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Speaker 1 Okay. 115.

Speaker 2 Steve, can I just say that I would be remiss if I didn't thank. Even publicly, even though he's not watching Dr. Ken Minkoff, who is the international systems change expert on Co-occurring, who definitely mentored me through the process of creating the document. So instead of giving me the PHD, let's just give the props to him. I just. I feel like the lawyer in me feels the need to be forthright.

Speaker 1 That's very kind and thoughtful.

Speaker 2 Sounds like you take the credits. No, no, no. But really, Dr. MINKOFF, really?

Speaker 1 I met Dr. MINKOFF probably 20 years ago fighting this fight, which continues to go on. It's nice to know that he's still out there.

Speaker 2 Oh yeah. The Mid-Hudson whole R project. So I was funded to bring him in. So he works with us all the time. One of the tens a leadership summit. We're having one on July 25th and.

Speaker 1 Perhaps he's even watching. Thank you, Stephanie. All right. So let's try to work off of the, I think, positive energy that we created in the first half of the meeting. You know, I'm reminded that we have this remarkable opportunity, but also that we're not starting from whole cloth. There are some actually you mentioned Dr. MINKOFF, an international expert, but we have state and county and city experts throughout our county who have devoted their lives to this work. And I think that clearly we don't have enough of what we need. But I do think it's important to remember that we're building on the backs of many people, some of whom are in this room, who have devoted their lives to this work, takes the pressure off a little bit, but not that much. We don't have to start from scratch. So I left on your on your spot on the table. The we were able to get the minutes, in fact, from our last meeting. And and I want to give you an opportunity to take a look at them. I don't know. Did anyone get a chance yet? I'd like to review them and pass through if we can. We could do that later on in the afternoon. Or we'd like to take a minute right now. Looks like you are reading. Why don't we? Can we take five, 10 minutes?

Speaker 3 Can you send then?

Speaker 1 Sorry.

Speaker 3 Can they be sent?

Speaker 1 Well, I'm sure we can, but the idea. Oh. Who said that? Justine. Oh, I'm sorry. I didn't mean to forget you. Okay. So we could do it tomorrow. All right. Is that fair enough? All right. Well, I don't have them electronically, but we can.

Speaker 4 We'll handle it, OASIS staff will take care of.

Speaker 1 Great. Thank you for that procedural recommendation. All right. So we were we were talking about the charter and Stephanie's contribution. I did ask in previous communications with you all to think about the charter and come ready to to suggest modifications and edits. And I invite others who might have as well either prepared

something or wanted to comment in particular about the last iteration of the charter. Are you standing for? Anybody? Yes.

Speaker 4 Sure that hurts me more. And it's not urgent.

Speaker 1 I'm not. No, I'll clarify my comment. I didn't know until last night that Stephanie was really anything. I'm glad she did. But I had invited you all to bring your thoughts, ideas about modifications. Given that Stephanie has made a substantial suggestion, that does require us, I think, to digest it and think about it and ultimately approve the charter at a future point, hopefully soon. But the request still stands through all of you. What else do you think about the document? And Ashley, please.

Speaker 5 And you also said to bring our recommendations. Right. So we can move forward with recommendations.

Speaker 1 Yes. Yes, absolutely. I just wanted to again, we I wanted to see if there was anything in addition to Stephanie's. So.

Unidentified Yes. What's that?

Speaker 1 You can't hear.

Speaker 2 From the prevention lens, I would ask that you add in risk and protective factors, strategic prevention framework and evidence based practices. Thank you.

Speaker 1 Ashley.

Speaker 5 I just wonder if it would be helpful if we had a working document so that we could all add our suggestions, kind of see other comments. Is that something that we would be allowed to do?

Speaker 1 I don't know if it's allowed is the question. I'm not a big fan of that because that can get endlessly complex.

Unidentified I don't know.

Speaker 1 You know, that is, I'm told, not allowable.

Speaker 3 Like meetings, conducting business. Outside of the public rise, we will be exchanging ideas, making suggestions, those kinds of things.

Speaker 1 Right

Speaker 4 So I think that where we were I'd like to pick up that is, I think Torian and Dr. Easterling, I mentioned as well as others, that we can develop a vision statement.

Speaker 1 I'm sorry.

Speaker 4 Develop a vision statement or a paragraph on vision. And prior to that, that rested on notions of what the spirit of the charter should. We should folk. I think we should sort of keep it as generic as possible. But with due attention in the vision statement to Dr. Brown's comments around equity and social determinants of health protective factors. And

I a and I also like to add, and I think someone said recovery. I think that I also want to add something on on harm reduction as well. I'm Mary with that statement.

Speaker 1 So the the the general. Justin, please.

Speaker 3 I want to bring up that idea again of separating the charter from the mission statement charter. From the vision mission.

Speaker 1 Can you say more, please?

Speaker 3 Is it worthwhile to just take a look at at the document that lays out the steps of what will happen for the year separately from the sort of northstar of the vision and mission, just to get a piece of work done. If that if people don't have lots of. Suggestions for the. The charter itself. Just a thought.

Speaker 1 You know, Justin, if I could ask you, you had contributed some of the initial ideas about the charter. Uh, actually, I think even the idea that we should have a charter, the by the bylaws are in our. In our charge. We decided, am I correct to come up with a charter to help with kind of put a rubric.

Speaker 3 That was the idea that.

Speaker 1 I'm sorry.

Speaker 3 Dan and Deb both suggested that we had. Right. A mission vision. Right.

Speaker 1 So I guess I'm leading up to a question. Could not the charter document be truly an organic document that in our initial stages of growth, we continue to add to it where the bylaws had to be approved and are? He created.

Speaker 3 And I agree with that. I agree with that. If it were something just like that in within the charter itself, things, it's annually updated or something like that know like we accept it for right now, but we're going to look at it again in a year and update it again. Because what I worry about is what I, what I want is a process. And I'm worried that if the process go, if we don't say we're going to have a process, it's important to have a mission and ambition, but it's also important to have a process. And so I'm worried that a process could be eliminated. And I don't care really what the process is. I just want to be sure there is a process.

Speaker 1 Well, I guess part of my question, Justine, is do we have enough now to take back and develop another version of the charter for our digestion the next time we should meet and continue to try to refine it and get on today to talking about recommendations, or are you suggesting that we in fact work to finalize the charter? I'm just trying to understand the difference.

Speaker 3 I had been I had been suggesting that if if there weren't that many questions about the actual how work would be done part that it might be good to get that done and then separate the various mission vision. But if there's lots of that, there is more drafting needed, then absolutely continue as you're going.

Speaker 1 Thanks, Justine. What do people think at the table? Avi, I, I, I think that we should table the charter for today. I think some of the stuff that Stephanie brought needs to

be looked at, and, and I'm not prepared to admit the whole thing as a whole. I would like to look at it and maybe make some adjustments. And so if we can skip that and move on to the next business. I would really I think for all of us, I really would like to move on to the next business. We seem to be getting stalled with the mud over here. Okay, well, we could shake them off.

Speaker 2 I just have one. So making recommendations and I'm not trying to be like a pain with this, but making recommendations without an overlay on. What our common vision is seems a little challenging. That's not to say that we shouldn't have the presentations, but I think that if we're going to spend and this is what I wrote in one of the emails, we're going to spend 6 hours on recommendations. What's. I'm sorry, Dr. Easterling, to once again look to your department, but what's our litmus test? And so I don't know how we kind of rectify that kind of gap.

Speaker 1 I hear you. And I also am sensitive, though, to the fact that we are, you know, three meetings into the probably the part in our life span of this board that we need to get the most work done in the least amount of time. Next year it'll be it'll be a little bit easier, hopefully, and subsequent years and subsequent boards. So I guess I wonder if you would consider doing both. I'd like to I'd like to start the discussion of what's important to us in terms of our recommendations. We might find through our discussions a little clarity on our vision, which we could then you've been through with our charter, and you're going to see.

Speaker 3 What I think to to your point, what we're missing is a work plan that has key objectives accomplished by certain times, because I think we have to force ourself with some structure to say, well, if we need to do that, if we need to make recommendations about the money, what is absolutely essential. Prior to that, I'm going to say that I think there's nobody that would disagree with a lofty mission or vision goal. The problem that we're missing is a lot of the data, what's already been invested in what the like. I'm completely unprepared to make recommendations without information. So if what we're going to be doing is hearing presentations that will inform I'm interested in in that. But I will just going to say I'll abstain on every single recommendation until I know what we're talking about, because I am not going to be responsible to misappropriate or waste this kind of money.

Speaker 1 Now, if I just say with one thing to discuss recommendations and another to make recommendations, and I guess I was talking about discussing that.

Speaker 3 I'm sorry. Hi. Sorry about that. So along those lines, in terms of what you just said and what the comment and made before, I'm wondering if it's positive. It's possible for us to begin to have the discussions and then those discussions can then drive us in a direction of knowing what data information we need. And then that will then filter into recommendations because I think. We still have to formulate to some degree what information we need to get from the state. And I think what can drive that is based on where our discussion around recommendation recommendations are going. The other thing I just wanted to mention. Housing. We do have housing. It's listed as part of our the original China piece that we have. And as we're thinking about it, I wonder if we could think about what types of housing setups we're thinking about, because housing is really broad and it varies, you know, for different parts of the state. So I think as we are, you know, thinking through the China piece, I would also suggest that we think about housing in a little bit with a little bit more meat to it in terms of what we're thinking about with regard to housing.

Speaker 1 Dr. Brown, please. I think we have a bit of a conundrum. On the one hand, I think there is a sense that we need some kind of guidance to make recommendations that is, in fact, and talks about the data. And I want to underscore, the data is not just the availability of services. The data also has to speak to the issues about the liabilities or the risks that exists. So we need it from that standpoint, as long as if we go forth with making are discussing recommendations. And I think it would be useful to say to what extent this touches what particular spirit on North Star. As long as we do that. And I do agree with the issue about housing, because one of the North Stars, I think, should be the issue about the social determinants. If we're not actually also focusing on those, then we're missing some of the spirit upon which we can then deal with these unmet issues. I agree entirely. Yes, sir. Harvey, we first heard the presentation that this whole show had was supposed to give us, because then we can really find out how the money is being divided, what's going to happen, and then we can start putting in a recommendation. You know, right now I'm looking at okay, we all have idea of how to make your recommendation, how to spend money, how to do this. But we really don't know what Oasis has in mind or or my age or anybody else. I don't know what anybody has in mind, and I can't speak to that. I mean, we can come up with the idea and give it to you and say, here is our here's my one recommendation for whatever. I hear you. I appreciate that. I guess I, I, I sense the conundrum that Dr. Brown was talking about. But again, I think there's there's a place for us to move forward here. I think I know what's important to some of you. I don't know for sure. I think having that dialogue as a board to begin to refine our sense of understanding of where we're all coming from and what we think is important is not the same as obviously is not is not the same as recommending a program or a. But for example, there are so many things we've talked about social determinants. I would like to go deeper into that. The harm reduction, the peer movement, all of these things I think are worthy of sharing our expertise and perspective, and we refined that down eventually into recommendations when we hear the budget report. Okay. So I would say then, Steve, you start pick a subject, okay? Because I mean, we could start right from prevention and move on to access to treatment. Yes. And move on to, you know, housing after treatment, support in recovery support, transportation. I think both are worth all of that stuff. Yes. I mean I mean, we all have ideas of what to do. And so I tell you what, I'm going to throw the ball to you. And I would love for you to start if you're sure. It's just a ball. Just the ball, buddy. No, just a ball, my friend. That said, I actually have. Yeah.

Speaker 5 I do. I have a question. So when we are talking about even just discussing recommendations, you know, and I think housing needs to be, as you said, it's broad. So it can't just be housing after treatment. You'll notice that it says all stages of housing in the actual legislation that is on purpose. I was told that harm reduction housing couldn't be listed that way because there would be a debate on the floor. So anyways, housing and just in general. But what I want to say is we're also not 100%, at least I'm not. Are we going to be able to provide recommendations on all of the funds? Yes, we have to have. Right. The presentation by by DOB, you know. But what does that look like when we're discussing recommendations? Because I'm sure it's going to be very different if you guys come back and you say, oh, well, it's only the 45 million of unallocated funds or so I would we be able. I think what I'm understanding is that we can make recommendations on the score card, but that would mean that we would have to go within their parameters.

Speaker 1 I'm sorry, go ahead.

Speaker 5 But so I just want clarity because I'm all about having discussions. I think we all have. We're chosen for a reason, you know, but I want to ensure that we're not just kind of

talking and skirting the issue, not even knowing the amount. I mean, I have questions on like future investments. What does that mean? I even have questions on data.

Speaker 1 Right. I appreciate that. I think. And Justin, I'll get to you in a second. I see your hands up. Um, I guess I'm trying to direct the conversation to what is in front of us at this moment. I think we are going to hopefully get the budget discussion tomorrow. We were hoping to have it today. I think in the absence of that, maybe there is a blessing to some degree that we could start to less. Let's formally explore what's important to us. I don't think we've done that. And that might serve a number of purposes so that we can then refine it down to, I think, the the issue of how much we have to spend, although critically important, has very little to do for me with what's important to me about spending. And, you know, so it's almost like two separate discussions. And the the only one we can have today is the one about our ideas for recommendation. So that's kind of where I'm coming from. Justine, you had a comment, please. You're on mute.

Speaker 3 It feels like there's a circular conversation going on. And what I think is happening or what I'm interested in seeing is an operationalising of the board. And I think a lot of people are saying sort of the same thing and different words in what it sounds like we need in order to operationalize the board is we need a charter and a mission where we out by what is what are the overlays that's important that are important to everyone. What what is in Stephanie's great document and all in social determinants of health. So we need that mission and vision. We also need a workflow, which I thought was the charter, but it's just a workflow which is asking for a certain amount of data from each of the agencies and having recommendations come to us in a certain way, and then having these really final conversations over with the public health overlay, how we want to make decisions and then making our recommendations. And in addition to the work plan, we probably need, I think and suggested it a timeline. And so I think it's how do we operationalize all these things but not get too focused in this conversation itself about why I want this data or that data, it might be more like, okay, that will go in the workplan or this will grow here. And I think what I'm hearing from you is you want to focus on the mission vision for today. My wrong in terms of.

Speaker 1 I'm sorry. Are you are you directing that to me?

Speaker 3 Why? I guess I feel like we're I feel like what we're looking for is what are the items that we need operationally to move on? Do we need a mission vision? Do we need a work plan? Do we need a timeline? And. And it feels like those are the things that we need.

Speaker 1 I don't disagree. I just I just don't think we have all the information today that that will help us in that regard. I mean, yeah, Ashley.

Speaker 5 So what I'm hearing, let me just make sure, because that's I'm asking more of a question. So we are going to discuss the things that are important to us today that could lead to recommendations. We will have a rubric and a charter to overlay what is important to us to see if it meets our litmus test. And then make recommendations from there that kind of like, am I? Because I'm just trying to.

Speaker 1 I think that that's the only thing you're missing. There is the timeline. And the timeline is, I think, you know, somewhat important because we have at least you look.

Speaker 5 In a in our rubric wouldn't that when we.

Speaker 1 Well the workflow requires a timeline.

Speaker 5 Right. So that's why I thought it would. That's not included.

Speaker 1 No. Okay. Yeah. As long as it's in there. I think we have we have as we've was pointed out before, we have a November 2022 deadline for a report. I had an opportunity to talk to Peggy or Shay between our last meeting in this meeting, and I need to hear her say all this again, hopefully. But I understood that we have at least two crunch points here. The November deadline is the latest point that we could make recommendations for the current budget year, but also to start making recommendations for the next budget year. And what's in front of us now is as soon as we can get something, you know, on paper and recommended, it could influence the decision makers for this year's budget. And that gets into what on the score card are we able to actually spend or not? Because I think a lot of that scorecard was loaded in an effort to spend something, but unfortunately wasn't with our discussion. With our input, yes. Oh, I thought you guys had some. So I think.

Speaker 2 Steve, can you just clarify what you just said at the end? Because you said without our input, but now the understanding is that it is with our input. And so yeah.

Speaker 1 I'm saying up until this point up, up until where we were last meeting, there was a sense that there were things put into the scorecard. We hadn't had an opportunity yet to talk. We were prepared today, as many of us have shared, to be led to believe that everything was open for review and discussion. Right. But but I think there's to spend points. Look, I'm not the money guy, but but I understood there is we could start doing recommendations now. And then there's a report formally that is in November. So I'm just going to cloud this more if I keep talking. So I'm sorry. Good. Absolutely.

Speaker 5 So I think just guessing is important. And I do take this role pretty seriously. So I went out to my community because you guys all know my motto is nothing about us without us. And there were a lot of commonalities. And in terms of what people would like and families want, the dollars to go where a waste is is not already budgeted in terms of like support for families, you know, different things. A lot of the stuff that I got too was like harm reduction based even with some of the syringe exchange programs that we have, right? Like the mobile. They might only go like, let's just say Troy, because it's close, right? They go there. I'm I think it's twice a month. I mean, I'd have to double check, but somebody was like, you know, I'd like them to to come more. I mean, we really need to, you know, start looking at that kind of stuff. So is that the kind of stuff that we're going to do moving forward?

Speaker 1 I personally would love to discuss these kinds of items. Okay. Yes, please. Tricia.

Speaker 6 I just need to offer two clarifications, and I will also clarify that I am not the money person. I don't do math for a reason because I'm bad at it. But two clarifications. One, there's a difference between disbursement and allocation. So I just want to point that out. Money has not been spent. There are pots that you guys talked about before. So you guys, I think our hope for you, your hope is to have a conversation about that money. But with the exception of the money that runs directly through the algae use, which does not touch the state coffers at all and is therefore not something that we have any control over.

Speaker 1 Although I will just tell you that I was I was led to believe this is where we get into treacherous ground. I was led to believe that although we don't have the same touch on that money, that there was an interest in what the board's recommendation and guidelines were so that Oasis could share that with the localities. So that and I will tell you one last thing. In my county, I know that. And I'm sure that there's others around the 57 other counties, not including New York City, that are looking to us to come up with some direction. So whether we can we. We can spend that money or not. I think we have an important voice in how this. Hope settlement is conceived and spent.

Speaker 6 I believe that that is a bird pot of money. So there is the money that goes to the locals directly outside of the state funds. And then there's a money pot that goes to the LGUS then. Then there's the other money.

Speaker 1 I believe that is true too, as the three in a row. And then we have to go to other, go ahead.

Speaker 5 No. So I again, because the AG has a treasurer. I'll just say that again, we were involved in the advocacy, so there is the Treasurer. Then there's the monies that go to the local governmental units through this actual fund and it doesn't matter anyways. So what I wanted to say though, right, is that there there is commonality from the community. I would like to mention that out of I think it was seven of individuals that are actually involved in current program. I think seven of them had mentioned that they would like, you know, co-occurring or psychiatric help the harm reduction services. So I think it's really important that, you know, as we're going forward and I get it, like, I mean I think I'm coming at this probably from a different lens than a lot of other people because I am in the trenches. But I think it's really important to have those that have been afflicted and those that have, you know, historically been sort of oppressed and disadvantaged. Like it's really important to bring their voice to this table and how we will move forward in spending these money. So in terms of the scorecard, like expansion of treatment. Right. Let's I'm just going to target that because it's the first one, 60 million it could look like for this. You know, an X amount is going to be for harm reduction. We could add another agency and like D.O. H. I would also like, you know, just to go on the record and say, you know, for the the matters, they're currently under docket. So I think that, you know, that money could be given to D.O.H directly and then let them do a procurement process. Because Tricia, I believe, like our first meeting said, not to go to specific organizations, it was to be generalized. So I think just offering MAT and then being able to look at metrics. But so there's we do get to offer suggestions on that, right?

Speaker 1 I think we are offering them now.

Speaker 3 Mm hmm.

Speaker 1 Avi you threw me the ball I hit out of the park and you left. Got a very good call. Know. Oh. Good for you. Good for you. Congratulations. Yes, Deb.

Speaker 3 Thanks. Thanks, Tricia. I just want to go back to the LGU conversation for a little bit and thank you for that point of clarification, because I think it's it's good to clarify it here and also publicly, because I think as as providers and family members and and folks in the field begin to hear the news release about these funds. That folks understand exactly where these recommendations for these moneys and where they're going are coming from and not pointing to because I've gotten some of those already. Well, we heard that this organization or this place got this money. You know, did that go through

your counsel? I mean, so I think it's really important for us to to clarify this. But I also think it's important for us to understand where the LGU's are putting some of their funding so that we don't duplicate or we support their effort or we we figure out if they're doing something that they are funding in an area and it's not, you know, probably hitting the mark fully that it might be something that we might support in a smaller fashion to then make it whole or just don't duplicated at all. So I'm wondering if there is some sort of information that can come back to this council about where the LGU's are spending their money.

Speaker 6 It's actually required under the statute. There's a report that the state agencies do, but it also relies upon receiving information from the locals in terms of what they did with any money that they receive. So it's not something that is currently available because I think the money is new ish. Right. But but it is a mandate. So something that would happen going forward. So again, I would remind you, this board is going to be like an 18 year board. By the time we're done with this, the person would be able to go to college. So we don't have it yet, but we will.

Speaker 2 Happen. can i follow up on it just on

Speaker 1 Avi had a question

Speaker 2 Sorry.

Speaker 1 Stephanie.

Speaker 2 Thank you.

Speaker 1 There's one thing that that I'm looking at the old scorecard and something that's really bothering me. And I think we need to bring that up because I think it's a fact. It's it's really affecting everybody in New York State. And that is what are we doing to retain, train and keep workforce. There's nothing in this scorecard about workforce, you know, and it's very to me, it number one, a lot of the treatment facilities and including we're not treatment, but we are harm reduction in getting people into treatment. We can keep people working. And I'm not done yet. Steve, what are one of the things that that we would like to do is I mean, I see, you know, some peanuts over here for, you know, education. All right. It has to be a substantial amount of money to go out to providers. How are we going to do that? I don't know. We would like to hear if the state has any suggestion or anything like that. But for instance, how do we how are we we provide our workforce training. How do we keep them working? How do we give them some good benefits so they don't have to go to Blue Cross Blue Shield or, you know, some in some other insurance company? You know, and that's important because in recovery, if you keep saying different, you keep seeing different faces all the time. There's no trust. You know, and the one thing that we want to establish with people in recovery as you help a safe person and and if you come in there and every week there's a new face, the person goes right back to using. So I'd like to see a chunk of money that goes towards maintaining training, maintaining labor and them some decent salary. Harvey, thank you for that. I actually didn't say anything when you left the room, but if I had, I would have underscored this. This is one of the biggest challenges that we face in my county and I hear from my counterparts across the state, and it's actually true to it. You can have that one. It's devastating. It's devastating. And I think the issues are are are not on resolvable, but they're multifaceted. This has to do with not only retention in terms of paying school living salaries, but it has to do with our educational facilities and valuing the work that we are all finding ourselves in. So it is training, it is education, it is salaries. Without a workforce, none of what we do, which I mentioned

earlier about a firm foundation for the next 18 years without addressing workforce. That foundation will be weak. So I second what you have said. I think it's one of our biggest and it's not just in the addiction co-occurring world, you know, all all throughout human services, but certainly in our world. Yes. Dr. Smith.

Speaker 2 Thank you so much for mentioning what you said. I'd like to go a little bit deeper on that and talk about diversity and inclusion and language access, because, yes, we don't have a behavioral health care system, quite frankly, that looks like me, that speaks the languages that I do. I'm also here on behalf of my community, which is a community that has the second largest deaf population in this country. And we don't have a deaf program. And in my county. And so when we're talking about folks that are hearing impaired and then deaf, we don't have a lot of places for them to go when we're talking about this. And so if we're going to talk about workforce development and education, we need to talk about that from a perspective of dealing with language access and and access for those of our are those of our citizens in this county or in the state who have hearing issues.

Speaker 1 If I could just respond and there's another speaker who would like to jump in to me. I don't think this kind of discussion is a waste of time. I know you could tell me otherwise, but it reminds me of why I'm doing what I'm doing. It reminds me of the challenges that we have in front of us. But, you know, we talk about co-occurring. It's much more complicated than mental illness and addiction. We have developmental disabled, mentally ill addicted people with chronic health conditions who are immigrants. The challenges are enormous. And I think we have to in our effort to to kind of, you know, break down silos. Remember that there are many silos that still need to be connected. And I appreciate your comment very much. Please you have. Microphone, please. You're supposed to watch this for me. We did have a person that was deaf. What we ended up doing is getting her a cell phone so we can communicate by text. And it worked out good. Yeah, but that's going to take money. Right? Yeah, we. I know that it's more than that. It's actually more than that.

Speaker 2 I mean.

Speaker 1 I don't think that was a quick fix.

Speaker 2 And they shouldn't have to either. They should be able to sit across from a therapist that can.

Speaker 1 Write Deborah.

Speaker 2 In sign language. So.

Speaker 1 Yeah. We have a comment with Deborah Davis from Oasis. Has some thought perhaps on the workforce issue or.

Speaker 6 Yeah, I'm the assistant commissioner for fiscal administration at Oasis. And I was just going to jump in when we were talking about sort of the scorecard and the pieces of moneys that are in the different pieces and whether they're enough or not. And I definitely you know, it's a national workforce crisis we're under and it certainly hits the study field in a very significant way. So. But I was just going to share that, I think what DOB you know, Peggy was going to be able to share was how all the money did end up, you know, being in the settlement agreements attributed to the LGU's. And there's a

couple of different ways or some where they were litigating entities and they went directly to the counties. Some are regional amounts of money. And so there was going to be an explanation about how all the parts have been developed through discussions they had in sharing charts with the AG's office and through lots and lots of research and understanding of the settlement agreements. Right, because nothing simple. And so they were going to run through how all that money flows. There were some moneys that didn't come through the state treasury at all. They were developed through a third party and released through that third party. Then there are monies that came directly through the opioid settlement fund. Right. And they're distributed through certain processes. And she was going to review the ones for the local government units and the municipalities. And and certainly is, as Tricia has already shared for you, a lot of the monies that the counties are receiving, there will be a reporting on what they've been funding. There's also going to be a national reporting mechanism as well that's being developed as part of the settlement agreements as well. And so, you know, that that's sort of the the groundwork that Peggy was just going to share with you and share how that money was developed, and obviously share sort of what was in the scorecard. And then that would be part of your your discussions, certainly. And you know, where there's money that you're thinking is falling short for activities such as workforce, you know, then that would be part of your sharing.

Speaker 1 Thank you, Deborah. We hope that we will hear her tomorrow. Thank you. Please.

Speaker 2 So the county peace, the multiple pots of money that come in. In a perfect world, we would have been charged earlier and started to do the work where the state we would be making recommendations and there'd be the state money and then the counties would get a vision of what's going on. So now we're kind of in the opposite situation where counties are creating plans with multiple pots of money, some of which we're recommending on, and some of which they have more discretion on their own on. How do we kind of forget about the fact that we're in sort of a backwards world and look at this so that we can be the most strategic possible, so that when they're creating their county plans, we can maybe access the ones that are ahead of the game. In meeting and doing so, we can see what those look like and see how they're anticipating using funds so that we can kind of guide what we're recommending on. I don't know, it just seems like there's multiple paths, but there's got to be a strategy.

Speaker 1 So again, you know, as part of a long term vision, I think, you know, as a representative of the conference, the mental hygiene directly through as well, I mean, that is a resource that we can and should be able to draw on because there are some counties that are a little bit farther along. But I will tell you that there are some counties I have no clue what to do with their money. So I think it was an.

Speaker 3 I have to weigh in on both of these conversations. First of all, regarding the county by county is recipient of one of the largest chunks of money. And I've already seen what they did with their money and there is no strategy attached to it. It's nonsensical. I'll give you an example. My organization runs the only 24 seven crisis stabilization unit in the area, and we received zero money despite ongoing workforce issues, despite needing the support of a 24 seven workforce. Without such, we don't stay open and people literally die. Okay. So I can tell you there is in every county no strategy and I would challenge them to tell me that there is. That being said, the other thing I want to challenge is this workforce problem. That is the nationwide problem. Okay. The truth is that we in behavioral health have had a workforce problem for 15 years. And the compounding of all of these issues in the national workforce is we were already at the bottom. We're below the bottom. Okay.

And now we have private equity companies coming in and picking off our trained therapists for their for profit ventures. Okay. If we want to talk quality, impact, access, accountability, we don't have therapists. By the way, if you're a trained therapist of color and you're trained in evidence based practices, you know what you can earn. And in the private sector, not with us, by the way. So, you know, let's let's put workforce on the table. I would love to, because as far as I'm concerned, you could take all this money that we're talking about and I have no idea. I'm still lost. Is the 45 million is it 200 million? I don't know. 45 million is less than my annual operating budget. And I'm spending this kind of time coming here for 45 million. I hope to God, not 200 million. It's literally a drop in the bucket. And then we could be done and go home and just say we need a workforce strategy because the investments are done in certain segment areas, tons and tons and tons and tons and tons of money. And I'll say empty is one of those areas with the opioid, federal opioid money and all of the target, tons and tons of money, record level deaths. Show me what else we're going to fund in that area, because I'm interested.

Speaker 4 Well, I have another suggestion. Sorry, I completely agree with with you on workforce development. I I'd like to add that when I think of workforce development, I'm thinking about the people we serve. I'm thinking about the people that come through our doors. I think that a job is the best way, the best way to go into recovery and manage your drug use and integrate. So that said, I am here for a reason to. We've never discussed. I thought we were going to return to the side letter. And did we have 60 million out of the 80 million? And I'm willing to put that on the side. For the moment. But I'm here to. And we need to. We haven't. The Bronx has the highest 46.2% opioid overdose rate. And so I think that I you know, the number of of of Bronx sites New Yorkers that are dying is is just simply unacceptable. And I and I would love to leave this meeting with a message to everyone, but to my constituents that we are going. That this board will make sure that we put money into overdose prevention centers. Without that happening. I don't think that we're going to move. I'm sorry for the pun. The needle in any way or make anything. It has to be integrated. I completely agree with my colleagues. But there is no way that these lives can wait and can sit on, you know, and living under such horrific conditions as they live. Workforce development would help these very same people, by the way. Absolutely. We should have money to give our people incentives, get them to work, introduce them to the work force. Those are things that are really important, as important as getting a a woman of color or a man of color to finish up there, you know, be able to get a good, decent pay at our agencies and not have to leave us because we know what all that we're offering is 70,000, which is completely an insult to somebody. Well, in New York City, that's a complete insult given the cost of living. But I don't want to we were talking about recommendations, and I want to make sure that that stays on this table that we need to support. And we need a commitment from everyone here for overdose prevention centers, and that that has to be part of the state budget. And and to my colleague in the city, part of that, the Easterling part of our priorities as a city, there is no way we can we we cannot not do that. And my other point is, is that I think that the State Department of Health is being shortchanged here. Right. I think that the amount of money that they're getting is given the monumental work that they have done in creating a harm reduction portfolio. And I mean and and I know that there are people on this table who have been working as long as I have on HIV prevention. And, you know, that we have all worked and the State Department of Health has managed an incredible growth of a portfolio that is the admiration of the nation. And so I think that my colleagues in the State Department of Health should have the funding. I mean, eight. This is just the scorecard is just simply an insult to their hard work and to our hard work in almost ending the epidemic and in really doing the hard work of meeting people, you know, really talking to people, engaging them, them. The integration that we do in these in our agencies is really never we don't get to

publish it because we're so busy doing it. Your colleagues, here are my priorities for you, and I hope that you will embrace them.

Speaker 1 Joyce, thank you so much. Well said. Dr. Brown, I think you had a comment. Please. Okay. Mr. Chair, this conversation we've been having recently underscores the fact that almost every issue that we deal with is very complex. So let's look at workforce. Workforce varies and communities across the state. First of all, what's the demand? And secondly, what's the supply? So I think we need to take into consideration we can't say one factor recipe will fit every community. We have to look at it, the complexity. So in many parts of the states for, let's say, New York City, we're competing with academic centers that are close together. There are seven medical schools in New York City that you are competing with. So there's a bittersweet thing on the one hand. Many of those centers recognize behavioral health. So they're, in fact, recruiting staff that happen to be staff that we're competing with as a small not for profit. So I think that we need to realize for every issue that we deal with, there's gonna always be an equity issue. What are the fact the assets, the predictive things that in fact help that factor? What are the fact? Are the liabilities? Are the risks that actually hurt that factor? And we're going to need to understand that. We're going to need to figure out a way to do that that actually helps all but citizens of the state of New York. But we won't be able to do it if we're going to, in fact, have Peter versus Paul. This is what it seems to me that's happening here, and that we need to make sure that we avoid that because we've seen examples of that in the past. Disrupt was promising to do great things. It, in fact, had. And it did some great things. It did. It involved many community based organizations. But when we look at the resources that were split between the academic centers, the large medical centers and the community programs, there is clearly a disparate difference between the two of them. So I think that we need to realize that when we talk about and please forgive me for being so passionate because I've been around for many years too. And the fact of the matter is that sometimes I think we think that we have a solution and we have to look at, well, if we had such a great solution, why haven't we done it in the past? Then we have to look at those things that actually were the mitigating factors or the prohibitive factors preventing us from doing it the best. So that when we talk about almost any topic, we just happen to be talking about workforce right now. But we have a complex set of issues that we have to deal with at the same time, one of which is the issue of equity. No need to excuse passion. Actually.

Speaker 5 Yeah. I just want to say that I totally agree with Joyce and to Dr. Brown. I think a lot of why we didn't do it in the past and I don't I mean, I don't want to offend anybody. But, you know, I'm grateful that you all have been doing this for a long time. But I don't want to be your age sitting at this table saying that, oh, I've been trying to do this for 30 years. You know, like literally sometimes when you guys say things, I'm like, Oh, like, you started before I was born. Cool. I want to start saving my friends lives today. And I think that why we have not been able to is because, you know, it was a different mindset back then. I mean, we had the war on drugs, like let's just be honest, right? That's that's not based in equity, that's for sure. And I think that we have an obligation to, you know, bring these new thoughts and these new ideas because, you know, my generation and generations after me, you know, are the future. And we need overdose prevention centers. We need to, you know, fund. And I think that syringe exchanges are the solution. I mean, they were fought against in the very early stages. People had to do it, you know, illegally. But we then were able to see the value in, you know, lessening the spread of diseases and different things. But I do want to I have questions actually, because we've talked about data and age. And so like per the, you know, data that was sent out and this has been something that's been like kind of like grinding me a little bit. So DOH has the opioid overdose prevention programs and they're all around the state, right. And that's what that

8 million. No, no, that's opioids. You're thinking of opioids? I'm talking about overdose prevention programs. That those are Narcan distributors. Sorry. So in there, all over the state. So the 8 million. So I went back and I looked at, like past budgets I want to see. Maybe I went back to 2008 or 17. I can't remember, but it's been there. Budget has only been $2 million. But I would actually would it be okay if I asked the Health Commissioner a question.

Unidentified The designee can I at this one. I don't have a.

Speaker 1 Problem with that. Just be nice.

Speaker 5 Can I?

Speaker 4 Yeah.

Speaker 5 So would you say that the state of New York only spends $2 million on your overdose prevention programs?

Speaker 4 No, we do not only spend $2 million.

Speaker 3 Okay.

Speaker 5 What would you estimate that the cost of running the program is each year?

Speaker 4 What I'll speak to is the cost of actually distributing naloxone, and so that runs about 13.5 million.

Speaker 5 So I would just go ahead.

Speaker 4 No, I was just going to say. So, in fairness, if you think about the program, the program was originally initiated back in 2006. At that time, of course, it was a much, you know, lesser known intervention. And the funding was, I think, at that time, maybe around $160,000 through the years. Of course, as we've seen the increase in in opioid overdose, the demand and supply. As was was mentioned before, has continued to increase tremendously. We, too, have been fortunate that our partners across the state have also been willing to to rise to the occasion, if you will, and increase accordingly. The cost of the program associated include, of course, the distribution of the product, as well as making sure that education, materials and an established system is available in the state for the ordering and supply. That doesn't include and I'll leave that as sort of a secondary is the cost to actually run the full process.

Speaker 5 So what I'm hearing and that's why I wanted to ask questions, right, because part of the law is that funds are not supplanted. So I just heard that it cost 13, right. They were only budgeted 2 million. The scorecard offered eight. So, I mean, you know, math eight plus two is ten. So that's still leaving them three short on. So I would question if that was the plantation. And to Joyce's point, I think that, you know, if we're going to talk about a public health lens, you know, I think it's very important to be funding appropriately. You know, the organizations that are have been dedicated for, you know, as long as I've been on this planet to really, you know, providing that person centered approach and these life saving tools and techniques. So that's what I wanted to ask you. So what like all right, because we're talking about it. So if you guys were going to, you know, like expand even

like syringe services, right? Because we've been talking about maybe even like mobile or different things, like what would be your ideal budget? Like, what would you need?

Speaker 4 So there are multiple. Chair. Am I? Okay, okay.

Speaker 1 Just don't get yourself in trouble.

Speaker 4 Well, there's always that. So, I mean, I think that that's a that's a very interesting question. And I think, as was stated earlier, there are multiple nuances to that. You talked about one particular program, that being the opioid overdose prevention centers and the distribution of naloxone, but understanding that the full continuum of harm reduction includes many other areas. Many of you, as you've discussed, certainly spoke to the syringe exchange programs. As we as we've seen in past in more recent years, many have met some of our syringe exchange programs, have also become health hubs in which individuals are assisted as an example, from the point of an emergency room or an emergency department directly to an individual working within those hub systems so that individuals are not lost to care and or individuals made to feel as though they are on their own as a matter of finding the resources. In addition to that, you know, I should specify and I apologize because I know many of you know.

Speaker 2 All these details, but.

Speaker 4 For those who are interested in this discussion and perhaps just watching, it's important to understand that syringe exchange programs are not solely about the distribution of syringes. What syringe exchange programs are about are providing all wraparound service. Since we talk about equity, I have heard you discussed health, social determinants of health, and that's what syringe exchange programs have always been since the 1990s. I heard the words evidence based syringe exchange programs have proven to be evidence based. If you look at some of the chronic illnesses that many of the individuals who utilize the programs have have lived with that significant decrease that we've been able to see in HIV as well as hepatitis C, because these are screenings as well as access to treatment that is offered through a syringe exchange program. Not to mention for the individuals who are homeless. For many, syringe exchange programs are the.

Speaker 2 Sites in the spaces.

Speaker 4 Where individuals who are homeless are able to access a meal, access particular treatments, be it clinical or otherwise, and perhaps do something such as take a shower. So as you can imagine, the last two years have been particularly compromising for many of the people that we serve, given the prevention interventions that were necessary to protect people from COVID. So to your original.

Speaker 2 Question of how much.

Speaker 4 Money do we need, that is a set of nuanced answers that certainly, given the opportunity we could walk through based on each of the individual areas of harm reduction. But please.

Speaker 6 Know, and.

Speaker 4 I think one of the documents you received which would speak to this to some degree, know that it is a much broader discussion and that harm reduction is a significant continuum to the work that you're doing at this table today. Absolutely.

Speaker 2 Can I just ask.

Unidentified Yeah. Do remember.

Speaker 1 Speaker. I'm sorry. Actually, thank you for the question. Joanne Thank you for the answer. My answer, when asked How much do I need is always a little more. And I think that's what you were alluding to.

Speaker 2 Actually, a little.

Speaker 4 More and maybe I'll say a lot more.

Speaker 2 I just want to clarify one thing, because I think originally what Ashley was getting to was the amount that's on the scorecard, the amount that's in the budget, maybe the amount you get from the federal government. But the concern that some on this board might have that we don't want your original budget to be supplanted. You want to say what Joyce is looking at expansion. When we're talking about it, we're talking about like growth in what's happening as opposed to sliding in an opportunity to take away and replace. And so I think that's kind of an area of concern.

Speaker 4 Shouldn't let me add that the irony here is, is that the DOH is only receiving 8 million on this scorecard. And that the larger issue that that we have talked that we were talking about was how much Oasis was getting and whether they were supplanting line items. I think I think that so the irony here is, is not that the the the old state, the old age is going to supplant. I mean, they they they need more than their current programs a lot more.

Speaker 2 Everybody's budgets, I think it's not just the Oasis alone needs to say. I think that we should have all of the information as well in the way that expands services.

Speaker 1 Yes. Suzanne, I know you have a question. I'm going to get to you in a moment. I just would say that the issue of the plantation is one that has come up many times. And it should be if we had the documents in front of us, an empirical question. If, you know, if the original budget went down and the scorecard went up, then if the plantation if the original money is the same and more was put in, it's not the plantation that we should be.

Unidentified And you know, for. Let me. Let's say, for instance, that 33 million people.

Speaker 1 Okay. Well, I can't speak to it, but you can. I guess I don't. I don't know anything about it. Oh, we ask Peggy. Okay. What happened would would $21 million and kept getting the repeated answer that we bought. MAT Where did you buy that MAT? Where did you get that MAT? Show us something. But because there's a rumor that Mr. Cuomo has given $21 million to Oasis and yet deducted $21 million out of Oasis budget. So there's always all kind of games that we don't know about. And yes, to, you know, to Stephanie, we would like to see the budget. We would like to make sure that there's nothing being supplanted. Oh, I hear you, Avi. And I'm I guess my point was simply that

now there is a board who can ask that question and look. But then I've been ignoring you. Sorry.

Speaker 2 So one of the things that I would certainly recommend is that we look at the complexities of an urban population, but also a rural population. You know, when we talk about workforce in the north country where I'm from, we are struggling desperately because we can't get people to come up north to work and we can offer tremendous salaries, but still they will not come to the North Country. Social determinants of health have a different twist in the rural population. So I think we really have to. It behooves us to look at the differences between our state, both rural, very rural, almost frontier in some places and urban. So I just want to make sure that we do not lose sight of that.

Speaker 1 Thank you. So when you say the answer to that would.

Speaker 2 Be if you can figure it out, please share it with me. Because yeah, just because you could go.

Speaker 1 To some areas of the state and have nothing, nothing at all. I'm talking about the nuts I mean it's not very commonly and I agree county. Joining together in Orange County for you. Yet you can go to the agricultural or not even have a bus service for methadone. You know, you have to take a bus from the city of Lockport to the city of Buffalo, take another bus to the city of Niagara Falls to get a month ago, and then that four hour drive, and then you got to do the same thing every single day. So. So. We talked about in The Good Doctor and everybody said that. I. Oh. We go. People die? Both. Compare that to their. That's five point percent higher.

Unidentified Well, we to move. Every person in this state.

Speaker 1 Once you get on top. We make it available for them because the opposite to that is going to the back bedroom. Get the shotgun and blowing your head off. And that's not acceptable. So what I what I'm trying to say is when you got somebody like Horizon, that's that gets the biggest provider in Erie county but doesn't get a goddamn penny from the county. That's really not fair. Okay. We have to kind of, like, set some kind of of a framework over here that the counties and everybody else will have to follow, you know, and provide for God sake services to people and everywhere, anywhere around the state. You know, every life matter, every single life matters, you know, and and and a junkie is somebody's kid. And if we don't look at them like that and we don't have the compassion. You know what? Let's just get the hell out of here and forget about it. Once again, agree that I've just been waiting for a long time. Sorry. Justine.

Speaker 3 It's okay. I was I was really thankful to see the slides on the Department of Health slides with the maps, but they don't really and I guess that they don't really give any details. So, for example, I worked at the first health hub and still do in Ithaca, New York at it would be great to see something like numbers, numbers of patient touches, numbers in the health hubs themselves. How much what's the retention rate? Because I know when we started a health hub in Ithaca, which is what led to reach the retention rates were really quite high. And it would be interesting to see as an organization, dollar for dollar, what are the retention rates for dollar wage and for Oasis, and also be able to comparatively understand whether more dollars or an equal amount of dollars needs to go to the wage. But I'm sort of I just don't feel like the data was that helpful and it just seemed like a small amount of data and most that we're interested in matters like how many referrals were there? Did it equal any engagement? And I'm also interested I attended our summit and

they were doing they gave a presentation at our summit on this really fascinating idea of working with the medical examiner in circling back around and this whole idea of nonfatal and fatal overdoses. And so I'm just not sure why we got four slides with maps as opposed to do they not have any more information to share with us? Because it seems like a really small amount. Maybe they don't have enough information to share with us, maybe they don't have those numbers, but it would be nice to see them if they do.

Speaker 1 Thank you, Justine. I can. If you have something that you.

Speaker 4 I can speak to that.

Speaker 1 Oh, sure.

Speaker 4 So thanks so much, Dr. Waldman. And what I can say is that clearly what you're looking for are the direct outcomes to understand the impact of each of these programs, which certainly would, you know, certainly would provide you with information as to how you want to continue to move forward so we can get that right. We're happy to share outcome information with Oasis, and then that would be distributed as agreed upon.

Speaker 1 Thank you for the question, Justine. Thank you for the answer. Join Deborah. Did you have something you want to say?

Speaker 6 Hi. I just wanted to respond to one of the things that was brought up a couple of times. The funding definitely cannot supplant. So everything that was developed through budget negotiations was developed from, you know, each agency presenting estimates, and it was meant to be in addition to current spending. So you're all the people who brought that up to the relevant point, and it is not to supplant. So I did want to clarify that and make that really clear. The other piece I did want to say I'm not an expert because DOCS isn't my budget, but I did want to say that, you know, funding from the opioid settlement was in the is in Doc's budget there's 11 million in the current fiscal year. The new you know, the 2022 to 23 budget has 11 million. And then there was 11 million reappropriated from fiscal year 2022, which is the 21,22 budget and 11 million plan to be appropriated in this upcoming next budget. So that's where it's intended to be spent from.

Speaker 1 Patricia has something for you. Yes. Yes.

Speaker 6 Small, small clarification. I believe that the past year's appropriations this year and possibly then next year's appropriation for that money comes from the McKinsey settlement, which is not included in this this settlement funds. I just want to thank. Yeah, I meant that.

Speaker 1 Joyce has been asked. Yeah.

Speaker 4 So to Justine's point about metrics of success, maybe, perhaps our different partners can talk about what the metrics of success are. Not to over that, to overstate the obvious and not to put too fine a point on it. The the metric for success for an OPC is to save the life. Let's just be right clear around that. They're not dying. They're being saved. We have right now in New York City, we have an agency, one of one of the steps that, you know, is saving has save an enormous number of lives. All of these steps actually save lives. But the because people don't have to inject to have an overdose, they could just simply sniff a bag of fentanyl and that's that. All right. So anyone in your agencies could have an overdose. It's not a just solely about it, about one form of ingesting a drug.

Therefore, you know, so the metric for success is the actual saving of a life. We can talk about what to do with that and how they should do it, but it's the actual saving of a life. We don't talk about the rubrics, right, about, you know, treatment, recovery, all of our entire continuum of care. And I'm not trying, you know, I, I really I am working and have worked on and on a continuum of care because that's how we understand the situation that people flow in and they flow out and and and they can manage use. But if we're going to talk about metrics, I mean, I think everyone should be prepared to to to say, you know, the SS piece, for instance. And and it's really quite true that we really are in and we created that that that continuum of care, all of those wraparound services is how we we move people in and out and keep them engaged so that they can possibly, with the biggest referrals to treatment, the drug use, the HEALTHHUBS and the SSP is the number one referral to treatment and has always been that way for the last 30 years. You guys treatment folks get get their referrals primarily from the ssps and the drug use help hubs. So so we need to come back to that that point about what are the metrics. And I want to again saving a life is the. Any reason that these monies came to us to to as a you know, I'm making an amend, as it were, how we make amends to our communities, whether they're up in rural New York or down in the city. The legislation is an attempt to make amends and to tell the prescribers and the men that something needs to happen. So I want to refocus us on making amends and how we make amends and and move forward with that.

Speaker 1 Thank you, Joyce. Avi was next? Yeah, I'd like to change the subject and move on because I.

Speaker 4 Have to respond. Yeah.

Speaker 3 Anne, lives are being saved all over the system. And if a provider serves 10,000 people and they lose 23 lives, then they've saved the other lives. So lives are being saved everywhere. We can't say that that this saves all the lives, that saves all people. I know we have to choose their path and their path is individual. And we know that if you're seeing them, if you have access, if you have culturally responsive services, if there's a connection, that life is going to be saved.

Speaker 4 No n determinants of health. There's certainly huge inequity. Racial inequities, economic inequities. The whole notion of an individual being free to choose their path is absolutely not true. And you even know that my real estate location is everything. Zip code.

Speaker 3 I wish you would let me finish.

Speaker 4 Sorry, I apologize to the person centered.

Speaker 3 Is its person directed? We don't we don't mandate people. They have to find a path that they can accept and and follow. And I can tell you, it is different for everybody. I don't know your part of the world. I'm telling you about my part of the world. So if we're going to talk about lives saved, I'm going to talk about lives lost to lives saved and lives lost. People that go to overdose prevention and I'm all about it. Yay! Hooray! For some people that are going to choose to follow their path, that is going to save their life. It's going to prevent overdose. Yay! There's I don't know. I wish I did. How many tens of thousands of people are active in the treatment system at any given time, we have to have solutions that will respond to where those people are and what they need. That's all I can say about.

Speaker 4 May I add that the whole question of I mean, I'm trying I'm going to I'm going to hold back because I have a feeling that I might just be a little bit too much so we can revisit this. I mean, my, my, my point is that they're in the emergency room, saves lives and OPC saves, in particular a life that has been challenged by a particular round of of use of of of an event. They need to be there. Treatment needs to be there, too. I'm happy we send our people over to treatment. It's wonderful. Then. Then they then they lapse and they come back to us and we make them supple again and engage them and give them showers and food and, you know, robustly take care of them. And they then they say, yeah, I want to go to treatment. Yay! That's what we've done. A lot of people that become social workers and on and on. Yeah. But for some people that that path is not that's the ideal path. It's not realistic for them and we don't want them to die. So every, every, every possibility should be a ideally every possibility for all of us. We should help to create optimal an optimal society.

Speaker 1 You know, it's interesting that I don't see any disagreement between what anyone saying. The point is, we're not saving enough lives.

Speaker 2 And there's a there's a bridge. I feel like I feel like you're I think everything needs to go into saving lives. But as you say, it's almost like an E.R., right? So what happens when somebody goes to the E.R.? The next place they go is usually in using best practices, evidence based practice with a robust workforce, with with like really good steps that the likelihood that somebody has to go back to the E.R. again is reduced. So you're doing the critical work of keeping people here and staying engaged. You're doing the critical work that, if funded appropriately on both ends, the system is better because the likelihood that people are going to come back to you or reduced if we're doing the kind of work that I say, which is person centered, co-occurring capable, complexity, capable, no wrong door, so that it all comes. So I don't think I don't think that what you're saying is different. I just think that. Together as an entity, we're going to build a continuum of care that addresses people along their stages of change, recovery oriented. If they don't want to change, but they want to be safe. I mean, all of those things I think fit in. But I think that somehow it got like everybody is passionate about what they believe. And I kind of hopefully look just like the whole thing, like I think that that everybody should be addressed at their point. And I think that you need to be alive in order to make it here. But you need to invest in here in order for people to stay alive. Beyond the job isn't just to keep them alive for the moment. It's to support their whole life. Let's start there. Yeah, there's other entry points. There's touch points.

Speaker 1 Can I. Yes, Deb has. Deb has a comment.

Speaker 3 Hi. And I think this is I think I'm happy that this conversation is happening as a board because it really demonstrates the different perspectives that we come from. But at the sake of repeating what Stephanie said just said, I will say it my way. We are working within a community that experience addiction and behavioral health and mental health services in different ways. And if we go about as a community structuring it as one school of thought for everyone, we're going to lose most. And I think the beauty of what we have around this table is really various kinds of interventions that can help our community. And I think pitting one against the other is not helpful for us to get to a place of recommendation. I think, understanding that we are building a recommendation that will suit a continuum to me, which is really what is it really is what we have in the in the community is a continuum of care. So to me, as we approach the recommendation is to really approach the recommendation from that continuum and from the specific groups that we work with. And we had a really good conversation this morning about about prevention, for example, a

group that sometimes we often don't don't think about. So I think as we talk about it, I think it's a really great conversation. And I think it's a conversation that really helps us to identify that we're coming from different places. But what we're building is just not one place. We're building a continuum.

Speaker 1 Now, can I change the subject? Yeah. If I could just have one last comment on this, then we'll go right to you. Okay. Saving the life issue. Is why we're here. But it's also a point in time in Albany County. We have too many overdoses over 100 last year, but we have 2500 people in addiction treatment today. My answer to this question is 2500 people are alive today. Tomorrow. I can tell you where it's going to be at the an array of services, treatment, prevention, recovery. But as long as I'm just speaking from my perspective, as long as we have a touch in that person's life in a meaningful way, they're alive today. God knows what's going to be tomorrow. We just need to be here tomorrow. Okay. So I just want to say that to me, saving lives is I don't know if the life we saved today is going to be the life we saved tomorrow.

Speaker 4 Steven, I agree. And I just want to clarify that our conversation is a robust conversation is about making our recommendations. It is not pitting one against the other. It is in fact, I myself have talked about a continuum of care that I have been working on for the last 32 years. So it's not pitting one against the other. Last year, 2020 data, we've had increases in overdose across this country and there are over 34% in New York City. In New York State, like New York City reports in 2020, that report over 2000 overdoses. Evenly spread again across white, black and Hispanic Latinos. So these are huge numbers. Just just in my borough of the Bronx, it's over 350. So it's it's not about pitting us, Deb. It's about all of us. It's cry. It's a critical telling, all of us that we need to come to the table from our respective places to come together to in the spirit of our of this legislation, to to to honorably.

Unidentified Act on behalf of the people we serve. Well. Thank you. Okay.

Speaker 1 I think we're all here to save lives. But in order to save lives, we need funding. So I have a question. And it's been running around my mind for now. The last this is the third meeting. And I want to ask the folks at Oasis, because right now, Oasis is kind of slow in getting funding to providers and everybody right back is Oasis. I mean, I'm assuming that Oasis is going to be handling this this funding and getting it out to the public. Are they going to be able to handle that? I mean, we've got a lot of money going on over here. And and, you know, there are little slow right now what's going to how we're going to get the money out to save the lives on time.

Speaker 6 So what I would say is I can't comment on exactly what your personal experience is in terms of the speed with which your organization is receiving grants. So I will save that for our fiscal person. But you know, what you guys keep saying is there is an urgency to the money, there's an urgency to saving lives. So I don't think it's a question of whether or not we can do it. I think it's just a fact that we will.

Speaker 1 And then let me ask you this, Trish. Who's going to oversee that?

Speaker 6 In what context?

Speaker 1 Who's going to oversee that? That money gets out? Is that you or is that going to be a separate entity or is the state control got to make sure that money goes out? Who's going to make sure that money goes out and gets to the right people?

Speaker 6 I mean, there's a standard process all state agencies follow to push money out the door. The OSCE, in certain circumstances has a role in that, either auditing on the back end or otherwise, again, not the fiscal person. So don't want to misstate anything there. But I guess I'm confused about what your question is.

Speaker 1 Well, I think I stated at the beginning that oasis are slow and get money out and contracts out. And I'm not the only one that that's complaining. If you talk to the rest of the people around the state, they'll tell you the same thing. You know, are you going to add on staff? Are you going to. How are you going to get money out to the to the people? There's $208 million over here or or more than that.

Speaker 6 And I think I answered your question already, which is it's not.

Speaker 1 Now, you didn't answer my question.

Speaker 3 You will have.

Speaker 1 You didn't answer my.

Speaker 3 Question.

Speaker 1 That's you didn't answer my question at all. But I'm not going to get into an argument with you because it's useless. So I'm going to tell you this. I would like to know, as does Oasis have a plan of getting the money out? And before this, the next couple of session or whatever it is, I would like to see something that can assure the rest of us that Oasis has a plan to make sure money gets out to the community, to providers, to whoever it is on time. And no, you did not answer my question. Point by point. Point point was made. I actually.

Speaker 5 So I'm going to actually go back to the lives. Can you guys hear me okay? Just because. Remember how I said I've been collecting letters? Well, I collected them, like, from around the state. I happened to have the number. So from on site, which is the two pieces in NYC, in the eight months that they have been in operation, 365 overdoses have been and are being done. So that's 365 lives that potentially could have been lost. And I think that, you know, we didn't really touch on that. You do you have a continuum of care, right? Just as syringe services. Thank you, Joanne, for your statement earlier. You know, really touching on that continuum that syringe services provide. So do pieces. So does treatment. Right. I think we but like I think what's being missed is, you know, people talk about, oh, they get to celebrate and, you know, like everybody gets to choose their path. That's not always true in our current system. We still have very old thinking providers, even some that, you know, don't support M-80. I mean, we're still like moving. So I just think it's really important to touch on that, especially like when you get further, like past the Tappan Zee. We have some antiquated ideas up there, unfortunately. I mean, I'm pretty sure most of my communities think I'm very drunk, right? Because I've actually been talking about OPC since 2016, before we even had a Senate version on the floor when just Linda Rosenthal supported it. And I think I'm just sick of losing my friends and to Joyce's brain, like we need to save lives, right? Like dead people don't recover. Dead people don't go to treatment. And yes, we need better quality treatment. I just think it's really important to touch on that. Right, is like we need to keep people alive. I think that that should definitely be part of our mission statement because I don't know about anybody else here, but I go to funerals quite regularly and I'm really sick of it. And often I get told by individuals that

they don't get to choose their own pathway. They're told what their treatment plan is going to be when it's supposed to be collaborative. So I think really working on the quality of treatment that people get, you know, needs to come, but we need to keep them alive first. So I do want to make a commitment to, you know, taking some of the burden. I said this, I think the first meeting I want to take some of the burden off the legislature, because I do know it's controversial. And I think that we all do agree that saving lives and if anybody is interested in any of the data, I've been collecting data for years on opioids and I'm sure Joyce has as well. And she's a researcher by trade and they're evidence based also. So I just sorry, but that's how I feel and I really would like to allocate some funding for them.

Speaker 1 Ashley, thank you. I want to go to Dr. Thomas Smith in a moment, but if I could just ask you a question. I too have found the research very interesting and I am definitely prepared to talk about it and hope the board will entertain it. But I came I came across a Alberta study which the data is not consistent with the rest of the data in the field. And I just wondered if you had any awareness of it or if you could look into it. Um.

Speaker 5 I'd be happy if you shared the DOI with me. Is it a meta analysis or.

Speaker 1 It's a study done in Alberta, Canada, on their safe injection site program, and the data was just not consistent with anything else. And I'm wondering if the other researchers are missing something or there was a bias to the research. Basically, people, they weren't overdosing or dying in the facility, but they were overdosing and dying in the street on the corner. And the numbers were not improved by. So I just.

Speaker 5 We could even look at decorum leading to legalization to have like quantity control for substances. I just think that, you know, we need to mitigate harms for individuals that use Substances Act any way possible.

Speaker 1 I agree with you. I just think that.

Speaker 5 But I will look at.

Speaker 1 Not just the Smiths an outlier because it's an outlier. There is something in there that I don't get.

Speaker 5 I would I would love to look at the study, if you can send it to me and then we can look. What do you know if it was double blind?

Speaker 1 It was just an analysis of the of the of the success of the Alberta.

Speaker 4 Is it is it new or is it an old.

Speaker 1 It's new. Well, new in the sense of like a year or two.

Speaker 4 The SSP OPC's actually function as a net widening intervention. So not only do they save lives, but they are a net widen is because they, as I said earlier, they connect folks to they widen the net of services that are available to people who would likely get them. I'm not quite sure if you go in and you. Are they the same population.

Speaker 1 That the same patients are? Are you are using in the facility dying in the alley behind that? And they were saying that it would challenge that the data that internationally has basically no one dies in these facilities. Right. So I would just say.

Speaker 2 In 2020 study from Alberta it's a government study.

Speaker 4 Can get into.

Speaker 3 DOI.

Speaker 2 I'm looking.

Speaker 1 Thank you all because I would love I want to be able to make sense of why that's an outlier. But Dr. Smith, you wanted to raise the question.

Speaker 3 I don't know. This is.

Speaker 1 Helpful. It's helpful for me to.

Speaker 3 Hear the different perspectives.

Speaker 1 And.

Speaker 3 Opinions that.

Speaker 1 People have.

Speaker 3 And because it is starting, you know, to me.

Speaker 1 Anyway, the key.

Speaker 3 Elements.

Speaker 1 Or guiding principles for this group, I think, are.

Speaker 3 Becoming more and more clear. So we are going to get to the point where we.

Speaker 1 Will be discussing specific.

Speaker 3 Either interventions or programs or.

Speaker 1 Geographic needs.

Speaker 3 I wonder whether you could ask some, you know, develop our own kind of scorecard or rating tool because we're identifying these these elements. And with each particular program, you can rate them.

Speaker 1 Like how how likely is this program to save lives.

Speaker 3 In the immediate future? Some interventions are more likely than others to do that. Some programs how how.

Speaker 1 Likely is this to to address the.

Speaker 3 Ethno racial disparities.

Speaker 1 In access in outcomes in the city programs? How likely is it to promote integrated care?

Speaker 3 I think we're starting to get a sense in our head of what these elements of our vision or guiding principles for how we're going to rate the different potential programs or projects that we fund. I hope we can get all this down on.

Speaker 1 Paper and.

Speaker 3 Maybe we can end up with some formal processes. Okay. We're going to talk about this one. We have our five dimensions here. Let's all rate or score on these dimensions and use that information over time.

Speaker 1 My hope was that this kind of discussion would lead us in that direction. Thank you, though, Dr. Smith. And then we have a break that we're late for, so we'll we'll take it. Yes. Thank you.

Speaker 2 Sir. Mr. Chair, I just have a quick question from Oasis. If we could potentially get the information on the map programs that are available in docs like spelling out like which docs facilities have MAP programs and where that money is coming from. I know you mentioned 11 million, 11 million, 11 million for the next year. I'm just curious as to which docs facilities have MAP programs and where that money.

Speaker 1 I'm sorry.

Speaker 2 Sorry. What's going on with that? Not necessarily what's going on with the money, but I want to know which docs facilities have map programs to account for the.

Speaker 1 Facilities of the state. When we're in that, we have the jails through our conference of local mental hygiene directors. That's separate from the docs money.

Speaker 2 Specifically for docs or. No, no, no. I'm not interested in the jail. I'm interested more in the docs since you're talking $11 million was allocated in the last budget, 11 million this budget, and 11 million for the next budget. I'd like to know the state of the the docs programs. The map programs in the docs, please.

Speaker 1 All right. Let's take a break. How much did they use?

Speaker 4 This is not about use. This is not about crime.

Speaker 3 Are we going to break it up? Yeah.

Speaker 1 What is it? I'm sorry I spoke.