

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

**Center for Substance Abuse Treatment (CSAT)
79th Meeting of the CSAT National Advisory Council
(NAC)**

**August 1, 2018
5600 Fishers Lane
Rockville, MD 20857**

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Council Members Present:

Chideha Oluoha, Chair
Tracy Goss, DFO
Kristen Harper [on telephone]
Jason Howell
Andre Johnson
Sharon LeGore
Judith A. Martin
Lawrence Medina
Arthur Schut

Other Participants:

Anthony Campbell
Wilson Compton
Darrick D. Cunningham
Steve Daviss
Donna Hillman
Arne Owens
Onaje Salim
Amy B. Smith
Audra Stock

PROCEEDINGS

Agenda Item: Call Meeting to Order

MS. TRACY GOSS: Good morning. The 79th meeting of the Center for Substance Abuse Treatment National Advisory Council is hereby called to order, Dr. Chiheda Ohuoha, Chair, presiding.

Agenda Item: Welcome, Opening Remarks

DR. CHIDEHA OHUOHA: Thank you, Tracy.

Good morning. Welcome to everyone. Although I've had an opportunity to speak with you virtually during our recent grant review, I'm looking forward to engaging with you in person today.

First, although she's not with us today, I would like to acknowledge Ms. Kathryn Power, who graciously led this organization and agreed to lead CSAT until my arrival and supported me through my transition.

I also want to acknowledge our guest, who is not here yet, but will be here, Dr. Wilson Compton, who is the Deputy Director at the National Institute on Drug Abuse. He will be speaking with you later this morning about using research to respond to the opioid crisis. We are very fortunate to have Dr. Compton with us, and I know his presentation will inspire some lively discussion.

I would like to just briefly introduce myself and give you a short history. Before joining CSAT, I served as the Deputy and Director of Addiction Medicine at Fort Belvoir Community Hospital, Virginia, for 7 years. There, I was responsible for implementing the Co-Occurring Partial Hospital Program. Previously, while there, I was chief psychiatrist for the Wounded Warrior Transition Brigade. Before that, I was the Medical Director for the Mobile Community Outreach Treatment Team, using the Assertive Community Treatment paradigm at St. Elizabeth's Hospital in Washington, D.C.

I've also filled various teaching and assumed leadership positions at NIDA, NIMH, New England Medical Center, and Texas A&M University, Howard University, and George Washington University School of Medicine. I look forward to applying my experience as a physician and captain in the United States Public Health Service to ensure that CSAT programs and activities continue to bring quality treatment and services to the population that we serve.

Finally, I'm very pleased to announce that Ms. Audra Stock, whom you previously met, is now our new Deputy Director and has accepted the position

very, very, very, very wisely.

[Laughter.]

MS. TRACY GOSS: Before we begin the actual meeting, I would like to do a roll call. We're going to start with those on the phone.

Bertrand Brown?

[No response.]

MS. TRACY GOSS: Trenette Clark Goings?

[No response.]

MS. TRACY GOSS: Kristen Harper?

MS. KRISTEN HARPER: [on telephone] Present.

MS. TRACY GOSS: Terrance Range?

[No response.]

MS. TRACY GOSS: And now for those in the room. Jason Howell?

MR. JASON HOWELL: Present.

MS. TRACY GOSS: Andre Johnson?

MR. ANDRE JOHNSON: Present.

MS. TRACY GOSS: Sharon LeGore?

MS. SHARON LEGORE: Present.

MS. TRACY GOSS: Lawrence Medina?

MR. LAWRENCE MEDINA: Present.

MS. TRACY GOSS: Arthur Schut?

MR. ARTHUR SCHUT: Present.

MS. TRACY GOSS: And Judith Martin?

DR. JUDITH A. MARTIN: Here.

[Laughter.]

MS. TRACY GOSS: Thank you. We have a quorum.

Agenda Item: Member Introductions and Updates

DR. CHIDEHA OHUOHA: Now I invite each of you to introduce yourselves and provide a short introduction. We will begin with those on the phone. How many did you get on the phone?

MS. TRACY GOSS: Just Kristen Harper.

DR. CHIDEHA OHUOHA: Can we have Kristen Harper, please?

MS. KRISTEN HARPER: Sure. Yes, good morning. I am so sorry that I can't be there with you all. My travel schedule has been a bit tight lately.

My name is Kristen Harper, and I am a consultant. I created a company last year and do most of my work with collegiate recovery and also just recently joined as a PTOC, or part-time on call staff, for our Center for Social Innovation, working on the STR grant. So I am really looking forward to the conversations today and also want to say hello to my dear friend Andre, who is in the room there. I wish I could chat with him about our upcoming project in Ghana.

We are doing a documentary, flying me over in September to talk about the rush of the drug trade and recovery resources that have been set up in Ghana. So I look forward to hearing how everybody else is doing.

DR. CHIDEHA OHUOHA: Now I want to give a chance to other members to introduce themselves and update on any new projects or concerns that they have. Can we start with Sharon LeGore?

MS. SHARON LEGORE: Sure. My name is Sharon LeGore -- oops, sorry -- from Pennsylvania, and I work with families. I lost a daughter to a heroin overdose and began an organization called MOMSTELL to join families together and provide support. And that just moved on. I worked for CSAT doing some of the grantee visits, representing families. Also started co-directing with Shannon CrossBear on the National Family Dialogue for families of youth with substance use disorders.

And I have a son who has a co-occurring disorder, bipolar schizophrenia and also a son who was in a severe car crash that got, unfortunately, hooked on opiates. Still struggling with recovery today. So the recovery issue, the treatment issue is very close to my heart.

One of the things that you mentioned, to talk about concerns, so one of the

concerns I have is for the grieving families and the outreach to siblings and to the other family members that we focus so much on the recovery of the person who is trying to get into treatment and get into recovery. And I know, as a parent, I was so laser-focused on saving my daughter that I didn't realize the harm that was coming to my other children as well.

So I think this is a real health problem across the country and something that's not addressed. And I would love to see, now that we're focusing on opiates, not just focused on a target population where we see the most problems right now, but really looking at the full continuum of care going from those pregnant moms who are addicted and dealing with the entire family problem because it may not just be the mother and the baby.

There is a whole -- may be siblings that are involved, and they're not getting treatment for trauma issues and addiction issues, of course, and what happens. And if we can reach them at 0 to 5 when, you know, everything is being formed character wise and get them the help they need, we might be able to keep them from eventually entering the adult population.

So those are the main things that I'm concerned about, and I thank you very much.

DR. CHIDEHA OHUOHA: Thank you very, very much, Sharon. Mr. Lawrence Medina?

MR. LAWRENCE MEDINA: Thank you. Good morning. Again, my name is Lawrence Medina. I'm from Taos, New Mexico.

I like to advocate for rural and frontier areas. I think a lot of times rural and frontier areas fall through the cracks, and we have a lot of issues. I am currently the executive director for Rio Grande Alcoholism Treatment Program, a program that's been providing services for over 40 years in northern New Mexico. And I recently was part of a project to open up a women's transitional living program, women coming out of prison, pregnant women, women with a child. The program is called Sangre de Cristo House.

And just grateful to be here. I like, you know, when I have the opportunity to participate in the committee to learn more, network, and you know, share resources. I mean, times are, you know, tough. And but by, you know, not only my fellow committee members, but also the staff to take advantage of learning more and seeing what information and resources are available.

Thank you.

DR. CHIDEHA OHUOHA: Thank you very much, Mr. Medina. Mr. Jason Howell?

MR. JASON HOWELL: Good morning, everybody. My name is Jason Howell. I'm a person in long-term recovery from both mental health and substance use issues. And recovery has been such a gift to me. It allowed me to do things that I would not have been able to do in my active addiction. One example would be I'm the executive director of a nonprofit called RecoveryPeople. We're based in Texas, and our focus is on recovery support services, peer- and family-led recovery support services. We're not direct service providers. We focus more on training, technical assistance, advocacy, community organizing.

And then at a national level, I also serve on the board of the National Alliance for Recovery Residences, which has identified four different types of recovery housing out there, and we've built some national standards and really looking currently at so how do we make sure that recovery housing is medication-assisted treatment capable? I mean, historically, you have medication-assisted treatment and recovery housing have not interfaced. But in this current opiate epidemic, it's really important for us to find ways to make sure that individuals who choose to be on MAT can connect with the recovery support services they need, including recovery housing.

So three concerns, real quick, that I'll just raise. We are also honored -- RecoveryPeople is honored to be a grantee of the RCSP Statewide Network, and there's been a shift in the way the technical assistance has been provided. Rather than Federal contractors providing technical assistance, I think some money is going to be allocated to each grantee, and then we can decide how to use that.

I know that I received an email asking me to opt in to that, and of course, I did. I don't -- that just kind of now it seems like it's behind a black wall. I don't know when we get those resources, if we get those resources. And then when I talk to some of my fellow grantees, they never received the email, and so they're a little concerned that they've missed out on that funding. So any -- any news that we can get about when we get those resources, or for those that didn't get the email, how we can get them plugged into those resources would be great.

The other thing that, you know, in Texas, we have more persons dying of methamphetamines and then also more people dying of alcohol-related disease compared to opiates. And I don't want to take anything away from the opiate crisis because we need to be pouring resources into that. But my concern is that some of the funding streams that are coming out are so narrowly focused in addressing opiates that we're missing an opportunity to build out a larger infrastructure.

Because today, it's opiates. Tomorrow, there will be another substance that kind of pops up, and we'll have our lawmakers kind of turning to SAMHSA and to us as a community going, "Why aren't you doing something about XYZ?" And so to the extent that we can proactively leverage some of the dollars so that when that

happens, we can say here is our plan, this is what we're doing, and we can address something more comprehensively.

And then my -- my last comment is we're seeing a wave of legislation coming through Congress and probably another wave of funding. And I also see -- my understanding or notion is that SAMHSA is a little understaffed. And so, as that wave of resources come in, I'm wondering if SAMHSA has the staff to be able to handle all those, you know, new responsibilities and everything else that you're currently doing in a very timely way.

So I -- you know, with my own organization, we're always looking at staffing plans and what's on the future, and so I'm curious to see, you know, what SAMHSA's staffing is based on the opportunities that we'll likely see.

Thank you.

DR. CHIDEHA OHUOHA: Thank you very much, Mr. Howell. Mr. Andre Johnson?

MR. ANDRE JOHNSON: Hi. Good morning again. I'm the president and chief executive officer of the Detroit Recovery Project. I'm also a person in long-term recovery for over 30 years now, and I'm also the founder of Detroit Recovery Project. We just celebrated 13 years of being in operation in Detroit.

And a big part of that success has been due to the CSAT office because we were one of the RCSP recipients in 2011, and we've been able to -- well, we were able to use that money and leverage local funding from our State -- economy of the State and some foundation funding. So to be in existence for over 12 or 13 years and still being able to stay true to our mission, which is helping individuals sustain long-term recovery.

I'm sure you all have heard of the [inaudible] Detroit, you know, where we have some comeback times, huge changes in our economy. But we still have some of the very challenges that we've always had, which is lack of employment, education, and training opportunities for people who need it. I think when our folks stay clean and sober, there is correlation of having some financial stability, some housing stability.

And if I can ask one thing, it's that we really wrap our arms around building more partnerships to help people be self-sufficient. I'm not talking about helping somebody get a job at McDonald's. I'm talking about helping somebody get a job and making a meaningful salary for themselves so that they could support their families. We average about 400 people coming through our doors per month. We have two recovery centers in the City of Detroit, and we do an array of services from social supports, sober dances, domino clubs. They talk about you real bad when they're playing dominos.

[Laughter.]

MR. ANDRE JOHNSON: You want a good laugh, you can always get one. But we have a team of recovery coaches. We have about 25 State-certified recovery coaches, and each one of them average 25, 30 people. And we are making the change in terms of promoting long-term recovery, supporting recovery, engaging our recovery community, working with our Federally Qualified Health Centers, working with our prevention and treatment provider network, working with our local county government, working with our local universities. And we're doing a whole lot with small resources, and it's actually changing the perspective in our community.

We're actually working on the stigmatization that occurs with people who have substance use disorder. So it's -- you know, it's a busy, busy, busy job all the time. But I just want to say we work with the downtrodden. We may have somebody who's been standing on the corner for 5 years finally say "I give up." And you know, it's easy to shove them through a 30-day, 90-day residential treatment program. I think that's the easiest part of this business.

But once they're done, now what? And how do we keep those contacts and make sure that we can turn this person who's downtrodden to a productive member of society. And I think with employment or education and training and certification, it helps.

We are a recipient of HRSA funding. We provide training opportunities for recovery coaching, working with our State. So that's been a good component, but we also need to allow some of these people to become skilled trades, whether you're a welder or you have aspirations of being an electrician, a plumber. I think these are really low-hanging fruit opportunities that we need to think about collectively to really help people create a more meaningful life.

I didn't mean to talk too much, Doctor, but I can't help myself. Thank you.

DR. CHIDEHA OHUOHA: Thank you, Mr. Johnson, for such good work. Dr. Martin?

DR. JUDITH A. MARTIN: Thank you. I'm glad to be here.

So I'm an addiction medicine specialist. My initial training was family practice, and then I became addiction medicine board certified, and I've worked in mostly treatment of heroin-addicted patients and their families since 1986. And since 2012, I've been the Medical Director of Substance Use Services for the City and County of San Francisco. So I'm in charge of the safety net part of addiction treatment in the city.

Some of the things we're working on now that I think are really useful is, in terms

of opiates, increasing the availability of opiate agonist treatment among patients who don't access our very available treatment services in methadone clinics and office-based buprenorphine. So these are street medicine patients. And so the street medicine team has developed a program of meeting patients in a situation. They're not patients yet. They're homeless people who are thinking about using heroin and saying how about buprenorphine instead?

And are able to start people on buprenorphine and sometimes keep them on it. So we're following certain outcome measures like abstinence, of course. But also retention in treatment, we think even some buprenorphine in your body probably prevents an overdose in that population. And we have about 300, going on 400, patients right now. And they get their medicine at the behavioral health pharmacy with clinical pharmacists doing observed doses. And the pharmacists are psych pharmacists, so they can address some of the psychiatric comorbidities.

So we're following that. It's still new, but we think it's an addition, and it's addressing a population that even though we have seven methadone clinics in the city, they just were not accessing that treatment. They're probably retraumatized by the very rigid regulations in the opiate treatment programs.

Our city has the highest income disparity in the country, and many of our younger families with children are leaving because they can't afford to live in the city. Even if you have three jobs, you can't afford to live in the city. So our population doesn't have many youth, and we have been very successful in preventing opiate overdoses with community-available naloxone since 2003. Our opiate overdose rate has stayed steady throughout the years.

We do see an increase in the percent of overdoses that are due to fentanyl. What we do see, even though the overdose rate is steady, we see skyrocketing bystander opiate overdose reversals, way over 1,000 in 2017 for a city of 850,000 people. That means that people are taking care of each other in the community, which is good to hear. On the other hand, we wish those people would be in treatment so that they wouldn't have overdoses.

And lately, what we've been seeing, which is very disturbing, is that a number of -- the latest four overdoses that we've had have been in people who thought they were using stimulants. So all of the drug supply is contaminated with fentanyl. And we've handed out the little dipstick to our drug-using population at the syringe access programs, and it's almost not useful because it's very sensitive, but not specific to an overdose level. And it's almost always possible -- positive, I'm sorry. Almost every single time. So we've started giving naloxone to every drug user, not just opiate drug users.

We've seen an increase in methamphetamine use, and psych emergency services has maybe 40 to 50 percent now of the people who go there are

psychotic and are brought in mostly because of police contact. And it turns out that they have been using stimulants, mostly methamphetamine. So we developed a PES step-down facility run by peers on the campus of the hospital, hoping to be able to get some of those folks into treatment, not just back on the street.

So that's one of the things we're working on right now, and I feel like we don't have a lot of tools other than the treatment we have, and we're treatment rich, but still, that rate is going up. We're doing a major effort to increase the use of alcohol treatment medications. It's underutilized, and this is something we've been working on since 2009. And we keep working on it, but we're doing -- continuing to educate people on how to use those medications.

Almost every marker we follow of negative outcomes, for example, overdose rates and availability of alcohol use medications, almost all of those [inaudible] alcohol have a racial disparity, and I know that's true all over the country, and it's also true in San Francisco. So we're focusing on that. The overdose rate, even though the population in San Francisco is only 6 percent black and African American, the overdose rate is three times what it is among white Caucasian population.

And the death rate from related to alcohol is almost twice as high. So almost all the work we do has an equity component, trying to address the social determinants because that's what it takes. You almost have to work in the community. We know the problem. We don't have a lot of research on what to do about it and how to address it.

Another thing that's happening all over California is the counties have become health plans in terms of the Medicaid substance use treatment, and that's true in San Francisco as well. We are now a drug Medi-Cal organized delivery system health plan. Along with this comes all of the CMS rules about health plans, and one of the major ones that is getting a lot of emphasis in the State is care coordination. And there are several blocks. I mean, we've been working on integration since 2007, and of course, we know that the privacy constraints for substance use means that our treatment programs are siloed even from each other, so it's hard to coordinate care.

And for sure, the general health plan doesn't see who's in treatment. The mental health, like PES, they don't see if this person is in treatment in order to arrange continuity of care upon discharge. And so we believe that the privacy rule is one of the blocks to integration of care. Another one that we run into frequently is not just the fractured funding streams, but also differences in regulations and how things are applied. And the medical necessity rules for serious mental illness means that our patients with primary substance use disorder who also have mental health disorders have trouble getting treatment in the mental health. It's hard to integrate those two, mental health and drug abuse, sometimes Medicaid

treatment programs.

So we're doing interesting things, and we're interested in following not only how many people have disorders, but also how many are in treatment and how many have success in treatment. And it's hard to do that since we're not -- you know, we don't have a national healthcare system that could allow that and also because opiate treatment programs are isolated from, say, the Prescription Drug Monitoring Program that would show us buprenorphine treatment. So it's hard to even follow how many -- even if we have estimates of how many people have opiate use disorder, it's hard to say what percent of those are in treatment.

And then beyond that, what percent of those have been in at least 6 months of treatment and what percent have achieved abstinence. So all of those markers we would like to be able to follow, and we're looking at how to do that but have not been completely successful.

Thank you.

DR. CHIDEHA OHUOHA: Thank you very much, Dr. Martin. Mr. Schut?

MR. ARTHUR SCHUT: Schut.

DR. CHIDEHA OHUOHA: Schut. I'm sorry. It's a difficult name --

MR. ARTHUR SCHUT: Yeah, well, yours is more difficult than mine, I think.

[Laughter.]

MR. ARTHUR SCHUT: You probably have greater challenges around that. So I have been in the substance use disorder field for in excess of 45 years. I spent - - and I'm much older than I look, actually. I spent 30 of those years as a CEO of a comprehensive organization in Iowa and then one in Colorado, both of which had a complete continuum of treatment care, including prevention.

I also spent -- when I was in Iowa, I also had a faculty appointment at the University of Iowa master's program in addictions, and I taught there for 21 years while I was the CEO of an organization. So I have this mix of academic and practical. I've had -- I've participated in a series of science-to-practice and practice-to-science, and I've done that with a variety of organizations. And I was part of the NIATx project, which was the Network for the Improvement of Addiction Treatment. I was part of the NQF preliminary development of substance use disorder standards and then the subsequent development.

I served on -- I currently serve on a behavioral health managed care company board of directors in Colorado, and I've done a variety -- just suffice it to say that I have a vested interest in science-to-practice and practice-to-science. I find the

adoption period in terms of science to be very, very long before it's fully developed, and I also find that there's very little fidelity sometimes to what people say they're doing in terms of that.

The advantage to going last is I agree with almost everyone about everything. The couple things I'd like to highlight, I think that the change in the TA provision, I'd like to know whether SAMHSA actually has an evaluation project, if they're going to do an evaluation of that change to see, in point of fact, if that's more effective than it previously was. So I think that's important from my perspective.

I'm also concerned about how we create a continuum of care, and we do that in a formal way. We've been working on that in Colorado in terms of identifying sort of gaps in the continuum in various regions and seeing if we can use, you know, I'm not supposed to say this, but the marijuana money to change that. And it's really been an opportunity to try to look at is how do you have a continuum that includes prevention and a variety of forms of treatment and case management and integration and a relationship with primary care and medicine and recovery support subsequent to that?

There is a great deal of venture capital money that has gone into new residential facilities. They are gorgeous. They obviously reflect the fact that there's a lot of money there. Having spent over 45 years working with a safety net, we live largely in a culture of poverty and have, frankly, in terms of how we provide things, and having the system rise to the point where we actually provide the same kind of facilities for people who are in the safety net that we do for the people who can pay cash is something that I think we need to make a priority. Frankly, there is inequity and a tremendous amount of inequity about what is available.

Dr. Martin, I think, mentioned all the multiple payment sources and regulations, and it -- and including what SAMHSA collects for information and what States do to the TEDS system in terms of, I mean, Colorado has 90 questions that are on their TEDS entry, and you have to do it at the beginning of admission. I'd like to know who really uses all that information. It'd be nice to get it down to what really -- like the five things we really need to know rather than that, and that would actually be useful.

I'm also concerned about where we go in terms of community health and improving community health and improving health outcomes and the extent to which payment systems, including commercial payment systems, Medicaid and Medicare, don't pay for those things, even though those items are -- have a huge impact on outcomes. And Andre talked about employment, housing. There are a variety of things that really support recovery in a way that makes it happen, and we really are largely incapable of coordinating those.

I have a lot of opinions about a lot of things, and I'll spare you that at the

moment. So that's sort of the across the top.

DR. CHIDEHA OHUOHA: Thank you, Mr. Schut. I hope I said that better.

MR. ARTHUR SCHUT: You did.

Agenda Item: Consideration of the February 14, 2018, Minutes

DR. CHIDEHA OHUOHA: We now need to vote on the February 14, 2018, minutes, which was forwarded to you electronically and asked for your review. Did everybody get them?

DR. JUDITH A. MARTIN: Thanks, Tracy, for sending them. And I vote to approve. I felt like I was there when I read them.

MR. ARTHUR SCHUT: I second.

DR. CHIDEHA OHUOHA: Any discussions? Was there anything that we omitted?

[No response.]

DR. CHIDEHA OHUOHA: Okay. Then those in favor, let it be known by saying aye.

[A chorus of ayes.]

DR. CHIDEHA OHUOHA: All right. No one opposed, I can see.

Agenda Item: CSAT Division/Office Director's Update

DR. CHIDEHA OHUOHA: Next I would like to direct your attention to the printed Director's report in your packets. The report includes all the details pertaining to CSAT activities during the period of time since the last report, and I encourage you to read it at your leisure.

Since this is my first CSAT NAC, I'm going to turn the agenda over to CSAT senior leadership to update you on the activities since you last met. We will start with Ms. Audra Stock, who will be providing an update on the Division of Services Improvement activities.

MS. AUDRA STOCK: Good morning, everyone. Very nice to see you again. So I'm switching roles momentarily back to my Division Director role for Division of Services Improvement.

And it's my pleasure to provide you some updates about what that great division is doing and want to acknowledge the staff who helped develop some of these updates during our time of transition. So some of those updates will include the activities they're all doing, and so I'll introduce them as I go through.

So with DSI, I'll start with our Quality Improvement and Workforce Development Branch, and a couple priorities that we're focusing on right now are supporting practitioner education. And this is really in partnership and collaboration across many entities in SAMHSA and HHS, and we're really working on training materials and a few of our grant programs. One specifically is our Historically Black Colleges and Universities Program and also our Minority Fellows Program.

We're also -- in this branch, we have the recovery portfolio, and some of you all are familiar with that through our grants through RCSP, and we're continuing to work on establishing a stronger accessible continuum of recovery supports. And actually, parallel to the NAC right now, we have a recovery research panel that's going on, and so a lot of our staff that are involved in recovery work are part of that panel today.

And Sharon Amatetti leads that branch. I think you all have met her, and she's helping us shape that focus and priority area.

Our Targeted Populations Branch, which is led by Twyla Adams, is doing some really exciting work with the National Association of Drug Court Professionals and our Office of Equity Inclusion on the 18th floor. And we've just identified 19 grantees to help us pilot an equities inclusions toolkit so we can address racial disparities in our drug court programs. So we're very excited to see how that toolkit is piloted and how we can eventually expand the use of that.

We're currently designing a policy academy for SAMHSA's grantees under our youth treatment initiative to really identify effective prevention, treatment, and recovery service delivery models and approaches and quality care performance measures and financing. Like how do we actually pay for this and make it sustainable? And this is usually focused on -- and Sharon, to your point, on youth and families. And when we talk about families in our Targeted Populations Branch, we try to be really inclusive in that.

Our pregnant and postpartum women grant and our youth grant, in the funding announcement language, we really value multifamily engagement. Every parent, step-parent, sibling should be getting care from those programs. So, yeah, I wanted to make that point because that's certainly the intent behind it. We can probably do more to strengthen that language and having noted your comments.

And then we're also working with three new pregnant and postpartum women pilot sites to provide more appropriate onboarding to help them understand what we're doing with pregnant and postpartum women programming. Previously, this

has all been a residential-focused grant award, and so we really tried to expand this past year under the CARA implementation to do more of an outpatient continuum of care for pregnant and postpartum women. That is undergoing an evaluation, and we're working with our CBHSQ partners to develop and implement the evaluation on that.

And then the Health Systems Branch, which is led by GG Somerville and who also was helpful in getting our -- covering DSI and supporting me as I've been transitioning. They're really working on aligning our activities with the National HIV/AIDS Strategy 2020, the National Viral Hepatitis Action Plan, and coordinating efforts across all the Federal agencies to learn how we integrate care for substance use disorders, co-occurring disorders, and HIV and hepatitis.

We're working on enhancing the adoption of medication-assisted treatments referrals and improving our health information technology capabilities. And we're using our SBIRT portfolio in a lot of ways to enhance that. SBIRT has also shown an increased uptick in utilization across different sites like schools, adolescents, and other populations that have not traditionally been focused on with an SBIRT approach.

I think previously we've highlighted that the National Guard is using SBIRT, and a couple different States -- at least Massachusetts -- have actually implemented SBIRT as a requirement for schools screening youth for substance use disorders.

And then really exciting and really speaks to your comment, Jason, about how are we going to take on the challenges of all these grants and the very important work that's coming our way? So one area is our Medication Assisted Treatment-Prescription Drug and Opioid Addiction Program. MAT-PDOA is the short name. We recently announced a new funding stream for that, MAT-PDOA, a grant announcement that instead of going to States is going to organizations, nonprofits, health plans. And we're anticipating awarding over 125 grant awards here shortly.

So looking at some of our accomplishments, I hope by now you've all heard about our publication, the Treatment Improvement Protocol No. 63, which, as of May 2018, we've had nearly 10,000 hard copies distributed and a little less than that downloads from our SAMHSA store. We also -- Dr. Compton is familiar with this work. We've done a lot of collaboration in partnership with him and his teams and other HHS agencies. We've been working to implement the Protecting Our Infants Act. I don't know if many of you are familiar with that, but it's really targeting and addressing neonatal abstinence syndrome, also more familiar with neonatal opioid withdrawal syndrome, excuse me, is a more standard term at this point in time.

And HHS was working with the legislation that was put in place in 2015 to

develop a strategy and implementation plan, which is in clearance currently. But what's really notable about that is there are over 400 different HHS activities targeting neonatal opioid withdrawal syndrome. And that's not just for infants, but it's mothers, infants, families, research and evaluation, program service development, funding strategies, and evaluation. It's really -- it's an area of focus for HHS.

And then I just want to highlight a few other things. Targeted Populations Branch working a lot on sharpening language and increasing access for families to care. We're doing a lot of that through our funding announcement review and getting ready for our next round of funding announcement development.

Our Health Services Branch again, like GG, they've done some really great work in partnership with CDC and other health plans to begin implementing an alcohol screening brief intervention measure. And that's really to increase the uptake of screening in primary healthcare settings to screen for alcohol use and that actually primary care physicians can get paid for that. So we're hoping to get more of that happening.

And then looking ahead, we're looking at releasing some new Treatment Improvement Protocols -- relapse prevention and recovery promotion, and behavioral health services for American Indian and Alaska Natives. That would all be coming out soon. And I guess I want to move on at this point and offer a chance for my other colleagues to share other updates.

DR. CHIDEHA OHUOHA: Thank you, Audra. Our next presenter is Dr. Onaje Salim, Director of the Division of State and Community Assistance. He will update us on their activities.

DR. ONAJE SALIM: Good morning, everyone. Welcome back to SAMHSA. Good to see you. Looking forward to the robust discussions today.

The Division of State and Community Assistance has three branches -- Performance Measurement, the Performance Partnership Grant Branch that houses the block grant, Co-Occurring and Homeless Activities Branch that focuses on the homeless treatment systems. I will have a few overview -- a few updates on some of the activities that we've been doing.

In the Performance Measurement Branch, we focus on some of the plumbing of data collection. We support the work of the Center for Behavioral Health Statistics and Quality by operating our portion of what's called SAMHSA's Performance Accountability and Reporting System. So if you hear SPARS, that's what we're talking about, where we collect data from grantees. It's different from NSDUH, which is the public data collection activity that's done in CBHSQ.

We are improving that, and I'll talk about that a little later in terms of refining the instruments for data collection because, of course, we need to sharpen our understanding of what is going on with our grantees and the recipients of services. We also have focused on supporting the Assistant Secretary in SAMHSA's initiative in confidentiality. As you may know, the confidentiality regulation was recently updated and perhaps not sufficiently updated to meet the Assistant Secretary's desire that we preserve confidentiality, but that the rule does not maintain an encumbrance to quality and comprehensive care.

So we continue to look at how we can make the utilization and the adherence to the rule something that people in the field can do in the context of our digital era and electronic health records and what have you. We have provided an FAQ guidance document, and I'm sure that we'll have much more to say about that going forward.

In the Performance Partnership Grant Branch, we have historically managed the substance abuse block grant, and Congress has continued to support a billion-dollar program. It's at \$1.8 billion, and the recognition that the block grant is a key ingredient in the delivery system throughout the States and the other jurisdictions is quite important. And we have been working closely with the States, and I'll talk about how we want to improve our coordination and communication with States in looking ahead.

Of course, more recently in DSCA, we have been the budgetary home for the State opioid -- State targeted opioid -- the STR, State targeted response grants, opioid State targeted response grants. Everybody is familiar with that, \$500 million the first year, \$500 million this year. And of course, we're looking forward to that amount doubling going forward.

This is a part of my presentation, but I think that we need to recognize that the STR program, which you'll hear about later, is supported across the center. It's not just in this, but we have staff throughout the center working on STR.

In terms of accomplishments, we continue to, as I've said, have strong connections with the States. We've done compliance reviews. As of today, actually, in eight States, we just finished Minnesota's compliance review this past week. We'll be going to Massachusetts and Utah before the end of the fiscal year, and there will be some refinements coming to how we do these compliance reviews. We also have State project officers who visit just about every State and territory in the nation to maintain good communication and understanding of how the block grant and other grant activities are functioning.

Our Homeless Activities Branch again historically has been very active. Since 2001, 379 service grants have gone out, 89 as of this fiscal year, and I just signed off on another about 35 off-the-shelf grants. And we're making inroads in homelessness in terms of particularly with the veterans population.

In terms of looking ahead, I mentioned new and improved data collection. I'm not the person necessarily to talk about it, but we are sharpening up the instrument. We're asking more questions. We're including things like ICD-10 and diagnostic questions that haven't been there before for client-level data. We are operating a grantee review board, where we're using the data that we collect from SPARS and talking to project officers about how grants are performing internally for performance improvement.

Again, you'll be hearing more about the new technical assistance strategies and improved coordination with tribes. We're doing a tribal State policy academy in August, in this month. It's the first of three, and I think you've seen that the tribes themselves are going to be getting some direct funding. So coordination is going to be very important.

I think the last thing I would mention before I stop is that very exciting activity is the development of recovery housing standards. We had a Technical Expert Panel on recovery housing and MAT and working diligently to develop some national standards with folks like Jason and NARR and other stakeholders who have strong interest in this area.

So thank you, and I look forward to talking with you more.

DR. CHIDEHA OHUOHA: Thank you, Onaje. Next we will hear from Dr. Tony Campbell, who is sitting in for Danielle Johnson Byrd, the Director of the Division of Pharmacologic Therapies.

DR. ANTHONY CAMPBELL: Good morning, and it's always a pleasure to present to the NAC and also see familiar faces. That kind of makes it a little bit easier.

And as was mentioned, I'm presenting for our Director, Danielle Johnson Byrd, and we want to give you a snapshot picture of some our accomplishments, as well as some of the things we have coming down the pike. And I was told I have 2 minutes to do this. So I am talking fast because that's not a lot of time.

The top three priorities that we are dealing with right now, we want you to know and highlight is that we are dealing with the -- we're responsible for the opioid treatment program certification and regulation of those treatment programs. To date, we have over 1,600 OTPs that serve more than 300,000 patients per year. And this is all under the regulation of the 42 CFR Part 8.

When we talk about the DATA waiver management, we kind of manage all of the DATA waiver processes as far as the certification and candidate waiver processing queue [inaudible] on those DATA waiver processes as well. This major effort is basically to address the shortage of qualified providers throughout the country. So this is a major vehicle that's an exclusion to some of the

activities that we do.

Thirdly, I'd like to mention a little bit more detail on the Providers' Clinical Support System, which basically is our educational component, as well as TA resource for our providers out in the field, many in the outpatient basis. So this is a very important vehicle, and we have expanded that program and continue to use that. And I'll mention we do have a hybrid of this particular program. This is a 3-year grant that we announced to the universities, and I'll talk about that later.

Some of the accomplishments we have up to date, again as I said before, over 1,600 active or certified OTP programs. We basically -- in this year alone, we had 87 original applications for establishing new OTPs, and so we continue to monitor that, and we are very excited about the actual progress we're making in that particular area.

Looking at our DATA waiver practitioners, as you can see there, all 50,000 DATA waiver practitioners to date. You see the breakdown there. We have about 42,000 physicians who are actually being DATA waived. And we have about a little bit over 6,000 nurse practitioners and a little over 1,700 PAs. We're very excited about that because that is in response to the 2016 CARA Act, so that began to address the shortage of providers in the actual field.

We're working on PCSS grants, and to date, we're very happy to say that we have over 115,000 practitioners who have been trained overall. And again, the PCSS grant is basically a [inaudible] project, and so we're going into our second year of our PCSS medication-assisted grant, and we're very excited about the activities we have there. And just this year alone, we have trained over about 5,000 practitioners. This is also including our nurse practitioners and physician assistants, and this number just continues to climb. We are very excited about the activities here.

We also have some products that we put out this year, and basically, one was the opioid overdose prevention toolkit. We're very proud about that. We also put out the Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants, which we felt was a very key process and has been well received to date. And so we're very excited about that and got that out on time. And of course, tobacco cessation toolkit is another one of our highlight products.

Looking ahead down the pike, we want to look at our system enhancement, mainly we want to look at our OTP extranet system, and what we want to do there is to actually enhance our ability to get data and analyze that data on an annual basis as well as a semi-annual basis. And so we're looking at enhancing that particular process.

Again, as I mentioned before, we have a hybrid of the Providers' Clinical Support

System for universities. And basically, this is an attempt to try to get addiction treatment into our medical schools and our professional schools, more [inaudible] including nursing schools as well as the PAs.

And I'd like to extend my apologies now because I might have to step out this afternoon because the applications for that particular grant have come in, and they are due. And they have to be reviewed by the close of business today. So I will be going in and out.

We have -- we're going to be giving 24 awards for this particular grant. It's a 3-year grant and \$150,000 each. And we have 29. That's my last count. Usually when I step out and go away from my computer and go back, that count usually has a tendency to go up. So we will see. But that's something that we're going to be doing today, and hopefully, this will make a difference in the overall impact in educating and getting more qualified health providers to address this shortage for our providers in the field.

And with that, I will give up the remainder of my time. That was 2 minutes? Two minutes.

DR. CHIDEHA OHUOHA: Next we'll hear from AMY B. SMITH, who is speaking for Marla Hendriksson, Acting Director for the Office of Consumer Affairs. Amy?

MS. AMY B. SMITH: Thank you, Dr. O. And welcome, everyone.

As he mentioned, I'm here representing the Office of Consumer Affairs. We are an office under the Office of the Director, actually, very small office, and Marla Hendriksson is our Acting Director, and she is on a much-needed vacation right now.

I want to start by thanking our Assistant Secretary, Dr. O, and Audra, who -- and Kathryn, by the way -- who always supported the work of OCA and our engagement. So thank you so much.

Okay. So the Office of Consumer Affairs, OCA, we have a set of priorities, and many of you who have been involved with the NAC, you are familiar with them. As always, our goal is to strengthen the voice of the consumer and their families. Consumer meaning people who are in recovery or are seeking recovery. We want to ensure that they have a voice through the materials and programs that we create.

We do want to expand our office work beyond Recovery Month. We are the hub for National Recovery Month. We produce products for National Recovery Month, but our priorities going forward are to expand what we do beyond National Recovery Month.

We also want to integrate our functions and support within CSAT among other divisions within CSAT. Our divisions have been supportive of many of the efforts that we've put forward down through the years. Moving forward, we'd like to be more engaged in their activities and their programs and be a support to them. And as always, we want to boost the public awareness and engagement of -- and engagements in HHS and SAMHSA priorities.

Our accomplishments, this year we've launched the 2018 National Recovery Month campaign. Our toolkit is online. You can see some of our materials that help support national awareness of Recovery Month and recovery for those who have been in recovery short term, long term, and their families. And we encourage you to go to our website, RecoveryMonth.org to see more about that.

We also held a BRSS-TACS Policy Academy. We support the BRSS-TACS initiative along with our sister Office of Consumer Affairs in CMHS, and that was very well attended and a very productive policy academy, really building recovery support services at the State level. We convened a monthly recovery live webinar, and that's held throughout the month. Again, that's supported through our BRSS-TAC initiative. And those webinars are on recovery-related topics.

And we completed a pilot program that we're very proud of, and that pairs a certified peer -- it pairs a peer mentor that is established as an RCO with an emerging RCO and helping that emerging RCO really come up to capacity. That pilot program was very successful, and you can contact our office for more information on that.

Some of our other accomplishments are we conducted a training for peer mentors to keep youth and young adults out of the criminal justice system and to support those who need treatment and recovery to get that support and to prevent reincarceration among youth and young adults. We had a leadership training program using the peer-to-peer recovery model that was very successful for recovery community organizations.

We are very excited about our behavioral health workforce forums that was held at four universities throughout the nation. This is our third year -- fourth year, I believe, conducting such forums, where we go to the university and really promote behavioral health careers. And this year, we included high school students. So we had high school students as well as freshmen and sophomore college -- collegiate students involved in the forums. It was very successful. Our last forum was held last week, I believe, and we had 500 participants really interested and involved.

We've completed webcasts for healthcare professionals to look at the problem of discrimination with people with mental and substance use disorders, looking at language, perceptions. Those webcasts are on our website, and you can find them on the SAMHSA website. And for the very first time through our office, we

conducted an all-Spanish webcast on behavioral health needs in the Latino community. It was called Nuestra Salud, and those webcasts are also available on our website, samhsa.gov.

Looking ahead to our future in the Office of Consumer Affairs, some of you are familiar with our National Recovery Month Planning Partners. It's when we come together to really look at what our focus will be for the next year. That's going to be here at SAMHSA September 5th. We will have our National Recovery Month kickoff.

Typically, we will pair that with the release of the NSDUH data, and we will have a press conference. We're not doing that this year, but we will have a kickoff event at the Hubert Humphrey building, and we will have a very good panel set up. And we will have people with lived experience, families, as well as some of our organizations that we fund sharing what are the current trends and the future of recovery needs on these panels. So we're very excited about that.

We will have a Recovery Month walk/run event here at SAMHSA, and this is for our employees, but if you're in the building, you're welcome to join us. And we are excited to have a recovery and States' rights educational seminar -- webinar, rather. And this is looking at the specific rights in these States -- in Rhode Island, Georgia, Illinois, Kansas, Colorado, and California.

We're looking at what are the rights for people who are incarcerated or coming out of incarceration as it relates to their education, their employment, their healthcare needs? Will they be able to help? How easy would it be for them to get jobs, to get housing, to really start a life outside of incarceration? As it relates to their recovery, how are they acclimated to recovery support networks if they're in recovery once leaving the criminal justice system?

So the work that we're doing with these six States really focuses on those States specifically and what are the Federal laws and how can we make sure that their rights are addressed as relates to access to services.

And moving forward, we intend to collaborate more with our centers and our -- I'm sorry, with our divisions within the center. We've already begun that by being involved in workgroups and planning -- planning teams within CSAT, and we hope to expand our engagement in the months to come.

And now the reason why you all took a plane or train to get here, you wanted to see our PSAs for this year. So I'm going to ask Tracy to -- okay, here she is. Okay. She's going to play -- they're both 30 seconds, so they aren't too long.

These are our public service announcements. The first one is "Voices for Recovery," and the second one is "R is for Recovery." While she sets that up, the second one, "R is for Recovery," we're in the process of getting that

trademarked so that no one can take it and make money off of it, if you will, or use it for other purposes. It will be for the general public's use. So when you see the R as we designed here in the second PSA, it could be used for everyone who wants to promote recovery.

All right. Thank you.

[Video presentation.]

MS. AMY B. SMITH: These PSAs are available without the SAMHSA tagline. You can put your own organization's tagline and run them in your lobbies or wherever, your community center's logo and their own information there.

DR. CHIDEHA OHUOHA: Thank you, Amy.

MS. AMY B. SMITH: Okay. Thank you. And you can find our PSAs on RecoveryMonth.gov. Thank you.

DR. CHIDEHA OHUOHA: And finally, Dr. Steve Daviss, CSAT's Medical Director, will update you on some of our activities. Dr. Daviss?

DR. STEVE DAVISS: Good morning, everyone. Okay, good morning.

So I'm Steve Daviss. I'm -- so I wear a couple of hats at SAMHSA. I've been here since September. I met a few of you in February. So I am the senior medical advisor in the Office of the Chief Medical Officer, which is led by Dr. Anita Everett. And I also serve as the Medical Director here in the Center for Substance Abuse Treatment.

And my slides don't really have a whole lot on them. So you're not going to miss anything if this doesn't work out here. But so my role in CSAT is to serve as medical leadership, and now that we have Dr. Ohuoha here, we have more medical leadership here around all of the division programs. And so I'm not just in one division or branch, but really serve as a resource for the whole center.

But the way that the medical leadership in the Office of the Chief Medical Officer is being used, as a way to integrate some activities across the centers. So the Center for Substance Abuse Prevention and for the Center for Mental Health Services because, as we heard some flavor of earlier, co-occurring disorders are, you know, more the rule than the exception. And yet SAMHSA and many other -- most other places kind of divide things up into substance abuse and mental health, and we're really trying to, you know, walk the talk/talk the walk around integrating behavioral health, both mental and substance abuse treatment.

So that's sort of the roles that I serve here. I spend a lot of my time interfacing

with external organizations. One of the things that Congress bestowed upon the Office of the Chief Medical Officer is that we serve as a liaison between us at SAMHSA and other organizations, particularly professional organizations. So, for example, I have a monthly call with leaders from ASAM, and I also have a monthly call or a regular call with leaders from the Academy of Psychosomatic Medicine, psychiatrists who work in integrated care settings.

And each of us, and there are about five or six of us now in OCMO, that have these relationships with other organizations, and we serve as an easy way for them to learn about some of the things that SAMHSA is doing, but also hearing feedback from the field about what's needed, and so that kind of linkage is really critical. Also wind up spending time looking at and reviewing and commenting on a number of pieces of legislation for technical assistance, regulations that are being written not just by SAMHSA, but other entities like NIDA, for example, or CMS or ONDCP.

And then, finally, participating and leading in different meetings. So, for example, today I'm here talking to you all, but also you may know next door, there's a Recovery Research Technical Expert Panel meeting for the next 2 days, and they're there to set the research agenda for recovery.

So that sums things up, and we're only 5 minutes late. So thank you very much.

DR. CHIDEHA OHUOHA: Thank you, Steve.

We're going to be taking a break in a few minutes, but before we do, I would like to introduce Darrick Cunningham, who recently joined us as the Director of the Office of Program Analysis and Coordination. Darrick is going to give a short budget update for us.

[Audio difficulties.]

Agenda Item: SAMHSA/CSAT Budget Update

MR. DARRICK CUNNINGHAM: Hi, good morning. I'm Darrick Cunningham. I'm a bit newer to SAMHSA staff, so I'll take a few seconds to introduce myself.

I'm a licensed clinical social worker at the board-certified diplomate level. I also have an international certification in treating substance use disorders. But basically, my entire career up to this point has been spent with the Department of Defense in uniform with the Air Force. My last job before coming here, I was a consultant to the Air Force Surgeon General to kind of build a mental health infrastructure for the citizen soldiers or kind of National Guard folks.

So a pleasure meeting you. Hopefully, I'll get the chance to come around and meet and greet you individually.

Okay. Yeah, next slide.

All right. So, basically, this slide, where I'll have you focus -- I know it's a bit of an eye chart. But you know, our authorized spending for FY '18 is \$3.7 billion, which is, again, you know? So what I'd like to do to kind of put that number in context for you is to talk just a little briefly about historical spending at SAMHSA.

So in 2016, SAMHSA was appropriated \$3.4 billion. Our center, CSAT, was appropriated \$2.2 billion of that, which was 65 percent of SAMHSA's total budget. In FY '17, \$4.3 billion was appropriated to SAMHSA, and \$2.7 billion of that, representing 63 percent, went to CSAT. For '18, SAMHSA was appropriated \$5.7 billion, and \$3.7 billion of that is going to go to CSAT, representing 65 percent.

So also a little further context, in 2016, SAMHSA was awarded 198 new grants; 2017, 302 new grants; 2018, we're going to be awarding 969 new grant awards. So as you can tell, that's basically tripled the amount from just a few years ago.

So I actually won't go into the slides that come after this. What it does, it kind of gives a more granular look at, you know, the breakout of these specific areas. If you'd like more information about that, certainly it's in your slide deck, and I can provide more of that as well if you need that.

Thanks, and thanks for coming.

DR. CHIDEHA OHUOHA: Thanks, Darrick.

And now it's that time for us to take a 15-minute break. Please try to be back to your seats promptly. Tracy, can you remind everyone about the logistics?

MS. TRACY GOSS: If you need to get something to drink, the cafeteria is right there. Across the atrium is a little store, a [inaudible] store where you can get some drinks, and I also brought snacks for you guys. So please take advantage of those.

DR. CHIDEHA OHUOHA: Thank you.

[Recessed at 10:19 a.m.]

[Reconvened at 10:35 a.m.]

DR. CHIDEHA OHUOHA: Can we have our seats? Welcome back.

We're going to begin -- we're going to begin this session with a presentation by Dr. Wilson Compton. As I mentioned earlier, we're very fortunate to have him. For those who don't already know him, Dr. Compton is the Deputy Director for the National Institute on Drug Abuse within the National Institutes of Health.

NIDA supports most of the world's research on health aspects of drug abuse and addiction related to preventing drug abuse, treating addiction, and addressing serious health consequences of addiction. Included are related to HIV/AIDS and other conditions.

Dr. Compton received his undergraduate education at Amherst College and his medical education at Washington University in St. Louis. Over his 25-year career, he has achieved multiple scientific accomplishments, and he's the author of more than 150 articles, including widely cited papers on the opioid crisis. Over his career, Dr. Compton has received multiple awards, including the American Psychiatric Association's Senior Scholar Health Services Research Award in 2008 and Health and Human Services Secretary's Award for Meritorious Service in 2013, and Distinguished Service in 2014. And FDA Cross-Cutting Award in 2017, and the National Association of Addiction Treatment Providers James W. West, M.D. Quality Improvement Award in 2018.

Dr. Compton?

Agenda Item: TOPIC: Using Research to End the Opioid Crisis

DR. WILSON COMPTON: Thanks very much, and it's a pleasure to join my friends and colleagues here at CSAT and really to be part of the welcoming committee for Dr. Ohuoha -- I hope I did that justice -- but we're so excited to be able to continue our longstanding collaboration between the National Institute on Drug Abuse and our colleagues here at CSAT, as we work together to improve the health of the populations affected by drug abuse and drug addiction.

And I'm going to -- you know, it was really nice to be able to hear the roundtable and discussion from all of you about your interests and your key challenges and goals. I'm going to, of course, focus on the opioid crisis, because that's what I've been asked to talk to you about, and some of our new funding opportunities related to opioids. But I really think it's important to endorse some of the themes I heard earlier, which is opioids don't exist in a vacuum, that people that are misusing opioids misuse all sorts of other substances.

It turns out by the time you develop a serious addiction to heroin, to fentanyl, to prescription opioids, it's exceedingly rare not to also misuse and have serious problems related to multiple other substances, not the least of which is tobacco. And when we look at what actually kills people with opioid use disorders or other conditions, tobacco is a major culprit. It's not just the overdose, but it's the long-term health conditions related to all sorts of other behaviors. That's just one example of many.

But at the same time, I'm very pleased with the attention that the opioid crisis has

received because this provides a vehicle for us to, I hope, change the way addictions are addressed throughout our healthcare system and throughout our social service agencies. It's not atypical for NIDA to participate in work here at SAMHSA. We're longstanding partners with SAMHSA.

As a matter of fact, we were part of the same organization 25 years ago until we were split off and bifurcated between the research arm at NIH and the service delivery system that's now at SAMHSA. But it is really different for us to have the welcome throughout the rest of organized medicine, and we're trying to take advantage of this to try to shape the discussion about how our patients are treated throughout healthcare and the healthcare system.

All right. That's my background. I'm going to stand back because it's a little easier for me, and I'll carry this around [inaudible].

All right. This is data from the CDC. The most recent data is 2016. We do have preliminary data from 2017 to suggest that the opioid crisis continues to grow. The number of deaths in 2016 was about 63,000. The majority of those were related to opioids. But what these maps show you, and these are all the different counties across the U.S., is I think two bits of information.

One, this is heat-coded, so you can kind of easily understand the changes over that 17-year period of time, and you see increases everywhere. Every single part of the country has seen increases. But what you'll also immediately notice is that they're not evenly distributed. And I'm intrigued by the fact that even when you look back before anybody was really paying attention to this issue, you see the initial burning embers in certain parts of the country, whether that's the rural southwest in New Mexico or the Appalachian region. That's two of the obvious hotspots even almost 20 years ago.

There's been some very nice work showing that, unfortunately, these overdose deaths are related to major shifts in population health, and there was some very nice work done by our colleagues here at SAMHSA to draw attention to these issues. What this graph shows you, this is work by Anne Case and Angus Deaton. Angus Deaton, a Nobel Prize-winning economist who's been focusing on demographic shifts and some of the underlying economic issues that may be driving these changes in health, the most serious health outcomes.

Well, what you see is that for, in this case, middle-aged, non-Hispanic whites, we see an increase in deaths in the U.S. That's the red line. So less survival in that population while virtually every other developed country has seen improvements in health for this same general population. And even looking at U.S. Hispanics, we see improvement in this age group as well. So there's something unique going on in that population, and it seems to be driven both by the overdose crisis that we're focusing on, but also alcohol and suicide. So all of the issues that SAMHSA targets across your different centers have an impact in terms of

population health.

Now it's been pretty clear that this is not a single epidemic. But while the spark may have started with overprescribing and an excess focus on opioids, it shifted over time to where heroin, starting in the mid 2000s and really increasing after about 2009, we see as the people involved with prescription opioids found that their habit became more and more severe, the prescription opioids weren't always as available to them. It didn't take very long for drug dealers to figure out that there was a huge market for their product.

And so we now see heroin sold and distributed in parts of the country that never used to have a significant heroin problem. You heard that I worked -- I trained and worked in St. Louis for about 20 years. St. Louis wasn't really a heroin center at all during my time there in the 1980s and '90s. But unfortunately, it had the hallmarks of a burgeoning market, and it now is a major heroin center. And so the treatment system has had to adapt in that urban area, just as we've seen in many rural and suburban areas around the country.

Unfortunately, economics are driving the most recent scourge, the fentanyl -- and put "fentanyl" in quotes because it's not really medical fentanyl, and it's not necessarily fentanyl itself, but it's fentanyl-related compounds have been associated with a huge increase in overdoses. Again, I think this is driven by the economics. Fentanyl has been really cheap to produce in factories in China and is shipped to the U.S. using commercial carriers or the postal service. And because of its relatively low price, the profit margins are just extraordinary.

Wall Street Journal did a really -- produced a really nice graphic showing that about \$1,000 worth of fentanyl ordered from overseas and shipped to the U.S. can be sold on the streets for something like \$1 million. Now even assuming that there are a number of people taking cuts along the way, that's an awful lot of profit margin to be driving behavior. So the economic issues of the drug trade are something that I bring up because I think we often don't think about it.

When we're talking about our patients, trying to bring people into treatment, do prevention and treatment services, there's an interaction with the marketplace that is extraordinary. It reminds me more of the tobacco field than it does other areas of like infectious disease epidemiology because we have purveyors, the salespeople who are actively trying to recruit more customers at the same time as we're working to take them out of -- out of the commercial illicit marketplace.

It's not just the overdose deaths, but as you heard mentioned, infectious disease is a major issue. We've seen increases in hepatitis C. We saw the HIV outbreak in Indiana in 2015. We've seen a couple of additional outbreaks, at least one in Massachusetts I've been hearing about recently. And CDC estimated that there are at least some 200 counties around the country who have a similar risk profile as Scott County, Indiana. So these are hotbeds for potential HIV outbreaks.

They already have endemic hepatitis C, but we may see additional infectious disease spread in at least these regions, if not others. We launched a series of grants to rural areas, and we are doing this in collaboration with Audra's division here at CSAT, as well as with the CDC's Viral Hepatitis Division and the ARC. Here's another acronym you may not know. That's the Appalachian Regional Commission.

And I'm particularly proud of their collaboration because they're not really a health organization. They're an economic development group, but they realize that health and economies go hand in hand. So they're investing in the Appalachian regional grants, which are designed to bring healthcare to remote rural areas, not an easy thing to do. We not only don't have hepatitis C or HIV interventions, we don't have much public health infrastructure or health infrastructure in general.

So how do we use telemedicine? How do we use mobile health? How do we do other novel and, hopefully, cost-effective approaches bringing healthcare to remote regions? That's a challenge, and we hope that these nine grantees will teach us some new lessons over the next couple of years.

You heard mention about neonatal opioid withdrawal syndrome. Marked increases in the number of infants exposed increasing costs. This has been a major focus for Federal efforts and State efforts as we realized that the opioid crisis has touched so many lives in addition to the families directly impacted through the overdose deaths.

So the Department has a broad strategy focusing on the upstream drivers in terms of understanding the public health data infrastructure, in terms of focusing on research needs, but specifically addressing better access to prevention, treatment, and recovery services. And I'm not going to focus a lot on recovery services, but that's a big theme, and we haven't completely figured out how to do research in this space of what the key questions are. So I look forward to hearing results of the meeting next door that's going on right now to help guide some of the efforts that we need to make at NIH to improve the recovery treatment system.

Saving lives by rescuing people who have overdosed is, of course, a key theme. That's never going to be enough, but I can't do treatment or prevention on a diseased body. So we're extraordinarily grateful for the outreach efforts and the way the community and the population has really come onboard to focus on saving lives, but we need to also make sure that we use that opportunity to help people engage in long-term treatment and long-term recovery for their unwilling addiction.

If one of the issues was overuse of opioids, we've been focusing extensively on better treatment of pain that don't include addictive substances. That, of course,

is a major theme, and I'll come back to that.

Now NIDA has been supporting for some time what used to be called our Community Epidemiology Workgroup, but we rebranded it and relaunched it a couple of years ago, and the University of Maryland spearheads our Coordinating Center for the National Drug Early Warning System. And I highlight for you things they do, which is identify emerging epidemics. They just alerted the country to emerging problems in suburban areas with fentanyl outbreaks, but we did a study in New Hampshire that had a key finding. We weren't surprised to find that fentanyl was involved in overdoses. That's been known for a few years. But what surprised me and others was with about a third of the drug users that they interviewed actively were seeking out fentanyl when they would hear about it.

So unlike other areas of health where I usually think of somebody dying as a way to scare people away and want them to move away from that behavior, to a certain subgroup, that indicated potent, powerful opioids that they wanted for their addiction and for the effects it may have on them. So that is a reality in our field that we have to pay attention to, that what many of us would think of as a -- and it doesn't mean that it isn't frightening people who have drug addiction, but they also see it as potentially an opportunity to get high, and so that's part of what we deal with in terms of doing outreach to our patients and finding ways to help them turn their lives around.

We've certainly focused on making naloxone more readily available. We worked with a company directly on the nasal spray version, and following a meeting that CDC, NIDA, and FDA conducted a number of years ago now, we saw the development of the auto-injector come onboard and release the SU auto-injector device. So we now have two readily administered by nonmedical personnel forms of naloxone.

When we saw the Surgeon General issue an advisory just a couple of months ago encouraging those who are at risk and also, much more broadly, members of the public -- and I was very curious about how the public has responded in San Francisco and other areas to rescue many, many people that otherwise wouldn't be around to participate in our treatment programs and really contribute to society. But there remain questions. With fentanyl being a major product, do we need to change our formulations, more potent or long-lasting versions?

Might there be alternative approaches that address not just opioids, but other overdose risks in terms of otherwise to stimulate breathing? It's stopping breathing that kills people when they overdose. So not only can we block the effects of opioids, which is what naloxone does, can we use other ways to keep people alive?

The second major theme would have to do with expanded access to treatment,

and I highlight for you a couple of pieces of data. One, even when we looking at how many clinicians are there with buprenorphine training, if every one of them saw their maximum, we still wouldn't have enough clinicians, and we also know that most people aren't actually seeing their maximum, and many of the buprenorphine-trained clinicians never see any patients in this area. They go through the training for a variety of other reasons and don't start seeing patients. So there is room for improvement.

I also was pretty astounded that a lot of the programs that potentially take care of persons with opioid use disorder don't necessarily offer access to medication-assisted treatment. Not that all of our patients should take it, but at least it ought to be potentially available. And I'm pretty horrified that a clinical center would advertise or market itself as treating persons with an opioid use disorder, but not make medication-assisted treatment available.

I saw a major shift a couple of years ago when the Betty Ford Hazelden group changed from being purely 12-step facilitation as how they addressed opioid use disorder to adding buprenorphine and a long-acting naltrexone to their armamentary. That was a major shift for these programs, and it was driven by the fact that they saw that their patients were leaving treatment at an exceptional risk for overdose and death. So they were responding to the evolving nature of the crisis and changing their clinical practices. I hope that they are a peer leader for the rest of the treating communities.

So what is NIDA, what's research community doing? I'm going to zip through these, wrap up in a couple of minutes, I hope, so we could have some discussion around what you see is our -- what you recommend that we do as our next steps.

But a key area has been patients aren't always going to treatment, but they do show up in emergency rooms. And instead of just referring people to treatment, there's now a major study, and we're following up with a multisite trial to see if other emergency rooms can do this. But the Yale emergency room showed us that you can start buprenorphine in an emergency department, and indeed, it leads to less drug use over the ensuing at least short term and better engagement in care.

So is it just Gail D'Onofrio and colleagues at Yale that can do this, or could we do this in a variety of emergency department settings? That's a bit of an open question, but it seems pretty clear that implementation of this emerging practice is the next key step.

We certainly recognize the criminal justice populations are a key place to intervene. This is just highlighting for you one study that looked at the addition of long-acting naltrexone for persons on probation and parole, showing that even those under supervision, who have, you know, the long arm of the law looking

over their shoulder, their behavior and their outcomes were better when you added long-acting naltrexone as part of their care.

Recently, we saw work comparing direct head-to-head comparisons of long-acting naltrexone and buprenorphine, the suboxone formulation. And there are sort of two key messages. One, buprenorphine was clearly superior in the sort of intent to treat analysis. So if you look at who was assigned to which one, buprenorphine did much better. Most of that is explained, though, by the difficulty in inducing people onto the long-acting naltrexone. For those who were successful in being induced, so they were able to be weaned off of opioids and you could start the naltrexone, they seemed to do about equally well.

So that's what you see here. You see those lines looking different at first, but then once you started people on the medications, they are pretty well parallel and the outcomes are quite similar.

Most recently, there was a new medication approved following some work that we did with the company developing this, a new medication for withdrawal. And this may play a role in helping people be weaned off of opioids so that you could consider using naltrexone. That looks pretty promising to me, but I think there's always a trap in that detox alone is not treatment. And so I think we have to be careful about having new medication for withdrawal. To people, that's helpful. That's an important ingredient. But that's not recovery, and that is not our goal. Our goal is not just to get you off of opioids, but help you figure out how to stay off of opioids.

I highlighted the prison population because I think this is a such a key area. And we saw this really in what I think of as a landmark study. It's a small study, but it was the entire State of Rhode Island. They developed a new treatment system so that every single person leaving their jail and prisons -- I don't think I should put an "s" on that because it's a single facility, being a small enough place, that one jail and one prison is enough for Rhode Island, at least in the State system. And they -- by getting virtually everybody onto medication-assisted treatment, they reduced their overdose deaths by 60 percent in that population and about 12 percent overall for the whole State. So that's a way to influence population health by addressing such an important high-risk subgroup.

Now the latest program is our opportunity to take advantage of additional resources that Congress allocated to us. There was \$500 million allocated to the NIH, NIDA and other institutes, to address two key aspects of the opioid crisis. One is to do a better job of research into pain, to reduce the reliance on opioids. And the second would be to improve treatment for opioid use disorder and better rescue approaches as well. So saving lives and then helping people enter recovery.

With this funding, we're focusing on a number of new priorities. There was a just

a publication. It was released online in June and then published in July by Dr. Francis Collins, along with Walter Koroshetz and Nora Volkow of the Neurological Diseases and Stroke. That's Dr. Koroshetz and our Director, Dr. Volkow, at NIDA. And the three of them coauthored this JAMA commentary to highlight for the whole country about how NIH is focusing its efforts in this Helping End Addiction Long-term, HEAL initiative.

I'll just zip through these. You've got the slides. You can read them and ask questions, if you'd like. But there's a major focus on neonatal opioid withdrawal and trying to improve -- both improve the acute care, but I'll be curious to see what happens to these infants long term and how can we support the mothers, mostly mothers, but mothers and the whole families to improve the outcomes over the long haul. So it's not just a matter of those 2 or 3 weeks of acute care in the hospital or in step-down units, but also what happens in the next year and years as these infants develop and are at such risk for multiple complications.

We are, of course, emphasizing medication development as a key focus, whether these are new formulations of existing medications. As much as I'm pleased to have three different medications to use treat opioid use disorder, even when they're perfectly administered, they really don't reach an awful lot of people. So we have marked room for improvement in how we address addiction, and that's why we'll continue to engage in what we hope will be transformative research when it comes to new addiction medication treatments.

In particular, there is some interesting work looking at immunotherapies, vaccines, and monoclonal antibodies that might help people with opioid use disorder by keeping the drugs out of their brain, by keeping it in their circulation. That's a vaccine will do. It will latch onto the heroin or the fentanyl and keep it from entering the brain. So the goal in that case would be you don't get high, and it doesn't get to your central nervous system. And so whatever behavior you engaged in, as I like to say, you end up with an empty wallet, a sore arm, and no high. So the behavior may change over time. That's a theory, but there is research going on to try to develop these new treatments.

We've added additional funding to our Clinical Trials Network, and they will be launching a large number of studies related to all sorts of different aspects related to the opioid crisis. And if you're interested in learning more about that, we will have additional news about what programs and what specific projects we're funding quite -- quite soon.

We're focusing on a major initiative on the justice area with a collaborative agreement with a number of sites, as well as a national survey to look at justice practices so that we can look at changing them from a policy and practice area. And then the last major addiction project I'll highlight for you is what we're calling our HEALing Communities Research Study. This will be a large-scale community-based trial looking at how well integrated approaches, using pretty

much all the evidence-based approaches to address the opioid crisis, if you put them together in communities, can we reduce overdoses as much as we hope?

That is similar to what Rhode Island did in terms of just that one population, criminal justice. But if we did criminal justice, plus work with the healthcare system, plus work with communities directly, plus better outreach so that when somebody overdoses and then you can use that as an opportunity to engage them in care. I was really intrigued by the low-level buprenorphine treatment. The community bringing treatment out onto the streets as something that might be a model for these communities to consider. Those are the kind of practices that we will look at how well they will work when fully integrated and implemented with a similar to a community coalition-based approach to assessing your community and implementing programs, excuse me, based on local needs.

We're doing this in collaboration with our colleagues at SAMHSA, and so we're very excited because we think those communities need to build on the SAMHSA-funded programs and projects. With all the additional money going out to the States, this is a way to test when you integrate that funding stream in a clear and coherent way, is that better than simply encouraging communities to apply for the funding generally? That will be the science question to be addressed with this implementation project.

I mentioned for you that pain is the second major component. That's half the money, but it won't be half my time. I'm just going to highlight it for you. We will be focused on everything from basic research to applied, to even studies like how about nonpharmacological approaches? How about acupuncture and physical therapy?

And there was a wonderful review of all of these nonpharmacological approaches showing that they can be useful in treating some kinds of pain. Well, how do we get them more implemented more widely out to the people who could benefit from them so they don't end up relying on what is a short-term benefit and a long-term problem in terms of opioid medications?

That's what I had for you today. This is a summary of our current HEAL initiative. We expect this to be evolving, and if you're interested, you can follow it on the website, nih.gov/healinitiative.

And with that, I'm done, and I look forward to some discussion with all of you. Thank you.

Agenda Item: Council Discussion

DR. CHIDEHA OHUOHA: Thank you, Dr. Compton.

I'd like to open up the floor for council discussion, questions and hear your

thoughts on the topic.

MR. JASON HOWELL: First of all, thank you so much for coming in and giving your presentation. I was wondering if you all have done any research to better understand sort of why there are so many physicians that are getting trained and getting a waiver, but yet not practicing. Some things that we're hearing anecdotally from the field is that many of them don't want to deal with, you know, the DEA or some of the extra requirements. But also if they've never worked with individuals with substance use disorder in the past, they discover that we can be really high needs -- I'm a person in long-term recovery.

And so many of them don't feel that they are equipped to fully sort of support our community. And I'll kind of shift that into that's the very reason why we should be looking at research around recovery support services because treatment is not recovery. The vaccine sounds amazing, but that's not recovery. You know, managing my cravings and naloxone can keep me breathing, but then I'm left to face the underlying problems of why I was using to begin with.

And so I'm really excited to hear that you all are interested in studying recovery support services, and I realize that from a methodology standing, it can be a little bit of a challenge to research.

And then my other comment was just to thank you for your interest in researching pain, pain management. I've had multiple back surgeries, and pain is a big part of my story. And medications made me not care. It was that short-term solution that you talked about. It was things like acupuncture, yoga, and massage and more of the nonpharmacological solutions that helped me along my journey.

So thank you for taking a look at that.

DR. WILSON COMPTON: Well, it's better than an aside, but unfortunately, the opioids, for many forms of pain, actually make things worse in the long run. So that they make you feel better for a little while, but then you end up with the pain coming back even worse. This is most apparent in migraine and headache where it's kind of contraindicated to use opioids, and yet those are very frequently administered in acute care settings and despite there being a pretty strong literature on that not just not being terribly useful long term, but may actually end up being worse for people.

Your comment about the importance of not just thinking about medications in a vacuum, but the question about the newly trained folks for buprenorphine, why don't they take up the practice? I don't think we know the answers to that completely, but I'm looking at Dr. Daviss here because I think he has some insights into this, among other colleagues at SAMHSA. We're thrilled to see the PCSS program as one of the tools to help reduce the barriers to adoption of

buprenorphine treatment by anxious or reluctant clinicians.

Anytime a clinician learns a new practice, they want somebody to call or rely on for both formal and informal support in starting it. There's always a process of learning whenever you're taking up a new clinical practice, and you need support, particularly early on. After a while, you can be one of those that supports others. It's not that different from recovery support communities, where those early in recovery are probably not the best to provide guidance for those entering it, but the more experienced folks can be very helpful in guiding new people through that process.

The other barriers in terms of things like concern about the regulatory requirements, whether that's here of the DEA or the recordkeeping requirements, are definitely a real barrier. And I think that's one where we can work on that in terms of helping people with simpler approaches, and I look forward to ideas from some of you all about these won't necessarily be huge research studies, but modest projects to help provide that advice to folks to allow things like electronic health records to help you with that rather than be a barrier.

And there may even be markets for some of that. And so I would look for -- to a degree to our Small Business Innovative Research Program, where we fund companies to develop products to address these issues as one place where we might find some novel ways that NIH could support this area with very practical solutions to some of these issues. There's probably more we could talk about, but that's enough.

DR. CHIDEHA OHUOHA: To add to what Dr. Compton just said, one of the first things I was told to do when I first came here in June was to figure out exactly how we're going to increase the number of X-waiver physicians practicing. So it is something that we are really actively involved in looking into.

DR. WILSON COMPTON: We are tracking the number of clinicians and also the number of buprenorphine prescriptions written as a way to indirectly measure this, and we are seeing continued increases. So it's changing. Maybe not as fast as any of us would like or think is needed, but it is changing over time. And the nurses and physician's assistant field were zero 2 years ago. So that's huge.

I'm not sure who was next, but we'll go down this way.

MS. SHARON LEGORE: Well, one of the things as family members that we're seeing that is a barrier is not having -- you may get the doctors who can write the prescriptions, but not having follow-up with treatment. So buprenorphine alone is just not the treatment. There needs to be more.

So you were talking about initiating in the emergency room. So what happens next after they get that? And also within the criminal justice system, what we're

seeing is there's a lot of people detoxing without anything, and then not having any medication or any treatment whatsoever within the criminal justice system, coming back out and then going right back to using. And then, you know, with all the time clean, you end up, you know, having a lot of overdose deaths.

So without that continuum of care, it seems that it's sort of like at a standstill unless these doctors can be trained and really provide what's needed besides just getting through all the red tape to prescribe, to really actually help them in the treatment process. So you said -- I know I go a lot, but you said about the I think it was the New Hampshire study in the criminal justice system. So --

DR. WILSON COMPTON: [Inaudible] criminal justice.

MS. SHARON LEGORE: But was there aftercare there besides the buprenorphine within the system, any counseling treatment of any sorts --

DR. WILSON COMPTON: Absolutely. And particularly --

MS. SHARON LEGORE: -- or follow-up once they got out of criminal justice?

DR. WILSON COMPTON: Well, when you think about how to develop a system of care, its medications are one piece, but clearly, that's not the answer in the long run. Helping people turn their lives around may require medications as a starting point, but it's not the ending point. It's only a starting point.

One of the most discerning bits of data is how long do people remain on these? These are lifelong chronic conditions. Not in every case, but for so many. And yet the typical duration of treatment of either the long-acting naltrexone, the injection, or buprenorphine or methadone is woefully inadequate. It's people typically stay on these medications a matter of 1 to 6 months. Well, that's not enough.

And so that's a key place where I don't have the answers. That's what research is all about is when you identify a problem and you have a creative idea, we want to fund you to test your creative idea, see if recovery coaches added to the emergency department. That one is a little bit easier because even at Yale, they weren't just given buprenorphine. They also had to follow up with recovery coaches in the ER to help with that at least initial process.

Their goal, of course, was engagement in treatment outside of the emergency departments. But they had found previously that when -- they were making active referrals, but people weren't showing up for treatment. And so by starting medication, that was a good entryway to encourage greater engagement in care, at least short term. But the long-term outcomes, we have a lot of work to do to go from first engagement in care to long-term treatment success and recovery.

MS. SHARON LEGORE: I just want to say one last thing, and that's a problem that we're also seeing is diversion. Because when you don't have the follow-up care, and then you have access to buprenorphine and no other care, they can be sold on the streets and buy heroin and a lot more. So it's --

DR. WILSON COMPTON: It's interesting that some of the observational studies suggest that people using opioids illicitly often use buprenorphine kind of in what sounds almost like a pseudo medical purpose. So it can be used for intoxication, to get high. We see that both in the U.S. at times and internationally. There are a number of examples of that.

But we also see an awful lot of people who are not in treatment using it when they're having withdrawal. So at least it's a start of sort of tempering their own -- the severity of their own symptoms. I hope that becomes an entry point into treatment, and I'd be curious what Dr. Martin and others would say because they have a lot of experience in this area.

But certainly, there are concerns about diversion. That's why we have this extra buprenorphine training requirement. I mean, that's not the only reason, but that's one of the key reasons for the DATA waiver process is to make sure that those clinicians providing buprenorphine are the adequate quality and are monitoring outcomes and paying attention to their patients' behavior.

Healthcare is regulated at a State level, though. So I encourage you, if you're identifying local problems, to work with your State medical authorities to make sure that those are being addressed. I remind people of that, both us at NIH doing research and those at SAMHSA with some regulatory authority have very limited tools because healthcare, as it should be, is a State-level regulatory issue.

MR. ARTHUR SCHUT: So I've been involved in integrating clinicians into primary care offices, and my observation is they're very happy to have a clinician be there because a clinician can actually see the client when they come in to see the provider. The challenge is paying for that arrangement. And so if you have a provider from -- a community-based substance use disorder provider in a primary care setting, you tend to have an instant connection, and you can do this quite well.

The logistics around getting paid for this are phenomenally difficult, both for the primary care setting and as well as the community-based provider. And it would be really good to look at that, I think.

The other thing I've encountered is a lot of providers think that the person has to be admitted into a substance use disorder program before they can be medicated. And I actually did the reverse. I made sure that people got medicated first and then admitted, if that makes sense. Because you really --

you draw people in that way.

Another way to contact criminal justice folks is parole, pending revocations, and we did that by having a physician and a nurse go to county jails that were holding people who were on parole pending revocation who actually got there because of a substance use disorder involvement. And they were actually in a position where they were -- they had already been detoxed, right? So you could do long-acting naltrexone in that setting. That was an opportunity.

And then it would be worthwhile looking at the billing system for the drugs that you're trying to access. So long-acting naltrexone, for example, in Colorado at least there is a buy and bill arrangement. And if you're going to -- you have to be fairly large to order, you know, above 25 doses at a time to get the discount. And the other issue then is if you're initially authorized to do it or you do it and the commercial payer refuses to pay for it, then you eat the expense as a primary care practice.

So I think part of this has to do with the availability of an elegant payment system to do it, and then there are just sort of unrealistic things. For example, when I first wanted to do extended-reach naltrexone, the State allocation to me, which was I believe all the money they said was available to do it, was \$37,000, right? So that's like 37 doses with no payment for physician services or those kinds of things. So we would do oral naltrexone in a variety of settings where it was in residential waiting to get out.

Eventually did a little mini research project that actually looked at revocations in the criminal justice side and recidivism and got actually back to the legislature and got additional funding to do that for that population. But I think part of it is, is how you support -- I think you support primary care docs by having access to the appropriate substance use disorder.

And then I've also done a whole project around actually for a number of years with 20 emergency rooms and going in and having a response team that takes people out and puts them in a lower-level detox and then engages them there and attaches case management to it. So --

DR. WILSON COMPTON: I think what you're reminding us is both the complexity of our healthcare system, or the lack of system at times, and some of what you raise seemed to me to be amenable to research. Some of them less research and more practical, how do we get this done in our local area using our local resources and the variation in our State or community system? That's always the challenge in our field, and I -- to the extent that we can collaborate with CMS, who may be able to influence some of the financing system, we certainly are always interested in those opportunities.

There's also been a push by the private sector to the commercial insurance to

enter this area more than I've ever seen before. So we have outreach from some of the major insurance companies to look at what they can do in terms of their practices and also their ability to influence what they'll pay for and the expertise of the clinicians that they -- that they fund. Because as much as -- not every clinician is as good as some others. Not all of them are the Dr. Martins of the world or the folks represented around this table in terms of my medical colleagues.

And so, you know, it's a complicated world. And we're not the only one facing that. It's mental health and even general health has some of the same issues.

MR. ARTHUR SCHUT: I've found it's so tricky. Perhaps what you want to do is find the innovator and work with the innovator --

DR. WILSON COMPTON: I'm also intrigued that it takes -- you described something I think is an important factor in that we want to see behavioral health integrated into general medicine, and we've done some demonstration projects into research. We particularly emphasized integrating addiction care into HIV treatment, thinking that it's a natural fit because you have another chronic disease being taken care of.

And so you have people showing up on a regular basis might be amenable to adding behavioral health there. We've done some interesting work on that particular niche that may have implications for general medicine more broadly.

DR. JUDITH A. MARTIN: So --

DR. WILSON COMPTON: Don't forget to turn on your microphone.

DR. JUDITH A. MARTIN: Yeah, thank you. So all of the presentations this morning were very interesting and full of information and provocative, and so I wrote down a lot of things that I want to talk to people about. I think one thing that you might be able to know that I don't know is do you know if there's any research on how much or how long buprenorphine lasts or how much buprenorphine it takes to protect you against something like fentanyl or an overdose?

It's one of the things that frequently comes up in the emergency room stats, you know? Like should I load him up, give him like a whole 32 milligrams and then send him out? Will it last longer in case they don't make it to the transfer center?

And also it comes up in the street medicine treatment where there is diversion, we think, we expect, because there's an informal economy on the street, obviously. And what we're using is tox screening where if the person has a positive tox screen, then we keep treatment going. If they come in frequently with negative buprenorphines -- I mean, a test for treatment. You know, a test

for the buprenorphine being present, we think they're protected, but are they?

You know, if they have a positive tox screen that shows buprenorphine. I mean, that would be negative. I know sometimes we say -- in other words, a favorable test that shows that they took their medicine.

DR. WILSON COMPTON: We see that in pain clinics where we encourage clinicians to test for the medication you're providing in your long-term patients because there will be not a large number, but some who will be getting their opioids and not taking them themselves, but it becomes an economic source of - they sell them.

You raised -- the key question about do we know whether buprenorphine and what dose might be protective against a fentanyl overdose? No, I don't think we do, but I'm not 100 percent sure. And there are certainly some of the behavioral pharmacologists and others who -- and animal studies that might be able to shed some light on that question. Some of it is not always -- our patients don't just use one substance when they overdose, and so that's always a key issue.

And that while we're worried about the opioids, there's also alcohol. There's sedatives. We heard about methamphetamine. We see the illicit drug supply being poisoned with fentanyl in many, many cases. A series of case reports about cocaine being -- having fentanyl added, which wasn't somebody trying to speedball, but it was the cocaine itself being -- having --

DR. JUDITH A. MARTIN: Laced, laced.

DR. WILSON COMPTON: -- fentanyl -- laced with fentanyl. Those are just examples, and a number of you brought up the methamphetamine situation, which is our work is not done.

DR. JUDITH A. MARTIN: Yeah, the meth --

DR. WILSON COMPTON: And I'm a pretty optimistic person, but there's a lot of work to be done.

DR. JUDITH A. MARTIN: Yeah. What we find with the homeless people on the street in San Francisco is a lot of times people use methamphetamine during the night because the nights are especially dangerous. And then they use opiates in the daytime, and they sleep in the daytime.

MR. LAWRENCE MEDINA: Thank you. Great presentation. And understanding what NIDA or your department does, I think also for when looking at rural and frontier areas, and sometimes when I come here, I sound like a broken record because the big cities of Denver, Detroit, respectfully, LA, San Francisco. But we look at rural and frontier areas and also how it's destroying our communities

and our families, not that there's any big difference from the city, but from smaller communities and how it really shakes a community.

And without services and how that -- and what does that look like becoming a norm? It's pretty scary. You know, when they fall through the cracks, you know, statistically, they don't -- there's no statistics because the numbers are so low, but they are big. And I don't know if it's in your area that -- in your department, and how do we advocate with these pharmaceutical companies that are pushing this?

And like the tobacco company, you know, is paying for classes and help funding people to stop smoking, I really feel like rural and frontier areas that, you know, you look at the State of New Mexico. We're poor. Our data is worst -- we're the worst of the worst list of them all, and we don't have any funds for methadone clinics.

You know, our State representatives or those departments say, well, it's a money maker. So if you could raise the money to start a methadone clinic, you could make money. And I think that's kind of a bad way to look at a cash cow priority, then you know, providing these individuals in rural areas, you know, these type of treatment, the MATs. In some cases, they're utilizing Medicaid transportation to get transported an hour, hour and a half one way every day for their dose.

So in looking at how we're going to fund these for such areas, of all areas, but especially rural and frontier areas, you know, you can't even -- there's not no methadone clinics or limited, you know, docs for to administer those medications. But ways to help fund this not only just from the State level or the Federal, but what about these pharmaceutical companies and participating in the healing process rather than just making the money?

And that's kind of like the big, fat, white elephant in the room that nobody wants to talk about that. Are they part of the problem or not? And is that something in your -- in NIDA, do they address that in working with or communicating with pharmaceutical companies? And how are they part of the problem, or are they part of the solution?

DR. WILSON COMPTON: I'm not sure that that's an either/or question. Certainly, they've been absolutely part of the problem. That's well documented. You have criminal convictions of the Purdue Pharmaceutical Company for their illegal marketing of OxyContin a number of years ago with a huge fine, and that wasn't civil. Those were criminal charges leveled against them. We see major lawsuits going on against multiple levels within the pharmaceutical industry.

Of course, NIDA is not -- I mean, we're a research group. So we're -- but I pay attention to what I read in the paper because I think that's part of public health -- understanding the public health situation and response.

We're going to let Tracy make an intervention.

MS. TRACY GOSS: Hi there. I just want to remind everybody who is listening in to please mute your lines. We can hear you.

DR. WILSON COMPTON: Thank you.

[Laughter.]

DR. WILSON COMPTON: So you might pay attention to whether some of your local jurisdictions or your State are participating in some of the major lawsuits. I don't recall New Mexico in the newspaper articles I've been reading. I remember West Virginia and parts of Ohio, and I don't remember the others. So you'll have to figure that out. That is at least I have no idea whether that will lead to funding sources or not, but that is something that some of the jurisdictions are doing.

I also think that it's important to remember that there are parts of the pharmaceutical industry that we have to take advantage of. Medications for treating this condition are different than the medications for treating pain and the misuse of opioids. They're different. They're often different companies, but sometimes it may be different branches within the same company, and that is -- that presents ethical complications for us as we're trying to figure out how can the research that we support be used.

Because we don't market medications, and we don't help distribute them. There's a whole infrastructure that is the pharmaceutical industry to do that. So how can we work successfully with those partners for this? And we do that every day, and we do the best -- and we manage those potential conflicts as carefully as we can.

DR. JUDITH A. MARTIN: So on the issue of overdose help that's not naloxone, there's that place in Boston where people go when they're high. It's a safe place to be high, and it's run by nurses and even physicians. They have oxygen, and they have oxygen sensors, and they claim that they don't have to use as much naloxone because they'll notice that the oxygen level drops before the person looks like an overdose. And so they just start the oxygen, and then it doesn't happen.

DR. WILSON COMPTON: Whenever you hear about truly innovative practices, those are opportunities for somebody to study to see whether is it kind of a one-off that won't work other places, or is it a model that might be able to be used in other locations? I don't know. I've certainly heard of that facility in Boston, and that would be the kind of thing that NIH would be interested in making sure that there's the appropriate research to understand who it will work for, who it doesn't help.

Is it a major innovation or just a not terribly helpful? And I could certainly understand how that could be helpful, but we'd love to see data to help confirm or disconfirm how useful it is.

DR. JUDITH A. MARTIN: Probably expensive.

DR. WILSON COMPTON: I would imagine, but also community deaths and overdoses are just devastating for so many. And so the expense, if you would have it, is extraordinary. So we have the opportunity to -- to reinvest in novel ways. But I also think that's why research would be useful in that case because it's not cheap to implement that. So making sure that it looks useful and at least effective, if not cost-effective, would be essential.

MS. SHARON LEGORE: Has there been any research done within the criminal justice system for the drug courts to see if they implement and require treatment and the drug screenings and all the way through? The ones that do, you know, really a much better job of it, do they see higher success rates?

DR. WILSON COMPTON: Yes. There's a very well-established body of evidence around drug courts. But I'd like to say drug courts can be effective. It doesn't mean that every drug court is effective.

MS. SHARON LEGORE: Right.

DR. WILSON COMPTON: Because not all of them use the principles of effective care, whether that's -- and I would encourage you to take a look at the National Association of Drug Court Professionals. They have a lot of information on their website. Some of their work was supported over the last now 20 years or a little longer by the National Institute of Justice and some by National Institutes of Health. And certainly, SAMHSA has had a long-term funding program that works with drug courts and other healing court systems.

Because you have drug courts, we have veterans courts, we have mental health courts, which all have that similar model of combined public health and public safety. The basic concept is some of the population that we'd like to bring services to aren't that eager or able to participate in services on their own. And what's law enforcement good for? Well, it's really good at enforcing and shaping behavior.

So you can use the enforcement and the requirements that a court can provide or law enforcement, writ large, can provide in combination with the help that comes from the public health systems and the intervention systems. And working together, they seem to be much more effective than either one by itself.

MS. SHARON LEGORE: And is there any research on the family involvement in the recovery process?

DR. WILSON COMPTON: There is less on -- there is certainly some, but I don't think that's as well researched. There's been tremendous work on family involvement in prevention services, on changing long-term outcomes, on -- I think of the family interventions for infants, for little kids, for toddlers, for entering school age kids, for adolescents, all of which have a very strong evidence base now to look at their long-term prevention outcomes.

We have treatment interventions at the adolescent age group that are family based that have a very strong evidence base. There is less in terms of research on family-based approaches for adult patients, but it certainly looks like they should be included, and that's an area where I think we could benefit from additional studies. But I think the good treatment programs all include that component.

But Audra was going to say something.

MS. AUDRA STOCK: I was just going to highlight some of the programs that we have within CSAT that may be of interest, and I can get you our program profiles. But we have a really robust drug court grant program, adult treatment drug courts, which we've had for many years. And we have veteran treatment drug courts. We have tribal healing to wellness drug courts. And we also have family treatment drug courts, which are a little different than your criminal justice sector drug court.

Hopefully, all of you are familiar with them, but we're really proud of that, that model, and it's expanding, especially with the opioid crisis, where we have parents who are involved with the child welfare system as a result of their substance use challenges. And so they get involved in a problem-solving court, which partners with child welfare and about taking care of that family, family counseling, substance abuse counseling, childcare, child counseling for trauma, et cetera, and reunification is the goal.

So we have a lot of wonderful, robust programs, grant programs around that and a good partnership with the National Association of Drug Court Professionals. And I can provide some more specific information about that.

MS. SHARON LEGORE: That would be great. What we're looking at as well is families who don't know how to be that support system or that are told the best thing for you to do is just walk away and leave. And so then those, you know, people have no one. And so the families are tied in a lot of areas not knowing what to do, you know?

So what does research say is the best thing we can do as families to support our loved ones without being told either, you know, you just put them away and forget about it, or you know? Because we don't want to enable, we don't want to hurt, we don't want to harm. But we need that research to tell us, okay, here are

things that we know work that you can do in the process to support the loved ones. Because I think with the family support, I know in my own family, with my son, he has said many times he doesn't know how he would have made it. I don't even know how I made it because knowing everything I know kind of to access and get the treatment and supports was extremely difficult.

So if there was some research there to help the families as well know what it is we could do to help, I think that would go a long way for those struggling across the country. Because by the time we lose our kids, then we have a whole other set of problems to deal with. So if we could cause that, you know, death rate to go down by knowing how to be supportive, I think that would help in the process, too.

DR. WILSON COMPTON: I agree, and I think that building on some of the success in family-based interventions for adolescent treatment and extending that into young adults and even beyond could be very helpful. Plus, I think what you're talking about is, is how do we incorporate a family-centered approach into drug treatment? It's going to be a key component of all treatment, but what's the best way to organize and implement that?

MS. SHARON LEGORE: Yes.

MR. ARTHUR SCHUT: I have a couple just data issues. And one is particularly related to marijuana that it appears that youth are often reported as 12 to 24 years of age, and it would be nice to see that be under 18 and 18 and up. Because if you look at some of the surveys in Colorado, for example, perception of risk for those under 18 has gone down, and use of marijuana for those under 18 has gone down. But if you look at the 18 and over folks, it's really, you know, gone up significantly.

But when they get put together, it gives the appearance that, in fact, the under 18 use has gone up, when in point of fact that it has not. It's decreased. And if you look at the perception of risk has also gone down at the same time, which is an interesting thing to have happen. So it would be nice if we could all find a report 12 to 24, but it gives this illusion that there's this huge increase for those under 18.

And then my second concern is that a lot of the data that you may get may be underreported. I know there used to be an epi-group in Denver, for example, and I know they had trouble getting information from -- that was accurate from a lot of other counties and that deaths weren't always reported. The cause of death wasn't always what it could be. I mean, there are just a lot of what appeared to me to be underreporting, and that group was funded locally, and I think it doesn't exist anymore.

So I wonder if you have that experience nationally where you're really not getting

the kind of quality of information that you would like?

DR. WILSON COMPTON: I'll give you a key example of that. When, you know, I showed you some of the death data. About 15 percent of deaths in 2016 that were overdoses just say "drug overdose." They don't specify what substance was involved. And while if that were sort of evenly and randomly distributed, because sometimes you can't figure it out, that would be -- make some sense. But it's not evenly and randomly.

Most of you all are from locations that have medical examiners, have full death investigations that include toxicology. But there are some -- many jurisdictions that have coroner systems that use elected officials or sometimes funeral directors to do their death investigations, and some of those will be fine, but a lot of them will be inadequate and tend to be those that just say "drug overdose."

Well, that's a problem. We can't really plan effectively if you don't know what the -- what the substances are. Because it's a big -- the interventions are very different from whether it's an opioid or methamphetamine or cocaine. There's some overlap. Drug overdose is a useful category to a certain extent, but understanding that is a key gap.

Those are while CDC collects and collates that information, these are State and county-funded positions, and so they depend on local and State officials. There has been a real increase in CDC support for the infrastructure. So we've -- I just told you it was 15 percent. It was 25 percent just a few years ago. So that's an improvement. But we still have a long way to go just in that one area, where we're not identifying what substance was involved, and it should be closer to 98 percent where we get it specified. That's what the really strongest jurisdictions are able to produce.

When it comes to reporting youth, I actually don't see 12 to 24 as the category. In the Federal data systems, it's almost always 12 to 17 and then 18 to sometimes 24, sometimes 25. The age in the data itself is the year of birth or some variation on that. So if you have access to the data, we can cut and slice it, and you can ask data analysts to cut and slice it any way you would like.

There's typically a break under age 18 and over because the consent procedures are different. With a 17-year-old, you've got to get parental consent, and an 18-year-old can consent for themselves. And particularly for 12- and 13-year-old, that's an even bigger deal than a 17-year-old. And, but I would totally agree with you that the developmental range from 12 to 24, those are all in the adolescent group broadly speaking, but there's major shifts in terms of peer groups and behavior and ability to manage their own decision-making across that age range. So I would totally agree with your concern.

MS. KRISTEN HARPER: Hi, this is --

DR. WILSON COMPTON: And I'd be curious why Colorado is doing that. Yeah?

MS. KRISTEN HARPER: This is Kristen Harper. I was wondering if I could jump in here? You're kind of speaking my language when you get into the adolescent and emerging adult conversation.

So I -- first of all, thank you so much for your comments. I do primarily work with collegiate recovery programs, recovery high schools, and actually just started doing a little bit with the STR grants. So expanding a little bit of recovery support services through that process as well. And was curious if you heard about the new journal that was just created, the Journal of Recovery Sciences. Are you familiar with that?

DR. WILSON COMPTON: No.

MS. KRISTEN HARPER: Okay. So it's --

DR. WILSON COMPTON: But I'll look for it.

MS. KRISTEN HARPER: Yeah, it just started this year, and what really got me excited about it was the editor list that it has on there some of the really kind of more profound and established recovery researchers.

DR. WILSON COMPTON: I'm sure John Kelly is one of them.

MS. KRISTEN HARPER: Yes, he is. Yes, but I'm sure they're probably all right next door to where you guys are meeting today. But I'm curious, when it comes to recovery research, I know you talked at great length about this necessity for reaching the continuum of care, which thank you so much for identifying that as a major need. What areas do you think it would be most impactful when it comes to recovery science, is what we're trying to frame it in the field now, as far as helping get communities the resources that they need to really make an impact in what's going on, especially with the epidemic, but in the broader sense of the word when it comes to the continuum of care?

What do you think would be really interesting? Is it studying, you know, cost-benefit analysis of recovery? Looking at the economics of recovery, not just as addiction? You know, looking at subpopulations? What do you think would be really exciting for NIDA to see?

DR. WILSON COMPTON: Well, I would turn this on its head and ask you what you think we should be focusing on because that's my job here today. But I will point out to you that some of what's appealed to me in the recovery area is the importance of a long-term perspective. That there has always been this sort of

notion that, well, fix it and forget about it in the addiction field. And that just isn't the way human behavior changes and that we now have enough long-term studies to suggest that people need to be abstinent and in recovery for it looks like at least 3 to 5 years before you really think of their recovery being stable and long term.

Now does that mean treatment goes on for that whole time? No, of course not. But what it does mean is that we need a system of care to help coach them through that process, to support them and intervene quickly when people relapse in that timeframe. So that's -- that's -- I'd like to see some of that work expanded. I think one of the novel ways that NIDA will be the only ones to do work in this area will be in some of the neuroscience of recovery and understanding what happens with decision-making? How do the front lobes, where we know judgment and decision-making are so important, do they really come back online, or do we need to work on some other strengthening mechanism so that people aren't so tempted by immediate needs and immediate short-term benefits.

Because that's what substances are all about. They make you feel good or better right now. Even though you may know that it's going to ruin your life in the long run, you're so enamored of like the next 30 seconds or 5 minutes or 20 minutes that you're not thinking about a day, a week, a month later even if it will - - as easily.

And so how do we change that, and how do we understand that process? That's what I'm -- that is at least one area where there's nobody but NIH that will do that kind of work. And that can be very influential in influencing policy in the long run.

Now I'm not going to -- I'm not going to diminish the need for all of the clinical research that you describe. That's something we can often do jointly with our colleagues at SAMHSA because while novel programs are being supported by SAMHSA, we can pay for some of the research on top of that. It makes the research less expensive because we're paying for the key research components only. It also means that there may be a ready home for the findings because you got people who are interested who are actively doing the work already.

That's why we funded now several studies, five directly by NIDA, a few more by another NIH institute, and some by an outside foundation that are embedded with a State targeted response program. I was very excited that we were able to issue an RFA to fund people who could take advantage of States trying something innovative and use that as a platform for developing evidence on how strong some novel approaches might be.

We've announced that we would like to try the same approach when it comes to the Indian -- the American Indian and tribal efforts that SAMHSA will be funding this year and next year, that we think that that could be a platform for research

as well. We'll see if anybody comes to try to take advantage because we depend on investigators working with the communities to come up with good research ideas. But we'll continue to put out these announcements to try to solicit those kind of proposals.

Thank you, Kristen.

MS. KRISTEN HARPER: Yes, thank you so much.

MR. JASON HOWELL: This is Jason. Building on what Kristen said, you know, looking at when you're doing research on what are recovery outcomes, I think that, you know, if we are just focused on abstinence or, in some cases, we just focus in on reducing overdose deaths, we're really not looking at how you measure recovery and whether we're looking at maybe the recovery capital scale or quality of life scale. If our system is keeping the end in mind, then I think that we can even capture what is really getting us there.

I think that when we talk about recovery support services and the need for studying them, and I know sometimes I use that word, assuming that everybody knows what I'm talking about. But there's an array of different recovery services. Kristen mentioned the collegiate recovery programs and recovery high schools. There's recovery housing, recovery community centers. We need to research those and make sure that we're researching those that are using best practices.

The recovery community has identified a lot of standards and fidelity mechanisms, and so in some places where I see people looking to research these services, the subjects that they're researching may not be using -- they may not be certified, they may not be using best practices or having fidelity. So I'd just ask to keep that in mind.

DR. WILSON COMPTON: Well, I certainly think that's a notorious issue that if we end up studying something that isn't as well implemented as it should be, if it looks like it has an impact, then you may be able to -- that may be useful. But if it doesn't show an impact, then you don't know. You're left wondering, well, is that because they didn't do it very well or is that because the program really isn't a useful approach? And that's really a difference -- those two conclusions matter hugely.

So you want to make sure in these clinical studies that it is a high-quality implementation with fidelity to the model. So we can really look at the mechanisms and understand what causes those, the improvements or the lack of improvements. Because some people won't respond, and we need to know who isn't reached by our current system so that the next generation can do a better job of helping those.

DR. JUDITH A. MARTIN: So I saw that JAMA article about long-term elimination

of addiction or the HEAL, the long-term addressing addiction. And it's sort of provocative to think about that. And I wondered if like several years ago, the research came out about adult-born neurons as part of healing from addiction. Like if you -- like alcohol kills brain cells, but exercise maybe helps new ones form. And I wondered if that's one of the paths.

And then the other thing that I thought about was the -- like the Carl Hart book and the rat farm, or rat park, that maybe to prevent development of addiction, looking people having, you know, meaningful activities and ways to develop themselves as people and having jobs that make sense as a way of maybe making it less likely or more possible that our prevention activities really work.

And I don't know if that's part of the package of what you're looking at.

DR. WILSON COMPTON: I think you're touching on a very broad range of possible topics. Everything from is the brain able to learn new things once you are done with adolescence? Of course, the answer is yes. We are learning and changing our behavior every day, and the neuroscience in some ways is catching up with what careful observers have known for a long time, that people can. It's harder. Little children shape and change readily and quickly. Adults less so, but they will change.

We know this from stroke recovery and from others where even when there's major structural damage to the brain, there can be -- there is significant recovery over time, but it's a slow, long-term process. Will it be as good as if the damage hadn't been done or if the behaviors hadn't been shown? Probably not, not given our current approaches. But definitely, recovery is possible, and real change happens, even in older adults.

So that's at least one message. And the neuroscience is helping us understand that, be able to map it, and hopefully to enhance it, whether that's with mechanical techniques like transplanting a magnetic stimulation that might be able to help brain pathway growth in certain key areas. That looks pretty intriguing to me. Is it ready for you and other clinicians to use? It is in depression care, but it isn't in addiction yet. But at least that's something that we're examining as a possibility.

The second issue you raised had to do with what about long-term trajectories, and I think this is -- this is better established than people recognize. There is now a large body of work showing the importance of -- of changing the environment as a way to raise healthy -- healthy children and healthy adults.

Whether that's the nurse-home partnership program of David Olds that looks at a way to prevent child abuse by sending home health nurses into high-risk households to provide guidance and encouragement, mostly to moms, but to families, about how to take care of infants. These are particularly important for

moms that don't have a large family support system, which is where most of us learn parenting skills, from others that have done it before and provide helpful advice.

Those outcomes are both short term and now very long term. So, to me, it's awesome that you can do this relatively low-level intervention with infants and still see improvements in their outcomes 12 to 15 or 20 years later, and some of those studies have now gone on long enough to show those long-term changes.

There are similar studies with early childhood family-based interventions. The Good Behavior Game is a school intervention that can interrupt the trajectories into deviant behavior by the biggest impactor on acting-out little boys at ages 5, 6, and 7, that by giving teachers the tools to keep those kids engaged in the classroom and not ostracized from their peer groups, it sets them on a very positive life course trajectory that now some of the studies are 20 and 30 years later show they're doing much better in terms of mental health and behavior outcomes.

Those are just a couple examples. We have several studies that show that middle school interventions, particularly those family-focused, Strengthening Families -- SFP, Strengthening Families Program 10 to 14, is useful 10 years later in reducing the misuse of opioids. Well, they didn't really focus on opioids with the 12- and 13-year-olds. But what they did focus on is helping families with those two key developmental challenges, which is providing a loving, nurturing environment -- in other words, not chopping their heads off when they're 13-year-olds and getting on your nerves all the time -- and providing appropriate supervision.

And that balancing act is true for parents of every age group, but particularly at puberty, that's very difficult for parents of all kids. And so these broad-based universal approaches have now been shown to produce a long-lasting impact, whether that was implemented as part of the PROSPR study in a large community study of multiple towns in Pennsylvania and Iowa and in two other large-scale clinical trials. That's -- I think that's remarkable, and yet have we implemented those in every community around the country?

DR. JUDITH A. MARTIN: We used our SAPT grant for prevention --

DR. WILSON COMPTON: Thank you very much.

DR. JUDITH A. MARTIN: -- for Strengthening Families first. It really trains youth to communicate to their parents and parents to communicate to their youth.

DR. WILSON COMPTON: I encourage you to make sure that these are -- there are some programs that have less of an evidence base, and I do encourage you all, as you're working with your communities, to think about making sure that

your coalitions and others are engaged in evidence-based adoption. Because especially in the prevention field, we have a long history of things that seem like a pretty good idea and haven't panned out as well in practice.

The drug education programs of the early '70s and '80s are a prime example. They seemed like a good idea, but they were -- they backfired in a major way. Maybe at the time people knew they would backfire, but lots of communities implemented them trying to help protect their kids, and then it didn't work.

CSAP is having their advisory council at the same time. I'm ex officio on their council. So maybe I'll hear about this, talk about it.

I wasn't sure how long I was supposed to sit with you all, but I hope I'm not monopolizing, and if there are --

DR. CHIDEHA OHUOHA: You've done very well. We are going to break for lunch now. Please be back promptly at 1:00 p.m. so that we can engage in discussions with the Principal Deputy Assistant Secretary, Mr. Owens.

[Recessed at 11:58 a.m.]
[Reconvened at 1:01 p.m.]

DR. CHIDEHA OHUOHA: Welcome back, everyone. I'm very pleased to introduce you to Arne Owens. He is the Principal Deputy Assistant Secretary for the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Mr. Owens came to SAMHSA following his service on Capitol Hill as a healthcare policy advisor to Senator Bob Corker and Senator David Vitter and as global health policy advisor for the U.S. Senate Committee on Foreign Relations.

Previously, he served in the State government as chief deputy director of the Virginia Department of Health Professions under the then-Governor Bob McDonnell; at SAMHSA, as senior advisor to the administration -- senior advisor to the Administrator in the administration of the then-President George W. Bush; and as Deputy Commissioner of Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services under the former Governor James Gilmore.

Until 1997, Mr. Owens was a career officer retiring as a lieutenant colonel officer after serving in a variety of executive and staff assignments throughout the world, including Korea, the Persian Gulf, and Iraq during Operation Desert Storm. He completed his military service in the Office of the Secretary of Defense, supporting the Assistant Secretary of Defense for Public Affairs and the Assistant Secretary of Defense for International Security Affairs.

Mr. Owens is a graduate of the U.S. Military Academy at West Point and holds a master's of science degree from the University of Southern California. Arne, welcome.

Agenda Item: SAMHSA Leadership Discussion with CSAT Council Members

MR. ARNE OWENS: Thank you very much, Dr. O. We certainly appreciate having you here now as our relatively new Director of CSAT, and we know you've made a tremendous contribution to this field over the years, and we just look forward to your continued contribution here at SAMHSA.

So thank you for that introduction. I forget many of the crazy things I've done throughout a career spanning many years since graduating from the military academy. I never expected to end up in the behavioral healthcare field, but that came about back in 2000, when I did, in fact, join the Virginia Department of what was then called the Department of Mental Health, Mental Retardation, and Substance Abuse Services. It's now the Department of Behavioral Health and Developmental Services, which is a little bit better nomenclature, I think. It's still a bit of a mouthful, but that's the nature of bureaucracies, I guess.

And they wanted my leadership operations management experience, to be able to apply that to the operations of a State agency, and then from there, I just kind of picked up a lot of the policy things along the way. I'm not a clinician. I'm not a researcher. So I've not been out there in the field like many, if not all, of you providing services or treatment.

I certainly haven't done what Dr. O has done, providing services on the streets of the District of Columbia to people in very great need. But I have served in these other capacities and am happy to be back here at SAMHSA. I was here 10 years ago working for then Administrator Charlie Curie and Terry Cline, who you all may recall. Yeah, yeah?

So that was a great experience. That was a good intro. So it's good to be back.

Dr. McCance-Katz would normally be here doing this, but she is on another mission right now on behalf of the Secretary of Health and Human Services. She's on a site visit to Percy, Arkansas, as part of the Federal Commission on School Safety. She's representing him on that. This is a commission that was created a short while back to take a look at these issues around school safety that have been kind of -- well, we see the issues are related to these school shootings that have occurred around the country, and so this commission was formed, is making site visits around the country, and it's going to produce a report for the White House that will contain a whole series of recommendations.

I don't know what those recommendations will be, but hopefully, they'll be helpful in informing the dialogue around what to do. And hopefully, that dialogue will lead to some actions that we can take over the long term to try to just help address this issue.

But she did share with me some of the -- some of the talking points that she's been using as she's gone around Washington and around the country, providing updates on what's going on at SAMHSA and providing information on the vision on the future of SAMHSA. Much of it revolves around implementation of the 21st Century Cures Act that was passed the end of last year, or I should say the end of 2016 and was implemented last year, and we continue to implement that here at SAMHSA this year.

Just as a little bit of a sidebar, it's interesting for me in that while I was on the Senate staff, I worked for a member of the Senate who's an M.D. and also very interested in mental health reform, Senator Bill Cassidy of Louisiana. And I crafted a mental health reform bill, and it didn't deal just with mental health. It also dealt with substance use and substance abuse services.

And so I was a part of the working group that crafted the bill that was then merged into the 21st Century Cures Act, and you're probably familiar with that. That bill, 21st Century Cures dealt with a lot of different things, a lot of NIH stuff, but Division B was the Helping Families in Mental Health Crisis Act, and that was a combination of this bill that I helped to craft as a part of the working group that dealt with mental health. There was also Senator Cornyn's bill that was more focused on the justice system, and former Representative Tim Murphy had some -- had a bill, and some of his work got merged into this, and that all became part of what was finally passed out.

So it's interesting that here I was kind of participating in that, and now here I am at SAMHSA as we implement this bill. But what I've seen at SAMHSA now is, in fact, the implementation. It's underway. The bill directed some changes among SAMHSA leadership, changing the nomenclature of the agency head, for instance, from Administrator to an Assistant Secretary for Mental Health and Substance Use, changing the name of the Deputy Administrator to Deputy Assistant Secretary for Mental Health and Substance Use.

And I think that that actually kind of enables the Department or the agency to have a little more influence. You know, perhaps there's the perception that that title carries a little more influence. So that helps with communicating the various points we really need to make regarding mental health and substance use and the services that we provide. So that's been implemented.

We've got a reorganization that's underway. We're about to complete that. Some key components of the reorganization include the creation of an Office of the Chief Medical Officer. When 21st Century Cures was being written back in

2016, in the early part of 2016, there was no psychiatrist at SAMHSA, for instance. While the bill was being moved, SAMHSA did bring Dr. Anita Everett onboard, but now that requirement is in statute. So SAMHSA has to have a psychiatrist onboard as Chief Medical Officer.

It's interesting now we've got four psychiatrists here. So, so it's working. You've all met, I think, by now Dr. Steve Daviss and heard from him, and so we want to continue to ensure that professional clinical expertise is available not just in CSAT, but also over in CMHS, and we're actively seeking a clinician for CSAP, who's got some background in prevention. So that's a big accomplishment, quite frankly, and we think that this clinical expertise and the availability of a clinician on staff will just help to inform other staff in our centers as they make decisions, recommendations, develop programs, manage programs. So we think that's very helpful.

The other -- or another big development was the creation of the National Mental Health and Substance Use Policy Laboratory. We just call it the "Policy Lab." That's up and running here now. We still have to -- there's more staffing we need to take care of to get it fully up and running. But the idea there is that the Policy Lab will be used to promote evidence-based practices and service delivery models by evaluating different models that we pick up on, that are recommended to us or we become aware of by evaluating those models that we think could benefit from further development and through expanding, replicating, or scaling evidence-based practices across a wider area.

So the idea is this is an innovation hub, if you will, or a Center of Excellence, or whatever you want to call it. We like the term policy laboratory because we can -- you know, we can just -- there's a lot you can do there in terms of just innovating and learning what's working and then kind of helping to propage those evidence-based practices out into the -- into communities around the country. Maybe down the road, there will be some funding, and we could actually do some demonstration projects and pilots. And so we have -- we're looking forward to that.

There is -- well, as far as -- as far as CSAT is concerned and the work you do, obviously, they're going to be looking closely at evidence-based practices and service models for substance disorders with a focus on opioid use disorder. So I know that's one of our top agency priorities.

They're also going to have a good working relationship with the National Institutes of Health and in particular the three centers we work with a lot, NIDA, NIAAA, and of course, NIMH. You know, they're also going to work closely with the FDA and the Agency for Healthcare Research and Quality. So there's going to be a lot of interagency collaboration. That's the plan, and that's what's actually coming about right now.

The other big piece that was required by the 21st Century Cures Act was that SAMHSA prepare and write a strategic plan for the agency. It would address the range of -- full range of mental health and substance use issues. And so the Policy Lab Director is actually -- has actually taken the lead in writing that plan, and we owe that to -- as I recall, I think we owe it to the Hill in the next few months. And that's going to be -- quite frankly, that's going to be a little different than the strategic plans I've seen us submit in the past, which are these, you know, big, half-inch thick documents that I don't know if anybody ever reads them or not.

This is going to be a true strategic planning document with, you know, agency mission and vision, and we're going to have overarching goals that we want to achieve. And we're going to list the top priorities and goals for those priorities and measurable objectives. And then there's going to be some metrics that'll be a part of all that. So it'll point the way that we want to go. It will have the objectives we need to achieve along the way, and we'll be able to use this plan and the metrics that are a part of it to determine whether or not we've actually achieved those objectives. So pretty excited about that.

I don't need to necessarily get into this, although I'm sure you're interested. We've got the Interdepartmental Serious Mental Illness Coordinating Committee that was mandated by 21st Century Cures, and that's underway. SAMHSA is the lead on that. The need for that was detected quite a while ago because there are multiple Cabinet departments, as well as agencies within HHS and within some of the other departments, that are involved in behavioral health in one way or another.

You know, Housing and Urban Development does, you know, Section 8 housing and various housing aspects. Department of Justice is involved in it through the Bureau of Prisons and training for law enforcement, and they've got their own programs that go out that are prevention related, and you know, they fund -- they fund some services. Education has a role because they're -- you know, they're focused on the schools. The School Safety Commission is actually chaired by the Secretary of Education. DOD obviously has programs and Department of Veterans Affairs is involved.

So the question that Congress had was how is the coordination and collaboration going? Well, if you're familiar with Government, it wasn't necessarily going all that well, okay? So much in Government and any bureaucratic organization is you have a lot of compartmentalization, silos, whatever you want to call it, but you know, and at the -- just at a really granular level, I mean, who wants to talk to the person in the next cubical over, right? Especially if you don't like them or don't have anything in common. You just don't communicate.

So the idea is let's have a venue where everybody can come together, and we can improve coordination and collaboration and communication. And so the

ISMICC is up and running, and we're pleased about that.

But back to the need for some of this. We have our -- we have our national survey of drug use in American households, the NSDUH, the NSDUH data that comes out. We're going to have our 2017 data, and that should be released in September. And so you'll get more information on that. But if you look at even the 2016 data, you see the extent of the problem.

One in three Americans, 33 percent, struggle -- among those with a substance use disorder, one in three struggled with illicit drugs. Three in four struggled with alcohol use. One in nine struggled with illicit drugs and alcohol. So that's our challenge. Over 2 million Americans have an opioid use disorder. Only 20 percent of those with an OUD actually received specialty addiction treatment, and of them, only 37 percent of those received medication-assisted therapy.

Just almost 64,000 drug overdose deaths, 2016, you know, of which over 42,000, or 66 percent, were from opioids. You've heard these statistics before. I don't need to belabor them, but there's a great need out there.

HHS has a five-point opioid strategy. I'll just hit the high points on it. The first -- the first point is strengthening public health surveillance. We just got to -- we just got to surveil more and increase our awareness of what's going on out there on the ground and be able to react more quickly.

Advancing the practice of pain management. It doesn't all have to be opioids. There are alternatives to that.

Third point is improving access to treatment and recovery services. That's a big role for SAMHSA, obviously.

Fourth, targeting availability and distribution of overdose-reversing drugs. We're very involved in naloxone and doing what we can to just incentivize that getting out across the country and being used. And it is, as you know.

And supporting cutting-edge research. A lot of that, again, over at NIH, and so that's very important.

The plan for addressing the opioid crisis obviously involves the commitment of resources, and FY '18, in fact, saw increased resources in the substance abuse treatment area, \$3.18 billion, actually, for FY '18 is being put out versus -- well, which is actually an increase of over \$1 billion from FY '17. So there are more money flowing out.

You probably heard about the new \$1 billion opioid grant program. The previous amount was -- we call that the State -- I'm sure you're familiar with all of this, the State Targeted Response grant funding, half a billion, just almost half a billion in

the first year. Another almost half a billion the second year, actually this year.

And now we've got this new -- this new funding for State Opioid Response grants that will go out to the States of just under \$1 billion. Fifty million of that has actually been set aside for tribes. Addiction is a real problem in tribal areas across the country, and so we've got a tribal opioid response grant that is also underway. Those funding announcements have gone out. Applications are coming in. And the awards -- the award of the grants will have to be made by September 30th. So in the next few -- well, next few weeks, couple of months we'll see all of that out there.

There's been additional funding in other programs. I don't need to necessarily go into all of it because I know we're -- I see we're butting up against time, and I'd like to hear from you all a little bit, too. But we are very concerned about this.

Workforce development is another significant concern. Dr. McCance-Katz is very aware of this. I mean, we've got -- we've got providers delivering services and treatment out there now, but she's very concerned about increasing the role of primary care practitioners, getting them more involved. And of course, all of that kind of connects to this DATA waiver and getting more people with a DATA - - more practitioners with a DATA waiver out there who are able to provide treatment, especially medication-assisted treatment because the evidence shows that that's -- that there's evidence that shows that it works, that it's successful.

So there are efforts underway to encourage a national certification program for peer workforce, establish training on recognition and treatment of substance misuse, abuse, use disorders in healthcare professional training programs. Again, that should also help prepare primary care practitioners. We need to encourage entry into the field through incentives. We're working with HRSA on this. They're really the healthcare workforce entity, and they have the National Health Service Corps. They have a variety of other programs to incentivize practitioners to serve especially to get educated and then serve especially in these health practitioner -- healthcare practitioner shortage areas.

We can call them HPSAs. They've got acronyms for everything in the Government. But there are programs underway, and we just need to continue those efforts.

Telehealth, health IT also a part of the solution, and another element I'll just as a side note, you know, HRSA does have the Federally Qualified Health Centers, and they are playing an increasing role in the provision of behavioral health services. So a lot of important work going on.

On the justice side, we're also involved in that with our targeted responses, mainly our criminal justice programs. We do have some of those here at

SAMHSA. We have jail diversion program grants that are helping. We help with drug treatment courts, adult drug courts. For instance, drug court grantees may use up to 20 percent of their award for medication-assisted treatment.

So there's a lot of things we're doing. Offender re-entry, we're working to expand access to substance use treatment services for individuals who are re-integrating into communities after release from incarceration. So there's a lot of work being done.

I did want to flag some of the products we're putting out. You've probably seen it. This is my favorite. TIP 63, right? Medications for Opioid Use Disorder. There's a lot of informational products that we push out, and if you allow me to digress for just a second, what we are, really, is a resource provider as an agency. We provide the financial resources to fund and finance the services in States and communities through public entities or also through, you know, private nonprofits, see a lot of that. But we also provide what I call knowledge-based resources, such as this TIP and such as some other publications that we're putting out. So a lot going on.

As you all know, addiction has been a problem for a long time, and substance use disorder has been an issue for a long time. It isn't just drugs. It's also alcohol, but we did see this ramp-up in prescription drug abuse a number of years ago. I saw this when I was in Virginia back in 2000. We started getting the first reports in of the abuse of OxyContin out in southwest Virginia, and you're all familiar with that problem.

What we were seeing there was kind of the onset of this abuse of prescription drugs, and over the years since then, we've seen the response to that. And we've seen -- we've seen funding for Prescription Drug Monitoring Programs go out. We've seen a lot of work done in that area. You know, in recent -- over the last couple of years, there's been emphasis by insurance companies to cut off reimbursement for opioid drugs at 7 days instead of, you know, reimbursement for up to 30-day supply, which you probably don't need unless you got a real chronic pain issue. There's exceptions for those folks. But there's a lot of work that's been done.

I just say that to then be able to highlight that there is actually progress being made. Opioid prescribing has been declining since 2011. So we're seeing some success there. Receipt of medication-assisted treatment from treatment facilities is actually increasing, going up. There's an increasing number of patients receiving buprenorphine and prescriptions of Vivitrol from pharmacies. We're seeing that trend line head up.

And we're seeing dramatic increases in naloxone dispensing from U.S. pharmacies, and the bottom line there, as you all know, is that saves lives, okay? I still remember several years ago when Virginia was having this debate on

whether to allow naloxone dispensing. And one of the -- one of the operators of a treatment program in Richmond, who I knew quite well, brought this young woman with him to testify before the committee that was considering the bill.

And I chatted with her a minute, and she had OD'd. She'd almost died. First responders were able to get there and administer naloxone, and it saved her life. But I just thought now this nice, beautiful young woman would be dead if it weren't for this dispensing of naloxone. And so it's saving lives, and that's just so important. So there is progress being made.

The opioid epidemic continues to evolve. There is the -- there's an urgent need to prepare the workforce rapidly and deliver evidence-based prevention as well as treatment and recovery services. We've got evidence that progress is being made, but work continues to be done and needs to be done, and we're going to keep moving forward in that regard.

So there's a lot going on. I'm not going to get into the mental health side. I just came from the Center for Mental Health Services, and we talked some with them on some of the programs that have more of a direct mental health application. But obviously, there's co-occurring disorder, you know, and so there's a lot of overlap.

One final or one of the final points I'll make is SAMHSA is kind of reconfiguring the way in which we do technical assistance and training. It's evidence-based. It's local training. It's a nationwide scope that's kind of our philosophy here. What we're moving to is combined efforts at the State, regional, and local levels oriented to all health professionals, and we're going to have regional -- what would we call here, regional prevention, addiction, serious mental illness collaborating technology transfer centers. So this is going to be a series of grants that go out.

We're going to have these technology transfer centers in each of the 10 Federal regions around the country, and we hope that's going to be more responsive to the needs of communities around the country. And we hope that that will be very helpful.

So, again, there's a lot going on. We are going to continue the -- continue the work. We appreciate your role. I like to tell -- I like to tell everyone, if you're going to craft public policy, you need to involve the public. If you're a Federal agency, you need to have a connection to members of the public. And especially like for SAMHSA and CSAT, you need connections to people who are members of the public, but also involved in the behavioral health field, and so it's very important that you all are here. We appreciate what you do.

There's a great -- I know there's a great program today that you've been going through, and I'd just like to thank you again and throw it open to any questions

you might have. If I can't answer them -- I've only been here for 3 months. So there's a good chance I won't be able to answer them, but Dr. O could or some of our other experts here. Yes?

Agenda Item: Council Discussion

DR. JUDITH A. MARTIN: Thank you for the overview of what you're working on.

I had a couple questions. One is since you just met with CMS, do you think at any time for co-occurring disorders the funding streams could blend? So that the person doesn't have to have two treatment plans.

MR. ARNE OWENS: Yeah. Well, yeah, I met with CMHS, the Center for Mental Health Services here at SAMHSA. As far as the funding that's provided through Medicaid especially, through CMS, about all I can say at this point is we now have -- we have a good connection with CMS. We're working with them on their reimbursements and what they finance and what they don't finance.

We have now in the Office of the Assistant Secretary a senior staff person who does healthcare financing. So about all I can say right now is we're working, you know? We're working on the problem. And if you've got some recommendations, shoot them to me.

DR. JUDITH A. MARTIN: It's a headache to treat people with co-occurring disorder, and the two barriers that we see the most, that we run into like brick walls the most is the medical necessity for SMI and the privacy rules for substance use.

MR. ARNE OWENS: On that last point, the privacy rules, I think you're referring to 42 CFR Part 2. We've been discussing that a lot here at SAMHSA. We discussed it, you know, on Capitol Hill a couple of years ago. Back when 21st Century Cures was being crafted, there was the question as well, you know, should we be -- should Congress be more directive in just like eliminating it or making it just aligning it more with HIPAA. And the thought was at that point in time, as I recall the conversations, is that SAMHSA at the time had a rulemaking underway. So the thought was let's see how that goes, and let's just have SAMHSA share more information on 42 CFR.

And so then there was another rulemaking, as I understand it, a year ago or beginning of this year, I guess it wrapped up. We're continuing to look at 42 CFR Part 2. The Assistant Secretary is very concerned about it. We're discussing it. I can tell you that what we are doing and is very much focused on the information-sharing side, in addition to the two rules or the two regulatory actions we took in 2017 and '18. We held a listening session to just gather more information earlier this year in January. We've drafted a legislative proposal that we hope that may be helpful in all of this.

We -- we take input through a specific Web address, and that helps us really to see what's going on out there and be able to address that. We're doing presentations and meetings and forums. There was a webinar just a couple of weeks ago that the American Bar Association actually hosted, but it was supported by SAMHSA. And from what I understand, there were over 1,000 attorneys participating in that webinar, and it's now going up on the ABA's website. And the idea being to just get more information out there on 42 CFR, you know, what it covers, who it affects, and you know, and what it all actually means in terms of patient privacy. But also for a practitioner, what they can do and what they can't do.

So, I mean, it's a challenge, which we'll soon be introducing some frequently asked question guidance that's going to be posted on our website. That's coming soon. And we just released the Funding Opportunity Announcement accepting an application for a Center of Excellence for protected health information related to mental and substance use disorders.

DR. JUDITH A. MARTIN: Yeah, we saw that. That's exciting.

MR. ARNE OWENS: We love this nomenclature, you know? But it's a 5 -- you know, it's a grant, \$5 million over the next 5 years, and we hope to have this Center of Excellence, which can help share this information. Is it enough? Well, keep talking to us, you know?

DR. JUDITH A. MARTIN: We appreciate all of that. Is the new -- so is ATTC changing what it is then into a more behavioral ATTC? Is that what you're announcing today or shared with us earlier?

MR. ARNE OWENS: No, it's just -- it's rather than contracts, it's going to be more grant based, and hopefully, it's going to be out in the regions, and it's going to be a little more responsive to communities. More details to follow. I'm not the expert. You might have more on it, Dr. O. I don't know. But we hope to have something in place that's just going to be more helpful and more responsive to communities when they need it.

DR. CHIDEHA OHUOHA: No, I really don't have much more information than you just gave them. However, what we're trying to do is to really have this happening. We want to be able to get responses on how it's working for you and so that we can see exactly how we're going to be able to refine what's going on. But the whole idea is what just Arne said, okay? We want to make it regionally so that we can see exactly what all is more helpful to the public than what we do have right now.

DR. JUDITH A. MARTIN: We use it -- I'm from San Francisco. We use our Southwest ATTC a lot, and especially for psychosocial training, CBT, and motivational interviewing trainings. Yeah. So it's a useful -- it's useful thing to

have.

DR. CHIDEHA OHUOHA: What's your experience?

DR. JUDITH A. MARTIN: Excellent. Excellent people. They come from UCLA, and so their, you know, top people come and train our providers, which is really great. But we're relatively close to the node. You know, we're in San Francisco. So it's like 6 hours away and available to us. Maybe somebody a little further away wouldn't have such access, I don't know.

DR. CHIDEHA OHUOHA: Well, at least that's a good start.

DR. JUDITH A. MARTIN: Yes. Definitely.

DR. CHIDEHA OHUOHA: That's exactly some of what we are actually envisioning that's going to happen so we are ready to get those feedback so that we now can figure out exactly how we're going to enhance the programs.

DR. JUDITH A. MARTIN: One of the things in the last ATTC grant that we noticed was the inclusion of performance improvement technology, kind of like NIATx used to do or still does. And I don't -- we haven't heard back about how that went or how -- what they developed, or was it successful or not. We haven't heard a report back about that.

DR. CHIDEHA OHUOHA: We're still working on that. Still meeting on how we're going to be able to collect the data that we need, right? So more to come very soon. We met last week, so --

DR. JUDITH A. MARTIN: Yeah, good. I look forward to it. Thank you.

MR. ARNE OWENS: Yes?

MR. ARTHUR SCHUT: I'm sort of curious about whether NIATx has been involved in that or not, and since they did that, they had a Robert Wood Johnson Foundation grant to begin with to do process improvement, and then SAMHSA put some money into it and did a joint venture with Robert Wood Johnson Foundation. So it's well established.

And I don't know how many thousands of I guess, 3,000 or 4,000, 5,000 organizations adopted that and have that. So, and it's out of the University of Wisconsin and the College of Engineering and their Center for Health Enhancement Services. And it might be -- I'm actually on the board of directors of NIATx foundation, which is a not-for-profit.

So I think there are assets there that would be available that might be very helpful to look at how they've done that and how that could be incorporated. And

my experience also with the ATTCs has been very positive, including the one in -
- I'm in Colorado, and I don't have anything to do with the one in California, per
se. But you can go to any ATTC and get -- they have different aspects of
expertise. It'd be nice to preserve that in whatever remake or redesign that
occurs.

And I have one other question. You mentioned having a clinician in each center.
Are you referring specifically to psychiatrists? And I think there's -- there are lots
of different professions within healthcare that have clinicians that have expertise.
I mean, a lot of ASAM-certified physicians are family practice docs, and so there
are a variety of clinicians. I don't know if you were referring specifically to just
psychiatrists or you're going to have medical directors or psychologists or social
workers or licensed counselor. I don't know what's meant by that, whether
there's diversity to that or --

MR. ARNE OWENS: Well, I think, you know, I guess the commonality is we're
looking for an M.D., but it could be someone with a specialty in addiction
medicine. It could be someone -- it could be an addiction psychiatrist. You
know, I think that's kind of what we'd be looking for. You may have some views
on this, Dr. O, for CSAT. You know, on the mental health side, CMHS, they're
clearly looking for a, you know, for an M.D. with a psychiatry specialty, and that's
who we -- and that's, I think, who we're looking for really to be the Chief Medical
Officer.

But you know, I don't know if that kind of clarifies it any, but that's kind of the
intent.

MR. ARTHUR SCHUT: I'm happy with Dr. O. But the --

[Laughter.]

MR. ARTHUR SCHUT: Yeah, I wasn't sure what you meant by "clinicians."
Because lots of people --

MR. ARNE OWENS: Yeah, that's what we're looking for. We're really looking
for M.D.s within the Office of the Chief Medical Officer who can provide a level of
expert knowledge that's very helpful to staff.

Right now, we have, you know, Dr. Steve Daviss. He's connected to CSAT, and
his office is down in the CSAT area where he's accessible and he can kind of
blend in and connect with the culture. He is assigned to the Office of the Chief
Medical Officer, but he's down there where he can directly support CSAT staff,
and we have a comparable M.D. over in the Center for Mental Health Services,
and that's operated the same way. So --

MR. ANDRE JOHNSON: I wanted to just add, first, let me just say thank you for

your presentation. My name is Andre Johnson with the Detroit Recovery Project. And we are a great recipient in terms of Great Lakes Addiction Transfer Technology Center, and I think they may have been dismantled, though -- I don't know what happened -- or defunded a couple years ago. But we benefitted greatly of that organization out of University of Illinois, Chicago.

I was really glad to hear when you discussed the workforce as relates to hiring this useful person. I did want to share with you our nonprofit is a recovery community organization, and we've worked really, really hard over the years as the need will continue to change. And when I say that, I mean when we first started, our emphasis was on supporting the recovery community and building a recovery community. And then years later in our area, there was a movement to integrate mental health with substance use disorder. So quite naturally, we worked on that. I don't know how successful we've been without blended funding, but we are working with our local mental health organizations to refer people who receive psychiatric services. Because we do get a lot of severely persistent mentally ill clients who may need education, yada, yada, yah.

And so we do have, many years later, we need to integrate with physical health. So everytime you do one integration, in the end, you've got another big idea that there's no funding to support this to really occur, and so you got to be creative. You know, I'm in a very large urban environment. We were birthed out of the public health department. So I'm very aware of various health challenges we have in the Detroit area, ranging from some of the highest rates of young people or kids with asthma. HIV rates have been fairly the same for the last 20-plus years.

I sit on a board for Ryan White funding and for our State. You know, hepatitis very prevalent, a lot of people of color are dying from hepatitis, former IV drug users. Data are not really being collected in terms -- in the community around the specifics as relates to addiction. I mean, I sat down with our coroner's office, and they said we average an overdose every day. But not really, you know, they may say a cocaine overdose or it may say heroin overdose.

But I know I'm going all over the place. One thing I wanted to share is that we have a HRSA grant, a paraprofessional HRSA grant, they called it a BHWET, and what we proposed was to increase our workforce by training recovery coaches to help provide recovery support services for this growing opioid population in our community. And I think -- I just wanted to make sure that, you know, we really hone in on the importance of building the recovery community organizations.

You know, our CSP started in 2000, late 1999. There was a large, you know, a decent pot of money for our CSP, and it seems like every other year, the money goes and comes, goes and comes, and it's not a priority. And so I think with 500 million new dollars, I guess I feel like I would assume that some money would be

more designated to the recovery community support organizations because when people put substance use -- or kick the opioids, they're going to need recovery. They're going to need recovery support.

And so I just think sometimes we miss out on the low-hanging fruit that's at our table. And so I really, really, really hope moving forward that we really consider making sure that we don't lose the momentum of keeping individuals from the recovery community involved and at the table. Even, you know, the clinicians, you know, that's important to have the help.

Our center, we have worked with our local universities to have resident students come out and train our coaches on just basic 123s of physical health symptoms or signs, not that we're trying to provide physical health, but we are trying to work hard to build strong partnerships because a number of our clients have diabetes. A number of our clients have dental needs. A number of our clients have optical needs. And we've actually done research in our community, and we found that some near 80 percent of people want physical health support. They want a personal physician. They want a personal dentist, but they don't know how to take it.

And then you've got the transportation, which is a huge barrier. And I've seen that in the Detroit area, urban area, rural areas. Transportation is really, really important. People can't get from A to B. You can't make an appointment. You can't get to the support place you may need to get to maintain their recovery. That's vital. And then you can't get to a job. You know, I mean, it's really sad when job opportunities arise and people say, hey, I don't have no bus or way of getting there.

So I think, you know, transportation is a huge barrier. Housing, again, I was glad to hear you talk about the housing. We can't -- we don't -- we have inadequate recovery housing in our community, and I'm talking about, you know, Jason talked earlier about the recovery housing accreditation, which is really important. You know, we increase long-term recovery by providing a safe, recovery-friendly environment for people who need it.

And so I know I've said a lot, but I think it's important, and I'm very passionate about this, just making sure that we keep recovery on the radar.

All right. Thank you.

MR. ARNE OWENS: No, recovery is very important. It's extremely important, recovery support services especially.

DR. CHIDEHA OHUOHA: We have to take a break. Mr. Owens can hang around for a few more minutes so that if you have any more questions, please feel free to ask him. And come back by 2:00 p.m. for our next presentation.

MR. ARNE OWENS: I'll stick around a minute if anybody wants to chat.

[Recessed at 1:55 p.m.]

[Reconvened at 2:01 p.m.]

Agenda Item: TOPIC: State Targeted Response to the Opioid Crisis Grants' Impact on the Opioid Crisis

DR. CHIDEHA OHUOHA: Welcome back. Our next topic is on State targeted response to the opioid crisis grants. But before we get started, as you are aware, SAMHSA received \$1 billion under the 21st Century Cures Act to address the nation's opioid crisis. Since that time, the STR grantees have made significant strides in increasing access to medication-assisted treatment, expanding access to naloxone to first responders and the public.

I've asked Ms. Donna Hillman, Assistant Lead Public Health Adviser, to update you on this tremendous work that grantees have been doing with this funding. Donna?

MS. DONNA HILLMAN: Thank you, Doctor. And it's a real pleasure for me to be here with all of you today and an honor to be able to talk about the State targeted response to the opioid crisis, which has been up and running now for we're in our second year. So we have a lot of -- a lot of interesting information.

I'm going to break with tradition a little bit because I want all of you in the room to meet the Government project officers that are working with me on this from CSAT, and if you guys wouldn't mind standing up when I call your names? Jamal Bankhead. Spencer Clark. Kim Thierry-English. And Monica Flores. We are blessed to have her as an intern, you know, and she helps keep all of our little statistics and all of that stuff in place.

So it's a real pleasure to have them working with me. It's a big job because they're not only covering the opioid STR, but they're also monitoring the current MAT-PDOA grants that are part of this, part of the mix right now.

Okay. This is kind of the information that Doctor -- that the doctor just talked about, about where the funding came from. The initial budget was for \$1 billion, \$500 million for the first year and \$500 million for the second year. When you roll out a grant that is that big, it takes a little bit to get things moving on the ground, you know? But the States really rose to the occasion.

There were 57 grantees, the 50 States, the District of Columbia, the Republic of Palau, American Samoa, the Commonwealth of Northern Mariana Islands. Who did I forget? Puerto Rico and U.S. Virgin Islands. How could I forget them? So

there were 57 grantees all together. There are 57 grantees.

This is a service grant, and the purpose of this funding was to supplement activities that were already in existence in the States. So we were not looking for people to start a lot of new things, you know, although there's been some branching out. We were looking for them supplement the activities that were already there that are being funded with other funds.

Technologically challenged. These are -- I just got a list here of the required and allowable activities. I'm not going to spend a whole lot of time on those because you guys have all got those on a PowerPoint presentation, and I think most of you know what they are. One thing about the formula that was used to --

[Audio interruption.]

MS. DONNA HILLMAN: -- components to that. And one of them was the drug poisoning deaths, which was provided by the CDC surveillance data. And what some of the States did with that was they took a look at that and they said, well, drug poisoning deaths is important to us, but how many of these are attributable to opioids or heroin? And we have heard from many of the States that what they have done is they have gone to their medical boards, and they have gone to the county coroners and the medical examiners and asked them to be -- to change their system to be a little more precise about what exactly is involved in those overdose deaths, what drugs are present.

So I think we're going to be getting a lot more precise data on how many of those are actually attributable to opioids, heroin, fentanyl, fentanyl analogs, and those kind of things. I think we can all certainly understand why that wasn't necessarily prevalent before. I don't think anyone who has ever had a family member or someone close to them die of an overdose wanted to see the death certificate and wanted to see on the death certificate that they had died from a drug overdose. So, but I think this will be very helpful information for all of us.

So some of the other required activities, implement or expand access to culturally -- clinically appropriate evidence-based practices for OUD. That has -- the States have really picked up on that, and they have a lot of good practices going.

And to provide assistance to patients who are uninsured or underinsured. Many of the States have applied for CMS 1115 waivers, which is an opportunity for the State to have some additional flexibility to design and improve their programs to address and better serve their Medicaid populations. So many of them have done that. I know California has applied for an 1115 and gotten an 1115 waiver, and I think California has tribal populations have applied for an 1115 waiver also.

So provide treatment, transition, and coverage to patients re-entering

communities from criminal justice settings. We all know that when people leave the criminal justice systems persist, particularly if they've only been like in a county jail or a local incarceration facility. They've only been there for a short time. Stepping out of that environment and not having a support system and some help with their opioid use disorder is a time for high risk, very high risk for them. If they go out and use again, you know, their risk of an overdose is greatly increased.

Enhance and support provision of peer and recovery support services for long-term recovery. Andre was talking a little bit about that previously. So, and we're going to get into some of this a little bit more in a minute.

The allowable activities, we've done a lot of training of physicians, physician assistants, and nurse practitioners and expanded the number of people who are certified to provide medication-assisted treatment. Support innovative telehealth and social media programs. We talked a little bit about that, too.

Purchase and distribute naloxone and train multiple audiences to administer. A lot of this has been done by our colleagues in the Center for Substance Abuse Prevention, and they have done an enormous amount of training, and they have done an enormous amount of purchasing and distributing naloxone. They are not alone in the States in purchasing and distributing naloxone. In many of the States, the police departments, law enforcement, the fire departments, and everything, sometimes even the local and county boards and stuff provide funds that go towards purchasing naloxone so that everybody who needs it is not only - not only has it available, but they also are trained in how to use it.

I, myself, have a Narcan kit. Not because I'm out there a lot of times and everything, but you never know. Okay?

Enhance the PDMP to increase sharing and use of data, and we'll talk about that in a little bit, too. And establish statewide community-based recovery support systems and networks.

Somebody is probably going to have to stop me from talking about these because this is where my heart lies, and this is where the action is. And it is action right now. Like I said, we were off to a little bit of a slow start the beginning of the first year. Things are moving.

Not -- well, because the States are moving. They are expanding their systems. They are expanding people trained in different areas and all of the services that they provide. So one of the things that many of them have done is many of the States have established a governor's level task force designed to bring individuals from all levels together and coordinate the efforts of multiple agencies and entities for a more comprehensive approach to the crisis.

They have a task force that includes all of their agencies in their State, and they meet and decide who does what, who has the funds to cover what, and it provides a system whereby more can be done because it's a coordinated effort. Multiple States have established a prerelease program for incarcerated individuals where the State office and local providers work with their Department of Corrections to begin -- sometimes to begin even the initiation of medication-assisted treatment while the individuals are still incarcerated and to provide supportive psychosocial services and community connections based upon the release date to ensure that those people who are leaving incarceration have the supports they need. And it provides a warm handoff to providers and support services in the community.

And many times, the people who pick those people up and take them to the community services and introduce them to the community connections are the peer support folks and the recovery support folks.

Developing hub-and-spoke systems. I know you've all heard of hub-and-spoke systems. Vermont is just one of the States that's developed a hub-and-spoke system, and it connects medication-assisted treatment programs in rural areas with MAT specialists in a regional hub site for support and information. Vermont's Care Alliance for Opioid Addiction, introduced in 2014, greatly increased access to treatment and to new clinical and supportive services not typically included in MAT previously. But the expansion of the psychosocial and the biopsychosocial services that are available has been greatly increased.

Linking nonfatal overdose patients to community services. That, again, is where many of our peer support specialists and our recovery coaches step into the emergency rooms. We like to call it "reaching in" because they do. They reach in, they take the hands of the people who are there who have had a nonfatal overdose, and they walk them through the system. They help them navigate when they get out. They help them navigate and connect with those community services and the recovery support services that are so vital to them when they leave there.

Increasing access to naloxone for law enforcement and other first responders. We talked about that a little bit. Infrastructure expansion and surveillance. Expanding the use of the PDMP. I think all of you know about the Prescription Drug Monitoring Programs. There's one in just about every State, and the database that's established to store the prescription history of patients and make that history available to physicians and pharmacists to ensure that prescription medications are compatible, prescriptions are provided upon a doctor's order, patients are not doctor shopping.

And I know that's a derogatory term, but for those of us that have worked in the clinical field, it's a very real reality. There are a lot of -- I know I used to have a lot of clients who had multiple prescriptions from multiple doctors. So it's -- the

PDMP helps to control that.

So they were originally developed basically to serve a single State, and now we're finding that the PDMPs are going cross borders so that people who go from State to State, those two PDMPs from State to State are connected so that they can check both of them.

Some examples of -- State examples of the implementations that we've been talking about -- oh, one thing I forgot about was developing practice guidelines for strength-based assessment. And Connecticut has -- is using what they call the COWs, which is the Clinical Opiate Withdrawal Scale, which standardizes the assessment process when someone in clinical withdrawal comes in. It gives them a very accurate picture of what's going on and where they're at with that.

So some of the other examples. Michigan is just one example of placing peers in the ER to connect with nonfatal overdose patients and provide a connection to community services. Michigan has a fantastic peer support and recovery support system.

Kentucky has a comprehensive ER model that includes a rapid response team, which is available 24/7, 24 hours a day, 7 days a week. And they have bridge clinics. And the bridge clinics are clinics that are interim places where people can go from the hospital to the bridge clinic and where they can be provided with services until someone can come and connect them with the community-based services. So it's kind of a safety feature in between.

Colorado is definitely increasing the number of peer recovery coaches. So there's one in each of their managed care organizations across the State, which makes those services available to anyone in the sub-State planning area. So just having that outreach and particularly in a largely rural State like Colorado, just some place where people know they can go and they can connect with people.

North Carolina is doing the same thing as Colorado through their LMEs. Pennsylvania expanded integration of their PDMP data at the point of care before physicians write a prescription for opioid pain medication for use in clinical decision-making. That is one of the purposes of the PDMP. But many times, I think when the PDMPs first came out, doctors found that it was kind of time consuming to go back and check all of those records, you know? But I think they've improved the system, and now it's just check the system. If they have a prescription, then we need to go somewhere else with this.

California has an extensive hub-and-spoke system. I was just talking to Dr. Martin about that. And they have an MAT expansion project underway, which supports development of a tribal-specific hub-and-spoke system. So it's culturally appropriate for the tribes. It has been developed by the tribes, along

with the great folks in California who are working on this.

DR. CHIDEHA OHUOHA: I think you are a couple of slides behind.

MS. DONNA HILLMAN: Oh, I probably am. Sorry. Okay. That's where we're at. Sorry about that.

Setting prescription limits for the dispensing of opioid prescriptions to limit firsthand exposure to opioids. Many of the State legislatures have taken that upon themselves. They have set limits as to how many days' supply can be dispensed for a first prescription. A lot of them have set a 7-day supply for acute pain.

Now I know there has been some feedback about -- from many people about the fact that this is beneficial in limiting access to pain medication, but States are kind of proceeding with a little bit of caution so as not to limit access to people who really need pain medication. So I think they're doing a good job of that, too.

The CDC has developed prescribing guidelines, which have been in place in CDC-funded programs and which provide a road map to prescribers, which also reduces the risk of developing -- of the development of an opioid use disorder. So many of the States have implemented the CDC prescribing guidelines.

Expanding the prevention efforts in schools and communities have brought the opioid crisis to the forefront through extensive drug awareness and education efforts by prevention specialists. Surveys have indicated that many persons living in the community and students attending the schools are not aware of the addictive potential of opioids, and what the prevention programs have done, they've done a wonderful job of bringing the message home in a coordinated and comprehensive way.

Expanding the number of DATA waived, DATA 2000 waived physicians in opioid treatment programs. The States are definitely looking at that and are doing that. We have so many States that are increasing the number of DATA waived physicians that they have, which allows them to provide medication-assisted treatment in an office-based setting. So there are many, many people who are becoming certified to do that, and I think all of you are aware of the Providers' Clinical Support System program that SAMHSA has that has training available to train those folks to do that.

One of the expansions going on in several States is the use of telephonic and social media-based recovery check-ups and support. Many of the peer support groups and recovery support groups have a connection, and they connect with people on a regular basis. Some States are also using these methods to conduct group sessions and maintain services in rural and frontier areas where services are less available.

I know that North Dakota -- I used to be the project, block grant project officer for North Dakota. And when I did my last site visit there, they had a telephonic and telehealth set up to do group sessions that had been in place for about 2 years at that time, you know? So, and it was really working well. The people in the rural areas, you know, they didn't have a whole lot of services out there in the rural and frontier areas. So it helped them have a connection, and I was amazed.

I asked them how many of the people actually call in or, you know, access the Web, and they said just about all of the group members were there every time they were on. So it was really beneficial for them.

Expanding recovery support services and increasing training for recovery support specialists and recovery coaches. That continues at -- I think right now it's at a phenomenal rate because everybody is expanding their peer services and recovery support services in the ED and in the community.

Many of the emergency departments now provide induction to MAT to overdose survivors who wish to seek treatment and recovery services. The peers like in Georgia and Pennsylvania provide a warm handoff to community providers for the patients and assist them in navigating the system to seek other services. Peers also maintain connections with their patients via regular wellness checks and availability for support.

North Carolina right now is working on expanding their peer services to include workforce development, employment systems, and training to their opioid use disorder clients to assist them in finding employment.

Utilizing mobile outreach techniques. This is something Rhode Island is just one State, but it has had a mobile outreach program for quite a while, and they do -- they have mobile vans that go around to areas where there are a lot of people who are at high risk for opioid use disorders, and they also have folks who walk the streets and form relationships with people who are at high risk for opioid use disorders. And not only that, but they have some measures that they implement like they have syringes and stuff in their vans, you know, to reduce exposure to communicable diseases like HIV, hep C, and et cetera.

Am I behind again? Yeah.

Working with colleges and universities to link communities to -- community providers to clinical specialists. I think we've all heard of Project ECHO, which was developed at the University of New Mexico School of Medicine. And several of the States are using Project ECHO to connect people to a virtual learning community, where they can -- people who are available to treat people with opioid use disorders who have clinical -- they have access to clinical specialists to make sure that they have -- and it's also a place for consultation on complex

cases because sometimes people who are out in the field, they get a very complex case that has a lot of, say, primary health conditions and other issues that they're dealing with, and the Project ECHO works for them.

And I think – [Pause.]

So New Mexico also has what they call a TeleECHO clinic, which has become very useful for the rapid dissemination of information relevant to clinical practice providers for MAT. And California has a learning collaborative partnership with UCLA. That's basically the update on where we are right now with opioid STR, and I'm more than happy to, if possible, answer any questions that you might have.

Agenda Item: Council Discussion

DR. JUDITH A. MARTIN: I have a question. I heard through our -- through our regional SAMHSA officer that one of the programs in Arizona is using STR to stay open 24 hours for an OTP. Do you know anything about that?

MS. DONNA HILLMAN: They're doing what?

DR. JUDITH A. MARTIN: They're keeping an OTP open 24 hours.

MS. DONNA HILLMAN: Yes. Arizona has more than one --

DR. JUDITH A. MARTIN: How does that work? I can't imagine that.

MS. DONNA HILLMAN: They have -- what do they have now, Kim, two or three?

MS. KIM THIERRY-ENGLISH: They have two.

MS. DONNA HILLMAN: Two OTPs that are open 24 hours a day.

DR. JUDITH A. MARTIN: Full service? Not just for dosing, but they do intakes at night, too? Not just --

MS. KIM THIERRY-ENGLISH: -- 24/7. And they've also incorporated peers. They have also incorporated peer support within their judicial system. So it's almost like a peer diversion or an OUD diversion-type program, where they work with the county jails, and it's very comprehensive and impressive. And it is a pilot that they didn't think would take off as well as it has. But I'm sure they'll continue to build on, but what they developed is very impressive.

MS. SHARON LEGORE: What was the group? Was that Maricopa County?

MS. KIM THIERRY-ENGLISH: Maricopa County and Tucson. Phoenix.

DR. JUDITH A. MARTIN: So this was a way to extend their capacity?

MS. KIM THIERRY-ENGLISH: Correct.

DR. JUDITH A. MARTIN: Interesting. So I really appreciate in our -- we have one hub that took part of the grant in San Francisco, even though we're treatment rich. And they're providing services there was a gap, you know, people who still don't have their insurance and didn't feel, you know, like entitled to come in. But they could have, but they didn't feel entitled to come in.

Plus, I guess now they're going to work with the city jails to provide naltrexone. We already have methadone maintained throughout the jail stay and buprenorphine starts before leaving, but they're adding injectable naltrexone to that. So being able to use the funds to actually provide medication has been really useful.

And then the other thing I wanted to say is this is, as you point out, many organizations are working the opiate crisis. So, in California, this is sort of convergent with something the California Healthcare Foundation was already working on. And so through them, we have like snapshots for each county that says, you know, how many overdoses, and are we middle or low or high?

For example, my county, it said if all the buprenorphine X number of docs had their total census, we would be fine. Whereas other counties, it says you need more docs, right? So I thought that was really useful as a way of sort of benchmarking what we need to do. And of course, in California, the -- well, I don't know if I should say "of course," but chiming in with what Lawrence was saying, that the rural counties are the ones that have the least treatment and the highest overdose rate.

MS. DONNA HILLMAN: Yeah, and I think that's -- I think that's a situation in a lot of the States, and that's -- I think that's where the telehealth and the outreach via social media and stuff can always make a difference. But we -- you know, more physicians, more trained.

DR. JUDITH A. MARTIN: Yeah. Our professional organization, CSAM, has taken, you know, funds through STR. They fund 75 primary care clinicians to come in and meet mentors at our conferences. And so it's like PCSS, only more in person and adding kind of inclusion and a network of substance use providers. I think it's sort of, as I've said, PCSS on steroids.

MS. DONNA HILLMAN: Right, right.

DR. JUDITH A. MARTIN: It just really expands the --

MS. DONNA HILLMAN: Thank you. And I would love to -- and I've been

thinking about this as part of what our Government project officers do when they contact their States is to get a report from the States because a lot of them have held statewide conferences on the opioid crisis and get report from that and with some detailed information about what it accomplished and where their services are and everything. I think that would be very useful.

MS. KRISTEN HARPER: Hi, Donna.

MS. DONNA HILLMAN: Yes?

MS. KRISTEN HARPER: This is Kristen Harper on the phone. How are you?

MS. DONNA HILLMAN: I'm fine. How are you, Kristen?

MS. KRISTEN HARPER: I'm doing good. I thank you so much for your report. I have a couple of questions for you.

The first one is in relation to the assessment piece. Not necessarily an individual assessment, but are you aware of any community-wide assessments that could be used as tools when either the State or other grantees are trying to assess kind of the priorities for what they need to put first, what their needs are, what their assets are, those types of things?

MS. DONNA HILLMAN: I personally am not aware of any. I don't know if any of anyone else that's here?

DR. CHIDEHA OHUOHA: Maybe we can research that and send you some reply to that question.

MS. KRISTEN HARPER: Okay, thank you so much. In my -- because I'm doing technical assistance with the work with this project, and it's been very difficult to determine what the States actually are trying to accomplish first. As you can imagine, it's so overwhelming. You know, since we are at an epidemic level, I think that sometimes it's so much to try to put together that it's just a very difficult process in prioritizing.

The other piece of it, too, is often we're finding in some of the State offices aren't familiar with how to incorporate recovery into a whole system. So, you know, you highlighted some really great examples like North Carolina, Kentucky. There are a handful of States that are out there. I think it would also be really helpful if there was a way for us to put together a guide or maybe just an info sheet for State offices to have access to a sample of how to incorporate the recovery voice in not only just sharing their lived experience, but then also, you know, helping to manage the ongoing recovery support within the State.

So we've seen some issue with supervision. We're seeing some issues with

now CMS has at the Federal level basically cut the legs out from underneath Medicaid funding for peer support coaches and specialists. So I think that some of that needs to be looked at when we're talking about STR, especially for the recovery world and kind of how do States navigate that kind of confusing recovery piece of this all.

MS. DONNA HILLMAN: Excellent. Thank you for the suggestion.

MR. JASON HOWELL: Donna, first of all, thank you for the report and thank you for bringing your staff. You all are a really big part of this solution, and you've talked about a lot of wonderful things that are happening across the United States. And so thanks, everybody, for working so hard.

You know, reaching across my network across the United States, there are some of us that are kind of concerned because for years, we've needed money. We've needed money to do things. Now we've got money, but it's my understanding that a lot of the States aren't able to get the money out. And so I don't know if there's a report anywhere that we could see to see the States that to what percent have they been able to spend STR or looking at the carryover. I understand that a lot of States are asking for carryovers. In some States, the perception is that they're hoarding money or trying to save it for a rainy day.

And I know that in Texas, part of the challenge was that you've got this big wave of money coming down, and the State did not have the contracting capacity to process that amount of money. And so, you know, hats off to those in Texas Health and Human Services for working really hard and trying to get that money out.

There seems to be this leaning towards fewer contracts, fewer bigger contracts and, you know, in some cases, that may carve recovery organizations out that don't have the infrastructure to be able to submit those really large proposals. And then my just kind of thinking, and so what are the barriers, other barriers that States could be experiencing not getting the money out? I think I brought this up last time. Some States interpret how they can use that STR money in a very narrow way, and so I don't know if we're able to kind of help them, you know, broaden their understanding of how they could use it.

I really like Kristen's example, but one of the examples I heard of, and I think you called it "reaching in," so reaching into the hospital. Have a recovery coach reaching in and then, you know, talking with someone with an opiate use disorder. And some interpretations is that individual is not choosing to be on MAT, that coach can no longer support them.

And so I understand why that there is the emphasis on MAT, but in some cases, it would be really important in that particular example to keep engaged with that individual because they may choose to be on MAT later on and keeping engaged

could reduce a future overdose. It seems like I'm rambling now. So I'm going to go ahead and stop and hear your perspective.

MS. DONNA HILLMAN: And thank you for all of that, and I think there are some very cogent points that need to be identified and that we can move forward on. One of the things about -- and in our last meeting with our Assistant Secretary, you know, I know that the understanding out there was if they aren't engaged in MAT, then we can't help them. That's -- Dr. McCance-Katz said they need to be offered MAT, but it is always the client's choice, okay?

We can't force them to take medication. Medication-assisted treatment is the gold standard for dealing with opioid use disorders, but there are those folks that are not willing, you know, to do that. That doesn't mean that they can't access recovery support services and everything. They still have an opioid use disorder, and that's the population that we're focused on.

So the recovery coaches and the peer support people can still assist them with everything they need to assist them with. It's just that the person will not be on medication-assisted treatment, you know? And Dr. McCance-Katz made that very clear to us that, you know, yes, medication-assisted treatment is the gold standard, but the client always has a choice.

The other thing is the level of care that some people are providing, some people are insisting that, you know, people go to residential treatment. That is not always the best level of care. That, again, is a clinical decision and should be left to the clinicians as to what level of care the client needs and where they go for services. But you brought up some -- the fact that the recovery support and peer support folks can't -- sometimes don't have the capacity to respond to those big contract requirements. And if there is some way to assist them in doing that, you know, that we could look at, that would be good.

As far as the carryover for the States, what we saw when this -- the opioid STR first started was there was funding, and it was funding for 2 years, okay? And what we heard from the States and what we heard from a lot of the treatment people was that it's difficult to hire additional staff, and it's difficult to get people to come to work in a State system if they know that it's only -- that it's grant supported, and there's only money for 2 years.

Now we know that, you know, we're not going to drop this opioid crisis, you know? There's going to be support for it. But it kind of slowed down the process of expanding the workforce because -- and that has picked up, you know, and they have really worked on that. But, and part of it was that they would go to hire people and -- I guess I can say this, seeing as how I used to be a State director - - sometimes it's the procurement system within the State. There's a level of things that they have to go through in order to hire a State personnel, you know?

And sometimes that's kind of a slow process. So I think there was some slowdown in the beginning, and now that the States have started to pick up and the services are starting to pick up and the programs are expanding and everything, the money is moving out a lot faster, okay? But there is a lot, you know, we are going through the carryover process now for the opioid STR. And all of those carryover requests are being considered, and then, of course, they have already received their notice of award for the second year funding, too.

So it's kind of like, okay, you know? But I really think that -- and you know, this is just my opinion, but I really think that as this progresses and as we work across agencies and across Federal Government, across State government, across county and city government, and everybody comes together to address this, I think we'll see a system that will have a greater impact on what we're doing. None of us can do this alone.

Yes?

MR. LAWRENCE MEDINA: Thank you for the presentation. And I see this funding being so important, you know, and I just hope that in the future that the outcomes, that is shared, you know? And it's concerning that sometimes, one, there was a short window for providers or entities to apply in the State of New Mexico, and that made it tough, especially if smaller organizations that don't have that infrastructure or capacity to respond in less than 10 days.

The formula of how the money is distributed within a State, understanding there's probably some autonomy by the State, but could SAMHSA have some input on making sure that it's distributed? Here's an example, that there's SAPT funding that one agency is receiving, and now they're getting STR, you know, and they're not spreading it out.

I'm very intrigued with learning more about developing hub-and-spoke systems, and I'd like to get in contact with experts on that. I think that would be great for New Mexico, but I don't want to be -- it was tough. There was a lot of talk about providers who submitted proposals. It was competitive. They didn't get it. They felt left out. They felt it was political at the State level, you know? But bottom line, we'll take all the resources that we can get, and but I'm hoping, one, that there's good evaluations or outcomes that SAMHSA is holding the States accountable.

Thank you.

MS. DONNA HILLMAN: Thank you.

MS. SHARON LEGORE: Hi. I just want to say thank you for your presentation as well. I'm curious to know if any of the States involve families in any way or have looked at the fact that they're dealing with the opioid crisis and recovery

addressing the issues within the family and recovery as well?

MS. DONNA HILLMAN: Actually, that has been a focus for a lot of the States is to ensure that not only significant partners are involved in the process, but the families and relatives are involved in that, too. Because healing the relationships within those families and stuff is important.

I think it's a matter of taking a look at what are the issues with the person that's sitting across the table from you, and what exactly do they need, you know, in order to address all of the issues? I think when we talk about families, I think that includes issues like domestic violence and abuse and, you know, a stable income, and you know, there's just a whole bunch of issues when we start looking at that, you know? And I think that's just a matter of clinical practices that are in place.

You know, when we talk about the biopsychosocial services that are necessary, you know, certainly integrating the care for people with opioid use disorders with primary healthcare, you know? Sometimes people in substance use services are not quite as willing to talk about some of the issues they're having as they might be with their primary care physician, you know? So having those two integrated and having the primary healthcare, the behavioral healthcare, and along with the peer support and the recovery people who are sometimes the person that for the person with the opioid use disorder, sometimes those peer support and recovery support people are their first connection, you know? And then they sometimes are able to talk to them at a level that where they're more comfortable with discussing some of those things.

But it's a matter of looking at who's sitting across the table from you and finding out what their concerns are and ensuring that those services are there. And that includes bringing in the family.

MS. SHARON LEGORE: Because I think that the integrating with medical is really important because we're seeing a lot of families that are having to deal with medical issues as a result of a loved one's substance use disorders. And so it's a great cost to the economy across the United States.

MS. DONNA HILLMAN: Yes, it is.

MS. SHARON LEGORE: And to making sure that that's addressed as well, you know, it's really -- it's critically important. You know, it's all our families.

MS. DONNA HILLMAN: It is critically important to all families, and one of the large issues right now that people are looking at is the pregnant and postpartum women and the impact on the infants in those cases. And that is, you know, I mean, they have -- and I'm sure you're all aware of this, but they're looking at separating out from neonatal abstinence syndrome, they're now looking at

neonatal opioid withdrawal syndrome to specifically focus on those infants that have been born to a mother who was using opioids and stuff.

And taking care of the dyad, you know? You can't separate those two. You can't separate -- I was just reading an article the other day about a hospital in I think it was Philadelphia that is setting aside six of their rooms for what they call a "rooming in." The mothers will be in the hospital as long as the infants are there, particularly the infants that are born with neonatal opioid withdrawal syndrome or even neonatal abstinence. And the mothers will be there.

And the requirement is that they're with their child 23 hours a day. So they will be rooming in. They will both be in the same room. They will be there for all of the things that need to go on, you know, with the child. And part of that has to do with the breast feeding, and part of it has to do with we all know what the stresses are for a woman who has just given birth. You know, sleeplessness and the feeling inadequate to take care of this small child and everything.

But it'll get them through that initial process, and then they will both go home together. So --

MS. SHARON LEGORE: I would hope that you all could consider as well the young children that might be at home that are separated.

MS. DONNA HILLMAN: Yes.

MS. SHARON LEGORE: And the trauma and, you know, like you had mentioned violence in the home. We don't really know what is going on. But to be able to get recovery help for those children as well.

MS. DONNA HILLMAN: Yes. Very much focused on the family.

DR. CHIDEHA OHUOHA: Thank you, Donna.

MS. DONNA HILLMAN: Thank you.

DR. CHIDEHA OHUOHA: I would like to make a slight change in our schedule. Who wants a 10-minute break before we go to the next phase?

[Response.]

DR. CHIDEHA OHUOHA: Okay. All right. Ten minutes break. Yeah.

[Recessed at 2:50 p.m.]

[Reconvened at 3:01 p.m.]

Agenda Item: RECAP: Putting It All Together

DR. CHIDEHA OHUOHA: We're going to restart and --

MS. TRACY GOSS: Bring us to order.

DR. CHIDEHA OHUOHA: -- I'm going to open the floor up for general discussions of some of the things that we've been talking about all day. Go ahead, begin.

DR. JUDITH A. MARTIN: So I have a list. But one of the things that I was thinking about, I see in the Director's report, I think it is, that PCSS is going to do avatar training?

DR. CHIDEHA OHUOHA: Yes.

DR. JUDITH A. MARTIN: That's coming in. So I remember talking to Jeff Wilkins, who was in the VA at the time, that he developed avatar training for motivational interviewing, and it was, of course, because it was military-connected people that they were treating, it was a Marine who had substance use disorder. I wonder if we could do -- include that psychosocial avatar training, if the VA would loan us that if it really worked?

Because not only do treatment providers need that, but even in the primary care setting, it would be good for, say, medical assistants or nurses who are doing the SBIRT, and it would be really good for recovery coaches. The example that Jason gave of somebody who really is precontemplative about using a treatment doesn't mean -- I mean, they could still have motivational interviewing connections and check-ins, and it's a very useful technique.

DR. CHIDEHA OHUOHA: When I was at Fort Belvoir just before I got here, all our staff went through motivational interviewing twice a year. That was required of all my staff. So I quite agree with you that it's a very, very good technique.

DR. JUDITH A. MARTIN: And one of our wellness models in San Francisco is that the person is stable enough that their addiction services can happen in primary care. So the doctor can prescribe the medications and the medical social worker, the FQHC can talk to them and do the counseling. But I think it should really be a core competence of anybody who works in medicine to be able to monitor somebody who is in recovery.

You know, like if there's a crisis, ask them about their craving or know -- have somehow a flash page or something that this person, you should be careful with anything that might stimulate craving or re-addiction or --

DR. CHIDEHA OHUOHA: That's a good point. One of the things -- one of the

things that I had as a vision when I came here that I told Dr. Katz is that I believe very strongly that a lot of our colleagues, you know, have not really paid a lot of attention to addictions. And one of the things that we really have to start trying to do is to go back and educate all specialties, not even just primary care. Everyone. Everyone needs to know exactly, you know, what their patients really look like.

At some point, hopefully, we'll figure out exactly how to do that, and that's one of my visions being CSAT Director.

MS. SHARON LEGORE: Just a question. Would that include dentists in the medical field or not? Because I'm really concerned about the dentists because they really are passing out a lot of painkillers.

DR. CHIDEHA OHUOHA: You're talking about dentists. We just -- we're doing a study right now looking at the schools of social work and their curriculum for addictions, and it's amazing how very few schools of social work have addiction curricula. So it's not just, you know, dentists. I think it's something that's --

MS. SHARON LEGORE: So it's across the board.

DR. CHIDEHA OHUOHA: -- across the board, and we have to go back and restart educating our colleagues first at least, and then making inroads to broader behavioral health specialties that are supposed to be able to help us do this.

When I was at Fort Belvoir, it was so difficult to hire a social worker that has had enough training in addictions that we finally decided that the best thing for us to do -- or even a nurse practitioner. The best thing that we had to do is to bring them in and then train them ourselves, and that's -- that's what I did for 10 years. We had to do that training ourselves. So this, the issue of workforce enhancement is a very, very, very big issue for us.

MS. SHARON LEGORE: And then you have to deal with the stigma issue with the families and people in recovery, even with the social workers and the workers who haven't been trained in the medical field.

MR. ANDRE JOHNSON: I wanted to add that one of the things we've been doing in Detroit is we worked with our State university graduate nursing program. And so they have master's and Ph.D. nurse practitioners, and we use our locations as a site for individuals doing internships. But, and so that's one mechanism to really get -- and this is a cross-training opportunity where we teach them about the work we're doing as it relates to recovery, and there's a learning curve.

A lot of them are from all over our region, and some people have never had the

experience of seeing how addiction is a travesty in the community. So it's a benefit for both us, as well as the students. And then we do something similar with the resident program that consists of med students throughout the entire State. And so I think building those parts of the system in synergy, and we work with the school of social work in my State as well, master's program, and so it gives you an opportunity to slowly plant the seed.

Because what I feel like, and I've been around this area for a little while, it's still not a priority for students who pursue social work degrees, psychology degrees, counseling degrees. It's not an attractive industry. "I don't want to work with them people" is what I've had people utter to me.

I've had CEOs of a Federally Qualified Health Center say, hey, we need to build a partnership, and he sent one guy to me a few years ago. He said, "You know, we don't work with those people." And I said, you know, those people are below poverty level, and that's stipulated in your contract with HRSA. But --

DR. JUDITH A. MARTIN: They are working with them. They just don't know it.

MR. ANDRE JOHNSON: And I start with, "Who do you think you're working with?" But --

[Laughter.]

DR. JUDITH A. MARTIN: Exactly.

MR. ANDRE JOHNSON: But I think, you know, we really want to reach out to our universities and teach them because the field has evolved in the last 10, 20 years as well. And so as the field evolves, I think that, you know, the new educated students need to know impacts and inroads and how there's been a paradigm shift. And one in particular is the whole recovery coach philosophy and recovery coach model.

And I think it's important that we don't lose traction of how valuable recovery coaches are in our communities throughout our country. You know, our recovery coaches have been trained on the model, Strengthening Family model, the best practice model, and we're doing Strengthening Families, you know? I know, Sharon, you've spoke quite a bit on families today. And so I'm going to be a spokesperson. It's vitally important.

However, when you're in an urban environment, what we've seen is there's so much tension in the families where it's almost if, what they say, irreconcilable. You know, there's a large disconnect when you have folks who've been using on an average of 20 years, in and out of prison, neglecting the kids, neglecting the family. A lot of resentments, a lot of anger, a lot of pain, a lot of grief, a lot of hurt, a lot of trauma. We see it.

MS. SHARON LEGORE: Do you think that's from loss of hope?

MR. ANDRE JOHNSON: Well, what I would say is when I get a person -- let me just give you a little profile. I get a young lady who may be about 37 years old. She may have spent 10, 12 years in prison. She may have about three, four kids. She has no college, no high school education, no training, no home. No skills. No employment.

She wants her kids back. She wants a home. No driver's license. No automobile. And so I was really glad to hear the speaker earlier say that it takes X number of years to have long-term recovery. And so early on, people really have to focus on their personal recovery because sometimes family, those old family issues that come up can cause -- make a person want to go back and use. Because the old, there's so much unresolved pain and trauma and issues like that.

MS. SHARON LEGORE: It's generational.

MR. ANDRE JOHNSON: And so what I would say, and this is just from my experience because, again, I'm in a large, urban metropolitan community, where there's a large disconnect, family disconnect. And so we're working with the individuals to teach them to learn how to love themselves, and once you do that, now we've got to work with them loving their kids. If that opportunity is even present itself, you know what I mean? Because there's a lot of kids that's like "I don't want to be bothered with you by now. You know, you've been absent for so many years."

So there's a lot of pain, but this is real important. But again, you know, just as important it is, it's also vitally important to help that one person who has the drug problem find and sustain long-term recovery and, I think 4 or 5 years later, be in a better position typically maybe financially to try to help and be a contribution in terms of your children's lives, et cetera, et cetera.

Do you follow what I'm saying?

MS. SHARON LEGORE: I understand.

MR. ANDRE JOHNSON: So it's -- it's not an easy thing. That's all I'm saying. It's a lot of work. And so just give you an idea. In Detroit, Detroit alone averages on any given day, 15,000 people in the treatment system. Our population consists of 700,000. Out of that 700,000, over half of the residents are living below the poverty level. And out of that below poverty level, I can't even tell you how many have substance use disorders. I can't tell you how many people have mental health disorders.

It's projected in Wayne County alone, we have 70,000 individuals who are being

treated for mental health illness. So with those numbers not including the incarceration, not including the poor health, you know, the health inequities that exist, not including the high, high student dropout rate, not including the high unemployment rate.

We have three casinos in Detroit that gross \$1 million a day. And the average salary at a casino is about \$60,000 a year. The casinos have a responsibility to hire 50 percent of Detroit residents. Guess what? The Detroiters can't pass the drug test. Now we've got recreational marijuana about to be approved on the ballot in a few months. And then the Detroiters that do pass the drug test, that does get hired, after a year or two of employment, they move to the suburbs.

So, you know, it's so many -- it's a multilayer amount of issues that we're -- which is happening on any given day, any given moment. You follow what I'm saying? And so, and that's why I think for us, you know, I recognize the importance of partnerships because we can't do everything. But if we can build strong partnerships and we can get the support from SAMHSA to say, hey, we need to have conversations with HUD, you know? HUD provides Section 8 housing. HUD needs to be a little more lenient and not -- you know, the whole thing about people who have a criminal record can't live in the HUD property. How does that sound?

DR. CHIDEHA OHUOHA: One of the things that the Assistant Secretary just wanted us to begin to think in terms of is the part that work and housing plays in recovery. So we are going to set up a panel over the next few months to basically bring in experts in various fields and the Department of Housing to be able to discuss exactly what kind of guidelines that we'll be able to produce to be able to emphasize many of the things that we have been talking about today. That's one of the responsibilities I have.

MR. ANDRE JOHNSON: I'll tell you, I've advocated with our local government. We have some HUD money. We provide -- we have 21 single bedroom apartments, and people can live in these apartments for up to 18 months' rent free. Now we really need about 500. You know what I mean? Because we average 12,000 people being released from prison per year. We have 55,000 people incarcerated in the State of Michigan, and 80, 90 percent are disproportionately African American -- 55,000.

That budget is \$3 billion. That's your budget. Our budget is \$3 billion for Michigan Department of Corrections in the State of Michigan. So we're dealing with, you know, a large population of homeless people. We're dealing with a large population of individuals who come into our community that have criminal records, and then they're faced with these, you know, stigmas as well. So you got a stigma for having a mental health illness. You got a stigma for having a criminal record. You have a stigma for having an addiction.

MS. SHARON LEGORE: And then you go to drug court, and there's no place to live. And so you have to wait for housing, and you have to wait for housing in the prison system. So you have mentally ill, and I know this from experience and my own child, 3 months in prison and then go to recovery 4 months until a bed opens up. And so the housing is huge and the employment is huge because now he's in recovery, but who wants to hire somebody that, you know, has a felony or has been in prison. And you can't say, well, I've been in prison because I didn't have any place to live. You know?

It's just like you said, Andre, multilayered, and I'm just going to throw this out because I threw it out before. Because I heard it mentioned that the Government or Congress wants people to work together. So this might just be a little way, but it's a way to start.

I think about the Systems of Care because we have them across the country and the Circles of Care, and I sit -- in my community, I volunteer on our System of Care, and we have representatives from all the different agencies, whether it's mental health, substance abuse, child welfare, justice, faith-based community, education. And maybe this might be a way to get the addictions training to talk with them about doing the cross-training in addictions for everybody.

At least it's a start somewhere. Where we can start collaborating, coordinating like Andre said, and working together, you know, with the other -- with CMHS and see how we can get that education started. Because I know it needs to go in the medical field, but it also needs to go in the community.

DR. CHIDEHA OHUOHA: I quite agree with you.

MR. ARTHUR SCHUT: I have a couple of things. One is housing, and I've been involved in a project that has Section 8 vouchers attached to apartments that were for women and children, and it was good for up to 24 months. But the Section 8 voucher stayed with the apartment, and so the objective was to get -- it was actually a women and children's treating program. But the objective was to get them to the point where they could have housing in the community.

But the Section 8 voucher did not go with them, and it also had a provision where they had to be -- a condition of having that Section 8 voucher in that setting required continuing treatment and continuing involvement in women's services. And it had a provision to evict people who were bringing drugs into the facility, that kind of thing.

There's also a model where you can use tax credits to create and there's a collaborative arrangement with a developmental disabilities organization and a health center and the substance use treatment center that I formerly was at that actually has a community development -- community housing development association and uses tax credits to rehab apartment buildings and then provides

housing for those three organizations for their folks and also provides case management. And it requires no upfront money from any of those three organizations because it comes through -- I don't understand tax credits, and here you do all of that very well. But there's somebody there who does, and it's an exquisite way to get apartments and have somebody else fund them through tax credits.

And then the other thing is that --

DR. CHIDEHA OHUOHA: Before you go on to your next question, I just need to ask you this question before I forget.

MR. ARTHUR SCHUT: Pardon?

DR. CHIDEHA OHUOHA: For those people who are in Section 8 housing in that program, what happens to them if they relapse during that --

MR. ARTHUR SCHUT: If they relapse and they continue in treatment, then they're fine.

DR. CHIDEHA OHUOHA: Okay.

MR. ARTHUR SCHUT: If they bring drugs into the facility and give it to the other people in the other apartments or try to, then they're gone.

DR. CHIDEHA OHUOHA: Okay.

MR. ARTHUR SCHUT: Yep. That's sort of my rule. And then there's also an organization called Peer Assistance Services, who does impaired professionals in Colorado. It does everyone except physicians, I think, like dentists and nurses and counselors and all of those folks. And they have been -- they've done SBIRT for the last 10 years with Federal funds, and now they have State funds. One of the things, and these started at the hospitals and reach into practices and did all over.

But they now have an avatar program that is for individuals, but also for health professionals that lets you go in and interact with the avatar. And if you do all the right things, the patient responds well, and then it has the opportunity to do all the wrong things and find out what you get from doing that. And they have made a major investment in that. And the website is ShiftTheInfluence.org.

MS. SHARON LEGORE: Shifting what?

MR. ARTHUR SCHUT: ShiftTheInfluence.org. And I think it's worth looking at before anybody develops a new avatar program to change health professionals because it's something that you can do online. You can do it by yourself. And it

actually is responsive to a wide range of stupid ways to do it as well as appropriate ways to do it. So --

MS. AMY B. SMITH: Is it public facing?

MR. ARTHUR SCHUT: Pardon me?

MS. AMY B. SMITH: Is it public facing, free?

MR. ARTHUR SCHUT: Yeah. Yeah, part of it is public facing, and I don't know about the health professional piece. But they made a big investment in this.

MR. JASON HOWELL: So definitely thanks to my fellow members for bringing up housing. That is the subject that I'm probably the most passionate about because so much of my work in recovery has been around recovery housing and housing in general. And to our partners over at HUD, with all due respect, they don't understand substance use or much less recovery.

And much of their funding, and they've got the lion's share of housing dollars, but their policy priorities are such that individuals that can access those programs have to meet a really high bar of chronic homelessness, and so many of our community never meet that threshold and don't access those housing resources. And if they do, over the past couple of decades, HUD has really moved towards a Housing First philosophy. And Housing First provides housing to individuals with low barriers, no barriers, including usage.

And so for individuals with a primary mental health condition that move into their own SRO, and there are individuals that are using substances within that community, it doesn't impact them that much. But someone like me that has a moderate to severe substance use disorder, when we live around other people who are using, that significantly increases our chance of relapsing. And then when we move into those Housing First communities, we become behavioral issues, and we get evicted.

Housing First communities actually don't like persons with substance use issues because we ruin their numbers. They're graded on, you know, continuous days housed, and so to the extent that they can filter us out, they appreciate that because it makes them look good on numbers.

So all that being said, when SAMHSA looks at addressing housing, because it's one of the four supported dimensions of wellness, oftentimes I hear, "Well, that's in HUD's arena." But I do think that there is an opportunity to either better educate HUD or encourage them to carve some of their dollars out specifically to serve our population, or we carve out our own pool of money to support our community because it helps support the overall goals.

Other things -- we ran out of time, but when I talked to Arne Owens afterwards, he mentioned the strategic plan, and I think it's, you know, that the policy lab heading that up I think is great. But my question was so what is the mechanism to ensure stakeholder input? Especially individuals with lived experience and those that have been working in the recovery field for an extended period of time.

I'm really glad that we have, you know, more psychiatrists on the team and adding that expertise, but there are people out there that have, you know, "Ph.D.s in recovery" and it's because of their lived experience. And so how can we make sure that those voices are at the table so that that can help, you know, guide the strategic plan as well?

Yes, sir?

DR. CHIDEHA OHUOHA: Before you continue --

MR. JASON HOWELL: Yes, sir.

DR. CHIDEHA OHUOHA: -- I just don't want folks to leave here thinking that what Arne Owens was saying as far as bringing more clinicians in is done, you know? A part of what the Assistant Secretary is trying to do is to bring in a lot of newer people with new experience on the ground, okay? Clinicians who have really practiced it, okay, recently. Okay, not 20, 30 year ago, but recently. Back into the centers so that we can begin to look at some of these things that we are really talking about, housing, all these kinds of things, you know, in real life, okay?

MR. JASON HOWELL: Right.

DR. CHIDEHA OHUOHA: So I don't want us to leave this place thinking that what he was saying was that there was any real particular move of doing that. That it's very important for us to bring people who have done the work very recently, you know, to come back into SAMHSA.

MR. JASON HOWELL: And thank you for saying that. I hope that by me highlighting that you're bringing on more psychiatrists, I mean I really appreciate that those that are coming in --

DR. CHIDEHA OHUOHA: Yeah, [inaudible].

[Laughter.]

MR. JASON HOWELL: Yeah. Have the lived experience, as you said, working in the field. But when SAMHSA talks about developing standards for recovery housing, where is the credibility in SAMHSA doing that if they don't have the lived experience? There are organizations out in the community that have been

doing that. So to the extent possible, let's create mechanisms for that expertise to trickle -- to trickle up.

And then my last point and I will let go of the mike because I feel like I've been hogging it up a little bit, I really appreciate Sharon talking about families and that component. As in Texas, we're developing a family recovery coaching program, and I just got through teaching one of those classes. And what I'm realizing is that when we're looking at families, there are so many dynamics there.

Typically, we think of families and receiving services or the focus based on I'll call them "the qualifier," the person with the substance use disorder. But what I'm finding in that class, there were grandmothers who are now parenting their grandchildren, and their son or daughter maybe still be in active addiction. And so now they have these kiddos who have experienced trauma. They've experienced separation. They have a genetic predisposition for substance use issues, and so we've got to be thinking about prevention for these -- for these young individuals.

I talked to a mother whose ex-husband had a substance use issue. But now she wasn't in the workforce. She was taking care of the six kids. You know, now she has to go out and find employment, find a way of raising these kids, and then also is concerned about given their predisposition, how does she, you know, prevent them from developing substance use issues?

And there's just the family dynamic is so complex, and I hope that we can figure out not only how to support them, but then what's that funding mechanism so that we make sure that family members that need the support, we can fund those services. So thank you.

DR. CHIDEHA OHUOHA: Go ahead, sir.

MR. LAWRENCE MEDINA: Thank you, and just, you know, continuing on with the family. And Sharon, I commend you. But sometimes the reality of, you know, it's known nationally for family involvement in treatment is very low, and you could -- and I don't mean to make it by class, but there's a lot of families that have lived in dysfunction all their life. They know nothing else, and they don't want help.

In New Mexico, we suffer -- our families -- what we call, they call it enabling, we call it mijito/mijita syndrome. You know, it's a term of endearment, and we need more Sharons out there to be attracted to these families because they are suffering just as bad. And I know on the 12-step site, sometimes they'll say, well, the family is just as sick as the addict or the alcoholic. They don't like that term, but there's some truth to that.

MS. SHARON LEGORE: It is true.

MR. LAWRENCE MEDINA: And, but I wish we can get -- you know, in writing and theory, and also sometimes in class, you have people living in the different type of living than middle class and upper class. It's a whole different world. How do you do intervention for those folks in poverty areas? And I'm not putting them down because I come from there.

So, Sharon, I wish and I hope and I hope SAMHSA would look at, you know, more interventions for families that are suffering.

MS. SHARON LEGORE: Yes.

MR. LAWRENCE MEDINA: And ultimately because on paper, I could write, you know, family involvement for our intensive outpatient and make it sound real pretty. But the reality is very difficult, and actually, it's very frustrating. And say that for one of our intensive outpatient programs. So we have family night, and only two family members show up. And you're like, oh, it's family night and it's pretty, but we want everybody there.

But in reality, I think Andre had some good examples of the realities that we're faced with. So God bless you, Sharon, and I commend you.

A couple of things with -- and I think there was some discussion about we're seeing in New Mexico some, and I don't know if you would call it conflict, but peer support clashing with the clinical. And I think it's just a matter of lack of training, you know? You've got these little resources that it's paying for a peer support. They don't really have a lot of training behind that, and I think peer support is a great resource, and we need to use it more, but I hope that -- and I know like the State of New Mexico would provide more training so there's better integration of peer support into that clinical field.

And matter of fact --

DR. CHIDEHA OHUOHA: What basic -- what basic requirements do you think we should have for peer supports?

MR. LAWRENCE MEDINA: That's a good question. Well, just -- like we just had a case where for -- to give you an example, we have a program that provides peer support services. Now they're doing training, and they did a training, and they made the name of something "arm wrestling with the devil," and somebody from the clinical said that's kind of stigmatizing mental health.

But you know what? When I work with the peer support or I see them, observe them interacting with the client, I mean, they interact better with the client than clinicians do. They have a really good connection. So I think it's both sides, you know, the peer support understanding the clinical world and treatment planning --

and I'm sure they do when they get certified -- but also the clinicians understanding the peer support. If that's any help?

DR. CHIDEHA OHUOHA: This is something that we're very much interested in because, you know, the qualification of the so-called peer support varies with each State, and you know, the kind of people one State may be using may be so different from the kind of people, but one of the things that you did say that I think, you know, comes across from all the ones that I've been told about is the connection between the peer and the patient or the client, okay?

MR. LAWRENCE MEDINA: Right.

DR. CHIDEHA OHUOHA: It's that connection is what really is endemic in almost all the ones that I've been told. And I think it's very important. What I'm really trying to figure out is, is there anything more that they need to know, okay, that we can standardize?

Dr. Martin?

DR. JUDITH A. MARTIN: I am not a peer, but in our organization, we have something like 25 percent of the people who work in my building have lived experience, and some of those are peer programs. And what I notice in some of the full-service partnerships where a lot of it is peers is that you have to have some kind -- because both mental health and addiction can have relapses and recurrences, there has to be some way to protect the peer when that happens so that they don't lose everything just because their illness is happening, right?

Like if a diabetic ate a donut, you wouldn't kick him out, right? So the other thing is one thing, you know, like we and those of us who've gone through long trainings and have licenses, that whole process has socialized us in a certain way, which in some ways makes us less effective than peers. On the other hand, there are these sort of professional ethical boundaries and things like confidentiality and also whose business is it -- you know, that kind of thing -- that I think is hard to learn. And even me, it probably took me years before I figured that out. Who knows?

But I think that we -- they stamp us out, and we're just that kind of person. So the peers have amazing talent in de-escalating, for example. You know, "I've been through that. Come on, let's go have a smoke." Something that I couldn't do.

And also because they don't have a license to lose, they're often the people who are very creative, you know? Oh, this person just got like a check, and they're going to get in trouble with it. I'll take you shopping. And then they get rid of the old clothes and take off the tags of the new clothes so that it doesn't end up being relapse situation. You know, a lot of things that somebody with a license

probably wouldn't do.

So you don't -- you don't want to get in the way of really -- it's kind of like a really creative case management, what most people would call it. And I think that there's a bond that there isn't in almost every treatment program I've been. Some of the most effective counselors were, you know, like in recovery themselves because they just knew how to talk to people.

MR. JASON HOWELL: So some things I think that SAMHSA has done really well, towards your question, for several years, they supported, you know, peers from the mental health side, peers from the substance use side coming together and really identifying sort of what the core competencies, and SAMHSA ended up publishing the core competencies. For -- there for a while, SAMHSA was funding the development of we'll call it supervision. So similar to clinical supervision, but it's really so it's almost kind of like performance support and for the peers really looking at so what should that look like?

And then I know that SAMHSA had in the BRSS-TACS project, there was some of that work being done. There was a contract with Altarum to develop some resources. I don't think that has ever been officially published. So getting those resources out there, what that does is so as these States, you know, come up with 50 different ways of training, they can look to the core competencies and look to those supervision resources to develop those sources.

I think the other thing I see, you know, there is a lot of emphasis on integrating peers into what I'll call traditional settings, whether they be clinical settings where the culture is predominantly clinical. And some of the challenges that we see is the clinicians may not fully understand what the peers do, and if the clinician is then the supervisor of the peer, they do what they know. They supervise them as a clinician, and then there becomes role conflict and tension and this kind of war between the clinicians and the peers within that organization.

So to the extent that peer workers are integrated into these clinical, more traditional settings, it's very key to almost have a transformation of the organization, or the organization at least going through an assessment to see whether they're ready to support peers because in some cases, they're just not.

Now my bias is that peers are best placed in organizations like Andre's, in recovery community organizations where they have -- you know, they're the coaches of coaches. They have their training, their supervision, all of their supports, and so a traditional provider can contract with Andre's organization to do -- to do outreach or reach in, I think, is my new term that I heard earlier today, and then it becomes this really great bridge. As an individual moves through the clinical services or more traditional services, they have their recovery coach. It's just that natural bridge into those community services.

So my concern is there's not been enough effort in developing out more Andre's or more organizations like RCOs and figuring out so how are those organizations going to be sustainable? So when I look at how do we improve peer workforce, there's a couple other things layered into that that I think we have an opportunity to more comprehensively approach.

MS. KRISTEN HARPER: Hi. This is Kristen Harper on the phone. I just wanted to jump in because I think these comments may be relative to what Jason was just sharing. I do also want to just piggyback on what was shared that part of this that also needs to be figured in is the Medicaid reimbursement for peer support. We do know that there's 15 States currently that are doing the Medicaid reimbursement for peer services.

Now each of the States has different criteria, but CMS has recently made some changes. So for Medicaid, to be able to bill for Medicaid, you only have to take a 2-hour training module at the Federal level to be able to be a Medicaid biller for peers. So that's really kind of taking some of the steam out of what a lot of these States were doing from their training perspective with peers because now really what's the point if they can get Medicaid reimbursement from just taking this 2-hour training online?

The other piece of it, too, is some of the States, the managed care organizations have been the billable organizations forever, pretty much. They're even written into some of the legislation. North Carolina and South Carolina is a really good example of that. And so, you know, what Jason was saying about an organization like Andre's becoming a more robust peer contractor or service, it makes it very difficult because the MCOs are already kind of in that role. And so then there has to be another subcontract with the MCO between the MCO and the RCO.

So if the entire system really were to be sustainable, at least in the public sector, it has become very complex, as you know much better than I do. So I would just encourage SAMHSA to take a look at Medicaid systems for that as well.

MR. LAWRENCE MEDINA: I just had one more point.

DR. CHIDEHA OHUOHA: Go ahead.

MR. LAWRENCE MEDINA: On another -- on another topic just -- and then I'm done. I see in smaller communities when it comes to doctors or practitioners prescribing, you know, suboxone is a good example, that there's a lack of promoting treatment or even mandating treatment. I know in larger cities, you go to a behavioral health clinic or they provide, it's all there, including drug testing. And I think another component that's very important is that a lot of our clients, even in a small community, are court mandated. And there's really no compliance monitoring and not from a punitive standpoint.

But so they get their prescription or they go into treatment, individual and groups. Are they getting drug tested periodically or random? And then are they -- and if they're not abiding by that from a less punitive standpoint, but letting the doctor know that he or she is not meeting up to those requirements. And I know that communication breakdown is promoting relapse, and so I know -- I know very little in terms of doctors or professionals getting certified or getting under the DATA waiver, that I hope that that's communicated, especially in smaller communities where resources are limited.

DR. CHIDEHA OHUOHA: I hope that anybody who's X-waived knows about the practice guidelines and can effectively use them, or at least if you are X-waived, those things are taught on how you are going to be able to do it. So, hopefully, in the rural area, they didn't forget how to practice medicine.

[Laughter.]

MR. ARTHUR SCHUT: I'd like to go back to the conversation about people with lived experience, and you know, the original drug treatment programs and alcohol treatment programs were almost totally people in recovery. The boards of directors were totally people in recovery. And there were a series of challenges around how that was any different than attending an AA meeting or doing those kinds of things and what the boundaries are between being a counselor and being in the mutual assistance outside organizations.

And I think it's worth a conversation, a longer conversation just about how -- I have a couple of things. You know, I helped a recovery organization get money and a grant. I used my organization as a fiscal agent, for example. I've hired, you know, staff from other places. But I think there are issues around boundaries in that situation, and how do you help people with boundaries?

It's like, you know, if you're a counselor and you go to AA meetings, and people want to talk to you about your counseling at the AA meeting you go to, how do you handle that? That there are also issues around licensure and certification. You know, in Colorado, if you're a certified addiction counselor and you have a relapse, you, in essence, end up with your license suspended, your certification, and I think it's for like 2 years or something.

So it's not like -- and see, and I'm in favor of treating things like an EAP. You know, you have an employee who has a problem. If they're having problems with alcohol or drugs or their absence is because their diabetes isn't under control, et cetera, then you treat that like an EAP, and you provide services. And there are when you get -- if you get to the point in the process of that that the person is so impaired, they can't perform their duties, then they can't perform their duties, and they can't be there.

I think there are regulatory issues with that, and there are liability issues if you

have people who are -- no matter whether they're a licensed clinician or certified or a recovery coach or mentor, you have liability issues if people don't have appropriate boundaries. And the amount of liability is great.

So I think it's worthwhile having a conversation about what those issues are and how we maybe have more of a -- we've had some solutions in Colorado in terms of certifying folks through the ICRC system. And we involved all the recovery, you know?

MS. SHARON LEGORE: One last idea. This doesn't have to do with [inaudible], but it's like a recommendation. There was, years ago, Jutta Butler, who used to work here at CSAT, took me to a meeting that was formed, a collaborative meeting that had all the heads of all the agencies there, including Housing. I can't remember the name. I have the notebook at home, so I can get you the information.

But they focused on adolescents. So everybody at the Federal level was focusing on the adolescents. If that's still in operation, you know, maybe an idea would be to get them all together again to focus on the opioid crisis, and that way, you could educate across the agencies, bring in recovery people, families to talk and explain, you know, what's going on. And the clinical people and the medical people, all that you need there, and you would be able to hit all the agencies at once and collaboratively come at the opiate crisis through each of the agencies.

MALE SPEAKER: That was JMATE.

MS. SHARON LEGORE: No, not JMATE. It wasn't JMATE. No.

MALE SPEAKER: Okay.

MS. SHARON LEGORE: Yeah, we did a lot of JMATE when we were able to -- it wasn't JMATE. It was a meeting at the Department of Housing. I believe Estelle Richman, who was from Pennsylvania, I believe ran the meeting.

MALE SPEAKER: Was Kim [inaudible] there from Indiana?

MS. SHARON LEGORE: No, no. I was the only -- Jutta and I were the only ones there from substance abuse, and I asked the question why wasn't substance abuse represented?

MALE SPEAKER: I don't remember what meeting that was, but --

MS. SHARON LEGORE: I have the notebook at home. So I can get the information.

Agenda Item: Public Comment

DR. CHIDEHA OHUOHA: We've not received any of our routine submissions from the public for any comments. Are there any members of the public who would like to address the council?

MS. TRACY GROSS: Operator, if there's any listeners who would like to address the council, now would be the time.

OPERATOR: If you would like to ask a question, please press * followed by 1 on your touchtone phone. You will queue up and be asked to record your name and announce into conference. If you have a public comment at this time, please press *1. Please give your parties a few moments to queue.

[No response.]

OPERATOR: So far, we have no one in the queue.

DR. CHIDEHA OHUOHA: Okay. So we have allotted some time for the public to make some comments. I think that as those things, we don't have them, I think I have the luxury of closing the meeting earlier than we planned.

And having said that, before we recap, I would like to ask your assistance to provide some recommendations on what products and publications that SAMHSA should be producing in the upcoming year. As practitioners and professionals in the behavioral health field, you are in a unique situation to inform us of what the pressing informational needs of the field are.

Tracy provided you with a template, and that we asked you to fill out with your recommendations for the products before you came. If anyone didn't receive that, please let us know, and Tracy will also provide links to some of the recent publications that SAMHSA has published, and I would like you to take a few minutes -- did you give it to them?

MS. TRACY GOSS: Yes. Yep, they received it.

DR. CHIDEHA OHUOHA: All right. Okay. So I'd like you to take a few minutes to discuss some of those recommendations.

MR. JASON HOWELL: So I didn't do my homework, but on the drive over here, we did talk about this, and we're kind of trying to brainstorm. One idea I just I call it buyer's --

MS. KRISTEN HARPER: Could you turn your microphone on?

MR. JASON HOWELL: Sorry, Kristen. This is Jason. So on the shuttle ride

over here, we were brainstorming ideas. One idea that I kind of called the buyer's guide is really helping consumers, individuals, and family members and perhaps even service providers could use this to really understand what does this process of going through treatment and recovery services look like? What is the expectation?

I think that many families, they don't know what they don't know. And all of a sudden, they're in crisis. And I realized that community to community, State from State, the landscape can look very different. But perhaps some overarching resource to help the families understand that recovery is possible, treatment works, this is a process, here are the different types of funding streams that you could potentially look for.

Parity, I think there are some -- there are some general information that can be provided that might empower them as they're trying to develop a plan for themselves or for their family.

MR. ANDRE JOHNSON: I'm going to add components for a how-to guide on how to develop or create an integrated health and wellness recovery resource center that would encompass a nurse practitioner or physician and psychiatrist that covers the whole gamut -- mental health piece, physical health, as well as recovery therapists, [inaudible] therapists -- in a multi-service team. I just think it's vital to make sure that we keep in mind at the end of the day we all are here for one great purpose, and that's to help people sustain long-term recovery.

And I think we got to keep working on it. Thank you.

MS. KRISTEN HARPER: I'm going to jump in real quick, if that's okay, with my other recovery brothers. I submitted my form to Tracy, as I couldn't be there in person, and so you'll see my notes that I would really love to see a very similar concept for educators and for administrators. I think that there's a misconception that education is just for the traditional 18- to 21-year-olds that are going to a 4-year State university.

And we're actually seeing a really sharp rise with community college recovery. We have a pilot program right now going on to study community college recovery programs that will be published in the fall. But I would love to see SAMHSA put together an explanation of the full continuum of care on a college campus, pull in those various elements like housing and workforce development because we know that it is housing, workforce, and education that really helps to sustain a recovery for long term.

So some of the ideas were just probably going to play a lot off of what's happening next door in the research meeting today and tomorrow. We'd really like to see, you know, what are the best practices that colleges and universities should be using for prevention, intervention, like SBIRT, and then treatment,

whether that be treatment referrals or actually on-campus treatment, which we're starting to see emerge. But then, of course, the recovery support services for students as well.

And then the third thing would be how are we going to take the information and turn it into a product that still relates back to the research. So maybe developing a one-pager or a brief kind of research quick fact sheet or something that we can distribute to universities that they can use as they develop these programs for their students.

DR. CHIDEHA OHUOHA: Thank you.

DR. JUDITH A. MARTIN: I've thought about a lot of things, and first, I'd like to say that I love TIPs. I'm a TIP user, and I really appreciate a lot of the publications that come from SAMHSA. I also like the physician locator for buprenorphine. I think -- I get calls a lot about who's in my area that I can go to, and I use it, and I recommend it to people.

In spite of all of our education and advocacy in the community, addiction still remains really stigmatized, and our patients often have bad experiences not only in the community, but even in the healthcare system. Sometimes especially in the healthcare system. So if there's any advice, for example, to an orthopedist who's doing hip surgery, right? Like which drugs will mean that this person won't recover, like, for example, cocaine might cause vasoconstriction, and it won't heal properly. So would nicotine maybe?

I think that the medical specialists who are trying to offer the state-of-the-art technology to our patients and clients often don't know how to do that, and what happens is they don't get offered. They say come back when you're in recovery, and I'll help you instead of I know enough about these drugs that I know how to handle this with you and how to work with you on it.

I think -- and another area that I think we need a lot of materials is for neonatal nurses. They hate our patients. The women who come in having been on opiate agonist treatment, and then the nurses are often the ones who are evaluating the abstinence syndrome or withdrawal in the baby. And they take the side of the baby -- they often do in many cases anyway for other things -- and further injure and traumatize the woman.

And I think even for the families and the mother herself to look forward to what's going to happen. I'm on methadone or buprenorphine, and now I'm having a baby. What should I expect? One of the things that happens that can be surprising is that when they keep the baby in the hospital, it outs the treatment. The family may not know that this person is in treatment, but the baby is kept, and everybody is worried, "Why is their baby still in the hospital?" And it ends up being the mother didn't expect it, but now everybody knows about her.

So I think there are a lot of pitfalls. If we have information that's hard enough to publish about the pathways to homelessness, one of the areas that one of our researchers found in the Bay area is not having money for bail. And it especially affects people of color, who are more likely to be picked up by the police. And even if later on they're never charged, they've lost their job. They haven't been able to show up for work. And I think an investment in providing bail money to people might prevent some of the tragedies that happen later.

I don't know if that would be sent out and published.

MR. ARTHUR SCHUT: Well, the other folks that don't like mothers are the child protection welfare people. I mean, their job is to protect the child, but oftentimes, they detest the mother, who is usually a single mom. And it's a real -- it's a real problem.

Somebody ought to mute their -- is that you, Kristen?

MS. KRISTEN HARPER: It is not me. I promise.

[Laughter.]

MR. ARTHUR SCHUT: Oh, okay.

MS. SHARON LEGORE: And I'd like to see more information on family peer-to-peer support services. And for our siblings that, you know, look into some sort of support system, treatment system for the siblings of those who, you know, are families that are seeking treatment for a sibling. And so those who aren't in treatment because it really is a family disease.

MR. ARTHUR SCHUT: Another comment about TIPs. I'm a TIPs fan also. Some of the TIPs have been revised, but --

DR. CHIDEHA OHUOHA: We're actually in the process right now of looking at all the publications that SAMHSA has done over the years to see which ones we need to archive and what are the ones that we need to revise and, you know, the ones that we need to, you know, print a lot more. So that's another project that I'm working on as we move forward.

MR. ARTHUR SCHUT: That'd be great.

DR. CHIDEHA OHUOHA: So we are in the process of making sure that we review some of these materials.

MR. ARTHUR SCHUT: So, for example, the one on detox, the one on case management, both say that they were revised I think in 2015.

DR. CHIDEHA OHUOHA: Mm-hmm.

MR. ARTHUR SCHUT: I don't have a clue what changed. I mean, I've read them both extensively, and for some funding purposes, it was made an obligation that -- applied for that funding would be that we'd use that as a guidance. But when I look at the TIP itself, I can't find what's different in the revision. I don't know if somebody read it and said, oh, gee, it looks pretty good. I don't know.

DR. CHIDEHA OHUOHA: Well, hopefully, when we go through this process again, we won't make that same mistake. So that's nice for us to know that you were able to find that we didn't do our work right. So --

MS. AMY B. SMITH: That's before our time.

DR. CHIDEHA OHUOHA: Yes, right. Yes.

[Laughter.]

MR. ARTHUR SCHUT: It's almost before my time.

DR. CHIDEHA OHUOHA: Yes, sir?

MR. LAWRENCE MEDINA: Yes. I had suggested more information for rural and frontier areas, whatever information that could be helpful, even, you know, examples of this hub-and-spoke systems. But I was also thinking, too, that I recently was exposed to workforce development, and having something around professional development or workforce readiness, better yet, that would address soft skills and hard skills. I mean people coming out of treatment. You know, we ran a program where we were -- we had to get down to the basics of teaching people that it's not okay to say the F-word in every other sentence. I mean, just these basic soft skills.

Transferrable skills, looking at career interest assessments that would -- you know, there are some manually that you can take based on best practice, John Holland Codes that -- you know, I guess what I'm trying to say by these workforce development training or resources is contributing to bridge the gap between treatment and long-term recovery, and employment is a big piece to that.

And so having this career exploration piece in addition for individuals that some sort of publication to resume writing, to interviewing skills, and so forth, I think that would be great because these -- you know, and then also a piece where if you have felony I mean, how do you explain to somebody that it hasn't ended. It just begun, you know, even if you do have a felony that there's thousands of people out there that have been successful in recovery and in the workforce with a criminal background.

So I think this would be a very good resource.

DR. CHIDEHA OHUOHA: Go ahead.

MR. ARTHUR SCHUT: One thing that Lawrence brings up for me that to me is just obvious, but I'm not sure that it's obvious to the outside world. That really, people who function -- are functioning well and start and use -- get into substance use and deteriorate are then rehabilitated. There's a whole other group of people that never functioned well, and they're really being habilitated. And many of the people in that top 5 or 10 percent that the public system largely works with and that I largely work with are people who never functioned well.

And there is a big difference in the approach and what needs to happen with the folks who need to be habilitated versus the people who need to be rehabilitated. And oftentimes, the public thinks about it as rehab. And I'm concerned that there's not a distinction between the two because when you look at what needs to be done to have a positive outcome, it's very different with a population that requires habilitation than it is a population that's being rehabilitated.

MR. LAWRENCE MEDINA: But just to add, Art, one could be like both rehab would address that directly that they would qualify, so they have more support for that target population?

MR. ARTHUR SCHUT: I think that's more difficult. If I recollect correctly, Ronald Reagan's administration did away with both rehab for people with substance use disorders, right? He declared it no longer a disability?

MS. KRISTEN HARPER: Yes, this is Kristen. I can confirm that. You have to have -- their priority is stability. You have to do something nonrelated to substance use, but it can be secondary.

MR. ARTHUR SCHUT: Yeah, along with doing an SSDI and --

MS. KRISTEN HARPER: Correct.

MR. ARTHUR SCHUT: And SSI. So --

Agenda Item: Adjourn Open Meeting

DR. CHIDEHA OHUOHA: All right. I promised for us again to end on time, and hopefully, we'll save these 10 minutes. I want to thank every NAC member and guest for a very productive day. I realize how busy everyone is, and I appreciate the fact that you took time to be with us, either in person or virtually. Your experiences and insights will be very valuable to us as we continue this work towards improving the lives of the vulnerable population of this nation.

If there are no further comments or questions, I will ask that we adjourn.

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

MS. SHARON LEGORE: Second.

DR. CHIDEHA OHUOHA: All right. Thank you very much.

[Whereupon, at 4:07 p.m., the meeting was adjourned.]