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Speaker 1 All right, everyone, thank you very much. There you go.

Speaker 2 Can do the government thing.

Speaker 1 It is. Can you not hear me? Ah, there you go. Thank you. Yeah, that's a blessing and a curse, if that's not spoken words, in other words. So a couple of things, though. We have.

Speaker 2 In.

Speaker 1 The last segment of our meeting this afternoon, there is going to summarize some of the things we've kind of identified as part of our Northern Star creation. But Debra is going to offer some comments about, I think, the procurement process that that are relevant to a question that was brought up before, please.

Speaker 2 Thank you. So I just wanted to share I know that we did review this at the last meeting, I think, but it is confusing. And so I'm happy to review it again and say I'm not an expert either. So it's always good to review. Contracting is definitely a process in the state, in the language, in the Opioid Settlement Fund account, we have what is called procurement relief to some of the state finance law requirement and the economic development law, specifically sections two 163 of the state finance law and Section 142 of the economic development law. Both of them are notwithstanding it's called notwithstanding language in the in the appropriation language for the opioid settlement fund. And what it really means is that we don't have to have the procurement be a competitive. Procurement does not have to be a request for proposal, which would then have to be the process would have to be reviewed. There's a certain time period for it to go into the contract. Reporter It's 15 days and that depends on when you actually submitted it. And there's other rules around how long it needs to take for scoring, evaluation, all of those things. It doesn't mean when you have procurement leave that you don't do a competitive procurement. You can certainly do one. And we often do. And Oasis is just saying that you don't have to have it reviewed by OSE and you don't have a time requirement to have it posted for a certain length of time that helps make the process a little more efficient. You know, also with the notwithstanding the economic development law, it means that, you know, it does not, like I said, doesn't have to go into the contract report or however we didn't notwithstanding Section 112 of the state finance law, which means the contract itself still has to go to the attorney general's office, which they have 30 days to respond with their review and hopefully approval. And then it goes to the office of the State Comptroller, which they have 90 days to respond. So all contracts, regardless of whether it was competitively procured or something, was awarded or whatever it was, because we have relief, it's still the contract still has to be reviewed by those two entities. So that still could add, you know, time to the contract itself.

Speaker 1 So can I can I ask the the impetus behind seeking that procurement relief was efficiency.

Speaker 2 It was efficiency. It can add by by allowing that we eliminate 3 to 6 months of bureaucracy.

Speaker 1 Yeah, I saw that when I read some of the logs that you guys sent, and I appreciate it. I wondered why not? And the notion of getting the money out quickly is

particularly helpful in this instance. Why not do that all the time? From a county standpoint, the the procurement process that the county then has on top of the state, we spent half of the year trying to get the money. Then we have a month or two to spend it and then we have to report on what we did with it. And it almost, you know. The real relief would be, I think, is if you didn't have if they weren't annualized somehow you know that that every year.

Speaker 3 A year ago. We have not got the microphone. Everyone. We have a contract from a year ago that we're not going to get into August, but we have seven months to spend it.

Speaker 1 That's a lot of time for us. When there's federal money, there seems to be more of a of a hard time on the back end, which makes it look any procurement relief is welcome. And it sounds like there was an effort to try to move this money. Uh, but I would. I would vote for making a permanent.

Speaker 2 I will just add also that when you do that right and you're thinking about, you know, how you get money out the door, you know, part of that is writing your scope of work very clearly. And I would also recommend not trying to do too much meaning. Don't have scope creep, don't try to say, oh, you can do this, this, this and this. And, you know, so there's you're right. Sometimes you want to make it broad, but sometimes you make it too broad and then you don't get any response because people don't really know what you want. So you do have to make it informative. And then also your scoring tool, you have to really think about what is important, how do I weight all of these things that I want to wait to be able to award it? And then, you know, as you get applications in, you think, oh, maybe I didn't want to weigh it that way. And hindsight is 2020, so you want to be careful. Those are the things that will slow down a procurement because you're like, Oh goodness, I didn't think of this. Or No one responded, No, I have to rewrite it and we send it out and that could happen. So, you know, it's it's not it's not always, you know, anyone's fault. Sometimes they get delayed because you have more thinking, you have more information from your providers that responded. And, you know, you do it from that perspective as well.

Speaker 1 I appreciate the clarification. And I think to the degree that we have anything in our control, we should always remind ourselves of that. It's interesting that you talk about the tool because we had an interesting conversation earlier in the afternoon about a tool. I'd like to actually get back to that. But Deb, you were going to summarize kind of what you heard earlier on, but thank you very much for that. Appreciate it.

Speaker 2 Okay. So I'm going to try my best to do that. A quick little summary of what I think came out of the discussion this morning. Anything I missed? Just just please correct me. So, of course, we did our bylaws. We did a charter and and, you know, we had some discussion on that, but we definitely passed the bylaws. Then we moved into a discussion around sort of recommendations and various areas that we areas of focus that we think are important. We started off with, with, um, with Stephanie's well written document and well-thought out document on integrated care. And the group seemed very much engaged and involved and supportive of, of, of making sure that that gets included in the existing charter that exists now where a host of other areas are highlighted. We then went into a conversation around workforce and the importance that workforce plays and the role that it plays and the need to really, again, emphasize it as part of of the charter. Then we moved into harm reduction and the importance of harm reduction and making sure that that gets included as part of the rubric that that we are that we that we have going. And then in

between that those conversations data came up and we, you know, pointed to specific pieces of the conversation around data and spoke to the age about what they provided was really helpful but needed a little bit more information. And I think Joanne took great notes and have the information that she is going to get in from further information for our son. Um, in between there, we then had some information around OMH and some additional information from, from OMH that I know Stephanie whispered to us that she would like to have been talking to Dr. Smith about. So we'll we'll hear more about that. So I think our sort of, you know, making sure we crystallize what data requests we we want coming out of this meeting to go into. If not, tomorrow's meeting might be unlikely, but the next meeting after that would be helpful. And then Dr. Smith took us to a really interesting place around a tool. So we've heard all of the various areas that so far, again, this is just so far, we we still have more talking to do that. So as we talk about all these different areas, what are we going to do done with it and how are we going to go about sort of as a group figuring out where we want to put our emphasis and and see certain percentage of dollars be spent. So with that two place and two item, we came back here and we were asking Oasis legal team for guidance around what we can and cannot do based on, you know, the the open meeting. Not so that we don't violate open meeting laws. And I think at this juncture here, I'll turn it back over to Steven because he had some thoughts about that that he wanted to share.

Speaker 1 You want me to violate? Thank you. I will just say there was one item I think that is not on your list. And I thought it was you know, it was acknowledged as pervasive in terms of all of our discussions. And that has to do with the inequities and inequities in our system of care and the effect of social determinants. I was pointing, oh, boy, that is a big difference. Sorry about that. I was thinking, Deb, for her summary and mentioning that I thought there was one item that hadn't been included in that summary, and it was an item that is kind of pervasive and it was involved in much of what we discussed in that had to do with inequities in our system of care and the the the whole issue of social determinants. And I think if we're summarizing what's important to us as we create the Northstar vision, I think that's part of it. Yes. Who who was first? Dr. Smith? Oh, Carmen. Great.

Speaker 4 I wanted to also mention that with.

Speaker 2 Regard to the. Workforce. We also referred to workforce for the consumers as.

Speaker 1 Yes, yes, yes, yes. That's very important.

Speaker 4 Yes. Thank you. And also the language and access inclusion. And then also I asked for some data specific to the amounts of money that were spent from the McKinsey settlement on the New York State DOCS Mat programs. Um, that was, uh, 11 million last year, 11 million this year, and 11 million next year. If we could.

Speaker 2 Talk about the.

Speaker 4 State of where we are at in New York State with regard to MAT and DOCS.

Speaker 2 That would be.

Speaker 1 Great. Yeah, well, I would just say that.

Speaker 2 All right.

Speaker 1 You know, the budget questions I would like to save for tomorrow just so that we you know, if at the end of the day, tomorrow, we don't have those answers. Perfect. Let's let's push it a bit. I think I'm likely to get the wrong answer on that one if I don't go to the experts. But we have it on our list.

Speaker 2 But Steven, I have something to say.

Speaker 1 Oh, yeah, choice.

Speaker 2 Excuse me and thank you. And the harm reduction and thank you for that gets included. But let's acknowledge that it's a continuum. And there. I'm sorry. I'm sorry. Let's acknowledge that it's a continuum. And so we want to make sure that there are many interventions within harm reduction. And in the case that the point that I wanted to make sure that we put that we talk about OPC's just just to make sure because it's really it's a continuum of care within harm reduction. Thank you.

Speaker 1 Thanks for the clarifications. So there was that interesting discussion with you, Dr. Thomas Smith, about developing a tool. And I'm intrigued by that. And I wondered if the rest of the board might similarly be interested in maybe brainstorming a little bit around that. Do you have any more thoughts? I want to put you on the spot, but it seem like an obvious.

Speaker 5 No, we do that like when we're creating RFP and we're we know we're going to get applications, we have to score them.

Speaker 1 Well, like Deborah was talking about the scoring that you do for your.

Speaker 5 OR when we're getting when we're submitting grants, you can create your own templates. You have identified the guiding principles are the key scoring elements. If you want to assign actual points and wait certain elements, you can or you can just identify five or six key elements and have them all rated 0 to 10. You know, whoever's rating or even group discussion, you can arrive at a consensus. Okay, this project gets a six for equity and gets a ten for saving lives and gets a two for, you know, a person centeredness. Right. It sort of gives you a template and a map and you could even score them up if you want and come up with final scores. You can get as rigorous as you want or use it simply as a guideline.

Speaker 1 So it's tempting to we were talking earlier about subcommittees, and that's the kind of challenge or task that would be great to break off and work on. But we can't do that. It's tempting to ask if anyone is willing to volunteer, and I think we could put two people together to work on something like that. But I also think we have an hour and a half left in this afternoon's meeting. Is it worth, do you think, our attention together to try to develop the the the the elements of least of a of a ratings tool for the recommendations that we are hopefully soon to start making.

Speaker 4 Does this mean you're on?

Speaker 1 It would be content specific though to our.

Unidentified To modify your style framework.

Speaker 4 We could modify it for our purposes.

Speaker 2 It really goes to each individual program that you're funding. So for example, the rubric that we have for Community Coalition grant is going to be very different than the rubric.

Speaker 4 We had to do.

Speaker 2 Expert services or some other level of services. So it's a rubric, but not you don't have one size fits all. Mm hmm.

Speaker 1 Well, to the degree that to the degree Dr. Lynch joins us, I think to the degree, though, that we were having a discussion earlier about common themes, isn't there. Couldn't you make the case that, yes, every proposal would be unique? But but does it embrace or touch our common themes? I think that.

Speaker 5 Or how does it score out on these elements that are our our our guiding principles, our North Star? I think we've done much of that work already. We've identified, you know.

Speaker 1 That's why.

Speaker 5 We're wrong door access.

Speaker 1 That's why I was wondering, are we at a place where we could actually put this put this down? Well, no, I was just saying I felt the same way, Dr. Smith, that we had talked around this. Might we be at a point where we can kind of make this into a thing?

Speaker 5 Sure.

Speaker 1 Yes, sir.

Speaker 3 Can I? So I just had a short conversation with Dr. Smith regarding some kind of collusion between Oasis and the Office of Mental Health.

Speaker 5 Because collusion.

Speaker 3 And collaboration. I'm sorry. I'm sorry. Collusion. I'm sorry. We had a conversation that.

Speaker 1 A Freudian slip for me. Was that a Freudian slip?

Speaker 3 It was. It was. It was. I'm sorry. I'll rephrase. We had a conversation about getting some cooperation because all the attacks said on the Office of Mental Health Realm. And there's there's there is a need for some mental health. Is there a way.

Speaker 5 To do something like that.

Speaker 3 To do some cooperation between the two and, you know, provide some mental health from the, you know, to the ATCs and then vice versa? Is it possible to do that? That's. And he thinks that there's something that can be done about it.

Speaker 5 Well, it touches on two of our guiding principle elements. One is integrated care, and the other is access to care. We got a bunch of substance use treatment, folks, right next door to a bunch of mental health treatment folks. Why can't they open their windows and talk to each other? So that would score high and it would also score high on feasibility, you know, something easy to do. So, yeah, we should look into that.

Speaker 1 Anne.

Speaker 2 Make sure that we're all.

Speaker 1 Microphones.

Speaker 4 I know, but I talk so loudly already.

Speaker 1 But they can't record you.

Speaker 4 Oh, okay. We're not evaluating specific line item proposals were allocating funds in categories and I'm hope I'm hoping in regions. Right. So we need to be talking about categorical distribution, not program distribution. Is that correct?

Speaker 5 Sounds about right. Do you know what those categories are, though? Do you approve those eight?

Speaker 4 I think that the categories exist. And then I guess I might add innovation in as a category. But the categories exist. Right. And in the principles that we've been talking about, we've got. We've got a lot of them. Mm hmm. And so, you know, like you say, broken record. What's missing is the data. Where are the people being seen? Because before you do anything innovative, you need to make sure that you have security in what's currently taking care of the people. Right. If you don't have that, then you have chaos. So innovation development, in my opinion, if I was running the world would be on the back of stability of some piece of the system. Right. So. That would be my suggestion, although.

Speaker 2 That's so vague that I'm not quite sure that's even helpful in terms of innovation being on the back of some system. I mean, the fact that know innovation by its very notion, by its very nature notion is a paradigmatic challenge to existing methodologies. And so with paradigmatic change, you're actually to some extent you're basing it on existing systems, but you're also challenging them. And it's always the case that, you know, you are in the vanguard of a moment, you know, the zeitgeist of that moment. Some people can read better than others. So I'm not quite sure, you know, by saying that we are in a a paradigm revolution is just precisely about, you know, not everybody gets it. And when the people that do get it, you know, steer ahead forward and they pull, you know, they pulled the system into transformative change. So I'm not quite sure about this last statement. Dr. Smith. I kind of I, I, I do like when you first presented this about this idea that we could sort of, you know, you know, sort of rank this. And I had the feeling my sense when I heard you was that it would be much not so specific, but that it would be a way of capturing within a concept or within an intervention the the variability of it and then ranking that variability. I thought that's what you had said when you that's what I understood when you first set it back earlier.

Speaker 4 Yeah. I just want to point out that a lot of the system, to Pat's point, is built on evidence based research practices. And it is not it doesn't all require transformation. It requires strength and some diversity. We don't if what we're about, and I don't think we

are, is throwing out what we know to get to what we think. That's not that's not a model I could ever support. We have to do both.

Speaker 2 That's not what we're saying. I mean, I just want to be clear that I'm not saying that I think that all of us who follow the science understand how paradigms work, and we also understand how change occurs in science. And so my comment had to do oftentimes in our field, early interventions such as providing syringes to individuals was a completely revolutionary idea. The mere idea that people would, you know, anything other than seeing drug use as suicidal was viewed as like what? That that doesn't make any sense. And and then came the HIV epidemic. And so it became a way to, you know, we actually changed the paradigm that became the most effective intervention in the HIV continuum of care. I mean, it is whether, you know, it is an effective intervention. It works. And so what I'm suggesting here is, is that I mean, however we categorize this, where the you know, the categories are work force, so, you know, harm reduction in offices or however we do that and I I'm all for the categories, but I'm all in. But if we talk about innovation, that would be clearer. That innovation isn't just some, you know, just tossing things up against a wall and thinking that somehow whatever sticks is okay. That's not what I'm talking about. I think that that innovation, as we will discuss it, has is is is embedded in good practice.

Speaker 1 Understood. Dr. Brown, please, first of all, my.

Speaker 3 Apologies because I'm going to have to leave soon. But I wanted to.

Speaker 1 Leave you at least on a positive note, too.

Speaker 3 It would seem to me that categories make sense with the tool. I think there are some cross-cutting.

Speaker 1 Themes and principles such as equity, so that there are categories. And then we can say.

Speaker 3 What should be the cross-cutting.

Speaker 5 Themes or principles.

Speaker 1 For which in fact, we would weigh these categories. All right. Thank you very much. That was what he said. That's what that that's what I was thinking, that we were on the verge of that. So I think we're on the verge of and I'm sorry that you have to leave us. You're going to be here with us tomorrow for virtually. Yes. Thank you very much. Travel safe.

Unidentified Has a personal project.

Speaker 2 To go to the microphone.

Speaker 1 Thank you. Thank you very much for that.

Speaker 2 As a person witnessing this. Is there a button I'm on? Okay. And I'm witnessing I'm an advocate. I've met many of you, at least by email, but you're circling.

Speaker 4 And you need a whiteboard.

Speaker 2 Or someone to post up on here. There are a dozen facts you guys all agree on and you keep talking about it and you have to make a list of the things you all agree on so that those come off the table and you talk about the things that need discussion. And so you kind of need a list of. Yes, yes, yes, yes. A quick, easy whiteboard list of all the things that you all know has to get done. And then you can worry about problem spots. So you don't tie yourself up with that. And I'm just saying, get a whiteboard, somebody tomorrow, bring a whiteboard in and be able to write this stuff down so that you can move forward on what needs to get really accomplished.

Speaker 1 So we're always ready to get pushed to the next level, I guess. I appreciate that. I think we're on the verge of coming to that ourselves. But thank you. What's your name? Please, Sue.

Speaker 2 Martin. I'm a person sustained recovery since 1983. I am a pharmacist and I am a family member of people in suffering with addiction and mental illness. Like co-occurring. It struck a good nerve with me.

Speaker 1 Thank you so much. You're welcome. Can't argue with that.

Speaker 2 Steve.

Speaker 1 Who was saying that?

Speaker 4 Justine.

Speaker 1 Oh, I'm sorry. You're Justin. Yes, please.

Speaker 4 Right. Mark For my for the record, that all of what she said I 100% agree with and all of this, again, is laid out in the charter. We need a certain amount of data. We're going to move forward with next steps. We're going to come up with a rubric. And I think that what I don't like about an organic workflow process is one of the big things we're supposed to be doing as this group is setting a precedent, have how the other boards will run. And so what I think we keep missing this upper layer of just one easy task that we could get done, which is saying that every year we meet, we're going to need this data. Every year we're going to look at the rubric, every year we're going to look at the mission statement or whatever and make the next steps. And I think that that we could all of that is there. But we keep getting caught in the actual discussions around what parts of the data are going to be important today. I still think it's like one thing you could check off if we were to look at it or look at it separately, but it's frustrating in that way.

Speaker 1 So what are you proposing, Justine?

Speaker 4 I'm just proposing the same thing that I think it was Sue Martin just said. If you look at the charter, one of the things in there is that we asked to have data from all of the agencies every year. Does everyone agree with that? If yes or quarterly or whatever it is, let's get a charter down that sets a precedent for how we're going to move forward every year. And then a lot of the steps will these steps will be done or outlined at least I just want to outline the steps. All I'm looking for is can we just outline the steps that every year the board is going to take?

Speaker 1 Yeah, I appreciate that. I don't think that's what she was talking about, but I think what you're suggesting is not a bad idea either. We were talking about themes and

categorizing them so that we could come up with a rubrik. Well, okay, but it has to do with what we've already produced rather than what we're waiting for in terms of data from other people. So I guess maybe it's two sides of the same coin. I'll take a suggestion. Stephanie. Yes.

Unidentified We can talk about of things that we.

Speaker 4 Can we can we list the things we agreed.

Speaker 2 To and commit them to paper.

Speaker 1 Yes.

Speaker 4 So that we have the beginning of what we agree on.

Speaker 1 I thought that was limited. I thought that's what we were starting.

Speaker 4 I want to actually get a little more maybe a little more granular. A little more granular that might lead to a decision rubric when we're actually sure. Okay. So we've talked about all of this and we agree on data informed and data driven. We agree on equitable, we agree, I think, and region specific that what a solution in one place is not a solution and another that it's integrated. And I want to say inclusive of public health, mental health and study so that it's.

Speaker 1 At least.

Speaker 4 At least so inclusive that it's evidence based. That that allows for innovation improvement, significant improvement. And I wrote down access because we've talked around about access, but we haven't actually said the word. Yeah, I think what we just have to clarify is that's what we agree on. There are still other topics that most of this I'm thinking so far. That's the list. I've been making a list of things that I agree.

Speaker 1 About absent the whiteboard that we. Yes, the reminder that we need you've.

Speaker 4 Listed and listing.

Speaker 1 And debiting rapidly more.

Speaker 5 You get the life saving the potential for immediate.

Speaker 1 Yeah that was one of our well.

Speaker 4 That's my data thing. So the life saving is not for me but for me being adequately defined because again, if you have 10,000 people in a program and 30 have died, you potentially saved all those lives. No, we actually have to look at it. I'm not finished yet for from my opinion, we need to look at it by harmful consequences and incidents, which for me, overdose numbers, suicide and deaths due to overdose and suicide. There are actually four different numbers.

Speaker 1 Well, we started out at day one acknowledging that saving lives and reducing suffering were the sparkling parts of our star. So what you're not do you're not challenging that. You're saying, what does that prove it? What does that mean?

Speaker 2 How do we prove it? Well, there is plenty of proof and an overdose overdose prevention center saving lives. There is just globally there is plenty of proof that they do. And and so that should not be off the table. And if you're saying that evidence based is something that has been research, say whatever you know let's say say by the CDC or whatever, you know, any other institution and in fact, denying the global research, then you're you're perpetuating the some of the myths that America that that that separate us Americans from other countries and their practices that are, you know, their science practices, their their practices on health care. And we should not be worrying, you know, we should be aware of our nation's pitfall when it comes to drugs and drug policy and drug harms. And that should be part of what we do here as well. We are a group of experts. And so the reality that that the America's role in punitive prohibition is legendary across the country. And and we should be able to see where it has gone awry and connect the dots. That said, syringe exchange has not been declared an evidence based practice. And yet by every metric, it is an evidence based practice. So I, I want us to be clear when we agree about evidence based, that we're clear that what that what that concept means and what it's missing. And you might want to I am not going to be myopic around the science that we have pioneered and that is globally substantiated. I'm just not going to sit here and say, okay, well, we're just going to look at it in this very myopic way.

Speaker 4 I would say zero one the I mean co-occurring SAMHSA says evidence based like you meet the person where they are integrated treatment. But when it comes to evidence based treatment modalities, they're limited. So I thought when and was talking about innovation, I understood your discomfort with the term innovation, but I see it more as promising practices, best practices, which are things that are rooted in leaning towards maybe they didn't get through the research the way that an evidence based practice would. So I think that that might sort of solve it because it solves it for me and it probably would solve it for you.

Speaker 2 It does. It's fine with me. I'm good with that.

Speaker 1 Patricia, I'll get you in a minute. I just want to make a comment about this. This is for a long time, but a concern of mine, because I think we use empirical evidence based way too loosely and we throw it out because we think if we say it just because it worked, you know, in one program. Well, evidence based evidence based is very rare in terms of of of repeated trials in different locations with similar methods that. Received the same result. But I don't know that that. I just think we should be on the alert for for the fact that there is a misuse of that term. I have always thought that if we stick to the requirement of an evidence based practice, we miss out on promising practices. And we all know that every evidence based practice that actually has been demonstrated to be one started out as a promising practice. And we better not lose that in our efforts of trying to start making hard and fast.

Speaker 4 Can I just follow with one thing? Because it was when and I'm sorry, but just on the data piece, because I'm going through the bullet points. I remain concerned that there are no solid data points for New York State on co-occurring disorders. I think that there have been attempts and efforts, but I think that unless every person was comfortable sharing in a mental health space their substance use and every person in a substance use program was comfortable sharing their mental health diagnoses. Then you might have data. I think that there are numbers that are in the the I think there's going to be a presentation that includes numbers. I'm going to posit that those numbers are significant

and I can hang my hat on them, but I still think that they are significantly lower than it would be if a person felt comfortable in any setting sharing their whole story.

Speaker 1 Well, let me ask you one question, and this is a horrible thing for I guess I would say I am a behavioral scientist to say why are we are why are we arguing about something that is so obvious irrespective of whether there is convincing data? Every one of us knows that co-occurring interventions have to be at the core of what we're doing. Why do we need to find this unicorn of data?

Speaker 4 You're preaching to the choir, my friends. But I think that. But then the. But, but the bottom line then becomes when we're doing presentations and I would ask that, for example, we're looking I looked at the PowerPoint, there's the the Article 32 clinics throughout the state and you see where they're scattered. And so you kind of get to the geography yet I don't see this similar data for Article 31 clinics that are using M0UD, And so if we're really looking at the landscape of our state and what services are offered and what we want to fund, I think we're only getting part of the story with the data. So I think that the the same series of questions that went to the Department of Health should also be including omeje. And then beyond that, where is the overlap? What what are the agency visions on integration that we can then kind of bolster or say, well, you've gone here, we'd like to go this much further and let's look at the dollars for that.

Speaker 1 Dr. Lynch, you. Oh, I'm sorry. I think.

Speaker 2 That's okay. That's okay. I would just ask again, I come from the prevention lens that the categories be broad enough. The conversation obviously is very treatment focused here. It's very harm reduction focus. It's very recovery focus. And I would just ask that as you look at what you're defining, that it is broad enough because I hear some terms and things that are concerning to me as a prevention is prevention is also save lives through delayed initiation, through early interventions. And sometimes that's not counted the same way other programs are counted. So I'm just asking that and I agree with your point. I mean, we're very much evidence based focus in the prevention world, but also we've looked at promising practice and research informed practices. So I think it's very important that we look at the entire IOM continuum as we set these parameters.

Speaker 1 tricia I will say that I will I pledge to you that that will not be overlooked. Dr. Lynch.

Speaker 6 Thanks, I. I was listening on my train right here. And it seems that the word, the terms, evidence, base and data we're kind of getting hung up on. And it it almost seems to be kind of a dividing force, which it really shouldn't be. It really doesn't have to be. I mean, I think that looking at evidence base and yes, it's certainly nice to say that. Right. I think that term makes us all feel better. But in terms of promising programs, I think it's really more appropriate to think about it like evidence and experience based. Right. So there may not be double blinded peer review studies on a lot of the work that we're engaged in or much of the work that we're engaged in. But that doesn't mean that there's not evidence and it doesn't mean that there's not life saving experience that's been had there. And in terms of data, I don't I don't necessarily think that that saying data and saying we're going to require data and review data is a me as it is a way to be restrictive in excluding certain programs or certain efforts, because a lot of that doesn't have it. But looking at data as a way to level set and to help us understand where the needs are, whether it's geographically or programmatically, some some geographic regions will have much less. Obviously, that's the way that I take it. So I don't I don't think about this at all. Like if there's

a if there's a program, a syringe exchange, an overdose prevention center that I've seen in the emergency department directly save lives, that just because they're they're not published in the journal doesn't mean that that's not a program that's worth supporting.

Speaker 1 I would agree entirely. And I would also say that, uh, I think that the asks for data which should continue to come from this committee over the next 18 years, shouldn't be the condition that holds us up from making a decision based on promising experience. All evidence, which is evidence that's almost a hand up.

Speaker 3 Well, you know, we're talking about a lot of stuff that's it's not even happening yet. It's not it's not even happening yet. You know, the core courage treatment, you know, the people that need to help, you know, it's not spread out around the state. How are you going to get data about that? Wouldn't work when we haven't even done it yet.

Speaker 1 But we know we need to.

Speaker 3 We need to. So the point is we're going around in circles over here and get nothing done. What we need to do is say this has to be done, and then we'll look at it in two years or three years and see if that work or that didn't work, if it worked. Thank you, Jesus. If that didn't work, let's change it. You know, let's let's just move on, because we're going around in circles, you know, and I'd like to get to the goddamn meat and potatoes over here.

Speaker 1 Well, with all due respect, I think this is all meat and potatoes. I mean, we've we've spent an afternoon clarifying, beginning to clarify what's important to us as a board and how.

Speaker 3 It is rooted in addiction and vice versa. We all know that anybody that doesn't know that should not be at this table. So there is definitely a need to get people help who go in and out of treatment, in and out of treatment and and outreach. Because I've seen people that I've talked to treatment in one year, probably five or six times. Sure. Okay. So there's obviously just eschewed. Does not help.

Speaker 1 All right. So so we are a group that is hopefully going to be together for a while. We're clarify that they're getting to know people. What's important to you, too? We're coming up with a pretty maybe evident in retrospect list, but a good list. Another thing that we talked about today, by the way, and if you could maybe add to your whiteboard, there is the need to get people to the dam treatment and the quick access and how that, you know. So I think that well, I think it has to do with ? and transportation and that that has to be somewhere in our evaluation of whatever we talk about.

Speaker 3 Ashley That is that is so that is a great point that we haven't touched on yet.

Speaker 1 Well, but that should be on our.

Speaker 3 That's that should be one of the top.

Speaker 1 Okay. So this is not a waste of a patient. This is not a waste of time. This is meat and potatoes way.

Speaker 3 That's that's what I want to talk about. I love meat.

Speaker 1 Ashley. Please.

Speaker 3 And then I'll take the potatoes, too. All right. I'm not even over.

Speaker 1 I'm just trying to make the point. If we're all here with open minds and hearts, nothing is irrelevant.

Speaker 3 Let me just say.

Speaker 1 It's all meat and potatoes. Okay.

Speaker 3 You and I are going for dinner. Oh.

Speaker 1 Maybe it might be dangerous.

Speaker 3 I mean, let me just say something. We have treatment facilities in our part of the world. You know, just for you guys who lives on the other side of the Hudson, it's called New York State. We have facilities who discriminate against take in people. An excuse will always be well, they need makeup. Guess what? They walk in with a cane. Oh, they need nebulizer or they got. They need a wheelchair. Okay. What they need is all they have been here, and it hasn't been a month and they can't get in. Okay. We have to find a way of eliminating some of this dumb excuses, get people into treatment when they're ready and they want to. And the number one thing we had saved Americans so far in six months drove almost 70,000 miles because some treatment facilities in our part of the world don't want to take people that have mental health. So what's the answer to that? You know, we haven't come up with an answer to that and we can wait another eight or ten months because you know what? Those people will be dead. Right. So, Steve, I'm not done yet. Well, what I would like to see a discussion is to come up with some kind of answer. We have doctors who are sitting over here. We have mental health experts. We have providers. You know, I'm I'm just a taxi driver. But I'd like to see some things happening that would I know I call a treatment facilities. They're not going to tell me, oh, no, this guy's not coming in because he's argumentative. God dammit. I see people argue over a parking spot. You know, we need to get down to the basics that people can get into treatment and we can get them that, give them the transportation to get there and they don't get rejected. That's what I want to talk about.

Speaker 1 I will only say that we are. As close as we've ever been. But we are we are creating a list of what is important to us. So I don't yeah, I don't think we're avoiding getting to that. I just don't think right at this moment that until everyone feels like they've had their say, we're creating our vision.

Speaker 3 I totally understand that.

Speaker 1 I'm sorry. I have a.

Speaker 3 Program. You can have any evidence of data.

Speaker 1 I understand. I understand. I'm sorry. It feels slow, but I think we're getting somewhere.

Speaker 7 Ashley Yeah.

Speaker 2 Criteria that have to be evidence based before and probably, right?

Unidentified Yeah, fine. Yeah.

Speaker 1 Almost. Almost a due diligence review. I think someone had their hand up. Sorry.

Speaker 7 Yeah, I have maybe forgot. I think because we were talking, so. Oh, I know. All right. So we were talking about sort of what we have agreed on. Are we talking about what specific? Because I know that we just talked about transportation. Everybody kind of was in agreement. So are we there yet? There where like are we there to where? We want to talk about different things that are there.

Speaker 1 If you want to start?

Speaker 7 Well, I do I do think transportation is crazy.

Unidentified For the service so I can drive things and I will send it out here. So.

Speaker 7 What? Thank you very much. And I think, too, like for the mission and you kind of touched on it. I heard you say social determinants, but I also would like to focus a lot on underserved or not served populations. You know, when we talk about barriers and we talk about access to treatment, it poverty is huge, too, you know. So we need to really. But that's not what I was gonna talk about. So specifically for gender specific and maybe I'm partial, right? Because I'm a female, but there's a lot of lack of treatment. There's a lot of lack of services in general for women, especially women with children or pregnant.

Speaker 3 Yes.

Speaker 7 So, you know, and I feel like everybody that's probably not so controversial, maybe people can get behind that. But I was just kind of thinking of some things because, you know, I spoke to people that are out there in different programs, too, like, you know, potentially offering, because I think one of the things is like at risk. And I know somebody touched on prevention, but anyways, at risk youth, which could be just children in general, I think I'm not really an adolescent person. They're not my drive. But, you know, we do need like programs so that moms or new moms or women who, you know, and they're not protected either. Like if someone is actively using their essentially their child is at risk and I in of even being taken away and I don't think that's right I think that we really need to, as a group, work on strategies that are specific for women. Um, I will just say that like I have secondhand, not personal knowledge with it, but so that's something that I would like this group to focus on. And I think, you know, everybody's talking about data, but I do believe that we have to give out reports and we're going to get reports of how this money is spent and the efficacy of what we do. So I think that we're sort of commissioned with setting up case studies that look like recommendations, right.

Speaker 1 Dr. Lynch.

Speaker 6 Just a quick point to add to Anne's list, and I apologize if this was discussed before, but access to health coverage, um, you know, in the emergency department will treat you no matter what. But what happens after you leave the emergency department, it can be vastly different if you have health insurance or inactive Medicaid and getting you to an organization or in front of a facilitated enroll or in short order is really important.

Especially probably the most importantly for folks with substance use and or mental health disorders, their options go from slim to none when that happens. And just another just one other quick point about sustainability is that this is great if we can fund programs to get them going or expand, but if they don't have a plan to get their patients, clients, whoever are under some sort of health coverage, ambarella, it's going to be really hard to sustain that program moving forward. And, you know, what we see in the emergency department is substance use, a mental health disorder. Patients have a disproportionately high rate of not having of being on or under-insured. I think it needs to be a priority and our responsibility to make sure that we keep that in mind.

Speaker 1 You know, I think it would be a shame if we ended up coming up with a list of one shots that couldn't be sustained over time. That would be a crime. Yes Deb.

Speaker 2 Yeah. To add to its list, I think also it's important to add treatment of care.

Unidentified And supportive services. Case management here.

Speaker 2 Right?

Speaker 3 Yeah. Yeah. Right. And you said that she's going.

Speaker 2 To to.

Unidentified It by. Before that.

Speaker 2 Even.

Speaker 1 Yeah. Carmen. Oh, who said that? Justine, I'm sorry. You were justine.

Speaker 4

Speaker 3

Speaker 4 Okay. I just. I just wanted to add one thing, and that is that I.

Speaker 2 Haven't heard that all day, and that is legal services for sustainability. You know, they come with, God knows, a baggage full of legal legal problems. They can't move.

Speaker 4 Ahead. They they get treatment, they get workforce.

Speaker 2 Development, they get certifications. They get all kinds of health insurance, all of the amenities that comes with with recovery. But yet we don't look at the legal legal aspect of it all. But some of them have opened warrants that they have, felonies that they have, and they all are obstacles for employment and other other things.

Speaker 1 Thank you. Justine. Justine, you are raising your hand.

Speaker 2 I just.

Speaker 4 We lead by. Yeah. Just leap back to what Carmen was saying around the idea. I think it's someone had once said it's like an added social determinants of health, which is

the system itself. So DSS it. CPS, all of the things that keep people. So I know at least in our local area someone is.

Speaker 2 Known to use.

Speaker 4 I think it's use or make methamphetamines. They can never get housing again. So there are you know, there is. And and the.

Speaker 2 People who are.

Speaker 4 Criminally justice involved, black box, all of these things are huge issues that I think we need to spend some money.

Speaker 1 Thank you, Justine. Ashley. Well, Ashley had an end of.

Speaker 7 Okay, reintegration. That's somewhere where we're really failing.

Speaker 1 Prison jail.

Speaker 7 From and, yeah, from corrections into society. But I and I also just want to touch on to because you were saying, like, if you go to the ED, you get treatment. That's not always the case. Like maybe it is if you have a decent doctor. But in my area, the Adirondacks, that is not the case. You're very much what do they call them?

Speaker 4 You go for get out of the.

Speaker 7 Oh, get out of my emergency room. So I just want to ensure that like whatever we're doing, we need to have oversight, right? And I know there's supposed to be oversight, you know, at the state level, but I get it. Like, everybody can't do all of the things right. And so I just think that we need to be mindful of the different regions and maybe how things are not as good. Does that make sense?

Speaker 1 What I'm hearing?

Speaker 7 But I yeah, I just how can I just say one more thing? Because we keep talking about jobs for individuals, right? I'm just get I'll go on record. I don't care. You know, that sometimes I have to let people have my urine so that they can get a job. Do you know why? Because. Because jobs. Drug test. So because of someone's status as either active or inactive use, it's going to determine if they can have a job or not. And I feel like there's stuff that we could do behind that, too. Just because you use a substance doesn't mean that you're not, you know, worthy of having a job. I mean, and that, in essence, we're essentially creating that, you know, criminality. And then they go to prison because they're left to do something illegal because they can't work for their money to purchase their substance. So I just think, like, like we keep talking about it, but I really want to look at like the over art, like everything.

Speaker 1 I think if, if, if that falls in the category of barriers to recovery, I guess that's worth looking at. I think that depending depending on the job, of course, it may have. I mean, I'd like I'd like my airline pilot to have a urine test. I'm just saying.

Speaker 7 So, like, I mean, you work at a cafe.

Speaker 1 And I get your point. I'm just saying that there are there are parameters to this, of course. Avi.

Speaker 3 Yeah, there's there's another barrier to recovery that we encounter a lot as people, especially when when COVID came around as people that all the older folks, a little more mature folks who have medical conditions. And that stops them from going into treatment. So a lot of treatment facilities will not take somebody with asthma or what have you. You know, that's that's another barrier to treatment that we have to somehow address because there's quite a few hospital based treatment facilities who are not really hospital based, meaning it's a treatment facility based in the hospital, but that's about it. They're only going to do a study and you have a hospital there that can help some of these folks. But it's not being done. And I don't know if Oasis can somehow get involved with that and help with that, but that's something that we need to do.

Speaker 1 Well, one of the things that might in on our list of things that we want to kind of take into account and almost rate is does whatever we end up recommending remove a barrier? Because we all know that at some point we're going to have to be like rationing here. We all know we need more of everything. But does it remove a barrier, for example, is an important forum for me. That would be an important consideration. There's a lot included in that, but if it doesn't remove a barrier, it might be a little lower on the list. Stephanie.

Speaker 4 I think a topic that has only been peripherally touched upon when we talk about barriers, we're talking about systems barriers, but there is also caregiver and familial barriers. And so looking at things like craft and how certain modalities work alongside the process, while there are still those who have touch time with either providers or community groups that support, you know, only abstinence, contract writing, kicking them out. And so how do we kind of lift up programming that would support the family better? And then on the other end, as as we're reentering or not even, I mean some of the programming we're looking now at co-occurring is once a week therapy not an RTF like your home in in your community but some of them align with pro-social non substance using activities and for our teens transitional age, youth, young adults, most of their people, places and things when they're in the community setting getting treatment involve people who they've hung out with through the years who are often substance involved. And so how do we support programming that creates community hubs of positive pro-social activities? And so I just think that as we're thinking of the continuum of care prevention all the way through to sustainable recovery, whatever recovery looks like for that individual.

Speaker 1 I agree with that. I appreciate that. I think what we're also doing is identifying all of the contributing factors to suffering in our world because the absence of those kinds of things are really critical. Patricia.

Speaker 2 I just to have one thing that I had not heard at this table today is screening brief intervention, referral to treatment. I have not heard expert today and I would ask that you look at expert. How we can better integrate expert into communities and through the primary care system.

Speaker 1 Well, if I could if I'm sorry, Doctor, in just for moment, if I would just say so. I think we're just changing levels there for a minute. That would be an example of an intervention that could address quick access and cross system. And and so aspirin is certainly something we should consider. But I think it falls within.

Speaker 4 And it.

Speaker 2 Also falls into because sometimes we're very quick about espert to the treatment side is how do we better support the intervention side so.

Speaker 1 That at the point of contact.

Speaker 4 We'll kind of go on this. You want to go first?

Speaker 2 Yeah, I'll go first. My I'm so espert is really for questions and oftentimes they're not even people to people questions often oftentimes it's just somebody comes in and they give the four questions either through a machine or through some other. I'm not quite sure how. I mean, there's money in aspect. There's loads of money in in that spirit. Yes. If you look at some systems are fantastic. But so I mean, I, I guess I would go with your point, Stephen, that how does X intervention remove a barrier and as as ESPERT practice. It's, it's really they said we're really lacking in one on one that begins a conversation or even an honest conversation. So I just just just I.

Speaker 1 Appreciate I appreciate the counterpoint. And I'm going to ask that we when we come to talk about programs, interventions and specific recommendations, we come back to that just because the different level of of where we're at doctor went through the.

Speaker 4 Innovated it which was I talked to in.

Speaker 6 Just one point about under the prevention in the prevention bucket you know that there are if you go to an emergency department, we ask you all kinds of questions in triage that may or may not be relative to your life. But one question, one question or a couple of questions that are never asked in triage of everyone are mental health I'm sorry, mental health is now in New York, but but substance use disorder is not. And I can't tell you how many times that someone has come to the emergency department for some other generic complaint. And in the course of discussion, we realize they have a raging substance use disorder and sometimes not all the time, but that becomes a great opportunity to engage that person into offering treatment, offering them access to a low threshold place that they can go get a coffee and at least start on the process down. And I don't necessarily know if that's, you know, really a funding thing, but it's something that we should all keep in mind that we ask all kinds of questions about suicidality. Do you have firearms in the home? Do you feel safe in the home? Through adding a question of substance use disorder, however, we would ask that I guarantee would save lives.

Speaker 1 Right? So so one example is your point about asert, but it's not the only way to do it and it's probably not the only.

Speaker 6 Aspirin, certainly a tool that can be used and and not necessarily every, you know, not necessarily applicable to every single circumstance. One one drop to add to the bucket of access to care, though, is telehealth or telemedicine or virtual access actually quite mentioned earlier about that. There are places in the state that have really minimal treatment. Brick and mortar treatment facilities, while extending access at least virtually might not be the solution for everyone. But we saw in COVID that there was certainly a lot of people that engaged in telemedicine that really kind of went rapid in the spring of 2020, that would have never sought care anywhere else what we did.

Speaker 1 And we also found that there were parts of our county that didn't have freaking Internet access.

Speaker 6 Right. Right. But that that might also be a way to check the box. You know, I was hearing offering kind of wraparound services, legal support to help people that have warrants, job coaching, to get them back on their feet and sustained recovery. Things like that are a that's a big pill to swallow for a small treatment organization that's out in the rural areas. Right. But if if the state kind of provided virtual wraparound services and let the clinic focus on what they're good at, that could that also could be a key to success.

Speaker 4 Can't I kind of put some of that under the heading of training on the side, the mental health side and the issue side, because I'm going to start with people don't want to do bad or not well, right. Oftentimes, they don't have sufficient training and how to do the intervention. So we're talking about training, broad workforce in the current issues and what to do with them is a point of intervention.

Speaker 7 Ashley So I hear everybody kind of like saying recovery. I guess I would just like to clarify, like what is everybody's definition of recovery? Because like I keep, like we're talking a lot about treatment. Treatment's great when an individual wants to engage in treatment. So I'd, you know, I'm sure I has a definition and it's like self-directed, you know, healthier, happier, but the individual determines what that is for them.

Speaker 1 So at earlier in the day when we were talking about Stephanie's document and I said I thought it was missing the word recovery for me, talking to people who come to our community, who marvel at the fact that it's rich in peer support and, and networks of peer recovery advocates, uh, I work backwards and say, well, we know what it looks like when there is no healthy network of peer support. So to me, you know, prevention, treatment and recovery just means to have that end of the continuum where however it is you're proceeding through your recovery. There is a support network in the community.

Speaker 7 I know. I just I just wanted to ask just because, like, I know we're I mean, treatment is great. Like I said, if an individual wants to go, but like I've heard intervention. And so sometimes I don't even think it's so much as like a, you know, I'm a peer, so I never go to my recovery and tell them what they're going to do. It's their plan, right? I just help them meet their goals. If I can move their ambivalence with other tools like motivational interviewing or whatever the case is, then I will, if you know what I mean. Or I can point out discrepancies if they tell me one thing, but like I, I just because a lot of times currently and this is, I guess my gripe, right, is that treatment is not supposed to like be the old abstinence based model. Does that make sense? But a lot of times it seems like abstinence is the goal and they're connecting abstinence to recovery. And I just want to be really cautious because sometimes abstinence is not the goal. And that's that's awesome. I've had people that have came to me with the goal of maybe they want to stop using cocaine, right? Because they're having negative life effects, but they still want to drink and they still want to smoke weed or they whatever they want to do. Right? I don't know. Maybe they only want to use cocaine on the weekends. So when they obtain that goal, I'm like, yes, welcome to recovery, because you're in recovery when you say you are. So, you know, I just want to make sure that we're not like focusing that like treatment is the only path to recovery. Treatment is the goal of someone getting into recovery. I just want people to have autonomy.

Speaker 1 I think we're not a I don't think we're a we in the extent that any of us would answer that question in the same way, I think that having recovery on the table and

allowing for there to be a network or a continuum of recovery supports and services is sufficient for me how you define it and what program it is, or even if it is a program. I just think it is. If you go back to the idea of reducing suffering, I think that might be an important part of it. Um, you know, we're kind of winding down and I would like to throw out an idea, uh, with some trepidation, but I'm not exactly sure why, because it seems like the long term idea. But Dr. Smith, Dr. Tom Smith, you might have some think they had on this. New York state has a psychiatric research institute. Why don't we have a New York State Addiction Research Institute? Why can't we finish? Please, why can't we begin to think about the 18 year path, even though we have problems in front of us, to start to develop the the the mechanisms to get us the data and the research that we're talking about wishing we had now. Now you've got to tell me there already is one I didn't know there was.

Speaker 4 Well, I mean New York State through OMH has has like the Center for Practice Innovation but like they for example, created the whole fit model focus on integrated treatment. So I wouldn't necessarily reinvent the wheel, but I would start accessing even though it's technically housed in Omeje. I think that every time we talk about this or that, we miss the point. I think that, you know, what I've encouraged at the state level, even with the legislature, is when you're talking about mental health and addiction, you should be talking about integration and just the overlay of everything to good. You're setting up another mechanism.

Speaker 1 Good reminder, we started with that point and we should remember it through that. I guess my thought only is. That we could lay the foundation for research while we are trying to solve more near-term problems than Dr. Lynch and Dr. Smith and Ashley.

Speaker 6 Just a quick offer. The University of Buffalo has a clinical and research institute on addictions, and I'd be happy to connect anyone at the state with leadership from there to not reinvent the wheel.

Speaker 1 I think it's worth not invent reinventing the wheel, but I think it's important to take ownership over research. Dr. Smith. I think.

Speaker 5 Dr. Thomas Smith, we have we there are two research institutes, the New York State Psychiatric Institute and the Nathan Kline Institute, which is in Rockland County. Those are state operated institutes. I love the idea of a third addiction research institute, but that may be hard to do. We do have there is a pretty significant substance use research division at the New York State Psychiatric Institute. They're doing much more basic research, however, not so much translational or applied research. But this group, this board could charge them a challenge that it's a state. Right challenge or task them with doing something along the lines. Stephanie said more like what CPI does or having more of a translational or practical approach to some of their their findings.

Speaker 1 It's hard to really get my head around that, but we are at the front of a generational task and it could very well be that in 18 years research that starts next year could be fundamental in that paradigm shifting.

Speaker 5 That's usually how long it takes, unfortunately.

Speaker 1 Well, then another 20 years before it's integrated into practice, right? Somewhat of a problem.

Speaker 7 Yeah. Me, we, we can also commission I think, or ask for studies to be done as a as a board and something that I think that we should add to the list and is medication for stimulant. Like I meant it. So we talked about this in the past. Okay, so you guys, everybody's like always talking about medication assisted treatment, medication assisted treatment, right? So we can, you know, individuals that struggle with alcohol use disorder, we could give them a medication, individuals that struggle with opioid use disorder, we can offer them a medication. I know that there's been some studies done on like risperidone, which is an antipsychotic for cocaine dependence. There's been other like I believe maybe the ad or what was it, maybe that's so like I'm just going to, you know, really begin to look at right at what.

Speaker 1 We should.

Speaker 7 Be. And I think that we could do that under this because we are beginning to see cross contamination in supplies. So even though we're the opioid settlement board, I believe that that would be something that we could.

Speaker 1 Do or I think that would really be great.

Speaker 2 Just one clarification from settlement agreements and statute. So I believe the limitation is that it has to be according to the settlement agreements, OST, opioid use disorder and co-occurring substance use disorder. So just noting that clarification.

Speaker 1 Well, yeah, we can, we could look into that. I think that I'd like to stick to. Yeah.

Speaker 2 Just one friendly amendment. So what. And just mentioned I would also in the I would like to see us really push for research to practice in a more expedient where I think things stay in the laboratory for too long.

Speaker 1 All right, here, here, here, here. Um, all right, so we're. We're approaching the 5:00 hour. I am. I think this was meat and potatoes. And, um, and I thank you for that. I. Tomorrow, we. Hopefully Peggy or Shay will be better. Whatever ails her, if not her.

Speaker 2 Not her confirmation.

Speaker 1 Okay, well, I'm hoping for that. I'm hoping that if not her, someone will speak for her. We have the minutes that I've sent to you to review. Um, what does that say? Oh, think about the next meeting. Well, I mean, not tomorrow. Yeah. Right. Well, we have to think about, but let's get through tomorrow. I think we can start to begin to talk about, um, if we can get a budget discussion tomorrow, I think we're. Then we're at the place to start talking about recommendations. You know, I would like to just ask Avi. Um, Dr., um, Easterling, we haven't heard from you. Are you okay? Are you okay out there?

Speaker 3 Yep. I'm good.

Speaker 1 All right, good. We appreciate.

Speaker 3 It. I received the minutes from the last meeting.

Speaker 1 Okay, we'll. We'll send them to you. But I appreciate your being there to give our regards to your boss. Yes, sir. Avi, sir. Yes, sir.

Unidentified So are we.

Speaker 1 Headed for future meetings? Yeah, I. I think we could. I think, though, that we have to really be aware that crunching meetings together like we have makes it hard to get information out to you.

Speaker 3 I understand that the meeting is based on a monitor.

Speaker 1 Right. I'm thinking that already the the discussion about I think with a two and a three, that might be way too soon. But let's talk about that tomorrow. All right. I think that I don't know about you guys, but at my age, this the this is starting to get challenging. So perhaps we could have. Yes, ma'am, I. Could you go to the microphone? We can hear you, please. Uh, yeah, if you can put them on the table over there. Yes. Hi.

Speaker 4 Hi. My name is Diana Kowalski. Brigadier. My son died of a drug overdose in 2019. My brother's birthday. I would like to know who on this panel has lost a child to drug overdose. And I'm very sorry for that, for your loss or anyone else that has lost a loved one. So when I listen to everything that is being talked about here, I have a feeling of urgency that is needed for this this board.

Speaker 2 To continue.

Speaker 4 Quickly because there are other people that are out there dying all the time. My son struggled for years with a learning disability. He had mental health issues and then subsequently substance use. He went to jail and after he went to jail, his mental health status declined and he died. So there is the great pain that I feel. And when I listen to you, you know, I know that there are laws and I know that there are charters, and I know that there is bureaucracy and politics involved. But I urge you to act quickly and I ask you to please focus on what you're doing, because everything counts, every minute counts. And there and the pain, the excruciating pain that you have to live with when losing a child is unbearable. And I thank you for the work that you're doing, but I urge you to move along and act quickly. Thank you.

Speaker 1 Thank you. The motion to adjourn.

Speaker 2 So.

Speaker 1 Yeah. Whoo hoo! Bill and Ashley. All right, everyone. I'm assuming that that would be voted in the affirmative.