SAMHSA/HHS: An Update, Including the Opioid Crisis

Jon Perez, Ph.D.
Regional Administrator HHS IX
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

PAIHS Integrated Care Summit
5-15-18
Serious Mental Illness:

- In 2016: Over 11 million adults with SMI and over 7 million children and youth with SED
- 35.2% of adults with SMI did not receive mental health treatment
- Lack of use of evidence-based practices: Nearly a third receive medications only with no psychosocial or psychotherapeutic services
- Only 2.1% receive AOT and 2.1% receive supported employment services
- 2 million people are incarcerated every year; 20% SMI and up to 50% with SUD; only 1/3 of those will get any treatment for mental illness
- Creates a revolving door of incapacity, with consequences of inability to be stably housed or employed
- Higher rates of suicide – people with serious depression and/or psychotic disorders have a rate 25x that of the general public
- Higher rates of co-occurring mental and physical health problems: people with SMI die 10 years earlier than the general population

Opioid Crisis:

- Over 2 million Americans have an OUD—only 1 in 5 receive specialty treatment for illicit drug use
- 63,632 drug overdose deaths in 2016 – 44,249 (66%) from opioids
• Establishes an Assistant Secretary for Mental Health and Substance Use to head SAMHSA. Requires the Assistant Secretary to:

  – Maintain a system to disseminate research findings and EBPs to service providers to improve prevention and treatment services
  – Ensure that grants are subject to performance and outcome evaluations; conduct ongoing oversight of grantees
  – Consult with stakeholders to improve community based and other mental health services including for adults with SMI and children with SED
  – Collaborate with other departments (VA, DoD, HUD, DOL) to improve care to veterans and service members and support programs to address chronic homelessness
  – Work with stakeholders to improve the recruitment and retention of mental health and substance use disorder professionals
Refocusing of SAMHSA

- Efforts to develop a system to disseminate research findings and EBPs to service providers to improve prevention and treatment services: National Mental Health Substance Use Policy Laboratory

- Focus on the most seriously ill/tackling the biggest issues in behavioral health:
  - People living with SMI
  - Opioid Crisis
• Will promote evidence-based practices and service delivery models through evaluating models that would benefit from further development and through expanding, replicating or scaling EBPs across a wider area
  – SMI: Particularly schizophrenia and schizoaffective disorder as well as other serious mental illnesses
  – EBP and service models for substance disorders with focus on OUD
• Establishing EBP online resources
• Review of and modification to data collection tools
• Closer relationships with NIH
SERIOUS MENTAL ILLNESS

Creating a system that works for everyone living with SMI and SED and their families
• 21st Century Cures Act required establishment of a Public/Federal partnership to review current programs/practices within the federal government and encourage more collaboration between agencies
  – SAMHSA will lead these efforts over the next 4 years
  – Collaboration with HUD, DOL, DOE, CMS, DoD/VA, SSA
  – Plan to bring Administration for Community Living and Administration for Children and Families into the efforts
  – December 2017 Report to Congress with 45 recommendations: Federal collaboration, treatment issues: access/engagement/EBP, justice diversion/services, community recovery services, finance models
Importance of ISMICC

- To keep federal government focused on SMI needs
- To provide feedback about ongoing issues; participate in SAMHSA activities related to special topics in mental illness
- To help in urgent issues: working with SAMHSA leadership and staff on approaches to problems, media contacts/communications with the public, implementation/dissemination
Plan to Address SMI

- Address SMI prevention potential
- Increase access to treatment:
  - Increase treatment capacity
  - Innovative approaches
  - Healthcare practitioner education
- Reduce suicide
- Training and technical assistance to communities
- Justice intervention programs for those with mental health issues
- Enforce parity laws/work with insurers on best approaches to coverage for SMI/SED
• 21st Century Cures Act required establishment of a Public/Federal partnership to review current programs/practices within the federal government and encourage more collaboration between agencies
  – SAMHSA will lead these efforts over the next 4 years
  – Collaboration with HUD, DOL, DOE, CMS, DoD/VA, SSA
  – Plan to bring Administration for Community Living and Administration for Children and Families into the efforts
  – December 2017 Report to Congress with 45 recommendations: Federal collaboration, treatment issues: access/engagement/EBP, justice diversion/services, community recovery services, finance models
SAMHSA funds programs to assist states/communities with provision of mental health care:

- Block grants to states: MHBG increased by 305.9 million to 1.49 billion for FY 18
- 10% set aside for SMI: FEP
- Children’s Mental Health Services: increased by 6 million to 125 million for FY 18
- Integrated Care Programs: CCBHCs allocated additional 100 million for FY 18
- Assistance in Transition from Homelessness
- New Assertive Community Treatment: 5 million FY 18
- Assisted Outpatient Treatment
- Suicide Prevention Programs
- Criminal Adult and Juvenile Justice Programs

- New Infant and Childhood MH program (Cures) $5M
- AWARE increased by $14M in FY 18 to total of $71M; MHFA-type training programs increased by $5M to total of $20M
- Healthy Transitions increased by $6M to total of $26M for FY 18
- NCTSI increased by $5M to total of $54M for FY 18
Increase Access to Treatment

• Innovative Programs:
  
  – Certified Community Behavioral Health Centers
    • Integrates mental health, substance use disorder, physical healthcare
    • Requires that all aspects of a person’s health be addressed
    • Requires 24-hour crisis intervention services
    • Community recovery services connections
    • Peer supports
    • 2-year demonstration and evaluation
    • FY 18: increase funding to additional states to help in program implementation

  – Support of programs to integrate BH into primary care
Reduce Suicide

- National Lifeline
- Grants to communities/tribal entities to prevent youth suicide
- Zero Suicide: training of healthcare providers to:
  - Ask about suicidality
  - Make safety plans with person and family
  - Assure that person gets to treatment
  - Follow up contact to verify
• Adult and Youth Treatment Court Collaboratives:
  – Focuses on connecting with individuals early in their involvement with the criminal justice system

• Early Diversion Grants:
  – Establishes or expands programs that divert adults with SMI or COD from CJ system to community-based services prior to arrest

• Assisted Outpatient Treatment: civil commitment to outpatient treatment
  – Implements and evaluates new AOT programs
  – Identifies evidence-based practices with goal to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and CJ system interactions
Develop a national network of training and technical assistance to assure that behavioral health professionals are equipped to meet patient needs

- Repository of evidence-based practices on which to base program services: NMHSUPL
- Clinical Support System for SMI/Center of Excellence for Psychopharmacology
- Regional networks of local trainers to assist colleagues in their communities

Increase BH workforce: encourage more psychiatry residency training positions; loan repayment programs for BH professionals
Financing Care and Treatment of SMI

• Enforce existing parity laws
• Work with insurers to educate about SMI
  - What clinical evidence there is for treatment approaches
  - Encourage insurers to require use of evidence-based models of care inclusive of both medication and psychosocial services
  - Encourage insurers to manage spectrum of needs of those living with SMI to assure psychiatric care, physical healthcare, and recovery services in community (e.g. peer support, case management, housing, education and employment)
  - Encourage payments for behavioral health services that are equivalent to those for medical services
Mental Health Services Budget

• FY 2019 PROPOSED PRESIDENT'S BUDGET
  – MHBG is restored to $562M
  – Healthy Transitions restored to $20M
  – ACT increased from $5 to $15M
  – MH CJ increased from $4 to $14M
Opioid Crisis

• 2.1 million Americans with Opioid Use Disorder (OUD)

• Only 20% with OUD received specialty addiction treatment and only 37% of those received MAT

• Over 63,632 drug overdose deaths in 2016 of which 42,249 – 66% from opioids
MILLIONS CONTINUE TO MISUSE RX PAIN RELIEVERS WHILE HEROIN USE CLIMBED THEN STABILIZED

11.8 MILLION PEOPLE WITH OPIOID MISUSE (4.4% OF TOTAL POPULATION)

- 11.5 MILLION Rx Pain Reliever Misusers (97.4% of opioid misusers)
- 6.9 MILLION Rx Hydrocodone
- 3.9 MILLION Rx Oxycodone
- 228,000 Rx Fentanyl
- 641,000 Rx Pain Reliever Misusers & Heroin Users (5.4% of opioid misusers)
- 948,000 Heroin Users (8% of opioid misusers)

HEROIN USE – PAST YEAR

- 2002: 828,000
- 2015: 404,000
- 2016: 948,000

Heroin Deaths:
- 2002: 2,013 (est)
- 2015: 13,101
- 2016: 15,469

1.4 fold increase in heroin users
6.7 fold increase in heroin deaths
Deaths in 2006

Estimated age-adjusted death rates for drug overdose
Deaths in 2016

Estimated age-adjusted death rates for drug overdose
Known or suspected exposure to fentanyl in past year (n = 121)

<table>
<thead>
<tr>
<th>Behavior or experience</th>
<th>APR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular heroin use</td>
<td>4.07</td>
<td>1.24–13.3</td>
<td>0.020</td>
</tr>
</tbody>
</table>

Source: Carroll et al, Int. J. Drug Policy, 2017 and CDC Epi-Aid 2015-2016 OH and MA
The crisis in context

Drug overdose death rates from 1968-2016

Drug overdose deaths per 100,000 population (age-adjusted)

Heroin

Cocaine

Opioids

HHS.GOV/OPIOIDS
Treacherous potency

Lethal doses of heroin, fentanyl, and carfentanil
[LEFT TO RIGHT]
Nonmedical Use of Prescription Opioids Significant Risk Factor for Heroin Use

3 out of 4 people who used heroin in the past year misused prescription opioids first.

7 out of 10 people who used heroin in the past year also misused prescription opioids in the past year.

2016: 2.1 million with opioid use disorder

What is Needed at the Federal Level?

HHS FIVE-POINT OPIOID STRATEGY

1. Strengthening public health surveillance
2. Advancing the practice of pain management
3. Improving access to treatment and recovery services
4. Targeting availability and distribution of overdose-reversing drugs
5. Supporting cutting-edge research
Complete strategy

HHS Five-point strategy to combat the opioids crisis

1. Better addiction prevention, treatment, and recovery services
2. Better data
3. Better pain management
4. Better targeting of overdose reversing drugs
5. Better research

HHS.GOV/OPIOIDS
Plan to Address the Opioid Crisis: Getting it Right

1. Assessing the Need
   What do Americans know and understand about risks of prescription pain medications and heroin?
   What is the current state of service delivery for OUD?

2. Establishing effective practice
   Prevention education
   First responder training
   Naloxone
   MAT/psychosocial supports/community recovery supports

3. Workforce
   Is there a trained workforce ready to take on OUD in a variety of medical settings?
   How do we train the workforce?
   How do we assure that individuals with OUD are detected and get to the care/services they need?

4. Increasing Prevention/Treatment/Recovery Funding/Resources
   How much funding is needed to address the epidemic? How should that funding be distributed? How do we determine that money is being spent appropriately and obtaining desired outcomes (metrics/data analysis)

5. Implementation
   Rapid, efficient service delivery
   Timely, safe, and effective interventions
   Close observation and modifications in real time
FY2017

Estimated HHS opioid-related funding (in millions) for 2018 & beyond

$3.6 B

- Improve treatment & prevention efforts
- Find alternative pain medications
- Workforce Needs
- Behavioral Health
- OTHER

HHS.GOV/OPIOIDS
STR Region IX Awards

Arizona $12,171,518
California $44,749,771
Hawaii $2,000,000
Nevada $5,663,328
Plan to Address the Opioid Crisis: FY 18 Increased Resources

- Substance Abuse Treatment: $3.18B, an increase of $1.05B from FY17
- New $1B Opioid grant program
  - $50M set-aside for tribes
  - 15% set-aside for states hardest hit
  - Includes prevention, treatment, and recovery language
- MAT PDOA increased by $28M (total: $84M)
- PPW increased by $10M (total $29.9M)
- CJ increased to $89M ($70M for Drug Courts)
- BCOR (peer specialist training programs) increased by $2M (total: $5M)
- MFP: addiction psychiatry, addiction medicine, psychology ($1M increase to total of $4.5M)
- Reinstatement of Drug Abuse Warning Network (DAWN) at 10M
Plan to Address the Opioid Crisis: President Trump’s Budget Proposal

• STR grants to states: 500 M/yr through Cures FY 17 and 18; President’s budget continues increased funding at 1 B in FY 19
  • Public outreach: prevention/education/treatment/recovery services
• Overdose Reversal Drug Access Programs: increased from 24 to 48 M in FY 18
• President’s budget: increase to 75 M FY 19
• MAT-PDOA
• Block grants to states
• Pregnant/post partum women/NAS: increase from 20 to 40 M in FY 19
• CJ programs with MAT; increase from 60 to 80 M in FY 19
• Recovery Coaches
• HIPAA/42 CFR: Family inclusion in medical emergencies: overdose
• FY 19 DFC proposed as new program to SAMHSA at 100 M
• New Injection Drug/HIV Program at $150M
• Consistent with President’s Opioid Commission Report recommendations
Healthcare Practitioner Training/Preparation

- STR Technical Assistance/Training Grant: individualized training according to state needs by local teams of addiction treatment providers
- DATA waiver training in pre-graduate settings: medical, NP, PA programs
- Encourage national certification program for peer workforce
- Establish training on recognition and treatment of substance misuse/abuse/use disorders in healthcare professional training programs
- Integration of BH including OUD treatment into primary care/FQHCs
- Use of telehealth/HIT: alternative training method/increased access to care
Distribution of 169 Active SAMHSA Tribal Grants*
by IHS Area (4/30/18)

*Does not include Urban Indian Health Organizations
What Does Evidence-Based Treatment Look Like?

Combination of FDA-approved medication (Medication Assisted Treatment (MAT)): for as long as the person benefits from the care

- Naltrexone: once a month injectable medication, blocks effects of opioids
- Methadone: long acting, once-daily, opioid from specially licensed programs
- Buprenorphine/naloxone: long acting, once daily/once monthly, opioid from doctor’s offices; available by prescription

Medical Withdrawal (“Detoxification”)

- > 80% relapse rate in the year following treatment
- High risk for overdose and death when relapse occurs
- Should not be a stand alone treatment

Addressing Safety: Naloxone dispensing
What Does Evidence-Based Treatment Look Like?

• **Psychosocial therapies/treatment components**
  Counseling: Coping skills/relapse prevention
  PDMP use
  Toxicology screening

• **Community Recovery Supports: Rebuilding One’s Life**
  Social supports to bring the person back into the healthy community: family, friends, peers, faith-based supports
  Recovery Housing
  Employment/Vocational training/education
  Assistance with needs that can impact treatment: transportation, child care

• **Patient-centered evaluation of treatment setting need: outpatient vs. inpatient/residential**
  Majority can be treated in outpatient settings
  Co-occurring disorders (need alcohol, benzodiazepine withdrawal)
  Co-occurring serious mental or medical illness needing treatment
  Homeless

---

SAMHSA Substance Abuse and Mental Health Services Administration
Medication Assisted Treatment: Effective and the Standard of Care

MAT treatment of Opioid Use Disorders in criminal justice population
- Methadone
- Buprenorphine/naloxone
- Injectable naltrexone

Medication treatment while in DOC; referral to ongoing care for OUD on release

Comparison of opioid overdose deaths first 6 months of 2016 vs. 2017:
61% reduction in opioid-associated overdose deaths upon release from incarceration

Overall 12% reduction in opioid overdose deaths in Rhode Island (2016-2017)

Importance of MAT and warm handoff to outpatient providers

Green TC, et al. JAMA Psychiatry, 2018
Medication Assisted Treatment Makes Recovery Possible

- Use of medication to treat opioid use disorder is not continuing addiction, not ‘substituting one drug for another’
- Opioid medications used to treat opioid addiction:
  - Block withdrawal
  - All three medications help to reduce opioid craving
- Use once monthly to once daily: eliminates compulsive use of drug multiple times a day
- Development of tolerance
- Numerous studies show that relapse occurs at high rates when medication is stopped
- Discontinuation needs to be done carefully and in collaboration with healthcare providers
- Treatment helps people to re-establish healthy lifestyles, work on rebuilding relationships, obtain employment, care for their families
- Opioid use disorder is a chronic illness; medication may be needed chronically
Signs of Progress: Opioid prescribing declining since 2011

Source: IQVIA National Prescription Audit, data extracted 2016-2018
Signs of Progress: Receipt of MAT from treatment facilities

Source: SAMHSA NSSATS
Signs of Progress: Consistent increases in number of patients receiving buprenorphine and naltrexone from retail pharmacies

Source: IQVIA National Prescription Audit, data extracted 2016-2017
Signs of Progress: Dramatic increases in naloxone dispensing from U.S. pharmacies

State laws changing on Naloxone at rapid pace

Source: IQVIA National Prescription Audit, data extracted 2016-2018
Signs of Progress

• Youth prescription opioid misuse declining over past decade; heroin use stable among youth

• Prescription opioid misuse initiation declining

• Plateauing of overdose deaths involving commonly prescribed opioids

• Some states seeing a leveling off of overdose deaths
Conclusions

- The opioid epidemic continues to evolve
- Urgent need to prepare workforce rapidly and deliver evidence-based prevention, treatment and recovery services
- Substantial efforts underway to combat the opioid epidemic, but gaps in the evidence base remain
- Some emerging signs of progress
- Work continues to aggressively address the epidemic
Evidence-Based Practices Resource Center

• New SAMHSA website launching today

• Aims to provide communities, clinicians, policy-makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings

• Contains a collection of scientifically-based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources

www.samhsa.gov/ebp-resource-center

Behavioral Health Treatment Services Locator
findtreatment.samhsa.gov