. I just wanted to make that comment because what's the sense of getting old if you can't share the advantages of getting old and bring a little history to the table.

MS. SHANNON TAITT: Well, it's not old; it's just wisdom. That's all. It's just wisdom. Any other questions or comments? Yes?

MS. CAROLYN HARDIN: I just want to comment to Tom's question about peers and drug courts. So we do see across the country that a number of drug courts have graduates who become peers. There are two very big programs in St. Paul, Minnesota and in Syracuse, New York. In Syracuse, they had a Peer Recovery Support Specialist grant, and they actually trained folks who went into their alumni association to be peers to come back and work their programs. So they are piloting a program in Minnesota to do that statewide. Minnesota does have one of the juvenile drug court participants go in, and they become peers to their juveniles. So we are seeing that. When we wrote the standards, there was not a lot of research on it, so we were cautious in our precautions with folks. But we are seeing that it is a trend as we talk about the recovery process of having folks to incorporate peers. So we're seeing a lot more of that.

MS. SHANNON TAITT: Thank you. That's really good to know, especially involving juvenile peers. That's great. Anyone on the phone have any questions or comments?

(No response.)

Okay. We have one more question here in the room. Thank you very much. It must be getting close to lunchtime.

DR. ONAJE SALIM: Thank you. I want to commend both presenters. This is Onaje Salim from the Division of State and Community Assistance in CSAT. I had a question for Carolyn. I really wanted to commend you on the work you're doing, in terms of training.

MS. CAROLYN HARDIN: Thank you.

DR. ONAJE SALIM: I've had the experience, as an opioid treatment director, working in liaison with the drug courts, where the judge actually forced premature detoxification many years ago. I would hope that the kind of training that you're doing is changing attitudes and empowering judges to embrace MAT when it's appropriate. How would you gauge the effect of the training?

MS. CAROLYN HARDIN: So one of the things about the training that we're seeing is that we are having some positive impact. We're hoping that with what we are instituting more of this year of our six-month follow-up with the teams that we are training that we're getting more information about that. But we also seeing a trend, too, that many of our states who are adopting our standards as a part of their standards, they don't allow blanket prohibitions either.

So you now will have where judges may have consequences. We don't have consequences for them, but they could in their state. So you actually have a couple of states right now. New Jersey and New York have come out with here are our guidelines. We are working with the State of Ohio who are building specific guidelines as it relates to MAT. So we are being a part of that with different states to go around and help do that. But again, we are also providing for each of the states because we provide speakers for them at no cost. So this year, anybody who asks, I was like, "Oh, we have MAT." "We don't want MAT." Well, you're probably not going to get anything else either. So they kind of want MAT.

So we have a big push of trying to get that message out. Again, what we're seeing, back what you saw back then, we're not seeing so much of that, but our biggest issue is they don't a) understand it, and b) they have been told some different things from their treatment providers. So let's take a stop and think about who their providers are. Some of them are very old school, very this. And so one of the things I had to tell somebody the other day is drug courts don't have a doctor sitting on their team. It's a licensed clinician, whatever that means in that state. So that may be somebody with just years of recovery who has had no formal education or doesn't know what the new - the research says oh, no, that's switching a drug for another drug. And so you have a court that's saying well, that's who we contract with. Their contract is not up, so they can't switch at that time.

So even in the curriculum that we're developing, we're also giving them a request for proposals that have in there, specific questions that they need to ask. So when they go out to look for these providers, they need to know, do they offer medication-assisted treatment? What is their philosophy regarding that? Because the other issue, too, is you have some providers still today, which is sad and shocking, they say oh, you tested

positive two times, three times. You got to go. That's what addicts do. That's what people who use do; they use drugs. We can't kick them out.

So there are a number of pieces. I think you will start to see more of a change because we're telling them how to do it, how to actually implement it. It's not even just how. If they want, they call me and say we don't get it, and I'll send somebody to help them build it. That doesn't cost them anything; we have funding to do that.

MS. SHANNON TAITT: Thank you very much. I think for the sake of time, that is our last question. Can we give one more round of applause to Ms. Hardin and Mr. Johnson for their great presentations today? I'm going to turn it back over to Tom.

MR. TOM HILL: Thank you so much, Shannon. And thank you to Andre and Carolyn for the really informative and thought-provoking discussion. We're up on the noon hour. That means we're ready to break for lunch. We will reconvene promptly at 1:00 p.m. Enjoy your lunch.

**(Whereupon, at 12:00 p.m., a luncheon recess was taken.)**

### **Agenda Item: SAMHSA Acting Administrator's Discussion with Council Members**

MR. TOM HILL: It's a little past 1:00. Acting Administrator Kana Enomoto and Acting Deputy Administrator Amy Haseltine.

MS. AMY HASELTINE: Amy. Amy. Just go with Amy.

MR. TOM HILL: They are here to speak with us. So I'm going to open up the floor. And of course, Tom Coderre is here also. Anybody else?

MR. LEVINE GILBERT: Levine Gilbert.

MR. TOM HILL: Levine Gilbert. Welcome, you guys. I'm just going to turn it over to the front of the room.

MS. KANA ENOMOTO: Good afternoon. This is the time where I'll let you go ahead and applaud me for bringing on such a fantastic leadership team for CSAT. I feel super lucky to be working with such fantastically smart people. We have Dr. Kim Johnson, Tom Hill. I'm a longtime fan of both of theirs, and we're so honored that Tom agreed to come on for the duration of the Administration and that Kim has made the lifetime commitment as the director for the Center for Substance Abuse Treatment.

DR. KIMBERLY JOHNSON: You call it lifetime SES. No, career SES.

MR. TOM HILL: She'll outlive us all.

MS. KANA ENOMOTO: So the Center for Substance Abuse Treatment is at the heart of what SAMHSA does. You guys are super important to us. The staff, the programs, the people, the council deserve great leaders, and I think you do have them. So I'm just really, really proud of that. I'm also proud of the team that we have in the Office of the Administrator. So I'm going to let Amy and the chief of staff talk. Tom Coderre, who you all probably know. You may know him, but now he's chief of staff, and that is a role in and of itself. Both of these guys are doing so much work to help SAMHSA navigate some of the very sensitive waters in which we see ourselves. I just feel like we've gotten top tier talent to go into many of the places that we need the most help here at

SAMHSA. I would like to have Amy and Tom introduce themselves and tell you a little bit about what they're doing here.

MS. AMY HASELTINE: So good afternoon, everyone. Are there people on the phone or no?

DR. KIMBERLY JOHNSON: There should be.

MS. AMY HASELTINE: Okay. Hey, to people on the phone. I'm Amy Haseltine, and I'm truly privileged to get to be a part of SAMHSA. I've been with the federal government for more than 25 years, so I am a career bureaucrat. I really hope to think of myself more of a career public servant because at the heart of being in the federal government and actually at the heart of being in state, local government is this mention of public service. And what better place to think about public service and to execute a mission that involves serving the public than in SAMHSA?

So this is really like the ultimate job that I could ever dream and hope for. In my tenure, I've done work on the IT side of the house. Most recently, writing regulations and setting government-wide policy for grants and acquisition and doing a lot of work in data transparency, data exchange. So recognizing, again, the important work that SAMHSA has to do also involves being sure that we have access to the right data at the right time and in the right format so we can use that information to better inform our strategies, policies, and programs going forward.

Within SAMHSA, what is my current job? I primarily focus on our business operations and the way we actually help execute that mission. So part of what I see my role here is to ensure that as we get up in the morning every day and truck to work, we all have, collectively, the importance of this mission in our mind. What my job is to make sure

that our business processes and systems and policies help us execute that in the most efficient and effective way possible. Because at the end of the day, we want to make the conversation about the strides that we're making in substance abuse treatment and substance abuse prevention.

We also want to make sure we're talking about behavioral health issues. We do not want to spend our time talking about policies and procedures related to acquisition. So the less we talk about my world, the more we talk about your world, the better off we are. That is sort of my charge for success. I'm very, very grateful to be here. I can't say enough about the work that you all are doing, and I look forward to learning from you. I think every day will be a chance to learn something new and different, and I'll do my best to contribute back. So thank you.

MR. TOM CODERRE: Thank you, Amy, and thank you, Kana. This group is not new to me. I have some empathy for where you sit, Kim, at the moment because about a year ago when -- no, about 18 months ago. Well, I can't remember exactly how long ago it was, but whenever Dr. Clark left, Daryl, Kate and I, you know, Pam and Kana asked Daryl, Kate and myself to come down and help out in the Center. We worked with a tremendous staff here. I think it was the first week we were here was the NAC. So it was kind of introduction by fire to this wonderful group of advisors that we have. So welcome, Kim, to CSAT and to SAMHSA.

Thank you, Tom, for your leadership over the last couple of months serving as the acting director. You've been a tremendous asset to the Center. We've received a lot of comments from the staff about the work that's being done here, and it couldn't have happened without your leadership. So thank you for that. Kana wanted me to just touch on a couple of things that I'm doing in my role as chief of staff. In addition to representing SAMHSA with the Department and the White House and some of the

other federal agencies, whether it be on the BHCC or the ICCPUD. They have a coordinating council, or the Interagency Coordinating Committee for the Prevention of Underage Drinking. I was doing acronyms, which I shouldn't be doing with our National Advisory Council.

I've gotten right into the federal speak. I know all the acronyms now. Most of them. Some I still have to look up from time-to-time, but those two projects that we do really help SAMHSA get our foothold and our programs and our educations and processes throughout the federal government. So it's really, really critical, and it's important. I've been able to work with the entire staff here at SAMHSA to represent us on those interdepartmental committees and intradepartmental committees. In addition, we're working on a certain general's report, which is a very exciting project. It's going to be about substance use addiction and health. It's the first of its kind. You guys have been hearing a little bit about it. We're moving quite far along now. We're in our third draft.

MR. TOM HILL: Draft three just got turned in.

MR. TOM CODERRE: We just completed our third draft. So the next draft will actually get a preclearance draft. So this is a real exciting time. We're on schedule to have the report released in September. Just like the mental health report of 1999, 15 years ago or more, this report we're hoping will have the same impact on the field to really help the American public and practitioners who are working in the field to know what the best science is. Not just know, but be able to use it so that it's put forward in a consumable fashion. So we're working very, very hard on that.

In addition, Kana has asked me to work with our stakeholders, our behavioral health stakeholders. Both on the mental health side and on the addiction recovery side to try to make sure -- because they are our constituents. We want to make sure that we're

hearing from them on a regular basis. We know what their concerns are. We learn from them, and we help educate them about our programs and processes. One of our most important stakeholders, of course, is Congress. So we're spending a lot of time on the Hill, whether it's in staff briefings or having coffee with staffers and members, or communicating SAMHSA's priorities. We're doing a lot.

Kana is up there on a regular basis briefing staff members and committees about our important work, and we're making sure that our budget priorities are known as well. This is an important time for SAMHSA. Kana is going to talk about our budget and how important that is. So those are some of the things I've been engaged with. I couldn't do it without your support and good friends that are around this table. I am not a career bureaucrat. I am a political appointee like Tom. So we're only here through the end of the Administration. So the goals that we've set, we're really intent on achieving them. So we're going to work really, really hard over the next 11 months to do just that. Hopefully, we'll set up SAMSHA and CSAT for years to come. That's our goal. Thanks.

MS. KANA ENOMOTO: I don't have prepared remarks, and we don't have a set agenda for this time. So I think we really wanted to leave it to you guys to ask the questions that you're most interested in and have a conversation with all of us.

MR. ARTHUR SCHUT: I don't have a question, but I have something I would like SAMHSA to do. There is the perception across the United States that the expansion of Medicaid has solved all our problems. It has not. I think there are a number of states that are acting as if they can repurpose the block grant a variety of other things because the indigent care issues are all taken care of with the expansion of Medicaid. There is a huge population of people just above the expansion population that is seen as being able to access coverage, the insurance exchanges. Most of those people are buying high deductible, high co-pay and were not permitted to use block grant dollars to make

up that difference. So we have this whole population of people who benefitted from support of the block grant previously, who now, in many instances, are prohibited from doing that. The provider network is required, in terms of their contracts with insurance companies, to not subsidize deductibles and co-pays.

So there's a real issue with that whole group of folks that are the 135 percent of the federal poverty level. Up to 200, or 250 or 300, however high you want to go, who frankly, are in subsidized policies, but the premium they're paying and able to pay, frankly, is very, very minimal. And therefore, the coverage tends to be catastrophic, and it's a real issue, nationally. The perception among the state, and it's more than one state, policy folks that, in fact, Medicaid is taking care of all the indigent care is an illusion. The ability of the not-for-profit safety net to create the resources to do this is frankly, not available. It would be nice to have a consistent message to all SSAs that says this doesn't work. And if you're going to repurpose dollars, then you need to look at the people who cannot afford to access services and supporting those folks.

MS. KANA ENOMOTO: I think when we talked about the allowable uses of the block grant, in terms of population, we say the uninsured and the underinsured. So we're very clear on that in our guidance. I think it is probably somewhat up to a state's interpretation. More than one state may have interpreted it that way, but that is certainly not our guidance.

MR. ARTHUR SCHUT: Could you assist with them without them interpreting it? They all submit state plans. I'm not sure what you do with the state plans. The state plans include this reallocation. Big Brother/Big Sister would come along and say, "Nah, this is not good."

MR. TOM HILL: That'd be great.

MR. JOHN PAUL MOLLOY: Of course, you're in Colorado, so you're fortunate. You've got all that marijuana.

MR. ARTHUR SCHUT: That's not enough.

MS. KANA ENOMOTO: I think you are making a good point. That's why in our budget presentation we talk about four major priorities, which is engaging people with serious mental illness and quality care and addressing the opioid crisis, preventing suicide and maintaining the behavioral health safety net. So we use those words with intention. Although we know we are in an era of delivery system reform, of value-based purchasing, of healthcare reform. And we are participating like gangbusters in everything that dedicate expansion and the ACA have to offer. We want our field to benefit to the utmost. We recognize that the block grants play a really meaningful role in the treatment infrastructure of this country, and we're continuing to emphasize that in our messaging. And so I'm happy to talk with Kim and with Onaje about how we can work with the states to better understand how they're conceptualizing them.

MR. ARTHUR SCHUT: I might add one other thing. As an enthusiastic participant in the transformation of healthcare and integration into medicine and all those kinds of things, the payment mechanism still doesn't exist yet. I mean, they really don't. The value-based payments are any kind of goal of capitation arrangements. All those things are extremely tentative and not well implemented at this point. It's really difficult to make the transition from where we are and have the boat float until we get to doing it. Many of us are unable to be compensated for what we do that is innovative.

MS. KANA ENOMOTO: I know it will probably continue to be a challenge, even as we get into more evolved forms of financing. We are taking it on. The Secretary met with

a group of key behavioral health stakeholders about a year ago.

MR. TOM CODERRE: Exactly last year.

MS. KANA ENOMOTO: Yes. Exactly. That's right. One of the priority recommendations they made around value-based purchasing and delivery system reform was the need to recognize that this is a time of transition for our field. Again, all of medicine is going through a transition. We are going through a transition more than others because of where we started. So there is a great need for technical assistance support. Working, partnering with CMS very actively with the state, state Medicaid directors. We met with **NAMID** a couple of weeks or months ago and are in active conversations with them because we recognize that SAMHSA has an opportunity and a responsibility to make sure that as many providers, communities, what-have-you, transition successfully as possible into this new way of doing business. And recognizing, we're building the plane as we're flying it. Like you said, some of the new modes don't exist yet. They're in CMMI. They're in demos. They're in pilots. So it's all evolving as we go.

And yet, we know that there are some basic plumbing issues that a lot of folks still need help getting up to speed with before they can even entertain going to the next level. So we see an opportunity for ourselves to work with CMS. CMS will be providing their technical assistance to their pace car states or their innovation state at that level. We have an opportunity to the ones who aren't in those innovation grants or at the substrate level to also provide technical assistance. So your input and advice on how we can best do that for the lowest hanging fruit or the biggest bang for the buck, that would be great.

MR. ARTHUR SCHUT: One other thing, and then I'll quit. I think the biggest issue is

capital. If you look at a system that is paid on a block grant that moves to a reimbursement method, there is a gap in the reimbursement. There is a significant time gap. If you aren't in an organization that has a lot of cash resources, just dealing with moving from block grant to reimbursement is difficult, no matter how much Medicaid you get. The Medicaid is delayed a little bit, in terms of payment.

So the whole issue of capital in that system is difficult. If you just look at metropolitan Denver and you add the resources of all the substance use disorder organizations and all the mental health centers, in terms of their reserve, it is less than one hospital. Not one hospital chain or system, but less than one hospital. The venture capital folks are out in force, and they want to acquire a variety of businesses, including not-for-profit businesses. And they are targeting some of the safety net folks. I'm very concerned about what happens, in terms of the capital available for organizations to be able to survive. It's becoming more difficult. Thanks.

DR. LORI SIMON: I'm going to piggyback on what Arthur was saying. I don't even remember if we brought it up the last time, but the Affordable Care Act, I was a huge proponent of because I think to get more people insured is an absolute necessity. What I'm concerned about is that now that the health insurance exchanges have been created, there is a perception that okay, well, this is just working fine. And it's not. And primarily because the insurance companies are implementing it. Most of the, not all, commercial insurance companies are for-profit companies. Their priority is not patient care. Their priority is profits.

The plans that are out on the health insurance exchange, I know New York and I know New Jersey are getting worse and worse. I was just helping one of my patients a couple of weeks ago, you know, looking, trying to find a plan for him. And they're terrible. The premiums are getting higher. The coverage is getting less. The networks

are getting less. I noticed in New Jersey a couple of the insurance companies are now doing this just for in-network, are coming up with tiers within the networks where, you know, if your provider is in Tier 1, there is no deductible, which is great, but if your provider is in Tier 2, now you got a \$1,000 deductible.

Last week, I think I must've called insurance companies five times last week, trying to get medication for patients because there is another problem with generic medications. Increasingly, the quality control is not there. Some of it is because they are being manufactured in China. There is also, you know, it has to be on a more technical level with the active ingredients. They're supposed to be the same, but there's wiggle room there. And so I have one patient who literally lost a year of her life because the medication that she was on for years before she came to me, all of a sudden she started getting depressed. She tried other things, blah, blah, blah. She finally came to me. She wanted to go holistic because she was so fed up with the medications. I don't blame her. Long story short, I put her on the brand names, and now she's fine.

So to try to get approval companies to get brand name is pulling teeth. So that's an issue. And then when you call, they assume that all anti-depressant medication is the same. So they'll ask, and they'll go, "Oh, has the patient been on blah, blah, blah?" You know, and to be honest with you, sometimes I even lie, you know, whatever, to get the approval. But literally, that's what I'm doing. So I don't know if there's a recognition somewhere. This is certainly beyond SAMHSA because it's not just behavioral health, but it affects behavioral health. And I don't know whether that recognition is there, but there is a huge, huge, problem out there.

MS. KANA ENOMOTO: I'm not in all of the highest level conversations, but I do know that the Secretary has been meeting with insurers as well and that there is recognition that this is sort of a necessary partnership to move forward to make it all work well and

work to everyone's benefit. I mean, I think you could say yes, their goal is profit, but at the same time, I think there is a recognition that if the product you're delivering is health insurance, that health has to be somewhere in there. So that is also a goal.

DR. LORI SIMON: But there needs to be that accountability. They need to have that accountability. I'm not sure to what extent it is at right now.

MS. KANA ENOMOTO: Related to that, and it's not the whole thing, but we are also working really actively with the Department of Labor and with CMS on parity and parity implementation. And the White House is also really engaged and interested in that issue. So I think we'll see more on that in the near future.

DR. LORI SIMON: Okay.

MS. OMISADÉ ALI: One of the things that I would love to see SAMHSA take leadership in is that across the United States, there are many communities of recovery and ways that people heal that are not found in any formulary. ATR was wonderful in providing the opportunity to have what some people call nontraditional recovery support services funded. According to the budget, there is no more ATR after this cycle, after this particular ATR-4. But there are still those pockets of healing that are going on, especially across Native America. With traditional healers and the medicines that they use, there are movements in some of these pockets to have third-party reimbursement for these healing ways that are working. And again, you're not going to find them in a textbook. There is no evidence base around them that's written. Is it all possible to put these things on SAMHSA's radar so that our conversations are more about evidence-informed, evidence-suggested, and practice-based evidence? Because these things are working for us, especially across Native America.

I see cultural competency. I want to scream every time I see that term or hear that term because it's overused, undervalued, and it has lost its meaning. So I think SAMHSA has both the responsibility and a really big opportunity to help some of these organizations who are actually -- especially those through ATR, who have actually provided these services and are no longer going to be able to provide them or not to provide them in any formalized way. To work with the insurers and the third-party payors to say these are valid and they don't have to be in a formulary to be evidenced as working for specific populations of people who have used them for a very long time.

So I'm always going to put that on the table. Every time I get a chance to do that, I'll do that because I think it's really important. What are considered evidence-based practices, in my community, they're not validated on us. There are no behavioral health evidence-based practices that have been validated on indigenous people in this country. So as much as SAMHSA and as the leadership of SAMHSA can advocate for - I won't say validation because that's the wrong word, but the support of what we call traditional, someone else may call nontraditional ways. For us, they're thousands of years old. That's my dream.

MS. KANA ENOMOTO: So I had the opportunity to visit the Navaho Nation a couple of months ago and someone said, "Look, we've been doing it for 1,000 years." That's a 1,000 years of evidence base. I hear you loudly and clearly. I had the great opportunity to work with Surgeon General Satcher on the Departmental Health Culture, Race, and Ethnicity. We did the analysis of the evidence-based treatment guidelines for four conditions. I think it was ADHD, bipolar depression and anxiety. Oh, actually, I think it was schizophrenia. Found that none of them had -- very few of the studies that were included in between the development of the guidelines were even reported whether or not they included ethnic minorities in different populations. Most of them reported whether they had women or men. Very few of them reported whether or not they had

significant populations of people of color. And if they did, it was usually just African American or black, and then other. Then none of them had any subanalyses or data on any subpopulation in any of the four conditions that had treatment guidelines. I'm going to say treatment guidelines. That was in 2001.

I don't know that we're much further along in 2016, but I know that there is process. I think some of it started coming out when Surgeon General Satcher did his report that culture counts and that it plays a major role in how people respond to heal from and maintain their recovery from mental and substance use disorders. So it's really important to take into account. So I feel you, and I feel that issue very deeply. At SAMHSA we have talked a lot about this topic, I think, at our Advisory Council meetings, to your leadership and others. So we heard loudly and clearly that we needed to make sure that there was space for this in our national registry for evidence-based programs and practices. I hope you have seen this.

We have done a relaunch. There is what the CBHSQ staff calls practice-based evidence corner on there because we wanted to give a space to really feature and allow for a learning community to develop around the practice-based evidence and indigenous practices, culturally-based practices and/or other innovative practices that do not yet have the evidence-based that allow them to sort of qualify for an NREPP review or to be listed on the main NREPP registry, but deserve some attention. And whether or not that's just to share what people are doing that's working, or whether or not that's to find an evaluation partner, someone would be interested in helping a model developer or a practice kind of shepherd to collect more data and do more studies to move their practice along or not. You know, I think we're open to that.

So whether or not those kinds of things get reimbursed by Medicaid, I think that is up to the state and what kind of waiver it does and not so much a SAMHSA decision. I think

you'll find most of our grant programs and our project officers are very open to practice-based evidence, to culturally-based or indigenous practices. It's certainly a strongly held value at SAMHSA, and it's also that we know that you have to speak to people in more than one way, whether it's their faith, or their culture, or their family. You have to touch them in ways that are meaningful to them, even if we are hoping that a medication is going to be something that helps them recover or if you think cognitive therapy is something that will help them recover. If you cannot engage them in a way that touches their heart or their mind, you've lost them already.

So the CBT or the MAT will never have a chance to take effect. I strongly believe it's those things in combination, probably. But for some people, it'll be one, and for some people, it will be the other. There are many pathways to recover, and we certainly can respect that. I think SAMHSA, more than most agencies, really gives room for exactly what you're talking about. If you see places where we're not doing that, please let us know. If you can see places where we could be doing it better or me being more of a leader or more articulate, I think we're happy to do that as well. Thank you.

MR. TOM HILL: I didn't know folks had an interest in any of the budget initiative stuff where people feel like they're up to speed on SAMHSA's budget request for '17.

MS. KANA ENOMOTO: It wasn't on my thing, but I didn't know if you guys got it or not or if you guys talked about it yet.

DR. KIMBERLY JOHNSON: We did a review of the budget, but we didn't really have any conversation about it. We reviewed the budget.

MR. TOM HILL: CSAT's budget.

DR. KIMBERLY JOHNSON: CSAT's budget. We didn't really discuss it in any way. So I think if people have questions or anything, I think this would be a good time.

MR. TOM CODERRE: The two initiatives I was thinking about were the opioid initiative and, obviously, the PPW initiative. That would be good to bring to people's attention.

MS. KANA ENOMOTO: Some of the PPW initiative came out of a joint conversation. And for those of you who don't know, there was a joint session where we pulled back the wall, and the ACWS and the CSAT and NAC met together. And we talked about the Pregnant and Postpartum Women program. Well, I know Arapahoe has this --

MR. TOM HILL: Yeah. It just ended.

MS. KANA ENOMOTO: Right. And I know Arapahoe has this in it, centers around women and trauma, and various other things, for a very long time. We had Dan Lustig on the ACWS as well, and we had our program staff talking. In that conversation, there were some key folks in the audience who heard that and then took that down to the Hill. So there is some legislation that is proposing some pilots in the PPW program. That sort of came in a parallel process to us also thinking about PPW and doing some piloting or demoing of a little bit more flexibility within the grant programs.

So 25 percent of the funds would be to pilot grants, to allow grantees to propose alternate configurations of PPW programs. So right now, and you probably know better than I do, but there is a circumscribed set of services that must be provided by statute. So it's by law that you have to provide all of those services. And it can only serve women who are in residential treatment. So it's not flexible to say, "Well, you have a job, and you're taking care of your aging parents so you'd rather stay at home. You can

just join us for the intensive outpatient.” No, you have to be a resident. Otherwise, you are not statutorily covered by the PPW program.

We were trying to think that perhaps, a more flexible approach would allow more women access to that support in services, especially now when many people are worried about NAS, Neonatal Abstinence Syndrome. Also, we've observed that over the period of time that we've had the PPW program, very few of the programs are able to sustain without grant funding. So far, to my knowledge, no state is implementing the PPW model as it is prescribed in statute, statewide. So it doesn't appear to be a scalable model as it is. We're very interested. It is a great program. It is a super important population, and we are not backing away from that one iota. What we are trying to do is, there are more women and more children affected by these issues that aren't getting treatment by the PPW program. We also have a women set aside in the SAPG that is not necessarily implementing the PPW model.

So if this is truly the best practice, how do we figure out to get it financed? How do we get it so that it's sustainable and scalable and maybe look at why your scale implementation, be it the block grant or anything else? I don't know if there was anything that people had thoughts about, but I thank this group, for participating in the stimulating conversation that got us to this place.

MR. ARTHUR SCHUT: I know states have been encouraged to do waivers for residential treatment by CMS. Some of them have not done this and not participated. It might be nice -- and maybe you've already done this -- if SAMHSA and CMS could talk about how to braid funding in a way in models of rating that states that this is a way to expand services and do this. I know a number of states have done this. A long time ago, I was in Iowa and the contract with **Migelin** and braided both Medicaid and the block grant to provide expanded services in case management for women and kids.

But somehow, I don't know that every state sees this as an opportunity to braid or is concerned that braiding is double-dipping. That, in fact, getting money out of the block grant and getting money out of Medicaid when you're actually using those dollars to pay for different things.

MS. KANA ENOMOTO: Well, again, some of you probably know this better than I, but every sort of treatment program that I've ever visited, especially the ones with women, it's been kids, have an amazing number of funders and an amazing number of streams that they are braiding together and programs that they are running at the same time because they are serving a population that crosses over so many different systems.

One of the things that we realize with PPW is that we didn't have a good enough picture of how people were funding their programs. We sort of knew that you're getting the half-million dollars from the PPW grant, and that's kind of where we left it. I think we also need to do more work ourselves. How are these residential treatment programs for women and their children getting paid for? The ones that are able to sustain, what are they doing? So before we go to CMS and say here's a potential solution, I think we need to probably put a little fire point on it to identify well, these are the things that are getting funding this way; and these are the things that are getting funding that way. Here are the things that they're not sustaining.

I just had a chance to go visit Meta House. They did not have a PPW grant, but they are sustaining much of their PPW programming, not all of it, though. So I don't know how many people are able to keep it going exactly as it is funded under the grant. I don't know if we really identified "and this is the key ingredient" or "these five things are the key ingredients that really should be maintained." That's part of what this pilot is about to really assess out what are the key ingredients? How do you pay for them? And then how do you translate that to other places and other settings so that all the women in

this country in need of these services can get them.

MS. AMY HASELTINE: So on the federal level, when the Office of Management and Budget wrote, drafted, and then completed the new grant's reform regulations, there actually is a provision inside of those grant reform regs that allows the blended and braiding of funding, depending upon how your program is authorized. There is actually also guidance out by the Association of Government Accountants, which talks to state and local governments in particular about how to approach a blended and braided scenario, particularly if you have an area where it looks like your authorizing language is going to give you the flexibility, but you just are having to overcome, perhaps, the cultural concerns about doing that. So I just would suggest both of those things, at least our resources again. It kind of is dependent upon what your authorizing stat sheets and regs say, but if that is an okay thing, then we do have some tools out there for you.

MR. ARTHUR SCHUT: It would be great if we could have links to those things so that the advocacy groups that we are connected with could help educate.

MS. AMY HASELTINE: It'll be good. It's pretty good. We'll talk you through how to do all that. I do have to run out to a meeting, but I wanted to jump in just to make sure I said thank you for the opportunity to meet with you. Again, thanks for the opportunity here. I look forward to learning your perspectives going forward. And yes, we'll get those two links out.

MR. ARTHUR SCHUT: That's great.

MS. AMY HASELTINE: Thanks.

MS. KANA ENOMOTO: Thank you. So I know today you're talking about opioids at large. Did you go through all the different components of the \$1 billion? So the President has announced that he is going to come at \$1 billion over the next two years towards the opioid crisis. So \$950 million of that \$1 billion is coming to SAMHSA. \$920 million of that is going to grants to states, based on a formula. The formula grants will include prevention treatment and workforce and recovery. So those are all very good things, things that need to get done. So the \$30 million, and this is spread across two years, the other \$15 and \$15 million will be for a study on MAT. So looking at treatment outcomes of medication-assisted treatment. The other \$50 million, which is important for you to know, is for the National Health Service Corps. So \$25 million for two years will go to HRSA to provide National Health Service Corps grants to behavioral health professionals for medication-assisted treatment. So that is very exciting news.

There is another \$50 million on the mental health side going to the National Health Service Corps for mental health providers. So that's \$100 million over the course of two years for building out the behavioral health workforce, in addition to our \$10 million proposal for our peer workforce development programs. So we're really excited about that potential investment in our workforce because we know it's so needed. If we're going to expand services, whether that's by parity or whether that's by these presidential initiatives, we know we need the people to actually deliver those services.

DR. LORI SIMON: Does Congress have to approve this?

MS. KANA ENOMOTO: Congress has to appropriate the funds. That's right. Yes.

DR. LORI SIMON: Okay.

MS. KANA ENOMOTO: So that's just a little burden, a little hurdle that we have to get

over.

DR. LORI SIMON: Just a little.

MS. KANA ENOMOTO: That's a good question. It's my job just to put it out there. It's everyone else's job to get it funded. The good news is that there is such incredible bipartisan and public support for addressing these issues. I think there is widespread recognition with the numbers of overdoses that we're seeing, the babies at NAS that we're seeing and the lost lives, the lost productivity is unacceptable. And that it is a solvable problem. The Secretary has three prongs to her initiative. I'm sure you've heard about them. SAMHSA is really pleased to be playing a part in each of those prongs. So whether that's the prescribing practices and our PSSO, and our participation with CDC, our longtime partnership with NIDA, you know, prescribing practices are on the front end. And also, our CSAP grants that will be SPF access, Strategic Prevention Framework for prescription drugs, will allow communities to really rally and to help create an awareness of how the two things are related, you know, our pain management strategies and our addiction to opioids has come together.

Obviously, the access to MAT. We've put an MAT requirement that you cannot preclude people from participating in the drug court if you have one of our grants. If they are on MAT, that was new for us. That was really a bold statement by SAMHSA of which we navigated, amazingly, to the other side. And I think people have come to an agreement on it. I've been places where a judge told me I would not allow this in my court if it weren't for that SAMHSA grant, but we're going to be compliant with the grant. So I think we changed a few lives. And over time, I hope we also change a few minds, but part of that means ensuring that a high-quality medication-assisted treatment is available when people need it because that is part of the challenge. I think it's that people have had negative experiences, or they see people not achieve a level of

recovery that they think they might have or that their families wish that they could have with MAT that perhaps, a little more psychosocial support they could help.

So in addition to the state grants, we continue to have with the mandatory funding, we have our MAT grants, which this year we received an increase as well. So we'll have new medication-assisted treatment grants for states out of CSAT. In '16 and '17, we're proposing a buprenorphine prescribing authority demo. Did you talk about that? We have the rule that will be coming out this year, increasing the cap for physicians. So there's sort of a two-prong approach on buprenorphine. And then on CSAP's side, this year we have, I call them Naloxone grants, but they're grants to prevent prescription drug opioid overdose related deaths in the Center for Substance Abuse Prevention, as well as the SPF access. We're continuing both of those into '17. I think when you take it together, it's a very robust, a very well-rounded approach to addressing opioids.

We're working really closely with ASPE and CDC and FDA and NIDA. It is a great partnership across the department because the Secretary, you know, Tom Frieden calls it a winnable battle. We have the tools; we have the science; we have the knowledge. We need the funding; we need the political will to get it done. If you guys have thoughts about how we can be doing it better or if there are some messages that I need to be taking or Tom needs to be taking to the Department or the White House, ONDCP, you know, that advice would be really helpful.

DR. KIMBERLY JOHNSON: Now is your chance, guys.

MR. TOM CODERRE: Shifting gears, did you guys talk at all about 42 CFR as well?

MR. TOM HILL: Briefly.

MS. KANA ENOMOTO: They have been through a lot, and it's only 2:00. That's amazing.

MR. TOM CODERRE: I know. That's great. If there are any questions about that too, we'd be happy to answer about what the process is. I think if you've already talked about it, you probably know.

DR. KIMBERLY JOHNSON: No one had comments then, either.

MR. TOM CODERRE: Okay. Well, thank you. It has been great spending time with you.

MR. ARTHUR SCHUT: I do want to add that I'm very happy with the leadership decision that you made for CSAT.

MS. KANA ENOMOTO: Great. Thank you.

MR. TOM HILL: Big thanks to Kana and Tom. Thanks so much for coming by.

MS. KANA ENOMOTO: Great. Thank you guys.

## **Agenda Item: TOPIC: Peer Recovery Support Services in Diverse Settings**

MR. TOM HILL: Before we move on, Terrance and Mohammad on the phone, can you just remember to mute your lines so we don't hear any background noise. That would be very helpful.

MR. MOHAMMAD YUNUS: Hello?

MR. TOM HILL: Is that Mohammad? In the next session, when you're not asking questions or something, could you just mute your line?

MR. MOHAMMAD YUNUS: Okay.

MR. TOM HILL: Okay. Thank you. And that's on the official record. Let's go to the next session. Where are my crib notes? I think I am moderating the next session. We're going to be talking about two different things today, intertwining. We're going to talking about medication-assisted treatment and also medication-assisted recovery and how those things interrelate, as well as integrating peer recovery support services and different kinds of programs. So today we have the esteemed Paul Molloy from Oxford House, who is really going to talk about, I hope -- Oxford House is based on a peer model. It's always been based on a peer model. And he'll talk about what kinds of peer services or supports happen within that model. It is a really interesting thing for us to look at as something that's been existing for a long, long time, for decades, in fact.

Wilma Townsend -- is Wilma here?

MS. TRACY GOSS: She's coming.

MR. TOM HILL: Someone just checked in. They're getting Wilma down here from the 13th floor. Wilma is with CSAT's Division of Pharmacological Therapies. She's going to be talking about the idea of integrating peer recovery support services within medication-assisted treatment, specifically on the first tier of OTPs, Opioid Treatment Programs. That is sort of the first tier. The second, which is a little bit more

complicated, talking about peer services within buprenorphine prescribers. The OTPs are a little bit more centralized, and so it may be an easier place to start. She put together a meeting at SAMHSA last fall, bringing people together from the community and from the field to talk about peer recovery support services in those settings. I'm going to turn it over to Paul to start us off. And then hopefully, Wilma will be joining us in a timely manner.

MR. JOHN PAUL MOLLOY: My name is Paul Molloy. I am quite used to introducing myself by saying I am a recovering alcoholic. I've been recovering now for a long time, over 40 years. Oxford House is probably something that you all are familiar with. It is self-run, self-supported recovery housing. I think it is unique because early on, when the first house started in 1975, it started from the premise that relapse did not have to be part of the recovery process. And if you returned to drinking or using illicit drugs, your peers were to throw you out right away. And that created a mixed bag among folks who were in the field and among folks in the 12-Step community.

Oxford House is not connected with the 12-Step programs. Although, most people in Oxford House go to a lot of 12-Step meetings. It not required for anybody who lives in a house to go to any 12-Step meetings, but we take surveys regularly; and we find that the average person residing at an Oxford goes to 5.2 meetings a week. AA headquarters in New York, they do periodic surveys every three or four years and find that the average person at AA goes to two meetings a week. For some reason, at Oxford House, their number of meetings is considerably more. I think there are a number of reasons. Of course, there are lots of stories of why this is so.

In one of the Oxford Houses early on, a fella was very anti 12-Step programs, and it became a challenge to his 13 roommates at the house to get him to go to meetings. So they would come back every Tuesday night and say, "You should see the new girl that

was at the meeting tonight.” They would do everything they could to entice them to go. He lived in Oxford House for three years and did not go to any meetings at all. He moved out at the end of three years into his own apartment. I think everyone in that house wanted and hoped that he would relapse soon to prove the point that you needed AA meetings. And he didn’t. But he did come back to the house every Tuesday and Saturday to "check his mail." What Larry was doing was he had substituted that group of 13 men in the house for his socialization. So it was the equivalent of what many people can get out of a one-hour AA or NA meeting. He had found this group that had the same common bond of trying to figure out how to stay clean and sober and to be comfortable and happy about it, rather than not.

I lived in a halfway house run by Montgomery County, Maryland in Silver Spring, Maryland, right where the Discovery Building is now in Silver Spring. The first three months I was there, 11 people had to leave because there was a six-month time limit. There was a six-month time limit because there were 13 beds in the halfway house, but an obligation to the taxpayers to turn over the beds so that you could put some new people in and not keep the same people there forever. These 11 who had to leave because their six months were up, 10 of the 11 relapsed within 30 days. Joe Spellman and I were figuring out how can we manipulate the system and con the hell out of the county because we didn’t have any place else to go.

As we were in the process of doing this, the county announced that they were closing that halfway house because in 1975, there was a down flow in money. The county had three other halfway houses and received word on July 6 that the house would close on October 1st. So we went to an AA meeting that night at the Hot Shops, which is located, no more, but it used to be at Wheaton Plaza. And we told all the old timers in AA how unfair life was. Here we were making this great sacrifice to stop drinking and stay stopped and now the county was closing the halfway house. The folks at AA

listened to us for maybe two minutes and said, "Get off the pity pot. Why don't you take it over yourselves?" And that thought had never occurred to us, but we went home that night and called the county, only to discover that the county did not own the building but that they rented it. And they said, "We're sure that the landlord will rent it to you guys for \$750 a month, which is what it cost us to rent the building."

So we went back the next night to the AA group with long faces. Everybody said, "You're not going to do it?" We said, "We can't. We have to put \$750 upfront, and none of us has that money." A guy in AA gave us a check for \$750 and said, "Pay me back when you can." I sometimes don't tell that story because it took us roughly 10 years to pay that guy back his \$750. We now have a loan program where we would really chastise any house that doesn't make their monthly repayment of \$170 a month in order to pay back the \$4,000 loan they get to start the houses.

Starting the Oxford House was trial and error, sort of. I came from a little town in Vermont; Arlington, Vermont, which was 12 miles down the street from where Bill Wilson was born and brought up. In my town, Orlando Coleman had come into AA in 1941. Bill was a sponsor, and Bill came by Arlington to visit from time-to-time. I went to my first AA meeting in 1967, after I had called John Volpe, who was Secretary of Transportation, at his home at the Watergate in the middle of the night, complaining that he wasn't supporting RailPAC, which created Amtrak. Among other things, called him a goddamn WASP.

When I came into the office the next morning, Senator Pastore from Rhode Island was leaving Senator Prouty's office, who was a republican from Vermont and my mentor. Prouty called me in and said, "I've never been so embarrassed. John Volpe, a democrat is in here complaining about the fact that the Republican Council of the Senate Congress Committee called John Volpe last night in the middle of the night.

I think that Norris Cotton and Hugh Scott are going to want to fire you. I can't defend you." I said, "Well, I'll have to do something about my drinking. I was drunk last night. It was 2:30 in the morning, and the Caroline's had closed; and I just let him have it." He said, "You better do something." So I went to meetings every day and Prouty said, "Report to me every day." And I would come in and I said, "I went to a meeting yesterday, and the guy who sold insurance stole money." Then the senator said, "Anybody we know?" And I said, "No, I don't think so."

I came in and reported every day for 30 days. At the end of 30 days, I said, "Senator, this has been so fortunate for me because I learned I wasn't drinking properly, and now I can be on the right track." And the senator said, "Thank God. We've missed you. Come on in, and have a drink." And I was back on the merry-go-round. And that merry-go-round went on. My wife became a lawyer. I was a lawyer. We had five children. We were yuppies of our day. Quite affluent. Quite rich. Lived in a fancy neighborhood. I was once picked up with my wife in the car, going crookedly on North Capitol Street, out towards Silver Spring. The police stopped me, and I had explained to them that I had been to a party and that that's why I was all over the road. They asked if my wife drove. And she said yes. They said, "Well, will you drive him home?" She said, "Sure."

And as the police were walking away, this was 1966, I said to them, "You pigs. You wouldn't treat me that way if I were black." And they grabbed me out of the car, put me in the paddy wagon and brought me to the precinct. And at that point in time, there was not a single black police officer on the police force in the District of Columbia. As I organized the folks in the precinct to get lawyers and legal representation, the desk sergeant came out to my wife who was waiting in the lobby, and said, "Will you take that bastard home?" And she did. I mentioned that story only to point out the kind of drunk I was. I also was a spousal abuse kind of drunk. My wife was a lawyer who

brought the first cases to spring people from St. Elizabeth's Hospital because they were not getting appropriate treatment. She did that in part because she was a good lawyer. And she also did it in part because her father was committed to Brattleboro Retreat, which a hospital for the mentally ill, in 1957, where he stayed until he died in 1985.

It was with great reluctance that she had a Commitment Order filed against me because I had tried to kill her for the seventh time. And off I went to the psych ward, where I immediately called Frederick Williams, which was a fancy lawyer in the District of Columbia and a smart one. He said, "Paul, I don't practice in Maryland." So he sent a partner out to talk to me in the psych ward. I explained to the partner what this terrible wife had done. He said, "Paul, I've been in AA for five years. If you'll go into treatment, I'll spring you right away." And he recommended that I go to Chit-Chat, which is now called Caron Foundation. He previously suggested that for my wife, who wanted a divorce and separation. And she said to him, "There has been enough chit-chat." And I'd like to think that Jane contributed to them changing their name to the Caron Foundation.

In any event, we were divorced and stayed divorced for 13 years. Fought the divorce, as two lawyers who were aggressive lawyers. We'd fight for a long time. Jane continued her work as a leading lawyer. She had been to the Woodrow Wilson School at Princeton on a government fellowship and was a very good lawyer. I, in a halfway house, got a call from the House Energy and Commerce Committee, and was not going to go in for an interview because I thought I was an imperious drunk. I was living in a halfway house. And Father Bizon, who is still alive, stopped by every day to drink a Coke in the Coke machine and cheer the folks on. He said, "Paul, you've got to go in." I said, "I can't. I haven't got any money for gas." And he gave me \$20. I went in and was hired. I immediately told the person interviewing me, I'm a recovering alcoholic and I've been sober three months; and I live in a halfway house. And Lou Barry said, "Fine.

One drink, you're fired, if we decide to hire you." He said, "Jim Brueghel must think a lot of you." And I said, "I don't know Jim Brueghel." The Brueghel furniture guy from North Carolina. Brueghel was walking through the office and Lou said to him, "This is that guy you recommended to be minority counsel of the committee." Brueghel said, "Oh. If I recommended him, he must be good." And they hired me, and Brueghel and I became friends. And to this day, we do not know where he got my résumé or how it was that I got hired.

For me, it meant that beginning right then, in 1975, I can be open about the fact that I was a recovering alcoholic. And I told everybody. The first guy to come see me was a labor union guy who said, "My boss sent me over and said you're a republican. You're starting over here, and you're going to screw labor. And he wants me to watch you like a hawk. But the real reason I'm here," Jack said, "is that I've been in AA for 25 years. If you ever need a meeting, I'm around." I'll take you to a meeting. And so it was, lots of people became friendly. I became the informal employee assistance person for the House of Representatives. And I mention that only because I left in 1981 after Reagan was elected and went downtown to be a lawyer with a fancy law firm. And I asked the Bar Council if there was any problem of alcoholism or drug addiction among the lawyers in the District of Columbia. And he said no. But in 1980, 20 lawyers had been disbarred.

I visited the first five on the list, and they were all alcoholics. So we organized something called Lawyers Helping Lawyers. Between 1980 and 2001, which was the last time I've checked, 4,800 lawyers have had intervention and had gone into treatment and had gotten clean and sober. So I'm a believer in intervention. I'm a believer that intervention is necessary as it was for me. Not everybody needs to be divorced for 13 years like I was, but my wife remarried me 28 years ago. But I do think that there usually has to be intervention because few of us wake up one morning and

decide we want treatment. And that's why I was strong supporter and helped get the National Association of Drug Court Professionals going in 1987. Jeff Tauber and I looked for lawyers who were in recovery to try to get it going.

When the county closed that halfway house, the first thing I did was to call Orlando Coleman, who was the guy from back home in Arlington, Vermont, and say, "We're not going to politicize AA, and we don't want to be connected with it. We don't think we're doing anything wrong, but we want to be just like AA in creating this Oxford House." And he got on a Greyhound bus, came down and spent a couple of days with us to tell us how we could do it. We were also, at the very time, a therapeutic community was falling apart. That therapeutic community was falling apart. They shot at each other. They put rattlesnakes in mailboxes. Part of the problem was they were fighting over money. They had started various programs, including car shops and repair shops and hotels. So we said we've got to avoid that. So from Day 1 of starting Oxford House, we said Oxford House will never own any property and we'll give you in any wealth. And 41 years later, we haven't.

Our friend Orlando said, "You can be similar to AA without being AA or violating the fourth tradition of AA. Just don't associate yourself with them, and don't require that people go to the 12-Step meetings." And we didn't. And then we worried. But as I mentioned earlier, the average person goes to 5.3 a week. The other thing we worried about was who was going to be the big boss. Everybody else in the house said, "Paul is such a pain in the ass to live with now, and he'll want to be a big boss. What the hell are we going to do about that?" And Orlando said, "The select men in Arlington, Vermont can only serve for a year. Why don't you have a six-month time limit?" And so Oxford House, from Day 1 said we'll have five offices, but they can only serve for six months. You have to have another election. And that has turned out to avoid bosses. No big boss at Oxford House. But there is a total commitment to self-reliance. There

was a belief from the beginning that the inmate could run the asylum. And I think that's one of the reasons that Oxford House has been successful. The individuals who come into the house may come in from the street. Sixty-three percent of our folks have been homeless for over six months. They may come in from incarceration. Seventy-eight of the folks at Oxford House has done jail time, averaging about 11 months. They may come in with a situation like mine where they were well off but in deep trouble because somebody had you committed.

When they come in, they're like Charlie, as I talk about, he's voted in. You have to be voted into an Oxford House. It takes an 80 percent vote. So today, we've got 2,000 Oxford Houses. There are 16,400 beds as we talk right now. And in each of those houses, the folks who get in there, get in there because their peers voted. It takes an 80 percent vote to get in. It's a practical matter. Everybody is voted in if there is a vacancy. Whenever there is a vacancy, other folks in the house, their equal share of expenses becomes more. You got to make up for that vacant bed. Today, the equal share of expenses nationwide is \$112 a week. That's amazing. And yet, when you look at last year, the men and women at Oxford House paid the landlords and household expenses, like utility bills, of \$91 million.

Oxford House, Inc. is an umbrella organization that tries to get these houses going and keeps them on track. Our total budget was \$5.5 million. So we have a point to prove, and that is that we really do think that you can involve the community into working together to solve the big problem without a lot of extra support, either from insurance companies or from the government, or from the individuals themselves. But what it's based on is this notion that there's a uniqueness in American democracy of a commitment to self-help and self-reliance. So it's a combination of a ratio. Bill Wilson and my friend Orlando Coleman agreed that we stumbled into something that's pretty good. Each of these houses, by the way, runs itself. But then six or seven, or eight

houses within an area become a chapter, and the officers from each of those houses meets once a month to kind of watch each other. What they watch each other for is the house following the charter that we've given them. The charter says 1) you have to be democratically self-run; 2) you have to be financially self-supporting; 3) you have to kick anybody out who relapses.

Since we began expansion, we've done lots of things. Three houses opened last year at the University of North Carolina, Chapel Hill. Where the university has recovery dorms, but they also say to their students there is off-campus housing at an Oxford House, rented from the University of North Carolina, Chapel Hill. We have a team of folks who go into prisons and recruit within the prisons for people in recovery. They come into an Oxford House when you leave the jail or leave the prison. And because we know each other, we don't trust them to get to our house on their own. So on the day they leave prison, Curtis or one of the fellas goes and gives them a ride to the Oxford that's accepted.

The interview between the prisoner and the Oxford House has been by Skype. And I should mention, we wouldn't have been able to expand all over the country and done all of this stuff, except for technology. We live in an amazing time. On the one hand, we have Robert Putnam, who writes *Bowling Alone*. That's we've all become lonelier and more isolated. On the other hand, the magic of the cell phone. The magic of the internet has been marvelous. I used to worry about a guy in the New Jersey house who had built up a big phone bill because he was feeling depressed, and he would start setting up a relapse; and he'd call his girlfriend in California. And then he would relapse. And then he would go see his girlfriend. And then the poor house would have a \$2,100 phone bill. Did you know today, you can get a landline for \$49, and it includes long-distance calls? We're lucky.

We have a vacancy system now that recognizes that with that modernization, there's a downside. And that downside is that sometimes houses don't answer the landline. So we've devised a system that one person in the house will go into our cell phone contact list and twice a week, his cell phone gets a text: "Do you have any vacancies?" And if they say yes, you automatically get a text 30 minutes after its house meeting to verify whether it's filled. So with our 16,000 beds out there, we can tell you right now where the vacancies are and where they're located. And that's something that has been done because of democracy and American entrepreneurship.

Normally, we reward ourselves, as lawyers, or any other profession, with money that we can figure how to get. But here is this group of individuals -- last year, 31,800 went through Oxford Houses. Now, I mention this to you in part because I have a selfish motive. I want to rev you all up so that you go talk to your sisters and your brothers and your neighbors, your bosses and say, "Why the hell aren't we promoting more Oxford Houses?" Because the heroin epidemic that we have is cyclical. If David would still be alive, he'd say to you, "These things go through cycles." Well, it's going to get worse and will be worse unless we can figure out a way that folks don't relapse. When you look at the TEDS data, the Treatment Episode Data Set, you'll find 60 percent of the folks have been through treatment three and-a-half times. Think of all the beds you open up if you could stop the relapse.

So my sales talk. I'm sorry I talked over, Tom. We even accept folks who are on medically-assisted treatment: buprenorphine, methadone and so on. I'd like to say we had great luck with that. We haven't. Most of the folks who are on Suboxone cheat. They sometimes grind it up and sell it. They're voted out of the house. They sometimes use heroin to supplement what they're using it for. Those are voted out too. Last night or the night before last, a young man, 26 years old, overdosed and died out of Millhouse, out in Beltsville, Maryland. It's our first overdose in Maryland. Sad and

difficult, but it's hard to deal with. We do have the antidote, naloxone, is it? -- in all the houses in North Carolina and all the houses in Delaware, all the houses in New Jersey. We do not have them in all the houses in Maryland. Even though in this particular case, it wouldn't have mattered if we did because the fella was found 12 hours after he died. So we're dealing with a troublesome disease. Oxford House is a clever way to solve some of the problem, and I encourage you to pass on the good news. Thanks.

MR. TOM HILL: Thank you so much, Paul. Next, we're going to hear from Wilma Townsend from CSAT.

MS. WILMA TOWNSEND: Thank you. Hello, everyone. Thank you for inviting me. I'm going to talk a little bit about the MAT, as well as peer support. We always start off by saying it takes a village. It's a well-known phrase that people use. I want all of you to know you're part of that village. So that means you have the responsibility to do certain things to help people who have an addiction problem.

I'm going to focus in on peer recovery support services and talk about how peer recovery services really does make a difference and seeing them as part of that overall village and being a part of that village. Peer support -- let me back up. We had a meeting back at the end of September, where we brought together a group of peers, a group of recovery community organizations, someone from Medicaid and some individuals who are directors of opioid treatment programs. Our purpose for doing that was we wanted to talk about and dialogue with them about what does it take to get opioid treatment programs or methadone clinics to really understand the benefits and the challenges of having peer support services within their organization, whether that meant the hiring of individuals who were recovery coaches or whether that meant contracting with recovery community organizations already established in their communities.

As a result of that meeting, we ended up where the group came up with a number of benefits of why OTP should be using peer support services. Number 1, it provides individuals who've been through treatment. So we went through a whole thing in talking about how lived experience can make a difference to a person, just like what John just talked about a few minutes ago. How that lived experience can give a person a sense of hope, but it also can give a person a reality that as a professional, sometimes you don't feel comfortable saying certain things that we can say to each other. And that doing that can make the person look at their reality from a different perspective, the understanding and the compassion that peer support offers to individuals. That is something that, again, a lot of people don't think about. I'm going to give you some examples in a few about that.

Some of the contributions -- and I'm not going to read each of these, but look at the holistic wellness and give guidance so the people can then also think about some of the advocacy efforts. And it helps with stigma reduction. Because when people stand up, and I think John just gave a wonderful presentation in terms of when he was able to get that job. And from then on, he said that he was an alcoholic, it made for that stigma that people knew that was around him. And when that person came in and said, "Hey, I'm here because the union sent me, but the bottom line is, if you need support and you need to know where the meetings are, I'm here. It doesn't matter if you're a democrat, republican or whatever, union or management; this is how we can help each other." So the whole stigma reduction becomes critical with this.

Engagement and empowerment that by sharing that lived experience, it really does make a difference. It gives people a sense of, "I can do this too. I can make it. I don't have to let my life end up being where I'm totally destroyed." Again, the sense of hope, workforce expansion. We don't have enough people in this field -- I'm out here doing

these MAT-PDOA site visits. As I'm going around to the different states, the number of people are saying we don't have doctors. We don't have enough social workers. Now, we train and have peers out there; it's another way of dealing with some of the workforce issues. Improved client outcomes. What we have found -- and I need all of you to read that, but I'm going to give you a story that will tell you about the outcome.

One of the programs we went to visit was in Maryland. It was at the emergency room. This emergency room, I forgot how many number of people, that have come through in a year that have overdosed. They just hired some peer specialists. What happened before was when a person, if they didn't die from an overdose and they came out of it, the hospital said the only thing we could tell them was, "This is what happened to you. You need to go for treatment. Here are some places where you may be able to get into treatment. Bye-bye."

So they wake up an hour later, and they're back out on the streets, using. They said they felt so bad because they didn't know what to do. They didn't know how to connect people up. They hired these peer specialists. They started working January 10th. When the individuals come out of the overdose and from the doctor, the doctor talked to them and said the same thing: "This is what you've gone through," yada, yada. As soon as the doctor had done this, he said, "Let me introduce you to this individual who is a peer recovery coach." The first words that come out of the recovery coach's mouth is, "I don't know whether you realize it or not, recovery is possible, and you don't have to go through this by yourself. We're here. If you want to get into treatment, I'll take you there. If you want to hook up with AA or NA, I can do that with you. If you want to get on some medication that can assist you, I can help you with that." And then walk them through the process.

Ninety percent -- 90 percent of the individuals who have overdosed and hooked up with these peers have ended up going into treatment. Ninety percent. And from January 10th to the date we went there, which was a week or two weeks ago, they had 12 people who had OD'd. It sounds like a lot, but in some of the other communities, it's a whole lot worse. Again, what they are seeing is that they're helping people to get to treatment. We know that once they get into treatment and they have peer support services that it helps them to be able to move on with their life. They begin to understand what recovery is. They begin to understand what it may take. The peers are a way of getting them to build that village around them, which helps them to really be able to make some more steps. Not saying that everybody who comes through. I also know relapse can be part of the process. There is no process when there's death. You're going. So all of these things are the things that we're saying are peer support that they had major, major outcomes with.

Some of the methods to integrate peer recovery support services, 1) hire some recovery coaches. It is saying to all of our OTPs, you need to hire some recovery coaches. Again, those are the benefits. One of the things they always say to me, "Oh, we can't pay for this. So that's why we had a Medicaid person do that." That link is the link that talks about the -- somebody, I'm not for sure who exactly hired these individuals -- who went out and did a study on the rates that is being paid across the country for a peer recovery coach. It is for mental health and substance abuse. You won't be able to tell the difference, but what they have the rate that is being paid. So if your state is going to start it and they've never done it before, at least they can use that as a barometer for the result. I will say, though, when they use it for the barometer, aim higher, not lower. Okay.

Develop a peer program within your opioid treatment program. Again, I'm talking specifically for the opioid treatment program, but I'm saying this for any program at all

that's within substance abuse, whether it's OTPs, where there is an MAT, a Medication-Assisted Treatment program that is within another type of facility that we should be doing this. It's more sustainable, and it gauge's patients beyond one-on-one coaching again. Partner with recovery community organizations. We have, I can't say exactly how many, but if anybody wants it from me, I have a listing of all the recovery community organizations they're on.

MR. TOM HILL: Over 100.

MS. WILMA TOWNSEND: It's over 100. Okay. They're all on Faces and Voices of Recovery. The problem, though, is they only have the listing by name, and they don't have them by state. So I broke them out by state so that you'll know who they are and where they are. So if you want that, you can get it from me. The point is that those organizations had things set up in their community that is peer based, and they really do an excellent job of helping people in their recovery and helping them do things in the overall community. They are not treatment oriented at all. They are very recovery oriented.

I'm going to turn it over at this point, to my colleague, Mary Lou, who is going to start talking about the reimbursement.

MS. MARY LOU OJEDA: Good afternoon. So I'm going to go over the reimbursement piece and some other things that we identified at this meeting. In 2007, the Centers for Medicare and Medicaid Services issued a letter to the state Medicaid directors. This letter told them that they were allowed to include peer services as part of a comprehensive mental health and substance abuse service delivery option. Also, it detailed what services to provide, the supervision, training requirements and how to apply for reimbursement. This is something a lot of programs don't know. Other

funding options that were identified were HMOs, state and county contracts, and federal grants. The evidence of success was seen at a program at a CSAT recovery community support program. At a six-month follow-up, it showed that there were 75 percent of clients reporting no substance use. So there was an increase of 19 percent from when it started. I'm not going to read all the bullet points, but the last one was also a good one. Fifty-two percent of clients reported being housed. This was a 27 percent increase.

MS. WILMA TOWNSEND: Look at that second one, too. Ninety-six percent of the clients reported no arrests at the six-month follow-up.

MS. MARY LOU OJEDA: And these were people who were involved in the PRSS Services.

MR. TOM HILL: Can you go back to that slide also? I think it's important to note also that a 19 percent increase, it may not seem like a lot, but for folks that are already in recovery, who come into a program with reporting no substance use, that is a bigger jump than you might think. So it's not like you're going into treatment and still using. They're going into a program already in recovery or early recovery. I just wanted to make that distinction.

MS. MARY LOU OJEDA: Yeah. Over a half-a-year, six months' period. Also, there was also a positive note made on the mental health outcomes. So it's important to keep in mind that these patients are dual diagnosed. They experienced a 21 percent decrease in both serious depression and serious anxiety. There was also a 26 percent decrease in experiencing trouble in understanding, concentrating or remembering things. And 29 percent decrease in suicide attempts. So this data shows that peer recovery services touches all areas of treatment.

There was also another study that was done with people with co-occurring psychiatric and substance use disorder. There were two groups: one that received the service and another group that did not receive the service. The group that received the service showed a dramatic decrease in crisis of hospitalizations, with alcohol and drug use, improved living circumstances, and enhanced income, and enhanced health. The last bullet here is a very important benefit. What it showed is that there was an observation in increased rates of family reunification. So like Wilma said at the beginning, it takes a village. The peer recovery service not only brings in the staff at the program, but it involves the community and it brings in the family, which, in turn, creates a positive reinforced network around the patient.

Now, like there is with everything, challenges were identified. The first one is the most prominent one. OTP lacked the knowledge or awareness of PRSS. Either they see it as unnecessary, they don't see the value of incorporating it, or they think it's expensive. Also, they don't know that there is a reimbursement for it. Another one is that OTPs have not traditionally been part of the recovery community, and they need to shift their focus to include recovery oriented treatment, not just treatment. It's a long journey.

MS. WILMA TOWNSEND: That is a major one. As we are going out doing the site visits, many of the places are treatment providers. They are treatment agencies. When we go in and talk to them about recovery -- many of them have even hired peers. When we talk to them about recovery and ask them how are you training your staff to understand what are the values of the abstinence and how we can work within your recovery, they thought nothing about it. And I said, "Well, what is your staff saying to people who are getting on medicine?" And they realized that staff is telling people, "You should only be on it for 30 days," or, "You really shouldn't do this." So that culture change is a major piece within that field.

MS. MARY LOU OJEDA: And a few more challenges were the staffing had to recertify them. How should they be supervised? What kind of training do we have to offer? That is all a big gap in knowledge about it and the specifics of it. We already covered costs. So if we could bridge that knowledge gap, we can have programs buy into either hiring someone, implementing this program or setting up some type of agreement with an outside PRSS, and then we'd be able to collect more research and evidence-based practices, which is something that this still lacks.

Another thing that's not on any of these slides, Wilma and I went on a visit to a program, and then she took me to a recovery program in Dallas, Texas. And a unique thing that I saw at this program was that they also involved the university in mainly the nursing program. So they would let nursing students come into the program and either talk about nutrition or whatever it was that they were specializing in, which, you know, brought the community into this program and also gave the chance for these nurses to see that there is another field that they don't get told about or experience in. We lack people in substance abuse treatment and recovery. So I thought that was a really unique component of that program.

MS. WILMA TOWNSEND: Lastly, there are all types of support groups for chronic health conditions, from in-person to social media that are proven to be successful and important components of treatment plans. So what we are saying is we need the exact same thing. One of the things that's key is that NA and AA have a process, and they have a mechanism. MAT can do the exact same thing. We can learn from each other. It's not about one is bad and one is good. It's according to what is the pathway that you choose to take to assist you. That's what becomes critical. I was so pleased with this group of people that we brought in September. One of them is sitting right here with us today, one of your members, Andre. Do you want to say just a couple of sentences,

Andre?

MR. ANDRE JOHNSON: Well, I think that we talked about many pathways to recovery. For me, running a recovery community organization, we have an array of support groups that target the different populations, meaning that we have a dual recovery, anonymous support group for people who have co-occurring. We have a fellowship anonymous support group, which is a support group for people who are on methadone maintenance. So we have these different groups to reach out to the many different targeted groups from within this subculture.

So I think you guys hit a lot of points. I really like this last one, in terms of there is a lot of digital type support groups, via cell phones. And I think CSAT just recently had a technology grant that was released. I was glad to see that because we did apply for it. More importantly, we have to really be creative as it relates to educating and informing people. I think social media, it would behoove us not to use that as an outlet to promote recovery and to create a support or system via cell phone usage, going a little beyond tele-medicine and stuff like that. But we could create -- we have the brain power to create a support system via cell phones, whether it's text messages, emails, et cetera. Thank you.

MS. WILMA TOWNSEND: Let me end with saying that one of the results of that meeting was that they said to us, "Please get this information out to the field as soon as you can." And so what we're giving to you today is we have done a "Dear Colleague" letter that is going out to all 1,400 OTPs, as well as the proceedings from the meeting in under six months. For SAMHSA, that's a miracle. So you each will have a copy of this. Like I said, it's going out. And please, if you want it electronically, let us know. You can contact us so that you can get it out. Like I said when I started, you are a part of the village. So you have the responsibility, after hearing me today, to get the word out.

Thank you.

## **Agenda Item: Recovery Month Update**

MR. TOM HILL: Thank you, Wilma and Mary Lou. Thank you, Paul. We're going to go into discussion, but first we're going to hear from Ivette Torres, the director of the Consumer Affairs Office at CSAT. And after her presentation, we'll follow-up with discussion, and then we'll take a break at 3:15.

MS. IVETTE TORRES: Good afternoon. Are we all awake after sitting all day?

DR. LORI SIMON: No.

MS. IVETTE TORRES: Well, I'm certainly going to wake you up. I only have 10 minutes. I had to reduce this thing by seven slides. You know I'm going to go fast. Okay. I'm going to put this on. Actually, I'm going to first talk to you. Are we on, or shall I do it from memory?

MS. AISHA WALKER: No, you're on.

MS. IVETTE TORRES: Okay. Good. I'm standing in front of it. Okay. So I'm going to stand up because I've been sitting too. I think that's too much sitting. So first I'm going to talk to you about 2015, and then I'm going to talk about 2016. We all know what Recovery Month is about. Dr. Watts, were you here before?

MS. GERVEL WATTS: Are you talking to me?

MS. IVETTE TORRES: Yes.

MS. GERVEL WATTS: I'm not a doctor. I'm the court reporter.

MS. IVETTE TORRES: Oh, okay. So you're not a new member because I hadn't seen you before.

MS. GERVEL WATTS: You've seen me for the last three years, but you didn't know who I was.

MS. IVETTE TORRES: Exactly. There you go. So anyway, you know what Recovery Month is about. We try to really get to individuals that are in recovery to celebrate their recovery so they can show up at events and activities with their families. And also to give those that are in need of recovery to realize that recovery is effective and that it does happen. And through these events, they can see, through the public service announcements, through the television show that I'm going to talk about, that everything works.

In addition to that, let us not forget that Recovery Month at the beginning was freely lauding the efforts of the individuals that are in the field. And so we also recognize those in our efforts. Recovery Month 2015 was "Join the Voices for Recovery: Visible, Vocal and Valuable." From January 1, 2015 to December 31, they were 121,885 who used the Recovery Month website, with about 300+ thousand generated page views.

Now, I'm really going to take a little bit longer here because we went down in the number of events, not necessarily that were hosted. I want to make that clear. It was in the events that were posted, Paul Molloy. Paul Molloy?

MR. JOHN PAUL MOLLOY: I hear you.

MS. IVETTE TORRES: Two thousand homes, a little dinner per home posted on the Recovery Month website can send up through the roof. Oxford House is one of my favorites because Oxford House has gone up to at least 350 to 400 events, and really, one year, put us over the top. But not this year. All right. So I really want to underscore that if you know that things are happening in your community, if you know that they are going on somewhere, somehow, and no one has posted it, please tell them to post it.

**Darlene Sagar** and Amy Smith, who is online, they've both been working arduously to really try and -- they have sent a note to everybody who posted a Recovery Month event. We're getting people that are saying, "Well, I only posted one, but we did the events the whole month." And now they're sending us the entire month, and we can't even post them anymore.

We know for a fact that the numbers that they're putting online, we went to verify and we surpassed. We also say, "Ah, we get about a million and-a-half people that go to events." Well, we know for a fact that Darlene has told me that now we have verified from this. We didn't do a survey. Tell OMB, we did not do a survey. No survey here. But she has said, "Ivette, out of the 250 people -- listen to this -- 250 people responded, and now we're surpassing the 1.5 million people in events because people are sending in the actual number of people that went to events." I hate to say it, but we've been missing the boat, somewhere, somehow. Not that we've done badly. We haven't done badly, but we could've really been in a bigger, broader, smashing category.

The Kick-Off, Dr. Oz came. I wasn't here. I had to take care of a family emergency in Puerto Rico, but I understand he was at the news conference. He didn't speak, but he spoke at the luncheon. And it was a very grand event. This year the luncheon was hosted by the National Council. Next year it's going to be CADCA. The 82 Recovery

Month Proclamations, that is another thing we're working on. We're working on having our SSAs. We're going to encourage them again to try and go to their governors to try and get us all the 50 -- in the 19 years I've been doing this, I haven't seen every single state have a proclamation. By God, before I leave, I'm going to try and get that, or I'm going to get very tired trying. But the beautiful thing about this 82 is that really, it comes from municipalities. It comes from city managers. It comes from native -- pardon?

MS. TRACY GOSS: Nothing.

MS. IVETTE TORRES: Tell me. You can speak.

MS TRACY GOSS: No, no, no. I'm listening.

MS. IVETTE TORRES: Oh, okay. I have five minutes. She was sitting there when I practiced and she was, like, saying, "You're taking too long." That why she says you only have five minutes. So anyway, 82 proclamations. Voices for Recovery; we got 25 voices for recovery. Please, if anyone here is in recovery, post your story. You've all got wonderful, wonderful stories. Paul, I've never seen you post your story.

MR. JOHN PAUL MOLLOY: I'm anonymous.

MS. IVETTE TORRES: We're not going to put your picture. Just put Paul, and don't mention Oxford House and they'll know. But it really is a way for other people -- they do go in and they do read the stories, Tom. You know?

MR. TOM HILL: I'm in this?

MS. IVETTE TORRES: There you go. Okay. Next. PSAs. Look at this. 103.53

broadcast hours at 20 seconds and 15 seconds a pop. So you know, people are not only airing the one year that we put out the PSAs, but they're also going back and using previous years' PSAs that we've already done. We must have on hand in our archives two per year for 19 years. Do the math. So all of them get re-aired, and re-aired, and re-aired. But the beauty of it is if we want to buy this air time, it costs us \$1.5 million, which we don't have. Not only that, it has generated all of this work between the television and the radio PSAs. Last month, Michelle told me that we got sometime in 2015, 60,000 calls to the help line. 60,000 calls to the help line, which is incredible.

*Road to Recovery* T.V. radio series. You know that they're produced by SAMHSA. Many of you have been on the panel. Paul has been on the panel. Some of you other folks too. If you want to be on one of the shows, I always invite you to go to [www.recoverymonth.gov](http://www.recoverymonth.gov). Look at the topics this week. On the 10th of March, we're taping suicide and LGBT issues in recoveries. After that, we're doing generational, family generational, and another topic that I cannot remember. So they are available. Incredible numbers: 58 million households if we were to pay for this. If SAMHSA would have to pay for that, it would be \$21 million worth of exposure for the agency.

For 2016, the theme is "Join the Voices for Recovery: Our Families, Our Stories, and Our Recovery." That, of course, will target military veterans and families; lesbians, gay, bisexual, transgender; victims of trauma; family members of those with mental and substance use disorders. Our toolkit should be available late spring, early summer because we've already cleared a lot of the copy for it. The awards programs. There are two awards programs. So if you know anybody who really did a great, great job at a 2015 event, have them go to [recoverymonth.gov](http://recoverymonth.gov) and apply for being recognized as a member. We've got three categories. There're all explained on the website. The other one is the Ramstad Kennedy Award given by the Recovery Month Planning Partners. And that is going to be given at the -- we used to call it the SSDP conference. What's

the new name?

MR. ARTHUR SCHUT: The National Block Grant conference?

MS. IVETTE TORRES: Oh, no. It's the SSDP. No, I'm kidding. Everybody still calls it the SSDP. But it's going to be given at what he said. And it is very covered. I mean, Michael Botticelli, you know, from ONDCP, everywhere he stands, he says, you know, "I was recognized by the Recovery Month Planning Partners," and he's very proud of it. So we're proud of it too.

The PSAs, we're going to be taping them in Atlanta on March 14th through 16th. They should be ready. Are you meeting again? Are they coming back?

MS. TRACY GOSS: In August.

MS. IVETTE TORRES: So in August, if I get two minutes, not 10, I'd be able to show the PSAs. This year, we have a veteran who goes into a hotel room, and it's on. We're using new technology, so he's going to be actually online in counseling, but then all of a sudden, you're going to see the pictures of his family and so on and so forth. So this should be really nice. The second one, that one is called *Stories from Home*. The second one is *Portraits*. This one is people talking about I'm a mother; I'm a sister; I'm this; I'm that, and I'm the other; and I'm in recovery. So that one should be quite nice.

How can you help? My goodness. We have these banners at [www.recoverymonth.gov](http://www.recoverymonth.gov). I usually make you say it to me, but we're in a hurry. Do go in there. And in your home pages of your organizations, put the banner down so that we can get referrals from your page. They're beautiful this year. Look at that little girl. Isn't she precious? So therefore, I'm asking you, if you know other organizations that you

know, please have them put it on as well. This is our new website. This is the look and feel for 2016. It is now part of the SAMHSA nomenclature of websites. You can also go by yourself at [recoverymonth.gov](http://recoverymonth.gov) and bypass SAMHSA still.

Mark your calendars. September 7, 2016, Recovery Month Planning Partner meeting, and September 8th is the National Kick-Off luncheon. If you're in town, let us know because you will get an invitation to come and join us. Any questions?

MS. KIMBERLY JOHNSON: Thanks. I think I have my information.

MS. IVETTE TORRES: No questions? Thank you very much.

MR. TOM HILL: So thank you so much, Ivette, all your planning partners and staff and others who make Recovery Month one of the premiere SAMHSA activities. Thanks, Ivette. So we're up on 3:00. We have a break at 3:15. Question: Take a break now, and come back at 3:15? Do you sort of want to get into some discussion with Wilma and Paul while those presentations are still fresh in your mind? Who would like to stay and discuss and then wait for the break until 3:15?

MR. JOHN PAUL MOLLOY: It would be nice to take a break now.

MR. TOM HILL: We'll take a break now and come back at 3:15. Great. Thank you.

**(Whereupon, at 3:00 p.m., a brief recess was taken.)**

### **Agenda Item: Council Discussion**

MR. TOM HILL: Welcome back. One of the people that we would be directing our

questions and comments to would be Paul Molloy, who is not in the room, but Wilma is. So is there any discussion around the two presentations regarding peer support?

Lori?

DR. LORI SIMON: I have just a comment. Paul and I were discussing it offline before. I think what the two of you point out so well is how important it is for people to have support. And what makes the difference, a lot of times, when I used to work with the homeless, is recognizing that if people in that community had support, sometimes it made the difference of whether you became homeless or not as to what degree you had support, in terms of addiction problems. So what you're providing with the peer support and what Paul is providing in the Oxford House is that emotional and logistical support. It's just incredibly key.

As a psychiatrist, I am by far not a typical psychiatrist. I get thrown out of psychoanalytic training. But I do have several clients who I brought in from when I was doing the homeless work. I stopped doing it, so I brought them into my private practice. I can't tell you that we're sitting here and doing heavy duty psychoanalytic stuff all the time because we're not. But they know that I'm there. They know that I care and, you know, I think I provide that. They don't have that from other people, so I just wanted to point out how key it is.

MS. WILMA TOWNSEND: My comment back to you on that is that it's absolutely necessary, but people, unfortunately -- and when I say "people," I mean the general community and the professional community, have a tendency to think that if you are giving some type of medicine, that's the cure-all, to end all. That may be just a door opening to start. Without those supports, the medicine doesn't get you there.

DR. LORI SIMON: The medicine is a start. That is all. It will stabilize somebody. It will put that floor under them. For example, if somebody is really depressed, they're not totally, you know, their objectivity is back to where they can sort of see maybe a path out. They can deal, and everything doesn't feel like it's climbing Mount Everest. If you're having an addiction problem, you know, it helps you get off the addictive prop, which causes day-to-day problems. You may be stealing or whatever because you need to support your habit. But yes, you are absolutely right. Without the psychiatric services that are needed for people who have the emotional problems, then just the day-to-day support, emotionally and logistically, is absolutely key.

DR. INDIRA PAHARIA: I had to go feed the meter when we were talking about reimbursements, so I missed that. I wanted to know, and I apologize if you have to reiterate what has already been said, but are managed care companies reimbursing peers? I think it's critical, and I don't know that it's happening. Many of you know, I once upon a time worked in that environment, and I know how hard it can be to get some of these things reimbursed.

MS. WILMA TOWNSEND: They can. It doesn't mean they all do. Okay. First of all, they check to see whether or not the state is an expansion state. And almost all of the expansion states have in their Medicaid waivers for peer recovery coaches to be paid. The states that is not an expansion state, what ends up happening is if it is a not-for-profit, they go and negotiate with their county government to see if they can get it put in. I would say only about 10 percent of them get it in. So those states, if they don't get it into their overall rate in some kind of way, they don't hire. That's the reason why we ended up doing this paper itself was because we have 1,400 OTPs. Out of those 1,400, there are probably only about 300 or 400 of them that have peer support services.

MR. TOM HILL: I'll just jump in. Even aside from Medicaid, there are a number of, a small number of managed care organizations that do fund for peer services. Just because they've seen that it reduces emergency room visits and hospitalization. It's a way for them to save money. So Migelin, value options. I'd say the ring leader is OptumHealth. They have three people with experience on their staff that have sort of developed mental health and addiction services. I mean, I can give you those contacts and whatnot. But it really sort of pushed the idea of this is not only cost effective for them, but it's also cost effective for the whole community.

MS. WILMA TOWNSEND: In fact, all three of those ones that I had time to do, they have a whole division of recovery services.

DR. LORI SIMON: Tom, are those for Medicare and Medicaid-managed care program or regular commercial insurance?

MR. TOM HILL: Both.

DR. LORI SIMON: Oh, really? So the regular commercial --

MR. TOM HILL: Right. That was my point that it was -- beyond Medicare, they also are for commercial insurance.

MS. ANN MAHONEY: Hi. I'm Ann Mahoney, and I'm representing EPJ American Public Health Association. I have a question. I was on a work group a number of years ago for APHA, which had a big influence and membership from the community health workers group at APHA. And this was when, I would describe, Medicare and Medicaid had money falling out of their pockets to try new models. But in any case, which included community health workers. So my question is, did you look at any of the CHC

-- CHW models for staffing for peer support and also reimbursements surrounding that issue? Because I think they may provide you with some dimension that could be helpful or maybe you've already done that in your good work.

MS. WILMA TOWNSEND: We have done that.

MS. ANN MAHONEY: Congratulations.

MS. WILMA TOWNSEND: We looked at all of the healthcare. And was like, six years ago when I first came here. We learned a lot. Interestingly enough, though, we had set up systems that trained our peers. Most of them are so passionate about helping each other within the substance abuse field that we're trying to get them to understand that it's bigger than just substance abuse and mental health. It's the whole healthcare field. And so that some of them should also look at getting jobs in other places. But we found so many curriculums. We found the training. We found models that people use. We looked at the way in which they did, for example, supervision training for the staff in hiring them. So we learned a lot from those other areas.

MR. TOM HILL: I would just add that aside from the positive side of that, being able to glean a lot of really good information. Because the community health workers had come along first in states, and sort of worked with certification, they sort of became -- and some states, sort of the gold standard that we had not always fit into, but had been sort forced to fit into in ways that didn't always serve well, especially in terms of lived experience as being a qualifier. So there has just been some tension around that. They're not obstacles, but things to be aware of in terms of turf. That always seems to happen and I think it was unexpected turf because we had looked to them as sort of role models and then they became the gatekeepers. So it's just an interesting turn of events.

MS. ANN MAHONEY: I will just add that because the CMS findings are just coming out after that three-year cycle at the beginning of the ACA, there might be some literature that's helpful. And one of the things that I would do during these calls would be community health workers via APHA, was talk about peer support and how are you including substance use workers.

MR. TOM HILL: Yeah. Thank you very much.

MR. ARTHUR SCHUT: But your presentation was about OTP and peer support. I think there is peer support now in a variety of substance use disorder and mental health. One of the big issues, from my perspective, and commercial included, is how it's paid for and what the rates are. And whether it's paid more as an episode or an hourly, or a timed event. What the frequency is and what is reimbursable. So if you're doing a lot of outreach and you have a lot of travel, there are some issues around how you fund the travel portion of it because you're only getting paid for the contact.

MS. WILMA TOWNSEND: Yeah. Make sure you look at that paper that we had the link to because they get into all of that.

MR. ARTHUR SCHUT: That's great. Thank you.

MR. TOM HILL: OmiSadé?

MS. OMISADÉ ALI: Yes. I have to say, as an editorial comment, that it's kind of ironic to me because when I got into the field in 1970, the only degree you needed was the degree from the School of Hard Knocks, and we all had that. So peer support isn't anything new. We've been doing it since the advent of addictions treatment. One of

the things that I didn't see in the presentation, and Tom kind of mentioned it, was the aspect of diversion that's created when people work with each other on that level. I started a few peer programs in emergency departments in Connecticut. Remember when you came and spoke at our first recovery conference years ago?

MS. WILMA TOWNSEND: Uh-huh.

MS. OMISADÉ ALI: It was a long time ago. The doctors and the nurses didn't have time to spend the time with people who were coming in for -- it was both, psychiatric emergencies and substance use challenges. And the peers that worked in the emergency departments, as much as the medical staff were kind of like leery of having somebody there who had just been in the emergency department themselves, six months ago. Pretty soon, they were asking me where is the peers? Where are the peers? Because they provided this service, this degree of service that they didn't have the time to do and were able to join with the person who was not always there needing that level of help, but just wanted somebody to talk with, just that human connection.

One of the other things that we really need to be cognizant of, and we had this in Philadelphia because we have -- our peer specialists are paid almost as much as some of the clinicians in the treatment program. Even though Pennsylvania was not a Medicaid expansion state, they had worked out that agreement with managed care to be able to pay them and pay them pretty well. Although we had done all of this training with the peer specialist, we didn't -- we found out we needed to do this and then subsequently did it. We needed to train the environment first because even though our peer specialists were well trained, they were credentialed by the state; they were getting certified by the Certification Board. People were not comfortable with them being in the environment with them and actually sitting at the table where clinical decisions were being made. So there really needs to be a training of the environment. And when you

hire one, you need to hire two, at least two.

MS. WILMA TOWNSEND: At the least.

MS. OMISADÉ ALI: Because they need peers themselves. We all need peers in our workforce.

MS. WILMA TOWNSEND: What I would say about that, Sadé, even though that's a critical piece of peer support, for this meeting, we decided not to get into that because we know that is a next step. It really is. And most of my work has been, as you know, in this whole arena. There is so much work that needs to be done when you talk about hiring peers. It's the same work that I said that needs to happen with the cultureship from thinking about the different pathways from abstinence to medication-assisted treatment and all those in between. It's the same thing with peers.

I had a gentleman just yesterday, I was on the phone with him, and I asked him did they have any recovery coaches, the peer specialists working within their organization. And he said, "Oh, no. We tried that; it didn't work." He says, "Now, I'm going to try to be blunt with you" -- I said, "Well, why didn't it work?" He said, "I'm going to try to be blunt with you." And he said to me, "The professional did yada, yada." I said, "Well, it sounds like what you're saying is the professionals didn't do the" -- and he said, "No, no, no." I said, "Well, we want to then." What this man really was saying, and he caught himself, what he was really saying was, "My professionals weren't that good. So my peers came in, and I had to say they weren't as good. So in the end, what I did was fired all the peers." Which is ridiculous. Absolutely ridiculous. But it was because the environment had not been set up where they were trained and understood the role, how we work together, what's the outcomes of what the professionals get versus the outcome, and how we work as a team. They had none of that. That is a whole other

set of stuff. So that's not in this here. Okay.

MR. TOM HILL: I have a question for Paul. It's two questions. It's about your national policies. Can you talk about your MAT policy, Medication-Assisted Treatment policy and your relapse policy and how those -- you know, integrated in the MAT policy. There was some problems with it on the ground. The relapse policy, I'm just wondering about because I understand how it may have made sense in 1975. I even know how it may make sense on a practical level, but in terms of referring people out, I would like to know is there recourse for them to get that? Like those kinds of things.

MR. JOHN PAUL MOLLOY: Okay. Number 1, on the medically-assisted treatment, in the beginning, we did not accept people -- Oxford House did not accept people on methadone. And the reason for that is we started here in Washington, D.C., and our population was primarily African American. When Dr. Primm was here, Dr. Beny Primm, I wanted to get us into that area. And then Dr. Clark came, and I suggested that we accept folks on methadone.

The Board, which was then made up of the presidents of the houses, fired me. And said I didn't understand that methadone was a white man's ploy to enslave blacks forever. And so I was fired for two weeks. I took the guts to the computer so they couldn't use it. And they then hired me back. And they refused to accept my notion of Cambridge House. I said okay, I won't do that deal. Let's do Cambridge Houses for methadone.

But I knew Karst Besteman; he was a friend of mine from a long time back, Herb Clever and everybody else. I kept insisting, you know, saying, "Give me some evidence that this damn methadone works." There are lots of studies. People can argue over the validity of the evidence; however, at the annual convention, seven years ago, the

members of Oxford House voted to leave it up to each house to accept folks on methadone or buprenorphine or any other opiate.

Even Montgomery County, for example, where there are now 19 houses, I think, we had 23 folks who were living in the houses who were taking Suboxone. And we did a study for Dr. DuPont, because DuPont was a buddy of the guy who created methadone back in 1963. They came from the same hometown in Ohio. We got good -- we're keeping track of that, and we've kept track now for those individuals for over six years. And I'm able to do that better without you all knowing that or getting the government involved or playing any game other than to say we're going to keep track of you folks. So we'll tell you more on whether it works or not. In some cases, it has worked. We've had more difficulty with methadone than we have with Suboxone. We've had folks in the houses grinding up the Suboxone and selling it on the street and trading it for heroin. And that has been some problems.

When people were thrown out or voted out of an Oxford House, if you're living with somebody, you know when that person has relapsed. And I have always argued with old-timers within Oxford House that said, "You don't need all this formal testing." One of the downsides of the drug court program and the criminalization of addiction is that everybody is an expert on drug testing now. And it also relieves everybody of responsibility, a personal responsibility of making a judgment. They say, "Ah, you proved it." So they vote them out.

North Carolina is a place we track what happens to the people who are voted out. And about 80 percent of the folks who are voted out will be back into an Oxford House within six months. Now, in most cases, the individual is taken to a treatment place or detox, but in most cases where there's a relapse, a person doesn't want to make the individual choices. Get away from these dead people who don't use. But nevertheless,

it is interesting in North Carolina, and we've tracked that. This is something we should try more.

Unfortunately, there was very little research in this area. In 1975, there has got to be more. We'd like to think that we encourage a lot of research. Dr. Clark used to go up the wall when I would say, "I don't know why the hell we can't put a chip in everybody's ear and keep track of them." And he would mention that that was a republican thing. But a lot of folks at Oxford House already have things in their ear. So it wouldn't be that difficult. Anyhow, does that answer your question?

MR. TOM HILL: Enough. Yes. Thank you. Any other questions or comments on this particular topic?

MR. ANDRE JOHNSON: I did want to add that when we talk about peer support services and diverse settings, I've also seen where peers are now doing SBIRT services in some communities, as well as the community health. We had a team, once upon a time, that were doing the needle exchange program in the Detroit area and also doing Rapid HIV testing. So peers are being utilized in other aspects of healthcare. So I'm really glad that Wilma pointed that out. Thanks for the great presentation. Thank you.

### **Agenda Item: RECAP: Putting It All Together**

MR. TOM HILL: Okay. Going to move onto the next item on our agenda, which is Kim and I giving a recap of what we've heard today. And then we'll move on to public comment from any of the folks who aren't on the council that are in the room that would like to make any comment, and then follow that up with a council roundtable and then adjourn.

DR. KIMBERLY JOHNSON: There's a lot to recap in a few minutes. All I'm going to say is we've heard a lot. This has been a great discussion, and I think we've raised a lot of issues and had some examples of solutions. So we heard some presentations from some of our members who have examples of solutions that are working. At some point, I would like to have more discussion about the issues and some more examples of solutions or more conversation about solutions. I was saying to Doreen, before she left, she talked a lot about the kinds of issues around getting access to treatment in general and access to medication for adolescents, but we really didn't have much time to ask what can we really do about it? So we know that there were access issues, right? There are access issues for minority populations. There are access issues for people in rural areas, which we didn't get into today. There are a lot of access issues, and we've raised a lot of those issues. We haven't talked about them much; we just said these are issues. So I'm looking forward to an ongoing conversation about how we resolve those issues. And also, talk about what CSAT's role is in resolving those issues. How can we partner with you all, with communities, with the states, with all of the different partners? So that was more of my stump speech as opposed to the wrap-up. But it's been a great discussion, and I'm looking forward to more of those.

MR. TOM HILL: Thanks, Kim. I think I agree. I think that meetings like this can be a little frustrating because in a day, you can only cover so much, and let's see what advice or counsel we're getting from the council. Here are sort of some random thoughts that I wrote down as the day went on. When Sadé was presenting, she was really thinking about with substance use and substance addiction, what are the root causes? What are the things underneath all of the things that are propensities for people to use? And to sort of look at those as well as what's on the surface.

The whole balance between practice-based evidence and evidence-based practice,

what we know works. And even as an extension of that, we talked about research-to-practice, but we also need to talk about practice-to-research and how do we make those connections? When we are continually asked to provide evidence-based practice and we don't have it or we don't have the resources to get there, but we need help. And we need those kind of conversations between researchers and evaluators and practitioners to figure out how to work collaboratively to move those things forward and to get the resources to do that.

What are the appropriate responses for specific group and cultures regarding strategies to address that abstinence of symptoms is not recovery? So we know that the pill will sort of abate the symptoms, but learning how to engage in a life in recovery is a whole other thing. So we know now to connect the pill-taking with psychosocial services with counseling and even peer support. These aren't things that are new to us, but just things that keep surfacing over and over again.

In drug courts, transitioning from treatment and drug courts in the community, what are the components, besides treatment that make that successful? And that was sort of the big component of drug courts in the beginning. Still a big one, but one that needs to be augmented by a lot of other components. What are they? And how do we have evidence that they promote successful recovery? The whole idea of training for drug court providers, from judges, all the way down, about medication-assisted treatment, is something I'm very interested in because it really is talking about a paradigm shift. It's talking about all pathways to recovery in a way that's real and sensible, but also, it's something I've heard all day long. I haven't heard it said in these words. They're my words, but it's how do we start instituting a recovery culture in these diverse settings? So if there is a recovery culture in drug courts, it's going to look very different. And there are drug courts that are putting that forward. And how can that training help to sort of lift up that consciousness?

I wrote down what was on Andre's slide, why not involve peers in drug courts? The idea of lived experience with folks that come in untrusting of the system, untrusting of any system, being there not on their own volition, to have somebody navigate and guide them through, especially the alumni, for people who have been there already and can sort of say I did it. You can do it too. It's a huge thing. And developing that trust is not always going to happen with the judge, right. So then I was interested that Andre provided several working models for using peers in drug courts. Again, with criminal justice and incarceration, what are the root causes? Often, they are substance use and addiction, but they're also other root causes underneath that.

Then with the presentation on Oxford House and the OTPs with peers, again, it's really about this culture of recovery. So Oxford House is not only a safe place to live where people aren't using, it's also living with people that are role modeling recovery. That are role modeling how to develop recovery skills. That could be about making your bed or doing chores, but are also about how do you be honest. Like, how do you be honest with a group of people under one roof? That's an incubator for recovery that I think is really worth looking at.

Then with OTPs, or with Medication-Assisted Treatment, people who have been using medications have often not even been introduced to the concept of recovery, much less been invited into a culture or climate for recovery. So we would have people that were using medication and not using opioids or heroin, but would be smoking pot or drinking. And that was okay. And they'd still be okay if you look at it in terms of harm reduction. In terms of living a life in recovery, it's a very different outlook. So to give people that opportunity and that hope in a place that has never existed before, I think is a huge, huge paradigm shift. And one worth looking at, in terms of medication assistance. Because we know that when people are connected to community and connected to

those supports, they are able to achieve recovery. First of all, you have to name it, and then you have the hope that you can achieve it also. So I think that's a really big shift that we're living in.

And then finally, I think with the opioid epidemic, as tragic as it is, and tragic to see so many people and young people dying of overdoses or getting addicted when they didn't plan to -- not that anybody plans to -- that there's an opportunity for a new conversation and new ways to address in way that maybe we haven't thought about before. So I heard a lot of those various things today. I'm really delighted by the presentations, the depth and breadth of them. It would be ideal to have another day to really sort of dig down and ask the really difficult questions now.

So thank you all very much. I don't know if I encapsulated that very well, but that's all I got from my crib notes.

### **Agenda Item: Council Roundtable**

MR. JOHN PAUL MOLLOY: Tom, let me just mention one thing. For anyone who is interested, on the home page of our webpage, some sessions from our last convention are there, including one where Dr. Clark gave his first speech after having left the agency. He's very good. Also, General Session III is an excellent presentation by Stuart Gitlow, who was then president of the American Society on Addiction Medicine. He really talks about culture being such an important part of what triggers addiction and the fact that we've gotten rid of cigarette commercials. That sort of stuff on television has probably contributed to reduction in our smoking.

As I sit there now, as an old man, looking at television and seeing all these medicines that I could've taken or should have taken and then I listen to all the caveats that they

might kill me, I guess that is trying to scare me off. But I kind of think it's not surprising that we have some folks who get hooked on heroin, and Vicodin, Percocet and these other things. We may have to revisit, as a government, whether or not you have this kind of blatant advertising in medications. I know the argument for it is that a lot of uninformed people will never get the medicines if they don't hear about them on television, go to their doctor and say, "Hey, how about this medicine for the nervous feet I've got as a result of my diabetes," or whatever. But that is something that I hope CSAT and SAMHSA will begin to look at. And I'm sure that if my party guy who appears to be headed for that nomination comes in, he'll blast all those people real fast, as he moves for making America great again.

DR. KIMBERLY JOHNSON: You have another comment or question or something?

MR. TOM HILL: Oh, I'm sorry. Lori? I'm looking right past you.

DR. LORI SIMON: It's late in the day. Just a couple of things. Interestingly, oxycodone is actually being studied, I think up at Mass General, but I'm not sure, for anti-depressant properties. So that might be another factor as to why people get addicted to it. Again, that's self-medication, another aspect of it. Just a couple of suggestions just to throw out. You know, you might want to think about maybe reaching out to some of the professional provider organization that deal with the constituents we're talking about.

So for example, the American Psychiatric Association has two main conferences every year. One is in May, but the one in September/October is the Institute for Psychiatric Services, and that is much more of a public psychiatry focus. And just thinking about maybe going and talking and setting up where you can interact and see what the problems are, in terms of being able to deliver care for the population we're talking

about.

Also, social workers. Social workers deal with discharging patients from hospitals. What problems do they have with, for example, low-income or homeless patients who need medication, who need psychiatric services? I know in New York City, sometimes there's a six-week wait to get into a mental health clinic. So reaching out in that way to establish a dialogue. The other thing is in terms of, you know, how things are in Congress. Nowadays, as we know, it's difficult to get things through and get funding and things. A lot of times it just boils down to funding for all these great ideas that people have. I don't know what extent you guys reach out to private sources of funding or nonprofit foundations or something like that. I mean, is that feasible at all? Or do you do that?

MS. WILMA TOWNSEND: Yes, we have.

MR. ARTHUR SCHUT: There have been partnerships with that, yeah.

DR. KIMBERLY JOHNSON: Those were the words I was exactly trying to say. There have in the past been partnerships. Many years ago, actually, not that many years ago, I was involved in a partnership between SAMHSA and Robert Wood Johnson Foundation. So we, as an organization, have done that in the past.

MR. ARTHUR SCHUT: So I would like to, at some point, have a conversation about rehabilitation versus habilitation. In part, medical insurance is aimed at rehabilitating people. And so it is hesitant to pay for habilitation. I equate the people who are -- you are not rehabilitating them to a prior level of function because they never had it. At some level, I equate it to a congenital illness. You know, you have people who are created in a setting where they just never function well, and yet, they tend to end up

residing in therapeutic communities and much longer-term treatment and need longer-term treatment. And yet, the health system is loath to pay for that because it is not rehabilitation, or it pays for it. And then it says, "Well, see, they get rehabilitated, and they act like they never functioned well to begin with."

So I'd like to have a conversation about that and what we would think we could do as CSAT in terms of framing that conversation and then what the implications are in terms of how the services are delivered. And then one other thing about practice-to-research is -- and excuse my longevity in the field -- but there was a point in time where NIAAA actually had called a group of providers together and said, "What do you need in terms of research?" And NIDA actually did the same thing. And it has probably been, I don't know, 20 years ago or 25 years ago. They only did it once. We're talking about a culture clash again. You're talking about people doing basic research and people wanting practical solutions. But to have that conversation again with them would be a nice conversation to have, I think.

MR. ANDRE JOHNSON: I would like to add, you know, really thinking about the local jail system and the high recidivism rate. It's a cycle. I think it's a missed opportunity for our government to encourage partnerships with peer organizations. The local jail systems usually keep people who are typically misdemeanors. A lot of them are reoffenders. So I've noticed that over the years, CSAT has really worked diligently, partnering with the drug courts, but I also think it's a missed opportunity if we don't look at exploring partnering with our local jail systems because the same people are going in and out of their system. I did have one other little comment as a side note, and that is I noticed over this last year that a lot of CSAT grants, it appeared to me that a lot of grants were being awarded to universities. It seemed like they kind of diminished from awarding the grants to community-based organizations.

I don't know if there has been a shift or a change in direction or focus, but me representing a community-based organization, I'd like to say we really have our boots on the ground. To have a decline in being able to access funding during this already crazy climate, in terms of the whole Affordable Care Act and Medicare and Medicaid, it's been a nightmare. It's been a nightmare to keep the doors open to provide services for our community. Our particular facility services about 400 to 500 people a month.

I think Art did a good job earlier when he talked about how some of the states who have -- they're playing with the block grant dollars and redirect the block grant dollars because they now have this overload of Medicaid dollars. So that means that the block grant dollars that were once going to agencies is now going somewhere else. So I'm number one, really excited. The stuff I'm talking about was prior to time in Kimberly's post, but I just wanted to put that on your mind because it has been a concern of mine over the last several months, just seeing how things are changing in this shift in climate. We want to really continue to encourage and embrace community-based organizations. And so when we talk about peers, it's going to be important that we're able to have basic resources to support the peers because the peers are doing extraordinary work on the front lines of our communities. So I'm just really happy to see the leadership. That's another thing; we didn't even have leadership last year. Everybody was "acting." Everybody said they were acting. So it's good to see some permanency. I personally wanted to congratulate you and welcome you.

So when I first heard of Kimberly Johnson, I'm like, "Is that my cousin?" I do have a Dr. Kimberly Johnson who is a cousin in Maryland. So I was like, "Oh, yes. We got a black woman?"

DR. KIMBERLY JOHNSON: And then you saw me and said --

MR. ANDRE JOHNSON: And you're just beautiful just the way you are. But no, I'm excited. And even at NIATx, I know you bring a lot of experience with that. That may even be something, a pilot program for peer-led, peer-ran, peer-driven efforts to something we can explore. We were doing it when NIATx started in Detroit years ago.

And then lastly, Tom, I'm drawing a blank on the name of the organization that started to accreditate peer organizations.

MR. TOM HILL: CAPRSS.

MR. ANDRE JOHNSON: CAPRSS. I don't know, have you ever heard of CAPRSS?

MR. TOM HILL: Pull your mic back a little bit more.

MR. ANDRE JOHNSON: I know. It's driving me crazy. CAPRSS is an accreditation body that accredits peer-led organizations. What I've seen is that everybody wants to say they have peers now. And so I think it's already been clear that a lot of organizations have not been trained, but CAPRSS has some tools to ensure that if you say you are peer-led, you have to meet certain standards and certain expectations. Some people are using the word "peers" very loosely. And so it's important that we understand what a real peer-to-peer organization looks like. It would behoove you all to look at CAPRSS. That's C-A-P-R-R-S.

MR. TOM HILL: C-A-P-R-S-S.

MR. ANDRE JOHNSON: Oh, okay.

MR. TOM HILL: It's the Council on the Accreditation for Peer Recovery Support

Services dot org.

MR. ANDRE JOHNSON: Thank you, Tom.

MR. JOHN PAUL MOLLOY: As long as we always keep in mind that a lawyer like me make laws and more laws and more laws. The tendency, over time, is for total immobilization. And the reason for that is that nobody is smart enough to anticipate the future. And you have to base the system more on values and education rather than certifications and things that can often be artificial. We were welcomed to Texas by a guy who was a 12th AA fellow to come to Texas. And he said, "I've given up total hope because folks were leaving AA." His sobriety date was April 4, 1946. And he said, "Gee, we're leaving AA and joining up and becoming certified counselors." It had changed the whole organization that he had become part of. And then Oxford House came back to town and said, "If you're starting off with sobriety, come out and live with us." And that had restored him, but then of course, he died a couple of years later. But he was 94 or something. So it was probably time for him.

MR. ARTHUR SCHUT: That's pretty young, you know.

MR. JOHN PAUL MOLLOY: I know. It's younger and younger to me all the time.

MR. ARTHUR SCHUT: I think there's some issues. I know that I've encountered around peer assistance and peer coaches the desire to make more and more regulations about that and certification. And we actually had one. It was an accountable care organization that saw a medical group that wanted to use peers, but they wanted them to all have MSWs.

DR. KIMBERLY JOHNSON: Oh, geez. There are some.

MR. ARTHUR SCHUT: There are some, yes. There are. But the universe of MSWs is a problem already, in terms of shortage of -- but it does sort of tend to go in that direction after a while. Colorado, in particular, has this approved treatment provider for folks that work with criminal justice clients, and you can't have any past criminal offenses in order to get qualified. I mean, and they're working at changing that now. But there all sorts of impediments that come up to actually having peer recovery coaches and peer mentors or whatever you want to call them.

MR. JOHN PAUL MOLLOY: Is it Nike that says, "Just Do It?"

MR. ARTHUR SCHUT: What's that?

DR. LORI SIMON: Yes.

MR. JOHN PAUL MOLLOY: Is it Nike that has the ad, "Just Do It?"

MR. ARTHUR SCHUT: Yeah.

MR. JOHN PAUL MOLLOY: And can you just slap people's hands when they want to regulate and certify?

DR. KIMBERLY JOHNSON: Well, it's an interesting tension. It would be a great debate because I think --

MR. ARTHUR SCHUT: There has to be something.

DR. KIMBERLY JOHNSON: Well, you regulate when problems happen. I mean, that's

when regulation is created. It's when something goes wrong. But it's a great debate for this industry because we've had it more than once, right?

MR. TOM HILL: History repeats itself. But totally understanding the basis of your argument, Paul, the issue often is that other people set the steps of credentialing and accreditation standards. So if you're not proactive and sort of address those head on, they'll be made for you.

MR. JOHN PAUL MOLLOY: Well, for example, and I agree, and you'll notice that some states are putting in regulations with respect to recovery homes.

MR. TOM HILL: Right.

MR. JOHN PAUL MOLLOY: And every one of those states exempts Oxford House. And the reason they exempt Oxford House is they know the minute they try to go after us, we would go into court and argue that under the First Amendment to the Constitution, they cannot do this. And we would win.

DR. INDIRA PAHARIA: But you do understand why some of those states are doing it, because in some states, there have been a lot of abuse of people --

MR. JOHN PAUL MOLLOY: I don't think so. I don't think that's the reason that these are cropping up in states. I think it's cropping up because individuals believe they can now make money because of the Medicaid extension. And I think that's the primary reason. I went to the folks here and folks at Justice and so on, before we brought the case to the Supreme Court that said recovering individuals were protected under the Federal Fair Housing Act that couldn't discriminate. And the reason I went to them was -- and I went to Philadelphia. This was when SSI was paid to alcoholics and drug

addicts.

I went to Philadelphia, and a guy had a three-bedroom house with 43 deep there. All of them were getting their SSI checks. And we argued, internally, should we even bring the case? Because by bringing the case, that fellow had a chance to abuse his fellow human beings longer, unless we were very careful. So I do think -- and we did win the case. And we have been very careful, and we made sure that guys like that are treated as boarding houses and are subject to the full regulations of the Federal Fair Housing Act. So I do think it's possible to have responsible citizens out there. Responsible organizations that have nothing to do with government. They are just plain old lawyers liking to stir the pot.

MS. WILMA TOWNSEND: A couple of comments. I agree with you, but it's the same thing. And I'm going to say it again. Like abstinence in recovery and the stuff in the middle, everybody has to see what part of the system they want to play. If you want to play that it's just you, and you don't want to be a part of the government, high-five to you. If you want to play where you think you, as a recovery organization, can get accredited so that you can let other peers out there know about you and you can charge Medicaid for it so you can hire more people, high-five to them too. And anything in between. But I don't think we should get caught up --

MR. JOHN PAUL MOLLOY: Oh, I agree with you.

MS. WILMA TOWNSEND: Don't get caught up in the fight because we need all of us.

MR. JOHN PAUL MOLLOY: I agree with you. And I think one of the good things about the substance abuse field and the mental illness field is that there's a great deal of

patience, tolerance, and understanding. In many ways, we set an example for the rest of society not to polarize, but to try to figure out how to work out things.

The good news about alcoholism, drug addiction, and mental illness is that they're egalitarian diseases. And it's a nice thing. Rich, poor, black, white all get hit with it. And because we do, we all got to work our way out of it. But I do think that it's always good to remember that regulation begets more regulation and more regulation. And at some point, it's the lawyers who are having the heyday, and the clients are lost long ago --

DR. LORI SIMON: That's true.

MR. JOHN PAUL MOLLOY: -- to the game-playing of lawyers. And maybe we need a bumper sticker, "Be Aware of Lawyers."

DR. LORI SIMON: And put it on your car?

MS. WILMA TOWNSEND: I think it already exists. The last thing I wanted to say was we were talking about the courts and peers. The game center who handles TA for SAMHSA, they have a TA thing with SAMHSA for peers working in drug courts. And I met with a group of them. Half of them are peers within the substance abuse, and the other half was within the mental health. And they are collecting some information on them. We may need to check and maybe have them talk about what it is they're doing. I will say when I met with them, these peers are very, very isolated. They don't know. And if the courts hired them, I don't even know how they found these folks. They didn't go down to the peer center. They didn't go to Oxford House. They didn't go anywhere. But they got these peers who are very good, but they don't have the support they need. The game center, I think, would be a good place for us to learn some stuff about what it

is that they've done with peers in the court systems.

MR. JOHN PAUL MOLLOY: Yeah. And then you get great variation between drug courts.

DR. KIMBERLY JOHNSON: Other comments?

MR. TOM HILL: Yes. Do we have any members of the public with us today who would like to address the Council? If so, please identify yourself before speaking. You would have to come up to the table.

(No response.)

Are we finished with the Council Roundtable?

MR. ARTHUR SCHUT: I, of course, have one more thing, always one more thing. It would be nice to have a conversation about fidelity and how you get fidelity to evidence-based practices without -- you know, I've been part of the NIDA Clinical Trials Network, for example, and also part of motivational interviewing and motivational enhancement that the fidelity measures are huge, in terms of how you actually measure fidelity. It would be nice to have a set of ways of measuring fidelity that are short, economical, easy to implement because everybody in the world says they do evidence-based practices, but if you actually look at it, they don't. And the whole issue of fidelity to practice is important. But it doesn't get implemented because there aren't nice, quick, clean ways to measure fidelity. It would be nice to have those. They don't have to be perfect, but they'd be better than what we don't implement now because we're not going to implement it because it's too onerous. That's it. Nothing more.

DR. KIMBERLY JOHNSON: Do we have to define fidelity before we even do that? Is that part of the conversation?

MR. ARTHUR SCHUT: I don't know. That's like defining "quality."

MR. JOHN PAUL MOLLOY: That chip in the ear is coming back, isn't it? Body cameras and chip in the ear to watch these people.

### **Agenda Item: Adjourn**

MR. TOM HILL: We're ready to adjourn?

MR. ANDRE JOHNSON: I make a motion that we adjourn.

DR. INDIRA PAHARIA: I second.

DR. LORI SIMON: Will our binders get brought over?

MS. TRACY GOSS: Actually, you can take the binders with you, and then you guys will have them with you tomorrow.

DR. LORI SIMON: Okay.

MR. TOM HILL: Okay. We got a motion. We got it seconded. All in favor?

(Whereupon, council members unanimously vote "aye.")

MR. TOM HILL: All opposed?

(No response.)

Meeting adjourned at 4:12 p.m.

**(Whereupon, at 4:12 p.m., the CSAT NAC meeting adjourned.)**